

Partnerships, Population Health and Planning Committee

Tue 27 January 2026, 09:30 - 12:30

Microsoft Teams



Agenda

1. PRELIMINARY MATTERS

PPHPC 20260127 Agenda - Approved.pdf (2 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on 7th October 2025

Attached *Chair*

PPHPC 20260127 1.4 PPHPC 20251007 Minutes - CHAIR APPROVED.pdf (13 pages)

1.5. Committee Action Log

Attached *Chair*

PPHPC 20260127 1.5 Committee Action Log.pdf (3 pages)

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

There are no items for inclusion in this section.

3. ITEMS FOR DISCUSSION

3.1. Committee Risk Report

Attached *Director of Corporate Governance*

PPHPC 20260127 3.1 Committee Risk Report.pdf (6 pages)

PPHPC 20260127 3.1 Committee Risk Report - Appendix 1 Strategic Risk Report.pdf (17 pages)

3.2. Approval status of 2025/26 IMTP

Attached *Director of Strategy, Planning and Partnerships*

PPHPC 20260127 3.2 Approval status of 2025-26 IMTP.pdf (22 pages)

PPHPC 20260127 3.2 Approval status of 2025-26 IMTP - Appendix 1 - Progress Levels.pdf (6 pages)

PPHPC 20260127 3.2 Approval status of 2025-26 IMTP - Appendix 1.1 Action Plan.pdf (8 pages)

PPHPC 20260127 3.2 Approval status of 2025-26 IMTP - Appendix 2 - NHS Wales.pdf (7 pages)

PPHPC 20260127 3.2 Approval status of 2025-26 IMTP - Appendix 2.1.pdf (13 pages)

PPHPC 20260127 3.2 Approval status of 2025-26 IMTP - Appendix 2.2.pdf (29 pages)

- PPHPC 20260127 3.2 Approval status of 2025-26 IMTP - Appendix 2.3.pdf (13 pages)
- PPHPC 20260127 3.2 Approval status of 2025-26 IMTP - Appendix 3.pdf (55 pages)

3.3. Development of 2026/27 IMTP

Attached *Director of Strategy, Planning and Partnerships*

- PPHPC 20260127 3.3 Development of 2026-27 IMTP.pdf (10 pages)
- PPHPC 20260127 3.3 Development of 2026-27 IMTP - Appendix 1a CabSec Letter - NHS Wales Planning Framework 2026-29.pdf (8 pages)
- PPHPC 20260127 3.3 Development of 2026-27 IMTP - Appendix 1b Planning Framework 2026-29 Annex 1 - Delivery Expectations.pdf (3 pages)
- PPHPC 20260127 3.3 Development of 2026-27 IMTP - Appendix 1c Planning Framework 2026-29 Annex 2 - Enabling Actions.pdf (5 pages)
- PPHPC 20260127 3.3 Development of 2026-27 IMTP - Appendix 1d DG Letter to NHS Chief Executives Supporting Governance Arrangements.pdf (5 pages)
- PPHPC 20260127 3.3 Development of 2026-27 IMTP - Appendix 2a Monmouthshire NCN Plan - IMTP Final.pdf (24 pages)
- PPHPC 20260127 3.3 Development of 2026-27 IMTP - Appendix 2b BG IMTP 26-29.pdf (45 pages)
- PPHPC 20260127 3.3 Development of 2026-27 IMTP - Appendix 2c Caerphilly NCN IMTP Plan 2026-29.pdf (23 pages)
- PPHPC 20260127 3.3 Development of 2026-27 IMTP - Appendix 2d Newport NCN IMTP 2026-2029.pdf (25 pages)
- PPHPC 20260127 3.3 Development of 2026-27 IMTP - Appendix 2e Torfaen NCN IMTP Plan.pdf (29 pages)

3.4. Business Continuity Planning

Attached *Director of Strategy, Planning and Partnerships*

- PPHPC 20260127 3.4 Business Continuity Planning.pdf (7 pages)
- PPHPC 20260127 3.4 Business Continuity Planning -Appendix 1 Internal Audit Report.pdf (13 pages)

3.5. Development of Clinical Services Plan update

Presentation *Director of Strategy, Planning and Partnerships*

- PPHPC 20260127 3.5 Development of Clinical Services Plan update.pdf (21 pages)

3.6. Deep dives on Place Based Care in Blaenau Gwent and Torfaen including key change issues

Attached *Director of Public Health*

- PPHPC 20260127 3.6 Place Based Care in Blaenau Gwent and Torfaen.pdf (17 pages)

3.7. Health Protection & Vaccination Programme Update

Attached *Director of Public Health*

- PPHPC 20260127 3.7 Health Protection & Vaccination Programme Update .pdf (11 pages)

3.8. Regional Partnership Board Update

Attached *Director of Strategy, Planning and Partnerships*

- PPHPC 20260127 3.8 Regional Partnership Board Update.pdf (7 pages)
- PPHPC 20260127 3.8 Regional Partnership Board Update - Appendix 1 Integrated Community Care System Year 3.pdf.pdf (42 pages)

3.9. Public Services Board Update

Attached *Director of Public Health*

- PPHPC 20260127 3.9 Public Services Board Update.pdf (5 pages)

3.10. Regional Planning Update

Attached *Director of Strategy, Planning and Partnerships*

- PPHPC 20260127 3.10 Regional Planning Update.pdf (7 pages)

3.11. Digital Strategy

Presentation

Director of Digital

 PPHPC 20260127 3.11 Digital Strategy.pdf (28 pages)

4. ITEMS FOR INFORMATION

4.1. Audit Wales Eye Care Report

Attached

Director of Strategy, Planning and Partnerships

 PPHPC 20260127 4.1 ABUHB Eye Care Review Report.pdf (32 pages)

4.2. Review of Committee Programme Annual Programme of Business 2025/26

Attached

Director of Corporate Governance

 PPHPC 20260127 4.2 Review of Committee Programme Annual Programme of Business.pdf (4 pages)

 PPHPC 20260127 4.2 Review of Committee Programme Annual Programme of Business - Appendix 1.pdf (6 pages)

4.3. Cybersecurity Audit

Attached

Director of Digital

 PPHPC 20260127 4.3 Cybersecurity Audit.pdf (4 pages)

5. OTHER MATTERS

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

Oral

Chair

5.2. Any Other Urgent Business

Oral

Chair

5.3. Date of the Next Meeting: 7th April 2026



**CYFARFOD BWRDD IECHYD PRIFYSGOL
ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
MEETING
PARTNERSHIPS, POPULATION HEALTH AND
PLANNING COMMITTEE**

AGENDA

Date and Time	Tuesday 27th January 2026 09:30am – 12:30pm
Venue	Microsoft Teams

Item	Title	Format	Presenter
1	PRELIMINARY MATTERS		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 7th October 2025	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	ITEMS FOR APPROVAL/RATIFICATION/DECISION		
	There are no items for inclusion in this section.		
3	ITEMS FOR DISCUSSION		
3.1	Committee Risk Report	Attached	Director of Corporate Governance
3.2	Approval status of 2025/26 IMTP	Attached	Director of Strategy, Planning and Partnerships
3.3	Development of 2026/27 IMTP	Attached	Director of Strategy, Planning and Partnerships
3.4	Business Continuity Planning	Attached	Director of Strategy, Planning and Partnerships
3.5	Development of Clinical Services Plan update	Presentation	Director of Strategy, Planning and Partnerships
3.6	Deep dives on Place Based Care in Blaenau Gwent and Torfaen including key change issues	Attached	Director of Public Health
3.7	Health Protection & Vaccination Programme Update	Attached	Director of Public Health



3.8	Regional Partnership Board Update	Attached	Director of Strategy, Planning and Partnerships
3.9	Public Services Board Update	Attached	Director of Public Health
3.10	Regional Planning Update	Attached	Director of Strategy, Planning and Partnerships
3.11	Digital Strategy	Presentation	Director of Digital
4	ITEMS FOR INFORMATION		
4.1	Audit Wales Eye Care report	Attached	Director of Strategy, Planning and Partnerships
4.2	Review of Committee Programme Annual Programme of Business 2025/26	Attached	Director of Corporate Governance
4.3	Cybersecurity Audit	Attached	Director of Digital
5	OTHER MATTERS		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: 7 th April 2026		

Motion to Exclude Members of the Public and the Press

There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting:

“Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”.

Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960





CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

MINUTES OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

Partnerships Population Health and Planning Committee

DATE OF MEETING	7 th October 2025
VENUE	Microsoft Teams

PRESENT	Phil Robson, Chair
	Dafydd Vaughan, Independent Member
	Akmal Hanuk, Independent Member
	Penny Jones, Independent Member
IN ATTENDANCE	Ann Lloyd, ABUHB Chair
	Hannah Evans, Director of Strategy, Planning and Partnerships
	Bevleigh Evans, Assistant Director of Population Health
	Lucy Windsor, Head of Corporate Risk and Assurance for item 3.2
	Emily Howells, Audit Wales Representative
	Hannah Capel, Assistant Director of Strategic Capital Planning for items 3.5, 3.6 and 3.7
	Jamie Marchant, Divisional Director of Estates and Facilities for item 3.6
	Rhian Guard, NWSSP, Audit and Assurance
	Naomi Murtagh, Board Business Manager
	Thomas Jaynes, Governance Support Officer
Apologies	Rani Dash, Director of Corporate Governance
	Tracy Daszkiewicz, Director of Public Health
	Paul Solloway, Director of Digital

PPHPC0710/01	Welcome and Introductions
	Phil Robson (PR), Chair, welcomed everyone to the meeting.
	Apologies for Noting
	Above Apologies were NOTED .
	Declarations of Interest for Noting
	There were no Declarations of Interest to note.



	Draft Minutes of the Partnerships, Population Health and Planning Committee, held on 1st July 2025 The minutes of the meeting held on 1st July 2025 were RECEIVED and were AGREED as an accurate record of the meeting.
	Committee Action Log for Review The Committee received the action log and were content with the progress made in relation to completed actions.
PPHPC0710/03	Review of Committee Programme Annual Programme of Business 2025/26 Naomi Murtagh (NM), Board Business Manager, presented the report to the Committee and highlighted there had been no updates made to the programme of business since the last Committee meeting. Hannah Evans (HE), Director of Strategy, Planning & Partnerships, suggested deep dives on priority programmes which would include key change issues to be included on the Committee's Forward Work Plan to align with updates provided to the Executive Committee. Action: Committee Secretariat The Committee NOTED the updated Committee Programme of Business for 2025/26.
	Committee Risk Report Lucy Windsor (LW), Head of Risk and Assurance, introduced the report for assurance and confirmed there had been no changes or updates to the risks under this Committee since the last report. LW highlighted ongoing work with the Corporate Risk Register and noted that higher-level operational risks that may impact delivery of Committee objectives were now being tracked more visibly. The Committee noted that more information would be shared as risk assessments develop further. The Committee NOTED the delegated Committee risks and further NOTED the continued efforts to bring all risks to within the agreed threshold for the risk appetite.



Update on Priority Programmes

Hannah Evans (HE), Director of Strategy, Planning & Partnerships, introduced the report for discussion and presented an update on the Committee's priority programmes.

HE noted that seven priority programmes had been selected to continue to progress with the Health Board's commitments in the Integrated Medium Term Plan (IMTP) and outlined each programme with high-level summaries, governance structures, milestones, metrics, team details, and key risks.

The Committee discussed key areas within the priority programme and HE outlined the Planned Care Programme and noted there was a dual focus on delivery and transformational change. The Committee noted cross-divisional work and recent deep dives at Finance and Performance Committee and noted the Health Pathways programme faced uncertainty due to potential withdrawal of national funding with decisions pending from Welsh Government.

HE reported on developments in cancer services and the Committee noted the opening of the radiotherapy unit and a successful skin cancer awareness campaign that had increased referrals.

The Committee noted updates to the Six Goals for Urgent and Emergency Care programme which was acknowledged as large and complex. The Committee was informed of recent initiatives such as the 45-minute Ambulance handover work and the Community Assessment Lounge pilot.

The Committee noted the Place-Based Care and Populations at Risk Programme, led by Tracy Daszkiewicz, Director of Public Health. It was noted that these were areas of growing engagement with primary care teams and integrated planning groups. HE noted the programme was shifting the focus toward prevention and population health with further updates planned for future committee meeting.

HE outlined Mental Health Transformation was being brought into greater focus with sustainability and estate issues under review. The Committee was informed that no



decisions had been made yet regarding the Dementia Ward relocation.

The Committee noted the decarbonisation programme led by Rob Holcombe, Director of Finance and Procurement, was active and was developing a strategy to be brought to the Committee for consideration.

Phil Robson (PR), Chair, asked about the effectiveness of programme management, particularly the matrix approach to cross-departmental working, and stressed the need for clarity on programme objectives and outcomes. HE informed the Committee highlight reports were created for the Programme Board and included deep dives. The Committee noted matrix management was working well within the organisation due to the legacy of the arrangement for the Grange University Hospital (GUH) and Clinical Future Programme guided by Executive Sponsorship.

Akmal Hanuk (AH), Independent Member, queried the progress of 25% of theatre utilisation at the mid-point of the programme. The Committee noted improvements in theatre utilisation show by a deep dive in July 2025. It was agreed for the deep dive to be shared to the Committee.

Action: Director of Strategy, Planning and Partnerships

Dafydd Vaughan (DV), Independent Member, requested deep dives on cross cutting themes including dependencies across all programmes especially digital foundations and sharing of information and digital infrastructure.

Action: Director of Strategy, Planning and Partnerships

The Committee expressed support for the direction of the priority programmes and welcomed the proposal to conduct more detailed deep dives in future meetings. The Committee acknowledged the challenges of managing complex, cross-cutting initiatives and emphasized the need for ongoing engagement, clear objectives, and robust risk management.

The Committee **NOTED** the 'Programme on a Page' summaries for the 2025/26 priority transformation



programmes and **NOTED** that progress updates would be provided at future meetings.

IMTP/Annual Plan Development

Hannah Evans (HE), Director of Strategy, Planning and Partnerships, introduced the report for discussion and the Committee was informed that the Health Board had begun the process of developing the Integrated Medium-Term Plan (IMTP) for the next year (2026-27).

HE highlighted that the planning cycle had started with key milestones and a detailed timeline to maintain discipline in the process. The Committee noted that some milestones were fixed, such as Board and Committee development sessions, while others would need to be more agile to accommodate the realities of the organisation, including the impact of the winter period. HE emphasised the importance of engaging with colleagues across the organisation, not just operational staff, but also those in Digital, Public health, Finance, and Workforce, to ensure collective ownership of the plan.

The Committee was informed that the planning process was taking place in the context of national uncertainty, with an upcoming Welsh Parliament elections and unclear future planning frameworks or targets. HE stressed the need to remain focused on the organisation’s own improvement and strategic priorities, regardless of external changes. The Committee noted that next year’s plan would be shaped around the organisation’s strategy, aiming to deliver better health, better care, and better lives, with priorities to be tested and refined.

The Committee discussed the importance of understanding demand and capacity across the whole system, including beds, theatres, job plans, rosters, and triangulating this with activity, workforce, and finance. HE described how the organisation’s approach to D&C was mature but still evolving with best practice spreading from areas like surgery to mental health services. HE highlighted the role of Business Partners in supporting operational teams through the planning process.

Penny Jones (PJ), Independent Member, asked about lessons learned from the previous year’s planning cycle and how these would inform the current process. HE noted that spreading best practice and improving the involvement of



Business Partners were key lessons learnt. The Committee was informed of the use of self-assessment and the planning maturity matrix to track progress and identify areas for improvement.

Ann Lloyd (AL), ABUHB Chair, raised the challenge of keeping the plan alive throughout the year, rather than allowing it to lose focus after initial approval. HE suggested that future reports to the Board and Committees could reference and locate their work within the plan to make connections clearer for colleagues.

The Committee discussed the need for flexibility in the plan and recognised that new priorities could emerge during the year, sometimes requiring the de-prioritisation of existing items. Dafydd Vaughan (DV), Independent Member, suggested that the IMTP should explicitly call out changes and their impact, using a clear narrative to explain why certain items were added or removed. HE noted that building this flexibility into the plan would be important, especially given the likelihood of disruption from a new government and changing circumstances. DV suggested a clear narrative and tracking of changes, referencing practices in UK government departments.

Akmal Hanuk (AH), Independent Member, sought assurance that the Plan would be submitted by the Welsh Government deadline. The Committee noted the plan would be submitted within time.

The Committee **NOTED** the IMTP approach for the next planning cycle.

Estates Strategy Review

Hannah Evans (HE), Director of Strategy, Planning and Partnerships, introduced the report for discussion and presented the current position of the Estates of the Health Board and its approach to developing an Estates Strategy. HE noted that the existing Estates Strategy was originally developed in 2018 and had been refreshed in 2021. The Committee noted this remained live but required further updating and a full refresh to reflect changing priorities and service needs.



HE outlined the strategic drivers that shaped the previous Estates Strategy and progress since 2018 which had included: the development of the Grange University Hospital; the emergence of Health and Well-Being hubs; rationalisation of services; partnership working, and the need to support an agile workforce. The Committee was informed of the team's capacity challenges and the need to balance new developments with maintaining existing estate. The Committee noted that whilst significant progress had been made on high-priority projects there remained areas where further work was needed.

HE described that the Health Board was exploring options to use existing buildings rather than defaulting to new builds, and working closely with divisions to align estate planning with service needs. The Committee was informed that urgent maintenance was being addressed where necessary especially in the Mental Health Division.

The Committee noted a major Welsh Government exercise in March 2025 which required the Health Board to prioritise capital investment needs which in turn helped secure funding for key projects that included: an additional MRI at the Grange, and decontamination projects. HE stressed the importance of aligning future investment priorities with risk, clinical need, and opportunity, while also engaging with Welsh Government and shared services to ensure realistic and deliverable plans.

HE outlined the proposed scope of the Estates Strategy which would cover all owned and leased estate and recognised the importance of understanding service models, population needs, and the condition and utilisation of the estate. HE explained that a detailed baseline of the estate had already been completed and would be reviewed to identify opportunities for rationalisation, asset sharing, and partnership working. The Committee noted the strategy would be anchored in the organisational and digital strategy and informed by ongoing work to finalise clinical plans, particularly in mental health and place-based care. The Committee was informed that the development of the draft strategy had begun.

HE informed the Committee that a key element of the strategy development would be the commissioning of a four-facet survey to obtain robust, needs-based intelligence on the state of the estate. HE noted that the survey, last conducted eight years ago, was essential for identifying

HE described that the Health Board was exploring options to use existing buildings rather than defaulting to new builds, and working closely with divisions to align estate planning with service needs. The Committee was informed that urgent maintenance was being addressed where necessary especially in the Mental Health Division.

The Committee noted a major Welsh Government exercise in March 2025 which required the Health Board to prioritise capital investment needs which in turn helped secure funding for key projects that included: an additional MRI at the Grange, and decontamination projects. HE stressed the importance of aligning future investment priorities with risk, clinical need, and opportunity, while also engaging with Welsh Government and shared services to ensure realistic and deliverable plans.

HE outlined the proposed scope of the Estates Strategy which would cover all owned and leased estate and recognised the importance of understanding service models, population needs, and the condition and utilisation of the estate. HE explained that a detailed baseline of the estate had already been completed and would be reviewed to identify opportunities for rationalisation, asset sharing, and partnership working. The Committee noted the strategy would be anchored in the organisational and digital strategy and informed by ongoing work to finalise clinical plans, particularly in mental health and place-based care. The Committee was informed that the development of the draft strategy had begun.

HE informed the Committee that a key element of the strategy development would be the commissioning of a four-facet survey to obtain robust, needs-based intelligence on the state of the estate. HE noted that the survey, last conducted eight years ago, was essential for identifying



risks and gaps and would require significant investment from the capital program. The Committee noted the results of the survey would inform prioritisation and engagement with stakeholders, including clinical teams and local authorities.

The Committee discussed the importance of shifting focus from new builds to maintaining and rationalising the current estate, given financial constraints to the Health Board. The Committee emphasised partnership working with Local Authorities and the third sector and the need for demographic analysis to prioritise investments. The Committee agreed the need to involve clinical experts early in the process to ensure the strategy supported and enabled service delivery. HE agreed that clinical model clarity was essential, especially for mental health, and that new leadership would bring fresh challenge and ownership.

The Committee discussed the need for different levels of detail in the strategy, from high-level principles to more granular plans, to support board decision-making and cross-check investments. The Committee discussed the importance of partnership working, demographic analysis, and breaking the strategy into manageable components. The Committee was informed that the capital team was working closely with divisions and partners to ensure the strategy responded to service needs and opportunities for targeted investment.

The Committee supported the proposed approach to developing the Estates Strategy, with further updates and opportunities for committee involvement to be scheduled as the strategy progresses.

The Committee **NOTED** the presentation.

Update on St Woolos Hospital

Jamie Marchant (JM), Divisional Director of Estates and Facilities, introduced the presentation for discussion and outlined the status of the work to rationalise the older estate at St Woolos Hospital. JM explained that large areas of the old estate were unoccupied but it was emphasised that approximately 5,000 square meters remained in use.

JM outlined the strategic importance of the site and the challenges associated with relocating services and teams



from the older parts of the estate. JM provided an update on recent efforts that had focused on vacating the doctor's residences and kitchen, moving staff into temporary locations within the newer Casnewydd building. The Committee was informed the kitchen relocation was already underway with a new model being commissioned and expected to be operational in November 2025. The Committee was informed that a staff welfare point was also being established to provide basic amenities in the absence of a canteen.

JM gave a financial update of running costs and the Committee was informed of a backlog of maintenance estimated at £15 million, but acknowledged that these figures were seven years old and that more accurate assessments were being developed. JM highlighted to the Committee the deteriorating condition of the estate and the Committee noted water leaks, heating failures and pest infestations. JM noted the strategic aim was to consolidate services into Casnewydd and decommission the older estate which faced major backlog maintenance issues.

The Committee was informed that the immediate priority and strategic aim was to close the doctor's residences and relocate affected teams, with signage being updated to direct people to the Casnewydd entrance. JM informed on the use of Matterport technology to map the site and assess space utilisation, and noted that IT was a key enabler for the temporary moves. The Committee noted funding for these changes was being provided through the Targeted Estates Fund.

JM outlined plans for a wider rationalisation of the site, including the commissioning of a Strategic Outline Case with external partners. The Committee acknowledged the complexity of the project, particularly the need to address the boiler house, which feeds the Royal Gwent Hospital, and the challenges of declaring surplus estate for disposal. JM emphasised that the project would require significant capital investment and would be delivered over an extended period.

The Committee discussed the urgency of the immediate changes and the importance of keeping staff informed and involved in the process. Phil Robson (PR), Chair, stressed the need for early communication with staff and any concerns to be managed, particularly regarding the loss of amenities such as the canteen. JM advised that affected



catering staff had been consulted and that most staff were supportive of the moves and recognised the poor condition of the old estate.

The Committee agreed that the changes represented a positive development as part of moving staff out of unfit accommodation and into better facilities. Hannah Evans (HE), Director of Strategy, Planning and Performance, reinforced the importance of linking the rationalisation of St Wools Hospital with investment in the Royal Gwent estate to support the redirection of services. The Committee expressed general support for the direction of travel and encouraged the Estates Team to continue progressing the urgent changes while developing the longer-term plan.

The Committee **NOTED** the presentation.

Development of Nevill Hall Hospital

Hannah Evans (HE), Director of Strategy, Planning & Partnerships, introduced the item for discussion and summarised the outcome of the recent public engagement on the future of Nevill Hall Hospital. The Committee was informed engagement had reached more people than comparable exercises and feedback had focused on retaining services, transport concerns, and the need for clear information.

Hannah Capel (HC), Assistant Director of Strategic Capital Planning, noted the Strategic Outline Case was for significant investment in Nevill Hall Hospital which aimed to transform the site into a modern, sustainable, and fit-for-purpose local general hospital.

Hannah Evans (HE), Director of Strategy, Planning and Performance, clarified the Strategic Outline Case aligned with the Health Board's Clinical Futures Strategy; the Estates Strategy, Digital and Workforce Strategies, and Welsh Government policy. The Committee was informed the preferred way forward involved comprehensive reconfiguration of the site that included new build elements, retention and refurbishment of existing ward areas and consideration of services currently based at Maindiff Court. The Committee noted the investment would address structural risks, replace outdated infrastructure, rationalise estate use, and enable refreshed clinical models to meet population needs and future service demands.



	HC provided an overview of the Strategic Outline Case's design principles and the Committee was informed these emphasised sustainability, community-first planning, asset-based rather than site-based thinking, minimum necessary specifications, data-driven decisions, and innovative service models. The Committee members raised questions about the clinical model and the rationale for retaining or rebuilding specific areas, and the importance of clear communication with stakeholders. Ann Lloyd (AL), ABUHB Chair, stressed caution and noted that the clinical model had not yet been fully consulted or agreed and that public messaging must clarify that no final decisions had been made. The Committee noted that the clinical model for Nevill Hall had not yet been fully consulted on, and that further engagement would be required at the Outline Business Case stage. The Committee discussed the need for flexibility in planning, benchmarking costs against other major projects in Wales, and ensuring that the SOC remained a living document that could adapt to changing priorities and funding realities. The Committee noted that the strategic outline case was based on feasibility studies, demand and capacity modelling, and independent cost advice and was informed the cost estimates included equipment and furnishings, not just the building shell. HC outlined the strategic outline case would be submitted to Welsh Government for endorsement which would enable the Health Board to proceed to the next stage of planning and appoint supply chain partners. The Committee acknowledged the scale and complexity of the project, the importance of ongoing engagement with clinical teams and the public, and the need for robust management and governance structures as the project progresses. The Committee expressed support for the direction of travel and agreed that further updates and more granular engagement would be required as the strategic outline case moved towards Board approval and subsequent stages. The Committee NOTED the presentation.
PPHPC0710/02	Regional Partnership Board Update Hannah Evans (HE), Director of Strategy, Planning and Partnerships, introduced the report for discussion and noted the report included the Board's most recent activities. The



	Committee was informed the Regional Partnership Board was conducting workshops to review work and set priorities. HE outlined ongoing revenue challenges and the Committee noted the use of slippage money from the Regional Partnership Board to support winter pressures., The Committee expressed concern regarding winter preparedness with the absence of dedicated winter funding this year and concerns were expressed concerns on reduced funding for neurodevelopmental services The Committee NOTED the report.
	Public Services Board Update The Committee noted there had been a recent meeting and requested a note from the Director of Public Health if any decisions had been made. Action: Director of Public Health
	Regional Planning Update Hannah Evans (HE), Director of Strategy, Planning and Partnerships, introduced the report for discussion and the Committee received a summary of recent developments and ongoing workstreams. The Committee noted the terms of reference for the Regional Joint Committee (RJC) had been agreed. It was also noted that the date for the first RJC meeting had not yet been set as a recent meeting was cancelled. The Committee was informed that there was a new Chair in Cardiff and scheduling was being finalised. HE updated the Committee on the Outline Business Case for the Llantrisant Health Park, noting it had been received by the Board. The Committee received and agreed on an assessment of need regarding regional orthopaedics which would inform a future the Official Business Case. The Committee noted Ophthalmology remained a pressure point within the Health Board and there was close collaboration with the appointed provider. It was noted that there had been significant scrutiny and weekly oversight from NHS Wales and the National Programme for Eye Care.



	HE outlined a range of regional planning activities and the Committee noted that the new Regional Joint Committee arrangements would prompt a review of the programme of work, scope, and delegation and the Committee noted leadership changes at a regional level. The Committee NOTED the report.
PPHPC0710/5.1	Items to be Brought to the Attention of the Board and Other Committees The Committee agreed the Update on St Woolos Report and agreed for a short report on next steps for Developments on Nevill Hall Hospital would go to Board. Action: Director of Strategy, Planning and Partnerships
PPHPC0110/5.2	Any Other Urgent Business There was no other Urgent Business to note.
PPHPC0710/5.3	Date of the Next Meeting The next meeting is scheduled for 27 January 2026.

Partnerships, Population Health and Planning Committee ACTION LOG

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
October 2025	PPHPC0710/03/03.1	Committee Secretariat to schedule deep dives on priority programmes including key change issues to be included on the Committee's Forward Work Plan to align with updates provided to the Executive Committee.	Committee Secretariat	January 2026	Completed <u>November Update</u> Action has been included in the Committee forward work plan.
October 2025	PPHPC0710/03/03.3	Director of Strategy, Planning and Partnerships to share July 2025 deep dive on Theatre Utilisation with Committee members	Director of Strategy, Planning and Partnerships	January 2026	Completed <u>December Update</u> Circulated to Committee members on 15 th December 2025

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
October 2025	PPHPC0710/03/03.3	Director of Strategy, Planning and Partnerships to ensure deep dive include cross cutting themes including dependencies across all programmes especially digital foundations and sharing of information and digital infrastructure.	Director of Strategy, Planning and Partnerships	January 2026	Completed <u>January update</u> Director of Strategy, Planning and Partnerships has noted the action for future deep dives.
October 2025	PPHPC0710/03/03.9	Director of Public Health to include any key decisions made by the Public Services Board in most recent meeting with Committee members.	Director of Public Health	January 2026	Completed <u>January Update</u> Public Services Board action log was shared with Committee members on 15 th January 2026.
October 2025	PPHPC0710/03/05.1 Transferred to Board	Director of Strategy, Planning and Partnerships to schedule an update on St Woolos Hospital and Nevill Hall Hospital for Board	Director of Strategy, Planning and Partnerships	January 2026	Completed <u>November Update</u> Action has been transferred to the Board action log.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					Both reports scheduled to come to Novembers Board meeting.

All actions in this log are currently active and are either part of the Board's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Board meeting will be ready.

Once the Board is assured that an action is complete, it will be removed. This will be agreed at each Board meeting.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 January 2026
CYFARFOD O: MEETING OF:	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

Er Sicrwydd/For Assurance

The purpose of this report is to provide an overview of the current strategic risks assigned to the Partnerships, Population Health, and Planning Committee (the Committee) for monitoring on behalf of the Board.

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation & Cefndir / Background

Since the last report to the Committee, in October 2025, there have been no changes to the risk profiles assigned to this Committee for oversight.

Asesiad / Assessment

The Committee risk portfolio, outlined in Table 1, contains **four** principal risks with **eight** sub-risks. In accordance with best practice, all risks are reviewed within the appropriate timeframe for their respective levels of risk.

The review focuses on the control environment, ensuring that the controls remain robust and adequate for managing the identified risks. Additionally, the assurances are tested to verify the robustness of the controls. Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 001 Theme Service Delivery Appetite Open Score 17 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality quality safe and sustainable services which meet the changing needs of the population.	e) Due to inadequate strategic plans which respond to population health and socio-economic needs.	Moderate 2 x 4 (8)	Y
		f) Due to unsustainable service models.	Moderate 2 x 4 (8)	y
SRR 002 Theme Compliance & Safety Appetite Minimal Score 8 and below	There is a risk that there will be a significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aerated Concrete (RAAC) within structures.	Extreme 3 x 5 (15)	N
		b) Due to significant levels of backlog maintenance and structural impairment.	High 3 x 4 (12)	N
SRR 004 Theme Compliance & Safety Appetite Minimal Score 8 and below	There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident, or critical incident.	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident	Moderate 2 x 4 (8)	Y
		b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.	High 3 x 4 (12)	N
SRR 007 Theme Transformation & Partnership Working Appetite Open Score 17 and below	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	Moderate 2 x 4 (8)	Y
		b) Due to the impact of fragile services across the regional and supra regional geography.	High 3 x 3 (9)	Y



Risk Exposure

The risk exposure of the eight sub-risks is illustrated in the infographic below. Most of the risks sit within bottom left quarter of the risk matrix, representing a balance between the probability of occurrence and the severity of the consequences. These risks require a proportional management approach necessitating increasingly robust responses to avoid moving toward the higher-risk categories.

Risk Scoring Matrix					
Likelihood/ Frequency	Consequence/Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain (91%)					
4. Likely (61-90%)					
3. Possible (41-60%)			SRR 007B	SRR 001F *SRR 002B *SRR 004B	*SRR 002A
2. Unlikely (11-40%)				SRR 001E SRR 004A SRR 007A	
1. Rare (1-10%)					

*Outside of appetite

Risks Outside of Appetite

The table below highlights **three** key strategic risks within the compliance and safety theme, all of which currently exceed the Board's stated appetite.

The Board has articulated a minimal risk appetite in relation to compliance and safety, reflecting its commitment to meeting statutory obligations and ensuring the safety of patients, staff, and visitors. Under this appetite, risks with a residual score above the defined threshold of 8 are expected to be actively managed, reduced, or eliminated where feasible. As such, they require targeted action and close oversight.

Risk ID	Sub Risk Description	Current Score	The Board should:
SRR 002A	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	15	Tolerate the risk until it can be Terminated .
SRR 002B	Due to significant levels of backlog maintenance and structural impairment.	12	TREAT the risk through proactive estate investment and maintenance planning.
SRR 004B	Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident	12	TREAT the risk by developing, standardising, and testing effective Business Continuity and Critical Incident Response Plans.



Strategic and Corporate Risk Registers

The Health Board maintains both a Strategic Risk Register (SRR) and a developing Corporate Risk Register (CRR) as core components of its Risk Management Framework. While aligned, each operates at a different level of oversight.

Strategic Risk Register

The SRR sets out a small number of high level, long- term risks that could materially affect delivery of the Health Board's organisational objectives. These risks typically span multiple years, cut across functions, and require Board- l-level visibility and assurance.

Corporate Risk Register

The CRR captures significant operational and thematic risks that fall below the strategic level but still require Executive oversight. These risks may arise within specific services, be cross-cutting in nature, or require coordinated management across the organisation.

How the Registers Interface

The SRR and CRR operate as a connected system:

- Risks may escalate from the CRR to the SRR if their impact or trend demonstrates broader strategic significance.
- Risks may de-escalate from the SRR to the CRR as mitigation reduces exposure.
- Both registers draw on intelligence from divisional risk registers, ensuring a clear line of sight from operational to strategic risk.
- Insights from the CRR help shape and refine the SRR, ensuring strategic risks remain informed from the operating environment.

Together, the SRR and CRR provide a layered and coherent approach to organisational assurance.

The continued development of the CRR during 2025/26 will directly support the review and refinement of the SRR. The CRR will provide a stronger evidence base to identify emerging themes, assess shifts in risk exposure, and inform decisions and will therefore act as a key input into the routine Boardl level- review of strategic risks.

Priorities for 2025/26

The focus for 2025/26 will be on strengthening overall risk maturity across the Health Board through:

1. Refinement of Strategic Risks

Ensuring the SRR reflects current and emerging strategic challenges through horizon scanning, alignment with national priorities, and review of organisational objectives.

2. Strengthening Risk Management Across the Health Board

Embedding consistent, high quality- risk practice across the Health Board,



supported by targeted training, improved risk information, and clearer linkage between local, corporate, and strategic risks.

3. Increasing Visibility and Assurance

Enhancing escalation routes, review cycles, and assurance mapping to provide the Board and its Committees with improved visibility of key risks and progress against mitigation.

Argymhelliad / Recommendation

The Committee is requested to:

- **DISCUSS** and **NOTE** the delegated strategic risks;
- **NOTE** the ongoing efforts to reduce the three sub-risks to within the Board's risk appetite;
- **NOTE** the ongoing efforts to ensure the Committee remains informed of risks that could impact the delivery of a collaborative and sustainable health service for the population of Gwent.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. N/A Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:



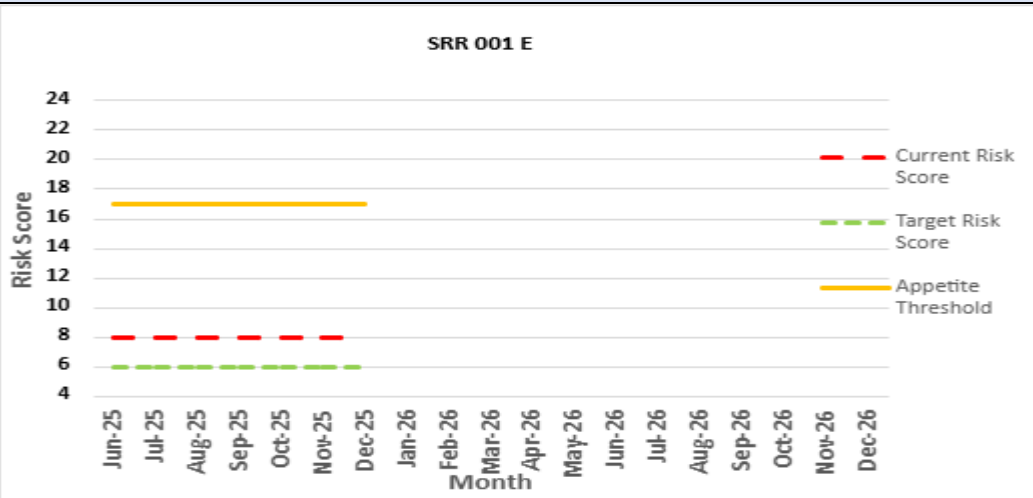
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

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



				Risk Score													
Risk ID and Description				IMTP Link	2	3	4	5	6	8	9	10	12	15	16	20	25
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a) Due to an inability to recruit and retain staff across all disciplines and specialities.	Workforce & Culture					X				●		◇		
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff							×		●		◇			
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board’s estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	Estates	X					◇				●			
			b) Due to significant levels of backlog maintenance						X	◇			●				
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident	System Change					X	● ◇							
			b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.					X	◇			●					
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	System Change & Regional Plans			X			●					◇		
			b) Due to the impact of fragile services across the regional and supra regional geography				X				●		◇				

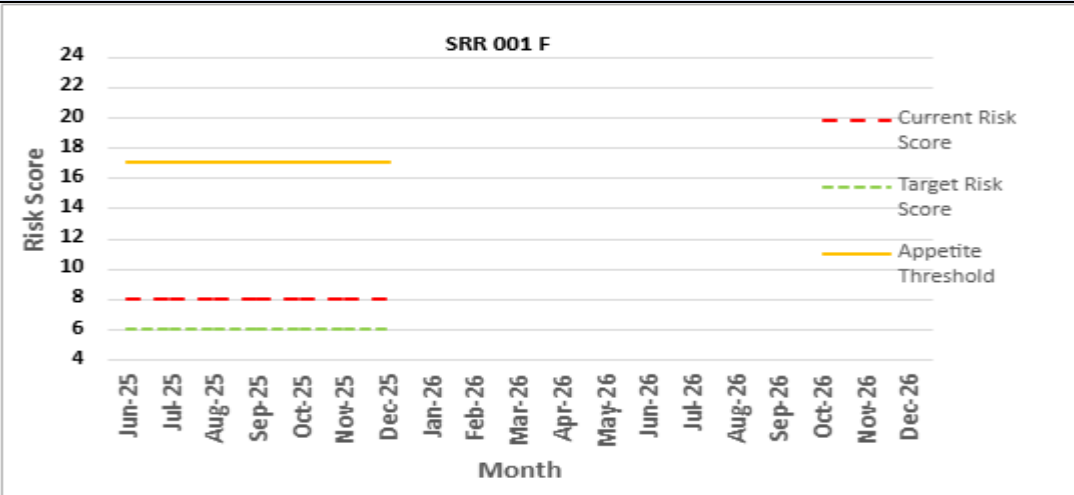
Key	Current Score	●
	Target Score	×
	Appetite Threshold	◇

RISK THEME	SERVICE DELIVERY						
LINK TO IMTP	SECTION 3: SYSTEM CHANGE						
Strategic/ Corporate Risk SRR 001 E	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to inadequate strategic plans which respond to population health and socio-economic needs.				Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Increased patient acuity levels - Worsening of health inequalities - Worsening of health outcomes	<u>Staff</u>	<u>Organisation</u> - Failure to train teams in multi-morbidity management - Failure to comply with the Wellbeing of Future Generations Act (Wales) - Reputational damage and loss of public confidence - Increased demand		Risk Appetite Threshold – SCORE 17 AND BELOW Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.		
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
Lead Director	Director of Strategy, Planning and Partnerships		Risk Exposure	Current Level	Target Level		
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee		Likelihood	2 <i>(Unlikely)</i> x	2 <i>(Unlikely)</i> x		
Initial Date of Assessment	01 June 2023		Impact	4 <i>(Major)</i>	3 <i>(Moderate)</i>		
Last Reviewed	01 November 2025		Risk rating	= 8 <i>(Moderate)</i>	= 6 <i>(Moderate)</i>		
Next Review (Six monthly based on risk score)	01 May 2025						

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Health Board IMTP and associated KPIs - Public Health Wales surveillance data - Qliksense – performance dashboard - Population Needs Assessment and Area Plan - Marmot Region Programme	- Area plan is being refreshed through the RPB - Marmot Region Implementation Plan - Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. - Refresh organisational strategy with a central focus on population health and wellbeing. - Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.

Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Actions to Address Gaps (What further evidence is required to provide the effectiveness of controls)
Level 1 Operational (Implemented by the department that performs daily operation activities)		
- Qliksense – performance information - SFN – performance information		Effectiveness of the plans in delivering improvements
Level 2 Organisational (Executed by risk management and compliance functions)		

• IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee	• Regional Planning reporting to Population Health, Planning and Partnerships Committee		
Level 3 Independent (Implemented by both auditors internal and external independent bodies)			
Internal Audit Reviews 2023-24 • IMTP Planning (Q1) Outcome – Reasonable Assurance Internal Audit Reviews 2024-25 • Internal Audit Partnership Arrangements – Limited Assurance		• Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan	
Assurance Rating (Overall Assessment of controls and assurances) Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	SERVICE DELIVERY						
LINK TO IMTP	SECTION 3: SYSTEM CHANGE						
Strategic Risk SRR 001 F	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to unsustainable Service Models				Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Increased demand - Increased patient acuity levels - Worsening of health inequalities - Worsening of health outcomes	<u>Staff</u> N/A	<u>Organisation</u> - Failure to train teams in multi-morbidity management - Failure to comply with the Wellbeing of Future Generations Act (Wales) - Reputational damage and loss of public confidence		Risk Appetite Threshold – SCORE 17 AND BELOW Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.		
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
							
Lead Director	Director of Strategy, Planning and Partnerships.		<u>Risk Exposure</u>	Current Level	Target Level		
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee		Likelihood	2 (Unlikely) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023		Impact	4 <i>(Major)</i>	3 (Moderate)		
Last Reviewed	01 November 2025		Risk rating	= 8 (Moderate)	= 6 (Moderate)		
Next Review (Six monthly based on risk score)	01 May 2026						

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- The Health Board’s Integrated Medium-Term Plan (IMPT) and associated KPIs - Strategic Programmes in place - Public Health Wales surveillance data – Covid, flu and other communicable diseases. - QlikSense – performance information. - Population needs assessment and area plan development by the RPB. - Southeast Wales Plan for fragile services.	- Area plan is being refreshed through the RPB. - Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. - Review of enhanced local general hospital service models to ensure sustainable quality services. - Development of SEW plan for fragile. - Review of organisational strategy

Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Actions to Address Gaps (What further evidence is required to provide the effectiveness of controls)
Level 1 Operational (Implemented by the department that performs daily operation activities)		
- Public Health Wales surveillance data – COVID, flu and other communicable diseases. - QlikSense – performance information		Evidence of individual arrangements in place to deliver service plans.

Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- IMTP delivery and outcomes reporting to Board. - RPB reporting to Board and Population Health, Planning and Partnerships Committee. - Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.	- Regional Planning reporting to Population Health, Planning and Partnerships Committee. - Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Reviews 2023-24 - IMTP planning Q1. Outcome – Reasonable Assurance. Internal Audit Reviews 2024-25 - IMTP – Service Plans (Q2) – Outcome - Reasonable Assurance - Partnership Arrangements. Outcome – Limited Assurance	Recommendations identified in the Limited and Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	Implementation of the management responses to close off recommendations	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	COMPLIANCE AND SAFETY																																																																																									
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES																																																																																									
Strategic Risk SRR 002 A	There is a risk that there will be significant failure of the Health Boards Estates.								Publication Status	Public																																																																																
Threat <i>(As a result of)</i>	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.					Risk Appetite Level – MINIMUM Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.																																																																																				
Impact <i>(Consequences of the threat)</i>	Patient - Harm or injury to patients - Adverse impacts on delivery of care to patients across acute and non-acute settings		Staff Harm or injury to staff		Organisation - Litigation & Financial Penalties - Loss of estate		Risk Appetite Threshold – Score 8 and below Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.																																																																																			
							SUMMARY The current risk level is OUTSIDE of the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold																																																																																			
Lead Director	Chief Operating Officer		Risk Exposure	Current Level	Target Level	SRR 002A <table border="1"><caption>Risk Score Data</caption><thead><tr><th>Month</th><th>Current Risk Score</th><th>Target Risk Score</th><th>Appetite Threshold</th></tr></thead><tbody><tr><td>Jun-25</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Jul-25</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Aug-25</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Sep-25</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Oct-25</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Nov-25</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Dec-25</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Jan-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Feb-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Mar-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Apr-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>May-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Jun-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Jul-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Aug-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Sep-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Oct-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Nov-26</td><td>15</td><td>2</td><td>8</td></tr><tr><td>Dec-26</td><td>15</td><td>2</td><td>8</td></tr></tbody></table>					Month	Current Risk Score	Target Risk Score	Appetite Threshold	Jun-25	15	2	8	Jul-25	15	2	8	Aug-25	15	2	8	Sep-25	15	2	8	Oct-25	15	2	8	Nov-25	15	2	8	Dec-25	15	2	8	Jan-26	15	2	8	Feb-26	15	2	8	Mar-26	15	2	8	Apr-26	15	2	8	May-26	15	2	8	Jun-26	15	2	8	Jul-26	15	2	8	Aug-26	15	2	8	Sep-26	15	2	8	Oct-26	15	2	8	Nov-26	15	2	8	Dec-26	15	2	8
Month	Current Risk Score	Target Risk Score	Appetite Threshold																																																																																							
Jun-25	15	2	8																																																																																							
Jul-25	15	2	8																																																																																							
Aug-25	15	2	8																																																																																							
Sep-25	15	2	8																																																																																							
Oct-25	15	2	8																																																																																							
Nov-25	15	2	8																																																																																							
Dec-25	15	2	8																																																																																							
Jan-26	15	2	8																																																																																							
Feb-26	15	2	8																																																																																							
Mar-26	15	2	8																																																																																							
Apr-26	15	2	8																																																																																							
May-26	15	2	8																																																																																							
Jun-26	15	2	8																																																																																							
Jul-26	15	2	8																																																																																							
Aug-26	15	2	8																																																																																							
Sep-26	15	2	8																																																																																							
Oct-26	15	2	8																																																																																							
Nov-26	15	2	8																																																																																							
Dec-26	15	2	8																																																																																							
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee		Likelihood	3 (Possible) x	1 (Rare) x																																																																																					
Initial Date of Assessment	01 June 2023		Impact	5 (Catastrophic)	2 (Minor)																																																																																					
Last Reviewed	01 January 2026		Risk rating	= 15 (Extreme)	= 2 (Low)																																																																																					
Next Review (Monthly based on risk score)	01 February 2026																																																																																									

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (surveys ongoing in December 25 and January 26) - Funding agreed from Welsh Government to implement actions related to surveys and specific actions relating to ‘skylights’. Some will require more substantial work -which are being scoped. - Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance - Remediation work to areas of high-risk areas undertaken - Controlled access to roof areas which is being enhanced with proposals around cameras and designated walkways - Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. - Ongoing engagement with expert surveyor - Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management - Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. Note: H&S assessments are around the location of props have been reviewed by H&S team and feedback provided to departments - Links with NHS England and other Health Boards in Wales for shared learning. - Regular dialogue with Welsh Government and Shared Services Estates. - Management Action Plan agreed following Internal Audit including the development of a Management Strategy and submitted to the ABUHB Health and Safety ‘Committee’ in March 2025	- Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues - Management Strategy and the Management Plan are completed and was approved at the Health & Safety Committee in April

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Monthly checks in place for the props albeit fortnightly checks in new prop locations in OPD 2 department - Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) - Review of existing arrangements in place supported by external body		Ongoing management of the issues.	N/A
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor - risks and issues associated with any remedial measures implemented. - Outcome of H&S risk assessment in place and reviewed May 2025. H&S team reissuing the assessments to Department Leads in January 26 to review locally - Formal reporting to the Board/Committees in place - SOC approved by Health Board and submitted to Welsh Government		None	N/A
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit 2024/25 Plan – report received as Reasonable Assurance (albeit Substantial Assurance on the process relating to surveys. Report submitted to Audit Committee November 2024. - Internal Audit also commented that the risk appetite needs to reflect the current position of monitoring and managing the RAAC pending SOC and FBC hence appetite of 15 should be considered by Board.		Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	- Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implements Internal Audit 2024/25 Plan - Implementation of the management responses to close off recommendations been concluded.
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
REASONABLE			

RISK THEME	COMPLIANCE AND SAFETY						
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES						
Strategic Risk SRR 002 B	There is a risk that there will be significant failure of the Health Boards Estates.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to significant levels of backlog maintenance and structural impairment.				Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.		
Impact <i>(Consequences of the threat)</i>	Patient - Harm or injury to patients. - Adverse impacts on the delivery of care to patients across acute and non-acute settings.		Staff Harm or injury to staff.		Organisation - Non-compliance with health and safety legislation. - Litigation and financial penalties. - Loss of estate		Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.
							SUMMARY The current risk level is OUTSIDE of the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Chief Operating Officer		Risk Exposure	Current Level	Target Level	SRR 002B Risk Score Month Jan-25 Mar-25 May-25 Jul-25 Sep-25 Nov-25 Jan-26 Mar-26 May-26 Jul-26 Sep-26 Nov-26 — Current Risk Score — Target Risk Score — Appetite Threshold	
Monitoring Committee / Group	Partnerships, Health Protection & Planning Committee		Likelihood	3 (Possible) x	3 (Possible) x		
Initial Date of Assessment	01 June 2023		Impact	4 (Major)	2 (Minor)		
Last Reviewed	01 January 2026		Risk rating	= 12 (High)	= 6 (Moderate)		
Next Review (Quarterly based on risk score)	01 April 2026						

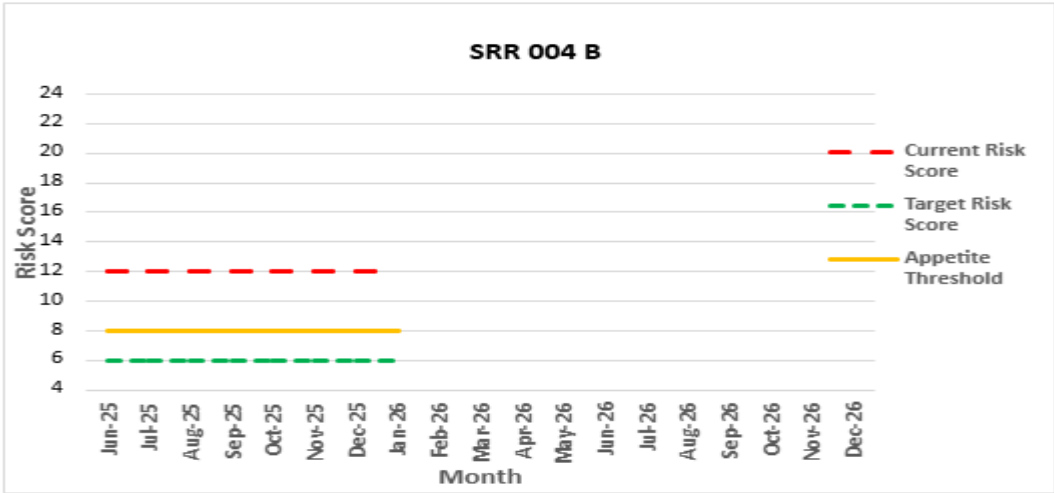
Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i> (Short, Medium, and Long-Term Plans need to be included)
- Health Board Estates Rationalisation Strategy - Health Board Estates Strategy - Health Board policies and procedures related to the maintenance of Health Board estate. 6 Facet survey completed in 2019. - Divisional Risk Register - Multiple policies and SOPs published and communicated to staff. - A robust internal training programme in place covering all aspects of estate management including food hygiene. - Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) - Asbestos reinspection programme (over the next 3 years) - Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation - HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants - A clear approach to compliance monitoring and escalation of AE reports has been implemented	- Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. - Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. - Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. - Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. - Drive clinical service engagement in compliance meetings where engagement is low. - Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible. - Continuation of the additional £500k backlog maintenance allocation by the Board to the Estates and Facilities Division in 2025/26 and in 2026/27 (subject to formal board approval of capital plan) - Informed by the risk assessment processes of the Estates and Facilities Division, the Health Board has secured significant investment in estate during 2025/26 and 2026/27 from the All-Wales Targeted Estates Fund (TEF) - Elements of St Woolos Hospital estate being closed as part of the Board agreement to rationalise the site and remove use of old and poor estate. - Condition survey (commonly referred to as 6 facet) being scoped for completion in early 2026/27 to inform the estates strategy

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Divisional reporting of Statutory and Mandatory training of staff - Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance.		If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration.	Performance reporting
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group. - Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee. - Divisional Director Estates and Facilities presented to Committee in December 2024 and scheduled to present in February 2025. - Divisional Director Estates and Facilities presented to Committee on St Woolos Hospital project in October 2025.		None	N/A
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Reviews 2023- 24 - Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and - Finance and Performance Committee Internal Audit Plan 2024-25 - Estates Assurance – Energy Management (Q2) Outcome = Reasonable Assurance. Reported to the November ARA		Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	Internal Audit 2024/25 Plan - Implementation of the management responses to close off recommendations - Audit Wales completing an all-Wales audit on estate condition in Q4 2025/26
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
REASONABLE			

RISK THEME	COMPLIANCE AND SAFETY					
LINK TO IMTP	SECTION 3: SYSTEM CHANGE					
Strategic Risk SRR 004 A	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a business continuity incident or critical incident				Publication Status	Public
Threat <i>(As a result of)</i>	Due to emergency planning arrangements at both the corporate and operational levels lacking the necessary robustness to ensure an effective response.				Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.	
Impact <i>(Consequences of the threat)</i>	<u>Patient</u>	<u>Staff</u>	<u>Organisation</u>		Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.	
	- Adverse impacts on delivery of care to patients across acute and non-acute settings - Harm or injury to patients	- Inability to respond to a major incident to meet needs of those affected - Harm or injury to staff	- Health Board breaches statutory duties under the Civil Contingencies Act 2004 - Litigation & Financial Penalties - Reputational damage and loss of public confidence		SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships		Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee		Likelihood	2 (Unlikely) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023		Impact	4 (Major)	3 (Moderate)	
Last Reviewed	01 October 2025		Risk rating	= 8 (Moderate)	= 6 (Moderate)	
Next Review (Six-monthly based on risk score)	01 May 2026					

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Local/Divisional action cards are in place in key areas - Training undertaken service-specific relating to local response. - Major incident exercise ‘Euclid’ undertaken 20 June 24. Approx. 100 participants and external observers, demonstrated that the Health Board was able to successfully respond to an incident. As a result of the exercise action cards refreshed and renewed with teams to incorporate learning - Internal strategic on call training - Executive Team attending 2-day strategic training. - Loggist training is provided and accessed regularly - New all Wales logbooks are in place for use - Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) - Joint Planning and Training with LRF and across Wales. - Ongoing Participation in exercises UK, Wales, LRF and HB. - Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP) - Continuing to work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner	- Continue to deliver training programmes to support staff preparedness to response to an incident. - Additional ‘local’ team and intra team exercises to take place for areas to practice and embed their response to a major incident together - Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. - BCPs in place across all services. Work with the Corporate Governance Directorate (Head of Corporate Risk and Assurance) to support improvements in the development of BCP’s across key operational areas. - National pandemic exercise Pegasus Autumn 2025 - Development of a pan plan to support pandemic pathways (HCIDs e.g., MPOX)

LRF Pandemic Solaris undertaken			
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Departmental debrief following an incident to inform learning and enhance controls. - Training records - Plans and action cards in place and up to date - Debrief with key stakeholders following an incident to inform learning and enhance controls.	All key operational departments could actively respond to a BC incident without EP intervention due to the absence of BSPs.	Work with key areas to support development of BCP's and action cards with the support of Corporate Governance Directorate.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Report to the EPRR Group from debrief of incidents - Reports to the PPHP Committee on Emergency Planning Preparedness	EPRR Thematic Risk Register	Develop an EPRR	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Review(s) - Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response - Reasonable Assurance - Outcome and feedback from national exercises	Identification of recommendations to ensure the Health Board is prepared and has the capabilities ato respond effectively.	Implementation of the recommendations and subsequent management responses.	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				
Strategic Risk SRR 004 B	There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to Business Continuity incidents.			Publication Status	Public
Threat <i>(As a result of)</i>	Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident			Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.	
Impact <i>(Consequences of the threat)</i>	Patient - Harm or injury to patients - Adverse impacts on delivery of care to patients across acute and non-acute settings	Staff - Staff absence (injury, wellbeing) - Harm or injury to staff	Organisation - Operational flow if services fail to prepare BCPs against the 5 key themes - Loss of infrastructure; - Financial implications due to staff absence - Health Board breaches statutory duties under the Civil Contingencies Act 2004; - Litigation & Financial Penalties; - Reputational damage and loss of public confidence	Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
					
Lead Director	Director of Strategy, Planning and Partnerships		Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee		Likelihood	3 (Likely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023		Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 October 2025		Risk rating	= 12 (High)	= 6 (Moderate)
Next Review (Quarterly based on risk score)	01 January 2026				

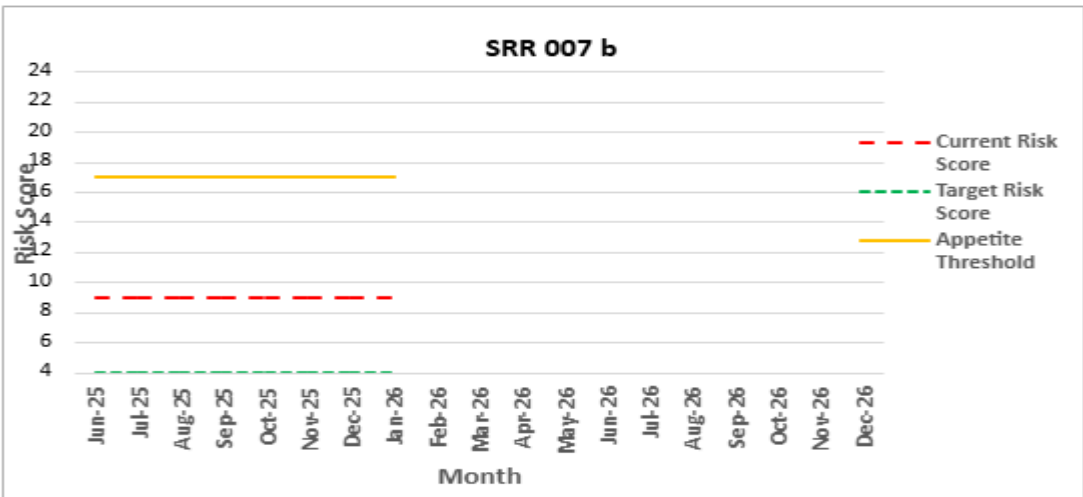
Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- BC Policy - BC Response Guidance - BC Template & guidance (reviewed and updated April 2025) - Divisional, Directorate & Service BC Plans across a number of key operational areas - BC Exercise - BC debrief learning. - HB and LRF Plans. 3C (Command/Control, Communication) structure in place to respond to incidents. 1-2-1 training with Divisional BC leads and delivering BC workshops for services. - EPRR Group Established. - Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. - Awareness raising of the requirement for BC across the Health Board through various training programmes - Infectious Diseases plan - Joint plan with PH in response to infectious diseases and public health incidence response overall - Internal strategic on call training - Executive Team attending 2-day strategic training. - Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) - Joint Planning and Training with LRF and across Wales. - Ongoing Participation in exercises UK, Wales, LRF and HB. - Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).	- Ongoing support to develop business continuity plans. - Continued engagement with Divisions, Directorates, and service areas to embed contingency planning into the culture of the organisation, Conduct BIAs, develop plans, train staff, test & exercise, and review plans to mitigate the risks and threats to service delivery. - Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. - Continue to engage with the communication team to improve incident cascade during an event to ensure a Health Board wide awareness in a timely manner. - Each Division to identify on their risk register any outstanding business continuity plans against the 5 key themes for their areas and escalate any identified risks to the HB risk group for review. - Development of a business continuity dashboard that enables divisions & directorates to manage, RAG rate and provide assurance of their BC planning arrangements. - Joint working with partners – Exercise Pegasus - Pull together a task and finish group to review and plan for the BC recommendations from the Ex Mighty Oak exercise debrief. - Develop an off the shelf BC exercise for divisions, directorates & services. - Work with the Corporate Governance Directorate (Head of Corporate Risk and Assurance) to support improvements in the development of BCP’s across key operational areas.

• Ability to warn & inform the organisation of critical BC incidents via the Health Board communications team. • Health Board service BC supporting plan – to provide a generic response framework if they have no specific plans are in place. • A dedicated business continuity lead for IT applications and networks to reduce the highest key theme risk. • The introduction of a business continuity Incident Response Group in the event that a BC incident that escalates to critical. • Joint working with LRF partners – Exercise Solaris			
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
• Plans and action cards in place and up to date. • Div/Service BC risk registers • Service BC training records • Departmental debrief following an incident to inform learning and enhance controls. • Debrief with key stakeholders following an incident to inform learning and enhance controls.	• All key operational departments could actively respond to a BC incident without EP intervention due to the absence of BSPs.	• Work with key areas to support development of BCP's and action cards with the support of Corporate Governance Directorate.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
• Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness •	• EPRR Thematic Risk Register	• Develop an EPRR	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Review(s) Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – Reasonable Assurance • Outcome and feedback from national exercise	• Identification of recommendations to ensure the Health Board is prepared and has the capabilities ato respond effectively.	• Implementation of the recommendations and subsequent management responses.	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING						
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				SECTION 4: ENABLERS - REGIONAL PLANS		
Strategic Risk: SRR 007A	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.				Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> Unmet patient need resulting in harm	<u>Staff</u> N/A	<u>Organisation</u> - Ineffective use of combined resource Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence		Risk Appetite Threshold – SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.		
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
	</						

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: - The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. - The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. - In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. - Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	- Governance review of Regional Partnership Board undertaken in August 2023. - Renewed Strategy for strategic partnership Capital in place and revised governance processes. - New Long-Term Strategy for Health Board to focus on Partnership approach.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- PMO reporting to the Director of Strategy, Planning and Partnerships. - Regional Leadership Group Reporting		- Systematic reporting of outcomes - Systematic evaluation of schemes - Governance of financial control arrangements	- Implementation plan to be developed following RPB governance review. - Health Board strategy development approach to focus on partnership approach
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Assurance reporting to the Population Health, Partnerships, and Planning Committee. - Assurance reporting to the Board.		None	N/A
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Plan 2024/25 - RPB Governance Review (Q4) – Outcome = Limited Assurance. Reported to ARAC September 2024 - Partnership Arrangements Review (Q1) Deferred		Recommendations identified in the Limited Assurance RPB Governance Revie	Implementation of the management responses to close off recommendations
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
REASONABLE			

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING					
LINK TO IMTP	SECTION 3: SYSTEM CHANGE			SECTION 4: ENABLERS – REGIONAL PLANS		
Strategic/ Corporate Risk SRR 007 B	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.				Publication Status	Public
Threat <i>(As a result of)</i>	Due to the impact of fragile services across the regional and supra regional geography			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	Patient - Unmet patient need resulting in harm - Adverse impacts on delivery of care to patients across acute and non-acute settings	Staff N/A	Organisation - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence - Ineffective use of combined resources - Delayed decision making		Risk Appetite Threshold – SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Strategy Planning and Partnerships	Risk Exposure	Current Level	Target Level		
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	3 (Possible) x	2 (Unlikely) x		
Initial Date of Assessment	04 January 2024	Impact	3 (Moderate)	2 (Minor)		
Last Reviewed	01 November 2025	Risk rating	= 9 (High)	= 4 (Low)		
Next Review (Quarterly based on risk score)	01 March 2025					

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. - The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. - Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. - Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. - The south east Wales health boards agreed revised joint priorities and working arrangements for regional planning in 2024, following a review workshop attended by Chief Executives. Workstreams are underpinned by a Memorandum of Understanding between the participating health boards, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. - When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. - In addition to these arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	Additional direction and guidance have been received from Welsh Government, placing greater emphasis on the role of regional planning to achieve sustainable longer-term positions for a range of services where fragilities currently exist. The principal actions are:- - Requirement to develop a portfolio of documents to inform and drive the forthcoming development of a regional diagnostic and treatment centre at Llantrisant Health Park (LHP). These will include a clear outline strategy, comprehensive demand & capacity modelling for proposed LHP services, future development opportunities and programme governance arrangements - Direction for the participating health boards to establish a Joint Regional Committee in quarter 3 of 2025/26, to exercise the facilitation and oversight of regional planning and drive effective collaboration and regional working. The health boards are progressing the above on a collaborative basis. There remains an absolute commitment to delivering on the existing regional programmes of work, and following ‘re-baselining’ work during 2024/25, there is a continued regional consensus on objectives, outcomes, and planning assumptions.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
Service Divisions reporting to the Chief Operational Officer		Alignment and effectiveness of partners to deliver integrated services	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Assurance reporting to the Population Health, Partnerships, and Planning Committee. - Assurance reporting to the Board. - Regular touchpoint meetings of all key players to review progress and issues arising		None	N/A
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 January 2026
CYFARFOD O: MEETING OF:	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	National Escalation and IMTP approval status, including application of the Planning Maturity
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Trish Chalk, Assistant Director of Planning and Performance Marie- Claire Griffiths, Head of Strategic Planning

Pwrpas yr Adroddiad Purpose of the Report

Er Sicrwydd/For Assurance

The purpose of this report is to update Partnerships, Population Health and Planning Committee on the issues relating to re-escalation of the health board for planning and the revocation of the IMTP approval status.

Key to this is the updated self-assessment against the planning Maturity Matrix which is part of the Health Board's the actions to support de-escalation and the Planning Process for 2026/2027.

The Partnerships Population Health and Planning Committee are asked to:

- Note the change in planning escalation and revocation of IMTP approval
- Note the completion of key de-escalation requirement and the assessment against the planning Maturity Matrix

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The IMTP is the key planning document for Aneurin Bevan University Health Board setting out the milestones and actions for the next year. It is based on the health needs of the population, responds to the Welsh Government's Planning Framework and Ministerial priorities, and sets out the steps we will take to deliver our long-term strategy.

Following a change in financial forecast in month 8, it was confirmed in December 2025 that the health board was escalated to from Level 3 (enhanced monitoring) to

level 4 (targeted intervention) for Planning and Finance. In addition, the Cabinet Secretary wrote to the Chair confirming that due the “deteriorating financial position, along and ongoing performance challenges” the approval on the IMTP which was confirmed in June 25 was being revoked “with immediate effect”. The Health board is awaiting confirmation of the detailed de-escalation criteria which will be shared in the form of a Health Board Escalation Framework. A detailed report on escalation status is going to the Board meeting on 28th January therefore the rest of this paper will focus on the assessment against the planning maturity matrix.

The Planning Maturity Matrix was first introduced in 2024 as a response requirement to the Health Boards’ escalation status. NHS Wales organisations that are in escalation for planning, strategy and finance are required to undertake planning maturity self-assessments on an annual basis as part of their de-escalation criteria and submit a Board approved return to Welsh Government Planning team. Organisations that are not in escalation are not mandated to undertake self-assessment however; they are encouraged to.

The Planning Maturity Matrix has undergone a review and has been updated in September 2025.

Cefndir / Background

The requirements associated with the national escalation status will be set out in the Health Board’s bespoke Escalation Framework. The Health Board’s previous Framework set out the expected outcomes, which were expected to be achieved for de-escalation and included a confidence assessment in delivery against the Planning Maturity Matrix first released in 2024 (Appendix 1).

The 2024 Maturity Matrix was based around 8 domains and 97 measures demonstrating assurance in the following areas:

Table 1

Key Elements	Assurance to be assessed with each measure scored on a scale of 0-5: 0 – No progress. 1 – Basic level (Principle accepted and commitment to action). 2 – Early progress (Early progress in development). 3 – Results (Initial achievements). 4 – Maturity (Results consistently achieved). 5 – Exemplar (Others learning from our consistent achievements).
Strategy development	
Strategy alignment and development of an Annual Plan with 3 year focus	
Dynamic and engaged planning	
Best Practice approach to improvement	
Realistic and deliverable	
Systems and processes for performance, accountability, and improvement.	
Measurable and improving performance	
Use of analysis to evidence the forward plan and assumptions	

One of the de-escalation criteria within the 2024 Targeted Intervention Framework was that the organisation achieves at least a minimum level 3 across all domains.

The first assessment was submitted in July 24 following sign off by the Committee and is summarised below:

Table 2

Element	Level	Assessment as at July 2024
Strategy development	3	Internal review highlighted that the planning principles and integration is evident, and this being further strengthened. At the time of review, the Performance Management Framework was not fully tested, over a period of time, against operational delivery assurance or the application of the joint strategic needs assessment.
Strategy alignment and development of an Annual Plan with 3 year focus:	2	Evidence of strategic alignment needed further review along with the business case process. The application of the QIA process was emerging and to be fully tested in next year's planning process. The three-year road map was in development.
Dynamic and engaged planning	3	Engagement approach could be evidenced and has been further strengthened through the development of the 10-year strategy.
Best Practice approach to improvement	2	At the time of review the process for identifying, implementing and tracking efficiency and improvement opportunities is in development with the establishment of the Value and Sustainability Board and accountability framework.
Realistic and deliverable	2	There is development of a 10-year strategy and the 3-year route map to sustainability.
Systems and processes for performance, accountability, and improvement.	3	There is evidence of an integrated approach to performance and accountability, which will be further strengthened by the application of the PMF.
Measurable and improving performance	2	Whilst there is strong evidence of understanding what of is deliverable and the ability to determine realistic delivery from operational to system level, the measure of success is delivery of the KPI's and cannot currently be evidenced.
Use of analysis to evidence the forward plan and assumptions	4	There is the functionality, understanding and focus from operational through to system level to understand cause and effect and risk. There is ability to understand access data for D and C planning for most services which supports the narrative decision and plan.

The action plan in **Table 3** set out the baseline assessment of where ABUHB was against level 3 and the actions, that were to be undertaken to strengthen the planning process and support de-escalation.

Table 3

Element	Actions Summary	Progress as at September 2024
Strategy development	1. Strategy engagement programme. 2. Clinical services plan assessment. 3. ELGH programme review and plan. 4. Integrated planning process review and update. 5. Timebound Plan for the integrated planning process. 6. Regional acute services plan. 7. 3-year road map to sustainability.	• In place and commenced • Completed and in progress • In progress • Completed • Completed • In progress
Strategy alignment and development of an Annual Plan with 3 year focus:	1. Review of the PIP process and BC's planned. 2. QIA process established. 3. PMF reviewed and in use. 4. Divisional escalation levels reviewed annually. 5. Project plan for integrated Plan. 6. Executive led meetings in place. 7. Replace the planning and strategy network with Integrated Planning Groups. 8. Alignment of transformation programmes. 9. Demand and Capacity baseline. 10. Commissioning intentions.	• In progress • In progress • In progress • Completed • Completed • Completed • Completed • In progress • Completed • In progress
Dynamic and engaged planning:	1. Regular, executive led meetings in place focused on the plan and plan delivery. 2. Post Annual Plan 23/24 review. 3. Develop of annual divisional plans and improvement strategies.	• In progress • Completed • In progress
Best Practice approach to improvement	1. QIA process. 2. Agree efficiencies and plan principles that must be included in Divisional Plans. 3. Value and sustainability Board in place 4. Executive Team prioritisation process in place of all service change.	• In progress • In progress • Completed • In progress
Realistic and deliverable	1. Agree efficiencies and plan principles that must be included in Divisional Plans. 2. Defined planning parameters agreed. 3. Refresh Performance Management and Accountability Framework with escalation levels and reviews.	• Completed • Completed • In progress • In progress

	4. Presentations at System Leadership Group to launch the planning cycle. 5. Demand and capacity baseline agree delivery mechanisms for cross-cutting workstreams. 6. QIA process for 24/25 plan. 7. Quality measures developed with an update QOF. 8. Integrated communication and meeting network. 9. Integrated plan submission process.	- Completed - In progress - In progress - Completed - Completed
Systems and processes for performance, accountability, and improvement	1. Process established to agree and disseminate updated planning objectives for 25/26. 2. Timeline in place from Division to Board for communication, development, feedback and sign off. 3. Demand and capacity baseline assessments. 4. Commissioning intentions issued to Divisions and NCNs. 5. Executive team prioritisation of all service change. 6. Annual Divisional plans and Improvement Strategies.	- Completed - Completed - Completed - In progress - In progress - In progress
Measurable and improving performance	1. Integrated Planning process Plan 2. Divisional integrated Plans and outputs under Workforce/ Planning/Finance. 3. Agree milestones July – March 25 4. Refresh Performance Management and Accountability Framework. 5. Establishment of the permanent QIA process for 24/25 plan. 6. Quality measures developed with an update QOF. 7. Services in escalation reviews to support de-escalation plans.	- Completed - In progress - In progress - In progress - In progress - In progress
Use of analysis to evidence the forward plan and assumptions	1. Refresh baseline for planning assumptions. 2. Demand and capacity baseline assessments. 3. Agreed Commissioning intentions issued to Divisions and NCNs. 4. Develop detailed operational plans for 25/56 for all Divisions to specialty level which can be aggregated to system level.	- Completed - Completed - In progress - In progress
Updates and Considerations for 2025		

The Maturity Matrix was reviewed and updated in September 2025 (Appendix 2). The Matrix now contains 6 domains, listed below. Within each domain, themes have been created from the elements within the previous matrix. These themes have been made progressive and are progressed through the 5 levels of maturity and Health Boards must demonstrate assurance in the following areas:

Domain	Description
Strategy Development/Clarity of Purpose, Vision and Strategy	Evidence of a clear purpose, vision and strategy for the organisation. Responds to national, regional, local and partnership priorities, and the wider determinants of health. Translates national policies into local strategy, planning, and delivery.
Strategy Alignment and Development of an IMTP	Evidence of alignment of strategy with components of the plan.
Dynamic and Engaged Planning	Reflecting a dynamic, engaged and ongoing approach to planning. Process is positively influencing outcomes. Organisation identifies fragile services and has plans in place to address / mitigate risks and proposals in place for more robust service models e.g. via regional solutions, consolidation of services etc.
Operational Planning	Evidence of demand and capacity planning, linking to triangulation of operational plans, workforce and finance. Embedding a culture of reducing unwarranted variation, improved performance and outcomes end evaluation of improvements
Best Practice Approach to Improvement	Ambition to deliver best practice levels of equity, efficiency, effectiveness, quality and safety.
Realistic and Deliverable:	Sensitivity analyses, risk assessment of deliverability, reference to track record of delivery. Sustainable and affordable.

Asesiad / Assessment

The Maturity Matrix provides a valuable opportunity to reflect and review how we operate the planning process, and what needed to put in place to support the requirements de-escalation.

The Maturity Matrix is part of our Targeted Intervention status and seeks to baseline the Health Board against the updated six key domains highlighting critical areas requiring targeted improvements. It facilitates an understanding of how we could improve our organisational planning and what would be needed to advance to each next level. This update is intended to be an open, transparent and review following on from the initial assessment.

The process of review has included:

1. A review of the existing action and progress against level 3 of the 2024 maturity matrix (Action Plan: Appendix 4).
2. An assessment and new action plan against the 2025 Planning Maturity Matrix (Appendix 3)

Review of the existing actions and progress

A full breakdown of progress against the action plan can be found in Appendix 3 . Of the 22 actions 21 were completed and 1 is in progress at the commencement of the 2025/26 planning cycle in August 2025.

Current Assessment

The table below sets out our initial assessment of where the health board currently is against the matrix 2025/2026 Assessment against the 2025 framework.

Element	Level	Assessment as at December 2025
Strategy Development/Clarity of Purpose, Vision and Strategy	3	This element of the matrix returned the largest range maturity scores. Delivery of the underpinning strengths from 2024 action plan included the Board approved ten-year Organisational Strategy, Gwent 35, with a measurable outcomes’ framework. The strategy aligns with refreshed Healthier Wales actions and draws on extensive engagement, representing nearly 7,000 individuals and reflecting Gwent’s diverse demographics. Six key strategic areas support the plan: People, Quality, Financial, Estates, Digital Transformation, and Green Health, each with specific actions. Planning and prioritisation are informed by an established Joint Strategic Needs Assessment which is leading the way in Wales. This is alongside the annual planning parameters, with oversight from the Board and Executive.
Strategy Alignment and Development of an IMTP	2	Whilst there is strong alignment between the new Organisational strategy Gwent 35 and the Annual Planning approach, maturity in this section is now weighted toward having the refreshed Clinical Services Plan in place. This part of the action plan for 25/26. The areas that are of strength include, the Integrated Delivery Plans, there is triangulation between services, activity, workforce and finance at service level and processes to support the identification of gaps and risks.

		Prioritisation is determined using the planning parameters established for each annual planning cycle. These parameters are approved by the Executive and the Board and developed with Divisional Management and Clinical colleagues through Cross Divisional sessions. There is a process in place to assess clinical risk to prioritisation through the Clinical Advisory forum and QIA's. Service transformation was planned over three years, with year one featuring quarterly milestones and detailed demand, capacity, and risk mitigation plans. For 2025/26, Integrated Delivery Plans were aligned to Gwent 35 priorities and reviewed retrospectively. Delivery is supported by refreshed frameworks for performance, accountability, and quality, with outcomes tracked in Integrated Performance Reports.
Dynamic and engaged planning	3	Gwent 35's development involved extensive engagement and co-design with partner organisations, Health Boards, staff, and the public, gathering feedback from nearly 7,000 individuals. The SEW regional network, established before the formal joint committee, facilitated joint planning across several clinical areas. Risk management is addressed through corporate and divisional registers, with regular assessments of operational, workforce, and capital risks. ABUHB has led regional service developments, including cataracts, and implemented structured engagement approaches for key service changes and hospital developments.
Operational Planning	3	Demand and capacity planning within the organisation varies in maturity but is conducted across all RTT specialties. Where formal processes are not in place, activity-based planning with SPC methodology is used. The Corporate Modelling, Analytics and Performance Team aids in embedding demand and capacity planning digitally, supporting regional delivery and transformation initiatives. Outputs are used collaboratively with Operations, Finance, and Workforce teams to inform funding and assess delivery capability. Clinical leadership contributes through various forums, and the Clinical Advisory Forum oversees Quality Impact Assessments to ensure proposed changes consider quality and patient safety. Integrated Delivery Plans are integral to aligning

		demand and capacity modelling with finance and workforce plans, identifying gaps and interdependencies to manage risks.
Best Practice Approach to Improvement	3	The engagement programme for Gwent's strategy development ensured demographic representation. Community Engagement and Integrated Wellbeing Networks continuously support service changes, such as MIU hours, the NHH Project and the reconfigurations of stroke services, in line with the Strategic Equality Plan. NHS benchmarking tools and the ABHB compendium support annual planning and Value-Based programmes. Governance structures, ratified through formal frameworks, oversee all strategic plans and ensure alignment with organisational goals. The updated Performance and Accountability Framework now include new domains for Leadership and Corporate Governance, with clear expectations and responsibilities defined at all levels through accountability agreements.
Realistic Deliverable	& 3	The Annual Plan approach assesses the feasibility of Integrated Delivery Plans, which are built on current clinical models, demand analysis, and capacity planning. Risks are identified during plan development, with annual lessons learnt reviews informing future cycles and shared across teams. ABUHB previously had approved Integrated Medium-Term Plans (IMTPs), but recent financial challenges led to revocation of approval. Nonetheless, the planning process establishes clear service transformation expectations, set quarterly milestones for progress and accountability, and is closely monitored through integrated performance reports and regular reviews. Delivery and performance goals are embedded in leadership agreements and supporting enabler plans are developed to meet divisional needs and organisational objectives.

Action Plan 25/26

Following the assessment against the 2025 Maturity Matrix, the table below sets out the key delivery actions which can also be found in Appendix 3:

Element	Summary of 25/26 Action Plan
Strategy Development/Clarity of Purpose,	Completed lessons learnt review 24/25, outcomes to inform preparation process, approach, parameters and principles for the 25/26 plan

Vision and Strategy

- Completed delivery plan for the Clinical Services Strategic Plan.
- PPH&P Cte Paper in January 26 providing the Clinical Services Strategic Plan Approach
- Develop priority Clinical Service Plans with appropriate stakeholder engagement
- Strategy Deployment and Delivery plan actions are incorporated into operational work plans, assurance processes
- The Annual Review Process in place with the production of report and recommendations completed
- Quarterly Integrated Performance reporting
- Annual Report produced
- Engagement Materials developed which clearly set vision and priorities
- Strategic Plan submitted to Board, and communicated to stakeholders through online, materials, meetings
- Completion of all actions set out in the assurance processes to progress against actions
- Adopt the strategy and service change engagement approach for Clinical Services Strategic Plan, built on the methodology used for Gwent 35, for all service changes, (engagement, horizon scanning, data)
- NHH Comms and Engagement Plan actions complete
- Stroke engagement completed, which includes the recommendations from the Midpoint review regarding patient and staff groups
- Develop the 26/27 approach and approval by the Divisions, Board and Executive
- Continued development of the Joint Strategic Assessment
- Through joint project work programmes, and the delivery plan sharing data and intent with partners for example: Housing, Local Authorities, Planning Education, Police and Sports and Leisure organisations as outlined in Strategy Delivery and Deployment Plan
- Complete a review of the priority Clinical Service Plans against the Strategic needs assessment and equality plan
- Clinical Advisory Forums set up with documented outcomes that feed into decision making processes
- This work led by the planning team and actioned through Board papers, Cross Divisional Meeting notes, individual engagement meetings as determined by the piece of work
- Horizon scan reports reviewed and updated
- Updated horizon scan information to inform planning cycle 2027/28 through the HBs planning framework and guidance
- Update of the pre Annual Plan approach and information
- Updated the Joint Strategic Assessment information.

Strategy Alignment and Development of an IMTP	• Development of Clinical Services Strategic Plan to update service models from Clinical Futures service models developed for opening of the GUH • Update the corporate risk actions within the scope of the IMTP, identifying risks to delivery and mitigation strategies. • Annual review of benefits and outcomes linked to strategic objectives and service transformation. • Cross divisional triangulation session completed reviewing resource requirements (workforce, finance, activity, plus enablers e.g digital, estates) to each priority. • Develop an approvable IMTP • Triangulated of performance, workforce, finance and quality data at the point of plan submission and reviewed monthly/quarterly as appropriate • Transformation programmes baselined with resources and benefits identified • Issuing of the Integrated Frameworks which include triangulation evidence across operational planning aligned to Annual plan/IMTP process • Completed triangulation sessions completed reviewing resource requirements (workforce, finance, activity, plus enablers e.g digital, estates) to each priority. • Submission of a triangulated plan which identifies areas of imbalance and plans to address over the 3-year period Triangulation assessed throughout the year to inform delivery assessment of Annual Plan • Update assurance measures and reporting and issuing of the accountability conditions • Review of the Commissioning intentions against the Strategy Deployment and Delivery Plan carried out
Dynamic and engaged planning	• Stakeholder engagement strategy adopted for Clinical Services Strategic Plan. • Updates provided via cross-divisional meetings. • Executive discussion papers submitted before launch of the next planning cycle. • Engagement and consultation plans approved by divisional leadership prior to start. • Assurance processes assess risk registers and workforce profiles for service fragility. • Strategic Decision-Making Framework established. • QIA process and program manage change-related risks. • Active participation in Regional Joint Committee and implementation of regional service models. • Participation in Regional Digital Committee.
Operational Planning	• All areas have time-defined D and C processes. • The plan triangulates resources, staff, finance, and activity.

	• Population Health Management Implementation Plan guides IMTP planning and prevention priorities. • Clinical Advisory Forum and decision-making process scheduled. • Clinical Exec and assurance meetings held, with notes and actions documented. • Cross-divisional meetings established. • Clinical leadership is integrated into the Clinical Services Strategic Plan. • Clinical services plan developed collaboratively with clinical teams. • Clinical Services Strategic Plan updates service models from Clinical Futures for GUH opening. • Triangulation will include quality data in 26/27 submission. • Updated D and C template includes follow-ups. • MH and Therapies D and C in place; triangulation ongoing. • Inpatient therapies D and C initiated. • NHH OBC model review underway.
Best Practice Approach to Improvement	• Progress against the Strategy Deployment and Delivery Plan • Value Based Health Care programme and outcomes reporting • Compendium production • Planning guide updated and available • Integrated frameworks completed • Performance and Accountability Framework implementation • Accountability conditions produced • Escalation reviews in place
Realistic Deliverable &	• Maintain and regularly review risk registers • Complete divisional assurance and action plans • Integrated frameworks completed and updated for 26/27 • Submit an approvable Annual Plan • Implement benefits realisation plans for all transformation programmes • Identify V and SB priorities and action plans • Quantify Value Based Health Care programmes • Establish and publish accountability conditions • Report quarterly on integrated performance • Complete QOF reporting • Implement performance and accountability framework actions

Underpinning evidence

The Maturity Matrix is underpinned by a wide range of supporting documentation, providing robust evidence for the assessment, implementation, and ongoing impact evaluation. These core documents, reports, and strategic frameworks collectively ensure that all aspects of planning, delivery, governance, engagement,

performance, and risk management are considered and reported. The following documentation have and will be used, it should be noted many of these documents have been revised or developed in the past year as part of the strategy development, PMF review and QOF review.

Core Delivery and Planning Documents

- Delivery Plan for the Clinical Services Strategic Plan
- Strategy Delivery and Deployment Plan
- Clinical Services Strategic Plan
- Annual Plan
- Transformation Programme Plan and Reports

Governance and Oversight

- PPHP Committee Papers
- Board and Executive Papers
- Board Annual Review of Strategy Deployment and Delivery Plan

Engagement and Feedback

- Engagement Session Outputs
- Engagement Materials
- Stroke Engagement Plan
- NHH Engagement Plan
- Service Change Updates
- Patient Stories
- Patient Experience Report
- Staff Survey

Performance, Quality, and Risk

- Integrated Performance Reporting
- Quality Management Group Minutes and Actions
- Quality and Outcomes Framework (QOF)
- Risk Registers
- JSA and Indicator Framework

Supporting Strategies

- Quality Strategy
- Our People Plan
- Financial Strategy
- Estates Strategy
- Digital Transformation Strategy
- Green Health Strategy

Prioritisation and Planning

- RPB RIF Prioritisation
- Planning Approach and Guide
- Reporting and Annual Review
- Annual Report

- Integrated Reporting

Summary of progress against the refreshed Planning Maturity Matrix 2025/26

The 2025/26 review of progress against the refreshed Planning Maturity Matrix has demonstrated that ABUHB successfully achieved all actions set out from 2024. This includes meeting key planning objectives such as the development of the ten-year strategy. The strategy development process involved engagement with a wide and diverse stakeholders across Gwent, which is crucial for effective service planning and for ensuring that the needs of the entire population are represented.

The objective to attain level 3 maturity is largely being fulfilled. Notably, the refresh of the Clinical Services Plan has been identified as an area for prioritisation in the coming period. The assessment has also highlighted notable strengths, particularly in the use of the Joint Strategic Assessment (JSA), which has become an integral and valuable component of ABUHB’s planning processes.

Updates to key governance processes—including the PMF, QOF, and risk management procedures have further strengthened the approach to monitoring progress. These updates have established expectations and a robust basis for measuring the impact.

Argymhelliad / Recommendation

The Partnerships Population Health and Planning Committee are asked to:

- Note the change in escalation status with respect to planning and finance and the revocation of the approval of the IMTP,
- Note the updated assessment against the updated Planning Maturity matrix

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	007
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply All Health & Care Standards Apply Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Digital, Data, Intelligence

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Improve the access, experience and outcomes of those who require mental health and learning disability services Choose an item.
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Yes, outlined within the paper
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies

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

Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

Appendix 1



Appendix%20%20 Appendix%203%20
ABUHB%20maturity%20Maturity%20Matrix%

Appendix 2



Maturity Matrices Planning Maturity
Guidance2025.docx Matrix 2025.docx

Appendix 3



Planning Maturity
Self-Assessment Sub

Appendix 4 Assessment of progress against 2024 Action Plan

Element	Actions Summary	Actions as@ September 2024	Update as at September 2025
Strategy development	1. Strategy engagement programme. 2. Clinical services plan assessment. 3. ELGH programme review and plan. 4. Integrated planning process review and update. 5. Timebound Plan for the integrated planning process. 6. Regional acute services plan. 7. 3-year road map to sustainability.	1. In place and commenced 2. Completed and in progress 3. In progress 4. Completed 5. Completed 6. In progress 7. In progress	1. Completed 2. Completed scoped 3. Completed and updated in line with NHH SOC and programmes 4. Completed 5. Completed 6. Completed 7. Completed and under review
Strategy alignment and development of an Annual Plan with 3 year focus:	1. Review of the PIP process and BC's planned. 2. QIA process established. 3. PMF reviewed and in use. 4. Divisional escalation levels reviewed annually. 5. Project plan for integrated Plan. 6. Executive led meetings in place.	1. In progress 2. In progress 3. In progress 4. Completed 5. Completed 6. Completed 7. Completed	1. Completed 2. Completed 3. Completed 4. Completed 5. Completed 6. Completed 7. Completed

	7. Replace the planning and strategy network with Integrated Planning Groups. 8. Alignment of transformation programmes. 9. Demand and Capacity baseline. 10. Commissioning intentions.	8. In progress 9. Completed 10. In progress	8. Completed 9. Completed 10. In progress
Dynamic and engaged planning:	1. Regular, executive led meetings in place focused on the plan and plan delivery. 2. Post Annual Plan 23/24 review. 3. Develop of annual divisional plans and improvement strategies.	1. In progress 2. Completed 3. In progress	1. Completed and Ongoing 2. Completed 3. Completed and ongoing
Best Practice approach to improvement	1. QIA process. 2. Agree efficiencies and plan principles that must be included in Divisional Plans. 3. Value and sustainability Board in place 4. Executive Team prioritisation process in place of all service change.	1. In progress 2. In progress 3. Completed 4. In progress	1. Completed and in place 2. Completed 3. Completed 4. Completed
Realistic and deliverable	1. Agree efficiencies and plan principles that must be included in Divisional Plans.	1. Completed	1. Completed

	2. Defined planning parameters agreed.	2. Completed	2. Completed
	3. Refresh Performance Management and Accountability Framework with escalation levels and reviews.	3. In progress	3. Completed
	4. Presentations at System Leadership Group to launch the planning cycle.	4. In progress	4. Completed
	5. Demand and capacity baseline agree delivery mechanisms for cross-cutting workstreams.	5. Completed	5. Completed
	6. QIA process for 24/25 plan.	6. In progress	6. Completed
	7. Quality measures developed with an update QOF.	7. In progress	7. Completed
	8. Integrated communication and meeting network.	8. Completed	8. Completed
	9. Integrated plan submission process.	9. Completed	9. Completed
Systems and processes for performance, accountability, and improvement	1. Process established to agree and disseminate updated planning objectives for 25/26.	1. Completed	1. Completed
	2. Timeline in place from Division to Board for communication, development, feedback and sign off.	2. Completed	2. Completed

	3. Demand and capacity baseline assessments. 4. Commissioning intentions issued to Divisions and NCNs. 5. Executive team prioritisation of all service change. 6. Annual Divisional plans and Improvement Strategies.	3. Completed 4. In progress 5. In progress 6. In progress	3. Completed 4. In progress 5. Completed 6. Completed
Measurable and improving performance	1. Integrated Planning process Plan 2. Divisional integrated Plans and outputs under Workforce/ Planning/Finance. 3. Agree milestones July – March 25 4. Refresh Performance Management and Accountability Framework. 5. Establishment of the permanent QIA process for 24/25 plan. 6. Quality measures developed with an update QOF. 7. Services in escalation reviews to support de-escalation plans.	1. Completed 2. In progress 3. In progress 4. In progress 5. In progress 6. In progress 7. In progress	1. Completed 2. Completed 3. Completed 4. In progress 5. Completed 6. Completed 7. In progress

Use of analysis to evidence the forward plan and assumptions	1. Refresh baseline for planning assumptions.	1. Completed	1. Completed
	2. Demand and capacity baseline assessments.	2. Completed	2. Completed
	3. Agreed Commissioning intentions issued to Divisions and NCNs.	3. In progress	3. In progress
	4. Develop detailed operational plans for 25/26 for all Divisions to specialty level which can be aggregated to system level.	4. In progress	4. Completed

Progress Levels ➔ Key Elements ↓	0 - No Progress	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy development: Responds to national, local and partnership priorities, and the wider determinants of health. Translates national policies into local strategy, planning, and delivery.	No vision or evidence of a clear understanding of national, local and partnership priorities, or the wider determinants of health.	- Agreed vision, scope and methodology with clear leadership at a Board and strategy programme level. An understanding of all Wales, local and partnership priorities. - Establishment of a governance structure to provide oversight and direction. - Clear demonstration of alignment to our Strategic and Planning Objectives,	- Development of a co-designed long term integrated clinical services strategy with evidence of strong clinical, stakeholder and public engagement and involvement throughout. A patient led approach is evident. - Identified clinical leads that own and drive strategic developments. - The Well Being of Future Generations Act's five ways of working, along with the Health Board's well-being objectives (and strategic objectives) and the principles of A Healthier Wales are apparent and embedded. - The strategy is embedded into organisational plans and is informed by population health needs, locality needs	- The strategy reflects national and local health and partnership priorities, is informed by population and health needs assessments and incorporates the wider determinants of health. - Board approved patient centred clinical services strategy that delivers sustainable health and well-being outcomes for the local population.	- Local plans and national policy are aligned showing contribution to the wider economy, impact on health and well-being and effectiveness. - Key enablers such as quality, safety, workforce and finance are fully aligned. - A performance and accountability framework/ Performance Management Framework (PMF) is in place that delivers the strategy and is linked to population health outcomes.	- The strategy is responsive to national/local and partnership priorities with clear links to the Research, Innovation & Improvement Co-ordination Hub, Regional Partnership Board and Public Service Boards. - At the forefront of new skills and techniques. Strategic achievements and learning for improvement is shared elsewhere via conferences and publications. - Capacity to support strategic planning is evident and is not perceived as separate to core business. Demonstrable working across public and third sector with clearly described outcomes and benefits to the ABUHB population, those with protected characteristic and socio-economically disadvantaged groups.

Progress Levels ➡ Key Elements ↓	0 - No Progress	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
			assessments and patient/ carer experience.			
Strategy alignment and development of an Annual Plan with 3-year focus): Evidence of alignment of strategy with components of the plan.	No alignment is visible between the IMTP and national and/or Health Board strategies.	- Alignment is visible between the IMTP and strategy. The organisation plans on a continuous annual cycle. - Linked to the business case planning process, including and informed by local and national evidence base. - The Board sets out commissioning intentions.	- Evidence of triangulation between operational services, workforce and finance. The IMTP is tested for cost impact and able to support schemes that require longer term funding models. Robust and profiled projections of demand and capacity. - Directly linked to performance and accountability and informed by detailed and future facing modelling.	- The business case planning process informs the development of an IMTP. - Prioritisation framework agreed and implemented. - Agreed governance and accountability framework to underpin development of the IMTP at a Programme level. - Robust gateway review process and prioritisation framework in place. The IMTP is tailored to deliver clear service transformation. Impact of commissioned or supporting organisations taken into consideration.	Coherent aligned plans, including a commissioning plan, are performance managed, with staff owning, acting on and learning from variation.	Plan is achieving the quadruple aim (cost, outcomes, clinical and patient experience). Elements of our IMTP are shared and adopted elsewhere across Wales and the UK.
Dynamic and engaged planning:	No evidence that IMTP is owned across the organisation and	Staff and partners are aware of and engaged in IMTP and 10-year strategy development.	Stakeholders are engaged in and co-design priority setting using, or	Joint development and communication of and 10-year strategy / IMTP with	The 10-year strategy/ IMTP benefits patients, carers, the public, partners and health communities.	Feedback and learning from continuous engagement activities including protected characteristic groups and

Progress Levels ➔ Key Elements ↓	0 - No Progress	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Reflecting a dynamic, engaged and ongoing approach to planning. Process is positively influencing outcomes.	within the community.	Organisational staff respond to corporate requirements but may not 'own' the process.	'continuous engagement' model and a patient led approach. - Engagement at individual, team and organisational level is improving. - Strengthened partnership working arrangements. - NHS Wales Planning guidance is embedded in the planning process.	- key partners including other health boards, local authorities, third sector, patients, carers and members of the public. - Organisational engagement is evident in practice and reflected in and 10-year strategy/ IMTP. - Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	- Planning is co-ordinated throughout the organisation. Feedback from engagement activities influences and challenges the plan. - Track record of continuous engagement with stakeholders	socio-economic disadvantaged groups informs local priority setting and the development of the Clinical Services Strategy/ IMTP.
Best Practice approach to improvement: Ambition to deliver best practice levels of efficiency, effectiveness, quality and safety.	No evidence of ambition to achieve best practice. No evidence of benchmarking.	Published commitment to best practice with training, improvement and innovation strategy in place. Commitment to and engagement with national programmes.	Utilises a value-based healthcare approach to planning. Benchmarking within NHS delivers improvements.	Demonstrable improvements that can be evidenced and delivered.	Maintain the value-based healthcare approach. Plans are future proofed and based on changes in technology and healthcare innovation reflecting clinical excellence and patient experience.	Centres of excellence for clinical and/or teaching services. High performing across non-clinical measures e.g. staff survey, corporate standards.
Realistic and deliverable: Sensitivity analyses, risk assessment of deliverability, reference to track record of delivery. Sustainable and affordable.	One-year Annual Plan developed but limited evidence that it is credible and deliverable.	Development of a robust annual plan that builds assurance as a key step towards submission of an approvable IMTP and includes a finance and delivery framework.	Development of an approvable outcomes focused IMTP that reflects the and 10-year strategy priorities and includes a robust 3-year financial plan. IMTP to reflect return on	Track record and current performance illustrates achievement on a wide range of issues and themes. Evidence of plans for delivery and implementation.	Forward look risk assessments anticipate problems to assure resilience.	Ability to modify plans and actions to keep on track is recognised by others via conferences and publications.

Progress Levels ➡ Key Elements ↓	0 - No Progress	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
			investment, evidence of impact and key success factors. Key risks (quality, service, access, workforce, finance) identified with evidence of controls.			
Systems and processes for performance, accountability, and improvement. Rigorous systems for individual, team, and organisation wide accountability. Agreed Escalation processes are operational. Culture of ownership and striving for improvement permeates the organisation.	No alignment of performance outcomes and key metrics to national strategies to drive the priorities on an all Wales or local basis. Accountability and escalation arrangements are not clear or operational. Lack of understanding and willingness to use performance management tools and engage in performance management at an individual, team or organisation wide level.	• Clear metrics and reporting against all Wales and evidence based local priorities as per Health Board Annual Plan/ Integrated Medium-Term Plan. • Top-down performance management demonstrated in reporting and early feedback with alignment to service transformation support. • Accountability for delivery is demonstrated but is not consistently in place across the organisation.	• Performance processes in place with regular reporting on finance, performance, quality and workforce. Trends identified and clear corrective actions with associated timescales reported to Board. • Early identification of sub-optimal performance managed using techniques such as Impact Improvement Plans. • Performance and Accountability Framework in place. Regular service reviews by the Executive, and key performance messages acted on by Divisions.	• Performance processes connect to agreed strategic priorities including those of other key partners and reflect an integrated approach to performance and accountability. • Processes, supporting metrics and outcome assessments are considered in advance with Board contribution and approval. • Performance and accountability processes reflect objectives, and work is in place to embed at the appropriate organisational level. • Transparent lines of accountability. Escalation and	• Integrated approach to performance and accountability at all levels of the organisation and demonstrated with reporting at Board, associated Sub Committee's, and Divisions. • All Health Board strategies have prioritised outcomes that are reflected in Board and local reporting. • Feedback and learning is embedded in organisational processes and benchmark reporting takes place. • Management of team and individual performance both operationally and in relation to strategic delivery. • Full alignment to the Health Board's Board Assurance Framework,	• Improvement, performance and accountability is fully integrated throughout the Health Board. • The Health Board can provide clear transparency in terms of resource utilisation and performance achievements to a wide range of internal and external stakeholders. • Positive performance culture where accountability for service and programmes is fully understood and demonstrably achieves significant improvements in delivery and quality of partnership working with local communities. • All services are clear on the key organisational performance priorities over the next 5 years. • Performance focussed assessment by Board and services on developments and improvements.

Progress Levels ➔ Key Elements ↓	0 - No Progress	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
			Alignment of the transformation programme and performance priorities has commenced.	- ownership of performance issues is considered normal business. - Matrix management/delivery to support service integration has commenced.	- corporate risk and service risk registers. - Resources required to deliver outcomes have been quantified and funding source identified i.e. additional or re-allocation of existing resources. - Alignment between Personal and Development Reviews (PADRs), service outcomes, and the Health Board's strategic outcome measures.	Peer review, transformation support benchmarking aligns and feed into the strategic planning cycle.
Measurable and improving performance: Improved access to appropriate, timely healthcare, and planned care in line with national requirements and locally agreed priorities, delivered by robust application of a pathway approach. Sustained improvement in performance, quality and patient experience in unscheduled care delivered by robust application of a pathway approach.	Plans that support delivery do not have clear agreed whole system outcome measures. Processes for measuring performance are under-developed and not consistently applied across pathways. Key elements of service delivery are not quantified, and timescales are not defined.	- Operational plans are in place and contain an appropriate level of detail to support service delivery. - Pathway plans clearly set out month on month performance trajectories.	- Tangible action being taken, and measurable performance improvement demonstrated across patient pathways. - Operational plans are regularly reviewed, and remedial action undertaken. Service delivery is not in line with performance trajectories.	- Performance trajectories achieved in key priority pathway areas. - Evidence of improved timely access to end-to-end healthcare services and sustained improvement in performance, quality and patient experience.	- The majority of national and local priority performance measures are achieved, and performance is sustained across the entire patient pathway. - Individuals, Teams and the organisation use performance reports to build on service improvement with the aim of optimising the use of the resources available to the Health Board to maximise performance.	Health Board performance is on par with other top performing healthcare organisations across the UK.

Progress Levels ➔ Key Elements	0 - No Progress	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Assurance: Clarity on monitoring, assurance and delivery mechanisms.	Insufficient evidence of local monitoring, assurance and delivery mechanisms.	Board and organisation clear on roles and accountabilities.	Board demonstrates how it will ensure effective leadership and governance accountability with adequate capacity, processes and engagement in place to deliver strategic priorities and the IMTP.	Board has track record of dealing successfully with difficult issues. Delivery, monitoring and evaluation mechanisms in place.	Resilience assured through accountability, succession planning and external independent assurance. Core processes manage plan objectives.	Board members are recognised advocates of good governance. Clear and robust arrangements for tracking delivery in place.
Use of analysis to evidence the forward plan and assumptions Assurance: Clear understanding of measuring the plan and sources of information and insight that provide progress assurance. Mechanisms in place for understanding the realistic delivery of the Plan which are supported by metrics	Delivery Forecast and understanding is produced from a variety of sources, No QA in place Data cannot be tracked over time Definitions are unclear and inconsistent between years	Systems are in place that have the capacity and capability to produce scenarios reflecting and testing the deliverability of the plan	- There is understanding and evidence of the scope for producing the outputs and forecasts - The scope and scale of the data to be used is defined and accessible	- Systems in place to track and monitor forecasts are used as intended, with the relevant context and caveats included to be able assess delivery - There are skills from service to Board to design, input and inform development of the plan	- Evidence decisions are underpinned by a sound understanding of all relevant evidence, including associated risks and uncertainties. - There is quantitative evidence which demonstrates the consistent use of planned vs actual and understanding over a number of years There is the ability to link data sets to understand patient journeys and the effect of planned changes.	- Evidence of understanding from operational level data through to system level and the ability of understand the cause and effect of planned changes - Evidence that at all levels there is an understanding of outcome data and there is ability to understand access data for D and C planning in all services which supports the narrative decision and plan

Action Plan to support development of planning function as part of Targeted Intervention

Background to Action Plan

This action plan has been developed as part of the Health Board's response to the planning element of Welsh Government's Targeted Intervention. The Plan responds to initial review of the planning process, the maturity matrix, plus reflections and internal lessons learnt from previous plans.

Progress Levels  Key Elements 	Target Minimum Level 3	Initial assessment as at June 2024	Actions	Success Measures	Evidence of progress
Strategy development: Responds to national, local and partnership priorities, and the wider determinants of health. Translates national policies into local strategy, planning, and delivery.	The strategy reflects national and local health and partnership priorities, is informed by population and health needs assessments and incorporates the wider determinants of health. Board approved patient centred clinical services strategy that delivers sustainable health and well-being outcomes for the local population.	Level 3 The strategy reflects national and local health and partnership priorities, is informed by population and health needs assessments and incorporates the wider determinants of health. Board approved patient centred clinical services strategy that delivers sustainable health and well-being outcomes for the local population	- Commence engagement programme with timelines in place for the development of our long-term strategy. - Assessment completed of the current clinical services plan in line with regional and Clinical Futures plans. - Programme plan for NHH SOC development and eLGH's plan. - Strategic population needs assessment developed and in use. - Annual Plan developed and strategic engagement with Llais, TUPF and staff bodies. - Integrated Planning process - Plan developed with clear deliverables and timescales. - Divisional Integrated Plans developed and with clear outputs for Workforce/Planning/Finance. - Agreed milestones July – March 25. - Set up Acute Regional Planning Group and timescales for development of a plan.	- Successfully manage and improve pathways aligned to Ministerial priorities. - Adopt a data-driven, patient-centric approach in plan development, which can be evidenced for each measure. - Robust handling of Fragile Services: which effectively addresses and manages fragile services and those in escalation. - Regional service delivery in line with agreed plans. - Effective Management of Planned Care, UEC and MH Pathways. - Regional acute services plan.	- Gwent Strategic Needs Assessment. - Urgent Care and Mental Health escalation meeting and action plans. - Signed of Executive Integrated planning process. - Regional acute services plan. - Integrated Plan Paper. - Annual Plan. 3 Year Route Map to Financial Sustainability.
Strategy alignment and development of a 3-year Integrated	The business case planning process informs the	Level 2	- Review the process and communication of the PIP process, and BCs planned. - Establish formal QIA process.	Board Approval of Annual Plans and achieve Board approval for long term strategy.	- Urgent Care and Mental Health Escalation meeting and action plans. - Signed off the Executive Integrated planning process.

Progress Levels  Key Elements 	Target Minimum Level 3	Initial assessment as at June 2024	Actions	Success Measures	Evidence of progress
Medium Term Plan (IMTP): Evidence of alignment of strategy with components of the plan.	development of an IMTP. Prioritisation framework agreed and implemented. Agreed governance and accountability framework to underpin development of the IMTP at a Programme level. Robust gateway review process and prioritisation framework in place. The IMTP is tailored to deliver clear service transformation. Impact of commissioned or supporting organisations taken into consideration.	The business case planning process informs the development of an IMTP. Prioritisation framework agreed and implemented. Agreed governance and accountability framework to underpin development of the IMTP at a Programme level. Robust gateway review process and prioritisation framework in place. The IMTP is tailored to deliver clear service transformation. Impact of commissioned or supporting organisations taken into consideration.	- PMF reviewed and in use. - Divisional escalation levels reviewed annually in line with the plan. - Project plan in place with clear milestones to the end of March. - Regular, executive led meetings in place focused on the plan and plan delivery. - Replace the Planning and Strategy network with Integrated Planning Executive Oversight Group and Integrated Planning Group.	- Ensure plans align with Health Board's strategic direction. - Adopt a data-driven, patient-centric approach in plan development, which can be evidenced for each measure. - Robust handling of Fragile Service, which effectively address and manage fragile services and those in escalation. - Regional service delivery in line with agreed plans. - Effective Management of Planned Care, UEC and MH Pathways. - Regional Acute Services Plan. - QIA reviews and outcomes.	- Regional Acute Services Plan. 3 Year Route Map to Financial Sustainability. - Approved Annual Plan. - PIP outputs and reviews. - QIA Framework. - Escalation Action Plans. - PMF.
Dynamic and engaged planning: Reflecting a dynamic, engaged and ongoing approach to planning. Process is positively influencing outcomes.	Joint development and communication of and 10-year Strategy/IMTP with key partners including other Health Boards, Local Authorities, Third Sector, Patients, Carers and Members of the Public.	Level 3 Joint development and communication of a 10-year Strategy/IMTP with key partners including other Health Boards, Local Authorities, Third Sector, Patients, Carers and Members of the Public.	- Regular, executive led meetings in place focused on the plan and plan delivery. - Post Annual Plan 23/24 review of performance against plan and KPIs in operational services. - Develop Annual Divisional plans and Improvement Strategies aligned with Clinical Futures plans with clear annual	- Engagement process which is representative of our population and communities. - Completed D and C for all operational areas which go beyond the MDS. - Ensure Balanced Decision-Making and be able to demonstrate financial sustainability and high standards of patient care.	- D and C Plans. - MDS completed. - Commissioning intentions .

Progress Levels  Key Elements 	Target Minimum Level 3	Initial assessment as at June 2024	Actions	Success Measures	Evidence of progress
	Organisational engagement is evident in practice and reflected in and 10-year Strategy/ IMTP. Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	Organisational engagement is evident in practice and reflected in and 10-year strategy/IMTP. Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	deliverables delivered through the PMF. - Through Clinical Futures design principles and reporting, set out how enhanced governance and risk management in projects. - Ensure alignment of operational plans from Directorate to specialty level through to system. - Demand and Capacity baseline assessments completed in July. - Agreed Commissioning intentions issued to Divisions and NCNs.		
Best Practice approach to improvement: Ambition to deliver best practice levels of efficiency, effectiveness, quality and safety.	Demonstrable improvements that can be evidenced and delivered.	Level 2 Utilises a Value-Based healthcare approach to planning. Benchmarking within NHS delivers improvements.	- Ensure QIA process in place to assess risk for service change and potential reduction. - Set out and agree efficiencies and plan principles that must be included in Divisional Plans. - Value and sustainability Board in place with clear objectives. - An Executive Team prioritisation process in place of all service change that is not cost neutral or generates savings captured through the Divisions integrated plans.	- Greater understanding of staff in post and variable pay usage. - Greater understanding of core activity and efficiency opportunities.	- QIA outcomes. - MDS. - Annual Plan. - Outcomes of scrutiny meetings. 3 Year Route Map to Financial Sustainability.

Progress Levels  Key Elements 	Target Minimum Level 3	Initial assessment as at June 2024	Actions	Success Measures	Evidence of progress
Realistic and deliverable: Sensitivity analyses, risk assessment of deliverability, reference to track record of delivery. Sustainable and affordable.	Track record and current performance illustrates achievement on a wide range of issues and themes. Evidence of plans for delivery and implementation.	Level 2 Development of an approvable outcomes focused Annual Plan that reflects the ABUHB priorities and includes a robust 3-year financial plan. IMTP to reflect return on investment, evidence of impact and key success factors. Key risks (quality, service, access, workforce, finance) identified with evidence of controls.	- Set out and agree efficiencies and plan principles that must be included in Divisional Plans. - Value and Sustainability Board in place with clear objectives. - Defined planning parameters agreed. - Refresh Performance Management and Accountability Framework with escalation levels and reviews. - Scheduled presentations at System Leadership Group to launch the planning cycle, agree demand and capacity outputs and agree delivery mechanisms for cross-cutting workstreams. - Establishment of the permanent QIA process for 24/25 plan. - Quality measures developed with an update QOF. - Integrated communication and meeting network set up. - Integrated plan submission process in place led by BP's split into the following outputs. Planning - Delivery Plan: Milestones, Workforce, Finance, Benefits & Risks. - Efficiency Targets: Quarterly trajectories. - Bed Plan: Funded WTE. - Interdependencies and Risks. - Discretionary Capital Requirements. - Service Change.	- Greater understanding of staff in post and variable pay usage. - Greater understanding of core activity and efficiency opportunities. - Board Approval of Annual Plans and achieve Board approval for long term strategy. - Ensure plans align with Health Board's strategic direction. - Adopt a data-driven, patient-centric approach in plan development, which can be evidenced for each measure. - Robust handling of Fragile Services which effectively address and manage fragile services and those in escalation. - Regional service delivery in line with agreed plans. - Effective Management of Planned Care, UEC and MH Pathways. - Regional Acute Services Plan. - QIA reviews and outcomes.	- QIA outcomes. - MDS. - Annual Plan. - Outcomes of scrutiny meetings. 3 Year Route Map to Financial Sustainability.

Progress Levels  Key Elements 	Target Minimum Level 3	Initial assessment as at June 2024	Actions	Success Measures	Evidence of progress
			- Enablers: Intents & Opportunities e.g. Digital, estates. Workforce - Staff in Post and WTE workforce requirements. (investment, savings). - Retirements and Turnover. - Variable Pay. - Educational Commissioning. Finance - Financial Plan. - Risks. - Opportunities. - Inflationary Pressures. - Savings.		
Systems and processes for performance, accountability, and improvement. Rigorous systems for individual, team, and organisation wide accountability. Agreed Escalation processes are operational. Culture of ownership and striving for	Processes, supporting metrics and outcome assessments are considered in advance with Board contribution and approval. Performance and accountability processes reflect objectives, and work is in place to embed	Level 3 Performance processes connect to agreed strategic priorities, including those of other key partners and reflect an integrated approach to performance and accountability. Processes, supporting metrics and outcome assessments are considered in advance with Board contribution and approval. Performance and accountability processes reflect objectives, and	- Establish a process to agree and disseminate updated planning objectives for 25/26, which engages the senior leadership of the organisation. - Timeline in place from Division to Board for communication, development, feedback and sign off. - Demand and Capacity baseline assessments completed in July. - Agreed Commissioning intentions issued to Divisions and NCNs.	- Regular, Executive led meetings in place focused on the plan and plan delivery. - Agreed process and assumptions for 25/26 plan. - Regular BP led planning meetings with Directorate and Divisions about the plan.	- Performance Management Framework. - Escalation meetings. - Integrated Planning meetings.

Progress Levels  Key Elements 	Target Minimum Level 3	Initial assessment as at June 2024	Actions	Success Measures	Evidence of progress
	improvement permeates the organisation. at the appropriate organisational level. Transparent lines of accountability. Escalation and ownership of performance issues is considered normal business. Matrix management /delivery to support service integration has commenced.	work is in place to embed at the appropriate organisational level. Transparent lines of accountability. Escalation and ownership of performance issues is considered normal business. Matrix management/delivery to support service integration has commenced.	- An Executive Team prioritisation of all service change that is not cost neutral or generates savings captured through the divisions integrated plans. - Develop annual Divisional plans and Improvement Strategies aligned with Clinical Futures plans with clear annual deliverables delivered through the PMF. - Refresh Performance Management and Accountability Framework with escalation levels and reviews.		
Measurable and improving performance: Improved access to appropriate, timely healthcare, and planned care in line with national requirements and locally agreed priorities, delivered by robust application of a pathway approach. Sustained improvement in performance, quality and patient experience in unscheduled care delivered by robust application of a pathway approach.	Performance trajectories achieved in key priority pathway areas. Evidence of improved timely access to end-to-end healthcare services and sustained improvement in performance, quality and patient experience.	Level 2 Tangible action being taken, and measurable performance improvement demonstrated across patient pathways. Operational plans are regularly reviewed, and remedial action undertaken. Service delivery is not in line with performance trajectories.	- Integrated Planning process Plan. - Set out the Divisional integrated Plans and outputs under Workforce/Planning/Finance. - Agree milestones July – March 2025. - Refresh Performance Management and Accountability Framework with escalation levels and reviews. - Establishment of the permanent QIA process for 24/25 plan. - Quality measures developed with an update QOF. - Put in place dates for Services in escalation to have regular monitoring and review of de-escalation plans.	- Prioritise patient safety and complete quality impact assessments for any service reduction. - Achieve balanced financial position, any service developments funded within budget. - Achieve a reduction in variable pay and admin, any workforce increases funded within budget. - Prioritise their capacity on treatment of Cancer. - Achieve activity efficiencies. - Deliver Ministerial Targets.	- Urgent Care and Mental Health escalation meeting and action plans. - Signed of Exec Integrated planning process. - Regional Acute Services Plan. 3 Year Route Map to Financial Sustainability. - Approved Annual Plan. - PIP outputs and reviews. - QIA Framework. - Escalation Action Plans. - PMF.

Progress Levels  Key Elements 	Target Minimum Level 3	Initial assessment as at June 2024	Actions	Success Measures	Evidence of progress
Assurance: Clarity on monitoring, assurance and delivery mechanisms.	Board has track record of dealing successfully with difficult issues. Delivery, monitoring and evaluation mechanisms in place.	Level 3 Board has track record of dealing successfully with difficult issues. Delivery, monitoring and evaluation mechanisms in place.	- As part of the planning process set dates and sessions for Board scrutiny - Develop a 3-year road map to sustainability which is signed off by the Board - Include the priorities in the 3-year road map in the Divisional Plans	- Signed off Annual Plan - From Directorate to Board participation in development of the plan triangulated at every level	3 Year Route Map to Financial Sustainability. - PMF. - Annual Plan. - D and C plans.
Use of analysis to evidence the forward plan and assumptions Assurance: Clear understanding of measuring the plan and sources of information and insight that provide progress assurance. Mechanisms in place for understanding the realistic delivery of the Plan which are supported by metrics.	Systems in place to track and monitor forecasts are used as intended, with the relevant context and caveats included to be able assess delivery. There are skills from service to Board to design, input and inform development of the plan.	Level 4 Evidence decisions are underpinned by a sound understanding of all relevant evidence, including associated risks and uncertainties. There is quantitative evidence, which demonstrates the consistent use of planned vs actual and understanding over a number of years. There is the ability to link data sets to understand patient journeys and the effect of planned changes.	- Update and refresh baseline for planning assumptions and align in data platforms agreed with Divisions. - Demand and Capacity baseline assessments completed in July. - Agreed Commissioning intentions issued to Divisions and NCNs. - Develop detailed operational plans for 25/26 for all Divisions to specialty level which can be aggregated to system and as a minimum understand the following pathways and the interdependencies: - Emergency - Elective (inc day case) - Diagnostic - Treatment - Outpatients - Pathways of Care - Discharge - GMS, Dental, Optom - Cancer - Mental Health - CHC - Develop Comprehensive Planning and Communication: Create	- Planning tools developed and in used in key areas. - Implement Plans in Key Areas: Effectively implement and deliver operational plans in specified areas (Ministerial Priorities). - Ensure Balanced Decision-Making: Maintain financial sustainability and high standards of patient care. - Utilise planning tools effectively in key service areas including Dynamic Planner, trackers, accountability framework. - Align with 25/26 Overall Plan: with operational plans. - Transformation plans in place for key change areas, as agreed by Executive and Board. - An understanding of Balance Workforce and Service Delivery Needs: Achieve balance between staff well-being and service delivery? - Evidenced Prioritise Quality of Patient Care: Focus on quality of patient care in planning decisions.	3 Year Route Map to Financial Sustainability. - PMF. - Annual Plan. - D and C plans. - MDS.

Progress Levels Key Elements → ↓	Target Minimum Level 3	Initial assessment as at June 2024	Actions	Success Measures	Evidence of progress
			detailed change plans with clear roles and communication.		



Llywodraeth Cymru
Welsh Government

NHS Wales

Strategy and Planning Maturity Self-Assessment Guidance

September 2025

Planning Maturity Self-Assessment

Submission Guidance

2025

Introduction

This guidance is intended to support NHS Wales organisations in undertaking planning maturity self-assessments and subsequent submission. The Planning Maturity Matrix has undergone a review and has been updated in September 2025.

The matrix has been strengthened with themes identified in each domain to provide further clarification on definitions. Each theme has been produced from elements seen in the previous matrix and made progressive. Nothing additional has been added to the matrix.

Background & Purpose

NHS Wales organisations that are in escalation for planning, strategy and finance are required to undertake planning maturity self-assessments on an annual basis as part of their de-escalation criteria and submit a Board approved return to Welsh Government Planning colleagues. The de-escalation criteria is: *‘Welsh Government’s confidence in delivery, as assessed by the planning maturity matrix’*. The self-assessment, therefore serves as a source of assurance to the organisation’s Board whilst Welsh Government gains insight and confidence in the organisation’s evidence to justify its current maturity level and the robustness of its action plans to progress and develop maturity.

Organisations that are not in escalation are not mandated to undertake self-assessments. However, they may find it beneficial to undertake the exercise to support their evaluation of their planning maturity. We would be happy to receive and review these.

The matrix (Annex 1) which is the version organisations should use, builds on the original maturity matrix which was developed by the Good Governance Institute. It has been further refined over time and in collaboration with NHS Wales colleagues.

The purpose of this exercise is to prompt self-reflection and assessment of planning maturity within an organisation against a defined set of planning maturity levels. It aims to support NHS Wales organisations in setting clear levels, targets, and goals for in planning capability and capacity, with the aim of improving services and outcomes for patients. It also provides an opportunity to raise the profile planning

across the organisation, including opportunities to discuss integrated planning capability and capacity organisation wide at Board and Executive level.

The matrix is a tool to assess the current status of planning and identify areas for improvement. It is also a useful tool for mapping the improvement journey towards de-escalation (where applicable), ultimately leading to greater maturity in planning capability and capacity– resulting in improved services and better outcomes for patients

General Guidance

Part of the de-escalation criteria for planning, strategy and finance is that a self-assessment must be completed and approved by the Board. This ensures that the Board is fully sighted on the organisation's current position, receives assurance regarding it's planning maturity, and is confident that the organisation is actively working towards de-escalation; and

It is acknowledged that the assessment submissions will demonstrate an organisation's position at a point in time and that various iterations of submissions should be used to assess an organisation's development journey towards improved planning maturity.

Although there is no prescribed timeline for advancement along the maturity matrices, the organisation is expected to demonstrate a sustained commitment to implementing positive change effectively.

To ensure clarity throughout this document and develop understanding, this is what is meant by domain, then level and element.

A) Strategy & Plan Development					
Domain	Level				
	1 - Basic Level	2 - Early Progress	3 - Results	4 - Maturity	5 - Exemplar
	Principle accepted and commitment to action	Early progress in development	Initial achievements	Results consistently achieved	Others learning from our consistent achievements
	Theme	Theme	Theme	Theme	Theme
	Theme	Theme	Theme	Theme	Theme
Strategy & Plan	No CSS or delivery plan in place but strategic framework for its development in development.	Initial CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.
Vision & Purpose	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board discussion takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and All Level partnership priorities	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WSPG Act and AHW are apparent and embedded in the agreed approach.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WSPG Act and AHW principles and integrated throughout.	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with clear links to the Regional Partnership Board and Public Service Boards.	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPB's and PSB's are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the wider local economy, improved health and well-being and operational effectiveness.

Scoring

To achieve a defined level of maturity, organisations must demonstrate that they fulfil the requirements of and can robustly evidence elements. Organisations must be able to supply evidence for each element of the domain and level.

As the levels have now been made progressive, evidence for one level of each element is required.

Organisations may identify they can evidence elements at different levels across domains. Highlighting in green as below to show what organisations can evidence may help to demonstrate where the balance of evidence, and therefore scoring, lies. Organisations will then take a **judgement** based on the scoring for each element and what they can evidence and justify to identify their overall maturity score for each domain.

As an example, scoring below reflects a level 2 for Strategy and plan and level 3 for vision & purpose, and alignment with national policy.

A) Strategy & Plan Development					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy & Plan	No CSS or delivery plan in place but strategic framework for its development in development.	Draft CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.
Vision & Purpose	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board discussion takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and A&E Level partnership priorities	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WSG Act and AHW are apparent and embedded in the agreed approach.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WSG Act and AHW principles are integrated throughout.	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with clear links to the Regional Partnership Board and Public Service Boards.	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPBs and PSBs are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the wider local economy, improved health and well-being and operational effectiveness.

Conversely, some elements of the matrix may not apply to certain organisations. For example, the requirement for a clinical services plan. Where this is the case, organisations should put N/A.

Evidence

The self-assessment must be supported by robust and well-documented evidence linked to each element. A lack of evidence will undermine the organisation's ability to justify its proposed scores and reach a credible assessment.

Organisations must be able to demonstrate clear evidence for elements in the domain and level to justify their score. Additionally, organisations should record evidence for any higher-level elements they believe they meet. When recording evidence, organisations may wish to consider:

- **Avoid using general statements** such as “*for example*”, “*communication in place*”, “*good performance management*” or “*process in place*”. Be specific and detailed.
- **Consider and demonstrate the impact** the evidence has had - ask the “so what?” and describe the difference it has made.
- **Document new processes** (e.g. new escalation processes), including any supporting documents, the impact they’ve had, and how that impact is being measured.
- **Reference specific key documents** and provide links where appropriate to support transparency and traceability.

Actions

Alongside the evidence of self-assessment, this is the most important element of the process - understanding where the organisation can improve and establishing actions and plans that support improvement.

Good practice was seen in the 2024 self-assessments (but was not limited too) with actions that:

- Were specific, clear, and focussed.
- Had a high-level timeline.
- Had a short description on how the impact would be measured.
- Had a short description on how the impact of the action would be evidenced in future.
- Were linked to the relevant element of the level for each domain where the organisation recognised the need for improvement/ambition.
- Were related not only to products (e.g. clinical service plan) but on the planning capability and capacity of the organisation including the underpinning processes.

Submission

A template for submission (Annex 2) has been developed based on good practice seen in previous year. It has been provided to help organisations based on the advice above. However, organisations may choose whether or not to use this template and can submit in a style to suit them (as long as the content requirements are delivered). Organisations should consider including coloured elements to highlight which elements they believe they can evidence. An example is:

A) Strategy & Plan Development					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy & Plan	has CSS or delivery plan in place but strategic framework for its development in development.	Draft CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.
Vision & Purpose	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board decision takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and AS-Level partnership priorities	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WSPG Act and AHWI are apparent and embedded in the agreed approach.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WSPG Act and AHWI principles are integrated throughout.	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with clear links to the Regional Partnership Board and Public Service Boards.	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPB's and PSB's are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the wider local economy, improved health and well-being and operational effectiveness.

Whatever your submission looks like, we would expect to receive a board approved:

- Copy of your maturity scores for each theme and domain
- Copy of the evidence you have used for each judged element
- A copy of your actions for improvement

Please send your submission to hss-planningteam@gov.wales

Receiving Feedback

Feedback will be provided in a realistic but timely manner. The feedback will respond to the six domains in the matrix, rationale, supporting evidence, and the actions identified. An informal conversation will be offered to organisations ahead of any formal feedback, providing an opportunity to discuss the submission, share initial observations and clarify any matters.

Written feedback will be provided by the Director of Strategic Planning who will consult with senior officials in the Health, Social Care and Early Years Group in Welsh Government to ensure that the response is as in depth and rounded as possible.

Feedback is provided in the spirit of support and helpfulness, as the aim of this process is to encourage self-assessment and self-awareness for development. It is intended to support organisations in strengthening their planning approach in a way that promotes and recognises system-wide improvement.

Where possible, examples of good practice will also be shared—not to compare one organisation to another, but to ensure that others can learn from it and encourage a positive, evidence-based planning culture.

Should an organisation wish to seek further clarification or wish to receive further feedback, please contact hss-planningteam@gov.wales

Annex 1



Planning Maturity
Matrix 2025.docx

Annex 2



Planning Maturity
Self-Assessment Subr

NHS Wales

Strategy and Planning Maturity Matrix

The NHS Wales Planning Maturity Matrix has been reviewed and updated in September 2025. The Matrix contains 6 domains and as listed below. Within each domain, themes have been created from the elements within the previous matrix. These themes have been made progressive and are progressed through the 5 levels of maturity.

The 6 Domains and their descriptors are:

Domain	Description
A) Strategy Development/Clarity of Purpose, Vision and Strategy	• Evidence of a clear purpose, vision and strategy for the organisation. • Responds to national, regional, local and partnership priorities, and the wider determinants of health. • Translates national policies into local strategy, planning, and delivery.
B) Strategy Alignment and Development of an IMTP	• Evidence of alignment of strategy with components of the plan.
C) Dynamic and Engaged Planning	• Reflecting a dynamic, engaged and ongoing approach to planning. Process is positively influencing outcomes. • Organisation identifies fragile services and has plans in place to address / mitigate risks and proposals in place for more robust service models e.g. via regional solutions, consolidation of services etc.
D) Operational Planning	• Evidence of demand and capacity planning, linking to triangulation of operational plans, workforce and finance. • Embedding a culture of reducing unwarranted variation, improved performance and outcomes end evaluation of improvements
E) Best Practice Approach to Improvement	• Ambition to deliver best practice levels of equity, efficiency, effectiveness, quality and safety.
F) Realistic and Deliverable:	• Sensitivity analyses, risk assessment of deliverability, reference to track record of delivery. Sustainable and affordable.

A) Strategy Development/ Clarity of Purpose, Vision and Strategy Plan

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy & Plan	No CSS or delivery plan in place but strategic framework for its development in development.	Draft CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP. Implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.
Vision & Purpose	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board discussion takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and All-Level partnership priorities	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WBFG Act and AHW are apparent and embedded in the agreed approach.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WBFG Act and AHW principles and integrated throughout.	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with clear links to the Regional Partnership Board and Public Service Boards.	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPB's and PSB's are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the wider local economy, improved health and well-being and operational effectiveness.

Key Enablers	Key enablers—such as quality, safety, workforce, finance, digital technology, and research—are identified but not yet aligned to strategic planning. Their role in enabling delivery is recognised but not actively managed or coordinated.	Key enablers are identified, with plans underway to align them with the organisations overarching CSS. Quality expectations are defined, and initial steps taken to coordinate enabler contributions across programmes.	Key enablers are fully aligned with strategic objectives. Their potential is well understood and actively explored to support delivery. Quality expectations are clearly defined and embedded in planning processes, with enablers contributing to strategic coherence.	Key enablers underpin the development and delivery of the CSS and CSP. Opportunities linked to enablers are translated into actionable deliverables. Quality is integrated throughout the key enabling strategies and plans driving performance and improvement.	Key enablers are embedded across all strategic functions and are delivering measurable improvements and are considered best practice. Their impact is tracked through performance metrics, and they are continuously optimised to support innovation, agility, and system-wide transformation. Quality is not only integrated but drives strategic refinement and outcome achievement.
Engagement in Development	The duties of the Health and Social Care (Quality and Engagement) (Wales) Act (the Act) are identified as integral to the development and implementation of the CSS.	Engagement plans are in place to support the development of CSS.	Engagement plans are agreed and reflect strong clinical leadership. Plans meet the requirements of the Act	Plans are being implemented effectively with robust processes in place to capture diverse voices (internal and external) with strong clinical leadership, and where appropriate and necessary, offers opportunities for stakeholder involvement in shaping the development of CSS.	Organisation operates best practice and continuous engagement with both internal and external stakeholders, exemplifying the values seen in the quality and engagement act, ensuring voices from all communities are heard and reflected in the annual review of the CSS.
Population Health Needs Assessment	Plans are in place to undertake a population health needs assessment.	A basic high level population health needs assessment has taken place and is being used to shape the CSS.	CSS and CSP development is informed by population and health needs assessments and incorporates the wider determinants of health.	There is a single, detailed and regularly updated population health needs assessment in place. Strategies are updated regularly to clearly reflect the outcome of the assessment.	Population health needs assessment is recognised as best practice and is recognised and used by partner organisations (such as PSB and RPB) to form a common and shared understanding. CSS/CSP is regularly tested against current, emerging, and future population health needs.
Priorities & Achievability	The organisation does not have a prioritisation methodology or a recorded list of priorities. Planning is reactive and lacks strategic direction.	The organisation has an approved prioritisation framework related to population health needs assessment and has basic understanding of its priorities but is not yet reflected in plans. health needs.	A prioritisation framework is fully implemented. Priorities are recorded and aligned to population health needs assessments and Cabinet Secretary expectations. Early progress is made to reflect priorities in plans,	The organisation has a published, best-practice prioritisation methodology. It is fully aligned to population health needs and Cabinet Secretary expectations. Prioritised services are proactively reviewed and updated, with robust	Prioritisation is embedded across all planning and decision-making processes. The methodology is sector-leading based on the outcome of the population health needs assessment and Cabinet Secretary's expectations. It is co-produced with stakeholders, and continuously refined through evidence, evaluation, and engagement. Priorities are transparently linked to outcomes, resource

			with initial monitoring arrangements in place.	monitoring and governance of decisions embedded in planning cycles.	allocation, and national policy, with real-time monitoring and adaptive planning in place.
Horizon Scanning	Horizon scanning is infrequent and informal, with no structured process or discussion at Executive or Board level. Strategic planning is reactive, lacking foresight into emerging risks, trends, or opportunities.	Annual horizon scanning is conducted to identify key risks and opportunities. Findings begin to inform strategic thinking, but integration into planning and governance remains limited.	Horizon scanning is carried out regularly and used to test and validate strategic plans against future trends and risks. Insights are reviewed annually and inform planning cycles, with growing Board-level engagement.	Horizon scanning is embedded into strategic planning and governance processes. Findings are discussed at Board level annually, and strategies are actively validated and adjusted based on emerging insights. The organisation uses structured methods to anticipate change and mitigate risk.	Horizon scanning is systematic, forward-looking, and published. It informs biannual Board-level strategic discussions and enables flexible, data-driven adjustments to CSS. Insights are used to anticipate future scenarios, align with system-wide priorities, and ensure the organisation remains agile, resilient, and future-ready.

B) Strategy Alignment and Development of an IMTP

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
IMTP Development	Organisation has an annual plan which responds to some but not all elements of planning framework and cannot provide a financially balanced plan over 3 years.	Organisation has an approved IMTP that aligns with the core elements of the planning framework. The plan demonstrates a structured approach to strategic priorities and is informed by baseline data. It includes initial consideration of risks, outcomes, and resource requirements.	IMTP meets almost all policy expectations and is tailored to deliver clear service transformation aligned with an agreed CSP and reflects a shift from operational delivery to strategic impact. Growing maturity in linking planning to measurable impact, return on investment, and strategic priorities. Risks are clearly identified, with evidence of controls and early mitigation strategies.	The IMTP meets all policy expectations and is consistently delivering against the quadruple aim and is embedded across the organisation and transforming services through the CSP. Risks across quality, access, workforce, and finance are actively managed with evidence of controls and mitigation and demonstrates clear alignment between planning, performance, and transformation.	The IMTP exceeds all national policy expectations. It is recognised as a benchmark for excellence, driving system-wide transformation and delivering sustained impact across the quadruple aim. The plan is co-produced, future-focused, and underpinned by robust evidence, innovation, and adaptive governance. It demonstrates clear and advanced triangulation, delivery timelines and milestones, and integrated risks and mitigation.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	Some alignment is visible between the annual plan and CSS with the organisation planning on a continuous annual cycle.	Alignment is clear and coherent between the IMTP and CSS with the organisation planning on a continuous annual cycle.	The IMTP is tailored to deliver clear service transformation in line with an agreed Clinical Services Plan. Plans are directly linked to quality, performance and accountability and informed by detailed and future facing modelling.	Coherent aligned plans, including a commissioning plan are performance managed, with staff owning, adapting, acting on and learning from variation.	Planning is owned by all staff and fully integrated and aligned across organisational tiers and system partners. There is a clear golden thread between local, national and regional strategies and partnerships with dynamic alignment to the CSS and Plan, IMTP, commissioning intentions, resulting from horizon scanning results, detailed population health needs assessment and enabling strategies (e.g. workforce, digital, estates).
Triangulation of Services	Basic high-level triangulation is taking place between services, activity, workforce and finance.	Clear triangulation between services, activity workforce and finance.	Detailed triangulation between services, activity workforce and finance at service level.	Clear detailed and robust triangulation and analysis of activity, workforce and finance which considers other holistic requirements such as	Triangulation is system-wide, predictive, and continuously refined through real-time data and advanced analytics. It informs strategic decision-making, resource optimisation, and service redesign across organisational boundaries. The organisation demonstrates a proactive approach

				training and working regionally.	to managing interdependencies, future workforce needs, financial sustainability, and service demand, with clear links to population health, regional collaboration, and innovation.
Commissioning	The Board sets out high level commissioning intentions primarily focused on statutory requirements and broad service categories. Commissioning is reactive, with limited strategic alignment or stakeholder engagement.	The organisation has an approved and operational commissioning process. Intentions begin to reflect service priorities and are informed by basic population health data and stakeholder input.	Commissioning decisions are prioritised based on service need, population health data, and performance metrics. The impact of commissioned and supporting organisations is actively considered.	The organisation has a clear, transparent commissioning plan that includes a transparent prioritisation framework and actions for both commissioning and decommissioning ensuring risk to patients are minimised. Decisions are evidence-based, responsive to changing needs and communicated effectively to stakeholders.	Commissioning is strategically embedded across the organisation and system, with clear alignment to the population health needs assessment, clinical priorities, and service transformation goals. The process is co-produced with stakeholders with a clear and transparent prioritisation framework, underpinned by robust evidence, and includes pro-active decommissioning where appropriate with detailed communication strategies. Commissioning decisions are transparent, equitable, and continuously evaluated for impact on quality, access, and outcomes.

C) Dynamic and Engaged Planning

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Stakeholder Engagement	Staff and partners are aware of CSS/CSP and there is a public commitment in place to undertake stakeholder engagement.	Organisational engagement is evident in practice and reflected in the CSS/CSP. Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	Stakeholders are engaged in and co-design priority setting using the 'engagement cycle' model and a person-centred approach. Staff engagement at an organisation level is increasing.	Full and proactive continuous engagement including diverse communities which informs, owns and tests all impact assessments. Feedback from engagement activities influences and challenges the plan. Planning is also embedded and co-ordinated throughout the organisation.	Internal continuous engagement sees a fully engaged and informed workforce who are able to co-produce. Feedback and learning from continuous engagement activities including protected characteristic groups and socio-economic disadvantaged groups informs local priority setting and the development of the CSS/CSP.
Service Delivery Risk and Issue Management Approach	Organisation has a service risk management approach in place, but it has not been fully adopted across all areas.	Organisation has service risk management approach embedded across all areas of the organisation and has robust plans in place to address / mitigate risks	A risk management approach is evident and consistent across organisation. The organisation stop fragile services are identified.	The risk management approach enables the early identification of fragile or soon to be fragile services allowing for early intervention to ensure service sustainability. Organisation sees less urgent service changes.	Potential fragile services identified early and robust risk management across organisation pre-emptively responding to emerging service risks and the organisation is able to flexibly adjust plan. The Board are informed and regularly updated on fragile services and organisation rarely sees urgent service changes.
Service Model / Regional Design	Organisation has no route, or route is ineffective to discuss potential opportunities or joint risks. Regional collaboration is minimal, ad hoc, and lacks strategic intent.	Strengthened partnership working arrangements are in place. A methodology for working together is developed, with early efforts to align priorities and build trust.	Opportunities for regional working and shared solutions are identified and developed collaboratively. Planning is increasingly aligned across organisations, with joint priorities and resource sharing.	Agreed proposals for robust regional service models (e.g. consolidation, shared services) are in place and delivery is underway. Governance structures support joint accountability and performance management.	Regional collaboration is fully embedded, strategically led, and continuously evolving. The organisation is a proactive system leader, driving the development, implementation, and optimisation of shared service models and regional solutions. Collaboration is underpinned by co-produced strategies, shared governance, and dynamic intelligence. The organisation anticipates future needs, fosters innovation, and delivers measurable improvements in equity, efficiency, and outcomes across the region.

D)Operational Planning

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Demand & Capacity Modelling	Basic demand and capacity work is undertaken and contains an appropriate level of detail to support service delivery	Demand and capacity planning undertaken at speciality level to support the design of current and future services. Data is more structured and used to inform service-level decisions	Robust and profiled projections of demand and capacity are used to inform the development of individual service plans, the Clinical Services Plan, and the IMTP. Planning is increasingly data-driven and cross-functional.	The organisation uses detailed and advanced modelling capability to support strategic planning. Demand and capacity modelling is embedded in the IMTP and informs transformation, workforce, and financial planning. Predictive analytics and AI tools support long-term planning.	Demand and capacity modelling including modelling projections is at the core of planning processes across the organisation. Predictive analytics and AI tools support long-term planning. Modelling triangulates resources, staff, finance and activity. It is able to undertake modelling at all levels of prevention and illustrates scenarios for improvement for the IMTP.
Clinical Leadership & Input	Clinical leads are identified and their roles are defined. Engagement is limited to basic consultation or information sharing	Clinical leads begin to inform service planning and contribute to performance improvement discussions. Their input is considered but not yet central.	Clinical leads are embedded early in the planning cycle to ensure that service design is clinically credible and patient-centred. Clinical leads co-produce plans and provide leadership in development processes. Their involvement is structured and increasingly strategic.	Clinical leadership is embedded in operational planning. Clinical teams actively shape service direction in alignment contributing to future direction services in line with clinical services plan.	Clinical leadership sits at the heart of planning and performance with a strong focus on quality and improvement. Clinical leaders co-produce plans and drive the future direction of plans through developing a culture of quality, innovation, and continuous improvement, fostering deep engagement and ownership across clinical teams.
Planning Process	Organisation has basic operational plans and planning process in place.	Operational plans are regularly reviewed and remedial action undertaken.	Operational plans have robust triangulation and modelling of plans based on a clear and consistent approach to demand and capacity modelling across the organisation	Coherent aligned and triangulated plans with clear links to CSS and CSP, including, with staff owning, adapting, acting on and learning from variation and inequity.	Operational plans are fully aligned and integrated into the development of IMTP and CSP. Staff own the process and act on opportunities and learning to improve holistic service provision and patient experience.

E) Best Practice Approach to Improvement

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Engagement	Engagement is minimal and reactive. Feedback is collected from patients and staff, but there is no structured approach to measuring the effectiveness of engagement activities or approach. Insights are rarely used to inform decision-making.	The organisation has a visible commitment to best practice, supported by training and an improvement strategy. Engagement with national programmes is active, and structured methods for collecting feedback and measuring impact are in place, though not yet fully embedded.	Organisation is developing an engagement strategy/plan and is proactive in identifying and learning from best practice in engagement to ensure voices are captured from all stakeholders especially clinical, minority and diverse voices.	Engagement is embedded across all organisational activities—planned and unplanned. The engagement strategy ensures robust inclusion of diverse and clinical voices, supported by strong data collection and analysis. Feedback directly informs action, driving continuous improvement.	Stakeholder engagement is transformational—co-designed and co-led by patients, staff, and communities. Real-time feedback tools enable adaptive responses, while inclusive practices ensure diverse voices shape decisions. The organisation is nationally recognised for its leadership in engagement, with a clear link between stakeholder input and measurable improvements
Benchmarking	Organisation is beginning to explore value-based healthcare principles, but planning remains reactive and output-focused. Benchmarking is ad hoc, with limited structure or consistency. There is minimal understanding of how comparative data can drive improvement, and benchmarking is not yet linked to strategic goals.	Value-based planning is gaining traction, and regular benchmarking is conducted with other NHS organisations. The organisation begins to use structured benchmarking methods to identify best practice, though application is inconsistent. Staff awareness is growing, and benchmarking is starting to inform service reviews and improvement discussions.	Benchmarking processes are formalised, consistently applied, and span across Wales and the UK. The organisation uses comparative data to identify performance gaps and inform strategic planning. Benchmarking is aligned with value-based healthcare principles, and results are used to prioritise improvement initiatives. Staff are engaged in interpreting data and applying insights to their areas.	Benchmarking is fully integrated into planning and performance cycles. Staff across the organisation actively lead benchmarking and improvement initiatives, using data to drive decisions and measure impact. There is a strong culture of ownership and continuous learning. Benchmarking includes qualitative and quantitative measures, peer comparisons, and outcome-focused metrics aligned with patient value. Insights are shared across teams and used to scale best practice.	Demonstrates full integration of benchmarking and value-based planning across strategic, operational, and clinical areas. Advanced analytics, including predictive and real-time data, drive proactive improvements and innovation. Recognised as a leader in the NHS, the organisation shapes best practice while fostering a culture where staff lead continuous improvement and scalable innovation.
Governance	Governance arrangements are informal, fragmented, or unclear. Oversight of IMTP development is minimal, with limited	A governance structure has been established to provide direction and oversight for IMTP	A formal governance and accountability framework is in place for IMTP development and	Governance is embedded across the organisation, with a mature CSS and oversight mechanisms that are	Governance is fully integrated, agile, and strategically aligned across all levels. Oversight of the IMTP, CSS and CSP is co-produced with clinical leaders and stakeholders, supported by

	accountability, transparency, or alignment to strategic priorities. There is no structured process for risk management, stakeholder involvement, or performance monitoring.	development. Roles and responsibilities are defined, and basic reporting mechanisms are in place. There is growing awareness of the need for structured governance, but integration with programme-level planning and delivery is still emerging.	monitoring at programme level. IMTP and CSS/CSP governance is aligned with strategic objectives, includes defined escalation routes, and supports performance tracking. IMTP Governance is periodically tested for improvements.	reviewed annually for relevance and effectiveness. IMTP and CSS/CSP governance structures support cross-functional collaboration, robust data use, and continuous improvement. Governance is constantly and pro-actively tested for improvements.	real-time data, predictive analytics, and dynamic risk intelligence. IMTP/CSS/CSP governance structures are benchmarked against national best practice, continuously refined, and used to drive innovation, accountability, and system-wide impact. Decision-making is transparent, inclusive, and outcome-focused.

F) Realistic & Deliverable

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Risk Identification & Management	Risk identification and management are inconsistent and reactive. Risks to IMTP delivery are not systematically captured or monitored. There is limited ownership or visibility of delivery risks.	A formal risk management process exists and is applied to IMTP delivery at a high level. Risks are identified at the planning stage and tracked through basic registers and reviewed periodically. Ownership is clearer, but integration with delivery assurance is limited. Escalation processes in place but not always followed.	Risk identification and management are embedded in IMTP development and delivery processes. Risks are identified early and linked to specific objectives, milestones, and outcomes. Controls are monitored, and mitigation actions are tracked. Risk registers are dynamic and inform delivery with clear ownership.	Risk management is proactive, strategic, and forward-looking with an agreed and clear risk appetite. Risks are anticipated and identified through horizon scanning, sensitivity analysis and scenario planning. The organisation adapts delivery plans in response to emerging risks with regular reviews. Lessons learnt informs future IMTP cycles.	Risk management is fully embedded across the organisation and system partners and is triangulated across workforce, finance, digital and clinical lenses. It is predictive, real-time, and continuously informs IMTP delivery through live dashboards and predictive analysis. The organisation leads in using risk intelligence to drive improvement, resilience, and transformation. The organisation operates continuous learning and is recognised for excellence in risk-informed delivery assurance.
Development of IMTP and track record	The organisation has a track record of submitting annual plans that do not meet the requirements of the planning framework, Cabinet Secretary expectations or provide a financially balanced plan over 3 years. Planning is largely operational and short-term, with limited strategic integration and has limited clinical or financial planning alignment and limited stakeholder engagement.	The organisation consistently develops robust annual plans that build assurance as a key step toward an approvable IMTP. Plans begin to reflect medium term priorities, include a finance and delivery framework, and show early signs of strategic alignment including financial forecasts and delivery milestones.	The organisation has developed an approvable, outcomes-focused IMTP that reflects strategic priorities, enabling plans and clinical service plans. A robust 3-year sustainable financial plan is included, with clear links to service transformation (with milestones and timelines) with clearly articulated risks and mitigations.	The organisation has a history of submitting high quality IMTP's that are strategically integrated and includes a comprehensive delivery and assurance framework. It demonstrates alignment across all enabling strategies and is informed by detailed modelling, population health intelligence, and with significant stakeholder input.	The organisation is recognised for excellence in IMTP delivery and assurance and has a long history of developing and submitting high quality IMTP's which surpass policy expectations and is recognised as a system-leading exemplar. It is co-produced and informed by detailed analysis and predictive tools to drive transformation across the health system, delivers the quadruple aim.
Monitoring and Delivery	Monitoring of annual plan or IMTP delivery is ad hoc and reactive and focused on immediate operational issues. There is limited visibility of progress, and	The organisation has a structured approach to monitoring annual plan or IMTP delivery with ownership of delivery emerging across services.	Monitoring of IMTP delivery is consistently seen as business as usual and integrated with performance	IMTP delivery is monitored through a robust, outcome-focused framework which includes impact evaluation. The organisation adapts delivery plans based on	IMTP monitoring and delivery are embedded in real-time, system-wide performance and governance structures. The organisation demonstrates strategic leadership in delivery assurance, advanced triangulation, using predictive analytics, scenario planning, and co-

	reporting is inconsistent. Accountability is unclear and delivery risks are not systematically managed.	Key milestones and actions are tracked, and reporting mechanisms are in place through basic dashboards and reported to the Board regularly. Accountability is improving, but integration with performance and risk management is limited.	management reviews and risk assurance processes. Progress is tracked against outcomes, and corrective actions are taken. Delivery is supported by enabling functions and aligned with strategic priorities. Delivery is starting to inform future planning.	performance insights, emerging risks, and system pressures. Staff are engaged in owning and delivering IMTP priorities.	produced improvement plans. Delivery is continuously optimised to achieve the quadruple aim. Continuous improvement cycles are embedded, with clear evidence of impact and the

Organisation Name

Strategy and Planning Maturity Self-Assessment

November 2025

Domain	Self-Assessment
Strategy Development/Clarity of Purpose, Vision and Strategy	
Strategy Alignment and Development of an IMTP	
Dynamic & Engaged Planning	
Operational Planning	
Best Practice Approach to Improvement	
Realistic & Deliverable	

Strategy Development/Clarity of Purpose, Vision and Strategy

A) Strategy Development/Clarity of Purpose, Vision and Strategy

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy & Plan	No CSS or delivery plan in place but strategic framework for its development in development.	Draft CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP. Implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously reviewed and refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.
Vision & Purpose	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board discussion takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and All-Level partnership priorities	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WBFG Act and AHW are apparent and embedded in the agreed approach.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WBFG Act and AHW principles and integrated throughout.	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with clear links to the Regional Partnership Board and Public Service Boards.	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPB's and PSB's are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the wider local economy, improved health and well-being and operational effectiveness.

Key Enablers	Key enablers—such as quality, safety, workforce, finance, digital technology, and research—are identified but not yet aligned to strategic planning. Their role in enabling delivery is recognised but not actively managed or coordinated.	Key enablers are identified, with plans underway to align them with the organisations overarching CSS. Quality expectations are defined, and initial steps taken to coordinate enabler contributions across programmes.	Key enablers are fully aligned with strategic objectives. Their potential is well understood and actively explored to support delivery. Quality expectations are clearly defined and embedded in planning processes, with enablers contributing to strategic coherence.	Key enablers underpin the development and delivery of the CSS and CSP. Opportunities linked to enablers are translated into actionable deliverables. Quality is integrated throughout the key enabling strategies and plans driving performance and improvement.	Key enablers are embedded across all strategic functions and are delivering measurable improvements and are considered best practice. Their impact is tracked through performance metrics, and they are continuously optimised to support innovation, agility, and system-wide transformation. Quality is not only integrated but drives strategic refinement and outcome achievement.
Engagement in Development	The duties of the Health and Social Care (Quality and Engagement) (Wales) Act (the Act) are identified as integral to the development and implementation of the CSS.	Engagement plans are in place to support the development of CSS.	Engagement plans are agreed and reflect strong clinical leadership. Plans meet the requirements of the Act	Plans are being implemented effectively with robust processes in place to capture diverse voices (internal and external) with strong clinical leadership, and where appropriate and necessary, offers opportunities for stakeholder involvement in shaping the development of CSS.	Organisation operates best practice and continuous engagement with both internal and external stakeholders, exemplifying the values seen in the quality and engagement act, ensuring voices from all communities are heard and reflected in the annual review of the CSS.
Population Health Needs Assessment	Plans are in place to undertake a population health needs assessment.	A basic high level population health needs assessment has taken place and is being used to shape the CSS.	CSS and CSP development is informed by population and health needs assessments and incorporates the wider determinants of health.	There is a single, detailed and regularly updated population health needs assessment in place. Strategies are updated regularly to clearly reflect the outcome of the assessment.	Population health needs assessment is recognised as best practice and is recognised and used by partner organisations (such as PSB and RPB) to form a common and shared understanding. CSS/CSP is regularly tested against current, emerging, and future population health needs.
Priorities & Achievability	The organisation does not have a prioritisation methodology or a recorded list of priorities. Planning is reactive and lacks strategic direction.	The organisation has an approved prioritisation framework related to population health needs assessment and has basic understanding of its priorities but is not yet reflected in plans. health needs.	A prioritisation framework is fully implemented. Priorities are recorded and aligned to population health needs assessments and Cabinet Secretary expectations. Early progress is made to reflect priorities in plans,	The organisation has a published, best-practice prioritisation methodology. It is fully aligned to population health needs and Cabinet Secretary expectations. Prioritised services are proactively reviewed and updated, with robust	Prioritisation is embedded across all planning and decision-making processes. The methodology is sector-leading based on the outcome of the population health needs assessment and Cabinet Secretary's expectations. It is co-produced with stakeholders, and continuously refined through evidence, evaluation, and engagement. Priorities are transparently linked to outcomes, resource

			with initial monitoring arrangements in place.	monitoring and governance of decisions embedded in planning cycles.	allocation, and national policy, with real-time monitoring and adaptive planning in place.
Horizon Scanning	Horizon scanning is infrequent and informal, with no structured process or discussion at Executive or Board level. Strategic planning is reactive, lacking foresight into emerging risks, trends, or opportunities.	Annual horizon scanning is conducted to identify key risks and opportunities. Findings begin to inform strategic thinking, but integration into planning and governance remains limited.	Horizon scanning is carried out regularly and used to test and validate strategic plans against future trends and risks. Insights are reviewed annually and inform planning cycles, with growing Board-level engagement.	Horizon scanning is embedded into strategic planning and governance processes. Findings are discussed at Board level annually, and strategies are actively validated and adjusted based on emerging insights. The organisation uses structured methods to anticipate change and mitigate risk.	Horizon scanning is systematic, forward-looking, and published. It informs biannual Board-level strategic discussions and enables flexible, data-driven adjustments to CSS. Insights are used to anticipate future scenarios, align with system-wide priorities, and ensure the organisation remains agile, resilient, and future-ready.

A) Strategy Development/Clarity of Purpose, Vision and Strategy Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Strategy & Plan			
Vision & Purpose			
Alignment of National Policy and All-Level partnership priorities			
Key Enablers			
Engagement in Development			
Population Health Needs Assessment			
Priorities & Achievability			
Horizon Scanning			
Overall Judged Score			

Strategy Development/Clarity of Purpose, Vision and Strategy Actions						
Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Strategy & Plan						
Vision & Purpose						
Alignment of National Policy and All-Level partnership priorities						
Key Enablers						
Engagement in Development						
Population Health Needs Assessment						
Priorities & Achievability						
Horizon Scanning						

Strategy and Plan Alignment, and Development of IMTP

B)Strategy and Plan Alignment, and Development of IMTP

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
IMTP Development	Organisation has an annual plan which responds to some but not all elements of planning framework and cannot provide a financially balanced plan over 3 years.	Organisation has an approved IMTP that aligns with the core elements of the planning framework. The plan demonstrates a structured approach to strategic priorities and is informed by baseline data. It includes initial consideration of risks, outcomes, and resource requirements.	IMTP meets almost all policy expectations and is tailored to deliver clear service transformation aligned with an agreed CSP and reflects a shift from operational delivery to strategic impact. Growing maturity in linking planning to measurable impact, return on investment, and strategic priorities. Risks are clearly identified, with evidence of controls and early mitigation strategies.	The IMTP meets all policy expectations and is consistently delivering against the quadruple aim and is embedded across the organisation and transforming services through the CSP. Risks across quality, access, workforce, and finance are actively managed with evidence of controls and mitigation and demonstrates clear alignment between planning, performance, and transformation.	The IMTP exceeds all national policy expectations. It is recognised as a benchmark for excellence, driving system-wide transformation and delivering sustained impact across the quadruple aim. The plan is co-produced, future-focused, and underpinned by robust evidence, innovation, and adaptive governance. It demonstrates clear and advanced triangulation, delivery timelines and milestones, and integrated risks and mitigation.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	Some alignment is visible between the annual plan and CSS with the organisation planning on a continuous annual cycle.	Alignment is clear and coherent between the IMTP and CSS with the organisation planning on a continuous annual cycle.	The IMTP is tailored to deliver clear service transformation in line with an agreed Clinical Services Plan. Plans are directly linked to quality, performance and accountability and informed by detailed and future facing modelling.	Coherent aligned plans, including a commissioning plan are performance managed, with staff owning, adapting, acting on and learning from variation.	Planning is owned by all staff and fully integrated and aligned across organisational tiers and system partners. There is a clear golden thread between local, national and regional strategies and partnerships with dynamic alignment to the CSS and Plan, IMTP, commissioning intentions, resulting from horizon scanning results, detailed population health needs assessment and enabling strategies (e.g. workforce, digital, estates).
Triangulation of Services	Basic high-level triangulation is taking place between services, activity, workforce and finance.	Clear triangulation between services, activity workforce and finance.	Detailed triangulation between services, activity workforce and finance at service level.	Clear detailed and robust triangulation and analysis of activity, workforce and finance which considers other holistic requirements such as	Triangulation is system-wide, predictive, and continuously refined through real-time data and advanced analytics. It informs strategic decision-making, resource optimisation, and service redesign across organisational boundaries. The organisation demonstrates a proactive approach

				training and working regionally.	to managing interdependencies, future workforce needs, financial sustainability, and service demand, with clear links to population health, regional collaboration, and innovation.
Commissioning	The Board sets out high level commissioning intentions primarily focused on statutory requirements and broad service categories. Commissioning is reactive, with limited strategic alignment or stakeholder engagement.	The organisation has an approved and operational commissioning process. Intentions begin to reflect service priorities and are informed by basic population health data and stakeholder input.	Commissioning decisions are prioritised based on service need, population health data, and performance metrics. The impact of commissioned and supporting organisations is actively considered.	The organisation has a clear, transparent commissioning plan that includes a transparent prioritisation framework and actions for both commissioning and decommissioning ensuring risk to patients are minimised. Decisions are evidence-based, responsive to changing needs and communicated effectively to stakeholders.	Commissioning is strategically embedded across the organisation and system, with clear alignment to the population health needs assessment, clinical priorities, and service transformation goals. The process is co-produced with stakeholders with a clear and transparent prioritisation framework, underpinned by robust evidence, and includes pro-active decommissioning where appropriate with detailed communication strategies. Commissioning decisions are transparent, equitable, and continuously evaluated for impact on quality, access, and outcomes.

Strategy and Plan Alignment, and Development of IMTP Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
IMTP Development			
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan			
Triangulation of Services			
Commissioning			
Overall Judged Score			

Strategy and Plan Alignment, and Development of IMTP Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
IMTP Development						
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan						
Triangulation of Services						
Commissioning						

Dynamic and Engaged Planning

C) Dynamic and Engaged Planning

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Stakeholder Engagement	Staff and partners are aware of CSS/CSP and there is a public commitment in place to undertake stakeholder engagement.	Organisational engagement is evident in practice and reflected in the CSS/CSP. Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	Stakeholders are engaged in and co-design priority setting using the 'engagement cycle' model and a person-centred approach. Staff engagement at an organisation level is increasing.	Full and proactive continuous engagement including diverse communities which informs, owns and tests all impact assessments. Feedback from engagement activities influences and challenges the plan. Planning is also embedded and co-ordinated throughout the organisation.	Internal continuous engagement sees a fully engaged and informed workforce who are able to co-produce. Feedback and learning from continuous engagement activities including protected characteristic groups and socio-economic disadvantaged groups informs local priority setting and the development of the CSS/CSP.
Service Delivery Risk and Issue Management Approach	Organisation has a service risk management approach in place, but it has not been fully adopted across all areas.	Organisation has service risk management approach embedded across all areas of the organisation and has robust plans in place to address / mitigate risks	A risk management approach is evident and consistent across organisation. The organisation stop fragile services are identified.	The risk management approach enables the early identification of fragile or soon to be fragile services allowing for early intervention to ensure service sustainability. Organisation sees less urgent service changes.	Potential fragile services identified early and robust risk management across organisation pre-emptively responding to emerging service risks and the organisation is able to flexibly adjust plan. The Board are informed and regularly updated on fragile services and organisation rarely sees urgent service changes.
Service Model / Regional Design	Organisation has no route, or route is ineffective to discuss potential opportunities or joint risks. Regional collaboration is minimal, ad hoc, and lacks strategic intent.	Strengthened partnership working arrangements are in place. A methodology for working together is developed, with early efforts to align priorities and build trust.	Opportunities for regional working and shared solutions are identified and developed collaboratively. Planning is increasingly aligned across organisations, with joint priorities and resource sharing.	Agreed proposals for robust regional service models (e.g. consolidation, shared services) are in place and delivery is underway. Governance structures support joint accountability and performance management.	Regional collaboration is fully embedded, strategically led, and continuously evolving. The organisation is a proactive system leader, driving the development, implementation, and optimisation of shared service models and regional solutions. Collaboration is underpinned by co-produced strategies, shared governance, and dynamic intelligence. The organisation anticipates future needs, fosters innovation, and delivers measurable improvements in equity, efficiency, and outcomes across the region.

Dynamic and Engaged Planning Self-Assessment			
Domain	Assessed level	Evidence Used	Any Supporting Narrative
Stakeholder Engagement			
Service Delivery Risk and Issue Management Approach			
Service Model / Regional Design			
Overall Judged Score			

Dynamic and Engaged Planning Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Stakeholder Engagement						
Service Delivery Risk and Issue Management Approach						
Service Model / Regional Design						

Operational Planning

D)Operational Planning

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Demand & Capacity Modelling	Basic demand and capacity work is undertaken and contains an appropriate level of detail to support service delivery	Demand and capacity planning undertaken at speciality level to support the design of current and future services. Data is more structured and used to inform service-level decisions	Robust and profiled projections of demand and capacity are used to inform the development of individual service plans, the Clinical Services Plan, and the IMTP. Planning is increasingly data-driven and cross-functional.	The organisation uses detailed and advanced modelling capability to support strategic planning. Demand and capacity modelling is embedded in the IMTP and informs transformation, workforce, and financial planning. Predictive analytics and AI tools support long-term planning.	Demand and capacity modelling including modelling projections is at the core of planning processes across the organisation. Predictive analytics and AI tools support long-term planning. Modelling triangulates resources, staff, finance and activity. It is able to undertake modelling at all levels of prevention and illustrates scenarios for improvement for the IMTP.
Clinical Leadership & Input	Clinical leads are identified and their roles are defined. Engagement is limited to basic consultation or information sharing	Clinical leads begin to inform service planning and contribute to performance improvement discussions. Their input is considered but not yet central.	Clinical leads are embedded early in the planning cycle to ensure that service design is clinically credible and patient-centred. Clinical leads co-produce plans and provide leadership in development processes. Their involvement is structured and increasingly strategic.	Clinical leadership is embedded in operational planning. Clinical teams actively shape service direction in alignment contributing to future direction services in line with clinical services plan.	Clinical leadership sits at the heart of planning and performance with a strong focus on quality and improvement. Clinical leaders co-produce plans and drive the future direction of plans through developing a culture of quality, innovation, and continuous improvement, fostering deep engagement and ownership across clinical teams.
Planning Process	Organisation has basic operational plans and planning process in place.	Operational plans are regularly reviewed and remedial action undertaken.	Operational plans have robust triangulation and modelling of plans based on a clear and consistent approach to demand and capacity modelling across the organisation	Coherent aligned and triangulated plans with clear links to CSS and CSP, including, with staff owning, adapting, acting on and learning from variation and inequity.	Operational plans are fully aligned and integrated into the development of IMTP and CSP. Staff own the process and act on opportunities and learning to improve holistic service provision and patient experience.

Operational Planning Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Demand & Capacity Modelling			
Clinical Leadership & Input			
Planning Process			
Overall Judged Score			

Operational Planning Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Demand & Capacity Modelling						
Clinical Leadership & Input						
Planning Process						

E) Best Practice Approach to Improvement

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Engagement	Engagement is minimal and reactive. Feedback is collected from patients and staff, but there is no structured approach to measuring the effectiveness of engagement activities or approach. Insights are rarely used to inform decision-making.	The organisation has a visible commitment to best practice, supported by training and an improvement strategy. Engagement with national programmes is active, and structured methods for collecting feedback and measuring impact are in place, though not yet fully embedded.	Organisation is developing an engagement strategy/plan and is proactive in identifying and learning from best practice in engagement to ensure voices are captured from all stakeholders especially clinical, minority and diverse voices.	Engagement is embedded across all organisational activities—planned and unplanned. The engagement strategy ensures robust inclusion of diverse and clinical voices, supported by strong data collection and analysis. Feedback directly informs action, driving continuous improvement.	Stakeholder engagement is transformational—co-designed and co-led by patients, staff, and communities. Real-time feedback tools enable adaptive responses, while inclusive practices ensure diverse voices shape decisions. The organisation is nationally recognised for its leadership in engagement, with a clear link between stakeholder input and measurable improvements
Benchmarking	Organisation is beginning to explore value-based healthcare principles, but planning remains reactive and output-focused. Benchmarking is ad hoc, with limited structure or consistency. There is minimal understanding of how comparative data can drive improvement, and benchmarking is not yet linked to strategic goals.	Value-based planning is gaining traction, and regular benchmarking is conducted with other NHS organisations. The organisation begins to use structured benchmarking methods to identify best practice, though application is inconsistent. Staff awareness is growing, and benchmarking is starting to inform service reviews and improvement discussions.	Benchmarking processes are formalised, consistently applied, and span across Wales and the UK. The organisation uses comparative data to identify performance gaps and inform strategic planning. Benchmarking is aligned with value-based healthcare principles, and results are used to prioritise improvement initiatives. Staff are engaged in interpreting data and applying insights to their areas.	Benchmarking is fully integrated into planning and performance cycles. Staff across the organisation actively lead benchmarking and improvement initiatives, using data to drive decisions and measure impact. There is a strong culture of ownership and continuous learning. Benchmarking includes qualitative and quantitative measures, peer comparisons, and outcome-focused metrics aligned with patient value. Insights are shared across teams and used to scale best practice.	Demonstrates full integration of benchmarking and value-based planning across strategic, operational, and clinical areas. Advanced analytics, including predictive and real-time data, drive proactive improvements and innovation. Recognised as a leader in the NHS, the organisation shapes best practice while fostering a culture where staff lead continuous improvement and scalable innovation.
Governance	Governance arrangements are informal, fragmented, or unclear. Oversight of IMTP development is minimal, with limited	A governance structure has been established to provide direction and oversight for IMTP	A formal governance and accountability framework is in place for IMTP development and	Governance is embedded across the organisation, with a mature CSS and oversight mechanisms that are	Governance is fully integrated, agile, and strategically aligned across all levels. Oversight of the IMTP, CSS and CSP is co-produced with clinical leaders and stakeholders, supported by

	accountability, transparency, or alignment to strategic priorities. There is no structured process for risk management, stakeholder involvement, or performance monitoring.	development. Roles and responsibilities are defined, and basic reporting mechanisms are in place. There is growing awareness of the need for structured governance, but integration with programme-level planning and delivery is still emerging.	monitoring at programme level. IMTP and CSS/CSP governance is aligned with strategic objectives, includes defined escalation routes, and supports performance tracking. IMTP Governance is periodically tested for improvements.	reviewed annually for relevance and effectiveness. IMTP and CSS/CSP governance structures support cross-functional collaboration, robust data use, and continuous improvement. Governance is constantly and pro-actively tested for improvements.	real-time data, predictive analytics, and dynamic risk intelligence. IMTP/CSS/CSP governance structures are benchmarked against national best practice, continuously refined, and used to drive innovation, accountability, and system-wide impact. Decision-making is transparent, inclusive, and outcome-focused.

Best Practice Approach to Improvement Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Engagement			
Benchmarking			
Governance			
Overall Judged Score			

Best Practice Approach to Improvement Actions						
Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Engagement						
Benchmarking						
Governance						

Realistic & Deliverable

F) Realistic & Deliverable

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Risk Identification & Management	Risk identification and management are inconsistent and reactive. Risks to IMTP delivery are not systematically captured or monitored. There is limited ownership or visibility of delivery risks.	A formal risk management process exists and is applied to IMTP delivery at a high level. Risks are identified at the planning stage and tracked through basic registers and reviewed periodically. Ownership is clearer, but integration with delivery assurance is limited. Escalation processes in place but not always followed.	Risk identification and management are embedded in IMTP development and delivery processes. Risks are identified early and linked to specific objectives, milestones, and outcomes. Controls are monitored, and mitigation actions are tracked. Risk registers are dynamic and inform delivery with clear ownership.	Risk management is proactive, strategic, and forward-looking with an agreed and clear risk appetite. Risks are anticipated and identified through horizon scanning, sensitivity analysis and scenario planning. The organisation adapts delivery plans in response to emerging risks with regular reviews. Lessons learnt informs future IMTP cycles.	Risk management is fully embedded across the organisation and system partners and is triangulated across workforce, finance, digital and clinical lenses. It is predictive, real-time, and continuously informs IMTP delivery through live dashboards and predictive analysis. The organisation leads in using risk intelligence to drive improvement, resilience, and transformation. The organisation operates continuous learning and is recognised for excellence in risk-informed delivery assurance.
Development of IMTP and track record	The organisation has a track record of submitting annual plans that do not meet the requirements of the planning framework, Cabinet Secretary expectations or provide a financially balanced plan over 3 years. Planning is largely operational and short-term, with limited strategic integration and has limited clinical or financial planning alignment and limited stakeholder engagement.	The organisation consistently develops robust annual plans that build assurance as a key step toward an approvable IMTP. Plans begin to reflect medium term priorities, include a finance and delivery framework, and show early signs of strategic alignment including financial forecasts and delivery milestones.	The organisation has developed an approvable, outcomes-focused IMTP that reflects strategic priorities, enabling plans and clinical service plans. A robust 3-year sustainable financial plan is included, with clear links to service transformation (with milestones and timelines) with clearly articulated risks and mitigations.	The organisation has a history of submitting high quality IMTP's that are strategically integrated and includes a comprehensive delivery and assurance framework. It demonstrates alignment across all enabling strategies and is informed by detailed modelling, population health intelligence, and with significant stakeholder input.	The organisation is recognised for excellence in IMTP delivery and assurance and has a long history of developing and submitting high quality IMTP's which surpass policy expectations and is recognised as a system-leading exemplar. It is co-produced and informed by detailed analysis and predictive tools to drive transformation across the health system, delivers the quadruple aim.
Monitoring and Delivery	Monitoring of annual plan or IMTP delivery is ad hoc and reactive and focused on immediate operational issues. There is limited visibility of progress, and reporting is inconsistent.	The organisation has a structured approach to monitoring annual plan or IMTP delivery with ownership of delivery emerging across services.	Monitoring of IMTP delivery is consistently seen as business as usual and integrated with performance management reviews and	IMTP delivery is monitored through a robust, outcome-focused framework which includes impact evaluation. The organisation adapts delivery plans based on	IMTP monitoring and delivery are embedded in real-time, system-wide performance and governance structures. The organisation demonstrates strategic leadership in delivery assurance, advanced triangulation, using predictive analytics, scenario planning, and co-

	Accountability is unclear and delivery risks are not systematically managed.	Key milestones and actions are tracked, and reporting mechanisms are in place through basic dashboards and reported to the Board regularly. Accountability is improving, but integration with performance and risk management is limited.	risk assurance processes. Progress is tracked against outcomes, and corrective actions are taken. Delivery is supported by enabling functions and aligned with strategic priorities. Delivery is starting to inform future planning.	performance insights, emerging risks, and system pressures. Staff are engaged in owning and delivering IMTP priorities.	produced improvement plans. Delivery is continuously optimised to achieve the quadruple aim. Continuous improvement cycles are embedded, with clear evidence of impact and the

Realistic & Deliverable Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Risk Identification & Management			
Development of IMTP and track record			
Monitoring and Delivery			
Overall Judged Score			

Realistic & Deliverable Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Risk Identification & Management						
Development of IMTP and track record						
Monitoring and Delivery						



Llywodraeth Cymru
Welsh Government

NHS Wales

Strategy and Planning Maturity Matrix

The NHS Wales Planning Maturity Matrix has been reviewed and updated in September 2025. The Matrix contains 6 domains and as listed below. Within each domain, themes have been created from the elements within the previous matrix. These themes have been made progressive and are progressed through the 5 levels of maturity.

The 6 Domains and their descriptors are:

Domain	Description
A) Strategy Development/Clarity of Purpose, Vision and Strategy	• Evidence of a clear purpose, vision and strategy for the organisation. • Responds to national, regional, local and partnership priorities, and the wider determinants of health. • Translates national policies into local strategy, planning, and delivery.
B) Strategy Alignment and Development of an IMTP	• Evidence of alignment of strategy with components of the plan.
C) Dynamic and Engaged Planning	• Reflecting a dynamic, engaged and ongoing approach to planning. Process is positively influencing outcomes. • Organisation identifies fragile services and has plans in place to address / mitigate risks and proposals in place for more robust service models e.g. via regional solutions, consolidation of services etc.
D) Operational Planning	• Evidence of demand and capacity planning, linking to triangulation of operational plans, workforce and finance. • Embedding a culture of reducing unwarranted variation, improved performance and outcomes end evaluation of improvements
E) Best Practice Approach to Improvement	• Ambition to deliver best practice levels of equity, efficiency, effectiveness, quality and safety.
F) Realistic and Deliverable:	• Sensitivity analyses, risk assessment of deliverability, reference to track record of delivery. Sustainable and affordable.

A) Strategy Development/ Clarity of Purpose, Vision and Strategy Plan

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy & Plan	No CSS or delivery plan in place but strategic framework for its development in development.	Draft CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP. Implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.
Vision & Purpose	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board discussion takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and All-Level partnership priorities	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WBFG Act and AHW are apparent and embedded in the agreed approach.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WBFG Act and AHW principles and integrated throughout.	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with clear links to the Regional Partnership Board and Public Service Boards.	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPB's and PSB's are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the wider local economy, improved health and well-being and operational effectiveness.

Key Enablers	Key enablers—such as quality, safety, workforce, finance, digital technology, and research—are identified but not yet aligned to strategic planning. Their role in enabling delivery is recognised but not actively managed or coordinated.	Key enablers are identified, with plans underway to align them with the organisations overarching CSS. Quality expectations are defined, and initial steps taken to coordinate enabler contributions across programmes.	Key enablers are fully aligned with strategic objectives. Their potential is well understood and actively explored to support delivery. Quality expectations are clearly defined and embedded in planning processes, with enablers contributing to strategic coherence.	Key enablers underpin the development and delivery of the CSS and CSP. Opportunities linked to enablers are translated into actionable deliverables. Quality is integrated throughout the key enabling strategies and plans driving performance and improvement.	Key enablers are embedded across all strategic functions and are delivering measurable improvements and are considered best practice. Their impact is tracked through performance metrics, and they are continuously optimised to support innovation, agility, and system-wide transformation. Quality is not only integrated but drives strategic refinement and outcome achievement.
Engagement in Development	The duties of the Health and Social Care (Quality and Engagement) (Wales) Act (the Act) are identified as integral to the development and implementation of the CSS.	Engagement plans are in place to support the development of CSS.	Engagement plans are agreed and reflect strong clinical leadership. Plans meet the requirements of the Act	Plans are being implemented effectively with robust processes in place to capture diverse voices (internal and external) with strong clinical leadership, and where appropriate and necessary, offers opportunities for stakeholder involvement in shaping the development of CSS.	Organisation operates best practice and continuous engagement with both internal and external stakeholders, exemplifying the values seen in the quality and engagement act, ensuring voices from all communities are heard and reflected in the annual review of the CSS.
Population Health Needs Assessment	Plans are in place to undertake a population health needs assessment.	A basic high level population health needs assessment has taken place and is being used to shape the CSS.	CSS and CSP development is informed by population and health needs assessments and incorporates the wider determinants of health.	There is a single, detailed and regularly updated population health needs assessment in place. Strategies are updated regularly to clearly reflect the outcome of the assessment.	Population health needs assessment is recognised as best practice and is recognised and used by partner organisations (such as PSB and RPB) to form a common and shared understanding. CSS/CSP is regularly tested against current, emerging, and future population health needs.
Priorities & Achievability	The organisation does not have a prioritisation methodology or a recorded list of priorities. Planning is reactive and lacks strategic direction.	The organisation has an approved prioritisation framework related to population health needs assessment and has basic understanding of its priorities but is not yet reflected in plans. health needs.	A prioritisation framework is fully implemented. Priorities are recorded and aligned to population health needs assessments and Cabinet Secretary expectations. Early progress is made to reflect priorities in plans,	The organisation has a published, best-practice prioritisation methodology. It is fully aligned to population health needs and Cabinet Secretary expectations. Prioritised services are proactively reviewed and updated, with robust	Prioritisation is embedded across all planning and decision-making processes. The methodology is sector-leading based on the outcome of the population health needs assessment and Cabinet Secretary's expectations. It is co-produced with stakeholders, and continuously refined through evidence, evaluation, and engagement. Priorities are transparently linked to outcomes, resource

			with initial monitoring arrangements in place.	monitoring and governance of decisions embedded in planning cycles.	allocation, and national policy, with real-time monitoring and adaptive planning in place.
Horizon Scanning	Horizon scanning is infrequent and informal, with no structured process or discussion at Executive or Board level. Strategic planning is reactive, lacking foresight into emerging risks, trends, or opportunities.	Annual horizon scanning is conducted to identify key risks and opportunities. Findings begin to inform strategic thinking, but integration into planning and governance remains limited.	Horizon scanning is carried out regularly and used to test and validate strategic plans against future trends and risks. Insights are reviewed annually and inform planning cycles, with growing Board-level engagement.	Horizon scanning is embedded into strategic planning and governance processes. Findings are discussed at Board level annually, and strategies are actively validated and adjusted based on emerging insights. The organisation uses structured methods to anticipate change and mitigate risk.	Horizon scanning is systematic, forward-looking, and published. It informs biannual Board-level strategic discussions and enables flexible, data-driven adjustments to CSS. Insights are used to anticipate future scenarios, align with system-wide priorities, and ensure the organisation remains agile, resilient, and future-ready.

B) Strategy Alignment and Development of an IMTP

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
IMTP Development	Organisation has an annual plan which responds to some but not all elements of planning framework and cannot provide a financially balanced plan over 3 years.	Organisation has an approved IMTP that aligns with the core elements of the planning framework. The plan demonstrates a structured approach to strategic priorities and is informed by baseline data. It includes initial consideration of risks, outcomes, and resource requirements.	IMTP meets almost all policy expectations and is tailored to deliver clear service transformation aligned with an agreed CSP and reflects a shift from operational delivery to strategic impact. Growing maturity in linking planning to measurable impact, return on investment, and strategic priorities. Risks are clearly identified, with evidence of controls and early mitigation strategies.	The IMTP meets all policy expectations and is consistently delivering against the quadruple aim and is embedded across the organisation and transforming services through the CSP. Risks across quality, access, workforce, and finance are actively managed with evidence of controls and mitigation and demonstrates clear alignment between planning, performance, and transformation.	The IMTP exceeds all national policy expectations. It is recognised as a benchmark for excellence, driving system-wide transformation and delivering sustained impact across the quadruple aim. The plan is co-produced, future-focused, and underpinned by robust evidence, innovation, and adaptive governance. It demonstrates clear and advanced triangulation, delivery timelines and milestones, and integrated risks and mitigation.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	Some alignment is visible between the annual plan and CSS with the organisation planning on a continuous annual cycle.	Alignment is clear and coherent between the IMTP and CSS with the organisation planning on a continuous annual cycle.	The IMTP is tailored to deliver clear service transformation in line with an agreed Clinical Services Plan. Plans are directly linked to quality, performance and accountability and informed by detailed and future facing modelling.	Coherent aligned plans, including a commissioning plan are performance managed, with staff owning, adapting, acting on and learning from variation.	Planning is owned by all staff and fully integrated and aligned across organisational tiers and system partners. There is a clear golden thread between local, national and regional strategies and partnerships with dynamic alignment to the CSS and Plan, IMTP, commissioning intentions, resulting from horizon scanning results, detailed population health needs assessment and enabling strategies (e.g. workforce, digital, estates).
Triangulation of Services	Basic high-level triangulation is taking place between services, activity, workforce and finance.	Clear triangulation between services, activity workforce and finance.	Detailed triangulation between services, activity workforce and finance at service level.	Clear detailed and robust triangulation and analysis of activity, workforce and finance which considers other holistic requirements such as	Triangulation is system-wide, predictive, and continuously refined through real-time data and advanced analytics. It informs strategic decision-making, resource optimisation, and service redesign across organisational boundaries. The organisation demonstrates a proactive approach

				training and working regionally.	to managing interdependencies, future workforce needs, financial sustainability, and service demand, with clear links to population health, regional collaboration, and innovation.
Commissioning	The Board sets out high level commissioning intentions primarily focused on statutory requirements and broad service categories. Commissioning is reactive, with limited strategic alignment or stakeholder engagement.	The organisation has an approved and operational commissioning process. Intentions begin to reflect service priorities and are informed by basic population health data and stakeholder input.	Commissioning decisions are prioritised based on service need, population health data, and performance metrics. The impact of commissioned and supporting organisations is actively considered.	The organisation has a clear, transparent commissioning plan that includes a transparent prioritisation framework and actions for both commissioning and decommissioning ensuring risk to patients are minimised. Decisions are evidence-based, responsive to changing needs and communicated effectively to stakeholders.	Commissioning is strategically embedded across the organisation and system, with clear alignment to the population health needs assessment, clinical priorities, and service transformation goals. The process is co-produced with stakeholders with a clear and transparent prioritisation framework, underpinned by robust evidence, and includes pro-active decommissioning where appropriate with detailed communication strategies. Commissioning decisions are transparent, equitable, and continuously evaluated for impact on quality, access, and outcomes.

C) Dynamic and Engaged Planning

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Stakeholder Engagement	Staff and partners are aware of CSS/CSP and there is a public commitment in place to undertake stakeholder engagement.	Organisational engagement is evident in practice and reflected in the CSS/CSP. Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	Stakeholders are engaged in and co-design priority setting using the 'engagement cycle' model and a person-centred approach. Staff engagement at an organisation level is increasing.	Full and proactive continuous engagement including diverse communities which informs, owns and tests all impact assessments. Feedback from engagement activities influences and challenges the plan. Planning is also embedded and co-ordinated throughout the organisation.	Internal continuous engagement sees a fully engaged and informed workforce who are able to co-produce. Feedback and learning from continuous engagement activities including protected characteristic groups and socio-economic disadvantaged groups informs local priority setting and the development of the CSS/CSP.
Service Delivery Risk and Issue Management Approach	Organisation has a service risk management approach in place, but it has not been fully adopted across all areas.	Organisation has service risk management approach embedded across all areas of the organisation and has robust plans in place to address / mitigate risks	A risk management approach is evident and consistent across organisation. The organisation stop fragile services are identified.	The risk management approach enables the early identification of fragile or soon to be fragile services allowing for early intervention to ensure service sustainability. Organisation sees less urgent service changes.	Potential fragile services identified early and robust risk management across organisation pre-emptively responding to emerging service risks and the organisation is able to flexibly adjust plan. The Board are informed and regularly updated on fragile services and organisation rarely sees urgent service changes.
Service Model / Regional Design	Organisation has no route, or route is ineffective to discuss potential opportunities or joint risks. Regional collaboration is minimal, ad hoc, and lacks strategic intent.	Strengthened partnership working arrangements are in place. A methodology for working together is developed, with early efforts to align priorities and build trust.	Opportunities for regional working and shared solutions are identified and developed collaboratively. Planning is increasingly aligned across organisations, with joint priorities and resource sharing.	Agreed proposals for robust regional service models (e.g. consolidation, shared services) are in place and delivery is underway. Governance structures support joint accountability and performance management.	Regional collaboration is fully embedded, strategically led, and continuously evolving. The organisation is a proactive system leader, driving the development, implementation, and optimisation of shared service models and regional solutions. Collaboration is underpinned by co-produced strategies, shared governance, and dynamic intelligence. The organisation anticipates future needs, fosters innovation, and delivers measurable improvements in equity, efficiency, and outcomes across the region.

D)Operational Planning

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Demand & Capacity Modelling	Basic demand and capacity work is undertaken and contains an appropriate level of detail to support service delivery	Demand and capacity planning undertaken at speciality level to support the design of current and future services. Data is more structured and used to inform service-level decisions	Robust and profiled projections of demand and capacity are used to inform the development of individual service plans, the Clinical Services Plan, and the IMTP. Planning is increasingly data-driven and cross-functional.	The organisation uses detailed and advanced modelling capability to support strategic planning. Demand and capacity modelling is embedded in the IMTP and informs transformation, workforce, and financial planning. Predictive analytics and AI tools support long-term planning.	Demand and capacity modelling including modelling projections is at the core of planning processes across the organisation. Predictive analytics and AI tools support long-term planning. Modelling triangulates resources, staff, finance and activity. It is able to undertake modelling at all levels of prevention and illustrates scenarios for improvement for the IMTP.
Clinical Leadership & Input	Clinical leads are identified and their roles are defined. Engagement is limited to basic consultation or information sharing	Clinical leads begin to inform service planning and contribute to performance improvement discussions. Their input is considered but not yet central.	Clinical leads are embedded early in the planning cycle to ensure that service design is clinically credible and patient-centred. Clinical leads co-produce plans and provide leadership in development processes. Their involvement is structured and increasingly strategic.	Clinical leadership is embedded in operational planning. Clinical teams actively shape service direction in alignment contributing to future direction services in line with clinical services plan.	Clinical leadership sits at the heart of planning and performance with a strong focus on quality and improvement. Clinical leaders co-produce plans and drive the future direction of plans through developing a culture of quality, innovation, and continuous improvement, fostering deep engagement and ownership across clinical teams.
Planning Process	Organisation has basic operational plans and planning process in place.	Operational plans are regularly reviewed and remedial action undertaken.	Operational plans have robust triangulation and modelling of plans based on a clear and consistent approach to demand and capacity modelling across the organisation	Coherent aligned and triangulated plans with clear links to CSS and CSP, including, with staff owning, adapting, acting on and learning from variation and inequity.	Operational plans are fully aligned and integrated into the development of IMTP and CSP. Staff own the process and act on opportunities and learning to improve holistic service provision and patient experience.

E) Best Practice Approach to Improvement

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Engagement	Engagement is minimal and reactive. Feedback is collected from patients and staff, but there is no structured approach to measuring the effectiveness of engagement activities or approach. Insights are rarely used to inform decision-making.	The organisation has a visible commitment to best practice, supported by training and an improvement strategy. Engagement with national programmes is active, and structured methods for collecting feedback and measuring impact are in place, though not yet fully embedded.	Organisation is developing an engagement strategy/plan and is proactive in identifying and learning from best practice in engagement to ensure voices are captured from all stakeholders especially clinical, minority and diverse voices.	Engagement is embedded across all organisational activities—planned and unplanned. The engagement strategy ensures robust inclusion of diverse and clinical voices, supported by strong data collection and analysis. Feedback directly informs action, driving continuous improvement.	Stakeholder engagement is transformational—co-designed and co-led by patients, staff, and communities. Real-time feedback tools enable adaptive responses, while inclusive practices ensure diverse voices shape decisions. The organisation is nationally recognised for its leadership in engagement, with a clear link between stakeholder input and measurable improvements
Benchmarking	Organisation is beginning to explore value-based healthcare principles, but planning remains reactive and output-focused. Benchmarking is ad hoc, with limited structure or consistency. There is minimal understanding of how comparative data can drive improvement, and benchmarking is not yet linked to strategic goals.	Value-based planning is gaining traction, and regular benchmarking is conducted with other NHS organisations. The organisation begins to use structured benchmarking methods to identify best practice, though application is inconsistent. Staff awareness is growing, and benchmarking is starting to inform service reviews and improvement discussions.	Benchmarking processes are formalised, consistently applied, and span across Wales and the UK. The organisation uses comparative data to identify performance gaps and inform strategic planning. Benchmarking is aligned with value-based healthcare principles, and results are used to prioritise improvement initiatives. Staff are engaged in interpreting data and applying insights to their areas.	Benchmarking is fully integrated into planning and performance cycles. Staff across the organisation actively lead benchmarking and improvement initiatives, using data to drive decisions and measure impact. There is a strong culture of ownership and continuous learning. Benchmarking includes qualitative and quantitative measures, peer comparisons, and outcome-focused metrics aligned with patient value. Insights are shared across teams and used to scale best practice.	Demonstrates full integration of benchmarking and value-based planning across strategic, operational, and clinical areas. Advanced analytics, including predictive and real-time data, drive proactive improvements and innovation. Recognised as a leader in the NHS, the organisation shapes best practice while fostering a culture where staff lead continuous improvement and scalable innovation.
Governance	Governance arrangements are informal, fragmented, or unclear. Oversight of IMTP development is minimal, with limited	A governance structure has been established to provide direction and oversight for IMTP	A formal governance and accountability framework is in place for IMTP development and	Governance is embedded across the organisation, with a mature CSS and oversight mechanisms that are	Governance is fully integrated, agile, and strategically aligned across all levels. Oversight of the IMTP, CSS and CSP is co-produced with clinical leaders and stakeholders, supported by

	accountability, transparency, or alignment to strategic priorities. There is no structured process for risk management, stakeholder involvement, or performance monitoring.	development. Roles and responsibilities are defined, and basic reporting mechanisms are in place. There is growing awareness of the need for structured governance, but integration with programme-level planning and delivery is still emerging.	monitoring at programme level. IMTP and CSS/CSP governance is aligned with strategic objectives, includes defined escalation routes, and supports performance tracking. IMTP Governance is periodically tested for improvements.	reviewed annually for relevance and effectiveness. IMTP and CSS/CSP governance structures support cross-functional collaboration, robust data use, and continuous improvement. Governance is constantly and pro-actively tested for improvements.	real-time data, predictive analytics, and dynamic risk intelligence. IMTP/CSS/CSP governance structures are benchmarked against national best practice, continuously refined, and used to drive innovation, accountability, and system-wide impact. Decision-making is transparent, inclusive, and outcome-focused.

F) Realistic & Deliverable

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Risk Identification & Management	Risk identification and management are inconsistent and reactive. Risks to IMTP delivery are not systematically captured or monitored. There is limited ownership or visibility of delivery risks.	A formal risk management process exists and is applied to IMTP delivery at a high level. Risks are identified at the planning stage and tracked through basic registers and reviewed periodically. Ownership is clearer, but integration with delivery assurance is limited. Escalation processes in place but not always followed.	Risk identification and management are embedded in IMTP development and delivery processes. Risks are identified early and linked to specific objectives, milestones, and outcomes. Controls are monitored, and mitigation actions are tracked. Risk registers are dynamic and inform delivery with clear ownership.	Risk management is proactive, strategic, and forward-looking with an agreed and clear risk appetite. Risks are anticipated and identified through horizon scanning, sensitivity analysis and scenario planning. The organisation adapts delivery plans in response to emerging risks with regular reviews. Lessons learnt informs future IMTP cycles.	Risk management is fully embedded across the organisation and system partners and is triangulated across workforce, finance, digital and clinical lenses. It is predictive, real-time, and continuously informs IMTP delivery through live dashboards and predictive analysis. The organisation leads in using risk intelligence to drive improvement, resilience, and transformation. The organisation operates continuous learning and is recognised for excellence in risk-informed delivery assurance.
Development of IMTP and track record	The organisation has a track record of submitting annual plans that do not meet the requirements of the planning framework, Cabinet Secretary expectations or provide a financially balanced plan over 3 years. Planning is largely operational and short-term, with limited strategic integration and has limited clinical or financial planning alignment and limited stakeholder engagement.	The organisation consistently develops robust annual plans that build assurance as a key step toward an approvable IMTP. Plans begin to reflect medium term priorities, include a finance and delivery framework, and show early signs of strategic alignment including financial forecasts and delivery milestones.	The organisation has developed an approvable, outcomes-focused IMTP that reflects strategic priorities, enabling plans and clinical service plans. A robust 3-year sustainable financial plan is included, with clear links to service transformation (with milestones and timelines) with clearly articulated risks and mitigations.	The organisation has a history of submitting high quality IMTP's that are strategically integrated and includes a comprehensive delivery and assurance framework. It demonstrates alignment across all enabling strategies and is informed by detailed modelling, population health intelligence, and with significant stakeholder input.	The organisation is recognised for excellence in IMTP delivery and assurance and has a long history of developing and submitting high quality IMTP's which surpass policy expectations and is recognised as a system-leading exemplar. It is co-produced and informed by detailed analysis and predictive tools to drive transformation across the health system, delivers the quadruple aim.
Monitoring and Delivery	Monitoring of annual plan or IMTP delivery is ad hoc and reactive and focused on immediate operational issues. There is limited visibility of progress, and	The organisation has a structured approach to monitoring annual plan or IMTP delivery with ownership of delivery emerging across services.	Monitoring of IMTP delivery is consistently seen as business as usual and integrated with performance	IMTP delivery is monitored through a robust, outcome-focused framework which includes impact evaluation. The organisation adapts delivery plans based on	IMTP monitoring and delivery are embedded in real-time, system-wide performance and governance structures. The organisation demonstrates strategic leadership in delivery assurance, advanced triangulation, using predictive analytics, scenario planning, and co-

	reporting is inconsistent. Accountability is unclear and delivery risks are not systematically managed.	Key milestones and actions are tracked, and reporting mechanisms are in place through basic dashboards and reported to the Board regularly. Accountability is improving, but integration with performance and risk management is limited.	management reviews and risk assurance processes. Progress is tracked against outcomes, and corrective actions are taken. Delivery is supported by enabling functions and aligned with strategic priorities. Delivery is starting to inform future planning.	performance insights, emerging risks, and system pressures. Staff are engaged in owning and delivering IMTP priorities.	produced improvement plans. Delivery is continuously optimised to achieve the quadruple aim. Continuous improvement cycles are embedded, with clear evidence of impact and the

Organisation Name

Strategy and Planning Maturity Self-Assessment

November 2025

Domain	Self-Assessment
Strategy Development/Clarity of Purpose, Vision and Strategy	3
Strategy Alignment and Development of an IMTP	2
Dynamic & Engaged Planning	3
Operational Planning	3
Best Practice Approach to Improvement	3
Realistic & Deliverable	3

Strategy Development/Clarity of Purpose, Vision and Strategy

A) Strategy Development/Clarity of Purpose, Vision and Strategy

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy & Plan	No CSS or delivery plan in place but strategic framework for its development in development.	Draft CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP. Implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously reviewed and refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.
Vision & Purpose	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board discussion takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and All-Level partnership priorities	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WBFQ Act and AHW	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPB's and PSB's are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the

		WBFG Act and AHW are apparent and embedded in the agreed approach.	principles and integrated throughout.	clear links to the Regional Partnership Board and Public Service Boards.	wider local economy, improved health and well-being and operational effectiveness.
Key Enablers	Key enablers—such as quality, safety, workforce, finance, digital technology, and research—are identified but not yet aligned to strategic planning. Their role in enabling delivery is recognised but not actively managed or coordinated.	Key enablers are identified, with plans underway to align them with the organisations overarching CSS. Quality expectations are defined, and initial steps taken to coordinate enabler contributions across programmes.	Key enablers are fully aligned with strategic objectives. Their potential is well understood and actively explored to support delivery. Quality expectations are clearly defined and embedded in planning processes, with enablers contributing to strategic coherence.	Key enablers underpin the development and delivery of the CSS and CSP. Opportunities linked to enablers are translated into actionable deliverables. Quality is integrated throughout the key enabling strategies and plans driving performance and improvement.	Key enablers are embedded across all strategic functions and are delivering measurable improvements and are considered best practice. Their impact is tracked through performance metrics, and they are continuously optimised to support innovation, agility, and system-wide transformation. Quality is not only integrated but drives strategic refinement and outcome achievement.
Engagement in Development	The duties of the Health and Social Care (Quality and Engagement) (Wales) Act (the Act) are identified as integral to the development and implementation of the CSS.	Engagement plans are in place to support the development of CSS.	Engagement plans are agreed and reflect strong clinical leadership. Plans meet the requirements of the Act	Plans are being implemented effectively with robust processes in place to capture diverse voices (internal and external) with strong clinical leadership, and where appropriate and necessary, offers opportunities for stakeholder involvement in shaping the development of CSS.	Organisation operates best practice and continuous engagement with both internal and external stakeholders, exemplifying the values seen in the quality and engagement act, ensuring voices from all communities are heard and reflected in the annual review of the CSS.
Population Health Needs Assessment	Plans are in place to undertake a population health needs assessment.	A basic high level population health needs assessment has taken place and is	CSS and CSP development is informed by population and health needs assessments and	There is a single, detailed and regularly updated population health needs assessment in place. Strategies are updated	Population health needs assessment is recognised as best practice and is recognised and used by partner organisations (such as PSB and RPB) to form a common and shared understanding.

		being used to shape the CSS.	incorporates the wider determinants of health.	regularly to clearly reflect the outcome of the assessment.	CSS/CSP is regularly tested against current, emerging, and future population health needs.
Priorities & Achievability	The organisation does not have a prioritisation methodology or a recorded list of priorities. Planning is reactive and lacks strategic direction.	The organisation has an approved prioritisation framework related to population health needs assessment and has basic understanding of its priorities but is not yet reflected in plans. health needs.	A prioritisation framework is fully implemented. Priorities are recorded and aligned to population health needs assessments and Cabinet Secretary expectations. Early progress is made to reflect priorities in plans, with initial monitoring arrangements in place.	The organisation has a published, best-practice prioritisation methodology. It is fully aligned to population health needs and Cabinet Secretary expectations. Prioritised services are proactively reviewed and updated, with robust monitoring and governance of decisions embedded in planning cycles.	Prioritisation is embedded across all planning and decision-making processes. The methodology is sector-leading based on the outcome of the population health needs assessment and Cabinet Secretary's expectations. It is co-produced with stakeholders, and continuously refined through evidence, evaluation, and engagement. Priorities are transparently linked to outcomes, resource allocation, and national policy, with real-time monitoring and adaptive planning in place.
Horizon Scanning	Horizon scanning is infrequent and informal, with no structured process or discussion at Executive or Board level. Strategic planning is reactive, lacking foresight into emerging risks, trends, or opportunities.	Annual horizon scanning is conducted to identify key risks and opportunities. Findings begin to inform strategic thinking, but integration into planning and governance remains limited.	Horizon scanning is carried out regularly and used to test and validate strategic plans against future trends and risks. Insights are reviewed annually and inform planning cycles, with growing Board-level engagement.	Horizon scanning is embedded into strategic planning and governance processes. Findings are discussed at Board level annually, and strategies are actively validated and adjusted based on emerging insights. The organisation uses structured methods to anticipate change and mitigate risk.	Horizon scanning is systematic, forward-looking, and published. It informs biannual Board-level strategic discussions and enables flexible, data-driven adjustments to CSS. Insights are used to anticipate future scenarios, align with system-wide priorities, and ensure the organisation remains agile, resilient, and future-ready.

A) Strategy Development/Clarity of Purpose, Vision and Strategy Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Strategy & Plan	3	- Organisational Strategy Gwent 35 and the Delivery and Deployment Plan - Gwent 35 Outcomes Framework - Specified actions in the Strategy Delivery and Deployment Plan include the development of an updated Clinical Services Plan - Approach approved by the Board, Executive Team, Divisions, with delivery timeline	The ABUHB ten-year Organisational Strategy Gwent 35 was approved by the Board in July 2025, followed by the endorsement of the Delivery and Deployment Plan in November 2025. Gwent 35 is supported by an outcomes framework that includes defined measurable targets. Inclusion in the Delivery Plan for years 1 and 2 is to update the Clinical Services Plan in alignment and building on the existing Clinical Futures Clinical Plan, which reviewed all clinical models during the 2018–2020 period following approval of the Full Business Case for the Grange University Hospital.
Vision & Purpose	3	- Organisational Strategy Gwent 35 and the Delivery and Deployment Plan - Gwent 35 Outcomes Framework	The Board approved the ten-year Organisational Strategy Gwent 35 in July 2025, followed by the Delivery and Deployment Plan in November 2025. The plan committed to and in depth an annual review to be presented to the Board for assurance. Gwent 35 is supported by an outcome's framework with defined measurable targets.
Alignment of National Policy and All-Level partnership priorities	4	Health Board Strategic Aims and Wellbeing Objectives	The Health Board's strategic aims, which serve as our wellbeing objectives, were set when the Board approved the Strategy in 2025. The Strategy incorporates refreshed Healthier Wales actions, and these updates were included in the horizon scanning library that supported the Strategy's development.

Key Enablers	3	• Strategy Delivery and Deployment Plan	Six keys to success have been identified in strategy development, which include: • Our People Plan • Quality Strategy • Financial Strategy • Estates Strategy • Digital Transformation Strategy • Green Health strategy with corresponding actions and requirements for these strategic plans to support the Strategy Delivery and Deployment Plan
Engagement in Development	4	• Gwent 35 Strategy • Engagement Report to PPH&P Committee January 25	The engagement programme for the development of the Strategy reached nearly 7,000 people and included an assessment and representation of the population with protected characteristics to reflect Gwent's demographics. Findings were presented in the Engagement Report. 'A conversation for a health future' helped ABUHB to understand where we should focus over the next ten years. People were asked 'What's important for you to feel healthy?' A range of activities were developed for people to take part in during face to face events. For example: • Completing a paper survey • Writing an idea on a post-it note • Drawing ideas on a 'gingerbread' person • Creating a healthy business idea for Dragon's Den • Designing a landmark for a healthy local community. We also developed an online survey – with both short and long response options – for people to complete in their own time.

			The Community Engagement team and Integrated Wellbeing Networks regularly support service change engagement across Gwent which have included: MIU hours changes, NHH Hospital and the current Stroke reconfiguration.
Population Health Needs Assessment	5	• Joint Strategic Assessment and Indicator Framework • Gwent 35 Strategy • Population Health Organisational Development Sessions • Savills presentation on population planning for Health - November 2025 which identified the Gwent Strategic needs assessment as leading in Wales and	The Health Board has an embedded a population needs assessment currently established through the Gwent Joint Strategic Assessment and Indicator Framework. This has been incorporated at both RPB and PSB meetings, is regularly utilised by partner organisations to guide planning and local area strategic planning, as well as for the Health Board. An annual review process is implemented to maintain current data and expand data sets by incorporating new areas of development. The engagement for Gwent 35 used a methodology called Mixed Methods Triangulation which involved bringing together the findings from our numerical and non-numerical data. We developed our findings around our numerical data using Regression Techniques; these techniques allowed us to identify the relationship between people's backgrounds and what is important for people to feel healthy. We developed our findings around our non-numerical data using a methodology called Reflexive Thematic Analysis; this methodology provided a step-by-step process to creating themes around what is important for people to feel healthy.

Priorities & Achievability	2	• Strategy Delivery and Deployment Plan • Strategic Decision-Making Framework outline • Planning approach slide deck • 26/26 Planning Guide • Board and Executive papers on the planning approach	Prioritisation is determined using the planning parameters established for each annual planning cycle. These parameters are approved by the Executive and the Board and developed with Divisional Management and clinical colleagues through Cross Divisional sessions. The Board-approved Strategy Delivery and Deployment Plan detail the production of a Strategic Decision-Making Framework to prioritise (and de-prioritise)
Horizon Scanning	3	• Planning Parameters • Strategy Delivery and Deployment Plan • Strategic Decision-Making Framework • Gwent JSA and Indicator Framework • Clinical Service Plan Approach approved by Executives Q3	The Board-approved Strategy Delivery and Deployment Plan detail the production of a Strategic Decision-Making Framework to prioritise (and de-prioritise). By way of example the example below sets out the proposed methodology agreed for the Clinical Services Plan Engagement • All Staff and Clinicians on their areas of expertise • Testing existing Clinical Futures Models • Partner Engagement • Public engagement building on strategy Horizon Scanning • Best practice in CSP development across UK • Drivers for change Data • Population Needs Assessment (JSA) • Quality Outcomes and Clinical Audit • Fragile services risk assessment • Workforce sustainability • Patient Experience • Demand and Capacity Overview

Overall Judged Score	3		

Strategy Development/Clarity of Purpose, Vision and Strategy Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Strategy & Plan	3	3	- Completed lessons learnt review 24/25, outcomes to inform preparation process, approach, parameters and principles for the 25/26 plan - Completed delivery plan for the Clinical Services Strategic Plan. - PPH&P Cte Paper in January providing the Clinical Services Strategic Plan Approach - Develop priority Clinical Service Plans with appropriate stakeholder engagement	Q1 Q2/3 Q3 26/27 Q3 25/26	Delivery plan for the Clinical Services Strategic Plan PPHP Committee Papers Board and Exec papers Engagement session outputs	This plan actions can be referenced in decisions at all levels through: - Enabling Action progress - Strategy outcomes progress, - QOF, - Transformation, programme progress
Vision & Purpose	3	3	- Strategy Deployment and Delivery plan actions are incorporated into operational work plans, assurance processes - The Annual Review Process with the production of report and recommendations completed - Quarterly Integrated Performance reporting	Ongoing Quarterly reporting Q1 26/27	Integrated Performance reporting Annual Report Engagement Materials Staff Survey Risk Registers QOF	Through reviewing reporting, escalation surveys, review if ABUHB's organisational vision remains relevant and aligned with strategic priorities. This will include strengthened governance by regular review and risk identification through: - QOF 6/12 Monthly assurance reviews

			- Annual Report produced - Engagement Materials developed which clearly set vision and priorities			Divisional and Corporate risk register reviews
Alignment of National Policy and All-Level partnership priorities	4	4	- The actions in Strategy Deployment and Delivery Plan are progressed within timescales set - Develop priority Clinical Service Plans with appropriate stakeholder engagement	Review quarterly	Strategy Deployment Action Plan RPB RIF Prioritisation	This plan actions can be referenced in decisions at all levels through: - Enabling Action progress - Strategy outcomes progress, - QOF, - Transformation, programme progress
Key Enablers	3	3	- Strategic Plan submitted to Board, communicated to stakeholders through online, materials, meetings - Completion of all actions set out in the assurance processes to progress against actions	Q3 Quarterly	Board approved Strategic and action plans - Our People Plan - Quality Strategy - Financial Strategy - Estates Strategy - Digital Transformation Strategy - Green Health strategy Committee progress reports	This plan actions can be referenced in decisions at all levels through: - Enabling Action progress - Strategy outcomes progress, - QOF, - Transformation, programme progress
Engagement in Development	2	3	Adopt the strategy and service change engagement approach for Clinical Services Strategic Plan, built on the methodology used for Gwent 35, for all service changes,	Ongoing Q4	Clinical Services Strategic Plan Stroke engagement plan NHH Engagement Plan Service Change updates and Midpoint review Patient stories Patient Experience report Quality Management Group minutes and actions	Robust engagement strategies and programmes which demonstrate stakeholder confidence and understanding Patients and their families involved at the centre of strategic decisions, and this is evident in the design and delivery

			(engagement, horizon scanning, data) • Develop priority Clinical Service Plans with appropriate stakeholder engagement • NHH Comms and Engagement Plan actions complete • Stroke engagement completed, which includes the recommendations from the Midpoint review regarding patient and staff groups • Develop the 26/27 approach and approval by the Divisions, Board and Executive	Q4 Q2 26/27		
Population Health Needs Assessment	5	5	• Continued development of the Joint Strategic Assessment • Through joint project work programmes, and the delivery plan • sharing data and intent with partners for example: Housing, Local Authorities, Planning Education, Police and Sports and Leisure organisations as outlined in Strategy Delivery and Deployment Plan	Ongoing	JSA and Indicator Framework Strategy Delivery and Deployment Plan	The plan actions can be referenced in decisions at all levels through: • Partner decisions • RPB programmes and decisions • Enabling action progress • Strategy outcomes progress, • Quality Outcomes Framework, • Transformation, programme progress

			Complete a review of the priority Clinical Service Plans against the Strategic needs assessment and equality plan			
Priorities & Achievability	2	3	- Progress of the Strategy Deployment and Delivery Plan Actions Strategic Decision-Making Framework in place - Develop the 26/27 approach and approval by the Divisions, Board and Executive - Clinical Advisory Forums set up with documented outcomes that feed into decision making processes	Reviewed quarterly Q4 and as required	Strategy Deployment and Delivery Plan Actions Strategic Decision-Making Framework	The plan actions can be referenced in decisions at all levels through: - Partner decisions - RPB programmes and decisions - Enabling Action progress - Strategy outcomes progress, - QOF, - QIA process and Clinical Advisory forum outcomes - Transformation, programme progress
Horizon Scanning	3	3	- The approach adopted for the Strategy, CSP and IMTP embedded as part of Board Annual Review of Strategy Deployment and Delivery Plan - This work led by the planning team and actioned through Board papers, Cross Divisional Meeting notes, individual engagement meetings as determined by the piece of work - Horizon scan reports reviewed and updated	Q1 26/27 Q2 26/27 Q1 26/27	Board Annual Review of Strategy Deployment and Delivery Plan JSA Planning approach and Guide Board Committees	This updates as a result of horizon scanning can be referenced in decisions at all levels through: - Annual Plan production - Production in strategic plans - Assurance reviews Strategic decision-making Framework - Transformation, programme progress and reviews

			• Updated horizon scan information to inform planning cycle 2027/28 through the HBs planning framework and guidance • Update of the pre annual plan approach and information • Update of the JSA			

Strategy and Plan Alignment, and Development of IMTP

B) Strategy and Plan Alignment, and Development of IMTP

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
IMTP Development	Organisation has an annual plan which responds to some but not all elements of planning framework and cannot provide a financially balanced plan over 3 years.	Organisation has an approved IMTP that aligns with the core elements of the planning framework. The plan demonstrates a structured approach to strategic priorities and is informed by baseline data. It includes initial consideration of risks, outcomes, and resource requirements.	IMTP meets almost all policy expectations and is tailored to deliver clear service transformation aligned with an agreed CSP and reflects a shift from operational delivery to strategic impact. Growing maturity in linking planning to measurable impact, return on investment, and strategic priorities. Risks are clearly identified, with evidence of controls and early mitigation strategies.	The IMTP meets all policy expectations and is consistently delivering against the quadruple aim and is embedded across the organisation and transforming services through the CSP. Risks across quality, access, workforce, and finance are actively managed with evidence of controls and mitigation and demonstrates clear alignment between planning, performance, and transformation.	The IMTP exceeds all national policy expectations. It is recognised as a benchmark for excellence, driving system-wide transformation and delivering sustained impact across the quadruple aim. The plan is co-produced, future-focused, and underpinned by robust evidence, innovation, and adaptive governance. It demonstrates clear and advanced triangulation, delivery timelines and milestones, and integrated risks and mitigation.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	Some alignment is visible between the annual plan and CSS with the organisation planning on a continuous annual cycle.	Alignment is clear and coherent between the IMTP and CSS with the organisation planning on a continuous annual cycle.	The IMTP is tailored to deliver clear service transformation in line with an agreed Clinical Services Plan. Plans are directly linked to quality, performance and accountability and informed by detailed	Coherent aligned plans, including a commissioning plan are performance managed, with staff owning, adapting, acting on and learning from variation.	Planning is owned by all staff and fully integrated and aligned across organisational tiers and system partners. There is a clear golden thread between local, national and regional strategies and partnerships with dynamic alignment to the CSS and Plan, IMTP, commissioning intentions, resulting from horizon scanning results, detailed population health needs assessment and

			and future facing modelling.		enabling strategies (e.g. workforce, digital, estates).
Triangulation of Services	Basic high-level triangulation is taking place between services, activity, workforce and finance.	Clear triangulation between services, activity workforce and finance.	Detailed triangulation between services, activity workforce and finance at service level.	Clear detailed and robust triangulation and analysis of activity, workforce and finance which considers other holistic requirements such as training and working regionally.	Triangulation is system-wide, predictive, and continuously refined through real-time data and advanced analytics. It informs strategic decision-making, resource optimisation, and service redesign across organisational boundaries. The organisation demonstrates a proactive approach to managing interdependencies, future workforce needs, financial sustainability, and service demand, with clear links to population health, regional collaboration, and innovation.
Commissioning	The Board sets out high level commissioning intentions primarily focused on statutory requirements and broad service categories. Commissioning is reactive, with limited strategic alignment or stakeholder engagement.	The organisation has an approved and operational commissioning process. Intentions begin to reflect service priorities and are informed by basic population health data and stakeholder input.	Commissioning decisions are prioritised based on service need, population health data, and performance metrics. The impact of commissioned and supporting organisations is actively considered.	The organisation has a clear, transparent commissioning plan that includes a transparent prioritisation framework and actions for both commissioning and decommissioning ensuring risk to patients are minimised. Decisions are evidence-based, responsive to changing needs and communicated effectively to stakeholders.	Commissioning is strategically embedded across the organisation and system, with clear alignment to the population health needs assessment, clinical priorities, and service transformation goals. The process is co-produced with stakeholders with a clear and transparent prioritisation framework, underpinned by robust evidence, and includes pro-active decommissioning where appropriate with detailed communication strategies. Commissioning decisions are transparent, equitable, and continuously evaluated for impact on quality, access, and outcomes.

Strategy and Plan Alignment, and Development of IMTP Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
IMTP Development	2	Integrated Delivery Frameworks IMTP development Ministerial Priorities 24/25 Delivery Expectations IMTP Approach paper	The 24/25 IMTP met the majority of policy expectations articulated within the planning framework that were achievable within available resources assessed at the time. Delivery expectations over a three-year period set for service transformation with quarterly milestones included for year 1, Integrated Delivery Plans developed by service leads underpinned by current Clinical Futures service models and detailed demand and capacity plans. Risks to delivery are identified as part of the Integrated Delivery Plans with mitigations included. For 25/26 Integrated Delivery Plans developed by service leads assessed against the priorities and intentions with the Gwent 35 with a retrospective review of 24/25.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	2	Accountability Letters Clinical Futures Delivery Plans Refreshed Performance Management Framework QOF Integrated Performance Reports IMTP Integrated Delivery Plans	Delivery expectations over a three-year period set for service transformation with quarterly milestones included for year 1 Integrated Delivery Plans developed by service leads underpinned by Clinical Futures service model and detailed demand and capacity plans Through the refreshed Performance and Accountability Framework the commitments in the plan issues as accountability conditions accountability letters Quality outcomes framework refreshed and the measures have been included within

			Integrated Performance Reports which detail delivery against IMTP.
Triangulation of Services	3	Integrated Delivery Plans MDS Clinical Futures Delivery Plans	Through the Integrated Delivery Plans there is triangulation between services, activity, workforce and finance at service level and identification of where there are gaps and risks. The planning approach sets out how the integrated framework capture this information in one place to the same deadlines and review periods
Commissioning	2	Strategy Deployment and Delivery Plan Committee reports Integrated Delivery Plans	Prioritisation is determined using the planning parameters established for each annual planning cycle. These parameters are approved by the Executive and the Board and developed with Divisional Management and Clinical colleagues through Cross Divisional sessions. The organisational planning cycle is outlined within the Strategy Deployment and Delivery Plan
Overall Judged Score	2		

Strategy and Plan Alignment, and Development of IMTP Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
IMTP Development	2	3	- Development of Clinical Services Strategic Plan to update service models from Clinical Futures service models developed for opening of the GUH - Update the corporate risk actions within the scope of the IMTP, identifying risks to delivery and mitigation strategies. - Annual review of benefits and outcomes linked to strategic objectives and service transformation. - Cross divisional triangulation session completed reviewing resource requirements (workforce, finance, activity, plus enablers e.g digital, estates) to each priority. - Develop an approvable IMTP	Q3 26/27	Clinical Services Strategic Plan Annual Plan Integrated reporting Transformation programme reports QOF	The plan actions and impact can be referenced in decisions at all levels through: Progress against the objectives and targets as set out in the - Annual Plan - Delivery expectations - Enabling action progress - Strategy outcomes progress, - QOF, - Transformation, programme progress
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	2	3	Development of Clinical Services Strategic Plan to update service models from Clinical Futures service models	Q3 26/27	Clinical Services Strategic Plan Annual Plan Integrated reporting Transformation programme reports	The plan remains on track throughout the year, assessed quarterly.

			developed for opening of the GUH • Triangulated of performance, workforce, finance and quality data at the point of plan submission and reviewed monthly/quarterly as appropriate • Transformation programmes baselined with resources and benefits identified	Q3 Q3/4	QOF	
Triangulation of Services	3	3	• Issuing of the Integrated Frameworks which include triangulation evidence across operational planning aligned to Annual plan/IMTP process • Completed triangulation sessions completed reviewing resource requirements (workforce, finance, activity, plus enablers e.g digital, estates) to each priority. • Develop an approvable IMTP • Submission of a triangulated plan which identifies areas of imbalance and plans to address over the 3-year period Triangulation assessed	Q4 Q4 and Q1 26/27	Annual Plan Accountability Conditions Annual Plan Commitments, baselines and targets Divisional and corporate risks Escalation status - internal	The plan actions and impact can be measured through: Progress against the objectives and targets as set out in the • Finance submissions • People plan progress • Internal assurance and escalation • Annual Plan • Delivery expectations progress • Enabling action progress • Strategy outcomes progress, • QOF,

			throughout the year to inform delivery assessment of Annual Plan Update assurance measures and reporting and issuing of the accountability conditions			
Commissioning	2	3	Review of the Commissioning intentions against the Strategy Deployment and Delivery Plan carried out	Q4	Strategy Deployment and Delivery Plan Committee reports Integrated Delivery Plans QOF QMG reports	There is the ability and a mechanism to measure the impact of commissioning against patient experience, service delivery and within planned resources

Dynamic and Engaged Planning

C) Dynamic and Engaged Planning

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Stakeholder Engagement	Staff and partners are aware of CSS/CSP and there is a public commitment in place to undertake stakeholder engagement.	Organisational engagement is evident in practice and reflected in the CSS/CSP. Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	Stakeholders are engaged in and co-design priority setting using the 'engagement cycle' model and a person-centred approach. Staff engagement at an organisation level is increasing.	Full and proactive continuous engagement including diverse communities which informs, owns and tests all impact assessments. Feedback from engagement activities influences and challenges the plan. Planning is also embedded and co-ordinated throughout the organisation.	Internal continuous engagement sees a fully engaged and informed workforce who are able to co-produce. Feedback and learning from continuous engagement activities including protected characteristic groups and socio-economic disadvantaged groups informs local priority setting and the development of the CSS/CSP.
Service Delivery Risk and Issue Management Approach	Organisation has a service risk management approach in place, but it has not been fully adopted across all areas.	Organisation has service risk management approach embedded across all areas of the organisation and has robust plans in place to address / mitigate risks	A risk management approach is evident and consistent across organisation. The organisation stop fragile services are identified.	The risk management approach enables the early identification of fragile or soon to be fragile services allowing for early intervention to ensure service sustainability. Organisation sees less urgent service changes.	Potential fragile services identified early and robust risk management across organisation pre-emptively responding to emerging service risks and the organisation is able to flexibly adjust plan. The Board are informed and regularly updated on fragile services and organisation rarely sees urgent service changes.
Service Model / Regional Design	Organisation has no route, or route is ineffective to discuss potential opportunities or joint risks. Regional collaboration is minimal, ad hoc, and lacks strategic intent.	Strengthened partnership working arrangements are in place. A methodology for working together is developed, with early efforts to align	Opportunities for regional working and shared solutions are identified and developed collaboratively. Planning is increasingly aligned	Agreed proposals for robust regional service models (e.g. consolidation, shared services) are in place and delivery is underway. Governance structures support joint	Regional collaboration is fully embedded, strategically led, and continuously evolving. The organisation is a proactive system leader, driving the development, implementation, and optimisation of shared service models and regional solutions. Collaboration is underpinned by co-produced strategies, shared governance,

		priorities and build trust.	across organisations, with joint priorities and resource sharing.	accountability and performance management.	and dynamic intelligence. The organisation anticipates future needs, fosters innovation, and delivers measurable improvements in equity, efficiency, and outcomes across the region.

Dynamic and Engaged Planning Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Stakeholder Engagement	4	SEW regional Joint committee RPB reports and minutes Annual Plan Engagement reports Gwent 35	For the development of Gwent 35, partner organisations and Health Boards in the region were engaged with and co-designed. First draft of strategy was shared with over 300 stakeholders and events held in the community sessions for their comments. The engagement process for the strategy reached almost 7000 members of the population. The approach focussed on 'going to' the people of Gwent, rather than asking the population to 'come to' us. We attended large-scale events with lots of attendees, as well as smaller groups which were made up of people with specific interests and needs. It was important for us to speak to a representative sample of the Gwent population, and we used the data from the 2021 Census to help us identify who we should speak to. To analyse the outcomes a methodology called Mixed Methods Triangulation was used which involved bringing together the findings from our numerical and non-numerical data. Findings were developed around our numerical data using Regression Techniques; these techniques allowed us to identify the relationship between people's backgrounds and what is important for people to feel healthy. We developed our findings around our non-numerical data using a methodology called Reflexive Thematic Analysis; this

			methodology provided a step-by-step process to creating themes around what is important for people to feel healthy. Values and Strategy development undertaken at the same time with targeted staff engagement, including co-design workshops and dedicated staff drop-in session on hospital sites. The establishment of the SEW regional network prior to the formal joint committee has led to joint plans for Vascular services, LHP, Diagnostics, Trauma, Orthopaedics, Ophthalmology. A partnership approach paper been developed for discussion at PPH&P Committee in Jan 26 ABUHB engagement approach in place for MIU changes, NHH hospital development and Stroke configuration.
Service Delivery Risk and Issue Management Approach	3	Corporate and Divisional Risk registers Performance and Escalation Framework Annual Planning approach Integrated Delivery Plans NHH SOC	The Corporate and Divisional risk registers hold service fragility risks The refreshed Performance and Accountability Framework has included two new domains for leadership and corporate risk alongside Finance, Operational Delivery and Quality Escalation is formally assessed every 6 months for Operational Divisions Workforce assessment undertaken on an annual basis through Annual Planning process which identifies workforce fragility Capital Estates risks are assessed through the Capital programme in conjunction with service transformation programme priorities, and example of this is development of NHH project.

Service Model / Regional Design	3	Ophthalmology programme Board and Committee updates Internal Regional Group governance	The establishment of the SEW regional network prior to the formal joint committee has led to joint plans for Vascular Services, LHP, Diagnostics, Trauma, Orthopaedics, Ophthalmology ABUHB has led Regional Cataracts service and the regions approach to performance reporting and forecasting
Overall Judged Score	3		

Dynamic and Engaged Planning Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Stakeholder Engagement	4	4	- Strategy stakeholder engagement approach adopted for Clinical Services Strategic Plan - Updates and input through cross Divisional meetings - Discussion papers through Executives prior to launch - Engagement meetings for information and information sharing and feedback on IMTP development held, to include Divisional - monthly, Cross Divisional - monthly, Business partners and enablers - every 2 weeks, Planning team - every week, Executive - every 2 weeks and wider Exec - monthly, Board - 2 per quarter, TUPF and Llais, Quarterly, Enablers - monthly - Engagement and consultation plans in place prior to planned service change commencement which have been signed off	Ongoing Quarterly Ongoing	Approach papers and outputs Committee papers Consultation Plans	Robust engagement strategies and programmes which demonstrate stakeholder confidence and understanding Evidence patients and their families involved at the centre of strategic decisions, and this is evident in the design and delivery

			by Divisional leadership			
Service Delivery Risk and Issue Management Approach	3	3	- Through the PMF assurance processes, assessment of all risk registers and workforce profile to understand organisational service fragility - Strategic Decision-Making Framework in place - QIA process and programme in place to manage risk to change - The Corporate Governance team ongoing oversight and actions in place overseeing reviews of the most significant operational risk	Operational Divisions monthly and formal review 6/12 months Corporate 12-month review Ongoing	Assurance meetings Divisional and Corporate risk registers Clinical Advisory Forum QIA process Audits (clinical and non-clinical)	The outputs from scheduled risk reviews The recommendations and actions taken as a result of audit (clinical and non-clinical) Progress updates provided at Assurance reviews Progress against action plans as a result of escalation
Service Model / Regional Design	3	3	- Active involvement in the Regional Joint Committee and further delivery of regional service models - Involvement in the Regional Digital Committee and action plan develop to delivery 1 year agreed action (shared PTL)	Ongoing Q4	Board and Committee minutes Ophthalmology reports Regional Joint Committee minutes and actions LHP meeting notes Cancer Programme reports	Delivery of Ophthalmology Services, progress against delivery forecasts and plans Shared PTL to support improved patient outcomes Progress of Digital Pathology Radiology Capacity assessments and waiting lists Progress against Ortho Arthroplasty Plans Progress of joint Cancer actions

						Progress against the Strategy outcomes framework Delivery of the enabling actions and delivery expectation

Operational Planning

D) Operational Planning

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Demand & Capacity Modelling	Basic demand and capacity work is undertaken and contains an appropriate level of detail to support service delivery	Demand and capacity planning undertaken at speciality level to support the design of current and future services. Data is more structured and used to inform service-level decisions	Robust and profiled projections of demand and capacity are used to inform the development of individual service plans, the Clinical Services Plan, and the IMTP. Planning is increasingly data-driven and cross-functional.	The organisation uses detailed and advanced modelling capability to support strategic planning. Demand and capacity modelling is embedded in the IMTP and informs transformation, workforce, and financial planning. Predictive analytics and AI tools support long-term planning.	Demand and capacity modelling including modelling projections is at the core of planning processes across the organisation. Predictive analytics and AI tools support long-term planning. Modelling triangulates resources, staff, finance and activity. It is able to undertake modelling at all levels of prevention and illustrates scenarios for improvement for the IMTP.
Clinical Leadership & Input	Clinical leads are identified and their roles are defined. Engagement is limited to basic consultation or information sharing	Clinical leads begin to inform service planning and contribute to performance improvement discussions. Their input is considered but not yet central.	Clinical leads are embedded early in the planning cycle to ensure that service design is clinically credible and patient-centred. Clinical leads co-produce plans and provide leadership in development processes. Their involvement is structured and increasingly strategic.	Clinical leadership is embedded in operational planning. Clinical teams actively shape service direction in alignment contributing to future direction services in line with clinical services plan.	Clinical leadership sits at the heart of planning and performance with a strong focus on quality and improvement. Clinical leaders co-produce plans and drive the future direction of plans through developing a culture of quality, innovation, and continuous improvement, fostering deep engagement and ownership across clinical teams.

Planning Process	Organisation has basic operational plans and planning process in place.	Operational plans are regularly reviewed and remedial action undertaken.	Operational plans have robust triangulation and modelling of plans based on a clear and consistent approach to demand and capacity modelling across the organisation	Coherent aligned and triangulated plans with clear links to CSS and CSP, including, with staff owning, adapting, acting on and learning from variation and inequity.	Operational plans are fully aligned and integrated into the development of IMTP and CSP. Staff own the process and act on opportunities and learning to improve holistic service provision and patient experience.

Operational Planning Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Demand & Capacity Modelling	3	Integrated Framework submissions Dynamic Planning methodology Activity based forecasting D and C tools and web pages Transformation Programme Insight reports D and C progress plan Ophthalmology Plan	Demand and capacity planning is at different levels of maturity across the organisation, and is carried out at the level of individual specialities for all RTT specialties, providing insight and assurance of delivery in our Integrated Framework submissions and bid for discrete delivery funds This enables informed decision-making at the service level and in some area's subspecialty, ensuring that resources are allocated efficiently, and gaps are known. Where D and C has not been in place there has been activity-based planning and forecasting using SPC methodology and capacity assumptions developed with the clinical services. The activities of the Corporate Modelling, Analytics and Performance Team support the design and deployment of resources and activities to embed D and C across the organisation which is available digitally working with Digital. This has also supported regional performance and delivery, and service planning in the transformation programmes. Working with Ops, Finance and Workforce, the D and C outputs inform funding submissions and a robust assessment of delivery against available resources.

Clinical Leadership & Input	3	Clinical Advisory forum Clinical Exec meetings QOF Assurance meeting notes and actions Cross Divisional meetings	Clinical leadership and input into planning occurs in a number of forums and mechanisms which include: • Clinical Executives • Cross Divisional • Monthly Assurance • Clinical Advisory Forum • Clinical sessions assigned to the transformation programmes The Clinical Advisory Forum was established to provide comprehensive oversight and review of Quality Impact Assessments throughout the planning cycle. This structured approach ensures that all proposed changes are thoroughly evaluated for their impact on quality, patient safety, and clinical effectiveness, supporting decision-making within the planning process
Planning Process	3	Integrated Framework submissions Dynamic Planning methodology Activity based forecasting D and C tools and web pages Transformation Programme Insight reports D and C progress plan Ophthalmology Plan	Integrated Delivery Plans play a crucial role in ensuring that demand and capacity modelling is a core requirement in the planning process and sufficient detailed to triangulate finance and workforce plans as part of the Annual Planning Process and assess the expected Performance out turn. Having this process in place also informs the areas which are not robust and has formed a work plan to ensure D and C is in place across the organisation. Through the application of Integrated Delivery Plans by Division there is triangulation and the ability to identify interdependencies between services, activity levels, workforce, and financial resources. By doing so, it ensures that all elements are

			considered together and risks to delivery can be identified.
Overall Judged Score	3		

Operational Planning Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Demand & Capacity Modelling	2	3	- D and C Templates completed for all RTT specialties, MDS and Performance Measures. - Identified Plan for non-reportable specialties and sub specialties - Time defined plan in place for all areas to have D and C processes in place - Plan has the ability to triangulate resources, staff, finance and activity - Population Health Management Implementation Plan in place that informs IMTP planning and identify prevention priorities	Q3 Q4 Q4	Integrated Framework submissions Annual Plan Board and Committee reports Dynamic Planning methodology Activity based forecasting D and C tools and web pages Transformation Programme Insight reports D and C progress plan Population Health Management Plan JSA and Indicator Framework Ophthalmology Plan	Triangulated Plan which either balances or understand the gaps with a defined plan to address any deficits Decisions taken which inform QIA submissions Use of the JSA in service and partnership planning
Clinical Leadership & Input	3	3	- Clinical Advisory Forum dates planned and decision-making process - Clinical Exec meetings programme - Assurance meeting notes and actions - Cross Divisional meetings programme in place	Q4 and ongoing Ongoing Ongoing	QOF Clinical Audit Strategy Outcomes Framework Clinical Services Plan Approach	Improvements in patient outcomes assess through clinical audit, Strategy Outcome framework and QOF, staff survey results, and the delivery of service change withing the planned timelines.

			- Clinical leadership embedded within Clinical Services Strategic Plan and development - Clinical services plan co-designed with clinical teams	Q3 26/27		
Planning Process	3	3	- Development of Clinical Services Strategic Plan to update service models from Clinical Futures service models developed for opening of GUH - Triangulation to include quality data for next year's submission - Updated D and C template to include follow ups - MH and Therapies D and C in place and triangulation, - Commencement of inpatient therapies D and C - NHH OBC model review commenced	Q3 26/27 Q4 Q4 (Subject to approval)	D and C templates NHH OBC Theatre model Cote Frailty Model ELGH place Capital and estates strategy Therapy strategy and workforce plan Clinical Services Plan Planning approach Annual strategy review	The updated D and C templates, and the implementation of new processes across Mental Health, Therapies, and inpatient settings is included in next years triangulated plan NHH OBC model development has commenced which incorporates the wider system model changes, including: - Theatre model supporting the enabling actions - Cote Frailty Model - ELGH place - Capital and estates strategy - Therapy strategy - Clinical Services Plan

E) Best Practice Approach to Improvement

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Engagement	Engagement is minimal and reactive. Feedback is collected from patients and staff, but there is no structured approach to measuring the effectiveness of engagement activities or approach. Insights are rarely used to inform decision-making.	The organisation has a visible commitment to best practice, supported by training and an improvement strategy. Engagement with national programmes is active, and structured methods for collecting feedback and measuring impact are in place, though not yet fully embedded.	Organisation is developing an engagement strategy/plan and is proactive in identifying and learning from best practice in engagement to ensure voices are captured from all stakeholders especially clinical, minority and diverse voices.	Engagement is embedded across all organisational activities—planned and unplanned. The engagement strategy ensures robust inclusion of diverse and clinical voices, supported by strong data collection and analysis. Feedback directly informs action, driving continuous improvement.	Stakeholder engagement is transformational—co-designed and co-led by patients, staff, and communities. Real-time feedback tools enable adaptive responses, while inclusive practices ensure diverse voices shape decisions. The organisation is nationally recognised for its leadership in engagement, with a clear link between stakeholder input and measurable improvements
Benchmarking	Organisation is beginning to explore value-based healthcare principles, but planning remains reactive and output-focused. Benchmarking is ad hoc, with limited structure or consistency. There is minimal understanding of how comparative data can drive improvement, and benchmarking is not yet linked to strategic goals.	Value-based planning is gaining traction, and regular benchmarking is conducted with other NHS organisations. The organisation begins to use structured benchmarking methods to identify best practice, though application is inconsistent. Staff awareness is growing, and benchmarking is starting to inform service reviews and	Benchmarking processes are formalised, consistently applied, and span across Wales and the UK. The organisation uses comparative data to identify performance gaps and inform strategic planning. Benchmarking is aligned with value-based healthcare principles, and results are used to prioritise improvement initiatives. Staff are	Benchmarking is fully integrated into planning and performance cycles. Staff across the organisation actively lead benchmarking and improvement initiatives, using data to drive decisions and measure impact. There is a strong culture of ownership and continuous learning. Benchmarking includes qualitative and quantitative measures, peer comparisons, and outcome-focused metrics aligned with patient	Demonstrates full integration of benchmarking and value-based planning across strategic, operational, and clinical areas. Advanced analytics, including predictive and real-time data, drive proactive improvements and innovation. Recognised as a leader in the NHS, the organisation shapes best practice while fostering a culture where staff lead continuous improvement and scalable innovation.

		improvement discussions.	engaged in interpreting data and applying insights to their areas.	value. Insights are shared across teams and used to scale best practice.	
Governance	Governance arrangements are informal, fragmented, or unclear. Oversight of IMTP development is minimal, with limited accountability, transparency, or alignment to strategic priorities. There is no structured process for risk management, stakeholder involvement, or performance monitoring.	A governance structure has been established to provide direction and oversight for IMTP development. Roles and responsibilities are defined, and basic reporting mechanisms are in place. There is growing awareness of the need for structured governance, but integration with programme-level planning and delivery is still emerging.	A formal governance and accountability framework is in place for IMTP development and monitoring at programme level. IMTP and CSS/CSP governance is aligned with strategic objectives, includes defined escalation routes, and supports performance tracking. IMTP Governance is periodically tested for improvements.	Governance is embedded across the organisation, with a mature CSS and oversight mechanisms that are reviewed annually for relevance and effectiveness. IMTP and CSS/CSP governance structures support cross-functional collaboration, robust data use, and continuous improvement. Governance is constantly and pro-actively tested for improvements.	Governance is fully integrated, agile, and strategically aligned across all levels. Oversight of the IMTP, CSS and CSP is co-produced with clinical leaders and stakeholders, supported by real-time data, predictive analytics, and dynamic risk intelligence. IMTP/CSS/CSP governance structures are benchmarked against national best practice, continuously refined, and used to drive innovation, accountability, and system-wide impact. Decision-making is transparent, inclusive, and outcome-focused.

Best Practice Approach to Improvement Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Engagement	3	Gwent 35 Strategy Engagement Report to PPH&P Committee January 25 Strategic Equality Plan People Plan Engagement report JSA	The engagement programme for the development of the strategy reached nearly 7,000 people and included an assessment and representation of the population with protected characteristics to reflect Gwent's demographics. Findings were presented in the Engagement Report which went to the PPH&P Committee on January 25. The Community Engagement team and Integrated Wellbeing Networks regularly support service change engagement across Gwent which has included MIU hours changes, and the current Stroke reconfiguration. The continued work to engage and consult with diverse communities is aligned with the Strategic Equality Plan actions
Benchmarking	3	Benchmarking Compendium Value and Sustainability Board Programme of work Planned Care work Programme GIRFT Action Plan Enabling Actions Submissions Savings and Efficiency Plans	ABUHB utilises NHS benchmarking tools as a key component in the development of the Annual Plan and value and sustainability Board. Development of the ABHB compendium are shared with the Divisions to specialty level to identify opportunities and Value-Based work programme. The Compendium supports the development of the integrated framework submissions, efficiency opportunities that will be prioritised alongside the Enabling Actions.
Governance	3	Performance and Accountability Framework Corporate Governance Framework Accountability Agreements Assurance meetings Accountability Agreements	Formal governance structures have been established to oversee both the development of the Annual Plan, Performance and Accountability and all strategic and operational plan development. These structures and processes are formally agreed and ratified through the Board and Corporate Governance Framework, ensuring

			alignment with the organisation’s overall objectives The refreshed Performance and Accountability Framework has included an additional Domain for Corporate governance. Performance expectations and delivery commitments relating to the development and delivery of the Annual Plan are clearly defined and included within Executive and Divisional Accountability Agreements. This approach aligns with the accountability, framework with clear roles and responsibilities assigned to leaders at every level across the organisation.
Overall Judged Score	3		

Best Practice Approach to Improvement Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Engagement	3	3	- Develop a co-production framework that supports an organisational approach to embedding population voice into service design and embed community impact stories into our performance reporting, - Progress the actions in Strategy Deployment and Delivery Plan - Progress the actions in the Value Based Health Care work programme and outcomes reporting - Cross divisional triangulation sessions completed reviewing resource requirements (workforce, finance, activity, plus enablers e.g digital, estates) to each priority.	Q1 26/27 Q1 26/27 Q1 26/27	VBHC Annual review Engagement reports QOF Patient Stories	Measures will provide both quantitative and qualitative insights into how well population perspectives experiences are being integrated into service design, delivery, and performance reporting. These include engagement rates of the proportion and diversity of participants. the number and scope of service changes directly resulting from population input, referenced in decision-making records. Community and patient Impact Stories Patient and Stakeholder Satisfaction including use of Civica and captured through the QOF and annual Quality report Measurement of improvements in service outcomes and user experience through PROMS and PREMS
Benchmarking	3	3	- Compendium production - Planning guide - Integrated Frameworks	Q3 Q3	Compendium V&SB plans and notes Savings tracker	The inclusion of opportunities in the plan submission and progress tracked through V&SB

Governance	3	3	• Performance and Accountability Framework implementation • Accountability conditions • Escalation reviews	Q4 Q1 26/27	Corporate Risk registers PMF Accountability Letters Escalation letters Productivity assessments	Through implementation of the refreshed PMF, improved clarity of roles and responsibilities and timeliness assurance meetings actions Through the implementation of the PMF there will be increased understanding of escalation and deescalation (internal and external) reasons measured through progress plans The delivery of accountability conditions through individual and collective awareness. Clear escalation and de-escalation processes leading to the improvement of service delivery and safety. Risks are addressed in line with the action plans, enabling timely interventions and support where needed. Escalation reviews result in, minimising delays and reducing the risk of improving overall patient outcomes. Through the assurance meetings and performance measures in the accountability framework data used to inform decisions, resulting effective resource allocation, improved

						productivity and reduced waste

Realistic & Deliverable

F) Realistic & Deliverable					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Risk Identification & Management	Risk identification and management are inconsistent and reactive. Risks to IMTP delivery are not systematically captured or monitored. There is limited ownership or visibility of delivery risks.	A formal risk management process exists and is applied to IMTP delivery at a high level. Risks are identified at the planning stage and tracked through basic registers and reviewed periodically. Ownership is clearer, but integration with delivery assurance is limited. Escalation processes in place but not always followed.	Risk identification and management are embedded in IMTP development and delivery processes. Risks are identified early and linked to specific objectives, milestones, and outcomes. Controls are monitored, and mitigation actions are tracked. Risk registers are dynamic and inform delivery with clear ownership.	Risk management is proactive, strategic, and forward-looking with an agreed and clear risk appetite. Risks are anticipated and identified through horizon scanning, sensitivity analysis and scenario planning. The organisation adapts delivery plans in response to emerging risks with regular reviews. Lessons learnt informs future IMTP cycles.	Risk management is fully embedded across the organisation and system partners and is triangulated across workforce, finance, digital and clinical lenses. It is predictive, real-time, and continuously informs IMTP delivery through live dashboards and predictive analysis. The organisation leads in using risk intelligence to drive improvement, resilience, and transformation. The organisation operates continuous learning and is recognised for excellence in risk-informed delivery assurance.
Development of IMTP and track record	The organisation has a track record of submitting annual plans that do not meet the requirements of the planning framework, Cabinet Secretary expectations or provide a financially balanced plan over 3 years. Planning is largely operational and short-term, with limited strategic integration and has limited clinical or financial planning alignment and limited stakeholder engagement.	The organisation consistently develops robust annual plans that build assurance as a key step toward an approvable IMTP. Plans begin to reflect medium term priorities, include a finance and delivery framework, and show early signs of strategic alignment including financial forecasts and delivery milestones.	The organisation has developed an approvable, outcomes-focused IMTP that reflects strategic priorities, enabling plans and clinical service plans. A robust 3-year sustainable financial plan is included, with clear links to service transformation (with milestones and timelines) with clearly	The organisation has a history of submitting high quality IMTP's that are strategically integrated and includes a comprehensive delivery and assurance framework. It demonstrates alignment across all enabling strategies and is informed by detailed modelling, population health intelligence, and with significant stakeholder input.	The organisation is recognised for excellence in IMTP delivery and assurance and has a long history of developing and submitting high quality IMTP's which surpass policy expectations and is recognised as a system-leading exemplar. It is co-produced and informed by detailed analysis and predictive tools to drive transformation across the health system, delivers the quadruple aim.

			articulated risks and mitigations.		
Monitoring and Delivery	Monitoring of annual plan or IMTP delivery is ad hoc and reactive and focused on immediate operational issues. There is limited visibility of progress, and reporting is inconsistent. Accountability is unclear and delivery risks are not systematically managed.	The organisation has a structured approach to monitoring annual plan or IMTP delivery with ownership of delivery emerging across services. Key milestones and actions are tracked, and reporting mechanisms are in place through basic dashboards and reported to the Board regularly. Accountability is improving, but integration with performance and risk management is limited.	Monitoring of IMTP delivery is consistently seen as business as usual and integrated with performance management reviews and risk assurance processes. Progress is tracked against outcomes, and corrective actions are taken. Delivery is supported by enabling functions and aligned with strategic priorities. Delivery is starting to inform future planning.	IMTP delivery is monitored through a robust, outcome-focused framework which includes impact evaluation. The organisation adapts delivery plans based on performance insights, emerging risks, and system pressures. Staff are engaged in owning and delivering IMTP priorities.	IMTP monitoring and delivery are embedded in real-time, system-wide performance and governance structures. The organisation demonstrates strategic leadership in delivery assurance, advanced triangulation, using predictive analytics, scenario planning, and co-produced improvement plans. Delivery is continuously optimised to achieve the quadruple aim. Continuous improvement cycles are embedded, with clear evidence of impact and the

Realistic & Deliverable Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Risk Identification & Management	3	Annual Plan Approach Board and Committee Papers Cross Divisional Presentations Divisional and Corporate risk registers Accountability Conditions Lessons learnt review at the end of each Planning cycle	The organisational risk register is part of the Annual Plan Approach supporting the assessment of deliverability of the Integrated Delivery Plans that are developed Division. These plans are underpinned by the current clinical mode and detailed demand, and capacity plans identifying gaps and risks. Risks to the delivery of services are currently identified as part of the integrated plan development. Each year a structured lessons learnt review is conducted to inform future planning cycles. Lessons identified are shared through the Executive Team, and lessons learnt sessions are facilitated by Business Partners through the Divisions.
Development of IMTP and track record	2	IMTP Gwent 35 Deescalation letter	Pre Covid ABUHB has a successful track record of approved IMTP's. Following escalation in 2023, in 2025, the Health Board developed IMTP that informed and supported the development of organisation's strategy development Gwent 35 and was approved. The IMTP established clear expectations for service delivery and transformation across a three-year period. To ensure implementation, quarterly milestones were set for the first year, providing targets for progress and accountability against the ministerial priorities, enabling actions and delivery expectations. However, at this point in time approval has been revoked due to the worsening financial position
Monitoring and Delivery	3	Annual Plan Approach Board and Committee Papers Cross Divisional Presentations Divisional and Corporate risk registers Accountability Conditions	The monitoring of Integrated Medium-Term Plan (IMTP) performance is integrated and an important component of the performance and accountability framework. This process is through the integrated performance report, monthly

			assurance and 6/12 monthly reviews to ensure delivery against established expectations. Performance expectations and delivery are reflected in both Executive and Divisional Accountability Agreements, ensuring that all levels of leadership are aligned with the plan's objectives. Clear delivery expectations have been established for service transformation over a three-year period. For the first year, quarterly milestones have been defined to track progress and drive achievement of key targets. The attainment of quarterly milestones is monitored through the Integrated Performance Report, which is produced on a quarterly basis. This enables ongoing oversight and timely intervention where required. The plan is underpinned by performance expectations Enabler plans are developed in response to divisional requirements, supporting the IMTP objectives.
Overall Judged Score	3		

Realistic & Deliverable Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Risk Identification & Management	3	3	- Maintenance of the risk registers and regular review - Divisional Assurance and action plans - Integrated frameworks completed - Implementation of the new measures, triggers and actions in the new Corporate Governance domain in the updated PMF	Ongoing Monthly Q3/4	Divisional and corporate risk Registers Integrated Frameworks Annual Plan Approach	Through the effective management of risks the following impacts will be tracked Improved productivity Reduced waste Reduced patient safety incidents Improved audits Progress against escalation plans towards escalation Delivery of enabling actions and delivery expectations
Development of IMTP and track record	2	3	Submission of an approvable Annual Plan	Q4	Annual Plan submission	De-escalation
Monitoring and Delivery	4	4	- Benefits realisation plan in place for all transformation programmes, - V and SB priorities identified - Value Base Health care programmes of work identified and quantified - Accountability conditions in place - Integrated performance reporting quarterly - QOF reporting	Q1 26/27 Q1 26/27 Quarterly	QOF V and SB action progress Integrated performance report VBHC reports PMF Accountability conditions and letters Integrated Performance report	Through the effective management of risks the following impacts will be tracked: - Improved productivity - Improved patient outcomes measured through strategic outcomes framework, clinical audit, QOF and Quality Management System - Reduced waste - Reduced patient safety incidents

			• Performance and accountability framework actions completed			• Improved audit outcomes • Progress against escalation plans towards escalation • Delivery of enabling actions and delivery expectations

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 January 2026
CYFARFOD O: MEETING OF:	Planning, Population Health and Partnerships Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	IMTP 2026-29 Development and Neighbourhood Care Network Plans
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Executive Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Trish Chalk, Assistant Director of Planning and Performance Marie-Claire Griffiths, Head of Strategic Planning

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Health Board is currently developing the plan for 2026-2029 due to be submitted to Welsh Government on 31st March following Board Approval. The context for next year's plan in the recent re-escalation from level 3 to level for Finance and planning. This paper sets an update on the development of the plan which will be aligned to the new organisational strategy Gwent 35: Better Health, Better Care, Better Lives.

This paper includes the Neighbourhood Care Network Annual Plans which have their own guidance issued directly and require submission to Welsh Government on 31st January.

Cefndir / Background

The NHS Wales Finance Act (2014) requires the Health Board to annually submit an Integrated Medium-Term Plan (IMTP) that can financially balance over a three period to Welsh Government for approval. This is a statutory duty. Each year Welsh Government issues an NHS Wales Planning Framework that sets out the requirements for Health Boards to plan against, including the national policy context, priorities, statutory obligations and a Minimum Data Set (MDS) adopted as the mechanism that provides assurance on delivery of core services. Welsh Government issued the Planning Framework on 19th December 2025 which confirmed a submission date of 31st March 2026. The requirements for MDS and Ministerial Templates have not yet been confirmed. This correspondence confirms that if organisations are unable to develop a balanced plan then this is to be communicated to Welsh Government via an Accountable Officer letter by 13th February 2026.

The financial allocation was received on 19th December which specifies the initial funding for the Health Board for 2025-26.

A Board Briefing session was held on 7th January which went through in detail the requirements set out in the NHS Wales Planning Framework and the financial allocation highlighting the impact of both of these on the Health Board.

Within Primary Care there is specific Welsh Government guidance and expectations for the development of local annual plans at cluster or neighbourhood care network (NCN) level which require submission to Welsh Government on 31st January. Each Local Authority area within the Aneurin Bevan Health Board area consists of 2 to 3 NCNs. These are supported by Integrated Service Partnership Boards (ISPBs) that ensure joined up delivery, commissioning and partnership working for each Local Authority area.

In July the Board approved the Health Board's new organisational strategy Gwent 2035: Better Health, Better Care, Better Lives. This new strategy signals a step change, and our future planning needs to demonstrate how it will achieve the ambition that by 2035 we want everyone across Gwent to have the same chance to live a long, healthy life and have an improved healthy living expectancy. A Board Development Session was held on 22nd October which agreed alignment of strategy delivery and IMTP, developing plan as Better Health, Better Care, Better Lives. Therefore, this IMTP needs to demonstrate our approach to embed the three aims of Better Health, Better Care and Better Lives and the actions we will take for the first three years of delivery.

The approach for 2025/26 has previously been supported by the Board and provided a clear steer into the organisation and operational teams on the priorities for 2024/25 and the agreed planning parameters. The plan for 2025/26 will have quality and safety embedded underpinned by a move towards sustainable models with a focus on productivity, maximising use of core and existing resources.

The approach for the development of the IMTP building on our learning from the previous cycle is summarised below:



The approach continues to be aligned with Planning Maturity Matrix Assessment which has been updated and a reassessment carried out for 2025/25. This assessment supports achieving further de-escalation from targeted intervention for planning and finance.

Following a reassessment against the NHS Wales oversight and escalation framework in December 2025, the ABUHB escalation levels were raised to:

- Level 4 for finance, strategy and planning

The NHS Wales Planning Framework and Financial Allocation was received on 19th December these documents are included as **Appendix 1**. The diagram overleaf summarises the expectations contained within the planning framework.

NHS Wales Planning Framework 2026 Summary		
Strategic Priority	Expectation (New in Purple)	19 Delivery Expectations 26 Enabling Actions - baseline position, and the improvements that you will deliver
Timely Access to Care	- Strengthen patient communication on waiting lists, better informed about likely waiting times. - Maximising what can be done in primary and community care via Community by Design. - All Handovers within 45 minutes. - Prevention and earlier intervention e.g. quit smoking, live healthier lives, reduce obesity rates, especially amongst our children and managing chronic diseases such as diabetes.	Include an assessment of progress and commitment to deliver during 2026-27: - MAG recommendations on performance and productivity - Improving Performance Together
Population Health & Prevention	- Drive an uptake in vaccinations & reduce vaccine inequity. - Commissioning and provision based on your population's health needs - Population health management approaches - Marmot principles - Delivery of integrated services in the community, moving from a hospital by default approach to one of community by design - Supporting people with long-term conditions or frailty remain well and receive care in their communities	System Leadership and Transparency - Continue to develop leadership and culture to ensure the safety, health and well-being of their workforce to enable them to deliver, optimise their team effectiveness and improve their services. Clinical leadership is critical to this. - Identify successful innovation – applying a principle of "adapt, adopt or justify". This includes the need to make far greater use of digital innovation. - Set out tangible regional proposals, showing how your organisations will work together to strengthen services, and maximise the skills and facilities available in your regions to improve patient outcomes - Planning and delivery must be built upon the domains of improving quality, safety, outcomes and value, supported in turn by robust enabling plans for capital, digital, collaborative working, the NHS workforce, and within available resources
Community by Design	- Plan to co-design service models with communities and increase the proportionate spend on primary and community-based services over the course of 2026-29 - Support a collective effort with social care services to avoid unnecessary hospital admission and a further improvement in timely hospital discharge. - Alignment with and commitment to delivering RPB plans will be key.	- NHS Wales Decarbonisation Strategic Delivery Plan - Anti-Racism Wales Action Plan - Welsh Language and the delivery of priorities in Mwy na geiriau / More than just words - Principles of the Wellbeing of Future Generations (Wales) Act 2015 - Embrace Value Based Health Care
Mental Health Access	- Transforming our system to open access mental health support - Ensure mental health services are shaped in alignment with the Mental Health and Wellbeing Strategy 2025-35	
Women's Health	- Establish a pathfinder women's health hub by March 2026 and build on this in 2026 - Work towards the expectations set out in the Quality Statements, including those for cancer, circulatory diseases, diabetes, and Palliative and End of Life Care.	
Quality & Safety	- Plan to address clinical services that meet the principles for fragility described in the National Clinical Framework - The variation reported in Quality and Outcomes Framework and National Clinical Audit and Outcome Review Programme should be routinely used, and improvement actions regularly considered as part of your quality assurance and governance arrangements.	

In addition, the table below summarises the 19 ministerial delivery expectations for 2026-27;

Strategic Priorities 26-29	Ministerial Delivery Expectations 26-27
Timely Access to Care	- Ensure no ambulance patient handover waits over 45 minutes - No patients waiting more than 104 weeks for referral to treatment.
	Number of patients waiting more than 8 weeks for a specified diagnostic – target zero
	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.
	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. (*New)
Population Health & Prevention	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. (*New)
	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. (*New)
	Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes.

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.
	• 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.
Mental Health Access (*New Measures)	• Implement and evaluate Open Access Mental Health Support by March 2027
	• Improve safety in Secondary Care Mental Health services (measured through agreed mental health safety matrix and PROM ReQuol) by March 2027.
Women's Health	• Improve Physical Health of People with long term MH problems by carrying out mortality reviews and implementing improvement plans from the learning by March 2027.
	• Further expansion of the Women's Health Hub model in each health board area by March 2027 (aligned to the Women's Health Plan)
Quality and Safety (*New Measures)	• Improving the quality of our maternity services by reducing perinatal mortality rates. (*New)
	• Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.
	• Days of safe care delivered since the last never event, monitored using SPC T-Chart
	• Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027
	• 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.

In addition to the Ministerial delivery priorities above, Enabling Actions have been refreshed and reissued for 2026/27. These are in Annex 2 of the Planning Framework attachment and focus on efficiency and productivity measures and are framed as "adopt or justify".

3. Emerging Plan

A Board Briefing Session was held on 7th January which provided the Board the opportunity to reflect on the NHS Wales Planning Framework and scrutinise the emerging plan.

The IMTP planning processes are embedded throughout the organisation from Board to front line teams. By ensuring strategy delivery is rooted within the IMTP we are building the principles into the business architecture of the organisation.

Priority Areas

Aims	Priorities			
Better Health: Together we will support people to be healthy, active, and happy. Better Care: Together we will deliver what matters to people – supporting our staff to thrive and achieving quality, kind, and sustainable care. Better Lives: Together we will create strong, safe, and connected communities.	Health Protection	Health Improvement	Prevention	Early Years to Young Adulthood
	Vaccination and screening uptake and equity	- Healthy Weight supported through active and sport partnership - Smoking Cessation	- High Risk Populations and PHM - Preventable Premature Mortality Programme - Reducing Cancer Inequalities	- Perinatal Health Attachment - Maximising outcomes for Babies, Children & Young People
	Place Based Care	Access & Sustainability	Improving Quality & Experience	Embedding Value & Efficiency
	- Testing of model for PBC in Torfaen and BG - Women's Health and Hub	- Sustainable model for GMS - Regional Planning via RJC - Sustainable model for medical assessment - Frailty/COTE & associated capacity plan	- Urgent & Emergency Care – embed model & Learning from GPs/ONP - Mat/Neo configuration - Mental Health – service and estate configuration	- Efficiency in planned care (theatres and outpatients) - Review and develop theatres model - Enhanced and Commissioned Care
	Healthy Places	Resilient & Connected Communities	Safe Spaces	Quality of Life
	- Commercial determinants of Health & Green Spaces - Developing effective Education & School Partnerships	- Social Prescribing - Carers - Transport	- Reducing Domestic Abuse - Housing - Environmental Safeguarding	- Waiting Well - Recovery & Rehabilitation - End of Life Care

With each Service area we have further developed the process for activity planning and demand and capacity. The outputs from this process will accompany the development of the delivery expectations for this year's plan, which will be based on the extensive insight from the submissions. This will continue to be developed over the forthcoming weeks including updated information from divisional submissions to gain further granularity on the forecasted position against our performance ambitions. A paper that summarises our performance ambitions and ability to meet the Welsh Government delivery expectations will be discussed on 23rd February at Finance and Performance Committee.

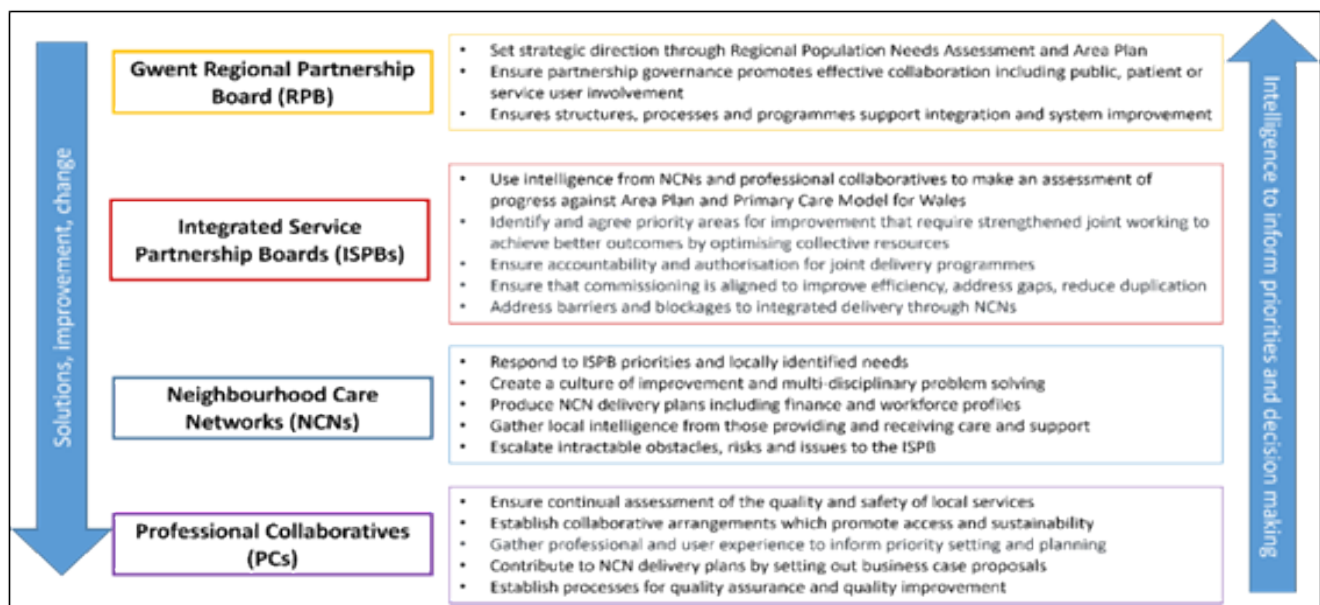
Risks

The following risks have been identified to the submission of an approvable plan;

- Ability to deliver financially balance plan within core funding
- Ability to meet or improve against ministerial targets in core resources
- Ability to make progress on strategy delivery in resource constraints
- Any additional escalation requirements
- Capturing costs and timing of release of efficiencies
- Timescales for plan development
- Recruitment, retention and wellbeing of staff across different cohorts
- Capacity to respond to estate improvements / new build
- Capacity of Corporate Enablers e.g. Digital

4. Neighbourhood Care Network Plans

Within Primary Care there is specific Welsh Government guidance and expectations for the development of local annual plans at cluster or neighbourhood care network level. Each Local Authority area within the Aneurin Bevan Health Board area consists of 2 to 3 NCNs. These are supported by Integrated Service Partnership Boards (ISPBs) that ensure joined up delivery, commissioning and partnership working for each Local Authority area. The RPB which is established to cover Gwent provides oversight and sets the strategic direction through the regional population needs assessment and area plan.



In June 2023 the 5 ISPBs across the Health Boards region published their 3-year plan (2023-2026) reflecting the strategic drivers, aims and objectives of the refreshed RPB area plan.

For 2026/27, NCN plans have been developed on a local authority basis with any differences at an NCN level highlighted within their plans. A standardised format was also agreed across all five localities to support consistency this includes a plan on a page within each. Each plan for the local authority area which includes multiple NCNs have been provided in Appendix 2.

Each of the NCN areas face different challenges in providing the right support for their citizens based on population need, these are detailed in the needs assessment and specific requirements for their population included in their action plans.

This year a step change was taken in NCN plan development where shared areas of focus were agreed at the outset these were;

Priority	Description	2026/27 Actions
Implementation of Place Based Care	Building resilient, connected communities through partnership, prevention, & lifelong support for independent living	Set up Locality Teams for integrated community care Track NCN progress with annual reviews Embed MDT care in primary care clusters Create a standard MDT model across NCNs Enable digital collaboration to support Place-Based Care Align estates strategy
Reducing premature mortality and morbidity	Reduce premature cardiovascular deaths by finding and managing hypertension, & preventing diabetes	Agree unified AWDPP & CVD model Align protocols for hypertension, pre-diabetes & smoking cessation Train primary care teams on new integrated workflows Support combined reporting & monitoring systems
MDT working for people with 0.5% complex needs who are most at risk	Support people with complex needs to live safely & independently at home, avoidable hospital use	Identify complex patient cohorts using risk stratification Maintain structured MDT meetings and strengthen core membership Enhance professional collaboratives by building on existing models Monitor, share, and scale proven MDT approaches across ABUHB
Equity of access to supplementary/enhanced services across Gwent	To ensure people have high quality and equitable access to supplementary/enhanced services	Map services and identify gaps Evaluate enhanced services Pilot in high-need areas (e.g. care homes) Monitor uptake, outcomes, equity Use MDT forums for complex case coordination Boost capacity and engagement
Agree NCN contribution to the Women's Health Programme	Embed equitable, community-focused care in Women's Health by aligning NCN contributions to local needs and expertise	Define NCN role in Women's Health and key contribution areas Assess local needs and NCN capacity for women's health Draft framework for NCN contributions in clinical care, outreach, and integration

Apart from one NCN, all plans submitted were financially balanced within their budgets summarised in table below. The NCN that did not submit a financially balanced scheme

provide options of savings opportunities that would result in financial balance. The split of the below may be subject to change as we move to further align with the Marmot principles.

NCN	2026-27
BLAENAU GWENT WEST	£268,589
BLAENAU GWENT EAST	£239,129
CAERPHILLY SOUTH	£351,468
CAERPHILLY NORTH	£447,736
CAERPHILLY EAST	£403,182
MONMOUTHSHIRE SOUTH	£251,408
MONMOUTHSHIRE NORTH	£340,171
NEWPORT EAST	£495,903
NEWPORT WEST	£538,077
TORFAEN NORTH	£337,402
TORFAEN SOUTH	£293,913
NCN GENERAL	£60,000
	£4,026,979

The NCN plans have also reflected and demonstrated alignment to the aims and objectives of the refreshed RPB area plan.

Collaborative working will continue over the next twelve months to ensure NCN plan development continues to reflect local population need balanced with meeting the national strategic and local Health Board priorities.

All five plans will be submitted to Welsh Government on 31st January as per the planning guidance.

5. Next Steps

The following key next steps will be taken forward ahead of plan submission to Welsh Government on 31st March;

- Exec Cte review of the Organisational Demand and Capacity Model – 8th January
- Dedicated TUPF engagement session – 13th January
- PPH&P Cte to receive an update on plan development and endorse NCN plans ahead of NCN Plan WG Submission – 27th January
- Exec Cte prioritisation of choices within plan and scrutiny of performance expectations– 29th January
- F&P Cte discussion on financial plan and performance expectations – 23rd February
- Board Development session on the First draft of plan – 25th February
- Public Board scrutiny of the Final Draft of the Plan – 25th March

Argymhelliad / Recommendation

The Planning, Population Health and Partnerships Committee to **discuss** and **note** the update on IMTP development and the final NCN plans.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg
Corfforaethol a Sgôr Cyfredol:

The monitoring and reporting of committee business is a key element of the Health Boards assurance framework

Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Yes not yet available An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

**Deddf Llesiant
Cenedlaethau'r Dyfodol – 5
ffordd o weithio
Well Being of Future
Generations Act – 5 ways
of working**

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

Not Applicable
Choose an item.



Eich cyf/Your ref
Ein cyf/Our ref

NHS Chairs

19 December 2025

Dear colleagues,

Transforming Services to Deliver Better Health and Care - NHS Wales Planning Framework 2026-2029

We issue every year a new Planning Framework for the NHS. It's a crucial point in our annual calendar, setting our next priorities. These priorities are Ministerial choices, designed to make services better, and help steer the NHS towards a more sustainable future. And they build upon a fundamental requirement for all health bodies in Wales, which are non-negotiable and never change: to provide safe and high-quality care for all those who need it, within given resources, and sustainably.

I know the context this year is really challenging. I am asking the NHS to keep services safe and make improvements, when financial pressures are significant, demand is increasing, and staff already deliver more every year. But I have great confidence that the NHS will rise to this challenge. Your ambition for improvement is as great as mine, your innovation and creativity are undimmed, and we all know that standing still will not deliver an NHS fit for the future. I am also clear in my expectation that your plans will need to make hard choices and not include many improvements which would otherwise be desirable, outside the six areas of focus set out below.

We have seen some good progress over the past twelve months, and I would like to thank everyone in NHS Wales for their huge efforts and commitment during a challenging time. For example, we have seen a reduction in number of patients waiting over 2 years for planned care treatment and an improvement in cancer waiting times, reduced ambulance handover delays and fewer delays in hospital discharges. It is also good to see that all health boards have plans in place to establish pathfinder Women's Health Hubs by the end of the financial year and that work is underway to deliver a national lung cancer screening programme.

It is important that we build rapidly on this progress to improve people's health and well-being, and ensure patients can access the care they need, where and when they need it.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1SN

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400

Gohebiaeth.Jeremy.Miles@llyw.cymru
Correspondence.Jeremy.Miles@gov.wales

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

We must tackle the challenges of today, whilst at the same time driving forward speedily the transformation which will lead over the longer-term to a more effective and sustainable service, and better health outcomes.

To give you clear and consistent direction for the period ahead, the NHS Wales Planning Framework for 2026-2029 echoes and builds on the previous Framework, and is aligned with the commitments made by the First Minister in relation to planned care, delayed pathways of care and women's health.

We must build on the progress made this year, to deliver the recommendations of the [Ministerial Advisory Group on Performance and Productivity](#) and the priorities I set out in my letter of 3 July 2025, *Improving Performance Together*. This Planning Framework reiterates those expectations, and I expect NHS organisations to ensure these are embedded in your planning arrangements.

I am aligning this Framework to financial allocations to health boards. These will help mitigate the impact of unavoidable inflationary and demand pressures on frontline services, but it is a challenging financial settlement, with no discretionary funding for investment I expect health boards to do more to address waste, harm, and variation, in addition to increasing productivity and efficiency.

I am expecting all health bodies to develop and submit plans that achieve financial balance.

My 3-Year Strategic Priorities for NHS Wales

This Framework sets out the strategic priorities that must be delivered by all health boards, and (where relevant) other NHS organisations over the next three years.

The areas on which you must focus are:

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

The minimum delivery expectations under each of these strategic priority areas have been refreshed for 2026-27 and are set out in Annex 1.

The areas of focus remain broadly the same, to provide continuity, though I have chosen to bring together our priorities on quality and safety and to highlight them in this Planning Framework.

Timely Access to Care

We have refreshed our referral to treatment guidance and provided faster access to tests and scans. This means we are reducing the time patients wait for diagnostics, reducing hospital treatment waiting times, especially for those who have been waiting longest and reducing the overall total waiting list. But there is much further to go.

I expect NHS organisations to explore opportunities to strengthen the way in which they communicate with their patients on waiting lists to enable patients to be better informed about their likely waiting times. It can be an anxious and difficult time for patients, and I believe it is important that they are fully engaged in their care, so they know what to expect.

Whilst focusing on those already waiting for treatment, we must also take the opportunity to think differently about how we deliver care in the future by utilising the opportunity we have of integrated health boards and maximising what can be done in primary and community care via Community by Design.

We know there continue to be pressures on our emergency departments and that long ambulance handover waits present significant and avoidable risk of harm to patients. I welcomed the MAG recommendation setting out the need to plan to deliver all handovers within 45 minutes. We have seen progress this year, but I expect health boards to improve patient flow rapidly, so that this expectation is met as standard practice, across all parts of Wales.

Population Health and Prevention

We know we need to improve people's long-term health and reduce health inequalities to improve life expectancy and the well-being of our population. Wales has higher rates of preventable deaths than similar countries. This requires a focus on prevention and earlier intervention in your plans including support for people to quit smoking, live healthier lives and to reduce obesity rates, especially amongst our children and managing chronic diseases such as diabetes. Your plans should also drive an uptake in vaccinations, including childhood immunisation, building on catch up programmes over the last year and reducing vaccine inequity.

In line with Community by Design, the commissioning and provision of health and care services in your area must be based on your population's health needs. I am keen to see population health management approaches reflected in the integrated planning of your services especially at a community level, which will be supported by a national population segmentation and risk stratification tool.

At the population level, Wales will become a Marmot nation to support our work in reducing health inequalities by working locally and nationally in applying the Marmot principles - from early childhood and education to employment, preventing ill-health, housing, and community wellbeing. I am keen to see how you will work with other partners outside the NHS to take forward these approaches,

Community by Design

As well as placing prevention and population health at the core of NHS Wales we must make greater progress with the delivery of integrated services in the community, moving from a hospital by default approach to one of community by design, in particular supporting people with long-term conditions or frailty remain well and receive care in their communities. I expect to see how you plan to co-design these service models with your communities, working with GP practices, other key partners and stakeholders, to deliver integrated services in the community and how you will increase the proportionate spend on primary and community-based services over the course of 2026-29.

We must recognise that rising demand for services and increasing costs mean our social care system remains under pressure. I expect NHS organisations to continue working closely with their key partners to help ensure the care provided is person-centred, compassionate and flexible enough to adapt to an individual's changing needs and it is important that your plans support a collective effort with social care services to avoid unnecessary hospital admission and a further improvement in timely hospital discharge. Alignment with and commitment to delivering Regional Partnership Board plans will be key.

Mental Health Access

We are committed to ensuring there are seamless mental health services, that are person centred and needs-led. Earlier this year the NHS Wales Performance & Improvement Strategic Programme for Mental Health developed guidance, 'Transforming our system to open access mental health support – Supporting Information', setting clear expectations for the remainder of 2025-26. This is aligned to a 'Community by Design' approach and vital in order to continue to improve quality, safety, experience and outcomes, and driving this agenda at pace will place our mental health services in a stronger position to deliver the sustainable services we need to deliver through collaboration. I expect your plans for 2026-29 to build on this and ensure mental health services are shaped in alignment with the [Mental Health and Wellbeing Strategy 2025-35](#).

Women's Health

Progress over the last year in strengthening women's health services has been encouraging, but we need to do more to address the health inequalities women continue to face. We know there are serious challenges in accessing healthcare, including taboo, stigma and a lack of understanding by others when discussing their health and wellbeing - which can be a barrier to receiving the right help. The Women's Health Plan sets out the improvements required across Wales. I am encouraged by the commitment shown by health boards to establish a pathfinder women's health hub by March 2026. We must build on this to provide women with the care and support they need, as locally as possible and to deliver better outcomes. I am keen to see this reflected in your plans.

Quality and Safety

Addressing harm, waste and unwarranted variation in clinical services must be at the forefront of organisational planning and operational delivery. Your organisations are subject to the [Duty of Quality](#) and the [Health and Care Standards](#) - and this should shape your decision making. I would like to see this more strongly reflected in your planning and, as a minimum, I would like to see how your organisations are planning to work towards the expectations set out in the [Quality Statements](#), including those for cancer, circulatory diseases, diabetes, and Palliative and End of Life Care.

You should also identify and plan to address clinical services that meet the principles for fragility described in the [National Clinical Framework](#). The variation reported in [Quality and Outcomes Framework](#) and [National Clinical Audit and Outcome Review Programme](#) should be routinely used, and improvement actions regularly considered as part of your quality assurance and governance arrangements.

Year 1 Delivery Expectations for 2026-27

The minimum delivery expectations set out in Annex 1 highlight those areas of greatest priority and should therefore be the focus of your year-1 plans (2026-2027).

Securing these outcomes should be at the centre of how you use your resources and capacity to speed up delivery within existing resources. Progress in some of these areas will require you to prioritise partnerships with social care. Meeting these expectations will help achieve the improvements in performance and outcomes that we would all wish to see in year 1 of your plans (2026-27). I expect to see continual and consistent improvement towards delivery across all the strategic priority areas over the three years.

Enabling Actions

To support you to deliver against these expectations, I am also setting out a refreshed set of enabling actions (attached as Annex 2) which I am again mandating on the basis of “adopt or justify”.

These have been updated to reflect the progress made over the last twelve months and aim to drive forward improvements on a consistent basis and reduce variation. Each has an evidence base to demonstrate improved efficiency and/or outcomes, without driving additional cost. They are the product of work undertaken by the National Strategic Programmes and the Value and Sustainability Board. Several of the enabling actions relate to activity which must be deprioritised and stopped where there is evidence of waste, harm or variation resulting in no (or low) clinical value or effectiveness. Delivering the mandated enabling actions, along with an assessment of the associated productivity, efficiency and/or financial gains must also be reflected in your plans.

I am disappointed that not all the enabling actions for 2025-26 will have been achieved by year end. These are “just do it” actions, and, acknowledging the progress which has been made over the last year, much more must be done to ensure implementation during 2026-27. **I am expecting a clear organisational assessment of the baseline position, and the improvements that you will deliver, by enabling action, to feature as an annex to your plan.**

Your plans must also include an assessment of your progress in delivering the MAG recommendations on performance and productivity and the priorities set out in Improving Performance Together, as well as your commitment to deliver these during 2026-27.

Although this Framework is clear about the national priorities that your plans need to focus on most, I recognise of course that NHS organisations need to commission and/or provide a wide range of services to improve the health of your populations and to meet the strategic objectives of *A Healthier Wales*, within the resources available to you. I trust that your Boards will keep this balance in mind when making decisions and choices in other areas.

As NHS organisations, you are best placed to identify the needs of your local populations, so whilst setting out my expectations for delivery against the 3-year national strategic priorities, Year 1 delivery expectations and enabling actions, I recognise that this means greater flexibility in delivering on other areas. As you develop your plans, it would be helpful to have an open dialogue with you as you consider the options and choices open to you.

Financial Framework

The expectations set out in this Planning Framework should be achieved within existing resources. Delivering the progress required in 2025/26 on enabling actions, as well as cutting the waiting list will improve the effectiveness and sustainability of services on an

ongoing basis. However, we must go further within existing resources to appropriately reduce cost, increase productivity and address variation, whilst improving outcomes.

I expect all health bodies to develop and submit plans that achieve financial balance.

In developing your plans, I emphasise the following:

- New additional funding provided in the allocation letter is to support inescapable demand and unavoidable inflation, in supporting front line services. **It is to be utilised for this purpose only.** I expect plans to be free of discretionary investment.
- My officials have undertaken work to baseline as much funding as possible into core allocations and in return expect health boards to plan on living within that resource.
- I expect a step change in the achievement and consistent delivery of all enabling actions.
- Health bodies will need to ensure clarity and visibility for significant savings in non-core areas and overheads to prioritise front-line services, to ensure that savings and mitigations delivered in 2025/26 are maintained in full on a recurrent basis, and to deliver the savings and cost mitigations that are required to achieve financial balance. No area of expenditure can be exempted from this and the need to increase productivity. The first draft of the NHS Wales total factor productivity model will be provided to health boards over coming months, and I expect all boards to develop clear quantified plans showing how their actions will deliver a quantified productivity gain in 2026/27.
- I expect health bodies to proactively reach agreement on commissioning and providing services across organisational boundaries and strengthened collaboration on a regional basis.
- Your organisations must continue to have the highest levels of strong and effective financial management, that support cost control.
- Given the scale of investment in 2025/26 to address treatment backlogs, with the action on enabling actions, and productivity, a number of areas will have sustainable solutions on a recurrent basis. I am retaining £20m of funding to support a reduction in waiting times in areas of residual challenge. This will be used on a directive basis, only when all opportunities to deliver sustainability and productivity have demonstrably been exhausted. This position will be assessed through the planning process.
- I have taken a decision to invest in GMS services to proactively increase capacity and activity in primary care, closer to home, in support of the expected focus and development of the Community by Design programme. I expect your plans to show how you will shift activity and resource from a secondary care setting into primary and community care.
- There will be an increase in discretionary capital allocations, which is a 12% uplift on the baseline allocation, to support local plans and resilience.

System Leadership and Transparency

This is my second Planning Framework as Cabinet Secretary for Health and Social Care, and I am still amazed by the dedication of our NHS workforce. They are at the heart of all we do for our patients. We must continue to focus, in social partnership, on ways to engage and empower our people to deliver safely, effectively and flexibly.

We must continue to lead with compassion at all levels across the NHS and this involves engaging the workforce. They are the key to delivering the transformation and improvements we all wish to see. I expect to hear how organisations continue to develop their leadership and culture to ensure the safety, health and well-being of their workforce to enable them to deliver, optimise their team effectiveness and improve their services. Clinical leadership is critical to this, directing the NHS to improvement in patients' interest. I have been pleased to see real improvements already in this area, nationally, regionally and locally, and look forward to seeing even more in coming months.

There is more for us to do together to streamline the relationship between the Welsh Government and NHS organisations, so that we can ensure that our data reporting, accountability and other systems are transparent, proportionate and reduce duplication. We have already taken action in some areas, for example the new Public Accountability Meetings, but there is more to do. I think that by engaging more – and more effectively - with our patients and staff, showing transparently what we are doing and welcoming accountability and honest reflection, we embed improvement in our working lives.

I am keen to ensure all parts of our NHS seek continuously to learn from best practice both from within the NHS in Wales and beyond, proactively working together to identify successful innovation – applying a principle of “adapt, adopt or justify”. This includes the need to make far greater use of digital innovation. The rewards for patients are huge. We will continue to work with you to ensure a strong national digital architecture.

Regional solutions will be necessary in order to deliver quality, access and levels of care that often cannot be delivered by one organisation alone. Where such challenges exist, I expect your plans to set out tangible regional proposals, showing how your organisations will work together to strengthen services, and maximise the skills and facilities available in your regions to improve patient outcomes.

All organisational planning and delivery must be built upon the domains of improving quality, safety, outcomes and value, supported in turn by robust enabling plans for capital, digital, collaborative working, the NHS workforce, and within available resources.

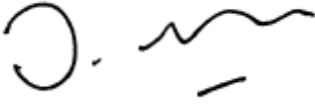
We must not lose sight of the cross-Government priorities such as the refreshed NHS Wales Decarbonisation Strategic Delivery Plan, Anti-Racism Wales Action Plan, Welsh Language and the delivery of priorities in Mwy na geiriau / More than just words to name but a few. In addition, I would naturally expect you to work within the context and principles of the Wellbeing of Future Generations (Wales) Act 2015 and embrace Value Based Health Care to deliver the care we all aspire to on a sustainable basis.

Outcomes that matter to people

We must continue to balance better long-term outcomes with addressing the here and now issues that face our communities, our patients, our workforce and our health and social care system. I am struck by the commitment of your staff working on the front line and delivering care in our communities, and how much making a difference for patients and their families

means to them. Working together I am confident that we can make the improvements we all want to see, and the people of Wales deserve.

Yours sincerely,

A handwritten signature in black ink, consisting of a large 'J' followed by a series of loops and a horizontal stroke.

Jeremy Miles AS/MS

Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care

Annex 1 – Key Delivery Expectations for 2026-27

Strategic Priorities for 2026-29	Ministerial Delivery Expectations for 2026-27 (where applicable)
Timely Access to Care	• Ensure no ambulance patient handover waits over 45 minutes • Ensure no patient spend spends 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge. • No patients waiting more than 104 weeks for referral to treatment. • Number of patients waiting more than 8 weeks for a specified diagnostic – target zero • 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.
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. • 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. • 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.

	• Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes.
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. • 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. (National requirements and expectations will be specified by the Community by Design Transformation Programme Board)
Mental Health Access	• Implement and evaluate Open Access Mental Health Support by March 2027. • Improve safety in Secondary Care Mental Health services (measured through agreed mental health safety matrix and PROM ReQuol) by March 2027. • Improve Physical Health of People with long term MH problems by carrying out mortality reviews and implementing improvement plans from the learning by March 2027.
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) • Improving the quality of our maternity services by reducing perinatal mortality rates.

Quality and Safety	• Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate. • Days of safe care delivered since the last never event, monitored using SPC T-Chart • Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027 • 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.

Annex 2- Enabling Actions for Delivery in 2026/27

New Actions for 2026/27

Strategic Priority	Enabling Action
Productivity	Health boards to 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.
Mental Health	Health boards to implement actions to deliver a material reduction in the number of out of area placements in 2026/27, and associated costs.

Actions to be rolled over to 2026/27 using the existing definition

Strategic Priority	Enabling Action
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 HVLC General Surgery procedures on an all-day list made up of hernias/gallbladders by end of Q2
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.
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.
	Medicines Management - ensure full implementation of the high value medicines Value & Sustainability Board programme, which includes delivering opportunities against each of the programme areas.
	Estate - ensure strengthened actions are taken to improve estate utilisation including the appropriate repurposing & disposal of under-utilised estate.
	CHC - ensure implementation of Value & Sustainability Board recommendations which include continued actions to improve clinical and financial effectiveness associated with packages of care.
Improving Value, Optimising Outcomes, &	Ensure progress with the implementation of Value & Sustainability Board High Value High Impact pathway - Bone Health

minimising Variation	
Workforce Productivity	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.
	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.
	Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular
	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.
	Ensure a reduction in sickness absence in 2026/27 in comparison to 2025/26, through maximising adherence to the requirements of agreed attendance at work policies and adhering to the all-Wales Occupational Health minimum service levels.

Actions to be rolled over to 2026/27 with re-defined action definition

Strategic Priority	Newly defined action for 26/27
Timely Access to Care	Ensuring the full implementation of the National Optimal Pathway (NOPs) in Cancer
	Theatre session utilisation is improved to achieve GiRFT standard of 85%- late starts (>15 mins), early finishes (>60 minutes) and overall utilisation are reported as key KPIs to underpin the 85% standard
	Consistent clerical and clinical validation should be in place using the national SOP - 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
	Each Health Board should see a referral return rate of 20+% and/or a reduced referral rate per 100,000 population by December 2026 - utilising Health Pathways optimally.
	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.

	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.
	Deliver medical same day emergency care (SDEC) and acute frailty services at the front door of hospitals in line with all principles set out in national SDEC policy and strategy documents, and the six goals for urgent and emergency care programme <i>Front Door Acute Frailty Service (AFS) Framework for Acute Hospitals</i> .
	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.
	Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme single point of access (SPOA) 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 WAST and Local Authorities, to deliver coordinated and effective care across the urgent care pathway.
Population Health & Prevention	Ensure progress of the focused Diabetes High Value High Impact pathway
Improving Value, Optimising Outcomes, & minimising Variation	Eradicate unsupported systems and devices and ensure a clear cyber response plan for the organisation.

Appendix 1

Actions not rolled forward from 2025/26

Strategic Priority	Enabling Action	Note
Timely Access to Care	Implementation of CIN follow up criteria both prospectively and retrospectively to established Follow-up waiting lists.	Action completed
	On 90% of days planned care inpatient/day case/theatre recovery capacity should be protected from unscheduled care pressures and outlying of patients by the end of Q1.	Action completed – should now be considered as business as usual
	Ensure monitoring of DNA/CNA rates is in place for every Outpatient clinic. When DNA/CNA as a combined rate is greater than 5%, overbooking additional patients should be implemented and monitored.	Action completed – should now be considered as business as usual
	Implement national guidelines with thresholds by Clinical Implementation Network (CIN) and procedure. This includes delivery of effective outpatients through See on Symptom (SOS) and Patient Initiated Follow-up (PIFU) by default. Individual CINs will establish PIFU / SOS targets by specialty & sub-specialty on an ongoing basis by March 2025.	The action should become BAU but should continue to be monitored through programme and performance meetings
	Deliver improvements in day surgery rates, with an expectation to achieving a BACDS day case rate of 70% from April 2025, moving to 80% by the end of June 2025.	Action completed – should now be considered as business as usual
	Maintaining the actions within the 50 Day challenge that can be delivered consistently with minimal additional resource, within organisations and as a priority within regional partnership arrangements.	Action will be taken forward under OHFF under UEC.
	All new Cataract referrals should be direct listed to treatment stage of the pathway following an admin triage by the end of Q2.	Action completed – should now be considered as business as usual
	Progress implementation of the national approach to Interventions not normally undertaken (INNU) Deliver the 8 priority procedures determined for implementation as part of Phase 1.	Remove and propose performance management via optimisation framework
	Progress implementation of the national approach to Interventions not normally undertaken (INNU) - continue to implement ongoing recommendations throughout 2025/26.	Remove and propose performance management via optimisation framework

	Ensuring full compliance with straight to test guidance	Remove as included in the rolled over Cancer National Optimal Pathway (NOPs in Cancer action
Improving Value, Optimising Outcomes, & minimising Variation	Ensure progress with the implementation of Value & Sustainability Board High Value High Impact pathway - Arthroplasty (Hip & Knee).	Remove and propose performance management via optimisation framework

**Cyfarwyddwr Cyffredinol Grŵp Iechyd, Gofal Cymdeithasol a'r
Blynyddoedd Cynnar / Prif Weithredwr GIG Cymru**

**Director General Health, Social Care & Early Years Group / NHS
Wales Chief Executive**



**Llywodraeth Cymru
Welsh Government**

NHS Wales Chief Executives

Our Ref: JT/BS

19 December 2025

Dear Colleagues

NHS Wales Planning Framework 2026-29: Supporting Governance Arrangements

You will be aware that the Cabinet Secretary for Health and Social Care has written to your organisation's Chair setting out the NHS Wales Planning Framework for 2026-29: Transforming Services to Deliver Better Health and Care.

Before I set out the supporting governance arrangements and my own expectations, I would like to express how proud I am to have been appointed as NHS Wales Chief Executive and Director General for the Health, Social Care and Early Years Group, Welsh Government. It is truly an honour and privilege to work with you all to deliver the improvements we all want to see across our health and care system. I have been hugely impressed with the professionalism and commitment I have seen in my role thus far and I am keen that we continue our joint efforts at pace during what remains a hugely challenging time.

I have been impressed with the integrated planning approach taken here in Wales and I am firmly committed to this way of working as we aim to strengthen the delivery of sustainable, quality health and care services to our communities. I am therefore pleased to issue this as my first letter on the back of the recently published NHS Wales Planning Framework 2026-29, which sets out the Cabinet Secretary's priorities for the next planning cycle.

Supporting Governance Arrangements

You will know that the refreshed *A Healthier Wales* actions were published last year, and were supplemented by the Ministerial Advisory Group recommendations on performance and productivity as well as the expectations the Cabinet Secretary set out in *Improving Performance Together*. It is important these continue to be reflected in your planning going forward, including the need to demonstrate prevention throughout organisations' plans. The Well-being of Future Generations (Wales) Act 2015 continues to set the context and requirements, including prevention, within which organisations make decisions.

Integrated Medium-Term Plans (IMTP) must set out how your organisations will secure compliance with their break-even duty over a rolling three-year accounting period, while improving the health of the people for whom they are responsible and the provision of

healthcare to such people. Organisations must also continue to plan for the longer term and to support delivery in line with strategic objectives and clinical services/organisational strategies. The Cabinet Secretary sets out his expectation very clearly on receiving plans that deliver financial balance.

IMTPs will need to follow the familiar formula for the three-year plans with 'Firm, Indicative and Outline' levels of detail and a clear progression over time. Submissions should therefore include a narrative three-year plan, and completion of the Ministerial templates. This must align to the Minimum Data Set (MDS) which also underpins the development of plans.

The narrative three-year plan should set out what has been delivered, what has been progressed and what was unable to be delivered from the previous submission. Year one of your plans must contain firm delivery commitments that provide clarity on milestones, actions and projections that set the ambition for operational delivery and management of risk for the year ahead, along with financial sustainability. In doing so, you must set out clearly the delivery of financial balance.

You will have seen the key three-year strategic priorities set out by the Cabinet Secretary for Health and Social Care for 2026-29 are broadly similar to the previous Framework, with Quality and Safety being added. This is important in terms of ensuring consistency and stability during what is a challenging and complex planning environment. These priorities are supported by a number of delivery expectations and mandated enabling actions for year 1 of your plans, as directed by the Cabinet Secretary. These priorities, expectations, performance improvements and actions must be central to year one plans with resources clearly identified and committed. In approving your plan for submission to Welsh Government, your Board will be confirming and signing up to the delivery commitments to be made by your organisation.

The Framework is clear that these are the top priorities plans need to focus on, but do not exclude the wider range of services NHS organisations still need to commission and/or provide to improve the health of their populations within the resources available.

For clarity, I expect Boards to ensure all opportunities are fully explored to enable organisations to deliver the priorities in line with allocated resources and in a sustainable way going forward. Boards must fully understand and set out any risks to delivery of the plans and have mitigations identified prior to submission of plans. This will help us with the assessment of plans, together with supporting the Cabinet Secretary in making early decisions about plan approvals.

As in previous years, quality, safety and the reduction of health inequalities within and across communities must continue to underpin NHS planning. Evidencing the approaches being taken across these areas need to be set out in the narrative three-year plans. Quality and equity are important threads running through all service and care provision that organisations will want to demonstrate. Your Anti Racism Wales Action Plans should continue to address employment and service delivery as a specific part of your wider approach to equality, inclusion and diversity. The Duty of Quality in particular places a requirement on all of us, as individuals and organisations, and we must take into account the 12 Health and Care Quality Standards when making decisions and planning services. This framing will also be used in the assessment of plans. I am aware that this will be familiar to you, but I want to emphasise the importance I give to quality and outcomes and this is what the Cabinet Secretary and I want to see driving your plans.

Financial Planning

I recognise the significant pressures the NHS in Wales is experiencing, pressures which are not just being seen here in Wales of course. However, this necessitates an even greater focus from NHS organisations to deliver improvements in financial terms, and delivering sustainable financial positions is a priority for NHS bodies. The Cabinet Secretary has been clear on the expectation on where funding is provided, what it is intended to support, expectation on improving use of existing resources, and an expectation of financial balance. Delivering this will involve changing the 'status quo' and exploring a range of innovative ways to reshape and transform your services.

I therefore fully expect to see plans to show an improvement in terms of the delivery and efficiency of services within available resources, and for those plans to be set on a firm base. I want to see greater financial improvement at pace, alongside other priorities, as you work to achieving financial balance.

Continued scrutiny, nationally and locally, on financial management is central to ensuring that progress continues to be made by organisations in driving down financial risk. Please ensure that there are mechanisms in place to consistently align and understand the impact of any financial or workforce decisions on the delivery of plans.

The continued challenges of the financial environment are well understood and therefore maximising all opportunities for transformation, utilising new technologies that create efficiency, productivity and improved patient experience and outcomes must be delivered. The rollout of digital solutions continues to be a part of our future service provision and must be accelerated where it is possible to do so within available resources. The priority focus areas are captured as the enabling actions that must be implemented as outlined in the Planning Framework. Some good progress has been made against a range of the enabling actions set last year, but the opportunities they present have not yet been fully optimised across all organisations. I will be ensuring the Value & Sustainability Board continues to build on this agenda nationally continues as we work together to deliver the key priorities and expectations set out by the Cabinet Secretary. Organisations must develop plans locally that deliver on these requirements.

The NHS Allocation Welsh Health Circular (WHC (2025) 055) and supporting allocation tables are included for your information as follows:

- WHC Cover Letter
- 2026-27 Health Board Allocation Circular
- 2026-27 Health Board Allocation Final Tables
- 2026-27 Health Board Allocation Explanatory Notes

As we continue to strengthen our approach to national and regional working, I am keen to ensure that health bodies who commission and provide services from each other have robust agreements and mechanisms to do so. I will require your confirmation by 27 February that you will be able to agree your respective plans with supported Long-Term Agreements (LTA's) for 2026/27.

Integrated arrangements

The new Performance Framework, which will be issued shortly, reflects the range of key performance information and complements the Minimum Data Set (MDS) that you will provide alongside your narrative three-year plans.

The Cabinet Secretary will require Ministerial templates setting out the delivery of year 1 commitments against each of the key strategic priorities, aligned to your plans to accompany the submission.

NHS plans must continue to be underpinned by collaboration across health board and public sector boundaries and for example ensure they are aligned to Cluster, Pan Cluster Planning Group (PCPG), Regional Partnership Board (RPB) and Public Service Board (PSB) plans. Regional planning between health boards is also a key requirement. We expect to see firm and tangible commitments to regional delivery in your plans.

There are legislative requirements that need to be considered in your planning. These being:

The Well-being of Future Generations (Wales) Act 2015 provides Wales with groundbreaking legislation that places a statutory duty on public services to ensure that we make the best decisions that address the here and now as well as the future. It provides the overarching context for *A Healthier Wales* (including the refreshed actions) and the driver for better health outcomes going forward. To give current and future generations a good quality of life we need to think about the long-term impact of the decisions we make. While this provides clear challenges, the opportunities are immense. Using the sustainable development principle and the five ways of working, as part of our governance and decision making, we can create the environment in which populations can thrive.

Social Partnership and Public Procurement (Wales) Act 2023 – complements the Wellbeing of Future Generations (Wales) Act 2015 and will require NHS bodies to consider the new social partnership requirements when taking specified actions, including the setting or revising of their wellbeing objectives in light of the new requirements. The NHS is already a leader in social partnership and procurement and much of the legislation will already be familiar. The link to key information is attached [Social Partnership and Public Procurement \(Wales\) Act | GOV.WALES](#)

The Health Services (Provider Selection Regime) (Wales) Regulations 2025 were agreed earlier this year and commenced on 24 February 2025. This has given the NHS Wales and local authorities in Wales the ability to implement more flexible procurement practices when sourcing services provided as part of the health service in Wales.

The Duty of Quality and Duty of Candour came into effect in April 2023. It is incumbent on all of us to ensure we are delivering safe quality services. We need to keep in mind the 12 'Health and Care Quality Standards'. Similarly, the series of Quality Statements that have been issued by Welsh Government, offer strong guiding principles on what 'good services' should aspire to, and boards must satisfy themselves that they have achieved the right balance in their planning.

Timetable for submission

The submission of final plans is due by 31 March 2026. Welsh Government will support early assessment of plans to help ensure that there is no pause in the delivery of key priority areas. However, decisions on plan approvals will come after the Senedd elections. In the meantime, accountability conditions and escalation status already in place will remain extant until any further communication is made.

You will be required to submit an Accountable Officer letter to me by 13 February 2026 if your organisation is unable to produce a balanced IMTP. It will be clear at this point whether the organisation will have breached its statutory duty which may lead to further required actions and potentially escalation. For clarity, I would not expect your submission in March to deteriorate from the position described in your AO letter and, if anything, would like to see how mitigation has been put in place to improve on that position.

The escalation status of your organisation and specifically alignment with any de-escalation criteria (where applicable) will need to be reflected in your plans. Colleagues within the NHS Wales Performance & Improvement should support your actions where appropriate.

By 13 February 2026 - Accountable Officer letter (if appropriate)

By 27 February 2026 – confirmation of ability to agree LTAs and plans for commissioned and provider services.

By 31 March 2026 – Final Board approved Plan, Ministerial templates and MDS submission, including the financial templates. Earlier submissions will be welcomed.

Please note the Ministerial template and MDS template will be circulated to your Directors of Planning in due course.

In addition to publishing your Board approved plans, each organisation is asked to develop a short video summarising what your plan will deliver, which can be shared with your stakeholders on your websites and social media channels.

Thank you for your leadership and support for these crucial strategic and operational planning arrangements. A secure and planned system is essential to deliver the improvements we all want to see, and I look forward to receiving your plans in March.

The HSCEY Planning Team will share technical guidance on the development of plans with NHS planners in due course and will engage with your organisations as you finalise your plans.

If you have any questions, please contact Samia Edmonds, Director of Strategic Planning who will provide further details if required and will continue to liaise with NHS Directors of Planning.

Finally, I want to reiterate my thanks to you and your teams, not just for the progress you have made this year, but also for your unwavering focus on improving the health of our nation.

Yours sincerely



Jacqueline Totterdell

MONMOUTHSHIRE NORTH and SOUTH Neighbourhood Care Networks (NCN) Integrated Medium Term Plan (IMTP) 2026-2029



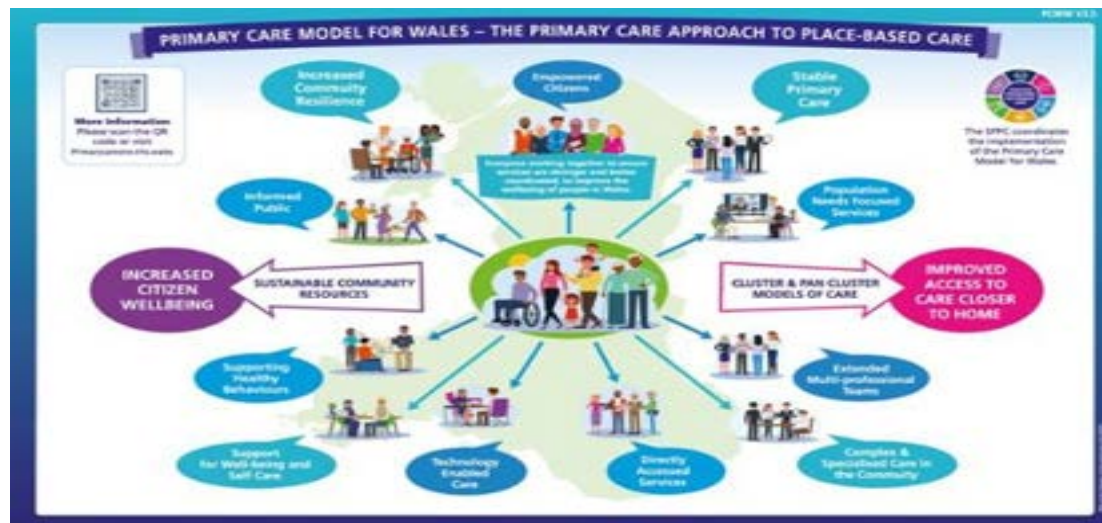
NCN Executive Summary:

This Monmouthshire Neighbourhood Care Network (NCN) Plan sets out our response to strategic and local priorities for both North and South NCNs over the next three years. We will demonstrate progress we have made against previously agreed priorities, and outline new projects and developments aimed at improving outcomes for people of all ages. We will continue to work at pace with key partners to deliver the Place-Based Care (PBC) agenda and ensure we retain sight of the needs of people living in and around Monmouthshire.

We continue to rely on local and National information sources and guidance to underpin and inform our work. The Primary Care Model for Wales, A Healthier Wales and the Social Services and Wellbeing Act continue to be integral to the direction our NCNs have taken.

We make reference to the Gwent Regional Partnership Board's (RPB) Population Needs Assessment and the Monmouthshire Integrated Services Partnership Board (ISPB), key strategic partners driving the PBC agenda, along with Public Health Wales.

The diagram on the right details how we see our resident population being at the heart of the PBC ethos, with NCNs driving the delivery of care as close to home as possible, as directed by strategic partners.



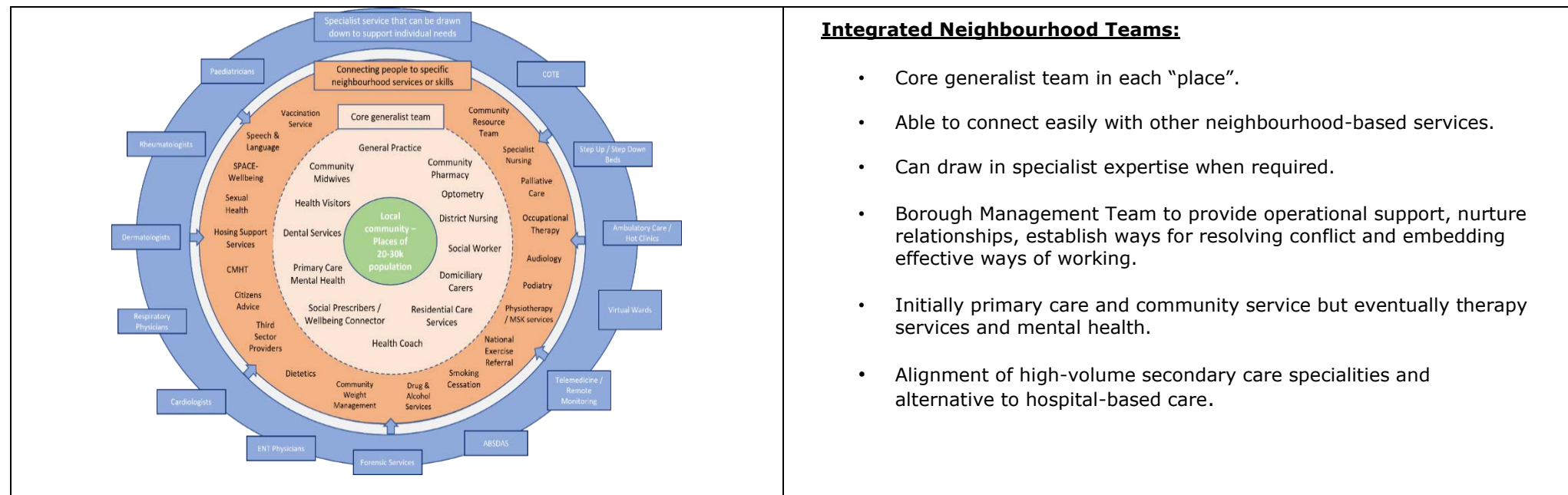
We will set out our priorities and key milestones for the next three years, underpinned by a national policy framework, which includes: A Healthier Wales, the Primary Care Model for Wales and Wellbeing of Future Generations Act, and also demonstrate how our priorities link closely with the Aneurin Bevan University Health Board's 10-year strategy via the continued growth of Integrated Neighbourhood Teams, providing care closer to home, seeking out new digital innovations and by retaining prevention and early intervention as a key priority. We already work closely with Health, Social Care, Integrated Wellbeing Network and Third Sector colleagues to explore new service models and ensure people can access the right support as close to home, or at home, when possible.

By building on existing structures, for example, the multi-disciplinary teams working together in and around each 'place', we will embody the 10-year strategy's ethos of shifting the reliance on hospital-based care, to community-based settings. As NCNs, we have the ability to bring together a range of people and services across health, social care and the Third Sector, to work collaboratively, to plan for delivering integrated, person-centred care based on need.

Place-Based Care, NCNs and the Integrated Services Partnership Board:

A key driver for the Monmouthshire ISPB, and therefore NCNs, is delivering care as close to home as possible, on a place-based basis. Place-Based Care promotes collaboration amongst local services, the third sector and the community itself. In Monmouthshire, we have identified 5 key 'places': Abergavenny, Monmouth, Usk, Chepstow and Caldicot and as NCN Leads, are currently participating in a number of workshops, with Public Health, ISPB and Third Sector colleagues to develop a business case for the delivery of PBC across Monmouthshire.

Linked to PBC, the diagram below shows an idealistic view of what an Integrated Neighbourhood Team could look like.



Population and Context:

Serving a population of approximately 105,000 people, we face continued challenges specific to Monmouthshire, namely a growing older population with increased complexities of long-term conditions, plus, Monmouthshire is a large rural and semi-rural borough surrounding the 5 key towns mentioned. It is important to note that there are approximately 15,000 people who are registered with a Monmouthshire GP and live outside the Monmouthshire border, for example in Powys, Hereford and Gloucester. There are specific challenges in delivering care to this population and some of these will be explored later in this plan. We acknowledge that we need to continue to engage at ISPB level with both Health Board and Monmouthshire County Council service leads e.g.; relating to safeguarding and immunisation programmes, ensuring we meet the needs of children and young people, supporting service leads to deliver high level care for people of all ages in Monmouthshire.

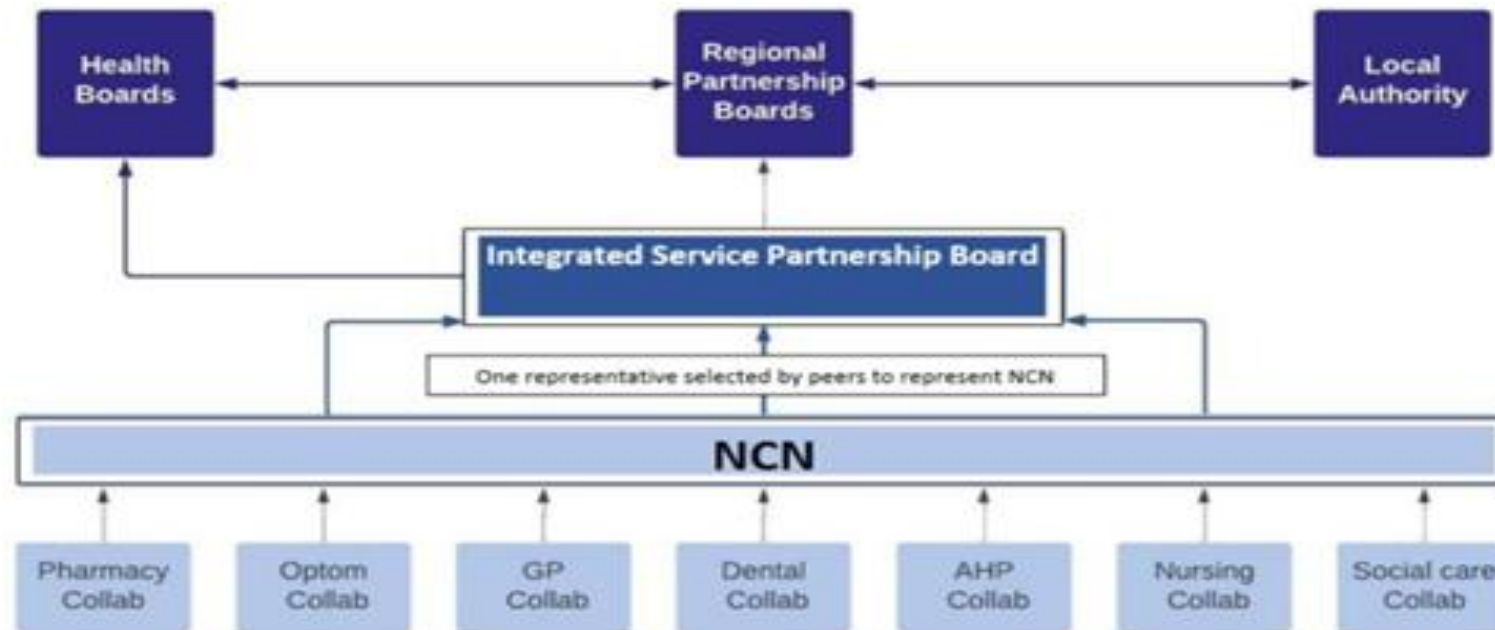
Summary: We believe this NCN Plan provides a timely reflection on the positive work already undertaken, and going forward outlines a framework for delivery of shared priorities as stated. Over the next 3-years progress will be measured via a collaborative approach as determined by the ISPB, and include, specifically for the NCNs: project evaluations, service delivery reviews and oversight as provided by the ISPB and Aneurin Bevan University Health Board. This plan reinforces our strong commitment to partnership working through shared values, ensuring local people and communities are can access support locally for their mental health and wellbeing, which is central to the work we do. We will continue to address inequalities as we find them, in-spite of challenging financial circumstances, exploring alternative funding streams where possible. Threaded throughout this plan are examples of joined-up working across clinical and non-clinical teams, demonstrating our ability to deliver against key challenges as already stated. We will continue to enable people in and around Monmouthshire to receive the care and support they need, as close to home as possible through a shared commitment and vision.

Dr Annabelle Holtam (South Monmouthshire NCN Lead) & Dr Brian Harries (North Monmouthshire NCN Lead)

Strategic Partners:

Governance and Reporting Across Strategic Partners:

The diagram below highlights the current governance and reporting framework providing opportunities for core resources to be optimised with partnership funding held in one place. This framework provides a real opportunity going forward, to shift the focus towards prevention and reducing inequalities.



Gwent Regional Partnership Board

Gwent's framework for health and social care planning is implemented through the Gwent Regional Partnership Board (RPB). The RPB is a statutory body bringing together local authorities, the health board, third sector, and others to jointly assess needs, plan, commission, and oversee health, care, and wellbeing services in the Gwent region. The legal basis for this framework comes primarily from the Social Services & Well-being (Wales) Act 2014, which mandates that a Population Needs Assessment (PNA) is made available, providing a joint assessment of the level of care & support needed, including prevention, levels of service and emerging needs. Our NCNs are directly linked to the RPB via Health Board and Local Authority representatives of the ISP. Information provided by the PNA was used to underpin the priorities outlined within this 3-year plan with the 3 key RPB goals below applied across our NCN priorities:

<u>Start Well</u> Improving outcomes for children and families, working together to start well.	<u>Live Well</u> People at the heart of everything we do, working together to live well.	<u>Stay Well</u> Ensuring the right help is available at the right time, working together to stay well.

Monmouthshire Integrated Services Partnership Board and NCNs:

The Monmouthshire ISPB or Pan Cluster Planning Group (PCPG), enables key partners to come together, including NCN Leads, to focus on strategic, long-term priorities and agree delivery plans. The ISPB is a sub-group of the RPB and Health Board and acts as a decision making and information sharing forum, providing direction for NCNs based on agreed priorities. NCNs also bring together local services from health, social care and the Third Sector (GAVO), to plan and deliver local solutions, based on ISPB priorities, to meet the needs of people in and around Monmouthshire. We are a key component of the ISPB facilitating service delivery based on need. We link closely with a range of groups and individuals who are a valuable source of information such as GAVO and the Integrated Wellbeing Network (IWN), enabling us to ensure our plans retain a strong community focus.

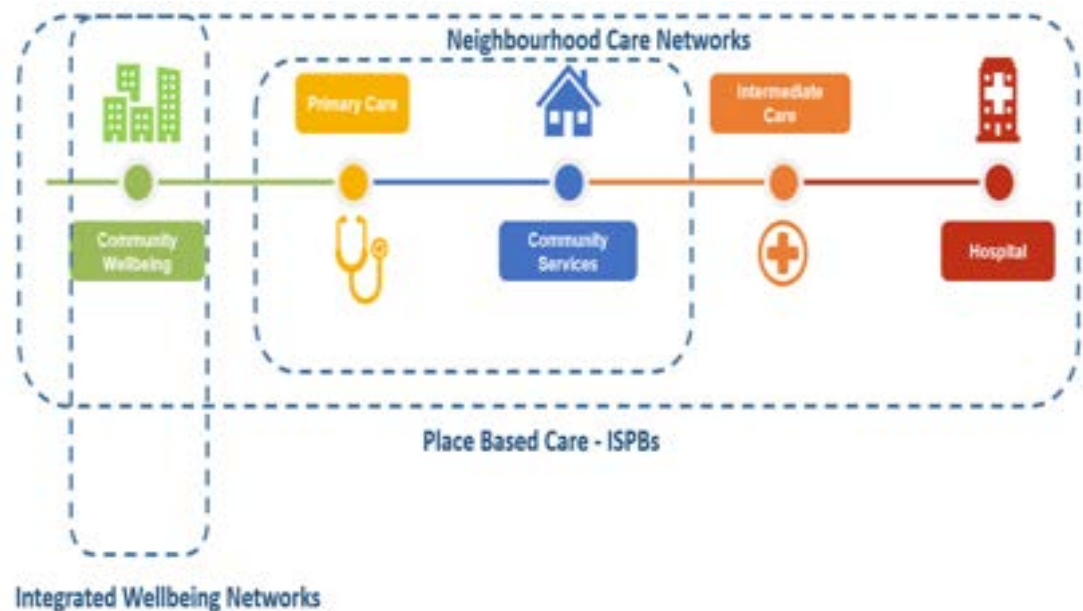
Professional Collaboratives (ACD) Programme:

The aim of ACD is to enhance progress already made by NCN Clusters, to hasten the impact of NCN delivery in meeting the health and wellbeing needs of local people on a place-based basis where possible. Some Professional Collaborative Leads attend NCN meetings to help us understand complexities of service delivery, and also the needs of their respective service users. It's important to note the varying levels of maturity across the collaboratives. For example, GMS, Community Pharmacy and Optometry representatives are incentivised via their contracts. Nursing Leads undertake this role within their core hours and at the time of writing, there is no incentivisation for a Dental Lead. However, it is understood that this may change in 2026/27.

Place-Based Care - Integrated Wellbeing Networks, NCNs and the ISPB coming together:

The diagrams below, and on the previous page, highlight the relationship across strategic and operational / delivery partners in Monmouthshire. It is important to not underestimate the complexity of planning and delivery of services across such a large rural and semi-rural borough. We rely on 'joined-up' thinking and working, goodwill and trust across statutory and non-statutory partners to ensure people in Monmouthshire receive the most appropriate support, when they need it, and as close to home as possible.

The Place-Based Care Continuum:



- **Place-based collaboration:** The network is developed from the ground up, focusing on the unique strengths and assets within specific towns and rural areas in Monmouthshire.
- **Community-based hubs:** These hubs act as central points for connecting residents with local services and support.
- **Connecting people and services:** The IWN works to create better links between people and their communities, connecting them with the support they need, whether through community groups, care navigators, or social care services.
- **Easy access to information:** The network aims to make information about wellbeing support readily available to residents.

Health Board and NCN Priorities

ABUHB IMTP 2026 – 2029 & 10-Year Strategic Priorities



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

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

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

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

Best Start in Life

OUTCOMES

People will have more Healthy Days at Home

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

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

OUTCOMES

People will find it easier to connect with their communities, use local services, and feel respected

Our budget spent on services in the community will have increased

More people will engage with their local community to reduce loneliness and support good health

PRIORITIES

Healthy Places

Resilient & Connected Communities

Safe Spaces

Quality of Life

Progress Made Against Agreed NCN Priorities 2025/26

Priority 1:

Connecting people to non-medical activities, groups and services in their community which can address their practical, social and emotional needs.

What we have achieved:

- The IWN increases individual and community resilience. Working closely with the IWN Lead and the wider GAVO, we continually develop our knowledge and understanding of the needs of people in and around Monmouthshire. Through strong partnership working over a number of years, we have collaborated to identify the most useful interventions. The network has a track record of piloting new services and interventions such as Community Conversations, IAA / Wellbeing Information Hubs and the Wellbeing Link Service. As NCNs we understand the importance of building strong partnerships and therefore engage with key stakeholders to test / implement new community based options to help and support people when they need it most.
- We have joint funded the Wellbeing Link Advisor (WLA) service for a number of years, hosted by GAVO, the advisors help us to really understand what matters most to people who may be struggling with the impact of daily living in Monmouthshire. We have the equivalent of two full-time advisors working across the 11 GP practices with promotional literature etc. on display supported by a range of resources via the GAVO network such as weekly publications. The advisors arrange to meet people in the community such as in cafes, community or garden centres. There are also confidential options if necessary with enough time allocated to listen and understand people's concerns. Together they can discuss local support options that will be useful. Our advisors can then follow up by providing relevant information, or introduce the person to other relevant support options as required. The advisors are informal and flexible depending on each person's needs, which has proven a successful approach over the years.
- As NCNs we will continue, where funding allows, to support the service financially. Each year we have regular contact with the advisors and GAVO colleagues, review data, and importantly, powerful individual stories (please see example at appendix 3). We believe these are strong indicators and evidence of the impact the service is having on people who are struggling with their day-to-day lives.

Next steps:

- To be informed by, and support delivery of the Living Well Strategy and Implementation Plan. The strategy articulates Monmouthshire County Council's new approach to enabling people to access vibrant and inclusive places to meet and get appropriate support.
- This will involve partners and stakeholders both within, and external to the council [4c Living Well Implementation plan App 2.pdf](#)
- Outcome of Blaenau Gwent 'Elemental' Pilot if applicable
- Support the development of a Service Directory as required.
- Continue to support development of the Place-Based communications approach

Challenges & Risks:

- Limited capacity to link directly with monthly Community Conversations networking meetings, which allow service staff, organisations and groups to meet, share news and build relations – to remain under review.
- Potential NCN budget restrictions for existing staff to develop their MDT roles and therefore, their ability to connect individuals to community resources.
- Service Directory / Asset-mapping are prone to inaccuracy due to short-term project instability from financial risk e.g.; RIF funding timeframes – additional investment needed in administrative role to maintain the directory.

Priority 2: Multi-Disciplinary Team (MDT) working for people with complex needs who are most at risk of deterioration	<u>What we have achieved:</u> We have established MDTs in both North and South NCNs, which identify, review, assess and plan to ensure people who are vulnerable, with complex needs including frailty, can live safe, independent and fulfilled lives at home where possible. MDTs help minimise risk e.g.; of adverse events that might potentially lead to a hospital attendance. • Implemented Terms of Reference (ToR) with annual review • Implemented monthly data sharing to inform learning, planning and aid reviews that help measure progress – linked to the Health Board's Re-design programme • South NCN funding proposal in place to implement Place-Based Care Coordinators (PBCCs) to work out of the 4 GP practices and link directly with patients, the frailty response team, wellbeing link advisors and Newport MDT colleagues for professional development. <u>Next steps:</u> • Implement PBCCs • To implement agreed milestones • Continue to link with Divisional redesign programme to ensure outcomes fulfil Health Board requirements. <u>Challenges & Risks:</u> • Potential impact of NCN budget reduction creates uncertainty re long-term funding plans. • Insufficient capacity for some professional roles to be released to support the MDT process. • Data capture variation across Gwent teams may lead to inconsistent outcomes.
Priority 3: Reducing premature morbidity and mortality through prevention and management of diabetes and cardiovascular risk factors.	<u>What we have achieved:</u> • Each year we acknowledge and report that there are a number of areas of deprivation within Monmouthshire, and therefore, we will continue to monitor data and facilitate relevant discussion re enabling all people in Monmouthshire to reduce the risk of premature morbidity from cardiovascular disease, through hypertension case finding and optimising blood pressure management. • We will also work together to optimise our response to people at risk of diabetes and reduce the risk of macrovascular / microvascular complications in people with type 2 diabetes.

	Next steps: CVD: Review & discuss progress at collaborative level against the contractual requirement and report accordingly: • Aggregate practice-level data on the number of hypertensive patients treated to target. • Accuracy of data and process for refinement. • Discuss, share best practice, and consider adaptation of QI processes if applicable. • GMS Collaborative lead themes for discussion shared with the wider cluster. • GMS Collaborative or Cluster to consider introducing initiatives to benefit the delivery of improved interventions in identified behaviours. • GMS Collaborative or Cluster escalate deficiencies in systems/services or suggestions for system wide improvement. Diabetes: Benchmark progress of the South Monmouthshire Healthy Living Project across the collaborative, with shared learning and experiences to inform next steps.	Challenges & Risks: • Increasing up-take of people attending X-Pert Patient and Education Patient Programmes (self-care) programmes. • GMS Collaborative Healthy Behaviours QI project: Refresh understanding of processes / pathways for systematic referrals into Help Me Quit, NERS, Community Weight Management programmes etc. • Capacity to work with the Public Health Team and IWN to embed Making Every Contact Count (MECC) principles, linked to ambition for Health Coaches within PBC (Integrated Neighbourhood Teams). • Engage GMS & Community Pharmacy Collaboratives re the Hypertension Case Finding Supplementary Service to assess provision of brief interventions for those with a new diagnosis of hypertension (e.g.; Farming Communities). • Map GMS Collaborative engagement in the All-Wales Diabetes Prevention Programme to assess delivery • Identify successful approaches to increase the proportion of patients with Type 2 diabetes

Priority 4: Provision of equity of access to Supplementary Services (SS) across Monmouthshire.	<u>What we have achieved:</u> - We have mapped Supplementary Service (SS) up-take across our 11 practices and identified gaps in provision that will inform NCN level discussions. We aim to ensure that we have meaningful discussions as a collaborative, to understand issues and challenges preventing the up-take of some SSs. People can expect to have access to equitable, high-quality care across Monmouthshire and therefore these discussions will help realise if we can overcome barriers especially for our most vulnerable people experiencing homelessness, issues with substance dependency / misuse leading to mental health and wellbeing concerns. - We hope that through strengthened collaborative working across cluster boundaries, using data and working where necessary with key partners, we can reduce variation, increase equity and improve outcomes for Monmouthshire people. <u>Next steps:</u> - Contracting Team formal Inter-practice Referral Agreement for LARC and Substance Misuse. - Health Inclusion Service review and report to be considered at NCN level with plans for named HIS Nurses aligned to each locality to liaise/support practices providing the supplementary service for Homelessness and Asylum Seekers and Refugees. - Assess residual level of unmet need across the GMS collaborative and facilitate discussions about how gaps in provision and unmet need can be addressed. <u>Challenges & Risks:</u> Homelessness: Baseline 2025/26 Information: 263 open homeless cases; 77 open under a prevention duty (at risk of homelessness); and 52 cases open under triage. Of the 263, 161 are in temporary accommodation with Monmouthshire County Council. - Only 2 of 11 practices in Monmouthshire have taken up the Supplementary Service with both in the North of the borough. Feedback from GMS colleagues highlights concerns regarding historical remuneration levels. Minor Surgery: Mapping tells us 10 of 11 practices are commissioned to provide category A & B Minor Surgery with all 11 providing category B. However, only 1 practice (in the South NCN) provides the service to non-registered practice patients. - The NCN aims to review this with both clusters to understand barriers. - Support a proposal to the Enhanced Services Operational Group re investment to improve equity of access. - Aim to liaise with the ISPB and Secondary Care directorates engaging specialist services, local authority and third sector to build wrap-around support and reduce inequity. - Assess outcome of new digital solutions trial, improving administrative capacity to support increased up-take in SSs. Substance Misuse: Mapping uptake tells us that 3 of the 11 practices in Monmouthshire, all in the North have taken up the Supplementary Service. - The NCN aims to review this with both clusters to understand the barriers but in context, there is a wider issue to explore in that on a Pan-Gwent basis, only 10 of 68 practices have been commissioned to provide this service. Asylum Seekers & Refugees: Mapping uptake identified that 7 out of 11 practices (5 from 7 North & 2 from 4 in the South) have taken up the Supplementary Service - In comparison, only 15 from 68 Practices have been commissioned across Gwent. Please refer to appendix 4 for the outcome of the mapping exercise.

Priority 5: Building Sustainability & Resilience in Primary Care	What we have achieved: Continued investment in schemes linked to enhancing our Primary Care response by delivering Care Close to Home, Building Capacity and Resilience: • Multi-Disciplinary Teams – Supporting the most vulnerable 0.5% population • Practice Based Pharmacists (North) – Improving GP capacity & access using localised clinical expertise • Practice Manager lead role (North & South) – Collaborative co-ordination & sharing of good practice etc. • GP led Safeguarding Forum (North & South) – Shared expertise and knowledge across GMS • Wellbeing Link Advisor Service (North & South) – Signposting people impacted by social determinants of ill-health • Psychological Health Practitioners (North) – Local access to mental health assessment / support • Multi-agency Winter Planning event: Collaboratives coming together with social services and third sector to plan for service delivery pressures. • Community Clinical Placements (CCPs) / Longitudinal Integrated Clerkship: Partnership between Monmouthshire County Council (MCC) and Cardiff University to place Student Doctors with GP practices and Community Medicines Projects hosted by MCC. Planned placements for 5 students in 2026/27 – projects meet Health Inclusion agenda (Farmer's Health / Frailty linked to MDTs) and contribute to long-term sustainability in primary care.	
	<table> <tr> <td data-bbox="470 691 1301 1335"> Next steps: • Although not included in the priorities included for 2026/29, all of the above examples of projects remain as on-going workstreams (dependent on NCN funding decisions). It may be that the commissioning of some workstreams leads to reinvestment in new priority schemes as part of the NCN IMTP / business cycle. • The CCP scheme is Welsh Government funded and provided on a recurrent basis. The NCN Leads will remain as key partners with MCC and Cardiff University to help support sustainability in primary care in Monmouthshire. </td><td data-bbox="1301 691 2123 1335"> Challenges & Risks: • Potential impact of further reductions to NCN budget leading to uncertainty regarding long-term financial commitments </td></tr> </table>	Next steps: • Although not included in the priorities included for 2026/29, all of the above examples of projects remain as on-going workstreams (dependent on NCN funding decisions). It may be that the commissioning of some workstreams leads to reinvestment in new priority schemes as part of the NCN IMTP / business cycle. • The CCP scheme is Welsh Government funded and provided on a recurrent basis. The NCN Leads will remain as key partners with MCC and Cardiff University to help support sustainability in primary care in Monmouthshire.
Next steps: • Although not included in the priorities included for 2026/29, all of the above examples of projects remain as on-going workstreams (dependent on NCN funding decisions). It may be that the commissioning of some workstreams leads to reinvestment in new priority schemes as part of the NCN IMTP / business cycle. • The CCP scheme is Welsh Government funded and provided on a recurrent basis. The NCN Leads will remain as key partners with MCC and Cardiff University to help support sustainability in primary care in Monmouthshire.	Challenges & Risks: • Potential impact of further reductions to NCN budget leading to uncertainty regarding long-term financial commitments	

NCN Planning - 2026/2027			
Identified Quarterly Milestones Against Agreed NCN Priorities for 2026/27			
Priority	Milestones		Enablers, Risks, Challenges
Priority 1: Connecting people to non-medical activities, groups and services in their community which can address their practical, social and emotional needs <i>(Linked to the Integrated Wellbeing Network [IWN] & Wellbeing Link Advisor [WLA] Service)</i>	Quarter 1: IWN: To work with the Integrated Wellbeing Network (IWN) Lead to understand the Living Well strategy requirement & contribute to progress measures as necessary - To agree NCN support for delivery via the implementation plan - To support consultation at NCN / ISPB level WLA: Continue to capture monitoring data for the Wellbeing Link Advisor role to ensure on-track with agreed service specification / business continuity & respond to anticipated fragility around service delivery etc.	Quarter 2: - Continue Q1 milestones IWN: As defined by the implementation plan - Bi-monthly reporting at ISPB - Progress updates provided to quarterly NCN meetings - Monthly data capture as available demonstrates progress / gaps & impact on local people / communities. - Undertake 6 monthly review of monitoring tool with IWN Lead to measure progress against the implementation plan WLA: Undertake 6 monthly review to ensure service reach is meeting expectation - Link with NCN Communication Team to promote referrals etc. as required	Enablers: 4c Living Well Implementation plan App 2.pdf - IWN / ISPB - Data, surveys, case studies and outcomes / evidence of working with individuals - Bridging, linking and co-ordinating well-being assets in a place. - Connecting people to community assets via hubs, active signposting / care navigation and local directories of services - Individual & group behaviour change interventions (PHW) - Opportunities for involving communities in decision making Risks: Insufficient NCN funding resource - Conflicting professional / agency priorities - mutual understanding linked to delivering core services, roles & responsibilities - Maintaining momentum with phased approach.
	Quarter 3: - Continue Q2 milestones IWN: As defined by the implementation plan - Bi-monthly reporting at ISPB - Progress updates provided to quarterly NCN meetings - Monthly data capture as available demonstrates progress / gaps & impact on local people / communities. WLA: To review / evaluate the Wellbeing Link Advisor service to inform future commissioning decisions	Quarter 4: - Continue Q3 milestones IWN: As defined by the implementation plan - Bi-monthly reporting at ISPB - Progress updates provided to quarterly NCN meetings - Monthly data capture as available demonstrates progress / gaps & impact on local people / communities. - Undertake year-end review of progress supporting the IWN Lead & agree measures for year 2. WLA: NCN budget review determines next steps	

Priority 2: Multi-Disciplinary Team (MDT) working for people with complex needs who are most at risk of deterioration	Quarter 1: - Monthly NCN led review of South NCN & North Monnow Vale based MDT meetings to understand challenges / issues and evidence - Liaise with Redesign team re evidence of reduced hospitalisation & non-medical support if available - Agree Terms of Reference - Implement Place-Based Co-ordinators	Quarter 2: - Continue Q1 milestones - Hold collaborative discussions to review progress of both North & South MDTs - Review outcome of Redesign Team evidence base / data - Monitor progress of PBCCs - Facilitate peer sessions with Newport MDT co-ordinators	Enablers: Budget reviews enable options for reinvestment e.g.; North MDT - ToR review at fixed point - Strong NCN level leadership & support - Clearly defined roles - Effective & timely information sharing - Collaborative, person-centred culture - Partner sign-up / commitment Risks: Data sharing & inability to integrate IT systems - MDT representatives with different priorities - Lack of patient / carer involvement - Over-inflated expectation related to reducing hospital admissions etc.
	Quarter 3: - Continue Q2 milestones - Mid-year collaborative discussions & progress review of North & South MDTs - Review outcome of Redesign Team evidence base / data - Continued support to PBCCs - Facilitate peer sessions with Newport MDT co-ordinators	Quarter 4: - Continue Q3 milestones - Review Terms of Reference ready for year 2 - Year-end collaborative discussions to review progress of North & South MDTs - Year-end review of Redesign Team evidence base / data - Undertake year-end review of PBCC role and evaluate progress - Include Newport MDT co-ordinators in PBCC review - Outcome of NCN funding review informs commissioning	
Priority 3: To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs	Quarter 1: - NCN led data review against baseline measures for NCN funded Healthy Living Project (South) - Aggregate practice-level data on the number of hypertensive patients treated to target – check data accuracy & process - Discuss, share best practice, and consider adaptation of QI processes if applicable at collaborative level. - Consider introducing initiatives to benefit delivery of improved interventions in identified behaviours. - Escalate deficiencies in systems / services with suggestions for improvement if applicable.	Quarter 2: - Continue Q1 milestones - Respond to aggregated data process & data checks - Follow-up on outcome of QI discussions - Review initiatives to benefit interventions as relevant. - Review need to escalate system concerns with suggestions for improvement if necessary.	Enablers: NCN Led data review - Patient empowerment & education via MDTs - Performance measures for continuous quality improvement Risks: Lack of sufficient data - Transport links - lack of reliable transportation making it difficult for patients to attend in-person programs.

NCN IMTP 2026-2029

	Quarter 3: - Continue Q2 milestones - Review aggregated data process & confirm data confidence. - Follow-up on outcome of QI discussions - On-going review of interventions as required. - Facilitate escalation of system concerns with suggestions for improvement as necessary.	Quarter 4: - Undertake year-end process of Review re data. - Cluster review and report as necessary to meet QI requirement. - Year-end review of effectiveness of interventions as required. - Review system concerns raised throughout process and report as required.	
Priority 4: Provision of equity of access to Supplementary Services (SS) across Monmouthshire.	Quarter 1: - Monitor up-take following increased administrative capacity from new digital innovation (pending approval) - Maintain engagement at NCN & contracting team level to monitor progress re Inter-Practice Referral Agreement (LARC & Substance Misuse) - Explore option to engage on multi-agency basis reducing inequity - Respond to outcome of Health Inclusion Service report & support HIS nurse implementation if applicable - Support proposal to the Enhanced Services Operational Group re investment to improve access	Quarter 2: - Continue Q1 milestones - Monitor new capacity from potential digital solutions providing increased equity if applicable - Maintain engagement at NCN & contracting team level to understand resistance (if any) to taking on specific SS - Undertake gap analysis, mapping, data review & engagement at fixed points in year and report issues / challenges to contracting team accordingly	Enablers: New capacity from potential digital solutions - Identify inequities in provision - Engagement with patients, carers, and community representatives, including those from "hard-to-reach" groups - Participate in peer reviews / benchmarking Risks: Cost of staff training, new technology, resources - Workforce pressure from diverting staff away from core provision - Historic remuneration levels
	Quarter 3: - Continue Q2 milestones - Undertake gap analysis review and discuss collaboratively to understand if continued resistance / issues & challenges - Liaise with contracting colleagues as required	Quarter 4: - Continue Q3 milestones - Undertake year-end review & gap analysis - Discuss at final NCN meeting with contracting team as a collaborative looking into year 2 to overcome challenges where possible	

Finance Profile 2026/27

Monmouthshire North NCN		Monmouthshire South NCN		
The North NCN commits approximately 90% of its annual budget on a recurrent basis for clinical and non-clinical support to meet sustainability concerns and reduce the reliance on GP times. Pharmacists, Psychological Health Practitioners and Wellbeing link advisors reflect the needs of a growing older population. As a result, there is limited option to test new concepts. We anticipate a breakeven position at financial year-end.		The South NCN has circa 10% of its annual budget allocated recurrently to funding clinical and non-clinical roles. As a result, there is greater flexibility in terms of being able to fund short-term projects. The NCN, through dynamic leadership, has a proven track record of testing new concepts successfully e.g.; MDT / Healthy Living project and Digital Innovation packages.		
Monmouthshire NCN Forecasts 2026/27				
(Includes 3.0% uplift assumption for NHS Agenda for Change pay awards)				
	North NCN		South NCN	
Project / Role / Item	WTE	Total	WTE	Total
Practice Based Pharmacists	3.1	£234,732	-	-
Place-Based Co-ordinators x 4	-	-	2.0+	£91,500
Psychological Health Practitioners	1.2	£56,250	-	-
Community Phlebotomy Service	1.5	£9,591	2.0	£18,859
Wellbeing Link Advisors (match funded)	1.0	£23,958	1.0	£23,958
Digital Innovation	-	£6,500	-	£60,100
GMS Collaborative Lead Roles (Safeguarding/Practice Manager)	1.0	£4,742	1.0	£4,742
Multi-Disciplinary meetings / events	-	-	-	£22,500
Healthy Living Project (Diabetes/Hypertension)	-	-	-	£26,000
Protected Learning / Cluster Development		£3,150		£1,600
Other related spend (tech support etc.)		£800		£800
Annual Budget		£340,171		£251,408
Forecast expenditure		£339,723		£250,059
Anticipated Underspend /Overspend		£448		£1,349

Monmouthshire North and South NCNs Finance (Continued):

- Monthly Divisional & NCN level finance meetings provide greater transparency & governance contributing to confidence, resilience and sustainability;
- Financial flow scrutiny reduces 'bottle-necks' in processing, supports in-year adjustments and offers greater assurance;
- Both NCNs have been subject to budget reductions: a) To support deprivation linked initiatives in other boroughs, and b) By absorbing NHS Wales pay awards (although this was reinstated in 2025/26). As a result, there remains an element of uncertainty around the potential for budget 'remodelling' in future. A number of difficult commissioning decisions were needed in 2024/25 leading to a circa £30k reduction in a number of schemes in the North to underpin our confidence in achieving a breakeven position. In 2025/26 both NCN forecast breakeven positions and we anticipate the same for the 2026/27 financial year.

NCN IMTP 2026-2029

NCN Funded Workforce Profile 2026/27

The table below describes the investment in terms of workforce employed to deliver the NCN priorities in 2026/27:

Service	Purpose	Outcomes																																													
Practice Based Pharmacists (North)	Addresses GMS Collaborative sustainability concerns by enhancing the clinical workforce and providing direct benefits to patients from increased local, practice-based pharmacy expertise.	This service has evaluated well year-on-year and demonstrates additional expertise available thus reducing the reliance on GP time. ➤ Improved quality and effectiveness of medicines management within practices. ➤ Provision of patient focussed, prudent healthcare. ➤ Promotion of medicines safety and addressing polypharmacy. ➤ Progressed the practice pharmacist role as core member of the team working effectively across the MDT to deliver services to patients by providing prudent services & supporting sustainability.																																													
	<table><tr><th>NCN</th><th>2017/18</th><th>2018/19</th><th>2019/20</th><th>2020/21</th><th>2021/22</th><th>2022/23</th><th>2023/24</th><th>2024/25</th></tr><tr><td>South</td><td>£95,099</td><td>£98,252</td><td>£75,294</td><td>£93,144</td><td>£136,213</td><td>£81,352</td><td>-</td><td>-</td></tr><tr><td>North</td><td>£53,964</td><td>£62,547</td><td>£100,263</td><td>£180,114</td><td>£213,996</td><td>£144,085</td><td>£153,456</td><td>£182,380</td></tr><tr><td></td><td>£149,063</td><td>£160,799</td><td>£175,557</td><td>£273,258</td><td>£350,209</td><td>£225,437</td><td>£153,456</td><td>£182,380</td></tr><tr><td colspan="9">Total Monmouthshire Investment: £1,670,159</td></tr></table>		NCN	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	South	£95,099	£98,252	£75,294	£93,144	£136,213	£81,352	-	-	North	£53,964	£62,547	£100,263	£180,114	£213,996	£144,085	£153,456	£182,380		£149,063	£160,799	£175,557	£273,258	£350,209	£225,437	£153,456	£182,380	Total Monmouthshire Investment: £1,670,159								
	NCN	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25																																						
South	£95,099	£98,252	£75,294	£93,144	£136,213	£81,352	-	-																																							
North	£53,964	£62,547	£100,263	£180,114	£213,996	£144,085	£153,456	£182,380																																							
	£149,063	£160,799	£175,557	£273,258	£350,209	£225,437	£153,456	£182,380																																							
Total Monmouthshire Investment: £1,670,159																																															
Psychological Health Practitioners (North)	• Supports GMS Collaborative by providing local practice-based access to mental health advice and support. PHPs help reinforce a cycle of support for people by signposting to Wellbeing Link Advisor colleagues where appropriate. • The service has evaluated well and addresses a growing concern in terms of the number of people presenting with mental health issues.	Led to a reduced reliance on GP involvement and meets the Health Inclusion agenda. • Watchful waiting: Information/advice & return option. • Self-directed learning: On-line CBT and/or other evidence-based resources e.g.; Melo. • Signposting to community support e.g.; Wellbeing Links, CAB, other local 3rd sector organisations. • Direct referral to Local Primary Care Mental Health Support Service waiting list. • Redirection back to GP – only if necessary.																																													
	<table><tr><th>2020-2021</th><th>2021-2022</th><th>2022-2023</th><th>2023-2024</th><th>2024-25</th><th>2025-26</th></tr><tr><td>£109,484</td><td>£112,661</td><td>£77,747*</td><td>£52,902</td><td>£46,162</td><td>£54,987</td></tr><tr><td colspan="6">Total Monmouthshire Investment: £453,943 (*South de-commissioned at this point)</td></tr></table>		2020-2021	2021-2022	2022-2023	2023-2024	2024-25	2025-26	£109,484	£112,661	£77,747*	£52,902	£46,162	£54,987	Total Monmouthshire Investment: £453,943 (*South de-commissioned at this point)																																
	2020-2021	2021-2022	2022-2023	2023-2024	2024-25	2025-26																																									
£109,484	£112,661	£77,747*	£52,902	£46,162	£54,987																																										
Total Monmouthshire Investment: £453,943 (*South de-commissioned at this point)																																															

NCN IMTP 2026-2029

Wellbeing Link Advisors (North & South)	• Service managed by GAVO and linked to the PHP service responding to people presenting with the impact of social related concerns e.g.; housing & finance etc. The service will also link with the Place-Based Care Coordinator role (if funded) to further support the most vulnerable 1% of our population and also reduce the reliance on GP services. • This service has evaluated well year-on-year and continues to demonstrate its success in supporting the wellbeing agenda and reducing the reliance on GP time. • NCN funding is provided with the proviso that it continues to be 'match-funded' by the Public Health Team. • This also meets the Health Inclusion agenda.																																				
	<table><tr><th>2021-2022</th><th>2022-23</th><th>2023-24</th><th>2024-25</th><th>2025-26</th></tr><tr><td>£2,700 <i>(Set-up costs)</i></td><td>£58,078.50</td><td>£41,930.50</td><td>£43,313</td><td>£47,916</td></tr><tr><td colspan="5">Total Monmouthshire Investment £193,938 <i>(Last 4 Years)</i></td></tr></table>		2021-2022	2022-23	2023-24	2024-25	2025-26	£2,700 <i>(Set-up costs)</i>	£58,078.50	£41,930.50	£43,313	£47,916	Total Monmouthshire Investment £193,938 <i>(Last 4 Years)</i>																								
	2021-2022	2022-23	2023-24	2024-25	2025-26																																
	£2,700 <i>(Set-up costs)</i>	£58,078.50	£41,930.50	£43,313	£47,916																																
Total Monmouthshire Investment £193,938 <i>(Last 4 Years)</i>																																					
<table><tr><th>2021-2022</th><th>2022-2023</th><th>2023-2024</th><th>2024-2025</th><th>2025-2026</th></tr><tr><td>£0</td><td>£48,303.50</td><td>£42,420</td><td>£46,664</td><td>£47,916</td></tr><tr><td colspan="5">Total (Matched) Investment £185,303.50 <i>(Last 3 Years)</i></td></tr></table>		2021-2022	2022-2023	2023-2024	2024-2025	2025-2026	£0	£48,303.50	£42,420	£46,664	£47,916	Total (Matched) Investment £185,303.50 <i>(Last 3 Years)</i>																									
2021-2022	2022-2023	2023-2024	2024-2025	2025-2026																																	
£0	£48,303.50	£42,420	£46,664	£47,916																																	
Total (Matched) Investment £185,303.50 <i>(Last 3 Years)</i>																																					
Community Phlebotomy (North & South)	This service meets the long-standing NCN priority of delivering care at home, or as close to home as possible. The service meets the needs of people requiring blood to be taken as part of their on-going secondary care treatment plan, and avoids long journeys in both Wales and England. As the service is delivered in the main by Health Care Support Workers (2.3 WTE in Monmouthshire), there is contingency in that the District Nurses will cover the service in the event of unplanned absence.	If this service was not funded by the NCNs then phlebotomy provision, especially in the vulnerable / housebound cohort would fall to District Nurse and therefore reduced capacity to care for people with long-term complex conditions. This meets the Health Inclusion agenda. • For the South NCN’s community Phlebotomy service, a minimum of 1,400 patients are seen each year with an average appointment time of 5 minutes or less. This suggests a cost saving to secondary care of around £25,900. The saving is likely to be much greater when taking into account the North service also (not NCN funded).																																			
	<table><tr><th>2017-18</th><th>2018-19</th><th>2019-20</th><th>2020-21</th><th>2021-22</th><th>2022-23</th><th>2023-24</th><th>2024-25</th><th>2025-26</th></tr><tr><td>N/A</td><td>£4,033</td><td>£4,033</td><td>£4,033</td><td>£4,033</td><td>£4,033</td><td>£5,293</td><td>£6,106</td><td>£6,289</td></tr><tr><td colspan="9">Total South Monmouthshire Investment £37,853</td></tr><tr><td colspan="9">Total North Monmouthshire investment £4,580 <i>(Set-up costs)</i></td></tr></table>		2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	N/A	£4,033	£4,033	£4,033	£4,033	£4,033	£5,293	£6,106	£6,289	Total South Monmouthshire Investment £37,853									Total North Monmouthshire investment £4,580 <i>(Set-up costs)</i>							
2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26																													
N/A	£4,033	£4,033	£4,033	£4,033	£4,033	£5,293	£6,106	£6,289																													
Total South Monmouthshire Investment £37,853																																					
Total North Monmouthshire investment £4,580 <i>(Set-up costs)</i>																																					

NCN IMTP 2026-2029

GP Safeguarding Lead Role (North & South)	NCN commissioned (nationally recognised) GP led role. Dr Rowena Christmas plans and hosts quarterly meetings of the GMS Collaborative to share experiences, expertise and individual case studies, thus greatly enhancing awareness across Monmouthshire. In 2025, Dr Christmas hosted a workshop which enhanced understanding and awareness of all members of GP practices in relation to safeguarding principles, legislation and the role every member of the team can play. Dr Christmas is also nationally recognised for her work in safeguarding.				This service evaluates well year-on-year and consistently meets its aims: • Sharing best practice. • Reducing workload by sharing protocols, presentations, templates. • Discussing interesting / challenging cases in a supportive, confidential setting. • Improving resilience through peer support. • Focused learning on local Safeguarding issues. • Cluster Safeguarding lead availability between meetings The group addresses growing safeguarding concerns around domestic violence etc. and is regarded best-practice. This meets the Health Inclusion agenda.																														
	<table><tr><th>2018-2019</th><th>2019-2020</th><th>2020-2021</th><th>2021-2022</th><th>2022-2023</th><th>2023-2024</th><th>2024-2025</th><th>2025-2026</th><th>2026-2027</th></tr><tr><td>£4,800</td><td>£7,200</td><td>£7,200</td><td>£7,200</td><td>£7,200</td><td>£7,524</td><td>£7,976</td><td>£8,295</td><td>£8,627</td></tr><tr><td colspan="9">Total Monmouthshire Investment £66,022</td></tr></table>								2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026	2026-2027	£4,800	£7,200	£7,200	£7,200	£7,200	£7,524	£7,976	£8,295	£8,627	Total Monmouthshire Investment £66,022								
	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026	2026-2027																										
£4,800	£7,200	£7,200	£7,200	£7,200	£7,524	£7,976	£8,295	£8,627																											
Total Monmouthshire Investment £66,022																																			
Practice Manager Lead Role (North & South)	This role promotes collaborative working across both NCN clusters, planning for and hosting quarterly meetings to discuss GMS related issues, share ideas to create efficiencies in business functions and explore innovative options e.g.; Artificial Intelligence.				Due to financial challenges, finance for this role was reduced following review – remaining key functions are: • Cluster support, planning and collaboration • Business continuity • Co-ordinating a positive network of communication • Acting as first point of contact for the collaborative • Canvassing views relating to new services / innovations • Advising Practice colleagues regarding GMS contract detail																														
	<table><tr><th>2020-2021</th><th>2021-2022</th><th>2022-2023</th><th>2023-2024</th><th>2024-2025</th><th>2025-2026 Apr-Sep</th><th>2025-2026 Oct-Mar</th></tr><tr><td>£930*</td><td>£7,440</td><td>£7,440</td><td>£7,775</td><td>£7,775</td><td>£4,249</td><td>£428</td></tr><tr><td colspan="7">Total Monmouthshire Investment £36,037</td></tr></table> *3-month pilot phase								2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026 Apr-Sep	2025-2026 Oct-Mar	£930*	£7,440	£7,440	£7,775	£7,775	£4,249	£428	Total Monmouthshire Investment £36,037												
	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026 Apr-Sep	2025-2026 Oct-Mar																												
£930*	£7,440	£7,440	£7,775	£7,775	£4,249	£428																													
Total Monmouthshire Investment £36,037																																			

NCN IMTP 2026-2029

Place-Based Care 'Wish-List'	In order to progress the development of PBC and in partnership with ISPB colleagues, we are undertaking a 'stock-take' in terms of where we sit now, in comparison with where we want to be. This work includes how we re-align existing resources and how PBC might be delivered in the future. We acknowledge that this work forms part of the wider Public Health Wales Business Case development and continue to support that initiative as active members of the ISPB.															
Scoping exercise for examples of possible future investment as part of wider ISPB / PHW planning.	<table><tr><td>Place-Based Co-ordinator(s)</td><td>£160,209 (x 7 0.53 WTE)</td></tr><tr><td>Data Analyst</td><td>Band & WTE to be agreed</td></tr><tr><td>Administrative Support</td><td>Band 3 - WTE to be agreed</td></tr><tr><td>Community Conversation Resources</td><td>TBC</td></tr><tr><td>Health Coaches</td><td>TBC</td></tr><tr><td>Information, Advice & Assistance Role</td><td>TBC joint funded with MCC</td></tr><tr><td>Wellbeing Link Advisors</td><td>£50,000 (x 2-1.00 WTE match funded or: £100,000 (x 2 not match funded)</td></tr></table>		Place-Based Co-ordinator(s)	£160,209 (x 7 0.53 WTE)	Data Analyst	Band & WTE to be agreed	Administrative Support	Band 3 - WTE to be agreed	Community Conversation Resources	TBC	Health Coaches	TBC	Information, Advice & Assistance Role	TBC joint funded with MCC	Wellbeing Link Advisors	£50,000 (x 2-1.00 WTE match funded or: £100,000 (x 2 not match funded)
Place-Based Co-ordinator(s)	£160,209 (x 7 0.53 WTE)															
Data Analyst	Band & WTE to be agreed															
Administrative Support	Band 3 - WTE to be agreed															
Community Conversation Resources	TBC															
Health Coaches	TBC															
Information, Advice & Assistance Role	TBC joint funded with MCC															
Wellbeing Link Advisors	£50,000 (x 2-1.00 WTE match funded or: £100,000 (x 2 not match funded)															

NCN Planning 2027/2028 – 2028/2029

Proposed Milestone for Agreed Priorities for 2027/2028 and 2028/2029

	2027/2028	2028/2029
Priority 1: Connecting people to non-medical activities, groups and services in their community which can address their practical, social and emotional needs.	• Seek assurance re status of Integrated Wellbeing Network lead role beyond contracted period (RIF) • As detailed by the Living Well Strategy and Implementation Plan • Outcome of annual budget review enabling re-investment where possible. • Annual reviews of funded schemes to ensure fit for purpose and value for money.	• Assurance needed re status of Integrated Wellbeing Network lead role beyond contracted period (RIF) • As informed by the Living Well Strategy and Implementation Plan • Outcome of annual budget review enabling re-investment where possible. • Regular NCN led reviews of funded schemes to ensure fit for purpose and value for money
Priority 2: Multi-Disciplinary working for people with complex needs who are most at risk of deterioration.	• Undertake annual review of funded projects using local data • Assess outcomes against delivery plans • Assess alignment with the Place-Based Care agenda • Undertake Terms of Reference stakeholder review	• Undertake annual review of funded projects using local data • Assess outcomes against delivery plans • Assess alignment with the Place-Based Care agenda • Undertake Terms of Reference stakeholder review
Priority 3: Reducing premature morbidity and mortality through prevention and management of diabetes and cardiovascular risk factors.	• Undertake annual reviews underpinned by locally available data to identify success / deficits • NCN led discussions at Collaborative meetings	• Undertake annual reviews underpinned by locally available data to identify success / deficits • NCN led discussions at Collaborative meetings
Priority 4: Provision of equity of access to Supplementary Services (SS) across Monmouthshire.	• Engage with GMS Collaborative to identify resistance to taking-up SS offer. • Review gap analysis / mapping at fixed points • Review data collaboratively at fixed points & respond to issues & challenges • Continue to review data sources / need on an on-going basis to ensure fit for purpose.	• Engage with GMS Collaborative to identify resistance to taking-up SS offer. • Review gap analysis / mapping at fixed points • Review data collaboratively at fixed points & respond to issues & challenges • Continue to review data sources / need on an on-going basis to ensure fit for purpose.

2026-27 Monmouthshire NCN Delivery Plan													
Title	New or Existing project	Brief Description	Results/Benefits expected by end of March 2027	Strategic alignment against ABUHB and NCN Priorities	Areas of Focus				Budget	Funding Source	Current Status	Comments	Activities or projects planned to commence during 2026/2027, as well as those ongoing from 2025/2026
					1	2	3	4					
Multi-Disciplinary working for vulnerable people	Existing	Bi-weekly MDT meetings	Increased intervention for most frail / vulnerable & hospital avoidance	RPB, SPPC, AHW, ISPB, RSfOP, PBCC 1,2,3,4,5			✓		£22,550	South	Approved	Annual Review	Key: Alignment to NCN Agreed Priorities 1. Connecting people to non-medical activities, groups and services in their community which can address their practical, social and emotional needs. 2. To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations 3. To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs 4. Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees.
	New	Place Based Care Co-ordinators	4 x 0.53 wte response in post to support most frail population	SPPC, AHW, RPB, ISPB, PBCC 1,2,3,4,5	✓	✓	✓		£91,500	NCN	Approved	Annual Review	
	Existing	Multi-Disciplinary / agency Winter Planning event	Integrated Planning across Health & Social Care	RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4,5	✓	✓	✓		£1,000	North & South	Approved	Collaborative working	
Connecting people to non-Medical Support	Existing	Third Sector / Wellbeing Link Advisors	Supporting people with social determinants of ill-health	RPB, SPPC, AHW, WBoFGA (2015), ISPB, PBCC 1,2,3,4	✓	✓			£47,916	North & South / IWN (RIF)	Approved with SLA	Annual Review	
Accelerated Cluster	Existing	GMS Collaborative: Practice Pharmacists	Access to local clinical expertise in GMS	SPPC, AHW, RPB, ISPB, PBCC 1,2,3,4			✓		£234,732	North	Approved	Annual review	
	Existing	GMS Collaborative: Protected Learning	Shared Learning Collaborative maturity	SPPC, AHW, PBCC 1,2,3,4			✓		£4,750	North & South	Approved	Annual Review	
	Existing	GMS & Optometry Collaboratives: Digital innovation (AI)	Increased efficiencies in core business functions	SPPC, AHW, PBCC 1,2,3,4			✓		£60,100	South	Approved	Annual Review	
	Existing	GMS Collaborative: Practice Manager lead role	Shared Collaborative learning/best practice	SPPC, AHW, ISPB, PBCC 1,2,3,4			✓		£887	North & South	Approved with SLA	Annual Review	
	Existing	GMS Collaborative: GP led Safeguarding role	Shared Learning, Joint cluster level leadership	SPPC, AHW, ISPB, PBCC 1,2,3,4			✓		£8,628	North	Approved with SLA	Aspects of MDT/ scrutiny	
	Existing	Independent Advisor support (Top sliced)	Professional advisory role	SPPC, AHW			✓		£1,986	North & South	Top sliced	Annual scrutiny	
	Existing	GMS Collaborative: Psychological Health Practitioners	Increased access to local mental health support	RPB, SPPC, AHW, MH Strategy, PBCC 1,2,3,4	✓	✓	✓		£56,250	North	Approved	Annual Review	
Accelerated Cluster/ Care Closer to Home	Existing	Community Nursing Collaborative: OPD Phlebotomy Service	Access to care closer to home avoiding long journeys	RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4,5	✓		✓		£6,662	South	Approved with SLA	Annual Review	
	Existing	Community Nursing Collaborative: DN Phlebotomy	Provision at home for people considered housebound	RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4,5	✓		✓		£21,789	North & South	Top sliced	Annual Review	
Supplementary Services	Existing	GMS Collaborative: Influenza immunisation programme	WIS surveillance data benchmarking on local & national level	RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4	✓	✓	✓	✓	£0	North & South	Seasonal planning	High achieving clusters	
Supplementary Service linked to NCN Priorities	Existing	GMS Collaborative: Healthy Living Project (Diabetes / CVD risk)	Risk management/Data analysis leads to needs based interventions	RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4	✓			✓	£26,000	North & South	Seasonal planning	High achieving clusters	
	New	To map availability of supplementary services	Identify gaps in service for homeless, IUD's, minor surgery, substance misuse, asylum seekers & refugees	RPB, SPPC, AHW, ISPB, PBCC 1,2,3,4	✓			✓	£0	South	Approved	Annual Review	

MONMOUTHSHIRE NORTH and SOUTH NCNs – PLAN ON A PAGE 2026/2027

Our Key Actions

NCN Areas of Focus

- 1.Connecting people to non-medical activities, groups and services in their community which can address their practical, social and emotional needs.
- 2.To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of health, social care and third sector organisations
- 3. To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs
- 4.Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees

Area of Focus 1:

- Working with the Integrated Wellbeing Network lead to implement the Living Well Strategy (LWS)
- Agree NCN level support for delivery via the LWS implementation plan
- Facilitate LWS consultation at NCN ISPB level
- Use data to assess effectiveness of the Wellbeing Link Advisor role & measure against previous baseline
- Work with GAVO & Public Health Team re impact of continued funding risk

Area of Focus 2:

- Continue to fund (where available) South Monmouthshire Multi-disciplinary Team working to monitor impact & outcomes for the most 0.5% vulnerable population
- Identify options as necessary, to fund / grow the North Monmouthshire Multi-disciplinary Team & continue to develop close links with the Rapid Frailty Response (RFR) team & Wellbeing Link Advisors etc.

Area of Focus 3:

- South NCN level review of baseline data Healthy Living Project
- Aggregate practicelevel data re hypertensive patients treated to target – check data accuracy & process
- Discuss, share best practice, and consider adaptation of QI processes if applicable at collaborative level.
- Explore option re initiatives to benefit delivery of improved interventions in identified behaviours.

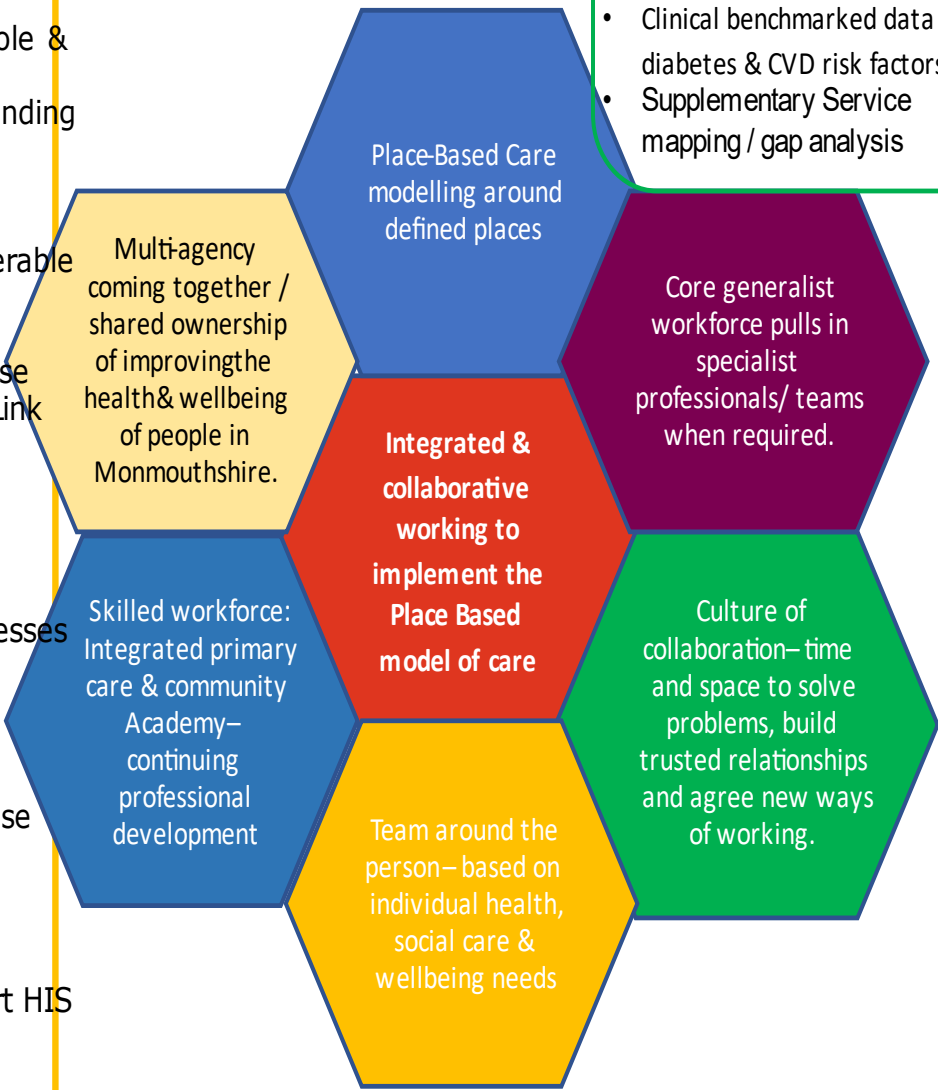
Area of Focus 4:

- Monitor impact of digital innovations releasing capacity to increase up-take of Supplementary Services
- Engage contracting team to monitor progress re InterPractice Referral Agreement (LARC & Substance Misuse) & explore other options
- Respond to outcome of Health Inclusion Service report & support HIS nurse implementation if applicable
- Support proposal to the Enhanced (Supplementary) Services Operational Group re future investment to improve access.



Enablers

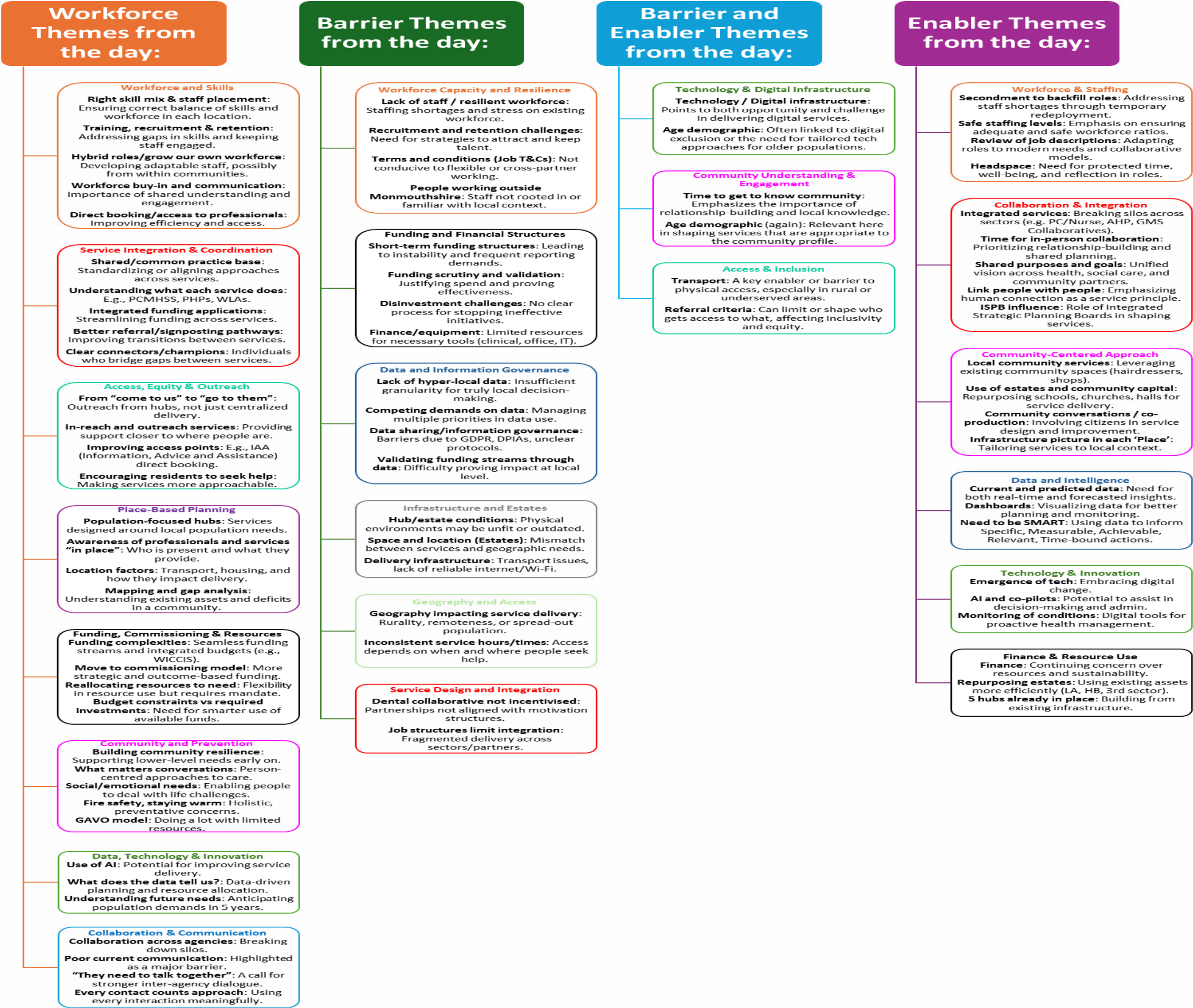
- Place-Based Population Needs Assessment (RPB)
- Integrated & Collaborative working across Partnerships
- Clinical benchmarked data re diabetes & CVD risk factors
- Supplementary Service mapping / gap analysis



How will we know if we have made a difference?

Progress will be monitored via a range of primary & community level dashboards, NCN & Integrated Services Partnership Board reporting schedule

Appendix 2: ISPB Place-Based Care Workshop Outcomes



Appendix 3: A Case Study – Wellbeing Link Advisors

GP Referral: I would like to refer this 65 year-old blind gentleman who is being taken advantage of by his neighbour. He has capacity and knows he has options but doesn't know how to access help. He relies on neighbours for shopping and pays what I consider to be over the odds to cover petrol, and he also pays for everyone (4 of them) to have breakfast when they go out. For instance, he's had to pay his neighbour £20 to get to the surgery to see me today and his neighbour charges him £10 to pick up his prescriptions. I'm not sure that Mr * fulfils the criteria for a vulnerable adult, as he knows what he's doing, but he is most definitely being taken advantage of. He is also bored and would like to have more to do.

The Wellbeing Link Advisor contacted the gentleman and liaised with the Coordinator of the Monmouthshire Car Scheme. A joint visit took place and the following topics were discussed: ♦ Social Isolation ♦ Lack of Independence ♦ Health Issues ♦ Financial Abuse Awareness ♦ Transport Issues, with information provided relating to available options: ♦ Monmouthshire Car Scheme ♦ Council Meals on Wheels Service ♦ Council Visual Impairment Team ♦ RNIB resources and Services ♦ Sight Cymru ♦ Befriending Service ♦ Local Lunch & Social Groups.

The gentleman was very pleased to learn about the local services and registered as a Car Scheme passenger. He was particularly keen to regain the ability to do his own food shopping, as he went without meals due to a lack of provisions. He mentioned a supermarket outside his area that he previously couldn't access and was also unable to receive deliveries from, as it falls outside their delivery zone therefore the Car Scheme Co-ordinator confirmed that this was something the service could assist with.

Additionally, the WLA agreed to provide further follow up by contacting the Visual Impairment Team, RNIB, Sight Cymru, and the Befriending Service on his behalf to explore other specific support options that could help improve his situation. The gentleman took the time to pass on this message, which was subsequently sent to the referring GP: **"Thank you so much for all you have done for me - you have made the world of difference to me already", with the GP response below: "That's wonderful news – this is the wellbeing links at its best! Thanks for your help, I hope he now has a good improvement in his quality of life. I think you offer a really amazing service for our patients".**

Appendix 4: Supplementary Service Mapping Exercise to identify inequity and generate Collaborative level discussions:

2025/26 Supplementary Services mapping exercise	Practice Name	NCN	Asylum Seeker	Homeless	Substance Misuse	Depo-Provera	Depo/Sayana Press	Contraceptive Implants (Nexplanon)	Contraceptive Implants (Nexplanon Non Registered Patients)	IUCD Registered	IUCD - Non registered	Minor surgery - Fee A & B	Minor surgery - Fee B Only	Minor Surgery non-Registered patients
	Caldicot Medical	Monmouthshire South				Y		Y		Y	Y	Y	Y	
	Mount Pleasant	Monmouthshire South				Y	Y	Y		Y	Y	Y	Y	
	Vauxhall Practice	Monmouthshire South				Y		Y		Y	Y		Y	
	Town Gate	Monmouthshire South	Y			Y		Y		Y	Y		Y	Y
	Castle Gate	Monmouthshire North	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	
	Dixton Surgery	Monmouthshire North	Y	Y	Y	Y		Y		Y	Y	Y	Y	
	Hereford Road	Monmouthshire North	Y		Y	Y	Y	Y		Y	Y	Y	Y	
	Old Station	Monmouthshire North	Y			Y	Y			Y		Y	Y	
	Usk Surgery	Monmouthshire North				Y				Y		Y	Y	
	Tudor Gate	Monmouthshire North	Y			Y		Y		Y		Y	Y	
	Wye Valley	Monmouthshire North				Y		Y		Y		Y	Y	



BLAENAU GWENT (EAST& WEST) NCN IMTP 2026-2029



NCN Executive Summary:

Blaenau Gwent Borough covers a geographical area of 109 km² (42 square miles) with a population of approximately 70,000. Its main towns—Abertillery, Brynmawr, Ebbw Vale, and Tredegar. Health and social care provision in the area relies on a collaborative approach, bringing together independent contractors, the local authority, and third sector organisations.

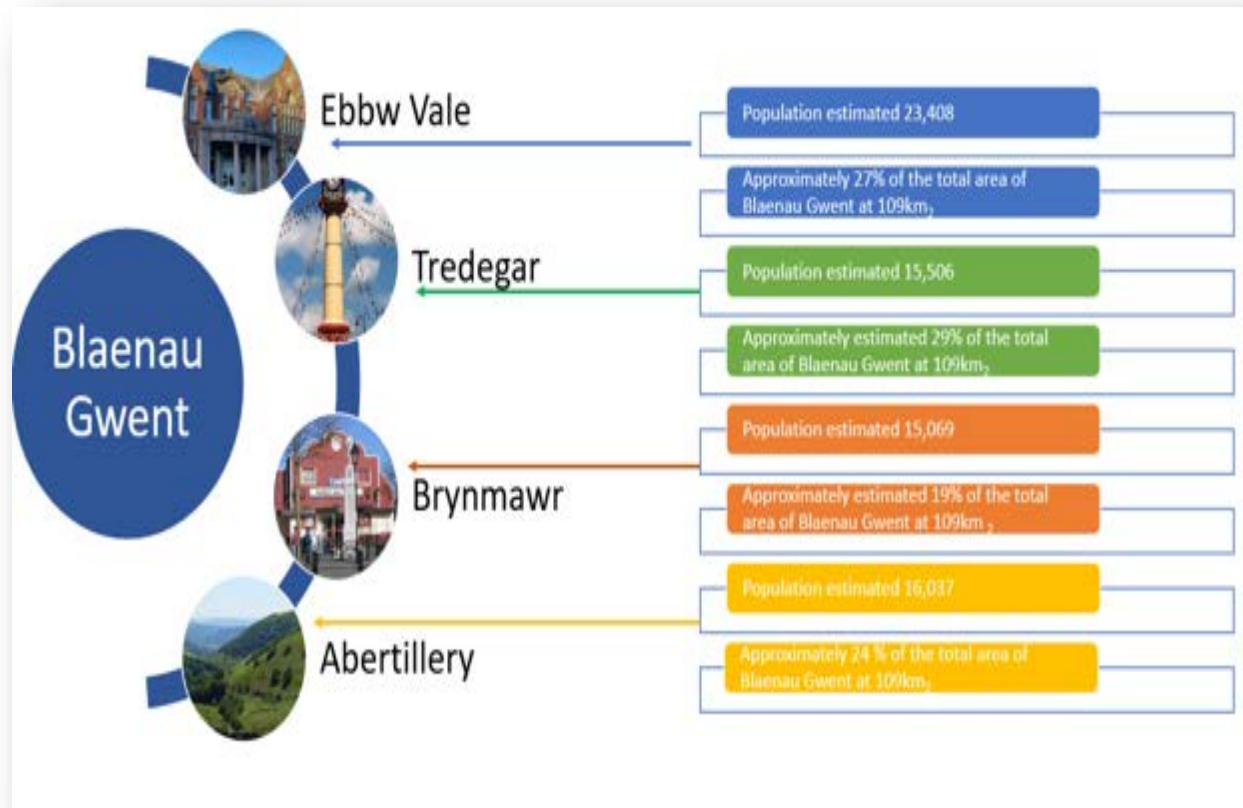
In Blaenau Gwent, there is a notable disparity in healthy life expectancy between the most affluent and the most disadvantaged members of our community. This inequality is compounded by the inverse care law, which highlights the challenge of managing chronic conditions and reducing premature mortality. Consequently, our services are accessed by a high number of individuals with complex and multiple health needs. This plan sets out our commitment to addressing those needs.

Our approach is grounded in the **Care Aims Framework**, which guides us in achieving better outcomes for service users. It provides a set of principles that support informed decision-making, underpinned by a shared public service duty to “do the most good, least harm, for the most people in a fair way.” We aim to foster a resilient community by embedding person-centred care, empowering individuals and families to take ownership of their health and wellbeing through prevention, self-care, and early intervention—driving the change our communities need.

Data and anecdotal evidence show that Blaenau Gwent has a significantly lower healthy life expectancy compared to the Welsh average—by approximately six years for both males and females. Services are frequently under pressure, resulting in delays in accessing timely support. Through this plan, the **Neighbourhood Care Network (NCN)** will continue to support community led services. This will be achieved by working collaboratively across acute, secondary, social care, independent contractor, primary care, community, and third sector services.

The borough is part of the **Deep End Wales network**, which represents general practices serving the most socioeconomically deprived communities. This status highlights the significant health inequalities faced locally, including a high burden of illness and complex care needs. Practices in these areas experience elevated demand for mental health support, chronic disease management, and face persistent barriers to access, all within the constraints of limited resources.

Blaenau Gwent (BG) is organised into two **Neighbourhood Care Networks (NCNs)**, each addressing the distinct needs of their communities:



Blaenau Gwent West NCN- Serving approximately 36,800 residents across Ebbw Fawr Valley and Sirhowy Valley. BG West consists of 26 *lower layer super output areas* (LSOAs), according to the *Welsh Index of Multiple Deprivation* WIMD Data 2025 7 (27%) of these are in the top 10% most deprived areas in Wales and 17 (65%) in the top 50%. Notably 81% of LSOAs are in the top 50%

Blaenau Gwent East NCN - Serving approximately 35,000 residents across the Upper Ebbw Fach and Lower Ebbw Fach parts of Blaenau Gwent. BG East consists of 19 LSOAs, according to the WIMD Data 2025 2 (10%) of these are in the top 10% most deprived areas in Wales and 17 (90%) in the top 50%. Notably 100% of LSOAs are in the top 50% for employment.

Key Findings identified for Blaenau Gwent in Welsh Index of Multiple Deprivation (WIMD) 2025

Blaenau Gwent remains one of Wales most deprived local authorities, with a highest proportion of small areas in the most deprived 10% (20%).

- **Overall Deprivation:** Blaenau Gwent has the highest proportion of its areas in the most deprived 10% and 50% in Wales.
- **Employment:** It has the highest percentage of areas (24%) in the most deprived 10% for employment
- **Health:** The authority shows the lowest (most deprived) median rank for health.
- **Community Safety:** It has a high proportion (28%) of areas in the most deprived 10% for community safety.

Our priorities align with those of **Aneurin Bevan University Health Board (ABUHB)**, the **Blaenau Gwent Integrated Service Partnership Board (ISPB)**, and the **Gwent Regional Partnership Board (RPB)**. We will adopt a distributed leadership model to ensure full engagement from all partners, enabling us to coordinate high-quality support for the people of Blaenau Gwent. The focus areas outlined in this plan are consistent with our 2026–2029 strategy and are driven by the **Primary Care Model for Wales**.

Our goal is to demonstrate how primary and community health services can work alongside the community, third sector agencies and local authority partners as a unified system to deliver our place-based care vision of a **“Happy, Healthy Blaenau Gwent”**,

Strategic Partners:

Strategic Context:

The NCNs are part of an integrated system of decision making, all of which impacts on the effective functioning of the health and care system.

Workstreams are managed and taken forward via NCN three-year plans. This shapes the decisions taken by the Integrated Services Partnership Board (ISPB) and help to achieve the priorities set out by the Regional Partnership Board (RPB). This ensures that NCNs annual plans are aligned with ISPB priorities and RPB needs assessments.

Regional Partnership Board (RPB)

- **Start Well;** Improving outcomes for children and families, working together to start well.
- **Live Well;** People at the heart of everything we do, working together to live well.
- **Stay Well;** Ensuring the right help is available at the right time, working together to stay well

Blaenau Gwent Integrated Service Partnership Board (ISPB)

Following the federation of Blaenau Gwent and Torfaen Councils, there is now a single Integrated Services Partnership Board (ISPB) serving both Blaenau Gwent and Torfaen. The ISPB comprises representatives from all parts of the health and care system. In Blaenau Gwent and Torfaen, it represents 8 distinct “places”: 4 in Torfaen and 4 in Blaenau Gwent. While these localities share the same board, each set of NCNs will maintain their own distinct identity to reflect the priorities and needs of their own places.

Throughout 2025, the Blaenau Gwent and Torfaen (BGT) ISPB is preparing for the introduction of Place-Based Care (PBC), having been selected as the pilot localities for the new PBC operating model. The PBC operating model has to be more than a shuffling of the existing resources. It has to be more than additional ‘partnership’



meetings. And it has to be more than a growth in local services. It is a call to arms to do things differently. To think about data and insight differently; to plan services differently; to take decisions differently; and to direct investment differently.

The ISPB is the engine room of Place-Based Care. It will assess our places' performance against the priorities set by the RPB, and coordinate changes/interventions across the system when an outcome is not improving at the level or pace we would have expected. To fulfil this role, in 2026, the BGT ISPB will be reshaping its vision, objectives, priorities, datasets, and meeting structures as it rolls out the new PBC operating model. This will align with and inform the investment plans for the 8 places.

- Recognising that there is still work to do before the ISPB plan is in place, the 2026 NCN plan will retain the objectives and priorities set in the previous year by the Blaenau Gwent ISPB so that it can continue to support people to access local support and community skills within their neighbourhoods.

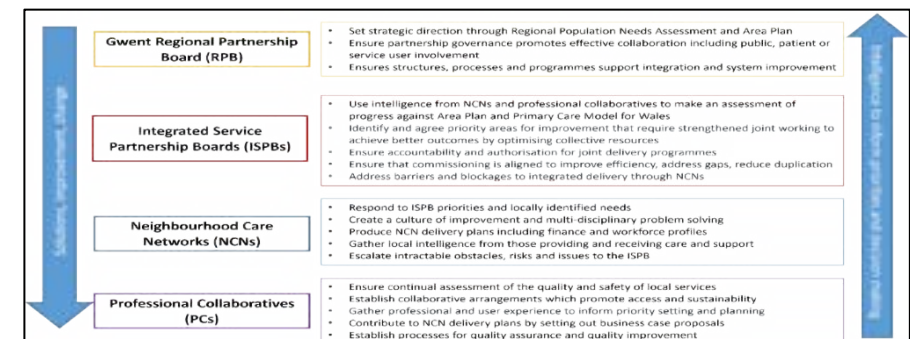
ISPB objectives:		ISPB priorities:
- Deliver local implementation of RPB priorities - Coordinate available resources to meet population needs - Provide strategic direction - Support partnership working - Ensure plans reflect population health intelligence	← Solutions, Improvement, Change → ← Intelligence for priorities & decision making →	- Third Sector as full partner - Integrated workforce for the future - Place Based Working - Redesigning services for older people - Ensure fit for purpose estate - Enhanced Financial scrutiny

Collaborative (NCN) Clusters

The objectives of the NCN are to bring together all local services involved in health and social care to deliver local solutions and promote the wellbeing of individuals and communities. NCNs are a key component of the ISPBs and will operationally deliver needs that are identified through this forum and aim to tackle the inequalities that present in Blaenau Gwent. The Integrated Wellbeing Network (IWN) forms the community arm of the NCN allowing local intelligence to be gathered on the needs of the community that can be considered within plans.

Professional Collaboratives - Accelerated Cluster Development Programme (ACD)

The aim of ACD is to meet the cluster population health need through effective and robust planning and service delivery. The professional collaboratives widen stakeholder attendance across our NCN/Cluster to ensure full collaboration to meet population needs. We seek to create sustainable system change through the integration of health and social care services, raising awareness of the benefits and opportunities for improving population outcomes through collaboration and strengthening partnership arrangements.



Health Board and NCN Priorities

ABUHB IMTP 2026 – 2029- & 10-Year Strategic Priorities



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

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

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

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

Best Start in Life

OUTCOMES

People will have more Healthy Days at Home

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

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

OUTCOMES

People will find it easier to connect with their communities, use local services, and feel respected

Our budget spent on services in the community will have increased

More people will engage with their local community to reduce loneliness and support good health

PRIORITIES

Healthy Places

Resilient & Connected Communities

Safe Spaces

Quality of Life

2025/26 Agreed NCN Priorities

The Health Board agreed NCN priorities for the 2025/2026 annual plan.

-  1. To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care
-  2. To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a 'social prescribing' model that connects people to activities, groups and services in their community addressing practical, social and emotional needs
-  3. To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations
-  4. To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs
-  5. Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees

From 2027-2029 Agreed NCN Priorities- 1 and 2 have been combined as one priority reflected below –

-  1. Connecting people to Non-Medical activities, groups, and services in their community which can address their practical, social and emotional needs
-  2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors
-  3. MDT working for people with complex needs who are most at risk of deterioration or adverse events
-  4. Equity of access to supplementary/enhanced services across Gwent

Progress Made Against Agreed NCN Priorities within 2025/2026

Over the next three years, all NCNs across ABUHB have committed to the NCN strategic priorities that will shape their delivery focus. These priorities are fully integrated within the place-based care model, positioning NCNs as the central mechanism for delivering care that is locally responsive, well-coordinated across services, and closer to home.

Priority 1:

To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care

The following provides a summary of progress made in Blaenau Gwent against the agreed NCN priorities for 2025/2026.



As part of our 2025/26 Annual Plan, our goal was to align with the key priorities set out for Neighbourhood Care Networks (NCNs) by developing a community-focused model of primary care. This approach is rooted in a deeper understanding of local assets and population needs, with particular attention to socially vulnerable and marginalised groups. This is being delivered through our place-based care strategy: **“Happy, Healthy Blaenau Gwent.”** To note; While Happy Healthy Blaenau Gwent includes a social prescribing element, our vision is for it to serve as the overarching framework for place-based care and collaborative working—bringing all initiatives together under one unified brand.

Launched in July 2025, *Happy Healthy Blaenau Gwent* is a locally driven initiative that reflects our vision for Blaenau Gwent as a compassionate and collaborative community. Our aim was to foster resilience by empowering citizens to access local resources that support their health and wellbeing.

The framework was aligned with the **Welsh Government’s National Framework for Social Prescribing**, and its core objectives are being locally interpreted to drive the programme forward.

Our ambitions include:

1. Empowering individuals to care for themselves and support one another
2. Building stronger, more resilient communities
3. Collaborating with partners to deliver high-quality, equitable services now and into the future

This vision is underpinned by national strategies such as *The National Primary Care Programme*, *A Healthier Wales*, and *Prosperity for All*, which advocate for sustainable workforce models and greater integration of third sector support to meet rising service demands. Regional Integrated Funding (RIF) has enabled us to embed the *Happy Healthy Blaenau Gwent* model as the key component of our place-based approach.

As part of our social prescribing model within **HHBG**, in partnership with Blaenau Gwent Local Authority, GAVO, and Aneurin Leisure Trust, we have recruited four community-based **Wellbeing Coaches** through a service level agreement. These coaches are embedded within the four localities of Blaenau Gwent, rather than being based in GP practices. This model allows for tailored, locally rooted support. Referrals into the programme are facilitated via the **Access Elemental** platform.

- **Strengthening Our Partnership with Trailblazer**

We're proud to be deepening our collaboration with the **Trailblazer project**, a vital initiative focused on supporting economically inactive individuals with health needs. Through this enhanced partnership, **Happy, Healthy Blaenau Gwent (HHBG)** has expanded its reach by offering personalised support that helps people take meaningful steps toward future employment.

This marks a powerful stride in tackling the broader determinants of health and empowering individuals to build better lives. We believe this project will have a lasting impact—not only for the people and families of Blaenau Gwent, but also for the professionals who walk alongside them.

By working together, we're building a more connected, supported, and resilient community—one where everyone has the opportunity to thrive.

- **In-Work Support Service – Blaenau Gwent GP Practice Pilot**

In collaboration with Case UK, we launched an exciting pilot in November 2025 across GP practices in Blaenau Gwent, offering one clinic per week in both the East and West areas of the borough.

The **In-Work Support Service (IWS)** is designed to provide rapid access to work-focused interventions for employees and self-employed individuals across Wales. Its core aim is to support people in managing health conditions—particularly common musculoskeletal and mental health challenges—so they can stay in work or successfully return following sickness absence.

Through a range of **evidence-based interventions**, including psychological therapies, the service empowers individuals to take control of their wellbeing and thrive in their professional lives.

- **Communication and Engagement – 2025/26 in the development stages**

As part of the *Happy Healthy Blaenau Gwent*, the locality is currently developing a Communication and Engagement strategy. This includes scoping the creation of a professional and citizen-facing website, which will host a comprehensive compendium of resources related to HHBG. The platform will be accessible to all residents and organisations across Blaenau Gwent, supporting improved access to information, services, and community wellbeing initiatives.

- **Championing Community Wellbeing**

We've continued to support local wellbeing schemes, guided by annual reviews and community intelligence to ensure we're addressing the most pressing needs each year.

- **Promoting Oral Health for Young People**

Through our established Children and Young Adult Task and Finish Group, we've worked closely with ABUHB's Community Dental Service and Dental Collaborative to explore innovative ways to promote oral hygiene and education.

- **Improving Dental Access**

Dental access in Blaenau Gwent has significantly improved through the Dental Access Portal.

- **Tackle Poverty and Reduce Inequalities**

In partnership with IWN, we've used local intelligence to direct funding where it's needed most, helping communities navigate the cost-of-living crisis.

- **Expanding Stakeholder Engagement**

We've broadened stakeholder involvement across the NCN to strengthen collaboration and ensure the local voice is central to our work. This supports our vision for **place-based care** and a **Happy, Healthy Blaenau Gwent**, driving sustainable change through integrated health and social care services.

- **Empowering Frontline Staff – Wellbeing Friends Initiative**

We've developed training for frontline staff (Care Navigators, District Nurses, CRT, etc.) to improve awareness and access to GDS, Optometry, Pharmacy, and GMS services. This initiative focuses on prevention, early intervention, and building resilience through self-care and social support networks.

- **Launching the Bevan Health and Wellbeing Centre**

The official opening of the Bevan Health and Wellbeing Centre – a flagship example of integrated, community-based care. It brings together health, social care, and voluntary sector partners under one roof to better serve our population.

- The NCN continued to profile hub timetables to enable Care Closer to Home in terms of delivering services for children and adults.

- **Blaenau Gwent Estates Strategy Development**

A comprehensive estates strategy has been developed for Blaenau Gwent, identifying risks and setting clear priorities across short-, medium-, and long-term timeframes.

- **2–3-Year-Old Flu Programme Delivery**

The flu vaccination programme for 2–3-year-olds continues to strengthen through effective collaboration between NCNs, GP practices, the vaccination service, and preschool/education settings. This strong partnership has led to increased uptake across the area.

- **District Nursing Housebound Flu Delivery Process**

In partnership with Blaenau Gwent District Nursing teams and the vaccination service, a Standard Operating Procedure (SOP) has been created for the 2025/26 flu delivery to housebound patients. This SOP ensures clarity and consistency in delivery and has been shared as an example of good practice with other localities across Gwent.

- **Partnership Working – NCN, Third Sector, and IWN Marketplace & Wellbeing Events**

Community wellbeing events were delivered in response to identified population needs. These events featured contributions from a wide range of partners, including Aneurin Leisure, Health Visiting, Family Information Service, Gwent Association of Voluntary Organisations, Expert Patient Programme, Llais, Age Cymru, Adferiad, Small Woods, School Nursing, Flying Start, and Help Me Quit.

- **Practice Protected Learning Time (PLT)**

A children-focused PLT session was organised and facilitated by the NCN, in collaboration with Blaenau Gwent Youth Services, Flying Start, Community Dental Service, Health Visiting, School Nursing, SPACE, and Neurodiversity services

- **Green Spaces**

The locality team continues to identify and coordinate relevant training opportunities.

Priority 2:

To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a 'social prescribing' model that connects people to activities, groups and services in their community addressing practical, social and emotional needs

- Worked in partnership with IWN to use local intelligence to direct funding effectively, supporting communities through the cost-of-living crisis.
- Collaborated with IWN to expand the network of Wellbeing Friends, creating a stronger mechanism for sharing information about local support and activities aimed at reducing loneliness and isolation.
- Increased the number of community buildings signed up to the Community Wellbeing Hub network in partnership with IWN. The NCN and IWN applied asset-based approaches to create accessible community resources that support integrated care. These resources were shaped by community aspirations, enabling health, social care, and third-sector services to be delivered in informal, familiar settings. This approach addressed social, economic, and environmental factors contributing to poor health and wellbeing. By using a strength-based model, previously separate services collaborated to develop solutions focused on what matters most to individuals, families, and communities. Through shared understanding, the NCN, IWN, and PBC Team strengthened collaboration with third-sector and community organisations to deliver early intervention, prevention, and chronic disease management, with a focus on diabetes, CVD, mental health, and social prescribing through wellbeing coaches.
- Worked with IWN to further populate the “**BG in This Together**” community map, improving visibility of local resources and support.

Priority 3:

To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations

Blaenau Gwent MDT Progress 2025/2026

During 2025/26, the locality team has worked in collaboration with the Local Authority Community Resource Team (CRT) to develop a joint approach for delivering a Multidisciplinary Team (MDT) model across Blaenau Gwent. As part of the Pathways of Care Transformation Grant, two MDT Coordinators have been appointed to facilitate the model, ensuring coordinated support for individuals with complex needs who are most at risk of deterioration or adverse events.

- **Professional Stakeholder Engagement**
Engaged with GP practices and NCNs through one-to-one practice visits, focusing on the development and integration of the Multidisciplinary Team (MDT) approach.
- **Collaborative MDT Project Development and Governance**
Jointly developed the MDT project with key stakeholders and established a robust governance framework to ensure effective delivery, accountability, and oversight.

NCN Roles Supporting Multi-Disciplinary Team (MDT) Working: - 25/26 continued to evaluate the progress of-

- Blaenau Gwent & WAST APP Hospital Avoidance Project.
- Ongoing Evaluation of the Blaenau Gwent WEST First Contact Physiotherapy MSK Project
- Rolling Out the Blaenau Gwent WEST NCN Pharmacist Housebound Programme

Priority 4

To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs

In 2025/26, the locality team completed the initial scoping phase of this priority, identifying key areas and opportunities for collaboration in delivering diabetes prevention and managing CVD risk factors. Insights from this work have informed the design of a systematic and scalable approach for implementation across the locality.

- **Diabetes Prevention Programme**
Successful roll out of the All-Wales Diabetes Prevention Programme across both clusters where patients, in the pre-diabetic stage, are offered a brief intervention which includes lifestyle advice with the hope of reducing their HBA1c over the longer term to reduce or prevent the progression of diabetes.
- **Cardiovascular Risk Quality Improvement**
During 25/26 practices continued to review hypertension registers to identify opportunities to optimise patient care and reduce the risk of future complications. This is a live project, launched in recent months, and forms part of a three-year Quality Improvement (QI). Practices are actively sharing learning and best practices, contributing to improved patient outcomes. There is also potential to collaborate with our collaboratives (GMS, Optometry, Pharmacy, Nursing and Allied Health Professionals) to enhance this work further, which we are keen to explore as the project becomes more embedded.
- **Hypertension Case Finding and Community Engagement**
A targeted hypertension case finding project is underway within GP practices, delivered as part of an enhanced service. The initiative seeks to identify individuals with undiagnosed hypertension through structured screening. Looking ahead, we are working in partnership with the IWN to expand visibility

and engagement through community-based activities, including the “Know Your Numbers” campaign. Subject to securing suitable venues, future plans include delivering opportunistic screening in community settings such as wellbeing cafés, or via mobile units visiting workplaces and local hubs to promote healthy behaviours and early detection

- Through a shared understanding the NCN, IWN and PBC Team have strengthened collaboration with third sector and community organisations to deliver early intervention, prevention and chronic disease management with a focus on diabetes, CVD, mental health and social prescribing through wellbeing coaches.

Priority 5:

Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees

Enhanced Services and Health Inclusion Mapping

Ongoing collaboration with the General Medical Services (GMS) team is focused on assessing the specific health needs of the Blaenau Gwent locality and identifying the most effective models for delivering place-based services. Where local practices are unable to meet service demand, alternative providers may be commissioned to deliver targeted interventions—such as long-acting reversible contraception (e.g., coils and implants).

In parallel, mapping work is being undertaken in partnership with the Health Inclusion Team to better understand service gaps and opportunities for improving access and equity across the locality.

Certain enhanced services, including those supporting asylum seekers and individuals experiencing homelessness, may be best delivered directly by GP practices. Others, such as contraceptive procedures, may be more appropriately provided through locality-based hubs to ensure accessibility and consistency.

Recognising the operational pressures faced by practices in Blaenau Gwent, discussions are underway with the Primary Care Contracting Team to explore the development of a financial model that would incentivise and support greater uptake of enhanced services. This approach aims to balance service sustainability with meeting local population health needs.

NCN IMTP 2026-2029

The table below shows the current service provision and identifies gaps in enhanced services across the Blaenau Gwent locality. *Cells highlighted in yellow indicate services currently delivered by practices, while cells in white represent areas where the enhanced service is not being provided*

Practice Code	Practice Name	List Size- July 2025	NCN	Place- based	Homeless	Asylum Seeker	Substance Misuse	Depo-Provera	Depo/sayana Press	Contraceptive Implants (Nexplanon)	Nexplanon (Non-registered)	IUCD Registered	IUCD Non-Reg	Minor Surgery	Minor Surgery – Fee A	Minor Surgery- Fee B
W93009	Aberbeeg Medical Practice	4654	East	Abertillery				Y							Y	Y
W93075	Abertillery Group Practice	5844						Y								Y
W93007	Cwm Calon Surgery	5558						Y							Y	Y
W93115	Blaina Medical Practice	6493		Brynmawr				Y							Y	Y
W93068	Brynmawr Medical Practice	10825					Y	Y								Y
W93619	Cwm Health Centre	5082	West	Ebbw Vale				Y		Y		Y			Y	Y
W93032	Glan Rhyd Surgery	10339						Y							Y	Y
W93623	Pen Y Cae Surgery	9845				Y		Y				Y			Y	Y
W93065	Glan yr Afon Medical Practice	7019		Tredegar		Y		Y							Y	Y
W93063	Tredegar Medical Practice	6829						Y								

NCN IMTP 2026-2029

Challenges, risks and barriers to successful delivery of agreed milestones within 2025/2026

Challenges, Risks and Barriers	2025/2026
Financial Constraints	Pay awards have led to unpredictable fluctuations beyond our control, making it difficult to commit to long-term planning or pilot new initiatives. <i>Happy Healthy Blaenau Gwent</i> is a key workstream due to its significant impact on the local population and its alignment with NCN and Place-Based Care priorities. The project currently operates with limited funding and is awaiting confirmation that the Regional Integration Fund (RIF) will be extended to March 2027. If funding is not extended, there is a risk that NCN-funded projects may be withdrawn to ensure resources are focused on initiatives that align with NCN and Place-Based Care priorities.
Workforce retention, recruitment & resilience	• Ongoing uncertainty around workforce capacity, fluctuating staffing levels, and challenges in recruiting clinical professionals significantly hinder our ability to plan and deliver services effectively. • There is also uncertainty regarding the continuation of funding for key programmes such as <i>Happy Healthy Blaenau Gwent</i> and <i>Integrated Wellbeing Networks</i>, which impacts sustainability
Rising Deprivation Levels	• Blaenau Gwent continues to experience significant health inequalities, closely linked to socio-economic deprivation. The current financial crisis is exacerbating these issues, placing additional strain on services. • Demand for health and social care is increasing, driven by an ageing population with more complex needs, further pressuring already stretched services across health, social care, and the third sector
Poverty and Inequalities	• The ongoing cost of living crisis is having a profound impact on mental health and wellbeing, resulting in increased demand for local support services.
Bureaucratic Processes	• Lengthy and complex procedures often delay the implementation of key priorities, reducing our ability to respond swiftly to emerging needs
Sustainability of Primary Care Services	• Three GP practices (two from January 2026) have recently returned to managed status, raising concerns about long-term sustainability. • A number of single-handed practices operate within the cluster, with uncertainty surrounding their future over the next 2–3 years. • In the next 5 years approximately 763 new housing builds will take place, the NCN will need to scope the impact it may have on our primary care independent contractor's sustainability.
Estates	• While some improvements have been made, many estate facilities remain unfit for delivering place-based care. • Limited capacity and inadequate buildings restrict our ability to reduce service demand and seize opportunities for transformation. • Progress is heavily reliant on a constrained capital programme, which limits the pace of estate strategy implementation.
Demand, Capacity and Operational pressures	• Rising service demands and operational pressures continue to divert focus away from service development, • Innovation, and initiatives aimed at alleviating system strain. • System-wide pressures are impacting the delivery and effectiveness of services across the board.

NCN IMTP 2026-2029

NCN Planning - 2026/2027		
Identified Quarterly Milestones Against Agreed NCN Priorities for 2026/2027		
Priority	Defined Delivery Milestones	Defined Delivery Milestones
1. Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs	Q1	Complete Evaluation of Happy Healthy Blaenau Gwent - Gather and analyse data to assess impact on population wellbeing. - Identify gaps and opportunities for service improvement. Dental Collaborative Lead - Appoint a designated GDC lead for the Blaenau Gwent West Dental Collaborative to provide leadership, coordination, and support for ongoing progress. Expanding Stakeholder Engagement: - Broadening NCN participation to ensure inclusive collaboration and maintain a strong local voice
	Q2	2–3-Year-Old Flu Campaign - Plan and agree on the continuation of the flu vaccination campaign for 2–3-year-olds, working collaboratively with GMS, the Vaccination Service, and education and preschool settings. Green Space Initiative - Improve health and wellbeing through the use of gardens and outdoor spaces.
	Q3	Support for Community Wellbeing Schemes working with other assets/groups i.e., Local Wellbeing Partnership Reviewed annually using local intelligence to identify priority needs

Q1, Q2, Q3, Q4
Ongoing
progress/discussions
throughout 2026

Define Expansion Strategy for Place-Based Care

- Use evaluation findings to inform future service design.
- Prioritise interventions that address identified population needs.

Secure Long-Term Sustainability

- Initiate discussions at ISPB level regarding funding options.
- Develop a proposal to transition Happy Healthy Blaenau Gwent from a time-limited RIF-funded project to a core service.

Stakeholder Engagement and Governance

- Align plans with ISPB priorities and local care strategies.
- Ensure collaborative input from NCN, IWN, LA, Third Sector and community partners

Place Based Care Implementation Planning

- Draft roadmap for service integration into mainstream provision.
- Set timelines for phased delivery and resource allocation.

Oral Health Promotion

- Continue collaborating with ABUHB Community Dental Service and the Dental Collaborative to identify and implement opportunities for promoting good oral hygiene across the community.

Tackle Poverty and Reduce Inequalities

- Partnering with IWN and Local Wellbeing Partnership to direct funding based on local intelligence

Estates Strategy

		- Estates Strategy: Continue progressing and, where possible, implementing short-, medium-, and long-term priorities across the locality. Partnership Working - Maintain delivery of Community Wellbeing Events across all four place-based areas within Blaenau Gwent, strengthening local engagement and collaboration. Ensuring that local services and support are brought to places where people gather - Embed a culture of active signposting as a 'light touch' approach, based on <i>Making Every Contact Count</i> principles, where existing staff engage people in conversations about what matters to them and provide information to signpost them to services, groups and activities, using local knowledge or directories. The relevant MECC training materials and courses will be promoted to partners. - To continue to utilise the expertise and skills of Behavioural Change Practitioners to educate and support individuals in managing their own health. - Support delivery of social prescribing and monitor activity and outcomes to avoid duplication. - Continue with the development of the BG in this together website, community hub and asset mapping. - Within current community assets explore preventative interventions for the most vulnerable patients such as those suffering from chronic respiratory disease, these will include opportunities to attend warm hubs.
2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors	Q1 Q2	Diabetes Prevention - Continue NCN participation in the Diabetes Prevention Programme. - Use data to identify at-risk patients and develop invitation plans for structured education and lifestyle programmes.

NCN IMTP 2026-2029

	Q3	Collaborate with community partners to deliver group sessions and digital support for behaviour change. Review outcomes and adjust interventions to reduce progression from pre-diabetes.
3. MDT working for people with complex needs who are most at risk of deterioration or adverse events	Q1 Q1 & Q2	To deliver integrated, proactive, and person-centred care that improves outcomes for individuals with complex needs, reduces duplication, and supports early intervention and prevention. Integrated Assessment & Planning - Conduct joint assessments considering clinical and social circumstances. - Develop integrated care and support plans tailored to individual needs. Effective Coordination - Allocate referrals via the Elemental system to the MDT Coordinator. - Facilitate MDT meetings with the right professionals at the right time. Information Sharing - Enable secure, timely sharing of information across health and social care. - Person & Family Engagement - Involve individuals, carers, and families in planning and goal setting. Culture of Collaboration - Foster strong working relationships across health, social care, and third-sector partners. Cardiovascular Risk Reduction - Support practices to review and optimise treatment for patients on hypertension registers. - Facilitate peer learning and data sharing across practices. - Engage pharmacy collaborative for medication optimisation. - Embed programme as part of a 3-year QI initiative with measurable outcomes. Community Campaigns for Self-Care and Symptom Management

- Identify local community needs and priority areas for preventative health campaigns.
- Plan and schedule campaign days across Blaenau Gwent in partnership with IWN.
- Deliver targeted events promoting self-care and symptom management.
- Evaluate impact and refine approach for future campaigns.

Hypertension Case Finding

- Implement enhanced service for targeted screening in practices.
- Partner with IWN and community groups for “Know Your Numbers” campaigns.
- Deliver community-based screening opportunities (well-being cafés, mobile health units at workplaces and local venues).
- Link screening with lifestyle advice and referral pathways; evaluate impact.

Chronic Kidney Disease (CKD) QI Project

- Increase urine ACR testing to identify proteinuria and risk-stratify patients.
- Embed CKD risk profiling into practice workflows.
- Provide targeted clinical reviews and optimise prescribing for high-risk patients.
- Share learning and best practice across NCN through QI meetings.

Q2

Integrated Community-Level Working

- Strengthen collaborative working across cluster partners.
- Expand use of hot clinics and community-based step-up facilities.
- Monitor impact on reducing reliance on acute services and improving care closer to home.

Evaluate outcomes and refine processes for seamless transitions.

Outcome Monitoring

- Jointly monitor and evaluate outcomes, adjusting plans as needed.

Q4

		NCN Roles Supporting Multi-Disciplinary Team (MDT) Working: Blaenau Gwent & WAST APP Hospital Avoidance Project • Evaluate effectiveness and amend processes as needed. • Complete annual review and report findings. Blaenau Gwent WEST First Contact Physiotherapy MSK Project • Continue data collection and monitoring of patient outcomes. • Conduct interim evaluation and identify improvement areas. • Implement amendments based on findings. • Finalise evaluation and share recommendations. Blaenau Gwent WEST NCN Pharmacist Housebound Programme • Review medication management outcomes and patient feedback. • Amend processes to optimise delivery. • Complete evaluation and plan next steps for scaling Review of Psychological Health Practitioner Programme • Begin comprehensive review of the current delivery model. • Assess alignment with local population needs and GMS requirements. • Draft recommendations for improvement and integration into mental health pathways.
4. Equity of access to supplementary/enhanced services across Gwent	Q1 Q3	Enhanced Services Delivery • Work with the GMS Collaborative to assess local needs and capacity for enhanced services. • Develop place-based delivery models, including: ○ Practice-based services for asylum seekers and homeless health.

NCN IMTP 2026-2029

Q3

- Locality hub services for contraceptive care (coils/implants).
- Commission alternative providers where practices cannot meet demand.
- Explore opportunities for new income streams aligned with local health needs.

Enablers required to deliver 2026/2027 quarterly milestones

- Data & Intelligence
- Partnership Infrastructure
- Workforce Development
- Workforce Capacity
- Digital Tools
- Funding & Commissioning:
- Community Engagement
- Evaluation Framework
- Outcome monitoring
- Clinical Support
- Evaluation and Monitoring

NCN IMTP 2026-2029

Challenges, risks and barriers to successful delivery of agreed milestones within 2026/2027

Challenges, Risks and Barriers	2026/2027
Financial Constraints	Pay awards have led to unpredictable fluctuations beyond our control, making it difficult to commit to long-term planning or pilot new initiatives. <i>Happy Healthy Blaenau Gwent</i> is a key workstream due to its significant impact on the local population and its alignment with NCN and Place-Based Care priorities. The project currently operates with limited funding. There is a risk that NCN-funded projects may be withdrawn to ensure resources are focused on initiatives that align with NCN and Place-Based Care priorities.
Workforce retention, recruitment & resilience	• Ongoing uncertainty around workforce capacity, fluctuating staffing levels, and challenges in recruiting clinical professionals significantly hinder our ability to plan and deliver services effectively. • There is also uncertainty regarding the continuation of funding for key programmes such as <i>Happy Healthy Blaenau Gwent</i> and <i>Integrated Wellbeing Networks</i>, which impacts sustainability
Rising Deprivation Levels	• Blaenau Gwent continues to experience significant health inequalities, closely linked to socio-economic deprivation. The current financial crisis is exacerbating these issues, placing additional strain on services. • Demand for health and social care is increasing, driven by an ageing population with more complex needs, further pressuring already stretched services across health, social care, and the third sector
Poverty and Inequalities	• The ongoing cost of living crisis is having a profound impact on mental health and wellbeing, resulting in increased demand for local support services.
Bureaucratic Processes	• Lengthy and complex procedures often delay the implementation of key priorities, reducing our ability to respond swiftly to emerging needs
Sustainability of Primary Care Services	• Two GP practices have recently returned to managed status, raising concerns about long-term sustainability. • A number of single-handed practices operate within the cluster, with uncertainty surrounding their future over the next 2–3 years.
Estates	• While some improvements have been made, many estate facilities remain unfit for delivering place-based care. • Limited capacity and inadequate buildings restrict our ability to reduce service demand and seize opportunities for transformation. • Progress is heavily reliant on a constrained capital programme, which limits the pace of estate strategy implementation.
Demand, Capacity and Operational pressures	• Rising service demands and operational pressures continue to divert focus away from service development, innovation, and initiatives aimed at alleviating system strain. • System-wide pressures are impacting the delivery and effectiveness of services across the board.

NCN IMTP 2026-2029

Finance Profile 2026/2027

Current forecast for budget allocation next year is indicative, we are basing our spend plan on the assumption that there will be no change to the allocation for 26/27 for both East and West and that there will be pay increase. To achieve a breakeven position, the following projects are at risk:

- Community Wellbeing Schemes
- Chronic Diseases Management
- Mental Health and Wellbeing
- Flu Delivery Support
- Digital Solutions and Inclusion
- Staff Wellbeing
- Winter Planning / PLT
- Training and Education

Blaenau Gwent East		Total Allocation; £239.129
Pay		2026/27
Subjective	Scheme	Total
22250-Independent Contractors	Top Slice - Independent Advisers	161
2AA31-Nursing HCA/HCSW Band 3	Top Slice - Phlebotomy	9,747
2E481-Pharmacist Band 8A	Practice Based Pharmacists	66,173
2E351 Psychological Health Practitioner	Psychological Wellbeing Practitioners	114,347
2A471 - Hospital Admission Avoidance Paramedic	Hospital Admissions Avoidance Paramedic	41,628
		£232,056
Non Pay		
Details	Scheme	Total
33610 Travel & Subsistence	Practice Based Pharmacists	150
Dementia Road Map	Top Slice - Dementia Roadmap	375
Community Wellbeing schemes (Winter/Dental)	Community Wellbeing Schemes	225
Chronic Disease Management	Expert Patient Programme (EPP)	6,323
Practice manger facilitator	Practice Manager Conference	-
Mental Health / Wellbeing	Mental Health / Wellbeing	-
Flu Delivery Plan Support	Room Hire - Flu Vaccinations	-
Digital Solutions and Inclusion	Telehealth	-
Staff Wellbeing	Wellbeing workshop	-
Release of prior year accruals	Accountancy gains	-
Winter Planning/PLT	Training - Workflow Optimisation	-
Independent Prescriber	Independent Prescriber	-
		7,073
Total Funding		239,129

Blaenau Gwent West		Total Allocation; £268.589
Pay		2026/27
Subjective	Scheme	Total
22250-Independent Contractors	Top Slice - Independent Advisers	185
2AA31-Nursing HCA/HCSW Band 3	Top Slice - Phlebotomy	8,526
2E481-Pharmacist Band 8A	Practice Based Pharmacists	41,777
2E351 Psychological Well-being Practitioner	Psychological Wellbeing Practitioners	109,217
2A471 - Hospital Admission avoidance paramedic	Hospital Admissions Avoidance Paramedic	41,523
		£ 201,228
Other Non-Pay		
Details	Scheme	Total
33610 Travel & Subsistence	Practice Based Pharmacists	-
Community Wellbeing schemes (Winter/Dental)	Community Wellbeing Schemes	5,463
Dementia Road Map	Top Slice - Dementia Roadmap	375
Chronic Disease Management	Chronic Disease Management	6,523
Digital Solutions and Inclusion	Telehealth	-
Mental Health / Wellbeing	Mental Health / Wellbeing	5,000
Flu Delivery Plan Support	Flu Delivery Plan Support	-
Staff wellbeing	Wellbeing Workshop	-
Development of Hubs/BG West	First Contact Physio	50,000
Independent prescribing qualification	Independent Prescriber	-
Winter Planning PLT	Training - Workflow Optimisation	-
		£ 67,361
Total Funding		£ 268,589

Workforce Profile 2026/2027

Please outline your workforce profile for 2026/2027

Workforce Challenges and Place-Based Opportunities in Blaenau Gwent

Clinical recruitment remains the most significant workforce risk within Blaenau Gwent. The locality is experiencing the effects of change fatigue, alongside an aging workforce and a notable gender imbalance. These factors, combined with high levels of deprivation and complex health needs, have created a fragile workforce landscape across core services.

However, these challenges also present a unique opportunity to adopt a **place-based approach** to workforce planning—one that is rooted in the specific needs, demographics, and strengths of the Blaenau Gwent population. By aligning workforce development with local priorities, we can begin to build a more sustainable and responsive model of care.

The **Primary Care Plan for Wales** supports this direction, encouraging the implementation of multidisciplinary teams that draw on a broad range of clinical and non-clinical skillsets. In Blaenau Gwent, this means exploring alternative roles and competencies that can enhance capacity and better meet the evolving needs of our communities.

A key priority for the locality is to take a holistic, population-focused view—developing a workforce that is not only clinically capable but also equipped to address the wider determinants of health. This includes investing in new ways of working, such as community hubs, and designing roles based on competencies rather than traditional professional boundaries.

Cross-Sector Recruitment Showcase Event

In collaboration with Primary Care, Community Services, Local Authority and Third Sector partners, the locality is planning to design and deliver an interactive recruitment showcase event. The event will provide a unique opportunity for attendees to apply, interview, and be appointed on the day, with the aim of addressing workforce vacancies across all sectors in Blaenau Gwent. This innovative approach supports integrated workforce planning and aims to attract talent from Blaenau Gwent and surrounding localities into key roles within the locality.

Workforce Sustainability Concern (2027–2029)

While this workforce profile focuses on the **2026/2027** period, it is important to highlight a significant emerging concern for the **years 2027 to 2029**. Specifically, within General Medical Services (GMS), the age profile of the GP workforce in Blaenau Gwent indicates a growing proportion of aging practitioners. This trend presents a substantial sustainability challenge for service continuity and workforce planning, requiring proactive strategies to mitigate future risks to primary care delivery within Blaenau Gwent.

NCN IMTP 2026-2029

NCN Planning 2027/2028 – 2028/2029

Proposed Milestone for Agreed Priorities for 2027/2028 and 2028/2029

Priority	Q	2027/2028	Q	2028/2029
1. Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs	Q1	Happy Healthy Blaenau Gwent – Post-Evaluation Actions – subject to funding post March 2027 - Implement recommendations from the 2026/27 evaluation to enhance population wellbeing. - Develop targeted improvement plans based on identified gaps and opportunities. - Monitor ongoing impact through quarterly data reviews.	Q1	Happy Healthy Blaenau Gwent – Post-Evaluation Actions (Subject to funding beyond March 2027) Implement recommendations from the 2027/28 evaluation to further enhance population wellbeing.
		Collaborative Leadership - Maintain and strengthen the role of collaborative leads across Blaenau Gwent. - Support leadership in driving innovation and continuous service improvement. - Develop targeted improvement plans addressing gaps and opportunities identified in the latest review. - Continue monitoring impact through quarterly data reviews to ensure progress.	Q2	Collaborative Leadership - Maintain and strengthen the role of collaborative leads across Blaenau Gwent. - Support leadership in driving innovation and continuous service improvement. - Develop targeted improvement plans addressing gaps and opportunities identified in the latest review. - Continue monitoring impact through quarterly data reviews to ensure progress.
		- Maintain and strengthen role of the collaborative leads across Blaenau Gwent - Support leadership in driving innovation and service improvements.	Q1, Q2, Q3, Q4	Expansion Strategy for Place-Based Care - Finalise and commence implementation of the expansion plan informed by 2027/28 evaluation findings. - Scale up interventions that meet priority population needs across all four place-based areas.
		Stakeholder Engagement Expansion		

		• Broaden NCN participation further to ensure inclusive collaboration. • Increase community representation in decision-making forums.		• Track performance metrics for expanded services.
	Q2	2–3-Year-Old Flu Campaign • Deliver flu vaccination campaign in collaboration with GMS, Vaccination Service, and education/preschool settings. • Evaluate uptake and refine approach for future years.		Long-Term Sustainability • Embed sustainability principles into all new initiatives and service developments.
	Q1 Q2 Q3 Q4	Expansion Strategy for Place-Based Care • Finalise and begin implementing the expansion plan informed by evaluation findings. • Scale up interventions that address priority population needs across all four place-based areas. • Establish performance metrics for expanded services.		Stakeholder Engagement and Governance • Continue to strengthen governance structures to support the expanded place-based care model. • Continue to deepen collaboration with NCN, IWN, LA, Third Sector, and community partners through quarterly engagement forums. • Ensure continued alignment with updated ISPB priorities and regional strategies.
		Long-Term Sustainability • Secure agreement at ISPB level for sustainable funding model.		Place-Based Care Implementation • Continue to Deliver integration of services into mainstream provision as per the updated roadmap. • Allocate resources and workforce for full implementation. • Review and adjust timelines based on progress and stakeholder feedback.
				Community Wellbeing Schemes • Continue to conduct annual reviews using local intelligence to identify emerging priority needs. • Continue to expand schemes where evidence demonstrates positive impact.

- Transition Happy Healthy Blaenau Gwent from RIF-funded project to a core service within mainstream provision.
- Embed sustainability principles into all new initiatives.

Stakeholder Engagement and Governance

- Strengthen governance structures to support expanded place-based care.
- Deepen collaboration with NCN, IWN, LA, Third Sector, and community partners through quarterly engagement forums.
- Ensure alignment with updated ISPB priorities and regional strategies.

Place-Based Care Implementation

- Deliver phased integration of services into mainstream provision as per roadmap.
- Allocate resources and workforce for full implementation.
- Review and adjust timelines based on progress and feedback.

Oral Health Promotion

- Continue partnership with ABUHB Community Dental Service and Dental Collaborative.
- Monitor impact on any oral health initiatives implemented 27/28.

Tackle Poverty and Reduce Inequalities

- Continue to work in partnerships with IWN and Local Wellbeing Partnership to refine funding allocation based on updated local intelligence.
- Introduce additional targeted interventions for vulnerable groups based on local informed intelligence.

Community Asset Mapping

- Continue to use findings to address gaps and integrate community resources into service planning.
- Ongoing evaluation of mapping services across 3rd Sector assets

Estates Strategy

- Review and evaluate implementation of short-, medium-, and long-term priorities.
- Ongoing delivery of agreed estate improvements where feasible.

2–3-Year-Old Flu Campaign- depended on outcome 27/28

Community Wellbeing Schemes

- Conduct annual review using local intelligence to identify emerging priority needs.
- Expand schemes where evidence shows positive impact.

Oral Health Promotion

- Continue partnership with ABUHB Community Dental Service and Dental Collaborative.
- Launch new community oral health initiatives based on previous year's learnings.

Tackle Poverty and Reduce Inequalities

- Work with IWN to refine funding allocation based on updated local intelligence.
- Introduce additional targeted interventions for vulnerable groups.

Community Asset Mapping

- Complete comprehensive mapping of third sector assets across Blaenau Gwent.
- Use findings to address gaps and integrate community

- Deliver flu vaccination campaign in collaboration with GMS, Vaccination Service, and education/preschool settings.
- Evaluate uptake and refine approach for future years.

Partnership Working

- Ongoing delivery of Community Wellbeing Events across all four place-based areas.
- Continue to Introduce new engagement formats to strengthen local voice.

Green Space Initiative.

- Continue to develop opportunities to deliver health and wellbeing utilising the green space agenda

		resources into service planning. Estates Strategy • Progress implementation of short-, medium-, and long-term priorities. Partnership Working • Continue delivery of Community Wellbeing Events across all four place-based areas. • Introduce new engagement formats to strengthen local voice. Green Space Initiative • If funding secured, implement green space project to promote health and wellbeing. • Monitor impact and explore opportunities for scaling. • Continue with the development of the BG in this together website, hand in hand with community hub development and asset mapping. Build capacity within staff (CIO, Wellbeing Coaches and other link worker		

		roles through PBC model) to develop and update the website. Continue the development of 'community wellbeing hubs' in collaboration with the local authority and third sector, ensuring these assets can connect people with health and wellbeing resources, activities and other people to support their own wellbeing.		
2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors	Q1, Q2, Q3, Q4	Community Campaigns for Self-Care and Symptom Management - BCP to prioritise high risk patients who are still smoking for smoking cessation support. - Behaviour Change Practitioners (BCPs) within the Blaenau Gwent IWN Team to support the management of behavioural risk factors. In addition to providing a universal smoking cessation offer, a targeted offer, using a population health management approach, will be implemented to identify and prioritise high-risk patients, particularly those with chronic respiratory conditions, to offer smoking	Q1, Q2, Q3, Q4	Community Campaigns for Self-Care and Symptom Management - Continued identification of high-risk patients and planning of behaviour change approaches to support the management of behavioural risk factors, based on prevalence of disease, winter planning priorities or local need. - Identify local community needs and priority areas for preventative health campaigns. - Plan and schedule campaign days across Blaenau Gwent in partnership with IWN. - Deliver targeted events promoting self-care and symptom management. - Evaluate impact and refine approach for future campaigns. Diabetes Prevention - Continue NCN participation in the Diabetes Prevention Programme.

		cessation support to. As part of this intervention identified individuals will be encouraged to take up the offer of vaccinations if they are eligible and to engage with warmer home initiatives. - Identify local community needs and priority areas for preventative health campaigns. - Plan and schedule campaign days across Blaenau Gwent in partnership with IWN. - Deliver targeted events promoting self-care and symptom management. - Evaluate impact and refine approach for future campaigns. Diabetes Prevention - Continue NCN participation in the Diabetes Prevention Programme. - Use data to identify at-risk patients and develop invitation plans for structured education and lifestyle programmes. - Collaborate with community partners to deliver group sessions and digital support for behaviour change.		- Use data to identify at-risk patients and develop invitation plans for structured education and lifestyle programmes. - Collaborate with community partners to deliver group sessions and digital support for behaviour change. - Review outcomes and adjust interventions to reduce progression from pre-diabetes. Cardiovascular Risk Reduction - Continue to support practices to review and optimise treatment for patients on hypertension registers. - Continue to facilitate peer learning and data sharing across practices. - Continue to Engage pharmacy collaborative for medication optimisation. - Continue to embed programme as part of a 3-year QI initiative with measurable outcomes. Hypertension Case Finding - Monitor and evaluate impact of enhanced service for targeted screening in practices. - Monitor and evaluate implemented campaigns in partnership with IWN. - Continue to deliver community-based screening opportunities (well-being cafés, mobile health units at workplaces and local venues). - Continue screening with lifestyle advice and referral pathways; evaluate impact.

- Review outcomes and adjust interventions to reduce progression from pre-diabetes.

Cardiovascular Risk Reduction

- Support practices to review and optimise treatment for patients on hypertension registers.
- Facilitate peer learning and data sharing across practices.
- Engage pharmacy collaborative for medication optimisation.
- Embed programme as part of a 3-year QI initiative with measurable outcomes.

Hypertension Case Finding

- Implement enhanced service for targeted screening in practices.
- Partner with IWN and community groups for “Know Your Numbers” campaigns.
- Deliver community-based screening opportunities (well-being cafés, mobile health units at workplaces and local venues).

Chronic Kidney Disease (CKD) QI Project

- Monitor the impact of increased urine ACR testing to identify proteinuria and risk-stratify patients.
- Monitor impact of CKD risk profiling into practice workflows.
- Continue to provide and monitor impact
- Continue sharing and learning of best practice across NCN through QI meetings.

		• Link screening with lifestyle advice and referral pathways; evaluate impact. Chronic Kidney Disease (CKD) QI Project • Increase urine ACR testing to identify proteinuria and risk-stratify patients. • Embed CKD risk profiling into practice workflows. • Provide targeted clinical reviews and optimise prescribing for high-risk patients. • Share learning and best practice across NCN through QI meetings.		
3. MDT working for people with complex needs who are most at risk of deterioration or adverse events	Q1, Q2, Q3, Q4	Deliver fully integrated, proactive, and person-centred care that consistently improves outcomes for individuals with complex needs, eliminates duplication, and embeds early intervention and prevention as standard practice. Integrated Assessment & Planning	Q1, Q2, Q3, Q4	Continue to deliver fully integrated, proactive, and person-centred care that consistently improves outcomes for individuals with complex needs, eliminates duplication, and embeds early intervention and prevention as standard practice. Integrated Assessment & Planning

- Explore digital tools for joint assessments, ensuring real-time input from clinical, social care, and third-sector partners.
- Standardise integrated care plans across NCN, incorporating predictive analytics for risk stratification.

Effective Coordination

- Automate referral triage through Elemental access system
- Institutionalise MDT scheduling with dynamic rostering to ensure timely access to specialist input.

Information Sharing

- Achieve full interoperability between health and social care systems, enabling seamless data exchange.

Person & Family Engagement

- Co-design care pathways with service users and carers, embedding feedback loops into service improvement.

- Embed digital technology for joint clinical, social care, and third-sector input, ensuring predictive modelling for early risk identification.

Effective Coordination

- Fully automate referral triage and care navigation through Elemental and complementary platforms.

Information Sharing

- Achieve universal interoperability across health, social care, and voluntary sector systems.
- Explore opportunities for patient-controlled data sharing to enhance transparency and trust.

Person & Family Engagement

- Monitor Co-produce care pathways
- Monitor personalised digital engagement tools

Outcome Monitoring

- Continue the use of real-time dashboards for joint outcome monitoring.

- Expand digital engagement tools for goal setting and progress tracking.

Outcome Monitoring

- Implement real-time dashboards for joint outcome monitoring across health and social care.
- Use population health analytics to inform continuous improvement and resource allocation.

Culture of Collaboration

- Formalise cross-sector governance structures to sustain integrated working.
- Develop joint workforce development programmes to strengthen collaborative culture.

NCN Roles Supporting MDT Working

Blaenau Gwent & WAST APP Hospital Avoidance Project

- Explore opportunities to embed the role and associated processes as a core component of place-based care, leveraging alternative

- Continue to use population health analytics to inform proactive resource allocation and service redesign.

Culture of Collaboration

- Embed cross-sector governance, ensuring sustainability of integrated working.
- Deliver joint workforce development programmes to strengthen collaborative culture.

NCN Roles Supporting MDT Working

Blaenau Gwent & WAST APP Hospital Avoidance Project

- Transition the role into a core component of place-based care, supported by sustainable funding models and integrated digital pathways.

Blaenau Gwent First Contact Physiotherapy MSK Project

- Fully embed as a standardised NCN service across East and West, leveraging predictive demand modelling and alternative funding streams.

Blaenau Gwent NCN Pharmacist Housebound Programme

- Fully embed as a standardised NCN service across East and West

Review of Psychological Health Practitioner Programme.

funding streams beyond NCN resources.

Blaenau Gwent WEST First Contact Physiotherapy MSK Project

- Explore opportunities to embed the role and associated processes as a core component of place-based care, leveraging alternative funding streams beyond NCN resources.
- Explore opportunities to expand this service to Blaenau Gwent East NCN to ensure equitable service

Blaenau Gwent WEST NCN Pharmacist Housebound Programme

- Continue to be influenced by programme outcomes.
- Explore opportunities to expand this service to Blaenau Gwent East NCN to ensure equitable service

Review of Physiological Health Practitioner Programme

- Explore opportunities to embed the role and associated processes as a core component of place-based

- Fully embed as a standardised NCN service across East and West, leveraging predictive demand modelling and alternative funding streams.

Integrated Community-Level Working

- Operationalise community hubs as digital-first care centres, offering multi-disciplinary step-up/step-down care with virtual MDT support.
- Embed virtual MDT consultations as default practice, reducing delays and improving access.
- Measure impact using predictive analytics and real-time dashboards, focusing on acute demand reduction and population health outcomes.

NCN IMTP 2026-2029

		care, leveraging alternative funding streams beyond NCN resources. Integrated Community-Level Working • Establish community hubs offering multi-disciplinary step-up/step-down care. • Embed virtual MDT consultations to reduce delays and improve access. • Measure impact on acute demand reduction using predictive analytics.		
4 Equity of access to supplementary/enhanced services across Gwent	Q1, Q2, Q3, Q4	Milestones – Enhanced Services Delivery • Strengthen collaboration with the GMS Collaborative to implement findings from the 2026/27 needs assessment and ensure equitable access to enhanced services across Blaenau Gwent. Expand place-based delivery models, including: • Fully operational practice-based services for asylum seekers and homeless health,	Q1, Q2, Q3, Q4	Milestones – Enhanced Services Delivery • Embed enhanced services into core delivery models, ensuring consistency and resilience across all practices and localities. • Fully integrate place-based services for asylum seekers and homeless health into mainstream pathways, with measurable outcomes on health equity. • Expand contraceptive care hubs to include broader sexual health services. • Diversify income streams through preventative health programs, digital health innovations, and community-based initiatives aligned with population health priorities.

		with integrated pathways to community support. • Scale up locality hub services for contraceptive care (coils/implants) to meet increasing demand and improve patient choice. • Introduce alternative provider partnerships where capacity gaps persist, ensuring timely service delivery and reducing patient waiting times. • Develop innovative income streams aligned with population health priorities, exploring digital health solutions and preventative care initiatives.	

Title	New or Existing project	Brief Description	Results/Benefits expected by end Mar 2027	Strategic alignment against ABUHB and NCN Priorities	Areas of Focus				Budget	Funding Source	Current Status	Comments	NCN Delivery Action Plan Please List activities or projects planned to commence during 2026/2027, as well as those ongoing from 2025/2026 Key: Alignment to NCN Agreed Priorities 2025-2027 1.Connecting people to Non-Medical activities, groups, and services in their community which can address their practical, social and emotional needs 2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors 3. MDT working for people with complex needs who are most at risk of deterioration or adverse events 4. Equity of access to supplementary/enhanced services across Gwent
					1	2	3	4					
Health Protection Services/ Building Community Resilience	Existing	Development of Health Prevention services in collaboration with the third sector, IWN and IAA, identifying social networks to help address the wider determinants of health	To improve uptake amongst the 2–3-year-old cohort across the borough in 23/24 the NCN Flu programme will- Work in partnership with Local Education Authority Leads to jointly promote the importance uptake with parents and careers Programme to deliver vaccinations to all eligible 2–3-year-olds across all education and preschool settings.	Prevention & Wellbeing Communication and Engagement Transformation and Vision for cluster					£500	NCN	Ongoing – funding at risks	This delivery model is a proven concept; however, without broader system and community support beyond the NCN, the project faces a significant risk of not being implemented in the next campaign.	
Health Protection Services	Existing	Dental - Development of Health Prevention services in collaboration with the third sector, IWN and IAA, identifying social networks to help address the wider determinants of health.	Working with ABUHB Community Dental Service and the Dental Collaborative via the Children and Young Adult Task and Finish Group to promote oral hygiene	Healthier Wales Population Health					£0	Funding to be sourced	Ongoing	A designated collaborative GDC lead must be identified for the Blaenau Gwent West Dental Collaborative to support progress and coordination.	
Health Protection Services	Existing	Community Wellbeing Schemes	Work in partnership with IWN to use local intelligence to direct funding towards priority issues identified within the community	Supporting Social Care/Health Workforce Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Transformation and Vision for clusters Communication and Engagement					£1000	NCN funding	Ongoing - funding at risk		
Accelerated Cluster Development	Existing	Broadening NCN participation to ensure inclusive collaboration and maintain a strong local voice	Widening stakeholder attendance across our NCN to ensure full collaboration to meet population needs and maintain local voice. We will seek to implement our place based care strategy of a Happy Healthy Blaenau Gwent by creating a sustainable system of change through the integration of health and social care services, raising awareness of the benefits and opportunities for improving population outcomes through collaboration, strengthening partnership arrangements with the third sector and health colleagues such as the local authority, WAST, Direct care and other key partners to meet the specific health and wellbeing needs of our communities	Healthier Wales Working alongside Social Care Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development						No funding	Ongoing		
Estates Mapping	Existing	Utilising an assets-based approach to refine our Estates Strategy	Utilise an assets-based approach to refine our Estates Strategy around our four places – Tredegar, Ebbw Vale, Abertillery and Brynmawr, harnessing existing infrastructure to support integrated delivery on the ground.	Supporting Social Care/Health Workforce Healthier Wales Population Health					£4,000 financial year 2025/2026	RIF Funding	Ongoing – Funding at risk	Will need partner support to ensure map is as up to date as possible	

NCN IMTP 2026-2029

			Continue with the development of the BG in this together website, community hub and asset mapping.	Prevention & Wellbeing 24/7 model Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology								
Building Community Resilience Population Health Health Protection Services	New	Utilise the expertise and skills of Behavioural Change Practitioners to educate and support individuals in managing their own health.	Leverage the expertise of Behavioural Change Practitioners to empower individuals in self-management of health, aligning with prevention, patient activation, and population health goals	Healthier Wales Population Health Health Protection Framework Prevention-Based Health and Care Framework					Behaviour coaches funding – Permanent funding	Welsh Government	Ongoing	
Training and Education	New	Embed Active Signposting Through MECC Principles	Embed a culture of active signposting as a 'light touch' approach, based on <i>Making Every Contact Count</i> principles, where existing staff engage people in conversations about what matters to them and provide information to signpost them to services, groups and activities, using local knowledge or directories. The relevant MECC training materials and courses will be promoted to partners.	Healthier Wales Making Every Contact Count (MECC) Promote, Prevent and Prepare for Planned Care					The signposting training can be facilitated by IWN		Ongoing	IWN can facilitate the light touch sign posting briefings for professionals and community volunteers and Wellbeing
Building Community Resistance Population Health Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design Estates Mapping Accelerated Cluster Development	Existing	Happy Healthy Blaenau Gwent - establish a whole system approach to deliver place-based care where people can access a range of seamless care and support at or close to home, based on their unique needs and what matters to them	The NCN in partnership with our all our IWN partners will build community resilience through connections to increase social prescribing and community development in collaboration with the third sector, monitor activity and outcomes to avoid duplication Align the work of the NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing					£256,054 – HHBG	RIF Funding	Ongoing	
Health Protection Services Building Community Resilience	/Existing	Building community resilience through connections to increased social prescribing and community development in collaboration with the third sector, Integrated Wellbeing Networks, Social Care and 3rd Sector as part of Happy Healthy Blaenau Gwent	Increased social prescribing and community development in collaboration with the third sector, Integrated Wellbeing Networks, Social Care and 3rd Sector. Development of Wellbeing Friends (training for front line staff such as Care Navigators, DNs, CRT etc) improving access to and awareness of GDS, Optometry, Pharmacy and GMS services. Our focus is on building resilience through prevention and early interventions to enhance wellbeing and self-care, identifying social networks to help address the wider determinants of health such as Vaccination programmes, EPP mental health initiatives,	Working alongside Social Care Mental Health and Emotional Wellbeing Population Health Healthier Wales Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology					£256,054 – HHBG As per spend plan attached	RIF Funding	Ongoing	GP cluster commitment to continue to 2024/25
Pathway Optimisation	New / Existing	The ongoing sustainability of all health and social care services on	To support the NCN will undertake a mapping of services – both clinical and non-clinical to	Supporting Social Care/Health Workforce					TBC	NCN Funding	Ongoing	We are in the early scoping phase of projects aimed at

NCN IMTP 2026-2029

		an operational footing level is paramount,	ensure that people with the right skills and experience work in an environment that is fit for purpose. Keeping a key focus on local population need and will include Immunisation and Vaccination, GMS sustainability and access, Psychological Wellbeing, Diabetes Prevention, CVD risk factor management, Obesity Pathway, Oral Health, Advanced Paramedic for home visiting/CRT/Care Home and FCP. Work in partnership with the IWN to explore community assets that can support with preventative interventions for the most vulnerable patients such as those suffering from chronic respiratory disease, these will include opportunities to attend warm hubs.	Healthier Wales Working alongside Social Care Population Health								diabetes prevention and CVD risk factor management, with the goal of delivering these programmes systematically and at scale across NCNs. Funding requirements are still to be determined.
Health Protection Services Building Community Resilience Population Health	New	Integrated, Person-Centred Care for Complex Needs	Deliver proactive, coordinated care through joint assessments, integrated planning, and effective MDT collaboration. Engage individuals and families, share information securely, monitor outcomes, and foster a culture of collaboration across health, social care, and third-sector partners.	Supporting Social Care/Health Workforce Healthier Wales Prevention & Wellbeing Strategic Programme for Primary Care						LA funding	Ongoing	
Health Protection Services	New / Existing	Community-Based Prevention and Risk Reduction for Diabetes and Cardiovascular Health	Deliver targeted campaigns and structured programmes across Blaenau Gwent to support self-care, symptom management, and early intervention. This includes: Diabetes Prevention: Identify and engage individuals with pre-diabetes through education, lifestyle programmes, and community partnerships. Cardiovascular Risk Reduction: Optimise hypertension management, facilitate peer learning, and embed a 3-year QI programme. Hypertension Case Finding: Implement proactive screening via practices, community venues, and mobile health units, linking results to lifestyle advice and referral pathways. Participation in the Diabetes Prevention Programme across both clusters for pre diabetic patients to be offered a brief intervention which includes lifestyle advice with the hope of reducing their HBA1c over the longer term to reduce or prevent the progression of diabetes	Population Health Healthier Wales Prevention & Wellbeing								
Accelerated Cluster Development	Existing	Utilise NCN funding to innovate and test concepts relevant to our population needs which improve outcomes for all our residents.	To utilise NCN funding to innovate and test concepts which are relevant to our population needs and able to improve outcomes for all our residents, these include, SEM Scanners, assisted technology, locality	Healthier Wales Working alongside Social Care Population Health					As per attached spend plan	NCN funding	Ongoing GP Cluster Commitment to continue to 26/27	

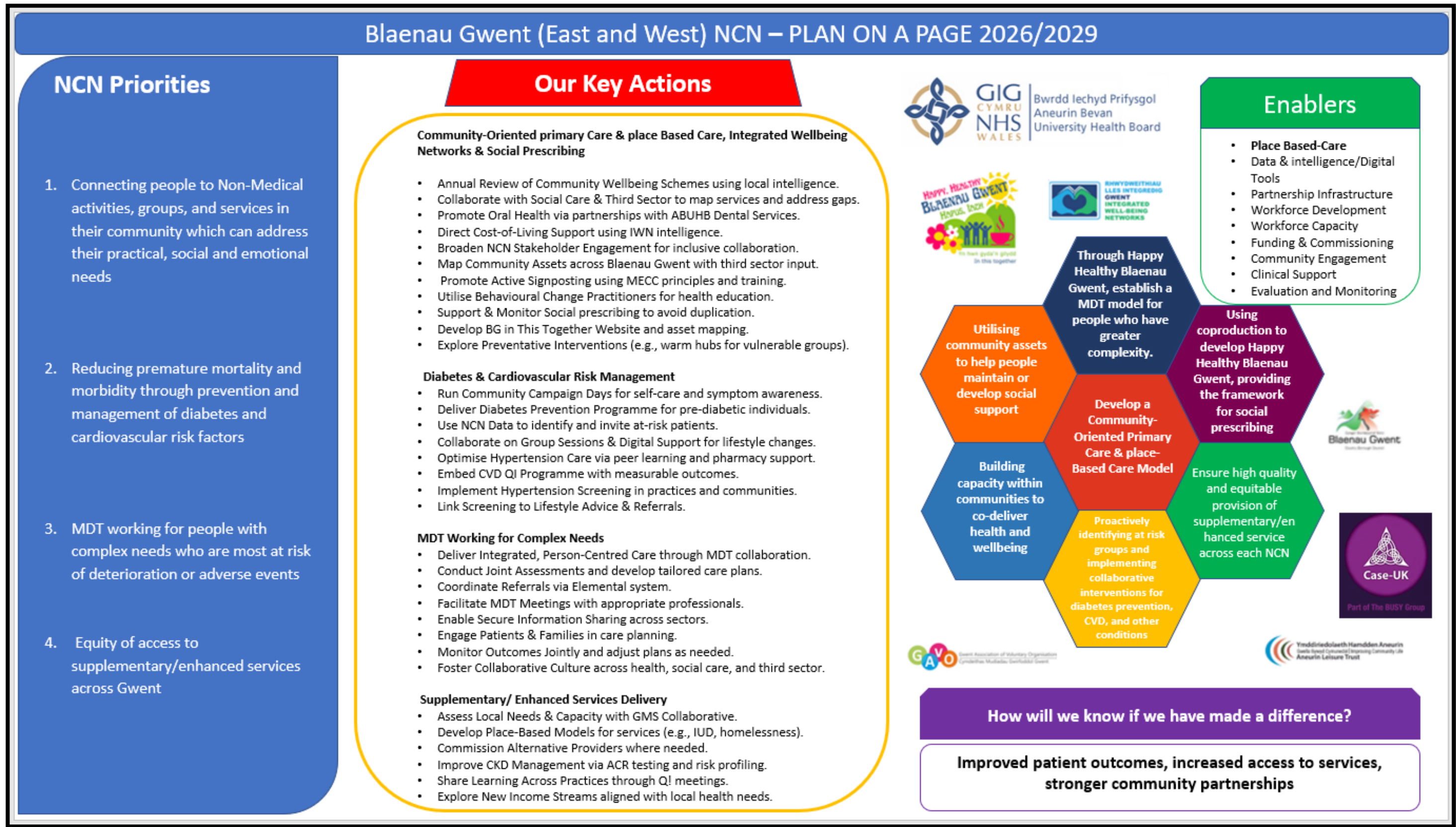
NCN IMTP 2026-2029

			<i>based FCP and Advanced Paramedic programmes</i> , reducing the impact of on the day demand. Developing exit strategies to enable proven concepts such as Psychological Wellbeing Practitioners and Practice Based Pharmacists to be core funded.	Prevention & Wellbeing Communication and Engagement Transformation and Vision for clusters Workforce & Organisational Development								
Health Protection Services	New	Enhanced Services and Chronic Disease Management	Seek to develop services that are high quality and equitably across the Borough for supplementary/enhanced services with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees. Deliver equitable access to enhanced services across Blaenau Gwent through place-based models and alternative providers where needed. Focus on improving early identification and management of chronic conditions, including CKD, by embedding risk profiling, optimising treatment, and sharing learning through NCN QI initiatives. Explore new income streams aligned with local health needs to ensure sustainability. Continue to map our services to identify where the gaps are and work more collaboratively between our GMS partners to deliver services that are more equitable and, on a population, needs basis	Healthier Wales Population Health Prevention & Wellbeing					TBC		New	We are in the early scoping phase of projects aimed at developing services that are high quality and equitably across the Borough, with the goal of delivering these programmes systematically and at scale across NCNs. Funding requirements are still to be determined
Building Community Resilience Population Health	Existing	Marmot Region	NCNs will support the Marmot Review which sets out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies.	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing					£0	No funding	Ongoing	
Care Closer to Home/Pathway re-design	Existing	Future service model for the development of sustainable Placed Based primary care services across both clusters	The NCN is undertaking work to profile timetables to enable Care Closer to Home in terms of delivering services for all our citizens and sustainable placed based care:	Supporting Social Care/Health Workforce Healthier Wales Prevention & Wellbeing Population Health Communication and Engagement Transformation and Vision for clusters					£0	No funding	Ongoing	
Accelerated Cluster Development	Existing	prioritise the establishment of Pan Cluster Groups	Continue to develop the ISPB priority actions with our partnership board landscape. To develop and strengthen the relationship with the Gwent Regional Partnership Board						£0	No funding	Ongoing	
Green Agenda	Existing	Committing to creating a greener, stronger and fairer Wales.	The locality team will explore and coordinate training opportunities to raise awareness of how						Funding at risk	NCN funding	New funding at risk	

			practices can become more environmentally sustainable.									
Redesigning Community Services for Older People	Existing	Explore opportunities to deliver a sustainable community resource model.	Explore opportunities to deliver complex care closer to home through a sustainable community resource model which encompasses hospital @ home/step closer to home pathways , helping our residents to have their health and social care needs met as close to home as possible in a seamless and integrated way through models of care which reduce admission and long term care dependence, utilising a varied clinical skillset able to meet the demands of changing service needs and deliver on the D2RA pathways to provide preventative care and where needed a rapid response to prevent admission or, where admission is needed, the CRT Tyleri model will be available to provide a short clinical interventions prior to supporting individuals to be discharged to recover at home as quickly and safely as possible.							Other	Ongoing	
Redesigning Community Services for Older People Reablement Hospital Liaison OT	Existing	Building on D2RA Project	Blaenau Gwent ISPB to align with the strategic priorities of the Health Board, Local authority and A Healthier Wales's vision of a whole system approach to health and social care, focussed on health and well-being and on preventing illness with access to a wide range of seamless community-based services.	Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing 24/7 model and Vision for clusters Workforce & Organisational Development					£0	No funding	Ongoing	
Redesigning Community Services for Older People	Existing		As part of the redesign of Frailty services we will review our existing hot clinic pathways and ensure that these are fit for purpose, providing rapid access clinics for older people to undertake assessment, diagnostics, and treatment on an ambulatory basis. CRT In-reach Model which brings alignment between health and social care services to support residents to remain in their usual place of residence for as long as possible. Within YAB the locality team have supported and developed an additional staffing resource which will support a nurse led Tyleri Ward service. Part of the model includes direct admission and transfer pathways to support an 8 bedded CRT unit. Facilitate the introduction of the Graduated Care model across to supports seamless pathways from hospital to home utilising nurse led units to minimise the time being spent in hospital settings.	Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing 24/7 model and Vision for clusters Workforce & Organisational Development					None, staff attending clinic will be from the core district nursing teams		Planned to commence when staffing levels improve	
Accelerated Cluster Development	Existing	Utilising opportunities that technology can bring to increase access to services	The principles of the Primary Care Model for Wales to increase the digital offer around triage and	Supporting Social Care/Health Workforce					Funding at risk	NCN Funded	ongoing	

NCN IMTP 2026-2029

			signposting to ensure patients are seen by the right person at the right time in the right place. Working with Blaenau Gwent GP surgeries to increase numbers utilising technology to improve access to GMS services.	Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology								
Accelerated Cluster Development	Existing	Continue to progress with the ACD Programme	Develop and support both exit strategies and business cases to enable proven concepts to be transitioned over to core funding. Raising awareness of the benefits and opportunities for improving population outcomes through collaboration and strengthening partnership arrangements. Support with the Happy Healthy Blaenau Gwent strategy as a key priority across all professional collaboratives.	Healthier Wales Population Health Supporting Social Care/Health Workforce Working alongside Social Care Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development					£0	No funding	Ongoing	
Staff wellbeing	Existing	Supporting our Health and Social Care staff within Blaenau Gwent staff within Primary and Community Care to feel valued, engaged with in a positive sense of wellbeing at work	The NCN is committed to providing wellbeing support to well deserving staff, offering a wellbeing space, but also to provide a warm personal welcome from the Blaenau Gwent Health and Social Care Team and well-being support and guidance.	Supporting Social Care/Health Workforce					£0	No funding	Ongoing	





CAERPHILLY NCN IMTP 2026-2029

NCN Executive Summary:

This plan encompasses all three Neighbourhood Care Networks (NCNs) within Caerphilly Locality, which are geographically distributed across the East, North, and South of the Borough. Collectively, the NCNs aim to support, sustain, develop, and enhance services at a local level, working collaboratively across public and third sector organisations. Our approach is rooted in meeting the needs of local populations, addressing inequalities, and empowering individuals and communities to lead healthy, independent lives.

Caerphilly Borough spans a substantial area of 278 km² (107 square miles) and shares borders with Cwm Taf Health Board and Cardiff & Vale University Health Board. It has an estimated resident population of 176,865 (Stats Wales, Mid-Year 2024), with a GP-registered population of approximately 187,000. Out-of-hospital health and social care is delivered by a mix of independent contractors, local authority services, and third sector providers. Within Caerphilly, independent contractors include 20 GP practices, 41 community pharmacies, 21 dental practices, and 18 optometry practices.

This plan sets out the key areas of need and priority areas that will shape the core business of the NCNs. It provides a framework for delivery, monitoring, and accountability.

To meet current and future population needs, health and social care services must be resilient, responsive, and fit for purpose. Recognised service pressures require us to work flexibly and innovatively. Key challenges to address include:

- Rising demand due to an ageing population with increasingly complex health needs.
- Financial constraints and workforce shortages affecting service sustainability short, medium and longer term.
- Persistent inequalities linked to socio-economic deprivation, intensified by the current economic climate.
- Estate limitations that hinder service delivery.

During 2026–29, NCNs will focus on delivering the priorities outlined in this plan, while also exploring and implementing new initiatives and workstreams as opportunities arise. Services will continue to be delivered locally, tailored to population needs, and spanning



acute, secondary, social, primary, community, and third sector care settings. The accelerated NCN development programme and its associated collaboratives will serve as key enablers for local delivery.

All three NCNs recognise the vital role of our communities and citizens in shaping and sustaining our work/what we do. The Integrated Wellbeing Network (IWN) will play a central role in fostering community resilience by encouraging individuals to take ownership of their health and wellbeing. The IWN connects people with services, supports both new and existing community wellbeing initiatives, and provides accessible / relevant wellbeing information.

The NCNs' key priorities for 2026–29 will be supported by a set of enabling themes: Quality & Patient Safety, Financial Management, Communication & Engagement, Workforce, and Staff Wellbeing.

Strategic Partners:

Health and social care services are facing increasing complexity and rising demand. To ensure care is delivered at home or as close to home as possible, we must rethink and reshape how services are provided. This shift will help ensure that hospital care is reserved for situations where no other viable option exists.

Our strategic direction is guided by multiple drivers, with *A Healthier Wales* remaining the overarching policy framework for health and social care across Wales. This underpins our commitment to delivering seamless, place-based care. Central to this are the *Primary Care Model for Wales (PCMw)* and the *Strategic Plan for Primary Care*, both of which prioritise what matters most to individuals, ensuring timely access to appropriate care from the right source at the right time.

Effective transformation requires robust infrastructure to support enhanced multi-professional collaboration across health, social care, and the third sector. Local facilities and data systems must be adaptable and responsive to future needs, enabling integrated working. People should be empowered to access care digitally, and direct access to community-based services will help deliver high-quality care closer to home. By improving population health and wellbeing, strengthening communities, and supporting staff wellbeing, we can enhance recruitment and retention and build more sustainable models of care.

Locally, a key priority is the redesign of services of older people and the integration of community teams to support individuals at risk of deterioration due to long-term conditions. The goal is to provide round-the-clock care, delivered as close to home as possible. Preventative approaches are also vital to building resilient communities and ensuring long-term sustainability of services.

These ambitions align with the *Six Goals for Urgent and Emergency Care*, which aim to ensure patients receive the right care, in the right place, first time.

In Gwent, the *Regional Partnership Board (RPB)* supports the implementation of the *Social Services and Wellbeing (Wales) Act*, with three core aims that guide local delivery:



NCN IMTP 2026-2029

1. **Start Well** – Enhancing outcomes for children and families through collaborative early intervention.
2. **Live Well** – Placing people at the centre of service design and delivery.
3. **Stay Well** – Ensuring timely access to appropriate support to maintain health and wellbeing.

In Caerphilly, the *Integrated Services Partnership Board (ISPB)* is well-established and alongside working collaboratively to deliver Place Based Care, has identified three priority areas that align with NCN objectives:

1. **Early Years & Best Start in Life**
2. **Mental Health & Wellbeing**
3. **Community Resilience**

For 2026 - 29, the Primary Care and Community Services Division will focus on delivering the following strategic priorities:

- Management and prevention of long-term conditions
- Improving access and service sustainability
- Redesigning services for older people
- Advancing NCN development and partnerships

The Integrated Wellbeing Network priorities include:

- Community engagement and capacity building
- Community asset mapping and organising
- Bridging, linking and co-ordinating wellbeing assets
- Individual and group behaviour change

To successfully deliver these priorities, it is essential that enabling foundations are in place. These include:

- Quality and patient safety
- Workforce, staff wellbeing, and organisational culture
- Communication and engagement
- Financial management
- Fit-for-purpose estate
- Digital technologies
- Value-based innovation and research

This plan sets out the national and regional strategic context alongside detailed local priorities. Population needs and local intelligence will shape our planning and delivery, helping us to define expected outcomes and benefits.

NCN IMTP 2026-2029

Health Board and NCN Priorities

ABUHB IMTP 2026 – 2029 & 10 Year Strategic Priorities



Better Health: Together we will support people to be healthy, active, and 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 Best Start in Life

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

OUTCOMES

People will have more Healthy Days at Home

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

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

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

OUTCOMES

People will find it easier to connect with their communities, use local services, and feel respected

Our budget spent on services in the community will have increased

More people will engage with their local community to reduce loneliness and support good health

PRIORITIES

Healthy Places Resilient & Connected Communities Safe Spaces Quality of Life

NCN IMTP 2026-2029

The Health Board agreed NCN priorities for the 2025/2026 annual plan and an agreement has been reached that these priorities will continue throughout the 2026 – 2029 IMTP NCN planning cycle:

1. Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs.
2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors
3. MDT working for people with complex needs who are most at risk of deterioration or adverse events
4. Equity of access to supplementary/enhanced services across Gwent

Progress Made Against Agreed NCN Priorities within 2025/2026

The Caerphilly NCNs have made strong, measurable progress across all priorities by embedding community-led approaches, strengthening cross-sector partnerships, and investing in preventative and wellbeing focused initiatives. This progress has been driven by a commitment to collaborative working, underpinned by the Accelerated NCN Development (ACD) framework and robust governance arrangements.

Key enablers include the integration of the Integrated Wellbeing Network (IWN), participatory budgeting, and social prescribing models all of which support a shift toward sustainable, place-based care that empowers individuals and communities. The establishment of multi-disciplinary team (MDT) model, success in targeted prevention programmes (such as smoking cessation and diabetes management), and the development of strategically located hubs further demonstrate tangible outcomes.

Professional Collaboratives have provided structure for peer learning, service improvement, and workforce engagement. Together, these efforts reflect a clear and ongoing commitment to delivering integrated, equitable, and preventative care, positioning Caerphilly to continue scaling enhanced services and improving population health across its diverse communities.

Priority 1: Delivered via Building resilient communities

In aligning NCN with other partners delivery plans we work towards the development of a community focussed model of primary care, informed by local assets and population needs, especially for vulnerable and marginalised groups. These combined efforts work towards connecting people to non-medical activities, groups, and services in their community to support and address their practical, social and emotional needs. Caerphilly has progressed via:

- **Collaborative Planning:** Stakeholders across sectors are actively engaged in planning and delivering services that address health inequalities and promote healthy lifestyle choices. The collaboratives have promoted awareness of Primary Care & Community Services such as WGOS and Common Ailment scheme to both service users and referring professionals.
- **Empowerment:** The Integrated Wellbeing Network (IWN) has developed localised initiatives that connect people, groups, and services, enabling communities to meet their own health and wellbeing needs.
- **Community-Specific Plans:** Outline plans have been co-produced with each IWN community, directly supporting NCN priorities.
- **Participatory Budgeting:** Delivered in partnership with GAVO and Caerphilly CBC, this initiative gives residents a voice in allocating public funds to local wellbeing projects, strengthening ownership and resilience.
- **Local Hubs:** These hubs are central to the borough's place based care strategy, bringing services closer to home and enhancing accessibility. This strategy is being costed and driven via Caerphilly ISPB ensuring all partners across the borough are engaged with the process.

To ensure NCNs understand and utilise IWN and community assets to co-produce a social prescribing model that supports social, emotional, and practical needs, Caerphilly has:

- **IWN:** Embedded within local communities the IWN team have enhanced and further developed CWTSH guides. CWTSH guides provide local detail of social activities available to the local population. Through a shared understanding of our diverse communities and population groups in most “at risk” and/or “high risk” categories, the NCN and IWN are evolving a PBC model. This model will act as a vehicle to design, develop and target community assets and interventions that provide proactive care and support to improve health and wellbeing. This will also proportionate universalism to reduce health inequalities, particularly in areas of high deprivation, cultural diversity and vulnerable and marginalised groups. We continue to develop a collaborative approach to develop a more community focussed model of primary care, through deeper understanding of the community assets and local needs. Work continues to expand the IWN’s place-based approach across community wellbeing and integrated health and social care services through enhanced links with MDT teams in Caerphilly.
- **Community Wellbeing Connectors:** funded and embedded within GP practices. Linked to IWN and the Nature Wellbeing Programme, these connectors provide tailored support to individuals and families, promoting independence and community engagement. The connectors are integral to the success and delivery of the MDT model, focussing on the non-medical / social factors that impact peoples health and wellbeing.
- **Nature Wellbeing Programme:** initiative which aligns with Welsh Government’s strategic framework, created a single point of access for nature based social prescribing in Caerphilly. Activities include walking, cycling, conservation, and horticulture and are delivered by voluntary and social enterprise partners.
- **Psychological Health Practitioners:** funded and embedded within GP practices. PHPs are experienced and knowledgeable practitioners, who provide low to mid-level mental health support and guidance, including information, self-management and onward referrals to other services.
- **Third Sector Collaboration:** Strong partnerships with GAVO and other third sector organisations have enhanced support for community groups, increasing resilience and enabling a thriving voluntary sector.
- **Preventative Focus:** NCNs continue to prioritise preventative screening, immunisation, and diabetes risk identification, building on the success of the diabetes prevention programme.

Priority 2: Delivered via Long Term Conditions – Prevention and Management

Delivering systematic and scalable prevention and management programmes for long term conditions, including diabetes and cardiovascular disease (CVD). Caerphilly’s progress is demonstrated via:

- **Diabetes Prevention Programme:** Rolled out across all GP practices, with IWN support for community based interventions targeting Type-2 diabetes and obesity.
- **CVD Prevention Focus:** worked with PHW to introduce a Health Coach role to support individuals in making positive lifestyle changes, identifying risk factors, and accessing appropriate services. The future planning for Behaviour Change Practitioners (BCPs / Health Coaches) is being led via IWN and implemented via NCNs.
- **Respiratory Services:** model has moved to Gwent-wide. NCNs support services through local place-based hubs. Support practice diagnosis of asthma as per NICE guidance with P.O.C.T. FENO testing. Support identification of P.O.C.T. COPD patients with targeted screening using COPD 6 machines.
- **Healthy Lifestyle Initiatives:** Locally programmes include weight management, exercise referral, smoking cessation, nature prescribing, and food access projects.

- **Immunisation Expansion:** NCNs have and continue to promote vaccination uptake across the board. Also provided an RSV focus in the North of the borough.
- **First Contact Practitioner:** funded and embedded within practices, offering capacity for patients suffering from Musculoskeletal conditions. The service provides direct access to an MSK specialist within their locality and receive expert assessment, advice, clinical intervention, and accurate referral to secondary care as required.
- **Practice Based Pharmacists:** funded and embedded within practices, PBPs work alongside GPs and other healthcare professionals to provide direct patient care, manage medication-related issues, conduct medication reviews, and help with prescription management to improve patient outcomes and support the wider clinical team.
- **Community Physiotherapy Pilot:** funded to focus on falls and care homes to support and positively impact on waiting lists. Attendance at local MDTs has enabled further partnership working, targeting those patients that are regular referrals or raise concerns.
- **Nature Wellbeing Programme:** Supports rehabilitation and outdoor activity for individuals with cardiac, pulmonary, and neurological conditions, enhancing recovery and wellbeing.
- **Behaviour Change Practitioners (BCP):** employed through PHW, BCP's offer support and interventions to individuals and groups. The roles are a core part of the place-based neighbourhood team and support building the capability of behaviour change through the delivery of formal and informal training. The practitioners apply relevant theory and behavioural science approaches to inform and deliver a range of health promoting interventions in areas such as smoking cessation, diabetes prevention, cardiovascular disease and healthy weight management.

Priority 3: Delivered via Encouraging Collaborative Working with a focus on Enhanced Services

By establishing multi-disciplinary team (MDT) working for individuals with complex needs, involving coordinated input from services within health and social care, Caerphilly has:

- **MDT Initiative:** established structured MDT meetings across all 3 NCNs in Caerphilly, enabling partners to collaboratively plan care for individuals with complex needs.
- **NCN Development (ACD) Programme:** This framework continues to drive robust planning, evaluation, and innovation across Caerphilly, supporting population health needs and reducing reactive demand.
- **Professional Collaboratives:** These groups (GMS, Pharmacy, Dental, Optometry, Nursing, AHPs) provide peer support, share best practice, and advocate for service improvement strengthening inter-professional dialogue and quality assurance, including supporting working relationships and the development of systems for communication.
- **Governance Model:** A bottom up and top down governance approach ensures local needs are identified and addressed in line with strategic direction.
- **Positive Outcomes Emerging:** Early successes, such as the optometry collaborative's contribution to smoking cessation, demonstrate the impact of cross boundary working.

Priority 4: Delivered via Encouraging Collaborative Working with a focus on Enhanced Services

Ensuring high-quality, equitable provision of enhanced services across NCNs, focusing on areas such as IUDs, minor surgery, substance misuse, homelessness, and care for asylum seekers and refugees has been a focus this year, progress includes:

- **Primary Care Contracting Engagement:** Caerphilly locality is working closely with the contracting team to promote GP involvement in enhanced service delivery.

NCN IMTP 2026-2029

- **Service Gap Identification:** Active scoping of local needs undertaken, with a specific focus on addressing longstanding gaps in care home service provision (notably 124 residents identified as underserved)
- **Equity of Access:** NCNs are committed to exploring solutions that ensure all residents, including those in care homes, receive consistent and equitable care.
- **Increased Service Uptake:** focus at NCN meetings on enhanced service provision individually and as NCNs undertaken. Increase in practices service uptake in Homelessness and IUCDs.

Challenges, risks and barriers to successful delivery of agreed milestones within 2025/2026

- Sustaining core services across health & social care settings due to:
 - Recruitment and retention difficulties
 - Increased demand on services
 - Backlog of waiting list demand
 - Public expectation regarding access to services
- Transitioning NCN funded roles to core service budgets limiting available NCN funds for major project investment.
- Loss of engagement when/if pilots/initiatives are discontinued.
- Short-term funding arrangements.
- Cost of living pressures impacting on people's wellbeing, increasing demand across health and social care.
- Increase in costs (particularly supported roles / uplifts) thus decreasing service provision
- Insufficient funding for collaborative roles limits engagement
- Non contractual participation across some collaboratives – impacts engagement
- Deficits in professional collaborative leads.
- NCN Support to Professional Collaboratives temporarily funded (SIM) – risk if not continued to next year.
- Caerphilly IWN support temporarily funded (IWN lead and Community Involvement Officer) – risk if not continued to next year.

NCN Planning - 2026/2027

Identified Quarterly Milestones Against Agreed NCN Priorities for 2026/2027

Priority	Defined Delivery Milestones
1. Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs	• Map and Understand Community Assets & Needs Continue asset mapping across Caerphilly, using population health data to identify vulnerable groups and highlight local strengths such as voluntary organisations, wellbeing hubs, food initiatives, and green spaces. • Align NCNs and IWNs through Integrated Planning Joint planning sessions to embed Place Based Care principles into strategies and operational plans, ensuring service development reflects community insights and costed model opportunities. • Expand Preventative and Community-Based Services Increase access to programmes like NERS, Behaviour Change Practitioners, Community Wellbeing Connectors, and Nature Wellbeing initiatives through hubs, care homes, and community venues.

NCN IMTP 2026-2029

- **Support Long-Term Conditions via Place-Based Hubs** Develop hubs offering specialist services (e.g. diabetes prevention, rehab pathways) and integrate Nature Wellbeing initiatives across cardiac, pulmonary, and neurological care.
- **Collaborate on Respiratory and CVD Models** Implement the Gwent-wide respiratory model and align CVD prevention with education, early risk identification, and the Hypertension project.
- **Build Resilient Communities through Social Prescribing**
 - Train NCNs on IWN functions and referral pathways, sharing CWTSH guides.
 - Co-produce and pilot social prescribing pathways, linking to food, activity, and wellbeing projects.
 - Embed social prescribing into QIF priorities and place-based hubs, supported by NCN-funded roles.
 - Strengthen community connections via IWN, GAVO, Connectors, and trusted local channels, extending membership and wellbeing friend networks.
- **Enable Delivery through Integration, Workforce, and Infrastructure**
 - Use NCN/IWN governance to embed Place Based Care and social prescribing.
 - Develop and upskill roles (Community Involvement Officers, Health Coaches, Connectors).
 - Enhance hubs and infrastructure to ensure accessibility for marginalised groups.
- **Monitoring and Evaluation**
 - Track and measure outcomes of service delivery provision.
 - Use feedback from community members to refine models and ensure relevance / local need.

Q1 - Building Resilient Communities

Foundations & Mapping

- Continue asset mapping across Caerphilly (community groups, voluntary organisations, wellbeing hubs, food initiatives, green spaces).
- Use population health data to identify socially vulnerable or marginalised groups.
- Hold NCN–IWN joint planning sessions to align priorities and embed Place Based Care principles.
- Deliver training for NCNs on IWN functions, referral pathways, and CWTSH guides.
- Establish governance structures for NCN/IWN integration.
- Collaboratives - Professional Collaborative Groups in the promotion of community Mental Health services such as MELO, PHP's and Community Wellbeing Connectors
- Inter-Collaborative communication and joint working, including digital systems to enhance and improve working

Q2 - Building Resilient Communities

Planning & Early Implementation

- Complete first phase of asset mapping and publish findings to partners.
- Expand access to preventative services (NERS, Behaviour Change Practitioners, Connectors, Nature Wellbeing) in selected hubs and care homes.
- Co-produce social prescribing model through joint design sessions with NCNs, IWNs, local authority, and voluntary sector partners.
- Pilot social prescribing pathways in areas with high prevalence of chronic conditions (e.g. diabetes, respiratory illness).
- Develop workforce roles (Community Involvement Officers, Health Coaches, Connectors) and begin upskilling teams in asset-based approaches.
-

NCN IMTP 2026-2029

	relationships and systems of communication (i.e. NHS Futures)	
	Q3 - Building Resilient Communities Service Expansion & Integration • Launch place-based hubs offering specialist services (diabetes prevention, rehab pathways). • Integrate Nature Wellbeing initiatives into cardiac, pulmonary, and neurological rehab pathways. • Implement Gwent-wide respiratory model locally and align CVD prevention with education and early risk identification. • Embed social prescribing into QIF priorities and place-based hubs, supported by NCN-funded roles. • Strengthen community connections via IWN, GAVO, Connectors, and trusted local channels; extend membership and wellbeing friend networks. • Enhance community hubs and infrastructure to improve accessibility for marginalised groups. • Collaboratives - Promoting awareness across Primary Care & Community Services such as Welsh General Optometry Services (WGOS), Social Prescribing and Common Ailment scheme (CAS) to service users and referring professionals.	Q4 - Building Resilient Communities Consolidation & Evaluation • Review and refine asset mapping, updating CWTSH directory and community hub resources. • Evaluate pilots of social prescribing pathways and scale successful models across Caerphilly. • Continue expansion of preventative services and long-term condition support through hubs. • Assess impact of respiratory and CVD models, including links to Hypertension project. • Monitor and measure outcomes of service delivery provision, using community feedback to refine models. • Produce end-of-year report embedding Place Based Care principles into strategic documents and operational plans, ensuring sustainability and accountability.
2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors	Delivery enablers and recommendations will be: Strategic Alignment – Embed diabetes and CVD prevention in NCN planning, QIF priorities, and ABUHB strategic frameworks. – Use ISPBs to ensure top-down and bottom-up alignment across sectors. Workforce and Roles – Secure future provision of IWN, Health Coach / Behaviour Change Practitioner and Community Wellbeing Connector roles to support prevention and signposting. – Engage NCN membership including collaboratives to support delivery. Community Infrastructure – Scope place-based hubs and care closer to home to deliver prevention programmes. – Ensure accessibility for vulnerable groups through outreach and flexible formats. Resources supporting healthy lifestyle messaging, particularly in areas such as Dental, vaccinations and smoking-cessation in Collaborative members premises	

NCN IMTP 2026-2029

	Q1 - Long Term Conditions – Prevention and Management • Embed CVD Risk Management in Community Settings – Use sports and wellbeing developments as sites for lifestyle interventions (e.g. exercise referral, smoking cessation, social prescribing). – Promote early identification of CVD risk factors through outreach and education. – Link Nature Wellbeing initiatives to cardiac rehabilitation and outdoor activity programmes.	Q2 - Long Term Conditions – Prevention and Management • Implement Health Coach / Behaviour Change Practitioner Roles – Embed roles within NCNs, GP Practices and community hubs. – Support individuals to develop personalised health and wellbeing plans, understand risk factors, and access local support. – Support the roles to link with rehabilitation programmes and voluntary sector partners.
	Q3 - Long Term Conditions – Prevention and Management – Develop Collaborative Pathways and Referral Models – Create integrated referral pathways between stakeholders and partners in the Caerphilly borough. – Support access to additional services and extended roles such as weight management, physical activity, and emotional wellbeing support. – Promote and support resources for healthy lifestyle messaging i.e. vaccinations and smoking-cessation (particularly in collaborative practice areas such as Dental, Pharmacy, Optom, GMS).	Q4 - Long Term Conditions – Prevention and Management • Monitor and Evaluate at Scale – Use NCN and ISPB structures to monitor programme delivery, uptake, and outcomes. – Evaluate impact on hospitalisation, long-term condition prevalence, and health inequalities. – Share learning
3. MDT working for people with complex needs who are most at risk of deterioration or adverse events	<i>Delivery enablers and recommendations will be:</i> System-Level Integration – Align MDT development with ABUHB’s strategic direction and Caerphilly’s governance model. Community Infrastructure – Explore digital infrastructure to support shared care planning and communication. Data and Evaluation – Track outcomes for individuals supported by MDTs (e.g. reduced GP attendance, reduced hospitalisation, improved wellbeing). Use feedback loops to refine MDT processes.	
	Q1 - Encouraging Collaborative Working with a focus on Enhanced Services • Strengthen Professional Collaboratives – Explore the use of existing collaboratives (GMS, Pharmacy, Dental, Optometry, Nursing, AHP), as well	Q2 - Encouraging Collaborative Working with a focus on Enhanced Services • MDT Structures and Governance – MDT meetings to continue their delivery in a structured model. – Enhance core membership to support patient need.

NCN IMTP 2026-2029

	as other specialist services, to identify complex cases and escalate to MDTs.	
	Q3 - Encouraging Collaborative Working with a focus on Enhanced Services - Strengthen Professional Collaboratives - Promote inter-professional dialogue and shared learning to improve quality and safety. - IWN to support relationships and networks between Primary Care Teams and Prevention and Inclusion teams including Community Connectors and Adult Services. The sharing of expertise will allow for a more holistic and joined up approach in delivering patient care without any unnecessary duplication and time delay	Q4 - Encouraging Collaborative Working with a focus on Enhanced Services - Monitor, Evaluate and Scale Proven Models - Monitor equity of access to MDT support across Caerphilly's population. - Evaluate MDT impact including patient outcomes, hospitalisation, wellbeing, and service demand. - Share learning across ABUHB to inform wider rollout. - Empower local collaborative leads to champion MDT approaches.
4. Equity of access to supplementary/enhanced services across Gwent	Q1 - Encouraging Collaborative Working with a focus on Enhanced Services - Service Mapping and Gap Analysis - Revisit and review provision across NCNs for: - Intrauterine Device (IUD) services - Minor surgery - Substance misuse support - Services for people experiencing homelessness - Services for asylum seekers and refugees - Identify geographic and demographic gaps, including care home populations and underserved communities.	Q2 - Encouraging Collaborative Working with a focus on Enhanced Services - Evaluate Enhanced Services - Explore targeted pilots in areas of greatest need (e.g. care homes) - Monitor uptake, outcomes, and equity of access. - Use MDT forums to support complex case management and service coordination.
	Q3 - Encouraging Collaborative Working with a focus on Enhanced Services - Develop Capacity and Engagement - Collaborative working with Primary Care Contracting to increase the uptake across the borough. - Encourage GP engagement through focused GMS Collaborative meetings / NCNs. - Identify champions or practices to deliver on behalf of the NCNs and share good practice.	Q4 - Encouraging Collaborative Working with a focus on Enhanced Services - Evaluation and Learning - Monitor service impact on health outcomes, demand reduction, and equity. - Share learning across NCNs. - Work with IWN communities to utilise their experience and expertise to inform and improve our work.

Further Enablers required to deliver 2026/2027 quarterly milestones

Quality & Patient Safety

The Caerphilly Quality & Patient Safety (QPS) Group is a well-established forum bringing together health and social care partners to provide divisional assurance on all matters relating to quality and patient safety across the borough. All NCN-related incidents and complaints are reported through this group. In 2026/27, the focus will be on ensuring that the outcomes of QPS meetings lead to meaningful learning and service improvements, with clear dissemination to relevant teams and services.

A key priority within the locality is the consistent delivery of safe and effective care. Regular participation of an NCN lead in QPS meetings enables timely reflection and implementation of learning from incidents and complaints. The NCNs will continue to work closely with all established collaboratives to advance the QPS agenda.

To strengthen oversight, the locality management team has introduced mini assurance meetings with service leads and budget holders. These sessions provide a platform to share good practice, identify areas requiring support, and review key operational elements such as team rosters, risk registers, budgets, and QPS indicators—including compliments, complaints, and incidents. Dedicated locality leads have been nominated to ensure robust team-level arrangements are in place.

Within primary care, the GMS Quality Improvement Framework (QIF) supports the QPS agenda. A further area of focus is the collaborative implementation between contractors (pharmacies, GPs, Optometrists etc) which aims to enhance patient experience, reduce unnecessary visits, support service sustainability, and free up capacity across the system.

Workforce & Staff Wellbeing

To build a resilient and sustainable workforce, it is essential to review existing staffing profiles, identify resource gaps, and address skill deficits. Several roles currently rely on non-recurrent funding, and a strategic plan is needed to transition these posts into core budgets. The development of Place-Based Care—ensuring residents can access services close to home is being progressed and will be supported through the following workforce initiatives:

Primary Care

- **Diversifying Clinical Roles:** Expanding the range of clinicians available to deliver appropriate interventions and offer alternatives to GP consultations. This includes paramedics, physiotherapists, occupational therapists, mental health practitioners, pharmacists, and advanced nurse practitioners.
- **Community Wellbeing Connectors:** Continued investment in lower-level community services through funding additional connectors who can signpost individuals and escalate cases when needed—helping to reduce pressure on higher-tier services.
- **Multidisciplinary Case Management:** Strengthening GP-aligned multidisciplinary working with regular meetings to proactively manage complex cases.

Community Resource Team

- **Frailty Pathway Review:** An ongoing review of the frailty service is informing the redesign of older persons care. CRT is being embedded as a core component of place-based care, playing a vital role in preventing hospital admissions and supporting timely discharge.

District Nursing

- **Comprehensive Home-Based Care:** The District Nursing Service delivers acute, complex, and end-of-life care in the community and is a key contributor to NCN cluster working and the Nursing Collaborative.
- **Service Coverage:** Operating 7 days a week from 8am to 8pm, the service comprises 7 teams aligned to 20 Caerphilly practices and several tertiary practices across neighbouring Health Boards. Referrals are accepted from both professionals and the public.
- **Role Review:** There is a need to reassess the scope of Health Care Support Workers, as current limitations require registered nurses to carry out lower-level tasks. Addressing this will improve efficiency and role clarity.
- **Recruitment Planning:** A rolling recruitment programme is being developed in collaboration with HR and divisional nurse education leads to manage workforce turnover and maintain service continuity.



Staff Wellbeing

The pressures across clinical services continue to challenge workforce resilience. Recognising the impact on staff wellbeing is critical to retaining and attracting skilled professionals. NCNs have supported a range of wellbeing initiatives, including local events and the introduction of *The Zen Den*—a therapeutic space for staff which has proven successful (winning the staff recognition award) and has been taken on tour across the borough.

Access & Sustainability

Ensuring timely and equitable access to appropriate services is a fundamental priority for Caerphilly. Services must be effective, resilient, and sustainable—both now and into the future. The *Primary Care Model for Wales* provides a framework to support these aims, with prudent healthcare principles guiding the delivery of care by the most appropriate practitioner.

General Practice remains a vital anchor within local communities and is often the first point of contact for individuals experiencing health or wellbeing concerns. Caerphilly has adopted a partial hybrid workforce model for planning purposes, which helps identify current gaps in clinical roles and anticipate future workforce needs. This approach supports robust succession planning and includes extended roles such as practice-based pharmacists, psychological health practitioners, and community wellbeing connectors. These developments also inform estate planning and capital investment prioritisation, as a broader skill mix requires more flexible physical infrastructure.

Sustainability challenges have been identified for independent contractors in Primary Care, particularly in light of rising costs associated with minimum wage increases and national insurance contributions. These pressures pose risks to long-term service viability.

Vacancies and staff absences across community teams continue to impact service delivery. Despite these challenges, clinical teams remain committed to providing timely and appropriate care. Within the borough, seven District Nursing teams are aligned to 20 GP practices. While alignment has improved, recruitment and retention remain longstanding issues, and service continuity is currently maintained through the dedication and flexibility of existing staff.

Local and national workstreams focused on community-based nursing provision are critical to ensuring Caerphilly is appropriately resourced to deliver care at or as close to home as possible and provides an equitable service across the borough. These workstreams must encompass all nursing roles, including rapid response teams (CRT), specialist nurses, and condition-specific expertise.

In collaboration with neighbouring localities, Caerphilly is exploring opportunities to strengthen community-based services. This includes expanding roles in generalist palliative care, care home in-reach, and other specialist areas to enhance core services and enable more residents to receive care in their communities.

The NCNs are mindful that service developments across Gwent are not always allocated proportionately based on whole-time equivalent (WTE) per resident population. This can disadvantage larger localities like Caerphilly. In 2026/27, NCNs will actively pursue strategies to improve recruitment and retention, including:

- Partnering with the Divisional Academy to explore apprenticeship pathways in both administrative and clinical support roles
- Collaborating across professional collaboratives to identify workforce solutions
- Working with communications and engagement teams to develop targeted recruitment campaigns
- Engaging with cross-sector partners to understand and address barriers to recruitment, including promoting the benefits of working locally

To support workforce development, NCNs have also invested in education and training initiatives aimed at upskilling staff and enhancing team capabilities to meet evolving service needs.

Fit for purpose estate

The size and population density of Caerphilly are central considerations in planning the borough's integrated *Place-Based Care* hub model. While some areas present opportunities for physical site development to support this approach, others with more limited infrastructure may require a flexible "hub and spoke" configuration to ensure equitable access.

From an acute and sub-acute care perspective, the borough is served by Ysbyty Ystrad Fawr, an enhanced local general hospital. Additionally, Rhymney Integrated Health and Social Care Centre provides 12 community inpatient beds. Both facilities are purpose-built and well-equipped, although the Redwood Unit in Rhymney poses geographical challenges. The Caerphilly Community Resource Team, based at Ty Graddfa in Ystrad Mynach, delivers services across the entire borough.

GP practices remain the most local and accessible "anchor" points for health and care services, often serving as the first contact for people to seek help. Several sites have been identified as priorities for redevelopment:

- **Aber Valley:** This area has the most significant estate need. The Health Board has secured Welsh Government approval for funding to develop an outline business case and appoint a Supply Chain Partner for a new, fully compliant site. The proposed development will integrate GMS, health, social care, and third sector services, providing advice, treatment, information, and community support under one roof.

- **Ystrad Mynach:** A key priority for both GMS provision and the creation of an integrated health and social care hub. Oakfield Street Surgery is currently at full capacity and unable to accommodate further growth or service expansion within its existing premises.

To support the development of integrated hub services, the NCN and locality teams continue to pursue capital funding opportunities and collaborate with divisional colleagues on GMS improvement grants. Joint bids have been developed with the Divisional Estates team for the following sites:

- **Pontllanfraith Health Centre:** An ABUHB owned site hosting a GP practice, community pharmacy, and various clinical services. Delays in capital investment have hindered modernisation efforts, particularly for co-located independent contractors. Key deficits such as non-compliance with DDA standards and inadequate WiFi infrastructure, these are recorded on the Datix Risk Register.
- **Trethomas Health Centre:** ABUHB-owned, this site offers integrated services and has made significant progress with minimal investment. However, faces challenges with DDA compliance and maintenance needs, limiting its capacity to deliver modern fit-for-purpose care.

Both centres require substantial upgrades to meet current service expectations and support future delivery models. Addressing these estate challenges is essential to realising the borough's vision for accessible, integrated, and sustainable place-based care.

Digital technologies

Technology is a vital enabler in the delivery of modern, effective care. To fully realise its potential, it is essential that our estate is underpinned by robust digital infrastructure and connectivity. The rapid deployment of digital solutions during the COVID-19 pandemic demonstrated the sector's adaptability, as highlighted in the 2021 *NHS Wales COVID-19 Innovation and Transformation Study Report*, where the workforce embraced innovation at pace and scale.



To maximise the return on digital investment, we must prioritise solutions that offer the greatest impact—enhancing access for patients and improving efficiency for professionals. A number of national initiatives are currently under review across Wales, with the aim of identifying those suitable for wider adoption and scale-up.

We continue to promote the benefits of the NHS 111 service, including 111 'Option 2'—a dedicated pathway for individuals experiencing urgent mental health concerns. This aligns with prudent healthcare principles by offering timely support and reducing unnecessary GP appointments, emergency department attendances, or police involvement.

To build a digitally enabled workforce, Welsh Government is advancing a 'Think Digital' approach to service delivery and redesign. This aims to optimise clinical input, support value-based care, and alleviate workload pressures. As part of the national workforce implementation plan, digital platforms currently used in general practice—such as AccuRx, eConsult, SurgeryApp, and Attend Anywhere—are being considered for national funding and standardisation. ABUHB is also reviewing these platforms with a view to procuring a unified system that ensures consistency and value for money.

The utilisation of the CIVICA platform continues across Community Nursing teams in Caerphilly, supports more efficient and coordinated care delivery. The Welsh Community Care Information System (WCCIS) has been successfully implemented, providing a shared digital platform for community nurses, mental health professionals, social workers, local authority teams, and therapists. This system enhances collaboration by enabling secure information sharing across services albeit has its challenges across organisations.

Future NHS is being reviewed and developed for the collaboratives ensuring access and information sharing across independent contractors.

We remain committed to exploring and adopting assistive technologies that support people to live safely and independently at home for as long as possible. The NCNs have consistently championed innovation, funding equipment that supports early diagnosis and improved communication—and will continue to do so where it delivers meaningful impact.

Communication & Engagement

The NCNs benefit from dedicated support through the ACD Communication and Engagement Officer, who has made significant strides in strengthening this area of work in Primary and Community Care since taking up post. Looking ahead to 2026/27, the focus will be on further enhancing communication efforts across ISPB partners to promote the benefits of working within Caerphilly, particularly to support recruitment into key roles where workforce gaps exist.

The NCNs will continue to showcase local initiatives and achievements through regular contributions to the *Pulse* intranet, including news updates and good news stories. The team also maintains regular engagement with the organisational communication and engagement team to ensure consistent information sharing and alignment.

Collaborative communication remains central to our approach. We work closely with partners across health, social care, and the third sector to share service information through multiple channels, including GP practice screens, community pharmacies, CWTSH guides, and the DEWIS directory. These efforts help ensure residents and professionals alike are informed and connected to the support available within their communities.

Challenges, risks and barriers to successful delivery of agreed milestones within 2026/2027

- Sustaining core services across health & social care settings due to:
 - Recruitment and retention difficulties
 - Increased demand on clinical services
 - Backlog of waiting list demand
 - Public expectation regarding access to services
- Digital technology
 - NHS Wales app delays, slow to develop additional functionality
- Transitioning NCN funded roles to core service budgets limiting available NCN funds for major project investment.
- Loss of engagement when/if pilots/initiatives are discontinued.
- Short-term funding arrangements.
- The high level of waiting times across the NHS in Wales will impact on an individual's health, wellbeing, and outcomes.
- The insufficient funding for collaborative roles limits engagement
- Non contractual participation across some collaboratives – impacts engagement
- NCN budget committed, therefore limiting development opportunities within the NCN constraints.
- Annual variability of funding e.g., sickness, recruitment timescales etc.
- Limited resource from management team.
- Organisational and silo working creates barriers and can make integration difficult.

NCN IMTP 2026-2029

- Lack of sustainable Primary Care workforce.
- cost of living pressures impacting on the wellbeing of people and is likely to increase demand across health and social care.
- No inflationary increase on budgets
- Increase in costs (particularly supported roles / uplifts) thus decreasing service provision
- Primary care contractors increased cost pressures i.e. NI contribution

Finance Profile 2026/2027

Recurrent funding will continue to support a range of key roles and services across Caerphilly, including specialist advisory posts in Optometry and ongoing investment in the Community Phlebotomy Service. NCN funding for 2026/27 will also sustain the remaining Practice-Based Pharmacists, Psychological Health Practitioners, First Contact Physiotherapists, and Community Wellbeing Connectors. Support for innovation remains a priority, with NCNs backing the introduction of digital and clinical technologies to broaden the scope of Primary Care services and improve patient access and experience. However, future provision and planning will be required to sustain current delivery across Caerphilly.

The NCNs maintain a forward-looking approach, actively horizon scanning to build a portfolio of established programmes and explore new pilot initiatives. To supplement core budgets, additional funding opportunities are being considered, including the Regional Integrated Fund (RIF), Participatory Budgeting, Further Faster funding, and pooled budgets via the Integrated Services Partnership Board (ISPB) and Regional Partnership Board (RPB).

A divisional review of practice systems is currently underway, with the aim of implementing a unified digital platform across ABUHB. A business case has also been submitted for the Psychological Health Practitioners. If successful these transitions will support budget optimisation and/or enable NCNs to release funding to reinvest in other initiatives impactful to services, service delivery and ultimately patients / staff.

Caerphilly NCNs Spend Forecast 2026/27

Project/Role/Item	East NCN		North NCN		South NCN		Caerphilly NCNs Combined Costs
	WTE	COST (£)	WTE	(£)	WTE	COST (£)	(£)
Community Phlebotomy Team (Top Sliced across all ABUHB NCNs)	-	12,837	-	16,173	-	15,267	44,277
Independent Contractors (Top Sliced across all ABUHB NCNs)	-	2,423	-	2,543	-	2,021	6,987
Psychological Health Practitioners	3.8	164,916	3.6	156,236	3.0	130,197	451,349
Community Wellbeing Connectors	1.33	67,980	1.33	67,980	1.33	67,980	203,940
First Contact Physiotherapists	1.0	71,375	1.0	71,375	1.0	71,375	214,125
Practice Based Pharmacists	0.6	49,130	1.32	108,087*	0.2	16,376	173,595
Pharmacists – Subsistence costs	-	200	-	1,500	-	200	1,900
Pan Caerphilly NCN Conference Event	-	500	-	500	-	500	1,500
Room Hire	-	-	-	-	-	400	400
Caerphilly Borough MIND – Counselling Service	-	1,613	-	1,613	-	1,613	4,839
Digital Systems (Econsult, Accurx, SurgeryApp)	-	21,700	-	1,300	-	16,500	39,500
Education & Staff Development	-	1,500	-	1,500	-	2,500	7,500

NCN IMTP 2026-2029

Place Based Care/Hub Development	-	1,500	-	1,500	-	2,500	7,500
Staff Wellbeing – Consumables	-	500	-	500	-	500	1,500
Winter Initiatives	-	8,383	-	7,939	-	7,344	24,500
Allocation (£)		403,182		447,736		351,468	1,202,386
Forecast Spend (£) - before red (text) items		404,557		438,746		335,273	1,178,576
Underspend (£)				8,990		16,195	25,185
Overspend (£)		-1,375					-1,375

NB: The financial forecast does not include any uplifts.

Workforce Profile 2026/2027

NCN funded roles currently for 2026/27:

Roles	East	North	South	Caerphilly Total
Psychological Health Practitioners	3.8	3.6	3.0	10.4
Community Wellbeing Connectors	1.33	1.33	1.33	3.99
First Contact Physiotherapists	1.0	1.0	1.0	3.0
Practice Based Pharmacists	0.6	1.52	0.2	2.32

As previously noted health and social care is delivered by a mix of independent contractors, local authority services, and third sector providers. Caerphilly independent contractors include 20 GP practices, 41 community pharmacies, 21 dental practices, and 18 optometry practices.

NCN Planning 2027/2028 – 2028/2029

Proposed Milestone for Agreed Priorities for 2027/2028 and 2028/2029

Priority	2027/2028	2028/2029
1. Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs.	Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services. Continue to utilise the IWN Collaboratives and its network of community partners and stakeholders to deepen the links between primary care and the community through an effective ABCD approach to identify local needs and strengths. Establish IWN Collaborative sub/action groups to drive forward specific agendas and programmes in the areas e.g. ASB, community health events, Over 50's, social prescribing.	Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services. Extend the IWN's place-based approach across community wellbeing, integrated social care and health services through enhance links with MDT teams across the Caerphilly brough. Continue effective partnership working with NCN networks, identifying gaps in provision and utilising NCN data to direct workstreams.
2. Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors	Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.	Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.

NCN IMTP 2026-2029

	Raise awareness of the smoking cessation service and highlight the increased risks for individuals with respiratory conditions. Messaging will be disseminated through established channels and community-based organisations the Age-Friendly Communities Networks, Cost of Living Networks, IWN Collaboratives, Local Authority Housing Support Services, Registered Social Landlords, COPD support groups, Wellbeing Friends network, and across the network of community hubs.	
3. MDT working for people with complex needs who are most at risk of deterioration or adverse events	Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services. Behaviour Change Practitioners (BCPs) within the Caerphilly IWN Team to support the management of behavioural risk factors.	Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services. Continued identification of high risk patients and planning of behaviour change approaches to support the management of behavioural risk factors, based on prevalence of disease, winter planning priorities or local need.
4. Equity of access to supplementary/enhanced services across Gwent	Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.	Continuation of milestones from 2026 / 27. Noting potential evolving and implementation of services.

	New or Existing project	Brief Description	Results/Benefits expected by end Mar 2027	Strategic alignment against ABUHB and NCN Priorities	Areas of Focus				Budget	Funding Source	Current Status	Comments
					1	2	3	4				
Independent Advisors	Existing	Long standing top-sliced initiative, across all ABUHB NCNs	Specialist Contractors providing expertise and support to NCNs	Supporting the Health & Care Workforce. NCN Development.			X	X	E - £2,423 N - £2,543 S - £2,021	Cluster Funding	Active - NCN Development & Partnerships. Support collaboratives.	
Community Phlebotomy	Existing	Long standing top-sliced initiative, across all ABUHB NCNs	Community based Phlebotomists sitting within locality District Nursing teams providing increased capacity.	Provide effective, high quality, sustainable healthcare. Supporting the Health& Care Workforce. NCN Development		X	X		E - £12,837 N - £16,173 S - £15,267	Cluster Funding	Active - Access & Sustainability.	
Cluster Pharmacy Team	Existing	Practice Based Pharmacists	Improved GP access. Improved patient safety and medicines management in general practice.	Provide effective, high quality, sustainable healthcare. Supporting the Health & Care Workforce. NCN Development. Development of PCMW			X		E - £49,130 N - £108,087 S - £16,376	Cluster funding – proven move to central funding	Active - NCN Development & Partnerships. Access & Sustainability.	
Psychological Health Practitioner (PHP) Team	Existing	Practice Based Psychological Health Practitioners (PHP)	Enables GP to focus on GP time to spend on patients with complex medical needs. Prudent healthcare with low-level MH issues dealt with in by qualified practitioners.	Provide effective, high quality, sustainable healthcare. Supporting the Health & Care Workforce. Mental Health & Emotional Wellbeing. Development of PCMW			X		E - £164,916 N - £156,236 S - £130,197	Cluster funding – proven move to central funding	Active - Mental Health & Wellbeing. Access & Sustainability.	
Community Wellbeing Connectors	New	Aligned with GP surgeries to provide non-clinical social prescribing and isolation avoidance	Enables GP to focus on GP time to spend on patients with complex medical needs.	Mental Health & Emotional Wellbeing. Population Health. Development of PCMW. NCN Development. Community Infrastructure	X		X		E - £67,980 N - £67,980 S - £67,980	Cluster funding	Active - Community Resilience. Mental Health & Wellbeing.	
First Contact Physiotherapy Team	Existing	Re-established face to face appts within GP practices	Improved access to GPs. Provision of MSK assessment with direct referral from within community.	Supporting the Health and Care Workforce. PCMW. NCN Development.			X		E - £71,375 N - £71,375 S - £71,375	Cluster funding – proven move to central funding	Active. NCN Development & Partnerships. Access & Sustainability.	
Pan Caerphilly NCN Conference Event	Existing	Pan Caerphilly NCN (East, North, South) themed conference event	Lead to joint working opportunities across services to benefit patients / public and associated service providers	Working alongside Social Care. Supporting the Health & Care Workforce. PCMW. NCN Development	X	X	X		E - £500 N - £500 S - £500	Cluster funding	Active - NCN Development & Partnerships.	
Caerphilly MIND- Counselling service	Existing	Provision of one-to-one counselling service to residents of Caerphilly Borough to support people to address mild to moderate mental Health issues	Continue to provide additional mental health resource to support the Primary Care Mental Health Team for Caerphilly residents. Reduce demand on PCMHSS by providing additional sessions.	Mental Health & Emotional Wellbeing. Population Health. Development of PCMW. NCN Development.	X		X		E - £1,613 N - £1,613 S - £1,613	Cluster funding (Joint funding with RIF)	Active - Community Resilience. Mental Health & Wellbeing.	
eConsult	Existing	Funding support for GP practices to continue with providing the eConsult service to patients	Improved access to GPs. Patients forms-based service to request GP advice without the need to book an appointment or contact the GP practice face to face or by telephone	Population Health. Community Infrastructure.			X		E - £14,600 N - £1,300 S - £5,800	Cluster funding - interim to national solution	Active. Digital Technologies. Access & Sustainability.	
AccuRx	Existing	Funding support for GP practices to continue with providing AccuRx service to patients	Improved access to GPs. Patients able to use this forms-based service to request advice without need to book appts or contact the practice	Population Health. Community Infrastructure.			X		E - £7,100 N - £0 S - £10,700	Cluster funding - interim to national solution	Active. Digital Technologies. Access & Sustainability.	
Education & Staff Development	Existing	Provision of funding to upskill of NCN affiliated services staff across the locality	Improved knowledge and skills for health and wellbeing staff. Resulting in the provision of high quality care and support for the residents of Caerphilly borough.	Supporting the Health and Care Workforce. NCN Development. Community Infrastructure.	X	X		X	E - £2,500 N - £2,500 S - £2,500	Cluster Funding	Active. NCN Development & Partnerships.	
Place Based Care / HUB Development	Existing	Funding to provide opportunities to develop/improve community-based health and wellbeing hubs.	Versatility to existing HUBs across the NCN localities. Enables a variety of services to offer clinics within community settings and out of hospital.	NCN Development. Community Infrastructure.	X	X	X	X	E - £2,500 N - £2,500 S - £2,500	Cluster Funding	Active. NCN Development & Partnerships. Access & Sustainability.	
Winter Initiatives	Existing	Funding to support asthma diagnosis via Feno machines	Support practice diagnosis of asthma via POCT testing.	Provide effective, high quality, sustainable healthcare. Population Health		X			E - £8,500 N - £8,500 S - £7,500	Cluster Funding	Active - NCN Development & Partnerships. Access & Sustainability.	

NCN Delivery Action Plan

Please List activities or projects planned to commence during 2026/2027, as well as those ongoing from 2025/2026

Key: Alignment to NCN Agreed Priorities

1. To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care

2. To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a ‘social prescribing’ model that connects people to activities, groups and services in their community addressing

3. To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations

4. To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs

5. Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees.

NCN IMTP 2026-2029

Staff Wellbeing	Existing	Funding for consumables	HUB based staff wellbeing service in Caerphilly (The Zen Den). Offers Caerphilly staff from across services to receive complimentary therapies and improve stress/mental health.	Supporting the Health and Care Workforce	X				E - £500 N - £500 S - £500	Cluster Funding	Active. Workforce & Staff Wellbeing. Mental Health & Wellbeing.	
Specialist Pharmacist to support Chronic Disease Management	Potential	Introduce 1 WTE IP Pharmacist to work alongside the PCDSN Team	Improved access to medicines expert for chronic disease conditions and support PCDSNs.	Provide effective, high quality, sustainable healthcare. Supporting the Health and Care Workforce PCMW and NCN Development					E - £22,433 N - £22,433 S - £22,433	Proposed cluster funding	On Hold. Access & Sustainability. Long-term Conditions.	
Minor Illness Hub	Potential	Development of a Minor Illness Hub, run by clinicians i.e ANP, MSK specialists, Paramedics, Prescribing Pharmacists.	Improved access for GPs by freeing up their time to enable them to see more complex and relevant patients	Supporting the Health & Care Workforce Population Health					E - TBC N - TBC S - TBC	TBC	On Hold. NCN Development & Partnerships. Workforce & Staff Wellbeing.	
Nurse Practitioner	Potential	Review patients for preventative needs. Supporting winter planning / frail elderly.							E - TBC N - TBC S - TBC	TBC	On Hold. NCN Development & Partnerships. Workforce & Staff Wellbeing.	
NCN Development Programme / ACD	Existing	Maintaining and enhancing the Caerphilly ISPB	Create sustainable system change through integration of health and social care services,	Healthier Wales, Working alongside Social Care, Population Health, Supporting Social Care/ Health Workforce, Prevention & Wellbeing, Communication and Engagement, Transformation and Vision for clusters						SPPC	Active – Fixed Term funding	
	Existing	Evaluate and implement exit strategies	Enable proven concepts to be diverted from NCN budgets.							SPPC	Active – Fixed Term funding	
	Existing	Continue local working with collaboratives	GMS, Optometry, Dental, Pharmacy, Allied Health professionals, Nursing							SPPC	Active – Fixed Term funding	

The NCNs priorities What we are doing/ going to do:

Building resilient communities

- Continuing the Integrated Wellbeing Network work programme.
- Promote and support the Community Wellbeing Connectors and Nature prescribing services to improve population health & wellbeing.
- Improving uptake of preventative and screening programmes.
- Focus on Place Based Care including costed model opportunities.

Encouraging collaborative working with a focus on enhanced services

- Develop & enhance partnership working.
- Continue to support & promote GP engagement with enhanced services.
- Continue and enhance MDT working.
- Continue to support the integration of the ACD development programme.

Long Term Conditions – Prevention & Management

- Developing service models, pathways, and teams to meet the needs of a diverse population.
- Focus on Prevention Programmes and promotion of healthy lifestyle choices and preventative services.
- Support and promote immunisation and vaccination programmes



Working Together to Develop, Deliver & Sustain Services on a Local Level

Caerphilly NCN (East, North, South) Plan – 2026-27

Areas of Focus

- To align the work of NCNs and Integrated Wellbeing Networks to develop a more community orientated model of primary care through deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care.
 - To ensure NCNs have a good understanding of Integrated Wellbeing Networks in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks.
 - To co-produce a 'social prescribing' model that connects people to activities, groups, and services in their community which can address their practical, social and emotional needs.
 - To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events, such as hospitalisation, to live safe, independent and fulfilled lives. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapists, housing and third sector organisations.
 - To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs.
 - To establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker / refugees.
- Delivered via:
- Robust partnership and collaborative working across health, social service and third sector organisations
 - Team & Assurance meetings.
 - QPS – implement focus on learning outcomes.
 - Working across services to support staff wellbeing.
 - Working to ensure we have an agile and mobile workforce equipped with the skills to meet population needs.
 - Maintain support for robust and sustainable services.
 - Prudent healthcare principles to ensure appropriate level of service.
 - Ensuring appropriate utilisation of estate infrastructure.
 - Development of capital bids.
 - Embedding appropriate and financially viable digital platforms across primary and community services
 - Ensure regular budget review and opportunities for re-investment.
 - Utilise alternative funding streams to support current NCN budgets as appropriate.

How are we delivering change?



Bardod Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



Partnership Working
with Local Authority
in estate
prioritisation &
rationalisation

Work with
partners to
establish wrap
around health and
wellbeing services

Use of
preventative, early
opportunity, and
self-management
approaches

Integrated
approach on
Caerphilly NCN
Footprints

Use prudent
pathways to
improve planned
care

Use
Multidisciplinary
Team to undertake
active signposting

Recruit, train &
educate our
workforce to ensure
needs of population
met



How will we know if we have made a difference?

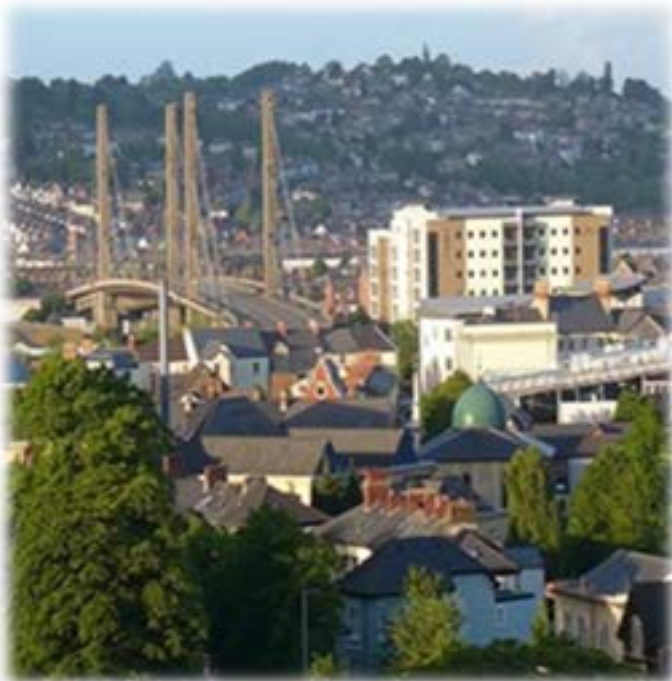
NCN Accelerated Development, Evaluation & Reporting Process/
Patient Experience, ISPB & NCN reporting, Assurance Meetings

Newport Neighbourhood Care Network IMTP



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Hedyn



NCN IMTP 2026-2029

A Healthier Wales remains the overarching policy context for health and social care and drives our commitments to deliver seamless, place-based care. Newport NCN has developed its plans to align with the ministerial focus on improving population health as the mechanism to deliver health equity, learning from the pandemic and addressing the impact of issues such as obesity and poor mental health on people's health and well-being outcomes.

Working as an NCN that incorporates General Medical (GPs), Dental and Optometric Practitioners, Pharmacists, Community Nursing, Allied Health Professionals (AHP), Integrated Wellbeing Network, Social Care and third sector organisations combine their detailed knowledge and expertise ensures care is better coordinated to assess population needs, identify service improvement priorities and develop local solutions to promote the wellbeing of individuals and communities.

This integrated medium term plan (IMTP) outlines the vision and priorities of Newport Neighbourhood Care Network (NCN) articulating how these will be achieved over the next three years.

Our NCN plans have developed over the last few years to adapt and meet the changing needs of our diverse and growing population. Regarded as the gateway to South Wales, Newport has a population of nearly 160,000 and is the second most diverse and densely populated unitary authority in Wales with communities rich in culture, tradition and language. Our NCN experiences significant contrast between wealth and deprivation with 23 of the 95 most deprived Lower Super Output Areas in Wales being in Newport, the highest proportion of any authority in the country, correlating with significant prevalence's of mental health illness in our communities. We exceed national averages of chronic health conditions including diabetes, cardiovascular, respiratory disease, have the highest homelessness rate in Wales and 14.5% of our population constitute of ethnic minorities.

Through the delivery of our NCN IMTP, we work to offer better care, better lives and better health and to meet the Quadruple Aims set out for Health and Social Care Systems in Wales. This will be achieved this in the context of the Primary Care Model for Wales.

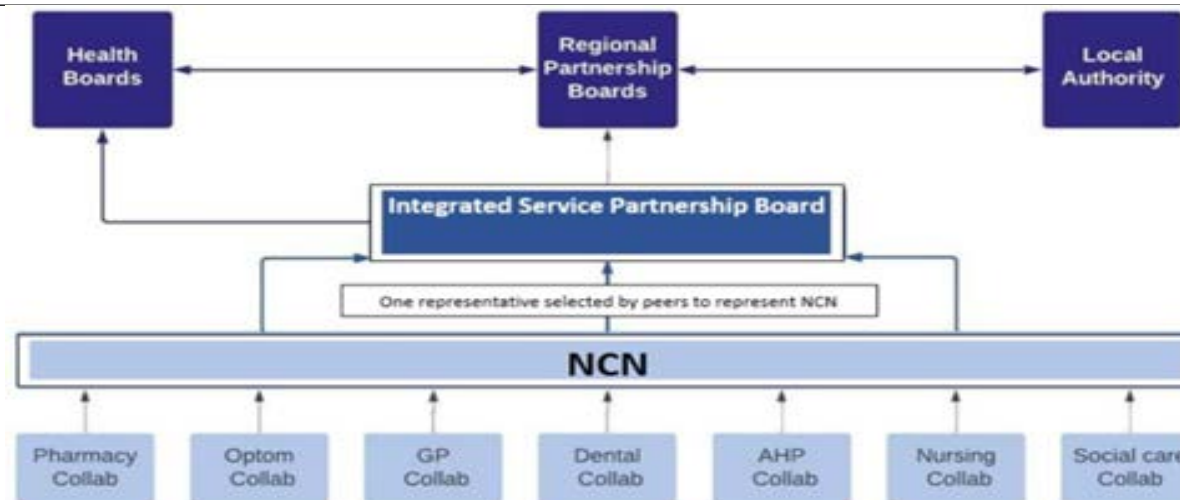
About Newport

Newport is a multi-cultural city, with a population of 164,702 (as per GP registered individuals).

- Newport has the second highest proportion of population from Black, Asian and Minority Ethnic backgrounds in Wales, with 48 different languages spoken amongst 20 identified communities.
- It has been identified that there are 2340 households within Newport that do not speak English or Welsh as a main language.
- Newport has an ageing population, with a current over 65 years population of 27,510.
- Estimated ageing population projection to 37,241 by 2039
- Newport is facing a significant housing issue with high demand far outstripping supply, leading to a long waiting list for social housing and a rapid rise in homelessness and temporary accommodation use. Newport City Council have also recently announced that there are approximately 9000 individuals on the social housing waiting list.



NCN IMTP 2026-2029



Gwent Regional Partnership Board

Gwent's framework for health and social care planning is implemented through the Gwent Regional Partnership Board (RPB). The RPB is a statutory body bringing together local authorities, the health board, third sector, and others to jointly assess needs, plan, commission, and oversee health, care, and wellbeing services in the Gwent region. The legal basis for this framework comes primarily from the Social Services & Well-being (Wales) Act 2014, which mandates:

- A Population Needs Assessment (PNA) is available and provides a joint assessment of the level of care & support needed across Gwent, including prevention, levels of service and emerging needs.

Evidence provided by the current PNA was used to support the priorities outlined within this 3-year plan with the 3 key RPB goals below applied across our NCN priorities:

Start Well Improving outcomes for children and families, working together to start well.	Live Well People at the heart of everything we do, working together to live well.	Stay Well Ensuring the right help is available at the right time, working together to stay well.

Newport's Integrated Services Partnership Board:

The Newport ISPB is a sub-group of the RPB and a conduit for information sharing, decision making and providing direction over NCN delivery plan priorities. It enables key partner representatives to work together on strategic, long-term plans, to agree and develop priorities linked to, for example; the Social Services & Well-being of Future Generations Act, Strategic Programme for Primary Care, and A Healthier Wales. It facilitates a whole-system approach to improving health and wellbeing, integrating Health, Local Authority and Third Sector services thereby providing the best possible services to our residents. Newport ISPB has a shared objective, aligning to the Marmot Principles, and delivering against national and local strategic drivers through:

- Placed based care: Strengthening services with a key focus on prevention and early intervention, based on an evidence base and tailored to needs of residents, through a place-based approach
- Co-production: Designing and delivering effective, efficient services in partnership with residents and stakeholders

NCN IMTP 2026-2029

- Workforce quality: Ensuring Services are delivered by a capable, integrated workforce

ISPB objectives: • Deliver local implementation of RPB priorities • Coordinate available resources to meet population needs • Provide strategic direction • Support partnership working • Ensure plans reflect population health intelligence	← Solutions, Improvement, Change → ← Intelligence for priorities & decision making →	ISPB priorities: • Third Sector as full partner • Integrated workforce for the future • Place Based Working • Redesigning services for older people • Ensure fit for purpose estate • Enhanced Financial scrutiny

Current services need to evolve to be able to sustain and improve. There is a necessity to change historical ways and patterns of working that no longer meet the needs of today's society and the needs of the future population, notwithstanding the changes to our service delivery and communication brought about by the covid pandemic. Newport NCN is dedicated to enhancing service delivery to meet current and future needs.

The consideration of the strategic priorities of the ISPB and RPB into NCN planning will ensure that Newport is able to offer a robust person-centered model of care that reflects the values of collaboration, prevention, and equity.

6 areas within Newport have been identified as 'places' within the city. Place based care will be multifaceted to be centered on the communities in each place. This will ensure that these 'places' are best equipped to design, develop and implement services that will improve communities within the defined place which will result in better outcomes for individuals.



Neighbourhood Care Network (NCN)

NCNs bring together all local services involved in health and care across a geographical area, to combine local expertise and knowledge these include:

- General Medical (GPs),
- Dental and Optometric Practitioners
- Pharmacists,
- Community Nursing,
- Allied Health Professionals (AHP)
- Local Authority
- Third Sector Organisations

NCN IMTP 2026-2029

- Integrated Wellbeing Network

Functioning as an NCN ensures care is better coordinated to assess population needs and are a key component in identifying service improvement priorities and develop local solutions to promote the wellbeing of individuals and communities.

Newport is currently established around 2 Neighbourhood Care Networks (NCNs), East and West, with an ambition to improve and develop primary care and community services within the local communities.

Professional Collaboratives

6 Professional collaboratives have been created as a result of Accelerated Cluster Development which is a key component of place-based care. Each of 6 collaboratives are represented at NCN meetings and help understand the local and regional needs of each service which then helps to inform planning. The professional collaboratives are made up of representation from:

- GMS
- Nursing
- Pharmacy
- Optometry
- Allied Health Professionals
- Dental

The Place-Based Care Continuum:

NCN IMTP 2026-2029



NCN IMTP 2026-2029

Health Board and NCN Priorities

ABUHB IMTP 2026 to 2029- & 10-Year Strategic Priorities



Better Health: Together we will support people to be healthy, active, and 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	Best Start in Life

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

OUTCOMES			
People will have more Healthy Days at Home	Our provided and commissioned services will meet the relevant quality and clinical standards	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

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

OUTCOMES			
People will find it easier to connect with their communities, use local services, and feel respected	Our budget spent on services in the community will have increased	More people will engage with their local community to reduce loneliness and support good health	
PRIORITIES			
Healthy Places	Resilient & Connected Communities	Safe Spaces	Quality of Life

NCN IMTP 2026-2029

Previous NCN Achievements Progress Made Against NCN Priorities within 2025/2026

Priority 1 Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs

- Strengthened relationships with Newport Integrated Wellbeing Network (IWN) to extend the IWN's place-based approach across community wellbeing and integrated social care and health services through enhanced links with MDT teams in Newport. As a result of collaborative engagement, funding was allocated to 'Kid Care 4 U which is a registered charity that aims to support families to acquire the skills and confidence they need to turn their potential into success at school, the workplace and beyond.
- NCN funding via the local authority Participatory Budgeting scheme; combined amount of £10k was gifted by the NCN to support local community groups in line with the identified NCN priorities such as mental health, dementia, women's health and wellbeing.
- The NCN provided support and funding for equipment in relation to Public Health 'Health Fayres' that were held 4 times throughout a 12-month period. All events were held within Mosques and community venues in order to engage with communities that recorded lower uptake in vaccinations and screening. The main aim of the events was to raise awareness of accessing support for:
 - *Coronary vascular disease*
 - *Hepatitis screening and advice,*
 - *General health advice,*
 - *Flu & Covid 19 adult vaccinations,*
 - *Childhood immunisations & vaccinations information,*
 - *National screening programmes for breast, bowel and cervical cancer as well as aortic aneurysm*
- Worked in collaboration with IWN and the local authority in the Implementation Community Connector roles in Ringland & Bellevue Medical Practices supporting individuals to connect to social groups, maximise their income, access carer support and received general signposting to support services. The NCN and IWN use asset-based approaches to create accessible community resources that support integrated care. These resources are shaped by the aspirations of the community, allowing health, social care and third sector services to be delivered in informal, familiar settings. The approach focuses on the social, economic, and environmental factors that contribute to poor health and wellbeing. By using a strength-based model, previously separate services are brought together to collaborate and develop solutions that focus on what matters most to individuals, their families and communities. Through a shared understanding the NCN, IWN and PBC Team have strengthened collaboration with third sector and community organisations to deliver early intervention, prevention and chronic disease management with a focus on diabetes, CVD, mental health and social prescribing through community connectors.
- RIF and NCN funding have been invested to commence implementation of the NFSP which has enabled Community Connectors to be allocated to Bellevue and Ringland Medical Practices.
- A snapshot of Ringland Q2 data shows us that the Community Connector assisted 58 individuals with mainly anxiety, financial worries, carer strain and housing issues. Feedback from the individuals supported includes: -
 - *"You have been absolutely amazing. I didn't know this sort of help existed. Some people struggle more than me and they are left with nothing. Thank you so much for everything*
 - *"We are desperate, and you are helping us, thank you" –*
 - *"Not many people know how to help me, people don't help each other anymore. You have made me very happy, I'm grateful. Thank you"*
 - *"I feel better, feel lighter and I tell no one my business. It's strange my head feels better. You don't know how you are helping me*

Integrated care approaches were developed aligned to IWN priorities to ensure that the most can be achieved from shared resources to enable individuals to have good quality of lives and cope with adversity.

NCN IMTP 2026-2029

Collaboration in shaping long term preventative services is ongoing utilising community assets to improve access, engagement and social connectedness so that individuals are encouraged to participate in rewarding activities that improve wellbeing and have the support needed to address wider determinants that negatively impact health.

- The 19 Hills Health and Wellbeing Centre opened in January 2025 with £29m Welsh Government investment. The primary objective of the Health and Wellbeing Centre is to develop an integrated model of support offering care closer to home and service delivery to address health inequalities in the local population. The centre currently offers:

General Medical Services: Offered by Ringland Medical Practice and Park Surgery.

Community Dental Services and General Dental Services (provided by Ringland Dental Practice)

ABUHB Community Services: including Family and Therapy Services, Audiology, AAA Screening, Diabetic Retinopathy, Mental Health Support Services

The aim of the Centre is to address the holistic needs of the community by promoting wellness, supporting the management of health conditions, and emphasising the co-production of health and social care services. It provides opportunities for the integration of primary care and public health, free space for wellbeing activities delivered by community groups. A schedule of regular planned wellbeing activities had been developed up until April 2026 which include:

- Menopause and Cancer Café
- Self-Care Week
- Breastfeeding and parenting Groups
- MDT Wellbeing Clinics
- Wellbeing Book Clubs
- Department of Works and Pensions pop up surgeries
- Public Christmas Event
- New Year New You Event
- Diabetes focussed event

A Community Involvement Officer has been employed at 19 Hills Health & Wellbeing Centre until April 2026, to develop the community activities in conjunction with the IWN team, to ensure that services and community groups are aligned to provide wrap around care and support.

NCN IMTP 2026-2029

- Behavioural Change Practitioners (previously Help Me Quit practitioners) have been employed within Public Health Wales who offer support and interventions to individuals and groups. The roles are a core part of the place-based neighbourhood team and support building the capability of behaviour change through the delivery of formal and informal training. The practitioners apply relevant theory and behavioural science approaches to inform and deliver a range of health promoting interventions in areas such as smoking cessation, diabetes prevention, cardiovascular disease and healthy weight management.

Priority 3 MDT working for people with complex needs who are most at risk of deterioration or adverse events

- As an NCN, Newport has long recognised the value of MDT and multi sector working to deliver collaborative joint care planning for individuals with complex conditions so that when needs escalate, shared plans are agreed that ultimately improves outcomes whilst optimising the use of finite health and care resources. Introduced in Newport West GP Practices in 2019, the virtual ward model set the innovative landscape for developing holistic, patient-centred assessment; multidisciplinary partnership working between GPs, other primary care professionals, social care and third sector colleagues. Utilising RIF and NCN funding, a Placed Based Care Service has been established to further develop the virtual ward model which consists of a hub team of Clinical Nurse Leads, OT, Pharmacists and Coordinators who work in in the spirit of a shared endeavour with GP Practices, primary, community, social care, the independent and third sector services to promote a collective intent to align resources that deliver a pragmatic and integrated health and wellbeing model attuned to the diverse needs of population groups in Newport particularly those living and/or at risk of developing complex needs, long term conditions and frailty so they are empowered to proactively manage their own health rather than being passive recipients of services. Achievements so far include: -
 - Strengthening of established MDT team meetings in GP Practices to enhance care for complex patients and ease GMS pressures, the Newport Place Based Care Service continues to move and expand at pace.
 - Multidisciplinary coordination: the team coordinates care for complex patients, acting as a central hub for communication between different professionals involved in a patient's care.
 - Multidisciplinary placed based partnership development that meets the needs of individuals and communities in Newport particularly vulnerable and marginalised groups so that use of community assets that support individuals access to health and wellbeing resources is maximised. In 25/26, 1,446 stakeholders attended MDT meetings
 - MDT meetings occur in every GP Practice where individuals with complex, long-term conditions, frailty, poor mental health are the primary beneficiaries from receiving patient centred shared care planning that includes biopsychosocial influences that construct ill health. Through collaboration the individual receives holistic coordinated care that addresses their needs, improves their outcome and reduces risks of decline. In 24/25 2,986 individuals were support by the PBC Service and 310 MDTs held
 - Proactive and anticipatory care planning for individuals who have historically received uncoordinated ad hoc care due to the complexity of their conditions
 - Wellbeing Clinics are held to address social, economic and environmental factors that overlap ill health so that individuals receive the appropriate support to improve their ADL's and social connectedness.
 - Reduced strain on GMS, NHS & LA resource by ensuring the individual receives the right care closer to home that is more preventative, cost-effective and productive therefore reducing reliance on GP, secondary care and statutory services.
 - Building on the principles outlined in the Primary Care Model for Wales and the quadruple aims of "A Healthier Wales", Newport NCN continues to work collaboratively with Primary, Community, Social Care, third sector and external providers to maximise all opportunities to achieve place based seamless multi-professional and/or cross sector responses as close to home as possible for individuals to avoid crisis and escalation of their care needs, where feasible.

NCN IMTP 2026-2029

- Secured community space (West Market Street) to deliver PBC Clinics that provide a multifaceted, preventative patient centred approach that also addresses biological, social and environmental factors that construct ill health for high risk stratified individuals with 3+ NCDs
- The District Nursing service and National Exercise Referral Scheme worked in collaboration to identify housebound bariatric patients that would benefit from light exercise sessions within their own home in an attempt to reduce Body Mass Index (BMI).

Priority 4 Equity of access to supplementary/enhanced services across Gwent

- Regular monitoring and discussions with practices around the flu vaccination uptake, sharing good practice and up to date uptake figures
- There is ongoing work to determine how low GMS uptake in particular areas can be increased either through inter practice agreements or support from community services. This will provide equity of services within the city and ensure better health and care are provided locally. The consideration of vulnerable groups will be of high importance to ensure that appropriate health care is available to all citizens of Newport.

As of April 2025, Public Health Wales data identifies that with Newport there are:

- 402 individuals registered as asylum/refugees
- 819 individuals classed as homeless/owed a duty of care under the Housing Act.
- Of the 819, 25 are registered as rough sleepers
- 172 individuals recognised a Roma gypsy/traveller community.
- 83 registered sex workers.

Newport is one of three designated dispersal areas in Wales; support was given to the Health Inclusion Service (HIS) and local authority in the health registration process of the resettlement of asylum seekers and refugees.

Challenges, risks and barriers to successful delivery of agreed milestones within 2025/2026

- Sustainability risks within teams due to budget restraints.
- Risk to staff retainment due to fixed term contracts.
- NCN budget is predominately allocated to the Place Based Care team which increases as staff uplifts are awarded.
- NCN funded proven projects remain within NCN budgets rather than reallocated to health board core funding
- Aging workforce and increased work life balance opportunities resulting in reduced working patterns pose a risk in stability
- Some difficulties with the recruitment of roles, such as GP Partners
- NCN structure recently destabilised
- Public messages of additional services still appear to be unclear such as the use of the Common Aliment Scheme and community pharmacy interventions, i.e. Test and Treat.
- Estates are an issue to further utilise and expand community services, i.e., HIS Team do not have allocated clinic space other than in external organisational buildings. GMS practices are full to capacity which hinders their ability to provide additional services and roles.
- Access to patient systems used by partners such as WICCIS to avoid silo working and duplication.

Proposed Milestone for Agreed Priorities for 2026/2027

Priority 1 Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs

NCN IMTP 2026-2029

Q1. • Gather and understand the local community intelligence that exist and where gaps exist. • Understand the mapping exercise undertaken by the ISPB of community assets/Link Workers across aligned 6 places. • Continued development of 'Your Newport, Your Wellbeing' • Commence implementation a social prescribing referral system • Work with IWN and GAVO to develop a small grants scheme	Q2. • Align Your Newport, Your Wellbeing Link Workers to the identified 6 places. • Review of investment to align existing community resources to bridge gaps in service provision. • Implementation of a social prescribing referral system pilot
Q3. • Continue the social prescribing communication system pilot	Q4. • Evaluate the social communication pilot and complete the rollout into year2
End of Year Objectives • To have an active culture of signposting amongst health and wellbeing services within Newport • To have a system in place to support the delivery of social prescribing and monitor activity and outcomes.	
Priority 2 Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors	
Q1. • Engage GP practices in a collaborative approach to the Healthy Behaviours QI project and the processes and pathways for systematic referral into local services and programme (e.g., Help Me Quit, National Exercise Referral Scheme, Community Weight Management) • To determine how the NCN Community Pharmacists can support the hypertension case finding and CKD • Identify and agree an optimal approach for structured brief intervention in patients with a new diagnosis of hypertension. • Explore the role of primary care dietetics in the reduction of diabetes	Q2. • Scoping of roles that will assist with chronic conditions management. • Scope how the NCN can support individuals with long terms conditions
Q3. Facilitate a 'Health Coach' role that will complete patient checks for populations at risk such as CVD and Diabetes and complete a standardised 30-minute intervention session. It is envisaged that one Health Coach will be allocated to service populations of up to 30,000.	Q4. Evaluate the scoping exercise in Q2 of roles and create a draft plan for the coming year
End of Year Objectives • Behavioural Change practitioner embedded in community teams. • Health Coach that will be able to support practices with hypertension • NCN response to the rising demand of long-term conditions	

NCN IMTP 2026-2029

- Have a defined understanding of the role of primary care dietetics in the reduction of diabetes
- Complete a mapping exercise with each professional collaborative to determine what support can be offered in regards to diabetes and CKD.

Priority 3 MDT working for people with complex needs who are most at risk of deterioration or adverse events

Q1.

- The current 'Place Based Care' team within Newport is to be relaunched with a rebranded name to avoid confusion with the wider place-based care concept
- Service criteria, roles and responsibilities to be redefined to provide clarity and understanding of the future direction of the service.
- Define 'complex need' criteria to ensure that this cohort of patients are not overlooked whilst moving focus to the rising risk population.
- Continue to develop and refine the evaluation strategy for the work of the place-based care team
- Connect the dedicated Newport HIS Nurse to the PBC team

Q2.

- A review of the NCN Pharmacy Provision (East) will be undertaken to provide a clear explanation of roles and availability to understand if a place-based approach that Newport West has adopted within this professional cohort could be mirrored to allow for uniformity across the city

Q3.

- Expand the professional input within the MDT meetings such as social services and Health Inclusion Service presence.
- MDT Coordinators to strengthen working processes with the Health Inclusion Service with a focus on outreach work.
- Align MDT Coordinators to identified areas in line with place-based care

Q4.

- Further understand the processes and procedures of partners that impact directly upon outcomes and decisions of the place-based care team, such as the local authority's First Contact referral process

End of Year Objectives

- Rebranded new identify of the Newport PBC service
- Stronger relationships with other health board services and partners

Priority 4 Equity of access to supplementary/enhanced services across Gwent

Q1.

- Identify service gaps that exist within the local supplementary/enhanced services across Newport.

Q2.

- Support inter-practice service agreements with GP practices in the NCN.

Q3.

Q4.

NCN IMTP 2026-2029

- Facilitate stronger relationships with GMS and the High Intensity Services to ensure that continued specific individual care and medication is identified and provided.

End of Year Objectives

- Agreed hub and spoke model for LES/DES services where gaps have been identified exist.

Enablers required to deliver 2026/2027 quarterly milestones

- Additional IWN roles and continued progress.
- Developing strong relationships with various stakeholders, i.e., ISPB and GAVO.
- Extended funding opportunities via local authority.
- Access to appropriate data streams to avoid duplication.
- Core funding for NCN funded projects, i.e., Psychological Health Practitioners.
- Professional Collaboratives working effectively together and continue to develop.
- Positive feedback from patients, practices, care homes, and district nursing
- Temporary positions within teams permanently secured Place Based Care Team
- Staff completing further education, which enables them to perform more advanced clinical assessments and interventions, to release GP time
- Increased partnership working through ISPB
- Improved integrated working and understanding of partners working processes.
- Engagement from key stakeholders
- Relevant representation at meetings such as MDT's
- Alignment of MDT coordinators as a place-based approach.

Challenges, risks and barriers to successful delivery of agreed milestones within 2026/2027

- Sustainability risks within teams due to budget restraints.
- Risk to staff retainment due to fixed term contracts.
- Inability to shift service/projects to release resource to invest.
- NCN budget is predominately allocated to the Place Based Care team which increases as staff uplifts are awarded.
- NCN funded proven projects remain within NCN budgets rather than reallocated to health board core funding.
- Financial pressure within practices, inflation impacting practice and uplifts do not cover rising costs
- Aging workforce and increased work life balance opportunities resulting in reduced working patterns pose a risk in stability
- Some difficulties with the recruitment of roles, such as GP Partners
- NCN structure recently destabilised
- Educating patients to access appropriate services such as the Common Aliment Scheme and medical pharmacy interventions.
- Estates are an issue to further utilise and expand community services, i.e., HIS Team do not have allocated clinic space other than in external organisational buildings.
- Access to patient systems used by partners such as WICCIS to avoid silo working and duplication.

Finance Profile 2026/2027

The Health Board are required to deliver a breakeven financial plan for the 2026 – 2029 IMTP, please outline your breakeven Financial Profile for 2026/2027

NCN IMTP 2026-2029

East Spend Plan Summary	2026/27
Annual Budget	495,903
Top Slice: Advisers, Phlebotomy, Dementia Roadmap	£19,415
Practice Based Pharmacists	£177,118
B4 Coordinator	£40,155
MDTs (based on 2 pm)	£40,800
PHPs (based on 4wte)	£175,926
Hub Team Lead	£58,790
Other	£0
Total Expenditure	£512,205
Forecast position	(£16,302)

West Spend Plan Summary	2025/26
Annual Budget	£538,077
Top Slice: Advisers, Phlebotomy, Dementia Roadmap	£20,334
Practice Based Pharmacists	£199,784
PHPs (based on 4wte)	£183,751
Team Lead & Occupational There	£14,698
Clinical Nurse Lead	£64,116
MDTs	£33,600
AccuRx / e-consult	£25,094
Accruals	
Link	£0
Other Non Pay	£0
Total Expenditure	£541,377
Forecast position	(£3,300)

NCN IMTP 2026-2029

The NCN budgets are largely devoted to the work of the place-based care model, this remains under consent review and any funding that becomes available will be reinvested as required.

In order to balance the financial budget and ensure that all funding is relevant to the NCN priorities, there are a number of options being discussed.

Workforce Profile 2026/2027

Please outline your workforce profile for 2026/2027

The current workforce profile is as follows:

Service	Roles	Brief Description	Risks, Challenges, Barriers
Place Based Care	- Clinical Lead Nurses - PBC Clinical Pharmacists - Occupational Therapist - MDT Coordinators - Link Worker	To provide health and social care support within the community and addressing local need. The goal is to keep people healthy and at home by offering services closer to where they live, supported by multi-agency teams that connect community members and local services.	- Budget - Staff Uplift costs - Fixed Term Contracts - Estates - Service duplication
Pharmacy	Practice-Based Pharmacists	Alignment of Community NCN Pharmacists with PBC team, exploring how their professional skills can be utilised in reducing chronic conditions via intervention and medicine management.	- Pan Gwent model - Budget - Difference in NCN models - Staff Uplift costs
Mental Health	Psychological Health Practitioners (PHPs)	Reduce demand on GP appointments for low level psychological health concerns. Intervention provided to prevent crisis mode occurring.	- Staff turnover - Budget

Intended Additional Workforce Profile for 2026/27 and beyond

The ISPB has designed a Place Based Care model which splits Newport into 6 "places" which require targeted interventions to support individuals and communities in Newport to improve their health, wellbeing and resilience whilst also addressing socio-economic challenges that construct ill health and lead to poor outcomes and systemic differences that currently exist. This cannot be achieved without appropriate investment to secure a dedicated workforce to deliver the model. Whilst the ISPB will continue to develop place-based partnerships to share resources and the NCN will continue to maximise all funding opportunities to recruit into the roles desperately needed, permanent recurring funding is required to deliver a robust person-centred Place Based Care model.

NCN IMTP 2026-2029

The current Place Based Care Team deliver MDT working for complex patients registered with Newport GP Practices, holistic clinical nurse lead and OT person centred interventions and support rising risk cohorts to prevent deteriorations. The current workforce is insufficient to meet the levels of need that exist in Newport. Permanent funding is therefore required to increase the workforce in alignment with ISPB and NCN plans to deliver holistic patient centred care that is underpinned on addressing wider factors that influence health. Current demand is continuously outstripping PBC Service capacity despite the team working proactively to share workload and utilise all available pathways for alternative support. Increasing the workforce will enable the team to work far more up stream delivering preventative care and interventions that prevents deterioration and reduces GMS, Primary Care and Secondary Care demands. Therefore, the following roles have been identified as required in the future going forward and will be captured within the costed model as there are insufficient funds within the NCN budgets.

Additional Occupational Health Therapist x 1wte	Better Care-Place Based Care	£60,068
New Pharmacy Technician x 1wte	Better Care-Place Based Care	£68,448
New Chronic Conditions Nurse x 1wte	Better Care-Place Based Care	£60,068
Additional Link Worker x 4wte	Better Care-Place Based Care	£177,420
New Social Prescriber x4wte	Better Care-Place Based Care	£241,098
New Community Involvement Officer x 2wte	Better Care-Place Based Care	£80,336
New Business Officer x 1wte	Better Care-Place Based Care	£32,127
New Paramedic x 1wte	Better Care-Place Based Care	£62,277
New Physiotherapist x 1wte	Better Care-Place Based Care	£62,277

NCN IMTP 2026-2029

Proposed Milestone for Agreed Priorities for 2027/2028 and 2028/2029

Priority	2027/2028	2028/2029
Priority 1 Connecting people to non-medical activities, groups, and services in their community which can address their practical, social and emotional needs	Continue to utilise the IWN Collaboratives and its network of community partners and stakeholders to deepen the links between primary care and the community through an effective ABCD approach to identify local needs and strengths.	Continue effective partnership working with NCN networks, identifying gaps in provision and utilising NCN data to direct workstreams.
	Continue the development of 'hubs' in collaboration with the local authority and third sector, such as West Market Street, Alway, Gaer, St Julians, 19 Hills, ensuring these assets can connect people with health and wellbeing resources, activities and other people to support their own wellbeing.	.
Priority 2 Reducing premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors	Continued identification of high-risk patients and planning of behaviour change approaches to support the management of behavioural risk factors, based on prevalence of disease, winter planning priorities or local need.	Establish a chronic disease team across the NCN that will specialise in the management of long-term health conditions, such as diabetes, diet, heart disease, and asthma, by providing proactive care, patient education, and collaborative treatment planning within the multidisciplinary place-based care team. The role will conduct annual reviews, manage medication, monitor symptoms, and help patients with lifestyle changes to improve their quality of life and wellbeing.
	BCP's to raise awareness of the smoking cessation service and highlight the increased risks for individuals with respiratory conditions. Messaging will be disseminated through established channels and community-based organisations the Age-Friendly Communities Networks, Cost of Living Networks, IWN Collaboratives, Local Authority Housing Support Services, Registered Social Landlords, COPD support groups, Wellbeing Friends network, and across the network of community hubs. The aim is to ensure that key health messages reach a broad audience, particularly those at heightened risk with respiratory illnesses. Content will focus on: Encouraging uptake of the Help Me Quit smoking cessation programme	

NCN IMTP 2026-2029

	- Promoting the importance of winter vaccinations for respiratory health and encouraging eligible individuals to take up the offer of seasonal vaccinations - Signposting individuals to relevant support services, including Warm Homes initiatives and local well-being resources	
Priority 3 MDT working for people with complex needs who are most at risk of deterioration or adverse events	Support the work of the MDT teams in diabetes prevention by developing community-based support to promote and encourage healthy behaviours and support mechanisms in partnership with third sector organisations such as Diabetes UK, e.g., Peer Support Groups, Food Control.	
Priority 4 Equity of access to supplementary/enhanced services across Gwent	Continue to monitor supplementary and enhanced services across Newport	

Title	New or Existing project	Brief Description	Results/Benefits expected by end Mar 2027	Strategic alignment against ABUHB and NCN Priorities	Areas of Focus				Budget	Funding Source	Current Status	Comments
					1	2	3	4				
Building Community Resistance Population Health Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design Estates Mapping Accelerated Cluster Development	Existing	Establish a whole system approach to deliver place-based care where individuals can access a range of seamless care and support at or close to home, based on their unique needs and what matters to them	In partnership with IWN and third sector partners we will build community resilience through collaborative approaches and connections to increase social prescribing and community development Align the work of the NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets, gaps in provision and local community needs within the population, particularly for socially vulnerable or marginalised groups. Behavioural Change Practitioners and Link Worker roles will be key enablers	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing	1	2			£25,074	NCN IWN	In Development	
Building Community Resistance Population Health Health Protection Services Care Closer to Home/Pathway re-design Accelerated Cluster Development	Existing	Continue to promote signposting to the most appropriate groups and activities to the Newport wellbeing offer	Staff will engage people in conversations about what matters to them and provide information to signpost them to services, groups and activities, using local knowledge or directories MECC training undertaken.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing	1	2				N/A		
Accelerated Cluster Development Building Community Resistance Population Health	Existing	Continue to progress with the ACD Programme	Develop and support both exit strategies and business cases to enable proven concepts to be transitioned over to core funding. Raising awareness of the benefits for improving population outcomes through collaboration and strengthening partnership arrangements.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health		2	3			N/A		

NCN IMTP 2026-2029

Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design			Continue with the Place Based Care model as a key priority across all professional collaboratives.	Workforce Working alongside Social Care Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development								
Building Community Resistance Population Health Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design Accelerated Cluster Development	Existing	To continue to develop the 6 Professional Collaboratives to create a subgroup of professionals that feed into the NCN Management team.	To have identified support from the professional collaboratives in regard to the NCN priorities. To have identified project assistance/funding from the professional collaboratives in line with NCN priorities.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Working alongside Social Care Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development	1	2				N/A	Ongoing	No payments allocated to collaboratives to attend and participate
Building Community Resistance Population Health Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design	Existing	Continue to embed, expand and resign the Newport Place Based Care team	Additional roles and expertise offered to meet population need and ensure sustainability within workforces. Work in collaboration with High Intensity Service, IWN and Local Authority. Service criteria, roles and responsibilities to be redefined.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing	1	2		4		NCN RIF	Ongoing	Funding for additional roles is yet to be determined

NCN IMTP 2026-2029

Building Community Resistance Population Health Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design	New	Explore the use of technology such as an electronic social prescribing system to support place-based care.	Extend IWN's place-based approach across community wellbeing, integrated social care and health services through enhance links with MDT teams and Support delivery of social prescribing and monitor activity and outcomes to avoid duplication.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing	1	2			£23,350	NCN	In Development	Full invest cost. Phased approach in implementation
Building Community Resistance Population Health Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design Accelerated Cluster Development	New	To determine how the NCN Community Pharmacists can support QI projects in the reduction of cardiovascular disease, diabetes and chronic long-term conditions.	Extend the support to the Long-Term Conditions team of the Community Pharmacist in the reduction of cardiovascular disease. Ensure GP practice engagement in the All-Wales Diabetes Prevention Programme to enable equitable delivery across all NCN for the estimated 18,000 people in a pre-diabetic range	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing		2	3		East £ West PBC 2.4wte £167,668	NCN	In Development	Is this just the PBC?
LES & Enhanced Services Place Based Care Population Health	Existing	Unmet Population Health Needs	Assess the residual level of unmet need across the GMS collaborative and facilitate discussions about how gaps in provision and unmet need can be addressed. Identify where inter practice agreements can be created to deliver services on behalf of surrounding practices., in particular services in relation to women's health such as IUD's but also minor surgery, substance misuse, homelessness and asylum seekers	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing				4		N/A	Ongoing	Welsh Government/Contr actual
Building Community Resistance Population Health Health Protection Services Pathway Optimisation	New	High Intensity Service	Support MDT processes with Newport GPs that provide the enhanced services with the dedicated HIS Nurse, HIS Psychologist and local authority to support patients with housing.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health				4		N/A	n Development	

NCN IMTP 2026-2029

Care Closer to Home/Pathway re-design				Workforce								
Estates Mapping				Prevention & Wellbeing								
Accelerated Cluster Development												
Building Community Resistance	Existing	Health Hub Promotion	To continue to promote 19 Hills Health and Wellbeing Centre as a health hub which offers a variety of health and wellbeing services for women.	Healthier Wales	1	2		4		IWN	Ongoing	
Population Health				Population Health								
Health Protection Services				NHS Recovery								
Pathway Optimisation				Supporting Social Care/Health Workforce								
Care Closer to Home/Pathway re-design												
Estates Mapping				Prevention & Wellbeing								
Accelerated Cluster Development												
Building Community Resistance	Existing	To continue to support the Vaccinations & Screening programmes targeting the most vulnerable groups utilising data informed screening to monitor uptake.	To increase the uptake of vaccinations and screening within community settings. Continue to collaborate with local authority and educational services in regard to the uptake of 2- to 3-year-olds	Healthier Wales	1			4		N/A	Ongoing	Contractual element of the GMS contact
Population Health				Population Health								
Health Protection Services				NHS Recovery								
Pathway Optimisation				Supporting Social Care/Health Workforce								
Care Closer to Home/Pathway re-design												
Estates Mapping				Prevention & Wellbeing								
Accelerated Cluster Development												
Estate Mapping	Existing	To continue to address estate issues within GMS and community service provision.	Continued efforts will be given to supporting the planning of future service developments in the neighbourhood network. This will include ensuring that services and facilities for the neighbourhood meet the needs of the local population in the context of the finite resources available.	Healthier Wales								
Building Community Resistance				Population Health								
Population Health				NHS Recovery								
Health Protection Services				Supporting Social Care/Health Workforce								
Pathway Optimisation												
Care Closer to Home			Collaboration will be maintained with local NCN and	Prevention & Wellbeing								

NCN IMTP 2026-2029

			ISPB partners, to ensure optimal use of suitable and available estates within the borough. Knowledge and understanding of the premises and service plans of local general practices will be maintained, to enable support and signposting to sources of support for them									

Newport East and Newport West NCNs – PLAN ON A PAGE 2026/2027

NCN Areas of Focus

1. To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a 'social prescribing' model that connects people to activities, groups and services in their community addressing practical, social and emotional needs
2. To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations
3. To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs
4. Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees

Our Key Actions

1. Social Prescribing & Integrated Wellbeing Network

- Promote active signposting utilising MECC principles
- Integrate community based roles such as Link Workers, Behavioural Change Practitioners and Social Prescribers in to the Place Based Care Team
- Map and develop community assets such as community groups and activities
- Support the transition to place based working and investment in workforce capacity

2. MDT Working

- Continue to deliver integrated person centred care via the MDT concept
- Embed additional roles into MDT practice to ensure a well-rounded person centred approach
- Work collaboratively with Social Care and Third Sector partners to avoid duplication of work

3. Diabetes & Cardiovascular Disease

- Explore how NCN Pharmacists can support the Hypertension Care Finding and CVD QI projects
- Identify and agree an optimal approach for patients with a new diagnosis of hypertension
- Explore the role of Primary Care Dietetics in the reduction of Diabetes
- Scope roles such as Health Coaches and Long Term Conditions professionals

4. Enhanced Services

- Identify service gaps that exist within the local supplementary/enhanced services across Newport
- Support inter-practice service agreements with GP practices in the NCN
- Facilitate stronger relationships with GMS and the High Intensity Services to ensure that continued specific individual care and medication is identified and provided

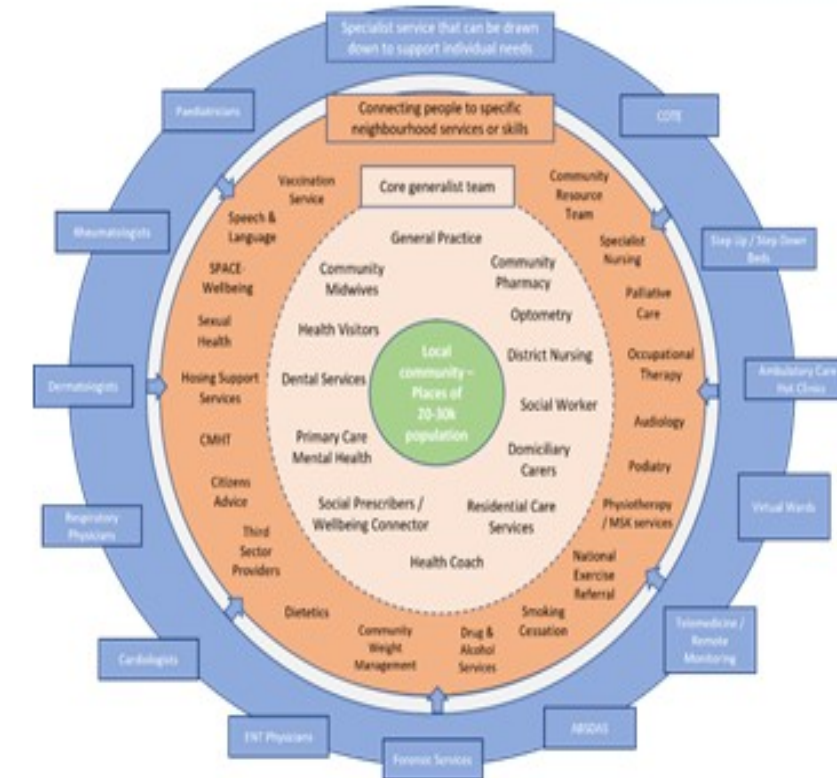


GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Enablers

*Integrated Neighbourhood Teams
Skilled & confident workforce
Compassionate and inclusive culture
Balancing rights & responsibilities
ethos
Fit for purpose facilities & premises
Digital technology*



How will we know if we have made a difference?

Improved Patient Outcomes

Stronger Community Partnerships

Increased Access to Services



Torfaen NCN Plan 2026-29



Torfaen NCN IMTP 2026-2029

The last 2 to 3 years have been a period of change across Wales as we transition from the well-established Neighbourhood Care Network (NCNs) Clusters, to implementing the Welsh Government's: Accelerated Cluster Development (ACD) programme. Historically, NCNs have been required to develop annual plans that reflect local issues across our communities and assessed against a range of evidence including for example, Population Needs Assessments. This plan is shaped by contributions from colleagues in health, social care and the Third Sector and is underpinned by the values of the Gwent Regional Partnership Board, placing people at the heart of everything we do as collaborative clusters, serving Torfaen.

Background Information:

Torfaen is currently established around 2 Neighbourhood Care Networks (NCNs), North and South, which work collaboratively to strive to improve primary care and community services within the local area. Previous priorities for 25/26 included:

1. Sustainability of services across the NCN
2. Accelerated Cluster Development – Professional Collaboratives and Multidisciplinary Working
3. Building Resilient Communities

Demand for healthcare continues to escalate in proportion to population growth. We have an ageing population, with patients living longer with more complex needs, further intensifying the challenges faced by the NHS and partners. Torfaen's aim is to provide a more integrated system of primary care with place-based care in community and wellbeing services; offering co-ordinated care, closer to home with collaboration of professional skills across multi-disciplinary teams (MDT). Torfaen has increased collaborative working across the NCN and Integrated Service Partnership Board (ISPB) aiming to strengthen community resilience, respond to population need, and deliver patient-centred care through its three key Care Closer to Home workstreams:

- Prevention, Wellbeing and Self-care
- Access and Sustainability
- Integrated Primary and Community Care

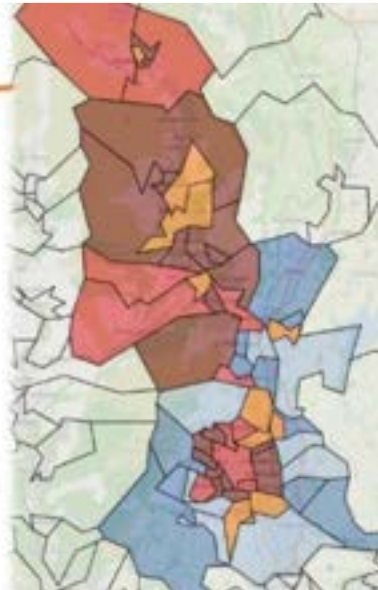
Understanding Torfaen: Population health and wellbeing analysis.

Torfaen's population of 98,300 faces significant health and wellbeing challenges. Over 30% of these residents live in areas with high levels of deprivation, while another 20% live in the second most deprived areas. High deprivation levels in Torfaen bring significant challenges. These areas often have poorer health, lower education levels, and fewer community and public resources. The main issues linked to deprivation in Torfaen are unemployment, poor housing, and low income. Addressing these problems is key to improving the health and wellbeing of our community.

Torfaen NCN IMTP 2026-2029

Understanding Torfaen

Over 30% of the Torfaen population live in an area of high deprivation.



Torfaen Life Expectancy

■ Males ■ Females

78.1 years
for Men

81.3 years
for Women

Life expectancy: The gap in years at birth between the most and least deprived people living in Gwent by local authority



Healthy life expectancy: The gap in years at birth between the most and least deprived people living in Gwent by local authority



Over the next 20 years Torfaen's 65 and over population is projected to increase 22%.

18 in 100 people have at least one chronic condition (Cwmbran)

The number of residents aged over 65 in Torfaen is growing. This shift means we will likely see more chronic illnesses and a greater need for social care and community support. It's crucial that our community are prepared to handle these changes to ensure our older population stays healthy and well-supported.

Torfaen NCN IMTP 2026-2029

Primary care data used as part of the WIMD in 2019 showed a recorded prevalence of chronic disease of 18% and a recorded prevalence of mental health conditions of 30% specifically in Cwmbran. Excessive drinking is a major health concern. In 2017/2018, 1,824 Torfaen residents per 100,000 were hospitalised for alcohol-related incidents. 78% of working-age adults in Torfaen are at an unhealthy weight. Torfaen has the highest percentage of loneliness among the five Local Authorities, with 20% of residents feeling lonely. This is 7.1% above the Welsh national average. We know that prolonged loneliness can lead to significant mental health problems, and physical effects such as a weakened immune system and increased inflammation in the body.

Data shows 49% of Torfaen's economically inactive population are inactive due to long terms sickness. This equates to 5,800 adults at the end of 2023. This is higher than the Welsh and British rates and has increased since 2014. This will present challenges to many households. These factors collectively strain our community resources and highlight the need for comprehensive, multi-faceted health and wellbeing strategies.

According to the Gwent Joint Strategic Assessment, men in Torfaen have the lowest median earnings in the region at £30,175. In contrast, women in Torfaen have the highest median earnings among women in Gwent, at £30,992.

Torfaen faces a complex mix of health and wellbeing challenges due to deprivation, an aging population, lifestyle factors, and social determinants. By addressing these issues through integrated services, community engagement, and initiatives, we can build a healthier, more resilient and vibrant community.

Information Provided by PHW Cluster Dashboard

Strategic Partners:

Strategic Context:

Torfaen's strategic direction is aligned with the RPB's Start Well, Live Well, Stay Well framework, ensuring that services are designed to support individuals across the life course. The NCNs aim to deliver place-based care, with a strong emphasis on prevention, early intervention, and co-production, ensuring services are responsive to local needs and delivered by a skilled, integrated workforce.

Workstreams are managed and taken forward via NCN three-year plans that feed into the Integrated Services Partnership Board plans (ISPB) and into the Regional (RPB). This alignment ensures that NCN annual plans reflect both regional needs assessments and strategic priorities.

Regional Partnership Board (RPB)

- **Start Well;** Improving outcomes for children and families, working together to start well.
- **Live Well;** People at the heart of everything we do, working together to live well.
- **Stay Well;** Ensuring the right help is available at the right time, working together to stay well

Torfaen Integrated Services Partnership Board (ISPB)

Following the federation of Blaenau Gwent and Torfaen Councils, there is now a single Integrated Services Partnership Board (ISPB) serving both Blaenau Gwent and Torfaen. The ISPB comprises representatives from all parts of the health and care system. In Blaenau Gwent and Torfaen, it represents 8 distinct "places": 4 in Torfaen and 4 in Blaenau Gwent. While these localities share the same board, each set of NCNs will maintain their own distinct identity to reflect the priorities and needs of their own places.

Throughout 2025, the Blaenau Gwent and Torfaen (BGT) ISPB is preparing for the introduction of Place-Based Care (PBC), having been selected as the pilot localities for the new PBC operating model. The PBC operating model has to be more than a shuffling of the existing resources. It has to be more than additional 'partnership' meetings. And it has to be more than a growth in local services. It is a call to arms to do things differently. To think about data and insight differently; to plan services differently; to take decisions differently; and to direct investment differently.

Torfaen ISPB has rapidly matured through excellent engagement and collaboration. It facilitates a whole-system approach to improving health and wellbeing, integrating Health, Local Authority and Third Sector services thereby providing the best possible services to our residents. Torfaen ISPB has a shared objective, aligning to the Marmot Principles, and delivering against national and local strategic drivers through:



Torfaen NCN IMTP 2026-2029

- Placed based care: Strengthening services with a key focus on prevention and early intervention, based on an evidence base and tailored to needs of residents, through a place-based approach
- Co-production: Designing and delivering effective, efficient services in partnership with residents and stakeholders
- Workforce quality: Ensuring Services are delivered by a capable, integrated workforce

ISPB objectives:		ISPB priorities:
• Deliver local implementation of RPB priorities • Coordinate available resources to meet population needs • Provide strategic direction • Support partnership working • Ensure plans reflect population health intelligence	← Solutions, Improvement, Change → ← Intelligence for priorities & decision making →	• Third Sector as full partner • Integrated workforce for the future • Place Based Working • Redesigning services for older people • Ensure fit for purpose estate • Enhanced Financial scrutiny

Current services need to evolve to be able to sustain and improve. There is a necessity to change historical ways and patterns of working that no longer meet the needs of today's society and the needs of the future population, notwithstanding the changes to our service delivery and communication brought about by the covid pandemic. Torfaen NCNs are committed to evolving service delivery to meet current and future needs. This includes:

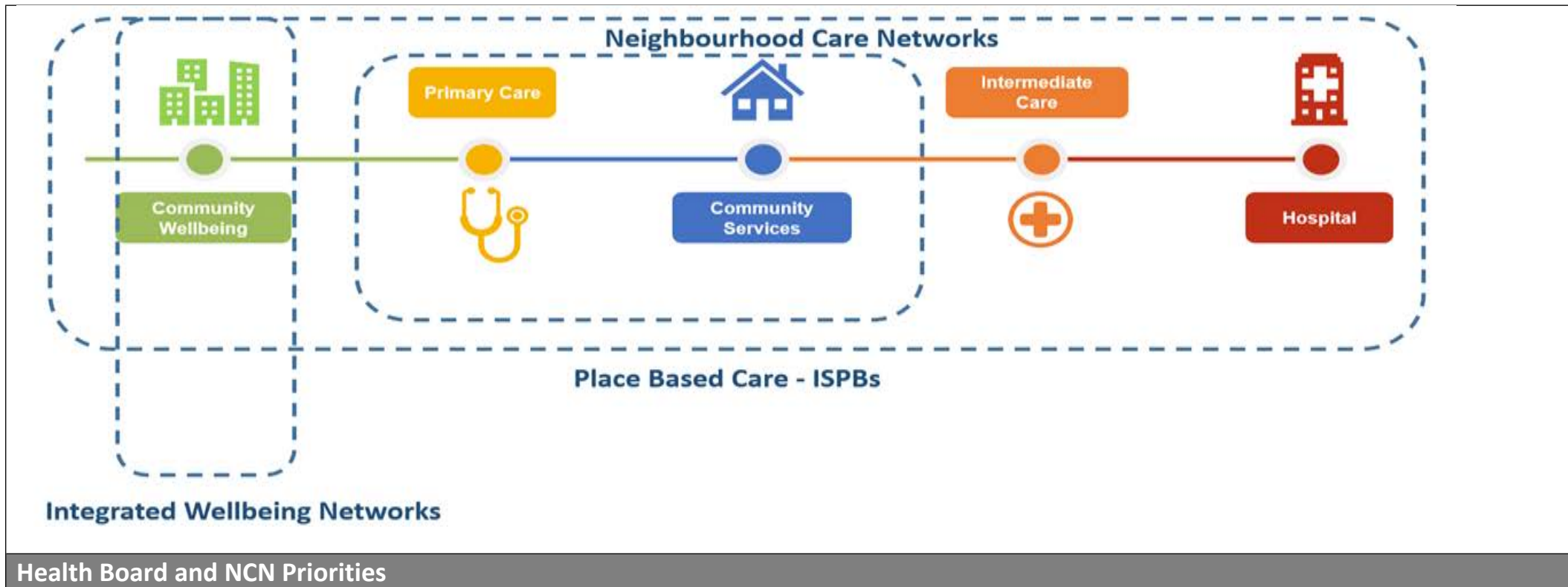
- Adapting to the growing demand for health and social care, we have an aging population, with patients living longer and with more complex needs, which intensifies the challenges faced by all sectors.
- Ensuring sustainability across all sectors in the short, medium, and longer term.
- Tackling health inequalities linked to socio-economic deprivation; closing gaps in life expectancy and healthy life expectancy
- Responding to demographic changes, including asylum seekers and refugee populations.
- Modernising the estate to support integrated, accessible services.

By embedding the strategic priorities of the ISPB and RPB into NCN planning, Torfaen is building a resilient, inclusive, and person-centered system of care that reflects the values of collaboration, prevention, and equity.

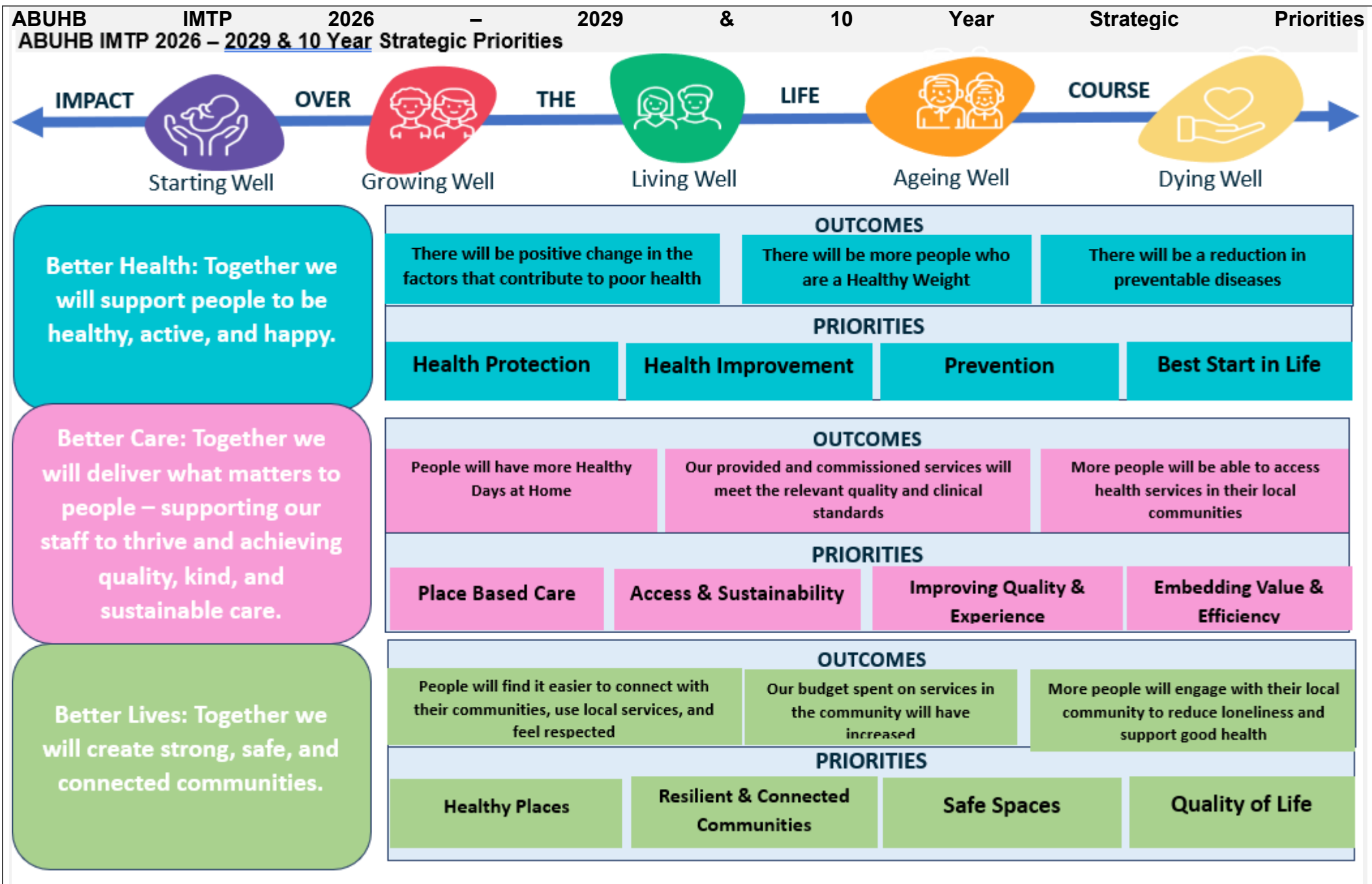
Collaborative (NCN) Clusters:

Neighbourhood Care Networks (NCNs) bring together local services across health, social care, and the Third Sector (including TVA) to plan and deliver tailored solutions that meet the needs of Torfaen residents at both individual and community levels. As a key component of the Integrated Strategic Partnership Board (ISPB), NCNs enable needs-based service delivery and help address health inequalities. The Integrated Wellbeing Network (IWN), closely linked to the ISPB, NCNs, and TVA, strengthens a community and place-based approach by gathering local intelligence, as reflected in this plan.

Torfaen NCN IMTP 2026-2029



Torfaen NCN IMTP 2026-2029



Torfaen NCN IMTP 2026-2029

2025/26 Agreed NCN Priorities

The Health Board agreed NCN priorities for the 2025/2026 annual plan and an agreement has been reached that these priorities will continue throughout the 2026 – 2029 IMTP NCN planning cycle.

Priority 1	To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care
Priority 2	To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a 'social prescribing' model that connects people to activities, groups and services in their community addressing practical, social and emotional needs
Priority 3	To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations
Priority 4	To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs
Priority 5	Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees

Progress Made Against Agreed NCN Priorities within 2025/2026

Over the next three years, all NCNs across ABUHB have committed to the NCN strategic priorities that will shape their delivery focus. These priorities are fully integrated within the place-based care model, positioning NCNs as the central mechanism for delivering care that is locally responsive, well-coordinated across services, and closer to home.

Torfaen NCN IMTP 2026-2029

Priority 1	Progress to date: - Recruiting a Service Development Lead into the vacant post in Torfaen. This is an important first step in re-establishing the programme in the borough. - Focus on embedding the new lead into the borough and building effective working relationships with our partners. The new lead has spent time meeting with partner organisations to scope out the current landscape in the community and share our strategic vision. - These include regular discussions with partners across ABUHB, Torfaen Borough Council, community groups and TVA. - Torfaen NCN and the IWN continue to work collaboratively as part of a whole system approach to deliver on the 'A Healthier Wales's Strategy. - We have raised local awareness of community assets and 'community hubs' where people can access practical support. - Mapping work undertaken on link worker roles to avoid duplication - Behavioural Change Practitioners have been incorporated into the IWN team and aligned to the borough ensuring dedicated BCP's are able to build relations with key partners which allows them to effectively signpost and support those most at need. - BCP's are undertaking work with GP practices to help support vulnerable patients this winter. This involves proactively contacting patients with respiratory conditions to offer support such as the Help me Quit programme, vaccinations and warm homes advice.
Priority 2	Progress to date: - Early identification of opportunities for collaborative working with partners which has seen project plans being implemented, funding bids being agreed and plans being progressed into the next quarter. - Work is underway with local authority partners to provide practices in Torfaen with easy-to-use information on community wellbeing activities in the locality of each practice. - A project has been initiated to review the opening doors model across Torfaen to align it to the place-based care model and to classify hubs in line with the Welsh Government's community hub model. - Care Navigation – Practices refer to the NCN developed Care Navigation Padlet to signpost patients to community services - NCN funded Community Connectors engage people in conversations about what matters to them and provide information to signpost them to services, groups and activities, using local knowledge or directories. - Collaboration established with Public Health Team and ISPB partners to develop a Torfaen social prescribing model
Priority 3	Progress to date: - High Impact Individuals Multi-Disciplinary Team (MDT) is actively addressing the needs of complex and repeat individuals. Additional MDT models are under development via ISPBs. - Current MDT working being scoped with GP Practice to provide baseline from which to develop and share good practice. - Prospective PBC model and implementation plan is in development - Engaged with local authority to establish a single point of access 'Torfaen Connect' - Psychological Health Practitioners (PHP's) link people with health and social needs with third sector and community groups - Compassionate Future Care Planning provided in Primary Care through strong partnership working with CATCH, Palliative Care and St David's Hospice

Torfaen NCN IMTP 2026-2029

Priority 4	Progress to date: • Offer of support from the Value Based Healthcare Team generated practice engagement at the Torfaen GMS Collaborative meeting on 13th November to improve uptake of ACR screening and foot checks for patients with T2DM. • Regular practice discussions demonstrate progress towards the GMS QI project on CVD prevention and delivery of the Hypertension Case Finding Local Enhanced Service Torfaen Place Based Care plans include a Health Coach that will provide behaviour change interventions for: • Patients in a pre-diabetic range i.e. the AWDPP intervention • Patients with a new diagnosis of hypertension • Patients on a hypertension register identified at high risk through the GMS QI project on CVD prevention Cardiovascular disease (CVD) prevention in people with high blood pressure GOV.WALES Discussions held at Torfaen GMS Collaborative meeting, November 2025 to promote the All-Wales Diabetes Prevention Programme (AWDPP), led by Public Health Wales and funded via Welsh Government was introduced to primary care networks in 2022. The programme offers targeted support to people who are at an increased risk of type 2 diabetes, with the aim of preventing them from developing this condition. The programme sees dedicated, trained healthcare support workers, with oversight from dietitians, deliver a brief intervention to people who have had a blood test that shows that they are at an increased risk of type 2 diabetes. Aligned with the GMS Healthy Behaviours QI project, National Exercise Referral Service (NERS) presented in April 2025 NCN meeting to increase collaborative working with the NCN and partners. Through several NERS pathways that offer support to diabetes and cardiovascular disease, Torfaen health professionals improve patient access to: - Chronic condition prevention and management - 16-week pathway that includes Musculo Skeletal issues, mental health, weight management / diabetes, mild respiratory condition, referral from Rehabilitation. - Weekly Cardiac rehab circuit and Neuro@NERS Rehab gym sessions at Cwmbran Stadium - Behaviour change to embed positive physical activity habits, improving health and wellbeing
Priority 5	Progress to date: In alignment with national priorities and the principles of prudent healthcare, specifically to enhance the delivery and uptake of enhanced services targeted at vulnerable population groups. This includes collaborative service development initiatives focused on improving access, equity, and outcomes for individuals with complex needs, including those experiencing homelessness, substance misuse, or mental health challenges. Through strengthened cluster working, data-informed planning, and co-production with service users and third sector partners, we aim to reduce unwarranted variation and ensure that enhanced services are responsive, inclusive, and sustainable. Ongoing support and training for primary care teams, alongside robust monitoring and evaluation frameworks, will

Torfaen NCN IMTP 2026-2029

underpin continuous improvement and ensure alignment with the Welsh Government's strategic objectives for population health, care quality and well-being.

To address this and drive improvement, we are working collaboratively within the NCN to implement targeted actions. These include engaging in structured discussions with practices to identify barriers and opportunities, securing appropriate funding to support initiatives, and strengthening community engagement through clear and consistent communication strategies. Collectively, these measures aim to enhance participation and ensure progress against the stated priority.

Progress to date:

- Held year on year discussions with relevant practices to provide Care Home DES, also aligning patients and practices to agreed care homes.
- Ongoing discussions with contracting team to provide an ABUHB wide care home DES with the funding via GMS budget
- "Vulnerable Groups" discussion with practices at NCN to improve access for homeless, asylum seekers, refugees, including presentations from PPV (post payment verification) to answer concerns with uncertainty around specifications for claiming.
- Gender Identity ES discussions at NCN to improve uptake, i.e. inter practice referrals
- Regular monitoring and discussions with practices around flu uptake, sharing good practice.

The current uptake figures for the supplementary services are outlined in the attached appendix. [Appendix..docx](#)

Additional Priorities

- To deliver against priorities detailed with this year's action plan.
- To monitor Collaborative Cluster progress against the ACD Toolkit and annual self-reflection (maturity) process.
- To undertake annual evaluations of all funded schemes to ensure value for money, effectiveness and identify opportunities for reinvestment.
- Continue to address estate issues, agile working, and available accommodation space for both clinical and administration staff.
- Prevention programmes support and promote vaccine uptake
- CATCH positive evaluations to influence movement to core funding and equitable care to residents within care homes across ABUHB

Challenges, risks and barriers to successful delivery of agreed milestones within 2025/2026

- Sustainability, budgets, fixed term roles, Limited funding available inhibits large scale projects
- NCN budget is tied into valuable roles
- NCN funded projects that have been evaluated with successful outcomes are not progressed with core funding, prohibiting further NCN investment in innovation
- Financial pressure within practices, inflation impacting practice and uplifts do not cover rising costs
- Workforce retention and recruitment issues across the NCN
- Aging workforce/retirements pose a threat to future sustainability in the current models
- Issues with the recruitment of particular roles, such as GP Partners, practice nurses and advanced nurse practitioners
- Many practices are dependent upon locums which can be costly, and negotiation of services included is often required
- Dental Access and a practice closure (Dental Nova Cwmbran)
- Stability around NCN structure
- Regular high escalation levels in practice
- Educating patients to access appropriate services

Torfaen NCN IMTP 2026-2029

NCN Planning - 2026/2027

Identified Quarterly Milestones Against Agreed NCN Priorities for 2026/2027

Priority	Defined Delivery Milestones	
Priority 1 To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a 'social prescribing' model that connects people to activities, groups and services in their community addressing practical, social and emotional needs	Q1 Continue of 25/26 progress - IWN team to deliver behaviour change interventions focussed on agreed priorities for local communities including for socially vulnerable or inclusion health groups. - To work with communities to identify local issues and priorities to inform decision making and action by strengthening the skills, resources and abilities of communities, and the individual people within them, to be able to thrive. 2 Behavioural Change Practitioners are now working within Torfaen. A mapping exercise is currently underway to identify areas with the highest levels of smoking prevalence, and we will align the BCP offer to areas of the borough with the highest need. We will identify suitable venues to host clinics with an increased number of clinics for those areas with the highest need.	Q2 Continue in year priorities - IWN lead to provide link between NCN and public health team work on health inclusion groups. - IWN to arrange community engagement events to help highlight community support available within the borough and to gain insight from the community that can inform future interventions - Extend the IWN's place-based approach across community wellbeing, integrated social care and health services. - Embed a culture of active signposting across Torfaen. - To bridge, link and coordinate well-being assets creating stronger, integrated support networks that enhance health, well-being and resilience of individuals and communities. Reduces social isolation and creates a cohesive and socially connected communities. - Explore the use of technology to support delivery of social prescribing and monitor activity and outcomes.
	Q3 Continue in year priorities - Continue ongoing work alongside partner organisations undertaking community hub mapping exercise. This will allow us to identify, connect and mobilise the existing strengths within a community that can be leveraged to enable communities to thrive. - IWN collaboratives to be aligned to the places identified under the placed based care model.	Q4 Continue in year priorities - Use evaluation findings to inform future service design. - Prioritise interventions that address identified population needs. Secure Long-Term Sustainability - Initiate discussions at ISPB level regarding funding options.

Torfaen NCN IMTP 2026-2029

		Place Based Care Implementation Planning • Draft roadmap for service integration into mainstream provision. • Set timelines for phased delivery and resource allocation.
Priority 2 To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations	Q1 Continue of 25/26 progress • Scoping current MDT working within primary care and sharing good practice • High Impact Individuals Multi-Disciplinary Team (MDT) begins to develop a systematic way of identifying patient cohorts with likely complexity either through risk stratification (e.g. Electronic Frailty Index) and/or clinical impression (e.g. frequent attenders in general practice or when people discharge from hospital). • Progress ISPB Place Based Care and MDT model co-design	Q2 Continue in year priorities • Streamline current pathways of care to prepare for effective MDT and primary care referrals • Identify appropriate staffing to support effective data collection
	Q3 Continue in year priorities Key steps: • Map services in each 'place' and identify the practitioners and professionals that can provide proactive care for people with complex need who require personalised and co-ordinated multi-professional support.	Q4 Continue in year priorities • Implement an effective process for providing assurance to ISPB and other stakeholders • Encourage joint planning between GPs, community services, third sector organisations, and local authority teams. • Start to establish pathways into preventative services (e.g. assistive technology, home adaptations, falls prevention clinics) and pathways into urgent response services for patients in crisis or with acute exacerbations.

Torfaen NCN IMTP 2026-2029

Priority 3 To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs	Q1 Continue of 25/26 progress • Encourage increased Torfaen GP practice engagement in Hypertension Case Finding Local Enhanced Service. • Collaborate with Public Health to deliver the Hypertension Case Finding Local Enhanced Service where there is no capacity at GP practice level. • Engage GP practices in a collaborative approach to the Healthy Behaviours QI project and the processes and pathways for systematic referral into local services and programme (e.g., Help Me Quit, National Exercise Referral Scheme, Community Weight Management) • Public Health Behavioural Change Practitioners offer support and interventions to individuals and groups in areas such as smoking cessation, diabetes prevention, cardiovascular disease and healthy weight management.	Q2 Continue in year priorities • Discuss and evaluate Healthy Behaviours QI project • Monitor delivery of All Wales Diabetes Prevention Programme, identifying good practice and addressing any gaps in service • To determine how the NCN Community Pharmacists can support QI projects in the reduction of diabetes and cardiovascular disease.
	Q3 Continue in year priorities • To scope the creation of a Chronic disease Team across the NCN that will specialise in the management of long-term health conditions, such as diabetes, diet, heart disease, and asthma, by providing proactive care, patient education, and collaborative treatment planning within the multidisciplinary place-based care team. The role will conduct annual reviews, manage medication, monitor symptoms, and help patients with lifestyle changes to improve their quality of life and wellbeing.	Q4 Continue in year priorities • Create a 'Health 'Coach' role that will complete patient checks regarding populations at risk and complete a standardised 30-minute intervention session.
Priority 4 Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees	Q1 Continue of 25/26 progress • Map out the current provision of supplementary/enhanced services to fully understand activity levels and gaps in provision. • Discuss increasing equitable access to health inclusion groups including: -Develop culturally sensitive and accessible communication materials to	Q2 Continue in year priorities • Use population health data to identify vulnerable groups (e.g., people experiencing homelessness, asylum seekers, and substance misuse issues). • Align enhanced service specifications with cluster priorities and incentivise uptake through QI frameworks.

Torfaen NCN IMTP 2026-2029

	-Employ link workers or community connectors to build trust and facilitate access -Extend hours or provide walk-in options to accommodate those with unstable living conditions or chaotic lifestyles.	• Monitor uptake and outcomes using robust data systems and share insights to drive improvement. • Involve service users and community representatives in designing and evaluating services. • Ensure feedback mechanisms are in place to adapt services based on lived experience.
	Q3 Continue in year priorities • Assess the level of latent capacity across the existing network of GMS providers and explore the potential for utilising this capacity for inter-practice referrals. • Assess the residual level of unmet need across the GMS collaborative and facilitate discussions about how gaps in provision and unmet need can be addressed. • Work with the Primary Care Contracting Team to quantify the level of investment required to respond to the level of unmet need and gaps in provision e.g. minor surgery. • Identify enhanced service gaps and work with the wider NCN, ISPB and secondary care directorates to engage specialist services, local authority and third sector organisations (e.g. substance misuse, sexual health, community dental, optometry, BBV, housing and homelessness services) to build wrap-around support and an MDT approach for practices delivering the enhanced services for substance misuse, homelessness and asylum seekers and refugees.	Q4 Continue in year priorities • Prepare a proposal for the Enhanced Services Operational Group on the plan for investment in each GMS collaborative to improve equity of access.

Enablers required to deliver 2026/2027 quarterly milestones

- Permanent IWN/Sim Role for stability and continued progress
- Developing strong relationships with various stakeholders, i.e. ISPB and TVA
- Additional funding streams from TVA for COPD pilot project
- Extended funding opportunities via local authority
- Access to appropriate data streams, i.e. WIS,
- Increased maturity of the ISPB
- Core funding for NCN funded projects, i.e. CATCH

Torfaen NCN IMTP 2026-2029

- Technology
- Professional Collaboratives working effectively together and continue to develop.
- Whilst the collaboratives are still in their infancy, they have successfully been able to utilise Population Needs Assessment data to identify service gaps and have subsequently undertaken improvement projects.
- Highly valued services in Torfaen NCNs
- Positive feedback from patients, practices, care homes, and district nursing
- Permanent Roles have been secured
- Staff completing further education, which enables them to perform more advanced clinical assessments and interventions, to release GP time
- Increased partnership working through ISPB
- Integrated working
- Engagement from key stakeholders
- Strong representation

Challenges, risks and barriers to successful delivery of agreed milestones within 2026/2027

- Sustainability, budgets, fixed term roles, Limited funding available inhibits large scale projects
- NCN budget is tied into valuable roles
- NCN funded projects that have been evaluated with successful outcomes are not progressed with core funding, prohibiting further NCN investment in innovation
- Financial pressure within practices, inflation impacting practice and uplifts do not cover rising costs
- Workforce retention and recruitment issues across the NCN
- Aging workforce/retirements pose a threat to future sustainability in the current models
- Issues with the recruitment of roles, such as GP Partners, practice nurses and advanced nurse practitioners
- Many practices are dependent upon locums which can be costly, and negotiation of services included is often required
- Dental Access and a practice closure (Dental Nova Cwmbran)
- Stability around NCN structure
- Regular high escalation levels in practice
- Educating patients to access appropriate services

Torfaen NCN IMTP 2026-2029

Finance Profile 2026/2027

The Health Board are required to deliver a breakeven financial plan for the 2026 – 2029 IMTP, please outline your breakeven Financial Profile for 2026/2027

North Spend Plan Summary	2025/26	2026/27		South Spend Plan Summary	2025-26	2026-27
Annual Budget	£ 337,402.00	£ 337,402.00		Annual Budget	£ 293,912.00	£ 293,912.00
Top Slice: Advisers, Phlebotomy, Dementia Roadmap	£ 12,320.40	£ 12,678.76		Top Slice: Advisers, Phlebotomy, Dementia Roadmap	£ 10,791.70	£ 11,104.20
Practice Based Pharmacists	£ 73,467.57	£ 75,667.57		Practice Based Pharmacists	£ -	
Community Connectors	£ 65,448.00	£ 65,448.00		Community Connectors	£ 65,448.00	£ 65,448.00
CATCH	£ 114,680.05	£ 119,299.82		CATCH	£ 127,731.69	£ 131,556.88
PWPs	£ 65,351.47	£ 67,312.01		PWPs	£ 74,231.67	£ 74,451.33
App Levy	£ 1,009.42	£ 1,039.70		Pay award	£ 3,135.29	£ 627.06
Pay award	£ 4,114.42	£ -		App levy	£ 168.90	£ 173.97
Drop TL lewis accrual	£ -			Jayex	£ 1,439.87	
Med Equipment	£ -	£ -		HHI	£ 18,996.20	£ 19,996.00
HHI	£ -	£ -			£ -	£ -
Telephone Triage		£ -		IT equipment	£ -	£ -
Flu	£ -			Flu	£ -	£ -
Staff training	£ -			TM Lewis accrual dropped	-£ 1,560.00	
Laptop / IT / mysurgery	£ 8.00					
Total Expenditure	£ 336,399.34	£ 341,445.87		Total Expenditure	£ 300,383.32	£ 303,357.43
Uncommitted Expenditure	£ 1,002.66	-£ 4,043.87		Uncommitted Expenditure	-£ 6,471.32	-£ 9,445.43
Check	£ -	£ -		Check	£ -	£ 627.06

Workforce Profile 2026/2027

Please outline your workforce profile for 2026/2027

Torfaen NCN IMTP 2026-2029

There have been various challenges with the NCN budgets, we have had to absorb the annual NHS Wales pay awards for staff and therefore a few difficult commissioning decisions needed to be taken by the NCN Lead. In 2026/27 we are anticipating (at the time of writing), a small overspend. However, due to the fluidity of NCN budgets in respect of in-year slippage, especially from planned and unplanned absence, that we expect to be in a breakeven position on 31st March 2026. The monthly finance review of our budget will ensure increased governance and scrutiny.

Service	Brief Description	Risks, Challenges, Barriers
Placed Based Care – See below additional workforce	To provide health and social care support within the community and addressing local need. The goal is to keep people healthy and at home by offering services closer to where they live, supported by multi-agency teams that connect community members and local services.	• Estate • Staffing • Resource • Permanent contracts
Practice Based Pharmacists	Support practices with a pharmacist to alleviate pressures and increase medication reviews	• Uplift Costs
Psychological Health Practitioners	Reduce demand on GP appointments for low level psychological health concerns. Intervention provided to prevent crisis mode occurring.	• Staff Retention • Access/Care Closer to Home • Consistent Staff/Relationships • Uplift Costs
CATCH	Provide support for GP practices, with home visits for patients who are residents in nursing and residential care homes	• Core Funding • Staff Retention • Enhanced Service Coverage • Sickness
Community Connectors	Work with groups, activities, organisations and other stakeholders in the community to support, promote, collaborate and ensure community resilience.	• Uplifts in staff costs
District Nursing Team	Core community nursing services aligned with individual locality GP Practices	• Staff Retention • Rising and changing patient acuity • Mature workforce – partial retirements • Flexible working & succession planning • Lack of digital efficiency • Roll out of training programmes inhibited by staffing

Place Based Care Additional Workforce Profile

- We are in the early stages of mapping our workforce requirements for Place Based Care and this will be our priority in the forthcoming ISPB meetings

NCN Planning 2027/2028 – 2028/2029

Torfaen NCN IMTP 2026-2029

Proposed Milestone for Agreed Priorities for 2027/2028 and 2028/2029		
Priority	2027/2028	2028/2029
Priority 1 To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a 'social prescribing' model that connects people to activities, groups and services in their community addressing practical, social and emotional needs	- Continue to utilise the IWN Collaboratives and its network of community partners and stakeholders to deepen the links between primary care and the community through an effective ABCD approach to identify local needs and strengths. - Establish IWN Collaborative sub/action groups to drive forward specific agendas and programmes in the areas e.g. ASB, community health events, Over 50's, social prescribing. - Strengthen the relationships between IWN/ NCN and the socially vulnerable groups by building on existing networks. - Facilitate relationships and networks between Primary Care MDT Teams and key stakeholders such as the local authority and anchor organisations. - Develop and formalise a Collaborative action plan to represent IWN/ NCN priorities, projects and actions identified to meet community need. - Strengthen the process of sharing and receiving information with the Collaboratives, NCN and wider partners. - Utilise local intelligence data and community insights to provide a place-based approach to service delivery and community support. - Explore the creation of a joint social prescribing framework, utilising leading sector specific software through a partnership approach between NCN, IWN, local authority partners and the community. - Manage the implementation and promotion of the social prescribing framework, through a coordinated communication plan.	Develop and establish Collaboratives in each of the 4 'places' identified under the place-based care model in Torfaen. - Extend the IWN's place-based approach across community wellbeing, integrated social care and health services through enhanced links with the MDT's once established in Torfaen. - Continue effective partnership working with NCN networks, identifying gaps in provision and utilising NCN data to direct workstreams. Expansion Strategy for Place-Based Care Q1, Q2, Q3, Q4 - Finalise and commence implementation of the expansion plan informed by 2027/28 evaluation findings. - Scale up interventions that meet priority population needs across all four place-based areas. - Track performance metrics for expanded services. Long-Term Sustainability Q1, Q2, Q3, Q4

Torfaen NCN IMTP 2026-2029

		- Continue with the development of the Connect Torfaen website and the Wellbeing friends Facebook page, hand in hand with community hub development and asset mapping. Build capacity across IWN and NCN staff to develop and update partner organisations and the community using our online and social media presence. - Continue the development of 'hubs' in collaboration with the local authority and TVA, ensuring these assets can connect people with health and wellbeing resources, activities and other people to support their own wellbeing. Expansion Strategy for Place-Based Care Q1, Q2, Q3, Q4 - Finalise and begin implementing the expansion plan informed by evaluation findings. - Scale up interventions that address priority population needs across all four place-based areas. - Establish performance metrics for expanded services. Long-Term Sustainability Q1, Q2, Q3, Q4	
Priority 2	To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations	- Set local strategy and operating model - Design and monitor an outcomes framework - Establish MDT working in each of the 4 places established in the PBC model - Cross reference the patient cohorts with the register of high-risk patients (i.e. 0.5% cohort) identified by the GP practice delivering the High-risk cohort supplementary service.	Strengthen Collaborative Working Across the NCN - Facilitate regular multi-disciplinary meetings to share best practices and coordinate care. - Encourage joint planning between GPs, community services, third sector organisations, and local authority teams. - Embedding reliable teams that can work towards one strategy, one

Torfaen NCN IMTP 2026-2029

		• Employ/identify clinical leads and place-based care coordinators and a hub for patients identified through local intelligence functions or referred by local professionals. • Provide backfill or financial support to release GPs to participate in MDT meetings or align MDT meetings to GP practice undertaking enhanced care reviews and ongoing monitoring through the High-risk cohort supplementary service.	operating model and one culture for all decisions relating to the wellbeing system • Develop a shared care record across health and social care for the proactive care and MDT support for the identified cohort.
Priority 3	To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs	• Shared learning and best practice across NCN through QI meetings. • Evaluation of CVD/Diabetes/Hypertension/CKD intervention outcomes to date. • Health Coaches support the management of behavioural risk factors eg smoking cessation, vaccination uptake and healthy home initiatives. • Provide targeted clinical reviews and optimise prescribing for high-risk patients. • Cardiovascular Risk QI key learning and service improvements are shared and embedded in GP practice. • Explore joint working with Torfaen collaboratives (GMS, Optometry, Pharmacy, Nursing and Allied Health Professionals) to enhance this work, identify opportunities and widen the scope of patient care. • Hypertension Case Finding and Community Engagement promotes healthy behaviours and early detection by delivering screening in community settings such as libraries, community hubs and workplaces. • Collaboration with IWN and Public Health to widen the reach into the community. • Continued NCN participation in the Diabetes Prevention Programme.	• Shared learning and best practice across NCN through QI meetings. • Evaluation of CVD/Diabetes/Hypertension/CKD intervention outcomes to date. • Collaborate with community partners and Health Coaches to deliver behaviour change coaching in a community setting. • Continued targeted clinical reviews and optimise prescribing for high-risk patients. • Cardiovascular Risk Reduction QI - Continue to support practices to review and optimise treatment for patients on hypertension registers. • Continue to facilitate peer learning and service improvements across practices and professional collaboratives. • Hypertension Case Finding - Monitor and evaluate impact of enhanced service for targeted screening in practices and in partnership with Public Health and IWN. • Continue to deliver community-based screening opportunities.

Torfaen NCN IMTP 2026-2029

		• Use data to identify at-risk patients and develop invitation plans for structured education and lifestyle programmes. • Review outcomes and adjust interventions to reduce progression from pre-diabetes. • Chronic Kidney Disease (CKD) QI – Practices have CKD risk profiling embedded as routine. Monitor the impact of practice to date.	• Continued NCN participation in the Diabetes Prevention Programme. • Use data to identify at-risk patients and develop invitation plans for structured education and lifestyle programmes. • Chronic Kidney Disease (CKD) QI –Continue to provide CKD risk profiling and monitor impact
Priority 4	Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees	• Provide training for primary care teams on trauma-informed care, safeguarding, and working with marginalised populations. • Review of the CATCH Care Home DES model to be discussed in conjunction with the NCN MDT working model.	• Offer enhanced services in community settings or through mobile clinics.

Title	New or Existing project	Brief Description	Results/Benefits expected by end Mar 2027	Strategic alignment against ABUHB and NCN Priorities	Areas of Focus				Budget	Funding Source NCN Funding	Current Status	Comments	NCN Delivery Action Plan Please List activities or projects planned to commence during 2026/2027, as well as those ongoing from 2025/2026
					1	2	3	4					
Health Protection Services/ Building Community Resilience	Existing	Development of Health Prevention services in collaboration with the third sector, IWN and IAA, identifying social networks to help address the wider determinants of health	Flu programme will- Work in partnership with Local Education Authority Leads to jointly promote the importance uptake with parents and careers Programme to deliver vaccinations to all eligible cohort.	Prevention & Wellbeing Communication and Engagement Transformation and Vision for cluster	1			4			Ongoing GP cluster commitment to continue to 2024/25		Key: Alignment to NCN Agreed Priorities 2025-2027 1. To align the work of NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population particularly for socially vulnerable or marginalised groups. To support the development of Place Based Care 2. To ensure NCNs have good understanding of Integrated Wellbeing Networks (IWN) in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks. Coproduction of a ‘social prescribing’ model that connects people to activities, groups and services in their community addressing practical, social and emotional needs 3. To establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations 4. To facilitate a collaborative approach in the delivery of diabetes prevention and CVD risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs 5. Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees.
Health Protection Services	Existing	Dental - Development of Health Prevention services in collaboration with the third sector, IWN and IAA, identifying social networks to help address the wider determinants of health.	The NCN will liaise with ABUHB Community Dental Service and Dental collaborative, through our fully established Children and Young Adult Task and Finish Group, to explore opportunities of promoting the importance of Oral Hygiene and visiting the dentist.	Healthier Wales Population Health	1								
Building Community Resilience Population Health	New	Marmot Region	NCNs will support the Marmot Review which sets out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies.	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing	1	2	3						
Care Closer to Home/Pathway re-design	Existing	Future service model for the development of sustainable Placed Based primary care services across both clusters	The NCN is undertaking work to profile timetables to enable Care Closer to Home in terms of delivering services for all our citizens and sustainable placed based care:	Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing Communication and Engagement Transformation and Vision for clusters				4					
Pathway Optimisation	Existing	The ongoing sustainability of all health and social care services on an operational footing level is paramount,	To support the NCN will undertake a mapping of services – both clinical and non-clinical to ensure that people with the right skills and experience work in an environment that is fit for purpose. Keeping a key focus on local population need and will include Immunisation and Vaccination, GMS sustainability and access, Psychological Wellbeing, Diabetes Prevention, CVD risk factor	Supporting Social Care/Health Workforce Healthier Wales Working alongside Social Care Population Health		2		4		NCN Funding			

Torfaen NCN IMTP 2026-2029

			management, Obesity Pathway, Oral Health, Advanced Paramedic for home visiting/CRT/Care Home and FCP.	Prevention & Wellbeing Transformation and Vision for clusters Communication and Engagement								
Health Protection Services	New	Supporting the needs of the local population with the cost-of-living crisis	Work in partnership with IWN to use local intelligence of where funding should be directed to support with the cost-of-living crisis.	Supporting Social Care/Health Workforce Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Communication and Engagement	1							
Accelerated Cluster Development	Existing	prioritise the establishment of Pan Cluster Groups	Continue to develop the ISPB priority actions with our partnership board landscape. To develop and strengthen the relationship with the Gwent Regional Partnership Board							WG Funding		
Health Protection Services	Existing	Diabetes Prevention Programme	Participation in the Diabetes Prevention Programme across both clusters for pre diabetic patients to be offered a brief intervention which includes lifestyle advice with the hope of reducing their HBA1c over the longer term to reduce or prevent the progression of diabetes	Population Health Healthier Wales Prevention & Wellbeing			3			NCN Funding		
Accelerated Cluster Development	Existing	Utilise NCN funding to innovate and test concepts relevant to our population needs which improve outcomes for all our residents.	To utilise NCN funding to innovate and test concepts which are relevant to our population needs and able to improve outcomes for all our residents, these include, SEM Scanners, assisted technology, locality based FCP programmes, reducing the impact of on the day demand. Developing exit strategies to enable proven concepts such as Psychological Wellbeing Practitioners and Practice Based Pharmacists to be core funded.	Prevention & Wellbeing Communication and Engagement Transformation and Vision for clusters Workforce & Organisational Development							Ongoing GP Cluster Commitment to continue to 25/26	
Health Protection Services	New	Seek to develop services that are high quality and equitably across the Borough for supplementary/enhanced services with an initial focus on IUD, minor surgery, substance misuse, homelessness and asylum seeker and refugees.	We will look to map our services to identify where the gaps are and work more collaboratively between our GMS partners to deliver services that are more equitable and, on a population, needs basis	Healthier Wales Population Health Prevention & Wellbeing				4				
Accelerated Cluster Development	Existing	Widening stakeholder attendance at NCN	Widening stakeholder attendance across our NCN to ensure full collaboration to meet population needs and maintain local voice. We will seek to implements our place based care strategy of a Happy Healthy Blaenau Gwent by creating a sustainable system of change through the integration of health and social care services, raising awareness of the benefits and opportunities for improving population outcomes through collaboration, strengthening partnership arrangements with the third sector and health colleagues such as the local authority, WAST, Direct care and other key partners to meet the specific health and wellbeing needs of our communities	Healthier Wales Working alongside Social Care Population Health NHS Recovery Supporting Social Care/Health Workforce Prevention & Wellbeing Transformation and Vision for clusters	1	2		4				

Torfaen NCN IMTP 2026-2029

				Workforce & Organisational Development								
Training and Education	Existing	Continue to support with training programmes for primary care settings	Continue to progress student support for university entry, as well as support the primary care academies with their onward programme and in turn support services with the academy placements of clinical roles within primary care settings. Continue with NCN Nurse model to support practices with nursing skills i.e., shingles, childhood immunisations, chronic disease management, wound care. Explore NCN nurse facilitator role to train and upskill general practice nurses this will include supporting the training and development of academy nurses and making the academy attractive to practices within the Blaenau Gwent area.	NHS Recovery Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development								
Building Community Resistance Population Health Health Protection Services Pathway Optimisation Care Closer to Home/Pathway re-design Estates Mapping Accelerated Cluster Development	Existing	Happy Healthy Blaenau Gwent - establish a whole system approach to deliver place-based care where people can access a range of seamless care and support at or close to home, based on their unique needs and what matters to them	The NCN in partnership with our all our IWN partners will build community resilience through connections to increase social prescribing and community development in collaboration with the third sector. Align the work of the NCN and IWN to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups	Healthier Wales Population Health Transformation and Vision for clusters Prevention and Wellbeing Communication and Engagement Mental Health and Emotional Wellbeing	1	2		4				
Redesigning Community Services for Older People	Existing	Explore opportunities to deliver a sustainable community resource model.	Explore opportunities to deliver complex care closer to home through a sustainable community resource model which encompasses hospital @ home/step closer to home pathways , helping our residents to have their health and social care needs met as close to home as possible in a seamless and integrated way through models of care which reduce admission and long term care dependence, utilising a varied clinical skillset able to meet the demands of changing service needs and deliver on the D2RA pathways to provide preventative care and where needed a rapid response to prevent admission or, where admission is needed, the CRT Tyleri model will be available to provide a short clinical interventions prior to supporting individuals to be discharged to recover at home as quickly and safely as possible.									
Redesigning Community Services for Older People Reablement Hospital Liaison OT	Existing	Building on D2RA Project	Blaenau Gwent ISPB to align with the strategic priorities of the Health Board, Local authority and A Healthier Wales's vision of a whole system approach to health and social care, focussed on health and well-being and on preventing illness with access to a wide range of seamless community-based services.	NHS Recovery Supporting Social Care/Health Workforce Healthier Wales Population Health								
Redesigning Community Services for Older People	Existing		As part of the redesign of Frailty services we will review our existing hot clinic pathways and ensure that these are fit for purpose, providing rapid access clinics for older people to undertake assessment, diagnostics, and treatment on an ambulatory basis. CRT In-reach Model which brings alignment between health and social care services to support residents to remain in their usual place of residence for as long	Prevention & Wellbeing 24/7 model and Vision for clusters Workforce & Organisational Development					None, staff attending clinic will be from the core district nursing teams	Planned to commence when staffing levels improve		

Torfaen NCN IMTP 2026-2029

			as possible. Within YAB the locality team have supported and developed an additional staffing resource which will support a nurse led Tyleri Ward service. Part of the model includes direct admission and transfer pathways to support an 8 bedded CRT unit. Facilitate the introduction of the Graduated Care model across to supports seamless pathways from hospital to home utilising nurse led units to minimise the time being spent in hospital settings.									
Health Protection Services Building Community Resilience	/Existing	Building community resilience through connections to increased social prescribing and community development in collaboration with the third sector, Integrated Wellbeing Networks, Social Care and 3rd Sector	Increased social prescribing and community development in collaboration with the third sector, Integrated Wellbeing Networks, Social Care and 3rd Sector. Development of Wellbeing Friends (training for front line staff such as Care Navigators, DNs, CRT etc) improving access to and awareness of GDS, Optometry, Pharmacy and GMS services. Our focus is on building resilience through prevention and early interventions to enhance wellbeing and self-care, identifying social networks to help address the wider determinants of health such as Vaccination programmes, EPP mental health initiatives,	Working alongside Social Care Mental Health and Emotional Wellbeing Population Health Healthier Wales Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology	1					NCN Funded	Ongoing GP cluster commitment to continue to 2024/25	
Accelerated Cluster Development	Existing	Practice Managers Forum will continue to innovate, transform, and provide new ways of working collaboratively across the NCN footprint.	Innovate, transform, and provide new ways of working collaboratively across the NCN footprint.	Healthier Wales Working alongside Social Care Population Health Prevention & Wellbeing Communication and Engagement Transformation and Vision for clusters			3		£3000		ongoing- as part of the collaborative cluster working 2025-26	
Accelerated Cluster Development	Existing	Utilising opportunities that technology can bring to increase access to services	The principles of the Primary Care Model for Wales to increase the digital offer around triage and signposting to ensure patients are seen by the right person at the right time in the right place. Working with Blaenau Gwent GP surgeries to increase numbers utilising technology to improve access to GMS services.	<i>NHS Recovery</i> <i>Supporting Social Care/Health Workforce</i> <i>Healthier Wales</i> <i>Working alongside Social Care</i> <i>Population Health</i> Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development Development Data & Digital technology								

Torfaen NCN IMTP 2026-2029

Accelerated Cluster Development	Existing	Continue to progress with the ACD Programme	Develop and support both exit strategies and business cases to enable proven concepts to be transitioned over to core funding. Raising awareness of the benefits and opportunities for improving population outcomes through collaboration and strengthening partnership arrangements. Support with the Happy Healthy Blaenau Gwent strategy as a key priority across all professional collaboratives.	Healthier Wales Population Health NHS Recovery Supporting Social Care/Health Workforce Working alongside Social Care Prevention & Wellbeing Transformation and Vision for clusters Workforce & Organisational Development								
Estates Mapping	New/Existing	Utilising an assets-based approach to refine our Estates Strategy	Utilise an assets-based approach to refine our Estates Strategy around our four places – Tredegar, Ebbw Vale, Abertillery and Brynmawr, harnessing existing infrastructure to support integrated delivery on the ground.	NHS Recovery Supporting Social Care/Health Workforce Healthier Wales Population Health Prevention & Wellbeing 24/7 model Transformation and Vision for clusters Workforce & Organisational Development Data & Digital technology								
Staff wellbeing	Existing	Supporting our Health and Social Care staff within Blaenau Gwent staff within Primary and Community Care to feel valued, engaged with in a positive sense of wellbeing at work	The NCN is committed to providing wellbeing support to well deserving staff, offering a wellbeing space, but also to provide a warm personal welcome from the Blaenau Gwent Health and Social Care Team and well-being support and guidance.									

NCN Delivery Action Plan

Please List activities or projects planned to commence during 2026/2027, as well as those ongoing from 2025/2026

Torfaen Neighbourhood Care Networks (NCNs) – PLAN ON A PAGE 2026/2027

NCN Areas of Focus

- 1.Connecting people to non medical activities, groups and services in their community which can address their practical, social and emotional needs.
- 2.To establish Multidisciplinary team (MDT) working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation. This MDT approach will require care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapist, housing and third sector organisations.
- 3.To facilitate a collaborative approach in the delivery of diabetes prevention and Cardiovascular disease (CVD) risk factor management to ensure that these programmes can be delivered systematically and at scale across NCNs.
- 4.Establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on intrauterine devices, minor surgery, substance misuse, homelessness and asylum seeker and refugees.

Our Key Actions

Area of Focus 1:

- Work with communities to identify local issues and priorities to inform decision making and action by strengthening the skills, resources and abilities of communities, and the individual people within them, to be able to thrive.
- Identify, connect and mobilise the existing strengths within a community that can be leveraged to empower communities.
- Bridge, link and coordinate well-being assets creating stronger, integrated support networks that enhance health, well-being and resilience of individuals and communities.
- Understand the causes of health behaviour and create interventions to improve the health and well-being outcomes of individuals, groups, communities and the population.

Area of Focus 2:

- Scope and develop MDT models through partnership working.
- Progress Torfaen Integrated Service Partnership Board Place Based Care and MDT model co-design.

Area of Focus 3:

- Work with Public Health Behavioural Change Practitioners, Value Based Healthcare providing support in smoking cessation, diabetes prevention, cardiovascular health, and weight management.
- To scope the creation of a Chronic Disease Team across the NCN.
- Embed CVD Quality Improvement Programme with measurable outcomes.
- Implement Hypertension screening in practice and communities.

Area of Focus 4:

- Map out the current provision of supplementary/enhanced services to improve uptake , particularly people experiencing homelessness, asylum seekers, and substance misuse issues).
- Use appropriate datasets to establish areas of need.
- Continue to work with practices and the local community to improve vaccination uptake .
- Support proposal for Enhanced Services Operational Group that could provide further funding for improved access.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Enablers

- Placed Based Care
- Partnership Working
- Technology
- Skilled Workforce
- Financial Resource
- Fit for Purpose Estate
- Clinical Data

How will we know if we have made a difference?

Improve patient outcomes, increase access to services,
stronger community partnerships

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 January 2026
CYFARFOD O: MEETING OF:	Partnership, Populations Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Business Continuity Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Executive Director for Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Wendy Warren, Head of Planning – Civil Contingencies

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Following the 2025/26 Internal Audit on Business Continuity (BC), which provided *reasonable assurance*, The Audit Committee requested that the PHPP Committee consider BC plans and exercising in more detail.

This report outlines the approach to Business Continuity in the Health Board and ongoing plans to embed the process, test and exercise.

Cefndir / Background

As a Category 1 responder, with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has business continuity plans in place for emergency preparedness, resilience, and response. Business Continuity (BC) is defined as the capability of the organisation to continue delivery of services at an acceptable predefined level following and during a disruptive incident" (ISO 22301).

The Emergency Preparedness Resilience and Response (EPRR) Team have produced comprehensive business continuity guidance: the Business Continuity Policy, Business Continuity Response Guidance, and the Business Continuity Planning

template "short version" can be accessed by all staff via AB Pulse. [Emergency Planning - BC Guidance - All Documents](#)

The Business Continuity Policy states:

'The Chief Executive has delegated responsibility by the Board for ensuring that ABUHB has in place effective arrangements to respond to an incident that has the potential to affect service provision. Strategic overview is the responsibility of the Director of Strategy, Planning & Partnerships and operationalised by Divisional, Directorate and Service Managers'

As a Category One Responder under the Act and through compliance with NHS EPRR Core Competencies, preparing to respond to emergencies is an element of business-as-usual activities for all staff at all levels.

The business continuity key themes are loss of or disruption to:

- Department, building or site.
- Staff due to - pandemic, industrial action, or adverse weather.
- IT networked applications or hardware
- Utilities (heating, electricity, water & sewerage)
- Critical Equipment or 3rd party supplier

The EPRR team can provide services with support to development BC plans; this includes.

- a) Business impact assessment that scopes the service functions, risk assess the likelihood and impact and produce a RAG rate score that identifies single points of failure.
- b) Initial response considerations
- c) Command & Control
- d) Communication & Escalation
- e) Response Action Cards
- f) Recovery

The team also provides workshops, support testing of plans, and be available for any day-to-day queries.

Asesiad / Assessment

The following sections provides updates against the key components of BC in the Health Board

BC Review Process

The approach to ensuring that BC plans cover the requirements include alert, activation and response is for the EPRR team to review, check, and provide advice to the plan author. It is important that plans are achievable, user friendly and have the required detail to meet the requirements of a BC response. Where needed expert advice can be sought from any supporting services, an example being the Digital, Data & Technology team for clinical applications and Estates for anything utilities related.

Command, Control & Coordination (C3 Structure)

The Command-and-Control structure emphasises the importance of **Operational** - 'hands in' **Tactical** - 'hands on' and **Strategic** - 'hands off' but to be in place to set the strategic intent to manage an incident response.

The Health Boards BC response guidance states:

'a fundamental part of business continuity under the Civil Contingencies Act 2004 (CCA).

Alerting and escalating an incident through Health Board tactical and strategic command structures must form part of the service initial actions and be articulated in the roles & responsibility action cards". Setting a battle rhythm of regular communication across affected stakeholders is imperative to ensure all services involved in the incident response have a situational awareness'.

The incident command structure will be dictated by the level of incident disruption to local services or Health Board wide.

Example.

- a) A BC incident that is localised to one key service or function and is causing a minor disruption to services, the BC response should be managed locally (Operational-Bronze – service led). Also inform site operational manager
- A BC incident that is causing significant disruption to service delivery, the BC response must be coordinated by the service/directorate manager or Senior Management Team – (Tactical-Silver command). Also inform site operational management team
- b) A BC incident that is affecting several cross-cutting services and is impacting patient flow – the command and coordination will be led by the hospital site operational management team with stakeholder advice and engagement.
- c) If the BC incident is impacting on large parts of the organisation, the response must be escalated to the service director, (Strategic-Gold command).

Compliance – 'Organisation/Service Position'

Business Continuity incidents that have impacted operational capability across the organisation and have required the activation of service BC plans and set up of a C3 response structure, these include:

- a) June 2021 – burst pipe flood of Pathology dept at GUH.
- b) November 2021 – loss of VMWare which impacted IT networks and applications across the organisation.
- c) August 2022 – Cyber infiltration of the Adastra IT application that supports GP OOH, this was a long-term disruption to normal services that required a Health Board wide coordinated response.
- d) April 2023 – BT disruption that impacted the IT & Networks across the organisation for 4 days which resulted in the Health Board declaring a critical incident.
- e) June 2024 - Burst water main in Abergavenny that impacted the water supply to NHH, response managed by Facilities & Estates strategic management.

These incidents have focused the need to have resilience across the organisation and for divisions, directorates, and services to engage with the EPRR team to embed contingency planning into their everyday service functions.

Over the past 12 months there has been a marked improvement across the Health Board, 85% of organisational services are now working towards developing plans, compliance varies between 20 – 100% against the key themes. The 15% that are outstanding are being targeted by the EP team to commence the BC lifecycle process. Some services have been able to make resources and time available to reach 100% compliance.

As a team are cognisant of the backdrop of service day-to-day operational pressures that can limit the time spent on BC planning by divisions, directorates, and services but we will continue to engage, support and review.

A digital dashboard was introduced in 2025 to provide services with autonomy to RAG rate their own compliance against the key themes, testing of plans, reviews, and staff training. The dashboard will provide a Divisional & Directorate SMT's with an easy ClickView of BC compliance for their services.

Organisational/Service Risks

It is a requirement of any category 1 organisation to identify risks that could disrupt service provision, if these risks cannot be mitigated/managed through response planning they must be recorded as an organisational risk. Service risks that have been identified using the BC service impact assessment process that cannot be mitigated/managed at a local service level must be escalated to the Health Boards Risk Management Community of Practice Group for strategic oversight.

Training, Exercising and Awareness

There have been a series of BC roadshows, and further dates planned, to raise wider awareness of and engagement in BC. Training and exercising has already taken place in some service areas, with plans in place to expand this into 26/27. The EPRR team work with services to undertake training of managers to enhance understanding and enable them to engage with their teams, and provide support for exercises.

Across the organisation there are knowledge gaps at an operational staff level of service BC plans, the response actions they need take and the command/escalation pathways to report incidents. There needs to be a commitment from Divisions & Directorates to work with the EPRR team to address the gaps through service BC workshops and tabletop exercises. The team are currently developing a BC response tabletop training exercise for operational managers. The training scenario will test service plans on the key areas of incident alert, coordination, escalation, communication, stakeholder engagement, receiving or providing timely sitreps to Senior Management Team's, understanding the need for a battle rhythm of meetings and setting an agenda. The training will provide Operational managers with the tools needed to introduce the training to staff within their own service areas

The EPRR team are also developing a BC engagement & training register which will allow divisions to provide the organisation with quarterly progress updates to the Health Board EPRR group.

Further development to support BC compliance

In addition to the current tools in place the EPRR team are developing a standalone BC training PowerPoint with notes for services to address the BC knowledge gap that exists in operational areas. It will cover the BC key themes, where plans are stored (hard copies with actions cards), how to activate, who to contact, and what their initial response actions are until a service manager is available to take control.

They will also provide all service areas with a BC aide memoire that will guide them through a BC incident, to include a standardised list of role specific action cards that services will be required to introduce as part of their response action cards, and provide a standardised clinical & administrative forms/documents resource list for services to refer to, with a caveat that areas add any service specific forms or documents.

There will also be a list of equipment for a BC battle box, for example, plans/actions cards, ward packs, mobile phone/s, laptop/s and a standalone laser printer. Ownership of purchasing and maintaining battle box will sit with divisions on a need basis.

From Q1 26/27 the EPRR team will work with areas to undertake a supportive audit process, identifying progress, gaps and identify where the team can best support. Reviewing the dashboard, service plans, training and exercises. Also considering real events that have taken place where plans have been applied. Linking this process with aspects identified on the service risk register.

Health Board Division/Service BC Repository

[ABUHB Business Continuity Plans](#)

Health Board Division/Service BC Dashboard

[Emergency Planning - Business Continuity Dashboard - A. Divisions](#)

Emergency Planning BC Guidance for Services

[Emergency Planning - BC Guidance - All Documents](#)

Argymhelliad / Recommendation

Business Continuity Planning continues to progress across the Health Board, with service engagement and support from the EPRR team. Supporting documents, a dashboard for recording process, training and exercising is in place. Further materials and tools are being developed to support services and make the development of BC plans, training and exercising as simple as possible to support engagement. The EPRR team will work with services to undertake local audits to understand compliance and support the reduction of risks.

The Committee are asked to:

- NOTE this report, outlining the BC systems in place and plans to continue improvement.

Appendix 1



ABU 2526 06 BCP
Final Internal Audit

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework Business Continuity: 8
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Choose an item. Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	N/A

Parties / Committees consulted prior to University Health Board:	

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

Business Continuity Plan

Final Internal Audit Report 2025/26

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan.....	3
Appendix A	11

Review Reference	ABU-2425-06
Fieldwork	August – September 2025
Executive Sign Off	October 2025
Audit Committee	December 2025
Executive Lead	Hannah Evans, Director of Strategy, Planning and Partnerships
Audit Team	Stephen Chaney, Head of Internal Audit Eifion Jones, Deputy Head of Internal Audit Chris Scott, Internal Audit Manager



Executive Summary

Purpose

The review of Business Continuity Plan (BCP) was completed in line with Aneurin Bevan University Health Board’s (the ‘Health Board’) 2025/2026 Internal Audit Plan.

As a Category 1 responder, with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has robust plans in place for emergency preparedness, resilience and response.

The audit examined and assessed the adequacy and completeness of business continuity plans and response protocols in a sample of the services within the Health Board’s divisions. However, we did not include IT disaster recovery testing within this review, as it is assessed separately.

Overview

We have concluded reasonable assurance on this area, as we confirmed that BCPs are in place for the sample tested, including action cards. However, further work is required to embed and increase staff awareness over the BCP process, including the testing arrangements and subsequent updates to the BCPs (including action cards). The significant matters requiring management attention include:

- None of the three services in the audit sample reported having conducted any testing of their BCP.
- Incident response action cards in the audit sample were not role specific, did not record the event that would trigger their use, were not all critical function specific and were not stored in hard copy in a safe place ready for use.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	There is an effective business continuity management system in place.		Substantial
2	There were robust business continuity plans in place, which had adequately been tested, so that core business functions can continue to be delivered in the event of a disruptive incident.	1,2	Limited
3	Business continuity plans were easily accessible within each service delivery group and for appropriate staff; and that there was access to the guidance and framework for business continuity management.	1	Reasonable
4	Processes were in place to warn, inform and advise relevant stakeholders on a timely basis in the event of a business continuity incident.	3	Reasonable

Management Actions

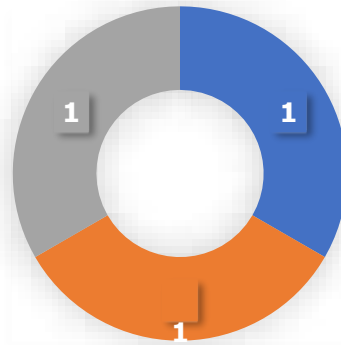


High Priority



Medium Priority

Themes



Information, Data
■ Quality & Data
Accuracy

■ Risk Management

■ Training &
Development

Risk Types

Quality or Safety Issues

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: There is an effective business continuity management system in place.

Substantial

Overview / Summary of Observations

The Health Board has an organised approach to business continuity management, built around its Emergency Planning team and has developed and adopted a model that responds to the business continuity duties of Category One responders set out in the following authoritative sources:

- Civil Contingencies Act 2004;
- NHS Emergency Prepared, Resilience and Response Guidance; and
- NHS Health and Care standards.

Collectively, these prescribe Business Continuity Plans (BCP) that incorporate the following elements:

- Risk Assessment and Resilience;
- Command and Control Structures;
- Training;
- Plan test exercises;
- Governance and Accountability;
- Multi-agency Engagement;
- All-Hazards Approach; and
- Compliance Monitoring.

The audit reviewed the policy, guidance and template materials that make up the Health Board's Business Continuity Management Model and confirmed their inclusion of these elements, prior to then testing a sample of division's and services business continuity plans for compliance.

Objective 2: There were robust business continuity plans in place, which had adequately been tested, so that core business functions can continue to be delivered in the event of a disruptive incident.

Limited

Overview / Summary of Observations

Business continuity plans (BCPs) are developed and maintained at service level, ratified through their clinical and management teams, signed off by divisional, directorate or department management and uploaded to the Health Board's BCP repository.

To assess BCP compliance, completeness etc. we conducted a range of audit tests on a random sample of three BCPs selected from different services within the divisions of the Health Board.

1. Risk Identification and Assessment

A Business Impact Assessment (BIA) tool was used to assess a service's activities to identify its critical functions (CF) that require a BCP to protect them against interruption. The services sampled had utilised a different approach to identifying CFs (some at a more detailed level than others), different formats had been employed and the level of evidence of this step in the process varied across the sample.

We noted that for one of three sample services, BCP interruption risks (e.g. loss of electrical power, loss of services/ supplies) were evident in the service's risk register, but other divisions reported there was no expectation that services would replicate/ reflect BCP risks in service risk registers.

2. Continuity Planning

Our review found that the BCP of only one of the three services in the audit sample examined all five of the business continuity threats (loss of: IT, staffing, utilities, premises and key supplier(s)) in the Health Board's emergency planning BCP model but accept that continuity planning is a continuous developing process.

3. BCP Testing and Monitoring

None of the three sampled services had conducted nor scheduled any test exercises of their BCPs (**Finding 1**). The Emergency Planning team had recently introduced a business continuity dashboard. However, this recorded that only one of the Health Board's 108 service level BCPs had conducted any test exercises.

BCPs record incident response plans accompanied by action cards. The latter are designed to provide unambiguous instructions of exactly what officers need to do in the event of an incident occurring, but we noted the following weaknesses with these (**Finding 1**):

- action cards did not record triggers i.e. the event that would trigger their use;
- action cards were not role specific;
- not all action cards were CF specific but were more broad, describing generic level actions; and
- hard copy action cards should be stored in a safe, accessible place ready for use, but two of the three services in the audit sample reported not doing so.

4. Training and Awareness

In our sample services, we were advised that only a small number of senior staff were familiar with the BCP protocols, processes and procedures, mainly through their involvement with the preparation of BCP materials. All three sample services examined acknowledged the need to extend BCP training to further key staff but had not yet scheduled any training events (**Finding 2**).

5. Governance and Escalation

For all service BCPs sampled we did not see populated formal document control panels (prepared by, approved by, expiry etc.).

We were provided with an example of a division monitoring and co-ordinating the production the BCPs of its services, but no evidence of division management sign-off of these.

Division managers reported BCP status to the quarterly Emergency Preparedness Resilience and Response (EPRR) strategy group in a Business Continuity Update standing agenda item.

Key Findings		Risk & Impact	Agreed Management Action
1	BCP and action cards We noted none of the three sampled services had conducted nor scheduled any test exercises of their BCPs. Additionally, we noted the following weaknesses with BCP action cards: • action cards do not record triggers i.e. the event that would trigger their use; • action cards are not role specific; • not all action cards are critical function specific, but are more broad-based describing generic level actions; and • hard copy action cards are not stored in a safe place ready for use.	Risk that BCP do not operate effectively and planned responses to interruption events may not be enacted fully and effectively.	Agreed Action: The EPRR team will work with all service areas to ensure that local Business Continuity Plans (BCPs) are regularly tested and that action cards are updated to address identified weaknesses. Specifically: • Develop and roll out a train-the-trainer package and supporting test and exercise toolkit to enable divisions/directorates to conduct and record regular BCP exercises. • Support services to review and update all action cards to: ○ include clear activation triggers; ○ define role-specific responsibilities; and ○ align actions to critical functions. • Ensure that hard copies of BCPs and action cards are securely stored and readily accessible in key operational areas. Monitor completion and effectiveness through local BCP assurance audits and reporting to the EPRR Group.

			Expected Evidence of Implementation • Approved train-the-trainer and test/exercise toolkit. • Records of completed BCP exercises conducted by services. • Sample updated BCP action cards showing: ◦ documented activation triggers, ◦ named roles/responsibilities, and ◦ linkage to critical functions. • Confirmation and/or photographs of securely stored hard copies in operational areas. • Divisional/local BCP audit reports confirming plan review and compliance. • Standing EPRR Group agenda item capturing divisional assurance updates on BCP testing and action card maintenance.
	Theme: Risk Management	High Priority Control Design	Officer: Head of Planning – Civil Contingencies Target Implementation Date: 31 March 2026
2	Training for key staff in their role and responsibilities in respect of delivering business continuity We were advised that in the sample services that we examined, only a small number of senior staff are familiar with the BCP protocols. All three sample services examined acknowledged the need to extend business continuity plan training to further key staff, but had not yet scheduled any training events.	Risk that staff are unaware of their responsibilities during planned responses.	Agreed Action: The EPRR team will ensure that key operational and managerial staff across all divisions/directorates receive appropriate training in their roles and responsibilities for delivering business continuity. Specifically: • Identify and confirm Business Continuity (BC) leads within each division/directorate. • Develop and deliver a stand-alone, role-specific training package focused on staff responsibilities for activating, managing, and maintaining BCPs. • Ensure BC leads are equipped to cascade this training to other key staff within their areas. • Monitor completion and effectiveness through service-level audits and regular reporting to the EPRR Group. These actions will ensure that all key staff understand their specific roles within the business continuity framework and can implement BCPs effectively during service disruption.

			Expected Evidence of Implementation: • List of appointed BC leads for all divisions / directorates • Approved and issued BC role-specific training package. • Training attendance records demonstrating that BC leads and key staff have completed training. • Evidence that training has been cascaded to relevant operational staff (e.g., attendance logs, training summaries). • Local BCP audit reports confirming that staff are aware of their responsibilities and can evidence training completion. Standing EPRR Group updates capturing divisional assurance on training delivery and coverage.
		Medium Priority	Officer: Head of Planning – Civil Contingencies Target Implementation Date: 31 March 2026
	Theme: Training & Development	Control Design	

Overview / Summary of Observations

The Health Board’s Emergency Planning SharePoint pages serve as a repository for all BCPs and action cards as well as guidance documents and templates for information and use. Documents are deposited in this repository when they have been completed by a service and ratified by their divisional management, but we noted that at the time of the audit this was sparsely populated. The Emergency Planning team operate a matrix format dashboard that indicates whether BCPs are deposited but we noted this does not accurately record the documentation that is present and requires update.

For local storage/ availability of BCP related documentation and materials we noted that only one of the three services examined reported keeping hard copy action cards in a safe place and ready for use in the event of an interruption event. **Finding 1.**

Overview / Summary of Observations

Command, control and co-ordination protocols were present in each of the service BCPs sampled in the audit, including for determining incident severity rating and linked escalation pathways, roles and responsibilities of operational response, and command and control teams and their contact details for prompt alerting and liaison.

BCPs examined in the audit record incident response actions designed to lead to a resumption of a service. This can involve co-ordinating with a wide range of individuals and teams internally and externally. Action cards provide a step-by-step response plan and where appropriate, include steps to contact/ liaise with individuals or teams – however, weaknesses in the action cards have been identified at **Finding 1**.

BCPs examined in the audit included contact tables to facilitate prompt liaison in the BCPs but in one case, the BCP document, instead of listing these for each individual involved, inappropriately provides a link to a SharePoint location that may not be operable in during a continuity event **Finding 3**.

Key Findings		Risk & Impact	Agreed Management Action
3	BCP contact details protocols We noted an instance in the testing where BCP stakeholder contact details were recorded in the form of a SharePoint location that may not be operable in an interruption event and mean key resources cannot be mobilised.	Risk that incident response plans may not be successfully implemented.	Agreed Action: The EPRR team will ensure that current and accessible contact details for all key stakeholders is available and usable during any service interruption. Specifically: - Each service area will maintain hard copy BCP and action card folders containing up-to-date contact details for all critical staff, partner organisations, and stakeholders. - These folders will be stored securely and accessibly in designated operational areas to ensure they can be used if electronic systems (e.g., SharePoint) are unavailable. These actions will ensure that essential contact information remains accessible during an interruption, enabling timely and effective incident response. Expected Evidence of Implementation: - Confirmation showing hard copy BCP and action card folders are available in each service area.

			• Evidence of up-to-date contact lists included within those folders. • EPRR audit reports confirming that hard copy plans and contact details are in place, accurate, and accessible. Divisional assurance updates presented to the EPRR Group demonstrating ongoing compliance.
		Medium Priority	Officer: Head of Planning – Civil Contingencies Target Implementation Date: 31 March 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Aneurin Bevan University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Developing our Clinical Services Plan

Partnerships, Population Health & Planning Committee
27th January 2026



Make up of a Clinical Services Plan

- Defines what services will be provided, where and how
- Service specific, operational configuration
- Focuses on workforce, infrastructure and service locations
- Tactical planning: 3 years
- Sets service delivery models, resource allocation, capacity planning

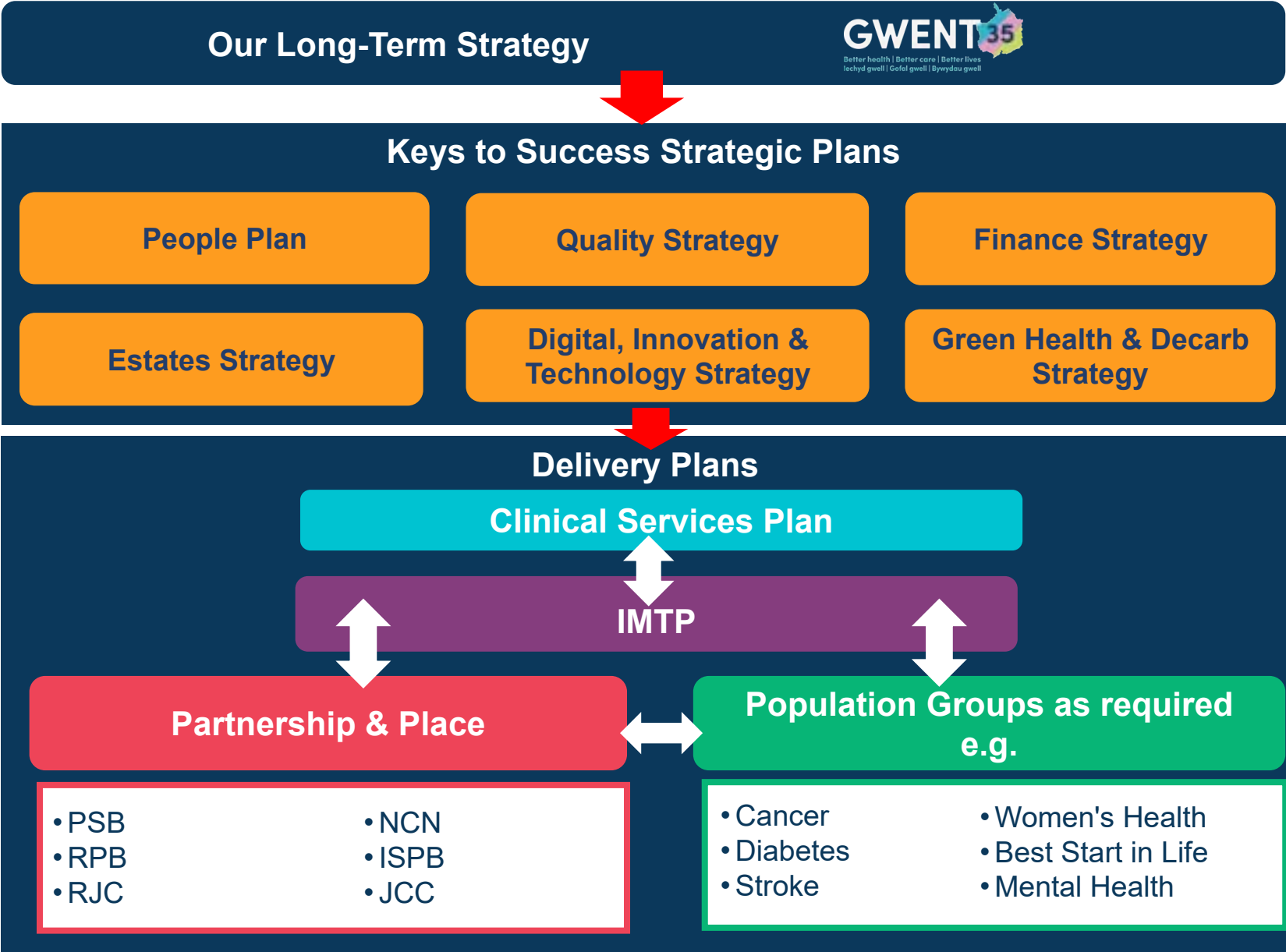
Differs from a Clinical Strategic Plan which:

- Sets system-wide long-term vision and strategic priorities for services
- Is system-wide, cross service, high-level direction
- Focuses on quality, safety, integration, innovation and partnerships
- Has duration of 5-10 years
- Sets strategic priorities and guiding frameworks

Why do we need a Clinical Services Plan?

- Enable us to deliver/commission the best patient care improving quality and patient experience through sustainable services
- To set out a framing and model for the provision (us or others) of services for our population
- To set the direction of transformational change
- De-escalation requirement “...must provide evidence of a clear roadmap and the formal evidence of its Clinical Services Plan”
- Planning Framework 2026-29: “Identify and plan to address clinical services that meet the principles for fragility described in the National Clinical Framework”

Organisational Planning Framework



Proposed Approach



**Evidence and Data
Driven**



Risk Assessment



**Staff & Partner
Engagement**



Delivery of Gwent 35



Different Lenses



**Mix of what we have
now and where we
want to be**

Proposed Methodology

Horizon Scanning

- Best practice in CSP development across UK
- Drivers for change

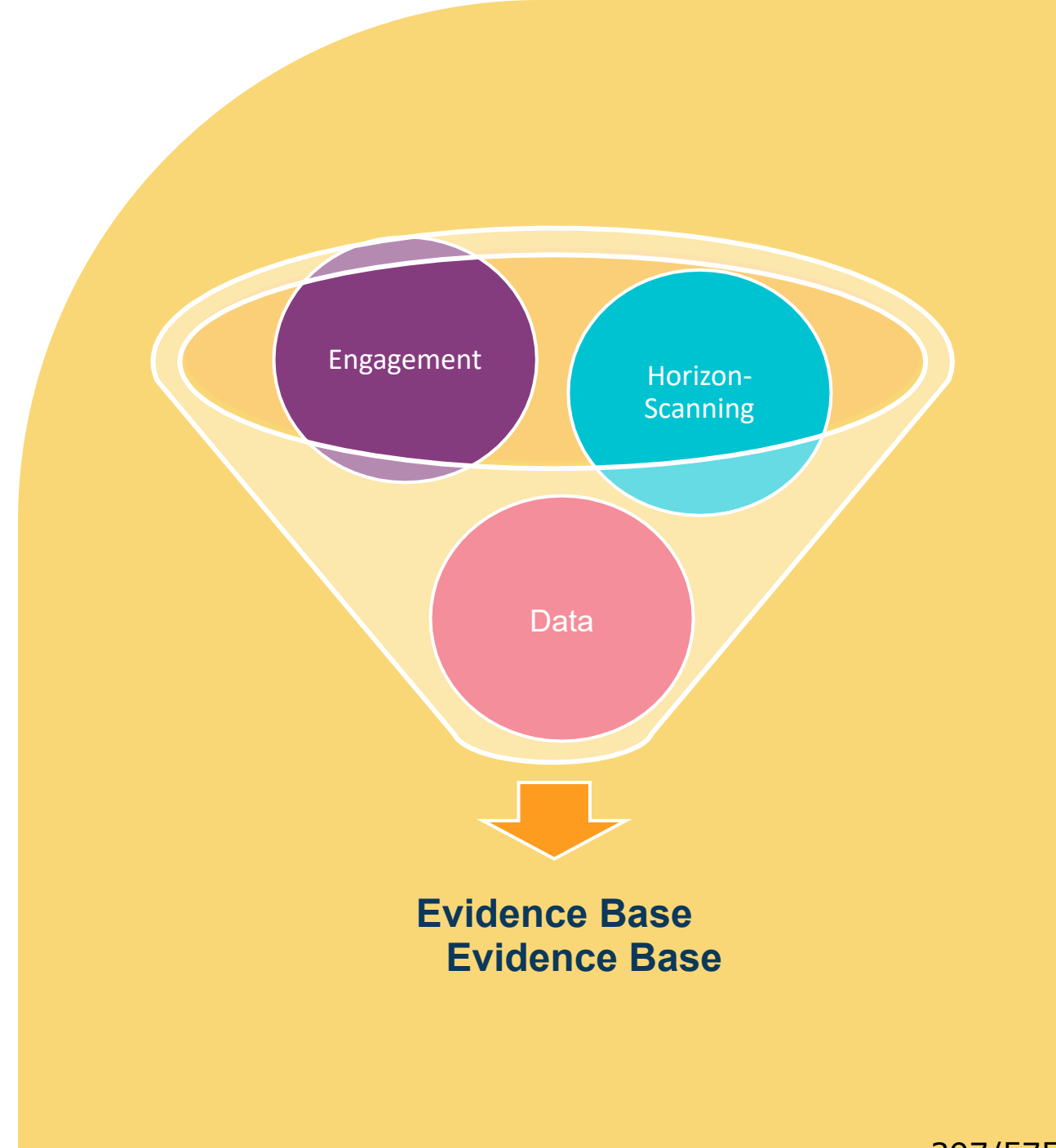
Data

- Population Needs Assessment (JSA)
- Quality Outcomes and Clinical Audit
- Fragile services risk assessment
- Workforce sustainability
- Patient Experience
- Demand and Capacity Overview

Engagement

- All Staff and Clinicians on their areas of expertise
- Testing existing Clinical Futures Models
- Partner Engagement
- Public engagement building on strategy

abuhb.nhs.wales



Horizon scanning approaches

Welsh Government



Ulywodraeth Cymru
Welsh Government



A Healthier Wales:
our Plan for Health and Social Care

National Clinical Framework:
A Learning Health and Care System

abuhb.nhs.wales



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board





GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Better Together

Shaping the future of safe, quality health services for Powys



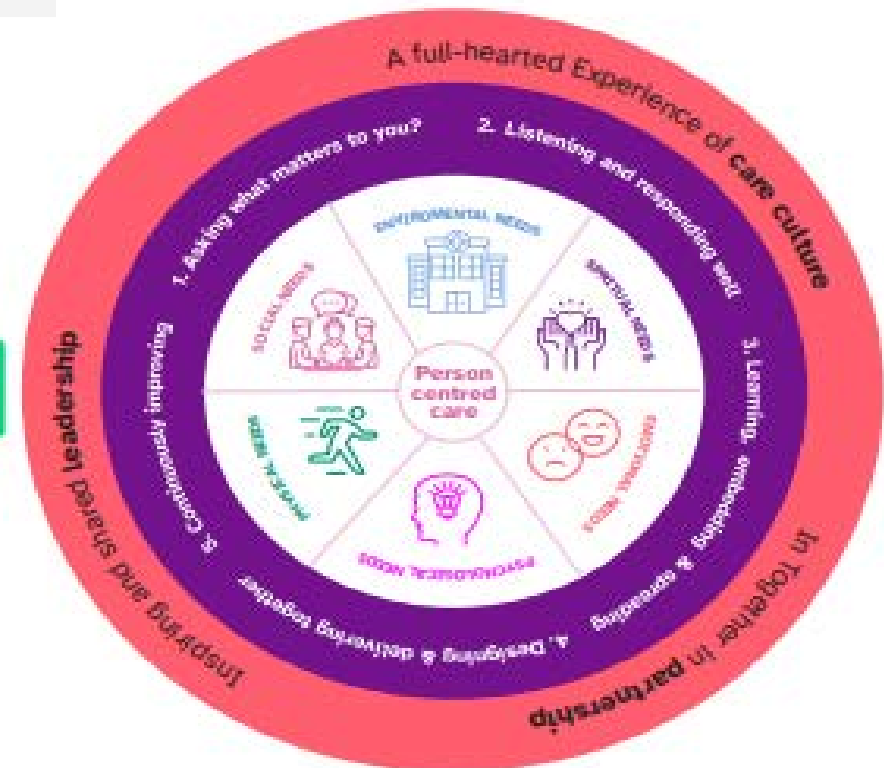
Shaping Our Future
**Clinical
Services**

Cardiff & Vale UHB

Reflections from UHBW



Our clinical strategy describes our ambitions for how our clinical services will deliver care



Our experience of care strategy describes how patients will receive and experience this care

Our Digital Strategy

- A resilient and reliable foundation
- Accessible clinical information
- A Digital First approach
- One digital identity

Our People Strategy

- Growing for the future
- New ways of working
- Looking after our people
- Inclusion and belonging

Our Estates Strategy

- UHBW 5 year capital programme
- Delivery of Net Zero
- Joint UHBW and NBT strategic estates plan
- Bristol, North Somerset and South Gloucestershire ICS infrastructure strategy (BNSSG)

Story so far.....

Stroke

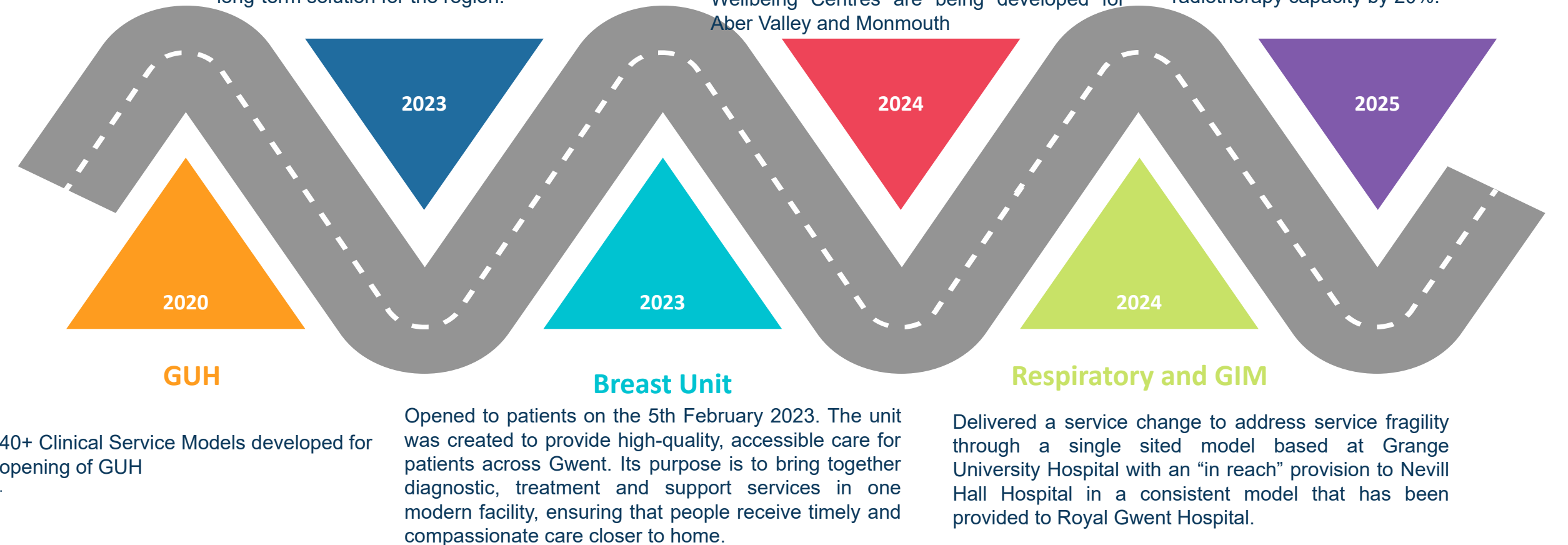
In 2023 services were urgently relocated to Ysbyty Ystrad Fawr and the temporary change has highlighted the need for a sustainable, long-term solution for the region.

Health and Wellbeing Centres

During 2023 and 2024 two developments were delivered – 19 Hills Health & Wellbeing Centre in Newport and Bevan Health & Wellbeing Centre in Tredegar. Further Health and Wellbeing Centres are being developed for Aber Valley and Monmouth

Satellite Radiotherapy Unit

Extension of Velindre Cancer Centre for patients in SE Wales, increasing radiotherapy capacity by 20%.



Regionally we delivered a SE Wales Vascular Network and a regional hub for Cataract in NHH

Live Service Planning

Place Based Care

Outputs

- Partnership delivered prevention, early intervention model
- Non-medical model building resilient communities
- Addressing Health Inequalities
- MDT working for people with complex needs who are most at risk of deterioration or adverse events



Phase 1 in
2026/27

Mental Health Models of Care

Outputs

- Open Access in line with Mental Health and Wellbeing Strategy
- Full plan for co-location of Older Adult Dementia Wards
- Continue inpatient and community models



Phase 1 in
2026/27

Nevill Hall Hospital

Outputs

- Addressing structural Risk and Estate condition
- Alignment with clinical strategy
- Service Model
- Decarbonisation and Estate Rationalisation
- Workforce Sustainability



Phase 1 in
2028

Clinical Redesign Programme

Outputs

- Older Persons Clinical Model
- Acute Medical Model
- Bed Plan/Model
- End of Life



Phase 1 in
2026/27

Other areas include six goals developments, planned care transformation, women's health hub

How do we frame the Clinical Services Plan approach?

Different Lenses



Chronic Conditions

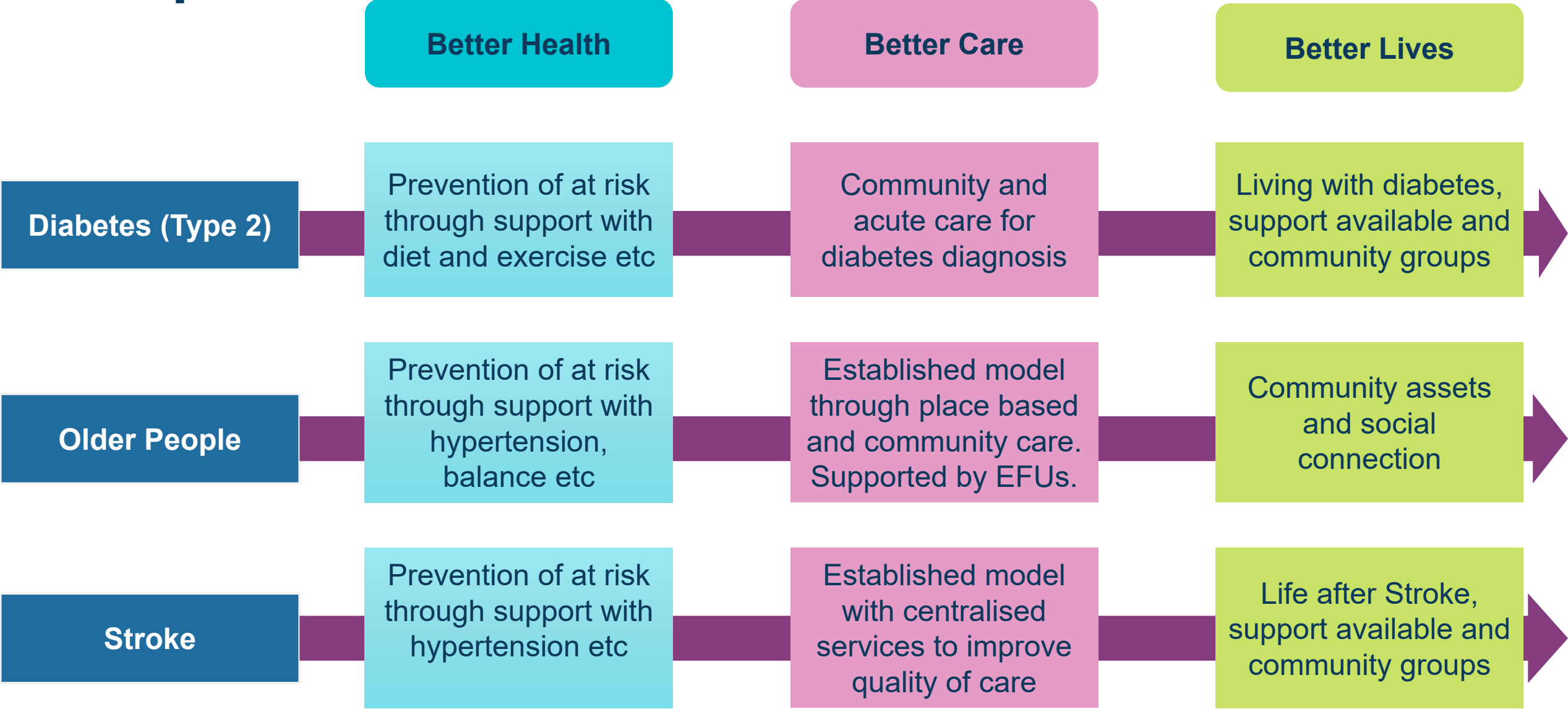
Pathways

- **Diabetes**
- **Stroke**
- **Cancer**
- **Cardiac Care**
- **Critically Ill**
- **Neurological Conditions**
- **Respiratory Conditions**
- **Gastrointestinal Conditions**
- **Maternity and Neonatal**
- **Musculoskeletal**
- **Palliative and End of Life Care**

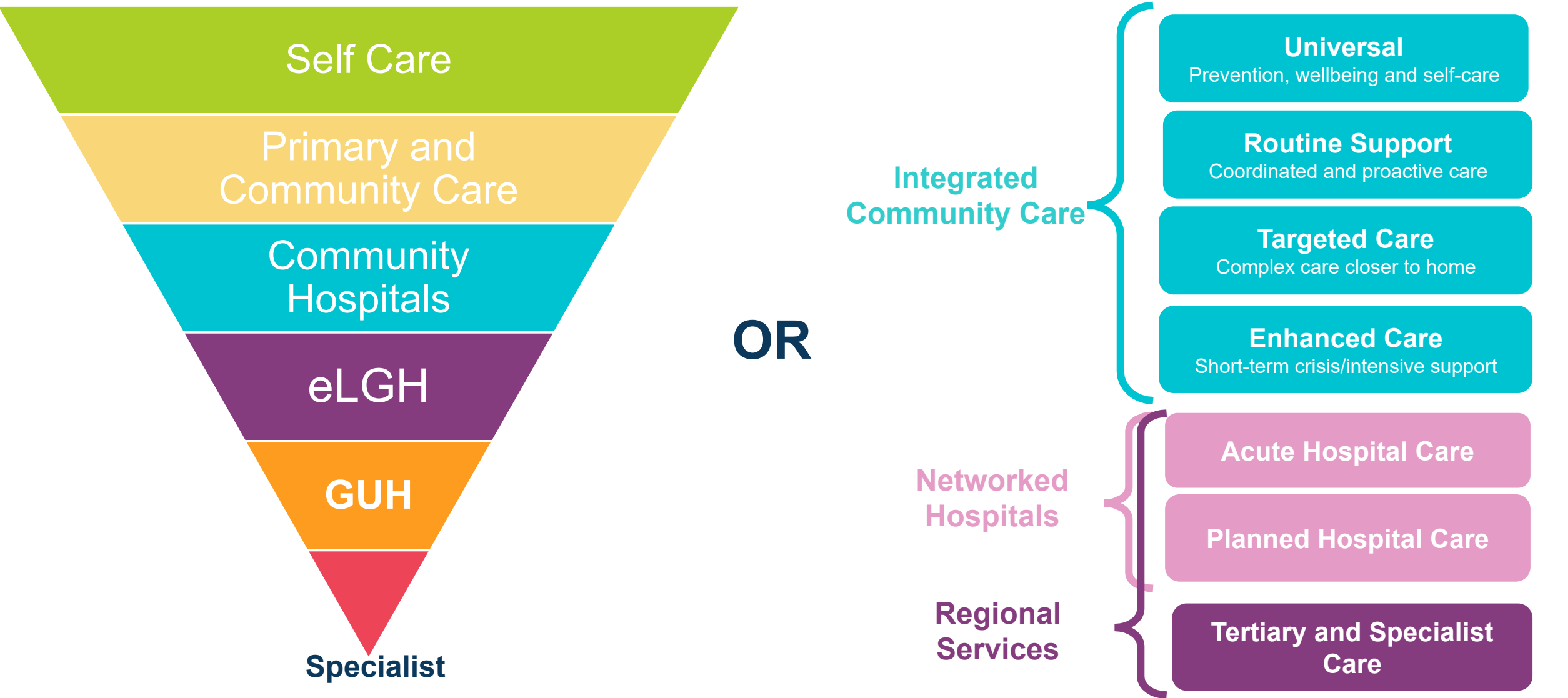
These reflect the National Clinical Networks (except Women & Child Health)

Have we missed any?

Examples



Levels of Care



Our Communities

Monmouthshire	
Better Health	Exercise Smoking Cessation Vaccinations Screenings
Better Care	Neighbourhood Hubs Community Pharmacies Urgent Care Planned Care Mental Health
Better Lives	Community Connection Recovery & Rehabilitation End of Life Care



Hospitals



Grange University Hospital (GUH)

- Specialist & Critical Care Centre
- Most seriously ill patients
- 24-hour Acute Assessment Unit
- Emergency Department
- Children's Assessment Unit
- Inpatient Beds
- Emergency Surgery

Sustainability of current model

Royal Gwent Hospital (RGH)



- Assessment Unit
- Inpatient Beds
- Outpatients and Treatments
- Elective Surgery
- POCU

Nevill Hall Hospital (NHH)



- Assessment Unit
- Inpatient Beds
- Outpatients and Treatments
- Day Surgery
- Children's Centre

Ysbyty Ystrad Fawr (YYF)



- Stroke Rehabilitation
- Breast Unit
- Assessment Unit
- Inpatient Beds
- Elective Surgery
- SDEC

Future role of our sites

Community Hospitals

- County Hospital
- Chepstow Community Hospital
- Ysbyty Aneurin Bevan
- Monnow and Vale
- Rhymney Integrated Centre



- Rehabilitation Beds
- Complex Discharge
- End of Life Care
- Step Up/Step Down

Already progressing potential change (NHH)

Priority Population Groups

Populations at higher risk of poor health outcomes due to various socioeconomic, environmental, or health-related factors

Proposed Groups

- Children
- Older Adults
- Women
- Ethnic Minorities
- Learning Disabilities
- Dementia
- Neurodivergence
- Homeless
- LGBTQ+



Regional

Strategy & Delivery

Prioritisation of the organisation and delivery of services within the Southeast Region to meet the needs of the local and wider population.

Local delivery vs Regional Opportunity:

- Workforce
- Funding
- Accessibility
- Value
- Commissioning
- Quality

Joint Understanding
of next stage

Risk Assessment
across the region
once?

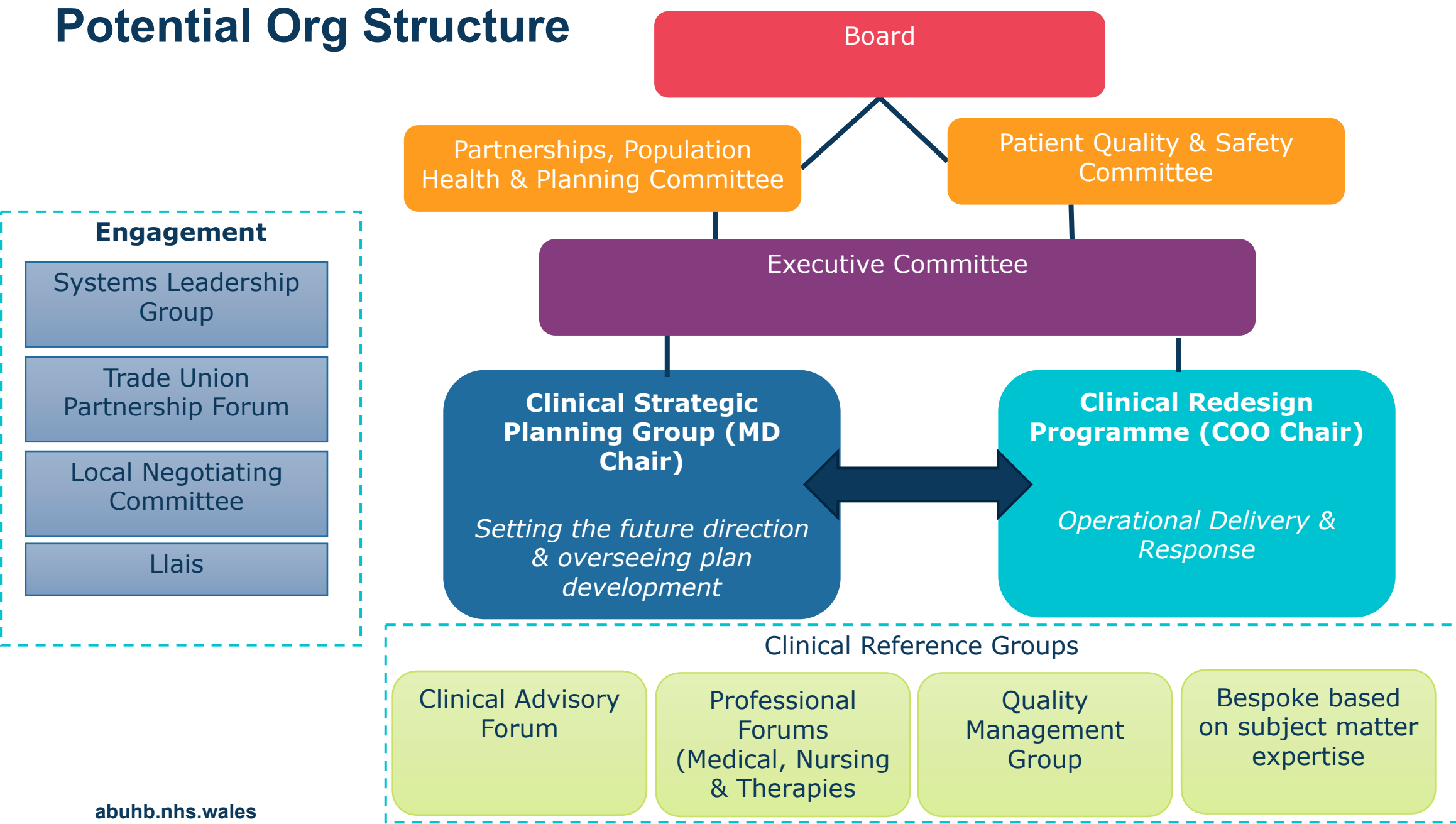
Current Priorities

- Ophthalmology
- Llantrisant Health Park
 - Endoscopy
 - Ortho (Arthroplasty)
 - Radiology
- Cellular Pathology
- Stroke
- Cancer
- Tertiary Services

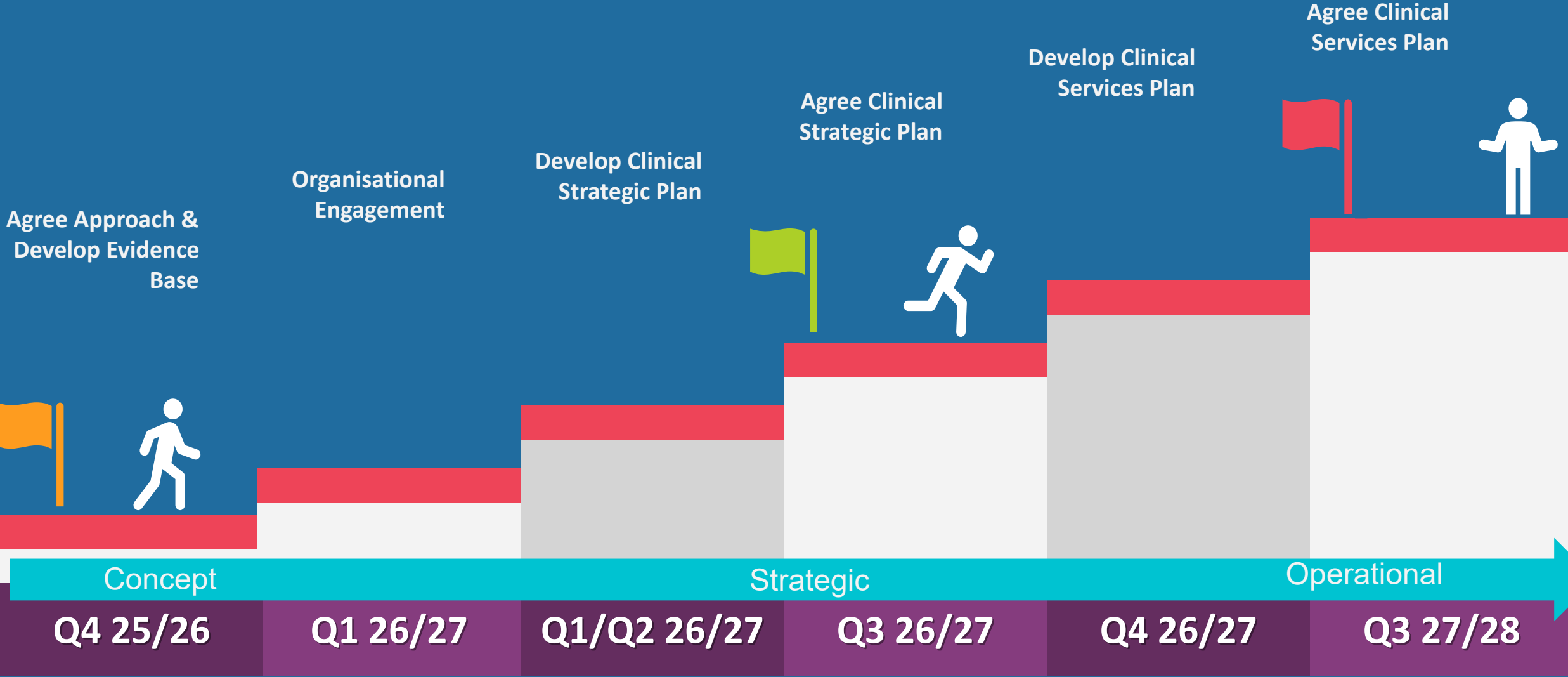
Ongoing - review

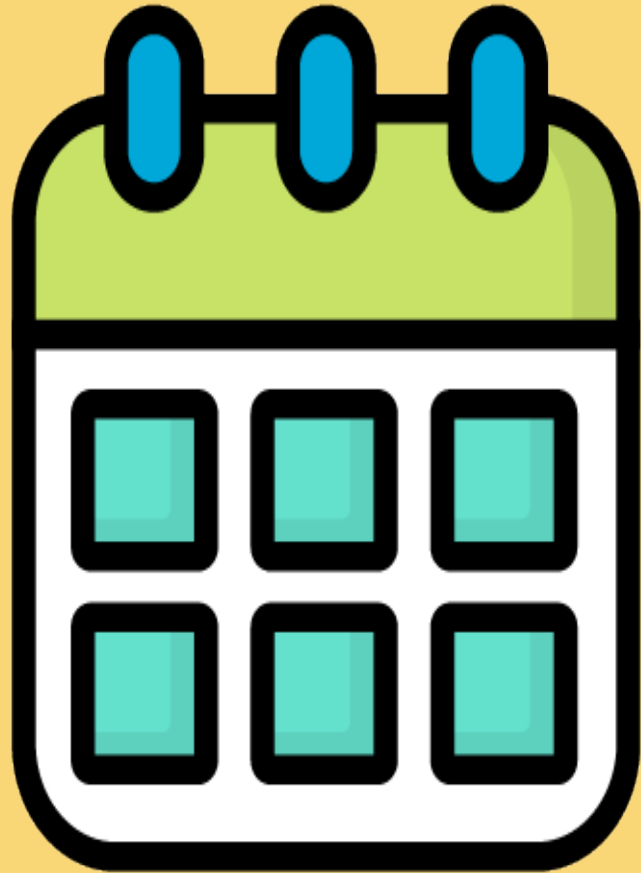
- Vascular
- Critical Care
- LTA- Services

Potential Org Structure



Proposed Timeline





Next Steps

- Agree:
 - Framing of approach Clinical Services Plan
 - Organisational Structure
 - Timeline
 - Engagement approach
- Hold a Board Development session to gain their insights and commitment

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 January 2026
CYFARFOD O: MEETING OF:	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Place Based Care: Blaenau Gwent and Torfaen
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Tracy Daszkiewicz, Executive Director for Public Health and Strategic Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Lloyd Hambridge, Divisional Director of Primary Care, Community Services, and Complex and Long-Term Care

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This paper provides an update on the progression of the Place Based Care Programme, including a specific update on the progress that has been made within Blaenau Gwent and Torfaen, and next steps.

Cefndir / Background

Health and care in Gwent are delivered at a moment of significant challenge and opportunity. Demand is growing, the population is forecast to grow by 4.1% by 2036 with a 147% increase in over-85s, and the system is under pressure: life expectancy and healthy life expectancy have plateaued, health inequalities are widening, services are fragmented, the workforce is stretched and ageing, and funding remains constrained.

Differences in health outcomes

There are stark differences in healthy life expectancy, mental well-being, and equitable access to healthcare services for people living across Gwent. These

disparities are compounded by factors such as poverty, education, and access to meaningful employment. These translate into daily realities that affect people's opportunities to live happy, healthy, and fulfilled lives.

Across Gwent, other than Monmouthshire, the life expectancy for both men and women are lower than the Wales average¹. When considering the potential impact of deprivation and the drivers of differences in health outcomes, the highest proportion of the population living in the most deprived 20% is Blaenau Gwent (44.2% of residents) which has the lowest life expectancy for both males and females¹ (see Figure 1).

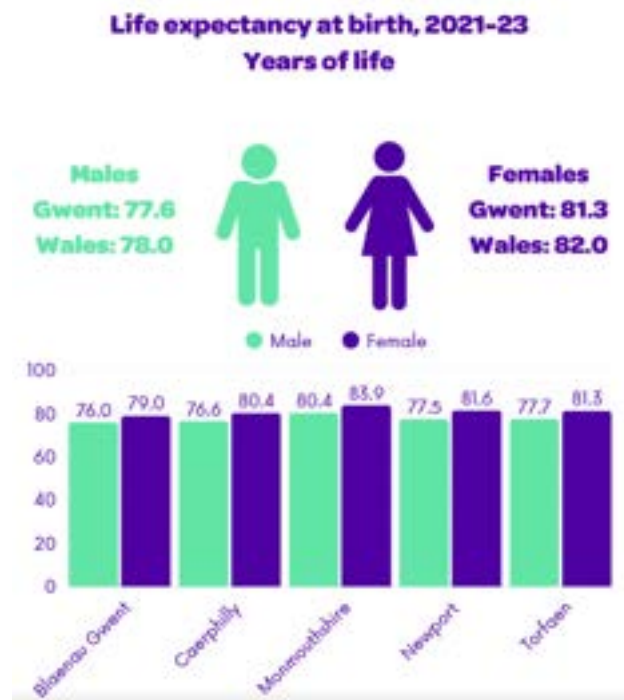


Figure 1: Life expectancy at birth across each area of Gwent, comparing males and females².

Like life expectancy, healthy life expectancy is lower in areas of higher deprivation. Figure 2 shows the difference in the number of years of healthy life that a newborn may expect, based on being born in the least deprived vs the most deprived areas across Gwent.

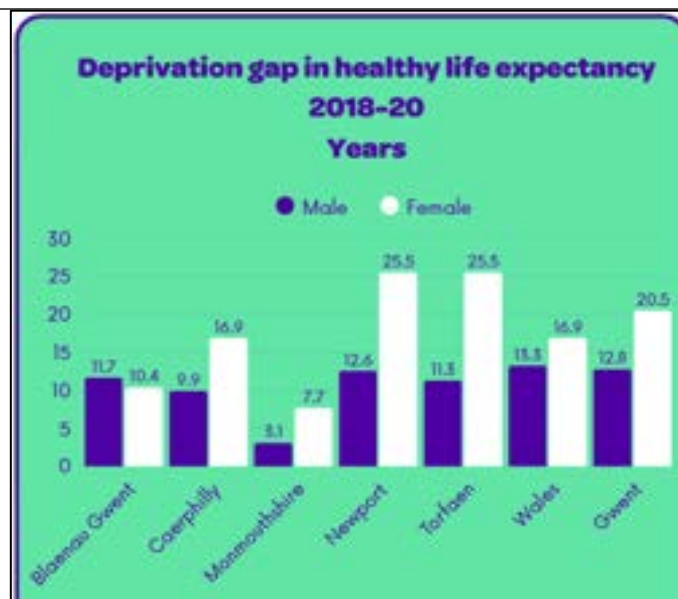


Figure 2: Deprivation gap in healthy life expectancy between males and females across each areas of Gwent and Wales².

These variations are unjust, and there is an opportunity to narrow this gap and change the story for the people of Gwent.

Changing the story

Factors outside of traditional healthcare settings often have the greatest impact on health inequalities and in 2022 partners across Gwent committed to “changing the story” by coming together as a Marmot Region to tackle health inequalities to build a fairer Gwent for all. Our future health and care system in Gwent needs to be more joined up and coordinated through an integrated approach that supports the whole person in their community. To support the growing number of people with multiple long-term conditions, the health and care system will need to focus on breaking down traditional barriers between care organisations, teams and funding streams, rather than viewing each encounter with the services as a single, unconnected episode.

This needs to be accompanied by a rapid shift towards prevention and self-care which focuses on the things that really matter to people. Individual preferences on the type and location of care and support people receive can differ quite widely. With the right support, people of all ages can be empowered to take more control over how they receive services and support which builds on their strengths and social support networks.

ABUHB 10-yr Strategy

The ABUHB 10-Year Strategy responds to this reality by setting out a shared vision developed with nearly 7,000 people: to improve the health of everyone who lives in Gwent, to embed research and evidence in everything we do, to listen to the voices

of our communities, and to co-design our future together. The strategy sets out how it will work with partners over the next decade to achieve the following aims:

- Better Health – Making it easier for people to stay well by improving access to vaccines, mental health support, and advice, and working with communities to design interventions that meet local needs.
- Better Care – Delivering high-quality, person-centred care that focuses on what matters most to individuals and helps keep people well in their communities.
- Better Lives – Shifting from fixing problems to prevent them by investing in jobs, housing, and community wellbeing.

Place Based Care is the mechanism that will, through neighbourhood-anchored working, deliver those aims and address the challenges that our system and population face.

Strategic Aim, Vision and Objectives of Place Based Care

Following a recent development session with the ABUHB Place Based Care Programme Board, the programme's vision, strategic objectives and leadership, governance and accountability structures were reviewed and agreed. Members include representatives from the third sector and local authority to ensure system wide ratification and alignment.

The overarching strategic aim is to make Gwent a region of connected, resilient communities where everyone, regardless of their circumstances, can live healthy, independent, and fulfilled lives with support close to home. In practice, this means shifting more care and preventive support into local communities, integrating services around neighborhoods, and focusing on what matters to people in their daily lives. This aim aligns directly with ABUHBs 10-year strategy: *Better Health, Better Care, Better Lives*, by promoting better health through prevention and equity, delivering better care via integrated local teams, and enabling better lives by tackling wider determinants of health in partnership with communities.

Vision

The vision for place based care is:

"We want Gwent to be a place of connected communities where everyone – regardless of their circumstances – is supported in their neighbourhood to live happy, independent and fulfilled lives. Care, when required, should be provided as close to home as possible with support from place-based teams that coordinate services around people and communities to ensure support is tailored to local need".



This vision and the strategic objective will underpin all of the planning for place based care, ensuring that our transformation focuses on keeping people well, delivering care closer to home, and improving outcomes and equity.

Strategic Objectives

Table X provides a summary of how the PBC programme objectives align to the Health Board's 10yr strategic aims.

ABUHB 10yr Strategic Aim	Place Based Care Programme Objectives
Better Health	-Reduce health inequalities: Identify areas and cohorts with the poorest health outcomes using granular neighbourhood data and engage directly with those communities to co-design targeted prevention programmes and ensure equitable access. -Focus on prevention and early intervention: Develop an intelligence-led approach to identify health risks in the community and intervene earlier e.g. proactive management of chronic disease risk factors (obesity, hypertension) and robust wellbeing support, to make it easier for people to stay healthy.
Better Care	-Create a culture and team structures where decisions are taken together across the system: Establish Integrated Neighbourhood Teams that bring services together (GP, community nursing, social care, mental health, etc.) to provide coordinated, person-centered care in community settings, minimizing unnecessary hospital referrals. Care will be designed around "what matters" to the individual and delivered at the most local appropriate level, improving quality and access. -Provide care closer to home: Map capacity and gaps; design and open locality One-Stop centres; trial mobile/digital clinics; set up a single point of entry for specialist referral; adopt a Home First discharge protocol. -Streamline access to specialist support: Utilising population health intelligence and allocative efficiency data to identify different ways of connecting specialists to NCNs, strengthening relationships and appreciation of skills between primary care clinicians and hospital consultants, create a Community Clinical Desk to provide safe alternatives to acute



	hospital admission. The Clinical Desk will bring together senior clinical decision makers with access to step-up intermediate care options such as acute frailty, ambulatory care units and SDEC.
Better Lives	-Build resilient and connected communities: Build strong partnerships across health, local government, and third sector to improve the broader conditions for health. PBC empowers local communities by mobilising community assets e.g. wellness hubs, volunteer networks, social clubs, to support physical, social and mental wellbeing. By investing in community capacity and co-producing solutions with citizens, the programme helps people live independent, meaningful lives (beyond just receiving clinical care). -Co-production and citizen voice: Ensure that local people are actively involved in designing and continuously improving services. PBC embodies the “voice and control” principle, engaging residents in decisions and tailoring support to community priorities. This objective aligns with Better Lives by recognizing that improved health and happiness come from empowering people and improving factors like social support, purpose, and environment.
Cross Strategic Aims	-Strengthen community resources to prevent avoidable admissions and optimise discharge: Align budgets across partners for rapid response teams, flexible crisis relief pots, community reablement and a formalised Home First approach. -Support leadership, governance and capacity for place-based working: Secure Board and Executive sponsorship; delegate authority and budgets to ISPBs; build the professional leadership pipeline; embed governance; permanently resource Integrated Wellbeing Networks. -Promote continuous feedback, transparency and learning: Promote continuous feedback, transparency and learning: Build into every workstream a feedback loop with surveys, listening events, learning reviews, publication of neighbourhood scorecards and internal innovation pipelines.

Guiding Principles

The following principles provide a framework for designing and delivering Place Based Care that is both person-centered and supported by the strengths of local communities.

Design:

- Involve communities in design delivery
- Enable community led solutions
- Consider people as equal partners not simply passive recipients of services
Integrate neighbourhood assets and services so people receive seamless support when they need it
- Anchor teams and resources in local neighbourhoods
- Devolve power and autonomy to neighbourhood teams – encourage curiosity and creativity
- Create an ethos of collaboration where relationships are more important than referrals
- Apply the 'proportionate universalism' principle to resource allocation

Interactions:

- Focus on what matters to people
- Consider the whole person – physical, mental, emotional and social wellbeing
- Be aware of previous life events and trauma
- Take a strengths-based approach in the context of the person's life and circumstances
- Harness assets in the local community
- Combine assessing and managing of risk with resolving dilemmas and creating agency
- Create space for shared decision making
- Focus on motivational interviewing to enhance behavioral intentions and self-efficacy
- Spend time enabling people to develop their social connections
- Avoid hand offs and roll in support from other practitioners or neighbourhood services where needed

Strategic Context: Community by Design

Recently launched and sponsored by the Chief Medical Officer for Wales, Community by Design (CbD) is a health transformation programme to deliver better outcomes through integrated services in the community. A CbD approach is intended to drive service planning from the perspective of service users and assumes, unless proven otherwise, that care can be provided in the community setting with hospitals only being utilised when this is required due to complex or escalating clinical need.



Community by Design aims to achieve a healthier Wales through an integrated, sustainable, population-focused system delivering care closer to home, with prevention and wellbeing at its core where:

- People and staff can navigate care pathways easily.
- Appointments are timely and appropriate to need, in the right setting.
- Staff wellbeing is enhanced through better flow, role clarity, and multidisciplinary support.
- Population health management and prevention are business-as-usual, systematically embedded into every contact.
- By 2028 there will be a significant shift in resource into health, well-being and prevention as opposed to hospital based care and treatment.

There are several key themes that both Place Based Care and CbD are focused on, these include:

- Governance and leadership
- Service transformation: prevention and population health management, chronic conditions management and urgent and same day care
- Key enablers to delivery: data and digital and workforce transformation

However, one key difference is the proportionate focus that Place Based Care will make on community well-being and community capacity building, which is vital to enabling a sustainable and effective shift towards prevention. We must acknowledge the similarities that exist between CbD and Place Based Care and every effort will be made to avoid duplication, ensure ongoing alignment of work where appropriate and ensuring that the focus remains on delivering the intended outcomes for the population of Gwent.

Asesiad / Assessment

Over the last 18months there has been a significant amount of work to ready the system for the implementation of Place Based Care. This section provides insight into progress to date, along with the developments emerging specifically from the Blaenau Gwent and Torfaen Integrated Services Partnership Board (ISPB).

Governance and Strategic Leadership

The delivery of Place Based Care is overseen through a multi-tiered governance structure that involves regional, locality, and programme-specific components. Existing planning and delivery structures within the Health Board, Local Authorities and across the system in Gwent will be used to provide the strategic and professional leadership for PBC. These structures will be reviewed, and where appropriate enhanced, as the programme and any service transformation programmes are implemented and learning from the monitoring and evaluation of the programme is considered. Figure 3 outlines the current planning and delivery structures that are in place that are relevant to PBC.



Strategic leadership will be provided through the Regional Partnership Board (RPB), ensuring the consistent and co-ordinated delivery of regional priorities and facilitating a system-wide approach that is aligned with shared accountability for outcomes. Integrated Service Partnership Boards (ISPBs) will act as the delivery vehicles and provide focused leadership including monitoring and responding to opportunities and challenges within their respective localities. Delegating authority to ISPBs in this way will provide the opportunity for resources to be optimised and partnership funding to be held within one place which will provide the ability to truly shift the focus away from acute response and towards prevention, improving outcomes for people and communities and reduce inequalities.

The professional leadership and the foundations for PBC are through NCNs, ensuring alignment between clinical priorities and the integration of services at a community level. Each NCN operates with clearly defined mechanisms for managing budgets and commissioning projects/services, ensuring financial spend and cluster activity is aligned to local population health need and informs wider Health Board and system-wide priorities.

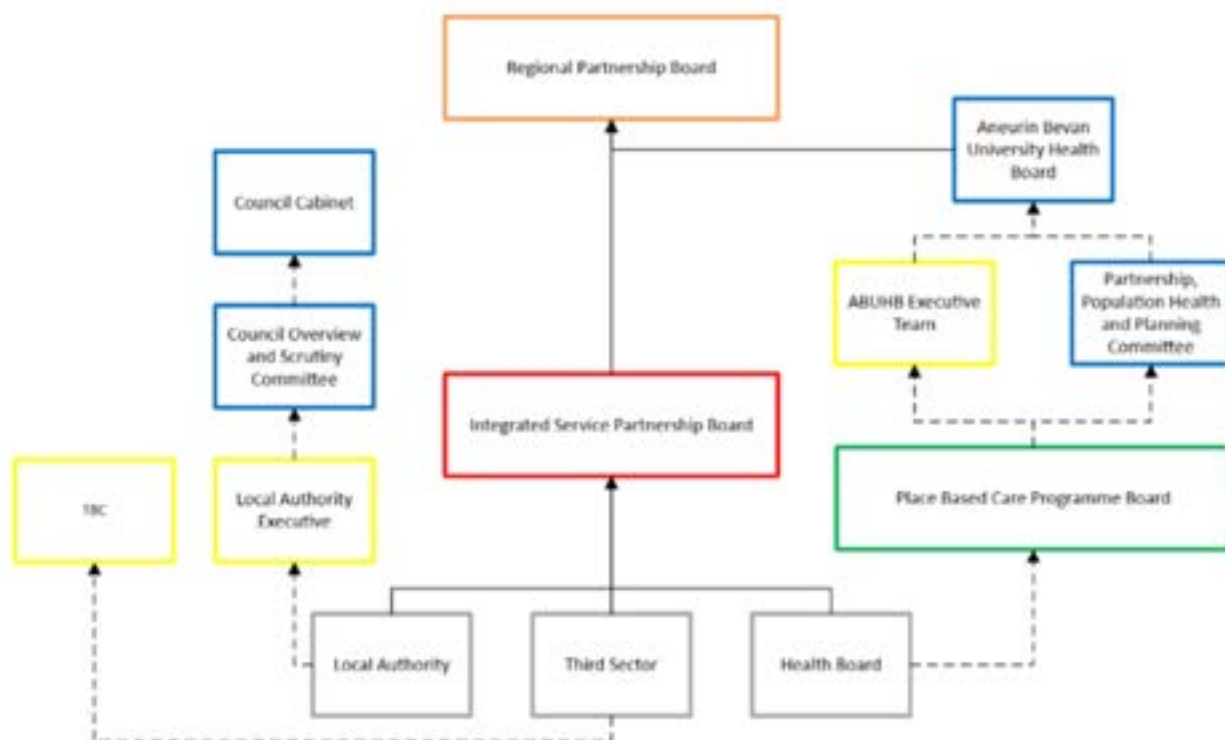


Figure 3: Governance and reporting structure

Place Based Care Programme Board

Internal (Health Board) governance of the PBC programme is through the Place Based Care and Population Health Programme Board led by the Executive Director of Public Health and supported through operational engagement and leadership by the Chief Operating Officer (COO). The programme board reports formally to the Population and Public Health Partnership (PPHP) subcommittee; providing assurance to the Health Board on progress and delivery, risks and outcomes. External governance and accountability will be maintained through the ISPB chairs; Local Authority Strategic Directors who will ensure that programme objectives are embedded within the corporate planning and scrutiny processes within their respective organisations.

The Programme Board brings together specifically the ABUHB approach and response to Place Based Care and co-ordinates an approach across Gwent. There are several workstreams, the leads of which are held to account on delivery. These workstreams include:

Workstream	Aim
Financial Strategy	To develop a financial strategy to advance and sustain place-based care long term and as core business.
Workforce Development	Develop a workforce strategy to ensure the programme has an appropriate, skilled and high functioning workforce to deliver and sustain place based care.
Intelligence and Evaluation	Provide the intelligence to inform decision making and the ability to monitor and evaluate if the programme is delivering against its intended outcomes.
Digital, Data and Technology	To align, and where required create, the infrastructure to enable to enable place based care to be delivered, including data flows and improve system efficiencies.
Communication and Engagement	Develop and implement a communication and engagement strategy to deliver programme priorities.
Estate and Facilities	To lead the development of an estate strategy, guided by the Six Facet Survey, and to enable the delivery of safe, sustainable, and appropriate facilities and in a way that meets the needs of the programme.

Blaenau Gwent and Torfaen



Blaenau Gwent and Torfaen have been identified as the two local authority areas within Gwent whereby the development and delivery of Place Based Care should start. This is for several reasons that include, but are not exhaustive of, the high levels of need, the stark inequalities that exist within both areas and, based on the Welsh Index of Multiple Deprivation (WIMD), having many of the most deprived areas within them compared to the rest of Gwent (see figures 4 and 5). However, the communities within Blaenau Gwent are considered engaged and ready for change and an ISPB that has strong leadership and is ready to commence at pace.

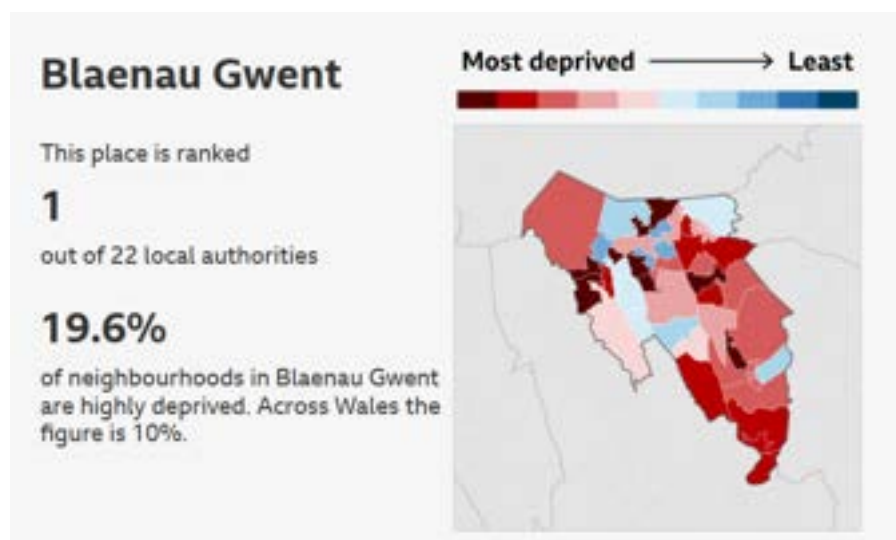


Figure 4: Neighbourhoods in Blaenau Gwent and their levels of deprivation

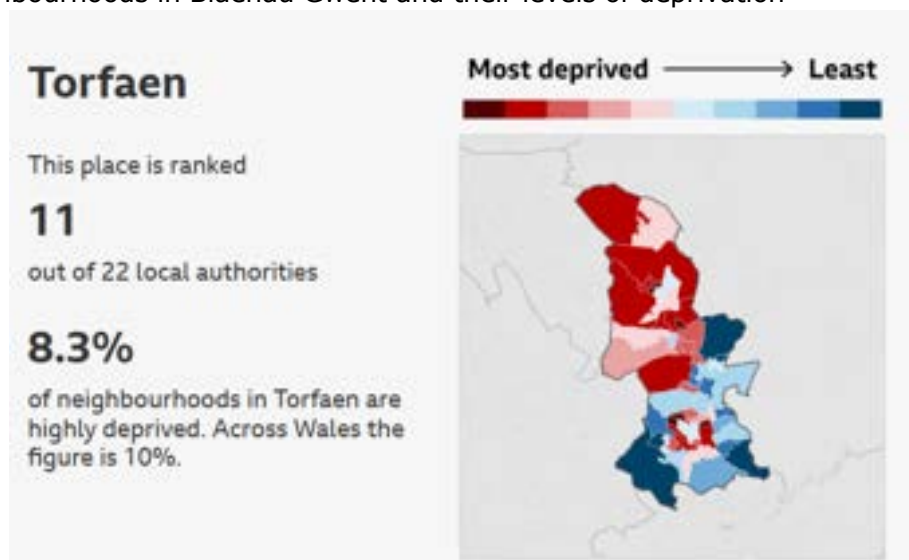


Figure 4: Neighbourhoods in Torfaen and their levels of deprivation

Blaenau Gwent has a population of approximately 67,873 people, making up an estimated 11% of the population of Gwent³. There are a range of key health, social and community challenges which include, but are not exhaustive of:

- Lower than the Wales and Gwent average of healthy life expectancy at birth amongst both females and males¹.
- A stark 18-year gap in health life expectancy between its most affluent and most deprived communities⁴.

- Having the lowest level of satisfaction with their local area with only 68.5% of the population reporting they are satisfied⁵.
- Having the lowest sense of ability to have influence on decisions affecting their local area (14.6% compared to 29.6% in Monmouthshire)⁵.
- The highest number of premature deaths from non-communicable diseases⁶.
- 71.3% of people aged 16-64 in employment, the lowest across Gwent⁷.

Torfaen has a population size of approximately 92,300 people, making up an estimated 15.7% of the population of Gwent³. Like Torfaen Blaenau Gwent has a range of key health, social and community challenges which include, but are not exhaustive of:

- Lower than the Wales average and the lowest in Gwent for healthy life expectancy at birth amongst both females and males¹.
- The biggest difference in healthy life expectancy between females born in the least vs the most deprived areas across Gwent (25.5years) and a difference of 11.3yrs for males⁴.
- The highest rate of material deprivation on Gwent, and higher than the Wales average⁵.
- Higher than average premature deaths from non-communicable diseases including cancer and diabetes⁶.
- Second lowest employment rate amongst people aged 16-64 (73.6%) in Gwent⁷.
- The second highest number of households threatened with homelessness in Gwent, and higher than the Wales average⁸.

Blaenau Gwent and Torfaen ISPB

Following the federation of the Blaenau Gwent and Torfaen councils this has been reflected in the development of a joint ISPB for Blaenau Gwent and Torfaen. This joint ISPB has and will continue to be the mechanism for developing and delivering Place Based Care locally.

To date there has been a series of workshops held with ISPB members across Blaenau Gwent and Torfaen to agree the vision, aims, objectives and fundamental principles for Place Based Care to be effective. Through these workshops it has been agreed by members to move away from a collection of partners and towards teams. These teams will work together to achieve the same strategic aims, adopt one operating model and the same culture for all decisions that relate to the well-being system and improving the health and well-being of the population of Blaenau Gwent and Torfaen. By adopting this collective approach, the ISPB can manage resource appropriately with appropriate delegated authority in line with the needs of the local population and communities.

Developing an Operating Model

For Torfaen and Blaenau Gwent, the Place Based Care operating model will be built around 8 'places', these are:

Blaenau Gwent	Torfaen



Ebbw Vale	Blaenavon
Tredegar	Pontypool and Abersychan
Abertillery	East Cwmbran
Brynmaur	West Cwmbran

At the heart of the approach for Place Based Care is the idea of Integrated Neighbourhood Teams (INTs). (see appendix 1) These are professionals who work in local neighbourhoods with a strong sense of connection to each other and the local community. These teams will build on what already works and connect services to make care and support simpler, more personal and easier to access; helping to shift the focus from tertiary prevention and hospitals to primary prevention and into communities.

INTs bring together staff from the NHS, local authority, housing and third sector organisations to work as one team in a local neighbourhood. They focus on the specific needs of people living in that neighbourhood, caring for the whole person and not just their medical needs. For example, someone living with frailty might get coordinated support from a district nurse, social worker, pharmacist, housing officer, and social prescriber, all working together through the neighbourhood team.

Work is underway to baseline the current capacity and operational configuration of professionals and practitioners that exist within the Blaenau Gwent and Torfaen using the suggested workforce requirements that feature within the INT diagram (appendix 1). Once this baseline assessment is complete, the next steps will include designing an operating model that can be used to effectively deliver Place Based Care. This will include appropriate and proportionate realignment of professionals and practitioners from across all sectors and organisations to best meet the needs of the people within the 8 agreed places. This process will also provide insight, based on population need, into any gaps in capacity requirements.

Next Steps

The intention is that once a baseline assessment is complete, including the process of understanding the totality of available resources and how it can be effectively aligned to meet population needs, an operating model will be developed. Once developed, a draft model will be shared for scrutiny across all organisations and their respective governance mechanisms to ensure alignment across the system to be able to effectively commence implementation. Implementation will be supported by a comprehensive implementation plan. This plan will provide a clear roadmap and timeline that will translate how the model will be implemented throughout Blaenau Gwent and Torfaen; with clear actions that define how, who, when and with what resource work will be implemented, monitored and learnt from to inform necessary next steps for successfully delivering Place Based Care.

Risks and Mitigations



There are several risks that unless resolved have the potential to hinder the ability to effectively and efficiently progress the Place Based Care Programme. These are outlined within the table below along with suggested mitigations.

Risks	Mitigations
Lack of formalised delegated authority and accountability for delivery to ISPBs.	Work ongoing with Regional Partnership Board (ROB), including contributing to RPB development sessions and structure planning workshop.
Inadequate alignment of operational teams to each place.	Working closely with Divisional Directors within the Health Board to understand barriers and utilising appropriate governance mechanisms to escalate concerns, e.g. PBC programme board and ISPBs. This will also include ensuring that programme objectives are embedded within the corporate planning and scrutiny processes within each respective organisation. As well as Health Board Directors work will also be done with Third Sector and Local Authority operational leads to ensure alignment across the system and identified places.
Acute/urgent care pressures drawing on focus and capacity, particularly for operational teams.	Utilisation of internal Health Board governance via the Place Based Care programme board to ensure operational engagement and leadership by the Chief Operating Officer to support value based, safe, decision making that is focused on outcomes.
Lack of financial strategy and no 'new money' available within the system.	Programme board workstream, led by the ABUHB Assistant Finance Director, to develop a financial strategy to advance and support place-based care long term as core business.

Argymhelliad / Recommendation

Committee members are asked to receive this paper for assurance on the progress and next steps to designing and delivering Place Based Care across Blaenau Gwent and Torfaen and note the associated risks to delivery. The Committee are requested to endorse the next steps approach to the completion of the baseline assessment and the development of a comprehensive implementation plan.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)



Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Many of the regional work streams are informed by risk assessment and have been established to address and mitigate system risks
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Choose an item. Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well All IMTP priorities are relevant
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	PBC – Place Based Care ISPB – Integrated Service Partnership Board GAVO – Gwent Authority Voluntary Organisation TVA – Torfaen Voluntary Alliance
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item.



	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

References

1. ONS (2024). Available from: [Life expectancy for local areas of Great Britain](#) - Office for National Statistics
2. Gwent Strategic Assessment (2025), Available from: [JSA 2024/25](#)
3. ONS (2025). Available from: [Estimates of the population for England and Wales](#) - Office for National Statistics
4. ONS (2024). Available from: [Health state life expectancy, all ages, UK](#) - Office for National Statistics
5. National Survey for Wales (2025). Available from: [National Survey for Wales: results viewer | GOV.WALES](#)
6. Public Health Outcomes Framework for Wales, Public Health Wales (2025). Available from: [PHOF Reporting Tool](#)
7. Office for National Statistics (2025). Available from: [Annual Population Survey/Labour Force Survey - Data Sources - home - Nomis - Official Census and Labour Market Statistics](#)
8. Stats Wales (2025). Available from: [Prevention of Homelessness by Area and Measure \(Section 66\)](#)
9. Welsh Government via BBC Wales News (2025). Available from: [Rhyl neighbourhood named as Wales' most deprived area in report - BBC News](#)

Appendix 1

Integrated Neighbourhood Teams (INTs)





DYDDIAD Y CYFARFOD:	27 January 2026
CYFARFOD O: MEETING OF:	Partnerships, Population Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health Protection Update 2025-26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Tracy Daszkiewicz, Executive Director for Public Health and Strategic Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Anna Morgan, Deputy Head of Public Health, Gwent Public Health Team

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

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This report details the system activities for health protection across Gwent.

Following the allocation of Welsh Government recurrent funding to health boards, sustainable and permanent structures have been developed and agreed for the different elements of the health protection system; designed with the intention to strengthen the system to allow it to plan, mitigate and respond to public health incidents and threats.

Cefndir / Background

During 2024/25, a sustainable health protection structure was established within ABUHB. This new structure improved recognition of health protection as a domain of public health the health board and the wider system. Health protection focuses on preventing and managing threats to health. In ABUHB, health protection has a well-developed and ambitious workplan covering a wide range of topics, including blood borne viruses, tuberculosis, high consequence infectious diseases, sexual health, vaccinations, vaccine equity, preparedness for future threats, as well as operational delivery and acute response.

A number of health board teams and services contribute to the health protection structure, including the health protection team in the Gwent Public Health Team; PC HeaRT and the Vaccination Service within Primary Care, Community Services, and Complex and Long-Term Care division; and local authority public protection colleagues.

Asesiad / Assessment

1. Infectious disease management

Elimination plans

Welsh Government has three key elimination targets relating to health protection: Eliminating hepatitis B and C as a public health threat by 2030; zero new transmissions of HIV by 2030 and eliminating TB in Wales by 2030.

Progress against the three key elimination targets is being led and co-ordinated by the health protection team. The team co-ordinate and chair the hepatitis B and C local implementation group and have developed the local elimination plan for 2025-28.

Notable achievements have included positive feedback from Welsh Government on work undertaken to date and the local elimination plan for 2025-2028; the number of community pharmacies in Gwent offering a needle and syringe programme and who offer Oraquick for hepatitis C and/or dry blood spot testing; and BBV testing in probation services and in custody suites.

As part of the hepatitis B and C elimination work, the health protection team has provided funding to GDAS to purchase a Cepheid Xpert Point of Care BBV test machine to enhance access to hepatitis C testing, as well as 1 WTE clinical staff member (until March 2027) to support the project and facilitate the implementation and operation of the Orasure and Cepheid machine. This will help increase our case finding across the Gwent area.

The health protection team has established and facilitated the first ABUHB TB Operational Group, which brings together partners from across the organisation and externally. The purpose of the group is to provide assurance around delivery and provision of TB services, ensure a safe TB service including latent TB case finding, screening and treatment, identify gaps in service provision, training and knowledge and facilitate collaborative working.

The health protection team continues to support the respiratory directorate and health board by funding a dedicated TB nurse to lead key service developments. This includes developing a sustainable business case and job descriptions, and the development of SOPs.

Sexual health and HIV

The health protection team work with the health board's sexual health team to address the 30 actions within the HIV action plan for Wales. As part of this, the health protection team are represented on the Fast Track Gwent steering group and are strengthening the provision of c-card outlets and distributors of test and post kits.

An evaluation of the c-card scheme was undertaken in September 2025 which aimed to identify:

- Active issue points regularly supporting young people through the scheme
- Non-active issue points wanting to resume the scheme
- Barriers to effectively running the C-Card scheme
- Interest in introducing Test & Post to C-Card
- Support needs of providers.

Learning from this evaluation is being implemented during 2026/27, with an electronic c-card scheme considered for launch. A further aim for the health protection team is to establish a Gwent Sexual and Reproductive Health and Wellbeing Board to prioritise sexual health and wellbeing for the population of Gwent. The overall aim of the group will be to reduce disease and stigma, widen access to services and champion objectives such as elimination targets for hepatitis and HIV.

Acute response

The health protection team and PC HearT remain responsible for the mobilisation of a response to TB cases and clusters, providing additional workforce capacity to the TB service, such as phlebotomy trained staff, and proactively seeking to eliminate the diseases as a public health threat via targeted interventions. PC HearT is also responsible for the implementation of enhanced case management for TB cases via direct observed therapy and video observed therapy. This helps ensure adherence and completion of TB treatment as well as reducing the risk of drug resistance resulting in erratic or incomplete treatment.

PC HearT prepared and developed pathways and processes for the changes made to the national anti-viral service requirements, as of 1st June 2025. The changes were outlined in a lunch and learn session with GP practices and PC HearT also retain elements of the provision of antivirals for care homes in outbreak, where timely administration is imperative. This team have also provided support, in partnership with the Local Public Health, Health Protection Team, with influenza outbreaks in our prisons and remain engaged with prison healthcare staff to outline procedures in outbreak response and to ensure they have their lists of high-risk patients up to date to ensure a timely response if needed.

ABUHB continues to have a notable increase of scabies outbreaks in care homes. Many of these outbreaks have required significant resource from the health protection team and PC HearT, as well as wider health board teams such as primary care and community pharmacy. A working group will be set up in the near future to agree an appropriate and proportionate response to dealing with scabies outbreaks, which remains the responsibility of the Health Board due to it not being a notifiable disease to Public Health Wales.

In late September 2025, the health protection team and PC HearT were notified of a case of hepatitis A affecting a school-aged child in the ABUHB area. A request was made to ABUHB to mobilise an urgent response to offer post-exposure prophylaxis and vaccinate 15 staff and 83 children of reception age in a very tight timeframe.

Internal groups were established to facilitate the response including communications with the school, communications to parents of the affected classes, wider communications with the rest of the school and development of a reactive communications strategy. An operational plan was developed at pace and clinics

were held at the school over two days at the beginning of October 2025. The clinicians from PC HearT delivered the vaccinations while staff from the health protection team provided administrative and operational support. The clinic was very successful and delivered the following:

- 14 out of 15 staff vaccinated
- 64 children out of 83 vaccinated
- 78 vaccines total given across staff and pupils
- 9 child refusals/declined
- 3 children had vaccine elsewhere prior to the clinic.

Our outcomes and speed at which we mobilised the response was highly commended by Public Health Wales, with the recommendation to write-up the work for publication.

Preparedness

The health protection team, along with other local resilience forum partners, contributed to the tier 1 national Exercise Pegasus in autumn 2025 - the largest ever simulation of a pandemic in UK history. This will inform the review of the Health Board's current Public Health Incident Plan and Pandemic Plan, which will be supported by a comprehensive plan to ensure the plans are embedded and exercised frequently.

The pathway for the provision of rabies post exposure prophylaxis is now functioning and has been shared across the health board, with referrals made by ED and MIUs as well as GPs. Clinicians from PC HearT deliver the remaining course of post exposure vaccinations for each patient following referral and risk assessment by Public Health Wales. The vaccines are delivered out of our hospital bases across the area so patients can attend the premises most convenient to them. During Q1 & Q2, PC HearT received 28 referrals, which equates to 83 vaccines given.

Similar to the rabies post exposure pathway, PC HearT have developed a post exposure pathway for needle stick injuries in the community for MIUs and ED. The intention is that after the initial assessment at these sites, referral is then made to PC HearT to follow up and administer any further actions including bloods, accelerated hepatitis B vaccine and hepatitis immunoglobulin, as indicated.

During 2025/26, PC HearT have collaborated with the public health team to update and develop sustainable pathways and procedures for the sampling and testing of patients for COVID-19, influenza, measles, diphtheria, avian flu and mpox, as well as the provision of timely post-exposure prophylaxis, including vaccinations and immunoglobulins.

Sampling has continued to be provided to eligible care home residents, which supports outbreak management of acute respiratory infections in these vulnerable settings. Providing sampling to this population ensures those eligible for antivirals can receive their medication within the appropriate timeframe and protects our most vulnerable populations.

2. Immunisations

A number of teams and services in the health board have a remit for delivering vaccinations, including school nursing and the Vaccination Service.

The Vaccination Service opened their flagship vaccination centre in Cwmbran in April 2025. Open Monday to Saturday, 9am to 5pm, the centre is staffed by a team of experienced immunisation nurses and practitioners who can provide advice, check vaccine eligibility and status, and administer a wide range of vaccinations for all age groups including Covid-19, flu, HPV and many others. During the festive period, the vaccination centre also offered extended opening hours on Thursdays, to improve flu vaccination access for the public and health board staff.

The Covid-19 spring campaign was delivered through a blended model of GPs, community pharmacies and the Vaccination Service. The Vaccination Service also delivered to domiciliary patients and those aged under 18 that were eligible.

The Vaccination Service took responsibility for delivering COVID-19 vaccinations in care homes and uptake in Gwent care home residents was 80.81%; the highest in Wales.

Governance

Governance for immunisations in the health board is provided through two groups: The Vaccine Operational Group (VOG), which meets fortnightly, and the Strategic Immunisation Group (SIG), which meets every two months.

The VOG is facilitated by the Vaccination Service. Its purpose is to provide direction and oversight across the spectrum of vaccine delivery for our population. The group ensures the operational oversight, management and evaluation of existing and novel programmes of work with the overall objective of equitably increasing vaccination coverage across the Gwent population.

The SIG is facilitated and chaired by Gwent Public Health Team. Its purpose is to bring together relevant individuals to provide strategic direction and oversight for what is required to successfully deliver the National Immunisation Framework within Gwent, and protect the health of the population from vaccine preventable diseases.

Proactive vaccinations

The team continue to lead the planning and implementation of the staff flu vaccination programme, with a dedicated project manager recruited to support its delivery.

The staff flu vaccination programme is also supported by a communications and engagement strategy, including the use of SMS messaging to ensure staff who do not have regular access to email or the intranet are informed on how to access their vaccination. Delivery of the programme continues to build on the existing tripartite model of flu champions, occupational health and the Vaccination Service. This has provided multiple routes to vaccination for staff, as well as the offer of evening and weekend sessions where possible.

As of 30th November 2025, uptake of the flu vaccination for health board staff is 40.2%, which already exceeds last year's end of season uptake.

In spring 2025, following a PHW briefing on the increased risk of meningococcal disease following travel to Saudi Arabia, the health protection team undertook a piece of work to understand the barriers to uptake of the MenACWY vaccination and address this through additional and innovative ways of working.

Working in collaboration with the Vaccination Service, school nursing service and communications team, the health protection team developed a plan to discuss opportunities to offer MenACWY vaccination. Working with Muslim Doctors Cymru, the team created two videos to promote the vaccination opportunities and to make it clear which route the prospective member of the public would need to take. The videos and accompanying information were shared using targeted strategies: Community engagement and communication; pharmacy and travel sector collaboration; and faith-based outreach.

Vaccine Equity

The health board has developed a Vaccine Equity Strategic Framework, which outlines how the health board plans to build on the established work to address barriers amongst the cohorts with sub-optimal vaccination uptake.

A local action plan will be developed during 2026, to ensure that our population is protected against vaccine preventable diseases and that vaccine equity is considered in developing immunisation programmes. Equity is not everyone benefitting from the same offer; it is ensuring that everyone gets the offer they need.

To further develop the health board's equity strategy and outreach offer, in October 2025, the health protection team took delivery of a mobile outreach unit, affectionately named 'Nye BeVAN'.

The introduction of a health protection mobile unit is an innovative and proactive approach to improving community health. The mobile unit will bring health protection services directly to communities and will:

- Deliver health protection services where they're needed most
- Increase community engagement
- Reduce inequalities by reaching vulnerable and underserved communities.

Nye BeVAN was used to support HIV testing week in November 2025, where the health protection team and Gwent Drug and Alcohol Service encouraged members of the public to get tested and know their status. For HIV testing week, the team offered test and post kits to the public, provided advice and answered questions about HIV testing and prevention. The mobile unit has also visited parts of Gwent, offering flu and RSV vaccinations to eligible members of the public.

A steering group continues to meet to provide strategic oversight, planning, and coordination for the deployment and operation of Nye BeVAN. It will ensure the unit delivers its objectives effectively: increasing vaccine uptake, reducing inequity, and supporting case finding and public health interventions in underserved communities.

The Big Gwent Vaccination Conversation

Throughout Q2, the health protection team planned 'The Big Gwent Vaccination Conversation'. Held early October 2025, the event brought together community voices, grassroots leaders, Gwent partners and those with influence in their communities so we can start to understand how we can change the conversation around vaccinations in Gwent and help protect our communities.

We know that across our communities, vaccine confidence has declined. Fewer people are receiving their routine immunisations; not because they don't care, but because barriers of trust, access and misinformation stand in the way.

Recommendations from the event will future planning for improving vaccination uptake across Gwent and reducing inequity.

3. Local authority public protection teams

Service level agreements have been developed with local authority public protection teams and align with the goals of the review of the Welsh Health Protection system, to provide a sustainable and collaborative health protection function for the Gwent population.

Each local authority has used their funding to increase the capacity and resilience of their workforce and further develop skills and knowledge by investing in the environmental health/public protection workforce. These roles include graduate posts and apprentice roles and their additionality has enabled local authorities to undertake health protection work they are not statutorily obliged to complete. Proactive infection prevention support has been offered to schools, nurseries and care homes; vaccine advocacy with care homes as part of winter preparedness; and a novel project has been initiated with tanning shops, in order to improve standards and protect consumers from injuries and over exposure to UV, resulting in increased risk of skin cancer.

4. All hazards approach

Environmental changes which include climate change, extreme weather events, and shifts in ecological conditions continue to shape the risk landscape for public health across the UK. Increasing temperatures, altered weather patterns such as increased intensity of rainfall and ecological disruptions are driving significant changes in how we are exposed to environmental hazards. These hazards have direct implications for communicable disease and our ability to prepare, control and respond to it as a system.

Flooding and extreme weather

Flooding remains one of the most immediate climate-related threats driven by increased rainfall intensity and frequency. This is associated with major health risks:

- Contaminated water sources which heighten the burden of waterborne pathogens such as *Campylobacter* and *Salmonella*.
- Disruption of essential services including utilities, healthcare and transport
- Impact on people living in damp cold homes that have flooded and require time and effort to dry out, which in turn can cause or exacerbate chronic and acute conditions such as asthma and COPD
- Mental health impacts following displacement, property damage and trauma

In November 2025 a major incident was declared in Monmouth due to severe and widespread flooding across the town and surrounding communities. A multi-agency emergency response was mounted that included Gwent Police, WAST, South Wales Fire and Rescue and the Health Board. Almost 700 homes and businesses were affected by the flooding and following the initial response a humanitarian action group was established, led by Monmouthshire County Council (MCC) to support the community and the individuals affected to recover. Individuals from the ABUHB Emergency Planning Team and Health Protection Team were core members of this group, working alongside MCC, British Red Cross, and Third and Voluntary Sector to ensure an appropriate plan for recovery was in place.

Work carried out within this space by the Public Health Team included:

- Working closely with Primary Care providers to raise awareness of the increased risk of water-borne infections and respiratory illnesses and ensuring they were able to respond appropriately should patients present.
- Working closely with Public Health Wales to monitor any changes in gastrointestinal incidents
- Ensuring appropriate advice for how to safely return home and ensure homes were well ventilated and dried out properly was shared to reduce the risk of developing new or exacerbating existing respiratory illnesses.
- Distributing resources to enable people to seek support for their mental well-being should they need it.

Vector-Borne Disease Risks

Climate change is altering the distribution, survival, and behaviour of disease-carrying vectors. The UK has already observed:

- Increasing suitability for non-native mosquitoes, including *Aedes albopictus*, facilitated by warmer temperatures and global travel/trade routes.
- First detection of West Nile virus in UK mosquitoes, signalling meaningful ecological shifts even though current public risk remains low.
- Rising imported malaria and dengue cases, reflecting both global incidence trends and increased post-pandemic travel.

The expanding risk of vector-borne diseases highlights the importance of sustained surveillance, rapid detection, and the ability to mount a multidisciplinary response. Recently Public Health Wales led a session called 'Exercise Biteback' that led sessions on how responses could be mounted based on scenarios that involved invasive mosquitos, attended by members of the Gwent Public Health Team and Local Authority EHOs. Learning from which will inform ongoing planning to strengthen the ability to respond to these events. Areas of Gwent such as the port in Newport will be considered as potential areas of high risk within this work.

Air quality and heat stress

Changing climate conditions also contribute to:

- Worsening air quality, driven by heatwaves and wildfires, with subsequent increases in respiratory illnesses such as asthma.
- Amplification of existing health inequalities, where socially deprived communities, young children, older adults, and people with chronic conditions experience disproportionate harm.
- Heat-related mortality and morbidity, which already incur significant economic costs and are projected to rise substantially by 2050.

These indirect impacts interact with infectious disease risks, socioeconomic factors, and spatial inequalities, making adaptation planning a cross-sectoral priority.

Wider ecological and environmental risks

As well as the above there are a number of ecological and environmental that pose a risk to our populations. These include:

- Zoonotic disease emergence which is influenced by e.g., changing human-animal interactions and land use patterns
- Water and food system vulnerabilities where supply disruptions and contamination risks are expected to increase.
- Burdens on public health services which face increasing demand related to prevention, preparedness and recovery from environmental incidents.

5. Award-winning service

The health board's Health Protection Service was honoured with the Community Public Health Hero Award at the 2025 UK Public Health Register (UKPHR) Awards in November, recognising the outstanding dedication to protecting and improving public health across Gwent.

It was acknowledged that the seamless, collaborative approach to tackling infectious diseases, managing outbreaks, and reducing health inequalities by the health protection team, Vaccination Service and PC HeaRT, has ensured a rapid and effective response to a wide range of public health challenges and increased the level of support and resilience available.

Argymhelliad / Recommendation

The PPHPC receive the update and note the breadth of work being undertaken across the health protection system to strengthen its capabilities in planning and responding to incidents and threats.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the health board's assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy 1.1 Health Promotion, Protection and Improvement 5. Timely Care 5.1 Timely Access
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Digital, Data, Intelligence
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse

Strategic Equality Objectives 2020-24	Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Health protection team: Strategic team within Gwent Public Health Team, with oversight for health protection incidents and leading key areas of work, notably the elimination targets. PC HeaRT: Acute health protection response team, consisting of clinical staff and who administer five broad functions: Sampling and testing; post-exposure prophylaxis/treatment; COVID-19 antiviral treatment; enhanced case management of hepatitis and TB patients and pathway integration with urgent primary care to increase business continuity and resilience. Vaccination Service: A core immunisation resource within ABUHB and offers offer a variety of vaccines and support the planning and delivery of vaccination programmes.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 January 2026
CYFARFOD O: MEETING OF:	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Regional Partnership Board Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans – Executive Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Amy Dolben – Assistant Director of Partnership & Integration Rebecca Stanton – Regional Children & Families Transformation Lead

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

1. Sefyllfa / Situation

The Social Services and Wellbeing Act 2014 sets out the requirement for Local Authorities and Local Health Boards to establish Regional Partnership Boards (RPB), to manage and develop services to secure strategic planning and partnership working. RPBs need to work with wider partners such as the third sector and providers to ensure care and support services are in place to meet the needs of their respective populations.

This report provides an update on the activities of the Gwent RPB.

2. Cefndir / Background

This report is provided to the Committee for information only to ensure consistent messaging and updates between the RPB and the Health Board.

3. Asesiad / Assessment

3.1. Welsh Government updates

3.1.1. Integrated Community Care System

In December 2024, Welsh Government issued a position statement for the Regional Integration Fund (RIF), the Housing with Care Fund (HCF) and the Integration and Rebalancing Care Fund (IRCF) and proposed Integrated



Community Care System (ICCS). Welsh Government’s vision for an ICCS is to build a healthier Wales through integrating health and social care systems and building capacity for people to receive the care and support they need at or closer to home.

Welsh Government has now issued a refined position statement which aims to consolidate its vision to move from pilot projects to systemwide, integrated community care at-scale. A full copy of the position statement can be found in **Appendix 1**.

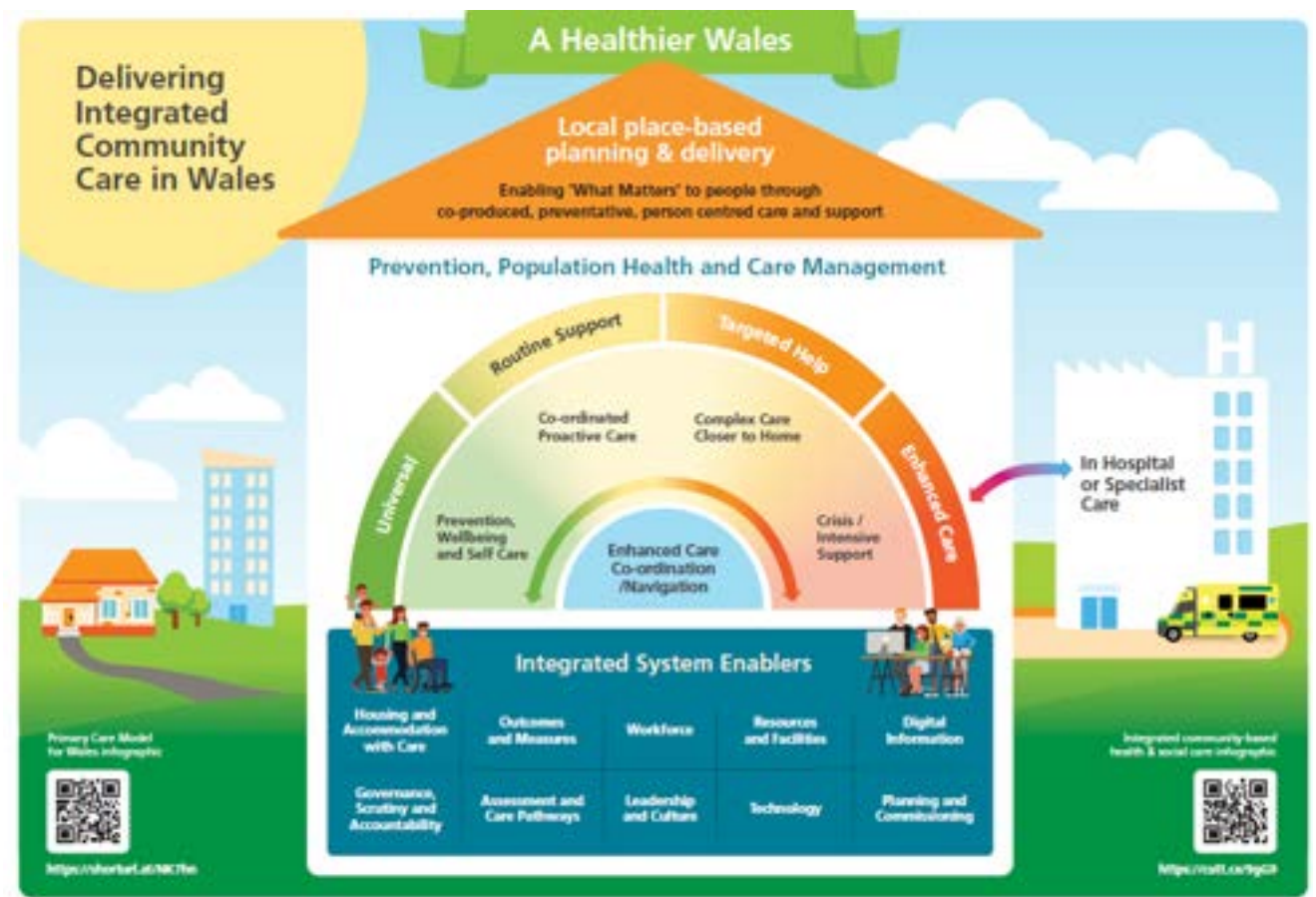


Figure 1: Integrated Community Care System blueprint V4 2025

The inclusion of wider programmes within the position statement (e.g. Six Goals of Urgent and Emergency Care and the Strategic Programme for Primary Care) highlights their key contribution to ICCS delivery, namely: keeping people well at home; reducing hospital pressures; and delivering more consistent, equitable care across Wales.

The overarching priorities for 2025/26 described within the position statement demonstrate a willingness for improved alignment across various funding streams and a stronger role for RPBs as system-change leaders. This provides significant opportunity to strengthen partnership working to support improved health and wellbeing outcomes.

However, given the complexity of the political landscape, RPBs might anticipate some challenges in delivering against the ambitions outlined within the position statement. Indeed, Welsh Government has not yet confirmed the funding arrangements following the conclusion of RIF, HCF and IRCF on 31 March 2027;



this presents uncertainty for all partners and creates risk around future service delivery for the ICCS. RPBs have received indicative assurance that one year's notice will be given to either terminate or transition to an alternative funding stream.

Since the launch of the ICCS policy, Welsh Government have launched Community by Design. A programme led by the Chief Medical Officer and focusing on:

- **Pillar 1** – Urgent & Same Day Care
- **Pillar 2** – Chronic Conditions and Long-Term Care
- **Pillar 3** – Prevention & Population Health

There is further clarity required on the alignment of these two policy areas and the Health Board is engaging in these discussions.

3.2. Regional Partnership Board Update

3.2.1. RPB Development Work

A structured series of workshops have been held to review and refine the RPB priorities. This initiative will be supported by the commencement of work on the Population Needs Assessment and the development of the Area Plan in conjunction with the Regional Partnership Team (RPT).

3.2.1 Frailty Section 33

A review of the Gwent Frailty Programme was commissioned by RPB in early 2025. The review was intended to comprise two parts to be undertaken concurrently as follows:

1. "To look at the financial and legal implications of changing commitments aligned to the Section 33 Agreement and governance arrangements
2. To review service delivery and evaluate its effectiveness against funding allocation on a locality basis."

A working group with representation from all partners and all localities was responsible for undertaking this review. This group has developed a paper which will be discussed by RPB at its meeting on 20 January 2026.

Within this paper, all local authorities indicate their intention to withdraw from the pooled funding arrangement – indicating that they believe the Section 33 had fulfilled its purpose of loan repayment to Welsh Government. The local authorities would prefer local arrangements, and propose service-level agreements or memoranda of understanding for each element of the current Frailty Programme.

By contrast, the Health Board wishes to further understand the second component of the commissioned review – namely, service delivery – in order to come to a firm decision on future funding and service arrangements.

Should the local authorities choose to withdraw from the arrangement, a one-year notice period would be required. It is worth noting that whilst the RPB commissioned the Section 33 review, it does not hold decision-making authority



over the pooled funding arrangement – this is the responsibility of individual partners.

3.3 Revenue Portfolio

3.3.1. Impact Assessments

The impact assessment process for this financial year commenced in September 2025 – this process will inform funding and delivery decisions for 2026/27. A RAG-rating has been applied to all projects with an assessment undertaken against: (i) strategic alignment; and (ii) delivery and outcomes.

RAG-ratings have not been used to automatically determine outcomes for 2026/27. Rather, they have been used to inform discussions and support decision-making around future funding and delivery. In order to ensure outcomes-focussed delivery, projects may be subject to a review and/or redevelopment or renewal of a Project Initiation Document or Business Case.

The decision-making process concludes on 20 January 2026 and project award letters will be issued following Welsh Government confirmation of RPB funding for 2026/27. Based on previous funding allocations and decisions made to date, the RPB can anticipate approximately £667,000 of unallocated funds for 2026/27. The RPB will need to make decisions on how it wishes to utilise these monies following conclusion of the assessment process.

The March Board report will also provide a summary of Health Board-hosted projects – including changes to funding and delivery in 2026/27. Below is a table showing initial RAG-ratings for Health Board projects.

Impact Assessment Initial Rating for Health Board Projects

Strategic Partnership	Red	Amber	Green	Unrated due to extenuating circumstances	Total
Carers				5	5
Children and Families			7		7
Dementia		4	4		8
Gwent Adults	1	1	20	2	27
Health, Social Care and Housing					0
Mental Health and Learning Disability		1	4		5
Total	1	6	35	7	42

As shown in the table above, one Health Board project received a Red RAG-rating. This was the Wellbeing Workforce project which received one year’s notice of funding withdrawal at the start of the 2025/26 financial year. Therefore, RPB funding for this project will cease on 31 March 2026. The project team has been preparing for the withdrawal of RPB funding and will submit a Project Closure Report.



A very small number of projects across the portfolio have not been subject to a RAG-rating due to extenuating circumstances. This includes:

- Projects which received non-recurrent in-year funding for a standalone event or occasion which has been reported to RPB via other mechanisms (and therefore has received appropriate scrutiny and will not require future funding)
- Projects funded via Further Faster which is a recurrent fund with no end date and is currently managed differently than all other RPB funding streams which are due to come to an end on 31 March 2027 – however, following RLG agreement these projects will be subject to an assessment going forward.

3.4 Capital Portfolio

3.4.1 Annual Portfolio Funding

The following table outlines the funding streams available to support capital developments in 2025/26.

Funding Stream	Funding Allocation
IRCF	£70 million across Wales, on a first-come-first served basis
HCF	£11.609 million for Gwent (Objective 3 Minors: £1.161m, Objective 3 DFG: £0.581m)

At Month 8, £7.127m of approved schemes are expected to be delivered in-year, with a further £8.199m planned for 2026/27 and beyond. For 2025/26 the programme remains under-utilised by £5.745m. Despite a strong pipeline, overall utilisation is projected at 67% for HCF in 2025/26. Dependant on phasing, anticipated utilisation for 2026/27 is approximately 77%.

The RPB continues to proactively consider ways to address the current challenges in utilising the full allocation, including expediting approval processes via virtual approvals. A list of Health Board committed projects for the next financial year 25/26 will be outlined in the March Board paper.

3.4.2 Strategic Capital Plan

The RPB is required to submit a Strategic Capital Plan (SCP) to Welsh Government on an annual basis. Work has been ongoing with the Strategic Partnerships and the Gwent Citizen Network to gather insights.

The refreshed document will be submitted to Welsh Government in March 2026.

4. Argymhelliad / Recommendation

The Committee is asked to note the updates included in this report.

Appendices

Appendix 1: ICCS position statement



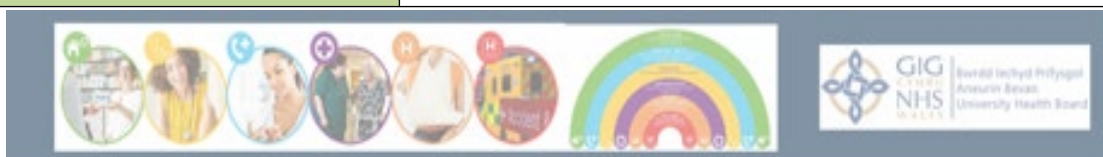
building-an-integrated-community-care



Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life Getting it right for children and young adults Adults in Gwent live healthily and age well Older adults are supported to live well and independently Dying Well as part of life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Partnership First
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	HCF Housing with Care Fund IRCF Integration and Rebalancing Care Fund RPB Regional Partnership Board RIF Regional Integration Fund RLG Regional Leadership Group ICCS Integrated Community Care System
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb	No does not meet requirements



Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves





Llywodraeth Cymru
Welsh Government

Building an Integrated Community Care System

A joint 2024/25 position statement for Welsh
Government funds supporting early intervention,
prevention and integrated community support.

Contents

Foreword	1
Realising a Seamless Health and Care System: The Integrated Community Care System for Wales (ICCS)	3
Allied Health Professions (AHP) Investment supporting an Integrated Community Care System	7
Further Faster Programme: Accelerating Integrated Community Care System in Wales	8
Housing with Care Fund (HCF) Overview and Spotlights	11
Integrated Rebalancing Care Fund (IRCF) Overview and Spotlights	17
Regional Integration Fund (RIF): Driving Transformation in Health and Social Care	23
– A Year in Review	26
– Understanding The Data: How Much We Did and What Difference it Made for People	27
– Models of Integrated Care	30
Six Goals for Urgent and Emergency Care	35
Strategic Programme for Primary Care (SPPC)	38
Conclusion and Next steps	39

Foreword

As Ministerial colleagues, we are pleased to present this updated position statement, reflecting the progress made over the past year in our collective efforts to transform health and social care in Wales. This position statement reaffirms our commitment to a collaborative, whole-system approach to investment and reform, with a clear focus on delivering an Integrated Community Care System (ICCS) for Wales.

Over the past year, continued strategic investment totalling more than a quarter of a billion pounds annually – through the Allied Health Profession investment, Further Faster funding, Housing with Care Fund (HCF), the Integration and Rebalancing Capital Fund (IRCF), and the Health and Social Care Regional Integration Fund (RIF) – has enabled significant strides toward our shared ambition. These funds are central to reshaping how care is delivered, ensuring it is person-centred, preventative, and rooted in communities. While this statement focuses on these major funds, we also acknowledge the vital contributions of other national programmes such as the Urgent and Emergency Care Six Goals programme, the Strategic Primary Care Programme, and the Social Prescribing Framework. Together, these initiatives are helping to embed the principles of the ICCS across Wales.

A central aim of the ICCS is to keep people well and out of hospital wherever possible. Prevention and early intervention must be at the heart of our approach. The duty to co-operate applies equally to local authorities and health boards, ensuring shared responsibility for early intervention and integrated service delivery. ‘A Healthier Wales’ sets out our national vision for transformation, with a strong emphasis on prevention, early intervention, and community-

based care. All of the funds are designed to support this shift, enabling people to live well at home or in their communities, reducing pressure on hospitals. The newly announced £30 million Pathways of Care Transformation Grant will further support community capacity, helping to prevent escalation of need and avoidable hospital admissions. This new investment must be seen alongside wider Regional Partnership Board (RPB) and Health Board efforts to build community capacity. Strategic alignment across health and social care is essential to maximise impact and value for money.

We want to be clear that RPBs are not simply vehicles for managing Welsh Government cross sector grants. They are driving system collaboration and service integration. It is essential that all partners engage meaningfully with their RPBs, recognising their strategic role in shaping the future of care in Wales. Under the revised Social Services and Well-being (Wales) Act Part 9 guidance, each Health Board and Local Authority has been asked to identify a ‘responsible person’ for integration. As Ministers, we will meet annually with these individuals and RPB Chairs to strengthen focus, accountability, and alignment with our integrated approach.

The work of the Care Action Committee and the winter planning arrangements through the 50-Day Challenge has shown the power of cross-sector collaboration in delivering better outcomes for people. Over the past 12 months, we've seen excellent examples of innovation and partnership that we must now deepen, extend, and embed. Through the 50-Day Challenge, we've shared good practice examples from across Wales. Wales is too small a nation to justify the level of variation we currently see. We must share, learn, and adapt to deliver greater consistency and public confidence in our health and care system.

We are also proud to have announced that Wales will become the world's first 'Marmot Nation', committing to tackling health inequalities. Local authorities and health boards, as statutory partners on both RPBs and Public Service Boards, have a vital role in delivering services that support the wider determinants of health and wellbeing - such as housing, employment, and social inclusion.

As we look ahead, we will continue to work closely with RPBs and statutory partners to share, scale, and spread good practice. Our goal is a consistent and equitable integrated community care offer across Wales, ensuring that wherever people live closer to home, they can access effective, joined-up support. We also remain committed to supporting our front-line workforce by simplifying processes and fostering collaboration across organisational boundaries. This will help teams work more effectively together and provide holistic support to people in their communities.

We acknowledge the continued progress made to date, but we are clear that further focus and effort are needed. By deepening partnerships, strengthening accountability, and accelerating integrated service delivery, we will continue to transform our system and realise the ambition of an Integrated Community Care System for Wales.



Jeremy Miles MS
Cabinet Secretary for
Health and Social Care



Jayne Bryant MS
Cabinet Secretary
for Housing and
Local Government



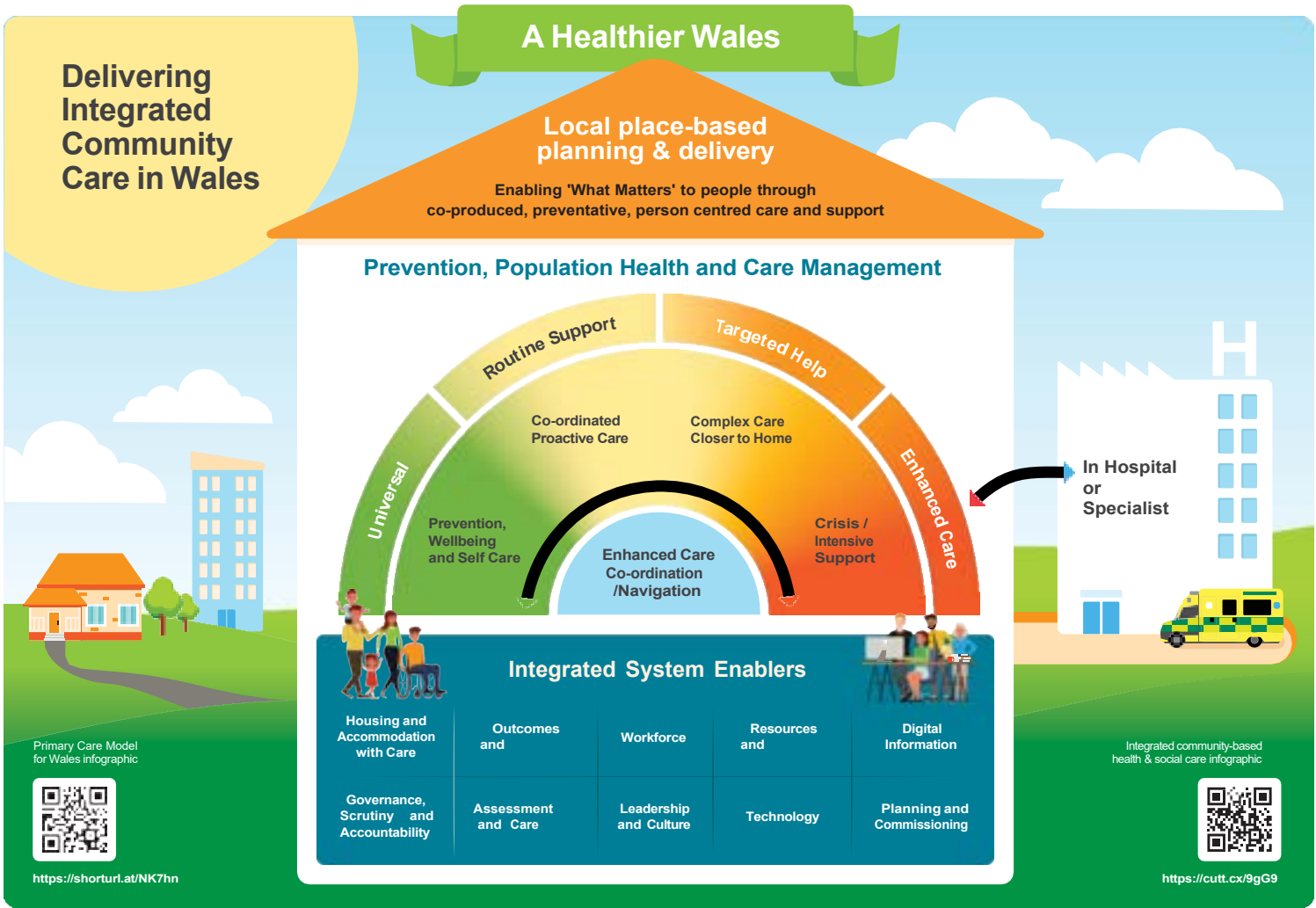
Dawn Bowden MS
Minister for Children
and Social Care



Sarah Murphy MS
Minister for Mental
Health and Wellbeing

Realising a Seamless Health and Care System: The Integrated Community Care System for Wales (ICCS)

Figure 1: Integrated Community Care System blueprint V4 2025



Our commitment to creating an Integrated Community Care System (ICCS) for Wales is a significant step towards achieving the goals of **A Healthier Wales** as well as responding to some of the findings of the Darzi report 2024.

Fundamentally it is our approach to developing a preventative and integrated community/place-based care offer that is nationally enabled (by Welsh Government), regionally facilitated (by Regional Partnership Boards) and locally delivered (by cluster and community level arrangements).

The ICCS is a strategic transformation framework. It aligns policy, funding, and delivery across sectors to create a seamless, integrated care experience that enables people to live well at home, avoid unnecessary hospitalisation, and access timely, joined-up support when needed.

From Vision to Delivery: A Maturing System

Now in its second year of development, the ICCS blueprint (figure 1) has evolved from concept to implementation. It is underpinned by a clear ambition to deliver “*what matters*” most to people through a system that is:

- Proactive in promoting health and preventing escalation of need.

- Person-centred in supporting independence and wellbeing at home.
- Integrated in delivering care and support closer to home.
- Responsive in ensuring safe, timely transitions (discharge) from hospital back into the community.

Integrated System Enablers: Building the Conditions for Success

To deliver this transformation at scale, we are investing in the critical enablers of system change:

- Shared **outcomes and measurement frameworks** to drive accountability and learning.
- A confident, capable **workforce** operating across organisational boundaries.
- Interoperable **digital infrastructure** to support real-time information sharing.

- **Integrated governance and accountability** to enable joint decision-making.
- Pooled resources and **joint planning and commissioning** to maximise value and impact.
- Collaborative **leadership and culture** that champions innovation and partnership.
- **Technology-enabled care** that empowers people to manage their own health and wellbeing.

Progress so far

The winter pressures of 2023/24 and 2024/25 prompted a range of collaborative responses across Wales, that have helped us to accelerate some of the key building blocks for our ICCS. Among these, the Ministerially led Care Action Committee (CAC) played a significant role in accelerating improvements in discharge and flow, contributing to a broader shift toward integrated, preventative care and support, as part of the vision of delivering an ICCS for Wales.

Initially convened to address urgent winter pressures, the CAC helped test and accelerate integrated care approaches and saw some notable successes through the 50-Day Integrated Care Winter Challenge and the additional £19m resources provided to help build capacity and improve system flow. Its work informed the continued development of the ICCS approach, which now provides an evidence base for the model and ongoing system improvement, as well as prompting a system wide approach to planning for winter 2025/26.

The 50-Day Integrated Care Winter Challenge marked a turning point in Wales' approach to integrated winter resilience and care delivery.

This year, we have worked collaboratively with health, social care, and other partners to develop a number of core infrastructure elements intended to advance new ICCS model. These efforts include mapping and aligning shared outcomes and measures and creating the Integrated Care governance arrangements with associated terms of reference, the new Integrated Care meeting arrangement are described below.

Through the seven Regional Partnership Boards, we have seen the positive development of ICCS strategic planning approaches and will support regions to maximise the opportunity to fully embed the ICCS principles.

Strategic Alignment and Investment

Welsh Government has strengthened the governance architecture to support ICCS delivery, building on the groundwork laid by the former Care Action Committee. This includes the establishment of:

- The Integrated Care Strategic Leadership Group, chaired by the Cabinet Secretary for Health and Social Care.
- The Integrated Care Delivery Group, bringing together senior responsible officers.
- Annual Regional Integration Accountability meetings with each Regional Partnership Board (RPB).

These structures ensure alignment across a wide range of programmes, including the Strategic Programme for Primary Care, 6 Goals for Urgent and Emergency Care, Regional Integration Fund (RIF), Health and Care Fund (HCF), Integration and Rebalancing Capital Fund (IRCF), Further Faster, and Allied Health Professional investment – collectively representing over **£300 million in annual investment**. This alignment is enabling a strategic consolidation of Wales' policy and funding landscape, ensuring that resources are targeted toward integrated, sustainable models of care in the community.

Regional Leadership and Local Innovation

Regional Partnership Boards and Pan Cluster Planning Groups remain pivotal in shaping and delivering the ICCS. Their role is to ensure that national ambition is translated into locally responsive, person-centred delivery. To support this, Welsh Government has revised the Part 9 Statutory Guidance on Partnership Working,

clarifying the relationship between RPBs and Pan Cluster Planning Groups and reinforcing the shared responsibility for building an integrated community care system.

Looking Ahead: A System with Purpose and Momentum

The ICCS represents a bold, long-term commitment to transforming care in Wales. It is a system designed not just to meet today's challenges, but to anticipate tomorrow's needs, anchored in prevention, driven by outcomes, and powered by collaboration.

As we move forward, the focus must remain on furthering integration, scaling good practice, and embedding innovation, ensuring that every person in Wales can access the right care, in the right place, at the right time.

Allied Health Professions (AHP) Investment supporting an Integrated Community Care System

The recurrent £5 million additional AHP Investment, launched in April 2023, marks a significant step forward in strengthening Wales' community and primary care workforce. This funding is strategically targeted to expand the presence of registered Allied Health Professionals (AHPs) and support worker roles within community settings ensuring timely, person-centred care that supports people to live independently and well.

This investment is a cornerstone in building a resilient, sustainable, and Integrated Community Care System for Wales, aligned with the ambitions of Accelerated Cluster Development and the broader health and

social care transformation agenda. Under the leadership of Executive Directors of AHPs and Health Science, and Directors of Primary and Community Care, Pan Cluster Planning Groups (PCPGs) have played a pivotal role in shaping local delivery, with endorsement through Regional Partnership Boards ensuring a truly collaborative, system-wide approach to developing an ICCS for Wales.

The Strategic Programme for Primary Care (SPPC) continues to provide national leadership, oversight, and assurance, with robust reporting to Welsh Government demonstrating the value and impact of this investment.

Key Achievements to Date

- **102.6 WTE** additional posts created across Wales.
- **Substantive transformation** of AHP services, enabling:
 - A strategic **shift to community-based care**, improving access and responsiveness.
 - Enhanced **community capacity**, reducing avoidable hospital admissions and supporting safe, timely discharge.
 - Strengthened **cluster working**, with a focus on prevention and population health.

This investment is not only delivering immediate benefits it is also laying the foundation for a more integrated, proactive, and sustainable model of care across Wales. To access detailed mid-year and end-of-year reports, showcasing the impact and learning from across regions, click on links below:

[Additional Allied Health Professions Investment – Primary Care One](#)

[Buddsoddiad Ychwanegol mewn Proffesiynau Perthynol i Iechyd – Gofal Sylfaenol Un](#)

Further Faster Programme: Accelerating Integrated Community Care System in Wales

Further Faster was launched to help accelerate some of the key workforce components as part of developing an ICCS for Wales. With an annual investment of £11.95 million, Further Faster focuses on three priority areas to increase community capacity, in line with the ICCS aim to:

- Shift care closer to home and avoid hospital admissions.
- Build community capacity and reduce reliance on acute services

- Deliver 'what matters' to individuals through proactive personalised care and improving population outcomes.

Whilst investment is issued to health boards across Wales, the funding comes with a requirement for health and social care partners to work together through Regional Partnership Boards, to ensure investment is strategically aligned.

2024/25 Priorities

Targeted actions and timelines were identified to deliver tangible improvements for:

1. Community Nursing Capacity

- Community Nursing Specification: Prioritising universal Registered Nursing at home, with enhanced weekend District Nursing capacity (targeting 80% of weekday levels).
- Specialist Palliative Care Access: Expanding 7-day access, including partnerships with commissioned third sector and hospice providers.

2. Community Services Capacity

- Allied Health Professions: Increasing workforce capacity to meet growing community needs.
- Enhanced Community Care: Aiming for a 20% increase in capacity by March 2025, as guided by the Care Action Committee.

3. Future Care Planning for people at high risk of hospitalisation

- Future Care Planning: Developing anticipatory/future care plans for the 0.5% of individuals at highest risk, with a Once for Wales approach under active development.

2024/25 Progress

In 2024/25, the full £11.95 million Further Faster investment was allocated across all regions, with notable examples of good practice and emerging opportunities reported across each priority area, particularly for initiatives that support an expansion of Enhanced Community Care.

Going forward work will continue to develop and strengthen a consistent approach to Future Care Planning for our high-risk populations.

Community Nursing Specification

By March 2025, national progress toward achieving 7-day District Nursing service improved. Most regions demonstrated meaningful improvement, driven by targeted recruitment, strategic planning, and enhanced data reporting. Weekend activity levels increased across the board, supported by workforce expansion and integrated training initiatives. Month-on-month growth in weekend coverage was evident, with some areas doubling their weekend

workforce and embedding new roles to support service delivery.

These collective efforts reflect a strong commitment to strengthening weekend community nursing services. Continued investment in workforce development, education, and strategic planning will be essential to closing the coverage gap and ensuring equitable access to care across all regions.

Specialist Palliative Care Access

Weekend access to specialist palliative care has been strengthened across Wales through Further Faster funding, with most regions implementing new roles, expanding coverage, and enhancing coordination. Improvements include consistent specialist presence in acute settings, uplifted community support, and targeted initiatives for non-cancer diagnoses. These developments have enabled earlier interventions, improved symptom management, and supported timely discharges and home-based end-of-life care.

Patient and carer feedback has been positive and continuity of care has improved. Continued investment in workforce development, service integration, and data capture will be essential to ensure equitable access and further progress, particularly in regions where expansion is still pending.

Enhanced Community Care – Community Capacity

Enhanced Community Care received the largest share of Further Faster investment across Wales, with most regions using the funding to expand urgent response capacity, embed virtual ward models, and strengthen community-based alternatives to hospital admission. Services such as Safe@home, acute frailty response teams, and integrated equipment services have enabled timely care at home, reduced emergency pressures, and supported discharge and recovery. Initiatives also included workforce expansion, rapid response logistics, and digital upgrades to improve flow and coordination.

Community-led projects were supported through small grants, promoting wellbeing, reducing isolation, and enhancing anticipatory care planning. While data integrity is still developing, early indicators show significant bed day savings, high patient satisfaction, and improved system flow. Continued alignment of investment with strategic priorities and robust regional planning will be key to sustaining and scaling these gains.

Future Care Planning (FCP)

Investment in Future Care Planning (FCP) was limited across most regions during 2024/25. However, a one-off allocation of £5 million by Welsh Government in December 2024, as part of the 50-Day Integrated Care Winter Challenge, provided a catalyst for accelerated development. Several areas used this funding to enhance multidisciplinary working, strengthen anticipatory care planning for high-risk cohorts, and improve data systems to support outcome tracking. While some regions opted not to use Further Faster funding for FCP, existing services such as virtual wards and cluster-based models continued to support delivery.

Collectively, these efforts signal a growing recognition of the importance of proactive care planning in reducing hospital admissions and supporting person-centred care. Continued development and integration of FCP into community and primary care pathways will be essential to ensure consistency and sustainability across Wales.

Further Faster Summary

Overall, Further Faster investment throughout 2024/25 supported the development and introduction of increased community capacity provision, with the aim of supporting more people closer to home, with initiatives introduced not only to help avoid hospital admission but also to further integrate and streamline existing ways of working to ensure future service efficiency and sustainability.

Further work and focus are undoubtedly required, particularly in respect of Future Care Planning work and Third Sector involvement across Wales.

[Welsh Government – Further Faster Statement of Intent](#)

Housing with Care Fund (HCF) Overview and Spotlights

The primary objective of the Housing with Care Fund (HCF) is to increase the stock of housing to meet the needs of people with care and support needs.

The HCF is a preventative programme, building on the previous Integrated Care Fund (ICF) capital programme and underpins the Programme for Government Commitment (PfG) to ‘support innovative housing to meet care needs.’

The programme contributes to the commitment to ‘fund regional residential services for children with complex needs ensuring their needs are met as close to home as possible and in Wales wherever practicable’ and also contributes to the PfG commitment under the same theme to ‘Eliminate private profit from the care of children looked after’.

Finally, in producing new homes, HCF programme activity also contributes to delivering the PfG commitment to deliver 20,000 new low carbon homes for social rent during the 2021-2026 Senedd term.

The purpose of the HCF is to support independent living in the community for people with care and support needs, and to provide intermediate care settings in the community so that people who need care, support and rehabilitation can return to living independently or maintain their existing independence.

As well as larger strategic projects, HCF capital investment is also being used to provide specialised equipment such as assisted technology and aids and adaptations for people’s homes. These are all critical in reducing unnecessary hospital admissions, inappropriate admissions to residential care, and delayed transfers of care.

Priorities for Investment

The three-year HCF programme budget has been in place since 2022-23 with £60.5m available per annum. A further year of indicative funding for 2026-27 is also expected. Priority Groups include:

- older people, including people with dementia
- children and young people with complex needs

- people with learning disabilities, neuro-diverse and neurodevelopmental conditions
- unpaid carers
- people with emotional health and mental well-being needs.

HCF delivers three types of accommodation:

• Objective 1:

Long term tenured housing with care, such as extra care for older people and supported living for adults with a learning disability. These schemes may be funded entirely from HCF or through a blend of HCF funding and Social Housing Grant.

• Objective 2:

Short and medium-term settings, such as step up / step down, rehabilitation settings in the community, transitional accommodation for young people leaving care, and residential care for children with complex needs.

• Objective 3:

Minor projects that meet the HCF aims. RPBs are responsible for determining how to allocate the discretionary funding for minor projects in their region.

Progress to Date

Tables 1 and 2 provide an overview of spend by client group and project type for the HCF programme over the past two financial years, and demonstrates an increase in spend as the programme has bedded in.

HCF has provided a level of programme resource funding at a regional level, which several regions are utilising. This has helped with the delivery of projects and will continue to do so during 2025/26.

Table 1: Priority Group

	2022/23		2023/24		2024/25	
	Projects	£	Projects	£	Projects	£
Children and Young people with complex needs	21	£7,272,879	35	£13,504,896	34	£18,344,357
Older people including people with dementia	5	£5,469,028	6	£9,243,013	8	£13,003,799
People with emotional health and mental well-being needs	3	£1,548,756	4	£2,074,746	2	£671,013
People with learning disabilities, neurodiverse and neurodevelopmental conditions	15	£7,683,054	24	£7,007,678	25	£8,033,325
Unpaid carers	0	0	1	£48,000	1	£168,000
Objective 3	-	£8,724,980	-	£9,267,060	-	£11,246,925
Total	44	£30,698,697	70	£41,145,393	70	£51,467,419

Table 2: Project Type

	2022/23		2023/24		2024/25	
	Projects	£	Projects	£	Projects	£
Extra care	2	£5,090,208	4	£8,234,627	7	£12,739,836
Children's Home	4	£1,443,030	3	£1,284,247	3	£2,350,679
Children's Residential	17	£7,011,478	27	£10,241,543	23	£12,692,997
Intermediate care	2	£549,000	2	£152,000	1	£975,000
Other	4	£446,618	3	£96,651	2	£815,905
Transitional Accommodation	1	£632,256	-	-	-	-
Independent Living	-	-	1	£208,184	-	-
Sheltered Housing	0	0	0	0	1	£334,158
Supported Living	14	£6,612,114	31	£11,661,081	33	£10,421,893
Objective 3	-	£8,913,993	-	£8,997,206	-	£10,895,520
Programme resource	-	-	-	£269,854	-	£234,189
Total	44	£30,698,691	70	£41,145,393	70	£51,467,419

Joined up working

Alongside HCF, the Integration and Rebalancing Capital Fund (IRCF) programme supports the development of community hubs and rebalancing of the residential care sector. The two funds are complementary and are supported by Regional Integration Fund (RIF) revenue funding to support new models of preventative care.

Together the two capital funds and the revenue fund represent a significant increase in funding to accelerate the move towards independent living and care closer to home, as set out in *A Healthier Wales*.

Looking forward

Since its inception, the annual commitments made through the HCF programme have increased, with 2024-25 being the most successful year yet. The HCF team will continue to engage with the Regional Partnership Boards and partners to facilitate the delivery of accommodation-based solutions to meet the needs of the population of Wales.

The funding will continue to be invested in housing designed to ensure people with care and support needs can continue to live independently in a home which meets their needs whilst allowing them to maintain their independence.

CASE STUDY

Region: **Powys**

Project: **Neuadd Maldwyn, Welshpool**

Neuadd Maldwyn is a new extra care scheme providing high-quality, safe, warm homes for elderly people from the Welshpool area developed by Clwyd Alyn Housing Association (CAHA) in partnership with Powys County Council.

The first residents began to move into their homes on April 25. The new apartments offer a supportive environment for residents, with the opportunity to live alongside like-minded people and socialise in a community setting. As well as the 66, one-and-two-bedroom modern apartments, the scheme features a large restaurant, multi-activity room, landscaped gardens, communal lounge, laundry, buggy store, separate assisted bathroom, and a variety of other communal spaces for the residents to use and enjoy.

CAHA received approx. £3m through the ICF capital programme (predecessor to HCF) to deliver a 60-bed extra care scheme in the centre of Welshpool. This was a jointly funded project with SHG.

Neuadd Maldwyn is a grade II listed building which was previously Council offices/chamber, and this has been extended to deliver the 60 beds with many of the features maintained.



CASE STUDY

Region: **West Wales**

Project: **Clynfyw Care Farm Supported Living Scheme**

Clynfyw Care Farm in North Pembrokeshire provides supported accommodation for adults with learning disabilities and neurodevelopmental conditions.

In March 2025, £270,000 of Welsh Government HCF funding enabled the acquisition of four cottages, securing ten long-term tenancies and two staff units. Located on a 395-acre organic farm, the scheme offers day services, education, and work opportunities, promoting independence and inclusion.

The acquisition safeguarded a vital service in an area with limited provision and ensured residents could remain close to their communities. The scheme supports regional housing needs and maintains stable placements in line with the wishes of current occupants, helping preserve continuity of care and community connection.



CASE STUDY

Region: **Gwent**

Project: **Ty Ash, Newport**

At Ty Ash, Action for Children (AFC) will support children and young people between the ages of 8–18 years with complex needs and challenging behaviours, who live under the care of Local Authorities and are likely to have experienced repeated placement breakdowns. The scheme will provide four bed spaces for children and young people.

The property is owned by AFC, having been used as a school in recent years. The property was vacated by previous tenants in October 2022. The Housing with Care Fund (HCF) has invested just over £1m to refurbish the property into a children's home.

This will be a Gwent wide project and offer long-term placements for children/young people looked after by local authorities across the region.



Integrated Rebalancing Care Fund (IRCF) Overview and Spotlights

The Integrated Health and Social Care Hubs (IHSCCH) Programme was established to deliver the Programme for Government (PfG) commitments to ***‘Invest in a new generation of integrated health and social care centres across Wales’*** and ***‘Develop more than 50 local community hubs to co-locate front-line health and social care and other services’***.

The IHSCCH programme covers a wide range of activities including the development and implementation of a capital funding programme delivered via the Health and Social Care Integration and Rebalancing Capital Fund (IRCF) established to directly support the PfG commitments and has three priority programme areas:

1. a coherent approach to planning the co-location and integration of health and social care services within the community across Wales
2. the rebalancing of adult residential care provision by increasing delivery from within the not-for-profit sector
3. support the elimination of profit from the provision of children’s residential care (incentives to support a change of business model in children’s residential care towards a not-for-profit model).

Regional Partnership Boards lead a joined-up approach to planning health social care and housing capital investment to enable seamless service delivery closer to home; and manage use of the IRCF fund across Wales.

Each RPB has developed a 10-year Strategic Capital Plan which also sets out a list of prioritised health and social care projects forecasting the necessity of IRCF investment over the short to medium-term.

IRCF has a capital ringfenced budget of up to £70m in 2025/26 and 2026/27.

Alongside this Capital funding, Welsh Government has made specific revenue funds available for RPBs to aid programme delivery:

- £200,000 – Resource capacity which should include capital project managers whose primary role will be to deliver the regional integrated Health and Social Care strategic capital plan but may also provide strategic support to partner organisations in project development.
- £250,000 – Co-ordinate and facilitate the development of seamless, integrated delivery of services through health and social care hubs.

Progress

At date of publication, 38 schemes across Wales have been awarded funding up to a total of £114.4 million through IRCF.

In terms of the 3 priority areas, 30 of the schemes will deliver integrated hubs, 6 schemes support the rebalancing of the adult residential care provision and 2 support eliminating profit from looked after children (HCF also fund proposals for Eliminate). All RPB regions have secured funding for schemes in their region and, 16 of the 22 Authorities have had IRCF projects approved to date.

We continue to work with the RPB Capital Teams to develop a programme of work for the funding period up to April 2027 and beyond. New guidance was published in May 2025 in line with the funding programme.

[Health and social care integration and rebalancing capital fund: guidance 2025 to 2027 | GOV.WALES](#)

Over the course of the programme to date, there has been a wide range of applications received from large complex investments, requiring outline and full business cases (OBC/FBC) to smaller lower value schemes (both new build and refurbishment) based on a business justification case (BJC).

The integrated nature of the schemes approved highlight the reach of the schemes in terms of health, social care and well-being.

The IRCF process is based around the five-case business model with projects submitted subject to a multi staged application and approval process; the number of stages is determined by the scale and risks of the project. IRCF funding covers a mix of proposals from small scale refurbishments, bringing buildings back into use and larger scale new build health and social care hubs.

All schemes are based on being multi-agency developments with a lead organisation and are at varying stages of development with significant builds to date including 5 IRCF hub schemes have already been completed and it is anticipated that 7 more will be completed this year. The completed schemes are from across Wales and range in scale and type from Type B hubs to Type E hubs.

Identifying key success factors and demonstrating impact

Having been established in 2022, the IRCF is still in the early stages in terms of the outcomes and successes of the programme. It has however, made significant progress through the RPBs approach of enabling partners across sectors to work together to develop and implement 10-year Integrated health and social care strategic capital plans. These plans have and will continue to demonstrate the investment needed to make the PfG commitments a reality over the short, medium and longer term.

As identified within the revised 2025-27 guidance, RPBs need to align their benefits register to the RIF Outcomes Framework and the Model of Care high level outcomes that relate to, for example community-based care and accommodation based solutions, and to the other Models of Care outcomes where there is interface and relevance to provide the story of intended change for the priority population groups.

Having only been established in 2022, the IRCF From the perspective of the model of care high-level outcomes of RIF, the establishment of hubs across Wales aligns to:

- People's needs are improved through accessing co-ordinated community-based solutions through the services delivered from a hub.
- Local prevention and early intervention solutions support people to avoid escalation and crisis interventions from the range of provision based within communities that are accessed through the front door of health, social care and well-being hubs.

An IRCF Benefits (Social value) Framework is being developed to capture the benefits identified for the Programme in meeting its objective to help people to remain active and independent in their own homes and to live longer, healthier and happier lives, reducing the need for hospital care; deliver at a local level a future-proofed, whole system Operating Model for a more accessible and integrated approach to health and social care service and deliver services closer to home, designed around people's needs in the locality.

Working Towards Whole Life Net Zero Carbon

The Welsh Government is committed to a carbon neutral public sector by 2030 and a 100% reduction in emission of greenhouse gases in Wales by 2050. The NHS in Wales adopted the NHS England Net Zero Standard on 1st October 2023.

IRCF has adopted the Net Zero Standard for all projects.

The IRCF programme presents a unique opportunity, right at the very heart of our communities, to make significant advancements towards a net zero whole life carbon health and social care infrastructure in Wales.

CASE STUDY

Region: **North Wales**

Project: **Coed Y Ddraig**

Coed y Ddraig is an innovative integrated service hub supporting adults with learning disabilities, autism and mental health support needs.

Located in a rural woodland setting, a short walk from Mold town centre, Coed y Ddraig provides a purpose-built hub offering day services and work opportunities for adults with profound or complex learning disabilities through horticulturally-based activities. The hub will be managed by Hft, with integrated service provision from social services and Betsi Cadwaladr University Health Board teams.

This new hub will offer adults of working age with learning disabilities the chance to develop life skills, gain confidence, increase their independence and engage in training to help gain employment.

The facility will be Flintshire's first building that operates at net-zero, with all carbon emissions generated by the use of the building offset by a series of innovative carbon-reducing measures.

A £4.8m project, £2.9m of financial support has been provided by the Welsh Government's Health and Social Care Integration and Rebalancing Capital Fund (IRCF) with the remaining funds provided by Flintshire County Council's capital programme.

The hub is planned to be operational in the Autumn of 2025.



CASE STUDY

Region: **North Wales**

Project: **Llanrwst Family Centre**

Conwy County Borough Council acquired and refurbished Llanrwst Family Centre to extend the services offered to families and increase opportunities for partnership working.

The Llanrwst Family Centre Project included the purchase and refurbishment of the building that has housed the family centre for the previous 23 years. The property was previously owned by the Church in Wales, with the Family Centre occupying via a lease. In 2023 the Church in Wales advised the property was no longer viable for them and were seeking to sell. The acquisition by Conwy CBC enabled the authority to safeguard and continue to provide this essential service, whilst the refurbishment offered the ability to grow and improve the early intervention and prevention service provision.

Conwy CBC purchased the building in July 2024 and in October 2024 commenced a programme of refurbishment work. This included reconfiguring the layout to make better use of the space, improving accessibility, and replacing windows to improve energy efficiency.

Services were relocated during the 34-week refurbishment and the centre re-opened on 9 June 2025.

More services can be delivered at the same time in the upgraded space, saving rural families repeated long journeys to the centre. The centre offers a range of support, including weekly baby clubs co-delivered with health visitors, young carers groups, and domestic abuse support for people of all ages.

The project has received £600,000 investment through the Welsh Government's Health and Social Care Integration and Rebalancing Capital Fund (IRCF).



CASE STUDY

Region: **West Wales**

Project: **Pembroke Hwb – South Quay**

The Pembroke Hwb – South Quay will when completed be a modern, accessible social care, health and community hub in Pembroke.

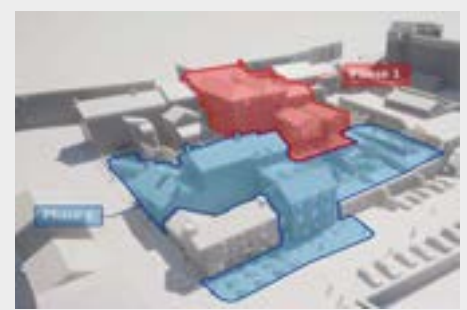
The Hwb supports the region's aim to build active, resourceful, connected, sustainable and creative communities.

The Hwb was awarded £6.5 million from the Integration and Rebalancing Capital Fund (IRCF), with additional match funding from Pembrokeshire County Council and the Levelling Up Fund, bringing the total project value to £12,075,811.

Aligned with the regional integration plan developed by Hywel Dda University Health Board, the Hwb will co-locate a range of services including health clinics, social care assessments and community prevention services.

Flexible, bookable spaces will accommodate ad hoc services, while dedicated areas for dementia care and independent living will support delivery by occupational health, physiotherapy, and speech and language therapy teams.

Construction started in August 2024 and is due to be completed in April 2026.



Regional Integration Fund (RIF): Driving Transformation in Health and Social Care

As we step into the fourth year of the **£146.8 million per annum Regional Integration Fund (RIF)**, we're building on a strong foundation laid since its launch in 2022.

This five-year programme (2022–2027) is a cornerstone of our commitment to delivering the vision set out in *A Healthier Wales* for a truly seamless health and care system for everyone.

The RIF was shaped by lessons learned from the Integrated Care Fund, Transformation Fund,

and insights from Audit Wales. It's designed to be bold, responsive, and future-focused, supporting the development of an Integrated Community Care System (ICCS) across Wales.

We're now at a pivotal moment in our mission to move from local innovation to national impact. The challenge ahead is to scale up successful regional models and embed them nationally, ensuring that every citizen, wherever they live, benefits from consistent, high-quality, integrated care.

RIF Core Values and Strategic Priorities

- Prevention and early intervention at the heart of care.
- National models of integrated care that are scalable and sustainable.
- Communities of Practice to share learning and foster innovation.
- Long-term investment to mainstream new approaches.
- Pooled funding arrangements to support collaboration.
- Robust regional planning and partnership infrastructure.

What Success Looks Like: Six National Models of Care

By 2027, six integrated care models will be fully established and embedded across Wales, transforming the way services are delivered:

1. Community-based care – prevention and coordination.
2. Complex care closer to home – reducing reliance on hospital settings.
3. Emotional health and well-being – proactive and person-centred support.
4. Family support and therapeutic care – keeping families together safely.
5. Home from hospital – smoother transitions and recovery.
6. Accommodation-based solutions – tailored support for independent living.

Tracking Progress: Evidence, Impact, and Learning

Over the past three years, we've seen significant progress across all six models, with many success stories emerging from regional initiatives. The RIF's unique design has enabled cross-sector collaboration and shared learning, helping us identify and amplify what

works. A national learning conference was held in September 2024 with Regional Partnership Boards to share good practice. Each of the RPBs presented a best practice model to support wider adoption and upscaling of successful programmes.

National Evaluation: A Deeper Dive into Impact

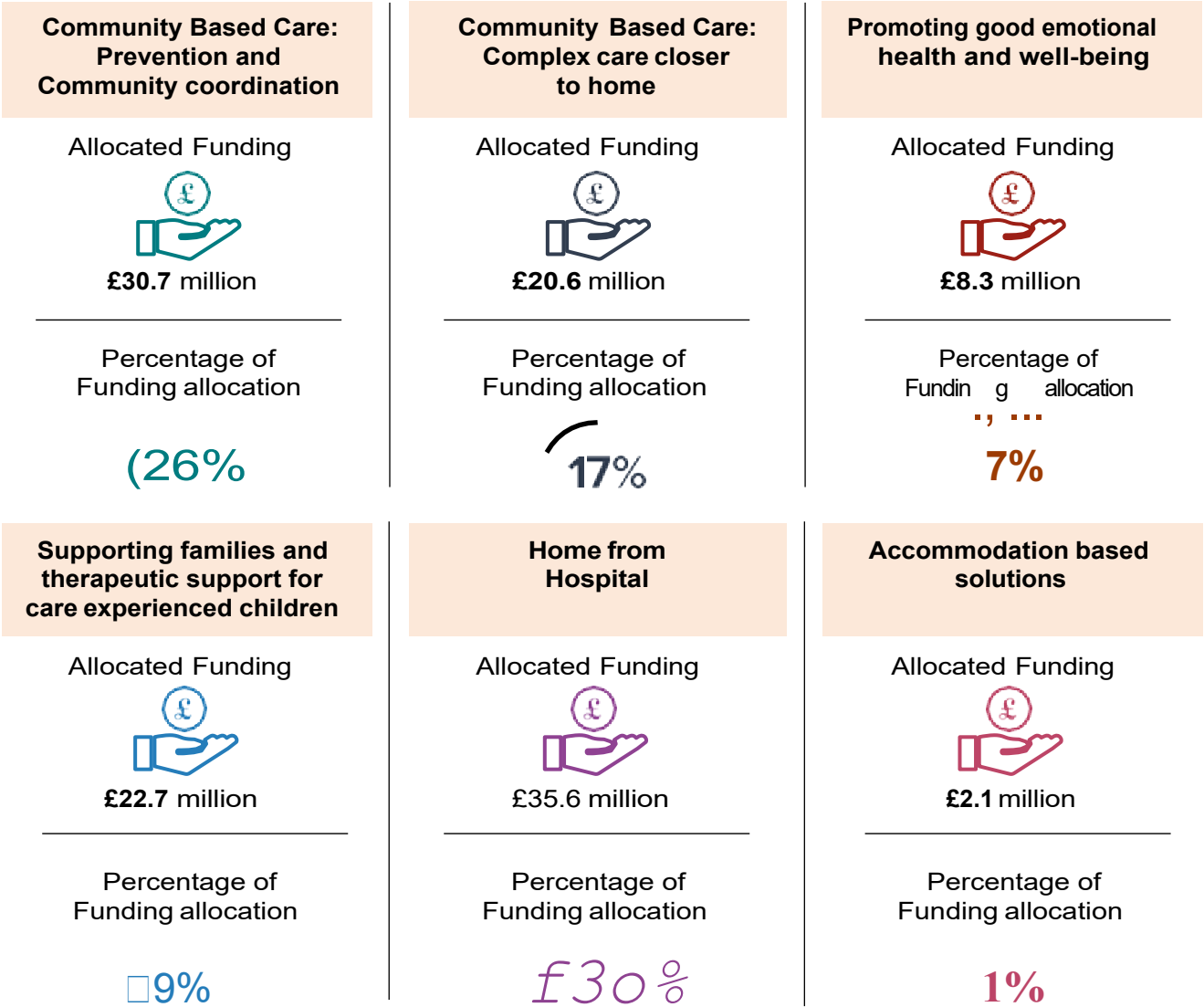
Commissioned in 2022, the independent national evaluation is led by the Welsh Institute for Health and Social Care (WIHSC) at the University of South Wales, in partnership with Swansea University and Old Bell 3 Research, supported by Welsh health economists.

Using an innovative methodology, the evaluation explores how RIF principles are understood and applied and most importantly, how they're improving people's lives.

- Phase 1 reports are being published and will inform ongoing development.
- Phase 2 will analyse 20 core performance measures, delve into health economics, and gather qualitative insights from staff and service users to ensure a rich, inclusive understanding of impact.

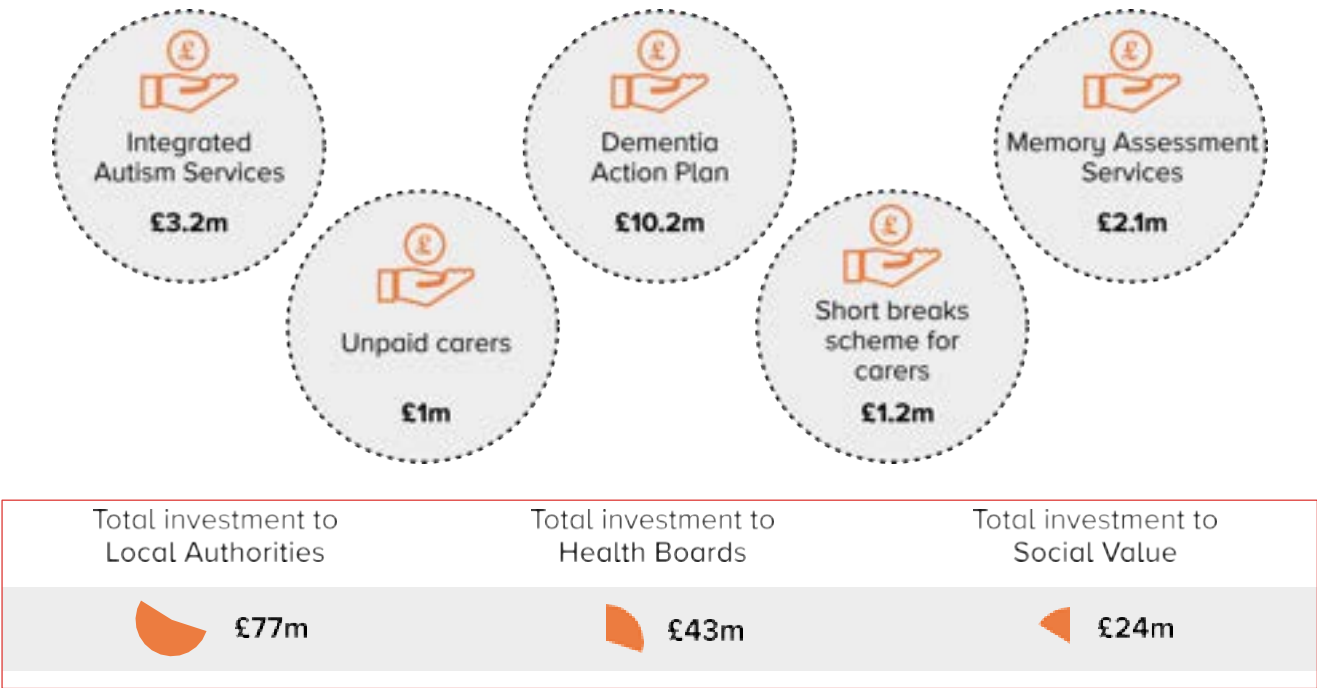
A Year In Review

Total regional allocated funding by model of care



Total regional allocated ringfenced funding

Regional Partnership Boards were allocated ringfenced funding to deliver against national ministerial commitments.



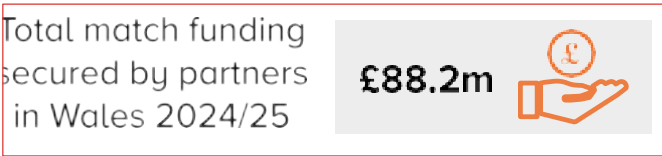
Tapering and Match funding

One of the original design principles of the Regional Integration Fund (RIF) was to encourage the alignment of core resources from partner organisations, with a view to gradually reducing the RIF’s contribution over time. This tapering approach aimed to achieve a balanced 50:50 funding model to support the long-term sustainability of successful projects and services.

Regional Partnership Boards (RPBs) continue to demonstrate a strong commitment to this principle and recognise the importance of working collaboratively to draw in local resources that build on the success of the RIF helping more people to live well and stay well at home.

Since the RIF was first established, the economic landscape and the complexity of health and social care needs have evolved significantly, particularly in the wake of the COVID-19 pandemic. In recognition of these challenges, and following engagement with RPBs and delivery partners, Ministers agreed in January 2024 to remove the tapering requirement from the fund to prevent destabilisation of investment to date.

Importantly, RPBs have continued to secure match funding for the three National Models of Integrated Care – Community Co-ordination, Complex Care Closer to Home, and Home from Hospital – which are central to building community capacity. These efforts demonstrate the enduring value of partnership working and the shared commitment to delivering integrated care that meets people’s needs in the right place, at the right time.



Understanding The Data: How much we did and what difference it made for people

A bespoke outcomes-focused reporting mechanism, with its own person-centred outcomes framework, was developed for the RIF and based on following principles:

1. **Intentional Developmental Approach**

The RIF's reporting framework was designed to evolve over time. In its early years, the focus has been on building capacity and embedding consistent practices across regions. The current data reflects a natural and expected phase of maturation.

2. **Qualitative Evidence Adds Depth**

The mechanism does not rely solely on quantitative data. The robust collection of qualitative evidence – including feedback, case studies, and stories of change – provides rich context and insight alongside the difference made measures for individuals and communities. This mitigates any temporary gaps in numerical consistency.

The data presented offers a valuable indication of performance and progress across regions. Regional Partnership Boards are continuing to strengthen the statistical validation and comparability of data, helping to build a more robust and consistent evidence base throughout

3. **Core Measures Provide a Strong Foundation**

The core set of 20 performance measures ensures a shared national framework. Regions are aligned in their focus, and current data contributes to a meaningful national picture of progress.

4. **Indicative Data Demonstrates Value**

The data available at the end of year three offers clear examples of impact and the scope of RIF activity. This proves the system's potential and effectiveness, whilst data consistency is achieved.

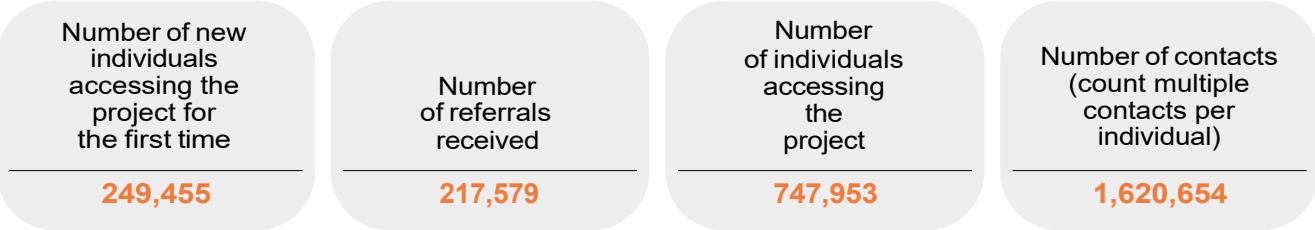
5. **Continuous Improvement Is Built In**

The RIF reporting mechanism is iterative by design. Lessons learned from early implementation are actively shaping improvements across the fund.

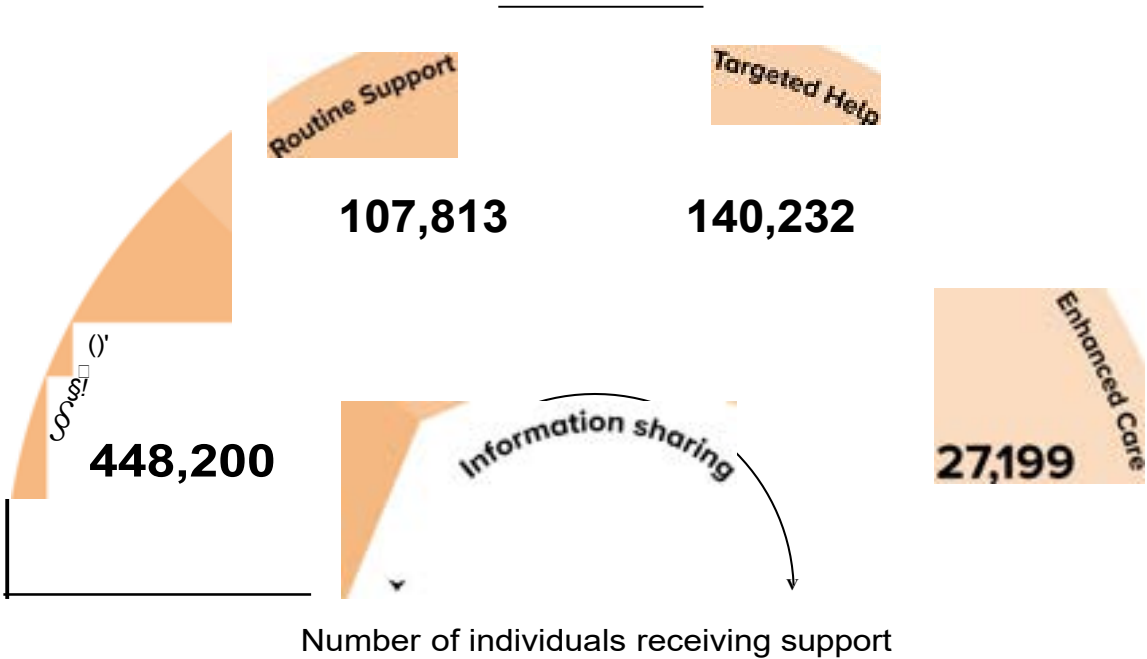
the duration of the RIF. The data supports ongoing learning, dialogue, and improvement, and is considered as part of a wider set of evidence produced by RPBs such as case studies, research and external evaluations.

National Core Performance Measures

Measures of how much we did



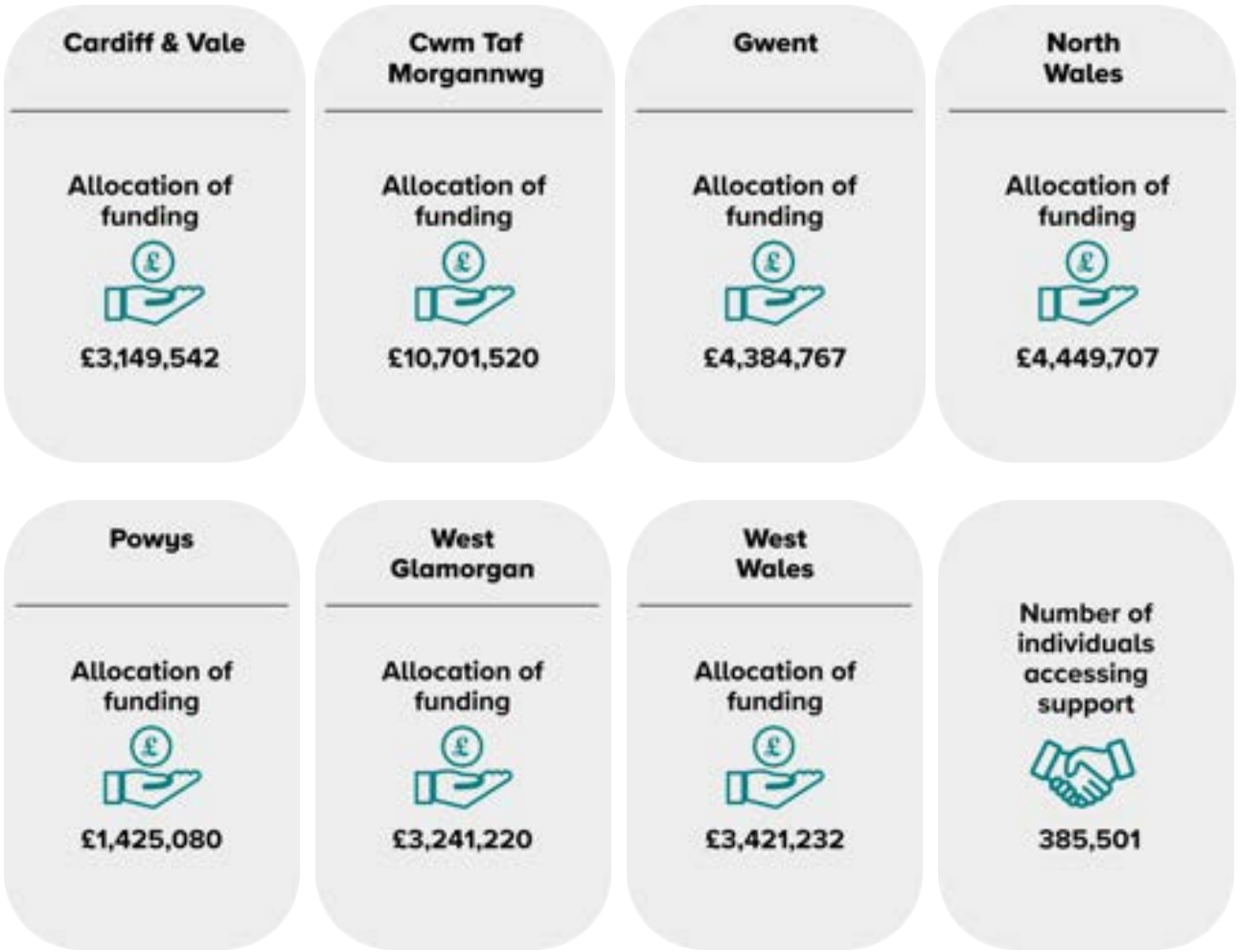
Projects and models of care developed by the RIF range right across the spectrum of intervention, from universal through to specialist. The diagram below illustrates the spread of activity across the four levels of intervention by showing how many people were supported at each level.



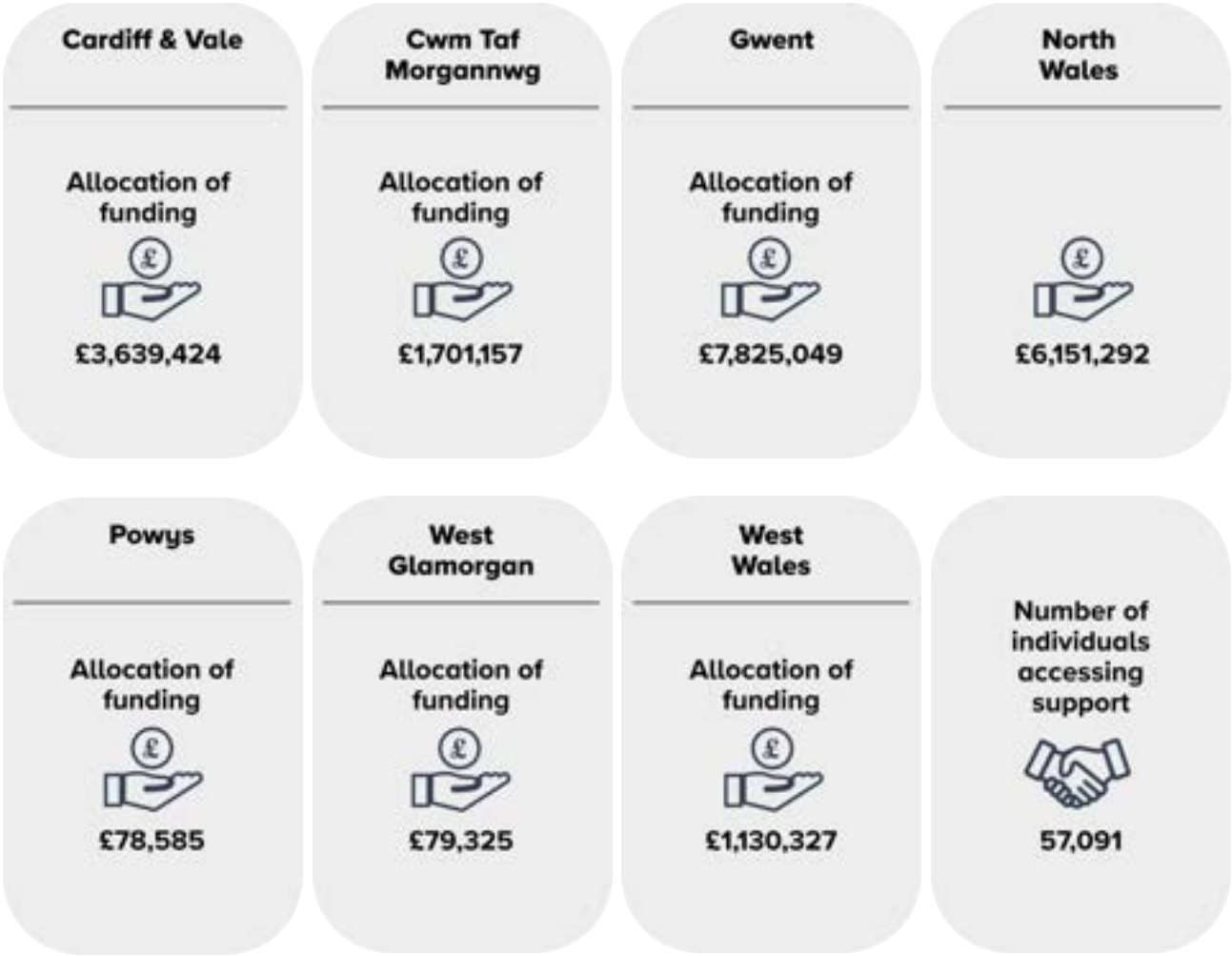
ALL Wales Model of care Level data - Difference Made (of this people surveyed)



Community Based Care Prevention and Community Coordination Model of Care 2024/2025

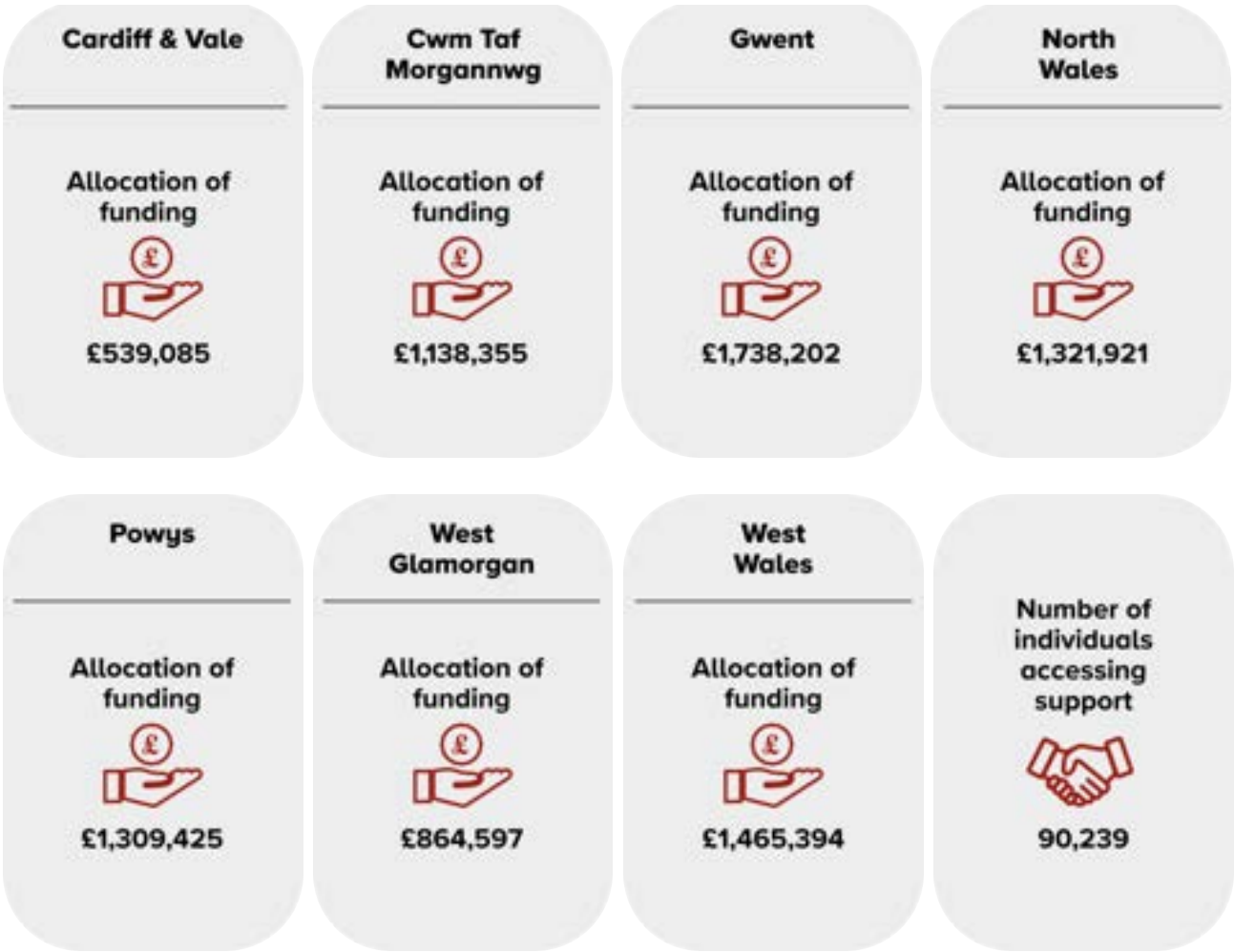


Community Based Care Complex Care Closer to Home 2024/2025

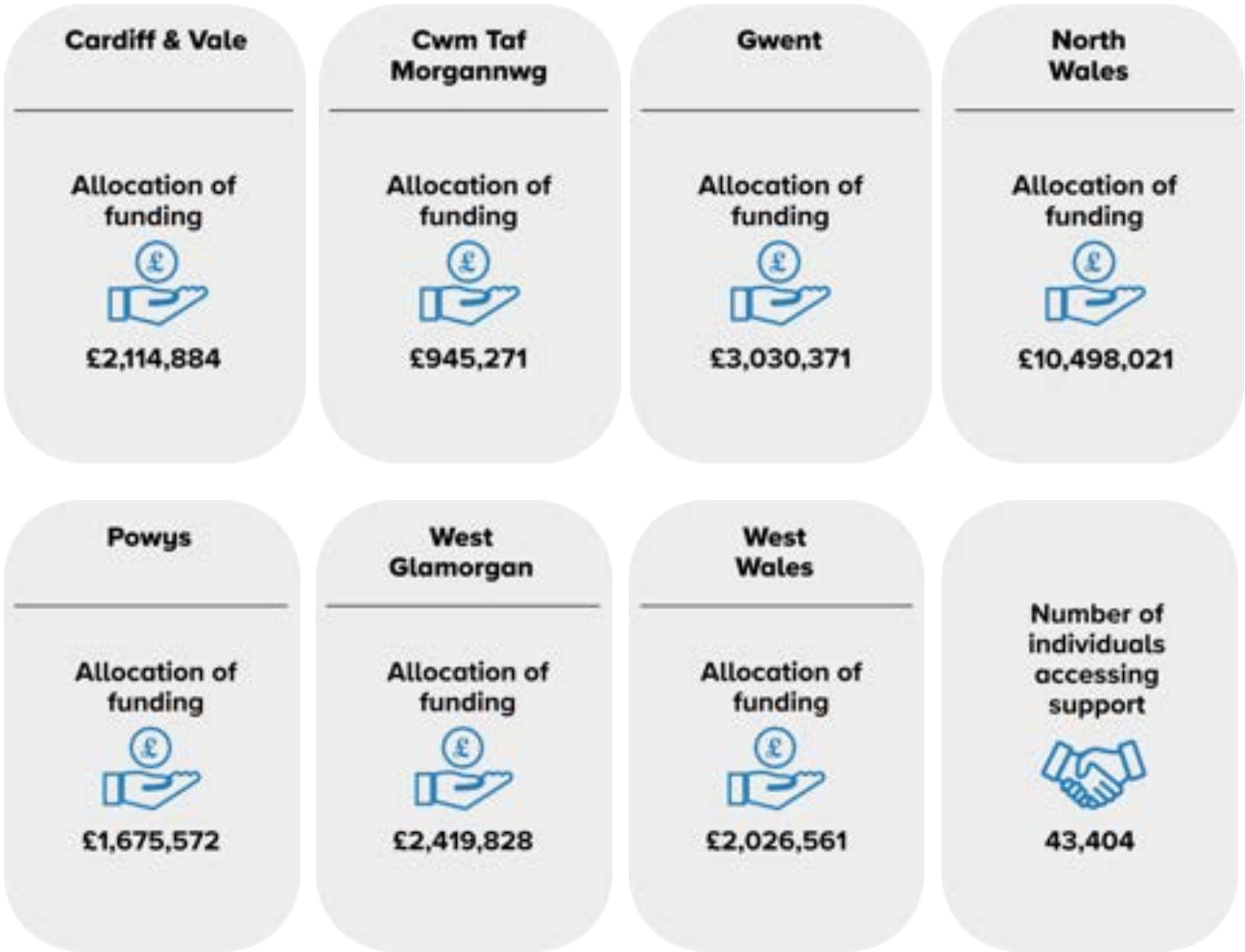


Promoting Good Emotional Health and Wellbeing

Model of Care 2024/2025

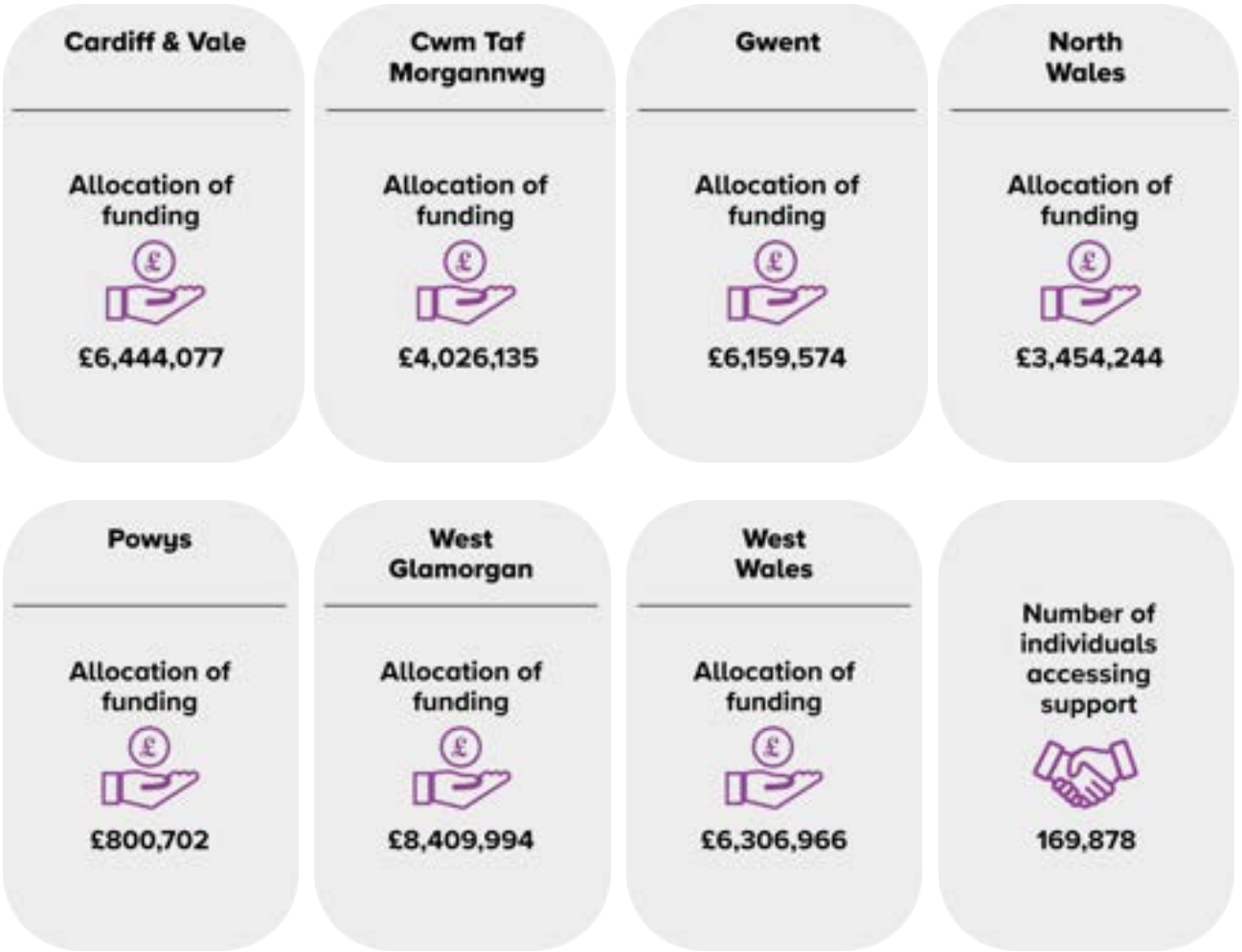


Supporting Families and Therapeutic Support for Care Experienced Children Model of Care 2024/2025

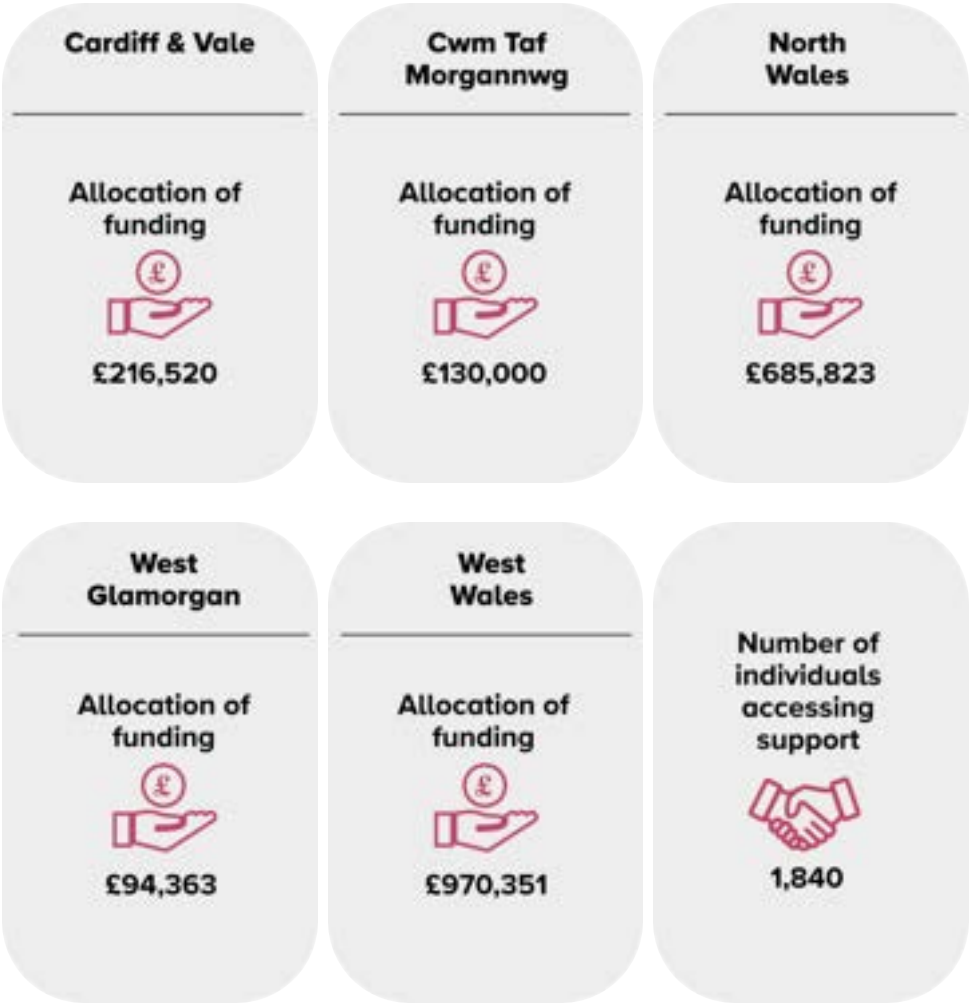


024/2025

Home from Hospital Model of Care 2024/2025



Accommodation Based Solutions Model of Care 2024/2025



Six Goals for Urgent and Emergency Care

Older people represent a significant proportion of those accessing urgent and emergency care in Wales. The Six Goals for Urgent and Emergency Care provide a strategic framework to deliver timely, person-centred, and integrated care, reducing avoidable hospital admissions and improving outcomes.



Aligning these goals with integrated care pathways for older people is essential to meet the challenges of an ageing population and ensure sustainable health and social care services.

The Six Goals and relevance to an Integrated Community Care System for Wales

Goal 1: Coordination, planning and support for people at most risk of needing urgent or emergency care

Goal 2: Signposting people with urgent care needs to the right place, first time

Goal 3: Safe admission avoidance

Goal 4: Rapid response in crisis

- Older people often experience complex health needs and uncertainty about where to seek help.
- Work has been undertaken to enhance access to 24/7 clinical advice and triage via the WAST clinical contact centre, NHS 111 and LHB Single Points of Access intended to support early intervention and prevent unnecessary escalation of care to ambulance response and transport to hospital.
- Enhancing falls response services is critical to reducing avoidable harm and hospital admissions among older people. The [National Community-Based Falls Response Framework for Wales](#) aims to improve outcomes and experience for those who fall by improving the initial response times and reducing the risk of long lies which can result in an increased length of stay in hospital. The framework sets out the requirement for all local health boards to have Level 1 and Level 2 falls response services operational 12 hours a day, 7 days a week, with full geographical coverage and an urgent care response within 2 hours.

- Increasing access to Same-Day Emergency Care services and increasing direct access from community services and WAST is a priority – these services and acute frailty services at the front door of hospital can reduce hospital admissions for older people with acute but manageable conditions.

Goal 5: Optimal hospital patient care and discharge practice from the point of admission

- Preventing hospital-acquired deconditioning is essential to maintaining function and quality of life for older people. Integrated discharge models such as Discharge to Recover then Assess (D2RA) and visual management systems like Red2Green support timely transitions from hospital to home, minimising risk and promoting recovery.

Goal 6: Home first approach and reduce the risk of readmission

- Older people are disproportionately affected by pathways of care delays. Streamlined discharge planning and integrated care coordination are critical.
- Older people often present with multimorbidity and social vulnerabilities. Coordinated care pathways improve safety and experience and implementing discharge-to-assess models across health and social care is a key priority.

Outcomes in 2024/2025

- The national programme led the development and launch of the SDEC strategy for Wales to ensure consistency of services and robust clinical pathways are in place to enable direct access from key services/health professionals.
- Services are being developed to support the integration of frailty services across the ‘front door’ hospital-based services, including emergency departments, ambulatory or short stay units and SDECs - seeing around 9,500 patients a month with more than 80% being discharged without needing a hospital stay.
- 105 care homes received falls lifting equipment and 1000 care home staff across Wales have received Level 1 falls management and response training, delivered by St John Ambulance Cymru.
- To assess the impact of the Optimal Hospital Flow Framework, four key measures are now reportable at aggregate level for every health board. A national database and dashboard have been developed to support D2RA metrics.
- The National Preventing Patient Deconditioning Summit took place on the 4 of November 2025 where the Six Goals programme formally launched the DEWI tool which allows the measurement of deconditioning syndrome, reducing harm in hospitals improving discharge through supporting people to remain as independent as possible.
- A Fracture Liaison Service (FLS) has been established in six health boards, with agreements in place between Powys and adjacent general hospitals to ensure Powys communities have access to FLS.

Conclusion

Embedding the Six Goals within integrated care models for older people will improve access, reduce delays, and enhance quality of life. This approach supports the vision of a seamless

health and social care system in Wales, ensuring older people receive the right care, in the right place, at the right time.

Strategic Programme for Primary Care (SPPC)

The Strategic Programme for Primary Care (SPPC) continues to drive transformation across Wales, focusing on integrated models that improve access, prevention, and sustainability.

Urgent Primary Care Centres and the 24/7 model have expanded access to care outside traditional hours, improving responsiveness for patients. Digital and data improvements have advanced shared platforms and analytics, while workforce initiatives have introduced new training pathways and flexible roles to enhance recruitment and retention. Prevention and wellbeing remain central, with increased emphasis on obesity prevention and mental health support.

A key enabler of this progress has been the £3.8 million SPPC Fund, of which £2.1 million supported the ACD programme, providing essential resources for governance and integrated planning. The fund also backed obesity prevention projects, including the All Wales Diabetes Prevention Programme, aligned with the Healthy Weight Healthy Wales strategy. These investments accelerated transformation, ensured continuity of services, and fostered community engagement and digital innovation.

Recruitment and training needs are a key enabler and present opportunities to strengthen workforce planning and develop innovative solutions for future resilience. The overall impact to workforce has been positive, embedding learning across health boards and reinforcing evaluation frameworks.

Looking ahead, there is a strong opportunity to build on achievements by:

- **Enhancing workforce resilience** through expanded training and flexible roles.
- **Further integration between health and social care**, ensuring seamless services for communities.
- **Reviewing digital infrastructure** to unlock the full potential of data-driven care.
- **Scaling successful innovations** and embedding cluster working as a foundation for sustainable transformation.
- **Increasing public engagement and co-production** to shape services that reflect local needs and priorities

Conclusion and Next Steps

The Integrated Community Care System (ICCS) for Wales is being actively advanced through the strategic alignment and use of funding and transformation programmes, which has optimised Welsh Government investment and sustained synergy between revenue and capital investment projects. Regional Partnership Boards have a key role in developing and delivering an ICCS for Wales, growing cross sector support and ensuring policy collaboration.

The priorities for 2025/26 will ensure further alignment, clarity and greater learning opportunities from across the funding programmes and will focus on:

- 1

Deepening Alignment Across Funding Streams

Strengthen integration across funding programmes, ensuring greater synergy between revenue and capital investments to support cohesive service delivery.
- 2

Scaling and Sharing Impactful Practice

Expand the reach of successful projects across Regional Partnership Board (RPB) areas, while actively promoting best practice and innovation to drive system-wide improvement.
- 3

Enhancing Qualitative Insight and Storytelling

Advance the collection and use of qualitative data by embedding person-centred engagement throughout the project lifecycle, capturing the evolving ‘story of change’.
- 4

Strengthening Quantitative Performance Measurement

Improve consistency and depth in the reporting of the 20 core quantitative measures to better understand impact at both individual and system levels.

- 5

Building National Models Through Shared Learning

Continue to foster Communities of Practice to share learning and co-develop national specifications for integrated models of care and their key components.
- 6

Showcasing Integrated Delivery at Scale in development of ICCS for Wales

Established Communities of Practice will continue to identify and highlight integrated service models that leverage resources across all funds, demonstrating tangible benefits for people and communities.
- 7

Advancing Strategic Capital Planning

Further develop and refine regional Strategic Capital Plans to support integrated, long-term capital investment aligned with service transformation goals.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 January 2026
CYFARFOD O: MEETING OF:	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Gwent Public Services Board Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Tracy Daszkiewicz, Executive Director for Public Health & Strategic Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Professor Tracy Daszkiewicz, Executive Director for Public Health & Strategic Partnerships.

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

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This paper is to provide Committee members with an update on the current work of Gwent Public Services Board (PSB).

Cefndir / Background

Gwent Public Services Board brings public bodies together to work to improve the economic, social, environmental and cultural well-being of Gwent. The PSB is responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of a local (five year) well-being plan. The statutory member organisations are:

- Blaenau Gwent County Borough Council
- Caerphilly County Borough Council
- Newport City Council
- Monmouthshire County Council
- Torfaen County Borough Council
- Aneurin Bevan University Health Board
- South Wales Fire and Rescue Service
- Natural Resources Wales

Gwent Public Services Board approved its first five year well-being plan in July 2023. The plan contains two strategic objectives and five delivery steps. These are:

Strategic objectives:

1. We want to create a fairer, more equitable and inclusive Gwent for all
2. We want a climate-ready Gwent, where our environment is valued and protected, benefitting our well-being now and for future generations

Delivery steps:

1. Take action to reduce the cost of living crisis in the longer term.
2. Provide and enable the supply of good quality, affordable, appropriate homes
3. Take action to reduce our carbon emissions, help Gwent adapt to climate change, and protect and restore our natural environment
4. Take action to address inequities, particularly in relation to health, through the framework of the Marmot Principles.
5. Enable and support people, neighbourhoods, and communities to be resilient, connected, thriving and safe.

A copy of the Gwent well-being plan is available at:

<https://www.gwentpsb.org/en/well-being-plan/gwent-well-being-plan/>

The PSB developed four Areas of Focus. The four areas of focus are:

1. That every child has the best start in life;
2. That everyone lives in a place they feel safe;
3. That everyone has the same economic chances;
4. That everyone lives in a climate-ready community where their environment is valued and protected.

The aim is for each Area of Focus to have a partnership group that can drive actions forward.

Asesiad / Assessment

The Gwent Public Services Board last met on 11th December 2025. This meeting was Chaired by the Chair Cllr Anthony Hunt.

The main points from the meeting were as follows:

Economic Chances Area of Focus

Work is underway to clarify the Public Services Board's (PSB) unique role in supporting economic opportunities across Gwent. Following the proposal from GSWAG, members agreed to convene an initial workshop—hosted by the University of South Wales—to explore the PSB's added value, ensure alignment with existing regional structures, and prevent duplication.

The workshop will help define whether a dedicated focus group is needed and will support the identification of a lead organisation by March 2026, in line with Scrutiny Committee recommendations.

Gwent Climate Change Risk Assessment

The PSB received an update on progress with the Climate Change Risk Assessment, led by Netherwood Sustainable Futures. Work packages cover risk identification, GIS analysis, organisational knowledge gathering and community workshops.

Two leadership seminars are scheduled (25 February and 4 March), and members were strongly encouraged to prioritise attendance to support high-level decision-making and cross-sector collaboration. Housing, infrastructure, and public communication have been identified as key themes requiring early attention.

Safer Communities Partnership

The Board discussed progress within the newly established Gwent Strategic Safer Communities Board. While there has been positive partnership activity and engagement with Home Office initiatives, concerns were highlighted regarding the consistency of leadership and attendance.

The PCC confirmed that legislative changes will place additional demands on partnerships and may require further resourcing. The Board agreed that co-chairing arrangements should be reviewed to strengthen resilience.

Future Generations Report – PSB Action Planning

The PSB reviewed organisational responses to the Future Generations Commissioner's recommendations. Approximately 15 recommendations have been collated, with distinctions made between PSB-specific and organisation-specific actions.

A small working group will be convened to propose a light-touch action plan for PSB-related recommendations ahead of the March meeting. The group will also explore the potential for 'futures champions' across member organisations.

Well-being Assessment (2027–2028)

The Board confirmed that the Joint Strategic Assessment (JSA) will form the core evidence base for the next statutory Well-being Assessment, due in 2027. The assessment will integrate quantitative data, lived experience, and community insight.

Partners emphasised the importance of continued engagement, iterative updates, and ensuring the assessment accurately reflects local realities and inequalities.

PSB–RPB Collaboration

The PSB and Regional Partnership Board (RPB) identified opportunities for deeper collaboration, including joint priority setting, shared structures, and the potential for a joint Gwent conference.

The Board also supported exploring an extended and potentially in-person PSB meeting in March to allow sufficient time for major agenda items.

Changes to the role of The Police and Crime Commissioner.

The Board received an update on the UK Government's announcement to abolish the PCC role by May 2028. While statutory responsibilities remain unchanged in the interim, significant uncertainty remains regarding future governance arrangements.

Work is ongoing at national level with WLGA, Welsh Government, and the Home Office to design a Welsh-specific policing governance model.

Argymhelliad / Recommendation

The Committee is asked to note the update of this paper.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Partnership First
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	Gwent well-being plan https://www.gwentpsb.org/en/well-being-plan/gwent-well-being-plan/ Gwent Joint Strategic Assessment https://abuhb.nhs.wales/health-advice/gwent-joint-strategic-assessment/
Rhestr Termiau: Glossary of Terms:	N/A

Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 January 2026
CYFARFOD O: MEETING OF:	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Regional Planning Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Trish Chalk, Asst. Director of Planning and Performance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report provides an update of progress in respect of a number of ongoing regional and South Wales service planning programmes. All significant work and recent developments are summarised in this paper.

Cefndir / Background

The South east Wales Health Boards (Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg) are committed to collaborating on projects and programmes to improve clinical service delivery, access and sustainability for patients across the region.

The Cabinet Secretary's and the Director General's expectation for regional planning and delivery across Wales remains high, with the establishment of the Regional Joint Committee (RJC) and continued outlined commitments set out in the Planning Framework for 2026/27. Health Board planning team with other corporate colleagues support clinical, and operational colleagues and work together to agreed programmes of work to address strategic challenges, deliver ongoing regional collaborative programmes, and to consider future opportunities for closer working to benefit patients across the South east Wales area.

Asesiad / Assessment

An overview of current programmes is set out below:

- **Regional Joint Committee**

A Regional Joint Committee first met on 19th November 2025 (first in a workshop style and second as the formal meeting) to understand members' expectations, challenges, and priorities for delivering regional collaboration in healthcare commissioning and service delivery. The key expectations from the meeting included:

Purpose: The establishment of the Committee and agreed programme of work to focus on the importance of improving patient experience and outcomes, achieving strategic alignment with an agreed shared narrative, ensuring economies of scale, and addressing commissioning and infrastructure challenges.

Challenges: barriers include potentially misaligned drivers across organisations, capacity constraints, differing priorities, accountability processes that restrict collaboration, skill gaps in cross-organisation working, lack of clarity in roles as providers versus commissioners, historical perceptions, and inconsistent strategic and transactional behaviours.

Priorities for the next 12 months: agreed to focus on delivering existing commitments, developing a regional commissioning and contracting framework, creating a shared narrative to demonstrate collective operation, and establishing a process to identify key regional service opportunities. Emphasis was placed on clarity, trust-building through new accountability arrangements, and evidence-based regional clinical planning.

Enablers and next steps: include advancing a regional digital plan to facilitate data sharing, improving workforce planning and mobility, and commissioning an organisational development partner to support regional working.

1.1. Progress with Digital Integration

A workshop was held in December 2025 to share objectives and alignment on regional ambitions and build a shared pathway for digital transformation. It recognised that despite ongoing efforts, there remain notable areas where progress has stalled i.e. the continued lack of advancement in establishing shared waiting lists, which is critical for effective delivery and patient safety access across the region.

The key priorities from the workshop include:

- Making patient care seamless and safe by enabling the sharing of information and resources across organisations.
- Ensuring that data sharing supports, rather than impedes the design and implementation of patient pathways.



- Building digital solutions on existing architectural frameworks, rather than developing entirely new products, while recognising that the rationale for the lack of progress in this approach has not yet been clearly identified.

The role of Digital Health and Care Wales (DHCW), including confirmation of responsibilities relating to the National Data Resource (NDR), remains to be clarified. Establishing clear lines of accountability within the digital transformation process is essential for progress. It was agreed to set out what tangible progress should look like within the next 12 months. This includes defining targets for a shared Patient Tracking List (PTL) for ophthalmology to support regional programmes and to measure advancement effectively.

Priority actions and next steps:

- Prioritising the development of shared patient records to facilitate coordinated care delivery.
- Mapping existing gaps in digital provision—recognising that some of this work may already have been undertaken—and focusing on developing a practical example and use case to demonstrate benefits.
- Establishing a regional digital structure to provide governance, support, and direction for ongoing digital integration efforts.

- **Llantrisant Health Park (LHP)**

Llantrisant Health Park is being taken forward via a number of phases. Phase 1 is the development of a Diagnostic Centre (radiology and endoscopy) and the Full Business Case (FBC) for this Phase was presented at the November 2025 Board meetings of the three South east Wales Health Boards. The FBC was for CTM to approve and the other 2 Health Boards to support, this milestones was achieved.

- **Radiology**

The Regional Radiology Task and Finish Group reviewed its work following completion of key priorities including the regional demand and capacity which inform the LHP Phase 1 FBC. This work recognised the need for future ongoing work with areas of focus to include AI – working with the National Imaging Academy for Wales on this rather than duplicating efforts locally and regional reporting. A virtual Clinical Summit is proposed in the New Year to review original aims and objectives and future of group with a broader remit beyond single projects, working towards regional sustainability and quality and being responsive to requirements arising from emerging healthcare priorities i.e. rollout of lung screening.

- **Endoscopy**



The LHP Phase 1 FBC includes a sustainable solution for meeting regional demand and capacity needs, including support for workforce development through a training academy.

- **Orthopaedics**

Phase 2 of the LHP development is an orthopaedic elective centre including beds and theatres. The ABUHB Board approved the submission of the Phase 2 Outline Business Case (OBC) (which includes additional regional resources of three theatres at LHP) to Welsh Government. Support for the FBC would be dependent on the identification of additional revenue resources.

A process has been established to deliver a regional arthroplasty plan by April 2026, which includes a delivery structure, care pathway, workforce, standards, procurement and financial flows.

- **Ophthalmology**

A strategic refresh of priorities has been undertaken to support the development of a regional workforce plan to support the transition of the cataracts service into business as usual, ensuring consistency and sustainability across the region.

Service delivery continues to increase due to a combination of recurrent investment, enhanced efficiency within the core service capacity and the allocation of non-recurrent funding. An additional four outsourcing providers have been engaged to provide significant increases in capacity for Q4.

Digitally, the Open Eyes electronic patient record system is live in C&VUHB and is being implemented at pace in CTMUHB and ABUHB, where the planned go live date is January 2026. The new national electronic referral system is also being implemented and will be live in mid 2026.

In November, Ophthalmology became the first service to be providing data on a regional basis to DHCW and Welsh Government following changes to the coding and reporting mechanisms across the three health boards and DHCW.

1.2. **Pathology**

To ensure consistency in the assessment, documentation and reporting of pathology cases across the region, there has been agreement to implement the Royal College of Pathology points system.

A combined asset register has been established, providing a picture of the full regional capacity and identifying key challenges.

Regional demand and capacity planning is ongoing, with all health boards now supplying relevant data to inform current and projected needs, ensuring that service provision can be matched appropriately to demand.



Additionally, a non-financial option appraisal process has been undertaken to identify potential sites for future pathology capacity. This process allowed for the evaluation of possible locations based on non-financial criteria, supporting informed decision-making for the expansion and enhancement of pathology services in the region and resulted in a preferred location of Cardiff Edge. It continues to be the Health board position that moving to a single regional pathology service must bring additional benefits and should be predicated on full implementation of the digital cell path system and the standardisation work outlined above.

- **Stroke**

A regional stroke meeting was held in December 2025. CTMUHB fed back that changes implemented within the HB (consolidating stroke admissions on the Royal Glamorgan site) has had a positive impact. The impact report is nearing completion with preliminary findings suggesting that there has been no significant effect on patient flows or admissions, while the overall quality of care has improved. It is important to note that these findings are currently based solely on CTMUHB data and ABUHB and C&VUHB data has now been requested to allow for a more comprehensive evaluation.

1.3. **Upper Gastro-intestinal surgery**

Notice has been served by C&VUHB on the current Service Level Agreement (SLA) for Upper Gastro-Intestinal Surgery following the retirement of a Consultant GI Surgeon. A Surgeon will continue to attend ABUHB MDTs virtually and they will continue to accept curative patients for treatment in Cardiff. Implications of this other than attendance at MDT being virtual rather than in person are currently being discussed with the service.

Argymhelliad / Recommendation

The Partnerships, Population Health and Planning Committee is asked to:

- **Note** the update report for information.

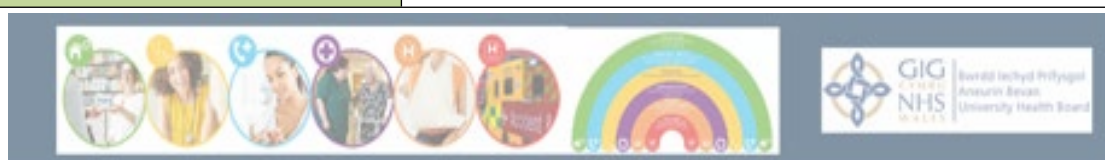
Amcanion: (rhaid cwblhau)	
Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Many of the regional work streams are informed by risk assessment and have been established to address and mitigate system risks
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 5.1 Timely Access 7.1 Workforce Choose an item.



Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	DHCW: Digital Health and Care Wales FBC: Full Business Case LHP: Llantrisant Health Park NDR: National Data Resource OBC: Outline Business Case PTL: Patient Tracking List
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs



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





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

ABUHB Digital Transformation Strategy

Putting Digital to work for Better Health, Better Care & Better Lives

Consultation

Purpose:

Consultation to finalise our Digital Transformation Strategy in support of Gwent 35

Todays session will provide:

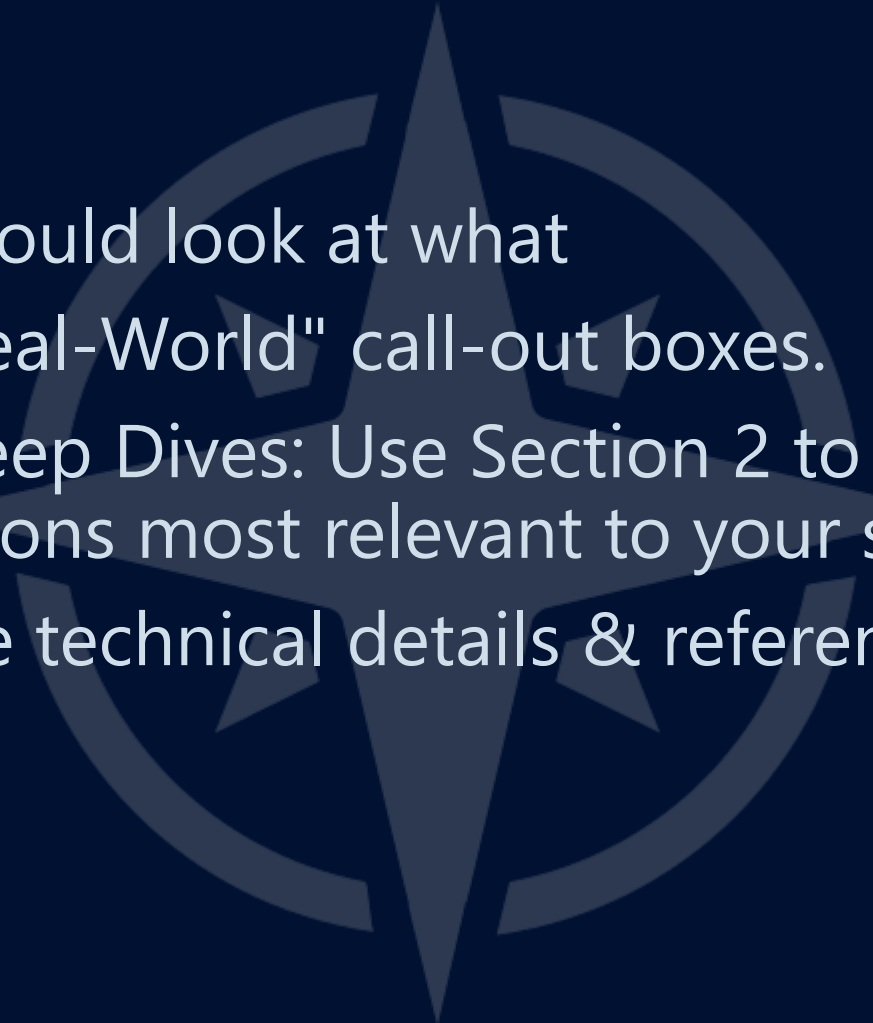
- - An overview of the document and how to read it.
- - A set of summary slides on the content
- - How to access & comment on the Strategy

ABUHB Digital Transformation Strategy – The Document

- Executive Summary
- Part 1- Strategic Alignment - Gwent 35
- Part 2 – The Strategic Response
- Part 3 – Implementation
- Appendices



Navigation: How to Use the Strategy



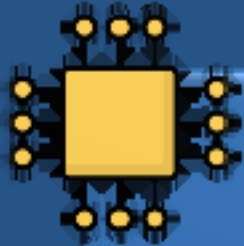
- Guidance on who should look at what
- The "Vignettes" - "Real-World" call-out boxes.
- Mission - Specific Deep Dives: Use Section 2 to jump directly to any of the 6 Digital Missions most relevant to your specific department
- Appendices for more technical details & references, abbreviations etc
Glossary

ABUHB Digital Transformation Strategy

*Putting Digital to work for Better
Health, Better Care & Better Lives*

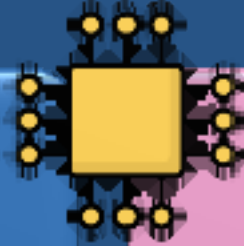
Part 1 – Strategic Alignment: Delivering Gwent 35

Gwent 35 - Why Digital, Why Now



Better Health

Use digital, innovation, and technology to provide tools to support a healthy thriving Gwent with connected communities



Better Care

Ensure our services have good digital infrastructure and people can be supported at home through technology



Better Lives

Equip people in our communities with the access, skills, and confidence to engage with digital services

Drivers: Digital & Data Strategy for Health & Social Care in Wales (Welsh Government 2023)

Digital Skills

Developing our workforce with the skills and confidence to make most of digital services

Digital Economy

Partnerships with Health & Social Care providers, academia and private sector to create added value and strengthen the economy of Wales

Data & Collaboration

Ensure high quality data is available to inform every part of health and social care delivery and support digital services

Digital Infrastructure & Connectivity

Developing secure, stable and sustainable foundation for seamless sharing of health and social care data

User Centred Services

Deliver high quality digital services designed around the needs of the citizen, professionals and services

Digital Inclusion

Equip users with the access, skills and confidence to engage with digital health and social care services

The Digital Response

ABUHB Digital Transformation Strategy: *Putting Digital to work for Better Health, Better Care & Better Lives*

A practical, disciplined response to deliver Gwent 35.

- Translate strategic ambition into clear digital objectives.
- Address gaps in infrastructure, data, capability and governance.
- Build a modern digital health & care record and supporting platform.
- Ensure digital services are safe, reliable, inclusive and trusted.

This is not a separate digital programme — it *is* a key enabler to make Gwent 35 a reality

Gwent 35 = Digital Transformation



Digital Transformation – the challenges



Underinvestment & fragmented funding

Funding well below benchmarks, reliance on one-off projects limits sustainability



Balancing National with Regional & Local Need

Aligning national direction with regional collaboration & local service adaptation



Interoperability gaps & legacy systems

Disconnected systems & outdated tech blocking safe care



Workforce Digital Capability & Confidence

The challenge of building digital knowledge & skills at all levels to enable digital adoption



The Pace of Change and Emerging AI

Managing relentless digital change and the safe integration of AI technologies



Digital Exclusion & Equity Risks

Moving care online risks widening inequalities with inclusion strategies

Digital Transformation – Opportunities Ahead

Safe Care

Now: Safety relies on individuals remembering tasks and manual checks.

Future: Digital systems prompt the right actions and close the loop, giving clinicians & families confidence.



Timely Care

Now: Delays happen because information sits in queues & handovers fail.

Future: Information flows automatically, handovers become seamless, care moves at the speed of need



Effective Care

Now: Clinicians juggle multiple systems and re-enter data repeatedly.

Future: A unified digital view with structured documentation and decision support makes care consistent & reliable.



Efficient Care

Now: Discharge means hours of paperwork and duplicated effort.

Future: Automated workflows free time for care, speeding up discharge and reducing waste reliable.



Equitable Care

Now: Inequalities persist because we can't see who needs help most.

Future: Data-driven insight targets support to those at greatest risk, closing gaps in care.



Person-centred Care

Now: People often work around the system to get things done.

Future: Digital services fit around people's lives, with one trusted front door for appointments, care plans, and messaging.



ABUHB Digital Transformation Strategy

*Putting Digital to work for Better
Health, Better Care & Better Lives*

Part 2 – Strategic Response

The Digital Strategic Response to Gwent 35



Strategic Response: Our vision

“Create a digitally enabled health and care system that empowers and connects our communities, supports our workforce, and improves outcomes – delivering **Better Health, Better Care, and Better Lives** for everyone in Gwent”

Strategic Response: Scope

- Aligns with Gwent 35 ambition in a national context
- Information and communication
- Defines organisational capabilities
- Mission framework and enabling plans
- A balanced approach to managing digital priorities (innovation / business as usual / removing legacy)



Strategic Response: Principles

Start with user need —
for patients, families,
staff and partners.

Digital should work like
electricity — always on,
always available.

Safety and
interoperability must
be built in from the
start.

Design once, reuse
widely; connect safely
and adapt locally.

Structure the data —
capture once, use
many times.

Create digital teams —
skilled, empowered &
user centred

Digital is an adaptive
change, not just a
technical change.

Embed governance,
security and ethics in
everything we design
and deliver.

Inclusion is non-
negotiable — no one is
left behind.

Strategic Digital Objectives

Empower Patients

Simple, safe digital access for all.

Success: Patients manage care confidently.

Clinical Pathways

Joined-up workflows for safer care.

Success: Clinicians use structured records everywhere.

Better Teamwork

Connected tools for collaboration.

Success: Shared care plans replace fragmented communication.

Population Needs

Data-driven planning for fairness.

Success: Dashboards inform proactive interventions.

Safer Care

Accurate, timely information at point of care.

Success: Interoperable systems reduce risk.

Sustainability

Digital choices reduce carbon impact.

Success: Lifecycle planning tracks environmental benefits.

Build Capability

Agile systems and skilled teams.

Success: Modular platforms and confident workforce.

Working Lives Easier

Reduce friction and improve usability.

Success: Staff report simpler workflows.

Productivity

Automation frees time for care.

Success: Measurable efficiency gains.

Strategic Response: 6 Missions



Mission 2: Designing with Data to drive Improvement

To capture and transform health data into actionable insight & knowledge for preventing ill health, better care, services, planning and research.

Goal 1: Improving data governance & workforce data capability

Deliver a strategic, structured approach to managing and using data as a core asset across the Health Board.

- Data, Analytics & information Management Strategy Delivery including Data & Analytics academy, new governance arrangements & the improvement of our data maturity

Goal 2: Leveraging National Platforms & Cloud Infrastructure

Maximise the value of national data platforms and cloud technologies to enable integrated, scalable, and secure data use

- ABUHB NDR Engagement & Implementation Plan to support migration of products to the National Data Resource & investment in skills & training to support cloud adoption

Goal 3: Making Design Central to Digital Delivery

Embedding design thinking and enterprise architecture to shape a future-ready digital estate

- Technical Design Authority to drive the adoption & maintenance of standards across digital software, data & infrastructure aligned with National Target Architecture

Mission 6: Building Organisational Capability for Digital Transformation

From Bedside to Back-Office to Board:
empowering people, strengthening
governance, and enabling digital change at
scale

Goal 1: Building the DDaT Operating Model

A unified operating model that connects every part of the Digital, Data & Technology (DDaT) service into a single, coherent lifecycle

- DDaT Operating Model Blueprint & Workforce Capability Development Plan

For example:

- Refreshed Divisional engagement
- New Digital Service request Process
- Alignment with national digital blueprint operating model
- DDaT workforce professionalisation

Goal 2: Building Workforce Capability for Digital Transformation

Develop a digitally confident, capable, and inclusive workforce across all roles and levels of the organisation.

- ABUHB Digital Workforce Strategy & Plan – aligned with People Plan

For example:

- Skills and Capability Frameworks Implementation
- Digital Induction
- Training and Support Programmes
- Workforce Digital Inclusion Policy
- Governance & Resource Requirements

Goal 3: Digital Governance & Assurance

Embed governance, assurance, and financial control into every stage of digital transformation

- DDaT Governance & Assurance Framework e.g. refresh of Digital, Data & Technology Group
- Information Security Strategy providing cyber security
- Health Records Standards Plan for managing health records assurance
- Business Assurance Unit Framework/Policy to fully implement financial control procedures & digital procurement

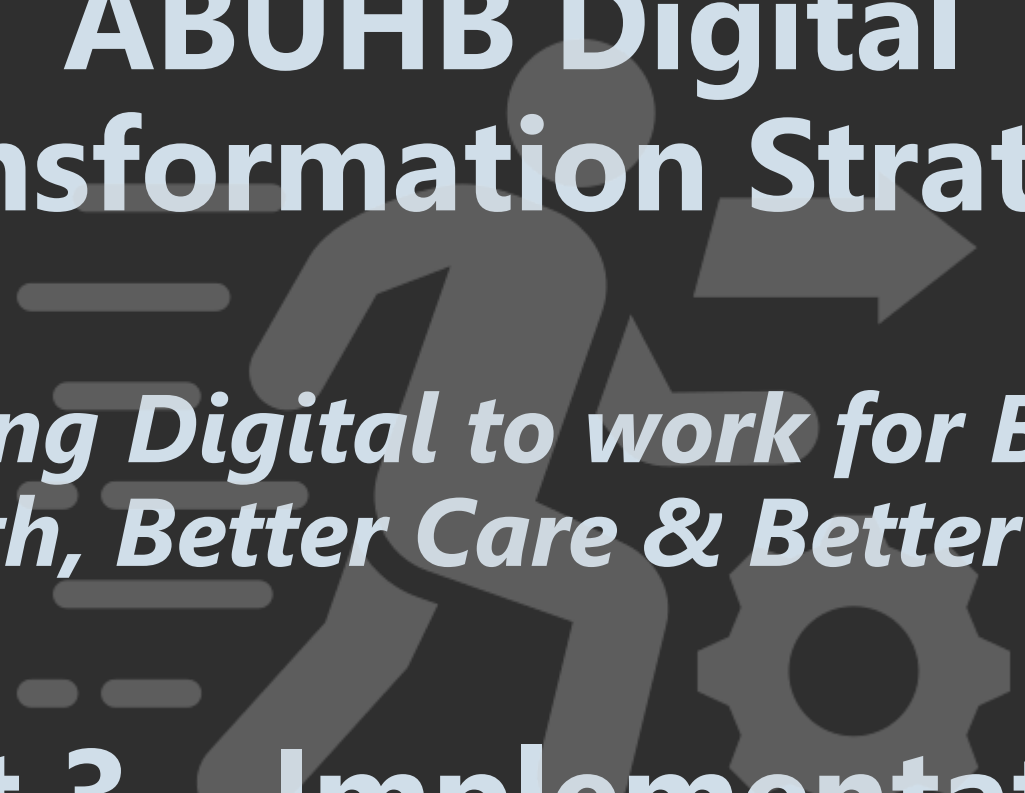
e:

Goal 4: Embedding Digital Innovation, support for Research and Sustainability

Enabling responsible innovation that strengthens care, research and sustainability

- Research-Ready Digital Platform – to create a digital health record environment that meets standards & enables trial participation
- Digital Lifecycle Decarbonisation Plan – for end to end carbon management & reduction
- Benefits Identification & Realisation Framework building on existing framework to clarify carbon benefits

ABUHB Digital Transformation Strategy



*Putting Digital to work for Better
Health, Better Care & Better Lives*

Part 3 – Implementation

Implementation: From Strategy to Action

- **Enabling products are the first deliverables** - strategies, plans and business cases that define scope, cost, sequencing and risk. They are not optional extras; they create clarity and readiness for delivery.
- **Clear ownership with multidisciplinary support** - clinical, technical, analytical and financial input ensures enabling products are robust and actionable.
- **Prepare for scale and cost** - these plans will reveal the true investment, capacity and trade-offs required for transformation.
- **DDaT Operating Model is critical** - a unified lifecycle for design, governance and delivery underpins success.

This disciplined approach turns strategic ambition into a practical, affordable and sustainable programme of change.

How we will deliver safely and sustainably

- **Nationally aligned:** “Once for Wales” (three tiers from local to national), national Technical Architecture, National Digital Blueprint (operating model)
- **Clear standards:** Technical Design Authority
- **Strong assurance:** Information governance, cyber security and clinical safety from the start.
- **Good governance**
 - Executive oversight
 - Internal DDaT leadership
- **Phased delivery:**
 - **Three Horizons** approach supported by:
 - a **strategic partnership** that builds internal capability,
 - **business cases** to secure resource to deliver



Three Horizons Planning

- **Horizon 1 – Foundations**

e.g. Stabilise core systems and complete essential enabling products.

- **Horizon 2 – Scaling**

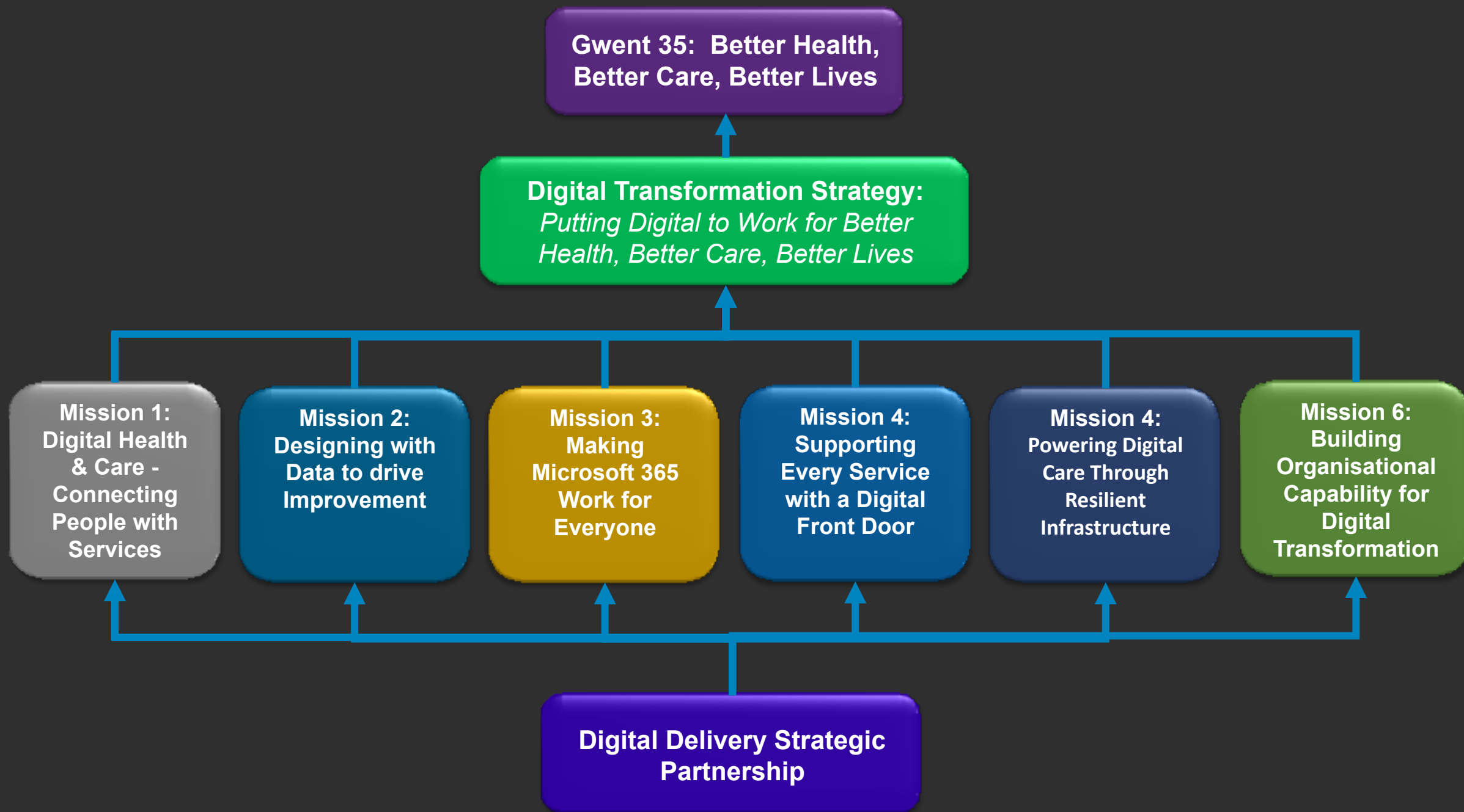
e.g. Extend digital capabilities across pathways and integrate services.

- **Horizon 3 – Future-Ready**

e.g. Adopt advanced analytics, automation and region-wide digital services.

How it works

Horizons overlap; reviewed annually for disciplined but adaptable delivery – part of Integrated Medium Term Plan



Strategic Partnership – What It Means

A partnership to accelerate delivery, build capability and ensure safe, standards-led transformation.

What it is - A trusted partner working *with* us to accelerate delivery and build internal capability.

Why it matters - Supports major programmes, strengthens governance, and reduces risk.

How it works - Zero-sum contract: activated only when a business case is approved.
Operates fully within ABUHB structures.

What it delivers

- Accelerated readiness for core strategies and enabling products.
- Stronger governance, clearer lifecycle, reduced technical debt.
- Scalable support for regional collaboration across South East Wales.



The Consultation

Consultation: How It Works

- Read Digital Transformation Strategy – PDF consultation version available on DDaT pages on 'Pulse' ABUHB Intranet

Digital Transformation Strategy - Staff Consultation

- Feedback via Microsoft Form (QR code provided).
- Consultation closes: 28 Feb 2026
- Final strategy updated based on feedback.
- Board: 25th March for approval.



We welcome views on **clarity, gaps, risks, priorities** and **readiness**.

Questions & contact



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

Contact: john.frankish@wales.nhs.uk

Message via **Microsoft Teams: John Frankish**

Thank you for helping shape a strategy that works for everyone



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

Eye Care Review – Aneurin Bevan University Health Board

Audit year: 2024

Date issued: August 2025

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000.

The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Audit Wales are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

Summary

About this report	4
Key messages	5
Recommendations	6

Detailed report

Regional partnership working	8
Health Board plans for eye care services	10
Leadership and governance arrangements	13
Ophthalmology performance	15
Managing the risk of harm	18

Appendices

Appendix 1 – Audit methods	19
Appendix 2 – Audit criteria	21
Appendix 3 – Management response	24

Summary

About this report

- 1 Eye care services are becoming more important as the UK population ages. An ageing population means there are more incidences of age-related eye conditions, such as cataracts, age-related macular degeneration and glaucoma. Many, if caught early, can often be managed effectively with existing treatments and medicines. But delays can also result in increased risk of harm and irreversible sight loss. As a result of the increased risk of harm, in 2019 NHS Wales introduced the 'Eye Care Measure' which is an approach for prioritising and measuring waiting times based on clinical condition and risk of harm. Ophthalmology waits also continue to be recorded and reported as part of the wider referral to treatment time metrics.
- 2 In March 2021, Welsh Government published NHS Wales Eye Health Care - Future Approach for Optometry Services. The plan forecasts a long-term growth in the prevalence of major eye conditions over the next 20 years including:
 - 47% increase in the numbers of people with age-related macular degeneration;
 - 50% increase in the numbers of people having cataracts; and
 - 44% increase in the numbers of people living with glaucoma.
- 3 At the end of May 2025, across Wales, 32,683 ophthalmology patient pathways had waited over a year for treatment and 1,730 over two years, and 20,283 over a year for their first outpatient appointment¹. The three health boards with the most challenging position in respect of ophthalmology waits are Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University health boards.
- 4 Given these challenges Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University Health Boards committed to work in partnership and launched the 2022-2025 South East Wales Regional Ophthalmology Strategy (the regional strategy). Aneurin Bevan University Health Board is the lead organisation for the regional ophthalmology programme. The Auditor General has included a review of eye care services within his local audit plans for all three health boards.
- 5 This report sets out the findings of our work at Aneurin Bevan University Health Board (the Health Board). We reviewed local and regional plans to improve eye care services, leadership arrangements to drive improvements and address barriers to progress; and whether the Health Board is actively managing the harms resulting from long ophthalmology waits.
- 6 The work has been undertaken to help discharge the Auditor General's statutory duty under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure the efficient, effective, and economic use of its resources. Our work was delivered in accordance with

¹ Data source: Referral to treatment times, Welsh Government.

INTOSAI² audit standards. **Appendices 1 and 2** provide more information about our work.

Key messages

Overall conclusions

- 7 Whilst the Health Board has been able to reduce its longest ophthalmology waits, it has not met the Welsh Government's planned care recovery targets. Performance against the 'eye care measure' is poor and, as a result, some patients are likely to be coming to avoidable harm.
- 8 In the context of these challenges, there is a need to strengthen local planning of eye care services, broaden the scope of regional working, secure further productivity and efficiency gains, and strengthen board and committee oversight of ophthalmology services.

Key issues

Regional partnership working

- Delivery of the regional eye-care approach sets out a positive direction of travel. However, it was slow to start and diverges from its original specialist service ambitions by focussing on creating short-term service capacity for cataract procedures.
- The regional cataract approach is targeting long waits, but it is not making a marked difference on overall numbers of patients waiting for treatment.
- Governance arrangements to oversee regional strategy delivery are in place, but the process for decision making on business cases can be slow and cumbersome involving multiple groups across the three Health Boards.

Health Board plans for eye care services

- The current planning approach for local eye care services is fragmented, with unclear ambitions and timescales, and insufficient focus on longer term service needs.
- The Health Board is taking appropriate steps to improve the productivity and efficiency of its eye care services, but it has not yet led to sustained improvements.
- Ophthalmology service capacity remains a concern, with consultant vacancies and a 30% reduction in the ophthalmology medical workforce between March 2021 and March 2025.

² International Organisation of Supreme Audit Institutions

Leadership and governance

- There is good executive, clinical and operational leadership that are focussing on driving short-term improvements in eye care services.
- There is insufficient Board and committee oversight of eye care services. In particular, the Patient Quality Safety and Outcomes committee should receive clear assurance on the harms caused as a result of a delay and lessons learnt.
- Risk management arrangements do not adequately cover eye-care risks.

Ophthalmology performance

- While referral to treatment ophthalmology waits over two years have significantly reduced, the Health Board has missed Welsh Government’s target for those waiting longer than one year. Since April 2023, waiting lists have grown from around 19,000 waits to over 23,000 waits.
- The Health Board has consistently failed to meet Welsh Government’s eye-care measure target. Most recent nationally report performance is 44.3% falling substantially short of the 95% target.

Managing the risk of harm

- While appropriate processes are in place to prioritise ophthalmology waiting lists and to identify and learn from any harm caused by delays, there remains an opportunity to strengthen assurance. Some patients have experienced harm, and reporting at committee level does not consistently capture these incidents or provide assurance on how lessons are being applied to reduce future risk.

Recommendations

- 9 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board’s response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations	
Regional ophthalmology strategy	
R1	To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases. (see paragraph 17)
R2	Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy. (see paragraph 18)

- R3 Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy. **(see paragraph 18)**

Health Board plan for eye care services

- R4 The Health Board should urgently complete development of its eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is:
- based on current and projected future demand for services.
 - includes capacity plans based on realistically ambitious levels of productivity.
 - costed, at a minimum, for the medium term (3-5 year).
 - supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models.
 - supported by clear delivery actions and milestones.
 - approved by the Board. **(see paragraph 26)**
- R5 Once the eye care plan has been approved by the Board, an appropriate committee should receive at least twice-yearly updates on the plan's delivery, clearly articulating any risks to delivery. **(see paragraph 38)**

Managing eye care risks

- R6 The Health Board should review its operational and strategic risk registers to ensure risks related to eye care services are appropriately captured and managed. **(see paragraph 40)**

Managing the risk of harm

- R7 The Patient, Quality, Safety Outcomes Committee should receive assurance on:
- how patients on the ophthalmology waiting list are managed to prevent harm;
 - lessons learned from actual reviews and how lessons have been applied to strengthen arrangements; and
 - actual harm caused by ophthalmology waiting delays. **(see paragraph 54)**

Detailed report

Regional partnership working

- 10 We considered whether the regional ophthalmology strategy supports the delivery of sustainable ophthalmology services, and whether there are appropriate governance arrangements in place to support its implementation.
- 11 We found that **while now progressing, delivery of the regional eye-care approach was slow to start and diverges from its original specialist service ambitions by focussing on creating short-term service capacity.**
- 12 In 2022, Cardiff and Vale, Cwm Taf Morgannwg and Aneurin Bevan University Health Boards launched the 2022-2025 Regional Ophthalmology Strategy (the regional strategy). It responds to key issues from the 2021 Pyott Review³, including rising demand, limited specialist capacity, and reliance on English providers.
- 13 The strategy sets out a clear vision for sustainable, high-quality services, with complex care delivered regionally and routine care closer to home. It aims to establish a Regional Centre of Excellence and deliver complex eye care regionally, while less complex care is provided closer to patient's homes.
- 14 The regional strategy identifies key clinical risks, including sight loss from long waits, rising demand, and workforce shortages. It sets high-level targets for 2023–2025, including expanded cataract and emergency services, a regional vitreoretinal service, workforce development, and plans for a Regional Centre of Excellence.
- 15 Aneurin Bevan University Health Board is the regional lead for the new partnership approach, with involvement and engagement from its regional partners. The programme is split into three phases with annual milestones, these are:
 - by 2023: Regional expansion in capacity for cataracts will be fully utilised, Regional Vitreo Retinal Service will be operational, Regional Eye Casualty and Out of Hours Care will be in place (**Phase 1**).
 - by 2024: Research, Innovation and Development will be well established, Workforce Development Programme will be in place (**Phase 2**).
 - by 2025: Regional Centre of Excellence network funding will be agreed (**Phase 3**).
- 16 While governance arrangements to oversee regional strategy delivery are clear, there is a risk that the structure is too complex, causing delays. The Regional Ophthalmology Programme Board meets monthly and is supported by the Delivery and Development Group. Both have clear objectives, effective management, and strong clinical engagement from each health board. The Programme Board reports to the Regional Portfolio Oversight Board, which oversees all regional programmes. In April 2025, the Cabinet Secretary for Health and Social Care instructed the south-east region to further establish a joint regional committee during 2025–26.

³ External Review of Eye Care Services in Wales (rcophth.ac.uk) undertaken by Andrew Pyott

- 17 While decisions are being made through the established governance groups, they are also being taken separately by each health board. For example, the business case for regional cataract services required approval at ten different meetings, resulting in delay. The creation of the joint regional committee presents an opportunity to also consider how delegated authority and decision-making processes are streamlined (**Recommendation 1**).
- 18 Phase 1 of the strategy aimed to expand key regional services by 2023, but overall progress has been slower than planned. The focus on creating regional cataract service capacity was pragmatic because of the waiting list backlog, but slow to progress. Other elements of the regional strategy have also been slower to deliver particularly those set out in phases 2 and 3 above relating to a specialist centre of excellence and research. There are many factors constraining progress. This includes the focus on short-term planning detracting attention from the longer-term priorities, and operational and clinical workforce challenges (**Recommendation 2**). To help better monitor strategy delivery, there needs to be clearer reporting against the original strategy commitments, setting out clear delivery timescales (**Recommendation 3**).
- 19 It is clear that the new regional arrangements are creating new service activity in addition to the core activity provided by each Health Board. In July 2023, Welsh Government agreed £7 million recurrent funding to deliver the Regional Cataracts Business Case. From a slow start, particularly because of recruitment challenges in the Nevill Hall north hub, the levels of cataract procedures have now increased (**Exhibit 2**).

Exhibit 2: Profiled and actual delivery of cataract procedures facilitated by recurrent Welsh Government funding, by delivery hub

Financial year	Provider	Profiled	Actual
2023-24	South hub	2905	2764
	North hub	39	26
	Regionally outsourced	750	676
	Total	3694	3466
2024-25	South hub	2049	1930
	North hub	950	846
	Regionally outsourced	1308	1308
	Total	4307	4084

Source: Aneurin Bevan University Health Board

- 20 While the regional cataract approach is targeting long waits, it is not making a marked difference on overall numbers of patients waiting across the region. The funding used for regional working is being used to treat patients waiting a long time for cataracts services. However, there are more people on the referral to treatment ophthalmology waiting list now than there was in March 2023. In March 2023, there were 45,930 patients waiting across the region and this increased to 54,977 by 2025. Without the regional investments, the position would have been worse, but the regional arrangements are not yet significantly resulting in reduced overall level of ophthalmology waits.
- 21 In October 2024, Welsh Government awarded the region a further £7.5 million non-recurrent funding to help reduce the long waits, particularly those waiting more than 2 years. Following Ministerial Advisory Group recommendations, and supported by £19.5 million non-recurrent funding, the region may further increase its use of the independent sector during 2025-26.
- 22 To support equitable access to treatment, regional capacity has not been distributed equally across the three health boards. Instead, it has been focused on patients who have been waiting the longest. Because the proportion of very long waits are not the same across the health boards, the Welsh Government has provided more regional funding to Cwm Taf Morgannwg University Health Board than the others. This targeted allocation aims to reduce waiting lists in a way that promotes fairness across the region. While this may not appear a 'fair share', it reflects a practical and equitable approach to addressing variation in access across the region. This approach is also supported by a regional booking team, helping to ensure more consistent access to treatment

Health Board plans for eye care services

- 23 To ensure patients receive timely eye care in an appropriate setting, and prevent avoidable, irreversible harm, it is essential that the Health Board has a clear plan to improve its current, community and hospital-based eye care services and develop a sustainable model of care for the future. We considered whether there are realistic plans to improve eyecare services at a local level, considering whether:
- the Health Board has an agreed plan to improve eye care services, covering hospital and community services, which seek to address current and longer-term challenges; and
 - the Health Board's eye care plans have sufficient focus on improving the efficiency and productivity of its services.
- 24 We found that **the Health Board's planning approach for local eye care is fragmented and lacks clear long-term direction, and while steps have been taken to improve efficiency, these have yet to deliver sustained results.**

Local eye care plans

The current planning approach for local eye care services is fragmented, with unclear ambitions and timescales, and insufficient focus on longer term service needs.

- 25 The Health Board has a good understanding of the barriers to improving eye care services. These include growing service demand, insufficient workforce capacity and inadequate digital and estates infrastructure. However, the Health Board does not have an overarching eye care plan to guide long-term service improvement and address these challenges. Instead, its eye care priorities are articulated in several plans. These include the Health Board's Annual Plan, the supporting ophthalmology service plan, eye care action plan covering hospital and community eye care, and focused plans such as implementing the Getting it Right First Time (GIRFT) recommendations and Welsh General Ophthalmic Services (WGOS) pathways⁴. Whilst there is crossover between these plans, the current approach is uncoordinated and short-term in nature. The Health Board recognises the need to develop a single eye care plan and is in the early stages of this process.
- 26 The Health Board has recently developed an eye care action plan. The action plan is aligned to the [National Clinical Strategy for Ophthalmology](#), which was launched in October 2024, mirroring its strategic themes⁵. The Health Board reported that it is in the process of developing an approach to deliver its action plan. Initially it will focus on priority areas, with task and finish groups being established to progress work in these areas. The task and finish groups⁶ will report to the Eye Care Board. While this progress is positive, the eye care action plan is high-level, the timescales for delivery are unclear, as are the Health Board's long-term ambitions for eye care services. Given the challenges with ophthalmology waiting times, the Health Board must urgently complete its eye care plan, which should be Board approved, to guide long term, sustainable service improvements **(Recommendation 4)**.
- 27 In the short term, the Health Board's service intentions are effectively shaped by demand, capacity and what can realistically be delivered. Each service, including ophthalmology, completes an annual planning template, which includes high-level demand and capacity planning. This helps the Health Board understand current pressures and plan accordingly. For example, the ophthalmology annual plan compares planned and actual activity, such as referrals, outpatient appointments, and emergency admissions, to adjust plans for the following year and identify capacity gaps.

⁴ The WGOS ([Wales General Ophthalmic Services](#)) pathway is a structured framework designed to enhance eye care services in Wales.

⁵ The strategic themes are organisational reform, clinical networks, pathway transformation and sustainable delivery model.

⁶ The task and finish groups are as follows: ophthalmology cataract group, regional ophthalmology delivery and development group, medical retina clinical reference group, estates accessibility group and digital ophthalmology groups.

- 28 The approach above supports the development of a sustainable eye care plan by providing clearer insight into long-term resource needs. However, the capacity of the ophthalmology service is a concern. The Health Board has had three long-standing vacancies for ophthalmology consultants. Encouragingly, all positions have now been successfully filled; however, two of the appointed consultants are not expected to commence their roles until August 2026. In overall terms the Health Board has seen a 30% decrease in its ophthalmology medical workforce between March 2021 and March 2025⁷.

Plans for improving service efficiency

While the Health Board is taking appropriate steps to improve the productivity and efficiency of its eye care services, it has not yet led to sustained improvements.

- 29 The Health Board's is focussing on improving efficiency and productivity. It aims to increase theatre utilisation, increase cataract surgery productivity and reduce outpatient inefficiencies. It also seeks to optimise optometrist roles by implementing the WGOS pathways and upskilling hospital optometrists. Similar measures are outlined in the Health Board's Annual Plan for the planned care service, which includes ophthalmology. This pragmatic approach supports sustainable services by maximising use of current resources. The hospital and community eye care action plans also address broader barriers, with workstreams targeting waiting times, regional collaboration, workforce development, integrated care, and digital transformation.
- 30 Despite the past and current focus on productivity and efficiency, there are significant opportunities for improvement. As at 4 August 2025, the theatre utilisation rate for the ophthalmology service was 80% against the Health Board target of 90%, the average late start and early finish theatre rates were 37% and 49% respectively, the short notice theatre cancellation rate was 11.9%, attributable to both the patient and hospital, and the 'Did not Attend rate for new ophthalmology outpatients was 8.4%⁸.
- 31 The report from the Ministerial Advisory Group on NHS Wales Performance and Productivity also makes recommendations to reduce unwarranted variation in treatment waiting times and adopting best practice in theatre management. This includes a recommendation to create Local Theatre Optimisation Boards to boost productivity within theatres, and best practice of cases per theatre session. For ophthalmology this means 10 cataract procedures in a 4-hour theatre session, and 8 procedures if it is a training session. Currently, the Health Board's cataract surgery lists include 7-8 patients per list. In June 2025, the service successfully

⁷ In March 2021, there were 18 full time equivalent ophthalmology medical staff, compared to 12.5 in March 2025. Data source: Welsh Government medical workforce data.

⁸ Data source: Aneurin Bevan ophthalmology referral to treatment compelling scorecard, fiscal week 19. Figures shown are based on a 12-week rolling average.

trialled a 10-patient cataract list, with an improvement plan in place to consistently deliver high-volume lists.

Leadership and governance arrangements

- 32 Clear leadership and governance arrangements are key to supporting well managed service improvement. We considered whether the Health Board has:
- clear and effective executive, operational and clinical accountability;
 - appropriate Board and committee level oversight and scrutiny; and
 - appropriate arrangements to capture, manage and oversee operational and corporate risks.
- 33 We found that **there is good executive, clinical and operational leadership to drive short-term improvements, but there is insufficient Board oversight, and risk management for eye-care services needs improving.**

Operational and clinical leadership

The Health Board has good executive, clinical and operational leadership to drive short-term improvements in eye care services.

- 34 The Health Board has clear leadership and accountability for its eye care services, with the Chief Operating Officer overseeing both acute and primary care. The ophthalmology service, within the surgery division, is led by a strong triumvirate leadership team. The team is made up of an ophthalmology directorate manager, clinical director and two senior ophthalmology nurses. The service has appropriate executive and operational clinical leadership, who oversee clinical governance, performance, and incidents, while community optometry contracts are overseen by the Primary Care Divisional Lead and a dedicated optometry professional lead.
- 35 In general, we found good executive and operational oversight of ophthalmology performance. Performance is reviewed routinely through the Health Board's Planned Care Programme Board structure, Chief Operating Officer's directorate performance assurance meetings, surgery directorate meetings and ophthalmology service meetings. Oversight mechanisms tend to focus on improving waiting times and service efficiency and productivity, which are valid but have a short-term focus.
- 36 The Health Board has re-established its Eye Collaborative Care Board and Eye Care Working Group. The Eye Care Working Group is responsible for overseeing development of the Health Board's overarching eye care plan. This should improve the focus on longer-term service improvements.

Board and committee oversight

There is insufficient Board and committee oversight of eye care services.

- 37 Board level oversight of eye care services needs strengthening. While various committees receive updates, these are often ad-hoc or embedded within other

reports. This makes it difficult to fully understand the totality of service, quality and performance risks. Ophthalmology is featured within the planned care update of the integrated performance report received by the Finance and Performance Committee and the Board, but ophthalmology performance is not separated. The Patient, Quality, Safety Outcomes Committee receive various reports where ophthalmology is mentioned such as the Primary Care Annual Quality Report and the Putting Things Right Annual Report. Only the Partnership Population Health and Planning Committee receives consistent updates focused on regional ophthalmology work.

- 38 In June 2024, the Health Board conducted a comprehensive ophthalmology deep dive, but this has not featured in any committee papers, neither have updates against the ophthalmology GIRFT recommendations. Given the level of risk posed by the ophthalmology waiting list, there needs to be a greater level of Board assurance. Once the eye care plan has been approved by the Board, an appropriate committee should receive routine progress updates (**Recommendation 5**).

Risk management arrangements

Risk management arrangements do not adequately cover eye-care risks.

- 39 Generally, the Health Board's ophthalmology directorate and surgery division risk registers capture operational risks. These include issues with medical equipment, follow-up outpatients over their target dates, retina clinic capacity, estate issues, specialist ophthalmic nursing capacity and difficulties recruiting a cornea specialist. However, we note some fundamental gaps, such as risks related to current gaps in the paediatric and glaucoma ophthalmologist workforce and inadequate digital infrastructure, especially related to the use of Open Eyes electronic patient record. The Health Board should review its ophthalmology service risk register to ensure all risks are adequately managed. The Health Board is currently developing its approach to managing corporate risks.
- 40 Our 2025 planned care review found that planned care risks, including ophthalmology, are reported to the Planned Care Programme Board. However, there is no Planned Care Programme Board specific risk register, which may result in some risks or mitigating actions not being effectively tracked or prioritised. At Board level, the Health Board's strategic risk register includes several risks which are relevant to ophthalmology, such as those related to maintaining high quality and safe services, and inadequate digital and estate infrastructure. However, there is insufficient focus on the risk of patient harm associated with treatment delays (**Recommendation 6**).

Ophthalmology performance

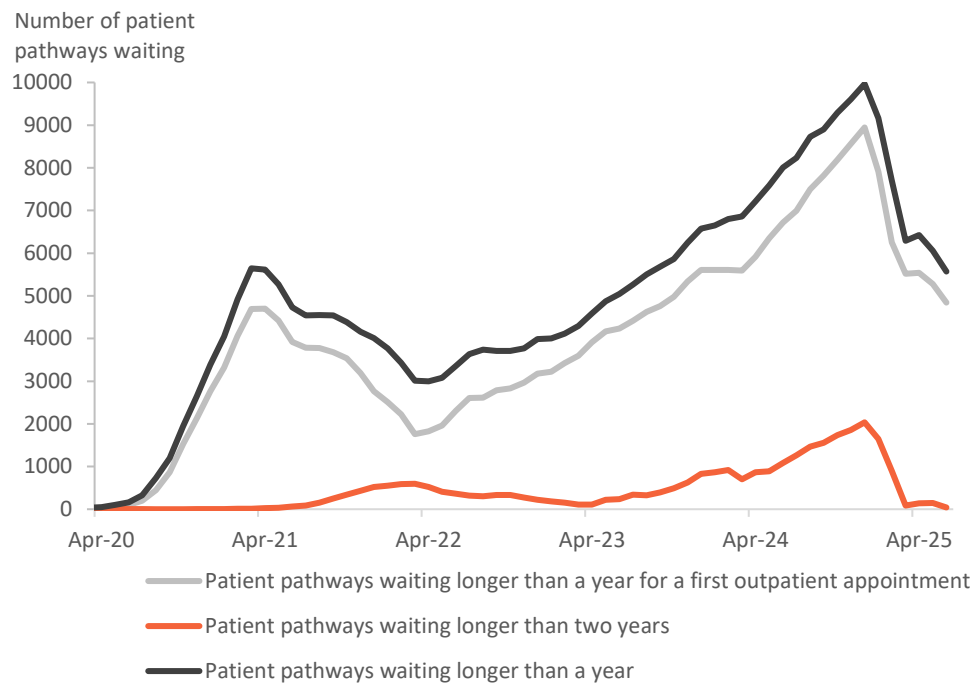
- 41 We analysed ophthalmology waiting list performance and trends to determine whether the Health Board is meeting Ministerial priorities and Welsh Government national targets related to reducing long waiting lists. The targets are as follows:
- no one waiting longer than a year for their first outpatient appointment by the end of 2022 (target date revised to December 2023);
 - eliminate the number of people waiting longer than two years in most specialities by March 2023 (target date revised to March 2026); and
 - eliminate the number of people waiting longer than one year in most specialities by Spring 2025.
- 42 In addition, ophthalmology services are measured using the eye-care measure. This measures the extent of delay for those patients at most risk of harm because of a delay in treatment. This approach is explained in **Exhibit 4**.
- 43 We found that **while long waits over two years for ophthalmology have significantly reduced, the Health Board continues to fall short of Welsh Government's targets for the eye-care measure and patients waiting over one year.**

Performance against Welsh Government planned care targets

While ophthalmology waits over two years has significantly reduced, the Health Board has missed Welsh Government's target for those waiting longer than one year.

- 44 **Exhibit 3** shows the Health Board's performance against Welsh Government planned care waiting list targets. In June 2025 the Health Board had:
- 5567 patients waiting longer than a year on the ophthalmology waiting list;
 - 4842 patients waiting longer than one year for their first ophthalmology outpatient appointment; and
 - 44 patients waiting longer than two years on the ophthalmology waiting list.
- 45 All three measures have seen a general deterioration since the pandemic. Whilst there has been some improvement from January 2025 onwards, the improvements coincide with additional Welsh Government non-recurrent funding to address long cataract waits. Between April 2021 and April 2025, the Health Board has seen 51% increase in ophthalmology referrals. Overall referral to treatment waits in the last two years has increased from around 19,000 to over 23,000. This growth alongside the long-term trends identified in **Exhibit 3** suggest that the Health Board needs to do much more to address both long waits, and the overall level of waits.

Exhibit 3: the number of ophthalmology patients waiting longer than two years and one year, Aneurin Bevan University Health Board



Source: Referral to treatment times, Welsh Government

Eyecare measure waiting list performance

The Health Board has consistently failed to meet Welsh Government's eye-care measure target, falling substantially short of the 95% target.

46 In addition to the referral to treatment time waiting list, NHS Wales reports patient waits for those who are most at risk of harm because of a delay. **Exhibit 4** provides a basic explanation of this measure.

Exhibit 4: A basic introduction to the eye care measure

Welsh Government introduced the eye care measure to help prioritise those most at risk of harm as a result of a delay in accessing services.

Ophthalmology patients are risk assessed based on their condition and then given a target date to be seen. If a patient who is categorised as the highest risk (R1)⁹ waits 25% longer than the clinically assessed target date, then it counts as a breach.

⁹ The highest risk is known as Risk Factor 1 or R1. R1 category is for patients that have been assessed as being at risk of irreversible harm or significant adverse outcome should their target date be missed.

Example: Mrs Jones has wet AMD and has been clinically assessed as needing to be seen in 4 weeks. Mrs Jones waits just over 6 weeks – therefore the target has been breached. Within 5 weeks, this would not have been a breach.

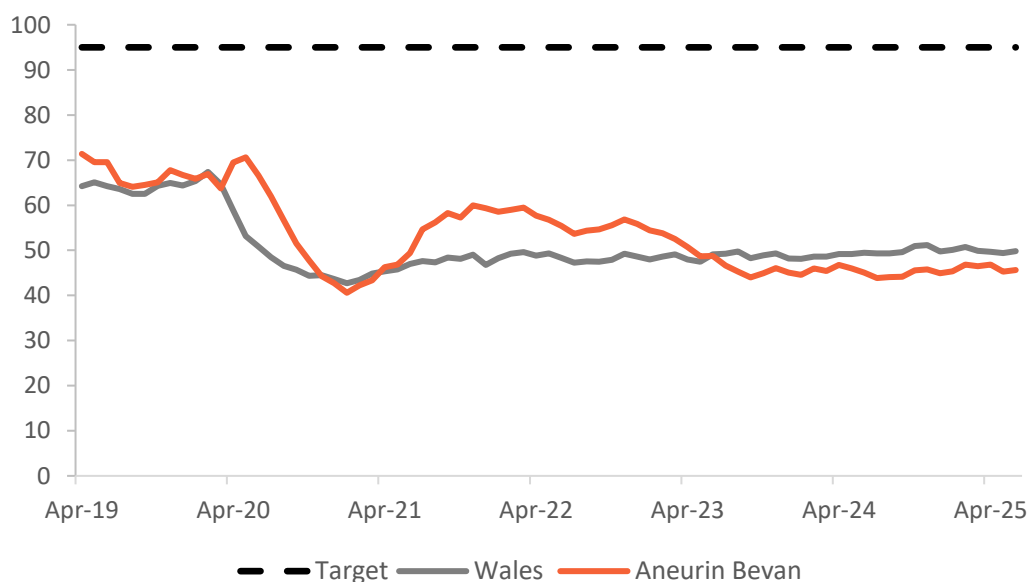
The national target is for 95% of patients on the Eye Care Measure waiting list to be seen by their target date or within 25% beyond their target date.

Source: Audit Wales

- 47 **Exhibit 5** shows performance against the Welsh Government eyecare measure target. Since July 2023, the Health Board's performance dropped below the Welsh average and has not recovered. In June 2025, performance was 45% against the national target of 95%. Patients identified as Health Risk Factor R1 have an increased potential risk of harm and permanent sight loss.

Exhibit 5: Percentage of eye care patients seen by their target date or within 25% beyond their target date, Aneurin Bevan University Health Board

Percentage within target date



Source: Eye Care Measure performance, Welsh Government

- 48 The Health Board's performance against the eye care measure remains a significant concern and means that there is a real and continued risk of patients coming to avoidable harm and suffering irreversible sight loss.

Managing the risk of harm

- 49 Patients' eye conditions may deteriorate while waiting, causing pain, anxiety, affect their quality of life and ability to work or care for others. It is important that the Health Board actively manages harms associated with long waiting list delays. We considered whether the Health Board:
- has effective processes to record and report on incidence of harm that results from eye care waiting list delays; and
 - is taking appropriate action to manage the risk of patient harm, particularly sight loss.
- 50 We found that **while appropriate processes are in place to prioritise ophthalmology waiting lists and to identify and learn from any harm caused by delays, there remains an opportunity to strengthen assurance. Some patients have experienced harm, and reporting at committee level does not consistently capture these incidents or provide assurance on how lessons are being applied to reduce future risk.**
- 51 The Health Board has appropriate mechanisms in place to prioritise its waiting list. It uses a risk stratification tool, as recommended by the GIRFT review, to prioritise ophthalmology patients based on clinical need, with R1 patients at highest risk. A separate tool supports glaucoma care decisions, helping to determine whether patients can be managed by community optometrists or require hospital care.
- 52 Waiting list validation is primarily carried out by validation clerks with clinical input. Some of the validation clerks are relatively new and training is being provided to support more complex case management.
- 53 The Ophthalmology Service has several processes to identify and review harm. It has invested in a senior nurse dedicated to reviewing current and historic ophthalmology harms recorded on the DATIX system. Regular patient safety meetings and weekly Executive Hub reviews support oversight of serious incidents, some of which may trigger Duty of Candor or Welsh Government's serious incidents process. These reviews help identify learning, shared through forums such as clinical audit meetings and ophthalmology team meetings. They also help correct patient pathways and prioritisation, which may be lost or delayed on the waiting list.
- 54 The Health Board reported that between July 2024 and July 2025, 10 ophthalmology related incidents involving delays were recorded on Datix. Nine concerning delays in patient assessment and one in treatment. Of these, two were graded as low harm, five as moderate harm, and three as severe harm. We have seen evidence of serious incidence and harm being reported through executive performance reviews, a service specific deep dive and monthly eye care measure reports. While executive and operational oversight arrangements for ophthalmology harms and serious incidents are sound, there is very little reporting of actual ophthalmology harms to the Patient, Quality, Safety Outcomes Committee or assurances that lessons are being applied to reduce the risk of harm in future **(Recommendation 7)**.

Appendix 1

Audit methods

Exhibit 6 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Regional Ophthalmology Strategy, associated programme management documentation and progress reports. • Local eye care plans (ophthalmology and optometry), delivery/implementation plans and progress reports. • Documentary evidence on the use of Welsh Government funding. • Performance dashboards/reports related to eye care services. • Documents related to programme governance and oversight arrangements related to delivery eye care plans, harms reviews and learning from incidents of harm. • Plans or proposals for insourcing / outsourcing / waiting list initiatives. • Operational risk register(s) for eye care services. • Documents showing procedures, including responsibilities, for clinical assessment of patients on the ophthalmology waiting list.
Interviews	We interviewed the following: • Chief Operating Officer • Deputy Medical Director • Deputy Director of Nursing • Ophthalmology Directorate Manager • Assistant Ophthalmology Directorate Manager • Ophthalmology Consultant and Clinical Director • Senior Nurse Ophthalmology • Senior Interim Nurse Ophthalmology • Assistant General Manager Surgery • Primary Care Divisional Lead • Primary Care Ophthalmology Lead • Consultant ophthalmic surgeon

Element of audit methods	Description
	• Chair of Patient, Quality, Safety Outcomes Committee • Regional Eye Care Programme Lead.
Observations	We observed the South East Wales Regional Ophthalmology Programme Board.
Data analysis	We analysed key ophthalmology service data on: • waiting list performance; • referrals; • medical workforce; • outpatient and inpatient activity and efficiency; • surgical cancellations; and • inpatient and day case admissions.

Appendix 2

Audit criteria

Main audit question: **Does the Health Board have effective arrangements to improve eye care services?**

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
Does the Health Board have realistic plans to improve eyecare services at a regional and local level?	Does the Health Board have an agreed plan to improve eye care services, covering hospital and community services, which seek to address current and longer-term challenges?	- The Health Board has a clear eye care plan, which has been approved at Board level which: - seeks to address current and future challenges with a view to developing sustainable eye care services; and - supports delivery of the Health Board's strategic objectives/priorities and aligns with the ambitions set out in national strategies/plans and legislation. - The eye care plan appropriately reflects regional plans, which the Health Board is invested in, which aim to deliver sustainable ophthalmology services on a regional basis.
	Is the Health Board's eye care plan realistically deliverable?	- The eye plan is supported by/includes a clear delivery plan with clear actions and milestones. - The eye care plan is based on current and projected future demand for services. - Capacity plans are based on realistically ambitious levels of productivity. - The plan is costed, at a minimum, for the medium term (3-5 year). - The plan is deliverable within the resources available to the Health Board.
	Do the Health Board's eye care plans have sufficient focus on improving the efficiency and productivity of its services?	The Health Board is proactively targeting and improving eye care service efficiency in a range of areas such as reducing DNAs and cancellations in outpatients and surgical settings, improving surgical productivity (particularly cataracts), maximising eye-care theatre list utilisation, and utilising see on symptom and patient initiated follow ups.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
		- Plans include national and local performance and efficiency measures, and draw upon the work of GIRFT reviews where relevant. - The Health Board is working with others effectively to drive wider efficiency improvements. - The Health Board is making use of digital systems to improve service efficiency. - Use of outsourcing has been considered / implemented as a mechanism to help reduce waiting list backlogs, supported by the necessary considerations of value for money and service safety.
Does the Health Board have appropriate leadership arrangements to drive improvements in eye care services and address the barriers that might inhibit progress?	Are there appropriate governance and leadership structures to drive forward the necessary improvements?	- There is clear Executive and Senior Management accountability for the delivery of eye care improvement plans. - There is clear clinical leadership for the delivery of eye care improvement plans. - There is evidence of operational oversight of the delivery of eye care improvement plans. - There is evidence of oversight and scrutiny of the delivery of eye care plans at the appropriate Committee and at Board. - Risks are appropriately captured within operational and corporate risk registers. - There are escalation mechanisms in place in the event of services failing to meet required standards / targets / milestones.
	Is the Health Board identifying and addressing the barriers to improving its eye care services?	- The Health Board has a clear understanding of the barriers that might prevent it delivering its eye care improvements/improvement plans and intentions. - The Health Board can demonstrate that it is putting in place arrangements to tackle the barriers that could impede delivery of the improvement plans.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
	Is the Health Board effectively delivering its improvement plans for eye care services?	The Health Board can demonstrate that it is making good overall progress implementing eye care plans and initiatives, and the achievement of milestones, targets and outcome measures identified within its plans.
Is the Health Board actively managing the risk of harm resulting from ophthalmology waiting list delays?	Does the Health Board have effective approaches to record and report on incidence of harm that results from eye care waiting list delays?	- The Health Board has appropriate arrangements to identify, capture, and report on harm associated with long waits for eye care treatment: - There is a clear process for identifying and capturing patient harm caused by delays to eye care treatment. - The Health Board is reporting on actual harm caused by delays to eye care treatment to its Quality and Safety Committee. - The Quality and Safety Committee receives assurances that the Health Board is learning from incidence of harm to prevent it in the future.
	Is the Health Board taking appropriate action to manage the risk of patient harm, particularly sight loss?	- The Health Board has an appropriate system to assess patients on the eye care waiting list to ensure those most at risk of sight loss are treated first. - The eye care waiting list is frequently reviewed by a clinician to ensure clinical risks are up to date and correctly prioritised. - The Health Board is managing potential health inequalities in access to eye care services. - The Health Board is applying the principles of Welsh Governments' promote, prevent, and prepare policy to help patients on eye care waiting lists.

Appendix 3

Management response

Exhibit 7 below sets out the Health Board's response to our recommendations.

Recommendation	Management response	Completion date	Responsible officer
R1 To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases.	The Regional Joint Committee (RJC) that will come into existence towards the end of 2025 will streamline regional decision making for all regional programmes.	December 2025	Chair of Regional Ophthalmology Programme Board
R2 Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy.	The Regional Programme Plan for 25/26 includes a regional workforce review along with the ongoing demand and capacity reviews for each sub speciality.	March 2026	Chair of Regional Ophthalmology Programme Board

Recommendation	Management response	Completion date	Responsible officer
R3 Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy.	The Regional Ophthalmology Strategy pre-dates the National Clinical Strategy for Ophthalmology. As a result the Regional Strategy will be reviewed as part of the programme plan in 25/26, with appropriate phasing and timeframes assigned to programme priorities.	March 2026	Chair of Regional Ophthalmology Programme Board
R4 The Health Board should urgently complete development of its eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is: • based on current and projected future demand for services. • includes capacity plans based on realistically ambitious levels of productivity. • costed, at a minimum, for the medium term (3-5 year). • supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models. • supported by clear delivery actions and milestones. • approved by the Board.	The Health Board acknowledges the urgency and importance of completing the Eye Care Plan and is actively progressing work to meet the outlined requirements. The following steps are being taken to ensure the plan is robust, sustainable, and Board-approved: 1. Demand-Based Planning • The draft Eye Care Plan has been completed. • Ophthalmology capacity and demand modelling takes place yearly, ensuring data remains up to date as service capacity flexes. • The plan is being developed using current service activity data and projected demand modelling, including cataract treatment volumes and outpatient trajectories. • Regional benchmarking and national variation intelligence are being used to inform future service needs. 2. Capacity and Productivity • Capacity plans incorporate realistic yet ambitious productivity targets, including improvements in theatre utilisation and outpatient throughput. • Initiatives such as the “golden patient” process, interface GP schemes are being scaled to optimise clinical efficiency and the planned insourcing activity with HBSUK.	April 2026	Associate Director of Planned Care

Recommendation	Management response	Completion date	Responsible officer
	3. Medium-Term Costing - Financial modelling has been completed for FY25/26, with further costing underway for a 3–5-year horizon, including sustainability plans for ophthalmology. - Further sustainability plans will be submitted via division by March 2026. 4. Resource Planning - Workforce plans include confirmed appointments for three ophthalmology consultants (cornea, glaucoma, paediatrics) with start dates through 2026. - Cornea consultant will start 01/09/2025 - Glaucoma consultant has accepted and will start fellowship August 2025 and due to be in post August 2026 - Paediatric consultant has accepted and will start fellowship August 2025 and due to be in post August 2026. - Infrastructure and digital enablers (e.g., E-consent, clinic room booking, theatre system replacement) are being scoped and procured to support service delivery. 5. Delivery Actions and Milestones - Four key Task and Finish Groups have been established to monitor the workstreams arising from the Eye Care Plan - The Task and Finish Groups meet monthly, with progress updates provided to the Eye Care Board (ECB) on a quarterly basis.		

Recommendation	Management response	Completion date	Responsible officer
	- The Eye Care Working Group and Programme Board have agreed Terms of Reference and are tracking delivery milestones, including pathway redesign and discharge protocols. - Monthly Planned Care Programme Board meetings oversee progress and escalate risks as needed. Governance and Timelines The completed draft Eye Care Plan will be further refined and submitted for formal Board approval by April 2026.		
R5 Once the eye care plan has been approved by the Board, an appropriate committee should receive at least twice-yearly updates on the plan's delivery, clearly articulating any risks to delivery.	The Eye Care Plan has now been approved by the Eye Care Board, which meets bi-monthly to review progress against key workstreams. Updates on performance, risks, and mitigation actions are discussed regularly through this forum, ensuring continuous oversight and alignment with Board governance expectations. Once the Eye Care Plan is approved by the Board, the Health Board will ensure that the Finance and Performance Committee receives updates on delivery at least twice a year. These updates will clearly articulate progress, risks to delivery, and any mitigating actions to support transparency and accountability. This will be ensured by adding the Eye Care Plan to the Committee's Forward Work Programme.	April 2026	Associate Director of Planned Care / Director of Corporate Governance

Recommendation	Management response	Completion date	Responsible officer
R6 The Health Board should review its operational and strategic risk registers to ensure risks related to eye care services are appropriately captured and managed.	The Health Board acknowledges the recommendation and is committed to ensuring that risks related to eye care services are appropriately captured and managed within its established governance framework. Ophthalmology risks are managed through the Health Board's Risk Management Framework to support safe, sustainable, and high-quality service delivery. At the operational level, divisional risks - including those related to long waits, workforce shortages, and service pressures are actively monitored and reviewed through directorate and divisional governance structures to ensure timely mitigation and oversight where required. At the strategic level, there are currently no discrete ophthalmology risks recorded on the corporate or strategic risk registers. Relevant issues are reflected within broader strategic risks, such as recruitment and retention across specialties, the adequacy of strategic planning, and the delivery of planned care waiting list targets, which collectively encompass ophthalmology. Specialty-specific risks are owned and managed at the directorate and divisional level, assessed against the Health Board's approved risk appetite and tolerance. This position will be kept under review, with escalation to a corporate ophthalmology risk if thresholds are met. Oversight is maintained through regular reporting to the Eye Care Board and via Directorate and Divisional Assurance meetings.	December 2025	Associate Director of Planned Care

Recommendation	Management response	Completion date	Responsible officer
	The Health Board is further strengthening assurance by: - Ensuring ophthalmology risks are captured and updated within the relevant risk registers. - Providing regular updates on the delivery of the Eye Care Plan to the Finance and Performance Committee, with clear articulation of risks and mitigating actions. - Drawing on learning from harm reviews and best practice to inform a review of long-waiting patients, overseen by the Planned Care Board.		
R7 The Patient, Quality, Safety Outcomes Committee should receive assurance on: - how patients on the ophthalmology waiting list are managed to prevent harm; - lessons learned from actual reviews and how lessons have been applied to strengthen arrangements; and - actual harm caused by ophthalmology waiting delays.	The Health Board acknowledges the recommendation and recognises the need to strengthen assurance on ophthalmology patient safety and waiting list management. The Health Board is committed to ensuring that the Patient Quality, Safety and Outcomes Committee (PQSOC) receives clear assurance on harm prevention, lessons learned, and any actual harm arising from ophthalmology waiting delays. All patient safety incidents in Ophthalmology are assessed via Datix to determine risk and required actions. Any incident resulting in moderate or greater harm triggers a formal harm review, which includes a detailed patient timeline and is assessed using ophthalmology-specific harm criteria. Rapid harm reviews are coordinated by the Quality and Patient Safety (QPS) Team and escalated to the weekly Executive Safety Huddle, ensuring timely oversight and shared learning across the Health Board. Lessons identified from harm reviews are translated into service-level action plans, and shared across the wider clinical team. Thematic	October 2026	Clinical Director for Ophthalmology

Recommendation	Management response	Completion date	Responsible officer
	findings and learning outcomes are reported through Divisional governance, and will form part of the assurance reports to the PQSOC. Through these reports, PQSOC will receive assurance on: The waiting list for <u>initial</u> Ophthalmology appointments is currently being addressed through HBSUK insourcing activity, with the aim of significantly reducing the backlog by the end of the financial year. Early indications show that a good number of patients are being discharged to alternative care pathways, and efforts are being made to target all areas of eye care, noting cataracts are being progressed as part of the regional solution. Additionally, the Patient Initiated Follow-Up (PIFU) initiative is in place as a flexible outpatient care model. This allows eligible patients to arrange hospital appointments themselves when their symptoms worsen, rather than relying on routine scheduling. Together, these activities are part of a broader strategy to minimise harm caused by delays in care and improve patient outcomes. • Lessons learned from harm reviews and how they have been applied, through summaries of completed reviews, resulting actions, and thematic learning. • Any actual harm arising from ophthalmology waiting delays, via aggregated and case-level data from Datix, rapid harm reviews, and formal investigations coordinated by the QPS team and reported through the established governance pathway.		

Recommendation	Management response	Completion date	Responsible officer
	While monitoring and reporting harm remains primarily retrospective and resource intensive this process provides robust assurance of oversight, learning, and continuous improvement. Forward-looking actions, including a bespoke review of long-waiting patients (covering Referral to Treatment and Follow-ups), will further inform PQSOC assurance and strengthen governance around ophthalmology waiting list risks.		



Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 January 2026
CYFARFOD O: MEETING OF:	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Partnerships, Population Health and Planning - Committee Forward Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Governance Support Officer

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

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Partnerships, Population Health and Planning Committee is asked to review the agreed Committee Forward Work Plan appended to this report as **Appendix A**.

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

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

Cefndir / Background

In line with good governance practice, the Partnerships, Population Health and Planning Committee has a Forward Work Plan that has been developed to ensure statutory requirements for items of Committee business are scheduled in across

the year. The Forward Work Plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

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

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

Additional items on the Forward Work Plan that were actions from October 2025 meeting and will be presented at January 2026 meeting:-

- Deep dives on priority programmes including key change issues
- Audit Wales Eye Care report

These changes have been reflected on the updated Forward Work Programme.

Asesiad / Assessment

The Committee is requested to **NOTE** the updated Partnerships, Population Health and Planning Committee Forward Work Plan as provided in **Appendix A**.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECEIVE** and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each future Committee meeting for oversight.

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

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item.

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

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

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

Annual Programme of Business for 2025-26

Committee Name: Partnerships, Population Health and Planning

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

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of Committee self-assessment for 2024
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:
The purpose of the Partnerships, Population Health and Planning Committee is to seek assurance on: • The robustness of the Health Board's approach, systems and processes for developing strategies and plans, including those developed in partnership; • Plans and arrangements for the following matters are adequate, effective, and robust and achieving intended outcomes: Joint committee and partnership planning; Engagement and communication; and Civil Contingencies and Business Continuity; • That partnership governance and partnership working is effective and successful; and

- that those arrangements in place to improve population health and wellbeing are robust and effective and delivering intended outcomes.

The Committee also has a role in providing accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters consistent with the Board's overall strategic direction:

- Strategy, strategic frameworks and plans for the delivery of high quality and safe services, consistent with the board's overall strategic direction;
- Business cases and service planning proposals;
- The alignment of supporting and enabling strategies, including workforce, capital, estates and digital;
- The implications for service planning arising from strategies and plans developed through the Joint Committees of the Board or other strategic partnerships, collaborations or working arrangements approved by the Board; and
- The Health Board's priorities and plans to improve population health and wellbeing.

MATTERS TO BE CONSIDERED (Report Title)	Lead	Frequency of Report	Schedule of Meetings			
			QTR 1 Apr to June 02/04/25	QTR 2 July to Sept 01/07/25	QTR 3 Oct to Dec 07/10/25	QTR 4 Jan to Mar 27/01/26
Preliminary Matters						
Attendance and Apologies	Chair	SI	✓	✓	✓	✓
Declarations of Interest	All members	SI	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	SI	✓	✓	✓	✓
Action Log and Matters Arising	Chair	SI	✓	✓	✓	✓
Committee Governance						
Development of Committee Annual Programme of Business 2025/26	DoCG/ Chair	AN	✓			
Review of Committee Programme of Business	DoCG/ Chair	SI	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2025/26	DoCG/ Chair	AN	✓			
Annual Review of Committee Effectiveness 2025/26	DoCG/ Chair	AN	✓			
Committee Annual Report 2024/25	DoCG/ Chair	AN	✓			
Committee Risk Report	DoCG	SI	✓	✓	✓	✓
Strategic Planning						
Update on the Delivery of a Long- Term Strategy	DoSP&P	SI	✓	✓	✓	✓
IMTP/Annual Plan Development	DoSP&P	An			✓	

Development of any plans and strategies aligned to the IMTP and Annual Plan	DoSP&P	SI	✓	✓	✓	✓
Emergency Planning Assurance Report	COO/ DoN	An		✓		
Primary Care Sustainability Report	COO	An	✓			
Estates Strategy Review	DoSP&P	AN			✓	
Nevil Hall Hospital Strategic Outline Case	DoSP&P	AN			✓	
St Woolos Hospital rationalisation	DoSP&P	AN			✓	
Digital Strategy	DOD	AN				✓
Planning Maturity Matrix	DoSP&P	AN			✓	
Deep dives on priority programmes including key change issues PPHPC0710/03/03.1	DoSP&P	Action				✓
Strategic Partnerships						
Regional Partnership Board	DoSP&P	SI	✓	✓	✓	✓
Public Services Board	DPH	SI	✓	✓	✓	✓
Regional Planning	DoSP&P	SI	✓	✓	✓	✓
Population Health						
Population Health Management Update Report	DPH	An		✓		
Joint Strategic Needs Assessment Update	DPH	An		✓		

Health Protection & Vaccination Programme Update	DPH	Bi-An	✓			✓
Audit Wales Eye Care report ARAC 1209/22	DoSP&P	Action				✓

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

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	!/2 yearly
Schedule of Meetings	
v	Scheduled agenda item in FWP

D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 January 2026
CYFARFOD O: MEETING OF:	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Cyber Security Audit
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Paul Solloway, Director of Digital
SWYDDOG ADRODD: REPORTING OFFICER:	Paul Solloway, Director of Digital

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board (the 'Health Board') underwent an internal audit to evaluate its cyber security governance, risk management, and incident response capabilities. The audit concluded that the Health Board has achieved a **reasonable** level of assurance in managing cyber security risks, with active oversight and reporting processes in place. However, several areas were identified that require immediate management attention to further strengthen the organisation's cyber resilience. Key issues included:

- outdated controls in the Strategic Risk Register
- insufficient recording of cyber risks
- low staff training compliance
- an untested Cyber Incident Response Plan

These factors present moderate risk exposure, particularly considering increasing cyber threats and regulatory expectations.

Cefndir / Background

The Health Board manages cyber security risks as part of its wider digital risk register, with oversight provided by the Cyber Security Team and the Information Governance Sub-Group. The strategic risk register references cyber security controls but does not explicitly outline cyber risk as a standalone threat. The Digital Governance Structure is newly established, aiming to improve oversight and staff awareness across the organisation's 14,000 employees. Systems such as

Palo Alto have been deployed to enhance asset management and identify shadow IT. Despite progress, staff engagement and resources remain a challenge. Recent phishing campaigns demonstrated a high click rate (12%), while mandatory training completion rates were below the target (77% vs 85%), indicating vulnerabilities due to low awareness. The Cyber Incident Response Plan exists but has not been formally tested, and action cards for response team members are absent. Communications for external audiences have not been prepared, and internal expertise and resources to manage cyber events are lacking. Third-party support for incident response has not been formally agreed.

Asesiad / Assessment

The audit identified several strengths and weaknesses in the Health Board's cyber security arrangements.

Risk Management: Cyber risks are actively managed on the Digital Risk Register, but not recorded on Datix as required by policy, limiting visibility and alignment with organisational risk appetite. The Strategic Risk Register contains outdated controls and does not explicitly define cyber risk. Senior staff expressed uncertainty about the adequacy of current cyber risk management.

Management Actions:

- Conduct a comprehensive review of SRR 006A to ensure risks and controls are current, relevant, and aligned with organisational risk appetite. Explicitly reference cyber security risk and ensure appropriate categorisation by appetite theme **(Date for completion: 31/01/2026)**.
- Record all corporate and strategic digital risks on Datix, while continuing operational risk management via the SharePoint Digital Risk Register until the new risk system is in place. Add risk appetite and theme to the directorate SharePoint register **(Date for Completion: Completed)**.

Governance: The Digital, Data & Technology (DDaT) governance structure has improved oversight, with cyber security now a standing agenda item in key meetings. Monthly reporting and performance metrics are tracked, though limited documented KPIs exist. Resource pressures on the Cyber Security Team remain a concern.

Management Actions:

- Formalise reporting timescales for the NIS Assurance Group to ensure regular updates to the Board and committee. Address resource constraints to ensure timely completion of objectives.

Staff Awareness & Training: Phishing simulation results indicate a persistent vulnerability, with 12% of staff clicking on simulated malicious links. Training rates are below target, and targeted follow-up training for compromised staff has not been implemented. Awareness campaigns are ongoing, but further improvement is needed.

Management Actions:

- Continue and enhance phishing simulation programmes, deliver targeted follow-up training to compromised users, and increase communication efforts. Ensure that cyber security staff awareness is monitored within the corporate risk framework **(Date for completion: 31/01/2026)**.

Incident Response: The Cyber Incident Response Plan is in place but untested. Action cards for response team members are missing, and external communications have not been drafted. The Cyber Security Team lacks forensic investigation expertise and formal third-party support, reducing preparedness for a cyber event.

Management Actions:

- Test the Cyber Incident Response Plan within three months using tailored tabletop exercises, develop action cards for team roles, and create external communication templates. **(Date for completion: 31/01/2026).**
- Review options for securing specialist third-party support (e.g., forensic investigation retainer) and update response plan documentation accordingly. **(Date for completion: 31/01/2026).**

Overall, the Health Board demonstrates a reasonable level of assurance in cyber security, with substantial progress in some areas but limited assurance in incident response and staff awareness.

Argymhelliad / Recommendation

The committee is asked to note the audit report and the associated management actions.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.4 Information Governance and Communications Technology Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Digital, Data, Intelligence
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:	
Ar sail tystiolaeth: Evidence Base:	ABU-2526-22 – Cyber Security Audit
Rhestr Termiau: Glossary of Terms:	DDAT – Digital, Data & Technology NIS – Network & Information Systems Regulations
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not Applicable

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