GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

GWENT 35
Better health | Better care | Better lives
Iechyd gwell | Gofal gwell | Bywydau gwell

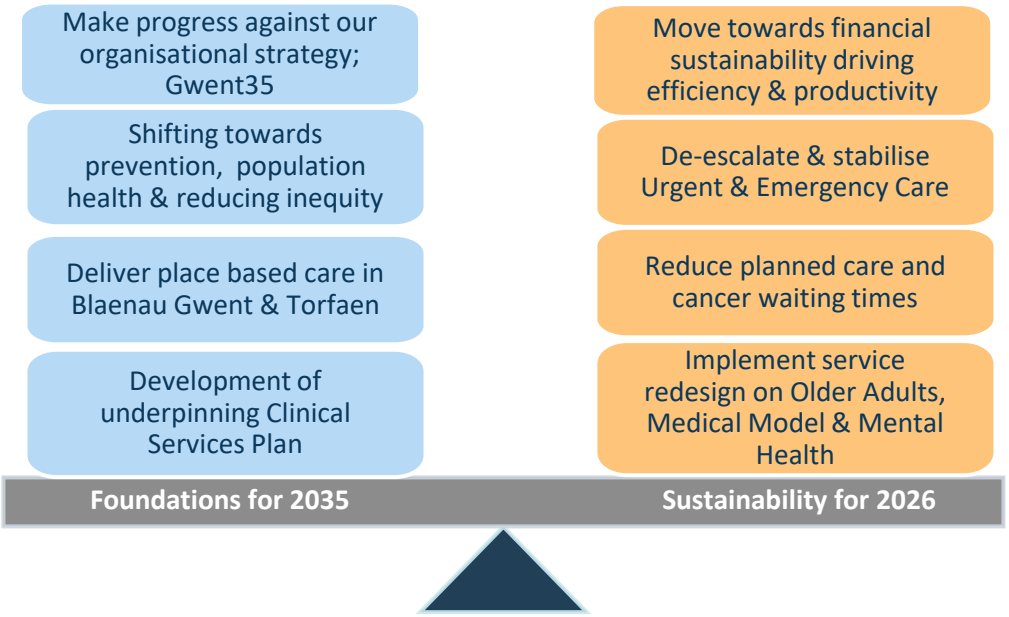
Annual Plan 2026/27

3 Year Intent

The Health Board's plan ('the Plan') for 2026/27 sets out what will be achieved for the Gwent population over the next three years, but with a greater level of detail on the next 12 months. Following the launch of a new organisational strategy Gwent 35, the Plan outlines the targeted actions we will take against the three strategic aims;

1. **Better Health:** Together we will support people to be healthy, active, & happy
2. **Better Care:** Together we will deliver what matters to people – supporting our staff to thrive & achieving quality, kind, & sustainable care
3. **Better Lives:** Together we will create strong, safe, & connected communities

Through the Plan we are intent on making progress in our strategic direction as set out in Gwent 35 whilst in parallel addressing the immediate financial, service and quality challenges and opportunities:



Quality and Safety remain a golden thread and our achievements and commitments are evidenced throughout. The plan sets out how we will purposefully advance prevention priorities including, population health management and place based care starting in deprived communities. This will be demonstrated through our continued partnership working across Gwent.

Much has been delivered over the past 12 months including:

- Reduced the number of patients waiting over 104 weeks for treatment
- Significantly reduced patients waiting over 52 weeks for outpatients
- Achieving over 80% on mental health Part 1a and Part 1b targets for adults and children
- Significantly reducing the number of ambulance handover delays
- Grange University Hospital achieved its highest ever 12 hour compliance
- Sustained progressed made with Pathway of Care Delays by reducing the volume & numbers of days delayed
- Weight & Measurement at 8 weeks has massively improved throughout the year
- Continued to shift services into the community through common ailment services and independent prescribing in community pharmacies

Despite our continued efforts, the Health Board remains in a higher escalation status of Targeted Intervention for Planning & Finance and Urgent & Emergency Care. This has been a year of continued challenges including:

- Rising complexity of patients causing increased needs for ongoing care
- Considerable pressures on our system during Winter resulting in a critical incident
- Challenging financial context supported with non-recurrent initiatives

Following the contents page, a "plan on a page" sets out the framework for the Plan coupled with a Delivery Statement which outlines the key commitments to be delivered in 2026/27. The key below supports navigation and alignment of commitments through all sections of the Plan.

Action Category	Colour Coding
Organisation Escalation; Targeted Intervention	TI
Partnership Actions (Regional Partnership Board/Public Service Board)	P
Ministerial Delivery Expectations (Welsh Government Planning Framework)	MD
Enabling Actions (Welsh Government Planning Framework)	EA

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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

Delivery Statement

The delivery statement below provides a clear summary of key deliverables and priorities for 2026/27.

Service Change	Performance	Enablers
Proof of concept for Place Based Care in Blaenau Gwent & Torfaen	Achieve 75% against the Single Cancer Pathway	Embed a consistent Quality Management System across all front line teams
Redesign of the Older Persons' Pathway achieving care closer to home	Deliver de-escalation criteria for UEC incl. improvement with Ambulance Handovers, 12 hrs waits & ED waits to be seen	Continue delivery of People Plan focusing on retention & attraction, providing opportunities for fair & meaningful work & career development
Optimal model for Acute Medicine including Medical Takes and bed base	Reduce pathways of care delays to lowest levels ever achieved	Significant financial savings through driving efficiency and change
Mental Health Transformation to deliver service and estate configuration	Deliver zero patients waiting more than 8 weeks for specified diagnostics	Develop refreshed Estates Strategy & undertake Facets Survey
Delivery of Preventable Premature Mortality programme & actions to combat Diabetes	Improve theatres and outpatient efficiency	NHH RAAC management and Outline Business Case development
Development of the Women's Health Hub	Improvement on 8 care processes for Diabetes	Modernise core clinical digital systems with major programmes incl. LIMS, RISP, Care Cubed & Open Eyes
South East Wales Regional priorities through Regional Joint Committee	Further increase weekend community nursing capacity	Develop climate response plan to embed climate adaptation & decarb biodiversity
MatNeo reconfiguration progressed to develop transitional care space & additional postnatal beds	Continue to maintain part 1a and 1b for mental health across Adults, Children & Young People	Continue to embed Value Based Healthcare and expand Research to deliver meaningful patient outcomes

The Plan responds to a number of UK, National, Regional & local drivers that form the strategic context. Throughout the plan we have evidenced our commitment to the duties of quality & candour including implementation of quality statements which have informed our delivery plan development. The launch of our new strategy Gwent 35 champions population health & puts the Wellbeing of Future Generations Act at the heart of everything we do to improve the health of our population through partnerships. Our three Strategic Aims of *Better Health, Better Care, Better Lives* also serve as our organisational wellbeing objectives as required under the Wellbeing of Future Generations Act.

Top Down Drivers

UK & WELSH GOVERNMENT

- NHS Planning Framework 2026/27
- Performance Framework 2026/27
- Ministerial Delivery Expectations
- Ministerial Advisory Group & Improving Performance Together
- National Programmes, for example Six Goals for Urgent & Emergency Care
- Contract Reform

HEALTH BOARD

- Joint Strategic Assessment showing needs of population
- Inequalities
- End of Year delivery for performance & finance
- Financial Sustainability
- Quality Strategy
- Organisational Escalation; Targeted Intervention
- Regional Planning & Expectation
- Gwent 35 (10 Year Strategy)
- Key Risks; Estates, Infrastructure

DEMAND & CAPACITY

- Anticipated Demand & Acuity
- Core Capacity & Efficiencies
- Performance Trajectories

DELIVERY PLANS

- Service Sustainability & Risk
- Workforce Opportunities & Risk
- Finance Opportunities & Risk
- Enablers

Bottom-Up Drivers

The Welsh Government Planning Framework sets out six three-year strategic priorities. Throughout the strategic aims section of our plan, we have included these priorities & the year 1 delivery expectations in the following areas

Timely Access to Care	Better Care	Mental Health Access	Better Care
Population Health & Prevention	Better Health	Women's Health	Better Care
Community by Design	Better Care, Better Lives	Quality & Safety	Better Care, Quality

We continue to collaborate across Wales to deliver the National Clinical Framework identifying fragile services and the collective actions we need to take for service sustainability.

A key partner and advocate for our population is Llais who have recently published their manifesto & people principles. Gwent35 will enable us to embed the 8 people principles across our organisation ensuring we deliver what matters to our communities;

1. Access that works for everyone
2. Dignity and respect, every time
3. Clear and honest communication
4. Joined-up care that feels seamless
5. Timely care, and support while waiting
6. Care should recognise and respond to the whole person
7. Care and support that enables independence
8. Inclusive, accessible and fair services for all

We continue to embed the social partnership duty and submitted our annual report in September and this is published on our website Social Partnership Duty Report.

We continue to work in partnership with a number of all Wales organisations with agreed collaborative priorities as summarised in the table on the right hand side. Our specific commitments for the South East Wales region can be found in our Regional Plan section later in the document.

Organisation	Collaborative Priorities
Digital Health & Care Wales	• Plans in place to flow data into the National Data Resource • Mental Health WCCIS replacement & national eye care digitalisation • Support rollout of NHS App & proof of concept work for national e-referrals • Implementation of digital solution for Healthy Child Wales Programme 2 & E-PMA rollout • Radiology Informatics System procurement, LIMS 2.0 & National digital cellular pathology
Health Education & Improvement Wales	• Improve retention of staff and attraction through more flexible skill mix • National workforce plans coupled with Education Training & Commissioning pipelines • Increase supply through career entry pathways that improve diversity & widen access • Create compassionate cultures & delivery of leadership programmes • Improve quality & effectiveness of workforce planning • Support transition into employment for students & trainees upon qualification
Joint Commissioning Committee	• Deep Dives for renal and kidney services, individual patient requests and Thrombectomy • Strategic Reviews for Neonatal, Cardiac, Mental Health, Learning Disabilities and Vulnerable Groups and Ambulance Model • Enabling Projects for pathways ad referral management transformation project
NHS Wales Shared Services Partnership	• Continue to collaborate with customers to drive efficiencies, improve resilience & support • Support standardisation & value & sustainability e.g. recruitment, procurement & pharmacy
Velindre University NHS Trust	• Regional oncology workforce plan • Review of Phase 2 of Regional SE Wales AOS Business Case • Development of SACT Outreach services in Gwent • Ongoing work through to spring 2027 aligned to new cancer centre opening
Public Health Wales Trust	• Working in partnership on national screening programmes & surveillance data • Delivery of data insights that target preventative work programmes • Contribute to the National Child Death Review and embedding local actions • Development and implementation of Health Impact Assessments
Welsh Ambulance Service Trust	• Support care homes through enhanced education, robust escalation processes • Simplify access to urgent & emergency care services through single point of access • Delivery of right place, first time pathways for appropriate patients who could benefit from an initial timely assessment through an alternative service

Achievements

Throughout 2025/26 a number of achievements have been delivered, below is a selection mapped against the 12 Health & Care Quality Standards:

Leadership

- 864 colleagues completed leadership programme
- Talent & Succession Planning Framework embedded
- Nursing & Midwifery Leadership Academy supporting progression – 32% achieving promotion
- Good Governance Institute development programme with Board and Executive team

Whole System Approach

- Strengthening South East Wales leadership through Regional Joint Committee
- Strengthened partnership delivery across Public Service Board, Regional Partnership Board & Integrated Services Partnership Boards in each locality
- Expanded Place Based Care through Integrated Teams
- Embedding support for families & children at the edge of care

Learning, improvement & research

- Quality Management Framework & System launched
- Expanded patient & staff stories as a core part of learning & improvement
- Continued implementation of research & development strategy and achieved 80% Time to Target research performance
- Delivered local Value Based Healthcare education programmes

Workforce

- Refreshed People Plan 2025-30 approved & launched
- Nursing & Medical vacancies reduced through targeted recruitment & retention
- Further reduced reliance on variable pay
- Widening Access opportunities enhanced working with partners & education providers

Culture

- Speaking up Safely culture strengthened
- Increase in NHS Wales Staff survey, staff engagement increased from 13.3% to 32.5%
- New Values & Behaviours Framework co-produced & launched
- Strengthened quality, diversity & inclusion culture aligned to national frameworks

Information

- Continued high utilisation of HealthPathways platform
- Improved data infrastructure for quality reporting
- Improved population health intelligence through Joint Strategic Assessment
- AMaT embedded as a single transparent audit system
- Sustained & significant improvement in Nationally Reported Incidents compliance

Safe

- Continue to be one of the highest in the All Wales peer group for Risk Adjusted Mortality Index
- Strengthened Deteriorating Patient & Sepsis Pathway
- Enhanced Infection Prevention Control & Health & Safety Compliance
- Strengthened End of Life Care & Bereavement Support (GRACE Model)

Timely

- Increased utilisation of Same Day Emergency Care
- Part 1a & 1b Mental Health Targets exceeding national target of 80% for over 18s & under 18s
- Improved Urgent & Emergency Care Flow & Ambulance Handovers
- Increased diagnostic capacity & reduced long waits
- Reduced waiting times for treatment & outpatients

Effective

- Continuing to improve rates of See on Symptom & Patient Initiated Follow Up
- Acute Frailty Response rolled out across all sites
- Increased uptake of Common Ailments Service & number of Pharmacists with Independent Prescribers
- 161 areas now taking part in ward accreditation programme with 38 at bronze & 10 achieving silver

Efficient

- Improved theatre efficiency and GIRFT aligned productivity gains
- Reduction in outsourced diagnostic reporting
- Improved Flow Centre efficiency (GP & WAST referrals)
- Cancer straight to test and pathway redesign
- Increased use of High Volume Low Complexity Lists
- Achieved 40m financial savings

Equitable

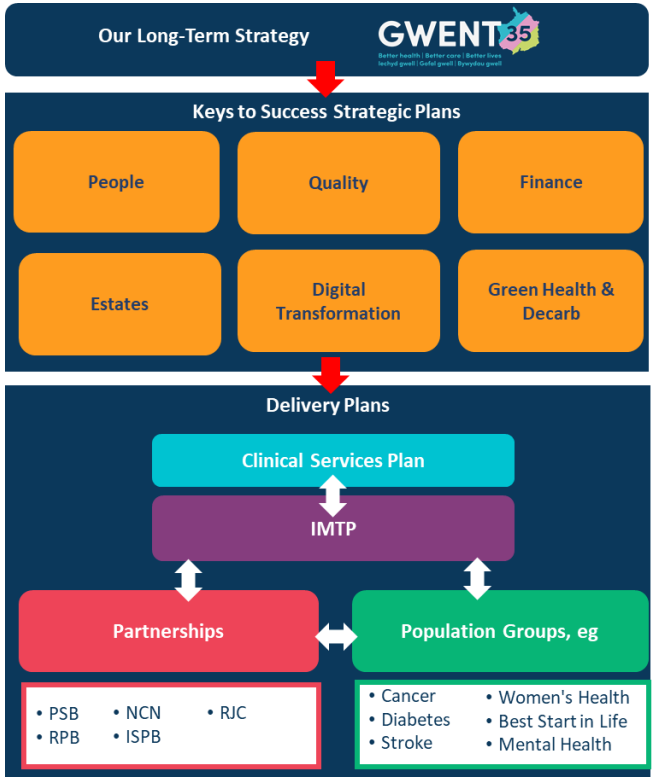
- Targeted vaccination equity work
- Cancer prevention and screening outreach in low uptake communities
- Acute Frailty & Older People Safety Improvements
- Continuation of the Women's Health Network
- Pilot Youth Board to strengthen young people's voice
- Best Start in life programme improving early years equity

Person Centred

- Expanded PROMs and PREMs collection
- Continued development of Health & Wellbeing Centres
- Expansion of Diabetes Prevention Programme
- Improved Putting Things Right experience through more timely responses
- Continuation of co-produced social prescribing model

Planning Approach

We have introduced a strengthened organisational planning framework, aligning the Plan with the new strategy Better Health, Better Care, Better Lives. This year marks a significant shift by setting multi year commitments directly linked to strategic aims, explicitly embedding strategy delivery into the organisation's core business processes.

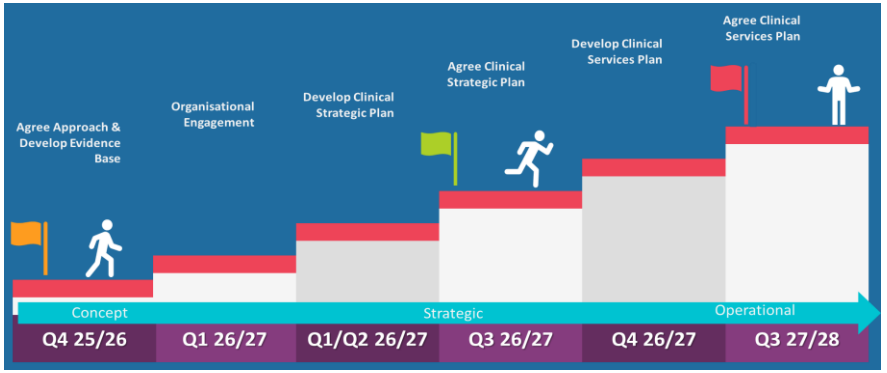


To guide plan development, a number of planning assumptions were set and communicated throughout the organisation outlining expectations and required ambition within available resources. These included:

- Prioritising patient safety & applying QIA screening for changes affecting care
- Delivering a balanced budget
- Moving to a sustainable workforce model and reducing variable pay
- Demonstrating efficiency opportunities within core capacity
- Setting realistic progress against Ministerial targets based on available resources

Substantial progress has been made in redesigning clinical services, beginning with the development of new models ahead of the Grange University Hospital (GUH) opening. Since GUH became operational, the clinical redesign programme has driven major service changes such as MIU reorganisation, centralised stroke rehabilitation, and revised maternity provision. Parallel developments have strengthened Mental Health care models and advanced the ambition for Place Based Care.

Regionally and nationally, the Health Board is working with partners to stabilise fragile services and ensure long term sustainability. The foundations of a clinical services plan are already in place; the next step is to bring this work together through strong clinical engagement to ensure it is future fit. The accompanying diagram sets out the key steps to complete the Clinical Services Plan.



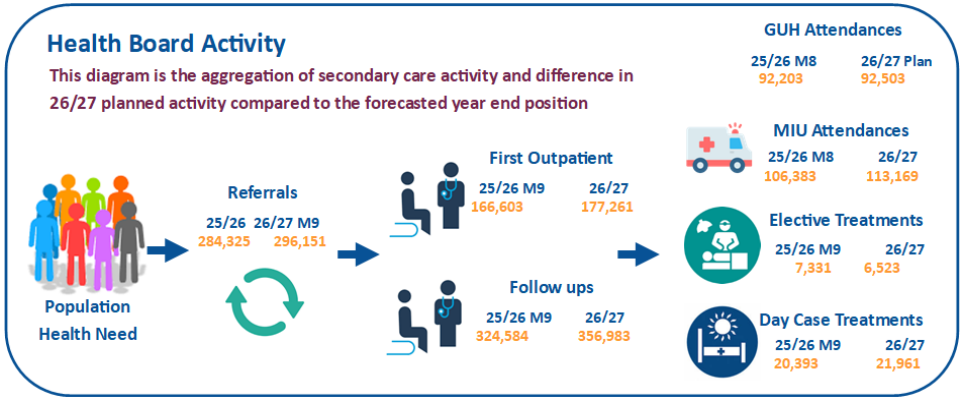
The South East Wales Regional Joint Committee (RJC) first met in October 2025 and brings together ABUHB, Cardiff & Vale, and Cwm Taf Morgannwg UHB to oversee regional planning and service delivery for a population of more than 1.5 million. For 2026/27, the RJC has set four priorities:

- Deliver existing regional programmes (Ophthalmology, Orthopaedics, Diagnostics and Llantrisant Health Pak (LHP))
- Develop an operating model for the RJC including a framework for regional commissioning and contracting.
- Create a process to identify and prioritise opportunities for regional clinical services.
- Develop and implement a regional digital plan to support regional working.

The Health Board continues to refine and mature its demand and capacity capability and methodologies, key highlights and challenges from this year's forecasts include:

Primary and Community Care: GMS appointments in Primary and Community Care are projected to decrease by 7.6% in 25/26; with no recovery expected in 26/27. Urgent Primary Care is forecasted to grow by 4.8% depending on funding and care navigation. Driven by the new dental contract Emergency Dental activity is expected to drop 7.5% in 25/26, and then stabilise for 26/27. Optometry activity is forecasted to rise by 2% (2026/27), predominantly due to WGOS 4 and 5, and the Common Ailments Scheme activity is forecast to grow substantially by 19.1% however risks to achieving this are any pharmacy closures. District Nursing activity is expected to rise by 3.4%. CHC placements likely to remain at current levels pending changes in investment.

Mental Health services, including Adults and CAMHS: The impact of Open Access is still emerging and may affect the current assumptions with only modest demand growth expected and current modelling indicating the ability to sustain 80% performance levels. There are areas that indicate a rising risk due to rising demand and backlog, especially for Integrated Autism Service and ADHD access. The Memory Assessment Service is also experiencing more referrals and longer waiting lists, with demand exceeding current capacity and affecting diagnostic performance.



Urgent and Emergency Care : Emergency Department attendances are forecast to rise by 2.4% in 2026/27 with MIU activity projected to grow by 6.4% (95,678 attendances). Flow Centre activity via GP referrals is expected to rise by 6.5% and WAST 10% (15,000). Medical referrals from ED to specialty, through the pathway redesign are expected to rise 21.3% (14,400) and surgical referrals up 13.9% (13,308). Acute medical ward admissions are also forecasted to increase by 3.91%; and SAU admissions by 5.46%. Overall emergency assessment attendances are forecasted to rise by 3.8% due to rises in demand with Emergency inpatient admissions forecast to rise by 4.1%.

Diagnostics: For 26/27 CT demand will grow by 6%, requiring 93,100 capacity versus 100,206 demand. MRI activity is projected at 40,000 which is 5% increase from 25/26. Non-obstetric ultrasound (NOUS) demand remains high, requiring 46,590 capacity against 61,452 demand; supported by 9,804 agency or locum hours. Improvements have enabled the elimination of Plain Film outsourcing and capacity set for 26/27 is forecasted at 262,392. Nuclear Medicine activity is not forecasted to increase. Diagnostic Cardiology and Neurophysiology is forecasted to maintain a zero wait list position and through delivery of the Endoscopy plan activity will increase to 22,452 patients and a zero wait list position. Delivery of the diagnostic waits remain vulnerable to a number of in year pressures and present a risk that will require close monitoring.

Elective: Demand is projected to rise in 2026/27, with referrals up 4.2% from 25/26. A focus on productivity and efficiency opportunities is also affecting forecasts. New outpatient appointments are expected to increase by 6.8% and follow-up appointments will grow by 9.9%. Day case activity is anticipated to rise by 7.7% as plans progress to move more activity to day case, Elective treatments are forecast to decrease by 11%. The overall volume of treatments will rise by 2.7% due to improved Theatre efficiency and implementation of the GiRFT standards. Cancer referrals will grow by 3%, stabilising after post-pandemic increases. Although the current trajectory forecasts circa 3,000 patients waiting over 104 weeks, opportunities to improve this internally will continue to be explored and should additional monies be made available, there are draft delivery plans in place to deliver 0 patients over 104 weeks, subject to timing of decisions.

Organisational Escalation - Targeted Intervention

The Welsh Government Oversight & Escalation Framework sets out the approach to national escalation of NHS organisations. In December 2025 the Health Board's national escalation status was raised to **Targeted Intervention** (Level 4) for Finance, Strategy & Planning, and Urgent & Emergency Care. Progress is tracked by Welsh Government via monthly oversight meetings and internally via a number of mechanisms. The Health Board's response to de-escalation is also in the context of the refreshed Performance Management & Accountability Framework approved in September 2025 and the self assessment against the updated 2025 Planning Maturity Matrix. Focus will continue into 2026/27 on the actions & improvements required to achieve de-escalation. A Health Board specific Escalation Framework was published in January 2026 and confirms the interface arrangements and de-escalation criteria:

Finance

- Demonstrate that there are robust financial governance & robust financial control environment in place with risks minimised.
- Make substantial progress in delivering the level 4 action plan, including actions to improve the organisation's understanding of the existing deficit & key drivers & development & realisation of opportunities.
- Demonstrate a clear, credible & deliverable plan to achieve financial balance.

Strategy & Planning

- Submission of a balanced & credible three-year medium-term plan or acceptable annual plan in line with the current planning framework.
- Evidence a clear roadmap & implementation of the health board's clinical services plan.
- increase Welsh Government's confidence in delivery based on an assessment against an agreed planning maturity matrix.
- Delivery of commitments set out within the annual plan.

Performance & Outcomes

- Continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months & maintained for three months (agreed baseline of 658).
- Continuous improvement towards no-more than 7% of patients waiting over 12 hours at each individual site & across the Health Board (agreed baseline of 7.6%).
- Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60-minutes (agreed baseline of 147 minutes).
- Continuous reduction in delayed pathways of care (with a focus on those caused by assessment issues) of 5% for three consecutive months & then maintained (agreed baseline of 165).

The Health Board has a clear ambition to de-escalate from level 4 in both domains and is committed to, via the commitments in this plan, making progress against this ambition to deliver a sustainable platform for further de-escalation and is keen to work with WG and NHS P&I in order to deliver the required improvements. The actions and performance delivery as set out throughout this plan is in line with the detail or the UEC recovery plan and de-escalation criteria. Similarly the financial section of the plan and underpinning detail supports a number of the financial requirements.

The escalation framework sets out the requirement to update the Health Board's self assessment against the WG Planning Maturity Matrix 6 domains. This assessment is summarised below and an evidence base supports this.

1. Strategy Development/Clarity of Purpose, Vision & Strategy	Assessed level 3	4. Operational Planning	Assessed level 3
2. Strategy Alignment & Development of an IMTP	Assessed level 2	5. Realistic & deliverable	Assessed level 3
3. Dynamic & engaged planning	Assessed level 3	6. Best Practice approach to improvement -	Assessed level 3

GWENT 35

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Section 2 Drivers

- Joint Strategic Assessment
- Gwent 35
- Quality
- Performance Expectations
- Financial Sustainability
- Risks

The **Joint Strategic Assessment (JSA)** provides a comprehensive overview of the health and well-being of the people of Gwent in an accessible format. The power of data informed conversations through a prevention lens has become evident since the establishment of the JSA supporting the region to tackle the root causes of the issues. Both the PSB and RPB have accepted the Gwent JSA as the "single source of truth".

The JSA can inform decision making by providing the evidence base to make positive change through unified and linked data. Establishing and sharing this with partners has allowed a shift in the focus to a wider population health approach.

A clear measurement of inequity across Gwent is the difference in healthy life expectancy, and Gwent has the widest gap of any Health Board in Wales. Males from the least deprived areas live 12.8 years longer in a healthy life state than in the most deprived areas. Females in the least deprived areas live 20.5 years longer in a healthy state compared to in the most deprived areas.

The JSA continues to develop with the establishment of data sharing agreements with partners.

The next refresh is planned for early 2026/27 following refinement and expansion based on wide stakeholder engagement.

Monmouthshire

A rural community bordering England, **Monmouthshire is the least deprived of the five communities**, but it has the highest percentage of adults who drink above the Chief Medical Officers' low risk drinking guidelines of no more than 14 units a week.

- **6%** population increase in 20 years
- **3%** of people are from an ethnic minority background
- **95%** are satisfied with their local area as a place to live
- **44%** of working age adults with a healthy weight
- **80 yrs** life expectancy for males (healthy life expectancy 66 yrs)
- **84 yrs** life expectancy for females (healthy life expectancy 66 yrs)
- **17%** of males aged 11 to 16 who have tried vaping
- **23%** of females aged 11 to 16 who have tried vaping
- **7%** of adults smoke

Caerphilly

One of the two ex-mining communities in Gwent, Caerphilly covers a large geographical area (107 square miles) and has the **highest percentage of household members who speak Welsh.**

- **1%** population increase in 20 years
- **2%** of people are from an ethnic minority background
- **88%** are satisfied with their local area as a place to live
- **28%** of working age adults with a healthy weight
- **77 yrs** life expectancy for males (healthy life expectancy 59 yrs)
- **80 yrs** life expectancy for females (healthy life expectancy 58 yrs)
- **27%** of males aged 11 to 16 who have tried vaping
- **33%** of females aged 11 to 16 who have tried vaping
- **14%** of adults smoke

Blaenau Gwent

The birthplace of the NHS, and an ex-mining community, **Blaenau Gwent is the most deprived of the five communities.**

- **0%** population increase in 20 years
- **2%** of people are from an ethnic minority background
- **69%** are satisfied with their local area as a place to live
- **19%** of working age adults with a healthy weight
- **76 yrs** life expectancy for males (healthy life expectancy 57 yrs)
- **79 yrs** life expectancy for females (healthy life expectancy 55 yrs)
- **22%** of males aged 11 to 16 who have tried vaping
- **33%** of females aged 11 to 16 who have tried vaping
- **16%** of adults smoke

Newport

The only city in Gwent and the most diverse, Newport also has the highest reported domestic abuse rates in Gwent.

- **11%** population increase in 20 years
- **15%** of people are from an ethnic minority background
- **79%** are satisfied with their local area as a place to live
- **34%** of working age adults with a healthy weight
- **78 yrs** life expectancy for males (healthy life expectancy 58 yrs)
- **82 yrs** life expectancy for females (healthy life expectancy 57 yrs)
- **22%** of males aged 11 to 16 who have tried vaping
- **33%** of females aged 11 to 16 who have tried vaping
- **14%** of adults smoke

Torfaen

One of the most easterly of the South Wales urbanised valleys, Torfaen has the **highest reported number of looked after children** in Gwent.

- **4%** population increase in 20 years
- **3%** of people are from an ethnic minority background
- **91%** are satisfied with their local area as a place to live
- **35%** of working age adults with a healthy weight
- **78 yrs** life expectancy for males (healthy life expectancy 59 yrs)
- **81 yrs** life expectancy for females (healthy life expectancy 53 yrs)
- **18%** of males aged 11 to 16 who have tried vaping
- **26%** of females aged 11 to 16 who have tried vaping
- **16%** of adults smoke

In July 25, the new strategy for the Health Board was approved by the Board, Gwent 35: Better Health, Better Care, Better Lives Gwent 35: Our Ten Year Strategy.

The strategy signals a step change – fundamentally rebalancing focus towards healthy communities whilst setting out intent to become powered by innovation & improvement in all we do. It sets the ambition that by 2035 we want everyone to have the chance to live a long, healthy life & improved healthy life expectancy.

After listening to what is important to the people of Gwent, & learning from research, we developed three aims;

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

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

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

The values underpinning the strategy are an integral part of the strategic direction. The newly agreed values of — Kindness, Integrity, & Respect — are the foundation of the compassionate care provided, the relationships, & the culture required for the future. The outcomes to achieve our ambition for 2035 focus on:

- The reduction of the prevalence of preventable diseases & the factors that contribute to poor health & support healthy behaviours
- Improving the standards of care & access to local services to enable healthy days outside of hospitals
- Improve access to healthcare services for all communities, community connection & the proportion of budget spend on out of hospital services.

A delivery and deployment plan underpins the strategy in order that Gwent 35: Better Health, Better Care, Better Lives drives not only the direction of travel of services but shapes the "operating model" for the Health Board, embedding the intent of the strategy in all we do. An annual report of strategy delivery & deployment will be developed in September 26.

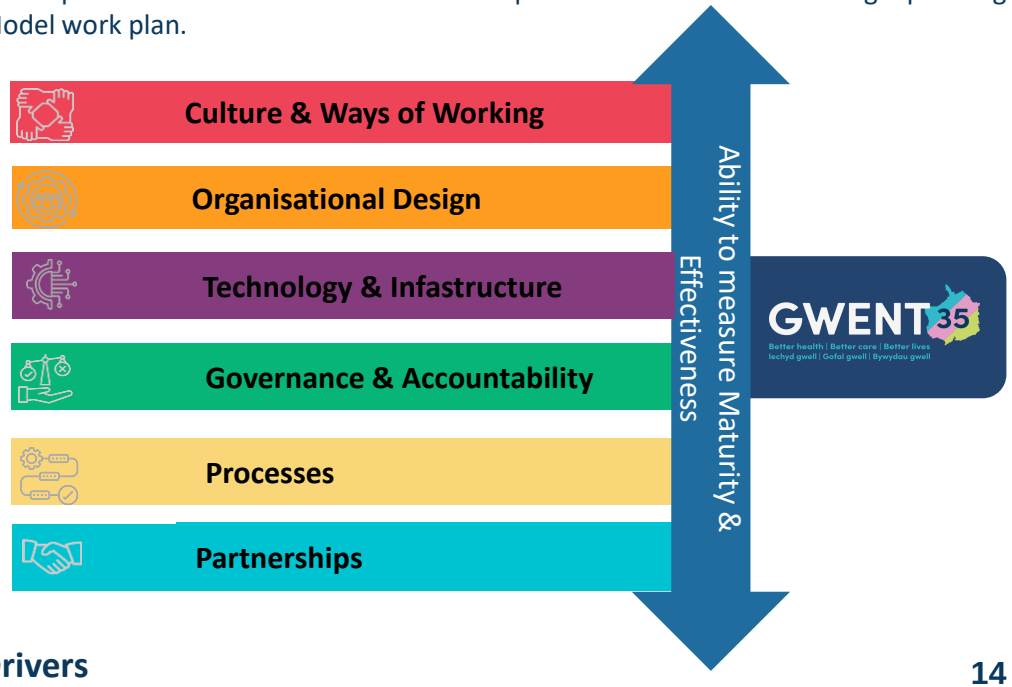
Strategy Delivery : What we do

The Strategy sets out the strategic actions for 2026/27 & beyond. This Plan and future IMTPs will be a key vehicle through which the strategy will be driven, outlining the actions over 3 year timeframes. There are two key elements that support strategy delivery. The outcomes framework & the strategic plans from the keys to success

Strategy Deployment : How we do it

Strategy deployment relates to "How" as an organisation we re-orientate, review & refresh how we work (our operating model) to ensure the intent, ambitions & goals of the strategy run through everything we do.

Work has commenced to review, test and strengthen the Health Board's Operating Model taking account of Culture & Ways of Working, Organisational Design, Technology & Infrastructure, Governance & Accountability, Processes and Partnerships. The detailed action plan can be found in Making it Happen, our strategy deployment & delivery plan. The actions are framed around the themes below. This action plan is a live document and will be updated to reflect the evolving Operating Model work plan.



Quality, patient safety and patient experience remain the core purpose of the Health Board, reinforced by the Quality & Engagement (Wales) Act 2020, which introduces new duties for quality, candour and citizen voice. These duties require transparent, evidence-based decision-making that improves outcomes, experience and equity.

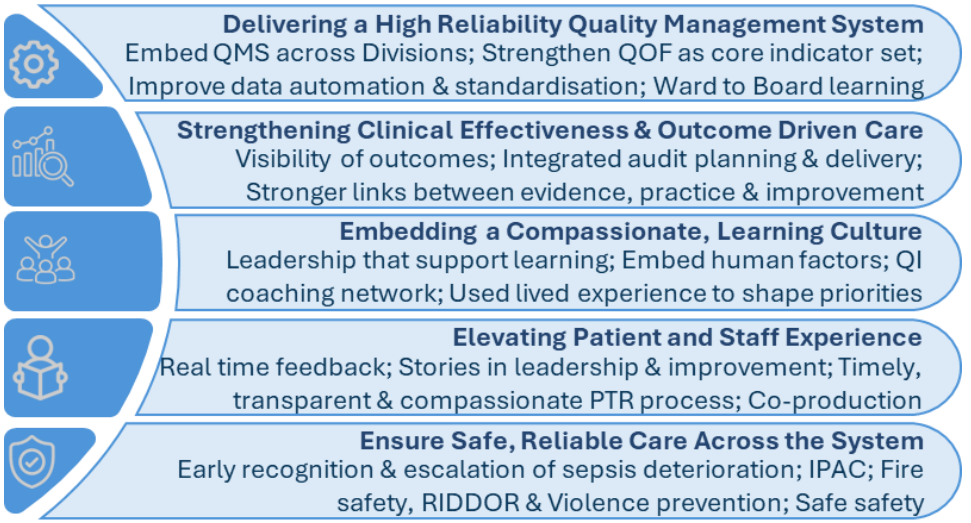
For 2026/27, quality is positioned as a strategic driver of system performance and improvement, not just an assurance function. We will continue to mature our Quality Management Framework and embed the Quality Management System as the method for delivering safe, effective, compassionate care at scale. Quality shapes how services are transformed, how the workforce is supported, how data is used, and how population health improves.

Over the past three years, we have strengthened our approach through the Quality Strategy, Patient Experience & Involvement Strategy, and the Listening & Learning Framework. Together, these have created a more coherent and system-wide learning culture based on openness, compassion and psychological safety.

Our ambition is to become a high reliability organisation where quality is actively lived and not just reported. This means:

1. Improving outcomes & reducing unwarranted variation
2. Strengthening the voice & experience of patients, families & communities
3. Embedding a Just Culture & psychological safety
4. Ensuring transparency, accountability & learning
5. Building system wide improvement capability

Our strategic Quality priorities for 2026/27 are:



As we look ahead, we will also prepare to adopt the new National Safety Framework once published, ensuring alignment with emerging national standards and reinforcing our commitment to proactive, evidence-based safety. During 2026/27 quality will drive:

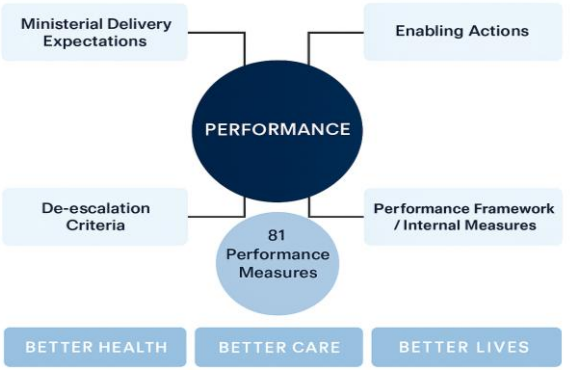
- **Service transformation** through evidence-based pathways & outcome focused redesign
- **Workforce wellbeing & retention** through psychological safety & Just Culture
- **Digital innovation** through real time visibility & automated quality data
- **Financial sustainability** through reduction of harm, waste & unwarranted variation
- **Population health improvement** through equitable access, lived experience & community voice

In 2026/27, we are committed to delivering safe, effective and compassionate care by embedding quality as a strategic driver of system performance. Through a strengthened QMS, a modernised QOF, a deepened learning culture and a focus on outcomes and experience, we will build a more reliable, transparent and compassionate health system for our population.

Performance Expectations

The performance expectations set out within this plan are derived from four key domains of national and local priority:

- **The NHS Wales Planning Framework,** which outlines the Ministerial Delivery Expectations and supporting Enabling Actions.
- **The NHS Wales Performance Framework**, reflecting the priorities within the NHS Wales Planning Framework 2026–2029 and aligned to the 'A Healthier Wales' quadruple aims.
- Welsh Government **de-escalation criteria,** associated with the Health Board's national escalation status of Targeted Intervention for Urgent and Emergency Care (UEC).
- The Health Board's **internal performance measures**, aligned to the Gwent 35 Strategy and representing key areas of organisational delivery and improvement.



For 2026/27, the plan includes 81 performance measures against the 3 aims of the strategy, **Better Health, Better Care, Better Lives,** & across the 4 domains as follows:

- 23 Ministerial Delivery Expectations (MDEs)
- 5 Enabling Actions included as core performance measures
- 2 measures related to the UEC Targeted Intervention de-escalation criteria, with the remaining two already captured within MDEs
- 51 measures drawn from the NHS Wales Performance Framework or the Health Board's internal measures

The trajectories associated with each performance measure balance ambition with achievable improvement, set within the realities of operational constraints and the delivery pace of our strategic programmes. At a high level, the performance expectations within this plan aim to deliver the following:

Better Health:	We will strengthen our focus on prevention and population health, driving sustained improvement in vaccination uptake, particularly among younger & older people, reducing inequity between the most and least deprived communities. We will continue to monitor delivery against the Healthy Child Wales measures to ensure the best possible start in life, while increasing the proportion of children who are a healthy weight. In addition, we will continue to prioritise the prevention of long term conditions (LTCs) & improve the management and outcomes of people already living with them.
Better Care:	We will expand community capacity to provide safe, effective alternatives to pathways traditionally accessed through primary or secondary care. Through our urgent care recovery plan, we will deliver improvements across the pathway, enabling better whole system flow so patients move more efficiently to the next stage of their care. This will reduce ambulance handover delays, prolonged Emergency Department stays, delayed discharges & improve overall discharge rates. In Planned Care, we will aim to ensure that no patient waits more than 8 weeks for diagnostic testing. We will also improve compliance with the Suspected Cancer Pathway to achieve the national 75% standard. In Mental Health, we will maintain delivery of the national standards for Parts 1a, 1b & 2, & improve performance against the 26 week Psychological Therapies standard.
Better Lives:	We will increase weekend patient contacts delivered by District Nursing teams, ensuring safe and continuous care at home & preventing avoidable hospital admissions. We will also improve the proportion of Specialist Palliative Care referrals assessed within two days, recognising the importance of timely, expert support for people with life limiting conditions & their families. We will monitor engagement with the Melo website, which provides immediate access to trusted, evidence based self-help resources without the need for referral or appointment, reducing barriers for mental health & wellbeing support.

Financial Sustainability

NHS Wales remains under significant and persistent financial pressure, characterised by structural deficits, demand pressures, workforce costs, and constrained budget growth. Recent independent audits, budget documents, and Senedd evidence highlight a system struggling to reach financial balance despite increased investment and substantial savings efforts.

Health Boards are required to develop a financial plan that balances over a rolling 3 year period. The Health Board has not been able to operate within available funding and has a rolling 3 year deficit. The outlook for 2026/27 remains financially challenging based on the operational and performance ambitions of the Board. The Board has advised Welsh Government that a financial deficit forecast is likely for 2026/27, in line with guidance the Board will produce an annual financial plan for 2026/27, with the ambition to recover to financial balance over a 3 year period.

The Performance & Accountability Framework is well established with Finance as one of the five performance & accountability domains. We have an established Value and Sustainability Board mechanism and structure which will be used to continuously search for further opportunities and a pipeline of potential savings going forward. This will be the key mechanisms to deliver long term financial recovery through a revised route map to sustainability and financial balance.

Following the development of this plan key service redesign work programmes have been identified with designated Executive Leads as well as the thematic areas which also have Executive Leads. These are summarised below;

Service Redesign Programme	Deliverables	Executive Lead
Clinical Redesign	Bed Plan; Acute Medical Model; Older Persons Pathway	Chief Operating Officer
Mental Health Transformation	Reduction of footprint linked with service Change	Chief Operating Officer
Theatres	Delivery & consolidation of efficiencies	Director of Strategy, Planning & Partnerships
Estate Rationalisation	Opportunities to consolidate Estate	Director of Strategy, Planning & Partnerships
Therapies Workforce Review	Opportunities to consolidate Estate	Director of Therapies & Allied Health Professionals

Medicines Management – Medical Director

Continuing Healthcare – Chief Operating Officer

Workforce – Director of Workforce & Organisational Development

Non Pay - Director of Finance & Procurement

Section 2 Drivers

Risks

There are 9 strategic risks that are managed & monitored at Board level. It is essential that the Plan recognises and responds to these risks to ensure it is grounded in real issues and challenges. The table below summarises each of the strategic risks & highlights where the actions we are taking to reduce the risk are included within the Plan.

There is a risk that	Due to	Score	Plan Section
The Health Board (HB) will be unable to deliver & maintain high quality safe & sustainable services which meet the changing needs of the population.	Staff recruitment & retention; Staff Wellbeing; Leadership Level; Service models.	12	Workforce & Culture Strategic Aims
	Industrial action.	16	
	Strategic plans.	8	
	Sustainable finance.	20	Finance
	Failure to implement the required performance improvements in some areas of the organisation.	12	Performance Workforce & Culture
There will be significant failure of the HB's Estate.	Reinforced Autoclaved Aeriated Concrete (RAAC).	15	Estates
	Backlog maintenance.	12	
The HB is unable to respond in a timely, efficient & effective way to a major incident, business continuity incident or critical incident.	Ineffective & insufficient emergency planning arrangements.	8	Strategic Aims
	Insufficient arrangements across all service areas.	12	
The HB will be unable to deliver & maintain high-quality, safe services across the whole of the healthcare system.	Inadequate arrangements to support system-wide patient flow.	16	Strategic Aims
The Health Board has inadequate digital infrastructure & systems to maintain high-quality, safe service delivery .	Full or partial failure of existing systems.	16	Digital
	Implementation of new systems; Failure to develop sustainable & fit for the future solutions.	12	
The HB will be unable to deliver truly integrated health & care services for the population.	Likelihood of further austerity measures.	8	Strategic Aims
	Impact of fragile services.	9	
The HB fails to build positive relationships with patients, staff & the public.	Inadequate arrangements to listen & learn from patient experience & enable patient involvement.	8	Quality
The HB will fail to protect the Health & Safety of staff, patients, & visitors in-line with its duties under the Health & Safety at Work Act 1974.	Inadequate & ineffective systems, processes, governance, & assurance arrangements.	12	Quality Workforce & Culture
The HB will be unable to meet the carbon reduction target set by WG of a 16% reduction by 2025 & a 34% reduction by 2030.	Limitations to change estate & implement strategic changes at scale.	15	Green Health

GWENT 35

Better health | Better care | Better lives
Iechyd gwell | Gofal gwell | Bywydau gwell

Section 3 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

Throughout this section we have cross referenced back to the Ministerial Templates (MT) in the Technical Supporting Documents e.g. [MT: Community by Design]

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

Outcomes

- There will be positive change in the factors that contribute to poor health
- There will be more people who are a Healthy Weight
- There will be a reduction in preventable diseases

Priorities

- Health Protection
- Health Improvement
- Prevention
- Babies Children & Young People

Quality Statements

SAFE	Improve chronic condition management services to address any increased risk across the whole population
EFFECTIVE	Promotion of health, across the life-course, through provision of advice on healthy lifestyle
EQUITABLE	Engage with the population to identify the challenges they face & use this information to improve access
TIMELY	Minimise treatment delays, maximise join-up of services, ensure good communication & make every contact count
EFFICIENT	Provide a framework for delivery at organisational level consisting of population outcome indicators
PERSON CENTERED	People are signposted to, or provided with, evidence based information including voluntary organisations

Why this is a Priority

Improving population health is essential to securing a sustainable future for services across Gwent.

Health protection focuses on areas such as vaccination and screening. Vaccination is one of the most effective tools for preventing illness, yet uptake across Gwent is declining. HPV vaccination has reduced cervical cancer rates in England by 87%, but uptake in Gwent is almost 30% below the national target. Screening programmes are another important tool in helping to detect and treat problems at an early stage. While bowel cancer screening rates have been increasing in Wales, in Gwent there is a 17% difference between uptake in our most and least-deprived areas, demonstrating the need to remove barriers experienced by our communities.

Health improvement is concerned with positive changes in the factors that contribute to poor health. Over a third of adults in Gwent report being active for fewer than 30 minutes per week, and 76% eat fewer than five portions of fruit and vegetables a day. While Wales aims to be smoke free by 2030, around 12% of residents still smoke.

We are taking action to help residents improve their health through proactive information and services including smoking cessation and weight management.

Prevention of premature mortality is a key focus, with 1 in 3 residents dying earlier on average compared to other areas across Wales. Heart disease, diabetes, liver disease and some late stage cancers can be prevented through lifestyle changes, yet many residents face barriers to adopting healthier habits. We aim to support residents by making it easier to make healthy choices.

The earliest years shape lifelong wellbeing, making **babies, children and young people** a key area to embed healthy behaviours and reduce inequity for future generations. Around 80 of the brain's structure forms by age 3. The first 1000 days sets the foundation for future health with adults who had stable, nurturing early environments show better mental health, stronger cognitive function, and greater resilience.

By focusing on prevention, early support and family resilience, we can reduce inequalities, improve healthy development, and protect future generations from avoidable ill health.

What we will deliver – 2026/27

Priority	Workstream		Q1	Q2	Q3	Q4
Health Protection	Screening & Vaccination *[MT: Population Health & Prevention]*	MD	Cancer prevention focus on screening within low uptake areas reducing inequity & addressing inequalities	Increase the number of Bowel Screening accredited clinicians	Establish in-house education on cervical screening for practice nurses	Finalise action plan for Lung Health Screening commencing in 2027
		MD	Implementation of Blaenau Gwent Vaccination Centre; Commence delivery of Brief Advice Awareness sessions	Implement Vaccination Equity plan; Priorities from DHP report targeted & delivery planned	Delivery of seasonal & staff vaccination programme with data analysis to inform targeted approach	Continued delivery of vaccination equity action plan & staff vaccination programme
	Infection & Disease Control	P	Develop partnerships with GDAS to deliver Hepatitis B&C elimination plan	Commence pilot latent TB case finding service & implement TB action plan	Implement needle exchange mobile - part of Hepatitis B&C elimination plan	Evaluate pilot latent TB case finding service & agree approach for 27/28
		P	Develop HIV action plan with Fast Track Partners; Digital C-Card & increase condom access	Progress local HIV action plan; Implement C-Card evaluation action plan & service expansion	Progress local HIV action plan for Gwent & continue delivery of STI action plan	Progress local HIV action plan for Gwent; Apply for the All Wales C-Card Accreditation
	Emergency Planning	P	Development of robust training & exercise plan from learning from Pegasus	Develop incident pathways for Public Health Response Plan; Major Incident Exercise	Commence implementation of Exercise Pegasus training & exercise plan	Full implementation & embedding of Public Health Response plan
Health Improvement	Health Education & Training	P	Implement early years Make Every Contact Count (MECC) hub/spoke model	Delivery of Gwent Connect5 training in Blaenau Gwent & Torfaen to improve wellbeing	Ongoing support to Health Visiting to implement MECC into family conversations	Develop early years MECC evaluation plan & continue roll out of training
	Active & Sport Partnerships	P	Following successful pilot Bite-Sized Mental Health Sessions at 9 Rugby Clubs further roll out	Further develop Healthy Weight Alliance & collaborate with Gwent Sports Partnership	Deliver Parkrun partnerships improving participation in physical activity	Projects with sports via community psychology aligned with NEST/ NYTH
	Healthy Weight	P	Commission Level 2 weight management from local providers, fitness & wellbeing tools	Continue progress made with managing demand & 'right sizing' for specialist weight management services	Identify gap in weight management service provision & develop action plan to support patients with diabetes	Evaluate the Level 2 weight management to embed learning for 27/28; Continue to deliver Healthy weight vision
	Preventing & reducing harm	P	Implementation of plan to increase treated smokers & % CO validated quits	Implement local action plan for suicide prevention & self harm community response	Develop & begin to implement an alcohol licencing triage & response system	Continued delivery of Try Dry Local project; Launch alcohol licencing risk matrix

What we will deliver – 2026/27

Priority	Workstream		Q1	Q2	Q3	Q4
Prevention	High Risk Populations *[MT: Population Health & Prevention]*	MD	Develop evidence based patient identification method for 0.5% population at greatest risk of admission & those rapid risers i.e. proactive frailty	Scale up MDT support model & embed within place based care through the 4 Integrated Service Partnerships Boards	Partner with 4 GP practices to compare primary care & acute data sets supporting outcome measurement	Progress with primary & social care data to fully assess outcomes; Increase the Future Care Plans utilisation
	Preventable Premature Mortality *[MT: Population Health & Prevention]*	MD	Continue to implement CVD risk-factor model embedding learning from 25/26 & combining with diabetes prevention	Develop Health Coach team & align to GP Practices for delivery of Brief Intervention; Train primary care on Diabetes & CVD unified model	Commence delivery framework for Diabetes & CVD unified model; Heart Health event for World Heart Day	Roll out CVD risk factor model across 68 GP Practices; Continue delivery of diabetes delivery framework
		MD	Cancer prevention group focusing on symptom awareness within under served population groups	Review & development of Cancer Prevention as part of the Gwent Cancer 2035 delivery framework	Continue delivery of Nicotine Control Alliance workplan & implement actions from Part 2 of Nicotine Discovery Report	Implementation of Cancer Prevention as part of the Gwent Cancer 2035 delivery framework
	Population Health Management	p	Import Primary Care data into Public Health Data Warehouse & agree initial cohorts	Surface intelligence around agreed cohorts to stakeholders for proactive prevention action	Refine reports & cohorts based on observation & feedback	Commence evaluation of GP practice action
Babies, Children & Young People	Perinatal Health *[MT: Women's Health]*	MD	Embed evidence-based care across maternity pathway with early optimisation public health messaging; Establish a single point of access for maternity triage for all women	Strengthen clinical risk recognition, & early escalation with improved recognition of maternal & foetal compromise via early warning systems; Review national audit findings	Implementation of updated approach for maternity smoking cessation; Implementation of Birmingham Symptom-specific Obstetric Triage System (BSOTS)	Review opportunities for provision for vulnerable groups including rainbow clinic for bereaved parents
	Maximising outcomes for Babies, Children & Young People *[MT: Population Health & Prevention]*	P	Develop 1st 1001 Days project plan that aligns to 1001 Critical Days Foundation Grant	Seek PSB approval of Best Start in Life (BSIL) delivery plan & agree monitoring framework	Breastfeeding uptake increased by pump loan scheme, peer support & improvement plan	Continued implementation of BSIL delivery plan
		MD	Review Child Measurement process & identify service improvements; Implement training on amplifying the voice of the baby across social care	Undertake preparation for September 26 School term ensuring learning from 25/26 is applied; Develop action plan to deliver Healthy Child Wales 2	Maximise Make every Contact Count to improve healthy weight for children; Pilot Youth Board supporting integration of young peoples voice	Explore opportunities for a Youth Justice Hub in Newport; Evaluation of school health model to drive improvements in service & heathy weight

Priority	Workstream		Q1	Q2	Q3	Q4
	Whole Family Wellbeing	P	Develop monitoring framework to identify actions to progress against parenting charter	Targeted engagement with families re-referred to SPACE wellbeing to improve outcomes aligned to NEST/ NYTH	As part of parenting charter support care leavers into employment & training opportunities	Progress ACES & Trauma Information Approaches Report recommendations & monitor implementation

What we will deliver – 2027/28

Deliverables	
Scale delivery of targeted screening outreach programmes in low-uptake communities	Expand CVD risk factor model to all GP practices and develop targeted interventions & operationalise the Health Coach team across NCNs
Targeted vaccination programmes for underserved groups using improved analytics	High-risk population model improves outcomes for the most vulnerable 0.5% with reduced avoidable admissions
Secure All-Wales C-Card accreditation & expand condom access	Implement 1001 Critical Days project plan and full delivery of the Best Start in Life programme with PSB oversight & quarterly monitoring
Embed learning from Level 2 weight management evaluation & establish integrated weight-management pathways for people with diabetes.	Embed youth voice through all partnership work with established Youth Board

What we will deliver – 2028/29

Goals	
Increased & equitable uptake of screenings & vaccinations across Gwent	Deliver population health management insights to GP practices to drive proactive prevention
MECC embedded across all family and early-years pathways	Measurable reductions in smoking rates and nicotine dependency
Embedded prehabilitation reducing variation in cancer & elective care outcomes	Children receive a strong start in life through fully delivered 1001 Critical Days and Best Start in Life programmes
Significant reduction in preventable premature mortality through fully embedded CVD & diabetes frameworks	Trauma-informed & whole-family approaches embedded across education, care, & community services

Measuring our success: Performance Expectations		National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Reduce inequity in the uptake in the most and least deprived areas in preventing ill-health especially in relation to vaccination, screening & diabetes prevention & care.	MD	↓	Yes	N/A	Baseline data	Reporting	Reporting	Reporting
% children up to date with vaccinations by age 5		95%	No	85.3%	87%	88%	89%	90%
% of children receiving HPV vaccination 1 dose by the age of 15		90%	No	67.9%	72.5%	75%	77.5%	80%
% uptake of the influenza vaccination amongst adults aged 65 years and over		75%	Yes	73.4%	-	-	-	75%
% uptake of the Respiratory Syncytial Virus (RSV) for those turning 75 years old		70%	No	55%	-	-	-	65%
% adult smokers who make a quit attempt via smoking cessation services		7.5%	No	4.4%	1.3%	2.5%	3.8%	5%
% adult smokers who made a quit attempt via smoking cessation services who are carbon monoxide-validated as quit at 4 weeks		40%	Yes	20.4%	25%	30%	35%	40%
Maintain physical examination at 6 weeks rates (Healthy Child Wales)		-	-	96.5%	90%	90%	90%	90%
Increase weight and measurement at 8 weeks rates (Healthy Child Wales)		-	-	90.2%	90%	90%	90%	90%
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	MD	↑	Yes	75.1% (2023/24)	-	76% (data expected Q2 28/29)	-	-
Increase in % of patients (aged 12 years & over) with diabetes who received all eight NICE recommended care processes	MD	80%	No	44.3%	47%	48%	49%	50%
Percentage of patients (aged 12 years & over) with diabetes who have had foot surveillance recorded within last 15 months		80%	No	66.9%	70.2%	73.5%	76.7%	80%
Percentage of patients (aged 12 years & over) with diabetes who have had their urine albumin recorded within last 15 months		80%	No	67.5%	70.7%	74%	77.1%	80%
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.	MD	90%	Yes	N/A	-	-	-	90%
Improving the quality of our maternity services by reducing perinatal mortality rates.	MD	↓	Yes	5.2	-	-	-	5.1
Uptake of eligible patients who attend cardiovascular disease risk factor management programme (CVDRFMP)		-	-	N/A	3,125	3,125	3,125	3,125
% of people who attended CVDRFMP diagnosed		-	-	N/A	312	312	312	312
No. starting 12-week intervention with Level Two Adult Weight Management Service		-	-	N/A	1,500	1,500	1,500	1,500
No. with end weight recorded who accessed 8+ sessions who lost >5% weight		-	-	N/A	450	450	450	450

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

Outcomes

Our provided & commissioned services will meet the relevant quality & clinical standards

People will have more Healthy Days at Home

More people will be able to access health services in their local communities

Priorities

Place Based Care

Access & Sustainability

Improving Quality & Experience

Embedding Value & Efficiency

Quality Statements

SAFE	Organisational learning & system review is highlighted where safe care is questioned
EFFECTIVE	Consistent use of nationally agreed evidence-based pathways
EQUITABLE	Care & treatment are determined by clinical priority
TIMELY	Timeliness of pathways is measured across their entire length, beyond first definitive treatment
EFFICIENT	Detection, diagnosis & effective management of high-risk conditions
PERSON CENTERED	Person-centred care is embedded through a common approach to assessing & managing people's needs

Why this is a Priority

The aim of Better Care is to provide quality care with an individual focus, helping to promote lasting health and building an efficient and sustainable healthcare system for the future.

Place based care is an approach to delivering care that meets people's unique needs by using the resources of the community where they live or that they feel connected to. It focuses on the resources available in an area to make sure that people get the right care, in the right place, and at the right time. This not only helps to provide early intervention and reduce hospital admissions but delivers value for money and aims to reduce inequity of care in our communities. We are focussing on providing place-based care across Gwent according to the health needs of the local population, such as Breathlessness hubs for those with chronic respiratory conditions. Place based care is also a key commitment in the NHS-led Women's Health Plan, with the opening of our first pathfinder women's health hub this year. Women and girls make up just over 50% of our population but research suggests that women's health concerns are not sufficiently discussed or taken seriously. The introduction of this hub will enable women to gain timely access to services and obtain the care they need while promoting preventative measures and empowering them to take charge of their health and wellbeing. One measure underpinning this is determining the number of Healthy Days at Home which is an annual measure based on each person within the population having 365 days to spend at home or receiving care. In Gwent, the number of Healthy Days at Home is currently between 359-360, indicating an average of 5-6 days of receiving care per person.

Access and sustainability is about providing services in the right places for our residents but also ensuring these are viable for the long term. This spans all elements of our healthcare system, from increasing our primary care services, streamlining the flow through our hospitals, reducing patient wait times and ensuring specialist services are available in the most appropriate places, whether locally or regionally. In Planned Care, a key focus is on reducing the time it takes to be seen by the right professional for your needs. This is especially important in suspected cancer, as timely diagnosis & treatment leads to improved survival rates. Recent modelling by Public Health Wales has projected that by 2035, there will be around 24,000 new cancer cases each year, up from around 20,000 in 2019. The Suspected Cancer Pathway is a Welsh Government target for diagnosis and starting treatment more quickly, aiming to wait no more than 62 days from point of suspicion to starting definitive treatment.

The National Target is 75% but the Health Board has yet to reach more than 67% compliance in the past year. We are also committed to delivering regional services where one organisation cannot meet population demand, as exemplified by The South East Wales Regional Ophthalmology Programme. This was the first regional programme of its kind, led by ABUHB and spanning health boards within the South East of Wales. The aim is to ensure sustainable Ophthalmology Services that deliver high quality care and improved outcomes to patients in a timely way. The programme's success can be seen in the reduction of all 104-week waits to 0 by March 2025 and over 20,000 eyes treated to date. While the programme began with extra funding for outsourcing, the goal now is to increase NHS capacity by using high volume centres that can treat more patients, ensuring a sustainable model for the future.

Improving quality and experience is a priority for the organisation and is well reflected in the results of our Patient Experience CIVICA survey. Since its introduction in May, the overall satisfaction score ranges between 86-88%, with the lowest scoring question consistently relating to waiting times. A key area of national interest is improving patient experience in our emergency department and minor injury units, as our hospital system continues to see a rise in demand for urgent and emergency care. Despite this rise, ambulance handovers exceeding one hour at the Grange University Hospital have steadily improved over the past two years, recently reaching the lowest monthly figures for more than four years in September 2025. This demonstrates the hard work and dedication staff provided to help achieve the national Ambulance Performance Framework protocol. However, a difficult winter period has had a significant impact with the latest figures almost double the September low. This period had a negative impact on other measures including the patient waiting times.

The downstream effect of greater demand at the front door can also be seen in the number of patients admitted as an emergency who have stayed in hospital for more than 21 days, which reached its highest December figure for three years. The Health Board was consequently escalated into Targeted Intervention for performance and outcomes related to urgent and emergency care in recognition of these pressures.

interventions including the re-launch of the Our Next Patient initiative with a focused, time-limited plan to reduce ambulance handovers and restore continuous flow in the hospital system, leading to an improvement in quality of care and patient experience.

Embedding value and efficiency in how we provide care is essential for ensuring a sustainable health service in Gwent. We want to maximise the services we offer, ensuring they are managed efficiently, while providing the best value for patients. 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. A recent success was the introduction of the Health Pathways platform, which provides the latest pathway guidance for specific conditions, as well as information on navigating the primary/secondary care interface, producing efficient pathways for both patients and clinicians. We now have 180 pathways live with the plan to introduce 32 more in the coming year. We are also focussing actions on our outpatient provision, overseen by our Outpatient Transformation Programme team. The rate of patients not attending or cancelling appointments has been steadily decreasing over the past year but is still performing above the 5% national target, requiring a targeted approach in areas with the highest rates. The team have also been focussed on the longest waiting patients on follow-up lists, as those waiting 100% past their follow-up rate has been steadily increasing over the past year. Patient validation has been key to identify discharge opportunities and those suitable for retrospective application of see on symptom and patient initiated follow-up pathways. By taking a whole system approach to embedding value and efficiency, we can provide the best experience for our patients.

By providing timely, quality services tailored to individual needs, we aim to deliver what matters most to our residents and create a sustainable care model where our staff can thrive.

What we will deliver – 2026/27

Priority	Workstream		Q1	Q2	Q3	Q4
Place based care	Neighbourhood Teams & Community Pathways *[MTs: Community by Design, Population Health & Prevention]*	MD	Define local integrated neighbourhood team roles & responsibilities aligned with Place-Based Care principles	Engage partners across social care & voluntary sector to co-design implementation for Torfaen & Blaenau Gwent	Establish integrated pathways and collaborative forums to align services with population health needs	Refine model and prepare plan for scaling Place-Based Care approach across additional localities
		MD	Define multi-disciplinary team best practice and scale up across ISPBs; Develop & agree frailty patient identification	Bring together clinicians from across Gwent to agree future MD approach delivery defining role in place based care	Partner with 4 GMS practices to compare data; Develop outcome measurement for patients & health system	Gather additional partner data to fully assess outcomes; Increase utilisation & access of first contact practitioners
		MD	Pilot Breathlessness hubs to improve early intervention in care for patients with chronic respiratory symptom	Following pilot evaluation, agree implementation approach; Explore options for community Audiology	Develop integrated breathlessness care pathways aligned with evidence-based practice	Implement integrated breathlessness care pathway through targeted approach to test feasibility
		MD	Strengthen weekend working across community nursing maintaining 57% average	Review progress and work toward achieving 61% weekend working	Review progress, apply previous learning and work towards achieving 65%	Consolidate learning from the year aligned with national expectations to achieve 69%
	Women's Health *[MT: Women's Health]*	MD	Rollout of Women's Health Pathfinder Hub through digital platform & service expansion of Gynae Ambulatory Care Unit & Sexual Health Services	Continue to develop women's health single point of access (SPOA) for referrals; Training focused on removing stigma & patient-centred engagement	Scope expansion of women's health to next priority area; Ongoing development of SPOA for referrals; Implementation of delivery plan	Continue partnership engagement through ISPBs to further develop local community models that address women's health needs
Access & Sustainability	Primary Care Sustainability		From 1st April management & ensure ongoing GMS provision of GP practices without independent contractor status	Completion of procurement for returning available directly supported GP practices to independent contractor status	Support the returned GP Practices through enhanced monitoring ensuring access of care for the communities	Work with the returned GP Practices to ensure sustainability for the future year & long term sustainability
			Implement initial variation for dental practices of the new dental contract reform	Respond to individual dental practice requests and monitor for additional adjustments	Analysis of 1st six months of contract monitoring to maximise application to meet population need	Undertake evaluation of the 1st year contract delivery to adjust plans for 27/28
			Full implementation of all Welsh Government Optometry Services pathway 4 elements	Maximise Pharmacy Independent Prescribing and Common Ailment Service	Timely management of urgent eye care issues by increasing Optometry Services activity	Maximise Pharmacy Independent Prescribing and Common Ailment Service

What we will deliver – 2026/27

Priority	Workstream		Q1	Q2	Q3	Q4
Access & Sustainability	Urgent Care & Emergency Care *[MTs: Urgent & Emergency Care Community by Design]*	MD	Enhance integrated front-door by streamlining access & Community Assessment Lounge (CAL) evaluation to inform future model	Relaunch of Care Home Escalation Framework; Commence agreed CAL model post evaluation; Refresh Community Capacity analysis	Develop plan using learning from Caerphilly pilot of wider rollout of care home support; Develop Community Capacity map & share across Gwent	Implement Care Homes Support Programme to additional locality; Evaluate impact of Future Care Planning training delivered in Q1-Q3
		MD	Simplify access developing an options appraisal for sustainable clinical model for Single point of Access (SPOA)	Continue review of flow centre pathways; Assess opportunity for community falls response linked to assistive tech	Implement integrated reporting system for SPOA referrals & outcomes; Develop a falls prevention programme with partners	Develop pathways to integrate community falls response in SPOA; Enhance front door response & timeliness for non-injurious falls
		MD	Continue to embed Optimal Hospital Flow Framework & criteria led discharge across all sites monitoring progress & benefits; Identify areas to pilot the Trusted Assessor (TA) model through engagement with stakeholders	Continue to ensure the Criteria Led Discharge framework is applied 7 days a week ; Define the optimal discharge pathway & co-design with stakeholders; Monitor impact & identify further areas to pilot TA	Implement the single integrated digital discharge platform; Pilot the optimal discharge pathway and refine for wider roll out; Commence implementation of new Optimal Staffing Discharge model	Evaluation of Criteria Led Discharge framework to evidence impact; Continue implementation of Optimal Staffing Discharge model; Roll out TA in phases coupled with optimal discharge pathway across Gwent
	Longest Waiting Patients *[MT: Planned Care & Cancer]*	MD	Commence pilot of service improvements in Endoscopy including Cytosponge, Colon Capsule, Trans Nasal Endoscopy & Speedboat	Continue oversight of 8 week trajectories diagnostics improving MR, CT & Ultrasound	Development of proposal for 3C service model in Endoscopy to improve sustainability & reduce waiting times	Achieve 0 patients waiting more than 8 weeks for a specified diagnostic through improving MR, CT, Ultrasound & Endoscopy
		MD	Commence implementation of Audiology sustainability action plan to improve waiting times for babies, children & Adults	Take targeted actions on demand management schemes to benefit 52 week outpatient position	Delivering of efficiency & productivity schemes to reduce longest waiting patients for treatment	Deliver demand management, efficiency & productivity to benefit longest waiting patients for outpatients and treatment, achieving expected trajectory
		MD	Lower GI Cancer recovery plan driving reduction in time to scope; Establish Upper GI & Breast cancer recovery groups	Quarterly cancer backlog reduction to 9% or less; Monitor pathway cancer recovery groups compliance	Quarterly cancer backlog reduction to 7% or less; Review pathway cancer recovery groups compliance	Quarterly cancer backlog reduction to 5% or less; Revise pathway cancer recovery groups based on compliance

What we will deliver – 2026/27

Priority	Workstream		Q1	Q2	Q3	Q4
Access & Sustainability	Longest Waiting Patients *[MT: Mental Health Access]*	MD	Commence action plan delivery to meet national target for Memory Assessment Service; Maintain Part 2 Care & Treatment Plan Adults national target of 80%	Maintain Adults Part 1a & Part 1b national target of 80% compliance; Complete pathway review to improve psychological therapies waiting times	Commence action plan delivery to meet national target for Memory Assessment Service; Maintain Part 2 Care & Treatment Plan Adults national target of 80%	Maintain Adults Part 1a & Part 1b national target of 80% compliance; Implement pathway changes to improve psychological therapies waiting times
		MD	Maintain CAMHS Part 1a & Part 1b national target of 80% compliance; Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	Improve Neurodevelopment (ND) waiting times compliance to 80%; Maintain CAMHS Part 2 Care & Treatment Plan (national target of 80%)	Maintain CAMHS Part 1a & Part 1b national target of 80% compliance; Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	ND waiting times compliance meets 80%; Maintain CAMHS Part 2 Care & Treatment Plan national target of 80%
		MD	Start to embed Open Access principles by expanding self-referral pathways	Engage with partners on plan to fully implement Open Access services for all ages	Implement plan to develop Open Access services across all ages	Evaluate opportunities to further develop Open Access services for all ages
	Models of Care		Define the optimal service model for Acute Medicine & undertake service modelling	Design Acute Medicine patient pathways, workforce model and financial plan	Draft implementation plan; Service model shared with Llais and wider stakeholders ahead of engagement	Engagement and consultation with staff and the public to ensure shared understanding, and collective ownership
			Deliver Stroke Improvement Board agreed action plan aligned with revised National Stroke Quality Statement	Undertake 12 week consultation period on Stroke inpatient rehabilitation model	Implement outcomes of consultation on Stroke inpatient rehabilitation model	Evaluate Stroke action plan delivery to inform 2027/28 ensuring aligned with National Stroke Quality Statement
			Incorporate feedback into the Older Persons model to ensure alignment with strategic priorities	Engage wider stakeholders, including Local Authorities, voluntary sector, primary care, and community partners	Test the Older Persons model through a pilot to gather further feedback and refine	Implement the Older Persons model in phased stages with communication & staff training
			Agree strategic estate direction for inpatient & community based Mental Health service model	Identify Mental health estate requirements & potential options Further plans for Adult Mental Health Rehab ward as we move to Community Model	Confirm preferred Mental Health estate approach & phasing aligned to service & workforce; Progress Adult Community Rehab Service	Detailed plans for all Mental Health In-patient services developed; Progress the co-location of Mental Health Older Adults wards

What we will deliver – 2026/27

Priority	Workstream		Q1	Q2	Q3	Q4
Access & Sustainability	Regional Planning		Primary arthroplasty model & pathway developed with workforce & finance model Regional diagnostics management group established Development of a Business Case for Regional Cellular Pathology Unit;	Radiology Workforce plan development RJC Agreement of the business case for Regional Cellular Pathology Regional Ophthalmology Alliance Model – Cataracts Pilot; Implementation of Open Eyes, OPERA & shared Patient Treatment List (PTL); Develop comprehensive strategic workforce plan	Refresh arthroplasty demand & capacity (D&C) & assess performance monitoring metrics Endoscopy training academy model & operating model for regional units established; Repeat D&C to inform Llantrisant Health Park; Consideration of complex procedure model with JCC Implementation of single Cataracts regional pathway Shared Cancer PTL established	Develop plan for sub-specialty orthopaedics opportunities Regional response & offer to Lung Screening programme Following agreement of Cellular Pathology business case, site agreement & associated development; Consistent SEW Cancer MDTs implementation of National MDT Charter & guidance; Implementation of cancer MAG actions; Regional Oncology workforce plan
Improving Quality & Experience	Primary Care		Undertake review of NCN supplementary services to understand the gap in provision	Explore options to engage on a multi agency basis to reduce inequity	Assess the level of latent capacity for GMS providers and explore capacity for inter practice referrals	Undertake end of year review to inform gap analysis and embed learning for27/28
	Urgent Care Recovery *[MT: Urgent & Emergency Care]*	MD	Review interim ED clinical model and identify if there are any digital opportunities to support delivery	Evaluation of eTriage; Develop Head injury pathway, initially looking at navigation within hospitals	Mapping of ED patient process & identify challenges, risks & areas for improvement	Identify opportunities for system flow within ED to create space within the department
	Babies & Children *[MT: Women's Health]*	MD	MatNeo A3 progressed to develop transitional care space & additional postnatal beds; Workforce review of sonography services & ongoing audit of small gestational age babies with shared learning	Continued improvements to Neonatal Ward through implementation of risk assessment action plan; Strengthen interface between maternity & neonatal services with MDT staff wellbeing training	MatNeo A3 Development progressed to develop transitional care space & additional postnatal beds; Improve investigation process & rigorous review of all stillbirths & neonatal deaths	Continued Improvements to Neonatal Ward through implementation of risk assessment action plan; Implement Parental review following baby deaths as a Patient Reported Experience Measures (PREMS)

What we will deliver – 2026/27

Priority	Workstream		Q1	Q2	Q3	Q4
Improving Quality & Experience	Planned Care & Cancer		Undertake gap analysis of GIRFT recommendations & develop action plan; Develop plans to improve psychology support for cancer patients	Specialties to progress and track compliance with CIN Frameworks; Implement plans to improve psychology support for cancer patients	Implement GIRFT recommendations action plan; Implementation of plan to ensure Eye Unit meets RNIB compliance standards	Delivery of NICE drugs for Haematology patients; Implement prehabilitation for patients waiting for surgery as part of their cancer pathway
	Mental Health *[MT: Mental Health Access]*	MD	Complete Older Adults ward accreditation to at least bronze level	Complete Adults & Learning Disabilities ward accreditation to at least bronze level	Complete Adults & Learning Disabilities ward accreditation to at least bronze level	Complete Community ward accreditation to at least bronze level
		MD	Carry out mortality reviews and ensure mechanisms for capturing learning in place	Carry out mortality reviews and develop improvement plans based on learning	Implement improvement plans incorporating learning from mortality reviews	Embed improvement plans incorporating learning from mortality reviews
Embedding Value & Efficiency (Enabling Actions)	Theatre Maximisation *[MT: Planned Care & Cancer]*	EA	Capture detailed learning from T&O Perfect Month & national benchmarking to achieve EA standard; Drive improvements in late starts/early finishes & theatres	Use Perfect Month learning & national benchmarking to design an action plan for wider roll out; Direct listing for cataracts; HVLC in General Surgery roll out (subject to coding agreement)	Continue to track improvements & problem solve in late starts/ early finishes and cancer patients attending Theatre within 21 days as per National Optimal Pathways	Achieve 25% HVLC Day Case Rate; Continue to track improvements & problem solve in late starts/ early finishes
	Health Pathways *[MT: Planned Care & Cancer]*	EA	Implement additional 8 new pathways; Develop approach to monitor consistency & GP feedback loops post triage	Implement additional 8 new pathways; Embed through targeted communication & clinical interface groups	Implement additional 8 new pathways; 6 monthly review of data, usage, impact & learning	Implement additional 8 new pathways; Reflect opportunities from 6 monthly review into focused actions
	Outpatient Transformation *[MT: Planned Care & Cancer]*	EA	Review outpatient space utilisation through audits of room use/start & finish time; SOS/PIFU retrospective application roll out; Implement Validation Strategy;	Template review & standardisation roll out by speciality (new, follow ups); Pilot of outpatient booking app in RGH; Additional specialities in Outpatient treatment Unit	Further Did Not Attend/Can Not Attend deep dives, Work with specialties to improve utilisation, roll out of booking app to NHH and YYF;	Continue working with specialties to improve utilisation
	Enhanced & Commissioned Care	EA	Delivery of Direct Payments aligned to legislation from April 2026; Roll out Care Cubed Digital platform	Develop alternative accommodation options for Learning Disabilities reducing out of area placements	Continued implementation Care Cubed Digital platform	Develop alternative Adult Mental Health accommodation options reducing out of area placements

What we will deliver – 2027/28

Deliverables	
Scale Place-Based Care model to additional localities informed by learning from Torfaen and Blaenau Gwent pilot	Begin phased implementation of the agreed Acute Medicine service model across all sites, including workforce realignment
Implement MDT core components and governance across all NCNs based on 26/27 evaluation learning	Implement full Open Access self-referral pathways for children, adults and older people
Strengthen community-based women's health pathways through Integrated Service Partnership Boards	Complete implementation of Mental Health service model redesign aligned to estate consolidation
Deliver targeted interventions for practices experiencing instability, using NCN-level demand and capacity analysis	Continue to work across SE Wales to deliver regional models of care for fragile services
Continue to identify pathway opportunities where clinical review before conveyance would enhance patient experience and outcomes	Deliver improved neonatal transitional care capacity and embed risk-assessment actions consistently
Achieve consistent criteria-led discharge and full operationalisation of the integrated digital discharge platform	Deliver targeted action for Theatre Maximisation and Outpatient transformation
Implement 3C Endoscopy Service model to reduce waiting times and increase sustainability	Embed the Care Cubed digital platform for CHC commissioning

What we will deliver – 2028/29

Goals	
A fully embedded, Gwent-wide Place-Based Care model providing coordinated, proactive support in every locality	Fully accredited Mental Health services demonstrating high reliability and improved safety outcomes
A sustainable primary care system with stable contractor models, extended multi-professional pathways and improved same-day access	Widespread adoption of GIRFT and national frameworks improving quality and reducing unwarranted variation
Seamless urgent and community care pathways reducing conveyance, hospital attendance and delayed discharge	Significant improvements in efficiency through Theatre Maximisation and Outpatient transformation
Optimised hospital flow with reduced length of stay and improved patient experience	Significant reduction in out-of-area placements

Measuring our success: Performance Expectations		National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Increase in people accessing Pharmacy Independent Prescribing Services where they would have visited their GP		-	-	36,649	11,405	22,810	34,215	45,620
Maintain the number of consultations undertaken by community pharmacy under the Common Ailments Service		-	-	88,603	24,968	49,936	74,903	99,871
Maintain the number of patients accessing NHS Optometry Services		-	-	265,118	66,820	132,559	198,839	265,118
Number of patients accessing urgent emergency services - Dental		-	-	36,173	9,043	18,087	27,130	36,173
Increase in number of accepted referrals to Rapid Response services		-	-	4,885	1,267	2,534	3,801	5,068
Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s		-	-	8%	8.5%	8.5%	8.5%	8.5%
Maintain the number of Urgent Primary Care contacts (inc. virtual)		-	-	96,371	25,437	50,873	76,310	101,746
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	MD	↓	Yes	180	150	140	130	120
Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard	MD	↓	Yes	6,085	4,500	4,200	4,160	3,840
Ensure no ambulance patient handover waits over 45 minutes - All Locations	MD	0	No	1,471	733	455	374	364
Ensure no ambulance patient handover waits over 45 minutes – Grange University Hospital Emergency Department	TI	11% ↓ for 3 months	Yes	943	578	400	330	320
Reduce the number of ambulance crew hours lost – All Locations		-	-	3,556	1,949	1,250	1,031	960
Reduce the number of ambulance crew hours lost – Grange University Hospital Emergency Department		-	-	2,653	1,559	1,000	825	768
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	MD	0	No	1,089	1,066	875	908	799
Increase and maintain national target of the percentage of patients waiting <4 hours in Emergency Department/Minor Injury Units		95%	No	73.5%	75%	76%	76%	77%
Reduction in time from arrival to Emergency Department triage: no waits over 60 mins		-	-	414	300	200	400	200
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.	TI	<60 mins	Yes	135 mins	100	80	80	60
% of suspected stroke patients scanned within 20 minutes of clock start		40%	No	24.1%	25%	28%	31%	35%

Measuring our success: Performance Expectations		National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
% of patients directly admitted to an acute stroke ward <4hrs of clock start		50%	No	7.7%	20%	21%	22%	23%
% of unique stroke patients given thrombectomy (all stroke types)		10%	No	4.5%	5%	5%	6%	6%
% Assessed by one of Occupational Therapy & Physical Therapy within 24hrs, and Speech and Language Therapy within 72hrs		-	-	OT 20% PT 20.7% SaLT 64.4%	OT 25% PT 22.5% SaLT 66%	OT 27.5% PT 25% SaLT 68%	OT 30% PT 27.5% SaLT 70%	OT 32.5% PT 30% SaLT 72%
Improve the % of pre-noon Provider Spell discharges		33%	No	16.3%	16.5%	16.7%	16.9%	17.1%
12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	MD	75%	Yes	55.9%	66.5%	74.3%	74.8%	75%
Reduction in backlog of patients waiting over 62 days (single Suspected Cancer Pathway)	MD	↓	Yes	342	350	300	240	170
Reduction in backlog of patients waiting over 104 days (single Suspected Cancer Pathway)	MD	↓	Yes	99	105	90	72	50
% of urgent suspected cancer patients diagnosed within 28 days from point of suspicion		-	75%	69.6%	72.5%	75%	75%	75%
Numbers of patients waiting over 104 weeks (all stages)	MD	0	No	434	842	1,577	2,213	3,022
Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic	MD	0	Yes	2,387	3,048	2,559	1,292	0
Number of patients waiting over 52 weeks for Outpatients		0	No	1,834	3,587	5,435	5,578	5,898
Number of patients waiting over 26 weeks for Outpatients		0	No	12,222	15,772	19,475	20,948	22,361
Reduction in referral rate per 100,000 population by December 2026 - utilising Health Pathways optimally	EA	↓	Yes	900	900	900	800	800
Monitoring of Did Not Attend rates Outpatient clinics		<5%	Yes	5.2%	5%	5%	5%	5%
Reduction in the number of patients waiting 100% past Outpatient follow-up target date		25% ↓	Yes	31,592	29,150	27,542	25,574	23,606
Increase in the rate of See On Symptom and Patient Initiated Follow-ups		↑	Yes	12.9%	13.5%	14%	14.5%	15%
No patient waiting more than 14 weeks for a therapeutic assessment		0	No	237	395	540	685	830
Number of adults waiting more than 14 weeks for all audiology pathways		0	No	5,628	5,988	6,432	6,932	7,385
Number of children waiting more than 6 weeks for all audiology pathways		0	No	1,455	1,177	1,428	1,512	1,762

Measuring our success: Performance Expectations		National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Theatre Utilisation: late starts to less than 15%	EA	15%	No	37%	35%	32%	29%	25%
Theatre Utilisation: early finishes to less than 15%	EA	15%	No	30.7%	22.5%	20%	17.5%	15%
Theatre Utilisation: session utilisation to 85%	EA	85%	Yes	83.1%	85%	85%	85%	85%
Deliver improvements in day surgery rates, measured through British Association Of Day Surgery day case rates		80%	Yes	77%	78%	79%	80%	80%
Maintain Adults Part 1a to national target (assessment within 28 days)		80%	Yes	93.3%	80%	80%	80%	80%
Maintain Adults Part 1b to national target (intervention within 28 days)		80%	Yes	93.2%	80%	80%	80%	80%
Maintain Adults Part 2 rates (no of individuals with a valid care & treatment plan)		90%	Yes	91%	90%	90%	90%	90%
Maintain rate of psychological therapy received within 26 weeks		80%	No	48.8%	56%	58%	60%	62%
Maintain Child and Adolescent Mental Health Services Part 1a national target (assessment completed within 28 days)		80%	Yes	100%	80%	80%	80%	80%
Maintain Child and Adolescent Mental Health Services Part 1b national target (intervention completed within 28 days)		80%	Yes	88.3%	80%	80%	80%	80%
Maintain Child and Adolescent Mental Health Services Part 2 national target		90%	Yes	98.3%	90%	90%	90%	90%
Improvement in Neurodevelopment waiting times compliance		80%	Yes	57.2%	60%	60%	60%	60%
Maintain 80% compliance of Specialist Child and Adolescent Mental Health Services Choice Assessments within 28 days from referral		80%	Yes	92.5%	80%	80%	80%	80%
Implement actions to deliver a material reduction in the number of out of area placements in 2026/27, and associated costs.	EA	↓	Yes	0	0	0	0	0
Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.	MD	↓	Yes	1.36%	1.39%	Programme to predict %	Programme to predict %	Programme to predict %
Days of safe care delivered since the last never event, monitored using SPC T-Chart	MD	Implement	Yes	Not in place	Implement	Implement	Implement	Implement
Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027	MD	40%	Yes	33.9%	35%	36.5%	38%	40%
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 national measures.	MD	95%	No	88.9%	91%	91%	91%	91%

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

Outcomes

- People will find it easier to connect with their communities, use local services, & feel respected
- Our budget spent on services in the community will have increased across Gwent
- More people will engage with their local community to reduce loneliness & support good health

Priorities

- Healthy Places
- Resilient & Connected Communities
- Safe Spaces
- Quality of Life

Quality Statements

SAFE	Ensure a system wide focus across all service areas including housing, leisure, TEC, third sector & others
EFFECTIVE	Embed a culture that encourages & enables innovation to improve outcomes
EQUITABLE	Co-produced services that utilise local needs assessment to understand & meet needs of population
TIMELY	Provide evidence based interventions, treatments & care in the most appropriate setting
EFFICIENT	Value-Based approach to improve outcomes that matter most to people in a way that is sustainable
PERSON CENTERED	Work in partnership with third sector to provide peer support opportunities for those with lived experience

Why this is a Priority

As a Marmot Region, Gwent is committed to reducing health inequalities by focussing on the social determinants of health.

Healthy places encompass the local areas we spend time in. Gwent residents have identified feeling part of a community, & being able to socialise as important factors for good health. Recent data shows that only around two thirds of Gwent residents agree that they belong to the area, that people from different backgrounds get on well together, & that people treat each other with respect & consideration. Additionally, people living in rural areas often reported feeling isolated and wanted better transport options to help them travel across Gwent.

To support **resilient and connected communities**, we are committed to increasing the budget and capacity for services in the community. In Gwent, around 12% of adults report being lonely, while more than a third of young people report that they can't count on friends when things go wrong. Evidence demonstrates the detrimental effect of loneliness with it significantly increasing the risk of premature death, the equivalent of 15 cigarettes a day. Wales is leading the way with its National Social Prescribing framework and we are committed to connecting & mobilising the existing strengths within communities to enable them to thrive.

Having access to **safe spaces** is an important aspect of wellbeing, & pertinent considering Gwent still has the highest rate of domestic abuse-related incidents recorded by police in England & Wales, with 34 per 1,000 population in 2025. Around 57% of residents feel safe after dark when at home, travelling, or walking in their local area. However, this ranged from 47% in Blaenau Gwent to 76% in Monmouthshire, highlighting diverse challenges across our local communities.

Quality of life is a culmination of our social, physical and emotional wellbeing, and we want to enjoy a good quality of life for as long as we live, in sickness & in health. We are committed to supporting the wellbeing of residents through initiatives such as support cafes, Melo, our self-help website for mental health, and new "prehabilitation" programmes designed to speed up recovery & reduce complications following treatment.

By prioritising Better Lives, we can build stronger, safer, & more connected communities & give everyone the chance to live longer, healthier, & happier lives.

What we will deliver – 2026/27

Priority	Workstream		Q1	Q2	Q3	Q4
Healthy Places	Built Environment & Green Spaces	P	Enhance health through the built environment in planning processes & integrated collaboration across Gwent	Blaenau Gwent Green Space initiative to improve health and wellbeing through the use of gardens and outdoor space	Enhance health through the built environment in planning processes & integrated collaboration across Gwent	Embed nature partnerships across integrated wellbeing networks aligned to place based care
	Education & School Partnerships	P	Whole school approach for emotional & mental wellbeing programme develop & commence delivery plan with Cynefin	Continue roll out of bitesize skills sessions for teachers including grounding techniques & stress response	Following successful pilot in Newport roll out transitions workshops for year 6s across Gwent	Continued implementation of whole school approach for emotional & mental wellbeing delivery plan in partnership with Cynefin
Resilient & Connected Communities	Building Community Capacity & Social Prescribing	P	Map existing community assets and implement social prescribing pathway to align with Place Based Care model; Enhance recruitment of wellbeing friends network	Co-produce social prescribing model through joint design sessions with NCNs, Integrated Wellbeing Networks, local authority, & voluntary sector partners	Ongoing work alongside partner organisations to identify, connect & mobilise the existing strengths within communities to enable them to thrive.	Continue partnership working with NCN networks, identifying gaps in provision & evaluate pilots of social prescribing pathways to scale up across Gwent
	Carers	P	Developing carer specific outcomes & partnerships across the programme	Establishing & rolling out Carer Friendly Accreditation model	Continued implementation of Carers Hub plan	Implementing end of Regional Integrated Fund transition plans
	Transport	P	Find a new voluntary sector delivery partner for patient transport	Develop a transport & health needs assessment to identify access barriers	Engage with partners on outcomes of transport & health needs assessment	Pilot community-based transport solutions for key health access challenges
Safe Spaces	Reducing Domestic Abuse	P	Promote Men's Ally Network & provide understanding of Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) impact	Implement VAWDASV needs assessment recommendations with multi-agency partners	Continue delivery of Serious Violence Duty within Gwent	Development of 2027 VAWDASV strategy, aligned to national strategy
	Housing	P	Review Public Health & Severn Wye evaluation & implement findings into Gwent Warmer Homes project	Working in Partnership Analyse primary care data, working with GP Practices to identify people for the Warmer Homes Project	Finalise & deliver 2026 offering for Warmer Home Support; Finalise Housing & Health assessment & benchmarking with partners	Working in Partnership Evaluate the success of incorporating primary care data into the Warmer Homes cohort identification

What we will deliver – 2026/27

Priority	Workstream		Q1	Q2	Q3	Q4
Quality of Life	Keeping Well	P	Review Third Sector commissioned work to understand how they can best support reduction in loneliness & isolation	Improve health & wellbeing for patients accessing planned care through pro-active preparation for treatment	Continued development and engagement across our communities on Melo supporting mental wellbeing	Improve health & wellbeing for patients accessing planned care through pro-active preparation for treatment
	Recovery & Rehabilitation	P	Develop a community directory outlining pre-hospital & discharge services; Set up a further Cancer Café, run by volunteers in 19 Hills Wellbeing Centre	Develop National Dementia Advocacy service specification with ambition of place-based delivery aligned with local hub	Implement organisational rehabilitation framework following development through wide engagement	Explore capital scheme to host existing dementia hub service delivered by Alzheimer's Society
	End of Life Care		Operationalising new workstreams (Workforce, Clinical Delivery, Digital & Data, Children Young people & Families & Bereavement & Carer support) aligned to New National Service specification & competency framework	New workstreams commence with a whole system approach and measurement of success agreed with key performance indicators	Continued implementation of key objectives against the five workstreams aligned to National specification & competency framework with whole system accountability	Evaluation of delivery of the key objectives identified against the five workstreams to inform delivery in 27/28

What we will deliver – 2027/28

Deliverables	
Implement a framework for assessing health impact within local area planning	Finalise and launch the new VAWDASV strategy
Establish a cross-education health partnership forum	Scale Warmer Homes interventions across priority cohorts
Expand the wellbeing friends network and embed across NCNs	Embed the community directory for pre-hospital and discharge services
Maturity assessment of the Carers Hub with recommendations for sustainability	Implement psychological support pathway across specialist palliative care

What we will deliver – 2028/29

Goals	
Health impacts consistently considered in all major planning decisions	Regional VAWDASV strategy delivers measurable reductions in harm
Community wellbeing & social prescribing fully embedded across Gwent	Improved health outcomes through prehabilitation & rehabilitation pathways
Health impacts of poor housing reduced	Consistent & equitable End of Life Care across all settings

Measuring our success: Performance Expectations		National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
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	MD	↑	Yes	75,940	29,556	59,112	88,667	118,223
Maintain 95% of Palliative Care referrals assessed within 2 days		-	-	91.4%	92%	93%	94%	95%
Number of visits to the Melo Website		-	-	12,063	3,000	6,000	9,000	12,000

With our partners there is ongoing work to define the Better Lives performance indicators throughout 2026/27. This work includes development of the Gwent Public Health Indicators Framework & Gwent Public Health Outcomes Framework. This work will be evidenced in performance reporting and our plan for 2027/28.

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Better health | Better care | Better lives
Iechyd gwell | Gofal gwell | Bywydau gwell

Section 4 Enablers

- Quality
- Workforce & Culture
- Digital, Data & Technology
- Estates
- Finance
- Green Health
- Value, Innovation & Research

Quality and safety remain the Health Board's highest priority, underpinned by the statutory Duty of Quality and Duty of Candour. These duties shape how assurance flows from ward to Board and are embedded through the strengthened Quality Management Framework (2025–28) and the developing Quality Management System (QMS), which together provide a consistent, organisation-wide method for planning, control, assurance and improvement.

Bringing together Quality & Patient Safety, PTR, Legal Services and Quality Improvement has improved consistency, strengthened escalation, and accelerated movement from incident or audit findings to action and assurance. Real-time data, lived experience and clearer governance structures now drive decision-making through our structures.

The focus for 2026/27 is to continue embedding the QMS, stabilise the Quality Outcomes Framework, and strengthen the systems, processes and culture needed for high reliability. Visible leadership for safety, psychological safety and real-time assurance will be essential. Ministerial expectations for quality are captured in *[MT: Quality]*.

Quality Management System & Quality Outcomes Framework – In 2025/26 we strengthened the operating discipline of the QMS by introducing more standardised indicators, clearer narrative and consistent visualisation across the organisation. Work to automate data flows and stabilise definitions across the six pillars improved reporting reliability. Granular run-chart data for key indicators, such as pressure ulcers and falls, enabled earlier identification of variation and supported more targeted action. In 2026/27 we will:

- Embed QMS operating discipline, shifting from framework to standard work
- Enable QOF dashboards to drill down to clinical area level
- Strengthen capability to interpret variation using standardised charts
- Provide clearer quarterly learning syntheses for QMG and PQSOC
- Deepen collaboration with Digital Data and Technology to maintain a unified visual language and support automation.

Embedding a Learning Culture - Embedding a learning culture means consistently identifying themes across incidents, complaints, audits, mortality reviews and feedback, and turning these insights into sustained improvements. Stronger triangulation, structured reviews, accessible learning repositories and deeper engagement with patients, families and staff are making learning more visible, traceable and connected to outcomes as the QMS matures. In 2026/27 we will:

- Embed standardised Clinical Effectiveness reporting
- Strengthen outcome data and integrated audit planning
- Ensure visible, traceable learning loops, linked to improvement actions
- Expand learning, knowledge sharing and use of the learning repository
- Strengthen triangulation of quantitative & qualitative evidence, including lived experience

Deteriorating Patient & Sepsis Pathways - Significant progress was made in implementing NEWS2, PEWS and NEWTT2, supported by strengthened training through ESR and local packages. Preparations for Call 4 Concern (Martha's Rule) advanced through coordinated communications. The Big Conversation on Sepsis brought powerful lived experience into improvement work, reinforcing the need for reliable escalation systems, clear communication and early recognition. In 2026/27 we will:

- Complete full EWS adoption across all areas, including maternity once the national template is available
- Resolve operational interface issues & reduce dual-chart risks
- Track impact through time-to-recognition, time-to-escalation & harm-related proxy measures
- Adopt CareFlow's real-time "helicopter view" for ward visibility & early risk identification

Clinical Outcomes, Mortality, Audit & Effectiveness – We progressed Audit delivery under an agreed programme, supported by AMaT as a single transparent system for managing findings and actions. Learning from Death processes were strengthened through improved templates, enhanced data validation and better triangulation with audit, safety and outcome data. Thematic outputs informed CSEG, QMG and PQSOC, providing a more integrated view of harm and system variation. During 2026/27 we will:

- Integrate the CSEG audit tracker with the QMS

- Focus the Audit Plan on completed actions and demonstrable change
- Provide quarterly "closing the loop" summaries to QMG and PQSOC
- Strengthen mortality learning, ensuring visible actions linked to outcomes

Patient Experience, PTR & the Learning System - PTR processes improved through earlier acknowledgement, more consistent initial contact and the introduction of Datix validation dashboards. Targeted LEAN work, particularly in Medicine, reduced delays and improved data quality. Patient and staff stories played an increasingly important role in shaping improvement and supporting a compassionate, just learning culture. During 2026/27 we will:

- Consolidate improvements in PTR cycle time and backlog control
- Expand real-time feedback coverage
- Publish bi-monthly learning digests for front line teams
- Monitor Datix error reduction and data quality through QMS run charts
- Co-produce stories that illuminate system issues & improvement actions
- Strengthen transparency & trust through story-driven learning and compassionate engagement.

Infection, Prevention and Control and Health and Safety Compliance - IPC and H&S fundamentals have been strengthened through enhanced surveillance, improved RIDDOR oversight, policy standardisation & the close out of fire safety enforcement actions. Environmental risks linked to estates issues were reduced, and early development of the Violence Prevention & Reduction Strategy reflected the growing need to support staff safety and psychological wellbeing. In 2026/27 we will:

- Maintain statutory compliance while shifting to proactive risk reduction
- Track RIDDOR training and reporting timeliness
- Deliver targeted safety walkarounds
- Sustain fire safety improvements and clear the policy backlog
- Implement data-led violence prevention interventions
- Strengthen front line teams ownership of IPC and H&S risks, including environmental factors.

End of Life Care and Bereavement – This continues to strengthen through the GRACE model, with clearer pathways, earlier support and closer coordination across ward, palliative, chaplaincy, mortuary and community teams. A single point of contact, community-based Graces' Places and Grief Awareness training are improving continuity, communication and staff confidence, helping ensure families receive compassionate, consistent support before and after death. During 2026/27 we will:

- Embed the GRACE model with clear pathways and a single point of contact
- Strengthen anticipatory planning and documentation
- Expand Graces' Places and community bereavement support
- Improve multidisciplinary coordination across end-of-life services
- Increase Grief Awareness training to build staff confidence.

Quality Improvement - We began embedding the Quality Improvement Capability Framework 2025–2028, strengthening our culture of continuous improvement through the launch of the QI Coach Programme with measurable improvements in cancer pathways, surgical flow, theatre safety & ward deterioration. Next year we will:

- Embed QI practice & supporting QI coaches
- Establish a QI Faculty and pipeline of QI leads across the organisation
- Pilot the new QI Leads Development Programme

Our key enablers align with the enablers within the Health & Care Standards:

We reaffirm our commitment to delivering safe, effective and compassionate care by embedding the QMS operating discipline, stabilising the QOF, strengthening deteriorating patient and sepsis pathways, and ensuring learning leads to demonstrable change. This operational focus will build the capability, conditions and connections needed for high reliability and measurable improvement in outcomes and experience.

What we will deliver – 2026/27

2026/27 Milestones		
QMS, QOF, Data Integration & QI	Q1	Embed QMS processes across the organisation and evaluate year 1; Implement standardised charts and run chart interpretation; Establish QOF data interpretation group & agree All-Wales aligned QOF indicator set
	Q2	Launch revised QMS post-evaluation; Pilot automated QOF data flows; Provide updated quarterly QMS/QOF summary; Embed QI practice
	Q3	Improve consistency of QMS outputs; Publish refined All-Wales aligned QOF indicator set; Establish QI Faculty
	Q4	Achieve full organisational adoption of the QMS, Complete year end QOF automation stability check; Annual review of QOF metrics; Pilot QI Leads Development Programme
Patient Safety	Q1	Full EWS adoption in adult inpatient areas
	Q2	Integrate CareFlow real time risk overview
	Q3	Full maternity EWS adoption (national readiness dependent)
	Q4	Embed CareFlow outcomes and evaluate harm related metrics
Clinical Effectiveness, Aduit & Mortality	Q1	Launch CSEG audit tracker
	Q2	Deliver first quarterly “closing the loop” audit summary
	Q3	Strengthen alignment of audit, mortality and QMS outputs
	Q4	Final annual audit and improvement summary
Patient Experience, PTR & Learning System	Q1	Implement faster PTR cycle (early acknowledgement, consistent contact)
	Q2	Circulate bi monthly learning updates across organisation
	Q3	Embed co produced patient and staff stories into operational business
	Q4	Deliver year end PTR outputs demonstrating faster cycles and story driven learning

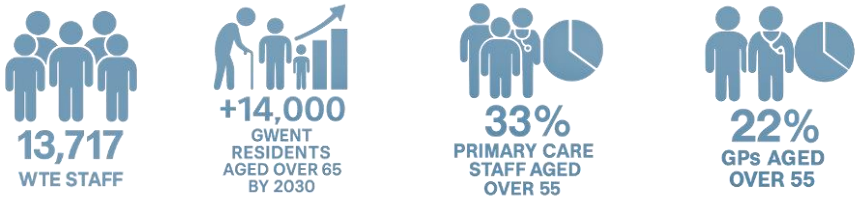
2027/28 Deliverables
Full automation of QOF and QMS reporting
Integrated safety and learning system, combining data into a single triangulated view
Mature Divisional learning cycles, with standardised learning, routine thematic reviews and demonstrate evidence of learning-to-action loops

2028/29 Goals
Fully embed high reliability operating model with proactive risk identification
Consistent, organisation wide delivery of Clinical Effectiveness
Sustained safety culture improvement, evidenced through psychology safety measures and year on year reductions in avoidable harm

Our People Plan 2025–2030 builds on our previous workforce strategy & sets a clear direction for supporting & developing our people. Shaped through wide engagement across the Health Board, it reflects real experiences & aspirations. The Plan continues our commitment to improving employee experience, strengthening leadership, enabling transformation, & recognising the vital contribution of our volunteers, who give over **20,000** hours each year.

We have made meaningful progress in recent years. Nursing & medical vacancies have reduced through targeted recruitment & retention, & stabilised retention has helped cut agency reliance & improve continuity of care. We have co-produced a Values & Behaviours Framework, strengthened our Speaking Up Safely culture, expanded wellbeing services, embedded equality & inclusion practices, & introduced new digital systems to enhance analytics & support efficiency across the Medical & Dental workforce.

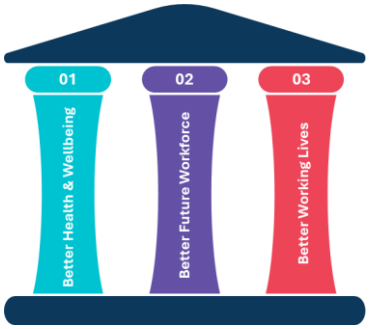
We recognise that challenges remain. Changing population needs, persistent health inequalities, & an ageing demographic are increasing service pressures. Workforce expectations are shifting, digital capability is advancing quickly, & future supply is uncertain. These factors highlight the need for a future-focused, agile workforce & shape the ambitions of this Plan.



Our workforce today & challenges we face

The Health Board employs **13,717** WTE staff - an increase of **479** WTE over the past year, with the greatest growth in Nursing & Midwifery. Our demographic context presents long-term pressures: by 2030, Gwent is expected to have around **14,000** more residents aged over 65, while fewer young people are entering the labour market. With a quarter of our workforce already over 55, we face rising retirement-driven attrition & widening gaps in critical areas. Primary Care reflects the same trend, with **33%** of staff - & **22%** of GPs - aged over 55.

Sickness absence remains a significant ongoing challenge. Rates remain consistently above 6%, with **33%** of all absence attributed to stress, anxiety, & depression. Absence is higher among our ageing workforce, reflecting wider trends in healthy life expectancy & chronic conditions. While progress has been made to reduce vacancies in key professions, skills shortages persist in some clinical & technical roles.



To meet these challenges, the People Plan is structured around three interconnected pillars - **Better Health & Wellbeing**, **Better Future Workforce**, & **Better Working Lives**. Collectively, they provide the platform for developing a resilient, compassionate, & future-ready workforce that supports our vision of empowering our people to thrive so we can care better for our communities.

Better Health & Wellbeing

Supporting colleagues to stay healthy, feel valued, & thrive is critical to building a resilient, productive workforce. The People Plan commits to strengthening wellbeing services, sustaining Occupational Health capacity, improving attendance, & embedding compassionate, restorative people practices.

This year, we continue to enhance our culture of psychological safety & speaking up. Building on the Speaking Up Safely Framework, we have expanded the infrastructure required for staff to confidently raise concerns & see timely resolution. Staff Survey engagement increased from **13.3%** to

32.5%, providing stronger insights into where the we needs to focus efforts to build trust, belonging, & safety.

We continue to embed compassionate leadership as the foundation for culture change. Last year, **864** colleagues completed leadership programmes, with **32%** of Nursing & Midwifery Academy participants achieving promotion. Leadership development is becoming more inclusive, with strengthened EDI data capture to ensure equitable access. Talent & succession planning workshops are helping managers identify high-potential individuals who may previously have been overlooked.

Reducing sickness absence is a major priority for the coming years. We are deepening our understanding of the root causes & strengthening support for staff experiencing stress, anxiety, & depression. Through better use of data, enhanced manager capability, & accessible, sustainable Occupational Health & wellbeing services, we aim to support colleagues earlier & reduce long-term absence.

Better Future Workforce

Developing a modern, agile & future ready workforce is essential for delivering high quality care across acute, community, primary care & preventative settings. Aligning with the emerging Digital Strategy, we will focus on key initiatives including national digital systems, robotics & digitally upskilling our workforce to enabler modern practices & efficiencies.

Our plan commits to strategic, data led workforce planning to understand service demands, align resources, & strengthen capability. We will work with HEIW to deliver national priorities across Mental Health & Learning Disabilities, Health Care Scientists, Allied Health Professionals, Urgent & Emergency Care, Primary Care, & education & training pipelines.

Regional workforce collaboration will remain central to strengthened sustainability across South East Wales & we will continue to support & inform to support & inform regional programmes in Ophthalmology, Orthopaedics & Cancer, ensuring our regional plans optimise capacity, resilience & support long-term sustainability.

To meet evolving service needs, we will create innovative, flexible roles that respond to changing care models, technology & population complexity. We will strengthen advanced practice & expand multidisciplinary, community based workforce models, including ACPs, Nurse Consultants, CAAPs & emerging Health Coach roles. Advanced practice will also grow in reporting radiography, with extended pharmacy technician & assistant roles supporting technician led wards, medicines optimisation & new perioperative innovations. Support & governance for SAS doctors has been strengthened through the SAS Charter, including the Autonomous Practice Policy, enhanced Portfolio Pathway support & improved IMG induction & mentorship, career progression, wellbeing & safe autonomous practice.

We will build on recruitment & retention learning to support colleagues to develop & grow, strengthening sustainable multidisciplinary teams, reducing variable pay & improving efficiency. Our aim is a workplace where people choose to join, stay & progress, embedding a resilient, future-focused workforce model.

The new Resident Doctor Contract, coming into effect in August 2026, introduces a modernised pay structure & stronger safeguards for training & wellbeing. While beneficial, it will require us to review medical workforce models & service transformation opportunities due to its operational impact. Our Steering Group, chaired by the Medical Director, will lead implementation & consider the risks and opportunities to ensure a safe, sustainable transition.

Our nursing workforce will evolve over the coming year under the National Agreement for Health Care Support Workers, with a more flexible skill mix that strengthens our models of care. This will ensure fair pay, support skills development, & enable staff to work at the top of their competence. A focused skill-mix review, targeted training, & new pipelines—such as Level 4 healthcare science apprenticeships in audiology & dietetics—will help us deliver more effective, responsive care & build a sustainable workforce for the future.

Looking ahead to 2026/27, we will mobilise the new Future NHS Workforce Solution - a modern, cloud-based platform that will streamline processes, improve data quality & enhance staff experience. While the benefits are significant, the transition brings risks linked to the capacity & specialist support needed for readiness & implementation. Our priority will be to progress foundational readiness & strengthen internal programme structures to ensure a safe, sustainable transition.

Better Working Lives

The Health Board is committed to creating a workplace where people feel proud to belong & grow. We will continue to strengthen our role as an anchor institution through partnership working &, as the largest employer in Gwent, invest in meaningful local employment particularly in communities facing economic inequality. We are exploring local entry routes & supporting skills development through initiatives such as the Gwent College Consortium, supported internships, Skills Surgery, the RCN Cadet & Connect schemes, & the Future Nurse Academy. These programmes widen access for local residents, including those furthest from the labour market, & promote fair, secure & meaningful careers that support community wellbeing & a locally developed workforce for the future in line with foundational economy principles.

In parallel, the Health Board meets its duties under the Social Partnership & Public Procurement (Wales) Act 2023 by working closely with Trade Unions to co-design workforce changes, embed fair work principles & ensure decisions are informed by strong social dialogue. This strengthens trust, equality & shared ownership of change. Our first Social Partnership Report (September 2025) outlines how we are meeting the Duty. Over the coming year, we will deepen this approach through a joint self-assessment with Trade Unions, embedding Social Partnership principles into procurement, broadening representative voices in key forums, extending partnership into decarbonisation & net-zero plans, & exploring a Social Partnership Champion initiative.

Our wider equality obligations will be delivered by aligning our work to the Anti-Racist Wales, LGBTQ+, Disabled People's Rights & VAWDASV Action Plans, as well as the All-Wales Accessible Communication & Information Standards. This is supported by our Strategic Equality Plan 2024–28 & our staff equality networks, which drive delivery & engagement. Looking ahead, we will focus on improving workforce ethnicity data, ensuring fair & inclusive recruitment & progression, building leadership capability, providing targeted support for internationally educated staff, & delivering the updated accessibility standards.

The Health Board is committed to a robust bilingual skills strategy, ensuring Welsh language requirements are assessed for every new or vacant role. A new digital tool will improve the accuracy of these assessments & support recruitment managers. We are implementing a strategy to increase clinical consultations in Welsh, ensuring new digital systems are fully bilingual, & offering wide ranging learning opportunities to help staff build confidence & capability in using Welsh, aligned to More than Just Words.

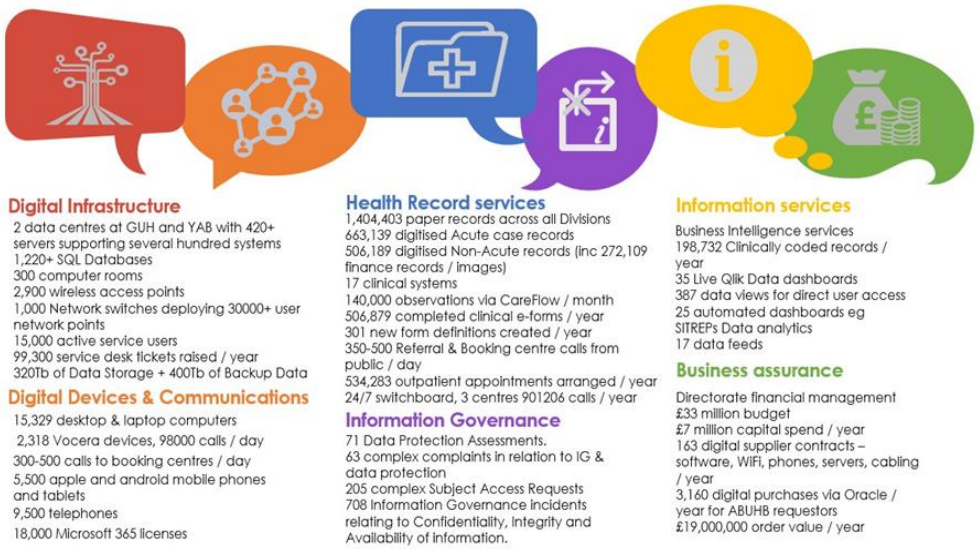
Our People Plan will set out the actions needed to address current & longer-term workforce challenges. Our next steps will focus on building thriving teams & cultures while improving efficiency through better systems, ways of working & innovation.

What we will deliver – 2026/27

2026/27 Milestones			
Better Health & Wellbeing	Q1	Commence implementation of the sickness absence programme to achieve 6.49% target, using scrum methodology, mapping triggers, reviewing early-intervention processes & developing dashboards to track reduction trends.	EA
	Q2	Demonstrate improvement in Occupational Health KPIs & introduce new monitoring dashboards.	
	Q3	Sustain wellbeing service activity, diversify the offer, ensure outcome monitoring, & maintain >90% satisfaction rates.	
	Q4	Improve staff survey scores on wellbeing & safety culture, & increase the number of people who feel able to speak up & are more engaged.	
Better Future Workforce	Q1	Engage with Digital & Analytics to scope the digital workforce strategy, including workshops, maturity assessment & future-state modelling.	
	Q2	Develop & implement local actions supporting national progression & career development frameworks. Deliver targeted interventions to meet PADR (>85%) & Stat/Mand compliance (>85%)	
	Q3	Expand volunteering, apprenticeship, & supported employment roles by reviewing entry-level posts, mapping pipeline opportunities, expanding anchor institution commitments, & strengthening partnerships with FE/HE institutions.	
	Q4	Increase workforce planning capacity & capability through training, shared resources & development of a strategic plan for priority areas.	
Better Working Lives	Q1	Implement values & behaviours framework, embed into recruitment, PADR, leadership programmes, & establish a monitoring dashboard triangulating with quality, safety, & staff relations indicators	
	Q2	Continue scrutiny of high variable pay usage, in line the Variable Pay & Agency Control Framework Welsh Health Circular, with deep dives, enhanced performance reporting, recovery plans, & targeted reduction in admin agency usage to achieve 30% reduction	EA
	Q3	Achieve sustained reduction in organisational vacancies & turnover through targeted recruitment campaigns, review of selection processes, retention incentives, development pathways, & improved onboarding experience	
	Q3	Improve job planning compliance to 80% alongside the implementation of the suite of Medical E-Systems	EA
	Q4	Improve diversity & representation across all staff groups & leadership roles, delivering against Wales' Anti-Racism, Accessible Communications, Disability & LGBTQ+ Action Plans, aligned to our Strategic Equality Plan, & increasing Welsh language KPIs.	
	Q4	Increase the number of staff participating in development programmes including leadership & development programmes	

2027/28 Deliverables	2028/29 Goals
Continuing to deliver & embed leadership & management support	Demonstrate a shift towards sustainable, future-ready workforce model & reduced variable pay
Implement new workforce solution – People Portal	Delivered the ambitions of our Strategic Equality Plan 2024-2028
Build upon targeted workforce plans supporting sustainability, regional working & place based care	Seamless implementation of future workforce solution

Digital is a key enabler that enhances safety, improves outcomes, strengthens integration, supports staff & provides the data foundation for a modern, sustainable NHS. It is essential for meeting current & future demand & with patient-facing digital applications & supports the ambitions of our Gwent 35 strategy.



Demand for digital services is rising & there are opportunities to use digital tools to improve our processes, some of which are listed below:

- Digital Health Communications that help patients engage & co-produce their care.
- Transform Inpatient & Outpatient care by using new technologies.
- Improving patient flow with electronic ward boards & data dashboards.
- Artificial Intelligence that is a reality, delivering real-world benefits.
- Increased deployment, where appropriate, of Robotic Process Automation Technology with opportunities for efficiency & cash releasing savings.
- Seizing on further opportunities that Microsoft 365 presents.
- Increased clinical leaders in digital to support transformation.
- Data analytics guiding public health & supporting people to stay healthy at home.

Despite these opportunities, there remain several **challenges**:

- Maintaining our digital estate while investing in new technologies.
- Continuing challenges of digital suppliers adopting cloud only services rather than historical on-premise infrastructure & implementations - resulting in increased revenue financial requirements.
- Ensure we adopt digital inclusion initiatives in all our work.

Over the next three years there will be numerous strategic opportunities to create a sustainable service that is able to meet our digital transformation needs. In 2026/27 these are:

Digital Transformation Strategy	Our new Digital Transformation strategy is currently in consultation stage with authorisation being sought for the strategy to be in pace for the start of 2026/27. This work will focus on the use of digital technologies & tools including AI & automation technologies approved by NICE and Health Technology Wales the development of an engaged digital workforce with the skills & capability at all levels to support digital adoption & exploit the benefits of technology, & an investment strategy working within the national digital policy context.
Digital Strategies	Completing a set series of strategies & plans for: • Digital Technology Infrastructure Strategy. • Service Management Strategy (how services operate). • Information Governance & Assurance & Cyber Security. • Digital software & application development capacities. • Health Records Governance. • Patient facing application strategy. • Digital Workforce Strategy. • Revisit clinical coding improvement plan.
Leadership & Board Development	Continue to engage & present regularly at Board development sessions; A Digital Clinical Council has been established & built into the overall Digital Governance structure; The council will work on securing ringfenced clinician time via discussions & support from the Medical Director.
Digital Transformation Planning	Building on established regular engagement meetings with stakeholders to develop medium to long term digital plans for front line teams & our transformational programmes.

Digital, Data & Technology

Directorate structure & governance improvement	Completion of Digital organisation change process; Planning controls to continue to embed in digital governance life cycle; Technical Design authority is established to ensure our developments are aligned to professional & national digital standards, patterns, policies & principles; Continue application of user centred design principles.
Digital Health & Care Record	Re-present business case for addressing the Clinical Workstation (CWS) risks along with associated technologies & capacity risks.
Data, Analytics & Information Management (IM) Strategy	Launch & commence delivery plans of the Data, Analytics & IM Strategy; Development of the Analytics Service & Data & Analytics Academy supporting skills development.
National Data Resource (NDR)	Working with the NDR team to maximise the opportunities & develop insights to improve patient services & support population health activities.
Information Governance, Assurance & Cyber Security	We will develop a business case for the creation of a Governance Assurance Team to proactively increase compliance & assure governance. We will continue to make progress against the Cyber Assurance Framework providing assurance into our committee structure. Provide Information Governance, including cyber security training to 85% of staff.
Decarbonisation	Continue to look at digital opportunities for decarbonisation & developing sustainable approaches to the digital life cycle.
Regional working	Continued engagement & planning with the Regional Digital Programme for South-East Wales Health Boards & Trusts to enable collaborative clinical service delivery with fit for purpose regional digital solutions.
Health Records	Consolidating physical record library locations. If expansion of piloting is successful, digitising areas of the non-acute record including Mental Health.
Business Assurance & Procurement	25 new & renewal contracts are scheduled to be managed & processed for 2026/27; Decarbonation standards have been established for digital- to be embedded during the next three years.
Digital Inclusion	Continue work to understand the digital needs of the workforce & patients to enable access our digital solutions; Accredit with & deliver against the digital inclusion charter.

We have priority ranking for digital developments as identified below:

Priority 1

- CWS Risks
- WCCIS Replacement
- Digital Dictation & Speech Recognition
- Digital Health Communications
- Robotic Process Automation.
- Governance & Assurance Audit Team

Priority 2

- Outpatient Booking
- Clinical Leaders
- MS365
- My Medical Record
- Growth Chart replacement
- Cardiology PACS
- Digital Cellular Pathology
- Welsh Intensive Care Information System

Priority 3

- E-Consent
- Imprivata
- Replacement Theatre System
- Virtual Ward (Doccla)
- CHC System
- Community Health System

30 Critical Infrastructure & Application Projects- capital dependant in the current 2026/27 forecast that carry risk if there is no progression.

129 new digital service requests- which may require funding for delivery.

21 additional new digital enabler support requests- identified from Clinical Teams.

Information Services: Our Digital Strategy will be launched shortly, progression of NRD development & Hybrid/Cloud transition work. There are emerging plans for the WPAS Team.

A high-level summary of funded projects & business cases grouped by the four key mission themes:

What we will deliver – 2026/27

2026/27 Milestones			
Digital Foundations	Q1	Capital Estates (Major)- Aber Valley & Dixton Surgery Monmouth.	
	Q2	Networks Critical Edge Refresh- NHH; Infrastructure Strategy.	
	Q3	Procurement for a Strategic Digital Partner	
	Q4	LGH Fibre Refresh Service Improvement Plan	
Digital Organisation	Q1	Radiology Informatics System Procurement; Eye Care Digitalisation - Open Eyes EPR; LIMS 2.0; ePrescribing Secondary Care (ePMA); Digital Cellular Pathology; Community: Dental EPR Upgrade ; National Eye Care Digitalisation - ERS (eReferral); Assessment of Patient Flow Solutions; CareFlow Connect; Welsh Nursing Care Record Paediatrics; MH & LD – WCCIS Replacement; RPA Business Case; Digital Dictation Implementation; Symphony v3 Upgrade; Digital Transformation Strategy; CWS risk business case; EPMA Phase 1: Allergy updates, meds to LCDR, CWS discharge, WRRS feed via HBIE, maintain MAR during transfers, & patient registration via CWS2; Cardiology Results feed to Local Clinical Data Repository; eAdvice Development CWS.	
	Q2	Digital Health Communications; Align with NHS Wales Identity management standards Eliminate cybersecurity risk associated with IS4 (Cyber Response Plan); Community Health Electronic Patient Record; Information Governance Audit Team Business Case; Symphony Upgrade 3.1.	EA
	Q3	Enable Histopathology Unexpected Result Notifications in CWS; Growth Chart - Replacement of legacy systems i.e CCUBE application	
	Q4	Health Records Governance Strategy.	
Digital Community	Q1	Support DCHW rollout of NHS Wales App	EA
	Q2	MyMR – scale & spread; Patient Facing Application Strategy	
	Q4	Digital Patient Communications (HCC) - Increase in service scope	
Digital, Data, Information & Intelligence	Q1	NDR - Move to Cloud / Hybrid; Development of Analytics Services; Dashboard development; Refreshed RTT training & guidance.	
	Q2	WPAS – Planned Care Academy Training	
	Q3	WPAS Improvement Plan	

2027/28 Deliverables
Connecting for Care - WCCIS replacement
ePrescribing Secondary Care (ePMA)
EPMA - Iteration 2

2028/29 Goals
Bed Management Solution
Regional Symphony ED Discharge Letter & Theatre Notes Integration
ECR/CCR Improvement Programme

Our 10-year Estate Strategy (2018-28), approved in January 2019 and refreshed in 2021/22, outlines twenty Strategic Objectives across five sub-categories. The capital programme is crucial for delivering this strategy and maintaining our estate. Significant discretionary capital funding will support statutory obligations, estate maintenance, infrastructure risks and timely equipment replacement.

There is a significant amount of work which has been carried out in delivering the priorities for the extant Estates Strategy. The Health Board will continue to progress this work through the development of a new Estates Strategy, which will be a 3 lens approach to focus on the Service Need and Organisational Strategy, Condition and Utilisation of the Health Board Estates. It will reflect the regional (health) and regional (RPB) capital and estates agenda to ensure opportunities are aligned and integrated.

A Facet Survey is currently being procured and will be used to inform the strategic direction from an estate perspective. The work will be aligned with the new Health and Quality Care Standards, with completion anticipated by the end of quarter 3 of 2026/27.

Key priorities for 2026/27 are the rationalisation of St Woolos Hospital and the reconfiguration of Nevill Hall Hospital due to the presence of Reinforced Autoclaved Aerated Concrete (RAAC). The All Wales Capital programme distinguishes between projects with some form of approval and those still in development. In 2025/26, we completed and opened the Satellite Radiotherapy Unit at Nevill Hall which is a joint project with Velindre University NHS Trust, the completion of the extension of the Emergency Department within the Grange University Hospital and also the delivery of a centralised Decontamination Unit at the Royal Gwent Hospital.

The Strategic Outline Case for the Nevill Hall reconfiguration was submitted to Welsh Government in November 2025 and discussions on next steps are continuing. In parallel with the longer term development, the Health Board continues to manage the risks associated with RAAC in line with prevailing technical guidance (which continue to emerge) with specialist support.

Health and Wellbeing Centres for Aber Valley and Monmouth are progressing through Integration and Rebalancing Capital Fund (IRCF), reproviding GP services alongside wider Health Board and Local Authority functions.

Following the opening of the Grange University Hospital, significant work continues across Local General Hospitals to align configurations with clinical models and patient flow. This includes service moves from St Woolos Hospital and Targeted Estates Fund investment in infrastructure, decontamination, decarbonisation, mental health, and infection prevention and control.

Phase 2 of the GUH extension - reconfiguring the old waiting area - will be delivered early 2026/27, creating a more appropriate space for patients who are 'fit to sit'.

The Health Board has secured two-year Targeted Estates Fund support. Extensive work has been delivered in 2025/26, with a full improvement programme continuing into 2026/27. Funding is provided on a 70% Welsh Government and 30% Health Board basis and allocated across the following areas:

Our Estates teams are vital for service delivery, and we are working on an estates and facilities workforce strategy to ensure sustainable services.

What we will deliver – 2026/27

2026/27 Milestones			
Capital Projects	Q1	Completion of Phase 2 of the Emergency Department Extension at the Grange University Hospital	
	Q2	Development of Outline Business Case for Aber Valley and Monmouth	EA
	Q3	Completion of the Health Board's Estates Strategy	EA
	Q3	Complete Strategic Outline Case for St Woolos Hospital	EA
	Q4	Delivery of approved Targeted Estate Fund priorities for 26/27	
	Q4	Outline Business Case for Nevill Hall Hospital	EA
Service Change & Improvement	Q1	Support and respond to any approved plans across the organisation which require the action of Estates & Facilities	
	Q1	NHH RAAC – monitor/manage issues; support redevelopment casework	
	Q2	SWH & Newport Campus – develop proposals to close old SWH estate and optimise Casnewydd & RGH utilisation	EA
	Q3	REFIT decarbonisation schemes – deliver programme to Oct 2026	
	Q3	NHH PFI energy contract – develop proposals for ongoing maintenance & management	
	Q4	Single Computer Aided Facilities Management system – maximise benefits of new system across ABUHB	
Integrated Regional Capital	Q1	Continue development of Mental Health capital developments to support availability and stability of placements in Gwent	
	Q2	Hub mapping to understand current Gwent provision & identify further opportunities for integrated hubs to support place-based care agenda	
	Q3	Establish Hub Network to share learning & increase collaboration across hub services for all population groups in Gwent	
	Q4	Finalise delivery of key small scale integrated hubs for key RPB population groups to support place base care with delivery partners	

2027/28 Deliverables
Full Business Case for Nevill Hall Hospital and ongoing RAAC management & Outline Business Case for St Woolos
Final Business Case for Aber Valley & Monmouth Health & Wellbeing Centres
Delivery of approved Targeted Estate Fund priorities for 27/28
Improve estate infrastructure, particularly at RGH & NHH

2028/29 Goals
Progress rationalisation of St Woolos Hospital
Mental Health Specialist Services Inpatient Unit commence build
Build for Aber Valley and Monmouthshire Health and Wellbeing Centres
Commence redevelopment of Nevill Hall Hospital

Health Boards are required to develop a financial plan that balances over a rolling 3 year period. ABUHB has not been able to operate within available funding and has a rolling 3 year deficit. The outlook for 2026/27 remains financially challenging based on the operational and performance ambitions of the Board. The Board has advised Welsh Government that a financial deficit forecast is likely for 2026/27, in line with guidance the Board will produce an annual financial plan for 2026/27, with the ambition to recover to financial balance over a 3 year period.

Financial Plan Aims

'Finance' and the resources invested in are enablers & the aims of the ABUHB Financial Plan for 2026/27 are:

- To develop a refreshed route map to recovery to achieve financial balance over 3 years.
- Reduce the underlying deficit, ultimately to zero.
- Reduce costs & increase recurrent savings across both workforce & non-pay throughout the deployed £2bn turnover.
- Demonstrate full delivery of enabling actions & improve efficiency & productivity across all budget areas with a focus on releasing cash.
- Demonstrate benefits realised from investments with quantified metrics & value based outcomes.
- Demonstrate continued financial grip & control and excellent governance.
- Redesign service delivery (back office and patient facing) to operate within affordability limits.
- Reduce demand, improve pathways, remove unwarranted variation, focus on improving value to patients.
- Improve allocative value efficiency through strategic prioritisation including shifting services outside of hospitals through community by design and place based care and prevention

The financial plan has been developed and triangulated with workforce and service plans and aspirations, including assumed performance and savings delivery.

The constitution of the financial plan:

The starting financial position is established from an analysis of the underlying position, this is the recurrent cost of running the operations of the organisation at the start of the year with no further new year costs or savings included, this presents a running cost deficit in excess of funding of £38.2m, which is reflective of non-recurrent savings delivered in previous years, non-recurrent funding ending and the full year effect of costs and savings from prior years.

Underlying deficit	Planned ULD closing 25/26	25/26 recurrent cost pressures into 2026/27 new in year	Opening Revised ULD 2026/27
	£m	£m	£m
Workforce pressures	2.0	13.4	15.4
CHC	2.6	2.5	5.1
Medicines management (prescribing and acute drug costs)	4.8	2.8	7.6
WHSSC / EASC (service growth in excess of funded levels)	5.0		5.0
Digital		5.1	5.1
Total	**14.5**	**23.8**	**38.2**

To mitigate this underlying deficit, savings have been developed and assumed to offset the underlying position as the first priority, these are estimated to be £28m identified and a further £17m opportunities to be confirmed, this savings target is c. 2% of turnover or over 3% when ring fenced funding is removed and is in excess of the 25/26 levels of savings.

There are risks to the full delivery of these currently. A Quality Impact Assessment process has been undertaken to provide a wider clinical and patient impact assessment of proposals to be considered.

ABUHB Savings Plans 26/27	£m	£m	£m
Confirmed budget holder savings for 2026/27	(13.3)		
QIA Savings Options:			
Confirmed	(1.8)		
Further work to confirm (assume Q3 and Q4 month impact for 26/27)	(6.1)		
Total Savings expected to deliver with plans		(21.2)	
Further savings opportunities			
Workforce V&SB	(3.7)		
QIA Early Delivery	(3.1)		
		(6.8)	
Total Savings identified		(28.0)	
Stretch Savings Target to deliver greater level than 25/26- Opportunities to be progressed		(17.0)	
Total Savings for IMTP plan			**(45.0)**

Funding for the new financial year includes allocation uplifts of £18.7m (1.11%) and assumed additional funding for Digital Priorities of £6m. Additional pay award funding is expected to cover 26/27 settlements. The Welsh Government expect 26/27 to be a non-discretionary investment year with additional spend limited to inescapable demand and unavoidable inflation.

The Board has assessed the new year costs for ABUHB as £75.2m. The most significant issues relate to unavoidable inflation and demand growth in CHC and drugs prescribing and essential digital system investments, costs of the ABUHB contribution to the Welsh Risk Pool and the national re-banding review of band 2 staff and the costs of patient services commissioned from other NHS organisations.

There are some limited value local investments proposed for quality improvement and cancer services as well as maternity, neonatal, diabetes and endoscopy service delivery. The table on the right hand side provides a summary:

ABUHB New Year costs 26/27	£m	£m
Demand and Inflation Growth (CHC, Drugs, 2%non pay)	28.2	
NHS Providers	8.8	
Local Pressures Quality	1.0	
Local Pressures cancer/Radiography	2.8	
National Pressures (WRP, B2 to 3)	29.4	
Winter/ONP	3.0	
RTT targets & endoscopy	2.0	
Total New Year costs 26/27		**75.2**

There are several risks to the delivery of this financial plan, including, growth and funding assumptions, delivery of full savings plans, specialised services growth and operational risks arising during the period of the plan.

Overall Financial Plan Summary

The table to the right provides a high level summary of the financial plan for 2026/27, presenting all the above elements to establish a forecast deficit of £43.7m. The 26/27 forecast deficit of 43.7m compares with the £18.3m deficit experienced in 25/26 and the unmitigated new Welsh Risk Pool cost pressure of £25m.

ABUHB 2026/27	Forecast £m
Starting Deficit	18.3
UL adjustments	19.9
OPENING UL DEFICIT	**38.2**
Savings (Green/ Amber)	-21.2
Savings QIA to deliver	-6.8
Further Savings to find (2+%)	-17
TOTAL SAVINGS	**-45**
FUNDING UPLIFT (& DPIF)	**-24.7**
Demand & Inflation	37
National Pressures	4.4
Local Quality priorities	1.2
Performance Delivery	4.6
Winter/ONP	3
TOTAL COSTS	**50.2**
FORECAST DEFICIT (BEFORE WRP)	**18.7**
Welsh Risk Pool (WRP)	25
FORECAST DEFICIT 26/7	**43.7**

The Health Board is already experiencing the impacts of climate change, which is exacerbating existing health inequalities & putting pressure on healthcare facilities & delivery systems. The Decarbonisation Framework sets out the Health Board's pathway to achieving a Net Zero position by 2030. It defines the priority areas for action, the goals & objectives required to meet national performance expectations, & the timescales & delivery plans that will guide progress over the coming years.

For 2026/27, the programme will continue to drive energy efficiency, reduce carbon emissions across all operational areas, & embed decarbonisation as a core principle of strategic planning & investment. The Framework also provides a clear governance & reporting structure to ensure accountability, transparency, & sustained organisational focus. Delivery is organised through five supporting workstreams:

Together, these workstreams provide the structure needed to coordinate action, monitor progress & accelerate the Health Board's transition to a low-carbon, climate resilient health system.

Estates: We are reducing the carbon impact of our estate through targeted energy efficiency measures, improved recycling & investment in low carbon infrastructure. Energy usage has fallen again in 2025/26, supporting a 4% reduction in carbon emissions. A key priority for 2026/27 is progressing the ReFit programme, with installation to commence following ministerial approval.

Communication & Training: We continue to strengthen staff awareness & engagement with the Health Board's Net Zero agenda through improved messaging & targeted content. A refreshed 'AB Green Healthcare Newsletter' has been developed alongside a new content calendar, & Climate Week promoted to highlight key sustainability priorities.

Clinical & Health Care: We're reducing the environmental impact of clinical practice by targeting medical gases, medicines waste, consumables, & behaviours. In 2025/26, we have progressed audits & trials to optimise gas use, improved cylinder management, Omnicell reviews, updated peri-operative guidance, & pilots to reduce unnecessary blood tests & draping, supported by staff education. We are also exploring funding for a Sustainability Nurse Lead to enhance nursing & ward level engagement.

Resources: We're strengthening carbon accounting, procurement, & performance monitoring to support Net Zero goals. Since 2018/19, we've reduced 4,380 tCO_2e from a baseline of 140,193 tCO_2e, with 6,000 tCO_2e more identified via planned solar generation at GUH. Current efforts include aligning with new reporting requirements, preparing for the refreshed NHS Wales Decarbonisation Plan, & improving dashboards for Type 1 & 2 emissions.

Wastes: We're advancing actions to meet new recycling regulations & maintain ISO14001 compliance. Waste segregation & environmental awareness training are progressing through approval, boosting staff understanding & supporting the Green Healthcare Champion network. Work is also underway to close gaps in toner & battery recycling & to introduce new internal recycling bins at RGH & GUH, aiming for full site compliance by Oct 2026.

This year, climate adaptation has become part of routine Health Board practice through completion of our first adaptation risk assessment, giving us a clearer picture of our highest risks & how to address them. In 2026/27, we'll develop a climate response plan to further embed adaptation, decarbonisation & biodiversity across the organisation.

A successful response to climate challenges can only be achieved through whole-system effort, influencing everything from estate management to clinical practice. Working closely with partners & stakeholders will be vital as we accelerate our transition.

What we will deliver

2026/27 Milestones		
Estates	Q1	ReFit Phase 1 LED Lighting completion & commencement of roof-top solar projects
	Q2	ReFit Phase 1 completion of roof-top solar projects
	Q3	ReFit Phase 1 solar car-port at GUH (subject to final Planning approval)
	Q4	Completion of ReFit Phase 1 & commencement of scoping for possible Phase 2
Comms	Q1 -4	Ongoing communications of decarbonisation activity
Clinical & Health care	Q1	COTE pilot of unnecessary blood test project
	Q2	Medical gases cylinder SOP
	Q3	Entonox switch from manifold to cylinders
	Q4	Decommission of the N2O manifold
Resources	Q1	Launch of ABUHB Carbon reporting dashboard
	Q2	Approve a strategy to reduce Procurement emissions through both increased accuracy (moving from Type 1 to Type 3 reporting) & increased analyses of the impact of clinical & health care projects
	Q4	Show progress against the agreed strategy & evidence the resulting reduction in emissions for 2026/27.
Wastes	Q1	Recycling bins ordered for RGH, GUH, & NHH. Expected delivery date during first week of April & then imbedding to follow.
	Q2	Divisional Management Team to review current compliance position with the new recycling regulations. More sites to be planned for compliance.
	Q3	Reusable sharps boxes kick off meeting with Theatre ODP, Environmental Manager, Stericycle, & other interested parties.

2027/28 Deliverables
Possible Refit Phase 2 – subject to future WG funding
Reusing of nursing uniforms
Spread & scale of the blood test project

2028/29 Goals
Reduction of unnecessary testing
To embed Green Health Care into working & educational practices

Value Based Healthcare

Value Based Healthcare (VBHC) remains central to delivering better health, wellbeing, outcomes & value for our people, workforce & communities. Our focus on doing what matters most to people is key to addressing challenges in the short, medium, & long term.

The ever-changing landscape heightens our ambition to collaborate & innovate with our partners & to capitalise on opportunities to translate new understandings to optimise how we use the resources available to us to improve health outcomes. We are strengthening our value-based healthcare programme to support the NHS Planning Framework it's 3-year priorities. Working with partners, including NHS Wales Performance & Improvement Value Transformation Directorate, we will encourage the consideration of the value in everything we do, across the full care pathway- from prevention to long term/end of life care.

Our VBHC enabling strategy will maintain a focus on:

- **Outcome Measurement & Action:** We will Systematically collect, monitor, analyse & act on outcomes that matter to patients.
- **Whole Pathways of Care:** Looking holistically at whole-person, system-based care reducing fragmentation of care provision between sectors.
- **Maximise existing resources & costs:** We will assess the use of financial & resource utilisation ensuring a focus on quality of care & outcomes, & we will aim to stop low value activities.
- **Data & Technology:** We will maximise the use of local & national data, analytics & technology to systematically collect, combine analyse & present costs & other key data to support evidence-based planning & decision making.
- **Mindset:** We will promote value-based health & wellbeing by focusing on prevention, early access & teachable moments, enabling people to understand the consequences of poor health decisions & support people to better manage their health. This will be driven by leadership, education, awareness & training.

Delivering Value & Transformation

- Improve & measure outcomes that matter to people, clinicians & the healthcare system.
- Ensure the best use of resources to deliver the best possible outcomes.
- Review data, services, processes & practice identifying opportunities for improvement.
- Measure impact & benefits of VBHC adoption.
- Work with partners & 3rd sector to explore opportunities to deliver better value to patients.

Development & Sustainability of VBHC approaches

- Local Person-Centred Value-Based Healthcare Education Programme.
- Promotion of results of VBHC projects.
- Monitoring of innovation portfolio, demonstrating impact on people, projects, budgets and partnerships
- Pre-Investment Panel Assessors for VBHC consideration.
- Engagement, Communication & Marketing.
- Awards.
- Research for Patient & Public Benefit.
- VHBC Staff Development

Digital Enablers

- PROMs collection (Local & National Pathways).
- Use of outcomes in direct care.
- Use of outcomes to support waiting lists & access to care when needed.
- Use of outcomes to support remote monitoring.
- Patient initiated PROMs.
- Support of PREM collection (where applicable).
- Collection of PROMs long term to demonstrate sustainable change & inform re-design of services.

Business Intelligence & Insights

- Improve access to data.
- Enhance VBHC Information Strategy.
- Visibility of PROMs via clinical systems.
- Combining outcomes & costing visualisations.
- Adoption of National DSCNs for PROMs.
- Development of Local Data Proms Standards.
- Submission of PROM data in line with WHC.

Research

We recognise that active research leads to better patient outcomes & improved staff recruitment, retention & satisfaction. As a core pillar of University Health Board status, our Research & Development (R&D) approach focuses on delivering essential clinical research that meets population needs & supports A Healthier Wales. We remain committed to embedding research in care pathways & continue to expand our research education programme, including reaching research-naïve staff through induction & online training.

As we enter year four of our five-year strategy, we are reflecting on what works well & what is still yet to be achieved. Implementation of the strategy has progressed, supported by the quarterly Research Strategy Group which provides oversight & ensures alignment with the NHSR&D Framework & wider HCRW & Welsh Government policy direction.

Greater focus has been given to expanding research leadership opportunities for non-medical professionals, with physiotherapists, nurses, & podiatrists now acting as Principal Investigators. This reflects a deliberate effort to diversify research leaderships across professions & services.

Key achievements include:

- Awarded 1.4 million in VPAG funding to increase the amount of industry funded research studies.
- Celebrated the 1-year anniversary of the Research Champions Programme.
- Medi-Wales Innovation Award for collaboration with industry for our work on the Sandbox Dementia Biomarker study which aims to transform the diagnosis of neurodegenerative disease.
- Continue to meet the 80% Time to Target metric for all closed commercial & non-commercial studies.
- The appointment of the department's first Clinical Research Fellow supporting Principal Investigators deliver clinical research
- Associate Medical Director for Research & Development awarded an Honorary Professorship at Cardiff University.

VPAG funding has accelerated investment in key staff & infrastructure to advance commercial research. As this funding is time-limited, a priority for 26/27 will be increasing industry-funded research to ensure long-term sustainability.

What we will deliver – 2026/27

		2026/27 Milestones	
Commercial Trial Focus	Q1	All VPAG funded posts to be appointed. Introduce a fast-track set-up process for commercial trials.	
	Q2	Introduce local scoring system to apply priorities from national & local metrics to support decision-making & performance improvement.	
	Q3	Establish an internal quarterly performance review process to highlight issues, monitor progress & agree remedial actions if required to ensure we are on course to meet VPAG objectives	
	Q4	Meet all T&Cs of VPAG funding	
Strategy Implementation	Q1	Facilitate access & offer support for staff at all levels who wish to undertake research.	
	Q2	Ensure research inclusion within HB induction programmes across relevant professions.	
	Q3	Collaborate with services to deliver, assess & report against the pillars of the NHS R&D Framework for Research Delivery.	
	Q4	Begin stakeholder engagement, collaboration & discussion to support development of the next research strategy.	
Business Delivery	Q2	Align adoption of 'new' National High Value, High Interventions (HvHi) including Diabetes and Bone Health	EA
	Q3	Enhance and upscale Value in Diabetes, Cancer Services, Heart Failure and MSK Services & Explore and adopt Value T&O opportunities	EA
	Q4	Continue to measure and deliver anticipated benefits of existing VBHC programmes of work	
Business Development & Digital BI Enabler	Q1	Digital Outcome and Experience collection; design, develop, test, implement and maintain VBHC data insights and reports	
	Q2	Initiative planning for future provision of PROMs platform & implement collection of PROMs in Radiology, Chronic Pain, IBD, Escape Pain	
	Q3	Enable the use of outcomes and costings to develop pathways that reduce unwarranted variation	
	Q4	Adopt a process for adoption and use of National dashboards for Value cases where applicable	
Sustainable of VBHC Approaches	Q1	Continue to deliver awareness and educational training programmes across the Organisation	
	Q3	Support services with demonstration of value and share learning for scale beyond ABUHB	
	Q4	Work across the Organisation to scope, design, implement outcome toolsets, collection and automation	

2027/28 Deliverables
Cost recovery targets met as per VPAG plan
Final review of strategic objectives, evaluating impact & success.

2028/29 Goals
Able to report the economic value of research.
New Board approved strategy & implementation plan in place

Our Delivery Framework

High performing organisations have clearly understood and effective Performance Management and Accountability Frameworks (PMF). Our internal PMF is the mechanism to enable, monitor and achieve delivery of the Health Board's strategic priorities, performance expectations and operational plans.
In 25/26 the PMF was reviewed and updated in line with feedback and learning from just over 12 months of its application. This resulted in updating our performance and accountability domains to 5 in total;

1. Quality & Safety
2. Leadership
3. Corporate Governance
4. Finance
5. Operational Performance & Delivery

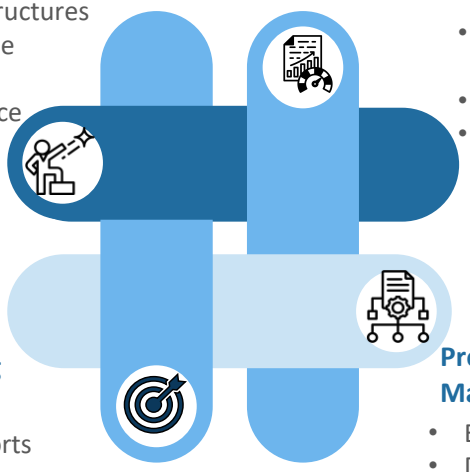
Our PMF coupled with our transformation programmes form a robust delivery framework for our organisation weaving together; Governance and Leadership, PMF, Programme Management Approach and Targeted Reporting.

Governance and Leadership

- Accountability Structures
- Monthly Executive Oversight
- Monthly Assurance

Performance Management & Accountability Framework

- Accountability Conditions
- Regular Reviews
- Robust Reporting



Targeted Reporting

- Integrated Performance Reports
- Quality Outcomes Framework
- Deep Dives

Programme Management Approach

- Executive Leadership
- Dedicated PMO
- Standardised Processes, Governance & Reporting

Further work is ongoing to finalise the change programmes that will support delivery in 2026/27. Below is a summary of our emerging transformation programmes. More detail on the Programmes is set out in Appendix 4 and these will be finalised in April 26 following plan approval.

Priority Programmes	Purpose
Place Based Care	Establish a clear community model for the organisation with a preventative approach, aligned to Community by Design
Urgent & Emergency Care	Delivery of clearly defined transformation within our Urgent and Emergency Care recovery plan to support de-escalation
Planned Care & Cancer	Transformation in planned care and cancer drawing in primary and secondary prevention and supporting improvement in waiting times
Value & Sustainability	A system wide focus on value & sustainability delivering service change and cross cutting themes in line with national VSB

Appendix 1: Ministerial Delivery Expectations

Ministerial Delivery Expectations for 2026-27		Baseline	Mar 27	
Timely Access to Care	Ensure no ambulance patient handover waits over 45 minutes. *Plan to deliver de-escalation criteria*	1,471	364	N
	Ensure no patient spend spends 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge. *Plan to deliver de-escalation criteria*	1,089	799	N
	No patients waiting more than 104 weeks for referral to treatment.	434	3,022	N
	Health Boards to achieve the suspected cancer pathway target of 75% through implementing the nationally agreed pathways, while reducing the backlog of patients waiting more than 62 days by end of March 2027.	55.9%	75%	Y
	No patients waiting more than 8 weeks for a specified diagnostic	2,387	0	Y
Population Health & Prevention	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.	75.1% (2023/24)	76%	Y
	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.	-	Quarterly reporting	Y
	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% (care pl an in place)	Y
	Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes.	44.3%	50%	Y
Community by Design	Deliver a 12-month reduction trend in both the number of people who are delayed in hospital and the total days delayed for these patients, as measured by the Delayed Pathways of Care dashboard. *Plan to deliver de-escalation criteria*	180 Vol 6,085 Days	120 Vol 3,840 Days	Y
	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.	75,940	118,223	Y

Appendix 1: Ministerial Delivery Expectations

Ministerial Delivery Expectations for 2026-27		Baseline	Mar 27	
Mental Health Access	Implement and evaluate Open Access Mental Health Support by March 2027.	-	Milestones	Y
	Improve safety in Secondary Care Mental Health services (measured through agreed mental health safety matrix and PROM ReQuol) by March 2027.	-	Milestones	Y
	Improve Physical Health of People with long term mental health problems by carrying out mortality reviews and implementing improvement plans from the learning by March 2027.	-	Milestones	Y
Women's Health	Further expansion of the Women's Health Hub model in each Health Board area by March 2027 (aligned to the Women's Health Plan).	-	Milestones	Y
	Improving the quality of our maternity services by reducing perinatal mortality rates.	5.22	5.067	Y
Quality & Safety	Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.	1.36%	Determined through 26/27	Y
	Days of safe care delivered since the last never event, monitored using SPC T-Chart.	-	Implement	Y
	Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027.	33.9%	40%	Y
	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.	89.9%	91%	N

Appendix 2: Enabling Actions

Enabling Actions: mandating on the basis of "adopt or justify"			**Baseline**	**26/27**
Productivity	Ensure utilisation of the total factor productivity model, and set out the actions and quantified productivity impact that will increase total productivity in 2026/27 from the baseline position.	**Y**	TPF model and methodology is still under development awaiting update	Through using the model for 26/27 when available opportunities will be assessed and prioritised in the following areas: bed plan , improved length of stay and rationalisation, operational efficiency to reduce costs with a focus on Theatres
Mental Health	Implement actions to deliver a material reduction in the number of out of area placements in 2026/27, and associated costs.	**Y**	0.	Hold to 0.
Population Health & Prevention	Ensure progress of the focused Diabetes High Value High Impact pathway	**Y**	All 8 care processes: 45.5% Foot surveillance: 66.9% Urine albumin: 67.5%	All 8 care processes: 50% Foot surveillance: 80% Urine albumin: 80%%
Building Community Capacity	Support the implementation and roll-out of the NHS Wales app for maximum impact and benefit to include the uptake of its use for repeat prescriptions.	**Y**	Waiting list, referral and appointment function of the APP live, .	Full implementation of next phase of the APP in development with national digital team
Maximising Value for Money	Non-Pay - ensure implementation of Value & Sustainability Board recommendations, which includes local implementation of clinically endorsed and mandated product choice to maximise market share and deliver best value.	**Y**	Oversight via Non Pay Board in our Value and Sustainability Programme. The theatre innovation group is reviewing national and local non-pay opportunities—such as sutures, energy devices, stapling, and orthopaedic products.	Minimum of £2.3m savings delivered through a range of schemes including utilities pricing and re:fit programme

Appendix 2: Enabling Actions

Enabling Actions: mandating on the basis of "adopt or justify"			**Baseline**	**26/27**
Maximising Value for Money	Medicines Management - ensure full implementation of the high value medicines Value & Sustainability Board programme, which includes delivering opportunities against each of the programme areas.	**Y**	ABUHB continues to have the highest uptake of established biosimilars in Wales. A review of generic contract medicines has been undertaken. Direct Oral Anticoagulants - 93% for Primary Care, 95% for WP10(HP) Blood Glucose Testing Strips(92%) Sodium-Glucose Co-Transporter-2 (SGLT2) 81% for Primary Care, 88% for WP10(HP)	Programme of work will continue, reporting into V&SB. Blueteq business case process ongoing Maintain status as highest uptake in Wales.
	Estate - ensure strengthened actions are taken to improve estate utilisation including the appropriate repurposing & disposal of under-utilised estate.	**Y**	Estates rationalisation workstream priorities agreed and include St Woolos, NHH, Monmouth, Aber Valley	Pending review key business cases progressed for Nevill Hall, Aber Valley and Monmouth Mental Health Service Redesign leading to estates rationalisation 2028–2038 strategy completed
	Continuing Healthcare - ensure implementation of Value & Sustainability Board recommendations which include continued actions to improve clinical and financial effectiveness associated with packages of care.	**Y**	Oversight via the Continuing Healthcare Board in our Value and Sustainability Programme includes ongoing monitoring, legal case progress, and unresolved eligibility issues with Local Authorities.	All Wales Digital Solution implemented Agreement progressed regarding eligibility and enhanced care with Local Authorities,. Delivery of £1.6 million savings across demand management and package reviews
Improving Value, Optimising Outcomes, & Minimising Variation	Ensure progress with the implementation of Value & Sustainability Board High Value High Impact pathway - Bone Health	**Y**	Increased fragility-fracture identification and treatment rates. Coding review, outcome tracking, and service evaluation are underway, with stable staffing.	Adoption of the Missed Opportunity measure within the FLS-DB. Subject to funding expansion of the dedicated Fracture Liaison Service Pharmacist and support roles.
	Eradicate unsupported systems and devices and ensure a clear cyber response plan for the organisation.	**P**	The Windows Server 2012 upgrade programme complete, with remaining servers covered by extended security updates while work begins on the 2016 upgrade and associated SQL Server updates. Cyber resilience continues to improve through incident-response exercises, expanded SIEM visibility, rollout of next-generation firewalls, and strengthened oversight via the Network and Information Systems Assurance Group.	Projects include: Removal of Windows server 2016 and MS Sequel 2012 ,2014 and 2016 Palo Alto implementation. Cyber exercising quarterly for 2026. CRU NIS CAF Audit Assessment June 2026.

Appendix 2: Enabling Actions

Enabling Actions: mandating on the basis of "adopt or justify"			**Baseline**	**2026/27**
Timely Access to Care	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 end of Q2, Arthroplasty 90% of lists to have 4 Primary joints per day and 90% of time achieve at least 6 High-Volume Low Complexity General Surgery procedures on an all-day list made up of hernias/gallbladders by end of Q2	**P**	Cataracts – 6.83 per list Arthroplasty – 3.6 per list General Surgery – awaiting relevant codes from National Team in order to be able to accurately baseline.	Cataracts – 7 per list Arthroplasty – 4 per list General Surgery – awaiting relevant codes from National Team in order to be able to accurately baseline.
	Ensuring the full implementation of the National Optimal Pathway in Cancer	**P**	National Optimal Pathways continue to be followed.	Map and cost a new malignancy of undefined primary origin/cancer of unknown primary pathway, with gap analyses and implementation planning for renal, myeloma, and sarcoma.
	Theatre session utilisation is improved to achieve national *Getting It Right First Time* standard of 85%- late starts (>15 mins), early finishes (>60 minutes) and overall utilisation are reported as key performance indicators to underpin the 85% standard	**P**	Late starts – 37% Early finishes – 30.7% Session utilisation – 83.1%	Late starts – 25% Early finishes – 15% Session utilisation – 85%
	Consistent clerical and clinical validation should be in place using the national standard operating procedure - any patient waiting greater than 26 weeks should be validated. Volumes of non-admitted closed pathways will be monitored as proxy supported by National Programme team visits	**Y**	All cohorts validated in line with the National Planned Care Policy Waiting List Validation Toolkit and Guidance.	Programme of work will continue across all stages, Validation strategy launched Q1 26/27.
	Referral return rate of 20+% and/or a reduced referral rate per 100,000 population by December 2026 - utilising Health Pathways optimally.	**P**	Referral rate: 900 per 100,000 population.	800 per 100,000 population.

Appendix 2: Enabling Actions

Enabling Actions: mandating on the basis of "adopt or justify"			**Baseline**	**2026/27**
Timely Access to Care	Through effective streaming of patients on arrival at the front door allied to a focus on safe, efficient and early discharges, deliver all ambulance patient handovers within a maximum of 45 minutes, aiming for achievement of >90% in 15 minutes by the end of 2026/2027.	**N**	Baseline at GUH ED is 24.9% within 15 mins, and 24.8% across all location types.	Achieve 80% within 45 mins at GUH ED and 100% at all other location types. Deliver de-escalation criteria
	Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme Optimal Hospital Flow Framework with a focus on 7-day working with leaner acute hospital processes and more efficient discharge transport services to facilitate earlier discharges and increasing weekend discharges.	**P**	Criteria-led discharge has been rolled out weekly scrutiny of the longest-stay patients embedding of Optimal Hospital Flow Framework. Winter Sprint work with Local Authorities and a newly simplified discharge policy implemented.	Roll out of the OHFF across all sites, evaluate the implementations from 2025/2026 to assess the benefits, and continue to embed the principles 2026/2027.
	Deliver medical same day emergency care and acute frailty services at the front door of hospitals in line with all principles set out in national same day emergency care policy and strategy documents, and the six goals for urgent and emergency care programme Front Door Acute Frailty Service Framework for Acute Hospitals.	**P**	The Community Assessment Lounge has been extended with 76% home-discharge rate, Centralised Home First Team at the Grange expanded front-door therapy coverage. Older-person programme in place to map system needs, with frailty support delivered through community services, eLGH front-door clinicians, and a therapy-led model at the Grange University Hospital.	Older person programme to deliver redesigned clinical model.

Appendix 2: Enabling Actions

Enabling Actions: mandating on the basis of "adopt or justify"			**Baseline**	**2026/27**
Timely Access to Care	Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme community-based falls response framework and, in support, implement a focus on prevention and early intervention in line with the policy statement on population health management.	**P**	Level 1 falls response increased to 34% up from 25%). Centralised therapist input via the Community Clinical Desk/Single Point of Access continues to strengthen falls triage and navigation. Conveyance rate baseline is 36%.	Continue programme of work and reduce 12-month average conveyance rate by a further 10%.
	Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme single point of access framework to ensure people with urgent care needs receive timely and appropriate support, minimising unnecessary escalation to emergency ambulance conveyance or hospital admission. Prioritise tailored interventions for frail and older adults, scaling up "call before convey" as a business-as-usual model and referrals to community nursing services enabling urgent response. Strengthen integration with key system partners, including Welsh Ambulance Services and Local Authorities, to deliver coordinated and effective care across the urgent care pathway.	**P**	The Community Clinical Desk pilot launched in November 2025 (based within the Single Point of Access Hub), assessing over 200 patients with more than 60% supported to remain at home. Running through Q4, the Multidisciplinary Team model is proving effective, with most referrals via Welsh Ambulance Services APPNAV/C3 Stack, and work underway with the LMC to explore expanding its scope	SPoA pilot will run to the end of Q4 with evaluation and options appraisal to follow.

Appendix 2: Enabling Actions

Enabling Actions: mandating on the basis of "adopt or justify"			**Baseline**	2026/27
Workforce Productivity	Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular	**Y**	Recruitment campaigns and a focus on retention and sickness actions ongoing. Current delivery balanced against volume of additional workstreams prioritised against these urgent areas.	Health Board actions implemented. Will be undertaking a review of all governance/booking arrangements to refresh and update in 2026/27
	Continue to deliver a further and sustained reduction in agency expenditure, with a target 30% reduction in 2026/27 from 2025/26 outturn and ensuring no off-contract expenditure	**Y**	Q3 position projects with full-year spend 13.5% below last year	Aimto reduce agency by 30% due to improved vacancy position and fully eradicate off contract agency
	Ensure effective implementation of job planning policy, to include ensuring that > 90% of all Consultants have an agreed job plan in place at all times by 30 September 2026 and aligned to service demand and capacity plans.	**P**	Consultant job planning compliance 53.4% as of Jan-26.	Trajectory 80% by September 2026.
	Organisations who have achieved a reduction in agency spend on Healthcare Support Worker, Admin & Clerical, and Estates & Ancillary staff to maintain that position. Organisations yet to deliver that position to deliver zero by 30th September 2026.	**Y**	Partially achieved 25/26 through strong recruitment, retention, and sickness-reduction efforts. Risk remains regarding additional bed capacity, levels of enhanced care, vacancies, and sickness absence.	Maintain significant reductions to date. Review of governance. Aim to achieve zero recognising skills shortages in particular for estates, catering and specific admin roles.
	Ensure a reduction in sickness absence in 2026/27 in comparison to 2025/26 to 6.49% which is the average sickness rate reported in 25/26 through maximising adherence to the requirements of agreed attendance at work policies and adhering to the all-Wales Occupational Health minimum service levels.	**Y**	Sickness absence 6.96% in Jan-26.	People Plan commitment to 0.5% reduction in absence. £0.9m within plan savings from divisions linked to reduced variable pay from absence management.

Appendix 3: Quality Statements

Quality Statement	Plans to Address
Care of the critically ill	• Maintain ability to surge level 3 capacity of 24 beds in line with escalation arrangements • Review of surge planning in take on board lessons learnt from critical incident • Working collaboratively with the Respiratory High Care Unit to ensure care is being delivered in the most appropriate setting
Care in Emergency Departments	• Deliver de-escalation criteria for urgent & emergency care incl. improvement with Ambulance Handovers, 12 hrs waits & waits to be seen • Simplify access to urgent & emergency care services within Gwent and Increase the utilisation of alternative pathways • Improve timely assessment by senior clinical decision maker • System upgrades in order to comply with Welsh Emergency Care dataset • Completion of Emergency Department main wait extension phase 2
Older people & people living with frailty	• Increase the number of care home residents with a robust Future Care Plan (FCP) in place expanding into new care homes • Delivery aligned to workstreams, campaigns to raise awareness, piloting of Hospital Acquired Deconditioning tool • Develop a falls prevention programme with partners • Actions in place to support our High Risk Adult Cohort in community settings • Embed processes to review Pathway of Care Delays with Local Authority Partners ensuring timely discharge • Roll our of Acute Frailty Response across all our sites • Pathway review of long ambulance handover waits of elderly patients • Develop Bereavement Pathway based on National Bereavement Standards • Prepare for the extended data entry requirements of the National Audit of Inpatient Falls (NAIF) to include all fractures & falls
Osteoporosis & bone health	• Embed changes to Fracture Liaison Service learning from Welsh Government funded pilot • Building on research current opportunities within Rheumatology, with a further three studies pending
Respiratory disease	• Delivery of respiratory seasonal vaccinations • Implementation of plan to increase treated smokers & % CO validated quits • Progress Asthma biologic management • Focus on Cancer Waiting times & outpatient to improve RTT • Implement integrated breathlessness care pathway through targeted approach to test feasibility
Heart Conditions	• Reduce the risk of premature mortality from cardiovascular disease • Identify those with undiagnosed Hypertension to provide early preventative advise • Hypertension case finding service embedded across Gwent • Hypertension treating to target programme embedded across Gwent • Enhance & upscale Value in Heart Failure • Heart Health event for World Heart Day

Appendix 3: Quality Statements

Quality Statement	Plans to Address
Cancer	• Deliver improvements in tumour site single cancer pathway through targeted recovery plans • Quarterly cancer backlog reduction to 5% or less • All cancer patients registered on WCP dataset forms & data now pulled from the cancer dataset dashboard • Development of Systemic Anti Cancer Therapy Outreach services in Gwent with Velindre University NHS Trust • Enhance & upscale Value in Cancer Services • Continuing to strengthen research links & close working partnerships with Velindre University NHS Trust & Cancer Research UK
Diabetes	• Expansion of Diabetes Prevention Programme, modelled to target underserved groups • Embedding of Diabetes recognition across all Care Homes • Population Health management approach to Diabetes prevention in partnership with NCNs • Improvement on 8 care processes for Diabetes • Develop integrated weight management pathway for Diabetes • Progress implementation of Diabetes pumps • Enhance & upscale Value in Diabetes
Kidney Disease	• Working in partnership with Cardiff & Vale Health Board to deliver additional dialysis capacity • Continued service improvements through commissioned service review with Cardiff & Vale Health Board
Liver Disease	• Level 2 (full) accreditation by the Improving Quality In Liver Services (IQILS) scheme, plans to maintain standard • Fibroscan pathway improvements to increase capacity • Embedded Alcohol support service • Develop & begin to implement an alcohol licencing triage & response system • Continued delivery of Try Dry Local project; • Launch alcohol licencing risk matrix • Partnership working to address alcohol attributable admissions
Musculosketal Health	• MoveBetterGwent enables people to remain active & independent for as long as possible, using technology to enable the safe & efficient management of MSK conditions with signposting to evidence based information • MSK Primary Care Hub in place to ensure deployment of nationally agreed, locally optimised, high value, evidence-based pathways of care • Development of supported self management approaches in conjunction with leisure trusts & community infrastructure & additional supported self management approaches • Presence of MSK Specialists within minor injury & urgent primary care services • Improved insight into patient experience through rollout of PROMs on new system • Continued involvement with Community Health Pathway development • Development approach for first contact practitioner service delivery across the Health Board

Appendix 3: Quality Statements

Quality Statement	Plans to Address
Neurological Conditions	• Progress Functional electrical stimulation • Undertake work to address epilepsy stabilisation • Focus on RTT stabilisation & compliance
Stroke	• Stroke Improvement Programme with redesign of services to support timely & effective care • HASU & rehabilitation review with implementation of recommendations • Address workforce sustainability through Speciality Doctor development & CNS review • Implement bed base changes & ringfencing to support timely care
Vascular Disease	• Regional Hub & Spoke Model in place through South East Wales Vascular Network • Actively contributing to Network review & supporting improvement plans as appropriate
Women's & Girls Health	• Rollout of Women's Health Pathfinder Hub through digital platform & service expansion of Gynae Ambulatory Care Unit & Sexual Health Services • Continue to develop women's health single point of access (SPOA) for referrals • Training focused on removing stigma & patient-centred engagement • Continue partnership engagement through ISPBs to further develop local community models that address women's health needs • Embed evidence-based care across maternity pathway with early optimisation public health messaging • Establish a single point of access for maternity triage for all women • Implementation of Women's Health Discovery Report Action Plan • Reduce the transmission of sexually transmitted infections & unintended pregnancies through community condom scheme & C-Card

Place Based Care

Over the last few decades, we have seen significant, disproportionate, growth in hospital-based services compared with prevention, primary care and community services. It is important, now more than ever, to deliberately redirect resources towards helping people in Gwent maintain good health and well-being so they can lead fulfilled and healthier lives for longer. Place Based Care has long been recognised as the strategic approach for:

- Building resilient and connected communities
- Prevention and earlier intervention
- Reducing health inequalities
- Collaborative working through multi-disciplinary teams
- Providing are closer to home and streamlining access to specialist care
- Reducing preventable admissions and optimal hospital discharge through a Home First approach

Place Based Care is critical to translating the strong ambition and early alignment into tangible, sustained system transformation that improves health and wellbeing outcomes for communities across Gwent. The delivery of Place-Based Care is overseen through governance structures that enables partners to work together within existing planning and delivery arrangements across the Health Board, Local Authorities and third sector. Furthermore, the partnership model addresses cultural and behavioural change challenges by fostering trust, shared accountability, and willingness to work differently across organisational boundaries.

The initial locality focus is Torfaen and Blaenau Gwent, targeting our most deprived communities. Our partnership approach dovetails place-based care with the "Torfaen deal" building resilience in communities. Our Place Based Care Programme service as our Community by Design delivery vehicle and one of the key change programmes (alongside the work of the RPB and PSB) in delivering the Better Health and Better Lives elements of our strategy.

Performance in 25/26

Delivery Expectation	ABUHB commitment	In month performance against trajectory
Increase in people accessing Pharmacy Independent Prescribing services where they would have visited their GP	**24,065** Mar-26	**30,541** Jan-26 (Q4 Trajectory: 24,065)
Maintain the number of consultations undertaken by community pharmacy under CAS	**79,553** Mar-26	**73,836** Jan-26 (Q4 Trajectory: 79,553)
Maintain the number of patients accessing NHS Optometry Services	**246,133** Mar-26	**220,932** Jan-26 (Q4 Trajectory: 246,133)
Number of patients accessing urgent emergency services - Dental	**43,153** Mar-26	**32,770** Jan-26 (Q4 Trajectory: 43,153)
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	**128,347** Mar-26	**75,940** Jan-26 (Q4 Trajectory: 128,347)
Increase in capacity of Enhanced Community Care to at least the required levels previously set for 2024/25	**5,277** Mar-26	**5,523** Jan-26 (Q4 Trajectory: 5,277)
Maintain 95% of Palliative Care referrals assessed within 2 days	**95%** Mar-26	**91.0%** Dec-25 (Dec-25 Trajectory: 95.0%)
Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s	**8.5%** Mar-26	**8.0%** Jan-26 (Jan-26 Trajectory: 8.5%)
Increase in people accessing PIPs where they would have visited their GP	**24,065** Mar-26	**30,541** Jan-26 (Q4 Trajectory: 24,065)
Maintain the number of consultations undertaken by community pharmacy under CAS	**79,553** Mar-26	**73,836** Jan-26 (Q4 Trajectory: 79,553)

Transformation Programme, Achievement 25/26 & Focus 26/27

Transformation Programme	Workstreams
Place Based Care *Executive Lead: Executive Director of Public Health*	Workforce Development,Financial Strategy,Digital Data & Technology,Estates & Facilities, Communication & Engagement,Intelligence & Evaluation

Programme Key Achievements in 25/26

During 25/26 we delivered the following achievements:

- ✓ Established robust Programme governance & strategic oversight including appointment of Programme Manager to drive delivery.
- ✓ Learning session with the National Association of Primary Care
- ✓ Held a series of joint leadership meetings with Torfaen and Blaenau Gwent Local Authority to set the ambitions and commitment
- ✓ Evaluation Report completed showing conditional support & cautious optimism among stakeholders.
- ✓ Engagement of Integrated Service Partnership Boards (ISPBs) as accountable vehicles for delivery.
- ✓ Identified critical risks including governance complexity, uneven ownership, & capacity gaps.
- ✓ Early examples of progress in community infrastructure through Integrated Neighbourhood Teams & Multidisciplinary Teams.
- ✓ Strong system alignment around prevention, partnership, & place-based care principles.

Place Based Care Focus for 2026/27

Area	Commitments
Oversight	• Agree and take forward detailed implementation plan that draws on the finding of the evaluation report • Establish a mechanism for Place Based Care (PBC) to serve as the delivery arm of the Community by Design programme • Ensure alignment between the Integrated Community Care System (ICCS) & the Community by Design programme to foster integrated system transformation • Strengthening governance and leadership by simplifying structures, clarifying accountability, and ensuring the programme is the primary organising agenda for system change
Delivering through Partnership	• Delegating clear authority to Integrated Service Partnership Boards (ISPBs) as accountable delivery vehicles with decision-making power over neighbourhood planning, workforce configuration, and investment • Developing and activating Integrated Neighbourhood Teams as core delivery units, within each NCN cluster, supported by workforce strategies aligned to population needs • Permanently establish the Integrated Well-being Networks team, as a core element of Place Based Care delivery, along with Behaviour Change Practitioners and a Health Coach Team
Community Focus	• Deepening community engagement and co-production to ensure interventions reflect lived experience and local needs, moving from awareness to genuine participation

Delivery against Strategic Aims (26/27)

Priority	Workstream		Q1	Q2	Q3	Q4
Prevention	High Risk Populations	MD	Develop evidence based patient identification method for 0.5% population at greatest risk of admission & those rapid risers	Scale up MDT support model & embed within place based care through the 4 Integrated Service Partnerships Boards	Partner with 4 GP practices to compare primary care & acute data sets supporting outcome measurement	Progress with primary & social care data to fully assess outcomes; Increase the Future Care Plans utilisation
	Preventable Premature Mortality	MD	Continue to implement CVD risk-factor model embedding learning from 25/26 & combining with diabetes prevention	Develop Health Coach team & align to GP Practices for delivery of Brief Intervention; Train primary care on Diabetes & CVD unified model	Commence delivery framework for Diabetes & CVD unified model; Heart Health event for World Heart Day	Roll out CVD risk factor model across 68 GP Practices; Continue delivery of diabetes delivery framework
		MD	Cancer prevention group focusing on symptom awareness within under served population groups	Review & development of Cancer Prevention as part of the Gwent Cancer 2035 delivery framework	Continue delivery of Nicotine Control Alliance workplan & implement actions from Part 2 of Nicotine Discovery Report	Implementation of Cancer Prevention as part of the Gwent Cancer 2035 delivery framework
	Population Health Management	p	Import Primary Care data into Public Health Data Warehouse & agree initial cohorts	Surface intelligence around agreed cohorts to stakeholders for proactive prevention action	Refine reports & cohorts based on observation & feedback	Commence evaluation of GP practice action
Place Based Care	Neighbourhood Teams & Community Pathways	MD	Define local integrated neighbourhood team roles & responsibilities aligned with Place-Based Care principles	Engage partners across social care & voluntary sector to co-design implementation for Torfaen & Blaenau Gwent	Establish integrated pathways and collaborative forums to align services with population health needs	Refine model and prepare plan for scaling Place-Based Care approach across additional localities
		MD	Define multi-disciplinary team best practice and scale up across ISPBs; Develop & agree frailty patient identification	Bring together clinicians from across Gwent to agree future MD approach delivery defining role in place based care	Partner with 4 GMS practices to compare data; Develop outcome measurement for patients & health system	Gather additional partner data to fully assess outcomes; Increase utilisation & access of first contact practitioners
			Pilot Breathlessness hubs to improve early intervention in care for patients with chronic respiratory symptom	Following pilot evaluation, agree implementation approach; Explore options for community Audiology	Develop integrated breathlessness care pathways aligned with evidence-based practice	Implement integrated breathlessness care pathway through targeted approach to test feasibility
			Strengthen weekend working across community nursing maintaining 57% average	Review progress and work toward achieving 61% weekend working	Review progress, apply previous learning and work towards achieving 65%	Consolidate learning from the year aligned with national expectations to achieve 69%

Priority	Workstream		Q1	Q2	Q3	Q4
Access & Sustainability	Primary Care Sustainability		From 1st April management & ensure ongoing GMS provision of GP practices without independent contractor status	Completion of procurement for returning available directly supported GP practices to independent contractor status	Support the returned GP Practices through enhanced monitoring ensuring access of care for the communities	Work with the returned GP Practices to ensure sustainability for the future year & long term sustainability
			Implement initial variation for dental practices of the new dental contract reform	Respond to individual dental practice requests and monitor for additional adjustments	Analysis of 1st six months of contract monitoring to maximise application to meet population need	Undertake evaluation of the 1st year contract delivery to adjust plans for 27/28
			Full implementation of all Welsh Government Optometry Services pathway 4 elements	Maximise Pharmacy Independent Prescribing and Common Ailment Service	Timely management of urgent eye care issues by increasing Optometry Services activity	Maximise Pharmacy Independent Prescribing and Common Ailment Service
Improving Quality & Experience	Primary Care		Undertake review of NCN supplementary services to understand the gap in provision	Explore options to engage on a multi agency basis to reduce inequity	Assess the level of latent capacity for GMS providers and explore capacity for inter practice referrals	Undertake end of year review to inform gap analysis and embed learning for27/28
Resilient & Connected Communities	Building Community Capacity & Social Prescribing	P	Map existing community assets and implement social prescribing pathway to align with Place Based Care model; Enhance recruitment of wellbeing friends network	Co-produce social prescribing model through joint design sessions with NCNs, Integrated Wellbeing Networks, local authority, & voluntary sector partners	Ongoing work alongside partner organisations to identify, connect & mobilise the existing strengths within communities to enable them to thrive.	Continue partnership working with NCN networks, identifying gaps in provision & evaluate pilots of social prescribing pathways to scale up across Gwent

Performance Expectations (26/27)		National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Increase in % of patients (aged 12 years & over) with diabetes who received all eight NICE recommended care processes	MD	80%	No	44.4%	47%	48%	49%	50%
Percentage of patients (aged 12 years & over) with diabetes who have had foot surveillance recorded within last 15 months		80%	No	66.9%	70.2%	73.5%	76.7%	80%
Percentage of patients (aged 12 years & over) with diabetes who have had their urine albumin recorded within last 15 months		80%	No	67.5%	70.7%	74%	77.1%	80%
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.	MD	90%	Yes	N/A	-	-	-	90%
Uptake of eligible patients who attend cardiovascular disease risk factor management programme (CVDRFMP)		-	-	N/A	3,125	3,125	3,125	3,125
% of people who attended CVDRFMP diagnosed		-	-	N/A	312	312	312	312
No. starting 12-week intervention with Level Two Adult Weight Management Service		-	-	N/A	1,500	1,500	1,500	1,500
No. with end weight recorded who accessed 8+ sessions who lost >5% weight		-	-	N/A	450	450	450	450
Increase in people accessing Pharmacy Independent Prescribing Services where they would have visited their GP		-	-	36,649	11,405	22,810	34,215	45,620
Maintain the number of consultations undertaken by community pharmacy under the Common Ailments Service		-	-	88,603	24,968	49,936	74,903	99,871
Maintain the number of patients accessing NHS Optometry Services		-	-	265,118	66,820	132,559	198,839	265,118
Number of patients accessing urgent emergency services - Dental		-	-	36,173	9,043	18,087	27,130	36,173
Increase in number of accepted referrals to Rapid Response services		-	-	4,885	1,267	2,534	3,801	5,068
Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s		-	-	8%	8.5%	8.5%	8.5%	8.5%
Maintain the number of Urgent Primary Care contacts (inc. virtual)		-	-	96,371	25,437	50,873	76,310	101,746
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	MD	↓	Yes	180	150	140	130	120
Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard	MD	↓	Yes	6,085	4,500	4,200	4,160	3,840

Enabling Action		Baseline	26/27
Diabetes High Value High Impact pathway	Y	All 8 care processes: 45.5%,Foot surveillance: 66.9%, Urine albumin: 67.5%	All 8 care processes: 50%,Foot surveillance: 80%, Urine albumin: 80%%

Urgent & Emergency Care

Urgent and Emergency Care demand is forecast to continue to increase Ambulance handovers at GUH ED by 9.11%, Minor Injuries Units attendances by 6.4%, Assessment Unit by 3.77%, Medical Assessment Units by 5.46%. Adults walk ins at GUH ED by 8.4%. Emergency inpatient admissions are forecast to increase by 4.06%

To support meeting this demand and to respond to the Welsh Government Escalation Framework which requires the Health Board to evidence that recovery and improvement plans for admission avoidance, reduced handover delays and stronger internal flow are in place, an Urgent and Emergency Care Improvement & Stabilisation Plan has been developed. The overall aim of the UEC Improvement & Sustainability Plan is to sustainably improve whole-system flow to reduce harm and improve patient experience by delivering the following objectives:

- Increase community care delivered away from emergency departments.
- Sustainably improve the time patients wait for Emergency Care.
- Deliver an effective acute medicine model
- Delivery of Older People's Pathway
- Increase system-wide discharges while reducing variation.

Welsh Government's criteria for Urgent and Emergency Care performance and outcomes de-escalation will serve as the core performance metrics supplemented by the 2026/27 trajectories and individual programme metrics.

A new governance model for the Urgent and Emergency Care Programme will consolidate the current UEC programmes of work under a single structure so that there is one clear route for assurance, escalation, support and challenge. The UEC Programme Board chaired by the Chief Executive Officer will provide overarching oversight, supported by programme, operational and divisional groups covering the workstreams in each of the individual programmes. This structure is intended to eliminate duplication between previous arrangements and make Discharge, Our Next Patient, the Older Persons Pathway and the Acute Medical model workstreams mutually effective.

Urgent and Emergency Care improvements are being driven both internally within the Health Board and through the Regional Partnership Board which, as part of the Discharge Improvement Programme, is reviewing discharge pathways across the system to identify opportunities to streamline process, reduce duplication and target resources more effectively. Any efficiencies identified through that work will be used to support resource shifts that strengthen flow.

Through the actions in the UEC Improvement & Stabilisation Plan, the Health Board is determined to achieve the de-escalation requirement during 2026/27.

Commitments in this UEC plan will be updated as the Improvement & Stabilisation Plan is finalised

Performance in 25/26

Delivery Expectation	ABUHB commitment	In month performance against trajectory
Reduce the number of ambulance patient handovers over 1 hour	**500** Mar-26	**687** Feb-26 (Feb-26 Trajectory: 578)
Reduce the number of ambulance crew hours lost at GUH ED (per month)	**2,500** Mar-26	**2,302** Feb-26 (Feb-26 Trajectory: 2,750)
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	**750** Mar-26	**1,089** Feb-26 (Feb-26 Trajectory: 731)
Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU	**80%** Mar-26	**73.3%** Feb-26 (Feb-26 Trajectory: 80%)
Reduction in time from arrival to ED triage - no waits over 60 minutes	**200** Mar-26	**343** Feb-26 (Feb-26 Trajectory: 250)
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-26	**136** Feb-26 (Feb-26 Trajectory: 70)
Maintain the number of Urgent Primary Care contacts (inc. virtual)	**95,147** Mar-26	**80,564** Jan-26 (Q4 Trajectory: 95,147)
% of patients directly admitted to an acute stroke ward <4hrs of clock start	**20%** Mar-26	**1.2%** Q2 25/26 (Q2 Trajectory: 20.0%)
% of unique stroke patients given thrombectomy (all stroke types)	**6%** Mar-26	**1.8%** Q2 25/26 (Q2 Trajectory: 6.0%)
% Assessed by OT within 24 hours		**21.9%** Jan-26
% Assessed by PT within 24 hours		**18.8%** Jan-26
% Assessed by SaLT within 72 hours		**75.8%** Jan-26
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	**160** Mar-26	**180** Feb-26 (Feb-26 Trajectory: 170)
Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard	**6437** Mar-26	**6,165** Feb-26 (Feb-26 Trajectory: 7,184)
Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment	**12** Mar-26	**13** Feb-26 (Feb-26 Trajectory: 14)
Continuous reduction in the number of people admitted as an emergency who remain in hospital over 21 days since admission	**370** Mar-26	**445** Jan-26 (Jan-26 Trajectory: 380)

Transformation Programme, Achievement 25/26 & Focus 26/27

Transformation Programme	Workstreams
Urgent and Emergency Care Programme *Executive Lead: Chief Operating Officer*	Our Next Patient Integrated Discharge Older Persons Pathway Acute Medical Model

Programme Key Achievements in 25/26

During 25/26 we delivered the following achievements:

- ✓ Completed the delivery of the approved investment in Emergency Department Consultant expansion with active locum recruitment underway to cover short term gaps
- ✓ Expanded the Transfer Lounge and associated model at the Grange University Hospital (GUH) enabling safer, faster and more patient centred flow across the Grange.
- ✓ Opened Phase 1 of the GUH Emergency Department extension which delivers a safer, modern waiting environment. Subsequent piloting of new operational approaches has provided valuable learning that is now directly informing the Phase 2 clinical model and design work due to begin in April/May 2026.
- ✓ Evolved the operational framework for U&EC into the 'Our Next Patient' (ONP) programme the progression of which is reflected throughout the recently developed Urgent and Emergency Care Stabilisation and Improvement Plan.

Urgent and Emergency Care Focus for 26/27

Area	Commitments
De-escalation criteria (Our Next Patient)	Ambulance waits > 45 mins - Focussed improvement in this area will start March 2026 for 90 days as part of the UEC Plan Stabilisation phase and will aim for the following stepped changes 12 hours in ED - Reduce to 7% or less from April 2026 Wait to be seen - Improve to 60 mins by March 2027
Integrated Discharge	Roll out of Optimal Hospital Flow Framework Roll out of criteria led discharge Review of all discharge schemes to develop single discharge pathway with LA partners Joint actions with LAs on Pathway of Care Delays
Older Persons pathway	Roll out of acute frailty at front door model Intermediate care Further development of Single Point of Access Emergency Care at home model Care homes programme
Acute medical model	Full options appraisal for sustainable model Bed reconfiguration

Delivery Against Strategic Aims 2026/27

Priority	Workstream		Q1	Q2	Q3	Q4
Prevention	High Risk Populations	MD	Develop evidence based patient identification method for 0.5% population at greatest risk of admission	Scale up MDT support model & embed within place based care through the 5 Integrated Service Partnerships Boards	Partner with 4 GP practices to compare primary care & acute data sets supporting outcome measurement	Progress with primary & social care data to fully assess outcomes; Increase the Future Care Plans utilisation
Access & Sustainability	Urgent Care & Emergency Care	MD	Enhance integrated front-door by streamlining access & Community Assessment Lounge (CAL) evaluation to inform future model	Relaunch of Care Home Escalation Framework; Commence agreed CAL model post evaluation; Refresh Community Capacity analysis	Develop plan using learning from Caerphilly pilot of wider rollout of care home support; Develop Community Capacity map & share across Gwent	Implement Care Homes Support Programme to additional locality; Evaluate impact of Future Care Planning training delivered in Q1-Q3
		MD	Simplify access developing an options appraisal for sustainable clinical model for Single point of Access (SPOA)	Continue review of flow centre pathways; Assess opportunity for community falls response linked to assistive tech	Implement integrated reporting system for SPOA referrals & outcomes; Develop a falls prevention programme with partners	Develop pathways to integrate community falls response in SPOA; Enhance front door response & timeliness for non-injurious falls
		MD	Continue to embed Optimal Hospital Flow Framework & criteria led discharge across all sites monitoring progress & benefits; Identify areas to pilot the Trusted Assessor (TA) model through engagement with stakeholders	Continue to ensure the Criteria Led Discharge framework is applied 7 days a week ; Define the optimal discharge pathway & co-design with stakeholders; Monitor impact & identify further areas to pilot TA	Implement the single integrated digital discharge platform; Pilot the optimal discharge pathway and refine for wider roll out; Commence implementation of new Optimal Staffing Discharge model	Evaluation of Criteria Led Discharge framework to evidence impact; Continue implementation of Optimal Staffing Discharge model; Roll out TA in phases coupled with optimal discharge pathway across Gwent
Improving Quality & Experience	Urgent Care Recovery	MD	Review interim ED clinical model and identify if there are any digital opportunities to support delivery	Evaluation of eTriage; Develop Head injury pathway, initially looking at navigation within hospitals	Mapping of ED patient process & identify challenges, risks & areas for improvement	Identify opportunities for system flow within ED to create space within the department

Performance Expectations 26/27		National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
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	MD	↓	Yes	180	150	140	130	120
Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard	MD	↓	Yes	6,085	4,500	4,200	4,160	3,840
Ensure no ambulance patient handover waits over 45 minutes - All Locations	MD	0	No	1,471	733	455	374	364
Ensure no ambulance patient handover waits over 45 minutes – Grange University Hospital Emergency Department	TI	11% ↓ for 3 months	Yes	943	578	400	330	320
Reduce the number of ambulance crew hours lost – All Locations		-	-	3,556	1,949	1,250	1,031	960
Reduce the number of ambulance crew hours lost – Grange University Hospital Emergency Department		-	-	2,653	1,559	1,000	825	768
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	MD	0	No	1,089	1,066	875	908	799
Increase and maintain national target of the percentage of patients waiting <4 hours in Emergency Department/Minor Injury Units		95%	No	73.5%	75%	76%	76%	77%
Reduction in time from arrival to Emergency Department triage: no waits over 60 mins		-	-	414	300	200	400	200
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.	TI	<60 mins	Yes	135 mins	100	80	80	60

Enabling Actions		Baseline	26/27
Ambulance Patient Handovers	N	Baseline at GUH ED is 24.9% within 15 mins, and 24.8% across all location types.	Achieve 80% within 45 mins at GUH ED and 100% at all other location types. Deliver de-escalation criteria
Optimal Hospital Flow Framework	P	Criteria-led discharge has been rolled out. Embedding of OHFF	Roll out of the OHFF across all sites
Same day emergency care and acute frailty services at front door	P	Community Assessment Lounge extended with 76% home-discharge rate, Centralised Home First Team & older-person programme in place	Older person programme to deliver redesigned clinical model.
Community-based falls response framework	P	Level 1 falls response inc to 34% from 25%. Centralised therapist input via SPOA. Conveyance rate baseline is 36%.	Continue programme of work and reduce 12-month average conveyance rate by a further 10%.
Single Point of Access	P	The Community Clinical Desk pilot launched in Nov 2025 (based within the SPoA Hub), assessed 200+ patients 60+% remaining at home.	SPoA pilot will run to the end of Q4 with evaluation and options appraisal to follow.

Planned Care & Cancer

Planned care demand continues to grow, with total referrals forecast to rise by 4.2% in 2026/27 compared with 2025/26, continuing the pattern of year-on-year post-COVID increases. New outpatient appointments are expected to reach 177,261 (a 6.8% rise), with follow-ups increasing by 9.9% to 356,983. Elective treatments are expected to fall by 11% to 6,523, though day case activity will increase by 7.7% to 21,961. Overall treatment volumes are forecast to increase by 2.7% compared to 25/26 forecast, supported through Theatre efficiency improvements and progress with GiRFT standards. The activity plan is based on core capacity on an assumption of no additional activity.

Cancer demand is forecast to grow by 3% for total and GP-initiated referrals, stabilising after periods of elevated post-pandemic growth. While no major increase in total treatment volumes is expected, improved performance will depend on increasing the proportion of cancer treatments initiated within 62 days from suspicion, requiring robust, tightly managed pathways across diagnostics, outpatient appointments and treatment planning.

As part of our plan development we have undertaken detailed demand and capacity modelling across Planned Care to inform delivery within core capacity, identify opportunities for productivity and efficiency, and forecast expected performance against key metrics. This work has demonstrated material demand and capacity deficits across several specialties with specific subspecialties driving the deficit, particularly at the treatment stage.

Performance against the 2025/26 Ministerial Delivery Expectation for 104-week Referral to Treatment (RTT) has only been achieved through significant additional activity delivered outside core capacity (including Waiting List Initiatives, backfill sessions, and insourcing). This additional activity has been supported through a combination of national allocations and non-recurrent internal funding. As at Month 11, total additional treatment activity has cost £7.1m, with a further £2m forecast in Month 12 and we continue to work towards a near-zero position for patients waiting over 104 weeks by year-end with some risks. Without comparable levels of non-recurrent investment going forward, performance at 104 weeks will deteriorate due to the underlying treatment-stage demand and capacity gaps in ENT, General Surgery, Ophthalmology, Oral & Maxillofacial Surgery, and Orthopaedics.

The national outpatient insourcing programme has reduced the total size of the waiting list. When comparing the 104-week cohort for 2025/26 with that of 2026/27, the total cohort entering the new year is approximately 10,000 patients smaller, but this reduction is concentrated exclusively at the outpatient stage.

At other stages of the pathway, cohort sizes have increased when compared to 2025/26:

- Stage 2 Diagnostics is 68% larger than at the start of 25/26;
- Stage 3 Follow-Up/Therapies is 3% larger, and;
- Stage 4 Treatment is 15% larger.

At the treatment stage alone, this represents approximately 1,500 additional patients in the 104-week cohort compared to the same point last year, with the largest increases seen in Oral & Maxillofacial Surgery and Orthopaedics. While the Health Board remains committed to delivering its transformation objectives and the Enabling Actions within Planned Care as outlined in this IMTP, maintaining current performance levels without the additional non-recurrent capacity that has supported delivery to date will be highly challenging. We could make further progress on 104 and diagnostics should additional money become available and we have draft delivery plans in place to achieve this.

Performance in 25/26

Delivery Expectation	ABUHB commitment	In month performance against trajectory
12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	**70%** Mar-26	**55.9%** (Jan-26 Trajectory: 69.0%)
Reduction in backlog of patients waiting over 62 days (SCP)	**200** Mar-26	**344** (Jan-26 Trajectory: 220)
Reduction in backlog of patients waiting over 104 days (SCP)	**50** Mar-26	**95** (Jan-26 Trajectory: 55)
Increase in rate of treatments starting within 28 days of decision to treat	**75%** Mar-26	**86.9%** (Jan-26 Trajectory: 75.0%)
Numbers of patients waiting over 104 weeks (all stages)	**3,291** Mar-26	**434** (Jan-26 Funded Trajectory: 459)
Number of patients waiting over 52 weeks for Outpatients	**18,095** Mar-26	**3,779** (Jan-26 EoY Trajectory: 4,237)
Reduction in the number of patients waiting 100% past Outpatient follow-up target date	**27,275** Mar-26	**31,478** (Jan-26 Trajectory: 28,750)
Increase in the rate of See On Symptom and Patient Initiated Follow-ups	**13.5%** Mar-26	**11.6%** (Jan-26 Trajectory: 13.0%)
Monitoring DNA/CNA for every Outpatient clinic. When DNA >5%, overbooking to be implemented & monitored and reduction of CNA	**5%** Mar-26	**5.2%** (Jan-26 Trajectory: 5.0%)
Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic	**1,077** Mar-26	**2,387** (Jan-26 Trajectory: 1,077)
Number of adults waiting more than 14 weeks for all audiology pathways	**5,440** Mar-26	**5,628** (Jan-26 Trajectory: 5,366)
Number of children waiting more than 6 weeks for all audiology pathways	**3,630** Mar-26	**1,455** (Jan-26 Trajectory: 2,783)
No patient waiting more than 14 weeks for a therapeutic assessment	**105** Mar-26	**366** (Jan-26 Trajectory: 110)
On 90% of days planned care inpatient/daycase/theatre recovery capacity should be protected from pressures and outliers	**90%** Mar-26	**96.3%** (Jan-26 Trajectory: 90.0%)
Theatre Utilisation late starts to less than 20%	**25%** Mar-26	**37.0%** (Jan-26 Trajectory: 30.0%)
Theatre Utilisation early finishes to less than 10%	**25%** Mar-26	**50.6%** (Jan-26 Trajectory: 31.0%)
Theatre Utilisation session utilisation to 85%	**85%** Mar-26	**83.1%** (Jan-26 Trajectory: 85.0%)
Deliver improvements in day surgery rates, achieving a BADS daycase rate	**55%** Mar-26	**77.0%** (Nov-25 Trajectory: 50.0%)
Number of adults waiting more than 14 weeks for all audiology pathways	**5,440** Mar-26	**5,628** (Jan-26 Trajectory: 5,366)
Number of children waiting more than 6 weeks for all audiology pathways	**3,630** Mar-26	**1,455** (Jan-26 Trajectory: 2,783)

Transformation Programme, Achievement 25/26 & Focus 26/27

Transformation Programme	Workstreams
Planned Care *Executive Lead: Director of Strategy, Planning & Partnerships*	HealthPathways, Keeping Well, Outpatients Transformation, Theatres & Planned Care Academy.
Cancer *Executive Lead: Chief Operating Officer*	Prevention, Early Detection, Timely Diagnosis, Improved & Standardised Care, Living With & Beyond Cancer & Improving our knowledge

Programme Key Achievements in 25/26

During 25/26 we delivered the following achievements:

- ✓ Achieved 180 live Healthpathways
- ✓ Launched Keeping Well service, supporting & signposting patients on elective treatment lists
- ✓ Successful roll out of Interface GP model across a number of specialties
- ✓ Scaled up HVLC lists with NHH focus for Day surgery & HVLC aligned to MAG report
- ✓ Successful delivery of Velindre @ NHH Radiotherapy Centre
- ✓ Theatre utilisation increased significantly from 56.5% → 79.1%, showing strong improvement & on track to meet GIRFT trajectories.
- ✓ Day surgery (BADS) performance has improved from 76% → 80%, demonstrating good progress towards national expectations.
- ✓ Significant innovation in diagnostics with deployment of AI in radiology, TNE and speedboat techniques in endoscopy
- ✓ Led the regional delivery of significant cataracts programme, supporting over 12,000 additional treatments compared to 2024/25

Planned Care Focus for 2026/27

Area	Commitments
Demand Management	• Establishment of primary and secondary care interface groups across key specialties to strengthen clinical leadership and joint ownership • Fully embedding the benefits of Health Pathways alongside development of additional pathways in high volume areas • Deep dives into GP referral data across specialties and with primary and secondary care • Deployment of e-advice to support two way communication between primary and secondary care
Outpatients	• Focus on follow up waiting list through SOS/PIFU application prospectively and retrospectively • Clinic template review by speciality
Inpatients & Diagnostics	• Drive Theatre efficiencies building on progress made in 2025/26 including utilisation and productivity, including perfect month in Orthopaedics • Develop system wide theatres plan covering Outpatients treatment Unit (& other ambulatory options), Day surgery & Surgical high risk to maximise existing infrastructure & inform planning for NHH & LHP • Next stages of detailed planning for orthopaedics as part of regional & LHP • Regional diagnostics plan including implementation plan for Phase 1 of LHP • Finalise sustainability plans for specialities not in recurrent balance including orthopaedics
Enablers	• Launch and deployment of Validation strategy • Ongoing exploitations of opportunities in CIN frameworks • Next stage development of Planned Care Academy and roll out of training • Key digital priorities to support Planned care including Open eyes, e-advice, outpatient booking app

Cancer Focus for 26/27

Area	Commitments
Planning	• Development of a long-term Cancer Improvement Plan to 2035 to provided continued evidence of planned improvement, governance and strategic priority following on from the Health Board's Cancer Strategy 2021-2026. • Review of the benefits realised from the previous Cancer Strategy to inform the new Plan
SCP Performance	• Suspected Cancer Pathway (SCP) performance trajectory is to clear the current backlog in Q1 and deliver a staged improvement through the remaining quarters to meet or be close to the national target of 75% by the end of the year. With regards to the 62 and 104 day backlogs, the trajectories seek to reduce these by over 50% through the course of 26/27
Demand management	• Stronger demand and capacity modelling will be undertaken to enable earlier anticipation of services pressures and ability to identify additional capacity where possible and required before performance deteriorates • Alignment of diagnostics to recommended pathway stages/internal pathway (NOP) noting increasing demand across modalities
Recovery	• Work across all tumour sites with focussed approach on Lower GI, Urology and Breast which have persistent sustainability issues . Formal improvement plans will be drafted setting out clear expectations on post MDT actions and pathway progression and Executive oversight will be provided where necessary.
Prevention	• Continue the effective communications in areas of prevention, awareness, screening uptake and earlier presentation. • Monitor operational impacts from targeted communications and utilise insights from responses to communication campaigns will feed into the Development of the Cancer Improvement Plan
Patient Experience	• Alongside the focus on compliance which directly impacts on patient experience, priorities of clearer communication with patients following MDT, smoother progression through pathways and service redesign that improves patient experience. Embedding patient feedback into the cancer pathway and acting on relevant results and Civica feedback.

Delivery against Strategic Aims (26/27)

Priority	Workstream		Q1	Q2	Q3	Q4
Prevention	Preventable Premature Mortality	MD	Cancer prevention group focusing on symptom awareness within under served population groups	Review & development of Cancer Prevention as part of the Gwent Cancer 2035 delivery framework	Continue delivery of Nicotine Control Alliance workplan & implement actions from Part 2 of Nicotine Discovery Report	Implementation of Cancer Prevention as part of the Gwent Cancer 2035 delivery framework
Access & Sustainability	Longest Waiting Patients	MD	Commence pilot of service improvements in Endoscopy including Capsule sponge, Colon Capsule, Trans Nasal Endoscopy & Speedboat	Continue oversight of 8 week trajectories diagnostics improving MR, CT & Ultrasound	Development of proposal for 3C service model in Endoscopy to improve sustainability & reduce waiting times	Achieve 0 patients waiting more than 8 weeks for a specified diagnostic through improving MR, CT, Ultrasound & Endoscopy

Priority	Workstream		Q1	Q2	Q3	Q4
Access & Sustainability	Longest Waiting Patients	MD	Commence implementation of Audiology sustainability action plan to improve waiting times for babies, children & Adults	Take targeted actions on demand management schemes to benefit 52 week outpatient position	Delivering of efficiency & productivity schemes to reduce longest waiting patients for treatment	Deliver demand management, efficiency & productivity to benefit longest waiting patients for outpatients and treatment, achieving expected trajectory
		MD	Lower GI Cancer recovery plan driving reduction in time to scope; Establish Upper GI & Gynaecology recovery groups	Quarterly cancer backlog reduction to 9% or less; Monitor pathway cancer recovery groups compliance	Quarterly cancer backlog reduction to 7% or less; Review pathway cancer recovery groups compliance . Rapid access to cancer diagnosis and treatment.	Quarterly cancer backlog reduction to 5% or less; Revise pathway cancer recovery groups based on compliance
Improving Quality & Experience	Planned Care & Cancer	EA	Undertake gap analysis of GIRFT recommendations & develop action plans for Lower GI and Complex Urology and plans to improve psychology support for cancer patients	Specialties to progress and track compliance with CIN Frameworks; Implement plans to improve psychology support for cancer patients	Implement GIRFT recommendations action plan; Implementation of plan to ensure Eye Unit meets RNIB compliance standards	Delivery of NICE drugs for Haematology patients; Implement prehabilitation for patients waiting for surgery as part of their cancer pathway
Embedding Value & Efficiency	Theatre Maximisation	EA	Capture detailed learning from T&O Perfect Month & national benchmarking to achieve EA standard; Drive improvements in late starts/early finishes & theatres	Use Perfect Month learning & national benchmarking to design an action plan for wider roll; Direct listing for cataracts; HVLC in General Surgery roll out (subject to coding agreement)	Continue to track improvements & problem solve in late starts/ early finishes and cancer patients attending Theatre within 21 days as per National Optimal Pathways	Achieve 25% HVLC Day Case Rate; Continue to track improvements & problem solve in late starts/ early finishes
	Health Pathways	EA	Implement additional 8 new pathways; Develop approach to monitor consistency & GP feedback loops post triage	Implement additional 8 new pathways; Embed through targeted communication & clinical interface groups	Implement additional 8 new pathways; 6 monthly review of data, usage, impact & learning	Implement additional 8 new pathways; Reflect opportunities from 6 monthly review into focused actions
	Outpatient Transformation *[MT: Planned Care]*	EA	Review outpatient space utilisation through audits of room use/start & finish time; SOS/PIFU retrospective application roll out; Implement Validation Strategy;	Template review & standardisation roll out by speciality (new follow ups); Pilot of outpatient booking app in RGH; Additional specialities in Outpatient treatment Unit	Further Did Not Attend/Can Not Attend deep dives, Work with specialties to improve utilisation, roll out of booking app to NHH and YYF;	Continue working with specialties to improve utilisation

Priority	Workstream		Q1	Q2	Q3	Q4
Quality of Life	Keeping Well	P		Improve health & wellbeing for patients accessing planned care through pro-active preparation for treatment		Improve health & wellbeing for patients accessing planned care through pro-active preparation for treatment

Performance Expectations 26/27		National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Numbers of patients waiting over 104 weeks (all stages)	MD	0	No	434	842	1,577	2,213	3,022
Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic	MD	0	Yes	2,387	3,048	2,559	1,292	0
Number of patients waiting over 52 weeks for Outpatients		0	No	1,834	3,587	5,435	5,578	5,898
Number of patients waiting over 26 weeks for Outpatients		0	No	12,222	15,772	19,475	20,948	22,361
Reduction in referral rate per 100,000 population by December 2026 - utilising Health Pathways optimally	EA	↓	Yes	900	900	900	800	800
Monitoring of Did Not Attend rates Outpatient clinics		<5%	Yes	5.2%	5%	5%	5%	5%
Reduction in the number of patients waiting 100% past Outpatient follow-up target date		25% ↓	Yes	31,592	29,150	27,542	25,574	23,606
Increase in the rate of See On Symptom and Patient Initiated Follow-ups		↑	Yes	12.9%	13.5%	14%	14.5%	15%
Theatre Utilisation: late starts to less than 20%	EA	20%	No	37%	35%	32%	29%	25%
Theatre Utilisation: early finishes to less than 10%	EA	10%	No	30.7%	22.5%	20%	17.5%	15%
Theatre Utilisation: session utilisation to 85%	EA	85%	Yes	83.1%	85%	85%	85%	85%
Deliver improvements in day surgery rates, measured through British Association Of Day Surgery day case rates		80%	Yes	77%	78%	79%	80%	80%
12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	MD	75%	Yes	55.9%	66.5%	74.3%	74.8%	75%
Reduction in backlog of patients waiting over 62 days (single Suspected Cancer Pathway)	MD	↓	Yes	342	350	300	240	170
Reduction in backlog of patients waiting over 104 days (single Suspected Cancer Pathway)	MD	↓	Yes	99	105	90	72	50
% of urgent suspected cancer patients diagnosed within 28 days from point of suspicion		-	75%	69.6%	72.5%	75%	75%	75%

104 Week Speciality Breakdown				
Specialty Name	**Q1**	**Q2**	**Q3**	**Q4**
Ear Nose & Throat	123	228	352	486
General Surgery	64	148	210	269
Maxillo-Facial	46	105	161	311
Ophthalmology	64	215	350	539
T&O - Spines	29	78	125	172
T&O – Arthroplasty	302	514	669	847
T&O – Other	214	289	346	398
T&O - ALL	545	881	1,140	1,417
Urology	0	0	0	0
TOTAL	**842**	**1,577**	**2,213**	**3,022**

Enabling Action	Adopt	Baseline	26/27 Plan
HVLC (Cataracts, Arthroplasty, General Surgery)	P	Cataracts – 6.83 per list Arthroplasty – 3.6 per list General Surgery – awaiting relevant codes from National Team	Cataracts – 7 per list Arthroplasty – 4 per list General Surgery – awaiting relevant codes from National Team
Ensuring the full implementation of the National Optimal Pathway in Cancer	P	National Optimal Pathways continue to be followed.	Map and cost a new malignancy of undefined primary origin/cancer of unknown primary pathway, with gap analyses and implementation planning for renal, myeloma, and sarcoma.
Theatre session utilisation	P	Late starts – 37%, Early finishes – 30.7%, Session utilisation – 83.1%	Late starts – 25%, Early finishes – 15%, Session utilisation – 85%
Consistent clerical and clinical validation	Y	All cohorts validated in line with the National Planned Care Policy Waiting List Validation Toolkit and Guidance.	Programme of work will continue across all stages, validation strategy launched Q1 26/27.
Utilising Health Pathways optimally.	P	Referral rate: 900 per 100,000 population.	800 per 100,000 population.

Mental Health

Demand for mental health services is sharply increasing and we need to find ways of supporting people earlier within the community to better support crisis prevention and recovery. The vision is to provide high quality, compassionate, person-centred mental health and learning disabilities services, striving for excellent outcomes for the people for Gwent. There are a number of national strategic drivers including the National Mental health & Wellbeing Strategy, Strategic Programme for Mental Health and National Programme for Suicide and Self harm Prevention.

In Mental Health, both Adults and CAMHS continue to use caseload-based demand and capacity modelling, with only modest demand growth expected and current modelling indicating the ability to sustain 80% performance levels, although the impact of the Open Access model remains uncertain and may influence future demand flows. CAMHS neurodevelopmental demand has risen during 2025/26, creating challenges in reducing the existing backlog and long waits, which will influence performance into 2026/27. Across Mental Health and Learning Disability services, a data-driven planning approach has been adopted, with early analysis indicating rising demand and a growing backlog in the Integrated Autism Service, exacerbated by constraints in ADHD access. The Memory Assessment Service is also experiencing sustained growth in referrals and increasing waiting lists, with demand outpacing modest gains in capacity, posing risks to diagnostic and assessment performance.

Performance in 25/26

Delivery Expectation	ABUHB commitment	In month performance against trajectory
Maintain Adults Part 1a to national target (assessment completed within 28 days)	**80%** Mar-26	**85.7%** Jan-26 (Jan-26 Trajectory: 80.0%)
Maintain Adults Part 1b to national target (interventions completed within 28 days)	**80%** Mar-26	**94.8%** Jan-26 (Jan-26 Trajectory: 80.0%)
Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan)	**90%** Mar-26	**91.7%** Jan-26 (Jan-26 Trajectory: 90.0%)
Maintain rate of psychological therapy received within 26 weeks	**60%** Mar-26	**47.0%** Nov-25 (Nov-25 Trajectory: 60.0%)
Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)	**80%** Mar-26	**96.8%** Jan-26 (Jan-26 Trajectory: 80.0%)
Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)	**80%** Mar-26	**83.8%** Jan-26 (Jan-26 Trajectory: 80.0%)
Maintain CAMHS Part 2 national target compliance	**90%** Mar-26	**92.6%** Jan-26 (Jan-26 Trajectory: 90.0%)
Improvement in Neurodevelopment waiting times compliance	**80%** Mar-26	**51.6%** Jan-26 (Jan-26 Trajectory: 80.0%)
Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	**80%** Mar-26	**93.2%** Jan-26 (Jan-26 Trajectory: 80.0%)

Transformation Programme, Achievement 25/26 & Focus 26/27

Transformation Programme	Workstreams
Developing Services Supporting the Mental Health and Wellbeing Strategy *Executive Lead: Chief Operating Officer*	Inpatient Service, Community Services, Open Access, Alternative Accommodation Options

Programme Key Achievements in 25/26

During 25/26 we delivered the following achievements:

- ✓ Achieved 85.7% in Adults Part 1a compliance
- ✓ Achieved 94.8% in Adults Part 1b compliance
- ✓ Achieved 91.7% in Adult Part 2 Rates
- ✓ Use of PROMS expanded to all wards across adult and older adult services
- ✓ Full engagement with National Patient Safety Programme
- ✓ Delivered pilot of Ty Lafant service model
- ✓ Positive outcome following several HIW inspections
- ✓ All Crisis services have been scoped as part of the work around a Single Point of Access and the development of our 111 press 2 Mental Health Service with pilot commencing in April
- ✓ Achieved 96.8% in CAMHS Part 1a compliance
- ✓ Achieved 83.8% in CAMHS Part 1b compliance
- ✓ Achieved 92.6% in CAMHS Part 2 Rates

Focus for 26/27

Area	Commitments
Inpatient Services	• Evaluate learning from Ty Lafant reduction in beds • Progress Co-location of Older Adults Wards Consider use of Adult Rehab ward at Maindiff Court as we move to Community Model • Agree strategic estate direction to support inpatient Models of Care • Further plans for Adult Rehab ward at Maindiff Court as we move to Community Model
Community Services	• Agree estate principles to support community based Models of Care • Progress Adult Community Rehab Service
Open Access	• Progress plan in line with the Open Access Steering group and direction from Welsh Government in respect of the Mental Health and Wellbeing Strategy • Commissioning of third sector partners to support Open Access
Alternative Accommodation	• Complete Assessment of needs for LD patients • Complete Assessment of needs for Adult Mental Health Services
Enablers	• Ward Accreditation and engagement with the National Safety Programme • Replacement Electronic patient record preparation for installation • Exploring option for robotic automation to support early triage and screening, with signposting to appropriate support

Delivery against Strategic Aims (26/27)

Priority	Workstream		Q1	Q2	Q3	Q4
Access & Sustainability	Longest Waiting Patients	MD	Commence action plan delivery to meet national target for Memory Assessment Service; Maintain Part 2 Care & Treatment Plan Adults national target of 80%	Maintain Adults Part 1a & Part 1b national target of 80% compliance; Complete pathway review to improve psychological therapies waiting times	Commence action plan delivery to meet national target for Memory Assessment Service; Maintain Part 2 Care & Treatment Plan Adults national target of 80%	Maintain Adults Part 1a & Part 1b national target of 80% compliance; Implement pathway changes to improve psychological therapies waiting times
		MD	Maintain CAMHS Part 1a & Part 1b national target of 80% compliance; Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	Improve Neurodevelopment (ND) waiting times compliance to 80%; Maintain CAMHS Part 2 Care & Treatment Plan (national target of 80%)	Maintain CAMHS Part 1a & Part 1b national target of 80% compliance; Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	ND waiting times compliance meets 80%; Maintain CAMHS Part 2 Care & Treatment Plan national target of 80%
		MD	Start to embed Open Access principles by expanding self-referral pathways	Engage with partners on plan to fully implement Open Access services for all ages	Implement plan to develop Open Access services across all ages	Evaluate opportunities to further develop Open Access services for all ages
	Models of Care		Agree strategic estate direction for inpatient & community based Mental Health service model	Identify Mental health estate requirements & potential options Further plans for Adult Mental Health Rehab ward as we move to Community Model	Confirm preferred Mental Health estate approach & phasing aligned to service & workforce; Progress Adult Community Rehab Service	Detailed plans for all Mental Health In-patient services developed; Progress the co-location of Mental Health Older Adults wards
Improving Quality & Experience	Mental Health	MD	Complete Older Adults ward accreditation to at least bronze level	Complete Adults & Learning Disabilities ward accreditation to at least bronze level	Complete Adults & Learning Disabilities ward accreditation to at least bronze level	Complete Community ward accreditation to at least bronze level
		MD	Carry out mortality reviews and ensure mechanisms for capturing learning in place	Carry out mortality reviews and develop improvement plans based on learning	Implement improvement plans incorporating learning from mortality reviews	Embed improvement plans incorporating learning from mortality reviews
Embedding Value & Efficiency	Enhanced & Commissioned Care	EA		Develop alternative accommodation options for Learning Disabilities reducing out of area placements		Develop alternative Adult Mental Health accommodation options reducing out of area placements

Performance Expectations 26/27		National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Maintain Adults Part 1a to national target (assessment within 28 days)		80%	Yes	93.3%	80%	80%	80%	80%
Maintain Adults Part 1b to national target (intervention within 28 days)		80%	Yes	93.2%	80%	80%	80%	80%
Maintain Adults Part 2 rates (no of individuals with a valid care & treatment plan)		90%	Yes	91%	90%	90%	90%	90%
Maintain rate of psychological therapy received within 26 weeks		80%	No	48.8%	56%	58%	60%	62%
Maintain Child and Adolescent Mental Health Services Part 1a national target (assessment completed within 28 days)		80%	Yes	100%	80%	80%	80%	80%
Maintain Child and Adolescent Mental Health Services Part 1b national target (intervention completed within 28 days)		80%	Yes	88.3%	80%	80%	80%	80%
Maintain Child and Adolescent Mental Health Services Part 2 national target		90%	Yes	98.3%	90%	90%	90%	90%
Improvement in Neurodevelopment waiting times compliance		80%	Yes	57.2%	60%	60%	60%	60%
Maintain 80% compliance of Specialist Child and Adolescent Mental Health Services Choice Assessments within 28 days from referral		80%	Yes	92.5%	80%	80%	80%	80%
Implement actions to deliver a material reduction in the number of out of area placements in 2026/27, and associated costs.	EA	↓	Yes	0	0	0	0	0

Enabling Action		Baseline	26/27
Implement actions to deliver a material reduction in the number of out of area placements in 2026/27, and associated costs.	Y	0.	Hold to 0.

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

Impact Across the Life Course

Starting Well

Babies, children, and their families receive early support through evidence-based perinatal pathways, targeted public health messaging, improved breastfeeding support, and enhanced early-years prevention programmes. Strengthened universal and targeted support through the Healthy Child Wales framework, perinatal optimisation, smoking cessation in pregnancy, and the 1001 Critical Days programme ensure that children have the healthiest possible start reducing inequalities from pregnancy into early childhood.

Growing Well

Children and young people benefit from emotionally supportive environments, timely access to mental health and strengthened prevention-focused health services. Improvements to emotional wellbeing and targeted support for vulnerable families, promote resilience, healthier behaviours, and improved developmental outcomes. The voice of babies, children and young people will be amplified informing how we tailor services to meet their needs. These integrated actions enable children and young people to thrive socially, emotionally, and physically as they grow.

Living Well

Adults are supported to live healthier lives through improved access an increased equity across screening, vaccinations and weight-management pathways. Avoidable harm is reduced preventing premature mortality through programmes reducing smoking, alcohol-related harm, and obesity. Enhanced focus on community prevention interventions including cardiovascular risk management and diabetes. Data helps us target support for those who need it most. Adults across Gwent maintain wellbeing, reduce avoidable illness, and stay active.

Ageing Well

Older people are supported to remain active, independent, and well for longer through targeted prevention for high-risk populations, integrated multi-disciplinary support, population health management, and proactive management of long-term conditions. Data-driven identification of those at highest risk of hospital admission, combined with Future Care Planning, rehabilitation programmes, and strengthened community support, enables healthier ageing reducing avoidable crises and inequalities in later life.

Dying Well

People approaching the end of life experience compassionate, personalised care supported by proactive planning, coordinated multi-agency support, and timely identification of needs. Strengthened Future Care Planning and improved palliative care approaches ensure that individuals and families feel informed, supported, and treated with dignity. Bereaved families receive consistent, high-quality support, helping them navigate loss respectfully and with care.

Appendix 5: Life Course Impact Statements

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

Impact Across the Life Course

Starting Well

Babies, children and families experience safer, more responsive care through strengthened maternity, neonatal and early years pathways. Improvements such as expanded transitional neonatal care,, enhanced perinatal support models, and better alignment of services ensure healthier early development, safer births, and more consistent follow-up. Integrated Place-Based Care and Early Help models ensure families receive seamless, proactive support from pregnancy through infancy.

Growing Well

Children and young people benefit from improved access to timely, appropriate care through consistent neurodevelopmental and mental health pathways, coordinated multi-disciplinary support and integrated community models. Enhanced CAMHS, SCAMHS and ND waiting-time performance, combined with better care navigation and place-based MDT support, ensures children receive help earlier and closer to home. Strengthened paediatric and neonatal improvements also create safer transitions during key developmental stages.

Living Well

Adults experience more accessible, coordinated and preventative care through stronger primary care sustainability, improved urgent and community care pathways, and expanded Mental Health self-referral/open access options. Integrated community teams, breathlessness hubs, improved diagnostics, and more efficient outpatient and theatres increase reliability, reduce waiting times and support people to remain well at home. Enhanced women's health pathways also improve equitable access and reduce unmet need.

Ageing Well

Older adults are supported to stay independent, safe and well through integrated discharge pathways, trusted assessor models, improved falls response, and the Gwent-wide rollout of the Older Persons Care Model. Enhanced community capacity, strengthened care-home support, dementia pathway improvements, and robust multidisciplinary working reduce unnecessary hospital stays, prevent deterioration, and ensure timely, compassionate support tailored to complex needs.

Dying Well

People approaching the end of life receive more coordinated, person-centred and timely care supported by improved discharge pathways, enhanced community MDT working, and strengthened place-based care. Better flow between hospital and community, improved escalation frameworks, and more integrated access points ensure dignity, choice and comfort. Consistent use of care-planning approaches and enhanced support to care homes and community teams improves the experience for individuals and their families at the end of life.

Appendix 5: Life Course Impact Statements

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

Impact Across the Life Course

Starting Well

Babies, children and families in Gwent experience healthier environments, emotionally supportive schools, and strong community networks that help them thrive from the earliest years. Integrated family-centred services ensures improved emotional resilience, reduced adverse childhood experiences, better educational, developmental, and wellbeing outcomes. Families feel connected, supported, and able to create nurturing home environments that help children start well in life.

Growing Well

Young people grow up in communities that foster resilience, inclusion, and opportunity. Schools, health services, and community partners work together to promote emotional wellbeing, social connection, and healthy lifestyles. Young people benefit from safer community spaces, and opportunities to engage in positive activities. This leads to enhanced mental wellbeing, improved physical health, greater confidence and preparedness for adulthood.

Living Well

Adults across Gwent are empowered to maintain and improve their health through strong community capacity, accessible wellbeing networks, and proactive prevention. People live in healthier homes, are supported to stay active and connected through integrated care and third sector support that address both physical and emotional needs. They live in strong, safe and connected communities that improves day-to-day wellbeing, reduces inequalities, and enables people to live fulfilling, independent lives.

Ageing Well

Older people experience coordinated, place-based support that keeps them active, connected, and living independently for longer. Communities, housing partners, social care, and healthcare services work together to reduce frailty, prevent crisis escalation, and ensure safe, warm homes. Improved access to rehabilitation, recovery pathways, and community assets enhances confidence, mobility, and wellbeing. People feel valued and able to age well in the communities they call home.

Dying Well

People approaching the end of their life receive timely, personalised, and compassionate care that reflects their values, preferences, and needs. Future Care Planning is consistently embedded across care settings, ensuring dignity, comfort, and coordinated support. Psychological care and specialist palliative pathways improve the experience of patients and their families. A reliable, equitable bereavement identification and support model ensures that families are cared for before, during, after loss and helping them cope and recover.

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