Bundle BCU Health Board 28 May 2026

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Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar
Dirprwy Brif Weithredwr, GIG Cymru

Health, Social Care and Early Years Group
Deputy Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

To All NHS Chairs and Chief Executive Officers

Our Ref: NW/

16 March 2026

Dear Colleagues,

Accountability Interface Arrangements

I am writing to set out a new approach to NHS Wales/Welsh Government oversight and interface arrangements for the coming year; these changes are a result of recent discussions at NHS Leadership Board and the responses to the two Ministerial Advisory Group (MAG) reports MAG Accountability and MAG Performance and Productivity.

Both reports made recommendations with regards to simplifying the current arrangements to drive clarity, transparency and a focus on clearer objectives aligned to a single performance reporting framework.

The first phase of the changes discussed with NHS leaders is to simplify the current interface arrangements and align the cadence of assurance meetings with the organisational levels of escalation.

As a result, we will be removing the monthly IQPD meetings and the twice-yearly JET meetings, this will be replaced with a NHS Wales CEO led Executive review meeting on a regularity related to organisational risk and escalation status.

NHS Wales organisations will be expected to meet the following requirements to support these changes:

- Provide timely, accurate data and updates via the common reporting pack.
- Utilises the single reporting pack within Board papers and discussions.
- Maintain delivery plans (IMTP/annual plan) and corrective action plans aligned to escalation requirements.
- Participate in risk-based **CEO/Executive Review Meetings** with the NHS Wales CEO (cadence set by escalation level) to reinforce earned autonomy.

As a result of feedback from Chairs and CEOS we will ensure we clearly articulate the key escalation /de escalation criteria to each of the escalation pillars and for each organisation this will ensure that all the Welsh Government interfaces are aligned to these principles.

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The escalation and intervention framework will set out the criteria and align the support provided to organisations through Welsh Government and NHS Performance & Improvement.

There have been several important questions regarding NHS P&I. The Framework's intent is to simplify the interface, with NHS P&I acting as the single operational conduit for Welsh Government - not as a policy-setter or as an exercising body of any statutory intervention powers.

NHS P&I, as a hosted body within Public Health Wales, cannot hold or exercise intervention powers; these rest exclusively with Welsh Ministers under section 26 of the Act.

The role of NHS Performance & Improvement in the NHS Wales system is set out below:

- Acts as the **single operational assurance interface** with each NHS organisation.
- Consolidates data and narrative against the four pillars (quality, workforce, finance, performance).
- Operates a structured support offer (diagnostic, targeted support, improvement plans) matched to escalation level.
- Provides monthly system synthesis to Welsh Government, including risks, mitigations and recommended actions.

This approach is a direct response to the two MAG report recommendations and is intended to support the move towards greater transparency and clearer accountability.

We intend to move to these arrangements in the first quarter of 2026/27 and will conduct a full review on the implementation of the changes with the NHS Leadership Board in quarter 3, to ensure that the desired outputs from the changes are achieved.

The changes outlined in this approach have been reviewed and discussed by the Cabinet Secretary and feature in a written statement released this week, we will of course be discussing the accountability arrangements with new ministers following the Senedd election and provide further updates to you should further change be required by the new government.

It is important to note that the legal and statutory framework is not changing

Boards and Chairs are accountable to Welsh Ministers, not the NHS Wales CEO; and CEOs are accountable to their Boards through the Chair.

I must also stress that current Board governance arrangements are not intended to be impacted by these changes.

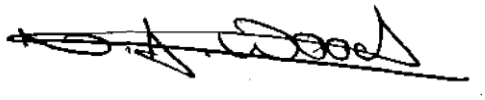
The purpose of CEO/Executive Review Meetings with the NHS Wales CEO/DGHSCEY is to obtain operational assurance to support Welsh Ministers in their formal accountability
I recognise that this is a considerable change in approach and will take time to embed, and I am sure you will also recognise the change in role of NHS P&I which will take time to both establish and mobilise. Chris Clayton (MD NHS P&I) is working with his team to ensure that both the oversight and intervention/support functions are prioritised in the reshaping of NHS P&I.

The proposed timetable for implementation is as follows:
We intend to move to the new arrangements in **Q1 of 2026/27**, with a phased stand-down of IQPDs across organisations as set out:

- April: Betsi Cadwaladr, Cardiff & Vale
- May: Aneurin Bevan, Swansea Bay
- June: Powys, Hywel Dda, Cwm Taf Morgannwg

Thank you to all those who have provided feedback on the changes and I hope that the arrangements we are putting in place whilst subject to further review have considered the views of organisations.

Yours sincerely



Nick Wood
Deputy Chief Executive – NHS Wales

Appendix

A NEW OPERATING & ACCOUNTABILITY INTERFACE - NHS WALES

1. Introduction

The NHS Leadership Board and HSCEYG EDT identified several areas for change and consolidation to the interface and accountability arrangements of the NHS Wales system these aligned to the Ministerial Accountability Group (MAG) accountability review recommendations and MAG Productivity and performance review.

Change is needed to meet the overarching objectives of modernising and simplifying the accountability and operating frameworks in NHS Wales.

This paper makes several recommendations to meet those overarching objectives and seeks agreement from NHS Wales system leaders and Welsh Government (WG) officials.

The paper has considered the recommendations/objectives from the recent discussions and MAG reviews, and the following principles have informed the recommendations in this paper:

- Meetings at national level to be standardised (in line with MAG recommendations) with a clear purpose aligned to the escalation and intervention framework.
- The interface needs to be focussed with clarity on objectives, timelines, accountability, and precision of assurance.
- The current measurement system (process measures, inputs, outputs) doesn't drive change and is over complicated with too many priorities. Need to utilise the MAG recommendation of a single agreed performance and outcomes framework which is agreed and reported by all parties.
- Need to optimise use of NHS Leadership Board structure as a national oversight meeting to drive change and improvement.
- NHS Performance & Improvement (NHS P&I) is central to system improvement, oversight and assurance and should occupy a system role in providing an appropriate bridge between the system and Welsh Government.
- The Escalation & Intervention Framework, which was updated this year, needs to provide clarity in escalation and de-escalation criteria alongside the available support to organisations to drive system and organisational improvement.
- This framework will be supported by clear interventions from NHS P&I to support organisations alongside a clarity of the consequences of non-delivery of de-escalation criteria.
- Continue the movement to greater transparency, accountabilities need to be clear and drawn from IMTP framework and promote a culture of improvement, support and early intervention.

2. Oversight and Assurance

This document sets out a streamlined, risk-based approach to oversight and assurance for NHS Wales. It:

- **aligns** with the Welsh Government NHS Oversight and Escalation Framework (five escalation levels from routine arrangements to special measures).
- **integrates** the current NHS Wales Framework measures and domains (quality, workforce, finance, performance), ensuring consistent reporting and focus.

- **implements** selected recommendations and intent from the Ministerial Advisory Group (MAG) on performance and productivity (e.g. simplifying interfaces, strengthened clinical leadership and increasing transparency in monthly performance reporting).

Design Principles

- **Fewer interfaces, clearer lines:** Reduce the number of direct interfaces between Welsh Government and NHS organisations by using NHS P&I as the principal conduit.
- **One version of the truth:** A single, governed dataset and narrative shared across WG, NHS P&I and NHS organisations for assurance and performance reporting.
- **Risk-based and proportionate:** Cadence and intensity of engagement tied to escalation level and risk profile, in line with the WG framework.
- **Earned autonomy:** High-performing organisations gain lighter touch oversight, more freedoms and reduced meeting burden; weaker performance triggers closer support and intervention. (This mirrors good oversight practice common across UK systems.)
- **Productivity and outcomes focus:** Progress tracked routinely across quality, workforce, finance and performance pillars derived from the Planning, Quality, Performance and Outcomes Frameworks.
- **The Health Outcomes Framework:** Will provide the model through which measures and indicators of quality, safety, productivity, and equity will be aligned to the delivery of improved population health. Outcomes will be used consistently across Welsh Government, NHS P&I, and NHS organisations to guide improvement, monitor progress, focus escalation, and ensure that performance management drives meaningful change in health and wellbeing rather than activity alone.
- **Public accountability:** Clear annual public accountability meetings for each organisation.
- **Clinical Leadership:** Strengthened and aligned to service improvement.
- **Regional and Collective Accountability –** The principles within this paper will be applied to the three regional structures to support collective accountability and oversight.

3. Scope and Roles

3.1 Welsh Government (HSCEY Group)

- Sets strategy and policy which then align to ministerial priorities IMTP framework.
- Establish professional and clinical guidelines and service standards.
- The Offices of the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO) provide national clinical leadership across Welsh Government and NHS Wales to ensure that policy intent translates into safe, effective, value based clinical practice. Through the CMO, CNO and their teams, they set clinical and professional standards, provide system level advice, and ensure a clear line of sight between ministerial priorities, clinical governance, quality, and population health outcomes. The CMO and CNO are the professional leads for NHS Wales and support the work of NHS P&I with clinical insight across quality, safety, productivity, equity, and outcomes to support proportionate escalation, targeted intervention, and sustained improvement across the system.
- Chairs a monthly **WG–NHS P&I Oversight Meeting** to receive a whole-system update against the 4 key pillars to inform progress, improvement and intervention criteria and outputs.
- Maintains links with scrutiny bodies (Audit Wales, Healthcare Inspectorate Wales) within the joint arrangements.

- Convenes appropriate and timely Tri-partite discussions to inform recommendations for escalation and deescalation.

3.2 NHS Performance & Improvement (NHS P&I)

- Acts as the **single operational assurance interface** with each NHS organisation.
- Consolidates data and narrative against the four pillars (quality, workforce, finance, performance).
- Operates a structured support offer (diagnostic, targeted support, improvement plans) matched to escalation level.
- Provides monthly system synthesis to Welsh Government, including risks, mitigations and recommended actions.

3.3 NHS Organisations (Health Boards, Trusts, SHAs)

- Provide timely, accurate data and updates via the common reporting pack.
- Utilises the single reporting pack within Board papers and discussions.
- Maintain delivery plans (IMTP/annual plan) and corrective action plans aligned to escalation requirements.
- Participate in risk-based **CEO/Executive Review Meetings** with the NHS Wales CEO (cadence set by escalation level) to reinforce earned autonomy.

4. Data and Reporting: "One Version of the Truth"

4.1 Shared Performance Pack

- **Content:** Core measures from the NHS Wales Performance Framework and Outcomes Framework - (including access, cancer, UEC, productivity/finance, quality indicators), plus organisation-specific risks and mitigations.
- **Ownership:** NHS P&I curates; organisations populate; Welsh Government and NHS Organisations utilise and report the same pack without alteration.
- **Frequency:** Monthly refresh; quarterly deep dives.
- **System Daily Reporting –** Utilises same data sets as Shared Performance Pack but is produced daily to inform system resilience and risk management.

4.2 Access for WG Policy Officials

- A **robust access mechanism** gives policy officials near-real-time data and board-level narratives to answer Ministerial and Senedd questions promptly.
- Access governed by information assurance protocols and role-based permissions; content sourced from the single dataset and evidence repository.
- This reduces duplication, improves responsiveness and supports transparency. (This approach is consistent with WG's drive to streamline oversight and reporting.)

5. Escalation Alignment

We adopt the **five escalation levels** and descriptions from the WG framework—routine arrangements (1) through to special measures (5)—and link these to a **meeting cadence** and **data/reporting requirements** proportionate to risk.

- **Levels reflect domains** (governance/leadership, performance/outcomes, finance, quality, strategy/planning, fragile services) and are applied per organisation and, where needed, per domain.
- **De-escalation criteria** are clear and mutually agreed and follow the framework (demonstrable sustained improvement and risk reduction).

6. Meetings and Interfaces (Reduced and Risk-based)

6.1 System-level

- **WG–NHS P&I Oversight Meeting (Monthly):** Whole-system update; escalation/de-escalation recommendations; cross-cutting risks (e.g., workforce, fragile services).
- **Public Accountability Meeting (Annual/Biannual per organisation):** Formal public session covering outcomes, finance, quality and delivery against priorities.

6.2 Organisation-level

- **CEO/Executive Review with NHS Wales CEO and team:** Cadence is tied to escalation level.
- **Whole Board Meeting with NHS Wales CEO and team –** organisations in Level 5
- **Targeted Support Clinics (as needed):** Time-limited improvement support aligned to the framework's "targeted support" provisions.
- **Individual Organisation or System Risks:** Time limited and aligned to agreed risk areas and performance profile

Existing IQPD/JET meetings are **removed** and replaced by the risk-based interface, with NHS P&I acting as the single operational interface.

The interface with other NHS organisations should align with this process – WAST, PHW, DHCW, and HEIW.

Note for consideration the hosting arrangements for NHS P&I.

6.3 Meeting Cadence by Escalation Level (Replacing IQPDs/JETs)

Risk-based cadence aligned to the **WG Oversight and Escalation Framework** levels.

Escalation Level (WG framework)	Description (summary)	CEO/Executive Review with NHS Wales CEO	WG–NHS P&I Oversight Touchpoint	Notes
Level 5 (Special Measures)	Very serious concerns; potential use of statutory Ministerial powers.	**Monthly**	**Monthly**	Intensive support; external review; strict consequences.
Level 4 (Targeted Intervention)	Serious concerns; time-limited targeted support.	**Every 2 months**	**Monthly**	Focused improvement plans; milestone reviews.
Level 3 (Enhanced Monitoring)	Serious concerns requiring close monitoring and proactive organisational response.	**Quarterly**	**Monthly**	Regular progress updates; data/evidence submissions.
Level 2 (Areas of Concern)	Early warning; prevent escalation through prompt corrective action.	**6-monthly**	**Monthly**	Formal notifications possible; targeted remedial actions.
Level 1 (Routine	Standard	**6-monthly**	**Monthly**	Light-touch;

Escalation Level (WG framework)	Description (summary)	CEO/Executive Review with NHS Wales CEO	WG–NHS P&I Oversight Touchpoint	Notes
Arrangements)	assurance; effective govern s		**(system)**	annual public accountability meeting.

Key change: IQPDs and JETs are **removed** and replaced with the above risk-based cadence, a common reporting pack, and the single operational interface via NHS P&I.

For Southeast and Southwest Wales, where Ministerial Direction has been given, regional meetings will be held between the health boards, Welsh Government and NHS Wales P&I on a six monthly basis to ensure collective accountability.

7. Earned Autonomy, Rewards and Consequences

7.1 Earned Autonomy (Rewards)

Organisations consistently meeting delivery expectations across **quality, workforce, finance and performance** will benefit from:

- **reduced meeting burden** (lower frequency and lighter touch).
- **flexibilities** in delivery (e.g., local pathway choice, discretionary improvement funding focus, streamlined approvals).
- **positive public narrative** at annual accountability meetings. (This mirrors best practice approaches used in other UK oversight regimes to incentivise performance.)

7.2 Consequences

Where performance or assurance falls short:

- **level-based interventions** (enhanced monitoring, targeted intervention, special measures) per the WG framework are implemented.
- **formal notifications** at Level 1 and Level 2 (recorded letters of concern/performance notices) signalling accountable officer responsibility and expectations to recover. (Consistent with the step-up model described in WG escalation arrangements.)
- **Escalation of CEO accountability:** Where sustained non-delivery persists, progression to Level 3/4/5 will carry progressively stronger consequences, including increased external review, limits on local flexibilities, and, at Level 5, use of statutory Ministerial intervention powers under the NHS (Wales) Act 2006 (as a last resort).

7.3 Accountability Mechanisms

In parallel, WG may review CEO accountability arrangements to ensure both **organisational** and **individual** accountability are clear, including formal warnings at Level 1 and Level 2 before further action if recovery does not occur (policy development required; legally compliant with existing statutory frameworks).

NB to be considered - a shift in escalation status decision making to align with revised arrangements.

Could include -DG/NHS Wales CEO to determine escalation status 1-3 with support from WG officials, with ministerial recommendations and decision at levels 4/5.

8. Role of NHS Performance and Improvement (NHS P&I)

Cabinet Secretary, in April 2025, stated that NHSP&I has a dual role to:

- Support NHS Wales to deliver better health services for patients and the public
- Support Welsh Government to hold NHS Wales to account for the provision of health services and delivery of statutory requirements.

The introduction of the role of Managing Director to provide leadership to NHS P&I is complete and he has the responsibility and accountability to act in redefining the approach and structure of the functions.

The functions of NHS P&I are being aligned to the accountability expectations set out in this paper.

The role of the clinical networks and national programmes alongside system leaders, will support the development of clinical leadership, system leadership and quality improvement.

In recognising the resources within NHS P&I the establishment of a support and intervention structure is being taken forward as part of this work.

The role of NHS P&I in system assurance will be defined to support the new interface with NHS organisations in development of the shared reporting pack and monthly monitoring.

9. Delivery Expectations and Tracking

To simplify and sharpen oversight, we will assess organisations against four pillar domains — Quality, Workforce, Finance, and Delivery/Performance — with a foundation domain of Leadership (Well-led) that sets the culture, behaviours and governance needed for sustainable improvement. This replaces the legacy set of escalation domains while remaining fully compatible with the Welsh Government's five escalation levels (routine arrangements to special measures). Escalation may apply to one or more pillars, and decisions will continue to follow the national framework and tripartite intelligence routes**.**

How this aligns with the current framework?

The national framework currently references domains such as finance, strategy and planning; performance and outcomes; quality of care, prevention; fragile services; governance; and leadership, capability and culture. These are now consolidated into the four pillars, with planning and governance embedded within Finance, Delivery/Performance and the Leadership foundation respectively, and fragile services managed through Quality and Delivery/Performance depending on the nature of risk**.**

Foundation domain: Leadership (Well-led)

Definition: Boards and senior leaders set clear purpose and strategy, role-model the values and behaviours required for high-quality care, nurture an open, fair culture, ensure strong integrated governance across quality, finance and operations, and drive continuous improvement and system working. This domain will be assessed using a framework inclusive of self-assessment and evidence.

Leaders evidence: (i) clear shared direction and culture; (ii) effective governance and risk management; (iii) transparent use of data and insight; (iv) compassionate, inclusive people leadership; (v) visible improvement capability; and (vi) constructive system relationships that support delivery at pace.

Escalation focus: Concerns about leadership capacity, governance, culture or capability (including lack of credible recovery planning or weak assurance) will be recorded under this foundation domain and may trigger or amplify escalation in one or more pillars.

Pillar 1: Quality
Definition: The safety, effectiveness and experience of care — including compliance with quality standards, learning from incidents, clinical outcomes, and reduction of unwarranted variation.
Evidence base: National quality measures and statements, triangulated with the National Quality Management System, patient experience feedback and external assurance (Healthcare Inspectorate Wales, Audit Wales). Fragile or high-risk services (for example, maternity and neonatal) are captured here and, where relevant, in Delivery/Performance.
Expectations: Sustained compliance with agreed quality standards and trajectories; evidence of learning translating into improved outcomes and reduced harm.

Pillar 2: Workforce
Definition: A safe, sustainable and engaged workforce with the right capacity, capability and culture to deliver plans — encompassing recruitment, retention, sickness, wellbeing, turnover, and productivity enablers.
Evidence base: People-measures within the national oversight approach (for example, staffing, skill mix, rota fill, training compliance, wellbeing indicators), supported by qualitative insights from staff surveys and speaking-up data.
Expectations: Delivery of safe staffing plans and trajectories; improved stability and engagement; demonstrable impact of workforce actions on quality and operational performance.

Pillar 3: Finance
Definition: In-month and year-to-date financial position, medium-term sustainability, savings delivery and use of resources, with credible, triangulated plans that balance quality, activity and workforce. Strategy and planning considerations sit here where they materially affect financial sustainability.
Evidence base: Monthly monitoring returns, integrated performance and finance reports, and assurance over financial governance and control. Deeper review where there is a significant underlying deficit or gaps to plan.
Expectations: Sustained delivery against the agreed financial trajectory; strengthened financial controls; approved and deliverable medium-term plan demonstrating recurrent balance.

Pillar 4: Delivery/Performance
Definition: Delivery against nationally agreed priorities and the Performance Framework — including urgent and emergency care, planned care and cancer, diagnostics, mental health, and other access standards — supported by credible recovery plans and trajectories.
Evidence base: The single performance pack and published performance measures, trend analyses, risks and mitigations. Where quality or fragile-service risks are operational in nature (for example, patient flow, access backlogs), they will also be tracked here.
Expectations: Sustained delivery of agreed milestones and outcomes; variance managed within agreed tolerances; performance maintained without disproportionate negative impact on quality, workforce or finance.

9.1 Applying escalation within the pillars

- Levels: We continue to use five escalation levels, from routine arrangements (Level 1) through areas of concern, enhanced monitoring and targeted intervention to

special measures (Level 5). Escalation can apply to one or multiple pillars and will be informed by proportionate, risk-based evidence.

- Tripartite and external assurance: Intelligence from Healthcare Inspectorate Wales, Audit Wales and other third parties will be considered, alongside organisational data and narratives.
- De-escalation: As per the framework, de-escalation will be agreed with clear criteria (typically one level at a time) and evidenced by sustained improvement.

9.2 Mapping from legacy domains to the new structure

- Quality of care ⟶ Quality pillar: Fragile services (for example, maternity and neonatal) monitored through Quality and Delivery/Performance as appropriate.
- Performance and outcomes ⟶ Delivery/Performance pillar: access, flow, recovery trajectories.
- Finance, strategy and planning ⟶ Finance pillar: with planning content embedded across Finance and Delivery/Performance according to impact.
- Governance; leadership, capability and culture ⟶ Leadership (Well-led): foundation domain.

9.3 Measurement and reporting

Each pillar will be evidenced through the single shared reporting pack and common dataset, with quarterly deep dives and a clear audit trail. Leadership (Well-led) will be evidenced through board evaluation, culture and speaking-up insights, external reviews and self-assessment against the well-led guidance.

1. **Diagnosis:** NHS P&I reviews trends, risks and variation using common pack.
2. **Support plan:** Organisation co-designs targeted actions.
3. **Review:** CEO/Executive risk-based meeting checks delivery and outcomes; WG–NHS P&I monthly oversight confirms escalation stance.
4. **De-escalation/Autonomy:** On sustained improvement, cadence reduces and flexibilities increase.

10. Information Governance and Transparency

- **Data assurance:** Single dataset governed by clear standards, definitions and audit trail to ensure accuracy and comparability. (Supports the “one version of the truth” principle.)
- **Publication:** Annual public accountability meetings will publish a concise performance summary and progress against ministerial priorities.
- **Privacy and security:** Role-based access for WG officials; compliance with legal and statutory duties.

Insight | Change | Management

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Penley Community Hospital Balanced Room No. 1

Outcomes Report

October 2025

Contents

Document	2519 BCUHB_Penley Balanced Room 1_Report		
Version	V1 (DRAFT)	**Date**	3 October 2025
Status	DRAFT: NOT FOR CIRCULATION		

1 INTRODUCTION

Background, context, and participants

1.1 Introduction

This report sets out the summary record of the deliberations and outcomes of a scenario development and appraisal session held on the 26th of September 2025. 15:30.

The session was designed to develop a longlist of scenarios for potential services at Penley Community Hospital following a temporary bed closure in late 2024

1.2 Essential Criteria

The agreed essential criteria, against which any scenarios developed in the session were to be appraised are shown in the table below.

Criteria	Test
Quality and Safety Services meet standards, minimise risk to patients and patients have a good experience.	Can the option provide safe, evidence-based care with sufficient registered staff, maintaining or improving outcomes and patient experience?
Efficiency and Effectiveness • Efficiency - Ability to do things well and without waste. • Effectiveness – the extent to which desired outcomes or results are achieved.	Can the option deliver services efficiently, following effective clinical pathways and achieve intended outcomes?
Deliverability That we can actually deliver what we say we will.	Is the option realistically achievable with available resources (e.g. finance, people) and within a reasonable timeframe?
Sustainability Ability to manage risk and adapt over time.	Can the option be maintained over time, adapting to workforce, demographic and technological changes, while supporting recruitment and retention?
Accessibility and Inclusion Services are equally available and accessible to all. **Note:** The Integrated Equality Assessment highlights the needs of older and disabled people (who are frequent users of community hospitals), as well as carers and those who are economically disadvantaged	Does this option avoid creating extra obstacles for these groups in accessing healthcare?

1.3 Participants

Participation in the event was recruited based on creating a 'balanced room.' The balanced room approach ensures that a diverse mix of perspectives is represented when developing and appraising Scenarios. Rather than allowing one group or viewpoint to dominate, participants are selected to reflect different stakeholder interests, levels of influence, and lived experience. This creates a fairer, more transparent process where evidence, values, and practical considerations are weighed collectively. The aim is not consensus at all costs, but a balanced discussion that tests assumptions, highlights trade-offs, and strengthens the legitimacy of the final outcomes.

The participants were in three broad categories:

- **Voting participants:** a mix of stakeholders and representatives of BCUHB, all of whom have equal voice and vote in deliberations.
- **Expert participants:** representatives of BCUHB on hand to provide expert opinion and input to deliberations.
- **Facilitation team:** the team who enabled discussions without taking part in decision making.

1.3.1 Voting Participants

Stakeholder group	Name
Staff - community matron	Lucy Reid
Staff - director of AHPs	Representative on behalf of Nesta McCluskey
Staff - facilities	Julie Sinclair
Staff - matron, Chirk	Victoria Sheffield
Helping Hands CIC	Paulina Dymnicka
GP - Hanmer Surgery	Kieran Redman
GP - Overton	Gareth Bowdler
NEWCIS - North East Wales Carers Information Service	Michael Langford
AVOW	Jane Edwards
The Rainbow Foundation	Caroline Tudor James
Wrexham Council	Victoria Bishop
Maelor South Community Council	Awyn Reay
Wrexham Council	John Pritchard
Hanmer Surgery Patient Group	Phil Jones
Hanmer Community Council	Lady Hanmer

1.3.2 Technical experts

Dr Sara Gerrie, Consultant Geriatrician, BCUHB

Erin Humphreys, Interim Associate Director of Nursing – East, BCUHB

Ryan Welch, Lead Manager, Community Services – East, BCUHB

Stephen Doore, Equality and Inclusion Manager, BCUHB

1.3.3 Event Facilitation Team (non-voting)

The facilitation team supporting the event's running consisted of:

- Independent Facilitator — Nick Duffin, ASV
- Joint SRO and facilitator — Paolo Tardivel, BCUHB
- Facilitator — Helen Stevens-Jones, BCUHB
- Scribe — Wendy Hooson, BCUHB
- Scribe — Andy Rogers, BCUHB

2 DELIBERATION

Discussions and considerations

2.1 Introduction

This section details the deliberative process undertaken to developing and appraising scenarios for the future service delivery around the Dyfi ward at Tywyn Community Hospital. Discussions employed the balanced room approach to ensure a fair and inclusive assessment.

Participants with diverse viewpoints engaged in thorough discussion. Each scenario was evaluated transparently and objectively using a structured scoring system and clear criteria.

2.2 Emerging Scenarios

Participants generated a range of “blue-sky” ideas for Penley Community Hospital’s future. A strong theme was creating a multi-disciplinary community health hub with integrated services. For example, staff proposed a hub where district nurses, physiotherapists, social care and third-sector teams could offer clinics and outreach together. Alongside this hub idea, there were calls for local diagnostics and outpatient care (blood tests, X-rays, minor injuries, chemotherapy infusions, etc.) so residents need not travel to larger hospitals.

Other ideas focused on bed-based rehabilitation: several groups suggested a 12–24 bed step-up/step-down facility for rehab or palliative care linked to local services (for example coordinated with the Rainbow Centre activities). Participants cautioned against duplicating existing services (noting the Rainbow Centre already offers physio, transport and meals) but said added beds could support patients discharged from the Maelor Hospital and relieve social isolation in this rural area.

Closely related was a push to partner with third sector and existing community services. The hospital could co-locate community support (memory or dementia clubs, mental health groups, befriending) and practical aids (help with blue badges, carer support) in the same building. Indeed, stakeholders noted Penley has no public transport and an ageing, digitally excluded population, so outreach and social support services are vital.

Several innovative service ideas also emerged: a few suggested a GP surgery in the building, supported living or warden-controlled accommodation, a mother-and-baby unit or autism support services. However, the overall message was to ensure any Scenario meets local needs, e.g. older people who cannot easily travel, and to avoid repeating what is already done elsewhere.

This exercise produced seven developed scenarios for assessment which reflect different approaches to balancing local needs, resources, and system priorities. In summary, these scenarios are:

1. **Health and Wellbeing Hub (Integrated)** – repurposing the hospital as a multi-professional hub where health, social care and potentially voluntary sector teams co-locate. The aim is to improve access to outpatient and preventative services closer to home, reducing travel and creating a focal point for care in Penley.

2. **Rehab / Step-down Facility with Beds** – restoring a bed-based function at Penley, focused on rehabilitation, step-down care from acute hospitals and possibly end-of-life support. This reflects community concerns about travel distances and the need for local recovery and respite beds.
3. **Health and Wellbeing Hub plus Third Sector Facility** – combining the integrated hub model with a more explicit role for third-sector partners. The proposal builds on existing strengths in the local voluntary sector to deliver health, wellbeing and social support alongside NHS-led services.
4. **Services in the Community (No Physical Building)** – redirecting resources away from maintaining a fixed site and investing instead in outreach and home-based services. This model prioritises flexibility and a "care closer to home" approach but carries risks if funding and workforce are not secured locally.
5. **GP Surgery** – using the building as a GP surgery, either as a new practice or as a branch of nearby practices. This option reflects public appetite for more accessible primary care, though feasibility depends on provider interest and patient demand.
6. **Care Home / Assisted Living** – converting the hospital into a care home or assisted living facility, providing supported accommodation for older people or those with additional needs. While this could address social care gaps, it raises questions about regulatory standards, capital investment, and whether it aligns with NHS priorities.
7. **Care Homes Providing Bed-Based Care** – meeting local demand through partnerships with existing care homes in the area, rather than re-using the Penley site directly. This option could expand capacity but has limitations around quality, inclusion, and whether it delivers the rehabilitative care that residents value.

Taken together, these options illustrate a spectrum of possibilities: from continuing an NHS service presence on the site (Scenarios 1-to-3), through alternative community service delivery (Scenario 4), to models that shift the function away from healthcare (Scenarios 5-to-7).

The next section provides a detailed assessment of each scenario based on the criteria, incorporating stakeholder input and group discussions.

3 OUTCOMES

The results of deliberations to reach consensus on selected scenarios.

3.1 Introduction

This section reviews each scenario by comparing pros and cons against key criteria. Using stakeholder input and group discussions, it aims to offer an objective assessment and underscore quality, sustainability, and practicality to guide suitable recommendations.

3.2 Consensus Discussion

Provided below is a summary of the discussion had to reach consensus on those scenarios against the essential criteria.

3.2.1 Scenario 1: Health and Wellbeing Hub (Integrated)

- **Quality and Safety:** An integrated hub was seen as a strong Scenario for quality care. Facilitating “multi-professional” teams under one roof can reduce risk and improve the patient experience. Participants noted this model is “proven to work” for involving partners and could improve clinical outcomes by providing care closer to home. However, success depends on the **service mix and staffing**: it “helps to reduce risk” only if sufficient therapy, nursing and social-work staff are provided, and if services are chosen wisely. In other words, the hub must include the right evidence-based services (e.g. rehabilitation, outpatient clinics) with enough registered staff to maintain standards.
- **Efficiency and Effectiveness:** A hub could streamline care by co-locating services and reducing duplicated effort. Stakeholders felt that by pooling resources (e.g. shared therapy staff, combined clinics) efficiency could improve for certain pathways. On the other hand, achieving efficiency is contingent on carefully designing the model: if the mix of services is poorly chosen, inefficiencies could arise. Workshop notes cautioned that the Scenario’s success was “subject to the services that are chosen to go there meeting the criteria”. Thus, while the integrated hub has potential for effective, joined-up care, it will require detailed planning to ensure it is not simply adding complexity.
- **Deliverability:** Delivering an integrated hub poses notable challenges. Participants queried whether it would add new services or simply relocate existing ones, and what estate works would be needed. A key concern was financing any refurbishment and ensuring the necessary workforce can be recruited or redeployed. The notes flag that “some investment might be needed” and that current estates requirements are unclear. In short, this Scenario is theoretically achievable, but only if capital funding is secured and partners commit resources. The hub’s deliverability also hinges on provider willingness – for instance, getting GPs, therapists and third-sector groups to contribute space/time.
- **Sustainability:** A well-designed hub could adapt to future needs by adding new clinics or programs. Having multiple partner organisations involved might help sustain it (through shared funding or staffing). Participants did not note major

sustainability red flags for the hub Scenario, but one caveat is reliance on partners. A diverse model is more robust, however there was a mention of potential vulnerability if any one organisation pulled out. Overall, with continued stakeholder engagement, the hub could be maintained over time, though it will require active coordination to adapt services as demand changes.

- **Accessibility and Inclusion:** This Scenario scored highly on access. By design, an integrated hub would provide a "broader range of the population" with local services. Bringing care into Penley (and offering outreach) directly targets the needs of older, rural residents noted in the longlisting. If well-promoted, it should improve equity – for example by hosting community nurses and therapists in the same building. One caveat is ensuring physical access: the hub location and any parking or transport arrangements must be suitable for less mobile or non-driving patients. Participants stressed that the design should consider deprived groups and those without internet, so the hub should be welcoming and well-signposted for all.

3.2.2 Scenario 2: Rehab/Step-down Facility with Beds

- **Quality and Safety:** Adding beds for rehabilitation or end-of-life care meets a clear local demand. A dedicated rehab unit can improve quality by allowing a smoother recovery closer to home. Stakeholders agreed this Scenario could be safe *if* done properly, but highlighted risks. They emphasised the need for adequate therapy resources (physio, OT) and clear clinical pathways: for example, "a discharge pathway should be in place before a patient is admitted". Safety depends critically on staffing levels and the type of care. As one note said, quality "will depend on what kind of care the beds are being used to provide". In other words, beds for complex rehabilitation require more specialist staffing and oversight than beds for simpler recovery. If these conditions are met, quality can be high, but otherwise patient outcomes could suffer.
- **Efficiency and Effectiveness:** A step-down unit can improve system efficiency by freeing acute beds and reducing delayed discharges. By providing local rehabilitation it should shorten hospital stays overall. However, efficiency gains depend on implementation: scribes warned it "must be implemented well and depends on who delivers the Scenario". The unit should be sized and staffed appropriately: notes repeatedly caveated that efficiency "depends on the number and type of beds". In practice, if too many or too few beds are commissioned (or the wrong specialisms), there is a risk of unused capacity or poor outcomes. Thus, while the model can be effective, it requires careful planning of capacity and partnership with acute and community teams.
- **Deliverability:** Delivering this Scenario has significant resource requirements. Stakeholders pointed out that both capital (to refurbish or refurbish for beds) and workforce (nurses, therapists, managers) must be secured. The appraisal notes repeatedly note deliverability "depends on the number and type of beds" and on who provides them. In a small community hospital, attracting sufficient staff can be hard. It also raises questions about funding the beds and who would commission and run them. In summary, this Scenario is plausible but only if financial and

workforce resources match the scale of the beds. There was no consensus on a specific bed-number, but it was clear that deliverability would hinge on detailed business planning and possibly partnerships with larger hospitals or care homes.

- **Sustainability:** Ongoing sustainability is uncertain and was noted as a caveat. If the step-down unit is financially viable (i.e. stays busy with referrals), it could be stable. However, scribes warned that sustainability "depends on workforce and finance". Aging demographics suggest some sustained demand for rehab beds, but any long-term plan would need built-in flexibility. For example, if patient numbers drop, the service could convert beds to another use (see Scenario 7 considerations). Longevity also depends on contract funding; changes in NHS priorities or social care funding could make sustainability precarious. In short, the bed model could last over time, but only with ongoing funding and an ability to adjust services.
- **Accessibility and Inclusion:** A local rehab facility scores well for access by definition – it brings care closer to patients who would otherwise have to travel out of area. Almost all participants saw this as an inclusive gain (easing family visits and reducing travel burden). The notes affirm it passed accessibility criteria without caveat. The only concern would be if beds fill up or are only for certain groups. In fact, scribes noted the unit should serve all ages, not just frail elderly, to maximise use. If properly commissioned, the facility should help vulnerable older and disabled people access step-down care without distant travel, aligning with community needs.

3.2.3 Scenario 3: Health and Wellbeing Hub plus Third Sector Facility

- **Quality and Safety:** This Scenario combines the integrated hub model (Scenario 1) with dedicated space or support for third-sector providers. The expected quality effects are like Scenario 1's. Stakeholders felt it could safely offer a broad range of services, as with Scenario 1. One additional note is that leveraging third-sector support (e.g. charities running day centres, dementia cafes) could enhance patient experience. No new safety-specific concerns were raised beyond those for the hub generally.
- **Efficiency and Effectiveness:** Merging NHS services and third-sector activities in one centre could boost efficiency by sharing space and referrals. For example, charitable activities (befriending, exercise classes) alongside clinical services can prevent hospital admissions and improve outcomes. The group noted this "dual model" could work well – using both commissioning and fundraising to deliver services. However, they cautioned that efficiency is linked to coordination: scribes asked "How susceptible is any third sector organisation?" meaning donor or volunteer groups can fluctuate. In summary, this Scenario may be very effective at providing wrap-around care if the partnership is strong, but it adds complexity in governance.
- **Deliverability:** Delivering this Scenario involves the same practical issues as Scenario 1 plus engagement with charities. It was noted that "some investment might be needed" and that the hub would require negotiation with any existing third-sector providers on site. One advantage is potential cost-sharing: local

charities may contribute space or fundraising. A downside is dependency on the third sector's commitments. The scribes point out that the sustainability of such a model hinges on the charities' stability. If a partner withdrew, NHS services might lose space or income. In other words, deliverability requires formal agreements and contingency plans but is achievable if partners align.

- **Sustainability:** The hybrid model's sustainability was a concern. On the positive side, funding streams are diverse (NHS budgets plus charitable funds), which can lend resilience. On the negative side, scribes explicitly noted a **susceptibility** risk for the third-sector element. For example, charities may rely on short-term grants; loss of a major funder could endanger services. Maintaining this Scenario long-term would thus require active support (e.g. integrated management, long-term leases, possibly a trust). Overall, it could be sustainable if formalised but would require oversight to avoid service gaps.
- **Accessibility and Inclusion:** As with Scenario 1, this model is very inclusive. By combining healthcare and community support in one place, it can reach people who might fall through the cracks. In workshops the hub-plus-third-sector idea was seen as highly accessible, reaching those most in need (elderly, disabled, isolated). The only caveat is, again, stability: if third-sector services were cut, some support groups might vanish. But in principle, this Scenario should improve access to health and social services for deprived or hard-to-reach residents.

3.2.4 Scenario 4: Services in the Community (No Building)

- **Quality and Safety:** This Scenario envisages re-focusing Penley's resource envelope onto home- and community-based care, without a central hub building. It was generally seen as maintaining a minimum standard of care. Participants felt that experienced community teams could deliver many services (e.g. therapy visits, outreach clinics) safely but noted that oversight is key. Quality would depend on having sufficient staff in the area; scribes flagged a question of whether redirecting funds outside Penley would leave gaps. In practice, providing safe care without a building is possible but requires strong coordination and protocols for patients (e.g. a clear substitute for hospital-based supervision when needed).
- **Efficiency and Effectiveness:** Removing the building might free up funding for community workers. This could improve efficiency if it reduces premises costs and allows more flexible service delivery. However, participants expressed caution: they asked whether such a model could achieve the intended health outcomes over time. Because there would be no local base, some loss of efficiency might occur (for instance, staff travel time). The scribes overall gave Scenario 4 a "Pass," but noted that it "high risk" unless managed well. Essentially, effectiveness will hinge on ensuring those redirected resources truly benefit Penley residents.
- **Deliverability:** In theory, this Scenario is easy to "deliver" because no construction or new facility is needed – existing community teams would just alter their focus. In workshops this was noted as a benefit (no capital needed). However, participants warned about **realistic resource use**. A note explicitly said deliverability depends on funding being "targeted at Penley and surrounding areas". In practice, this means the health board must commit to using the same

budget in Penley rather than elsewhere. So, deliverability is high only if stakeholders ensure that funds and personnel remain allocated to this community; otherwise Penley could lose services without the building to anchor them.

- **Sustainability:** Sustainability is a major concern here. While no building costs exist, this Scenario relies entirely on ongoing community funding. Workshop notes specifically question whether funding "would be maintained long term or ... removed". There is a risk that without a visible facility, community services could be seen as expendable in future budget cuts. Another risk is workforce: community staff may be redeployed elsewhere if no physical presence ties them to Penley. In summary, unless there is a clear guarantee of sustained investment, this Scenario could degrade over time, potentially leaving the community with fewer services.
- **Accessibility and Inclusion:** Without a local building, access could paradoxically worsen. All services would be "in the community," meaning people might rely on home visits or having to travel to scattered clinics. Workshop notes warn this is a high-risk scenario: if not carefully managed, it might "leave the community with less/fewer services". On the plus side, some outreach services (e.g. mobile clinics or visits) can be very inclusive, reaching housebound patients. But there are inclusion challenges: rural patients already struggle with transport, so having no central hub means fewer drop-in options. In conclusion, community-based care is accessible in principle, but it must be very well funded and organised to avoid inadvertently reducing access for vulnerable groups.

3.2.5 Scenario 5: GP Surgery

Quality and Safety: Establishing a GP surgery at Penley could provide strong primary care, but it hinges on GP participation. On paper, local GP access would improve continuity of care and preventive services. However, workshop participants flagged a major barrier: **provider interest**. Records show that a standalone new practice was deemed unviable. The Health Board did not approve plans for a new surgery combined with the hub, noting that "there is not the demand for another surgery in the area". Therefore, with no GP willing to set up there, quality cannot be realised. If a practice did operate, it would likely be a branch of an existing surgery (e.g. Overton or Hanmer), which might limit hours or service scope. Therefore, despite potential benefits, the workshop concluded that this Scenario fails on safety and quality deliverability due to lack of GP provision.

- **Efficiency and Effectiveness:** A local GP surgery could reduce demand on emergency and acute services by managing routine cases. Participants thought a branch surgery might bring efficiencies like shorter travel for patients. However, given the conclusion that a new practice is not viable, these benefits remain theoretical. In fact, the notes imply the alternative would be insignificant – using space for a part-time GP clinic rather than a full practice. In that scenario, efficiency gains would be minimal. In summary, if an existing practice simply ran occasional clinics, it might slightly improve access, but it would not transform local care pathways as hoped.

- **Deliverability:** This Scenario was judged undeliverable as proposed. Workshop notes bluntly state: “Scenario 5a: GP surgery – Outcome: Failed as GP not interested”. Stakeholders confirmed they “have not been allowed to take forward our GP practice plans by the Health Board”. In practical terms, no GP is available to lead the service, and one surmises patient numbers are too low to justify it. Even a branch surgery model was considered insufficient to use the space, implying poor utilisation. Therefore, deliverability is essentially zero: without a willing GP partner or a clear business case, this Scenario cannot proceed.
- **Sustainability:** If it were in place (e.g. a branch surgery), sustainability would depend on stable patient lists and funding. In rural areas this can be shaky; practices may close or reduce hours as rural populations fall. Since the workshop concluded “insufficient use”, any GP service in Penley would likely struggle financially and could be withdrawn. For these reasons, sustainability is questionable.
- **Accessibility and Inclusion:** A local GP would in theory improve inclusion by reaching homebound or immobile residents. The idea of not having to travel for routine appointments was noted as desirable. Yet, because the plan was rejected, patients must continue going to Overton or Hanmer. So, in effect, this Scenario as considered does not improve accessibility. The only potential model left (a satellite clinic) would have limited hours and only modest impact. Thus, while a GP presence was a popular idea at the outset, the workshops suggest it is not a viable path to better access.

3.2.6 Scenario 6: Care Home / Assisted Living

- **Quality and Safety:** This Scenario would convert the hospital into a form of housing with care (e.g. warden-controlled flats or an assisted living facility). In theory, such housing can provide safe, supportive living for older or disabled residents. However, stakeholders raised serious concerns. Workshop notes eventually rated this Scenario **“Fail: Viability is questionable. This Scenario would not meet regulatory standards”**. That implies significant quality/safety hurdles - current regulations for assisted living or care homes may not allow conversion of the hospital without major changes. Unless the facility underwent extensive upgrades and new licencing, it could not legally or safely operate as a regulated care home. Thus, although it was initially considered, later discussion concluded it falls short of necessary quality standards.
- **Efficiency and Effectiveness:** An assisted living model can be efficient in general by allowing people to live independently longer, potentially reducing hospital or full nursing home admissions. In context, this could free up NHS beds elsewhere. However, participants noted that making Penley into a care home would require significant additional services (nursing, 24/7 care, maintenance) – hence one scribble asked “capital to support it”. They did not see clear clinical pathways or NHS outcomes, since it is more of a social care model. In essence, while supported housing meets social needs, it is not an NHS clinical service per se, so its effectiveness in terms of health outcomes was unclear to the group.

- **Deliverability:** Deliverability is problematic. The initial longlist mark said outcome “Pass” with a caveat on capital, but the final workshop decision was that it could not proceed under current rules. Practically, converting a hospital into an assisted living facility would require raising large capital sums for renovation and ongoing care staffing, plus obtaining regulatory approval from social care authorities. The scribes mention that stakeholders had already tried moving forward but were blocked by the Health Board. In summary, this Scenario looks undeliverable unless significant policy or funding changes occur.
- **Sustainability:** If it could be delivered, an assisted living facility might be sustainable through rental income or social care payments. But given the viability doubts, sustainability is moot. The workshop notes imply that even if built, running costs and staffing would be high, and meeting care standards would require continuous oversight. One phrase said "viability is questionable" – suggesting that even long-term maintenance would not be assured.
- **Accessibility and Inclusion:** This model would target older or disabled residents needing support, which aligns with community needs. In theory, it would help some people stay in Penley. However, because it was deemed unworkable, it offers no actual improvement in access. Moreover, if it had proceeded, the type of occupants would likely be older pensioners, meaning younger or ambulant disabled people might be excluded. Participants did not specifically note inclusion for this Scenario beyond the viability issues, but one implication is that by converting to housing, the facility might exclude acute or rehabilitation patients. Ultimately, since it was rejected, no real accessibility benefits would materialise.

3.2.7 Scenario 7: Care Homes Providing Bed-Based Care

- **Quality and Safety:** This Scenario envisioned partnerships with local care homes to provide the “bed-based care” (e.g. rehab beds or end-of-life beds) that Penley lacks, instead of using the hospital itself. On paper, this could extend capacity without redeveloping Penley. In practice, however, stakeholders found it lacking. The appraisal gave this Scenario a **Fail**. Scribes commented that care homes would have to simply hold patients “in a bed” without guaranteed rehabilitative therapy, which would be of limited benefit. Quality concerns include variability in care-home standards and uncertainty that NHS-level care (therapy, monitoring) would be provided. Without strict agreements, patient safety and outcomes could not be ensured.
- **Efficiency and Effectiveness:** Relying on external care homes might seem efficient (using existing beds), but effectiveness is uncertain. Workshop notes highlight inefficiencies: sending patients to distant care homes prevents family visits and might slow recovery. Also, it could lead to NHS funds paying privately for minimal care. Since the Scenario failed, participants evidently judged it ineffective at improving outcomes.
- **Deliverability:** Formally, NHS commissioners could contract with care homes, so in theory it is deliverable. However, the failure of the Scenario suggests significant barriers. Local care homes may not have interest or capacity to take on NHS step-

down cases. Also, oversight is more complex when the beds are offsite. The scribes note “possible route via care homes coming closer”, but no solid plan was given. Essentially, this Scenario relies on negotiation with multiple private providers, which could be difficult.

- **Sustainability:** This model’s sustainability would depend on those care homes remaining open and willing to take patients. In practice, care homes can close or change services, so reliance on them is not very stable. The workshop implicitly judged it unsustainable, since the Scenario was marked fail.
- **Accessibility and Inclusion:** Participants explicitly noted this model would **compromise accessibility**. Few people would benefit – only those accepted by the contracted homes – and those homes may not be near Penley. The notes say it would benefit “a limited number of people” and that simply “keeping [someone] in a bed but not providing the rehab needed would not be beneficial”. In other words, it does not solve the accessibility issue for the broader community. Most community members would have to continue travelling for care, so inclusion goals would not be met.

3.3 Medium List of Scenarios

Following appraisal against the agreed essential criteria, four scenarios were assessed as meeting the minimum standards required to proceed. Each carried important caveats but was judged feasible in principle:

1. **Health and Wellbeing Hub (Integrated)**
   - Passed all criteria, seen as a strong model for co-locating multi-professional services.
   - Caveats: depends on which services are included, sufficient workforce availability, and clarity on estates investment.
2. **Rehab / Step-down Facility with Beds**
   - Passed all criteria, reflecting strong local support for bed-based rehabilitation and step-down care.
   - Caveats: quality and deliverability depend on the number and type of beds, and on securing adequate therapy and nursing staff.
3. **Health and Wellbeing Hub plus Third Sector Facility**
   - Passed all criteria, extending the hub concept by embedding voluntary sector organisations alongside NHS provision.
   - Caveats: sustainability may be vulnerable to fluctuations in third-sector funding and staffing.
4. **Services in the Community (No Physical Building)**
   - Passed all criteria in principle, offering flexible outreach and home-based care instead of a fixed hospital site.
   - Caveats: high risk if long-term funding is not ringfenced locally; could leave the community with fewer services if resources are diverted elsewhere.

APPENDIX ONE: SCENARIO APPRAISAL SUMMARY

Scenario	Quality & Safety	Efficiency & Effectiveness	Deliverability	Sustainability	Accessibility & Inclusion
Health and Wellbeing Hub (Integrated)	Stakeholders felt this model could reduce patient risk if well implemented, but success depends on offering the right mix of services and sufficient staffing and resources (some capital investment may be needed).	The integrated hub was seen as a proven model involving multiple partners; participants said it could increase efficiency by co-locating services, provided the right services are included.	Deliverability hinges on clarity about what's new versus existing services: estate requirements are unclear, and some investment might be needed.	Likely sustainable if initial funding and workforce are secured; no unusual long-term issues were flagged beyond the usual need for ongoing support.	Expected to improve inclusion: participants noted it could reach a broader range of the rural population.
Rehab / Step-down Facility with Beds	Quality depends on having sufficient therapy staff and a proper discharge pathway. For instance, participants stressed the unit should serve all ages, not only frail elderly.	Efficiency depends on strong implementation: stakeholders noted this model "must be implemented well" and success depends on the team providing the service.	Feasible if properly resourced: deliverability scales with the number/type of beds required (staffing and capital must match bed count).	Sustainability likewise varies with scale: funding and workforce must increase in line with bed capacity.	Could improve local access to step-down care, but transport and staffing constraints (e.g. specialist therapists) would still limit reach.

Scenario	Quality & Safety	Efficiency & Effectiveness	Deliverability	Sustainability	Accessibility & Inclusion
Health & Wellbeing Hub + Third Sector	Seen as safe by building on the integrated hub model; no special safety concerns were raised beyond those for Option 1.	Efficiency expected to be like the integrated hub; it leverages an existing hub, and no major efficiency issues were noted.	Generally deliverable by combining NHS and third-sector resources; no unique barriers identified aside from routine coordination.	Stakeholders highlighted a potential vulnerability: heavy reliance on third-sector funding could pose a risk to long-term stability.	Likely to enhance inclusion by adding voluntary-sector outreach, though no specific inclusion issues were noted in the workshops.
Services in the Community (No Building)	Considered safe under existing community services (all criteria passed in appraisal); no significant quality or safety issues were identified.	Viewed as effective, since it builds on home and community care to prevent hospital admissions (all criteria passed).	Easily deliverable using current local services, assuming funds are directed to Penley; participants raised no major feasibility concerns.	Major concern was funding continuity: participants asked whether resources would be maintained long-term, warning that cutting funds could remove services.	High risk noted if funding lapses - withdrawing support could leave the community with fewer services, compromising accessibility.

Scenario	Quality & Safety	Efficiency & Effectiveness	Deliverability	Sustainability	Accessibility & Inclusion
GP Surgery	Initial appraisal marked it as pass, but stakeholders insisted no new GP practice is needed: demand is lacking, and any surgery would likely be just a branch of existing local practices.	Inefficient idea: the building would be underused, duplicating nearby GP capacity. Stakeholders noted it would waste resources, as existing GPs (Overton/Hanmer) would run it.	Undeliverable: no GP was willing to establish a new surgery at Penley, so implementing this option was viewed as non-viable.	Not sustainable: the health board refused the standalone GP plans, and any attempt was scaled back, so long-term viability is effectively nil.	Would not improve access: without new providers, local GP access would remain unchanged, and rural patients would still face travel issues.
Care Home / Assisted Living	Rejected as unsafe/unviable: stakeholders said it would not meet care standards, and its overall viability was questionable.	Ineffective: cannot safely deliver community hospital care. It fails to meet clinical needs, so is not an effective use of resources.	Undeliverable without major investment: licensing and regulatory hurdles were noted, and capital costs make it unrealistic.	Not sustainable: it would be unable to maintain necessary staffing and standards long-term.	N/A (not applicable due to failure of concept; even if built, high costs and limited beds would mean minimal community benefit).
Care Homes Providing Bed-based Care	Rejected as unsafe: stakeholders warned that simply keeping patients in beds without rehabilitation is not clinically beneficial.	Not effective: it offers only bed occupancy without therapy, so patient outcomes would be poor.	Not deliverable in a beneficial way: essentially just a care-home model, which doesn't fit the community hospital remit.	Unsustainable: it has no long-term justification as a community service.	Compromises inclusion: only a few would benefit, and without rehab it "would not be beneficial" to patients.

Thank You

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University Health Board

Penley Community Hospital Balanced Room No. 2

Outcomes Report

November 2025

Contents

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1 INTRODUCTION

Background and Context

1.1 Introduction

This report sets out the summary record of the deliberations and outcomes of a second balanced room session, to help shape the future of inpatient services at Penley Community Hospital. The workshop was convened by Betsi Cadwaladr University Health Board (BCUHB) and held at Ruabon Village Hall, on the 29th of October 2025.

This workshop was part of the options development and appraisal process, which follows the process outlined below.

- **Balanced Room 1** was convened and independently moderated to develop a long list of options for consideration, which were then appraised using BCUHB's essential criteria to develop a medium list of options. Use of the essential criteria ensured that each option was operationally viable for further consideration.
- **Balanced Room 2** was convened with broadly the same audience to develop a set of desirable criteria reflecting the views of wider stakeholders not just the health board. Weightings were applied to each criterion and then the medium list of options was appraised using the co-developed and agreed essential criteria to develop a shortlist.

1.1.1 Background

The first balanced room developed a long list of potential scenarios and collectively applied the essential criteria (the minimum viable tests set by BCUHB) to develop a medium list, which comprised four options, as shown below.

A. **Health and Wellbeing Hub (Integrated)**: repurposing the hospital as a multi-professional hub where health, social care and potentially voluntary sector teams co-locate. The aim is to improve access to outpatient and preventative services closer to home, reducing travel and creating a focal point for care in Penley.

B. **Rehab / Step-down Facility with Beds**: restoring a bed-based function at Penley, focused on rehabilitation, step-down care from acute hospitals and end-of-life support. This reflects community concerns about travel distances and the need for local recovery and respite beds.

C. **Third Sector Led Health and Wellbeing Hub**: combining the integrated hub model with an explicit leadership and delivery role for third-sector partners. The proposal builds on existing strengths in the local voluntary sector to deliver health, wellbeing, and social support alongside NHS-led services.

D. **Services in the Community (No Physical Building)**: redirecting resources away from maintaining a fixed site and investing instead in outreach and home-based services. This model prioritises flexibility and a "care closer to home" approach but carries risks if funding and workforce are not secured locally.

Balanced room 2 aimed to collaboratively establish the essential criteria and scoring to create a shortlist of options for further review.

1.2 Participants

Participation in the event was recruited on the basis of creating a 'balanced room.' The balanced room approach ensures that a diverse mix of perspectives is represented when developing and appraising options. Rather than allowing one group or viewpoint to dominate, participants are selected to reflect different stakeholder interests, levels of influence, and lived experience. This creates a fairer, more transparent process where evidence, values, and practical considerations are weighed collectively. The aim is not consensus at all costs, but a balanced discussion that tests assumptions, highlights trade-offs, and strengthens the legitimacy of the final outcomes.

The participants were in three broad categories:

- **Scoring participants:** a mix of stakeholders and representatives of BCUHB, all of whom have equal voice and influence in deliberations and appraisal scoring.
- **Technical Advisers:** representatives of BCUHB on hand to provide expert opinion and input to deliberations as and when needed by participants.
- **Facilitation team:** the team who enabled discussions without taking part in decision making.

1.2.1 Scoring Participants

In total there were 15 participants who developed the essential criteria, their weighting and applied them to developing the short list of options, of those:

- 10 were external stakeholders.
- 5 were members of BCUHB staff with specialist knowledge and experience.

The full list of those participants who took part in the scoring was.

Victoria Bishop	BCUHB
Paulina Dymnicka	Helping Hands CIC
Jacqui Grice	Bangor on Dee Community Council
Phil Jones	Hanmer Surgery Patient Action Group
John Pritchard	Local councillor
Lucy Reid	BCUHB
Christine Roberts/Barbara Weeks	Hanmer Community Council
Victoria Sheffield	BCUHB
Faye Sheldon	BCUHB
Claire Sullivan	North East Wales Carers Information Service
Sarah Thomas	North Wales Access Panel
Caroline Tudor-James	Rainbow Foundation
Stuart Tunnicliffe	BCUHB

John Griffiths	Wrexham Council
Dr Kieran Redman (attended for a while but didn't score)	Local GP

1.2.2 Technical Advisers (non-voting)

A group of BCUHB staff attended to provide technical advice on clinical, operational, equalities, and estates matters as required:

- Andrea Hughes Director of Nursing – East IHC BCUHB
- Ryan Welch, Lead Manager, Community Services – East, BCUHB
- Dr Sara Gerrie, Consultant Geriatrician, BCUHB
- Jade Parry Assistant Project Manager, Capital Development Team East, BCUHB
- Jenifer Dowell-Mulloy, Equality and Inclusion Manager, BCUHB

1.2.3 Event Facilitation Team (non-voting)

The facilitation team supporting the event's running consisted of:

- Independent Facilitator — Andy Wright, ASV
- Senior Responsible Officer (SRO) — Paolo Tardivel (BCUHB)
- Table Facilitator/Scribe — Helen Stevens-Jones (BCUHB)
- Table Facilitator — Andy Roberts (BCUHB)
- Table Facilitator — Vicky Freeman (BCUHB)
- Table Scribe — Marie Lewis-Smith (BCUHB)
- Table Scribe — Becky Jones (BCUHB)

2 THEMATIC DISCUSSIONS

Group conversations informing the development of desirable criteria.

2.1 Introduction

This section presents an overview of the day's discussions organised by major themes in relation to options A to D outlining areas of agreement, points of contention, and notable concerns or suggestions raised by participants.

The discussion involved local community representatives, healthcare staff, and officials, focusing on future options for the Penley facility and services in South Wrexham. All participants emphasised the need for any solution to address wider system challenges, meet the needs of a largely rural and ageing population, and be sustainable for the future.

2.2 Estate and Infrastructure Suitability

Participants examined the suitability of the existing Penley healthcare facility and other local infrastructure.

2.2.1 Penley Hospital Building

Participants noted that the Penley building is relatively modern *"…the building [was] erected in 2004"* with were no known structural limitations that would preclude new service options. While some community members initially perceived the building as aging or inadequate (*"people might think the building is old and needs bulldozing"),* it was clarified that the facility was rebuilt in 2004 and remains fundamentally sound.

Routine maintenance issues (e.g. minor drainage problems) have been identified, but a significant maintenance backlog is not expected. Participants requested confirmation of any legal covenants on the property in case the site's use changes, though no specific covenants were known at the time.

2.2.2 Adaptability

There was a call to assess *"what the building is fit for – [and] could be adapted to"* in the context of each option. In other words, any proposed service model must align with the physical layout and capabilities of the Penley site. Participants felt it important to avoid retrofitting services that the building cannot appropriately accommodate. For example, if clinical inpatient beds were not feasible at scale, the building might be better purposed as a community hub for outpatient and wellbeing services. This emphasis on matching the estate to service models ties into the broader criterion of ensuring any solution is *"fit for the future"* and has longevity. The Penley facility should be utilised in a way that remains relevant 10–20 years from now, rather than implementing a short-term fix.

2.2.3 Local GP Practice

In addition to the Penley site, participants highlighted the condition of the local GP surgery. The current GP practice building in the area was *"declared unfit in 2016 and nothing has been done about it".* This was raised as a significant infrastructure gap. Any plans for Penley's healthcare provision should consider primary care facilities: improving or relocating the GP practice could be part of the solution, or else the

Penley site might supplement some primary care functions. Participants stressed that infrastructure upgrades are needed at the primary care level, as this is crucial for preventive care and keeping people out of hospital.

Use of Existing Assets

Participants expressed a strong interest in utilising existing community assets and facilities. For instance, Penley is already used for some services like physiotherapy, and *"this could be built on"* with additional clinics.

There was also discussion about utilising other local venues (e.g. *"they could go into the GP practice, not just into Penley"* for certain services). A specific example was given that something as simple as ear syringing currently requires patients to travel to Llangollen; participants saw an opportunity to provide such basic services closer to home, either at Penley or local GP surgeries.

The principle expressed was that even small or rural communities deserve a standard level of provision; *"a school still has to provide the curriculum even if [there are] small numbers. The same should apply to health services; they are still needed even if the population is low".*

In summary, the estate (Penley and other local facilities) is seen as a viable foundation for expanded local services, if planning is done thoughtfully to match building capabilities with community needs.

2.3 Care Delivery Challenges in the System

Participants underscored that any Penley solution must tackle broader care delivery challenges, not just create an isolated service.

2.3.1 Emergency Care Delays

Participants discussed stark examples of system stress, recounting recent incidents illustrating long waits for emergency care. In one case, an elderly patient with a broken hip waited outside A&E for an extended time; in another, a person with a burst appendix sat for 20 hours awaiting treatment and developed sepsis.

It was noted that Betsi Cadwaladr UHB has some of the *"worst ambulance conveyance times in Wales",* with patients facing extreme delays for transport to hospital.

These anecdotes reinforced a shared view: *"Whatever happens here [in Penley], [we] need to address this context"* of strained emergency and acute care.

Simply reopening a small inpatient unit at Penley would not solve the systemic issues of A&E backlogs, ambulance queues, and delayed admissions.

2.3.2 Delayed Discharges and Bed Blocking

Another critical challenge discussed was the difficulty in discharging hospital patients due to insufficient support in the community. Data was shared indicating there have been over *"8,000 delayed discharges in the South Wrexham area"* recently. Participants linked this to a shortage of home care packages and community-based intermediate care. They cautioned against solutions that only *"paper over the cracks".* For example, while adding step-down (rehabilitation) beds was considered (as in

Option B), many felt this addresses a symptom (hospital bed shortages) rather than the root cause. One participant argued that providing step-up/step-down beds alone *"does not address the lack of rapid access for domiciliary care",* which is a primary cause of discharge delays. In other words, if patients cannot get timely home care or residential care, they will remain stuck in any system, whether at the district general hospital or a step-down unit.

At the same time, some attendees pointed out the value of step-down beds when integrated properly. A local caregiver shared a personal story: her elderly mother had used a community hospital bed after an acute stay, and these step-down facilities *"were a major part of her recovery".* This was *"very important in rural areas,"* she emphasised, noting that *"we are not Wrexham town centre out here in Penley".* The rural context – where traveling to the main hospital (Wrexham Maelor) is difficult for patients and families – means local recuperation beds can greatly aid recovery and family involvement.

Step-down beds are not a complete solution, but participants agreed they have value in a wider model (such as Option A) particularly for elderly rural patients who would otherwise face extended hospital stays far from home.

2.3.3 Patient Suitability and Level of Care

NHS staff in the discussion noted that many inpatients today are too acutely unwell to be transferred quickly to a traditional community hospital. As one clinician observed, *"patients aren't fit for community hospital discharge"* in a lot of cases. By the time they are medically stable enough, they often can go straight home if support is available. This raises the question of what role an inpatient unit at Penley should play. Participants generally leaned away from trying to recreate a classic community hospital with long-stay beds (Option B). Indeed, Option B was seen by the group as essentially *"where we've come from"* (referring to the old Penley Hospital model) and not adequately working last time. The consensus was that simply reviving the previous service would serve *"only a few"* patients and fail to meet the wider community's needs. Instead, the focus should be on community-based care delivery that reduces admissions in the first place and speeds discharges by providing robust home and step-down support.

2.3.4 Social Care and Carer Support

A recurring theme was the interface between health services and social care. Many older patients ready for discharge cannot leave hospital because appropriate home care isn't immediately available. The group discussed ongoing efforts like a Pathways of Care Transformation grant, which is examining how to improve rapid access to domiciliary care (for example, expediting *"rapid access to domiciliary care, and moving with dignity"*).

The requirement for two carers to assist one patient, known as *"over-prescription of double handling",* worsens home care staffing shortages and delays arranging care packages. This points to workforce and policy challenges in social care that directly impact hospital flow. In addition, participants talked about carers' needs for support. For instance, caring for someone with dementia versus someone with purely physical

needs requires different services, and currently it is *"difficult to get care packages"* tailored to those needs.

Practical support for carers was also mentioned such as:

- *"…food boxes if a carer can't get out of the house,"* or
- help with *"removing furniture so a hospital bed can fit in the house"* when setting up home care.

These kinds of non-medical interventions can determine whether a patient can be safely discharged home.

Moreover, carers often feel adrift; they *"*, as having a single point of contact could prevent unnecessary re-admissions.

Carers often feel lost and want a single point of contact for questions, which could help avoid unnecessary re-admissions. They *"…need to know who their key contact is, who to phone with a question".*

The overarching message was that any new model in Penley must be part of an integrated care pathway that smooths transitions from hospital to home and supports carers, effectively reducing *"bed blocking"* by addressing why patients become stuck in the first place.

2.3.5 Population Health Needs

The demographic profile of the Penley catchment is skewed older compared to Wrexham town. Data noted in the session showed *"the Penley area has a proportionately greater number of over-50s than Wrexham town centre"*. This ageing population brings higher prevalence of chronic conditions, mobility issues, and dementia – and thus requires more healthcare and support services. Participants argued that the model should be tailored to these needs, for example by providing local wellbeing and preventive services that help keep seniors healthy and independent. They stressed a dual goal…

"…we need to prevent re-admission but also first admission".

Put simply, focus should be on both reducing hospital readmissions by improving post-discharge care and prioritising preventive measures and early intervention to minimise initial hospitalisations. This preventive approach was linked to ideas like enhanced primary care (hence the calls for a better GP practice) and community wellbeing programs at a hub.

Another community insight was acknowledging past utilisation of Penley. It was noted that…

"…the local population didn't use Penley [Hospital] before, so what do the locals need?".

This rhetorical question implies that, in the past, the services provided at Penley may not have fully reflected the needs of the community, potentially due to limited utilisation resulting from the availability of only a small number of inpatient beds. Any solution must be guided by local needs and demand, making community engagement and data analysis essential.

In summary, participants painted a picture of significant care delivery challenges: overloaded hospitals, slow discharges due to inadequate community care, an ageing rural population with limited alternatives, and caregivers under strain. They urged that whatever model is chosen for Penley, it must alleviate these challenges by boosting local capacity for care (both medical and social) and by focusing on keeping people well and cared for in the community.

2.4 Service Integration and Holistic Care

The discussions consistently highlighted the importance of integrating services across healthcare levels, as well as among health, social, and voluntary sectors, to deliver more comprehensive and holistic care. Participants believe Penley's future should be as a hub or catalyst for coordinated services rather than a standalone offer.

2.4.1 Wider System Approach

Participants repeatedly stated that the Penley solution must be part of *a "wider system approach".* They envisioned better integration between the hospital, community health services, GPs, social care, and third sector (voluntary) organisations. One participant put it clearly as...

> *"…the model/solution needs to address the wider system and meet local needs e.g. bed blocking".*

This implies designing services that actively fill gaps in the current system – for example, offering intermediate care, rehabilitation, or respite that eases pressure on acute hospitals, while also connecting to GP referrals and social services.

2.4.2 Co-location and Holistic Services:

The concept of a "community hub" at Penley (broadly corresponding to Option A) was popular, but attendees stressed it must be well-defined. They suggested a hub could host a range of services:

- Outpatient clinics,
- Therapy services,
- Preventative health programs,
- Perhaps some step-down care, and
- Even social support resources.

By *"co-locating services"* under one roof, people could more easily be *"signposted between services"* for holistic support. For example, an elderly patient visiting for a physiotherapy appointment might also be able to get a falls-risk assessment, speak with a social prescriber about community activities, or consult a benefits advisor – all in one trip. Participants saw this as an ideal to strive for:

> *"Well-being delivered locally and co-located with ... non-medical services should be considered."*

Bringing health and wellbeing services together would help address not just medical needs but social determinants of health.

2.4.3 Role of the Voluntary Sector

Option C referred to collaborating with the voluntary or community sector. Participants largely felt this was not an *"either-or"* alternative but a necessary component of any successful model.

In fact, it was noted that.

"Option A couldn't be done without the support of the voluntary sector, which is option C."

There was consensus that local charities, community groups, and volunteer networks should be involved in delivering services, whether:

- Running community activities in the hub;
- Providing volunteer drivers (for patient transport); or
- Supporting carers at home.

The voluntary sector can extend the reach of formal services and provide elements of care that the NHS struggles to, particularly in wellbeing and social support. Participants wanted to:

"…take advantage of the assets in the area".

Meaning both physical assets (like the community hall or school facilities that could host clinics) and human assets (community volunteers, support groups, etc.). Effective integration would improve sustainability, as leveraging these resources could help *"improve the sustainability"* of services and fill in gaps.

2.4.4 Avoiding Duplication and Strengthening Links

A warning was issued to make sure that services are not needlessly repeated or in conflict with each other. If Penley becomes a hub, it should complement existing services, not compete with, or replicate them unnecessarily:

"We need to avoid duplication of services…"

For example, if certain clinics are already available at the Wrexham Maelor or nearby community facilities, the hub should either coordinate to host those clinics on an outreach basis or focus on services not currently accessible locally.

Participants felt a mapping of current services was crucial:

"We should have reviewed the current services available now, and how realistically these could be built upon. Mapping should have been done."

For future planning, it is advisable to carry out a thorough service mapping and gap analysis in South Wrexham. This would identify which needs are unmet and ensure the Penley plan is targeted. Moreover, making the *population aware of all current services* was mentioned as important; integration is not just about providers talking to each other, but also about the public having a clear, navigable system.

Improved coordination between organisations is necessary, regardless of the outcome of this consideration of Penley's future service delivery. Participants asked:

"How are current services working together, what are the gaps and how can we address that?"

Existing health, social, and community services in the area are not felt to communicate or coordinate as effectively as they could. Implementing a hub model at Penley has the potential to enhance coordination efforts; however, its success would depend on the establishment of effective governance structures and robust inter-agency collaboration.

One practical idea was to establish a single *"key contact"* or care coordinator for carers (and presumably patients) to turn to with questions, to help navigate the system. This kind of integration (essentially case management) could prevent people from falling through the cracks or cycling back into hospital.

2.4.5 Preventative and Community Health

Integration also means refocusing on prevention and early intervention as part of the service mix. Participants were keen that any new facility prioritise wellbeing services, health education, and preventive clinics. The "prevention agenda" was highlighted as a must-have element. For instance, regular screening programs, exercise classes for older adults, or chronic disease management workshops could run out of a community hub. As one comment suggested:

> *"What can we do with a community hub to help keep people healthy?"*

There was acknowledgment that a strong primary care base (including a better GP practice locally) is key to prevention; hence integrating the hub's activities with local GPs is vital. This could mean GPs hold sessions at the hub or refer patients to hub programs (dieticians, smoking cessation, etc.), and conversely that hub staff coordinate with GP surgeries about patient care plans.

2.4.6 Specific Community Needs

The range of services suggested spanned all ages and needs, reflecting a holistic vision. Besides elder care, participants mentioned needs such as sexual health, family planning, mental health support, and respite care for families.

Youth services were mentioned too: e.g., a local high school (Madras School) already offers some community facilities for young people. This indicates potential for partnerships, the hub doesn't have to house every service itself if some needs are met in other community venues. Instead, the hub could act as a signposting centre or coordination point linking people to those resources.

End-of-life care, typically central to similar discussions, was not raised in this session. One participant noted its absence, suggesting palliative care deserves greater focus in future engagement. The need for hospice support or coordination with palliative care teams was identified as a follow-up item.

2.5 Transport and Access

Given the rural setting of Penley and its surrounding villages, transportation and access emerged as major considerations. Poor transport can negate the benefits of local healthcare facilities if patients, especially the elderly, cannot get there (or if staff cannot be recruited from farther afield due to commute issues).

2.5.1 Limited Public Transport

Participants described the local public transport as woefully inadequate. Penley village itself has only *"3 buses a day",* and *"surrounding villages have no buses"* at all. For those who cannot drive, this is a significant barrier to accessing any centralised service, whether it's in Wrexham town or in Penley. A community member asked whether there are any community transport schemes or local taxi services that could help, but it appears options are very limited. Transport poverty contributes to health inequality: people without cars in these rural areas struggle to attend appointments or visit relatives in hospital.

One consequence noted was the isolation of patients who end up in Wrexham Maelor Hospital, family and friends from villages like Penley often find it hard to visit due to distance and lack of transport.

"Isolation, of not having visitors when in the Maelor due to lack of transport, can affect outcomes,"

In other words, patients from rural areas may have worse recovery and wellbeing simply because they are cut off from their support networks during hospitalisation.

2.5.2 Impact of Driving Rules and Ageing:

The discussion also mentioned upcoming changes in driving regulations. *"New DVLA rules for the over-65s"* will require more frequent license renewals or health checks for older drivers, which participants fear will *"decrease the number of drivers in the rural area."*. In an area already heavily car-dependent, a significant portion of the population (seniors over 65) may soon face restrictions or challenges in driving themselves. This trend could further isolate older residents or make them reliant on family and community networks for transport. It underscores the importance of either bringing services closer to these residents or organising transportation solutions.

2.5.3 Travel Burden on Staff and Patients:

The current centralised model means not only patients, but also healthcare staff, have to travel long distances. Participants noted:

"We need to decrease the burden of travel for staff and for patients, and their families."

If more services (e.g., specialist clinics or therapy sessions) could be delivered locally at Penley or via outreach, it would save considerable time and expense for patients who currently travel to Wrexham, Llangollen or farther.

Similarly, health workers like community nurses or therapists spend a lot of time on the road covering a large rural patch; a hub might allow them to see more patients in one place or coordinate visits more efficiently. Reducing travel time is not just a convenience issue, it can improve access (more patients will use services if they are nearby) and potentially improve staff retention (jobs that don't require constant long drives might be more attractive).

2.5.4 Possible Solutions – Community and Digital:

While the fundamental lack of public transit is a challenge, participants brainstormed mitigating strategies. One idea was to create a “hub-and-spoke” model for services. In this concept, Penley might serve as the central hub, but certain services could be taken out to surrounding communities (the “spokes”) on a scheduled basis – for example, mobile clinics or regular visits by a district nurse to village halls. This would acknowledge that not everyone can come to Penley easily, so the service would occasionally go to them. Another suggestion was leveraging digital technology and telehealth to reach people at home. However, this was met with some scepticism: given the demographic, many felt that *“ageing population and dementia”* means high-tech solutions are not a complete answer. Some older residents may struggle with telemedicine or lack broadband access, and those with cognitive impairments benefit more from face-to-face contact. In short, digital interventions could *assist* (for instance, remote monitoring for certain patients or virtual consultations for those comfortable with them), but the consensus was that digital alone *“says no”* as a substitute for in-person services in this context.

Participants did emphasise exploring any existing community transport schemes, volunteer driver programs, or partnerships with local taxi firms as part of the solution. If a community hub is established, funding might be needed for a dedicated shuttle service or to reimburse volunteer drivers to get frail patients to and from the hub or hospital.

Accessibility was explicitly listed as a key criterion in evaluating options, meaning the physical location and design of services must be accessible (for disabled users, etc.) and realistically reachable for the target population. This may influence decisions such as offering multiple smaller hubs versus one central hub, or co-locating services in existing community centres to shorten travel distances.

In summary, transport is a critical concern for Penley’s future services. The participants made clear that without addressing access – either by bringing services closer to home, aiding with transportation, or supplementing with digital outreach – even the best-planned service models could fail the rural communities. Any chosen option will need an accompanying transport and access plan to ensure equity for those living in outlying areas.

2.6 Workforce Considerations

Any service change will depend on having the right workforce. Participants were keenly aware of workforce constraints and the need to make roles attractive and sustainable in a rural setting. In fact, “Recruitment and retention” of staff topped the list of essential criteria identified for evaluating options. Participants recognised that if Penley is to host new or expanded services, those services must be staffed appropriately – which has historically been challenging.

Workforce issues are central to Penley’s future. The community expects the Health Board to select an option that can be reliably staffed within current resources and provides a safe environment for staff, maximising patient benefit. Proposals needing significant new hires should consider recruitment challenges, while investing in

workforce development and innovative roles may offer strategic advantages. The focus remains on practical and sustainable staffing.

2.6.1 Staffing Challenges in Rural Areas:

Rural healthcare facilities often struggle to recruit clinicians, nurses, therapists, and care workers. Attendees highlighted this, making it clear that proposed options must be realistic about staffing. For example, if an option required 24/7 nurses for inpatient beds or a rotation of specialist doctors for clinics, is that feasible given the workforce supply? The criteria of *"maximum number of patients (scale)"* was mentioned alongside workforce and value-for-money considerations, suggesting participants want to maximise impact with the staff available – serving as many people as possible without compromising quality. Option B (inpatient beds) might score poorly on this, since running even a small ward is staff-intensive yet benefits relatively few patients at a time, whereas a hub with outpatient clinics could potentially reach more people with fewer staff.

2.6.2 Development and Support of Staff

"Development of staff" was listed as an important criterion. This suggests that participants, including health board staff, prefer models with training, career development, and professional support for employees. A community hub could, for instance, be a place where nurses or allied health professionals work in extended roles (gaining new skills) or where rotational programs bring in staff periodically (preventing professional isolation).

There was also mention of staff safety and security: any facility must ensure a safe working environment for staff (and of course patients). This is both a physical concern (e.g. adequate security measures if staff work alone or overnight) and a professional one (having sufficient colleagues or supervision so staff do not feel vulnerable or stressed).

2.6.3 Resource and Financial Considerations

While not strictly a workforce concern, participants associated staffing with the availability of resources and overall financial sustainability. They repeatedly brought up budget and value for money. There was a call for clarity on the budget envelope – *"need to understand [the] budget available",* before committing to an option.

This reflects that some options might be desirable but unrealistic if funding is insufficient for the required workforce or facilities. *"Value for money"* and *"best use of resources"* were explicitly flagged as decision criteria as well.

The community expects prudent use of funds, investing in solutions that yield the greatest benefit for the population served. A few participants were essentially analysing cost-effectiveness:

- If option A (community hub) can serve more people with a given staff and budget than option B (inpatient unit), then A was favoured.
- Similarly, a combined option might share resources across services for efficiency.

Ensuring any plan is financially and operationally sustainable (beyond the initial setup) is critical – tying back to the idea of being *"fit for the future / longevity of [the] option".*

2.6.4 Integration of Health and Care Workforce

The discussions also recognised that workforce extends beyond just NHS staff. Collaboration with social care and voluntary sector workers will be needed. For instance, to tackle home-care shortages, the health board might coordinate with the council on joint recruitment or new roles (like hybrid health-social care support workers). If volunteers are to play a role (Option C), they too need managing and supporting – effectively expanding the workforce with community assets but requiring coordination.

An additional consideration related to workforce concerns was raised in connection with domiciliary care staffing. The practice of requiring two individuals to complete specific home care activities (double-handling) was identified as an area that could be reassessed to enhance operational efficiency. Innovative workforce models or equipment that allow single-handed care could ease staffing pressures.

Additionally, having a local hub might improve staff efficiency by reducing travel (as mentioned earlier), allowing a given number of district nurses or therapists to see more patients instead of driving long distances between calls.

Participants emphasised that any option chosen should ensure or enhance care quality and outcomes, requiring a skilled and adequate workforce. "Outcomes of patients / quality of service" was a criterion on par with financial and workforce considerations.

Participants want assurance that the chosen model will deliver good results for patients (better recovery, health improvements, satisfaction) and that these outcomes will be measured and monitored. This is indirectly a workforce matter because good outcomes depend on having capable, well-supported staff in the right numbers.

2.7 Desirable Criteria

Following small group collaborative discussions, detailed above, a consensus session produced six 'desirable' criteria for evaluating service options to meet Penley's community needs.

These principles guided objective assessment of each option, leading to scoring and to select the most promising approaches for further development and public engagement.

The desirable criteria developed in the consensus discussions in the session were as follows:

1. **Sustainability and System Resilience:**
    a. Reduce pressures on the system.
    b. Future proof (avoid commissioning failure, not papering over the cracks.)
    c. Ensure there is a demand for the proposed services (including forecast demand.)
    d. Workforce recruitment, retention, development (applies to all.)
    e. Incorporates existing service delivery in the area.

f. Improve access to outpatient services e.g. physiotherapy (as much as possible)

2. **Prevention and Community Support:**
    a. Support prevention agenda.
    b. Support carers
    c. Help keep people at home / get home as soon as possible.
    d. Support local GP services – do not forget sustainability of local GP services in development / take account of GP referrals.
    e. Build on coordinate with existing service – avoid duplication.
    f. Take advantage of/work with existing assets in the area (thinking about their sustainability)
    g. Enable co-location of wellbeing services.
    h. Provides a community resource.
3. **Accessibility and Travel:**
    a. Accessibility of the site
    b. Reduce burden on people having to travel (patients/staff/carers/family)
4. **Safety and Security:**
    - Safety and security of staff/patients/visitors
5. **Clinical Outcomes:**
    - Improved patient outcomes
6. **Patient Experience:**
    - Improve patient experience.

NB: These criterion were developed by grouping the individual ideas and thoughts provided by each of the small groups into thematic clusters. The individual ideas are shown in the bulletpoints below the main criteria.

2.8 Criteria Weighting

Participants were then asked to provide an individual view of the relative weight of each criterion via an online system.

The results of this, while close, show that Prevention and Community Support and Clinical Outcomes are viewed as highest priority for consideration, with Safety and Security seen as lowest priority.

Criterion	Weight (%)
Criterion 1 Sustainability and System Resilience	16.7%
Criterion 2 Prevention and Community Support	17.2%
Criterion 3 Accessibility and Travel	16.3%
Criterion 4 Safety and Security	16.0%
Criterion 5 Clinical Outcomes	17.2%
Criterion 6 Patient Experience	16.4%

3 SHORTLISTED OPTIONS

Applying the Desirable Criteria to the Medium List

3.1 Emerging Consensus on Future Service Options

After extensive discussion, stakeholders reached a broad consensus on which service options should be taken forward for further development and public engagement. In the scenario appraisal exercise, four options (A, B, C, D) were considered. While the details of each option were not exhaustively discussed in the notes, the general outlines were:

A. **Health and Wellbeing Hub (Integrated)**: repurposing the hospital as a multi-professional hub where health, social care and potentially voluntary sector teams co-locate. The aim is to improve access to outpatient and preventative services closer to home, reducing travel and creating a focal point for care in Penley.

B. **Rehab / Step-down Facility with Beds**: restoring a bed-based function at Penley, focused on rehabilitation, step-down care from acute hospitals and end-of-life support. This reflects community concerns about travel distances and the need for local recovery and respite beds.

C. **Third Sector Led Health and Wellbeing Hub**: combining the integrated hub model with an explicit leadership and delivery role for third-sector partners. The proposal builds on existing strengths in the local voluntary sector to deliver health, wellbeing, and social support alongside NHS-led services.

D. **Services in the Community (No Physical Building)**: redirecting resources away from maintaining a fixed site and investing instead in outreach and home-based services. This model prioritises flexibility and a "care closer to home" approach but carries risks if funding and workforce are not secured locally.

The sentiment in the room was clear:

- Options A, C, and D were favoured to move forward.
- Option B was overwhelmingly rejected.

In discussions, the group eliminated Option B from further consideration, noting that it represented…

> *"…what* [had] *already [been] done" before and was akin to "going back to what we had before, and it didn't work last time".*

- There was recognition that Option B (pure inpatient reopening) would serve few people, as only a limited number of beds could be staffed, and it would not address root causes like community care gaps.
- Some also pointed out that Option B was not a single concept but *"actually two distinct options"* – rehabilitation vs. step-down care – which *"made it hard to score"* in the appraisal. This further eroded confidence in B due to its lack of clarity and focus.

By contrast, Option A and Option C were seen as complementary and even intertwined. In discussion, stakeholders noted A and C are *"very similar"* or would naturally integrate. Option A proposes making the Penley facility a community hub,

while Option C includes voluntary and community sector leadership of service delivery in its offerings.

The consensus was to *"put our efforts now into A & C (and include D in there too)."* In other words, the preferred path is a blended approach: develop a hub at Penley that delivers a range of health and wellbeing services (Option A), build strong partnerships with the voluntary sector and community-based providers to augment these services (Option C), and incorporate any promising innovative approaches (Option D) to enhance access and efficiency. Indeed, many felt that **Option A could not succeed without Option C** (voluntary sector support) as noted earlier, and that some elements of D (like digital support or mobile outreach) could make the A/C model more effective.

It was acknowledged that options A and C open the facility to the community rather than "[just] *inpatient beds – which is only for a few".* This reflects a desire to use Penley in a way that benefits a broader cross-section of the population (e.g. through clinics, classes, and drop-in services) as opposed to a small number of inpatients at any given time. Stakeholders felt this would yield more health impact per resource invested, aligning with their criteria of scale and value.

Need for Clarity and Focus: Although the hub concept (A) is attractive, participants were cautious that it must be well-defined. *"Hub needs greater clarity – it means different things to different people,"* one comment noted. Before moving to the next engagement phase, they suggested doing a piece of work to **define the specific "offer" of the hub**. What exact services would it include? Which population groups would it target primarily? How would it operate alongside GP practices and Maelor Hospital? Without this clarity, there's a risk of over-promising. There was a *"danger of trying to deliver too much in a small space"*, so the hub needs a clear focus and prioritisation of services. Executives will need to consider capacity (both physical space and workforce) when deciding which services are core for the Penley hub. Stakeholders suggested focusing on areas of greatest need and impact for the community – which, based on the discussions, likely include intermediate care (rehab/respite), chronic disease management, preventive health, and co-located social support.

3.1.1 Unresolved Questions:

While dropping Option B was straightforward, combining A, C, and D raises some questions that stakeholders want addressed:

- **What mix of services?**
  There were calls for further definition of the range and mix of services under consideration:

  "What could we have in there [the hub]?"

  "…what is "doable / sustainable" on-site versus what should be delivered elsewhere."

  For example…

  "…could the hub include a small number of step-down beds for rehabilitation?"

Some felt a hybrid model could be possible:

"Could we have a little bit of all 4 options?"

One attendee suggested including a couple of beds, clinic space, and community outreach. This idea of a mixed model indicates the final option might not be a pure single option but a tailored blend. Clarity is needed on this point.

- **Scope of "digital" solutions:**
  Participants wanted to know…

  "…if incorporating Option D, to what extent will digital interventions be used?"

  There was scepticism about relying on telehealth for older patients, but digital could still play a role in supporting staff (e.g., sharing care records between agencies) or providing some remote services for more tech-savvy groups.

  Stakeholders didn't reject digital solutions but emphasise it must fit the needs of the demographic served.

- **Transport and accessibility plan:**
  Many participants asked how people will get to the hub from remote villages. Should a hub be established in Penley, future planning must address the needs of individuals residing outside of the immediate Penley area.

  "Will there be satellite clinics, transport assistance, or other accommodations?"

  This remains an open question.

- **Resource and staffing realism:**
  Participants want to see the budget and staffing analysis for the preferred option. Before final decisions, they expect transparency on costs (capital and revenue) and confirmation that the workforce can be secured. This was implicit in the criteria discussion: value for money, budget awareness, and sustainability must underpin the final proposal.

- **Outcome measurement:**
  Participants wanted to know how to measure outcomes to determine if the solution improves patient care.

  Decision-makers will need to build in an evaluation framework (e.g., track readmission rates, patient satisfaction, health outcomes in the area) for whichever option is implemented.

- **Public engagement on details:**
  It was agreed that once a more concrete model is sketched out, it should be tested with the wider public regarding the specific services and proposals.

  "It would be useful to hear what the public think".

  Participants acknowledged that the group in the room was relatively small and felt broader community engagement will validate whether the consensus aligns with public preferences.

For instance:

- If a hub is proposed, what services do residents most want to see in it?
- Are there concerns about any aspect?

Proactive engagement can help identify these issues.

- **Best practices from elsewhere:**
  Stakeholders were keen to understand…

  "…how these options have worked in other areas."

  There may be lessons from similar rural community hospital transformations elsewhere in Wales or the UK. This suggests researching case studies or inviting input from regions that have implemented community hubs, virtual wards, etc., to inform the Penley plans.

Despite these questions, there was a positive feeling about the consensus reached. As one person noted,

"Consensus in the room is good; people want to use a wider range of services."

This shows a collective interest in shifting from the old inpatient only model to a wider range of services, represented by Options A, C, and D.

3.2 Outcomes: Shortlisted Options

The scoring using these criteria, with the agreed weightings applied, produced the following results, with Options A, C and D forming the shortlist for further consideration. In summary the shortlist is:

- **Option A**: reopen Penley as a health and wellbeing community hub (with a range of outpatient, preventive, and some intermediate care services).
- **Option C**: invest in community/voluntary sector services (potentially without heavy use of the building, focusing on outreach and support in homes and communities.)
- **Option D**: other innovative solutions such as digital health, telemedicine, or distributed "hub & spoke" services, although the discussions suggest D involved some new element that could complement A and C.

These were scored using the following desirable criteria developed by participants in the session:

Criterion 1.	Sustainability and System Resilience
Criterion 2.	Prevention and Community Support
Criterion 3.	Accessibility and Travel
Criterion 4.	Safety and Security
Criterion 5.	Clinical Outcomes
Criterion 6.	Patient Experience

The table on the next page shows the individual criteria and total weighted scores.

	Criterion 1	Criterion 2	Criterion 3	Criterion 4	Criterion 5	Criterion 6	Total (Weighted Scores)
Option A	**11.22**	**11.71**	**7.97**	**9.94**	**10.68**	**10.99**	**62.51**
Option C	**9.38**	**10.51**	**9.11**	**9.30**	**10.51**	**10.00**	**58.81**
Option D	**8.88**	**9.47**	**9.44**	**8.82**	**9.82**	**10.17**	**56.59**
Option B	8.37	7.23	8.46	8.34	8.96	8.86	50.22

Thank You

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Shaping the Future of Services at Penley Community Hospital

Pre-consultation report on engagement activity and feedback

1. Introduction

This report provides an overview of the pre-consultation activity and feedback that has taken place and been received on the future of services at Penley Community Hospital. It outlines the context and rationale behind the issues that led to the service review, summarises the efforts taken to involve the local community and stakeholders in the pre-consultation phase to support the development of options and sets out the legal framework guiding this process. The aim is to ensure transparency and meaningful participation as decisions are made about the provision of healthcare in Penley.

The feedback contained in this report represents the views of 355 respondents to BCUHB's online survey, social media activity and a range of face-to-face engagement events, conversations and hard-copy submissions to the Health Board.

2. Background

The inpatient beds at Penley Hospital were temporarily closed in December 2024 due to concerns around the sustainability of the care model and ongoing staffing challenges. Historically, Penley has provided care for patients who are well enough to leave a main hospital but not yet ready to go home.

The number of patients suitable for this type of care has been limited, and ongoing difficulties with recruitment and reliance on temporary staff have made it increasingly difficult to deliver safe and sustainable care.

Since July last year (2025), conversations have been happening with the local community; reviewed the challenges, listened to what people tell us matters most, and have explored different scenarios for delivering care that is safe, high-quality and sustainable.

Whilst gathering input, two multi-stakeholder sessions ("Balanced Rooms") have also been carried out to support the development of options for the future of services that will be subject to formal public consultation following Board approval of their appropriateness as potential sustainable long-term solutions.

3. Legal duties for communications and engagement relating to service change

As a public body, Betsi Cadwaladr University Health Board must adhere to all legislation regarding the involvement of its population in the planning, development and delivery of services.

Guidance from the Welsh Government states that:
Section 183 of the National Health Service (Wales) Act 2006 requires local health boards (LHBs), with regard to services they provide or procure, to make arrangements to involve and consult current and prospective service users, or their representatives, on:

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

Section 242 of the National Health Service Act 2006 extends this requirement to NHS Trusts in Wales. For the purposes of this guidance, the Welsh Government considers that Llais is a body representing current and prospective service users.

Llais represents the interests of the public in relation to health and social services in Wales. The need to secure safe and sustainable services and access for all to best practice within available resources is equally of concern to the NHS and its users and something which the NHS in Wales must work with Llais to achieve. NHS bodies should therefore engage with Llais as it works to improve services.

4. Approach taken

A wide range of engagement and stakeholder involvement has been undertaken since the closure of the ward in 2023 and since July 2025 there has been a more focused engagement exercise with local residents, staff, and stakeholders.

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

Phase one (July 2025 to October 2025)

This phase of communications and engagement focused on:

- Listening to what matters to people — their priorities, concerns, ideas and experiences.
- Recording the feedback
- Raising awareness of the listening exercise, issues surrounding the temporary closure and opportunities to shape the future of local services.

This was done via the following activity:

- Social media and digital awareness raising:

  Website views: 1,257

  Penley social media posts raising awareness of the survey:

  Impressions (reached people's feeds): 58,239 times,

  Social media users interacted with the posts 285 times.

- A total of 347 completed surveys were received by BCUHB. No surveys were completed or received in Welsh.
- Reaching out to stakeholder groups for face-to-face conversations and support in awareness raising.
- 07.10.2025: Attendance at the Maelor South Community Council
- Monitoring of correspondence. Five separate enquiries have been received and responded to specifically relating to the changes to Penley Community Hospital and the process being undertaken during this time.

Emerging key themes from online and face to face feedback were presented at the first of the "Balanced Room" discussions for Penley on Friday 26th September 2025.

At the second Balanced Room event on Wednesday 29th October 2025, key identified stakeholders worked to define a shortlist of options that shaped further engagement from November 2025 to March 2026.

Phase Two (November 2025 to April 2026)

Phase two of the communications and engagement activity focused on raising awareness of and inviting feedback on the shortlist of options; explaining the work to develop the options and actively seeking feedback from those who have been involved throughout, those most affected (as outlined by the Integrated Equalities Impact Assessment), staff and the wider community.

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

The following engagement events took place:

- 18.11.25: Hanmer Community Council
- 25.11.25: November - Maelor South Community Council
- 08.12.25: Overton on Dee Council
- 12.01.26: Willington and Worthenbury Community Council
- 05.03.26: Lunch Club (Rainbow Foundation)
- 06.03.26: Day Clients (Rainbow Foundation)
- 12.03.26: Madras Primary School (Years 5 and 6)
- 17.03.26: Bangor on Dee Community Council
- 08.04.26: Hanmer Surgery

Regular communications with Llais remains ongoing with proactive updates being provided as well as their active involvement in the "Balanced Room" conversations.

5. Pre-consultation feedback

It is important to note that participation in requests for feedback is voluntary, with respondents often being self-selecting. Views collected may therefore not fully represent the broader patient or public population though efforts have been made to gather a broad range of views from the community of different ages and with differing health needs.

5.1 Phase one findings

Conversations on the future of Penley Hospital so far have revealed a deeply rooted and widespread community desire to retain but repurpose the facility as a hub for local healthcare. Across hundreds of responses residents, carers, healthcare professionals and former patients expressed a consistent message which was presented by one respondent as: "Penley Hospital is not just a building - it is a vital part of the region's health infrastructure, heritage and identity."

Local provision and accessibility emerged as the most dominant theme. Respondents repeatedly emphasised the importance of having healthcare services close to home, particularly in rural areas where transport is limited and public services are stretched. Penley's location was seen as ideal for serving the Wrexham County villages and surrounding communities; offering a more accessible and less intimidating alternative to large hospitals like the Wrexham Maelor.

Step-down and rehabilitation care was another key priority. Many respondents described Penley as perfectly suited for patients who are medically fit but not yet ready to return home. It was felt that a model like this may help alleviate bed-blocking at Wrexham Maelor Hospital, improve patient outcomes, and reduce pressure on acute services. The hospital's peaceful environment and familiar staff were credited with aiding recovery and providing dignified end-of-life care.

There was strong support for expanding Penley's role into a multi-functional community health hub. Suggestions included minor injuries units, outpatient clinics, physiotherapy, mental health support and integration with local GP practices and third sector partners. Respondents envisioned Penley as a place where holistic, person-centred care could thrive - especially for the elderly, disabled, and neurodivergent individuals.

Workforce and operational concerns were also raised. While some respondents shared negative experiences, the majority praised the dedication of Penley's staff and called for better support, training and retention strategies. Ideas included rotating placements, recruiting locally, and offering visa sponsorship to overseas workers.

Underlying many responses was a sense of frustration with centralisation and a perceived lack of strategic planning by the Health Board. The closure of Penley was seen as an example of broader issues within the NHS in Wales - overcrowded hospitals, delayed diagnoses and fragmented care. Respondents urged the Health Board to think creatively, consult meaningfully and invest in community-based solutions.

Finally, the historical significance of Penley Hospital was a recurring theme. Originally established to care for Polish war veterans, the feedback suggests that the hospital is

seen as a special place to many. Its closure was described not only as a loss of service but linked to a loss of community identity and heritage.

5.2 Phase two findings

Similar themes have occurred throughout the pre-consultation period with the more detailed face to face conversations revealing:

- **A strong desire for local health provision**

There is consistent support for:

- Using the Penley hospital building, rather than leaving it vacant or allowing deterioration
- Services that reduce the need to travel to Wrexham, particularly given reported poor public transport, traffic and road condition concerns and older population needs.

"Access for local people, to save trips into Wrexham."

- **There has been some frustration with lack of clarity and detail**

A dominant theme is a feeling of having insufficient information so, particularly regarding:

- What each option delivers
- Who will run services (NHS vs third party)
- Staffing, funding, and governance arrangements

"People need to understand more clearly what the issues are and future options would bring."

A lack of clarity could lead to uncertainty rather than informed choices and will need to be addressed during the consultation phase.

- **Strong support for NHS-led or NHS-involved models**

Many respondents:

- Expressed concern about privatisation
- Wanted reassurance that services would remain NHS-run or NHS-led

- Preferred models involving the Health Board alongside partners rather than full third-party control
- **Desire for exploring step-down, intermediate, and minor injury services**

Repeatedly mentioned desired services include:

- Minor Injuries Unit / walk-in centre
- Step-down beds / intermediate care
- Physiotherapy
- Blood donation services
- Outpatient and preventative services (e.g. balance classes)

These were seen as supporting independence and prevention which could in turn, reduce pressure on the Wrexham Maelor Hospital, prevent admissions and support older residents and their carers.

- **Transport, accessibility, and infrastructure concerns**

Key concerns include:

- Increased traffic if services expand
- Poor public transport and bus provision
- Road conditions around Penley
- Accessibility for rural residents and older people

These concerns were typically raised as conditions to support success, not reasons to reject proposals.

- **Desire for community benefit beyond older people**

Several respondents noted:

- Existing provision already focuses heavily on older residents
- A gap in services for younger generations and families
- A lack of spaces that bring the whole community together

“There should be something more focused on the whole community.”
“Nothing really brings Penley together.”

This was particularly relevant in face-to-face conversation with pupils at the local primary school who felt that there was a lack of community provision for all ages and who suggested wellbeing services that focused on community integration, a

"community kitchen" or hub offering health, wellbeing, mental health and fitness provision for all.

When asked about alternative service provision, suggestions from across all feedback included:

- Minor injuries / walk-in clinic
- Physiotherapy
- Blood donation
- Weight management
- Mental health and addiction support
- Mother and baby support
- Elderly care advice
- The provision of social prescribing and community wellbeing activities
- Help with forms, digital access, and navigating services

This reinforces a broad vision for Penley that goes beyond a single service type or reversion to the previous model.

6. Next steps

All feedback will be presented to the Health Board as part of a decision-making meeting on which options should be taken forward for formal consultation from the summer of 2026.

The information will be used to better inform the Health Board's approach to engagement, ensuring all protected characteristics are considered and heard from; particularly those as identified in the next phase of the Integrated Equalities Impact Assessment.

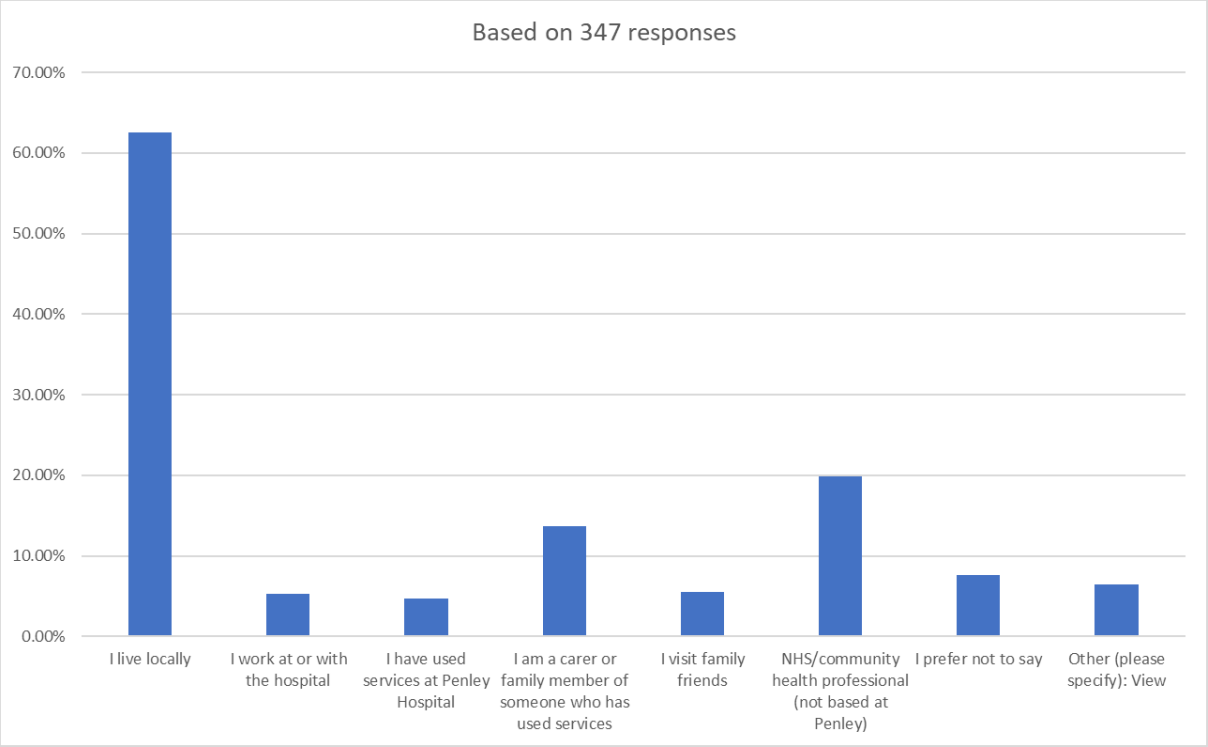
During the consultation phase, communications activity will build on the feedback, particularly around clarity concerns, and will take place across multiple channels to raise awareness of any proposals and ways in which to get involved.

7. Appendices

7.1 Question by question feedback from the Phase One survey

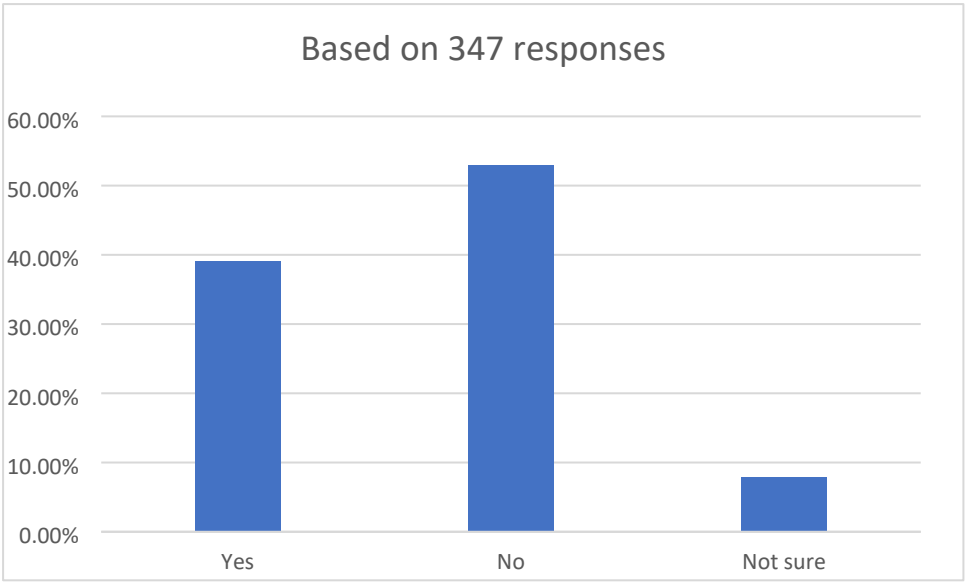
To note, key themes are ordered by frequency of mention.

1) What is your connection to Penley?

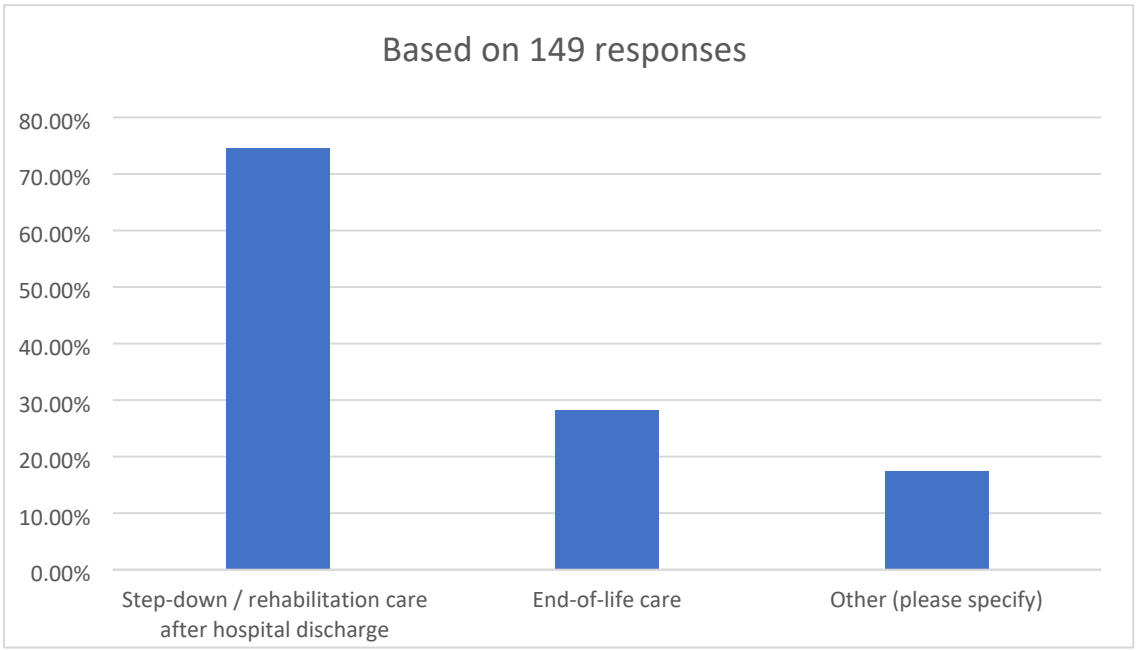


Note: all "other" responses are covered by the options available but some respondents chose to elaborate further.

2) Have you or someone you care for ever received care at Penley Hospital?

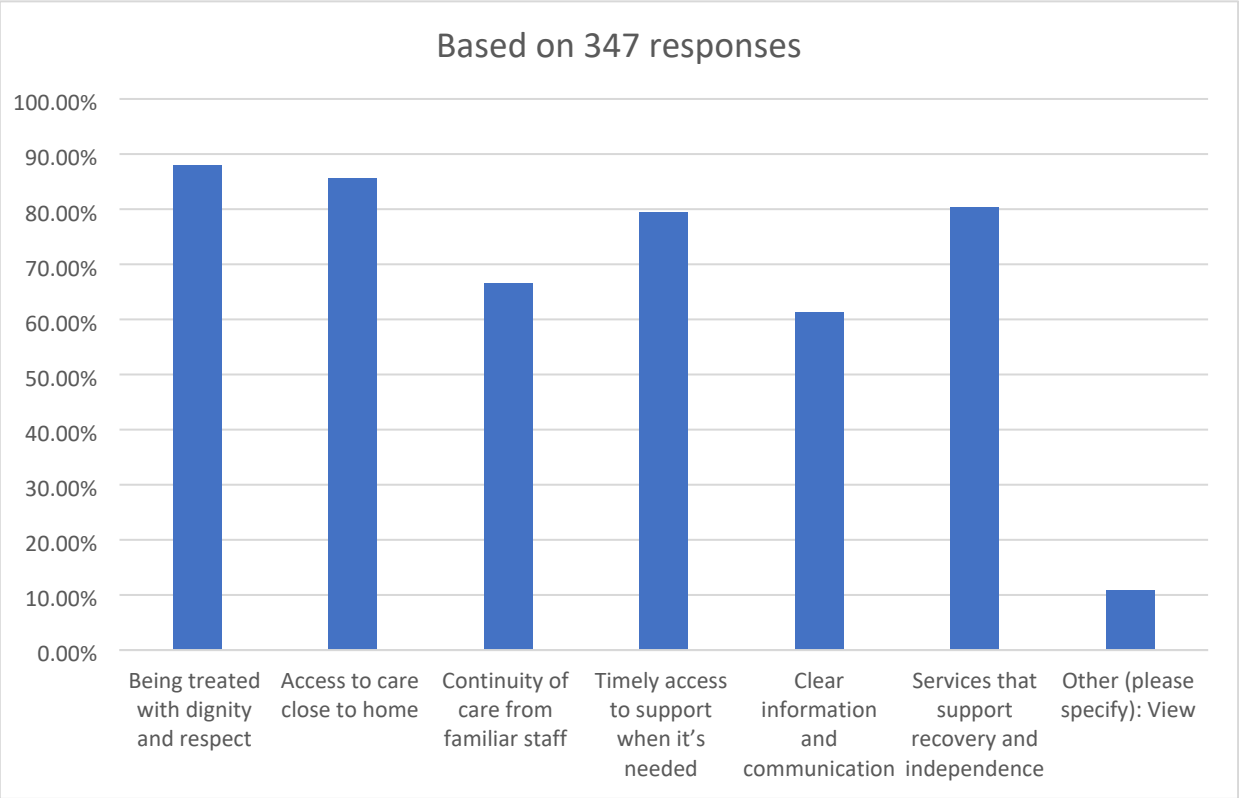


If yes, what type of care did you/the person receive?



The majority of "Other" responses were to highlight personal experiences of step-down care within the setting – some positive and some negative. Those with positive experiences praised this part of their care journey as being essential to recovery, those with negative cited long waits for discharge and care packages.

3) What matters most to you when accessing care in your local area? (Tick all that apply)



Those who chose "Other" cited the following themes most frequently:

- **Receiving high-quality, compassionate care from dedicated and caring staff**
- **Being close to home/Visiting loved ones easily**
- **Supporting elderly patients in familiar surroundings**
- **Reducing travel stress, especially in rural areas with limited transport**
- **End-of-Life and Hospice Care**
- **Rehabilitation and step-down services**
- **Avoiding overcrowded acute hospitals:** Wrexham Maelor Hospital was frequently mentioned in a negative context, with concerns about overcrowding, poor treatment, and lack of continuity. Community hospitals were viewed as a way to relieve pressure on acute services.
- **Sense of belonging and familiarity:** Being in a known and trusted environment was seen as vital for emotional wellbeing, especially for older adults. A local facility fosters a sense of safety and community.
- **Continuity and adaptable care:** Calls for care that adapts to people's situation - whether it's dignity at the end of life, independence during recovery, or continuity for chronic conditions.
- **Cross-border access and integration:** Some feedback calls for better links between Wales and England, especially for border communities who rely on services across both regions.

4) What would help you, your family or your community to stay well and supported locally?

Key themes from people's feedback are:

- **Local access to care:** There is a strong emphasis on having healthcare services close to home, especially in rural areas. People want to avoid long travel times to Wrexham Maelor and other distant hospitals and local facilities like Penley are seen as essential for maintaining independence and wellbeing.
- **Step-down and rehabilitation services:** Many respondents highlighted the need for intermediate care between hospital and home. Penley is viewed as ideal for recovery, reablement, and preventing hospital "bed-blocking."
- **Improved transport and accessibility:** Poor public transport is cited as a major barrier, especially for elderly and disabled residents. Calls for better bus services, circular routes, and easier access to clinics and GP surgeries.
- **Support for carers and families:** Carers need respite and practical support to manage their responsibilities with local care options reducing stress and allowing families to stay involved in loved ones' recovery.
- **Mental Health and Social Care:** Respondents requested more mental health services, neurodivergent-friendly support and social care provision. Integration between health and social services is seen as vital.
- **Minor Injuries and outpatient clinics:** Suggestions for walk-in centres, wound care, blood tests, and outpatient services at community hospitals. These would reduce pressure on A&E and improve timely access to care.
- **Continuity and quality of care:** People value familiar staff, personal attention, and a sense of community. Smaller hospitals are seen as more compassionate and less chaotic than large acute settings.
- **Community hubs and holistic support:** Ideas for multi-use facilities offering day centres, advice clinics, exercise groups, and social activities. The Rainbow Centre was frequently mentioned as a model for integrated community support.
- **Timely and coordinated services:** Respondents reported frustration with delays in appointments, diagnostics, and care packages. There is a desire for better communication between hospitals, GPs and social services.
- **Preserving local facilities:** There is a strong opposition to closing Penley Hospital with many seeing it as a vital resource that should be retained and repurposed to meet the evolving needs of the community.

5) What would you want the Health Board to consider when deciding on the future of services at Penley Hospital?

Key themes from people's feedback are:

- **The importance of local provision of care:** There is a strong and consistent message that services should remain close to home, especially for elderly and disabled residents. Penley Hospital is seen as a vital community asset, offering familiarity, dignity, and accessibility.
- **Step-down and rehabilitation services:** Many respondents advocated for Penley Hospital to be used as a step-down facility for patients discharged from Wrexham Maelor. Thoughts were that this would help reduce bed-blocking, support recovery, and ease pressure on acute services.
- **End-of-life and palliative care:** Penley Hospital was frequently described as ideal for end-of-life care, offering a peaceful and dignified environment. Families valued the ability to visit loved ones easily and felt the unit had previously provided compassionate, personalised care.
- **Workforce and staffing:** While workforce challenges were acknowledged, many felt these could be addressed through local recruitment, better support, and staff retention strategies. Several responses highlighted the dedication of local staff and the need to respect and retain local expertise.
- **Suggestions for alternative models of care, including:**

    - Nurse-led services
    - Minor injuries units
    - Outpatient clinics
    - Integration with a third sector partner – The Rainbow Centre for example is mentioned positively by local people
    - Hybrid models combining in-person and digital care

- **Transport and accessibility:** Poor public transport was a major concern, especially in rural areas. Penley's location was seen as more accessible than larger hospitals for many residents.
- **Recognition of community identity and heritage:** Penley Hospital holds historical significance, particularly for the Polish community. Many respondents expressed emotional attachment and a desire to preserve its legacy.
- **Joined-up thinking and system efficiency:** Calls for better co-ordination between primary, secondary and social care as well as respondents urging the Health Board to think strategically, avoid duplication, and use existing infrastructure wisely.
- **Increased mental health and social care support:** Several responses highlighted the need for neurodivergent-friendly services, mental health support and respite care. Integration with social care was seen as essential for continuity and recovery.
- **Economic and practical considerations:** Some respondents raised concerns about cost-effectiveness, value for money and sustainability. Others suggested using Penley for training, volunteering or shared staffing models.

7.2 Key themes from the Phase Two survey

Phase Two asked people to describe the perceived benefits and disadvantages of the options being further developed.

Commonly identified benefits include:

- Keeping the building in use
- Local access to care and advice
- Reduced pressure on:
    - GP surgeries
    - Emergency Departments ("A&E")
    - Acute hospitals
- Improved prevention, wellbeing, and early intervention
- Opportunity for better signposting and coordination of services

With positive feedback on any option that provided:

- Community hub models
- One-stop-shop approaches
- Preventative health and wellbeing services
- Co-location of health and social care advice

Commonly identified disadvantages of the emerging options discussed:

- Lack of detail
- Uncertainty around:
    - Staffing levels
    - Funding
    - Long-term sustainability
- Concerns about:
    - Third-party control
    - Gradual NHS withdrawal
    - Re-closure due to future funding gaps
- Physical limitations of the site (size)

Where disadvantages were stated as "none", this was often conditional on:

- Clear governance

- NHS involvement
- Proper planning and communication

Frequently raised points:

- Need for clear communication and promotion of any new services
- Importance of:
    - GP, nurse, and pharmacist engagement
    - Strong signposting and coordination
- Suggestion to:
    - Learn from other community hospital models
    - Engage frontline staff and voluntary sector in design

Several respondents emphasised the sentiment that, "Without good management, coordination, and visibility, even good services will fail."

Overall, there is strong opposition to leaving the building unused

- Concern about the building deteriorating beyond viable reuse
- Urgency in making a decision before refurbishment costs escalate
- Desire for transparency, realism, and honesty in future engagement

Overall sentiment

In summary, feedback shows:

- Strong local support for using Penley Community Hospital
- Clear preference for NHS-led or NHS-involved solutions
- Frustration with lack of detail, not with the principle of change
- A vision for Penley as:
    - A practical healthcare facility
    - A preventative and wellbeing hub
    - A community anchor for all ages

Respondents are not resistant to change, but ask for:

- Clarity
- Credibility
- Commitment
- Co-design with the community and frontline professionals

7.3 Overview of respondents

Pre-consultation activity attracted responses predominantly from individuals living in and around Wrexham, with a strong local connection to Penley Community Hospital. While a small number of responses were received from outside the immediate area, the dataset overall represents a highly local, community-informed perspective, particularly from residents likely to be affected by changes to Penley Community Hospital.

The equality and demographic questions were included to ensure the Health Board meets its legal duties in relation to Protected Characteristics and to assess whether responses reflect the whole population or highlight gaps in engagement. Where respondents selected "Other", this largely reflected questions about the relevance of collecting particular characteristics rather than unwillingness to engage.

Location of Respondents

Across the survey activity:

- Wrexham residents made up 87.02% of respondents.
- Smaller proportions were received from:
    - Flintshire (2.95%)
    - Denbighshire (2.06%)
    - Conwy (1.47%)
    - Gwynedd (1.18%)
    - Anglesey (0.29%)
    - Other (5.01%)

Most respondents selecting "Other" identified their location as Shropshire, reflecting cross-border connections.

This reinforces that the detailed qualitative feedback is rooted in direct lived experience of local services, transport, and access issues.

Ethnicity and National Identity

Across all respondents:

- British: 49.41%
- Welsh: 36.76%

- English: 6.76%
- Prefer not to say: 3.53%
- Other: 2.94%

Those selecting "Other" typically described themselves as European, Polish, or Asian, indicating some diversity but a predominantly White British/Welsh sample.

Age Profile

The overall consultation was heavily weighted toward older working-age and retired adults:

- 45–54 years: 22.39%
- 55–64 years: 27.16%
- 65–74 years: 17.31%
- 75+ years: 8.66%

Younger age groups weren't as prevalent:

- 16–24 years: 1.49%
- 25–34 years: 6.57%

Though a bespoke session was carried out within the local primary school to capture local youth voices in the development of options.

Within the Penley Part 2 responses:

- Ages ranged from 25–34 to 65–74
- Half of respondents were aged 55 and over

This strengthens confidence that much of the feedback reflects the views of people most likely to use community hospital, step-down, and outpatient services, while also indicating areas of focus and learning for the consultation phase.

Sex and Gender Identity

Across the whole dataset:

- Female: 79.06%
- Male: 17.11%
- Prefer not to say / Other: ~3.8%

Gender identity:

- 90.99% reported no change from sex assigned at birth
- 1.80% reported a change
- 7.21% preferred not to say

Sexual Orientation

Across all respondents:

- Heterosexual/Straight: 82.53%
- Prefer not to say: 12.05%
- Small proportions identifying as gay, lesbian, bisexual, or other

This suggests limited engagement from LGBTQ+ communities, though "prefer not to say" responses indicate some sensitivity around disclosure rather than absence.

Religion or Belief

Across the wider consultation:

- Christian (all denominations): 60.96%
- No religion: 26.73%
- Prefer not to say: 9.31%
- Small numbers identifying as Buddhist, Hindu, or Other

No specific equality impacts related to religion or belief were raised in the qualitative feedback.

Marriage / Civil Partnership

Across all respondents:

- Married or in a same-sex civil partnership: 61.49%
- Not married: 27.76%
- Prefer not to say: 10.75%

Disability and Caring Responsibilities

Disability

Across the activity:

- 16.32% identified as disabled
- 76.85% did not
- 6.82% preferred not to say

This is significant in the context of changes to community hospital provision and aligns to the Integrated Equalities Impact Assessment of needing to reach people living with long-term conditions.

Caring responsibilities

- 55.82% of respondents reported caring responsibilities
- Only 36.12% reported no caring role
- This directly influenced feedback around:
    - Transport
    - Accessibility
    - Step-down care
    - Local provision

Overall Interpretation of Respondent Profile

Taken together, the combined dataset shows that:

- **Responses largely reflect local, engaged, and affected communities**
- **The consultation successfully reached:**
    - Older adults
    - Carers
    - People with lived experience of health and access challenges

    All of which are groups identified for targeted reach within the Integrated Equalities Impact Assessment.

Further work in the consultation phase will take place to reach:

- Younger adults
- Non-British/Welsh population groups
- Men

7.4 Summary of questions raised in community council discussions (some questions are combined to avoid duplication)

- Why can't the hospital be reopened as it was to support pressure on acute hospitals
- Would community beds ease pressure on acute sites?
- What is being done to consider the aging rural population health needs?
- What services would/could be provided from a health and wellbeing hub?
- What is the area included in the scope for the provision of services from the hospital?
- If another organisation takes the lead on providing the health and wellbeing hub, what financial guarantees are there that it will be sustainable
- Wanted more information about what budget there was for services in the area
- Where does the money go if the hospital is sold?
- What services do other health and wellbeing hubs provide?
- What are the staffing/workforce issues?
- What is the process for engagement and decision making?
- Are you looking at best practice from other areas?
- What funding is available and will it change?
- Could private providers, such as a dentist or podiatrist, occupy space in the building?
- Have discussions with the GPs in Overton and Hanmer taken place?
- What is meant by the "third sector"?

Shaping the future of Penley Community Hospital – Service Change Quality Impact Assessment

Introduction

This Quality Impact Assessment evaluates how the temporary closure of Penley Community Hospital (December 2024) and any proposed future service changes may affect the Safe, Timely, Effective, Efficient, Equitable and Person-centred (STEEEP) Quality Standards of services provided to the Penley catchment area. Penley serves an ageing, rural population of approximately 6,477 residents, with a higher proportion of older people compared with wider Wrexham and Wales.

None of the three options proposed for further consideration include the reopening of inpatient beds at the Penley Community Hospital site, instead offering an increase in community service provision via integrated health and wellbeing hubs or increased community outreach services. The Quality Impact Assessment therefore focuses on the impact of a permanent closure of the inpatient beds against the proposed alternative community service provision across the three proposed options.

1 QUALITY IMPACT ASSESSMENT

1.1 Part 1: Health and Care Quality Standards assessment

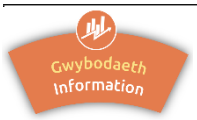
1a: Briefly outline how this proposal or strategic decision impacts on the delivery of healthcare services (in line with Safe, Timely, Effective, Efficient, Equitable and Person-centered (STEEEP) Quality Standards.				
Quality Standard *Click each icon for its definition*	**Overall Impact**			**Key points and rationale**
	Positive (+1) / Neutral / Negative (-1)	**Level of impact High (3) Medium (2) or Low (1)**	**Impact score (product of previous columns)**	
	1	2	2	Each of the proposed models (Integrated Hub, Third-Sector Hub, or Expanded Community Services) improve access to multidisciplinary professionals, reduce isolation of single-clinician working, and enhance clinical safety through clearer pathways and co-location or strengthened community teams. Redirecting services from an 8-bed unit that had sustainability and staffing safety issues improves overall patient safety by ensuring those requiring that inpatient care are placed in the most appropriate facility for their needs.

	1	2	2	Expanded community services and/or a local hub are designed to reduce delays in accessing routine community services such as physio, OT, mental health, wound care, falls management and antenatal clinics. Increasing local provision reduces the need to travel to Wrexham or other sites, improving timeliness of care.
	1	3	3	The options promote effective care by integrating multiple disciplines, improving coordination, reducing fragmentation, and supporting early intervention and prevention. The hub and community models target conditions such as frailty, chronic disease and mental health, which benefit from a multidisciplinary and multi-agency approach.
	1	2	2	All three-options show revenue affordability with the potential for surpluses in Option 2 and Option 3. Resources would be redirected away from an underused inpatient ward (average of 6 patients) to higher-benefit services for a larger population. Shared infrastructure increases efficiency, and community delivery reduces unnecessary acute utilisation.
	1	2	2	The options are explicitly designed to bring services closer to rural populations such as Penley, Bronington, Overton, and Hanmer. Although one LSOA has moderate deprivation, the shift toward community-based provision reduces barriers for low-income groups and improves equity of access across the South Wrexham area.

	1	3	3	All options emphasise holistic, person-centred care through prevention, community delivery, social prescribing, mental health support, and voluntary-sector involvement. Options 1 and 2 explicitly include wellbeing activities, social connection, counselling, and peer support, which strongly align with person-centred models. Option 3 is also focused on providing care within a person's home.
Overall impact	Overall, the impact of the proposed options is positive, with benefits highest in the Effective and Person-Centred domains. The level of overall impact is Medium to High, reflecting improvements to access, coordination, safety and overall patient experience. No domains are negatively impacted, and risks associated with the former inpatient unit (safety, staffing, sustainability) are mitigated through more robust models of care.			

1b: Briefly outline the amount of activity required to ensure successful implementation of the proposal or strategic decision (in line with enabling Quality Standards)

Quality Standard *Click each icon for its definition*	**Amount of activity required High (3), Medium (2) or Low (1)**	**Key points and actions to achieve the changes required**
	2	Effective leadership is required to co-design pathways with health, social care and third-sector partners, manage potential building redesign (Option 1/2), and ensure governance structures support integrated delivery.
	3	Workforce redesign is prevalent across all options, involving redistribution from inpatient roles to community posts, MDT expansion, and potential third-sector workforce coordination. Recruitment challenges in rural areas must be managed.
	2	Cultural change is required to shift from a bed-based model to community and preventative care. Feedback from the pre-engagement phase emphasises community desire to retain but repurpose the physical building for services that would be of greater benefit to the local population

	2	Digital and IT upgrades would be required, particularly in Options 1 and 2 (network upgrades, telephony, swipe access, wireless improvements). Clear communication with the public and partners is essential around services being provided.
	1	Routine quality monitoring and evaluation will be necessary with potential opportunities for service improvement through data collection on community outcomes.
	3	All options involve multi-agency working across primary care, community health, mental health, voluntary sector and social care. This enhances system integration and supports prevention and early intervention which could in turn reduce burden on secondary care.
Overall amount of activity required	The overall activity required to achieve the proposed change is **Medium to High**. Workforce redesign, IT upgrades, new pathways, partnership development and possible building reconfiguration all represent change. The activity level varies by option. Option 3 would require the least activity in order to mobilise/maintain as there will be no requirement for IT upgrades and building reconfiguration. However there will still be an element of activity in relation to the decommissioning of the building in addition to an initial governance change and workforce transformation.	

Part 2: High-level consideration of risk

Considering responses on all twelve Health and Care Quality Standards in Part 1, what level of risk to **Quality overall** is this proposal or strategic decision?

Level of risk to Quality of implementing this proposal	**Low**	**Low/medium**	**Medium**	**Medium/high**	**High**

Level of risk to Quality of **NOT** implementing this proposal	**Low**	**Low/medium**	**Medium**	**Medium/high**	**High**

Describe the main risks to Quality of implementing this proposal?

- Workforce recruitment challenges for community and MDT roles.
- Need for capital upgrades (IT, estates) in Options 1 and 2.
- Transition risks during implementation (service disruption, communications gaps).
- Long-term third-sector sustainability risks in Option 2.

Describe the main risks to Quality of NOT implementing this proposal?

- Continuation of an unsustainable inpatient model with workforce safety risks.
- Failure to meet population health needs and prevent avoidable admissions.
- Loss of opportunity to reinvest funding into community care (Options 2 and 3).
- Reputational risk due to failing to respond to engagement feedback.
- Ongoing estate costs with no service benefit.

Part 3: Option by Option assessment summaries

Quality Domain (STEEEP)	Option 1: Integrated NHS-Led Hub	Option 2: Third-Sector Led Hub	Option 3: Community Services (No Building)
Safe	**1 (Medium impact)** Safer than inpatient model; strong MDT on-site reduces single-clinician risk.	**1 (Medium)** Enhanced local clinics + wellbeing support; relies on robust governance.	**1 (Medium)** Home-based care reduces inpatient risk; needs strong coordination.
Timely	**1 (Medium)** Local outpatient and preventative services reduce waiting and travel time.	**1 (Medium)** Accessible drop-ins, wellbeing support; fewer delays accessing community services.	**1 (High)** Home visits increase timeliness and avoid travel-related delays.
Effective	**1 (High)** Strong MDT model; early intervention & prevention.	**1 (High)** Third-sector strengths in prevention, wellbeing, rehab.	**1 (Medium)** Effective for independence & chronic disease management, reliant on workforce capacity.
Efficient	**1 (Medium)** Affordable; shared infrastructure; replaces underused inpatient unit.	**1 (Medium)** Large revenue surplus for reinvestment; cost-effective model.	**1 (High)** Most efficient; avoids building costs; £31k surplus.
Equitable	**1 (Medium)** Improves access in rural areas; multiple services available locally.	**1 (Medium)** Third-sector strengths in engaging isolated/vulnerable groups.	**1 (Medium)** Home delivery of care improves equity in rural areas.
Person-Centred	**1 (High)** Increased access to social prescribing, counselling, wellbeing support.	**1 (High)** Strong person-centred offer though a community-owned, holistic model.	**1 (High)** Care delivered directly at home; personalised and holistic.
Overall assessment	**Positive (Medium-High)** – Strong MDT working, improved access to	**Positive (High) –** Similar to Option 1, person-centred with a strong focus on wellbeing, prevention,	**Positive (High) –** Timely, equitable and efficient, promoting

	care closer to home and prevention-focused.	and accessibility of care.	independence and localised support.

Enabling Activity Level per Option

Enabling Standard	Option 1: Integrated Hub	Option 2: Third-Sector Hub	Option 3: Community Model
Leadership	**Medium –** Multi-agency governance and building redesign.	**Medium –** Shared governance between NHS & third sector.	**Medium –** Coordination across District Nursing, Community Teams, Home First and Mental Health liaison.
Workforce	**High –** Most diverse workforce model; recruitment challenges.	**High –** Mix of NHS and third-sector roles; large mobilisation.	**High –** Largest shift into community roles; potential for rural recruitment risk.
Culture	**Medium –** Shifts expectations from inpatient unit to hub model.	**Medium –** Community-led ethos requires cultural shift.	**Medium –** Biggest cultural change away from building-based identity. There is strong community affiliation with the history of Penley Community Hospital and a reported desire to retain this.
Information	**Medium –**IT/estates upgrades needed.	**Medium –** IT needs potentially lower than Option 1 but still necessary.	**Low –** Mostly mobile equipment for community staff; no estate upgrades.
Learning, Improvement and Research	**Medium** - Improvement around co-production of local services to meet population need, using population health needs assessment outlined within case for change as basis for improvement	**Medium** - Learning and improvement around partnership working with the third sector	Potential for learning around monitoring the prevention of acute admissions and patients being treated within their own home

Whole-System Approach	**High –** Brings statutory, voluntary and social care together.	**High –** Most cross-sector collaboration.	**High –** Integrates community teams with potential for increased liaison needs between primary and secondary care.
Overall enabling activity	**Medium–High** Initial workforce, estates and IT requirements.	**Medium–High** High workforce change; moderate digital/estate requirements).	**Medium – High** Changed workforce model. Estates implications as to the permanent closure of the building and next steps.

High-level Risk per Option

Risk Type	Option 1: Integrated Hub	Option 2: Third-Sector Hub	Option 3: Community Model
Risk of Implementing	Estates and IT changes. Changes to workforce. Potential for increased travel for inpatient care.	Dependency on third-sector stability. Potential for increased travel for inpatient care.	Workforce changes and rural recruitment challenges. Potential increased travel for inpatient care.
Risk of not implementing	Unsafe/unviable inpatient model persists; lost opportunity for modernisation.	Loss of reinvestment opportunity, partnership working and increased prevention capacity.	Rural communities continue to face access barriers and no expansion of home-based services preventing acute admittance.

Penley Community Service Change

Integrated Equality Assessment

Version 0.9: Presented to Service Change Oversight Group in January 2026. Working draft to inform consultation preparation.

Evidencing Due Regard - Equality Impact Assessment form

These assessments will help to gather and record evidence of due regard to the equality duties. The key purpose to purpose is to provide evidence that the Health Board's decisions are compliant with **statutory requirements for the** Public Sector Equality Duty, Socio-economic Duty, Welsh Language Duty, Human Rights Act and Armed Forces Covenant. See the Equality BetsiNet pages for support.

Step 1

Complete Part A

Section 1

- General Information
- Which Assessments are Required
- Links to BCUHB Values and Strategic Equality Objectives
- Wellbeing of Future Generations

Section 2 – Evidence to support assessment

a. Record of Engagement and Consultation activity
b. Additional information

Complete Step 2 and 3 if required.

Format as Arial 12 black font.

Step 2

Complete Part B – Equality Impact Assessment (EqIA)

Section 1 - Equality Impact

Section 2 - Human Rights

Section 3 – Armed Forces Due Regard

Section 4 - Welsh Language

Section 5 - Assurance for Compliance

Section 6 – EQIA Action Plan

Section 7 – Equality Risks

Section 8 – Sign Off

[Guidance]

Step 3

Complete Part C - Socio-economic Impact Assessment (SEIA)

Section 1 - Assessment information

Section 2 - Impacts on Socio-economic Duty Domain Areas

Section 3 – SEIA Action plan

Section 4 – Sign Off

[Guidance]

Version Control

Version	Date	Author	Rationale
0.1	20.8.25	Andrea Hughes	First signed off version for review by Oversight Group
0.2	22.9.25	Steve Dooré	Updated after review by working group to reflect updated Issues Paper and review and comments from Independent Strategic Adviser.
0.3	25/11/25	Steve Dooré	Updated to reflect equality issues raised through Balanced Room 1, Balanced Room 2 and Engagement Phase 1.
0.4	28/11/25	Steve Dooré	Updated to include Issues Paper
0.5	28/11/25	Steve Dooré	referencing and proofing, and advice from independent advisors
0.6	5/12/25	Steve Dooré	Final proofing in preparation for impact assessment options workshops
0.7	10/12/25	Steve Dooré	Inclusion of analysis templates in PC sections
0.8	20/12/25	Steve Dooré	Completion of analysis sections in Parts B and C after holding workshops
0.9	24/12/25	Steve Dooré	Updated Action Plan

Part A – Information on assessment work required

Section 1 – General information

Title: Penley Hospital Inpatient Service Redesign
Assessment Lead: Andrea Hughes, IHC Director of Nursing
Who has been involved in undertaking this equality assessment: Steve Dooré (Equality and Inclusion Manager), Wendy Hooson (Head of Health Strategy & Planning), Andrea Hughes, Ryan Welch (Lead Manager, Community Services) , Erin Humphreys (Associate Director of Nursing, East), Kristy Ross, Andy Wright (Independent Strategic Adviser), Lucy Reid (Deputy Head of Community Nursing)

Quick guide on what assessments are required: This section will help guide you to which assessments are required for your proposal.

Types of decision being assessed:	**What is being assessed?** please tick the one which applies ✓	**EQIA Required** [Part B]	**SEIA Required** [Part C]
Strategic policy development with strategic directive and intent, including those developed at Regional Partnership Boards and Public Service Boards which impact on a public bodies functions		✓	✓
Health Board Wide Plans. Medium to long term plans (for example, corporate plans, development plans, service delivery and improvement plans)		✓	✓
Business Case/Capital Involvement/Options Appraisal required		✓	✓
Setting objectives (for example, well-being objectives, equality objectives, Welsh language strategy)		✓	✓
Changes to and development of public services/Closure of Services	✓	✓	✓
Decisions affecting service users, employees or the wider community including (de)commissioning or revised services		✓	✓
Efficiency or saving proposals, e.g., resulting in a change in community facilities, activities, support or employment opportunities		✓	✓
Directorate Financial Planning		✓	✓

Divisional policies and procedures affecting staff		✓	
New policies, procedures or practices that affect service delivery		✓	
Large Scale Public Events		✓	
Major procurement and commissioning decisions		✓	✓
Local implementation of National Strategy/Plans/Legislation (e.g. vaccination programme)		✓	✓
Other – please state (seek advice if not sure what assessments are required)			

Equality Impact Assessment	**Socio-economic Impact Assessment**
Start date: 9/6/25 Completed date: tbc	Start date: 9/6/25 Completed date: tbc
If not undertaking EqIA state reason: N/A	**If not undertaking SEIA state reason:** N/A
Please complete the rest of this section if EQIA / SEIA is required.	
Summary of the purpose and aims of the decision / service / policy / function / change being assessed: The Health Board is undertaking a review of the current service provision in the Penley area with a view to developing a variety of options to provide a suitable, equitable and sustainable service model for the future. The aim is to improve health, provide safe services and deliver the best possible standards of care to the local population of Penley and the surrounding area ensuring a sustainable service model. The assessment acknowledges that there are other statutory and regulatory pressures that are considered elsewhere. This assessment is focussed on compliance with the Public Sector Equality Duty and Socio-economic Duty.	

Links to BCUHB values Indicate any values that relate to the decision / service / policy / function / change being assessed.

		
Compassion	**Openness**	**Respect**
✓	✓	✓

Links to BCUHB Equality Objectives 2024-2028

The health board published Achieving Equity: Strategic Equality Plan (SEP) in 2024, for the period 2024-2028. Please indicate which objectives align for this decision / service / policy / function / change being assessed.

Strategic Equality Objective	Alignment
• Objective A: Achieving equity by working in partnership – 'nothing about you without you'	✓
• Objective B: Achieving equity by providing high quality inclusive services	✓
• Objective C: Achieving equity through Governance and Accountability	✓
• Objective D: Achieving equity by being a kind and compassionate organisation	✓
• Objective E: Achieving equity by innovation	✓

Well-being of Future Generations (WFG)
Indicate any goals of the WFG Act that are being considered within the decision / service / policy / function / change being assessed.
please tick the one which applies ✓

A Prosperous Wales	 A Resilient Wales	 A More Equal Wales	 A Healthier Wales	 A Wales of Cohesive Communities	 A Wales of Vibrant Culture & Thriving Welsh Language	 A Globally Responsible Wales
		✓	✓	✓		

A Healthier Wales: A society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood.

- The aim of the service change programme is to provide the best and most sustainable healthcare offer to the local population.

A More Equal Wales: A society that enables people to fulfil their potential no matter what their background or circumstances (including their socio-economic background and circumstances).

- The programme has equity at its heart, evidenced by the inclusion of essential criteria of "access and inclusion" at the options appraisal stage. The assessment will evidence significant efforts to engage with a diverse and representative stakeholder set.

A Healthier Wales: A society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood.

- The programme aims to design a sustainable, local healthcare solution that best fits the population of the area and their needs.

A Wales of Cohesive Communities: Attractive, viable, safe and well-connected communities.

- A local, sustainable and equitable healthcare model is a key foundation of a viable, safe and well-connected communities, providing connections, employment and community spaces in the local area.

Given the high profile and sensitive nature of the service change it is a recommendation of this Integrated Equality Assessment that the Well-being of Future Generations Commissioner is consulted with as part of the Engagement and Consultation Plans.

Is the decision / service / policy / function / change being assessed related to, or influenced by, other Policies or areas of work? This decision takes place within the context of the Health Board's Three-Year Plan and aligns to the Health Board's long-term objectives. The aims of the programme align directly with the Health Board's Strategic Objective 2: **Developing strategy and long-lasting change** Objective area 2 draws upon the need for the Health Board to be clear about population needs in North Wales and that services are configured in a way to get the highest value from the resources available to us. In this way the Health Board can provide services that are reliable, more cost-effective, and that make the best use of healthcare professionals
Governance Route for this assessment and Executive Sponsor (usually Director level): please state which Committee / Board will scrutinise and approve this assessment: This Integrated Equality Assessment will be signed-off by the Service Change Oversight Group.

Section 2 - Evidence to support assessment

a. Record of Engagement and Consultation

The drive towards closer integration of health and social services with improved public engagement is reflected in the aims of A Healthier Wales. This sets out the goal of ensuring citizens are placed at the heart of a whole-system approach to health and social care services and stresses the importance of listening to all voices through continual engagement.

a. What steps have you taken, or planned in order to engage and consult with people who share protected characteristics and how have you done this? Include consideration for co-design.

1. Steering Group Briefing

In July 2025 a briefing was presented to the Service Change Oversight Group with the following recommendations:

- Ensure that an evaluation of the impact of the initial closure of the beds is comprehensive and informed by lived experience and high-risk groups.
- Adopt the principle that Integrated Equality Assessments (including EqIA, Socio-economic Impact Assessment, Carers, Human Rights and Welsh Language Impact Assessment) are to be undertaken as part of the work programme and in such a way as to meet the Brown Principles as outlined above.
- Identify key decision points and other milestones where the Impact Assessment requires updating and inclusive and representative stakeholder involvement is necessary.
- Use the Achieving Equity in Decision Making Toolkit to guide the development of the service changes.
- Ensure all key decisions are taken in compliance with the “balanced room” model, including focused facilitated conversations with specific high-risk groups including disabled people, older people, Welsh Language speakers and carers.
- Ensure key equality groups are included in Stakeholder Mapping and Consultation and Engagement Plans.

2. Engagement Report

Phase one (July 2025 to October 2025)
This phase of communications and engagement focused on listening to what matters to people - their priorities, concerns, ideas and experiences, recording the feedback, raising awareness of the listening exercise, issues surrounding the temporary closure and opportunities to shape the future of local services.

- **Website:** There were 1,257 views of the website carrying the information.
- **Social media:** There were 58,239 impressions (reached people's feeds) and social media users interacted with the posts 285 times.
- **Survey**: A total of 347 completed surveys were received by BCUHB. No surveys were completed or received in Welsh.
- **Face-to-Face Sessions:** Reaching out to stakeholder groups for face-to-face conversations and support in awareness raising.
  - 07.10.2025 Attendance at the Maelor South Community Council

Five separate enquiries have been received and responded to specifically relating to the changes to Penley Community Hospital and the process being undertaken during this time.

3. Balanced Room Process

Balanced Room 1

Emerging key themes from online and face to face feedback were presented at the first of the “Balanced Room” discussions for Penley on Friday 26th September 2025. The outcomes of the first Balanced Room will enable more detailed information to be available to support discussions at the second Balanced Room event on Wednesday 29th October 2025, where key identified stakeholders will work to define a shortlist of options, or a preferred option that will shape further engagement throughout November 2025.

The first “Balanced Room” stakeholder session took place on 26th September 2025. During this day-long event, participants:

- generated a long list of creative options for future services.
- reduced the long list to a medium list using agreed essential criteria which included quality and safety, efficiency and effectiveness, deliverability, sustainability, accessibility and inclusion.
- reviewed and clustered ideas into clear “option families”.
- validated the output with participants in the room, ensuring that all perspectives were considered.

The criteria against which the options generated were to be appraised are shown in the table below.

Criteria	Test
Quality and Safety Services meet standards, minimise risk to patients and patients have a good experience.	Can the option provide safe, evidence-based care with sufficient registered staff, maintaining or improving outcomes and patient experience?
Efficiency and Effectiveness • Efficiency - Ability to do things well and without waste. • Effectiveness – the extent to which desired outcomes or results are achieved.	Can the option deliver services efficiently, following effective clinical pathways and achieve intended outcomes?
Deliverability That we can actually deliver what we say we will.	Is the option realistically achievable with available resources (e.g. finance, people) and within a reasonable timeframe?
Sustainability Ability to manage risk and adapt over time.	Can the option be maintained over time, adapting to workforce, demographic and technological changes, while supporting recruitment and retention?
Accessibility and Inclusion Services are equally available and accessible to all.	Does this option avoid creating extra obstacles for these groups in accessing healthcare?

Participants

Participation in the event was recruited based on creating a 'balanced room.' The balanced room approach ensures that a diverse mix of perspectives is represented when developing and appraising Scenarios. Rather than allowing one group or viewpoint to dominate, participants are selected to reflect different stakeholder interests, levels of influence, and lived experience. This creates a fairer, more transparent process where evidence, values, and practical considerations are weighed collectively. The aim is not consensus at all costs, but a balanced discussion that tests assumptions, highlights trade-offs, and strengthens the legitimacy of the final outcomes. The participants were in three broad categories:

- **Voting participants:** a mix of stakeholders and representatives of BCUHB, all of whom have equal voice and vote in deliberations.
- **Expert participants:** representatives of BCUHB on hand to provide expert opinion and input to deliberations.
- **Facilitation team:** the team who enabled discussions without taking part in decision making.

During this session the main themes of the desktop analysis in this Integrated Equality Assessment were presented to the group. This included highlighting the following high-risk groups:

- Older people
- Disabled People
- Race/Ethnicity
- Carers
- People living in low-income households
- People living in rural areas

The analysis that led to these groups being identified can be found in “Part B: Equality Impact Assessment with Human Rights”.

Emerging Options

This exercise produced seven developed scenarios for assessment which reflect different approaches to balancing local needs, resources, and system priorities. In summary, these scenarios are:

1. **Health and Wellbeing Hub (Integrated)** – repurposing the hospital as a multi-professional hub where health, social care and potentially voluntary sector teams co-locate. The aim is to improve access to outpatient and preventative services closer to home, reducing travel and creating a focal point for care in Penley.
2. **Rehab / Step-down Facility with Beds** – restoring a bed-based function at Penley, focused on rehabilitation, step-down care from acute hospitals and possibly end-of-life support. This reflects community concerns about travel distances and the need for local recovery and respite beds.
3. **Health and Wellbeing Hub plus Third Sector Facility** – combining the integrated hub model with a more explicit role for third-sector partners. The proposal builds on existing strengths in the local voluntary sector to deliver health, wellbeing and social support alongside NHS-led services.
4. **Services in the Community (No Physical Building)** – redirecting resources away from maintaining a fixed site and investing instead in outreach and home-based services. This model prioritises flexibility and a “care closer to home” approach but carries risks if funding and workforce are not secured locally.
5. **GP Surgery** – using the building as a GP surgery, either as a new practice or as a branch of nearby practices. This option reflects public appetite for more accessible primary care, though feasibility depends on provider interest and patient demand.
6. **Care Home / Assisted Living** – converting the hospital into a care home or assisted living facility, providing supported accommodation for older people or those with additional needs. While this could address social care gaps, it raises questions about regulatory standards, capital investment, and whether it aligns with NHS priorities.
7. **Care Homes Providing Bed-Based Care** – meeting local demand through partnerships with existing care homes in the area, rather than re-using the Penley site directly. This option could expand capacity but has limitations around quality, inclusion, and whether it delivers the rehabilitative care that residents value.

Balanced Room 1: Access and Inclusion Criteria: Scenario Analysis

- Scenario 1: Health and Wellbeing Hub (Integrated): Passed all criteria.

  - This Scenario scored highly on access. By design, an integrated hub would provide a "broader range of the population" with local servicesfile://file_000000002a306246b26fbecf7269944e/. Bringing care into Penley (and offering outreach) directly targets the needs of older, rural residents noted in the longlisting. If well-promoted, it should improve equity – for example by hosting community nurses and therapists in the same building. One caveat is ensuring physical access: the hub location and any parking or transport arrangements must be suitable for less mobile or non-driving patients. Participants stressed that the design should consider deprived groups and those without internet, so the hub should be welcoming and well-signposted for all.

- Scenario 2: Rehab/Step-down Facility with Beds: Passed all criteria.

  - A local rehab facility scores well for access by definition – it brings care closer to patients who would otherwise have to travel out of area. Almost all participants saw this as an inclusive gain (easing family visits and reducing travel burden). The notes affirm it passed accessibility criteria without caveat. The only concern would be if beds fill up or are only for certain groups. In fact, scribes noted the unit should serve all ages, not just frail elderlyfile://file_000000002a306246b26fbecf7269944e/, to maximise use. If properly commissioned, the facility should help vulnerable older and disabled people access step-down care without distant travel, aligning with community needs.

- Scenario 3: Health and Wellbeing Hub plus Third Sector Facility: Passed all criteria.

  - As with Scenario 1, this model is very inclusive. By combining healthcare and community support in one place, it can reach people who might fall through the cracks. In workshops the hub-plus-third-sector idea was seen as highly accessible, reaching those most in need (elderly, disabled, isolated). The only caveat is, again, stability: if third-sector services were cut, some support groups might vanish. But in principle, this Scenario should improve access to health and social services for deprived or hard-to-reach residents.

- Scenario 4: Services in the Community (No Building): Passed all criteria.

  - Without a local building, access could paradoxically worsen. All services would be "in the community," meaning people might rely on home visits or having to travel to scattered clinics. Workshop notes warn this is a high-risk scenario: if not carefully managed, it might "leave the community with less/fewer services"file://file_000000002a306246b26fbecf7269944e/. On the plus side, some outreach services (e.g. mobile clinics or visits) can be very inclusive, reaching housebound patients. But there are inclusion challenges: rural patients already struggle with transport, so having no central hub means fewer drop-in options. In

conclusion, community-based care is accessible in principle, but it must be very well funded and organised to avoid inadvertently reducing access for vulnerable groups.

- Scenario 5: GP Surgery: Failed on the basis of Access and Inclusion.

  - A local GP would in theory improve inclusion by reaching homebound or immobile residents. The idea of not having to travel for routine appointments was noted as desirable. Yet, because the plan was rejected, patients must continue going to Overton or Hanmer. So, in effect, this Scenario as considered does not improve accessibility. The only potential model left (a satellite clinic) would have limited hours and only modest impact. Thus, while a GP presence was a popular idea at the outset, the workshops suggest it is not a viable path to better access.

- Scenario 6: Care Home / Assisted Living: Failed on other criteria

  - This model would target older or disabled residents needing support, which aligns with community needs. In theory, it would help some people stay in Penley. However, because it was deemed unworkable, it offers no actual improvement in access. Moreover, if it had proceeded, the type of occupants would likely be older pensioners, meaning younger or ambulant disabled people might be excluded. Participants did not specifically note inclusion for this Scenario beyond the viability issues, but one implication is that by converting to housing, the facility might exclude acute or rehabilitation patients. Ultimately, since it was rejected, no real accessibility benefits would materialise.

- Scenario 7: Care Homes Providing Bed-Based Care (Removed on criteria including access and inclusion)

  - Participants explicitly noted this model would compromise accessibility. Few people would benefit – only those accepted by the contracted homes – and those homes may not be near Penley. The notes say it would benefit "a limited number of people" and that simply "keeping [someone] in a bed but not providing the rehab needed would not be beneficial". In other words, it does not solve the accessibility issue for the broader community. Most community members would have to continue travelling for care, so inclusion goals would not be met.

Following appraisal against the agreed essential criteria, four scenarios were assessed as meeting the minimum standards required to proceed. Each carried important caveats but was judged feasible in principle:

1. **Health and Wellbeing Hub (Integrated)**
   - Passed all criteria, seen as a strong model for co-locating multi-professional services.
   - Caveats: depends on which services are included, sufficient workforce availability, and clarity on estates investment.

2. **Rehab / Step-down Facility with Beds**

- Passed all criteria, reflecting strong local support for bed-based rehabilitation and step-down care.
- Caveats: quality and deliverability depend on the number and type of beds, and on securing adequate therapy and nursing staff.

3. **Health and Wellbeing Hub plus Third Sector Facility**
   - Passed all criteria, extending the hub concept by embedding voluntary sector organisations alongside NHS provision.
   - Caveats: sustainability may be vulnerable to fluctuations in third-sector funding and staffing.

4. **Services in the Community (No Physical Building)**
   - Passed all criteria in principle, offering flexible outreach and home-based care instead of a fixed hospital site.
   - Caveats: high risk if long-term funding is not ringfenced locally; could leave the community with fewer services if resources are diverted elsewhere.

Balanced Room 2

The workshop was convened by Betsi Cadwaladr University Health Board (BCUHB) and held at Ruabon Village Hall, on the 29th of October 2025. The discussion involved local community representatives, healthcare staff, and officials, focusing on future options for the Penley facility and services in South Wrexham. All participants emphasised the need for any solution to address wider system challenges, meet the needs of a largely rural and ageing population, and be sustainable for the future.

Following small group collaborative discussions, a consensus session produced six ‘desirable’ criteria for evaluating service options to meet Penley’s community needs. These principles guided objective assessment of each option, leading to scoring and to select the most promising approaches for further development and public engagement.

The desirable criteria developed in the consensus discussions in the session were as follows.

1. **Sustainability and System Resilience:**
   a. Reduce pressures on the system.
   b. Future proof (avoid commissioning failure, not papering over the cracks.)
   c. Ensure there is a demand for the proposed services (including forecast demand.)
   d. Workforce recruitment, retention, development (applies to all.)
   e. Incorporates existing service delivery in the area.
   f. Improve access to outpatient services e.g. physiotherapy (as much as possible).

2. **Prevention and Community Support:**
    a. Support prevention agenda.
    b. Support carers.
    c. Help keep people at home / get home as soon as possible.
    d. Support local GP services – do not forget sustainability of local GP services in development / take account of GP referrals.
    e. Build on coordinate with existing service – avoid duplication.
    f. Take advantage of/work with existing assets in the area (thinking about their sustainability).
    g. Enable co-location of wellbeing services.
    h. Provides a community resource.

3. **Accessibility and Travel:**
    a. Accessibility of the site.
    b. Reduce burden on people having to travel (patients/staff/carers/family).

4. **Safety and Security:**
    - Safety and security of staff/patients/visitors.

5. **Clinical Outcomes:**
    - Improved patient outcomes.

6. **Patient Experience:**
    - Improve patient experience.

    NB: These criterion were developed by grouping the individual ideas and thoughts provided by each of the small groups into thematic clusters. The individual ideas are shown in the bullet points below the main criteria.

Participants were then asked to provide an individual view of the relative weight of each criterion via an online system. The results of this, while close, show that Prevention and Community Support and Clinical Outcomes are viewed as highest priority for consideration, with Safety and Security seen as lowest priority.

Criterion	Weight (%)
Criterion 1 Sustainability and System Resilience	16.7%
Criterion 2 Prevention and Community Support	17.2%
Criterion 3 Accessibility and Travel	16.3%
Criterion 4 Safety and Security	16.0%
Criterion 5 Clinical Outcomes	17.2%
Criterion 6 Patient Experience	16.4%

After extensive discussion, stakeholders reached a broad consensus on which service options should be taken forward for further development and public engagement. In the scenario appraisal exercise, four options (A, B, C, D) were considered. While the details of each option were not exhaustively discussed in the notes, the general outlines were:

A. **Health and Wellbeing Hub (Integrated)**: repurposing the hospital as a multi-professional hub where health, social care and potentially voluntary sector teams co-locate. The aim is to improve access to outpatient and preventative services closer to home, reducing travel and creating a focal point for care in Penley.

B. **Rehab / Step-down Facility with Beds**: restoring a bed-based function at Penley, focused on rehabilitation, step-down care from acute hospitals and end-of-life support. This reflects community concerns about travel distances and the need for local recovery and respite beds.

C. **Third Sector Led Health and Wellbeing Hub**: combining the integrated hub model with an explicit leadership and delivery role for third-sector partners. The proposal builds on existing strengths in the local voluntary sector to deliver health, wellbeing, and social support alongside NHS-led services.

D. **Services in the Community (No Physical Building)**: redirecting resources away from maintaining a fixed site and investing instead in outreach and home-based services. This model prioritises flexibility and a “care closer to home” approach, but carries risks if funding and workforce are not secured locally.

Unresolved Questions:

There were two issues that remained unresolved.

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Scope of "digital" solutions:

Participants wanted to know what the extent of digital solutions would be in Option D. There was scepticism about relying on telehealth for older patients, but an acknowledgement that digital could still play a role in supporting staff or providing some remote services for more tech-savvy groups. Stakeholders didn't reject digital solutions but emphasise it must fit the needs of the demographic served.

Transport and accessibility plan:

Many participants asked how people will get to the hub from remote villages. Should a hub be established in Penley, future planning must address the needs of individuals residing outside of the immediate Penley area. Some participants wanted to know if there would be satellite clinics, transport assistance or other accommodations.

Outcomes: Shortlisted Options

The scoring using these criteria, with the agreed weightings applied, produced the following results, with Options A, C and D forming the shortlist for further consideration. In summary the shortlist is:

Option A:	Reopen Penley as a health and wellbeing community hub (with a range of outpatient, preventive, and some intermediate care services).
Option C:	Invest in community/voluntary sector services (potentially without heavy use of the building, focusing on outreach and support in homes and communities.)
Option D:	Other innovative solutions such as digital health, telemedicine, or distributed "hub & spoke" services, although the discussions suggest D involved some new element that could complement A and C.

These were scored using the following desirable criteria developed by participants in the session:

Criterion 1. Sustainability and System Resilience
Criterion 2. Prevention and Community Support
Criterion 3. Accessibility and Travel
Criterion 4. Safety and Security
Criterion 5. Clinical Outcomes
Criterion 6. Patient Experience

The table below shows the individual criteria and total weighted scores.

	Criterion 1	Criterion 2	Criterion 3	Criterion 4	Criterion 5	Criterion 6	Total (Weighted Scores)
Option A	**11.22**	**11.71**	**7.97**	**9.94**	**10.68**	**10.99**	**62.51**
Option C	**9.38**	**10.51**	**9.11**	**9.30**	**10.51**	**10.00**	**58.81**
Option D	**8.88**	**9.47**	**9.44**	**8.82**	**9.82**	**10.17**	**56.59**
Option B	8.37	7.23	8.46	8.34	8.96	8.86	50.22

Regular communications with Llais remains ongoing with proactive updates being provided as well as their active involvement in the Balanced Room conversations.

4. Phase two (November to December 2025)

Phase two of the communications and engagement activity will be to raise awareness of and invite feedback on the shortlist of options; explaining the work to develop the options and actively seeking feedback from those who have been involved throughout, those most affected (as outlined by the Integrated Equalities Impact Assessment), staff and the wider community.

Face to face engagement will be carried out as well as making hard copy and digital feedback options available on a large-scale across the local community.

b. Give a summary on how the decision / service / policy / function / change will be shared?

The outcome of this Integrated Equality Assessment will be presented to the Service Change Oversight Group and will be used to inform the next phase of consultation and/or engagement.

c. Are there planned arrangements for gathering feedback during implementation of the decision / service / policy / function / change being assessed?

Further feedback will be sought during the engagement and/or consultation period in 2026.

d. Summarise any emerging themes from the engagement work carried out:

Conversations on the future of Penley Hospital so far have revealed a deeply rooted and widespread community desire to retain but repurpose the facility as a hub for local healthcare. Across hundreds of responses residents, carers, healthcare professionals and former patients expressed a consistent message which was presented by one respondent as: **"Penley Hospital is not just a building - it is a vital part of the region's health infrastructure, heritage and identity."**

Local provision and accessibility emerged as the most dominant theme. Respondents repeatedly emphasised the importance of having healthcare services close to home, particularly in rural areas where transport is limited and public services are stretched. Penley's location was seen as ideal for serving the Wrexham County villages and surrounding communities; offering a more accessible and less intimidating alternative to large hospitals like the Wrexham Maelor.

Step-down and rehabilitation care was another key priority. Many respondents described Penley as perfectly suited for patients who are medically fit but not yet ready to return home. It was felt that a model like this may help alleviate bed-blocking at Wrexham Maelor Hospital, improve patient outcomes, and reduce pressure on acute services. The hospital's peaceful environment and familiar staff were credited with aiding recovery and providing dignified end-of-life care.

There was strong support for expanding Penley's role into a multi-functional community health hub. Suggestions included minor injuries units, outpatient clinics, physiotherapy, mental health support and integration with local GP practices and third sector partners. Respondents envisioned Penley as a place where holistic, person-centred care could thrive - especially for the elderly, disabled, and neurodivergent individuals.

Workforce and operational concerns were also raised. While some respondents shared negative experiences, the majority praised the dedication of Penley's staff and called for better support, training and retention strategies. Ideas included rotating placements, recruiting locally, and offering visa sponsorship to overseas workers.

Underlying many responses was a sense of frustration with centralisation and a perceived lack of strategic planning by the Health Board. The closure of Penley was seen as an example of broader issues within the NHS in Wales - overcrowded hospitals, delayed diagnoses and fragmented care. Respondents urged the Health Board to think creatively, consult meaningfully and invest in community-based solutions.

Finally, the historical significance of Penley Hospital was a recurring theme. Originally established to care for Polish war veterans, the feedback suggests that the hospital is seen as a special place to many. Its closure was described not only as a loss of service but linked to a loss of community identity and heritage.

Key considerations that have emerged from discussions at Health Board level include the impact of the change on travel time for staff, accessibility of service for patients, financial impact, quality and safe care delivery, recruitment challenges and travel time and costs for older people, disabled people, carers and people living with socio-economic disadvantage.

The themes from engagement phase 1 have been summarised in the relevant sections in Part B, and have formed the basis of the assessment of the options."

- **How has the engagement work influenced / or how will the planned engagement influence your work/guide your policy/proposal? Does the engagement work highlight any opportunities to address adverse impacts?**

In order to make a judgment on each option, the Integrated Equality Assessment Working Group has evaluated each shortlisted option against each of the relevant issues raised throughout the consultation from the point of view of people who share specific protected characteristics. If the group felt that the option reduces inequality on this issue it will score a green. If there is no impact it will score a grey dot. If there is negative impact it will receive a red cross.

In order for this Integrated Impact Assessment to support the options going forward, the option must either:

- Score all green ticks.
- Score all green ticks and grey dots.
- Score few red crosses and provide complete mitigation for these (i.e. neutralise the negative impact through some other means) or provide an "objective justification" for proceeding with the identified risks.

b. Additional information

Evidence to support assessment - your decisions must be based on robust evidence. What evidence base have you used in support?

Penley Hospital: Usage

Historically, maintaining occupancy of the 8 beds has been challenging, due to the admission criteria in place. Anecdotal feedback from families cite lack of transport to Penley to visit relatives as a matter of concern. From December 2023 to November 2024 the average occupancy rate at Penley Hospital was 80.5%. lower than the average occupancy rates at Chirk and Mold Community Hospitals were 95.2% and 101.7%, respectively.[1]

Of the patients admitted to Penley Hospital from December 2023 until its closure in December 2024, 49.2% normally resided in Wrexham and the surrounding areas, 27.9% in Chirk and the surrounding areas, 13.1% in Penley and the surrounding areas, 6.6% in Llangollen, and 1.6% each in Powys and Corwen.

At least 22 (37%) of patients in Penley during this time had community hospital provision available closer to their home.[2]

Current Service Provision in the Penley Area

The District Nursing Service: leads and delivers care within patient's homes, residential and care home settings, clinics and hospital settings:

- Point of contact for people to access community home based general nursing services.
- Promotion and maintenance of health,
- Providing support through ill health,
- Promoting and maximising independence, recovery, and/or the terminal stages of life. The District Nursing service:
- The provision of **end-of-life care** in Penley and the surrounding area is provided by the District Nursing Team supported by the CRT which consists of the GP service, District Specialist Palliative Care, Nursing and Residential Homes, Local Authority, Therapies, and Pharmacy.

[1] BCUHB, *Penley Community Hospital Issues Paper: Review of the Evidence,* p13
[2] BCUHB, *Penley Community Hospital Issues Paper: Review of the Evidence,* p15

Interim Service Mitigation since April 2023

In response to being unable to safely open the ward, the Health Board has focused on providing alternative models of care. These included providing health and care services directly in patient's homes, working closer with care homes in the area to provide services for their residents and enabling and providing the health support for patients to spend their last few weeks and days with dignity in their own home. Partnership working with key stakeholders including the Local Authority and Third Sector services has been key in delivering the service mitigations.[3]

Local Health and Demographics Profile[4]: Key Themes:

- Population projections predict the overall population of Wrexham is expected to decline by 1.8% between 2025 and 2040.
- The older population aged 65 years and over in Wrexham is predicted to increase by 15.7%, around 5,450 residents.
- The proportion of the BCUHB population able to speak Welsh (29.1%) is higher than the average for Wales (17.8%). At a regional level, the proportion of Welsh speakers ranges from 12.2% in Wrexham UA to 64.4% in Gwynedd.
- In North Wales, Wrexham has the highest proportion of people who are Black, Asian and Minority Ethnic (4.5%).
- The percentage of one-person households with person aged 66 years and over in MSOA Wrexham 018 (16.1%) is above the average for Wrexham UA (13.9%) and Wales (14.6%).
- Wrexham UA has second highest population density in North Wales and higher than Wales.
- Wrexham is expected to experience the largest decline in young residents as 0- to 15-year-olds are predicted to fall by 9% between 2025 and 2040.
- The gap between the employment rate for those with a long-term conditions and the overall employment rate in **Wrexham UA** (16.1%) is higher than the averages for BCUHB and Wales.
- In Wrexham UA, just under 22% of adults report eating at least five portions of fruit and vegetables the previous day, which is similar to the average for BCUHB but below the Wales average (28.5%).
- Around half of adults in Wrexham report meeting the recommended levels of physical activity each week.
- In Wrexham, just over 75% of working age adults report being in good health, which is the same as the average for BCUHB and above the Wales average (72.6%).
- Just under 73% of adults in Wrexham UA report being free from limiting long term illness, which is similar to the BCUHB average and higher than the average for Wales.
- Data from the 2021 Census on long term health problems or disability show that 6.4% of residents in MSOA Wrexham 018 report being disabled under the Equality Act, with day-to-day activities limited a lot; this is lower than Wrexham UA (9.4%) and Wales (10.3%).

[3] BCUHB, *Penley Community Hospital Issues Paper: Review of the Evidence,* p23
[4] BCUHB*, Health and Wellbeing Profile for Penley, Wrexham*, (March 2025)

- Wrexham UA's score of mental well-being score of 50 indicates better mental well-being compared to the other UAs in North Wales.
- 8.1% of people in Wrexham report feeling lonely which is the second lowest across the region and below the averages for BCUHB (10.4%) and Wales (12.7%).
- In Wrexham, 7.9% of babies are born with low birth weight, which is the highest across the region.
- 87.5% of children aged 4 years in Wrexham are up-to-date with routine immunisations.
- 27% of children aged 4 to 5 years in Wrexham are overweight or obese.
- Rising life expectancy is likely to increase the prevalence of frailty, which is estimated to affect around one in four people aged 85 years and over.
- **Wrexham UA** has a relatively high rate of hip fracture.

Wider Research: Health Inequality and the Inverse Care Law

The groups who often experience the worst health include (but are not limited to) black and ethnic minority groups, people sleeping rough, people living in poverty, disabled people or long-term health conditions, and those who are part of the LGBTQ+ community. The 'inverse care law' describes how people who most need health care are least likely to receive it.[5] In Wales, healthy life expectancy and mental wellbeing is poorer in deprived communities. The Wellbeing of Wales 2024 report showed little change in the gap in life expectancy between the most and least deprived areas, and that inequality in life expectancy and mortality remain wide. The proportion of total deaths that were avoidable continued to be substantially larger in the most deprived areas compared with the least deprived areas. People in the most deprived areas are twice as likely to die prematurely from cardiovascular disease than people in the least deprived areas.[6]

End of Part A

[5] The King's Fund, *Tackling the Inverse Care Law,* (2024), accessed at https://www.health.org.uk/sites/default/files/upload/publications/2022/Tackling%20the%20inverse%20care%20law.pdf

[6] Welsh Government, *Wellbeing of Wales 2024,*(2024), accessed at https://www.gov.wales/wellbeing-wales-2024-healthier-wales-html

Part B – Equality Impact Assessment with Human Rights

Section 1 - Equality Impact Assessment

Assessment – due regard relating to people / group who share protected characteristics

This section should record any known or potential impacts for those who share protected characteristics and other key groups. Impacts may be both negative and positive and the assessment will help to identify how different groups may be disproportionately impacted. Include consideration for any intersectional impacts. Evidence can link to Part A. You can copy and paste this tick: ✓

Age

Option	Positive effect	Negative effect	Neutral
A	7	0	5
B	5	0	7
C	7	0	5
D	10	0	2

Evidence / supporting narrative:

According to this assessment there are no specifically negative impacts identified through the options on the protected characteristic of Age. This is primarily due to the "Access and Inclusion" criteria being applied at the long-listing stage, as described in section 2. The assessment concludes that from a Public Sector Equality Duty perspective, the option that most satisfies the three parts of the general duty for this protected characteristic is option D.

Research and Service Knowledge

Evidence shows us that the affected population are older than the average population across Wales. This means they are more likely to be living with co-existing long-term conditions, frailty and impairments, and more likely to be in need of regular health support.
The risks posed by the current state has a disproportionate impact on older people, who are high users of community hospitals and inpatient beds. This impact assessment will identify the potential positive and negative impacts of each option to inform the options appraisal.

Current risks to this group of the current state have been identified through desktop analysis. These will be reviewed, challenged and redrafted through the balanced room engagement sessions and lived experience sessions.

- Decreased access to local inpatient beds providing rehabilitation and end of life care, with a subsequent negative impact on patient outcomes and patient experience.
- Increased travel time and potential increased waiting times.
- Potential reduction in carers, family and friends being able to visit due to time and distance with a subsequent impact on recovery time.

Survey Findings

The highest scoring issues that mattered most to respondents relevant to this protected characteristic are:

- Being treated with dignity and respect
- Access to care closer to home
- Timely access to support when needed
- Services that support recovery and independence

Those who answered “other” cited the following themes that are relevant to this group:

- Being close to home/Visiting loved ones easily
- Supporting elderly patients in familiar surroundings
- Reducing travel stress, especially in rural areas with limited transport
- End-of-Life and Hospice Care
- Rehabilitation and step-down services

When asked what would help them and their family stay well, they themes relevant to this group are:

- **Local access to care:** There is a strong emphasis on having healthcare services close to home, especially in rural areas. People want to avoid long travel times to Wrexham Maelor and other distant hospitals and local facilities like Penley are seen as essential for maintaining independence and wellbeing.
- **Step-down and rehabilitation services:** Many respondents highlighted the need for intermediate care between hospital and home. Penley is viewed as ideal for recovery, reablement, and preventing hospital “bed-blocking.”
- **Improved transport and accessibility:** Poor public transport is cited as a major barrier, especially for elderly and disabled residents. Calls for better bus services, circular routes, and easier access to clinics and GP surgeries.

When asked what they would want the Health Board to consider when deciding on the future of services at Penley Hospital, themes relevant to this group are:

- **The importance of local provision of care:** There is a strong and consistent message that services should remain close to home, especially for elderly and disabled residents. Penley Hospital is seen as a vital community asset, offering familiarity, dignity, and accessibility
- **Step-down and rehabilitation services:** Many respondents advocated for Penley Hospital to be used as a step-down facility for patients discharged from Wrexham Maelor. Thoughts were that this would help reduce bed-blocking, support recovery, and ease pressure on acute services.
- **End-of-life and palliative care:** Penley Hospital was frequently described as ideal for end-of-life care, offering a peaceful and dignified environment. Families valued the ability to visit loved ones easily and felt the unit had previously provided compassionate, personalised care.

Balanced Room 1

During Balanced Room 1, a number of scenarios were rejected on the basis of not meeting the Access and Inclusion criteria. In particular a number of scenarios were rejected on the premise that people, particularly older people, would have to travel further to access essential services. Other concerns expressed that are relevant to this group were the lack of rehabilitation services and concerns over digital exclusion of older age groups.

Balanced Room 2

During Balanced Room 2 participants, through collaborative discussions, produced desirable criteria for evaluating service options. These included criteria around prevention, community support, access and travel of particular relevance to older people. These included the accessibility of the site, the potential burden of travel. The ability to keep people at home and improved access to outpatient services focussed on rehabilitation and recovery.

Reviewing the findings summarised above we are able to combine some themes together to form the issues to consider for this group in this assessment Those issues are:	Source			
	Known	**Survey**	**BR1**	**BR2**
1. Access to rehabilitation services	√	√	√	√
2. Travel and transport	√	√	√	√
3. Impact on carers	√	√	√	√
4. Keeping people at or close to home/Care closer to home	√	√	√	√
5. Access to end of life care	√	√	√	
6. Access to palliative care	√	√	√	
7. Increasing frailty	√			
8. Dignity and Respect		√		
9. Timely access to support when needed		√		
10. Relieving isolation			√	
11. Accessible Sites and Services				√
12. Digital inclusion			√	√

OPTIONS			
A	Health and Wellbeing Hub (Integrated)	KEY	
B	Rehab / Step-down Facility with Beds	Positive Impact	✓
C	Health and Wellbeing Hub plus Third Sector Facility	Neutral Impact	●
D	Services in the Community (No Physical Building)	Negative Impact	X

Issue	**A**	**B**	**C**	**D**
1. Access to rehabilitation services	✓	✓ **	✓	✓
2. Travel and transport time	✓	●	✓	✓
3. Impact on carers	✓	✓	✓	✓
4. Familiar surroundings/keeping people at or close to home/Care closer to home	✓ *	✓ **	✓ *	✓
5. Access to end of life care	●	●	●	✓
6. Access to palliative care	✓ *	● *	✓ *	✓
7. Increasing frailty and high instances of hip fractures in the local area	●	●	●	●
8. Dignity and Respect	✓	✓	✓	✓
9. Timely access to support when needed	●	●	●	✓
10. Relieving isolation	●	●	●	✓

11. Accessible Sites and Services	✓	✓	✓	✓
12. Digital inclusion	●	●	●	●

Issue	Impact	Rationale
AA1	✓	This model would provide a rehabilitation service. It offers an opportunity for more services underneath one roof. However, it would not provide an inpatient rehabilitation service, so there may be a negative impact on a small number of people. Overall though this model increases the level of rehabilitation services available locally, but may not provide as comprehensive an offer as some of the other options.
AA2	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis.
AA3	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis – this in turn will have a positive impact on carers who often need to provide transport for older people.
AA4	✓*	Overall, this option represents a positive impact on the care closer to home offer. However, there is still a recognition that the hub would still require people to travel, albeit potentially short distances, and recognition that the catchment area is unclear at the moment and may increase travel in some areas.
AA5	●	Here the group noted that it is important to recognise the differences in End-of-Life Care and Palliative Care. The group agreed that End of Life Care, while important to the cohort, is out of scope for the service change being assessed.
AA6	✓*	The hub would offer a range of services that could be accessed by people on a Palliative Care pathway, for example blood tests. This comes with a caution as we are unsure of the detail of the full offer yet.
AA7	●	The group decided that frailty is absolutely a particular issue for the older cohort, but that this is a health need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.
AA8	✓	The group decided that dignity and respect is absolutely a particular issue for the older cohort, but that this is a values and behaviour-based issue. Every option will be developed with dignity and respect as a core theme of the service. The group therefore judged this as a positive across each option.
AA9	●	The group decided that timely access to services is a fair expectation from all residents from the NHS and that all options would be developed with this as a prerequisite.
AA10	●	The group decided that isolation is absolutely a particular issue for the older cohort, but that this is a wellbeing need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.
AA11	✓	The group judged that the hub would be an opportunity to develop more easily accessible services, from the points of view of travel and transport, developing services in a way that aligns to the needs of the local population, and avoiding some of the barriers of accessing services in large District General Hospitals such as car parking, wayfinding, availability of carers and the inaccessibility of some areas of the buildings.

AA12	●	The group concluded that the issue of Digital Inclusion is an area of work to ensure is addressed through each of the options when the details are developed, but that there are no inherent differences between the options at this stage.
AB1	✓**	The group concluded that while there is a clear positive in the offer of rehabilitation services on an inpatient basis with this option, the scope and breadth of the offer may not be as wide as in some of the other options due to the capacity of the facility. The group also noted that there is not necessarily a fully positive impact on the local disabled population if the criteria for admission leads to population from other areas of Wrexham.
AB2	●	The group judged this to be neutral at this stage as there is a lack of clarity currently on who would most likely be accessing this model of care. As it would not necessarily be the local community it is difficult to determine the impact. This will be revisited during the travel analysis.
AB3	✓	This model offers a level of care that would otherwise often fall to unpaid carers to cover, and the group therefore judged it as a potential positive impact, albeit on potentially a small cohort.
AB4	✓**	The group judged this to be a positive impact with a number of caveats, in that it is unclear currently if the majority of people accessing the service would be local. The model does offer the Health Board additional capacity for rehab beds so we acknowledge the potential for this to be closer to home on a small scale.
AB5	●	Here the group noted that it is important to recognise the differences in End-of-Life Care and Palliative Care. The group agreed that End of Life Care, while important to the cohort, is out of scope for the service change being assessed.
AB6	●*	This model does not offer any specific palliative care, but people on palliative care pathways may receive some benefit if they are admitted through symptom management.
AB7	●	The group decided that frailty is absolutely a particular issue for the older cohort, but that this is a health need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.
AB8	✓	The group decided that dignity and respect is absolutely a particular issue for the older cohort, but that this is a values and behaviour-based issue. Every option will be developed with dignity and respect as a core theme of the service. The group therefore judged this as a positive across each option.
AB9	●	The group decided that timely access to services is a fair expectation from all residents from the NHS and that all options would be developed with this as a prerequisite.
AB10	●	The group decided that isolation is absolutely a particular issue for the older cohort, but that this is a wellbeing need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.
AB11	✓	The group judged that a rehab/step down facility would be an opportunity to develop more easily accessible services, from the points of view of travel and transport, developing services in a way that aligns to the needs of the local population, and avoiding some of the barriers of accessing services in large District General Hospitals such as car parking, wayfinding, availability of carers and the inaccessibility of some areas of the buildings.

AB12	●	The group concluded that the issue of Digital Inclusion is an area of work to ensure is addressed through each of the options when the details are developed, but that there are no inherent differences between the options at this stage.
AC1	✓	This model would provide a rehabilitation service. It offers an opportunity for more services underneath one roof. However, it would not provide an inpatient rehabilitation service, so there may be a negative impact on a small number of people. Overall though this model increases the level of rehabilitation services available locally, but may not provide as comprehensive an offer as some of the other options.
AC2	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis.
AC3	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis – this in turn will have a positive impact on carers who often need to provide transport for older people.
AC4	✓*	Overall, this option represents a positive impact on the care closer to home offer. However, there is still a recognition that the hub would still require people to travel, albeit potentially short distances, and recognition that the catchment area is unclear at the moment and may increase travel in some areas.
AC5	●	Here the group noted that it is important to recognise the differences in End-of-Life Care and Palliative Care. The group agreed that End of Life Care, while important to the cohort, is out of scope for the service change being assessed.
AC6	✓*	The hub would offer a range of services that could be accessed by people on a Palliative Care pathway, for example blood tests. This comes with a caution as we are unsure of the detail of the full offer yet.
AC7	●	The group decided that frailty is absolutely a particular issue for the older cohort, but that this is a health need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.
AC8	✓	The group decided that dignity and respect is absolutely a particular issue for the older cohort, but that this is a values and behaviour-based issue. Every option will be developed with dignity and respect as a core theme of the service. The group therefore judged this as a positive across each option.
AC9	●	The group decided that timely access to services is a fair expectation from all residents from the NHS and that all options would be developed with this as a prerequisite.
AC10	●	The group decided that isolation is absolutely a particular issue for the older cohort, but that this is a wellbeing need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.
AC11	✓	The group judged that the hub would be an opportunity to develop more easily accessible services, from the points of view of travel and transport, developing services in a way that aligns to the needs of the local population, and avoiding some of the barriers of accessing services in large District General Hospitals such as car parking, wayfinding, availability of carers and the inaccessibility of some areas of the buildings.

AC12	✓	The group concluded that the issue of Digital Inclusion is an area of work to ensure is addressed through each of the options when the details are developed, but that there are no inherent differences between the options at this stage.
AD1	✓	This model would provide a rehabilitation service. It offers an opportunity for more services underneath one roof. However, it would not provide an inpatient rehabilitation service, so there may be a negative impact on a small number of people. Overall though this model increases the level of rehabilitation services available locally, but may not provide as comprehensive an offer as some of the other options.
AD2	✓	This model offers much more convenience for people who face additional barriers to transport as care would be provided in the person's home and the burden of travel is transferred from the service user to the service provider.
AD3	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis – this in turn will have a positive impact on carers who often need to provide transport for older people.
AD4	✓	Overall, this option represents a positive impact on the care closer to home offer as care would be provided in the person's home and the burden of travel is transferred from the service user to the service provider.
AD5	✓	Here the group noted that it is important to recognise the differences in End-of-Life Care and Palliative Care. The group agreed that End of Life Care, while important to the cohort, is out of scope for the service change being assessed. We did note, however, that there may be a secondary positive impact from Option D in that some End-of-Life Care may be able to be delivered under this model even if it isn't primarily designed to do so.
AD6	✓	Palliative care would be available and deliverable through District Nursing in this model.
AD7	●	The group decided that frailty is absolutely a particular issue for the older cohort, but that this is a health need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.
AD8	✓	The group decided that dignity and respect is absolutely a particular issue for the older cohort, but that this is a values and behaviour-based issue. Every option will be developed with dignity and respect as a core theme of the service. The group therefore judged this as a positive across each option.
AD9	✓	The group decided that timely access to services is a fair expectation from all residents from the NHS and that all options would be developed with this as a prerequisite. There is an acknowledgement that
AD10	✓	The group decided that isolation is absolutely a particular issue for the older cohort, but that this is a wellbeing need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact. However, the group recognised that there may be a particular benefit here in that a range of service would be available and coming regularly to people's homes.
AD11	✓	The group judged that the hub would be an opportunity to develop more easily accessible services, from the points of view of travel and transport, developing services in a way that aligns to the needs of the local population, and avoiding some of the barriers of accessing services in large District General Hospitals such as car parking, wayfinding, availability of carers and the inaccessibility of some areas of the buildings.

AD12	●	The group concluded that the issue of Digital Inclusion is an area of work to ensure is addressed through each of the options when the details are developed, but that there are no inherent differences between the options at this stage.

Mitigation action if adverse impact found:

We recognise that this assessment is an ongoing process and further analysis will be undertaken as part of the next phase of engagement. This will include specific sessions with older people and groups representing older people.

We also recognise that Age covers more than older people and that we have primarily focussed on the older cohort so far. We will ensure that the next phase of engagement covers:

- Children and young people.
- Working age people.
- Parents/guardians.

People from these cohorts will be invited to add to this analysis.

Disability
(Including long term conditions, mental health, neurodivergence and invisible impairments)

Option	Positive effect	Negative effect	Neutral
A	7		5
B	5		7
C	7		5
D	10		2

Evidence / supporting narrative:

According to this assessment there are no specifically negative impacts identified through the options on the protected characteristic of Disability. This is primarily due to the "Access and Inclusion" criteria being applied at the long-listing stage, as described in section 2. The assessment concludes that from a Public Sector Equality Duty perspective, the option that most satisfies the three parts of the general duty for this protected characteristic is option D.

Research and Service Knowledge ("Known")

Data from the 2021 Census on long term health problems or disability show that 6.4% of residents in **MSOA Wrexham 018** report being disabled under the Equality Act, with day-to-day activities limited a lot; this is lower than **Wrexham UA** (9.4%) and Wales (10.3%). (Issues paper, page 8)

There is tight criteria for admission to Penley so many disabled people are unable to be treated there:

- must not have medical needs which require frequent, planned, regular intervention
- patients with cognitive impairment who display challenging behavioural and psychological symptoms such as walking with purpose or who require close supervision because of, for example falls risks, cannot be safely managed
- Patients must have completed all therapy interventions

Current risks to this group of the current state have been identified through desktop analysis. The risks posed by the current state have a disproportionate impact on disabled people, who are high users of community hospitals and inpatient beds. This impact assessment will identify the potential positive and negative impacts of each option to inform the options appraisal.

Current risks to this group of the current state have been identified through desktop analysis.

These will be reviewed, challenged and redrafted through the balanced room engagement sessions and lived experience sessions.

- Decreased access to local rehabilitation care may impact mostly on disabled people and people living with long-term, chronic conditions.
- Increased travel requirements presents higher risks to disabled people who are more likely to use public transport as their primary mode of transport.

Survey

The highest scoring issues that mattered most to respondents relevant to this protected characteristic are:

- Being treated with dignity and respect
- Access to care closer to home
- Timely access to support when needed
- Services that support recovery and independence
-

Those who answered “other” cited the following themes that are relevant to this group:

- Reducing travel stress, especially in rural areas with limited transport
- Rehabilitation and step-down services

Asked what would help them and their family stay well the themes were:

- **Support for carers and families:** Carers need respite and practical support to manage their responsibilities with local care options reducing stress and allowing families to stay involved in loved ones' recovery.
- **Mental Health and Social Care:** Respondents requested more mental health services, neurodivergent-friendly support and social care provision. Integration between health and social services is seen as vital.

When asked what they would want the Health Board to consider when deciding on the future of services at Penley Hospital, key themes of the responses were:

- **Improved transport and accessibility:** Poor public transport is cited as a major barrier, especially for elderly and disabled residents. Calls for better bus services, circular routes, and easier access to clinics and GP surgeries.
- **Support for carers and families:** Carers need respite and practical support to manage their responsibilities with local care options reducing stress and allowing families to stay involved in loved ones' recovery.
- **Mental Health and Social Care:** Respondents requested more mental health services, neurodivergent-friendly support and social care provision. Integration between health and social services is seen as vital.

Balanced Room 1

During Balanced Room 1, a number of scenarios were rejected on the basis of not meeting the Access and Inclusion criteria. In particular a number of scenarios were rejected on the premise that people, particularly disabled people, would have to travel further to access essential services. Other concerns expressed that are relevant to this group were physical access and the current available estate, the design of services and access to step-down care. The needs of disabled people for access to home-based care were also noted.

Balanced Room 2

During Balanced Room 2 participants, through collaborative discussions, produced desirable criteria for evaluating service options. These included criteria around prevention, community support, access and travel of particular relevance to disabled people. These included the accessibility of the site and the potential increased difficulty of travel.

Reviewing the findings summarised above we are able to combine some themes together to form the issues to consider for this group in this assessment Those issues are:	Source			
	Known	Survey	BR1	BR2
1. Support for frailty and falls	√			
2. Access to rehabilitation services	√			
3. Increased travel requirements	√		√	√
4. Dignity and respect, person centred care		√		√
5. Care closer to home		√		
6. Timely access to support when needed		√		√
7. Services that support recovery and independence		√		
8. Support for carers		√		
9. Mental health support		√		
10. Neurodivergent inclusive services		√		
11. Physical access to services			√	√
12. Availability of home-based care			√	

OPTIONS			
A	Health and Wellbeing Hub (Integrated)	Key	
B	Rehab / Step-down Facility with Beds	Positive Impact	✓
C	Health and Wellbeing Hub plus Third Sector Facility	Neutral Impact	●
D	Services in the Community (No Physical Building)	Negative Impact	X

Issue	A	B	C	D
1. Support for frailty and falls	●	●	●	●
2. Access to rehabilitation services	✓	✓ **	✓	✓
3. Increased travel requirements	✓	●	✓	✓
4. Dignity and respect, person centred care	✓	✓	✓	✓
5. Care closer to home	✓ *	✓ **	✓ *	✓
6. Timely access to support when needed	●	●	●	✓

7. Services that support recovery and independence	✓	✓	✓	✓
8. Support for carers	✓	✓	✓	✓
9. Mental health support	✓	●	✓	✓
10. Neurodivergent inclusive services	●	●	●	✓
11. Physical access to services	●	●	●	●
12. Availability of home-based care	●	●	●	✓

Issue	Impact	Rationale
DA1	●	The group decided that frailty is absolutely a particular issue for the older cohort, but that this is a health need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.
DA2	✓	This model would provide a rehabilitation service. It offers an opportunity for more services underneath one roof. However, it would not provide an inpatient rehabilitation service, so there may be a negative impact on a small number of people. Overall though this model increases the level of rehabilitation services available locally, but may not provide as comprehensive an offer as some of the other options.
DA3	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis.
DA4	✓	The group decided that dignity and respect is absolutely a particular issue for the older cohort, but that this is a values and behaviour-based issue. Every option will be developed with dignity and respect as a core theme of the service. The group therefore judged this as a positive across each option.
DA5	✓*	Overall, this option represents a positive impact on the care closer to home offer. However, there is still a recognition that the hub would still require people to travel, albeit potentially short distances, and recognition that the catchment area is unclear at the moment and may increase travel in some areas.
DA6	●	The group decided that timely access to services is a fair expectation from all residents from the NHS and that all options would be developed with this as a prerequisite.
DA7	✓	This option offers much greater support for independence in locating services in the local area, increasing the access to support in the community and reducing the likelihood of being admitted to inpatient services.
DA8	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis – this in turn will have a positive impact on carers who often need to provide transport for older people.
DA9	✓	The model would include community mental health services being available through the hub.
DA10	●	The group judged this to be a positive as there is no specific neurodivergent support currently proposed in the option, however there will be opportunities through service design to ensure neurodivergent inclusive services.

DA11	●	The group decided that at this stage this is neutral across all options until we understand more of the infrastructure of each option.
DA12	●	The group agreed to rate this option as neutral. Although there is no provision for home-based care in this option it could be offered when the detail is worked up. The group also recognised that home-based care is not always the most appropriate care.
DB1	●	The group decided that frailty is absolutely a particular issue for the older cohort, but that this is a health need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.
DB2	✓**	The group judged this to be neutral at this stage as there is a lack of clarity currently on who would most likely be accessing this model of care. As it would not necessarily be the local community it is difficult to determine the impact. This will be revisited during the travel analysis.
DB3	●	The group judged this to be neutral at this stage as there is a lack of clarity currently on who would most likely be accessing this model of care. As it would not necessarily be the local community it is difficult to determine the impact. This will be revisited during the travel analysis.
DB4	✓	The group decided that dignity and respect is absolutely a particular issue for the older cohort, but that this is a values and behaviour-based issue. Every option will be developed with dignity and respect as a core theme of the service. The group therefore judged this as a positive across each option.
DB5	✓**	The group judged this to be a positive impact with a number of caveats, in that it is unclear currently if the majority of people accessing the service would be local. The model does offer the Health Board additional capacity for rehab beds so we acknowledge the potential for this to be closer to home on a small scale.
DB6	●	The group decided that timely access to services is a fair expectation from all residents from the NHS and that all options would be developed with this as a prerequisite.
DB7	✓	This options supports independence as the priority of the facility would be preparing people to be able to be discharged and to live independently.
DB8	✓	This model offers a level of care that would otherwise often fall to unpaid carers to cover, and the group therefore judged it as a potential positive impact, albeit on potentially a small cohort.
DB9	●	The group judged this to be neutral as the rehab/step down facility would not offer a specific mental health but, but would be able to identify any issues and signpost people.
DB10	●	The group judged this to be a positive as there is no specific neurodivergent support currently proposed in the option, however there will be opportunities through service design to ensure neurodivergent inclusive services.
DB11	●	The group decided that at this stage this is neutral across all options until we understand more of the infrastructure of each option.
DB12	●	The group agreed to rate this option as neutral. Although there is no provision for home-based care in this option it could be offered when the detail is worked up. The group also recognised that home-based care is not always the most appropriate care.
DC1	●	The group decided that frailty is absolutely a particular issue for the older cohort, but that this is a health need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.

DC2	✓	This model would provide a rehabilitation service. It offers an opportunity for more services underneath one roof. However, it would not provide an inpatient rehabilitation service, so there may be a negative impact on a small number of people. Overall though this model increases the level of rehabilitation services available locally, but may not provide as comprehensive an offer as some of the other options.
DC3	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis.
DC4	✓	The group decided that dignity and respect is absolutely a particular issue for the older cohort, but that this is a values and behaviour-based issue. Every option will be developed with dignity and respect as a core theme of the service. The group therefore judged this as a positive across each option.
DC5	✓*	Overall, this option represents a positive impact on the care closer to home offer. However, there is still a recognition that the hub would still require people to travel, albeit potentially short distances, and recognition that the catchment area is unclear at the moment and may increase travel in some areas.
DC6	●	The group decided that timely access to services is a fair expectation from all residents from the NHS and that all options would be developed with this as a prerequisite.
DC7	✓	This option offers much greater support for independence in locating services in the local area, increasing the access to support in the community and reducing the likelihood of being admitted to inpatient services.
DC8	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis – this in turn will have a positive impact on carers who often need to provide transport for older people.
DC9	✓	The model would include community mental health services being available through the hub.
DC10	●	The group judged this to be a positive as there is no specific neurodivergent support currently proposed in the option, however there will be opportunities through service design to ensure neurodivergent inclusive services.
DC11	●	The group decided that at this stage this is neutral across all options until we understand more of the infrastructure of each option.
DC12	●	The group agreed to rate this option as neutral. Although there is no provision for home-based care in this option it could be offered when the detail is worked up. The group also recognised that home-based care is not always the most appropriate care.
DD1	●	The group decided that frailty is absolutely a particular issue for the older cohort, but that this is a health need and a driver as opposed to an issue that can be analysed to differentiate the options, and is therefore a neutral impact.
DD2	✓	This model would provide a rehabilitation service. It offers an opportunity for more services underneath one roof. However, it would not provide an inpatient rehabilitation service, so there may be a negative impact on a small number of people. Overall though this model increases the level of rehabilitation services available locally, but may not provide as comprehensive an offer as some of the other options.
DD3	✓	This model offers much more convenience for people who face additional barriers to transport as care would be provided in the person's home and the burden of travel is transferred from the service user to the service provider.

DD4	✓	The group decided that dignity and respect is absolutely a particular issue for the older cohort, but that this is a values and behaviour-based issue. Every option will be developed with dignity and respect as a core theme of the service. The group therefore judged this as a positive across each option.
DD5	✓	Overall, this options represents a positive impact on the care closer to home offer as care would be provided in the person's home and the burden of travel is transferred from the service user to the service provider.
DD6	✓	The group decided that timely access to services is a fair expectation from all residents from the NHS and that all options would be developed with this as a prerequisite. There is an acknowledgement that
DD7	✓	The group concluded that this was a positive impact in that the service would be designed to be delivered in people's homes, supporting them in their own environment to live independently.
DD8	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis – this in turn will have a positive impact on carers who often need to provide transport for older people.
DD9	✓	The model would include community mental health services being available through district nursing and specific mental health support designed into the service delivery model.
DD10	✓	The group judged that there was a positive impact here as an opportunity arises to provide much more individualised care which may be of benefit to neurodivergent people.
DD11	●	The group decided that at this stage this is neutral across all options until we understand more of the infrastructure of each option.
DD12	✓	This option is based on home-based care.

Mitigation action if adverse impact found:

We recognise that this assessment is an ongoing process and further analysis will be undertaken as part of the next phase of engagement. This will include specific sessions with disabled people and disabled people's organisations. This will include extending an invitation to the North Wales Access Panel.

We also recognise that disability covers more a wide ranging and diverse cohort. We will ensure that the next phase of engagement covers:

- People living with a physical impairment
- People living with mental ill health
- People living with sensory loss
- People living with long-term conditions.
- Parents, guardians and carers of disabled children and young people.

- People whose first language is BSL.

People from these cohorts will be invited to add to this analysis.

Race/Ethnicity	Option	Positive effect	Negative effect	Neutral
	A	0	1	0
	B	0	1	0
	C	0	1	0
	D	0	1	0

Evidence / supporting narrative:

At this stage of assessment, we do not know the details of each option to the point where we can consider any risks to the community identity and heritage. This issue will be carried forward to further discussions to include the local community, with a particular focus on people of Polish heritage who are more likely to hold a personal connection to the history and heritage of the site.

The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to race. In Gwynedd, 3.8% of residents are Black, Asian and Minority Ethnic. Data from the 2021 Census shows that almost 96% of residents in South Meirionnydd Primary Care Cluster are White-British.

Responses from the survey showed that the historical significance of Penley Hospital was a recurring theme. Originally established to care for Polish war veterans, the feedback suggests that the hospital is seen as a special place to many. Its closure was described not only as a loss of service but linked to a loss of community identity and heritage. This impact assessment will consider how each option presented opportunities to preserve links to community identity and heritage.

OPTIONS			
A	Health and Wellbeing Hub (Integrated)	Key	
B	Rehab / Step-down Facility with Beds	Positive Impact	✓

C	Health and Wellbeing Hub plus Third Sector Facility	Neutral Impact	●
D	Services in the Community (No Physical Building)	Negative Impact	X

Issue	A	B	C	D
1. Opportunities to preserve links to community identity and heritage.	●	●	●	●

Issue	Impact	Rationale
RA1	●	We currently do not know the details of each option to the point where we can consider any risks to the community identity and heritage. This issue will be carried forward to further discussions.
RB1	●	We currently do not know the details of each option to the point where we can consider any risks to the community identity and heritage. This issue will be carried forward to further discussions.
RC1	●	We currently do not know the details of each option to the point where we can consider any risks to the community identity and heritage. This issue will be carried forward to further discussions.
RD1	●	We currently do not know the details of each option to the point where we can consider any risks to the community identity and heritage. This issue will be carried forward to further discussions.

Mitigation action if adverse impact found:

We recognise that this assessment is an ongoing process and further analysis will be undertaken as part of the next phase of engagement. This will include specific sessions with local Black and Ethnic Minority people and people whose first language is neither English, Welsh or BSL.

We also recognise that race and ethnicity covers more a wide ranging and diverse cohort and that we have primarily focussed on the older cohort so far. We will ensure that the next phase of engagement covers:

- Black and ethnic minority people
- People whose first language not Welsh, English or BSL.

People from these cohorts will be invited to add to this analysis.

We recognise that the unique heritage of the site is important to the local community and we will include the Wrexham Museum and Heritage Service in the next phase of engagement.

Sexual Orientation

The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to sexual orientation.

We recognise that this assessment is an ongoing process and further analysis will be undertaken as part of the next phase of engagement. This will include specific sessions with groups that represent LGBTQ+ people.

Gender Reassignment / Gender identity (including non-binary, gender fluid and intersex) The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to Gender Reassignment/Gender Identity. We recognise that this assessment is an ongoing process and further analysis will be undertaken as part of the next phase of engagement. This will include specific sessions with groups that represent LGBTQ+ people.
Sex / Gender The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to sex. We recognise that this assessment is an ongoing process and further analysis will be undertaken as part of the next phase of engagement. This will include specific sessions with groups that represent the specific needs of women and men.
Religion and Belief (including non-belief and Philosophical belief) The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to religion and belief. We recognise that this assessment is an ongoing process and further analysis will be undertaken as part of the next phase of engagement. This will include specific sessions with local faith groups through the North Wales Interfaith Network.
Pregnancy and Maternity The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to pregnancy and maternity. We recognise that this assessment is an ongoing process and further analysis will be undertaken as part of the next phase of engagement. This will include specific sessions with local parenting forums.

Marriage and Civil Partnership
The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to marriage and civil partnership.

This protected characteristic applies primarily to employment law. We will continue to ensure all staff are fully engaged with and listened during this process.

Unpaid Carers Future versions of this assessment will use this section to assess the potential impact of each option on this group once the options have been developed	**Option**	**Positive effect**	**Negative effect**	**Neutral**
	A	**6**	**0**	**1**
	B	**4**	**0**	**2**
	C	**7**	**0**	**0**
	D	**7**	**0**	**0**

Evidence / supporting narrative:

According to this assessment there are no specifically negative impacts identified through the options on the protected characteristic of Disability. This is primarily due to the "Access and Inclusion" criteria being applied at the long-listing stage, as described in section 2. The assessment concludes that from a Public Sector Equality Duty perspective, the option that most satisfies the three parts of the general duty for unpaid carers is options C and D.

Research and Service Knowledge

Potential risks of the current state have been identified through desktop analysis. These will be reviewed, challenged and redrafted through the balanced room engagement sessions and lived experience sessions.

- Potential increase in travel required to provide care.
- Potential increase in daily care needs if capacity is unstable in community or home care settings.
- Increase in reliance on limited transport opportunities locally.
- An increase in caring responsibilities can have a negative impact on the mental and physical well-being of carers.

May reduce local employment opportunities for people with less access to transport or those with increased caring responsibilities

Survey

Asked what would help them and their family stay well one key theme was Support for carers and families. It was clear from responses that Carers need respite and practical support to manage their responsibilities with local care options reducing stress and allowing families to stay involved in loved ones' recovery.

When asked what they would want the Health Board to consider when deciding on the future of services at Penley Hospital, issues of relevance to carers focused around Transport and accessibility: Poor public transport was a major concern, especially in rural areas. Penley's location was seen as more accessible than larger hospitals for many residents.

When asked what they would want the Health Board to consider when deciding on the future of services at Penley Hospital, issues of importance for carers focussed on:

- **The importance of local provision of care:** There is a strong and consistent message that services should remain close to home, especially for elderly and disabled residents. Penley Hospital is seen as a vital community asset, offering familiarity, dignity, and accessibility.

- **Transport and accessibility:** Poor public transport was a major concern, especially in rural areas. Penley's location was seen as more accessible than larger hospitals for many residents.
- **Increased mental health and social care support:** Several responses highlighted the need for neurodivergent-friendly services, mental health support and respite care. Integration with social care was seen as essential for continuity and recovery.
- **Economic and practical considerations:** Some respondents raised concerns about cost-effectiveness, value for money and sustainability. Others suggested using Penley for training, volunteering or shared staffing models.

Balanced Room 1

During Balanced Room 1, a number of scenarios were rejected on the basis of not meeting the Access and Inclusion criteria. Issues raised that are important to carers included:

- Opportunities to include the local voluntary sector to provide support alongside NHS-led services
- Improving the capacity of social care to address social care gaps that are often filled by unpaid carers

Balanced Room 2

During Balanced Room 2 participants, through collaborative discussions, produced desirable criteria for evaluating service options. These included criteria around future proofing the system, supporting prevention, supporting carers and working with existing assets in the area. All of these could potentially reduce the demand on unpaid carers.

Reviewing the findings summarised above we are able to combine some themes together to form the issues to consider for this group in this assessment Those issues are:	**Source**			
	Known	**Survey**	**BR1**	**BR2**
1. Increased travel to provide care	√	√		
2. Reduced demand on carers	√	√		
3. Wellbeing of carers	√	√		
4. Respite for carers		√		

5.	Mental health support for patients and carers		√		
6.	Maximising the capacity of the voluntary sector			√	√
7.	Supporting prevention				√

OPTIONS			
A	Health and Wellbeing Hub (Integrated)	KEY	
B	Rehab / Step-down Facility with Beds	Positive Impact	✓
C	Health and Wellbeing Hub plus Third Sector Facility	Neutral Impact	●
D	Services in the Community (No Physical Building)	Negative Impact	X

Issue	**A**	**B**	**C**	**D**
1. Increased travel to provide care	✓	●	✓	✓
2. Reduced local capacity increasing demand on carers	✓	✓*	✓	✓
3. Impact on life and wellbeing of carers of increased demand	✓	✓	✓	✓
4. Respite for carers	●	✓	✓**	✓
5. Mental health support for patients and carers	✓	●	✓	✓
6. Maximising the capacity of the voluntary sector	✓	●	✓	✓
7. Supporting prevention	✓	✓	✓	✓

Unpaid Carers Rationale

Issue	**Impact**	**Rationale**
CA1	✓	This options offers a much greater range of services locally, often services that people who are supported by carers people are disproportionate users of, and is highly likely to reduce the travel needs of people and their carers in the local area on a regular basis.
CA2	✓	This option creates more local capacity to offer wellbeing support and social support to the local population, which may reduce demand on carers.

CA3	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis – this in turn will have a positive impact on carers who often need to provide transport for older people.
CA4	●	While the hub may provide information and support for carers it would not provide any specific respite.
CA5	✓	The model would include community mental health services being available through the hub.
CA6	✓	There is the potential for third sector involvement in the wellbeing hub from a social care perspective.
CA7	✓	All options are being developed with a focus on supporting prevention.
CB1	●	The group judged this to be neutral at this stage as there is a lack of clarity currently on who would most likely be accessing this model of care. As it would not necessarily be the local community it is difficult to determine the impact on carers. This will be revisited during the travel analysis.
CB2	✓*	This option creates some local capacity to offer wellbeing support and social support to the local population, which may reduce demand on carers. The groups noted that this is a smaller positive impact than the other options.
CB3	✓	This model offers a level of care that would otherwise often fall to unpaid carers to cover, and the group therefore judged it as a potential positive impact, albeit on potentially a small cohort.
CB4	✓	This option will provide respite for carers for the period of time that the person being cared for is in the facility.
CB5	●	The group judged this to be neutral as the rehab/step down facility would not offer a specific mental health but, but would be able to identify any issues and signpost people.
CB6	●	This model does not involve the third sector.
CB7	✓	All options are being developed with a focus on supporting prevention.
CC1	✓	This options offers a much greater range of services locally, often services that people who are supported by carers people are disproportionate users of, and is highly likely to reduce the travel needs of people and their carers in the local area on a regular basis.
CC2	✓	This option creates more local capacity to offer wellbeing support and social support to the local population, which may reduce demand on carers.
CC3	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis – this in turn will have a positive impact on carers who often need to provide transport for older people.
CC4	✓**	The model from the Health Board side would not provide any specific respite for carers. However, this may be part of the third sector offer. This will be revisited as the detail is developed.
CC5	✓	The model would include community mental health services being available through the hub.
CC6	✓	This model integrates the third sector at the design stage, making the third sector part of the delivery of the model.
CC7	✓	All options are being developed with a focus on supporting prevention.

CD1	✓	This options offers a much greater range of services locally, often services that people who are supported by carers people are disproportionate users of, and is highly likely to reduce the travel needs of people and their carers in the local area on a regular basis.
CD2	✓	This option creates more local capacity to offer wellbeing support and social support to the local population, which may reduce demand on carers.
CD3	✓	This options offers a much greater range of services locally, often services that older people are disproportionate users of, and is highly likely to reduce the travel needs of older people in the local area on a regular basis – this in turn will have a positive impact on carers who often need to provide transport for older people.
CD4	✓	This model offers respite for carers as the care at home model will deliver some of the support that would otherwise be provided by carers.
CD5	✓	The model would include community mental health services being available through district nursing and specific mental health support designed into the service delivery model.
CD6	✓	There is the potential for third sector involvement in the model from a social care perspective.
CD7	✓	All options are being developed with a focus on supporting prevention.

Mitigation action if adverse impact found:

We recognise that this assessment is an ongoing process and further analysis will be undertaken as part of the next phase of engagement. This will include specific sessions with local carers group who will be invited to add to this analysis.

Other groups / communities of interest - Staff	**Option**	**Positive effect**	**Negative effect**	**Neutral**
Explanation:				
Mitigation action if adverse impact found:				
Intersectional disadvantages . We recognise that intersectional disadvantage can exponentially increase negative outcomes and experiences in the cohorts that have looked at in this assessment. We will ensure a focus on intersectionality through the next phase of engagement.				

Section 2 – Human Rights Assessment

Assessment – based on human rights-based approach in health Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our Betsi pages and additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker https://humanrightstracker.com We recognise the importance of Human Rights within context of developing healthcare services. We do not currently perceive any risks to human rights through the programme and no human rights issues have specifically been raised so far through the engagement work. We will continue to assess the options through a human rights perspective and any human rights issues raised will be included and assessed here.	

Here is a list of Human Rights (articles) and UN Conventions that may potentially impact on our patients, carers and staff. Please tick which are relevant to the proposal?	Use a tick ✓
Article 2 - Right to life	
Article 3 - Prohibition of inhuman or degrading treatment	
Article 5 - Right to liberty and security	
Article 8 - Right to respect for family and private life	
Article 9 - Freedom of thought, conscience and religion	
Article 14 – Prohibition of discrimination	
UN Convention on the Rights of the Child	
UN Convention on the Rights of Persons with Disabilities	
UN Convention on the Elimination of All Forms of Discrimination against Women.	
UN Principles for Older Persons	
Other articles – *please state:*	

Is the proposal aligned to the FREDA principles? You can copy and paste this tick: ✓

Fairness	Respect	Equality	Dignity	Autonomy
✓	✓	✓	✓	✓

If any negative impacts are identified, how will this be reduced/addressed? N/A

Section 3 – Armed Forces Covenant

All decision makers are required under the Armed Forces Act 2022 to have due regard to the principles of the Armed Forces Covenant. WP7 contains guidance and information to help complete this section. Decision makers should recognise the unique obligations of, and sacrifices made by, the Armed Forces and ensure there are no adverse effects and where possible a positive or increased positive effect on the armed services community. Special provision for Service People may be justified by the effect on such people of membership, or former membership, of the Armed Forces.

Due regard to the Armed Forces Covenant - Factors regarding impact to the Armed Forces community have been considered. You can copy and paste this tick: ✓	**Option**	**Positive effect**	**Negative effect**	**Neutral**
We do not envisage any particular impacts on the Armed Forces Community. Any issues of specific relevance to the Armed Forces Community will be noted and assessed here.	**1**			
	2			
	3			
	4			
	5			
Reasons for your decision There is no evidence that the current state has a disproportionately impact on the Armed Forces Community.				

Section 4 – Welsh Language

Having taken advice from the appointed Independent Strategic Advisers the Service Change Oversight Group have agreed that a separate Welsh Language Impact Assessment will be undertaken.

In this section you need to consider the impact, the evidence and any action you are taking for improvement. This is to ensure that the opportunities for people who choose to live their lives and access services through the medium of Welsh are not inferior to what is afforded to those choosing to do so in English, in accordance with the requirement of the Welsh Language Measure 2011.

Welsh Language Impact Assessment You can copy and paste this tick: ✓		
Will the proposal ensure that patients and carers can choose to live and receive services through the medium of Welsh? For example - delivered bilingually in Welsh & English. e.g. Consider if the proposal increase or decrease the opportunities for people to receive information or access information in Welsh.	Yes ✓	No
Will the proposal have an effect on opportunities for persons to use the Welsh language? Will the proposal encourage staff to use Welsh in the workplace and to have opportunities to learn and improve their Welsh? e.g. Consider if the proposal will alter the linguistic nature of the department. Consider opportunities to develop Welsh language skills within the department?	Yes	No ✓
Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts:		
Will the proposal act as a catalyst for Welsh cultural awareness, understanding, activity and integration? For example, encouraging new staff and students to take up Welsh language learning opportunities and to appreciate the socio-economic and cultural context of Wales.	Yes	No ✓
Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts:		

Will the proposal increase or reduce the department/division's ability to deliver services through the medium of Welsh?	Yes	No
		✓
Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: The Health Board's policy on Welsh Language provision will continue to apply		
Will the proposal treat the Welsh language no less favourably than the English language? e.g. Consider how Welsh speakers receive services to the same standard as those who access the same services through the medium of English.	Yes	No
		✓
Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts:		

Section 5 – Summary of assurance for compliance – Public Sector Equality Duty and Human Rights

Equality Legal Duties – summary of compliance	
Has BCUHB given due regard and given consideration for this proposal with the following:	
Eliminating unlawful discrimination, harassment, and victimisation? *Unlawful discrimination takes place when people are treated 'less favourably' as a result of having a protected characteristic*	Yes
Advancing equality of opportunity between people who share a protected characteristic and those who do not? *Making sure that people are treated fairly and given equal access to opportunities and resources*	Yes
Fostering good relations between people who share a protected characteristic and those who do not? *Creating a cohesive and inclusive environment for all by tackling prejudice and promoting understanding of difference*	Yes
Are there any potential Human Rights concerns?	No
Compliance to the Welsh Language requirements?	Yes
Compliance to giving 'due regard' to the principles of the Armed Forces Covenant?	Yes
Supporting narrative to support the above responses: At the current stage of the work this assessment has given due regard to the duties and has been given through the development and appraisal of the options. This assessment also provides evidence of a forward plan to ensure that the duties and the issues identified will inform final decision in alignment with the Brown and Bracking Principles.	
Do you consider the evidence used in this assessment to be robust? If you answer no, address this in the action plan (section 6)	Yes
Has this assessment been subject to scrutiny / been reviewed?	Yes

Section 6 – EQIA Action Plan and Recommendations

Date Added	Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
22.9.25	Engagement activities delivered through the "Right People in the Room" and "Balanced Room" frameworks provided by the Independent Strategic Adviser.	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included in the process.	None	Ongoing	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Complete
22.9.25	Lived Experience Sessions are being planned to focus specifically on the high-risk groups and the potential negative impacts identified in this impact assessment.	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment	None	Ongoing	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Scheduled

Date Added	Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
		are included in the process.					
22.9.25	Stakeholder Mapping exercise undertaken with a protected characteristic and socio-economic duty focus	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included in the process.	None	5.8.25	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Complete
22.9.25	Produce engagement summary report at the end of each phase, to include a dedicated section on equality, protected characteristics and high risks groups identified in this impact assessment.	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included	None	End of each phase	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Phase 1 Complete

Date Added	Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
		in the process.					
22.9.25	Agree to undertake Options Development and Options Appraisal in line with BCUHB Inclusive Decision Making Framework and agree weighting for equality scoring.	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included in the process.	None	Ongoing	Regular reporting to Service Change Oversight Group	Andrea Hughes	In development
22.9.25	Ensure arrangements are in place for all engagement activity to ensure all engagement opportunities are fully accessible to and inclusive of Welsh Language speakers, British Sign Language Users.	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included	None	Ongoing	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Complete

Date Added	Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
		in the process.					
22.9.25	Ensure that arrangement are agreed so that materials can be provided in other languages and/or formats upon request	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included in the process.	None	Ongoing	Regular reporting to Service Change Oversight Group	Andrea Hughes	Complete
22.9.25	Well-being of Future Generations Commissioner to be consulted with as part of the Engagement and Consultation Plans.	Ensure that alignment to the Well-being goals is properly addressed	None	TBC	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Ongoing
24.12.25	Ensure that the next phase of engagement includes specific sessions with: o Children and young people.	Ensuring a full range of voices are heard and have the chance to influence the	Strategic Adviser costs Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing

Date Added	Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
	○ Working age people. ○ Parents/guardians. People from these cohorts will be invited to add to this analysis.	final outcomes.					
24.12.25	Ensure that the next phase of engagement includes specific sessions with: People living with a physical impairment ○ People living with mental ill health ○ People living with sensory loss ○ People living with long-term conditions. ○ Parents, guardians and carers of disabled children and	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Strategic Adviser costs Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing

Date Added	Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
	young people. ○ People whose first language is BSL.						
24.12.25	Set up a session with the North Wales Access Panel	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Strategic Adviser costs Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Steve Dooré	Ongoing
24.12.25	Set up a session with the BCUHB Equality Stakeholder Group	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Strategic Adviser costs Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Steve Dooré	Ongoing
24.12.25	Hold discussions with the local community and Wrexham Museum and Heritage Service regarding the history and heritage of the building, with a particular focus on	Ensuring a full range of voices are heard and have the chance to influence the	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	

Date Added	Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
	people of Polish heritage who are more likely to hold a personal connection to the history and heritage of the site.	final outcomes.					
24.12.25	Identify and engage with local LGBTQ+ Groups	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing
24.12.25	Identify and engage with local groups that support the specific needs of women and men.	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing
24.12.25	Work with local faith group through the North Wales Interfaith Network.	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing

Date Added	Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
24.12.25	Work with local parenting forums.	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing
24.12.25	Work with local carers groups.	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing
24.12.25	Ensure all session in next phase include a focus on intersectionality.	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Steve Dooré	Ongoing
24.12.25	Continue to monitor all engagement activity for human rights issues being raised.	Ensuring a full range of voices are heard and have the chance to	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing

Date Added	Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
		influence the final outcomes.					
24.12.25	Continue to monitor all engagement activity for any issues raised that are of relevance to the Armed Forces Community.	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing

Section 7 Equality Risks

This section helps you work out the level of risk posed by any equality related risks identified above. Guidance is available **here** on completing this section, which may be helpful if you are not familiar with risk score analysis. If you have not identified any equality risks, please note this in the narrative box below. Examples include retrospective assessments and decisions that treat a protected characteristic unfavourably without objective justification.

Equality Related Risk Assessment Section					
If you have identified an equality risk, please use the table below to work out the risk score. Use the table below to record the highest risk score. If you have a score of 9 and above you **should escalate to risk management procedures**.					
	Level of risk				
Level of consequence	RARE: 1	UNLIKELY: 2	POSSIBLE: 3	LIKELY: 4	VERY LIKELY:5
1. Negligible	1	2	3	4	5
2. Minor	2	4	6	8	10
3. Moderate	3	6	9	12	15
4. Major	4	8	12	16	20
5. Catastrophic	5	10	15	20	25

If you have identified an equality risk: What is the consequence? What is the likelihood? Risk score = consequence x likelihood	Risk Score = 4 x 4 = 16 As of 30.7.25 24/12/25: 3 x 3 = 9
Any narrative relating to risk score: The initial status showed number of risks that the Health Board fails to provide accessible and equitable care. Through the application of the initial list of options of essential criteria, including "Access and Inclusion" criteria, and the ongoing analysis of the options through a detailed equality perspective we have brought these risks down.	

Section 8 – EQIA Sign off

Name of persons who signed-off this Equality Impact Assessment (see below): *As per the Health Board's Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board', to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Health Board as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions must have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.*
Approval Date:
Review Date:

Project Lead Sign-off	**Equality Team Sign-off (required when both EQIA and SEIA is required)**	**Committee Chair Sign-off**
I confirm that this Equality Impact Assessment has been carried out in accordance with Betsi Cadwaladr University Health Board's WP7 Procedure for assessment work for evidencing Due Regard for: Equality Impact, Socio economic Impact, Human rights, Welsh Language requirements and Armed Forces Covenant.	I confirm that I have reviewed this Equality Impact Assessment and I am assured that it contains sufficient evidence and rigour to be considered by the decision-making committee. Steve Dooré	I confirm that this Equality Impact Assessment represents evidence that we (The Health Board), in making this decision, have given due regard to the need to: 1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act. 2. Advance equality of opportunity between people who share a protected characteristic and those who do not.

Signed: (Project Lead)	Signed: (Equality and Inclusion Manager)	3. Foster good relations between people who share a protected characteristic and those who do not. Signed: (Committee Chair)

End of Part B. Only complete Part C if required.

Part C – Socio-economic Impact Assessment

The requirement for completion of Part C will have been identified in Part A and relates to complying with the Socio-economic Duty. This is a statutory duty with the aim of improving decision making to help improve outcomes for those who are socio-economically disadvantaged. The Socio-economic Duty gives us an opportunity to do things differently in Wales. It puts tackling inequality at the heart of decision-making, and will build on the good work public bodies are already doing.

This SEIA procedure should be commenced at the outset and inform the development of both new strategic decisions and when reviewing previous strategic decisions. It provides a clear audit trail for all decisions made under the 2010 Act.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see https://gov.wales/more-equal-wales-socio-economic-duty

Section 1 - Assessment information – evidence	
Has this assessment identified Stakeholder groups? *Supporting narrative if different to Part A.*	Yes – see part A
Has this assessment used a range of evidence? *Supporting narrative to consider socio-economic disadvantage and inequalities of outcome in relation to this decision? Note additional evidence if different to information within Part A.*	Yes – see part A
Has this proposal engaged with those impacted by the Policy / Strategy Proposal / Policy? *Supporting narrative if different to Part A.*	Yes – see part A

Relevant communities of interest identified that may be impacted by this proposal and engagement work undertaken:	**Proposal may impact these groups** Use a tick ✓	**Engagement undertaken** Yes / Planned	**Any supporting narrative / comments**
People experiencing poverty	✓	✓	See “Living Standards”
Carers	✓	✓	See Part B
People who share a common first language			
People experiencing homelessness			
Lone parent families	✓	✓	See “Living Standards”
Those seeking sanctuary			
Experience of local health and social care system			
Military Veterans and Armed Forces Community			
University students			
Long term caravan residents and second home visitors			

Other – please state:			
Relevant communities of place			
Urban areas			
Rural areas	✓	✓	See “Living Standards”
Areas of high levels of unemployment / deprivation	✓	✓	See “Living Standards”
Other – please state:			
How has / will this influence your work/guided your policy/proposal, or changed your recommendations? Supporting narrative:			

Section 2 - Impacts on Socio-economic Duty Domain Areas:

The Equality and Human Rights Commission monitor progress on equality and human rights across a range of areas of life in Great Britain. These domain areas include education, work, living standards, health, justice and personal security and participation.

It is helpful to consider where action can be taken to reduce inequality of outcome resulting from socio-economic disadvantage in regards to each of these areas, evidence is provided below and issues for consideration suggested.

Consider evidence from both research and any engagement already carried out. Who is being affected? Are some communities of interest or communities of place more affected by disadvantage than others? Betsi Net Equality pages provides further guidance.

What are the main socio-economic impacts of the proposal?

Domain area: Education	Option	Positive effect	Negative effect	Neutral
You can copy and paste this tick: ✓	A			
	B			
	C			
	D			

Supporting narrative:

Health is crucially linked with education; good health and wellbeing are associated with improved attendance and attainment at school, which in turn lead to improved employment opportunities and broader career options. The 2021 Census recorded around 106,340 (19%) adults aged 16 years and over in North Wales with no qualifications. Gwynedd has the lowest proportion with no qualifications (16.3%)[7] The desktop analysis has not highlighted any particular issues in regards to education from the proposal at this stage.

While no specific issues regarding education have been recorded during the research and engagement stages, we recognise that increasing opportunities to education can play a role in tackling ongoing workforce challenges. All options will therefore be tested against their potential to increase local education opportunities.

OPTIONS						
A	Health and Wellbeing Hub (Integrated)				KEY	
B	Rehab / Step-down Facility with Beds				Positive Impact	✓
C	Health and Wellbeing Hub plus Third Sector Facility				Neutral Impact	●
D	Services in the Community (No Physical Building)				Negative Impact	X
Issue		**A**	**B**	**C**	**D**	
1.	Opportunities to increase local education opportunities.	●	●	●	●	

The group concluded that at this stage there is not enough information to fully assess the potential to increase local education opportunities.

[7] Public Health Wales, *Health and Wellbeing Profile for Penley, Gwynedd,* (July 2025), p21

Issue	Impact	Rationale
EA1		The group concluded that at this stage there is not enough information to fully assess the potential to increase local education opportunities.
EB1		The group concluded that at this stage there is not enough information to fully assess the potential to increase local education opportunities.
EC1		The group concluded that at this stage there is not enough information to fully assess the potential to increase local education opportunities.
ED1		The group concluded that at this stage there is not enough information to fully assess the potential to increase local education opportunities.

Action / Opportunities that can be taken to reduce inequality of outcome resulting from socio-economic disadvantage:

The next phase of engagement will include education providers and people currently in education.

What are the main socio-economic impacts of the proposal?

Domain area: Health
You can copy and paste this tick: ✓

Future versions of this assessment will use this section to assess the potential impact of each option on this domain once the options have been developed

Option	Positive effect	Negative effect	Neutral
A			
B			
C			
D			

Supporting narrative:
While there may not be an immediate health risk posed at a population level by the current state, we need to be aware of the impact on people's perceptions of their access to healthcare, and the resultant impact on their trust in their health provider and on their mental health and well-being. The BCUHB Public Health 'Health and Wellbeing Profile' for Penley sets out the requirements for a

healthy and well population. Based on the determinants of health they include chronic condition management, healthy lifestyles and behaviours such as healthy weight, tobacco, alcohol consumption, nutrition, and physical activity.

Action / Opportunities that can be taken to reduce inequality of outcome resulting from socio-economic disadvantage? What are the opportunities for collaboration, have local third sector organisations been engaged and opportunities to promote access to financial wellbeing, social and other support maximised?

These themes will be explored with all groups in the next phase of engagement.

What are the main socio-economic impacts of the proposal?

Domain area: Living standards
You can copy and paste this tick: ✓

Option	Positive effect	Negative effect	Neutral
A	2		1
B	0		3
C	2		2
D	2		2

Supporting narrative:

On the basis of the assessment below the options that support the socio-economic duty from the perspective of living standards are options A, C and D.

The risks posed by the current state have a disproportionate impact on people living in poverty or other socio-economic disadvantage, who make up a higher-than-average proportion of the population of the local area and are high users of community hospitals and inpatient beds. All options will be assessed for their potential to make a positive impact on these potential risks:

- Increased travel for family and friends when visiting patients in the hospital

- Increased reliance on limited transport opportunities locally
- Reduced capacity to deliver care close to home in more rural and/or isolated areas.
- Increases in costs of travel will have a greater impact on this cohort, increasing the likelihood of this group – more likely to live with poor health – being unable to access healthcare, perpetuating the Inverse Care Law.

Reviewing the findings summarised above we are able to combine some themes together to form the issues to consider for this group in this assessment Those issues are:	Source			
	Known	Survey	BR1	BR2
1. Increased travel for family and friends when visiting patients in the hospital	√	√	√	√
2. Increased reliance on limited transport opportunities locally	√	√	√	√
3. Increases in costs of travel	√	√	√	√

OPTIONS			
A	Health and Wellbeing Hub (Integrated)	KEY	
B	Rehab / Step-down Facility with Beds	Positive Impact	✓
C	Health and Wellbeing Hub plus Third Sector Facility	Neutral Impact	●
D	Services in the Community (No Physical Building)	Negative Impact	X

Issue	A	B	C	D
1. Increased travel for family and friends when visiting patients in the hospital	✓	●	✓	✓
2. Increased reliance on limited transport opportunities locally	✓	●	✓	✓
3. Increases in costs of travel	●	●	●	●

Issue	Impact	Rationale
LSA1	✓	This options offers a much greater range of services locally, often services that people who are supported by carers people are disproportionate users of, and is highly likely to reduce the travel needs of people and their carers in the local area on a regular basis.
LSA2	✓	This options offers a much greater range of services locally, often services that people who are supported by carers people are disproportionate users of, and is highly likely to reduce the travel needs of people and their carers in the local area on a regular basis.
LSA3	●	The group was clear that though we recognise the costs of travel can be a barrier, this is beyond the control of the Health Board and therefore out of scope for this assessment.

LSB1	●	The group judged this to be neutral at this stage as there is a lack of clarity currently on who would most likely be accessing this model of care. As it would not necessarily be the local community it is difficult to determine the impact on carers. This will be revisited during the travel analysis.
LSB2	✓	This options offers a much greater range of services locally, often services that people who are supported by carers people are disproportionate users of, and is highly likely to reduce the travel needs of people and their carers in the local area on a regular basis.
LSB3	●	The group was clear that though we recognise the costs of travel can be a barrier, this is beyond the control of the Health Board and therefore out of scope for this assessment.
LSC1	✓	This options offers a much greater range of services locally, often services that people who are supported by carers people are disproportionate users of, and is highly likely to reduce the travel needs of people and their carers in the local area on a regular basis.
LSC2	✓	This options offers a much greater range of services locally, often services that people who are supported by carers people are disproportionate users of, and is highly likely to reduce the travel needs of people and their carers in the local area on a regular basis.
LSC3	●	The group was clear that though we recognise the costs of travel can be a barrier, this is beyond the control of the Health Board and therefore out of scope for this assessment.
LSD1	✓	This options offers a much greater range of services locally, often services that people who are supported by carers people are disproportionate users of, and is highly likely to reduce the travel needs of people and their carers in the local area on a regular basis.
LSD2	✓	This options offers a much greater range of services locally, often services that people who are supported by carers people are disproportionate users of, and is highly likely to reduce the travel needs of people and their carers in the local area on a regular basis.
LSD3	●	The group was clear that though we recognise the costs of travel can be a barrier, this is beyond the control of the Health Board and therefore out of scope for this assessment.

As part of your proposal what are the opportunities to reduce the impact of poverty on living standards?

The next phase of engagement will include people living with financial issues and peoples supporting people living with financial issues.

What are the main socio-economic impacts of the proposal?

Domain area: Work You can copy and paste this tick: ✓	**Option**	**Positive effect**	**Negative effect**	**Neutral**
	A			
	B			
	C			
	D			

Supporting narrative:

On the basis of the assessment below the options that support the socio-economic duty from the perspective of living standards are options A, C and D.

During the engagement process workforce challenges were acknowledged. Many respondents and participants felt these could be addressed through local recruitment, better support, and staff retention strategies. Several responses highlighted the dedication of local staff and the need to respect and retain local expertise.

Reviewing the findings summarised above we are able to combine some themes together to form the issues to consider for this group in this assessment Those issues are:	**Source**			
	Known	**Survey**	**BR1**	**BR2**
1. Development of local employment opportunities	√	√	√	√
2. Staff retention	√	√	√	√

3. Retention of local expertise		√	√	√	√

OPTIONS			
A	Health and Wellbeing Hub (Integrated)	KEY	
B	Rehab / Step-down Facility with Beds	Positive Impact	✓
C	Health and Wellbeing Hub plus Third Sector Facility	Neutral Impact	●
D	Services in the Community (No Physical Building)	Negative Impact	X

Issue	**A**	**B**	**C**	**D**
1. Development of local employment opportunities	●	●	●	●
2. Staff retention	●	●	●	●
3. Retention of local expertise	●	●	●	●

Work Rationale

Issue	Impact	Rationale
WA1	●	The group concluded that at this stage there is not enough information to fully assess the potential to develop local employment opportunities.
WA2	●	The group concluded that at this stage there is not enough information to fully assess the potential to improve staff retention.
WA3	●	The group concluded that at this stage there is not enough information to fully assess the potential to improve retention of local expertise.
WB1	●	The group concluded that at this stage there is not enough information to fully assess the potential to develop local employment opportunities.
WB2	●	The group concluded that at this stage there is not enough information to fully assess the potential to improve staff retention.
WB3	●	The group concluded that at this stage there is not enough information to fully assess the potential to improve retention of local expertise.
WC1	●	The group concluded that at this stage there is not enough information to fully assess the potential to develop local employment opportunities.
WC2	●	The group concluded that at this stage there is not enough information to fully assess the potential to improve staff retention.

WC3		The group concluded that at this stage there is not enough information to fully assess the potential to improve retention of local expertise.
WD1		The group concluded that at this stage there is not enough information to fully assess the potential to develop local employment opportunities.
WD2		The group concluded that at this stage there is not enough information to fully assess the potential to improve staff retention.
WD3		The group concluded that at this stage there is not enough information to fully assess the potential to improve retention of local expertise.

We will ensure we continue to include staff in the assessment of the options.

What are the main socio-economic impacts of the proposal?

Domain area: Justice and personal security

You can copy and paste this tick: ✓

	Positive impact	Negative impact	Neutral / No impact
Initial Closure			
1			
2			
3			
4			

Supporting narrative:

How does your proposal take account of local crime rates and feeling safe? Think about people who live in less safe areas and those more likely to be victims of domestic violence and abuse. Evidence suggests that domestic violence incidents are becoming more complex and serious, with higher levels of physical violence and coercive control.

How can your proposal promote and protect people's rights and increase their access to justice and personal security?

What are the main socio-economic impacts of the proposal?

Domain area: Participation
You can copy and paste this tick: ✓

Option	Positive effect	Negative effect	Neutral
Initial Closure			
1			
2			
3			
4			
5			

Supporting narrative:
How is participation enabled, how is engagement sustained with people with lived experience of socio-economic disadvantage and how has this informed your proposal? Think about digital exclusion and digital poverty, people living in rural areas and those unable to access services and facilities.

How can your proposal increase participation for people who experience socio-economic disadvantage?

Section 3 – Socio-economic Duty Action plan

Socio-economic Impact Assessment Action Plan and Recommendations Please include any related recommendations arising from this assessment. Include any positive action.						
Action identified	**Potential Outcomes**	**Resource implications**	**Target date**	**Monitoring arrangements**	**Lead person/ owner**	**Status**
Include all considerations and issues identified in this Socio-economic Impact Assessment in the Stakeholder Mapping Exercise	Representatives of all communities of place or interest are included in the stakeholder mapping exercise.	None	5.8.25	Report to Service Change Oversight Group	Steve Dooré	Completed

Undertake a travel analysis as part of the options development and appraisal	Impacts on people who rely on transport infrastructure are better understood.	TBC	TBC	Report to Service Change Oversight Group	Ryan Welch	Completed
include education providers and people currently in education in the next phase of engagement.	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing
Ensure issues raised in the Penley Health Profile are addressed in the next phase of engagement sessions	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing
Include people living with financial issues and peoples supporting people living with financial issues in the next phase of engagement.	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing

Continue to include staff in the assessment of the options.	Ensuring a full range of voices are heard and have the chance to influence the final outcomes.	Staff costs Catering and room hire	TBC – dependent on engagement plan for 2026	Report to Service Change Oversight Group	Helen Stevens-Jones	Ongoing

Section 4 – SEIA Sign off

Who signed-off this SED Impact Assessment: *As per the Health Board's Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board', to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Health Board as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions must have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.*		
Approval Date: tbc		
Review Date: tbc		
Project Lead Sign-off I confirm that this Socio-economic Impact Assessment has been carried out in accordance with Betsi Cadwaladr University Health Board's WP7 Procedure for assessment work for evidencing Due Regard for: Equality Impact, Socio economic Impact, Human rights, Welsh Language requirements and Armed Forces Covenant. Signed: (Project Lead)	**Equality Team Quality Check (required when both EQIA and SEIA is required)** I confirm that I have reviewed this Socio-economic Impact Assessment and I am assured that it contains sufficient evidence and rigour to be considered by the decision-making committee. **Signed:** Steve Dooré  (Equality and Inclusion Manager)	**Committee Chair Sign-off** I confirm that this Equality Impact Assessment represents evidence that we (The Health Board), in making this decision, have given due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. Signed: (Committee Chair)

End of SED assessment

"Right People in the Room" Checklist

Use this checklist to ensure your consultation or engagement activity includes the people most relevant to the decision, those affected by it, and those with the right knowledge or perspective.

How to Use This Checklist

This checklist is designed to help you assess whether the right individuals and groups have been included in your consultation or engagement process:

- For each question, consider the current stage of your project and tick **Yes**, **No**, or **Partially** as appropriate. (Click in the check box with your cursor)
- Use the “Partially” option if some effort has been made but further action is needed.
- Where gaps are identified, make a note of any planned follow-up steps.
- This tool is best used collaboratively by the project team to support transparency, fairness, and inclusive decision-making.

Checklist Questions:

1. Who is Affected?

Have we identified all those directly or indirectly affected by the decision or proposal?

Yes ☐

No ☐

Partially ☐

2. Who Has Lived Experience or Expertise?

Are people with relevant lived experience, local insight, or frontline knowledge included?

Yes ☐

No ☐

Partially ☐

3. Who Holds Influence or Responsibility?

Are those with decision-making power, policy responsibility, or implementation roles involved?

Yes ☐

No ☐

Partially ☐

4. Are Diverse Voices Present?

Have we actively included people from seldom heard or marginalised groups, and made adjustments for them to participate?

Yes ☐

No ☐

Partially ☐

5. Have We Covered Key Perspectives?

Do we have a range of viewpoints, including those who may challenge or disagree with the proposals?

Yes ☐

No ☐

Partially ☐

6. Are Gaps Acknowledged and Addressed?

Where key groups couldn't attend, have we taken other steps to include their views (e.g. interviews, outreach, intermediaries)?

Yes ☐

No ☐

Partially ☐

7. Have We Recorded Our Reasoning?

Is there a clear record of who was included, why, and how this was judged to be fair and sufficient?

Yes ☐

No ☐

Partially ☐

"Balanced Room" Checklist

Use this checklist to assess whether your consultation, co-production or engagement space includes a fair and diverse range of voices, perspectives, and stakeholder types, and whether any group is underrepresented or overly dominant.

How to Complete This Checklist

This checklist is designed to help you assess whether your engagement, consultation, or co-production session is inclusive and balanced:

- For each question, review the composition and dynamics of your group and tick **Yes**, **No**, or **Partially**. (Click in the check box with your cursor)
- Use the "Partially" option if efforts have been made but further action is needed.
- The checklist can be completed individually or as a team and should ideally be revisited at multiple stages.
- Use the Final Reflection section to determine whether your room is sufficiently balanced or if further adjustments are necessary.

Checklist Questions:

1. Representation and Diversity

1.1 Have we included a range of demographic groups (e.g. age, gender, ethnicity, disability, geography)?

Yes ☐
No ☐
Partially ☐

1.2 Does the group reflect the diversity of people affected by the issue or decision?

Yes ☐
No ☐
Partially ☐

2. Stakeholder Interests and Perspectives

2.1 Are different stakeholder types present (e.g. service users, staff, community leaders, campaigners, dissenting voices)?

Yes ☐
No ☐
Partially ☐

2.2 Is there a balance between supporters, critics, and those who are undecided?

Yes ☐
No ☐
Partially ☐

3. Power and Influence

3.1 Are less powerful or marginalised groups supported to participate fully (e.g. interpreters, access needs, digital support)?

Yes ☐
No ☐
Partially ☐

3.2 Have we prevented domination by powerful voices (e.g. senior professionals, loud stakeholders)?

Yes ☐
No ☐
Partially ☐

4. Participation and Voice

4.1 Are all participants being heard equally during the session?

Yes ☐
No ☐
Partially ☐

4.2 Are we using methods that allow quieter voices to contribute safely (e.g. breakout groups, written input)?

Yes ☐
No ☐
Partially ☐

5. Monitoring and Responsiveness

5.1 Are we actively reviewing who is in the room and who is missing?

Yes ☐
No ☐
Partially ☐

5.2 Have we taken additional steps to bring in underrepresented views (e.g. targeted outreach, focus groups)?

Yes ☐
No ☐
Partially ☐

6. Final Reflection

Based on the checklist above, is this a balanced room, or are there risks of consultation capture, under-representation, or power imbalance?

- ☐ Balanced
- ⚑ Some gaps identified
- ☐ Major imbalances: follow-up required

Appendix 2

Shaping the future of Penley Community Hospital – Travel Impact Assessment

Executive summary

This Travel Impact Assessment evaluates how the temporary closure of Penley Community Hospital (December 2024) and any proposed future service changes may affect patient, carer, staff, and community travel patterns in the Penley catchment area. Penley serves an ageing, rural population of approximately 6,477 residents, with a higher proportion of older people compared with wider Wrexham and Wales. Changes to local healthcare provision have the potential to increase travel time, costs, and accessibility barriers, particularly for older adults, individuals with disabilities, lower-income households, and carers making regular visits.

This assessment seeks to identify the impact on travel of the service change, noting that c.37% of inpatients in Penley Community Hospital in the year before closure also had alternative care provision available closer to their homes and the majority of those eligible for inpatient care at Penley are now being admitted to Chirk Hospital which is more readily accessible via public transport despite a slightly increased journey time overall.

1. Introduction

1.1 Purpose of the Assessment

The purpose of the Travel Impact Assessment (TIA) is to understand how changes to Penley Community Hospital services - the temporary closure in December 2024 and subsequent review to develop a sustainable solution for services - may affect patient, carer, staff and visitor travel patterns across the Penley catchment area. It aims to identify potential inequalities, additional travel burdens, risks to access and mitigations required to ensure safe and equitable access to care.

Any patient previously admitted to Penley Community Hospital would have been transferred from another BCUHB hospital site which means that patient transport would be available – and is still the case for any patient subsequently being transferred to another BCUHB site for similar care. The impact on travel for carers, friends and family from a visitor perspective has been a repeat concern throughout pre-consultation feedback, therefore the Travel Impact Assessment takes this into

account, as well as any adverse effect on staff impacted by the current service change.

1.2 Background and context

Penley Community Hospital previously provided eight inpatient beds for patients no longer requiring acute hospital care, including those awaiting care packages or care home placement, and some end-of-life patients. The facility closed temporarily in December 2024 due to:

- Sustainability issues, including a very limited number of suitable patients.
- Workforce challenges in staffing the low-occupancy unit safely.

No other clinical services operate from the Penley site.

Of the 59 patients admitted from Betsi Cadwaladr University Hospital sites to Penley Community Hospital from December 2023 to the temporary closure in December 2024:

- 49.2% (29) normally resided in Wrexham and the surrounding areas
- 27.9% (16) in Chirk and surrounding areas
- 13.1% (8) in Penley and the surrounding areas
- 6.6% (4) in Llangollen
- 1.6% (2) in Powys and Corwen.
- At least 22 of patients in Penley during this time had community hospital provision available closer to home.
- During this period, there was an average of 6 patients in Penley.
- At the time of the temporary closure, there were 4 patients who were all transferred to Chirk Hospital.

2. Population and Equality Profile

2.1 Overview of the local population

The Penley catchment area (Figure 1) corresponds broadly to Middle Super Output Area (MSOA) Wrexham 018, which includes four Lower Super Output Areas (LSOAs): Bronington 1, Bronington 2, Overton 1 and Overton 2. The MSOA has approximately 6,477 residents.

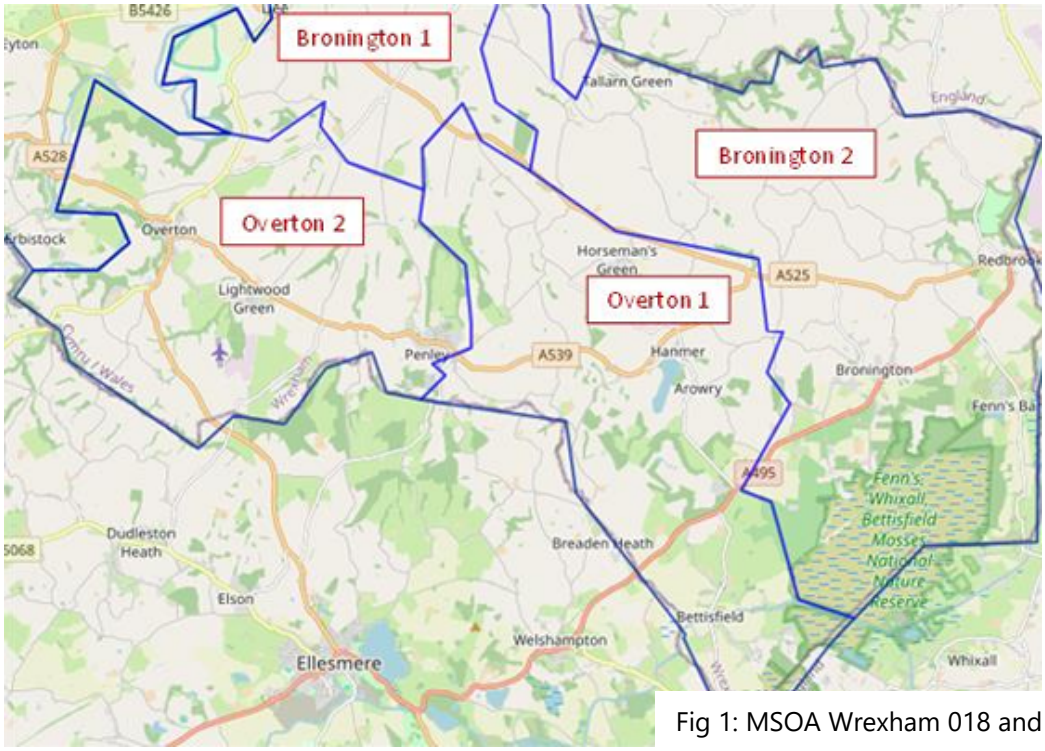


Fig 1: MSOA Wrexham 018 and LSOAs

Key characteristics within the local population relevant to travel impact:

Older population:

- Around 28% of residents in the MSOA are aged 65+, and 4.2% are aged 85+ - both significantly higher than local averages.
- Approximately 200 residents aged 65+ fall within the area currently served by Penley.

Implication: Older adults are more likely to need community hospital services and may face greater travel challenges living in rural areas.

Rural geography and dispersed communities:

- The MSOA covers multiple rural villages with limited public transport.

Implication: Increased travel distances and car dependency.

Health need and long-term conditions:

- South Wrexham Primary Care Cluster (which covers Penley) has the highest recorded prevalence in Wrexham for asthma, atrial fibrillation, epilepsy, hypertension, and stroke/TIA.

Implication: Higher need for accessible, routine and urgent care.

Deprivation considerations:

- Bronington 2 is the most deprived LSOA in the area, ranked 1,290th in Wales (moderate deprivation).

Implication: Some households may have reduced car ownership, making travel impacts more significant.

3. Baseline Travel Profile

3.1 Travel to and from Penley

Penley is centrally located for Bronington, Overton, Hanmer and surrounding villages. Access is primarily an A-road and smaller, rural routes.

Similarly, Chirk Hospital is accessed via the Chirk Bypass (A-road) and other smaller, rural routes (B-roads).

People in the Penley area requiring urgent and emergency care or secondary care, would predominantly access BCUHB services provided at the Wrexham Maelor site, a journey of under 30 minutes by car – less under "blue light" (via ambulance). This is outside of the scope of the Penley Community Hospital service review.

3.2 Access to Local GP Surgeries

Primary care in the area is typically accessed at:

- Overton
- Hanmer
- Bangor-on-Dee

These practices support around 2,000 registered patients each and provide multidisciplinary primary care services.

3.3 Transport Modes

Car travel is the primary mode due to the rural location and dispersed population.

Feedback from local community members from Penley and the surrounding areas during the pre-engagement phase gave a sense that public transport routes are limited, reportedly low-frequency and not always aligned with visiting hours or clinical appointment needs.

There is a Wrexham to Whitchurch bus service running Monday-Friday with a slightly reduced service over the weekend for visitors to Penley from the wider Wrexham area and vice versa; Penley to Wrexham. (Traveline Cymru - Journey Planning Wales – service run by Pat's Coaches).

Public transport between Wrexham and Chirk is more frequent with a more regular bus service between the two locations. There is also a train service running 32 times throughout the day between Wrexham and Chirk. (Trains Wrexham General to Chirk from £2.70 | Compare Times & Cheap Tickets | Trainline) with an onwards bus service allowing access to Chirk Community Hospital (Traveline Cymru - Journey Planning Wales)

3.4 Staff Travel

Penley's small staffing model (nurses, Healthcare Support Workers, limited medical sessions) meant staff travel was largely localised. Redeployment to other sites may increase commuting distances and time. Seven staff members who worked in Penley are currently redeployed to four locations. 4 in Chirk Hospital.

4. Impact Assessment

4.1 Overall impact

Based on car travel, for patients admitted to Penley Hospital between December 1st 2023 and November 30th 2024, the map below (Fig.2) illustrates travel times from their homes to the hospital.

The travel times are grouped into 15-minute intervals, with green indicating shorter drive times then yellow/orange showing increased drive times. This is working on the assumption that visitors, e.g., spouses, close family or carers, would be travelling from their home or the immediate surrounding area.

Alternatively, the Figure 3 displays the same patients, but it is based on the travel time if they had been admitted to Chirk Hospital instead of Penley.

When Penley Hospital was admitting patients, the median travel time for a patient from home was 10 minutes, with 85% of patients falling in the under 15-minute category. 100% of patients fell into the 15–30-minute category with all having a journey of 30 minutes or less.

Using this cohort as an example, if these same patients had been admitted to Chirk Hospital, the median travel time from their home would have been 15 minutes, with 96% having journey of 30 minutes or less. The remaining 4% would have had a journey of 30-45 minutes.

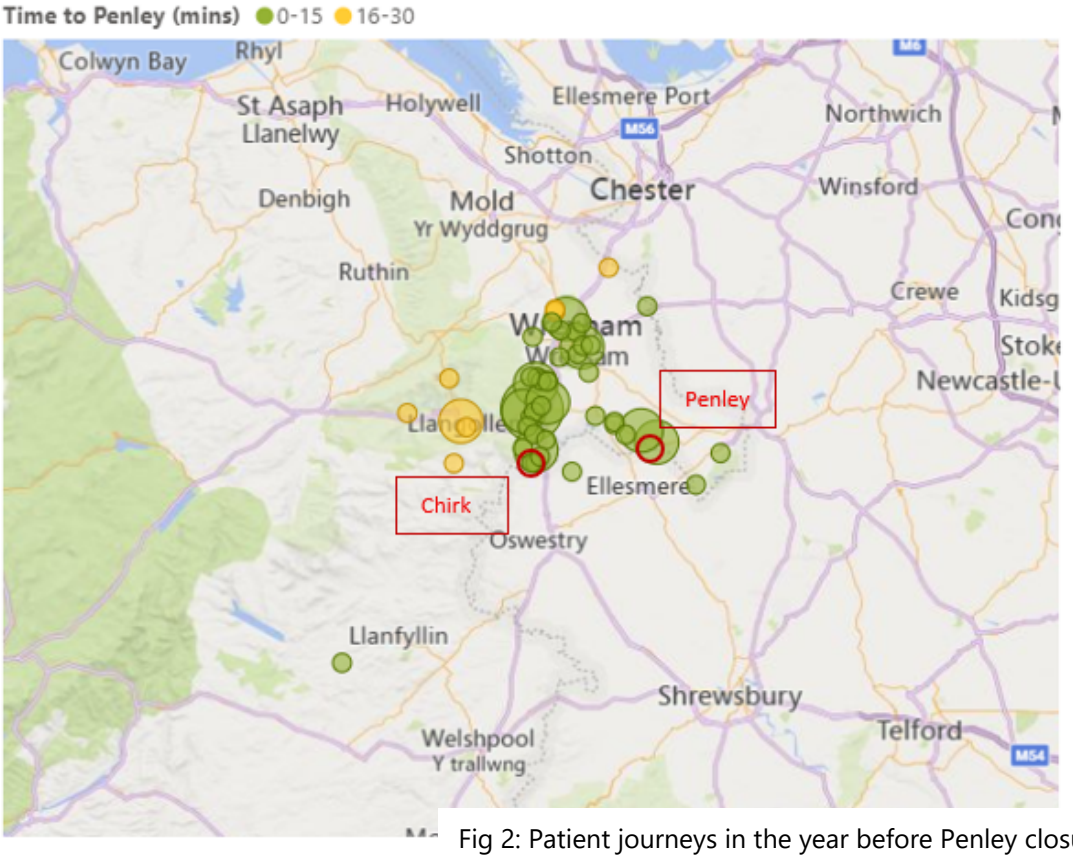


Fig 2: Patient journeys in the year before Penley closure.

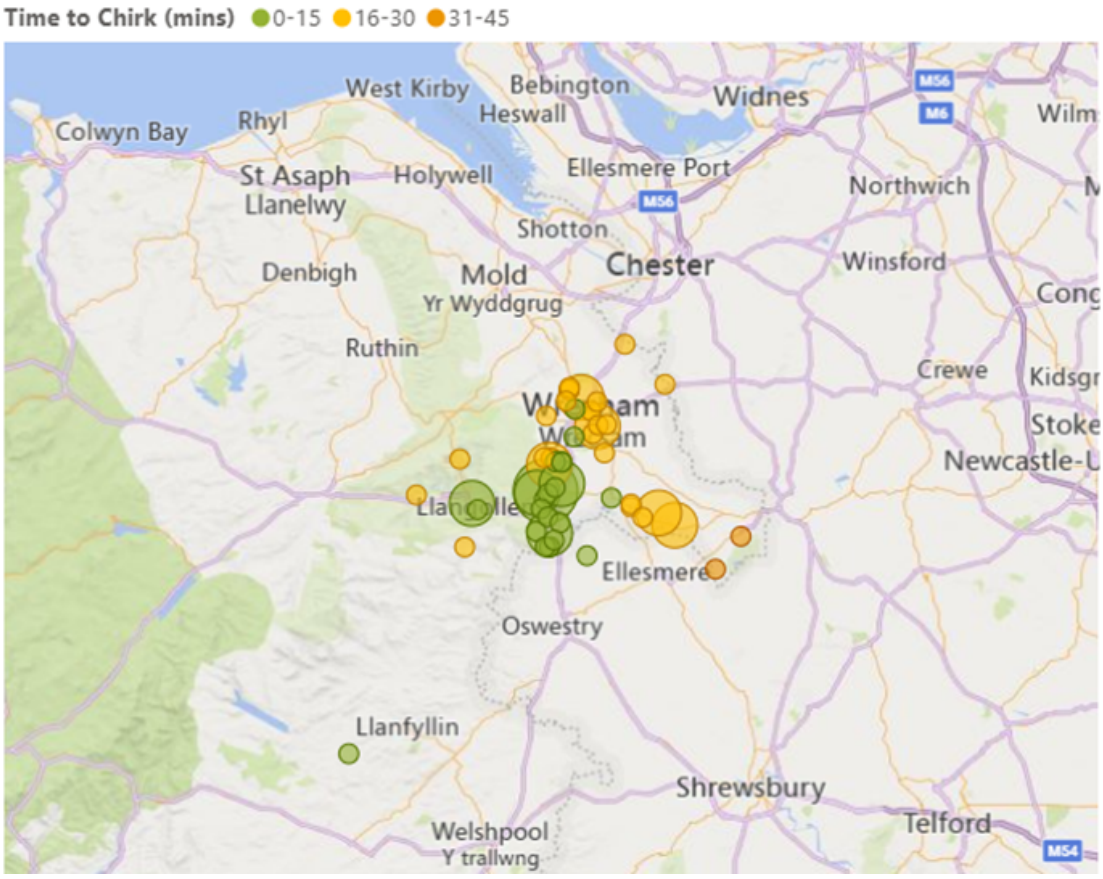

Time to Chirk (mins)
0-15
16-30
31-45
West Kirby
Bebington
Heswall
Widnes
Colwyn Bay
Rhyl
St Asaph
Llanelwy
Holywell
Ellesmere Port
Northwich
Shotton
Chester
Winsford
Denbigh
Mold
Yr Wyddgrug
Ruthin
Crewe
Newcastle-U
Ellesmere
Oswestry
Llanfyllin
Shrewsbury
Telford
Welshpool
Y trallwng
M56
M6
M54

Fig 3: Patient journeys if the same cohort had been admitted to Chirk Hospital.

	<15 mins	15-30 mins	30-45 mins
Penley	56 85%	10 15%	0 0%
Chirk	32 48%	32 48%	2 4%

Fig 4: Travel time bands.

4.2 Impact on those receiving end-of-life care

Just under 30% of people (44 people) responding to Phase One of the pre-engagement phase survey had experience of loved ones previously having received end-of-life care at Penley Community Hospital.

In the year before the temporary closure, (December 2023 – November 2024), 14 patients received end-of-life nursing at Penley Community Hospital. Feedback tells us that families valued the ability to visit loved ones easily and felt the unit had previously provided compassionate, personalised care. (bcuhb.nhs.wales/get-involved/shaping-the-future-of-penley-hospital/penley-key-documents/penley-phase-one-engagement-reportpdf/) and there is the acknowledgement of the difficulty faced by visitors when travelling to see loved ones at a distressing time.

4.3 Impact on low-income households

One area (Bronington 2) within the catchment is considered of "Moderate Deprivation" which means communities within them can be expected to face slightly below to average challenges with income, housing and health.

The assumption is therefore that deprived households may experience the below when accessing healthcare or visiting loved ones:

- Reduced ability to travel by car
- Increased dependency on public transport

4.4 Environmental impact

Any increase in the duration of private car journeys may marginally increase carbon emissions, conflicting with NHS Wales sustainability objectives.

4.5 Impact rating per population group

Population group	Impact rating
Older people requiring step-down, rehabilitation or end-of-life care.	Low – Patients would be transferred by via Patient Transport Services.
Carers and family members visiting frequently.	Medium – slight increase in journey time compared to Penley (from 10 minutes to 15 minutes) however 96% of journeys based on previous inpatient data remain under 30 minutes.
People awaiting care home placement.	Low – Patients would be transferred by via Patient Transport Services.
People with limited mobility or disabilities.	Low – Patients would be transferred by via Patient Transport Services. Potential medium impact for visitors with limited mobility or disabilities.
Households without access to private transport.	Low – greater access to public transport routes into Chirk than Penley.
Staff redeployed to other sites.	Medium – 7 staff members redeployed to alternative locations, 4 staff relocated in Chirk hospital which represents a slight increase in journey time.

5. Mitigation measures

5.1 Travel cost support

Under normal circumstances, patients are expected to attend hospital appointments at their own cost with the exception of medical emergencies or where a medical condition makes travel to hospital by private or public transport unsuitable.

For some patients, however, travel to receive healthcare can present difficulties, for example where the journey is lengthy, complex, costly, or there is poor access to public transport. In particular, patients on benefits or low incomes may find it difficult to meet the cost of travelling to hospital or other healthcare premises for treatments or diagnostic tests.

The Healthcare Travel Costs Scheme (HTCS), which forms part of the NHS Low Income Scheme, was set up to provide financial assistance to those patients who do not have a medical need for ambulance transport, but who may require assistance with their travel costs.

Betsi Cadwaladr University Health Board is committed to ensuring that all eligible patients and carers are reimbursed for travel costs in accordance with the HTCS.

Patients who would have previously been admitted to Penley Community Hospital would have received patient transport services.

5.2 Visiting times at Community Hospital sites, including for end-of-life care

Currently the Health Board operates flexible visiting hours which means that friends, relatives and carers can visit patients at any time at a time to suit them, not at a fixed or set time. Mealtimes however are usually protected so that patients are able to eat undisturbed.

Anyone wishing to visit a loved one is encouraged to liaise with the particular ward direct.

Even exceptional circumstances when a ward is closed to general visitors, e.g., for infection prevention and control measures, visits for end-of-life care are typically still permitted, provided precautions are followed

BCUHB also supports:

- Letter to Loved Ones: A service is available to send messages to patients via email to the ward, which staff will deliver.
- Virtual Visits: Free hospital Wi-Fi is available for video calls.

5.3 Potential increase in community provision

As a result of the service change review, options for sustainable solutions have been developed which would potentially see an increase in community health and wellbeing provision for the local area which may mean a reduction in travel for some services.

6. Conclusion

Based on available information, the patient population who would have been eligible for care at Penley Community Hospital do not appear to have been disproportionately affected by the temporary closure of the inpatient unit. Despite a slight increase in overall travel time on the assumption that patients would be admitted to Chirk Hospital, overall, 96% of visitors from the same postcode areas would still have a journey time of 30 minutes or less. There is also increased provision of public transport to the Wrexham and Chirk areas than there is to Penley.

The options being put forward for consultation have the potential to reduce the need for travel for some services for a larger number of the patient population than those who would have been admitted for inpatient care.

Feedback from the pre-engagement phase shows strong support for expanding Penley Community Hospital's role into a multi-functional community service with an opportunity to provide more or different care closer to home, which is vital for independence and wellbeing in rural communities.

Welsh Language Impact Assessment

1.1 Background – Welsh Language Impact Assessment	
Who is the lead Officer for this Assessment?	Eleri Hughes-Jones, Head of Welsh Language Services
What are the aims and purpose of this proposal?	Penley Community Hospital is a former community hospital founded in 1946 as part of an initiative to care for Polish ex-servicemen who fought alongside the allies in the second world war and their families who settled in the area. At that point the site was a large 720 bedded facility. In 2002 the hospital housed six patients who occupied one of the 30 wards on the site. It was closed in 2002 by the then North East Wales NHS Trust and in 2004 the wider hospital site was sold. The remaining Penley site is in the ownership of the BCUHB and a portion leased to the Trustees of the Penley Rainbow Centre. An 8 bedded bungalow was opened in 2004 to replace the previous facility which provides community inpatient care and serves the rural area of South Wrexham with an older population and growing care needs. It operates as a step-down facility – supporting patients who no longer require acute hospital admission but still need ongoing care whilst they recover prior to returning home or moving to another care setting. Historically, Penley Community Hospital provides step-down facilities only. Key features include: • Low acuity inpatient beds typically for older patients. • Step-down care following discharge from an acute hospital. • End of life-care although this was only available for patients with very specific health care needs and was not routinely provided.

	On 19th December 2024, Penley Community Hospital's inpatient beds were closed. Key issues behind the decision include: • Sustainability of the care model due to the very limited number of patients suitable for care in this particular setting. • Vacancies and temporary reliance on temporary staff. Given the challenges outlined above, closure of the inpatient beds are now the subject of a formal service review (which includes a programme of deep and extended engagement) to consider the provision of safe, long term and sustainable high-quality services that meets the needs of the local community. As part of the deep engagement process, two full day sessions were held with balanced representation from Health Board members and stakeholders. This participatory process created a stakeholder informed shortlist of options. Participants included councillors, local community groups, third sector providers, BCUHB staff and Llais. **Balanced Room 1 (September 2025)** • created a long list of service options • applied BCUHB's essential criteria (minimum viability test) to produce a medium list of four options **Balanced Room 2 (October 2025):** • developed desirable (value-based) criteria through stakeholder discussion • weighted those criteria • scored and appraised the medium-list of options to generate a shortlist for further development and public engagement. This collaborative process led to the development and short-listing of the following three options: • **Health and well-being Hub (Integrated)**

	Re-purposing the Penley Hospital site as a multi-professional hub for health, social care and third sector services – delivering outpatient, preventative and well-being objectives. • **Health and well-being Hub (third sector led)** Providing a hub model with an active third sector leadership role to deliver social and well-being support alongside NHS services • **Services in the Community (no fixed building)** Shifting resources towards home based outreach, and digital services rather than maintaining a permanent site. **This Welsh Language Impact Assessment is a review of the following option:** **Health and Well-being Hub (Integrated)**
Who is responsible for the proposal being assessed?	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning and Tehmeena Ajmal, Chief Operating Officer
Who would be affected by the proposal – adversely or positively, directly or indirectly?	• Members of the public and patients • BCUHB staff • Partners including Wrexham County Borough Council, Community Councils, Third Sector, local community services • Independent sector
1.2 Information Gathering – Welsh Language Standards and the Welsh Language Measure (Wales) 2011	
Does this proposal ensure that the Welsh language is treated no less favourably than the English	There is a commitment to offering Welsh medium provision to all patients in accordance with the Welsh Language Standards.

language, in accordance with the Welsh Language Standards?	
Is there an opportunity to offer more opportunities for people to learn and / or use the Welsh language on a day-to-day basis?	The numbers of Welsh speakers in this particular area is low in comparison with the Welsh speaking average both across Wales, and within the Health Board area, given its original purpose to serve Polish ex-servicemen, and its proximity to the English border. The data below from the 2021 census (taken from the Profile document for the Penley community, 9th December 2025) shows the percentage of Welsh speakers in the Middle Super Output Area (Wrexham 018) and the Lower Layer Output Area for Bronington and Overton: Wrexham 018 - 7% Welsh speakers Bronington 1 - 8.2% Welsh speakers Bronington 2 - 6% Welsh speakers Overton 1 - 7.8% Welsh speakers Overton 2 - 8.7% Welsh speakers The percentage of Welsh speakers within the county of Wrexham is 12.2%. In terms of current staff within the Penley cost centre, the current data (taken from the Health Board's ESR records) shows that of a total of 13 staff members, 4 have Welsh language skills level 3 and above, which is 30.7%, which is higher than the percentage of Welsh speakers in the community. Of the East IHC in total, the percentage of staff with Welsh Language Skills at level 3 and above is also higher than the community of Penley and the county of Wrexham No skills – 48.86% Lefel 1 – 12.94% Lefel 2 – 6.64%

	Lefel 3 – 6.99% Lefel 4 – 7.51% Lefel 5 – 13.15% Through mainstreaming the Welsh language and offering Welsh language training, there will be more opportunities for people to use the Welsh language on a day-to-day basis.
Will this project pro-actively offer services in Welsh for users?	There is an opportunity to strengthen Welsh medium provision with the implementation of Standard 110 of the Welsh Language Standards. Standard 110 states, if the Health Board is providing the service, it must: Publish a plan for each 5-year period setting out – (a) the extent to which you are able to offer to carry out a clinical consultation in Welsh; (b) the actions you intend to take to increase your ability to offer to carry out a clinical consultation in Welsh; (c) a timetable for the actions that you have detailed in (b).
Is the proposal likely to protect and promote the Welsh language within communities?	It is not the role of the Health Board to protect and promote the Welsh language within communities. However, as part of our work to implement the Welsh Language Standards across the Health Board, this will be reflected in the services offered to the community.
1.5 Information Gathering – Engagement	
What has been done to date in terms of involvement and engagement about this proposal?	**Engagement approach** A wide range of engagement and stakeholder involvement has been undertaken since the closure of the ward in 2024 and since July 2025 there has been a more focused engagement exercise with local residents, staff, and stakeholders. A phased approach to engagement is being carried out to support the service review process as follows.

	Phase one (July 2025 to October 2025) This phase of bilingual communications and engagement focused on: • Listening to what matters to people — their priorities, concerns, ideas and experiences. • Recording the feedback • Raising awareness of the listening exercise, issues surrounding the temporary closure and opportunities to shape the future of local services. This was done via the following activity: • Bilingual social media and digital awareness raising Website views: 1,257 Penley social media posts raising awareness of the survey: Impressions (reached people's feeds): 58,239 times, Social media users interacted with the posts 285 times. • A total of 347 completed surveys were received by BCUHB. No surveys were completed or received in Welsh. • Reaching out to stakeholder groups for face-to-face conversations and support in awareness raising. • 07.10.2025 Attendance at the Maelor South Community Council • Monitoring of correspondence. Five separate enquiries have been received and responded to specifically relating to the changes to Penley Community Hospital and the process being undertaken during this time. Emerging key themes from online and face to face feedback were presented at the first of the "Balanced Room" discussions for Penley on Friday 26th September 2025. The outcomes of the first Balanced Room enabled more detailed information to be

	available to support discussions at the second Balanced Room event on Wednesday 29th October 2025, where key identified stakeholders will work to define a shortlist of options, or a preferred option that will shape further engagement throughout November 2025. Regular communications with Llais remains ongoing with proactive updates being provided as well as their active involvement in the Balanced Room conversations. **Phase two (November to December 2025)** Phase two of the bilingual communications and engagement activity continues to raise awareness of and invite feedback on the shortlist of options; explaining the work to develop the options. Face to face engagement within the local community is being carried out as well as making bilingual hard copy and digital feedback options available on a large-scale across the local community. Some bespoke sessions are as follows: Hanmer Community Council, 18th November. Maelor South Community Council, 25th November Overton on Dee Council, 8th December Willington and Worthenbury Community Council, 12th December. Following this phase of engagement, all feedback will further support the development of options ahead of a proposed further deep engagement phase early in 2026 where we will we will seek further, targeted from those who have been involved throughout, those most affected (as outlined by the Integrated Equalities Impact Assessment), staff and the wider community.
What other information has been used to inform this assessment?	Conversations on the future of Penley Hospital so far have revealed a deeply rooted and widespread community desire to retain but repurpose the facility as a hub for

	local healthcare. Across hundreds of responses residents, carers, healthcare professionals and former patients expressed a consistent message which was presented by one respondent as: "Penley Hospital is not just a building - it is a vital part of the region's health infrastructure, heritage and identity." Local provision and accessibility emerged as the most dominant theme. Respondents repeatedly emphasised the importance of having healthcare services close to home, particularly in rural areas where transport is limited and public services are stretched. Penley's location was seen as ideal for serving the Wrexham County villages and surrounding communities; offering a more accessible and less intimidating alternative to large hospitals like the Wrexham Maelor. Step-down and rehabilitation care was another key priority. Many respondents described Penley as perfectly suited for patients who are medically fit but not yet ready to return home. It was felt that a model like this may help alleviate bedblocking at Wrexham Maelor Hospital, improve patient outcomes, and reduce pressure on acute services. The hospital's peaceful environment and familiar staff were credited with aiding recovery and providing dignified end-of-life care. There was strong support for expanding Penley's role into a multi-functional community health hub. Suggestions included minor injuries units, outpatient clinics, physiotherapy, mental health support and integration with local GP practices and third sector partners. Respondents envisioned Penley as a place where holistic, person-centred care could thrive - especially for the elderly, disabled, and neurodivergent individuals. Workforce and operational concerns were also raised. While some respondents shared negative experiences, the majority praised the dedication of Penley's staff and called for better support, training and retention strategies. Ideas included rotating placements, recruiting locally, and offering visa sponsorship to overseas workers.

	Underlying many responses was a sense of frustration with centralisation and a perceived lack of strategic planning by the Health Board. The closure of Penley was seen as an example of broader issues within the NHS in Wales - overcrowded hospitals, delayed diagnoses and fragmented care. Respondents urged the Health Board to think creatively, consult meaningfully and invest in community-based solutions. Finally, the historical significance of Penley Hospital was a recurring theme. Originally established to care for Polish war veterans, the feedback suggests that the hospital is seen as a special place to many. Its closure was described not only as a loss of service but linked to a loss of community identity and heritage
Are there any gaps in the information collected to date? If so, how will these be addressed?	Bespoke sessions with groups identified in the Integrated Equalities Impact Assessment are being arranged for Phase Three of engagement. All information will continue to be available in English and Welsh, as well as Polish to reference the historic covenant on the hospital.
Is the proposal relevant to how the Health Board complies with the public sector general duty relating to people who are protected by the Equality Act 2010:	
The elimination of discrimination and harassment	✓
The advancement of equality of opportunity	✓
The fostering of good relations	✓
The protection and promotion of human rights	✓

2.0 Welsh Language Compliance.	**Positive**	**Neutral**	**Negative**	**Explanation of Decision**	**Mitigation or Opportunities**

Implementation of the Welsh Language Standards	✓			Opportunity to strengthen provision	
Is the proposal influential in terms of dealing with the Welsh speaking public? • Will activities such as corresponding by letter, communicating by telephone, public meetings and other meetings comply with the Welsh language standards?	✓			In accordance with the Service Delivery Standards, the Health Board is committed to ensuring full compliance.	
• Will any new IT development comply with the Welsh Language Standards?	✓			Digital Data and Technology requirements will need to be explored in detail, at present there is limited network coverage on-site. A full review with DDAT technicians will be required in order to identify the required changes. Considerations to include • Upgrading Network hub • Introduction of swipe card access • Increased number of ports/switches • Improved telephony service	

				• Wireless connection improvement Further work will need to be undertaken to identify the required alternations once the model has been agreed. There will then be a requirement to identify the appropriate capital funding stream which would support the developments. Although the IT requirements are not currently known, there is a commitment to ensure that all IT requirements comply fully with the Welsh Language Standards.	
Is the proposal likely to impact upon the public image of the organisation? • Will all internal and external signs and notices comply with the Welsh language standards? • Will publications and forms be compliant? • Will any publicity material comply? • Will staff recruitment advertisements comply?	✓			We will operate in accordance with the Welsh Language Standards.	

• Will social media and digital and technological platforms comply?					
Is the proposal likely to have an impact upon implementation of the Welsh language standards? • Internal comms – (Policy for using Welsh internally -  WP70 - Health Board Wide Procedure - Usi	✓			Welsh Language Standards will be considered from the outset as part of planning process.	Commitment to work with the Welsh Language Team to ensure compliance with Welsh Language Standards
• Will the proposal create new jobs?		✓		Professional roles will be reviewed and re-allocated (if required) within the current financial envelope.	
• Will the staffing arrangements facilitate implementation of the language standards? Including structure of teams/departments		✓		Teams/department structure has not yet been determined	
• Welsh Language Awareness	✓			Welsh Language Awareness is a mandatory requirement for all staff. Refresher face to face training can be arranged.	

• Will the proposal offer training through the medium of Welsh?	✓			Identify gaps in language skills and provide training as required	
• Will any arrangements with third parties comply with the Welsh language standards?		✓		Currently arrangements with third parties are unknown. In the case of an individual attending a clinical consultation or a case conference, or an individual who is an in-patient, it is the standards that apply to the third party carrying out the activity or providing the service on behalf of the body that apply.	Welsh language requirements of third parties will be scrutinised by Welsh Language Team
• Will the proposal include any targets or indicators relating to the language?	✓			We will monitor data whether percentage of Welsh speaking staff reflects percentage of Welsh speakers in the community. In accordance with the Welsh Language Standards (Operational Standards) which relates to workforce planning, **Standard 106** requires the Health Board to assess Welsh language	

				needs for each post advertised, categorising roles as: (a) essential, (b) to be learnt on appointment, (c) desirable, or (d) not necessary. The Health Board must also: • assess staff Welsh language skills, • provide basic lessons during work hours, • offer free advanced training for those who complete basics. To meet these standards, the **Bilingual Skills Policy and Procedure** ensures effective recruitment and workforce planning so bilingual services can be delivered according to patient choice. Posts requiring Welsh at Level 3+ on the Electronic Staff Record are advertised accordingly, alongside	

				wider training opportunities. **Welsh Essential posts** include front-line roles such as switchboard staff, booking/call centre staff, ward clerks, and receptionists. These are automatically recorded as essential in ESR. Administrative and clerical posts may also be designated essential or "to be learnt" depending on local Welsh-speaking capacity. If recruitment fails: • internal adverts must be extended externally, • if no Welsh speaker is found, a non-Welsh speaker may be appointed if they commit to learning Welsh to the required level within a set timeframe. The Health Board must	

				then provide training support. The **Welsh Language Training Team** has developed a pathway to support staff appointed to "Welsh to be learnt" roles, ensuring they can meet language requirements.	
• How will performance be measured and monitored?	✓			Recording language choice of patients and monitor to what level this is achieved.	
3.1 Effect on Welsh speaking users					
• Will the proposal offer a language choice for users?		✓		Standards relating to written correspondence will be fully achieved offering language choice to service users.	
• Will it be possible for users to receive services in Welsh?		✓		Face to face bilingual service provision will be dependent on capacity of the workforce and demand for bilingual services. Currently there is a higher number of Welsh speaking staff than Welsh speakers in the community. This will	

				either be maintained, or increased.	
• Will there be a bilingual environment?		✓		Signage and Corporate identity will be fully bilingual in accordance with the Welsh Language Standards.	
Is there a risk for the proposal to discriminate against Welsh speaking service users? • Have the needs of Welsh speakers been considered in the proposal?	✓			Welsh language will be considered as part of the development and planning process. It will be dependent on workforce and demand for Welsh language services	
• Are Welsh speakers likely to receive the same standard of service as provided in English?		✓		Yes – the needs of Welsh speakers will be fully considered – environment, written correspondence, and recording of language choice.	
• Are Welsh language arrangements likely to lead to a delay in the service?		✓		Not with written communication, but face to face service provision will be dependent on workforce and availability of Welsh speaking staff.	
• Is the proposal likely to make Welsh more visible?		✓		As per policy, Welsh language signage in the local area and the hospital	

				will continue to be bilingual.	
• Is it likely to influence others to make more use of Welsh?		✓		Welsh language signage will be visible in the locality. Visual bilingualism will raise awareness and normalise the use of Welsh. The promotion of the Welsh language on site could increase the interest in the language locally but difficult to measure if it will influence others to make more use of the Welsh language.	
• Will the Welsh language service in relation to the proposal be accessible?		✓		Written documentation will be fully compliant. Face to face provision will be dependent on structure of the services offered, as well as workforce and demand for services. This will become clearer, when final structures are in place. Any gaps will be addressed.	
• Will the service be as accessible in Welsh as in English?		✓		Written documentation will be fully compliant. Face to face provision will be dependent on structure of the services offered, as well	

				as workforce and demand for services. This will become clearer, when final structures are in place. Any gaps will be addressed	
• Will the services be available at the same time?		✓		Written documentation will be available at the same time. Face to face provision will be dependent on structure of the services offered, as well as workforce and demand for services. This will become clearer, when final structures are in place. Any gaps will be addressed.	
3.2 Effect on Welsh speaking communities					
• Is the proposal likely to contribute towards safeguarding Welsh in communities?		✓		Option A will align with the strategic goal of providing care closer to home. Patients from the local area(s) currently have to travel a distance to access service which could be provided at an alternative site. This would avoid having to access services out of area making it more likely for them to access services in their preferred language.	

				It will assist in promoting the Welsh language locally and demonstrate that it is a living language.	
• Is it likely to contribute towards the local economy in Welsh speaking areas?		✓		Unknown at the moment.	
• Does the proposal take steps to promote and facilitate the Welsh language?	✓			Yes – in terms of service provision.	
• Does the proposal contribute towards Welsh medium community activities?				Not applicable	
• Does it contribute to add value to other activities relating to language?				Not applicable	
3.3 Contribution towards Welsh language standards and other relevant guidance relating to the Welsh language.					
The language policies of partners: • Is the Health Board working in partnership on the proposal?		✓		Dependent on partners – our role would be to scrutinise the partners' Welsh Language policies and make sure that they are aligned.	
• Which other organisations are likely to be affected by the development?		✓		Not yet known	

• Do those organisations have Welsh language standards or language policies?		✓		Not yet known	
• Does the proposal contribute towards these schemes?		✓		Not yet known	
• How does the proposal contribute towards the vision of the Welsh Government for one million Welsh speakers by 2050?	✓			Continue to provide training opportunities for staff to learn Welsh aligning with the Welsh Government's vision by increasing the use of Welsh in the workplace. The Health Board employs an in-house Welsh language tutor to provide Welsh lessons for staff. These are delivered via Microsoft Teams, and are open to all staff across the Health Board, therefore there are no accessibility issues in terms of location of courses, and travel. There is no data specific to the East IHC, but the total numbers of learners who	

				registered on some form of Welsh language training across the Health Board in 2024-2025 was **995**, an increase of 25% from 2023-2024. There are 22 different courses including weekly on line lessons, self-studying courses, residential courses at Nant Gwrtheyrn, sessions to prepare for the Language Skills Certificate, specific courses for receptionists, 1:1 raising confidence courses and more. Feedback – 96% of learners are very happy with the provision. 83% of learners stated that they have greater confidence in using the Welsh language after completing the courses.	
3.4 The impacts identified and assessed					
What impacts and effects have you identified? How do you plan to address these impacts to improve outcomes for the Welsh language? Detail mitigation measures / alternative options to reduce adverse impacts and increase positive impacts.					
Positive impacts	Opportunities to increase awareness Deliver specific training for staff.				

	Consider Welsh language as part of service development and workforce planning.
Adverse impacts	No adverse effects All proposals will comply with Welsh language requirements.
Neutral	Due to lower numbers of Welsh speakers in the East in particular, there have been difficulties in recruiting Welsh speakers. But due to lower than average demand for Welsh language services, there won't be any change to what is delivered currently. In accordance with the Welsh Language Standards (Operational Standards) which relates to workforce planning, **Standard 106** requires the Health Board to assess Welsh language needs for each post advertised, categorising roles as: (a) essential, (b) to be learnt on appointment, (c) desirable, or (d) not necessary. The Health Board must also: • assess staff Welsh language skills, • provide basic lessons during work hours, • offer free advanced training for those who complete basics. To meet these standards, the **Bilingual Skills Policy and Procedure** ensures effective recruitment and workforce planning so bilingual services can be delivered according to patient choice. Posts requiring Welsh at Level 3+ on the Electronic Staff Record are advertised accordingly, alongside wider training opportunities. **Welsh Essential posts** include front-line roles such as switchboard staff, booking/call centre staff, ward clerks, and receptionists. These are automatically recorded as essential in

	ESR. Administrative and clerical posts may also be designated essential or "to be learnt" depending on local Welsh-speaking capacity. If recruitment fails: • internal adverts must be extended externally, • if no Welsh speaker is found, a non-Welsh speaker may be appointed if they commit to learning Welsh to the required level within a set timeframe. The Health Board must then provide training support. The **Welsh Language Training Team** has developed a pathway to support staff appointed to "Welsh to be learnt" roles, ensuring they can meet language requirements.
3.7 Engagement	
During engagement, what questions do you wish to ask about the Welsh language impacts?	Do you have a view on any impacts our proposals may have on the Welsh language?
With whom are you engaging? How are Welsh language interest groups likely to respond?	Despite materials being available in Welsh, with Welsh translation available and Welsh speakers at events, no feedback has been received thus far in the Welsh medium. For Phase Three, we will consider further targeted work to identify Welsh-first speakers in the area.
Following engagement, what changes have you made to address language issues raised?	There haven't been any thus far.
3.8 Post engagement, final proposals and on-going monitoring	
Summarise your final decisions, list the likely effects on the Welsh language and how you will promote / mitigate these. Record your	

compliance with the Welsh language standards (you will need to refer to this summary in the impact assessment template)	
How will you monitor the on-going effects during implementation of the policy?	

Who signed-off this Impact Assessment: *As per the Health Board's Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board', to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Health Board as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions must have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.*		
Approval Date:		
Review Date:		
Project Lead Sign-off I confirm that this Welsh Language Impact Assessment has been carried out in accordance with Betsi Cadwaladr University Health Board's WP7 Procedure for assessment work for evidencing Due Regard for: Welsh Language requirements. Signed: (Project Lead)	**Welsh Language Team Quality Check** I confirm that I have reviewed this Welsh Language Impact Assessment and I am assured that it contains sufficient evidence and rigour to be considered by the decision-making committee. Signed: Eleri Hughes-Jones (Head of Welsh Language Services)	**Committee Chair Sign-off** I confirm that this Welsh Language Impact Assessment represents evidence that we (The Health Board), in making this decision, have given due regard to the need to reduce the Welsh language inequality. Signed: (Committee Chair)

Welsh Language Impact Assessment

1.1 Background – Welsh Language Impact Assessment	
Who is the lead Officer for this Assessment?	Eleri Hughes-Jones, Head of Welsh Language Services
What are the aims and purpose of this proposal?	Penley Community Hospital is a former community hospital founded in 1946 as part of an initiative to care for Polish ex-servicemen who fought alongside the allies in the second world war and their families who settled in the area. At that point the site was a large 720 bedded facility. In 2002 the hospital housed six patients who occupied one of the 30 wards on the site. It was closed in 2002 by the then North East Wales NHS Trust and in 2004 the wider hospital site was sold. The remaining Penley site is in the ownership of the BCUHB and a portion leased to the Trustees of the Penley Rainbow Centre. An 8 bedded bungalow was opened in 2004 to replace the previous facility which provides community inpatient care and serves the rural area of South Wrexham with an older population and growing care needs. It operates as a step-down facility – supporting patients who no longer require acute hospital admission but still need ongoing care whilst they recover prior to returning home or moving to another care setting. Historically, Penley Community Hospital provides step-down facilities only. Key features include: • Low acuity inpatient beds typically for older patients. • Step-down care following discharge from an acute hospital. • End of life-care although this was only available for patients with very specific health care needs and was not routinely provided.

	On 19th December 2024, Penley Community Hospital's inpatient beds were closed. Key issues behind the decision include: • Sustainability of the care model due to the very limited number of patients suitable for care in this particular setting. • Vacancies and temporary reliance on temporary staff. Given the challenges outlined above, closure of the inpatient beds are now the subject of a formal service review (which includes a programme of deep and extended engagement) to consider the provision of safe, long term and sustainable high-quality services that meets the needs of the local community. As part of the deep engagement process, two full day sessions were held with balanced representation from Health Board members and stakeholders. This participatory process created a stakeholder informed shortlist of options. Participants included councillors, local community groups, third sector providers, BCUHB staff and Llais. **Balanced Room 1 (September 2025)** • created a long list of service options • applied BCUHB's essential criteria (minimum viability test) to produce a medium list of four options **Balanced Room 2 (October 2025):** • developed desirable (value-based) criteria through stakeholder discussion • weighted those criteria • scored and appraised the medium-list of options to generate a shortlist for further development and public engagement. This collaborative process led to the development and short-listing of the following three options: • **Health and well-being Hub (Integrated)**

	Re-purposing the Penley Hospital site as a multi-professional hub for health, social care and third sector services – delivering outpatient, preventative and well-being objectives. • **Health and well-being Hub (third sector led)** Providing a hub model with an active third sector leadership role to deliver social and well-being support alongside NHS services • **Services in the Community (no fixed building)** Shifting resources towards home based outreach, and digital services rather than maintaining a permanent site. **This Welsh Language Impact Assessment is a review of the following option:** **Third sector led Health & Wellbeing Hub**
Who is responsible for the proposal being assessed?	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning and Tehmeena Ajmal, Chief Operating Officer
Who would be affected by the proposal – adversely or positively, directly or indirectly?	• Members of the public and patients • BCUHB staff • Partners including Wrexham County Borough Council, Community Councils, Third Sector, local community services • Independent sector
1.2 Information Gathering – Welsh Language Standards and the Welsh Language Measure (Wales) 2011	
Does this proposal ensure that the Welsh language is treated no less favourably than the English	There is a commitment to offering Welsh medium provision to all patients in accordance with the Welsh Language Standards.

language, in accordance with the Welsh Language Standards?	
Is there an opportunity to offer more opportunities for people to learn and / or use the Welsh language on a day-to-day basis?	The numbers of Welsh speakers in this particular area is low in comparison with the Welsh speaking average both across Wales, and within the Health Board area, given its original purpose to serve Polish ex-servicemen, and its proximity to the English border. The data below from the 2021 census (taken from the Profile document for the Penley community, 9th December 2025) shows the percentage of Welsh speakers in the Middle Super Output Area (Wrexham 018) and the Lower Layer Output Area for Bronington and Overton: Wrexham 018 - 7% Welsh speakers Bronington 1 - 8.2% Welsh speakers Bronington 2 - 6% Welsh speakers Overton 1 - 7.8% Welsh speakers Overton 2 - 8.7% Welsh speakers The percentage of Welsh speakers within the county of Wrexham is 12.2%. In terms of current staff within the Penley cost centre, the current data (taken from the Health Board's ESR records) shows that of a total of 13 staff members, 4 have Welsh language skills level 3 and above, which is 30.7%, which is higher than the percentage of Welsh speakers in the community. Of the East IHC in total, the percentage of staff with Welsh Language Skills at level 3 and above is also higher than the community of Penley and the county of Wrexham No skills – 48.86% Lefel 1 – 12.94% Lefel 2 – 6.64%

	Lefel 3 – 6.99% Lefel 4 – 7.51% Lefel 5 – 13.15% Through mainstreaming the Welsh language and offering Welsh language training, there will be more opportunities for people to use the Welsh language on a day-to-day basis.
Will this project pro-actively offer services in Welsh for users?	There is an opportunity to strengthen Welsh medium provision with the implementation of Standard 110 of the Welsh Language Standards. Standard 110 states, if the Health Board is providing the service, it must: Publish a plan for each 5-year period setting out – (a) the extent to which you are able to offer to carry out a clinical consultation in Welsh; (b) the actions you intend to take to increase your ability to offer to carry out a clinical consultation in Welsh; (c) a timetable for the actions that you have detailed in (b).
Is the proposal likely to protect and promote the Welsh language within communities?	It is not the role of the Health Board to protect and promote the Welsh language within communities. However, as part of our work to implement the Welsh Language Standards across the Health Board, this will be reflected in the services offered to the community.
1.5 Information Gathering – Engagement	
What has been done to date in terms of involvement and engagement about this proposal?	**Engagement approach** A wide range of engagement and stakeholder involvement has been undertaken since the closure of the ward in 2024 and since July 2025 there has been a more focused engagement exercise with local residents, staff, and stakeholders. A phased approach to engagement is being carried out to support the service review process as follows.

	Phase one (July 2025 to October 2025) This phase of bilingual communications and engagement focused on: • Listening to what matters to people — their priorities, concerns, ideas and experiences. • Recording the feedback • Raising awareness of the listening exercise, issues surrounding the temporary closure and opportunities to shape the future of local services. This was done via the following activity: • Bilingual social media and digital awareness raising Website views: 1,257 Penley social media posts raising awareness of the survey: Impressions (reached people's feeds): 58,239 times, Social media users interacted with the posts 285 times. • A total of 347 completed surveys were received by BCUHB. No surveys were completed or received in Welsh. • Reaching out to stakeholder groups for face-to-face conversations and support in awareness raising. • 07.10.2025 Attendance at the Maelor South Community Council • Monitoring of correspondence. Five separate enquiries have been received and responded to specifically relating to the changes to Penley Community Hospital and the process being undertaken during this time. Emerging key themes from online and face to face feedback were presented at the first of the "Balanced Room" discussions for Penley on Friday 26th September 2025. The outcomes of the first Balanced Room enabled more detailed information to be

	available to support discussions at the second Balanced Room event on Wednesday 29th October 2025, where key identified stakeholders will work to define a shortlist of options, or a preferred option that will shape further engagement throughout November 2025. Regular communications with Llais remains ongoing with proactive updates being provided as well as their active involvement in the Balanced Room conversations. **Phase two (November to December 2025)** Phase two of the bilingual communications and engagement activity continues to raise awareness of and invite feedback on the shortlist of options; explaining the work to develop the options. Face to face engagement within the local community is being carried out as well as making bilingual hard copy and digital feedback options available on a large-scale across the local community. Some bespoke sessions are as follows: Hanmer Community Council, 18th November. Maelor South Community Council, 25th November Overton on Dee Council, 8th December Willington and Worthenbury Community Council, 12th December. Following this phase of engagement, all feedback will further support the development of options ahead of a proposed further deep engagement phase early in 2026 where we will we will seek further, targeted from those who have been involved throughout, those most affected (as outlined by the Integrated Equalities Impact Assessment), staff and the wider community.
What other information has been used to inform this assessment?	Conversations on the future of Penley Hospital so far have revealed a deeply rooted and widespread community desire to retain but repurpose the facility as a hub for

	local healthcare. Across hundreds of responses residents, carers, healthcare professionals and former patients expressed a consistent message which was presented by one respondent as: "Penley Hospital is not just a building - it is a vital part of the region's health infrastructure, heritage and identity." Local provision and accessibility emerged as the most dominant theme. Respondents repeatedly emphasised the importance of having healthcare services close to home, particularly in rural areas where transport is limited and public services are stretched. Penley's location was seen as ideal for serving the Wrexham County villages and surrounding communities; offering a more accessible and less intimidating alternative to large hospitals like the Wrexham Maelor. Step-down and rehabilitation care was another key priority. Many respondents described Penley as perfectly suited for patients who are medically fit but not yet ready to return home. It was felt that a model like this may help alleviate bedblocking at Wrexham Maelor Hospital, improve patient outcomes, and reduce pressure on acute services. The hospital's peaceful environment and familiar staff were credited with aiding recovery and providing dignified end-of-life care. There was strong support for expanding Penley's role into a multi-functional community health hub. Suggestions included minor injuries units, outpatient clinics, physiotherapy, mental health support and integration with local GP practices and third sector partners. Respondents envisioned Penley as a place where holistic, person-centred care could thrive - especially for the elderly, disabled, and neurodivergent individuals. Workforce and operational concerns were also raised. While some respondents shared negative experiences, the majority praised the dedication of Penley's staff and called for better support, training and retention strategies. Ideas included rotating placements, recruiting locally, and offering visa sponsorship to overseas workers.

	Underlying many responses was a sense of frustration with centralisation and a perceived lack of strategic planning by the Health Board. The closure of Penley was seen as an example of broader issues within the NHS in Wales - overcrowded hospitals, delayed diagnoses and fragmented care. Respondents urged the Health Board to think creatively, consult meaningfully and invest in community-based solutions. Finally, the historical significance of Penley Hospital was a recurring theme. Originally established to care for Polish war veterans, the feedback suggests that the hospital is seen as a special place to many. Its closure was described not only as a loss of service but linked to a loss of community identity and heritage
Are there any gaps in the information collected to date? If so, how will these be addressed?	Bespoke sessions with groups identified in the Integrated Equalities Impact Assessment are being arranged for Phase Three of engagement. All information will continue to be available in English and Welsh, as well as Polish to reference the historic covenant on the hospital.
Is the proposal relevant to how the Health Board complies with the public sector general duty relating to people who are protected by the Equality Act 2010:	
The elimination of discrimination and harassment	✓
The advancement of equality of opportunity	✓
The fostering of good relations	✓
The protection and promotion of human rights	✓

2.0 Welsh Language Compliance.	**Positive**	**Neutral**	**Negative**	**Explanation of Decision**	**Mitigation or Opportunities**

Implementation of the Welsh Language Standards	✓			Opportunity to strengthen provision	
Is the proposal influential in terms of dealing with the Welsh speaking public? • Will activities such as corresponding by letter, communicating by telephone, public meetings and other meetings comply with the Welsh language standards?	✓			In accordance with the Service Delivery Standards, the Health Board is committed to ensuring full compliance.	
• Will any new IT development comply with the Welsh Language Standards?	✓			Digital Data and Technology requirements will need to be explored in detail, at present there is limited network coverage on-site. A full review with DDAT technicians will be required in order to identify the required changes. Considerations to include • Upgrading Network hub • Introduction of swipe card access • Increased number of ports/switches • Improved telephony service	

				• Wireless connection improvement Further work will need to be undertaken to identify the required alternations once the model has been agreed. There will then be a requirement to identify the appropriate capital funding stream which would support the developments. Although the IT requirements are not currently known, there is a commitment to ensure that all IT requirements comply fully with the Welsh Language Standards.	
Is the proposal likely to impact upon the public image of the organisation? • Will all internal and external signs and notices comply with the Welsh language standards? • Will publications and forms be compliant? • Will any publicity material comply? • Will staff recruitment advertisements comply?	✓			We will operate in accordance with the Welsh Language Standards.	

• Will social media and digital and technological platforms comply?					
Is the proposal likely to have an impact upon implementation of the Welsh language standards? • Internal comms – (Policy for using Welsh internally -  WP70 - Health Board Wide Procedure - Usi	✓			Welsh Language Standards will be considered from the outset as part of planning process.	Commitment to work with the Welsh Language Team to ensure compliance with Welsh Language Standards
• Will the proposal create new jobs?		✓		Professional roles will be reviewed and re-allocated (if required) within the current financial envelope.	
• Will the staffing arrangements facilitate implementation of the language standards? Including structure of teams/departments		✓		Teams/department structure has not yet been determined	
• Welsh Language Awareness	✓			Welsh Language Awareness is a mandatory requirement for all staff. Refresher face to face training can be arranged.	

• Will the proposal offer training through the medium of Welsh?	✓			Identify gaps in language skills and provide training as required	
• Will any arrangements with third parties comply with the Welsh language standards?		✓		Currently arrangements with third parties are unknown. In the case of an individual attending a clinical consultation or a case conference, or an individual who is an in-patient, it is the standards that apply to the third party carrying out the activity or providing the service on behalf of the body that apply.	Welsh language requirements of third parties will be scrutinised by Welsh Language Team
• Will the proposal include any targets or indicators relating to the language?	✓			We will monitor data whether percentage of Welsh speaking staff reflects percentage of Welsh speakers in the community. In accordance with the Welsh Language Standards (Operational Standards) which relates to workforce planning, **Standard 106** requires the Health Board	

				to assess Welsh language needs for each post advertised, categorising roles as: (a) essential, (b) to be learnt on appointment, (c) desirable, or (d) not necessary. The Health Board must also: • assess staff Welsh language skills, • provide basic lessons during work hours, • offer free advanced training for those who complete basics. To meet these standards, the **Bilingual Skills Policy and Procedure** ensures effective recruitment and workforce planning so bilingual services can be delivered according to patient choice. Posts requiring Welsh at Level 3+ on the Electronic Staff Record are advertised accordingly, alongside	

				wider training opportunities. **Welsh Essential posts** include front-line roles such as switchboard staff, booking/call centre staff, ward clerks, and receptionists. These are automatically recorded as essential in ESR. Administrative and clerical posts may also be designated essential or "to be learnt" depending on local Welsh-speaking capacity. If recruitment fails: • internal adverts must be extended externally, • if no Welsh speaker is found, a non-Welsh speaker may be appointed if they commit to learning Welsh to the required level within a set timeframe. The Health Board must	

				then provide training support. The **Welsh Language Training Team** has developed a pathway to support staff appointed to "Welsh to be learnt" roles, ensuring they can meet language requirements.	
• How will performance be measured and monitored?	✓			Recording language choice of patients and monitor to what level this is achieved.	
3.1 Effect on Welsh speaking users					
• Will the proposal offer a language choice for users?		✓		Standards relating to written correspondence will be fully achieved offering language choice to service users. In the case of an individual attending a clinical consultation or a case conference, or an individual who is an in-patient, it is the standards that apply to the third party carrying out the activity or providing the service on behalf of the body that apply.	

				This is dependent on which organisation is providing the care.	
• Will it be possible for users to receive services in Welsh?		✓		Face to face bilingual service provision will be dependent on capacity of the workforce and demand for bilingual services. Currently there is a higher number of Welsh speaking staff than Welsh speakers in the community. This will either be maintained, or increased. This is dependent on which organisation is providing the care. In the case of an individual attending a clinical consultation or a case conference, or an individual who is an in-patient, it is the standards that apply to the third party carrying out the activity or providing the service on behalf of the body that apply.	

• Will there be a bilingual environment?		✓		Signage and Corporate identity will be fully bilingual in accordance with the Welsh Language Standards.	
Is there a risk for the proposal to discriminate against Welsh speaking service users? • Have the needs of Welsh speakers been considered in the proposal?	✓			Welsh language will be considered as part of the development and planning process. It will be dependent on workforce and demand for Welsh language services	
• Are Welsh speakers likely to receive the same standard of service as provided in English?		✓		The needs of Welsh speakers will be fully considered – environment, written correspondence, and recording of language choice.	
• Are Welsh language arrangements likely to lead to a delay in the service?		✓		Not with written communication, but face to face service provision will be dependent on workforce and availability of Welsh speaking staff.	
• Is the proposal likely to make Welsh more visible?		✓		As per policy, Welsh language signage in the local area and the hospital will continue to be bilingual.	
• Is it likely to influence others to make more use of Welsh?		✓		Welsh language signage will be visible in the locality. Visual bilingualism will raise	

				awareness and normalise the use of Welsh. The promotion of the Welsh language on site could increase the interest in the language locally but difficult to measure if it will influence others to make more use of the Welsh language.	
• Will the Welsh language service in relation to the proposal be accessible?		✓		Written documentation will be fully compliant. Face to face provision will be dependent on structure of the services offered, as well as workforce and demand for services. This will become clearer, when final structures are in place. Any gaps will be addressed.	
• Will the service be as accessible in Welsh as in English?		✓		Written documentation will be fully compliant. Face to face provision will be dependent on structure of the services offered, as well as workforce and demand for services. This will become clearer, when final structures are in place. Any gaps will be addressed	

• Will the services be available at the same time?		✓		Written documentation will be available at the same time. Face to face provision will be dependent on structure of the services offered, as well as workforce and demand for services. This will become clearer, when final structures are in place. Any gaps will be addressed	
3.2 Effect on Welsh speaking communities					
• Is the proposal likely to contribute towards safeguarding Welsh in communities?		✓		This scenario aims to address the lack of step-down provision across Wrexham by supporting hospital discharge and improving patient flow. The plan would be to create a 9 bedded unit using the existing layout of Penley hospital. Combining the integrated hub/health centre model with a more explicit role for third-sector partners. The proposal builds on existing strengths in the local voluntary sector to deliver health, wellbeing and social support alongside NHS-led services.	

				It will assist in promoting the Welsh language locally and demonstrate that it is a living language.	
• Is it likely to contribute towards the local economy in Welsh speaking areas?		✓		Unknown at the moment.	
• Does the proposal take steps to promote and facilitate the Welsh language?	✓			Yes – in terms of service provision.	
• Does the proposal contribute towards Welsh medium community activities?				Not applicable	
• Does it contribute to add value to other activities relating to language?				Not applicable	
3.3 Contribution towards Welsh language standards and other relevant guidance relating to the Welsh language.					
The language policies of partners: • Is the Health Board working in partnership on the proposal?		✓		Dependent on partners – our role would be to scrutinise the partners' Welsh Language policies and make sure that they are aligned. In the case of an individual attending a clinical consultation or a case conference, or an individual who is an in-patient, it is the standards that apply to	

				the third party carrying out the activity or providing the service on behalf of the body that apply.	
• Which other organisations are likely to be affected by the development?		✓		Not yet known	
• Do those organisations have Welsh language standards or language policies?		✓		Not yet known	
• Does the proposal contribute towards these schemes?		✓		Not yet known	
• How does the proposal contribute towards the vision of the Welsh Government for one million Welsh speakers by 2050?	✓			Continue to provide training opportunities for staff to learn Welsh aligning with the Welsh Government's vision by increasing the use of Welsh in the workplace. The Health Board employs an in-house Welsh language tutor to provide Welsh lessons for staff. These are delivered via	

				Microsoft Teams, and are open to all staff across the Health Board, therefore there are no accessibility issues in terms of location of courses, and travel. There is no data specific to the East IHC, but the total numbers of learners who registered on some form of Welsh language training across the Health Board in 2024-2025 was **995**, an increase of 25% from 2023-2024. There are 22 different courses including weekly on line lessons, self-studying courses, residential courses at Nant Gwrtheyrn, sessions to prepare for the Language Skills Certificate, specific courses for receptionists, 1:1 raising confidence courses and more. Feedback – 96% of learners are very happy with the provision. 83% of learners stated that they have greater confidence in using	

				the Welsh language after completing the courses.	

3.4 The impacts identified and assessed	
What impacts and effects have you identified? How do you plan to address these impacts to improve outcomes for the Welsh language? Detail mitigation measures / alternative options to reduce adverse impacts and increase positive impacts.	
Positive impacts	Opportunities to increase awareness Deliver specific training for staff. Consider Welsh language as part of service development and workforce planning.
Adverse impacts	No adverse effects All proposals will comply with Welsh language requirements.
Neutral	Due to lower numbers of Welsh speakers in the East in particular, there have been difficulties in recruiting Welsh speakers. But due to lower than average demand for Welsh language services, there won't be any change to what is delivered currently. In accordance with the Welsh Language Standards (Operational Standards) which relates to workforce planning, **Standard 106** requires the Health Board to assess Welsh language needs for each post advertised, categorising roles as: (a) essential, (b) to be learnt on appointment, (c) desirable, or (d) not necessary. The Health Board must also: • assess staff Welsh language skills,

	• provide basic lessons during work hours, • offer free advanced training for those who complete basics. To meet these standards, the **Bilingual Skills Policy and Procedure** ensures effective recruitment and workforce planning so bilingual services can be delivered according to patient choice. Posts requiring Welsh at Level 3+ on the Electronic Staff Record are advertised accordingly, alongside wider training opportunities. **Welsh Essential posts** include front-line roles such as switchboard staff, booking/call centre staff, ward clerks, and receptionists. These are automatically recorded as essential in ESR. Administrative and clerical posts may also be designated essential or "to be learnt" depending on local Welsh-speaking capacity. If recruitment fails: • internal adverts must be extended externally, • if no Welsh speaker is found, a non-Welsh speaker may be appointed if they commit to learning Welsh to the required level within a set timeframe. The Health Board must then provide training support. The **Welsh Language Training Team** has developed a pathway to support staff appointed to "Welsh to be learnt" roles, ensuring they can meet language requirements.
3.7 Engagement	
During engagement, what questions do you wish to ask about the Welsh language impacts?	Do you have a view on any impacts our proposals may have on the Welsh language?
With whom are you engaging? How are Welsh language interest groups likely to respond?	Despite materials being available in Welsh, with Welsh translation available and Welsh speakers at events, no feedback has been received thus far in the Welsh medium. For Phase Three, we will consider further targeted work to identify Welsh-first speakers in the area.

Following engagement, what changes have you made to address language issues raised?	There haven't been any thus far.
3.8 Post engagement, final proposals and on-going monitoring	
Summarise your final decisions, list the likely effects on the Welsh language and how you will promote / mitigate these. Record your compliance with the Welsh language standards (you will need to refer to this summary in the impact assessment template)	
How will you monitor the on-going effects during implementation of the policy?	

Who signed-off this Impact Assessment: *As per the Health Board's Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board', to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Health Board as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions must have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.*		
Approval Date:		
Review Date:		
Project Lead Sign-off I confirm that this Welsh Language Impact Assessment has been carried out in accordance with Betsi Cadwaladr University Health Board's WP7 Procedure for assessment work for evidencing Due Regard for: Welsh Language requirements. Signed:	**Welsh Language Team Quality Check** I confirm that I have reviewed this Welsh Language Impact Assessment and I am assured that it contains sufficient evidence and rigour to be considered by the decision-making committee. Signed: Eleri Hughes-Jones	**Committee Chair Sign-off** I confirm that this Welsh Language Impact Assessment represents evidence that we (The Health Board), in making this decision, have given due regard to the need to reduce the Welsh language inequality. Signed:

(Project Lead)	(Head of Welsh Language Services)	(Committee Chair)

Welsh Language Impact Assessment

1.1 Background – Welsh Language Impact Assessment	
Who is the lead Officer for this Assessment?	Eleri Hughes-Jones, Head of Welsh Language Services
What are the aims and purpose of this proposal?	Penley Community Hospital is a former community hospital founded in 1946 as part of an initiative to care for Polish ex-servicemen who fought alongside the allies in the second world war and their families who settled in the area. At that point the site was a large 720 bedded facility. In 2002 the hospital housed six patients who occupied one of the 30 wards on the site. It was closed in 2002 by the then North East Wales NHS Trust and in 2004 the wider hospital site was sold. The remaining Penley site is in the ownership of the BCUHB and a portion leased to the Trustees of the Penley Rainbow Centre. An 8 bedded bungalow was opened in 2004 to replace the previous facility which provides community inpatient care and serves the rural area of South Wrexham with an older population and growing care needs. It operates as a step-down facility – supporting patients who no longer require acute hospital admission but still need ongoing care whilst they recover prior to returning home or moving to another care setting. Historically, Penley Community Hospital provides step-down facilities only. Key features include: • Low acuity inpatient beds typically for older patients. • Step-down care following discharge from an acute hospital. • End of life-care although this was only available for patients with very specific health care needs and was not routinely provided.

	On 19th December 2024, Penley Community Hospital's inpatient beds were closed. Key issues behind the decision include: • Sustainability of the care model due to the very limited number of patients suitable for care in this particular setting. • Vacancies and temporary reliance on temporary staff. Given the challenges outlined above, closure of the inpatient beds are now the subject of a formal service review (which includes a programme of deep and extended engagement) to consider the provision of safe, long term and sustainable high-quality services that meets the needs of the local community. As part of the deep engagement process, two full day sessions were held with balanced representation from Health Board members and stakeholders. This participatory process created a stakeholder informed shortlist of options. Participants included councillors, local community groups, third sector providers, BCUHB staff and Llais. **Balanced Room 1 (September 2025)** • created a long list of service options • applied BCUHB's essential criteria (minimum viability test) to produce a medium list of four options **Balanced Room 2 (October 2025):** • developed desirable (value-based) criteria through stakeholder discussion • weighted those criteria • scored and appraised the medium-list of options to generate a shortlist for further development and public engagement. This collaborative process led to the development and short-listing of the following three options: • **Health and well-being Hub (Integrated)**

	Re-purposing the Penley Hospital site as a multi-professional hub for health, social care and third sector services – delivering outpatient, preventative and well-being objectives. • **Health and well-being Hub (third sector led)** Providing a hub model with an active third sector leadership role to deliver social and well-being support alongside NHS services • **Services in the Community (no fixed building)** Shifting resources towards home based outreach, and digital services rather than maintaining a permanent site. **This Welsh Language Impact Assessment is a review of the following option:** **Enhance services in the community (no use of the physical building)**
Who is responsible for the proposal being assessed?	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning and Tehmeena Ajmal, Chief Operating Officer
Who would be affected by the proposal – adversely or positively, directly or indirectly?	• Members of the public and patients • BCUHB staff • Partners including Wrexham County Borough Council, Community Councils, Third Sector, local community services • Independent sector
1.2 Information Gathering – Welsh Language Standards and the Welsh Language Measure (Wales) 2011	

Does this proposal ensure that the Welsh language is treated no less favourably than the English language, in accordance with the Welsh Language Standards?	There is a commitment to offering Welsh medium provision to all patients in accordance with the Welsh Language Standards.
Is there an opportunity to offer more opportunities for people to learn and / or use the Welsh language on a day-to-day basis?	The numbers of Welsh speakers in this particular area is low in comparison with the Welsh speaking average both across Wales, and within the Health Board area, given its original purpose to serve Polish ex-servicemen, and its proximity to the English border. The data below from the 2021 census (taken from the Profile document for the Penley community, 9th December 2025) shows the percentage of Welsh speakers in the Middle Super Output Area (Wrexham 018) and the Lower Layer Output Area for Bronington and Overton: Wrexham 018 - 7% Welsh speakers Bronington 1 - 8.2% Welsh speakers Bronington 2 - 6% Welsh speakers Overton 1 - 7.8% Welsh speakers Overton 2 - 8.7% Welsh speakers The percentage of Welsh speakers within the county of Wrexham is 12.2%. In terms of current staff within the Penley cost centre, the current data (taken from the Health Board's ESR records) shows that of a total of 13 staff members, 4 have Welsh language skills level 3 and above, which is 30.7%, which is higher than the percentage of Welsh speakers in the community. Of the East IHC in total, the percentage of staff with Welsh Language Skills at level 3 and above is also higher than the community of Penley and the county of Wrexham No skills – 48.86%

	Lefel 1 – 12.94% Lefel 2 – 6.64% Lefel 3 – 6.99% Lefel 4 – 7.51% Lefel 5 – 13.15% Through mainstreaming the Welsh language and offering Welsh language training, there will be more opportunities for people to use the Welsh language on a day-to-day basis.
Will this project pro-actively offer services in Welsh for users?	There is an opportunity to strengthen Welsh medium provision with the implementation of Standard 110 of the Welsh Language Standards. Standard 110 states, if the Health Board is providing the service, it must: Publish a plan for each 5-year period setting out – (a) the extent to which you are able to offer to carry out a clinical consultation in Welsh; (b) the actions you intend to take to increase your ability to offer to carry out a clinical consultation in Welsh; (c) a timetable for the actions that you have detailed in (b).
Is the proposal likely to protect and promote the Welsh language within communities?	It is not the role of the Health Board to protect and promote the Welsh language within communities. However, as part of our work to implement the Welsh Language Standards across the Health Board, this will be reflected in the services offered to the community.
1.5 Information Gathering – Engagement	
What has been done to date in terms of involvement and engagement about this proposal?	**Engagement approach** A wide range of engagement and stakeholder involvement has been undertaken since the closure of the ward in 2024 and since July 2025 there has been a more focused engagement exercise with local residents, staff, and stakeholders.

	A phased approach to engagement is being carried out to support the service review process as follows. **Phase one (July 2025 to October 2025)** This phase of bilingual communications and engagement focused on: • Listening to what matters to people — their priorities, concerns, ideas and experiences. • Recording the feedback • Raising awareness of the listening exercise, issues surrounding the temporary closure and opportunities to shape the future of local services. This was done via the following activity: • Bilingual social media and digital awareness raising Website views: 1,257 Penley social media posts raising awareness of the survey: Impressions (reached people's feeds): 58,239 times, Social media users interacted with the posts 285 times. • A total of 347 completed surveys were received by BCUHB. No surveys were completed or received in Welsh. • Reaching out to stakeholder groups for face-to-face conversations and support in awareness raising. • 07.10.2025 Attendance at the Maelor South Community Council • Monitoring of correspondence. Five separate enquiries have been received and responded to specifically relating to the changes to Penley Community Hospital and the process being undertaken during this time. Emerging key themes from online and face to face feedback were presented at the

	first of the "Balanced Room" discussions for Penley on Friday 26th September 2025. The outcomes of the first Balanced Room enabled more detailed information to be available to support discussions at the second Balanced Room event on Wednesday 29th October 2025, where key identified stakeholders will work to define a shortlist of options, or a preferred option that will shape further engagement throughout November 2025. Regular communications with Llais remains ongoing with proactive updates being provided as well as their active involvement in the Balanced Room conversations. **Phase two (November to December 2025)** Phase two of the bilingual communications and engagement activity continues to raise awareness of and invite feedback on the shortlist of options; explaining the work to develop the options. Face to face engagement within the local community is being carried out as well as making bilingual hard copy and digital feedback options available on a large-scale across the local community. Some bespoke sessions are as follows: Hanmer Community Council, 18th November. Maelor South Community Council, 25th November Overton on Dee Council, 8th December Willington and Worthenbury Community Council, 12th December. Following this phase of engagement, all feedback will further support the development of options ahead of a proposed further deep engagement phase early in 2026 where we will we will seek further, targeted from those who have been involved throughout, those most affected (as outlined by the Integrated Equalities Impact Assessment), staff and the wider community.

What other information has been used to inform this assessment?	Conversations on the future of Penley Hospital so far have revealed a deeply rooted and widespread community desire to retain but repurpose the facility as a hub for local healthcare. Across hundreds of responses residents, carers, healthcare professionals and former patients expressed a consistent message which was presented by one respondent as: "Penley Hospital is not just a building - it is a vital part of the region's health infrastructure, heritage and identity." Local provision and accessibility emerged as the most dominant theme. Respondents repeatedly emphasised the importance of having healthcare services close to home, particularly in rural areas where transport is limited and public services are stretched. Penley's location was seen as ideal for serving the Wrexham County villages and surrounding communities; offering a more accessible and less intimidating alternative to large hospitals like the Wrexham Maelor. Step-down and rehabilitation care was another key priority. Many respondents described Penley as perfectly suited for patients who are medically fit but not yet ready to return home. It was felt that a model like this may help alleviate bedblocking at Wrexham Maelor Hospital, improve patient outcomes, and reduce pressure on acute services. The hospital's peaceful environment and familiar staff were credited with aiding recovery and providing dignified end-of-life care. There was strong support for expanding Penley's role into a multi-functional community health hub. Suggestions included minor injuries units, outpatient clinics, physiotherapy, mental health support and integration with local GP practices and third sector partners. Respondents envisioned Penley as a place where holistic, person-centred care could thrive - especially for the elderly, disabled, and neurodivergent individuals. Workforce and operational concerns were also raised. While some respondents shared negative experiences, the majority praised the dedication of Penley's staff and

	called for better support, training and retention strategies. Ideas included rotating placements, recruiting locally, and offering visa sponsorship to overseas workers. Underlying many responses was a sense of frustration with centralisation and a perceived lack of strategic planning by the Health Board. The closure of Penley was seen as an example of broader issues within the NHS in Wales - overcrowded hospitals, delayed diagnoses and fragmented care. Respondents urged the Health Board to think creatively, consult meaningfully and invest in community-based solutions. Finally, the historical significance of Penley Hospital was a recurring theme. Originally established to care for Polish war veterans, the feedback suggests that the hospital is seen as a special place to many. Its closure was described not only as a loss of service but linked to a loss of community identity and heritage
Are there any gaps in the information collected to date? If so, how will these be addressed?	Bespoke sessions with groups identified in the Integrated Equalities Impact Assessment are being arranged for Phase Three of engagement. All information will continue to be available in English and Welsh, as well as Polish to reference the historic covenant on the hospital.
Is the proposal relevant to how the Health Board complies with the public sector general duty relating to people who are protected by the Equality Act 2010:	
The elimination of discrimination and harassment	✓
The advancement of equality of opportunity	✓
The fostering of good relations	✓
The protection and promotion of human rights	✓

2.0 Welsh Language Compliance.	Positive	Neutral	Negative	Explanation of Decision	Mitigation or Opportunities
Implementation of the Welsh Language Standards	✓			Opportunity to strengthen provision	
Is the proposal influential in terms of dealing with the Welsh speaking public? • Will activities such as corresponding by letter, communicating by telephone, public meetings and other meetings comply with the Welsh language standards?	✓			In accordance with the Service Delivery Standards, the Health Board is committed to ensuring full compliance.	
• Will any new IT development comply with the Welsh Language Standards?	✓			Digital Data and Technology requirements will need to be explored in detail, at present there is limited network coverage on-site. A full review with DDAT technicians will be required in order to identify the required changes. Considerations to include • Upgrading Network hub • Introduction of swipe card access • Increased number of ports/switches • Improved telephony service	

				• Wireless connection improvement Further work will need to be undertaken to identify the required alternations once the model has been agreed. There will then be a requirement to identify the appropriate capital funding stream which would support the developments. Although the IT requirements are not currently known, there is a commitment to ensure that all IT requirements comply fully with the Welsh Language Standards.	
Is the proposal likely to impact upon the public image of the organisation? • Will all internal and external signs and notices comply with the Welsh language standards? • Will publications and forms be compliant? • Will any publicity material comply? • Will staff recruitment advertisements comply?	✓			We will operate in accordance with the Welsh Language Standards.	

• Will social media and digital and technological platforms comply?					
Is the proposal likely to have an impact upon implementation of the Welsh language standards? • Internal comms – (Policy for using Welsh internally -  WP70 - Health Board Wide Procedure - Usi	✓			Welsh Language Standards will be considered from the outset as part of planning process.	Commitment to work with the Welsh Language Team to ensure compliance with Welsh Language Standards
• Will the proposal create new jobs?		✓		Professional roles will be reviewed and re-allocated (if required) within the current financial envelope.	
• Will the staffing arrangements facilitate implementation of the language standards? Including structure of teams/departments		✓		Teams/department structure has not yet been determined	
• Welsh Language Awareness	✓			Welsh Language Awareness is a mandatory requirement for all staff. Refresher face to face training can be arranged.	

• Will the proposal offer training through the medium of Welsh?	✓			Identify gaps in language skills and provide training as required	
• Will any arrangements with third parties comply with the Welsh language standards?		✓		Currently arrangements with third parties are unknown. In the case of an individual attending a clinical consultation or a case conference, or an individual who is an in-patient, it is the standards that apply to the third party carrying out the activity or providing the service on behalf of the body that apply.	Welsh language requirements of third parties will be scrutinised by Welsh Language Team
• Will the proposal include any targets or indicators relating to the language?	✓			We will monitor data whether percentage of Welsh speaking staff reflects percentage of Welsh speakers in the community. In accordance with the Welsh Language Standards (Operational Standards) which relates to workforce planning, **Standard 106** requires the Health Board	

				to assess Welsh language needs for each post advertised, categorising roles as: (a) essential, (b) to be learnt on appointment, (c) desirable, or (d) not necessary. The Health Board must also: • assess staff Welsh language skills, • provide basic lessons during work hours, • offer free advanced training for those who complete basics. To meet these standards, the **Bilingual Skills Policy and Procedure** ensures effective recruitment and workforce planning so bilingual services can be delivered according to patient choice. Posts requiring Welsh at Level 3+ on the Electronic Staff Record are advertised accordingly, alongside	

				wider training opportunities. **Welsh Essential posts** include front-line roles such as switchboard staff, booking/call centre staff, ward clerks, and receptionists. These are automatically recorded as essential in ESR. Administrative and clerical posts may also be designated essential or "to be learnt" depending on local Welsh-speaking capacity. If recruitment fails: • internal adverts must be extended externally, • if no Welsh speaker is found, a non-Welsh speaker may be appointed if they commit to learning Welsh to the required level within a set timeframe. The Health Board must	

				then provide training support. The **Welsh Language Training Team** has developed a pathway to support staff appointed to "Welsh to be learnt" roles, ensuring they can meet language requirements.	
• How will performance be measured and monitored?	✓			Recording language choice of patients and monitor to what level this is achieved.	
3.1 Effect on Welsh speaking users					
• Will the proposal offer a language choice for users?		✓		Standards relating to written correspondence will be fully achieved offering language choice to service users.	
• Will it be possible for users to receive services in Welsh?		✓		Face to face bilingual service provision will be dependent on capacity of the workforce and demand for bilingual services. Currently there is a higher number of Welsh speaking staff than Welsh speakers in the community. This will	

				either be maintained, or increased.	
• Will there be a bilingual environment?		✓		Corporate identity will be fully bilingual in accordance with the Welsh Language Standards. As there will be no physical building, standards relating to bilingual signage are not applicable.	
Is there a risk for the proposal to discriminate against Welsh speaking service users? • Have the needs of Welsh speakers been considered in the proposal?	✓			Welsh language will be considered as part of the development and planning process. It will be dependent on workforce and demand for Welsh language services	
• Are Welsh speakers likely to receive the same standard of service as provided in English?		✓		The needs of Welsh speakers will be fully considered – written correspondence, and recording of language choice.	
• Are Welsh language arrangements likely to lead to a delay in the service?		✓		Not with written communication, but face to face service provision will be dependent on workforce and availability of Welsh speaking staff.	

• Is the proposal likely to make Welsh more visible?		✓		As there will be no physical building, standards relating to bilingual signage are not applicable.	
• Is it likely to influence others to make more use of Welsh?		✓		As there will be no physical building, standards relating to bilingual signage are not applicable.	
• Will the Welsh language service in relation to the proposal be accessible?		✓		Written documentation will be fully compliant. Face to face provision will be dependent on structure of the services offered, as well as workforce and demand for services. This will become clearer, when final structures are in place. Any gaps will be addressed.	
• Will the service be as accessible in Welsh as in English?		✓		Written documentation will be fully compliant. Face to face provision will be dependent on structure of the services offered, as well as workforce and demand for services. This will become clearer, when final structures are in place. Any gaps will be addressed	
• Will the services be available at the same time?		✓		Written documentation will be available at the same time. Face to face provision	

				will be dependent on structure of the services offered, as well as workforce and demand for services. This will become clearer, when final structures are in place. Any gaps will be addressed	
3.2 Effect on Welsh speaking communities					
• Is the proposal likely to contribute towards safeguarding Welsh in communities?		✓		This scenario will expand current health community services on offer across the South Wrexham area. This scenario does not require the use of the building, redirecting resources away from maintaining a fixed site and investing instead in outreach and home-based services. This model supports care closer to home in a flexible setting.	
• Is it likely to contribute towards the local economy in Welsh speaking areas?		✓		Unknown at the moment.	
• Does the proposal take steps to promote and facilitate the Welsh language?	✓			Yes – in terms of service provision.	

• Does the proposal contribute towards Welsh medium community activities?				Not applicable	
• Does it contribute to add value to other activities relating to language?				Not applicable	
3.3 Contribution towards Welsh language standards and other relevant guidance relating to the Welsh language.					
The language policies of partners: • Is the Health Board working in partnership on the proposal?		✓		The Health Board will not be working in partnership on this proposal.	
• Which other organisations are likely to be affected by the development?		✓		Not yet known	
• Do those organisations have Welsh language standards or language policies?		✓		Not yet known	
• Does the proposal contribute towards these schemes?		✓		Not yet known	

• How does the proposal contribute towards the vision of the Welsh Government for one million Welsh speakers by 2050?	✓			Continue to provide training opportunities for staff to learn Welsh aligning with the Welsh Government's vision by increasing the use of Welsh in the workplace. The Health Board employs an in-house Welsh language tutor to provide Welsh lessons for staff. These are delivered via Microsoft Teams, and are open to all staff across the Health Board, therefore there are no accessibility issues in terms of location of courses, and travel. There is no data specific to the East IHC, but the total numbers of learners who registered on some form of Welsh language training across the Health Board in 2024-2025 was **995**, an increase of 25% from 2023-2024. There are 22 different courses including weekly on line lessons, self-studying courses, residential courses at Nant	

				Gwrtheyrn, sessions to prepare for the Language Skills Certificate, specific courses for receptionists, 1:1 raising confidence courses and more. Feedback – 96% of learners are very happy with the provision. 83% of learners stated that they have greater confidence in using the Welsh language after completing the courses.	

3.4 The impacts identified and assessed	
What impacts and effects have you identified? How do you plan to address these impacts to improve outcomes for the Welsh language? Detail mitigation measures / alternative options to reduce adverse impacts and increase positive impacts.	
Positive impacts	Opportunities to increase awareness Deliver specific training for staff. Consider Welsh language as part of service development and workforce planning.
Adverse impacts	No adverse effects All proposals will comply with Welsh language requirements.

Neutral	Due to lower numbers of Welsh speakers in the East in particular, there have been difficulties in recruiting Welsh speakers. But due to lower than average demand for Welsh language services, there won't be any change to what is delivered currently. In accordance with the Welsh Language Standards (Operational Standards) which relates to workforce planning, **Standard 106** requires the Health Board to assess Welsh language needs for each post advertised, categorising roles as: (a) essential, (b) to be learnt on appointment, (c) desirable, or (d) not necessary. The Health Board must also: • assess staff Welsh language skills, • provide basic lessons during work hours, • offer free advanced training for those who complete basics. To meet these standards, the **Bilingual Skills Policy and Procedure** ensures effective recruitment and workforce planning so bilingual services can be delivered according to patient choice. Posts requiring Welsh at Level 3+ on the Electronic Staff Record are advertised accordingly, alongside wider training opportunities. **Welsh Essential posts** include front-line roles such as switchboard staff, booking/call centre staff, ward clerks, and receptionists. These are automatically recorded as essential in ESR. Administrative and clerical posts may also be designated essential or "to be learnt" depending on local Welsh-speaking capacity. If recruitment fails: • internal adverts must be extended externally, • if no Welsh speaker is found, a non-Welsh speaker may be appointed if they commit to learning Welsh to the required level within a set timeframe. The Health Board must then provide training support.

	The **Welsh Language Training Team** has developed a pathway to support staff appointed to "Welsh to be learnt" roles, ensuring they can meet language requirements.
3.7 Engagement	
During engagement, what questions do you wish to ask about the Welsh language impacts?	Do you have a view on any impacts our proposals may have on the Welsh language?
With whom are you engaging? How are Welsh language interest groups likely to respond?	Despite materials being available in Welsh, with Welsh translation available and Welsh speakers at events, no feedback has been received thus far in the Welsh medium. For Phase Three, we will consider further targeted work to identify Welsh-first speakers in the area.
Following engagement, what changes have you made to address language issues raised?	There haven't been any thus far.
3.8 Post engagement, final proposals and on-going monitoring	
Summarise your final decisions, list the likely effects on the Welsh language and how you will promote / mitigate these. Record your compliance with the Welsh language standards (you will need to refer to this summary in the impact assessment template)	
How will you monitor the on-going effects during implementation of the policy?	

Who signed-off this Impact Assessment: *As per the Health Board's Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board', to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Health Board as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions must have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.*
Approval Date:

Review Date:		
Project Lead Sign-off I confirm that this Welsh Language Impact Assessment has been carried out in accordance with Betsi Cadwaladr University Health Board's WP7 Procedure for assessment work for evidencing Due Regard for: Welsh Language requirements. Signed: (Project Lead)	**Welsh Language Team Quality Check** I confirm that I have reviewed this Welsh Language Impact Assessment and I am assured that it contains sufficient evidence and rigour to be considered by the decision-making committee. Signed: Eleri Hughes-Jones (Head of Welsh Language Services)	**Committee Chair Sign-off** I confirm that this Welsh Language Impact Assessment represents evidence that we (The Health Board), in making this decision, have given due regard to the need to reduce the Welsh language inequality. Signed: (Committee Chair)

Charity number: 1138976

DECLARATION OF TRUST

OF

BETSI CADWALADR UNIVERSITY HEALTH BOARD CHARITY ("the Charity")

THIS SUPPLEMENTARY DECLARATION OF TRUST IS MADE ON
The […….] 2026

by **THE BETSI CADWALADR UNIVERSITY HEALTH BOARD**
("the trustee")

WHEREAS

(A) The Charity holds charitable monies pursuant to a Declaration of Trust dated 23 September 2010 ("the Original Declaration").

(B) The Trust wishes to amend the said Original Declaration and the Charity Commission has provided prior written approval to the amendments specified in this supplemental deed.

(C) This supplementary Declaration of Trust shall replace the Original Declaration as the governing document for the Charity.

NOW THIS DEED WITNESSES AS FOLLOWS:

A. Administration

The charitable trust constituted by this deed ("the Charity") and its trust property ("the trust fund") shall be administered and managed by the trustee under the name of **BETSI CADWALADR UNIVERSITY HEALTH BOARD CHARITY** or by such other name as the trustee from time to time decides with the approval of the Charity Commission for England and Wales.

B. Trustee

The trustee of the Charity and the trust fund shall be **BETSI CADWALADR UNIVERSITY HEALTH BOARD** or such other trustee or trustees as may be appointed by Welsh Government Ministers by virtue of any legislation from time to time in force.

C. Objects

The trustee shall hold the trust fund upon trust to apply the income, and at its discretion, so far as may be permissible, the capital, either for the general or specific purposes of Betsi Cadwaladr University Health Board or for all or any charitable purpose or purposes relating to the National Health Service (hereinafter referred to as "the objects").

D. Powers

In furtherance of the objects but not otherwise the trustee may exercise any of the following powers:

1) to raise funds and invite and receive contributions: Provided that in raising funds the trustee shall not undertake any substantial permanent trading activity and shall conform to any relevant statutory regulations;

2) to buy, take on lease or in exchange, hire or otherwise acquire any property necessary for the achievement of the objects and to maintain and equip it for use;

3) subject to any consents required by law to sell, lease or otherwise dispose of all or any part of the property comprised in the trust fund;

4) subject to any consents required by law, to borrow money and to charge the whole or any part of the trust fund with repayment of the money so borrowed;

5) to co-operate with other charities, voluntary and statutory authorities operating in furtherance of the objects or of similar charitable purposes and to exchange information and advice with them;

6) to establish or support any charitable trusts, associations or institutions formed for the objects or any of them;

7) to employ such staff as are necessary for the proper pursuit of the objects and to make all reasonable and necessary provision for the payment of pensions and superannuation to staff and their dependants;

8) to charge against the trust fund the proportion of the cost of administrative overheads incurred by the trustee both in the administration of the Charity and in the discharge of other functions which are attributable to the administration of the Charity;

9) to permit any investments comprised in the trust fund to be held in the name of any clearing bank, any trust corporation or any stock broking company which is a member of the Stock Exchange (or any subsidiary of such a stock broking company) as nominee for the trustee and to pay such nominee reasonable and proper remuneration for acting as such;

10) to designate, at its discretion, particular funds out of the trust fund in order to give effect to the wishes of any donor to the Charity or for administrative or other purposes and power to vary and cancel such designation: Provided that any such designation or variation does not permit the use of any part of the trust fund other than for the objects of the Charity;

11) to accept and administer restricted funds for any purposes within the objects of the Charity but so that any restricted funds shall be administered in accordance with the trusts attaching to them;

12) to transfer the trust fund or any part of the trust fund to itself as a body responsible for the maintenance of a health service hospital or provision of health services or to any other such body for or in connection with the acquisition, improvement or maintenance of any property: Provided that in making any such transfer the trustee shall have regard to:

a. any restrictions or expressed wishes of the donors as to them terms and conditions on which such a transfer may be made; and

b. the general desirability of making the transfer subject to terms and conditions which will ensure that the property so acquired, improved or maintained will continue to be used for the purposes for which the funds were transferred;

13) to spend money on the insurance of any property comprised in the trust fund to its full value against such perils and upon such terms as the trustee thinks fit;

14) to make regulations from time to time, within the limits of this deed, for the management of the Charity and for the conduct of its business including the deposit of money at a bank and the custody of documents;

15) to establish non-charitable trading subsidiaries;

16) to do all such other lawful things as are necessary for the achievement of the objects.

E. Benefits and payments to the trustee and connected persons

1) The income and property of the Charity must be applied solely towards the promotion of the objects.

a. The trustee is entitled to be reimbursed out of the property of the Charity or may pay out of such property reasonable expenses properly incurred by him, her or it when acting on behalf of the Charity.

b. The trustee may benefit from trustee indemnity insurance cover purchased at the Charity's expense in accordance with, and subject to the conditions in, section 189 of the Charities Act 2011.

2) No trustee board member or connected person may:

a. buy or receive any goods or services from the Charity on terms preferential to those applicable to members of the public;

b. sell goods, services or any interest in land to the Charity;

c. be employed by, or receive any remuneration from, the Charity;

d. receive any other financial benefit from the Charity;

unless the payment or benefit is permitted by sub-clause (3) of this clause or authorised by the court or the Charity Commission. In this clause a 'financial benefit' means a benefit, direct or indirect, which is either money or has a monetary value.

3) Scope and powers permitting the trustee board member's or connected persons' benefits

a. A trustee board member or connected person may receive a benefit from the Charity in the capacity of a beneficiary of the Charity provided that a majority of the trustee board members do not benefit in this way.

b. A trustee board member or connected person may enter into a contract for the supply of services, or of goods that are supplied in connection with the provision of services, to the Charity where that is permitted in accordance with, and subject to, the conditions in, section 185 of the Charities Act 2011.

c. Subject to sub-clause (4) of this clause a trustee board member or a connected person may provide the Charity with goods that are not supplied in connection with services provided to the Charity by a trustee board member or connected person.

d. A trustee board member or a connected person may receive interest on money lent to the Charity at a reasonable and proper rate which must be not more than the Bank of England bank rate (also known as the base rate).

e. A trustee board member or connected person may receive rent for premises let by a trustee board member or connected person to the Charity. The amount of the rent and the other terms of the lease must be reasonable and proper. The trustee concerned must withdraw from any meeting at which such a proposal or the rent or other terms of the lease are under discussion

f. A trustee board member or connected person may take part in the normal trading and fundraising activities of the Charity on the same terms as members of the public.

4) Payment for the supply of goods only – controls

The Charity and the trustee board members may only rely upon the authority provided by sub-clause (3)(c) of this clause if each of the following conditions is satisfied:

a. The amount or maximum amount of the payment for the goods is set out in an agreement in writing between the Charity and a trustee board member or connected person supplying the goods ('the supplier') under which the supplier is to supply the goods in question to or on behalf of the Charity.

b. The amount or maximum of the payment for the goods in question does not exceed what is reasonable in the circumstances for the supply of the goods in question.

c. The other trustee board members are satisfied that it is in the best interests of the Charity to contract with the supplier rather than someone who is not a trustee board member or a connected person. In reaching that decision the trustee must balance the advantage of contracting with a trustee board member or a connected person against the disadvantages of doing so.

d. The supplier is absent from the part of the meeting at which there is discussion of the proposal to enter into a contract or arrangement with him or her or it with regard to the supply of goods to the Charity.

e. The supplier does not vote on any such matter and is not to be counted when calculating whether a quorum of trustee board members is present at the meeting.

f. The reason for their decision is recorded by the trustee in the minute book.

g. A majority of the trustee board members then in office are not in receipt of remuneration or payments authorised by this clause.

5) In sub-clauses (3)-(4) of this clause:
   a. 'Charity' shall include any company in which the Charity:
      i. holds more than 50% of the shares; or
      ii. controls more than 50% of the voting rights attached to the shares; or
      iii. has the right to appoint one or more trustees to the board of the company.
   b. In sub-clauses (2), (3) and (4) of this clause 'connected person' includes any person within the definition set out in section M (Interpretation) of this deed.

F. Trustee responsibilities

The Standing Orders of the Betsi Cadwaladr University Health Board set out the responsibilities of the trustee including:

a. Values and standards of behaviour and declaration of interest.

b. Appointment and delegation to committees established by the Board with detailed terms of reference and operating arrangements. These must establish its governance and ways of working, setting out, as a minimum:

   i. The scope of its work (including its purpose and any delegated powers and authority);
   ii. Membership and quorum;
   iii. Meeting arrangements;
   iv. Relationships and accountabilities with others (including the Board its Committees and Advisory Groups)
   v. Any budget and financial responsibility, where appropriate;
   vi. Secretariat and other support;
   vii. Training, development and performance; and
   viii. Reporting and assurance arrangements.

G. Accounts

The trustee shall comply with its obligations under the Charities Act 2011 (or any statutory re-enactment or modification of those Acts) with regard to:

1) the keeping of accounting records for the Charity;

2) the preparation of annual statements of account for the Charity;

3) the auditing or independent examination of the statements of account of the Charity; and

4) the transmission of the statements of account of the Charity to the Commission.

H. Annual Report

The trustee shall comply with its legal obligations under the Charities Acts 2011 (or any statutory re-enactment or modification of those Acts) with regard to the preparation of an annual report and its transmission to the Commission.

I. Annual Return

The trustee shall comply with its obligations under the Charities Acts 2011 (or any statutory re-enactment or modification of those Acts) with regard to the preparation of an annual return and its transmission to the Commission.

J. Amendment of Trust Deed

1) The trustee may amend the provisions of this deed, provided that:

    a. no amendment shall be made to clause B except to reflect a change of trusteeship determined and given legal effect, or agreed to in writing, by the Department of Health.

    b. no amendment may be made to clause C (the objects clause), unless it appears to the trustee that the objects can no longer provide a suitable and effective method of using the trust fund;

    c. no amendment can be made to clause C (the objects clause), clause E (Benefits and payments to the trustee and connected persons), clause M (Dissolution) or this clause without the prior consent in writing of the Commission; and

    d. no amendment may be made which has the effect of the Charity ceasing to be a charity at law.

2) Any amendment shall be made by deed.

3) The trustee must send to the Commission a copy of any amendment made under this clause.

K. Dissolution

If it appears to the trustee that the objects no longer provide a suitable and effective method of using the trust fund, the trustee may:

(a) transfer the trust fund to one or more other charitable bodies established for exclusively charitable purposes within, the same as or similar to the objects; or

(b) in these circumstances, but only so far as the trusts attaching to any particular gift to the charity may permit, hold the trust fund upon trust to apply the income and at its discretion, so far as may be permissible, the capital for any charitable purpose relating to the National Health Service.

L. Interpretation

1.1 In this deed, all references to particular legislation are to be understood as references to legislation in force at the date of this deed and also to any subsequent legislation that adds to, modifies or replaces that legislation.

1.2 "trustee" is the Betsi Cadwaladr University Health Board and shall include any successor bodies established for the same purpose. Any decisions to be made by the trustee should be made by the members of the Board of Independent and Executive Members of the Betsi Cadwaladr University Health Board ("trustee board members"), subject to any delegations which have been put in place from time to time

1.3 "connected person" means:

(a) a child, parent, grandchild, grandparent, brother or sister of the trustee;

(b) the spouse or civil partner of the trustee or of any person falling within sub-clause (a) above;

(c) a person carrying on business in partnership with the trustee or with any person falling within sub-clause (a) or (b) above;

(d) an institution which is controlled –

(i) by the trustee or any connected person falling within sub-clause (a), (b), or (c) above; or

(ii) by two or more persons falling within sub-clause (d)(i), when taken together

(e) a body corporate in which –

(i) the charity trustee or any connected person falling within sub-clauses (a) to (c) has a substantial interest; or

(ii) two or more persons falling within sub-clause (e)(i) who, when taken together, have a substantial interest.

(f) Sections 350 - 352 of the Charities Act 2011 apply for the purposes of interpreting the terms used in this clause.

IN WITNESS whereof acting under seal as determined by the Board on [……. 2026] and by signature of nominated officers

Signed as a deed by the said

……..

In the presence of:

…….

Witness name:

Witness address:

Signed as a deed by the said

……..

In the presence of:

…….

Witness name:

Witness address:

Agenda Item
x.x

Joint Commissioning Committee

Joint Commissioning Committee Governance Framework

Dyddiad y Cyfarfod / Date of Meeting	Click or tap to enter a date.
Statws Cyhoeddi / Publication Status	Open/ Public
Awdur yr Adroddiad / Report Author	Aaron Fowler, Committee Secretary NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Aaron Fowler, Committee Secretary NWJCC
Noddwr yr Adroddiad / Report Sponsor	Ian Green, Chair of the NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt /consideration at Committee/Group)		
Committee/Group/Individuals	**Date**	**Outcome**
ToR - Quality Safety and Outcomes (QSOC) Sub-Committee	23 February 2026	Endorsed Feedback assisted in developing the drafts
ToR - Planning Performance and Finance (PPF) Sub-Committee	26 February 2025	Endorsed Feedback assisted in developing the drafts
PPF and QSOC ToR - Joint Commissioning Committee	17 March 2026	The JCC Endorsed the updated ToR
Senior Leadership Team NWJCC and HB Director of Corporate Governance Draft Standing Orders and Standing Financial Instructions	13 April 2026	Feedback received and assisted in finalising the documents
Joint Committee - Draft Standing Orders and Standing Financial Instructions	26 May 2026	To be Approved

1. SITUATION

The purpose of this report is to present the NHS Wales Joint Commissioning Committee's (JCC) updated governance framework. In accordance with the JCC scheme of delegation and reservation of powers, approval of the Joint Committees governance framework is reserved to Local Health Boards (LHBs).

2. BACKGROUND

The Governance Framework for the JCC contains several key components which, combined, set out the legislative framework, constitution and ways of working for the JCC in its operations and handling of business. These documents are an integral part of the wider governance framework of LHBs and have been developed within that context.

The Governance Framework of the JCC contains the following.

Figure 1 – JCC Governance Framework

2.1 Standing Orders and Standing Financial Instructions

The Seven LHBs approved the JCC Standing Orders (SOs) and Standing Financial Instructions (SFIs) in March 2024. There were subsequently adopted by the Joint Committee at its inaugural meeting on 8 April 2024 following which they were included as a schedule to each of the Health Boards (HBs) own SOs and have effect as if incorporated within them.

During October 2025, WG issued updated Model Standing Orders for the NWJCC. The purpose of these amendments was to ensure consistency relating to the timescales for the publication of board and committee agendas and papers. Updates to the JCC's Standing Orders to incorporate these changes were approved at the November 2025 Joint Committee meeting.

A further review of the NWJCC Governance Framework commenced during Q3 of 2025-2026. Attached at **Appendix 1** is a table of the proposed amendments to the Standing Orders. The changes are largely administrative in nature and seek to either re-format or re-define the content of each document, or update sections to reflect operational reality. The changes to the Standing Financial Instructions are also mainly administrative. The more substantial updates include the following.

- Section 11 (highlighted in blue) replaced for the updated Procurement Regulations (including Schedule 1) and updated references for NWJCC/JCCT.
- Addition of a debt recovery paragraph in section 9 to reflect current processes.

Attached as **Appendices 2 and 3** are tracked changes versions of the Standing Orders and Standing Financial Instructions for approval.

2.2 Scheme of Delegation and Reservation of Powers

The NWJCC's Scheme of Reservation and Delegation of Powers forms an annex to the NWJCC's SOs, which form a schedule to each HBs own SOs and have effect as if incorporated within them. The Scheme of Delegation and Reservation of Powers, sets out in the context of the NWJCC's business:

- Those matters reserved for HBs;
- Those matters delegated from HBs and reserved for the NWJCC; and
- Those matters further delegated from the NWJCC to the Chief Commissioner (and other Officers as appropriate).

The Scheme of Delegation was approved by the JCC in May 2025 and was subsequently approved by Health Boards in July 2025. At present no changes are proposed to these documents.

2.3 The Hosting Agreement (HA) and memorandum of Agreement (MoA)

The Hosting Agreement (HA) and the Memorandum of Agreement (MoA) were endorsed by the Joint Committee on 17 September 2024 and were approved by the seven HBs at their September 2024 Board meetings. The governance arrangements within the Hosting arrangement have been working effectively. There is regular dialogue between the JCC and officers at Cwm Taf University Health Board (CTMUHB), complemented by more formal meetings between the two Accountable Officers where the Hosting Arrangements are discussed.

A formal review of the Hosting Agreement is scheduled during Q1 of 2026/27.

2.4 Accountability Map and Guidance on the Handling of Interests

The Accountability Map outlining the formal accountabilities and relationships between Welsh Government, LHBs, CTMUHB (as the JCC Host Body), the JCC and its Team; and the Guidance on the Handling of Interests which sets out the arrangements for the appropriate handling of declarations of interests within the NWJCC's business, were both received by the Joint Committee at its inaugural meeting on 8 April 2024. The Guidance on the Handling of Interests has been updated and minor changes have been proposed in track and attached at **Appendix 4.** No changes are proposed to the Accountability Map.

Appendices 1-4 will be presented to the May 2026 JCC meeting for endorsement.

2.5 JCC SUB-COMMITTEE STRUCTURE

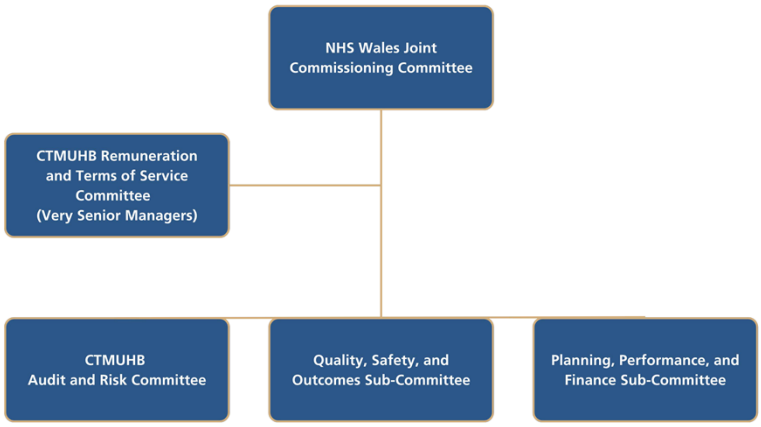
Paragraph 5.5 of the NWJCC Standing Orders states that the Joint Committee shall determine, for agreement by Health Boards, a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent Health Boards.

Paragraph 5.8 of the Standing Orders states that "As a minimum, it shall ensure that there are joint sub-Committee arrangements which cover the following aspects of Joint Committee business:

- Audit and Risk
- Quality, Safety and Outcomes
- Planning and Performance"

The NWJCC Sub-Committee structure was established in January 2025 with the introduction of the Quality, Safety and Outcomes (QSOC) and Planning, Performance and Finance (PPF) Sub-Committees. The NWJCC's Audit and Risk assurance arrangements are serviced by the CTMUHB Hosted Bodies Audit, Risk and Assurance Committee.

Figure 2 –JCC Sub-Committee Structure



Sub-Committee Terms of Reference are subject to annual review (Para 16.1 of the respective ToR). Following a full year of operation, consideration has therefore been given to the content of the QSOC and PPF ToR, and how they align with the NWJCC's governance framework and operational structure.

Updated QSOC and PPF ToR are presented at **Appendix 5** and **Appendix 6** for final approval, having previously been endorsed by the NWJCC Sub-Committees and Joint Committee. Proposed changes are detailed in track.

3. ASSESSMENT

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

4. RECOMMENDATIONS

Board Members are asked to **Approve:**

- the updated Standing Orders for the JCC (**Appendix 2**) [subject to formal approval by the NWJCC at the Joint Committee meeting of the 26 May 2026] [following approval at the Joint Committee meeting of the 26 May 2026].
- the updated Standing Financial Instructions (SFIs) for the JCC (**Appendix 3**). [subject to formal approval by the NWJCC at the Joint Committee meeting of the 26 May 2026] [following approval at the Joint Committee meeting of the 26 May 2026].
- the updated Guidance on the Handling of Interests (**Appendix 4**).
- the updated terms of reference (ToR) for the JCC Quality, Safety and Outcomes Sub-Committee (**Appendix 5**); and
- the updated terms of reference (ToR) for the JCC Planning, Performance & Finance Sub-Committee (**Appendix 6**).

Commented [AF1]: Delete as necessary.

5. NEXT STEPS

Following approval, the revised JCC Governance Framework will be published on the NWJCC website, and all hyperlinks within the associated documents will be updated to reference these approved materials.

Appendix 1

NWJCC Standing Orders

Suggested changes to version 2.1 Draft 13 October 2025

Organisation	Details of the provision including reference to para	Impact or risk associated with the current arrangement	Proposal for an appropriate and reasonable amendment
NWJCC	Paragraph 1.3	Nil	Removal of spare bullet point.
	Paragraph 1.7	Nil	Link to be updated, formatting of paragraphs to be changed (space between paras one and two).
	Para 2.22	Nil	Formatting of text and a gap to 2.23.
	Para 3.1 – Bullet point 1	Nil	At the end of bullet point 3 – add in (as set out at Annex 1) Please add Annex 1 to the Scheme of Delegation also.
	Paras 6.1 to 6.4	Nil	Spacing of paragraphs
	Para 6.3	Nil	Remove: [known as Lay Members]. This detail is referred to in the paragraph.
	Para 6.3 –	Nil	Delete Note: At the time of preparing these Standing Orders 3 Lay Member have been appointed.
	Para 6.11 and 6.12	Nil	Spacing

Para 6.13	Nil	Paragraph Spacing
Para 6.14	Nil	Documents alignment – 'Vice Chair' to drop to the next page.
Para 6.15	Nil	Formatting - Para 5 to be justified
Para 7.3	Nil	Fifth word – the 't' in 'not' to have the strikethrough removed.
Para 7.5? 7.4?	Nil	Formatting – Paragraph spacing.
Para 7.5 – Page 21 of 37	Nil	Inconsistency with Paragraph 7.12 as approved in recent WHC. Amend 7 calendar days to 5
Para 7.8 – final paragraph.	Nil	Confusing as this was a statement inserted when the first version was approved and was required as part of a transition in the first year Delete from "for the forthcoming year by the end of May 2025, and for subsequent years"
Para 7.11 and 12	Nil	Inconsistency with Paragraph 7.11 and 12 Amend 7 calendar days to 5
Para 7.11	Nil	To be updated as per WHC and November Board approval.

Para 7.13 – para 5	Nil	Formatting. Add space between paragraphs.
Para 7.15 – Amendments	Nil	Formatting. Add space between paragraphs.
Para 7.21	Nil	Line 3 – Update to 'minutes'
Para 8.1	Nil	Update the second paragraph to: The Joint Committee adopts the Standards of Behaviour Policy of the Host Body which will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, JCC Team officers and others, as appropriate. The framework adopted by the Joint Committee is the Standards of Behaviour Policy which will form part of the JCC SOs.
Para 8.2	Nil	Para 3 please add "(Annex 2)" after Guidance on Handling of Interests.
Para 8.8	Nil	Space to be added between 7 and LHBs – Last line.
Para 10.1	This paragraph is not reflective of current practice.	Proposed update as follows:

			The Joint Committee shall set out explicitly, within a ~~Risk and~~ Joint Committee Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers. The Joint Committee shall provide assurance on the processes in place to support this to the Host Body's Audit Risk and Assurance Committee ~~ensure that its assurance arrangements are operating effectively, advised by the~~

			~~Joint Committee's Audit Committee~~.
	PAGE 41 -	Nil	Below C4 there is an empty row to be deleted.
	Page 41 – Annex 1(D)	For detail	We need to update this table to confirm that this will be kept under review during 2026/27.

Appendix 2

STANDING ORDERS FOR THE NHS WALES JOINT COMMISSIONING COMMITTEE

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

Adopted from the Model Standing Orders issued by Welsh Government on 13 October 2025.

Date endorsed:	
Endorsed by:	JCC
Date approved:	
Approved by:	Health Boards
Review date:	Annual
Version:	2.1
Responsible Director:	Committee Secretary

1. INTRODUCTION

Foreword

1.1 Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. When agreeing Standing Orders Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the NHS Wales Joint Commissioning Committee's (JCC) proceedings and business to form part of each LHBs Standing Orders.

1.2 These JCC Standing Orders form a schedule to each LHBs own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024 and LHB Standing Order, paragraph 3.2 into day to day operating practice.

Together with the adoption of a Schedule of Powers reserved to the Joint Committee; a Scheme of Delegation to officers and others; and Standing Financial Instructions (SFIs), they provide the framework for the business conduct of the Joint Committee.

1.3 These documents, together with the following, are designed to ensure the achievement of the standards of good governance set for the NHS in Wales:

- Memorandum of Agreement which defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executive Officer of the constituent LHBs as individual members of the Joint Committee;
- Hosting Agreement which outlines the accountability arrangements and resulting responsibilities for Cwm Taf Morgannwg University Health Board (the Host Body) and the other 6 LHBs; and
- Cwm Taf Morgannwg University Health Board's Values and Standards of Behaviour Framework.

1.4 All LHB Board members (and employees where appropriate), Joint Committee members, and the NHS Wales Joint Commissioning Committee Team (JCCT) must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements for the Joint Committee. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/a-wp/governance-e-manual/

1.6 As a joint committee of the LHBs, the JCC is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf.
Ultimately, the 7 LHBs remain accountable for planning, securing and delivering health services to their respective populations.

1.7 Cwm Taf Morganwwg University Health Board is appointed as the Host Body under Ministerial Direction and is accountable for the delivery of the functions of host body, as required by the NHS Wales Joint Commissioning Committee (Wales) Directions 2024 (the JCC Directions). As the host body they are required to provide administrative support for the operation of the JCC and establish the JCCT.

The Board of the Host Body will not be responsible or accountable for the planning, funding and securing of those services delegated to the JCC by the 7 LHBs, or as directed by Welsh Ministers, save in respect of residents within the areas served.

2. CONSTITUTION AND PURPOSE

Statutory Framework

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

The functions and services of the Joint Committee are listed in Section 3(2) of the JCC Directions.

2.2 The principal place of business of the JCC is Unit G1, The Willowford, Treforest Industrial Estate, Pontypridd CF37 5YL.

2.3 All business shall be conducted in the name of the NHS Wales Joint Commissioning Committee (JCC) on behalf of LHBs.

2.4 LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the NHS (Wales) Act 2006 which is the principal legislation relating to the NHS in Wales.

Whilst the NHS Act 2006 applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

2.5 Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions.

2.6 LHBs must act in accordance with those directions. Most of the LHBs' statutory functions are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009.

However, in some cases the relevant function may be contained in other legislation.

2.7 Each LHBs functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and tertiary services for the citizens in their respective areas. The JCC Directions provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning, securing and commissioning of services delegated to it and will establish the Joint Committee for the purpose of jointly exercising those functions.

2.8 Under powers in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006 the Minister has made the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024 (the JCC Regulations) which set out the constitution and membership arrangements of the Joint Committee.

Certain provisions of the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (the Constitution Regulations) will also apply to the operations of the Joint Committee, as appropriate.

2.9 In addition to directions, the Welsh Ministers may from time to time issue guidance relating to the activities of the Joint Committee which LHBs must take into account when exercising any function.

2.10 The Host LHB shall issue an indemnity to the Chair and Lay Members, on behalf of the LHBs.

NHS Framework

2.11 In addition to the statutory requirements set out above, the Joint Committee, on behalf of each of the LHBs, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery.

The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

2.12 Adoption of the principles will better equip the Joint Committee to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

2.13 The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; and Standing Financial Instructions, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

2.14 The Welsh Ministers, reflecting their constitutional obligations and legal duties under the Well-being of Future Generations (Wales) Act 2015, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

2.15 The Well-being of Future Generations (Wales) Act 2015 also places duties on LHBs, NHS Trusts and Special Health Authorities in Wales and therefore is extended to the activity of the JCC. Sustainable development in the context of the act means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

2.16 The Health and Social Care (Quality and Engagement) (Wales) Act 2020 places requirements to:

- Ensure NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality); and
- Ensure NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour).

LHBs will need to ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance. These requirements therefore extend to the activity of the JCC, where relevant as set out within the JCC Scheme of Delegation.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

2.17 Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Ministers' Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at: https://nwssp.nhs.wales/a-wp/governance-e-manual/

Directions or guidance on specific aspects of Joint Committee/LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Purpose and Delegated functions

2.18 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the planning, securing and commissioning of:

- specialised services for:
  - cancer and blood disorders
  - cardiac conditions
  - mental health and vulnerable groups
  - neurosciences, and
  - women and children.
- services where there is agreement between the Local Health Boards that they should be arranged on a regional or national basis
- emergency medical services
- non-emergency patient transport services
- emergency medical retrieval and transfer services
- NHS 111 services
- sexual assault referral centres, and
- other services as directed by the Welsh Ministers.

2.19 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of services identified in 2.18 for residents within their area.

Role of the Joint Committee

2.20 The Joint Committee's role is to:

- Determine a long-term strategy for the commissioning of services delegated to the JCC
- Produce an Integrated Medium-Term Plan which describes how these services will be delivered on behalf of LHBs through clear 'commissioning intentions' which informs and compliments the LHBs Integrated Medium-Term Plans (IMTPs)
- In commissioning services, the JCC will act in accordance with the Directions and Scheme of Delegation of the health boards and will, for the relevant functions:
    - Identify and evaluate existing, new and emerging services and treatments and advise on the way in which these services should be delivered
    - Develop policies for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC
    - Determine annually those services that should be commissioned on a regional or national basis
    - Determine the appropriate level of funding for the commissioning of directed and delegated services at a regional or national level and determine the contribution from each LHBs for those services (which will include the running costs of the JCC and the Joint Commissioning Team) in accordance with any specific directions set by the Welsh Ministers
    - Secure the provision of services delegated at a regional and national level including those to be delivered by providers outside of Wales
- Ensure the JCC operates within an appropriate governance framework.

2.21 To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making delegated to the Chief Commissioner and others undertaken at the direction of the Joint Committee.

2.22 The Joint Committee must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Where LHBs have delegated decisions to the JCC, each **LHB shall be bound by the decisions of the Joint Committee in accordance with the Schedule of Powers reserved for the Joint Committee.**

In the event that the Joint Committee is unable to reach agreement, the dispute process set out within the Memorandum of Agreement should be followed.

2.23 The Joint Committee shall work with all its partners and stakeholders in the

best interests of the population of Wales.

3. SCOPE AND DUTIES

Joint Committee Framework

3.1 The specific governance and accountability arrangements established for the Joint Committee are set out within:

- These JCC Standing Orders and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation to others (as set out in **Annex 1)**
- The JCC Standing Financial Instructions (SFIs)
- JCC Accountability Map
- A Memorandum of Agreement which defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executive Officer of the constituent LHBs as individual members of the Joint Committee;
- A Hosting Agreement which outlines the accountability arrangements and resulting responsibilities for Cwm Taf Morgannwg University Health Board (the Host Body) and the other 6 LHBs; and
- Guidance on the Handling of Interests.

3.2 **Annex 2** to these Standing Orders provides details of the key documents that, together with these SOs, make up the Joint Committee's governance and accountability framework.

3.3 The Joint Committee may from time to time agree operating procedures which apply to Joint Committee members.

The decisions to approve these operating procedures will be recorded in an appropriate Joint Committee minute and, where appropriate, will be included in Annex 2 of these JCC SOs.

Applying JCC Standing Orders

3.4 The JCC SOs (together with the JCC SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any joint sub-Committees established by the Joint Committee, including any Advisory Groups.

The JCC SOs may be amended or adapted for the joint sub-Committees or Advisory Groups as appropriate, with the approval of the LHB Boards. Further details on joint sub-Committees and Advisory Groups may be found **in Annexes 3 and 4** of these JCC SOs, respectively.

3.5 Full details of any non-compliance with these JCC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit Committee to formally consider the matter and make proposals to the Joint Committee on any action to be taken. LHB Boards should be notified of any material non-compliance and the action taken, as determined by the

Committee Secretary.

All Joint Committee members and Joint Committee Team officers have a duty to report any non-compliance to the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported. Ultimately, failure to comply with JCC SOs is a disciplinary matter.

Variation and amendment of JCC Standing Orders

3.6 Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the Joint Committee determines that it is necessary to vary or amend the SOs during the year.

In these circumstances, the Chair of the Joint Committee, advised by the Committee Secretary, shall submit a formal report to each LHB Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the seven LHBs are in favour of the amendment, and
- Where the Welsh Ministers agree if it relates to part of the Standing Orders issued under direction, or
- In the event that agreement cannot be reached, Welsh Ministers determine that the amendment should be approved.

Interpretation

3.7 During any Joint Committee meeting where there is doubt as to the applicability or interpretation of the JCC SOs, the Chair of the Joint Committee shall have the final say, provided that the decision does not conflict with rights, liabilities or duties as prescribed by law.

In doing so, the Chair should take appropriate advice from the Committee Secretary.

3.8 The terms and provisions contained within these SOs aim to reflect those covered within all applicable legislation. The legislation takes precedence over these JCC SOs when interpreting any term or provision covered by legislation.

Relationship with LHB Standing Orders

3.9 The JCC SOs form a schedule to each LHBs own SOs, and shall have effect as if incorporated within them.

4. DELEGATED POWERS

4.1 Each LHB will have appropriate arrangements to equip their respective Chief Executive to represent the views of the individual Board and discharge their delegated authority appropriately.

Reservation and Delegation of Joint Committee Functions

4.2 Within the framework approved by each LHB Board and set out within these JCC SOs and subject to any directions that may be given by the Welsh Ministers; the Joint Committee may make arrangements for certain functions to be carried out on its behalf, so that the day-to-day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives.

In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made.

4.3 The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

1. Schedule of matters reserved to the Joint Committee
2. Scheme of delegation to joint sub-Committees and others, and
3. Scheme of delegation to the Chief Commissioner and others as appropriate

all of which must be formally adopted by the Joint Committee and approved by LHB Boards as a schedule to their own SOs.

4.4 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

Chair's action on urgent matters

4.5 There may, occasionally, be circumstances where decisions which would normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee. In these circumstances, the Joint Committee Chair and one Officer Member (CEO of an LHB) will take a decision after consulting with the Chief Commissioner, supported by the Committee Secretary.

The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

The Committee Secretary will determine a process for the use of Chair's action on urgent matters, ensuring that the requirements outlined within these SOs are achieved.

4.6 Chair's action may not be taken where either the Joint Committee Chair or the Officer Member (CEO of an LHB) has a personal or business interest in an urgent matter requiring decision, on the advice of the Committee

Secretary.

In this circumstance, a Lay Member acting as the Vice-Chair will take a decision on the urgent matter, as appropriate. In terms of the officer member, an alternate officer member would need to be sought.

These arrangements will cease if the Chair is suspended in accordance with Regulation 9 of the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024. Reference should be made to Regulation 11 of these Regulations and advice should be sought from Welsh Government.

5. AUTHORITY

Committee Authority

5.1 Approve those policies relevant to the business of the Committee as delegated by the LHBs or the host Board.

5.2 Each LHB Board may agree that designated board members or LHB officers shall be in attendance at Joint Committee meetings. The Joint Committee Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the relevant LHB Chair.

5.3 The LHBs jointly shall determine the arrangements for any meetings between the Joint Committee and LHB Boards.

5.4 As a Joint Committee of LHBs, the Joint Committee Chair will have a bi-lateral relationship with each of the Chairs of the 7 LHBs, in respect of the JCC's role carried out on their behalf and to ensure that the JCC's governance framework remains appropriate to the overarching governance framework of the 7 LHBs.

The Joint Committee Chair will have a relationship with the Host Body's CEO given their respective accountability arrangements with regard to their role in holding a shared accountability for the Chief Commissioner. The arrangements to support the relationship between the Joint Committee Chair and the Host Body CEO are further detailed in the Hosting Agreement.

Sub Committees

5.5 The Joint Committee may and, where directed by the LHB Boards jointly, or the Welsh Ministers must, appoint joint sub-Committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

The Joint Committee shall determine, for agreement by the LHBs, a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.

5.6 These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies, to be set out within agreed Terms of Reference and Operating Arrangements.

The membership of any such joint sub-Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers, and set out in respective Terms of Reference and Operating Arrangements for LHB Boards for approval.

5.7 Full details of the joint sub-Committee structure requirements determined by the Joint Committee, including detailed terms of reference for each of these joint sub- Committees are set out in **Annex 3** of these JCC SOs.

5.8 As a minimum, it shall ensure that there are joint sub-Committee arrangements which cover the following aspects of Joint Committee business:
- Audit and Risk
- Quality, Safety and Outcomes
- Planning and Performance.

The Joint Committee may make arrangements to receive and provide assurance to others through the establishment and operation of its own joint sub-Committees or by placing responsibility with the host LHB or other designated LHB. Where responsibility is placed with the host LHB or other designated LHB, the arrangement shall be detailed within the Hosting Agreement between the Joint Committee and the host LHB or the Memorandum of Agreement between the seven LHBs (as appropriate).

The LHBs shall agree the delegation of any of its functions to joint sub-Committees or others (including networks), setting any conditions and restrictions it considers necessary and following any directions of the Welsh Ministers.

The Health Boards shall agree and formally approve the delegation of specific powers to be exercised by joint sub-Committees which it has formally constituted on to others.

Full details of the joint sub-Committee structure established by the Joint Committee, including detailed Standing Orders for each of these joint sub-Committees are set out in **Annex 3** of these JCC SOs

5.9 Each joint sub-Committee established by or on behalf of the Joint Committee must have its own Terms of Reference and operating

arrangements, which must be formally endorsed by the Joint Committee for approval by LHB Boards.

These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority)
- Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum
- Meeting arrangements
- Communications
- Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups)
- Any budget, financial and accounting responsibility
- Secretariat and other support
- Training, development and performance
- Reporting and assurance arrangements.

In doing so, the Joint Committee shall specify which aspects of the JCC SOs are not applicable to the operation of the joint sub-Committee, keeping any such aspects to the minimum necessary.

6. MEMBERSHIP

Membership of the Joint Commissioning Committee

6.1 The membership of the Joint Committee is provided for within the Joint Committee Directions and the Joint Committee Regulations. It shall be 11-13 voting members and one associate member as detailed below.

Chair

6.2 The Chair is responsible for the effective operation of the Joint Committee and is appointed by the Welsh Ministers through the Public Appointments process.

Non-Officer Members ~~[known as Lay Members]~~

6.3 Up to 5 non-officer members, to be referred to as Lay Members, appointed by the Welsh Ministers through the Public Appointments process.

~~Note: At the time of preparing these Standing Orders 3 Lay Member have been appointed.~~

Officer Members

6.4 A total of 7, drawn from each Local Health Board in Wales (the Chief Executive Officer of each).

Associate Member

6.5 The Chief Commissioner of the JCC Team will be appointed as an Associate Member of the Joint Committee attending meetings on an ex-officio basis, without voting rights.

6.6 Where a post of Chief Commissioner is shared between more than one person because of their being appointed jointly to the post, either or both persons may attend and take part in a Joint Committee meeting.

In attendance

6.7 The Joint Committee should, at appropriate times, invite other members of the JCC team and key providers of services commissioned by the JCC to attend all or part of a meeting on an ex-officio basis to assist the Joint Committee in its work. Representatives from Llais may also be invited to meetings as required (Section 7.7).

In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Llais) and to demonstrate openness and transparency in the conduct of business.

Member Responsibilities and Accountability

6.8 The Joint Committee will function as a decision-making body, all voting members being full and equal members and sharing responsibility for all the decisions of the Joint Committee.

The JCC must discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must be acting clearly in the interests of the JCC and of the population of Wales, rather than furthering direct or indirect financial, personal, professional or organisational interests.

6.9 Members who are appointed to the Joint Committee must act in a balanced manner, ensuring that any opinion expressed is impartial and based upon the best interests of the population of Wales.

6.10 All members must comply with the terms of their appointment to the Joint Committee. They must equip themselves to fulfil the breadth of their responsibilities on the Joint Committee by participating in relevant personal and organisational development programmes, engaging fully in the activities of the Joint Committee and promoting understanding of its work.

6.11 The Joint Committee may also co-opt additional independent external members from outside the LHBs or the JCCT to provide specialist skills, knowledge and experience. These individuals would attend in an ex-officio capacity.

The Chair

6.12 The Chair is responsible for the effective operation of the Joint Committee:

- Chairing Joint Committee meetings
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Joint Committee business is conducted in accordance with JCC SOs
- Developing positive and professional relationships amongst the Joint Committee's membership and between the Joint Committee and each LHBs Board.

Supported by the Committee Secretary, the Chair shall ensure that key and appropriate issues are discussed by the Joint Committee in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

The Chair, shall be appointed by the Minister for Health and Social Services for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. The Chair may be reappointed but may not serve a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

The Chair is accountable to the Minister for Health and Social Services in respect of their performance as Chair of the JCC, upholding the values of the NHS and promoting the confidence of the public and partners. The Minister for Health and Social Services undertakes a performance appraisal of the Joint Committee Chair and sets objectives accordingly.

In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of and NHS body in Wales whilst also serving as the Chair of the Joint Committee.

Lay Members

6.13 On a day-to-day basis, Lay Members are responsible to the Committee Chair for discharging their roles as Lay Members of the JCC (and any subsequent sub-Committee). The Committee Chair will undertake performance appraisals of Lay Members on behalf of the Minister for Health and Social Services.

The Committee Lay Members are appointed by, and are accountable to, the Minister for Health and Social Services in respect of their performance as Lay Members of the JCC, upholding the values of the NHS and promoting the confidence of the public and partners.

In addition to the eligibility, disqualification, suspension and removal

provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of an NHS body in Wales whilst also serving as a Lay Member.

Vice Chair

6.14 The members of the Joint Committee may appoint one of the non-officer members, other than the chair, to be vice-chair for such period, not exceeding the remainder of that person's term as a member, as they may specify on the appointment.

They may, at any time resign from the office of vice-chair by giving notice in writing to the chair or, if the office of chair is vacant, to the members.

The appointment will cease if the Chair were to be suspended and advice should be sought from Welsh Government and reference made to Regulation 11 of the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024.

Chief Commissioner

6.15 The Joint Committee will delegate certain functions to the Chief Commissioner. For these aspects, the Chief Commissioner, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Commissioner will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

This must be considered and approved by the Joint Committee (subject to any amendment agreed during the discussion). The Chief Commissioner may periodically propose amendment to the Scheme of Delegation and any such amendments must also be considered and approved by the Joint Committee.

The Chief Commissioner is accountable to the Committee Chair in relation to discharging the role and functions delegated by the Joint Committee, on behalf of the 7 LHBs, to the Commissioning Team for the planning, securing and commissioning of the relevant services, by the Joint Committee, on behalf of the 7 LHBs.

In respect of personal performance this will include an annual performance review undertaken by the Committee Chair. This will take into account those functions delegated from the host, as set out within the Hosting Agreement, and will therefore be informed by the Chief Executive of the Host Body. Feedback from other Joint Committee members will also be sought in informing the appraisal of the Chief Commissioner.

As an employee of the Host Body, the Chief Commissioner will be accountable to the Chief Executive of the Host Body in respect of the

responsibilities delegated to the Chief Commissioner set out within the Hosting Agreement. As the employer, the Host Body is responsible for the Terms of Conditions and employment matters associated with the Chief Commissioner, informed by the Committee Chair.

As a Joint Committee of LHBs, the Chief Commissioner will have a relationship with the Chief Executive Officers and Executive Teams of the 7 LHBs, in respect of the role and functions delegated to the Commissioning Team by the Joint Committee, on behalf of the 7 LHBs.

The Committee Secretary

6.16 The role of the Committee Secretary is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee, and is a key source of advice and support to the Chair and Joint Committee members.

Independent of the Joint Committee, the Committee Secretary acts as the guardian of good governance within the Joint Committee:

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, its joint sub-Committees and Advisory Groups
- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role
- Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of a committee culture that embodies NHS values and standards of behaviour; and
- Monitoring the Joint Committee's compliance with the law, JCC SOs and the framework set by the LHBs and Welsh Ministers.

The Committee Secretary is accountable to the Joint Committee Chair for all matters in relation to the responsibilities delegated in respect of the JCC's Governance Framework, within the context of the overarching Governance Framework of the 7 LHBs. The Committee Secretary is accountable to the Chief Commissioner for their performance as an employee of the Host Body and a member of the JCC Commissioning Team.

As a Joint Committee of LHBs, the Committee Secretary will have a relationship with the Directors of Corporate Governance of each of the 7 LHBs, in respect of the overarching governance framework of the 7 LHBs. As an employee of the Host Body (CTMUHB), the Committee Secretary will also have a relationship with the Host Body's Director of Corporate

Governance with regard to the governance of those functions delegated to the JCC Team via the Hosting Agreement.

The Committee Secretary will have a relationship with the Head of NHS Governance within Welsh Government, as a Senior Governance Professional within NHS Wales

7. COMMITTEE MEETINGS

Chairing Joint Committee meetings

7.1 The Chair of the Joint Committee will preside at any meeting of the Joint Committee unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the vice-chair, if appointed, shall preside. If the Vice-Chair is also absent or disqualified, the Lay Members present shall elect one of them to preside.

The Chair must ensure that the meeting is handled in a manner that enables the Joint Committee to reach effective decisions on the matters before it. This includes ensuring that Joint Committee members' contributions are timely and relevant and move business along at an appropriate pace.

In doing so, the Joint Committee must have access to appropriate advice on the conduct of the meeting through the attendance of the Committee Secretary. The Chair has the final say on any matter relating to the conduct of Joint Committee business.

Quorum

7.2 Quorum will be met if at least 6 voting members, 4 of whom are Officer Members (LHB Chief Executives) and 2 are the Chair, Vice-Chair or Lay Members, are present to allow any formal business to take place at a Joint Committee meeting.

If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a deputy to attend on their behalf. The nominated deputy must be an Executive Director (and hold office in accordance with regulation 3(2) of the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009) of the same organisation who can fully engage and take decisions in the absence of the CEO.

Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

If the Chief Commissioner is unable to attend a Joint Committee meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting.

The quorum must be maintained during a meeting to allow formal business

to be conducted, i.e., any decisions to be made. Any Joint Committee member or their deputy disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Frequency of Meetings

7.3 Meetings shall be held not~~t~~ less than six times a year and otherwise as the Chair of the Committee deems necessary.

Meeting arrangements

7.4 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of each LHB, including any views expressed formally.

7.5 **Circulation of Papers**

The Committee Secretary will ensure that all papers are distributed at least 5~~7~~ calendar days in advance of the meeting.

Putting Citizens first

7.6 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities
- The selection of accessible, suitable venues for meetings
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read, where requested or required, and in electronic formats
- Requesting that attendees notify the Committee Secretary of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings, and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh, in accordance with legislative requirements, e.g. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

Working with Llais (Citizen Voice Body for Health and Social Care Wales)

7.7 The Joint Committee shall ensure arrangements are in place to engage and co-operate with representatives of Llais as appropriate.

Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs and Trusts in relation to the engagement and involvement of Llais in their operations, which are extended to the activities of the JCC.

The 2020 Act places a statutory duty on LHBs and Trusts to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

The 2020 Act also places a statutory duty on LHBs and NHS Trusts to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions.

Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. LHBs and Trusts must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant).

The Code of Practice on Access to Premises and Engagement with Individuals can be found at: https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

The LHBs and Joint Committee will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning, developing, considering proposals for service change and commissioning services.

Annual Plan of Committee Business

7.8 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall appear on every Joint Committee agenda.

The plan shall set out the arrangements in place to enable the Joint

Committee to meet its obligations to its citizens as outlined in Section 7.7 whilst also allowing Joint Committee members to contribute in either English or Welsh languages, where appropriate.

The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of joint sub-Committees, Expert Panels and Advisory Groups.

The Joint Committee shall agree the plan ~~for the forthcoming year by the end of May 2024, and for subsequent years~~ by the end of March, and this plan shall be published on the Committee's website.

Calling Meetings

7.9 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time.

Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

If the Chair does not call a meeting within seven days after receiving such a request from Joint Committee members, then those Joint Committee members may themselves call a meeting.

Preparing for Meetings

7.10 **Setting the agenda**

The Joint Committee Chair, in consultation with the Committee Secretary and the Chief Commissioner, will set the agenda.

In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from joint sub-Committees and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

Any Joint Committee member may request that a matter is placed on the agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting.

The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12-day notice period if this would be beneficial to the conduct of Joint Committee business.

7.11 **Notifying and equipping Joint Committee members**

Joint Committee members should be sent an Agenda and a complete set of supporting papers at least 5~~7~~ calendar days before a formal Joint Committee meeting. This information may be provided to Joint Committee members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration.

Impact assessments shall be undertaken, as appropriate, when planning, securing or commissioning those services delegated to the Joint Committee. They will also be completed on all new or revised policies, strategies, guidance and / or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

In the event that at least half of the Joint Committee members do not receive the agenda and papers for the meeting as set out above, the Joint Committee Chair must consider whether or not the Joint Committee would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Joint Committee Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

In the case of a meeting called by Joint Committee members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

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

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

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

Conducting Joint Committee Meetings

7.13 **Admission of the public, the press and other observers**

The Joint Committee shall encourage attendance at its formal Joint Committee meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the Joint Committee. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility.

The Joint Committee shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter affecting a JCC Member or a patient.

In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee shall resolve:

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

In these circumstances, when the Joint Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Joint Committee in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Joint Committee meeting held in public session.

The Committee Secretary, on behalf of the Joint Committee Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

In encouraging entry to formal Joint Committee Meetings from members of the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

Unless the Joint Committee has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Dealing with motions

7.14 In the normal course of Joint Committee business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g., where an aspect of service delivery is a cause for particular concern, a Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken.

The Committee Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Joint Committee unless moved by a Joint Committee member and seconded by another Joint Committee member (including the Joint Committee Chair).

7.15 **Proposing a formal notice of Motion**

Any Joint Committee member wishing to propose a motion must notify the Joint Committee Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out.

Where sufficient notice has been provided, and the Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

The Joint Committee Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Joint Committee business.

Amendments
Any Joint Committee member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Joint Committee alongside the motion.

If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

7.16 **Motions under discussion**
When a motion is under discussion, any Joint Committee member may propose that:

- The motion be amended
- The meeting should be adjourned
- The discussion should be adjourned and the meeting proceed to the next item of business
- A Joint Committee member may not be heard further
- The Joint Committee decides upon the motion before them
- An ad hoc committee should be appointed to deal with a specific item of business, or
- The public, including the press, should be excluded.

7.17 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.18 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Joint Committee Chair.

7.19 **Motion to rescind a resolution –** The Joint Committee may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Joint Committee members.

A Motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a joint sub-Committee/Chief Commissioner to which a matter has been referred.

Voting

7.20 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require a secret ballot or recorded vote if the majority of voting Joint Committee members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted.

In order to ensure balanced and collective decision, Members are not permitted to abstain during voting, given that the JCC must discharge its collective duty for the population of Wales.

The Associate Member may not vote in any meetings or proceedings of the Joint Committee.

In determining every question at a meeting, the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales. Such views may be presented to the Joint Committee through the LHBs utilising their formal Board Advisory Fora (Stakeholder Reference Group and Healthcare Professionals' Forum).

The Joint Committee will make decisions based on a majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

A nominated deputy of an LHB Chief Executive may vote. Absent Joint Committee members, who have no nominated deputy present, may not vote by proxy. Absence is defined as being absent at the time of the vote.

Record of Proceedings

7.21 A record of the proceedings of formal Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence and shall be submitted for agreement at the next meeting of the Joint Committee, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

Confidentiality

7.22 All Joint Committee members (including the Associate Member), together with members of any joint sub-Committee, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee

and/or LHB officials must respect the confidentiality of all matters considered by the Joint Committee in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Joint Committee Chair or relevant chair of a joint sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Standards of Behaviour Framework (including Gifts and Hospitality) Policy or legislation such as the Freedom of Information Act 2000, etc.

Committee members and attendees must not disclose any matter dealt with by or brought before the JCC in confidence without the permission of the Committee's Chair.

Expert panel and other groups

7.23 Where delegated by LHBs, the Joint Committee may also establish other groups to help it in the conduct of its business. The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers, must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed Standing Orders are set out in Annex 4 of the JCC SOs.

Any Expert Panel or Advisory Group established by the Joint Committee must have its own Standing Orders and operating arrangements, which must be formally approved by the Joint Committee. These must establish its governance and ways of working, setting out, as a minimum in the same way as for sub committees (section 7.5).

In doing so, the Joint Committee shall specify which aspects of the JCC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements or directions agreed by the LHBs or the Welsh Ministers, and set out in respective Terms of Reference and Operating Arrangements.

The Joint Committee shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the Joint Committee on their activities. Expert Panel or Advisory Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

Any Expert Panel or Advisory Group shall also submit an annual report to

the Joint Committee through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

Reporting activity to the Joint Committee

7.24 Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the Joint Committee on their activities.

Joint sub-Committee Chairs' shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

Each joint sub-Committee shall also submit an annual report to the Joint Committee through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

8. VALUES AND STANDARDS OF BEHAVIOUR

Values and Standards of Behaviour

8.1 The Joint Committee must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour framework.

~~These values and standards of behaviour will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, JCC Team officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the JCC SOs.~~The Joint Committee adopts the Standards of Behaviour Policy of the Host Body which will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, JCC Team officers and others, as appropriate. The framework adopted by the Joint Committee is the Standards of Behaviour Policy which will form part of the JCC SOs.

Declaring and recording Joint Committee members' interests
Declaration of interests

8.2 It is a requirement that all Joint Committee members should declare any personal or business interests they may have which may affect, or could be perceived to affect the conduct of their role as a Joint Committee member.

This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Joint Committee's business. Joint Committee members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations.

The JCC's Guidance on the Handling of Interests **(Annex 2)** provides further detail on the requirements of Joint Committee members.

The Committee Secretary will provide advice to the Joint Committee Chair and the Joint Committee on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour Framework. If individual Joint Committee members are in any doubt about what may be considered as an interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

Register of interests

8.3 The Committee Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Joint Committee members through the following processes:

The recording of JCC members' interests will be recorded as follows:

- JCC Chair – via the Host Body's policy and process for declaring and recording interests;
- JCC Lay Members - via the Host Body's policy and process for declaring and recording interests;
- JCC Officer Members – via their respective Health Board's policy and process for declaring and reporting interests; and
- Chief Commissioner - via the Host Body's policy and process for declaring and recording interests.

The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, working with LHBs in respect of Officer Members, through which Joint Committee members will be required to confirm the accuracy and completeness of the register relating to their own interests.

In line with the Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This may include publication on the Joint Committee's website.

Publication of declared interests in Annual Report

8.4 Joint Committee members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each LHB Board's Annual Report.

Dealing with Members' interests during Joint Committee meetings

8.5 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it is taken in an open, balanced, objective and unbiased manner.

In turn, individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales.

The JCC must discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must act in accordance with this principle, rather than furthering direct or indirect financial, personal, professional or organisational interests. This also includes ensuring that Officer Members do not seek to achieve a greater benefit for the population of their respective Local Health Board over and above that of others.

Where individual Joint Committee members identify an interest in relation to any aspect of Joint Committee business set out in the Joint Committee's meeting agenda, that member must declare an interest at the start of the Joint Committee meeting. Joint Committee members should seek advice from the Joint Committee Chair, through the Committee Secretary, before the start of the Joint Committee meeting if they are in any doubt as to whether they should declare an interest at the meeting.
All declarations of interest made at a meeting must be recorded in the Joint Committees minutes.

It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may vary dependent on the type of interest declared and further detail on the options takes are set out within the JCC's Guidance on the Handling of Interests.

For the purpose of the JCC's business, interests fall into the following categories with further detail set out within the JCC's Guidance on the Handling of Interests:

1. Personal Financial Interests
2. Non-Financial Personal Interests
3. Non-Financial Professional Interests
4. Indirect Interests
5. Provider Organisation Interests

In extreme cases, it may be necessary for the individual member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

Where the Joint Committee Chair is the individual declaring an interest, any decision on the action to be taken shall be made by a lay members acting as the Vice-Chair, on behalf of the Joint Committee.

In all cases the decision of the Joint Committee Chair (or the Vice-Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take advice from the Committee Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

Members with pecuniary (financial) interests

8.6 Where a Joint Committee member, or any person they are connected with has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it.

The Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

8.7 The Local Health Boards (Constitution, Membership and Procedures) Wales Regulations 2009 define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The JCC SOs must be interpreted in accordance with these definitions.

Reviewing how interests are handled

8.8 The Joint Committee will ensure that arrangements of the Handling of Interests relating to the JCC are reviewed through the Host Body's assurance arrangements as required within the Hosting Agreement and Memorandum of Agreement between the 7 LHBs.

Dealing with offers of gifts, hospitality and sponsorship

8.9 The Host Body's Standards of Behaviour Policy (Incorporating Declarations of Interest, Gifts, Hospitality, Sponsorship and Honoraria) applies to the Joint Committee's Chair, Lay Members and Chief Commissioner, and prohibits Joint Committee members from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

Gifts, benefits or hospitality must never be solicited. Any Joint Committee member who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Joint Committee member or JCC Team member. Failure to observe this requirement may result in disciplinary and/or legal action.

In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Committee Secretary as appropriate.

The Committee Secretary will ensure the recording of gifts, hospitality and sponsorship for the JCC's Chair, Lay Members and Chief Commissioner is embedded into the recording and reporting requirements of the Host Body.

The recording of gifts, hospitality and sponsorship for the JCC's Officer Members will be undertaken in accordance with the respective LHB's Standards of Behaviour Policy and reporting arrangements.

9. REPORTING AND ASSURANCE ARRANGEMENTS

Reporting to Health Boards

9.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the LHB Boards on the Committee's activities
- This includes written submission of Chair summary or highlight reports throughout the year and an in-person attendance at every LHB, meeting annually with Board Members
- Bring to the Board's specific attention any significant matters under consideration by the Committee
- Ensure appropriate escalation arrangements are in place to alert the Members, NHS Wales Chairs or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of NHS Wales.

Annual Reporting Requirements

9.2 The Committee shall provide a written, annual report to the host body on its work in support of the Annual Governance Statement.

The LHBs may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate.

The Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

Risk and Assurance

10.1 The Joint Committee shall set out explicitly, within a ~~Risk and~~Joint Committee Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks

Commented [AF1]: To be shared at the July 2026 JC meeting for approval.

in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

The Joint Committee shall ~~ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit Committee.~~ provide assurance on the processes in place to support this to the Host Body's Audit Risk and Assurance Committee.

10.2 **The role of Internal Audit in Providing independent internal assurance.**
The Host Body shall ensure the effective provision of an independent internal audit function for the Joint Committee as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Ministers.

10.3 **Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups**
The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its joint sub-Committees, Expert Panels and any other Advisory Groups.

Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

Each joint sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair to align with the LHBs annual reporting cycle, setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes
- Its Joint Committee Development Programme, as part of an overall Organisation Development framework, and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

10.4 **External Assurance**
The Joint Committee shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the Joint Committees operations, e.g., the Auditor General for Wales and

Healthcare Inspectorate Wales.

The Joint Committee may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Joint Committee itself may commission specifically for that purpose.

The Joint Committee shall keep under review and ensure that, where appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd's Public Accounts and Public Administration Committee and other appropriate bodies.

The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.1 Accountability

Taking account of the arrangements set out within these JCC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the citizens it serves, its officers and healthcare professionals.

The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.2 Support to the Joint Committee

The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee
- Co-ordinating and facilitating appropriate induction and organisational development activity
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others
- Ensuring the provision of secretariat support for Joint Committee meetings

- Ensuring that the Joint Committee receives the information it needs on a timely basis
- Ensuring strong links to communities/groups
- Ensuring an effective relationship between the Joint Committee and the Host Body, and
- Facilitating effective reporting to each LHB enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

12. REVIEW

12.1 The JCC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in JCC SOs, including the appropriate impact assessment.

Annex 1

NHS WALES JOINT COMMISSIONING COMMITTEE

SCHEME OF DELEGATION AND RESERVATION OF POWERS

A. MATTERS RELATING TO THE JCC, RESERVED FOR HEALTH BOARDS		
REF.	AREA	MATTER
A1.	Operating Arrangements	Approval of the Joint Committee's Governance Framework, including: • JCC Standing Orders • JCC Standing Financial Instructions • JCC Scheme of Delegation and Reservation of Powers • JCC sub-Committee Terms of Reference
A2.	Strategy & Planning	Endorse the long-term strategic plan for the development of those functions delegated to the NHS Wales Joint Commissioning Committee (the Joint Committee), as agreed by the Joint Committee
A3.	Strategy & Planning	Endorse the JCC Integrated Medium-Term Plan, as agreed by the Joint Committee for inclusion in LHB Integrated Medium-Term Plans
A4.	Strategy & Planning	Endorse the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure), as agreed by the Joint Committee

B. MATTERS RELATING TO THE JCC, DELEGATED FROM HEALTH BOARDS AND RESERVED FOR THE JOINT COMMITTEE		
REF.	AREA	MATTER
B1.	Operating Arrangements	Develop, vary, and amend the Joint Committee's Governance Framework for LHB approval, including: • JCC Standing Orders • JCC Standing Financial Instructions • JCC Scheme of Delegation and Reservation of Powers • JCC sub-Committee Terms of Reference
B2.	Operating Arrangements	Develop and approve arrangements for the handling of Interests declared by Joint Committee members, in alignment with the Host Body's Values and Standards of Behaviour Framework
B3.	Operating Arrangements	Develop and approve the Terms of Reference and Operating Arrangements for the following which are deemed necessary to provide the JCC with advice in

		the exercise of its functions: • Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field. • Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue.
B4.	Strategy & Planning	Develop and approve the long-term strategic plan for the development of those functions delegated to the NHS Wales Joint Commissioning Committee (the Joint Committee)
B5.	Strategy & Planning	Develop and approve the JCC's Integrated Medium-Term Plan, for LHB approval
B6.	Operating Arrangements	Ratify any urgent decisions taken by the Chair, in-line with JCC Standing Order requirements
B7.	Operating Arrangements	Receive report and proposals, after consideration by the appropriate Audit Committee, regarding any non-compliance with JCC Standing Orders (and schedules contained within), and where required ratify in public session any action required in response to failure to comply with JCC SOs for onward reporting to LHBs
B8.	Operating Arrangements	Adopt the Host Body's Values and Standards of Behaviour Framework for the JCC
B9.	Strategy & Planning	Determine and approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
B10.	Operating Arrangements	Approve the Joint Committee's Risk and Assurance Framework, ensuring alignment with the Host Body
B11.	Operating Arrangements	Approve the Joint Committee's Performance Management Framework
B12.	Performance & Assurance	Receive reports from the Chief Commissioner on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
B13.	Performance & Assurance	Receive assurance reports from the Joint Committee's sub-Committees and groups on the performance of those services commissioned by the JCC, and approve action required, including improvement plans, where required

B14.	Performance & Assurance	Receive reports produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-Committees (as appropriate)
B15.	Performance & Assurance	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required
B16.	Performance & Assurance	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Commissioner, set out in the JCC's SFIs, and in-line with any requirements of the Host Body
B17.	Performance & Assurance	Approve the Joint Committee's audit and assurance arrangements, in-conjunction with the Host Body as the provider of an internal audit function
B18.	Performance & Assurance	Receive assurance regarding the Joint Committee's performance against the Health and Care Quality Standards 2023 and the Duty of Quality and the arrangements for approving required action, including improvement plans, to provide onward assurance to LHBs and the Host Body.
B19.	Strategy & Planning	Approve policies for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC
B20.	Strategy & Planning	Approve the JCC's key plans and programmes required to exercise its functions relating to the planning, securing and commissioning of those services delegated to it (excluding the Integrated-Medium Term Plan [B5]).

C. MATTERS RELATING TO THE JCC, DELEGATED FROM THE JOINT COMMITTEE TO THE CHIEF COMMISSIONER		
REF.	AREA	MATTER
C1.	Performance & Assurance	Responsibility for the leadership and overall delivery of the JCC's: • Integrated Medium-Term Plan; and • Budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
C2.	Performance	Responsibility for the framework for planning and

	& Assurance	securing those services delegated to the JCC from LHBs, in-line with the approved Integrated Commissioning Plan (title to be confirmed)
C3.	Performance & Assurance	Responsibility for ensuring the Health and Care Quality Standards 2023 and the Duty of Quality is embedded within Joint Committee Team's activity
C4.	Performance & Assurance	Responsibility for implementing those policies approved by the JCC in relation to the planning and securing of those services delegated to the JCC from LHBs

D. MATTERS RELATING TO THE JCC, DELEGATED FROM THE JOINT COMMITTEE TO SUB-COMMITTEE AND OTHERS (INCLUDING INIDVIDUAL LAY MEMBERS)		
REF.	AREA	MATTER
	To be reviewed during 2026/2027	

Annex 2(a) NWJCC Standing Financial Instructions

The document can be accessed here

Annex 2(b) Hosting Agreement

The document can be accessed here

Annex 2(c) Memorandum of Agreement (MOU)

The document can be accessed here

Annex 2(d) Guidance on Handling Interests

The document can be accessed here

Annex 2(e) Accountability Map

The document can be accessed here

Annex 3

Sub-Committee Terms of Reference

Quality Safety and Outcomes Sub-committee Terms of Reference can be accessed here.

Planning, Performance and Finance Sub-committee Terms of Reference can be accessed here.

Annex 4 -– Advisory/Expert Groups

Not applicable.

Annex 2.1

STANDING FINANCIAL INSTRUCTIONS FOR THE NHS WALES JOINT COMMISSIONING COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the NHS Wales Joint Commissioning Committee Standing Orders and the Local Health Board Standing Orders (incorporated as Schedule 2.1 of SOs).

Foreword

These Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Each Local Health Board (LHB) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of the NHS Wales Joint Commissioning Committee's (the 'JCC') financial proceedings and business.

These JCC Standing Financial instructions (JCC SFIs) are an annex to the JCC Standing Orders (JCC SOs) which form a schedule to each LHBs own Standing Orders and have effect as if incorporated within them. They are designed to translate statutory and Welsh Government financial requirements for the NHS in Wales into day-to-day operating practice. Together with the adoption of a schedule of decisions reserved to the JCC; a scheme of delegations to officers and others; and JCC Standing Orders, they provide the regulatory framework for the business conduct of the JCC.

These documents, together with the following, are designed to ensure the achievement of the standards of good governance set for the NHS in Wales:

- Memorandum of Agreement which defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executive Officers of the constituent LHBs as individual members of the Joint Committee;
- Hosting Agreement which outlines the accountability arrangements and resulting responsibilities for Cwm Taf Morgannwg University Health Board (the Host Body) and the other 6 LHBs; and
- Cwm Taf Morgannwg University Health Board's Values and Standards of Behaviour Framework.

All JCC members, Hhost ~~LHB~~ Body and the Joint Commissioning Committee Team (JCCT) staff must be made aware of these JCC Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The JCC's Committee Secretary or the ~~Director of Finance~~Director of Finance and Value will be able to provide further advice and guidance on any aspect of the JCC SFIs or the wider governance arrangements for the JCC. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

Contents

NHS Wales Joint Commissioning Committee

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Each Local Health Board (LHB) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of the NHS Wales Joint Commissioning Committee's (the 'JCC') financial proceedings and business. The Standing Financial Instructions shall apply equally to members off the Joint Commissioning Committee (JCC) and staff of the JCC Team.

1.1.2 **These SFIs shall have effect as if incorporated in the JCC Standing Orders (SOs) (incorporated as Annex 2 of SOs), and both should be used in conjunction with the Hh~~h~~ost Bb~~b~~ody SOs and SFIs.**

1.1.3 These SFIs detail the financial responsibilities, policies and procedures adopted by the JCC. They are designed to ensure that the JCC's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of matters reserved to the JCC and the Delegation of Powers and Scheme of Delegation to others.

1.1.4 These SFIs identify the financial responsibilities which apply to members of the JCC, including its joint sub-Committees and the JCCT staff. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and Financial Control Procedure notes.

1.1.5 The general principle is that financial control procedures used by the JCC and the JCCT will normally be those of the Hh~~h~~ost Body unless otherwise approved by the appropriate process. In some cases, the financial control procedures of the Host Body may need to be amended to take into account the nature of the business of the JCC. In these exceptional circumstances, the financial control procedures must be scrutinised and recommended by the ~~Director of Finance~~Director of Finance and Value of the JCCT (as referred to as the ~~Director of Finance~~Director of Finance and Value within these SFIs) for approval by the Audit and Risk Committee that deals with the JCC matters. Prior to consideration by the Audit and Risk Committee, the ~~Director of Finance~~Director of Finance and Value will discuss any proposed changes to Financial Control Procedures with the Director of Finance of the Host Body.

1.1.6 Should any difficulties arise regarding the interpretation or application of these SFIs the advice of the Committee Secretary or ~~Director of Finance~~Director of Finance and Value must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the JCC's SOs.

1.2 Overriding Standing Financial Instructions

Full details of any non-compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the ~~Director of Finance~~Director of Finance and Value and the Committee Secretary, who will ask the Audit and Risk Committee that deals with the JCC matters to formally consider the matter and make proposals to the JCC on any action to be taken. LHB Boards should be notified of any material non-compliance and the action taken, as determined by the Committee Secretary.

1.2.1 All JCC members, members of joint sub-Committees and the JCCT staff have a duty to report any non-compliance to the ~~Director of Finance~~Director of Finance and Value and the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported.

1.2.2 Ultimately, failure to comply with JCC SFIs is a disciplinary matter.

1.3 Financial provisions and obligations of LHBs and the JCC

1.3.1 The financial provisions and obligations for LHBs are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The JCC exists for the purpose of jointly exercising those functions relating to the planning and securing a defined range of services on a national All-Wales basis, on behalf of each of the seven LHBs in Wales. Each LHB shall be bound by the decisions of the JCC in the exercise of its delegated functions. The JCC must agree an appropriate level of funding for the provision of these services and determine the contribution from each LHB to allow the JCC to plan and secure those services, including the running costs of the JCCT. The JCC will prepare an Integrated Medium-Term Plan (IMTP) which shall outline the funding requirements in relation to the relevant services. The JCC will also be responsible for developing a risk sharing framework which sets out the basis on which each LHB will contribute to the IMTP and any variation from the agreed IMTP.

2. RESPONSIBILITIES AND DELEGATION

2.1 The JCC

2.1.1 The JCC exercises financial supervision and control by:

a) Formulating and approving the Medium-Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium-Term Plan (IMTP)

b) Requiring the submission and approval of balanced budgets within approved allocations/overall funding
c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability), and
d) Defining specific responsibilities placed on JCC members and the Chief Commissioner, and joint sub-Committees, as indicated in the JCC's Scheme of Delegation and Reservation of Powers.

2.1.2 The JCC has adopted the JCC SOs and resolved those certain powers and decisions may only be exercised by the JCC in formal session. The JCC, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day-to-day business of the JCC may be carried out effectively, and in a manner that secures the achievement of the JCC's aims and objectives.

2.1.3 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of services for residents within their area.

2.2 The Chief Commissioner and ~~Director of Finance~~Director of Finance and Value

2.2.1 The Chief Commissioner and ~~Director of Finance~~Director of Finance and Value will, as far as possible, delegate their detailed responsibilities, but they remain ultimately responsible for financial control.

2.2.2 The Joint Committee will delegate certain functions to the Chief Commissioner. For these aspects, the Chief Commissioner, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Commissioner will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

2.2.3 The Chief Commissioner is accountable to the Committee Chair in relation to discharging the role and functions delegated by the Joint Committee, on behalf of the 7 LHBs, to the Commissioning Team for the planning, securing and commissioning of the relevant services, by the Joint Committee, on behalf of the 7 LHBs.

2.2.4 As an employee of the Host Body, the Chief Commissioner will be accountable to the Chief Executive of the Host Body in respect of the responsibilities delegated to the Chief Commissioner set out within the Hosting Agreement. As the employer,

the Host Body is responsible for the Terms of Conditions and employment matters associated with the Chief Commissioner, informed by the Committee Chair.

2.2.5 The Chief Commissioner will hold Accountable Officer status for certain elements of their role, namely the propriety and regularity for public finances delegated to them by the LHBs and will be accountable to the Director General/NHS Wales Chief Executive in this regard. Further detail on this accountability relationship is set out in an Accountable Officer Memorandum and an Interface Agreement between the Chief Commissioner and the Chief Executive of the Host Body.

2.2.6 The Chief Commissioner is responsible for ensuring that financial obligations and targets are met, and has overall responsibility for the JCCT's system of internal control.

2.2.7 It is a duty of the Chief Commissioner to ensure that JCC and JCCT members, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The ~~Director of Finance~~Director of Finance and Value

2.3.1 The ~~Director of Finance~~Director of Finance and Value is responsible for:

a) Implementing the JCC's financial policies and for co-coordinating any corrective action necessary to further these policies
b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions
c) Recommending to the relevant Audit and Risk Committee any Financial Control Procedures for the JCC, where the Host Body's cannot be applied, for approval
d) Ensuring that sufficient records are maintained to show and explain the JCC's transactions, in order to disclose, with reasonable accuracy, the financial position of the JCC at any time, and
e) Without prejudice to any other functions of the JCC, and employees of the ~~h~~Host Body~~LHB~~ and JCCT, the duties of the ~~Director of Finance~~Director of Finance and Value include:
   (i) ~~–~~The provision of financial advice to members of the JCC, joint sub-~~Committees,~~ Committees, Advisory Groups and the JCCT
   (ii) The design, implementation and supervision of systems of internal financial control, and
   (iii) The preparation and maintenance of such accounts, certificates, estimates, ~~records~~records, and reports as the JCC may require for the purpose of carrying out its delegated responsibilities.

2.3.2 The ~~Director of Finance~~Director of Finance and Value is responsible for ensuring

an ongoing training and communication programme is in place to affect these SFIs.

2.4 JCC members and Team, and joint sub-Committees

2.4.1 All members of the JCC, its joint sub-Committees, (including those employed to perform JCCT functions), severally and collectively, are responsible for:

a) The security of the property of the JCC and ~~host~~ Host Body~~LHB~~ where these are used by the JCCT
b) Avoiding loss
c) Exercising economy and efficiency and sustainability in the use of resources, and
d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of Delegation and Reservation of Powers.

2.4.2 For all JCC members and JCC Team staff, and joint sub-Committees who carry out a financial function, the form in which financial records are kept and the manner in which members of the JCC, joint sub-Committee and JCCT discharge their duties must be to the satisfaction of the ~~Director of Finance~~Director of Finance and Value.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the ~~host~~ Host Body~~LHB~~ to commit the JCC to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Commissioner to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit and Risk Committee

3.1.1 An independent Audit and Risk Committee is a central means by which the JCC ensures effective internal control arrangements are in place. In addition, the Audit and Risk Committee that deals with JCC matters provides a form of independent check upon the Team supporting the JCC.

3.1.2 The governance and issues relating to the hosting of the JCC will be incorporated into the standard business of the existing Host Body's Audit and Risk Committee. Assurance on the governance and issues relating to the hosting of the JCC will be reported to the Host Body's Board.

3.1.3 Issues relating to the functions of the JCC delegated from LHBs will be reported into a separate Host Body Audit and Risk Committee for the JCC specifically, operating within its own work cycle as required. The assurance from this will be reported to the LHB Boards. Detailed terms of reference and operating arrangements for this are set out in Annex 3 to the JCC's SOs. This Audit and Risk Committee will follow the guidance set out in the NHS Wales Audit and Risk

Committee Handbook.

NHS Wales Audit
Committee Handbook

3.2 **Chief Commissioner**

3.2.1 The Chief Commissioner is responsible for ensuring arrangements are in place within the JCCT to review, evaluate and report on the effectiveness of internal control, in line with the requirements of the Host Body's audit arrangements, as set out within the Hosting Agreement.

3.2 Chief Executive of the Host Body~~LHB~~

The responsibilities of the Chief Executive of the H~~h~~ost ~~LHB~~ Body are set out within the Host Body's SFIs (add link),

3.2.1 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
b) Access at all reasonable times to any land or property owned or leased by the ~~host~~ Host Body~~LHB~~.
c) Access at all reasonable times to JCC members and the JCCT
d) The production of any cash, stores or other property of the ~~host~~ Host Body~~LHB~~ under a JCC member or a member of the JCCT's control, and
e) Explanations concerning any matter under investigation.

3.3 Internal and External Audit

3.3.1 CTMUHB, as the Host Body, has responsibility for ensuring that appropriate internal and external audit of the activities of the JCC are in place. Details of these arrangements will be further set out within the Hosting Agreement.

3.4 Fraud and Corruption

3.5.1 In line with their responsibilities, the Chief Commissioner and ~~Director of Finance~~Director of Finance and Value shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The Chief Commissioner and ~~Director of Finance~~Director of Finance and Value shall report to the JCC and the ~~host~~ Host Body's~~LHBs~~ Local Counter Fraud Specialist any matters relating to fraud or corruption.

3.5.3 More detailed information about counter fraud can be found in section 3.5 of the ~~host~~ Host Body's~~LHBs~~ SFIs.

3.5 Security Management

3.5.1 The Chief Executive of the ~~host~~ Host Body~~LHB~~ has overall responsibility for controlling and coordinating security. The Chief Commissioner will ensure that adequate processes are in place to comply with the requirements.

3.5.2 In line with their responsibilities, the Chief Executive of the ~~host~~ Host Body~~LHB~~ will monitor and ensure compliance with Directions issued by Welsh Ministers on NHS Security management.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 Whilst the JCC is not a statutory body the JCC exists for the purpose of jointly exercising functions on behalf of each of the seven LHBs in Wales which means it must operate in a way which supports delivery of the Local Health Boards two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. Those duties are then set out and retained in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts."

WHC/2016/054 - English and Welsh Versions

WHC -2016- 054 - Statutory Financial Du

WHC -2016- 054 - Statutory Financial Du

4.3.2 To support the LHB's statutory duty the JCC is required to prepare an Integrated Medium-Term Plan. The Integrated Medium-Term Plan (IMTP) must reflect longer-term planning and delivery objectives for the ongoing development of those services commissioned on behalf of the seven health boards, in conjunction with the Welsh Ministers. The Integrated Medium-Term Plan should be continually reviewed based on latest Welsh Government policy and national and local priority requirements. The Integrated Medium-Term Plan, produced and approved annually, will be 3 year rolling plans. In particular, the Integrated Medium-Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

4.3.3 The NHS Planning Framework directs health boards and trusts to develop, approve and submit an Integrated Medium-Term Plan (IMTP) for approval by Welsh Ministers. Whilst there is not a statutory duty upon the JCC to develop an IMTP it is a requirement. The plan must:

- describe the context, including population health needs, within which the JCC will deliver key policy directives and operational targets from Welsh Government

- demonstrate how the JCC are:
  a) delivering their well-being objectives, including how the five ways of working have been applied,
  b) contributing to the seven Well-being Goals,
  c) establishing preventative approaches across all care and services,
- demonstrate how the JCC will utilise its existing commissioned services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to the quality and efficiency of services
- demonstrate how financial breakeven is to be achieved over a rolling three-year period.

4.3.4 Integrated Medium-Term Plans should be based on a reasonable expectation of future service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium-Term Plan (including a balanced Medium-Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium-Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium-Term Plan will incorporate the balanced Medium-Term Financial Plan and will incorporate the JCC's response to delivering the

- NHS Planning Framework
- Quality, governance and risk frameworks and plans, and
- Outcomes Framework.

4.3.6 The Integrated Medium-Term Plan will be developed in line with the Integrated Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based
- Details of major changes in activity, commissioned service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans
- Profiled activity, service, quality, workforce and financial schedules
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures.

4.3.7 The JCC will, in respect of those functions delegated to it by LHBs:

a) Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services
b) Develop national policies for the equitable access to safe and sustainable, high quality services across Wales, whether planned, funded and secured at national, regional or local level, and

c) Agree annually those services that should be planned on a national basis and those that should be planned locally.

4.3.8 The Chief Commissioner is responsible for the development of the plan and submission to the JCC, on an annual basis, the rolling 3 year Integrated Medium-Term Plan. The JCC's approved Integrated Medium-Term Plan will be submitted to Local Health Boards and Welsh Government in line with the requirements set out in the NHS Planning Framework.

4.3.9 The JCC will:

a) Approve the Integrated Medium-Term Plan prior to the beginning of the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Committee approval, the Plan will be submitted to Local Health Boards and Welsh Government prior to the beginning of the financial year of implementation
b) Approve a balanced Medium-Term Financial Plan as part of the Integrated Medium-Term Plan, which meets all financial duties, probity and value for money requirements
c) Agree the appropriate level of funding for the provision of those services delegated to the JCC , and determining the contribution from each LHB for those services (which will include the running costs of the JCC and the JCCT) in accordance with any specific directions set by the Welsh Ministers
d) Prepare and agree with the Local Health Boards a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Committee plan is not in place or in balance.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1 Budget Setting

5.1.1 Prior to the start of the financial year the ~~Director of Finance~~Director of Finance and Value will, on behalf of the Chief Commissioner, prepare and submit budgets for approval and delegation by the JCC. Such budgets will:

a) Be in accordance with the aims and objectives set out in the JCC Integrated Medium-Term Plan, and Medium-Term Financial Plan, and focussed on delivery of improved population health, safe patient centred quality services
b) Be in line with Revenue, Capital, Commissioning, Activity, Service, Quality, Performance, and Workforce plans contained within the JCC approved balanced IMTP
c) Take account of approved business cases and associated revenue costs and funding
d) Be produced following discussion with appropriate Directors and budget holders
e) Be prepared within the limits of available funds
f) Take account of ring-fenced, specified and non-recurring allocations and

funding

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents)
h) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and
i) Identify potential risks and opportunities.

5.2 Budgetary Delegation

5.2.1 The Chief Commissioner may delegate the management of a budget to permit the performance of a defined range of activities,. This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget
b) The purpose(s) of each budget heading
c) Individual or committee responsibilities
d) Arrangements during periods of absence
e) Authority to exercise virement
f) Achievement of planned levels of service, and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Commissioner, ~~Director of Finance~~Director of Finance and Value and delegated budget holders must not exceed the budgetary total or virement limits set by the JCC.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Commissioner, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Commissioner, as advised by the ~~Director of Finance~~Director of Finance and Value.

5.2.5 All budget holders must provide information as required by the ~~Director of Finance~~Director of Finance and Value to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The ~~Director of Finance~~Director of Finance and Value has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist

budget holders managing their budgets successfully.

5.3 Financial Management, Reporting and Budgetary Control

5.3.1 The ~~Director of Finance~~Director of Finance and Value shall monitor financial performance against budget and plans and report the current and forecast position on a monthly basis and at every JCC meeting. Any significant variances should be reported to JCC as soon as they come to light and the JCC shall be advised on any action to be taken in respect of such variances.

5.3.2 The ~~Director of Finance~~Director of Finance and Value will devise and maintain systems of financial management performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital (where applicable), to the JCC in a form approved by the JCC containing sufficient information for the JCC to:

- Understand the current and forecast financial position.
- Evaluate risks and opportunities.
- Use insight to make informed decisions.
- Be consistent with other JCC reports, and as a minimum the reports will cover:
  - Details of variations from the Medium-Term Financial Plan showing the contributions to be made by each LHB under the risk sharing framework.
  - Actual income and expenditure to date compared to budget and showing trends and run rates.
  - Forecast year end positions.
  - A statement of assets and liabilities, including analysis of cash flow and movements in working capital
  - Explanations of material variances from plan
  - Capital expenditure and projected outturn against plan (where applicable)
  - Investigations and reporting of variances from financial, activity and workforce budgets.
  - Details of any corrective action being taken as advised by the relevant budget holder and the Chief Commissioner's and/or ~~Director of Finance~~Director of Finance and Value's view of whether such actions are sufficient to correct the situation.
  - Statement of performance against savings target
  - Key workforce and other cost drivers
  - Income and expenditure run rates, historic trends, extrapolation, and explanations, and
  - Clear assessment of risks and opportunities.
- Provide a rounded and holistic view of financial and wider JCC performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible

c) An accountability and escalation framework to be established for the JCC to

formally address material budget variances

d) Investigation and reporting of variances from financial, activity and workforce budgets.
e) Monitoring of management action to correct variances.
f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will:

- be held to account for managing services within the delegated budget.
- investigate causes of expenditure and budget variances using information from activity, workforce, and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Commissioner subject to the JCC's scheme of delegation;
b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement; and
c) No permanent employees are appointed without the approval of the Chief Commissioner other than those provided for within the available resources and workforce establishment as approved by the JCC.

5.3.5 The Chief Commissioner is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Integrated Medium-Term Plan and Medium-Term Financial Plans.

5.4 Capital Financial Management, Reporting and Budgetary Control

5.4.1 The JCC is not normally allocated any capital expenditure. In the event that there is an allocation the general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers and ~~host~~ Host Body's procedures and processes.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Commissioner is responsible for ensuring that the appropriate monitoring returns for the JCC are submitted to the Welsh Ministers in accordance with published guidance and timescales.

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the ~~Director of Finance~~Director of Finance and Value and Chief Commissioner. This commentary should also highlight and quantify any significant risks with an

assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the JCC. There must be consistency between the Medium-Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly JCC reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The JCC is not a corporate body and does not therefore have a statutory duty to prepare annual accounts and reports.

6.2 However, the JCC is hosted by the ~~host~~ Host Body~~LHB~~ and therefore the Chief Executive of the H~~h~~ost Body~~LHB~~ is required to ensure that the financial results of the JCC are consolidated into its own financial statements and disclosed as appropriate. Details of what is required is set out in the Hosting Agreement and will be communicated to the JCC and JCCT by the Executive Director of Finance~~Director of Finance~~ of the Host Body.

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The JCC is legally hosted by the ~~host LHB~~Host Body and therefore all banking arrangements are the responsibility of the ~~host LHB~~Host Body. Further details of the banking arrangements can be found in section 7 of the ~~host LHBs~~Host Body's SFIs.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1.1 The JCC is generally only an expenditure incurring segment of the ~~host LHB~~Host Body. Any cash requirements for the JCC ~~is~~are likely to be incidental to its main activities.

8.1.2 All aspect relating to the recording, handling and collection of cash will be the responsibility of the ~~host LHB~~Host Body.

8.1.3 Further details of the processes and responsibilities can be found in section 8 of the ~~host LHB~~Host ~~s~~Body's SFIs.

9. INCOME, FEES AND CHARGES

9.1 General

9.1.1 The JCC is generally only an expenditure incurring segment of the ~~host LHB~~Host Body. Any income generated by the JCC is likely to be incidental to its main

activities, including recovery of contract underperformance or the cost of drug therapies under agreed rebate arrangements.

9.1.2 The main ~~All~~ aspects relating to the recording, handling and collection of income will be the responsibility of the ~~host LHB~~Host Body. The recovery of any overdue debt arising from invoiced income will remain the responsibility of the JCCT unless the debt requires referral to the Host Body's debt collection agency.

9.1.3 Further details of the processes and responsibilities can be found in section 9 of the ~~host LHB~~Host ~~s~~Body's SFIs.

10. NON PAY EXPENDITURE

10.1 Scheme of Delegation, ~~Non Pay~~Non-Pay Expenditure Limits and Accountability

10.1.1 The Chief Commissioner will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the JCC's Scheme of Reservation and Delegation of Powers.

10.1.2 The Chief Commissioner will set out in the operational scheme of delegation and authorisation:

a) The list of managers who are authorised to place requisitions for the supply of goods and services, and
b) The maximum level of each requisition and the system for authorisation above that level.

10.2 The ~~Director of Finance~~Director of Finance and Value's responsibilities

10.2.1 The ~~Director of Finance~~Director of Finance and Value will:

a) Advise the JCC regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs
b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay ~~expenditure~~expenditure.
c) Ensure systems are in place for the authorisation of all accounts and claims
d) Ensure Directors and officers (staff) strictly follow NHS Wales' system and procedures of verification, recording and payment of all amounts payable
e) Maintain a list of Directors and officers (including specimens of their signatures) authorised to certify ~~invoices~~invoices.
f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been ~~agreed~~agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs, and
h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures.

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the ~~Director of Finance~~Director of Finance and Value and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the ~~Director of Finance~~Director of Finance and Value in advance of both any commitment being made and NWSSP Procurement Services being ~~engaged~~engaged.
b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public ~~procurement~~procurement.
c) Contracts above specified thresholds are approved by Welsh Ministers prior to any commitment being made
d) goods have been duly received, examined and are in accordance with specification and ~~order~~order.
e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are ~~correct~~correct.
f) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to JCC members, members of the Host Body or any employee of the Host Body, other than:
   (i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
   (ii) Conventional hospitality, such as lunches in the course of working visits.

   This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7. of the ~~host LHB~~Host ~~s~~Body's Standing Orders and the JCC's Standing Order 8.9.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the ~~Director of Finance~~Director of Finance and Value on behalf of the Chief Commissioner.
h) All goods, services, or works are ordered on official orders except works and services executed in accordance with a contract and purchases from petty cash.

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds.

j) Goods are not taken on trial or loan in circumstances that could commit the JCC to a future uncompetitive purchase.

k) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the ~~Director of Finance~~Director of Finance and Value.

10.3.2 The Chief Commissioner and ~~Director of Finance~~Director of Finance and Value shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. The JCC must consult with NWSSP Procurement Services, ~~Host Body~~the Executive Director of Finance of the Host Body, ~~Director of Finance~~Director of Finance and Value and Committee Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the JCC, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable.

10.6 Prepayments

10.3.1 Prepayments should be ~~exceptional, and~~exceptional and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where ~~e~~ieither:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%)
- It is the industry norm e.g. courses and conferences.
- It is in line with requirements of Managing Welsh Public Money
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.
- The prepayment is part of the routine cash flow system agreed by the Directors of Finance.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate JCCT Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out

the effects on the ~~host LHB~~Host Body or JCC if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments.

b) The ~~Director of Finance~~Director of Finance and Value will need to be satisfied with the proposed arrangements before contractual arrangements proceed (~~taking into account~~considering the Public Contracts Regulations where the contract is above a stipulated financial threshold), and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Commissioner if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

General Information

11.1 Procurement Services

11.1.1 While the Chief Commissioner is responsible for procurement, as delegated by the Host Body, the service is delivered by NWSSP Procurement Services.

11.1.2 Procurement staff are employed by NHS Wales Shared Services Partnership (NWSSP) and provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Host ~~Health Board~~Body. Where the term Procurement staff or department is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of NWSSP Procurement Department, for example pharmacy and works who undertake procurement on a devolved basis.

11.2 Policies and Procedures

11.2.1 NWSSP Procurement Services shall, on behalf of the Host Body maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Revised General Consent to enter Individual Contracts.

11.2.2 The Chief Commissioner is ultimately responsible for ensuring that the JCC Members and JCCT staff strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures:

- Are kept up to date.
- Conform to statutory requirements and regulations.
- Adhere to guidance issued by the Welsh Ministers
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Legislation Governing Public Procurement

11.3.1 Legislation governs public sector procurement in the UK. From the 24 February 2025, the Procurement Act 2023 and associated subordinate instruments (together "**the 2023 Act**") and the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and associated subordinate instruments (together "**the PSR Wales Regulations**") are the key pieces of legislation which governs public sector procurement in the UK. The PSR Wales Regulations only apply to certain health services ("**In-Scope Health Services**") and further detail these can be found in the Welsh Government's statutory guidance titled "Health service procurement: statutory guidance". Goods and services which are not In-Scope Health Services ("**Goods and Non-Health Services**") fall within the scope of the 2023 Act. `

11.3.2 Where specific instruction relates only to procurements undertaken under the PSR Wales Regulations, the words **'In-Scope Health Services Only'** will appear at the start of the instruction paragraph. Where specific instruction relates only to procurements undertaken under the Act, the words **'Goods and Non-Health Services Only'** will appear at the start of the instruction paragraph. If such references do not appear at the start of the instruction paragraph, all information detailed is applicable to the procurement regimes under both the PSR Wales Regulations and the 2023 Act, save for any bracketed instruction reference following a phrase to either regimes applicability.

11.3.3 **'Goods and Non-Health Services Only'** The Act governs the procurement of Goods and Non-Health Services. The Welsh Government's Policy Framework and the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act also govern this area. A key objective of the legislation is to establish a flexible, ~~accessible~~accessible, and equitable framework for public procurement in Wales that maximises social, economic, environmental and cultural outcomes for communities across Wales. Legislation, policy, and guidance setting out procedures and requirements for awarding all forms of regulated contracts shall have effect as if incorporated in the ~~LHB~~JCCs SFIs. **In the event of any conflict between what is contained in the 2023 Act and the ~~LHB~~JCC's SFIs, the former shall prevail.**

11.3.4 **'In Scope Health Services Only'** The PSR Wales Regulations governs the procurement of In-Scope Health Services. Under this legislation, relevant

organisations to which the PSR Wales Regulations apply must also have regard to the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act. They must also have regard to the statutory guidance issued by the Welsh Government which sets out how the PSR Wales Regulations should be adopted. One of the key objectives of this legislation is to ensure there is more flexibility when selecting providers for health services, with competitive tendering being one tool for the ~~LHB~~JCC to use when it is of benefit; alongside other routes that may be more proportionate, and which better enable the development of stable partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the ~~LHB~~JCC's SFIs. **In the event of any conflict between what is contained in the PSR Wales Regulations and the ~~LHB~~JCC's SFIs, the former shall prevail.**

11.3.5 ~~All Directors and their~~ The Chief Commissioner, JCC members and all JCCT staff are responsible for ensuring that all legal requirements ~~in the area of~~in public procurement are understood and fully complied with. The provisions set out in the 2023 Act, the PSR Wales Regulations, Welsh Procurement Policy Notices and all associated subordinate instruments are the model upon which all procurement exercises should be based.

11.3.6 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the Chief Commissioner (JCCT) ~~LHB~~ and Procurement Services e.g., engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.3.7 All other relevant legislation, guidance and policy documents must also be observed, including but not limited to the following:

- Social Partnership and Public Procurement (Wales) Act 2023
- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'

- The Welsh Government Procurement Policy Framework, including: Wales Procurement Policy Notes (extant at the time of undertaking the procurement exercise)
- The Wales Procurement Policy Statement (WPPS) (section 14 of the Procurement Act 2023)

11.4 Procurement Principles and Objectives

11.4.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the JCCT~~LHB~~ to perform its functions, and furthermore embrace all building, equipment, consumables, and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.4.2 **'Goods and Non-Health Services Only'** The legal and governing principles guiding 'covered procurement' under the 2023 Act, and incorporated into these SFIs include but are not limited to the following:

- Having regard to the objectives of delivering value for money; maximising public benefit; sharing information for the purpose of allowing suppliers and others to understand the authority's procurement policies and decisions; acting, and being seen to act, with integrity; and removing or reducing the barriers faced by SMEs. Ensuring equal treatment by treating suppliers the same, unless differences between the suppliers justify different treatment (and where different treatment of suppliers is justified, to take all reasonable steps to make sure the different treatment does not put a supplier at an unfair advantage or disadvantage).

11.4.3 **'In Scope Health Services Only'** The legal and governing principles guiding procurement of In-Scope Health Services under the PSR Wales Regulations, and incorporated into these SFIs include but is not limited to the JCCT~~LHB~~ doing the following: Making decisions in the best interests of people who use the service by acting with a view to (1) securing the needs of the people who use the services; (2) improving the quality of the services; (3) improving efficiency in the provision of the services;

- Acting transparently, fairly, and proportionately;
- Having regard to the Welsh Government's Health Service Procurement: Statutory Guidance; and
- having regard to the Wales Procurement Policy Statement published under section 14 of the 2023 Act.

11.5 Procurement Procedures

11.5.1 To help towards ensuring that the JCCT~~LHB~~ is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers' guidance and policy, the Host Body ~~LHB~~ shall, through Procurement Services, ensure that it shall have procedures that set out:

- requirements for, and exceptions to, formal competitive tendering (**'Goods and Non-Health Services Only'**);
- tendering processes including post tender ~~discussions;~~discussions.
- requirements and exceptions to obtaining quotations (**'Goods and Non-Health Services Only'**);
- evaluation and scoring methodologies; and
- approval of firms for providing goods and services.

11.5.2 All procurement procedures must comply with all relevant legislation, the Welsh Ministers' guidance and the J~~LHB~~CC's delegation arrangements and approval processes.

11.6 Notification to Welsh Government and consent from the Welsh Ministers

11.6.1 **Schedule 1** details the requirement and notification process for entering into contracts.

11.6.2 The provisions of Schedule 1 do not remove the requirement for ~~the LHB's~~ the JCCT to comply with Standing Orders, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

Planning

11.7 Sustainable Procurement

11.7.1 To further nurture the Welsh economy and in support of social, environmental, economic, and cultural goals in Wales, the JCCT~~LHB~~ must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible and within the legislative framework. The principles of the Well-being of Future Generations (Wales) Act 2015 ("**the WBFG Act 2015**") should be adopted at the earliest stage of procurement planning.

11.7.2 For example, the WBFG Act 2015 requires affected public bodies to act in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. The WBFG Act 2015 also provides for a shared purpose through seven well-being goals for Wales which are indivisible from each other and explain what is meant by the well-being of Wales.

11.7.3 The seven well-being goals are:

- a prosperous Wales.~~;~~
- a resilient Wales.~~;~~
- a healthier Wales.~~;~~
- a more equal Wales.~~;~~
- a Wales of cohesive communities.~~;~~

- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

11.7.4 The WBFG Act 2015 puts in place a "sustainable development principle" which tells relevant public bodies how to go about meeting their well-being duty. Such bodies need to make sure that when making their decisions they take into account the impact they could have on people living in Wales now and in the future. The WBFG Act 2015 includes five principles that those public bodies need to think about to show they have applied the sustainable development principle, which by way of ~~brief summary~~summary are as follows:

- **Collaboration**: acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives
- **Integration**: considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies.;
- **Involvement**: the importance of involving people with an interest in achieving the well-being goals and ensuring that those people reflect the diversity of the area which the body serves.;
- **Long term**: the importance of balancing short-term needs with the need to safeguard the long-term needs; and
- **Prevention**: how acting to prevent problems occurring or getting worse may help public bodies meet their objectives.

11.7.5 The JCCT~~LHB~~ is required to consider the Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains and the Code of Practice on ethical employment in supply chains which includes aims to commit public, private and third sector organisations to a set of actions designed to eliminate modern slavery and support ethical employment practices.

11.7.6 The JCCT ~~LHB~~ shall make use of the tools developed by Welsh Government Commercial Delivery team in implementing the principles of the WBFG Act 2015. The JCCT~~LHB~~ shall benchmark its performance against the WBFG Act 2015. As detailed in WPPN 005, for the procurement of all contracts over £25,000, ~~LHBs are required to~~ the JCCT shall take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the Sustainable Risk Assessment Template

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with the 'covered procurement' objectives in the 2023 Act, Welsh Government's commitments are set out in Welsh Government's 'technical guidance for covered procurement' and the current and subsequent versions of the

Wales Procurement Policy Statement (WPPS). The JCCTLHB shall ensure that it provides opportunities for SMEs, TSOs and SFBs to quote or tender for contracts.

11.9 Planning Procurements

11.9.1 The Chief CommissionerLHB must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks and requirements governing public procurement.

11.9.2 A process of planning all procurement exercises must be undertaken with the Procurement Services and an appropriate representative from the service and other appropriate stakeholders, (depending on the value, risk, and complexity of the procurement). The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost.;
- the likely 'route to market' which will consider the legislative and policy framework set out above.;
- the availability of funding to be able to award a contract following a successful procurement process; and
- that the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the four principles of prudent healthcare:

- equal partners through co-production;production.
- care for those with the greatest health need first;first.
- do only what is needed; and
- reduce inappropriate variation.

For **'Goods and Non-Health Services Only'** Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position.

For **'In Scope Health Services Only'** Value Based Healthcare should be considered under the Key Criteria 'Value' where this is appropriate and applicable. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement (and is also a core objective of the 2023 Act).

11.9.4 Where free of charge services are made available to the JCCTLHB, Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the LHBHost Body does not unintentionally commit itself to a single provider or longer-term commitment. Regular reports on free of charge services provided to the JCCTLHB

should be submitted to the Host Body's Audit and Risk Committeeby the LHB Board Secretary to the Audit Committee.

11.9.5 The JCCLHB is required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government's Health and Social Care Finance Department, and the opinions of Procurement Services and NWSSP Legal and Risk prior to external opinion being sought, where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Host Body'sLHB's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those provided by the Welsh Government's Commercial Delivery team, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks (where access is permissible) shall take precedence over frameworks led by public sector bodies located outside of Wales.

11.10.2 **'Goods and Non-Health Services Only' -** In the absence of an existing suitable procurement framework to source the required item, a competition must be operated in accordance with the 2023 Act and the table below. The Chief CommissionerLHB must ensure the value of their requirement considers cumulative spend across the LHB for like requirements and opportunity for collaboration with other NHS Wales Organisations.

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition[1]	Form of Contract
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order

>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required[2]	Formal contract and Purchase Order

[1] subject to the existence of suitable suppliers
[2] in accordance with the requirements set out in SFI 11.6.3.

11.11.1 Advice from the Procurement Services must be sought for all requirements in excess of £5,000.

11.11.2 The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Host Body to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.3 Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 and require competition.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- Required timescales are achievable.
- Specifications are drafted which:
  - are fit for inclusion in competition documents.
  - are drafted in a manner encouraging innovation by the market
  - are capable of being responded to and do not narrow competition.
  - deliver in line with legislative and policy frameworks.
  - include robust performance measures to effectively measure and manage supplier performance, and
  - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the JCC and ultimately the improvement of patient outcomes and wider health and social care communities.

11.12.3 Criteria for selecting suppliers and achieving an award recommendation must:

- be appropriately weighted in consideration of quality/price
- consider cost of change where relevant
- be transparent and proportionate.
- deliver value for money outcomes.

- fully explore complexity/risk, and
- consider whole life cost.

11.13 Single Quotation Application or Single Tender Application

11.13.1 In exceptional circumstances, there may be a need to secure goods / services / works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition)
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause.
- a need to retain a particular contractor for genuine business continuity issues (not just preferences) or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an ~~all-Wales~~all-Wales competition / national strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The ~~Director of Finance~~Director of Finance and Value must approve such applications up to £25,000. The ~~Host Body's~~ Chief Executive of the Host Body is required to approve applications exceeding £25,000, in-line with the Host Body's Standing Financial ~~Instructions .~~Instructions. The recording and reporting of applications will be in-line with the Host Body's Standing Financial Instructions and governance arrangements.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Commissioner and ~~Director of Finance~~Director of Finance and Value, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided.
- A value for money test has been undertaken.
- No bias towards a particular supplier
- Future competitive processes are not adversely affected.
- No distortion of the market is intended.
- An acceptable level of assurance is available before presentation for approval in line with the JCC Scheme of Delegation, and
- An 'or equivalent' test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA

/ STA, where the JCCT has already entered into an arrangement directly.

11.13.2 The recording and reporting of SQA and STA will be in-line with the Host Body's Standing Financial Instructions and governance arrangements.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition is not possible.

11.13.8 For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA/STA's not endorsed by Procurement or any exceptional matters.

11.14 Disposals

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Health Board making use of any agreements covering the disposal of such items.

11.14.3 Disposals will be undertaken in-line with the requirements set out within the Host Body's Standing Financial Instructions.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of competitions via quotation or tender, must be undertaken by a minimum of 2 evaluators from within the JCCT. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the JCC's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be

managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, ~~in order to~~to deliver the business and operational objectives required by the contract and in particular, to achieve value for money.
The relevant budget holder~~,~~ shall oversee and manage each contract on behalf of the JCCT ~~so as to~~to ensure that these implicit obligations are met. This contract management will include:

- Retaining accurate records
- Monitoring contract performance measures
- Engaging suppliers to ensure performance delivery.
- Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services, and
- Permitting stage payments as part of a formally agreed implementation / delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 Extending, modifying, or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the JCCT

and the local Head of Procurement. The JCC Team must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The JCCT must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The JCC Team must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 In choosing the item to be supplied (or the service to be performed) the JCCT shall always obtain the best value for money. The JCCT will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract the JCCT shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with SFI 11.11 thresholds.

11.18.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The JCCT will ensure compliance with the 'No Purchase Order, No Pay' policy, the ~~All Wales~~All-Wales policy which was introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered.
b) State the terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the JCCT by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The JCC will commission healthcare services for the resident population of all Local Health Boards, both from the LHB provided services and from Trusts and other providers. The Chief Commissioner is responsible for ensuring the JCC enters into suitable Health Care Agreements, Individual Patient Commissioning Agreements and Contracts with service providers for health care services. These agreements will be entered to in the name of the Host ~~Body, and~~Body and authorised in line with the Host Body's Scheme of Delegation.

12.1.2 All Health Care Agreements, Individual Patient Commissioning Agreements and Contracts should aim to implement the agreed priorities contained within the Integrated Medium-Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Commissioner should ~~take into account~~consider:

- The standards of service quality expected.
- The relevant quality, governance and risk frameworks and plans
- The relevant national service framework (if any)
- The provision of reliable information on quality, volume, and cost of service and
- That the agreements are based on integrated care pathways.

All agreements must be in accordance with the functions delegated to the JCC by the Welsh Ministers.

12.2 Statutory provisions

12.2.1 The National Health Service (Wales) Act 2006 (c.42) enables Health Boards to commission certain healthcare services. The JCC commissions services on behalf of the seven health Boards, and the H~~h~~ost Body~~LHB~~ enters into these contracts. Further information is available in paragraph 12.2 of the Local Health Board SFI's and these provisions may extend to the JCC with regard to those services delegated to the JCC.

12.3 Reports to Committee on Health Care Agreements (HCAs)

12.3.1 The Chief Commissioner will need to ensure that regular reports are provided to the JCC detailing performance, quality and associated financial implications of all health care agreements. These reports will be linked to, and consistent with, other Committee reports on commissioning and financial performance.

12.4 Tendering for supply of health care services

12.4.1 Where the JCC is required or elects to invite quotes or tenders for the supply of healthcare services, the Hhost Body'sLHBs SFIs in relation to procurement shall apply in relation to such competitive exercises.

12.4.2 The procurement arrangements surrounding the provision of healthcare services is a complex area and as such legal advice must be secured where there is doubt over the applicability or not of applying competitive processes. Further guidance is provided in the Hhost Body'sLHBs SFI, Annex A.

13. GRANT FUNDING

13.1 Policies and procedures

13.1.1 The Hhost BodyLHB shall be responsible for all aspects of the grant funding process on behalf of the JCC. Further details can be found in section 13 of the Hhost LHBs Body's SFIs.

14. PAY EXPENDITURE

14.1 Appointments and Remuneration

14.1.1 Appointments to the JCC shall be in accordance with section 1.4 of the JCC SOs and the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024.

14.1.2 All other appointments or recruitments to the JCCT (including the Chief Commissioner) and any remuneration or employment contract related matters shall be dealt with by the hHost BodyLHB on behalf of the JCC in accordance with the Hhost LHBs Body's own SOs and SFIs.

14.1.3 Further details of the Hhost LHBs Body's responsibilities can be found in section 14 of the hHost LHBs Body's SFIs.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 General

15.1.1 The funding delegated by the JCC is mostly revenue in nature, however in the event thatif it is required all Capital plans, and annual capital programmes, must be approved by the JCC before the commencement of a financial year and should

be in line with the objectives set out in the approved Integrated Medium-Term Plan (IMTP) for the organisation. The actual capital plan and programmes must be delivered within capital finance resource limits.

15.1.2 Any capital plans, and capital investment and expenditure incurred, by the JCC or the JCCT shall be dealt with in accordance with section 15 of the Hhost ~~LHBs~~ Body's SFIs. This includes the recording and safeguarding of assets.

16. LOSSES AND SPECIAL PAYMENTS

16.1 Losses and Special Payments

16.1.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

16.1.2 The ~~Director of Finance~~Director of Finance and Value is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

16.1.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Commissioner and/or the ~~Director of Finance~~Director of Finance and Value or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the ~~Director of Finance~~Director of Finance and Value and/or the Chief Commissioner.

16.1.4 Where a criminal offence is suspected, the ~~Director of Finance~~Director of Finance and Value must liaise with the Executive Director of Finance of the Hhost and the Hhost ~~LHB's~~ Body's Counter Fraud Service to determine the next immediate action including when to inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the ~~Director of Finance~~Director of Finance and Value must inform the Hhost ~~LHBs~~ Body's Local Counter Fraud Specialist (LCFS) and the Counter Fraud Service (CFS) Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

16.1.5 The ~~Director of Finance~~Director of Finance and Value or the Hhost Body's LCFS must notify the Audit and Risk Committee dealing with JCC matters, the Auditor General for Wales' representative and the fraud liaison officer within the Welsh

Government's Health and Social Services Group Finance Directorate of all frauds.

16.1.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the ~~Director of Finance~~Director of Finance and Value must notify:
a) The Audit and Risk Committee on behalf of the JCC,
b) The ~~h~~Host B~~b~~ody Executive Director of Finance and LCFS, and
c) An Auditor General for Wales' representative.

16.1.7 The ~~Director of Finance~~Director of Finance and Value shall be authorised to take any necessary steps to safeguard the JCC's and the H~~h~~ost ~~LHBs~~ Body's interests in bankruptcies and company liquidations.

16.1.8 The ~~Director of Finance~~Director of Finance and Value shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.). The ~~Director of Finance~~Director of Finance and Value must consult with and notify the Executive Director of Finance of the Host B~~b~~ody on all losses and special payments.

16.1.9 The Host Body's Audit and Risk Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in in Annex 3 of the JCC SOs.

16.1.10 For any loss or special payments, the ~~Director of Finance~~Director of Finance and Value should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

16.1.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Executive Director of Finance of the Host Body and the Health and Social Services Group's Director of Finance.

16.1.12 All novel, contentious and repercussive cases must be notified to the Executive Director of Finance of the Host Body and referred to the Welsh Government's Health and Social Services Group's Finance Directorate, irrespective of the delegated limit.

16.1.13 The reporting of all losses and special payments will be in-line with the Host Body's Standing Financial Instructions and governance arrangements.

16.1.14 The JCC must obtain approval of the Executive Director of Finance of the Host Body and the Health and Social Services Group Director General's approval for

special severance payments.

16.1.15 The Host Body ~~LHB~~ must notify the JCCT of any changes to the reporting and approval requirements in respect of losses and special payments in order to facilitate full compliance with the Host Body's ~~hosts~~ SFIs.

~~16.1.16~~

17. DIGITAL, DATA and TECHNOLOGY

17.1 Digital Data and Technology

17.1.1 The JCC and the JCCT shall operate within the guidance set out in section 18 of the H~~h~~ost ~~LHBs~~ Body's SFIs.

18. RETENTION OF RECORDS

18.1 Responsibilities of the Chief Commissioner and ~~Host~~ Chief Executive of the Host Body

18.1.1 The ~~Host~~ Chief Executive of the Host Body is the accountable officer for the retention of records and the associated statutory duties. The Chief Commissioner is responsible to the ~~Host~~ Chief Executive of the Host Body in respect of retention of records ~~in order for~~for the ~~Host~~ Chief Executive of the Host Body to discharge their statutory body accountability for this function.

18.1.2 The Chief Commissioner shall have delegated responsibility from the Host Body in respect ~~of maintaining~~of maintaining archives for all records. in respect of JCC matters, in-line with the Host Body's Policy on Records Management.

18.1.3 The records held in archives shall be capable of retrieval by authorised persons.

18.1.4 Records held in accordance with regulation shall only be destroyed in-line with the Host Body's Policy on Records Management and Schedule for the Retention and Destruction of Records.

SCHEDULE 1

GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

This schedule included as "General Consent to enter individual contracts" replaces all previous versions of Schedule 1 and should be read in conjunction with the revised Model Standing Financial Instructions (SFI's) issued in relation to Chapter 11 for Local Health Boards and NHS Trusts and Chapter 12 for Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW).

PROCESSES FOR NHS WALES CONTRACTS, AND INTERESTS IN PROPERTY

Paragraph 13 of Schedule 2 to the National Health Service (Wales) Act 2006 states as follows:

"(1) Subject to sub-paragraph (3), a Local Health Board may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.

(2) In particular it may—

(a) acquire and dispose of property,
(b) enter into contracts,
(c) accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the JCCT or for any purposes relating to the health service).

(3) A Local Health Board may not do anything mentioned in sub-paragraph (2) without the consent of the Welsh Ministers (which may be given in general terms covering one or more descriptions of case)."

Section 10.1 of the NHS Wales Infrastructure Investment Guidance issued on 22 October 2018 ("**the Investment Guidance**") includes the following in relation to Local Health Boards:

"Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process are included in Welsh Health Circular WHC(2015)031. Organisations should

ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements."

This is also to be regarded as being applicable to HEIW and DHCW, which were both established after the two WHC's mentioned above were issued.

Section 10.2 of the Investment Guidance includes the following in relation to Trusts:

"Whilst formal Cabinet Secretary consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above."

Section 11 of the Investment Guidance also includes provision as to disposals and property protocols.

Welsh Health Circular WHC (2015) 031 issued 22 June 2015 includes arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process.

That WHC is also to be regarded as being applicable to HEIW and DHCW in the same way as it applies to LHBs.

Entering into contracts

This schedule confirms to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisition or disposal of a lease or any interest in property are delegated to the Director General, Health Social Care and Early Years.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Cabinet Secretary for Health and Social Care on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly, any issues relevant to the exercise of the Cabinet Secretary for Health, and Social Care's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

• All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSCEY prior to tendering for the contract;

• All eligible LHB and HEIW and DHCW contracts >£1m in total to be submitted to the Director General HSCEY for consent prior to award;
• All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSCEY for notification prior to award; and
• All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSCEY for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

i) Contracts of employment between LHBs, HEIW, or DHCW and their staff;

ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs, HEIW, or DHCW;

iii) Out of Hours contracts;

iv) All NHS contracts; that is where one health services body contracts with another health service body;

(v) Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Cabinet Secretary e.g. annual education and training commissioning also do not require further Ministerial notification or consent; and

(vi) Contracts between £500k - £1 million (for noting) and £1 million + (for approval).

a) Wales Public Sector Framework Agreements e.g., Frameworks established by the Welsh Government's Commercial Delivery team or NWSSP (not exhaustive) – no written approval required to award contracts under these Frameworks through a direct award or mini competition.

b) Third-Party Public-Sector Framework Agreements e.g., Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through minicompetition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

For non-capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

NHS Wales Joint Commissioning Committee

Guidance for the Handling of Interests

MayApril 202664

1. Context

1.1 The NHS Wales Joint Commissioning Committee (JCC) ~~(the Joint Committee)~~ is a joint committee of each Local Health Boards (LHB) in Wales, established under the NHS Wales Joint Commissioning Committee ~~(JCC)~~ (Wales) Directions 2024 (the JCC Directions). The JCC is hosted by the Cwm Taf Morgannwg ~~U~~University Health Board~~HB~~ (the Host Body) on behalf of each of the seven LHBs.

1.2 The specific governance and accountability arrangements established for the JCC are set out within:

- The JCC Standing Orders (SOs) and the Schedule of Powers reserved for the JCC and the Scheme of Delegation to others,
- The JCC Standing Financial Instructions (SFIs),
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A Hosting Agreement between the JCC ~~LHBs~~ and the Host Body~~the host LHB~~ in relation to the provision of administrative and any other services to be provided to the JCC.

Up to date Copies of these agreements can be found here.

1.3 As set out within the JCC SOs, the JCC must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour Framework. This will be set within the context of the Host Body's Values and Standards of Behaviour Framework (~~Standards of Behaviour Policy (nhs.wales)~~Standards of Good Governance and Probity (in Public Service Roles) Policy) (It should be noted that all references to Independent Members and Board Members and Board Level Directors in this policy are interpreted as references to JCC Lay Members and Senior Leadership Team Directors).

1.4 The Welsh Government's Citizen-Centred Governance Principles apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales. "Public service values and associated behaviours are and must be at the heart of the NHS in Wales"

1.5~~4~~ The JCC is strongly committed to being value-driven, rooted in the Nolan principles (See 1.6 below) and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

1.5~~6~~ The JCC and its members are expected to practice high standards of corporate and personal conduct, based on the recognition that the needs of patients must come first. The "Seven Principles of Public

Life", or the "Nolan Principles" form the basis of the Standards of Behaviour requirements of the JCC. These are:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;
- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;
- **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and
- **Leadership** – Individuals should promote and support these principles by leadership and example.

1.~~6~~7 In support of these principles, the JCC must be impartial and honest in the way that it fulfils its duties. The JCC must remain beyond suspicion at all times. The JCC, and its members, will achieve the "Seven Principles" set out above by:

- Ensuring that the interests of patients remain paramount;
- Being impartial and honest in the conduct of its official business;
- Using public funds to the best advantage of the service and the patients, always seeking to ensure value for money;
- Not abusing individual~~'s~~ or collective official positions for personal gain or to benefit family or friends;
- Not seeking to advantage or ~~to~~ further private business or other interests in the course of their official duties;
- Not seeking or knowingly accepting, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the JCC.

2. Purpose

2.1 The aim of this guidance is to set out arrangements for the appropriate handling of declarations of interests within the JCC's business, ensuring that the JCC operates within its SOs and the Host Body's Values and Standards of Behaviour Framework ~~Standards of Behaviour Framework set by the Host Body~~.

2.2 The Host Body's Values and Standards of Behaviour Framework ~~Host Body's Standards of Behaviour Policy~~ aims to ensure that arrangements are in place to support employees to act in a manner that upholds Host Body's Values and Standards of Behaviour Framework ~~the Standards of Behaviour Framework~~ as well as setting out specific arrangements for the appropriate declarations of interests and acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that the ~~Health Board~~JCC can be seen to have exemplary practice in this regard.

2.3 The JCC will discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must act in accordance with this principle, rather than furthering direct or indirect financial, personal, professional or organisational interests. This also includes ensuring that Officer Members do not seek to achieve a greater benefit for the population of their respective Local Health Board over and above that of others.

3. Scope

3.1 The membership of the JCC Joint Committee (JC) comprises the Chair and Lay Members appointed by Welsh Ministers, the Chief Executives of all seven Local Health Boards in Wales and the Chief Commissioner who is employed by the Host Body.

3.2 This guidance is intended to support the handling of declarations within the business of the JCC. In particular dealing with Members' interests during ~~Joint Committee~~JC meetings, in-line with the JCC SOs.

3.3 JC~~C~~ members should declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a ~~Joint Committee~~JC member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the ~~Joint Committee's~~JC's business.

3.4 The recording of JCC members' interests will be recorded as follows:

- JCC Chair – via the Host Body's policy and process for declaring and recording interests;
- JCC Lay Members - via the Host Body's policy and process for declaring and recording interests;
- JCC Officer Members (Chief Executive of the seven LHBs) – via their respective Health Board's policy and process for declaring and reporting interests, acknowledging that external auditors may, from time to time, request declarations of interest prepared specifically for the JCC; and
- Chief Commissioner - via the Host Body's policy and process for declaring and recording interests.

3.5 The scope of this guidance does not apply to the JCC Team. As employees of the Host Body, the Host Body's Values and Standards of Behaviour Framework ~~Host Body's Standards of Behaviour Policy~~ and process for the declaring and recording of interests will apply.

3.6 The Committee Secretary will ensure annual reporting of declaration of interests for all JCC Members (utilising the processes set out in 3.4) is reported through the JCC to inform annual reporting to the Host Body.

4. Handling of Interests in JCC Meetings

~~4.1 The JCC must discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must act in accordance with this principle, rather than furthering direct or indirect financial, personal, professional or organisational interests. This also includes ensuring that Officer Members do not seek to achieve a greater benefit for the population of their respective Local Health Board over and above that of others.~~

Commented [AF1]: Duplication with section 2.3

4.1 It is a requirement that at the beginning of every meeting of the JCC that members be invited to declare their interests in relation to any items on the agenda. Where an actual or potential conflict is declared, the Chair with the advice of the Committee Secretary, will consider the appropriate action to be taken using the guidance attached at **Annex A**.

4.2 The actual or potential conflict and the action taken will be recorded in the minutes of the meeting and the relevant Register of Interests will be updated if required.

4.3 Where it becomes evident part way through a meeting that there may be a potential conflict the JCC member must declare their interest

immediately. The Chair with the advice of the Committee Secretary, will consider the appropriate action to be taken using the guidance attached at **Annex A**.

5. Categories of Interests

5.1. An Interest is defined as "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold"1.

5.2 For the purpose of the JCC's business, interests fall into the following categories:

1. Personal Financial Interests
2. Non-Financial Personal Interests
3. Non-Financial Professional Interests
4. Indirect Interests
5. Provider Organisation Interests

Annex A sets out the definitions of each of the 5 categories above, along with examples of where these interests may arise, and the actions available to the Chair in mitigating any actual or perceived interests that arise.

6. Role of the Chair and Committee Secretary

6.1 The Chair is responsible for the effective operation of the JCC, including:

- Chairing Joint Committee meetings
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all JCC business is conducted in accordance with JCC SOs and Host Body's Values and Standards of Behaviour Framework~~its Standards of Behaviour Framework~~; and
- Developing positive and professional relationships amongst the JCC's membership and between the JCC and each LHBs Board.

6.2 In respect of the Handling of Interests in JCC meetings, the Chair will need to consider the action to be taken and to what extent this affects the balance of the JCC's discussion and decision-making process. In doing so the Chair should ensure that conflicts and potential or

1 NHS England: Managing Conflicts of Interests

perceived conflicts of interest do not, or do not appear to, affect the integrity of the JCC's decision-making processes.

6.3 The Committee Secretary is the guardian of good governance within the JCC and in doing so will include matters such as:

- Providing advice to the JCC as a whole and to individual JCC members on all aspects of governance;
- Facilitating the effective conduct of JCC business;
- Ensuring that in all its dealings, the JCC acts fairly, with integrity, and without prejudice or discrimination; and
- Contributing to the development of a culture that embodies NHS values and standards of behaviour.

6.4 The Committee Secretary has delegated responsibility for ensuring that the JCC is provided with competent advice and support regarding the effective and appropriate application of the Host Body's Standards of Behaviour Framework and the handling of interests.

ANNEX A

An Interest "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold".			
Category	**Description**	**Examples**	**Action for consideration in handling declared interests**
1 Personal Financial Interests	This is where an individual could or may get direct financial benefit from the consequences of a decision that they are involved in making. A benefit may arise from the making of gain or avoiding a loss.	Where an individual may get direct financial benefits from the consequences of a decision that they are involved in making. This could include: • A director (including a non-executive director) or senior employee in another organisation which is, or is likely to do business with an organisation in receipt of NHS funding • A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding • Outside employment • A secondary income • Receipt of a grant(s)	Where a JCC member has a direct pecuniary interest in any matter being considered by the JCC, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. This requirement is absolute as set out in *The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (Regulation 17)*. The JCC Chair may determine that the JCC member concerned shall be excluded from that part of the meeting.

An Interest "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold".			
Category	**Description**	**Examples**	**Action for consideration in handling declared interests**
		• Receipt of sponsored research • Receipt of other payments (e.g., honoraria, day allowances, travel or subsistence for attendance at an event) • Holding of patents and other intellectual property rights (either individually, or by virtue of their association with a commercial or other organisation).	
2 Non-Financial Personal Interests	This is where an individual may benefit (or be perceived to benefit) personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions that they are involved in making.	Where an individual may benefit personally from a decision that they are involved in making, in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.	If a member has an actual, potential or perceived interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records: • Requiring the member to not attend the meeting

An Interest "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold".			
Category	**Description**	**Examples**	**Action for consideration in handling declared interests**
	A benefit may arise from the making of gain or avoiding a loss.	This could include, for example, where the individual is: • A member of a voluntary sector/not for profit board or has a position of authority within a voluntary sector/not for profit organisation • A member of a lobbying or pressure group with an interest in health and care It is also important to consider an interest that a member of the public, who knew the relevant facts would reasonable consider to be so significant that it is likely to prejudice the JCC members judgment of what is in the public interest	• Ensuring that the member does not directly receive any confidential meeting papers relating to the nature of their interest • Requiring the member to not attend all or part of the discussion and/or decision on the related matter • Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate fully • Removing the member from the group or process altogether.

An Interest "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold".			
Category	**Description**	**Examples**	**Action for consideration in handling declared interests**
3 Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision that they are involved in making, such as increasing their professional reputation or status or promoting their professional career. A benefit may arise from the making of gain or avoiding a loss.	Where an individual may obtain a non-financial professional benefit from the consequences of a decision that they are involved in making, such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is: • An advocate for a particular group of patients • A clinician with a special interest. • An active member of a particular specialist body, e.g. Royal Colleges • An advisor for the Healthcare Inspectorate Wales, Care Quality	If a member has an actual, potential or perceived interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records: • Requiring the member to not attend the meeting • Ensuring that the member does not directly receive any confidential meeting papers relating to the nature of their interest • Requiring the member to not attend all or part of the discussion and/or decision on the related matter • Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate fully • Removing the member from the group or process altogether.

An Interest "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold".			
Category	**Description**	**Examples**	**Action for consideration in handling declared interests**
		Commission or National Institute of Health and Care Excellence. • Is undertaking a research role.	
4 Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making. A benefit may arise from the making of gain or avoiding a loss.	Where an individual has a close association with another individual e.g., a close family member, close friend, associate or a business partner, who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision that they are involved in making. This would include the examples above for personal financial, personal and professional non-financial interests.	If a member has an actual, potential or perceived interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records: • Requiring the member to not attend the meeting • Ensuring that the member does not directly receive any confidential meeting papers relating to the nature of their interest • Requiring the member to not attend all or part of the discussion and/or decision on the related matter • Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate fully • Removing the member from the group or process altogether.

An Interest "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold".			
Category	**Description**	**Examples**	**Action for consideration in handling declared interests**
			Where a JCC member declares an indirect pecuniary interest in any matter being considered by the JCC, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. This requirement is absolute as set out in *The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009.* The JCC Chair may determine that the JCC member concerned shall be excluded from that part of the meeting.

An Interest "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold".			
Category	**Description**	**Examples**	**Action for consideration in handling declared interests**
5 Provider Organisation Interests[2] (relevant to JCC Officer Members only given their role as a Chief Executive of one of the 7 LHBs in Wales)	This is where an individual's employing organisation, as a provider of services, may or be perceived to directly benefit financially because of decisions that they are involved in making. A benefit may arise from the making of gain or avoiding a loss. A benefit may arise from the making of gain or avoiding a loss.	Where a provider organisation (one of the 7 LHBS) may get direct financial benefits from the consequences of a decision that they are involved in making. This could include: • award of contracts as a single provider • award of contracts as a cohort of providers • agreement of financial uplifts.	The JCC must discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must act in accordance with this principle, rather than furthering direct or indirect financial, personal, professional or organisational interests. This also includes ensuring they do not seek to achieve a greater benefit for the population of their Local Health Board over and above that of others. In taking any actions to mitigate actual, potential or perceived conflicts of interest, the JCC Chair should act **proportionately** and should seek to preserve the spirit of collective decision-making, whilst balancing the benefits of having a particular individual involved. In looking at mitigations, the Chair may need to take account of a range of factors in order to determine what the risks are of including an individual with an actual or perceived conflict in

2 Informed by guidance to Integrated Care Board in NHS England: conflicts-of-interest-nhsp-advice-from-mwe-jun23.pdf (nhsproviders.org)

An Interest "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold".			
Category	**Description**	**Examples**	**Action for consideration in handling declared interests**
			the decision-making process and how that may be perceived or challenged. Where a JCC Officer Member declares an actual, potential or perceived Provider Organisation Interest, the Chair should determine whether this declaration could result in a material[3] benefit to the provider organisation and could therefore be deemed to influence the individual in decision-making. If a material interest is declared, the Chair will need to consider to what extent this affects the balance of the JCC's discussion and decision-making process, and in doing so the Chair should ensure that conflicts and potential or perceived conflicts of interest do not, or do not appear to, affect the integrity of the JCC's decision-making processes. If so, the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

3 NHSE, Managing Conflicts of Interest Guidance describes a material interest as 'one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision'.

An Interest "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold".			
Category	**Description**	**Examples**	**Action for consideration in handling declared interests**
			• Requiring the Officer Member to not attend the meeting • Ensuring that the Officer Member does not directly receive any confidential meeting papers relating to the nature of their interest • Requiring the Officer Member to withdraw from any decision or vote, but they may continue to participate in discussion recognising their role as a commissioner; • Requiring the member to not attend all or part of the discussion and/or decision on the related matter; • Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate fully, requesting clarity on any contributions made to be clear as to whether they are made as a provider or a commissioner of services

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Appendix 4

QUALITY SAFETY AND OUTCOMES SUB-COMMITTEE (QSOC)

Terms of Reference & Operating Arrangements
(Schedule 3.1 of the Standing Orders)

Document Author:	Committee Secretary
Lead Director	Director of Nursing and Quality
Endorsed By	~~Joint Commissioning Committee 17 September 2024~~ Joint Commissioning Committee 17 March 2026
Approved By	~~Health Boards – 25 and 26 September 2024 Board Meetings~~ Health Boards – May 2026
Issue Date	~~4 February 2025~~ 26 May 2026
Review Date	~~12 January 2025~~ March 2027
Version	4

Contents

Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1	Health Boards	17 September 2024	Approved at LHB September Board meetings	1 June 2025
Version 2	NWJCC Joint Commissioning Committee (JCC)~~CC~~	21 January 2025	Endorsed	12 January 2025
Version 3	Health Boards	21 January 2025	Approved at LHB Board meetings – with staff side rep removed.	12 January 2025
Version 3.1	QSOC	23 February 2026	Endorsed at QSOC subject to minor amendments to paragraph 11.2	
Version 3.2	JCC	17 March 2026	Endorsed	March 2027
Version 4	Health Boards	May 2026		March 2027

Sub-Committee Arrangements:

This schedule forms part of and shall have effect as if incorporated in the NHS Wales Joint Commissioning Committee Standing Orders.

1. Introduction & Constitution

1.1 In accordance with NHS Wales Joint Commissioning Committee (NWJCC) Standing Order 5.5, the ~~NHS Wales Joint Commissioning Committee (JCC – the~~ NWJCC Joint Committee~~)~~ (the JC) ' may and, where directed by the Local Health Board (LHB) Boards jointly, or the Welsh Ministers must, appoint joint sub-committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee or on behalf of the Joint Committee to each LHB Board and/or its other committees). The Joint Committee shall determine, for agreement by the LHBs, a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.

1.2 In accordance with Standing Orders (SOs) (and the NWJCC Scheme of Delegation), the ~~Joint Committee~~JC shall nominate annually a sub-committee to be known as the **Quality, Safety and Outcomes Sub-Committee**. The detailed terms of reference and operating arrangements set by the ~~Joint Committee~~JC in respect of this sub-committee are set out below.

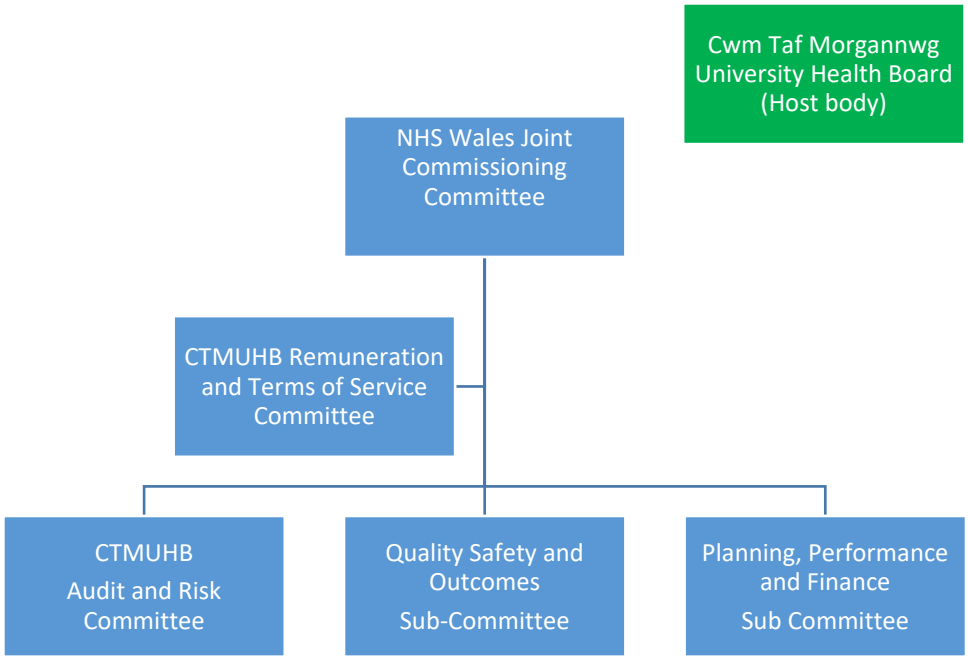
2. Purpose

2.1 The purpose of the Quality, Safety and Outcomes Sub-Committee "the Sub-Committee" is to be assured that the ~~Joint Committee~~JC is commissioning appropriate, high quality and safe services from providers (Local Health boards, Trusts and private sector providers) on behalf of ~~health boards~~LHBs in Wales.

This will be achieved by:

- Providing scrutiny and assurance to the Joint Committee for the Quality Safety and Outcomes of services commissioned from providers including local health boards, NHS Trusts and private providers who are accountable for the provision of safe, quality services~~)~~
- Reporting to and providing advice to the ~~Joint Committee~~JC, including escalation of issues that require urgent consideration and action by the J~~C~~C
- Addressing concerns delegated by the ~~Joint Committee~~JC ensuring that individual LHB Quality and Patient Safety Committees are informed of any issues relating to their population recognising that concerns of the services commissioned may impact on primary and secondary and vice versa (whole pathway) and contribute to the achievement of the Duty of Candour; and
- Providing assurance to the ~~Joint Committee~~JC in relation to improving the experience of patients, carers, citizens and those that come into contact with the services commissioned by the NWJCC.

Figure 1 – NWJCC Sub-Committee Structure



3. Scope and Duties

3.1 The Sub-Committee will provide scrutiny and assurance to the JC and LHBs in relation to the duties below ~~and will, in respect of its provision of advice to the Joint Committee~~:

- Monitor and support the development and implementation of the Commissioning Assurance Framework ensuring that there is continuous improvement in the commissioning of safe, effective and sustainable services for the people of Wales
- Consider the quality, patient safety and outcome implications arising from the development of commissioning strategies, including developments outlined in the agreed NWJCC Integrated Medium Term Plan (IMTP)
- Ensure that all aspects of commissioning activity, through regular reporting to the sub-committee consider quality, safety and outcomes as part of the commissioning of services
- Receive, when required, items for urgent consideration and escalation
- Ensure a robust process is in place for the development and approval of evidence-based service specifications, focussed on quality and safety of service provision, for all services commissioned by the NWJCC

- Have responsibility for the commissioning risks designated to the Sub-Committee for monitoring ensuring that quality, safety and outcomes of services commissioned are a priority for the organisation
- Monitor and scrutinise risk management and assurance arrangements for the risks designated to the Sub-Committee for monitoring from the perspective of clinical and patient safety risks
- receive assurance from provider organisations that concerns management arrangements are robust and reported through the appropriate governance routes; and
- Receive assurance that patient safety incidents, complaints and claims (relating to the services commissioned by the JCC) are routinely monitored and are considered a critical part of the evaluation of services in the JCC commissioning cycle.

Sub-Committee Programme of work

3.2 Each year the ~~Joint Committee~~JC will determine the Sub-Committee's priorities for its annual programme of work, based on the Joint Committee's Commissioning Assurance Framework (once approved) and Organisational ~~Corporate~~ Risk Register. This approach will ensure that the Sub-Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Sub-Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Sub-Committee's programme of work will be dynamic and flexible to meet the needs of the ~~Joint Committee~~JC throughout the year.

3.3 The Sub-Committee will provide onward assurance to the JC on all matters relating to its annual programme of work, as delegated.

4. Membership

Members

4.1 The Membership of the QS&O Sub-Committee is as follows:

Chair	Lay (Independent) Member of the Joint Committee
Vice Chair	Lay (Independent) Member of the Joint Committee
Member	One further Lay (Independent) Member of the Joint Committee
Member	~~One~~ Two LHB ~~representative~~ Chief Executive representatives, who shall alternate attendance, or designated nominated deputy who must be an Executive Director from a health board (and would be fully briefed on the issues to be discussed)

4.2 The membership of the Sub-Committee shall be determined by the ~~Joint Committee~~JC, based on the recommendation of the Chair of the ~~Joint~~

~~Committee~~JC and lay members, taking account of the balance of skills and expertise necessary to deliver the subcommittee's remit and subject to any specific requirements or directions made by Ministers or the Welsh Government.

~~4.3 The Chair of the Joint Committee and the Chair of the Sub-Committee, receive from nominations from the CEOs of Local Health Boards~~

~~4.4~~4.3 The Membership will be reviewed annually.

Support to Sub-Committee Members

~~4.5~~4.4 The Committee Secretary, on behalf of the Sub-Committee Chair, shall:

- Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role, and
- Co-ordinate the provision of a programme of organisational development for Sub-Committee members as part of the overall JCCs Organisational Development programme.

~~4.6~~4.5 **In Attendance**

JCC Director of Nursing and Quality (Lead Director for the Committee)
JCC Medical Director
JCC Director of Commissioning for Specialised Services
JCC Director of Commissioning for Ambulance and 111
JCC Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MH, LD & VG)
Committee Secretary or representative who will routinely attend meetings ensuring governance support and advice is available to the Committee Chair
Llais Representative

Directors may on occasion nominate a suitably senior deputy to attend the Sub-Committee on their behalf but should ensure that they are fully aware and briefed on the issues to be discussed.

By Invitation:

~~4.7~~4.6 The Chief Commissioner, and other directors / senior managers may be invited to attend when the Sub-Committee is discussing areas of risk, audit/review findings or matters that are the responsibility of that Director / member of staff.

~~4.8~~4.7 The Sub-Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Member Appointments

4.8 The membership of the Sub-Committee shall be determined by the Chair of the ~~Joint Committee~~JC, taking account of the balance of skills and expertise necessary to deliver the committee's remit and subject to any specific requirements or directions made by the Welsh Government.

5 Quorum & Attendance

5.1 A quorum shall be at least two members comprising of two Lay (Independent) Members.

5.2 For effective governance, at least two JCC Team directors, one of which must be a Clinical Director should be in attendance at the meeting.

6 Meeting Secretariat

6.1 The ~~JCC~~ Committee Secretary will determine the secretarial and support arrangements for the Sub-Committee.

7 Frequency of Meetings

7.1 The Meetings shall meet no less than 6 times a year, and otherwise as deemed necessary by the Chair of the Joint Committee.

7.2 Additional meetings may be called as appropriate with agreement of the Sub-Committee Chair.

7.3 Additional meetings may be held with the chairs of the LHBs Quality and Safety Committees where there is requirement.

7.4 Members will be ~~required~~ expected to attend a minimum of 75% of all meetings. Attendance will be monitored and reported to the Joint Committee through the Sub-Committee's Annual Report.

7.5 The Sub-Committee will arrange meetings and align with key statutory requirements during the year consistent with the Joint Committee's annual plan of Committee Business.

8 Withdrawal of Individuals in Attendance

8.1 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of ~~particular~~ specific matters.

9 Circulation of Papers

9.1 All papers will be distributed at least 5~~7~~ clear ~~calendar~~ days in advance of the meeting.

9.2 The Committee Secretaryiat will ensure that the draft minutes will be provided to the Sub-Committee Chair within ten working days following the meeting.

9.3 The JCC Committee Secretaryiat will ensure that a Sub-Committee highlight report is provided for presentation by the Sub-Committee Chair to the next Joint Committee meeting.

9.4 The Sub-Committee highlight report will also be shared with members and LHB Directors of Corporate Governance / Board Secretaries.

10 Access

10.1 The Chair of the Quality, Safety and Outcomes Sub-Committee shall work closely with the Director of Nursing and Quality and have reasonable access to the NWJCC Directors and other relevant senior staff within the NWJCC Team.

11 Accountability, Responsibility & Authority

11.1 Although health boardsLHBs have delegated authority to the Joint CommitteeJC and subsequently to this Sub-Committee for the exercise of certain functions as set out within these terms of reference, each healthLHBboard retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their organisation.

11.2 This Sub-Committee is responsible for providing scrutiny and assurance to the JCJoint Committee that Quality, Safety and Outcomes are being managed appropriately within the services commissioned by the NWJCC.commissioning cycles.

Authority

11.3 The Sub-Committee is authorised by the Joint CommitteeJC to investigate, or have investigated, any activity within its terms of reference.

11.4 The Sub-Committee is authorised by the Joint CommitteeJC to obtain outside legal or other independent professional and clinical advice and to secure the attendance of relevant external expertsoutsiders with relevant experience and expertise if it considers it necessary to support the Sub-Committee in the discharge of its duties. ,Such advice will be sought in accordance with the NWJCCs procurement, budgetary and other procedural and policy requirements.

11.5 The Sub-Committee will ensure that it is aware of and receives relevant reports on the activities and reports of external independent regulators and agencies, such as Healthcare Inspectorate Wales, Care Quality Commission,

National Audit Office and Audit Wales, that relate to the commissioning of services.

Sub Groups

11.6 The Sub-Committee may, subject to the approval of the ~~Joint Committee~~JC establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business.

Strategy

11.7 Oversee and monitor the development and implementation of the NWJCCs Strategies for patient quality, safety and outcomes:

- **Patient Quality, Safety and Outcomes**
  - Provide assurance to ~~Joint Committee~~JC on implementation of the Quality aspects within the Integrated ~~Medium Term~~Medium-Term Plan (IMTP) ~~for the Joint Committee~~
  - Provide support for the development and implementation of the Commissioning Assurance Framework and to subsequently provide assurance to the J~~C~~oint Committee in relation to the Commissioning Assurance Framework.
  - Contribute to and oversee the development of effectiveness of the Joint Committee's Annual Quality Statement and the Annual Governance Statement
  - Monitor quality via the Quality Dashboard.

- Monitor and receive reports on the organisation's progress with embedding and implementing the Health & Care Quality Standards
- Ensure arrangements are in place to review and act on clinical audit activity which responds to national and local priorities applicable to the business and services commissioned by the JCC as part of the commissioning cycle.
- Receive recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response.

Corporate Organisational Risk

11.8 Regularly review and provide assurance to the ~~Joint Committee~~JC on the risks included on the organisational Risk Register and assigned to the Sub-Committee by the Joint Committee.

Quality Improvement activities

11.9 ~~The Commissioning Assurance Framework provides the framework for quality improvement projects supporting compliance with the Duty of Quality.~~ The ~~Quality, Safety and Outcomes~~ Sub-Committee will:

- Provide scrutiny and assurance to the Joint Committee that priorities relating to quality, safety and outcomes are progressing.

11.10 **Patient Experience**

- Receive and review progress reports relating to Patient Experience and the emerging themes and trends identified in the performance management of providers and the NWJCC's escalation processes.~~requirements identified in the Commissioning Assurance Framework~~
- Ensure that the JCC engages with and co-operates with representatives of Llais as appropriate on ongoing patient engagement or major service change. (S.O. 7.7)

11.11 **Concerns**

- Receive~~ as presented within the quarterly quality report~~, reports on Concerns relating to the services commissioned by the NWJCC (reported patient safety incidents, complaints, compliments, clinical negligence claims and inquests) including reporting trends, with emphasis placed on ensuring that lessons are learnt and are built into the evaluation of services as part of the NWJCC's commissioning cycles.
- Receive assurance of effective and timely management of concerns (including incidents, complaints & claims) relating to commissioned services from across NHS Wales, in accordance with the legislation under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- Receive assurance of effective and timely management of concerns (including incidents, complaints & claims) contributing to LHB approaches providing information related to the services commissioned by the NWJCC to support them in complying with their ~~have~~ own legal and contractual requirements.

Delegated Powers

11.12 Although the ~~Joint Committee~~JC has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, the~~it~~ JC retains overall responsibility and accountability for ensuring the quality and safety of the services it commissions.~~,~~ ~~albeit~~Notwithstanding this, each LHB retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their ~~healthcare for its citizens through the effective governance of its~~ organisation.

11.13 This Sub-Committee is responsible for providing scrutiny and assurance to the ~~Joint Committee~~JC that Quality, Safety and Outcomes are being managed appropriately within the evaluation of services as part of the NWJCC's commissioning cycles.

The Sub-Committee will:

- Support the development of and sSeek assurance that the NWJCC's **Commissioning Assurance Framework** isremains appropriate, and is aligned to the Duty of Quality and ensuring that the duty is embedded in practice.
- Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:

    - Seeking assurance on the delivery of the NWJCC's Patient Experience Plan within the Commissioning Assurance Framework; and
    - Contributeing information from thea commissioning perspective to LHBs in their implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned through the commissioned service lens.

- Seek assurance that arrangements for the **provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:
    - the Commissioning Assurance Framework arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services
    - the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities
    - the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response
    - the development of the NWJCCJoint Committee's Annual Quality Statement including annual quality priorities; and
    - performance against key quality focussed performance indicators and metrics.

- Seek assurance on the arrangements in place to support **improvement and innovation**, including:
    - an overview of the research and development activity for commissioning within the organisation
    - alignment of the commissioning of services with the national objectives published by Health and Care Research Wales (HCRW);
    - an overview of the quality improvement activity for commissioned services within the organisation.

- Seek assurance that arrangements for commissioned services are **compliant with mental health legislation** are sufficient, effective and robust, including:
    - the Mental Health Act 1983
    - Mental Health Act Code of Practice for Wales and associated regulations (2016);
    - the Mental Capacity Act 2005 Code of Practice and associated regulations;
    - the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and associated regulations; and
    - the Mental Health Measure (Wales) 2010.

11.14 The Sub-Committee will seek assurances on the management of strategic risks delegated to the Sub-Committee by the Joint Committee, from the NWJCC Organisational Risk Register.

Dealing with Members interests during meetings

11.15 Declarations of interest will be a standing agenda item for all meetings.

11.16 Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for a meeting.

11.17 Interests declared at the start of, or during a meeting will be managed in accordance with section 8.2 of the NWJCC Standing Orders.

12 Reporting

12.1 The Sub-Committee Chair shall:

- Report formally, regularly and on a timely basis to the ~~Joint Committee~~JC on the Committee's activities. This includes:
  - Assurance that Quality, Safety and Outcomes are being managed appropriately
  - oral updates on recent activity
  - submission of written Sub-Committee highlight reports throughout the year
  - to receive annual reports, which will incorporate key information on quality, safety and outcomes.
- Bring to the ~~Joint Committee's~~JC's specific attention any significant matters under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the J~~Coint Committee~~ Chair, Chief Commissioner, LHB Chief Executive or Chairs of other relevant Sub-Committees of any urgent/critical matters that may affect the operation and/or reputation of the NWJCC and LHBs.

12.2 The Sub-Committee shall provide a written, annual report to the ~~Joint Committee~~JC on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Sub-Committees self-assessment and evaluation.

~~12.3 The Sub-Committee shall provide a highlight report to each HB after each meeting providing assurance that Quality, Safety and Outcomes are being managed appropriately, for inclusion on suitable HB Committee agendas.~~

~~12.4~~12.3 The ~~Joint Committee~~ JC may also require the Sub-Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Sub-Committee's assurance role relates to a joint or shared responsibility.

~~12.5~~12.4 The NWJCC Committee Secretary, on behalf of the J~~Coint Committee~~, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation.

Relationship with the Joint Committee and its Sub-Committees / Groups

~~12.6 Although the Joint Committee has delegated authority to the sub-committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and outcomes of healthcare for its commissioned services through the effective governance of its organisation.~~

~~12.7~~12.5 The Sub-Committee is directly accountable to the ~~Joint Committee~~ JC for its performance in exercising the functions set out in these Terms of Reference.

~~12.8~~12.6 The Sub-Committee, through the Sub-Committee Chair and members, shall work closely with the ~~Joint Committees~~NWJCC's other Sub-Committees to provide advice and assurance to the J~~C~~C through the:

- joint planning and co-ordination of JC~~Joint Committee~~ business; and
- sharing of information.

~~12.9~~12.7 In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the NWJCCs overall risk and assurance arrangements.

~~12.10~~12.8 The Sub-Committee, through its Chair and members, shall work closely with LHB Quality and Safety Committees to ensure that LHB Boards are informed of any issues relating to their population, recognising that concerns of the services commissioned by the JCC may impact on primary and secondary services and vice versa (i.e. the whole pathway). The Sub-Committee shall embed the JCC's standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

~~12.11~~12.9 The Sub-Committee shall embed the organisational values and strategic objectives through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

13 Applicability of Standing Orders to Sub-Committee Business

13.1 The requirements for the conduct of business as set out in the NWJCC Standing Orders are equally applicable to the operation of the Sub-Committee, except in the area relating to the quorum.

13.2 This Sub-Committee is a scrutiny and assurance sub-committee and therefore where a decision is required the matter will be referred to the NWJCC Senior Leadership Team or JC~~oint Committee~~, as appropriate.

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the NWJCC Committee Secretary as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with one other Lay (Independent) Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Sub-Committee for consideration and ratification.

14.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

15 In Committee (Private Meeting)

15.1 The Sub-Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16 Review

16.1 These Terms of Reference shall be adopted by the Sub-Committee at its first meeting and subject to review at least on an annual basis thereafter, with endorsement ~~ratified~~ by the ~~Joint Committee~~JC for onward approval by Health Boards.

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

Appendix 5

PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE (PPF)

Terms of Reference & Operating Arrangements
(Schedule 3.1 of the Standing Orders)

Document Author:	Committee Secretary
Lead Directors	Director of Finance and Value ~~Director of Finance and Information~~ Director of Corporate Strategy and Planning~~Director of Planning and Performance~~
Endorsed By	Joint Commissioning Committee ~~21 January 2025~~ 17 March 2026
Approved By	Health Boards – ~~January 2025~~ May 2027
Issue Date	~~4 February 2025~~ 26 May 2026
Review Date	~~12 January 2025~~ March 2027
Version	4

Contents

Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1	Health Boards	17 September 2024	Approved at HB September Board meetings	1 June 2025
Version 2	NWJCC Joint Commissioning Committee ~~JCC~~	21 January 2025	Endorsed	12 January 2025
Version 3	Health Boards	21 January 2025	Approved at HB Board meetings – with staff side rep removed.	12 January 2026
Version 3.1	PPF	26 February 2026	Endorsed at PPF subject to minor updates – added in commissioning Directors to regular attendees – 4.5 and wording of 4.7 amended to expected rather than required	-
Version 3.2	JCC	17 March 2026	Endorsed	- March 2027
Version 4	Health Boards	May 2026		- March 2027

Sub-Committee Arrangements:
This schedule forms part of, and shall have effect as if incorporated in the NHS Wales Joint Commissioning Committee Standing Orders.

1. Introduction & Constitution

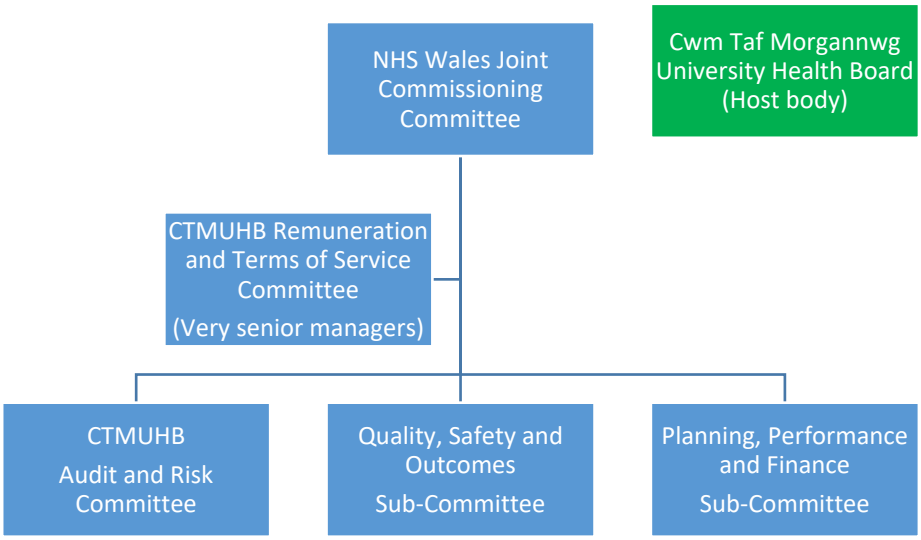
1.1 In accordance with NHS Wales Joint Commissioning Committee ("NWJCC") Standing Order 5.5, the ~~NHS Wales Joint Commissioning Committee (JCC – the~~ NWJCC Joint Committee~~)~~ (the "JC") may and, where directed by the Local Health Boards ("LHB") ~~Boards~~ jointly, or the Welsh Ministers must, appoint joint sub-committees of the NWJCC either to undertake specific functions on the NWJCC's behalf or to provide advice and assurance to others (whether directly to the NWJCC or on behalf of the NWJCC to each LHB Board and/or its other sub-committees). The NWJCC shall determine, for agreement by the LHBs, a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.

1.2 In accordance with Standing Orders (SOs) (and the NWJCC Scheme of Delegation), the JC~~Joint Committee~~ shall nominate annually a sub-committee to be known as the **Planning, Performance and Finance Sub-Committee**. The detailed terms of reference and operating arrangements set by the JC~~Joint Committee~~ in respect of this sub-committee are set out below.

2. Purpose

2.1 The purpose of the Planning, Performance and Finance Sub-Committee ("the Sub-Committee") is to be assured that the JC~~Joint Committee~~ is effectively managing the strategic planning, performance and financial duties outlined in the NWJCC's~~Joint Committees~~ SOs and Standing Financial Instructions (SFIs) relating to planning, securing and commissioning the services delegated to the NWJCC on behalf of LHBs in Wales.

Figure 1 – NWJCC Sub Committee Structure



3. Scope and Duties

The Sub-Committee will provide scrutiny and assurance in relation to the duties below:

3.1 **Planning**

- Monitor the process for the development of the Integrated ~~Medium Term~~Medium-Term Plan (IMTP) in line with the relevant SOs, SFIs and the NHS Wales Planning Framework
- Receive assurance on the delivery of the IMTP
- Scrutinise the alignment of service, workforce, digital and financial commissioning plans in the IMTP (as appropriate to the business of the NWJCC)
- Scrutinise the development and delivery of strategic or major service plans through the agreed Service Transformation Programme in the IMTP.

3.2 **Performance**

- Advise on and assure the development and implementation of the NWJCC's Performance Management Framework
- Monitor in-year performance against the financial plan and activity targets that support the relevant metrics agreed by the JC~~Joint Committee~~
- Monitor overall performance of commissioned services against the NWJCC's IMTP and the national targets for NHS Wales (Ministerial Priorities).

3.3 **Organisational Risk Register**

- Regularly review and scrutinise the planning, performance and finance risks included on the NWJCC Risk Register and assigned to the Sub-Committee by the NWJCC.

3.4 **Finance**

- Monitor delivery of financial plans and savings programmes
- Monitor risk to financial delivery including mitigating actions to appropriately manage the risks
- Robustly challenge and support progress against delivery of savings plans including consideration of impact on services
- Scrutinise investments in line with the Standing Financial Instructions (SFIs) and the Scheme of Delegation prior to submission to the JC~~Joint Committee~~ for approval
- Monitor activity and productivity including operational efficiency and effectiveness
- Report on significant financial variances and issues, including potential mitigation decisions.

3.5 **Sub-Committee Programme of work**

Each year the JC~~Joint Committee~~ will determine the Sub-Committee's priorities for its annual programme of work, based on the NWJCC's~~Joint Committee's~~ IMTP and Organisational ~~Corporate~~ Risk Register. This approach will ensure that the Sub-Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Sub-Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Sub-Committee's programme of work will be dynamic and flexible to meet the needs of the JC ~~Joint Committee~~ throughout the year.

3.6 The Sub-Committee, in monitoring and scrutinising the above areas, will discuss and recommend corrective action where necessary. This will include the transformation, recommissioning and value in health care approach.

3.7 The Sub-Committee will monitor the development of appropriate Key Performance Indicators (KPIs) across all parts of the organisation.

3.8 Where necessary, the Sub-Committee will undertake detailed "deep dives" of specific areas. These reviews will be supported by appropriate benchmarking information to ensure all of the NWJCCs commissioned services are striving to achieve "best in class" in relation to planning, performance and finance.

~~3.8~~3.9The Sub-Committee will provide onward assurance to the JC on all matters relating to its annual programme of work, as delegated.

4. Membership

Members

4.1 The Membership of the PPF~~SC~~ Sub-Committee is as follows:

Chair	Lay (Independent) Member of the JCC
Vice Chair	Lay (Independent) Member of the JCC
Member	One further Lay (Independent) Member of the JCC

Health Board Member	Two ~~One~~ LHB ~~representative~~ Chief Executive representatives, who shall alternate attendance, or designated nominated deputy who must be an Executive Director from a health board (and would be fully briefed on the issues to be discussed)

4.2 The membership of the Sub-Committee shall be determined by the JC ~~Joint Committee~~, based on the recommendation of the Chair of the JC~~Joint Committee~~ and lay members, taking account of the balance of skills and expertise necessary to deliver the sub-committee's remit and subject to any specific requirements or directions made by Ministers or the Welsh Government.

~~4.3 The Chair of the Joint Committee and the Chair of the Sub-Committee, will receive a nomination from the CEOs of Local Health Boards as outlined below.~~

4.~~4~~4.3 The Membership will be reviewed annually.

Support to Sub-Committee Members

4.~~5~~4.4 The Committee Secretary, on behalf of the Sub-Committee Chair, shall:

- Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role, and
- Co-ordinate the provision of a programme of organisational development for Sub-Committee members as part of the overall JCCs Organisational Development programme.

4.~~6~~4.5 **In Attendance**

Director of Corporate Strategy and Planning ~~JCC Director of Planning and Performance~~ (co-lead JCC Director)
Director of Finance and Value ~~JCC Director of Finance & Information~~ (co-lead JCC Director)
JCC Director of Commissioning for Specialised Services
JCC Director of Commissioning for Ambulance and 111
JCC Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MH, LD & VG)
Committee Secretary or representative who will routinely attend meetings ensuring governance support and advice is available to the Sub-Committee Chair

Directors may on occasion nominate a suitably senior deputy to attend the Sub-Committee on their behalf but should ensure that they are fully aware and briefed on the issues to be discussed.

By Invitation:

4.~~7~~4.6 The Chief Commissioner, and other directors / senior managers may be invited to attend when the Sub-Committee is discussing areas of risk,

audit/review findings or matters that are the responsibility of that Director / member of staff.

4.84.7 The Sub-Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Member Appointments

4.94.8 The membership of the Sub-Committee shall be determined by the Chair of the JCJoint Committee, taking account of the balance of skills and expertise necessary to deliver the sub-committee's remit and subject to any specific requirements or directions made by the Welsh Government.

5 Quorum & Attendance

5.1 A quorum shall be at least two members comprising of two Lay (Independent) Members.

5.2 For effective governance, the Director of Finance and Value Information and the Director of Corporate Strategy and Planning Director of Planning and Performance are required expected to attend all meetings.

6 Meeting Secretariat

6.1 The JCC Committee Secretary will determine the secretarial and support arrangements for the Sub-Committee.

7 Frequency of Meetings

7.1 The Meetings shall meet no less than 6 times a year, and otherwise as deemed necessary by the Chair of the Joint Committee.

7.2 Additional meetings may be called as appropriate with agreement of the Sub-Committee Chair.

7.3 Additional meetings may be held with the chairs of the LHBs Planning, Performance and Finance Committees where there is requirement.

7.4 Members will be expected required to attend a minimum of 75% of all meetings. Attendance will be monitored and reported to the Joint Committee through the Sub-Committee's Annual Report.

7.5 The Sub-Committee will arrange meetings and align with key statutory requirements during the year consistent with the Joint Committee's annual plan of Business.

8 Withdrawal of Individuals in Attendance

8.1 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of specific matters.

9 Circulation of Papers

9.1 All papers will be distributed at least 57 ~~calendar~~ clear days in advance of the meeting.

9.2 The Committee Secretary~~iat~~ will ensure that the draft minutes will be provided to the Sub-Committee Chair within ten working days following the meeting.

9.3 The ~~JCC~~ Committee Secretary~~iat~~ will ensure that a Sub-Committee highlight report is provided for presentation by the Sub-Committee Chair to the next Joint Committee meeting.

9.4 The Sub-Committee highlight report will also be shared with members and HB Directors of Corporate Governance / Board Secretaries.

10 Access

10.1 The Chair of the Planning, Performance and Finance Sub-Committee shall work closely with the Director of Finance and Value ~~Information~~ and the Director of Corporate Strategy and Planning ~~Director of Planning and Performance~~ and have reasonable access to the NWJCC Directors and other relevant senior staff within the NWJCC Team.

11 Accountability, Responsibility & Authority

11.1 Although LHBs ~~health boards~~ have delegated authority to the JC~~Joint Committee~~ and subsequently to this Sub-Committee for the exercise of certain functions as set out within these terms of reference, each LHB~~health board~~ retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their organisation.

11.2 This Sub-Committee is responsible for providing scrutiny and assurance to the JC~~JCC~~ that Planning, Performance and Finance are being managed appropriately within the commissioning cycles for the services commissioned by the NWJCC.

Authority

11.3 The Sub-Committee is authorised by the JC~~Joint Committee~~ to investigate~~,~~ ~~or have investigated,~~ any activity within its terms of reference.

~~11.3~~11.4 The Sub-Committee is authorised by the JC~~Joint Committee~~ to obtain outside legal or other independent professional and clinical advice and to secure the attendance of relevant external experts~~outsiders with relevant experience and expertise~~ if it considers it necessary to support the Sub-

Committee in the discharge of its duties. Such advice will be sought ~~,~~ in accordance with the NWJCCs procurement, budgetary and other procedural and policy requirements.

Sub Groups

~~11.4~~11.5 The Sub-Committee may, subject to the approval of the JC~~C~~ establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business.

Delegated Powers

~~11.5~~11.6 Although the JC~~Joint Committee~~ has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, ~~it~~ the JC retains overall responsibility and accountability for ensuring the quality and safety of the services it commissions. ~~,~~ Notwithstanding this,~~albeit~~ each LHB retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their ~~its citizens~~ through the effective governance of their ~~its~~ organisation.

Dealing with Members interests during meetings

~~11.6~~11.7 Declarations of interest will be a standing agenda item for all meetings.

~~11.7~~11.8 Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for a meeting.

~~11.8~~11.9 Interests declared at the start of, or during a meeting will be managed in accordance with section 8.2 of the NWJCC Standing Orders.

12 Reporting

12.1 The Sub-Committee Chair shall:

- Report formally, regularly and on a timely basis to the JC~~Joint Committee~~ on the Sub-Committee's activities. This includes:
  - Assurance that Planning, Performance and Finance matters are being managed appropriately
  - oral updates on recent activity
  - submission of written Sub-Committee highlight reports throughout the year
  - to receive annual reports, which will incorporate key information on planning, performance and finance
- Bring to the JC's~~Joint Committee's~~ specific attention any significant matters under consideration by the Sub-Committee; and
- Ensure appropriate escalation arrangements are in place to alert the JC~~Joint Committee~~ Chair, Chief Commissioner, LHB Chief Executive or Chairs of other relevant Sub-Committees of any urgent/critical matters that may affect the operation and/or reputation of the NWJCC and LHBs.

12.2 The Sub-Committee shall provide a written, annual report to the JCJoint Committee on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Sub-Committees self-assessment and evaluation.

12.2 The Sub-Committee shall provide a highlight report to each HB after each meeting providing assurance that Planning, Performance and Finance are being managed appropriately, for inclusion on suitable HB Sub-Committee agendas.

12.3 The JCJoint Committee may also require the Sub-Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Sub-Committee's assurance role relates to a joint or shared responsibility.

12.4 The NWJCCJCC Committee Secretary, on behalf of the JCJoint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation.

Relationship with the Joint Committee and its Sub-Committees / Groups

12.5 Although the Joint Committee has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the effective planning, performance and financial management of healthcare for commissioned services through the effective governance of its organisation.

12.612.5 The Sub-Committee is directly accountable to the JCJoint Committee for its performance in exercising the functions set out in these Terms of Reference.

12.712.6 The Sub-Committee, through the Sub-Committee Chair and members, shall work closely with the JCJoint Committees other Sub-Committees to provide advice and assurance to the JCC through the:

- joint planning and co-ordination of JCC and Committee business; and
- sharing of information.

12.812.7 In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the NWJCCs overall risk and assurance arrangements.

12.912.8 The Sub-Committee, through its Chair and members, shall work closely with LHB Planning, Performance and Finance Committees to ensure that LHB Boards are informed of any issues relating to their population, recognising that concerns of the services commissioned by the NWJCC may impact on primary and secondary services and vice versa (i.e. the whole pathway). The Sub-Committee shall embed the NWJCC's standards,

priorities and requirements e.g. equality and human rights, through the conduct of its business.

~~12.10~~12.9 The Sub-Committee shall embed the organisational values and strategic objectives through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

13 Applicability of Standing Orders to Sub-Committee Business

13.1 The requirements for the conduct of business as set out in the NWJCC Standing Orders are equally applicable to the operation of the Sub-Committee, except in the area relating to the quorum.

13.2 This Sub-Committee is a scrutiny and assurance sub-committee and therefore where a decision is required the matter will be referred to the NWJCC Senior Leadership Team or JC~~Joint Committee~~, as appropriate.

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the NWJCC Committee Secretary as appropriate, may deal with the matter on behalf of the Sub-Committee, after first consulting with one other Lay (Independent) Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

14.2 Chair's urgent action may not be taken where the sub-committee Chair has a personal or business interest in the urgent matter requiring decision.

15 In Committee (Private Meeting)

15.1 The Sub-Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16 Review

16.1 These Terms of Reference shall be adopted by the Sub-Committee at its first meeting and subject to review at least on an annual basis thereafter, with endorsement ~~ratified~~ by the JC~~Joint Committee~~~~.~~ for onward approval by Health Boards.

ASSURANCE REPORT
NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Services Partnership Committee**
Chaired by	Professor Tracy Myhill OBE, NWSSP Chair
Lead Executive	Neil Frow OBE, Managing Director, NWSSP
Author and Contact Details	Roxann Davies, Corporate Services Manager and James Quance, Assistant Director of Corporate Services
Date of Meeting	19 March 2026

Summary of key matters including achievements and progress considered by the Committee and any related decisions made

Chair's Report - The Chair updated the Committee on her activities since the meeting held on 22 January 2026. This included attendance at Chairs' meetings in January and February, with detailed discussion at the February meeting on the Welsh Risk Pool and its associated financial challenges. She also reported progress on the Governance and Accountability Review, attendance at Welsh Risk Pool meetings, and her contribution to Welsh Government work to develop a procedure for the performance management, removal and suspension of non-officer members across NHS Wales, drawing on her HR expertise. Additional activity included attendance at the NWSSP Audit Committee with Velindre, engagement with Welsh Government, Velindre and NWSSP on the Review Implementation Group, one-to-one meetings with the Chief Executive, and participation in the NWSSP Health and Wellbeing Conference, where she spoke on resilience. Forthcoming commitments were outlined, including further Chairs' and governance meetings and a joint session with Chairs, Chief Executives and the Director General.

Chair reflected on her 4.5-year tenure and thanked the Committee, Vice Chair, Senior Leadership Group and colleagues for their support and constructive challenge. She highlighted a number of key achievements and NWSSP's contribution during and beyond the COVID-19 pandemic, confirmed her intention to continue supporting NHS Wales in a different capacity, and expressed confidence in NWSSP's future. Committee Members formally recorded their thanks, noting the Chair's leadership, partnership working and the positive culture established during her tenure.

The Committee **NOTED** the Chair's Report.

Chair's Action – Ratification of All Wales e-Rostering Solution - The Committee **RATIFIED** the Chair's Urgent Action taken between meetings to approve the expansion of the All Wales e-Rostering contract to include Cardiff and Vale University Health Board medical and dental staff. It was confirmed that the action was taken in line with the Scheme of Delegation, that all necessary approvals had been secured, and that appropriate governance processes had been followed. For assurance, it was noted that Velindre Trust Board approval had also been sought and would be ratified via Chair's Action at the Trust Board meeting on 26 March 2026, and that a further paper would address the on-boarding of additional Health Boards.

Managing Director Update - The Managing Director presented a comprehensive update on key developments across NWSSP since the previous meeting. This included progress on the Governance and Accountability Review, with the Implementation Group meeting regularly and the review confirming the governance framework as fundamentally sound, with recommendations in hand to strengthen assurance. An update was provided on the Welsh Risk Pool, noting that the £49m Welsh Government support for 2025–26 is non-recurrent, creating future financial pressure. Work is underway to strengthen forecasting, data quality, transparency and mitigation, alongside a renewed focus on prevention, clinical learning and reducing patient harm as the root cause of risk. Committee Members emphasised the need for clearer response planning, improved intermediate-level intelligence and stronger system learning, with assurance provided on actions underway to address these issues.

Updates were also provided on the implementation of the Resident Doctor contract, highlighting complexity and risk, with a comprehensive update and future deep dive scheduled; workforce streamlining and supply challenges, including data gaps and funding constraints, with coordinated oversight in place; recent senior leadership appointments for the Medical Director and the Director of Pharmacy Technical Services; emerging work on the future hosting of NHS Employers; and accommodation challenges linked to the TrAMS programme, with a proposal submitted to Welsh Government.

The overarching report provided the Committee with updates across a range of service areas, including Transforming Access to Medicines (TrAMs), Radiopharmacy and the Hub Programme; the NHS Wales Influenza Vaccination Programme; a Procurement Services overview (including the potential impact of the Middle Eastern conflict and issues relating to Hi-Fatigue G bone cement); Primary Care Services and the Medical Examiner Service (including the Workforce Intelligence System and misdirected mail); Laundry Services; decarbonisation and adaptation activity; accommodation; engagement and leadership activity; and awards and recognition.

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

Items for Approval

Chair's Recruitment - The Committee **APPROVED** the recruitment arrangements for the appointment of the next NWSSP Chair by the SSPC, informed by the Governance and Accountability Review and ongoing engagement with Welsh Government, and Velindre as host. It was noted that further discussions had resulted in a revised and proportionate approach that aligns with a public appointment process, whilst remaining deliverable within the required timescales. The Committee agreed to proceed with Option 3, including the proposed composition of the appointment panel, the establishment of a stakeholder panel, and the progression of a minor amendment to the SSPC Standing Orders in collaboration with Velindre colleagues. It was confirmed that the recommendation of the appointment panel would return to the full Committee, for discussion.

All Wales e-Rostering System - The Committee **APPROVED** the award relating to the expansion of the All Wales e-Rostering contract to include Medical and Dental staff and to novate current local Medical and Dental contracts for Betsi Cadwaladr, Cwm Taf Morgannwg, Hywel Dda and Swansea Bay University Health Boards. It was noted that other NHS organisations may join the arrangements at a future point in time, requiring a Change Control Notice. Assurance was provided that the expansion aligns with the implementation of the Resident Doctor contract, is anticipated within the original procurement, complies with contractual and governance requirements, presenting no financial risk to NWSSP or Velindre, with corresponding approval to be sought from the

Velindre Trust Board.

Oversight Arrangements for NHS Wales Energy Procurement and Contract Management - The Committee **APPROVED** the revised Terms of Reference for the Wales Energy Group (WEG) and Wales Energy Operational Group (WEOG), following a review requested by the Committee to ensure proportionate and effective oversight. Assurance was provided that the arrangements are streamlined, reflect mature procurement and contract management processes, retain flexibility to respond to market volatility, and that arrangements had been supported by Directors of Finance.

Overarching Service Level Agreement (SLA) for 2026–27 - The Committee **APPROVED** the annual update to the overarching SLA for 206-27, noting that it had been reviewed by NWSSP Legal and Risk Services and that no fundamental changes were proposed. Assurance was provided that amendments were limited to clarification and incremental improvements, and that the SLA had been uplifted by 1.1% in line with the unequivocal pass-through expectation set by Welsh Government, reflecting ongoing engagement with Service Leads throughout the year, alongside end-of-year clarification.

All Wales Laundry Services Service Level Agreement (SLA) for 2026–27 - The Committee considered **APPROVED** revised All Wales Laundry Services SLA, noting that it provides the operational framework and performance metrics for the service. Assurance was provided that the document had been developed through stakeholder consultation, remains broadly consistent with the previous SLA, includes targeted amendments to improve clarity and alignment with standards, and had received positive feedback from customers.

Provision of Radiopharmaceutical Products Service Level Agreement (SLA)for 2026–29 - The Committee **APPROVED** the SLA for the provision of radiopharmaceutical products from NWSSP Pharmacy. Assurance was provided that the SLA had been developed through extensive stakeholder engagement and multi-stage review, sets out service scope, quality, performance and pricing arrangements, and supports readiness for service go-live in summer 2026, including transition arrangements with Swansea Bay University Health Board.

Items for Noting and Discussion

NWSSP Integrated Medium-Term Plan (IMTP) 2026–2029 – Financial Position Update - The Committee received the update to the financial position underpinning the NWSSP IMTP, relating to the underlying £0.744m deficit arising from unfunded employer national insurance costs had now been fully mitigated through the identification of recurrent savings. Assurance was provided that the IMTP has been updated to reflect a balanced position, with no other changes from those previously agreed, and remains on track for submission in line with planning deadlines. Opportunities to further support NHS Wales through an opportunities pipeline will be developed and brought back as part of the 2026–27 work plan. The Committee **NOTED** the amendments and continued to **ENDORSE** submission of the IMTP to Welsh Government.

Future NHS Workforce Solution Briefing - The Committee received an update on progress with the Future NHS Workforce Solution, noting confirmation of early adopter status for NWSSP alongside DHCW, Hywel Dda and HEIW, intended to ensure strong Welsh influence over system design. Committee Members noted ongoing risks and challenges associated with data quality, system design and delivery, and the scale of change involved. Assurance was provided that governance, reporting and escalation arrangements are in place, with continued engagement at national level and further detailed updates

scheduled. The Committee **NOTED** the progress made and **ENDORSED** the early adopter status for NWSSP.

Transforming Access to Medicines Services (TrAMS) Programme and Service Management Board Update - The Committee **NOTED** the update provided, noting the six-month review of the Programme Board Terms of Reference and confirmation that full representative membership from across NHS Wales is now in place. It was noted that no further changes are planned at this stage, with the next review aligned to the phased opening of the South-East Radiopharmacy and the establishment of a Service Management Board to oversee delivery and performance.

Finance, Performance, People, Programme and Governance Updates

Finance Report – The Committee noted the financial position as break-even at the end of February 2026, with the full-year forecast also at break-even following agreed distributions of £6m and the offsetting of the National Insurance savings. Capital expenditure remains within the approved allocation and agreed with Welsh Government, with minor in-year profile adjustments for Radiopharmacy and TrAMS schemes. An update on the Welsh Risk Pool confirmed the forecast position at £194.5m, requiring the full £49m Welsh Government allocation, with the risks at the upper end of the range not yet having materialised. The focus was now on year-end closure and review of the position for 2026–27.

People and Organisational Development (POD) Report – The Committee noted the latest workforce position as at February 2026. The report confirmed staff turnover remains slightly above the NHS Wales average, with further analysis underway, sickness absence remains stable, and progress continues across wellbeing, inclusion, leadership development and employee experience initiatives.

Performance Information Report – The Committee noted strong performance against agreed KPIs from October 2025 to January 2026, with two indicators below target and appropriate explanations and improvement actions in place. Committee Members welcomed the positive performance position while challenging whether current targets remain sufficiently ambitious, with assurance provided that this will be reviewed to ensure measures continue to drive improvement and value.

Outcome Measures Report – The Committee noted the report focused on outcomes aligned to NWSSP's strategic objectives across services, people and value, continuing to demonstrate NWSSP's value and impact. Strong performance across customer satisfaction, workforce engagement, professional influence and decarbonisation was reported. Committee Members noted enhancements to reporting and confirmed that outcome measures will continue to evolve, including greater benchmarking and trend analysis in future reports.

Transformation Management Office (TMO) Update Report – The Committee noted the update on the breadth of programme activity underway within the TMO. Oversight of a portfolio of 20 live initiatives was reported and generally positive delivery status across major programmes. Improvements in project RAG status were noted, alongside the addition of new projects. Committee Members reiterated the need to ensure delivery pace and challenge remain appropriate given the consistently positive position.

Integrated Medium-Term Plan (IMTP) Quarter 3 of 2025–26 Update - The Committee noted the latest progress update for quarter 3 of 2025-26, providing assurance on delivery of the plan and the effectiveness of quarterly monitoring arrangements. Most

objectives remain on track, with a small number at risk due to capacity or external factors. Committee Members highlighted the need for greater pace in specific areas, including Scan4Safety, with further benchmarking and costing work underway to inform future planning.

NWSSP Corporate Risk Register – The Committee noted the latest update with the current risk profile, including six red-rated risks relating to cyber security, pharmaceutical supply, TrAMS and Radiopharmacy delivery, financial and workforce pressures, the Future Workforce Solution and Welsh Risk Pool forecasting. It was noted that several risks are stable or reducing, due to management actions, with one new risk escalated relating to Resident Doctor terms and conditions.

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

Items for Information

The Committee received the following items for information:

- Finance Monitoring Returns (Months 9, 10 and 11)
- Personal Protective Equipment (PPE) Report
- NWSSP Audit Committee Assurance Report from 10 February 2026
- SSPC Forward Plan 2026-27

Part B - Private

The Committee **APPROVED** the proposals for Future Workforce Solution Charges, Linen Products and Microsoft Enterprise Agreement.

Matters requiring Board/Committee level consideration and/or approval

The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.

Date of Next Meeting	Thursday 14 May 2026, 10.00am to 12.00pm

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Health Board

ALL WALES APPROVED CLINICIANS AND SECTION 12(2) DOCTORS

BOARD REPORT – MAY 2026

Date of Meeting	28 May 2026
Publication Status	Open/Public Not Applicable
Report Author name and title	Meryl Roberts, All Wales Approvals Manager
Lead Executive Team Member name and title	Dr Clara Day, Executive Medical Director

Report Purpose	Endorse for Board Approval

Executive Summary

This report summarises recent approvals for **Approved Clinicians** and **Section 12(2) Doctors** across Wales, ensuring compliance with the Mental Health Act 1983 (amended 2007) and written approval processes. Betsi Cadwaladr University Health Board is the central approving board for all Health Boards and exercises this delegated function on behalf of Welsh Government.

Applications for approval under the Mental Health Act are checked and scrutinised by the Approvals Team then assessed by the All Wales Approval Panel who make recommendations for approval. The Approval Panel comprises of clinical Panel Members, a Vice-Chair and Chair drawn from all Health Boards and several Local Authorities. The Panel's recommendations for approval are then submitted in writing to the Executive Medical Director for approval using authority delegated at the March 2023 Board meeting. The Panel's recommendations are submitting in writing to the Executive Medical Director for approval, using authority delegated by the Board in March 2023. Approvals are then fully reported and ratified by the Board through this paper.

The approval process complies with Welsh Government delegated authority, Mental Health Act legislation, policies and written approval processes. It promotes transparency with details of recent approvals listed in Appendices 1 and 2.

Board Actions Requested:

- Note the contents of the report.
- Ratify the Approved Clinician and Section 12(2) approvals contained within Appendices 1 and 2.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Dates**	**Outcome, Evidence and Data**
Internal action letters submitted by the All Wales Approvals Manager to Deputy Executive Medical Director (DEMD) seeking ratification of Panel recommendations for approval, reapproval, reinstatement of approval and suspension of approval.	March 2026 to May 2026 Details below	Please see below.
DEMD	17.03.2026	Action letter submitted and approved
DEMD	24.03.2026	Action letter submitted and approved
DEMD	24.03.2026	Additional Action letter submitted and approved
DEMD	01.04.2026	Action letter submitted and approved
DEMD	10.04.2026	Action letter submitted and approved
DEMD	14.04.2026	Action letter submitted and approved
DEMD	21.04.2026	Action letter submitted and approved
DEMD	28.04.2026	Action letter submitted and approved
DEMD	01.05.2026	Action letter submitted and approved
DEMD	08.05.2026	Action letter submitted and approved
Acronyms / Glossary of Terms		
DEMD	Deputy Executive Medical Director	

All Wales Approved Clinicians and Section 12(2) Doctors – Board Assurance

1. SITUATION

1.1 This report provides Board assurance on the operation of the All Wales Approved Clinicians and Section 12(2) Doctors approval process and seeks ratification of approvals; authorised under delegated authority.

2 BACKGROUND

2.1 Betsi Cadwaladr University Health Board undertakes the All Wales approval function for all Health Boards on behalf of Welsh Government. Approvals for

approved clinicians are made in accordance with the Mental Health Act 1983 (amended 2007), the Approved Clinicians (Wales) Directions 2018, the Approval of Approved Clinicians Welsh Government Guidance Document and the All Wales Approved Clinician Procedural Arrangements Document. Approvals for Section 12(2) Doctors are made in accordance with the Mental Health Act 1983 (amended 2007) and the All Wales Section 12(2) Process and Criteria Document.

2.2 Applications for approval are scrutinised by the Approvals Team then assessed against written criteria by the All Wales Approval Panel.

3 SPECIFIC MATTERS FOR CONSIDERATION

3.1 Ratification of approvals previously authorised via action letter by the Executive Medical Director or the Deputy Executive Medical Director.

4 KEY RISKS / MATTERS FOR ESCALATION

4.1 No significant risks identified.

5 RECOMMENDATIONS

5.1 The Board is asked to:

- Ratify approvals

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

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** Choose an item.	**Domains of Quality** Choose an item.
	If more than one applies, please list below:	If more than one applies, please list below:
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	Choose an item.	
	If more than one applies, please list:	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	A formal assessment is not required as the report relates solely to governance and assurance arrangements

		only and does not introduce changes to service delivery.
	If no, please include rationale:	
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Legal	Yes (Include further detail below)	
	The approval and ratification processes described in this report are undertaken in accordance with Welsh Minister delegation to Betsi Cadwaladr University Health Board, the Mental Health Act (1983) (as amended), Welsh Government Guidance document, Approved Clinician Directions 2018 and S12(2) Process and Criteria Document (the written approval process). There are no identified legal concerns arising from the recommendations within this report.	
Reputational	Yes (Include further detail below)	
	Robust governance of Approved Clinicians and Section 12(2) Doctor approvals is essential to maintaining public protection and public confidence in mental health services in Wales.	

	The arrangements outlined in this report provide high level assurance that approvals are subject to appropriate scrutiny, transparency and Board oversight. No reputational risks have been identified.
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.
	There is no direct financial or workforce impact arising from the matters outlined in this report. The activity described, represents continuation of existing All Wales approval arrangements within current resources.

APPENDIX 1

Update of Register of Approved Clinicians in Wales	
	Approved Clinicians
Approvals and Re-approvals	20
Approvals suspended	1
Approvals re-instated	1
Left Wales and Removed from Register)	3
Retired	0
No longer Registered or Licensed to Practise with Professional Body	1
Transferred from AC register (to S12 Register)	0
Removed from S12 – Became AC approved	0
Approval Ended	1
Death in Service	0
Performance Metrics Reporting period: 11th March 2026 – 11th May 2026	
Total number of AC applications processed	27
Number awaiting completion of application by the applicant	2
Pending Approvals	5
Average approval time per completed application.	14.6 days
Number of lapsed approvals due to missed deadlines by the applicant	0

APPENDIX 1

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

Update of Register of Approved Clinicians - Wales

Ratification Period: 11th March 2026 – 11th May 2026

Approvals and Re-approvals: 20

Surname	First Name	Workplace	Date Approval Expires
Rema	Samuel	Betsi Cadwaladr University Health Board, Bryn Hesketh Unit, Colwyn Bay Hospital, Hesketh Road, Colwyn Bay, Conwy, LL29 8AT.	11th March 2031
Ethirmannasingam	Indra	Betsi Cadwaladr University Health Board, CAMHS, Talarfon, Holyhead Road, Bangor LL57 2EE.	11th March 2031
Duba	Bongani Innocent	Cardiff and Vale University Health Board, St David's Children's Centre, St David's Hospital, Cowbridge Road East, Cardiff, CF11 9XB	26th March 2028
Turic	Dragana	Cardiff and Vale University Health Board, Barry Hospital, Colcot Road, Barry, CF62 8YH	19th March 2031
Sohail	Faryal	Hywel Dda University Health Board, Heddfan, Glangwili Hospital, Dolgwili Road, Carmarthen, SA31 2AF	19th March 2031
Pranay	Pratyush	Aneurin Bevan University Health Board, 6 Gold Tops, Newport, Gwent, NP20 4PG	21st March 2031

Surname	First Name	Workplace	Date Approval Expires
Oluwajulugbe	Philip	Aneurin Bevan University Health Board, Cwm Coch Hospital, Ebbw Vale, NP23 6GL	22nd March 2031
Abdellatalif	Mostafa	Betsi Cadwaladr University Health Board, North Wales Adolescent Service (NWAS) – Kestrel Ward, Abergele Hospital, Llanfair Road, Abergele, LL22 8DP and Child & Adolescent Learning Disability Service (CALDS), Denbighshire Children's Centre, Hyfrydle Lawnt, Denbigh, LL16 4ST	22nd March 2031
Sameem	Hafeesa	Cwm Taf Morgannwg University Health Board, Taff Ely CMHT, Dewi Sant Health Park, Albert Road, Pontypridd, CF37 1LB	31st March 2031
Sharma	Sanjeev	Cwm Taf Morgannwg University Health Board, Tonteg Child and Adolescent Clinic, Tonteg Hospital, Church Village, Pontypridd	9th April 2031
Dojcinov	Ivana	Iris Care Group, Pinetree Court Independent Hospital, 904 Newport Road, Rumney, Cardiff, CF3 4LL	12th April 2031
Price	Jonathan	Betsi Cadwaladr University Health Board, Hergest Unit, Ysbyty Gwynedd, Bangor, LL57 2PW	12th April 2031
Callaghan	Rhiannon	Cardiff and Vale University Health Board, MHSOP, Llanfair Unit, University Hospital Llandough, Penlan Road, Llandough, Cardiff, CF64 2XX	13th April 2031
Prew	Thomas	Cardiff and Vale University Health Board, Links Centre, Cardiff Royal Infirmary, Glossop Road, Cardiff, CF24 0SZ	14th April 2031
del mar Adrover-Amengual	Maria	Swansea Bay University Health Board, Ty Penfro, 67a, Pembroke Road, Cardiff, CF5 1QQ	15th April 2031
Hales	Heidi Joanna	Betsi Cadwaladr University Health Board, North Wales Adolescent Service (NWAS) • Gwasanaeth Pobl Ifanc Gogledd Cymru (NWAS) Abergele Hospital, Llanfair Road, Abergele, LL22 8DP	20th April 2031
Rafiq	Nabeela	Aneurin Bevan University Health Board, Caerphilly Older Adults CMHT Services, Ysbyty Ystrad Fawr, Ystrad Fawr Way, Ystrad Mynach, Hengoed, CF82 7 GP	23rd April 2031

Surname	First Name	Workplace	Date Approval Expires
Jayawickrama	Dilum	Priory Healthcare, Llanarth Court Hospital, Raglan, Usk, Monmouthshire, NP15 2YD	26th April 2031
Bugelli	Tania	Betsi Cadwaladr University Health Board, Liaison Psychiatry Department, Ablett Unit, Ysbyty Glan Clwyd, Sarn Lane, Bodelwyddan, Rhyl, LL18 5UJ	27th April 2031
Graver	Faye	Betsi Cadwaladr University Health Board, Substance Misuse Service, 5-7 Brighton Road, Rhyl, Denbighshire, LL18 3EY	29th April 2031

Approval Suspended: 1 *(CCT not yet received)

Surname	First Name	Workplace	Date Approval Expires
*Mustafa	Saima	Betsi Cadwaladr University Health Board, Heddfan Psychiatric Unit, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD	19th February 2031

Approvals Reinstated: 1

Surname	First Name	Workplace	Date Approval Expires
Tint	Aung	Betsi Cadwaladr University Health Board, Hergest Unit, Ysbyty Gwynedd, Bangor, LL57 2PW	27th April 2027

Left Wales and Removed from AC Register: 3

Surname	First Name	Workplace	Date Approval Expired/Expires
Odume	Anthony	Betsi Cadwaladr University Health Board, Hergest Unit, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW.	3rd May 2026

Surname	First Name	Workplace	Date Approval Expired/Expires
Sreenath	Narasimhamurthy Sanghalli	Betsi Cadwaladr University Health Board, Heddfan Mental Health Unit, Maelor Hospital, Croesnewydd Road, Wrexham, LL14 7TD	12th July 2026
Reagu	Shuja	Elysium Healthcare, Aberbeeg Hospital, Aberbeeg, Abertillery, NP13 2DA	19th February 2029

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

No longer Registered or Licensed to Practice with Professional Body: 1

Surname	First Name	Workplace	Date Approval Ended
Dye	Timothy Edward	Cwm Taf Morgannwg University Health Board, Cynon Community Mental Health Team, Ysbyty Cwm Cynon, New Road, Mountain Ash CF45 4BZ	31st March 2026

Transferred from AC Register to S12 Register: 0

Surname	First Name	Workplace	Date Approval Expires

Approval Expired or Ended: 1

Surname	First Name	Workplace	Date Approval Expired
Fasehun	Adedamola	Formerly of Betsi Cadwaladr University Health Board, Cefni Hospital, Llangefni, Anglesey, LL77 7PP	6th April 2026

Death in Service: 0

Surname	First Name	Workplace	Date Approval Expired

APPENDIX 2

Update of Register of Section 12(2) Approved Doctors - Wales	
	Section 12(2) Approved Doctors
Approvals and Re-approvals	3
Approvals suspended	3
Approvals re-instated/ transferred/returned to work in Wales	2
Removed (Left Wales)	1
Retired	0
Registered without a licence to practise and retired	0
Transferred from AC register (to S12 Register)	0
Became AC approved	8
Approval Ended or Expired	2
Death in Service	0
Performance Metrics - Reporting period: 11th March 2026 – 11th May 2026	
Total number of Section 12(2) doctor applications processed	9
Pending approvals	4
Number awaiting completion of application by the applicant	2
Average approval time per completed application	26.66 days
Number of lapsed approvals due to missed deadlines by the applicant.	0

APPENDIX 2

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

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

Ratification Period: 11th March – 11th May 2026

S12 Approvals and Re-approvals: 3

Surname	First Name	Workplace	Date Approval Expires
Ibrahim	Mohammed Ibrihim Hassan	Betsi Cadwaladr University Health Board, Wepre House, Wepre Drive, Civic Way, Connah's Quay, Flintshire, CH5 4HA	23rd March 2031
Mitu	Tajnin	Betsi Cadwaladr University Health Board, Community Drug and Alcohol Services, Rowley's Drive, Deeside, Flintshire, CH5 1PU	26th March 2031
Ferrer	Katherine	Swansea Bay University Health Board, Tonna Hospital, Neath, SA11 3LX	8th April 2031

S12 suspended: 3

Surname	First Name	Workplace	Date Approval Expires
Malik	Mahdi	c/o Private Address	15th October 2027
Gupta	Sumanta	c/o Private Address	19th November 2030
Thompson	John	c/o Private Address	17th October 2026

S12 Approval Reinstated/Transferred/Returned to Wales: 2

Surname	First Name	Workplace	Date Approval Expires
Sayal	Kamlaj	Hywel Dda University Health Board, Gorwelion Resource Centre, Llanbadarn Road, Aberystwyth, SY23 1HB	25th March 2030
Akella	Anusha	Betsi Cadwaladr University Health Board, Wrexham Child Health Centre, Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD	25th February 2031

S12 Ended – Became an Approved Clinician: 8

Surname	First Name	Workplace	Date Approval Ended
Sohail	Faryal	Hywel Dda University Health Board, Memory Assessment Service, Caebryn, Prince Philip Hospital, Bryngwyn Mawr, Llanelli, SA14 8 QF	25th March 2026
Pranay	Pratyush	Aneurin Bevan University Health Board, St Cadoc's Hospital, Lodge Road, Caerleon, NP18 3XQ	26th March 2026
Oluwajulugbe	Philip	Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital, Ynysmaerdy, Pontyclun, Rhondda Cynon Taf, CF72 8XR.	26th March 2026
Bader	Mohamed M. Abdulhameed	Aneurin Bevan University Health Board, Vale Locality Mental Health Team Barry Hospital, Colcot Road, Barry, CF62 8YH	31st March 2026

Surname	First Name	Workplace	Date Approval Ended
Memon	Muhammad Ismail	Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital, Llantrisant, CF72 8XR	31st March 2026
Romeh	Amr	Swansea Bay University Health Board, Caswell Clinic, Pen-y-Fai, Tondu Road, Bridgend, CF31 4LN	31st March 2026
Jose	Avinash	Betsi Cadwaladr University Health Board, Ty Llywelyn Medium Secure Unit, Bryn y Neuadd Hospital, Llanfairfechan, Conwy, LL33 0HH	31st March 2026
Abdellatif	Mostafa	Betsi Cadwaladr University Health Board, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD	2nd April 2026

Removed (Left Wales): 1

Surname	First Name	Workplace	Date Approval Expires
Navarro-Trujillo	Rodrigo	Betsi Cadwaladr University Health Board, Wrexham Rural CMHT, Ty Derbyn, Wrexham Maelor Hospital, LL13 7TD	15th February 2027

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

Registered Without a Licence and Retired: 0

Surname	First Name	Workplace	Date Approval Ended

S12 Approval Ended or Expired: 2

Surname	First Name	Workplace	Date Approval Expired
Nathdwarawala	Sangeeta	c/o Private Address	21st April 2026
Wortelboer	Yvonne	Swansea Bay University Health Board, CMHT 3, Ty Einon Centre, Princess Street, Gorseinon, Swansea, SA4 4US.	9th May 2026

Death in Service: 0

Surname	First Name	Workplace	Date Approval Ended

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health Board / Trust	Betsi Cadwaladr University Health Board		
Date annual assurance report is presented to Board	Executive Meeting 6th May 2026 Board Committee Meeting 28th May 2026 *This annual report refers only to the period 6th April 2025 – 5th April 2026, however this report forms part of the 3 yearly assurance report for the reporting period from 6th April 2024 - 5th April 2027, that will be presented to Welsh Government in October 2027.*		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	Adult acute medical inpatient wards have remained unchanged/static during the reporting period: Total Medical wards = 25 Ysbyty Gwynedd 7 Ysbyty Glan Clwyd 9 Ysbyty Wrexham Maelor 9	Adult acute surgical inpatient wards have remained unchanged/static during the reporting period: Total Surgical wards = 17 Ysbyty Gwynedd 5 Ysbyty Glan Clwyd 6 Ysbyty Wrexham Maelor 6	Paediatric inpatient wards have remained unchanged/static during the reporting period: Total Paediatric Wards = 3 Ysbyty Gwynedd 1 Ysbyty Glan Clwyd 1 Ysbyty Wrexham Maelor 1
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	Adult acute medical inpatient ward staffing levels have been reviewed / recalculated on six occasions outside of the bi-annual calculation process: Funding changes between February and July 2025 resulted in the funded bed base fluctuating across 3 wards within the Ysbyty Maelor Wrexham site (Pantomime, Prince of Wales & Morris), with their escalated beds moving in and out of funded status. In January 2026, funding was permanently allocated from central HB reserves, establishing a fully funded bed base across these 3 wards.	Adult acute surgical inpatient ward staffing levels have been reviewed / recalculated on two occasions outside of the bi-annual calculation process: Funding changes between February and July 2025 resulted in the funded bed base fluctuating across 3 wards within the Ysbyty Maelor Wrexham site (Arrivals), with their escalated beds moving in and out of funded status. In January 2026, funding was permanently allocated from central HB reserves, establishing a fully funded bed base across this ward.	Staffing levels have not been reviewed / recalculated outside of the bi-annual calculation periods.

The process and methodology used to calculate the nurse staffing level.	This report focuses on wards to which Section 25B[1] of the Nurse Staffing Levels (Wales) Act pertains within BCUHB. In line with the requirements of the Nurse Staffing Levels (Wales) Act 2016, wards pertaining to Section 25B are subject to bi-annual reviews[2] in order to appropriately calculate planned nurse staffing levels. The narrative detailed within the annual assurance report appendices has attempted to demonstrate the rationale for any changes to the nurse staffing levels, for example changes to care quality outcomes, sustained change in the pattern of patient acuity and ward activity or changes to the funded bed base. In line with the Nurse Staffing Levels (Wales) Act 2016, nurse staffing calculations are to be approved by a designated person[3] who is authorised to undertake this calculation on behalf of the Chief Executive Officer. The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. Within Welsh health boards, including BCUHB, the designated person is the Executive Director of Nursing. In accordance with the Statutory Guidance[4] the calculation undertaken by the designated person must result in the nurse staffing level for the ward area. The nurse staffing level will be the required establishment i.e. the total number of staff to provide sufficient resource to deploy a planned roster, that will enable nurses to provide care to patients that meets all reasonable requirements in the relevant situation. The maintenance of the nurse staffing level should be funded from the health boards revenue allocation, taking into account the actual salary points of staff employed on its wards. **Methodology used to calculate the nurse staffing level:** Section 25C of the Nurse Staffing Levels (Wales) Act 2016 describes the triangulated method of calculation that must be applied when undertaking the nurse staffing level calculations / reviews. The triangulated methodology involves collecting, reviewing and interpreting data relating to Patient Acuity, Care Quality Indicators, and Professional judgement.

[1] Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies to adult acute medical inpatient wards; adult acute surgical inpatient wards; and paediatric inpatient wards. Areas excluded from the definition of Section 25B wards include outpatient departments, admission portals/assessment units, critical care/high dependency units, day case areas, rehabilitation areas, theatres, procedural units, coronary care units. These areas ordinarily undergo a (minimum) annual nurse staffing review to ensure there are sufficient nurses to provide timely and sensitive care to patients.

[2] Statutory calculations of nurse staffing levels across wards pertaining to Section 25B take place between March/April (reporting to Board in May) and August/September (reporting to Board in November).

[3] The designated person must act within the health boards governance framework authorising that person to undertake the nurse staffing calculation on behalf of the health boards Chief Executive Officer. In view of the requirement to exercise nursing professional judgement, the designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a Nurse staffing level in the clinical environment, such as the Executive Director of Nursing and Midwifery.

[4] Nurse Staffing Levels (Wales) Act 2016: statutory guidance

Patient Acuity data is measured using Welsh Levels of Care[5] evidence-based workforce planning tool. This measure of patients' levels of acuity indicates how much care is required in order to determine the nurse staffing level that is required to meet reasonable requirements of care. Within BCUHB the RL Datix SafeCare system[6] captures acuity data on a shift-by-shift basis, however across Wales, in all wards where section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies, formal acuity audits are undertaken every 6 months (January and June). To support the acuity audits a monthly dashboard[7] has been developed which provides information regarding patient acuity, patient flow and nurse staffing levels.

Care Quality Indicators are measures that are particularly sensitive to care provided only by a nurse and must be considered during the calculation process. The quality indicators shown to have an association with low nurse staffing levels are identified as:

- Patient falls - any fall that a patient has experienced whilst a patient on the ward
- Pressure ulcers - total number of hospital acquired pressure ulcers considered to have developed, or worsened, while a patient on the ward;
- Medication errors - any error in the preparation, administration or omission of medication by nursing staff
- Complaints – wholly or partly about care provided to patients by nurses made in accordance with the complaint's regulations.

Paediatric inpatient wards also include infiltration/extraversion injuries as part of their care quality indicator measurements.

In addition to the indicators set out above, any other indicator that is sensitive to the nurse staffing level may be considered. Examples may include, but are not limited to, patient experience, unmet care needs, failure to respond to patient deterioration, staff experience & well-being and compliance with mandatory training and performance development reviews.

Professional judgement is the application of nursing knowledge, skills and experience in order to make an informed decision regarding nurse staffing level calculations. Professional judgement will take into account the qualifications, competencies, skills, experience, professional development, and mandatory training requirements of the nurses providing care to patients within the ward. It will also consider the use of temporary staffing, conditions which may affect care

[5] The Welsh Levels of Care consists of 5 levels of acuity ranging from; Level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis, down to Level 1 where the patients condition is stable and predictable, requiring routine nursing care.

[6] RL Datix SafeCare is a daily staffing software system that displays real time nurse staffing levels and patient acuity enabling informed decision making on staffing levels across a hospital site. It enables visibility of staff to support deployment of resource in addition to the recording of red flags and professional judgement reasons and mitigating actions taken.

[7] Acuity report - Power BI Report Server

provision, support to students and learners, ward layout, the turnover of patients and overall bed occupancy, the complexity of patient needs in addition to their medical or surgical nursing needs and staff health and well-being.

During the process of calculating the nurse staffing levels using the triangulated approach there is no pre-determined hierarchy in terms of the evidence, with equal weighting given to all the information that informs this process. The Executive Director of Nursing and Midwifery as the designated person will make the determination of the nurse staffing levels based on an analysis of all the information collected about the ward and the contributions of those staff involved in the process.

In line with the Nurse Staffing Levels (Wales) Act 2016, and following consideration of these factors, an uplift of 26.9% is applied to both the registered nurse (RN) and health care support worker (HCSW) establishments to cover staff absences[8]. As per the requirements of the Nurse Staffing Levels (Wales) 2016 Act all Band 7 Ward Managers are supernumerary and are therefore not included in the required establishment figures.

Process used to calculate the nurse staffing level:

BCUHBs process of calculating nurse staffing levels has 3 steps:

Step 1: Initial Review
The review process is commenced at ward level with the Ward Manager presenting ward acuity data, care quality indicators, and professional judgement. Each ward completes the designated nurse staffing calculation proforma to evidence the review process and application of the triangulated methodology described above. This also ensures a consistent and transparent approach to undertaking nurse staffing level calculations. This is presented at site level, for review, discussion and supportive challenge.

The Integrated Health Community (IHC) Director of Nursing (DON) / Associate Director of Nursing (ADoN) leads the site reviews to calculate nurse staffing levels in collaboration with the Heads of Nursing, Matrons, Ward Manager, and colleagues from finance. The review is informed by both qualitative and quantitative information comprising of information and data gathered using the triangulated methodology covering Patient Acuity, Care Quality Indicators, and Professional judgement.

Additional information provided at the initial review includes, though is not limited to:

- Current ward bed numbers and speciality, including specific treatments or procedures.
- Ward environment, layout and geographical position
- Detail of service and patient pathway changes

[8] The 26.9% covers absences relating to annual leave, sickness and study leave but excludes maternity leave.

- Ward based initiatives, improvement programmes or action plans
- Current nurse staff provision, including those that are not included in the core roster (supervisory ward manager, frailty/rehabilitation support workers, dementia support workers, ward administrators etc.).
- Workforce/Staffing related metric data i.e., budgeted and actual establishments, Performance & Development Review (PADR) compliance, mandatory training compliance, sickness, maternity leave.
- Patient flow/activity related data for the previous 12 months.
- Finance related data i.e., pay/non pay expenditure/utilisation of permanent/temporary staff.

Step 2: Health Board Wide Review
A health board wide (multi-site, service specific) review is undertaken, led by the Director of Nursing for Workforce, Staffing and Professional Standards, taking into account national guidance and best practice evidence, to ensure a consistent health board wide approach. The review includes sharing good practice and lessons learnt and providing assurance of compliance with the Nurse Staffing Levels (Wales) Act 2016 requirements in that all workforce models must include an uplift of 26.9% and that a supernumerary Band 7 Ward Manager has been calculated within the overall workforce plan for each ward. Supportive challenge and discussions are undertaken between the senior nurse leadership team[9], and colleagues from workforce and finance to ensure the legitimate and validated application of the triangulated methodology.

Step 3: Formal Presentation of Nurse Staffing Levels to Executive Director of Nursing & Midwifery
Each Integrated Health Community Nurse Director / Associate Director of Nursing formally present their proposed nurse staffing levels to the Executive Director of Nursing and Midwifery as the confirmed designated person. The Executive Director of People Services & Organisational Development; & the Executive Director of Finance (or their nominated deputies) are also invited to the formal presentations. Final approval of the Nurse Staffing Levels is agreed by the Executive Director of Nursing and Midwifery as the confirmed designated person and on approval, these are formally presented to the Board.

- The spring 25 presentation took place on 3rd April 2025 with the outcome presented to Board on 29th May 2025[10].
- The autumn 25 presentation took place on 15th October 2025 with the outcome presented to Board on 27th November 2025[11].
- The spring 26 presentation took place on 23rd March 2026 with the outcome presented in appendix 3.

Amendments made during the spring 2026 review period are listed below:

- Arrivals ward YMW staffing increased by 8.53 WTE RN and 8.53 WTE HCSW

[9] Director of Nursing for Workforce, Staffing and Professional Standards, Integrated Health Community Nurse Director / Associate Director of Nursing and Heads of Nursing
[10] BCUHB Board Meeting Agenda Bundle 290525
[11] BCUHB Board Meeting Agenda Bundle 271125

	• Morris ward YMW staffing increased by 2.84 WTE RN and 2.84 WTE HCSW • Pantomime ward YMW staffing increased by 5.69 WTE RN and 4.27 WTE HCSW • Prince of Wales ward YMW staffing increased by 5.69 WTE RN and 5.69 WTE HCSW • Moelwyn ward YG staffing decreased by 2.84 WTE RN The staffing amendments across Arrivals, Pantomime and Prince of Wales are fully funded, whilst 2.84 WTE HCSW remains outstanding for Morris ward. While amendments to Moelwyn ward reduced the RN staffing requirement, the earlier unfunded increase in autumn 2024 means there is no resulting budget change.
Informing patients	In line with the requirements of the Nurse Staffing Level (Wales) Act 2016, information boards are located at the entrance to each of the wards displaying the planned nurse staffing levels on the wards and the date these were presented to the Board. Nationally agreed bilingual "Once for Wales" templates are utilised to display the planned staffing levels, with supplementary information available via a poster explaining the purpose of the Act and a Frequently Asked Questions leaflet (available bilingually in standard and easy read versions) to answer any more detailed questions a patient or a visitor may have about the Act. Ward staff are aware of, and endeavour to maintain Welsh Language Standards and translation services to ensure that patients are offered the opportunity to communicate through their language of choice. Ward Managers and Senior Nurse Managers are issued with guidance regarding their duties to inform patients under the Nurse Staffing Levels (Wales) Act 2016 prior to each bi-annual review and assurance is sought via the nurse staffing calculation proforma that these duties are being met. The refreshed Ward Manager and Accreditation metrics, due to launch in May 2026, feature a section within the Well Led Standards to confirm that the staffing boards are up to date and meet the Act requirements. Formal ward audits will be undertaken annually by the Nurse Staffing Programme Lead, results will be shared with the Executive Director of Nursing & Midwifery, the Directors of Nursing, Associate Directors of Nursing and Heads of Nursing. Work has been undertaken at a national level to develop a pragmatic solution to the availability of patient information, with the planned staffing levels template updated to feature a QR code. Patients and ward visitors will be able to scan this QR code on any smart phone and be directed to the national informing patient information documents, which are available in Welsh; English and easy read versions. The new templates will be introduced within BCUHB during 2026.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report

Extent to which the required establishment has been maintained within adult acute medical and surgical wards. NB: First cycle: spring 2025 following January audit Second cycle: autumn 2025: following June audit		**6th April 2025 – 5th April 2026**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of adult acute medical and surgical wards calculated during first cycle (May)	**42**	**851.66**	**769.89**
	WTE of required establishment of adult acute medical and surgical wards funded following first (May) calculation cycle	**42**	**842.71**	**758.41**
	Required establishment (WTE) of adult acute medical and surgical wards calculated during second calculation cycle (Nov)	**42**	**828.91**	**747.14**
	WTE of required establishment of adult acute medical and surgical wards funded following second (Nov) calculation cycle	**42**	**826.75**	**742.88**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 42**		

Accompanying narrative:

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

During the reporting period spring 2025 – autumn 2025, 38 wards have seen **no** changes to their required establishment, 4 wards have required a change to their required establishments. Of the wards requiring a change to establishment, the same four wards required changes in both spring 2025, (with these reported to the Board in May 2025[10]) and autumn 2024, (with these being reported to the Board in November 2024[11]). Details of the 5 wards requiring a change following the spring 2026 reviews have been included within this report previously.

Details of individual wards and their calculated nurse staffing levels can be found in the annual assurance report appendices. The narrative detailed within the annual assurance report appendices demonstrates the rationale for any changes to the nurse staffing levels. Nurse staffing levels presented to Board in November 202 will be considered within the 2026/27 financial planning cycle however, to mitigate the risks all Section 25B wards have been able to recruit and staff to the calculated required establishment figures utilising temporary staffing as necessary to achieve these levels.

	Following the uplift to the budgets in April 2025 the remaining budgetary deficit following the spring 2026 reviews is 7.1 WTE HCSW. This is comprised of: • 4.26 WTE HCSW from autumn 2024 reviews, presented to Board in November 2024, May 2025 and November 2025. • 2.84 WTE JCSW from spring 2026 reviews. The nurse staffing reviews continue to identify the routine use of escalation beds in response to system pressures. While staffing requirements associated with escalation beds are not included within Section 25B establishment data, this information is captured through the nurse staffing review process and considered through Integrated Health Community planning and IMTP prioritisation. Patient acuity has remained high across all inpatient areas. The health board is showing a trend of reduced Level 1 and 2 patients, and increased levels 3 and 4 patients in our adult acute medical and surgical wards. Acuity data for wards pertaining to Section 25B during June 2025 shows that an average of 74% of patients requiring care were Level 3 and 4, with 10% of patients requiring Level 5 care. Developments and processes for achieving required establishments across all Section 25B wards (adult & paediatric): As a health board there has been underpinning work to secure and assure plans for maintaining Nurse staffing levels and compliance with the 2016 Act to date, and ongoing. There is continual development as greater information, analysis and comprehension is gained locally and nationally. There are a range of both short and long term actions being taken by the health board to improve the extent to which a sufficient workforce is available to work within the registered nurses (RN) and healthcare support workers (HCSW) establishments across all health settings. Recruitment and retention of nursing and midwifery staff initiatives include: • Implementation of NU53 - Calculating and Maintaining Nurse Staffing Levels SOP, ensuring all patient care areas are included in establishment reviews and staffing is progressively aligned with patient acuity and demand • Quarterly nursing workforce optimisation reviews focusing on establishments, vacancies, rostering compliance, recruitment and temporary staffing utilisation • Annual workforce planning processes informing nursing education commissioning • Increase in Band 6 establishments to strengthen senior clinical leadership and out-of-hours support • Integration of additional roles to support nurse staffing for example Assistant Practitioners (Band 4) and Progress Chasers (Band 3) • Development of “grow our own” pipelines via Part-Time and Open University Bachelor of Nursing routes • Continued investment in education and development for staff at all levels, examples include healthcare support workers Qualification and Credit Framework which enables progression to the Level 4 Certificate in Healthcare

<table>
<tr><td></td><td colspan="4">Practice; RCN Healthcare Connect programme to support individuals to gain experience before applying to study a nursing degree; and post graduate development in conjunction with local universities via Clinical Skills Modules and Continuing Professional Development programmes
• The appointment of new graduates via the streamlining process continues to be a success.</td></tr>
<tr><td rowspan="8">Extent to which the required establishment has been maintained within <u>paediatric inpatient wards</u>
NB: First cycle: spring 2025 following January audit
Second cycle: autumn 2025: following June audit</td><td></td><td colspan="3">6th April 2025 – 5th April 2026</td></tr>
<tr><td></td><td>Number of Wards:</td><td>RN (WTE)</td><td>HCSW (WTE)</td></tr>
<tr><td>Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during first cycle (May)</td><td>3</td><td>85.29</td><td>28.43</td></tr>
<tr><td>WTE of required establishment of paediatric inpatient wards <u>funded</u> following first (May) calculation cycle</td><td>3</td><td>83.46</td><td>30.95</td></tr>
<tr><td>Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during second calculation cycle (Nov)</td><td>3</td><td>85.29</td><td>28.43</td></tr>
<tr><td>WTE of required establishment of paediatric inpatient wards funded following second (Nov) calculation cycle</td><td>3</td><td>85.29</td><td>28.43</td></tr>
<tr><td>WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)</td><td colspan="3">WTE: 3</td></tr>
<tr><td colspan="4">Accompanying narrative:

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the ‘nurse staffing level’ is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

The number of Section 25B wards within paediatrics has not changed during the reporting period and there have been no changes made to the required staffing establishments. Details of individual wards and their calculated nurse staffing levels can be found in the annual assurance report appendices.

Acuity data for the paediatric inpatient wards during the reporting period in June 2025 shows very few patients at level 1 on the paediatric wards, with the majority of patients being levels 2 and 3. There were no days without some patients at level 4 or 5 across the units. The paediatric wards have a very high turnover with average length of stay lower than that seen on adult wards. This is supported by the flow data with an average of 37 admissions per day, recorded across the three paediatric units.</td></tr>
</table>

Extent to which the planned roster has been maintained within adult acute medical and surgical wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	48395	20916	6932	9240	9105	95.45%
		43.22%	14.32%	19.09%	18.81%	

Accompanying narrative:

During April 2025 to April 2026 BCUHB has utilised the SafeCare system to capture data for the adult acute medical & surgical wards. SafeCare provides the ward user with the opportunity to record whether or not staffing was appropriate to meet the needs of the patients on a shift-by-shift basis. The information reported for the extent to which the planned roster has been maintained within adult acute medical and surgical wards is based on direct clinical care shifts; includes both substantive and temporary staffing as recorded on the rosters, and the response provided by the nurse in charge who utilises their professional judgement to record the appropriateness of the staffing levels on each of these shifts.

This is the fourth year of reporting in this way and significant improvements have been made in the quality of the data being reported with overall data completeness rising from 37.82% (first year) to 95.45% across the adult medical and surgical Section 25B during this reporting period. Work will continue to ensure that the improvements are sustained with data being monitored and validated at regular intervals throughout the year.

Extent to which the planned roster has been maintained within paediatric inpatient wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	3285	2162	123	729	181	97.26%
		65.81%	3.74%	22.19%	5.51%	

Accompanying narrative:

During this reporting period the paediatric inpatient wards have utilised the SafeCare system to enable the capture and analysis of data. This is the second year of all three paediatric inpatient wards collecting data in this way and positively

	there has been an improvement noted with the data completeness raising from 93.57% in the first reporting period to 97.26% in this reporting period. The information reported for the extent to which the planned roster has been maintained within the paediatric inpatient wards is based on direct clinical care shifts; includes both substantive and temporary staffing as recorded on the rosters, and the response provided by the nurse in charge who utilises their professional judgement to record the appropriateness of the staffing levels on each of these shifts. Work will continue to ensure that the improvements are sustained with data being monitored and validated at regular intervals throughout the year.
Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.	*NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Extensive work has been undertaken across NHS Wales to implement a national informatics system to enable health boards/trust to meet the reporting requirements of the Act and follow the Once for Wales approach to ensure consistency.* *Each health board/trust committed to implementing RL Datix (formally Allocates) Safecare system, with each organisation having implemented this system to their section 25B wards.* BCUHB implemented the SafeCare system across all Section 25B wards ahead of the national steer, with paediatric wards completing implementation in June 2023. In addition the system has been implemented across Section 25A wards such as, Assessment Units, Mental Health Wards, Community Hospital Wards and Critical Care Units. The system provides real-time visibility of staffing, skill mix and patient acuity and is well embedded across the organisation, supporting daily operational decision-making and professional judgement, including the temporary redeployment of resources to support timely and sensitive patient care. BCUHB has worked closely with the All-Wales SafeCare Implementation Group to support and ensure a consistent All Wales approach, with the All-Wales SafeCare Standard Operating Procedure adopted and in use across BCUHB.
Process for maintaining the Nurse staffing level	Maintaining nurse staffing levels is a continuous process involving operational oversight, escalation, workforce planning and staff support, demonstrating that all reasonable steps are taken to maintain safe staffing across Section 25B wards and wider services. In addition to the measures outlined earlier in this report, the actions below demonstrate how staffing levels are maintained across the Health Board, not only within Section 25B wards but across all services of the health board: • Nurse staffing escalation processes are outlined in the NU28 - Nurse Staffing Levels Act - Governance and Compliance Policy; NU53 - Calculating and Maintaining Nurse Staffing Levels Standard Operating Procedure and BCUHB Paediatric Escalation Policy

	• 24/7 operational oversight is provided through a clinical site management team and on-call nursing leadership, ensuring continuous senior decision-making and escalation across all services. This is supported by daily site operational meetings where capacity, staffing and system risks are reviewed, enabling real-time, risk-based decisions, including the redeployment of staff to maintain safe nurse staffing levels. • Use of temporary staffing (bank and agency) as a short-term mitigation where substantive staff are unavailable • Rostering optimisation and compliance monitoring in line with the WP28a Rostering Policy to ensure safe and effective rosters are in place • Staff wellbeing services and strategies are in place • Ongoing work and engagement at a local and national level to ensure the preceptorship standards and clinical supervision principles are implemented successfully within BCUHB • The provision of pastoral support and a structured preceptorship programme for graduates and internationally educated nurses to ensure they settle well and have a rewarding and fulfilling career within BCUHB Work is ongoing to strengthen the organisation's focus on staff retention, with Retention Leads identified across corporate and clinical areas to support delivery of the Nurse Retention Plan. This work is aligned with the All Wales National Workforce Implementation Plan; and the subsequent Strategic Nursing Workforce Plan. Together, these initiatives build on the established ethos of support for lifelong learning and staff development, and the provision of a positive work-life balance and with a strong emphasis on staff wellbeing, engagement and job satisfaction, thereby supporting workforce stability and sustainability. This reporting period has seen a small increase in the overall funded establishments across the Section 25B wards[12] for registered nursing posts (1007.6 WTE in April 2025 compared to 1014.1 WTE in March 2026). Actual registered nursing staff in post have risen across the period from 929.9 (WTE) in April 2025 to 983.7 (WTE) in March 2026, an increase of 53.8 (WTE). Successful recruitment into the Section 25B wards has meant that the vacancy rates for registered nurses within these areas has fallen from 7.7% (April 2025) to 3.0% (March 2026). Across the healthcare support worker funded establishments for the Section 25B wards[12] posts have remained relatively static for the reporting period (859.2 WTE in April 2025 compared to 860.1 WTE in March 2026). Vacancy rates within the HCSW staff group across the Section 25B wards continue to present workforce challenges, with the vacancy rates being 15.8% (136.1 WTE) at March 2026. Whilst recruitment activity continues, utilising the strategies outlined in this paper to address vacancy rates across both the RN and HCSW establishments, the Executive Director of Nursing & Midwifery has directed that detailed HCSW specific recruitment action plans are implemented. These plans will be supported by People Services and are intended to deliver a sustained reduction in vacancy rates within this staff group.

[12] Applicable to those wards pertaining to Section 25B as at 31st March 2025.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards				
Incidents of patient harm with reference to quality indicators and complaints about nursing care (note: all rows only include incidents that have been closed)	**Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).**	**Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).**	**Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).**	**Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))**
Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).	YWM 4	YWM 4	YWM 0	YWM 4 [13]
	YGC 23 [14]	YGC 13 [14]	YGC 0	YGC 1
	YG 9	YG 4	YG 0	YG 0
	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0
	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0
TOTAL	**36**	**21**	**0**	**5**
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	YWM 1	YWM 0	YWM 0	YWM 0
	YGC 8	YGC 6	YGC 0	YGC 0
	YG 1	YG 1	YG 0	YG 0
	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0
	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0
TOTAL	**10**	**7**	**0**	**0**

[13] At the end of the previous reporting period, YWM had two complaints that remained open and were subsequently closed within the current reporting period (compared with none for YG and YGC). This accounts for the comparatively higher figures reported for YMW in this reporting period.

[14] At the end of the previous reporting period, YGC had a higher number of incidents that remained open and were subsequently closed within the current reporting period. This resulted in a carry-over of fourteen incidents of avoidable hospital acquired pressure damage (compared with two incidents each for YG and YMW) and six falls (compared with one for YMW and none for YG). This accounts for the comparatively higher figures reported for YGC in this reporting period.

Number of those closed incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	YWM 0	YWM 0	YWM 0	YWM 0
	YGC 6	YGC 4	YGC 0	YGC 0
	YG 1	YG 1	YG 0	YG 0
	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0
	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0
TOTAL	**7**	**5**	**0**	**0**
Number of closed incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained	YWM 3	YWM 4	YWM 0	YWM 4
	YGC 15	YGC 7	YGC 0	YGC 1
	YG 8	YG 3	YG 0	YG 0
	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0
	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0
TOTAL	**26**	**14**	**0**	**5**
Number of those closed incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.	YWM 0	YWM 0	YWM 0	YWM 0
	YGC 0	YGC 1	YGC 0	YGC 0
	YG 0	YG 0	YG 0	YG 0
	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0
	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0
TOTAL	**0**	**1**	**0**	**0**

KEY: YWM - Ysbyty Wrexham Maelor / YGC - Ysbyty Glan Clwyd / YG - Ysbyty Gwynedd.

Accompanying narrative:

Based on a review of the health boards/trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; a report was presented to the Executive Directors of Nursing & Midwifery and the Chief Nursing Officer for Wales in 2021 which included a series of recommendations to improve and refine the reporting process. Following this a sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting

process; standardise reporting in line with the Duty of Candour[15] set out in the Health and Social Care (Quality & Engagement Act) (Wales) Act 2020[16] and broaden the reporting scope of incidences of harm to provide more meaningful data, with the aim of broadening the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication administration error incidents.

The work of the Reporting Sub-Group included a review of the measures for the adult medical and surgical inpatient wards and these were presented to the Executive Nurse Directors in August 2023, who approved the recommendations to take effect from the next reporting period i.e. 6th April 2024 – 5th April 2025. The agreed quality indicators for the adult acute medical and surgical inpatient wards from 6th April 2024 are as follows:

- *Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

The data to be reported for each of the above will be:

- *Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).*
- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*
- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

Following the Executive Nurse Directors agreeing the recommendations in August 2023 it became apparent that the Duty of Candour (DoC), which came into force on 1st April 2023, would impact the reporting metrics within the annual assurance reports as previous reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. Therefore, to align with patient safety incident reporting to Welsh Government this report, and all future reports, will report on closed patient safety incidents which have been validated with a reportable level of harm (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident. Consequently, the number of incidents reported within this, and subsequent, annual assurance reports may be lower than those in previous years.

In late 2024, it became apparent that there is significant variation in the types of complaints that are being reported within each organisation's nurse

[15] The NHS Duty of Candour | GOV.WALES
[16] Health and Social Care (Quality and Engagement) (Wales) Act: summary | GOV.WALES

staffing report due to local interpretation of the Operational Guidance. As a result, the Reporting Group presented an SBAR that outlined a proposed criteria for standardised complaint reporting to the DDoN Forum in February 2025. This criteria was agreed by the DDoN Forum on the basis that reports are reviewed later in 2025 to establish if the criteria is adequately sensitive and produces the right level of practically useful context as a quality indicator.

The agreed criteria reporting criteria for Complaints received by 25B areas are those that:

- *Have been closed within this reporting period;*
- *Are being managed through PTR;*
- *Have identified a breach in the duty of care;*
- *Are relevant to nursing care (with a guidance document developed to support identification).*

BCUHB have a number of initiatives in place to monitor and improve patient experience through the reduction of patient harm incidents, including but not limited to:

- The Pressure Ulcer Prevention and Management (PUPM) Standard Operating Procedure (SOP) which promotes patient cooperation and self-management to reduce the risk and treat and manage pressure ulcers and advocates all staff adopting a patient centred approach to Pressure Ulcer Prevention and Management incorporating the aSSKINg[17] framework to ensure pressure ulcer prevention and management is individualised.
- The introduction of the Pressure Ulcer Prevention and Management e-learning package.
- Pressure Ulcer Learning Forums
- The Quality and Assurance Dashboard, launched during 25/26, is an easy-to-use platform where staff can access key quality related data on Patient Safety, Patient Experience, and Workforce. Further enhanced by the addition of the Quality Scorecard highlighting key quality measures to enable transparency and support decision making processes. The dashboard and scorecard bring together the indicators that matter most for delivering safe, effective and compassionate care.
- Monthly strategic falls group meetings
- Continued monitoring of compliance with undertaking part 1a and 1b falls training
- Falls management processes, embedded within each IHC, are having a positive impact on the outcome of quality and detailed interventions within risk assessments.
- Electronic Prescribing and Medicines Administration (EPMA) has been implemented across the Health Board during 25/26. The EMPA system has reshaped how medications are prescribed, managed, and administered across the organisation.

Nationally, from 1st April 2026, the new Listening to People statutory guidance, was launched to replace the existing Putting Things Right guidance. These changes are designed to make it easier and quicker for patients, families and carers to raise concerns and / or provide their experience about NHS care. This new approach forms part of a national commitment to improve openness, compassion and learning across health services in Wales, and introduce clearer processes and better support for anyone who wishes to speak about their care.

[17] aSSKINg - assess risk; skin assessment and skin care; surface; keep moving; incontinence or increased moisture; nutrition and hydration assessment / support; and give information

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards					
Incidents of patient harm with reference to quality indicators and complaints about nursing care (note: all rows only include incidents that have been closed)	**Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).**	**Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).**	**Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).**	**Infiltration and extravasation injuries**	**Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))**
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**
Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).	0	0	0	0	0
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	0	0	0	0	0
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	0	0	0	0	0
Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained	0	0	0	0	0
Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.	0	0	0	0	0
Accompanying narrative:					

The work of the Reporting Sub-Group, mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Directors of Nursing & Midwifery in August 2023, along with the amended measures for the adult acute medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. 6th April 2024.

The quality indicators for the paediatric inpatient wards will be as follows:

- *Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Infiltration and extravasation injuries*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*
-

The data to be reported for each of the above will be:

- *Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.*
- *Total number of incidents/ complaints not closed and to be reported on/during the next year*
- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *)
Actions taken if the nurse staffing level <u>was not</u> maintained in wards where section 25B applies	As previously outlined, maintaining nurse staffing levels is a continuous process involving both short and long term planning at strategic/corporate and operational levels. This demonstrates that "all reasonable steps" have been explored and/or taken to maintain staffing levels, not only within Section 25B wards but across all services of the health board. Where staffing levels are not maintained, appropriate action, mitigation and escalation are implemented in line with NU28 - Nurse Staffing Levels Act - Governance and Compliance Policy; NU53 - Calculating and Maintaining Nurse Staffing Levels Standard Operating Procedure and BCUHB Paediatric Escalation Policy The impact on care quality is monitored operationally, with the senior nursing teams applying their professional judgment to ensure that the staffing levels wherever possible, were maintained – and, where not possible, mitigated. In addition to the actions previously noted above, the following are also undertaken: • Staff wellbeing support, including bespoke sessions via the Staff Wellbeing Service where sustained shortfalls occur • Shared learning through the Ward Managers and Matrons monthly meetings

	• Increased senior nursing team visibility (Matrons/ Heads of Nursing / Directors of Nursing) and People's Enquiry and Resolution Service (PEARS), through walkabouts/audit/patient feedback surveys • Daily incident reviews within the IHCs and Divisions, enabling timely review of falls and Hospital Acquired Pressure Ulcers (HAPU) incidents, with escalation of severe incidents • Weekly learning forums are in place and supported by relevant leads e.g. practice development nurses, fall champions, HAPU lead nurse. • Increased audit activity in areas of concern to support improvement work • Nursing Quality Assurance Framework - to ensure deep dives are conducted into each clinical area in support of Ward Accreditation • The Quality and Assurance Dashboard provides strategic and operational oversight of patient experience, patient harms incidents, patient complaints and staffing metrics.
	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A (NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	Section 25A of the Nurse Staffing Levels (Wales) Act 2016 sets out the responsibilities of health boards to have regard to the provision of appropriate nurse staffing levels across all nursing services, in order to support the delivery of safe, effective and timely patient care. This section summarises the wider work undertaken in relation to Section 25A areas during 2025/26. All areas providing care to patients are required to undertake nurse staffing calculations, and whilst these are not legally mandated under section 25A, it is expected that these reviews will be undertaken routinely and in response to changes in patient acuity and / or dependency; when there is a change in the service model or delivery; or when concerns are raised through exception reporting or clinical governance. Post-Legislative Scrutiny undertaken in 2024 highlighted the need for clear operational guidance to support the consistent application of section 25A, including the use of a triangulated approach to nurse staffing level calculations. This work is ongoing at a national level under the auspices of the All Wales Nurse Staffing Programme. Pending the publication of national guidance, BCUHB applies the NU53 - Calculating and Maintaining Nurse Staffing Levels Standard Operating Procedure ensuring that all nurse staffing reviews across the organisation follow the same evidence-based triangulated methodology described earlier in this report. BCUHB nursing services which have undertaken/commenced reviews of their nurse staffing levels using the above approach are: • 24/7 medical & surgical wards who do not pertain to Section 25B of the Act • Emergency quadrant wards and departments • Community hospital wards • Mental Health and Learning Disability wards

	• Mental Health Community Mental Health Teams • District Nursing Teams The processes for maintaining the nurse staffing levels, including the recruitment, retention and education strategies described previously within this paper are applicable to all areas where nursing services are provided.
	Conclusion & Recommendations
	The report provides assurance to the health board that, in line with statutory guidance, BCUHB is compliant with the requirements of the Nurse Staffing Levels (Wales) Act 2016 bi annual calculations for 25B adult inpatient medical and surgical wards; and paediatric inpatient wards. Throughout the past year, nurse staffing levels for all healthcare settings across BCUHB have been calculated at a level which demonstrates the commitment to having 'regard to the importance of providing sufficient nurses to allow time for the nurses to care for patients sensitively'. This statutory requirement has ensured that the staffing levels for all wards and areas across BCUHB caring for inpatients have been set and, wherever possible maintained. When it has not been possible to maintain staffing levels, appropriate action, mitigation and escalation is in line with NU28 - Nurse Staffing Levels Act - Governance and Compliance Policy; NU53 - Calculating and Maintaining Nurse Staffing Levels Standard Operating Procedure and BCUHB Paediatric Escalation Policy The Board are asked to note and support the following next steps: 1. In line with the Act and the Statutory Guidance the nurse staffing calculations presented within this report and associated appendices; approved by the Executive Director of Nursing & Midwifery, as the designated person, should be funded from the health boards revenue allocation. Where this is not possible, mitigating actions should be undertaken to maintain patient safety with oversight by the Board. Mitigating actions may include ward reconfigurations, bed closures or the use of temporary staffing. 2. Continuation of the many and varied registered nurse and healthcare support worker workforce recruitment and retention strategies to ensure a 'supply' of nursing workforce to support the maintenance of the nurse staffing levels. Key enablers are the All-Wales National Workforce Implementation Plan; HEIW Nurse Retention Plan and HEIW Strategic Nursing Workforce plan. 3. Continued development and enhancement of reporting dashboards, enabling the analysis of workforce and patient data to support and inform nursing workforce decisions 4. The planned roster demand templates to be amended within the rostering system to reflect the approved rosters to enable operational delivery and effective workforce planning. 5. Ward Managers to progress the recruitment of staff, based on the revised nursing establishment (where applicable) 6. Ward Managers will ensure the ward boards, displayed at the ward entrances, are updated to reflect any changes to the planned roster and the date the nurse staffing calculations were presented to Board

Appendix 2: Annual Assurance Report

Health Board/Trust:	Betsi Cadwaladr University Health Board
Period of the report	6th April 2025 (Spring review cycle) - 5th April 2026 (Autumn review cycle)
Adult Acute Medical Inpatient Wards	25

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Adult Acute Medical Inpatient wards

		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the start of this report (Spring 2025 calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the end of the period of this report (Autumn 2025 calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Site	**Name of Ward**		**TOTAL WTE RN (band 5,6)**	**TOTAL WTE HCSW (bands 2,3,4)**		**TOTAL WTE RN (band 5,6)**	**TOTAL WTE HCSW (bands 2,3,4)**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
YWM	Acton	1	25.58	19.9	1	25.58	19.9	Yes	No	No change to staffing	No			
YWM	ACU	1	31.27	14.21	1	31.27	14.21	Yes	No	No change to staffing	No			
YWM	Bersham	1	25.58	19.9	1	25.58	19.9	Yes	No	No change to staffing	No			
YWM	Bonney	1	19.9	19.9	1	19.9	19.9	Yes	No	No change to staffing	No			
YWM	Cunliffe	1	19.9	19.9	1	19.9	19.9	Yes	No	No change to staffing	No			
YWM	Fleming	1	11.37	5.69	1	11.37	5.69	Yes	No	No change to staffing	No			
YWM	Morris	1	19.9	24.16	1	17.06	21.32	Yes	Yes	Changes made outside of the biannual calculation cycle reviews due to reconfigurations of the funded bed base within the Wrexham Maelor site.	Yes	Jul-25	Yes	Staffing reviewed due to reconfigurations of the funded bed base within the Wrexham Maelor site.
YWM	Pantomime	1	21.32	19.9	1	15.63	14.21	Yes	Yes	Changes made outside of the biannual calculation cycle reviews due to reconfigurations of the funded bed base within the Wrexham Maelor site.	Yes	Jul-25	Yes	Staffing reviewed due to reconfigurations of the funded bed base within the Wrexham Maelor site.
YWM	Prince of Wales	1	19.9	19.9	1	14.21	14.21	Yes	Yes	Changes made outside of the biannual calculation cycle reviews due to reconfigurations of the funded bed base within the Wrexham Maelor site.	Yes	Jul-25	Yes	Staffing reviewed due to reconfigurations of the funded bed base within the Wrexham Maelor site.
YG	Aran	1	25.58	25.58	1	25.58	25.58	Yes	No	No change to staffing	No			
YG	Glaslyn	1	19.9	26.58	1	19.9	26.58	Yes	No	No change to staffing	No			
YG	Glyder	1	14.21	11.37	1	14.21	11.37	Yes	No	No change to staffing	No			
YG	Hebog	1	22.74	25.58	1	22.74	25.58	Yes	No	No change to staffing	No			
YG	Moelwyn	1	31.27	22.74	1	31.27	22.74	Yes	No	No change to staffing	No			
YG	Prysor	1	12.79	12.37	1	12.79	12.37	Yes	No	No change to staffing	No			
YGC	Ward 1	1	19.07	23.21	1	19.07	23.21	Yes	No	No change to staffing	No			
YGC	Ward 2	1	19.07	20.49	1	19.07	20.49	Yes	No	No change to staffing	No			
YGC	Ward 4	1	19.07	16.34	1	19.07	16.34	Yes	No	No change to staffing	No			
YGC	Ward 6 Respiratory	1	24.52	19.07	1	24.52	19.07	Yes	No	No change to staffing	No			
YGC	Ward 9	1	19.07	20.49	1	19.07	20.49	Yes	No	No change to staffing	No			
YGC	Ward 10	1	19.07	20.49	1	19.07	20.49	Yes	No	No change to staffing	No			
YGC	Ward 11 Stroke (was Ward 14)	1	21.79	20.49	1	21.79	20.49	Yes	No	No change to staffing	No			
YGC	Ward 12	1	21.79	19.07	1	21.79	19.07	Yes	No	No change to staffing	No			
YG	Alaw	1	17.66	14.21	1	17.66	14.21	Yes	Yes	Whilst there was no change to the required establishment, during autumn 2025 review the RN staffing was adjusted at the weekend to support out of hours triage requirements.	No			
YGC	Enfys	1	19.9	19.9	1	19.9	19.9	Yes	No	No change to staffing	No			

Appendix 2: Annual Assurance Report

Health Board/Trust:	Betsi Cadwaladr University Health Board
Period of the report	6th April 2025 (Spring review cycle) - 5th April 2026 (Autumn review cycle)
Adult Acute Surgical Inpatient Wards	17

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Adult Acute Surgical Inpatient wards

		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the start of this report (Spring 2025 calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the end of the period of this report (Autumn 2025 calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Site	**Name of Ward**		**TOTAL WTE RN (band 5,6)**	**TOTAL WTE HCSW (bands 2,3,4)**		**TOTAL WTE RN (band 5,6)**	**TOTAL WTE HCSW (bands 2,3,4)**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
YWM	Arrivals	1	22.74	19.9	1	14.21	11.37	Yes	Yes	Changes made outside of the biannual calculation cycle reviews due to reconfigurations of the funded bed base within the Wrexham Maelor site.	Yes	Jul-25	Yes	Staffing reviewed due to reconfigurations of the funded bed base within the Wrexham Maelor site.
YWM	Erddig	1	25.58	19.9	1	25.58	19.9	Yes	No	No change to staffing	No			
YWM	Mason	1	19.9	24.16	1	19.9	24.16	Yes	No	No change to staffing	No			
YWM	Glyndwr	1	25.58	17.06	1	25.58	17.06	Yes	No	No change to staffing	No			
YWM	U5	1	13.4	7.72	1	13.4	7.72	Yes	No	No change to staffing	No			
YG	Tegid	1	25.58	19.9	1	25.58	19.9	Yes	No	No change to staffing	No			
YG	Dulas	1	28.43	22.74	1	28.43	22.74	Yes	Yes	No change to staffing	No			
YG	Ogwen	1	19.9	25.58	1	19.9	25.58	Yes	No	No change to staffing	No			
YG	Enlli	1	14.21	14.21	1	14.21	14.21	Yes	No	No change to staffing	No			
YGC	Ward 3	1	21.79	21.79	1	21.79	21.79	Yes	No	No change to staffing	No			
YGC	Ward 5	1	21.79	19.07	1	21.79	19.07	Yes	No	No change to staffing	No			
YGC	Ward 7	1	21.79	21.79	1	21.79	21.79	Yes	No	No change to staffing	No			
YGC	Ward 8	1	19.07	19.07	1	19.07	19.07	Yes	No	No change to staffing	No			
ABH	Ward 6 Abergele	1	15.57	13.62	1	15.57	13.62	Yes	No	No change to staffing	No			
YGC	Ward 19a Glaslyn	1	11.37	7.72	1	11.37	7.72	Yes	No	No change to staffing	No			
YWM	Bromfield	1	11.37	5.69	1	11.37	5.69	Yes	No	No change to staffing	No			
YG	Ffrancon	1	11.37	8.53	1	11.37	8.53	Yes	No	No change to staffing	No			

Appendix 2: Annual Assurance Report

Health Board/Trust:	Betsi Cadwaladr University Health Board
Period of the report	6th April 2025 (Spring review cycle) - 5th April 2026 (Autumn review cycle)
Adult Acute Medical Inpatient Wards	3

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Paediatric Inpatient wards

		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the start of this report (Spring 2025 calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the end of the period of this report (Autumn 2025 calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Site	**Name of Ward**		**TOTAL WTE RN (band 5,6)**	**TOTAL WTE HCSW (bands 2,3,4)**		**TOTAL WTE RN (band 5,6)**	**TOTAL WTE HCSW (bands 2,3,4)**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
YWM	Childrens Unit	1	28.43	8.53	1	28.43	8.53	Yes	No	No change to staffing	No			
YGC	Childrens Unit	1	28.43	11.37	1	28.43	11.37	Yes	No	No change to staffing	No			
YG	Childrens Unit	1	28.43	8.53	1	28.43	8.53	Yes	No	No change to staffing	No			

Appendix 3: Annual Presentation of the Nurse Staffing Level to the Board report. A summary of Nurse Staffing Levels for wards where Section 25B applies.

Health board/trust:	Betsi Cadwaladr University Health Board
Period of the report	April 2025 - March 2026
Adult Acute Medical inpatient wards	25

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Medical inpatient wards

Site	Name of Ward	Reported to the Board in May 2025						Calculated during autumn 2025 cycle							Calculated during spring 2026 cycle							Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles				Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
		SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2024)		Required Establishment as stated within the annual presentation to the Board report (in November 2024) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	SHIFT	Planned roster calculated by the designated person during the spring 2025 cycle		Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2025 cycle		Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)										
YWM	Acton	Early	5	4	25.58	19.9	1	Early	5	4	25.58	19.9	1	15/10/2025	Early	5	4	25.58	19.9	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	4	3				Night	4	3					Night	4	3												
YWM	ACU	Early	6	3	31.27	14.21	1	Early	6	3	31.27	14.21	1	15/10/2025	Early	6	3	31.27	14.21	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	6	3				Late	6	3					Late	6	3												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	5	2				Night	5	2					Night	5	2												
YWM	Bersham	Early	5	4	25.58	19.9	1	Early	5	4	25.58	19.9	1	15/10/2025	Early	5	4	25.58	19.9	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	4	3				Night	4	3					Night	4	3												
YWM	Bonney	Early	4	4	19.9	19.9	1	Early	4	4	19.9	19.9	1	15/10/2025	Early	4	4	19.9	19.9	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	4	4				Late	4	4					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	3	3					Night	3	3												
YWM	Cunliffe	Early	4	4	19.9	19.9	1	Early	4	4	19.9	19.9	1	15/10/2025	Early	4	4	19.9	19.9	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	4	4				Late	4	4					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	3	3					Night	3	3												
YWM	Fleming	Early	2	1	11.37	5.69	1	Early	2	1	11.37	5.69	1	15/10/2025	Early	2	1	11.37	5.69	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	2	1				Late	2	1					Late	2	1												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	1				Night	2	1					Night	2	1												
YWM	Morris	Early	4	5	19.9	24.16	1	Early	4	4	17.06	21.32	1	15/10/2025	Early	4	5	19.9	27	1	24/03/2026	Yes	No	Changes made outside of the biannual calculation cycle reviews due to reconfigurations of the funded bed base within the Wrexham Maelor site.	Yes	Jul-25 & Dec-25	Yes	Staffing reviewed due to reconfigurations of the funded bed base within the Wrexham Maelor site.
		Late	4	4				Late	4	3					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	4				Night	2	4					Night	3	5												
YWM	Pantomime	Early	5	4	21.32	19.9	1	Early	4	3	15.63	14.21	1	15/10/2025	Early	5	4	21.32	19.9	1	24/03/2026	Yes	No	Changes made outside of the biannual calculation cycle reviews due to reconfigurations of the funded bed base within the Wrexham Maelor site.	Yes	Jul-25 & Dec-25	Yes	Staffing reviewed due to reconfigurations of the funded bed base within the Wrexham Maelor site.
		Late	4	4				Late	3	3					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	2	2					Night	3	3												
YWM	Prince of Wales	Early	4	4	19.9	19.9	1	Early	3	3	14.21	14.21	1	15/10/2025	Early	4	4	19.9	19.9	1	24/03/2026	Yes	No	Changes made outside of the biannual calculation cycle reviews due to reconfigurations of the funded bed base within the Wrexham Maelor site.	Yes	Jul-25 & Dec-25	Yes	Staffing reviewed due to reconfigurations of the funded bed base within the Wrexham Maelor site.
		Late	4	4				Late	3	3					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	2	2					Night	3	3												
YG	Aran	Early	5	5	25.58	25.58	1	Early	5	5	25.58	25.58	1	15/10/2025	Early	5	5	25.58	25.58	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	5	5				Late	5	5					Late	5	5												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	4	4				Night	4	4					Night	4	4												
YG	Glaslyn (Tues - Fri)	Early	4	6	19.9	26.58	1	Early	4	6	19.9	26.58	1	15/10/2025	Early	4	6	19.9	26.58	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	4	5				Late	4	5					Late	4	5												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	4				Night	3	4					Night	3	4												
	Glaslyn (Sat - Mon)	Early	4	5				Early	4	5					Early	4	5												
		Late	4	5				Late	4	5					Late	4	5												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	4				Night	3	4					Night	3	4												
YG	Glyder	Early	3	2	14.21	11.37	1	Early	3	2	14.21	11.37	1	15/10/2025	Early	3	2	14.21	11.37	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	3	2				Late	3	2					Late	3	2												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	2				Night	2	2					Night	2	2												

YG	Hebog	Early	5	5	22.74	25.58	1	Early	5	5	22.74	25.58	1	15/10/2025	Early	5	5	22.74	25.58	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	5	5				Late	5	5					Late	5	5												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	4				Night	3	4					Night	3	4												
YG	Moelwyn	Early	6	4	31.27	22.74	1	Early	6	4	31.27	22.74	1	15/10/2025	Early	6	4	31.27	22.74	1	24/03/2026	Yes	Yes	Staffing reconsidered following a review of Non-Invasive Ventilation (NIV) utilisation.	No				
		Late	6	4				Late	6	4					Late	6	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	5	4				Night	5	4					Night	4	4												
YG	Prysor (Mon - Fri)	Early	3	3	12.79	12.37	1	Early	3	3	12.79	12.37	1	15/10/2025	Early	3	3	12.79	12.37	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	2	2				Late	2	2					Late	2	2												
		Long Day						Long Day							Long Day														
		Twilight	0	0				Twilight	0	0					Twilight	0	0												
		Night	2	2				Night	2	2					Night	2	2												
	Prysor (Sat & Sun)	Early	3	2				Early	3	2					Early	3	2												
		Late	2	2				Late	2	2					Late	2	2												
		Long Day						Long Day							Long Day														
		Twilight	0	0				Twilight	0	0					Twilight	0	0												
		Night	2	2				Night	2	2					Night	2	2												
YGC	Ward 1	Early	4	5	19.07	23.21	1	Early	4	5	19.07	23.21	1	15/10/2025	Early	4	5	19.07	23.21	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	4	5				Late	4	5					Late	4	5												
		Long Day						Long Day							Long Day														
		Twilight	0	1				Twilight	0	1					Twilight	0	1												
		Night	3	3				Night	3	3					Night	3	3												
YGC	Ward 2	Early	4	4	19.07	20.49	1	Early	4	4	19.07	20.49	1	15/10/2025	Early	4	4	19.07	20.49	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	4	4				Late	4	4					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight	0	1				Twilight	0	1					Twilight	0	1												
		Night	3	3				Night	3	3					Night	3	3												
YGC	Ward 4	Early	4	3	19.07	16.34	1	Early	4	3	19.07	16.34	1	15/10/2025	Early	4	3	19.07	16.34	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	4	3				Late	4	3					Late	4	3												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	3	3					Night	3	3												
YGC	Ward 6	Early	5	3	24.52	19.07	1	Early	5	3	24.52	19.07	1	15/10/2025	Early	5	3	24.52	19.07	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	5	3				Late	5	3					Late	5	3												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	4	4				Night	4	4					Night	4	4												
YGC	Ward 9	Early	4	4	19.07	20.49	1	Early	4	4	19.07	20.49	1	15/10/2025	Early	4	4	19.07	20.49	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	4	4				Late	4	4					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight	0	1				Twilight	0	1					Twilight	0	1												
		Night	3	3				Night	3	3					Night	3	3												
YGC	Ward 10	Early	4	4	19.07	20.49	1	Early	4	4	19.07	20.49	1	15/10/2025	Early	4	4	19.07	20.49	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	4	4				Late	4	4					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight	0	1				Twilight	0	1					Twilight	0	1												
		Night	3	3				Night	3	3					Night	3	3												
YGC	Ward 11	Early	5	4	21.79	20.49	1	Early	5	4	21.79	20.49	1	15/10/2025	Early	5	4	21.79	20.49	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	5	4				Late	5	4					Late	5	4												
		Long Day						Long Day							Long Day														
		Twilight	0	1				Twilight	0	1					Twilight	0	1												
		Night	3	3				Night	3	3					Night	3	3												
YGC	Ward 12	Early	5	4	21.79	19.07	1	Early	5	4	21.79	19.07	1	15/10/2025	Early	5	4	21.79	19.07	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	5	4				Late	5	4					Late	5	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	3	3					Night	3	3												
YG	Alaw (Mon - Fri)	Early	4	3	17.66	14.21	1	Early	4	3	17.66	14.21	1	15/10/2025	Early	4	3	17.66	14.21	1	24/03/2026	Yes	Yes	During autumn 2025 review the RN staffing was adjusted at the weekend to support out of hours triage requirements.	No				
		Late	4	3				Late	4	3					Late	4	3												
		Long Day						Long Day							Long Day														
		Twilight	1	0				Twilight	1	0					Twilight	1	0												
		Night	2	2				Night	2	2					Night	2	2												
	Alaw (Sat & Sun)	Early	3	3				Early	4	3					Early	4	3												
		Late	3	3				Late	3	3					Late	3	3												
		Long Day						Long Day							Long Day														
		Twilight	1	0				Twilight	0	0					Twilight	0	0												
		Night	2	2				Night	2	2					Night	2	2												
YGC	Enfys	Early	4	4	19.9	19.9	1	Early	4	4	19.9	19.9	1	15/10/2025	Early	4	4	19.9	19.9	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	4	4				Late	4	4					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	3	3					Night	3	3												

Appendix: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	Betsi Cadwaladr University Health Board
Period of the report	April 2025 - March 2026
Adult Acute Surgical Inpatient Wards	17

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Surgical Inpatient Wards

Site	Name of Ward	Reported to the Board in May 2025						Calculated during autumn 2025 cycle							Calculated during spring 2026 cycle							Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
		SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2024)		Required Establishment as stated within the annual presentation to the Board report (in November		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	SHIFT	Planned roster calculated by the designated person during the spring 2025 cycle		Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2025 cycle		Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)									
YWM	Arrivals	Early	5	4	22.74	19.9	1	Early	3	2	14.21	11.37	1	15/10/2025	Early	5	4	22.74	19.9	1	24/03/2026	Yes	No	Changes made outside of the biannual calculation cycle reviews due to reconfigurations of the funded bed base within the Wrexham Maelor site.	Yes	Jul-25 & Dec-25	Yes	Staffing reviewed due to reconfigurations of the funded bed base within the Wrexham Maelor site.
		Late	5	4				Late	3	2					Late	5	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	2	2					Night	3	3												
YWM	Erddig	Early	5	4	25.58	19.9	1	Early	5	4	25.58	19.9	1	15/10/2025	Early	5	4	25.58	19.9	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	4	3				Night	4	3					Night	4	3												
YWM	Mason	Early	4	6	19.9	24.16	1	Early	4	6	19.9	24.16	1	15/10/2025	Early	4	6	19.9	24.16	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	4	5				Late	4	5					Late	4	5												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	3	3					Night	3	3												
YWM	Glyndwr	Early	5	3	25.58	17.06	1	Early	5	3	25.58	17.06	1	15/10/2025	Early	5	3	25.58	17.06	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	5	3				Late	5	3					Late	5	3												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	4	3				Night	4	3					Night	4	3												
YWM	U5 (Mon - Fri)	Early	3	2	13.4	7.72	1	Early	3	2	13.4	7.72	1	15/10/2025	Early	3	2	13.4	7.72	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	3	2				Late	3	2					Late	3	2												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	1				Night	2	1					Night	2	1												
	U5 (Sat & Sun)	Early	2	1				Early	2	1					Early	2	1												
		Late	2	1				Late	2	1					Late	2	1												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	1				Night	2	1					Night	2	1												
YG	Tegid	Early	5	4	25.58	19.9	1	Early	5	4	25.58	19.9	1	15/10/2025	Early	5	4	25.58	19.9	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	4	3				Night	4	3					Night	4	3												
YG	Dulas	Early	6	4	28.43	22.74	1	Early	6	4	28.43	22.74	1	15/10/2025	Early	6	4	28.43	22.74	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	6	4				Late	6	4					Late	6	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	4	4				Night	4	4					Night	4	4												
YG	Ogwen	Early	4	5	19.9	25.58	1	Early	4	5	19.9	25.58	1	15/10/2025	Early	4	5	19.9	25.58	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	4	5				Late	4	5					Late	4	5												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	4				Night	3	4					Night	3	4												
YG	Enlli	Early	3	3	14.21	14.21	1	Early	3	3	14.21	14.21	1	15/10/2025	Early	3	3	14.21	14.21	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	3	3				Late	3	3					Late	3	3												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	2				Night	2	2					Night	2	2												
YGC	Ward 3	Early	4	4	21.79	21.79	1	Early	4	4	21.79	21.79	1	15/10/2025	Early	4	4	21.79	21.79	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	4	4				Late	4	4					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	4	4				Night	4	4					Night	4	4												
YGC	Ward 5	Early	5	4	21.79	19.07	1	Early	5	4	21.79	19.07	1	15/10/2025	Early	5	4	21.79	19.07	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	3	3					Night	3	3												
YGC	Ward 7	Early	5	4	21.79	21.79	1	Early	5	4	21.79	21.79	1	15/10/2025	Early	5	4	21.79	21.79	1	24/03/2026	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4												
		Long Day						Long Day							Long Day														

		Twilight						Twilight							Twilight														
		Night	3	4				Night	3	4					Night	3	4												
YGC	Ward 8	Early	4	4	19.07	19.07	1	Early	4	4	19.07	19.07	1	15/10/2025	Early	4	4	19.07	19.07	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	4	4				Late	4	4					Late	4	4												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	3	3				Night	3	3					Night	3	3												
ABH	Ward 6 ABH (Mon - Fri)	Early	4	3	15.57	13.62	1	Early	4	3	15.57	13.62	1	15/10/2025	Early	4	3	15.57	13.62	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	4	3				Late	4	3					Late	4	3												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	2				Night	2	2					Night	2	2												
	Ward 6 ABH (Sat & Sun)	Early	3	3				Early	3	3					Early	3	3												
		Late	3	3				Late	3	3					Late	3	3												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	2				Night	2	2					Night	2	2												
YGC	Ward 19a Glaslyn (Mon - Fri)	Early	2	2	11.37	7.72	1	Early	2	2	11.37	7.72	1	15/10/2025	Early	2	2	11.37	7.72	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	2	2				Late	2	2					Late	2	2												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	1				Night	2	1					Night	2	1												
	Ward 19a Glaslyn (Sat & Sun)	Early	2	1				Early	2	1					Early	2	1												
		Late	2	1				Late	2	1					Late	2	1												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	1				Night	2	1					Night	2	1												
YWM	Bromfield	Early	2	1	11.37	5.69	1	Early	2	1	11.37	5.69	1	15/10/2025	Early	2	1	11.37	5.69	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	2	1				Late	2	1					Late	2	1												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	1				Night	2	1					Night	2	1												
YG	Ffrancon	Early	2	2	11.37	8.53	1	Early	2	2	11.37	8.53	1	15/10/2025	Early	2	2	11.37	8.53	1	24/03/2026	Yes	No	No change to staffing	No				
		Late	2	2				Late	2	2					Late	2	2												
		Long Day						Long Day							Long Day														
		Twilight						Twilight							Twilight														
		Night	2	1				Night	2	1					Night	2	1												

Appendix: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	Betsi Cadwaladr University Health Board
Period of the report	April 2025 - March 2026
Paediatric Inpatient Wards	3

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Paediatric Inpatient Wards

		Reported to the Board in May 2025											Calculated during autumn 2025 cycle										Calculated during spring 2026 cycle										Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles				Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2024)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2024) including**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**						**SHIFT**	**Planned roster calculated by the designated person during the spring 2025 cycle**		**Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**					**SHIFT**	**Planned roster calculated by the designated person during the autumn 2025 cycle**		**Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**															
			RN (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)								**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)								**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)															
YWM	**Childrens Unit**	**Early**			**28.43**	**8.53**	**1**						**Early**			**28.43**	**8.53**	**1**	**15/10/2025**					**Early**			**28.43**	**8.53**	**1**	**24/03/2026**					**Yes**	**No**	**No change to staffing**		**No**			
		Late											**Late**											**Late**																	
		Long Day	**5**	**2**									**Long Day**	**5**	**2**									**Long Day**	**5**	**2**															
		Twilight											**Twilight**											**Twilight**																	
		Night	**5**	**1**									**Night**	**5**	**1**									**Night**	**5**	**1**															
YGC	**Childrens Unit**	**Early**			**28.43**	**11.37**	**1**						**Early**			**28.43**	**11.37**	**1**	**15/10/2025**					**Early**			**28.43**	**11.37**	**1**	**24/03/2026**					**Yes**	**No**	**No change to staffing**		**No**			
		Late											**Late**											**Late**																	
		Long Day	**5**	**2**									**Long Day**	**5**	**2**									**Long Day**	**5**	**2**															
		Twilight											**Twilight**											**Twilight**																	
		Night	**5**	**2**									**Night**	**5**	**2**									**Night**	**5**	**2**															
YG	**Childrens Unit (Mon - Fri)**	**Early**			**28.43**	**8.53**	**1**						**Early**			**28.43**	**8.53**	**1**	**15/10/2025**					**Early**			**28.43**	**8.53**	**1**	**24/03/2026**					**Yes**	**No**	**No change to staffing**		**No**			
		Late											**Late**											**Late**																	
		Long Day	**5**	**2**									**Long Day**	**5**	**2**									**Long Day**	**5**	**2**															
		Twilight											**Twilight**											**Twilight**																	
		Night	**5**	**1**									**Night**	**5**	**1**									**Night**	**5**	**1**															