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Wales

# Performance and Insight Report

May 2026



# Report Overview

Our refreshed **Performance and Insight Report** focuses on delivering actionable insights and assurance whilst identifying areas for further improvement.

The report focuses on our performance across the following key areas:



## Section 1 Governance and Accountability

This section provides information and assurance for a number of areas key corporate accountability including **People Governance, Finance Governance and Corporate & Information Governance**



## Section 2 Service Delivery

This section provides information and assurance for the activities that our services carry out on a day-to-day basis including our **Health Protection and Screening Services, Health and Wellbeing services, Policy and International Health and our Research, Data and Digital services**



## Section 3 Strategy Delivery

This section provides information and assurance for the delivery of our strategic plan including **IMTP Milestone Delivery**, progress against our **Strategic Change Programmes** and updates for our **six strategic priorities**. The section also includes an update on **Inequalities** which is reported on a bi-monthly basis.



## Section 4 Outcomes Measurement

This section provides information and assurance on our developing work on **Outcomes Measurement**, including reporting of IMTP measurement system indicators and developing a strategically aligned Evaluation Programme for 2025/26 onwards. Update provided on a bi-monthly basis.



## Section 1

# Governance and Accountability



# Key Performance Indicator Summary



	Target	12 Month Look Back	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
<b>People Governance</b>														
12m Rolling Sickness Absence FTE %	<3.25%		4.51%	4.58%	4.61%	4.58%	4.57%	4.52%	4.58%	4.46%	4.52%	4.60%	4.64%	4.63%
Statutory and Mandatory Training	85%		93.2%	93.2%	93.0%	93%	92.9%	92.9%	92.9%	92.9%	92.8%	92.3%	92.4%	92.5%
Appraisal Compliance	85%		86.1%	86.2%	86.3%	86.8%	86%	86.5%	86.5%	86.0%	85.7%	83.4%	79.9%	78.6%
Diversity ESR Data	N/A		77%	77%	77%	77%	78%	77%	77%	77%	78%	78%	78%	78%
Agency Spend, % of Total Pay Bill	30% Reduction		1.4%	1.4%	1.4%	1.3%	1.2%	1.1%	1.0%	1.0%	1.0%	0.9%	0.8%	0.8%
<b>Financial Governance</b>														
Revenue Position YTD	Breakeven		£-10K	£-10K	£-33K	£-0.016k	£-0.002k	£-0.040k	£-0.069k	£-0.034k	£-0.054k	£-0.088k	£-5.000k	£-0.002K
Revenue Position Forecast	Breakeven		£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k	N/A	£0k	£0k
Capital Year-End Position	Breakeven		£23K	£62K	£225K	£0.282k	£0.656k	£0.738k	£1.014k	£2.149k	£3.304k	£4.607k	N/A	£0.132k
Public Sector Payment Policy (PSPP)	95%		97.00%	97.36%	97.56%	97.41%	97.38%	97.34%	97.34%	97.32%	97.27%	97.29%	97.00%	96.55%
<b>Information Governance</b>														
Freedom of Information Request Response*	Within 20-Days		4	2	1	1	1	0	0	1	0	1	2	
Subject Access Request Response*	1 Month Avg		0	0	0	0	0	0	1	0	1	1	0	
Personal Data Breaches Reported	N/A		2	7	1	2	1	3	3	4	2	2	3	
Personal Data Breaches Reported - Escalated	N/A		1	0	0	0	1	2	0	1	0	0	1	
Mandatory Information Governance Training	85%		91%	91%	91%	91%	91%	90%	90%	90%	95%	89%	89%	89%
<b>Clinical Governance</b>														
Moderate or above harm incidents - Monthly	N/A		6	0	0	2	1	2	7	6	6	22	4	6
Moderate or above harm incidents - YTD*	N/A		18	18	18	25	26	28	35	41	47	69	4	10
Number of externally reported incidents (NRI's, EWI, RIDDOR, IRMER) - In Month	N/A		1	0	2	3	1	0	4	1	0	1	0	0
Number of externally reported incidents (NRI's, EWI, RIDDOR, IRMER) - Rolling 12m	N/A		12	10	13	15	13	13	20	24	24	23	26	26
Incident Closure Compliance**	85% PHW		59.7%	65%	79%	79%	86%	85%	71%	70%	72%	74%		
Formal Complaints - Acknowledged within 5 working days**	75% WG 95% PHW		90% (3)	100% (4)	100% (3)	75% (4)	50% (4)	100% (5)	100% (2)	100% (3)	100% (4)	67% (3)		
Formal Complaints - Responded to within 30 working days**	75% WG 95% PHW		75% (3)	100% (4)	67% (2)	50% (4)	75% (4)	60% (5)	100% (2)	100% (3)	75% (4)	100% (3)		
Early Resolution Complaints - In Month***	75%													100%
Early Resolution Complaints - YTD***	N/A													13
Nationally reportable incidents open over 12 months*	0 NRIs		0	0	0	0	0	0	0	0	0	0	0	0
Number of never events *	0 Never Events		0	0	0	0	0	0	0	0	0	0	0	0

\*This data is YTD from 1 April 2026.

\*\*Note: NRI and never events introduced in NHS Performance Framework 2026/27

\*\*Note: Incidents and Complaints require 30 working days for closure, therefore this data pertains to March 2026

\*\*Note: Figure in brackets refer to total complaint numbers received.

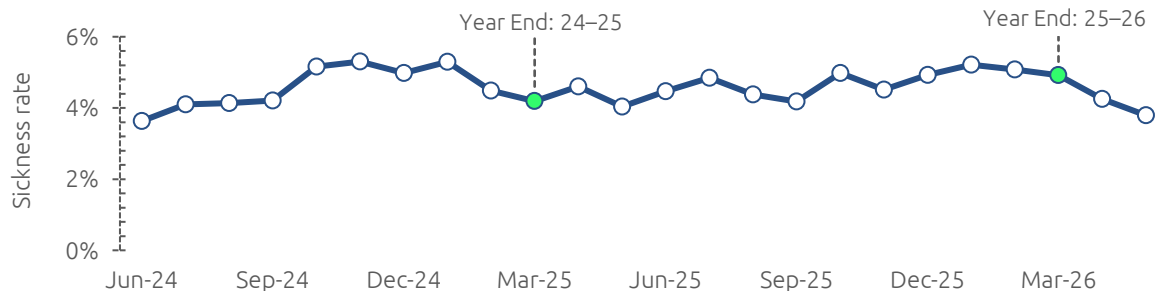
\*\*\*Note: Early Resolution Complaints was previously reported as Informal Complaints and is now presented as a percentage rather than a count. This change reflects new regulations introduced on 1 April 2026 and as a result data will be reported from May 2026 onwards



# People Governance: Sickness Absence

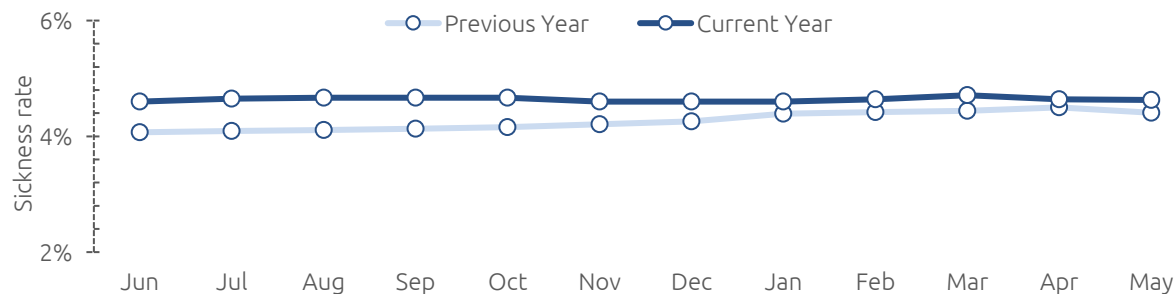


## Sickness Absence



**3.79%** Decreased by **0.47%** in May 2026.

## 12 Month Rolling Absence



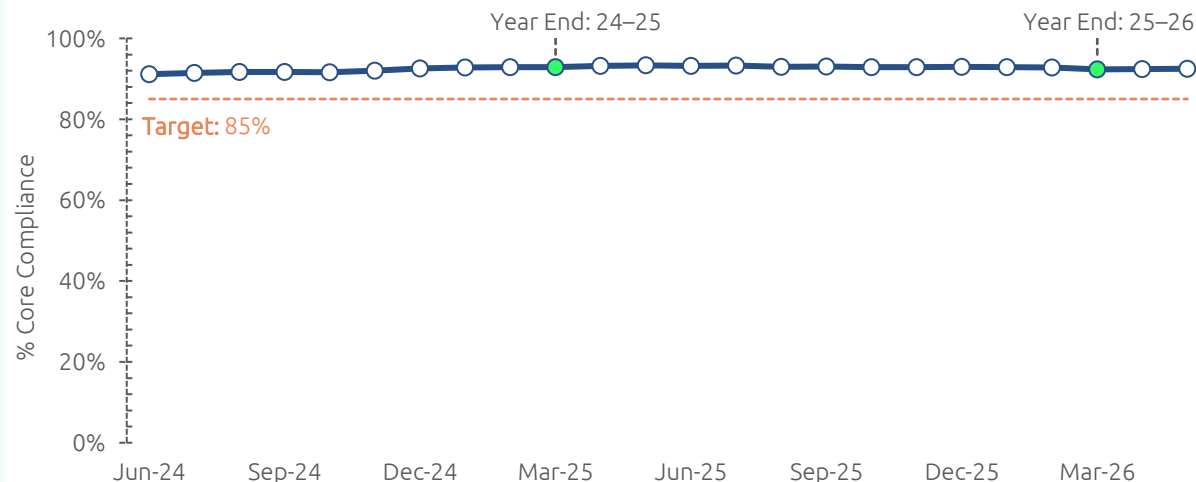
**4.63%** Achieving a reduction in sickness absence in 2026/27 in comparison to 2025/26 is a **Cabinet Secretary Enabling Action**. Trend levels remain consistently **above** target.

**+0.22%**  
Year on Year

Additional assurance is provided in the focus area on pages 6



## Statutory and Mandatory Training



**85%**

Remains **above** target in May 2026.

**92.5%**

All Directorates continue to **exceed** target within the financial year except for Board and Corporate (84.8%).

The module reporting lowest completion is Moving and Handling (87.7%).



# In Focus: Sickness Absence



## Key Insights

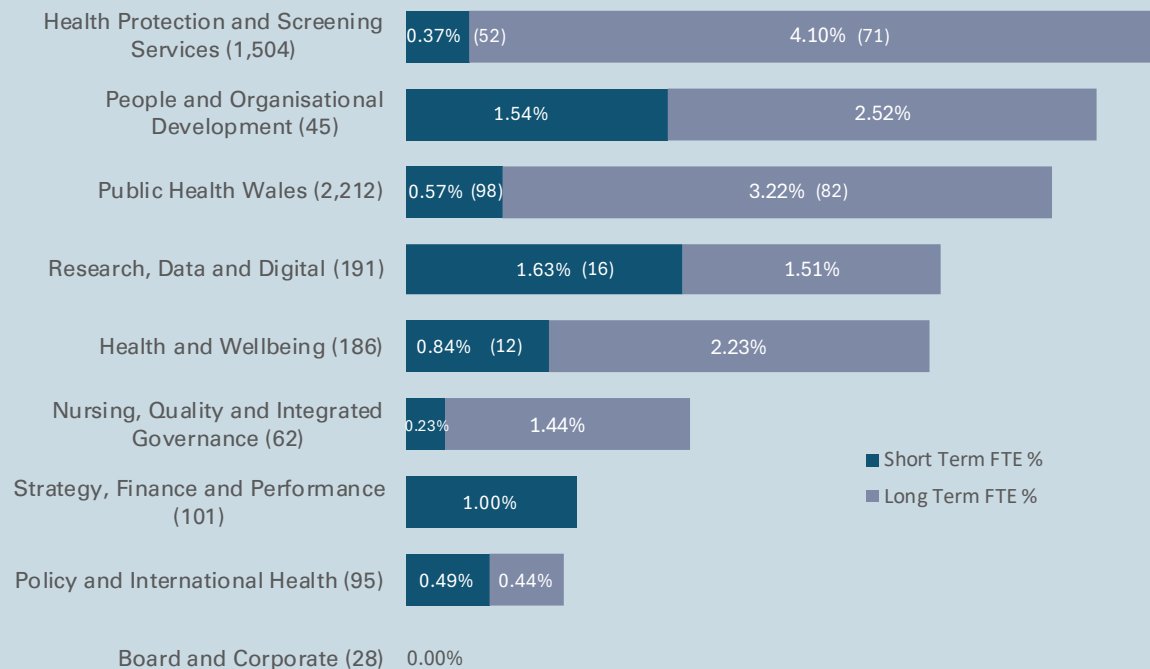
- Overall sickness absence reduced to 3.79% in May 2026, an improvement from 4.26% in April 2026.
- Long-term sickness absence continues to be the primary driver, accounting for 84% of FTE days lost in May 2026, with short-term absence representing 16%. This continues to indicate the importance of sustained case management and effective rehabilitation.
- Anxiety, stress, depression and other psychiatric illness remain the most reported reasons for absence. This aligns with national patterns, with CIPD evidence indicating that mental ill-health accounts for around a quarter of both short- and long-term absence. This underlines the need to maintain a consistent organisational focus on wellbeing, alongside early and proactive intervention.

## Assurance and Actions

- People and OD continue to support the management of long-term absence, providing advice to managers, attending review meetings and promoting early Occupational Health referral and other timely interventions, particularly for mental health-related cases.
- Managing Attendance at Work training remains in place with regular sessions for those with people management responsibilities, alongside ongoing access to HR Clinics for tailored case advice.
- The updated Workplace Adjustment Passport is now in use, supporting a more consistent approach to identifying and recording adjustments, and helping managers provide appropriate and timely support for employees.

## Sickness Absence by Directorate

The breakdown of Directorate level sickness absence for May 2026 is provided below, split by Short-Term (less than 28 days) and Long-Term (28 days or more) Absence FTE %.



\*NB. Number of sickness episodes are in brackets - fewer than 10 have been redacted in accordance with data confidentiality.

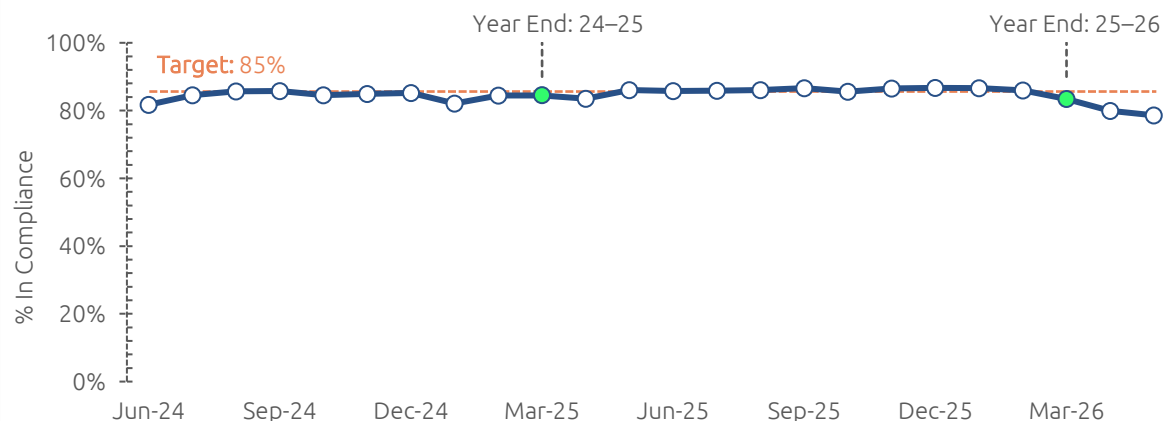




# People Governance: Sickness Absence



## Appraisal and Development Reviews



**85%** **78.6%**

Appraisal compliance has dropped further **below** the 85% target. Health & Wellbeing is currently below target at 79.3% with HPSS at 74.8%

Compliance may decline over the next three months if appraisals are not completed in a timely manner. People and OD continue to support improvement and address barriers to completion.

*\*Reported retrospectively taking into account updated data being reported following the monthly refresh. Previous reports may therefore demonstrate minor variances in monthly performance data.*

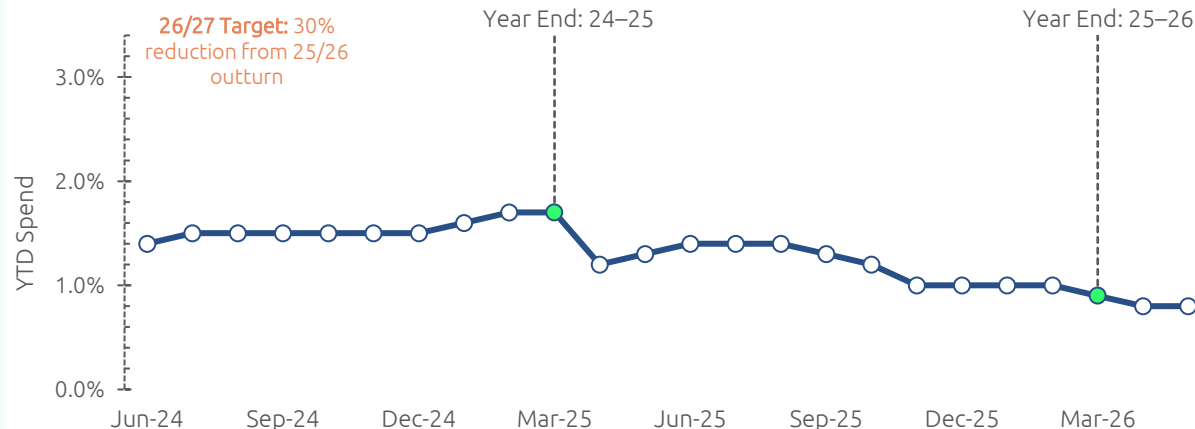
## Equality and Diversity

**78%**

We encourage all staff to record their diversity data in ESR so that we can use the data effectively and ensure we are meeting the needs of our workforce.

Our current Diversity data completeness has steadily improved over the last four years

## Agency Spend as A Percentage of Total Pay Bill



**0.8% YTD** **0.7% Forecast**

Forecast to be reduced below 2025/26 levels.

Year-to-date agency spend remains at 0.8% of the total pay bill and is forecast to be maintained at this level. While this represents a reduction from the 2025/26 outturn, no further reduction has been achieved in-year, and performance is not yet aligned with the 30% reduction target. In May, PHW spent £105k on agency staff, £47k of which was categorised as Admin and Clerical.

Our performance against the **Cabinet Secretary Workforce Enabling Action** to reduce Admin and Clerical agency use to nil by the end of September 2026 is reported as a workforce performance indicator and is monitored through our Monthly Monitoring Returns to Welsh Government. Month 2 financial forecasting indicates a failure to meet this target by month 6, highlighting the need to regularly review the robustness of our plans and take forward mitigating actions where required.

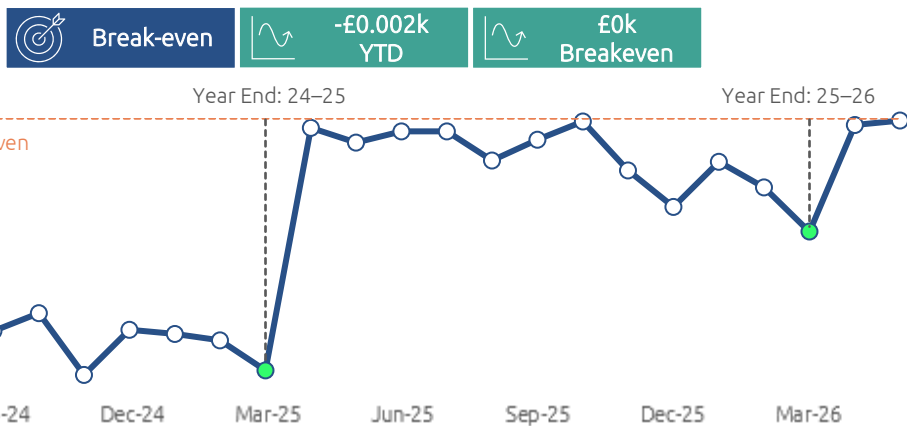
The use of agency staff remains under scrutiny, with all requests subject to review and early consultation between People and OD, Finance, and business leads, ensuring decisions balance operational risk, workforce capacity, and financial control.



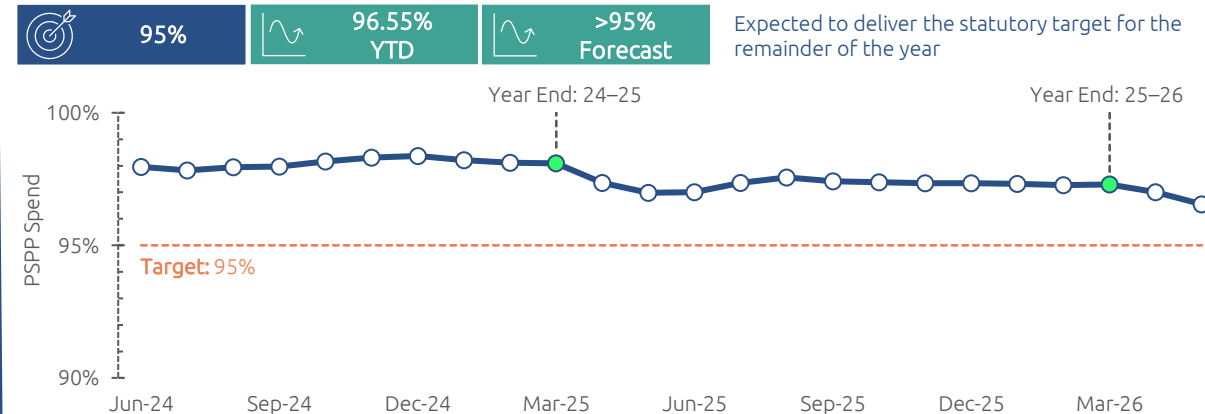
# Financial Governance



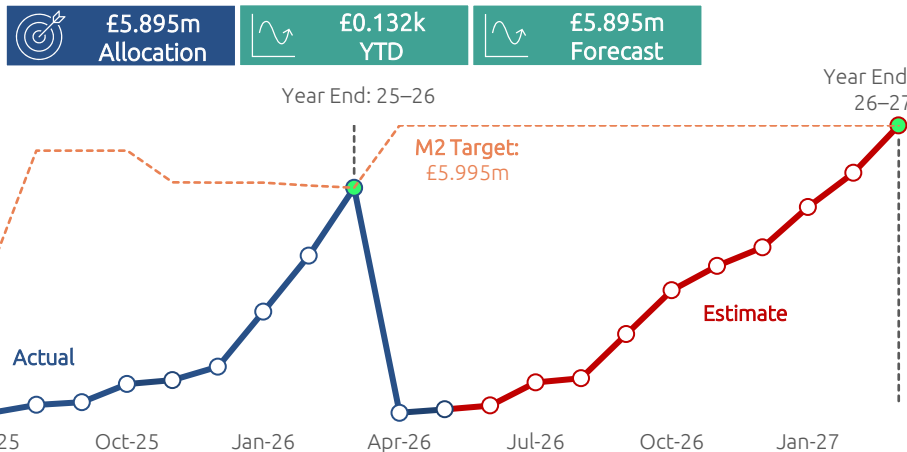
## Revenue Position



## Public Sector Payment Policy (PSPP)



## Capital Position



Click to access further detail in the latest Finance Board Report

The Capital position is **breakeven**. PHW capital funding is made up of a discretionary allocation of £1.809m and a strategic allocation of £4.086m.

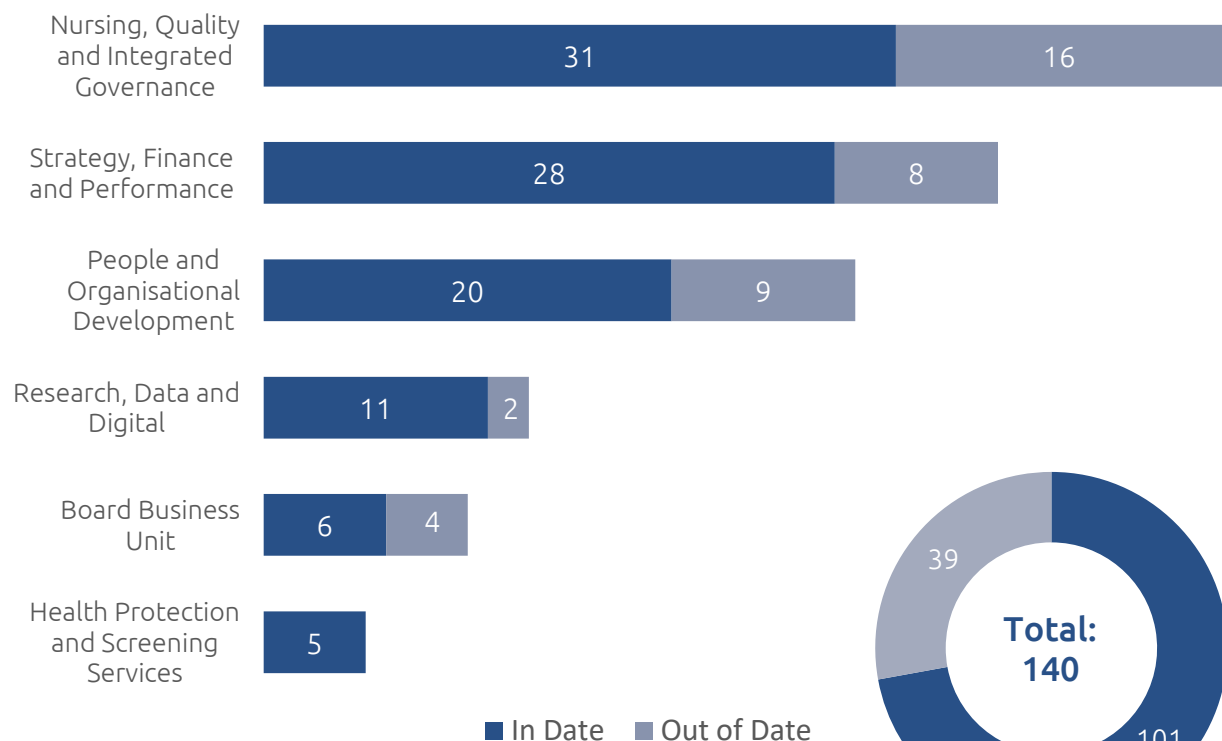


# Corporate and Information Governance



## Corporate Governance

### Corporate Policies Compliance



### In May 2026:

- 5 Policies were approved in Strategy, Finance and Performance.

### In date Policies

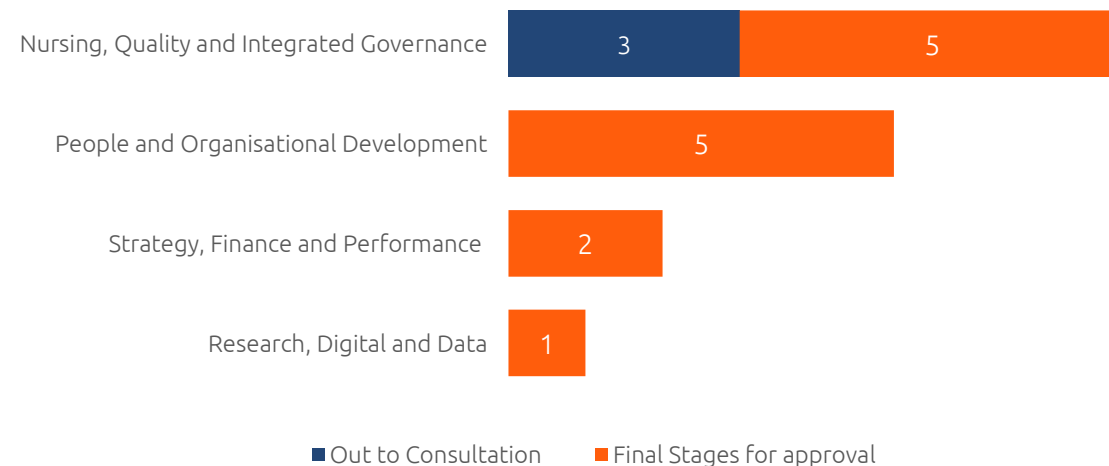
- 0 in date policies are in the final review stages.

### New Policies being developed

- 1 new policy is being developed.

### Review of Policies - Out of date

- Of the 39 Policies out of date, 16 policies / procedures are currently out to [consultation](#) / going through the approval process (numbers that are either out to consultation or awaiting a meeting for final approval).





# Corporate and Information Governance

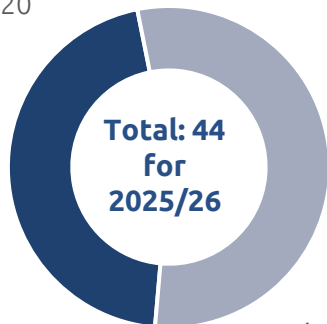


## Corporate Governance

### Welsh Health Circular (WHC) Compliance

2025/26

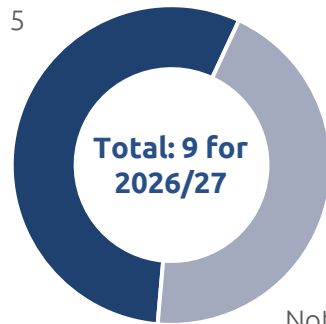
Applicable  
20



Not  
Applicable  
24

2026/27

Applicable  
5

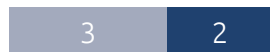


Not Applicable  
4

Of those applicable: 2025/26



Of those applicable: 2026/27



■ In Progress

■ Completed

### For the Period 1 – 31 May 2026:

3 WHCs received:

- **1 WHC assessed as applicable:**
  - **WHC 2026 (018)** – Reminder of Statutory Duties under the Notification of Infectious Diseases Regulations (Wales)
- **2 WHCs assessed as not applicable:**
  - **WHC 2026 (014)** – NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2026/27
  - **WHC 2026 (024)** – Regulation 28 Prevention of Future Deaths Report – Assurance on alarm “latching” functionality in acute monitored environments

### WHCs currently In Progress update:

- **WHC 2026 (038)** – All-Wales NHS Accessible Communication and Information Standards (received September 2025). This is subject to an ongoing Organisation-wide review being undertaken on behalf of the Leadership Team.
- **WHC 2025 (049)** – Welsh Health Circular in respect of development and implementation of a Patient Travel Policy (received December 2025). A Policy has been submitted to the HPSS SMT for approval, which will complete the WHC and enact it to close.
- **WHC 2026 (004)** – Refreshed Intellectual Property (IP) guidance and policies for NHS Wales organisations (received March 2026). A review is underway to ensure compliance.
- **WHC 2026 (008)** – NHS Research and Development Finance Policy 2026 (received March 2026). An internal review is underway, and an action plan developed.
- **WHC 2026 (012)** – Population Health Management (received April 2026). This is in progress with the Health and Wellbeing Directorate.
- **WHC 2026 (015)** – All Wales General Practice and Health Board Clinical Interface Standards (received April 2026). This is in progress with the Health Protection and Screening Services Directorate and will be closed June.



# Corporate and Information Governance



## Information Governance

### Data Protection (Subject Access) Requests

Please be aware, this data is currently only recorded as far back as October 2023.

- 5 Received
- 1 Month
- 0 Exceeded

In April 2026, 5 Data Subject Access Requests were registered.

All were responded to within the one calendar month deadline.

### Freedom of Information Act

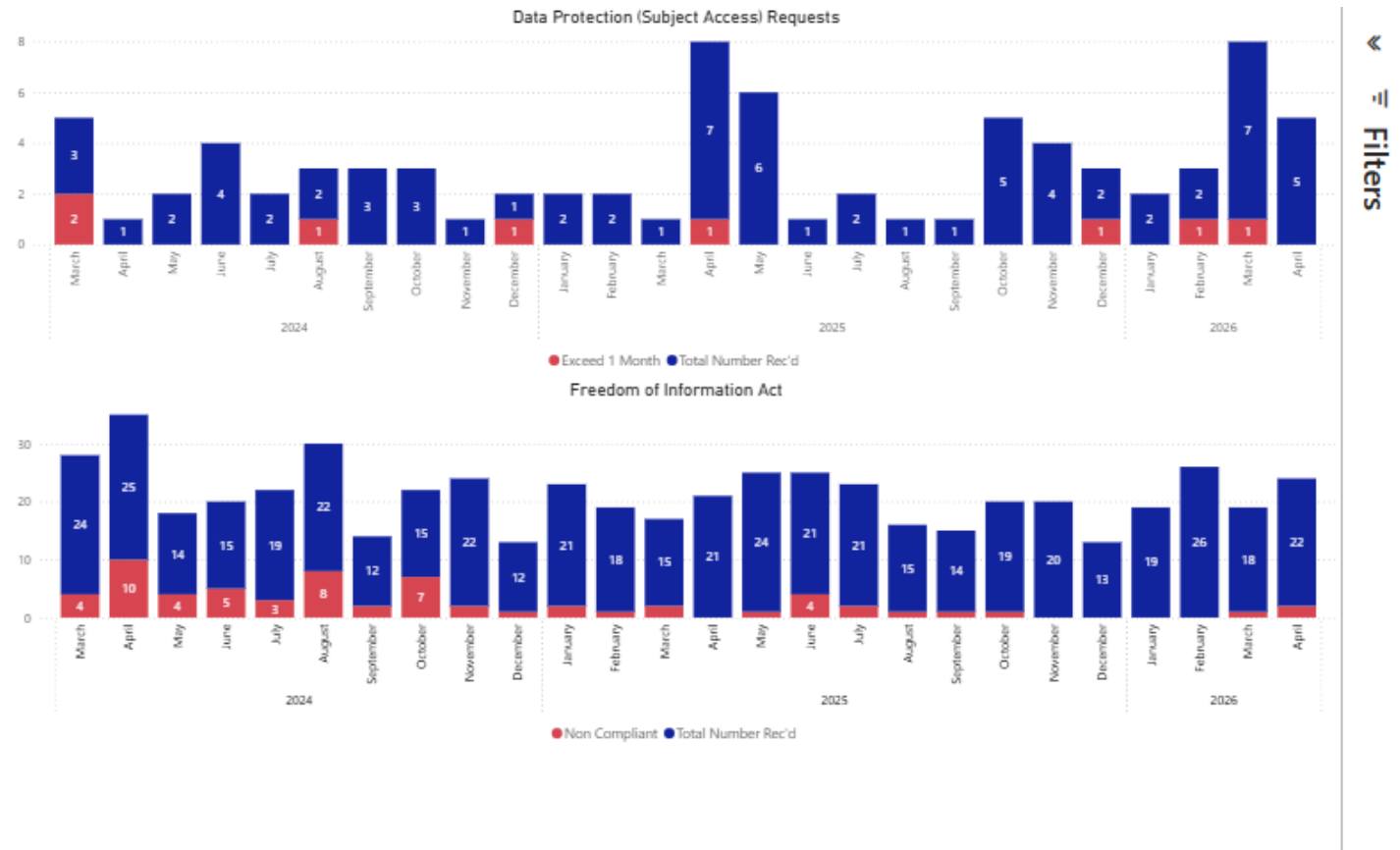
Non-compliant refers to the number of requests out of compliance with the legislation. Certain requests can be compliant and be over the 20-working day target.

- 22 Received
- 20 days
- 2 Non-Compliant

Of the 22 FOI requests received in April 2026, 2 were non-compliant.

The reason for non-compliance for the first FOI was complexity and the involvement/consultation with other divisions to compose a correct response.

The second FOI fell out of compliance due to late notification that other divisions may hold information to contribute to the response.



The data within this slide reflects a point-in-time position and is inherently subject to change. Therefore, variances between this data and subsequent quarterly or annual reports are expected in relation to FOI, SARs, and PDB activity, where records remain live and are updated until formal closure.

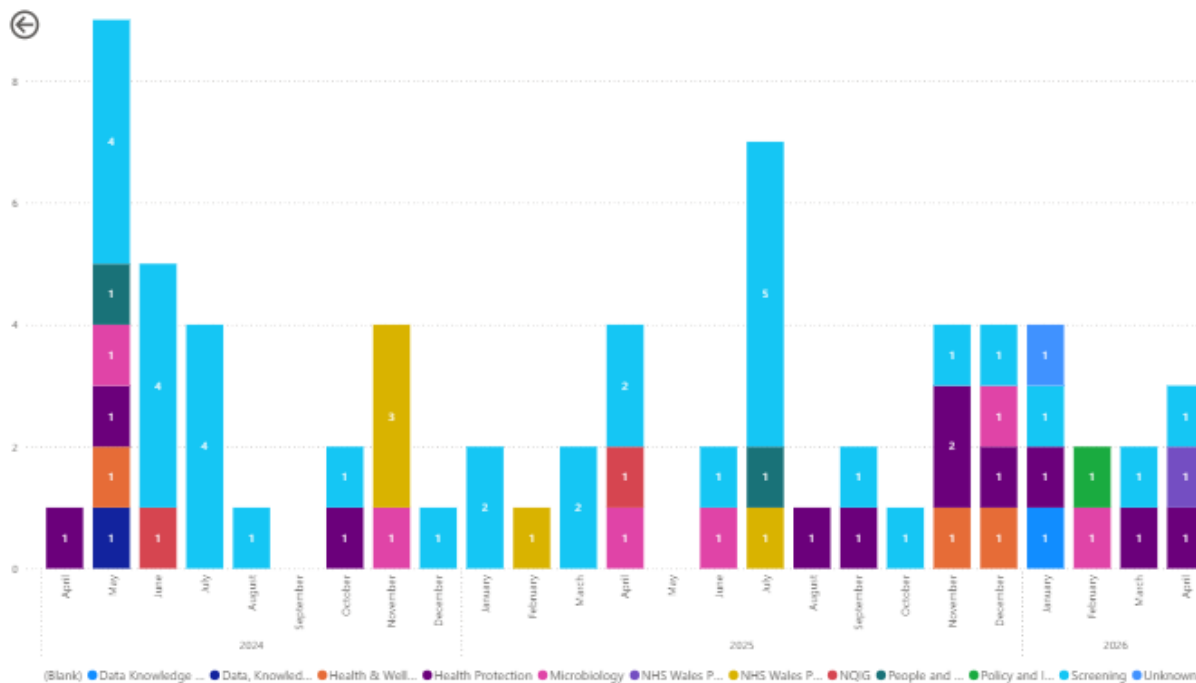


# Corporate and Information Governance



## Information Governance

### Personal Data Breaches



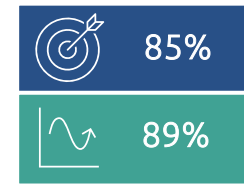
Reported	Escalated
3	1

Filters

There were 3 PDBs in April 2026:

- **ICO:** Related to six users of the STD Test and Post service who had their results sent to them by text message when they had specifically requested that this option was not to be used to inform them. This was because of an error in manual processing.

### Mandatory Information Governance Training



Organisation-wide compliance with Information Governance mandatory training **exceeds** the national target in May-26.



*Trend analysis and comparison to historic performance is included in the PAD*



# Clinical Governance, Quality, Safety and Improvement



## Externally Reportable Incidents - May update

- 0 Nationally Reportable Incidents reported
- 0 Early Warning Incident reported
- 0 Duty of Candour Incident reported
- 0 Post Investigation Harms (Moderate or above)

## Further Information

### Early Warning (EW) & Nationally Reportable Incident (NRI)

0 Early Warning or Nationally Reportable Incidents reported in May.

### Initially Reported Moderate or above harm incidents

6 Incidents initially reported as moderate harm.

4 have subsequently been downgraded to low harm and no harm following investigation.

2 remain under investigation with the final harm level to be determined.

### Incidents investigated and closed as Moderate harm or above

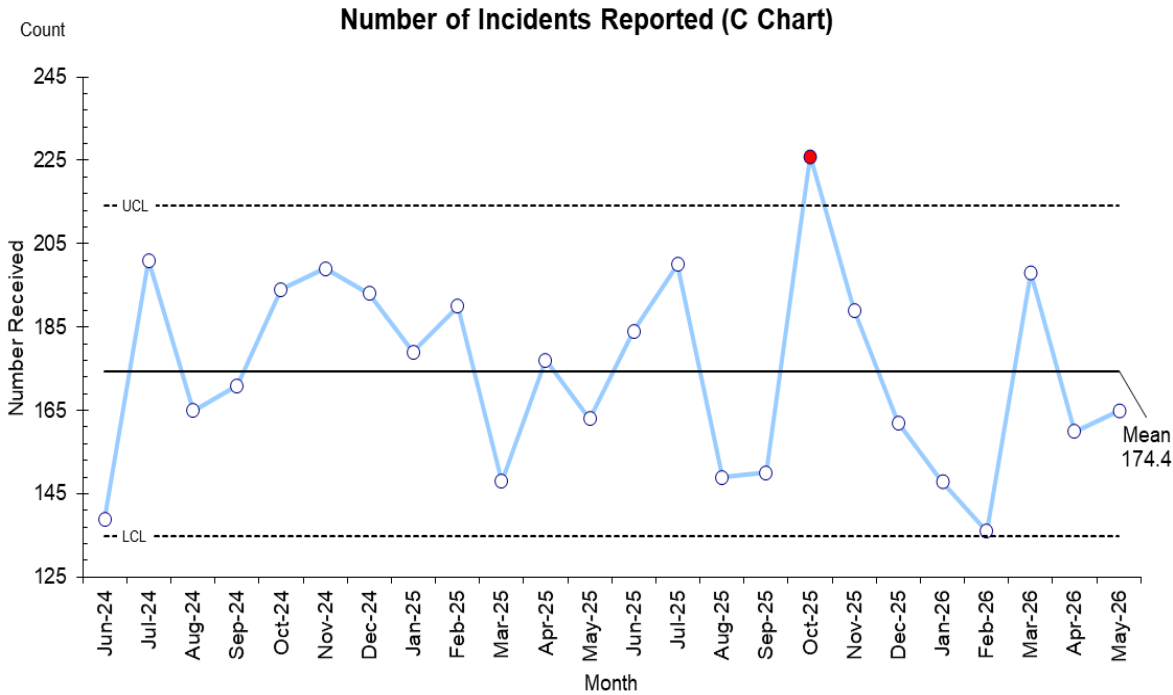
0 incidents have been closed with a moderate harm or above categorization.



# Clinical Governance, Quality, Safety and Improvement

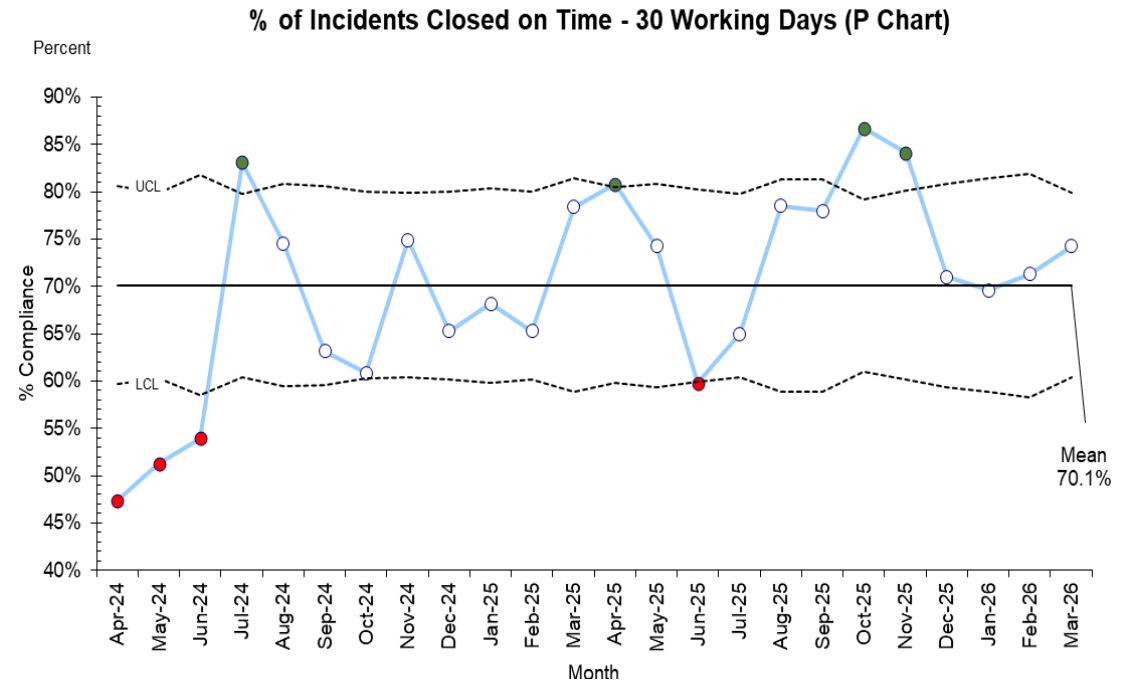


## Number of Incidents Reported Over Time



No recent special cause variation noted.

## Percentage of Incidents Closed within 30 Working Days



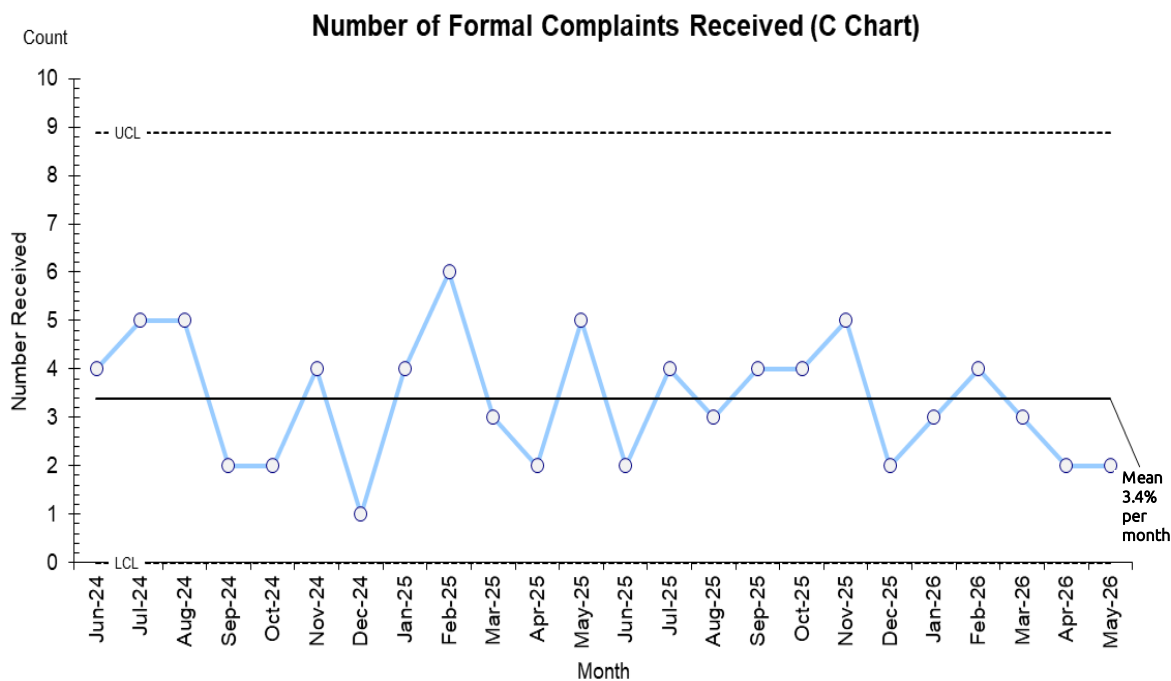
No recent special cause variation noted.



# Clinical Governance, Quality, Safety and Improvement



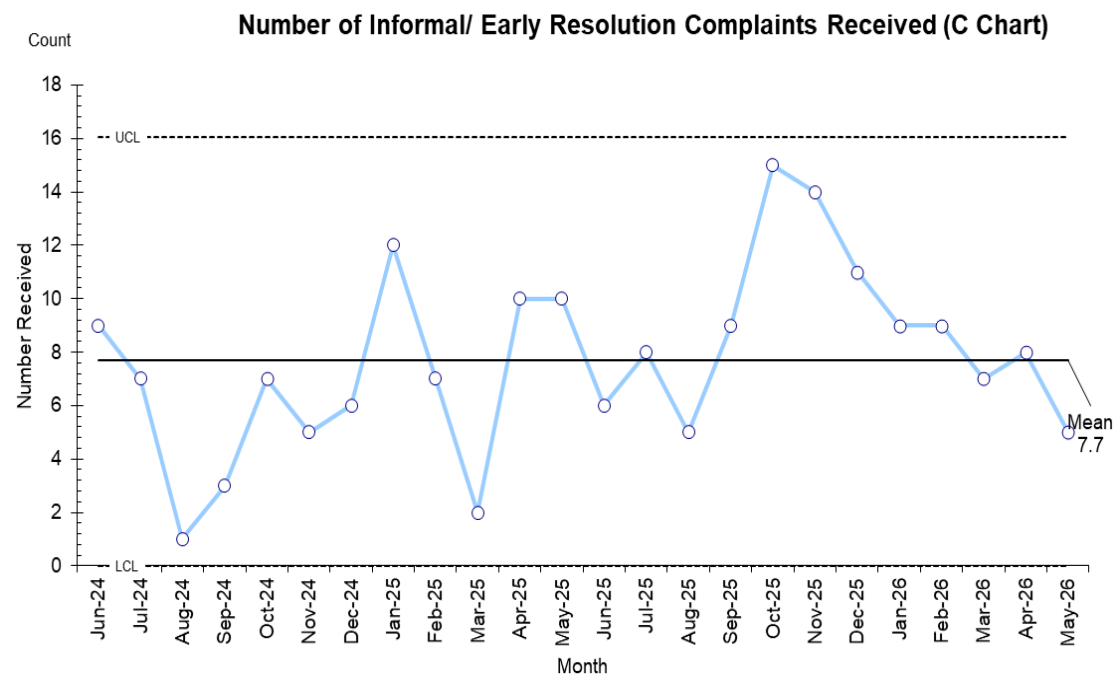
## Number of Formal Complaints Received



No recent special cause variation noted.

All complaints received since the 1st April 2026 are now managed via the Listening to People regulations.

## Number of Informal/ Early Resolution Complaints Received



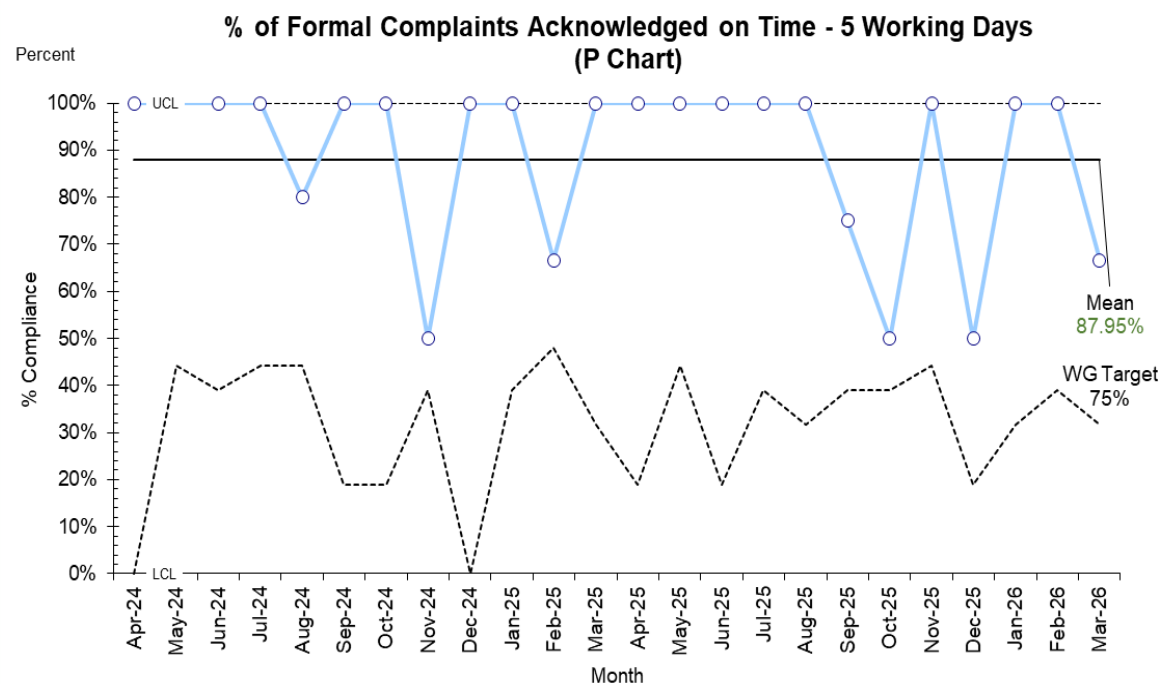
No special cause variation identified.



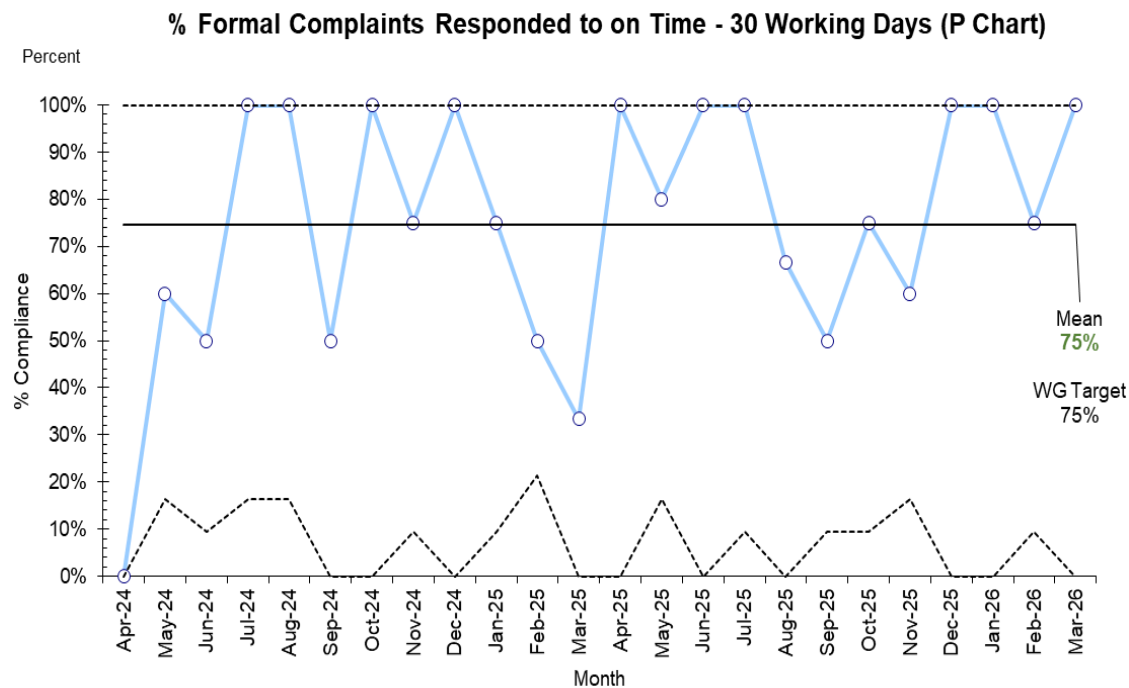
# Clinical Governance, Quality, Safety and Improvement



## Formal Complaints Compliance



Of the 3 complaints we had, 1 did not get acknowledged in the 5 working days. This was due to the complaint not being sent to us on time.



No special cause variation identified. Meeting Welsh Government target.



# Clinical Governance, Quality, Safety and Improvement



## Themes and Service Areas – May 2026



2 Formal complaints and 5 Early Resolution complaints received in May.

Please note: All complaints received since the 1st April 2026 are now managed via the Listening to People regulations.

## Claims

May 2026

1

1 new potential claims received in May. This was transferred from a Redress case.

Of the 35 ongoing claims, 28 are confirmed and 7 potential.

## Redress

May 2026

0

0 new Redress cases were received in May.

There are 7 ongoing Redress cases, 4 in Breast Test Wales and 3 in Cervical Screening Wales.

All Redress cases are being progressed in line with the Putting Things Right and Listening to People Regulations.



# Section 2 Service Delivery





# Key Performance Indicator Summary



Screening Services	Target	12 Month Look Back	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Bowel Screening Wales – Waiting time for index colonoscopy (4 weeks) (Health Board Delivery)	90%		4.9%	8.8%	14.1%	10.5%	19.7%	22.5%	28.5%	18.8%	24.1%	22.3%	11.8%	
Cervical Screening Wales – Waiting time for colposcopy appointment (8 weeks) (Health Board Delivery)	90%		98.8%	98.4%	98.8%	95.3%	98%	98.3%	98.9%	98.7%	99.0%	97.1%	98.2%	
Breast Test Wales – Assessment invitations (3 weeks)	90%		19.6%	24.1%	24.6%	31.6%	17.4%	41%	28.3%	13.5%	10.6%	45.7%	50.1%	23%
Diabetic Eye Screening Wales – Coverage (12 Months)	80%		39.3%	38.9%	38.4%	39.6%	39.6%	38.4%	38.4%	38.9%	39.5%	39.7%	39.8%	38.8%
Abdominal Aortic Aneurysm – Timely referral to elective vascular network (MTD)	100%		100%	66.7%	100%	100%	100%	100%	100%	83.3%	100%	100%	83.3%	100%
<b>Infection Services</b>														
Total Microbiology Rejection Rates	<5%		5.1%	5%	5%	4.8%	4.8%	4.8%	5%	5%	4.8%	4.8%	4.7%	
Total Microbiology Diagnostic Sample Requests	*N/A		162,252	178,612	156,429	168,719	184,730	167,313	164,861	172,196	157,115	171,858	162,373	
Blood Culture - Collected to Incubation SMI <4hrs	>95%		68.5%	68.3%	68.1%	68.3%	70.3%	69.9%	67.8%	69.7%	69.0%	68.4%	67.7%	
Blood Culture - Received (PHW Laboratory) to Incubation <4hrs	>95%		99.7%	98.4%	99.6%	99.6%	99.3%	99.2%	99.7%	99.7%	99.4%	98.3%	96.0%	
<b>Health Protection</b>														
Test and Post (STI self-sampling) – Test Turnaround Times (Less than 7 days)	99%		99.66%	99.94%	99.95%	99.97%	99.97%	100%	99.89%	99.98%	99.98%	99.92%	99.20%	
Response times by priority - Urgent (<4 hours)	90%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Response times by priority - High (<24 hours)	90%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Response times by priority - Medium (<48 hours)	90%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Compliance to surveillance reporting schedules	90%		100%	100%	79%	87%	79%	95%	92%	95%	87%	94%	91%	78%
<b>Health &amp; Wellbeing</b>														
JUSTB – Number of Schools with 2-day training completed by month**	40-50 Schools in total		4	N/A	N/A	1	4	5	1	4	5	6	5	7
JUSTB – Number of Schools with 2-day training completed YTD**			40	N/A	N/A	1	5	10	11	15	20	26	31	38
Whole School Approach – Percentage of schools with an Action in Place (All schools)	80%		87%	88%	88%	89%	90%	92%	93%	96%	96%	96%	97%	97%
Whole School Approach – Percentage of schools with an Action in Place (Secondary schools)	100%		99%	99%	99%	99%	99%	99%	99%	100%	100%	100%	100%	100%
Help Me Quit - Benchmark for timely first contact (NTSS)	90%		94%	89%	96%	93%	95%	95%	94%	94%	94%	79%	96%	
Help Me Quit – 4-week self-reporting quit rate (NTSS)	35%		48%	72%	75%	72%	59%	66%	81%	73%	76%	69%	74%	
<b>Research Data &amp; Digital</b>														
			Quarter 1 (25/26)				Quarter 2 (25/26)			Quarter 3 (25/26)			Quarter 4 (25/26)	
Number of Major Breaches	0 Major Breaches		0 Breaches				0 Breaches			0 Breaches			1 Breach	
Percentage of publications without breaches	100%		76%				76%			76%			76%	
Percentage of user follow up to RD&D products	100%		20%				33%			33%			33%	
<b>Policy and International Health</b>														
Indicators and targets to be developed where applicable														

\*N.B. Additional performance indicators reported on the Performance & Assurance Dashboard, including screening and turnaround times for infection services

\*\*N.B. JUSTB data is only collected and reported during school term time. As a result, data will not always be available.



# Health Protection and Screening Services



## Breast Test Wales (May 2026)

In May 2026 on an All-Wales level **23%** of women were given an assessment invitation within three weeks of screen against the standard of **>90%**. **35.4%** of women were given an assessment invitation within four weeks of screen against the standard of 100%. The average wait in weeks for assessment invitation was 5 weeks against a standard of three weeks; however, this has **improved** from a 6.4 week wait in February 2026. The waiting time range across Wales in May 26 was 2 to 11 weeks, with North at 5 to 11 weeks, South at 2 to 6 weeks and West at 2 to 4 weeks. There has been resolution of the pathway in North Wales to improve flexibility of the pathway, following executive level escalation which will further reduce the backlog of women waiting for assessment.

On a regional level, 0% of invitations were given within three weeks of screen in North Wales. In the South Wales region, there was an increase in the number of assessment invitations given within three weeks of screen, from 8.4% in February to 13.2% in May. In the West Wales region, there was also an increase in the number of assessment invitations given within three weeks of screen, from 33.3% in February to 68% in May.

**82.4%** of women had normal results sent within two weeks of screen against a standard of >90% and **21.8%** of women had abnormal results sent within two weeks of screen against a standard of >90%. The two-week time to reading interval is being reviewed to improve compliance with the standard.

## Breast Test Wales - Improvement plan

In May 2026 reading timeliness in the North remains on trajectory, supported by sustained cross-regional reading, weekly performance monitoring and continued progress in training and integrating new readers.

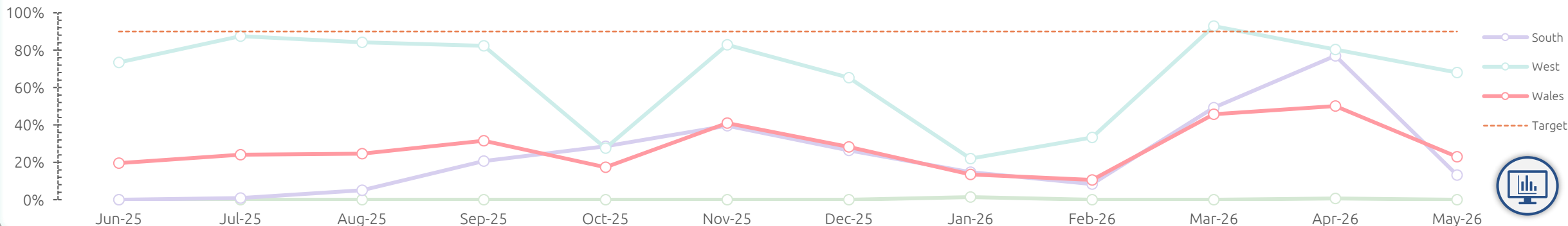
Assessment timeliness remains the principal operational risk, particularly in North Wales, driven by surgeon sickness, constrained onward pathways and reliance on maintaining safe radiology-led clinics where surgical cover is unavailable.

Round length recovery continues to be off trajectory and remains sensitive to workforce resilience, screening cancellations, mobile reliability and the availability of validated data to inform prioritisation. Modelling work is progressing, but further data validation and throughput consistency are required to support recovery. Workforce pressures remain a key dependency, with sickness, leave and staffing gaps contributing to cancellations and reduced resilience across the service.

Further engagement of the Breast Screening Review is currently in-progress, with the reflection of staff feedback being encompassed and clearer alignment between findings, existing improvement activity and resourcing.

Uptake and inequalities work continues through the Uptake Group, supported by planned Surge Team activity to better understand barriers to attendance and inform targeted interventions.

### BTW-006A: Assessment Invitations Given Within 3 Weeks of Screen





# Health Protection and Screening Services



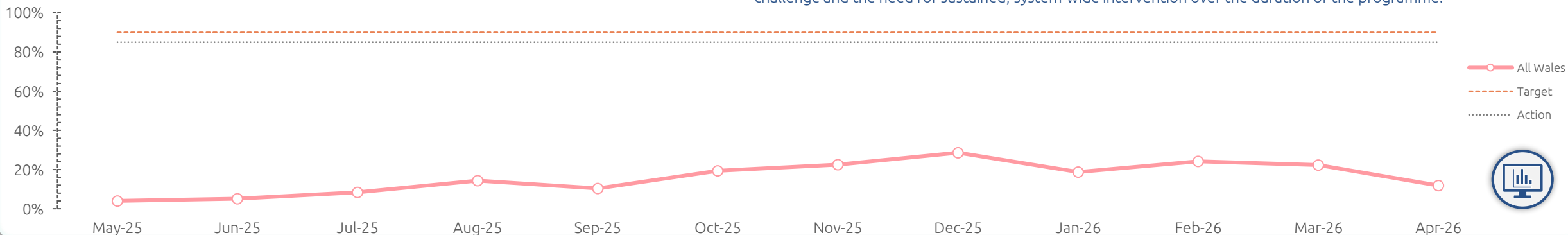
## Bowel Screening Wales (April/May 2026)

In May 2026, Bowel screening uptake and coverage both remain **above** the standard of >60%, reporting **66.1% and 62.1%**, respectively. 100% of participants were sent their screening test result within 7 days of receipt of test kit in laboratory.

In April, **11.8%** of participants were offered an appointment within 4 weeks with a current average waiting time for a screening colonoscopy of 6 weeks and 6 days. In comparison with April 2025, where 6.7% of participants were offered an appointment within 4 weeks, this is an improvement but still considerably below standard.

As of 29th April 2026, the average waiting time for a screening colonoscopy is at 6 weeks and 6 days. Waiting times range from 1 to 16 weeks across the 14 screening centres. Average Specialist Screening Practitioner waiting time is 6 days, which is within standard.

### BSW-007: Waiting Time for Index Colonoscopy/Flexi-Sig Procedure Within 4 weeks of Booking SSP Appointment – Looking Back



## Bowel Screening Wales - Improvement plan

In May 2026, governance and oversight arrangements have been fully established, with a national Project Board in place, defined terms of reference agreed, and five operational workstreams mobilised covering workforce, service delivery, quality assurance, regional collaboration, and innovation. Initial engagement has been strong, with broad representation from all health boards and partner organisations, and early programme milestones delivered, including project initiation, governance approval and commencement of structured workstream activity.

Early progress has focused on building the foundations for delivery. This includes the development of recovery plans across all health boards, strengthened performance oversight through revised reporting and planned patient tracking list implementation, and the establishment of a revised quality assurance framework and clinical audit programme. Workforce pipeline activity is progressing through accreditation planning and mentor identification, while service fragility assessments and demand and capacity modelling are informing recovery trajectories and regional solutions.

However, significant system constraints persist. Workforce capacity remains limited, alongside wider system pressures including constrained clinical and nursing availability, competing priorities across health boards, and financial limitations impacting the ability to invest in backlog recovery and service modernisation. In addition, there are emerging risks related to downstream demand, including pressure on pathology services, and reduced capacity within the central team affecting delivery of the clinical audit programme.

The programme is now transitioning from mobilisation to delivery. Workstreams are progressing from initial scoping to the development and implementation of recovery plans, improvement trajectories and system-wide recommendations. While all workstreams are currently reporting on track and foundational improvements are underway, overall performance remains below the national standard, reflecting the scale and complexity of the challenge and the need for sustained, system-wide intervention over the duration of the programme.





# Health Protection and Screening Services



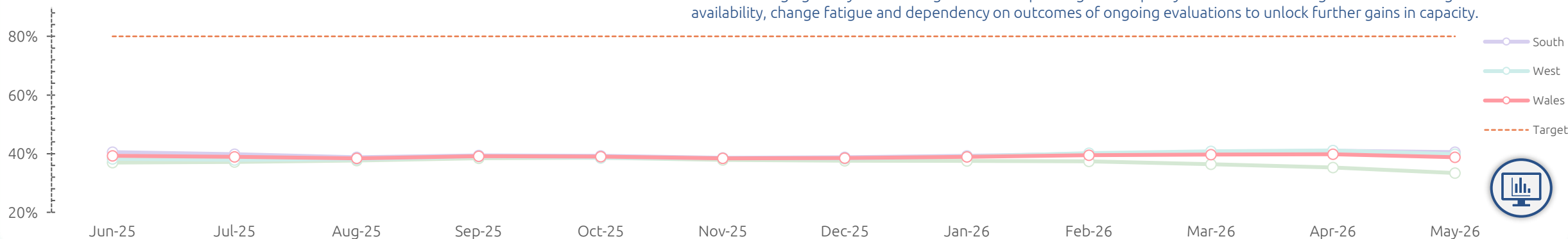
## Diabetic Eye Screening Wales (May 2026)

In May 2026, **38.8%** of eligible patients were offered an appointment in the last twelve months against a standard of **>80%**. Over a 24-month period for the low-risk recall pathway coverage in the same month is 78.3%, which is significantly higher but below the standard of >80%.

Uptake of eye screening has dropped below the 80% standard at 77% this month but positive service user experience elicited through the SMS (text message) pilot.

The number of inadequate images captured has **reduced** since the introduction of new cameras, with an **inadequate rate of 6.6% against the standard of <3%**.

### DESW-001: Coverage 12 Months



## Diabetic Eye Screening Wales - Improvement plan

The Diabetic Eye Screening Wales (DESW) Improvement Plan is delivering early improvements in service efficiency and clinic utilisation. Alternative clinic models, including drop-in clinics and the Low-Risk Recall Pathway (LRRP), are being implemented at pace and generating additional capacity, with recent activity demonstrating measurable increases in appointments and throughput. Clinic utilisation has consistently exceeded the 90% target and has recently achieved the 95% aspirational threshold at a monthly level, supported by strengthened booking processes and optimisation through Autobook and active backfilling.

Innovation remains a central component of delivery. The evaluation of retinal imaging without routine dilation is progressing strongly, with participant volumes exceeding required targets and providing early assurance on feasibility, safety and scalability. The next phase will focus on data analysis and formal evaluation, alongside delivery of an associated improvement plan, which is being managed through the established project group and transformation programme governance structure. Subject to evaluation outcomes, this model alongside a potential staged mydriatic approach offers the opportunity to significantly increase clinic throughput and improve participant experience, forming a critical element of the programme's longer-term capacity trajectory.

Progress has also been made in strengthening system oversight and operational performance management. Governance arrangements are well established, with routine monitoring through structured meetings at programme, divisional and directorate level. Improvements to Low-Risk Recall Pathway coding have been completed, supporting more effective participant flow and performance tracking, while utilisation and operational metrics are now reviewed regularly to inform delivery and decision-making.

However, delivery continues to be constrained by workforce and system limitations. Staff capacity, including vacancies and sickness absence, is impacting the ability to sustain and scale improvement activity, with manual processes and administrative burden emerging as key rate-limiting factors in expanding clinic capacity. There are also recognised risks relating to staff availability, change fatigue and dependency on outcomes of ongoing evaluations to unlock further gains in capacity.



# Health Protection and Screening Services



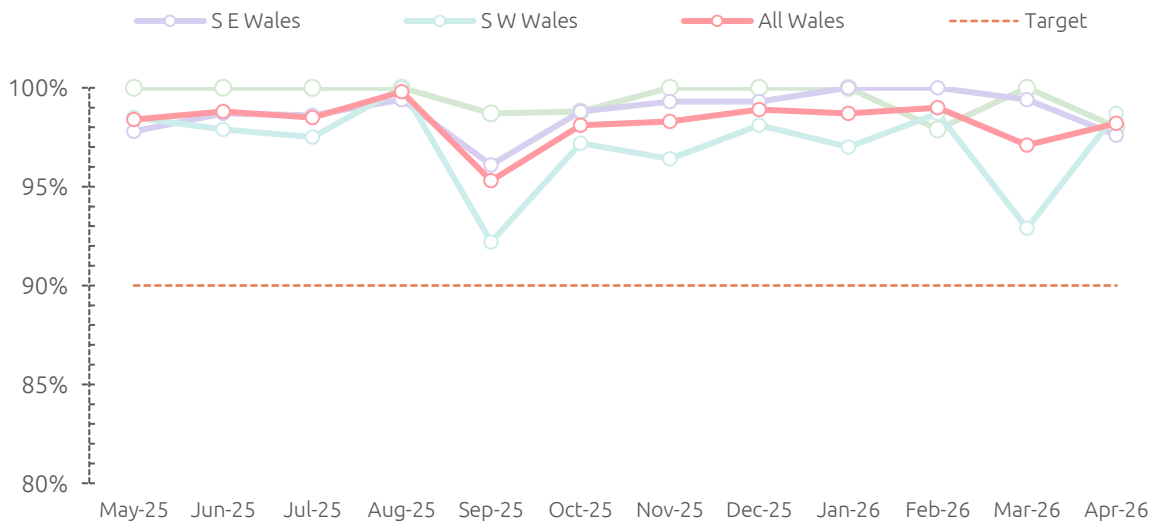
## Cervical Screening Wales (April/May 26)

Over the previous 12 months the 8-week appointment referral waiting time standard (CSW-005A) has remained within the required 90% standard, by **98.2%**. This is due to the regularised demand and capacity monitoring, mitigation and escalation of emerging risks and agreement of defined action plans to ensure continued delivery of waiting time standards.

Laboratory turnaround time for colposcopy histology results within two weeks reported **50.8%** against a standard of >80%. Regular CSW led meetings with Colposcopy and histology teams ensure any delays are communicated and improvement work continues to consider outsourcing to improve turnaround times.



### CSW-005A: Waiting Time for Colposcopy Appointment – All CSW Direct Referrals (8 weeks)



## Abdominal Aortic Screening Wales (May 2026)

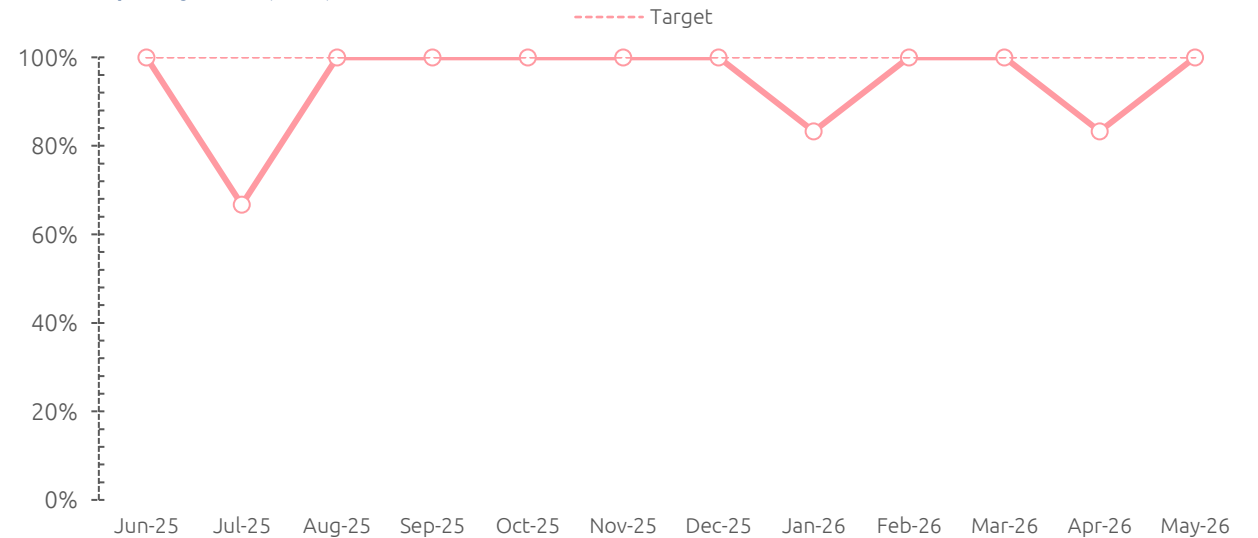
In May 2026, 100% of men were referred to the elective vascular network MDT by the end of the following working day or same day.

Over the last year a six-month evaluation of targeted outbound telephone calls to AAA screening non-responders was planned and delivered through the deployment of the National Support Team. The targeted calls demonstrated a positive impact, with increased appointment uptake among a population group with a higher positivity rate.

In April 2025, uptake within 4-months and 12-month were below the standard of >80%. Over the latest 4 months, improvement to the 12-month uptake has been sustained, aligning with the evaluation period and interventions of the National Support Team. Further improvement and reduction in Do Not Attend rates is anticipated through the planned introduction of SMS appointment reminders.



### AAA-005: Timely referral to Elective Vascular Network Multidisciplinary Team (MDT) – All Wales



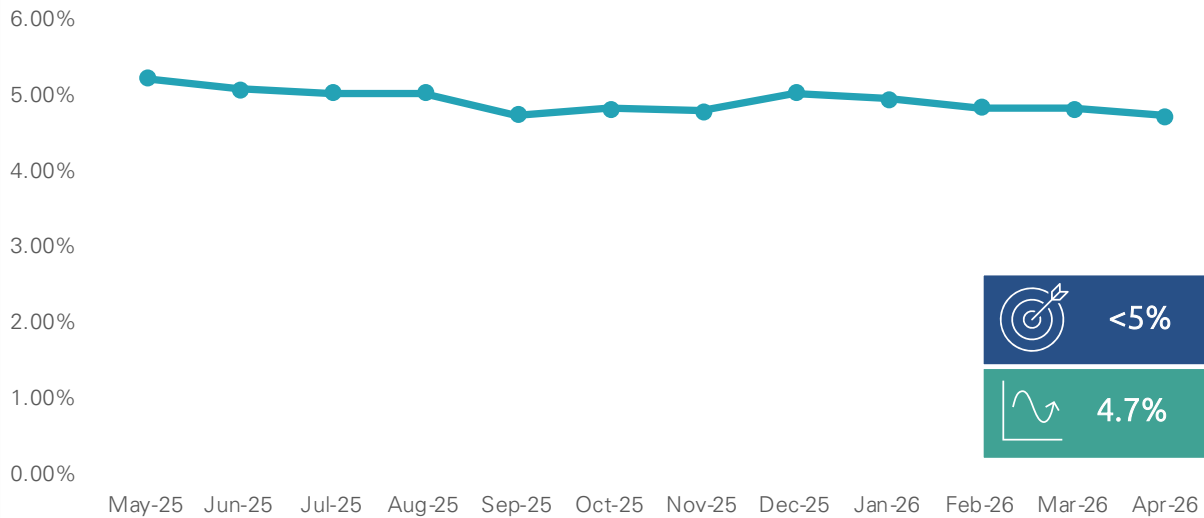


# Health Protection and Screening Services



## Infection Services

### Total Microbiology Rejection Rates

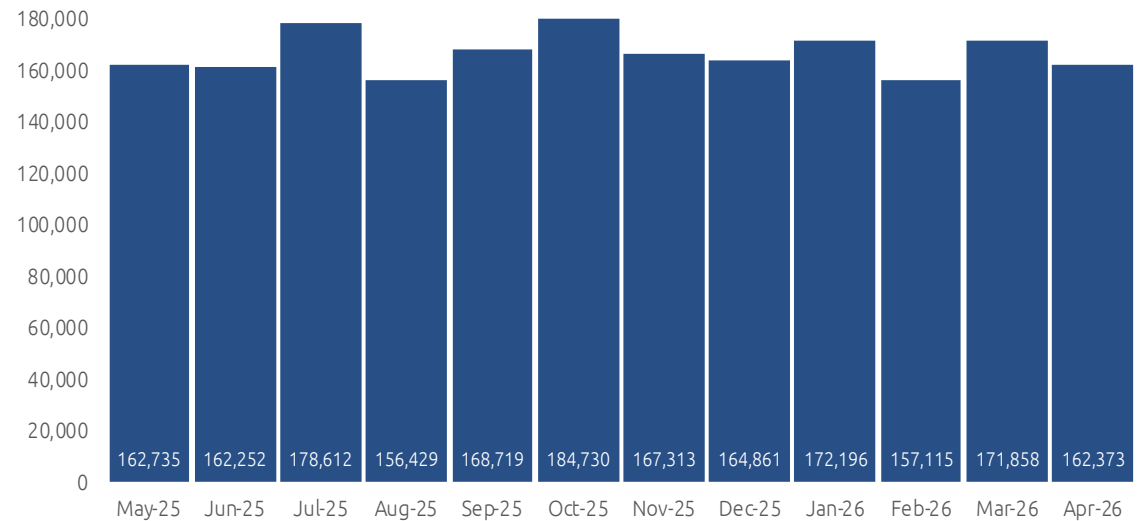


In April, 4.73% of 162,373 diagnostic sample requests were rejected. There are no defined targets for rejection rates but 5% is considered to be acceptable based on sample numbers.

We constantly monitor and review rejected samples to identify trends. Most rejections are due to damaged or improperly contained specimens. Rejection rates vary by health board, with no main cause identified. The Specimen Acceptance Policy ensures we can ensure accuracy in patient results.

Infection Quality Leads review trends monthly and work with service users to improve practices via health board portals and newsletters. The upcoming LIMS 2.0 system will enable tailored test sets and better data collection.

### Total Microbiology Diagnostic Sample Requests



Monthly requests for microbiology diagnostic samples have consistently exceeded 156,000 over the past 12 months. In April 2026 we saw a decrease from 171,858 to 162,373 requests.

The division is a demand led service meaning the division has little influence over the sample numbers that come into the division. Request volumes frequently fluctuate due to seasonal factors and outbreaks. Proactive planning and flexible resource management are essential to meet changing demand. Our service is ready to respond as needed throughout the year.

Health Boards oversee specimen collection and submission, and we work with Health Board colleagues on targeted initiatives to ensure tests are clinically justified and resources are used efficiently, maintaining high service quality during peak demand.

\*Target not applicable

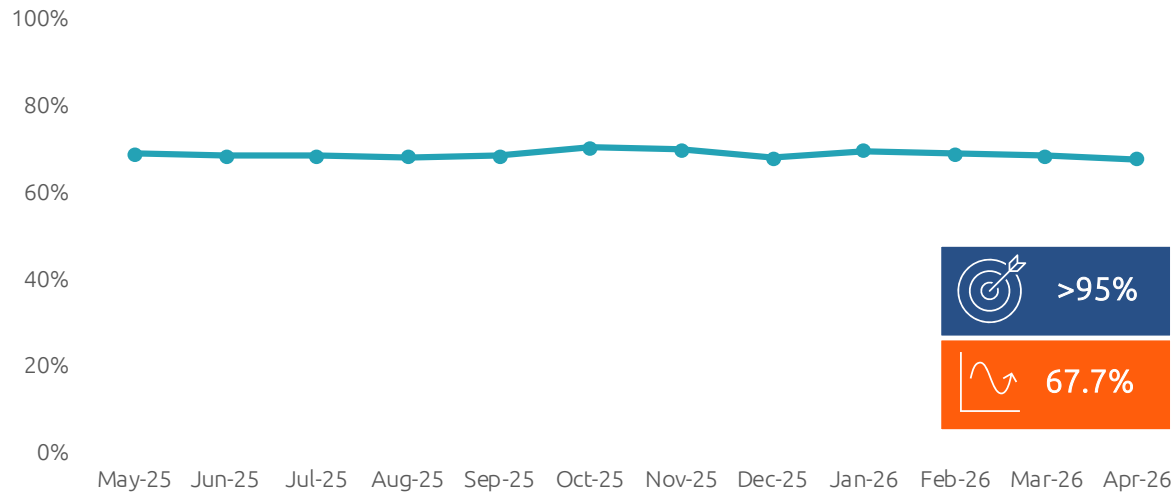


# Health Protection and Screening Services



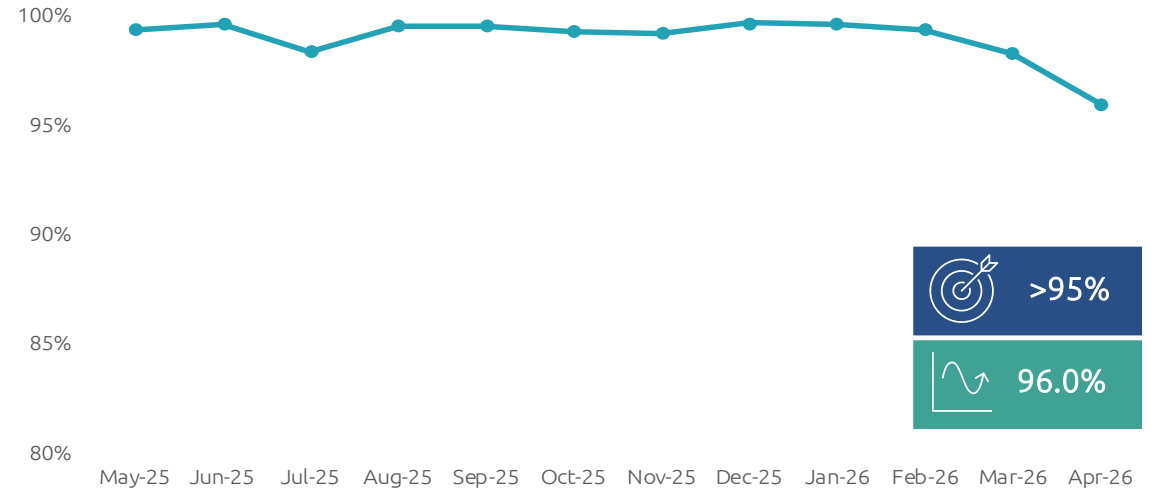
## Infection Services

### Blood Culture - Collected to Incubation SMI <4hrs



- The UK SMI requires blood culture samples to be incubated within four hours of collection. In April, compliance decreased slightly from 68.69% from 67.69% the previous month.
- Meeting the 4-hour limit is crucial for accurate diagnosis, particularly in sepsis cases. Efficient transport procedures within Health Boards are needed but can be challenging to maintain. Operational issues are reviewed with stakeholders and addressed through educational programmes and retraining to reinforce compliance.
- Additional transport runs have been implemented between UHL and UHW which will be reviewed to understand the impact when they have been in place a number of months.

### Blood Culture - Received (PHW Laboratory) to Incubation



- Compliance with the four-hour incubation target for blood cultures is measured from lab receipt to analyser loading. In April, the rate was 95.99%, showing a slight reduction since the previous month.
- The network is currently undergoing a series of implementing refreshed analysers which require verification. This has impacted on normal processes but has not had a negative effect on incubation time. However, in April, high temperatures in the Carmarthen laboratory meant samples had to be transported to Singleton as the Blood Culture analysers were not working correctly. This will have caused the reduction in the ability to achieve the 4hr time from receipt to incubation.
- The lab's scheduling and staffing support the timeliness of loading bottles. Timely specimen transport from wards remains the main challenge, but once specimens arrive, protocols are reliably followed.



# Health Protection and Screening Services

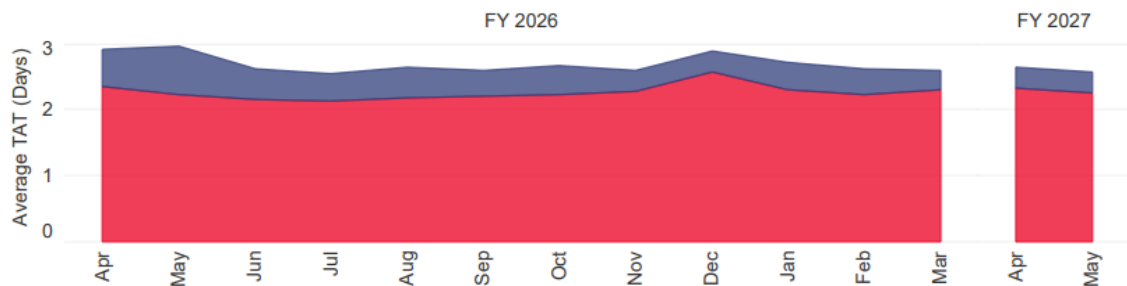


## Health Protection

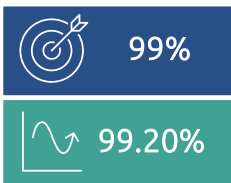
### Test and Post – STI self-sampling

#### Test Turnaround Times

TAT averages in days showing (Transit TAT | Lab TAT) for rolling year - by month.



- In April, Turnaround times for STI testing are important in identifying infection as soon as possible so that it can be treated to prevent damage to the individual's health and onward transmission to partners.
- In April, 99.20% met the 7-day turnaround standard.
- 7 request(s) of 5,313 total requests (0.13%) did not meet the 7-day TAT standard.
- 5,313 total requests equated to 20,624 tests being undertaken.

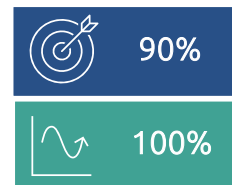


Actions to improve:

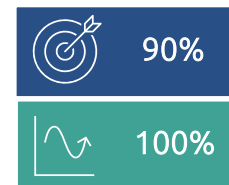
- Ongoing monthly monitoring
- LGV TAT – Secondary Testing

### AWARe Response Times by Priority

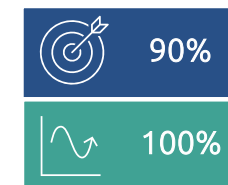
#### Urgent (<4 hours)



#### High (<24 hrs)

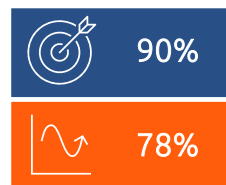


#### Medium (<48 hrs)



- In April, our response to cases of communicable disease cases within timescales is an important performance indicator because it ensures the necessary public health actions are initiated in a timely manner
- Response time performance has currently exceeded all priority level targets.

### Compliance to Surveillance Reporting Schedules (%)



- We have not achieved target in May.
- The delayed reports were caused by technical issues in particular to the IBID data

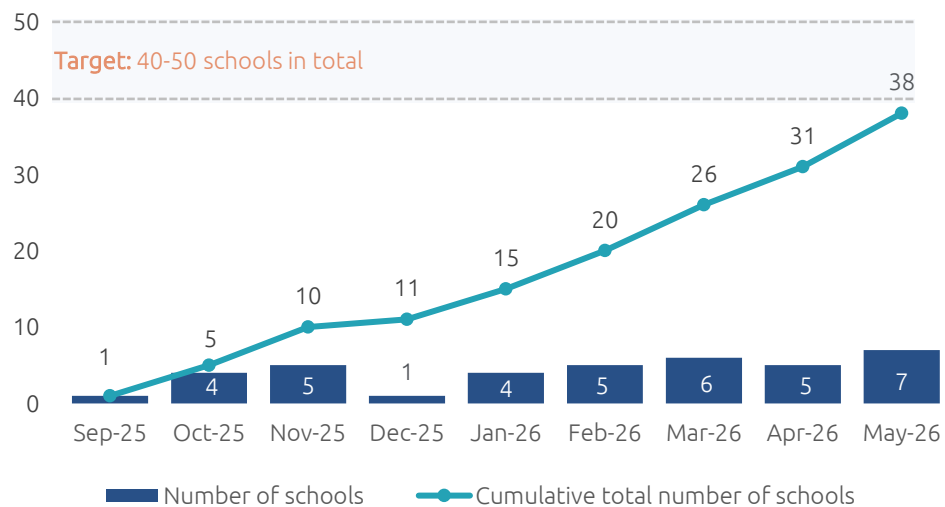


# Health and Wellbeing

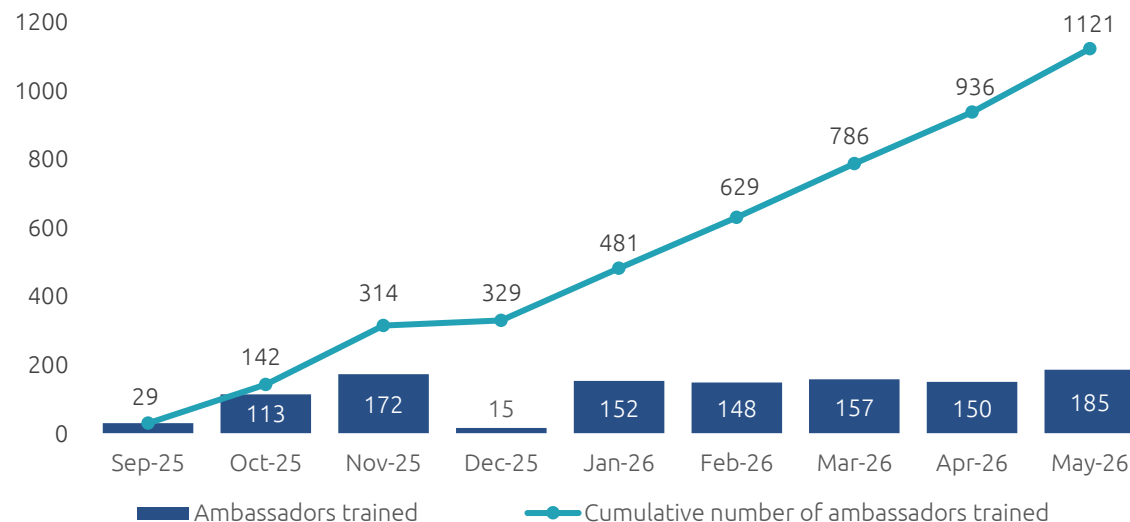


## JUSTB / BYW BYWYD

### Number of Just B Schools with 2-day training completed by month for 2025-26 academic year (year to date)



### Number of Just B Ambassadors trained by month for academic year 2025-26 (year to date)



- JUSTB / BYW BYWYD is an evidence-based smoking prevention programme that utilises peer influence and networks to disseminate smoke-free norms.
- The programme is delivered during term-time to Year 8 pupils in secondary schools with the highest smoking rates.
- We aim to deliver to **40-50 schools in total** during the 2025/26 academic school year.
- A review of the JUSTB programme will be carried out this year (26/27).
- This monthly report is designed to show progress over the academic year from September 2025 to June 2026 (Just B delivery window).
- A further 2 schools are booked for delivery in June which concludes our delivery year.

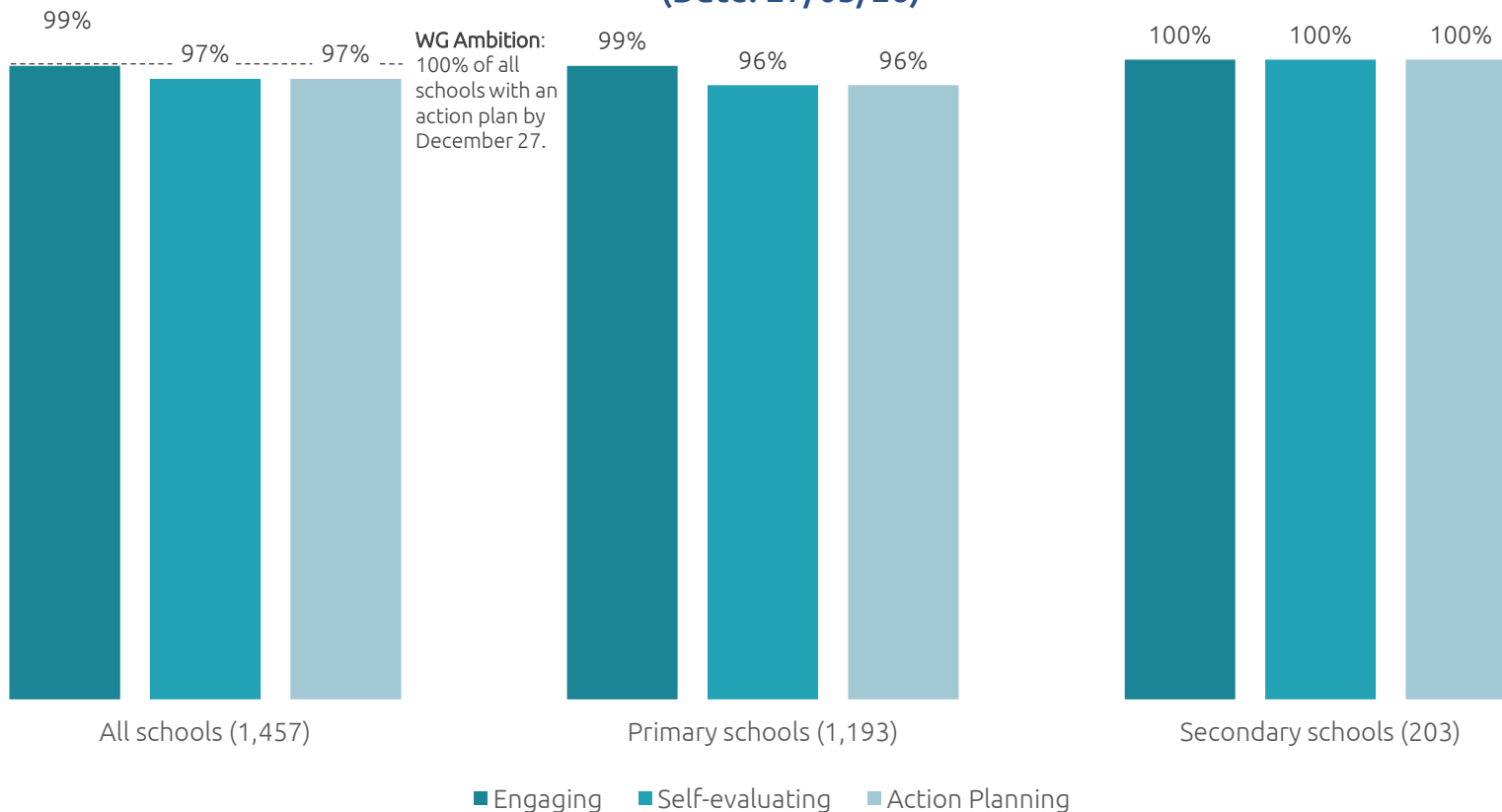


# Health and Wellbeing



## Whole School Approach to Emotional and Mental Wellbeing

Percentage of schools 'engaging', 'self-evaluating', or 'action planning' as part of their Whole-School Approach to Emotional and Mental Well-being (WSAEMWB) (Date: 27/05/26)



*Public Health Wales is accountable for the strategic oversight of the programme, direct support to schools is the responsibility of Health Board DsPH*

**'Engaging'\*** is where a school has responded to an offer of support and been advised on implementing the WSAEMWB framework, either in a 1:1 meeting with their Implementation Coordinator (or Health Promoting Schools Coordinator) or in a briefing session.

**'Self-evaluating'\*** means that the school has at least started self-evaluating against the WSAEMWB using either the Public Health Wales self-evaluation tool (SET) or an alternative tool.

**'Action Planning'\*** is where a school has identified actions and at least is planning implementation. Some schools have entered a continuous improvement cycle of scoping, action planning, implementing, and evaluating.

### Welsh Government ambition\*

100% of **all schools** will have an emotional and mental well-being action plan in place by **December 2027**. This is currently at **97%**, therefore, we do not expect significant changes in these data for the remainder of 2026/27.



# Health and Wellbeing



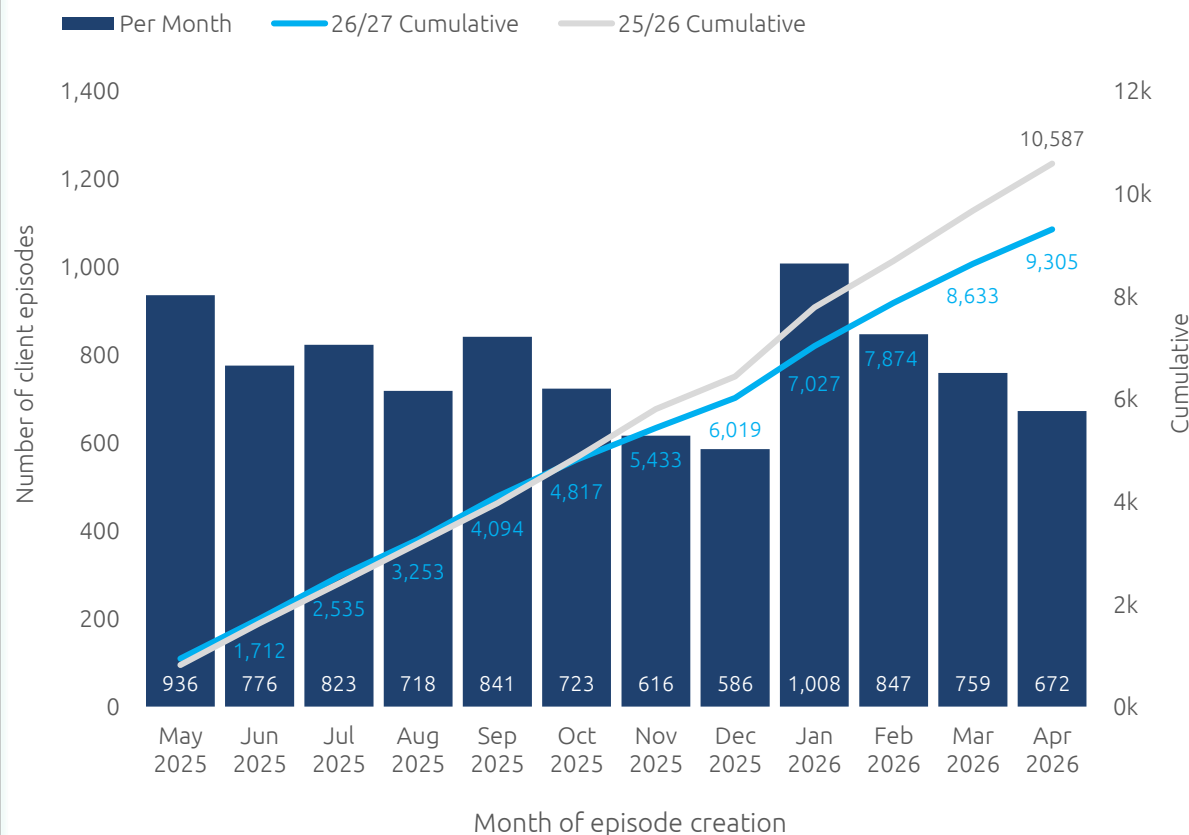
## Help Me Quit

In April 2026, the Hub was responsible for contacting 1,287 new referrals compared with 1,114 in the same month of the previous year. The Help Me Quit Hub handled 707 inbound calls (937 in April 2025), and the Hub created 672 new client episodes in April 2026 (916 in April 2025).

**Timeliness of first contact:** 96% received their first call attempt within two working days which is above the 90% target. This has increased from 79% in the previous month.

**National Telephone Support Service (NTSS):** The proportion of NTSS client episodes meeting the target of scheduling an assessment within 14 days of initial contact was 92% compared with 66% the previous month and 78% in the same month of the previous year.

### Number of client episodes created by the Hub



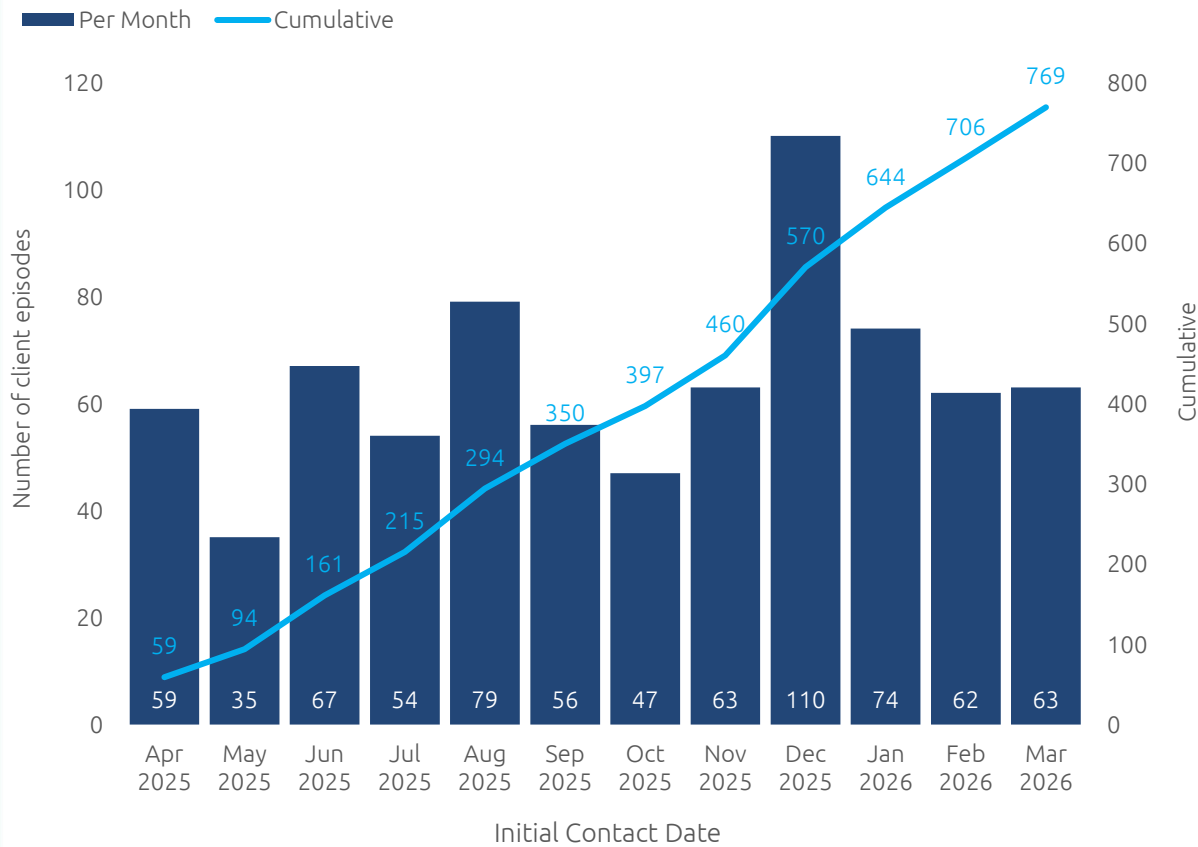


# Health and Wellbeing

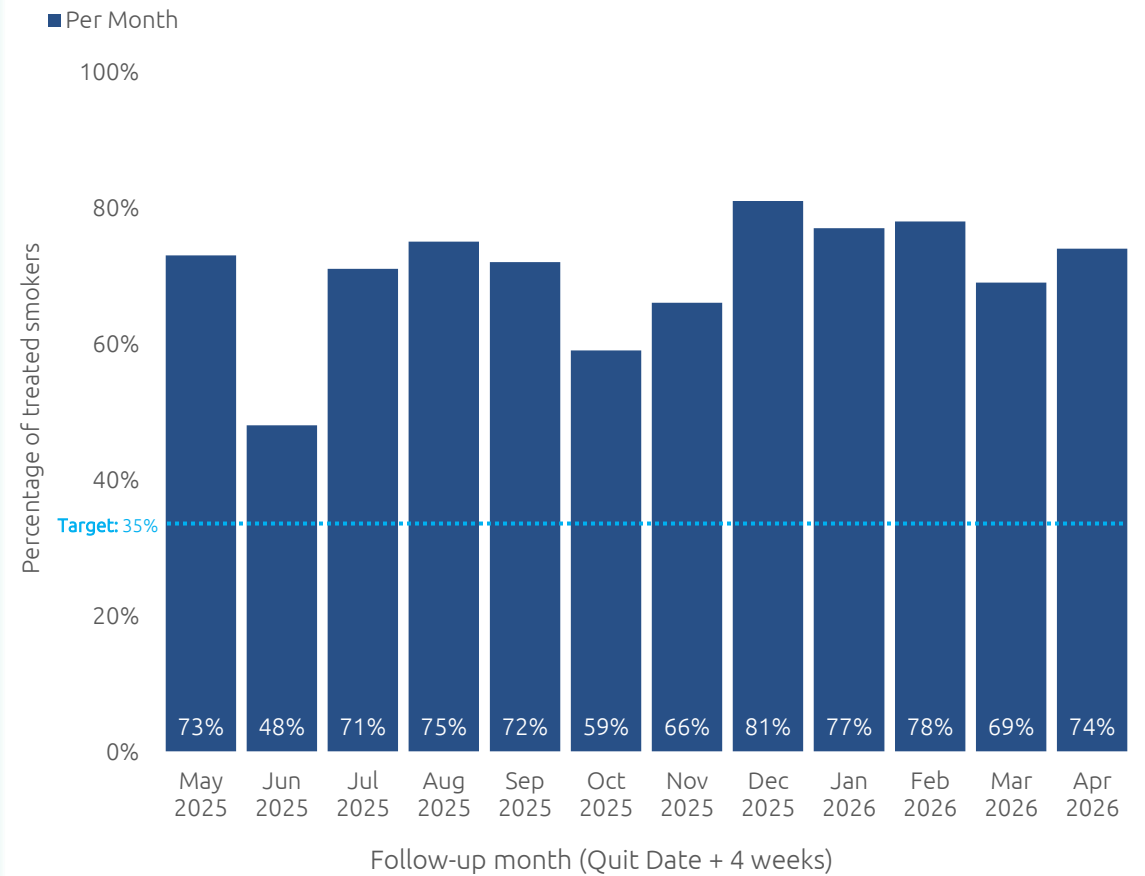


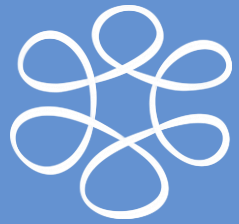
## Help Me Quit

### Number of clients who attend an assessment session (NTSS)



### 4-week self-reporting quit rate (NTSS)





**Section 3**  
**Strategy Delivery**





# Key Performance Indicator Summary



Strategic Plan	12 Month Look Back	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Strategic Plan – Percentage of milestones currently green or complete		91.8%	90.2%	89.3%	89.8%	88.5%	86.5%	85.2%	85.7%	84.4%	82.8%	94.5%	90.5%
Strategic Plan – Percentage of milestones currently red		2.1%	2.1%	0.8%	2.9%	1.6%	1.2%	2.9%	0%	1.6%	6.2%	0.0%	3.0%
Request for Change (RFC) – Number of milestone changes submitted for approval		8	5	5	7	5	7	8	1	8	15	2	9
Strategic Priority 1 – Wider determinants		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Strategic Priority 2 – Promoting mental and social wellbeing		81.8%	81.8%	81.8%	81.8%	81.8%	72.7%	72.7%	72.7%	72.7%	81.8%	100%	100%
Strategic Priority 3 – Promoting healthy behaviours		89.5%	89.5%	86.8%	89.5%	86.8%	84.2%	84.2%	84.2%	84.2%	84.2%	94.4%	94.1%
Strategic Priority 4 – Sustainable health and care system		93%	88.4%	88.4%	86%	91%	88%	91%	90.7%	90.7%	88.4%	100%	90%
Strategic Priority 5 – Excellent public health services		93.1%	91.4%	91.4%	91.4%	82.8%	77.6%	77.6%	79.3%	79.3%	79.3%	88%	84%
Strategic Priority 6 – Climate change		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Enabling delivery of our plan		91.3%	90%	88.8%	90%	91.3%	92.5%	87.5%	87.5%	83.8%	90.0%	93.0%	88.6%
Strategic Change Programmes – Percentage of milestones currently green/amber		100%	88%	88%	88%	89%	89%	88%	88.9%	75%	N/A	63%	75%
Strategic Change Programmes – Percentage of milestones currently red		0%	0%	0%	0%	0%	0%	0%	0%	0%	N/A	0%	0%



# Strategic Plan Milestone Delivery



## Strategic Priority Delivery Status

7  
Completed  
▲5

202  
Green  
▼18

15  
Amber  
▲4

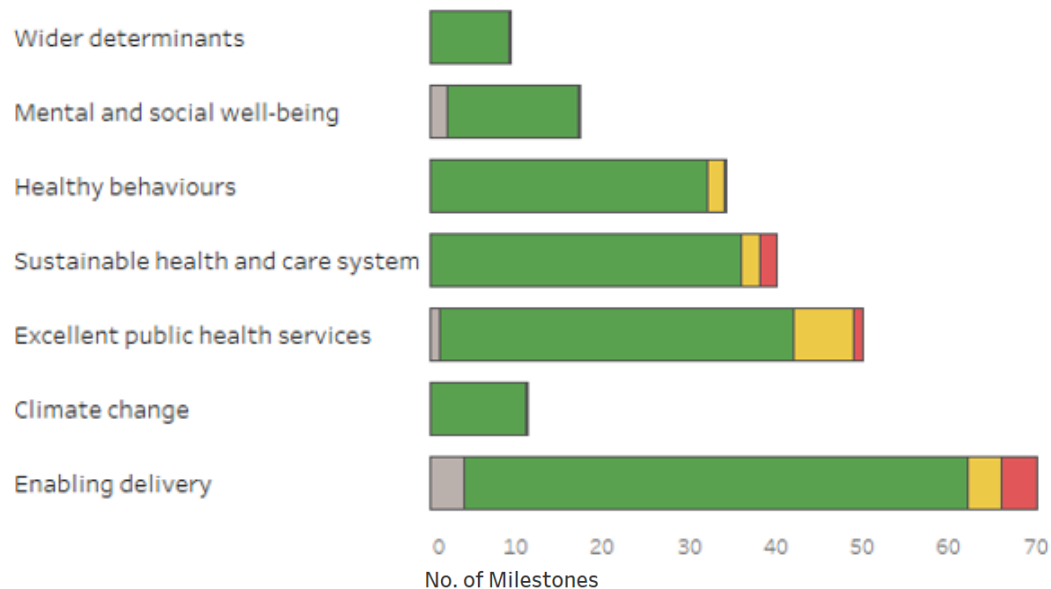
7  
Red  
▲7

## Request for Change

A total of 9 Request for Change were submitted for approval in May 2026.



## By Strategic Priority



## Month 2 Reporting

As at month 2, 90% of milestones are on track, with a further 7 completed. Key achievements include maturing the PHW risk architecture and progressing a forward look of viable AI activity. Overall, delivery remains strong. However, there are increasing pressures reflected in Amber and Red ratings, driven by dependencies on major programmes, resource constraints, and external dependencies.

There are 7 Red milestones, which is higher than at the same point last year. 2 relate to the Tackling Diabetes Together programme (where 3 RFCs have been submitted). 1 relates to the TB Action Plan, whilst 2 relate to our digital infrastructure.

There are 15 Amber milestones, with 7 unchanged from last month, indicating ongoing early warning risks. Many of these are linked to core public health services such as screening, infection and NERS. Common themes include dependencies on major change programmes, Welsh Government related activity, resource constraints, and technical delays. The persistence of Amber ratings suggests systemic delivery pressures rather than isolated issues. Several Amber milestones are linked to the Ministerial Templates submitted to Welsh Government alongside our IMTP.

## Request for Change

3 milestones have requested to close due to re-prioritisation, ensuring alignment with agreed scope and reducing duplication. The remaining requests include 4 date changes, largely driven by stakeholder engagement, governance processes and external dependencies, which includes delaying the strategic action plan arising from the BTW review. Further requests include 1 scope change to improve the accuracy of milestone reporting around TDT programme evaluation, and 1 suspension of implementing our strategic partnerships linked to wider strategic reprioritisation.

## Additional information: Rolled-Over Milestones from 2025/26

Engagement has taken place with directorates responsible for the rolled-over milestones from 2025/26, with assurance provided on their ongoing monitoring. 3 of the rollovers have submitted RFCs (included above), 2 of which request delays of less than 6 months.

4 milestones remain dependent on the DARC programme following the NDR funding pause. A further 2 milestones relate to screening services, including HPV self-sampling and DESW transformation.



# Strategic Plan Milestone Delivery

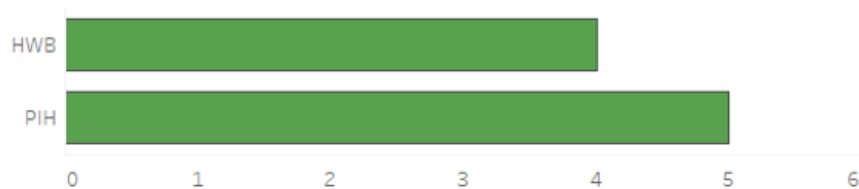


## Strategic Priority 1 – Wider determinants

### Current Delivery Status



### By Directorate



### In Year Changes to Plan

No requests for change received in month 2

## Strategic Priority 2 – Promoting mental and social wellbeing

### Current Delivery Status



### By Directorate



### In Year Changes to Plan

No requests for change received in month 2



# Strategic Plan Milestone Delivery

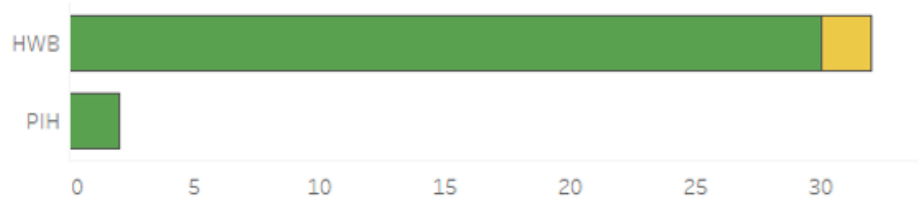


## Strategic Priority 3 – Promoting healthy behaviours

### Current Delivery Status



### By Directorate



### In Year Changes to Plan

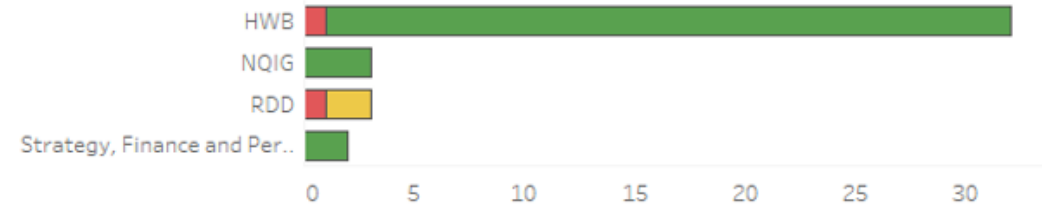
No requests for change received in month 2

## Strategic Priority 4 - Sustainable health and care system

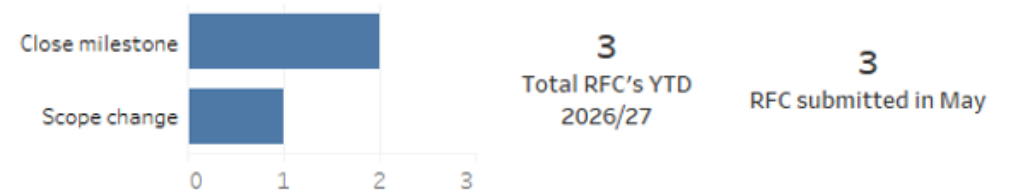
### Current Delivery Status



### By Directorate



### In Year Changes to Plan





# Strategic Plan Milestone Delivery

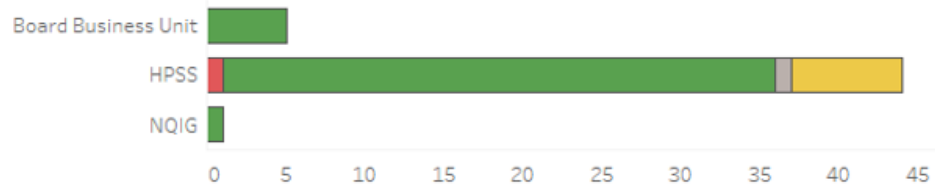


## Strategic Priority 5 – Excellent public health services

### Current Delivery Status



### By Directorate



### In Year Changes to Plan

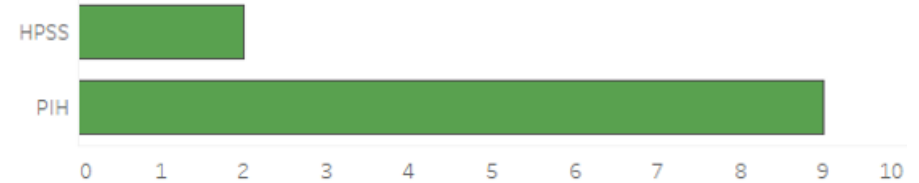


## Strategic Priority 6 – Climate change

### Current Delivery Status



### By Directorate



### In Year Changes to Plan

No requests for change received in month 2



# Strategic Plan Milestone Delivery

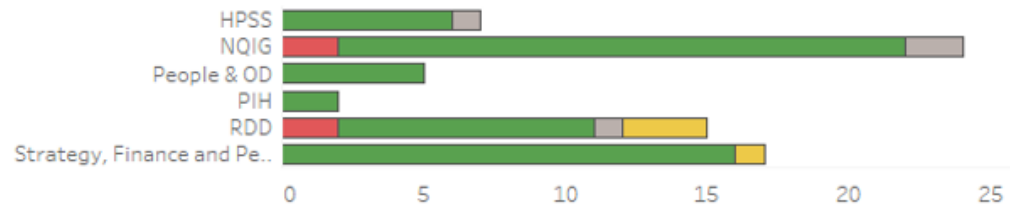


## Enabling delivery of our plan

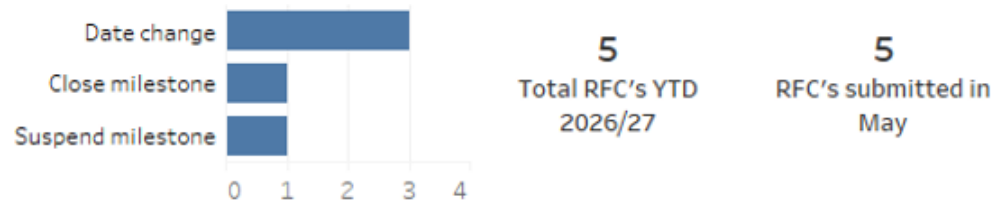
### Current Delivery Status



### By Directorate



### Changes to Plan



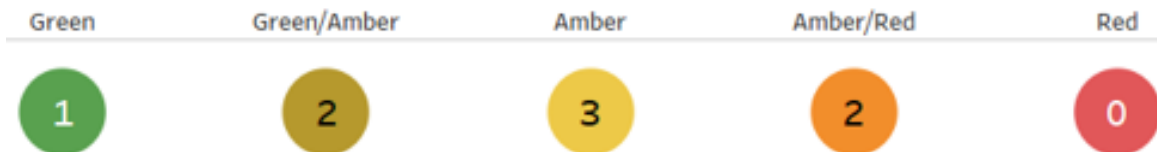


# Strategic Change Programme



## Strategic Change Programmes Overview

Detail on all programmes is available on the Performance and Assurance dashboard. A high-level summary of the DCA status for Tier 1 & 2 programmes, status of May 2026, is provided below.



## Key Information

This month's position is broadly unchanged from last month. There are three programmes facing different delivery challenges and risks, whilst the remainder are delivering more strongly with clear plans and pathways in place through to completion.

**Data, Analytics, Registers, Cloud** – Remains Amber/Red. Status reflects the ongoing pause and review of DHCW funding relating to the NDR programme (timescale currently unknown), as well as continued technical challenges with data migration. There is continuing progress, with RDD migration remaining on track for June and further planning of CDSC migration.

**Gambling Related Harm Reduction** – Remains Amber. Status reflects delays in agreeing a competitive grants process, and in agreeing a local offer (and funding allocation) with Directors of Public Health.

**DESW Transformation** – Remains Amber/Red. Continuation of the programme will be informed by scoping of a wider screening transformation approach. As an interim arrangement, the programme is currently supported by DESW's operational team.

**Digital Health Protection** – Remains Amber. Phase 1 remains on track for delivery in July. However, the lack of clarity around data sources and no agreed approach to roll out continue to require close attention to ensure scheduled delivery dates are met.

**Tackling Diabetes Together** – Improved to Amber. Change in status reflects continuing progress against programme deliverables. TDT will be presenting to Change Board in July to offer assurances on delivery and impact to date, along with options for mainstreaming and sustaining activity following programme close.

**Lung Cancer Screening** – Remains Green/Amber. The programme continues to be delivered in line with plans. Although some specific actions are behind target, these are not considered to represent a risk to the overall programme.

**Web Transformation** – Remains Green/Amber. The overall programme status remains at Green-Amber due to the successful go-live of the web estate on 12th May, whilst recognising the need to complete go-live for several outstanding sites, finalise key business processes (e.g. continuous improvement) and agree a sustainable resourcing model for the web estate.

## Programme Detail

Programme Name	Mar	Apr	May
Diabetic Eye Screening Transformation	A/R	A/R	A/R
Digital Health Protection	A	A	A
National Targeted Lung Cancer Screening	G/A	G/A	G/A
Tackling Diabetes Together	A/R	A/R	A
Data, Analytics, Registers, Cloud	A	A/R	A/R
Gambling Related Harm Reduction	A	A	A
North Wales Estate	G	G	G
Web Transformation	G/A	G/A	G/A

Further detail on the individual Programme DCA and commentary can be found on the dashboard.





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CYMRU  
NHS  
WALES

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Cymru  
Public Health  
Wales

*Gweithio gyda'n gilydd  
i greu Cymru iachach*

**Working together  
for a healthier Wales**