Finance and Performance Committee - Routine

Wed 10 June 2026, 15:30 - 17:00

MS Teams

Agenda

15:30 - 15:30
0 min

1. Preliminary Matters

1.1. Welcome and Introductions

Chair

1.2. Apologies for Absence

Chair

1.3. Declarations of Interest

Chair

1.4. Draft Minutes of the last Meeting held on 21st April 2026

Chair

- FPC 20260610 1.4 Draft Minutes Meeting held on 21st April 2026.pdf (11 pages)

1.5. Committee Action Log

Chair

- FPC 20260610 1.5 Draft Action Log.pdf (1 pages)

15:30 - 15:30
0 min

2. Items for APPROVAL/RATIFICATION/DECISION

15:30 - 15:30
0 min

3. ITEMS FOR DISCUSSION

3.1. Performance Management and Escalation Update

Director of Strategy, Planning & Partnerships

3.2. Integrated Performance Report, including performance against Ministerial Priorities

Director of Strategy, Planning & Partnerships

- FPC 20260610 3.2 Integrated Performance Report.pdf (7 pages)
- FPC 20260610 3.2 Integrated Performance Report Appendix 1.pdf (42 pages)

3.3. Pre-Investment Panel Annual Report

Director of Finance and Procurement & Director of Strategy, Planning & Partnerships

- FPC 20260610 3.3 Pre-Investment Panel Annual Report.pdf (8 pages)

3.4. Information Governance Report, including SIRO Update

Director of Digital

- FPC 20260610 3.4 Information Governance Report, including SIRO Update.pdf (15 pages)
- FPC 20260610 3.4 Information Governance Report, including SIRO Update Appendix A.pdf (2 pages)
- FPC 20260610 3.4 Information Governance Report, including SIRO Update Appendix B.pdf (7 pages)
- FPC 20260610 3.4 Information Governance Report, including SIRO Update Appendix C.pdf (8 pages)
- FPC 20260610 3.4 Information Governance Report, including SIRO Update Appendix D.pdf (34 pages)
- FPC 20260610 3.4 Information Governance Report, including SIRO Update Appendix E.pdf (36 pages)

3.5. Assurance reports from the Digital, Data and Technology Group, including an update on the Delivery of Digital Programmes

Director of Digital

- FPC 20260610 3.5 Assurance reports from the Digital, Data and Technology Group.pdf (12 pages)

3.6. Stroke Improvement Plan Update Report

Director of Allied Health Professionals and Health Science

- FPC 20260610 3.6 Stroke Improvement Plan Update Report.pdf (15 pages)

15:30 - 15:30
0 min

4. Items for INFORMATION

4.1. Committee Risk Report

Director of Corporate Governance

- FPC 20260610 4.1 Finance and Performance Committee Risk Report. April 2026.pdf (6 pages)
- FPC 20260610 4.1 Finance and Performance Committee Risk Report Appendix 1 Strategic Risk Dashboard and Assessments.pdf (13 pages)

4.2. Review of Committee Programme of Business 2026/27

Director of Corporate Governance

- FPC 20260610 4.2 Review of Committee Programme of Business 2026-27_.pdf (4 pages)
- FPC 20260610 4.2 Review of Committee Programme of Business 2026-27 Appendix A.pdf (7 pages)

15:30 - 15:30
0 min

5. OTHER MATTERS

5.1. Items to be Brought to the Attention of the Board and Other Committees

Chair

5.2. Any Other Urgent Business

Chair

5.3. Date of the Next Meeting: 22 September 2026

Chair

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

MINUTES OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

MINUTES OF FINANCE AND PERFORMANCE COMMITTEE

DATE OF MEETING	21 April 2026 13:30-16:00
VENUE	Microsoft Teams
PRESENT	
	Neil Patrick, Chair
	Dafydd Vaughan, Independent Member
	Iwan Jones, Independent Member
	Akmal Hanuk, Independent Member
	Helen Cunningham, Independent Member
IN ATTENDANCE	
	Trish Chalk, Assistant Director of Planning and Performance
	Robert Holcombe, Director of Finance and Procurement
	Paul Solloway, Director of Digital
	Leanne Watkins, Chief Operating Officer
	Greg Bowen, Assistant Finance Director
	Naomi Murtagh, Board Business Manager
	Dan Davies, Chief Business Officer
	Gavin Thomas, Governance Support Officer
	Harry Morris, Governance Support Officer
APOLOGIES	
	Hannah Evans, Director of Strategy, Planning and Partnerships
	Rani Dash, Director of Corporate Governance

Preliminary Items	
FPC/2104/01	**Welcome and Introductions** Neil Patrick (NP), Chair, welcomed everyone to the meeting.
FPC/2104/02	**Apologies for Absence** Neil Patrick (NP), Chair, **NOTED** the apologies received.
FPC/2104/03	**Declarations of Interest** There were no Declarations of Interest to record.

FPC/2104/04	**Draft Minutes of the last Meeting held on 23 February 2026** The Committee received and reviewed the previous draft minutes, and these were **AGREED** as a true and accurate record of the meeting.
FPC/2104/05	**Committee Action Log** The Committee received the Committee action log and Neil Patrick (NP), Chair, **NOTED** that there were no outstanding actions.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
	There were no items for discussion during this section.
ITEMS FOR DISCUSSION	
FPC/2104/06	**Performance Management and Escalation Update** Trish Chalk (TC), Assistant Director of Planning and Performance, presented the Performance Management and Escalation Update, including the outcome of the mid-year review and an update on the implementation of the revised Performance Management and Accountability Framework (PMAF). TC advised that the mid-year review had been undertaken against the previous Performance Management Framework, due to the timing of approval and phased implementation of the revised framework. It was noted that, as a result, existing escalation positions had been maintained to ensure continuity of oversight and delivery of agreed recovery actions. Full reassessment against the revised PMAF, incorporating the five domains, was planned to take place as part of the end-of-year review process. The Committee was informed that five divisions remained in escalation for finance. Urgent Care remained in escalation for operational delivery and for quality and safety, in line with the national escalation position, and Mental Health Services remained in escalation for quality and safety. TC outlined that the reasons for the continued escalation of Urgent Care included persistent ambulance handover delays and emergency department waiting times, noting that while measurable improvements had been achieved over the

	preceding period, these were not yet sufficient to support de-escalation. TC reported that the revised PMAF introduced clearer escalation and de-escalation criteria, defined expectations for recovery plans, and strengthened routes for assurance through Executive oversight and Board Committees. Assurance was provided that escalation was intended to act as a mechanism to drive improvement rather than solely as an assurance process, with clearer consequences and accountability for sustained escalation. Members discussed the effectiveness of escalation arrangements and expressed concern regarding prolonged escalation in some areas, particularly finance. TC advised that, under the revised framework, clearer expectations had been set for divisions in escalation to develop and present defined action plans through the appropriate Board Committees, with progress tracked against agreed milestones. Robert Holcombe (RH), Director of Finance and Procurement, advised that financial escalation reflected the ongoing systemic nature of the deficit and that previous mechanisms, including special budget meetings, had not delivered the required improvement. RH reported that the refreshed Value and Sustainability Programme was now the primary mechanism for delivering recovery, with executive-led programmes translating into divisional actions and accountable delivery. Leanne Watkins (LW), Chief Operating Officer, highlighted learning from Mental Health Services, noting that improved performance had been achieved through clearer metrics, structured oversight, and consistent executive challenge and support. LW advised that these principles were being applied more systematically across other escalated areas under the revised framework. Members sought assurance that the Committee would have appropriate visibility of recovery plans, particularly for financial escalation. TC confirmed that, under the revised PMAF, recovery plans for divisions in escalation would be brought through the relevant Board Committees to enable scrutiny, assurance, and challenge.

	The Committee recognised the strengthened approach set out within the revised Performance Management and Accountability Framework and noted the intention to review escalation positions comprehensively at year end, aligned to national escalation status and updated de-escalation criteria. The Committee **NOTED** the update
FPC/2104/07	**Integrated Performance Report, including performance against Ministerial Priorities** Trish Chalk (TC), Assistant Director of Planning and Performance, presented the Integrated Performance Report, providing an overview of performance against Ministerial priorities, national targets and local objectives. TC highlighted areas of improvement alongside ongoing system pressures relating to demand, workforce and financial sustainability. TC advised that the report covered population health, primary and community care, urgent and emergency care, planned care, cancer and diagnostics, mental health services, and enabling actions supporting productivity and efficiency. It was emphasised that performance should be considered within the wider system context. Members were advised that good progress continued to be seen in planned care, with significant reductions in long waiting times and DNA rates, and that mental health services were performing well against key access standards. Improvements were also noted across urgent and emergency care following winter pressures, supported by enhanced community capacity and focused work on patient flow and discharge. Ongoing challenges were highlighted in relation to childhood immunisation uptake, diagnostics (particularly non-obstetric ultrasound), emergency dental services, and neurodevelopmental pathways, with recovery actions in place and further work underway. Members discussed the report and sought assurance regarding data quality, particularly for childhood immunisation and stroke pathway performance. TC confirmed that corrective actions had been implemented and that improvements would be reflected in future reporting.

	The Committee **NOTED** the Integrated Performance Report and took **ASSURANCE** from the progress reported, while acknowledging continued system pressures and the need for sustained focus on delivery against Ministerial priorities.
FPC/2104/08	**Monthly Finance Report and Monitoring Returns** Robert Holcombe (RH), Director of Finance and Procurement, presented the Monthly Finance Report and Monitoring Returns, providing an update on the Health Board's financial position, key risks and progress against the agreed financial plan. RH reported that the Month 11 position continued to forecast a year-end revenue deficit of £18.3m, in line with the agreed plan, with planned savings of £43.5m. It was noted that the forecast position remained broadly stable compared with previous months, despite ongoing financial and operational pressures. RH advised that delivery of the forecast position remained dependent on confirmation of final national allocations. RH outlined continued cost pressures across workforce, continuing healthcare, medicines, specialised services and digital investment. It was reported that pay and non-pay run rates had remained largely flat overall; however, substantive pay costs had increased, reflecting continued recruitment to support service delivery. It was noted that this increase had not been matched by an equivalent reduction in variable pay, highlighting ongoing challenges in balancing workforce sustainability and affordability. In relation to income, RH reported uncertainty around a number of nationally funded programmes and reimbursement mechanisms, with elements of anticipated income yet to be formally confirmed. RH advised that engagement with Welsh Government had continued to address outstanding allocations and to secure clarity on funding expectations. It was noted that, subject to final confirmation, the forecast outturn was expected to remain aligned with plan. RH confirmed that capital expenditure and cash management remained within approved limits, with capital spend and cash balances being actively monitored to maintain compliance and liquidity.

	Members discussed the reliance on non-recurrent measures within the financial plan and noted the associated risks to longer-term sustainability. RH advised that work through the Integrated Medium Term Plan and the Value and Sustainability Programme aimed to reduce non-recurrent reliance over time and improve the underlying financial position, although delivery risks remained. Members also noted the challenges associated with defining and consistently reporting the underlying financial position, recognising this as a national issue. RH confirmed that work had been undertaken to improve clarity and transparency to support planning and engagement with Welsh Government. . The Committee **NOTED** the report
FPC/2104/09	**Value and Sustainability Assurance Update** Robert Holcombe (RH), Director of Finance and Procurement, presented a focused update on Continuing Healthcare (CHC) on behalf of the Value and Sustainability Board, highlighting expenditure trends, key drivers of cost growth and opportunities for improved value and sustainability. RH reported that CHC expenditure was approximately £153m, representing around 8% of total Health Board expenditure. It was noted that CHC costs had continued to increase, driven by a combination of price inflation, growth in the number of care packages and increasing complexity of patient need. RH advised that local expenditure levels were higher than the Welsh average, reflecting population characteristics and local market conditions. RH outlined that the Value and Sustainability Board had set a minimum savings expectation of 2% for CHC. Members acknowledged that achieving savings in this area was particularly complex due to statutory responsibilities, safeguarding considerations and limited control over market pricing. It was emphasised that savings activity needed to focus on value, appropriateness and outcomes rather than purely cost reduction. RH advised that work had been underway to strengthen CHC governance, including improved oversight of assessments, reviews and package authorisation. It was noted that timely reviews of existing packages and improved decision-making

	processes had been identified as key opportunities to ensure care remained appropriate and proportionate to need. The Committee acknowledged that CHC continued to represent a significant financial risk and noted the importance of sustained executive and Board-level oversight. RH confirmed that further detailed plans would be brought back through the Value and Sustainability Board and reported through the Committee for assurance as work progressed. The Committee **NOTED** update
FPC/2104/10	**Efficiency Opportunities and Update Report** Robert Holcombe (RH), Director of Finance and Procurement, introduced the Efficiency Opportunities and Update Report and welcomed Greg Bowen (GB), Assistant Director of Finance, who presented an overview of the efficiency dashboard and emerging opportunities across the organisation. GB advised that the efficiency dashboard, which had gone live towards the end of 2025, brought together 32 measures across five domains, with 14 priority key performance indicators identified to support organisational focus and improvement. It was noted that the dashboard provided real-time, automated data with the ability to drill down to divisional and directorate level, enabling more timely and consistent performance oversight. GB advised that the dashboard had been increasingly used across the organisation, including within the Value and Sustainability Programme, to support identification and prioritisation of efficiency initiatives. It was emphasised that the dashboard was intended to act as a tool to enable improvement rather than solely as a reporting mechanism. The Committee discussed the need to translate the intelligence generated by the dashboard into tangible improvement and cash-releasing action. Members emphasised that efficiency opportunities should be linked clearly to accountability, delivery plans and timescales, and should avoid creating additional reporting burden without impact. It was noted that achievement of efficiencies would

	require strong clinical engagement and alignment with quality and safety considerations. Members also discussed the distinction between efficiencies that supported performance improvement and those that delivered cash-releasing benefit, noting the importance of being clear where opportunities contributed primarily to activity, flow and patient access rather than immediate financial savings. The Committee welcomed the increased visibility provided by the efficiency dashboard and supported its continued use to inform decision-making and prioritisation. The Committee **NOTED** the update
FPC/2104/11	**Information Governance Report, including SIRO Update** Paul Solloway (PS), Director of Digital, presented the Information Governance Report, including an update on information governance arrangements, incidents and compliance. PS advised that the report provided assurance on information governance activity across the organisation, including data protection, information security and incident management. It was noted that information governance remained an area of organisational focus given the increasing reliance on digital systems and collaborative platforms. PS advised that 51 privacy impact assessments had been completed during the reporting period, with no significant risks identified that required escalation. Mandatory information governance and cyber security training compliance was reported at approximately 85%, with continued action underway to improve compliance, particularly among staff groups with lower completion rates. The Committee noted that 169 information governance incidents had been recorded during the reporting period. PS advised that none of the incidents met the threshold for reporting to the Information Commissioner's Office. Assurance was provided that incidents were reviewed in line with established processes, with learning captured and actions implemented where required.

	PS highlighted a reported risk associated with data retention and management within Microsoft Teams and SharePoint, reflecting increased organisational use of these platforms. It was advised that this risk had been reviewed and that appropriate information governance policies and guidance had been implemented to support compliant use, including clearer retention schedules and user responsibilities. Members were assured that this risk was being actively managed through governance arrangements. The Committee discussed training compliance and emphasised the importance of continued focus on raising awareness of information governance responsibilities, particularly in relation to new digital tools and flexible working arrangements. PS advised that targeted communications and training interventions had continued to support improvement. The Committee acknowledged the role of the SIRO in maintaining oversight of information risks and ensuring alignment between digital transformation and information governance requirements. Members noted the absence of high-severity incidents and welcomed the assurance provided regarding compliance and risk management. The Committee **NOTED** the update
FPC/2104/12	**Corporate Information Performance** Dan Davies (DD), Chief Business Officer, presented the Corporate Information Performance report, providing an overview of performance in relation to Freedom of Information (FOI) requests and handling correspondence from Members of the Senedd and Parliament. DD reported that FOI performance had remained strong, with statutory compliance continuing to exceed the Information Commissioner's Office threshold. It was noted that response times had been maintained despite sustained volumes, and that the number of complaints relating to FOI handling remained low. Members were advised that this reflected established processes, effective triage arrangements and continued focus on quality assurance. DD reported that volumes of Member of Senedd and Parliament correspondence remained high and had continued to increase in both volume and complexity. Average response times were reported to be slightly above the internal target,

	reflecting the level of detailed coordination required across services to respond effectively. DD advised that work had continued to improve consistency and timeliness of responses, including clearer internal deadlines and strengthened oversight. The Committee discussed the anticipated future impact of the planned expansion of the Senedd on correspondence volumes. DD advised that this was expected to increase demand on the corporate information function and would require ongoing monitoring and consideration of capacity and resourcing arrangements. Members acknowledged the pressures associated with managing high volumes of correspondence and information requests and recognised the importance of maintaining statutory compliance while ensuring the quality and clarity of responses. The Committee **NOTED** the update.
ITEMS FOR INFORMATION	
FPC/2104/13	**Committee Risk Report** The Committee **NOTED** the updated Programme of Business for 2025/26.
FPC/2104/14	**Review of Committee Programme of Business 2026/27** The Committee **RECEIVED** and **NOTED** the Committee Risk Report.
FPC/2104/15	**Decarbonisation programme annual report for 24/25** The Committee **NOTED** the Value and Sustainability Board Assurance Report.
FPC/2104/16	**Committee Annual Report** The Committee **RECEIVED** and **NOTED** the Revenue Budget Allocation Letter.
OTHER MATTERS	
FPC/2104/17	**Items to be Brought to the Attention of the Board and Other Committees** The Committee considered whether any matters arising from the meeting required escalation to the Board or referral to other Committees.

	It was **NOTED** that there were no items to be brought to the attention of the Board.
FPC/2104/18	**Any Other Urgent Business** There was no other Urgent Business.
FPC/2104/19	**Date of the Next Meeting** 10th June 2026

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
FINANCE & PERFORMANCE COMMITTEE ACTION LOG

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed

All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.
Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**
DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	10 June 2026
CYFARFOD O: **MEETING OF:**	Finance and Performance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Performance Report – June 2026/2027
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Trish Chalk, Assistant for Director Planning and Performance Paul Steynor, Head of System Planning and Performance Caroline Norris, Senior Performance Management Analyst
Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)	
Er Sicrwydd/For Assurance	

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation
The purpose of this paper is to provide the Finance and Performance Committee with an overview of operational performance against the 2026/27 Annual Plan Key Performance Metrics. Performance Metrics have been updated to reflect the latest, validated position. The full Performance Report details performance against the Ministerial Delivery Expectations and Annual Plan measures, across performance in 5 key areas within the Annual Plan 2026/27.

The Committee is asked to:

- **NOTE** the performance of the Health Board, as of the latest reporting periods.
- **NOTE** the insight and actions to address areas of concern

Cefndir / Background

This report focuses on specific performance against the organisation's key priorities in line with the Heath Board's Annual Plan, the National Performance Framework, and Cabinet Secretary priorities

Asesiad / Assessment

Delivery Expectations - performance against (trajectory in month)		
3/24 on track	5/24 off track within tolerance	4/24 off track
11/24 reported in future quarters		

What went well?

- The total number of POCDs has seen four months of consecutive reduction
- DNA rates remained at a record low, through improving outpatient utilisation and productivity.
- Performance for physical examination at 6 weeks continues to improve the past 4 months have shown exceptionally high performance, from 94.5%-96.7%,
- Ambulance handovers and lost hours improved in recent months and remained better than the same period last year.
- Diabetes processes performance is improving, with April performance increasing again to achieve 47.4% and meet the Q1 trajectory
- Adult mental health services and CAMHS maintained full compliance with national access standards across Parts 1 and 2.
- Stroke therapies: Physio and Occupational Therapy assessment within 24hrs both saw significant improvements, reaching 45.6% and 51.5% respectively and the highest levels recorded in our dataset from April 2024

What were the challenges?

- Childhood vaccination uptake declined and remains significantly below trajectory, raising concerns around sustained delivery and equity. Access to immunisation data remains a challenge, with limitations in data access, data quality, system functionality and accuracy constraining performance management and intervention.
- Overall Single Cancer Pathway compliance remains below national expectations.
- Audiology and Therapies services continue to experience a notable increase in 14-week breaches, driven by demand linked to wider planned care recovery activity.
- Neurodevelopmental services remain under sustained pressure, with growing waiting lists and declining 26-week performance, despite maintaining longest-wait requirements.

What actions are we taking to improve?

- Implementing the Vaccine Equity Strategic Framework to strengthen delivery and reduce variation.
Improving immunisation data quality, access and system functionality to support better performance management.
- Strengthening cancer recovery oversight through tumour-site recovery groups and senior leadership reviews.
- Implementing the updated UEC Plan to deliver improvement and deescalation.
- Expanding community-based alternatives to admission through the Community Clinical Desk and single-point-of-access models.
- Developing a recovery plan for children's neurodevelopmental services with additional Welsh Government funding.

What are our risks to delivery?

- Continued workforce constraints across diagnostics, therapies, audiology, community nursing, palliative care and neurodevelopmental services
- Stroke pathway dependencies, including pre-hospital delays and non-direct admissions, continue to risk compliance with national stroke standards and thrombectomy rates.
- Immunisation data quality, access and system limitations reduce confidence in performance insight, and assurance.
- Mental health pathway data limitations continue to constrain reliable oversight and impact timely decision-making.
- Reliance on short-term funding for planned care, outpatient insourcing and diagnostics creates a risk to sustaining 2025/26 gains into 2026/27.
- Inconsistent progress across cancer due pathway risks in three tumour sites (Lower GI, Upper GI and Urology) despite targeted recovery actions.

Key summary messages from the report include:

Prevention and Population Health

Delivery against this priority theme is mixed with some areas of challenge and other areas demonstrating progress. The Q3 performance for childhood vaccinations decreased to 83.8%, below trajectory of 92%. Delivery of HPV Q3 performance however showed first significant improvement in some time, rising by 3.9% to achieve 70.6% compliance. Work has progressed to enable wider digital consent for school-aged vaccinations piloting with a small number of schools for HPV Vaccinations. Once the pilot has taken place, learning and improvements will be made as required in areas where we have sub-optimal uptake to offer parents and young people an additional method and opportunity to receive vaccination.

Positively, performance for physical examinations at 6 weeks continues to improve and has consistently achieved the national target (90%) through the course of 25/26 to date. The past 4 months have shown exceptionally high performance, from 94.5%-96.7%, above the expected range of 90%-94%.

As part of the Public Health commitment to delivering place-based care, behaviour change practitioners responsible for the Health Board's smoking cessation service have been aligned to localities. The service has seen a 69% increase in CO validated quitters in March 2026 compared to March 2025 (pending final, validated data submission).

Primary and Community Services

The report demonstrates the continued increasing contribution that primary care services are providing to the population and system as a whole. Pharmacist Independent Prescribing Service (PIPS) consultations continue to perform well above trajectory in 25/26 and above the mean for the past 11 months. The number of community pharmacies offering PIPS has also risen every month since Apr-25, increasing from 49 to 68 by Apr-26 (+19). The Common Ailment Scheme (CAS) claims continue to improve, remaining above the mean since Sep-25 and significantly exceeding the Q4 trajectory for 25/26.

Urgent Primary Care (UPC) contacts currently show no significant change month-on-month and exhibit a wide expected range of 6,400-9,200 contacts per month. The mean number of contacts per month is 7,800, which is below the monthly target of 8,500 required to meet the Q1 IMTP trajectory.

Urgent and Emergency Care (UEC)

There have been updates to the measures for 2026/27 in line with the de-escalation criteria and the UEC Sustainability & Improvement Plan. Handover 45 is a key ministerial delivery expectation for 2026/27, replacing the previous >1 hour measure

in the NHS Wales Performance Framework. The Health Board's de-escalation criteria for targeted UEC intervention remain based on the >1 hour measure, but the 2026/27 Annual Plan includes handovers over 45 minutes as key measures for GUH ED and all location types across GUH and the eLGHs.

The new UEC plan aligns with Our Next Patient principles, aiming for handovers within 15 minutes and no more than 45 minutes. There has been improvement over the past 25 months, but performance remains above trajectory.

60-minute triage standard remain above April trajectory and higher than 12 months ago following the winter period. Triage improvement is a workstream within the Our Next Patient programme and will report to the new Urgent and Emergency Care programme board to track progress.

Wait to be seen (WTBS) has improved to 131 minutes in April, the best position since August 25, but remains above the 120-minute trajectory and the <60-minute de-escalation target. Actions focus on improving patient flow through stronger daily huddles, better daytime assessment capacity through clinician role redesign and effective SRAT rostering and protecting overnight cubicle availability through ONP escalation and boarding protocols.

The total number of Pathway of Care Delays (POCDs) has seen four months of consecutive reduction after reaching a 2025/26 high in December, with the last three months demonstrating below-mean performance. The April position of 174 is now slightly above the planned trajectory of 160 and marginally reduced from the position a year ago (-1.1%, 176). Significant focus remains on reviewing the longest staying patients, as well as new processes in place across Divisions to improve the accuracy of Estimated Discharge Dates (EDDs) and the recording of reasons that are preventing patients moving to the next step of the discharge planning process

Positive improvements have been seen in Stroke therapies. Occupational and Physiotherapy assessment within 24hrs both saw significant improvements in March, reaching 45.6% and 51.5% respectively and the highest levels recorded in our dataset from April 2024. Speech and Language assessment within 72hrs continued its improvement trend since the low of Jul 25 with the past three reportable months all above the mean.

Cancer and Planned Care

Single Cancer Pathway (SCP) compliance has improved over the past two months, reaching 63.1% in March 2026. Recovery planning meetings are now in place, led by the Cancer SRO and supported by Cancer Services. Weekly Head & Neck meetings have resumed, a pathway deep-dive is reducing backlog, and work is focused on challenges at the first diagnostic stage. High DNA and short-notice CNA rates in endoscopy continue to affect overall pathway compliance. 28-day diagnosis compliance

improved significantly in the second half of 25/26 and remains above the Health Board and UK target of 75% as of March.

Planned care waits over 104 weeks fell to 23 by year-end 2025/26, the lowest since April 2020. Although the number rose in April, positively this was less than the trajectory. The sustained reduction through 2024/25 and 2025/26 was supported by additional non-recurrent schemes in the Division of Surgery. As with 104-week RTT, the Health Board ran an intensive Q4 2025/26 programme, supported by additional funding, to reduce 8-week diagnostic breaches. March delivered a major reduction, from 1,557 in February to 233 at year-end. An April increase was expected, but deterioration was less than forecast.

Mental Health Services

The high levels of performance against the Mental Health access standards have remained strong throughout 2025/26, with Adult and CAMHS Part 1a and 1b standards consistently achieved. Adults Part 2 performance has delivered against IMTP trajectory through 25/26 to date, with compliance exceeding the IMTP trajectory since July and the national standard of 90% since August.

Psychological Therapies Performance remains an area of challenge and has trended downwards over the past 6 months, with vacancies impacting capacity and thus performance. A revised Divisional recovery plan has been developed to support the 26/27 trajectory, which aims to improve performance to 62% by the end of the year.

CAMHS Neurodevelopmental performance remains challenged, declining in the first half of 25/26 before stabilising at around 57%. The service continues to face rising referral demand and growing waiting lists. It has consistently met the ministerial requirement to keep the longest wait below 52 weeks, though this has adversely affected the 26-week performance. Screening has improved the consistency of directing referrals to Universal, Targeted and Specialist pathways. Early 2026/27 activity shows continued progress in screening and assessments as the Neurodiversity Early Support Hub (NESH) approach becomes fully embedded.

Argymhelliad / Recommendation

The Board is asked to:

- **NOTE** the performance of the Health Board, as of the latest reporting periods.
- **NOTE** the insight and actions to address areas of concern

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	

Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy 5.1 Timely Access 1.1 Health Promotion, Protection and Improvement 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Gender and pay - Develop a fuller understanding of the reasons for any differences in pay and take the necessary action to address this Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	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 Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

Finance & Performance Committee

Performance Report

June 2026

A & E

Performance Summary

Section 1: Ministerial Delivery Expectations

The Cabinet Secretary for Health and Social Services has outlined delivery expectations across 6 themes;

- Timely Access to Care
- Population Health and Prevention
- Community by Design
- Mental Health Access
- Women's Health
- Quality and Safety

In the Integrated Medium-Term Plan 2026-29, the Health Board established performance expectations for all measures, with agreement to achieve the national standard in every area except Prompt Access to Care and Quality and Safety

Section 2: Our Performance

This Performance Report outlines Health Board performance in 5 key areas within the Annual Plan 2026/27:

- Prevention and Population Health;
- Primary and Community Services;
- Urgent and Emergency Care Services,
- Cancer and Planned Care;
- Mental Health Services;

Each section includes a summary of performance against the Health Board's priorities and related performance ambitions, together with detail on Annual Plan commitments.

Section 3: Guidance on Interpretation of charts

To support interpretation of charts there are some guides at the end of the document covering run charts, Statistical Process Control (SPC) charts and SPC icons

What went well?

- The total number of POCDs has seen four months of consecutive reduction
- DNA rates remained at a record low, through improving outpatient utilisation and productivity.
- Ambulance handovers and lost hours improved in recent months and remained better than the same period last year.
- Diabetes processes performance is improving, with April performance increasing again to achieve 47.4% and meet the Q1 trajectory
- Adult mental health services and CAMHS maintained full compliance with national access standards across Parts 1 and 2.
- Stroke therapies: Physio and Occupational Therapy assessment within 24hrs both saw significant improvements, reaching 45.6% and 51.5% respectively and the highest levels recorded in our dataset from April 2024

What were the challenges?

- Childhood vaccination uptake declined and remains significantly below trajectory, raising concerns around sustained delivery and equity. Access to immunisation data remains a challenge, with limitations in data access, data quality, system functionality and accuracy constraining performance management and intervention.
- Overall Single Cancer Pathway compliance remains below national expectations.
- Audiology and Therapies services continue to experience a notable increase in 14-week breaches, driven by demand linked to wider planned care recovery activity.
- Neurodevelopmental services remain under sustained pressure, with growing waiting lists and declining 26-week performance, despite maintaining longest-wait requirements.

What actions are we taking to improve?

- Implementing the updated UEC Plan to deliver improvement and deescalation.
- Implementing the Vaccine Equity Strategic Framework to strengthen delivery and reduce variation.
- Improving immunisation data quality, access and system functionality to support better performance management.
- Strengthening cancer recovery oversight through tumour-site recovery groups and senior leadership reviews.
- Expanding community-based alternatives to admission through the Community Clinical Desk and single-point-of-access models.
- Developing a recovery plan for children's neurodevelopmental services with additional Welsh Government funding.

What are our risks to delivery?

- Continued workforce constraints across diagnostics, therapies, audiology, community nursing, palliative care and neurodevelopmental services
- Stroke pathway dependencies, including pre-hospital delays and non-direct admissions, continue to risk compliance with national stroke standards and thrombectomy rates.
- Immunisation data quality, access and system limitations reduce confidence in performance insight, and assurance.
- Mental health pathway data limitations continue to constrain reliable oversight and impact timely decision-making.
- Reliance on short-term funding for planned care, outpatient insourcing and diagnostics creates a risk to sustaining 2025/26 gains into 2026/27.
- Inconsistent progress across cancer due pathway risks in three tumour sites (Lower GI, Upper GI and Urology) despite targeted recovery actions.

Ministerial Delivery Expectations

Theme	Delivery Expectation	ABUHB commitment	Meet National Standard	In month performance against trajectory	Variance
Population Health & Prevention	Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	50% Mar-27	No	47.4% Apr-26 (Apr Trajectory: 47%)	H
	Reduce inequity in the uptake in the most and least deprived areas in preventing ill-health especially in relation to vaccination, screening and diabetes prevention and care.	Yes Mar-27	Yes	First reported Q2	
	Increase the proportion of children in Wales who are a healthy weight by halting the rise, and contributing to a year-on-year decrease in the levels of overweight and of obesity as measured and reported through the National Child Measurement Programme, focusing on those most disadvantaged	Yes Mar-27	Yes	Reported Q2 (expected Q2 2028/29)	
	At least 90% of individuals identified via the Audit Plus Frailty Tool (or its replacement) to receive proactive care in line with their agreed care plans.	90% Mar-27	Yes	Reported Q4	
Community By Design	Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25 and greater where possible	118,223 Mar-26	Yes	7,308 Apr-26 (Q1 Trajectory: 29,556)	H
	Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard	120 Mar-27	Yes	174 Apr-26 (Apr Trajectory: 160)	
	Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard	3,840 Mar-27	Yes	4,717 Apr-26 (Apr Trajectory: 4,800)	L
Women's Health	Improving the quality of our maternity services by reducing perinatal mortality rates.	5.067 Mar-27	Yes	Reported Q4	
	Further expansion of the Women's Health Hub model in each health board area by March 2027 (aligned to the Women's Health Plan)	Yes Mar-27	Yes	Reported Q4	

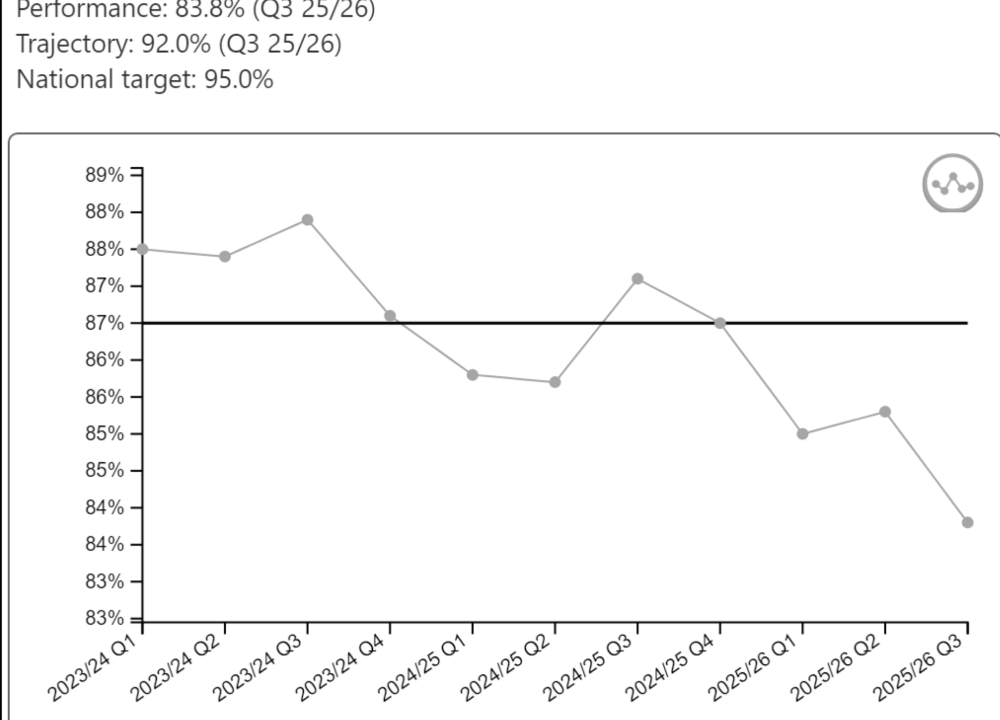
Ministerial Delivery Expectations

Theme	Delivery Expectation	ABUHB commitment	Meet National Standard	In month performance against trajectory	Variance
Timely Access to Care	Ensure no ambulance patient handover waits over 45 minutes [All location types, GUH & eLGHs]	364 Mar-27	No	1,189 Apr-26 (Apr Trajectory: 876)	
	Ensure no ambulance patient handover waits over 45 minutes [GUH ED only]	320 Mar-27	Yes	832 Apr-26 (Apr Trajectory: 660)	
	Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero	799 Mar-27	No	1,172 Apr-26 (Apr Trajectory: 1,065)	
	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	70% Mar-26	No	63.1% Mar-26 (Mar Trajectory: 70%)	
	Reduction in backlog of patients waiting over 62 days (SCP)	200 Mar-26	No	310 Mar-26 (Mar Trajectory: 200)	
	Reduction in backlog of patients waiting over 104 days (SCP)	50 Mar-26	No	92 Mar-26 (Mar Trajectory: 50)	
	Numbers of patients waiting over 104 weeks (all stages)	2,291 Mar-27	No	196 Apr-26 (Apr Trajectory: 195)	
	Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic	0 Mar-27	Yes	971 Apr-26 (Apr Trajectory: 1,256)	

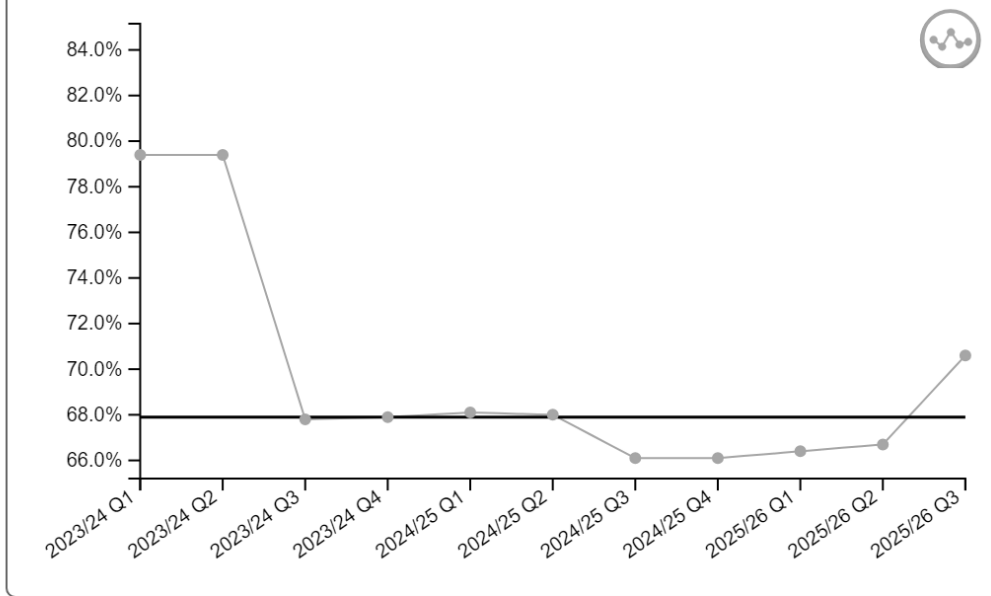
Theme	Delivery Expectation	ABUHB commitment	Meet National Standard	In month performance against trajectory	Variance
Mental Health Access	Implement and evaluate Open Access Mental Health Support by March 2027	Yes Mar-27	Yes	Reported Q4	
	Improve safety in Secondary Care Mental Health services (measured through agreed mental health safety matrix and PROM ReQuol) by March 2027.	Yes Mar-27	Yes	Reported Q4	
	Improve Physical Health of People with long term MH problems by carrying out mortality reviews and implementing improvement plans from the learning by March 2027.	Yes Mar-27	Yes	Reported Q4	
Quality and Safety	Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.	Programme of work to predict % Mar-27	Yes	First reported Q1	
	Days of safe care delivered since the last never event, monitored using SPC T-Chart	Yes Mar-27	Yes	To be implemented	
	Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027	40% Mar-27	Yes	First reported Q1	
	The clinical coding service must ensure that at least 95% of inpatient and day-case episodes are fully coded within one reporting month of discharge, in line with Welsh Government delivery measures. In addition, 90% of all identified coding errors must be corrected within 35 days of identification, ensuring timely and accurate data quality improvements across all health boards. There must be a focus on quality of coding with an emphasis on specificity, and comorbidity capture demonstrated by an increase in depth index by 10% year-on-year.	95% Mar-27	No	First reported Jul-26	

Prevention and Population Health

Measure: % children up to date with vaccinations by age 5
Performance: 83.8% (Q3 25/26)
Trajectory: 92.0% (Q3 25/26)
National target: 95.0%



Measure: % of children receiving HPV vaccination 1 dose by the age of 15
Performance: 70.6% (Q3 25/26)
Trajectory: 85.0% (Q3 25/26)
National target: 90.0%



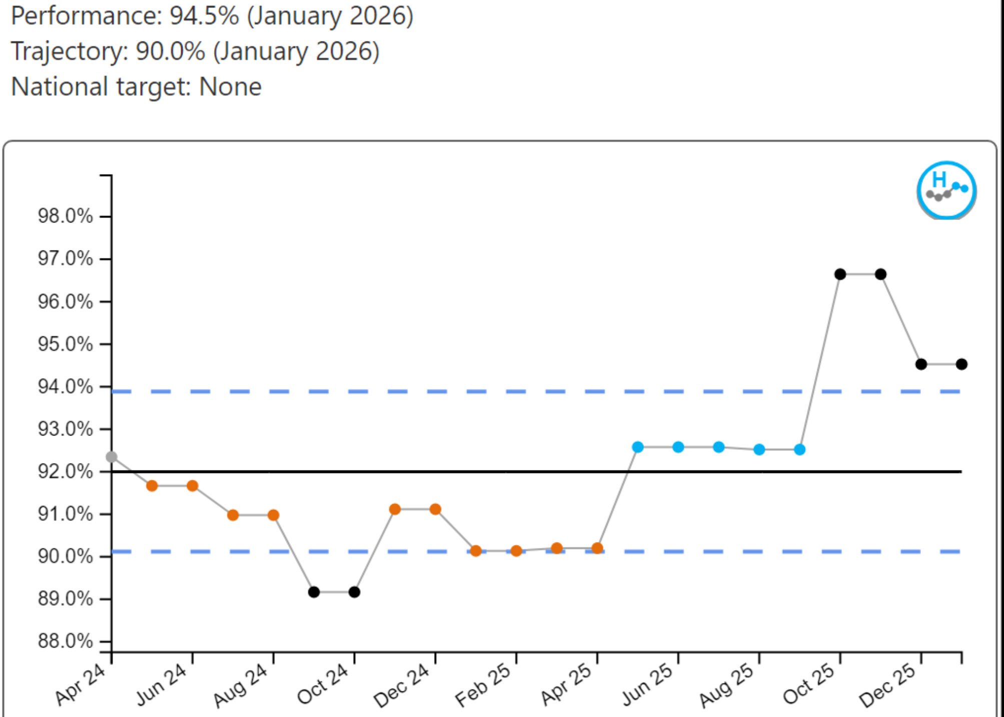
Insights and Actions

- Childhood vaccinations: Q3 performance decreased to 83.8%, below trajectory (92%). HPV: Q3 performance showed first significant improvement in some time, rising by 3.9% to achieve 70.6% compliance.
- For vaccinations by age 5, a task and finish group, led by Public Health Team and working with Health Visitors, Vaccination Service and Health Intelligence team will target work in areas of lower uptake. One key initiative is to work to develop a 'live' dashboard to understand if any of the interventions have a positive impact upon uptake. Initially this pilot will prioritise MMRV vaccination but will also utilise 'Making Every Contact Count' (MECC) approaches during contact with families. Colleagues involved will be offered to attend the new Vaccine Brief Advice Awareness Training that has been developed by the Health Protection Team – one of the recommendations from the Big Gwent Vaccination Conversation.

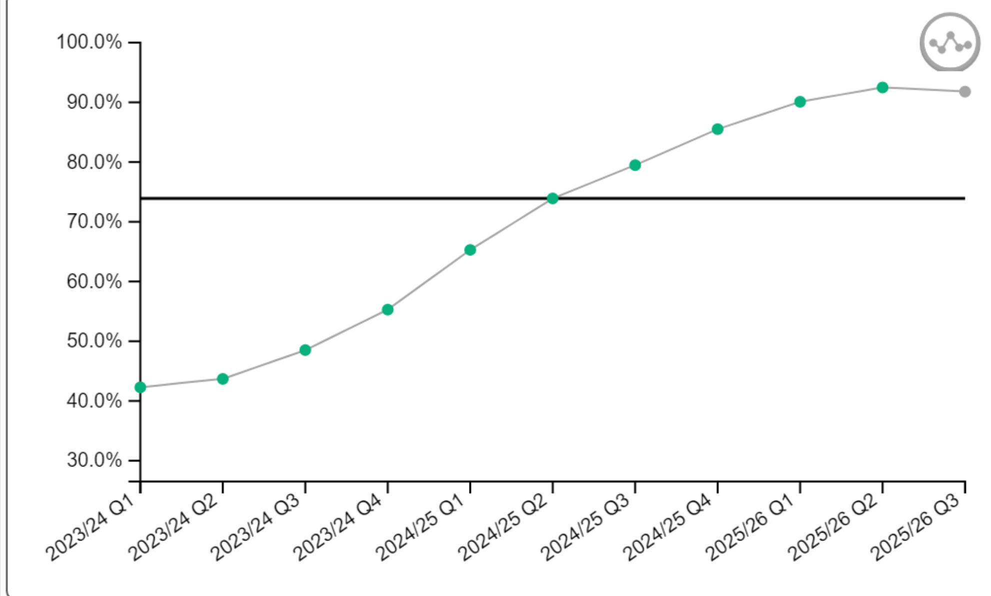
For HPV, work has progressed to enable wider digital consent for school-aged vaccinations piloting with a small number of schools for HPV Vaccination. Once the pilot has taken place, learning and improvements will be made as required with an intention to increase HPV Vaccination uptake across Gwent. In addition to the digital consent pilot, the utilisation of the mobile Nye BeVAN has commenced in areas where we have sub-optimal uptake to offer parents and young people an additional method and opportunity to receive vaccination.

Prevention and Population Health

Measure: Maintain physical examination at 6 weeks rates (Healthy Child Wales)
Performance: 94.5% (January 2026)
Trajectory: 90.0% (January 2026)
National target: None



Measure: Increase weight and measurement at 8 weeks rates (Healthy Child Wales)
Performance: 91.8% (Q3 25/26)
Trajectory: 76.0% (Q3 25/26)
National target: None



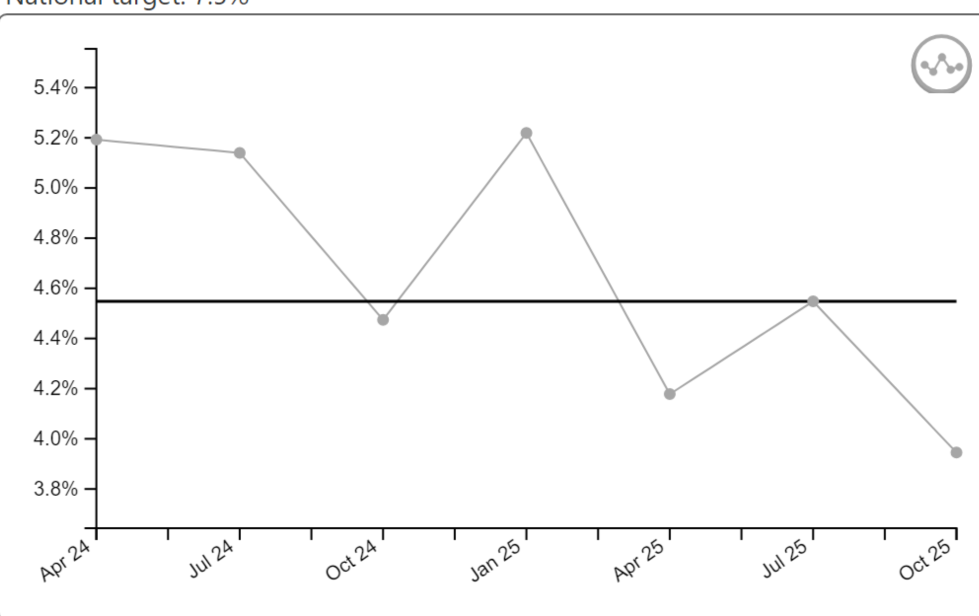
Insights and Actions

- Performance for physical examination at 6 weeks continues to improve and has consistently achieved the national target (90%) through the course of 25/26 to date. The past 4 months have shown exceptionally high performance, from 94.5%-96.7%, above the expected range of 90%-94%.

- Weight and measurement at 8 weeks: Q3 performance dropped slightly to 91.8%, which indicates the end of a consistent improvement trend from Q1 23/24, with performance now showing no significant change from the previous quarter. The trajectory has been comfortably exceeded every quarter through 25/26.

Prevention and Population Health

Measure: Percentage of adult smokers who make a quit attempt via smoking cessation services
Performance: 3.9% (Q3 25/26)
Trajectory: 5.0% (Q3 25/26)
National target: 7.5%



Measure: Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks
Performance: 22.2% (Q3 25/26)
Trajectory: 28.0% (Q3 25/26)
National target: 40.0%

Insights and Actions

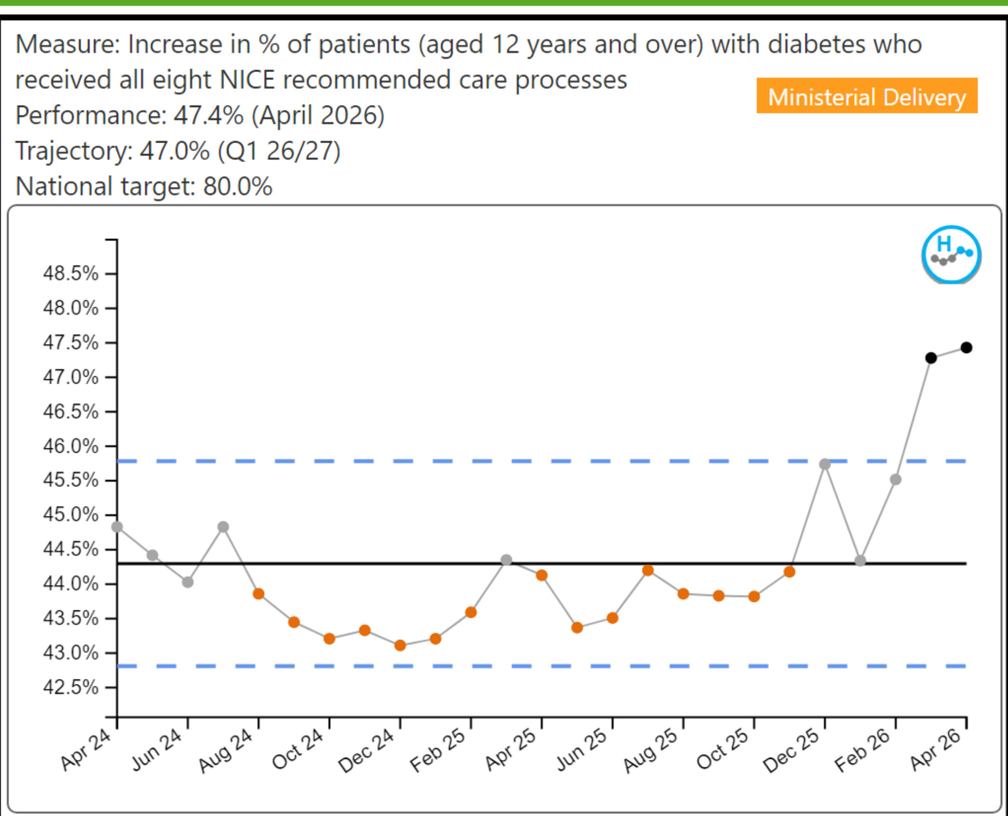
- Smoking cessation performance across the two measures is based on annualised targets, however, are presented here quarterly to give assurance on progress. Q3 quit attempt performance decreased to 3.9%, with cumulative performance through the first three quarters of the year now standing at 4.22%. CO validated quits rose to 22.2% in Q3, with cumulative performance through the first three quarters of the year now standing at 21.6%.
- As part of the Public Health commitment to delivering place-based care, behaviour change practitioners responsible for the Health Board's smoking cessation service have been aligned to localities and will form a core component of integrated neighbourhood teams. A comprehensive improvement programme is ongoing to optimise the service by reviewing and updating processes and placing greater emphasis on supporting individuals and groups to achieve carbon monoxide-validated quits at four weeks rather than just self-reported quits. This is being achieved by increasing community-based clinic capacity and ensuring that team members are given the opportunity to become embedded within their respective places and place-based teams. Work is also ongoing to ensure proportionate capacity is given to vulnerable populations at higher risk of tobacco related harm, e.g., those with mental health conditions, people with chronic conditions, pregnant women, and people at socio-economic disadvantage. As a result, the service has seen a 69% increase in CO validated quitters in March 2026 compared to March 2025 (pending final, validated data submission).

Prevention and Population Health

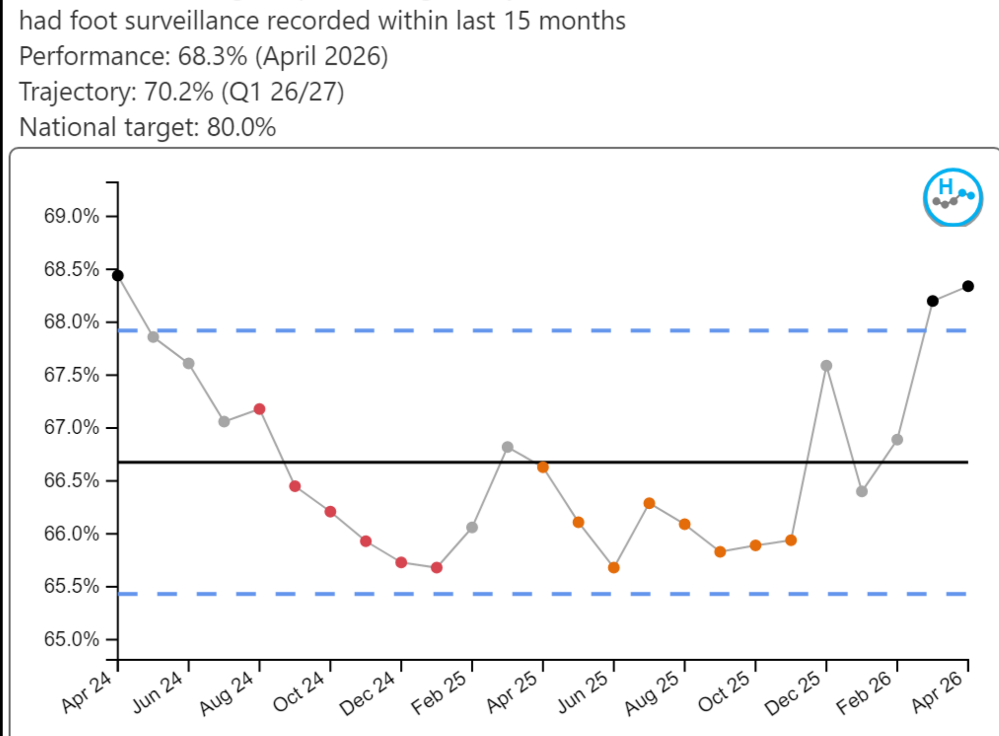
Measure: Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes

Ministerial Delivery

Performance: 47.4% (April 2026)
Trajectory: 47.0% (Q1 26/27)
National target: 80.0%



Measure: Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months
Performance: 68.3% (April 2026)
Trajectory: 70.2% (Q1 26/27)
National target: 80.0%



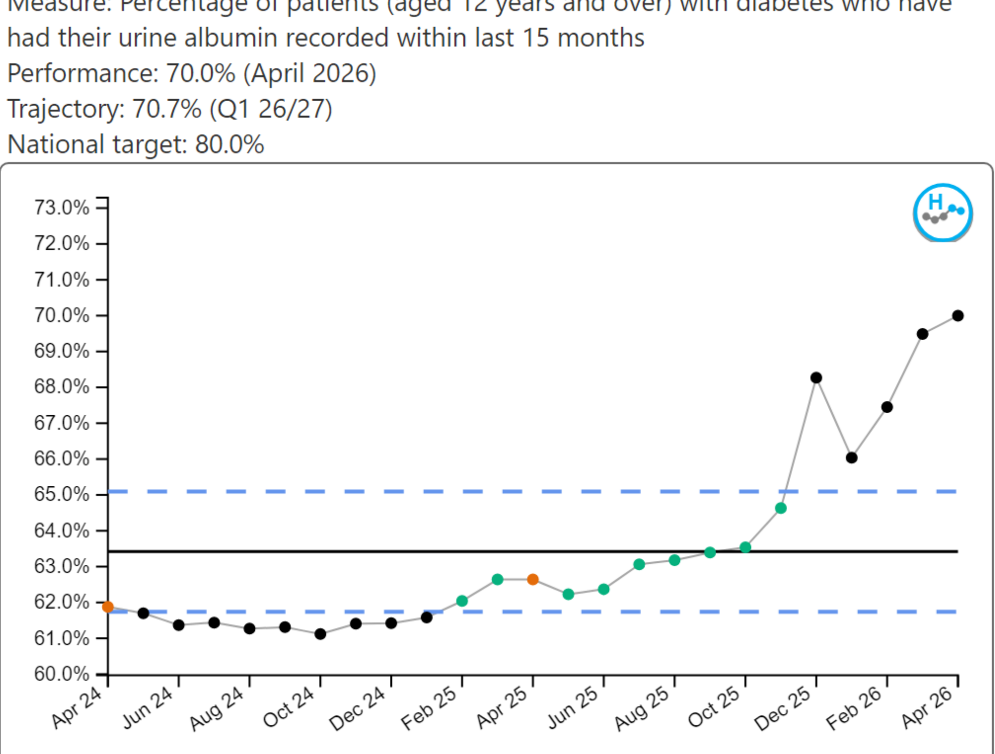
Insights and Actions

- 8 Diabetes processes: Performance is improving, with April performance increasing again to achieve 47.4% and meet the Q1 IMTP trajectory (47%). Additionally, Mar-26 and Apr-26 have reported exceptionally high values (47%+), compared to the expected performance range of 43%-46%.

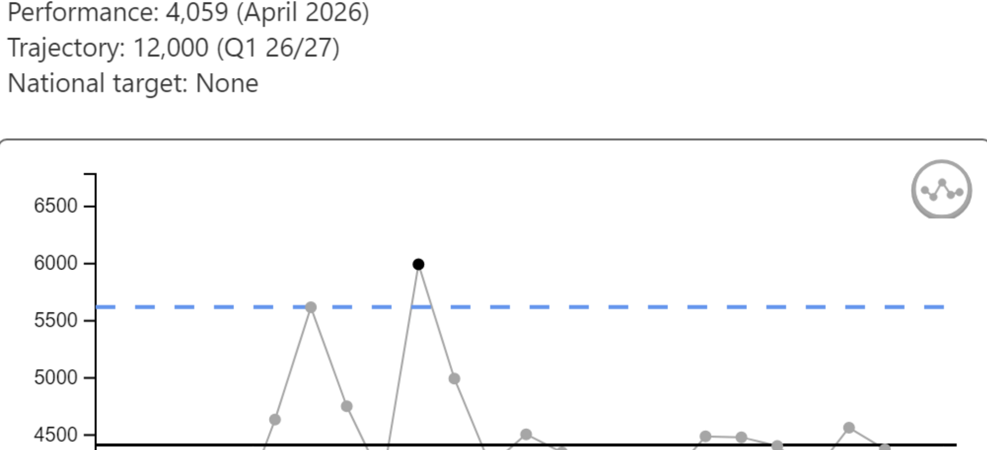
- Diabetes foot surveillance: Performance is showing a similar improvement trend to the 8 Diabetes processes, with April performance increasing again to achieve 68.3%, currently just below Q1 IMTP trajectory (70.2%). Mar-26 and Apr-26 have reported exceptionally high values (68%+), compared to the expected performance range of 65.5%-68%. The footcare project has continued to progress but has faced delays related to materials production and communications, resulting in an extension into Q2/Q3 of 26/27 to enable robust implementation and evaluation. Additionally, scoping work is underway to explore new opportunities in Gestational Diabetes and Transition to Adult Services in 26/27.

Prevention and Population Health

Measure: Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months
Performance: 70.0% (April 2026)
Trajectory: 70.7% (Q1 26/27)
National target: 80.0%



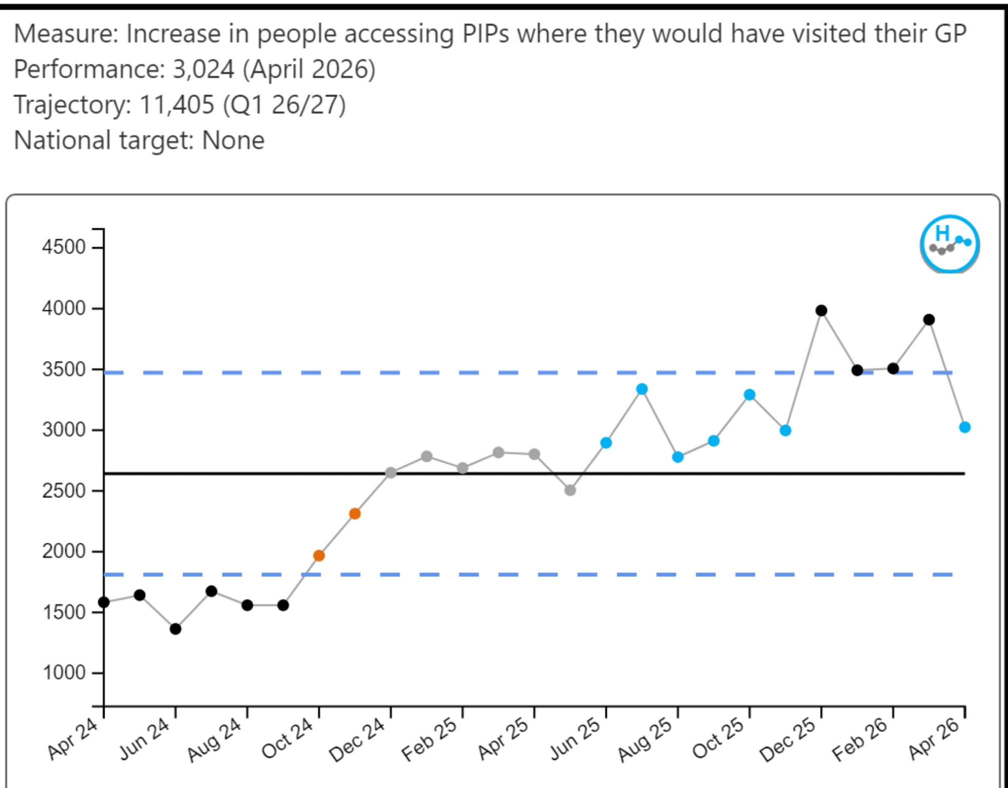
Measure: Number of visits to the Melo Website
Performance: 4,059 (April 2026)
Trajectory: 12,000 (Q1 26/27)
National target: None

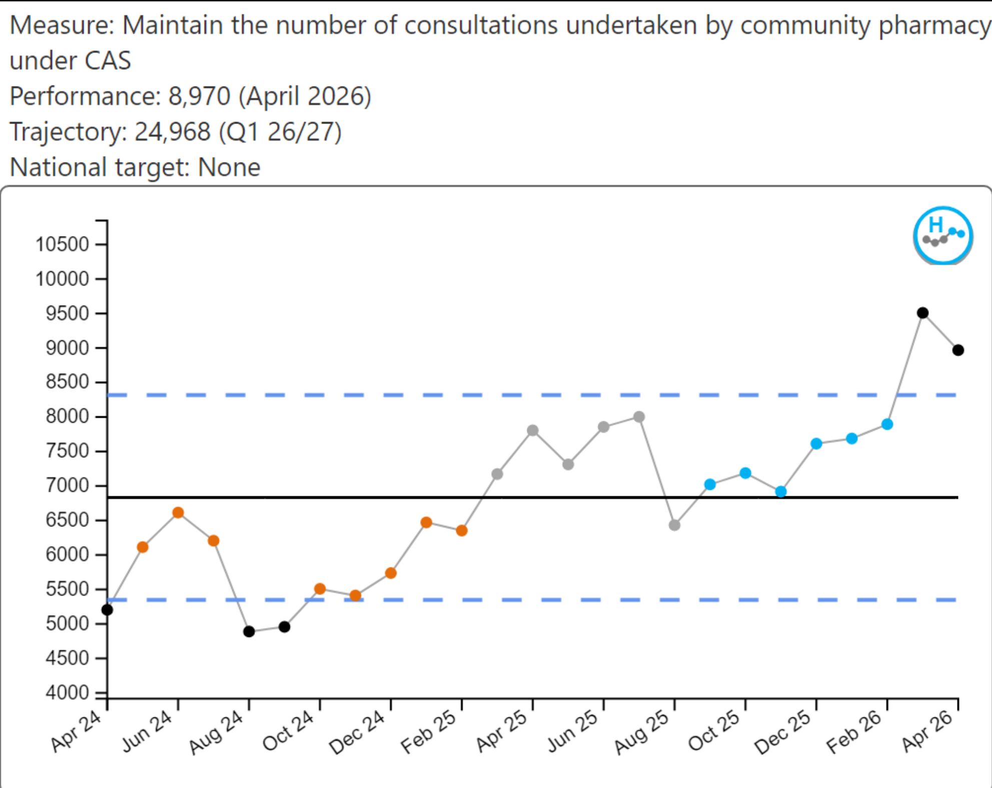


Insights and Actions

- Diabetes uACR: Performance has shown an improving trend since Feb-25, with exceptionally high values of 66%-70% achieved in the past 5 months, compared to the expected range of 62%-65%. April performance of 70% is currently just below the Q1 IMTP trajectory of 70.7%. The Urine ACR project is now entering its closure phase, with a detailed closure report and impact evaluation due at the end of April; while progress has been slightly delayed by limited GP data returns, early findings suggest a potential 4% improvement across ABUHB. The improvement programme has also published its findings to GMS collaboratives, highlighting high and low value activities across the screening pathway to support GP decision-making.
- Melo visits: The number of visits to the Melo website is currently showing no significant change month-to-month, however performance has become more consistent around the mean (4,413) in 25/26 compared to 24/25, now ranging from ~4,000-4,400 visits per month. April performance is at 4,059 and currently on track to achieve the Q1 IMTP trajectory of 12,000 visits.

Primary and Community Services



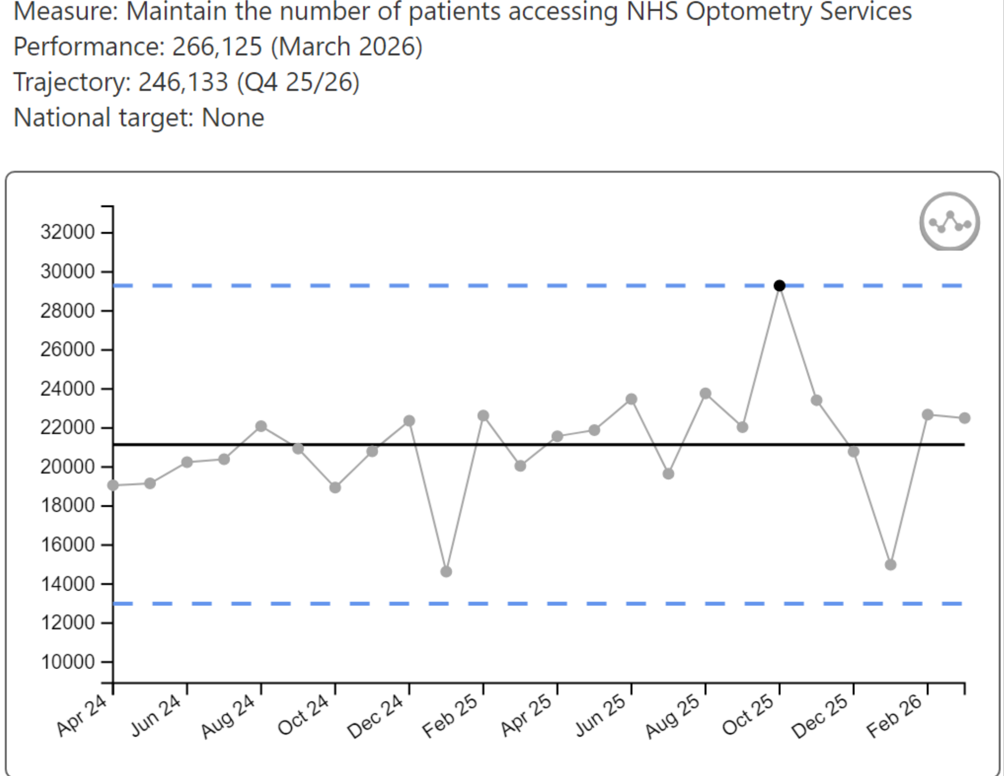


Insights and Actions

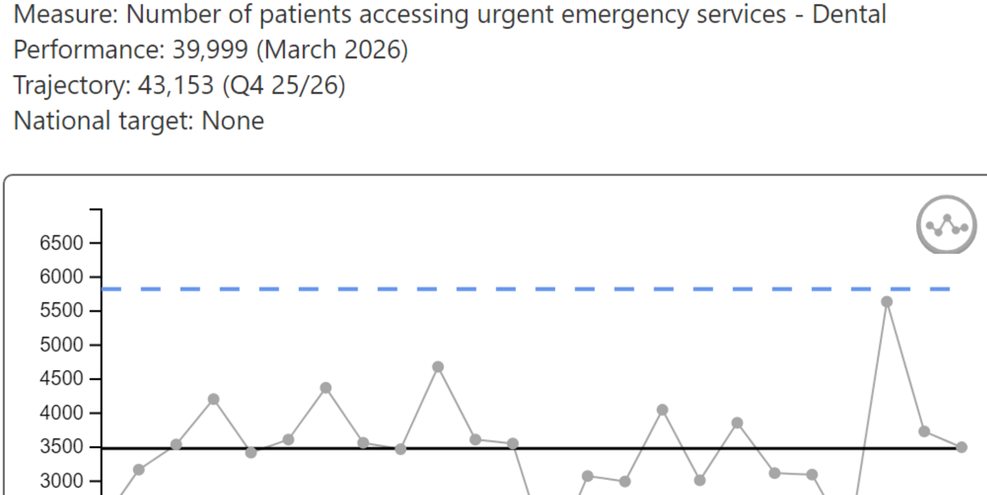
- Pharmacist Independent Prescribing Service (PIPS): PIPs consultations continue an improving trend, having delivered significantly above trajectory for 25/26 and showing above mean performance for the past 11 months. The number of Community Pharmacies providing the PIPs service also continues its improvement trend, having consistently increased every month from Apr-25, from 49 up to 68 in Apr-26 (+19).
- Common Ailment Scheme (CAS): CAS claims show an improving trend, with consistent above-mean performance from Sep-25, and having significantly exceeded the Q4 trajectory for 25/26. Mar-25 and Apr-25 performance has been exceptionally high, with the number of claims exceeding the expected range of 5,300-6,800 by several thousand.
- PIPS and CAS contacts continue to increase following an extension to the clinical conditions feasibly managed by the service and a successful public awareness campaign. It is anticipated that activity will continue to grow but at a lower rate in the coming years as we approach the ceiling for CAS in particular.

Primary and Community Services

Measure: Maintain the number of patients accessing NHS Optometry Services
Performance: 266,125 (March 2026)
Trajectory: 246,133 (Q4 25/26)
National target: None



Measure: Number of patients accessing urgent emergency services - Dental
Performance: 39,999 (March 2026)
Trajectory: 43,153 (Q4 25/26)
National target: None



Insights and Actions

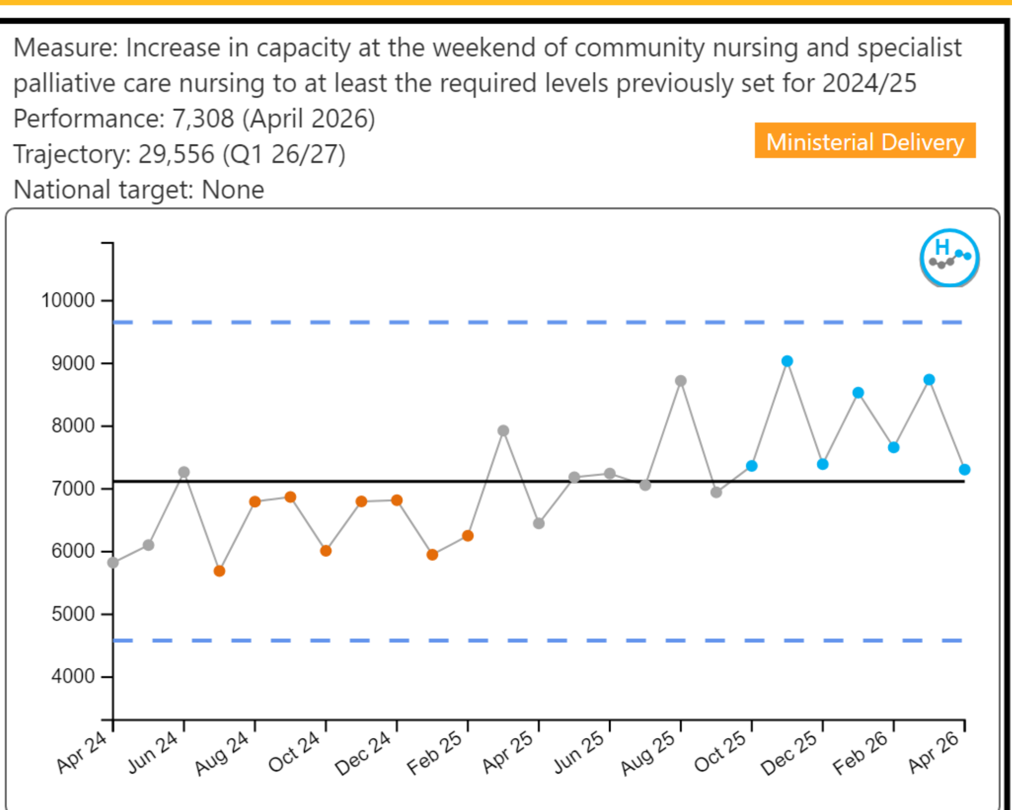
- Optometry Services: Performance for 2025/26 has exceeded the IMTP trajectory by almost 20,000 patients (8%). Implementation of the new WGOS pathways has seen an increase in patients accessing optometry services in the community, with the total number of patients accessing services in 2025/26 exceeding the annual total from 2024/25. Performance displayed some marked variability over the year, notably a drop to just under 15,000 in January, a trend observed in January 2025, and a rise to an all-time high of 29,292 patients in October.

- Emergency Dental: Performance over the course of 2025/26 represent 93% of the total IMTP trajectory, as well as a reduction in the total number of patients accessing Emergency Dental Services compared to the previous year. Overall performance also showed more variability than the previous year, with lows in April and December, as well as an all-time high of 5,640 patients in January.

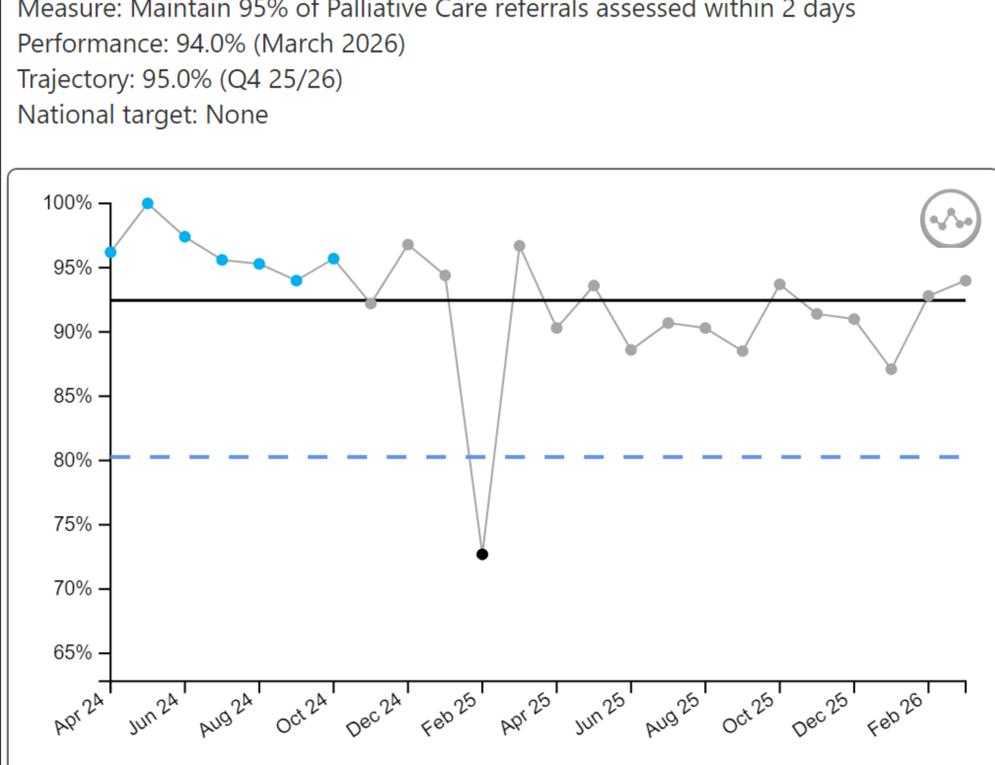
Primary and Community Services

Measure: Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25
Performance: 7,308 (April 2026)
Trajectory: 29,556 (Q1 26/27)
National target: None

Ministerial Delivery



Measure: Maintain 95% of Palliative Care referrals assessed within 2 days
Performance: 94.0% (March 2026)
Trajectory: 95.0% (Q4 25/26)
National target: None



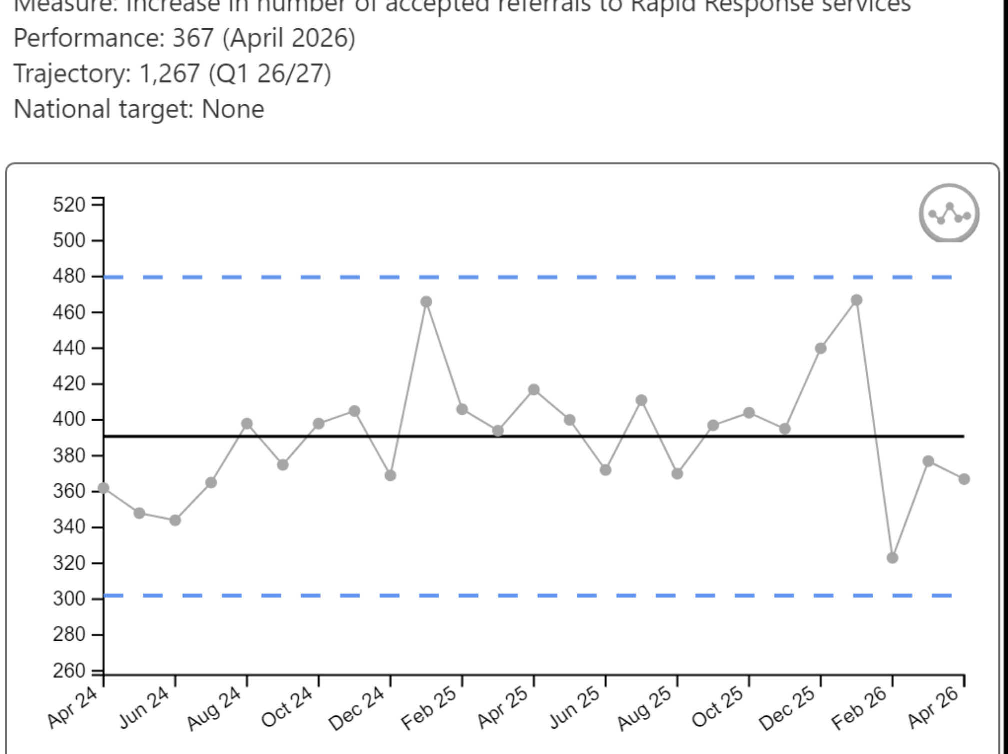
Insights and Actions

- Community Nursing: Performance is currently showing an improving trend, with above-mean capacity for the past 7 months. However, 25/26 performance finished significantly behind the expected trajectory, with only 72% of the IMTP trajectory delivered. Ministerial expectations set out that weekend activity reaches 80% of an average weekday level. Although weekend activity as a proportion of total activity is increasing and overall contacts are trending upwards as shown in the graph, achieving the ministerial measure from a volume perspective would demand a significant shift in service delivery towards weekends.

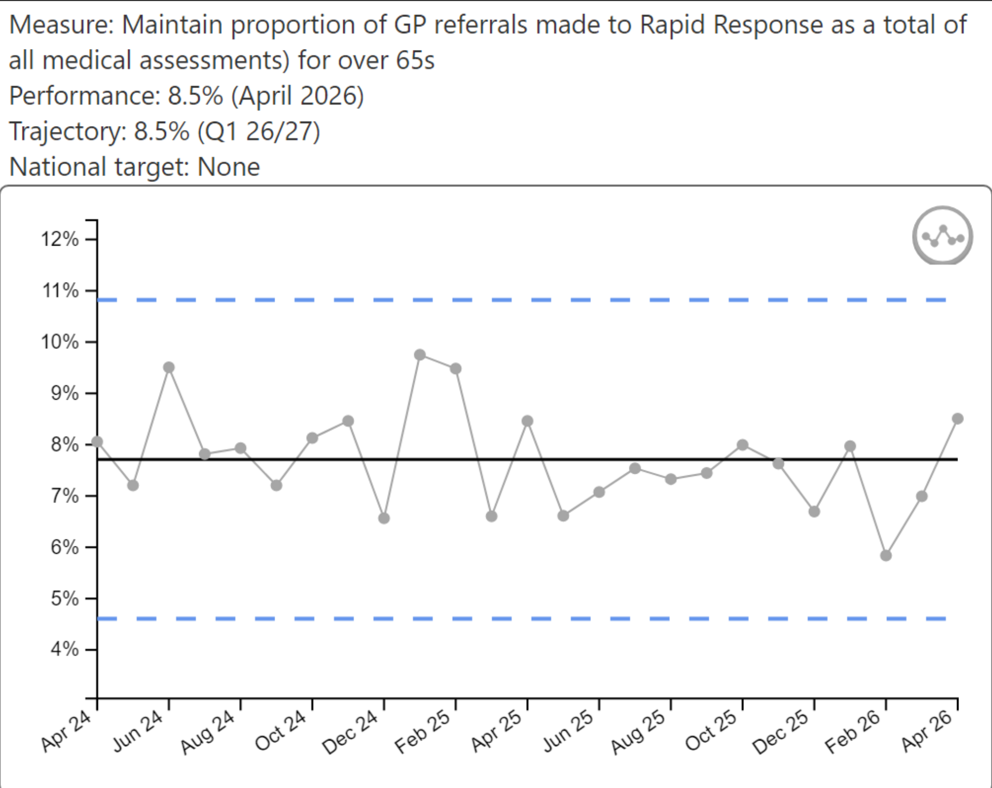
- Palliative Care: Overall performance for 2025/26 has decreased by just under 2% compared to 2024/25, with values remaining relatively consistent around 91%. The IMTP trajectory of 95% hasn't been met for any month this year. This is a result of a significant increase in demand, as well as having to manage periodic workforce capacity constraints. However, an improvement in February (+5.7%) and again in March (+1.2%) has brought end of year performance to 94%, marginally below the 95% trajectory.

Primary and Community Services

Measure: Increase in number of accepted referrals to Rapid Response services
Performance: 367 (April 2026)
Trajectory: 1,267 (Q1 26/27)
National target: None



Measure: Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s
Performance: 8.5% (April 2026)
Trajectory: 8.5% (Q1 26/27)
National target: None



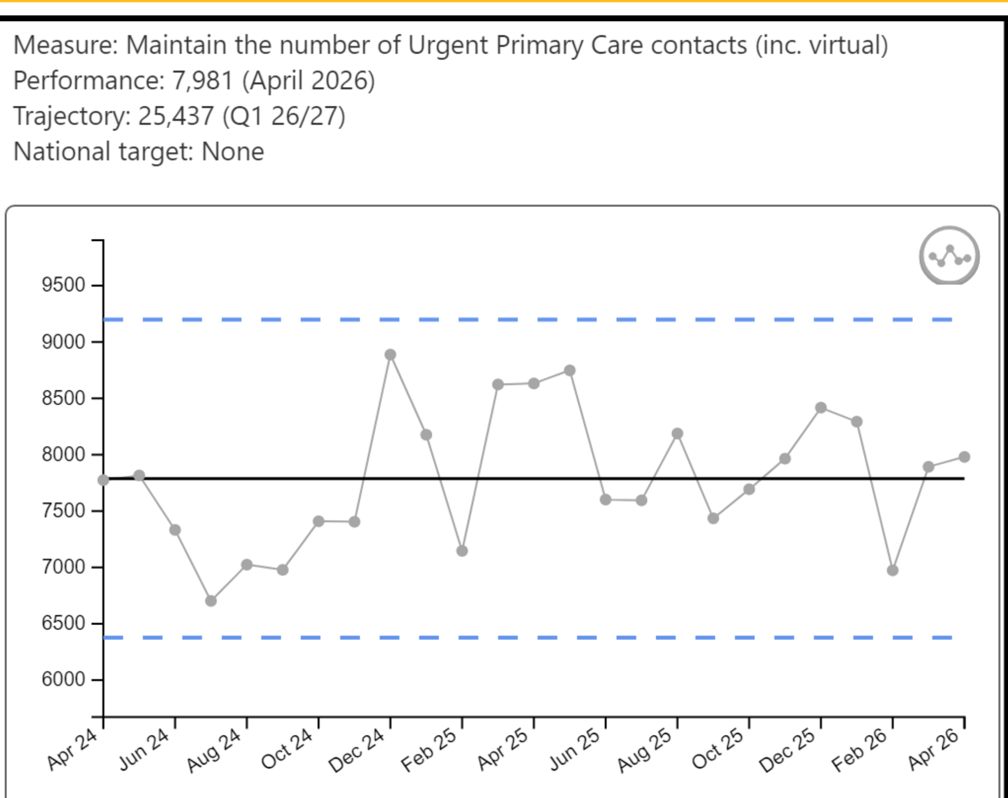
Insights and Actions

- Accepted referrals to Rapid Response: The number of accepted referrals currently shows no significant monthly change, with wide process limits indicating that performance is expected to vary between 300-480 accepted referrals per month.

- GP referrals to Rapid Response for 65+: The proportion of GP referrals made to Rapid Response for over 65s also shows no significant monthly change as of April. Again, there are wide process limits, indicating that the proportion referred is expected to vary between 5%-11%. The Q1 IMTP trajectory of 8.5% has been met in April and lies just above the mean of 8%. As part of the UEC transformation programme (older people workstream), one of the outcomes of the Navigation Hub/Single Point of Access will be to reduce barriers for GPs to access Rapid Response services.

Primary and Community Services

Measure: Maintain the number of Urgent Primary Care contacts (inc. virtual)
Performance: 7,981 (April 2026)
Trajectory: 25,437 (Q1 26/27)
National target: None



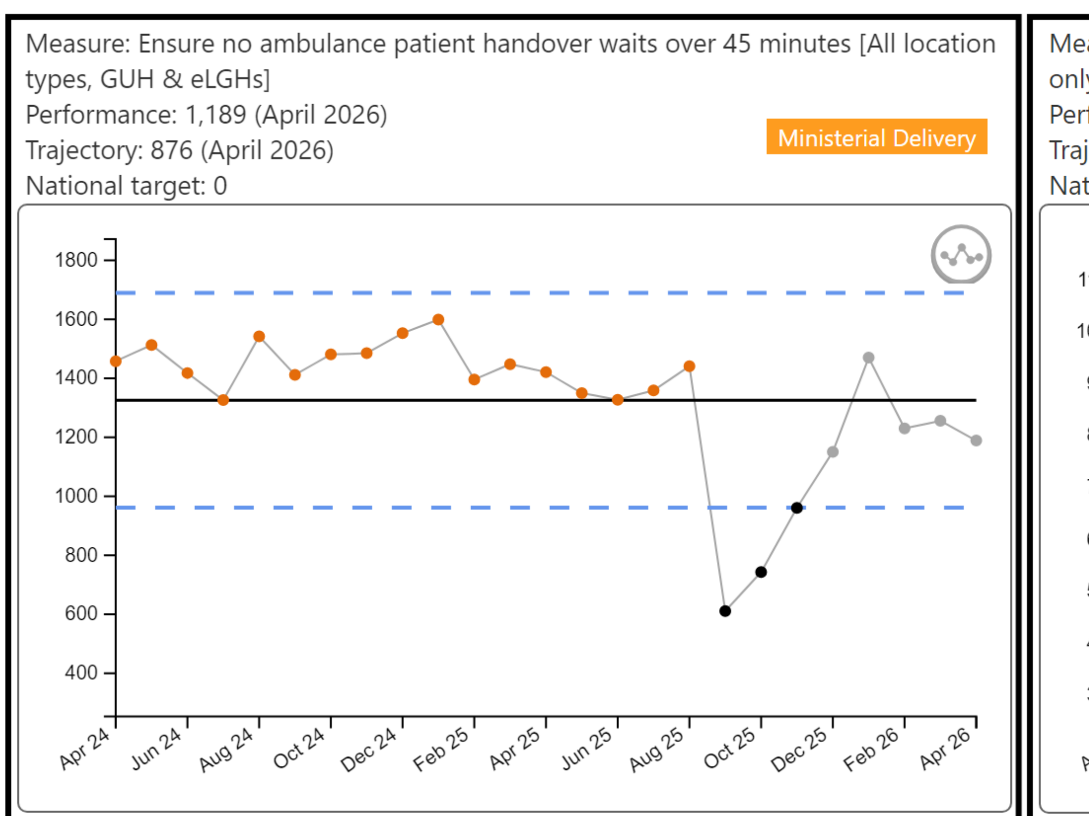
Insights and Actions

- Urgent Primary Care (UPC): UPC contacts currently show no significant change month-on-month and exhibit a wide expected range of 6,400-9,200 contacts per month. The mean number of contacts per month is 7,800, which is below the monthly target of 8,500 required to meet the Q1 IMTP trajectory.

Urgent & Emergency Care System

Measure: Ensure no ambulance patient handover waits over 45 minutes [All location types, GUH & eLGHs]
Performance: 1,189 (April 2026)
Trajectory: 876 (April 2026)
National target: 0

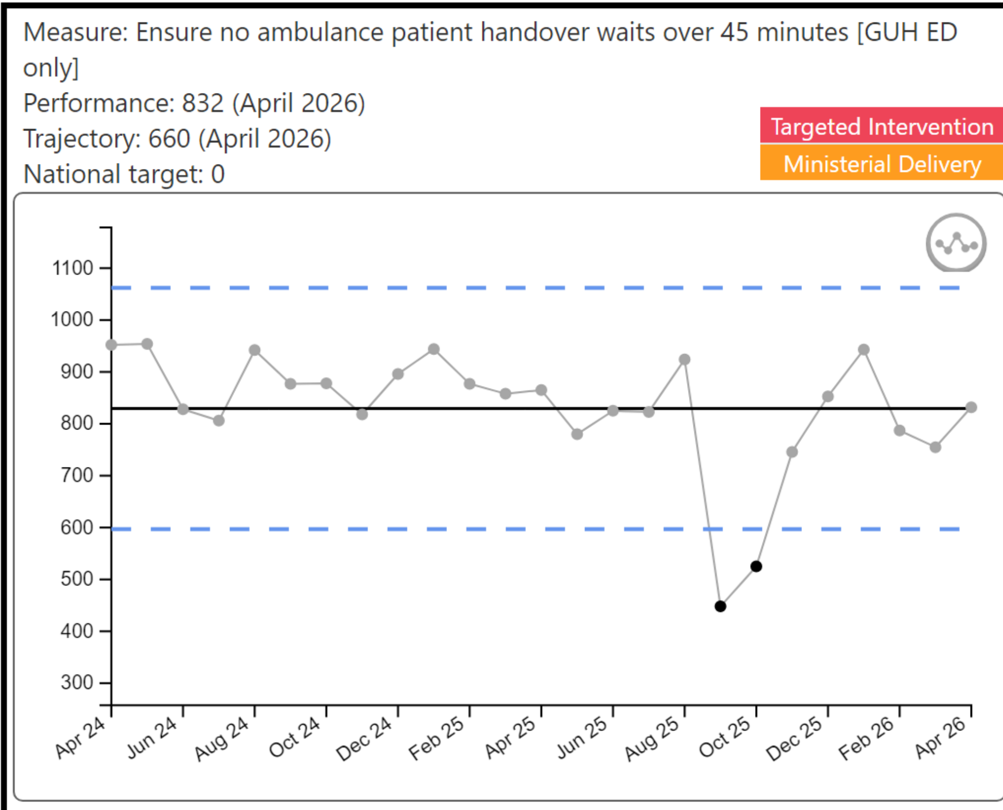
Ministerial Delivery



Measure: Ensure no ambulance patient handover waits over 45 minutes [GUH ED only]
Performance: 832 (April 2026)
Trajectory: 660 (April 2026)
National target: 0

Targeted Intervention

Ministerial Delivery

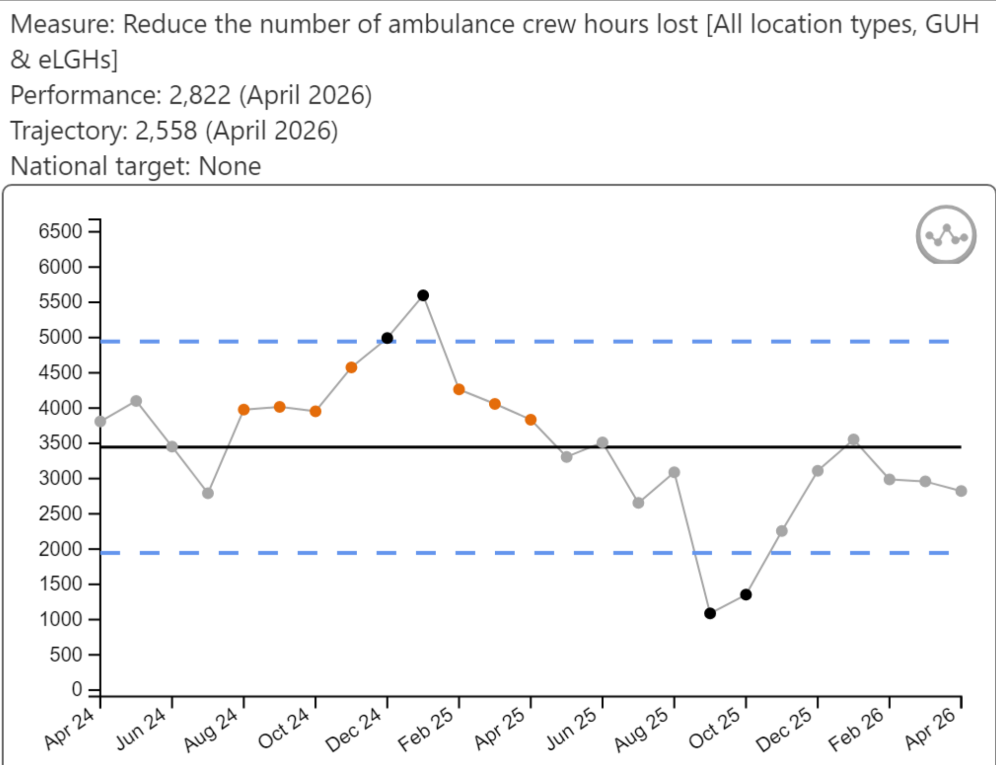


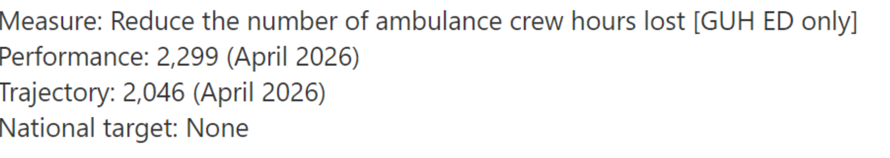
Insights and Actions

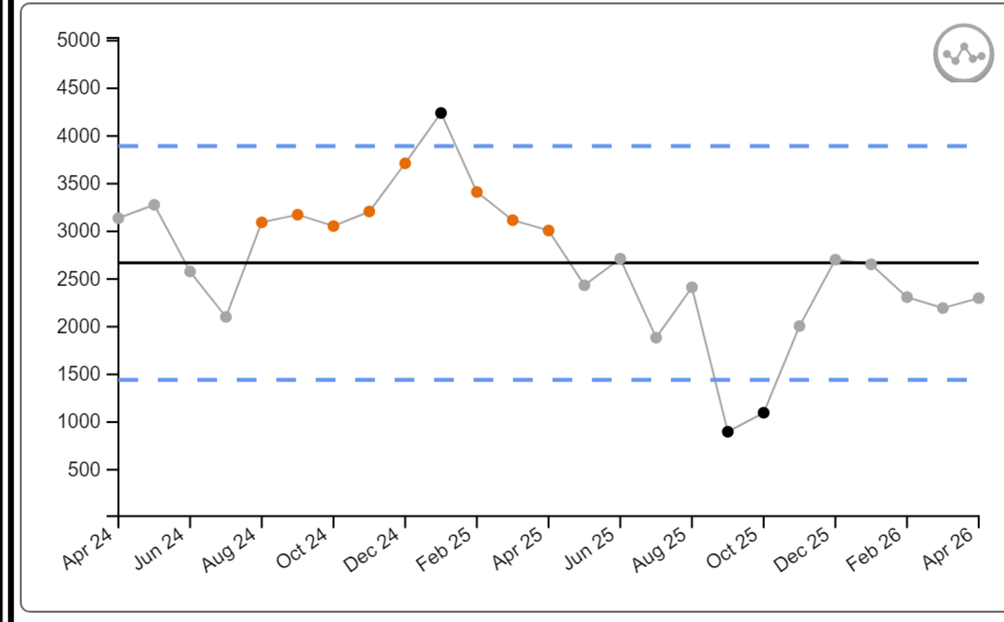
- Ambulance handovers over 45 minutes: Handover 45 is a key ministerial delivery expectation for 26/27, with the NHS Wales Performance Framework having moved away from the >1hr measure and now monitoring against handovers in excess of 45 minutes. The existing de-escalation criteria for the Health Board's targeted intervention status of Urgent & Emergency Care is still under the >1hr measure, however through the 26/27 Annual Plan the Health Board opted to include handovers over 45 minutes as key performance measures for both GUH ED only (shown on the right) and all location types (e.g. including Assessment Units) across GUH and the eLGHs. The new UEC plan seeks to embed the Our Next Patient principles of aiming to deliver handovers within 15 minutes and not in excess of 45 minutes across the Health Board. Both SPC charts indicate that there has been a broad improvement trend over the past 25 months however each is above trajectory as of the first month's data for this year. The UEC improvement plan was recently (May) presented to Board and there will be further discussions on the plan to deliver against the 45 minute handover with P&I in early June, which could result in the current annual plan trajectory being amended.

Urgent & Emergency Care System

Measure: Reduce the number of ambulance crew hours lost [All location types, GUH & eLGHs]
Performance: 2,822 (April 2026)
Trajectory: 2,558 (April 2026)
National target: None




Measure: Reduce the number of ambulance crew hours lost [GUH ED only]
Performance: 2,299 (April 2026)
Trajectory: 2,046 (April 2026)
National target: None



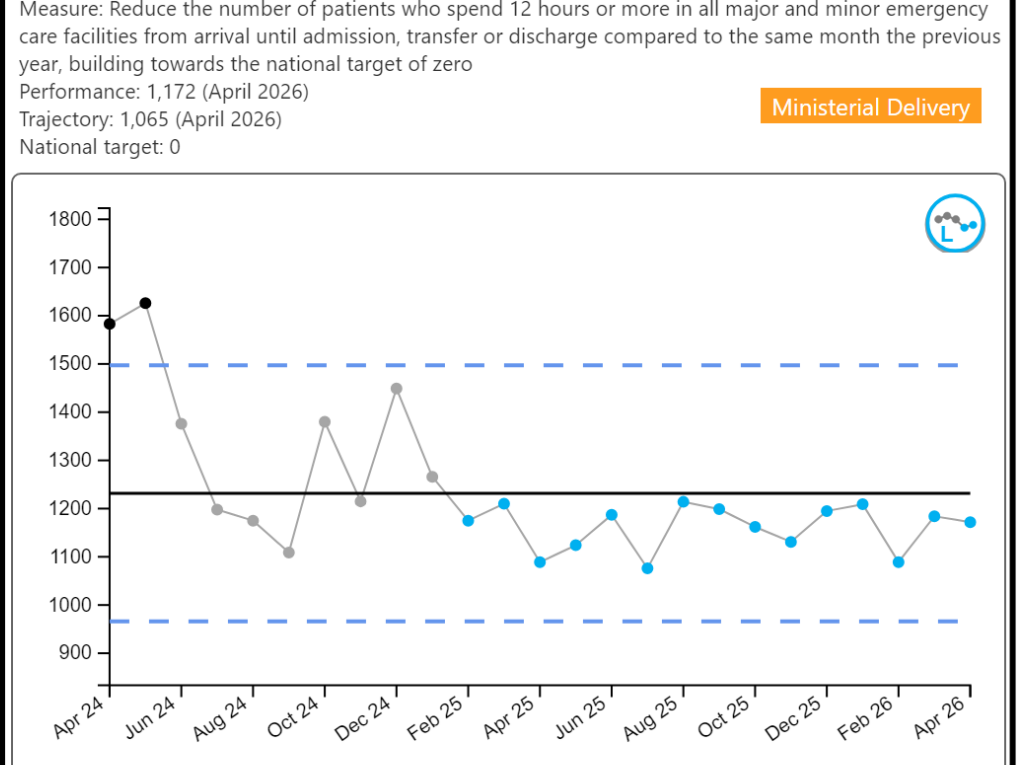
Insights and Actions

- Ambulance lost hours: As with handovers over 45 minutes, two lost hours measures have been included in the 26/27 Annual Plan (GUH ED only, and GUH & eLGHs across all location types). The Annual Plan lost hours trajectories are intrinsically linked to the >45minute handover trajectories and therefore also the UEC improvement, and thus may be subject to revision pending any resubmission. The improvements made over the past 25 months are more pronounced. As of the April position they are both marginally above the current trajectory.

Urgent & Emergency Care System

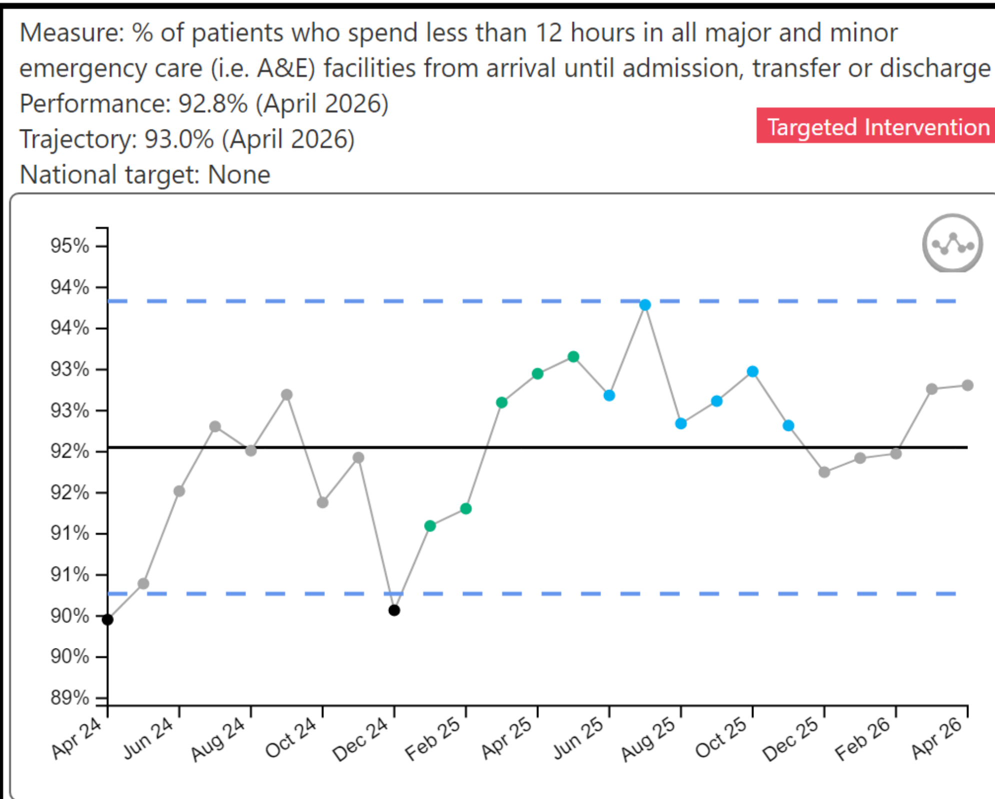
Measure: Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero
Performance: 1,172 (April 2026)
Trajectory: 1,065 (April 2026)
National target: 0

Ministerial Delivery



Measure: % of patients who spend less than 12 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge
Performance: 92.8% (April 2026)
Trajectory: 93.0% (April 2026)
National target: None

Targeted Intervention

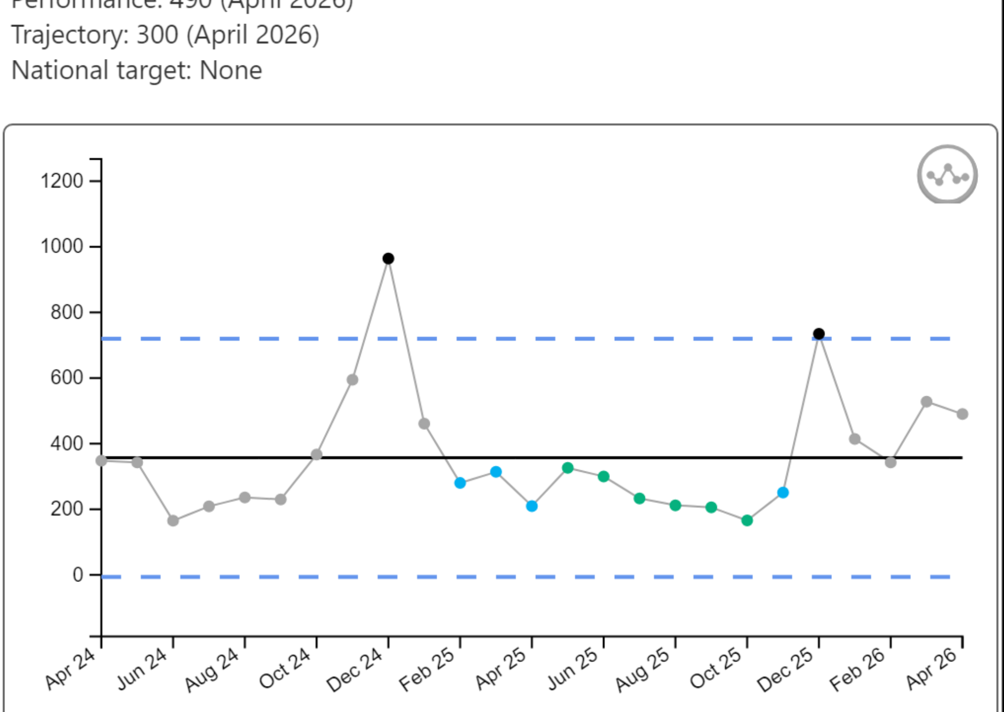


Insights and Actions

- 12hr EDMIU: 12hr EDMIU breaches by volume (shown left) remains a ministerial delivery expectation for 26/27. The Health Board targeted intervention de-escalation criteria measures 12hr compliance, which factors breach volumes as a proportion of total attendances. 25/26 saw much more stable performance for 12hr breaches with less variability. 12hr compliance has, after a more challenged winter period, returned to levels very close to the targeted intervention de-escalation criteria of 93% compliance. Aligned to the UEC transformation plan and Our Next Patient, the Health Board is seeking to embed the continuous flow mode through the entirety of the patient Urgent & Emergency Care pathway. Flow through this pathway is critical to ensuring that the Emergency Department and Assessment Units do not become congested, as this is the single largest factor in correlating directly with deteriorating ambulance handover performance, 12hr breaches/compliance and waits to be seen – three of the four targeted intervention de-escalation metrics.

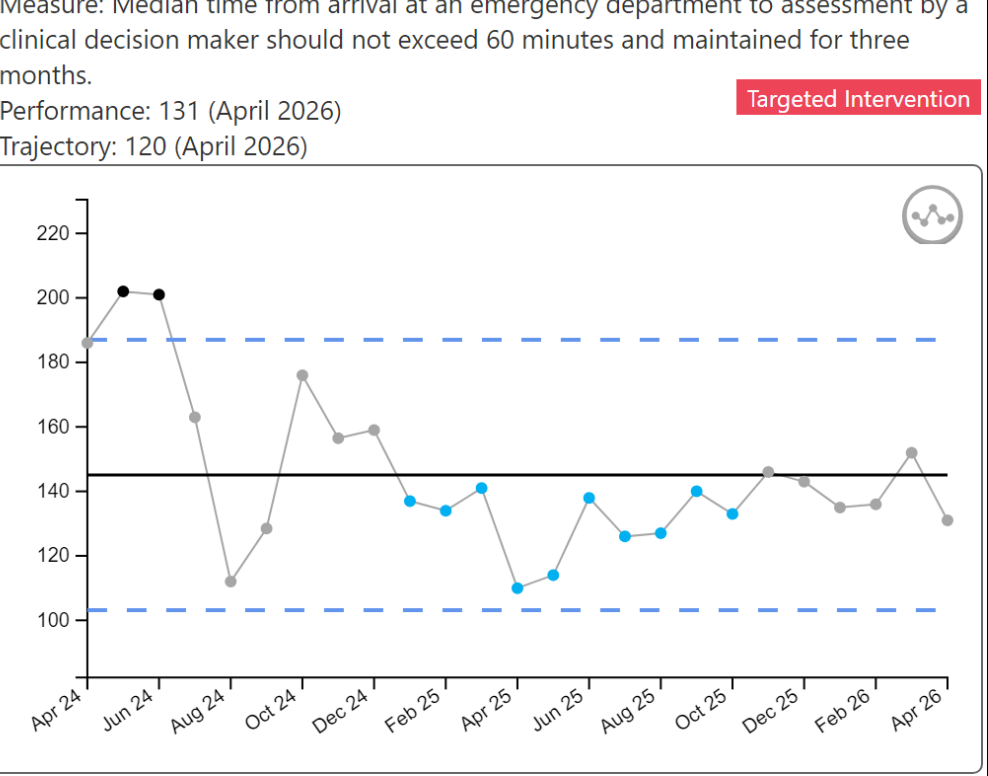
Urgent & Emergency Care System

Measure: Reduction in time from arrival to ED triage - no waits over 60 minutes
Performance: 490 (April 2026)
Trajectory: 300 (April 2026)
National target: None



Measure: Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months.
Performance: 131 (April 2026)
Trajectory: 120 (April 2026)

Targeted Intervention

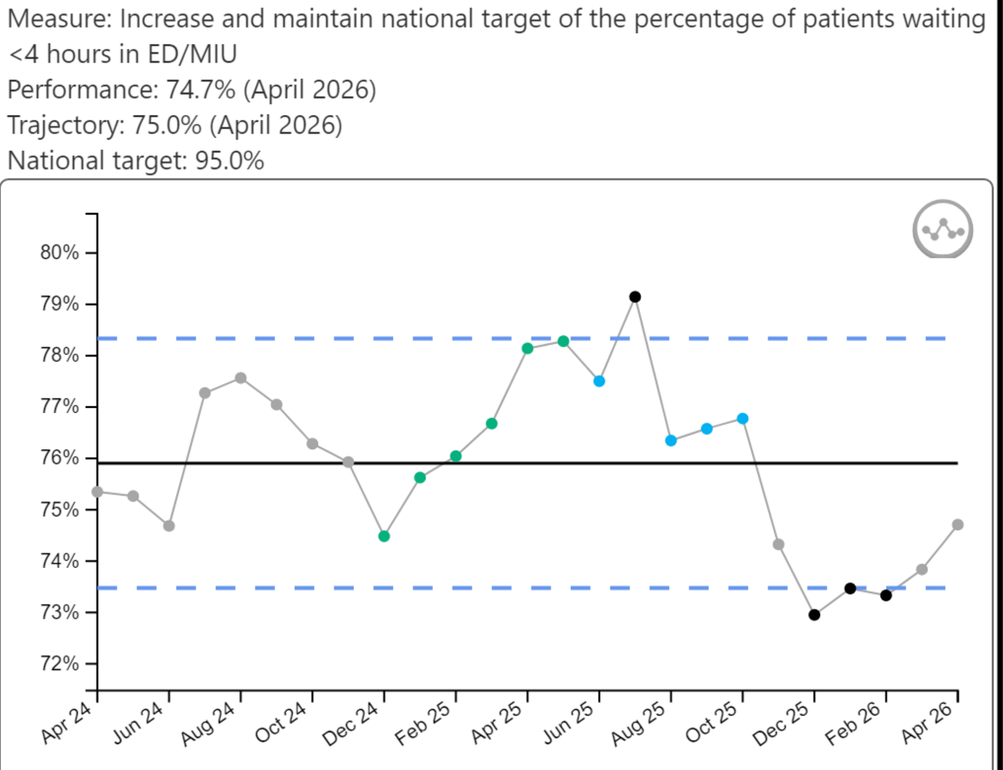


Insights and Actions

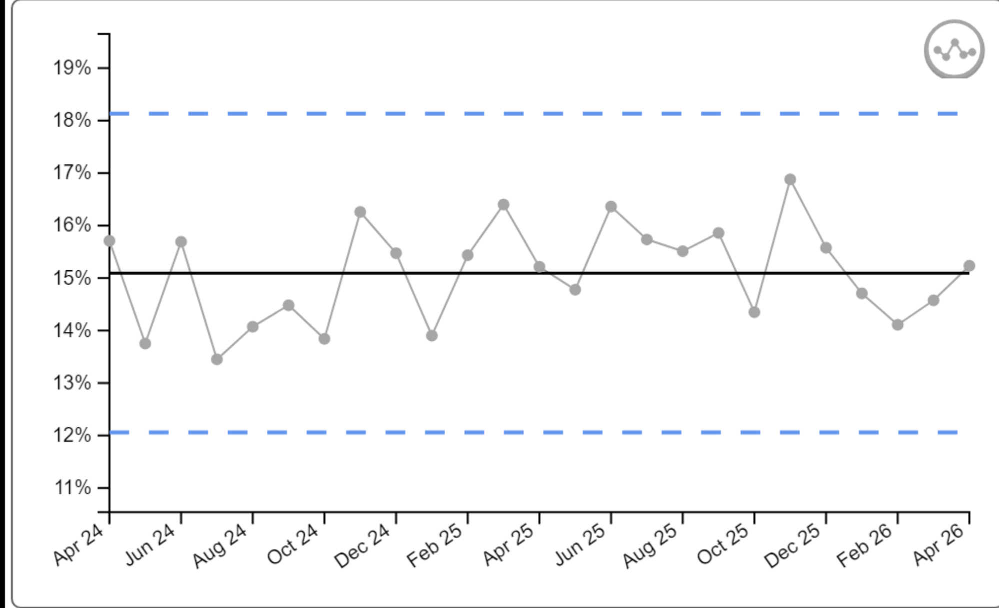
- Triage: 60 minute triage breaches remain higher than they were 12 months previous following the Winter spike and are above trajectory as of the April position. Triage improvement is included as one of the workstreams within the Our Next Patient programme and will report into the new Urgent and Emergency Care programme board to track progress against plans.
- Wait to be seen (WTBS): WTBS improved in April to 131 minutes, the best performance since Aug-25 and just above the trajectory of 120 minutes. Another targeted intervention measure, the de-escalation criteria is to achieve less than 60 minutes. To embed sustained continuous-flow across the Emergency Department, daily huddles are being strengthened and used as a mechanism to improve early patient movement, helping to prevent congestion within majors and assessment areas. Improving daytime assessment capacity is also key, building on ongoing clinician role redesign and effective Senior Rapid Assessment & Treatment (SRAT) rostering. This ensures assessment spaces' capacity is used to the maximum potential, reducing the delays that contribute to WTBS pressures. Finally, protecting cubicle availability overnight is essential, with enforcement of ONP escalation and adhering to boarding protocols so that clinical areas retain capacity, helping to avoid the deterioration in WTBS performance when overnight capacity is challenged.

Urgent & Emergency Care System

Measure: Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU
Performance: 74.7% (April 2026)
Trajectory: 75.0% (April 2026)
National target: 95.0%



Measure: Improve the percentage of pre noon Provider Spell discharges
Performance: 15.2% (April 2026)
Trajectory: 16.5% (Q1 26/27)
National target: 33.0%



Insights and Actions

- 4hr EDMIU: 4hr EDMIU compliance was severely impacted through the winter period as the system experienced sustained pressures. Improvement has been observed over the past two months and April performance is only marginally short of the Annual Plan trajectory of 75%. Again, delivery against all of the actions described in the UEC transformation plan will contribute to improving performance for this measure.
- Pre noon discharge performance: Pre noon discharge performance was one of the key metrics monitored by NHS P&I during the Winter Sprint periods and continues to form part of the daily operational returns submitted by the Health Board. It is recognised that earlier discharges enable better flow through the hospitals, and therefore the Health Board included this measure in the 26/27 Annual Plan for the first time. As backdoor flow remains a critical part of the overarching UEC transformation plan, the work underway through embedding the Optimal Hospital Flow Framework (OHFF) seeks to improve the rate of pre noon Provider Spell (e.g. patients going to their usual place of residence/leaving the system rather than transfers). April performance improved to just above the mean following the Winter period.

Urgent & Emergency Care System

Measure: Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard
Performance: 174 (April 2026)
Trajectory: 160 (April 2026)
National target: None

Targeted Intervention
Ministerial Delivery

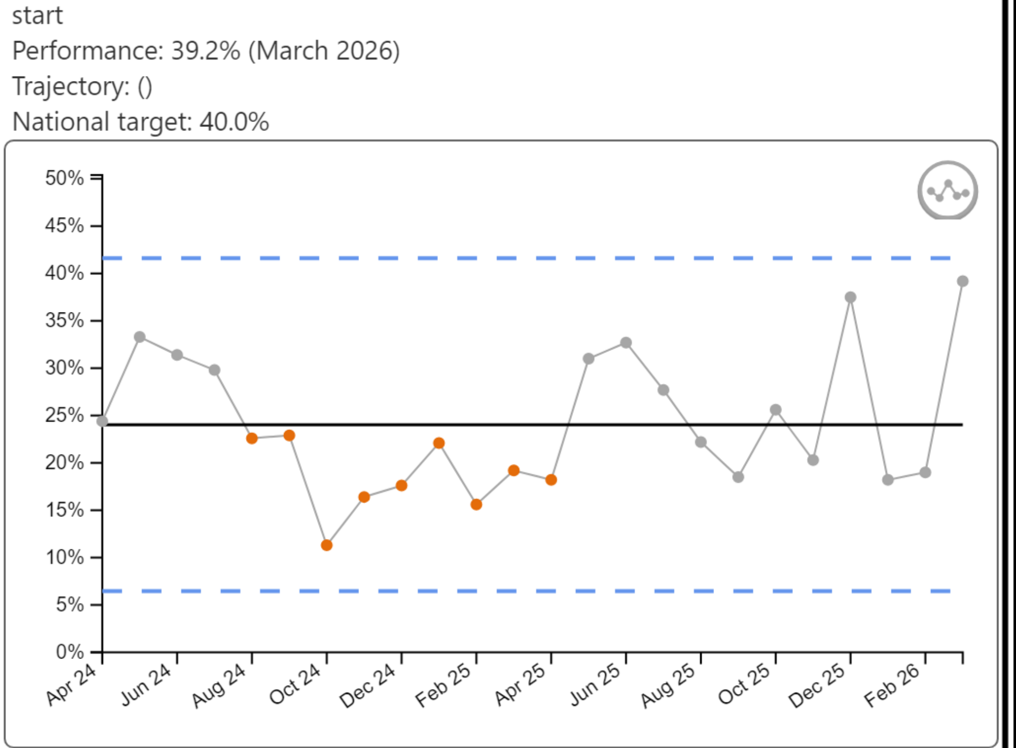
Measure: Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard
Performance: 4,717 (April 2026)
Trajectory: 4,800 (April 2026)
National target: None

Ministerial Delivery

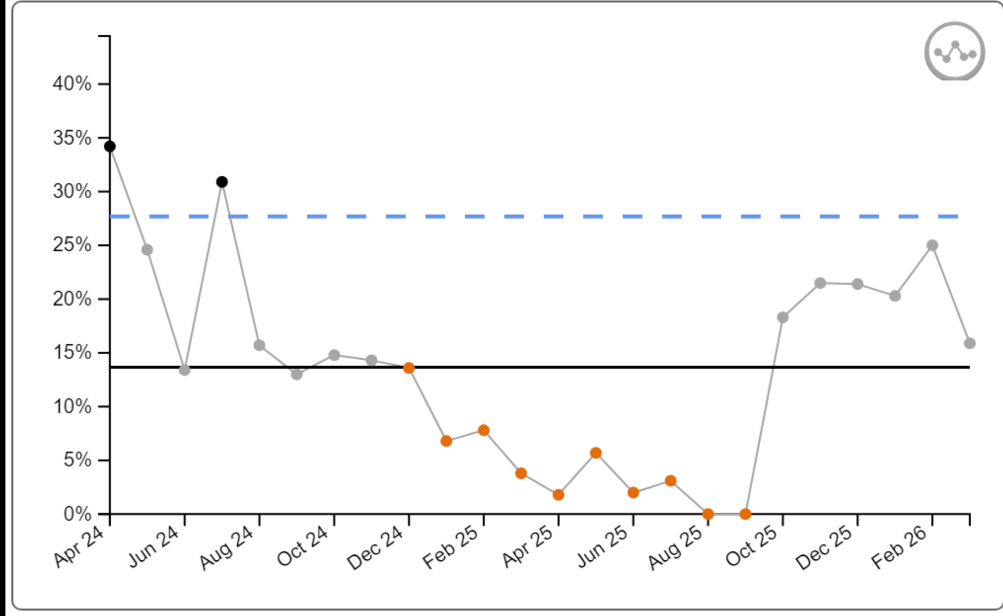
Insights and Actions

- Pathway of Care Delays (POCDs): The total number of POCDs has seen four months of consecutive reduction after reaching a 2025/26 high in December, with the last three months demonstrating below-mean performance. The April position of 174 is now slightly above the planned trajectory of 160 and marginally reduced from the position a year ago (-1.1%, 176). POCDs by days delayed remained stable from January to February but dropped to the exceptionally low value of 4,543 in March, the second lowest position since April '24 and a 27% drop on the position a year ago. This has risen marginally in April to 4,717 days but still represents an exceptionally low value compared to the expected range of 5,400-8,600 days. Average days delayed remains relatively constant at 27 days in April compared to 26 days in March. Significant focus remains on reviewing the longest staying patients, as well as new processes in place across Divisions to improve the accuracy of Estimated Discharge Dates (EDDs) and the recording of reasons that are preventing patients moving to the next step of the discharge planning process.

Urgent & Emergency Care System



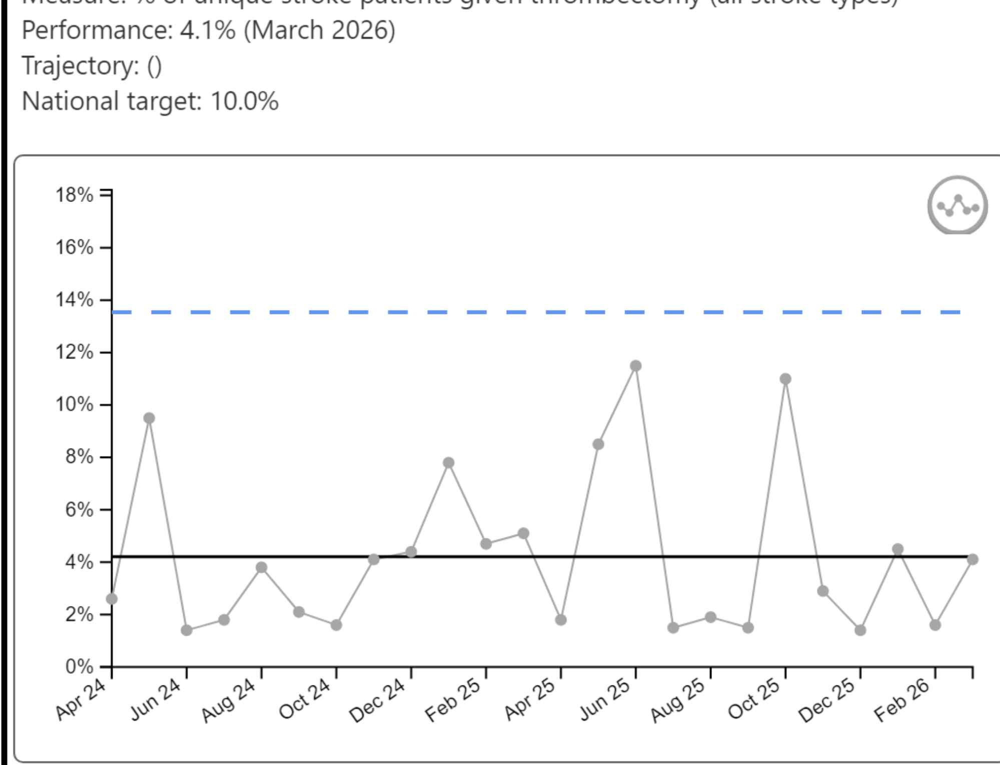
Measure: % of patients directly admitted to an acute stroke ward <4hrs of clock start
Performance: 15.9% (March 2026)
Trajectory: ()
National target: 50.0%

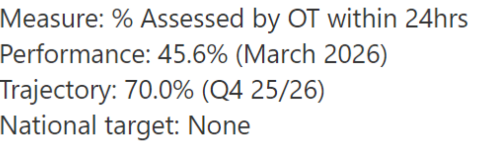


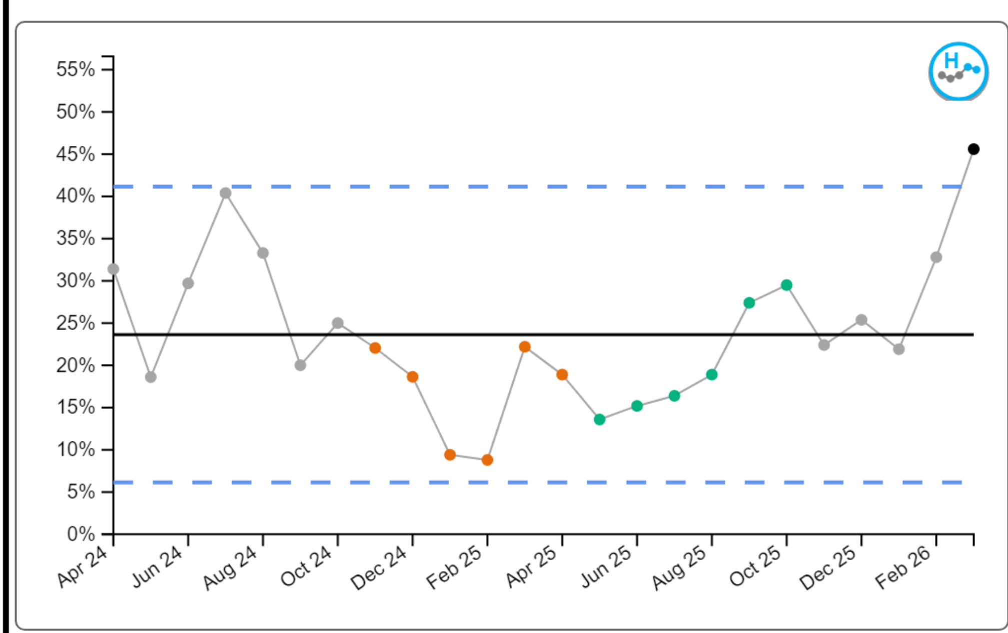
Insights and Actions

- Stroke time to scan: The percentage of patients scanned within 20 minutes of clock start has been included within the 26/27 NHS Wales Performance Framework and has been adopted by the Health Board as a core performance measure within the Annual Plan for 26/27. March performance of 39.2% was the highest in the held dataset (going back to Apr-24).
- Stroke 4hr target: A data recording error had depressed true performance against the four hour target during the parts of 2025, however this was rectified and performance increased to 20-25% as a result. March performance decreased slightly as the system experienced higher than expected demand. The Stroke Regional Network Group is placing an increasing focus on performance in new Urgent & Emergency Care Improvement programme. An updated stroke improvement plan is in place to address outstanding GIRFT actions and new NHS Wales Stroke Quality statement and standards.

Urgent & Emergency Care System





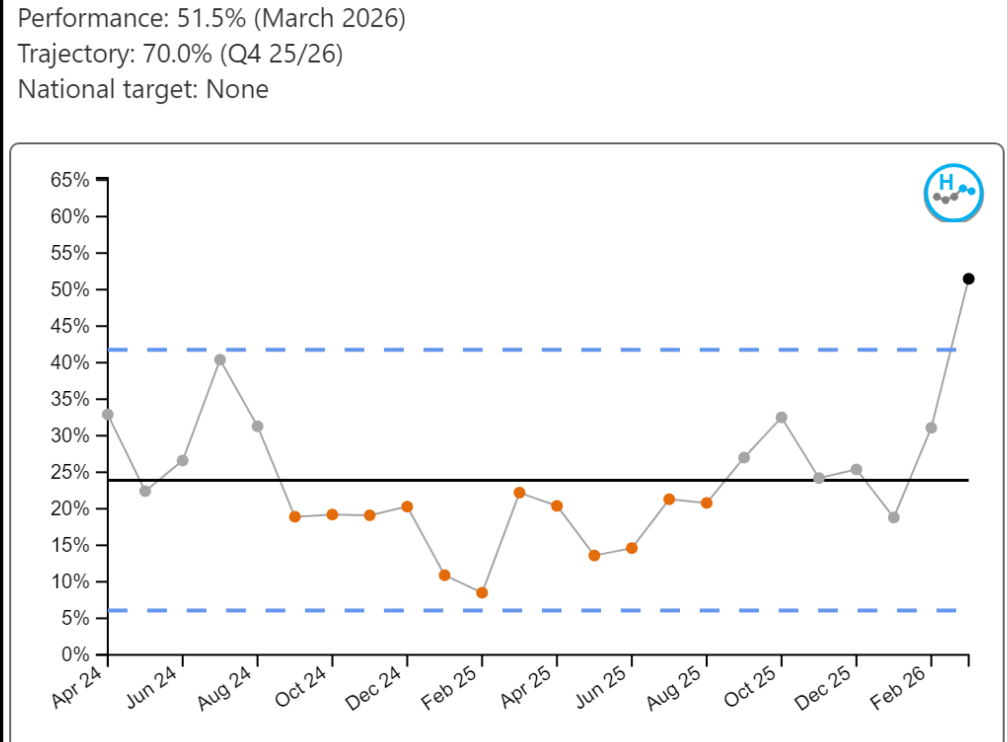


Insights and Actions

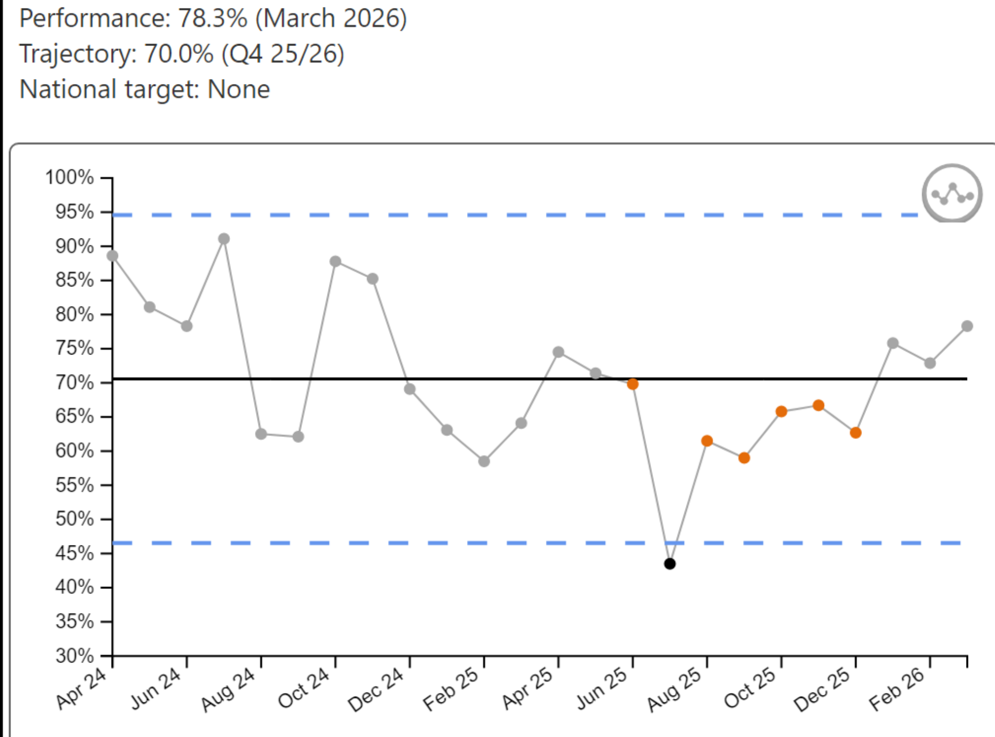
- Stroke thrombectomy: Q3 SSNAP data also shows improvement in thrombectomy rates up to 7.3% and meeting the IMTP trajectory. Thrombectomy commissioning and data capture has been discussed between ABUHB and NHS P&I. NHS P&I are liaising with the JCC around commissioning approach and particularly hours of service provided from Southmead (NBT), an extension to which could assist in improving rates further. The internal stroke improvement plan linked to improving thrombolysis rates is underway and will have linked benefit to thrombectomy where applicable.
- A national stroke performance dashboard aligned to the SSNAP measures has been set up and validated, enabling the reporting of Health Board performance by month and significantly decreasing the reporting delay (which was previously quarterly in arrears).

Urgent & Emergency Care System

Measure: % Assessed by PT within 24hrs
Performance: 51.5% (March 2026)
Trajectory: 70.0% (Q4 25/26)
National target: None



Measure: % Assessed by SaLT within 72hrs
Performance: 78.3% (March 2026)
Trajectory: 70.0% (Q4 25/26)
National target: None



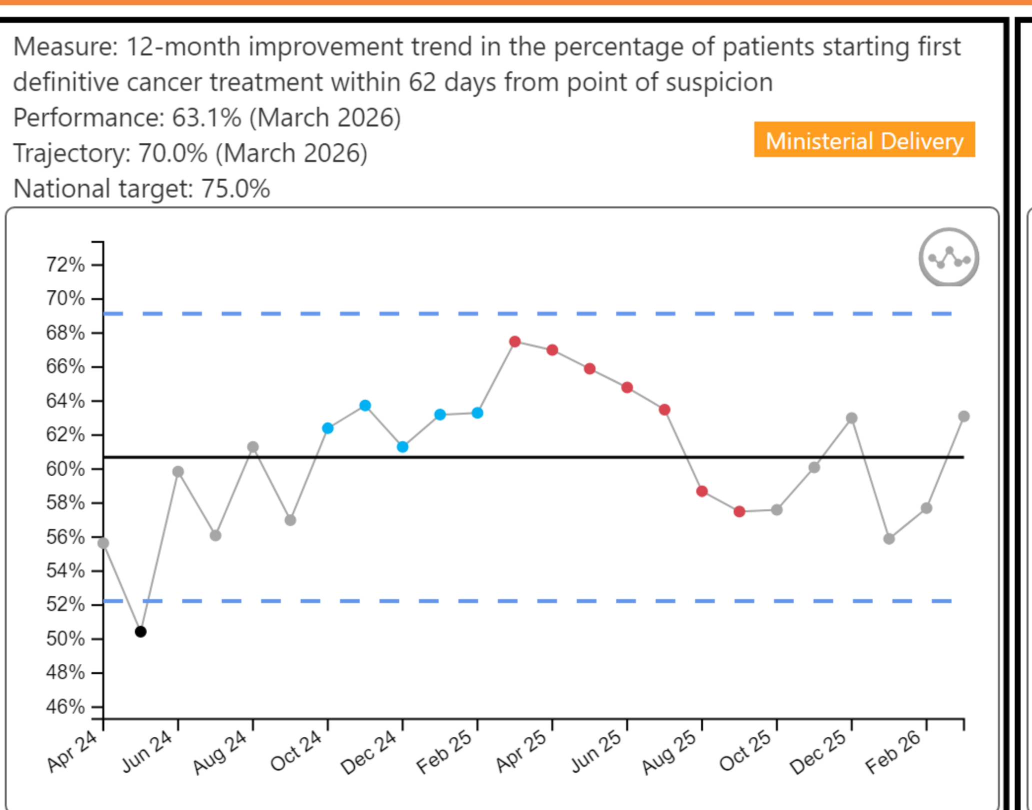
Insights and Actions

- Stroke therapies: Occupational (previous slide) and Physiotherapy assessment within 24hrs both saw significant improvements in March, reaching 45.6% and 51.5% respectively and the highest levels recorded in our dataset from April 2024. Speech and Language assessment within 72hrs continued its improvement trend since the low of Jul 25 with the past three reportable months all above the mean.

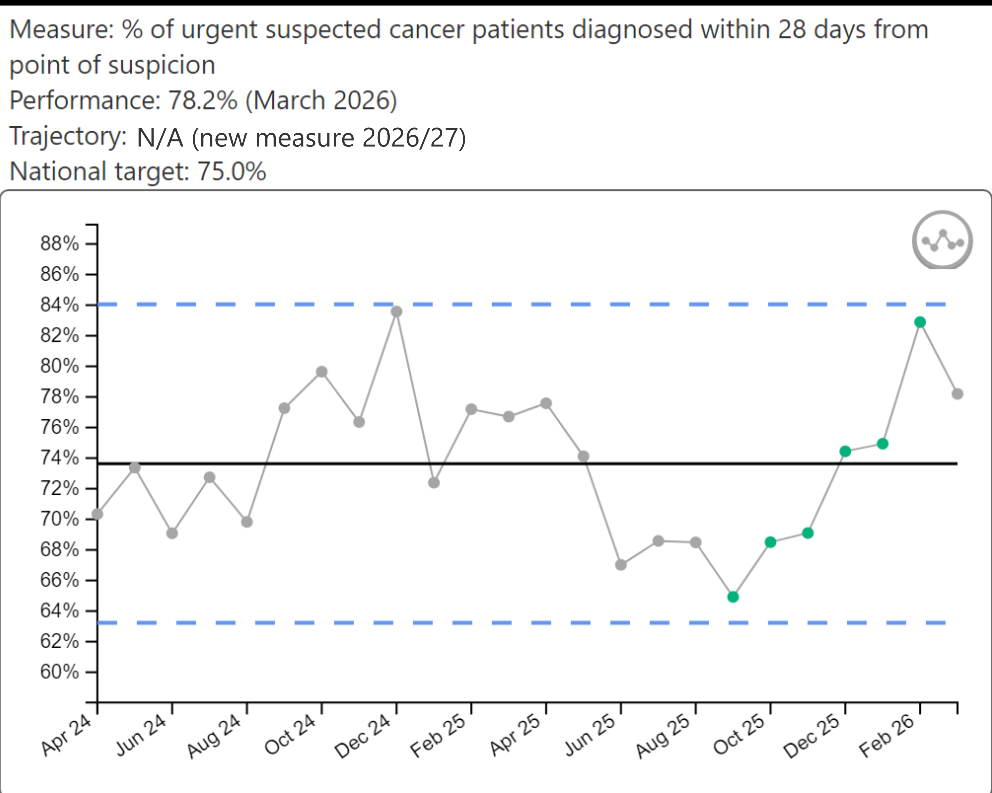
Cancer and Planned Care

Measure: 12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion
Performance: 63.1% (March 2026)
Trajectory: 70.0% (March 2026)
National target: 75.0%

Ministerial Delivery



Measure: % of urgent suspected cancer patients diagnosed within 28 days from point of suspicion
Performance: 78.2% (March 2026)
Trajectory: N/A (new measure 2026/27)
National target: 75.0%



Insights and Actions

- SCP compliance: Continued increase in performance for the past two months, with March position at 63.1%. Recovery planning meetings have been established, chaired by the Cancer SRO and supported by Cancer Services. Weekly meetings have resumed in Head & Neck and a pathway deep-dive is underway, with the backlog already reducing. Recovery planning group meetings in gynaecological oncology are beginning to demonstrate a positive impact, with February SCP compliance rising to an in-year high of 73.3% (37.5% in Nov-25), although the Mar-26 position has reduced to 36.4%. In colorectal services, a detailed action plan has been developed to support improvements in patient pathways and SCP compliance, supported by the establishment of a recovery action planning group to focus on key areas for improvement. A particular priority is addressing significant challenges at the first diagnostic stage of the pathway. The endoscopy service continues to experience high DNA and short-notice CNA rates, which are negatively impacting overall pathway compliance.
- 28 day diagnosis compliance: 28 day diagnosis compliance improved significantly through the second half of 25/26 and remains above the Health Board's and UK target of 75% as of the March position.

Cancer and Planned Care

Measure: Reduction in backlog of patients waiting over 62 days (SCP)
Performance: 310 (March 2026)
Trajectory: 200 (March 2026)
National target: None

Ministerial Delivery

Measure: Reduction in backlog of patients waiting over 104 days (SCP)
Performance: 92 (March 2026)
Trajectory: 50 (March 2026)
National target: None

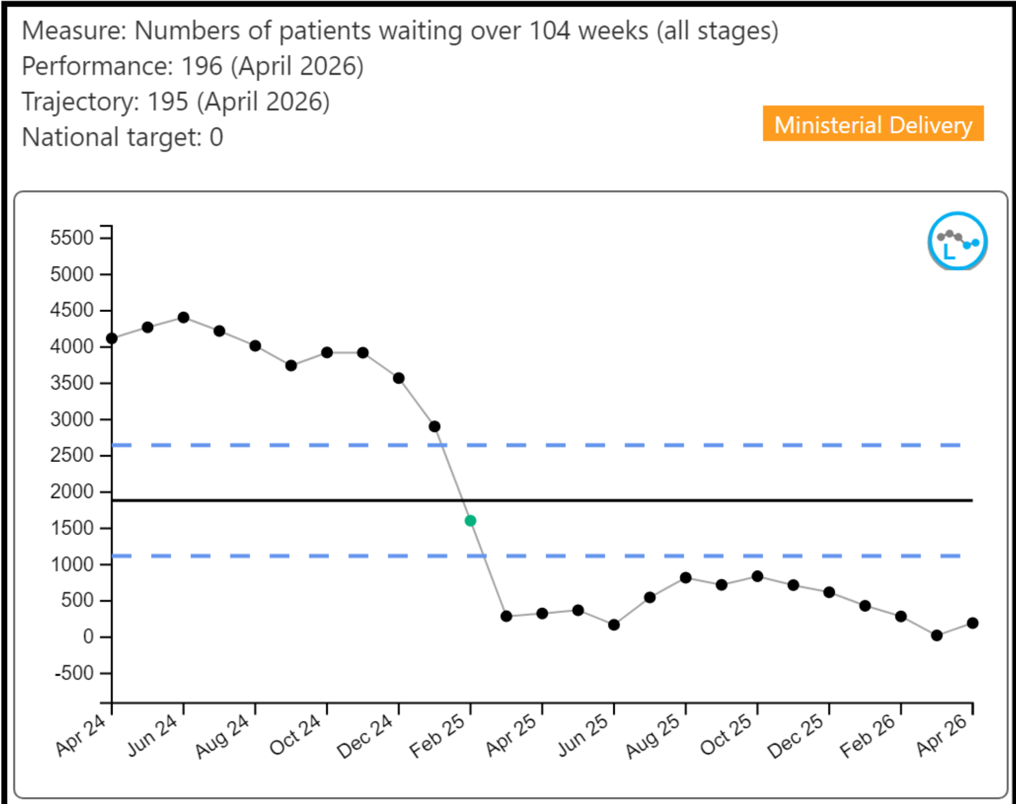
Ministerial Delivery

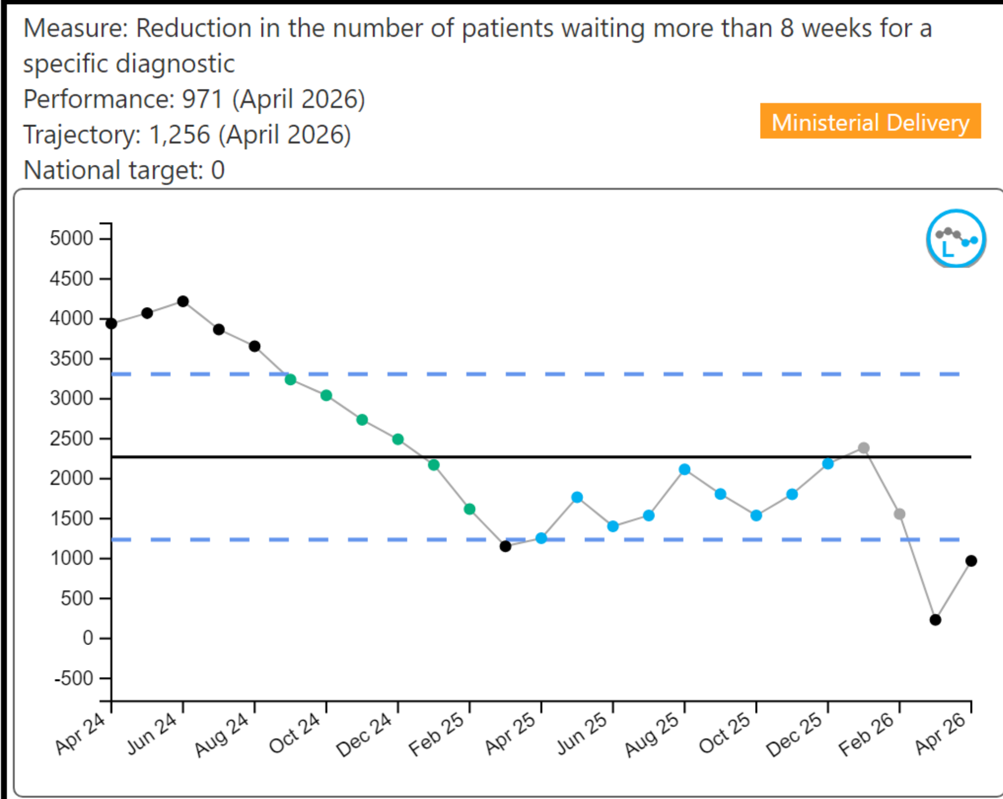
Insights and Actions

- 62 day backlog: The target for the 62 day backlog is to be ~10% of the SCP Census, which has increased through 25/26 reaching a high of ~3,900 in July. The PTL has continued to decrease and now sits at 3,232 as of March, and thus a backlog of 310 represents 9.6% of the total PTL. There remains a continued focus to reduce the backlog in the three tumour sites the make up over 75% of the entire 62 day backlog (Lower GI, Upper GI and Urology).

- 104 day backlog: The 104 day backlog has been largely stable over the past 6 months, even in the context of an SCP census that has been subject to significant fluctuation. The actions through the remainder of Q4 and into 26/27 will be focussed on reducing this backlog.

Cancer and Planned Care

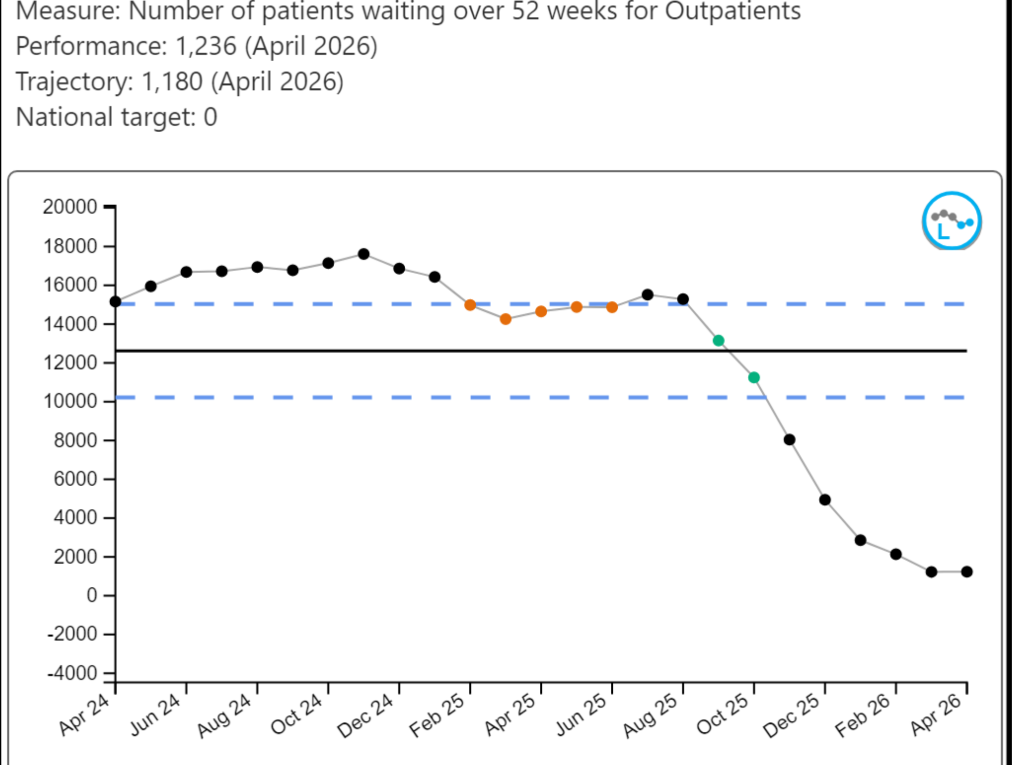




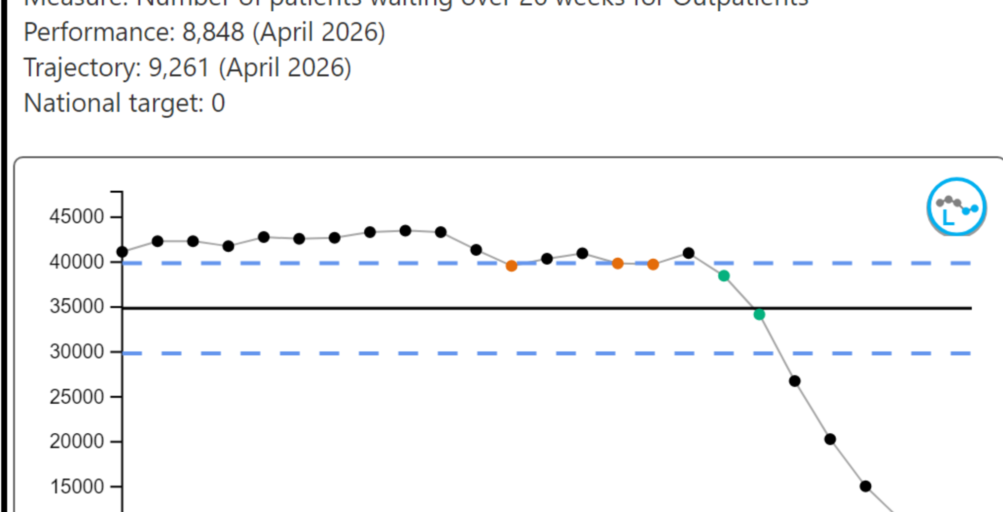
Insights and Actions

- 104 weeks RTT: Following the significant achievement in reducing planned care waits over 104 weeks to 23 as the end of the 25/26, the lowest number since April 2020. This number has risen in April but to a lesser degree than was forecast. The reduction shown in the chart in 24/25 and subsequent broad maintenance and further reduction in 25/26 were enabled by additional, non recurrently funded schemes within the Division of Surgery. There remain demand and capacity deficits within select specialties and the assumptions and forecasts within the Annual Plan were recently reforecast and adopted as an updated trajectory.
- Diagnostics: Similarly to 104wk RTT breaches, the Health Board had an intensive programme of work through Q4 25/26 to reduce 8 week diagnostic breaches, following the receipt of additional funding. March saw the Health Board deliver an extraordinary reduction in 8 weeks breaches, reducing from 1,557 in February to a year end position of 233. The April position was always expected to increase, however the deterioration has not been to the extent that was forecast. Modalities remain under supplementary pressures created through the 26 week outpatient insourcing programme, and solutions to mitigate underlying core demand and capacity gaps remain in train. Until these are confirmed and in place, the Health Board's 8 week breach position will increase, however a commitment was made in the Annual Plan to deliver to zero by the end of the year.

Cancer and Planned Care



Measure: Number of patients waiting over 52 weeks for Outpatients
Performance: 1,236 (April 2026)
Trajectory: 1,180 (April 2026)
National target: 0



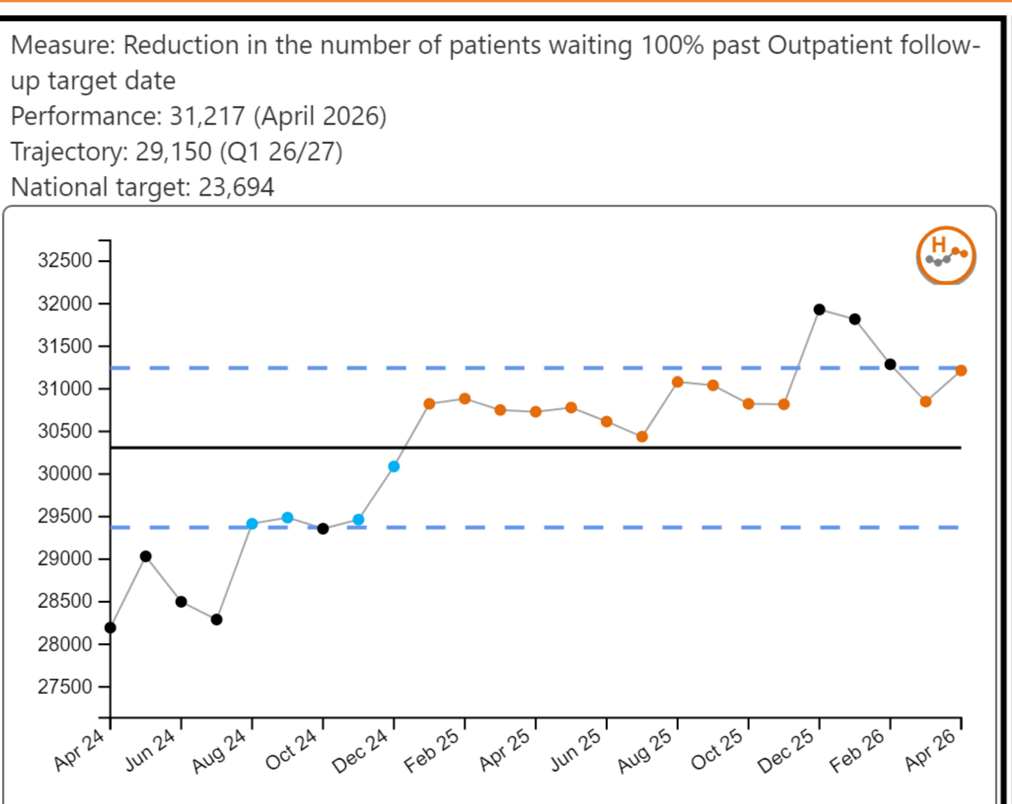
Measure: Number of patients waiting over 26 weeks for Outpatients
Performance: 8,848 (April 2026)
Trajectory: 9,261 (April 2026)
National target: 0

Insights and Actions

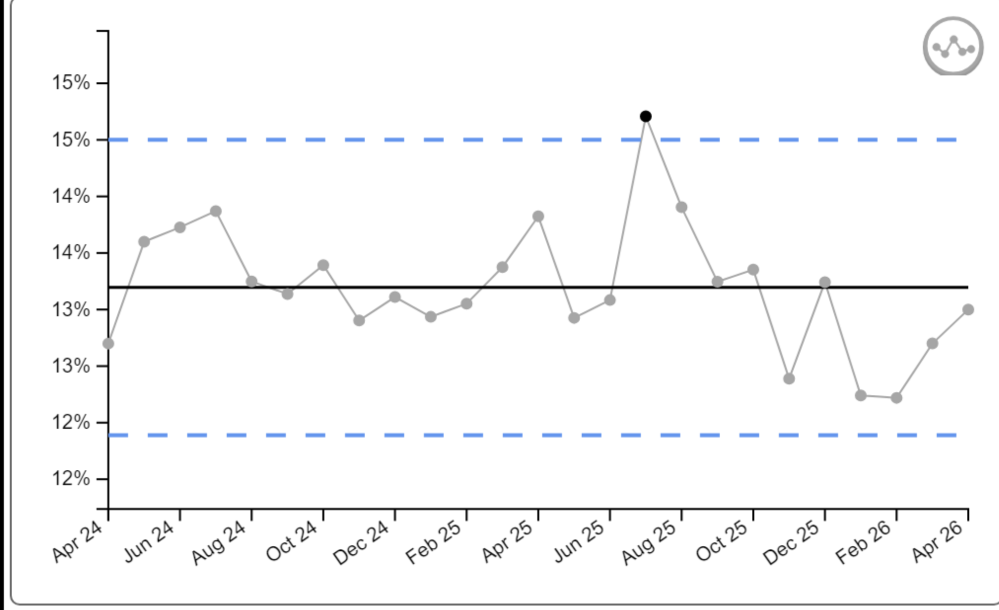
- 26 & 52 week new Outpatient: The charts for patients waiting over 52 and 26 weeks for a new outpatient appointment show the impact that the national outpatient insourcing programme, which delivered 33,202 additional appoints against a plan of 33,612, had on these two measures. This is clearly positive and has meant that the entire RTT waiting list decreased from 128,270 to 101,373 over the course of 25/26. However, there have been additional pressures created on specific services at diagnostic, therapies and follow up stages. Like with 104wk RTT, these forecasts have been recently updated to account for lower than forecast year end delivery and updated assumptions, and have been formally adopted by the Health Board to track against through 26/27.

Cancer and Planned Care

Measure: Reduction in the number of patients waiting 100% past Outpatient follow-up target date
Performance: 31,217 (April 2026)
Trajectory: 29,150 (Q1 26/27)
National target: 23,694



Measure: Increase in the rate of See On Symptom and Patient Initiated Follow-ups
Performance: 13.0% (April 2026)
Trajectory: 13.5% (Q1 26/27)
National target: None

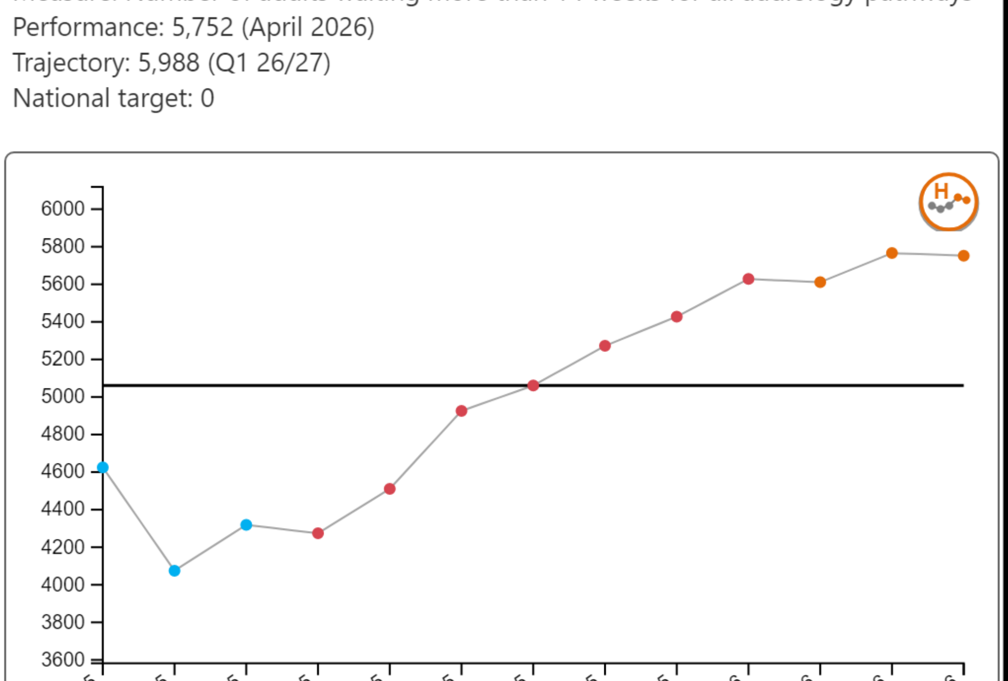


Insights and Actions

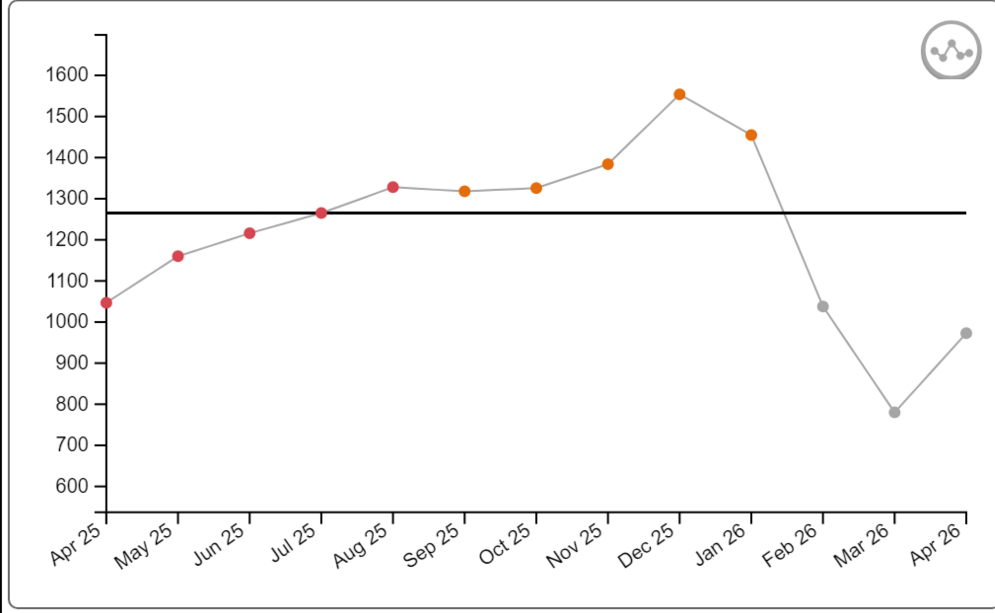
- The delayed follow up waiting list remains stubbornly high, although the rate of growth has stabilised to a degree since Jan-25. For 26/27, the Health Board has committed to delivering against the national expectation of reducing the size of this list by 25%. Improving rates of See On Symptom (SOS) and Patient Initiated Follow Up (PIFU) will be central to effectively reducing the volume of delayed follow ups. SOS and PIFU support a shift towards clinically led, patient-initiated follow-up, ensuring care is accessed when it is needed rather than through routine scheduling. Together, they reduce unnecessary outpatient appointments, improve access for higher-priority patients, and free up capacity across services. This helps deliver more efficient, responsive, and patient-centred care while supporting system performance and demand management. Performance increased again in April to 13.0%, slightly short of Q1 annual plan trajectory of 13.5%. The OPD Transformation Programme continues to monitor patients with the longest follow-up waits, working closely with Directorate teams to ensure patients are booked or appropriately clerically and clinically validated. There remains a strong focus on Straight to Discharge where appropriate, with the majority of CIN protocols embedded as standard practice.

Cancer and Planned Care

Measure: Number of adults waiting more than 14 weeks for all audiology pathways
Performance: 5,752 (April 2026)
Trajectory: 5,988 (Q1 26/27)
National target: 0



Measure: Number of children waiting more than 6 weeks for all audiology pathways
Performance: 973 (April 2026)
Trajectory: 1,177 (Q1 26/27)
National target: 0

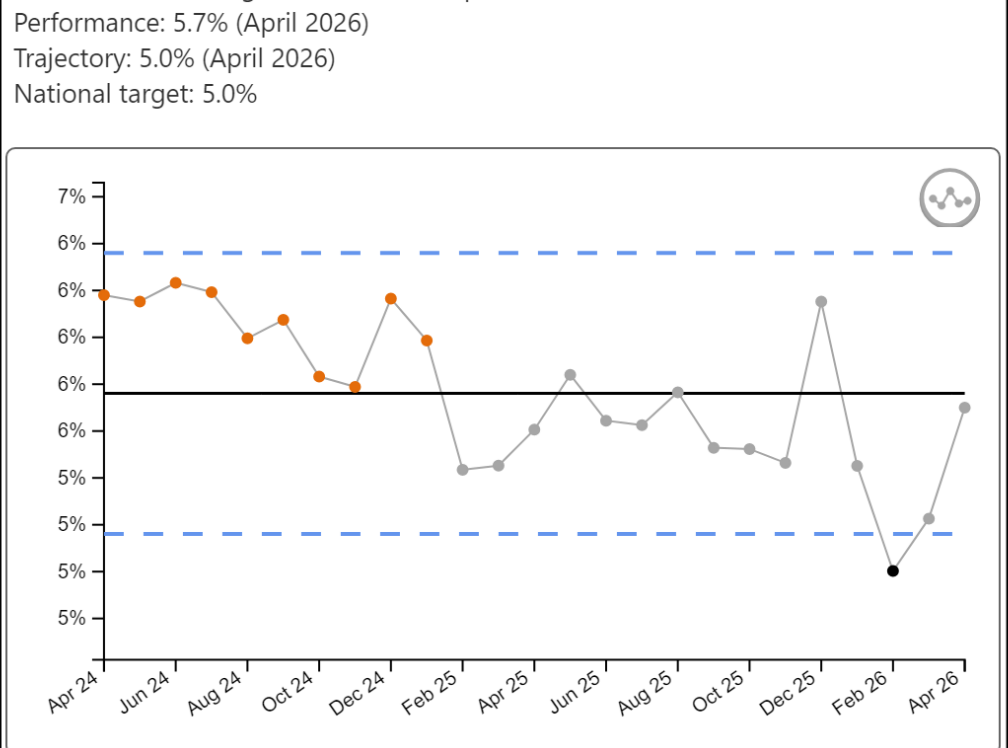


Insights and Actions

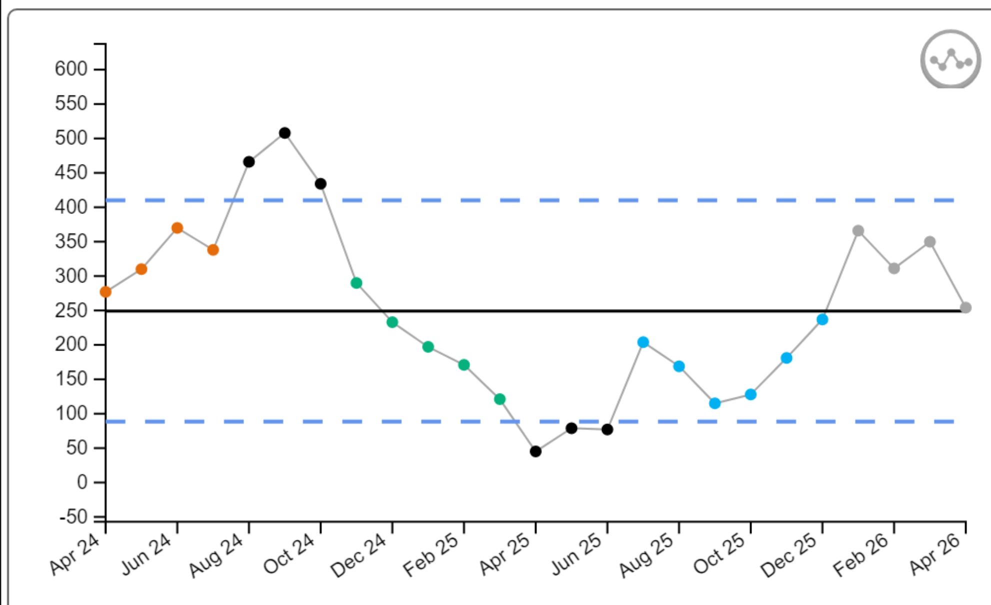
- Audiology: For adult pathways, there has been additional demand placed on the service due to increased demand to the Adult Hearing New (AHN) and diagnostic pathways, which is a result of the 26 week OP programme delivery in ENT. This led to 14 week breach numbers increasing at a greater rate than forecast in 25/26 as the service managed the surge in referrals within their existing capacity. For paediatric pathways, some additional, end of year funding enabled a significant reduction in waiting list breaches. The cessation of this has seen breaches climb again in the first reportable month of 26/27.
- A recently published external audit reported that the Audiology service at ABUHB met the overall national audit target (85%) and achieved required performance in 8 out of 9 standards, with strong practice noted in areas such as aural rehabilitation, collaboration, and links with specialist services. However, it reported some shortcomings on access standards, with key issues including long waiting times, challenges managing referrals, limited repair capacity in outreach settings, and insufficient access to ear care. Overall, it reported that, while the service performs well, addressing access, capacity, and outcome measurement is critical to improving quality and sustainability.

Cancer and Planned Care

Measure: Monitoring of DNA rates Outpatient clinics
Performance: 5.7% (April 2026)
Trajectory: 5.0% (April 2026)
National target: 5.0%



Measure: No patient waiting more than 14 weeks for a therapeutic assessment
Performance: 254 (April 2026)
Trajectory: 395 (Q1 26/27)
National target: 0



Insights and Actions

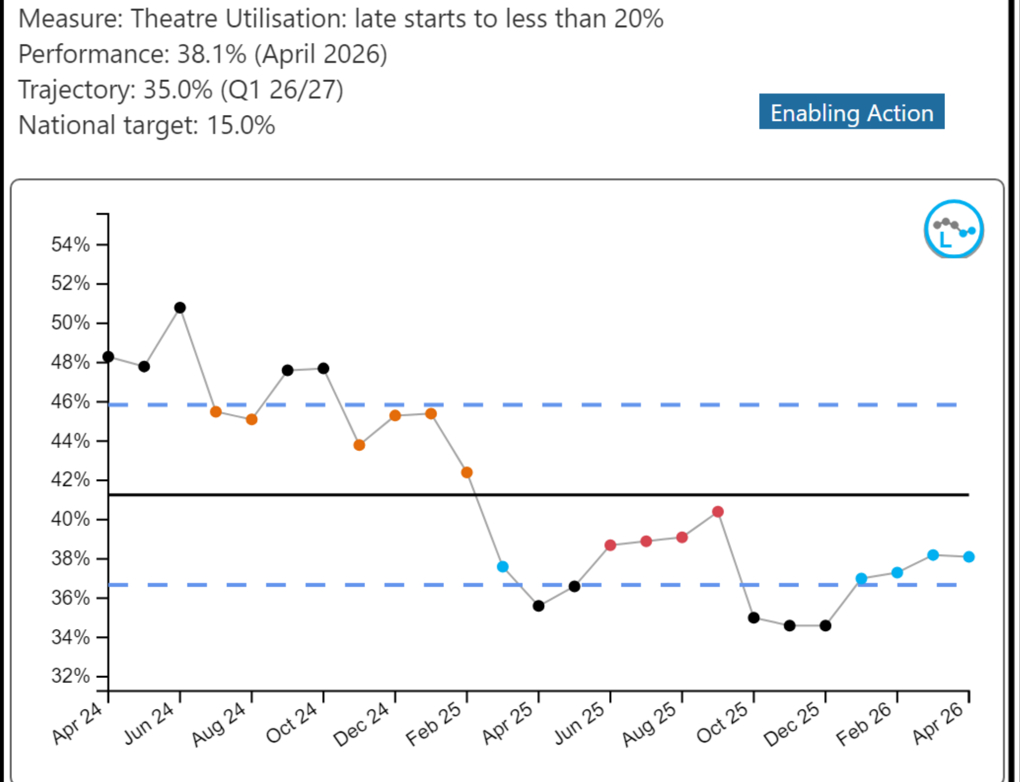
- DNA/CNA rates: Performance in February achieved a 2025/26 low of 4.9%, representing the lowest DNA rate on record (data available from April 2019). March performance increased slightly to 5.2% and marginally above the national target and IMTP trajectory, however the improvement delivered over the past 24 months is positive. A targeted approach continues to focus on areas with high DNA and short-notice CNA rates, supported by text message reminders which are now in place for the majority of clinics. Work has commenced with Public Health to better understand cohort-specific factors contributing to DNAs within COTE services.

- Therapies: Therapies 14wk breaches decreased in April to 254, with Physiotherapy breaches driving this reduction having fallen by 100 from the previous month to 168. Dietetics held its breach position at 68, with the remainder (18) across OT, SaLT and Arts LD. Both Physio and Dietetics have been under increased pressures as a result of capacity issues in Dietetics (Paeds and Gastro sub specialities) and Physio having diverted resource to support the 104wk RTT reduction.

Cancer and Planned Care

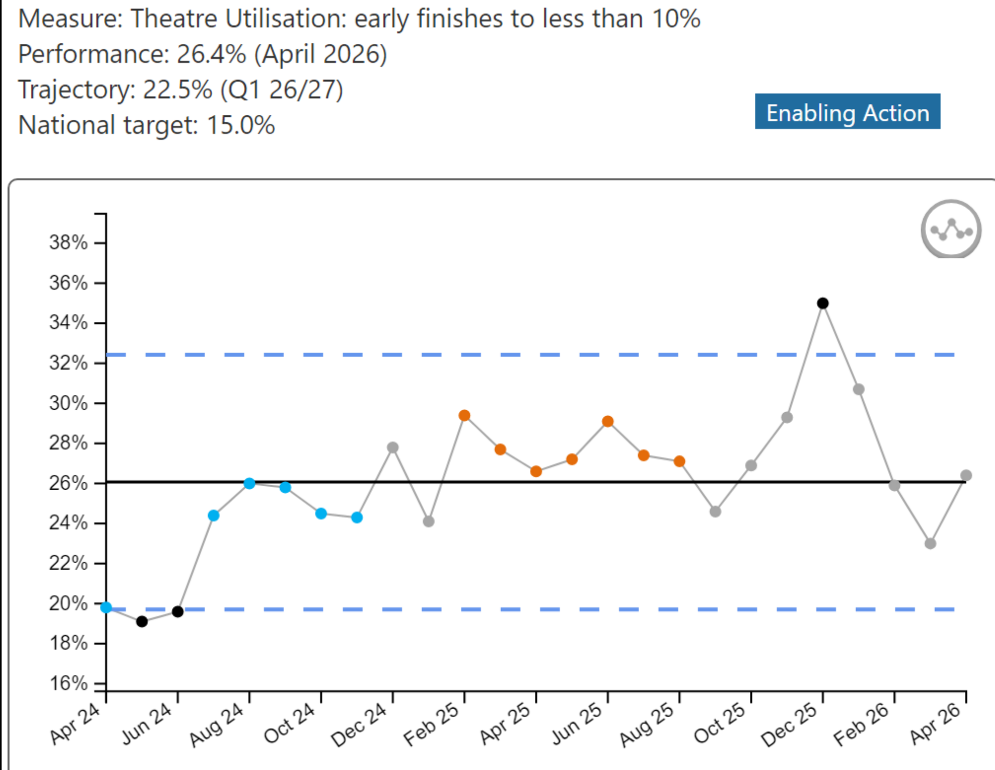
Measure: Theatre Utilisation: late starts to less than 20%
Performance: 38.1% (April 2026)
Trajectory: 35.0% (Q1 26/27)
National target: 15.0%

Enabling Action



Measure: Theatre Utilisation: early finishes to less than 10%
Performance: 26.4% (April 2026)
Trajectory: 22.5% (Q1 26/27)
National target: 15.0%

Enabling Action



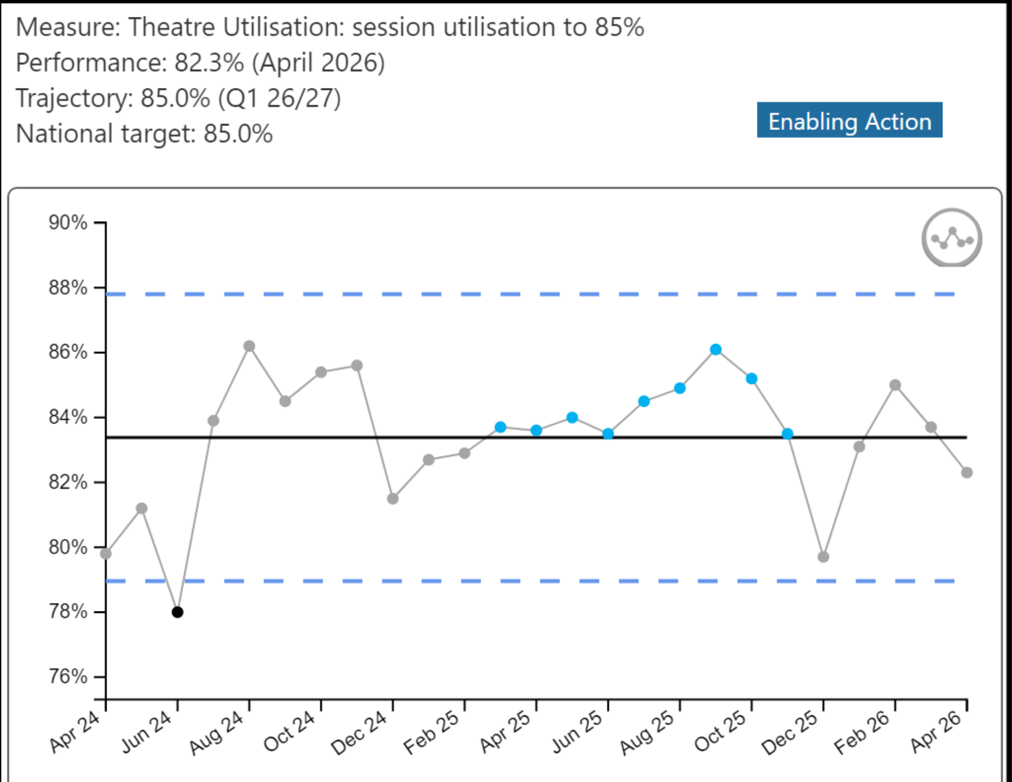
Insights and Actions

- The newly established Theatres Optimisation Programme Group met for the first time in May, with Theatres a key priority for the Health Board. It is a whole-system programme to build on improvements in theatre efficiency while addressing remaining challenges across the organisation. The work will align with both the Planned Care Programme Board and the Value and Sustainability Board, with streamlined reporting and a clear focus on shared priorities. It will be delivered through key workstreams including workforce, theatre productivity, right procedure/right place, and surgical hub accreditation, underpinned by consistent metrics and KPIs. A central aim is to simplify the wide range of existing data into a single, reliable set of measures to support decision-making and track improvement.
- Theatres late starts & early finishes: Late start performance has improved over the past 25 months and is currently only slightly above the Q1 26/27 trajectory. Early finishes are now reported under the >60 minutes measure to bring in line with the WG definition that has been issued as part of the Planning Framework for 26/27. Performance has been broadly stable over the past 12 months.

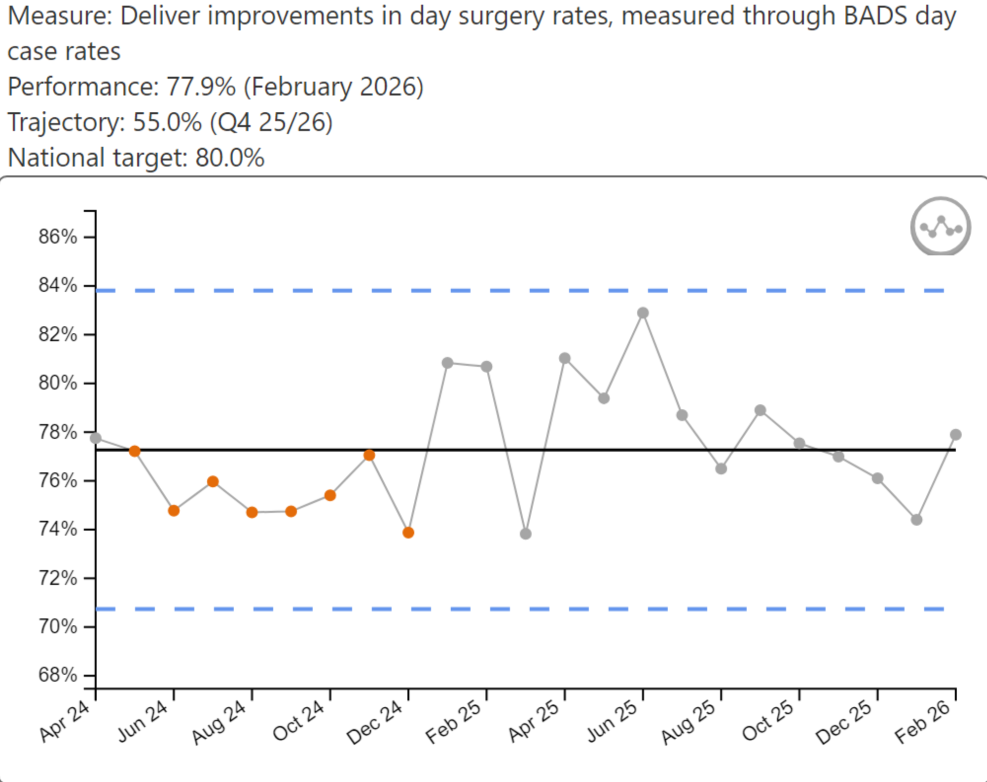
Cancer and planned care

Measure: Theatre Utilisation: session utilisation to 85%
Performance: 82.3% (April 2026)
Trajectory: 85.0% (Q1 26/27)
National target: 85.0%

Enabling Action



Measure: Deliver improvements in day surgery rates, measured through BADS day case rates
Performance: 77.9% (February 2026)
Trajectory: 55.0% (Q4 25/26)
National target: 80.0%



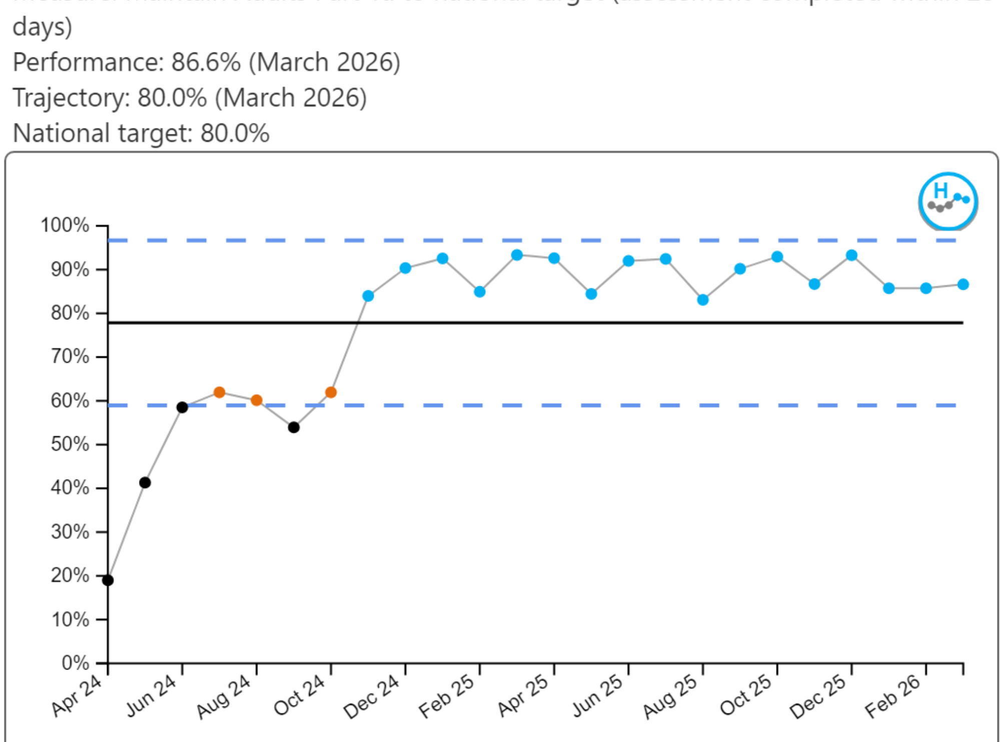
Insights and Actions

- Session utilisation: Performance had been relatively close to the national standard of 85% since July 2024. A 6-4-2 process has been implemented, where annual leave is finalised no less than 6 weeks in advance, lists are arranged 4 weeks in advance and then locked down 2 weeks before the date. Effective utilisation will be a key focus of the Theatres Optimisation Programme Group.

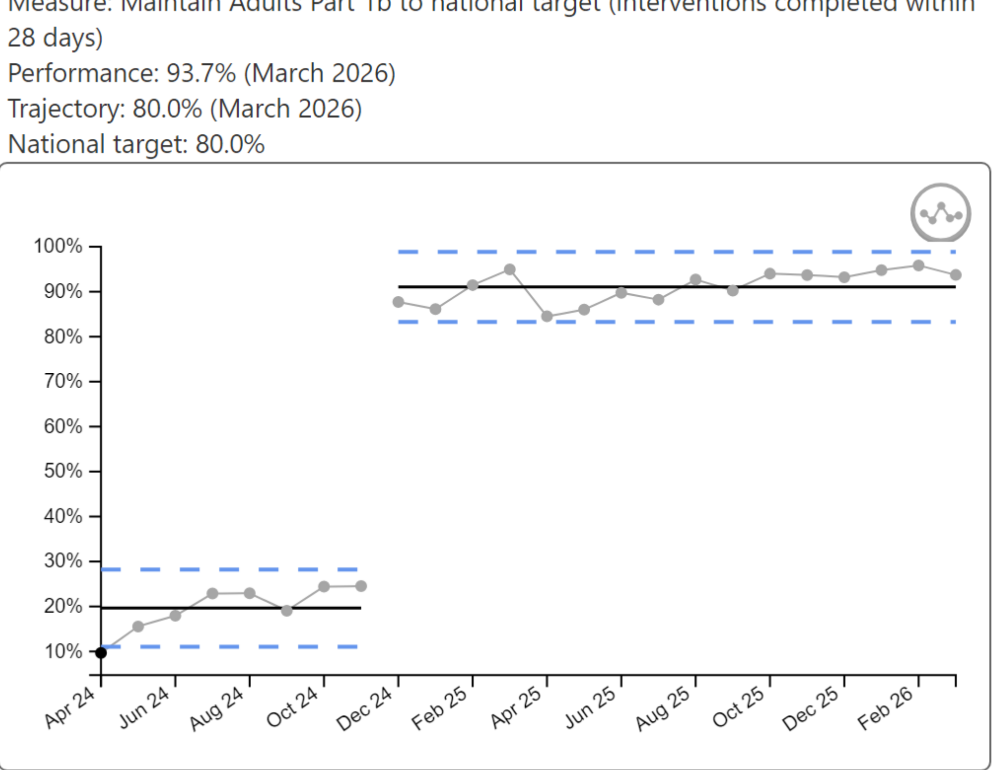
- British Association of Day Surgery (BADS) rates: BADS rates continue to track closely to the national standard of 80%. Through the annual planning process for 26/27, the treatment demand and capacity plans indicate that Day Case treatments are set to increase by 7.7% (set it the context of an overall treatment increase of 2.7%).

Mental Health

Measure: Maintain Adults Part 1a to national target (assessment completed within 28 days)
Performance: 86.6% (March 2026)
Trajectory: 80.0% (March 2026)
National target: 80.0%



Measure: Maintain Adults Part 1b to national target (interventions completed within 28 days)
Performance: 93.7% (March 2026)
Trajectory: 80.0% (March 2026)
National target: 80.0%

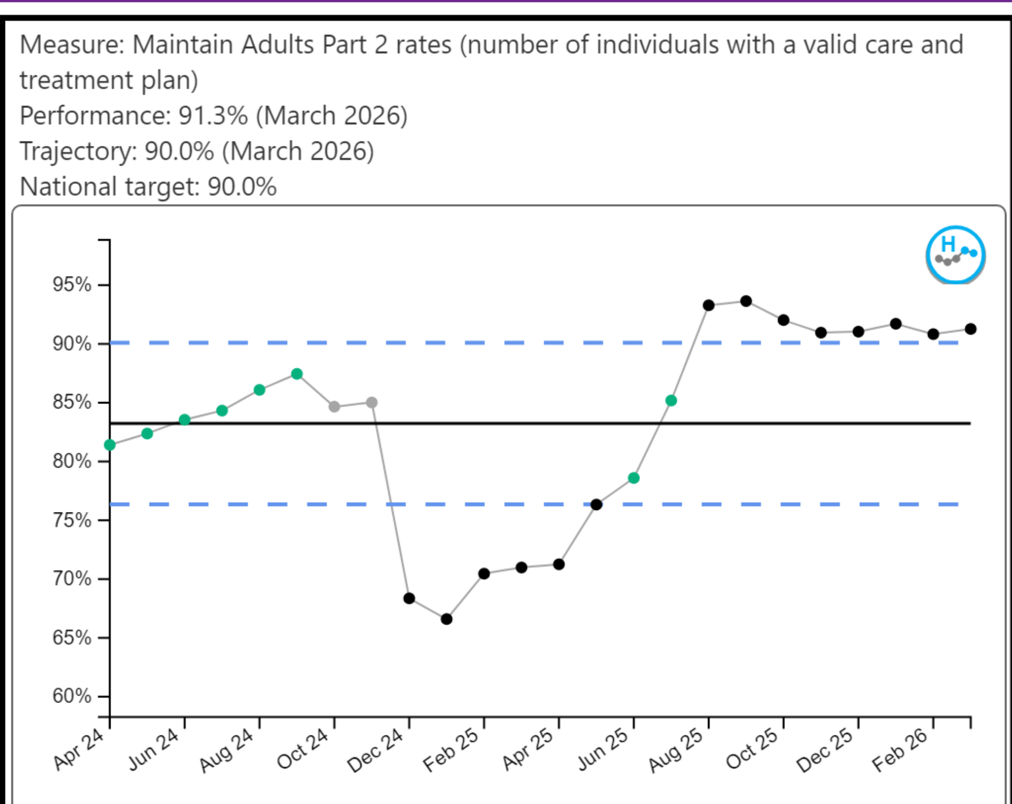


Insights and Actions

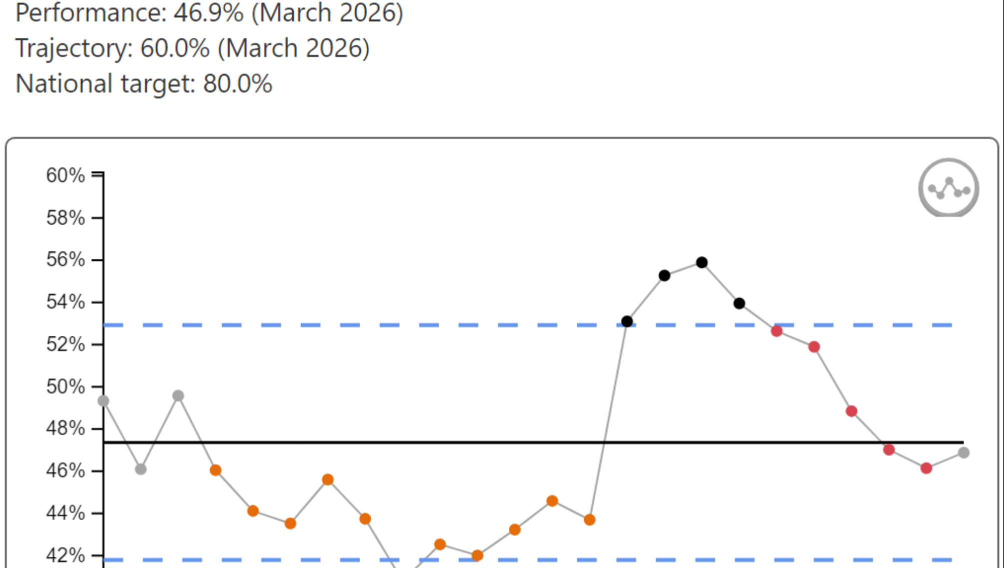
- Adults 1a & 1b: There are no issues with performance for these measures, with the service managing to balance both demand and capacity to ensure continued compliance with the national standard through the entirety of 2025/26. The SPC chart for Part 1b has had a process break inserted from December 2024 to reflect the change in performance since this time, following the extensive data cleansing work and service improvements that were delivered.

Mental Health

Measure: Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan)
Performance: 91.3% (March 2026)
Trajectory: 90.0% (March 2026)
National target: 90.0%



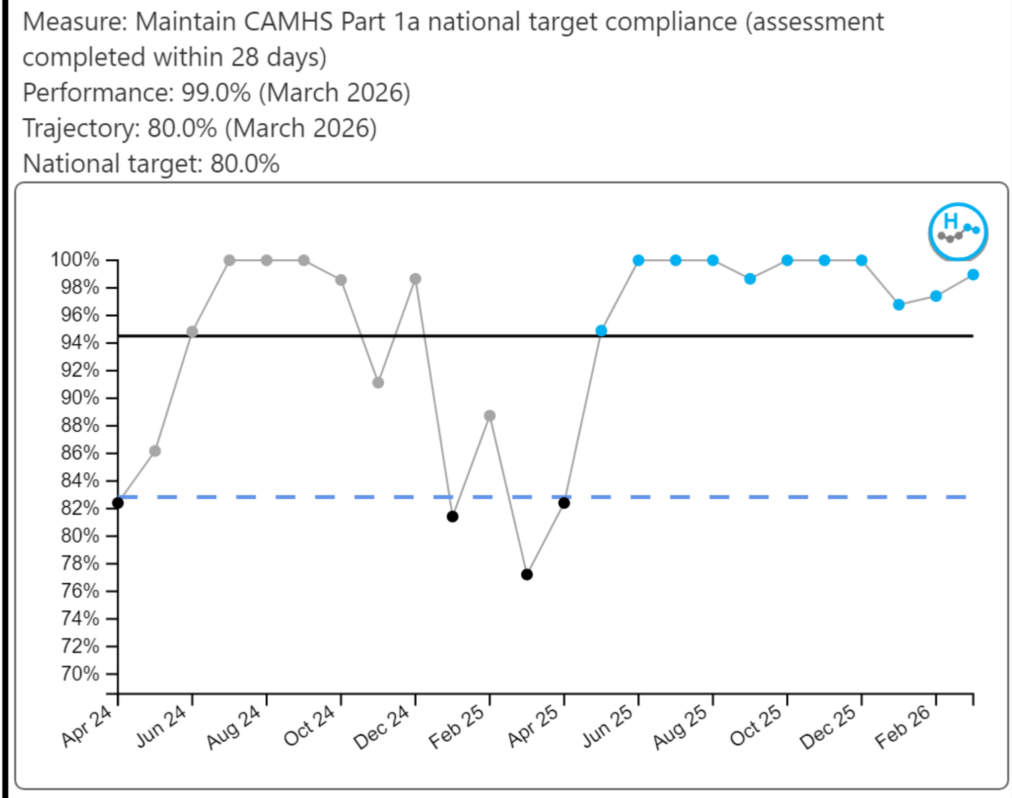
Measure: Maintain rate of psychological therapy received within 26 weeks
Performance: 46.9% (March 2026)
Trajectory: 60.0% (March 2026)
National target: 80.0%

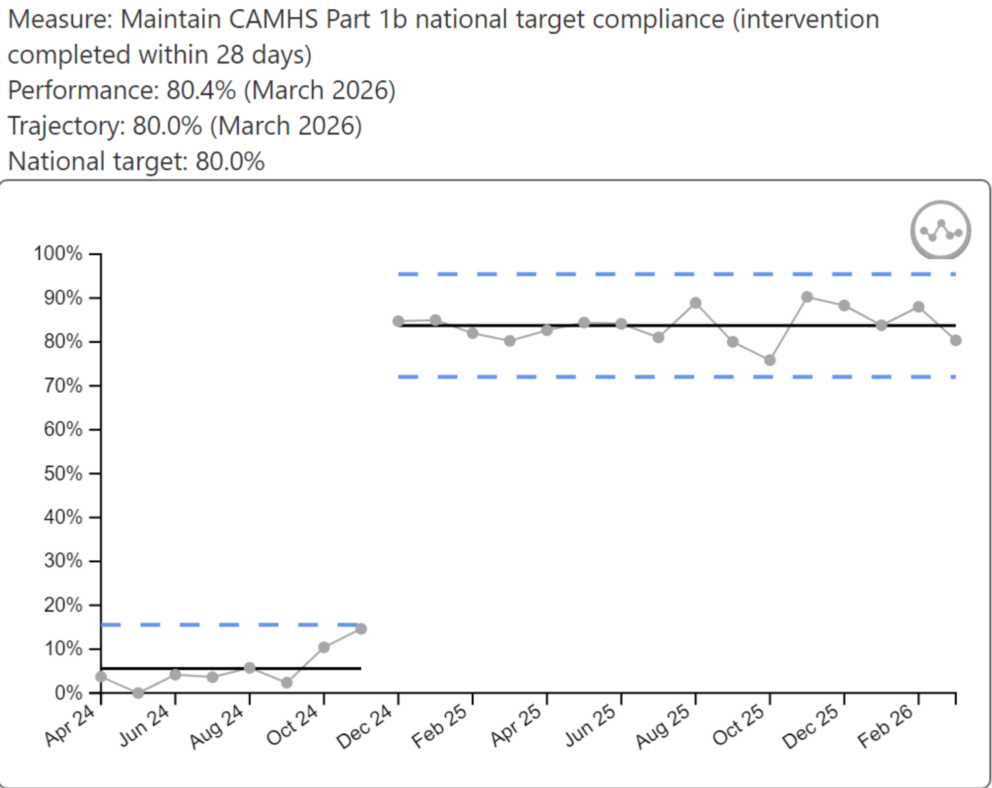


Insights and Actions

- Adults Part 2: Part 2 performance has delivered against IMTP trajectory through 25/26 to date, with compliance exceeding the IMTP trajectory since July and the national standard of 90% since August. Data cleansing remains in progress, however the volume of new Care and Treatment Plans (CTPs) and discharges from CTPs is expected to stabilise.
- Psychological Therapies: Performance has trended downwards over the past 6 months, with vacancies impacting capacity and thus performance. A revised Divisional recovery plan has been developed to support the 26/27 trajectory, which aims to improve performance to 62% by the end of the year. Dashboards are now in place for all adult teams, and booking process mapping has been completed with the future state process under development. There remain some data discrepancies due to historical incorrect use of diaries and appointment reference data, which are being worked through by the services to resolve. There is also continued work on resolving the RTT clock issue being experienced within the Electronic Patient Record (EPR) in Mental Health, which is negatively affecting performance; true March performance is indicated at ~54%. The Division are liaising with Information Services to ensure this is resolved.

Mental Health



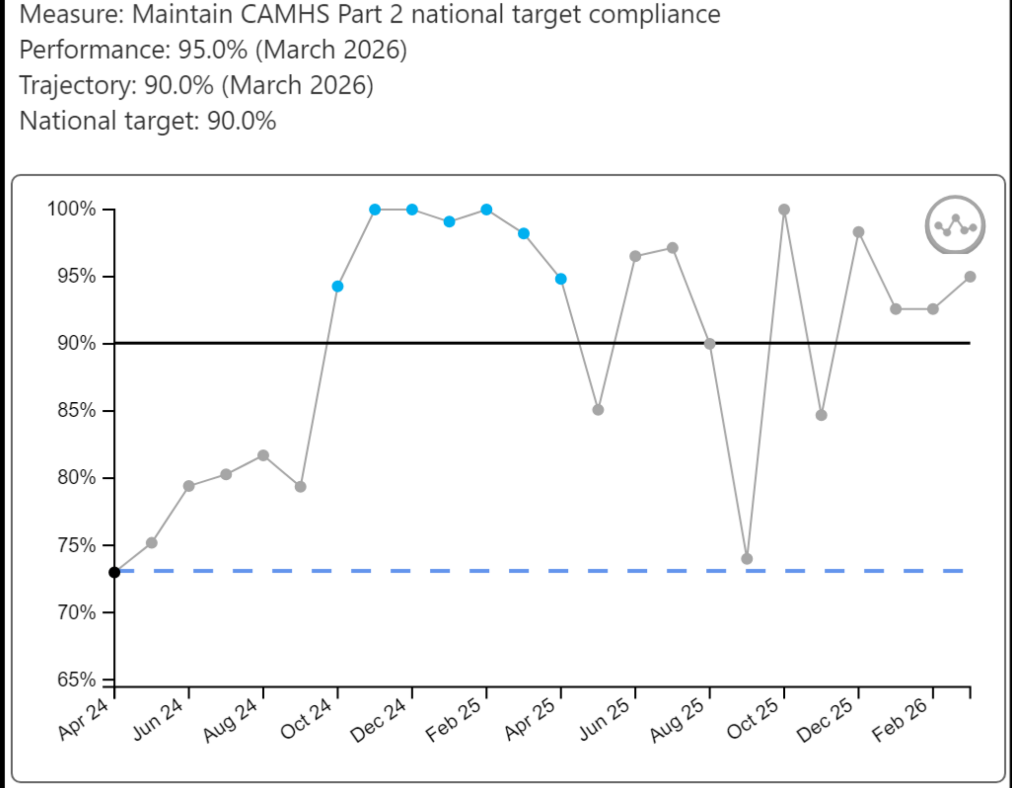


Insights and Actions

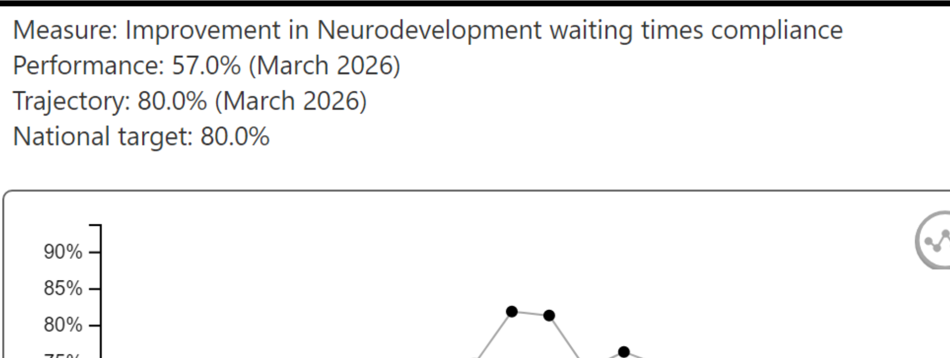
- CAMHS 1a & 1b: Like with Adults, there are no issues with performance for these measures, with the service managing to balance both demand and capacity to ensure continued compliance with the national standard, with 1a having met the national standard for the entirety of 2025/26. There was a decrease in October performance to below the national standard in 1b, however this was the result of a data entry issue that adversely affected performance. In response, the Division provided education and training to the clinical staff these errors related, to mitigate future repetition, and have been compliant in the proceeding five months. The SPC chart for Part 1b has had a process break inserted from December 2024 to reflect the change in performance since this time, following the extensive data cleansing work and service improvements that were delivered.

Mental Health

Measure: Maintain CAMHS Part 2 national target compliance
Performance: 95.0% (March 2026)
Trajectory: 90.0% (March 2026)
National target: 90.0%



Measure: Improvement in Neurodevelopment waiting times compliance
Performance: 57.0% (March 2026)
Trajectory: 80.0% (March 2026)
National target: 80.0%

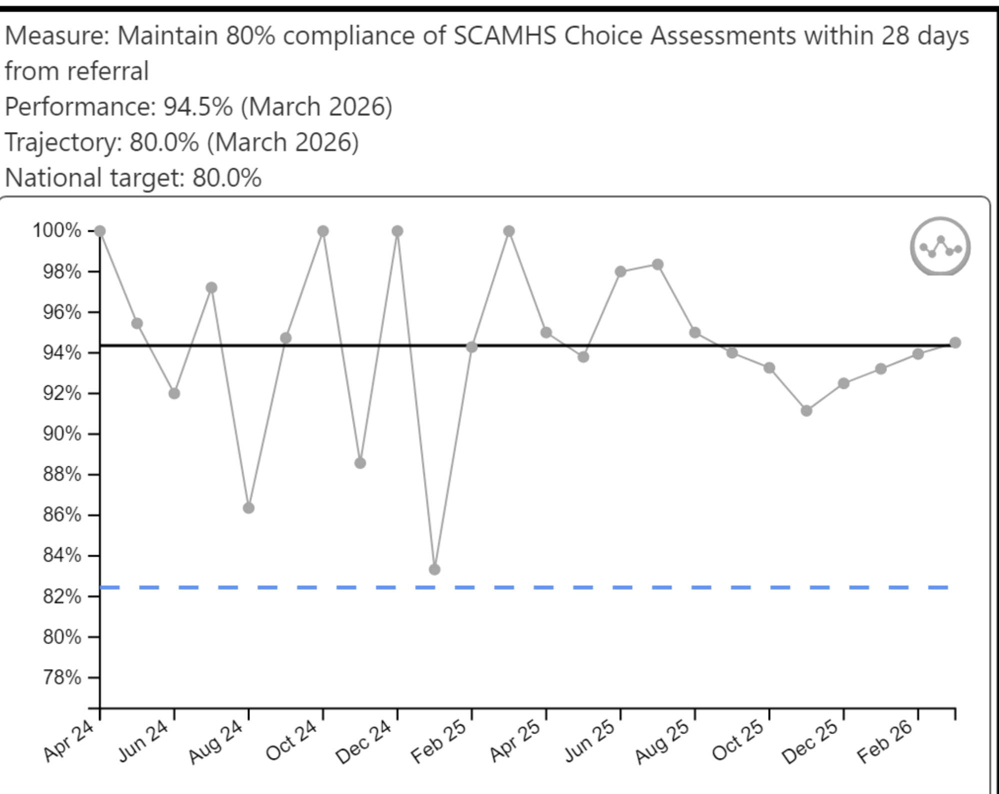


Insights and Actions

- CAMHS Part 2: There have been some issues which impacted performance over the past few months. These arose from ongoing non-compliance with CTP processes, including clinicians failing to upload plans, using incorrect dates, and missing mandatory timeframes despite repeated reminders and training. Some data errors are now being corrected through audit, and a designated CTP lead has been put in place within the Division to drive improved accuracy and compliance going forward. Performance over the past four months has returned to exceeding the national standard.
- CAMHS ND: Performance remains challenged, having trended downwards through the first half of 25/26 and subsequently entering into a period of stability at ~57%. The service continues to face sustained pressure, with referral demand increasing and waiting lists growing. The service has consistently maintained the ministerial requirement of keeping the longest wait below 52 weeks, however this has negatively impacted the 26 week performance measure. Screening processes have strengthened, improving consistency in directing referrals to Universal, Targeted, or Specialist pathways. Projected activity for early 2026/27 demonstrates continued momentum in screening and assessments as the service moves toward fully embedding the Neurodiversity Early Support Hub (NESH) approach.

Mental Health

Measure: Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral
Performance: 94.5% (March 2026)
Trajectory: 80.0% (March 2026)
National target: 80.0%

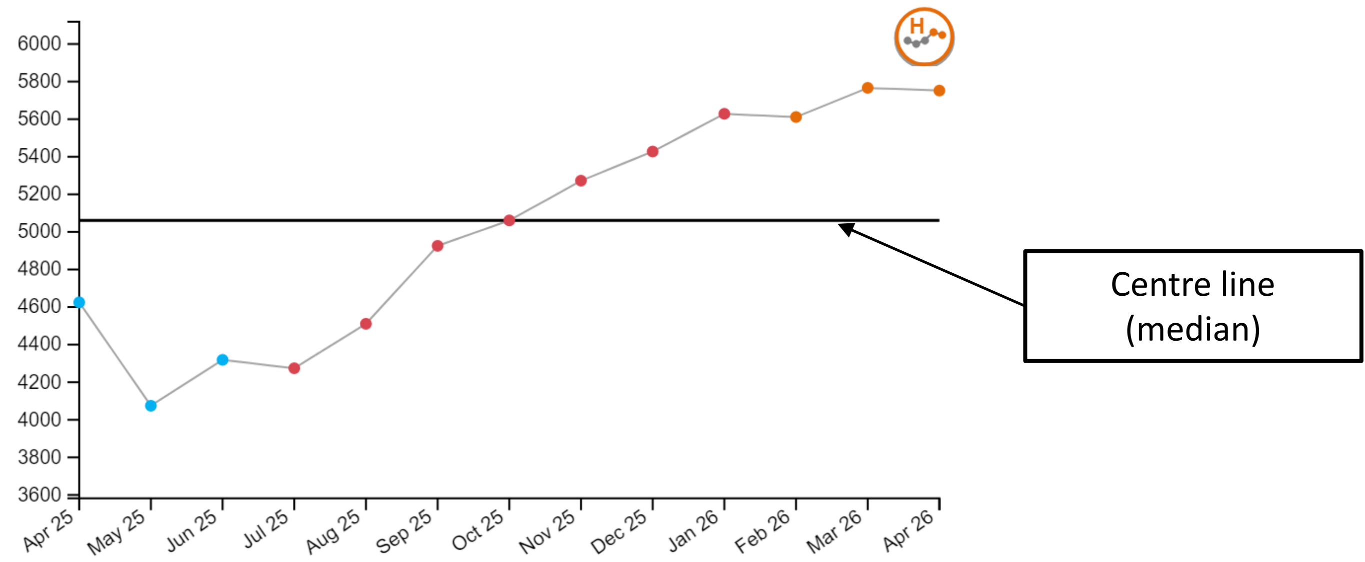


Insights and Actions

- Specialist CAMHS Choice Assessments: No issues, performance continues to track well above national standard of 80% despite decreases since July. The decreasing trend had been resultant from a reduction in capacity over the past few months, however, there has been an improvement in the past four months.

Key

- Deteriorating trend
- Negative shift from median
- Positive shift from median
- Improving trend



A Run Chart is recommended when there are **fewer than 15 data points** to plot on a time series

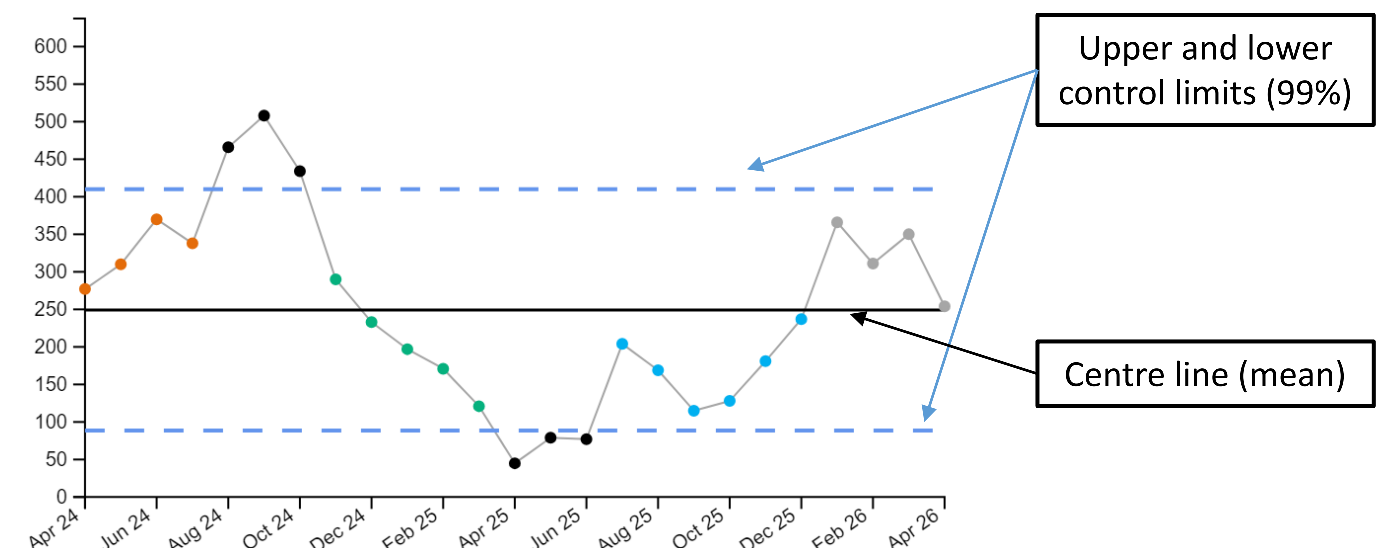
Centre reference line: the average line, represented by the median

Six consecutive points above or below the mean line (shift from mean): a run of six or more values above or below the average (median) line represents a trend that should not result from natural variation in the system. The nature of the shift (positive/negative) is dependent on the direction of improvement for each individual measure.

Five consecutive points increasing or decreasing (trend): a run of five or more values showing continuous increase or decrease is a sign that something unusual is happening in the system. The nature of the trend (improving/deteriorating) is dependent on the direction of improvement for each individual measure.

Key

- Astronomical point
- Deteriorating trend
- Negative shift from mean
- Positive shift from mean
- Improving trend



A minimum of **15 data points** is recommended for a Statistical Process Control (SPC) Chart

Centre reference line: the average line, represented by the mean

Upper and lower reference lines: the process limits, also known as control limits, set to 99%

Astronomical point: a single point outside the control limits. Whenever a data point falls outside a process limit (upper or lower) something unexpected has happened because we know that 99% of data should fall within the process limits.

Seven consecutive points above or below the mean line (shift from mean): a run of seven or more values above or below the average (mean) line represents a trend that should not result from natural variation in the system. The nature of the shift (positive/negative) is dependent on the direction of improvement for each individual measure.

Six consecutive points increasing or decreasing (trend): a run of six or more values showing continuous increase or decrease is a sign that something unusual is happening in the system. The nature of the trend (improving/deteriorating) is dependent on the direction of improvement for each individual measure.

Variation			Assurance		
	H L	H L	?	P	F
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: orange indicates concerning **special cause variation** requiring action; blue indicates where improvement appears to lie, and grey indicates no significant change (**common cause variation**)

Assurance icons: Blue indicates that you would consistently expect to achieve a target. Orange indicates that you would consistently expect to miss the target. A grey icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

NB: Assurance icons will be available from June 2026; a minimum of two data points in 2026/27 is required to plot trajectory lines.

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 June 2026
CYFARFOD O: MEETING OF:	Finance and Performance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Pre-Investment Panel Annual Report 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Claire Nelson, Deputy Director of Strategy, Planning & Partnerships Stephen Edwards, Assistant Medical Director

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT
Sefyllfa / Situation This paper provides a summary report of the Health Board's Pre-Investment Panel (PIP) over the past year (2025/26), covering current PIP arrangements, activities in the year, cases scrutinised/evaluated and actions, and recommendations for 2026/27. This is the third such report.
Cefndir / Background The PIP was instigated in 2017 to establish a forum whereby prospective business cases developed within the Health Board could be scrutinised against a consistent set of criteria to ensure that they are comprehensive and fit for purpose prior to submission to the Executive Committee for formal consideration of funding. PIP meets on a monthly basis and is chaired by an Assistant Medical Director. There is a wide membership (mainly at Assistant Director level) including finance, workforce and OD, planning, nursing, public health, therapies & health science,

value-based healthcare and informatics, with the aim of ensuring that each Director is represented to provide wide and comprehensive scrutiny of cases for investment.

PIP's terms of reference are not to 'approve' a case, but to ensure that it is fit for purpose so that the Executive Committee can make an informed decision on priority and investment.

A standard case template is used and it is expected that prior to coming to PIP, a case will have been fully worked up with input from finance / workforce business partners and planning support. They will have been formally signed off by the relevant Divisional Management Team or Executive as a priority area within the IMTP. Cases are presented at meetings by the case sponsors for review and discussion, with suggested amendments advised for inclusion into a final draft.

Once this is complete, the case should proceed to Executive Committee (with an Executive sponsor) with a one-page proforma which outlines the PIP review and confirms that the case is now complete for approval and funding consideration.

PIP also has an important role in receiving, reviewing and testing evaluations on business case delivery to ensure the investment objectives are met and the benefits realised in line with expectations.

Asesiad / Assessment

Prioritisation of cases in 2025/26

In view of the severely constrained financial position and the large number of business cases for investment known to be at various stage of preparation across the Health Board, an overall prioritisation exercise was undertaken at Executive level in 2024/25 and informed the priorities for 2025/26. The key aims of this were:

- To ensure a 'level playing field' when considering cases for investment
- To provide and communicate clear and transparent prioritisation criteria
- To provide clarity of funding streams and allocation decisions
- To avoid abortive case preparation work by service teams

A master list of existing cases was therefore compiled with the following prioritisation criteria applied:

- Addresses a significant safety / continuity risk for a key service
- Provides opportunity for spend to save (on a cash-releasing basis)
- Identifies a separate / external funding stream, not impacting on the Health Board's baseline position
- Clearly aligns to a confirmed strategic / IMTP priority

A shortlist of thirteen cases was agreed to progress through the PIP / Executive scrutiny process. Some cases have not proceeded or are still in progress but 5 of the cases outlined have been seen by PIP this financial year (2025/26). Some

additional cases have been brought to PIP where they have subsequently met the prioritisation criteria or were otherwise endorsed to proceed by the Executive.

PIP meetings and attendance

A total of eleven meetings were held over the year. Representative attendance was as follows:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Dec	Jan	Feb	Mar
Medical		✓	✓	✓		✓		✓	✓	✓	✓
Nursing	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Planning	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Workforce	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Operations	✓						✓		✓		
Therapies & HS			✓	✓	✓	✓	✓			✓	
Primary Care	✓		✓		✓			✓	✓		
Public Health						✓	✓				
Digital & Data	✓		✓	✓	✓		✓	✓	✓	✓	
Facilities											
Corporate Risk	✓	✓	✓			✓					
Capital Projects										✓	✓
VB Healthcare		✓	✓	✓	✓				✓	✓	
Data Modelling	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓

New cases reviewed

Based on the guidance provided above, new cases reviewed during 2025/26 were as follows:

Date	Case	Actions
Apr-25	Development of surgical robot	Suggested amendments to be incorporated prior to submission to the Executive Committee.
Jun-25	Hospital to home service (H2H)	Suggested amendments to be incorporated prior to submission to the Executive Committee.
	Transforming access to Medicines (TRAMS) national outline business case	PIP comments to be incorporate into covering papers/wider documents as required. Outline Business Case was approved by the Executive Committee and subject to additional information being included in the Final Business Case.
	Nevill Hall Hospital development strategic outline case	Members provided comments virtually due to an impending deadline.

Jul-25	Robotic process automation	Suggested amendments to be incorporated prior to submission to the Executive Committee.
Aug-25	Sustainability of asthma biologic therapy	Suggested amendments to be incorporated prior to submission to the Executive Committee.
	Advanced care practitioners in GUH ED	Suggested amendments to be incorporated prior to submission to the Executive Committee.
	Glaucoma diagnostic hub	Suggested amendments to be incorporated prior to submission to the Executive Committee.
	Second review of updated new business case: Psychological health practitioners	Amendments to be reviewed virtually to enable final sign off for Executive Committee Review.
	Open Eyes / Symphony software upgrades	Due to the cases being based on health board revenue contributions to national capital investment projects, both below to PP threshold cost, there same was not reviewed and decision to proceed with the projects/contribution was for the Executive to determine.
Sep-25	Clinical Workstation (CWR) Risk	Planning support to work with the team to simplify and clarify the case for Executive and Board audiences and the panel to provide feedback to support the revision process.
	Mental Health Community Electronic Patient Records	Suggested amendments to be incorporated prior to submission to the Executive Committee.
Oct-25	Primary PCI Service at Grange University Hospital	Suggested amendments to be incorporated and the case should be submitted to the Executive Committee.
Dec-26	In-House – HER2, ISH Testing and use of Artificial Intelligence to support	Case supported in principle and amendments to be incorporated. Subsequently a decision was made for the case to return for future PIP.
	Pharmacy Haematology Business Case Request	Suggested amendments were made and the case was endorsed for further development.

Jan-26	Haematology Clinical Model Business Case	Suggested amendments to be incorporated for the panel to review virtually.
Feb-26	Second review of updated new business case: Hospital to home service (H2H)	Suggested amendments made and the panel supported the submission of the business case to the Executive Committee.
	Second review of updated new business case: In-House – HER2, ISH Testing and use of Artificial Intelligence to support	Suggested amendments made and the panel supported the submission of the Business Case to the Executive Committee.
	BlueTeq High Drugs Cost System	Suggested amendments made and the panel supported the submission of the Business Case to the Executive Committee.
Mar-26	Digital Dictation Business Case	Suggested amendments to be incorporated for the panel to review further.
	Second review of updated new business case: ABUHB Clinical Pharmacy Service to Haematology Directorate	Further consideration and discussion of the case and the panel supported the submission of the Business Case to the Executive Committee.
	M365 Enterprise Agreement Renewal (reviewed virtually ahead of Board)	Case supported in principle and amendments to be incorporated.

Previous case evaluation and benefits delivery
Cases evaluated in 2025/26 were as follows:

Date	Case	Action
Apr-25	Additional Breast Consultant	Acknowledgement that the implementation of the case had delivered significant benefits for the service, staff and patients.
May-25	Digital Maternity Health Record – System Replacement Project	Acknowledgement that the implementation of the new system was successful and had delivered wider benefits for the service, staff and patients. Some aspects were still settling and recommendations were made.
Jun-25	Investment in a Clinical Pharmacy Service for the Emergency Department at GUH	Acknowledgement that implementation was successful and there were wide well-evidence benefits for the service.

Jul-25	Patient Advice and Liaison Service (PALS)	The person-centred approach giving valuable support and reassurance to people in a vulnerable situation was acknowledged. It was suggested that more measurable metrics were needed so that the benefits could be assessed more accurately which would be supported by PIP members.

It is important to reiterate the non-discretionary element of the evaluation element of PIP as some cases are still to come forward.

A review of cases due back for evaluation in 26/27 has been carried out in readiness to contact Divisions for cases to return, to explore the benefits realisation.

A paper in relation to the benefits realisation considered at PIP went to Finance and Performance Committee in February 2026 and is included in Appendix 1.

Review of PIP Documentation
In light of new members, the Terms of Reference was updated and agreed in March 2026 and is included in Appendix 2.

Priorities for 2026/27
Key priorities for the year ahead will include the following:

- To review and update the Business Case Template which is found to be duplicative by both the Panel and sponsors.
- Linking with the corporate governance team to strengthen the link between PIP and any meetings which progress the business cases, this is because there is lack clarity around cases progressing to Executive level meetings.
- Carrying out a comprehensive review of the cases which have been brought to PIP dating back to its inauguration to continue to build on the work relating to the evaluation of approved case implementation, with an emphasis on benefits delivery.
- The role of PIP in subsequent evaluation and benefits delivery scrutiny should continue to be strengthened, as a priority and expectation of the Finance and Performance Committee.

Argymhelliad / Recommendation
The Finance and Performance Committee is asked to note the annual report for information and assurance.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The work of PIP is informed by risk assessment and have been established to address and mitigate system risks
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 5.1 Timely Access 7.1 Workforce Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	PIP: Pre-Investment Panel
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper

Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	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 Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

Agenda Item:

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	10 June 2026
CYFARFOD O: **MEETING OF:**	Finance and Performance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Information Governance, Cyber Security, Clinical Coding & Health Records Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Paul Solloway, Director of Digital (Senior Information Risk Owner)
SWYDDOG ADRODD: **REPORTING OFFICER:**	Paul Solloway, Director of Digital (Senior Information Risk Owner)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides assurance on the Information Governance, Cyber Security and clinical coding arrangements for the Health Board with an update on recent activity.

Cefndir / Background

The Finance and Performance Committee is provided with performance information regarding the Health Boards compliance with the General Data Protection Regulation (GDPR), Data Protection Act 2018 (DPA 2018) and the Network & Information Systems regulations (2018) (NIS-R). The Health Board must monitor its performance against the regulations and needs to be assured that it's achieving an agreed and acceptable standard and have in place processes and procedures in order to achieve that standard.

The report also includes performance reports for Clinical Coding; Health Records & Referral & Booking

Reports from the IG Group are escalated to provide assurance on key performance indicators to the Finance and Performance Committee.

Asesiad / Assessment

1. KPI Dashboard

Information Governance

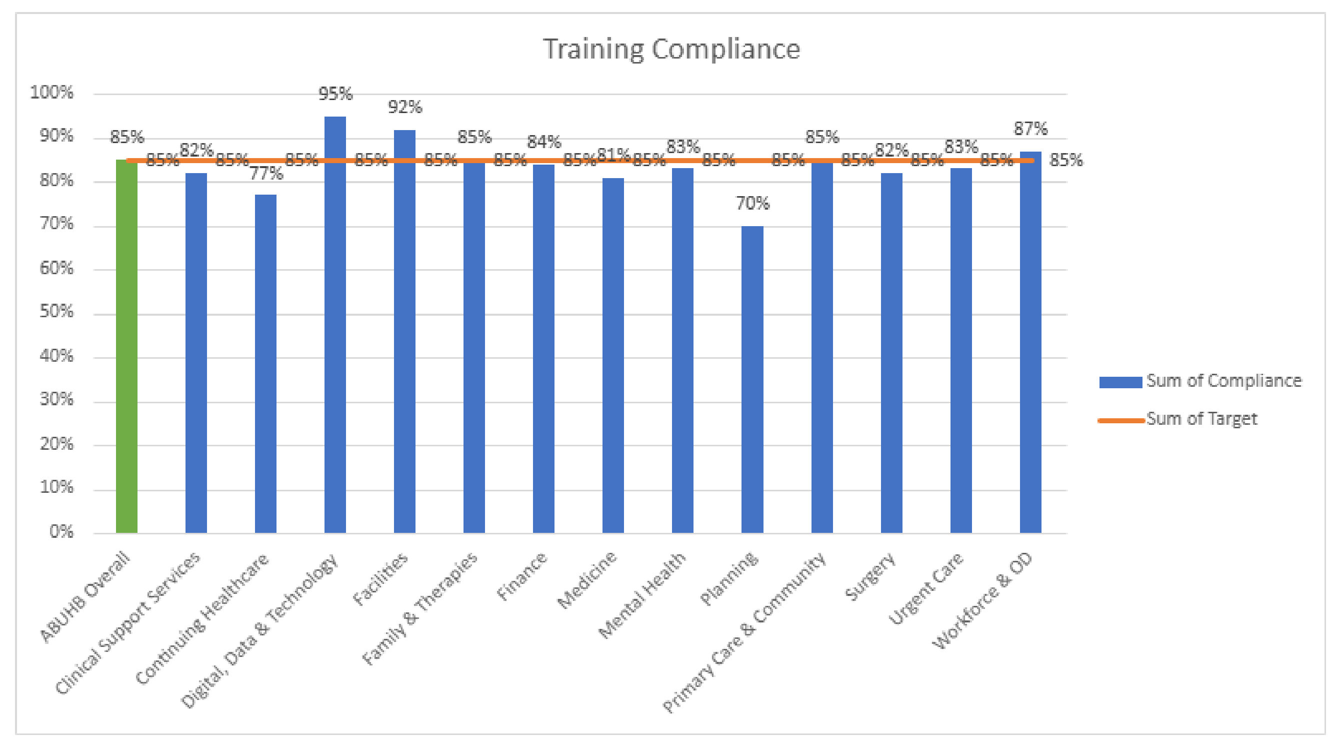
IG Training Compliance

The eLearning training package is a national product containing Cyber Security, Health Records and Information Governance which is taking staff a long time to complete which has affected the compliance rates of all health Boards. Discussions are ongoing on a national basis to review content and to separate the training into individual modules - Information Governance, Cyber Security and Health records which should improve compliance.

The Information Governance team continue to work with divisions to ensure mandatory Information Governance and Cyber Security training is undertaken and support through specific induction and bespoke training. A reminder has also been published on the intranet with a poster to remind staff of the need to undertake their training. There has also been a training video created which is posted on the Health Boards Intranet pages.

The current training compliance for the Health Board and divisions is shown below. The overall compliance is 85% which meets the target compliance rate for Wales.

The team will continue to target areas of low compliance.



Data Protection Impact Assessments (DPIA)

In compliance with the legislation DPIA's are developed in conjunction with the Information Governance team, project team/services and suppliers to assure that information is handled correctly and kept safe in our systems and processes.

There are two stages in the development of these:

- Stage 1 – screening questions are completed to gain a base line understanding of the project and to determine whether a full DPIA is required
- Stage 2 - completion of full DPIA if required

Any risks identified are managed in line with the Health Boards Risk Management framework.

The number of DPIA's completed, including Screening Questions are outlined below for information along with the full detail:

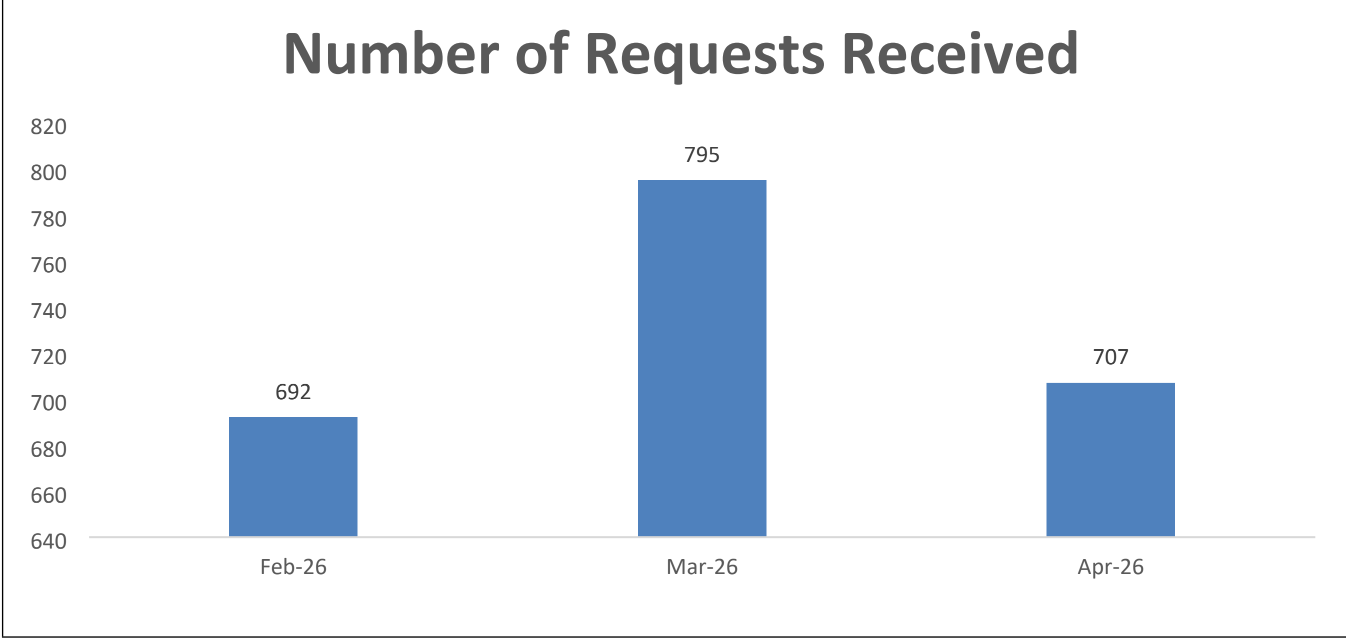
Period	Total number of DPIAs completed
1st February 2026 – 30th April 2026	31

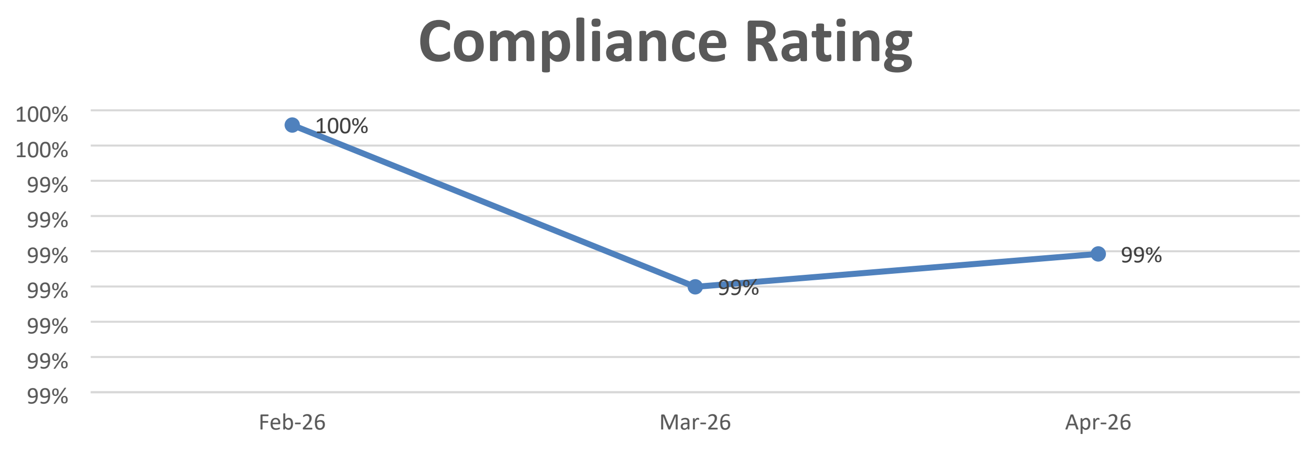
Information_Governance _ Data Protection

Subject Access Requests

The Access to Health Records Team consistently achieves 99% compliance rate when responding to subject access requests in compliance with the General Data Protection Act regulations and the Data Protection Act 2018. The team continue to see an increase in the number of subject access requests received each month, but there is a slight decrease for April.

However, compliance rates remain consistent following the implementation of the Civica case management system which allows for better workflows when managing these subject access requests.





Welsh Information Governance Toolkit – Submission 2025/2026

The Welsh Information Governance Toolkit is completed by Health Boards across Wales on a yearly basis to assess compliance with key information governance standards, with the submission date being the last day in March of each year. The toolkit comprises of the following sections: -

- Leadership and oversight
- Policies and Procedures
- Training and Awareness
- Individual Rights
- Records of Processing and Lawful Basis
- Contracts and Information Sharing
- Risks and Data Protection Impact Assessments
- Breach Response and Monitoring
- FOI and EIR
- Information Security
- Video Surveillance
- Business Continuity

For the 2025/2026 submission the Health Board has achieved an **"Expectation Exceeded"** rating with a compliance rating of 96% which is an improvement over the last submission and is reflective of the improvements in mandatory training.

2. Clinical Coding

There are two Welsh Government Targets in place which form part of the NHS Wales Delivery Framework:

1. 95% of episodes clinically coded within one reporting month post episode discharge end date.
2. 90% percentage of clinical coding accuracy attained in the DHCW national clinical coding accuracy audit programme.

The Health Board consistently achieves the 90% coding accuracy target but has historically struggled to meet the 95% completeness target. In September 2023, a clinical coding improvement plan was submitted and approved by the Executive Committee to enable the clinical coding service to achieve the Welsh Government 95% clinical coding completion target. This improvement plan was predicated on a

monthly volume of 18,500 finished consultant episodes per month and the workforce required to clinically code 95% of that volume of episodes monthly. Following the Executive Committees approval of the plan, a recruitment programme ran from January 2024 to July 2025 to ensure that the clinical coding department was fully established to meet the 95% completeness target. Following successful appointments to all posts, the clinical coding service has been operating at full capacity since September 2025.

With the clinical coding department being at full establishment, it was anticipated that the 95% completion target would be achievable with the service being able to consistently clinically code 95% of the anticipated 18,500 episodes on a monthly basis. This expectation however has not come to fruition as the volume of episodes monthly has increased to over 24,804 episodes since January 2025. The below table illustrates this increase with the increase since January 2025 highlighted in red font. Highlighted in green font is the volume of episodes coded since the clinical coding service became fully established in September 2025, it should be noted that the 95% target would have been achieved in these months if monthly activity had remained at the anticipated 18,500 episodes per month.

A significant portion of the rise in the Finished Consultant Episodes (FCE's) is attributed to the Regional Cataracts, which have increased by over 6000 annually. A small amount of agency support was utilised to support, however, due to insufficient documentation uploaded onto Clinical Workstation (CWS), we were unable to achieve the level of coding activity expected. Without additional support, continued growth in demand is likely to impact both current and future coding completeness targets.

Increase in FCE's since January 2025

Month	Episodes	Coded Episodes	% Compliance
Apr-24	17986	13864	77.1%
May-24	18492	14601	79.0%
Jun-24	17398	15147	87.1%
Jul-24	18555	13891	74.9%
Aug-24	17421	13622	78.2%
Sep-24	17909	15057	84.1%
Oct-24	18998	15536	81.8%
Nov-24	18177	15078	83.0%
Dec-24	17599	15384	87.4%
Jan-25	19778	17287	87.4%
Feb-25	18792	15384	81.9%
Mar-25	20938	17226	82.3%
Apr-25	18942	14787	78.1%
May-25	19216	16094	83.8%
Jun-25	19908	16094	80.8%
Jul-25	20057	18051	90.0%
Aug-25	18328	16792	91.6%
Sep-25	20452	17515	85.6%
Oct-25	21435	18218	85.0%
Nov-25	20655	17543	84.9%
Dec-25	21351	18454	86.4%
Jan-26	22844	19183	84.0%
Feb-26	20469	18730	91.5%
Mar-26	24804	20313	81.9%

3. Cyber Security

The committee can now view our Key Performance Indicator (KPI) dashboard using the link below and this will be improved over the coming period to include all of the KPI's presented to the committee:

F&P Dashboard

Desktop KPI's

Key points to note are:

- The % of fully patched end user desktops and laptops have shown an improving picture over the last three months from 81.22% to 87.24%
- Windows 11 deployment has increased from 91.01% to 93.87% with the remaining Windows 10 devices planned to be upgraded prior to the ending of extended support in October 2026
- 99.26% of Microsoft Office implementations are in support although the end of life of Office 2021 in October 2026 will cause an issue due to the requirement to use this version with our Digital Dictation solution. The procurement for a replacement product has completed and the business case is currently transacting through the Health Board's governance processes

Server KPI's

Key points to note are:

- The % of fully patched servers have remained above the target of 95% over the last three months and currently stands at 97.26%
- 98.26% of server operating systems are under support with only 6 servers out of 400 running an unsupported operating system
- Microsoft Server 2016 will go end of life in January 2027 and work is ongoing to identify decommissioning / upgrade plans for these servers (circa 15.41% of the server estate)
- 93.39% of our database servers are running a fully supported database platform and work continues to upgrade remaining instances which are end of support

Mobile KPI's

Key points to note are:

- 100% of Android mobile devices are on a supported version
- 100% of Apple mobile devices are on a supported version

Vulnerabilities

Key points to note are:

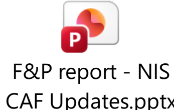
- Total number of vulnerabilities remain at circa 13,000 which is in the main attributed to varying versions of Adobe across the organisation

- The ICT teams are working to address this through greater use of Microsoft Edge for opening PDF's

Microsoft Secure Score

Our Microsoft secure score which gives a benchmark of our security posture is remaining static at around 70% which is benchmarking well against similar organisations at 49%.

Cyber Assurance Framework



F&P report - NIS CAF Updates.pptx

The Cyber Security team have created a Network and Information Systems Assurance Group (NIS AG) that meet bi-monthly for any updates. There have been no major updates as there is an upcoming audit in June 2026 and have been preparing evidence for the Cyber Resilience Unit (CRU) prior to the audit.

During the audit in June, the cyber team and CRU will be reviewing all outstanding recommendation to provide updates, which may lead to closure of remaining outstanding recommendations.

4. Referral & Booking

There are a number of locally agreed operational standards and Welsh Government Planned Care targets in place which underpin the delivery and performance management of outpatient access, Referral to Treatment (RTT) pathway management and contact centre services across the Health Board. These include:

- Urgent Suspected Cancer (USC) and urgent referrals processed within 24 hours and routine referrals processed within 48 hours of clinical triage.
- Partial booking letters issued a minimum of four weeks in advance, with appointments booked no greater than six weeks ahead.
- SMS cancellation and rebooking requests processed within 24 hours.
- Booking line calls answered within 6 minutes.
- Clinic outcomes processed within 48 hours following patient attendance.
- Validation activity undertaken in accordance with Welsh Government waiting list management requirements.

Welsh Government Planned Care performance targets continue to include:

- 95% of patients waiting less than 26 weeks for treatment.
- Elimination of waits greater than 36 weeks.

Delivery against these standards remains influenced by clinic capacity, workforce availability and the timeliness of clinical administrative activity across a number of specialities. Capacity constraints in some areas present ongoing risks to patient access, hospital-initiated cancellations and achievement of required turnaround times.

Timely completion of clinic outcomes remains a key dependency in maintaining waiting list accuracy and minimising delays across outpatient administrative processes. Delays in outcome completion within some specialities continue to impact validation activity, follow up management and the timely progression of patient pathways. Engagement with operational and clinical teams remains ongoing to improve compliance and reduce avoidable delays.

Validation activity continues in accordance with Welsh Government requirements and remains critical in maintaining data quality, reducing duplicate or incorrect pathway entries and supporting compliance with national reporting. Complimenting this, Keeping Well activity supports proactive patient engagement and clinically appropriate waiting list management.

Switchboard

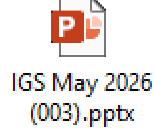
Switchboard continues to provide a critical communication function across the Health Board, supporting patients, staff and partner organisations through the management of significant call volumes and operational contact activity.

Local operational standards include:

- Calls answered within 3 minutes.
- Administration tasks completed within 24 hours

Increasing demand, workforce pressures and peak activity periods continue to place pressure on the service responsiveness. Given the critical nature of this function, any sustained disruption to switchboard resilience presents a wider organisational risk to communication flow, operational coordination and continuity of service provision.

The performance of the Referral & Booking service is shown below and this will be included in our KPI dashboard on future releases.



5. Health Records

The Health Records Service monitors performance through established dashboards covering scanning timeliness and processing efficiency. Performance is benchmarked against locally agreed operational targets and national best practice.

Assessment

- **Digitised Health Records (DHR) Operational Performance**
    - Inpatient supplementary record scanning
        - Target: within 48 hours of receipt
        - Total records returned (Feb – Apr): 46,056

- Performance (as of 21st May): **Needs Improvement**
  - Records returned on 14th May are being scanned (small backlog, recovery underway)
  - 33% of records returns scanned within 24 hours of receipt

- Outpatient supplementary record scanning
  - Target: within 24 hours of receipt
  - Total records returned (Feb – Apr): 64,651
  - Performance: **On track**

- Digitised Record Utilisation
  - % Of outpatient clinics using DHR: 92%
  - % Emergency Admissions using DHR: 99%
  - % Elective Admissions using DHR: 96%

- Additional Specialty Scanning
  - 20,116 Podiatry records
  - 221 Paediatric Diabetes records
  - 10,324 Cardiac Rehabilitation records
  - 467 Children's epilepsy records
  - 3,496 Lymphoedema records
  - 21,152 HSDU documents
  - 2,287 Adult Weight Management records
  - 214 CHANT records
  - 1,274 District Nursing records
  - 2,422 Mental Health archive records
  - 3,012 Speech & Language records

- **Referral & Inpatient Movement Processing**

  - Total referrals processed (Feb 2026 – Apr 2026): 54,377
    - Automation (RPA vs Manual): 56% : 44%

  - Admissions, Transfers, Discharge & Demographic notifications processed (Feb 2026 – Apr 2026): 137,902
    - Automation (RPA vs Manual): 89% : 11%

- **Compliance & Audit Assurance**

  - Filing bay checks: 97% compliant
  - DHR preparation standards: 87% compliant
  - DHR scanning standards: 99% compliant
  - Confidential Waste Checks: 100% compliant
  - Welsh Language Standards: 97% compliant

6. Risk Management

Information Governance Risks

Information governance risks are identified through various workstreams, but many are realised through the completion of Data Protection Impact Assessments and engagement with Divisions through the Governance and Assurance Groups. Some key risks identified in this reporting period are: -

Division	Risk Description	Mitigations	Risk Score
Corporate	ePMA – currently no functionality to allow Access to Health Records to export information for subject access requests.	Currently in discussions with provider, other HB's and DDaT colleagues to provide solution/workarou nd	9
Corporate	G2 Work Around. Use of WhatsApp for business continuity. Users have been reported adopting personal device voice memo and WhatsApp to dictate letters. This leads to a breach of UK GDPR, misidentification issues, records missing from CWS record and PII being stored on personal devices	Proposal to use audio recordings in one note was rejected as being too onerous a task to be undertaken by clinicians.	15
Corporate	Digital letter Patient Portal - As a result of the portal holding letters for 2 years, this means that when a Looked After Child moves from foster care to parents care the letters are visible for foster care parents addresses etc. Therefore, risk of breach of confidentiality. Also Safeguarding risk identified.	Risk of breach of confidentiality and inappropriate access to data/data sharing.	10

The entire Information Governance risk register is shown below:

IG_Risks.xlsx

Cyber Security Risks

The DDaT risk register has 3 open cyber risks with a score of 10+ as below:

ID	Title	Likelihood	Impact	Score	Progress
2030	Windows 10 end of life	3	4	12	Windows 10 update programme almost complete

2045	Supply chain security	3	4	12	Business support enhancing supply chain reviews, improvement driven by NIS CAF assurance group
2046	Shadow IT and IoT	3	4	12	New firewalls will identify devices and allow better network segmentation once fully operational

Extract below with full list of cyber risks:

Cyber_Risks.xlsx

Health Records Risks

The following key risks may impact the delivery of DHR performance standards:

Risk Description	Mitigations	Risk Score
DHR Infrastructure and System Upgrade: Core DHR functionality is currently operating on outdated server infrastructure, with an upgrade to the latest Electronic Document Record Manage ment System (EDRMS) delayed.	Extended server support in place until October 2026. 3-year contract with EDRMS supplier commenced in 2024 for an upgrade to the latest service however upgrade delivery remains under review.	**16**
Records Management Compliance: Variable adherence to records management procedures across areas.	Strengthened training (Ward Accreditation compliance criteria, the Journey of Excellence Corporate Induction for Nurses, Corporate Induction for Junior Doctors). A Health Records Support Network has been established to share best practice and support for ward clerks and ward staff. ABUHB Employee Handbook has been updated to include records management guidance	**12**

	and resources to support new starters. Health Records Awareness sessions continue to be scheduled bi-monthly, advertised via ABPulse. Storage areas identified as high risk have now been emptied and records transferred to Online house and Nevill Hall Hospital (St Cadocs Mental Health Records archive store, Goldcliffe ward and Langstone Hut)	
Storage Capacity & Digitisation Demand: Increasing demand for digitisation due to limited or inappropriate storage areas, compounded by extended retention due to public inquiries.	Ongoing digitisation programmes and clearance of high risk storage areas, progress constrained by staffing and funding.	**12**

7. Incidents

Information Governance

Incidents investigated by the Information Governance team have been risk assessed and all have been assigned as a low risk, the numbers of incidents investigated between February 2026 – April 2026 are shown below:-

Confidentiality – i.e. it has been made available or disclosed to unauthorised entities.
Integrity – i.e. the accuracy and completeness of information has been compromised.
Availability – i.e. the data is not accessible when required by authorised personnel.

Incident Type	Incidents Investigated	Number Reportable to Information Commissioners Officer (ICO)	Incidents Outstanding
Confidentiality	102	0	8
Integrity	37	0	7
Availability	41	0	3
Total	**180**	**0**	**18**

Cyber Security Incidents

Automated incidents for the period:

ID	Title	Severity	Category	Actions
1557498	Phishing	High	Login details compromise	Affected account sessions revoked, password re-set and monitored for suspicious activity
1546689	Phishing	High	Login details compromise	Email to 100+ NHS Wales accounts. Message was blocked and removed from inboxes. Clickers had sessions revoked and passwords re-set

Service Desk reported incidents for the period:

Title	Count	Actions
Lost or stolen equipment	32	Devices remote wiped, mobile sims barred. 1 device recovered from a pawn shop
Malware	1	False positive firewall alert
Suspicious emails	9	Several gift card scams, some false positives
Voice Phishing	1	Spoofed HMRC number
SMS Phishing	1	Spoofed DWP regarding benefits claims
Account compromise	4	Sessions revoked, passwords re-set, mutli-factor authentication verified as correct and accounts monitored for suspicious activity

Cyber incidents show that phishing attacks and successful account compromise is a key concern. As a result, Cyber have conducted themed tabletop exercises to rehearse and produce standard response procedures. Having full licencing for the phish simulation and awareness tool allows cyber to identify those most at risk and provide tailored training to support them.

Argymhelliad / Recommendation

The Finance & Performance committee is asked to note the content of the report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.4 Information Governance and Communications Technology Choose an item. Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Digital, Data, Intelligence
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Information Governance Sub-Committee Divisional Assurance Groups
Rhestr Termau: Glossary of Terms:	CAF – Cyber Assessment Framework CWS – Clinical Workstation DHCW – Digital Health & Care Wales DHR – Digital Health Record DPA – Data Protection Act DPIA – Data Protection Impact Assessment FCE – Finished Consultant Episodes GDPR – General Data Protection Regulations ICO – Information Commissioners Office KPI – Key Performance Indicators NCSC – National Cyber Security Centre NIS-R – Network & Information System Regulations RPA – Robotic Process Automation RTT – Referral to Treatment USC – Urgent Suspected Cancer WASPI – Wales Accord Sharing Personal Information
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Digital, Data & Technology team

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans;

	investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Yes, outlined within the paper
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Ticket ID	Division	Department	Summary	Ticket Type	Date/Time Logged	Site	Team	Status
288111	Medicine	Neurology	NDSR Tasks - IG Review - Neurology EPR - use of unsupported system in ABUHB_PatientCare_Katharine Harding	Information Governance - Data Protection Impact Assessment	05.02.2026 14:23	Royal Gwent Hospital	Information Governance	With User
304391	Clinical Support Services	Anaesthetics	NDSR Tasks - IG Review - New ultrasound machine connectivity - Sarah Elgarf	Information Governance - Data Protection Impact Assessment	08.04.2026 09:07	ABUHB	Information Governance	With User
291241	Digital Data & Technology	Health Records & Booking	DPIA - Hawkeye scanners - Anne McDonnell	Information Governance - Data Protection Impact Assessment	17.02.2026 09:01	Ty Gwent	Information Governance	Resolved
301995	Family Therapies	Maternity Services	Maternity Vaccination - Claire Haymond_DPIA	Information Governance - Data Protection Impact Assessment	27.03.2026 09:31	Ty Gwent	Information Governance	Resolved
290569	Digital Data & Technology	Digital Programmes	Information Governance - Data Protection Impact Assessment	Information Governance - Data Protection Impact Assessment	13.02.2026 10:39	Ty Gwent	Information Governance	Closed
302026	Surgery	Trauma & Orthopaedics	DPIA - Healthcare Business Solutions – HBS	Information Governance - Data Protection Impact Assessment	27.03.2026 10:24	Royal Gwent Hospital	Information Governance	Closed
293192	Complex Care		DPIA- CareCubed - Rachael Worlock - Cyber ticket 0285282	Information Governance - Data Protection Impact Assessment	24.02.2026 12:41	Ty Gwent	Information Governance	Approved
296099	Surgery	SC Urology	DPIA - GALEAS - Joanne James	Information Governance - Data Protection Impact Assessment	05.03.2026 11:46	Ty Gwent	Information Governance	Approved
296107	Clinical Support Services	Pathology	DPIA - mortuary and body store CCTV cameras - Heather Hughes	Information Governance - Data Protection Impact Assessment	05.03.2026 12:00	Ty Gwent	Information Governance	Approved
289822	Family Therapies	MSK Transformation	DPIA - Community Pathways PaRIS Patients/OECD analysis - ABUHB - Chris McConnell /0289822	Information Governance - Data Protection Impact Assessment	11.02.2026 12:58	Ty Gwent	Information Governance	Forwarded In
293651			NDSR Tasks - IG Review - URefer for management of self referral triage process in MSK - Sam HaworthBooth	Information Governance - Data Protection Impact Assessment	25.02.2026 13:35	Ty Gwent	Information Governance	Forwarded In
293737	Clinical Support Services	Pathology	ePMA SAR- DPIA to be reviewed please see 0265695 and DPIA in 0150620 - Possible go live 8th June 2026	Information Governance - Data Protection Impact Assessment	25.02.2026 14:57	Ty Gwent	Information Governance	Forwarded In
295157	Corporate	Public Health	Digital Weight Management Service – L2 Adults- David Bobs	Information Governance - Data Protection Impact Assessment	03.03.2026 11:03	Ty Gwent	Information Governance	Forwarded In

299238	Digital Data & Technology	Health Records & Booking	DPIA - Hawkeye scanners - Cyber Review	Information Governance - Data Protection Impact Assessment	17.03.2026 14:27	Ty Gwent	Information Governance	Forwarded In
303437	Clinical Support Services	Pathology	NDSR Tasks - IG Review - Cellular Pathology Digital Outsourcing NDSR 0276350	Information Governance - Data Protection Impact Assessment	02.04.2026 09:41	Royal Gwent Hospital	Digital PMO	Forwarded In
308154	Surgery	General Surgery	DPIA - My Pen - Surgery - Karen Perry	Information Governance - Data Protection Impact Assessment	16.04.2026 11:20	Ty Gwent	Information Governance	New

Aneurin Bevan Cyber Security Programme – NIS Update

Workstream Updates – NIS Update

NIS CAF	Recommendation from CRU	CAF Outcomes	Start	End	RAG progress	Comments
Objective A – A3: Asset Management – A3.a – Asset Management. Incomplete Asset Register. Without a complete asset register, some assets may not be tracked, leading to unmonitored vulnerabilities.	Perform a thorough audit of all IT assets, including hardware, software, data and network components. Dependencies should also be noted for critical systems.	Not achieved	09/24	Ongoing		CMDB Audit Planner has been created, which includes tasks to be undertaken throughout the year. With regards to dependencies, an Interactive Service Map is being developed to record relationships between services and their dependencies.
Objective B – B2: Identity & Access Control – B2.c – Privileged User Management & B2.d – Identity and Access Management (IdAM). Privilege creep is not easily detected. When privilege creep is not easily detected, employees or systems accumulate more access rights than necessary over time. Increases the risk of insider threats and accidental misuse.	Conduct periodic audits of user permissions to ensure that they align with current job roles. Remove any unnecessary privileges that users no longer need. Implement RBAC to define clear roles and associated permissions.	Not achieved	09/24	Ongoing		Starters, Movers, and Leavers (SML) Policy specifically for ABUHB is currently under review. Staff access is determined by line managers and based on organisational role. The auditing of the access for staff will be down to the line manager. Responsibilities for Movers is contained within the SML Policy. There is now a semi-automated process to handle leavers notified by HR/ESR through a HALO call. For individual user notifications, the process remains manual but follows the same steps. Audit for elevated account review NIS finding, which includes privileged and local accounts been initiates around accounts; however, a process needs to be defined and how often a review is carried out. This is an action with Cyber to put documentation together for the process.

RAG Status			
NIS CAF Ref	Reason	Actions Required	Date
A3.a	Finding has been open for 11 months.	Schedule Audit is required for asset management.	
B2.c & B2.d	SML policy is part of the Policy review.	Sign off required from Executives.	

Risks

Risk ID	Risk Description	Status	Owner	Progress

Items for Escalation

Description	Escalated to	Response due

Aneurin Bevan Cyber Security Programme – NIS Update

Workstream Updates – NIS Update

NIS CAF	Recommendation from CRU	CAF Outcomes	Start	End	RAG progress	Comments
Objective B – B2: Identity & Access Control – B2.b – Device Management. Use of generic accounts. Sharing of generic accounts on multiple workstations makes investigations of user abuse incredibly difficult, since multiple users share the same credentials, it becomes challenging to determine who performed a particular action or made changed to the system.	If generic accounts are required for clinical machines they should be locked to those machines and have restricted domain access. A risk should be noted and passwords reviewed upon turnover of staff. Alternatively, thin clients could be implemented and provide individual user accounts for each user to ensure accountability, traceability, and effective access control.	Not achieved	09/24	Ongoing		There are discussions happening around expanding the use of Imprivata for certain clinical areas to remove the need of generic accounts. Update – project is underway for Imprivata being implemented in certain clinical areas; however, there is a delay of completion. Expected completion for June 2026. Update – Risk 2137. There are technical capabilities to stop generic accounts being used at all sites e.g., GUH gen account being used at RGH; however, this would need resourcing.
Objective C – C1: Security Monitoring – C1.a – Monitoring Coverage & C2: Proactive Security Event Discovery – C2.b – Proactive Attack Discovery. Limited Monitoring coverage and Proactive attack discovery isn't carried out. Limited monitoring coverage means that not all critical systems, network segments, or user activities are being tracked or logged.	Continue to use the SIEM systems to aggregate and correlate data from difference sources, including detection rules based on the evolving threat landscape for different operating systems. This improves visibility across the network.	Not achieved	09/04	Ongoing		NGFW are implemented in GUH. There are project complexities and dependencies which have led to delays with implementation at secondary site and retention of Smoothwall until September 2026. ASA's to be replaced by Palo Alto. Project is working towards deadline timeline for replacing Smoothwall with Palo Alto Firewall; however, this is dependent on the transit link network project that is also ongoing.

RAG Status			
NIS CAF Ref	Reason	Actions Required	Date
B2.b	Delay in implementing Imprivata.	Imprivata to be procured and implemented in other ward areas.	
C1.a & C2.b	Palo Alto has been implemented at GUH but needs to be implemented at other sites.	Project to continue for implementation.	

Risks

Risk ID	Risk Description	Status	Owner	Progress

Items for Escalation

Description	Escalated to	Response due

Aneurin Bevan Cyber Security Programme – NIS Update

Workstream Updates – NIS Update

NIS CAF	Recommendation from CRU	CAF Outcomes	Start	End	RAG progress	Comments
Objective A – A4.a: Supply Chain. Contract reviews need to be carried out on existing contracts same as new contracts. The lack of consistent reviews for existing contracts may result in outdates terms, unmanaged risks, or missed opportunities ensuring the contracts are relevant and complaint.	Continue to extend the contract review process to all existing agreements. This should include prioritisation based on contract value, risk, and strategic importance, ensuring that all contracts are reviewed regularly and systematically.	Partially achieved	06/25	Ongoing		Remedial Action Owner attended the latest NIS Assurance Group and has been provided access to required documentation. An updated will be provided in the next NIS Assurance Group meeting (26/11). Some of the contract reviews are down to the service and not with Business Unit Team. Business Unit asks for copy of those meetings taking place (meeting minutes).
Objective A – A4.a: Supply Chain. Out of hours incident response needs easily accessible supplier contact list. In the event of an urgent issue arising outside of normal working hours, delays in locating supplier information could hinder timely response and resolution. This poses a risk to service continuity and may impact remediation efforts.	Develop and maintain a centralised, up-to-date directory of all out-of-hours suppliers, including full contact details. Ensure this directory is easily accessible to all relevant staff and regularly reviewed for accuracy.	Partially achieved	06/25	Ongoing		There is a Service Transition process that is ongoing and as part of the process is to update the Supplier Contact List within Halo.

RAG Status			
NIS CAF Ref	Reason	Actions Required	Date
A4.a			
A4.a			

Risks

Risk ID	Risk Description	Status	Owner	Progress

Items for Escalation

Description	Escalated to	Response due

Aneurin Bevan Cyber Security Programme – NIS Update

Workstream Updates – NIS Update

NIS CAF	Recommendation from CRU	CAF Outcomes	Start	End	RAG progress	Comments
Objective A – A4.a: Supply Chain. Certificate expiration needs to be tracked for existing suppliers. Without comprehensive tracking of certificates for existing contracts, there is a risk of missed expirations, which could lead to non-compliance.	Expand the certificate tracking system to include all existing contracts. Implement a phased plan to retrospectively capture and input certificate data.	Observation	06/25			Continue progressing capturing certificate expiration for suppliers. This is being revamped by members within the Business Unit Team.
Objective C – C1.a: Monitoring Coverage. Insufficient Integration of Threat Intelligence Across Monitoring Platforms. An underutilised SIEM reduces the organisation's ability to detect and respond to complex or coordinated threats. This fragmentation increases the risk of delayed or missed detection of security incidents and weakens the overall threat detection capability.	The national SIEM (Microsoft Sentinel) is not yet fully configured or accessible to meet local operational needs. As the configuration of the SIEM falls outside the remit of the OES, this may impact the effectiveness of local monitoring and incident response capabilities.	Observation	06/25			Marked down as an Observation by CRU that it poses a risk to the organisation; however, the responsibility of improvement is down to DHCW.

RAG Status			
NIS CAF Ref	Reason	Actions Required	Date

Risks

Risk ID	Risk Description	Status	Owner	Progress

Items for Escalation

Description	Escalated to	Response due

Aneurin Bevan Cyber Security Programme – NIS Update

Workstream Updates – NIS Update

NIS CAF	Recommendation from CRU	CAF Outcomes	Start	End	RAG progress	Comments
Objective C – C1.b: Securing Logs. Elevated account review. Without periodic reviews, there is a risk that users may retain elevated access unnecessarily, increasing the potential for misuse or accidental exposure of sensitive data, and weakening the overall security posture.	Implement a formal, scheduled review process for all elevated accounts to ensure access remains appropriate and aligned with current roles and responsibilities.	Partially achieved	06/25	Ongoing		Desktops have built and generated 3 different reports around domain admins, local admins and last user log ons. Currently, Cyber are reviewing report to check suitability before moving onto the roles and responsibilities for the audit process. There is a need for creating a process around reviewing Elevated Account privileges/access. Cyber to action of creating a process as same for "Objective B – B2: Identity & Access Control – B2.c – Privileged User Management & B2.d – Identity and Access Management (IdAM). Privilege creep is not easily detected."
Objective C – C1.c: Generating Alerts. Real time alert resolution This reliance on non-specialists on-call staff may lead to delays or ineffective responses to critical cyber incidents outside of business hours, increasing the risk of prolonged exposure or damage.	Implement an automated alerting system that directly notifies designated cyber staff of critical security events, regardless of the time of day. This will help ensure timely and expert response to incidents, even outside of standard working hours.	Partially achieved	06/25	Ongoing		Currently, there is a general review for all on call support teams with the possible removal of some teams from the rota. Awaiting results of review before progressing with findings. Review of on-call has taken place and are in the consultation period for those affected by the changes. Cyber are continuing with on-call and there are plans at creating playbooks for when incidents occur. There is however a need to look at workflow automation in Defender e.g., take the device off the network to contain the incident.

RAG Status			
NIS CAF Ref	Reason	Actions Required	Date

Risks

Risk ID	Risk Description	Status	Owner	Progress

Items for Escalation

Description	Escalated to	Response due

Aneurin Bevan Cyber Security Programme – NIS Update

Workstream Updates – NIS Update

NIS CAF	Recommendation from CRU	CAF Outcomes	Start	End	RAG progress	Comments
Objective C – C1.e: Monitoring Tools and Skills. Staff require more specialised training on systems they rely on. Dependence on default configurations may lead to suboptimal security settings, increasing the risk of vulnerabilities going undetected or unaddressed. This limits the organisation's ability to proactively manage cyber threats.	Develop and implement a targeted training programme to ensure staff are proficient in the use and configuration of specialised security tools. This should include vendor-led training.	Partially achieved	06/25	Ongoing		Resource training needs to be considered at project level when procuring a new system/tool that will be used by multiple staff within DDaT. There is a process to request training through our PMO team that is outside of vendor training.
Objective D – D1.a: Response Plan. Response plans need to look at long term downtime. In the event of a sustained disruption to critical systems, the organisation may be unprepared to maintain essential services or recover operations effectively.	Review and update the incident response and business continuity plans to include details procedures for managing long-duration outages of critical systems. This should involve scenario planning, resource allocation, communication strategies, and recovery timelines tailored to extended disruptions.	Not achieved	06/25	Ongoing		Service Plans are being developed with appropriate time scales responses included. Longer term solutions e.g., eforms are being developed on an ad hoc basis. There are some plans in place that look at long term downtime. There is a repository around long term downtime plans stored within our AB Pulse SharePoint site.

RAG Status			
NIS CAF Ref	Reason	Actions Required	Date

Risks

Risk ID	Risk Description	Status	Owner	Progress

Items for Escalation

Description	Escalated to	Response due

Aneurin Bevan Cyber Security Programme – NIS Update (New findings – June assessment)

Workstream Updates – NIS Update

NIS CAF	Recommendation from CRU	CAF Outcomes	Start	End	RAG progress	Comments
Objective D – D1.b: Response and Recovery Capability. Inadequate resources available (forensics). In the absence of a formal agreement, there is a risk that critical support may be delayed or unavailable during a cyber incident. This could hinder effective incident response and impact recovery times.	Establish a formal, documented agreement with DHCW outlining the scope, availability, and response times for incident and support. Consider securing a third-party retainer to ensure timely access forensic services when needed.	Not achieved	06/25	Ongoing		Cyber will explore costs for 3rd party forensics support, as there is currently no resource/competency within the team internally. There was a meeting that took place in December around Forensic Readiness with KPMG. KPMG supply a service to DHCW. ABUHB can call on DHCW for forensic support through KPMG.
Objective D – D1.c: Testing and Exercising. Exercising needs to be more regular and consistent Without a structured and regular exercising programme, the organisation may be unprepared to respond effectively to cyber incidents. This could lead to confusion, delays, or ineffective coordination during real events, reducing the overall resilience of the organisation.	Develop and implement a formal exercising schedule that included cross-team cyber incident simulations. These exercised should be varied in scope and complexity, conducted regularly, and followed by debriefs to identify lessons learned and areas for improvement.	Not achieved	06/25	Ongoing		Cyber have created their own scenario and discussed who the attendees should be. Cyber are looking to schedule and expand audience for exercises in 2026. TTX (Table-Top Exercise) around CWS failure had taken place on 16th of December. Notes were taken during the meeting and findings/recommendations have been shared with those that attended the meeting. Schedule to still be developed. During April, Rubrik arranged a Save the Data Workshop Table-Top Exercise, which invited those within Senior Management positions.

RAG Status			
NIS CAF Ref	Reason	Actions Required	Date

Risks

Risk ID	Risk Description	Status	Owner	Progress

Items for Escalation

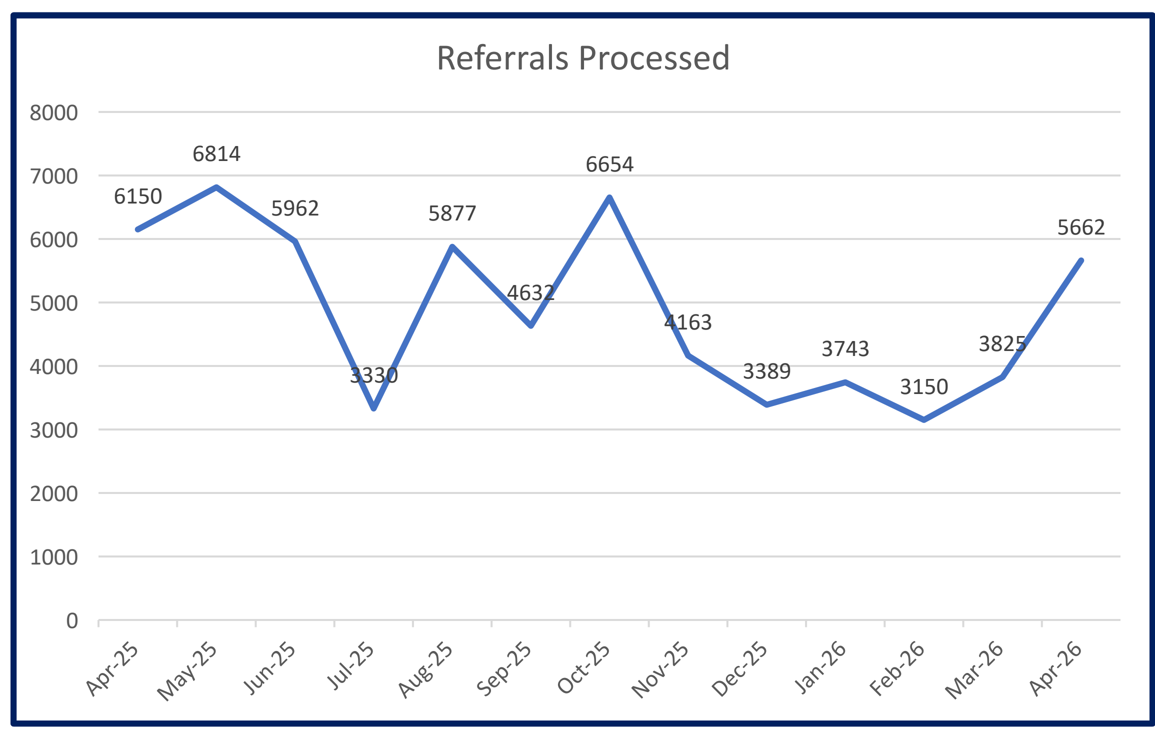
Description	Escalated to	Response due

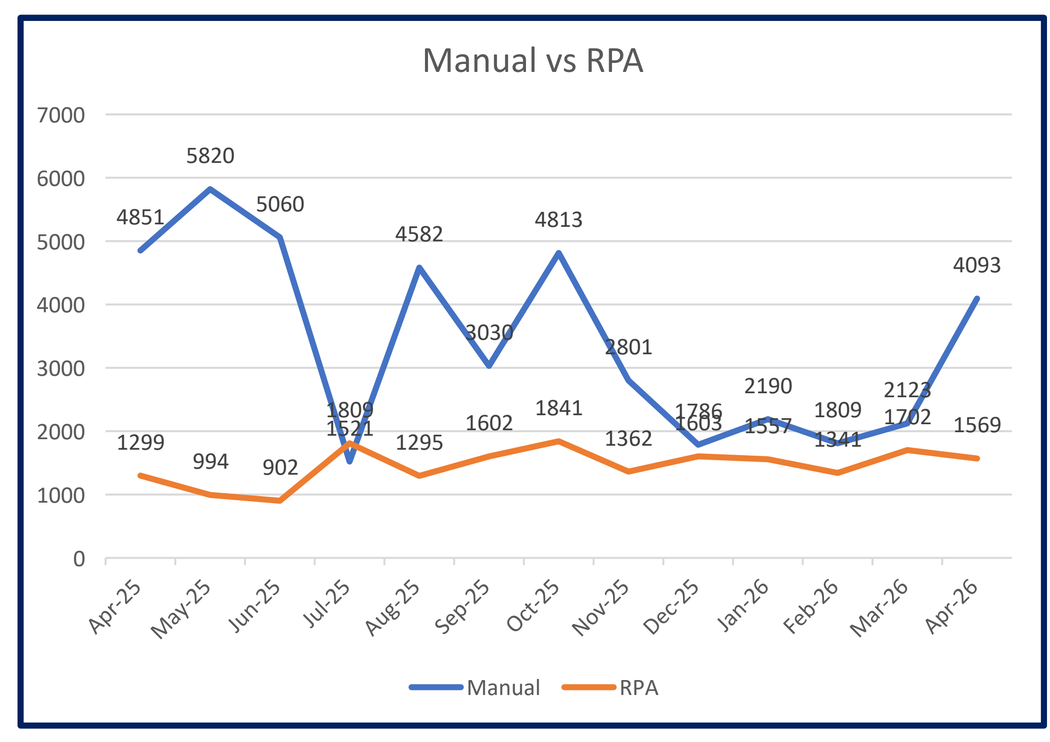
Referral & Booking Assurance Update
May 2026

Suzanne Davies

Head of Referral & Booking Services

Referral Prioritisation – Accepted and Rejected (Combined)





Booking Activity

RBC Activity Breakdown

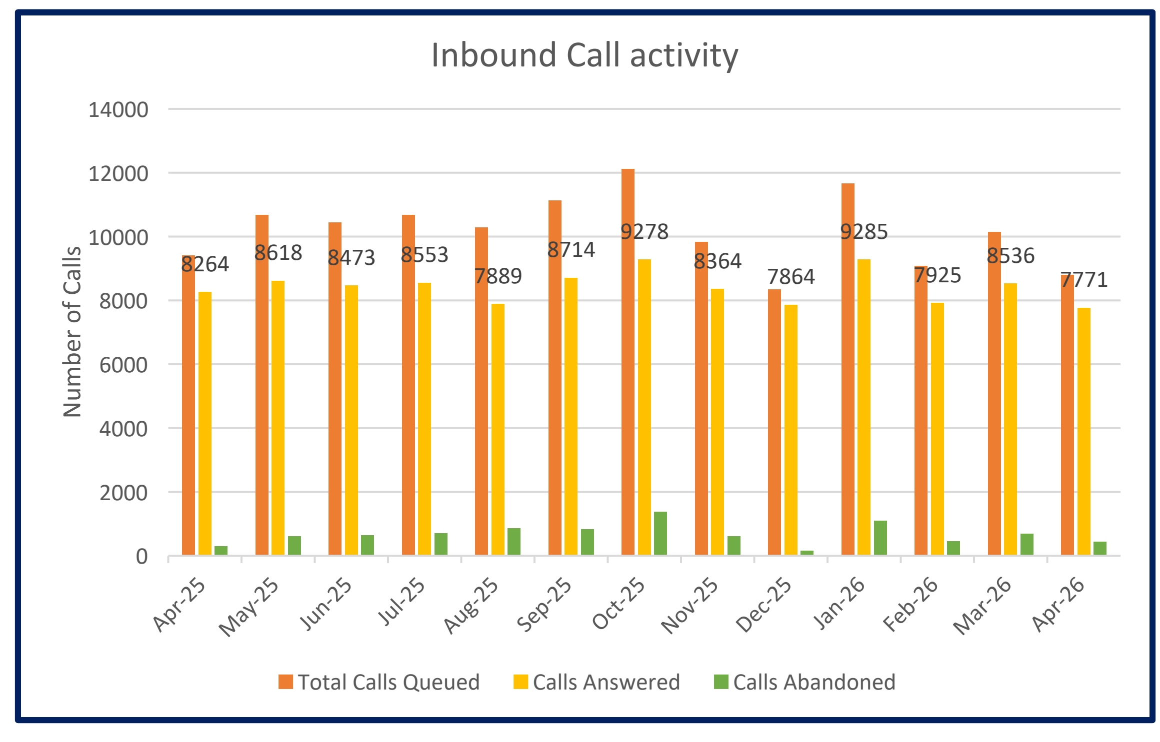
	Appointments Booked	Ward Discharges Processed	SMS Cancellation/Rebook Requests	Partial Booking Invites Sent	Cancelled/Reduced Clinics
Apr-25	9771	287	688	1986	449
May-25	9990	493	828	2125	568
Jun-25	11985	296	866	1838	441
Jul-25	11452	278	681	3604	412
Aug-25	10996	232	502	4405	384
Sep-25	12754	652	796	4226	523
Oct-25	11902	720	865	5110	612
Nov-25	12474	542	824	6249	330
Dec-25	7125	102	732	6773	441
Jan-26	7153	443	1797	4110	350
Feb-26	7309	277	934	1302	369
Mar-26	7515	468	1013	1703	398
Apr-26	7303	320	1021	1419	171

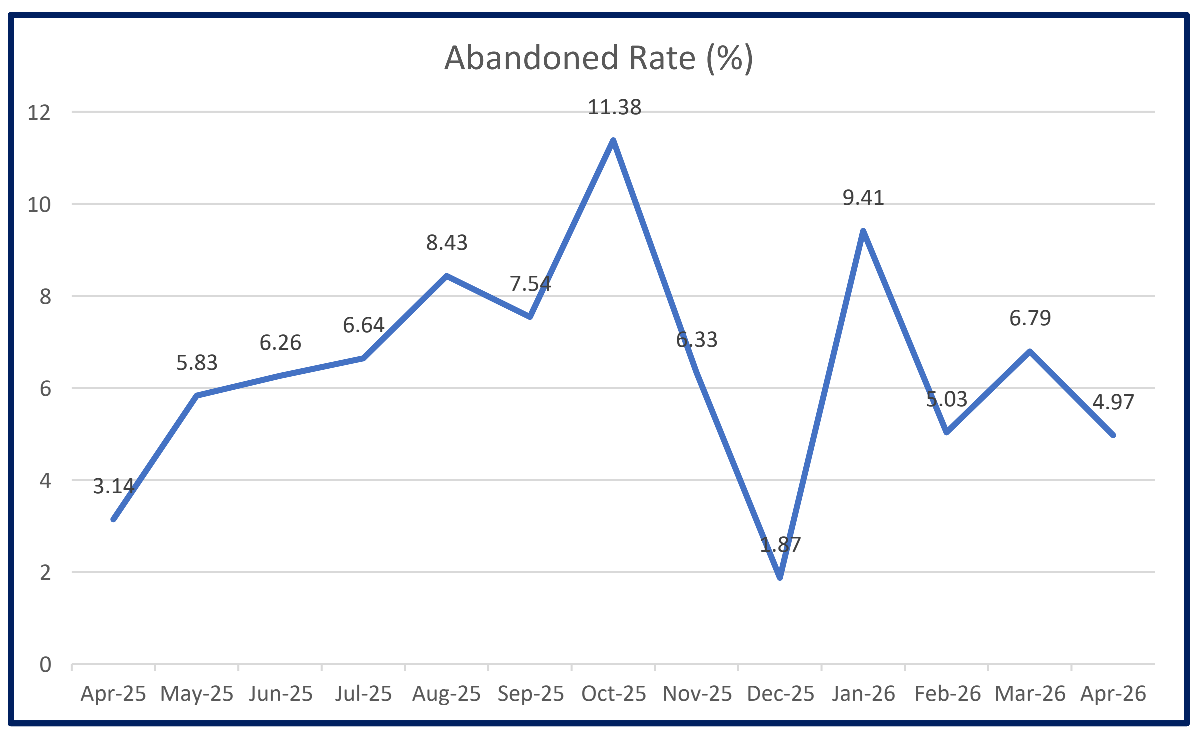
	Outcomes Completed	% Arrived	% DNA
Apr-25	20595	89.1	10.9
May-25	19270	88.45	11.55
Jun-25	22373	88.48	11.52
Jul-25	20616	88.89	11.11
Aug-25	19904	89.27	10.73
Sep-25	24189	90	10
Oct-25	25441	90.59	9.41
Nov-25	27545	91.06	8.94
Dec-25	26310	90.7	9.3
Jan-26	28701	91.1	8.9
Feb-26	24743	90.63	9.37
Mar-26	26377	91.8	8.2
Apr-26	26541	89.38	10.62

Outstanding Clinical Outcomes
4618

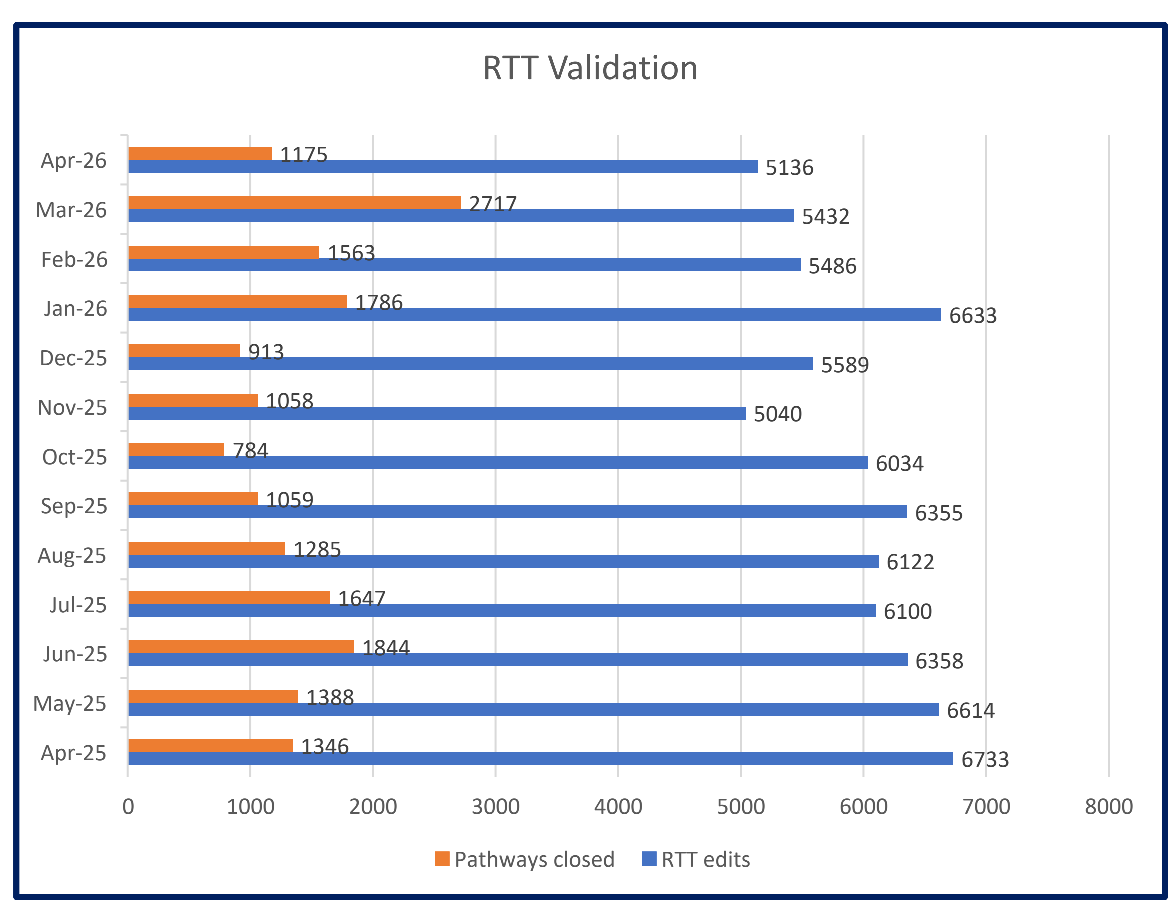
Outstanding WPAS Outcomes (Non RBC)
1238

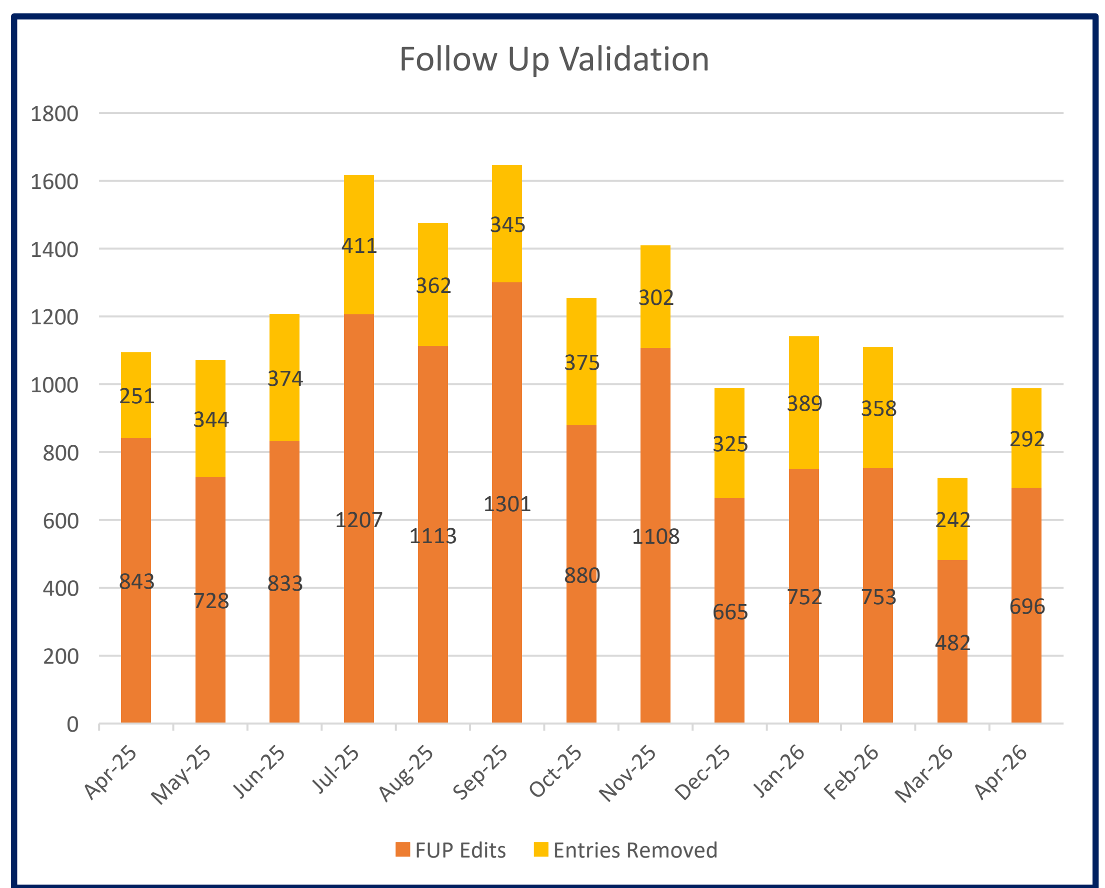
RBC Call Performance



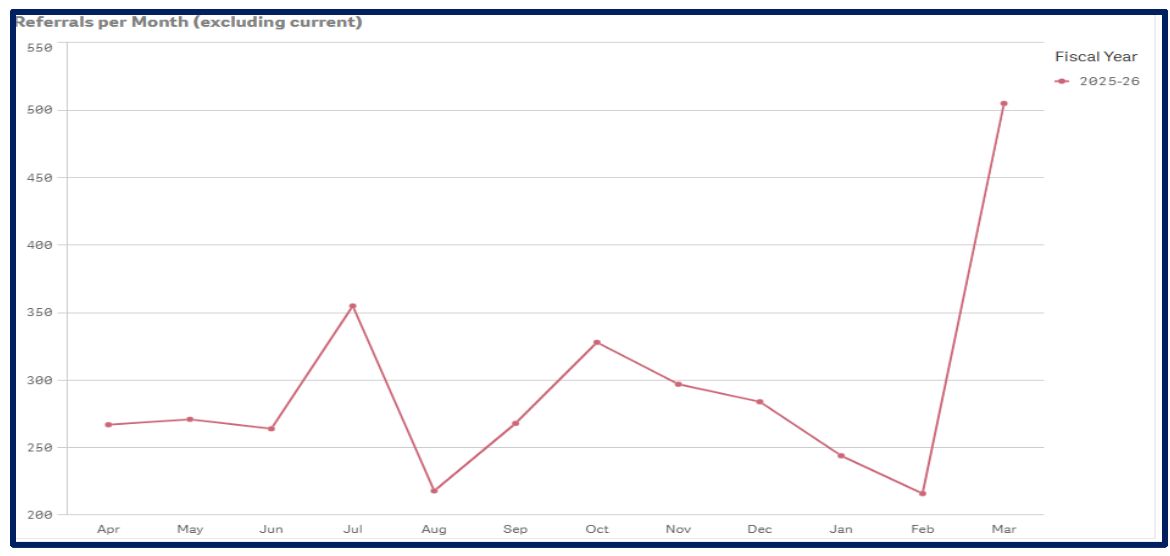


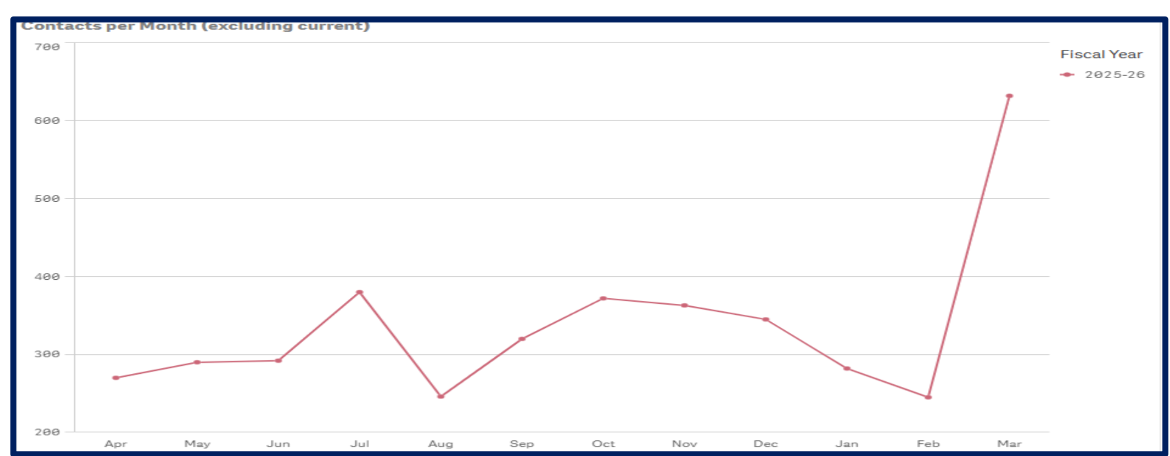
Validation





Keeping Well





Digidol, Data a Thechnoleg
Bwrdd Iechyd Prifysgol Aneurin Bevan
Aneurin Bevan University Health Board
Digital, Data & Technology

Switchboard Call Performance

Switchboard Call Performance

	Total Calls Queued	Calls Answered	Calls Abandoned
May-25	57439	52955	4484
Jun-25	55876	51983	3893
Jul-25	53117	49691	3426
Aug-25	54626	50535	4091
Sep-25	58553	54634	3919
Oct-25	59480	55681	3779
Nov-25	55108	52090	3018
Dec-25	24735	51463	3272
Jan-26	63188	58785	4403
Feb-26	53914	50065	3822
Mar-26	59046	55524	3522
Apr-26	54251	51317	2934

LUCY Stats

	Direct Transfer	Request Operator	Bailed to Operator	Hung Up
May-25	3932	10012	1556	2512
Jun-25	3866	10025	1640	2358
Jul-25	3914	10142	1684	2482
Aug-25	3868	9851	1608	2493
Sep-25	3982	9598	1659	2314
Oct-25	4214	10471	1689	2558
Nov-25	3536	10220	1592	2381
Dec-25	No Data			
Jan-26	3896	9664	1651	2308
Feb-26	3543	8892	1509	2168
Mar-26	3831	9852	1679	2439
Apr-26	3438	9399	1618	2161

Switchboard Activity

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Interpreting & Translation	339	370	356	303	328	302	267	244	298	253	297	277
Transport	1219	1187	1222	1096	1147	1303	1141	1146	1158	1091	1114	12
District Nursing	32	22	26	37	28	29	27	34	28	22	30	1106
ICT	41	47	53	44	60	33	38	44	49	60	27	26
W&E	465	439	408	398	438	441	515	382	444	420	397	47
Incidents	0	2	1	2	0	0	6	4	1	0	33	412
Clinical 2222s	297	296	268	240	295	289	302	273	26	29	0	5
Fast Bleep	23	17	21	28	22	31	27	31	308	258	337	301
Child Protection	18	31	31	14	35	27	24	14	42	25	38	34
Fire Activiaton	29	20	24	13	17	19	17	15	23	22	16	22
Helipad Activation	8	2	3	6	2	6	13	1	6	3	3	14

Title	ID
Business continuity plans	1308
Subject Access Requests	1309
Storage of patient records	1310
Images and voice recordings stored without IG knowledge	1311
Mental Health Professional Body Disclosure process for records that sit ou	1312
CCTV - lack of technology to obscure faces of people who are not relevant	1314
EPEX - decommissioning of service	1316
WCCIS - not all steps being undertaken when uploading information to W(	1317
Information Governance Training - Compliance of 85% across the HB - non	1318
Medico Legal extract not fit for purpose - specifically A&E and WinPath	1326
Inappropriate Access to Systems	1379
Significant data loss within Mental Health	1472
Local Authorities purchase of WCCIS replacement system which will not in	1519
EMPI	1673
G2 work around - IG	1817
Outlook autocomplete	1996

Medico Legal extract in open eyes not fit for purpose	2215
Open Eyes	2257
Digital letter Patient Portal Risk	2422

Cause
As a result of lack of understanding around the production of BCP's
As a result of a lack of understanding by staff across the HB regarding Subject Access Requests process
As a result of the lack of understanding of the Records Management Policy
As a result of images and voice recordings being stored without IG knowledge
As a result of operational pressures within the MH clinical team - staff are refusing/unable to undertake their obligation under the AHR Act 1990 - DPA 18 and UK GDPR to provide the data controller with professional advice regarding harm and distress exemption
As a result of the inability to obscure faces of people not relevant to request
As a result of the decommissioning of the EPEX system
As a result of the migration of information from EPEX to WCCIS being incomplete due to staff not completing all steps of the process when uploading information into WCCIS.
As a result of a lack of protected time for all staff groups of the Health Board to undertake their mandatory IG training
There is insufficient resource to develop A&E and WinPath data extract funcationality. Overtime was being used to develop this functionality and overtime has been stopped due to health board financial situation. The situation is being made worse for AHR as the number of requests and sources of data increases.
As a result of not all departments having starters, leavers and movers process
As a result of some files being set up as teams files as opposed to SharePoint files with a 7 year retention period placed on them
As a result of this proposal there is a risk that ABUHB data may be migrated onto this system.
As a result of inbound messaging from EMPI a numbers of data quality errors resulting in data breaches have occurred.
As there is currently no practical way to provide business continuity for G2 in the event of unacceptable speed or inaccessible application
As a result of staff across the HB using the autocomplete function within outlook

As a result of no set process for medico legal process in the new open eye system
Numerous risks have been identified inline with Articles under DPA2018 & UKGDPR, these have been highlighted on the Local Risk Assessment document
As a result of the portal holding letters for 2 years this means that when a LAC moves from foster to parents care the parents can see address of previous foster carers

Event
There is a risk of disruption to service due to resource of system failure
There is a risk that subject access requests are not being processed in a timely manner
There is a risk of records being stored inappropriately, not catalogued and unknown to both IG and AHR teams that these records exist
Information Governance are unable to comply fully with Subject Access Requests
There is a risk of disclosures not being actioned within the timescale of one calendar month
There is a risk of breach of confidentiality when providing CCTV footage as part of a subject access request
There is a risk of loss of information
There is a risk of loss of information
There is a risk of IG/Records Management and Cyber processes not being followed
If resource not available to develop Medical legal extract in Admin Portal and AHR have insufficient resource to safely maintain manual process within timescales.
There is a risk of staff being able to access information systems outside of their job role
There is a risk of information being deleted
There is a risk that ABUHB would not know where the information will be stored, would not know who would have access to the information
There is a risk of inappropriate disclosure of information/breach of data protection legislation
users are reported to be adopting personal device voice memo and whats apping
There is a risk of breach of confidentiality by sending information to an incorrect recipient

There is a risk of not being compliant with Subject Access Requsts
The Consultant Ophthalmologist and Senior Responsible Owner confirmed that from a clinical standpoint the Health Board should accept the residual risks.
There is a risk of a breach of confidentiality via inappropriate access/sharing

Effect
Which will lead to disruption of services within both AHR and IG teams
Which will lead to non compliance with UK GDPR Legislation
Which will lead to non compliance with UK GDPR Legislation
Which will lead to non compliance with UK GDPR Legislation
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Which will lead to non compliance with UK GDPR Legislation
Which will lead to non compliance with UKGDPR Legislation
Which will lead to non compliance with UKGDPR Legislation. This will also mean that we are unable to achive minimum standards for the IG toolkit which will have a knock on effect for CAG requests
Delays in producing medico legal extracts. Possible fines for breaching targets or additional staff costs to meet targets.
Which will lead to a breach in UKGDPR Legislation and is a breach of the Computer Misuse Act 1990
which will lead to a significant data loss for the HB
Which may lead to a significant loss of data for the HB
Which will led to non compliance of data protection legislation and loss of organisational reputation
which leads to a breach of GDPR, misidentification issues, records missing from CWS record, PII on personal devices
Which will lead to non compliance with UKGDPR

Which leads to a breach of GDPR

Risks highlighted non compliance with DPA2018 & UKGDPR

Which will lead to a breach of UKGDPR

AB - Risk Domain	Risk Level
22;#Service/Business Interruption / Environmental Impact	Department/Team
17;#Statutory Duty/Inspections	Corporate
17;#Statutory Duty/Inspections	Corporate
17;#Statutory Duty/Inspections	Department/Team
17;#Statutory Duty/Inspections	Corporate
15;#Quality/Complaints/Audit	Department/Team
17;#Statutory Duty/Inspections	Corporate
17;#Statutory Duty/Inspections	Department/Team
17;#Statutory Duty/Inspections	Department/Team
22;#Service/Business Interruption / Environmental Impact	Programme/Project
17;#Statutory Duty/Inspections	Directorate
20;#Safety - Patient/Staff/Public	Directorate
20;#Safety - Patient/Staff/Public	Corporate
17;#Statutory Duty/Inspections	Department/Team
17;#Statutory Duty/Inspections	Corporate
17;#Statutory Duty/Inspections	Corporate

17;#Statutory Duty/Inspections	Corporate
17;#Statutory Duty/Inspections	Directorate
17;#Statutory Duty/Inspections	Corporate

Department	AB - Team	Date Identified
Information Governance	307;#Access to Health Records	18.10.2024
Information Governance	499;#Information Governance	18.10.2024
Information Governance	499;#Information Governance	18.12.2020
Information Governance	499;#Information Governance	21.10.2024
Information Governance	499;#Information Governance	21.08.2023
Information Governance	499;#Information Governance	30.07.2021
Information Governance	499;#Information Governance	21.10.2024
Information Governance	499;#Information Governance	21.10.2024
Information Governance	499;#Information Governance	01.06.2021
Information Governance	313;#Software Development	07.09.2023
Information Governance	499;#Information Governance	18.11.2024
Information Governance	499;#Information Governance	12.09.2024
Information Governance	499;#Information Governance	24.10.2024
Information Governance	499;#Information Governance	13.03.2025
Information Governance	522;#Information Governance Team	03.06.2025
Information Governance	522;#Information Governance Team	22.04.2025

Information Governance	522;#Information Governance Team	16.01.2026
Information Governance	522;#Information Governance Team	16.01.2026
Information Governance	522;#Information Governance Team	07.05.2026

Raised By
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Assuring Group	Inherent - Likelihood	Inherent - Impact
Information Governance Group (IGG)	2	2
Information Governance Group (IGG)	2	2
Information Governance Group (IGG)	3	3
Information Governance Group (IGG)	3	3
Information Governance Group (IGG)	3	3
Information Governance Group (IGG)	2	2
Information Governance Group (IGG)	3	3
Information Governance Group (IGG)	3	3
Information Governance Group (IGG)	2	2
	4	2
Information Governance Group (IGG)	2	2
Information Governance Group (IGG)	3	3
Information Governance Group (IGG)	3	3
Information Governance Group (IGG)	3	3
Information Governance Group (IGG)	5	3
Information Security Assurance Sub Group (ISASG)	3	2

Information Governance Group (IGG)	3	3
Information Governance Group (IGG)	3	3
Information Governance Group (IGG)	2	5

Inherent - Risk Score	Risk Response
4	Treat
4	Treat
9	Treat
9	Treat
9	Treat
4	Treat
9	Treat
9	Treat
4	Treat
8	Transfer
4	Treat
9	Treat
9	Treat
9	Treat
15	Treat
6	Treat

9 Treat
9 Treat
10 Treat

Action Plan
Develop BCP's for IG and AHR
Raise importance of compliance with subject access requests via Governance and Assurance Groups, communication via AB Pulse and discussion between DPO, Caldicott Guardian and MH CD'
Formal and adhoc audits to be undertaken to identify areas of non compliance
Discussions to held via GAG's and Divisional Key contacts to ensure Information Asset Register is up to date
Raise importance of compliance with subject access requests via GAGS, communication via AB pulse and discussion between DPO, Caldicott Guardian and MH CD's
Review of procedure and systems to ensure compliance with UKGDPR Legislation
Bespoke training to be arranged for Facilities/Audit Days/Induction days. Sway communications to be developed. Notices put on ABPulse. Raise importance of undertaking this training via GAGS and Divisional Key Contacts.
Develop and submit business case for Digital Platform as part of ABUHB EHCR Delivery Strategy
SIGO's to work with Divisions to ensure S,M and L processes are in place and adhered to
DHCW has set up a new retention policy that excludes our affected sites from the overall All Wales wide retention policy. This means that going forward, these sites will retain all their data indefinitely.
Identify BC
Work to be undertaken across divisions regarding the the removal of this function

Further information required during DPIA process

Turn off electronic letters for all patients under 18

Actionee
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Progress
01/04/26 Health records plans in place, wider directorat plans to be developed. Jonathan working with Peggy Edwards to address this
SAR FAQ's developed, discussion regarding SARs to be added to GAG agendas
SBAR created for the storage of records in ST Cadocs Jon to provide update from IG group discussion regarding the outcome
Work ongoing with Divisions Update to be provided by SIGOs
AHR and MH SIM have worked to provide a SOP which should improve this situation by adopting an MDT approach to disclosures however, MH clinicians are now asking for admin staff to undertake reviews to identify harm and distress MH clinicians refusing to review notes ready for disclosure stating this is an admin role - BMA and Access to Health Records Act 1990 state that this review should be with a Health Professional - this is not a new process and has been in place for many years however, staffing levels and operational pressures are causing pushbacks.
Update required from GO on review of procedure and systems to ensure compliance with legislation
JJ and MM to speak to JM
JJ and MM to speak to JM
Discussions held nationally to review elearning package and locally to review compliance and training provision within HB
08/05/2025 - transfer to JM 20/02/2025 - submit risk as part of CWS business case after delivery of CGI Risk report MM to speak to CH
Update required from SIGOs
Update required
SBAR being looked at by Lynne Wilde to see impact of turning off messaging to other systemsS
Back up plan if G2 is down is to use audio recordings in one note ICT currently undertaking testing

Jonathan Meredith (Aneurin Bevan UHB - Digital Data and Technology),
DPIA completed
DPIA to be updated to reflect risks. mitigation actions

Review Date	Current - Likelihood	Current - Impact	Current - Risk Score
29.04.2026	2	2	4
22.12.2025	2	2	4
05.01.2026	3	2	6
30.04.2026	3	3	9
01.12.2025	3	3	9
20.10.2025	2	2	4
10.11.2025	3	3	9
13.10.2025	3	3	9
20.10.2025	3	3	9
13.10.2025	4	2	8
18.11.2025	1	1	1
21.09.2025	3	3	9
20.01.2026	3	3	9
22.12.2025	3	3	9
15.12.2025	3	5	15
12.01.2026	3	2	6

06.07.2026	3	3	9
22.09.2026	3	3	9
28.05.2026	2	5	10

Target - Likelihood	Target - Impact	Target - Risk Score	Related Risk	Status
				Open
				Open
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1		0	1815;#1815	Open
				Open

			Open
			Open
1	2	2	Open

Closed Date	Modified	Created	Item Type
	01.04.2026 14:11	18.10.2024 10:38	Item
	05.09.2025 15:29	18.10.2024 10:42	Item
	05.09.2025 15:29	21.10.2024 09:35	Item
	05.09.2025 15:29	21.10.2024 09:43	Item
	05.09.2025 15:29	21.10.2024 09:55	Item
	05.09.2025 15:29	21.10.2024 10:40	Item
	05.09.2025 15:29	21.10.2024 10:55	Item
	05.09.2025 15:28	21.10.2024 11:07	Item
	05.09.2025 15:28	21.10.2024 11:13	Item
	02.09.2025 09:41	24.10.2024 11:39	Item
	05.09.2025 15:28	18.11.2024 09:33	Item
	05.09.2025 15:28	23.12.2024 14:42	Item
	05.09.2025 15:28	23.01.2025 12:55	Item
	05.09.2025 15:28	13.03.2025 13:30	Item
	07.01.2026 12:09	03.06.2025 15:56	Item
	19.01.2026 14:42	02.09.2025 10:00	Item

	12.02.2026 10:56	19.01.2026 14:49	Item
	12.02.2026 10:57	12.02.2026 10:57	Item
	14.05.2026 15:02	14.05.2026 15:02	Item

Path
sites/ABB_Informatics_Programmes/Lists/Risk Log
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Title	ID	Review Date	Cause	Event	Effect
High privilege accounts that have internet access	1171	30.04.2026	As a result of high privilige accounts (a user account with extensive administrative capabilities and access to critical systems and data) that has internet access	There is a risk that malware entered the healthboard through internet access and it affected one of these accounts, the elevated privileges could be used by the virus writers to cause significant damage to infrastructure and data.	Which would lead to service disruption across the healthboard through the introduction of malware, ransomware, and other malicious activity such as loss and integrity of data.

Threat detection within ABUHB estate	1175	30.04.2026	as a result of insufficient systems & tooling to monitor & provide accurate threat detection	There is a risk that a security breach is not detected early enough and will spread through the wider ABUHB digital estate.	Which would lead to service disruption accross the healthboard through the introduction of malware, ransomware, and other malicious activity such as loss and integrity of data.

Server certificate checks disabled	1177	31.03.2026	As a result of server certificate checks have been disabled for internet explorer and Edge browser	There is a risk that staff are able to access possible malicious websites	Which would lead to service disruption accross the healthboard through the introduction of malware, ransomware, and other malicious activity such as loss and integrity of data.

Use of non-compliant NDAA CCTV systems	1220	30.06.2026	As a result of CCTV systems in operation within the HB estate that are not compliant under the National Defense Authorisation Act (NDAA)	There is a risk that a malicious actor will exploit security vulnerabilities of the CCTV solution	Which would lead to disruption to the operation / availability of the CCTV solution and/or allow remote access to the camera's feed.
Inability to scan Sysmex EPU with Nessus.	1304	31.03.2026	As a result of conducting a nessus scan against 7A600SRVSMEXDB1 (10.65.160.218) & 7A600SRVSMEXDC1 (10.65.161.177), the sysmex EPU runs really slow and halts the clinical service.	There is a risk that nessus will prevent the clinical service from operating.	Which would lead to lack of visability around any potential security vulnerabilities exisiting on those servers.

Log4j 1.x EOL Vulnerabilities	1307	31.03.2026	As a result of multiple servers use Log4j version 1 for applications which has now reached end of life and is now vulnerable.	There is a risk that a someone could exploit one of the vulnerabilities within the expired package. These could lead to SQL Injection and remote code execution. a threat actor can attempt these actions by simply having access to the network.	This could lead to service downtime as the server would be have been exploited and can then lead to execution of further vulnerabilities. It can also lead to Data ex filtration.
RDP on Urology Diagnostic Device	1345	30.04.2026	As a result of RDP being enabled on the Urology diagnostic machine in order to extract legacy patient data	There is a risk that port 3389 may be used by malicious actors to compromise the device.	Which could lead to unauthorized access to patient data and overall compromise of network security
Firepower Management Centre Licence expired	1387	31.03.2026	As a result of licence expiry for Anti-Malware Protection, and URLfiltering on the firewalls at GUH, these protection mechanisms will cease to	There is a risk that loss of these protection mechanisms at GUH may allow access to malware	Which would lead to a Cyber Security Incident

Desktop Patching Non Compliance with Service Level Agreements (SLAs)	1956	30.04.2026	Remote Workers inconsistently connecting their devices through VPN is impacting the delivery of security patches to those devices which is refected in an inability to meet monthly Service Level Agreements for patching compliance.	Remote devices require VPN connectivity to recieve the monthly security patching updates. Failure to connect over VPN creates a security risk for the organisation until, the device is reconnected over VPN or the staff member returns to site and connects allowing patches to be applied. Unpatched devices are highly vulnerable to cyberattacks, potentially leading to data breaches, malware infections,	Compromised endpoint or endpoints would lead to service disruption dependent on what services were connected and risk to the Health Board through the introduction and possible spread of malware, ransomware, and other malicious activity such as loss and integrity of data.
Windows 10 End of Life	2030	30.04.2026	After the 14th October 2025 Microsoft will no longer provide free patch's and security updates for Windows 10	There is a risk that malware, ransomware or exploitable vulnerabilities cannot be mitigated	There is a risk that malware, ransomware or exploitable vulnerabilities cannot be mitigated
Tickertape is an aged and unsupported application.	2041	31.03.2026	The 3rd party supporting tickertape has been defunct in 2022. The application hasn't been updated since 2014.	This could lead to two undesirable outcomes. 1. that TickerTape become inoperable due to other client updates. 2. That a vulnerability is exposed and taken advantage of.	We could lose the ability to communcate with our end users in the event of incidents. Malicious messages could be sent if vulnerabilites are exploited. Failure to comply with a number of standards, inclusing ISO27001, Cyber Essentials, NCSC

Security of the Supply Chain	2045	30.06.2026	As a result of a connected third party that has been compromised may introduce vulnerabilities into the ABUHB digital estate.	A compromised third party supplier or vendor that is connected to ABUHB introduces malware ransonware into the estate through direct network connectivity or through information exchange.	Malicious compromise of ABUHB systems impacting delivery of clinical services to patients possible disconnection from national services. Inability to support delievery of services to patients. data loss/breach enactment of BC/DR reputational damage and a period of service loss that could be short term days

Shadow IT and Medical IoT Devices	2046	30.04.2026	As a result of the historical legacy of connected IoT devices and medical equipment that was not managed through DD&T or previously visible/discoverable These devices which often lack adequate hardware and software security measures and receive infrequent updates, may be compromised. Such vulnerabilities could allow unauthorised access or	A compromised device introduces and spread malware/ransomware into the ABUHB network or allows malicious actors to gain access to network	Impact and disruption to patient services, ransomware demands /data loss Cancellation of services invocation of BC/DR plans reputational damage.
Assurance around use of Artificial Intellegence (AI) Systems	2047	31.03.2026	As a result of sensitive patient information being exposed to AI large language models through the implementation and incresed use of AI systems within Health Board	Exposure to the large lanuage models used to train AI systems could lead to disclosure of confidential information with such data being accessible on the internet or being encorporated into external AI training datasets	Possible data loss reputational damage Increased scrutiny from ICO due to non compliance to legislative and regulatory compliance

Use of Generic Accounts	2137	30.06.2026	The continued use of generic accounts predomonantly in clinical areas is affecting the Health Boards ability to fulfill its regulatory compliance with NIS CAF regulations as an Operator of Essential Services.	The practice to authenticate to a PC with a generic log on in clinical areas is well known and tolerated However it does introduce risk in terms of audit and accountability as a number of users can be assigned to a generic account, It is also deemed as poor security practice under NIS regulations. Evidence that poor password management security practices are associated with generic accounts password details (written on whiteboards or stuck to PC or monitor)	Increased scrutiny from Cyber Resilience Unit as directed by Welsh Gov who are the competent Authority in Wales for NIS. Risk of penalties to include monetary fines if a compromised generic account was the cause of security breach.
NEQIS washers using internal ABUHB NTP server for date and time	2270	30.06.2026	Currently cant use FQDN based rules in RGH to reach out to 3rd party NTP servers.	3rd party has raised th concern that an old ABUHB server they previously pointed to has been decomissioned and now the devices are losing their time and date. if the battery backups fail or run out it will leave them with the incorrect time and date.	if a NTP vulnerability was exploited it could lead to further exploits with further malicous intent.

Date Identified	Raised By	Inherent - Likelihood	Inherent - Impact	Inherent - Risk Score	Risk Response
26.09.2017		2	5	10	Treat

14.03.2018	3	5	15	Treat

20.09.2021	Mark Goodwin (Aneurin Bevan UHB - Digital Data and Technology)	3	4	12	Treat

19.06.2024	Owen Plumpton (Aneurin Bevan UHB - Digital Data and Technology)	2	4	8	Treat
11.01.2024	Owen Plumpton (Aneurin Bevan UHB - Digital Data and Technology)	3	3	9	Tolerate

23.09.2024	Owen Plumpton (Aneurin Bevan UHB - Digital Data and Technology)	3	5	15	Treat
04.11.2024		1	3	3	Treat
12.09.2024	Richard Davies (Aneurin Bevan UHB - Digital Data and Technology)	3	4	12	Treat

08.08.2025	Mark Goodwin (Aneurin Bevan UHB - Digital Data and Technology)	3	4	12	Treat
26.09.2025	Stuart Fowler (Aneurin Bevan UHB - Digital Data and Technology)	5	5	25	Treat
29.09.2025	Geraint Powell (Aneurin Bevan UHB - Digital Data and Technology)	2	2	4	Tolerate

01.10.2025	Mark Goodwin (Aneurin Bevan UHB - Digital Data and Technology)	3	4	12	Treat

09.10.2025	Mark Goodwin (Aneurin Bevan UHB - Digital Data and Technology)	3	4	12	Treat
01.10.2025		2	4	8	Treat

30.06.2025	Mark Goodwin (Aneurin Bevan UHB - Digital Data and Technology)	3	3	9	Treat
23.02.2026	Owen Plumpton (Aneurin Bevan UHB - Digital Data and Technology)	1	1	1	Treat

Progress

2/3/26 MG Work to review accounts still ongoing and National projects to enhance security of privileged accounts is also progresing
27/11/2025 MG Work still progressing through NIS Assurance Group with updates to CRU. Cyber with assistance from Desktop Team Leader have developed scripts to allow reporting on privileged accounts doamin and local admins which have been audited by the Cyber Team . These audits will continue periodically (6mths) to ensure no stale accounts exist. Work still progressing nationally to expand use of MFA outside of that already implemented for M365

04/04/25 MG Progress to implement MFA for privileged account still being tracked through NIS recommedations Work being undertaken nationally around Password Policy that includes use of MFA accounts for privileged access to all systems above that currently required for M365. Continue to monitor improvement through NI and Nationally through OSSMB
13/11 MG Continue to progress remediation inline with NIS CAF recommendation
Capture on NIS CAF risk register remedial action plan in place to explore extending 2FA for privileged accounts. Periodic reviews of privileged accounts to be undertaken.
MG Update 6/24   Recommendations to cover privileged accounts is addressed through NIS CRU recommendations Cyber meeting monthly with CRU through 2024 to progress
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The Health Board has appointed two staff in the systems team to work on server patching and compliance. This has worked well and over 70% of the server estate will receive the latest security patches automatically.
These staff will also work on business continuity testing. The first continuity test is planned for March 2019 and a programme of tests has been established.
A task and finish group has been set up to review system capabilities. This group is working on improving the availability of essential services in light of the national directives. This group has not met since the last audit report, but work is underway to review the changes required to improve the resilience of CWS.
The two staff appointed into the systems team continue to work on server patching and

27/11/2025 MG Implementation of NGFWs progressing however project completion not until mid 2026. Firewall logs ingested into SIEM however along with range of other system logs suggest await completion of NGFW implementation project when log from all appliances will be ingested giving greater visibility

04/04/25 MS Sentinel implemented and ingesting range of security logs work continues to implement NGFWs Palo Alto's advanced URL filtering will remove issue aroiund Smoothwall appliance preventing tracing IoCs back to orginating IP Will kep risk open until Palo implementation and smoothwall replacement completed
13/11/MG SIEM implementation and configuration ongoing wil progress further when resources available following DC migration

1/6/24 SIEM now being implemented by DHCW work wil continue throughout 2024 solution basec on MS Sentinel
16/01/24 MG DHCW have reported to OSSMB that SIEM solution will be MS Sentinel DHCW currently working with MS to identify requirements and procurement dependent on funding
15/11/23 MG No progress from DHCW to report
20/09/23 -MG Still no decision from DHCW around procurement of google Chronicle however DHCW CRU have akso appraoched Microsoft with a view to review licencing model for MS Sentinel however seems a procurement decision is not coming soon either.
05/07/23 Confirmation that DHCW will procure Google Chronicle suggested by end of 2023
16/5/23 MG Current SIEM solution is logrythum However DHW will be procuring replacement estimated Q4 23. Most probably Google Chronicle Cyber will await this replacement and build its log management and capture around whichever solution is procured.
9/12/22 (MG) Cyber continuing to support national SIEM replacement through DHCW with recommendation for ABUHB SIEM Possible SEIM solutions are being reviewed by Cyber and ICT Teams for ABUHB. However existing national solution will lbe inplace for at least 12 months. Cyber has arranged LogRythum training for Team to allow support of the National SEIM during the transition and ICT Teams and Cyber continue their efforts to get Log ingested from ABUHB security appliances.

27/11/2025 Cyber to reengage with Desktop team at the monthly compliance meeting to reassess this risk

12/11 MG Chase with Desktops at next compliance meeting
6/24 No progress MG will address with Desktops to get answer and can then close call if already completed and not global change
16/01/24 MG Cyber Still need to seek confirmation that this is not global setting. once confirmed would move to accepted risk for annual review
15/11/23 MG Following discussion with Dan re these devices Cyber wil confirm that only associated to McKesson machines and if so would recommend acceptance of risk and reduction of risk score
19/09/2023 MG Cyber has discussed remediation with Desktop Team and Desktops believed it was not a global change Cyber will continue to investigate
05/07/2023 Cyber arranging meeting with Desktops to review creation of specific OU for these devices (10/07/23)
9/12/22 (MG) Cyber wil approach McKesson to identify and resolve issue as the initial approach to remediate. If following engagement with Vendor this issue cannot be resolve then Cyber will work with internal Teams to reduce risk by moving devices to separate OU within Active Directory where this specific policy can be applied therefore reducing the risk to the whole estate with having a global policy
28/10/2022 Ownership needs to be moved from Cyber to IT Support and remedial recommendations implemented
15/05/2023 Cyber needs to re-engage with Desktop Team to explore placing McKesson devices into separate OU where specific browser settings can be applied
Current remediation still being investigated
Recommendation would be to resolve underlying local issue . However MCKesson not encountered issue with other customers. System now live so efforts should be made to limit risk by creating an AD group with only those people that need access to Cardiology included

2/3/26 MG Facilities are working to develop a standardised approach for CCTV Cyber have provided the initial SBAR to support this approach Hopefully procurement of a single CCTV solution aligned to the new standard for ABUHB will beimplemented going forward

27/11/2025 MG Cyber continues to advise on the security issues related to existing non compliant CCTV systems and provide advice inline with the SBAR recommendations for new procurements.

04/04/2025 MG Need to be focus on progressing a single vendor solution for CCTV coverage across estate Currently Cyber have provided SBAR and recommendations on CCTV solutions to avoid use of vulnerable chipsets. The remediation of existing risk posed by CCTV systems already installed is reliant on solutions from Works and Estates and available funding being available.
13/11/24 MG there needs to be a review between stakeholders around CCTV with aim to reduce number of solutions and aim to install if possible a NDAA compliant single solution going forward Work will continue to remediate issue in 2025

14/8/24 MG Cyber have provided an SBAR specifically for Tredegar and also recommends that future procurements should aim to provide NDAA compliant CCTV products where possible to reduce risk of compromise. Facilities as owners of the CCTV service should assess the current and future CCTV requirements Cyber has provided its recommendations and will assist facilities with any assurance if required.

Currently SBAR has been raised in relation to Tredegar only full review of CCTV across the Health Board should be undertaken Cyber will work with Project Team and Works and Estates on this issue
27/11/25 mG Currently no plans to upgrade from supplier so probabbly looking at future releases Cyber will continue to review risk and monitor any alerts/vulnerabilities against these servers while these servers remain excluded from VMS.
04/04/25 MG No movement on remediation of this risk and as stated no appetite to remediate from supplier Risk posture is to tolerate risk with scheduled reviews or if any unplanned incident requires review
14/08/24 MG Vendor shows no appetite to remediate this issue with Nessus scanning and Cyber have exhausted all efforts to remediate internally. Currently the servers are subject to our monthly patch management process and protected via Sophos for Antivirus they are however not subject to monthly VMS scans. This risk needs to be rescored to reflect risk of lack of VMS scanning.

12/03/26 MG Progress not being seen to be made on this risk Cyber need to escalate through SDMG

27/11/25 MG Progress has slowed with the ongoing identification and removal of this legacy application as there is a reliance on third party to carry out the removal or remediation ans some reluctance especially on live clinical applications. Cyber will continue to highlight this with DD&T teams and service mangement to progress
04/04/25 MG work has been undertaken to remove Log4J version one from internal managed systems however more effort is required to remediate risk from legacy third party applications. Cyber will rerun report and work with clinical Teams and suppliers to detail remediation
02/10/2024: networks removed the application form their servers. 08/10/2024 Voice have reached out to the 3rd party as no current update plan in place until one is built which may incur a cost.rty
2/3/2026 MG Need to speak to RPA Team to determine progress so that this temporary solution can be removed in favour of a permanent solution
28/11/25 HJ: contacted MD around this risk and informed me to contact to MA as its to do with RPA. After speaking to MA, this has been on hold due to other priorities. This will get picked up in due course.

Project kick off completed with Block, works ongoing for HLD/LLD

2/3/2026 MG WuFB now the main method for deployment WSUS stil used to limited degree but level of patching compliance has increased to over 92% and progress to meet SLA is captured within monthly cyber report

27/11/25 MG WuFB now implemented and levels for patch comp;iance are increasing Cyber will continue to monitor SLA monthly until roll out completed and SLAs recover to optimal level

Currently ABUHB Desktop Team are working with DHCW to address enrolement of devices and reporting accuracy before deployment of Windows Updates for Business. Until these issues are resolved then accurate patching SLA figures cannot be generated and devices remain at risk due to missing security updates.

2/3/26 MG Extended support provided for all BUHB managed devices project in place to remediate the small number of third party devices that will require upgrade.
Risk paper produced, Senior management agree to purchase Extended support
27/11 MG Confirmation recieved that all of the Windows 10 devices managed by DD&T and not yet upgraded to windows 11 will recieve Microsoft Extended Security Updates and also that funding has been made available to replace those ABUHB supplied Win10 devices that cannot currently be upgraded to Window 11. This will stil be managed through the ongoing upgrade project. Risk score has been reduced to reflect extended security support

06/01/2026 Cyber has commented on this risk as requested no update following Cyber comments passing risk to Service Management ownership/assessment as part of communications platform to support incident management Have extended review date to 31st March to allow for Service Management comment a possible procurement in 2026 financial year

2/3/26 MG Business Support still developing enhancements to supply chain reviews with support from Cyber Team.

Supply chain security is a recommendation arising from NIS CAF. Progress is being driven and reported throug NIS Assurance Group

Work to complete the implementaion of NGFW is ongoing
Cyber woring closely with Networks to identify IoT devices and alerting around IoT
Progress to identify the exact nature of these discovere devices and then work with clinical services and third parties to address identified vulnerability will progress into 2026 with a dependancy on completion of NGFW intallation outside of GUH. which is currently the only site.

Currentl blocking all AI other than licenced MS Copilot
and restricted group of users for Chat GPT based on a requirement for business support activities

06/01/2026 Risk still reported through NIS to CRU and managed through NIS Assurance Group. The limited introduction of Imprevata will be delayed into 2026 financial year possibly July 2026 this has been reported to CRU and therefore amending review date to June 2026
14/11/2025 Progress reported bi monthly through NIS Assurance Group and also to CRU as updates. Risk has been raised to DD&T risk register and reworded to include the Health Boards regulatory requirements as an OES towards NIS(R) Funding has been obtained to introduce Imprivata into a number of busy clinics bt this work will not commence until 2026. Cyber will track implementation progress throughout 2026 through NIS Assurance group

Current - Likelihood	Current - Impact	Current - Risk Score	Risk Report Link	Status
2	5	10		Open

2	4	8	Open

2 4 8 Open

2	4	8	Open
3	3	9	Open

3	5	15	Open
1	3	3	Open
3	3	9	Open

3	3	9	Open
3	4	12	Open
2	2	4	Open

3	4	12	Open

3	4	12	Open

2	4	8	Open

3	3	9	Open

1	1	1	Open

Agenda Item:

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	10 June 2026
CYFARFOD O: **MEETING OF:**	Finance and Performance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Assurance Report from the Digital, Data and Technology Group
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Paul Solloway – Director of Digital
SWYDDOG ADRODD: **REPORTING OFFICER:**	Paul Solloway – Director of Digital

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Digital, Data and Technology (DDaT) Directorate continues to deliver a broad portfolio of digital transformation and ICT activity aligned to the Health Board's operational priorities. Since the last report, progress has continued across several major programmes, including OpenEyes deployment in secondary care ophthalmology, local mobilisation for ophthalmology e-referral solution, continued rollout of CareFlow Connect, live deployment of the mortuary solution, EDEN, mobilisation of the Mental Health and Learning Disabilities (MH&LD) electronic patient record (EPR), and readiness for the June pilot of electronic Prescribing and Medicines Administration (ePMA).

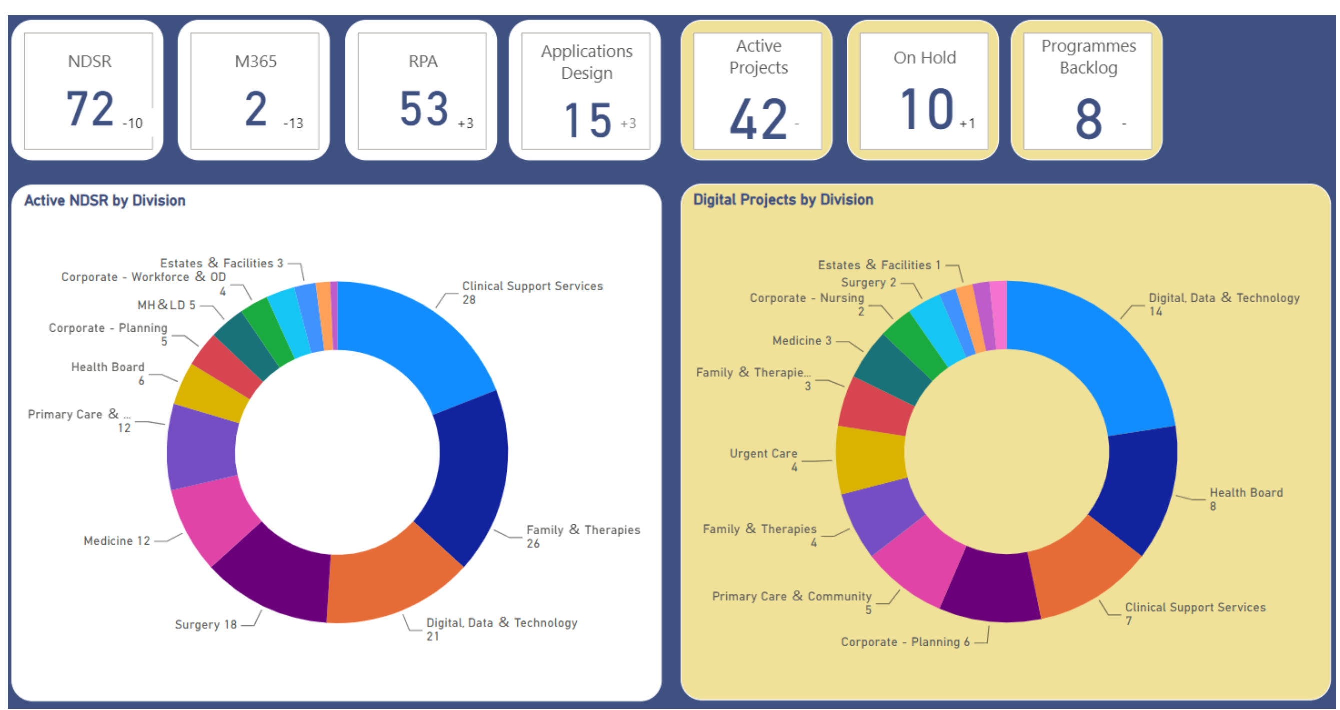
The main areas requiring ongoing oversight remain programmes dependent on national decisions, third-party suppliers, infrastructure readiness or specialist technical capacity. The most significant delivery pressures continue to relate to Laboratory Information Management System (LIMS 2.0), Radiology Information Systems Procurement (RISP), the replacement of Welsh Community Care Information System (WCCIS), Digital Dictation and Digital Health Communications, alongside wider infrastructure and software development constraints. These risks are also monitored as strategic and corporate risks.

Recent enhancements to the New Digital Service Request (NDSR) process and Divisional Engagement Meetings (DEMs) continue to broaden and clarify divisional endorsement and oversight of the digital portfolio.

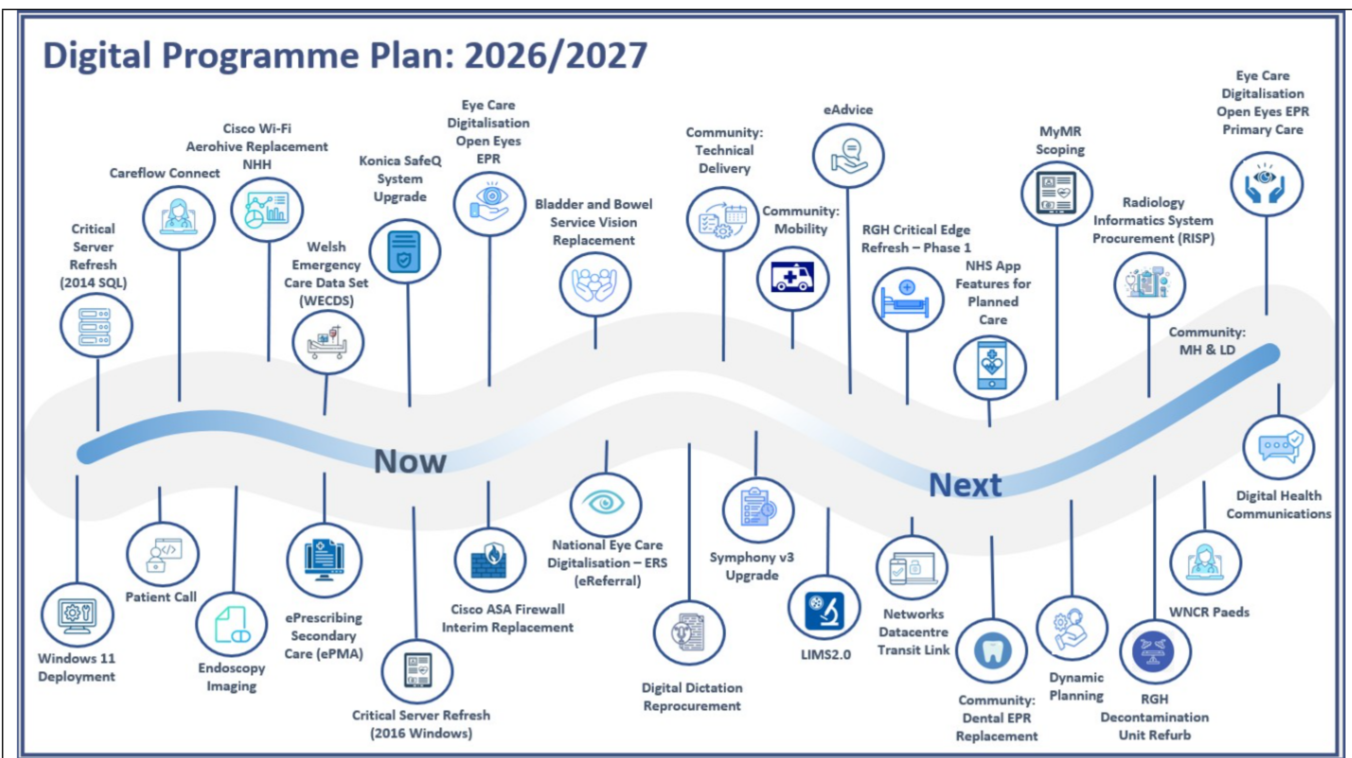
This report provides the Finance and Performance Committee with an update on recent delivery progress, key risks, financial and operational dependencies and the actions being taken to maintain momentum across the portfolio.

Cefndir / Background

A summary view of the digital portfolio is shown below:



A high-level roadmap of major digital projects can be found below:



Asesiad / Assessment

Recent programme and project updates indicate continued delivery across the portfolio, with a clear focus on those areas with material implications for performance, operational continuity, financial exposure and delivery confidence.

Major digital transformation projects are split across seven programmes and the key points for committee attention are summarised below.

1. Acute Programme

Eye Care Digitisation

Progress has accelerated in ophthalmology:

- OpenEyes is now live across secondary care ophthalmology services, except for cataracts, which remains paused pending biometry integration and confirmation of funding. Scoping for primary care rollout is continuing.
- Local readiness for a June 2026 implementation of OPERA, the national e-referral solution, has progressed with mobilisation documentation complete, the user testing environment established and tested and hazard review undertaken.
- Delivery risk remains high due to the number of interdependent ophthalmology changes and because there is still no confirmed national plan for funding or contractual continuity for OpenEyes and OPERA beyond 2026/27. This risk has been escalated through regional and national governance routes.

Digital Dictation Procurement:

Procurement for the replacement Digital Dictation, speech recognition and ambient AI solution has concluded, with a preferred supplier identified. The business case is progressing through internal governance, and immediate focus is on addressing usability, stability and scalability issues associated with the current solution. Contract extension arrangements for the incumbent supplier continue to be explored to maintain service continuity ahead of implementation.

Other key projects within the Acute programme include:

- The Welsh Emergency Care Data Set (WECDS) remains configured but national key performance indicator decisions are still pending with Welsh Government putting a hold on confirmation of the new measures until the new government is in place.
- Symphony v3 upgrade in Emergency Departments (ED) will commence following contract signing, with further scoping work on the roll out of Symphony into assessment units.
- eAdvice development is planned to restart later this year.

2. Digital Ward Programme

The programme continues to develop the digital infrastructure needed to support safer and more efficient inpatient care.

- Digital Health Communications has advanced into formal procurement phase, with the invitation to tender issued in April 2026. Significant preparatory work has been undertaken, including network surveys and development of infrastructure options; however, delivery remains highly dependent on the scale, cost and timing of network remediation required across hospital sites.
    - This creates both a delivery and financial planning dependency that will need to be managed through the next phase of the project.
    - A business case is being drafted and will be shared through internal governance processes on completion of the procurement evaluation.

Key risks with this project include:

Description	Score	Action Plan
Implementation of replacement solution before end-of-life contract dates for Vocera and paging solutions	12	Close monitoring of procurement and project timescales
Technical dependencies on wireless network (Wi-Fi) and infrastructure across the estate	12	Development of a phased implementation plan

- CareFlow Connect has moved beyond pilot stage and further rollout is progressing.
- Paediatric Welsh Nursing Care Record (WNCR) activity is also progressing, although national funding and workforce availability remain constraints.

This programme is strategically important for operational resilience, but delivery confidence is partly contingent on infrastructure investment decisions and sequencing with other digital and estates activity.

3. ICT Programme

The ICT programme continues to underpin delivery across the wider portfolio. Progress has been made in server refresh, Windows 11 deployment, firewall replacement and support to major estates developments. Recent programme

activity also highlights increasing focus on cyber resilience and replacement of ageing infrastructure, including new work associated with implementation of the new Internet filtering solution and wider network remediation. The main constraints remain specialist technical capacity, competing infrastructure priorities and the need to complete enabling works in time to support dependent transformation programmes.

This remains a cross-cutting dependency for portfolio delivery, with a continued requirement to prioritise finite technical resource against operational, cyber and transformation demands.

4. Clinical Support Services Programme

This programme includes some of the biggest challenges and risks in the digital portfolio.

LIMS 2.0 remains delayed at a national level and is currently expected to extend into quarter 1 2026/27, with the potential for further slippage into quarter 2 still under assessment. The Health Board's share of the currently identified delay cost has been confirmed at £0.76m, split across capital and revenue in line with the national business case methodology. Welsh Government has indicated verbally that quarter 1 delay costs will be supported, although formal written confirmation is still awaited. Whilst Cellular Pathology and Andrology are now live, Microbiology and Blood Sciences remain subject to national re-planning.

RISP is currently scheduled to go live on 22nd June 2026, but programme risk remains elevated due to supplier delays, technical documentation issues and the need to maintain business continuity ahead of existing contract timelines. In response, a short-term decision has been taken to move radiology test requesting and image viewing from Clinical Workstation (CWS) to Welsh Clinical Portal (WCP) to reduce implementation risk and support service continuity.

EDEN, the Health Boards Mortuary solution is now live, while the national procurement for Digital Cellular Pathology is also progressing.

5. ePMA Programme

The programme has made substantive progress since the previous report. User Acceptance Testing (UAT) has completed and been signed off, implementation governance has continued and a pilot go-live is scheduled for June 2026. This programme remains a high strategic priority given its direct contribution to medicines safety, standardisation and operational efficiency.

6. Digital Community Programme

The replacement programme for WCCIS has progressed into the final stages of contract negotiation for the Rio EPR, with programme governance established and detailed implementation planning underway. The extension of the current WCCIS contract to September 2027 has reduced the immediate risk of service discontinuity, but the strategic requirement to replace the legacy platform remains and the programme continues to work to a March 2027 implementation target.

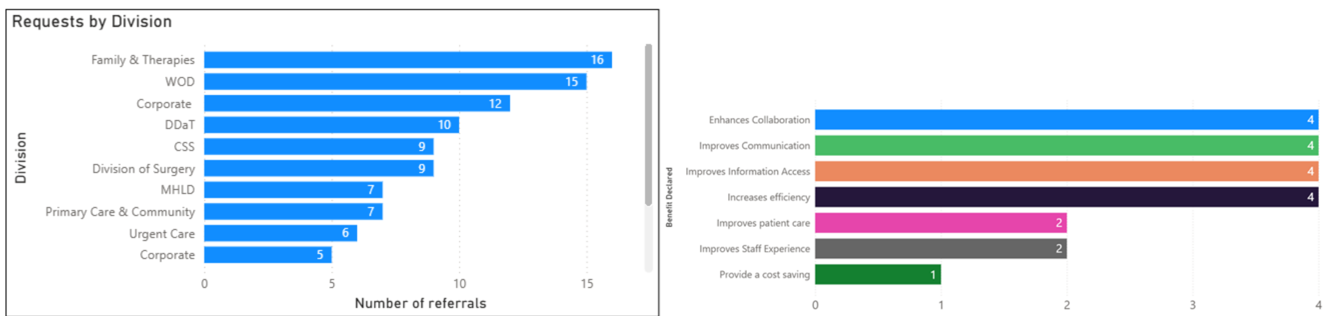
The key committee consideration is continued oversight of delivery pace against the revised contract position, ensuring that available time is used to strengthen readiness, migration planning and clinical engagement.

7. Digital Patient Programme

Delivery continues across patient-facing services, with ongoing expansion of digital communications capability and the continued use of the NHS Wales App to improve access to appointments and waiting list information. Current activity is focused on the continued phased implementation of digital letters. My Medical Record remains established for prostate cancer self-management, with additional service opportunities being scoped. The programme continues to support both patient experience and administrative efficiency, although progress in some areas remains dependent on defect resolution and service readiness.

Microsoft 365 Transformation

The Microsoft 365 workstream continues to support productivity, collaboration and service redesign opportunities across the organisation.



Programmes Backlog and Scoping

Several projects remain on the backlog awaiting progression, including the national Welsh Intensive Care Information System (WICIS), ESR 2.0 and a future project within the Clinical Support Services Programme to procure a replacement theatre solution.

Several new initiatives also remain in discovery or strategic review, including digital consent, telephony infrastructure, patient flow and optimisation of existing tools such as the complex care list. These areas are being considered through the strengthened portfolio prioritisation and divisional engagement arrangements to ensure that future investment and delivery remain aligned to organisational priorities and available capacity.

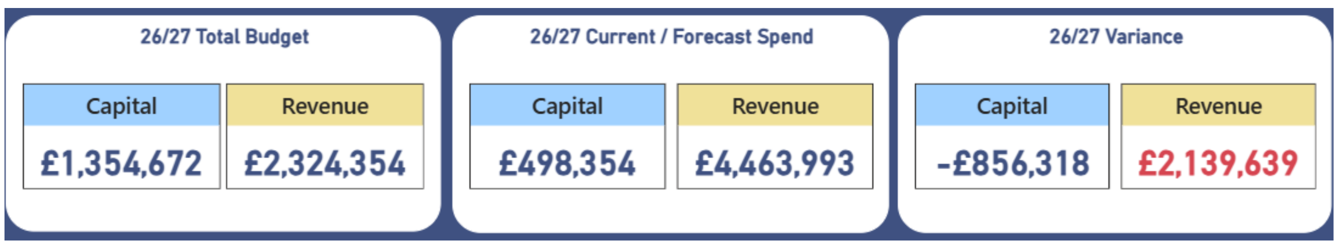
Financial position:

The key financial risks for the Committee relate to the affordability of enabling infrastructure, the local impact of national programme delays and the ongoing revenue consequences of approved business cases where recurrent funding has not transferred into baseline budgets.

These issues are being managed through phased business case development, escalation of national funding risks and close oversight of programmes with the

greatest financial exposure, including LIMS 2.0, RISP, Digital Community, ePMA, Digital Dictation and Digital Health Communications.

Finance summary:



The £2,139,639 revenue variance for 2026/27 is partly due to historic unfunded programmes. It also reflects more recent business cases approved by the Health Board where no recurrent funding was delegated to the budget including RISP, ePMA and Digital Community.

DDaT continues to seek funding through the Welsh Government Digital Priorities Investment Fund (DPIF) for Digital Community and ePMA. For 2026/27, funding has only been confirmed in principle for ePMA, and the Health Board is still awaiting the formal funding letter.

Although Welsh Government and DPIF funding support digital transformation, they do not meet the ongoing operational costs that fall to the Health Board once systems are implemented. As a result, approved business cases such as RISP, Digital Community and ePMA create continuing revenue commitments for the lifetime of those systems.

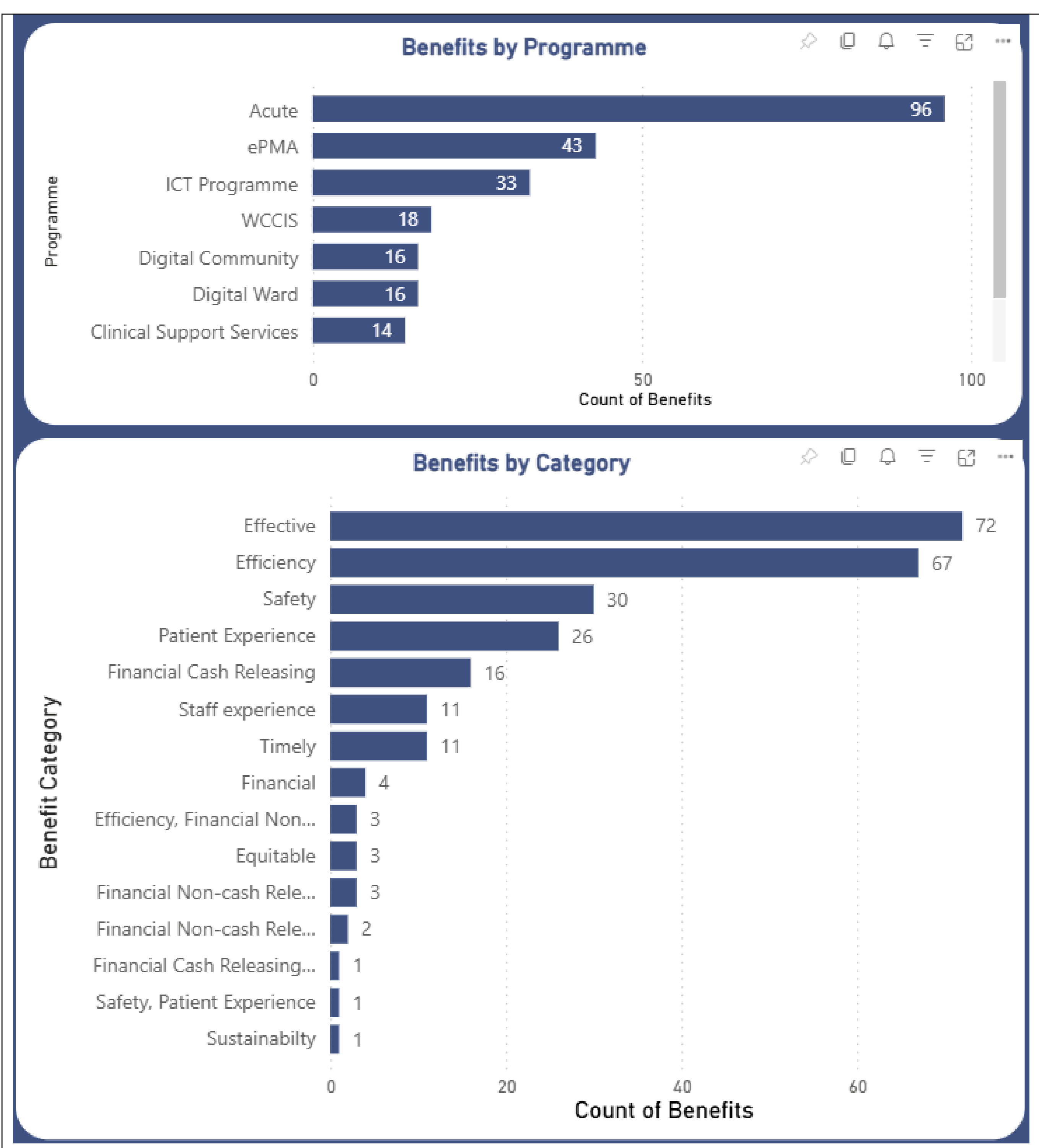
Portfolio Management and Strategic Alignment

Alongside programme delivery, the directorate continues to mature portfolio governance through Divisional Engagement Meetings, prioritisation processes and alignment of digital plans to the Integrated Medium-Term Plan. Work is also continuing the refreshed Digital Transformation Strategy and on development of the Clinical Workstation business case, both of which will shape future investment choices and delivery sequencing.

Benefits

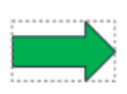
Overall, recent updates show continued delivery momentum and a growing evidence base of operational benefit, including improved clinical workflow, reduced reliance on paper and manual processes, stronger digital communication with patients and better foundations for resilience and productivity.

Each project tracks benefits through to realisation with frequent and ongoing benefits reviews. Programme teams are currently tracking over 230 benefits:



The following benefits have been realised since the last report in relation to the Winpath, blood transfusion system, implementation:

Clinical Support Services (CSS)
Blood Transfusion System Replacement (WinPath) Benefits Update



WINP01 - Efficiency

What? – Reduction of **20 hours per month** manually inputting blood group results.

Benefit Review Status – DELIVERED

WINP03 - Timely

What? – Faster processing of antenatal samples. Previously took an average of **25 days**. Results now available within **24 hours.**

Benefit Review Status – DELIVERED

WINP04 - Financial

What? - £2075.88 saved in FY25/26 £4151.75 in FY26/27. **Total saved £6227.64.**

Benefit Review Status – High Confidence to be delivered

WINP09 - Efficiency

What? – Automated rules eliminate manual entry and oversight, ensuring **100% compliance** in RHKel testing and **preventing risk of inappropriate blood issuance.**

Benefit Review Status – DELIVERED

Clinical Support Services (CSS)
Blood Transfusion System Replacement (WinPath) Benefits Update

WINP08 - Efficiency

What? – Reduction in TAT (turnaround time) as WPE **auto-validates** viable results. Target not met due to WPE **thorough** processes but new emergent benefit.

Benefit Review Status – Closed but emergent benefit raised (WINP10)

WINP10 – Effectiveness

What? – Enhanced **business intelligence,** ensuring 100% compliance through better **data quality.** Reducing **clinical risk,** improving long-term **reporting** capabilities.

Benefit Review Status – High Confidence to be delivered

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to note the recent progress across the digital portfolio, the benefits being realised or enabled through current delivery, the key risks and dependencies affecting major programmes and the mitigating actions in place to support affordability, operational continuity and delivery confidence.

Assurance is strongest where programmes have clear local control and defined implementation plans. Residual risk remains concentrated in nationally dependent or infrastructure-intensive programmes, where timescales, affordability, supplier

performance or technical readiness could affect delivery confidence and therefore continue to require enhanced oversight.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.4 Information Governance and Communications Technology 4.2 Patient Information 6.2 Peoples Rights 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well High quality care and best health outcomes for all
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Digital, Data, Intelligence
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve access to information and services for all communities Support equitable digital access and inclusion in service transformation

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	CWS – Clinical Workstation DDaT – Digital Data and Technology DEM – Divisional Engagement Meeting DHCW – Digital Health and Care Wales DPIF – Digital Priorities Investment Fund ED – Emergency Department EPR – electronic patient record ePMA – electronic Prescribing and Medicines Administration IMTP – Integrated Medium-Term Plan

	LIMS – Laboratory Information Management System M365 – Microsoft 365 MH&LD – Mental Health & Learning Disabilities NDSR – New Digital Service Request OPERA – Ophthalmology Patient Electronic Referral Application RISP – Radiology Information Systems Procurement UAT – User Acceptance Testing WCCIS – Welsh Community Care Information System WECDS – Welsh Emergency Care Data Set WCP = Welsh Clinical Portal WICIS – Welsh Intensive Care Information System WNCR – Welsh Nursing Care Record
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	Not Applicable
• **Workforce**	Delivery depends on a combination of programme resource, clinical engagement, digital specialist capacity and technical infrastructure expertise. Current pressures relate particularly to finite implementation, software development and infrastructure resource, which require active prioritisation across operational, cyber and transformation demands. These constraints are being managed through phased delivery, strengthened portfolio oversight and use of national or supplier support where available.
• **Service Activity & Performance**	The portfolio is intended to improve service access, operational efficiency, data quality and clinical safety through reduced manual processing, improved information flow, better communication with patients and more reliable digital support for front-line services. Short-term performance risk remains where programmes are dependent on national timescales, supplier readiness or local infrastructure, and these areas are subject to enhanced monitoring and mitigation to protect continuity of service.

• **Financial**	Financial impact is currently linked primarily to national funding availability, business case approvals, contract timing, supplier dependencies and the affordability of enabling infrastructure. There remains a risk of additional local cost pressure or slippage where national programmes are delayed or where interim arrangements are required to maintain service continuity. These risks are being managed through business case controls, contract oversight, escalation through national governance routes and prioritisation of investment against organisational capacity and benefit.
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Not Applicable
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	10 June 2026
CYFARFOD O: **MEETING OF:**	Finance and Performance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Stroke Improvement Plan Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Neil Miles, Programme Director, Allied Health Professions and Health Science

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The Aneurin Bevan University Health Board Regional Stroke Network Group was reformed in late Q3 2025/26 to:

- re-establish a strategic focus on the stroke improvement plan,
- consider the implications and opportunities of the then forthcoming Wales Quality Statement for Stroke (February 2026) and new NHS Wales Stroke Service Standards (October 2025)
- provide strategic oversight to changes to the delivery of stroke services in the Health Board

The Network Group also has a leadership role in linking with the national NHS Wales Stroke programme team and neighbouring South Central Stroke network covering Cardiff and Vale and Cwm Taf University Health Boards.

More recently, the (under-development) Health Board Urgent and Emergency Care Improvement and Stabilisation Plan includes Stroke Improvement as one of its 5 key workstreams.

This paper seeks to provide assurance to the committee of the work underway to improve stroke outcomes or our population by:

- documenting the plan and governance to improve stroke services for our population
- outlining the current position with regard to stroke service improvement in Aneurin Bevan University Health Board

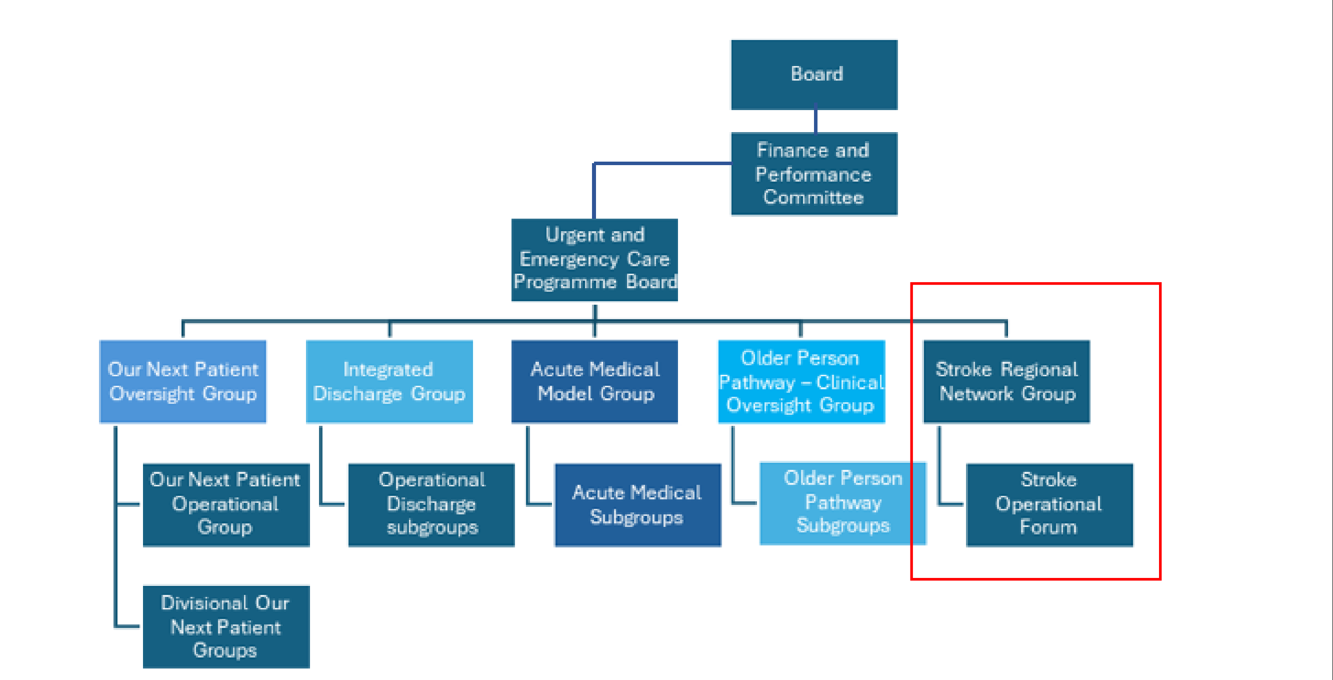
Cefndir / Background

The Stroke Programme aims to improve stroke survival rates and patient outcomes by enhancing every stage of care. The purpose is to optimise and maintain standards in provision of rapid access to emergency treatments (Scanning/thrombectomy/thrombolysis), timely access to specialist rehabilitation, and long-term, community-based support to maximize independence and quality of life for the population of Gwent.

Stroke service governance

The Stroke Network Regional Stroke Network Group is chaired by Peter Carr, Health Board Executive Lead for Stroke and includes members from the 3rd sector, Llais and NHS Performance and Improvement stroke team.

Currently, the Network Group is supported by a monthly Operational Forum. This has been focussed on the transition of inpatient rehabilitations services at Ysbyty Ystrad Fawr and comprises of colleagues and professions from operational teams involves in the stroke pathway.



UEC Programme Governance and Accountability structure

As part of the establishment of the UEC programme, additional subgroups are proposed to support the work on stroke, comprising:

- Prevention & Awareness
- Hyper Acute Care Standards (Scanning/Thrombolysis/Thrombectomy)
- Rehabilitation Model
- Community Support, Reablement and mitigation of further stroke risks

In addition to the establishment of the workgroups, alongside the other key UEC improvement areas, further support from corporate planning, finance and workforce teams will be established to support the executive lead and the Divisions in developing and delivering this detailed improvement programme with associated performance information, monitoring and reporting.

The stroke network group has the following aims and objectives:

Aims

- Primary prevention – seek to prevent as many strokes as possible, by working to improve the detection and management of underlying risk factors for stroke.

- Awareness raising – work to understand public awareness of stroke symptoms, and the action required when they occur, and support the delivery of FAST campaigns.

- Hyperacute care – optimise initial scanning and delivery of thrombolysis and efficient transfer of those requiring a thrombectomy service

- Early secondary prevention – seek to prevent as many additional strokes as possible by optimising the care of those who have suffered a stroke or TIA.

• Rehabilitation – Ensure the provision of high quality, holistic rehabilitation that is person-centred, accessible, delivered in the appropriate setting and patient outcomes and experiences measured.

• Psychological care – Ensure that the emotional and cognitive needs of those who have survived a stroke are given the same level of importance as their physical needs and recovery.

Objectives

• Acute Care Improvement: Improving timely access to Specialised Hyperacute Stroke Unit to improve timeliness and rates of brain scans, thrombolysis and thrombectomy (where transfer required to a specialist tertiary hospital)

• Specialised Rehabilitation: Embedding of Stroke Sub Acute Rehab model and community-based, person-centred rehabilitation to improve long-term outcomes.

• Integrated Care: Ensuring on-going support and rehabilitation for survivors within the community supported by specialist community practitioners

• Data & Quality Control: Utilizing the Sentinel Stroke National Audit Programme (SSNAP) to monitor performance and drive improvements.

• Workforce Training: Enhancing staff training and modernising the stroke workforce to ensure high-quality care

National stroke guidance and support

Stroke services in Wales are supported by a national meeting structure and team via NHS Wales Performance and Improvement. There are (part time) clinical and managerial leads in the national team. In addition, funding has been available for the past 18 months to the region in Wales to employ a dedicated stroke programme manager to support the whole pathway and improvement and transformation work.

In our region this role has supported the roll out of Brainomix imaging software, pre hospital video triage, stroke pathway flow improvements and the data collection and submission of the SSNAP audit data amongst many other operational improvements and collaboration with the network team. On the 31st March 2026 all regions were advised that these posts would cease to be funded centrally with a 12 week notice period. As with other areas of Wales, Aneurin Bevan University Health Board does not have funding to continue this role from its own resources.

The national stroke programme has produced two key guiding documents for the provision of stroke services in Wales in 2026:

- Welsh Government Quality Statement for Stroke (February 2026)
- NHS Wales, Stroke Service Standards (October 2025)

The Quality Statement outlines the ambition to reduce stroke incidence and improve outcomes of those who experience a stroke in Wales through the following approach

The NHS Wales Stroke Standards outline how health boards should resource and organise services to meet the ambition of the Quality Statement through the following areas:

- Infrastructure Standards
- Workforce Standards
- Clinical Standards

This includes the definitions and facilities required for acute and rehabilitation in patient care, community support post stroke, imaging standards and expectations, timeliness of access and workforce levels and hours of coverage required.

A review of current health board services against these new stroke standards is currently underway. These results are being shared with NHS P&I and collated across Wales and published. Whilst we are completing our review in Q1 it is not expected that the all Wales picture will be published until Q2/Q3 2026/27. Meetings are currently on going between P&I and the Health Boards to ensure consistency is being applied to interpretation of the standards and health board services when completing the returns.

Asesiad / Assessment

Stroke performance is monitored through the submissions of returns to the Sentinel Stroke National Audit Programme (SSNAP) by the Health Board. This national, peer reviewed and validated audit is published quarterly (one in arrears) and allows comparison between all stroke units in Wales, England and Northern Ireland.

The same information is submitted to NHS Wales Performance and Improvement on a monthly basis and a Power BI dashboard is published giving a monthly update and comparison between Welsh Stroke Units.

High level performance aims include:

- A minimum of 40% of patients having had a brain scan completed within 20 minutes of arrival to hospital
- A minimum of 20% of patients have received thrombolysis and ideally within 30 minutes of arriving to Hospital
- A minimum of 50% of patients admitted or transferred to a specialist stroke ward within 4 hours of arrival to Hospital
- Patients receiving specialist therapy assessment (Physiotherapy and Occupational Therapy) within 24 hours of arrival to hospital and 72 hours for Speech & Language therapy

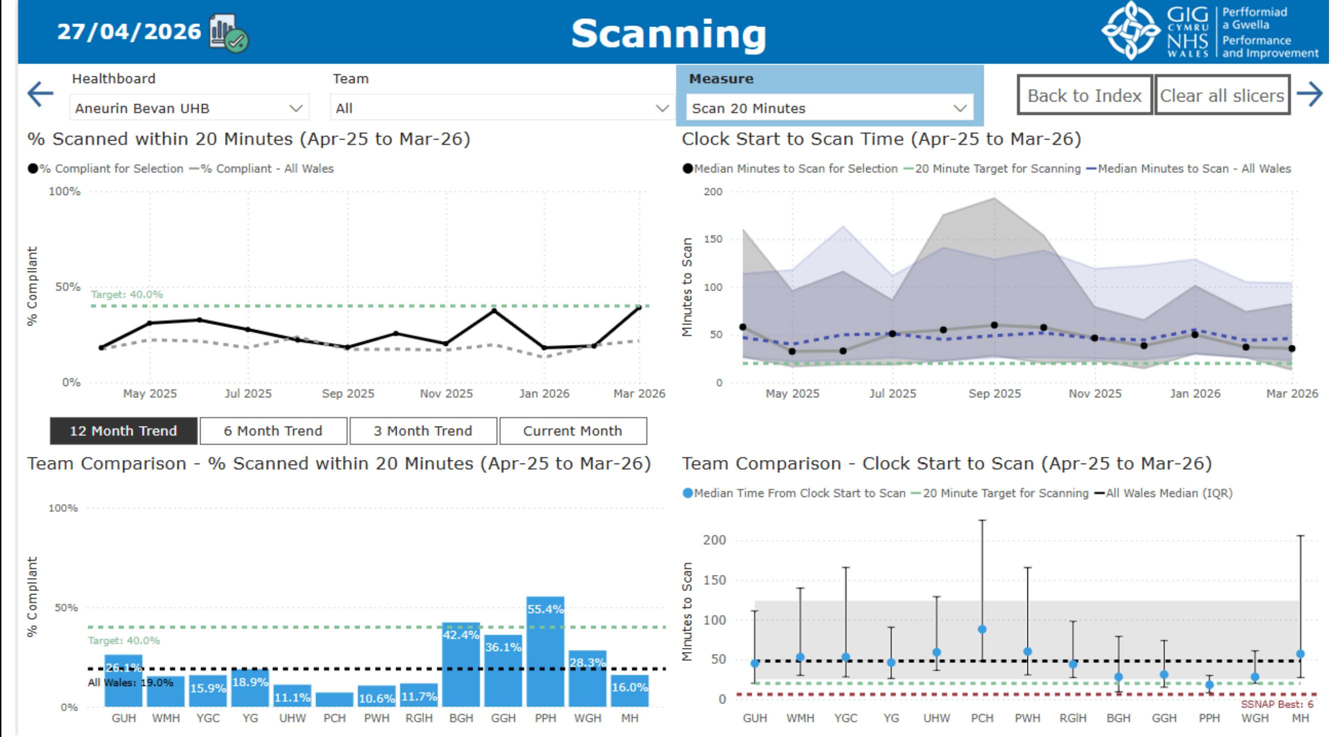
An update on these measures is presented to the Health Board as part of the overall Performance report on a bi monthly basis.

The NHS Wales Power BI dashboard collects and publishes the following measures, allowing all13 stroke units in Wales to be compared

- Scan <= 20 mins
- Thombolysed %
- Door to Needle < = 30 mins
- -ASU< = 4 hours
- Swallow Screening < = 4 hours
- Consultant < = 14 hours
- One Therapy < = 24 Hours
- Occupational Therapy < = 24 Hours
- Physiotherapy < = 24 Hours
- Formal Swallow Assessment < = 24 Hours
- Speech and Language Therapy < = 72 Hours
- 90% Stay on Stroke Unit Patients screened for nutrition & seen by a dietitian by discharge %
- Patients discharged with Early Supported Discharge (ESD)/Community Therapy MDT %
- Six Month Follow Up

The four key performance measures show the following trends over the past 12 months

1. Arrival at hospital and CT within 20 minutes

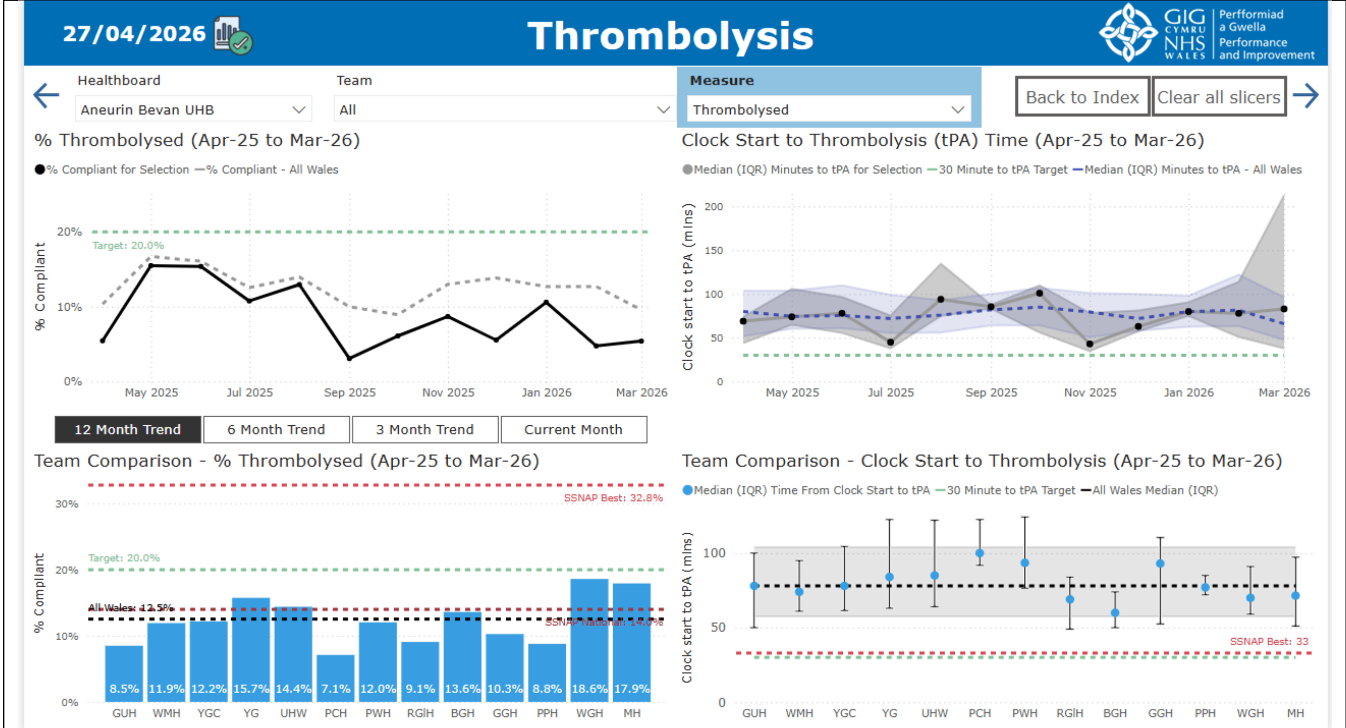


The above illustrates that whilst there has been some improvement in recent months, twice reaching the 40% target, over the past twelve months performance has been quite static. Recent steps to improve flow generally in ED at GUH have assisted with the recent improvement and there is a need to fast track more consistently those patients suspected of a stroke to CT scanning.

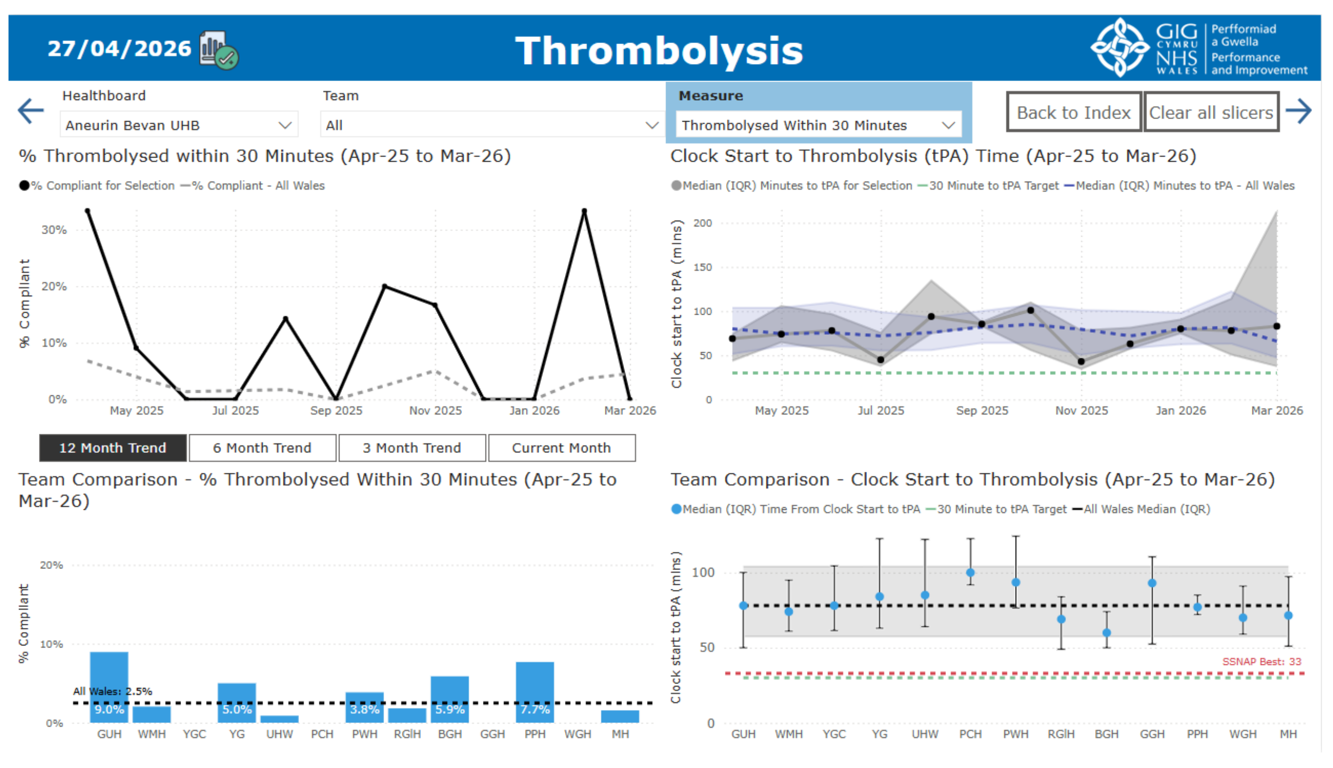
Pre hospital Video triage is also assisting in identifying those in urgent need of a scan prior to them arriving at the Grange.

The GUH performance is above the Welsh average over the past twelve months and stronger than similarly sized large stroke units elsewhere

2. % of patients receiving thrombolysis within 30 minutes



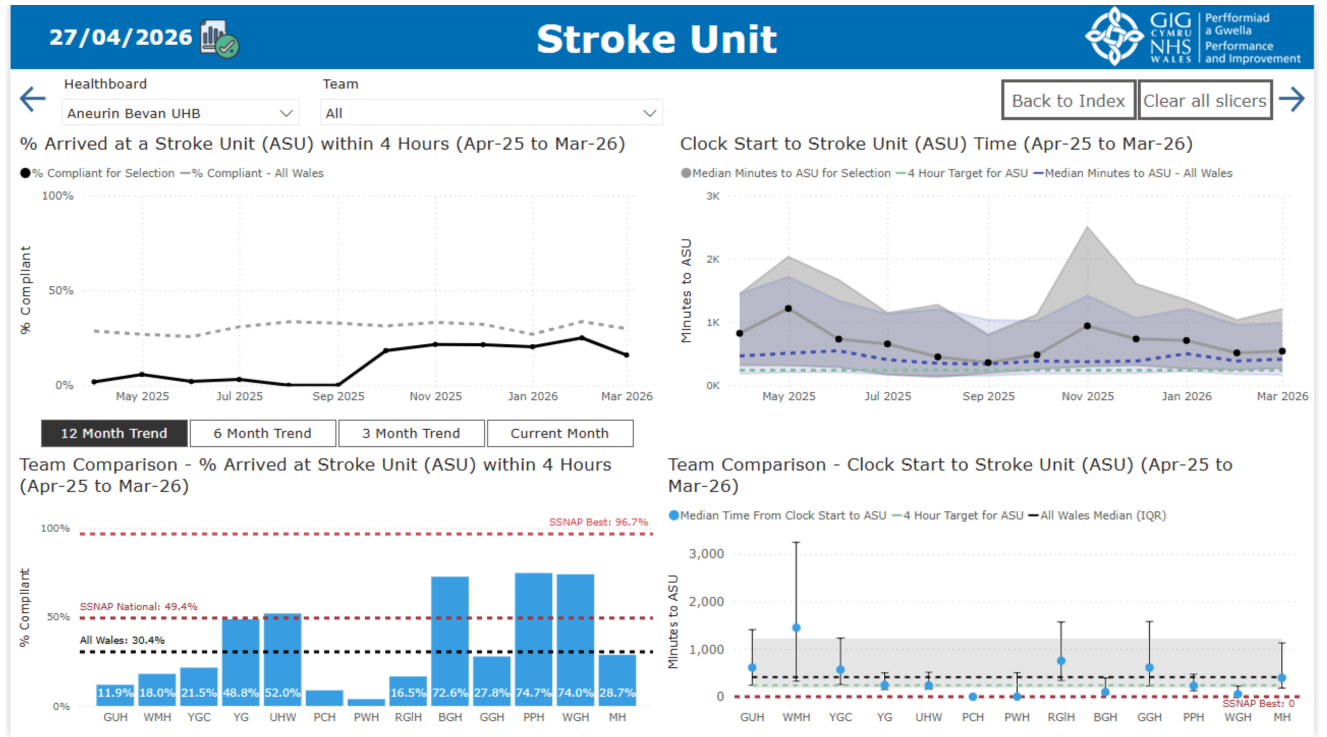
Overall performance on percentage of patients receiving thrombolysis is low and has declined slightly this year and is below the Welsh average and lower than similar sized units.



However, of those who are thrombolysis a high proportion are completed within the 30minute target which is higher than other units.

One aspect of the improvement plan to develop is perfusion CT scanning at the GUH which will support an increased thrombolysis window post stroke from 4 to 9 hours, bringing GUH in line with other units and facilitating greater levels of thrombolysis. The national team are developing new clinical pathways to support this and the new ABUHB Clinical Director for Stroke is working with the national leads to roll this out in GUH with colleagues.

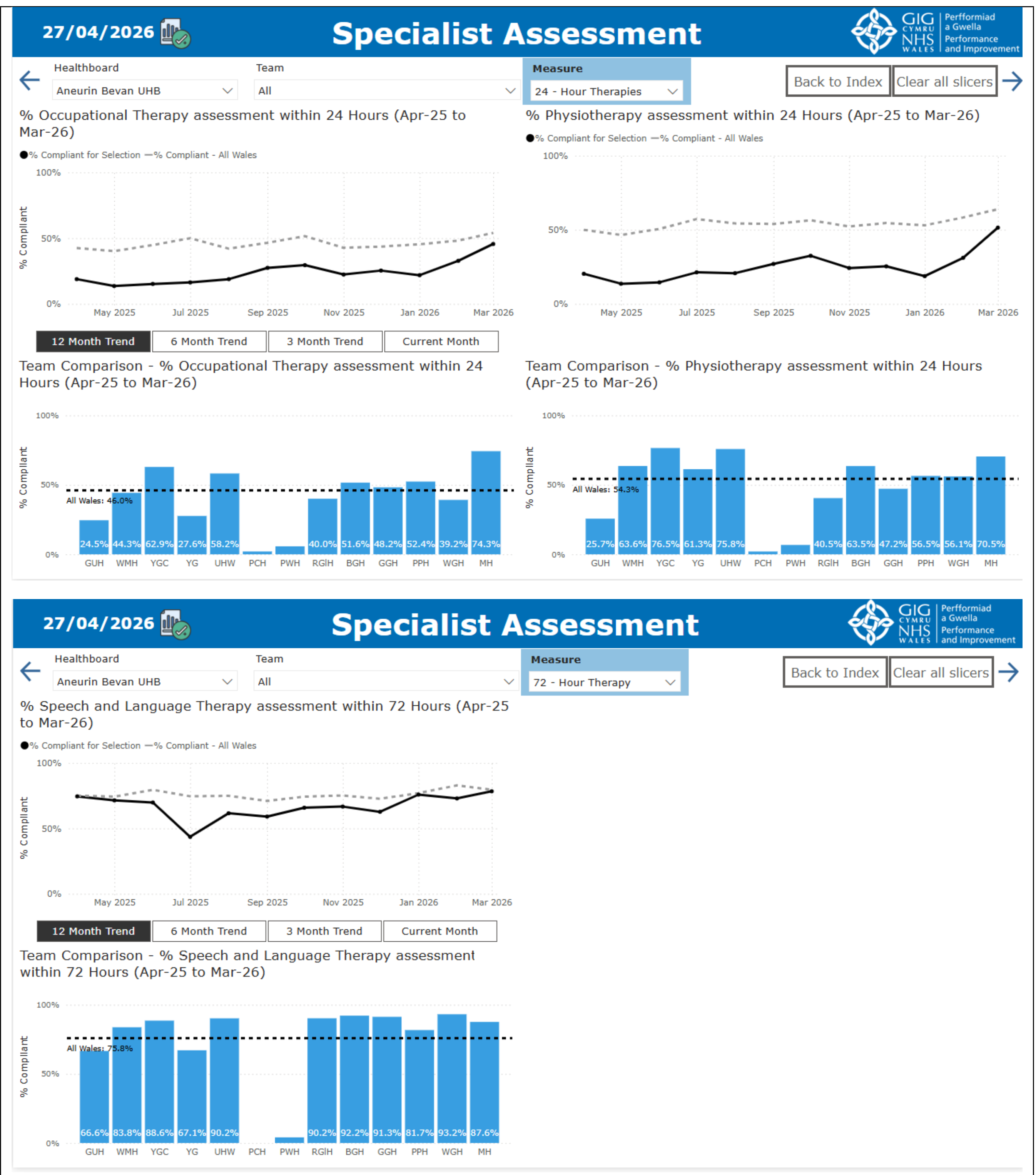
3. % of patients admitted to specialist stroke unit within 4 hours



The SSNAP target is for 100% of patients to be admitted to a stroke unit within 4 hours. Over the past 12 months the SSNAP overall position has been some way short of this at 49.4% with the highest performer being 96.7%. Across Wales that figure drops to 30.4% but with a wide range.

The GUH is in the lower range of all 13 Welsh stroke units with 11.9%. It should be noted that in the latter part of the year there has been an improvement in performance to mid 20% figure but still some way below the target and a position requiring focussed improvement.

4. % of patients receiving specialist therapy input



As the above charts show. the current service is not performing well with regard to therapy input within 24 hours of admission but improving within 72 hours. The stroke standards concentrate the therapy workforce within the stroke ward so improving the percentage against the 4 hours admission to this ward will go some way to improving therapy targets. However, workforce levels against the standards means that depending on the time of day of admission (or day of week) there still could be a challenge in achieving optimum performance.

In addition to the time and percentage targets shows above there is also a developing importance being placed on quality outcomes and patients and carer/relatives experience. Work is ongoing in partnership with the Stroke Association to improve the uptake of 6 months post stroke reviews and to develop national stroke patients reported outcome measures (PROMS). The Health Board is working with the national and Stroke Association team on this and the Stroke Association are a key member of our Regional Network Group.

Health Board Improvement Plan

Following a review of the Health Board stroke service by the Get it Right First Time (GIRFT) group and Health Inspectorate Wales in 2023 a combined action plan for the service was developed with 28 actions.

Progress against these actions was assessed in May 2024 with 15 marked as green/complete, 10 in progress and 3 as red. A reassessment in March 2026 provided the same review.

Of the elements of improvement still required there are two components causing challenge:

1. Consistent access to stroke facilities for stroke patients.
   Whilst stroke beds are prioritised for stroke patients, due to pressures in the system for beds generally this isn't always possible and flow therefore becomes challenges at times of escalation leading to stroke patients being cared for outside of the dedicated stroke unit.
2. Workforce consistency across a 7 day period to meet SSNAP and Wales Stroke Standards.
   The standards are prescriptive in terms of hours of cover of staff with specialist stroke skills either over a 24 hour or 7 day period or both. The established resources for stroke in the Health Board fall short of these in a number of areas.

During this time period the Health Board has reorganised post-acute inpatient rehabilitation services, moving from three eLGH sites having post-acute stroke wards to a single site in YYF. This concentration of resources was required to sustain the service due to shortages of medical and therapeutic cover for three sites. However, challenges remain. Recruitment has improved but there remain shortages against the standards in terms of hours of service covered due to budgetary constraints and for established funded posts there remain vacancies, albeit at a much lower rate than when the service was on three sites.

Formalisation of the outcome of the inpatient rehabilitation service is now underway. As part of this position, consideration will be needed to ensure the optimum environment and workforce is delivered to support inpatient rehabilitation and the onward pathway for patients returning to their own communities.

Summary of Improvement Plan Actions

The stroke improvement plan outstanding actions can be groups into three key areas:

1. Access

A key outstanding action is to improve access to the stroke unit for patients within 4 hours of their arrival at the Emergency Department. The latest SSNAP audit figures (Q3 2025/26) show some improvement. This is due to improved flow generally in the GUH and a focus on stroke. However, there is still much to do to meet the 90% standard in the improvement plan.

A daily 10am cross site stroke specific patient flow call runs 7 days a week in the Health Board. It is proposed that this will lead a focus on stroke beds and flow for a period in Q1 to understand how prioritising B4 and YYF stroke rehab beds for stroke patients only can assist with improved access. This will not solely deliver the 90% but will create a broader understanding of the additional measures needed (such as time to CT scan) and priority offload to assist with access. Length of Stay in both stroke areas, so ensuring consistent flow of patients through the system will be a key part of this workstream.

2. Workforce

As stated elsewhere, there are a number of areas of the GIRFT recommendations and the new Wales Stroke Standards that reference workforce cover on a 7 day basis including 24/7. A robust assessment of the current position (funded and in post) against this baseline is underway in Q1.

Further, consideration will be given to how roles and tasks can be carried out across the workforce and not just by specific professions appropriately through this period. Where there are gaps a detailed case for consideration for investment will be developed.

3. Leadership

Significant steps have been made to strengthen leadership across the organisation of stroke services with key appointments recently made to Clinical Director, Directorate Manager and Consultant Therapist roles. In addition, the revised Stroke Network Group and the inclusion of stroke as a key component of the health board urgent and emergency care improvement plan provide oversight and strategic leadership for the service which is delivered by multi divisional leadership teams.

However, the health board has not sent stroke leaders on a targeted stroke leadership programme. This was referenced in the original GIRFT report and subsequently the programme ceased running in Wales. However, at a recent Stroke Association conference GIRFT representatives notes the leadership academy is still running and has recently had some health board uptake from Wales. So, it is suggested this opportunity is re-explored in partnership with the Stroke Association for a multi-professional team to undertake the programme.

Argymhelliad / Recommendation

The report provides the Finance and Performance Committee with Assurance that there is robust governance to deliver stroke improvement in the Health Board. This is enhanced through the inclusion of stroke as a key component of the overall Urgent and Emergency Care Improvement Plan.

However, caution should be noted that over the past 12-24 months limited improvement has been sustained to overall stroke metrics as evidenced via the SSNAP audit. Two key areas of improvement emerge as a priority:

1. timely access to the acute phase of stroke care via scanning, the stroke unit at the Grange and the rehabilitation unit at YYF;
2. to undertake a review of current specialist stroke staff and 7 day cover arrangements to consider outcomes / benefits of 5 versus 7 day cover
3. a robust consideration of the implications and limitations on performance of not having the required workforce to meet the stroke service standards consistently across a 7-day week

In order to support this improvement, it will be important to establish additional support from corporate planning and performance teams to assist Divisions in data analysis, improvement measures and reporting of activity to the Health Board and national groups.

It is suggested that an updated report is presented in six months to outline progress.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities [Link to IMTP]	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives [Strategic Equality Objectives 2020-24]()	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the wellbeing and engagement of our staff Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Welsh Government, The Quality Statement for Stroke February 2026) [Quality Statement for Stroke 2026]() NHS Wales National Stroke Service Standards October 2025) [performanceandimprovement.nhs.wales/functions/networks-and-planning/stroke/stroke-docs/nhs-wales-national-stroke-service-standards/]() Sentinel Stroke National Audit Programme (SSNAP) [SSNAP - Home]()
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Aneurin Bevan University Health Board Regional Stroke Network Group

Effaith: (rhaid cwblhau)

Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives 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

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 June 2026
CYFARFOD O: MEETING OF:	Finance and Performance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

The purpose of this report is to provide the Finance and Performance Committee with a comprehensive overview of the strategic risks delegated to it by the Board.

This includes the current status of each risk, the mitigating actions in place, and the associated assurance mechanisms designed to monitor and manage these risks effectively.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

This report provides the Finance and Performance Committee with an updated assessment of the strategic risks delegated to it, reflecting the most recent position reported to the Board in March 2026.

The Health Board continues to operate within a highly constrained financial and operational environment. Financial sustainability and performance improvement remain the most significant areas of risk within the Committee's remit, with continued pressure arising from structural cost drivers, workforce challenges and demand growth.

The Committee is asked to note that, as set out in the March 2026 Board Strategic Risk Report, the overall strategic risk profile remains broadly stable; however, two

risks within the Committee's remit continue to sit outside the agreed risk appetite, requiring enhanced oversight and assurance.

Asesiad / Assessment

The Finance and Performance Committee retains oversight of the following strategic risks and sub-risks:

- **SRR 001G** – Financial Sustainability
- **SRR 001I** – Performance Improvement
- **SRR 006A, B & C** – Digital Infrastructure and System Delivery
- **SRR 011** – Climate Change / Green Health

Each is summarised below, reflecting the latest position approved by the Board

Table 1

Risk Details	High-Level Risk Description	Sub-Risk	Risk Level L x I	Within Appetite
SRR 001G Director of Finance & Procurement Theme Financial Sustainability Appetite Cautious Score 13 and below	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**g)** Due to the failure to deliver a sustainable financial position and longer-term financial plan	**5 x 4= 20** **Extreme**	**N**
SRR 001I Director of Strategy, Planning & Partnerships Theme Compliance & safety Appetite Minimal Score 8 and below		**i)** Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	**3 x 4= 12** **High**	**N**
SRR 006 A – C Director of Digital Theme	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-	**a)** Due to the full or partial failure of existing digital infrastructure and systems.	**3 x 4= 12** **High**	**Y**

Service Delivery Appetite Open Score 17 and below	quality, safe service delivery.	**b)** Due to an adverse impact on service delivery in the implementation of new digital systems.	**4 x 4= 16** **Extreme**	**Y**
		c) Due to a failure to develop digital solutions that are sustainable and fit for the future	**3 x 4 = 12** **High**	**Y**
SRR 011 Director of Finance & Procurement Theme Service Delivery Appetite Open Score 17 and below	There is a risk that the Health Board does not adequately anticipate, plan for, and respond to the impacts of climate change, green health requirements, and the need to adapt and decarbonise its services, estate and infrastructure.	Due to an ageing and complex estate, competing capital and revenue pressures, climate-related service demand and the absence of an organisation-wide climate adaptation approach.	**4 x 4 =16** **Extreme**	**Y**

<u>Risks Outside of Appetite</u>

SRR 001G: Financial Sustainability

SRR 001G remains outside the Committee's defined risk appetite, with a current risk score of 20 (Extreme).

The March 2026 Board update confirms that the organisation continues to face a substantial recurrent financial challenge. While strengthened financial governance arrangements are in place, including enhanced oversight through the Value and Sustainability Board, tighter vacancy controls, procurement optimisation activity and improved medium-term financial planning, the scale and structural nature of the recurrent gap means financial risk remains elevated.

The organisation continues to rely on non-recurrent measures to manage in-year pressures, and financial flexibility remains extremely limited. As a result, despite ongoing mitigation, SRR 001G remains outside appetite and requires continued enhanced scrutiny through this Committee.

SRR 001I: Performance Improvement

SRR 001I also remains outside appetite, with a current risk score of 12 (High).

Operational pressures persist across several domains within the Committee's remit, particularly in relation to urgent and emergency care flow, long waits, diagnostic

recovery and workforce capacity. High sickness absence levels and ongoing recruitment and retention challenges continue to impact performance delivery.

While recovery plans remain in place and some incremental improvements are evident, sustained compliance with Welsh Government performance standards has not yet been achieved. Enhanced oversight through the Performance Management Framework and strengthened divisional accountability arrangements continue, but performance remains fragile.

Risks Within Appetite Requiring Ongoing Oversight

SRR 006 A–C: Digital Infrastructure

Digital risks remain within appetite, but continue to require close monitoring due to their dependency on national digital programmes.

As reported to the Board in March 2026, there has been an increase in the risk score for SRR 006B, reflecting delays to national digital programmes including the Radiology Information System Programme (RISP) and the Laboratory Information Management System (LIMS). Corporate risks have been established for each programme to ensure focused executive oversight and mitigation planning.

While these risks remain within the Committee's delegated appetite, the Health Board's reliance on ageing digital infrastructure and continued uncertainty around national delivery timelines mean that digital risk remains a material concern for financial sustainability, operational resilience and service delivery.

SRR 011: Green Health / Climate Change

The Board approved the reframing and broadening of SRR 011 in March 2026 to reflect the wider strategic climate-related risks facing the organisation.

Oversight of operational decarbonisation targets sits with the Executive Committee, on the Corporate Risk Register. The broader strategic Green Health risk is now owned by the Board, with assurance feeding in from Executive and Committee-level oversight.

SRR 011 remains within appetite, but presents ongoing financial and operational implications, including:

- capital and revenue pressures linked to estate decarbonisation;
- competing investment priorities;
- resilience of infrastructure and services to climate-related impacts; and
- potential for unplanned expenditure arising from extreme weather events.

The Committee should note that financial oversight and assurance relating to decarbonisation delivery and climate resilience will continue to inform the Board-owned strategic risk.

Risk Scoring and Tolerance Assurance

The Committee should note that whilst several risks within its remit remain outside the agreed risk appetite and are therefore being managed at a tolerated level of residual risk in the current operating context.

To ensure that risk exposure is fully understood and appropriately articulated, targeted deep-dive reviews of risks will be undertaken. These reviews will focus on:

- validating that current risk scores accurately reflect the prevailing control environment;
- ensuring that target risk scores remain appropriate, credible and achievable; and,
- providing a clear rationale where risks remain above appetite for a prolonged period.

Overall Committee Assurance Position

As at March 2026:

- SRR 001G (Financial Sustainability) and SRR 001I (Performance Improvement) remain outside appetite and continue to require enhanced oversight; and
- Digital risks (SRR 006 A–C) and Green Health / climate-related risks (SRR 011 delegated elements) remain within appetite, but require continued monitoring.

While governance and mitigating actions continue to strengthen, the Committee is asked to note that the scale and structural nature of the challenges mean residual risk remains elevated.

Argymhelliad / Recommendation

The Finance and Performance Committee is requested to:

- **NOTE** the updated position of strategic risks,
- **NOTE** that SRR 001G and SRR 001I remain outside the agreed risk appetite and continue to be subject to enhanced oversight;
- **CONSIDER** whether it is assured that appropriate governance, mitigation and assurance.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	SRR 001 G & I SRR 006 A, B & C
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item.

	Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. N/A

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Contained within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A

Risk ID and Description				IMTP Link	Risk Score: 2	3	4	5	6	8	9	10	12	15	16	20	25
SRR 001	Director of Finance and Procurement	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.	g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	Finance						X			◊			●	
	Director of Strategy, Planning and Partnerships.		I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	Performance Expectations & Workforce & Culture						X ◊			●				
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	Digital, Data & Technology						X					● ◊		
			b) Due to an adverse impact on service delivery in the implementation of new digital systems						X						◊	●	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future							X			●		◊		
SRR 011	Director of Finance and Procurement	There is a risk that the Health Board does not adequately anticipate, plan for, and respond to the impacts of climate change, green health requirements, and the need to adapt and decarbonise its services, estate and infrastructure.	Due to an ageing and complex estate, competing capital and revenue pressures, climate-related service demand and the absence of an organisation-wide climate adaptation approach.	Green Health						X					● ◊		

Key		
Key	Current Score	●
	Target Score	×
	Appetite Threshold	◊

RISK THEME	FINANCIAL SUSTAINABILITY				
LINK TO IMTP	SECTION 4: ENABLER - FINANCE				
Strategic - SRR 001 G	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the failure to deliver a sustainable financial position and longer-term financial plan.**				
Impact *(Consequences of the threat)*	**Organisation** • Breach of statutory duty to breakeven over 3 years. • Instigation of NHS Wales Escalation & Intervention Arrangements. • Non–delivery of Health Board priorities, required improvements, and achieving longer-term sustainability. • Prioritisation and possible disinvestment in service delivery. • Reputational damage and loss of public confidence.				
Lead Director	Director of Finance and Procurement	Risk Exposure	**Current Level**	**Target Level**	
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	**5 x** (Almost certain)	**2 x** (Unlikely)	
Initial Date of Assessment	June 2023	**Impact**	***4*** *(Major)*	**4** (Major)	
Last Reviewed	April 2026	**Risk rating**	**= 20** **(Extreme)**	***= 8*** **(Moderate)**	
Next Review (Monthly based on risk score)	May 2026				

Risk Appetite Level – CAUTIOUS
Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls

Risk Appetite Threshold – Score 13 and Below
Risks relating to all aspects of the Health Board's financial performance and its ability to manage cost and efficiencies.

SUMMARY
The current risk level is **OUTSIDE** of target and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• IMTP 25/26-27/28 • IMTP Delivery Framework • Sustainability Route Map revision • Accountability Framework • Performance Framework • 3-year route map to sustainable recovery developed and approved by Board July 24. • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Final budget delegation • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Appropriately trained Finance Team (capacity & capability) • Budget holder training & other business training tools • Cost intervention procedures • 25/26 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Executive groups and structures established to deliver statutory duties. • Assessment of financial control environment within divisions and corporate teams. • Financial Escalation Meetings • Regular organisational Recovery plan meetings and briefings • Value & Sustainability Board established. • Revised accountability arrangements part of Executive governance. • Budget holder financial recovery deep dive meetings, • Enhanced forecasting and planning processes	• Revised V&SB approach for 2025/26 to help drive financial recovery, separating thematic and divisional scrutiny. • Service Redesign disaggregated as a V&SB theme • Review of programme structures to match V&SB thematic areas • Updated Route Map development • Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Day 5 comprehensive financial performance review – DoF led. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance	None	• Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. • Development of detailed 3-year recovery plan.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position.	None	• 2025/26 – 27/28 IMTP plans focussed on 'living within' budget levels. • 2025/26 savings plan to be delivered. • Detailed delivery plans will be a constant development over next 3 years.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit • Annual Report • 2024/25 Financial Sustainability – **Reasonable Assurance** Sept 2025 • 2025/26 - Audit Reviews **External Audit Reports** • 2024 -25 – Annual Report • 2025/26 - Audit Reviews **Welsh Government** • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government monthly • IMTP plan to WG end of March 2025	• Recommendations from audits	• Implement management actions to complete the recommendations from audit reports

Assurance Rating *(Overall Assessment of controls and assurances)* Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURANCE**

RISK THEME	COMPLIANCE AND SAFETY			
LINK TO IMTP	SECTION 2: DRIVERS – PERFORMANCE EXPECTATIONS	SECTION 4: ENABLERS – WORKFORCE & CULTURE		
Strategic Risk SRR 001 I	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, sustainable services that meet the needs of the population.**		**Publication Status**	**Public**

Threat *(As a result of)*	**Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Leadership, Corporate Governance, Operational Performance and Delivery, and Finance.**	**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Impact *(Consequences of the threat)*	**Patient**	**Staff**	**Organisation**
	• Unintended Patient Harm. • Negative Public/Patient Experience.	• Reduced Staff Morale leading to potential absence from work.	• Loss of patient/public trust and confidence. • Scrutiny from external organisations. • Adverse publicity. • Punitive Actions. • Financial implications.

Risk Appetite Threshold – SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **OUTSIDE** of target and the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning and Partnerships.	[Risk Exposure](#)	**Current Level**	**Target Level**
Monitoring Committee	Finance and Performance Committee.	**Likelihood**	**3 x** (Possible)	**2 x** (Unlikely
Initial Date of Assessment	April 2024	**Impact**	***4*** *(Major)*	**4** (Major)
Last Reviewed	March 2026	**Risk rating**	**= 12 (High)**	**= 8 (Moderate)**
Next Review (Quarterly based on risk score)	June 2026			

SRR 001 I
Risk Score
24 22 20 18 16 14 12 10 8 6 4
Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 May-26 Jun-26 Jul-26 Aug-26 Sep-26 Oct-26 Nov-26 Dec-26
Month
Current Risk Score
Target Risk Score
Appetite Threshold

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Performance Management and Assurance Framework- revised, updated and approved in 2025 • Executive Accountability letters • Divisional Directors Accountability letters • Monthly Assurance meetings with weekly meetings for Urgent Care • Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed at 6 months with proposed adjustments awaiting sign off • Reporting through to Finance and Performance Committee via Executives • Specific areas of focus are discussed at Value and Sustainability Board • System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. • External scrutiny via Welsh Government and NHS Executive through revised Escalation Framework • Capacity to run the performance framework and reporting requirements has been strengthened with revised corporate performance team structure, accountability and reporting processes	• 6-month review of Performance Management and Assurance • Alignment of internal mechanisms to national escalation linked to transformation programmes with clear deadlines • Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. • Standardised Divisional Assurance Templates (pre-populated) and revised as part of the Performance Management Framework review • Commission external reviews to support improvements where required. • Appropriate Business Partnering Support and analytical support • Realign capacity and/or redefine roles to provide explicit support and in line with the revised triggers for escalation

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• DMTs in place for all Divisions • Divisional oversight arrangements – monthly/fortnightly meetings • Divisional plans in place and focussed agendas • Cross Divisional meeting monthly – progress the wider system way of working. • System Leadership Team for awareness and updates • Divisional Assurance • Escalation meetings/Deep Dives as appropriate • Revised internal PMF • Update National Escalation Framework		
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established reporting to the Executive Committee • Established reporting to the Finance and Performance, Quality Management Group, People and Culture Committee and Patient, Quality and Safety and Learning Committee • Established reporting to the Board • Routine reporting through the IQPD process and Escalation meetings, e.g., Planning monthly Touchpoint and Finance monthly touchpoint	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit 2024/25 Plan • Divisional Governance Arrangements • HIW Inspections • Llais for feedback	• Findings and recommendations from the PMF review launched Q4 • Findings and recommendations from Directorate Reviews in line with escalation statuses	

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURANCE**

RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY			
Strategic Risk SRR 006 A	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the full or partial failure of existing digital infrastructure and systems.**			
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	
Lead Director	Director of Digital	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	**3 x** (Possible)	**2 x** (Unlikely)
Initial Date of Assessment	June 2023	**Impact**	*4 (Major)*	4 (Major)
Last Reviewed	January 2026	**Risk rating**	**= 12 (High)**	***= 8 (Moderate)***
Next Review (Quarterly based on risk score)	April 2026			

Risk Appetite Level – OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Score 17 and Below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **OUTSIDE** of target level but WITHIN appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*

• Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jun 2025. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed regularly.
• Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained.
• Information Governance and Cyber Security governance and assurance processes reviewed and implemented.
• Governance group terms of reference agreed. Meetings started in November 2023.
• Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff
• Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report.
• Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report and presented at monthly Service Delivery Management Group.
• Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation.
• Battle tested ABUHB cyber incident response, communication cascade and reporting to Cyber Resilience Unit.
• Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed to failover in a seamless fashion from one DC to the other with no service impact.
• Microsoft Defender provides inspection and protection from malicious links embedded within emails using telemetry from the whole NHS Wales tenant.
• Microsoft Sentinel security event and incident management tool in use to analyse systems and provide alerts.
• At least monthly simulated phishing emails to check email security awareness among staff.
• Scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber to run quarterly exercises.
	• Cyber Resilience Audit (CRU) undertaken in June 2025 showed an overall improvement. Some key recommendations such as incident management testing have been actioned, with others progressed and monitored via regular meetings with CRU and reported to Information Governance Group.
	• Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation, aligning with NIS CAF controls, and CIS (Centre for internet security) benchmarks.
	• Internal Audit review on Shadow IT scheduled for 2026.
	• Daily firewall reports on suspicious traffic, internet usage. Stats and trends reported monthly to the Service Delivery Management Group (SDMG)
	• Improvements to Vulnerability Management Service (VMS) to identify vulnerable 3rd party applications
	• Internet of Things reporting to show device security posture now being developed as new firewalls are being deployed.
	• Ingest NHS England Security Operations Centre (SOC) Indicators of compromise (IOC) feed into the Health Boards security tooling to provide additional early warnings.
	• Improvements in mandatory training compliance for Information Governance and Cyber Security.
	• Monthly Phishing simulations have identified colleague susceptibility and additional training. requirements - re-procurement of a phishing and education awareness tool in 2026 to support this
	• Health Board involvement in national cyber response exercise in September 2025.
	• Incident management;
	  o 2x members of Cyber security now CIPR (Cyber Incident Panning & response) accredited
	  o Cyber attend regular NHS England hosted Immersive labs tabletop exercises.
	  o 2x tabletop exercises for technical teams conducted in 2025 by Tarian (SW Police Cyber unit)
	  o Quarterly inhouse scenario-based tabletop exercises hosted by Cyber for technical teams and wider responders.

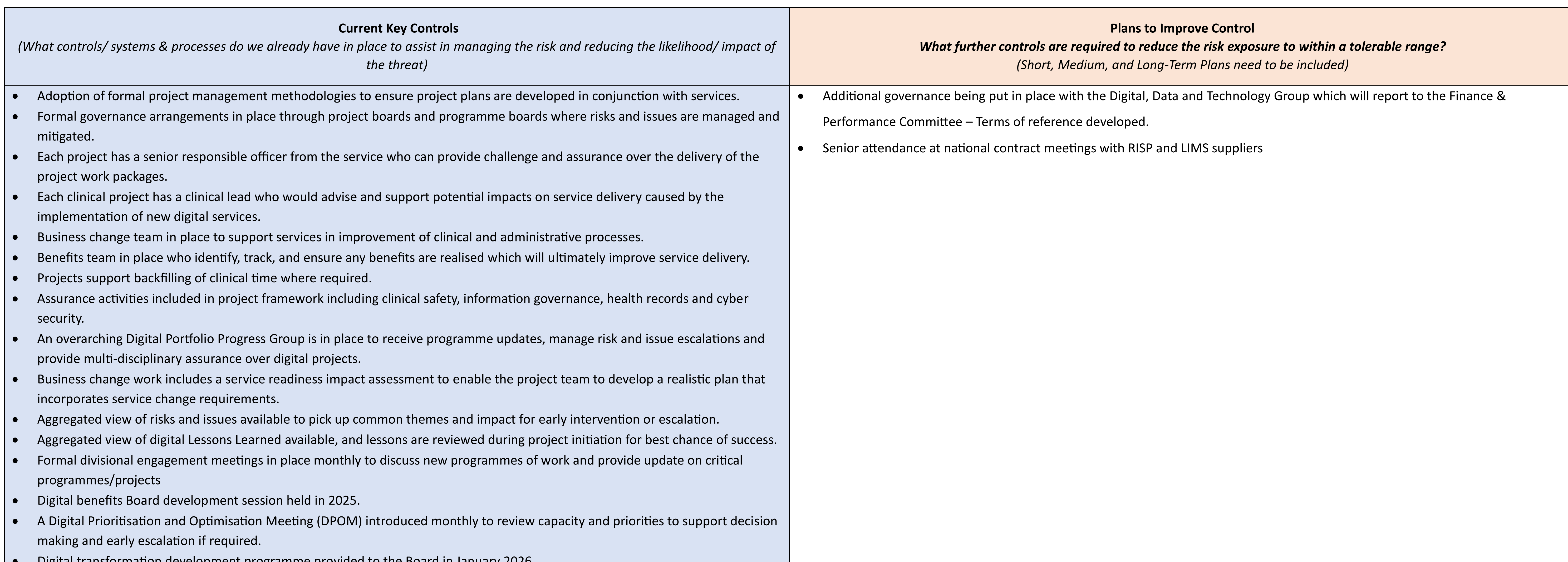
Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Single directorate risk registers now in place.	• None	• N/A
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan. Annual Senior Information Risk Owner report.	• None	• N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2024/25 • Oversight from NHS Wales Cyber Resilience Unit.	• None	• N/A

Assurance Rating *(Overall Assessment of controls and assurances)* Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURANCE**

RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY			
Strategic Risk SRR 006 B	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to an adverse impact on service delivery in the implementation of new digital systems.**		**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Digital	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	4 (Major) x	2 (Unlikely) x
Initial Date of Assessment	June 2023	**Impact**	*5 (Major)*	3 (Moderate)
Last Reviewed	March 2026	**Risk rating**	**= 20 (Extreme)**	***= 6 (Moderate)***
Next Review (Monthly based on risk score)	April 2026			

SRR 006 B



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Adoption of formal project management methodologies to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required. • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available, and lessons are reviewed during project initiation for best chance of success. • Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects • Digital benefits Board development session held in 2025. • A Digital Prioritisation and Optimisation Meeting (DPOM) introduced monthly to review capacity and priorities to support decision making and early escalation if required. • Digital transformation development programme provided to the Board in January 2026.	• Additional governance being put in place with the Digital, Data and Technology Group which will report to the Finance & Performance Committee – Terms of reference developed. • Senior attendance at national contract meetings with RISP and LIMS suppliers

• Welsh Government strengthening national governance with the introduction of a DDaT Leadership Board and supporting groups. • Regular reporting now in place to Chief Executive Management Team and Welsh Government DDAT Leadership Board due to concerns over timescales and deliverability to LIMS and RISP. • Local project tolerance levels changed to zero for both RISP and LIMS to ensure immediate escalation processes are enacted for risks or issues impacting delivery / timelines.	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) • Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework • Regular escalation reporting in place to Chief Executive Management Team and Welsh Government DDAT Leadership Board due to concerns over timescales and deliverability to LIMS and RISP.	• Escalation of risks and issues done on an Ad hoc basis to Director of Digital and Executive Committee in the absence of DdaT Sub-committee.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee • Regular reporting to Executive Committee Corporate risks logged for LIMS and RISP programmes	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2023/24 • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance **Internal Audit 2024/25** • Implementation of the Welsh Intensive Care System – future of programme to be decided	• Recommendations identified through audit work	• Recommendations identified through audit work

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable –** adequate evidence that the controls in place are working effectively.	**Positive –** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURANCE**

RISK THEME	SERVICE DELIVERY					
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY					
Strategic Risk **SRR 006 C**	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**				**Publication Status**	**Public**
Threat *(As a result of)*	**Due to failure to develop digital solutions that are sustainable and for the future.**					
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or injury to patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Unintended harm or injury to staff.		**Organisation** • Data breaches • Litigation & Financial Penalties • Reputational damage and loss of public confidence		
Lead Director	Director of Digital		Risk Exposure	**Current Level**	**Target Level**	
Monitoring Committee / Group	Finance and Performance Committee		**Likelihood**	**3 x** (Possible)	**2 x** (Unlikely)	
Initial Date of Assessment	June 2023		**Impact**	***4*** *(Major)*	**4** (Major)	
Last Reviewed	January 2026		**Risk rating**	**= 12** **(High)**	***= 8*** ***(Moderate)***	
Next Review (Quarterly based on risk score)	April 2025					

Risk Appetite Level – OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Score 17 and Below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

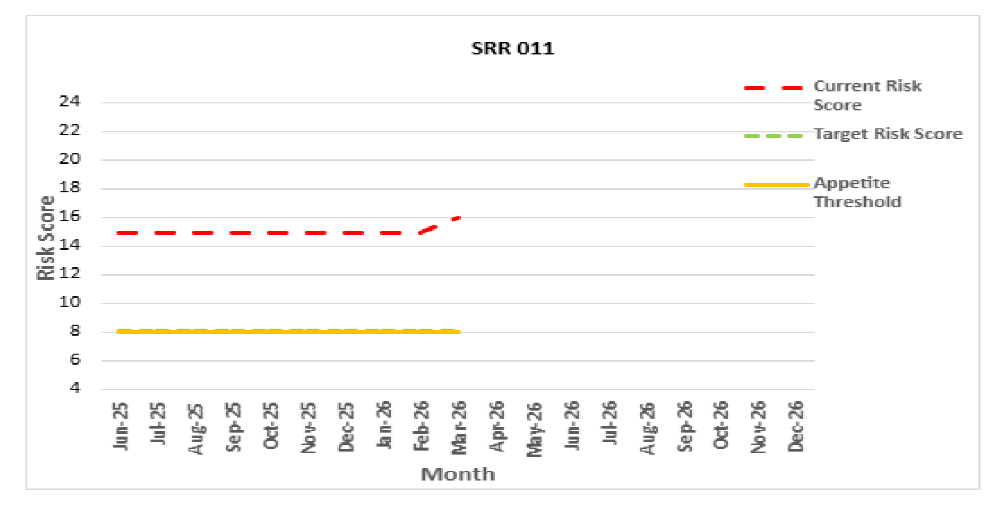
SRR 006 C

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
○ New Digital Service Request process in place which provides governance in several key areas: ○ Automation of request process via 'Seren' the ICT Portal ○ Information Governance – ensuring new services have appropriate controls to keep patient information safe. ○ Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. ○ Patient Safety – ensuring services do not introduce any patient safety risks. ○ Records – ensuring new systems comply with the requirements of records management. ○ Strong business analysis function in operation which ensures the "as-is" and "to-be" process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. ○ Business change function which ensures implemented systems are effective and deliver the benefits required. ○ Formal framework in place for the adoption of new digital services and best practice guidance followed. ○ Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process ○ New Digital Request processes include fortnightly senior leadership scrutiny of requests, ○ New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards ○ Annual operational plan completed and aligned with IMTP ○ Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place ○ Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints.	• Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for Division of Medicine, • Portfolio optimisation to ensure the resources of the service are aligned to key priorities • New Digital Request quarterly reporting to DDAT Group • New governance structures to be put in place further to directorate restructuring • Development of product management approach to delivery of core software applications and extending use of agile processes to ICT • Development of digital strategies including Digital Transformation Strategy linked to ABUHB 2035 – the new Health Board 10 year strategy and associated component strategies and plans including Electronic Health & Care Record and Infrastructure strategy.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
Quarterly reporting to DDAT Group	• If the NDSR process delivers anticipated improvements • The outcome of the EDRMS audit	• Monitor the performance of the NDSR process • Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2023/24 • LINC Programme– **Outcome Reasonable assurance** • Network Infrastructure (VPN) - **Outcome Reasonable assurance** **Internal Audit 2024/25** • Electronic document and records management solution -planned for Q4	• Recommendations identified through audit work	• Regular Reporting to the Finance & Performance Committee

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURANCE**

RISK THEME	SERVICE DELIVERY					
LINK TO IMTP	SECTION 4: ENABLER – GREEN HEALTH					
Risk (reframed) **SRR 011**	**There is a risk that the Health Board does not adequately anticipate, plan for, and respond to the impacts of climate change, green health requirements, and the need to adapt and decarbonise its services, estate and infrastructure.**				**Publication Status**	**Public**
Cause *(As a result of)*	**Due to an ageing and complex estate, competing capital and revenue pressures, climate-related service demand and the absence of an organisation-wide climate adaptation approach.**				**Risk Appetite Level – OPEN:** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	
Impact *(Consequences of the threat)*	**Patient / population** • Increased safety risks to patients arising from inadequately adapted buildings and infrastructure. • Reduced access to clinical services • Poor patient experience	**Staff** • Increased safety risks to staff arising from inadequately adapted buildings and infrastructure. • Low morale • Increased workload from staff absences	**Organisation** • Disruption to clinical services and business continuity • Greater demand on healthcare services • Non-compliance with Welsh Government policy and statutory duties under the Well-being of Future Generations (Wales) Act. • Increased operational and capital costs due to reactive rather than planned interventions. • Reputational damage • Missed opportunities to improve population health and prevention through green health approaches.		**Risk Appetite Threshold – SCORE 17 AND BELOW.** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Finance and Procurement	Risk Exposure	**Current Level**	**Target Level**		
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	**4 x** (Likely)	**4 x** (Likely)		
Initial Date of Assessment	November 2025	**Impact**	**4** (Moderate)	**2** (Minor)		
Last Reviewed	April 2026	**Risk rating**	**= 16** **Extreme**	**= 8** **Moderate**		
Next Review (Monthly based on risk score)	May 2026					



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Integrated Medium Term Plan (IMTP) and Annual Planning processes incorporating sustainability and green health priorities • Participation in NHS Wales and Welsh Government climate emergency, decarbonisation and sustainability programmes • Decarbonisation Programme Board and reporting arrangements • Carbon emissions measurement and reporting (Carbon Neutral metrics) • Capital planning, business case approval and estate management processes incorporating sustainability and resilience considerations • Estate's maintenance and backlog management • Health and safety, emergency planning and business continuity arrangements • Statutory environmental and sustainability reporting • Regulatory inspection and audit activity • Climate adaptation risk embedded in annual business planning • Estates Condition Survey (if up to date) • Environmental Management System (EMS) controls (ISO 14001)	• Development of a Board-approved, organisation-wide climate adaptation and green health strategy and plan • Completion of systematic climate risk assessments across all major sites and services • Strengthening alignment between capital investment prioritisation and climate resilience risks • Completion of bi-annual internal ISO 14001 audit to assess EMS effectiveness • Refit investment • Prioritise repairing weather damaged buildings. • Alteration to planning documents to include consideration of climate adaptation. • Adaptation KPI's being developed by Welsh Government with reporting required from 2026/27 • Direct reporting of risk assessment and adaptation plan progress to Welsh Government on an annual basis. • Review governance structure • Develop comms strategy to share adaptation advice, guidance and expectations. • Pull together a task and finish group to review and plan Climate Adaptation Risks identified in the Gwent PSB Climate Adaptation Plan

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Minutes of the subgroups to discuss position, monitor and new ideas • Minutes from the Estates operational meetings	• Detailed level metrics and measures are limited due to data capture equipment. • Each Division to identify on their risk register any outstanding climate risks on their risk register and share those risks with the Climate Adaptation Group	
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Finance & Performance Committee and Board Papers and Minutes • Decarbonisation Programme Board Papers and minutes • Executive Committee Papers and minutes • Strategic Risk Assessment • Corporate risk assessments • Audit recommendation tracking report • Incident reports	• Routine inclusion of Climate Adaptation risks on all Departmental Risk Registers.	• Commission baseline climate risk assessment across all divisions • Introduce divisional reporting on adaptation progress • Develop measurable climate adaptation KPIs • Improve real-time monitoring data availability
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Audit Wales reports and management letters • Head of Internal Audit Annual Opinion • Regulatory inspection outcomes • Well-being of Future Generations (Wales) Act Reporting • Bi-annual ISO14001 audit report	• Funding for a comprehensive ABUHB decarbonisation strategy is not available. • No external climate adaptation maturity assessment • Limited external validation of climate resilience at site level	• REFIT invest to Save capital opportunities being progressed. • Commission baseline climate risk assessment across all divisions

Assurance Rating (*Overall Assessment of controls and assurances) Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURANCE**

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	10 June 2026
CYFARFOD O: **MEETING OF:**	Finance and Performance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance and Performance Committee – Review of Committee Programme of Business 2026-27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Governance Support Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Finance and Performance Committee is asked to review the agreed Committee Forward Work Plan appended to this report as **Appendix A.**

The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2025/26 and to enable the Committee to:

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the Finance and Performance Committee has a Forward Work Plan that has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

The Forward Work Programme Plan is designed to assist the Committee in the review of its programme of business. It captures the timing of report submissions, identifies items that have been deferred, and captures new requests for reports. The plan also allows the Committee to monitor and review its business at each meeting.

Due to the Health Board currently operating under the NHS Wales Oversight and Escalation Framework at Level 4 – Targeted Intervention, the Board has agreed to hold an additional monthly meeting of the Finance and Performance Committee to support the focused scrutiny of the two key escalation areas of finance, strategy and planning, and performance and outcomes in relation to urgent and emergency care. These additional meetings will be chaired by the Health Board Chair

During the period the following requests and/or changes to the forward work plan have been included.

Additional items to the Forward Work Programme:

- There have been no additions to the Forward Work Programme during this reporting period.

Changes to the Forward Work Programme:

- There have been no additions to the Forward Work Programme during this reporting period.

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the updated Finance and Performance Committee Forward Work Plan as provided in **Appendix A**.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business are a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working	Not Applicable Choose an item.

https://futuregenerations.wales/about-us/future-generations-act/	

Annual Programme of Business for 2026-27

Finance and Performance Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2025/26
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

The purpose of the Finance & Performance Committee is to provide assurance to the Board on the achievement of the Board's aims and objectives as set out in its Integrated Medium-Term Plan. In doing so, the Committee will seek assurance that there is: • ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework; • that arrangements for financial management and financial performance are sufficient, effective and robust; • that services are improving efficiency and productivity and financial plans are being delivered;

- there is timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services; and
- risks are suitably identified, mitigated, residual risks controlled, and corrective actions are taken as required to sustain or improve performance.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

MATTERS TO BE CONSIDERED (Report Title)	Lead	Frequency of Report	Schedule of Meetings					
			QTR 1 Apr to June		QTR 2 July to Sept		QTR 3 Oct to Dec	QTR 4 Jan to Mar
			21st April 2026	10th June 2026	22nd Sept 2026	3rd Nov 2026	26th Jan 2027	9th March 2027
Preliminary Matters								
Attendance and Apologies	Chair	SI	✓	✓	✓	✓	✓	✓
Declarations of Interest	All	SI	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	SI	✓	✓	✓	✓	✓	✓
Committee Action Log	Chair	SI	✓	✓	✓	✓	✓	✓
Committee Governance								
Development of Committee Annual Programme of Business 2027/28	DoCG	AN						✓
Review of Committee Programme of Business 2026/27	DoCG	SI	✓	✓	✓	✓	✓	✓
Committee Risk Report	DoCG	SI	✓	✓	✓	✓	✓	✓
Committee Annual Report 2026/27	DoCG	AN						✓

• Annual Review of Committee Terms of Reference 2026/27 • Annual Review of Committee Effectiveness 2026/27 • Outcome of Annual Review of Committee Effectiveness 2026/27								
Performance Management								
Annual Review of Performance Management Framework	DoSP&P	AN						✓
IMTP/Performance Ambitions for Future Years	DoF&P/DoSP&P	AN						✓
Performance Management and Escalation Update.	DoSP&P	SI	✓	✓	✓	✓	✓	✓
AB Escalation Update	DoSP&P	SI	✓	✓	✓	✓	✓	✓
Integrated Performance Report, including performance against Ministerial Priorities	DoSP&P	SI	✓	✓	✓	✓	✓	✓
Reporting on Benefits Realisation Projects	DoF&P/DoSP&P			✓		✓		✓
Financial Performance								
Monthly Finance Report and Monitoring Returns	DoF&P	SI	✓	✓	✓	✓	✓	✓
Financial Outlook for Future Financial Year, including	DoF&P	AN						✓

Revenue Budget Allocation letter								
Value and Sustainability Assurance Reporting	DoF&P	SI	✓	✓	✓	✓	✓	✓
Efficiency Opportunities and Update Report	DoF&P	SI	✓	✓	✓	✓	✓	✓
Commissioning Update Report to include: • Primary Care • CHC • Intra NHS Agreements • SLAs	DoF&P	AN						✓
Service Activity and Performance								
Outpatient Transformation Programme Update	DoSP&P	AN				✓		
Stroke Improvement Plan Update Report	DoT&HS	AN		✓				
Theatres Efficiency	DoSP&P	AN			✓			
HBS Delivery	COO		✓					
Information Management								
Information Governance Report, including SIRO Update	DoD	SI	✓	✓	✓	✓	✓	✓
Corporate Information Performance.	DoCG	AN	✓					
Digital and IM&T								

Commented [GT(BUCS1]: Deferred from April

Assurance reports from the Digital, Data and Technology Group, including an update on the Delivery of Digital Programmes	DoD	SI	✓	✓	✓	✓	✓	✓
Capital, Estates and Facilities								
Estates Compliance including compliance with Health Technical Memorandums	COO	AN						✓

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item

An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee