

## **Bundle BCU Health Board 29 January 2026**

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## SUPPORTING PACK INFORMATION

### Health Board Action Plan Response to the RCPsych Invited Services Review – Review with Expert Advisory Group Input

As at 31 December 2025 (working document updated monthly)

Progress against the theme’s improvement actions outlined in the Royal College of Psychiatrists Invited Services Review as at 31 December 2025

Legend for Progress Status		
Colour Legend	Category	Number
Blue	Not reviewed by the Expert Advisory Group	12
<p>Those actions not receiving assessment by Expert Advisory Group received a Red, Amber or Green Rating by referring to the Evidence of Outcomes Group.</p> <p>Amber ratings have been attributed even when an action (early on in the process may have been completed) The focus has been on what impact this is having on a patient or family now and how this can be demonstrated</p>		
Green	Effective Progression	44
Amber	Progressed but need more support to embed	30
Red	Requires further focus	6

Theme 1 - Patient and User Centred Care Individual Priority Milestones Report						
No	Action	Assigned Too	Date discussed at EAG	EAG feedback	EAG Chair comments	Update since EAG meetings held
1.1	Progress the recruitment of the MH&LD Nurse Consultant Dementia.	Assistant Director of Nursing	16 <sup>th</sup> and 29 <sup>th</sup> May 3 <sup>rd</sup> July	The new nurse consultant met EAG members in June 2025. New in post, she was supporting a discussion and did not have allocated time to talk with members. She has subsequently met Tawel-Fan families to discuss progress in dementia care in mental health and the health board.	The new dementia nurse consultant focussing in older people’s mental health has been in post since May 2025 . In September 25 she met three Tawel fan family members sharing insights how she is leading dementia care in MHL and the wider HB. For Older Persons Mental Health to thrive, it is important the service has the right clinical leadership to support good care and a healthy culture. The Nurse consultant is a member of the Older Persons Mental Health Clinical Pathway group which has full Multi-Disciplinary Team leadership. Supplementary information requested in November 2025, has provided evidence of the Terms of Reference of this group, its meetings and focus. This looks sound, so long as Older Persons Mental Health clinical and operational leaders with full Board support can influence priorities for focus and development, and that these priorities are realised.	Older Persons Mental Health Clinical Pathway Group report into Service Transformation Delivery Group and Divisional Senior Leadership Team for awareness and input of clinical leadership in Divisional Tier 1 and Tier 2 meeting forums.
1.2	Achieve Finding the light in Dementia Care training compliance across the MH&LD Division to 85% for Tiers 1, 2 and 3	Training, Development and Wellbeing Lead	29 <sup>th</sup> May	Training in dementia care was considered essential for all clinical staff to ensure the lessons from Tawel fan and Holden and the other reports have been learned. We did not see data for all staff.	The dementia nurse lead presented information. This needs to be updated to look at the overall compliance levels in Mental Health and Learning Disabilities now. A 90% level of compliance or higher needs to be sustained and the training designated as mandatory ( if not already). Noted that staff prefer face to face training. It is good to see the current level of compliance for dementia awareness training. This has three levels and it is not clear which level this refers to. If Level 1 then this is at a basic level and Level 2 and 3 is relevant for staff working in OPMH and MHL. It is understandable that there is a need to streamline two sets of training on the same topic.	Divisional review of Dementia training across the division currently being reviewed by Training and Development Lead and Consultant Nurse Dementia. Discussed as part of the Mental Health & Learning Disabilities Training and Development Group meetings to agree the approach going forward.  Compliance reporting for Finding the Light in Dementia (FTLID) training requires further focus. As agreed with the Training and Development Lead, current systems do not provide accurate or

						<p>complete attendance records, nor a reliable breakdown by staff group or tier. FTLID data is held manually and is not integrated into Electronic Staff Record (ESR), limiting assurance around compliance percentages; any figures should therefore be presented as indicative only, with clear caveats.</p> <p>This is separate from mandatory Dementia Awareness (online) training, which is reliably reported via the Workforce Compliance Dashboard and currently shows 89% compliance. FTLID and Dementia Training Levels 1–2 are instead reported through ESR BI Education &amp; Learning dashboards, with validated data currently limited to MHL D for the period 01/01/2020–13/01/2026, pending more robust data capture and governance arrangements.</p>
1.3	iCAN teams to attend CMHT's and other opportunities such as Third Sector, Local Authorities and other partnership to present activity locally to strengthen partnership working and improve awareness.	Head of Integrated Strategy and Development	5 <sup>th</sup> June	Presentation 5 <sup>th</sup> June	<p>The presentation showed several meetings taking place. Expert Advisory Group members heard about strengths and weakness reported by the public. Positives included : kind and compassionate staff, feeling heard, receiving clear explanations, on time appointments. Weaknesses included: parking and accessibility, food, short notice cancellation of appointments, inconsistent communication, medication issues. This feedback needs collecting into themes and evidence about what has happened to address the issue demonstrated.</p> <p>There needs to be consideration of how impact can be assessed from the partners perspective This is ongoing work and will need to be monitored.</p>	<p>Divisional Patient, Carer experience meetings held, recently increased membership. Patient Stories shared, Caniad feedback and CIVICA reporting standard Agenda item.</p> <p>Ongoing development of Service User Engagement Plan, workshops held during 2025. Feedback and agreed next steps currently being developed.</p>
1.4	Use data to capture real time patient feedback and experience through the MH&LD Patient Carer Experience group to embed patient and carer centred care and demonstrate commitment to becoming an intelligence led and learning organisation.	Assistant Director of Nursing	5 <sup>th</sup> June	EAG members asked how this will be accessible to people with protected characteristic for example people with dementia or LD amongst others	<p>Mental health has been the first to map CIVICA to all mental health teams. This is significant progress. This is the basis of gathering real time patient experience data at source. The numbers are very small at present and a plan for scaling this up to receive feedback from ALL teams including Older Persons Mental Health, Adult Mental Health (and Learning Disabilities &amp; forensic) and all dementia services. Developing expertise to do analysis and ensuring it is feedback at team level are also crucial. Ensuring CIVICA is adapted to meet the needs of people with communication difficulties including dementia and LD needs to be built into this approach.</p> <p>Using the feedback to improve services needs to be demonstrated. This work has commenced and needs to be developed at scale. It is work in progress.</p>	<p>CIVICA Task and Finish Group currently linking in with Learning Disabilities and Older Persons Mental Health services to support bespoke feedback.</p> <p>Current CIVICA initiative for the Division is to interduce "Feedback Friday"</p>
1.5	Plan and attend bi-monthly engagement meetings with Head of Operations and Llais.	Head of Operations and Service Delivery	5 <sup>th</sup> June	Meetings commenced Nov 2025 on a 12-month schedule	Llais confirm meetings are taking place and planned going forward.	Reoccurring six monthly meeting schedules in place with all the five area triumvirates. To still arrange quarterly meetings with Directors.
1.6	Further develop the model of patient and carer engagement to ensure people with lived and living experience of our services are at the heart of the planning, delivery and evaluation	Assistant Director of Nursing	29 <sup>th</sup> May and 5 <sup>th</sup> June	Recognition this is in early stages. Whilst there has been significant engagement with EAG members, the support to offered individuals and satisfaction with participation and equal partnerships is not felt by all.	<p>Expert Advisory Group heard about engagement activities taking place . From Llais visits they saw good evidence of ward level groups and a Mental health strategic group is recommended to pull together all the internal engagement activity engagement.</p> <p>Co-Production with people with living and recent experience is in its early stages and needs to be further developed as the norm.</p> <p>Recovery College development is very positive and this needs to be funded substantively as part of the mental health model.</p> <p>Potential to develop peer support workers in community and inpatient teams as a new workforce adds value and an extra dimension to support for service users and families.</p>	<p>Recovery College (RC) options appraisal completed and approved by the Divisional Senior Leadership Team. Alongside the Service User Experience (SUE) work, this appraisal will help shape the strategic direction for enhancing co-production and embedding lived experience across the Division</p> <p>A proposal paper is being prepared recommending the integration of both the Recovery College and Service User Experience initiatives under a unified Co-Production and Lived Experience Framework. This approach aims to streamline efforts, reduce duplication, and strengthen the Division's commitment to meaningful service user involvement.</p>

	of services as equal partners.					At a national level, work is currently underway to develop a National Lived Experience Implementation Plan. The proposed direction within BCUHB aligns well with this emerging framework, positioning the Division to contribute proactively and remain at the forefront of best practice in co-production.
1.7	Review Local Authority (LA) working model in Community Mental Health Teams to ensure collaborative partnership working .	Director of Operations	Clinical services organisation presentation not detailed	Not reviewed in EAG	Expert Advisory Group has not looked at any evidence on this in detail. It is an important element of the care pathway to ensure good care and continuity of care. EAG Chair is aware there was a Community Mental Health Team presentation to Quality Safety and Experience Committee this year. The Report not seen but maybe a useful reference source.	<p>Evidence of Outcome Group reviewed as amber.</p> <p>Director to Director Health Board and Local Authority quarterly meeting schedule in place with the six Local Authorities. Held with 4 and 2 planned. Agreed a collaborative agenda to include service pressures and joint working. Key themes from meeting held</p> <ul style="list-style-type: none"> <li>➤ Service user, staff and partner feedback</li> <li>➤ Demand on services</li> <li>➤ Commissioning cycle of business</li> <li>➤ Mental Health and Wellbeing Strategy</li> <li>➤ Welsh Government Ministerial Priorities</li> <li>➤ Royal College recommendations</li> <li>➤ HEIW investment</li> </ul> <p>In addition, CMHT Establishment Review progressing with joint workshops being held to enhance collaborative working and service design led by frontline staff.</p>
1.8	Develop and improve Dementia care data to provide consistent Welsh Government reporting from reliable and accurate data.	BCUHB Dementia Improvement Manager	29 <sup>th</sup> May		Presentations received at Expert Advisory Group and well received	Six-monthly reports are submitted to the Welsh Government via the North Wales Regional Partnership Board. These reports are coordinated through the North Wales Regional Partnership Board and inform the regional Memory Support Pathway (MSP) report. This enables assurance on performance, quality and delivery against national dementia priorities, while supporting regional oversight, benchmarking and continuous service improvement across North Wales.
1.9	Promote HB uptake of "Finding the light in Dementia Care" Training for all tiers, calculate current compliance baseline as at June 2024, agree compliance target and measure improvement in compliance during the next six months.	BCUHB Consultant Nurse Dementia	29 <sup>th</sup> May	This training is very relevant and important to Tawel-fan family members. Important too for all areas with dementia patients within the Health Board	<p>The measure was overall Health Board uptake and the data reflects this. Update provided in June which there had been good attendance and feedback and no further information has been seen by Expert Advisory Group. This will continue into the future to be important measure.</p> <p>MH/LD needs to have and be informed by MH/LD data at team level which may show a different picture. This needs to be picked up in the oversight group.</p>	<p>Divisional review of Dementia training across the division been reviewed by Training and Development Lead and Consultant Nurse Dementia reviewing.</p> <p>BCUHB Dementia Awareness training compliance at 83.03% as at end of November 2025</p>
1.10	Continue engagement with Tawel Fan families via the Expert Advisory Group monthly meetings.	Director Of Partnership, Communications and Engagement	All EAG meetings Nov 24-October 25	Group meetings and one to ones have taken place throughout the year	<p>This has taken place with those families who chose to be involved. Involvement in the future to be determined through discussion with Tawel fan families.</p> <p>Tawel fan families feedback that the overall report findings are generic and it is important to maintain a dedicated focus on OPMH and dementia services and keep them informed.</p>	<p>Communication with Tawel Fan families is important to continue, especially to follow up on points they have made most recently. The reports to QSE Committee reflect this sentiment.</p> <p>The EAG Chairs Report has been shared with members of Tawel Fan families who were not members of the EAG.</p>
1.11	Continue engagement activities from Llais Wales, Patient Advice & Liaison Service, Caniad, wider partners and stakeholders aligned to	Director Of Partnerships, Communications and Engagement	5 <sup>th</sup> June	Llais have been engaged continuously in the EAG. They have also undertaken visits to wards.	<p>Forward plan not seen . Evidence of activity but less of impact. What are the issues and concerns people are raising and how are they being addressed?</p> <p>Feedback from Llais visits to AMH inpatient wards is included in the main Report. OPMH visits and AMH revisits are planned.</p>	See update for 1.3, 1.4 and 1.6 above to satisfy requirement

	patients and carer co-working.					
1.12	Organise opportunities to include Local Authority colleagues in Operational and strategic planning meetings.	Director Of Partnerships, Communications and Engagement	-	Not reviewed by EAG	Terms of reference for strategic partnership groups with Local Authority representation maybe useful, including evidence of meetings and feedback from them and how this is taken on board.	Evidence of Outcome Group endorsed as Green Supporting information provided by Head of Integrated Strategy and Development and include Regional Partnership Board Terms of Reference and meeting minutes
1.13	Undertake a Quality, Compliance and Outcomes audit of the DoLS applications in line with DoLS Legislation to inform Safeguarding training developments to highlight the required learning outcomes evidence by recognised themes.	Director of Safeguarding and Public Protection/ Head of Safeguarding Adults	16 <sup>th</sup> May	Personal experience of the impact when a timely capacity assessment did not take place highlights the impact this can have on families an importance to get this right.	Expert Advisory Group has seen evidence of the audit findings. This showed some areas of relative compliance and also poor performance. One audit showed @20% in and family involvement in capacity assessment. This needs a date for re-audit and the family involvement narrative needs to be fed into Mental Capacity Act training and completion of documentation.	6/01/26 – current numbers would suggest that 25.6% increase in the number of DoLS referrals and a significant reduction in the number of errors. In December 2025 12.7% of all referrals containing errors compared to 20.9% in 2024, this shows a significant improvement given the increased number of referrals. All assessments involve family where applicable unless there is a safeguarding issue or if the family is unable, evidence of this within internal audits, on every Best Interest Assessment form there is a section that records discussion with family, compulsory part of the form.  Internal audits are completed monthly and provided into safeguarding forums, Mental Health Capacity and Compliance Committee to provide Executive level oversight of the improvements or areas of consideration.
1.14	Develop Data Incidents tool to support identification of incidents and those resulting in Harm involving patients with Dementia.	Director of Safeguarding and Public Protection/ Head of Safeguarding Adults	27 <sup>th</sup> June & 3 <sup>rd</sup> July -	This was very important for families whose relatives had been harmed through poor or neglectful / abusive care.	System for reporting incidents has been shared and discussed by Expert Advisory Group. This is a real time measure for the future, and part of the Older Persons Mental Health and dementia workstreams. There is a need to develop specific Older Persons Mental Health trends and reporting. The clinical pathway group has a section on Quality Safety experience Committee and learning agenda	Adult at risk report is now able to reflect all incidents where the adult at risk is a person living with Dementia. Datix systems still in progress for adding the Dementia box. (national system beyond Health Board control) Adults at risk themes and trends are developed and reported weekly to the MHL Divisional and local level groups  The current capability within Datix until the national team makes changes can report on incidents aligned to Older Persons Mental Health and memory services.
1.15	Develop supporting materials to support the application of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS).	Director of Safeguarding and Public Protection/ Head of Safeguarding Adults	29 <sup>th</sup> May (TW)	Not reviewed by EAG		Evidence of Outcome Group endorsed as Green  Taken from the evidence form submitted and approved in April 2024. Easy-read MCA, DoLS and Best Interests materials have been developed, ratified and evaluated through the Safeguarding Reporting Framework to ensure they are accessible for staff across all settings, including isolated units, and have since been distributed Health-Board-wide. Additional Welsh Government funding enabled a secondment into an MCA Training Lead role, strengthening training delivery and resulting in increased compliance with mandatory MCA training during 2024–25. Compliance with MCA/DoLS documentation has also improved significantly, with recent data demonstrating a 25% uplift across services, supported by evidence in the latest Mental Health Legislative Committee Report. DoLS and MCA remain recorded as a Tier 1 risk on the Safeguarding and Public Protection Risk Register, monitored monthly through established governance routes, and no barriers to progress have been identified.  Improving the quality and reducing the errors means the assessments can take place in a more timely way. We are able to contact the

						correct individuals involved in the patients care and be more pro-active in relation to responses. Further quantitative data is above in 1.13.
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**THEME 2 - Legislation and Clinical Guidelines  
Individual Priority Milestones Report**

Priorty	Action	Assigned Too	EAG date	EAG members comments	EAG Chair comments	Update since EAG meetings held															
2.1	Undertake an Audit of falls data from Datix to highlight key learning to adopt into training, development and Improvement	Assistant Director of Nursing	16 <sup>th</sup> May	Family experience where falls were not appropriately reported or communicated.	An audit of falls in Mental Health wards initially showed relatively poor compliance with standards, Re-audit showed significant improvement. Plan for further reaudit and reporting to the new development group is needed. EAG heard these standards are now routinely included in Matrons audits which is good practice to receive monthly and not just through audit. It is important the new oversight group gives attention to the results/ outcomes. It is good to see they are included in the Practice development regular update.	Evidence in Matrons Audit reported into Quality Safety and Experience Committee – to ensure sustained. Clinical Effectiveness Group receives a Practice Development Nurse update.  Amber because there was no evidence provided of a reporting by team level or ward level as a result of the work. This has been requested but not received at time of report.  A MH&LD Falls report is submitted monthly into HB Fall meeting. Report includes <ul style="list-style-type: none"> <li>Falls data and link to Health Board wide data</li> <li>Patient handing safety training</li> <li>Falls Mandatory training</li> <li>Falls Champions activity</li> </ul>															
2.2	Increase attendance at current "Tool Box" talks by consideration of establishing MH&LD Divisional Learning Forums developed across all teams. Monitor, review and report into monthly Service Quality Delivery Group (SQDG).	Governance Lead		Not reviewed by EAG	Supplementary information shared in November show evidence of Learning Forums and Terms of Reference	Evidence of Outcome Group endorsed as Green  "Tool Box Talks" approach now aligned to the Health and Safety Executive Notice of Contravention training. Development of a Training Guidebook.  Part of training incorporates a competency assessment. The Restrictive Physical Intervention training will be undertaken in a purpose-built bedroom, to provide realistic training examples. Training Feedback also part of the new process to assess the impact of any training.  Therapeutic observations and search, restricted and prohibited training has been developed and this is recorded in ESR and monthly reports are provided by the planning and performance manager.															
2.3	Increase deteriorating patient training compliance across the Division from current level to 85% compliance. Monitor and review at MH&LD Training and Development Group meeting.	Training, Development and Wellbeing Lead	16 <sup>th</sup> May	A significant area of interest for families. This training is very important to ensure any preventative interventions, good basic physical care for inpatients and early identification of problems and responsive, effective physical care at the earliest opportunity	Training has taken place . Coverage needs to be all staff rather than a more modest target . Need update on current position. Plan to pick up in training matrix.	RRAILS and National Early Warning Score 2 training numbers reported into Service Quality Delivery Group. Training figures reported for December 2025 are as follows – <table border="1" style="font-size: small;"> <thead> <tr> <th>Module</th> <th>No Staff Completed Previous Month</th> <th>No Staff Completed Current Month</th> </tr> </thead> <tbody> <tr> <td>000 NHS Wales - National Early Warning Score (NEWS) (RRAILS)</td> <td>191</td> <td>192</td> </tr> <tr> <td>050 BCJHB Recognising &amp; Responding to Deteriorating Patients</td> <td>312</td> <td>402</td> </tr> <tr> <td>000 NHS Wales - NEWS2z Mental Health</td> <td>507</td> <td>546</td> </tr> <tr> <td>000 NHS Wales - NEWS2z Acute</td> <td>288</td> <td>296</td> </tr> </tbody> </table> <p style="text-align: right;">Awaiting adding this Health Bord wide mandatory training onto Electronic Staff Record, in order to capture compliance levels.</p>	Module	No Staff Completed Previous Month	No Staff Completed Current Month	000 NHS Wales - National Early Warning Score (NEWS) (RRAILS)	191	192	050 BCJHB Recognising & Responding to Deteriorating Patients	312	402	000 NHS Wales - NEWS2z Mental Health	507	546	000 NHS Wales - NEWS2z Acute	288	296
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2.4	Complete consultation and approval of Physical health Strategy in preparedness for implementation.	Medical Director	27 <sup>th</sup> June and 15 <sup>th</sup> August	Member's feedback this should have been in place many years ago. This is an area where people with living experience gave an example that Welsh and Health Board standard to have a physical health care plan as part of a comprehensive care plan was not met. It led to a wider discussion about care plan standards and how Health Board is meeting all elements of the mental health measure including access to a care coordinator and the person being involved in developing and agreeing their care plan. This was a Mental Health measure which has been in place for many years, yet it seems only now that a	The new physical health strategy has been developed and approved and a strategy for roll out is under development starting with inpatients. Dr Prem the lead presented it to one EAG group, but not all members present in the meeting he was available. It is a very comprehensive new policy which has been approved covering inpatients and outpatients.	This would be Amber as the action is consultation and approval which has been achieved. However, if it was to do with implementation this needs to be assessed in detail at team level. The new strategy is very comprehensive and thus is a big area of work for the oversight group to focus on. In order to be amber it needs an implementation plan and review at team level (with a date for completion) this will be sought but was not clearly available at the time of the report.															

				comprehensive policy and intention to do more to meet physical health standards consistently in all teams has been established.	<p>Whilst setting some clear standards there are concerns about the gap between aspirations and reality and the resources that will be needed (staff, premises and equipment) to deliver it.</p> <p>There are three core elements EAG highlighted. Evidence of a care plan including mental and physical health. Evidence it involved the person and their family and access to a care coordinator are vital elements of care which need regular reporting in the outcome's framework. How is this collected now or proposed to be collected? A supplementary paper was received by two group members about the mental health measure compliance which was subsequently shared.</p> <p>Identified as a priority area which has been escalated immediately for immediate management action ahead of publication of this Report.</p>	<p>In addition, the Mental Health Oversight and Development Group will oversee the matter raised regarding Mental Health Measure compliance through the Mental Health services division.</p> <p>30/12/25- MHL D communication plan now developed to support implementation of the policy, including inclusion on weekly bulletins and MHL D team briefings.</p>
2.5	Continue with the projected policy review, as provided as part of the National Collaborative Commissioning Unit (NCCU) Action plan.	Head of Governance		EAG member has highlighted a historical NCCU report on Hergest dated 2013. This needs cross referencing to current activities and plans. Some areas such as lack of permanent medical leadership on the ward and MDT staffing remain a gap.	<p>Document shared from MHL D but not discussed at EAG which showed all but one action completed. Elements of this may need to be picked up to ensure they continue to be implemented More information has been shared in November identifying how all actions from the plan have been implemented. Sustaining improvement will need to be picked up in the outcomes framework and other ways of reviewing performance and improvement.</p> <p>Policy extensions should be in place for all policies awaiting review.</p>	<p>Evidence of Outcome Group endorsed as Green</p> <p>Ongoing downward trajectory (which is positive) for policies expired review dates. Latest Policy Position report into Service Quality Delivery Group.</p> <p>MHL D currently has 85 policies/written control documents. Three policies to go through the process of removal, six approved documents being finalised and awaiting upload onto Betsi Net; leaving the Division with a projected compliance of 72% (increased from 52% in November 2024) documents within timescale. Apply Policy extension process to policies beyond the agreed review date.</p>
2.6	Continue to complete annual audits of antipsychotic medication prescribing, presenting findings to the Clinical Effectiveness Group to agree and learning to be implemented from the annual reviews	Deputy Medical Director	16 <sup>th</sup> May	This is an important area as inappropriate antipsychotic prescribing and administration was evident	<p>Annual audits presented. This gave reasonable assurance that the audits were taking place and prescribing met the standards . To be part of the ongoing clinical effectiveness work in the directorate Ensuring that improvement plans are implanted and annual audits remain in the audit plan will be important to see before closing this.</p> <p>Inappropriate prescribing was evident in the poor care of Tawel Fan relatives. The recent audit reviewed showed reasonable levels of compliance.</p>	Annual audits have taken place and evidence provided to Evidence of Outcomes Group.
2.7	Consider and agree use of tool for monitoring antipsychotic medication in inpatient settings.	Medical Director	Not seen	This is an area of interest and relevance for families . They were pleased to see evidence of audits taking place and generally of standards being met.	<p>In October the Chair heard about how proposed audit and the tool will be are used for community patients in care homes which is positive. Not seen any evidence.</p> <p>Clinical pharmacy input and audits has been developing tis but wasn't shared with EAG as part of Work Programme.</p>	<p>There is evidence for this and was approved by Evidence of Outcome Group in October 2025 - The evidence confirms the action has been met by showing that approved monitoring tools and policies for antipsychotic medication are in place, actively used in inpatient settings, and supported by audits and governance processes.</p> <p>Health Board Pharmacy have led an Wales group</p>
2.8	Progress the adoption of Learning Organisation Framework within MH&LD with direct support from BCUHB to enable learning to be shared, embedded and sustained within the	Senior Organisational Development Manager	Nov	Failure to learn and sustain improvement was a feature over many years. This is an area where EAG members feel health board and particularly mental health leaders have not demonstrated an ability to effect change over a protracted period of time.	<p>This needs focus at team level. There is developing evidence of the feedback loop but not of the impact this is having on improving safety, outcomes or reducing harm.</p>	<p>Evidence seen in November shows evidence of the Learning Organisation Framework within Mental Health. This included examples of closing the loop with improvements in teams arising from recommendations to demonstrate learning. However there needs to be more testing to demonstrate how learning has been embedded and sustained.</p> <p>Themes in reports showing the impact of learning something which needs to be demonstrated on a quarterly basis in Quality Safety Executive reports.</p>

	Division and the wider Health Board.					Repeated significant harms if highlighted indicate that more needs to be done to change culture and behaviour.
2.9	Undertake an audit of DoLS to highlight the required learning outcomes evidence by recognised themes / trends to integrate into Safeguarding /MCA/DoLS Training	Director of Safeguarding and Public Protection/ Head of Safeguarding Adults	16 <sup>th</sup> May	See above this audit took place and the level of patient and family involvement was unacceptably low.	It is important to focus on improving patient and Family involvement in future work  No confirmed date for re-audit planned reported to EAG	Endorsed for approval at Evidence of Outcome Group in July 2025. The DoLS audit identified training needs and informed updated MCA/DoLS training materials, with findings shared through briefings and forums, leading to improved compliance and reduced errors

THEME 3 - Governance Individual Priority Milestones Report						
No	Action	Assigned Too	EAG date	EAG members comments	Chairs comments	Update since EAG meetings held
3.1	Progress the approval of the Electronic Patient records business case to enable national procurement of an optimum system to replace Welsh Community Care Information System (WCCIS).	Head of Planning and Performance	15 <sup>th</sup> August	Lack of continuity of care, repeating information over and over again and care transitions were all issues EAG members experienced. Implementation of a full electronic patient record in mental health will be beneficial.	Action in progress and to deadline, action completion date 31/12/25. Presented at EAG on 15 August 2025. EAG members pleased to see the business case success, funds to support it and plans in place to procure and implement the new system and a small staff team to support this.	Making good progress – latest update. The Electronic Health Record procurement activity concluded in September 2025.  The Procurement Outcome report is currently held by the NHS Wales Shared Services Partnership Procurement team whilst a Procurement Assurance activity is undertaken by the Chief Executives of BCUHB and CTMUHB.  Preparation activity continues including the ICT device survey and procurement, launch of the digital skills survey and ongoing engagement with the teams involved.  All Ages Mental Health Project Board continues to mee monthly to progress the project. Programme Objective: To deliver an integrated shared care record for health and social care, enabling real-time access to person-centred information and supporting improved care pathways.
3.2	Audit on call medical staff to ensure they have their own personal login for Paragon.	Head of Operations and Service Delivery, SCS	16 <sup>th</sup> May & 15 <sup>th</sup> August	This was the paragon (forensic) electronic system. Are there any other systems where this maybe an issue? Have they been looked at?	The initial audit presented showed slow progress had been made. It was escalated for urgent management action. A re-audit presented by MHLD Operations showed improvement to @70% and an understanding a grasp of the issues being addressed. This is an area which needs management attention to ensure logins are not breaching GDPR and other standards. This will need to be picked up as work in progress. As it is not 100% and was a red risk for RCP, it was rated this as red not amber. EAG seen no further plan	All actions completed from previous action plan and re-audit scheduled for July, which will be reported into MH&LD PIDG. Action plan can be shared if required.  Additional assurance will be sought by Health Board digital team.
3.3	Progress the development of the MH&LD specific Ward Accreditation process and implement across all inpatient ward areas.	Practice Development Nurse	3 <sup>rd</sup> July	This was an area which there was a lot of interest. EAG members had a lot of feedback about the issue of ward accreditation. The fact that accreditation has been awarded without Section 12 being included (which was the MH specific standards). Therese standards were piloted in January 2025, and the level of co-production with people with living experience is unclear. Time frames for both are needed. There is a need to a re-audit using these standards and a timescale has yet to be approved. The view that internal accreditation was marking your own homework in a system where historically this has not driven improvement was raised. The value of external accreditation was discussed AIMS is the gold standard. It is not clear why decisions were taken to stop AIMS accreditation in 2018. And it is not clear what the future decision will be to restart external accreditation which would be valuable and also support the RCP Action to have more access to external benchmarks.	EAG had a detailed presentation on ward accreditation in MH/LD and its current status on bronze accreditation in most wards and three silver accreditations. This is a baseline audit and the plan for reaudit using the newly developed mental health standards was not shared. This is a priority to be completed.  The Chair supports to use of effective internal accreditation which includes peer audits and people outside of the mental health services being involved. It is best practice to use external accreditation in addition to internal accreditation AIMS is one approach Safewards is another  Information and insight from Llais illustrated that they and Health Board staff met with the All-Wales Mental Health Patient Safety Programme Team in early November 2025 at the Hergest Unit.	MH&LD modules developed. Awaiting Health Board system set up and ward inspection schedule. The interim Ward managers and Matrons continue to complete weekly and monthly checks which are reported into local and divisional Service Quality Delivery Group. Concerns are flagged from related issues that need attention  As described in the previous column the Health Board has been engaged with the Saferwards programme and this will need to be fully explored and considered in collaboration with Llais.

					<p>The Safer wards initiative has been very well received worldwide and initial trials in Wales have been successful. See the link below. Safe wards.</p> <p>The Chair was informed in January 26, that Hedfan unit has been part of the safe ward pilot sites in Wales. This is a positive move towards adopting external accreditation for inpatient wards, with the ability to compare practice across Wales, the UK and internationally.</p> <p>Llais believe that implementing the Safer wards project could be an alternative to Ward Accreditation. Saferwards is an ongoing proactive process. Accreditation is reflective and addresses issues after they have happened</p>	
3.4	Deliver engagement and socialisation activities aligned to the outcome of the MH&LD Operating Model review	MH&LD Director	3 <sup>rd</sup> July MH/LD structure and management discussion		Action in progress and to deadline, action completion date amended to 30/9/25. EAG were informed that a needs assessment had been completed and a business case was under development. No documents were seen. Whilst part of a wider Health Board operational review the lack of progress in this area which dates back to the original reports and recommendation over twelve years. It was good to hear in the October update about progress being made. However, this has not been reviewed by EAG or the Chair.	<p>Approved by Evidence of Outcome Group as Green</p> <p>Based on activity carried out in the absence of the HB progress with the Operating Model review, a range of engagement and socialisation activities have progressed i.e., Older Persons Mental health reflected in the Management structure as demonstrated in 5.2, reduction in interim roles and increase in substantive roles as in 5.1 and increased DSLT visibility through the implementation of the DSLT walkabout schedule as shown in 8.2 and 8.3.</p>
3.5	Develop and implement a robust process for sharing all learning from Serious Untoward Investigations with MH&LD and the wider Health Board.	Head of Governance	27 <sup>th</sup> June	This was an area of interest for all EAG members	<p>Action in progress and to deadline, action completion date amended to 30/9/25.</p> <p>EAG had a helpful presentation. A lot of work has gone into developing the process across the Health Board appears comprehensive. Reports EAG has seen are general across Health Board not Mental Health specific. Information specifying trends between teams for comparison and external referencing still needs to be developed. It is a good start and needs further development to ensure reports are more detailed and include benchmarks. It is also important to ensure action and improvement is linked to the learning outcomes that can be evidenced. This data also needs to be demonstrating impact in terms of reducing harm and mortality rates.</p> <p>In October 2025 more papers were received detailing the shared learning framework process with some examples.</p>	<p>The Divisional Learning Framework has been approved by the Division, albeit without additional resource at this time. However, despite this, MHLD are able to demonstrate learning and action through the below which are identified within the Divisional Learning Framework:</p> <ol style="list-style-type: none"> <li>1. The Divisional Learning Forum</li> <li>2. Sharing themes from mortality with the clinical effectiveness Group</li> <li>3. Presenting learning at the Organisation Learning Forum</li> <li>4. Regular attendance at the Organisational Learning Forum</li> <li>5. Implementation of the Actions from concerns/incidents Task &amp; Finish Group (ACIG)</li> <li>6. Planned Learning Events</li> </ol> <p>To further improve learning and action it is hoped that when additional resources become available learning activity will progress towards evaluating the impact of learning in the future.</p>
3.6	Develop a portal to communicate monthly Putting Things Rights learning in line with the Learning Organisational Framework to promote a lesson learnt knowledge.	Head of Governance		Not reviewed by EAG	<p>EAG heard this is in progress, not to deadline.</p> <p>Looks like a management action is the next step which does not involve EAG. This needs a rationale about how it will be met in other ways.</p>	<p>Approved by Evidence of Outcomes Group as Green</p> <p>Integrated Concerns Operational Panel portal update provided and reviewed by Peer Group.</p>
3.7	Establish a Health Board Oversight Group to ensure delivery of the Response plan including the approach	BCHUB Associate Director of Governance	21 <sup>st</sup> March	QSE groups and EAG and Evidence of Outcomes Groups established and met	<p>The governance structure supporting the review was discussed at EAG with input from members.</p> <p>This has been in place and has generated a lot of evidence. There is a building expertise in judging whether the evidence is adequate to close down the action. This will be finalised and approved through the new group draft Terms of Reference for Mental Health Oversight and Development Group. It would be helpful to share these with EAG members once formed.</p>	Mental Health Oversight and Development meeting, chaired by HB CEO, established with two meetings held to date.

	for evidence submission to discharge actions.					
3.8	Support with engagement events aligned to the MH&LD Operating Model to ensure all staff, partners and wider stakeholder are kept updated on progress with implementation.	Director Of Partnerships, Communications and Engagement		Not reviewed by EAG	Continue to evolve as Operating Model is confirmed	Evidence of Outcome Group rating as amber as needed more information that early progress was sustained. (Also note update for 3.4)
3.9	Support from Digital, Data Technology and Procurement colleagues to progress the implementation of Mental Health electronic patient records and change process	Chief Digital and Information Officer	15 <sup>th</sup> August		Action in progress and to deadline, action completion date 31/12/25  Presented at EAG on 15 August 2022. Evidence of good engagement and support was present at the meeting which will be ongoing. It is good news progress that the Welsh Government has approved the business case . EAG saw the plan for procurement and how team development and training will take place.	See update in 3.1
3.10	The development of an Integrated Complaints/Incidents/ Mortality Review Management Framework. To implement an Integrated Framework aligning the Patient Safety and Experience Departments	Deputy Director of Quality	27 <sup>th</sup> June & 3 <sup>rd</sup> July	An area of significant interest for all EAG members.  Presentation on how the new process works. Data and trend at Health Board level and data not shared specific to mental health . One EAG member has significant concerns about historic mortality comparative mortality data which appears to be showing BCUHB as an outlier , and no analysis or reports have been identified to review and explain these figures.  EAG saw no evidence to confirm whether the new mortality reporting process meets current mental health best practice and benchmarks with national and UK wide need to be developed.	Presentation demonstrating the comprehensive framework including integrated policy and process.  Data on current incidents Patient Safety Incidents and trends in mental health( rather than HB level ) not seen by EAG. Information requested.  Improvement in complaints waiting times and backlog which is good news so long as complaints are effectively resolved to the person satisfaction.  Detailed Mortality data in Mental Health not seen by EAG (data and trends at Health Board level )and were not shared at Mental Health or service line level.  The invited review states the importance of external benchmarks with external sources and best practice. This will be important to develop. Process for reviewing trends and detailed MH data to be examined in the new MH development meeting and compared with national and UK wide mental health services  The historic position on mortality data needs to be understood and explained to the Board and wider citizens.	Update on Mortality review was provided to one of the EAG members and there is a commitment to provide information from January 2026 to allow time for proper analysis.  This work will be fully aligned with a whole Health Board approach
3.11	Implementation of an agreed training plan for the Corporate and Operational teams in relation to Complaints Management and Patient Advice and Liaison Service (PALS).	Head of Patient & Carer Experience	5 <sup>th</sup> June		Plan in place, Training package shown to EAG members measuring impact at Mental Health team level to ensure compliance in all teams will be important	No further update required
3.12	Improve Complaints performance trajectory	Head of Patient &	5 <sup>th</sup> June	It was good to see the improvements in response times. However, EAG members were also concerned about the outcome. This includes evidence that in responding to timeliness targets, complainants also feel their	Evidence received of significant improvement. Data at the EAG meeting showed all overdue mental health complaints had been responded to. This needs to continue as a measure as this changes quarter by quarter.	Need to continue to monitor data to show sustained improvement.

	to achieve 75% of complaints responded to within less than 30 working days in line with PTR Guidance.	Carer Experience		complaint has been satisfactorily resolved. Personal experience is at variance with the outcome reported in the presentation.	Data seen subsequently shows a number of complaints with the ombudsman, this needs to be benchmarked .	
3.13	Implementation of the Telephony System to support an improved single point of contact for the public to raise concerns/enquiries.	Lead Complaint Manager and Patient & Carer Experience Lead	5 <sup>th</sup> June		Evidence seen this is in place. What impact this has had to improve access will be important to gather. Ensuring this accommodates people with communication difficulties such as dementia and LD	The impact this has had to improve access will be important to gather – update on data to show sustained improvement
3.14	Commence a formal campaign to promote how to raise concerns.	Lead Complaint Manager and Patient & Carer Experience Lead	5 <sup>th</sup> June	This is a very important area for EAG members. The ability to raise concerns is key to ensuring patients and families are safe from harm. This is an area that some family members feel the HB has not taken sufficient action to ensure new leadership and culture within the directorate is in place	<p>It is important to triangulate information, including:  Evidence of raising concerns and whistleblowing cases and outcomes.  Everyone’s responsibility to report any concerns,  Additional activities  Leadership walks arounds feedback  Health Improvement Wales reports, Llais visits, staff survey results and sources of patient and family feedback.</p> <p>Evidence of impact, including evidence staff are raising concerns and / or feeling they are able to, and evidence leaders have listened and responded.  Evidence of staff engagement at team level. Evidence that staff feel well supported by their managers. There is more triangulation and validation of the impact of the approach needed at team and service level.</p>	<p>Cultural Dashboard developed – shows key measurements.</p> <p>NHS Staff Survey responses increased for HB and MHL. MHL increased from 16.9% to 23.7%.</p> <p>Wellness, Work and Us Team will continue to be involved in reviewing the themes and trends of the responses.</p>

THEME 4 - Staffing Individual Priority Milestones Report						
No	Action	Assigned Too	EAG date	EAG review /comments	Chairs review /comments	Update since EAG meetings held
4.1	Recruit to the position of MH&LD Director of Nursing post.	MH&LD Director	Reported recruitment taking place Summer 25.	New Director of Nursing to meet EAG members to hear about their experiences first hand	In progress and due within deadline (30/11/2025) Interviews held on 15 August 2025. Appointment made and person started in post in November 2025	Zoe Prince commenced in post on 14/11/25. Four-week induction plan developed and implemented .
4.2	Recruit dedicated Consultant Psychiatrist for the Hergest Unit.	Medical Director	Not seen at EAG. update requested and received in November	This was a factor highlighted in 2014 report.	<p>This is important has been an issue which has had no solutions over a protracted period.</p> <p>No information received by EAG Chair until November, this showed despite successive attempts to recruit a substantive consultant this has not been successful. There has been a review of medical staffing with a skill mix. This has put in place some substantive consultants time covering some areas. However, three-month locum contracts are currently in place in the Hergest unit wards. Consistent leadership rather than locum cover is as important in the West as in the other areas. This needs to be raised as a Board priority with the new executive Medical Director</p>	<p>Summary of progress to support this action;</p> <ul style="list-style-type: none"> <li>•International recruitment: NWSSP sponsored international recruitment from India, yielded 7 doctors at SAS level and 1 Specialist (who has also been recently shortlisted for an Old Age West consultant post)</li> <li>•Recruitment events: Royal college conference stand, had previous success with recruiting and due to attend in 2026.</li> <li>•Review and use of specialist grade where possible: reimagined 2 consultant posts in difficult to recruit to areas, to trail posts for 2 years fixed term to ensure the specialist grade works as part of a new skill mix. 1 will be in NYG one in OPMH west</li> <li>• Portfolio pathway: to develop lead post for the portfolio pathway to support SAS grade to progress to consultant.</li> <li>•Trainee retention: In the last 5 years we have retained all but 1 higher trainee at consultant level.</li> <li>•Reviewing current medical establishment: due to delay with college publishing RC207 the role of the consultant may need to be evaluated with bolstering of the team at other levels due to lack of consultants nationally, undertake in the context of neighbouring trust to ensure competitive and appealing jobs.</li> <li>•Wider considerations to encourage recruitment: encouragement to join BCU with competitive and appealing jobs</li> <li>•Meetings held on a regular basis with Workforce Team to develop a targeted recruitment plan for the West area.</li> </ul>

						In addition, a Higher Trainee is due to commence in the West area in February 2026.
4.3	Continue to progress the recruitment and retention activities aligned to the MH&LD Recruitment and Retention plan.	MH&LD Operational Business Lead	28 <sup>th</sup> March	High Interest from EAG members on current and future performance and the length of time recruitment issues in mental health have persisted.	<p>In March EAG asked for detail about recruitment at team level rather than giving an average including the range of best and worst performing teams. This level of information will be important in future to clearly understand the impact. The use of bank and agency staff to provide temporary cover is also an important area not covered in this report</p> <p>EAG Chair requested update as there was a presentation in May and no information since at EAG meetings.</p> <p>Recruitment in all professions in the UK remains a national and UK wide challenge. Specific Mental health focussed initiatives have been successful in other UK mental health Trusts.</p> <p>During this meeting there was a lot of discussion about the data sources and comparison with historical data in the public domain. This was discussed outside of EAG meetings with individuals to understand it better. The conclusion was information was derived from different data sets.</p> <p>There needs to be a single source of reliable data which is used on all workforce reports.</p> <p>In October updated information was provided and showed progress. This needs to be an ongoing priority with clear measures for improvement and success.</p>	The Recruitment and Retention Impact Report highlights significant progress across MH&LD between October 2024 and June 2025, including a sustained reduction in divisional vacancy rates, strengthened recruitment pipelines, and increased visibility through attendance at 20 recruitment events and over 550 enquiries received. The introduction of Recruitment Champions, continued development of talent pool processes, and the successful onboarding of 14 international nurses have contributed to greater workforce stability and improved staffing resilience. Alongside this, the division has advanced plans for MH&LD-specific work experience and volunteer pathways, reduced agency spends, and maintained strong collaboration through the R&R Working Group. These combined efforts demonstrate a maturing, proactive approach to workforce planning that is beginning to deliver tangible, measurable impact across the division
4.4	Communicate Dementia Essential study days to all MH&LD staff to increase awareness and attendance	Director of Nursing	29 <sup>th</sup> May	Discussed at EAG	Data received about staff attendance received at EAG.	Dementia Essential study days have been widely communicated to MH&LD staff through multiple channels, including the MHLTD Training and Development Group, corporate bulletins, and planned staff briefings, ensuring staff are aware of upcoming opportunities. The traditional full study days have been redesigned into accessible bitesize Microsoft Teams sessions for 2025–26, with all dates shared via ESR and staff communications to maximise attendance. This shift to digital delivery increases reach, supports flexible access for staff across services, and strengthens overall awareness and engagement with dementia-specific training.
4.5	Implement a review process of cover arrangement when Dementia Support Workers are vacant to ensure continuity of service provision.	Director of Nursing	29 <sup>th</sup> May	EAG presentation	<p>EAG had a detailed presentation on dementia support workers and the good work they do. There was an intention to strengthen this.</p> <p>Awaiting strengthening following Evidence of Outcome Group peer review . This appears to show cover in place in the three IHC localities but not of the same cover approach in all three.</p>	There has been clear progress in strengthening cover arrangements, with East introducing reliable cross-cover between Hydref and Gwanwyn, West utilising existing Health Care Support Workers (HCSW) and bank staff to maintain activities, and Centre planning staffing eight weeks ahead to ensure continuity. Daily Safety Huddles and the ability of HCSWs to step into activity roles when coordinators are absent further demonstrate improved resilience and consistent service provision.
4.6	To progress the Business Case substantive funding for the MH&LD Wellness, Work and Us Service.	Director of Nursing	29 <sup>th</sup> May	EAG presentation	In progress but not to deadline. Interesting presentation on wellbeing support given to EAG. Staff experience and wellbeing measures are important include in the outcome's framework . The EAG presentation showed a lot of good work taking place .	Funding approved through RIGA up to end of March 2026.Funding beyond March 2026 Approved through Divisional funding on a six-month rolling basis whilst awaiting alternative substantive funding for the service.
4.7	Development of an options appraisal to support consideration for recruitment of a	Director of Nursing	29 <sup>th</sup> May	EAG presentation	<p>Awaiting strengthening following Evidence of Outcome Group peer review</p> <p>Different model proposed and is being worked up of how to achieve this within existing roles. Check update with Nurse Consultant.</p> <p>Practice educators work in the teams and they cover a variety of areas including dementia. Whilst the intention was for these to be dedicated roles pragmatically this may be a cost-effective way of achieving this outcome</p>	Pending final update

	dementia practice educator for MH&LD.					
4.8	Raise awareness and attendance of Health Board staff at Dementia Essentials study days.	BCUHB Consultant Nurse Dementia	29 <sup>th</sup> May	EAG presentation	Awaiting final assessment Tracey Williams demonstrated evidence at EAG of the process to raise staff awareness.	Training is advertised via training groups in BCU, newsletters, staff briefings, through other groups/committees e.g., Hospital Charter Group and Dementia Support Workers network, and regional dementia groups, Universities and at events e.g., Dementia Action Week

THEME 5 – Management Structure Individual Priority Milestones Report						
No	Action	Assigned Too	EAG date	EAG review/ comments	Chair review /comments	Update since EAG meetings held
5.1	Continue to progress recruitment of interim posts to substantive posts aligned to the MH&LD Operating Model and in line with the wider Operating Model review, aiming to reduce interim posts by 25% by 31/3/25	MH&LD Director	March 28 <sup>th</sup> update requested November	An important area where EAG members have experienced recruitment shortfalls in mental health teams over many years. The new data in March presents an improving picture from data two years previously. The accuracy of the data was raised as a concern .	When presented by MHL D Director there were concerns about the use of different data sets. This was resolved through discussions with MH leaders. The data presented suggest improvements . No update provided in EAG and was requested in March.  Data on recruitment to senior interim posts was 11/ 20 out of 20 in May November update showed positive update to 17/20.	Update for November 2025 – two posts remain interim in MH&LD Senior Leadership Team (reduced from 14) – East Head of Nursing due to secondment and West Head of Operations due to Health Board pause in recruitment to all band 8D posts.  Target met
5.2	Ensure that older adults mental health services are represented in the Directorate management structure.	Medical Director	27 <sup>th</sup> June 21 <sup>st</sup> August & update November	Ensuring older people’s clinicians have influence to improve and develop services and staff working in OPMH feel well trained and supported	Evidence of how Older Persons Mental Health (OPMH) is managed in an integrated management structure presented by MHL D Head of Operations. There is a clinical pathway lead Dr and the new nurse consultant AHP and psychology leadership.  Integrated management is one way of manging OPMH services. The clinical leads need to feel that important clinical and managerial issues ae addressed through this structure and they have influence on clinical and professional standards including improving patient a family experience and outcomes. would appear to balance the original RCP concern so long as the OPMH leaders feel they can influence senior leaders. Pathways also need good management support and one of the sector operational managers has been given more time to support the pathway. This is positive. The Older Adults clinical lead has not yet been made a clinical director which is a formal management position .	A diagram has been provided to the EAG Chair illustrating the structure
5.3	Support to progress recruitment of interim posts to substantive posts aligned to the MH&LD Operating Model.	Associate Director for People - Pan	28 <sup>th</sup> March and update November	This has been a longstanding issue it is good to see improvement . The pace of improvement was raised in March and feedback offered to managers.	Senior posts update 11/20 when presented this seems slow progress an update on current position is needed.  New information in November this now stands at 17/20. Plan to recruit other four posts. Overall positive progress with support to maintain. Update in December is that two posts in MLD are interim pending permanent appointment. ( See 5.1)	See update for 5.1

THEME 6 – Clinical Services Organisation Individual Priority Milestones Report						
Priority	Action	Assigned Too	EAG date	EAG review /comments	Chair review/comments	Update since EAG meetings held
6.1	Desk top audit of Multi-disciplinary (MDT)ward round in line with the Terms of reference to ensure assurance.	Medical Director	3 <sup>rd</sup> July	<p>Audit undertaken however it showed Poor compliance with standards is a concern to be escalated for more action.</p> <p>Lack of MDT input across the wards is a major longstanding gap. EAG member feedback was patients were kept waiting for many hours to attend ward rounds. They suggested having a time for attendance on a white board or in their rooms . This may also be a reason why other professionals are not attending the ward round if they are attending for single patients. The results of this audit were distressing for some members of EAG as it fitted with their own experience .</p>	<p>Presented to EAG. Significant concerns about performance in this audit and the gaps in Multi-Disciplinary Team (MDT) staffing and the impact this is having (which is not quantified) on day-to-day care . This concern was escalated immediately.</p> <p>The audit as a single source of evidence does not provide assurance that MDT ward rounds are taking place and meeting the required standards . It will be important to seek alternative sources of information to validate MDT input to care.</p> <p>The organisation, timeliness and MDT attendance at ward rounds is an immediate priority for improvement.</p>	<p>Recommendations from the audit still progressing in local areas. MDT ToR's developed and agreed with Medical Director to ensure consistent approach. Awaiting confirmation of date for re-audit.</p>
6.2	Develop dementia roles and responsibilities within Practise Development Nurse role.	MH&LD Consultant Nurse Dementia	29 <sup>th</sup> May	<p>In May, EAG heard how this was work in progress</p>	<p>Awaiting strengthening following Evidence of Outcome Group peer review</p> <p>Update provided in next column provides more assurance which is used for the rating</p>	<p>Progress continues toward developing dementia-specific roles within the Practice Development Nurse (PDN) function, with a proposed structure for dedicated dementia practice educator roles agreed in principle at the Corporate Nursing Seniors Group and further shaped through engagement with PDNs and the Consultant Nurse for Dementia. Although progress has been affected by capacity constraints, including long-term PDN absence and a vacant Consultant Nurse Dementia post (that has been in position since May 2025), an Options Appraisal outlining the model is now completed and progressing through divisional governance for approval. This work provides clear definition of dementia-related responsibilities, strengthens consistency of dementia practice across MH&amp;LD services, and has been co-produced with practice educators, improvement leads, and planning teams to ensure alignment with strategic priorities and long-term sustainability</p>
6.3	Development of an options appraisal to support consideration for extending regional pilot of applied behaviourists working with patients with complex needs	MH&LD Consultant Nurse Dementia	29 <sup>th</sup> May	<p>Evidence presented in EAG</p>	<p>Awaiting final assessment.</p> <p>EAG saw Option appraisal developed and Pilot funded externally. Evaluation of benefits will be important.</p> <p>When EAG met it looked as if this was progressing as described.</p>	<p>Progress toward developing the options appraisal has been substantial, with approval secured from Regional Dementia Groups to pursue research funding, active collaboration established with Bangor University to develop research proposals, and formal support gained from the BCU Research Team. Draft research plans and supporting documents have been completed, and a charitable funds application for a Behavioural Analyst-in-Residence project has been submitted alongside the formation of an advisory group. A clear action plan is now in place for February–September 2025 to deliver the pilot (subject to funding), conduct PPI engagement, and progress bids for wider research funding, demonstrating strong momentum toward extending the applied behaviourist model for patients with complex needs. This funding has been approved</p>
6.4	Continue monthly Consultant Nurse Dementia led network meeting with all MH&LD Activity Coordinators to	MH&LD Consultant Nurse Dementia	29 <sup>th</sup> May	<p>Evidence presented at EAG</p>	<p>Good evidence of this taking place, Important to continue but evidence to close.</p> <p>Great examples of good practice for example using playing cards</p>	<p>Dementia-led network meetings have continued consistently throughout 2024 and 2025, with all Activity Coordinators attending regularly and only occasional absences due to sickness, leave, or operational pressures, accessibility has been further strengthened by rotating meeting days to accommodate part-time staff. These sustained peer-support sessions provide an ongoing forum for shared learning and collaboration, helping to maintain and enhance patient experience and outcomes across MH&amp;LD services</p>

	ensure patients have improved patient outcomes and patient experience.					
6.5	Ensure all Centre and East Memory Assessment units attain Memory Service National Accreditation Programme (MSNAP) accreditation.	MH&LD Consultant Nurse Dementia )	29 <sup>th</sup> May	Evidence presented at EAG	Awaiting strengthening following Evidence of Outcome Group peer review .  Good evidence of one service with accreditation a plan for accreditation over two years for the other two services. Keep reporting progress to new group. A plan seems in place to deliver this which needs to continue to be supported.	Steady progress has been made toward ensuring all Centre and East Memory Assessment Services (MAS) achieve MSNAP accreditation, with West already fully accredited since 2015 and having successfully retained accreditation following a mid-cycle review in November 2024. Central MAS has implemented substantive service improvements and secured Health Board funding to progress to full accreditation in 2025/26, while East has made significant advancements—including relocating to suitable premises, adding a Band 6 post to strengthen staffing, reducing waiting times from 12–16 weeks to 6–9 weeks, and introducing a new triage process, positioning the service well for planned accreditation in 2026/27. Both Central and East remain affiliated with MSNAP through regional funding, ensuring ongoing access to resources and training, and a phased, strategically agreed accreditation roadmap has been formally endorsed at PIDG
6.6	Progress the pilot scheme for in reach workers in care homes, review and measure impact and outcomes and carry out options appraisal to expand to all care homes to enable consistency of service provision.	MH&LD Consultant Nurse Dementia		Not seen by EAG	Update appears to show this is making progress.	Evidence of Outcome Group endorsed as Green.  The pilot scheme has been progressed through the secondment of a Dementia Practice Educator for an 18-month period to work across four care homes, with responsibilities including supporting in-reach activity and implementing evidence-based initiatives such as the “Love to Move” programme. The educator has completed the required training and begun providing training to care home activity coordinators. Early implementation activities have included embedding the programme into routine care home practice, gathering initial staff and resident feedback, and putting plans in place for outcome measurement to inform a future options appraisal. This work will contribute to assessing the feasibility, impact and potential scalability of extending the model to additional care homes.
6.7	Continue monthly Consultant Nurse Dementia led network meeting with all MHL D Activity Coordinators to ensure patients have improved patient outcomes and patient experience.	MH&LD Consultant Nurse Dementia	29 <sup>th</sup> May	The presentation showed good examples of how this is working well.	Good evidence presented of network and great work they have done.	No further update required

THEME 7 – Training and Development Individual Priority Milestones Report						
Priority	Action	Assigned Too	EAG date	EAG review comments	Chair review /comment	Update since EAG meetings held
7.1	Further develop and implement networking opportunities of ward staff working across the range of Divisional service to promote and enable sharing of best practice.	Director of Nursing	Update November	Some evidence presented in October and December but not at EAG.	This needs a list of all external the networks which EAG has not seen. Additional information showed some external stakeholders evident . It does did include national and UK mental health or professional networks which are important. The next columns appear, to report this is now in place not seen by EAG or Chair.	This is close to a green status and will review in January 2026. List of internal networks shared in November that illustrates progress. This includes Mental Health specific national and UK and relevant professional networks .
7.2	Implement an agreed HCA career pathway to "Grow your own" MH&LD nurses for the future in collaboration with Health Board, aligned to the annual plan.	Assistant Director of Nursing	16 <sup>th</sup> May	Evidence presented in EAG	Process in place and people have taken up the opportunity. It will be important to continue with this as a recruitment opportunity.  This may be a good source (all be it longer term )of recruiting given the longstanding vacancies there has been in mental health nursing and other professions. To grow your own from people who like mental health work already living locally and invest in this is an option for the future. The nurse associate apprenticeship is one model to consider which has had positive benefits in England.	Work is ongoing to develop the HCA career pathway within MHL. Nationally, the Registered Nursing Associate (RNA) role is still awaiting addition to UK legislation, and therefore no confirmed start date is available. The current national aim remains for the first cohort to begin in academic year 2026/27, but this is dependent on legislative approval.  National preparatory work continues, including the development of parameters of practice and draft job descriptions, though these documents are not yet available for sharing. BCUHB is represented on all national groups, with Adrian Evans acting as the MHL representative on the BCU Implementation Group. While awaiting national timeframes, the MHL Recruitment & Retention Working Group is reviewing the use of existing Band 4 HCA roles to identify opportunities for consistency and improvement across the division.
7.3	Develop Divisional Learning Events rolling programme plan to include key external speakers to aid staff development. Link in with Workforce and Organisational Development (WOD) colleagues regarding future themes from leadership events	Governance Lead	Plans to date provided in November 2025	No evidence in EAG meetings. Evidence updates shared in November.	In progress, not to deadline (01/07/2025)  EAG not seen any evidence  November evidence showed examples of this taking place.	Close to green. Will review in January 2026.  Divisional Learning Event held September 2025 with an aim to have 2 events per year. This will enable a wide variety of stakeholder engagement as well as themed topics that will support learning and improvement across the division.  An additional 3 learning events are planned between September 2025 and April 2027, dates have been provisionally agreed. In order to confirm these sessions we are waiting on confirmation from speakers for the identified topics.  People Services colleagues now have sessions on the learning agendas for the next two sessions. The first session is linked to learning lessons from a HSE and wider perspective.  On this day People Services colleagues will provide an update on the work that they are undertaking to ensure we learn lessons in employee relations processes and the move towards a more compassionate approach to employee relations cases.  The second session will be an introduction to POD colleagues, the service and a POD general update.
7.4	Review of Dementia Support Worker/Activity Coordinator Job Description to reduce variation in roles.	BCUHB Consultant Nurse Dementia	29 <sup>th</sup> May	Presented at EAG	Awaiting final assessment.  Good assurance provided through the presentation and dialogue in the meeting	Dementia intranet pages have a section explaining Dementia Support Worker (DSW) role in addition to DSW posters on their wards and a dementia teaching resource explaining the role. <a href="#">Dementia Toolkit (sharepoint.com)</a>  DSWs presented on their role at the BCU HCA conferences in 2023 and 2024 to illuminate their role.

THEME 8 -Leadership and Staff Engagement Individual Priority Milestones Report						
No	Action	Assigned Too	EAG date	EAG review/comment	Chair review /comment	Update since EAG meetings held
8.1	Implement the MH&LD Communication and Engagement Plan. (Form part of the Health Board overall Citizen Engagement Commitments, ensuring that plans and priorities are informed by what matters to citizens)	Head of Integrated Strategy and Development	15 <sup>th</sup> August	Information presented to EAG in its early stages	Awaiting final assessment. Evidence of the plan seen. Less evidence of the impact of the plan	MH&LD Communication and Engagement working group established to implement the Communication & Engagement Plan. First meeting held to agree the TOR and Phase 1 of the implementation plan. Membership includes a range of departments, but also needs to include a range of staff groups.  Next meeting due to be held on 29/1/26
8.2	Capture the themes and feedback from the bi-monthly "Ask Divisional Senior Leadership Team" virtual sessions to develop a "You said, we did, we are going to do" staff engagement. Report updates into Tier 1 Divisional meeting and include summaries in the MH&LD Staff Briefing.	Director of Operations	16 <sup>th</sup> May and November update	Information presented to EAG with updates at other meetings	Awaiting final assessment  A lot of evidence about process of setting up the sessions . What has been done and the impact it has had is important to demonstrate before closure. This is an ongoing measure.	"We said, we did" poster circulated to provide staff with the key highlights from the walkabouts, including any improvements made.  All areas have been contacted to ask for feedback from the visits and how the approach could be improved. Themes and next steps presented and shared in DSLT and schedule of visits been planned for 2026/27.
8.3	Agree the 12-month Divisional Senior Leadership Team Walkabout schedule for 24/25, incorporating all lessons learnt from current arrangements.	Director of Operations	16 <sup>th</sup> may	EAG members would like to join and the opportunity to extend to other people with living experience	Awaiting final assessment Evidence these ae taking place seen at EAG and more information shared in November.  This will need to continue	As above
8.4	Commitment to develop leadership and management training using the Health Board Compassionate Leadership model and develop a variety of staff feedback mechanisms, including pulse surveys, to	MH&LD Director	28 <sup>th</sup> March	This is an area where family members involved in the EAG had a lot of very poor experience so the elements to prevent any abuse and omissions and poor care occurring is very important. People with current lived experience have also been active in feeding back positive and problematic experience throughout this process. Health Board process to address these matters have been used.  The value importance of all staff demonstrating kindness and empathy has been highlighted. There is a concern by some members that recommendations and learning from the Holden and NCU reports at the time have not been implemented.	Awaiting strengthening following Evidence of Outcome Group peer review  This is an important area. It is part of the HB wide improvement work. Understanding its impact in MH/LD in detail will be vital.  EAG heard that 5/6 mental health leaders have been part of the leadership development programme.  Staff experience and what is going on. A big area to cover in new meeting not well covered through EAG. Impact measurements are important.  November information shared a lot of evidence about themes form the staff survey at a local level and the work being done to make improvements. There	MH&LD have 25 staff who are Cultural Change Leaders. These staff are from a range of services and have taken part in the HB Cultural Change programme.  One of the Cultural Change Leaders was invited to the Wellness, Work and Us (WW&U) Project meeting to understand the main aims, objectives and expected outcomes – and what measurements are to be used.  The Health Board has developed a Culture Dashboard. This has been requested by senior managers to review.  The WW&U team will continue to analyse the Staff Survey results to share across the Division.

	measure and monitor culture within teams to build and create a compassionate and high performing culture.				has been an improvement in staff survey results in Mental Health which is positive  EAG heard positive feedback about improving national staff experience survey data in mental health teams which is good news. This was reassurance and no data reviewed .	When Llais undertook the Safe Space events for Mental Health, kindness was an issue raised consistently by respondents. It continues to be an issue that Llais and the Health Board hear about in complaints and other feedback. There are many areas of good practice within MHL and this needs to be nurtured and disseminated
8.5	Support with the implementation of the MH&LD Communication and Engagement Plan.	Director Of Partnerships, Communications and Engagement	Briefly covered in work programme	EAG informed this was happening	See 8.1	Evidence of Outcome Group endorsed as Green  See 8.1 above
8.6	Analyse staff survey findings, capture themes and agree actions and how we will strengthen communication and engagement with staff to improve and learn from good practice.	Director Of Partnerships, Communications and Engagement	28 <sup>th</sup> march & November update	Presentation and discussion 28 <sup>th</sup> March	Awaiting final assessment  This needs a detailed plan. Not seen at EAG.  Themes Plan shared in October detailed at service line level in mental health. Improvement in staff survey results positive progress but focus needs to be on improving outcomes and experience for staff at team level and be peer led.  Improvements to staff survey etc reported by staff (reassurance) data not seen. Some data presented which is showing areas of focus and improvement at team level. Improving staff engagement scores is an important indicator .	NHS Staff Survey responses increased for the HB and MHL. MHL improved from 16.3% to 23.7%. Action met but focus continues.  Wellness, Work and us working group established to support analysis of staff survey – noting <ul style="list-style-type: none"> <li>• Which areas in MHL did well (and explore why)</li> <li>• Which areas in MHL performed less well – and why</li> <li>• Any areas in the BCU that did particularly well in the BCU and share their lessons</li> <li>• Review the 2025 survey feedback</li> <li>• Review the 2024 Local Action Plans and consider how to support</li> <li>• Understand the role of the Culture Champions and link to everything else</li> <li>• Pull together action plans and recommendations for the division</li> <li>• Think about how we can best communicate what needs to be communicated</li> <li>• Be aware of different perceptions and balance different experiences of staff (recognise but not inflate negative perceptions)</li> <li>• Anything else that becomes apparent</li> </ul>
8.7	Support the creation of a culture within the MH&LD service that is consistently compassionate and high performing.	Associate Director for People - Pan	16 <sup>th</sup> May & update November	Some EAG members are concerned that longstanding directorate leaders have not created a culture that is consistently compassionate or high performing .	Evidence submitted to EOG, awaiting peer review  EAG has seen inconsistent standards in teams through audits and ward accreditation Patient feedback information through CIVICA at team level will be important.  Important area to develop how this will be measured and reported in future	See 8.4 re Cultural Change Leaders update.  Divisional Senior Leadership Team Walkabout and feedback from staff visiting.  Staff Voice Workshops held aligned to main themes from 2024 survey.  The new MH ODG needs to be able to develop then plan to monitor this through the outcome framework at team level

THEME 9 - Resources Individual Priority Milestones Report						
No	Action	Assigned Too	EAG date	EAG review /comment	Chair review/comment	Update since EAG meetings held
9.1	Review the role of pharmacy to consider further developing across the Division.	Consultant Mental Health Pharmacist	Not seen	This has been a gap since 2013/14	Not seen at EAG progress update requested. Minutes seen that indicate a pharmacy staffing model has been submitted for consideration.  A detailed resource and staffing plan and recruitment are needed if this action is to be met	An evidence pack was reviewed and endorsed by the Evidence of Outcome Group that shows that there has been significant work from Pharmacy to enhance their role within the division. This is evident in relation to the audit and resulting improvements on the prescription of antipsychotic medications. Using the MHLD governance structure to enact change. A detailed resource and staffing plan are will be developed.  The work needs to be monitored through the MH ODG and a review of this action will be undertaken in February 2026 to ensure consistency with similar improvement actions.
9.2	Review the demand and capacity arrangements for therapeutic options available to all inpatient units to identify any gaps and agree next steps.	Assistant Director of Allied Health Professionals (AHPs) and Health Sciences	Informed about needs assessment taking place. Not seen	This has been a gap since 2013/14	Awaiting final assessment. Informed this gap analysis has taken place. No update received in meetings but can see that the review was taken forward but now needs to be revisited in light of new operating model	A further follow up paper currently being developed to show the current therapies gap, and funding requirements for progression through Health Board governance.
9.3	For any identified gaps in therapeutic provision across inpatients units develop a business case where relevant for therapeutic staffing by accessing WG Improvement Funds.	Assistant Director of Allied Health Professionals (AHPs) and Health Sciences	Not seen. Informed business case is being developed	This has been a gap since 2013/14	Limited progress. Very important area as these dates back to the original report recommendations in 2013/14. MDT including AHP/ Psychology and pharmacy input to all teams and especially inpatients remain a gap and is an essential component of good mental healthcare  Update in October. Indication for minutes that therapy and psychology staffing models have been submitted for consideration.	As above
9.4	Ensure this is regularly reviewed with a clear escalation procedure if further equipment/facilities are needed to ensure swift resolution.	Assistant Director of Allied Health Professionals (AHPs) and Health Sciences	Not seen .	Llais visits found gardens closed due to lack of maintenance. Urgent issue feedback by expert by experience and Llais visits	As a result of the business case not being agreed this is considered to be a red status	This improvement is related to 9.2 and 9.3 above  Division currently linking in with volunteer gardeners to support with ongoing maintenance of garden areas within the acute units. In addition, meetings held in the West area with Estates to agree garden maintenance to be funded from Charitable funds. Further communication with Estates Director required to ensure progression of matters raised by EAG.
9.5	Dedicated resource from the Health Board Transformation and Improvement team to support with development of the action plan and for the	Director Of Transformation & Improvement	EAG outcomes framework development August 21 <sup>st</sup> and support with presentati	Improvement team input to support EAG presentations and the outcomes framework	Evidence of team involvement seen at EAG	Final report is evidence of progression

transformation/improvement activity required.	ons 16 <sup>th</sup> May		
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THEME 10 – Physical Environment Individual Priority Milestones Report						
Priority	Action	Assigned To	EAG date	EAG review/comment	Chair review /comment	Update since EAG meetings held
10.1	Strengthen escalation of any outstanding remedial environmental estates works from local area Estates meeting through to the MH&LD Capital and Estates meeting.	Head of Operations and Service Delivery	15 <sup>th</sup> August	<p>Comfort is a key issue and needs improving</p> <p>EAG heard an example where Service users are kept waiting for ward rounds and not kept informed.</p> <p>Ideas for improvement included using Notice boards of who are who and other process such as using white boards to ensure service users and families are aware of the timings of wards rounds so service users are more informed, and not kept waiting for unduly long periods of time .</p> <p>Family members sometimes find it difficult to know who is who.</p> <p>A coproduction group could resolve these issues and pick up on others coming from ward meetings</p>	<p>Funded Plans for reducing ligatures seen at EAG. There may still be other essential work which is needed which is not funded.</p> <p>If Ablett development is continuing to make progress, the Hergest unit modernisation and location of OPMH wards which are not co-located to acute sites are areas for review.</p> <p>Llais visits flag up privacy and dignity issues. Feedback from EAG members is the furnishings sofas and chairs are not comfortable and bedlinen and other areas could be looked at.</p> <p>This may benefit from a short -term group listening to Service User feedback including garden maintenance so outside spaces can be used, comfort as well as safety considered, and ward round organisation works better for everyone</p>	<p>Continue to review and act on Llais visit feedback, Patient Carer Experience feedback, CIVICA feedback.</p> <p>This is a priority area for the Mental Health Oversight and Development Group</p>
10.2	Progress Environmental Ligature Risk Assessment Audit, report outcome through Tier 1 meeting to progress actions to completion.	Governance Lead	15 <sup>th</sup> August		<p>Presented at EAG on 15 August 2025</p> <p>Evidence of audits in place. It needs a dynamic system reviewed through directorate safety committee to ensure audits achieve 100% compliance and training levels above 85%</p>	<p>Current MHL D Tripartite Ligature Risk Assessment 86%.</p> <p>Health and Safety Executive Notice of Contravention Action plans monitored and reviewed in Health Board/MHL D Governance</p>
10.3	Provide six monthly updates on progress of NCCU Action plan.	Director of Operations	15 <sup>th</sup> August		<p>Plan reported to EAG. One area outstanding. Pick up in outcomes and performance measures for future reporting</p>	<p>One National Collaborative Commissioning Unit actions outstanding aligned to Welsh Applied Risk Research Network training compliance. Current MH&amp;LD compliance at end of December is 82%</p>
10.4	Support progressing necessary actions for any outstanding remedial environmental MH&LD estates works escalated to the Divisional Estates and Capital Group or the Divisional Ligature Risk Reduction Group using a Tripartite approach within their area of expertise to enable safe	BCHUB Estate Operations Manager	15 <sup>th</sup> August	EAG presentation	<p>Presented at EAG on 15 August 2025 good evidence of work a progress which needs to be maintained . Evidence it's taking place but needs a careful eye on it in MH and HB governance groups</p> <p>This needs a forward annual plan to be approved a monitored</p>	<p>Tripartite Ligature Risk Assessment compliance reported into monthly Ligature Risk Reduction meeting, with Chairs Assurance report feeding into Service Quality Delivery Group. Memo circulated to reaffirm proactive planned to ensure annual reviews do not expire.</p>

	environments to be maintained.					
10.5	Support progressing necessary Divisional Capital Estates works as part of the annual plan to ensure all works are captured.	BCHUB Head of Capital Development	15 <sup>th</sup> August	EAG presentation and discussion	<p>Previously allocation of capital for Mental Health was delegated to Integrated Health Community's. The new capital allocation system needs to reflect and prioritise Mental Health following many years of under-investment.</p> <p>Plans to focus on the MHLD estate and large and small capital works programmes so the estate plans reflect the need to modernise all inpatient and other areas to be fully fit for purpose by current Mental Health building standards</p> <p>Llavis visits service user feedback (cited above) indicates this is an area to refocus on and ensure immediate issues and longer-term plans are in place supported by capital and revenue funding</p> <p>Good evidence of tripartite working observed at the EAG meeting, checking this applied generally through feedback from leaders and teams is important. There is some evidence of different experiences between corporate and MH leaders.</p>	<p>Divisional Capital and Estates meeting established to review capital, revenue and maintenance programmes.</p> <p>Ablett Redevelopment Project Board held an internal briefing meeting on 25/11/25, following the pause given the need to address the capital affordability issues.</p> <p>Next steps include:</p> <ul style="list-style-type: none"> <li>• Conclude the commercial arrangements for the Project and agree the revised project timeline (construction approximately 2 years from Full Business Case approval).</li> <li>• Produce revised capital costs.</li> <li>• Conclude on the revenue envelope for the Project.</li> <li>• Complete the Full Business Case once commercial arrangements, capital costs and revenue costs have been agreed.</li> <li>• Deep dive meeting held on 13/11/25.</li> </ul>
10.6	Support from Health and Safety aligned to ensuring an appropriate physical environment for patient including the ligature tripartite risk assessments.	BCHUB Assistant Director of Occupational Health, Safety and Security Corporate Office	15 <sup>th</sup> August	Presentation 15 <sup>th</sup> August	<p>Awaiting strengthening following Evidence of Outcome Group peer review Presented at EAG on 15 August 2025</p> <p>Good inter team working and support from Health and safety evident. It is important this continues.</p> <p>This was apparent during the EAG meeting and needs to continue see 10.6</p>	<p>Mental Health meetings have escalated two Health and Safety Executive Notice of Contraventions Actions that will progressed through the establishment of a ligature program board. Requires a whole Health Board approach.</p>
10.7	Support from Health and Safety to continue to provide advice, support and lead on the Ligature Environmental Risk Assessment training for staff.	BCHUB Assistant Director of Occupational Health, Safety and Security Corporate Office	15 <sup>th</sup> August	Presentation 15 <sup>th</sup> August	<p>See above this is evident and needs to continue</p>	<p>Next steps agreed - Progress the development of a Ligature Programme Board to oversee ligature reduction for the Division and the Health Board.</p> <p>Procure specialist expertise to support a risk-based approach to the ligature programme.</p> <p>Key learning from the annual tripartite ligature assessments analysis is the need for a standardised asset list, to be applied across the division/organisation to support consistent asset management.</p>
10.8	Support from Health and Safety to continue to undertake ad-hoc health and safety inpatient inspections.	BCHUB Assistant Director of Occupational Health, Safety and Security Corporate Office	15 <sup>th</sup> August		<p>Plan not seen</p> <p>Assurance gained through the meeting of good relations between health and safety and MH senior managers but not of this issue.</p>	<p>Evidence of Outcome Group endorsed as green</p> <p>Divisional Health and Safety meetings held – summary of key items reported, including ad hoc Health Board inspections.</p>

<b>Teitl adroddiad:</b> <i>Report title:</i>	Annual Delivery Plan 2025/26 - Quarter 2 Progress Report			
<b>Adrodd i:</b> <i>Report to:</i>	Performance Finance and Information Governance			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 18 December 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>This report provides an overview of progress against the Annual Delivery Plan (2025/26) as at Quarter 2 and the delivery confidence for the remainder of the financial year.</p> <p>The report outlines current progress and highlights areas and action for improvement.</p>			
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Performance Finance and Information Governance is asked to:</p> <ul style="list-style-type: none"> <li><b>RECEIVE ASSURANCE</b> on the progress made up to and including Quarter 2 along with the challenges highlighted.</li> </ul>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim)			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Emma Lea, Head of Business, Planning and Programmes – CIHC			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i> <input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhannol <i>Partial</i> <input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in Delivery</i></p>
<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p>				

<b>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</b>	
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <b>Link to Strategic Objective(s):</b>	Aligns to all strategic objectives in the Integrated Medium -Term Plan (IMTP).
<b>Goblygiadau rheoleiddio a lleol:</b> <b>Regulatory and legal implications:</b>	Not applicable
<b>Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b> <b>In accordance with WP7 (which now incorporates WP68) has an EqlA been identified as necessary and undertaken ?</b>	Not applicable
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b> <b>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</b>	Not applicable
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b> <b>Financial implications as a result of implementing the recommendations</b>	Not applicable
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b> <b>Workforce implications as a result of implementing the recommendations</b>	Not applicable
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b> <b>Feedback, response, and follow up summary following consultation</b>	Not applicable
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) <b>Links to BAF risks:</b> (or links to the Corporate Risk Register)	Not applicable
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b> <b>Reason for submission of report to confidential board (where relevant)</b>	Not applicable
<b>Next Steps:</b>	
<b>Rhestr o Atodiadau / List of Appendices:</b> Please refer to appendices for the detailed Annual Delivery Plan report. Please refer to the supporting information pack for the FINAL – Health Board – High Level Version of Annual Delivery Plan 2025-26 04.06.25	

# Integrated Medium Term Plan/Annual Delivery Plan Quarter 2 2025/26 Progress Report

## Introduction

The report provides a mid-year review against the organisations 2025/26 commitments set out in the 2025-2028 Integrated Medium-Term Plan and detailed in the 2025-26 Annual Delivery Plan (ADP).

The ADP has been developed to ensure full alignment with the organisation’s five ‘Key Strategic Objectives’. Each action, initiative and performance measure within the plan directly supports the delivery of these priorities, ensuring that resources, efforts and outcomes are strategically focused to achieve the desired impact.

A summary of the Strategic Objectives and underpinning priorities is set out below:<sup>1</sup>

<b>Objective 1: Building an effective organisation</b>		<b>Objective 4: Improving quality, outcomes and experience</b>	
1A	Effective systems of governance	4A	Prevention and Early Intervention
1B	Establishing the Foundations for the Future	4B	Primary Care including Clusters
1C	Responding to Legislative Requirements	4C	Community Care
1D	Implementing the Quality Management System	4D	Planned Care, Cancer & Diagnostics
<b>Objective 2: Developing strategy and long-lasting change</b>		4E	Urgent and Emergency Care
2A	Developing and delivering a Health Board Strategy and Clinical Services Plan	4F	Adult Mental Health & Learning Disability
2B	Strengthening Planning and Commissioning	4G	CAMHS
2C	Improving the Environment, Estate and Facilities	4H	Neurodevelopment
2D	Enhancing digital, data and technology approaches	4I	Dementia
2E	Developing and delivering value and sustainability	4J	Currently ‘Challenged Services’
2F	Improving workforce planning and development	4K	Women’s services
2G	Working with regional partners	4L	Children & Young People
<b>Objective 3: Compassionate culture, leadership &amp; engagement</b>		4M	Pharmaceutical services
3A	Culture Development	4N	Palliative, End of Life and Bereavement Care
3B	Leadership Development	4O	Dental services
3C	Citizen engagement and partnership working	4P	Diabetes
3D	Welsh language and culture	<b>Objective 5: Effective environment for learning and skills development</b>	
		5A	University & Further Education Partnerships
		5B	Research, Development and Innovation
		5C	Academic Careers
		5D	Intelligence Led
		5E	Learning Organisation

The ADP Report is structured to provide a clear overview of delivery against each of the 35 sub objectives within the context of the five Strategic Objectives. Whilst a focus of the report is the delivery position as at Quarter 2, the report provides an update on progress against sub-objectives detailed within the ADP, as at

<sup>1</sup> 2G no longer included within ADP as a separate monitoring mechanism will be implemented for these priorities which sit with external partners to deliver as approved at board 29<sup>th</sup> May 2025.

Q2, and confidence of delivery by end of Q4, highlighting areas on/off track, reasons for variance, and mitigating actions.

## Q2 Progress and Delivery Confidence by Q4

The full ADP Report, as at Q2, is included in the supporting appendices. Please refer to the Supporting Pack for the 'High Level Version of Annual Delivery Plan 2025-26'.

### Overall Summary

Roughly half the sub-objectives are progressing well and remain on track for Q4 delivery, with high delivery confidence in a number of the foundational and supporting areas as well as a few of the clinical service areas.

Areas identified with medium delivery confidence are largely due to resourcing issues, mixed performance of items within the sub-objective or challenging targets that remain achievable but require additional focus.

However, there are areas of risk identified where confidence of delivery remains low, the majority of which sit within Strategic Objective 4. This area will require significant focus during the remainder of the year to ensure delivery expectations are met and clinical services are strengthened.

### Summary by Strategic Objective and Sub-Objective

Strategic Objective - Sub-Objective	Summary and delivery confidence
<b>Objective 1: Building an Effective Organisation</b>	
Effective Governance (1A)	<b>High.</b> Governance improvements embedded; LFER backlog significantly reduced. Minor staffing delays but Q4 delivery expected.
Foundations for the Future (1B)	<b>High.</b> Structure design phase complete; phased implementation planned. Alignment with Strategy and Culture workstreams progressing.
Legislative Compliance (1C)	<b>High.</b> Discovery & Learning Steering Group established; Cyber Resilience Bill implications under review and details awaited. Compliance strengthening continues.
Quality Management System (1D)	<b>High.</b> Digital maturity tool rolled out; QMS confirmed as strategic enabler. Integration into Clinical Service Planning scheduled for Q4.
<b>Objective 2: Developing Strategy and Long-Lasting Change</b>	
Health Board Strategy & CSP (2A)	<b>Medium.</b> Strategic Intent due January; CSP preparatory work underway. Resource allocation under review.
Planning & Commissioning (2B)	<b>Medium.</b> Commissioning pace impacted by leadership gap. Planning maturity improvements embedded; commissioning work slower.
Estates & Facilities (2C)	<b>Medium.</b> Major capital schemes progressing; Estates Strategic Plan delayed due to dependency on 10-Year Strategy. External approvals may impact timelines.
Digital & Data (2D)	<b>Medium.</b> NHS Wales App live; ePMA rollout underway; EHR paused nationally creating risk. Cyber response plan drafted.

Value & Sustainability (2E)	<b>Medium.</b> Slight delays but positive progress. £40m savings target exceeded; refreshed programme operational. Clinical variation workstream redesigned.
Workforce Planning (2F)	<b>Medium.</b> Mixed progress. Band 5 nurse vacancy gaps closed; agency spend reducing; job planning delayed pending national policy.
<b>Objective 3: Compassionate Culture, Leadership and Engagement</b>	
Culture Development (3A)	<b>High.</b> Values & Behaviours Framework embedded; Synthesis Report submitted and peer-reviewed as best-in-class.
Leadership Development (3B)	<b>High.</b> Leadership programmes launched; next phase focuses on middle managers and coaching network review.
Citizen Engagement (3C)	<b>Medium.</b> Slight delay but recoverable; Youth Voice and councillor engagement progressing; governance strengthened.
Welsh Language (3D)	<b>High.</b> Operational delivery of Welsh Language Standards underway; training programme in development.
<b>Objective 4: Improving Quality, Outcomes and Experience</b>	
Prevention and Early Intervention (4A)	<b>High.</b> Weight Management review complete; immunisation targets met; social prescribing model development progressing.
Primary Care (4B)	<b>Medium.</b> Progress evident but moderate risk due to restructuring dependencies; Progress on pathways and dental procurement; cluster footprint review delayed; mitigation plans in place.
Community Care (4C)	<b>Low.</b> Enhanced Community Care and weekend service business cases delayed; funding constraints cited.
Planned Care / Cancer / Diagnostics (4D)	<b>Low.</b> Priorities overdue; alignment issues with national programme; escalation required.
UEC (4E)	<b>Low</b> for Q3/Q4; significant work underway across workstreams.
Adult Mental Health and Learning Disability (4F)	<b>High.</b> Crisis Care Model phase 1 implemented; MH EHR procurement progressing; national patient safety workstreams active.
CAMHS (4G)	<b>High.</b> Workforce plan agreed; compliance with Mental Health Measure improving; Q3/Q4 priorities scheduled.
Neurodevelopmental (4H)	<b>High.</b> Waiting list stratification complete; new assessment pathway implemented; ISP approved.
Dementia (4I)	<b>Medium.</b> Progress on training and environment improvements; two priorities overdue but mitigation in place.
Challenged Services (4J)	<b>Low</b> overall, but specialty-level detail shows mixed confidence: <b>Plastics, Oncology</b> and are on track for delivery in Q4 and under consideration for de-escalation from Special Measures. <b>Urology</b> and <b>Orthodontics</b> remains the highest risk for delivery with <b>Vascular, Ophthalmology, Dermatology,</b> and <b>T&amp;O</b> rated as medium risk - reinforcing the need for escalation and focused resources to support.
A. Urology	<b>Low:</b> Workforce gaps, estates limitations, IR access inequity
B. Vascular	<b>Medium:</b> Progress on pathways and governance; workforce sustainability and waiting lists remain critical

C. Dermatology	<b>Medium:</b> RTT targets supported by insourcing; delays in opening Connah's Quay due to estates and nursing recruitment.
D. Plastics	<b>High:</b> Estates issue delaying full opening, but high confidence of delivery for Q4. Being considered for de-escalation from Special Measures.
E. Oncology	<b>High:</b> SABR service approved; workforce recruitment progressing; EHR dependency sits with national programme. Being considered for de-escalation from Special Measures.
F. Ophthalmology	<b>Medium:</b> Position is mixed: Progress on cataract pathways and governance; however, risks remain around access delays, estates, and leadership gaps
G. Orthodontics	<b>Low:</b> National workforce shortage; backlog persists; medium confidence for Q4.
H. Trauma & Orthopaedics	<b>Medium:</b> Progress on data and rationalisation; ADP targets misaligned with programme plan. Mitigation: Specialty plans, workforce recruitment, estates solutions (Connah's Quay, Abergele), digital integration, and governance improvements.
Womens (4K)	<b>High</b> for Q4. Women's Health Hub development progressing; digital maternity solution scheduled for Q4.
Children and Young People (4L)	<b>High</b> for Q4. Parenting Charter delivered; Youth Voice Board and immunisation improvements scheduled for Q4.
Pharmaceutical Services (4M)	<b>Medium.</b> Medicines Value prevention arm operational; community pharmacy model and MPharm programme development underway.
Palliative Care, End of Life & Bereavement Care (4N)	<b>Medium.</b> SWAN model implemented; workforce strengthened; strategic delivery plan progressing.
Dental (4O)	<b>Medium.</b> GDS procurement complete; new contracts awarded; focus on CDS waiting list reduction and education strategy.
Diabetes (4P)	<b>Medium.</b> Programme established but delays in implementing eight care processes; likely roll-over into 2026/27.
<b>Objective 5: Effective Environment for Learning and Skills Development</b>	
University Partnerships (5A)	<b>High</b> for Q4; preparatory work progressing. MoUs with education partners progressing; alignment with Clinical Services Plan development.
Research & Innovation (5B)	<b>Medium.</b> Governance strengthened; focus on increasing research activity and academic partnerships.
Academic Careers (5C)	<b>High</b> for Q4; Community of Interest Group established; MoUs with universities progressing.
Intelligence-Led (5D)	<b>Medium.</b> IRIS dashboard live; predictive analytics and RPA proposals scheduled for Q4.
Learning Organisation (5E)	<b>High</b> Integrated Concerns and Complaints Policy embedding continues; discovery report informing Education Strategy.

## ■ Recommendations

The Committee is asked to:

- **RECEIVE ASSURANCE** on the progress made during Quarter 2 and note the delivery confidence for the remainder of the financial year.



**APPENDIX 1**

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# Quarter 2- 2025/26 ADP Monitoring Report November 2025

## Annual Delivery Plan Quarter 2 - Overview by Sub-Objective

<b>KEY:</b>	<b>On track for delivery of the sub-objective by end of financial year</b>	<b>Off track, but with a plan to course correct and complete by end of the financial year</b>	<b>Off track and high risk of non-completion by the end of the financial year</b>
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Sub-Objective	Executive Lead	Delivery Confidence
<b>1A Effective Systems of Governance</b>	<b>Director of Corporate Governance</b>	<b>Delivery Confidence</b>

### Overview

The Effective System of Governance sub objective is based around nine core priorities delivering measurable improvements to existing governance arrangements through the creation of a Governance Improvement Plan, improved governance arrangements with additional training and support, together with strengthening risk management practices and governance across the organisation. Outputs from this work are expected to result in improved governance arrangements, whole system quality-based decision making, improved recruitment and commissioning of goods and services and eliminate the backlog of overdue Learning from Events Reports (LFER).

### Current Position

The Health Board has made significant progress in strengthening governance, consistency, and transparency, for example within the LFER process where robust redress systems, senior oversight, centralised tracking, and proactive performance monitoring are now embedded, ensuring greater accountability and sustained improvement. Ongoing improvements to governance arrangements is supporting the delivery of the organisation's strategic objectives, keeping governance focused on the key strategic priorities and enabling a whole-system quality-based decision-making approach (1A.4) as seen in improvements to LFER backlog rates reported to the Audit Committee. These developments along with further commitments show a clear commitment to delivering high standards of governance and position the Health Board for measurable progress in managing legal and regulatory challenges.

### Remainder of the financial year

Whilst the programme has met with minor delays due to staffing pressures, the remaining deliverables around annual self-assessments and Structured Assessment recommendations remain on track for Q4 delivery.

Sub-Objective	Executive Lead	Delivery Confidence
<b>1B Establishing Foundations for the Future</b>	<b>Chief Executive</b>	<b>Delivery Confidence</b>

### Overview

The Establishment of the Foundations of the Future sub objective is about building an effective and sustainable organisation for the long term by ensuring the approach to five interlinked workstreams: Strategy, Culture, People, Process and Structures, are all aligned in the development of a new organisational operating model. The focus of the programme within this financial year consists of three priorities focusing on the final design, implementation and future development of the organisation. The programme is focused on making sure the Health Board has the most effective operating model to enable the best possible care for the people of North Wales with a shared ambition to work together to deliver the organisation's core purpose and strategic objectives with the right support and tools in place, to achieve this.

### Current Position

A draft core structure has been developed following extensive engagement across different services, covering primary and community care, acute, regional services, and corporate functions. Finance is progressing with costing, and staff groupings with potential Organisational Change Process (OCP) implications are being collated. Work on a business partner approach to a number of Corporate Services is also advancing. The structure is currently being socialised with leadership teams, and a report will be presented to Board over the next few weeks outlining the proposed phased implementation. Elements relating to the other workstreams (Strategy, Culture, People, Processes) are covered elsewhere in this report.

**Remainder of the financial year**

Outstanding actions focus on delivering the Governance Improvement Plan and embedding Structured Assessment recommendations to strengthen governance and accountability. This includes completing the Governance Hub and Toolkit with training, rolling out risk management audits and training, enhancing procurement and financial compliance through SOs, SFIs, and SoRD training, and improving accountability agreements for budget holders. These measures will ensure consistent governance, better decision-making, and robust financial and risk controls, supporting the Health Board’s aim of achieving high standards of governance and assurance.

<b>1C Responding to Legislative Requirements</b>	<b>Director of Corporate Governance</b>	<b>Delivery Confidence</b>
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**Overview**

The Responding to Legislative Requirements sub objective is based around eight core priorities delivering measurable improvements to regulatory assurance through the extensive review of current arrangements, improved processes for the preparation, response and implementation of requests from inquiries or new legislation. Outcomes from this work are expected to result demonstrate legislative compliance, and drive improvements to the Health Boards current policies, guidance and practices.

**Current Position**

The Discovery and Learning Steering Group has been successfully established, with Terms of Reference approved by the Executive Committee on 6 August 2025 and a Referral Process and Effectiveness Review endorsed by the Chair. This will provide a clear governance framework to support organisational learning and improvement in response to national inquiries and lays the foundation for an organisational system for monitoring audit recommendations (1C.3; 1C.5). While the Cyber Resilience Bill is still in its second reading and full implications remain uncertain, initial analysis indicates high confidence in defining requirements and responsibilities.

**Remainder of the financial year**

Focus remains on strengthening governance and compliance by reviewing regulatory assurance, re-establishing legislative processes, and delivering the Three-Year Plan using HSE methodology. Key actions include implementing a Health and Safety Improvement Plan, creating a robust audit system for medical devices and procurement compliance, and embedding Discovery and Learning Steering Group processes to drive continuous improvement.

<b>1D Implementing the Quality Management System</b>	<b>Executive Director of Nursing and Midwifery</b>	<b>Delivery Confidence</b>
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**Overview**

The implementation of the Quality Management System (QMS) sub-objective consists of five priorities delivering standardised QMS maturity assessments across the Health Board, development of governance frameworks, mobilisation and implementation planning across the health board, integration of QMS into Clinical Service Planning and Challenged Services and evaluation of the Health Boards design and implementation of the QMS. Outputs from this work are expected to result in strengthened knowledge and understanding of the QMS across the BCUHB workforce.

## Current Position

The Health Board has successfully delivered a comprehensive communication and engagement programme to embed the Quality Management System (QMS) across the workforce. Initiatives such as the QMS Hub, myth-busting bulletins, and leadership briefings have strengthened awareness and integration of QMS principles. Significant progress includes rollout of the digital QMS maturity assessment tool, now supporting Challenged Services and early adopters, with enhanced scalability through Data verse (1D.1). Formal evaluation confirms QMS as a strategic enabler for quality improvement, positioning BCUHB as a leader in NHS Wales (1D.4).

## Remainder of the financial year

Further work required to Integrate QMS principles into Clinical Services Planning and early identification of challenged services, and will form a core part of the IMTP Development for 2026/29. All deliverables remain on track for Q4 delivery

<b>2A Developing and delivering a Health Board Strategy and Clinical Services Plan (CSP)</b>	<b>Executive Director of Transformation and Strategic Planning</b>	<b>Delivery Confidence</b>	

## Overview

The implementation of this sub-objective consists of six inter-related priorities related to strategy development. They centre around the three main strategy development products of 1) Co-creating a Strategic Intent with partners for the population of North Wales, 2) The Health Board's 10-Year Strategy, 3) Strategic Plans to deliver the 10-Year Strategy e.g. Clinical Services Plan (CSP), Digital Roadmap (2A.6) , Estates Strategy (2C) etc.

## Current Position

The work across all three of the areas outlined above is progressing well, with the Strategic Intent being the first product due for delivery in January. A strategy development session, held with The Bevan Commission, was held on the 8th October and captured insights from a wide range stakeholders, partners, staff and the community, which will be used to inform to all three of the strategic products. This builds upon broader engagement with the Regional Partnership Board (RPB) and Board Members that took place earlier in the year. Over the course the next few months further engagement events are scheduled for November and December 2025 (with the December event focusing on primary and community care,) and January 2026.

Running concurrently to the development of the 10 Year Strategy is the development of the Clinical Services Plan, with delivery expected in the 2026/2027. The engagement and co-production approach to this work (with staff, partners and communities) is already contributing to improved relationships and reputation and supporting the foundations to implement the CSP.

The Digital Roadmap (2A.6) 'From Vision to Action 'Great Care Every Time' was supported by the Strategic Planning and Service Change Group in August and will be embedded into the broader Health Board Strategy and implemented through the 26-29 IMTP.

## Remainder of the financial year

All deliverables are still on track for Q4, although given they are all needing to be progressed simultaneously, work is underway to ensure sufficient resource is allocated to this area of work. A quick precis of the key commitments is:

- Strategic Intent – Published following Board in January.
- 10-Year Strategy – Complete the diagnosis work by end of March, as part of the broader Discovery phase due to complete by Q1 2026/27.

- Clinical Services Plan – Deliver improvements against Challenged Services (phase 1 of the CSP) and complete preparatory work for phase 2 of the CSP by end of March.

<p align="center"><b>2B Strengthening Planning and Commissioning</b></p>	<p align="center"><b>Executive Director of Transformation and Strategic Planning / Director of Performance and Commissioning</b></p>	<p align="center"><b>Delivery Confidence</b></p>

**Overview**

The Strengthening Planning and Commissioning sub-objective is about ensuring the organisation has effective planning and commissioning at the heart of service design and delivery, to provide more effective and sustainable services for the population of North Wales. There are several different aspects to the work with the overarching aim of improving the organisational capability in this space. There are two elements to this; one on Planning, informed by the Special Measures independent review of planning, and the other on Commissioning, with some specific reviews of commitments, Third Sector and insourcing / outsourcing contracting.

**Current Position**

Improvements in the organisations capability in planning contributed to the submission of the Health Board's first ever financially balanced IMTP last year. Progressing the planning and commissioning commitments will support more effective and sustainable services for the population of North Wales.

The focus of the Planning work is to enhance the organisational capacity and capability, building on the independent review of planning recommendations (2B.1). This is informed by stakeholder learning exercises (2B.2), Welsh Government feedback on the 2025-28 IMTP submission and completion of the Welsh Government’s Planning Maturity Matrix self-assessment (2B.3). Work has progressed well, coming together through a significant update to the organisation’s Integrated Planning Framework (2B.2), socialised through the Strategic Planning and Service Change sub-group of Executive Committee and PPHP, prior to being approved by Board in November. This is being put into practice through the current IMTP planning cycle and associated support and guidance. The Planning Maturity Matrix work has generated an action plan to support improvements in planning maturity in specific areas, which will be re-assessed within 12 months as part of the annual self-assessment.

Commissioning has been a focus for the in-year planned care long waits delivery, and further important pieces of work will be progressed during Q3 and Q4, although the absence of a substantive Director of Performance and Commissioning has impacted on pace of progress in this space.

**Remainder of the financial year**

The remaining year will focus on developing organisational capacity and capability for planning and commissioning and work is aligned to Foundations for the Future programme. Staffing capacity is impacting on the ability to progress this work, particularly the commissioning elements due to the absence of a Director of Performance and Commissioning to lead this priority area of work.

<p align="center"><b>2C Improving the Environment, Estate and Facilities</b></p>	<p align="center"><b>Director of Environment and Estates</b></p>	<p align="center"><b>Delivery Confidence</b></p>

**Overview**

The Improving the Environment, Estate and Facilities sub-objective consists of 12 priorities based around multiple areas to; identify, prioritise and deliver schemes through the Integration and Rebalancing Capital Fund (IRCF), review current standards and performance of existing estate, inform future developments whilst maximising potentials from strategic disposals, enhancing efficiencies and opportunities especially around business continuity, whilst minimising contributions too and impacts from climate change.

**Current Position**

Action to progress strategic capital developments have been successfully undertaken following the NHS All-Wales Capital Prioritisation exercise. Business cases are actively progressing for key projects including; the Adult & Older Persons Mental Health Unit, Nuclear Medicine Consolidation, and the Royal Alexandra Hospital Phase 1 addendum, with submissions planned to Welsh Government. Approval of capital funding for critical diagnostic and treatment equipment, such as two Linear Accelerators at the North Wales Cancer Centre and a SPECT-CT at Ysbyty Gwynedd, will significantly enhance service delivery and patient outcomes. The IRCF programme is under the remit of the Strategy Planning & Service Change Group, and a strategic overview of the Health and Wellbeing Hubs was well received at November Board.

Progress continues on key priorities, including major capital schemes and initiatives to maximise disposals and partnerships for reinvestment. Work is underway to support business continuity, collaborate with Bangor University on the North Wales Medical School, assess facilities standards, and complete the Welsh Government Climate Change Risk Assessment. Additional actions include building strategic partnerships and installing onsite renewable energy where viable. (2C.3).

Progress continues on key strategic priorities aimed at strengthening infrastructure and sustainability. This includes advancing major capital schemes and finalising an Estates Strategic Plan aligned to the Health Board’s emerging 10-Year Strategy to ensure long-term service resilience. Work is also focused on maximising asset disposals and forging partnerships to reinvest in patient care. Alongside this, initiatives are underway to enhance business continuity, collaborate with Bangor University on the North Wales Medical School, and assess facilities against national standards. Environmental commitments are being addressed through completion of the Welsh Government Climate Change Risk Assessment and exploring onsite renewable energy solutions. These actions collectively support improved estate efficiency, compliance, and sustainability, while building strategic partnerships to future-proof healthcare delivery.

**Remainder of the financial year**

Focus is on finding a way forward for each of the IRCF schemes, ensuring that there are Senior Responsible Officers (SROs) and appropriate programme teams in place to drive the whole service change work forward. Additionally, completion of the Estates Strategic Plan is dependent on the development of broader Health Board 10-Year Strategy (and Clinical Services Plan), meaning it cannot be delivered by March, impacting estate planning and linked initiatives.

<b>2D Enhancing digital, data and technology approaches</b>	<b>Chief Digital and Information Officer</b>	<b>Delivery Confidence</b>
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**Overview**

The Enhancing Digital, Data and Technology approaches sub objective is based around 14 priorities each delivering several technological improvements or advancements into the organisation, the benefits of which will enable service transformation, improve patient safety, and reduce reliance on paper-based processes. The programme includes major projects such as Electronic Health Records (EHR), Mental Health EHR, electronic prescribing (ePMA), maternity systems, and diagnostics platforms, all of which are critical enablers for future integrated care.

**Current Position**

Progress across the portfolio is mixed, with several projects facing significant challenges. The EHR Transformation Programme remains on hold pending Welsh Government’s national roadmap, despite completion and local approval of the Outline Business Case. This delay creates uncertainty around timelines and investment planning. The Mental Health EHR programme has secured Welsh Government funding but delays in Procurement assurance checks is preventing completion of the full business case prior to Health Board approval.

The ePMA rollout is progressing with early adopter sites scheduled for December and phased deployment across acute sites through to March 2026. Key risks include resource constraints, a capital funding gap and retention of fixed term staff if funding extensions are not secured. Timescales remain challenging for the maternity EHR project which is scheduled to go live across all sites in March 2026. The LIMS implementation faces significant delays due to legacy data migration and system configuration issues, making the March 2026 target unlikely.

Positive milestones include the Radiology RISP system which successfully went live in September and is stabilising, though technical issues remain unresolved and Phase 2 timelines are to be agreed. The NHS Wales App has also gone live with new referral and outpatient reminder functionality in October 2025, improving patient engagement, and the endorsement of the Digital Roadmap. The repeat prescription functionality for the NHS Wales App however requires national change control, delaying full delivery.

The Digital Roadmap: From Vision to Action: Great Care, Every Time, has been endorsed and will now be embedded within the Health Board’s broader strategy. A draft EPRR cyber response plan has also been developed and is scheduled for review in December. Challenges remain to deliver the remaining objectives by the end of the financial year.

**Remainder of the financial year**

The focus for the rest of the year is to mitigate risks and maintain momentum on deliverables. For maternity and ePMA, intensive training and phased go-lives will be required, alongside efforts to secure additional resources. Diagnostics work will prioritise stabilising RISP operations and accelerating LIMS progress, while contingency planning for infrastructure risks will continue. For EHR and Mental Health, engagement with Welsh Government and completion of assurance processes will be critical to progress. Across all projects, emphasis will remain on robust governance, risk management, and stakeholder engagement to ensure alignment.

<b>2E Developing and delivering value and sustainability</b>	<b>Executive Director of Finance</b>	<b>Delivery Confidence</b>
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**Overview**

The Developing and delivering value and sustainability sub objective is based around four priorities: Delivering a refreshed value and sustainability programme, maximising opportunities to reduce waste, harm and clinical variation ultimately building knowledge and capacity in delivering value-led improvement into the wider organisational frameworks. The programme consists of the following workstreams: 1) Medicines Management 2) Continuing Health Care (CHC) 3) Workforce 4) Non-Pay & Procurement 5) Clinical Variation & Service Reconfiguration 6) Value-Based Health Care

**Current Position**

A refreshed Value & Sustainability Programme is operational and designed against the core national thematics for 25/26 (e.g. Medicines Management – maximising biosimilar usage, branded to generics, reduction in low-value prescribing). A full review has been undertaken of the programme against all other Welsh Health Board initiatives to ensure all opportunities are maximised. At end of Q2 (Month 6), the programme had identified its target of £40m ‘Green’ RAG-rated savings against a wider plan (which includes Red and Pipeline Schemes) of £45.3m. At end of Q2 (Month 6) year-to-date, the programme had over-delivered by £2.1m against forecast.

In relation to specific schemes to address clinical variation, two new projects were established in Q2 - 1) Orthopaedic Implant Rationalisation and 2) Orthopaedic Pathway Redesign (based on GIRFT-best practice). Also, delivery against the 5 High Value High Impact (HVHI) pathways (Cabinet Secretary Enabling Actions) continues, with Diabetes, Bone Health & Hip/Knee progress and performance presented to the National Value Finance Leadership Group. In addition, following the appointment of the new Medical Director, work also commenced on the redesign of the Clinical Variation workstream, which will also integrate the newly formed Value Based Health Care workstream into a single approach.

Work continues to hardwire Value Based Health Care into organisational structures and architecture. Value principles are now reflected within the integrated planning framework and reinforced through planning guidance. A new IMTP Collaborative Planning Group has been commissioned and has senior Value representation as part of its membership, to ensure the principles are proactively designed into 26/27 submissions. Value was also the foundation for the operating principles for the Health Board, to support the shift to a value-led organisation.

Work continues to develop foundational knowledge of Value (particularly with clinical colleagues), with a formal session delivered on the Advanced Clinical Leadership Programme.

### Remainder of the financial year

By Q4, a fully refreshed Clinical Variation Workstream will be operational with priority pathways identified. A refined benefits framework will be operational, which will support a wider view of value, which focuses equally on non-financial value metrics (patient/population health outcomes, experience etc). Work will be underway to develop the draft programme for 26/27, based on this revised benefits framework. The emerging Foundations for the Future MCP will help drive value into the 'DNA' of the organisation and a specific value-led competency framework for senior managers will be developed.

Plans for a Value Academy will be matured and a training package to increase foundational knowledge will be designed and tested.

<b>2F Improving workforce planning and development</b>	<b>Executive Director of People Services and Organisational Development</b>	<b>Delivery Confidence</b>
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### Overview

The Improving workforce planning and development sub objective includes 10 priorities delivering a wide range of benefits for the organisation. Outputs from this workstream includes ensuring detailed workforce analysis and plans are in place supported by a suite of framework documents, planning tools, guidance and training. These outputs will be enablers to deliver better outcomes for patients like improved access to services, seeing the right clinician first time etc Resulting in measurable reduction in agency expenditure, effective job planning and reduced sickness levels together with better outcomes for patients, improved access to services and ensuring the right care in the right place at the right place.

### Current Position

Workforce planning is progressing across all challenged services, with training delivered and plans at varying stages of development. Resources to support planning are being finalised for launch on BetsiNet by the beginning of Q4, although planning assumptions and links to support are available within the recently released Planning Guidance. A tool supporting teams in the development of their plans (2F.1) has been developed and is being utilised. Therapy Services continue annual workforce reviews, supported by successful recruitment strategies such as over-recruitment (i.e. hiring more staff than the initially planned or budgeted number of positions for a given role, department, or project) extra staff to account anticipated attrition, service demand fluctuations, and training pipelines for clinical roles) and new graduate pipelines, including the first Wrexham University cohort and workplace degree initiatives. Nurse vacancy levels have improved, particularly at Band 5 with near full quota levels, though challenges remain for Band 6–7 and specialist nurse posts (due to the historically large number of vacancies we have carried at band 5). Now the Band 5 gaps have been closed plans to recruit and build succession pipelines should close those gaps over the next few years, in the meantime. mitigated through development and rotation opportunities.

Agency spend is reducing, with Health Care Support Workers (HCSWs) and Estate & Ancillary (E&A) at zero and Administrative and Clerical (A&C) nearing target, though some off-contract use persists to support Planned Care recovery. Job planning implementation has been delayed pending national policy; a local policy is now scheduled for rollout by end of Q3. Current compliance stands at 51% of consultant job plans agreed as of October 2025 (2F.9).

### Remainder of the financial year

Whilst progress is evident, there are several other priorities scheduled to be completed in Q3 & Q4, a number of these priorities are directly outside of the workforce team's control as they are directly impacted by organisational priorities and pressures. This is reflected in the overall confidence of delivery rating.

### 3A Culture Development

Executive Director of People Services and Organisational Development

Delivery Confidence

#### Overview

The Cultural Development sub objective is covers seven priorities aiming to deliver a number of benefits for the organisation. Outputs from this workstream includes implementation of a new values & behaviours framework into each organisational activity, production of a synthesis report which will guide our future culture and leadership approach and complete roll out of the culture change leadership programme. The Health Board is implementing the Kings Fund, Culture and Leadership Programme, with support from HEIW and the author Professor Michael West. Improved governance arrangements will support and align to the delivery of the organisation's strategic objectives. Anticipated outcomes include improved staff engagement, morale, and well-being leading to better patient care.

#### Current Position

The Values and Behaviours Framework (V&BF) embedding plan is progressing well, with most communication and socialisation actions completed and clear timelines for integration into remaining organisational processes. The V&BF toolkit has been successfully launched on BetsiNet and is actively promoted by Culture Change Leaders, supporting wider adoption. Welsh Government has acknowledged significant progress in addressing special measures de-escalation criteria, particularly in strengthening leadership and embedding core values. The Synthesis Report has been submitted to key governance groups and was presented to Board in November, reinforcing alignment with organisational development priorities (3A.2). Over 200 Culture Change Leaders have now been recruited to help embed the programme locally. The Synthesis Report has been peer reviewed by Professor Michael West and he has confirmed that the depth and quality of the report is one of the best of over 80 NHS organisations he has peer reviewed.

#### Remainder of the financial year

Remaining priorities on track for delivery by Q4, including to 1) Co-produce draft Design Phase priorities for 2026/27 to strengthen compassionate, inclusive leadership, 2) Complete rollout of the Culture Change and Leadership programme, 3) Build staff engagement through the engagement plan, including survey actions, PADR objectives, and events, 4) Improve governance to align with strategic objectives, using the RACI model to clarify roles and accountability.

### 3B Leadership Development

Executive Director of People Services and Organisational Development

Delivery Confidence

#### Overview

The Leadership Development sub objective is based around seven priorities delivering a number of benefits for the organisation. Focus is directed around the further development of the Integrated Leadership Development Framework combined with review and evaluation of existing leadership programmes. Outputs from this sub objective include building core management competency frameworks across NHS Wales professionalising operational management and leadership across the organisation.

#### Current Position

A comprehensive data analysis of user engagement, themes and attrition rates has informed targeted recommendations, which are being integrated into the next phase of the two leadership programmes to strengthen staff engagement and learning outcomes. These enhancements, embedded within the Integrated Learning Development Framework (ILDF), will support leadership development at all levels, contributing to improved experiences for staff and better outcomes for patients across the Health Board. Three key milestones have been achieved, including the development and socialisation of workshop content, commencement of workshops in June 2025, and the successful launch of the "Learning to Lead & Manage" programme following its pilot. The Leadership Hub on Gwella is established and active, with ongoing collaboration ensuring reporting requirements remain fit for purpose (3B.1, 3B.6, 3B.7).

## Remainder of the financial year

The next phase will focus on developing a core programme for middle managers and leaders, aligned with the national strategy in collaboration with HEIW and academic partners. In addition, a comprehensive review of BCUHB's Coaching and Mentoring Network will be undertaken to ensure sufficient capacity, active engagement, and robust support structures. Where possible programmes are being developed to run across Mid Wales Health Boards as well as BCU to increase facilitation capacity.

<b>3C Citizen engagement and partnership working</b>	<b>Director Of Partnerships/communications And Engagement</b>	<b>Delivery Confidence</b>

### Overview

The Citizen engagement and partnership working sub objective is based around nine priorities delivering a number of benefits for the organisation focused on full implementation of the recommendations of the independent review of engagement. Outputs from this sub objective include expansion of engagement programmes across North Wales.

### Current Position

The Health Board has strengthened its strategic role within the Regional Partnership Board (RPB) through refreshed representation and a structured reporting process embedded in formal governance arrangements. These improvements ensure clear accountability, alignment with organisational priorities, and consistent senior-level input. Regular reporting to the BCU Planning, Population Health and Partnerships Committee provides enhanced oversight, while initiatives such as councillor engagement pilots and the development of a Youth Voice Framework that embeds the perspectives of children and young people in Health Planning and decision making.

## Remainder of the financial year

Although delivery is slightly delayed due to scheduling difficulties with drop-in sessions, strong leadership, clear next steps, and positive partner engagement provide assurance that objectives remain on track for completion within 2025/26.

<b>3D Welsh Language &amp; Culture</b>	<b>Executive Director of Allied Health Professionals and Health Science</b>	<b>Delivery Confidence</b>

### Overview

The Welsh Language and Culture sub objective is based around five priorities delivering a number of benefits for the organisation focused around transition from planning to operational delivery of the Welsh Language Standards within the Welsh Language (Wales) Measure 2011 and the Welsh Governments Strategic Framework for Welsh Language Services in the Health Care sector 'More than just words' .

### Current Position

The Welsh Language Strategic Forum's approval of the promotional plan provides a clear pathway to enhance visibility, staff engagement, and cultural awareness. Actions underway—including increased Welsh language presence in communications, tailored training, and cross-service collaboration—support integration of Welsh language and culture into everyday

practice. The development of a Welsh Language Champions approach, supported by case studies and recognition of best practice, establishes a strong foundation for promoting bilingual service delivery and advancing organisational objectives.

**Remainder of the financial year**

Key actions include adopting the Language Choice Scheme for specific vulnerable patient groups and, in collaboration with the National Centre for Learning Welsh, delivering a tailored training programme for Mental Health and Learning Disability Service.

<b>4A Prevention and Early Intervention</b>	<b>Executive Director of Public Health</b>	<b>Delivery Confidence</b>

**Overview**

The majority of what the NHS sees now is a result of long-term conditions - all of which have modifiable factors, and the majority have significant preventable factors. Our focus must be on reducing the prevalence (the number of people with long term conditions) and reducing the progression of these conditions (reducing the severe complications of long-term conditions) if we are to stop and then reverse the current widening gap between healthy life expectancy and life expectancy.

There are four areas of focus as established in the 25/26-27/28:

1. Working with partners to address the wider determinants of health
2. Reducing Health Inequalities
3. Improving the ability of people to maintain healthy lifestyles
4. Improving the wellbeing of the population

**Current Progress & Future Progress**

Progress to date includes the completion of a Weight Management Service review, with recommendations now under review. In order to maximise the use of targeted grant funds which support Prevention and Early Intervention a review of existing spending plans and establishment of Memorandum of understanding have been implemented with services. Population health intelligence has supported the development of the strategic intent, further supporting the ongoing development of the health board strategy. The Health Protection have increased activity in Care Home settings to improve infection protection controls. There has been progress in developing co-commissioning of Social Prescribing models which will expand the offer and accessibility, together with our Local Authorities. An Anchor Framework model which promotes actions which improve the health and wellbeing of the population is being explored with the Regional Partner Board. We continue to make good progress against the National Immunisation Framework and are meeting targets associated with COVID and Flu.

**Remainder of the financial year**

Whilst there have been some delays experienced against some key milestones, these are unlikely to affect most of the delivery in 25/26. The holistic models of prevention and anchor framework will be further developed alongside the population health data and intelligence.

<b>4B Primary Care including clusters</b>	<b>Chief Operating Officer</b>	<b>Delivery Confidence</b>

**Overview**

The primary Care sub objective is made up of 16 priorities the outcomes of which range from the implementation of the national ‘Primary Care Model’ for Wales and the national Primary Care Programme, dentistry, training, increased research opportunities, through too maximising opportunities for primary care as an alternative to ED attendance.

## Current Progress

Progress has been made across key areas; however, significant work remains to achieve full delivery by Q4. Cluster Footprint Review – Dialogue with cluster leads, senior coordinators, and Assistant Director Primary Care (ADPC) has commenced during November, and a proposed solution will be presented to the Executive Team in due course. Implementation is anticipated for the new financial year, but timelines remain tight. Contract Assurance Framework (CAF) has been successfully transitioned to ‘business-as-usual’ within Primary Care Contracting and IHC teams. The Delivery plan has been aligned with national timescales, and lessons learned have been incorporated. An all-Wales Task and Finish Group is being established for 2026/27. Community Health Pathways continues to be rolled out. Early evidence shows positive impacts particularly to referral quality and patient flow, but further embedding and monitoring is required (4B.3). General Dental Service Procurement – Contracts have been awarded for GDS, orthodontics, oral surgery, and non-urgent access sessions, strengthening service provision across North Wales (4B.5). Performance Framework – The integrated performance framework and governance structures are under review following organisational changes. While key reporting duties are being maintained, alignment to the new structure is outstanding. Overall, good progress is evident however there is a risk to full delivery by Q4 due to dependencies on organisational restructuring and tight timelines. Mitigation plans are in place, and updates will continue through established governance routes for overdue priorities and priorities due for delivery in quarter 3 and 4 (4B.9).

## Remainder of the financial year

Mitigation plans are in place, and updates will continue through established governance routes for overdue priorities. Priorities due for delivery in Quarters 3 and 4 include those involving the implementation of the national primary care model and expanding suitable training environments for medical students.

<b>4C: Community Care</b>	<b>Chief Operating Officer</b>	<b>Delivery Confidence</b>

### Overview

The Community Care subobjective consists of 12 priorities, the outcomes of which aim to develop increased provision of Enhanced Community Care, through increasing District Nursing / community nursing and specialist palliative care weekend provision. However, a number of these proposals are subject to business case approval.

### Current Position

This sub objective is red due to delays against the original schedule as outlined in the Ministerial Priority submission; however, progress has been made with key priorities during Quarters 1 & 2 in areas such as options for additional weekend Specialist Palliative Care CNS hours (4C.10) and business cases for Enhanced Community Care (4C.2) and increased weekend community nursing capacity (4C.6) are in development, outlining costs, benefits, and funding streams but subject to provision of suitable project governance structure and clinical / operational leads.

## Remainder of the financial year

Work to continue the development of business cases and identification of funding sources will continue through the remainder of the year. A number of priorities are scheduled for delivery in quarters 3 & 4 in the areas of weekend specialist palliative care and enhanced community care through weekend community nursing.

<b>4D Planned Care, Cancer &amp; Diagnostics</b>	<b>Chief Executive / Chief Operating Officer</b>	<b>Delivery Confidence</b>

## Overview

This subobjective is made up of thirty-nine priorities separated into three categories;

- A. Planned Care
- B. Cancer Care
- C. Diagnostics

## Current Progress

Priorities under Planned Care, Cancer Care, and Diagnostics, remains at risk due to delays against the original schedule; however, progress has been made with key priorities during quarters 1 & 2. A number of ADP targets initially scheduled have been revised and agreed through the Planned Care Programme Board, particularly as more detailed programme plans have been developed. Several of these priorities are now expected to commence and be delivered by Q4.

## Remainder of the financial year

Progress will continue to be undertaken and reported in accordance with the Planned Care Programme and overseen by the Planned Care Programme Board (chaired by the CEO). The risk of delay remains particularly as several priorities are not due to commence until Q3 and Q4.

## Individual Services Breakdown – Current position and focus for end of year.

### A. Planned Care (Red)

#### Current Position

Planned Care is progressing across key workstreams. Direct cataract referral listing has progressed, WPAS coding has been corrected, and Phase 2 demand and capacity modelling is underway to inform one-stop capacity requirements, though increasing outpatient and POA capacity remains a challenge.

The Health Pathways Community project is exceeding targets, with 128 localised pages (58 formal) and 228 in progress, including over 10 orthopaedic pathways nearing sign-off. Work is being enhanced with a prioritisation framework, although funding for GP Clinical Editors is not yet confirmed.

For Consultant Connect, national funding will cease beyond 2025/26, and a review of usage and impact is underway to assess implications for primary care advice and guidance.

Proactive DNA mitigation measures are in place, including extending clinic templates and overbooking strategies, visible in the Outpatients dashboard. Further work is required to ensure consistent reporting and application.

#### Remainder of the financial year

The Health Board will implement best practice standards for referral advice and guidance in high-volume specialties, roll out Health Pathways and the Pathway Alliance Programme, and progress the new Booking Service for a consistent approach. Work will continue to revise the Pre-Operative Assessment model, improving theatre utilisation, and expanding day case and minor procedure opportunities. Validation and data cleansing of follow-up lists will be undertaken, alongside the introduction of See on Symptoms (SoS) and Patient-Initiated Follow-Up (PIFU) in priority specialties. Enhanced demand and capacity modelling will be introduced, supported by in-year commissioned capacity for 2025/26 delivery. Finally, integrated specialty plans for 2026/27 will be developed, covering workforce, finance, and commissioning requirements.

(4D.a.4,6,8,9)

### B. Cancer Care (Amber)

## Current Position

Cancer care is a key priority with additional external resources commissioned for endoscopy and dermatology to maintain timely access to care. These measures have supported service delivery while sustainable models of care are being developed and recruitment progresses, ensuring stability during the transformation period. In addition, the Community Health Pathways tool was successfully launched to all GPs in July 2025, and a nursing team has been recruited to support implementation. Induction will take place in Q3, with service launch planned for Q4. Work continues, led by the Women’s Division and Radiology, to define the most appropriate model and resource requirements for future service delivery.

## Remainder of the financial year

The Health Board will continue work to recover cancer performance and improve compliance with the Suspected Cancer Pathway, aiming for 80% of patients treated within 62 days by March 2026. Clearing the current backlog of over 62-day waits will be a priority over the next six months. Plans include optimising the teledermoscopy service and building the case for its expansion, developing a proposal for robotic-assisted cancer surgery, and considering repatriation of selected services from England to North Wales. Additionally, the Health Board will work with Maggie’s and the Steve Morgan Foundation to open a new Maggie’s cancer support centre at Ysbyty Glan Clwyd.

(4D.b.4,5,7)

## A. Diagnostics (Amber)

### Current Position

A rapid review of workforce capacity and skill mix is underway to inform the recruitment and retention strategy. Completion of this has been delayed due to significant non-recurrent activity required to deliver the 8-week and 104+ week Stage 2 targets and OPD programme diagnostics, with completion now anticipated in Q4. In addition, the Endoscopy business case is scheduled for Executive review early in Q3, ensuring progress on service development priorities

Demand and capacity reviews for all diagnostic services are underway, with improvement plans being implemented to secure sustainable performance and meet forecast trajectory targets. Non-recurrent HB/WG funding approved in Q2 is enabling targeted diagnostic recovery actions focused on 8-week, 104+ week, stage 2, and OPD programme diagnostics. Recovery schemes are now being procured and implemented through Q3/Q4, with progress monitored against agreed improvement trajectories and full completion expected in Q4. Delivery of major national IT programmes in Radiology and Pathology continues to progress, with the Radiology Informatics System Project successfully implemented in September—significantly ahead of other Welsh Health Boards. The Laboratory Information Management System 2.0 is advancing as planned; however, national delays have necessitated a revised implementation target of end Q4.

### Remainder of the financial year

The Health Board will complete demand and capacity reviews for all diagnostic services and begin implementing improvement plans to deliver sustainable performance against trajectory targets. Estates reviews will progress with priority projects, while major national IT initiatives in Radiology and Pathology continue, subject to resource prioritisation. Development of the medical illustration.

(4D.c.3,8)

4E UEC

Chief Operating Officer

Delivery Confidence

### Overview

The UEC sub objective consists of seven priorities under four workstreams;

1. Support at the Individuals Front Door
2. Hospital Front Door

- 3. Hospital Flow
- 4. Discharge from Hospital

Outputs from which will include implementation of a remote clinical services framework, a 'Single Point of Access' Hub, a community-based falls response service supported by an acute front door frailty service and community frailty service. It is anticipated that this work will ensure patients get the right care for their needs quickly reducing demand on acute sites, reducing deconditioning and optimising hospital flow.

**Current Position**

A significant amount of work is progressing across multiple workstreams such as: Remote Clinical Assessment & SPOA Hub – Progressing to simplify urgent care access and trial alternative pathways. Community Falls Response – Developing services to improve response times and reduce ED demand. Primary Care Model & Same Day Offer – Implementation aligned with national programme. Acute Front Door Frailty – Plans have been established for all acute hospitals, integrated with community services. Ambulance Handover Guidance – WHC implementation is underway to improve transfers. Optimal Hospital Flow – Actions to reduce delays is supported by facilitators and training. Discharge Planning – Work continues on delay validation, trusted assessor model, and community capacity.

**Remainder of the financial year**

All sub objective priorities are scheduled with continued focus on implementation of the remote clinical assessment framework, implementation of community-based falls response services and implementation of acute front door frailty service.

4F Adult Mental Health & Learning Disability	Executive Director of Allied Health Professionals and Health Science	Delivery Confidence
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**Overview**

The Adult MHL D sub objective consists of eight priorities the outcomes of which include continued improvements to quality and safety of care, development of a coherent overarching model for delivery of care improving access and reduced waiting times for care.

**Current Position**

Areas of delivery for MHL D are progressing well with the Crisis Care Model agreed at Executive level and implementation of phase 1 starting in year. Phase 2 of the Crisis Care model links in with the development of Community Mental Health Services and BCU have been approved as 1 of 3 demonstrator sites across Wales for the development and delivery of a Mental Health Open Access Model, which covers adult and CAMHS. Specialist MH services are operational, and patient are seeing the benefit of these services, but full delivery of plans have experienced challenges due to accommodation issues, staffing and funding; solutions have either been found or are being worked through which will enable success but will delay the original delivery targets into 2026/27.

The NHS Performance and Improvement Patient Safety Programme is being honed nationally and BCU are supporting the development and the delivery of actions with leads appointed across the 6 workstreams. Progress so far includes the development of national anti-ligature standards which BCU led on, the introduction of person-centred safety plan training, consultation on discharge standards with roll out planned by year end, and national patient safety site visits scheduled for each MH unit within BCU in Quarter 3.

Development of an overarching care model and delivery of Phase 1 of the Mental Health Electronic Health Record. The procurement stage of the Mental Health Electronic Health Record is drawing to conclusion, and work is continuing with colleagues in DDaT and CAMHS on supporting elements including capability and training needs, intermediate and longer term staffing and skills requirements and active engagement session planned throughout Q4.

## Remainder of the financial year

All sub objective priorities are scheduled and on track for completion by the end of the financial year particularly around the full delivery of the Royal College of Psychiatry Review and the development of the overarching model for people experiencing mental health crisis.

4G CAMHS

Chief Operating Officer

Delivery Confidence

### Overview

The CAMHS sub objective consists of five priorities the outcomes of which focus around revised workforce planning and training, actions to ensure continued compliance with Mental Health Measure (MHM) Part 1a (targets for assessment) and attainment of Part 1b (targets for intervention across all teams), together with associated actions to sustain service provision as the service eliminates long waits.

### Current Position

Best practice from other Health Boards has been shared and is informing local service development, including group provision and psycho-education to support delivery against MHM therapeutic intervention target (Part 1b). This is being reviewed through the Regional Access Group alongside a scoping exercise of local provision. Actions to date demonstrate a proactive approach to ensuring services are appropriate, equitable, and aligned with the national CAMHS specification, reducing unwarranted variation and improving outcomes for children, young people, and families. The CAMHS Strategic Workforce Plan has been agreed and implementation will be monitored through the Regional Workforce Implementation Group (4G.1).

## Remainder of the financial year

Further priorities remain on track for delivery during Q3 and Q4 including developing proposals for alternatives to admission and evaluation of the implementation of the schools in reach approach to emotional health and wellbeing.

4H Neurodevelopment

Chief Operating Officer

Delivery Confidence

### Overview

The Neurodevelopment sub objective consists of five priorities focused on improving services for children and young people with Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD). Support for children and young people whilst on the waiting list and post-diagnosis relies on a whole-system approach working closely with partners across education and social services supported by the Children's Regional Partnership Board (RPB). The priorities relate to reducing waiting lists and the development of a needs-led service model combined with greater information sharing protocols with partners.

### Current Position

The waiting list stratification has been completed (4H.1), and focus is now on reducing waits over three years in line with Ministerial priorities. A new assessment pathway, aligned with NICE guidance, has been developed to improve efficiency and realise 30% efficiencies in the current assessment process (4H.2). This will be monitored through Welsh Government Performance and Improvement (P&I) Division touchpoint meetings. The Integrated Service Plan (ISP) has been approved by Welsh Government and the Regional Partnership Board, with local procedures for shared information access being developed between IHCs and Local Authority partners. (4H.4)

## Remainder of the financial year

Further priorities remain on track for delivery by the end of the financial year with development of a needs led service model and formal approval of information sharing protocol.

4I Dementia	Executive Director of Nursing and Midwifery	Delivery Confidence
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**Overview**

Dementia care is complex and requires skilled, person-centred approaches across all health services. Patients with dementia often occupy a significant proportion of hospital beds and present unique challenges that, if unmet, negatively impact outcomes, experience, and resource use. With dementia prevalence rising rapidly, the Health Board must strengthen care standards, reduce variation, and invest in workforce training and service improvements. A regional partnership and the Dementia Improvement Team are driving progress aligned with national policies and guidance, focusing on diagnosis, education, and personalised care. Effective dementia care benefits patients, families, and the wider health system by improving resource utilisation and supporting strategic goals. The Dementia subobjective consists of 11 priorities focused on prevention activities and patient experience improvements through training, best practice and environment improvements.

**Current Position**

Most priorities under this sub-objective are scheduled through Q3 and Q4, focusing on embedding dementia improvement initiatives across Emergency Departments (ED) and Integrated Health Communities. Work has been progressing to identify best practice, enhancing dementia training and developing local action plans also progressing. Two priorities are currently overdue: 4I.6 - Facilitate an extensive assessment of environments has been fully undertaken in two IHC’s with the third currently learning from areas of excellence in terms of environment for care of patients with Dementia. Additionally, 4I.9 - the creation, collation, and sharing of prevention resources has been delayed pending further engagement on an update to the existing Modifiable Risk Flyer to include newly identified risk factors prior to circulation.

**Remainder of the financial year**

While it is unlikely that some priorities will not be delivered by the end of Q4, significant progress continues to be made. Several key priorities remain on track for completion by the end of the financial year. Areas of focus include delivering an enhanced range and volume of dementia education and training, prevention activities, dementia appropriate environments and emergency department experiences.

4J Challenged Services	Chief Operating Officer	Delivery Confidence
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**Overview**

This sub objective is made up of fifty-six priorities separated into eight categories;

- A) Urology
- B) Vascular
- C) Dermatology
- D) Plastics
- E) Oncology
- F) Ophthalmology
- G) Orthodontics
- H) Trauma & Orthopaedics

## Current Progress

There is a significant volume of priorities across challenged services scheduled for delivery over Q2, Q3, and Q4. While progress has been made and some actions have been completed across different service areas, a some remain overdue and are at risk of not completing within the planned timeframe. There is mixed progress across this mini portfolio, with some improving sufficiently to be considered for de-escalation from Special Measures, whilst others are struggling to overcome some of their key challenges e.g. Workforce.

A summary of the current position and focus for the remainder of the financial year by challenged service is set out below.

### Remainder of the financial year

Overall, the risk of delivery remains high, however specialty-level detail shows mixed confidence and is reflective of the complexity in scale of the tasks varying between the eight categories of challenged services: Plastics and Oncology are on track for delivery in Q4. Urology remains the highest risk for delivery with Vascular, Dermatology, Orthodontics and T&O rated as medium risk. Some of the reasons identified as a risk to non-delivery of this sub-objective include workforce sustainability, performance, leadership gaps, estates and logistical challenges, and programme resource. Focused resources and escalation processes are needed to support completion of outstanding priorities by the end of Q4.

### Challenged Services Breakdown – Current position and focus for end of year.

#### A) Urology (Red)

##### Current Position

A urology workshop, supported by the Urology Clinical Implementation Network (CIN) lead and NHS Performance & Improvement, was held in June 2025; this focussed on developing a comprehensive integrated Specialty Plan for sustainable service delivery. Strengthening governance, the Urology Steering Group has been re-established under the leadership of the Urology CIN lead, and a paper aimed at reducing diagnostic delays to prostate biopsy has been approved through both the Prostate Cancer Pathway Forum and the Urology Steering Group. The Urology Steering Group also agreed to advance major urology cancer surgery developments with the Wirral, including commissioning Robot Assisted (RAS) prostatectomies and planning partnership work for repatriation. In addition, the West Integrated Health Community (WIHC) has recruited a new Urology clinical lead, strengthening onsite leadership and decision-making. Three non-medical staff have joined the national Local Anaesthetic Transperineal Prostate Biopsy (LATP) training programme, supporting a sustainable long-term model outlined in the LATP SBAR paper. A business case has been developed for a Urology Investigation Unit in Wrexham (East Integrated Health Community (EIHC)) - already in place in West and Central) to meet Getting it Right First Time (GIRFT) recommendations, which if prioritised would expand capacity in the EIHC to address demand pressures. Cystectomies have been transferred to the Wirral for care closer to home. Further proposals include recommissioning vasectomy procedures within Primary care, and a national service request paper has been completed for the myMR (my medical record) system integration. Welsh Clinical Portal e-referrals are live, improving waiting list management.

##### Remainder of the financial year

Building on the work and progress outlined above, the Urology service will continue to develop and agree a sustainable on-call rota model, clarify the case for a robotic assisted surgery platform, consolidate the cancer service to the Wirral alongside a robotic training package for Consultants and embed a sustainable model to reduce delays to diagnostic element of the prostate cancer pathway. Within this financial year improvements included in their Challenged Service plan are Vasectomy services commissioned in Primary Care (RAG rated Red), recruitment of a pan BCU Clinical Lead to support service modernisation and consistency of practice (RAG rated RED), development of a Urology Investigation Unit (dependant on business case approval) and implementation of digital enablers for improved efficiency (RAG rated Green). LATP insourcing will commence in the New Year until March 2026 (with a Task and Finish Group established to oversee) commencing with process mapping to understand the current pathway.

(4.J.a.1, 3, 5, 6, 7, 8, 9, 10, 11)

#### B) Vascular (Amber)

##### Current Position

Progress continues across service redesign, pathway development, and governance. A strategic workforce plan is in motion. Work is underway to apply new referral guidance for varicose veins, supported by WLIs to reduce waiting lists. Key pathways are advancing: the Diabetic Foot pathway is agreed, discharge and limb ischaemia transfer pathways are mapped, and a digital pathway tracker is in development with data analyst recruitment progressing. Nurse-led clinics at YGC are improving urgent referrals and long waits, while AAA service review with University Hospitals of North Midlands (UHNM) informs a sustainable model. A consolidated improvement plan and implementation schedule is in place, driven by the Vascular Improvement Group, with 57 of the total 94 actions complete. Engagement with the Limbless Association is ongoing to scope peer-support sessions, and Learning From Events Reports (LFER) backlog is reducing.

### Remainder of the financial year

Workforce sustainability remains critical due to current workforce age profile and national shortages, exacerbated by large waiting lists and delays to treatment. Multi-Disciplinary Team working requires strengthening, and further work is needed to embed an integrated clinical strategy across hub and spoke sites. Plans are in place to explore the role of PIFU and SOS clinics in the West.

(4J.b.3,5,6,8)

## C) Dermatology (Amber)

### Current Position

Dermatology services have maintained a strong focus on waiting list management and remain on track to achieve zero 104-week waiters, supported by a national insourcing contract to deliver Referral To Treatment (RTT) targets. Preparations for opening the Connah's Quay site are in the final stages, with Infection Prevention and Control recommendations processed and shared accommodation agreements pending targeting Q4 for opening (4j.c.6). Teledermoscopy expansion is progressing well, and options being explored to extend provision in the West using BCU resources. A high-volume one-stop approach for lesion management has been agreed. The dermatology workshop held on 24th September provided clear outcomes to support a sustainable clinical and workforce model. Work is also underway with the Quality Directorate to identify patient harm themes and develop mitigation plans.

### Remainder of the financial year

The priority for the remainder of the year is to open the Connah's Quay site and resolve temporary nursing recruitment issues. Teledermoscopy will be further expanded to the West, and discussions with Primary Care will continue, including the potential introduction of General Practitioner with a Special Interest (GPwSI) posts. Outcomes from the September workshop will be implemented to start embedding a sustainable service model, alongside ongoing efforts to reduce long waits and improve 62-day target and RTT performance. Further work required to address facility constraints to enable minor operative procedures and one-stop clinics, together with strengthening workforce resilience through strategic and operational planning.

(4.J.c.3,5,6,8)

## D) Plastics (Green)

### Current Position

There has been a significant reduction in waiting lists due to validation and waiting list initiative (WLI) activity with a 4% reduction in overall waiting list in month including a 33% in patients waiting over 1 year; the service has maintained zero 104-week position since the end of 2024. There has been a transfer of Central patients to East capacity to equalise waits across the Health Board.

Appropriate accommodation has been identified in Connah's Quay Medical Centre for additional plastics outreach clinics and theatre provision, supporting care closer to home, and minor works identified to ensure it complies with Infection Control guidance have been agreed.

There has been infrastructure and operational support resulting in new agreed clinic templates, theatre equipment and full IT access (in place since 2024), and an increase in theatre throughput from 3 to 4 per list in West from April 2025. A positive meeting with WG in August of this year indicated that once the additional capacity and Connah's Quay Medical Centre is operational, the service may be de-escalated from 'challenged service' status

## Remainder of the financial year

Additional capacity in Connah's Quay, following minor works, for dermatology is planned for the beginning of Q4; once opened a start date for Plastics will be agreed with JCC and Merseyside and West Lancashire (MWL). A decision re de-escalation will be considered once this is in place. Discussions will commence with both MWL and JCC on future model and possible transfer of commissioning arrangements.

(4.J.d.3)

## E) Oncology – (Green)

### Current Position

The business case for replacement linear accelerators has been successfully submitted and approved by WG providing potential opportunity for additional capacity in future. Stereotactic Ablative Radiotherapy (SABR) for lung cancers has been approved to commence reducing the need for patients to travel to neighboring organisations for treatment. Three consultant roles have been appointed with a further three pending approvals of job description from Royal College of Physicians. A further four specialist trainees commencing in 25/26 filling long term gaps (2x clinical, 2x medical) with ongoing career opportunity promotion to students. Following a WG Challenged Service Touchpoint Meeting in August 2025, WG felt that the service should be considered for de-escalation from Special Measures due its progress in addressing its workforce issues following submission of chemotherapy and radiotherapy data (demonstrating that we are in line with (or better than) other services in Wales); we are currently waiting for a decision.

### Remainder of the financial year

Whilst collaboration with the development of a single Welsh contract for Chemocare continues with high confidence of delivery for Q4, the ultimate provision of the All Wales Contract is outside of BCU control. As a result of the work undertaken to date, Oncology is being considered for de-escalation from Special Measures by Welsh Government.

(4.J.e.4,5,6)

## F) Ophthalmology (Amber)

### Current Position

Patient safety, experience and timeliness of access and care is being addressed through progress reported in "All Wales Cataract Pathway model" delivery and Data Quality improvements: with staged embedding of High-Volume Low Complexity (HVLC) surgery, WPAS process refinement and patient recoding for effective patient streaming for internal Cataract "One stop" Preoperative Assessment Clinics (POACs), HVLC surgery and outsourcing. Refreshed Project lead resourcing is enabling business case progression to deliver the Digital Electronic Patient record and E-Referral system.

Key enablers for offering timelier care have commenced, including refreshed outsourcing (Cataract) and insourcing (Glaucoma & Medical Retinopathy). Improved future capacity and resilience of the Primary Care optometry workforce continues to be supported by Teach and Treat (Glaucoma and Independent Prescribing) centres with successful expansion to include postgraduate (Medical Retinopathy). Workforce review commenced in Q1 but progression has been impacted by project team staffing challenges and impacts of conflicting demand on engagement.

### Remainder of the financial year

Eye care services across North Wales face challenges impacting patient safety, service quality, and sustainability. While progress is evident, critical risks remain around access delays, fragmented service delivery, programme resource and long-term clinical leadership gaps and aging estates. These require urgent attention to ensure effective plan delivery of service resilience and improved patient outcomes.

The Ophthalmology hi-level plan outlines its commitment to: undertaking focussed harm reviews to enhance its learning already gained via the integrated concerns management approach (eg incident reporting, complaints and claims), ongoing outsourcing of longest waits to support the reduction in harm due to delay in access and those experiencing long waits to treatment, delivering additional capacity through Teach and Treat Independent prescribing post-graduate and higher certificate glaucoma and developing post graduate medical retina (including HCQ) courses with Cardiff University, delivery of WGOS 4 optician pathways, maintain the focus on cataract pathway efficiencies (supported by the Planned Care Major Change Programme) and ensuring BCU readiness for national digital enabler e-referral and electronic patient record.

(4.J.f.1,4,6,7,9,11)

## G) Orthodontics (Red)

### Current Position

Orthodontics remains a significant area of concern, with continued challenges relating to workforce, backlog and access to waiting times across primary and secondary care; infrastructure (estate and digital) and the lack of a sustainable service model. The workforce challenges reflect a national shortage including a lack of consultant and alternative professional staff, compounded locally with the loss of a Consultant since the GIRFT review (January 2025) and upcoming maternity leave. Despite the challenges there has been a reduction in waiting times for those waiting over 156, 104 and 52 weeks, although issues with demand and available capacity continue to present challenges.

A collaborative consultant body is working across the three IHCs highlighted by the GIRFT team as examples of good practice. Building on this, an agreement has been reached to form a North Wales orthodontic group, designed to support the development and delivery of a sustainable service plan. Efforts to diversify the orthodontic workforce are underway, including the training of a dental nurse as an orthodontic therapist, making her one of two now employed within BCUHB. Opportunities for Dentists with Special Interest are also being expanded, with treatment plans and follow-up advice overseen by orthodontic consultants to ensure quality and consistency. A recent recruitment campaign for a consultant post has been launched, offering a wider range of incentives to attract candidates.

Progress is evident in waiting list reductions between January and October 2025, with significant decreases across key categories: 52+ weeks from 974 to 431, 104+ weeks from 591 to 251, and 156+ weeks from 277 to 71. Referral guidelines for General Dental Services are being updated, including requirements such as the inclusion of photographs to improve assessment and triage. An outsourcing process is being developed to manage a cohort of orthodontic patients, aimed at further reducing waiting times, though the options for contracting and/or insourcing are limited. Finally, work is underway on a business case for the acquisition of a CBCT scanner, alongside training for consultant orthodontists to support its use.

### Remainder of the financial year

Work is ongoing to optimise the referral processes and explore insourcing opportunities to help with demand, although the options for contracting and/or insourcing are limited. ADT ADP targets for Orthodontics will be realigned with programme plan for Foundations for the Future Programme and timescales. The majority of orthodontics actions are programmed for Q3 and Q4.

The orthodontic service will be holding a planning workshop at the end of Q3 to establish a unified roadmap for Orthodontics including short-, medium- and long-term actions.

(4.J.g.1,2,3,6)

## H) Trauma & Orthopaedics (amber)

### Current Position

Progress in a number of areas scheduled for Q1 and Q2 deliver has been achieved, particularly in improving data quality, developing proposals to increase patient activity in Abergele Hospital, pan BCU expansion of the consistent application of the See on Symptoms follow-up pathway.

The Orthopaedic Network (hosted by West IHC) has progressed several key workstreams during Q1 & Q2 and the first part of Q3 (2025/26). These have included follow up backlog reduction planning with roll out to East and Centre planned in Nov; Clinical Condition Coding including MOPs coding (and adoption of national coding practice once agreed). The Implant rationalisation workstream has now started led by the Value and Sustainability team and assisted by Welsh Orthopaedic Network, with clinical engagement due to started in October

and further engagement in November. Clinical pathway development, implementation and adoption continue. Whilst some workstreams are slow to progress, others are taking shape quickly.

Between the start of Q2 of 2024 and Q2 2025, arthroplasty procedures in Abergele showed a steady increase, while the overall 104-week cohort volumes across BCUHB declined significantly from 1,296 to 454. MOPs rooms were fully operational across all integrated health centres, with hand and wrist procedures rising to 339 compared with 182 in the previous year. Alongside this, the HSQ trial was initiated in the East. Clinical and operational teams reached agreement to use SOS for backlog patients after their twelve-month review, and validation of the overdue cohort was completed in full; SOS letters have been sent to a test cohort. Strong leadership has been established for the specialty and the Llandudno orthopaedic project, supported by executive oversight through the programme board. Work is also progressing to expand the role of nursing staff and allied health professionals in hand, hip, and knee pathways, aiming to strengthen follow-up services and increase stage one capacity.

**Remainder of the financial year**

Orthopaedic priorities will be delivered in line with the programme plan, rather than original ADP milestones, with the remaining orthopaedic actions currently programmed for Q3 and Q4 delivery with medium confidence reported.

The hi-level plan for Orthopaedics includes: transition to a subspecialty focus pan North Wales enhancing opportunity for standardisation including improving data quality at a sub-specialty level through more effective coding practices; working with orthopaedic clinical leadership to deliver standardised effective job-planning and address workforce gaps through approved recruitment/upskilling of existing non-medical workforce; and ring-fencing of acute site beds to accommodate the longest waiting patients and completion of the Llandudno orthopaedic unit for cold site sustainability.

(4.J.h.3,5,7,8,10)

<b>4K Women's</b>	<b>Chief Operating Officer</b>	<b>Delivery Confidence</b>
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**Overview**

The Women’s services sub objective contains 10 priorities including the establishment of women’s health hubs, implementation of prevention-based women’s health initiatives, digital infrastructure improvements and prioritisation of seven key actions which align to the MatNeo Safety Support Programme.

**Current Position**

Progress has been made where funding has been successfully secured to ensure the continued delivery of the specialist Infant Feeding Lactation Support Service across the Health Board. In addition, development of a local Perinatal Quality Dashboard is progressing as planned. This dashboard will provide robust data and insights to inform key committees, in alignment with the recommendations outlined in the SSP Discovery Report.

**Remainder of the financial year**

All sub objective priorities are scheduled and on track for completion by the end of the financial year. Key actions include supporting the establishment of a Women’s Health Hub, recovery of Gynaecology Cancer and Planned Care, progressing business cases for pathway trackers and SPOA for referrals, implementing the Preconception Strategy, delivering the Maternity and Neonatal Quality Management plan, advancing the Digital Maternity Solution, and implementing the Perinatal Engagement Framework and workforce plan. Work also includes developing a Perinatal Quality Surveillance Dashboard and progressing the business case for specialist infant feeding support across IHC areas.

<b>4L Children &amp; Young People</b>	<b>Chief Operating Officer</b>	<b>Delivery Confidence</b>
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## Overview

The Children and Young People sub objective contains six priorities focused around supporting the Children's Charter and the Parenting Charter together with initiatives to increase the 'youth voice' within the organisation, as well as a focus on increasing the uptake levels of Children's immunisation and further support to children with complex needs.

## Current Position

The Health Board's commitment to safeguarding and promoting the rights and life chances of care-experienced children and young people has been delivered, with formal approval at the Board meeting (30.05.24) and the Parenting Charter signed by the CEO (10.04.25). This demonstrates the organisation's pledge to equity for care-experienced young people and complements the existing Children's Charter.

## Remainder of the financial year

Further priorities remain for delivery in Q4, including raising awareness and implementing the Children's Charter, establishing a Youth Voice Board, improving immunisation uptake, developing transition pathways, and working with partners on the Right Door approach for children with complex needs

**4M Pharmaceutical Services**

**Chief Operating Officer**

**Delivery Confidence**

## Overview

Work within the Pharmaceutical Services sub objective is based around five priorities: Implementing prioritised actions from the Independent Review of Hospital Clinical Pharmacy Services across all hospital settings, cost efficiencies through Medicines Value prevention (particularly in diabetes care), additional community pharmacy services, and the launch of a general pharmaceutical council approved master in pharmacy qualification with Bangor University.

## Current Position

Work to establish a Medicines Value prevention arm for medicines has been undertaken with a system for monthly monitoring of GP prescribing for diabetes medicines is in place monitoring monetary spend and the increase and decrease in spend and volume. Summary reports for all prescribed primary care medicines including diabetes shared with primary care. Challenges remain in evidencing the value of spend of diabetes medications against outcomes of condition outcomes due to variations in the severity of conditions, and variations of extent of self management of diabetes condition.

## Remainder of the financial year

Remaining priorities are scheduled for delivery by the end of the financial year. In areas such as: Implement prioritised actions from the Independent Review of Hospital Clinical Pharmacy Services across all hospital settings, including MHL, Cancer, and Women's services, subject to available resources. Develop a business case to centralise Radiopharmacy services in alignment with the Nuclear Medicine Programme and supported by the national TrAMs team. Scope and test a commissioned community pharmacy model for long-term condition management, starting with hypertension. Progress plans to launch the first MPharm cohort at Bangor University in 2025, working with the GPhC towards achieving Step 4 accreditation by the 2025/26 academic year.

**4N Palliative, End of Life and Bereavement Care**

**Executive Director of Nursing and Midwifery**

**Delivery Confidence**

## Overview

The Palliative, End of Life and Bereavement Care sub objective contains four priorities all of which are scheduled for delivery within Q4. The outcomes of these priorities include development of a Strategic Delivery Plan for Palliative Care and End of Life Care (PEoLC), supporting patients and their families through implementation of the Sign/Words/Actions/Needs) SWAN model for bereavement care and revision of operating model and supporting workforce plan to improve PEoLC in line with the Welsh Government Quality Statement for Palliative and End of Life Care.

## Current Position

Two WTE SWAN nurses have been successfully recruited and are now in post, strengthening the delivery of end-of-life care standards. A SWAN Implementation Group has been established and formally incorporated into the Bereavement Quality Group, ensuring governance and oversight. Additionally, six-monthly bereavement performance reporting is now in place and completed, providing ongoing monitoring and assurance of service quality.

## Remainder of the financial year

All sub objective priorities are scheduled and on track for completion by the end of the financial year. Key actions include supporting the strategic Delivery Plan for Palliative and End of Life Care (PEoLC) implementation of the SWAN bereavement care model, creation of a model and workforce plan aligned to Welsh Government Quality Statement, finalisation of a Quality Improvement Strategy and development of an options appraisal/business case for PEoLC.

40 Dental

Chief Operating Officer

Delivery Confidence

## Overview

The Dental sub objective consists of 10 priorities incorporating a wide range of activities, the outcomes of which are designed to increase GDS provision, capacity and performance whilst also leveraging better value from current financial resources. Together with measures to enhance workforce stability and provide upskilling, training and development opportunities whilst supporting a community-based service and reducing waiting times for treatment.

## Current Position

The Primary Care Board is now established with supporting subgroups. The Managed Services subgroup will commence in November 2025, with Community Dental Service performance as a standing item, while GDS contract performance reports to the Contract Management subgroup. Both feed into the Primary Care Board for escalation of concerns and aim to improve Board visibility of the service (4O.10). Primary Care dentistry is also monitored through IPEDG, chaired by a BCU Executive member. Work has begun to improve dental reporting in collaboration with Performance and Transformation teams. The General Dental Service (GDS) procurement process – Provision of Primary Care Dental Services) was successfully completed in early 2025, and contracts have now been awarded. This includes a £4m GDS award to eight practices across Flint, Conwy, Bangor, Mold, Wrexham, Llanrwst, St Asaph, and Llandudno—six as expansions of existing practices and two as new sites in Denbighshire and Conwy. Additionally, £750k of orthodontic activity has been awarded to two GDS providers in Wrexham, £180k for Tier 2 Oral Surgery Services to two providers in Anglesey and Gwynedd, and £670k for Non-Urgent Access Sessions across six providers in Anglesey, Denbighshire, Wrexham, Conwy, and Gwynedd. Linked to 4B.5.

## Remainder of the financial year

The Health Board will focus on increasing GDS service provision through innovative solutions and collaboration with key partners, including the Chief Dental Officer for Wales and Local Dental Committee. A re-evaluation of areas of need will inform a new GDS procurement process in 2025, with improvements to the tender framework to broaden bidder participation. Work will progress on the Dental Education Strategy to position North Wales as a centre of excellence, including partnerships with Bangor University and expansion of the Primary Care

Academy approach to enhance workforce skills and stability. Continued delivery of national oral health programmes such as *Designed to Smile* and *Gwên am Byth* will remain a priority. Additional actions include addressing CDS waiting lists through resource optimisation and KPI-driven management, undertaking a demand and capacity review for CDS services, and developing a clear domiciliary dental pathway with robust eligibility criteria through co-design with care providers.

<b>4P Diabetes</b>	<b>Executive Director of Public Health</b>	<b>Delivery Confidence</b>
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**Overview**

The Diabetes programme focuses on delivery of the Cabinet Secretary priorities and on improving the outcomes of people with diabetes in our population. It also sets out to respond to wider delivery targets associated with the change pathway for Diabetes treatment, prevention and early intervention.

**Current Position**

The programme is now established, and the governance arrangements are in place to support this. The delivery of some elements of the programme has experienced delays related to wider resourcing challenges. A steering group is in place to address outstanding issues, including staffing challenges and the complexity of implementing eight care processes alongside national programmes such as the HCL business case. Primary care data has been reviewed in relation to the NICE 8 Care processes and the enhanced service for Diabetes, options are now being explored. GP leads have been identified to support the development of the plan focusing on delivery of the eight care processes. This programme is also linked to Value & Sustainability and High Value High Impact interventions for Diabetes.

**Remainder of the financial year**

The Health Board Diabetes Programme will focus on increasing the percentage of people aged 12+ receiving all eight care processes by improving data quality and reporting, addressing variation in primary care and prescribing, and implementing management plans for Type 1 diabetes across care settings. Work will progress on medication use in line with NICE guidance, shared learning, and preparation for future models of care. A business case will be developed in relation to implementing Hybrid Closed Loop technology. Plans are in place for delivery of the Diabetes Programme Deliverables however delays and capacity issues mean the overall programme is likely roll over into a better-informed plan for delivery in 26/27-28/29.

<b>5A University and Further Education Partnership</b>	<b>Executive Medical Director</b>	<b>Delivery Confidence</b>
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**Overview**

The University and Further Education Partnership sub objective is based around seven priorities delivering a number of benefits for the organisation focused around further developing relationships with all higher and further education partners in North Wales to improve research and development, education and training, all supporting continued University designation.

**Current Position**

Building on the collaborative partnership work with Bangor University, progress so far in 2025/26 has seen the development of a MoU with Grwp Llandrillo Menai with a Strategic Steering Group being established to support the delivery of the aims and objectives agreed. For Q3 and Q4 the focus will be on strengthening partnerships with Coleg Cambria and Wrexham University and it is expected that MoUs will have been developed and arrangements in place by early 2026. The work to develop partnerships with higher and further education institutions seeks to maximise impact across research, education, training, and innovation, supporting continued achievement of University Designation.

Building on existing relationships, the benefits of a regional approach to collaboration with education partners will be explored. The development of the Clinical Services Plan will be aligned to the work with education provider, ensuring opportunities for transformational and innovative change are embedded. In addition, following the successful establishment of the North Wales Medical School, the Health Board will maintain actively engaged with partners to deliver strategic projects that advance shared objectives

**Remainder of the financial year**

All remaining priorities are scheduled and on track for completion by the end of the financial year with continued focus on innovation, research and partnership working.

<b>5B Research, Development and Innovation</b>	<b>Executive Medical Director</b>	<b>Delivery Confidence</b>
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**Overview**

The Research, Development and Innovation sub objective is based around three priorities focused around increasing both commercial and non-commercial research activity and to further develop supporting infrastructure with partners.

**Current Position**

Research, development and innovation is a key priority for the new Executive Medical Director who is currently providing strategic, governance and process leadership within this space. Increasing sustainably both commercial and non-commercial research activity remains a priority, as does expanding joint and honorary research appointments with academic partners, strengthening research capacity and fostering innovation across the organisation

**Remainder of the financial year**

All priorities are scheduled and on track for completion by the end of the financial year with continued focus on innovation, research and partnership working.

<b>5C Academic Careers</b>	<b>Executive Director of Allied Health Professionals and Health Science</b>	<b>Delivery Confidence</b>
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**Overview**

The Academic Careers sub objective is based around two priorities delivering a revised academic careers pathway, however pending agreement of a formal national definition of academic careers scope of this sub objective will be limited to provision of a local working definition.

**Current Position**

The Community of Interest Group has been established and held its first meeting on 3 November 2025, providing a foundation for collaborative progress with a workshop scheduled for early March 2026 (5C.1). Delivery confidence remains high, supported by ongoing work to define governance for joint and honorary appointments and alignment with national initiatives led by Health & Care Research Wales. A Memorandum of Understanding with Bangor University is in place, underpinned by an executive-led Strategic Steering Group, and discussions with Wrexham University are at an advanced stage to implement similar arrangements.

**Remainder of the financial year**

Further actions to explore the academic career pathway framework, informed by best practice from other health and academic organisations is being progressed. Partnerships with Further Education partners are also progressing with an MoU due to be signed with Grwp Llandrillo Menai in December. Arrangements with Coleg Cambria are also moving forward with agreement to also develop and sign an MoU.

<b>5D Intelligence Led</b>	<b>Chief Digital and Information Officer</b>	<b>Delivery Confidence</b>
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**Overview**

The Intelligence Led organisation sub objective is based around six priorities delivering enhanced automation of processes to reduce reliance on manual intervention, support improved decision making and reduce reliance on legacy systems.

**Current Position**

Activities for the redeveloped IRIS dashboard have been completed, positioning the platform as a core intelligence portal to support service management, planning, and decision-making. Technical progress includes enhanced data sharing, capacity management, and outcome monitoring, with future developments set to expand content and link hospital activity, quality, and clinical outcomes. With the direction of a newly established task team, progress is being made towards completion of a data maturity matrix assessment of urgent and emergency care (5D.6), with completion expected in post-launch user feedback will guide ongoing improvements to ensure IRIS continues to drive informed, impactful decisions.

**Remainder of the financial year**

Work scheduled for delivery by the end of Q4 include: the continued development of proposals for a Robotic Process Automation (RPA) to reduce manual processes. Development of a Health Board data quality kite-mark and to extend the RTT data models. Advance forecasting and introduction of predictive analytics which aim to improve planning for planned and urgent care will be progressed. A documented roadmap for data warehousing, decommissioning of legacy systems, and commencement of the transition to cloud technology via the National Data Analytics Platform, aligned to the Care Data Resource.

<b>5E Learning Organisation</b>	<b>Executive Director of Nursing and Midwifery</b>	<b>Delivery Confidence</b>
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**Overview**

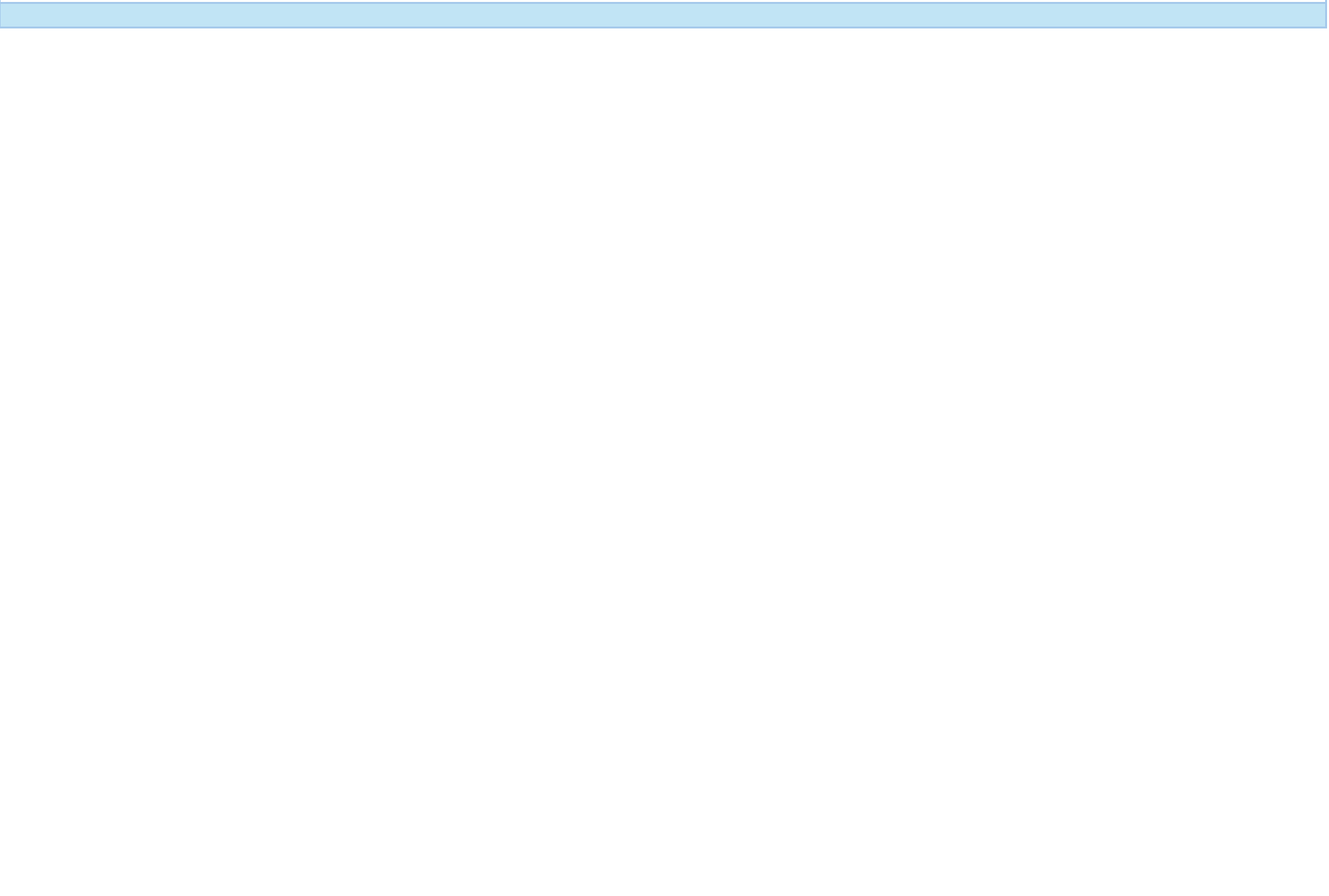
The Learning Organisation sub objective is based around four priorities delivering improvements to how the organisation learns from its own investigations of serious incidents and complaints together with any requests arising from national inquiries. Combined with improvements to systems and processes used to ensure transfer of learning to improve patient care.

**Current Position**

The Health Board will continue to evaluate how learning from serious incidents and complaints is embedded through the Integrated Concerns and Complaints Policy. Work focusing on strengthening systems and processes to improve the transfer of learning, enhancing opportunities to share learning and improve patient care is ongoing. Additionally, a discovery report will continue to inform the Education Strategic Plan, and processes will be improved to prepare for, respond to, and embed learning from any national inquiry requests.

**Remainder of the financial year**

All remaining priorities to fully embed the Integrated Concerns and Complaints Policy and ensure the effective transfer of learning to improve patient care are scheduled and on track for completion by the end of the financial year.



# Betsi Cadwaladr University Health Board

## Annual Delivery Plan 2025-26



We are committed to improving the health and wellbeing of everyone in North Wales. Over the next three years, we will provide high-quality, effective, and efficient healthcare services, working closely with our communities and partners.

Our new plan (the first, financially balanced “Integrated Medium-Term Plan” produced by Betsi Cadwaladr University Health Board) sets out how we will deliver on national priorities and respond to the serious challenges that led to our escalation to Special Measures in 2023.

The Annual Delivery Plan for 2025/26 describes the priorities that support us in achieving those longer term aims and is set against our five key strategic objectives of:

- Building an Effective Organisation
- Developing Strategy and Long-lasting Change
- Creating Compassionate Culture, Leadership and Engagement
- Improving Quality, Outcomes and Experience
- Establishing an Effective Environment for Learning

We will live our values—Openness, Compassion and Respect—in everything we do. These values were shaped by our staff and partners, and we are proud to uphold them.

The Annual Plan, as part of the wider IMTP, forms the basis of all our work for the next year and should be incorporated into all team and personal objectives with progress against each recorded on an ongoing basis.

Carol Shillabeer, Chief Executive.

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
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## 2025/26 Annual Delivery Plan

1: Building an effective organisation						
1A: Effective systems of governance						
1A.1	Develop and progress a Governance Improvement Plan to continuously improve governance arrangements, embedding recommendations from the 2024/25 Structured Assessment. The plan will include measurable actions to improve governance arrangements, ensuring that Board and Committee effectiveness is reviewed on an ongoing basis and improved accordingly	Director of Corporate Governance				Q4
1A.2	Undertake an annual formal board effectiveness self-assessment in accordance with good practice	Director of Corporate Governance				Q4
1A.3	Develop a Governance Hub, Governance Toolkit and handbook and ensure that training and support is available for managers to understand the governance arrangements across the Health Board	Director of Corporate Governance			Q3	
1A.4	Improve governance arrangements so they align to and support delivery of the organisation's strategic objectives and enable whole system quality-based decision making	Director of Corporate Governance		Q2		
1A.5	Conduct risk maturity audits to measure and strengthen risk management and risk governance to ensure consistency in risk management practices across the Health Board	Director of Corporate Governance			Q3	
1A.6	Complete the roll out of the three levels of the agreed risk management training	Director of Corporate Governance			Q3	
1A.7	Deliver the training and support to managers in application of the SOs, SFIs and SoRD, with specific focus on procurement in securing value for money and engagement with the wider market in placement of orders for goods and services (linked to 3A.6)	Director of Corporate Governance			Q3	
1A.8	Enhance the Accountability Agreements Framework with all staff who have responsibility for managing expenditure within the budget issued, for the purposes for which it was provided and adherence to the Health Boards approved SOs, SFIs and SoRD, specifically in regard to recruitment and commissioning of goods and services	Director of Corporate Governance			Q3	
1A.9	Deliver a recovery plan to eliminate the backlog of overdue Learning from Events Report (LFERs, which are part of the claims and redress process with the Welsh Risk Pool), and embed a new process to ensure future timely submission and also a reduction in the number case LFERs that are 'red deferred' (which necessitate significant review and resubmission)	Director of Corporate Governance	Q1			

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
<b>1B: Establishing the Foundations for the Future</b>						
1B.1.	1B.1. Conclude the Design Phase, having been through a process of co-design, testing and consultation, gaining formal approval to proceed to the delivery phase and implementation via the necessary governance	Chief Executive		Q2		
1B.2	Implement the first phase of the new operating model, completing the 2025/26 work plan across structures, strategy, people, processes and culture (linked to 3A.6)	Chief Executive			Q3	
1B.3	Develop the operating model work plan for 2026/27, including implementing the second and third phases and mechanisms to continue to monitor how it is being embedded and sustained across all aspects of structures, strategy, people, culture and processes	Chief Executive				Q4
<b>1C: Responding to Legislative Requirements</b>						
1C.1	Complete a review of the current arrangements in relation to Regulatory Assurance to ensure the governance arrangements are robust and demonstrate improvements in compliance	Director of Corporate Governance			Q3	
1C.2	Re-establish the legislation library, processes to capture new legislation, the dissemination of that legislation to the relevant areas of the Health Board and the development of plans to deliver any necessary changes	Director of Corporate Governance			Q3	
1C.3	Improve processes to prepare for, respond to and embed learnings from any requests made by national Inquiries	Director of Corporate Governance		Q2		
1C.4	Implement the Health Board's Three-Year Plan based upon the Health and Safety Executive (HSE) HSG65 Plan, Do, Check, Act process methodology	Director of Environment & Estates				Q4
1C.5	Develop options for the introduction of an organisational wide system for monitoring audit recommendations	Director of Corporate Governance		Q2		
1C.6	As an Operator of Essential Services, implement any actions required resulting from the forthcoming Cyber Security and Resilience Bill	Chief Digital & Information Officer		Q2		
1C.7	Develop a Health and Safety Improvement Plan ensuring improvements are made to the Health Board's current Health and Safety Policy, guidance and practices	Director of Environment & Estates			Q3	
1C.8	Develop a robust system of audit and action which informs the Health Board's readiness and implementation of the latest Medical Devices and Procurement Regulations	Executive Director of Allied Health Professionals & Health Science				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
<b>1D: Implementing the Quality Management System (QMS)</b>						
1D.1	Ratify a standardised QMS Maturity Assessment for Health Board services and development of a governance framework to enable operationalisation and agree an associated rollout plan	Executive Director of Nursing & Midwifery		Q2		
1D.2	Complete a series of communication exercises and briefing sessions to keep BCUHB workforce informed about QMS utilising an educational and myth busting approach designed to strengthen knowledge and understanding of QMS	Executive Director of Nursing & Midwifery	Q1			
1D.3	Integrate a QMS approach into the approach to Clinical Services Planning and early identification of challenged services	Executive Director of Nursing & Midwifery			Q3	
1D.4	Evaluate the Health Board's design and implementation of the QMS	Executive Director of Nursing & Midwifery		Q2		
1D.5	Improve the quality of estates infrastructure and buildings through <i>(linked to 2C.5)</i>	Executive Director of Nursing & Midwifery				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
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## 2: Developing strategy and long-lasting change

### 2A: Developing and delivering a Health Board Strategy and Clinical Services Plan

2A.1.	Work with partners to develop a high-level Strategic Intent for North Wales that will provide an outline of the joint priorities and areas of collaboration for the next 10-Years	Executive Director of Transformation & Strategic Planning				Q4
2A.2	Complete the diagnosis phase of the 10-Year Strategy development including agreement on the scope and development of a baseline assessment setting out a summary of the population health needs; performance; drivers for change; outcomes and quality standards	Executive Director of Transformation & Strategic Planning				Q4
2A.3	As part of the broader engagement on strategy development, review the Health Board Well-being objectives, ensuring continued alignment with the requirements of the Well-being of Future Generations (Wales) Act 2015 and Social Partnership and Public Procurement (Wales) Act 2023	Executive Director of Transformation & Strategic Planning				Q4
2A.4	Maintain regular dialogue with partners and stakeholders to inform strategy development via partnership boards and stakeholder groups	Executive Director of Transformation & Strategic Planning				Q4
2A.5	Complete phase 1 of the CSP focusing on services that are currently assessed as most challenged. This will develop well rounded plans based on a Quality Management System (QMS) approach, prioritising service improvements that can be made in the short to medium term in order to stabilise these services	Executive Director of Transformation & Strategic Planning			Q3	
2A.6	Develop a Digital and Data Roadmap to underpin the Health Board's clinical and organisational transformation (linked to 2D.2)	Chief Digital & Information Officer	Reporting through 2D.2			

### 2B: Strengthening Planning and Commissioning

2B.1	Develop proposals to enhance capacity and capability for organisational wide planning, building upon the action plan produced following the Independent Review of Planning in 2024/25	Executive Director of Transformation & Strategic Planning		Q2		
2B.2	Conduct a review of learning with stakeholders of the most recent planning cycle, updating the Integrated Planning Framework with any associated improvements and implementing them in the next planning cycle	Executive Director of Transformation & Strategic Planning				Q4
2B.3	Complete the National Planning Maturity matrix assessment and incorporate the outputs into the plans to improve the organisation wide planning system and capability	Executive Director of Transformation & Strategic Planning				Q4

<i>Ref</i>	<i>Descriptor</i>	<i>Lead Executive</i>	<i>Qtr1</i>	<i>Qtr2</i>	<i>Qtr3</i>	<i>Qtr4</i>
2B.4	Undertake a review of current and future commissioning commitments, drawing out the capacity required. This will form a baseline from which feasibility, risk and inter-dependencies can be assessed	Director of Performance and Commissioning			Q3	
2B.5	Conduct a Third Sector review, undertaking a review of unit price and contract currencies within contracts and complete an exercise to ensure that the standard and consistency of commissioned documents and processes meets expected standards	Director of Performance and Commissioning				Q4
2B.6	A review of insourcing/outsourcing contracting will be undertaken leading to a plan for improvement and development	Director of Performance and Commissioning	Q1			
<b>2C: Improving the Environment, Estate and Facilities</b>						
2C.1	Review the schedule of prioritised business cases in light of the outcome of the all-Wales capital prioritisation exercise	Director of Environment and Estates	Q1			
2C.2	Progress work in relation to major capital schemes including prioritisation of: Orthopaedics Hub in Llandudno, Electrical Infrastructure at Glan Clwyd Hospital, Royal Alexandra Hospital in Rhyl, Ablett Mental Health unit in Glan Clwyd Hospital, Nuclear Medicine consolidation, Health and Well-being hubs, decarbonisation and anti-ligature work	Director of Environment and Estates				Q4
2C.3	Align ambitions relating to Health and Wellbeing Hubs to available capital funding. These play an important role in the Health Board's plans relating to primary care, the medical school, partnership working and shift left	Director of Environment and Estates		Q2		
2C.4	Develop and commence implementation of a fit for purpose estates strategy to include estate rationalisation, decarbonisation and climate resilience, as well as maximising the potential and use of existing estate and opportunities with partners. Acknowledging that the estates strategy will be led by and informed by the Health Board's 10-Year Strategy and Clinical Services Plan	Director of Environment and Estates				Q4
2C.5	Maximise the potential of strategic disposals, partnership work and resultant capital receipts to reinvest in a modern and fit for purpose estate and infrastructure	Director of Environment and Estates				Q4
2C.6	Support organisational business continuity through the capital process, including the Wrexham Maelor and Ysbyty Gwynedd business continuity cases	Director of Environment and Estates				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
2C.7	Work with Bangor University to support the development and growth of the North Wales Medical School	Director of Environment and Estates			Q3	
2C.8	Provide leadership in the identification, prioritisation and delivery of schemes through the Integration and Rebalancing Capital Fund (IRCF), including participation in the Regional Partnership Board (RPB)	Director of Environment and Estates		Q2		
2C.9	Undertake a comprehensive assessment of facilities standards and performance, informing at improvement and development plan	Director of Environment and Estates			Q3	
2C.10	Complete the Welsh Government Adaptation Climate Change Risk Assessment, develop an action plan to address the risks identified, utilising the adaptation toolkit and liaising with PSB and other key partners	Director of Environment and Estates				Q4
2C.11	Build strategic relationships with partners including Local Authorities and Third Sector organisations to understand the opportunities to collaborate and implementation routes	Director of Environment and Estates				Q4
2C.12	Install onsite renewable energy generation facilities where viable to do so.	Director of Environment and Estates				Q4
<b>2D: Enhancing digital, data and technology approaches</b>						
2D.1	Secure a multimillion-pound investment from Welsh Government for the EHR Transformation Programme which will reduce paper records and be a key enabler for service transformation	Chief Digital and Information Officer			Q3	
2D.2	Develop a Digital and Data Roadmap to underpin the Health Board's clinical and organisational transformation (linked to 2A.6)	Chief Digital and Information Officer		Q2		
2D.3	Delivery of a digital maternity EHR and patient facing app, which will eliminate paper records	Chief Digital and Information Officer				Q4
2D.4	Completion of the implementation of the replacement diagnostics systems, RISP and LIMS	Chief Digital and Information Officer				Q4
2D.5	Procurement and delivery of Phase 1 of the Mental Health EHR programme informing the wider EHR transformation agenda	Chief Digital and Information Officer				Q4
2D.6	Complete the Therapies Manager System developments and increase the user satisfaction rating through Floorwalking and Engagement Teams	Chief Digital and Information Officer				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
2D.7	Complete the minimum viable recruitment of expertise to deliver basic 2020s DDaT services, appointing to all key funded posts within 25/26	Chief Digital and Information Officer				Q4
2D.8	Effectively deliver, through strict prioritisation and effective resource management, the DDaT enabled portfolio of projects and programmes, with particular focus on benefits realisation. This exercise will include pausing or deferring some projects where necessary due to financial pressures	Chief Digital and Information Officer				Q4
2D.9	Complete delivery of phase 5 Welsh Patient Administration System (WPAS) including treatment function codes, cancer tracker, copy correspondence and patient numbering	Chief Digital and Information Officer				Q4
2D.10	Implement electronic Prescribing and Medicines Administration (ePMA) across acute sites	Chief Digital and Information Officer				Q4
2D.11	Develop a proposal for a Digital Academy training programme and launch a communications campaign so that staff feel empowered to use technologies	Chief Digital and Information Officer				Q4
2D.12	Support the implementation and roll-out of the NHS Wales App for maximum impact and benefit to include the uptake of its use for repeat prescriptions	Chief Digital and Information Officer		Q2		
2D.13	Eradicate unsupported systems and devices in line with available resources	Chief Digital and Information Officer				Q4
2D.14	Develop a clear cyber response plan for the organisation	Chief Digital and Information Officer		Q2		
<b>2E: Developing and delivering value and sustainability</b>						
2E.1	Design and deliver a refreshed value and sustainability programme for 2025/26, which has clear outcomes based on broader measures of value, to deliver qualitative, performance and financial improvement. This includes delivery of nationally aligned initiatives under the five workstreams of: Clinical Value, Workforce, Continuing Healthcare, Medicines Management and Non-Pay and Procurement	Executive Director of Finance				Q4
2E.2	Focus on Clinical Variation to take advantage of nationally identified opportunities to expedite reductions in waste, harm and unwarranted variation	Executive Medical Director				Q4
2E.3	Build on work to embed value principles into the wider organisational frameworks: planning, commissioning, multi-professional workforce modelling, performance, leadership and quality	Executive Director of Finance		Q2		
2E.4	Design a value training programme as part of the journey towards a Value Academy for North Wales and a longer-term commitment to building knowledge and capacity in delivering value-led improvement	Executive Director of Finance				Q4
<b>2F: Improving workforce planning and development</b>						
2F.1	Fully embed the training programme for workforce planning across the organisation with easy access guides and how to access support for teams to develop their plans	Director of People		Q2		

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
2F.2	Detailed workforce plans to be in place for all key services across the organisation	Director of People				Q4
2F.3	Develop a suite of workforce planning tools to support teams and services develop and maintain their workforce plans	Director of People			Q3	
2F.4	Develop an organisational strategic workforce planning framework, including integration into the other relevant organisational frameworks such as Planning and Quality	Director of People			Q3	
2F.5	Conduct a comprehensive workforce analysis for therapy services in a prioritised manner	Executive Director of Allied Health Professions & Health Science		Q2		
2F.6	Development of therapy services plan, contributing to new clinical service models to support reductions in waiting times	Executive Director of Allied Health Professions & Health Science			Q3	
2F.7	Develop a Governance Framework to guide the operationalisation of the HEIW Professional Framework for Enhanced, Advanced and Consultant Clinical Practice in Wales (for HCPC registered professionals)	Executive Director of Allied Health Professions & Health Science				Q4
2F.8	Fully implement Variable Pay and agency control framework and ensure a 30% reduction in agency expenditure during 2025/26. This will be supplemented by no off-contract expenditure and reductions to zero spend for specific staff groups	Director of People		Q2		
2F.9	Ensure effective implementation of job planning policy to include ensuring that >90% of all Consultants have an agreed job plan in place at all times	Director of People		Q2		
2F.10	Reduce sickness absence levels through adherence to key policies such as Attendance at Work	Director of People			Q3	
<b>2G: Working with regional partners</b>						
***	A separate monitoring mechanism will be implemented for these priorities which sit with external partners to deliver					

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
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### 3: Creating compassionate culture, leadership and engagement

#### 3A: Culture Development

3A.1	Fully implement and embed the Values & Behaviours Framework into our organisational policies, processes and practices so that staff live the values and behaviours in their day-to-day work	Director of People	Q1			
3A.2	Conclude the Discovery phase of the Culture & Leadership Programme through a Synthesis Report which will guide our future culture and leadership approaches	Director of People		Q2		
3A.3	Co-produce draft Design phase priorities for further development in 2026/27 which shapes our compassionate, diverse and inclusive leadership approaches, identify what is going well and which areas need to be strengthened	Director of People			Q3	
3A.4	Complete roll out of the Culture Change Leader (CCL) programme. The CCL role has been established to support the Culture & Leadership Programme. Leaders are drawn from a cross section of staff across the organisation who come together to make a difference by looking at the Health Board's current culture and helping to shape culture for the future	Director of People			Q3	
3A.5	Build staff engagement through implementation of the staff engagement plan (including staff survey actions, staff stories, common PADR objectives (golden thread) and engagement events/activities) hard wiring engagement throughout leadership and management structures to the front line	Director of People				Q4
3A.6	Improve governance arrangements so they align to and support delivery of the organisation's strategic objectives and enable whole system quality-based decision making. This alongside using the RACI model (Responsible, Accountable, Consulted, Informed) in role profiles to describe individuals roles and responsibilities for activities and deliverables will support creating high autonomy and accountability across all roles	Director of People				Q4
3A.7	The Health Board will improve its systems and processes to ensure the transfer of learning as a Learning Organisation is increasing the opportunity to share learning and improve patient care	Director of People	Reporting through 5E.2			

#### 3B: Leadership Development

3B.1	Design a series of workshops to strengthen key areas of the Integrated Leadership Development Framework (LDF), with a focus on developing leadership skills in specific areas for example, workshops to embed the principles of compassionate leadership to enable leaders and managers to understand the benefits of a compassionate approach and how to apply compassionate behaviours in the workplace and to support to leaders and managers to have conversations with their staff through a compassionate lens, to build confidence and skills in managing difficult or challenging situations	Director of People		Q2		
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Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
3B.2	Develop a core programme/offering for middle managers and leaders across the organisation. To be aligned with the ongoing national strategy building a core management competency framework across NHS Wales working with Health Education and Improvement Wales (HEIW) and a range of academic partners	Director of People				Q4
3B.3	Review and evaluate the first senior level programme – Glyder Fawr (Advanced Clinical Leadership Programme) delivered in 24/25 in readiness for the second cohort of this national HEIW led programme commencing at the end of Q1 25/26	Director of People	Q1			
3B.4	. Undertake a review of BCUHBs Coaching and Mentoring Network which will include: - A review of the effectiveness of the coaching network to ensure there are sufficient coaches to meet demand, that coaches on the network are actively coaching, that appropriate resources and support /supervision is in place. - A toolkit will be developed to support mentors across the organisation along with a co-designed mentoring network proposal.	Director of People				Q4
3B.5	Evaluate the outcomes from previous cohorts of the Mynydd Mawr – Foundations of Leadership and Management programme (delivered 24/25) to identify learning outcomes and impact in the workplace	Director of People	Q1			
3B.6	Launch new programme 'Leadership for All – 'Moel Famau', providing an introduction to leadership for all staff across the organisation irrespective of whether they are in a formal leadership role	Director of People		Q2		
3B.7	Develop a set of metrics and reports from the Leadership hub, to analyse: user engagement, themes, attrition rates	Director of People		Q2		
<b>3C: Citizen engagement and partnership working</b>						
3C.1	Complete implementation of the recommendations in the independent review of engagement specifically: - Finalise and implement the 'Betsi Way' engagement framework, ensuring it is evidence-informed, high quality, and co-developed with agreed engagement principles. - Implement a structured reporting system to track and publicly share at least three concrete examples of how community feedback has influenced corporate plans, services and improvements - Establish a community of engagement practice within the Health Board, providing at least two training sessions and developing a toolkit to support staff with best practices and evidence-based approaches	Director of Partnerships/ Communications & Engagement				Q4
3C.2	Increase engagement reach by 30% through targeted on-line community interactions, including at least four digital campaigns and expanded use of social media platforms	Director of Partnerships/ Communications & Engagement				Q4
3C.3	Expand the engagement programme across at least five North Wales communities, collaborating with key partners to ensure added value for residents, stakeholders and the Health Board	Director of Partnerships/ Communications & Engagement			Q3	
3C.4	Review the strategic approach to engagement with communities, specifically mapping out the next two years	Director of Partnerships/			Q3	

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
		Communications & Engagement				
3C.5	Conduct at least three community listening events in rural areas, ensuring participation from at least 50 local residents, to gather feedback on healthcare needs and service improvements	Director of Partnerships/ Communications & Engagement				Q4
3C.6	Reset the Health Board's representation at the Regional Partnership Board establishing a structured reporting process to improve decision making	Director of Partnerships/ Communications & Engagement	Q1			
3C.7	Trial a surgery-style approach with local councillors in two local authorities to support issue identification, evaluating its effectiveness in improving communication and engagement, with a view to expanding the approach across all local authorities	Director of Partnerships/ Communications & Engagement		Q2		
3C.8	Further the Health Board's commitment to children and young people by developing an approach to ensure their voices influence decision making (Youth Voice approach) (linked to 4L.2)	Director of Partnerships/ Communications & Engagement		Q2		
3C.9	Work with partners to co-develop and publish an Anchor Institution Principles and Charter with clearly defined principles ensuring alignment with community needs and organisational priorities	Director of Partnerships/ Communications & Engagement				Q4
<b>3D: Welsh language and Culture</b>						
3D.1	Build on the planning completed within 2024/25 and transition from planning to operational delivery of the Standards and 'More than just words', focusing initially on acute settings	Executive Director of Allied Health Professions & Health Science			Q3	
3D.2	Adopt the Language Choice Scheme to a specific vulnerable patient group	Executive Director of Allied Health Professions & Health Science			Q3	

<i>Ref</i>	<i>Descriptor</i>	<i>Lead Executive</i>	<i>Qtr1</i>	<i>Qtr2</i>	<i>Qtr3</i>	<i>Qtr4</i>
3D.3	Explore the potential of adopting a 'Welsh Language Champions Programme' in order to encourage and celebrate language development success within the workforce	Executive Director of Allied Health Professions & Health Science		Q2		
3D.4	In collaboration with the National Centre for Learning Welsh, deliver a tailored training programme in Speech and Language Therapy Services, which have been identified as a priority workforce group	Executive Director of Allied Health Professions & Health Science			Q3	
3D.5	Promote the use of Welsh Language within the organisation	Executive Director of Allied Health Professions & Health Science	Q1			

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
<b>4: Improving quality, outcomes and experience</b>						
<b>4A: Prevention and Early Intervention</b>						
4A.1	Implement plan to target resources for the most vulnerable groups (e.g. – those experiencing homelessness, Gypsy, Roma and Traveller communities) which will contribute to reducing inequalities in healthy life expectancy	Executive Director of Public Health				Q4
4A.2	Creating the foundations for change, providing the Health Board with the means to demonstrate the impact of current prevention and early intervention activity across identified priority areas and determine where this could be improved	Executive Director of Public Health				Q4
4A.3	Develop proposals for Health Board to prepare and respond to health protection threats, enhancing the delivery of Health Board services to protect people in North Wales against existing, new and emerging health protection threats and hazards	Executive Director of Public Health				Q4
4A.4	Implement the National Immunisation Framework (NIF) for Wales locally and continue to provide improved resilience and variation	Executive Director of Public Health				Q4
4A.5	Refer to 'Section 4P – Diabetes' for the 2025/26 delivery priorities	Executive Director of Public Health	Reporting through 4P			
<b>4B: Primary Care including Clusters</b>						
4B.1	Full engagement in the implementation of the national 'Primary Care Model' for Wales and focus on delivering the national Primary Care Programme. This will include development of proposals to complete the rollout of the audiology first point of contact and earwax removal service (see also Diagnostics 4D.c.11)	Chief Operating Officer				Q4
4B.2	Develop the Primary Care 'same day' offer to provide more equitable access to primary care as alternatives to Emergency Department attendance. This relates to in-hours primary care access and also to the provision of out-of-hours primary care, 111 and Minor Injury Units	Chief Operating Officer				Q4
4B.3	A pathways of care approach will be adopted to ensure that primary care professionals have access to the resources they need so that secondary care referrals only occur where they will add value to the patient	Chief Operating Officer		Q2		
4B.4	A 'Primary Care Academy' approach will support healthcare professionals to develop advanced skills within primary care that allow skill-mix changes and increased workforce stability	Chief Operating Officer				Q4
4B.5	Access to primary care dentistry is a key priority and a GDS procurement process will be moved forward alongside consideration of new and innovation ideas to increase patient access (linked to 4O.1)	Chief Operating Officer		Q2		
4B.6	Sustainability support will be reviewed in order to bolster support to contractors that are in difficulty. Where appropriate discussions will be held with national partners	Chief Operating Officer				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4B.7	Progress the strategic approach to a mixed model of primary care that supports contractors to remain independent contractors and identifies ways in which directly managed practices can innovate, support independent contractor 'neighbours', test new ways of working, and increase involvement of primary care in research	Chief Operating Officer			Q3	
4B.8	Implement the new GMS Contract Assurance Framework	Chief Operating Officer	Q1			
4B.9	Improve accuracy, visibility and use of primary care performance data	Director of Performance & Commissioning		Q2		
4B.10	Develop proposals that address areas of poor primary care estate impacting upon care delivery, including the proposals currently progressing in Penygroes, in Conwy West locality, in Bangor, in Denbigh and in Holyhead	Director of Environment & Estates				Q4
4B.11	Work with Primary Care providers in North Wales to prepare and expand suitable training environments for Medical Students from the North Wales Medical School	Executive Medical Director	Reporting through 2C.7			
4B.12	Scope and test a model for commissioned community pharmacy services focused on long-term condition management, starting with hypertension	Chief Pharmacist	Reporting through 4M.4			
4B.13	Develop proposals to expand the use of cluster-based Care Home support services that can provide timely assessment to minimise otherwise avoidable hospital conveyances and improve outcomes for Care Home Residents, including support to carers	Chief Operating Officer				Q4
4B.14	'One stop' models of care that enhance the delivery of care for people with diabetes and related conditions will continue to be tested and if successful, expanded	Chief Operating Officer				Q4
4B.15	Discussions (internally and with partners) will be progressed to a conclusion as to whether the current 14 cluster footprints are optimal or whether a change of focus to pan-cluster footprints would be preferable	Chief Operating Officer	Q1			
4B.16	Generate a proposal to develop a community collaborative model as an integrated Health and Social Care provision for North Wales, ensuring 'pooled' resources for 7-day provision as a collective through utilising established practices such as Trusted Assessor	Chief Operating Officer			Q3	
<b>4C: Community Care</b>						
4C.1	Generate options to increase provision of Enhanced Community Care (ECC)	Chief Operating Officer	Q1			
4C.2	Develop a business case for increased ECC outlining options, costs, benefits, risks and possible funding streams	Chief Operating Officer		Q2		

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4C.3	Progress business case through Health Board governance to seek support for preferred option	Chief Operating Officer			Q3	
4C.4	Subject to available funding, undertake any necessary staff consultation, commence recruitment for agreed staffing, implement pathway changes, commence delivery of increased provision for ECC	Chief Operating Officer				Q4
4C.5	Review options to increase District Nursing provision at the weekend including the nature and level of weekend demand	Chief Operating Officer	Q1			
4C.6	Develop a business case for increased weekend community nursing capacity outlining the options, costs, benefits, risks and possible funding streams	Chief Operating Officer		Q2		
4C.7	Progress business case through Health Board governance to seek support for preferred option	Chief Operating Officer			Q3	
4C.8	Subject to available funding, successful recruitment and outcome of staff consultation, work to agree implementation plans, commence recruitment and commence increased community nursing for weekends	Chief Operating Officer				Q4
4C.9	Review opportunities to increase Specialist Palliative care capacity in the East to bring cover up to the same level as other parts of BCU	Chief Operating Officer	Q1			
4C.10	Seek options to identify and secure funding additional weekend Palliative Care CNS hours	Chief Operating Officer		Q2		
4C.11	Commence recruitment for agreed SPC CNS hours and undertake consultation with existing staff on changing work patterns; subject to available funding	Chief Operating Officer			Q3	
4C.12	Develop implementation plans to commence increased SPC CNS capacity for weekends and bank holidays; dependent on staff consultation, recruitment and prioritisation of resources	Chief Operating Officer				Q4
<b>4D: Planned Care, Cancer &amp; Diagnostics</b>						
<b>4Da: Planned Care</b>						
4D.a.1	Develop and implement the next stage of the Validation Approach in the Health Board; focusing on delivering high levels of data quality, updated waiting lists and application of waiting list policies	Chief Executive	Q1			
4D.a.2	Implement locally the 8 nationally agreed Interventions Not Normally Undertaken (INNU), and the pipeline of INNUs that follow	Chief Executive	Q1			
4D.a.3	Develop and implement best practice standards (GIRFT/Optimisation Framework) for referral advice and guidance (pre-referral) focusing on high volume, high opportunity specialties as a priority and rolling through other specialties thereafter	Chief Executive				Q4

<i>Ref</i>	<i>Descriptor</i>	<i>Lead Executive</i>	<i>Qtr1</i>	<i>Qtr2</i>	<i>Qtr3</i>	<i>Qtr4</i>
4D.a.4.	Assess the opportunities for Referral Triage and Alternative Pathways in high volume specialties as a priority; drawing up and commencing the implementation of service redesign proposals, learning from other organisations	Chief Executive		Q2		
4D.a.5.	Implement the Health Pathways (including Pathway Alliance Programme) in priority specialties	Chief Executive			Q3	
4D.a.6.	Implement specific specialty 'direct listing', specifically focused on ophthalmology as a priority	Chief Executive		Q2		
4D.a.7.	Progress the implementation of the new Booking Service, enabling a consistent approach across the organisation	Chief Executive				Q4
4D.a.8.	Review and update outpatient clinic templates, incorporating GIRFT/Optimisation Framework standards, across high priority specialties	Chief Executive		Q2		
4D.a.9.	Implement a revised DNA/CNA approach, including overbooking mechanisms where DNA/CNA rates are above 5%	Chief Executive		Q2		
4D.a.10.	Develop and implement the revised model for Pre-Operative Assessment	Chief Executive			Q3	
4D.a.11.	Identify specialty by specialty high utilisation opportunities to enable focused and targeted approach to achieve the 85% utilisation threshold	Chief Executive				Q4
4D.a.12.	Review each specialty to identify opportunities for increased day case, and minor-ops/procedure room (Right Patient, Right Place-type) approach. Implement priority specialty improvements	Chief Executive			Q3	
4D.a.13.	Undertake a systematic approach to validating, data cleansing all Follow-up lists	Chief Executive			Q3	
4D.a.14.	Implement See on Symptoms (SoS) and Patient Initiated Follow-up (PIFU) on all priority specialties (linked to Optimisation Frameworks/GIRFT)	Chief Executive			Q3	
4D.a.15.	Recalibrate capacity from follow-ups to new appointments in priority specialties, following assessment of opportunity	Chief Executive	Q1			
4D.a.16.	Introduce an enhanced demand and capacity modelling approach that takes into account all aspects of planned care and cancer pathways	Chief Executive			Q3	
4D.a.17.	Implement a programme of in-year commissioned capacity to support 2025/26 delivery	Chief Executive				Q4
4D.a.18.	Develop integrated specialty plans for 2026/27 based on the progress made across specialties in 2025, to include workforce, finance, commissioning aspects	Chief Executive				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
<b>4Db: Cancer Care</b>						
4D.b.1.	Recovery of the Health Boards cancer position and improved performance against the Suspected Cancer Pathway referral to treatment target, aiming to achieve 80% of cancer patients treated within 62 days of suspicion of cancer by March 2026	Chief Operating Officer				Q4
4D.b.2.	Clearance of the over 62-day waits is a priority as this is currently a large number of pathways. The Health Board will need to factor in the backlog clearance over the first 6 months towards delivering the 80% treated within 62 days standard by March 2026	Chief Operating Officer				Q4
4D.b.3.	Commission of additional external resource in endoscopy and dermatology whilst seeking to develop and recruit to more sustainable models of care to meet the needs of our population across north Wales	Chief Operating Officer	Q1			
4D.b.4.	Work to improve referral pathways with the introduction of the Community Health Pathways tool	Chief Operating Officer		Q2		
4D.b.5.	Introduction of nurse led triage model for patients with suspected colorectal cancer to increase the number of patients referred straight to test and reduce overall waiting times	Chief Operating Officer		Q2		
4D.b.6.	Optimise the agreed teledermoscopy service and develop the evidence case to expand	Chief Operating Officer				Q4
4D.b.7.	Investigate the case for new models for the assessment of women with post-menopausal bleeding to reduce time to diagnosis of gynaecological cancers	Chief Operating Officer		Q2		
4D.b.8.	Develop a proposal for the expansion of robotic assisted cancer surgery	Chief Operating Officer				Q4
4D.b.9.	Consider a proposal to repatriate some services from England to north Wales; some plastic surgery and specialist radiotherapy procedures	Chief Operating Officer			Q3	
4D.b.10.	Work with the charity Maggie's and the Steve Morgan Foundation to open a new Maggie's cancer support centre in the grounds of Ysbyty Glan Clwyd in 2025	Chief Operating Officer				Q4
<b>4Dc: Diagnostics</b>						
4D.c.1.	Complete demand and capacity reviews for all diagnostic services, with implementation of identified improvement plans to deliver sustainable services and to deliver against forecast trajectory targets for reportable diagnostic services	Chief Operating Officer				Q4
4D.c.2.	Ensure service delivery is equitable and high-quality experience for patients	Chief Operating Officer				Q4
4D.c.3.	Undertake a rapid review of workforce capacity and skill mix to inform recruitment and retention strategy	Chief Operating Officer		Q2		

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4D.c.4.	Deliver the major national information technology projects currently underway in Radiology and Pathology; subject to available resource prioritisation	Chief Operating Officer			Q3	
4D.c.5.	Progress the development of the medical illustration service to support the teledermoscopy service	Chief Operating Officer				Q4
4D.c.6.	Complete estates reviews for all diagnostic services, with prioritisation and progression of identified improvement projects	Chief Operating Officer				Q4
4D.c.7.	Progress the Regional Diagnostics Hub project within the Planned Care Programme	Chief Operating Officer				Q4
4D.c.8.	Progress Endoscopy, Nuclear Medicine/PET-CT and Digital Cellular Pathology business cases	Chief Operating Officer		Q2		
4D.c.9.	Maintain capacity for a workstream to focus on transformational change, including AI	Chief Operating Officer				Q4
4D.c.10.	Integrate diagnostics quality assurance approaches with the Health Board QMS	Chief Operating Officer				Q4
4D.c.11	This will include development of proposals to complete the rollout of the audiology first point of contact and earwax removal service	Chief Operating Officer	Reported through 4B.1			
<b>4E: Urgent and Emergency Care</b>						
4E.1	Implementation of the remote clinical assessment services framework - Implement a 'Single Point of Access' (SPOA) hub for urgent and emergency care that simplifies access to services by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely, to improve patient outcomes regardless of where they present. The work will include assessing the current pathways, their effectiveness, consistency of usage and implementing alternative pathways that both reduce attendance at ED and provide suitable alternative to admission for ED clinicians to access when patients do present in an emergency. This will include trialling appointments in areas such as Ophthalmology, SDEC, Urgent Primary Care Centre's and Dental	Chief Operating Officer				Q4
4E.2	Implement Community Based Falls Response Services to enhance outcomes and experience for those who fall by improving initial response times, reducing the risk of long lies and ensuring service users access community falls pathways when appropriate. This Community Service will be both a stakeholder of the SPOA hub as well as a pathway out of it. Both of these interventions will ensure that high risk patient groups (such as falls and breathlessness that make large contributions to the demand on ED) are supported in the most effective way	Chief Operating Officer			Q3	

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4E.3	Ensure implementation of Primary Care Model, including delivery of national Primary Care Programme, and development of Primary Care Same Day Offer (4B.1 & 4B.2) is fully integrated into this workstream and delivers expected outcomes in terms of attendance at Secondary Care	Chief Operating Officer	Linked to 4B.2			
4E.4	Implement an Acute Front Door Frailty Service at all acute hospitals – integrated with community frailty services - that ensures that older people with frailty dependent on prioritisation of available resources are streamed to the most appropriate services within the hospital when required as quickly as possible and, where possible, discharged home on the same day. This will include an evaluation of the different approaches to acute front door frailty services in place inside and outside the Health Board	Chief Operating Officer				Q4
4E.5	Implement the Welsh Health Circular (WHC) - Ambulance Patient Handover Guidance to ensure timely transfer of patients from ambulance crews to Emergency Department (ED) staff	Chief Operating Officer		Q2		
4E.6	Implement actions described in the Optimal Hospital Flow Framework to ensure people who possess a clinical need for admission to hospital are discharged home when clinically ready, with the right support and without delay. This will support a reduction in deconditioning, and the early identification within the first 24hrs of admission and communication of any support requirements on discharge which should support a reduction in pathways of care delays once embedded across both acute and community inpatient areas. This will be supported initially by two Optimal Hospital Flow Facilitators who will create and roll out training resources – a national initiative that is being tested in BCU to assess its impact. This work on reducing pathway delays is critical to removing surge capacity from routine use	Chief Operating Officer				Q4
4E.7	Introduce actions to improve pathways of care delays and discharge planning through: a) a single North Wales approach to validation of delays to support more effective reviews with Local Authorities, b) increasing the number of assessments undertaken by 'trusted assessors' including ensuring assessment takes place the right environment, reducing the dependency on contended social care resource, and reducing assessment delays, c) exploring options in relation to right sizing of both step up and step down community capacity, subject to the prioritisation of available resources.	Chief Operating Officer				Q4
<b>4F: Adult Mental Health &amp; Learning Disability</b>						
4F.1	Work with the NHS Executive to deliver the emerging Mental Health strategic improvement programme including patient centred safety, crisis care and access to community services	Executive Director of Allied Health Professions & Health Science	Q1			
4F.2	Continue to improve quality and safety of care, including full delivery of the Royal College of Psychiatry (RCPsych) Mental Health Invited Service Review	Executive Director of Allied Health Professions & Health Science				Q4
4F.3	Continue to improve access to and reduce waiting times for North Wales citizens needing support from Community Mental Health Service	Executive Director of Allied Health				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
		Professions & Health Science				
4F.4	Develop a coherent overarching model for the delivery of care to people experiencing mental health crisis	Executive Director of Allied Health Professions & Health Science				Q4
4F.5	Deliver phase 1 of the Mental Health Electronic Healthcare Record (HER) programme as a developing template for the wider transformation above <b>(Linked to 2D.5)</b>	Executive Director of Allied Health Professions & Health Science	Reported through 2D.5			
4F.6	Deliver progress across specialist service improvement projects, including Perinatal and Eating Disorder services	Executive Director of Allied Health Professions & Health Science				Q4
4F.7	Deliver, with Capital Estates colleagues the 2025/2026 programme for Anti-Ligature estates work	Executive Director of Allied Health Professions & Health Science				Q4
4F.8	(Contribute to 2B.5, with focus on iCAN, Parabl (Talking Therapies) and Community Advocacy Service) 2B.5 Conduct a 3rd Sector review, undertaking a review of unit price and contract currencies within contracts and complete an exercise to ensure that the standard and consistency of commissioned documents and processes meets expected standards	Director of Performance and Commissioning	Reported through 2B.5			
<b>4G: CAMHS</b>						
4G.1	Develop a CAMHS Strategic Workforce Plan and refreshed Training Strategy which will be informed by our Training Needs Analysis undertaken across CAMHS	Chief Operating Officer		Q2		
4G.2	Sustain Mental Health Measure Part 1a compliance against target for assessment and deliver the Part 1b target for intervention across all teams	Chief Operating Officer			Q3	
4G.3	Incorporate learning through sharing best practice across Wales for a sustainable service provision as the service eliminates long waits	Chief Operating Officer	Q1			
4G.4	Develop proposals for Alternatives to Admission with our partners to ensure holistic provision of CAMHS is accessible for all children and young people including those young people who have chaotic lives with no access to safe accommodation	Chief Operating Officer				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4G.5	Evaluate the implementation of Schools in Reach into core CAMHS offer within IHCs to provide sustainable whole school approach to emotional health and well - being at the most accessible and consistent environment in young people's lives within all schools across North Wales	Chief Operating Officer				Q4
<b>4H: Neurodevelopment</b>						
4H.1	Complete the waiting list stratification exercise and consider prioritisation criteria	Chief Operating Officer		Q2		
4H.2	Launch a prudent assessment process across the teams	Chief Operating Officer		Q2		
4H.3	Finalise a business case to address the longest waiters	Chief Operating Officer	Q1			
4H.4	Gain approval for an Information Sharing Protocol with partners	Chief Operating Officer		Q2		
4H.5	Engage fully with the Children's RPB to develop a needs-led service model	Chief Operating Officer				Q4
<b>4I: Dementia services</b>						
4I.1	4I.1 Embed Emergency Department (ED) dementia improvement work in Integrated Health Communities (IHC)	Executive Director of Nursing & Midwifery				Q4
4I.2	4I.2. Identify good practices elsewhere	Executive Director of Nursing & Midwifery			Q3	
4I.3	4I.3. Identify current BCUHB Emergency Department (ED) practices	Executive Director of Nursing & Midwifery			Q3	
4I.4	4I.4. Enhance range and volume of dementia education and training	Executive Director of Nursing & Midwifery			Q3	
4I.5	4I.5. Evaluate training	Executive Director of Nursing & Midwifery				Q4
4I.6	4I.6. Facilitate extensive assessment of environments	Executive Director of Nursing & Midwifery	Q1			
4I.7	4I.7. Local action plan development and monitoring	Executive Director of Nursing & Midwifery			Q3	

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4I.8	4I.8. Allocation of improvement resources	Executive Director of Nursing & Midwifery				Q4
4I.9	4I.9. Creation/collate/share prevention resources	Executive Director of Nursing & Midwifery	Q1			
4I.10	4I.10. Identify opportunities to promote prevention	Executive Director of Nursing & Midwifery			Q3	
4I.11	4I.11. Collaborate with related specialities e.g., stroke	Executive Director of Nursing & Midwifery				Q4
<b>4J: Currently 'Challenged Services'</b>						
<b>4Ja: Urology</b>						
4J.a.1	4J.a.1 In-depth review to scope out non-medical workforce opportunities, ensuring their contribution to service delivery is maximized. Close remaining clinical and managerial lead role gaps supported by effective IHC leadership currently in post	Chief Operating Officer		Q2		
4J.a.2	4J.a.2 Establish a sustainable on-call model through a review of the current on call arrangements on a regional level, providing a resilient unscheduled care service to patients	Chief Operating Officer			Q3	
4J.a.3	4J.a.3 Develop plans to deliver specialist services at a regional level aligned to the GIRFT and Royal College of Surgeons recommendations following stakeholder engagement and consultation if required	Chief Operating Officer		Q2		
4J.a.4	4J.a.4 Improve patient outcomes, deliver increased service efficiencies and reduced waiting times	Chief Operating Officer			Q3	
4J.a.5	4J.a.5 Deliver equitable Interventional Radiology across the Health Board, including out of hours services (where appropriate). This will reduce the need for staff and patient travel as well as increasing the available treatment options	Chief Operating Officer		Q2		
4J.a.6	4J.a.6 Develop a long-term plan around robotic assisted urology surgery for the patients of North Wales, benefitting the recruitment and retention and whilst building a futureproof service model	Chief Operating Officer		Q2		
4J.a.7	4J.a.7 Improve the pre-investigation of patients via Straight to Test pathways with a focus on suspected cancer pathways. Ensuring we optimise nurse-led approaches to create consultant capacity where able	Chief Operating Officer		Q2		
4J.a.8	4J.a.8 Monitor Did Not Attend (DNA) and Could Not Attend (CNA) rates and implement mechanisms to mitigate reduced activity when the combined rate is greater than 5%, minimising the loss of clinical capacity	Chief Operating Officer		Q2		
4J.a.9	4J.a.9 Maximise day case and outpatient urology procedures, converting from inpatient where appropriate, to support improved in-patient average length of stay	Chief Operating Officer		Q2		

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4J.a.10	4J.a.10 Review of MDT utilisation: complex regional MDT and local MDT with a view to reducing duplication and recovering lost clinical capacity	Chief Operating Officer		Q2		
4J.a.11	4J.a.11 Utilise patient experience data to inform service delivery such as care closer to home, commissioning of major surgery, and timelier access to diagnostics and treatment	Chief Operating Officer		Q2		
<b>4Jb: Vascular</b>						
4J.b.1	Workforce: Agree sustainable clinical workforce model that: <i>(i) ensure patients are seen by the most appropriate professional for their needs, therefore, increasing capacity and ensuring consultants are freed up to support the most complex cases, and</i> <i>(ii) ensure that all staff are supported to work to the top of their competencies, through active training and learning.</i> <i>(iii) Develop network-wide to support job planning to ensure our workforce are deployed where demand is greatest, and develop a robust and business case to enable recruitment to any additional posts needed to deliver high quality patient care; include a review of non-medical roles to support vacancy gaps</i>	Chief Operating Officer			Q3	
4J.b.2	Develop integrated workforce plan to address recruitment and retention challenges within the service and support implementation of a positive working culture, which fosters inclusion and respect across all staffing levels	Chief Operating Officer				Q4
4J.b.3	Establish a sustainable medium-to-long-term model for Abdominal Aortic Aneurysm (AAA) services that ensures optimal patient outcomes	Chief Operating Officer		Q2		
4J.b.4	Commence work on implementing the revised patient-centric transfer, discharge and repatriation pathways and protocols to improve patient experience, reduced re-admissions and/ or 'failed discharges; and ensure appropriate follow-up arrangements are in place once patients are back in the community	Chief Operating Officer			Q3	
4J.b.5	Progress the quality improvement plan aligned to health board's QMS system to ensure that quality improvement underpins all that the service does, including clearly documenting leadership structures, escalation processes, including processes for managing risk	Chief Operating Officer		Q2		
4J.b.6	Commence an improvement programme for Chronic Limb threatening Treatment Ischemia with the aim of increasing the numbers of people being re-vascularised within 5 days of admission	Chief Operating Officer		Q2		
4J.b.7	Develop proposal for a patient information system that will enable tracking of vascular patients through their pathway, identify blockages and ensure patient care is expedited where necessary	Chief Operating Officer			Q3	
4J.b.8	Work with delivery partners, (e.g., COTE, stroke, palliative care, psychology, pain management, microbiology), strengthen and build opportunities for the development of a greater, more integrated multi-disciplinary team around the patient approach in order to ensure the holistic needs of the patient are met	Chief Operating Officer		Q2		
<b>4Jc: Dermatology</b>						
4J.c.1	Implement strategic and operational Workforce Planning to systematically analyse, forecast, and plan workforce capacity and demand. Identify critical gaps and develop targeted recruitment, retention, and workforce development strategies, including the utilisation of alternative and emergent roles, to ensure the	Chief Operating Officer			Q3	

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
	organisation maintains a highly skilled, flexible, and appropriately staffed workforce. This approach supports the achievement of strategic objectives and the delivery of high-quality, patient-centred care					
4J.c.2	Job planning to appropriately reflect all duties undertaken to better understand the workforce capacity and match it to patients' needs	Chief Operating Officer			Q3	
4J.c.3	Introduce dermatological Community Health Pathways to support effective referral management processes, reducing secondary referrals through better informed resources within Primary Care to deliver some Dermatological services	Chief Operating Officer		Q2		
4J.c.4	Ensure Minor Operation Procedure (MOP's) capacity is optimised within the available resources, to support expansion of Teledermoscopy i.e., the provision of dermatology services at a distance, using technology	Chief Operating Officer			Q3	
4J.c.5	Increase medical consultant support for primary care to support integrated working and extended roles, opening up educational opportunities to enhance knowledge and confidence with skin conditions, which will lead to fewer referrals into secondary care reducing the demand on the service and waiting times for patients	Chief Operating Officer		Q2		
4J.c.6	Open Connah's Quay facility to provide increased clinic and operating space including dressing clinics. Connah's Quay will release 10 Minor Op sessions on a weekly basis, alongside opportunity to run one-stop sessions. <i>(duplicate of 4J.d.3)</i>	Chief Operating Officer		Q2		
4J.c.7	Roll out Teledermoscopy across West IHC to maximise benefits across BCUHB	Chief Operating Officer			Q3	
4J.c.8	Optimise referral and triage processes to support e-referral (Welsh Admin Portal) roll out	Chief Operating Officer		Q2		
4J.c.9	Develop business cases for technological solutions to reduce follow up appointments, late cancellations, and DNA's	Chief Operating Officer			Q3	
4J.c.10	Act based on the insights gathered, delivering patient experience improvements such as delivering care closer to home where feasible, through integrated working and pathway development with primary care	Chief Operating Officer				Q4
<b>4Jd: Plastics</b>						
4J.d.1	Review of commissioning arrangements when they change in 2025 (actual date to be confirmed) - it is important to note providers will continue the outreach service irrespective of the commissioning arrangements	Chief Operating Officer				Q4
4J.d.2	Handover of waiting list management to MWL following agreed threshold as limited demand and capacity information is currently held by BCUHB (Central and West waiting lists are still held by BCUHB even though MWL are the service provider)	Chief Operating Officer				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4J.d.3	Develop the proposal to open Connah's Quay as a joint facility with dermatology to provide increased clinic and operating space and capacity including dressing clinics. (duplicate of 4J.c.3)	Chief Operating Officer		Q2		
4J.d.4	Consider options for further outreach capacity across North Wales to increase access across the region as the Connah's Quay facility will provide capacity for patients within the East and Central Integrated Health Communities only	Chief Operating Officer			Q3	
4J.d.5	Additional capacity: Review opportunities for increasing theatre throughput within existing facilities in East and West IHCs	Chief Operating Officer			Q3	
4J.d.6	Technology: Generate a business case for the expansion of 'My Medical Record' to manage skin cancer follow-up patients; My Medical Record gives access to patients own online health record containing jointly managed information between the patient and the service	Chief Operating Officer				Q4
4J.d.7	Patient Experience: Act based on the insights gathered, delivering patient experience improvements such as delivering care closer to home where feasible, through integrated working and pathway development with primary care	Chief Operating Officer				Q4
<b>4Je: Oncology</b>						
4J.e.1.	Increase the number of substantive oncology consultants dependent on levels of available funding; providing greater continuity of care (replacing short term locums)	Chief Operating Officer				Q4
4J.e.2.	Substantive recruitment to multi-professional roles across oncology (nursing, operational and pharmacy) to meet the current demands and improve service provision and patient safety following recurrent funding approval	Chief Operating Officer		Q2		
4J.e.3.	Develop a fully integrated service strategy to support future demand and innovation	Chief Operating Officer			Q3	
4J.e.4.	Complete business case for 2 linear accelerators to replace machines which are coming to the end of their safe working life. Funding is secured via Welsh Government and replacement will ensure reduced machine downtime which impacts on treatment capacity for patients. This will also give the department the opportunity to purchase machines with the latest developments which could provide greater access and/or more capacity	Chief Operating Officer		Q2		
4J.e.5.	Establish SABR (Stereotactic Ablative Radiotherapy) - a highly targeted form of radiotherapy which targets a tumour with radiation beams from different angles) service in North Wales, commencing with treatment of lung cancers. This type of treatment is delivered in fewer numbers of treatments (with potentially minimal side effects) than conventional radiotherapy	Chief Operating Officer		Q2		
4J.e.6.	Engagement with the implementation of the EHR; this is an essential element for Oncology as currently oncology records are stored within dedicated oncology records and are not visible to the wider services	Chief Operating Officer		Q2		

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
	through the main patient notes, placing a risk to patient safety when patients are admitted/seen elsewhere across the Board and the clinician does not have access to up to date clinical records					
4J.e.7.	Collaborate with the development of a single Welsh contract for Chemocare software to standardise the system across Wales with a view to reduce contract/service costs and ensure data is comparable	Chief Operating Officer			Q3	
4J.e.8	Patient Experience: Act based on the insights gathered, delivering patient experience improvements such as delivering care closer to home where feasible	Chief Operating Officer				Q4
<b>4Jf: Ophthalmology</b>						
4J.f.1	Recruit to funded regional clinical (medical and Optometry) and operational business support leadership roles to drive forward service delivery and improvements	Chief Operating Officer		Q2		
4J.f.2	Implement strategic and operational Workforce Planning to systematically analyse, forecast, and plan workforce capacity and demand. Identify critical gaps and develop targeted recruitment, retention, and workforce development strategies, including the utilisation of alternative and emergent roles, to ensure the organisation maintains a highly skilled, flexible, and appropriately staffed workforce. This approach supports the achievement of strategic objectives and the delivery of high-quality, patient-centred care	Chief Operating Officer			Q3	
4J.f.3	Optimise to NICE/GIRFT evidenced based pathways for all ophthalmology sub specialities, delivered through pan BCUHB sub speciality networks. <i>(Linked to 4L.f.4 and 4L.f.1)</i>	Chief Operating Officer				Q4
4J.f.4	Make best use of available resources to expand locally agreed regional integrated care pathways (glaucoma and retinopathy) with community Optometrists. Develop opportunities for the WGOS (Welsh Government Optometry Services) (extended workforce) to provide equity in care and treatment delivery and reduce demand across the region <i>(Linked to 4L.f.3 and 4L.f.1)</i>	Chief Operating Officer		Q2		
4J.f.5	Deliver cataract pathway efficiencies to improve timely access through: Pre – Operative Assessment Clinic (POAC) process improvement, direct listing, increased theatre utilisation (including High Volume Low Complexity (HVLC) and Minor Operating Procedures (MOPs), and monitoring of Hospital cancelled appointments and Did Not Attend to ensure maximum utilisation of available capacity and resources	Chief Operating Officer				Q4
4J.f.6	Undertake an estates review to identify challenges and risks (ageing buildings, fragile infrastructure, and access issues) and explore further estate and modular opportunities in community settings to prevent loss in available capacity for care and treatment and providing care closer to home	Chief Operating Officer		Q2		
4J.f.7	Ensure improvements in data quality	Chief Operating Officer		Q2		

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4J.f.8	Develop a business case for a centralised cataract hub and a centralised complex services centre to support regional service delivery (predeterminant of regional delivery would be 'go-live' of the ophthalmology national EPR)	Chief Operating Officer				Q4
4J.f.9	Introduce See on Symptom (SOS) and Patient Initiated Follow Up (PIFU) by default, for effective outpatient delivery, empowering patients to take control by giving them the choice and flexibility around when they access care and treatment	Chief Operating Officer		Q2		
4J.f.10	Undertake demand and capacity modelling to establish patient volume waiting times and appointment backlog for all sub specialities including the recruitment of Eye Care Validators (Linked to 4J.f.3b and C)	Chief Operating Officer			Q3	
4J.f.11	Ensure consistent use across North Wales of interim digital solutions (e-referral and Consultant Connect) to improve the referral process and reduce delays between referral and treatment whilst awaiting national systems delivery	Chief Operating Officer		Q2		
4J.f.12	Act based on the insights gathered within existing Harm Review process, delivering improvements in patient experience through direct referrals and expansion of alternative community based pathways	Chief Operating Officer				Q4
<b>4Jg: Orthodontics</b>						
4J.g.1.	Consolidate the Orthodontic and Oral Maxillo Facial Surgery (OFMS) services to become a networked single service with one operational manager and budget working across the three IHCs	Chief Operating Officer		Q2		
4J.g.2	Support the recruitment of funded consultant vacancies and implement a strategic and operational Workforce Planning review to systematically analyse, forecast, and plan workforce capacity and demand. Identify critical gaps and develop targeted recruitment, retention, and workforce development strategies, including the utilisation of alternative and emergent roles, to ensure the organisation maintains a highly skilled, flexible, and appropriately staffed workforce. This approach supports the achievement of strategic objectives and the delivery of high-quality, patient-centred care	Chief Operating Officer		Q2		
4J.g.3.	Create and deliver an improvement plan, implement and monitor GIRFT recommendations as supported by the Royal College of Surgeons (Faculty of Dentistry) and the British Orthodontic Society	Chief Operating Officer		Q2		
4J.g.4.	Introduce See on Symptom (SOS) and Patient Initiated Follow-Up (PIFU) by default, for effective outpatient delivery, empowering patients to take control by giving them the choice and flexibility around when they access care and treatment	Chief Operating Officer			Q3	
4J.g.5.	Deliver improvements in day case surgery rates and ring fenced beds	Chief Operating Officer			Q3	
4J.g.6.	Improve effective utilisation of theatre capacity, optimising the right procedure in the right place to reduce unnecessary theatre utilisation	Chief Operating Officer		Q2		

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4J.g.7.	Review management of, and validate, waiting list to support prioritisation of new patients, longest waiters and those requiring oral surgery as part of their pathway of care. Monitor DNA/CNA rates	Chief Operating Officer			Q3	
4J.g.8	Review and act prudently on introducing improvements to patient experience based on insights gathered to date, such as access to care and the CHC review of harm to children waiting for appointments and treatments	Chief Operating Officer				Q4
<b>4Jh: Trauma &amp; Orthopaedics</b>						
4J.h.1.	Work with orthopaedic clinical leadership to deliver standardised effective job planning and subspecialty focused North Wales services', to enable a reduction in unwarranted clinical variation	Chief Operating Officer			Q3	
4J.h.2.	Address workforce shortages through recruitment and upskilling of existing non-medical workforce led by effective pan-BCUHB and IHC clinical leadership	Chief Operating Officer			Q3	
4J.h.3.	Reduce unwarranted clinical variation to increase productivity and improve patient outcomes through implant rationalisation, improved multi-disciplinary team working, job planning, trauma rota and demand/capacity mapping, and increased utilisation of SOS, PIFU and PROMs pathways	Chief Operating Officer		Q2		
4J.h.4.	Development and adherence to BMI guidelines for surgery to increase conversation rates >70%. This will entail some patients partaking in the lifestyle management programme to reduce their BMI in order to increase their appropriateness for surgery and as such improve their post-operative outcomes	Chief Operating Officer			Q3	
4J.h.5.	Improve data quality at a subspecialty level through more effective coding practices, therefore allowing better understanding of the underlying issues and as such where improvements are required	Chief Operating Officer		Q2		
4J.h.6	Implement condition specific pathways for Carpel Tunnel Syndrome and Hip/Knee arthroplasty through collaboration with the national clinical implementation network and respective sub-specialty groups. This will reduce unwarranted variation in clinical practice and afford patients the same opportunities across the Health Board	Chief Operating Officer			Q3	
4J.h.7.	Review current outsourcing and external commissioning arrangements and through demand and capacity mapping establish whether there is appetite and potential to repatriate activity, providing patients with care closer to home	Chief Operating Officer		Q2		
4J.h.8.	Generate a proposal to increase patient activity in Abergele Hospital through an expansion of current Abergele criteria and / or investment into enhanced recovery on the site. Testing the link between optimising theatre utilisation and improving treat in turn rates	Chief Operating Officer		Q2		
4J.h.9	Implement consistent application of See On Symptom and Patient Initiated Follow Up pathways across North Wales. This will reduce the need for traditional in-person follow up appointments, creating capacity for patients that need to be seen	Chief Operating Officer			Q3	

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4J.h.10	Utilise patient experience data to improve patient care with initiatives such as providing care closer to home and timelier access to diagnostics and treatment	Chief Operating Officer		Q2		
<b>4K: Women's services</b>						
4K.1	Support the local establishment of a Women's Health Hub by March 2026 as a Ministerial Priority; dependent on the prioritisation of available resources. Principles of which will focus on preventative based women's health initiatives, accessibility to information and services with care as close to home as possible	Chief Operating Officer				Q4
4K.2	Lead on the recovery of Gynaecology Cancer and Planned Care in line with GIRFT recommendations and Ministerial Targets	Chief Operating Officer				Q4
4K.3	Progress business cases to secure Cancer and Planned Care Pathway Trackers and a Single Point of Access System for Gynaecology referrals to support recovery and pathway re-design	Chief Operating Officer				Q4
4K.4	Support the implementation of the Preconception Strategy to include preventative based women's health initiatives	Chief Operating Officer				Q4
4K.5	Develop a measurable plan to enable delivery of the Quality Management for Maternity and Neonatal Services, prioritising the 7 key actions which align to the MatNeo Safety Support Programme	Chief Operating Officer				Q4
4K.6	Progress the business case to implement the Digital Maternity Solution for Services	Chief Operating Officer				Q4
4K.7	Work in partnership with the NHS Executive to develop an implementation plan to deliver the Perinatal Engagement Framework commitments	Chief Operating Officer				Q4
4K.8	Collaborate with HEIW to prioritise year 1 actions to ensure delivery of the Perinatal workforce plan	Chief Operating Officer				Q4
4K.9	Develop a Perinatal Quality Surveillance Dashboard with key standard matrix with both network and national oversight in line with policy direction	Chief Operating Officer				Q4
4K.10	Progress the business case to support the equitable implementation of a specialist infant feeding - lactation support service team in the 3 IHC areas - to improve breastfeeding outcomes in North Wales	Chief Operating Officer				Q4
<b>4L: Children &amp; Young People</b>						
4L.1.	Work on raising awareness and implementing the Children's Charter across the Heath Board	Chief Operating Officer				Q4
4L.2.	Work towards the establishment of a Youth Voice Board in the Heath Board to ensure children's rights are upheld and children are consulted and involved in the development and provision of services (linked to 3C.8)	Chief Operating Officer				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
4L.3.	Progress the Health Board signing of the Wales Corporate Parenting Charter to support care experienced children to have the same opportunities as all children	Chief Operating Officer		Q2		
4L.4.	Further improvements in children's Immunisation uptake levels	Chief Operating Officer				Q4
4L.5.	Develop transition pathways	Chief Operating Officer				Q4
4L.6	Work with partners on the Right Door approach to support children with complex needs	Chief Operating Officer				Q4
<b>4M: Pharmaceutical services</b>						
4M.1.	Implement the prioritised actions from the Independent Review of Hospital Clinical Pharmacy Services across all hospital settings (including MHL, Cancer, Women's) subject to available resources	Chief Operating Officer				Q4
4M.2	Establish a Medicines Value prevention arm that leverages diabetes prescribing and Value-Based outcomes while optimising cost efficiencies	Chief Operating Officer		Q2		
4M.3	Develop a business case to centralise Radiopharmacy services, aligned with the nuclear medicine programme and supported by the national TrAMs programme team	Chief Operating Officer				Q4
4M.4	Scope and test a model for commissioned community pharmacy services focused on long-term condition management, starting with hypertension	Chief Operating Officer				Q4
4M.5	Launch the first MPharm cohort at Bangor University in 2025, working with General Pharmaceutical Council (GPhC) towards achieving Step 4 accreditation by the 2025/26 academic year	Chief Operating Officer			Q3	
<b>4N: Palliative, End of Life and Bereavement Care</b>						
4N.1	4N.1. Develop a Strategic Delivery Plan for Palliative Care and End of Life Care (PEoLC)	Executive Director of Nursing & Midwifery				Q4
4N.2	4N.2. Commence implementation of the SWAN model for bereavement care, to support and guide the care of patients and their loved ones during end-of-life care and afterwards	Executive Director of Nursing & Midwifery				Q4
4N.3	4N.3. Develop a model and workforce plan to improve PEoLC in line with the Welsh Government Quality Statement for Palliative and End of Life Care	Executive Director of Nursing & Midwifery				Q4
4N.4	4N.4. Finalise the Quality Improvement Strategy for End of Life Care Decision making. Develop an options appraisal and business case to improve PEoLC in accordance with the Quality Improvement Strategy for End of Life Care decision making	Executive Director of Nursing & Midwifery				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
<b>40: Dental services</b>						
40.1	Work to increase GDS service provision, this will require consideration of new and innovative solutions alongside existing methods. The Health Board will continue to liaise with partners such as the Chief Dental Officer for Wales and the Local Dental Committee, to support this in addition to working with other Health Boards where primary care dental services are performing well	Chief Operating Officer			Q3	
40.2	Re-evaluate areas of need and go back out to procurement for GDS access in 2025, working with the procurement team to improve the framework of the tender in order to expand the pool of potential bidders	Chief Operating Officer				Q4
40.3	Progress dental education strategy, setting out plans for all workforce in line 'Primary Care Model for Wales'. The aim of the strategy is to make North Wales a centre of excellence for all Dental professions by providing upskilling, training and development opportunities for all members of the dental team, including working with Bangor University to build on the Dental Hygienist and Dental Therapist courses, supporting a community-based service	Chief Operating Officer				Q4
40.4	Use the 'Primary Care Academy' approach to support healthcare professionals to develop advanced skills within primary care that allow skill-mix changes and increased workforce stability. The aim is to expand this work in order to offer development opportunities both within CDS and GDS which will ultimately benefit patient care	Chief Operating Officer			Q3	
40.5	Work with Public Health team in continued delivery of national programmes such as 'Designed to Smile' and 'Gwên am Byth'	Chief Operating Officer				Q4
40.6	Review and revise the dental budget to ensure appropriate support is given to services. This work will be revenue neutral and aims to leverage better value from the financial resources currently supporting the provision of dental services	Chief Operating Officer		Q2		
40.7	CDS waiting lists to be addressed to ensure patients are not waiting significant lengths of time. Solutions include optimising front line clinical resource, improving the patient appointment booking centre (PABC), and creating key performance indicators (KPIs) to underpin operational management	Chief Operating Officer				Q4
40.8	Undertake a demand and capacity review for CDS services to understand activity patterns to be able to effectively forecast when staffing will be required and to what degree	Chief Operating Officer			Q3	
40.9	The formation of a clear domiciliary dental pathway with a robust eligibility criterion. Agreeing the right approach will involve dental officers who are responsible for delivering the activity. As most of the domiciliary activity takes place within care homes, an inclusive approach will be taken to codesign any agreed pathways	Chief Operating Officer				Q4
40.10	Improve Board visibility of primary care dentistry performance data	Chief Operating Officer		Q2		

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
<b>4P: Diabetes</b>						
4P.1	<p>The Health Board Diabetes Programme will contribute to increasing the % of those aged 12+ receiving the 8 Care Processes by:</p> <p><i>Evaluating the limitations and sources of data being utilised to report the position</i>  <i>Understanding why variation exists in primary care and prescribing</i>  <i>Identifying improvement for data collection and instigating improved reporting from clusters</i>  <i>Evaluating the limitations and sources of data being utilised to report the position</i>  <i>Understanding why variation exists in primary care and prescribing</i>  <i>Identifying appropriate resources required for patients for managing diabetes</i>  <i>Providing appropriate management plans for individuals with Type 1 diabetes across primary and secondary care which tackle duplication and variation in care</i>  <i>Implementing improvement plans in relation to use of medication in line with NICE guidelines</i>  <i>Evaluating the improvement and shared peer learning</i>  <i>Utilising insight from 8 Care Processes to inform Primary Care model for 26/27</i></p>	Executive Director of Public Health				Q4
4P.2	Implementation of the NICE Technology Appraisal to provide 'artificial pancreas' technology called Hybrid Closed Loop (HCL) systems which offer people who develop this particular auto-immune condition the opportunity to enjoy normal glucose control. There is a significant resource requirement associated with this development, which is planned for implementation over a 5-year period, subject to the agreement of funding	Chief Operating Officer				Q4
4P.3	The Health Board will seek to strengthen the multi-disciplinary specialist diabetes team to support transition to adult services and to respond quickly to the increasing number of new presentations	Chief Operating Officer				
4P.4	In adult diabetes teams a more comprehensive service model will be required to deliver diabetes technology to people with Type 1 diabetes in line with the national directive	Chief Operating Officer				

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
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## 5: Effective environment for learning and skills development

### 5A: University and Further Education Partnership

5A.1	The Health Board will seek to build the relationships with all higher and further education partners to improve the impact across research and development, education and training and innovation thus supporting our continued achievement of University Designation	Executive Medical Director			Q3	
5A.2	Having maintained and developed relationships, BCU will explore the value in a regional approach to partnership with all stakeholders	Executive Medical Director				Q4
5A.3	Work with education providers in the development of the Health Board's Clinical Services Plan to increase their understanding and open up opportunities for transformational and innovative change to be reflected	Executive Medical Director				Q4
5A.4	Building on the successful establishment of the North Wales Medical School, we will continue to work with and support all partners in achievement of strategic projects	Executive Medical Director				Q4
5A.5	Launch the first Mpharm cohort at Bangor University in 2025, with General Pharmaceutical Council (GPhC) Step 4 accreditation achieved by 2025/26	Chief Operating Officer	Reporting through 4M.5			
5A.6	Work with the University of Wales Bangor to support the development and growth of the North Wales Medical School	Executive Medical Director	Reporting through 2C.7			
5A.7	Progress dental education strategy, setting out plans for all workforce in line 'Primary Care Model for Wales'. The aim of the strategy is to make North Wales a centre of excellence for all Dental professions by providing upskilling, training and development opportunities for all members of the dental team, including working with Bangor University to build on the Dental Hygienist and Dental Therapist courses, supporting a community-based service	Executive Medical Director	Reporting through 4O.3			

### 5B: Research, Development and Innovation

5B.1	Completed development of a support infrastructure and expert panel with M-SParc, OpTIC Technology Centre, Bangor University and Wrexham University, supported by Welsh Government. Innovators will be able to access the expert panel for advice and guidance	Executive Medical Director				Q4
5B.2	Continue to increase research activity, both commercial and non-commercial research	Executive Medical Director				Q4
5B.3	Increase the number of joint appointments and honorary research appointments with our academic partners	Executive Medical Director				Q4

Ref	Descriptor	Lead Executive	Qtr1	Qtr2	Qtr3	Qtr4
<b>5C: Academic Careers</b>						
5C.1	Whilst awaiting a national definition, hold a multidisciplinary workshop with those currently working in academic careers, and with those who aspire to this career pathway, to agree a local working definition	Executive Director of Allied Health Professions & Health Science		Q2		
5C.2	Explore the academic career pathway framework, utilising the outputs from the workshop to inform a paper, which will be built upon with proposals for the supporting governance framework, and supplemented by learning and best practice from other health and academic organisations	Executive Director of Allied Health Professions & Health Science				Q4
<b>5D: Intelligence Led</b>						
5D.1.	Build on proof-of-concept work to develop proposals for Robotic Process Automation (RPA) to reduce reliance on manual processes	Chief Digital & Information Officer				Q4
5D.2.	Delivery of a Health Board data quality kite-mark to improve data for decision making, supported by the extension of data models written for RTT	Chief Digital & Information Officer				Q4
5D.3.	Continued development of forecasting capabilities and proposals for the introduction of predictive analytics that will in turn support improved planning and decision making around planned and urgent and emergency care	Chief Digital & Information Officer				Q4
5D.4.	Roadmap for the further development of data warehousing will be documented, incorporating the de-commissioning of the Health Board's legacy warehouse. Commence implementation of Cloud Based Technology through transition to the National Data Analytics Platform for submitting data and establishing arrangements for transition from On-Premise to Cloud, all aligned to the Care Data Resource	Chief Digital & Information Officer				Q4
5D.5.	As part of the Operational dashboard (IRIS2) rollout, implement the necessary foundations that will enable use across all types of devices in an intuitive and bespoke manner	Chief Digital & Information Officer	Q1			
5D.6	Building on the progress made with Planned care data, the Health Board will undertake a data maturity assessment of urgent and emergency care and develop a programme of work to develop the use of intelligence and insight in this area	Chief Digital & Information Officer		Q2		
<b>5E: Learning Organisation</b>						
5E.1	The Health Board will evaluate how the organisation learns from its investigations of serious incidents and complaints following the introduction of the Integrated Concerns and Complaints Policy	Executive Director of Nursing & Midwifery				Q4
5E.2	The Health Board will improve its systems and processes to ensure the transfer of learning as a Learning Organisation is increasing the opportunity to share learning and improve patient care	Executive Director of Nursing & Midwifery				Q4

<i>Ref</i>	<i>Descriptor</i>	<i>Lead Executive</i>	<i>Qtr1</i>	<i>Qtr2</i>	<i>Qtr3</i>	<i>Qtr4</i>
5E.3	Develop a discovery report to inform an Education Strategic Plan for the Health Board	Executive Director of Nursing & Midwifery				
5E.4	Improve processes to prepare for, respond to and embed learnings from any requests made by national inquiries	Executive Director of Nursing & Midwifery				Q4

Delivery will be monitored through the Portal, newly refreshed for 2025/26, which allows all plans and reporting to be brought together with an “update once” approach.



## Health Board

# **ALL WALES APPROVED CLINICIANS AND SECTION 12(2) DOCTORS** **BOARD REPORT – JANUARY 2026**

<b>Date of Meeting</b>	29 January 2026
<b>Publication Status</b>	Open/Public
	Not Applicable
<b>Report Author name and title</b>	Meryl Roberts, All Wales Approvals Manager
<b>Lead Executive Team Member name and title</b>	Dr Clara Day, Executive Medical Director

<b>Report Purpose</b>	Endorse for Board Approval
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### **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 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.



The Board is asked to note that the All Wales Approval Panel Chair role is currently vacant. Following unsuccessful recruitment restricted to registered medical practitioners, approval was granted by the Executive Medical Director on 9<sup>th</sup> December 2025 to widen eligibility for other professionally registered approval panel members to apply. The role has since been readvertised accordingly.

**Board Actions Requested:**

- Note the contents of the report.
- Ratify the Approved Clinician and Section 12(2) approvals in Appendices 1 and 2.
- Approve the extension of eligibility for the All Wales Approval Panel Chair role to all professionally registered members of the All Wales Approval Panel.

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

<b>Committee / Group / Individuals</b>	<b>Date</b>	<b>Outcome, Evidence and Data</b>
Executive Medical Director and the Deputy Executive Medical Director	06.11.2025-05.01.2026	Recommendations for approval were made by the All Wales Approval Panel and authorised by the EMD and the Deputy EMD in line with delegated authority arrangements.
Executive Medical Director All Wales Approvals Manager	17.11.2025	Email containing revised Terms of Reference for the vacancy of All Wales Approval Panel Chair from Approval Manager submitted to the Executive Medical Director.
EMD All Wales Approvals Manager	08.12.2025	Further information requested by the EMD re: roles: who then sought guidance from the Head of Legal Services and Director of Corporate Governance.
EMD Head of Legal Services Director of Corporate Governance All Wales Approvals Manager	08.12.2025	The revised Terms of Reference and proposal were checked by the Head of Legal Services and response copied to the Director of Corporate Governance. Advice

		given that in England (which operates under separate legal Directions, health is a devolved matter) and the most recent tender for panel providers required the Chair to be a Consultant Psychiatrist, with the Vice Chair permitted to be from another profession. Advised that we ought to check for similar commissioning requirements from WG. None in place. Permission to proceed authorised.
Executive Assistant to the EMD	15.12.2025	Advertisement and revised TOR for Panel Chair role circulated to the All Wales Approval Panel

<b>Acronyms / Glossary of Terms</b>	
CCT	Certificate of Completion of Higher Specialty Training (contained with the indices attachment)
RMP	Registered Medical Practitioner
WG	Welsh Government
EMD	Executive Medical Director
DEMD	Deputy Executive Medical Director
TOR	Terms of Reference

## 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.



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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 authorised by the EMD and the DEMD.

3.2 Approval of revised eligibility criteria for the All Wales Approval Panel Chair role.

### 4 **KEY RISKS / MATTERS FOR ESCALATION**






4.1 No significant risks identified. The absence of a substantive Chair presents a short term governance risk which is being actively mitigated through revised eligibility criteria for the role and readvertisement. In the interim, the Vice Chair and existing Panel governance arrangements continue to provide effective oversight.

### 5 **RECOMMENDATIONS**

5.1 The Board is asked to:

- Ratify approvals
- Support the decision to approve revised TOR for All Wales Approval Panel Chair



ASSESSMENT	
<b>Link to Strategic Priorities</b>	    
	Choose an item.
	Improving quality, outcomes and experience
<b>Design Principles</b>	Consistency with Organisational Values If more than one applies, please list below:
<b>Corporate Risks and Board Assurance Framework</b>	
<b>Wellbeing of Future Generations Act – Wellbeing Goals</b>	A Healthier Wales
	If more than one applies, please list below:

IMPACT ASSESSMENTS		
<b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	A formal assessment was not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
<b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	A formal assessment was not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
<b>Quality</b> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Enablers of Quality</b> Choose an item.	<b>Domains of Quality</b> Choose an item.



	If more than one applies, please list below:	If more than one applies, please list below:
<b><u>Wellbeing of Future Generations Act – Wellbeing Goals</u></b>	A Healthier Wales	
<b>Environmental /Sustainability Impact (5Rs)</b>	If more than one applies, please list below:	
	Choose an item.	
	If more than one applies, please list:	
<b>Armed Forces Covenant Due Regard Duty</b> Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	A formal assessment was 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:	
<b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	A formal assessment was not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
<b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	A formal assessment was not required as the report relates solely to governance and assurance arrangements



		only and does not introduce changes to service delivery.
<b>Legal</b>	Yes (Include further detail below)	
	<p>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), WG Guidance document, Approved Clinician Directions 2018 and S12(2) Process and Criteria Document (the written approval process).</p> <p>There are no identified legal concerns arising from the recommendations within this report.</p>	
<b>Reputational</b>	Yes (Include further detail below)	
	<p>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.</p> <p>The arrangements outlined in this report provide assurance that approvals are subject to appropriate scrutiny, transparency and Board oversight. No reputational risks have been identified.</p>	
<b>Resource Impact</b> <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	
	<p>There is no direct financial or workforce impact arising from the matters outlined in this report.</p> <p>The activity described, represents continuation of existing All Wales approval arrangements within current resources.</p>	

## APPENDIX 1

<u>Update of Register of Approved Clinicians in Wales</u>	
	Approved Clinicians
Approvals and Re-approvals	17
Approvals suspended	0
Approvals re-instated	3
Left Wales and Removed from Register)	0
Retired	0
No longer Registered with Professional Body	7
Transferred from AC register (to S12 Register)	1
Removed from S12 – Became AC approved	0
Approval Ended	1
Death in Service	1
Performance Metrics Reporting period: 6 <sup>th</sup> November 2025 – 5 <sup>th</sup> January 2026	
Total number of AC applications processed	18
Number awaiting completion of application by the applicant	0
Pending Approvals	1
Average processing time per completed application.	<b>Initial AC approval:</b> 11.40 days (includes fast track applications). <b>AC reapproval:</b> 12.66 days
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: 6<sup>th</sup> November 2025 – 5<sup>th</sup> January 2026**

### Approvals and Re-approvals: 17

Surname	First Name	Workplace	Date Approval Expires
Roufael	Rim	Cwm Taf Morgannwg University Health Board, Prince Charles Hospital, Gurnos Road, Gurnos, Merthyr Tydfil. CF47 9DT	6 <sup>th</sup> November 2030
Lepping	Peter	Betsi Cadwaladr University Health Board, Liaison Psychiatry, Heddfan Psychiatric Unit, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham LL13 7TD	10 <sup>th</sup> November 2030
Gupta	Sumanta	Cygnnet Healthcare Ltd, Cygnnet Delfryn House, Argoed Hall Lane, Mold, Flintshire, CH7 6FQ	19 <sup>th</sup> November 2030
Isaac	Andrew	Swansea Bay University Health Board, Bridgend CLDT, Bridgend Resource Centre Picton Court Retail Park, Bridgend, CF31 3XX	19 <sup>th</sup> November 2030
Leo	Jean	Betsi Cadwaladr University Health Board, Ablett Unit, Glan Clwyd Hospital, Bodelwyddan, Denbighshire, LL18 5UJ	24 <sup>th</sup> November 2030
Grzegorzak	Grzegorz Stanislaw	Iris Care Group, St Peter's Hospital, Chepstow Road, Llandevaud, Newport, NP18 2AA	24 <sup>th</sup> November 2030

<b>Surname</b>	<b>First Name</b>	<b>Workplace</b>	<b>Date Approval Expires</b>
Chowdhury	Ashfaque	Cygnnet Healthcare Limited, Cygnnet Delfryn House, Alfonso, Argoed Hall Lane, Mold, Flintshire, CH7 6FQ	13 <sup>th</sup> March 2028
Brazzo	Daniela	Cwm Taf Morgannwg University Health Board, Children's Centre, Princess of Wales Hospital, Coity Road, Bridgend, CF31 1RQ	1 <sup>st</sup> December 2030
Sen	Sanjoy	Betsi Cadwaladr University Health Board, Denbighshire Community Learning Disabilities Team, Ruthin County Hall, Ruthin, Denbighshire, LL15 1EJ	3 <sup>rd</sup> December 2030
Jose	Avinash	Betsi Cadwaladr University Health Board, Bryn Y Neuadd Hospital Aber Road, Llanfairfechan, Conwy, LL33 0HH	8 <sup>th</sup> December 2030
Cressey-Rodgers	Justin	Hywel Dda University Health Board, Wellfield Research Centre, 22 Wellfield Road, Carmarthen, SA31 1DS	9 <sup>th</sup> December 2030
Anand	Indiresh	Powys Teaching Health Board, The Richardson Mental Health and Wellbeing Centre Older Adults Mental Health Department, Spa Road East Building, Llandrindod Wells, Powys, LD1 5ES	27 <sup>th</sup> February 2027
Chatfield	Andrew	Betsi Cadwaladr University Health Board, Ruthin Community Hospital, Llanrhydd Road, Ruthin, Denbighshire, LL15 1PS	10 <sup>th</sup> December 2030
Kashyap	Gursharan Lal	Swansea Bay University Health Board, Fendrod Ward, Cefn Coed Hospital, Cockett, Swansea, SA20GH	8 <sup>th</sup> May 2029
Bartlett	Robert	Betsi Cadwaladr University Health Board, Ablett Unit, Ysbyty Glan Clwyd, Rhuddlan Road, Bodolwyddan, Denbighshire, LL18 5UJ	21 <sup>st</sup> December 2030
Seruis	Maria Luisa	Cardiff and Vale University Health Board, North Cardiff Crisis Resolution and Home Treatment Team, Hafan y Coed, Llandough Hospital, Penlan Road, Llandough, Cardiff CF64 2XX	21 <sup>st</sup> December 2030
Ashfaq	Muhammad	Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital, Ynysmaerdy, Llantrisant, CF72 8XR	29 <sup>th</sup> October 2030

**Approvals Suspended: 0**

Surname	First Name	Workplace	Date Approval Expires

**Approvals Reinstated\*: 3**

Surname	First Name	Workplace	Date Approval Expires
Thorn	Laura* (CCT now received)	Cardiff and Vale University Health Board, University Hospital Llandough, Penlan Road, Llandough, Penarth CF64 2XX	10 <sup>th</sup> May 2030
Odume	Anthony	Betsi Cadwaladr University Health Board, Hergest Unit, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LI57 2PW.	3 <sup>rd</sup> May 2026
Fasehun	Adedamola	Formerly Betsi Cadwaladr University Health Board, Cefni Hospital, Llangefni, Anglesey, LL77 7PP, currently independent.	6 <sup>th</sup> April 2026

**Left Wales and Removed from AC Register: 0**

Surname	First Name	Workplace	Date Approval Expires

**Retired: 0**

Surname	First Name	Workplace	Date Approval Expired

**No longer Registered with Professional Body: 7**

Surname	First Name	Workplace	Date Approval Ended
Ali	Imad Mohammed	Formerly Swansea Bay University Health Board, Area 1 CMHT, 21 Orchard Street, Swansea, SA1 5AT	25 <sup>th</sup> November 2025
Garwood	Lynne Janetta	Formerly Cwm Taf Morgannwg University Health Board, North CMHT Maesteg Community Hospital, Maesteg, CF34 9PG	25 <sup>th</sup> November 2025
Gaur	Sandhya	Formerly Betsi Cadwaladr University Health Board, Heddfan Unit, Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD	25 <sup>th</sup> November 2025
Hunter	Stephen	Formerly Healthcare Inspectorate Wales (HIW), Welsh Government Rhydycar Business Park, Merthyr Tydfil, CF48 1UZ	25 <sup>th</sup> November 2025
Medford	Frank	Formerly Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital, Mental Health Liaison Team, Mental Health Unit Ynysmaerdy, Pontyclun, CF72 8XR	25 <sup>th</sup> November 2025
Sood	Ruchit	Formerly Betsi Cadwaladr University Health Board, Heddfan Unit, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD	25 <sup>th</sup> November 2025
Ellis	Elin Mererid	Aneurin Bevan University Health Board, Cwm Coch, Ysbyty Aneurin Bevan, Lime Avenue, Ebbw Vale, Blaenau Gwent, NP23 6GL	

**Transferred from AC Register to S12 Register: 1**

Surname	First Name	Workplace	Date Approval Expires
Owen	Angela	Rushcliffe Independent Hospital, Scarlet Avenue, Port Talbot SA12 7PH	23 <sup>rd</sup> November 2030

**Approval Expired or Ended: 1\* (later reapproved)**

Surname	First Name	Workplace	Date Approval Expired
Brazzo	*Daniela	Cwm Taf Morgannwg University Health Board, Children's Centre, Princess of Wales Hospital, Coity Road, Bridgend, CF31 1RQ	1 <sup>st</sup> December 2030

**Death in Service: 1**

<b>Surname</b>	<b>First Name</b>	<b>Workplace</b>	<b>Date Approval Expired</b>
Dr Melichar	Jan Krzysztof	Aneurin Bevan University Health Board, Dispensing and Treatment Team, The Angover Unit, Longcross Street, Cardiff, CF24 0SZ.	25 <sup>th</sup> November 2025

## APPENDIX 2

<u>Update of Register of Section 12(2) Approved Doctors - Wales</u>	
	<b>Section 12(2) Approved Doctors</b>
<b>Approvals and Re-approvals</b>	7
<b>Approvals suspended</b>	0
<b>Approvals re-instated/ transferred/returned to work in Wales</b>	1
<b>Removed (Left Wales)</b>	1
<b>Retired</b>	0
<b>Registered without a licence to practise and retired</b>	3
<b>Transferred from AC register (to S12 Register)</b>	0
<b>Became AC approved</b>	1
<b>Approval Ended or Expired</b>	3
<b>Death in Service</b>	1
<b>Performance Metrics - Reporting period: 6<sup>th</sup> November 2025 – 5<sup>th</sup> January 2026</b>	
<b>Total number of Section 12(2) doctor applications processed</b>	13
<b>Pending approvals</b>	2
<b>Number awaiting completion of application by the applicant</b>	4
<b>Average processing time per application</b>	Section 12(2) initial approval: 20.20 days Section 12(2) reapproval: 27.50 days
<b>Number of lapsed approvals due to missed deadlines by the applicant.</b>	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: 6<sup>th</sup> November 2025 – 5<sup>th</sup> January 2026**

**S12 Approvals and Re-approvals: 7**

<b>Surname</b>	<b>First Name</b>	<b>Workplace</b>	<b>Date Approval Expires</b>
Goldring	Katie	Cwm Taf Morgannwg University Health Board, Supported Recovery Unit, Ysbyty George Thomas, Mattie Collins Way, Treorchy, CF42 6YG	20 <sup>th</sup> November 2030
Owen	Angela	Independent Practitioner, c/o Private Address	23 <sup>rd</sup> November 2030
Ray	Jason	Independent Practitioner, c/o Private Address	24 <sup>th</sup> November 2030
Ali	Aysha	Cwm Taf Morgannwg University Health Board, Ysbyty George Thomas, Treorchy CF42 6YG	30 <sup>th</sup> November 2030
Scanlon	Kathleen	Aneurin Bevan University Health Board, Lodge Road, Caerleon, Newport, NP18 3XQ	30 <sup>th</sup> November 2030
Eid	Bahi Ibrahim Elmetwally Mohammed	Cwm Taf Morgannwg University Health Board, Crisis Resolution Home Treatment Team, Royal Glamorgan Hospital, Ynysmaerdy, Llantrisant, CF72 8XR	3 <sup>rd</sup> December 2030

Surname	First Name	Workplace	Date Approval Expires
Nwanonenyi	Maris-Stella	Cwm Taf Morgannwg University Health Board, Keir Hardie University Health Park, Aberdare Road, Merthyr Tydfil, CF48 1BZ	4 <sup>th</sup> December 2030

**S12 suspended: 0**

Surname	First Name	Workplace	Date Approval Expires

**S12 Approval Reinstated/Transferred/Returned to Wales: 1**

Surname	First Name	Workplace	Date Approval Expires
Farhadian	Farhad	Hywel Dda University Health Board, Hafan Hedd Resource Centre, Adpar, Newcastle Emlyn, SA38 9NS	

**S12 Ended – Became an Approved Clinician: 1**

Surname	First Name	Workplace	Date Approval Ended
Roufael	Rim	Aneurin Bevan University Health Board, Old Age Psychiatric Liaison Team, Nevill Hall Hospital, Brecon Road, Abergavenny, NP7 7EG and Royal Gwent Hospital Cardiff Road, Newport, NP20 2UB	12 <sup>th</sup> November 2025

**Removed (Left Wales): 1**

Surname	First Name	Workplace	Date Approval Expires
Wiredu	Solomon	Formerly Betsi Cadwaladr University Health Board, Heddfan, Croesnewydd Road, Wrexham, LL13 7TD.	30 <sup>th</sup> November 2026

**Retired: 0**

Surname	First Name	Workplace	Date Approval Expired

**Registered Without a Licence and Retired: 3**

Surname	First Name	Workplace	Date Approval Ended
Jones	Gaynor	Formerly Cardiff and Vale University Health Board, c/o Private Address	27 <sup>th</sup> November 2025
Jalal	Umer	Formerly Cardiff and Vale University Health Board, c/o Private Address	27 <sup>th</sup> November 2025
Edwards	Hugh	Formerly Cardiff and Vale University Health Board, c/o Private Address	5 <sup>th</sup> January 2026

**S12 Approval Ended or Expired: 3**

Surname	First Name	Workplace	Date Approval Expired
Thimmaiah	Neema	Betsi Cadwaladr University Health Board, Liaison Psychiatry, Ablett Unit, Glan Clwyd Hospital, Bodelwyddan, Denbighshire, LL18 5UJ	15 <sup>th</sup> November 2025
Cole-King	Alys	Independent Practitioner, c/o Private Address	25 <sup>th</sup> November 2025

<b>Surname</b>	<b>First Name</b>	<b>Workplace</b>	<b>Date Approval Expired</b>
Drury	Hazel	Betsi Cadwaladr University Health Board, Gwrych Medical Centre, Cae Eithin, Abergele, Conwy, LL22 8LJ	23 <sup>rd</sup> December 2025

**Death in Service: 1**

<b>Surname</b>	<b>First Name</b>	<b>Workplace</b>	<b>Date Approval Ended</b>
Balasuriya	Vasanthi	Aneurin Bevan University Health Board, South Caerphilly CMHT, Old School Building, Mill Road, CF83 2FD	27 <sup>th</sup> November 2025

## Joint Commissioning Committee

### Highlight Report from the Joint Commissioning Committee

<b>Dyddiad y Cyfarfod / Date of Meeting</b>	16/12/2025
<b>Statws Cyhoeddi / Publication Status</b>	Open/Public
	Not Applicable
<b>Awdur yr Adroddiad / Report Author</b>	Maxine Evans, Assurance and Risk Officer, NWJCC
<b>Cyflwynydd yr Adroddiad / Report Presenter</b>	Huw George, Chief Commissioner, NWJCC
<b>Noddwr yr Adroddiad / Report Sponsor</b>	Huw George, Chief Commissioner, NWJCC

<b>Pwrpas yr Adroddiad / Report Purpose</b>	For Noting
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<b>Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)</b>		
<b>Committee / Group / Individuals</b>	<b>Date</b>	<b>Outcome</b>
Health Boards	December 2025	Noted

## 1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer Members of the Joint Committee with a summary of the key issues considered by the NHS Wales Joint Commissioning Committee (JC) at its extraordinary public meeting on 16 December 2025.

Key highlights from the meeting are reported in Section 3.

## 2. PURPOSE

The Purpose and Role of the JC is set out in Paragraphs 2.18 and 2.20 of the NWJCC [Standing Orders \(SOs\)](#).

### 3. HIGHLIGHT REPORT

(Links to reports highlighted [December 2025 - NHS Wales Joint Commissioning Committee](#)).

Status	Update
<b>Alert / Escalate</b>	<ul style="list-style-type: none"> <li data-bbox="395 398 1431 1400"> <p>• <a href="#"><b>Care Home Framework</b></a></p> <p>Members received a paper providing additional information on the benefits, both financial and non-financial, of investment into the NWJCC Care Home Framework. It was noted that several iterations of the paper had been discussed at previous JC and Collaborative Commissioning Leadership Group (CCLG) meetings. Members noted the deadline for the Framework, due to expire in March 2026 and that a resolution was required.</p> <p>There was support for Option 4 as a sustainable, once for Wales solution on behalf of all Health Boards, maximising economies of scale and reducing duplication. Members approved the release of funding to support delivery of Option 4 as a spend to save opportunity noting the risks associated with not approving the recommendation.</p> <p>It was agreed that assurance would need to be provided regarding the improvement in outcomes, the ambition to generate savings and contain costs to be delivered. As a result, it was further agreed that the NWJCC will monitor savings to ensure that the benefits derived exceed the funding to be provided, working with the NHS Wales Finance Working Group with oversight provided by the CCLG. Regular updates will then be reported to the JC.</p> </li> <li data-bbox="395 1400 1431 2018"> <p>• <a href="#"><b>2025/26 Specialised Commissioning Financial Recovery - Managing Activity</b></a></p> <p>Members received a paper providing further financial detail, detail of risks and a plan of action for the three areas of opportunity to support an improvement in this year's financial position, that had been agreed at the JC meeting on 25 November 2025. The areas included:</p> <ul style="list-style-type: none"> <li>○ Reducing elective activity through the management of activity for English provider contracts during Quarter 4.</li> <li>○ To find mitigating Savings through:                             <ul style="list-style-type: none"> <li>• Early cessation of the Salford Obesity Surgery Contract</li> <li>• Understanding Local Health Boards pass through costs, identifying any efficiency opportunities.</li> </ul> </li> </ul> <p>A <a href="#">Quality Impact Assessment</a> of undertaking the actions was included and would continue to be refined subject to approval.</p> </li> </ul>

Status	Update
	It was noted that the above actions to improve the end of year deficit position could be taken forward immediately if a decision was taken at today's meeting, recognising however that the greater financial benefit would be realised in 2026-27. Welsh Government is sighted on the financial position of the JC and the expectation is on improvement wherever possible. Members approved moving forward with the proposed workplan with progress reports to be shared at future JC meetings.
<b>Advise</b>	<ul style="list-style-type: none"> <li>There were no matters to be raised.</li> </ul>
<b>Assure</b>	<ul style="list-style-type: none"> <li>There were no matters for assurance.</li> </ul>
<b>Inform</b>	<ul style="list-style-type: none"> <li>There were no matters for information.</li> </ul>
<b>Appendices</b>	None.

#### 4. ASSESSMENT

Objectives / Strategy	
<b>Dolen i Amcan (au) Strategol CBC</b> <b>Link to JCC Strategic Objectives(s)</b>	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
<b>Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /</b> <b>Link to Wellbeing of Future Generations Act – Wellbeing Goals</b> <a href="#">150623-guide-to-the-fg-act-en.pdf</a> <a href="#">(futuregenerations.wales)</a>	A Resilient Wales
	A Healthier Wales
<b>Dolen i Hwyluswyr Ansawdd</b> (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / <b>Link to Enablers of Quality</b> <a href="#">(Duty of Quality Statutory Guidance gov.wales)</a>	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
<b>Dolen i Feysydd Ansawdd</b> (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / <b>Link to Domains of Quality</b> <a href="#">(Duty of Quality Statutory Guidance gov.wales)</a>	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
	No - Not Applicable

<b>Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)</b>	
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<b>Impact Assessment</b>		
<b>Ansawdd</b> <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
<b>Cydraddoldeb</b> <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality</i> <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome for Equality (delete as appropriate): <del>POSITIVE/NEUTRAL/NEGATIVE</del>  Outcome for Welsh Language (delete as appropriate): <del>POSITIVE/NEUTRAL/NEGATIVE</del>	If no, please include rationale below: This is a summary of the latest meeting of the JCC
<b>Cyfreithiol / Legal</b>	There are no specific legal implications related to the activity outlined in this report.	
<b>Enw da / Reputational</b>	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
<b>Effaith Adnoddau</b> <i>(Pobl /Ariannol) / Resource Impact</i> <i>(People / Financial)</i>	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

## 5. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.



**ASSURANCE REPORT  
NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE**

<b>Reporting Committee</b>	<b>Shared Services Partnership Committee</b>
<b>Chaired by</b>	Professor Tracy Myhill OBE, NWSSP Chair
<b>Lead Executive</b>	Neil Frow OBE, Managing Director, NWSSP
<b>Author and Contact Details</b>	Roxann Davies, Corporate Services Manager and James Quance, Assistant Director of Corporate Services
<b>Date of Meeting</b>	14 November 2025
<b>Summary of key matters including achievements and progress considered by the Committee and any related decisions made</b>	
<p><b>Chair’s Report</b> - The Chair updated the Committee on activities since the last meeting, in addition to routine duties, approvals, and providing support to NWSSP, which included:</p> <ul style="list-style-type: none"> <li>• <b>Autumn Development Day</b> - Attended and contributed to the Autumn Committee Development Day and expressed appreciation to those who attended the worthwhile event.</li> <li>• <b>Chairs’ Meeting</b> - Participated in the October Chairs’ meeting, which included an introduction and discussion with the new Director General Health Social Care and Early Years, Jacqueline Totterdale.</li> <li>• <b>Engagement with NHS Leadership</b> - Met with the new Chair of Velindre University NHS Trust, Sara Mosley, on multiple occasions for introductory discussions.</li> <li>• <b>NHS Confederation Event</b> - Attended the NHS Confederation Dinner, engaging with colleagues and stakeholders.</li> <li>• <b>NWSSP Audit Committee</b> - Attended the NWSSP Audit Committee meeting held on 7 November 2025.</li> </ul> <p>The Committee <b>NOTED</b> the Chair’s Report.</p>	
<p><b>Managing Director Update</b> - The Managing Director presented his report, which included the following updates:</p> <ul style="list-style-type: none"> <li>• <b>Chair Tenure</b> - NF was pleased to report that TM has agreed to continue as Chair of the Committee for a further twelve months. The Welsh Government Governance and Accountability Review outcome is still awaited, and current arrangements remain in place under the Director General’s direction.</li> <li>• <b>Welsh Risk Pool</b> – Discussions are ongoing with Welsh Government and Chief Executive Officers (CEOs) regarding financial pressures and high-value cases, with a course of action agreed for further engagement. A presentation was delivered to CEOs by AR and Mark Harris (Director of Legal &amp; Risk Services and Welsh Risk Pool). Excluding the Welsh Risk Pool, NWSSP is forecasting a positive financial position and expects to achieve break-even, with potential financial distribution back to organisations.</li> <li>• <b>Transforming Access to Medicines Programme (TrAMS)</b> - The IP5 Radiopharmacy build is nearing completion of construction phase, with production</li> </ul>	

anticipated from April 2026. The South East Hub Full Business Case (FBC) is in development following agreement on scope, with detailed design work underway. Alternative sites are being considered for West Wales, and discussions with Betsi Cadwaladr University Health Board (BCUHB) on the North Wales Hub have been positive, with additional project management support planned. NF also praised the successful Medicines and Healthcare products Regulatory Agency (MHRA) inspection at IP5 for Pharmacy services.

- **Vaccination Programmes** - Vaccination programmes continue successfully, with nearly one million influenza vaccines delivered and 400,000 COVID doses distributed. NF commended the teams for their ongoing efforts.
- **Other Matters** - The overarching report highlighted progress made in Laundry Services, Primary Care and Medical Examiner Services, as well as Personal Protective Equipment, Accommodation and Decarbonisation. Senior Leadership events and Awards and Recognition were summarised, with NF confirming that he attended the More Than Just Words event, promoting Welsh language initiatives. Further, NF congratulated the NWSSP Payroll Services Team on winning the Shared Services Forum UK Future Vision Award for Team of the Year. NF was also pleased to confirm retention of NWSSP's organisational accreditation to the Cabinet Office's Customer Service Excellence standard, for a third consecutive year.

The Committee **NOTED** and **DISCUSSED** the Managing Director's Report.

## Presentation

**2026-2029 Integrated Medium-Term Plan (IMTP) Progress Update** - The Committee received an update on the development of the NWSSP IMTP for 2026–2029.

As a statutory requirement, the IMTP will be produced in line with Welsh Government guidance and financial allocations, which are expected by the end of November 2025. The plan remains iterative and shaped by Cabinet Secretary current priorities, including waiting lists, patient flow, women's health, prevention, community services and digital transformation. NWSSP's role is to support Health Boards in delivering their plans and ensure alignment through divisional objectives.

The planning process builds on previous work and reflects Welsh Government priorities. Divisional plans have been submitted and are undergoing scrutiny for financial viability and resource capacity. The aim is to present a draft IMTP to the Committee in January 2026, with final delivery by March 2026. A refreshed Digital Strategy is also being developed by the new Chief Digital Officer.

A successful Committee Development Day in October 2025 informed the direction of travel, and ongoing quarterly reviews with organisations are reinforcing alignment and identifying local priorities. Staff engagement remains central, with divisional plans developed from the bottom up and input sought from the Local Partnership Forum, the Equality, Diversity & Inclusion Group and Peer Networks. Five emerging themes have been identified, insofar as digital transformation and innovation, workforce development and culture, operational efficiency, sustainability and decarbonisation, and partnership engagement. The Committee was advised that timelines are on track and that the team is working to deliver a robust plan by March 2026.

The Committee **NOTED** the update and endorsed the approach to IMTP development, recognising the strong engagement process and alignment with National priorities.

## Items for Approval

**NWSSP Strategy Map Refresh for 2026-2029** - The Committee received the Strategy Map for approval and were informed that it was reviewed following the Committee Development Day to ensure alignment with current and future organisational priorities. Feedback from Committee Members and staff informed refinements to strategic objectives and outcomes. The mission statement, "*Delivering Value, Innovation and Excellence through Partnership,*" was confirmed as fit for purpose. Strategic objectives have been updated reflect emerging priorities, including a new objective, Our Partners, focussing on partnership and co-production across NHS Wales. Updated outcome definitions will strengthen performance reporting and provide a clear framework for NWSSP's contribution to NHS Wales priorities, underpinning the next IMTP cycle.

The Committee **APPROVED** the NWSSP Strategy Map Refresh for 2026-2029.

**Extension to the Service Level Agreement (SLA) for the Services supporting the National Influenza Immunisation Programme** – The Committee received an update that the current flu vaccination programme is 97% complete, equating to 885,000 vaccines delivered to approximately 1,800 sites across Wales. Welsh Government has requested NWSSP to run the same programme for 2026–27. The Committee received a proposal to extend to the existing SLA to enable this, noting that a purchase order would need to be signed by Velindre University NHS Trust within the next few weeks to secure manufacturing slots. The supply contract has already been extended for 12 months within the existing contract terms.

The Committee **APPROVED** the extension to the SLA for the services supporting the National Influenza Immunisation Programme and the procurement of next seasons vaccine. Further, the Committee **NOTED** Velindre's position to note the item.

**Revised Stockholding Requirements for Personal Protective Equipment (PPE) and Hygiene Consumable Products** – The Committee received the revised stockholding requirements, for approval. The proposed extension formalises Welsh Government's direction, via the Cabinet Secretary, for NWSSP to maintain a national stockpile of PPE and hygiene consumables. NWSSP is sourcing PPE nationally and internationally and has commenced deliveries to achieve the mandated stock levels. These levels are based on demand during the peak of the second COVID wave, with a minimum of 12 weeks' stock in hand for each product. Certain items, such as aprons, gloves, and Type IIR masks, are now considered business as usual and that NWSSP will rotate stock to minimise expiry-related write-offs.

The Committee **APPROVED** the Revised Stockholding Requirements for Personal Protective Equipment (PPE) and Hygiene Consumable Products, as set out in the Change Control Notice.

**Fleet Modernisation and Optimisation Programme Business Case (PBC)** – The Committee received the PBC for approval, which enables progression to the next stage of governance, which involves noting by the Velindre Trust Board. The PBC sets out a 10-year fleet replacement strategy split into two five-year programmes. NWSSP currently operates 306 vehicles, of which 198 are owned and 108 leased; 40 vehicles are fully electric, while 266 are diesel or petrol. The fleet covers approximately 4 million miles annually across NHS Wales services. The first five-year phase proposes replacing 124 vehicles, with the strategy considering cost, carbon reduction, air quality improvements, and noise reduction. An optimisation review will run in parallel to assess fleet mix, routing, load capacity, and specialist requirements such as cold-chain capability for vaccination

programmes. Annual business justification cases will follow to procure vehicles in line with the approved programme.

The Committee **APPROVED** the Fleet Modernisation and Optimisation Programme Business Case.

**Service Level Agreement (SLA) for the Provision of Commercial Medicines Contracting relating to Specialised Medicines** – The Committee received the SLA for approval, which was designed to formalise the collaborative arrangements between the Medicines Value Unit (MVU) and the NHS Wales Joint Commissioning Committee (NWJCC) for specialised medicines contracting, for a two-year term. The SLA introduces a structured governance framework to clarify roles, responsibilities, timelines and deliverables.

The Committee **APPROVED** the SLA for the Provision of Commercial Medicines Contracting relating to Specialised Medicines.

**Local Partnership Forum and Sub-Groups Terms of Reference** – The Committee received the updated Terms of Reference for the Local Partnership Forum and its sub-groups, for approval. The refresh includes strengthened provisions around speaking up safely and a restructured approach to recruitment and retention, with the former sub-group now renamed as the Attraction and Retention Sub-group. A dedicated sub-group for policy review has also been introduced to ensure systematic oversight of workforce policies. The revisions received positive feedback and endorsement from the Local Partnership Forum.

The Committee **APPROVED** the Local Partnership Forum and Sub-Groups Terms of Reference.

**Locum Hub Wales Contract Briefing Report** – The Committee received the Locum Hub Wales contract, for approval. The proposal is to extend the contract for two years on a 1+1 basis, allowing time for a full review of the scheme's scope before considering any recommissioning. There is no funding risk, as the programme is fully funded by Welsh Government with direct allocation to NWSSP. Due to the cumulative value of the extension, Velindre Trust Board approval will be required under the Scheme of Delegation.

The Committee **APPROVED** the contract extension for GP Locum Hub Wales, on a 1+1 basis.

### **Items for Noting and Discussion**

**Future NHS Workforce Solution - Electronic Staff Record (ESR) Transformation Programme** – The Committee received an update on the new NHS Workforce Solution, noting that the programme has moved from planning to mobilisation, at a significant pace.

The award of the £1.2 billion contract to Infosys to deliver the replacement for the ESR system and outlined key activities underway, including identification of early adopters and design workshops. Governance arrangements will involve NWSSP working with NHS Business Services Authority (NHSBSA) and Infosys to ensure a consistent approach, with reporting through this Committee, the NHSBSA Transformation Board, and Welsh Government. A programme management structure and overarching steering group will be established, supported by task-and-finish groups focused on readiness and business change. Funding discussions with Welsh Government are ongoing to address increased costs under the new contract. ESR audits will commence in January 2026, with formal action plans for organisations to ensure foundational readiness. Additional work includes

developing an executive briefing pack for Boards to support local communications. NWSSP will work with Welsh Government to confirm IMTP planning assumptions on costings and fundings arrangements to NHS organisations. Regular updates will be provided to the Committee and through peer-groups.

The Committee **NOTED** the update provided in relation to the Future NHS Workforce Solution – ESR Transformation Programme.

**NWSSP Duty of Quality (DoQ) Update** – The Committee was informed that NWSSP has successfully achieved re-accreditation for Customer Service Excellence for the third consecutive year across the organisation. The 'always on' reporting mechanism continues and staff engagement remains a key feature, to ensure updates are accessible and meaningful. The Committee receives DoQ updates on a six-monthly basis, with an Annual Report submitted for approval and subsequently published as a separate chapter in the Velindre Trust's Duty of Quality update.

The Committee **NOTED** the NWSSP Duty of Quality Update.

### **Finance, Performance, People, Programme and Governance Updates**

**Finance Report** – The Committee noted the financial position as at 30 September 2025, confirming a year-to-date surplus of £3.1m, driven by vacancies and underspend in health protection allocation. The forecast remains for a breakeven position by year-end, supported by continued review of expenditure and identification of savings opportunities. Capital expenditure to date stands at £1.9m against an annual limit of £9.4m, with successful funding secured for the next phase of work on the South East Wales TrAMS Full Business Case and further bids submitted for digital and estates schemes. Payment performance and new KPIs remain strong, with improvements noted in invoice processing. The Welsh Risk Pool forecast has risen sharply, creating significant financial pressure across NHS Wales and posing ongoing volatility that will impact next year's planning cycle.

**People and Organisational Development Report** – The Committee received the latest workforce update to 31 October 2025, which highlighted stable sickness absence trends, turnover has reduced, and compliance for mandatory training and PADRs is among the highest in NHS Wales. Progress continues on recruitment, retention, wellbeing, and diversity initiatives, including the launch of the Equality Diversity and Inclusion dashboard and promotion of the Work in Confidence platform. Preparations are underway for the NHS Wales staff survey and recognition awards. NWSSP also achieved national recognition at the ENEI Awards, receiving Highly Commended for Wellbeing and Belonging at Work.

**Performance Information Report** – The Committee received the report detailing the Key Performance Indicators (KPIs) from June to September 2025. The report confirmed that the majority of KPIs were met in September, with continued delivery against stretch targets and NWSSP having generated £58 million in professional influence benefits as at 30 September 2025. A review of performance targets is underway as part of IMTP development. There were no areas of concern to be brought to the Committee's attention.

**Outcome Measures Report** – The Committee received the report focused on outcomes aligned to NWSSP's strategic objectives across services, people and value. NWSSP continues to demonstrate progress in evidencing impact and the overarching report detailed high levels of customer satisfaction, strong employee engagement, and positive impact across procurement, decarbonisation and foundational economy, with 44% of procurement spend retained within Wales.

**Integrated Medium-Term Plan (IMTP) Quarter 2 of 2025-26 Update Report** – The Committee received the latest update in respect of progress made against NWSSP’s IMTP. The overarching report confirmed that 85% of objectives are on track, with targeted actions in place for off-track items. Performance remains stable, with 104 actions on track and six completed. Areas of challenge are being supported or deferred, where necessary.

**Transformation Management Office (TMO) Update Report** – The Committee received an update on the work of the TMO. The overarching report summarised the breadth of transformation activity across NWSSP and national programmes, indicating a stable position with 18 projects, 2 programmes and 5 initiatives currently being tracked. Of which, 2 are red, 7 are amber and 16 are green-rated projects. Overall, the portfolio demonstrates consistent delivery momentum across a diverse range of transformation and service improvement programmes, with 92% of projects rated green or amber and several nearing completion.

**NWSSP Corporate Risk Register** – The Committee received the latest Risk Register update, which was reported as stable and continues to be scrutinised regularly at each Senior Leadership Group meeting. The latest position identifies 17 risks for action, comprising six red, 11 amber and one yellow-rated risk. In addition, four risks are recorded for monitoring, including one amber and three yellow. The overarching report also outlines six emerging risks currently under consideration. Internal Audit has recently provided reasonable assurance on risk management processes.

**NWSSP Management Letter 2024-25** – The Committee received the Management Letter for 2024-25, which was prepared by Audit Wales and considered by the NWSSP Audit Committee on 7 November 2025. Positive assurance was provided to NHS external audit teams on the activities of NWSSP for accounts opinion purpose with no recommendations made, for the third consecutive year. Appreciation was expressed to the Finance team and all divisions for their contribution in achieving this outcome. Committee Members acknowledged the significance of this outcome and welcomed the assurance provided.

**Nationally Hosted NHS IT Systems Report 2024-25** – The Committee received the report prepared by Audit Wales, which was considered by the NWSSP Audit Committee on 7 November 2025. The report is positive and highlights the complexity of digital systems across NHS Wales and the need for continuous annual improvements. It notes close collaboration with Digital Health and Care Wales (DHCW) and a systems-based approach, emphasising the importance of maintaining robust controls, given ongoing cyber security risks. Audit actions will be addressed and monitored through the NWSSP Audit Committee and NWSSP Senior Leadership Group. Committee Members welcomed the assurance provided, noting it gives confidence to both the Committee and the NWSSP Audit Committee. Progress on IT key controls was commended, particularly given the backdrop of cyber threats.

The Committee **DISCUSSED** and **NOTED** the above Reports.

## **Part B - Private**

The Committee received the NHS Wales Energy Sourcing Decision for 2026/27 and **APPROVED** the Welsh Energy Group’s proposal in respect of the All Wales electricity source, to remain with Zero Carbon for Business.

In addition, the Committee received the Draft Welsh Energy Group Minutes of the meeting held on 3 November 2025, for information.

<b>Matters requiring Board/Committee level consideration and/or approval</b>	
The Board is asked to <b>NOTE</b> the work of the Shared Services Partnership Committee.	
<b>Date of next meeting</b>	Tuesday 22 January 2026, 10.00am to 12.00pm