

Finance and Performance Committee

Tuesday 22 September 2026, 13:30 - 16:30

MS Teams

Agenda

13:30 - 13:30
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 10th June 2026

Chair

 FPC 20260922 1.4 20260610 Minutes Approved.pdf (12 pages)

1.5. Committee Action Log

Chair

 FPC 20260922 1.5 Action Log.pdf (2 pages)

13:30 - 13:30
0 min

2. Items for APPROVAL/RATIFICATION/DECISION

13:30 - 13:30
0 min

3. Items for DISCUSSION

3.1. Performance Management and Escalation Update

Director of Strategy, Planning & Partnerships

-  FPC 20260922 3.1 Performance Management and Escalation Update.pdf (10 pages)
-  FPC 20260922 3.1 Performance Management and Escalation Update Appendix A.pdf (11 pages)
-  FPC 20260922 3.1 Performance Management and Escalation Update Appendix B.pdf (2 pages)

3.2. Integrated Performance Report, including performance against Ministerial Priorities

Director of Strategy, Planning & Partnerships

-  FPC 20260922 3.2 Integrated Performance Report.pdf (8 pages)
-  FPC 20260922 3.2 Integrated Performance Report Appendix A.pdf (54 pages)

3.3. Theatres Efficiency Report

Director of Strategy, Planning & Partnerships

-  FPC 20260922 3.3 Theatres Efficiency Report.pdf (16 pages)
-  FPC 20260922 3.3 Theatres Efficiency Report Appendix A.pdf (36 pages)

3.4. Information Governance Report, including SIRO Update

Director of Digital

-  F&P 20260922 3.4 SIRO Update.pdf (15 pages)
-  F&P 20260922 3.4 SIRO Update Appendix A.pdf (3 pages)
-  F&P 20260922 3.4 Siro Update Appendix B.pdf (7 pages)
-  F&P 20260922 3.4 SIRO Update Appendix C.pdf (24 pages)
-  F&P 20260922 3.4 SIRO Update Appendix D.pdf (1 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 20260922 3.5 Assurance reports from Digital, Data and Technology Group.pdf (11 pages)

3.6. Digital Patient Communications project benefits realisation update

Director of Digital

-  FPC 20260922 3.6 Digital Patient Communication Project.pdf (9 pages)

3.7. Cancer Services Report

-  FPC 20260922 3.7 Cancer Services.pdf (47 pages)

13:30 - 13:30 4. Items for INFORMATION 0 min

4.1. Committee Risk Report

Director of Corporate Governance

-  FPC 20260922 4.1 Committee Risk Report.pdf (7 pages)
-  FPC 20260922 4.1 Committee Risk Report.pdf (2 pages)

4.2. Review of Committee Programme of Business 2026/27

Director of Corporate Governance

-  FPC 20260922 4.2 Review of Committee Programme of Business 2026-27_.pdf (4 pages)
-  FPC 20260922 4.2 Review of Committee Programme of Business 2026-27 Appendix A.pdf (7 pages)

13:30 - 13:30 5. Other Matters 0 min

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

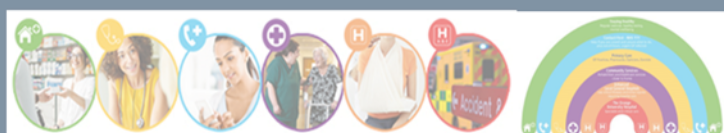
Chair

5.2. Any Other Urgant Business

Chair

DATE OF MEETING	10 June 2026 15.30-17.00
VENUE	Microsoft Teams
PRESENT	Neil Patrick, Chair Iwan Jones, Vice Chair Dafydd Vaughan, Independent Member Akmal Hanuk, Independent Member Helen Cunningham, Independent Member
IN ATTENDANCE	Robert Holcombe, Director of Finance and Procurement Leanne Watkins, Chief Operating Officer Hannah Evans, Director of Strategy, Planning and Partnerships Rani Dash, Director of Corporate Governance Peter Carr, Director of Allied Health Professions & Health Science Janice Jenkins, Assistant Director of Digital Transformation Lloyd Bishop, Deputy Director of Digital Naomi Murtagh, Board Business Manager Gavin Thomas, Governance Support Officer
OBSERVING	Thoko Owino, Aspiring Board Member
APOLOGIES	Paul Solloway, Director of Digital

Preliminary Items	
FPC/202606/01	Welcome and Introductions Neil Patrick (NP), Chair, welcomed everyone to the meeting.
FPC/202606/02	Apologies for Absence Neil Patrick (NP), Chair, NOTED the apologies received.
FPC/202606/03	Declarations of Interest



	Peter Carr, Director of Allied Health Professions & Health Science, declared that he was the Chair of the LIMS Programme for Wales ahead of the Digital Programme update agenda item. The declaration was NOTED.
FPC/202606/04	Draft Minutes of the last Meeting held on 21st April 2026 The Committee received and reviewed the previous draft minutes, and these were AGREED as a true and accurate record of the meeting.
FPC/202606/05	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/202606/06	Performance Management and Escalation Update Hannah Evans (HE), Director of Strategy, Planning & Partnerships, provided a verbal update on the application of the Performance Management Framework and escalation arrangements. It was noted that the end-of-year performance reviews were underway across divisions, with the majority completed and the remainder scheduled. The process was described as a key mechanism for assessing divisional performance and informing escalation status. HE advised that the Health Board's escalation domains aligned with updated national arrangements, ensuring consistency with Welsh Government expectations. It was further noted that elements of the framework would require ongoing refinement to maintain alignment with evolving national measures, including the introduction of a "well-led" domain. HE further updated on the implementation of accountability letters, which were to be issued to Executive Directors and cascaded through divisional structures. These letters were



	intended to provide clarity on financial, performance and delivery expectations, ensuring accountability was explicit and unambiguous. It was noted that finalisation had been delayed to align with agreed plans and national discussions, with issuance expected by the end of June. The Committee noted that early financial and performance challenges had been identified at the start of the new financial year. In response, a series of targeted budget meetings had been scheduled with divisions to support recovery planning and ensure delivery against agreed financial plans. Discussion focused on the effectiveness of accountability mechanisms and whether existing approaches would deliver improved outcomes. Iwan Jones (IJ), Independent Member, acknowledged that while accountability letters and structured reviews provided clarity, sustainable improvement would depend on consistent application, strengthened leadership, and cultural change across the organisation. HE further noted variability in the maturity of performance management processes across divisions, particularly in the consistency with which accountability and escalation arrangements were implemented at directorate level. Continued work was required to achieve a consistent standard across all divisions. The Committee noted that, whilst the framework provided a clear structure for performance management and escalation, there remained a need to demonstrate tangible impact. This included clearer evidence of delivery, improved organisational grip, and strengthened ownership at all levels, which would be monitored through future updates. The Committee NOTED the update.
FPC/202606/07	Integrated Performance Report, including performance against Ministerial Priorities Hannah Evans (HE), Director of Strategy, Planning & Partnerships, presented the Integrated Performance Report and noted that this was the first report aligned to the trajectories and commitments set out in the Annual Plan. HE confirmed that the report provided a structured



overview of performance against key Ministerial priorities and organisational objectives.

The Committee noted areas of positive progress within prevention and population health, including sustained improvements in elements of the Healthy Child Wales Programme and diabetes care processes. Improvements in validated smoking cessation outcomes were also acknowledged, although performance remained variable across measures.

Challenges were highlighted in relation to vaccination uptake, where performance remained below desired levels despite comparative performance across Wales. A range of targeted actions were in place to improve uptake, including focused work within specific communities and the use of innovative delivery approaches.

In primary and community care, activity levels were reported to be broadly in line with, or exceeding, planned levels, although pressures remained in specific areas, including community nursing. Urgent and Emergency care performance continued to require focus, particularly in relation to ambulance handover delays, within the context of increasing demand.

The Committee considered planned care performance and noted that, whilst delivery remained broadly in line with agreed trajectories, there was evidence of emerging deterioration in some areas. This was attributed in part to the absence of non-recurrent funding that had supported performance in the previous year. It was also noted that further national expectations regarding planned care could result in additional delivery requirements.

In relation to diagnostics, some deterioration in performance was anticipated due to the implementation of new digital systems, with recovery plans in place to address this. Cancer performance was reported to be improving in some areas, including reductions in backlog; however, challenges remained within specific tumour pathways, with targeted recovery actions underway.

Mental health performance remained stable against key Ministerial priorities, with sustained delivery in several areas. However, ongoing challenges were noted in access to psychological therapies and neurodevelopmental



	services, with further work required to improve timeliness and capacity. Neil Patrick (NP), Chair, emphasised the importance of interpreting performance within the context of increasing demand and capacity constraints. The Committee also recognised that further development of the report would be required to strengthen contextual information, including the integration of activity data to support a clearer understanding of performance trends. The Committee concluded that, whilst progress was evident in a number of areas, significant challenges remained, and continued focus on recovery actions and delivery against agreed trajectories was required. The Committee NOTED the report.
FPC/202606/08	Pre-Investment Panel Annual Report Hannah Evans (HE), Director of Strategy, Planning & Partnerships, presented the Pre-Investment Panel (PIP) Annual Report, which summarised the Panel’s activity over the preceding 12 months and outlined areas for further development. HE explained that the Panel continued to provide a structured forum to review and challenge business cases and investment proposals prior to consideration by the Executive Committee, and that this multidisciplinary approach was recognised as strengthening the quality and robustness of proposals and supporting greater consistency in decision-making. The Committee was advised that progress had been made in strengthening reporting arrangements, including clearer articulation of Panel feedback, the changes made to business cases as a result of that challenge, and the outcomes of proposals following Executive consideration. HE highlighted that, whilst the Panel’s intended scope was to review all investment and externally funded proposals, this had not been achieved consistently, and that further work was required to ensure that all relevant cases were routed through the Panel to provide appropriate scrutiny and assurance.



	The Committee noted that, in the current financial context, greater emphasis was required on evaluation and benefits realisation, rather than solely on new investment proposals. This included strengthening processes to review whether anticipated benefits, including financial savings, had been achieved following implementation. Iwan Jones (IJ), Independent Member, queried the Digital Patient Communications benefits realisation work and noted that he was uncertain whether these benefits had been reported to the Committee. Janice Jenkins (JJ), Assistant Director of Digital Transformation, confirmed that the benefits realisation work for this project had been completed and advised that an update, including evidence of impact and savings, would be provided to the Committee. ACTION: Assistant Director of Digital IJ highlighted the importance of improving the timeliness and quality of post-implementation evaluations, recognising that delays in closing the loop limited the ability to inform future decision-making and support disinvestment opportunities. HE advised that further work was underway to support divisions in developing robust evaluation processes and improving the consistency of reporting. The Committee AGREED that the Panel remained a key component of the organisation's governance framework for investment decision-making, with further development required to strengthen compliance, evaluation, and assurance of benefits realisation. The Committee NOTED the report.
FPC/202606/09	Information Governance Report, including SIRO Update Lloyd Bishop (LB), Deputy Director of Digital, presented the Information Governance Report, outlining the overall position in relation to compliance, risk and assurance. LB reported that training compliance for information governance and cyber security remained in line with national expectations, with the overall compliance rate meeting the Welsh Government target. Ongoing work was in place to further improve compliance through targeted



engagement, communications and bespoke training for areas of lower performance.

The Committee noted that arrangements to support data protection compliance remained robust. A number of Data Protection Impact Assessments had been completed to ensure that new systems and projects were appropriately assessed and that risks were identified at an early stage through the Health Board's established risk management framework.

LB reported that performance in relation to subject access requests remained strong, with high levels of compliance achieved despite sustained high volumes of requests. Improvements in digital systems and workflow processes had supported the effective management of demand. The Committee also noted that the organisation had achieved a high level of compliance against the Welsh Information Governance Toolkit, demonstrating continued maturity in governance arrangements, training and information security processes.

An update was provided on cyber security, noting that risks were actively managed within acceptable tolerances. Mitigation plans were in place for identified vulnerabilities, including infrastructure upgrades and system improvements. It was acknowledged that cyber risk remained a key area of focus, particularly in relation to staff awareness and susceptibility to phishing attacks, with ongoing education and awareness programmes in place to mitigate this risk.

Dafydd Vaughan (DV), Independent Member, queried the data relating to clinical coding. LB acknowledged the operational pressures within clinical coding, where performance continued to be impacted by workforce capacity alongside increasing activity levels. However, assurance was provided that actions were in place to improve productivity, including the introduction of automation and future digital solutions.

In addition, the Committee noted risks associated with digital systems and data access, including specific considerations for vulnerable cohorts. Appropriate mitigation measures were in place, alongside ongoing engagement with system suppliers to address these risks.



	Neil Patrick (NP), Chair, requested that a further update be brought back to the Committee on the approach and progress in resolving the risk relating to looked after children, specifically in relation to transitions between foster carers within the digital patient portal and the need to minimise unauthorised access. ACTION: Deputy Director of Digital The Committee AGREED that information governance arrangements remained effective, with strong levels of compliance and continued improvement. However, the Committee recognised the need for sustained focus on cyber security, workforce capacity and emerging digital risks. The Committee NOTED the report.
FPC/202606/10	Assurance reports from the Digital, Data and Technology Group, including an update on the Delivery of Digital Programmes Janice Jenkins (JJ), Assistant Director of Digital Transformation, updated the Committee on the delivery of the Digital, Data and Technology portfolio, including progress against key programmes and associated risks. JJ informed the Committee that a number of digital initiatives had progressed, including the implementation of electronic patient record systems, deployment of digital solutions to support clinical workflows, and continued rollout of infrastructure programmes such as server refresh, operating system upgrades and connectivity improvements. It was also noted that an electronic prescribing pilot had commenced, representing a significant step forward in digital transformation. JJ advised that further programmes were in development, including business cases for digital dictation and digital communications, with enhanced scrutiny provided through the Pre-Investment Panel. Preparatory work was underway to ensure appropriate infrastructure readiness to support these developments. JJ provided an update on major national programmes. It was noted that the radiology system replacement was approaching implementation, requiring contingency



	arrangements to mitigate technical dependencies. The laboratory information management system (LIMS) programme remained subject to national delays and continued to carry a high level of delivery risk. The Committee noted that the overall portfolio was operating within a constrained resource environment, with finite digital and technical capacity necessitating ongoing prioritisation across multiple competing organisational and national demands. JJ emphasised that dependencies on specialist resources, including network and development teams, remained a key constraint to delivery. Financial pressures were also highlighted, including a forecast variance arising from historic unfunded programmes and the absence of recurrent funding for previously approved business cases. The Committee was advised that efforts were ongoing to secure external funding where possible; however, financial risk remained. Iwan Jones (IJ), Independent Member, emphasised the importance of benefits realisation across the digital portfolio. It was noted that, whilst a significant number of benefits were being tracked, there remained an inherent lag between implementation and the realisation of measurable outcomes. Continued focus was required to ensure that digital investments translated into tangible service improvements and efficiencies. It was further noted that successful delivery of digital programmes required not only technical implementation but also cultural change across the organisation to support adoption and maximise value. The Committee AGREED that the digital programme remained a critical enabler of service transformation, with progress continuing despite significant risks and constraints. The Committee NOTED the report.
FPC/202606/11	Stroke Improvement Plan Update Report Peter Carr (PC), Director of Allied Health Professions and Health Science, updated the Committee on the Stroke



Improvement Plan, including current performance, key challenges and the revised approach to improvement.

PC advised that, whilst there were areas of strong clinical performance, overall delivery against national stroke standards remained inconsistent. Strengths were evident in relation to timely diagnostic scanning and the delivery of thrombolysis once initiated; however, performance relating to the proportion of patients receiving thrombolysis and timely admission to specialist stroke units remained below expected levels.

PC outlined that the principal drivers of underperformance were largely systemic. These included challenges relating to patient flow and access to specialist stroke beds during periods of escalation, alongside workforce capacity constraints across Medical, Nursing and Therapy services. It was further noted that limitations in delivering consistent seven-day specialist services continued to impact performance.

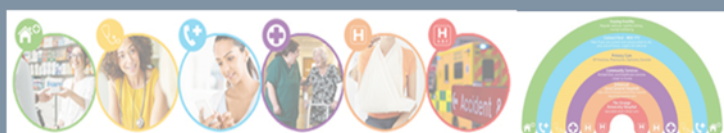
PC informed the Committee that governance arrangements had been strengthened, with stroke improvement now embedded within the Urgent and Emergency Care Programme, which provided clearer organisational oversight, strengthened accountability and improved alignment with wider system priorities.

The Committee noted that a revised improvement programme had been established, focusing on both the acute and rehabilitation phases of the stroke pathway. Within the acute pathway, priorities included improving patient flow, increasing access to timely treatment, enhancing multidisciplinary working and strengthening data collection processes to improve the reliability of performance reporting.

In relation to the rehabilitation pathway, PC advised that work was underway to improve patient flow into rehabilitation services, strengthen community-based support, reduce length of stay and enhance follow-up arrangements. The Committee recognised that further work would be required to establish a sustainable workforce model and to improve delivery against rehabilitation standards.



	The Committee also noted planned engagement with clinical teams through targeted workshops to support the development and implementation of improvement actions, with an emphasis on clinically led solutions and local ownership of delivery. The Committee AGREED that, whilst performance remained below the expected standard in a number of areas, the strengthened governance arrangements and clearer programme structure provided a more robust foundation for improvement. Ongoing monitoring of progress would be required to ensure sustained improvement in stroke performance. The Committee AGREED that an update on stroke performance would be presented in six months. ACTION: Committee Secretariat The Committee NOTED the report.
ITEMS FOR INFORMATION	
FPC/202606/12	Committee Risk Report The Committee RECEIVED and NOTED the Committee Risk Report.
FPC/202606/13	Review of Committee Programme of Business 2026/27 The Committee NOTED the updated Programme of Business for 2025/26.
OTHER MATTERS	
FPC/202606/14	Items to be Brought to the Attention of the Board and Other Committees The Committee considered whether there were any matters arising from the meeting that required escalation to the Board or referral to other Committees. It was NOTED that no specific additional items were identified for escalation. However, it was acknowledged that key issues discussed throughout the agenda, including performance challenges, financial pressures and high-risk



	digital programmes, would continue to be reported through established governance and assurance routes.
FPC/202606/15	Any Other Urgent Business There was no other Urgent Business.
FPC/202606/16	Date of the Next Meeting 22 nd September 2026

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee
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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2026	FPC/202606/08	Assistant Director of Digital Transformation to share with the Committee the benefits realisation work for the Digital Patient Communications project.	Director of Digital	September 2026	
June 2026	FPC/202606/09	Director of Digital to bring an update to the Committee on the approach and progress in resolving the risk relating to looked after children, specifically in relation to transitions between foster carers within the digital patient portal and the need	Director of Digital	September 2026	

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		to minimise unauthorised access.			
June 2026	FPC/202606/11	Stroke Improvement Plan Update to return to committee in 6 months	Committee Secretariat	December 2026	Complete – Item has been added to the FWP.

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:	22 September 2026
CYFARFOD O: MEETING OF:	Finance and Performance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Escalation – Update on national accountability arrangements and application of Health Board’s Performance Management Framework
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Trish Chalk, Assistant Director Planning and Performance

Pwrpas yr Adroddiad Purpose of the Report

Er Sicrwydd/For Assurance

The purpose of this report is to update the Committee on the national accountability arrangements, and the application of the Health Board’s internal Escalation Framework.

Specifically, the Committee are asked to:

- **NOTE** the context of national escalation and accountability arrangements and the updated approach
- **NOTE** status of the Health Board’s national escalation levels and progress made against the de-escalation criteria and the Health Board’s published escalation status
- **NOTE** the update against the Health Board’s Performance Management and accountability Framework including outcomes of the End of year reviews to date

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Accountability, Oversight and Escalation arrangements continue to operate at a national level and at a local level within the Health Board.

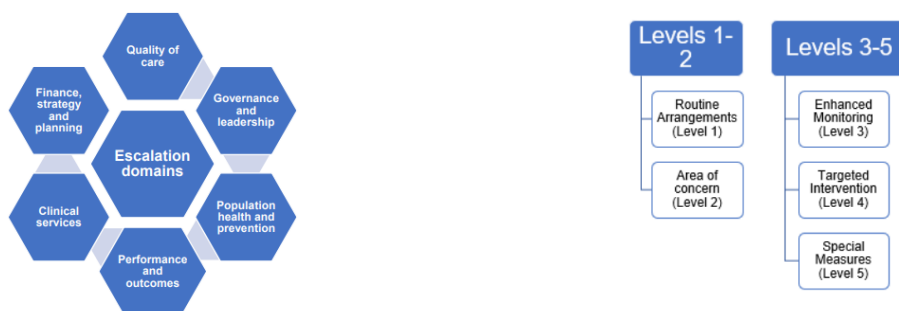
At a national level the framework is under review and transitioning from the July 2025 published NHS Oversight and Escalation Framework towards new

arrangements. This report updates on this transition and the national review underway. In addition, the report provides an update on the Health Board's national escalation levels including the updated ABUHB Escalation Framework in August 2026 and the revised de-escalation criteria.

The report also provides an update on the implementation of the Health Board's Performance Management and Accountability Framework (PMF), including a strengthening of Committee and Board oversight, end-of-year reviews and special budget meetings.

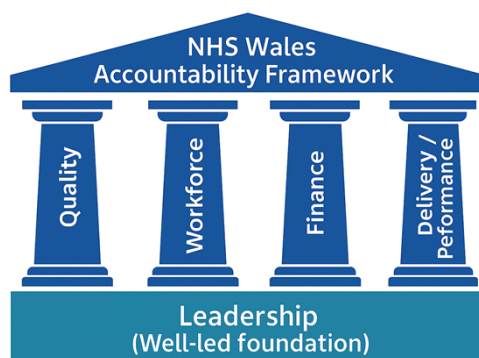
Cefndir / Background

The Welsh Government's extant and published NHS Oversight and Escalation Framework (July 25) has, in part, been overtaken by more recent communication regarding accountability. The extant framework ([NHS Oversight, Assurance, Escalation and Intervention Framework](#)) is set against 6 domains of escalation and 5 levels of escalation:



However, following the Ministerial Advisory Group's recommendations further strengthening of national arrangements have taken place. Initially these changes were set out in a letter from Nick Wood, Deputy CEO of NHS Wales in March 2026 (Appendix 1) which set out a new operational interface. This initial correspondence has been supplemented by additional presentations and communications. Key features of which include:

- Streamlined interface meetings between Health Boards and NHS Performance and Improvement (NHS P&I) and Welsh Government (WG)
- Greater clarity of role of Boards in accountability with WG, including in public sessions,
- Greater clarity on demarcation of roles between Welsh Government and NHS P&I,
- Level and frequency of oversight proportionate to level of escalation,
- The 5 levels of escalation were retained.
- The 6 domains were replaced with 4 pillars and a foundation domain of Well Led as per below:



The escalation status of NHS Organisations continues to be considered at least twice a year via a tri-partite process between Welsh Government, Audit Wales and Health Inspectorate Wales. In addition, escalation levels can now be reviewed and changed if urgent issues emerge and there is a commitment that these decisions will be evidence based and transparent going forward.

The table below charts the escalation history for the Health Board:

DATE	FINANCE AND PLANNING	URGENT & EMERGENCY CARE (performance and outcomes)
September 23	Level 3 – Enhanced monitoring	
January 24	Level 4 – Targeted Intervention	Level 3 – Enhanced monitoring – ED at the Grange
July 25	Level 3 – Enhanced monitoring	Level 3 – Enhanced monitoring– ED at the Grange
December 25 - current	Level 4 – Targeted Intervention	Level 4 – Targeted Intervention – Whole system

Internally the Health Board continues to operate the Performance management and accountability Framework (PMF). The domains of the internal framework align positively with the new pillars and foundational domain.

Assessment

NATIONAL ARRANGEMENTS

As set out above, the national oversight and accountability arrangements have undergone changes since March 2026 and continued under the new Government. Under these new arrangements the key areas of interfaces are set out below:

MEETING	FREQUENCY	ATTENDEES	DATES
NHS P&I interface Focus on all pillars	Monthly	HB Exec and P&I team	Monthly basis
Escalation Board Focus on areas of escalation	Bi-monthly	HB Exec and WG EDT and MD of NHS P&I	2 June 2026 30 July 2026
Accountability Meetings	Twice yearly – 1 maybe in public	HB Exec and WG EDT and MD of NHS P&I	4 December 2025 30 September 2026 8 March 2027

Focus on wider responsibilities of Health Board			
These meetings are all followed up with outcome letters and the Escalation Board and Accountability meetings are supported by evidence submissions. In addition to the above meetings, there are regular meetings with the Chair and Chief Executive with NHS P&I and the Chair with the Director General and Cabinet Secretary. As part of the 100 Day Plan a formal review of the NHS Wales Oversight and Escalation Framework was commissioned around six themes: • Strategic purpose • Governance and accountability • Risk identification and Escalation • Intervention and Improvement Support • Organisational Experience • Learning and Future Development As part of the Health Board response the following points were raised: • Clearer escalation and de-escalation criteria, supported by transparent decision-making; • A single source of truth for performance data, with greater automation and use of statistical process control; • Reduced duplication across related processes and stronger links with local governance frameworks; and • Stronger organisational learning through peer review, improvement collaboratives, shared learning and the spread of good practice across NHS Wales. Following the period of engagement and consultation it is expected that the new accountability and support framework will be implemented on 29th September 2026. Notwithstanding the above review, the Health Board does remain in high escalation (level 4 Targeted Intervention) for Urgent and Emergency Care, Finance and Planning. The escalation was being managed against the de-escalation criteria published in February 2026 as previously reported to the Committee. In view of changes in national metrics for ambulance handovers (a 45-minute standard) the de-escalation criteria for UEC have recently been updated. Appendix 2 sets out the communication of this change. In line with this change the Health Board’s escalation framework was updated from the February 2026 version to take account of this change. It was published on 10th September 2026 Aneurin Bevan University Health Board oversight and escalation framework: August 2026 [HTML] GOV.WALES			

The table below summarises the change in UEC ambulance handover criteria:

AB UEC Level 4		
Measure	Baseline Nov 25	Deescalation requirement *
Ambulance handovers over an hour (old methodology)	644	454
Ambulance handovers over 45 mins (new methodology)	930	651

Progress against UEC de-escalation requirements is reported on a monthly bases through the Finance and Performance Escalation Committee and so the detail is not repeated here to avoid duplication. Key headlines however to note are:

- Ambulance handover performance improved, with 80.2% of handovers at the Grange University Hospital completed within 45 minutes, exceeding the 75% trajectory. Since the Rapid Release Protocol was enacted on 12th August, 45-minute handover compliance at GUH ED has been 93.6% with several days achieving 100% compliance
- The number of handovers exceeding 45 minutes at the Grange also reduced to 279, performing better than the trajectory of 413, although neither measure has a formal de-escalation requirement.
- Across the Grange and enhanced Local General Hospitals, 340 handovers exceeded 45 minutes, remaining comfortably within the de-escalation requirement of 651.
- Other measures have remained above the required thresholds: 8.1% of Emergency Department patients waited 12 hours or more, compared with the 7% requirement;
- The median time to clinical assessment was 151 minutes, against a 60-minute requirement; and pathways-of-care delays stood at 152, compared with the required level of 141.

Planning and Finance escalation

Progress against the finance de-escalation criteria is reported through the Finance and Performance Escalation Committee and is not repeated here to avoid duplication.

From a planning perspective an update against extant de-escalation criteria is provided below:

De-escalation criteria	Update
Submission of a balanced and credible three-year medium-term plan or acceptable annual plan in line with the current planning framework	The Health Board's approach to achieving de-escalation is being integrated into the 2027 -2028 planning cycle. Development of the 2027/28 plan is overseen by an Executive Steering Group, with regular progress reports to the Executive Committee, the Planning, Health and Partnerships Committee and the Board. A Board development session is planned for 8 th October.
Evidence a clear roadmap and implementation of the health	Key areas of work informing updated Clinical Services Plan are: - Older Persons Pathway model

board's clinical services plan (CSP).	- Acute medical model review - Mental Health and LD service and Estate Transformation programme - Placed Based Care development - Models of Care for Nevill Hall Hospital in SOC - Development of regional CSP A timeline bringing these areas of work together will be presented to PPHP Committee and a future Board development session jointly led by the Medical Director and Director of Strategy, Planning and Partnerships.
Increase Welsh Government's confidence in delivery based on an assessment against an agreed planning maturity matrix.	The last Self-Assessment of January 2026 was reported into the PPHP Committee and assessment of the Health Board was mainly at level 2 and 3 (out of 5). Welsh Government provided positive feedback against this Self-Assessment and agreed with levels. Updated Self-Assessment is due 27th November 2026.
Delivery of commitments set out within the annual plan.	Delivery against plan is tracked through the Integrated Performance Report (IPR). On a quarterly basis, updates against plan commitments are included as part of the IPR. Progress against plan features as part of the NHS P&I oversight meetings.

HEALTH BOARD ARRANGEMENTS

In September 2025 the Board approved an updated Performance and Accountability Framework. Section 6.1 of the 2025 PMF sets out the arrangements for escalation across the five domains, including the two new domains for Corporate Governance and Leadership

The PMF allows for consideration of escalation levels to occur at any time in line with triggers in the same section. However, as a minimum, a formal review of status should occur every 6 months. It is for the Executive Committee, based on the information considered in the reviews, plus any other pertinent evidence, to decide on the escalation levels and report the agreed levels into the Finance & Performance and PQSOC Committees.

1

Quality & Safety

2

Leadership

3

Corporate Governance

4

Finance

5

Operational Performance & Delivery

In line with the 2025 Performance and Accountability Framework (PMF), End of Year Reviews were scheduled. These reviews used a standard agenda and information pack and are chaired by the Chief Executive.

End of Year Meeting Dates		
Date	Area	Status
11/05/2026	Estates & Facilities	Complete
14/05/2026	Urgent Care	Complete
21/05/2026	Mental Health & LD	Complete
04/06/2026	Digital	Complete
08/06/2026	Clinical Support Services	Complete
08/06/2026	Families & Therapies	Complete

10/06/2026	Surgery	Complete
16/07/2026	Planning	Complete
03/08/2026	Primary Care & Community Services	Complete
07/10/2026	Medical Director	Scheduled
13/10/2026	Nursing	Scheduled
15/10/2026	Workforce & OD	Scheduled
19/10/2026	AHP & HS	Scheduled
TBC	Governance	TBC

A summary paper was presented to the Executive Committee in July 2026 proposing the following changes to escalation levels:

- Urgent Care Division to be escalated for Finance from Normal Arrangements to Enhanced Monitoring
- Mental Health to be de-escalated to Normal Arrangements for Quality and Safety
- Digital, Data & Technology to be escalated to Enhanced Monitoring for Finance
- Primary and Community Care to be escalated to Enhanced Monitoring for Finance

The rationale of escalating Divisions for finance was that Divisions and/or corporate teams hit the triggers in the PMF so was a binary decision. The rationale for de-escalating Mental Health Division for Quality was:

- Strong positive external feedback on the open access and crisis models, which had been recognised as leading practice.
- Reduction in incidents and restrictive practice, with continued rollout of Safe Wards.
- Improved complaints performance and reduction in backlog.
- Completion of all HIW immediate actions, with learning disseminated across the Division.
- Clear strategic direction and transformation programmes in place.
- Embedded senior daily touchpoint meetings reviewing incidents from the previous 24 hours and daily safety briefings.
- Improved Patient Safety Incident Review processes with use of AMaT and strengthened accountability.
- Professional standards and improvement programmes supporting therapeutic observation and engagement practice.

Following robust discussion, the recommendations were supported by the Executive Committee so the summary position is as follows:

July 2026					
DIVISION	ESCALATION DOMAIN				
	Quality and Safety	Leadership	Corporate Governance	Finance	Operational Delivery
Facilities and Estates	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements
Surgery	Normal Arrangements	Normal Arrangements	Normal Arrangements	Enhanced Monitoring	Normal Arrangements
Urgent Care	Enhanced Monitoring	Normal Arrangements	Normal Arrangements	Enhanced Monitoring	Enhanced Monitoring
Medicine	Normal Arrangements	Normal Arrangements	Normal Arrangements	Enhanced Monitoring	Normal Arrangements
Primary Community Care and Complex Care	Normal Arrangements	Normal Arrangements	Normal Arrangements	Enhanced Monitoring	Normal Arrangements
Mental Health and LD	Normal Arrangements	Normal Arrangements	Normal Arrangements	Enhanced Monitoring	Normal Arrangements
Family and Therapies	Normal Arrangements	Normal Arrangements	Normal Arrangements	Enhanced Monitoring	Normal Arrangements
Clinical Support Services	Normal Arrangements	Normal Arrangements	Normal Arrangements	Enhanced Monitoring	Normal Arrangements
Workforce and OD	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements
Digital	Normal Arrangements	Normal Arrangements	Normal Arrangements	Enhanced Monitoring	Normal Arrangements
Public Health	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements
Medical Director	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements
AHP & HS	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements
Finance and Procurement	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements
Planning	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements
Nursing	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements
Governance	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements	Normal Arrangements

In response to the above the following actions have been taken;

- Special budget meetings have taken place for all Divisions and Corporate teams in financial escalation. These have been chaired by the CEO and have focused on recovery and improvement actions. These meetings have all been followed up with actions that are tracked through Divisional Assurance mechanisms
- Urgent Care Division's escalation oversight has been brought in line with UEC Programme to ensure direct alignment with the national escalation metrics and actions,
- Rising risks or issues have also been addressed through Executive level oversight, for example the additional oversight and review that was established for neonatal services.

In addition to the above, as part of application of the PMF, all Executive Directors and Divisional Directors have received Accountability letters setting out clearly the expectation in terms of delivery across the areas of the Framework including budgetary and performance.

Recommendation

The Performance and Finance Committee are asked to:

- **NOTE** the context of national escalation and accountability arrangements and the updated approach

- NOTE status of the Health Board's national escalation levels and progress made against the de-escalation criteria and the Health Board's published escalation status - NOTE the update against the Health Board's Performance Management and accountability Framework including outcomes of the End of year reviews to date

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	007
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply All Health & Care Standards Apply Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Every Child has the best start in life
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 prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Improve the access, experience and outcomes of those who require mental health and learning disability services 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)	
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	Yes, outlined within the 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/	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



To All NHS Chairs and Chief Executive Officers

Our Ref: NW/

16 March 2026

Dear Colleagues,

Accountability Interface Arrangements

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

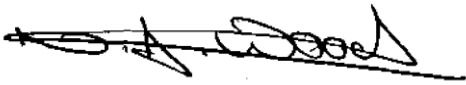
The proposed timetable for implementation is as follows:

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

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

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

Yours sincerely

A handwritten signature in black ink, appearing to read 'Nick Wood', written over a horizontal line.

Nick Wood
Deputy Chief Executive – NHS Wales

Appendix

A NEW OPERATING & ACCOUNTABILITY INTERFACE - NHS WALES

1. Introduction

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

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

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

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

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

2. Oversight and Assurance

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

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

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

Design Principles

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

3. Scope and Roles

3.1 Welsh Government (HSCEY Group)

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

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

3.2 NHS Performance & Improvement (NHS P&I)

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

3.3 NHS Organisations (Health Boards, Trusts, SHAs)

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

4. Data and Reporting: “One Version of the Truth”

4.1 Shared Performance Pack

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

4.2 Access for WG Policy Officials

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

5. Escalation Alignment

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

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

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

6.1 System-level

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

6.2 Organisation-level

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

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

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

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

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

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

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

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

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

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

7. Earned Autonomy, Rewards and Consequences

7.1 Earned Autonomy (Rewards)

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

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

7.2 Consequences

Where performance or assurance falls short:

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

7.3 Accountability Mechanisms

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

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

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

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

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

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

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

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

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

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

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

9. Delivery Expectations and Tracking

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

How this aligns with the current framework?

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

Foundation domain: Leadership (Well-led)

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

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

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

Pillar 1: Quality

Definition: The safety, effectiveness and experience of care — including compliance with quality standards, learning from incidents, clinical outcomes, and reduction of unwarranted variation.

Evidence base: National quality measures and statements, triangulated with the National Quality Management System, patient experience feedback and external assurance (Healthcare Inspectorate Wales, Audit Wales). Fragile or high-risk services (for example, maternity and neonatal) are captured here and, where relevant, in Delivery/Performance.

Expectations: Sustained compliance with agreed quality standards and trajectories; evidence of learning translating into improved outcomes and reduced harm.

Pillar 2: Workforce

Definition: A safe, sustainable and engaged workforce with the right capacity, capability and culture to deliver plans — encompassing recruitment, retention, sickness, wellbeing, turnover, and productivity enablers.

Evidence base: People-measures within the national oversight approach (for example, staffing, skill mix, rota fill, training compliance, wellbeing indicators), supported by qualitative insights from staff surveys and speaking-up data.

Expectations: Delivery of safe staffing plans and trajectories; improved stability and engagement; demonstrable impact of workforce actions on quality and operational performance.

Pillar 3: Finance

Definition: In-month and year-to-date financial position, medium-term sustainability, savings delivery and use of resources, with credible, triangulated plans that balance quality, activity and workforce. Strategy and planning considerations sit here where they materially affect financial sustainability.

Evidence base: Monthly monitoring returns, integrated performance and finance reports, and assurance over financial governance and control. Deeper review where there is a significant underlying deficit or gaps to plan.

Expectations: Sustained delivery against the agreed financial trajectory; strengthened financial controls; approved and deliverable medium-term plan demonstrating recurrent balance.

Pillar 4: Delivery/Performance

Definition: Delivery against nationally agreed priorities and the Performance Framework — including urgent and emergency care, planned care and cancer, diagnostics, mental health, and other access standards — supported by credible recovery plans and trajectories.

Evidence base: The single performance pack and published performance measures, trend analyses, risks and mitigations. Where quality or fragile-service risks are operational in nature (for example, patient flow, access backlogs), they will also be tracked here.

Expectations: Sustained delivery of agreed milestones and outcomes; variance managed within agreed tolerances; performance maintained without disproportionate negative impact on quality, workforce or finance.

9.1 Applying escalation within the pillars

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

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

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

9.2 Mapping from legacy domains to the new structure

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

9.3 Measurement and reporting

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

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

10. Information Governance and Transparency

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

Y Grŵp Iechyd, Gofal ac Atal
Dirprwy Brif Weithredwr, GIG Cymru

Health, Care and Prevention Group
Deputy Chief Executive, NHS Wales



Llywodraeth Cymru
Welsh Government

Nicola Prygodzicz
Chief Executive
Aneurin Bevan University Health Board

nicola.prygodzicz@wales.nhs.uk

Our Ref: NW/MR/AHD

25 August 2026

Dear Nicola,

Ambulance handover de-escalation criteria

The NHS Wales Performance Framework 2026-2027 introduced a new performance measure for ambulance patient handovers, with a target to achieve zero handovers over 45 minutes. As discussed at the recent escalation board meetings with your organisation, we are moving towards aligning escalation requirements to this new target.

Welsh Government has now received data that enables us to align your urgent and emergency care de-escalation criteria to the 45-minute handover measure. The methodology has been updated to reflect the total number of 45-minute handovers across all health board sites, rather than emergency departments alone, and is calculated based on the hospital the patient is taken to, not the health board area where they are picked up from.

The table below demonstrates your organisation’s requirements against the previous de-escalation criteria based on the 1-hour handover criteria (old methodology) and the new 45-minute de-escalation criteria.

Aneurin Bevan UHB - Urgent and Emergency Care - Level 4		
Measure	Baseline Nov-25	De-escalation Requirement
Ambulance handovers over 1 hour (old methodology)	644	454
Ambulance handovers over 45 minutes (new methodology)*	930	651

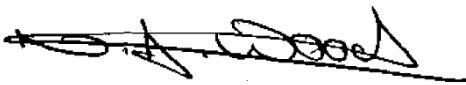
Please find below the updated UEC de-escalation criteria which will be revised within your escalation framework:

- 30% reduction in ambulance handovers over 45 minutes and maintained for three months (based on agreed baseline).

Your revised framework will be published on the Welsh Government website within the next two weeks.

If you have any queries, please contact performanceandescalation@gov.wales.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Nick Wood', with a horizontal line drawn through it.

Nick Wood
NHS Performance, Delivery and Oversight
Cyflawni, Perfformiad a Goruchwylio'r GIG

Cc: Jeremy Griffith, Director of Operations, Welsh Government
Leanne Watkins, Chief Operating Officer, Aneurin Bevan UHB

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 September 2026
CYFARFOD O: MEETING OF:	Finance and Performance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Integrated Performance Report: September 2026
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 report is to provide the Board with an overview of performance against the key Health Board and Ministerial Priorities as outlined in the Annual Plan 2026/27, with performance figures including the most up-to-date, validated positions. An appendix is also included detailing the progress against the Annual Plan Milestones as of Q1 26/27.

The Committee is asked to:

- **Note** the progress against key performance metrics as of the latest, available validated information,

- **Note** the insight and actions identified in context of performance achievement, and;
-

Cefndir / Background

The report focuses on performance against the organisation's key priorities in line with the Heath Board's 2026/27 Annual Plan. The Integrated Performance Report is structured across the following sections:

Section 1:	• Performance Summary & Ministerial Delivery Expectations
Section 2:	• Performance by Theme ○ Population Health and Prevention ○ Community by Design ○ Timely Access to Care – Urgent & Emergency Care ○ Timely Access to Care – Cancer, Planned Care & Diagnostics ○ Mental Health Access

Asesiad / Assessment

Population Health and Prevention

Theme	On track	Off track within tolerance	Off track	Not yet reporting in year
Population Health and Prevention	2/14	3/14	0/14	9/14

Q1 2026/27 vaccination performance has not yet been published and therefore there are no new updates from the previous report.

For Q4 25/26 childhood vaccination coverage improved to 86.2%. In Q4 25/26, HPV vaccination uptake reached 70.7% in the same period, continuing the trend of improvement over the past five quarters. Significant work is underway to improve vaccination uptake across Gwent, including delivery of Vaccination Brief Advice training, a targeted MMRV improvement pilot across Newport and Torfaen GP Practices, and outreach initiatives with Gypsy and Traveller communities to reduce inequalities and improve access. Healthy Child Wales measures remain strong, with physical examinations at six weeks consistently exceeding the 90% target and achieving 99.6% performance, while weight and measurement checks at eight weeks also remain well above target at 92%. Smoking cessation performance remains more challenging, with quit attempts marginally below trajectory and CO-validated quits significantly below target, although service redesign, community-based support and targeted communications are contributing to improving outcomes and a substantial increase in validated quits compared with the previous year.

Diabetes related measures show encouraging progress overall, with performance for all eight NICE diabetes care processes improving steadily and reaching 48.1%, slightly above the Q2 trajectory. Foot surveillance and urine albumin recording has also

improved compared with historical performance but remain below planned trajectories, prompting continued improvement work through the Foot Care Project, gestational diabetes initiatives and pathway reviews. The Urine ACR project has now concluded successfully, with more than half of participating practices achieving significant improvements in compliance. Meanwhile, engagement with the Melo wellbeing website has remained relatively stable, with performance becoming more consistent than in previous years, although visits have fallen slightly below trajectory during June and July despite plans to expand content and promotional activity.

Place Based Care

Theme	On track	Off track within tolerance	Off track
Place Based Care	3/9	5/9	1/9

Place Based Care Services continue to demonstrate positive performance across a number of primary and community care measures. Pharmacist Independent Prescribing Service (PIPS) consultations and Common Ailment Scheme (CAS) activity both show sustained improvement, supported by service expansion and increased public awareness, with CAS significantly exceeding its Q1 trajectory. NHS Optometry Services also performed strongly, comfortably exceeding planned levels of activity. These achievements highlight the continued shift towards care delivered closer to home and the successful utilisation of community based services to manage demand that might otherwise present to general practice or hospital settings.

Performance is more mixed across Community and Urgent Care pathways. Emergency dental activity remains significantly below trajectory following implementation of the new NHS Wales dental contract, which has redirected urgent appointments into general dental practices. Community nursing capacity is improving but remains behind the level required to meet Ministerial expectations, while Palliative Care assessments, Rapid Response referrals and GP referrals into Rapid Response are all slightly below planned trajectories. Urgent Primary Care activity remains stable but is also marginally behind target. Improvement efforts are focused on reducing barriers to Rapid Response access through the Urgent and Emergency Care transformation programme, strengthening integrated Community services, and continuing to expand alternative care models that support people to remain independent and receive care in Community settings, wherever possible.

Timely Access to Care: Urgent and Emergency Care

Theme	On track	Off track within tolerance	Off track
Timely Access to Care: Urgent & Emergency Care	8/18	4/18	6/18

Urgent and Emergency Care performance improved significantly during August, particularly in relation to ambulance handovers and ambulance lost hours. Following a

combination of operational interventions, enhanced executive oversight, discharge initiatives and implementation of the Rapid Release Protocol on the 12th August, the number of ambulance handovers exceeding 45 minutes reduced to the lowest levels recorded since the opening of The Grange University Hospital. Performance met both the Annual Plan trajectory and the Targeted Intervention de-escalation threshold, while ambulance crew hours lost also fell to record low levels. These improvements were supported by the six-week UEC Sprint programme, which delivered a range of pathway improvements including enhanced escalation processes, discharge planning, AMU reconfiguration, Hospital to Home developments and strengthened operational oversight.

Despite these improvements, wider front-door performance remains challenging. Twelve-hour Emergency Department waits continue to exceed trajectory, although there were some signs of improvement following the introduction of the Rapid Release Protocol. Performance against triage standards and median wait-to-be-seen times also remains below plan, with clinician waits continuing to exceed target levels despite recent improvements. Four-hour ED performance has deteriorated further and remains materially below both trajectory and historical performance levels. The Health Board recognises that improving patient flow across the entire Urgent and Emergency Care pathway is critical to addressing these pressures, with discharge processes, bed availability and system wide flow continuing to be key constraints. The Multi Agency Discharge Event (MADE) highlighted barriers including diagnostic delays, rehabilitation capacity constraints, workforce pressures and variation in discharge processes.

Performance in Pathway of Care Delays (POCDs) and Stroke Services presents a mixed picture. POCDs by volume reduced substantially in August, reaching the lowest level in the available dataset and is marginally above the Annual Plan trajectory and targeted intervention de-escalation criteria, POCDs by days delayed remain behind trajectory. Within Stroke Services, direct admission to a Stroke ward within four hours and Therapy assessments continue to perform strongly and exceed trajectories, demonstrating sustained improvement. However, stroke scanning within 20 minutes and thrombectomy rates remain significantly below target, prompting ongoing pathway reviews, service improvement initiatives and discussions regarding commissioning arrangements. Work is also underway to optimise rehabilitation pathways, strengthen Early Supported Discharge models and improve patient flow through dedicated Stroke Services

Timely Access to Care: Cancer, Planned Care & Diagnostics

Theme	On track	Off track within tolerance	Off track
Timely Access to Care: Cancer, Planned Care & Diagnostics	9/19	8/19	2/19

Cancer performance remains mixed, with strong progress in diagnostic performance and backlog reduction, but continued challenges in treatment timeliness. The 28-day diagnostic standard achieved 77.6% in July, exceeding both trajectory and the national target, while the 62-day and 104-day cancer backlogs continued to reduce and both

performed better than planned. However, Single Cancer Pathway (SCP) compliance fell to 60.2%, well below the July trajectory of 73.4%, driven by a higher than planned number of treatment breaches despite overall treatment volumes being delivered. Recovery work is particularly focused on Lower GI, Upper GI and Urology pathways, which account for most of the cancer waits, alongside detailed tumour-specific improvement plans and continued emphasis on earlier diagnostics.

Planned Care recovery continues to deliver strong results, particularly for the longest waits. Following the significant achievement of reducing 104-week RTT waits to just 23 patients at the end of 2025/26, the lowest level since April 2020, the Health Board submitted regional recovery plans with the elimination of 104-week waits identified as a core objective. Additional non-recurrent funding has already supported extra surgical activity across a number of specialties, contributing to continued improvement, with performance expected to fall to around 385 patients by August. Further funding is expected to be confirmed during September, and revised trajectories are being developed with the ambition of delivering a zero 104-week wait position by year end. Performance against 52-week and 26-week outpatient waits also remains ahead of plan following the benefits realised through the national outpatient insourcing programme. Diagnostics performance also remains stronger than forecast. While breach numbers have increased during the first four months of 2026/27, growth has been slower than anticipated and recovery plans continue to be refined. Updated trajectories are being developed alongside the Welsh Government recovery programme to reflect revised assumptions and additional funded activity. The implementation of the Radiology Information System Programme (RISP) has increased the level of month end validation required to ensure accurate performance reporting.

Demand pressures across Planned Care continue to increase, with referral rates remaining above trajectory and the RTT waiting list growing to 111,777 patients by July. The Health Board is responding through an intelligence led referral optimisation programme using Health Pathways, Interface GPs, Advice & Guidance Services and enhanced analytics to reduce unwarranted variation and improve referral quality. Delayed follow-up waiting lists also remain a significant challenge, with targeted work underway to validate waiting lists, expand See on Symptom (SOS) pathways and focus on the most delayed patients. Workforce and demand pressures continue to affect Audiology and Therapies Services, particularly Physiotherapy, contributing to rising waiting times despite performance generally remaining ahead of trajectory. Theatre productivity remains a key focus, with late starts increasing and utilisation remaining slightly below the 85% national standard. In response, the new Theatres Optimisation Programme has been established to improve theatre efficiency, reduce cancellations, improve utilisation and increase day-case activity to maximise available capacity and support continued Planned Care recovery.

Mental Health Access

Theme	On track	Off track within tolerance	Off track
Mental Health Access	6/10	3/10	1/10

Performance across core Adult Mental Health Services and CAMHS access standards remains strong. Adult Part 1a and Part 1b performance continues to exceed the national target, with the service successfully balancing demand and capacity throughout 2025/26 and into 2026/27. CAMHS performance is similarly positive, with both Part 1a and Part 1b measures maintaining compliance above national standards. Specialist CAMHS Choice Assessments continue to perform well above the 80% target, while performance against Out of Area Placements remains on track, with zero bed days recorded in 2026/27 to date, avoiding both the patient impact and financial cost associated with placements outside the Health Board area.

The main areas of challenge relate to Adult Part 2, Psychological Therapies and CAMHS Neurodevelopmental Services. Adult Part 2 compliance has fallen slightly below trajectory in recent months, and a focused programme of improvement work is underway to restore performance. Psychological Therapies has shown improvement in two of the last three months but remains below the annual trajectory, with a modelling project being undertaken with Cardiff University to identify the service changes and workforce requirements needed to achieve future access standards. Neurodevelopmental Services continue to face recovery pressures following a sustained focus on eliminating the longest waits. In response, significant NDIP funding has been secured for 2026/27 to protect existing capacity, recruit additional staff, fund extra clinical hours and introduce AI-supported waiting list management tools to improve RTT performance and service sustainability.

Argymhelliad / Recommendation

The Board is asked to:

- **Note** the progress against key performance metrics as of the latest, available validated information,
- **Note** the insight and actions identified in context of performance achievement, and;

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
- 2. Safe Care
- 3. Effective Care
- 5. Timely Care

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life Getting it right for children and young adults Adults in Gwent live healthily and age well Older adults are supported to live well and independently Dying Well as part of life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
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 the access, experience and outcomes of those who require mental health and learning disability services 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	Choose an item. 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



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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Finance and Performance

Performance Report September 2026



Section 1.1: Guidance on interpreting run charts & SPC icons

Section 1.2: Performance Summary

Section 1.3: Ministerial Delivery Expectations

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

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

A summary of the latest performance against these measures is included for quick reference.

Section 2: Our Performance

2.1: Performance by Theme

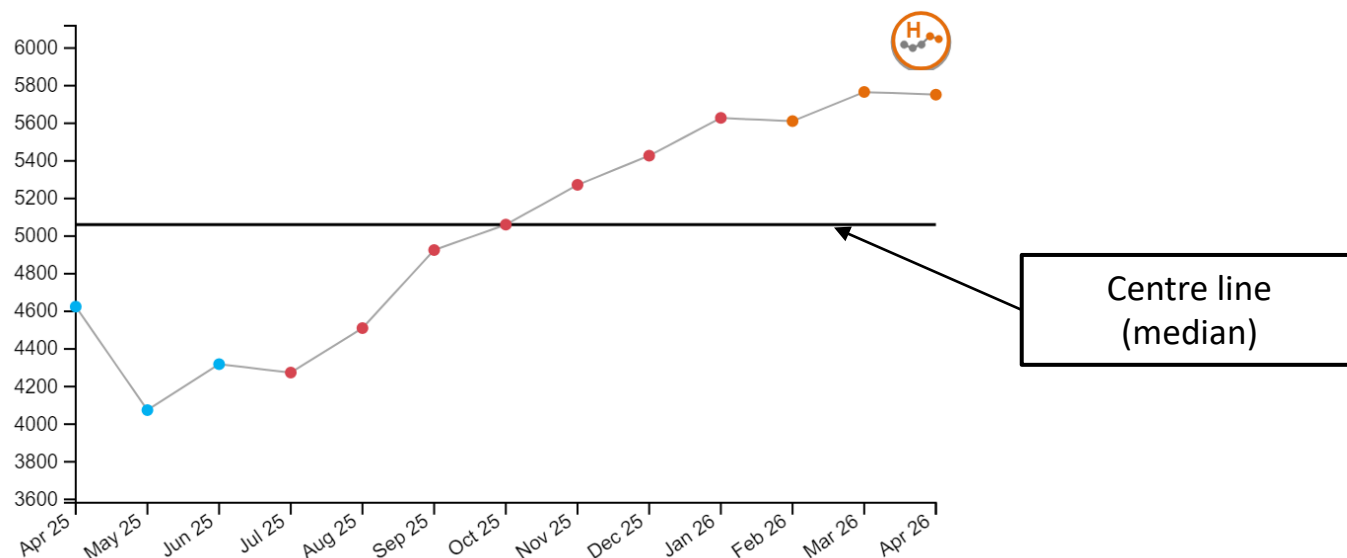
This section provides detail of Health Board performance across the core performance measures included within the 26/27 Annual Plan, as well as progress against Annual Plan milestones (updated quarterly). These have been grouped to align with the Welsh Government themes as follows:

- Population Health and Prevention
- Place Based Care
- Timely Access to Care – Urgent & Emergency Care
- Timely Access to Care – Cancer, Planned Care & Diagnostics
- Mental Health Access

Each measure also has a flag to show which strategic aim it relates to (Better Health/Better Care/Better Lives), as per the 26/27 Annual Plan.



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



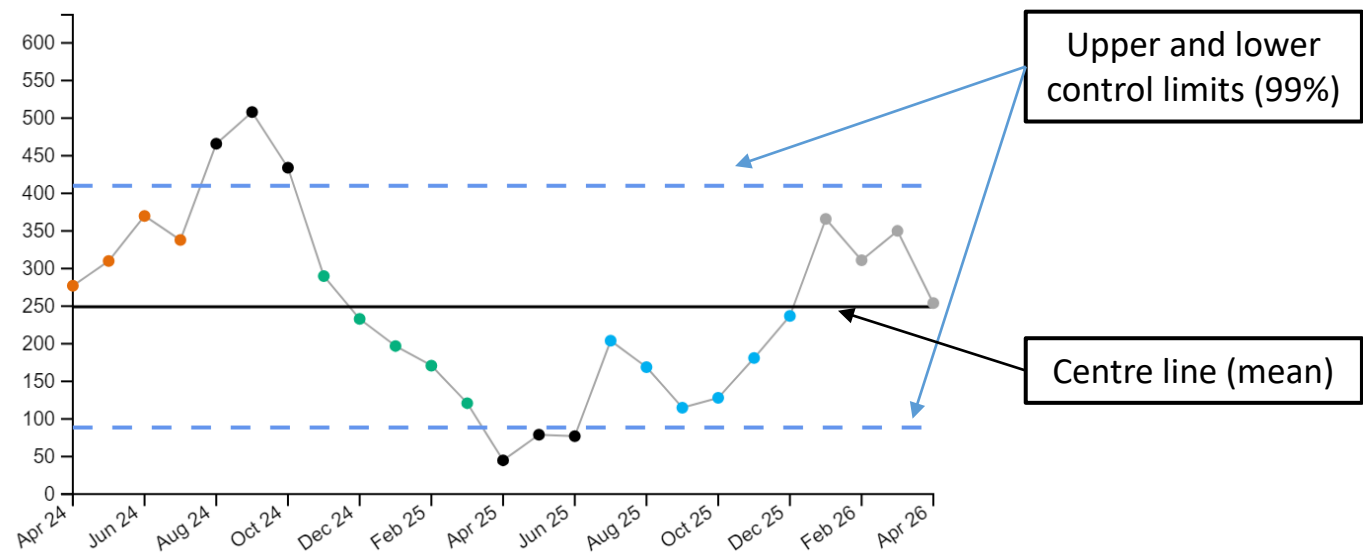
A Run Chart is recommended when there are **fewer than 15 data points** to plot on a time series.

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

Six consecutive points above or below the median line (shift from median): 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				
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.



What went well?

- August delivered the lowest number of 45 minute ambulance handover breaches since the opening of The Grange University Hospital, meeting both the Annual Plan trajectory and the Targeted Intervention de-escalation threshold following implementation of the Rapid Release Protocol and focused operational improvements.
- Six-week physical examination rates consistently exceeded the national target, reaching 99.6%.
- Within Stroke, the 4-hour admit to Ward and Therapist assessment measures all significantly exceeded trajectory.
- The Health Board has maintained zero Out of Area Placement bed days during 2026/27 to date, avoiding both patient disruption and associated costs.
- Both bank and agency usage reduced during the quarter, while medical agency usage continued its sustained downward trend, supported by increased direct engagement arrangements.

What were the challenges?

- Despite improvements in ambulance handovers, 12-hour performance, triage breaches and clinician wait-to-be-seen times remain above trajectory.
- Single Cancer Pathway (SCP) compliance remains below trajectory as of July. Whilst planned treatment volumes were achieved, the number of treatment breaches was higher than expected, resulting in underperformance.
- Within Emergency Dental, Q1 activity reached only 3,210 contacts compared to a trajectory of 9,043, reflecting the impact of the new NHS Wales dental contract and changes in urgent dental care delivery.
- Theatre productivity remains challenged in some areas, with late starts having trended in the wrong direction over the past few reportable months.
- Overall sickness absence increased to 7.15%, exceeding the IMTP target of 6.25%, with long-term sickness accounting for around 70% of all absence.

What actions are we taking to improve?

- Vaccination Brief Advice training, a MMRV improvement pilot across GP Practices, and focused outreach work to Gypsy and Traveller Communities are being implemented to improve uptake and reduce inequalities.
- The Older People's workstream and the development on the Navigation Hub/Single Point of Access will reduce barriers for GPs and improve referrals into Rapid Response services.
- The Multi Agency Discharge Event (MADE) has identified barriers to discharge and is supporting work to improve discharge processes, Estimated Dates of Discharge (EDD) management and pathway consistency across sites.
- Detailed tumour-specific recovery plans, particularly within colorectal services, are targeting diagnostic bottlenecks and treatment pathway delays to improve SCP compliance.
- Continued integration of patient feedback, complaints, incidents and safeguarding intelligence is supporting a more mature approach to quality governance, risk identification and service improvement.

What are our risks to delivery?

- Continued lower vaccination rates, particularly among hard-to-reach communities, risk widening health inequalities and preventing achievement of national immunisation targets.
- Referral rates continue to increase and the RTT waiting list is growing, creating additional pressure across Outpatient, Diagnostic and Treatment pathways.
- Growing demand for Community Services without equivalent capacity growth could impact delivery against Place Based Care trajectories.
- Sustaining recent ambulance handover improvements will require continued operational focus on whole system flow, which will become more challenged a Winter approaches.
- Failure to improve consultant and SAS job planning compliance could affect workforce productivity, service planning and delivery of operational performance objectives.

Section 1.3: Ministerial Delivery Expectations



Theme	Delivery Expectation	ABUHB commitment	Meet National Standard?	In month performance against trajectory	Variance	Assurance
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	48.1% Jul-26 (Q2 Trajectory: 48%)		
	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	30,524 Jul-26 (Q2 Trajectory: 59,112)		
	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	152 Aug-26 (Aug Trajectory: 140)		
	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	5,160 Aug-26 (Aug Trajectory: 4,200)		
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		



Section 1.3: Ministerial Delivery Expectations

Theme	Delivery Expectation	ABUHB commitment	Meet National Standard	In month performance against trajectory	Variance	Assurance
Timely Access to Care	Ensure no ambulance patient handover waits over 45 minutes [All location types, GUH & eLGHs].	91 Mar-27	No	352 Aug-26 (Aug Trajectory: 505)		
	Ensure no ambulance patient handover waits over 45 minutes [GUH ED only].	80 Mar-27	Yes	290 Aug-26 (Aug Trajectory: 413)		
	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	1,312 Aug-26 (Aug Trajectory: 941)		
	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion.	75% Mar-27	No	60.2% Jul-26 (Jul Trajectory: 73.4%)		
	Reduction in backlog of patients waiting over 62-days (SCP).	170 Mar-27	No	274 Jul-26 (Jul Trajectory: 335)		
	Reduction in backlog of patients waiting over 104-days (SCP).	50 Mar-27	No	86 Jul-26 (Jul Trajectory: 100)		
	Numbers of patients waiting over 104-weeks RTT (all stages).	2,291 Mar-27	No	458 Jul-26 (Jul Trajectory: 828)		
	Reduction in the number of patients waiting more than 8- weeks for a specific diagnostic.	0 Mar-27	Yes	2,465 Jul-26 (Jul Trajectory: 2,888)		



Theme	Delivery Expectation	ABUHB commitment	Meet National Standard	In month performance against trajectory	Variance	Assurance
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	1.35% Jun-26 (Q1 Trajectory: 1.39%)		
	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	93.9% Jun-26 (Q1 Trajectory: 35%)		
	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	Yes	90.1% May-26 (May Trajectory: 91%)		

Progress Against our Annual Plan

Drivers

Joint Strategic
Assessment

Gwent 35

Quality



Performance
Expectations

Financial
Sustainability

Risks

Strategic Aims

Better Health: Together we will support people to be healthy, active, & happy.

Health Protection

Health Improvement

Prevention

Babies Children & Young
People

Better Care: Together we will deliver what matters to people – supporting our staff to thrive & achieving quality, kind, & sustainable care.

Place Based Care

Access & Sustainability

Improving Quality &
Experience



Embedding Value &
Efficiency

Better Lives: Together we will create strong, safe, & connected communities.

Healthy Places

Resilient & Connected
Communities

Safe Spaces

Quality of Life



Enablers

Quality



Workforce &
Culture

Digital, Data &
Technology

Estates

Finance

Green Health

Value,
Innovation &
Research



Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance
Population Health and Prevention	% children up to date with vaccinations by age 5.	95% Mar-26	86.2% Q4 25/26 (Q4 Trajectory: 95%)	
	% of children receiving HPV vaccination 1 dose by the age of 15.	90% Mar-26	70.7% Q4 25/26 (Q4 Trajectory: 90%)	
	Maintain physical examination at 6 weeks rates (Healthy Child Wales).	90% Mar-27	99.6% Apr-26 (Apr-26 Trajectory: 90.0%)	
	Increase weight and measurement at 8 weeks rates (Healthy Child Wales).	80% Mar-26	92% Q4 25/26 (Q4 Trajectory: 80%)	
	Percentage of adult smokers who make a quit attempt via Smoking Cessation Services.	5% Mar-26	4.6% Q4 25/26 (Q4 Trajectory: 5%)	
	Percentage of adult smokers who made a quit attempt via Smoking Cessation Services who are CO-validated as quit at 4 weeks.	32% Mar-26	22.2% Q4 25/26 (Q4 Trajectory: 32%)	
	Uptake of eligible patients who attend cardiovascular disease risk factor management programme (CVDRFMP).	3,125 Mar-27	First reported Q2 26/27	
	% of people who attended cardiovascular disease risk factor management programme (CVDRFMP) diagnosed.	312 Mar-27	First reported Q2 26/27	



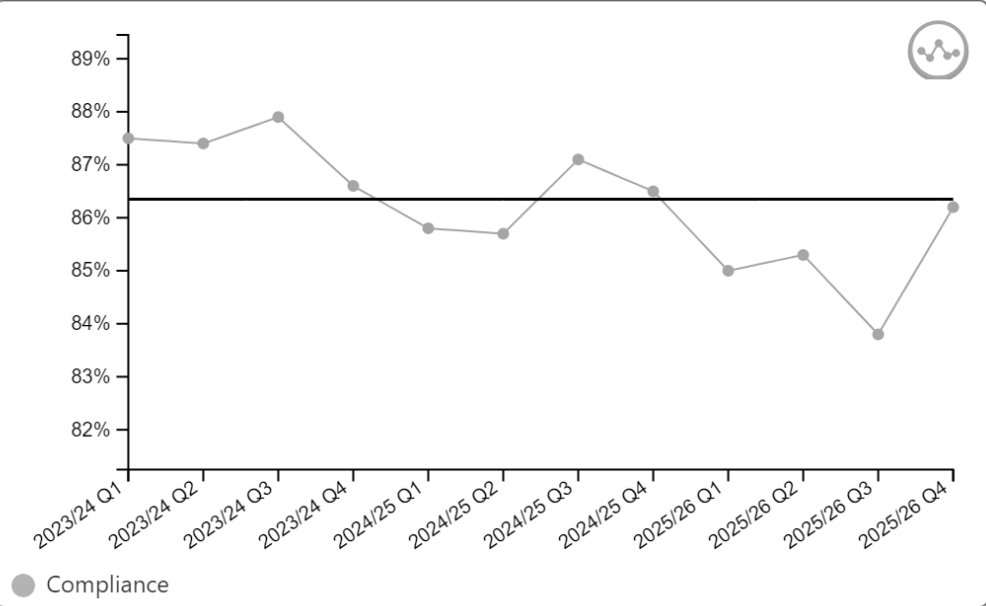
Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance
Population Health and Prevention	No. starting 12-week intervention with Level Two Adult Weight Management Service.	1,500 Mar-27	First reported Q1 26/27	
	No. with end weight recorded who accessed 8+ sessions who lost >5% weight.	450 Mar-27	First reported Q2 26/27	
	Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes.	50% Mar-27	48.1% Jul-26 (Q2 Trajectory: 48.0%)	
	Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months.	80% Mar-27	66.2% Jul-26 (Q2 Trajectory: 73.5%)	
	Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months.	80% Mar-27	71.9% Jul-26 (Q2 Trajectory: 74.0%)	
	Number of visits to the Melo Website.	48,000 Mar-27	15,896 Jul-26 (Q2 Trajectory: 24,000)	



Population Health and Prevention

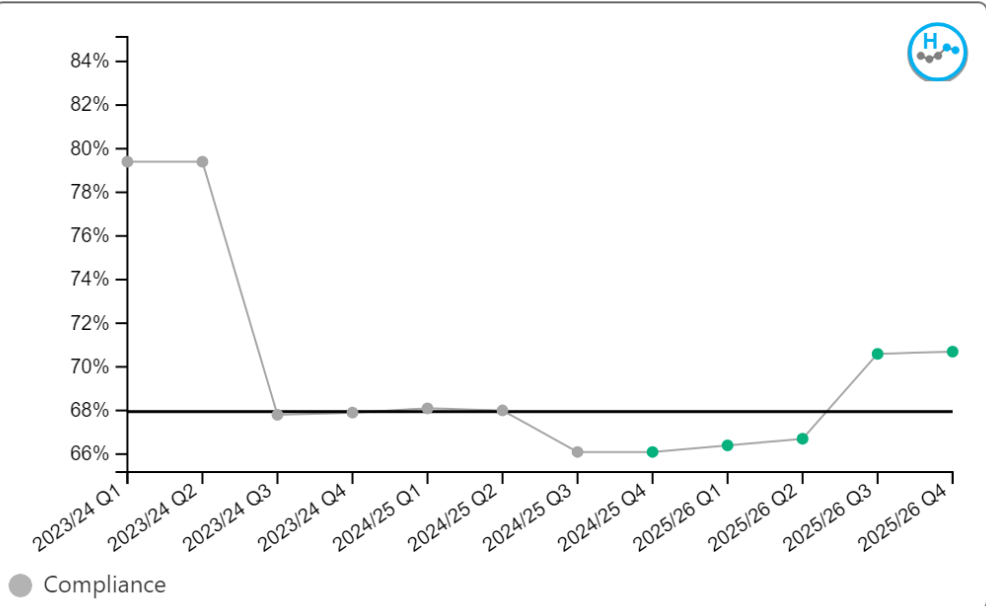
Measure: % children up to date with vaccinations by age 5
Performance: 86.2% (Q4 25/26)
Trajectory: 95.0% (Q4 25/26)
National target: 95.0%

Better Health



Measure: % of children receiving HPV vaccination 1 dose by the age of 15
Performance: 70.7% (Q4 25/26)
Trajectory: 90.0% (Q4 25/26)
National target: 90.0%

Better Health



Insights and Actions

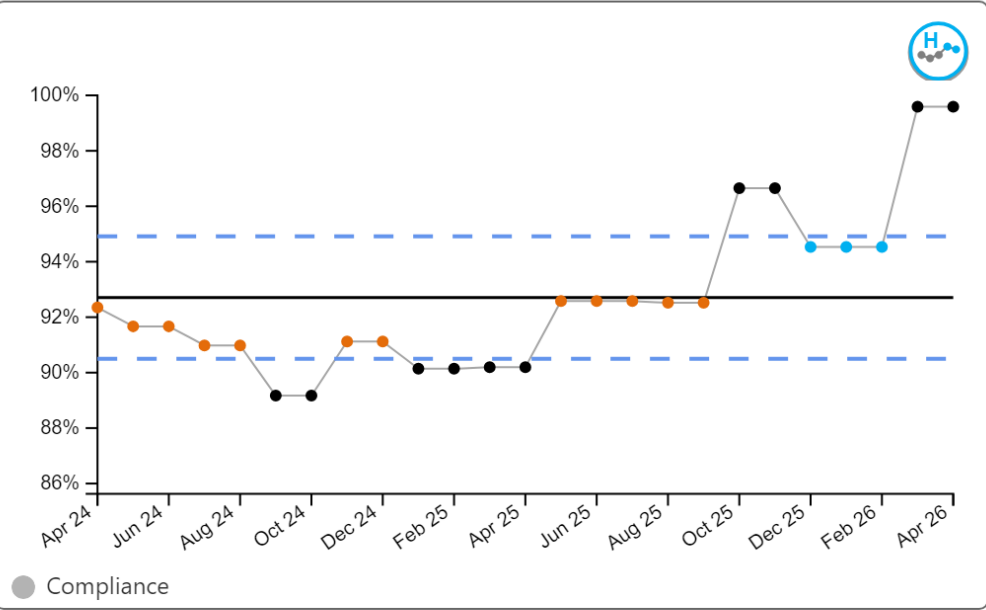
- Childhood vaccinations: Q4 performance increased to 86.2%, but overall performance across 25/26 is below trajectory (95%) and below the three-year average (86.3%).
- HPV: Q4 performance has maintained the above average improvement from Q3, with compliance at 70.7%. This continues an improvement trend for the last 5 quarters.
- Vaccination improvement work continues to progress across Gwent. Vaccination Brief Advice (VBA) training has been launched, with seven sessions delivered to date and a further nine planned, reflecting strong demand. The programme aims to improve healthcare professionals' confidence in addressing vaccine hesitancy and has also attracted interest from Betsi Cadwaladr University Health Board. The MMRV improvement pilot is commencing across six GP Practices in Newport and Torfaen to identify barriers to uptake, review vaccination processes, and develop sustainable approaches to improve coverage, reduce inequalities, and support equitable access. Targeted outreach through the Nye BeVAN has been developed to improve access for Gypsy and Traveller communities, with positive early engagement and seven children vaccinated across the first three outreach sessions. Key learning highlights the value of sustained community engagement, relationship-building, and flexible delivery models to support uptake among underserved groups.



Population Health and Prevention

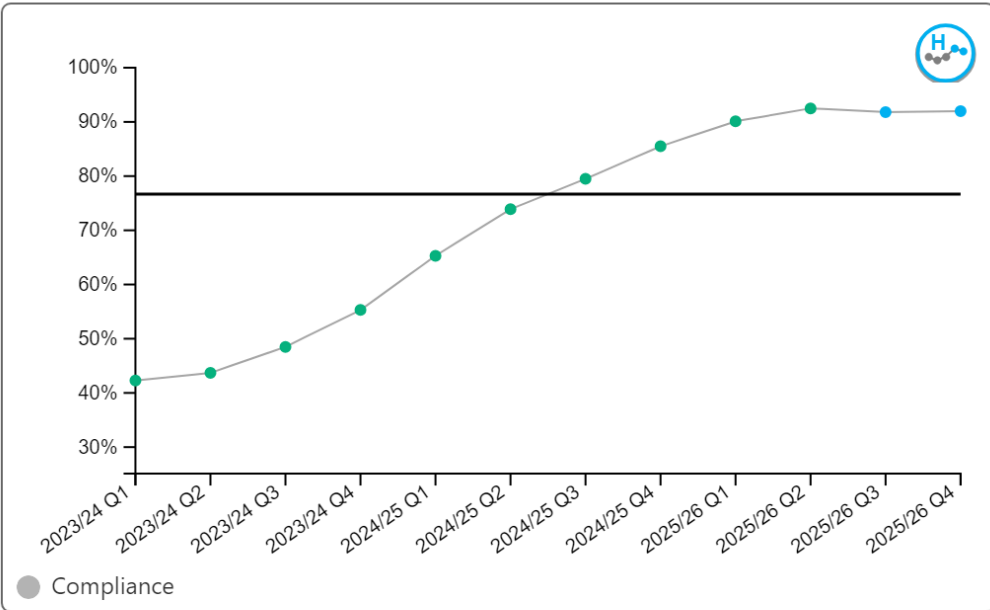
Measure: Maintain physical examination at 6 weeks rates (Healthy Child Wales)
Performance: 99.6% (April 2026)
Trajectory: 90.0% (April 2026)
National target: None

Better Health



Measure: Increase weight and measurement at 8 weeks rates (Healthy Child Wales)
Performance: 92.0% (Q4 25/26)
Trajectory: 80.0% (Q4 25/26)
National target: None

Better Health



Insights and Actions

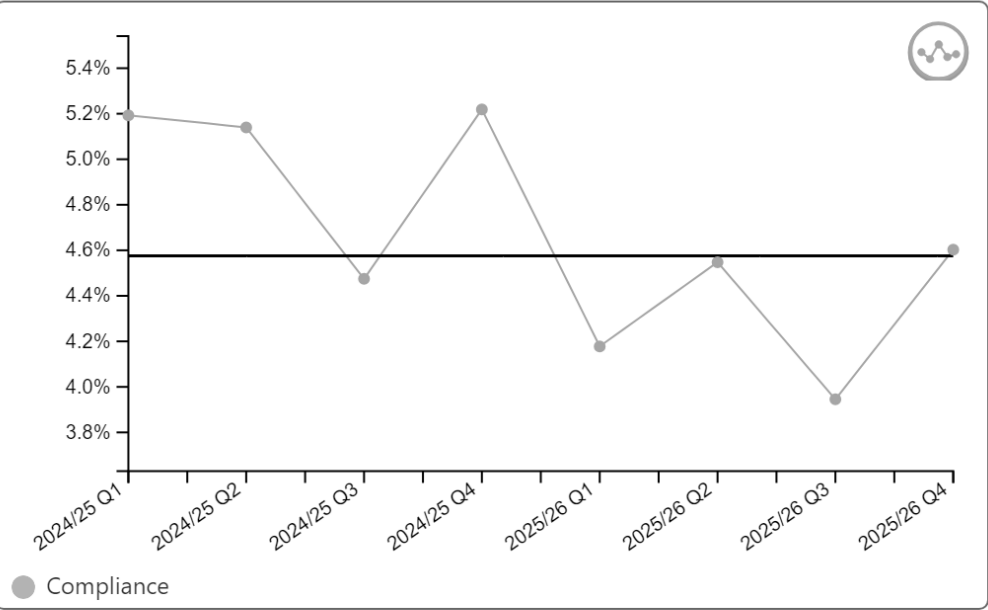
- Performance for physical examinations at 6-weeks continues to improve and has consistently achieved the national target (90%) through the course of 25/26. The past 2 months have shown exceptionally high performance at 99.6%, above the expected range of 90.5%-94.9%. The lower control limit is currently higher than the April trajectory (90.5% compared to 90%), demonstrating that the target will be consistently achieved.
- 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 met every quarter through 25/26.



Population Health and Prevention

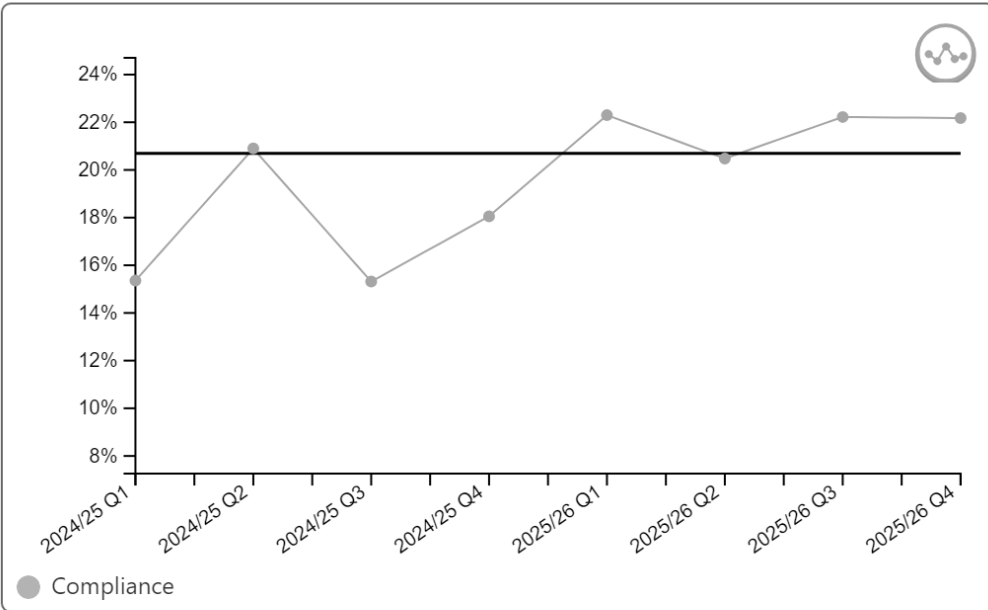
Measure: Percentage of adult smokers who make a quit attempt via smoking cessation services
Performance: 4.6% (Q4 25/26)
Trajectory: 5.0% (Q4 25/26)
National target: 7.5%

Better Health



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% (Q4 25/26)
Trajectory: 32.0% (Q4 25/26)
National target: 40.0%

Better Health



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. Q4 quit attempt performance increased to 4.6%, which represents the two-year average and is marginally short of the 25/26 trajectory of 5%. CO validated quits have been maintained at 22.2% in Q4, with the year end position finishing 10% below the trajectory of 32%.

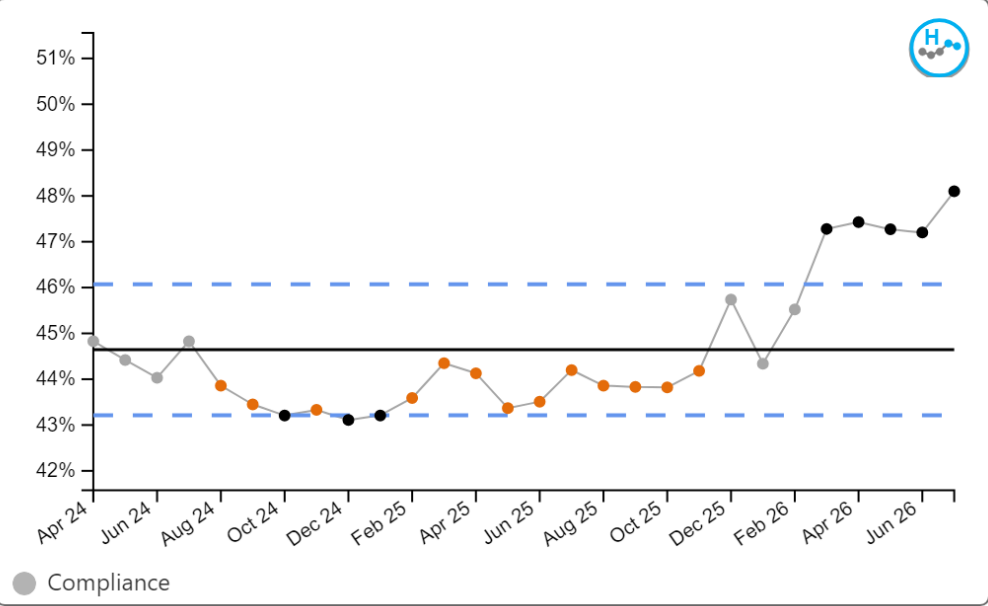
- Behaviour Change Practitioners within the Health Board's Smoking Cessation Service are continuing to embed within their localities and strengthen relationships with Partners and Communities. A comprehensive improvement programme is underway to optimise service delivery through the review and redesign of processes, with a greater focus on supporting individuals and groups to achieve CO-validated quits at four weeks, rather than relying solely on self-reported outcomes. This is being supported through increased Community-based clinic capacity and by enabling practitioners to become fully embedded within their respective localities and place-based teams. Work is also continuing to ensure that capacity is deployed proportionately to support vulnerable populations at greatest risk of tobacco-related harm. A communications plan has been developed for promoting Help Me Quit with community groups and stakeholders as well as continuous monitoring to ensure maximal attendance at clinics. As a result of these improvements, the service recorded a 69% increase in CO-validated quits in March 2026 compared with March 2025, subject to final validation and data submission.



Population Health and Prevention

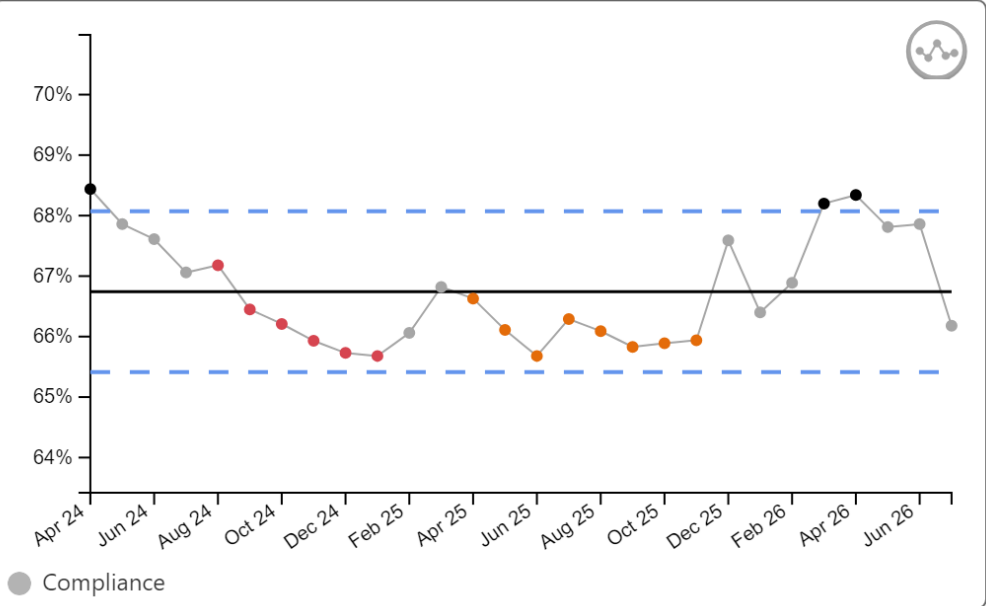
Measure: Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes
Performance: 48.1% (July 2026)
Trajectory: 48.0% (Q2 26/27)
National target: 80.0%

Ministerial Delivery
Better Health



Measure: Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months
Performance: 66.2% (July 2026)
Trajectory: 73.5% (Q2 26/27)
National target: 80.0%

Better Health



Insights and Actions

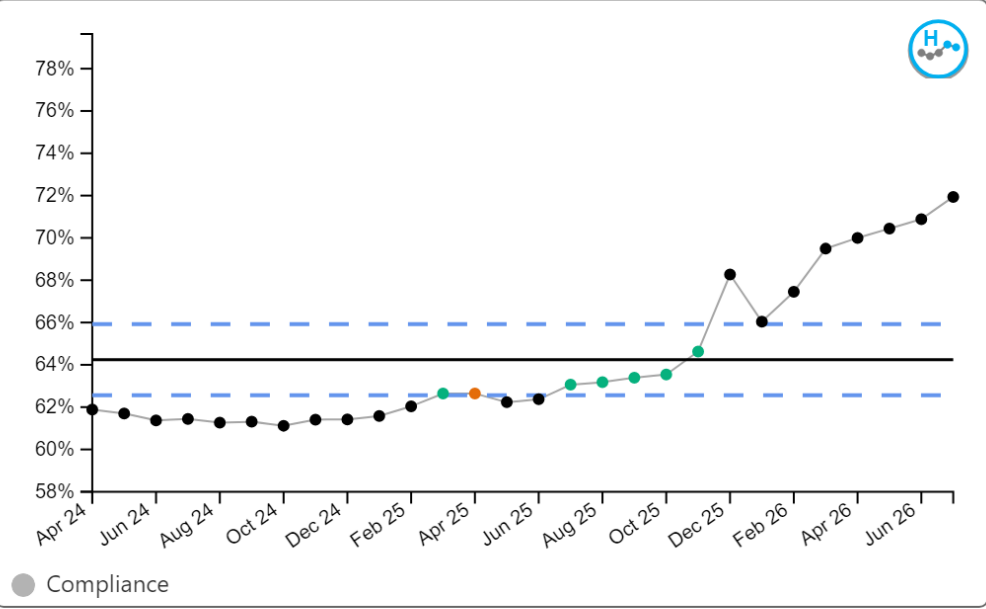
- 8 Diabetes processes: Performance is improving, with the past five-months showing out of normal range high values (47%+), compared to the expected performance range of 43%-46%. July performance of 48.1% has just exceeded the Q2 IMTP trajectory of 48%.
- Diabetes foot surveillance: Performance shows a similar improvement trend to the 8 Diabetes processes, with exceptionally high performance in March and April (68%+), reducing to in May and June. July performance has dropped below the mean to 66.2% and is currently behind the Q2 IMTP trajectory of 73.5%. The Foot Care project has distributed education materials across Secondary Care and all 68 ABUHB practices, with baseline data established. Follow-up analysis and pathway improvement work will continue in Q2. Additionally, the Gestational Diabetes project has established two workstreams focused on pre-conception care and postnatal follow-up. Early data shows only 43% compliance with follow-up testing within three months of delivery, with improvement work planned through Q2 and Q3. For Transition to Adult Services, pathway mapping and scoping have been completed. Demand and capacity pressures remain a challenge, and Q2-Q3 activity will focus on identifying improvement opportunities within existing resources.



Population Health and Prevention

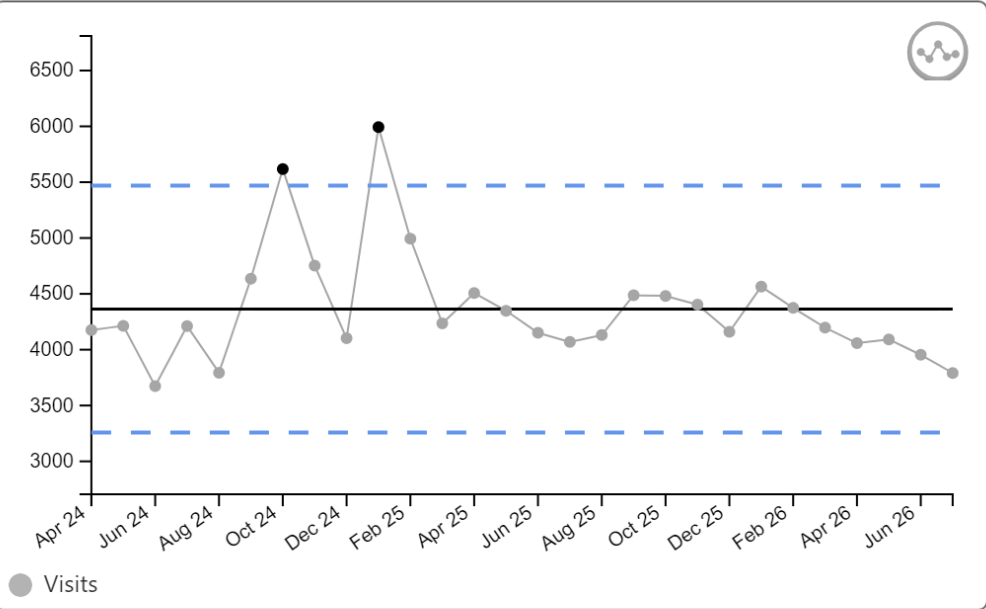
Measure: Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months
Performance: 71.9% (July 2026)
Trajectory: 74.0% (Q2 26/27)
National target: 80.0%

Better Health



Measure: Number of visits to the Melo Website
Performance: 15,896 (July 2026)
Trajectory: 24,000 (Q2 26/27)
National target: None

Better Lives



Insights and Actions

- Diabetes uACR: Performance has shown an improving trend since February 25, with improved performance of 66%-72% achieved in the past 8 months, compared to the expected range of 62.6%-65.9%. July performance of 71.9% is currently behind the Q2 IMTP trajectory of 74%. The Urine ACR project has now closed, with over half of participating practices achieving a >5% improvement in compliance at six months.
- Melo visits: Melo is the Health Board’s website containing information, advice and self-help resources to help people look after their Mental Health and wellbeing. Three new topics are being introduced in 2026 (Smoking and Mental Wellbeing, Hoarding, Neurodivergence) and free promotional materials are being made available to engage service users across ABUHB. The number of visits to the website is currently showing no significant change month-to-month, however performance has become more consistent around the mean (4,401) in 25/26 compared to 24/25, now ranging from ~4,000-4,500 visits per month. June and July have shown slightly lower monthly visits (<4,000) with the July position at 15,896 visits for the year to date.



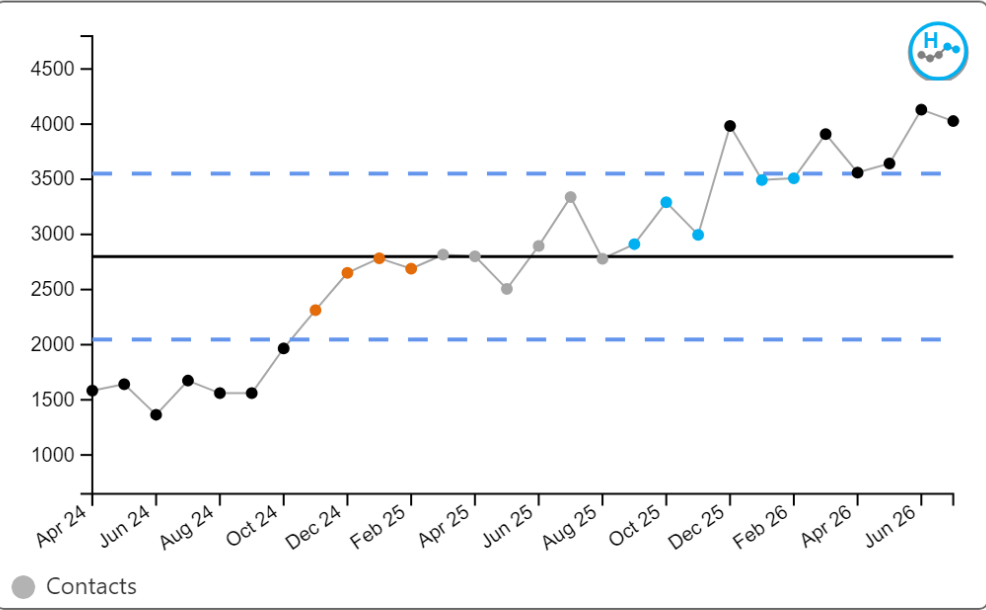
Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance
Place Based Care	Increase in people accessing PIPs where they would have visited their GP.	45,620 Mar-27	15,363 Jul-26 (Q2 Trajectory: 22,810)	
	Maintain the number of consultations undertaken by Community Pharmacy under CAS.	99,871 Mar-27	39,411 Jul-26 (Q2 Trajectory: 49,936)	
	Maintain the number of patients accessing NHS Optometry Services.	265,118 Mar-27	92,742 Jul-26 (Q2 Trajectory: 132,559)	
	Number of patients accessing urgent emergency services - Dental.	36,173 Mar-27	3,210 Jun-26 (Q1 Trajectory: 9,043)	
	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.	118,223 Mar-27	30,524 Jul-26 (Q2 Trajectory: 59,112)	
	Maintain 95% of Palliative Care referrals assessed within 2 days.	95% Mar-27	88.4% Jun-26 (Q1 Trajectory: 92%)	
	Increase in number of accepted referrals to Rapid Response services.	5,068 Mar-27	1,525 Jul-26 (Q2 Trajectory: 2,534)	
	Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s.	8.5% Mar-27	7.6% Jul-26 (Q2 Trajectory: 8.5%)	
	Maintain the number of Urgent Primary Care contacts (inc. virtual).	101,746 Mar-27	25,054 Jun-26 (Q1 Trajectory: 25,437)	



Place Based Care

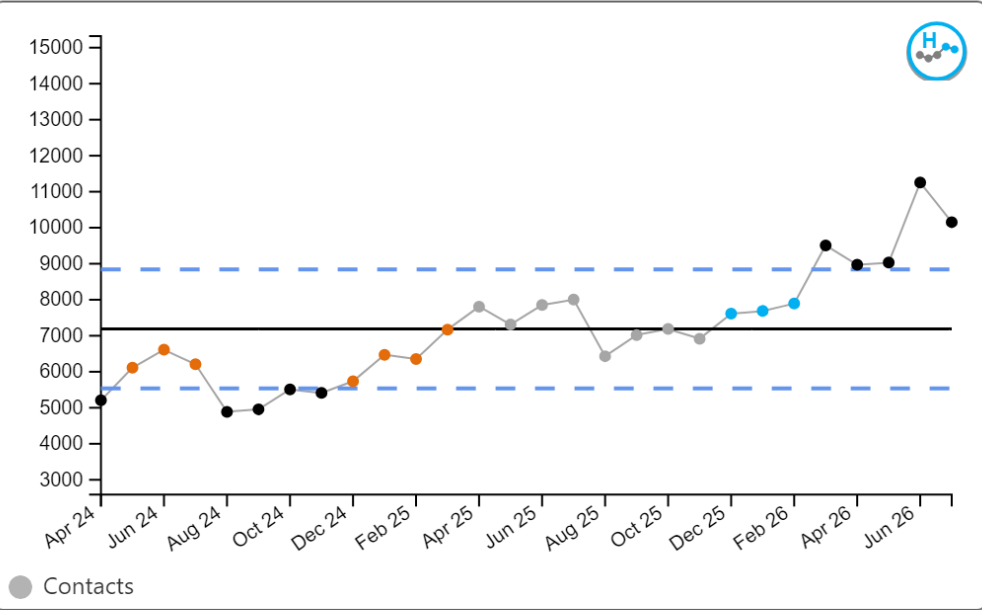
Measure: Increase in people accessing PIPs where they would have visited their GP
Performance: 15,363 (July 2026)
Trajectory: 22,810 (Q2 26/27)
National target: None

Better Care



Measure: Maintain the number of consultations undertaken by community pharmacy under CAS
Performance: 39,411 (July 2026)
Trajectory: 49,936 (Q2 26/27)
National target: None

Better Care



Insights and Actions

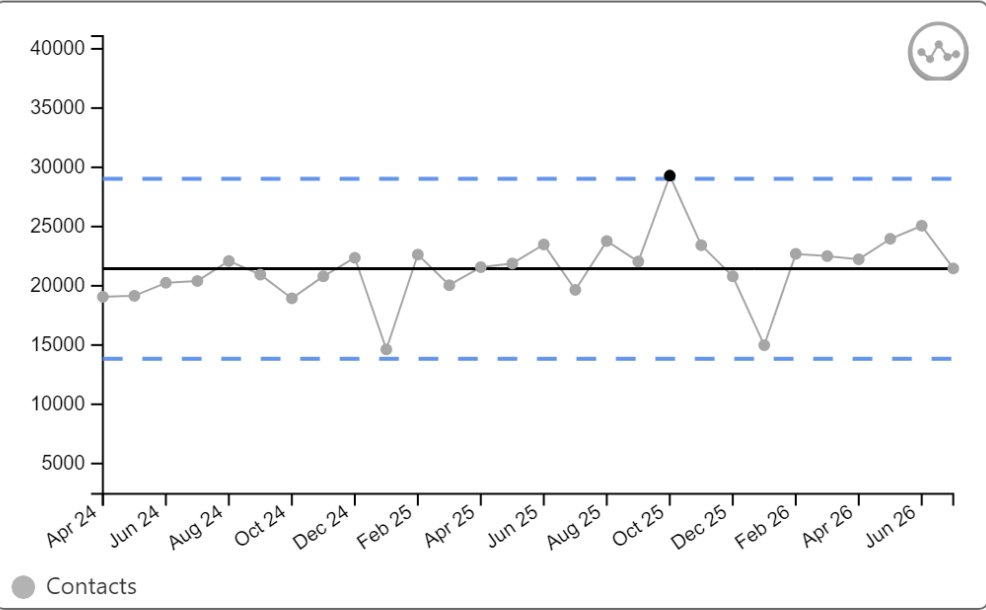
- Pharmacist Independent Prescribing Service (PIPS): PIPs consultations continue the improving trend, seen for the past 11 months and consistent improved performance (>3,551) for the past 5 months. Q1 performance finished just behind the Q1 IMTP trajectory with 11,336 contacts compared to 11,405 contacts. July performance to date is 15,363 contacts.
- Common Ailment Scheme (CAS): CAS claims show an improving trend, with consistent above-mean performance for the past 7 months. March performance to date has been excellent, with the number of claims exceeding the expected range of 5,540-8,840. Q1 performance exceeded the Q1 IMTP trajectory by over 4,000 contacts, with 29,256 contacts total compared to the trajectory of 24,968. July performance to date is 39,411 contacts.
- 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.



Place Based Care

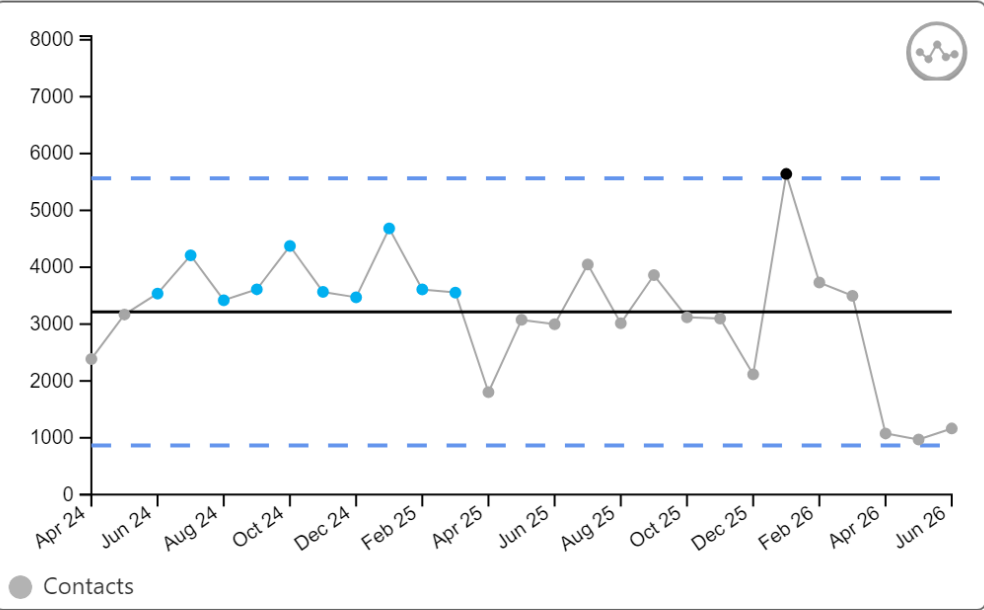
Measure: Maintain the number of patients accessing NHS Optometry Services
Performance: 92,742 (July 2026)
Trajectory: 132,559 (Q2 26/27)
National target: None

Better Care



Measure: Number of patients accessing urgent emergency services - Dental
Performance: 3,210 (June 2026)
Trajectory: 9,043 (Q1 26/27)
National target: None

Better Care



Insights and Actions

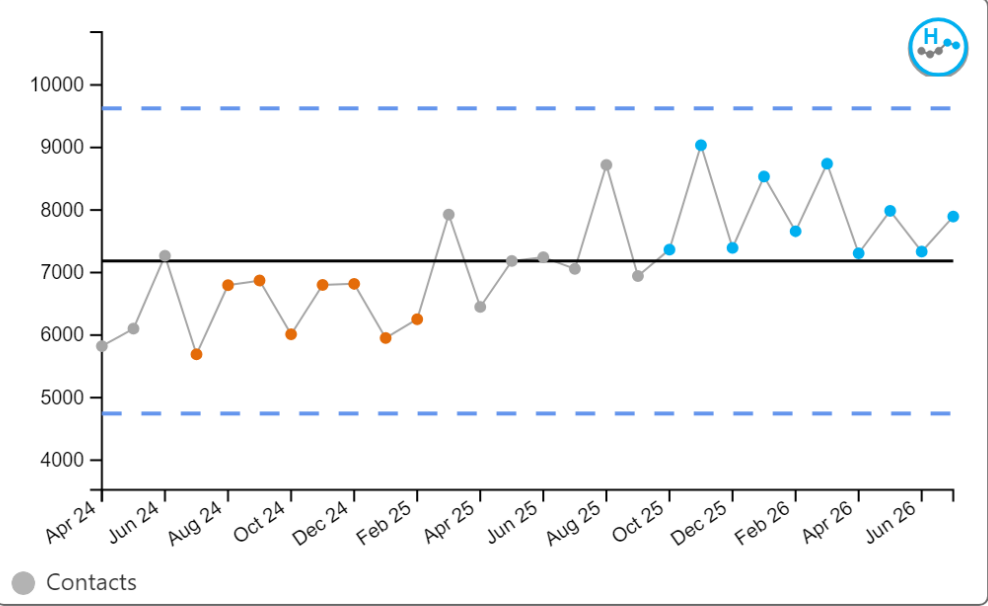
- Optometry Services: Performance for 26/27 has been above the mean of 21,436 patients per month to date. The total patients accessing NHS optometry services for Q1 was 71,270, comfortably exceeding the Q1 IMTP trajectory of 66,820 contacts. July performance to date is 92,743 contacts.
- Emergency Dental: Performance has dropped very close to the lower control limits for Q1 26/27, with around a 1,000 contacts a month compared to the average of over 3,000 in 2024/25 and 2025/26. This is due to implementation of the new NHS Wales dental contract, with all practices now required to see a proportion of urgent appointments. There are currently approx. 240 appointments a week available through practices compared to 60 through EDS, which has resulted in the significant reduction in performance. Subsequently, the Q1 IMTP trajectory of 9,043 has not been met, with 3,210 contacts in total for Q1.



Place Based Care

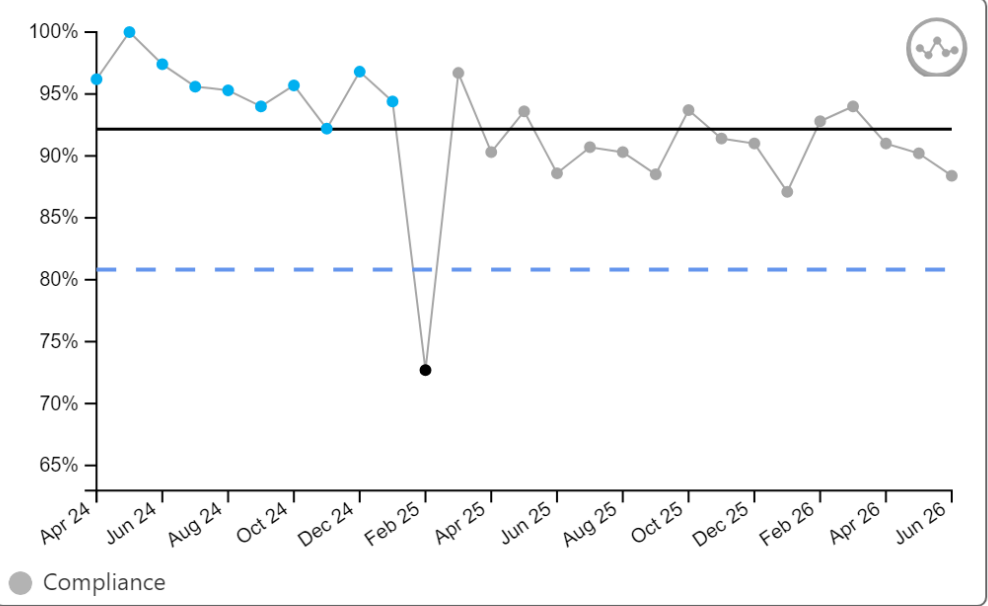
Measure: Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25
Performance: 30,524 (July 2026)
Trajectory: 59,112 (Q2 26/27)
National target: None

Ministerial Delivery
Better Lives



Measure: Maintain 95% of Palliative Care referrals assessed within 2 days
Performance: 88.4% (June 2026)
Trajectory: 92.0% (Q1 26/27)
National target: None

Better Lives



Insights and Actions

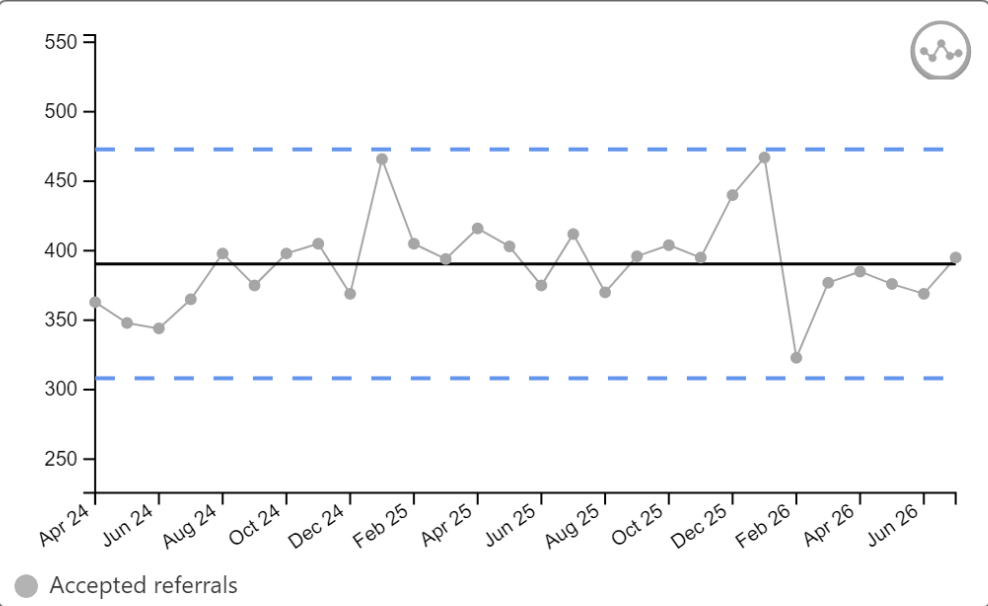
- Community Nursing: Performance is currently showing an improving trend, with above-mean capacity for the past 10 months. Q1 performance finished behind the expected trajectory, with only 77% of the IMTP trajectory delivered. Ministerial expectations set out that weekend activity reaches 80% of an average 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. July performance to date is 30,524 contacts.
- Palliative Care: Performance is currently showing no significant monthly change, and is just below the mean of 92%. The June position is 88.4% and just behind the Q1 IMTP trajectory of 92%.



Place Based Care

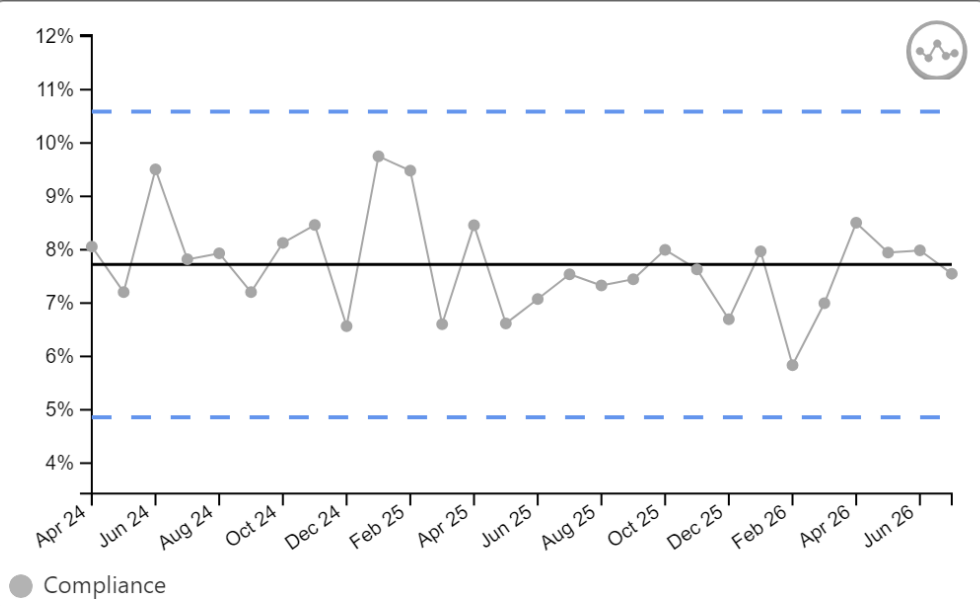
Measure: Increase in number of accepted referrals to Rapid Response services
Performance: 1,525 (July 2026)
Trajectory: 2,534 (Q2 26/27)
National target: None

Better Care



Measure: Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments for over 65s
Performance: 7.6% (July 2026)
Trajectory: 8.5% (Q2 26/27)
National target: None

Better Care



Insights and Actions

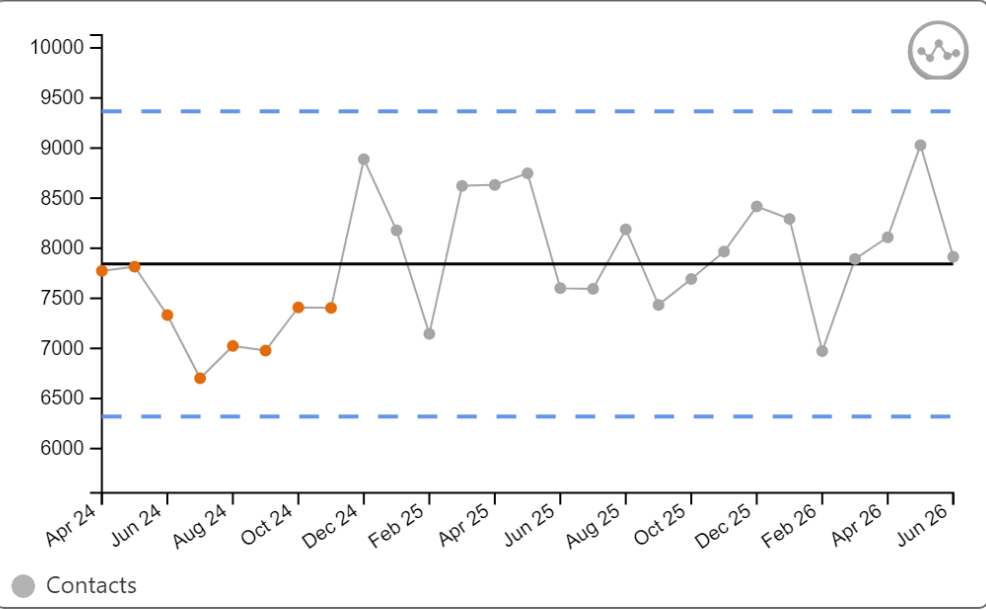
- Accepted referrals to Rapid Response: The number of accepted referrals currently shows no significant monthly change, with wide process limits indicating that performance is expected to vary between 310-470 accepted referrals per month. 26/27 performance to date has been more consistent at around 380 accepted referrals per month. Performance for Q1 was a total of 1,110 accepted referrals, around 150 less than the IMTP trajectory of 1,267. July performance to date is 1,525 referrals.
- 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. Again, there are wide process limits, indicating that the proportion referred is expected to vary between 5%-11%. April performance met the Q1 IMTP trajectory of 8.5%, but performance has been just under this in May (7.9%) and June (8%). July performance has continued this downward trend at 7.6%. 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.



Place Based Care

Measure: Maintain the number of Urgent Primary Care contacts (inc. virtual)
Performance: 25,054 (June 2026)
Trajectory: 25,437 (Q1 26/27)
National target: None

Better Care



Insights and Actions

- Urgent Primary Care (UPC): UPC contacts currently show no significant change month-on-month and exhibit a wide expected range of 6,300-9,400 contacts per month. Q1 performance finished on 25,054 contacts, around 400 contacts below the IMTP trajectory of 25,437.



Section 2.1: Timely Access to Care – Urgent & Emergency Care Performance Summary

Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Urgent and Emergency Care	Ensure no ambulance patient handover waits over 45 minutes [All location types, GUH & eLGHs]	91 Mar-27	352 Aug-26 (Aug-26 Trajectory: 505)		
	Ensure no ambulance patient handover waits over 45 minutes [GUH ED only]	80 Mar-27	290 Aug-26 (Aug-26 Trajectory: 413)		
	Reduce the number of ambulance crew hours lost [All location types, GUH & eLGHs]	960 Mar-27	539 Aug-26 (Aug-26 Trajectory: 1,733)		
	Reduce the number of ambulance crew hours lost [GUH ED only]	768 Mar-27	480 Aug-26 (Aug-26 Trajectory: 1,386)		
	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	1,312 Aug-26 (Aug-26 Trajectory: 941)		
	% 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	95% Mar-27	91.9% Aug-26 (Aug-26 Trajectory: 94%)		
	Reduction in time from arrival to ED triage - no waits over 60 minutes	200 Mar-27	546 Aug-26 (Aug-26 Trajectory: 300)		
	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.	60 Mar-27	151 Aug-26 (Aug-26 Trajectory: 100)		
	Increase and maintain national target of the percentage of patients waiting <4-hours in ED/MIU	77% Mar-27	71.8% Aug-26 (Aug-26 Trajectory: 75%)		

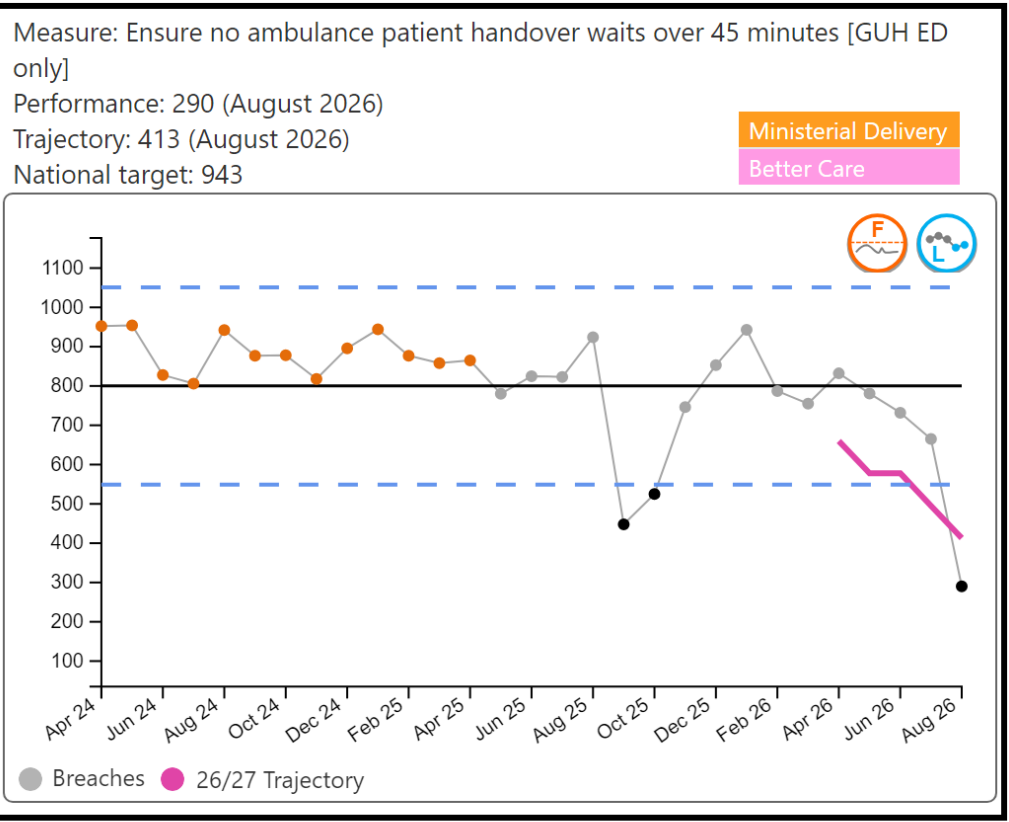
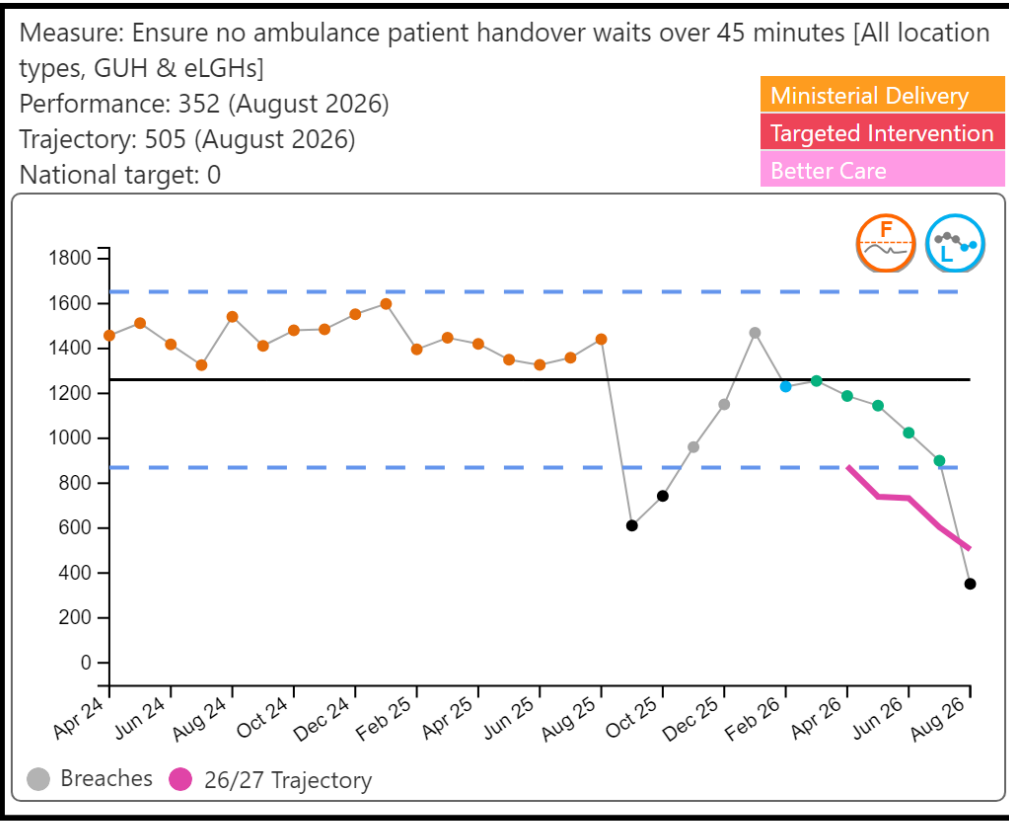
Section 2.1: Timely Access to Care – Urgent & Emergency Care Performance Summary



Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Urgent and Emergency Care	Improve the percentage of pre noon Provider Spell discharges	17.1% Mar-27	16% Aug-26 (Aug-26 Trajectory: 16.5%)		
	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	152 Aug-26 (Aug-26 Trajectory: 140)		
	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	5,160 Aug-26 (Aug-26 Trajectory: 4,200)		
	Percentage of suspected stroke patients scanned within 20 minutes of clock start	35% Mar-27	15.3% Jul-26 (Jul-26 Trajectory: 26%)		
	% of patients directly admitted to an Acute Stroke Ward <4-hrs of clock start	23% Mar-27	35.7% Jul-26 (Jul-26 Trajectory: 20%)		
	% of unique Stroke patients given Thrombectomy (all stroke types)	6% Mar-27	1.7% Jul-26 (Jul-26 Trajectory: 5%)		
	% Assessed by OT within 24hrs	32.5% Mar-27	47.5% Jul-26 (Jul-26 Trajectory: 28%)		
	% Assessed by PT within 24hrs	30% Mar-27	49.2% Jul-26 (Jul-26 Trajectory: 25%)		
	% Assessed by SaLT within 72hrs	72% Mar-27	89.7% Jul-26 (Jul-26 Trajectory: 68%)		



Urgent & Emergency Care System



Insights and Actions

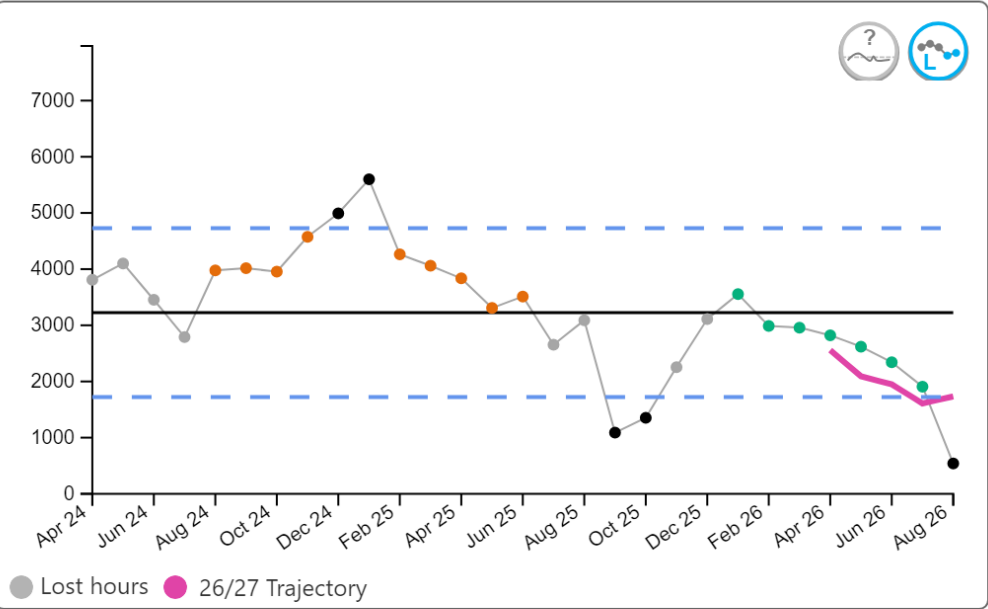
- Ambulance handovers over 45 minutes: August saw significant improvement achieved against the Handover 45 (H45) standard. Under both the new Targeted Intervention (TI) definition (ambulances over 45 minutes at GUH & eLGHs across all location types, previously ambulances over 1 hour at GUH ED only) and 45 minute breaches at GUH ED reduced to their lowest ever levels since the opening of the Grange. Under the new TI measure, both the annual plan performance trajectory (505) and the TI de-escalation threshold (651) have been met, however the latter does need to be maintained for three months to full satisfy the criteria. Since the Rapid Release Protocol was enacted from the 12th August, 45 minute handover compliance at GUH ED has been 93.6% with several days achieving 100% compliance. 45 minute handover compliance improvement is also evident at locations beyond GUH ED, with August performance of: GUH AMU: 89.3%; GUH SAU: 98.4%, and; eLGH AMUs: 95.8%.



Urgent & Emergency Care System

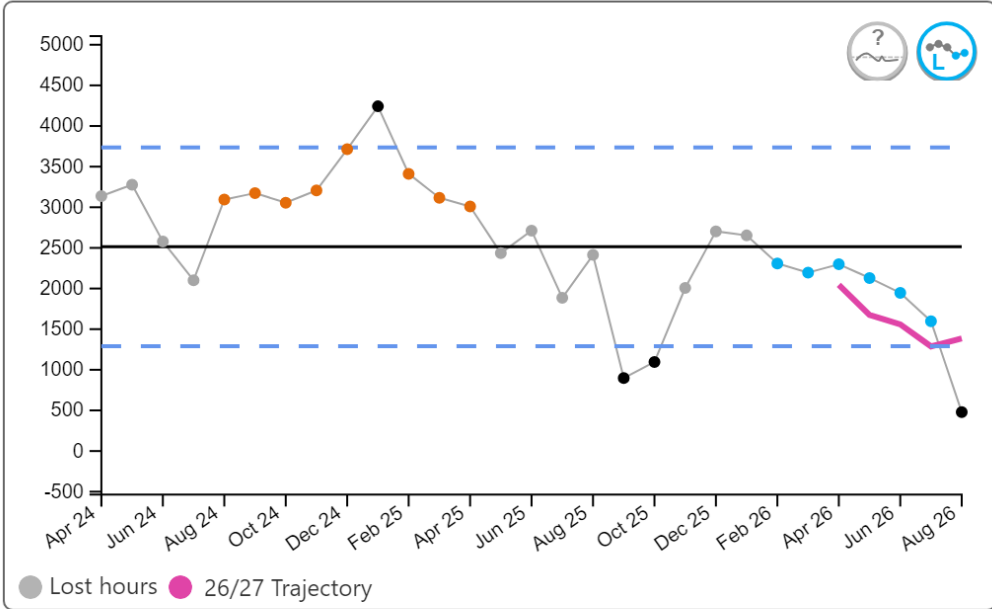
Measure: Reduce the number of ambulance crew hours lost [All location types, GUH & eLGHs]
Performance: 539 (August 2026)
Trajectory: 1,733 (August 2026)
National target: None

Better Care



Measure: Reduce the number of ambulance crew hours lost [GUH ED only]
Performance: 480 (August 2026)
Trajectory: 1,386 (August 2026)
National target: None

Better Care



Insights and Actions

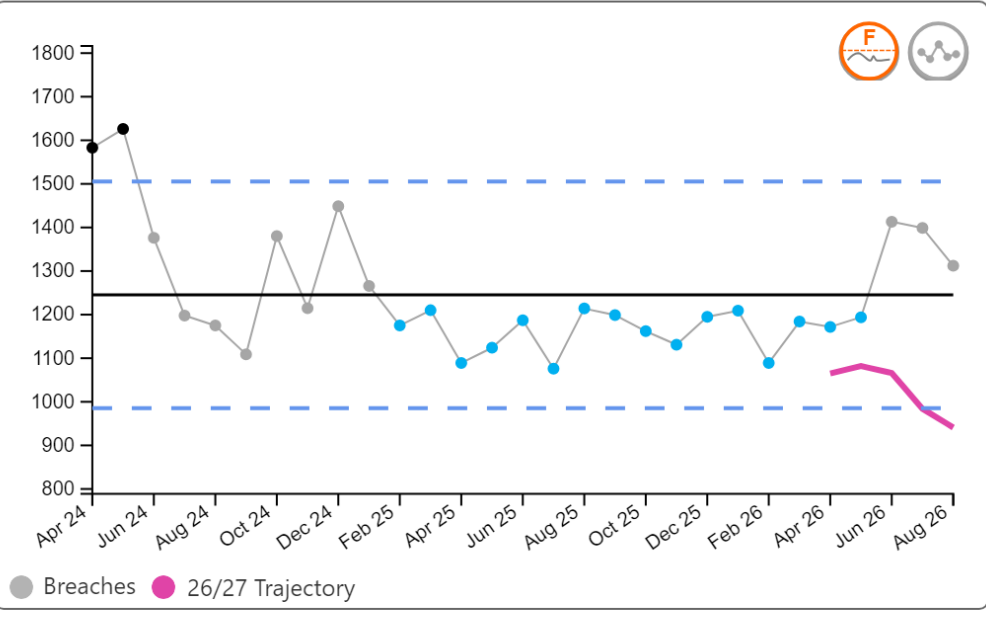
- Ambulance lost hours: Correspondingly, crew hours lost across both measures also saw reductions to record lows in August. At GUH ED, In the first part of August (from 1st to 11th Aug) lost hours was 346. From the 12th onwards crew hours lost totalled just 134. August average handover time was 34 minutes, with the isolated period since Rapid Release Protocol (from 12th to month end) Aug averaging 19 minutes. Under the wider measure (GUH & eLGHs), average handover reduced to 27 minutes for the month with the period from the 12th to month end being 17 minutes. 59 crew hours were lost outside of GUH ED in August, with just 23 from the 12th to month end. The six-week UEC sprint which ran through the summer was central to delivering a series of improvements across the entirety of the UEC pathway which has enabled improved handover performance, including strengthened escalation arrangements, standardised patient flow processes, enhanced discharge planning, improved operational oversight, AMU reconfiguration, Hospital to Home enhancements and the rollout of the "What Five Questions" approach.



Urgent & Emergency Care System

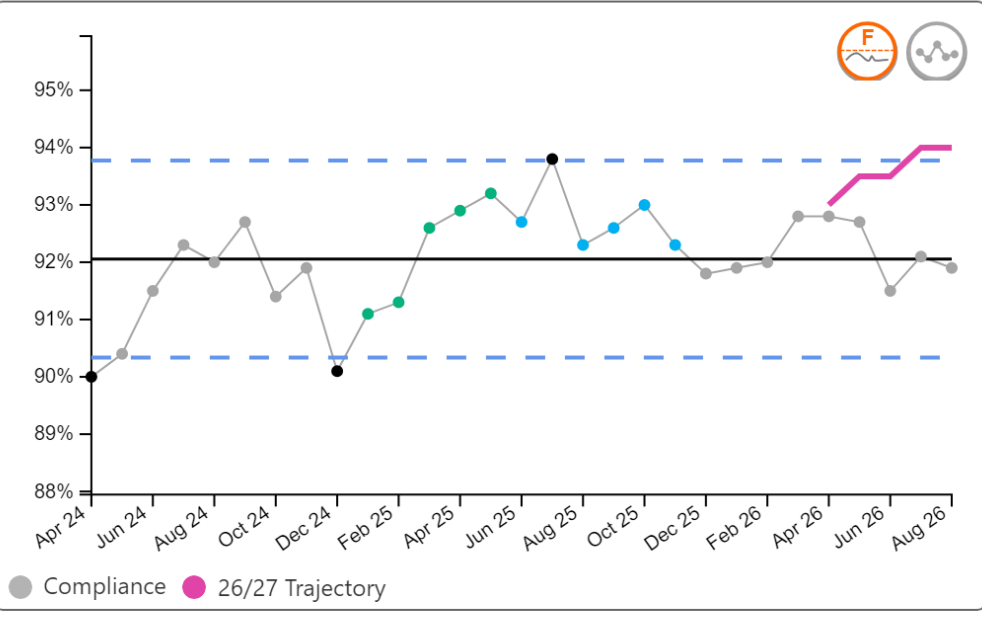
Measure: Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero
Performance: 1,312 (August 2026)
Trajectory: 941 (August 2026)
National target: 0

Ministerial Delivery
Better Care



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: 91.9% (August 2026)
Trajectory: 94.0% (August 2026)
National target: 93.0%

Targeted Intervention
Better Care



Insights and Actions

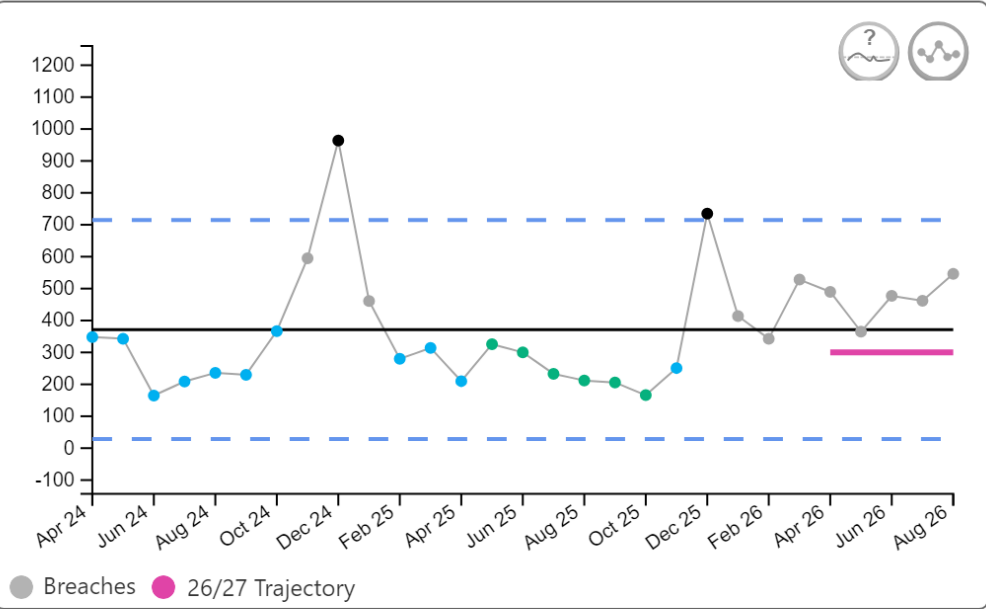
- 12hr EDMIU: 12-hour performance has been more challenged over the past three months, both by total breach volume and as a percentage of all attendances (e.g. compliance, shown on the right), with neither meeting the respective Annual Plan trajectories as of the August position. There was marginal improvement in performance when comparing August performance pre and post 12th August (introduction of the Rapid Release Protocol), with daily average breaches reducing by ~10, however more data points and adjacent flow indicators will need to be analysed before any confident assessment can be made on correlation with ambulance handover performance. Improved flow through the entirety of the UEC pathway remains central to delivering improved patient experiences and outcomes, as well as meeting the four measures within the targeted intervention criteria (ambulance handovers, 12hr performance, clinician waits to be seen, and pathway of care delays). The Multi Agency Discharge Event (MADE) brought together Health, Social Care and System Partners to review discharge processes and identify barriers preventing timely discharge. The event highlighted a number of common themes across sites, including delays in diagnostics and specialist reviews, limited therapy and rehabilitation capacity, variation in discharge pathways, workforce pressures, inconsistent management of Estimated Dates of Discharge (EDD), and increasing levels of patient complexity.



Urgent & Emergency Care System

Measure: Reduction in time from arrival to ED triage - no waits over 60 minutes
Performance: 546 (August 2026)
Trajectory: 300 (August 2026)
National target: None

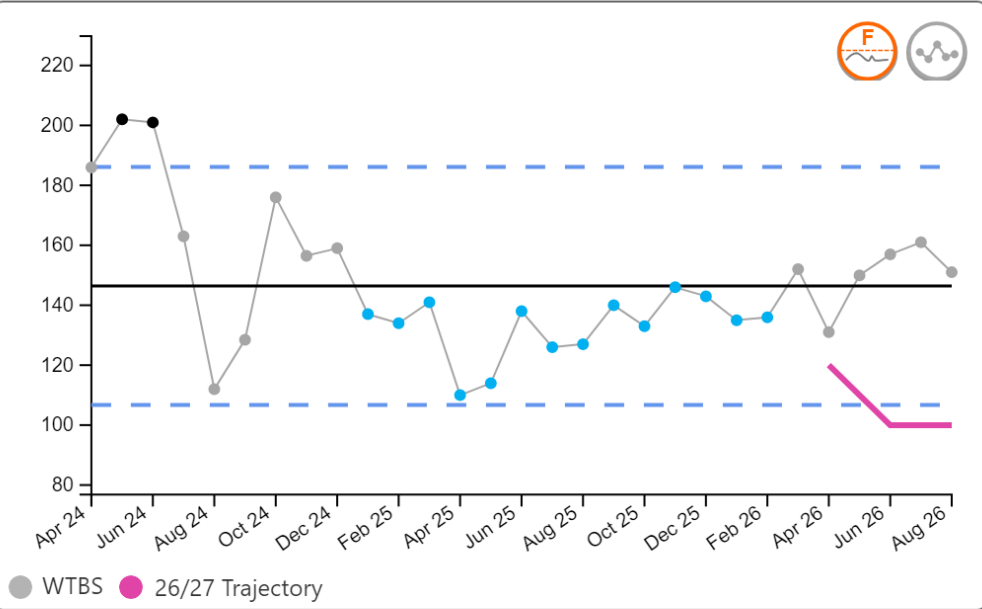
Better Care



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: 151 (August 2026)
Trajectory: 100 (August 2026)
National target: 60

Targeted Intervention

Better Care



Insights and Actions

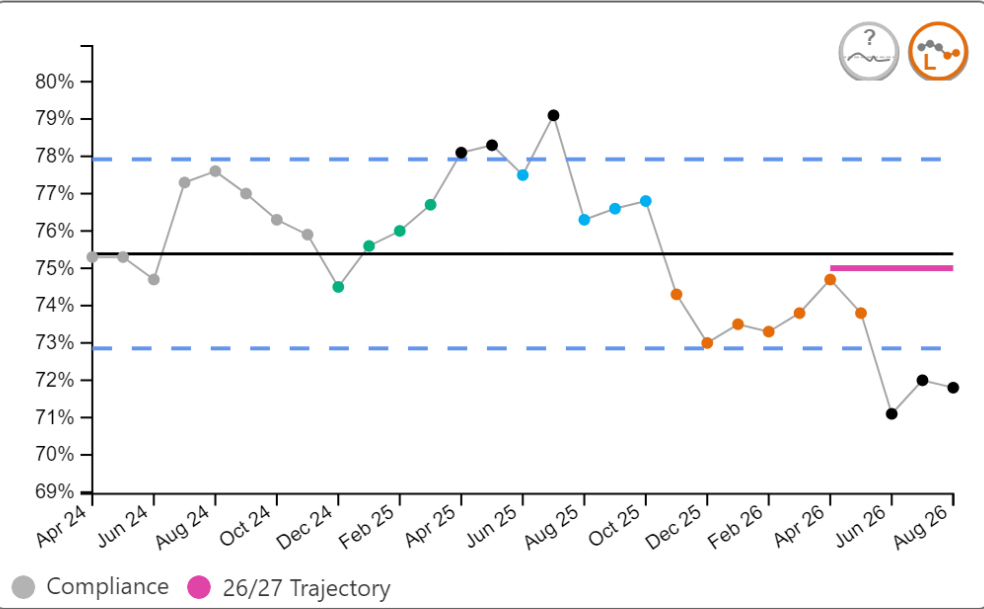
- Triage: Following the Winter peak in January, 60-minute triage breaches have remained elevated when compared to the same period in 2025. The August, daily, breach profile is analogous to that of the previous months this calendar year, whereby outlier days have a high volume of breaches. There is no significant variance in performance between the two pre and post 12th Aug periods.
- Wait to be seen (WTBS): Clinician Median Wait/WTBS has been on an a slight, overall upwards trajectory since Apr-25 and remains in excess of the Annual Plan improvement trajectory. In August there has been a small reduction median wait to be seen at GUH ED. There was a 24 minute improvement when comparing the pre and post 12th August periods. The rate of attendances seen within 60-minutes is improved again at 24.3% (May 21.3%, Jun 22.7%, Jul 23.4%), and the cohort of patients who wait more than 6 hours improved slightly by reducing to 19.9% (from 20.4% in July).



Urgent & Emergency Care System

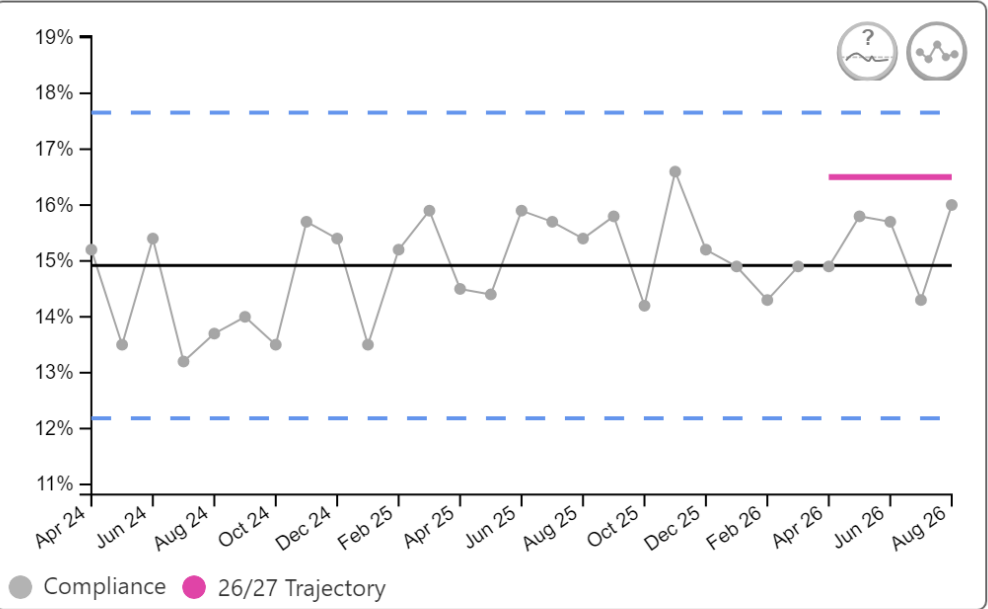
Measure: Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU
Performance: 71.8% (August 2026)
Trajectory: 75.0% (August 2026)
National target: 95.0%

Better Care



Measure: Improve the percentage of pre noon Provider Spell discharges
Performance: 16.0% (August 2026)
Trajectory: 16.5% (August 2026)
National target: 33.0%

Better Care

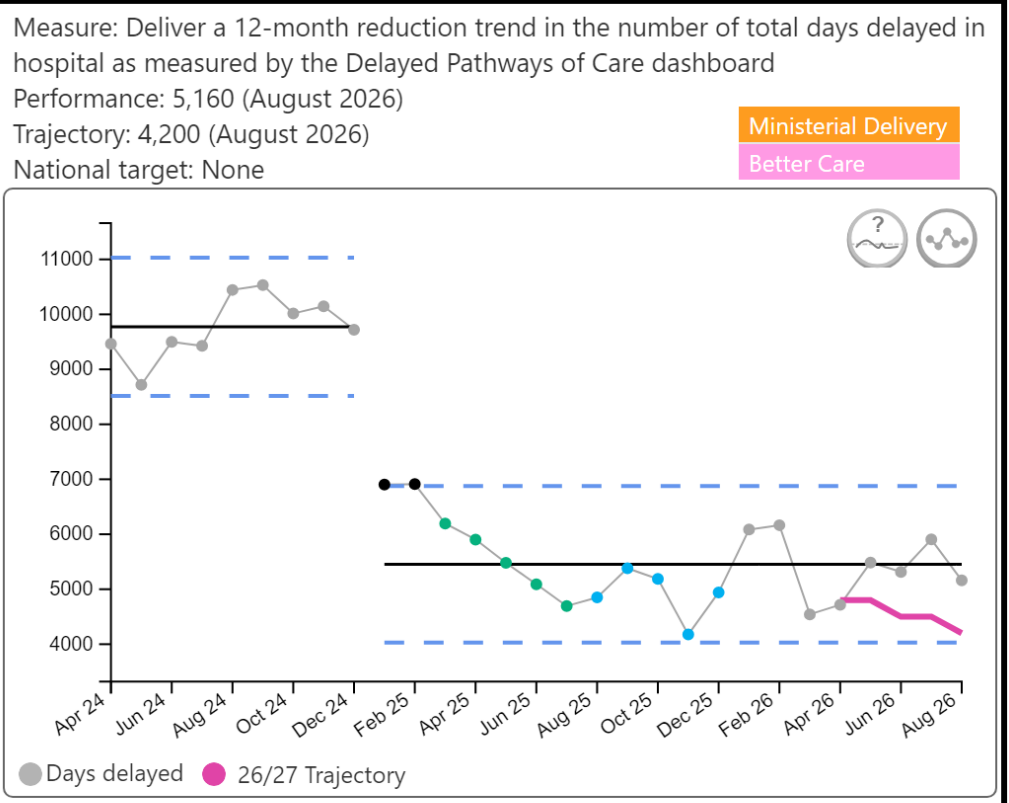
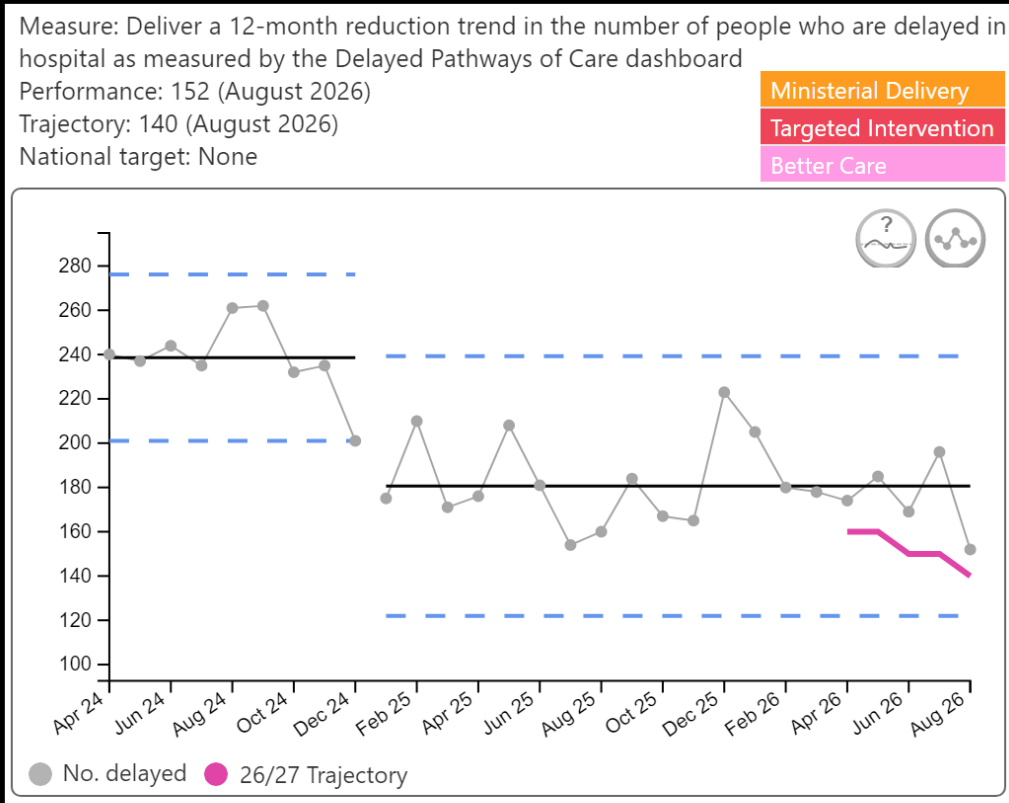


Insights and Actions

- 4hr EDMIU: 4-hour performance has been below the mean since October 25, driven by performance at the GUH. In the past three reportable months, performance has decreased further to levels outside of the lower process control limit and materially below the Annual Plan trajectory. GUH ED performance has decreased to below 45%, with decreases in compliance also observed at the eLGH MIUs. As per the actions already described around embedding the continuous flow model through the entirety of the UEC pathway, delivery of these is central to improving the performance of this front door metric.
- 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). August performance increased to 16% (0.5% lower than current trajectory), driven by improvements at GUH and NHH.



Urgent & Emergency Care System

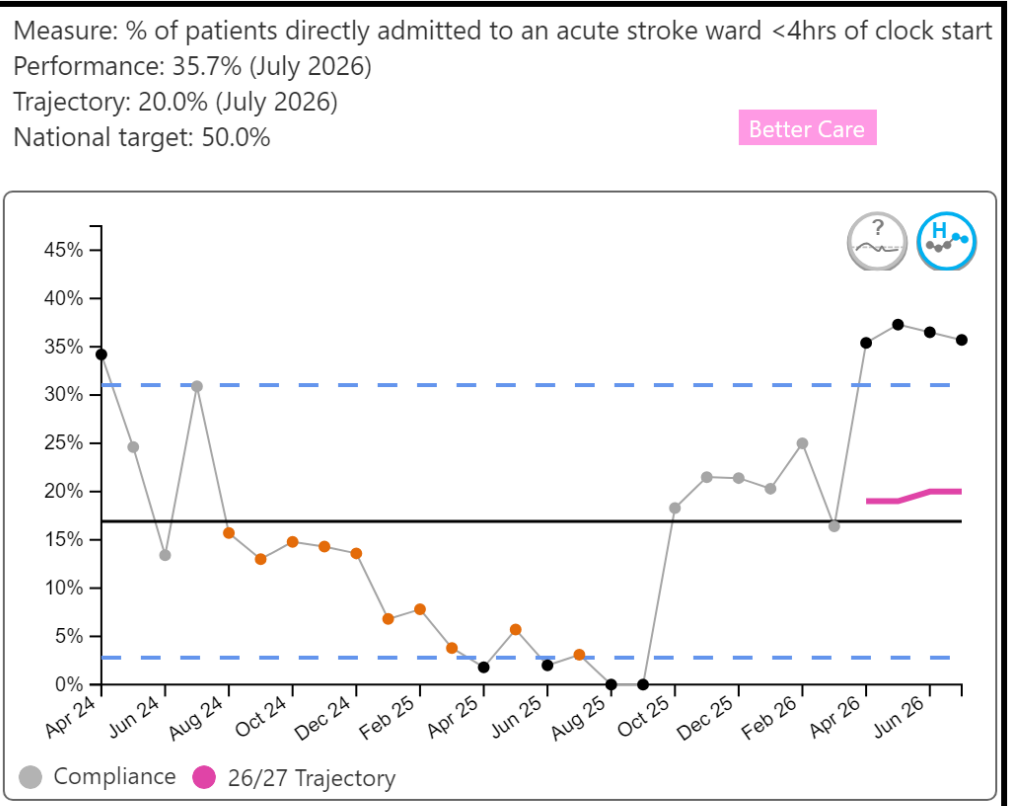
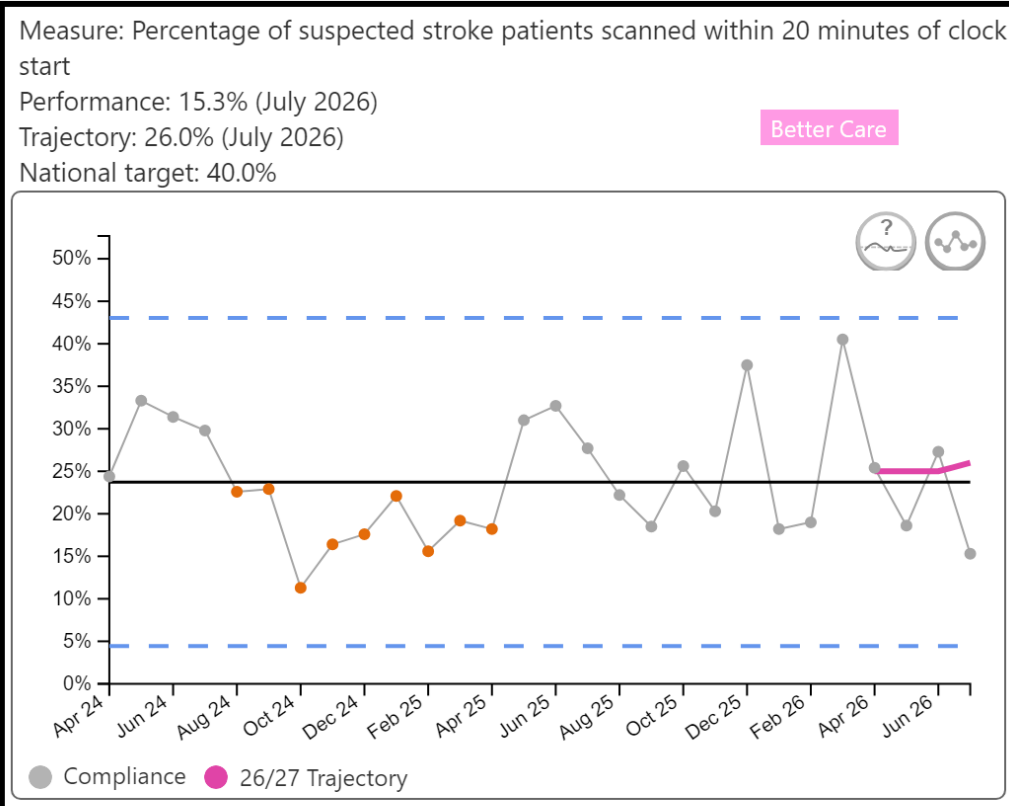


Insights and Actions

- Pathway of Care Delays (POCDs): The number of POCDs has been maintained around the mean of 178 from February 26, sustaining improvement from the 2025/26 high in December. The August position is a substantial reduction on July (-44, -22.4%) and the lowest position in the held dataset. This improvement has been primarily driven by a reduction in Joint and Social assessment delays. POCDs by days delayed has shown more variability but has demonstrated close to mean (5,455) performance for the past four months. The August position has reduced back down below the mean to 5,160 days, which is a reduction on the July position (-12.6%) but a slight increase on last year (+6.4%). Average days delayed increased consistently from March 26 (27 days) to June 26 (31 days), following the relative stability in POCDs and increase in days delayed. The substantial reduction in POCDs in August has been proportionally greater than the reduction in days delayed, increasing the average days delayed to 34 in August. Despite a substantial reduction in POCDs in August, POCDs by volume and days delayed remain behind the IMTP trajectories. 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



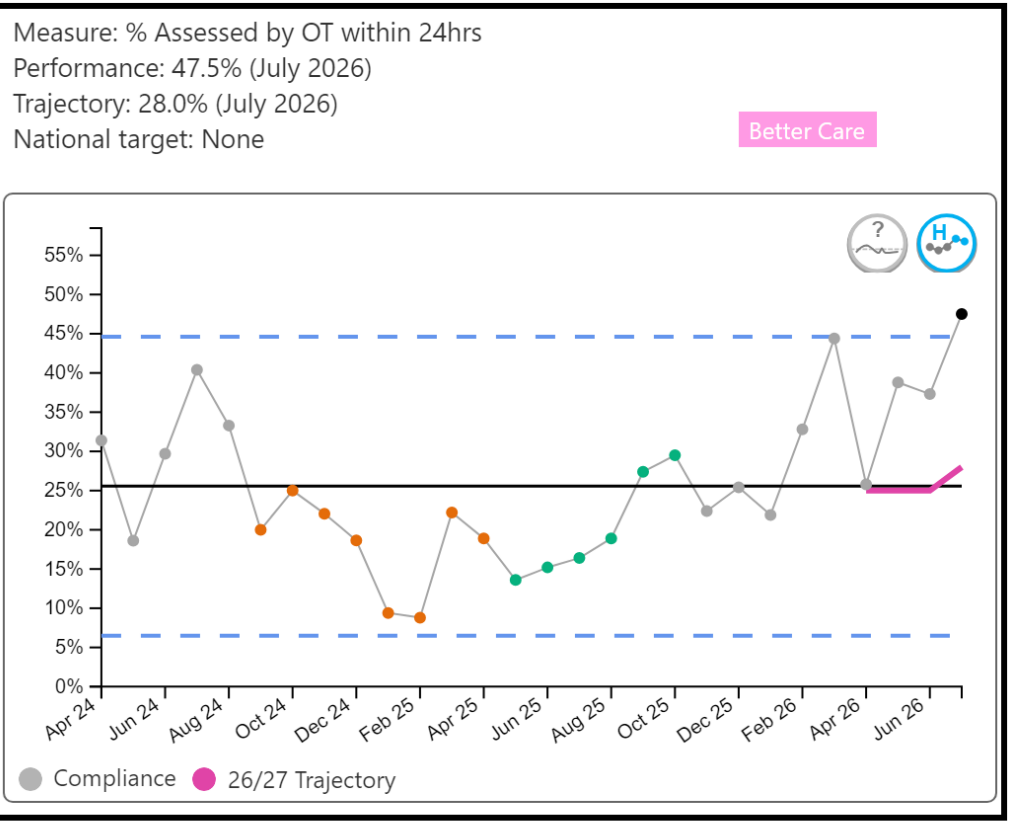
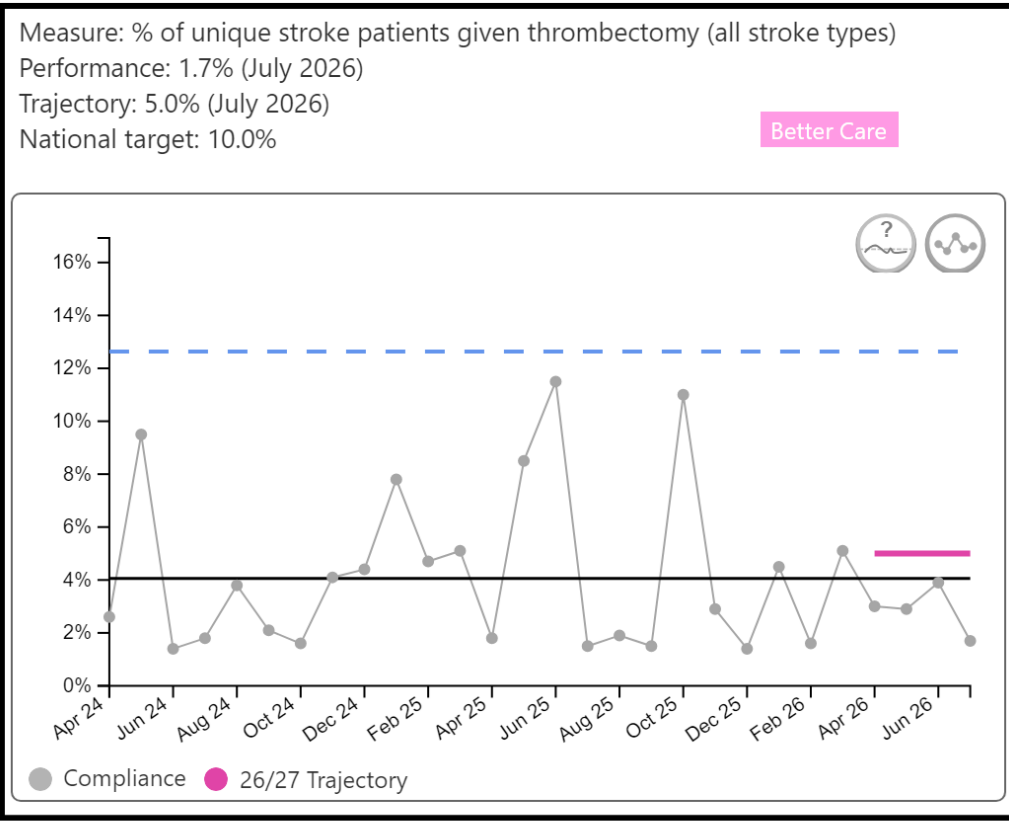
Insights and Actions

- 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. Year to date performance has fluctuated, with July performance decreasing to 15.3%. A review of the CT scanning pathway and adoption of perfusion scanning is underway.
- Stroke 4-hour target: Year to date 4-hour performance has been much improved and consistent, in excess of 35% and materially above trajectory. A pathway improvement workshop was held in July, identifying several opportunities to enhance performance, including reducing portering delays across the patient pathway, establishing clearer exit routes for stroke mimic patients to improve flow, and reviewing rehabilitation capacity and the availability of B4 beds to support timely transfers and reduce delays.



Section 2.1: Timely Access to Care – Urgent & Emergency Care

Urgent & Emergency Care System



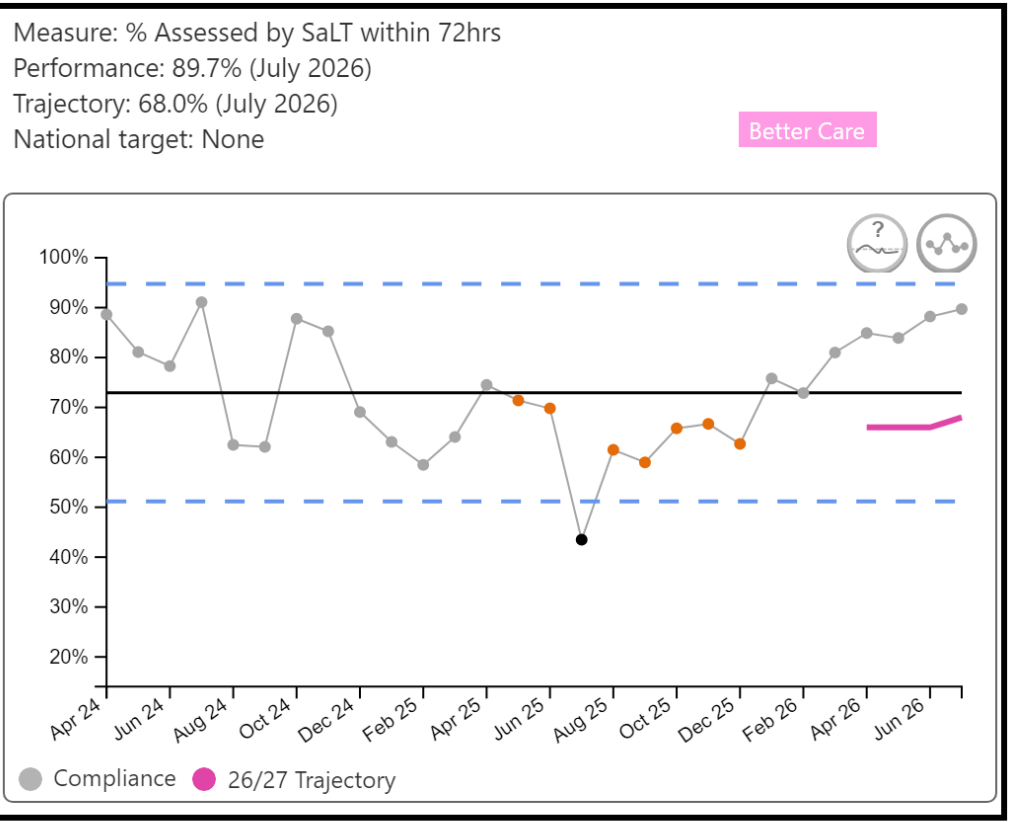
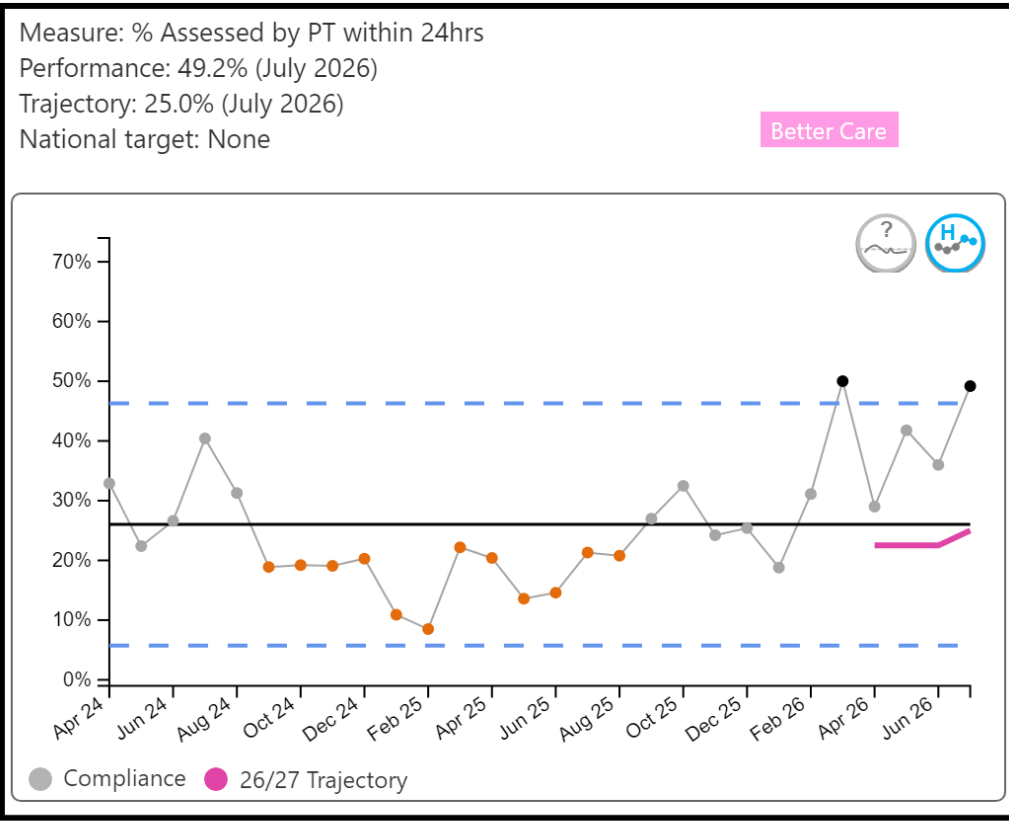
Insights and Actions

- Stroke thrombectomy: Thrombectomy rates were improved slightly through the first quarter of the 26/27, however there remains no overall variation in performance and July decreased to 1.7%. 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, with shared learning from other Health Boards who have introduced and significantly improved thrombolysis rates.



Section 2.1: Timely Access to Care – Urgent & Emergency Care

Urgent & Emergency Care System



Insights and Actions

- Stroke therapies: Occupational (previous page) and Physiotherapy assessment within 24-hours continue to demonstrate an overall improvement trajectory, with each recording their latest performance in excess of the upper control limit. Speech & Language within 72-hours also continues to deliver elevated levels of compliance. Work is underway with clinical teams to optimise Early Supported Discharge (ESD) pathways, including the development of direct discharge models from GUH and via YYF, alongside exploration of a dedicated Therapist model within GUH. Further opportunities include optimising length of stay within the dedicated Inpatient Rehabilitation Unit at YYF and reducing reliance on boarding within rehabilitation beds to improve patient flow and maximise rehabilitation capacity.

Section 2.1: Timely Access to Care – Cancer, Planned Care & Diagnostics Performance Summary



Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Cancer, Planned Care & Diagnostics	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	75% Mar-27	60.2% Jul-26 (Jul-26 Trajectory: 73.4%)		
	% of urgent suspected cancer patients diagnosed within 28-days from point of suspicion	75% Mar-27	77.6% Jul-26 (Jun-26 Trajectory: 72.5%)		
	Reduction in backlog of patients waiting over 62-days (SCP)	170 Mar-27	274 Jul-26 (Jul-26 Trajectory: 335)		
	Reduction in backlog of patients waiting over 104-days (SCP)	50 Mar-27	86 Jul-26 (Jul-26 Trajectory: 100)		
	Numbers of patients waiting over 104-weeks (all stages)	2,291 Mar-27	458 Jul-26 (Jul-26 Trajectory: 828)		
	Reduction in the number of patients waiting more than 8-weeks for a specific diagnostic	0 Mar-27	2,465 Jul-26 (Jul-26 Trajectory: 2,888)		
	Number of patients waiting over 52-weeks for Outpatients	3,012 Mar-27	1,389 Jul-26 (Jul-26 Trajectory: 2,299)		
	Number of patients waiting over 26-weeks for Outpatients	18,306 Mar-27	11,958 Jul-26 (Jul-26 Trajectory: 12,997)		
	Reduction in referral rate per 100,000 population by December 2026 - utilising Health Pathways optimally	6,600 Mar-27	7,100 Jul-26 (Jul-26 Trajectory: 6,700)		



Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Cancer, Planned Care & Diagnostics	Monitoring of DNA rates Outpatient clinics	5% Mar-27	5.7% Jul-26 (Jul-26 Trajectory: 5%)		
	Reduction in the number of patients waiting 100% past Outpatient follow-up target date	23,606 Mar-27	32,813 Jul-26 (Q2 Trajectory: 28,641)		
	Increase in the rate of See On Symptom and Patient Initiated Follow-ups	15% Mar-27	12.3% Jul-26 (Q2 Trajectory: 13.5%)		
	Number of adults waiting more than 14-weeks for all Audiology pathways	7,385 Mar-27	5,762 Jul-26 (Q2 Trajectory: 6,432)		
	Number of children waiting more than 6-weeks for all Audiology pathways	1,762 Mar-27	1,325 Jul-26 (Q2 Trajectory: 1,428)		
	No patient waiting more than 14-weeks for a Therapeutic assessment	830 Mar-27	562 Jul-26 (Q2 Trajectory: 540)		



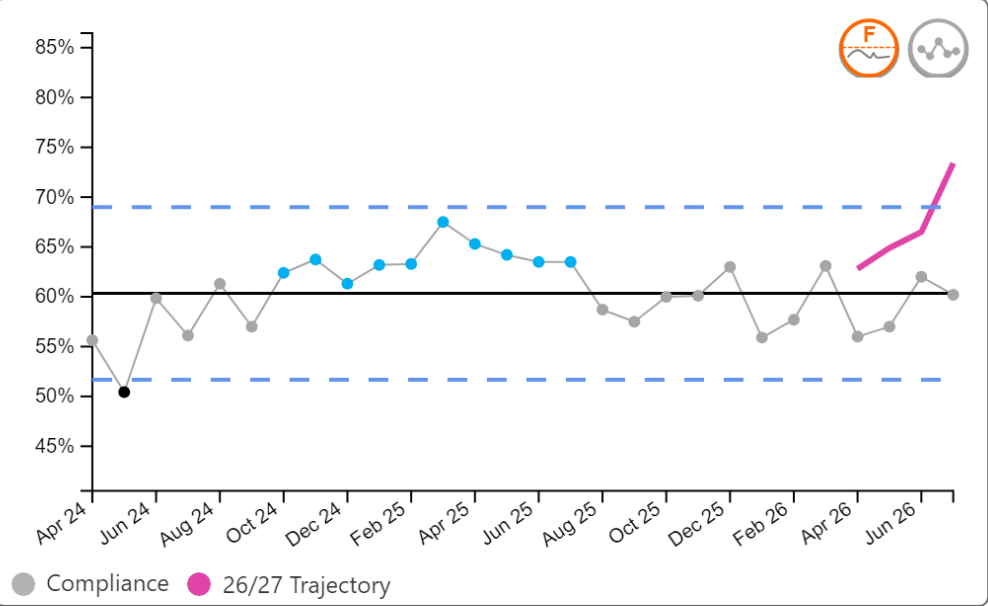
Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Cancer, Planned Care & Diagnostics	Theatre Utilisation: late starts to less than 20%	25% Mar-27	44.9% Aug-26 (Aug-26 Trajectory: 35%)		
	Theatre Utilisation: early finishes to less than 10%	15% Mar-27	24.6% Aug-26 (Aug-26 Trajectory: 22.5%)		
	Theatre Utilisation: session utilisation to 85%	85% Mar-27	82% Aug-26 (Aug-26 Trajectory: 85%)		
	Deliver improvements in day surgery rates, measured through BADS day case rates	80% Mar-27	77.2% Apr-26 (Apr-26 Trajectory: 78%)		



Cancer

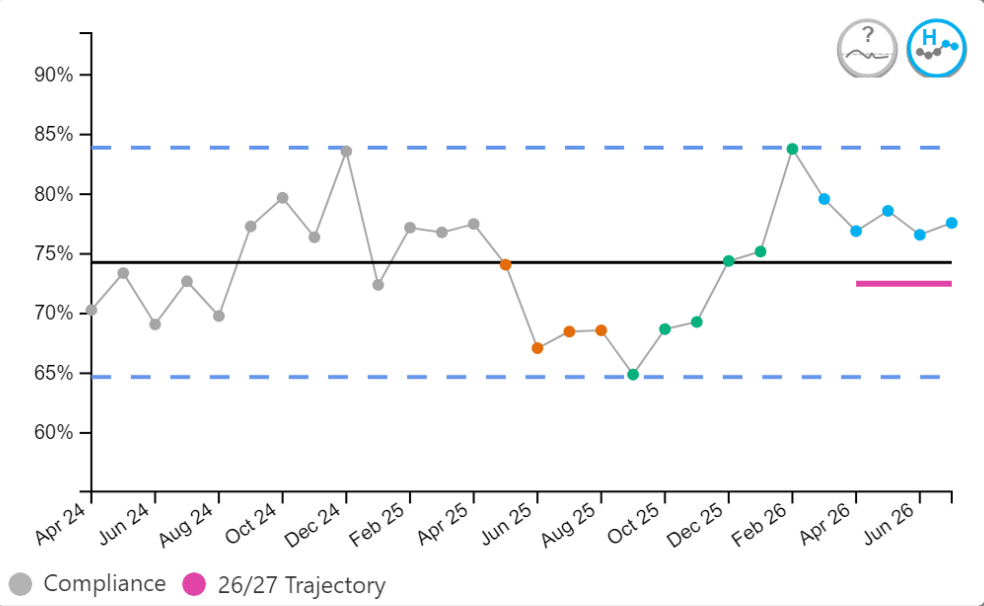
Measure: 12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion
Performance: 60.2% (July 2026)
Trajectory: 73.4% (July 2026)
National target: 75.0%

Ministerial Delivery
Better Care



Measure: % of urgent suspected cancer patients diagnosed within 28 days from point of suspicion
Performance: 77.6% (July 2026)
Trajectory: 72.5% (July 2026)
National target: 75.0%

Better Care



Insights and Actions

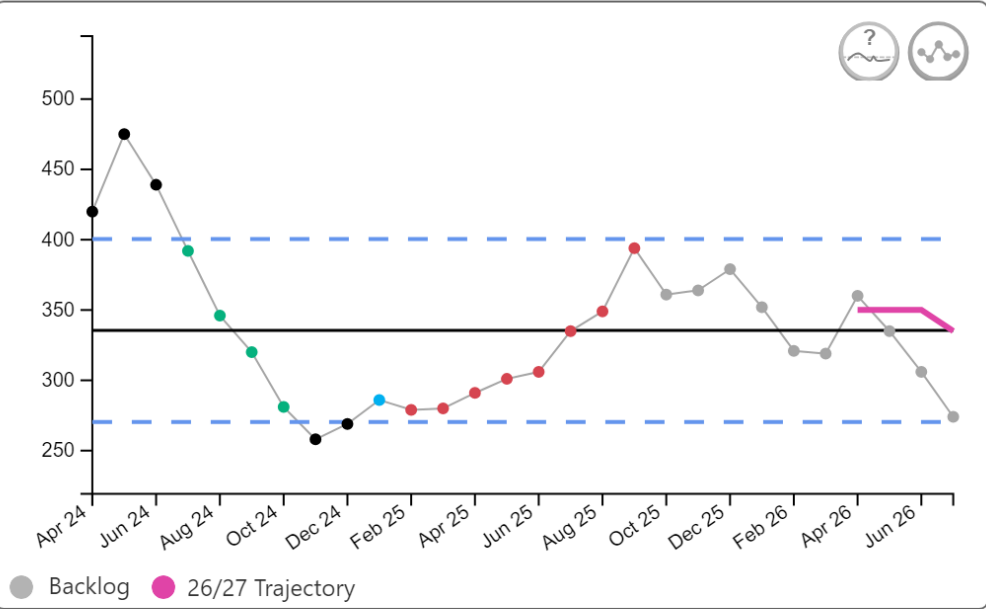
- SCP compliance: Performance dropped slightly in July, with compliance at 60.2%. The IMTP plan for July was 387 treatments, of which 103 would be breaches and 284 SCP achieved. Total treatments were as planned, but the volume of breaches was above plan (+51) leading to compliance not meeting the July IMTP trajectory of 73.4%. The majority of tumour sites showed below trajectory compliance for July, with only Head & Neck and Skin performing above trajectory and Gynaecological just meeting trajectory. Of note, LGI has maintained its improvement in compliance from 16% in May up to 49% in June, with 41% in July. 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 priority is addressing significant challenges at the first diagnostic stage of the pathway. Regionally some work on urology tumour site is being commissioned due to challenges across all Health boards
- 28 day diagnosis compliance: Performance has shown a period of improvement from the second half of 2025/26 and compliance remains above the mean (74.3%) into 2026/27. July performance is 77.6%, achieving the IMTP trajectory of 72.5% and surpassing the national target of 75%.



Cancer

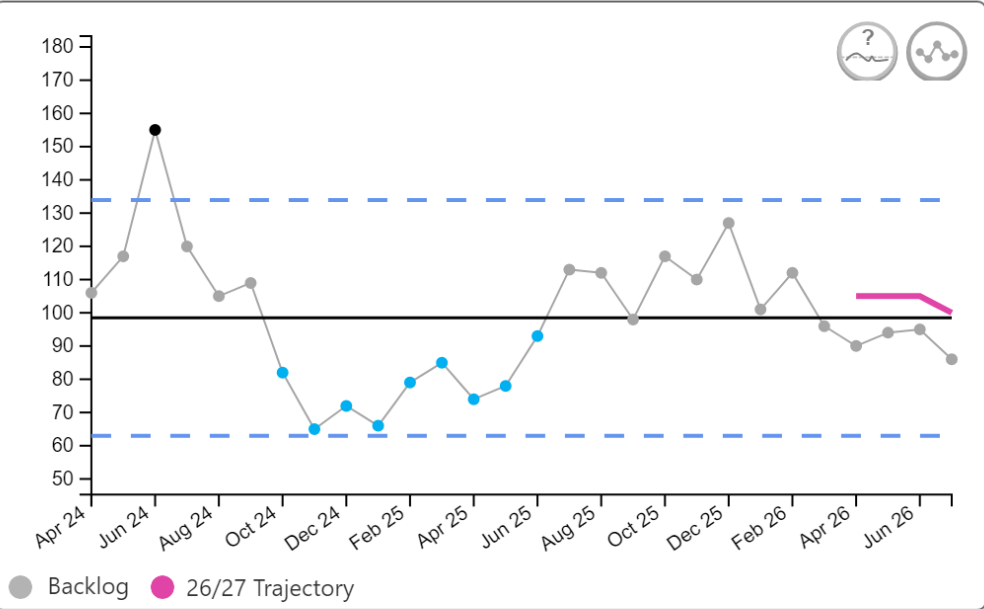
Measure: Reduction in backlog of patients waiting over 62 days (SCP)
Performance: 274 (July 2026)
Trajectory: 335 (July 2026)
National target: None

Ministerial Delivery
Better Care



Measure: Reduction in backlog of patients waiting over 104 days (SCP)
Performance: 86 (July 2026)
Trajectory: 100 (July 2026)
National target: None

Ministerial Delivery
Better Care



Insights and Actions

- 62-day backlog: The 62-day backlog showed a prolonged period of deterioration from February 25 until September 25, increasing by around 100 patients. This has been steadily reducing since, reaching a 9-month low in March 26. July performance has continued a 3-month reduction with performance at 274, surpassing the IMTP trajectory of 335. The commitment for the 62-day backlog is to be 10% of the SCP Census, aspiring to 5% of the SCP Census. The SCP Census has mirrored the 62 day backlog trend, increasing through 25/26 reaching a high of ~3,900 in July, followed by a sustained reduction, maintained at around 2,800 since May. The July backlog of 274 represents 9.7% of the total PTL. There remains a continued focus to reduce the backlog in the three tumour sites the make up over 66% of the entire 62 day backlog (Lower GI, Upper GI and Urology).
- 104-day backlog: The 104-day backlog has been largely stable around the mean (98) for the past year, even in the context of an SCP Census that has been subject to fluctuation. The last 5-months have seen performance drop back below the mean, with 86 patients in July surpassing the IMTP trajectory of 100. The commitment for the 104-day backlog is to be no more than 3% of the SCP Census, which has been met in July with 3% of the SCP Census waiting over 104 days.

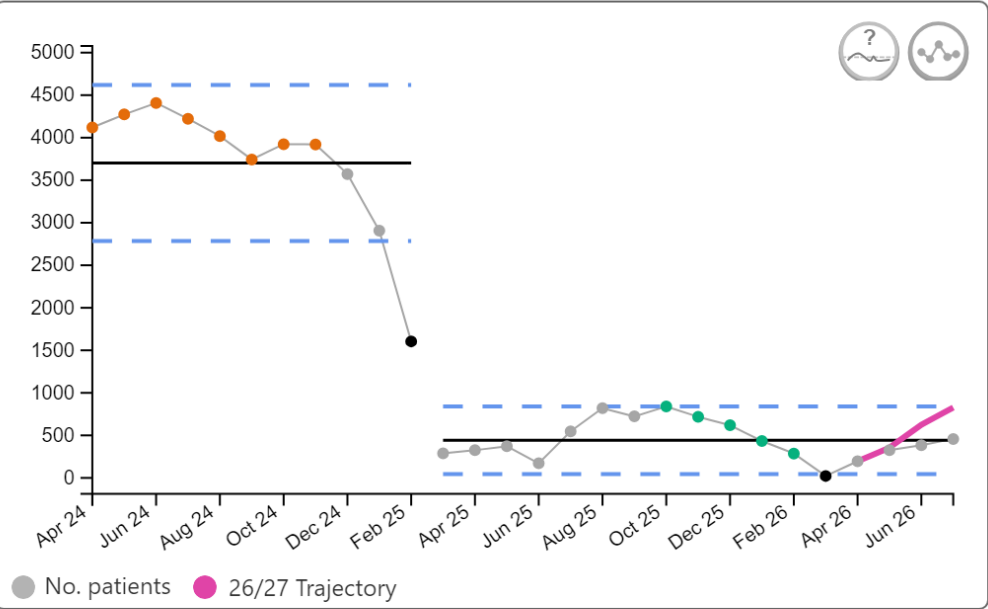


Section 2.1: Timely Access to Care – Cancer, Planned Care & Diagnostics

Planned Care & Diagnostics

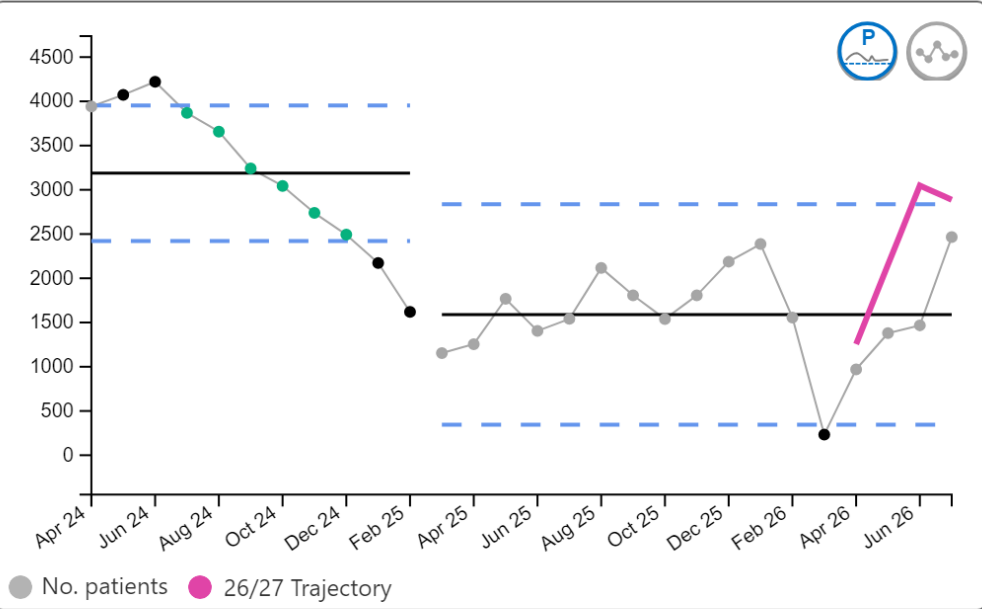
Measure: Numbers of patients waiting over 104 weeks (all stages)
Performance: 458 (July 2026)
Trajectory: 828 (July 2026)
National target: 0

Ministerial Delivery
Better Care



Measure: Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic
Performance: 2,465 (July 2026)
Trajectory: 2,888 (July 2026)
National target: 0

Ministerial Delivery
Better Care

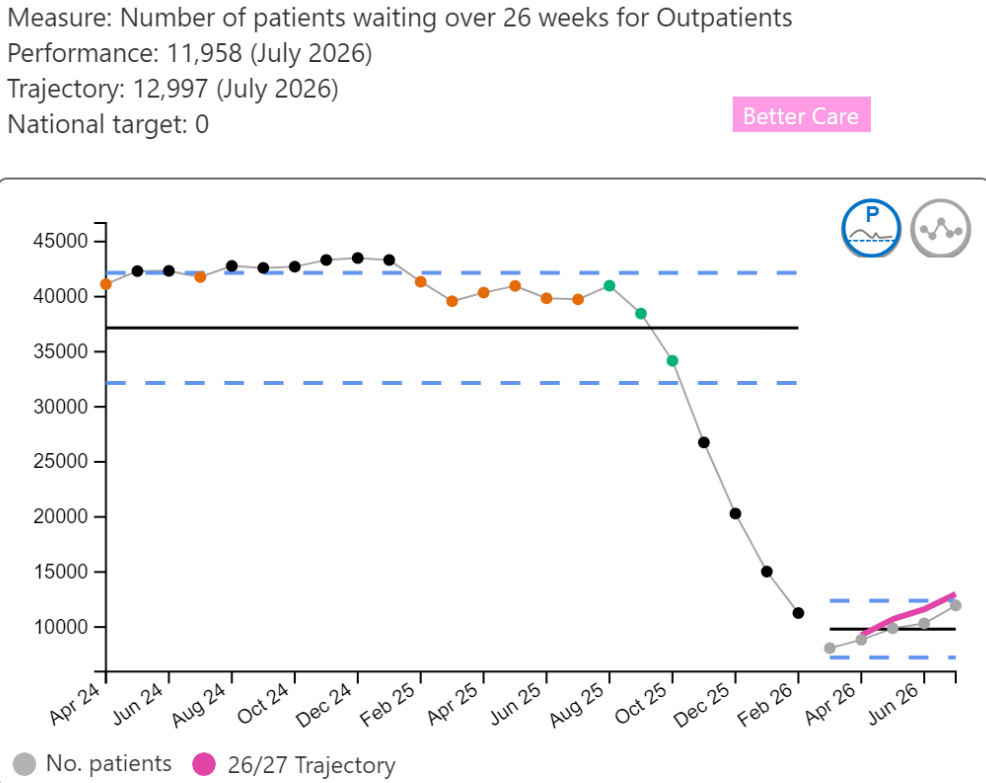
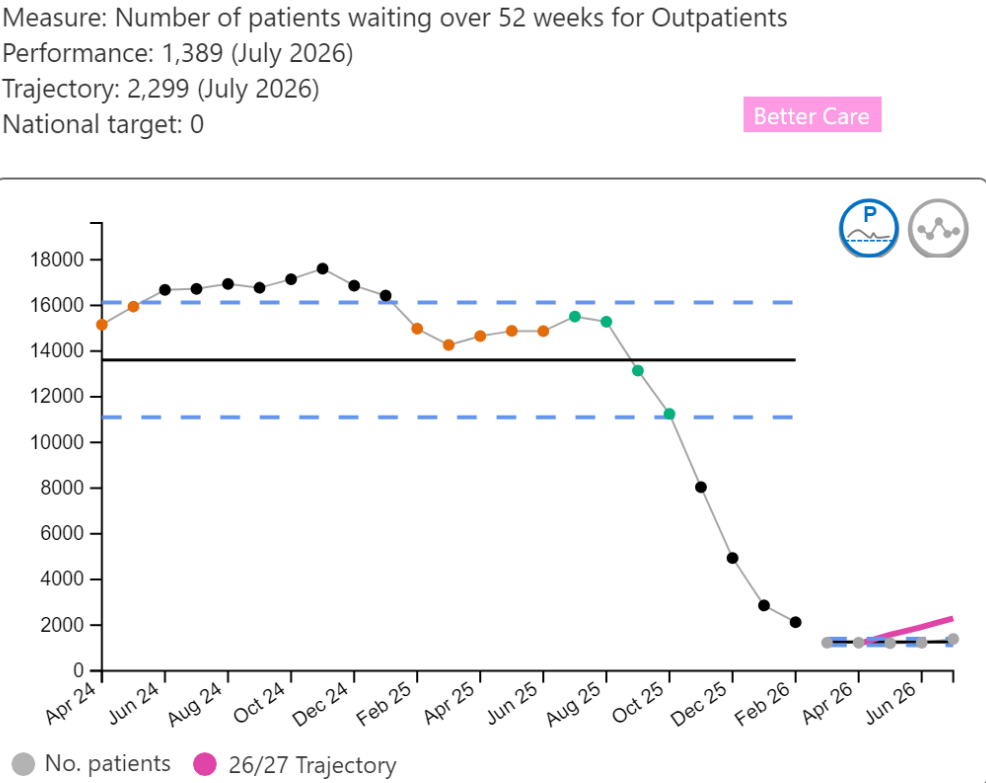


Insights and Actions

- 104 weeks RTT: Following the significant achievement in reducing planned care waits over 104 weeks to 23 at the end of the 25/26, the lowest number since April 2020, the Health Board responded to a national request by submitting (in collaboration with the SE Wales Regional Health Boards) Planned Care Recovery plans within which the elimination of 104wk waits was one component. As of the end of the August there has been a level of non-recurrently funded, additional to core activity delivered across several surgical specialities, which is reflected in the validated July and expected August positions (~385). A further funding announcement is expected to be confirmed during early September, and an end of year trajectory is being developed to reflect the additional activity that any new monies can facilitate.
- Diagnostics: Following the receipt of additional funding in the latter part of 25/26, 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 first four months of 26/27 have seen breach numbers increase although at a lower rate than forecast. Like with 104wk waits, diagnostic recovery was included in the plan submitted to WG and trajectories by modality are currently in the process of being updated to reflect not only updated assumptions from the original Annual Plan trajectory, but also to reflect any additionally funded delivery. RISP implementation has made in month reporting for Radiology more challenging, with significant month end validation required to ensure accuracy of reporting.



Planned Care & Diagnostics



Insights and Actions

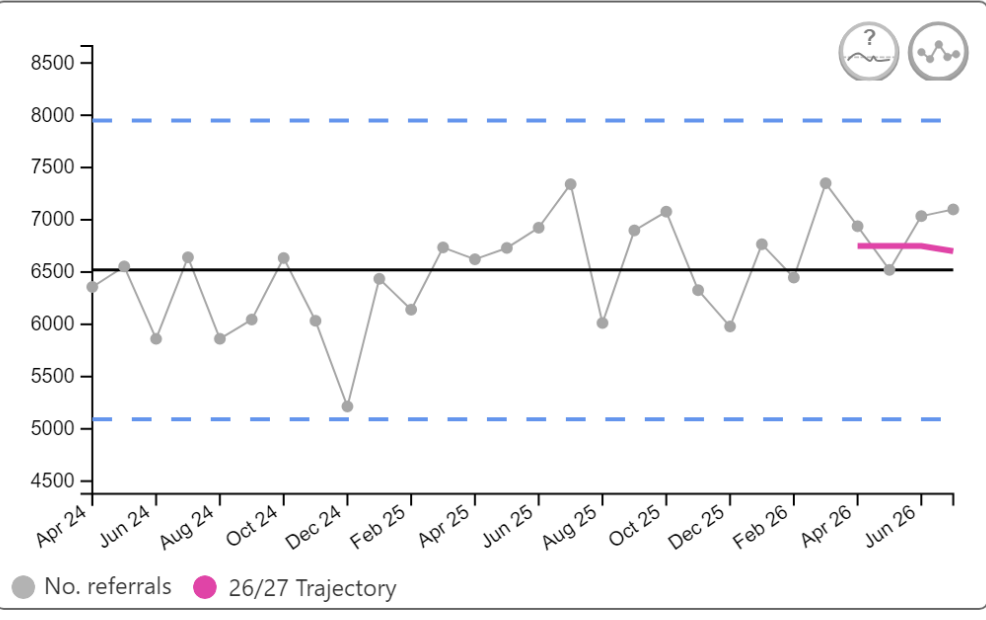
- 26 & 52 week new Outpatient: The charts for patients waiting over 52 and 26 weeks for a new outpatient appointment show the impact that the national outpatient insourcing programme, which delivered 33,202 additional appoints against a plan of 33,612, had on these two measures. This is clearly positive 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. The 52-week Outpatient breach position has held relatively stable through the first part of the year, with ongoing analysis on cohort reductions and ROTT rates underway to understand the variance. The 26-week Outpatient breach position is rising in line with the expected trajectory, however it remains under the forecast position as of July.



Planned Care & Diagnostics

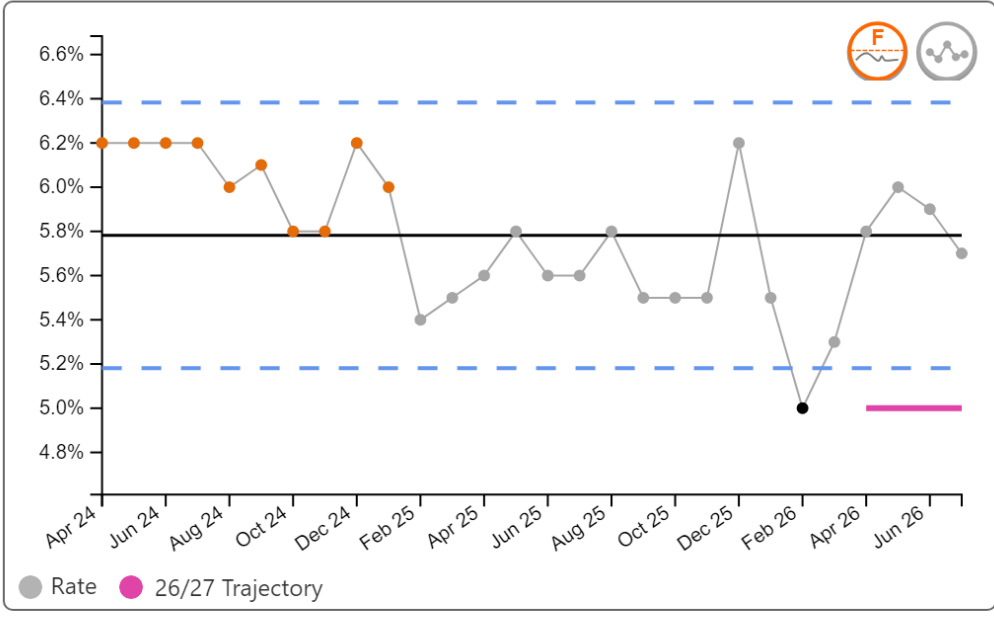
Measure: Reduction in referral rate per 100,000 population by December 2026 - utilising Health Pathways optimally
Performance: 7,100 (July 2026)
Trajectory: 6,700 (July 2026)
National target: None

Enabling Action
Better Care



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

Better Care



Insights and Actions

- Referral rates: A new Enabling Action for 26/27 is a reduction in Primary Care Planned Care referral rates. This rate has been on a sustained, upwards trajectory since 21/22. The total RTT waiting list has increased to 111,777 in July (+~10,500 from the end of 25/26 low), representing a higher rate of growth through the first four months of the year than that seen in previous years. There are several actions which seek to aid in demand management, including Health Pathways, Interface GPs and E-Advice. Work is underway to develop an intelligence-led referral optimisation programme, using linked Primary and Secondary Care data to identify unwarranted variation in referral patterns and support more effective clinical decision-making. The project will combine enhanced analytics, implementation of national requirements, greater use of Health Pathways and Advice & Guidance services, and targeted education and engagement to improve referral quality, reduce variation, and ensure patients access the most appropriate care pathway.

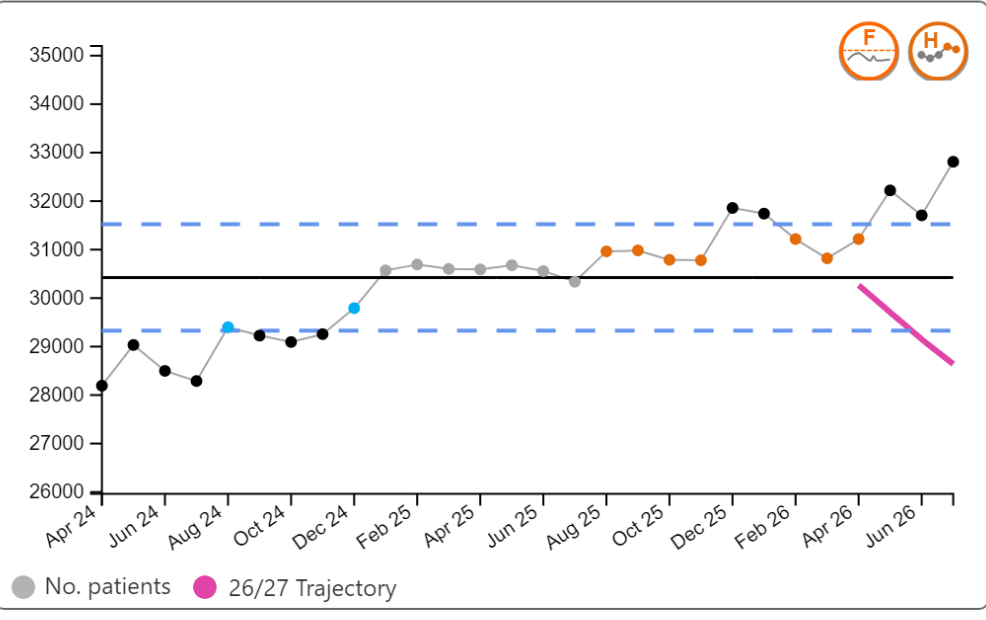
- DNA/CNA rates: Rates have reduced over the past two months following in the increases from March. The monthly DNA report and Hospital Initiated Cancellation directorate report recommenced in August. Diab and Endo directorate are working with DDAT on use of AI predictor model to allow identification of patients most likely to DNA and support an intervention e.g. nurse or admin phone call (currently used in Endoscopy).



Planned Care & Diagnostics

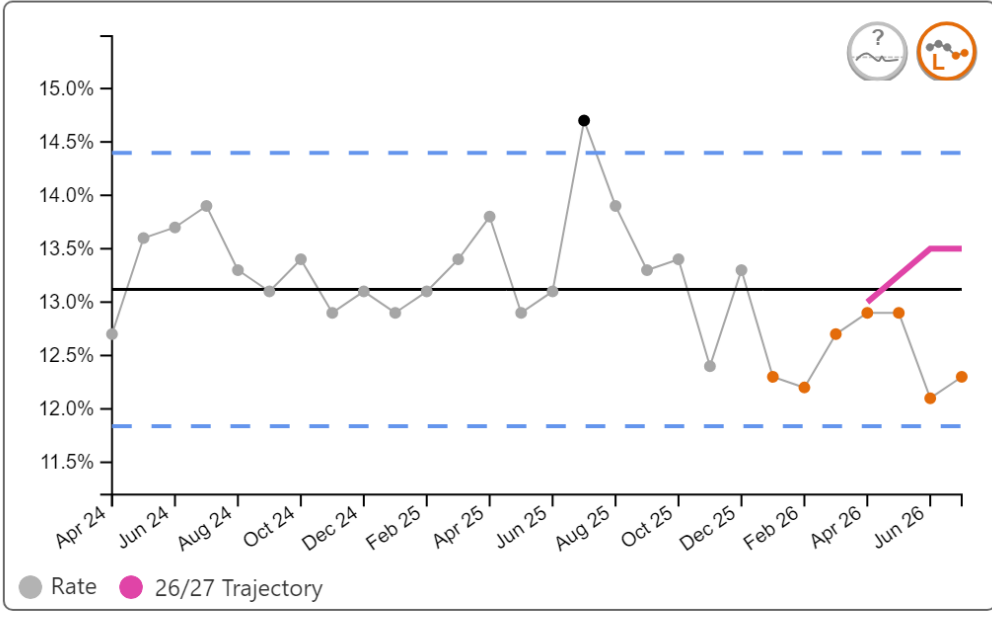
Measure: Reduction in the number of patients waiting 100% past Outpatient follow-up target date
Performance: 32,813 (July 2026)
Trajectory: 28,641 (July 2026)
National target: 23,694

Better Care



Measure: Increase in the rate of See On Symptom and Patient Initiated Follow-ups
Performance: 12.3% (July 2026)
Trajectory: 13.5% (July 2026)
National target: None

Better Care



Insights and Actions

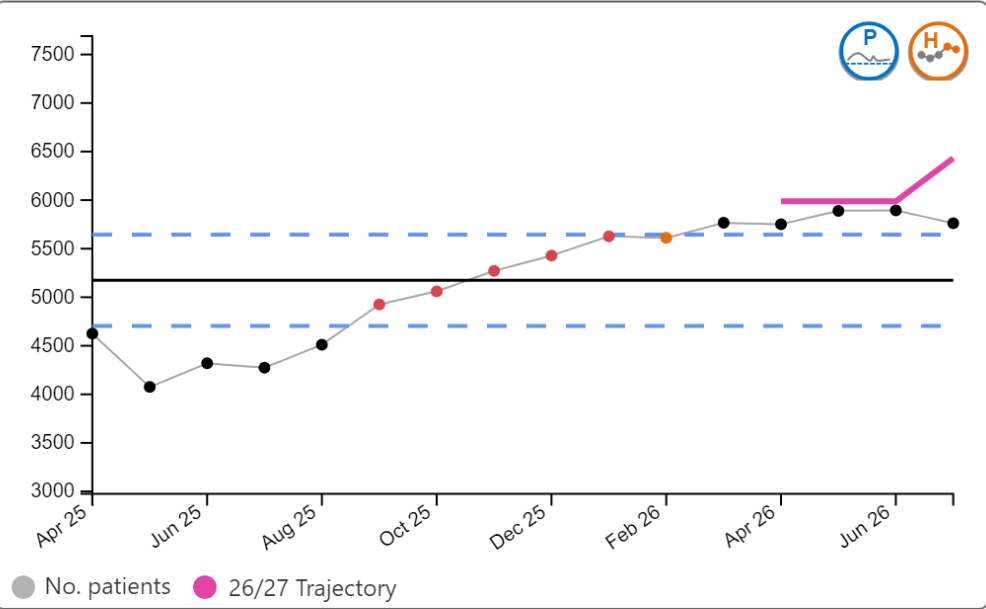
- The delayed follow up waiting list remains high, although the Health Board has committed to delivering against the national expectation of reducing the size of this list by 25%. Ongoing monitoring and validation of the most delayed patients continues, with weekly targeting of extreme long waiters (currently 2,106 patients waiting over 1,000% of their target wait). An audit of one week's Trauma & Orthopaedics (T&O) follow-up additions was undertaken to identify key themes. The Ophthalmology Directorate is undertaking application of the SOS pathway for the longest-waiting patients on the follow-up list. It should be noted that this activity does not impact reported SOS/PIFU rates, as patients are added to WPAS through the "Patients Seen Outside of Regular Clinic" process, which is excluded from these measures. However, the total number of patients on SOS/PIFU pathways has increased from 552 at the end of May to 994 in August. A validation, text messaging and removal letter process is currently being established to support waiting list validation activity. As part of this work, patient contact details are being reviewed and confirmed to ensure records are accurate and up to date.



Planned Care & Diagnostics

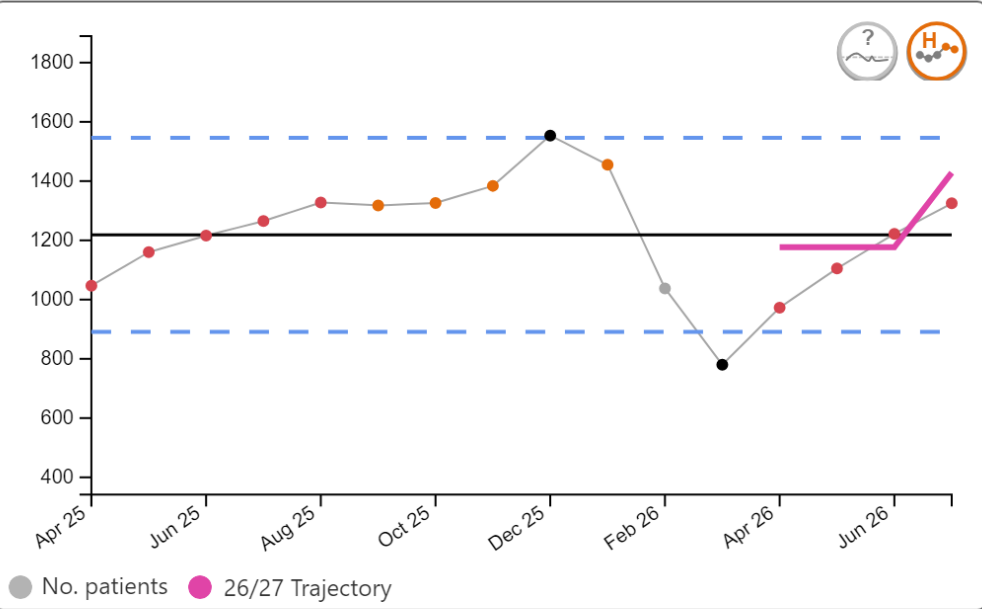
Measure: Number of adults waiting more than 14 weeks for all audiology pathways
Performance: 5,762 (July 2026)
Trajectory: 6,432 (July 2026)
National target: 0

Better Care



Measure: Number of children waiting more than 6 weeks for all audiology pathways
Performance: 1,325 (July 2026)
Trajectory: 1,428 (July 2026)
National target: 0

Better Care



Insights and Actions

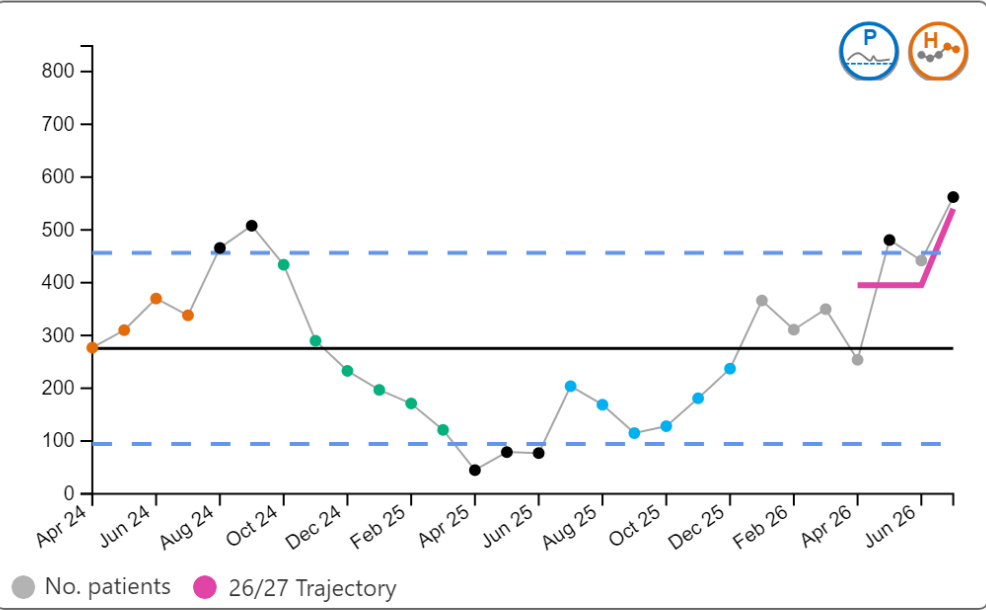
- Audiology: Adult pathway breaches were rising in line with forecast, however there was a slight reduction in July. The national OP insourcing programme has placed additional demand placed on the Service as a result of the activity undertaken within ENT, which has front loaded the rate of demand to the Adult Hearing New (AHN) and diagnostic pathways. Audiology has also faced workforce challenges, including long-term sickness absence of a Band 4 Associate Audiologist, redesign of a Band 6 Adult post to a split Adult/Paediatric role, and a Band 4 maternity leave. For Paediatric pathways, additional, end of year funding enabled a significant reduction in waiting list breaches. The cessation of this has seen breaches climb again through the first four months of the year, in line with forecast. 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.



Planned Care & Diagnostics

Measure: No patient waiting more than 14 weeks for a therapeutic assessment
Performance: 562 (July 2026)
Trajectory: 540 (July 2026)
National target: 0

Better Care



Insights and Actions

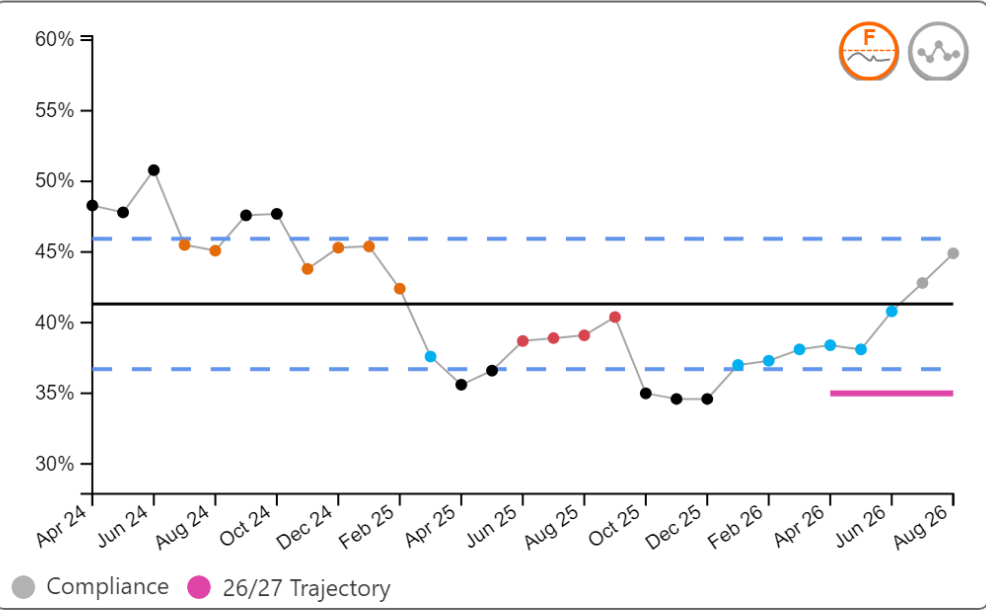
- Therapies: Therapies 14-week breaches increased in Jul, in line with trajectory. Physiotherapy is the therapy experiencing the most demand related pressure, with 488 breaches (+141 from June). The number of patients breaching waiting time standards continues to increase because of sustained growth in referral demand, particularly since January. The Service is also managing the impact of staff sickness and vacancies, which is contributing to the current position. To accommodate T&O patients approaching the 104-week RTT threshold (with a Physiotherapy RTT wait of 0 weeks), MSK capacity continues to be reduced by 12 new patient (NP) appointments per month. While this supports the T&O recovery trajectory, it is creating additional pressure on MSK waiting lists. Whilst the number of 104-week waiters has reduced, there remains a potential risk of six breaches in August and an unknown position for September. Consequently, the protected clinic capacity will remain in place and be reviewed at the end of August. Within Dietetics (48 breaches in July), Paediatric Dietetics Restrictive Eating Groups remains the highest breach area following integration of CAMHS/ARFID referrals. Discussions with CAMHS continue regarding sustainable demand, resourcing and referral criteria. Increased Paediatric Home Enteral Feeding demand limits capacity available for Outpatient clinics.



Planned Care & Diagnostics

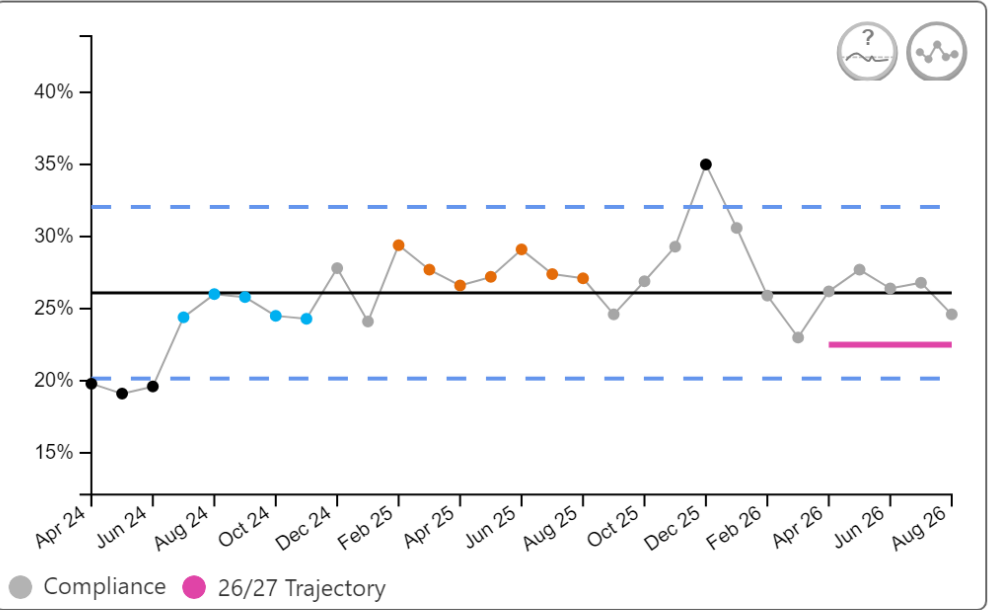
Measure: Theatre Utilisation: late starts to less than 20%
Performance: 44.9% (August 2026)
Trajectory: 35.0% (August 2026)
National target: 20.0%

Enabling Action
Better Care



Measure: Theatre Utilisation: early finishes to less than 10%
Performance: 24.6% (August 2026)
Trajectory: 22.5% (August 2026)
National target: 10.0%

Enabling Action
Better Care



Insights and Actions

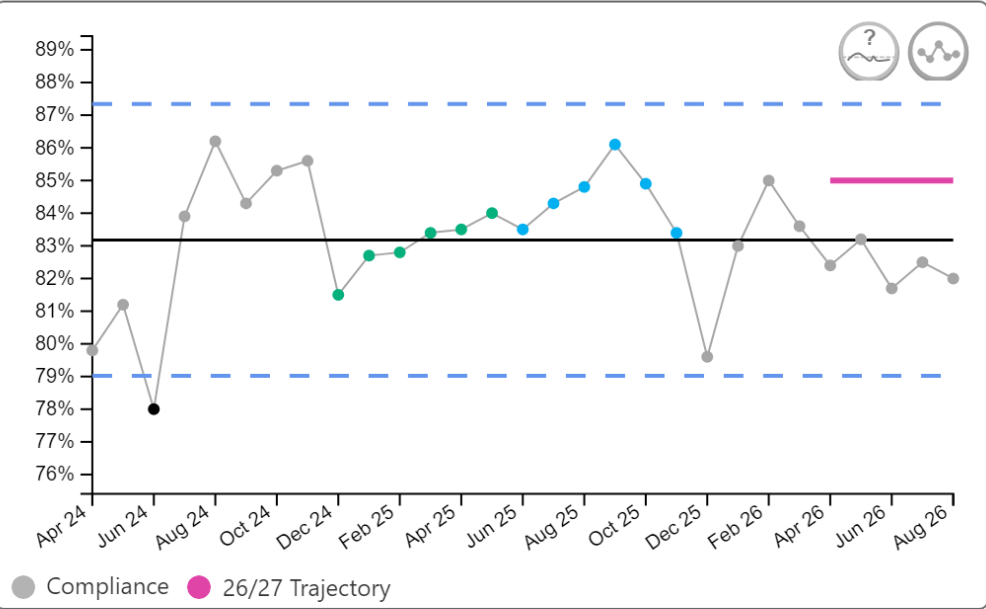
- Late starts have increased over the past 3 months following a period of relatively stable performance, and early finishes have remained in line with average performance through 26/27 to date.
- The Theatres Optimisation Programme (TOP) was refreshed in May, reinforcing Theatre Services as a key Health Board priority. The programme adopts a whole-system approach to improve theatre productivity and performance through workstreams focused on workforce, theatre efficiency, right procedure/right place, and surgical hub accreditation. A key objective is the development of a simplified, consistent set of KPIs and performance measures to support decision-making and track improvement. In October, the Theatres Utilisation Group (TUG) will be reformed to drive operational improvements, initially focusing on short-notice cancellations, late starts, procedures per list, early finishes, utilisation and BADS day-case rates, with additional productivity metrics currently under development.



Planned Care & Diagnostics

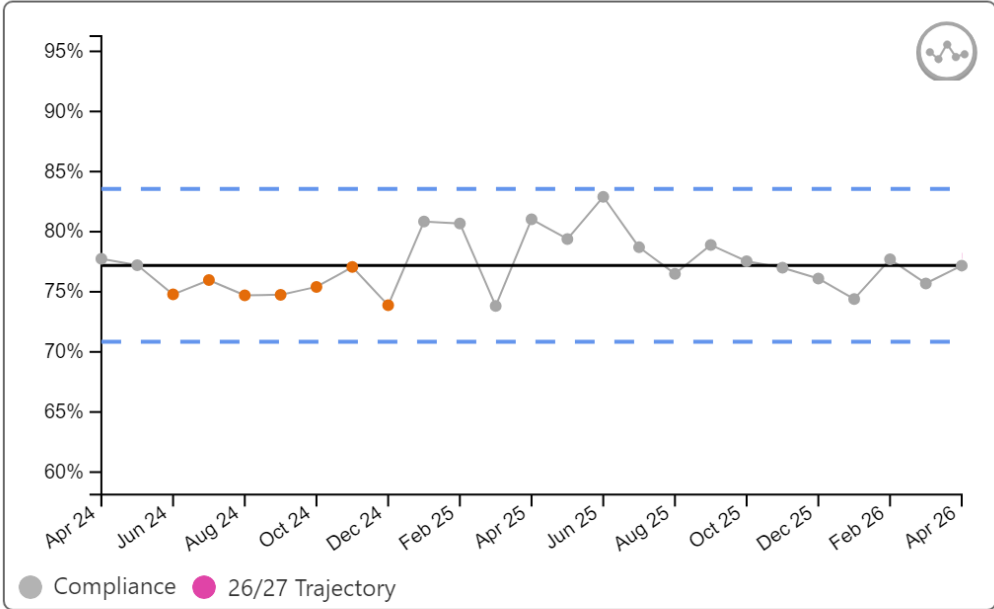
Measure: Theatre Utilisation: session utilisation to 85%
Performance: 82.0% (August 2026)
Trajectory: 85.0% (August 2026)
National target: 85.0%

Enabling Action
Better Care



Measure: Deliver improvements in day surgery rates, measured through BADS day case rates
Performance: 77.2% (April 2026)
Trajectory: 78.0% (April 2026)
National target: 80.0%

Better Care



Insights and Actions

- Session utilisation: Performance has been relatively close to the national standard of 85% since July 2024. Effective utilisation will be a key focus of the Theatres Optimisation Programme Group, as well as the reformed Theatres Utilisation Group. A decrease in June performance was anticipated, due to disruption from the heatwave and declaration of critical incident, with year to date performance marginally below the national expectation of 85%.
- 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 in the context of an overall treatment increase of 2.7%). In the Plan the Health Board has committed to attaining the 80% standard by the end of the year. Validated day case rates are subject to lag, however April performance is largely in line with the Q1 trajectory.

Section 2.1: Mental Health Access Performance Summary

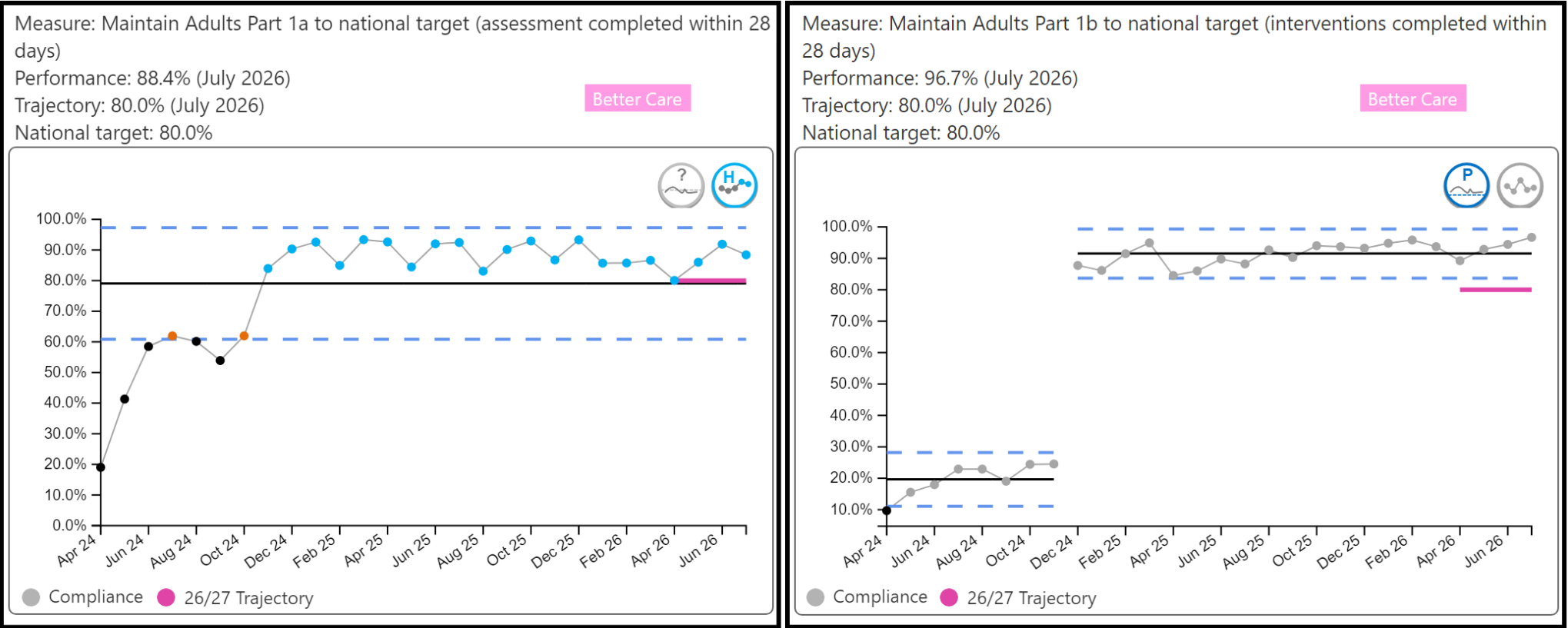


Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Mental Health Access	Maintain Adults Part 1a to national target (assessment completed within 28-days)	80% Mar-27	88.4% Jul-26 (Jul-26 Trajectory: 80%)		
	Maintain Adults Part 1b to national target (interventions completed within 28-days)	80% Mar-27	96.7% Jul-26 (Jul-26 Trajectory: 80%)		
	Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan)	90% Mar-27	83.5% Jul-26 (Jul-26 Trajectory: 90%)		
	Maintain rate of psychological therapy received within 26-weeks	62% Mar-27	52.5% Jul-26 (Jul-26 Trajectory: 56%)		
	Implement actions to deliver a material reduction in the number of out-of-area placements in 2026/27, and associated costs.	59 Mar-27	0 Jul-26 (Q2 Trajectory: 0)		
	Maintain 80% compliance of SCAMHS Choice Assessments within 28-days from referral	80% Mar-27	93.9% Jul-26 (Jul-26 Trajectory: 80%)		
	Maintain CAMHS Part 1a national target compliance (assessment completed within 28-days)	80% Mar-27	96.9% Jul-26 (Jul-26 Trajectory: 80%)		
	Maintain CAMHS Part 1b national target compliance (intervention completed within 28-days)	80% Mar-27	84.1% Jul-26 (Jul-26 Trajectory: 80%)		
	Maintain CAMHS Part 2 national target compliance	90% Mar-27	88.8% Jul-26 (Jul-26 Trajectory: 90%)		



Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Mental Health Access	Improvement in Neurodevelopment waiting times compliance	60% Mar-27	52.2% Jul-26 (Jul-26 Trajectory: 60%)		

Mental Health



Insights and Actions

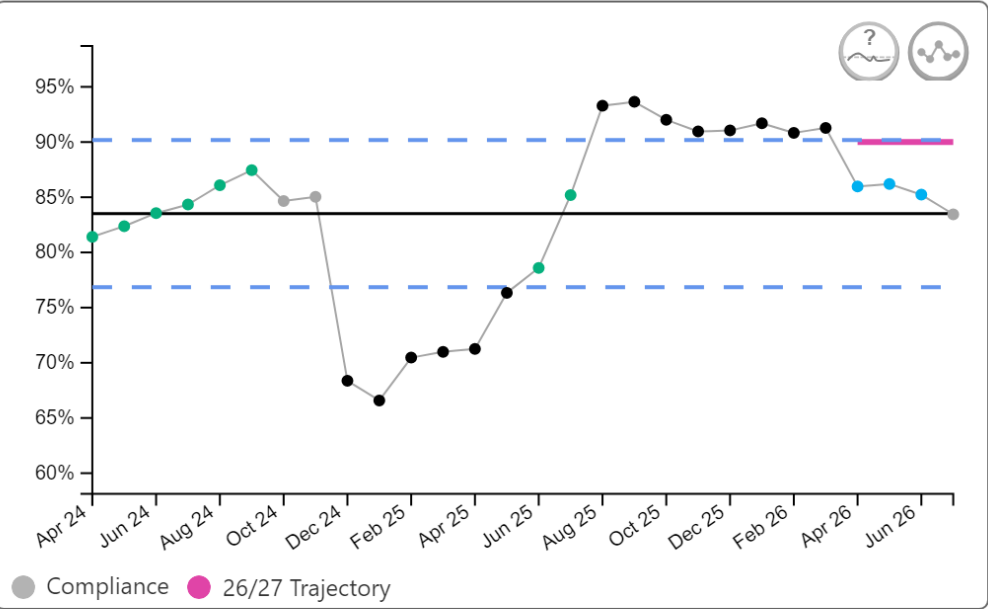
- Adults 1a & 1b: Delivery remains strong against these measures, with the Service balancing both demand and capacity to ensure continued compliance with the national standard through the entirety of 2025/26 and into 2026/27. The SPC chart for Part 1b has had a process break inserted from December 2024 to reflect the change in performance since this time, following the extensive data cleansing work and service improvements that were delivered.



Mental Health

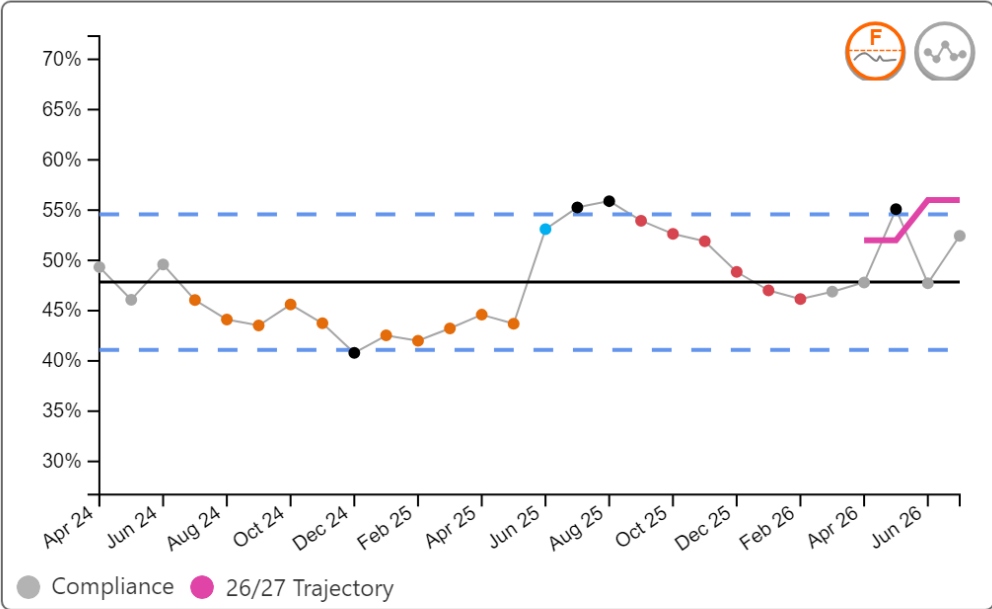
Measure: Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan)
Performance: 83.5% (July 2026)
Trajectory: 90.0% (July 2026)
National target: 90.0%

Better Care



Measure: Maintain rate of psychological therapy received within 26 weeks
Performance: 52.5% (July 2026)
Trajectory: 56.0% (July 2026)
National target: 80.0%

Better Care



Insights and Actions

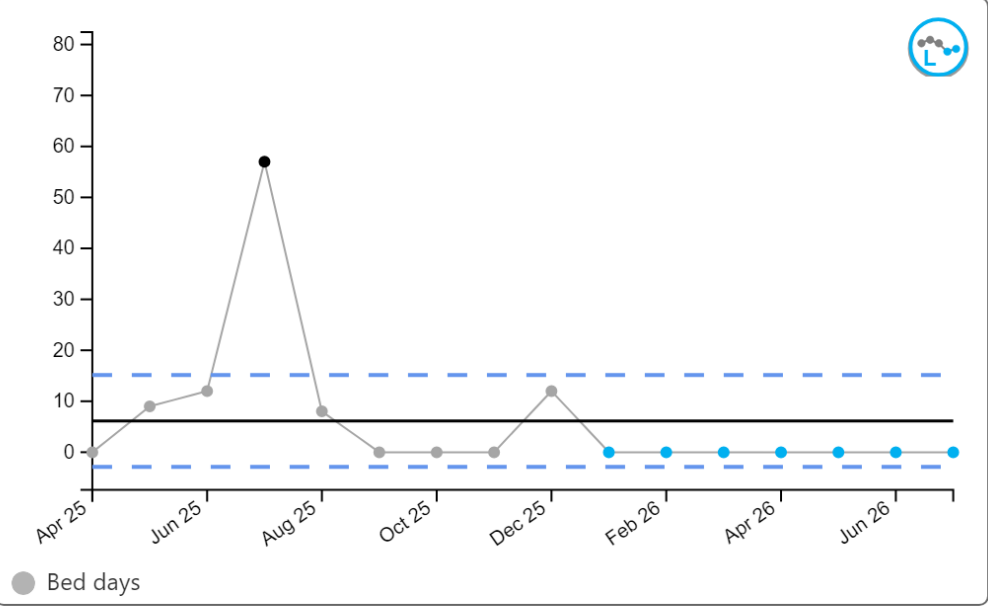
- Adults Part 2: Part 2 performance has decreased slightly below trajectory for the past three months with the Division commencing a targeted piece of work over Q2 to ensure compliance returns, however performance has remained in line or above with the average since Apr-24. Data cleansing remains in progress, however the volume of new Care and Treatment Plans (CTPs) and discharges from CTPs is expected to stabilise.
- Psychological Therapies: The Divisional recovery plan, which aims to improve performance to 62% by the end of the year, has shown improvement in two of the past three months however it remains slightly under the Annual Plan trajectory. ABUHB, in conjunction with Cardiff University, are hosting a Masters student to work with the Service over the summer of a project for an MSc dissertation. This project will develop a simulation model of adult psychological therapy pathways across the seven CMHTs in Gwent to understand the factors driving long waits and assess the impact of alternative service designs on patient flow and access to treatment. The model will test options such as different triage and treatment arrangements, changes to care coordination, workforce reconfiguration, and the effects of non-engagement and drop-out rates, to identify the staffing and service model required to achieve the Welsh Government target of 80% of patients starting treatment within 26 weeks. This project is scheduled for completion at the end of Q2.



Mental Health

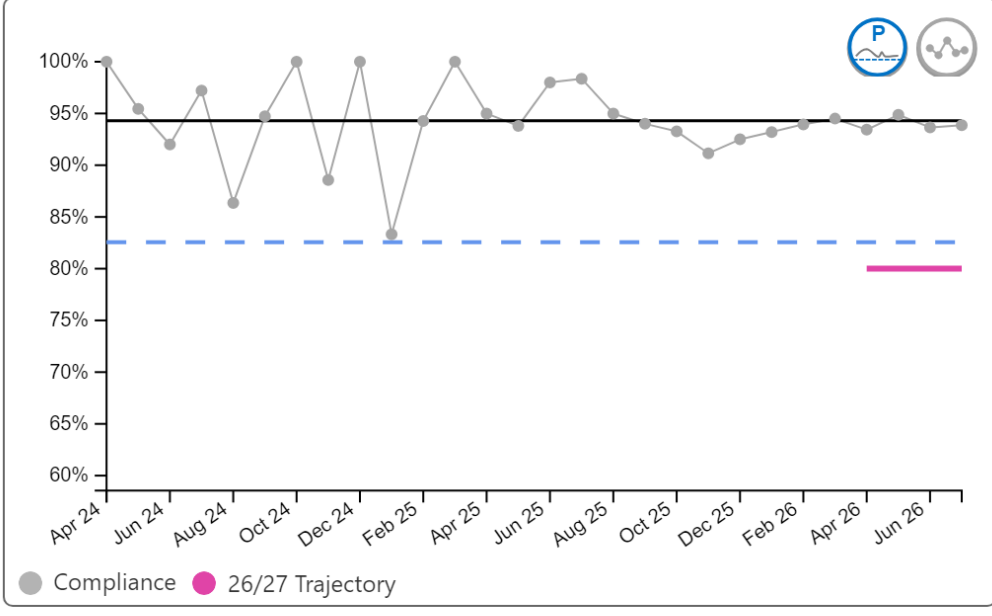
Measure: Implement actions to deliver a material reduction in the number of out of area placements in 2026/27, and associated costs.
Performance: 0 (July 2026)
Trajectory: 0 (Q2 26/27)
National target: None

Enabling Action
Better Care



Measure: Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral
Performance: 93.9% (July 2026)
Trajectory: 80.0% (July 2026)
National target: 80.0%

Better Care



Insights and Actions

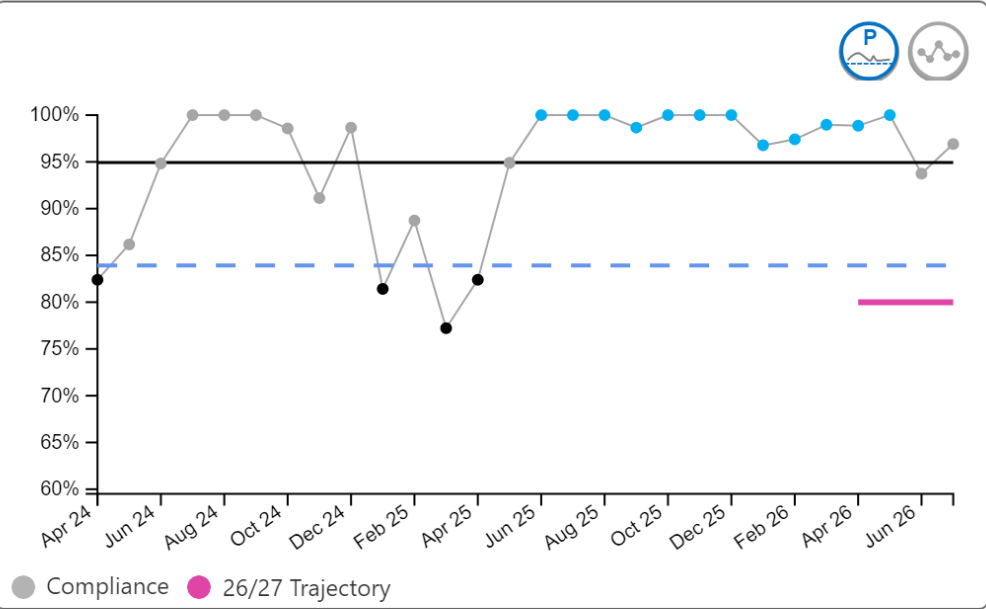
- Out of Area Placements (OAPs): A new Enabling Action for 26/27 and included in the Annual Plan as a core performance measure, the national directive is to reduce placements and the costs associated with them. OAPs can have a significant negative impact on mental health patients by separating them from their families, support networks, and local services, which are often critical to recovery. They can also lead to poorer patient experience, disruption to continuity of care, and increased lengths of stay, while creating additional financial pressures. The national reporting format was formalised after the submission of the plan, and the measurement is by bed days rather than the number of individual placements. Placement categories in scope of the reporting are: Adult & Adult PICU, and Older Adult and Older Adult PICU. In 25/26 the Health Board commissioned 98 bed days of OAPs with just four individual months of the year incurring them, at a total cost of £86,450. The 26/27 ambition in the plan is to deliver to zero bed days and thus cost, and as of July this remains on track.
- Specialist CAMHS Choice Assessments: No issues, performance continues to track well above national standard of 80%.



Mental Health

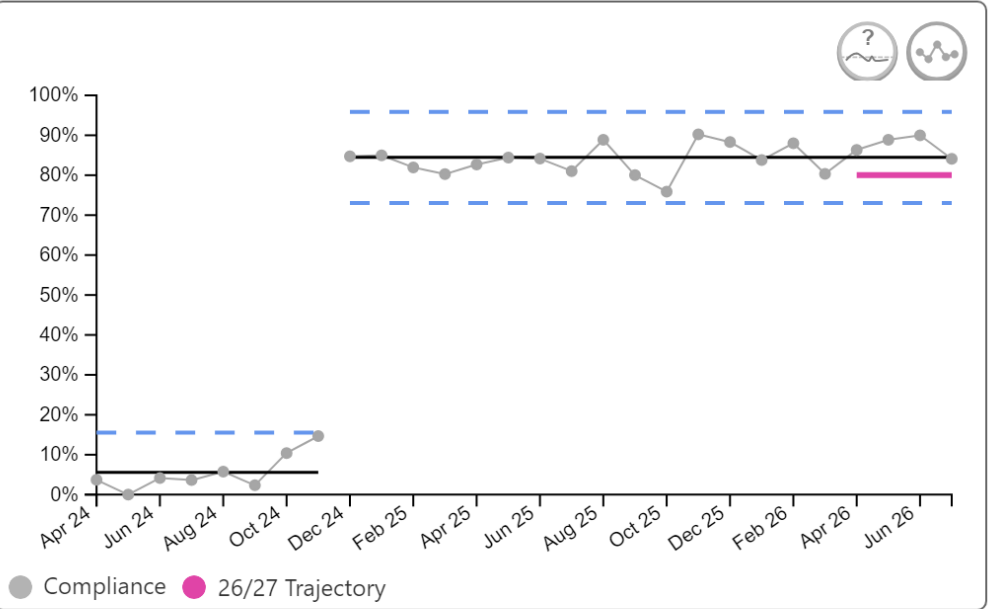
Measure: Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)
Performance: 96.9% (July 2026)
Trajectory: 80.0% (July 2026)
National target: 80.0%

Better Care



Measure: Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)
Performance: 84.1% (July 2026)
Trajectory: 80.0% (July 2026)
National target: 80.0%

Better Care

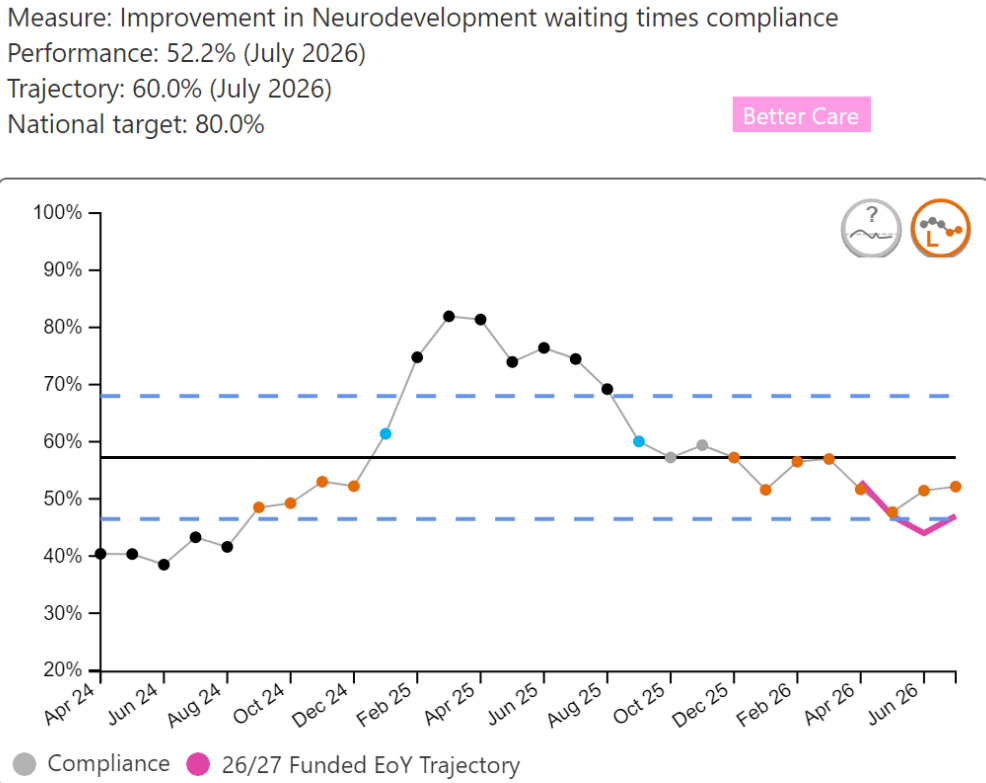
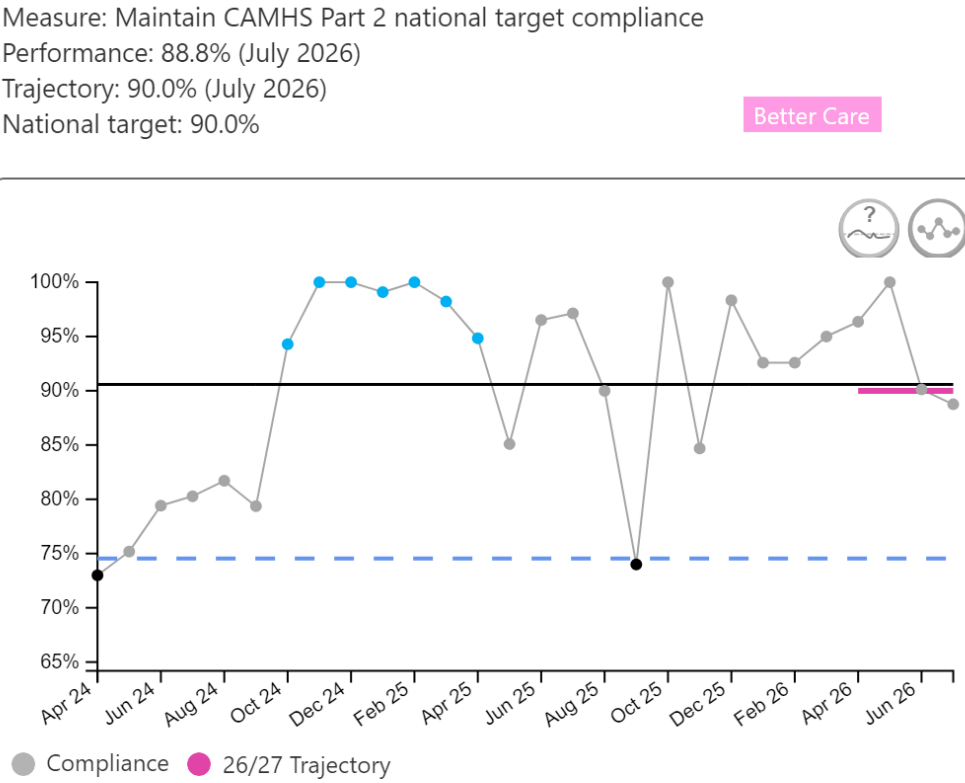


Insights and Actions

- CAMHS 1a & 1b: Like with Adults, strong delivery has been maintained for these measures, with the service balancing 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 and continued in to 2026/27. 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



Insights and Actions

- CAMHS Part 2: Whilst there has been a decrease in the past two reportable months, performance remains close to trajectory and the national standard.
- CAMHS ND: Following a period of extensive challenge within the Service, whereby it has prioritised keeping the longest waits under 52-weeks at the cost of the <26-week compliance measure, NDIP funding of £568,536 has been secured for 2026/27 to support CAMHS Neurodevelopmental (ND) Referral to Treatment Time (RTT) recovery and service sustainability. This includes £281,706 to address existing staffing funding shortfalls, ensuring current service capacity can be maintained, and £187,512 to establish additional workforce capacity, including 3.1 WTE Band 6 Practitioners, 2.0 WTE Band 4 Support Workers and 1.0 WTE Band 4 Administrative Assistant. A further £95,318 has been allocated to fund additional staff hours, increasing clinical delivery and supporting RTT recovery. This allocation also includes £4,000 for the CHRONOS AI pilot, which will support service efficiencies, improve waiting list management, and strengthen RTT performance monitoring and reporting. Collectively, this investment will help stabilise the service, expand capacity, and accelerate progress towards achieving RTT recovery targets.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 September 2026
CYFARFOD O: MEETING OF:	Finance and Performance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Theatres Optimisation Programme
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Julie Poole, SRO of Planned Care Greg Bowen, Assistant Director of Finance Simon Roberts, Head of Transformation and Delivery Catherine Pugh, Service Improvement Manager

Pwrpas yr Adroddiad Purpose of the Report
Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u> A Theatre Optimisation Programme Group (TOP) was re-launched in 2026 in order to identify and deliver efficiency and productivity opportunities across the theatres portfolio to optimise usage and enable release of capacity. The Health Board has demonstrated significant improvements in theatre productivity over recent years, reflecting the impact of ongoing service improvement initiatives. To further accelerate progress and support the delivery of a consistently high-performing theatre service, the Theatre Optimisation Programme was re-established in May to coordinate activity across five interdependent workstreams. The programme is intended to reduce unwarranted variation, release capacity, align workforce and infrastructure with demand, and support the £500,000 financial saving expectation for 2026/27. The Committee is therefore asked to note the current performance, the progress made, and the delivery risks associated. <u>Cefndir / Background</u> In April 2026, a dedicated theatre utilisation workshop was held with the Executive Team to review current theatre capacity, utilisation, performance, and

opportunities for optimisation. The session was led by the leadership teams of Surgery and Clinical Support Services Divison. As well as setting out the scale of the opportunity, the session also sought agreement on the key priorities and deliverables for improvement during 2026/27. As a result, approval was given to establish a Theatre Optimisation Programme, which commenced in June 2026. The supporting documentation considered as part of the workshop is provided in Appendix 1 and contains significant amounts of detailed information. Key messages from the slide deck are:

Strengths	Key Challenges	Opportunity and Impact
- Elective theatre capacity is being protected on 96.9% of days, exceeding the national target of 90%. - Theatre utilisation has achieved the GIRFT target of 85% overall. - There is available theatre estate and session capacity across several sites which could support future service redesign.	- Late starts and early finishes remain significantly above national expectations and represent the largest productivity opportunity. - Workforce arrangements, theatre staffing models and consultant job plans are not consistently aligned across sites. - Theatre plans do not fully reflect current activity patterns or changing demand.	- Only 7,845 of 9,155 planned theatre sessions were delivered during 2024/25. 1,310 sessions (14%) were not utilised, equating to an estimated annual opportunity cost of approximately £1.2 million. 744 sessions were cancelled within four weeks, with 690 considered avoidable. - The largest gaps are at Nevill Hall Hospital and Ysbyty Ystrad Fawr. - Analysis identified substantial unused capacity: A further review of "Right Procedure, Right Place" identified: 3,145 procedures undertaken in theatres that may be suitable for alternative outpatient or treatment settings. - This is equivalent to approximately 635 theatre sessions that could potentially be released for more complex surgery.

The Theatres Optimisation Programme has been developed in response to these opportunities with an overarching purpose of the programme is to identify and deliver efficiency and productivity opportunities across the theatres portfolio to enable release of capacity and improved patient access to care.

The primary **programme objectives** are:

- Optimisation of theatre capacity and utilisation across the Health Board, reducing unwarranted variation and improving productivity.
- Rationalisation of theatre infrastructure to align capacity with forecast demand and affordability requirements.
- Rebalancing activity between treatment rooms and theatres

The key workstreams have been designed to respond to identified opportunities and are set out below:

Workstream	Objective
Right Procedure, Right Place	The opportunity = Procedures that are currently being done in theatres that could be done in treatment/other rooms and release theatres capacity • To support the transfer of activity from main theatres into appropriate alternative settings
Theatre Productivity	The opportunity = the data shows that utilisation of theatres could be improved if there was a reduction in late starts and early finishes alongside a productivity improvement • To improve booking and scheduling to maximise theatre utilisation and reduce delays for patients and focus on reducing late starts, early finishes and cancellations
Optimise resource alignment	The opportunity = The deep dive demonstrated that one of the drivers of late starts is the misalignment of resources, including job plans and rosters • Review staffing and staffing of second CEPD/Trauma Theatre to maximise efficiency and ROI while maintaining emergency resilience • To align job plans across the MDT who deliver theatre lists and improve recruitment, retention and wellbeing of staff
Surgical Hub Accreditation	The opportunity = To drive improvement in theatre hubs by applying the GIRFT standards for accreditation and ultimately achieving accreditation • To embed top decile working across all specialties in the Hub to gain P&I accreditation

Annual Plan Performance Commitments

There are a multitude of metrics covering utilisation, productivity and efficiency of theatres, these derive from:

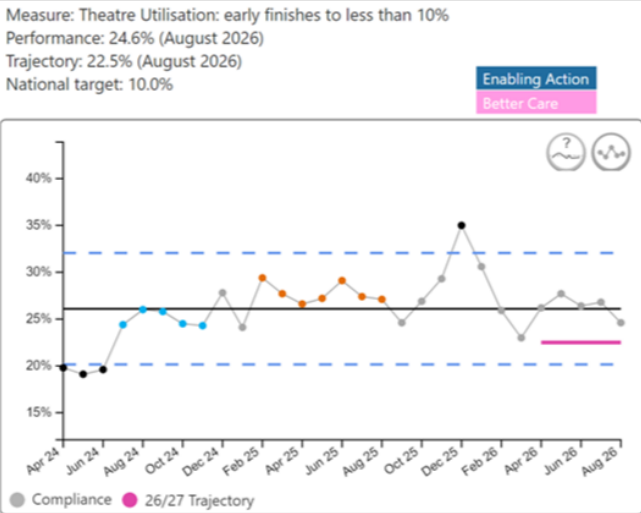
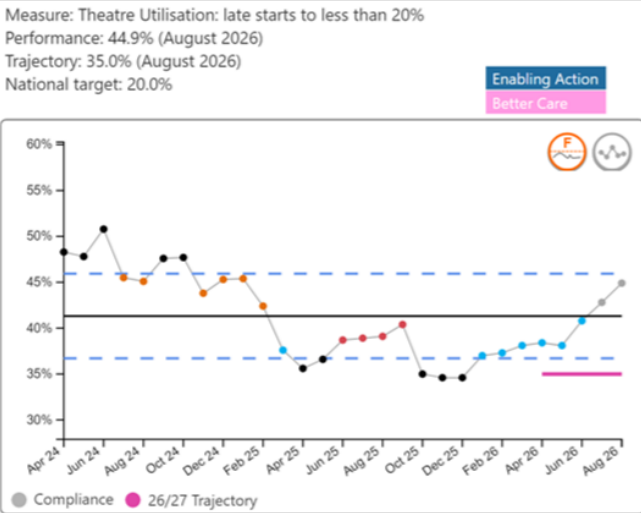
- NHS Planning framework and enabling actions
- NHS Performance framework
- NHS model hospital
- GIRFT and CIN frameworks on a specialty basis

The 2026/27 Annual Plan sets out trajectories for the seven performance expectations included in the plan across theatres. The performance measures are derived from the NHS Planning Framework, which includes both Ministerial Delivery Expectations and Enabling Actions, and the NHS Performance Framework.

The Health Board also includes supplementary, internal measures which provide additional assurance on measuring timely access to care and delivery of system efficiencies. The relevant performance measures are set out under the workstream updates below including the baseline position, the extant performance commitment and the Q1 performance.

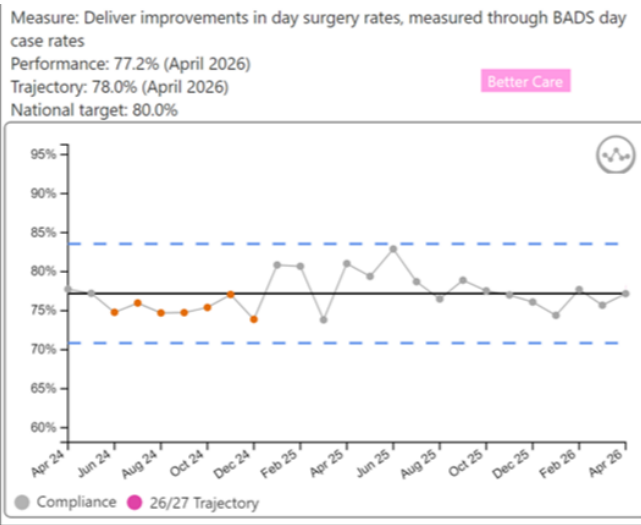
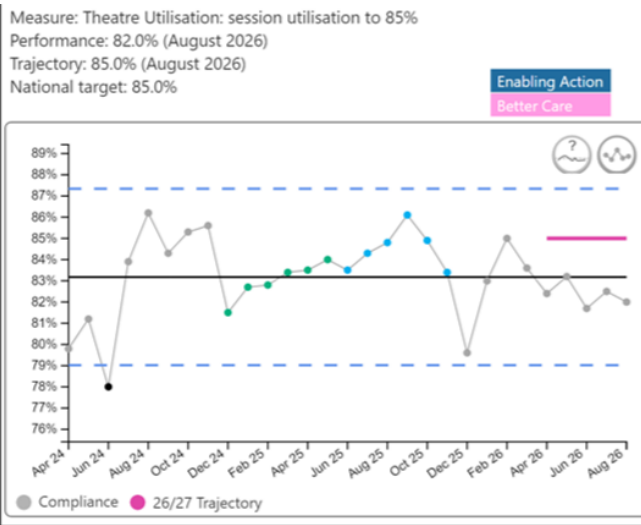
Metric	Source	March 26 baseline	March 27 Plan commitment	Latest position
Numbers of patients waiting over 104 weeks (all stages)	Ministerial Delivery Expectation	23	2,291	375 (Aug-26)
Theatre Utilisation: late starts to less than 20%	Enabling Action	37%	25%	47.9% (Aug-26)
Theatre Utilisation: early finishes to less than 10%	Enabling Action	30.7%	15%	24.6% (Aug-26)
Theatre Utilisation: session utilisation to 85%	Enabling Action	83.1%	85%	82% (Aug-26)
Deliver improvements in day surgery rates, measured through BADS day case rates	Internal Measure	77%	80%	77.2% (Apr - 26)
HVLC cataracts no. on list	Enabling Action	6.83	7	6.6
HVLC Arthroplasty no. on list	Enabling Action	3.6	4	4.2

Current Performance



Late starts performance had been below the mean (41.2%) since Mar-25 but have increased above the mean over recent months. 26/27 performance to date has also exceeded the IMTP trajectory of 35%.

Early finish performance has shown more variability around the mean (26.1%) but has shown close to mean performance for the past 4 months, with the August position at 24.5%, which is slightly above the IMTP trajectory of 22.5%.



Theatre session utilisation performance has been relatively close to the national standard of 85% since Jul-24. A decrease in June performance was anticipated, expected due to disruption from the heatwave and declaration of critical incident, with the August position showing an increase to 82%, just below the national standard.

BADS rates continue to track closely to the national standard of 80%. The most recent position of 77.2% is just below the IMTP trajectory of 78%, which will increase to 80% by the end of the year.

Workstream Updates

Right Procedure, Right Place

A significant element of the improvement work is to ensure treatment activity takes place in the most appropriate place so that prime resource and estate is reserved for the cases that require it. This work includes Outpatient Treatment unit, other treatment rooms, Day Case theatres, St Woolos' Hospital, Outpatient Surgical Unit, Surgical High Care in Royal Gwent Hospital and the Grange University Hospital. The key actions under way are:

	Right Procedure, Right Place
Objective	• Rebalance suitable activity (as per RPRP guidelines) out of main theatres into alternative appropriate settings • Two key products are required to support the work 1) the analysis of procedure codes that currently done in theatres that could be done in non theatres environments and 2) a mapping of all alternatives to theatres e.g. treatment rooms
Progress	• Analysis has been completed identifying procedures suitable for relocation, using Right Procedure, Right Place (RPRP) as the default framework – product 1 completed although under review • Identification of alternative treatment rooms underway with early opportunities highlighted. A pacing room has been identified at NHH that can be converted into a procedure room • Agreed priority being NHH where following cases are done in theatres: ○ Vasectomy ○ Spinal Injections ○ Carpal Tunnel
Forward Plans	• Plan to make identified change in NHH by 1st November • Quantification of liberated capacity underway • Identification of next opportunity after NHH to quantify the procedures that potentially suitable for alternative locations • Engage divisions to complete mapping of possible alternative treatment settings including primary care • Prioritise implementation based on impact and deliverability, including early “lift and shift” opportunities.
Risks	• Any proposed job planning changes may require consultation with staff groups that could result in delay • Identification and assurance of suitable alternative rooms/sites, staffing and funding with appropriate governance

	May require some small amounts of capital to relocate activity
Benefits	Releases theatre capacity and staffing for higher acuity and complex cases

Theatre Productivity

Best practice (GIRFT/HVLC) has demonstrated that implementing a consistent 8-hour full-day operating list model for all standard day elective theatres will improve productivity. In addition, speciality focused plans for cataracts and joints (matching the NHS Wales Enabling action expectations) are in place and monitored.

Theatre Productivity																																																																																																																																					
Objective	- Improve Optimisation of theatre capacity and utilisation across the Health Board, reducing unwarranted variation and improving productivity. - Rationalisation of theatre infrastructure to align capacity with forecast demand and affordability requirements																																																																																																																																				
Progress	- Digital pre-assessment across some sites - Standard lists are now at 7 for cataracts and 4 for arthroplasty - HVLC lists for general surgery are now BAU with practice developing in NHH (day case unit of the month) - General focus on Day case in NHH as demonstrated below <table><caption>Estimated Theatre Productivity Data (Number of Procedures)</caption><thead><tr><th>Quarter</th><th>General Surgery</th><th>Gynaecology</th><th>Maxillo-Facial</th><th>Ophthalmology</th><th>Trauma & Orthopaedic</th></tr></thead><tbody><tr><td>Q1 2021/22</td><td>300</td><td>150</td><td>0</td><td>0</td><td>100</td></tr><tr><td>Q2 2021/22</td><td>300</td><td>200</td><td>0</td><td>0</td><td>100</td></tr><tr><td>Q3 2021/22</td><td>250</td><td>200</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q4 2021/22</td><td>250</td><td>150</td><td>0</td><td>0</td><td>200</td></tr><tr><td>Q1 2022/23</td><td>200</td><td>150</td><td>0</td><td>0</td><td>200</td></tr><tr><td>Q2 2022/23</td><td>200</td><td>200</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q3 2022/23</td><td>250</td><td>200</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q4 2022/23</td><td>250</td><td>300</td><td>0</td><td>0</td><td>100</td></tr><tr><td>Q1 2023/24</td><td>250</td><td>300</td><td>0</td><td>0</td><td>100</td></tr><tr><td>Q2 2023/24</td><td>300</td><td>300</td><td>0</td><td>0</td><td>100</td></tr><tr><td>Q3 2023/24</td><td>250</td><td>250</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q4 2023/24</td><td>250</td><td>250</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q1 2024/25</td><td>350</td><td>300</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q2 2024/25</td><td>300</td><td>300</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q3 2024/25</td><td>350</td><td>300</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q4 2024/25</td><td>350</td><td>300</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q1 2025/26</td><td>300</td><td>300</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q2 2025/26</td><td>300</td><td>300</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q3 2025/26</td><td>350</td><td>300</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q4 2025/26</td><td>350</td><td>300</td><td>0</td><td>0</td><td>150</td></tr><tr><td>Q1 2026/27</td><td>300</td><td>300</td><td>0</td><td>0</td><td>150</td></tr></tbody></table>	Quarter	General Surgery	Gynaecology	Maxillo-Facial	Ophthalmology	Trauma & Orthopaedic	Q1 2021/22	300	150	0	0	100	Q2 2021/22	300	200	0	0	100	Q3 2021/22	250	200	0	0	150	Q4 2021/22	250	150	0	0	200	Q1 2022/23	200	150	0	0	200	Q2 2022/23	200	200	0	0	150	Q3 2022/23	250	200	0	0	150	Q4 2022/23	250	300	0	0	100	Q1 2023/24	250	300	0	0	100	Q2 2023/24	300	300	0	0	100	Q3 2023/24	250	250	0	0	150	Q4 2023/24	250	250	0	0	150	Q1 2024/25	350	300	0	0	150	Q2 2024/25	300	300	0	0	150	Q3 2024/25	350	300	0	0	150	Q4 2024/25	350	300	0	0	150	Q1 2025/26	300	300	0	0	150	Q2 2025/26	300	300	0	0	150	Q3 2025/26	350	300	0	0	150	Q4 2025/26	350	300	0	0	150	Q1 2026/27	300	300	0	0	150
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Q2 2025/26	300	300	0	0	150																																																																																																																																
Q3 2025/26	350	300	0	0	150																																																																																																																																
Q4 2025/26	350	300	0	0	150																																																																																																																																
Q1 2026/27	300	300	0	0	150																																																																																																																																
	- Increasing hernia activity from 4 procedures a day to 16 (across 2 theatres) via HIT - HIT paved the way for HVLC of 8 hernias or 6 gallbladders per list - Reduction in time to discharge by 25% - Proctology achieving 12 per list up from 6																																																																																																																																				

	• Achieving 8 Sedation hysteroscopy per session, delivered by SCP • Meeting GIRFT guidelines in multiple HVLC disciplines as outlined • Scheduling 6-4-2 meetings have been established to ensure best practice • Technical review of theatre KPI definitions • Review of current performance and compliance at Aug Theatre Optimisation Group Meeting
Forward Plans	• Embedding new revised TUG meeting • HVLC roll out in Gynae • Regional Planned Care group – exploring opportunities for NHH to support regional work • Meet with key stakeholders to discuss next steps to move to 8-hour operating day
Risks	• Proposed changes to working may require consultation with staff groups that could result in delay • Increased focus on productivity targets conflicts with quality leading to increased clinical incidents from increased cases on list, reduced theatre turnaround times and extended theatre hours
Benefits	• Increase throughput through core • To improve booking and scheduling to maximise theatre utilisation and reduce delays for patients and focus on reducing late starts, early finishes and cancellations

Resource Alignment

There are currently two CEPD/Trauma theatres at the Grange University Hospital. Analysis is ongoing to assess current demand and capacity aligned to each theatre in order to inform options that maximise capacity and where possible generate efficiencies.

	Resource Alignment Second CEPD / Trauma Review GUH
Objective	• Review staffing configuration and utilisation of the second CEPD/Trauma theatre at GUH • Maximise efficiency while maintaining emergency resilience
Progress	• Developed a series of options: ○ Adjusting rotas to release staffing hours (move from 7.00am-19.00pm to 8.15am-17.45pm to mirror RGH) ○ Repurposing staff to provide additional trauma lists (requiring further investment in medical workforce and consumables) ○ Using released resource to provide 3 additional elective lists. Will require additional anaesthetic workforce and consumables

	○ Extend the operating hours of the second CEPOD and trauma lists into the evening, which could reduce the need for costly weekend trauma lists and improve patient flow
Forward Plans	• Further costings and demand profiling are needed to support decision making associated with the options presented to Theatres group and on to Executives
Risks	• Any significant change to staffing or service specification will require an OCP • Decision required on how to “use” efficiencies released – take out or increase activity
Benefits	• Efficiency improvements, capacity release • Reduce the need for costly weekend trauma lists • Improve patient flow

Analysis demonstrates that there is an opportunity to improve start times across theatres by better aligning resources. Effectively this means a review of rosters and job plans to ensure optimal improve start times. A priority for 26/27 is to focus on Royal Gwent Hospital theatres.

	Resource Alignment Workforce
Objective	• Implement a consistent 8-hour full-day operating list model for all standard day elective theatres. • Review required to understand the efficiency of half-day theatre lists which can be associated with lower productivity • Assess practice and implications of travel time within Theatre Lists
Progress	• Progress has focused on reviewing the actions and outputs for this workstream, along with its interdependencies with the other workstreams. We have also considered a phased approach, given the scale of the work and the potential sensitivities involved • Actions to date have included reviewing workforce data availability to identify areas of misalignment with the theatre plan and across workforce groups
Forward Plans	• Finalise the methodology and extend the analysis across all workforce groups (surgeons, anaesthetics workforce, and Agenda for Change staff) by site • Work with Workforce colleagues to confirm and obtain the required data sources, supporting a more detailed assessment of opportunities for alignment. • In addition, establish monitoring arrangements for the proposed pilot of eight-hour operating days in targeted specialties as a proof of concept
Risks	• Additional staffing alignment required across medical, anaesthetic, nursing and ODP teams. • Consultant/SAS job plan review required

	- Financial impact from staffing changes, partially offset by improved utilisation - OCP / formal consultation required
Benefits	- Efficiency improvement - Releases theatre capacity and staffing for higher acuity and complex cases - Standard work arrangements

Surgical Hub Accreditation

The Strategic Programme for Planned Care is introducing the “Accreditation of Surgical Hub Programme” designed to support and recognise high-performing elective care services. This accreditation is in line with the English GIRFT accreditation well established model. The programme is intended to offer a series of system benefits, including increased staff morale and ownership, stronger alignment between planned care performance and future funding models and formal recognition for delivering high-quality, high-standard care.

	Surgical Hub Accreditation
Objective	Achieve Surgical Hub Accreditation at YYF Hospital
Progress	- Successful in nomination of Ysbyty Ystrad Fawr (YYF) in the first cohort of Surgical Hub Accreditation - Completion and submission of criteria and evidence to NHS P&I in accordance with deadline (14 August 2026) - Confirmation of date of formal visit- 23 October 2026 - Engaging with key stakeholders regarding any gaps in evidence and working to facilitate progress and close any gaps in these areas
Forward Plans	- Continue to work towards closing gaps of evidence. - Liaising with NHS P&I to confirm expectation around the visiting day - Confirm visit arrangements and availability with key stakeholders - Confirm cohort 2 candidate sites
Risks	- Unable to meet all required criteria unable to obtain Surgical Hub Accreditation - Support required from operational colleagues across the Health Board to collate and prepare evidence
Benefits	- To embed top decile working across all specialties in the Hub to gain P&I accreditation - To provide a blueprint for any future hub accreditation across ABUHB - Opportunities for staff to participate in peer accreditation visits, supporting shared learning and best practice spread

Divisional Improvements

In support to the Theatre Optimisation Programme, there are a number of priorities being pursued within Divisions that will support this agenda by identifying potential improvement opportunities that would enhance patient experience and drive local efficiencies, some of these initiatives are outlined below. These include:

- Increase in High Volume Low Complexity (HVLC) procedures – the Divisions of Surgery and Clinical Support Services have worked well in developing these models in NHH in particular
- Extension of Ambulatory CEPOD lists
- Streamlined pre-screening questionnaires
- Theatre teams achieving silver ward accreditation

Furthermore, specialties have engaged in the assessment against CIN (Clinical Implementation Networks) frameworks. In recent days the national reports on all CIN frameworks have been received and progress by individual health boards analysed and compared. These include Anaesthetic, ENT, Ophthalmology, General Surgery, Orthopaedics and Urology. These reports will be reviewed and fed back into the Theatres and Planned Care Programme more broadly.

Finance

Finance is providing dedicated support to the Theatre Optimisation Programme through the establishment of a theatre resource analysis workstream. This work is developing a comprehensive theatre-level baseline across the Health Board, incorporating pay and non-pay expenditure, workforce deployment, activity levels, productivity indicators and utilisation measures. The objective is to provide a robust evidence base to support scenario modelling, assessment of theatre reconfiguration opportunities and future decision-making.

In addition, Finance is leading the development of a quantified benefits framework to ensure a clear line of sight between programme activity and delivery of the Health Board's Financial Recovery Plan. This includes financial modelling of productivity initiatives, service redesign opportunities and potential capacity changes, enabling the programme to assess both operational and financial impacts and support delivery of the £500k savings requirement for 2026/27 and future years.

Key deliverables across all workstreams include:

- Convened a finance review with key stakeholders to identify delivery options and support achievement of the 2026/27 savings requirement
- Completed a detailed analysis to identify procedures suitable for transfer to non-theatre settings in line with the Right Procedure, Right Place (RPRP) methodology
- Commenced identification of alternates to theatres in line with RPRP having initially identified a pacing room at Nevill Hall Hospital requiring minimal investment to support relocation of appropriate procedures from main theatres, releasing theatre capacity for higher-complexity work

- Developed and shortlisted three options for the future staffing model of the second CEPOD/Trauma theatre, with initial engagement completed with Clinical Directors and senior nursing teams
- Established the foundations for enhanced theatre productivity governance including suite of metrics as part of the Theatre Utilisation Group (TUG)
- Submitted Surgical Hub Accreditation evidence to NHS Planning and Improvement for Ysbyty Ystrad Fawr and secured a formal assessment visit for 23 October 2026
- Presented to the All-Wales Clinical Expert Group on Surgical Hubs on the opportunity of Nevill Hall theatres suite in short, medium and long term

Key Programme Milestones for the Next Reporting Period

- Complete Divisional engagement and identify priority opportunities for implementation under the Right Procedure, Right Place programme
- Finalise costing and demand analysis for the second CEPOD/Trauma theatre review to support options appraisal and agreement of a preferred delivery model, noting any Organisational Change Policy requirements
- Complete the theatre costing model to quantify the financial impact of productivity and service reconfiguration opportunities and support delivery of the savings target
- Work with NHS P&I and internal stakeholders to address any outstanding evidence requirements ahead of the Surgical Hub Accreditation visit on 23 October 2026
- Fully embed the Theatre Utilisation Group to provide oversight of productivity metrics, KPI performance and cross-divisional improvement actions

Programme Risks

There are risks associated within each workstream that are managed as part of the theatre programme:

Theme	Risk Overview
Capacity / Efficiency	• Limited workforce, operational, and organisational capacity restricting delivery including emergency and elective demand • Any efficiency gains are absorbed by increased demand from both emergency activity displacing elective work and demand on elective waiting lists increasing • Identification of the point of efficiency in order to make clear decision on how to use that opportunity • Variation in clinical practice persists and job planning changes are not accepted leading to productivity improvements to be lower than forecast
Financial	• Increased efficiency can drive additional consumables mitigating some expected savings
Workforce	• Additional staffing alignment required across medical, anaesthetic, nursing and ODP teams • Consultant/SAS job plan review required

- Financial impact from staffing changes, partially offset by improved utilisation.
- OCP / formal consultation requirements

Conclusion

The Health Board has made tangible progress in strengthening theatre productivity and establishing the foundations for sustained improvement. This has been recently reflected back to the organisation through the CIN reports. This includes standardising cataract and arthroplasty lists, introducing 6-4-2 scheduling arrangements, increasing the productivity and throughput through NHH, identifying procedures that could transfer from main theatres to more appropriate settings, and developing options to improve the use and staffing of the second CEPOD/Trauma theatre. These developments demonstrate growing organisational focus on reducing variation, improving utilisation and making more effective use of theatre capacity and workforce resources.

The challenge remains identifying the points at which purposeful decisions on how efficiencies are “used” when they are often spread across a number of sites and specialities, this has made it difficult to identify the line of sight to cash releasing saving at this point.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **Note** the current theatre performance position;
- **Receive** assurance on progress across the five Theatre Optimisation Programme workstreams;
- **Note** the key workforce, operational, financial and consultation risks to delivery

APPENDIX 1 – Theatres Deep Dive

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):

Blaenoriaethau CTCI
IMTP Priorities

[Link to IMTP](#)

Governance, Leadership and Accountability
1.1 Health Promotion, Protection and Improvement
5.1 Timely Access
7.1 Workforce

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 the access, experience and outcomes of those who require mental health and learning disability services Choose an item. Choose an item. 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 No does not meet requirements
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	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	Choose an item. Choose an item. Not applicable to this report

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

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth:
Evidence Base:

Rhestr Termau:
Glossary of Terms:

ABUHB – Aneurin Bevan University Health Board

BADS – British Association of Day Surgery

CEPOD – CEPOD theatre refers to operating theatre capacity designated for urgent and emergency surgery.

CD – Clinical Director

EIA / EQIA – Equality Impact Assessment

GIRFT – Getting It Right First Time

GUH – Grange University Hospital

HVLC – High Volume Low Complexity

IMTP – Integrated Medium Term Plan

KPI – Key Performance Indicator

MDT – Multidisciplinary Team

NHH – Nevill Hall Hospital

NHS – National Health Service

NHS P&I – NHS Performance and Improvement

OCP – Organisational Change Policy

ODP – Operating Department Practitioner

RGH – Royal Gwent Hospital

ROI – Return on Investment

	RPRP – Right Procedure, Right Place SAS – Specialty and Associate Specialist doctors SRO – Senior Responsible Owner TOP – Theatre Optimisation Programme TUG – Theatre Utilisation Group YYF – Ysbyty Ystrad Fawr
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Theatres Workshop

16th April 2026 Support for reviewing job plans



Purpose of the Session

- Provide an overview of current theatre provision, utilisation and potential opportunities
- Note current management arrangements
- Test emerging priorities and alignment with key opportunities and financial plan
- Agree the top priorities and deliverables for the Theatres Programme for 2026/27
- Test emerging structure for the Theatres Programme for 2026/27
- Note areas for organisational support

Overview of Theatres Estate

Appendix 1 provides a detailed breakdown of sessions running in available theatres across all sites.

Key Points:

- There is theatre estate available at RGH and NHH
- There are session opportunities at RGH, NHH, GUH and the OTU
- There are other clean room areas e.g. County Hospital
- Specialties are operating out of multiple different sites
- Discussions are required on Theatre 3 at RGH
- There are opportunities for operational efficiencies at all sites
- Theatres in NHH and RGH require infrastructure review (e.g. Th14)
- Majority of theatres sit within PACCT however there are certain theatres/services which run separately:
 - St Woolos theatres (Orthopaedics)
 - Max Fax surgery in B Block at RGH (PACCT supplies anaesthetists and ODPs)
 - Ophthalmology in E Block at RGH (PACCT supplies anaesthetists and ODPs)
 - Regional Ophthalmology at NHH

Theatre Estate					
Site	Available Theatre Space		Decommissioned	Specialties	
	In Use	Total Available	Total		
Royal Gwent Hospital (Main Theatres)	13	14	2 (Th 10 and 11 - previously Gynae)	Gynae Urology ENT Max Fax	Gen Surg Head and Neck T&O
Royal Gwent Hospital (E Block)	2	2	0	Eyes	
Royal Gwent Hospital (B Block)	2	2	0	Max Fax	
Grange University Hospital	9	9	0	Gynae Max Fax	T&O ENT
Nevill Hall Hospital	4	6	0	Gynae Gen Surg	Orthopaedics
Nevill Hall Hospital - Llanwenarth Suite	2	2	0	Regional Ophthalmology	
Ysbyty Ystrad Fawr	3	3	0	Gynae Gen Surg	Orthopaedics
St Woolos Hospital	2	2	0	T&O	
Outpatient Treatment Unit - Theatres	2	2	0	General Surgery Gynae ENT	Max Fax Ophthalmology Dermatology
Total	39	42	2		

Overview of Theatres

Theatre Staffing

Key Points:

- Misalignment of staffing hours for Trauma lists, second CEPD list and YYF. Opportunity to standardise staffing hours across all theatres
- Theatre staff need to start 45 minutes before the theatre start time to account for setting up and a 15 minute brief before the start of the list
- A key barrier to aligning theatre times is job planning disputes
- Annual job plans vary:
 - Anaesthetics: 42 weeks
 - Theatre staff: 48 weeks
 - Surgeons: differs based on their on call system – ranges between 32 and 42

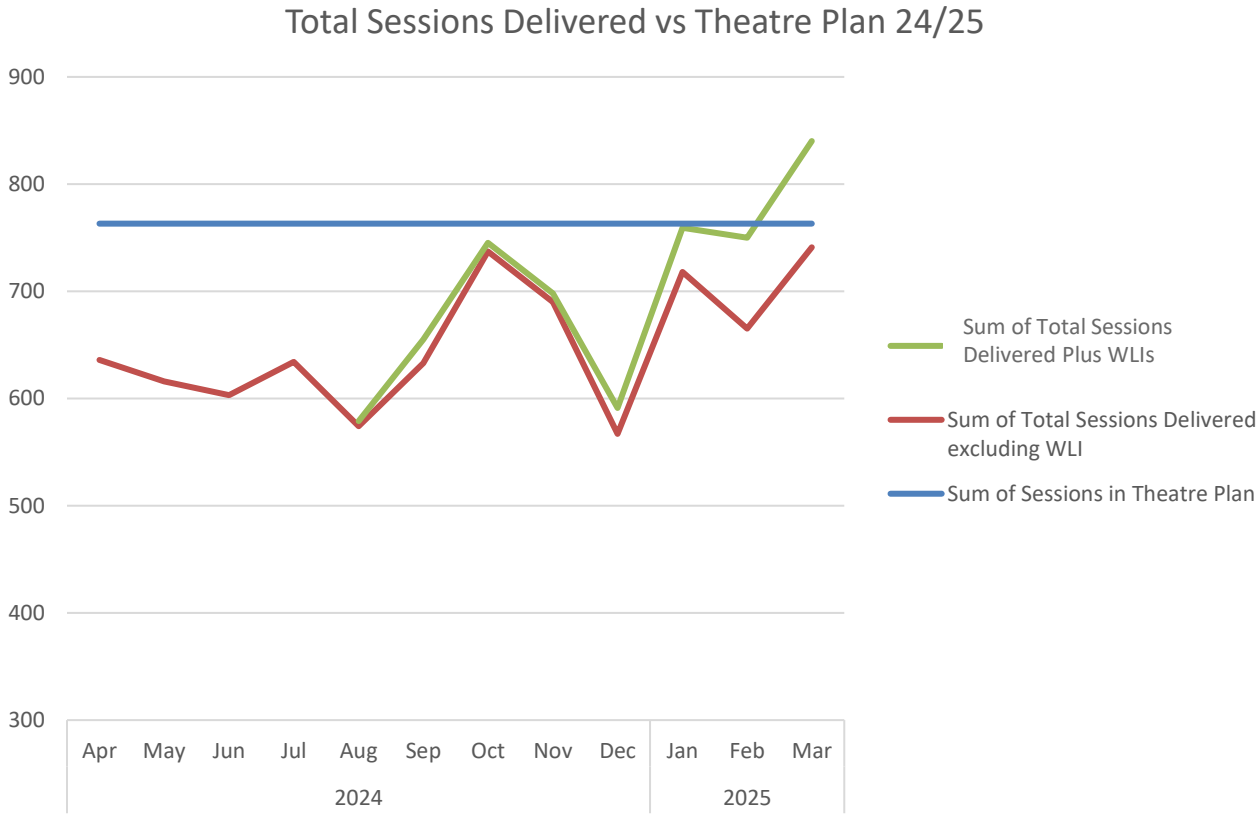
GUH	Speciality	Briefing Time	Start Time	Finish Time	Anaesthetic staffing	Theatre Staffing	Comments
GUH1	Trauma	08:45	09:00	18:00	08:00 - 19:00	07:00-19:30	Mon- Friday
GUH2	Trauma	24 hours			08:00-19:00 then CEPD team	07:00-19:30	24/7 rota to include on-call anaesthetist
GUH3	Mixed	08:45	09:00	17:00	08:00-18:00	08:15- 17:45	staffed as per theatre model
GUH4	CEPD	08:30	08:45	18:00	08:00-18:00	07:00-19:30	Mon-Friday
GUH5	Elective Gynae	08:45	09:00	17:00	08:00-18:00	08:15- 17:45	Monday - Friday
GUH6	Elective	08:45	09:00	17:00	08:00-18:00	08:15- 17:45	staffed as per theatre model
GUH7	Elective	08:45	09:00	17:00	08:00-18:00	08:15- 17:45	Monday - Friday
GUH8	Elective	08:45	09:00	17:00	08:00-18:00	08:15- 17:45	Monday - Friday
GUH9	CEPD	24 hours			08:00-20:00	07:00-19:30	24/7 rota to include on-call anaesthetist
Site	Speciality	Briefing Time	Start Time	Finish Time	Anaesthetist	Theatre Staff	Comments
RGH	Standard day	08:45	09:00	17:00	08:00-18:00	08:15- 17:45	Monday - Friday
NHH	Standard day	08:45	09:00	17:00	08:00-18:00	08:15- 17:45	Monday - Friday
SWH	Extended day	08:00	08:00	18.00	07:00-19:00	07:30-18:30	Monday - Friday
YYF	Standard day	09:00	09:00	17:00	08:00-18:00	08:30- 18:00	Monday - Friday
	Extended day	08:00	08:00	18.00	07:00-19:00	07:30-18:30	Monday - Friday

Sources of Key Metrics

- **National Metrics:**
 - Enabling Actions
 - CIN (Clinical Implementation Network) Optimisation Frameworks
 - BADS (British Association of Daycase Surgery) procedures and dataset
- **Local Metrics:**
 - Model Hospital Metrics
 - Locally agreed KPIs
- Detailed performance against the above metrics can be found in Appendix 3

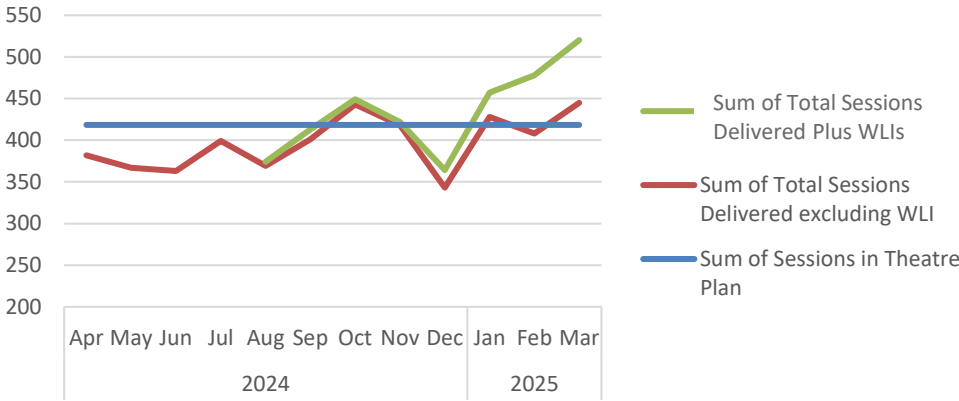
Total Sessions in PACCT

- This table demonstrates the total sessions delivered within PACCT theatres, WLI is stacked on top of core delivery
- Core delivery is not reaching the sum of sessions in the theatre plan
- Largest difference between sessions in theatre plan vs delivered is at **NHH and YYF**
- Requirement to **drill into data** to understand what the reasons are behind gaps
- Need to consider PACCT and non-PACCT

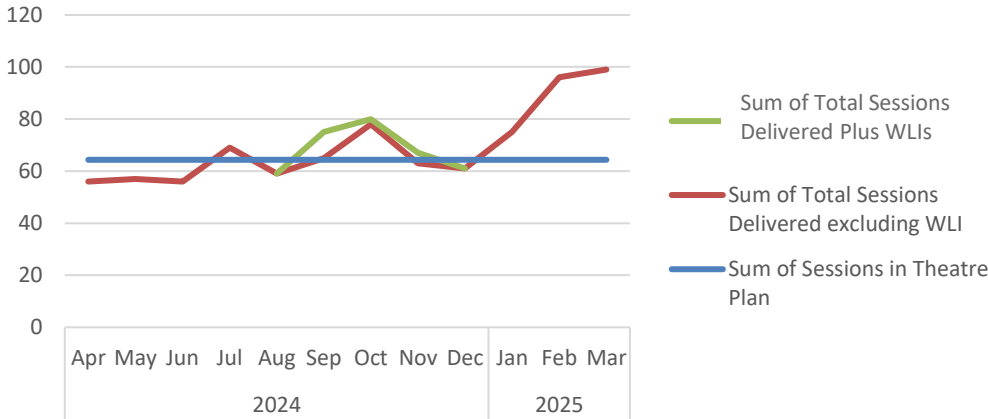


Total Delivered vs Theatre Plan (Including WLIs) by Site

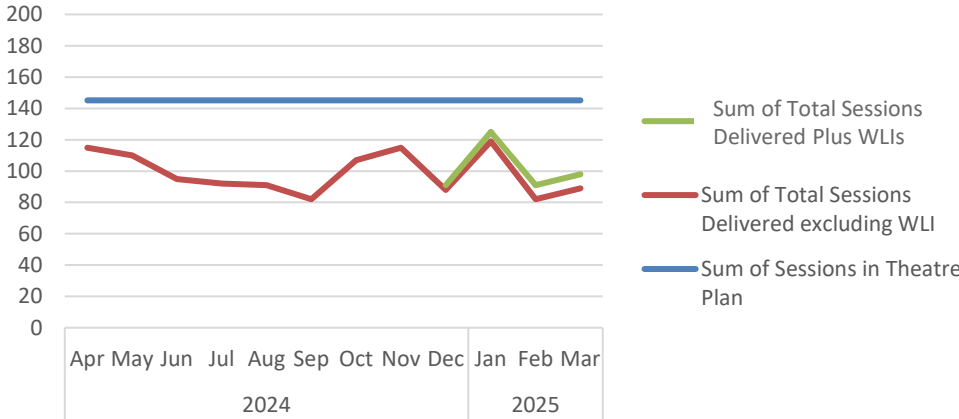
RGH Sessions Delivered vs Theatre Plan 24/25



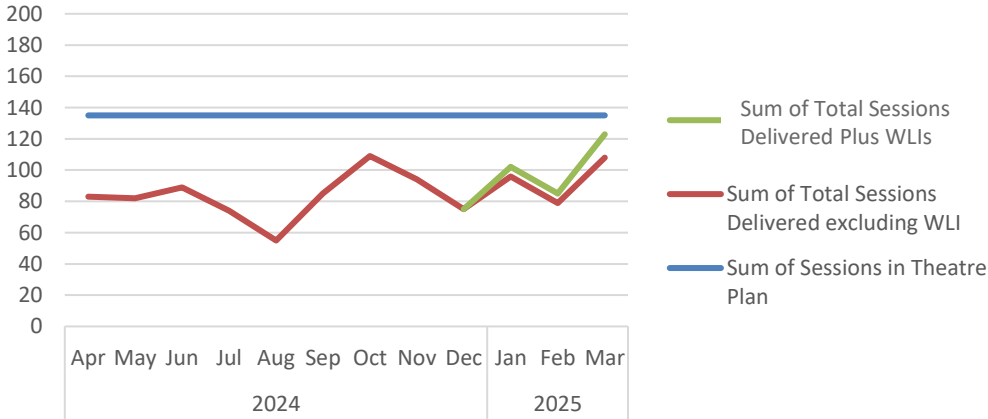
GUH Sessions Delivered vs Theatre Plan 24/25



NHH Sessions Delivered vs Theatre Plan 24/25



YYF Sessions Delivered vs Theatre Plan 24/25



Key Metrics

Enabling Actions 2025/26

Enabling Action	National Target	Performance (Feb 26)	RAG Rating
On 90% of days planned care inpatient/daycase/theatre recovery capacity should be protected from pressures and outliers	90%	96.9%	
Ensure effective utilisation of theatre capacity through: Reducing late starts to less than 20%	20%	37.3%	
Ensure effective utilisation of theatre capacity through: Reducing early finishes to less than 10%	10%	43.1%	
Ensure effective utilisation of theatre capacity through: Increasing session utilisation to the GiRFT standard of 85% by March 26	85%	85.1%	
Deliver improvements in day surgery rates, achieving a BADS daycase rate of 70% from April 2025, moving to 80% by the end of June 2025	80%	76.1% (Dec '25)	

Key Metrics

Right Procedure, Right Place – Example of Potential Opportunity

Across March–December 2025/26, **3,145 procedures** were carried out in PACCT theatres that GIRFT (Getting it Right First Time)/RPRP identifies as potentially suitable for delivery outside a traditional theatre setting.

This activity equates to approximately **635 theatre sessions**.

- 466 Procedures (155.6 Sessions) are identified as anaesthetic type General/Anaesthetist Involvement in their procedure on ORMIS.
 - RGH – 160 (44.71 sessions)
 - GUH – 41 (11.23 sessions)
 - YYF – 102 (56.3 sessions)
 - NHH – 163 (43.36 sessions)
- 2666 Procedures (475.77 sessions) either have no Anaesthetist assigned to the procedure on ORMIS or marked as local anaesthetic procedure.
 - RGH – 921 (199.15 sessions)
 - GUH – 76 (25.33 sessions)
 - YYF – 555 (91.81 sessions)
 - NHH - 1114 (159.48 sessions)

The information above is taken from ORMIS procedural level data, there are some minor mismatches however these are immaterial and does not alter the trend. Important to note theatre sessions could have mixed anaesthetic types within activity. Session calculation is taken from patient touch time in minutes divided by 210 (Current theatre session time as per ORMIS).

Key Metrics

Productivity Opportunities

St Woolos – Jan 25 to June 25

- An example of work completed by NHS P&I in Q2 2025/26
- The graph shows the maximum opportunity based on an additional one point for every 01:45 hours has been calculated in the graph
- This data does not show in session utilisation and any downtime within the session. In some lists consultants may work through without taking a break to finish the list early and this should be considered when reviewing additional opportunity.
- The data suggests:
 - A potential opportunity of 106 arthroplasty cases per year, using the number of lists for the last 6 months as a prediction of full year activity.
 - This opportunity would reduce to 24 arthroplasty cases, if a marker of 2 hours was used. It is worth noting than in session utilisation has not been analysed.
- Undertaking this analysis was a manually intensive piece of work but it would be beneficial to have this data readily available

Consultant	Average of Late starts	Average of Early Finish	Average Available time	Average of Points	Number of Sessions Q4/Q1 (6 months)	Average case mix point opportunity with available time	Additional case mix point Opportunity per year
Consultant Name	00:37	01:08	01:45	5.3	12	1	24
	00:39	01:07	01:37	3.7	9	0	0
	00:32	01:35	02:08	3.8	6	1	12
	00:32	01:03	01:36	4.0	10	0	0
	00:20	00:34	00:54	4.3	3	0	0
	00:25	00:50	01:15	3.9	9	0	0
	00:41	01:12	01:52	5.0	14	1	28
	00:15	01:45	02:00	4.2	6	1	12
	00:39	01:03	01:39	4.2	5	0	0
	00:35	00:57	01:16	3.7	7	0	0
	00:34	00:53	01:27	5.0	1	0	0
	00:29	01:07	01:32	4.1	9	0	0
	00:24	01:22	01:46	5.7	15	1	30
	00:27	01:08	01:36	3.0	4	0	0
	00:27	00:47	01:14	4.6	9	0	0
Grand Total	00:31	01:09	01:38	4.5	119	0	106

Summary Messages

- The theatres plan needs to be adjusted to fit current requirements and changing demand. A **full theatre plan review** is therefore required to ensure that it is efficient and fit for purpose
- Opportunities to **improve late starts / early finishes** by reviewing the theatre pathway and ensuring job plans are aligned
- Focus on **right procedure, right place** - options to move activity outside of a traditional theatre setting
- Requirement to focus on **alignment of workforce**
- Productivity measures generally focus on surgeon productivity - requirement to review productivity measures to focus on **opportunities across the entire theatre pathway.**

Priorities and Next Steps to Improve

Standardisation of 8-Hour Elective Theatre Lists

- Implement a consistent 8-hour full-day operating list model for all standard day elective theatres.
- Aligns with GIRFT/HVLC expectations and reduces under-running and inefficiency.
- Implications:
 - Additional staffing alignment required across medical, anaesthetic, nursing and ODP teams.
 - Consultant/SAS job plan review required.
 - Financial impact from staffing changes, partially offset by improved utilisation.
 - OCP / formal consultation required.

Right Procedure, Right Place

- Move suitable activity (as per RPRP guidelines) out of main theatres into alternative appropriate settings. Frees up theatre capacity and staffing for higher acuity and complex cases.
- Implications:
 - Job planning changes for consultants.
 - Identification and assurance of suitable alternative rooms/sites, staffing and funding with appropriate governance.

Alignment of Anaesthetic Criteria (YYF and NHH)

- Review and standardisation of anaesthetic eligibility criteria to reduce site variation.
- Benchmarking exercise against comparable units in Wales and England.
- Clinical assurance to maintain safety while improving utilisation.

Priorities and Next Steps to Improve

Review the Use of Half-Day Theatre Lists

- Review required to understand the efficiency of half-day theatre lists.
- Half-day lists can be associated with poor productivity and inefficient staffing models so this would need to feature as part of the full theatres plan review.

Travel Time in Theatre Lists

- Confirm that travel time is not permitted or compensated within theatre lists.
- Rationale:
 - Theatre time must be protected for direct clinical activity.
 - Supports consistency, fairness and value.

GUH Second CEPOD/Trauma Model Review

- Review staffing configuration and utilisation of the second CEPOD/Trauma theatre at GUH.
- Repurpose or realign staffing where possible to maximise efficiency and ROI while maintaining emergency resilience.

Wider Theatres Context

- Update against CIN Optimisation Framework – version 2 due by 15th May 2026
- Regional work - LHP and Cataracts
- Nevill Hall Hospital Outline Business Case (OBC)
- Development of clinical services plan – regional and local
- Financial opportunities assumed in 2026/27 IMTP
- Surgical Hub Accreditation Opportunities

CIN Optimisation Frameworks Version 2 – General Surgery

Checklist

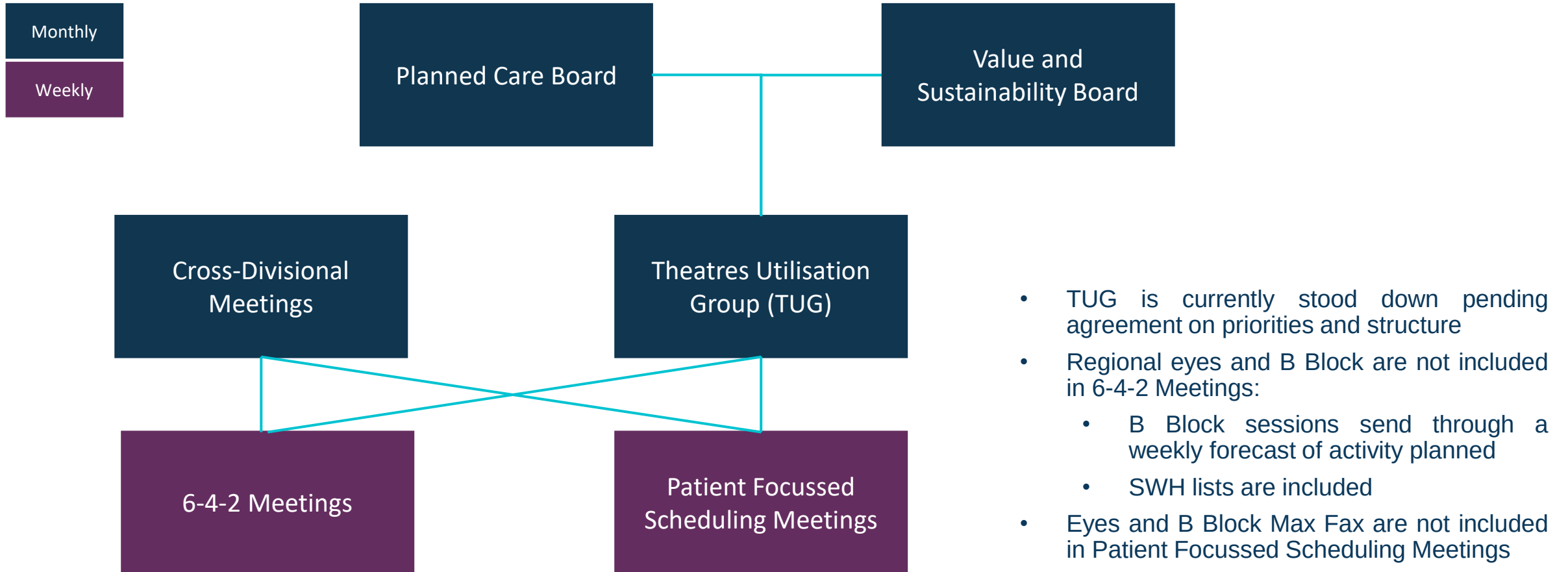
- ❑ Robust job-planned mechanisms are in place to adequately backfill all theatre capacity during leave, and during on-call commitments
- ❑ On-day cancellation rates should be reported, with a rate of <2% expected
- ❑ Pan-departmental job plans should allow time for pre-list patients reviews and team brief, and reflect pre-agreed list start times (auto-send for first patient)
- ❑ There is regular reporting on key theatre productivity measures (including utilisation, late starts and early finishes) in line with national guidance/ enabling actions
- ❑ Surgical hub accreditation criteria should guide the number of cases added to high-volume theatre lists
- ❑ Surgical bed capacity, commensurate with the requirements of the theatre complex, is ring fenced
- ❑ The proportion of theatre lists adhere to CIN guidance and GIRFT principles, to deliver high-volume capacity
- ❑ Regular operating capacity is labelled as high-volume, and utilised by a proportion of theatre lists adhering to GIRFT principles
- ❑ Day-case rates and length of stay metrics are recorded for all high-volume procedures, and reported quarterly
- ❑ Where HVLC lists routinely fall below established standards, health board mechanisms are in place to review performance and agree corrective action
- ❑ All avoidable theatre cancellations should be discussed at relevant departmental audit meetings, and TOG/ TUG meetings, with improvement opportunities clearly identified
- ❑ A 'Golden Patient' or 'Auto-send' policy is in place to ensure timely elective theatre starts
- ❑ There are effective processes in place to facilitate nurse-led discharge for day case procedures
- ❑ A clear communication process exists to engage clinical teams deemed to be under-booking or under-utilising theatre lists

Key Opportunities – Surgical Hubs Accreditation

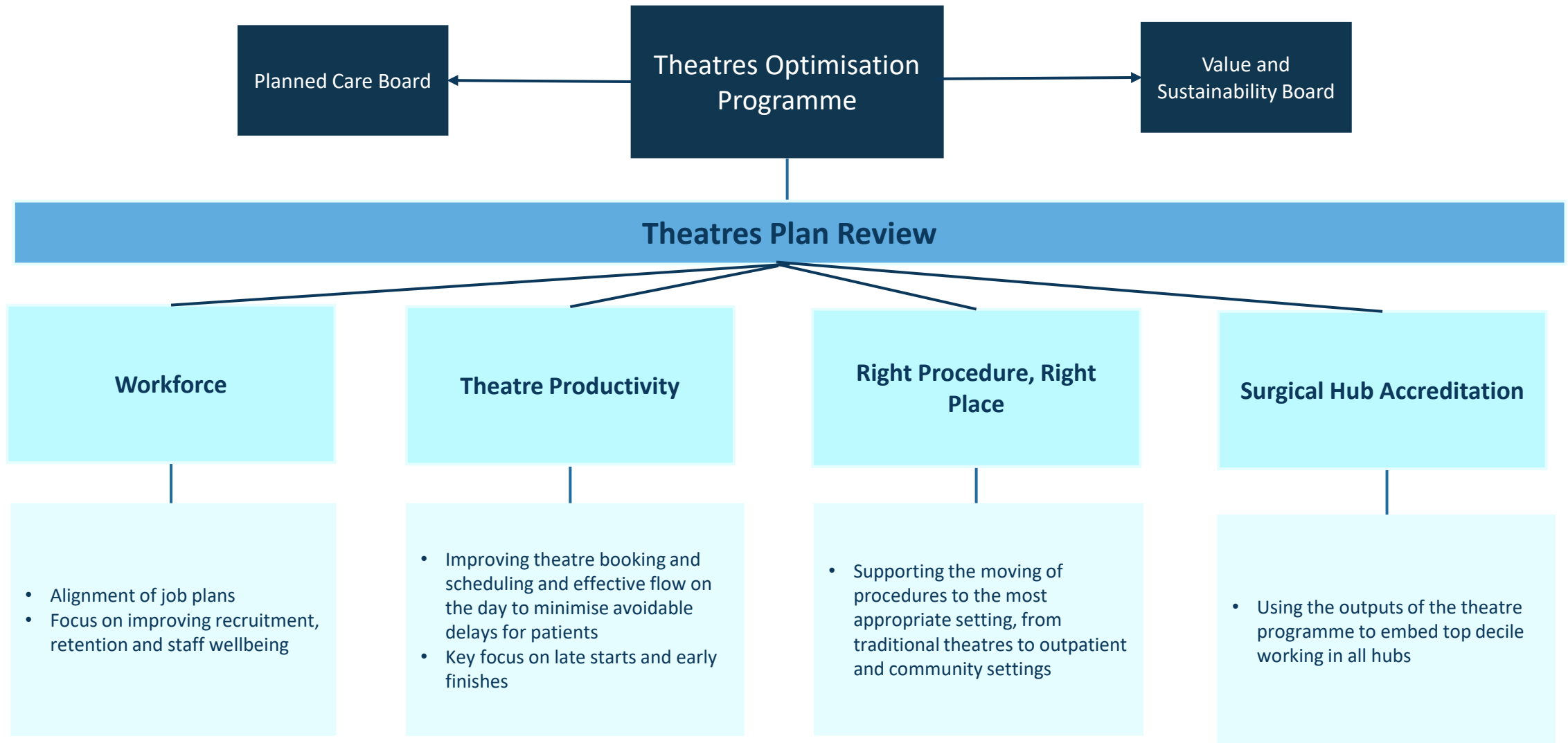
Overview:

- The Planned Care Strategic and Operational Group have outlined the 2026/27 Plan from the Strategic Programme for Planned Care, and the expectations for delivering the Ministerial Advisory Group (MAG) recommendation 4:
 - 4a) All Health Boards should reduce unwarranted variation on treatment waiting times and adopt best practice in theatre management to be overseen by the establishment of Health Board Theatre Optimisation Boards. Timescale – within 6 months
 - Health Boards should seek accreditation for all Surgical Hubs, and this should be a condition of further funding. Timescale – within 12 months.
- The Strategic Programme for Planned Care is therefore introducing the “Accreditation of Surgical Hub Programme” designed to support and recognise high-performing elective care services. The programme is intended to offer a series of system benefits, including:
 - Improved efficiency and streamlined pathways
 - Increased staff morale and ownership
 - Stronger alignment between planned care performance and future funding models
 - Formal recognition for delivering high-quality, high-standard care
 - Opportunities for staff to participate in peer accreditation visits, supporting shared learning and best practice spread
- **Requirement for the UHB to submit an Expression of Interest by 17th April 2026:**
 - Proposal to submit either YYF or SWH – the preference is YYF due to multiple specialties working at the site.

Current Oversight Arrangements



Proposed Theatres Programme



Outputs and Support Required

- Support for opportunities and priorities within the Theatres Programme for 2026/27
- Support to undertake full theatres plan review, from which there will be a need for:
 - **Workforce, Nursing and Medical support:** for reviewing job plans and implications of changes to long standing ways of working.
 - **Finance support:** focus on efficiencies, could be a requirement for changes to funding streams and potentially additional funding to optimise opportunities and exploration of costs/savings associated with potentially repatriating services. Opportunity to review funded vs unfunded theatre sessions.
 - **Information:** collaboration required with data analysts (support already identified).
 - **DDAT:** explore options for adding productivity measures to Qlik. A standard dataset is required across PACCT and non-PACCT.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Appendices



Appendix 1: Overview of Theatres

Royal Gwent Hospital

All 0900-1700 unless specified	Sun	Mon	Tues	Weds	Thurs	Fri	Sat
RGH							
Th1 - T&O	Closed	Ortho	Ortho	Ortho	Ortho	Ortho	Closed
Th2 - T&O	Closed	Ortho	Ortho	Ortho	Ortho	Ortho	Closed
Th3 - T&O	Closed	Closed	Closed	Closed	Closed	Closed	Closed
Th4 - T&O	Closed	Ortho	Ortho	Ortho	Ortho	Ortho	Closed
Th5 - MaxFax	Closed	ENT	ENT	MaxFax	MaxFax	Closed	Closed
Th6 - ENT	Closed	ENT	Gynae	ENT	ENT	Gynae	Closed
Th7 - GS	Closed	GS	GS	GS	Closed	GS	Closed
Th8 - GS / Urol / Robot	Closed	GS	Urol	Urol	Gynae	Urol	Closed
Th9 - GS	Closed	GS	GS	GS	GS	GS	Closed
Th12 (DSU1) - Gynae	Closed	PAEDS	Gynae	Gynae	Gynae	Gynae	Closed
Th14 (DSU2) - Gynae / GS	Closed	Closed	Closed	GS	Closed	Closed	Closed
Th16 - Urology	Closed	Urol	Urol	Urol	Urol	Urol	Closed
Th17 - Urology	Closed	Urol	Urol	Urol	Urol	Urol	Closed

Procedures that can be undertaken at RGH

- Adult surgical procedures requiring post-operative level 1/ 1.5 care.
- Paediatric day case procedures – Morning list only- ENT, Urology, Squints
- ENT: Adult Tonsillectomies – morning list only (no ENT list undertaken currently)
- Interventional radiology who fit RGH criteria for GA (list twice a month)

Surgical procedures not undertaken at RGH

- Vascular surgery
- Major Head and Neck surgery
- Paediatric surgery which warrants inpatient admission
- Obstetrics
- Any procedure requiring level 2/ 3 post-operative care

Appendix 1: Overview of Theatres

Grange University Hospital

GUH	Sun	Mon	Tues	Weds	Thurs	Fri	Sat	
Th1 - T&O	Closed	Trauma	Trauma	Trauma	Trauma	Trauma	Closed	Emergencies / Trauma
Th2 - T&O	Trauma	Trauma (Paeds alt)	Trauma	Trauma	Trauma	Trauma	Trauma	Elective Obstetrics
Th3 - Vascular	Closed	Trauma Alt	Closed	Closed	Closed	Closed	Closed	
Th4 - CEPOD	Closed	CEPOD	CEPOD	CEPOD	CEPOD	CEPOD	Closed	
Th5 - Obstetrics	Closed	Elective Obstetrics	Elective Obstetrics	Elective Obstetrics	Elective Obstetrics	Elective Obstetrics	Closed	
Th6 - Gynae	Closed	Closed	Closed	Gynae	Closed	Closed	Closed	
Th7 - GS/ENT	Closed	Closed	ENT	Closed	ENT	ENT	Closed	
Th8 - MaxFax	Closed	MaxFax Alt weeks	MaxFax	MaxFax	MaxFax	ENT	Closed	
Th9 - CEPOD	CEPOD	CEPOD	CEPOD	CEPOD	CEPOD	CEPOD	CEPOD	

Suitability for anaesthesia and surgery at the Grange University Hospital (GUH)

- GUH accommodates the majority of our high risk surgical patients.
- It houses 11 theatres, 2 IR theatres, an MRI suite and is the location for the critical care facility of the health board.
- This comprises 2 emergency surgical theatres, 2 trauma theatres, all vascular surgery, high risk general surgical, gynaecological, urological and ENT/Max Fax surgery. (Also 1 elective and 2 emergency obstetric theatres)
- It is also the location for in-patient paediatric surgery.
- It is therefore prudent that higher risk patients are streamed towards having their operation at the GUH site.
- The satellite sites can also provide safe care for elective patients and the following advice will guide the user to select the most appropriate site for the patients' care.

Appendix 1: Overview of Theatres

Nevill Hall Hospital

NHH	Sun	Mon	Tues	Weds	Thurs	Fri	Sat
Th3 (Blue) - Eyes only	Closed	Oph LA Alt	Oph LA				Closed
Th 4 (Red) - Shared	Closed	Gynae		Gynae	Gynae	Gynae	Closed
Th2 (Green)- Shared	Closed		Pain LA alt	Plas 1&3 LA AM / GS	GS	GS	Closed
Th5 (Orange) - GS	Closed	GS	GS	GS	GS	GS	Closed
Th6 (Jade) - Ortho	Closed	Ortho	Ortho	Ortho	Ortho	Ortho	Closed

- **Suitability for anaesthesia and surgery at NHH:**
 - Largely day case surgery so patients must meet day case criteria
- **The following patient groups remain unsuitable:**
 - BMI >45
 - Elective procedures requiring the planned use of intra operative cell salvage
 - Complex kit requirement
 - Paediatric patients
 - Obstetric patients
 - The following cases may be suitable for NHH:
 - BMI >45 only if a spinal with short acting local is pre-agreed at anaesthetic clinic

Appendix 1: Overview of Theatres

St Woolos Hospital

SWH	Sun	Mon	Tues	Weds	Thurs	Fri	Sat
Th1 - T&O	Closed	Ortho - 3 sessions	Ortho - 3 sessions	Ortho - 3 sessions	Ortho - 3 sessions	Ortho - 3 sessions	Closed
Th2 - T&O	Closed	Ortho - 3 sessions	Ortho - 3 sessions	Ortho - 3 sessions	Ortho - 3 sessions	Ortho - 3 sessions	Closed

Appendix 1: Overview of Theatres

Ysbyty Ystrad Fawr

YYF	Sun	Mon	Tues	Weds	Thurs	Fri	Sat
Th1 - T&O	Closed	Ortho - 3 sess	Ortho - 3 sess	Ortho - 3 sess	Ortho - 3 sess	Ortho - 3 sess	Closed
Th2 - GS	Closed	GS	GS	GS	GS	Ortho - 3 sess	Closed
Th3 - GS / Gynae	Closed	Gynae	GS	GS	Gynae	GS	Closed

- **General Conditions – General Anaesthesia Guidance at YYF:**
- **The following patient groups are unsuitable:**
 - Children under 16 years of age
 - Obesity with BMI > 40 or BMI 35-40 with significant co-morbidities
 - Known or anticipated difficult airway
 - Malignant Hyperpyrexia
 - Suxamethonium Apnoea
 - Allergic reaction to previous GA / multiple drugs
 - Complex pharmacology
 - More details on pages 35-39

Appendix 1: Overview of Theatres

Outpatient Treatment Unit

	Session	Theatre 1	Theatre 2	Wound Chairs (2)	Infusion Chairs (4)
Monday	AM	Maxillo Facial	Ophthalmology	Free	Ad Hoc infusions - Colorectal
			Free Week 1		
	PM	Dermatology	Gynae planned to start alt weeks	Free	Ad Hoc infusions - Colorectal, Neph and PAC
			Free alt weeks		
Tuesday	AM	Maxillo Facial	Dermatology	Derm Wound Clinic	Ad Hoc infusions - Colorectal
	PM	Dermatology	ENT	Neurology Lumber Punctures once a month	Ad Hoc infusions - Colorectal, Neph and PAC
				Free 3 weeks a month	
Wednesday	AM	Dermatology	Free	Derm Wound Clinic	Ad Hoc infusions - Colorectal
	PM	Free	Free	Free	Ad Hoc infusions - Colorectal and PAC
Thursday	AM	Derm	General Surgery	Derm Wound Clinic	Ad Hoc infusions - Colorectal
	PM	ENT	Free	Neurology Lumber Punctures	Ad Hoc infusions - Colorectal, Neph and PAC
		Free			
Friday	AM	Dermatology	Free	Derm Wound Clinic	Ad Hoc infusions - Colorectal
	PM	General Surgery	Free	Free	Ad Hoc infusions - Colorectal

Planned/Potential new pathways
Gynae one-stop HMB clinic (alt weeks Monday PM)
Potential Eyes injection (move from consultant led to Optometrist led)
Potential expansion of Derm cancer clinics
Potential expansion of ENT

To note – free sessions are not staffed

Appendix 1: Overview of Theatres

Outpatient Treatment Unit

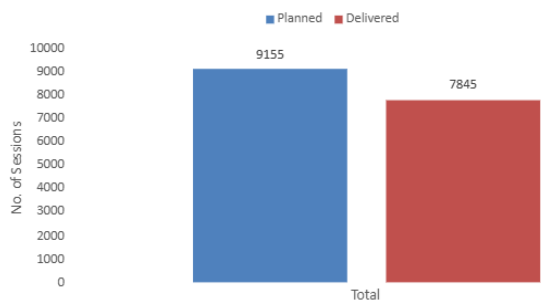
- 50% capacity since July 2022 Welsh Government Outpatient Transformation Funding (2 year)
- Currently funded as overspend by Division of Surgery. Business case approved in principle.

Current Pathways	
Specialty	Procedure
Max Fax	Minor Ops, complex wounds
General Surgery	Minor Ops, iron infusions (change from Nurse Prac to RN support)
Dermatology	Minor Ops, complex wounds
Ophthalmology	Oculoplastic
ENT	Epistaxis (nose bleeds), insertion of grommets, nasal fractures
Neurology	Lumbar Punctures (Move from MAU)
Nephrology	Iron infusions (previously patients travelled to Cardiff)

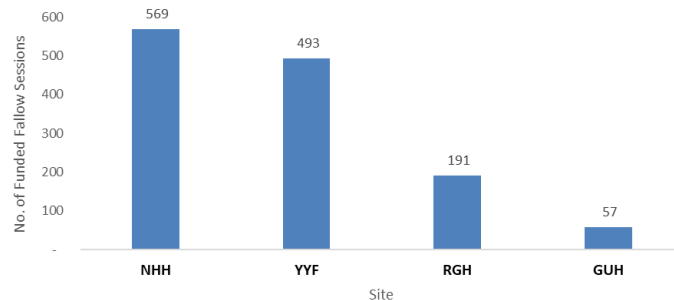
Year	Number of Patients Attended OTU
2022-2023 (opened July 2022)	557
2023-2024 (staggered start dates for some pathways)	2368
2024-2025	2801
April 25 – Jan 26	3289

Appendix 2: Total Summary: Un-utilised Sessions

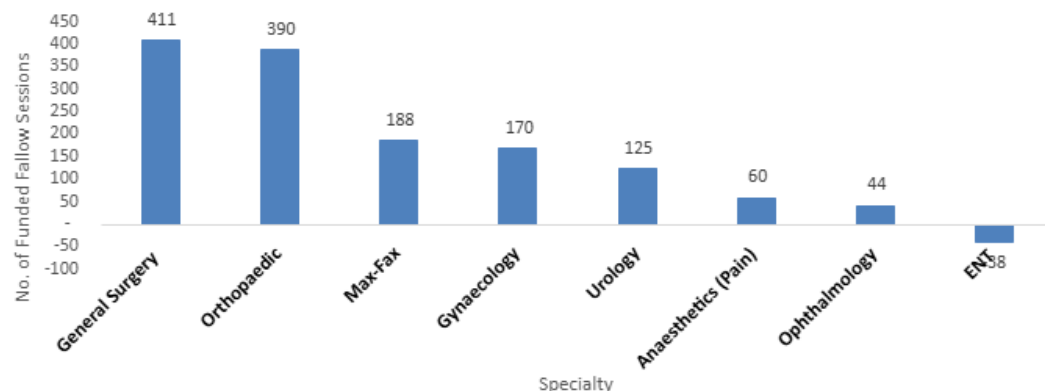
Total Planned Sessions Overview (2024-25)



Un-utilised Sessions by site (2024-25)

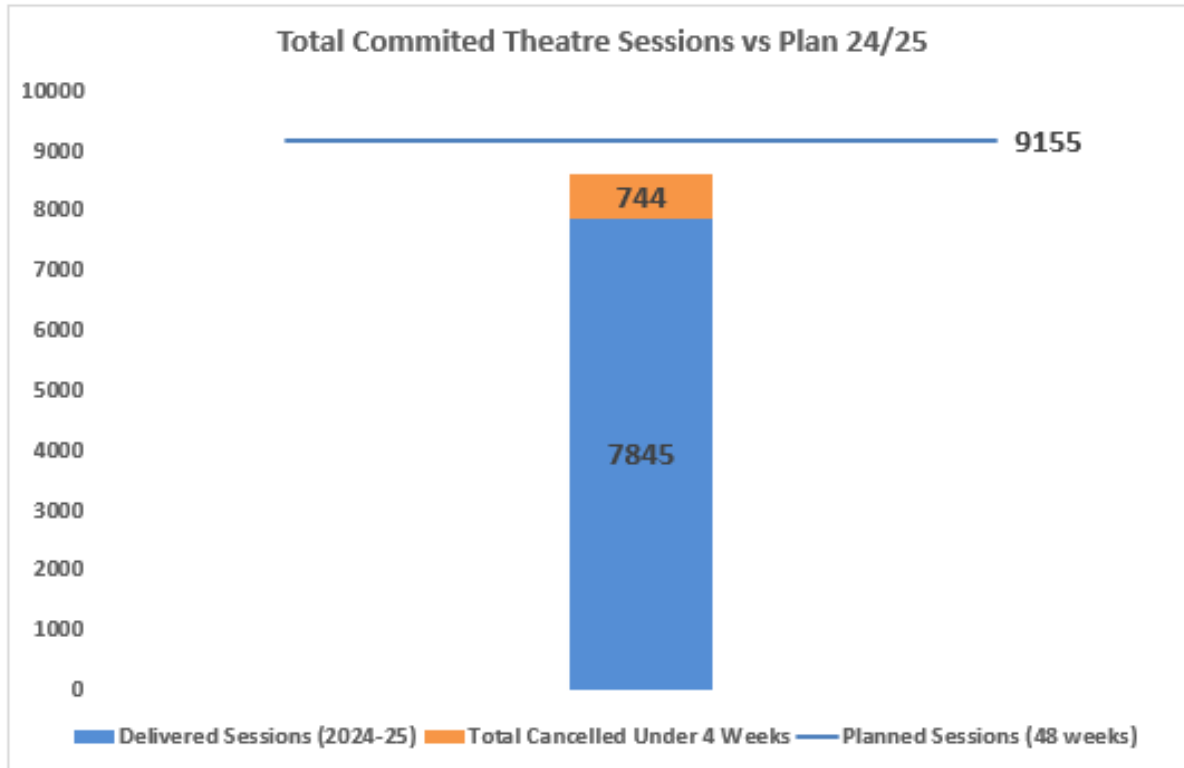


Un-utilised Sessions by Specialty (2024 -25)



- **7,845** out of 9155 planned theatres sessions were delivered in 2024/25 - **(86%)**
- **1,310** of planned theatres sessions were un-utilised **(14%)**, costing **c. £1.188m** for the year.
- NHH had 569 un-utilised sessions costing c. £569k
- YYF had 493 un-utilised sessions costing c. £392k
- RGH had 191 un-utilised sessions costing c. £126k
- The main specialties reporting un-utilised sessions across all sites include:
 - 30% Gen Surgery costing £378k
 - 29% Orthopaedics costing £378k
 - 14% Max Fax costing £31k
 - 13% Gynae costing £157k
 - 9% Urology costing £61k

Appendix 2: Total Summary: Sessions Committed vs Planned



- Total planned vs delivered showed an un-utilised session gap of **1,305**. This equates to **14%** of the total sessions planned.
- **Cancelled Under 4Wks**
744 sessions were cancelled under 4 weeks, which meant theatre teams were committed to deliver this activity. This equates to **8%** of total planned sessions.

690 of these sessions cancelled under 4 weeks were deemed avoidable under the agreed KPIs.
- The remaining **561** un-utilised sessions were not backfilled. This equates to **6%** of all planned sessions.

Appendix 3: Local Metrics

Model Hospital Metrics

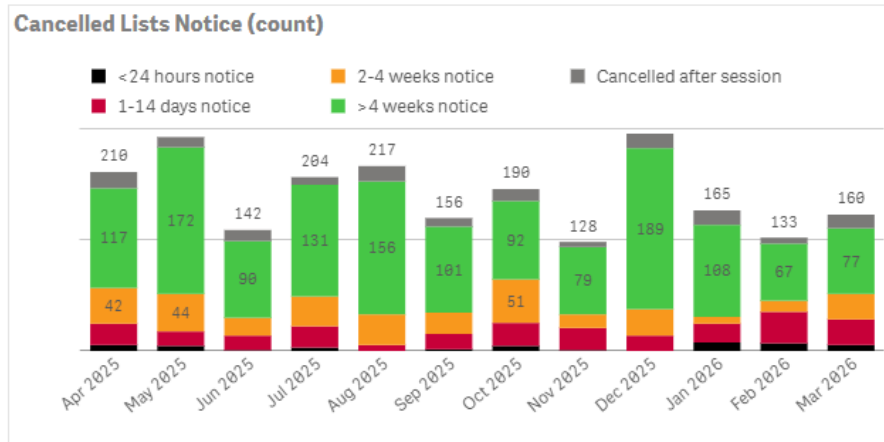
Model Hospital Metrics Summary

Values	Month Q											
	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
Uncapped Theatre Utilisation %	117.9%	117.2%	119.8%	113.1%	105.8%	110.9%	113.6%	119.6%	138.3%	121.7%	112.6%	118.5%
Uncapped Theatre Utilisation (touch time minutes)	20,615	27,168	19,077	17,063	17,431	16,568	15,704	19,732	26,809	23,877	15,741	23,720
Capped Theatre Utilisation %	109.8%	114.4%	116.7%	112.0%	102.5%	107.5%	114.4%	117.1%	116.5%	116.3%	109.0%	118.4%
Capped Theatre Utilisation (touch time minutes in planned session)	19,207	26,537	18,588	16,907	16,882	16,056	15,828	19,316	22,580	22,821	15,243	23,692
Average Lost Minutes of Late Starts	28	25	23	20	23	24	24	30	23	23	23	27
Average Lost Minutes of Early Finishes	100	72	93	66	91	57	77	73	53	117	60	69
Average Extra Minutes Early Starts	7	13	28	9	117	22	3	7	6	4	2	3
Average Extra Minutes Late Finishes	27	45	29	39	36	42	32	37	27	38	33	37
Unplanned Session Extensions (minutes)	414	556	399	143	705	487	259	458	380	816	470	334
Average Unplanned Session Extensions (minutes)	12	12	12	5	21	16	9	13	10	19	16	8
Emergency Surgery in Elective Lists	7	0	1	0	1	3	2	1	2	6	0	0
% Emergency Surgery in Elective Lists	4.1%	0.0%	0.7%	0.0%	0.7%	2.1%	1.5%	0.6%	0.9%	3.1%	0.0%	0.0%
Cases Cancelled on the Day %	4.0%	3.0%	1.6%	3.2%	0.5%	8.0%	1.2%	2.3%	0.4%	3.9%	5.6%	3.8%
Cases Cancelled on the Day	9	8	3	6	1	16	2	5	1	10	10	10
Session Turnaround Minutes (Total)	-3,277	-5,096	-3,856	-3,023	-1,910	-1,945	-2,860	-3,918	-3,754	-5,089	-1,409	-4,993
Average Session Turnaround Minutes	-15	-20	-21	-17	-10	-11	-17	-19	-15	-21	-8	-20

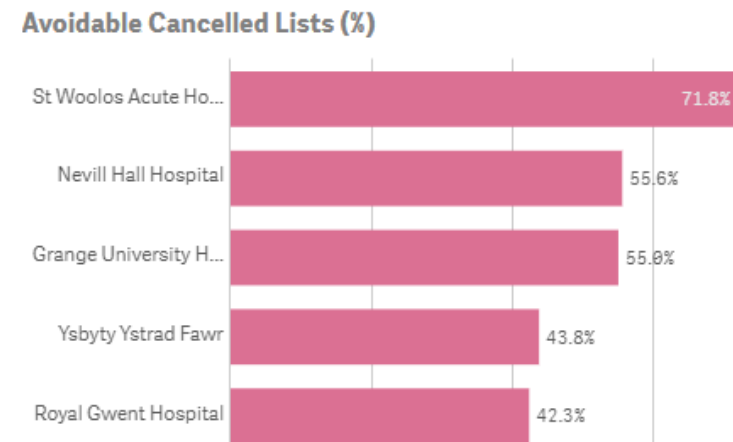
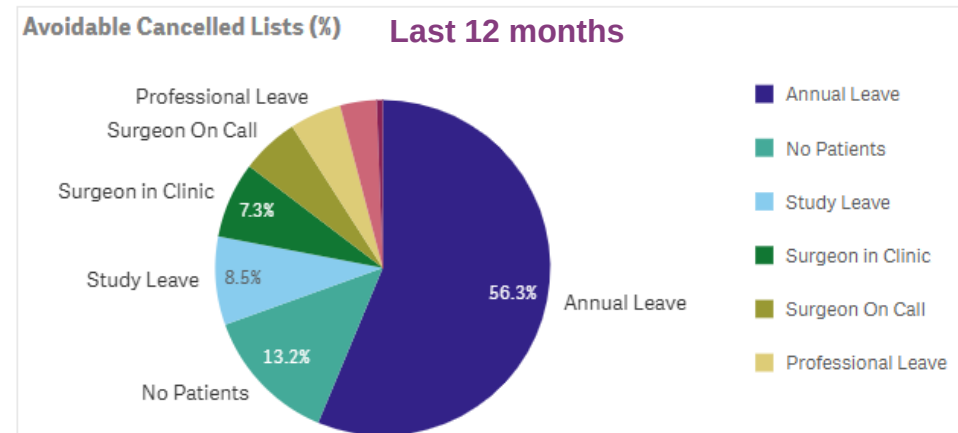
Appendix 3: Local Metrics

Locally Agreed KPIs

KPI1: Reduce list cancellations with less than 4 weeks' notice – 20%



KPI2: Cancellations with less than 4 weeks' notice outside of agreed tolerances (i.e. short notice sickness) – 0%



Appendix 3: Local Metrics

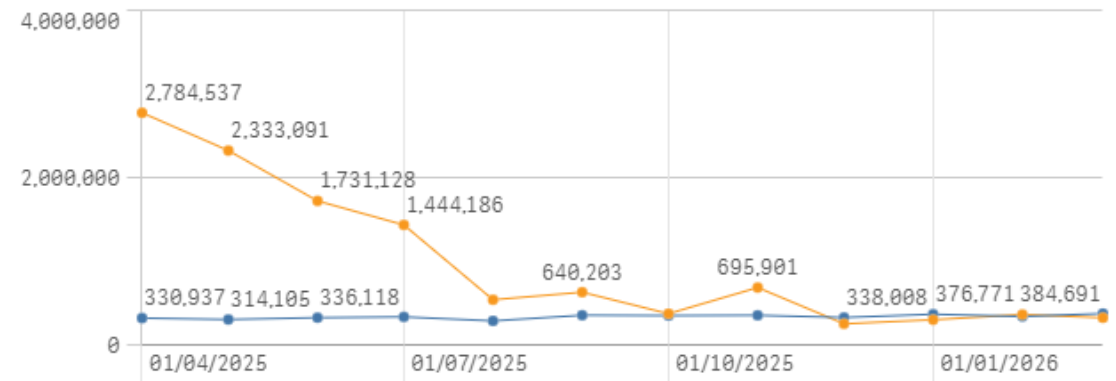
Locally Agreed KPIs

KPI3: Increase fill rates 2 weeks before planned list (85%)

- Fill rates for specialties are tracked through weekly scheduling meetings to ensure oversight
- There are nuances in the data across specialties as some leave spaces in to be filled by patients discussed at the previous week's MDT
- This measure cannot therefore be viewed in isolation as a snapshot. KPI4 provides a more accurate overview of where there might be issues with specialties not filling lists appropriately on a more consistent basis.

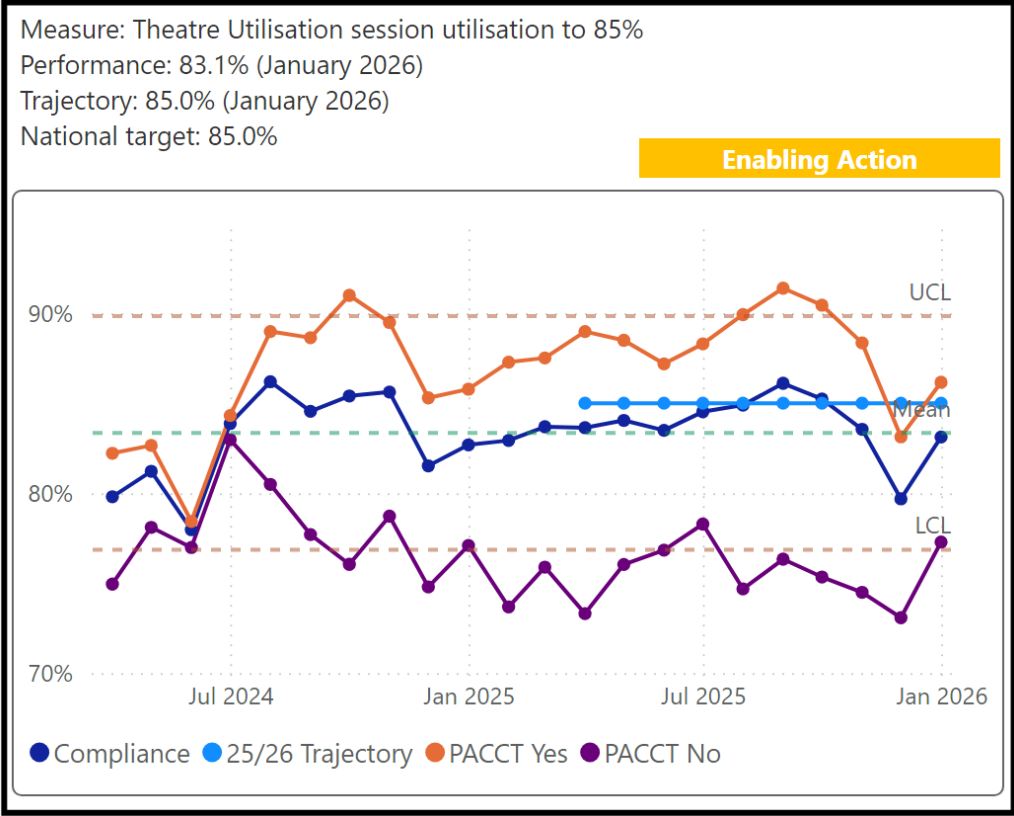
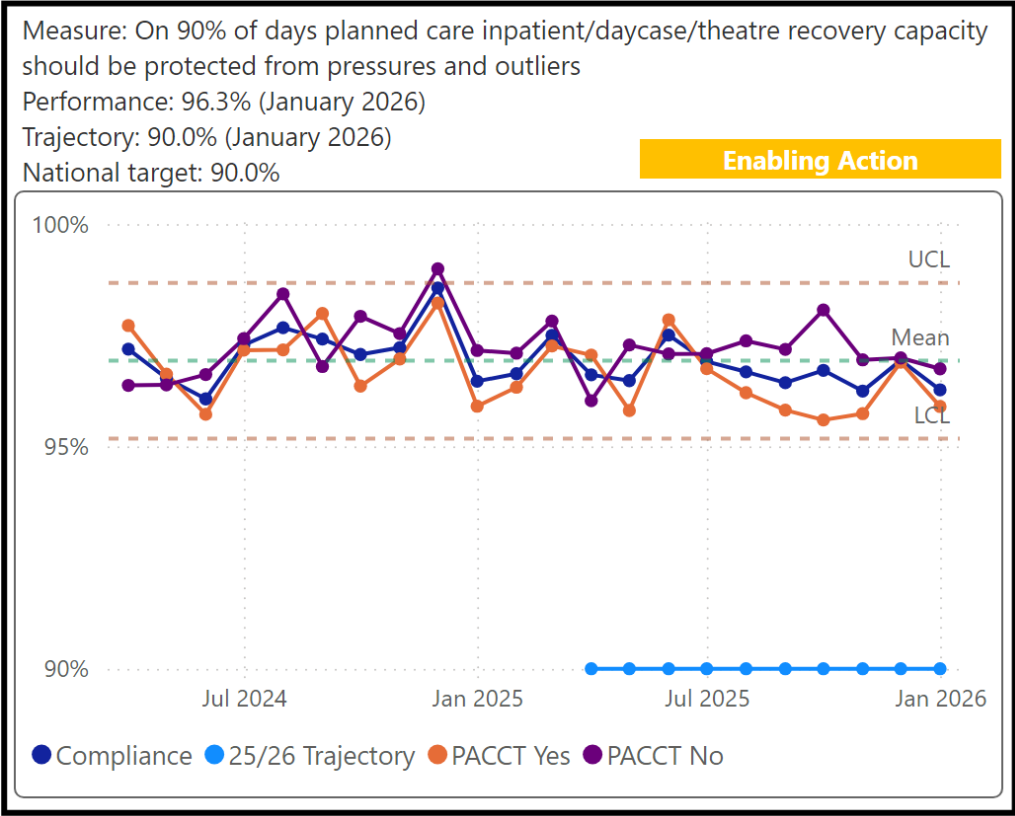
KPI4: Minutes booked vs delivered

Booked Minutes v Booked Minutes Used



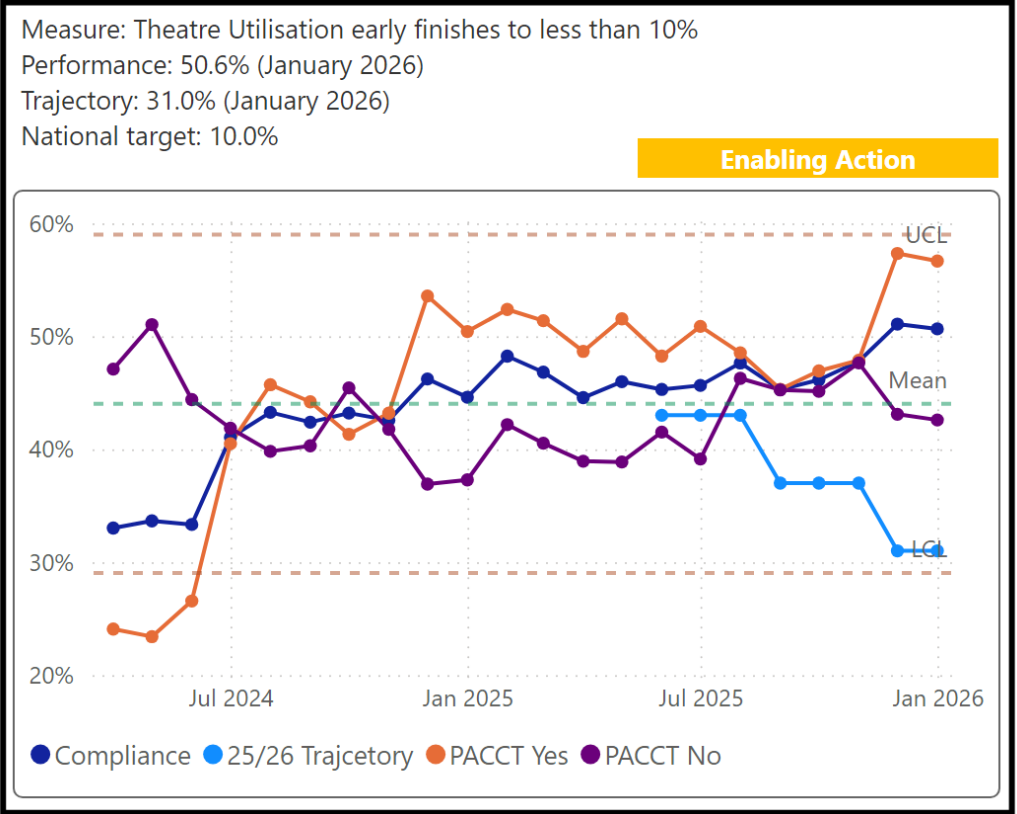
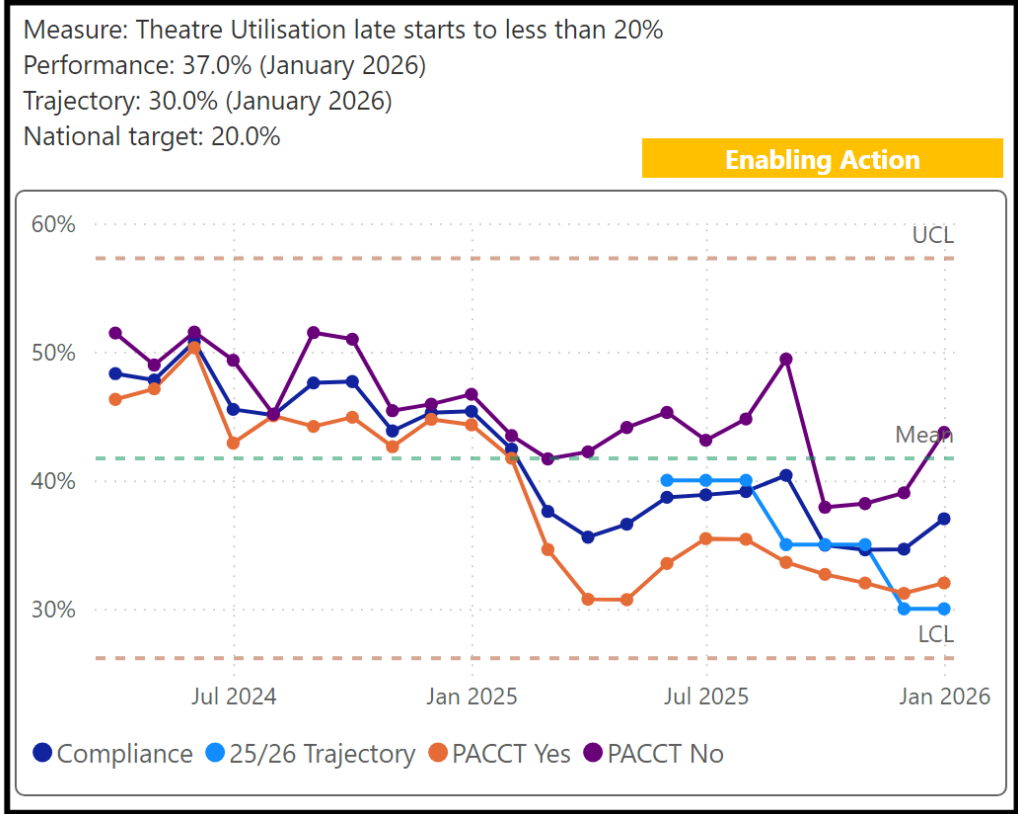
Appendix 3: National Metrics

Enabling Actions – 2025/26



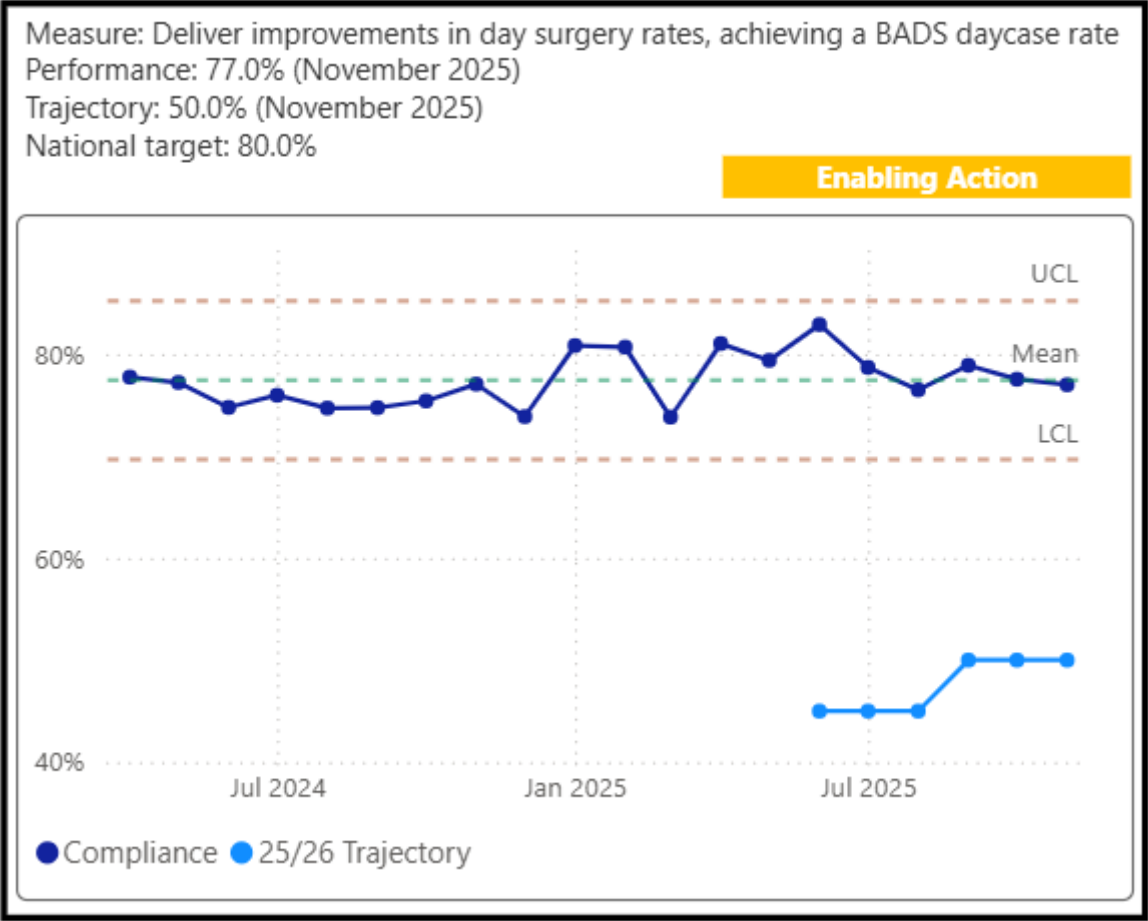
Appendix 3: National Metrics

Enabling Actions – 2025/26



Appendix 3: National Metrics

Enabling Actions – 2025/26



Appendix 3: National Metrics

Enabling Actions – 2026/27

- Improvement in the implementation and delivery of High Volume Low Complexity theatre lists, with an initial focus on:
 - Cataract 90% of lists to have 7 Cataracts per list by the end of Q2
 - Arthroplasty 90% of lists to have 4 Primary joints per day
 - 90% of time achieve at least 6 HVLC General Surgery procedures on an all-day list made up of hernias/gallbladders by end of Q2
- Theatre session utilisation is improved to achieve the GiRFT standard of 85% -
 - Late starts (>15 mins)
 - Early finishes (>60 minutes);
 - and overall utilisation are reported as key KPIs to underpin the 85% standard.

IMTP Commitments 26/27

Theatres Efficiencies

A key delivery area is our operating theatres, aiming to ensure patients receive treatment in a timely manner, avoid unnecessary cancellations and can continue their recovery at home without delay. Our performance for protecting elective theatre days has consistently exceeded the 90% national target, with session utilisation just under the 85% target. However, we are currently underperforming with regards to theatre late starts and early finishes, making these key areas of focus. Initiatives including direct listing for cataracts, increasing rates of high-volume low-complexity surgeries and the T&O Perfect Month aim to maximise our theatres performance.

The following areas of efficiencies have been committed to within the IMTP:

- Realisation of Enabling Actions
- Direct to listing
- HVLC lists
- Arthroplasty pathway improvement
- Golden patient
- Surgical care practitioners
- Coblation in tonsillectomy



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 September 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
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

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 Information Governance Group are escalated to provide assurance on key performance indicators to the Finance and Performance Committee.

Asesiad / Assessment

1. **Key Performance Indicators (KPI's)**

Information Governance

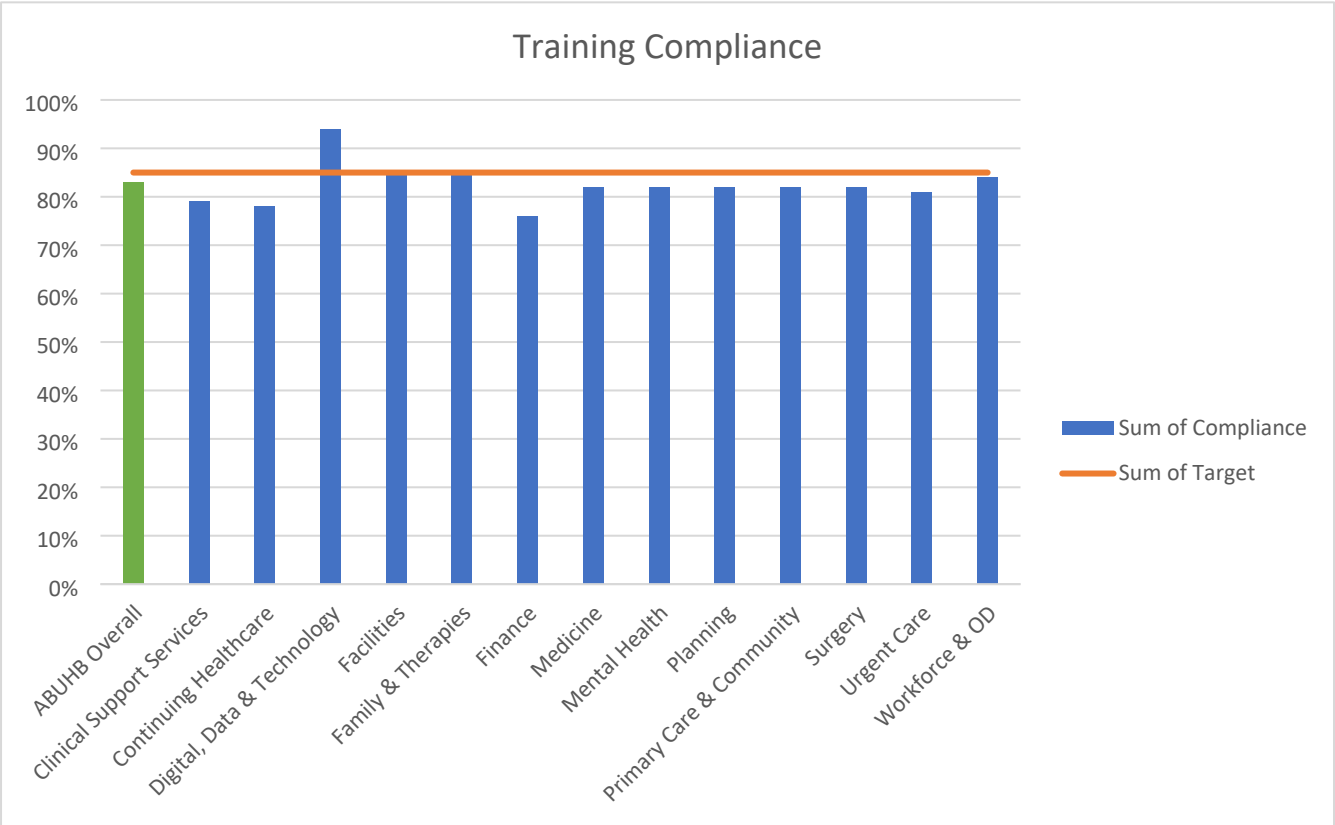
Information Governance Training Compliance

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 ease of training and improvements in 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 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.

Information Governance 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:

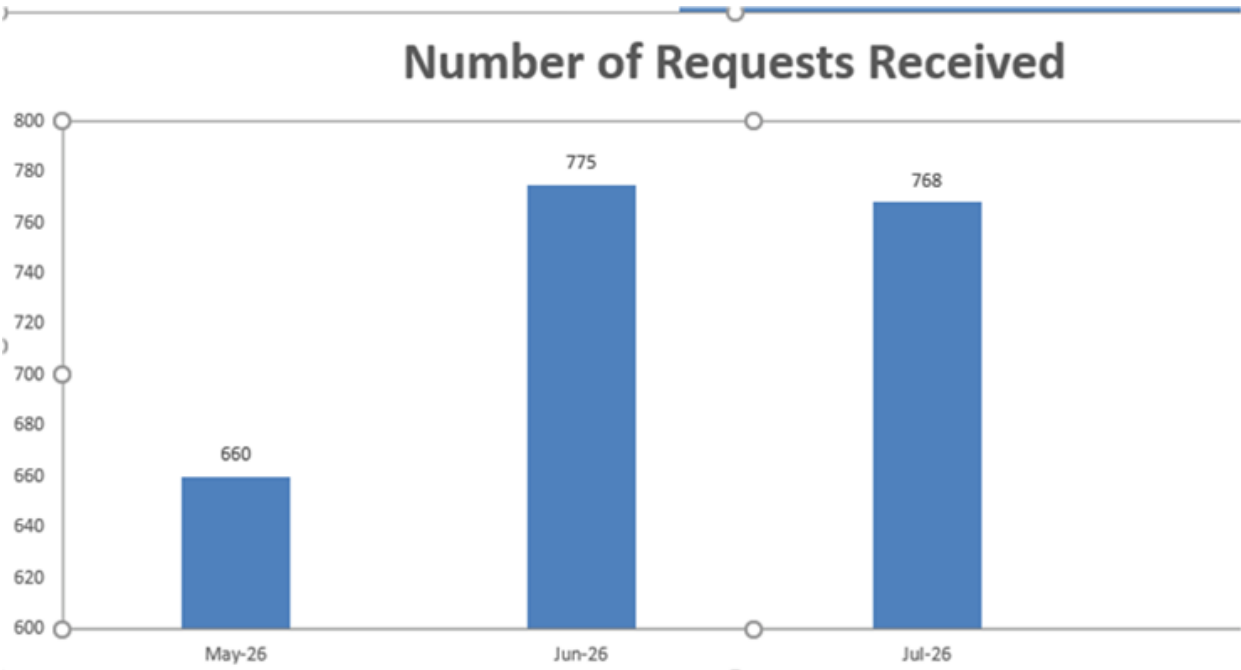
Period	Total number of DPIAs completed
1 st May 2026 – 31 st July 2026	51

Please see Appendix A for the full list of DPIA’s during the reporting period.

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 a general increase in the number of subject access requests received each month.

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.



2. Cyber Security

Desktop KPI's

Desktops computers are currently patched in two ways, the legacy Windows Server Update Service (WSUS) and Windows Update for Business (WUfB). WSUS can only update devices that are on the network, or connected to NHS Wales, whereas WUfB can update over the Internet over home or public Wi-Fi, meaning patch compliance has greatly improved.

Patching KPI target for desktops is 95%, current performance sits at around 90%. This will improve further when WSUS is retired.

The Windows 11 update project is nearing completion with approximately 211 Windows 10 computers managed by the Health Board awaiting upgrade to Windows 11, and approximately 26 that are managed by 3rd parties.

99.4% of computers are currently running a supported version of Microsoft Office, a little over 14,000 devices has Office 2021 which goes end of support on October 13th, 2026. The Health Board's digital dictation platform relies on this version and migration to the new digital dictation solution following Board approval in September 2027 will enable the retirement of Office 2021 in time.

Server KPI's

Server patching KPI target is 95%, with Health board managed and 3rd party servers consistently exceeding that metric.

1.57% of servers are on an unsupported operating system, and 2.4% of our database instances are unsupported. An ongoing refresh project is working though those with a view to migrate to supported operating systems, or purchase extended support when upgrading is not viable.

Mobile KPI's

91.3% of the android estate is on a supported version, with 93.6% of Apple devices supported.

Incidents

June saw a high number of false positive incidents triggered by some Philips radiology software and has since been reconfigured

Account compromise via phishing is one of the most seen attacks across the whole of NHS Wales. Cyber have a well-rehearsed response plan for this, and base phishing simulations on real world attacks which aim to capture user login details, with e-learning for those that need assistance in spotting suspicious messages.

High incidents in the dashboard were all account compromise attacks, and were all quickly remediated by the team.

One incident of note was a colleague downloading a compromised malicious file. Security tooling alerted the Cyber team, who immediately isolated the computer,

spoke to the person and arranged a wipe and reset of the computer, password changes, and additional monitoring of that persons account for suspicious behaviour. 48 hours later the National Cyber Security Centre (NCSC) contacted Digital Health & Care Wales (DHCW) about some suspicious Internet traffic they had detected in relation to this and were impressed with the speed of response of the Health Board team.

Vulnerabilities

Cyber began to work with digital operations and DHCW in May to address dormant accounts. For reference in January 2026 the health board had 8576 dormant accounts, progress has been steady with 4,864 under investigation. A dormant account is one that has never been logged into or has not been logged into for 90 days. Care must be taken so that the accounts of people on long term sick or parental leave are not removed. A dormant account is disabled until a request for access is received. After 13 months dormant accounts are deleted.

	May	June	July
Dormant accounts	No data	5165	4864

Microsoft security tools give organisations a “secure score”, the health board score has been steadily improving and sits at 70.41%. Organisations of a similar size average 51%.

A security tool performs monthly scans on the server estate to identify vulnerabilities and missing patches; results are then remediated by the systems team. Cyber have progressed plans to use Centre for Internet Security (CIS) hardening benchmarks for server operating systems.

Cyber dashboard can be seen here: [Power Bi Dash](#)

Cyber Assessment Framework

The DHCW Cyber Resilience Unit (CRU) reviewed the health boards compliance with the Cyber Assessment Framework (CAF) v4.0, published by the NCSC. CRU reviewed 13 outcomes across 2 objectives, (A1,A3,B2,B5,B6). The table below shows overall rating across all CAF objectives, as well as the overall objective rating based upon the outcome-level ratings. It includes the number of outcomes rated as “not achieved”, “partially achieved” and “achieved” within each objective.

Of the 13 outcomes assessed, 7 were assessed as “achieved”, 1 as “partially achieved” and 5 as “not achieved”. If one of more outcome is assessed as “not achieved” then the overrall rating for the health board is “not achieved”. CRU acknowledge the efforts and improvements made by the health board since the last assessment.

		Outcome-level ratings
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CAF Objective	Number assessed by CRU	Not Achieved	Partially Achieved	Achieved	IGP Compliance Gaps
A. Managing Security Risk	(4) outcome assessed out of 9	1	0	3	1
B. Protecting against cyber attack	(9) assessed out of 20	4	1	4	8
Total	(13) outcomes assessed out of 43	5	1	7	9

Cyber have created a Network and Information Systems Assurance Group that meet bi-monthly for any updates. An audit was conducted in June 2026, with improvements noted in the Cyber Education and Awareness efforts. More work is planned to address findings on asset & supplier management and the Joiner/Mover/Leaver process. Full current findings and action plans are in the above spreadsheet. CRU are creating a dashboard for all health boards to track progress and submit evidence.

Supporting information is provided in Appendix B and C respectively.

A full NIS CAF audit is planned for 2027.

4. 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.

1. Digitised Health Records (DHR) Operational Performance

- Inpatient supplementary record scanning
 - Target: within 48 hours of receipt
 - Total records returned (May – July): 43,238
 - Performance (as of 11th Sept): **On Track**
 - 33.61% of records returns scanned within 24 hours of receipt
- Outpatient supplementary record scanning
 - Target: within 24 hours of receipt
 - Total records returned (May – July): 58,104
 - Performance (as of the 11th Sept): **On Track**
- Digitised Record Utilisation
 - % Of outpatient clinics using DHR: 93.65%
 - % Emergency Admissions using DHR: 99.50%

- % Elective Admissions using DHR: 97.50%
- Additional Specialty Scanning (May – July 2026):
 - 2,909 Podiatry records
 - 1,493 HSDU documents
 - 6,026 Adult Weight Management & Dietetic records
 - 3 CHANT records
 - 2,419 District Nursing records
 - 1,933 Mental Health archive records
 - 4,154 Speech & Language records

2. **Referral & Inpatient Movement Processing**

- Total referrals processed (May 2026 – July 2026): 66,320
 - Automation (RPA vs Manual): 69.37%: 30.63%
- Admissions, Transfers, Discharge & Demographic notifications processed (May 2026 – July 2026): 141,340
 - Automation (RPA vs Manual): 91.99%: 8.01%

3. **Compliance & Audit Assurance**

- Filing bay checks: 99.22% compliant
- DHR preparation standards: 98.28% compliant
- DHR scanning standards: 97.54% compliant
- Confidential Waste Checks: 98.90% compliant
- Welsh Language Standards: 97.06% compliant

5. **Clinical Coding**

The Welsh Government has set ministerial target of 95% clinical coding completion for 2026/27. Following review of current activity levels and operational capacity, Aneurin Bevan University Health Board has submitted a performance trajectory of 91%, representing the highest level considered achievable within existing resources.

Alongside the ministerial target of 95%, maintaining high-quality coded data remains key priority. Aneurin Bevan University Health Board will continue its robust audit program, including individual coder and specialty-based audits, to ensure compliance with the accuracy standards outlined in the Terminology Delivery Service Clinical Coding Audit Methodology Version 19.0.

- 90% for the Primary Diagnosis and Primary Procedure
- 80% for the Secondary Diagnosis and the Secondary Procedures

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 on a monthly basis has increased to over 18,500 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 FCE’s is attributed to the Regional Cataracts, which have increased by over 6000 annually. Any further increase in demand is likely to affect the achievement of current and future coding completeness targets.

Increase in FCE’s since January 2025

Month	Episodes	Coded	% Compliance
Apr-24	17986	13864	77.1%
May-24	18826	14601	77.6%
Jun-24	17827	15147	85.0%
Jul-24	18949	13891	73.3%
Aug-24	17777	13622	76.6%
Sep-24	18336	15057	82.1%
Oct-24	19445	15536	79.9%
Nov-24	18581	15078	81.1%
Dec-24	17954	15260	85.0%
Jan-25	19778	17287	87.4%
Feb-25	18792	15384	81.9%
Mar-25	20938	17226	82.3%
Apr-25	19219	15168	78.9%
May-25	19554	15376	78.6%
Jun-25	20323	18051	88.8%
Jul-25	20561	17108	83.2%
Aug-25	18703	16792	89.8%
Sep-25	20241	17515	86.5%
Oct-25	20899	18218	87.2%
Nov-25	19519	17543	89.9%
Dec-25	20421	18454	90.4%
Jan-26	21955	19183	87.4%
Feb-26	20469	18730	91.5%
Mar-26	22688	19354	85.3%
Apr-26	20660	16942	82.0%
May-26	19846	17874	90.1%
Jun-26	21447	17785	82.9%

Work is ongoing to increase the amount of work done by Robotic Process Automation (RPA) which is used to automatically code the more straightforward

of cases. Along with exploring how Artificial Intelligence can be used to support with coding completeness levels.

The Health Board is has recently agreed to be one of the pilot sites for the DHCW Clinical Coding Workbench initiative, initially piloting Trauma and Orthopaedics.

4. Incidents

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 May 2026 – July 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	108	0	10
Integrity	51	0	4
Availability	21	0	0
TOTAL	180	0	14

Cyber Security Incidents

End User Devices Anti-Virus incidents for the period:

Amount	Title	Severity	Category	Actions
3	Phishing	High	Credential compromise	Malicious links blocked, emails removed
1	Phishing	Medium	Credential compromise	False positive
1	Phishing	High	Credential compromise	Password reset, sessions revoked and MFA verified as correct

Service Desk reported incidents for the period:

Title	Count	Actions
Lost or stolen equipment	3	Devices remote wiped
Suspicious emails	1	Several gift card scams, some false positives

Vishing	2	Suspicious phone calls
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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.

Phishing is when a malicious message is sent to attempt to steal information, credentials, or have someone take an action.

5. 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	Electronic Prescribing & Medicines Administration – currently no functionality to allow Access to Health Records to export information for subject access requests.	Currently in discussions with provider, other Health Boards and digital colleagues to provide solution/workaround	9
Corporate	Digital Dictation 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 Clinical Workstation record and personal identifiable information 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	Risk of breach of confidentiality and inappropriate access to data/data sharing.	10

	of confidentiality. Also Safeguarding risk identified.		
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Cyber Security Risks

The Digital, Data & Technology risk register has 4 open cyber risks with a score of 10+

ID	Title	Likelihood	Impact	Score	Progress
2566	Senior Cyber Security Analyst Vacancy	5	4	20	For approval to recruit
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 Internet of Things	3	4	12	New firewall will identify devices and allow better network segmentation once fully operational

This is in addition to the corporate and strategic cyber risks which are being presented to Board in its September meeting.

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 Management 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. Meeting rescheduled to pick up concerns, issues and plan to progress.	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), scheduled 27/10/2026, 28/10/2026 & 05/11/2026. A Health Records Support Network has been established to share best practice and support for ward clerks and ward staff. Employee Handbook has been updated to include records management guidance and resources to support new starters. Health Records Awareness sessions continue to be scheduled bi-monthly, advertised via Pulse, scheduled 26/10/2026. 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). Additional areas at St Cadocs that held personal identifiable information now emptied and relocated to Online House. All other documents remain in place but services notified to take corrective action.	12
Storage Capacity & Digitisation Demand:	Ongoing digitisation programmes and clearance of high	12

Increasing demand for digitisation due to limited or inappropriate storage areas, compounded by extended retention due to public inquiries.	risk storage areas, progress constrained by staffing and funding. Due to current day to day demands and priority tasks, additional scanning has slowed over the last month, however we aim to progress further from the 14/09/2026.	
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Argymhelliad / Recommendation

The Finance & Performance committee are 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:	

Rhestr Termau: Glossary of Terms:	CAF – Cyber Assessment Framework CIS – Centre for Internet Security CRU – Cyber Resilience Unit DHCW – Digital Health & Care Wales DHR – Digital Health Record DPA – Data Protection Act DPIA – Data Protection Impact Assessment EDRMS – Electronic Document Records Management System 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 USC – Urgent Suspected Cancer WSUS – Windows Software Update Services WU4B – Windows Update for Business
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	Not Applicable Choose an item.

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

Ticket ID	Division	Department	Summary	Ticket Type	Date/Time Logged	Team
345764	Facilities	Facilities	DPIA - ID Badge/Access Audit Request Form	Information Governance - Data Protection Impact Assessment	05/08/2026 12:15	Information Governance
345950	Primary Care & Community	Managed Practices	DPIA - AccuRx into EMIS - Managed GP Practices	Information Governance - Data Protection Impact Assessment	05/08/2026 15:43	Information Governance
349557	Workforce & OD	Workforce Planning Systems & Projects	DPIA Query Civica Occupational Health - NWSSP DPIA	Information Governance - Data Protection Impact Assessment	14/08/2026 12:38	Information Governance
336032	Complex Care		Lizzie Wilkinson - Complex Care Local Risk	Information Governance - Data Protection Impact Assessment	08/07/2026 16:36	Information Governance
349588	Primary Care & Community		Screening Questions IMPOWER - Louise Williams	Information Governance - Data Protection Impact Assessment	14/08/2026 13:41	Information Governance
347058	Planning		Screening Questions H2H - Jamie-Lee Cook	Information Governance - Screening Questions	07/08/2026 13:40	Information Governance
358128	MH & LD	Other Specialist MH Service	Filming Consent Form and Use for Melo Content - Louis Davies	Information Governance - Data Protection Impact Assessment	10/09/2026 09:17	Information Governance
339062	Corporate		Simon Green Annual Driving Licence Audit	Information Governance - Screening Questions	16/07/2026 13:39	Information Governance
351783			Screening Questions = Padlet Access	Information Governance - Screening Questions	20/08/2026 14:30	Information Governance
351783			Screening Questions = Padlet Access	Information Governance - Screening Questions	20/08/2026 14:30	Information Governance
355797	Medicine	Respiratory	SQs_Respiratory ILD Database Project	Information Governance - Screening Questions	03/09/2026 14:08	Information Governance
351509	Corporate		HOSPITAL TO HOME REFERRAL FORM - JAMIE-LEE COOK	Information Governance - Screening Questions	20/08/2026 09:17	Information Governance
351831	Primary Care & Community	Primary Care Projects	Screening Questions - Filming Consent Form and Use for Melo Content - Louis Davies	Information Governance - Screening Questions	20/08/2026 15:32	Information Governance
355584	Primary Care & Community	Dental	DPIA - MDU Form for Special Schools - Helen Boulter	Information Governance - Data Protection Impact Assessment	03/09/2026 10:57	Information Governance

345753	Surgery	Ophthalmology	Information Governance – Screening Questions	Information Governance – Screening Questions	05/08/2026 12:02	Information Governance
342225	Urgent Care	GUH Emergency Care (S)	Information Governance – Other	Information Governance – Screening Questions	27/07/2026 09:57	Information Governance
338175	Primary Care & Community		Information Governance – Screening Questions	Information Governance – Screening Questions	14/07/2026 15:36	Information Governance
345934	MH & LD		Screening Questions – Ty Cynnal	Information Governance – Screening Questions	05/08/2026 15:29	Information Governance
344149	MH & LD		Information Governance – Screening Questions	Information Governance – Screening Questions	31/07/2026 10:47	Information Governance
343741	Family Therapies	Sexual & Reproductive Health	WASPI DDA sexual and reproductive health for HB approval	Information Governance – Data Protection Impact Assessment	30/07/2026 11:20	Information Governance
342777	Family Therapies	Weight Management Service	Information Governance – Other	Information Governance – Screening Questions	28/07/2026 11:30	Information Governance
339448	Clinical Support Services		Screening Questions JAKi and IFN audit – Ali Mahdi	Information Governance – Screening Questions	17/07/2026 13:58	Information Governance
337765	Corporate	Research & Development	DPIA e – Data Protection Impact Assessment	Information Governance – Data Protection Impact Assessment	14/07/2026 08:29	Information Governance
346205	Digital Data & Technology		Vocera – Kelly Teasdale – Screening Questions	Information Governance – Screening Questions	06/08/2026 09:48	Information Governance
346181	Digital Data & Technology		Screening Questions – Securitas Bleep System – Kelly Teasdale	Information Governance – Screening Questions	06/08/2026 09:35	Information Governance
343369	Digital Data & Technology		LanguageLine – Kelly Teasdale	Information Governance – Screening Questions	29/07/2026 13:51	Information Governance
346162	Digital Data & Technology	Digital Programmes	Page One – Kelly Teasdale – Screening Questions	Information Governance – Screening Questions	06/08/2026 09:21	Information Governance
358458	Clinical Support Services	Clinical Support Services Management	DPIA – POCT Point of Care Testing – Amal Shandall – NDSR 0270713	Information Governance – Data Protection Impact Assessment	10/09/2026 15:18	Information Governance
351267	MH & LD	Adult Mental Health Services	Screening Questions – Emma Jones – Ty Cynnal Support House	Information Governance – Screening Questions	19/08/2026 13:52	Information Governance

337579	Family Therapies	CAMHS (Child Psychology)	CHRONOS tool – Tracey Smith	Information Governance – Screening Questions	13/07/2026 14:14	Information Governance
335028	Family Therapies	Speech & Language Therapy	online parent/carers workshop – Anna Hill	Information Governance – Screening Questions	06/07/2026 15:45	Information Governance
337268	Planning	Planning Team	Screening Questions Hermione Thomas Data Sharing with British Red Cross	Information Governance – Screening Questions	13/07/2026 09:59	Information Governance
345138	Corporate	Research & Development	Screening Questions Kirstin Davies – EDCRN	Information Governance – Screening Questions	04/08/2026 10:31	Information Governance
346594	Clinical Support Services	Radiology	Information Governance – Screening Questions	Information Governance – Screening Questions	06/08/2026 18:03	Information Governance
347913	Digital Data & Technology		Vocera Clinical Communication Platform – Kyle Mackay	Information Governance – Data Protection Impact Assessment	11/08/2026 09:13	Information Governance
353932	Digital Data & Technology	Information Governance	All Wales DPIA Group – Assemble	Information Governance – Data Protection Impact Assessment	27/08/2026 14:35	Information Governance
335010	Digital Data & Technology	Health Records & Booking	Neonatal Ward Discharge Request Form – Ieuan Billingham	Information Governance – Screening Questions	06/07/2026 15:19	Information Governance
353249	Not IG		Screening Questions – PSOA Padlet	Information Governance – Screening Questions	26/08/2026 08:42	Information Governance
350140	Digital Data & Technology	Service Delivery	Data Protection Impact Assessment – EE to Vodafone – Dan Lee and Maria Fryc	Information Governance – Data Protection Impact Assessment	17/08/2026 14:40	Information Governance
350828	Clinical Support Services		DPIA – HER2 – Neill Maynard	Information Governance – Data Protection Impact Assessment	18/08/2026 15:20	Information Governance
356303	Primary Care & Community	Dental	Screening Questions – Helen Boulter – Dental	Information Governance – Screening Questions	04/09/2026 14:36	Information Governance

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 outdated 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 16 th 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



Cyber Security Assurance Report

**Aneurin Bevan University
Health Board**

June 2026



Introduction

Background

Objectives

The independent assessment aimed to produce the following outputs:

1. An assessment of the compliance of Aneurin Bevan University Health Board to the CAF for Health Wales;
2. An assessment as to the veracity of Aneurin Bevan University Health Board's self-assessment and the Cyber Resilience Unit's level of confidence that the submission aligns to their assessment of the risk and controls.

The objective of this independent assessment is to identify cyber security and resilience risks and opportunities for improvement and help address those in the form of recommendations. This assessment also aims to satisfy the requirement for the NHS Wales Cyber Resilience Unit to undertake assessments of OESs' compliance to the Cyber Assessment Framework and, as a result, the NIS Regulations 2018.

Assessment Approach

Assessors conducted an assessment in person on 15th – 17th June 2026.

Our assessment comprised of the following high-level steps:

- Prior to our assessment, we undertook a review of the Aneurin Bevan University Health Board CAF findings from previous assessments and incidents.
- We requested and reviewed the documentation provided in relation to evidence texts that are in scope of this assessment prior to the interview sessions.
- We interviewed the relevant stakeholders who are responsible for each of the outcome evidence texts/self-assessment responses or people, processes and technology. Finally, we reviewed the operation of key technical controls using the Cyber Assessment Framework (CAF) as well as exercising professional judgement and knowledge of the organisation being assessed.

Introduction

Limitations of Scope

The scope of this review will be limited to the outcomes defined during the scoping exercise. The assessment will consider whether the organisation meets the requirement of each CAF outcome text and considers the broader maturity of the organisation's cyber security and resilience control environment. Results are based on interviews with key stakeholders as well as a review of key documents where necessary to attest controls/processes. As we have assessed the operational effectiveness of a sub-set of outcomes, our assessment should not be expected to include all possible control weaknesses that an end-to-end comprehensive compliance assessment might identify. We are reliant on the accuracy of what we have been told in interviews and what we have reviewed in documents. Efforts have been made to validate accuracy only on a subset of evidence texts and therefore there has a dependency on the organisation to provide accurate information.

Introduction

Version Control

Version	Updated by	Date updated	Change detail
V0.1	Rob Garlick	18/06/2026	Initial draft
V0.2	Ana Pereira	03/07/2026	Initial draft reviewed
V0.3	Rob Garlick	11/08/2026	Updated document to new CAF report format
V1.0	Ana Pereira	12/08/2026	Final review and approval

Executive Summary

Cyber Assessment Framework (CAF) Assurance Report Outputs

Our review followed the Cyber Assessment Framework v4.0, published by the UK National Cyber Security Centre (NCSC) on 6 August 2025. We have reviewed 13 Outcomes across 2 Objectives (A1, A3, B2, B5, B6) within the Cyber Assessment Framework. Where applicable, we have produced observations and recommendations for the in-scope outcomes. These are detailed in the ‘Key Findings’ slides. The Executive Summary outlines the high-level outputs of the assessment, in line with the guidance and framework methodology.

Understanding your report ratings - Overall Risk Rating

The table below shows the ‘Overall Rating Across all CAF Objectives’ as well as the ‘Overall Objective Rating’ based upon the ‘Outcome-level Ratings’. It includes the number of outcomes rated as “Not Achieved”, “Partially Achieved” and “Achieved” within each objective.

Of 13 outcomes assessed, 7 were assessed as ‘Achieved’, 1 as ‘Partially Achieved’, and 5 as ‘Not Achieved’. The overall rating for Aneurin Bevan University Health Board is ‘**Not Achieved**’. The overall rating is ‘Not Achieved’ if one or more of the CAF Outcomes are rated as ‘Not Achieved’. This reflects the dynamic nature of cyber risk and the need for continuous improvement. The Cyber Resilience Unit (CRU) acknowledges the efforts and improvements made by the Operator of Essential Services (OES).

CAF Objective	Number of CAF Outcomes Assessed by NHS Wales Cyber Resilience Unit	Outcome-Level Ratings			
		Number of Outcomes rated Not Achieved	Number of Outcomes rated Partially Achieved	Number of Outcomes rated Achieved	IGP Compliance Gaps
A. Managing Security Risk	(4) Outcome assessed out of 9 within the Objective	1	0	3	1
B. Protecting Against Cyber Attack	(9) Outcomes assessed out of 20 within the Objective	4	1	4	8
TOTAL	(13) Outcomes assessed out of 43 within the CAF	5	1	7	9

Executive Summary

Basic and Enhanced Thresholds

The Cyber Assessment Framework (CAF) defines two assessment profiles: Basic and Enhanced. These profiles provide a structured means of assessing an organisation's cyber resilience maturity and the effectiveness of its security controls.

The Basic Profile represents the minimum resilience standard expected of organisations and focuses on the implementation of fundamental security measures designed to protect against common cyber threats and attack techniques. Achievement of the Basic Profile demonstrates that an organisation has established the core capabilities necessary to identify, protect against, detect, respond to, and recover from routine cyber incidents.

The Enhanced Profile reflects a higher level of cyber resilience maturity and is intended for organisations that have already achieved the requirements of the Basic Profile. Enhanced outcomes require more sophisticated controls, greater assurance activities, and evidence of resilience against more advanced and persistent threat actors. As such, the Enhanced Profile is typically associated with organisations operating in environments where the potential impact of a cyber incident is greater.

The thresholds associated with each profile are derived from assessment scenarios and recognised best practices developed by the National Cyber Security Centre (NCSC) and the wider Critical National Infrastructure (CNI) community.

Throughout this report, assessment outcomes are presented against both the CRU Basic Threshold and CRU Enhanced Threshold. These thresholds represent the expected level of achievement for organisations operating at the respective CAF profile levels and provide a benchmark against which organisational performance can be measured.

A detailed breakdown of the Basic, Enhanced, and Aneurin Bevan University Health Board assessment ratings is provided in Appendix C. This provides a comparison of current performance against both CAF profile expectations and identify areas requiring further improvement to meet target resilience levels.

Key Findings

SIRO training may be out of date 1	Finding Discussions around training with ABU raised a lack of clarity around the refresh requirements for Paul Solloway and Lloyd Bishop’s SIRO training. At present there is no indication of when refresher training was due to be undertaken.	
CAF Outcome(s) A1.b Roles and Responsibilities	Implication A lack of clarity around training refresh intervals can lead to staff awareness/knowledge no longer meeting the organisation’s requirements. Training refresher sessions provide an opportunity to remind staff of their requirements, but also ensure that knowledge is up to date with any changes to industry best practice	Evidence gathered from assessment: Auditees confirmed at audit that Paul Solloway and Lloyd Bishop completed SIRO training in July 2024.
Finding Rating OBSERVATION	Recommendation Review, determine and record the organisation’s requirements around refresher intervals for key staff training and ensure that staff continue to meet these requirements.	Relevant CAF Outcome / IGP: This finding relates to the following A1.c “Achieved” IGP: <i>“Appropriately capable and knowledgeable staff fill those roles and are given the time, authority and resources to carry out their duties.”</i>

Key Findings

Out of date risk management framework document 2	Finding The risk management framework document provided as evidence has passed its review date. Investigation of ABUs documentation during audit found this to be the latest version. The framework document includes information required to support risk decision making (such as risk appetite statements).	
CAF Outcome(s) A1.c Decision Making	Implication Risk decisions based on criteria that are outside of an agreed review window may no longer reflect the organisation’s current risk appetite position.	
Finding Rating OBSERVATION	Recommendation Ensure that documentation around risk decision making is updated within the agreed review cycle, and evidence that review has taken place (even if the agreed position is that there is no change).	Evidence gathered from assessment: The Risk Framework document supplied in advance of the audit stated a review date of May 2026. When followed up at audit, there was no reviewed document available. Relevant CAF Outcome / IGP: This finding relates to the following A1.c “Achieved” IGP: “Risk management decisions are regularly reviewed to ensure their continued relevance and validity.”

Key Findings

Incomplete records of critical service responsible owners 3		CAF criteria / reasoning for rating	
CAF Outcome(s) A3.a Asset Management		Evidence gathered from assessment: Review of the critical services mapping on Halo identified gaps in ownership records and unsuitable generic contacts	
Finding Rating NOT ACHIEVED		CAF Impact: This finding indicates that the following IGP's under A3.a "Not Achieved" has been met: <i>"Inventories of assets relevant to the essential function(s) are incomplete, non-existent, or inadequately detailed."</i>	
		Finding During a demonstration of Halo records, a number of gaps were spotted in the key contacts field against critical services/assets, primarily around third party systems. Further conversations with ABU confirmed there are also some contacts listings referencing product managers or shared inboxes rather than targeted contacts to support the services	
		Implication Incomplete or inaccurate contact information against essential services could contribute to a lack of clarity around security responsibilities and reduce the organisation's efficiency in managing system issues or responding to incidents.	
		Recommendation Continue the work to populate Halo critical service records and subsequently review records to ensure that accurate and complete information has been captured.	

Key Findings

Lack of Network Access Controls (NAC) 4	Finding	CAF criteria / reasoning for rating
	Network Access Control (NAC) has not been fully configured or implemented. This means that the organisation does not have a robust mechanism in place to control, authenticate, and validate devices connecting to its network environment.	Evidence gathered from assessment: The networks team confirmed that most sites within the Health Board do not currently have Network Access Controls in place. CAF Impact: This finding indicates that the following IGPs under B2.a "Not Achieved" have been met: <i>"Unauthorised individuals or devices can access your network or information systems on which your essential function(s) depends."</i> In addition, the following IGPs under B2.b "Not Achieved" have been met: <i>"Physically connecting a device to your network and information systems gives that device access without device or user authentication."</i>
	Implication	
	The absence of a configured NAC solution significantly increases the risk of unauthorised or non-compliant devices gaining access to the network , which could introduce vulnerabilities, malware, or malicious activity into the environment. Without device authentication and posture assessment, compromised or unmanaged devices may connect without detection	
CAF Outcome(s) B2.a Identity Verification, Authentication and Authorisation B2.b Device Management	Recommendation	
	Continue ongoing work to mitigate the open risk and configure network security controls to mitigate. This should include defining and applying policies that ensure only authorised and compliant devices can connect, with appropriate segmentation for different device types (e.g. corporate, clinical, guest, and unmanaged devices).	
Finding Rating NOT ACHIEVED		

Key Findings

Current user account allocation is not regularly reviewed 5 CAF Outcome(s) B2.a Identity Verification, Authentication and Authorisation B2.c Privileged User Management B2.d Identity and Access Management (IdAM) Finding Rating NOT ACHIEVED	Finding	CAF criteria / reasoning for rating
	Following discussion at audit, the IT and Cyber teams confirmed their awareness of a lack of review around account allocation (both standard user and privileged). There are plans to put a review process together for accounts, but these still need to be completed.	Evidence gathered from assessment: The IT and Cyber teams confirmed at audit that there are currently no formalised checks of user and elevated account access CAF Impact: This finding indicates that the following IGPs under B2.a "Partially Achieved" has not been met <i>"The list of users and systems with access to network and information systems supporting and delivering the essential function(s) is reviewed on a regular basis, at least annually."</i> Additionally, the following IGPs under B2.c "Not Achieved" have been met: <i>"The list of privileged users has not been reviewed recently (e.g. within the last 12 months)."</i> Additionally, the following IGPs under B2.d "Partially Achieved" have not been met: <i>"You regularly review access rights and those no longer needed are revoked."</i>
	Implication	
	Without a formal review process into account allocation, accounts may stay open for longer than necessary. This introduces potential vulnerabilities where staff permissions have changed, and potentially increases the attack surface for malicious activity aiming to compromise active accounts.	
	Recommendation	
	Continue the work to formalise review activity for privileged, non-privileged and third party access to essential functions and determine a suitable scope and criteria to ensure consistency.	

Key Findings

Limited controls for third-party privileged access accounts 6	Finding Discussion at audit confirmed that accounts provided to third parties for support access are not subject to time limited controls and remain active by default without additional security measures. Additionally, visibility of which accounts have been issued is not easily accessible to the ABU IT and Cyber team, which limits the team’s ability to monitor system access.	CAF criteria / reasoning for rating Evidence gathered from assessment: The IT and Cyber teams confirmed at audit that there is limited visibility of third party privileged accounts issued, and that accounts are not consistently time restricted
CAF Outcome(s) B2.c Privileged User Management	Implication The existence of always active third party accounts and the limited information around what has been issued results in a potential security vulnerability that the organisation cannot easily monitor.	CAF Impact: This finding indicates that the following IGP’s under B2.c "Not Achieved" have been met:
Finding Rating NOT ACHIEVED	Recommendation Review the current approach to the issuing and control of third party privileged support accounts and determine suitable controls that are proportionate to manage security risks.	<i>“The identities of the individuals with privileged access to your essential function(s) network and information systems (infrastructure, platforms, software, configuration, etc) are not known or not managed.”</i>

Key Findings

Staff movers process does not remove access permissions 7	Finding The IT and Cyber team confirmed at audit that there is no automated account removal as a result of a staff member moving role within ABU/NHS Wales. Some teams are manually removing accounts, but the current national movers process does not communicate information to support a consistent process	CAF criteria / reasoning for rating Evidence gathered from assessment: The IT and Cyber teams confirmed at audit that management and removal of mover accounts from essential systems is not consistent.
CAF Outcome(s) B2.d Identity and Access Management (IdAM)	Implication Where system owners are not updated on staff movers, accounts may stay open to staff members who still retain access through their continued employment within the Health Board or wider NHS Wales. This potentially opens the risk of accidental or malicious access to systems and information to unauthorised personnel	CAF Impact: This finding indicates that the following IGP's under B2.d "Not Achieved" has been met:
Finding Rating NOT ACHIEVED	Recommendation Strengthen the movers process to ensure access rights are consistently reviewed, updated, and removed in a timely manner, with a particular focus on preventing accumulation of unnecessary privileges.	<i>"User access rights are not reviewed when users change roles."</i>

Key Findings

Resource limitations	Finding	CAF criteria / reasoning for rating
8	The cyber and business teams have conducted and recorded assessments around resource limitations. This has identified a single point of failure around the internet breakout (via PSBA) and identified the potential that rising server licencing costs associated with essential services could become unaffordable. At present, these risks have not been mitigated to a level acceptable to the health board.	Evidence gathered from assessment: The cyber and business teams confirmed at audit that there are resource concerns around reliance on PSBA and potential rising server licencing costs
CAF Outcome(s)	Implication	CAF Impact:
B5.b Design for Resilience	Unmitigated resource limitations may adversely affect the Health Board’s ability to support availability of service in the future, which may have an impact on patient care and system security.	This finding indicates that the following IGP under B5.b “Partially Achieved” has been met: <i>"Resource limitations (e.g. network bandwidth, single network paths) have been identified but not fully mitigated."</i>
Finding Rating	Recommendation	
PARTIALLY ACHIEVED	Continue working with senior management through the Health Board’s risk management process to identify, prioritise and implement controls required to mitigate these risks.	

Key Findings

Infrastructure diagram coverage 9 CAF Outcome(s) B5.b Design for Resilience Finding Rating OBSERVATION	Finding When asked for more specific system level infrastructure diagrams, the ABU team confirmed that some essential service systems were lacking detailed documentation.	Evidence gathered from assessment: Evidence reviewed ahead of audit showed broad availability of infrastructure level diagrams, but limited detail was available at system levels Relevant CAF Outcome / IGP: This finding relates to the following B5.b "Achieved" IGP: <i>"You review and update assessments of dependencies, resource and geographical limitations and mitigations when necessary."</i>
	Implication Limited visibility of system level design may result in key dependencies being overlooked during resilience testing reviews. This could result in unforeseen points of failure, which may delay specific system restoration in the event of an adverse event	
	Recommendation Continue to develop the existing infrastructure documentation and work with system teams to map out any areas of the Health Board essential services which are lacking sufficient detail.	

Objective A: Managing Security Risk

● Not Achieved	● Partially Achieved	● Achieved
1	0	3

Outcomes Assessed	Outcome Description	CRU Basic Threshold	CRU Enhanced Threshold	Assurance Assessment Outcome (CAF 4.0) 2026	Outstanding IGP Compliance Requirements	Number of Findings*
A1.a Board Direction	You have effective organisational security management led at board level and articulated clearly in corresponding policies.	A	A	A	All IGPs met	NA: [0] PA: [0] O: [0]
A1.b Roles and Responsibilities	Your organisation has established roles and responsibilities for the security of network and information systems at all levels, with clear and well-understood channels for communicating and escalating risks.	A	A	A	All IGPs met	NA: [0] PA: [0] O: [1]
A1.c Decision-making	You have senior-level accountability for the security of network and information systems, and delegate decision-making authority appropriately and effectively. Risks to network and information systems related to the operation of the essential function(s) are considered in the context of other organisational risks.	A	A	A	All IGPs met	NA: [0] PA: [0] O: [1]

*It is important to note that new findings may be identified through continuous auditing and monitoring processes. As a result, ratings are not static and may change over time to reflect newly uncovered risks, improvements, or regressions in controls and practices. This dynamic approach ensures that assessments remain current and aligned with the latest standards

*The finding score ratings are defined within Appendix D: Finding Scoring Methodology

Objective A: Managing Security Risk

● Not Achieved	● Partially Achieved	● Achieved
1	0	3

Outcomes Assessed	Outcome Description	CRU Basic Threshold	CRU Enhanced Threshold	Assurance Assessment Outcome (CAF 4.0) 2026	Outstanding IGP Compliance Requirements	Number of Findings*
A3.a Asset Management	Everything required to deliver, maintain or support network and information systems necessary for the operation of essential functions is determined and understood. This includes data, people and systems, as well as any supporting infrastructure (such as power or cooling).	A	A	NA	"Inventories of assets relevant to the essential function(s) are incomplete, non-existent, or inadequately detailed.	NA: [1] PA: [0] O: [0]

*It is important to note that new findings may be identified through continuous auditing and monitoring processes. As a result, ratings are not static and may change over time to reflect newly uncovered risks, improvements, or regressions in controls and practices. This dynamic approach ensures that assessments remain current and aligned with the latest standards

Objective B: Protecting Against Cyber Attack

● Not Achieved	● Partially Achieved	● Achieved
4	1	4

Outcomes Assessed	Outcome Description	CRU Basic Threshold	CRU Enhanced Threshold	Assurance Assessment Outcome (CAF 4.0) 2026	Outstanding IGP Compliance Requirements	Number of Findings*
B2.a Identity Verification, Authentication and Authorisation	You robustly verify, authenticate and authorise access to network and information systems supporting your essential function(s).	PA	A	NA	<i>"Unauthorised individuals or devices can access your network or information systems on which your essential function(s) depends."</i> --- <i>"The list of users and systems with access to network and information systems supporting and delivering the essential function(s) is reviewed on a regular basis, at least annually."</i> (PA IGP not met)	NA: [2] PA: [0] O: [0]
B2.b Device Management	You fully know and have trust in the devices that are used to access your networks, information systems and data that support your essential function(s).	PA	A	NA	<i>"Physically connecting a device to your network and information systems gives that device access without device or user authentication."</i>	NA: [1] PA: [0] O: [0]

*It is important to note that new findings may be identified through continuous auditing and monitoring processes. As a result, ratings are not static and may change over time to reflect newly uncovered risks, improvements, or regressions in controls and practices. This dynamic approach ensures that assessments remain current and aligned with the latest standards

*The finding score ratings are defined within Appendix D: Finding Scoring Methodology

Objective B: Protecting Against Cyber Attack

● Not Achieved	● Partially Achieved	● Achieved
4	1	4

Outcomes Assessed	Outcome Description	CRU Basic Threshold	CRU Enhanced Threshold	Assurance Assessment Outcome (CAF 4.0) 2026	Outstanding IGP Compliance Requirements	Number of Findings*
B2.c Privileged User Management	You closely manage privileged user access to network and information systems supporting your essential function(s).	PA	A	NA	"The list of privileged users has not been reviewed recently (e.g. within the last 12 months).." --- "The identities of the individuals with privileged access to your essential function(s) network and information systems (infrastructure, platforms, software, configuration, etc) are not known or not managed."	NA: [2] PA: [0] O: [0]
B2.d Identity and Access Management (IdAM)	You closely manage and maintain identity and access control for users, devices and systems accessing network and information systems supporting your essential function(s).	PA	A	NA	"You regularly review access rights and those no longer needed are revoked." (PA IGP not met) --- "User access rights are not reviewed when users change roles."	NA: [2] PA: [0] O: [0]

*It is important to note that new findings may be identified through continuous auditing and monitoring processes. As a result, ratings are not static and may change over time to reflect newly uncovered risks, improvements, or regressions in controls and practices. This dynamic approach ensures that assessments remain current and aligned with the latest standards

Objective B: Protecting Against Cyber Attack

● Not Achieved	● Partially Achieved	● Achieved
4	1	4

Outcomes Assessed	Outcome Description	CRU Basic Threshold	CRU Enhanced Threshold	Assurance Assessment Outcome (CAF 4.0) 2026	Outstanding IGP Compliance Requirements	Number of Findings*
B5.a Resilience Preparation	You are prepared to restore the operation of your essential function(s) following adverse impact to network and information systems.	A	A	A	All IGPs met	NA: [0] PA: [0] O: [0]
B5.b Design for Resilience	You design network and information systems supporting your essential function(s) to be resilient to cyber security incidents. Systems are appropriately segregated and resource limitations are mitigated.	PA	PA	PA	"Resource limitations (e.g. network bandwidth, single network paths) have been identified but not fully mitigated."	NA: [0] PA: [1] O: [1]
B5.c Backups	You hold accessible and secured current backups of data and information needed to recover operation of your essential function(s) following an adverse impact to network and information systems.	A	A	A	All IGPs met	NA: [0] PA: [0] O: [0]
B6.a Cyber Security Culture	You develop and maintain a positive cyber security culture and a shared sense of responsibility.	PA	A	A	All IGPs met	NA: [0] PA: [0] O: [0]
B6.b Cyber Security Training	The people who support the operation of network and information systems supporting your essential function(s) are appropriately trained in cyber security.	PA	A	A	All IGPs met	NA: [0] PA: [0] O: [0]

*It is important to note that new findings may be identified through continuous auditing and monitoring processes. As a result, ratings are not static and may change over time to reflect newly uncovered risks, improvements, or regressions in controls and practices. This dynamic approach ensures that assessments remain current and aligned with the latest standards

Appendices

A: Positive Findings

ID.	Positive Finding
PF1	The organisation demonstrated very positive engagement with the audit process, providing in-depth and open responses to queries and transparency around areas for improvement.
PF2	The organisation’s utilisation of Superna demonstrates a proactive approach to disaster recovery planning
PF3	The organisation demonstrated a varied and broad approach to cyber security awareness communications, with significant work and thought having gone into how to make the approach effective. The cyber awareness and training programme’s link to individual risk profiles for staff demonstrated very good practice
PF4	The Cyber Team have undertaken targeted face to face training sessions with individual directorates, showing a positive and proactive approach to engagement with staff

Appendices

B: Previous Audit Findings

Aneurin Bevan University Health Board have made significant strides in addressing and closing previous audit findings. Through targeted actions and sustained efforts, the OES has demonstrated a strong commitment to continuous improvement and compliance. The table below highlights the key areas where notable progress has been achieved, relating to previously closed findings that were validated by the CRU at the recent audit.

CAF Contributing Outcome	Previous Audit Finding	Finding Created	Resolution
A2.b – Assurance	Lack of assurance	26/01/2024	Assurance documents for information security and acceptable use are in place and undergoing regular review.
B2.b – Device Management B4.c – Secure Management	No dedicated devices	29/02/2024	Current CAF IGPs no longer require dedicated devices – audit confirmed that devices are subject to group policy secure configuration and cyber are working with desktop team leader to enhance review of elevated access
C1.c – Generating Alerts	Logs are not easily accessible and delays in receiving them	01/03/2024	DHCW have shared information on information access and usage via a wiki – this has improved access and is fit for purpose
C1.e – Monitoring Tools and Skills C2.b – Proactive Attack Discovery	No dedicated monitoring staff	26/01/2024	Monitoring has become part of the team’s daily operations. Still working on expanding the team further.
D1.a – Response Plan	Incident response lacking wider integration	26/01/2024	Integration with the IG team and a wider profile for cyber across the organisation has improved incident comms. Bi-monthly NIS group has supported reporting to exec team via the IG management group.
A1.c – Decision Making	Risk scoring is misrepresented	16/08/2024	Risk process uses a standardised sharepoint form which is widely accessible. Good uptake and usage by teams reporting risk since this has been implemented
C1.b – Securing Logs	Logs are easily manipulated	16/08/2024	DHCW completed a piece of work to remediate the issue and provided ABU with assurance that the work had been completed.

Appendices

C: Basic and Enhanced Profiles

The table outlines the expected outcomes for Aneurin Bevan University Health Board in alignment with both the basic and enhanced CAF (Cyber Assessment Framework) profiles. It serves as a benchmark for assessing performance standards and identifying areas for improvement.

Alongside these expectations, the table also presents Aneurin Bevan University Health Board's current position, based on findings from both previous and recent audit reports. This comparison offers a clear view of progress made and highlights any remaining gaps that need to be addressed to fully meet the CAF criteria.

It is important to note that this snapshot may not capture all improvements implemented since the last audit, particularly those that have not been formally assessed or documented in the current audit cycle. As such, the table should be viewed as a guide to inform ongoing development rather than a definitive measure of current compliance.

CAF Profiles			NHS 4.0		
CAF Objective	Principle	Outcome	Basic Profile	Enhanced Profile	ABU Rating
Objective A					
A1: Governance					
	A1.a: Board Direction		A	A	A
	A1.b: Roles and Responsibilities		A	A	A
	A1.c: Decision Making		A	A	A
A2: Risk Management					
	A2.a: Risk Management Process		PA	A	A
	A2.b: Understanding Threat		PA	PA	
	A2.c: Assurance		A	A	NA
A3: Asset Management					
	A3.a: Asset Management		A	A	NA
A4: Supply Chain					
	A4.a: Supply Chain		PA	A	PA
	A4.b: Secure Software Development and Support		PA	PA	
Objective B					
B1: Service Protection Policies and Processes					
	B1.a: Policy and Process Development		PA	A	NA
	B1.b: Policy and Process Implementation		A	A	PA
B2: Identity and Access Control					
	B2.a: Identify Verification, Authentication and Authorisation		PA	A	NA
	B2.b: Device Management		PA	A	NA
	B2.c: Privileged User Management		PA	A	NA
	B2.d: Identity and Access Management (IdAM)		PA	A	NA
B3: Data Security					
	B3.a: Understanding Data		PA	A	A
	B3.b: Data in Transit		PA	A	A
	B3.c: Stored Data		PA	A	A
	B3.d: Mobile Data		PA	A	A
	B3.e: Media Equipment Sanitisation		A	A	A
B4: System Security					
	B4.a: Secure By Design		PA	A	A
	B4.b: Secure Configuration		PA	A	A
	B4.c: Secure Management		PA	A	NA
	B4.d: Vulnerability Management		PA	A	PA
B5: Resilient Networks and Systems					
	B5.a: Resilience Preparation		A	A	A
	B5.b: Design for Resilience		PA	PA	PA
	B5.c: Backups		A	A	A
B6: Staff Awareness and Training					
	B6.a: Cyber Security Culture		PA	A	A
	B6.b: Cyber Security Training		PA	A	A
Objective C					
C1: Security Monitoring					
	C1.a: Sources and Tools for Logging and Monitoring		PA	A	A
	C1.b: Securing Logs		PA	A	PA
	C1.c: Generating Alerts		A	A	NA
	C1.d: Triage of Security Alerts		PA	PA	A
	C1.e: Personnel Skills for Monitoring and Detection		PA	A	PA
	C1.f: Understanding User's and System's Behaviour		PA	PA	
C2: Proactive Security Event Discovery					
	C2.a: Threat hunting		NA	A	NA
Objective D					
D1: Response and Recovery Planning					
	D1.a: Response Plan		A	A	NA
	D1.b: Response and Recovery Capability		A	A	NA
	D1.c: Testing and Exercising		A	A	NA
D2: Lessons Learnt					
	D2.a: Post-Incident Analysis		A	A	A
	D2.b: Using Incidents to Drive Improvements		A	A	A

Appendices

D: Finding Scoring Methodology

Score	Description
NOT ACHIEVED	A finding that presents a significant cyber security and/or resilience risk to the organisation being assessed. May have the potential to cause harm to patients or significant impact to the delivery of healthcare. Complete failure or lack of security processes or controls. Requires immediate action to remediate. Examples: • Failure of a critical security process, for example, not conducting risk assessments on critical systems. • Use of legacy, unsupported platforms without sufficient mitigating controls in place. • No or untested incident response plan. • Widespread failure to test backups.
PARTIALLY ACHIEVED	A finding that presents an actual or potential cyber security, resilience, or clinical risk to the organisation being assessed. Partial failure of a security process or control. Requires prompt remediation. Examples: • Single critical system missing a risk assessment. • Infrequent testing of incident response plan. • Infrequent testing of backup and restore processes.
OBSERVATION	An opportunity for improvement. Where existing controls meet the CAF outcome, however, require some attention to prevent future findings. Does not immediately cause a security risk to the organisation, though, may in the future. Examples: • Backup log not updated on a single day. • Document review date not updated after previous review.

Title	ID	Cause	Event	Effect	AB - Risk Domain	Risk Level	Date Identified	Inherent - Likelihood	Inherent - Impact	Inherent - Risk Score	Risk Response	Action Plan	Progress	Review Date	Current - Likelihood	Current - Impact	Current - Risk Score
Business continuity plans	1308	As a result of lack of understanding around the production of BCP's	There is a risk of disruption to service due to resource of system failure	Which will lead to disruption of services within both AHR and IG teams	22;#Service/Business Interruption / Environmental Impact	Department/Team	18/10/2024	2	2		4 Treat	Develop BCP's for IG and AHR	01/04/26 Health records plans in place, wider directorat plans to be developed. Jonathan working with Peggy Edwards to address this	29/04/2026	2	2	4
Subject Access Requests	1309	As a result of a lack of understanding by staff across the HB regarding Subject Access Requests process	There is a risk that subject access requests are not being processed in a timely manner	Which will lead to non compliance with UK GDPR Legislation	17;#Statutory Duty/Inspections	Corporate	18/10/2024	2	2		4 Treat	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'	SAR FAQ's developed, discussion regarding SARs to be added to GAG agendas	22/12/2025	2	2	4
Storage of patient records	1310	As a result of the lack of understanding of the Records Management Policy	There is a risk of records being stored inappropriately, not catalogued and unknown to both IG and AHR teams that these records exist	Which will lead to non compliance with UK GDPR Legislation	17;#Statutory Duty/Inspections	Corporate	18/12/2020	3	3		9 Treat	Formal and adhoc audits to be undertaken to identify areas of non compliance	SBAR created for the storage of records in ST Cadocs Jon to provide update from IG group discussion regarding the outcome	05/01/2026	3	2	6
Images and voice recordings stored without IG knowledge	1311	As a result of images and voice recordings being stored without IG knowledge	Information Governance are unable to comply fully with Subject Access Requests	Which will lead to non compliance with UK GDPR Legislation	17;#Statutory Duty/Inspections	Department/Team	21/10/2024	3	3		9 Treat	Discussions to held via GAG's and Divisional Key contacts to ensure Information Asset Register is up to date	Work ongoing with Divisions Update to be provided by SIGOs	30/04/2026	3	3	9
Mental Health Professional Body Disclosure process for records that sit outside of clinical waiver	1312	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	There is a risk of disclosures not being actioned within the timescale of one calendar month	Which will lead to non compliance with UK GDPR Legislation	17;#Statutory Duty/Inspections	Corporate	21/08/2023	3	3		9 Treat	Raise importance of compliance with subject access requests via GAGS, communication via AB pulse and discussion between DPO, Caldicott Guardian and MH CD's	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.	01/12/2025	3	3	9
CCTV - lack of technology to obscure faces of people who are not relevant to Subject Access Requests	1314	As a result of the inability to obscure faces of people not relevant to request	There is a risk of breach of confidentiality when providing CCTV footage as part of a subject access request	Which will lead to non compliance with UK GDPR Legislation	15;#Quality/Complaints/Audit	Department/Team	30/07/2021	2	2		4 Treat	Review of procedure and systems to ensure compliance with UKGDPR Legislation	Update required from GO on review of procedure and systems to ensure compliance with legislation	20/10/2025	2	2	4
EPEX - decommissioning of service	1316	As a result of the decommissioning of the EPEX system	There is a risk of loss of information	Which will lead to non compliance with UK GDPR Legislation	17;#Statutory Duty/Inspections	Corporate	21/10/2024	3	3		9 Treat		JJ and MM to speak to JM	10/11/2025	3	3	9
WCCIS - not all steps being undertaken when uploading information to WCCIS	1317	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.	There is a risk of loss of information	Which will lead to non compliance with UKGDPR Legislation	17;#Statutory Duty/Inspections	Department/Team	21/10/2024	3	3		9 Treat		JJ and MM to speak to JM	13/10/2025	3	3	9
Information Governance Training - Compliance of 85% across the HB - non compliance with IG toolkit	1318	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 a risk of IG/Records Management and Cyber processes not being followed	Which will lead to non compliance with UKGDPR Legislation. This will also mean that we are unable to achieve minimum standards for the IG toolkit which will have a knock on effect for CAG requests	17;#Statutory Duty/Inspections	Department/Team	01/06/2021	2	2		4 Treat	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.	Discussions held nationally to review elearning package and locally to review compliance and training provision within HB	20/10/2025	3	3	9
Medico Legal extract not fit for purpose - specifically A&E and WinPath	1326	There is insufficient resource to develop A&E and WinPath data extract functionality. 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.	If resource not available to develop Medical legal extract in Admin Portal and AHR have insufficient resource to safely maintain manual process within timescales.	Delays in producing medico legal extracts. Possible fines for breaching targets or additional staff costs to meet targets.	22;#Service/Business Interruption / Environmental Impact	Programme/Project	07/09/2023	4	2		8 Transfer	Develop and submit business case for Digital Platform as part of ABUHB EHCR Delivery Strategy	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	13/10/2025	4	2	8
Inappropriate Access to Systems	1379	As a result of not all departments having starters, leavers and movers process	There is a risk of staff being able to access information systems outside of their job role	Which will lead to a breach in UKGDPR Legislation and is a breach of the Computer Misuse Act 1990	17;#Statutory Duty/Inspections	Directorate	18/11/2024	2	2		4 Treat	SIGO's to work with Divisions to ensure S,M and L processes are in place and adhered to	Update required from SIGOs	18/11/2025	1	1	1
Significant data loss within Mental Health	1472	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	There is a risk of information being deleted	which will lead to a significant data loss for the HB	20;#Safety - Patient/Staff/Public	Directorate	12/09/2024	3	3		9 Treat	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.	Update required	21/09/2025	3	3	9
Local Authorities purchase of WCCIS replacement system which will not include ABUHB	1519	As a result of this proposal there is a risk that ABUHB data may be migrated onto this system.	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	Which may lead to a significant loss of data for the HB	20;#Safety - Patient/Staff/Public	Corporate	24/10/2024	3	3		9 Treat			20/01/2026	3	3	9
EMPI	1673	As a result of inbound messaging from EMPI a numbers of data quality errors resulting in data breaches have occurred.	There is a risk of inappropriate disclosure of information/breach of data protection legislation	Which will led to non compliance of data protection legislation and loss of organisational reputation	17;#Statutory Duty/Inspections	Department/Team	13/03/2025	3	3		9 Treat		SBAR being looked at by Lynne Wilde to see impact of turning off messaging to other systemsS	22/12/2025	3	3	9
G2 work around - IG	1817	As there is currently no practical way to provide business continuity for G2 in the event of unacceptable speed or inaccessible application	users are reported to be adopting personal device voice memo and whats apping	which leads to a breach of GDPR, misidentification issues, records missing from CWS record, PII on personal devices	17;#Statutory Duty/Inspections	Corporate	03/06/2025	5	3		15 Treat	Identify BC	Back up plan if G2 is down is to use audio recordings in one note ICT currently undertaking testing	15/12/2025	3	5	15
Outlook autocomplete	1996	As a result of staff across the HB using the autocomplete function within outlook	There is a risk of breach of confidentiality by sending information to an incorrect recipient	Which will lead to non compliance with UKGDPR	17;#Statutory Duty/Inspections	Corporate	22/04/2025	3	2		6 Treat	Work to be undertaken across divisions regarding the the removal of this function		12/01/2026	3	2	6
Medico Legal extract in open eyes not fit for purpose	2215	As a result of no set process for medico legal process in the new open eye system	There is a risk of not being compliant with Subject Access Requests	Which leads to a breach of GDPR	17;#Statutory Duty/Inspections	Corporate	16/01/2026	3	3		9 Treat	Further information required during DPIA process	Jonathan Meredith (Aneurin Bevan UHB - Digital Data and Technology),	06/07/2026	3	3	9
Open Eyes	2257	Numerous risks have been identified inline with Articles under DPA2018 & UKGDPR, these have been highlighted on the Local Risk Assessment document	The Consultant Ophthalmologist and Senior Responsible Owner confirmed that from a clinical standpoint the Health Board should accept the residual risks.	Risks highlighted non compliance with DPA2018 & UKGDPR	17;#Statutory Duty/Inspections	Directorate	16/01/2026	3	3		9 Treat		DPIA completed	22/09/2026	3	3	9
Digital letter Patient Portal Risk	2422	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	There is a risk of a breach of confidentiality via inappropriate access/sharing	Which will lead to a breach of UKGDPR	17;#Statutory Duty/Inspections	Corporate	07/05/2026	2	5		10 Treat	Turn off electronic letters for all patients under 18	DPIA to be updated to reflect risks. mitigation actions	28/05/2026	2	5	10



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 September 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 Information and Communications Technology (ICT) activity aligned to the Health Board’s operational priorities. The Digital Transformation portfolio currently comprises seven programmes and 40 live projects.

Recent milestones achieved include OpenEyes deployment in secondary care ophthalmology, OPERAi go-live, the Radiology Informatics System Procurement (RISP) solution going live, electronic Prescribing and Medicines Administration (ePMA) pilots on two wards, Microbiology implementation for Laboratory Information Management System (LIMS) 2.0, mobilisation of the RiO Electronic Patient Record (EPR) and continued rollout of Digital Patient Communications (DPC).

The principal areas requiring continued oversight are unfunded programme posts, patient communication data integrity, digital dictation continuity, legacy Welsh Community Care Information System (WCCIS) technology, supplier capacity and constrained network and application-development resource.

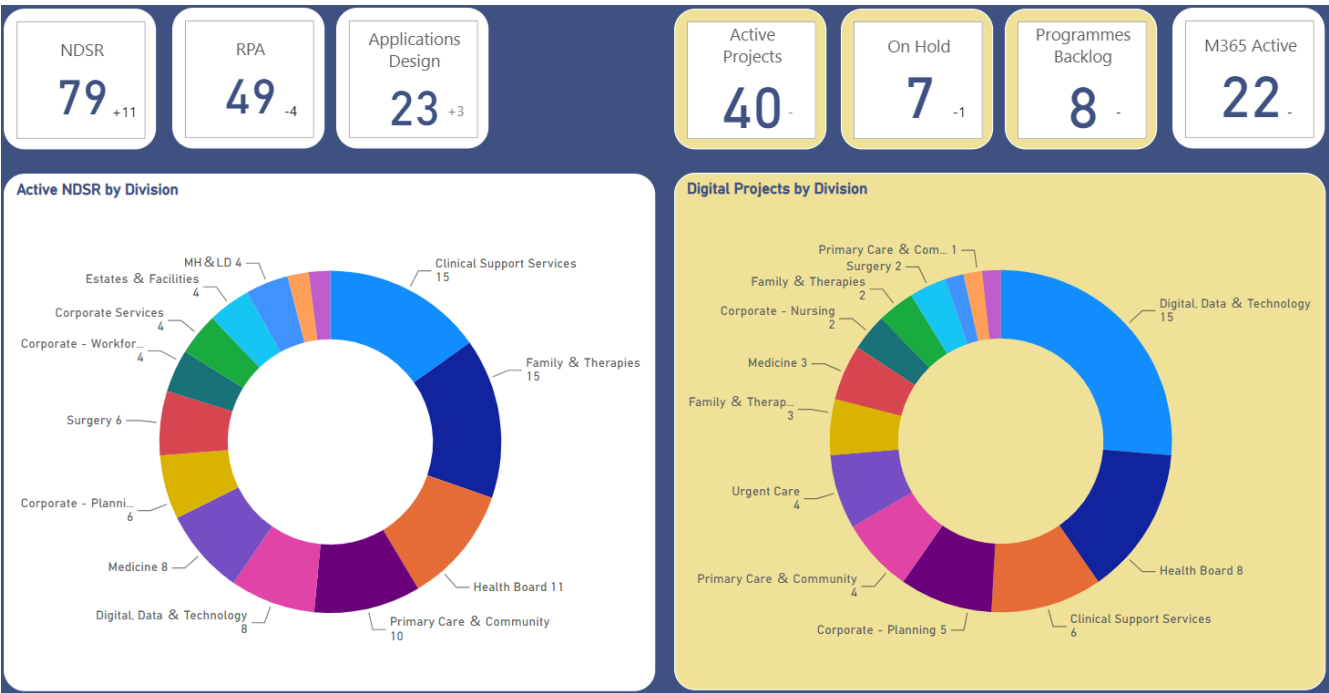
Recent enhancements to the New Digital Service Request (NDSR) process and Divisional Engagement Meetings (DEM) continue to broaden and clarify divisional endorsement and oversight of the digital portfolio.

A Quarter 1 review identified 129 New Digital Service Requests, of which 79 remain active, alongside 20 requests in the Application Development Prioritisation and Optimisation Pool. Demand continues to exceed available specialist and delivery capacity, and seven Integrated Medium-Term Plan commitments were still awaiting a corresponding request. The Digital, Data and Technology Group considered this position on 3 September 2026 and supported the proposed controls: a temporary pause on uncommitted requests requiring additional funding or capacity, subject to tightly defined exceptions, and a cross-divisional approach to establish a short, ranked Health Board priority list with protected delivery time.

This report provides the Finance and Performance Committee with assurance on current delivery progress to September 2026, the present financial position, portfolio-level risks and issues, benefits management and the actions required to maintain operational continuity and delivery confidence.

Cefndir / Background

A summary view of the digital portfolio is shown below:



Asesiad / Assessment

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

1. Acute Programme

- OpenEyes is live in secondary care ophthalmology, with Welsh Government funding confirmed for biometry integration to enable cataract services to go live during Quarter 3.

- OPERAi, the national eye-care Electronic Referral Solution (ERS), went live on 5 August 2026 after mitigation of more than 50 clinical-safety hazards and national reconfiguration of referral templates.
 - Early OPERAi usage data shows 1,825 referrals: 1,062 routine (58.2%), 615 urgent (33.7%) and 148 emergency (8.1%). Ophthalmology received 1,460 referrals, compared with 248 for Primary Care Services and 117 for Emergency Eye Services. Cataract was the largest clinic category, with 593 referrals, accounting for approximately one-third of all referrals.
 - Regional eye-care risks have been escalated in relation to the continuing financial and operational uncertainty when the OPERAi contract ends in March 2027, no integration between OpenEyes and OPERAi and the expiry of the OpenEyes support contract in January 2027.
- The Digital Dictation business case has been approved by the Executive Team, subject to formal Board approval on 28 September 2026.
- eAdvice development is planned to restart in September 2026, with go-live scheduled in January 2027.
- Welsh Emergency Care Data Set (WECDS) activity has restarted, with go-live scheduled in September 2026, subject to Welsh Government (WG) confirmation of reporting and impact. The project continues to plan an upgrade to the Symphony version used in the Emergency Department (ED) and to scope deployment within assessment units to support the electronic transfer of patients.

2. Digital Ward Programme

- Tender evaluation for Digital Health Communications, seeking to replace Vocera and bleeps, is nearing completion and business case drafting is underway.
- Paediatric Welsh Nursing Care Record (WNCR) funding has been confirmed with Digital Health and Care Wales (DHCW) for 2026/27, with assurance now required on delivery of national paediatric forms before detailed local implementation planning can conclude.
- CareFlow Connect implementation is being planned within Surgery; this will use the remaining available licence capacity, and any further expansion will require additional investment.

3. ICT Programme

The ICT Programme comprises 24 projects and remains a critical cross-portfolio dependency.

- The Bladder and Bowel Service Vision replacement is complete and moving to formal project closure.

- Limited internal technical and project capacity continues to constrain delivery, including the CCube electronic document and records management upgrade, for which the supplier is charging approximately £1,800 per month until completion, currently expected in Quarter 3.
- Two vacancies have further reduced capacity and the effect on priorities and timescales is being assessed.

4. Clinical Support Services Programme

- The RISP solution went live on 22 June 2026 using Welsh Clinical Portal (WCP) as an interim route for requesting, image viewing and reporting while Clinical Workstation (CWS) development continues.
- Post-implementation pressures include dual-system working, patient-context verification, reduced reporting productivity and outstanding cutover data migration. Testing of the transition back to CWS began in August and the latest plan runs to November 2026, subject to stakeholder availability, stable operations, development capacity and defect resolution.
- For LIMS 2.0, Microbiology went live on 24 August 2026 and Blood Sciences is planned for September 2026, subject to user acceptance testing, clinical quality assurance and readiness. Other activity includes national point-of-care testing and Digital Cellular Pathology procurements, an Operating Room Management Information System upgrade and potential Infection Control Network integration.

5. ePMA Programme

- The ePMA pilot is live on Bargoed and Penallta wards at Ysbyty Ystrad Fawr (YYF).
- Further rollout has been paused while actions are completed on admission, discharge and transfer (ADT) pipeline stability, medication transcription and validation, access-management delays, training compliance and Pharmacy impact assessment.
- A formal lessons-learned process and governance review are strengthening communication, clinical leadership, divisional accountability, escalation and go-live assurance. An updated deployment approach will be confirmed when the priority actions provide sufficient assurance to proceed safely.

6. Digital Community Programme

- The contract has been awarded to The Access Group (TAG) for implementation of the RiO electronic patient record for Mental Health and Learning Disabilities. Supplier and local teams are developing the implementation plan, configuration and data-migration activity while services validate Day 1 scope, workflows, forms and letters.
- The programme must move from the current WCCIS to RiO between March 2027 and September 2027. The critical path remains tight across

development, configuration, migration, integration, testing, training and service readiness.

7. Digital Patient Programme

- The Digital Patient Programme remains Amber/Red. The Executive Committee agreed a controlled pause following the go-live of the reduced Phase 2 scope for digital letters because clinical-safety, safeguarding, data-quality, resilience, supplier-assurance and financial risks outweigh the benefits of further scaling.
- Digital letters are live in 17 services, with 45% digital uptake and an average of 580 letters issued each weekday. Four services not managed by the Referral and Booking Centre (RBC) have been removed from scope, while a further six RBC-managed services have gone live to complete Phase 2. Under-18s have also been removed following a safeguarding risk, reducing digital uptake from 54% to 45%.
- The programme has operated at a financial loss over the eight months since digital letters went live. The next phase will stabilise live services, complete an external lessons-learned review and reset requirements, benefits and procurement options before the supplier contract ends in March 2027.

8. Microsoft 365 Transformation

- The Microsoft 365 workstream continues to support productivity, collaboration and service redesign. Recent developments include automated visa end-date notifications, a Theatre Specimen Tracker, a live Community Situation Reporting dashboard and an automated Internal Lateral Transfer Scheme. Identification badge and School Nursing Flu solutions are also in testing.
- Limited team capacity due to sickness absence and annual leave creates resilience and support risks, while regional opportunities are being scoped with Cwm Taf Morgannwg and Cardiff & Vale Health Boards.

Programmes Backlog and Scoping

- Eight projects remain in the programme backlog awaiting capacity, prioritisation and funding, including Digital Consent, urgent-care electronic observations, Theatre Management System procurement and the Welsh Intensive Care Information System.
- Discovery is progressing across patient flow, complex care, telephony infrastructure, neurodevelopment services, women's health, additional learning needs, Symphony integration within Urgent and Emergency Care and security systems.

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 DDaT 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:

26/27 Total Budget		26/27 Current / Forecast Spend		26/27 Variance	
Capital	Revenue	Capital	Revenue	Capital	Revenue
£1,773,672	£2,413,605	£615,259	£4,266,765	-£1,158,4...	£1,853,160

The forecast revenue variance for 2026/27 is £1.853 million. This reflects historic unfunded programmes and newer Health Board-approved business cases, including RISP, ePMA and Digital Community, where recurrent funding has not transferred into the DDaT baseline.

If the Board approves the Digital Dictation business case on 28 September 2026, the associated funding for both the required resource and the solution must transfer to DDaT; otherwise, the Directorate’s cost pressure will increase.

Welsh Government’s Digital Priorities Investment Fund (DPIF) support has now been confirmed for ePMA for 2026/27. The formal funding letter for Digital Community remains outstanding. Once confirmed, the funding is expected to remove the forecast Programmes overspend for the current financial year.

However, national transformation funding does not meet the ongoing operating costs that fall to the Health Board once systems are implemented. Approved business cases therefore create continuing revenue commitments for the lifetime of the systems, requiring close oversight of affordability, enabling infrastructure and any interim arrangements needed to protect service continuity.

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 (IMTP). The Strategic Digital Transformation Plan has now been approved by the Board and development of the Clinical Workstation business case will help shape future investment choices and delivery sequencing.

New Digital Service Request demand and prioritisation

The New Digital Service Request Framework now provides a consistent route from submission through weekly triage, Divisional Engagement Meetings, discovery and formal prioritisation to delivery or closure. Logging or scoping a request does not constitute a commitment to deliver; timescales can only be confirmed when priority, scope, assurance, funding, dependencies and capacity are understood.

Assurance capacity remains a significant constraint, with clinical safety, information governance and cyber security backlogs affecting lead times, while demand for Robotic Process Automation cannot currently progress without additional funded capacity.

The Quarter 1 review also identified ten cases where the agreed NDSR route had not been followed, reinforcing the importance of early DDaT involvement and compliance with the Digital Procurement Financial Control Procedure.

The DDaT Group reviewed this position on 3 September 2026 and endorsed a temporary pause on uncommitted requests that require additional funding or capacity, except where there is evidenced patient safety, statutory, cyber security, service continuity, local Executive-mandated or nationally mandated need. The Group also endorsed development of a short, ranked, cross-divisional Health Board priority list, with protected time for delivery and an explicit deferment or displacement decision whenever a new urgent priority is introduced.

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.

The Digital Benefits Register currently contains 276 benefits, of which 65 benefits have been realised to date. During the reporting period, benefits management activities focused on defining and refining the benefits associated with the Digital Dictation and Digital Healthcare Communications business cases. A review of the benefits identified for the ePMA, and ICT programmes was also completed, resulting in updates to the corresponding benefits plans.

In addition, benefits identification workshops were facilitated for a number of existing projects, including the Bladder and Bowel (Vision) replacement, CareFlow Connect and WNCR Paediatrics. During the next reporting period, benefits reviews will be undertaken for the WNCR Adults, Ophthalmology ERS, Maternity (BadgerNet), RISP, and Mortuary projects to determine the extent that the benefits relating to these projects have been realised. Further assurance on benefits realised will be brought to the next committee meeting.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **Note** the current delivery position, benefits, key risks and dependencies across the digital portfolio
- **Note** the forecast 2026/27 revenue variance and the continuing affordability risks where recurrent funding has not transferred into Digital, Data and Technology baseline budgets
- **Note** the detailed New Digital Service Request demand, governance, assurance and capacity position

- **Note** that the DDaT Group considered the New Digital Service Request position on 3 September 2026 and endorsed both the temporary pause on uncommitted requests requiring additional funding or capacity, subject to defined exceptions, and the cross-divisional approach to agreeing a short, ranked Health Board priority list with protected delivery time

Assurance is strongest where programmes have clear local control, defined implementation plans and disciplined prioritisation. The endorsement provided by the DDaT Group strengthens the governance response to demand exceeding capacity by establishing a clearer basis for pausing unfunded work, protecting delivery time and managing displacement decisions. Residual risk remains concentrated in nationally dependent or infrastructure-intensive programmes and in requests that bypass agreed governance, where timescales, affordability, supplier performance, assurance capacity 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:	
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	Governance
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:	Programme and project highlight reports; portfolio and benefits tracking; finance reports and funding correspondence; programme governance records; regional eye-care reporting; and approved business cases referenced within this report.
Rhestr Termau: Glossary of Terms:	ADT – Admission, Discharge and Transfer CWS – Clinical Workstation DDaT – Digital, Data and Technology DEM – Divisional Engagement Meeting DHCW – Digital Health and Care Wales DPC – Digital Patient Communications DPIF – Digital Priorities Investment Fund ED – Emergency Department ePMA – electronic Prescribing and Medicines Administration EPR – Electronic Patient Record ERS – Electronic Referral Solution ICT – Information and Communications Technology IMTP – Integrated Medium-Term Plan LIMS – Laboratory Information Management System NDSR – New Digital Service Request OPERAi – national eye-care Electronic Referral Solution RBC – Referral and Booking Centre RISP – Radiology Informatics System Procurement TAG – The Access Group WCCIS – Welsh Community Care Information System WCP – Welsh Clinical Portal WECDS – Welsh Emergency Care Data Set WG – Welsh Government WNCR – Welsh Nursing Care Record YYF – Ysbyty Ystrad Fawr
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Digital, Data and Technology Group, 3 September 2026. The Group considered the New Digital Service Request review and prioritisation paper and supported its recommendations.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	Material resource implications are described below and within the programme and financial updates. These include unfunded programme posts, specialist implementation and development capacity, infrastructure expertise, supplier support and recurrent operating costs arising from approved business cases.

• 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	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

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 September 2026
CYFARFOD O: MEETING OF:	Finance and Performance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Digital Patient Communication Project
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

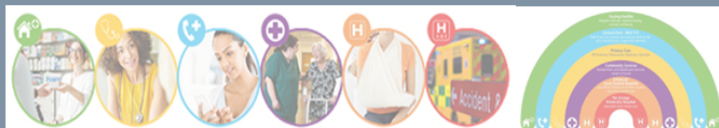
ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The reduced Phase 2 digital letter scope of the Health Care Communications project was completed in August 2026. Given the clinical safety, operational and financial issues identified, no further rollout or increase in scope is proposed. The position was presented to the Executive Committee on 20 August 2026, which agreed that an external review should be commissioned to identify lessons learned and inform the way forward. The current platform and existing live services will continue while the external review is undertaken, the Welsh Patient Administration System (WPAS) service improvement work develops, and the Referral and Booking Centre (RBC) process review is completed.

The expected cash-releasing savings have not been achieved. The January 2025 financial model forecast Phase 2 digital letter savings of £124,000 in Year 1 and £160,000 in Year 2. These were offset against an annual resource requirement of £125,189, resulting in a marginal Year 1 deficit of £1,189 and a Year 2 benefit of £34,811.



In practice, the programme has operated at a loss since digital letters went live on 29 January 2026. The financial case has been weakened by unforeseen complications which have led to a delayed rollout, reduced scope, extra staffing and continued reliance on hybrid mail.

The recommended approach is to stop further rollout, stabilise live services, complete an external lesson learned review and define a robust set of Health Board's requirements and procurement approach for a future safe and sustainable model for digital patient communications.

Cefndir / Background

In June 2023, the Health Board agreed to consolidate Short Message Service (SMS) reminders and hybrid mail into one patient communications platform. Healthcare Communications Ltd (HCC) was procured in early 2024 to consolidate the two existing systems, DrDoctor (SMS) and PSL Print Management Ltd (Hybrid Mail).

The original approval was progressed through a Situation, Background, Assessment and Recommendation (SBAR) report and Executive Team decision rather than a formal business case. The papers set out the case for consolidating text reminder and hybrid mail contracts, described the expected benefits and proposed a phased delivery approach. However, there was no full business case, quantified benefits plan or established business change model. The paper also identified that the new supplier had digital letter capabilities which could be explored for use in the Health Board.

Project delivery was structured across three phases:

- **Phase 1:** Replacement of hybrid mail and text reminder services (live from 21 March 2024)
- **Phase 2:** Exploration and implementation of a Digital Patient Portal for appointment-related correspondence for all WPAS and RADIS letters
- **Phase 3:** Management of all remaining Health Board correspondence via digital and hybrid mail solutions

The June 2023 SBAR recognised that wider rollout would need project management, business change and benefits support. It also stated that Phase 2 and Phase 3 would need business case development if additional resource was required. Because the original proposal was a like-for-like replacement of legacy systems for SMS and hybrid mail no formal business case was completed at the outset, therefore several assumptions were not fully tested in relation to digital letter implementation and rollout. These included affordability, deliverability, clinical safety, WPAS configuration and data quality issues, local processes, supplier performance, Welsh Language and accessibility requirements, resource capacity and change impact. These gaps contributed to underestimated complexity, delayed rollout, reduced scope, extra resource requirements and a weaker financial case.



In November 2023, the newly appointed Director of Digital confirmed that the project should transfer into the Digital Patient Programme. By that point, it had become critical to the Health Board's wider patient-facing digital strategy and needed stronger programme management, project support, business change and benefits capacity.

Phase 1 went live in March 2024 and continues to support high-volume text reminders and hybrid letters. It also exposed a significant dependency on Welsh Patient Administration System (WPAS) configuration and local data quality due to variation of booking processes across non-Referral & Booking Centre (RBC) led services in the Health Board. Inconsistent clinic codes, letter templates, printer selections and address fields now require ongoing manual checks to avoid missed, delayed or incorrect patient communications.

Phase 2 was split into three tranches and was paused several times. The main issues were Welsh Language standards, accessibility requirements and the level of operational and technical resource needed to implement and sustain the solution safely. The reduced Phase 2 scope was completed in August 2026. Seventeen services are now live with digital letters. Digital uptake across those services is 45%, with an average of 580 digital letters issued each weekday.

Since all agreed services went live, digital adoption has shown a consistent pattern:

- 45% of patients receive digital letters only.
- 5% of patients access their digital letters but also receive a paper copy.
- 50% of patients receive paper letters only.

The project will target the 5% of patients who do not access their digital letter within 24 hours, at which point a paper copy is issued, to explore whether digital uptake can be increased and duplicate paper correspondence reduced.

Tranches 1 and 2 of Phase 2 went live in January and February 2026. Of the ten services originally planned for Tranche 3, four were descoped because they would need to manually amend and manage clinical data in WPAS to support digital letter workflows. As this cannot be fully automated, there is a higher risk of human error and incorrect or failed patient communications. The risk is lower for services managed by the RBC, where processes are more standardised. The six RBC-managed services completed rollout in August 2026.

A key issue is the variation in data quality and booking practice across booking pods and locally managed services. The current model relies on WPAS fields being accurate and used consistently. This includes clinic codes, specialty and sub-specialty descriptions, appointment locations, letter templates, printer selections, contact details and patient communication preferences. Where these fields are incomplete or amended locally, digital communications can become unclear, incomplete or incorrect. They may also need manual intervention before they can be issued safely.



This is most visible outside the more standardised RBC model. Booking pods and locally managed services use different approaches to clinic template management, appointment booking, cancellations, outcome recording and patient contact. This variation affects the data passed from WPAS into patient communication systems. It increases the risk of incorrect clinic locations, missing contact information, delayed letters, avoidable patient calls, missed appointments and extra administrative work.

The operational support required to sustain the system has placed a significant and increasing burden on the RBC and Information Services teams, exceeding the levels anticipated at procurement. The current digital letter solution exposes existing variation in WPAS use and booking practice. Scaling the model would increase the number of services needing manual checks, remediation and local workarounds.

Asesiad / Assessment

The current operating model is not sustainable at scale as the supplier's technical solution design has introduced significant complexity. The solution requires the deconstruction of WPAS data, and its transfer to the supplier via complex data extracts from the Health Board's data warehouse, supported by extensive mapping tables (including letter "riders"). The data is subsequently reassembled by the supplier into standardised outputs for delivery via the patient portal or hybrid mail. Any changes in WPAS configuration need to be reflected in the data extracts manually as there is no automatic process for data transfer to the supplier's platform.

WPAS service improvement work is ongoing, although a defined delivery plan, priorities and timescales have not yet been agreed. Initial areas for review include clinic set-up, temporary addresses and ensuring letter templates are fit for purpose and linked to the correct clinics. However, without centralised control of booking practices and clinic template management these issues will continue to happen and will not provide sufficient mitigation to support further rollout of the current digital letter model, or indeed any further rollout of digital solutions using alternative products that would support digital letters or digital appointment management.

Clinical safety and safeguarding risk:

Two material safety issues have impacted the programme risk profile.

Datix 140452 related to a supplier processing failure where appointment and cancellation letters were not issued over several days and the failure was not detected through supplier monitoring.

Datix 142652 identified a high-impact safeguarding risk linked to change of guardianship arrangements. Historical patient information could be exposed through the portal. Under-18s have therefore been removed from digital letter delivery. This reduces immediate risk, but it also reduces scope and benefit.

Financial impact:



The anticipated savings have not been delivered. The original proposal relied on wider digital adoption and reduced paper and postage volumes. The approved resource model required £125,189 per year to fund a Band 7 Product Specialist in the Referral and Booking Centre (RBC) (£67,719) and a Band 6 Business Intelligence (BI) Analyst in Information Services (£57,470).

These costs were expected to be funded from digital letter savings. Those savings have been eroded by delayed rollout, reduced scope, continued hybrid mail reliance, extra staffing, manual checking and the removal of paediatric cohorts.

De-scoping four non-RBC services from Phase 2, Tranche 3, has removed around 4,300 potential digital letters each month. The programme is therefore delivering reduced value for money. It does not support further investment in scale and spread under the current model.

Financial issue	Specific impact
Original Phase 2 savings forecast	£124,000 Year 1 and £160,000 Year 2 digital letter savings were forecast, with a further Phase 3 opportunity estimated at £239,122.
Annual resource requirement	£125,189 per annum: Band 7 RBC Product Specialist £67,719 and Band 6 BI Analyst in Information Services £57,470.
Original net benefit	The original model showed a marginal Year 1 net deficit of £1,189, a Year 2 net benefit of £34,811 and a potential Phase 3 net benefit of £113,933.
Current realised position	The programme has operated at a loss of £4,100 since digital letters were implemented on 29 January 2026.
Reduced scope and volume	De-scoping four non-RBC services from Tranche 3 has removed approximately 4,300 potential digital letters per month, permanently reducing the savings opportunity under the current model.
Further rollout exposure	Further scale and spread would require additional mitigation, resource and contract effort without a credible route to recover the original benefits case.

The Health Board is not alone in facing these challenges (see Appendix 1). Across Wales, health boards use a mix of local patient communication platforms and hybrid mail. The national direction is moving towards greater use of the NHS Wales App for referral and appointment information however, digital letters, appointment management and hybrid mail are still at different stages of maturity across Wales. The strongest models are underpinned by standardised booking processes and reliable PAS data.

NHS Wales App alignment

The NHS Wales App is increasingly relevant to the future patient communications model. Secondary care referral and first outpatient appointment information is now available through the App, using information drawn from local PAS/WPAS systems. The current functionality is read-only. Patients cannot yet book, cancel or change



appointments through the App. Future development discussions include digital letters, appointment cancellation and amendment, self-booking, waiting list information, patient preferences, Patient Reported Outcome Measures (PROMs)/Patient Reported Experience Measures (PREMs), push notifications and wider integration with local and national systems.

The Health Board has already identified several opportunities for the NHS Wales App and a South-East Wales approach is also being developed to agree shared priorities and create a regional roadmap for discussion with Digital Health and Care Wales (DHCW). Future procurement or transition planning will test whether requirements can be delivered through, integrated with or made complementary to the NHS Wales App.

Strategic position:

The current contract with HCC ends in March 2027. Closing the project while temporarily continuing the current platform and live services requires an agreed transition plan that confirms the contractual route, affordability, service support and exit arrangements. This will prevent further rollout, protect existing patient communications and allow time to complete the WPAS service improvement work and RBC process review before a future model is defined.

The project has delivered important foundations, including standardised templates, improved accessibility and Welsh Language compliance. However, these benefits do not outweigh the cumulative clinical, operational and financial risks of continuing to scale the current solution.

Some key learning is that digital transformation cannot safely rely on strategic intent alone. A formal business case is needed to test affordability, deliverability, clinical safety, operational readiness, benefits and business change before a solution is scaled. In this case, key assumptions were not tested early enough. Stopping further rollout does not mean stepping away from digital patient communications. It means recognising that the current model is no longer safe, sustainable or financially viable and acting before further risk or cost is incurred.

Argymhelliad / Recommendation

The Board is asked to:

- **Note** the pause of the current Digital Patient Communications (DPC) Project following completion of the reduced Phase 2 scope in August 2026.
- **Note** the continuation of the current platform and existing live services while the external review is undertaken, the WPAS service improvement work develops, and the RBC process review is completed.
 - **Note** that changes arising from the RBC process review may materially affect how a future digital letters solution is configured and used.



- **Note** the Executive Committee's agreement on 20 August 2026 to commission an external review to identify lessons learned and inform the way forward. The review will support a reset of the requirements, benefits and procurement approach for any future solution, aligned with Health Board, South-East Wales regional and national NHS Wales App priorities, and be informed by the WPAS service improvement work and RBC process review.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	140452 142652
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.2 Communicating Effectively 4.2 Patient Information 3.4 Information Governance and Communications Technology 7. Staff and Resources
Blaenoriaethau CTCI Integrated Medium Term Plan (IMTP) Priorities Link to IMTP	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	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 Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	Published learning from NHS digital transformation programmes reinforces the need to test benefits, operational readiness and delivery assumptions before scaling. Benefits realisation should identify, measure and track the value expected from transformation projects. In practice, benefits planning and reporting in healthcare transformation is often underdeveloped. NHS implementation learning also shows that anticipated benefits can be
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	overstated without objective measurement and local validation. The decision to stop further rollout should therefore be viewed as a proportionate governance response. Where a digital project is no longer delivering the expected balance of benefit, safety and value, it is right to pause, stop, learn and reset before committing further resource.
Rhestr Termau: Glossary of Terms:	BI – Business Intelligence DHCW – Digital Health and Care Wales DPC – Digital Patient Communications HCC – Healthcare Communications Ltd PAS – Patient Administration System PKB – Patients Know Best PREMs – Patient Reported Experience Measures PROMs – Patient Reported Outcome Measures RBC – Referral and Booking Centre SBAR – Situation, Background, Assessment and Recommendation SMS – Short Message Service WPAS – Welsh Patient Administration System
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Julie Poole – Senior Responsible Owner Digital Patient Communications Project Board stakeholders

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is an Equality Impact Assessment (EIA) required and included with this paper? Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	An Equality and Quality Impact Assessment (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 DPC EQIA.docx (sharepoint.com)



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 Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives
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Appendix 1

Organisation	Current position
Aneurin Bevan University Health Board	Uses Healthcare Communications for SMS reminders, hybrid mail and digital letters. Phase 2 digital letters have delivered digital uptake, but further scale is constrained by clinical safety, WPAS data quality, booking process variation, supplier assurance and reduced benefits realisation.
Hywel Dda University Health Board	Uses Netcall for SMS and Digital Letters.
Swansea Bay University Health Board	Uses Patients Know Best (PKB), integrated with the NHS Wales App.
Cardiff and Vale University Health Board	Uses Healthcare Communications integrated with their local PAS, not WPAS.
Cwm Taf Morgannwg University Health Board	Uses Dr Doctor.
Betsi Cadwaladr University Health Board	Uses Healthcare Communications for SMS and looking to pilot digital letters in specific services.
Powys Teaching Health Board	Looking to procure a digital solution.
National NHS Wales App	Secondary care referrals and first outpatient appointment information are available in the NHS Wales App. Current functionality is read-only; patients cannot currently book, cancel or change appointments directly in the App. Development discussions include digital letters, appointment cancellation/amendment, self-booking, waiting list information, patient preferences, PROMs/PREMs and wider integration. Timelines for functionality are not currently available.



Are cancer services improving?

Aneurin Bevan University Health Board

August 2026

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Audit snapshot

What we looked at

- 1 We looked at Aneurin Bevan University Health Board's (the Health Board)'s approach to managing cancer services. This includes how it plans services, prevents cancer, supports early detection, and leads and oversees service performance.
- 2 We also reviewed trends in cancer service performance. Our 2025 [national report on cancer services](#) highlighted data quality concerns and recommended improvements at a national level. We have not reviewed data quality as part of this review.

Why this is important

- 3 Demand for cancer services is increasing, driven by factors such as:
 - an ageing population;
 - rising levels of obesity and alcohol use;
 - better survival rates, meaning patients need ongoing follow-up and monitoring; and
 - the ongoing introduction of new tests and treatments.
- 4 Cancer outcomes are worse when patients wait too long for treatment. Long waits can shorten life expectancy and reduce quality of life after treatment. This increases pressure on health boards to deliver timely care.
- 5 Cancer services account for a growing share of NHS spending. This is driven by increasing demand and the costs of new tests and treatments.

What we have found

- 6 The Health Board has worked well to manage increasing service demand without a corresponding significant worsening of waiting times performance. However, actions to improve cancer services have not yet led to lasting improvement. Performance is still well below the 75% target. In 2025–26, only 61% of patients started treatment within 62 days. The overall average performance also hides wide differences between services. In particular, urology and gastrointestinal pathways are underperforming.
- 7 The Health Board has taken steps to manage immediate pressures. These include running extra clinics, filling staff vacancies, and changing care pathways. These actions have helped to steady demand in the short term. Whilst they have improved capacity for treating breast and skin cancer, they have not dealt with deeper capacity problems. As a result, overall performance has not improved. The Health Board expects to meet national targets by late 2026–27, but current progress suggests it is not on track.
- 8 The Health Board has strengthened its cancer service leadership and operational oversight. This has helped to increase focus on cancer care. However, gaps in reporting, limited use of intelligence, and weak Board and committee scrutiny means that progress is slow. The Health Board is proactively taking steps to improve cancer prevention and screening, but we are concerned that scale of these initiatives might not be sufficient to have the required impact.
- 9 The Health Board understands the challenges it faces. However, its approach is mainly reactive rather than planned ahead. Whilst its working on updating its cancer strategy, it does not have a clear, detailed improvement plan. This makes it harder to respond to rising demand and to meet treatment targets. This is a growing concern, as cancer service costs are rising faster than inflation and there is no clear long-term financial plan.

What we recommend

10 We have made seven recommendations to the Health Board in the following areas:

- approving a new Cancer Strategy;
- monitoring the delivery of the plan;
- developing a costed cancer improvement plan to deliver the strategy;
- developing a long-term cancer workforce plan;
- improving the tracking of cancer improvement actions;
- working with partners to improve analysis of cancer screening data; and
- including a wider range of data in monitoring reports.

Key facts and figures



The number of new suspected cancer referrals rose by 11% between 2022–23 and 2025–26.



Spending on cancer services rose from £90 million to £138 million between 2019–20 and 2023–24. This is £31 million more than if spending had kept pace with inflation over the same period.



In March 2026, most referrals were for suspected lower gastrointestinal (748), breast (392) and upper gastrointestinal (373) cancers.



In March 2026, 63.1% of patients started treatment within 62 days compared with the 75% target.



In March 2026, there was wide variation in treatment waiting times. Performance ranged from 91% for skin cancer to just 36% for gynaecological cancer, against a 75% target.



Between 2002 and 2024 one-year cancer mortality rates have fallen by 15.9%.

Our findings

Cancer service improvement planning

Cancer planning is not joined up leading to fragmented, reactive cancer improvement, rather than longer-term sustainability

Cancer improvement plans

- 11 The Board approved a Cancer Strategy for 2020–25 that aligned with national policy, national targets and person-centred care. However, the strategy is now out of date and, although a refresh is in progress, the Health Board does not yet have clear reporting mechanisms in place to routinely monitor delivery of the strategy and provide assurance to the Board and its committees that implementation is on track.
- 12 The Annual Plan 2026–27 sets out high-level priorities for the year. These include redesigning pathways, addressing underperformance, and improving Multi-disciplinary Team governance. While these priorities broadly align with national expectations, the links to the All-Wales Cancer Improvement Plan 2023–26 are unclear. The Annual Plan 2026–27 understandably does not provide detail on the enabling workforce, finances, systems or estate to meet cancer demand in the short- or longer-term. This is a clear gap which a stand-alone cancer plan would need to address.
- 13 There is no clear approach setting out how the Health Board will meet the Suspected Cancer Pathway (SCP) standard or strengthen services to meet growing demand and growing costs for diagnosis or treatment. Actions to address cancer inequalities are underway, but again these are not yet clearly built into service planning.

- 14 The Health Board does assess adherence to National Optimal Pathways¹, but planning assumptions appear too optimistic. Recovery actions remain high-level and lack clear timescales, ownership, measurable impact, and clear links to performance recovery. As a result, responses to pressures are often short-term and rely on measures such as overtime and backlog initiatives.
- 15 The Health Board does not expect to meet national SCP targets until quarter 4 of 2026–27. However, the Health Board has not made sufficient progress against planned improvements to provide confidence that it will meet this aim.

Cancer intelligence and data

- 16 The Health Board needs to better use data analysis and intelligence to inform service planning. The Health Board uses referral data and projections to support day-to-day scheduling of services. However, this approach is generally reactive and not used to inform medium-to longer-term planning. Intelligence shows a clear increase in cancer demand. However, this has not led to a matching increase in workforce capacity. This could make it harder to achieve the SCP targets and directly affect patient outcomes.
- 17 The Health Board regularly reports cancer demand and performance data². Operational teams and Executives clearly understand the differing performance and risks for different cancers. This helps the Health Board to identify services that are under pressure and supports occasional detailed reviews.

¹ Standardised, evidence-based care pathways designed to improve cancer diagnosis and treatment.

² Cancer demand and performance data includes referral volumes, backlogs, waiting times, conversion rates and SCP compliance.

- 18 The Health Board collects data on different stages of the pathway, which it primarily uses for operational management. This includes time to first outpatient appointment, compliance with diagnosis within 28-days targets, and the time from decision to treat to treatment start. However, the Health Board does not routinely report this information to committees or the Board. This data would help the Board understand where pressures exist along the pathway to inform medium- to long-term investment prioritisation.
- 19 The Health Board is not making the best use of outcomes data to inform decision making and targeted action. As a result, focus is on meeting cancer targets rather than whether the Health Board is improving patient outcomes. We understand that the Health Board is planning to introduce a set of outcomes-based metrics. This includes information on survival, stage at diagnosis and longer-term outcomes.

Supporting fragile services

- 20 The timeliness of cancer treatment depends on the type of cancer a patient has. Most of the patients waiting longer than 62 days on the suspected cancer pathway are in the lower gastrointestinal, upper gastrointestinal and urology pathways.
- 21 The main causes of pressure are well known and regularly discussed. These include limited diagnostic capacity, shortages of staff and reliance on specialist (tertiary) providers³. The challenge using tertiary providers is ensuring timely radiotherapy, chemotherapy and/or specialist procedures. The Health Board has set up Gynaecological, Urology and Colorectal services recovery groups to help address underperformance. This shows a strong understanding of where risks to delivery are highest, and a commitment to address the issues.

³ Tertiary providers for the Health Board include Velindre University NHS Trust, Swansea Bay University Health Board, Cardiff & Vale University Health Board and NHS England.

- 22 Cancer is a priority for regional working. The Health Board discusses issues that it cannot resolve locally with their partners through regional planning forums. Regional cancer service models are also being developed, including shared workforce planning, outreach services and joint multidisciplinary team working. However, these arrangements are still developing, and it is not yet clear how or if they will improve service capacity and efficiency.

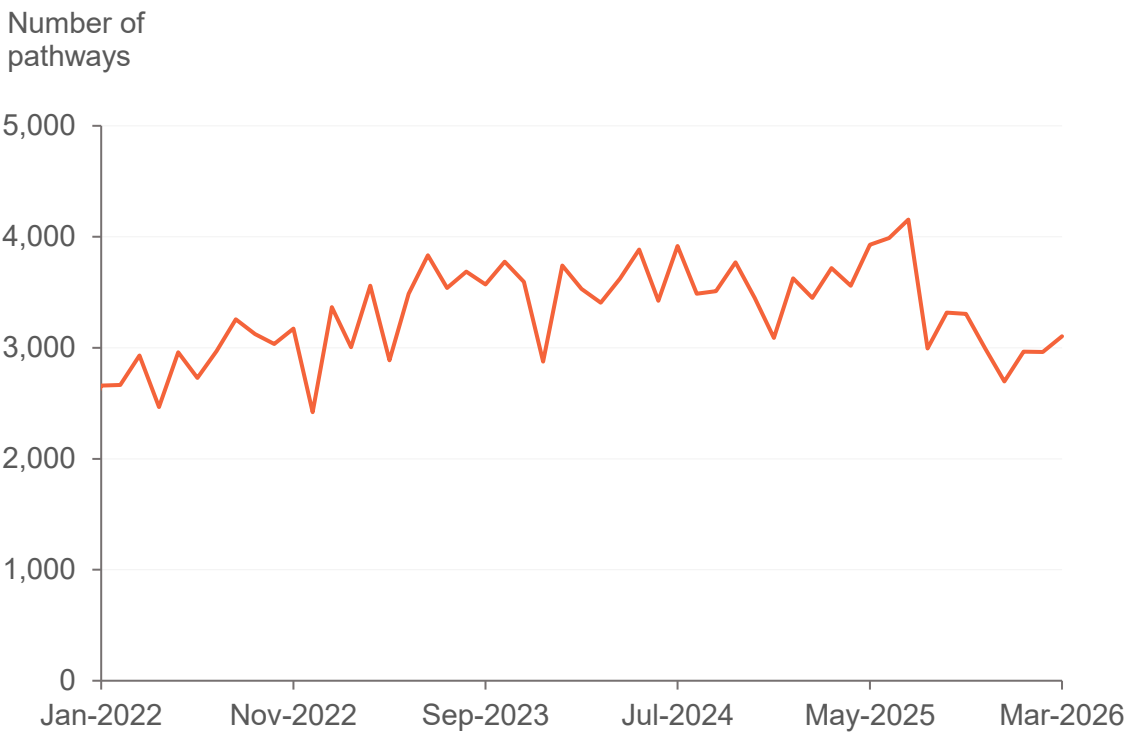
Financial and resource planning

The absence of comprehensive financial and resource plans for cancer services, limit assurance that resources can meet rising demand and national targets

Funding plans

- 23 The Health Board has not sufficiently costed the total investment required to fund its cancer service improvement actions. Instead, it relies on ad-hoc business cases and short-term funding for local developments. This makes it hard to see the full investment needed to drive service improvements to meet cancer standards and targets. It also does not provide the assurance that the totality of planned improvements needed to meet targets are affordable.
- 24 **Exhibit 1** shows the number of new suspected cancer pathways opened each month. This shows an ongoing increase until mid-2025, then a reduction. There has been a notable increase in referrals between 2022–23 and 2025–26 in head and neck (+26%), gynaecological (+16%) and breast (+15%) tumour sites. While new referrals are currently lower than a couple of years ago, the costs have risen faster than inflation (**Exhibit 2**).

Exhibit 1: newly opened suspected cancer pathways, Aneurin Bevan University Health Board, January 2022 to March 2026 (number)

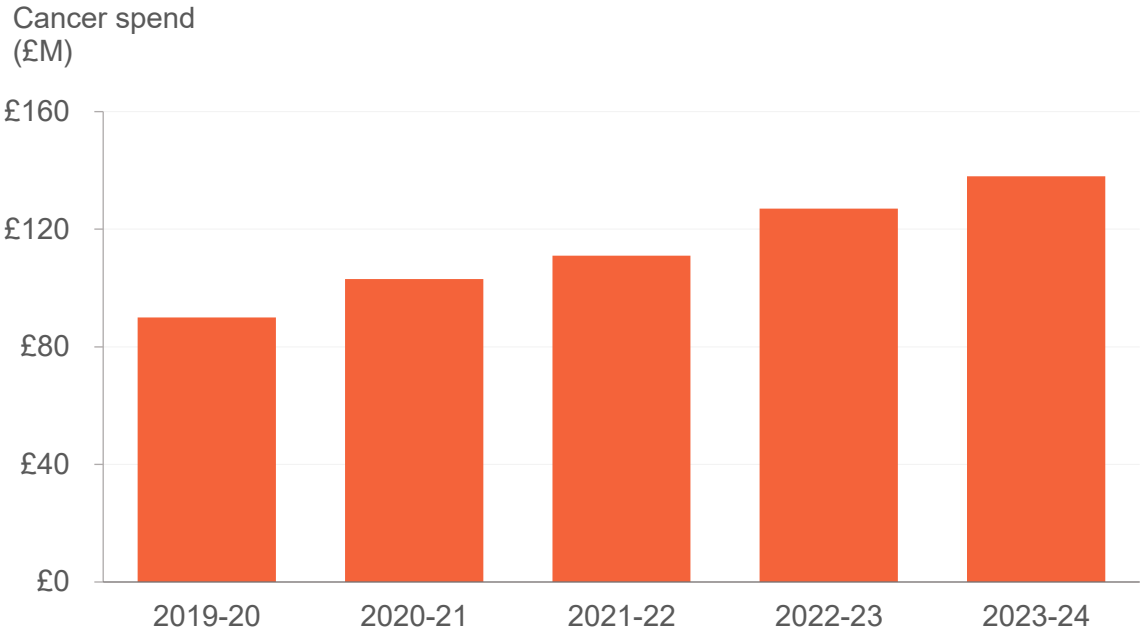


Source: Audit Wales analysis of Digital Health and Care Wales data

Note: Under the suspected cancer pathway (SCP), a pathway starts at the point of suspicion, for example when a GP makes a referral. Pathways are closed, and waiting times end, when patients start their first definitive treatment, are downgraded (told they do not have cancer), choose not to have treatment or if the patient died. Note that patients can be on more than one pathway

25 **Exhibit 2** shows spending on cancer services between 2019–20 and 2023–24. Over this period, the Health Board’s cancer spending rose by around 29% above inflation⁴. Hospital cancer medicines spending has also risen. Between 2019–20 and 2024–25, spending on cancer medicines increased from £10 million to around £15.4 million^{5,6}. This is about £3.1 million more than if costs had increased in line with inflation (2024–25 prices).

Exhibit 2: actual cancer services spend, Aneurin Bevan University Health Board, 2019–20 to 2023–24, (£million)



Source: Audit Wales analysis of Health Board data, sourced from the Welsh Government

⁴ Inflation is calculated using 2023-24 as a baseline and HM Treasury inflation data.
⁵ Some speciality medicine costs cover both cancer and other treatments but are included in the total. This is unlikely to have a substantial impact on the overall figures.
⁶ Medicine figures cover hospital spending by the Health Board only and exclude costs for patients treated elsewhere.

- 26 Cancer service costs are not set out in the Annual Plan 2026–27. While the Health Board has set out costs in divisional budgets, it is difficult to identify the totality of the planned cancer spend. This is a significant weakness given the scale of cancer services, rising demand, and ongoing cost pressures, including high-cost drugs. **Exhibits 1 and 2** broadly show that increases in cost align to increased demand. However, cost growth is exceeding inflation and needs to be effectively planned for.
- 27 The Health Board does not have a single costed delivery programme for cancer services. There is evidence of finance reporting to inform planning at individual service level, including forecasts, pay and non-pay costs, savings schemes, and known financial risks and pressures. However, this information is not used to inform a consolidated, costed plan for cancer.

Wider resourcing requirements

- 28 The Health Board clearly understands its workforce pressures. This includes vacancies, skills shortages, and limited capacity. These challenges are particularly evident in breast, gynaecology, and urology. It has taken action to manage current risks. This includes recruiting specialist staff and redeploying staff.
- 29 Workforce challenges are not confined to cancer services, with many staff contributing across both cancer and planned care pathways. While recognising these interdependencies, the Health Board does not have a clear workforce plan that sets out how it will develop and sustain the workforce needed to meet future demand. As a result, workforce planning remains focused largely on addressing immediate pressures rather than building longer-term capacity and resilience.
- 30 The Health Board includes cancer estates plans in its corporate estates strategy. Major developments, such as cancer centre designations and the Satellite Radiotherapy Unit⁷, show that cancer is a priority for estates investments.

⁷ The Radiotherapy Satellite Centre at Nevill Hall Hospital in Abergavenny is funded by the Welsh Government. This investment is part of a wider package announced in 2023 to upgrade

- 31 The Health Board has an established five-year diagnostic equipment replacement programme, including processes to prioritise additional capacity and replacement needs. However, equipment planning is managed separately from cancer service delivery planning and is not brought together within a single cancer delivery plan. As a result, there is limited assurance that future equipment requirements are systematically aligned to anticipated growth in cancer demand.
- 32 The Health Board recognises that digital capability is important. Live cancer tracking dashboards support day-to-day oversight. However, digital in the main supports day-to-day tracking, rather than service transformation.

radiotherapy services in Southeast Wales, with the facility designed to bring care closer to patients' homes. It is staffed by Velindre University NHS Trust.

Cancer prevention and population screening

While taking positive and innovative action, the Health Board is not maximising the benefits of cancer prevention

33 The All-Wales Cancer Improvement Plan estimates that 38% of cancers each year are preventable. To give this context, if the Health Board prevented 20% of cancers, it could have saved £2.3 million in bed day costs in 2024–25, based on the most recent available financial data. **Exhibit 3** shows the potential gains if the Health Board successfully implemented a cancer prevention strategy.

Exhibit 3: potential capacity gains from cancer prevention, Aneurin Bevan University Health Board, based on 2024–25 activity

		2024–25 actual	-10% reduction	-20% reduction	-38% reduction
	Finished consultant episodes	16,755	15,080 (1,676 reduction)	13,404 (3,351 reduction)	10,388 (6,367 reduction)
	Admission episodes	14,842	13,358 (1,484 reduction)	11,874 (2,968 reduction)	9,202 (5,640 reduction)
	Bed days	22,947	20,652 (2,295 reduction)	18,358 (4,589 reduction)	14,227 (8,720 reduction)
	Bed day cost savings		(£1.2 million)	(£2.3 million)	(£4.4 million)

Source: Audit Wales analysis and modelling of Digital Health and Care Wales data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets for Welsh providers

Note:

- 1) The analysis outlines the broad impact of a 10%, 20% and 38% reduction in cancer cases, based on 2024–25 activity levels.
- 2) Savings calculation based on £500 per day cost of an NHS bed in Wales used in our [2025 National Cancer Services Report](#).

Public health risk assessment

- 34 Population health intelligence is strong and well understood but this isn't yet driving large-scale cancer prevention initiatives. The Health Board has developed a Population Health Cancer Dashboard, which has received national recognition. The dashboard brings together data on cancer rates and key risk factors, such as smoking, alcohol use, and body mass index. It also shows differences by age, gender, deprivation, and location. This helps the Health Board understand cancer risk, variation, and inequalities across the population. It also provides assurance that there is understanding of where targeted prevention work would be beneficial.
- 35 The Health Board has set up a Cancer Board as a strategic forum for overseeing cancer service delivery. The Cancer Board uses the intelligence to inform discussions and decisions. However, beyond the Cancer Board, the Health Board does not sufficiently use population health data to inform cancer prevention planning, priorities and delivery plans.

Approaches to improving population lifestyles

- 36 The Health Board is delivering a range of programmes to promote healthy lifestyles that reduces cancer risk. However, the long-term impact of local cancer prevention initiatives is limited due to insufficient funding and prioritisation. The Health Board's Annual Plan 2026-27 clearly sets prevention and population health as priorities. However, interviewees indicated that spending on prevention is a small part of overall Health Board funding and more could be invested to improve overall impact.

- 37 Ongoing funding supports key programmes such as smoking cessation, healthy weight services, vaccination, and screening uptake. Programme uptake and outcomes are monitored by Public Health team, and some metrics at Finance & Performance Committee. This shows that the Health Board manages and evaluates prevention programmes.
- 38 The Public Health team also develop local prevention initiatives, along with targeted campaigns in areas of low uptake. These business cases go to the Executive Team for approval and are tested for alignment with priorities. Initiatives such as Alcohol “Try Dry” take an evidence-based approach to address lifestyle risks linked to cancer. However, some activities, such as the community-based skin cancer prevention initiative, depend on short-term funding or have limited staff capacity. This makes it harder to manage and may limit the positive impact that the schemes were designed to achieve.
- 39 The Health Board also participate in National public health programmes, including Help Me Quit and Healthy Weight Healthy You, strongly shape how prevention funding is used. These programmes support cancer prevention and focus on high-risk groups.

Targeted prevention and population screening

- 40 There are clear referral routes to diagnosis and treatment for patients whose cancer is detected through each of the national screening programmes. The Health Board has limited access to timely screening data. Screening data is not available in real time, which restricts the Health Board’s ability to monitor and plan to meet demand resulting from screening. Performance data also shows that screening is not consistently leading to timely diagnosis and consequently starting treatment, particularly for colorectal cancer, due to limited colonoscopy capacity.
- 41 The Health Board has some understanding of inequalities of screening uptake. The Health Board’s Public Health team analyses uptake by deprivation, geography, age and sex. They consider barriers such as access and health literacy to identify targeted actions. These actions include predicting non-attendance, active patient follow-up and the use of patient stories to address fear and disengagement.

- 42 Human papillomavirus vaccination (HPV) rates are below the Health Board's national target of 90%, last reported at around 77% in September 2025. The Health Board has introduced school-based delivery, community outreach, and other actions set out in the Vaccine Inequity Strategy. Despite this, these actions have not yet led to sustained improvement.

Cancer leadership and oversight

While leadership are supporting operational improvements, there is a need for better oversight of the strategic direction of cancer services

Managerial leadership

- 43 There is now clear leadership for cancer services, after a period of instability. The Chief Operating Officer has overall responsibility, supported by a Senior Responsible Owner and a Clinical Lead. This provides a clear and more joined-up approach to leadership. Prior to this, the COVID pandemic, changes in senior staff, service changes and regional tensions disrupted leadership stability and continuity. While recent appointments and executive focus aim to address this, the effects are still visible in cancer performance and progress.
- 44 Senior managers make decisions on priorities and spending within agreed limits. The Health Board's Divisional Management Team meetings are supporting timely decision making, when needed. In the past, this has included approving funding for extra clinics and other short-term actions to meet demand.
- 45 The Health Board's Cancer Board includes staff, primary care, third-sector partners, and patient representatives. This helps to promote openness and joint working to solve problems. This collaborative approach is also evident at operational level. Structured forums, including assurance meetings and tumour-specific recovery groups help teams keep track of performance and waiting lists and take shared action where needed.

- 46 Regional working and leadership are essential to make sure that patients get the right cancer care at the right time. In south-east Wales whilst health boards plan and deliver many parts of the cancer diagnosis and treatment pathway, they commission and fund Velindre University NHS Trust to provide non-surgical specialist cancer services⁸ for most patients. It is imperative that joint working ensures effective planning, referral, and continuity of cancer care across organisational boundaries.

Oversight and scrutiny

- 47 The Board and the Finance and Performance Committee regularly review cancer performance information. Reports include performance against the target for 75 per cent of patients to start treatment within 62-days of suspicion. The reports also include, waiting list backlog levels, performance trajectories, key risks, and key actions. This gives a good high-level view. However, reports are missing measures such as average waiting times, tumour-specific performance and cancer outcomes. This is important because the average performance can mask significant variation across tumour sites. This may limit the Board and Finance and Performance Committee's ability to seek targeted assurance on services that have the greatest impact on patient outcomes.
- 48 Finance and Performance Committee minutes suggest that there has been limited scrutiny when cancer performance targets are missed. Equally, Board and committee minutes show that challenge on the proposed actions needed is weak. This is a greater concern because reported improvement actions are often high-level and lack detail.

⁸ including radiotherapy, chemotherapy, and other systemic anti-cancer treatments (SACTs).

- 49 The Health Board has an established Cancer Board, chaired at Executive level (Chief Operating Officer), which has met bi-monthly since 2020 with consistent clinical engagement. Furthermore, they produce a comprehensive and well-structured Annual Cancer Report that provides assurance that improvement work is ongoing. However, it lacks detail on whether those activities are translating into sustainable improvements in performance and outcomes.

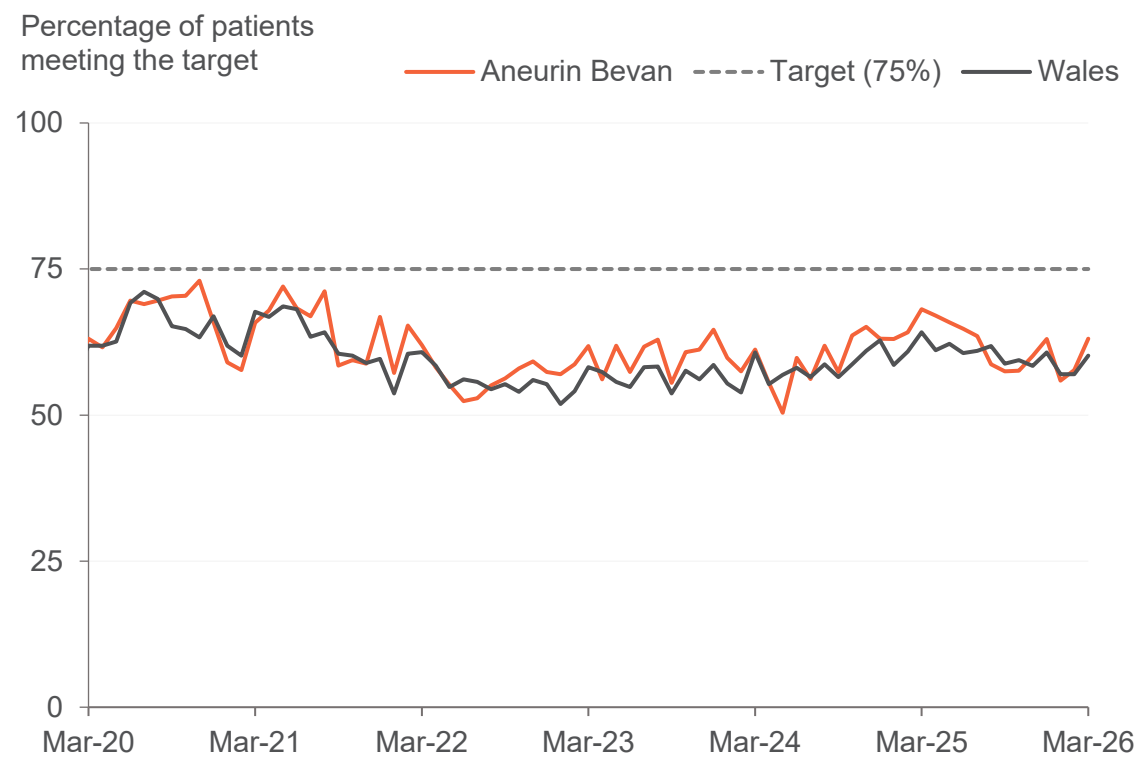
Cancer performance

Some patients are facing unacceptably long waits, and the actions to improve are not enabling the Health Board to meet its targets

62-day cancer performance

- 50 The Welsh Government target is for 75% of patients to start their first treatment within 62 days from the first point where cancer is suspected.
- 51 Early diagnosis and prompt treatment improve outcomes. They increase survival rates and enhance quality of life. Long waits can lead to more advanced cancer. This may reduce life expectancy, limit treatment options and affect physical health after treatment.
- 52 **Exhibit 1**, outlined earlier in the report, shows that the number of new suspected cancer pathways opened each month has grown. Despite this, the Health Board has done well to ensure performance has not deteriorated. However, the Health Board's performance, although reflecting the average achieved in Wales, is falling well short of meeting the national cancer target (**Exhibit 4**). It is widely accepted that the number of cancer cases will continue to increase in Wales and service pressures are expected to grow.

Exhibit 4: patients meeting the 62-day cancer treatment target, Aneurin Bevan University Health Board, March 2020 to March 2026, (percentage)



Source: Audit Wales analysis of Digital Health and Care Wales data

Note: The data includes patients who started treatment and those waiting for confirmation that they do not have cancer.

- 53 The Health Board is not meeting the 62-day Welsh Government target. However, overall performance also hides large differences between sex and tumour types. For example, between December 2025 and March 2026, between 8% and 14% more men than women waited beyond the target.
- 54 Some areas, such as skin cancer, are performing better. In March 2026, skin cancer pathways met the target with 88.3% of patients starting their treatment within 62 days. **Exhibit 5** shows performance across four common cancer tumour sites. It raises significant concerns about urological and lower gastrointestinal cancer case timeliness.

Exhibit 5: patients meeting the 62–day cancer treatment target by tumour site, Aneurin Bevan Health Board, 12-month average during 2025–26 (percentage)



Source: Audit Wales analysis of Digital Health and Care Wales data

Notes:

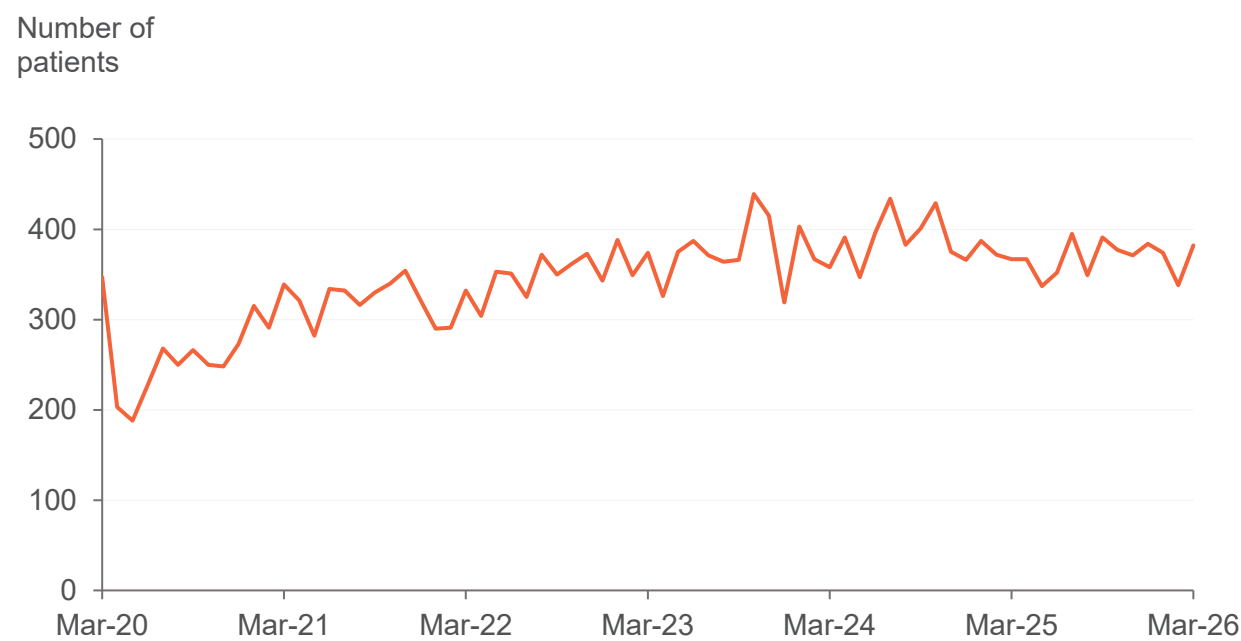
1. The data shown average 62- day performance over the most recent 12-month period (March 2025 to March 2026).
2. The data includes patients who started treatment and those waiting for confirmation that they do not have cancer

Impact of action to improve cancer services

- 55 The action taken by the Health Board is helping to manage short-term risks. But this is not significantly improving performance overall or addressing significant underperformance for some tumour sites. This is likely to be affecting the outcomes for some groups of patients.
- 56 Workforce pressures are a major challenge for cancer services. Managers have reactively responded to immediate risks. These include recruiting consultants and cancer nurse specialists, using locums and changing clinic scheduling. However, these actions do not close underlying capacity gaps or sustainably match capacity to demand.
- 57 The Health Board is trying to address diagnostic and treatment capacity shortfalls. Its actions include redesigning care pathways, speeding up pathology results and waiting list initiatives. If there are issues that teams cannot solve locally, they develop business cases to seek extra funding. This has supported investment in specialist equipment, such as surgical robots, new endoscopy solutions and specialist testing⁹.
- 58 Performance against the 62-day target suggest that the actions taken have not had sufficient impact to improve capacity. The number of new patients starting treatment each month has not notably increased since 2023 (**Exhibit 6**). However, the Health Board has indicated that wider overall treatment activity throughout the pathway have increased.

⁹ HER2 testing identifies if breast or stomach cancers have high levels of the HER2 protein or gene, which drives cancer growth. Testing helps determine eligibility for targeted therapies.

Exhibit 6: cancer patients starting treatment each month, Aneurin Bevan Health Board, March 2020 to March 2026 (number)



Source: Audit Wales analysis of Digital Health and Care Wales data

59 The Health Board needs to do more to reflect on the impact of the actions that it is taking. Improvement actions are not clearly prioritised and do not have realistic improvement targets. There is no routine evaluation of the impact of action taken and the resulting impacts. There is little evidence that learning from previous initiatives, including ‘Lean systems’ training, is consistently applied through formal improvement methods such as PDSA cycles¹⁰.

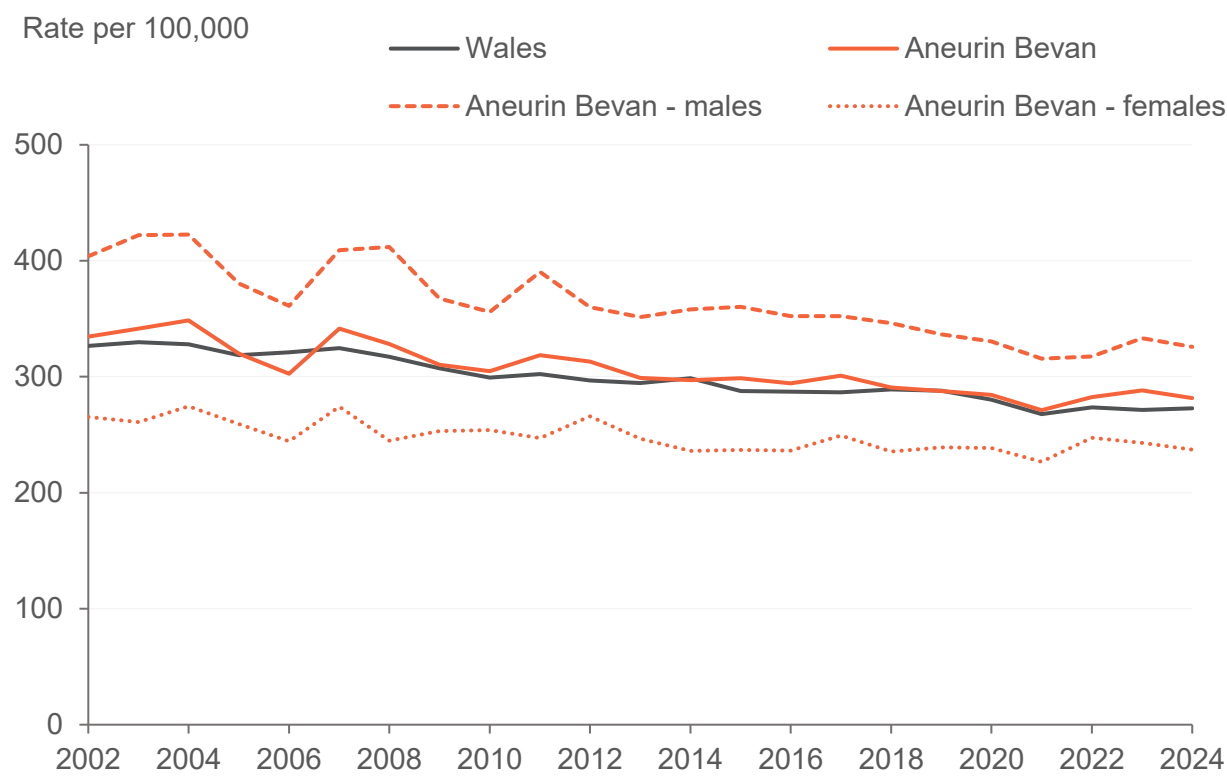
¹⁰ PDSA cycles (Plan-Do-Study-Act) are a four-stage, iterative problem-solving model used to test, implement, and refine changes for process improvement.

Improving cancer outcomes

60 Mortality, stage at diagnosis, PROMs and PREMs data are reviewed in specialty clinical effectiveness meetings. However, there is little evidence that services use outcomes data to inform priorities, recovery planning, or system-wide improvement.

61 **Exhibit 7** shows the one-year mortality rate for the Health Board.

Exhibit 7: one-year cancer mortality, Aneurin Bevan University Health Board 2002 – 2024 (rate per 100,000 population)



Source: Audit Wales analysis of Public Health Wales NHS Trust data

Note: Deaths where cancer is the primary cause, using the European Age Standardised Rate to enable fair comparisons over time and place.

- 62 Analysis of one-year cancer mortality data from 2002 to 2024 in **Exhibit 7** shows a consistent reduction in one-year mortality over the last 20 years. This represents a positive long-term trend and suggests that improvements in cancer prevention, early detection and treatment are having a beneficial impact. The Health Board's cancer mortality rate is also lower than the Wales average. However, outcomes for males remain worse than for females.

Recommendations

Cancer services planning

- R1** The Health Board should prioritise the completion and Board approval of its new Cancer Strategy (**paragraph 11**).
- R2** The Health Board should ensure reporting mechanisms are in place to operationally monitor the delivery of the cancer strategy and provide assurance to the Board and committees that delivery is on track (**paragraph 11**).
- R3** The Health Board should develop a fully costed organisation-wide cancer improvement plan to ensure sustainable delivery of the cancer strategy as demand increases (**paragraph 12**).
- R4** The Health Board should ensure that the cancer improvement plan includes SMART¹¹ cancer improvement actions with defined responsibilities for delivery (**paragraph 14**).

¹¹ Specific, Measurable, Achievable, Relevant, and Time-Bound

R5 The Health Board should develop a clear, long-term cancer workforce plan that sets out how it will address capacity and skills gaps to build sustainable workforce provision tailored to future demand **(paragraph 29)**.

R6 Health boards should work collectively with Public Health Wales NHS Trust to agree as soon as possible a comprehensive set of data analysis on screening services, including:

- Timeliness across each part of the current three cancer screening pathways and lung screening once it is fully rolled out.
- Information on uptake screening rates and variations by population groups (including age, location, sex (where applicable), and ethnicity).

(paragraph 40).

Cancer progress reporting

R7 The Health Board should improve cancer reporting by including average waiting times, tumour-specific performance, and outcomes to better support Board scrutiny and targeted assurance **(paragraphs 47 - 49)**.

Appendices

1 About our work

Scope of the audit

We looked at the following areas:

- How well the Health Board plans its cancer services and whether they align with the National Cancer Plan, Quality Statement and Cancer Recovery Programme.
- How the Health Board seeks to reduce cancer prevalence by targeting preventative actions and supports screening programmes to detect cancer sooner.
- How cancer services are led and managed to drive improvements.
- How services are performing and the actions that the Health Board is taking to drive service improvement and achieve better patient outcomes.

We did not consider service quality, clinical governance or patient experience.

We have also not completed an audit of the data used in this review, but we have looked at the all-Wales data validation process.

Audit questions and criteria

Questions

We used the following questions to focus our fieldwork:

- Has the Health Board clearly set out how it will achieve timely and equitable access to cancer diagnosis and treatment?
- Has the Health Board set out a coherent approach to cancer prevention?
- Is the Health Board providing strong leadership and governance for timely and equitable access to cancer diagnosis and treatment?

- Is the Health Board making progress to deliver timely and equitable access to cancer diagnosis and treatment?

Criteria

We assessed the Health Board's arrangements against the following criteria:

- The Health Board has clear funded plans based on sound business intelligence which sets out cancer services priorities and objectives, and the approach it is taking to achieve them.
- The Health Board has a clear approach to target population health improvements as means to reduce cancer prevalence in the longer-term.
- The Health Board's leadership for cancer services work collaboratively and are empowered to drive cancer service improvements in the short and longer-term.
- The Health Board is making continuous improvement on 62-day cancer performance, successfully addressing underperforming services and driving improvements to achieve better outcomes for patients.

Methods

Our audit methods included document review, data analysis, and interviews. We interviewed the following:

- Cancer Services Manager;
- Chief Operating Officer;
- Clinical Lead for Cancer;
- Division Director for Clinical Support Services;
- Head of Public Health; and
- Strategic Lead Cancer Nurse.

We also held a focus group with the operational specialty management leads.

2 Key terms in this report

Term	Description
Admission episodes	The first period of care under a consultant with a health provider's episode of care.
Bed days	A day during which a patient occupies a hospital bed and stays overnight in the hospital.
Bed days cost savings	The financial benefits gained from reducing the number of hospital bed days.
Cancer Quality Statement	National statement outlining quality expectations for cancer care and outcomes across NHS Wales.
Cancer Recovery Programme	Programme of actions intended to restore/improve cancer services post-disruption (e.g., COVID-19), focusing on waits, pathways and outcomes.
European Age-Standardised Rate (EASR)	A rate adjusted to a standard European population age-structure to enable fair comparisons over time/places.
Finished consultant episodes	Refer to the periods of patient care under a consultant's supervision that have concluded due to discharge, transfer, or death.
Multidisciplinary Team	Multidisciplinary Team working is where health and care professionals from different specialisms work together to agree a patient's care.
National Cancer Improvement Plan	National plan setting priorities and actions for improving cancer services across Wales, aligning health boards to common standards and trajectories.

Term	Description
Patient-Reported Experience Measures (PREMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PREMs focus on the experience of care (how it was received).
Patient-Reported Outcome Measures (PROMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PROMs measure the effectiveness of treatment on health status
Population health risks	Modifiable risk factors (e.g. smoking, obesity, alcohol) associated with cancer incidence in local populations.
Real terms spend	Expenditure adjusted for inflation to reflect true purchasing power over time.
Stage at diagnosis	The extent of cancer spread at the time of diagnosis, strongly linked to outcomes and treatment options.
Suspected Cancer Pathway (SCP)	The all-Wales performance standard that 75% of patients should start their first definitive treatment within 62 days from the point of suspicion.
Systemic Anti-Cancer Therapy (SACT)	Drug treatments circulating via the bloodstream (e.g., chemotherapy, targeted and immunotherapies) to treat cancer
Screening	A preventive medical test designed to detect cancer early, often before symptoms appear, improving the chances of successful treatment
Tumour site	The anatomical location/type of cancer (e.g. lower gastrointestinal, lung, breast, urological, skin).

Term	Description
Waiting list initiatives	Waiting list initiatives are targeted actions or interventions designed to reduce patient waiting times and manage waiting list backlogs (e.g. additional clinics, extra sessions, outsourcing or insourcing).

3 Management response form

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R1 The Health Board should prioritise the completion and Board approval of its new Cancer Strategy.	The Health Board has completed an evaluation of the 2020–2025 Cancer Strategy, which will be considered by the Executive Committee in July 2026. Development of a new Gwent Cancer Plan, aligned to the Gwent 2035 Strategy, is underway. Engagement workshops are being undertaken to inform the six strategic pillars of the plan, which will be submitted to the Executive Committee for approval. Following publication of the Welsh Government National Cancer Strategy, expected in February 2027, the Gwent Cancer Plan will be reviewed and, where necessary, updated to ensure alignment with the national strategic direction, priorities and implementation requirements.	31 March 2027	Chief Operating Officer Supported by: Assistant Medical Director for Cancer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R2 The Health Board should develop a fully costed organisation-wide cancer improvement plan to ensure sustainable delivery of the cancer strategy as demand increases.	The Health Board accepts this recommendation and will develop a fully costed Cancer Improvement Plan aligned to the current Welsh Government Quality Statement for Cancer, Single Cancer Pathway requirements, National Optimal Pathways and the Gwent Cancer Plan. The plan will identify the workforce, digital, infrastructure, service redesign and investment requirements necessary to support sustainable improvement in cancer services. It will include clear priorities, delivery milestones, affordability assessments, expected benefits and defined governance arrangements for implementation and monitoring. Following publication of the Welsh Government National Cancer Strategy, expected in February 2027, the Improvement Plan will be reviewed and updated, where necessary, to ensure alignment with the national strategic direction and implementation requirements.	31 March 2027	Chief Operating Officer Supported by: Senior Responsible Officer & Senior Programme Manager for Cancer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R3 The Health Board should ensure that the cancer improvement plan includes SMART ¹² cancer improvement actions with defined responsibilities for delivery.	Cancer Improvement Plans will include defined actions, measurable outputs, named responsible leads and delivery timescales. Action logs will be developed for each tumour site and approved by tumour site leads and divisional teams to support implementation. Progress and delivery against actions will be monitored and reported through Cancer Board governance arrangements.	31 October 2026	Chief Operating Officer Supported by: Cancer Services Manager
R4 The Health Board should develop a clear, long-term cancer workforce plan that sets out how it will address capacity and skills gaps to build sustainable workforce	Directorates will develop integrated workforce plans to support sustainable service delivery and future cancer demand. Plans will include workforce baselines, capacity gap assessments, demand modelling, skills mix reviews and recruitment and retention actions.	31 March 2027	Chief Operating Officer Supported by: Deputy Director of Workforce

¹² Specific, Measurable, Achievable, Relevant, and Time-Bound

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
provision tailored to future demand.	The workforce plan will inform the 2027/28 IMTP process.		
R5 The Health Board should ensure reporting mechanisms are in place to operationally monitor the delivery of the cancer strategy and provide assurance to the Board and committees that delivery is on track.	Oversight of delivery will be provided through Cancer Board reporting to the Executive Committee, with periodic assurance reporting and annual deep dives to the Public Board. Re-established and strengthened the Health Board Cancer Board with clear terms of reference, executive leadership and multidisciplinary membership. Evidence of regular meetings and action tracking is in place. Cancer Programme formally designated as one of the Health Board's priority programmes with executive sponsorship from the COO. This will ensure regular updates into Public Board, and scrutiny via our annual plan / IMTP process.	Completed July 2026	Chief Operating Officer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
	Cancer performance is now reviewed routinely through: • SRO Led performance meetings • Cancer Board • Divisional Performance Reviews • Executive oversight arrangements • Board Deep Dives and Board reporting. A dedicated Cancer Programme Deep Dive has been presented to Board setting out achievements, risks, performance and future priorities. Tumour-specific action plans and programme reporting are being developed to support delivery monitoring and accountability.		
R6 The Health Boards should work with Public Health Wales NHS Trust to	Public Health Wales now provides quarterly screening reports to Health Board representatives. The Health Board will continue to work with Public Health Wales to	Ongoing	Chief Operating Officer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
agree as soon as possible a comprehensive set of data on screening services, including: • Timeliness across each part of the three cancer screening pathways; and • Information on uptake rates and variations by population groups (e.g. age, location, sex (where applicable), and ethnicity).	develop an agreed dataset covering screening timeliness, uptake rates and variation across population groups. Opportunities to enhance reporting through more accessible and interactive platforms will also be explored. Progress is monitored through screening pathway improvement meetings and reported through established cancer governance arrangements.		Supported by: Head of Public Health team ABUHB
R7 The Health Board should improve cancer reporting by including average	Existing cancer reporting will be enhanced to include average waiting times, tumour-specific performance	31 March 2027	Chief Operating Officer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
waiting times, tumour-specific performance, and outcomes to better support Board scrutiny and targeted assurance.	measures and conversion-to-cancer rates by tumour site. Following approval of the Cancer Plan, a revised performance framework will be developed which includes a broader range of outcome measures aligned to the plan's strategic priorities.		Supported by: Cancer Services Manager & Senior Responsible Officer for Cancer

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

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Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 September 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 (the 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.

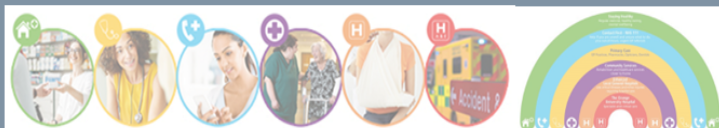
ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

This report provides the Committee with an exception-based assessment of the strategic risks delegated to it by the Board. It highlights risks outside appetite, material areas of exposure, the effectiveness of key mitigating actions and the matters requiring continued Committee scrutiny.

The overall risk profile has remained unchanged since the last report in June. However, Financial Sustainability, SRR 001G, and Performance Improvement, SRR 001I, remain outside the agreed risk appetite.

Both risks require enhanced oversight due to the scale of the financial challenge and the continuing fragility of operational performance.



Asesiad / Assessment

The Committee has oversight of:

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

The current scores and appetite positions are set out in Table 1. Further detail is contained in Appendix A.

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 Service Delivery Appetite Open	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.	3 x 4= 12 High	Y
		b) Due to an adverse impact on service delivery in the	4 x 4= 16 Extreme	Y



Score 17 and below		implementation of new digital systems.		
		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 2 = 8 Moderate	Y

Risks Outside Appetite

The following assessment focuses on the areas requiring the Committee's attention and assurance.

SRR 001G: Financial Sustainability

SRR 001G remains outside appetite, with a current risk score of **20 (Extreme)**. This reflects the scale and structural nature of the recurrent financial challenge, limited financial flexibility and the continuing risk to the delivery of a sustainable financial position.

Financial grip and accountability have been strengthened through enhanced corporate governance processes, tighter vacancy and expenditure controls, procurement optimisation, savings and productivity programmes, and improved medium-term financial planning.

A supporting corporate risk has also been established to connect the strategic risk directly to divisional financial performance and the risk to achieving breakeven. Overseen by the Executive Committee, this places clear accountability on Executive Directors to ensure that within their areas of responsibility there are credible recovery plans in place, mitigating actions are implemented and underperformance is addressed promptly.

These arrangements provide greater visibility of emerging pressures and support earlier intervention. However, the continued reliance on non-recurrent measures does not address the underlying structural deficit. Sustainable improvement will therefore depend on recurrent service, workforce and productivity changes being delivered without compromising patient safety, quality or operational resilience.



SRR 001I: Performance Improvement

SRR 001I remains outside appetite, with a current risk score of 12 (High), reflecting continued pressure across urgent and emergency care, patient and system flow, waiting times, diagnostics and workforce capacity.

A number of risks on the Corporate Risk Register focus on specific aspects of this broader strategic risk, including:

- Ambulance Handover Delays
- Whole-System Flow and Overcrowding
- Planned Care Waiting Times
- Unreported Waiting Lists
- Medical Job Planning
- Digital Delivery; and,
- Financial or Resource Constraints.

The management of these risks, alongside delivery of the associated recovery plans, supports the gradual reduction of the overall risk exposure.

Recovery plans continue to be monitored through the Performance Management Framework, with strengthened divisional and Executive accountability providing greater visibility of underperformance and enabling earlier intervention. While improvement is evident in some areas, progress is not yet sufficiently consistent or sustained to achieve the required performance standards or support a reduction in the current risk score.

Risks Within Appetite Requiring Continued Oversight

SRR 006A – C: Digital Infrastructure and System Delivery

SRR 006A – C remains within appetite but requires close monitoring due to ageing infrastructure, dependencies between local and national systems, and uncertainty regarding the delivery timescales of key national digital programmes.

The Director of Digital is maintaining oversight of supporting corporate risks through the governance arrangements for the relevant digital workstreams. Current areas of focus include:

- Digital radiology implementation
- Paper medical records management
- Artificial intelligence governance
- Unsupported devices and cybersecurity
- LIMS 2.0 implementation and laboratory resilience; and,
- Patient demographic data integrity.



The Health Board continues to engage with national partners, assess the local impact of changing delivery timescales and maintain proportionate contingency and business continuity arrangements.

Although the risks remain within appetite, delays in critical digital programmes or deterioration in infrastructure resilience could materially affect patient safety, service continuity, productivity and financial sustainability.

Risk Scoring and Tolerance Assurance

SRR 001G and SRR 001I remain outside the agreed risk appetite and are therefore being managed at a tolerated level of residual risk within the current operating context. Tolerance does not represent acceptance of the position. It requires the level of exposure to be clearly understood, justified, actively managed and subject to enhanced oversight.

Following Board approval of the refreshed Risk Management Framework, the revised risk assessment template will strengthen assurance by clearly setting out:

- the controls intended to reduce the likelihood and impact of each risk;
- evidence that those controls are operating effectively;
- gaps or weaknesses in the control environment;
- further actions required to reduce exposure; and
- the expected trajectory towards the agreed risk appetite.

This will support greater consistency and accuracy in risk scoring and help the Committee distinguish between risks that remain outside appetite despite effective controls and those requiring further action or stronger assurance.

Argymhelliad / Recommendation

The Finance and Performance Committee is requested to:

- **NOTE** the current position and direction of travel of the strategic risks within its remit;
- **NOTE** that SRR 001G and SRR 001I remain outside the agreed risk appetite and continue to require enhanced oversight;
- **CONSIDER** whether the controls, mitigating actions and governance arrangements provide sufficient assurance that the risks are being effectively managed; and
- **IDENTIFY** any areas requiring further assurance, escalation or management action.

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

STRATEGIC RISK AND ASSURANCE DASHBOARD

3 Principal Strategic risks	6 Risk components	2 Above appetite	0 Positive assurance	1 Reasonable assurance	5 Limited assurance
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Board Summary

- The dashboard contains 3 principal strategic risks with 6 separately scored threats/causes.
- 2 components have current scores above their stated appetite thresholds and require focused oversight of control effectiveness and delivery trajectories. There will be greater transparency of control effectiveness and assurance mechanisms in the next iteration of this report, noting the revised risk assessment template has been redesigned to improve Committee and Board assurance on the management of its principal risks.
- Underpinning Corporate Risk links and IMTP performance measures support integrated strategic risk reporting.
- The assurance outcomes contained within the Dashboard are based on the information currently documented in each risk assessment. As noted above, the revised risk assessment template will support a more robust evaluation of controls and assurance mechanisms, helping to strengthen the evidence available and improve confidence in future assurance conclusions.

ASSURANCE SCALE

Positive	Reasonable	Limited
Controls are operating effectively and sufficient evidence supports the judgement.	Controls are generally operating, but gaps, dependencies or delivery concerns remain.	Significant control weakness, adverse performance or unresolved dependency remains.

KEY: Score cells use the Health Board risk matrix colour bands. Assurance ratings are retained from the source register and should be reviewed alongside current performance and control evidence.

DETAILED STRATEGIC RISK AND ASSURANCE DASHBOARD

RISK INFORMATION	RISK EVENT	PRINCIPAL CAUSE	IMTP LINK	UNDERPINNING CORPORATE RISKS	IMTP PERFORMANCE MEASURES (Not an exhaustive list)	APPETITE THRESHOLD SCORE	CURRENT SCORE	TARGET SCORE	ASSURANCE CONCLUSION
SRR 001G 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 which meet the changing needs of the population.	g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	Enabler: Finance	CRR 008, 017, 024, 025, 026	- Achievement of financial balance; - Delivery of £40 million savings; - Increased recurrent savings; - Reduction in the underlying deficit.	13	20	8	Limited There is evidence of strengthened governance, oversight and financial control, but the current score of 20, continuing structural deficit, need for further recovery planning and lack of clearly articulated assurance gaps make reasonable assurance difficult to support.
SRR 001I 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.	System Change: Relevant to all Enablers: Performance Expectations & Workforce & Culture	CRR 011, 027, 030, 033	- Increased delivery of IMTP and Ministerial expectations; - Improvement against agreed trajectories; - Reduction in escalated measures.	8	12	8	Limited The assessment demonstrates that a performance management infrastructure exists, but it contains limited evidence of the effectiveness of that infrastructure or sustained improvement against agreed trajectories. Key assurance fields are incomplete.
SRR 006A 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 testing digital infrastructure and systems	System Change: Relevant to all Enabler: Digital, Data & Technology	CRR 028, 029, 032, 036	- Improvement in critical-system availability; - Reduction in critical incidents and unsupported systems; - Delivery of infrastructure-renewal milestones.	17	12	8	Reasonable There are technical controls, monitoring, incident exercises and some independent review. Reasonable assurance can be taken noting the Internal Audit outcome, open recommendations, unsupported-device position, patching compliance and infrastructure availability are clearly reported.
SRR 006B Director of Digital		b) Due to an adverse impact on service delivery in the implementation of new digital systems	System Change: Relevant to all Enabler: Digital, Data & Technology	CRR 020, 029, 030	- Increased delivery to time, cost and scope; - Achievement of readiness and training requirements; - Reduction in implementation incidents.	17	20	6	Limited The risk is scored 20 and outside appetite, with concerns over the timescales and deliverability of major programmes and an acknowledged governance gap. Existing project governance does not, by itself, demonstrate that programme risks are being controlled effectively.
SRR 006C Director of Digital		c) Due to a failure to develop digital solutions that are sustainable and fit for the future	System Change: Relevant to all Enabler: Digital, Data & Technology	CRR0 20, 21, 22, 28, 029, 032, 033, 035	- Delivery of Digital Strategy and infrastructure-renewal milestones; - Increased technical-architecture compliance and digital inclusion.	17	12	8	Limited The controls describe processes, but the assurance evidence is sparse. Quarterly reporting and previous audit work do not adequately demonstrate that solutions are sustainable, aligned to future requirements or delivering intended benefits
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.	a) Due to an ageing and complete estate, competing capital and revenue pressures, climate-related service demand and the absence of an organisation-wide climate adaptation approach.	Enabler Green Health	CRR 031	- Reduction in carbon emissions and energy use; 50% viable renewable-energy installation by 2026; - Increased LED coverage and waste compliance.	17	8	8	Limited The assessment itself identifies limited metrics, incomplete divisional risk identification, no external maturity assessment, limited site-level validation and the absence of a fully developed organisation-wide approach. These are material control and assurance gaps that do not support a reasonable assurance conclusion.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 September 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:

- **Digital Patient Communications Project Benefits Realisation Update** has been added from June’s Committee Meeting for September’s Committee Meeting 2026

Changes to the Forward Work Programme:

- **Stroke Improvement Plan Update Report** scheduled for update in March 2027 from January 2027

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.
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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/	
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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
			21 st April 2026	10 th June 2026	22 nd Sept 2026	3 rd Nov 2026	26 th Jan 2027	9 th 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	✓	✓	✓ D	✓	✓	✓
Financial Outlook for Future Financial Year, including	DoF&P	AN						✓

Revenue Budget Allocation letter								
Value and Sustainability Assurance Reporting	DoF&P	SI	✓	✓	✓ D	✓	✓	✓
Efficiency Opportunities and Update Report	DoF&P	SI	✓	✓	✓ D	✓	✓	✓
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								

Assurance reports from the Digital, Data and Technology Group, including an update on the Delivery of Digital Programmes	DoD	SI	✓	✓	✓	✓	✓	✓
Digital Patient Communications project benefits realisation update	DoD				✓			
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	
v	Scheduled agenda item in FWP
D	Deferred from this agenda
vD	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee