Partnerships, Population Health and Planning Committee

Tue 30 June 2026, 09:30 - 11:30

Microsoft Teams

Agenda

1. Preliminary Matters

PPHPC 20260630 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 27th January 2026

Attached *Chair*

PPHPC 20260630 1.4 Minutes 20260127.pdf (17 pages)

1.5. Committee Action Log

Attached *Chair*

PPHPC 20260630 1.5 Committee Action Log - Approved.pdf (2 pages)

2. Items for APPROVAL/RATIFICATION/DECISION

There are no items for inclusion in this section.

3. Items For Discussion

3.1. Update on Armed Forces Matters

Attached *Director of Workforce & OD*

PPHPC 20260630 3.1 Armed Forces Update PPHPC June 2026.pdf (7 pages)
PPHPC 20260630 3.1 AF Workstream_Board_20260521 - Appendix 1.pdf (9 pages)

3.2. Primary Care Sustainability Report

Attached *Chief Operating Officer*

PPHPC 20260630 3.2 Primary Care Sustainability Report LJH (002).pdf (20 pages)

3.3. Update and implications of new WG national GDS contract (Action transferred from FPC)

Attached *Chief Operating Officer*

PPHPC 20260630 3.3 Update and implications of new WG national GDS contract.pdf (16 pages)
PPHPC 20260630 3.3 Update and implications of new WG national GDS contract - Annex A - GDS Exec Report.pdf (15 pages)
PPHPC 20260630 3.3 Update and implications of new WG national GDS contract - Annex A1 GDS Position September.pdf (11 pages)
PPHPC 20260630 3.3 Update and implications of new WG national GDS contract - Annex B - ABUHB Transition Template.pdf (2 pages)
PPHPC 20260630 3.3 Update and implications of new WG national GDS contract -Annex Ba - Implementation Guide.pdf (10 pages)
PPHPC 20260630 3.3 Update and implications of new WG national GDS contract- Annex C - Vignettes - Version 2.pdf (41 pages)
PPHPC 20260630 3.3 Update and implications of new WG national GDS contract - Annex D - Care Package.pdf (1 pages)
PPHPC 20260630 3.3 Update and implications of new WG national GDS contract - Annex E GDS Contract Segmentation Feb.pdf (22 pages)

3.4. Regional Planning

Attached *Director of Strategy, Planning and Partnerships*

PPHPC 20260630 3.4 Regional Planning PHPP Committee update June 2026.pdf (5 pages)

3.5. Public Health Update Report

Attached *Director of Public Health*

PPHPC 20260630 3.5 Public Health Update Report.pdf (9 pages)
PPHPC 20260630 3.5 Public Health Update Report - Appendix 1 - Population Health Management.pdf (10 pages)
PPHPC 20260630 3.5 Public Health Update Report - Appendix 2 - Gwent JSA and GIF June 2026.pdf (5 pages)
PPHPC 20260630 3.5 Public Health Update Report - Appenidx 3 - PSB update June 2026.pdf (5 pages)
PPHPC 20260630 3.5 Public Health Update Report - Appendix 4 - PPHPC HP Vacc Update June 2026 v1.pdf (15 pages)

4. Items For Information

4.1. Review of Committee Programme of Business 2026/27

Attached *Director of Corporate Governance*

PPHPC 20260630 4.1 Review of Committee Programme Annual Programme of Business.pdf (4 pages)
PPHPC 20260630 4.1 Review of Committee Programme of Business - Appendix 1 -PPHPC 2026-27 Forward Work Plan.pdf (6 pages)

4.2. Regional Integration Fund Audit Report

Attached *Director of Strategy, Planning and Partnerships*

PPHPC 20260630 4.2 Regional Integration Fund Audit report.pdf (51 pages)

4.3. Committee Risk Report

Attached *Director of Corporate Governance*

PPHPC 20260630 4.3 Committee Risk Report_June 26.pdf (6 pages)
PPHPC 20260630 4.3 PPHPC Strategic Risk Assessments - Appendix 1 (002).pdf (17 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: 13th October 2026

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING – PARTNERSHIPS, POPULATION HEALTH AND PLANNING COMMITTEE

AGENDA	
Date and Time	Tuesday 30th June 2026 09:30-11:30
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 27th January 2026	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	Update on Armed Forces matters	Attached	Director of Workforce & OD
3.2	Primary Care Sustainability Report	Attached	Chief Operating Officer
3.3	Update and implications of new WG national GDS contract (Action transferred from FPC)	Attached	Chief Operating Officer
3.4	Regional Planning	Attached	Director of Strategy, Planning and Partnerships
3.5	Public Health Update Report	Attached	Director of Public Health
4	**ITEMS FOR INFORMATION**		
4.1	Review of Committee Programme of Business 2026/27	Attached	Director of Corporate Governance
4.2	Regional Integration Fund Audit report	Attached	Director of Strategy, Planning and Partnerships

4.3	Committee Risk Report	Attached	Director of Corporate Governance
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: 13th October 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	Tuesday 27th January 2026 09:30-12:30
VENUE	Microsoft Teams

PRESENT	Philip Robson, Chair
	Dafydd Vaughan, Vice Chair
	Neil Patrick, Independent Member
IN ATTENDANCE	Paul Solloway, Director of Digital
	Hannah Evans, Director of Strategy, Planning and Partnerships
	Eryl Powell, Consultant in Public Health
	Lloyd Hambridge, Divisional Director of Primary Care, Community Services & CHC (Item 3.6)
	Trish Chalk, Assistant Director of Planning and Performance (Item 3.2 & 3.3)
	Wendy Warren, Head of Planning and Civil Contingencies (Item 3.4)
	Claire Nelson, Deputy Director of Strategy, Planning & Partnerships
	John Frankish, Interim Assistant Director, Strategy, Planning & Design (Item 3.11)
	Rani Dash, Director of Corporate Governance
	Naomi Murtagh, Board Business Manager
	Fern Woodhead, Governance Support Officer
OBSERVING	Polly Frazer, Aspiring Board Member
	Sara Utley, Audit Wales
	Rhian Gard, Internal Audit
APOLOGIES	Tracy Daszkiewicz, Director of Public Health
	Akmal Hanuk, Independent Member
	Penny Jones, Independent Member

PPHPC 2702/01	**Welcome and Introductions** Phil Robson (PR), Chair, welcomed everyone to the meeting.
PPHPC 2702/02	**Apologies for Absence** Phil Robson (PR), Chair, noted the apologies for absence.

PPHPC 2702/03	**Declarations of Interest** There were no declarations of interest to record.
PPHPC 2702/04	**Draft Minutes of the last Meeting held on 7th October 2025** The minutes of the previous meeting held on 7th October 2025 were agreed as a true and accurate record. The Committee **APPROVED** the minutes from the previous meeting.
PPHPC 2702/05	**Committee Action Log** The Committee received the action log and was content with progress made on the completed actions. The Committee **NOTED** the report for information.
PPHPC 2702/07	**Committee Risk Report** Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of the Committee Risk report and the current strategic risks delegated to the Partnerships, Population Health & Planning Committee for oversight on behalf of the Board. There had been no changes to the strategic risk profiles allocated to the Committee since the previous report in October 2025. RD advised the Committee that the report was presented for the Committee for oversight and assured the Committee that it would also be submitted to the Board on 28th January 2026. The Committee **NOTED** the report.
PPHPC 2702/08	**Approval status of 2025/26 IMTP** Trish Chalk (TC), Assistant Director of Planning and Performance, provided the Committee with an update on the approval status of 2025/26 IMTP. The Committee was advised that the Health Board had been escalated from Level 3 (enhanced monitoring) to Level 4 (targeted intervention) for both finance and planning, following reassessment in December, the Health Board had also been escalated to targeted intervention for urgent and emergency care across the system.

	The Committee was advised that the Cabinet Secretary had revoked the previously approved 2025/26 IMTP, marking the first instance of IMTP approval being withdrawn from any Health Board in Wales. Hannah Evans (HE), Director of Strategy, Planning and Partnerships, advised the Committee that Welsh Government had not yet issued the revised Level 4 de-escalation criteria but indicated that rerunning the self-assessment against the Planning Maturity Matrix would be a core requirement. HE informed the Committee that the updated maturity assessment was recognised nationally as an example of good practice. The Committee was advised that regaining IMTP approval would require the plan to be financially balanced, although financial balance alone did not guarantee approval. Other Health Boards had submitted balanced plans which were not approved due to wider assessment considerations. The Health Board would therefore need to explore what choices were required to deliver a balanced plan for the next planning cycle. The Committee was advised that operating without an approved IMTP was not unusual across Wales, with only one Health Board (CTM) currently holding an approved plan. The Committee **NOTED** the approval status of 2025/26 IMTP.
PPHPC 2702/09	**Development of 2026/27 IMTP** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, informed the Committee that the Health Board was in the early stages of developing the 2026/27 IMTP and that significant work was underway to synthesise activity, financial detail, and national guidance. HE advised the Committee that the team was working through substantial operational and performance data alongside the updated guidance issued on 19th December 2025, noting that the timing had created pressures in the planning cycle. The Committee was advised that the Executive Team had scheduled a detailed session later in the week to examine emerging numbers, challenge underlying assumptions, and progress development of the plan. HE highlighted that the

	Board session originally planned for January had been moved to 11th February 2026 to ensure that the plan presented would reflect fully worked-through modelling and prioritisation. Trish Chalk (TC), Assistant Director of Planning and Performance, outlined the recent arrival of the technical guidance and minimum dataset requirements. The Committee was advised that while the overall structure of the dataset had not changed significantly, some areas particularly mental health and women's health had more detailed expectations. TC also highlighted strengthened quality requirements aligned with the new Quality Outcomes Framework. Further national requirements included integrating genomics, improving reproductive health access, aligning with population health priorities, and responding to new Welsh language obligations. HE advised the Committee that the national planning framework continued to emphasise the need for Health Boards to make clear and sometimes difficult choices, particularly given the financial context. HE advised that the National Value and Sustainability Board would shortly consider the extent to which national alignment on certain choices was required to avoid postcode variation across Wales. The Committee was advised that several significant operational programmes including the acute frailty and medical model work would continue irrespective of IMTP timelines because of their strategic and safety significance. The Committee discussed the need for the IMTP to clearly articulate major strategic priorities for patients, avoiding excessive focus on technical planning detail. The Committee also noted the importance of identifying investment requirements, the need to surface planning assumptions transparently, and the role of workforce culture and digital transformation in enabling sustainable change. HE advised the Committee that further detail on deliverables, modelling, and key decisions would be brought to the Board, following Executive challenge and refinement.

	The Committee **NOTED** the update on the development of the 2026/27 IMTP.
PPHPC 2702/10	**Business Continuity Planning** Wendy Warren (WW), Head of Planning and Civil Contingencies, provided the Committee with an overview of the business continuity planning and Health Board's current approach to business continuity (BC), noting that BC formed one component of the wider Emergency Planning, Preparedness and Response (EPRR) function. WW advised the Committee that all service areas were responsible for developing their own BC plans, with the EPRR team providing templates, tools, and guidance. WW emphasised that the team could not write plans on behalf of services, as each plan required detailed, operationally specific input. The Committee was advised that was variation in the quality and currency of BC plans across the organisation. Some areas, particularly within Community & Families and Therapies, had regularly tested and exercised their plans and demonstrated strong engagement. Other areas were still developing capability, and BC remained an ongoing improvement area requiring continued support. WW outlined the team's work programme, which included developing new exercising and testing tools, delivering targeted awareness-raising sessions for local teams, and supporting junior staff who may not have previously operated in non-digital or degraded-service environments. WW highlighted the importance of scenario-based exercises, especially given the increasing likelihood of cyber incidents or major system outages. In relation to digital resilience, WW noted that several real incidents had tested BC arrangements, including recent severe weather, flooding in Monmouthshire, and pathology system outages. The Committee was advised that collaboration with Digital Services had strengthened, particularly concerning preparations for potential Microsoft 365 outages. WW and Paul Solloway (PS), Director of Digital, advised that further work was required to ensure that critical services could operate during extended technology failures, including clarifying communication

	routes in the absence of email and Teams, and identifying systems that were mission-critical. PS advised the Committee that a critical asset register was being developed to identify and prioritise essential applications for BC planning and highlighted the importance of preparing for prolonged cyber events, noting national examples where organisations had taken months to recover from attacks. The Committee discussed the challenges associated with maintaining operational continuity during incidents lasting weeks or months, including staff fatigue, limited manual fallback processes, and volume-related pressures. The Committee was advised that additional supportive local audits were planned, with the EPRR team visiting departments to review plans, check operational readiness, and guide improvements. WW confirmed that major incident plans remained active and regularly tested, and that conventional fallback would continue to be used when required. WW advised the Committee of the positive partnership working through the Local Resilience Forum (LRF), highlighting coordinated multi-agency responses to flooding, severe weather, and public health threats. The Committee noted that the Gwent LRF had strong engagement and was widely regarded as one of the most effective partnerships in Wales. The Committee **NOTED** the update on business continuity planning.
PPHPC 2702/11	**Development of Clinical Services Plan Update** Claire Nelson (CN), Deputy Director of Strategy, Planning & Partnerships, provided the Committee with an update on the early development of the Health Board's Clinical Services Plan. The Committee was advised that the Clinical Services Plan was at an early stage of development and that no draft plan was being presented at this time. The Committee noted that the intention was to engage the Committee and the Board at an early point in the process, rather than present a completed plan at a later stage. The purpose of the Clinical Services Plan was outlined as providing a clear, service-focused description of how clinical services were configured, delivered and supported

	over a 3 year period, aligned to the Integrated Medium Term Plan (IMTP) and the Health Board's 10 year strategy. It was clarified that the Clinical Services Plan differed from a long-term clinical strategy, as it focused on service delivery models, workforce, estates, digital infrastructure and operational sustainability. The drivers for developing the Clinical Services Plan were described, including sustained pressures across urgent and emergency care, planned care backlogs, diagnostic capacity, workforce fragility and increasing demand. The Committee was advised that national expectations now required Health Boards to have a clear clinical services roadmap, including evidence of how fragile services were being addressed. CN advised the Committee that the Plan would align with existing strategic frameworks, including Gwent 35: Better Health, Better Care, Better Lives, digital and workforce strategies, and major infrastructure developments such as Nevill Hall Hospital. The Plan was intended to inform future IMTP cycles, while also being informed by existing operational and divisional planning activity. The Committee was advised that the proposed methodology would be evidence-led and would include horizon scanning, population health intelligence, demand and capacity analysis, risk assessment and engagement with clinicians, staff, partners and communities. It was emphasised that the Health Board was not starting from a blank position, with existing work already underway on service models, regional programmes and clinical redesign. A range of possible ways to frame the Clinical Services Plan was discussed, including clinical pathway, levels of care, place-based models, hospital configuration or population groups. The Committee considered that a pathway-based, end-to-end service approach was likely to be most effective in enabling meaningful change, clinical engagement and system-wide alignment. The importance of strong clinical and multi-professional leadership was emphasised. The Committee noted that engagement would need to be carefully structured to ensure relevance, ownership and productive use of clinical time, and to avoid duplication of existing work. CN advised the Committee that engagement would build on current

	programmes and regional planning activity, rather than delay or replace ongoing service developments. Proposed governance arrangements were outlined, with the Medical Director holding a central leadership role and clear reporting routes into Executive and Committee structures. The Committee was advised that the development timetable was indicative and had been adjusted to reflect organisational pressures, with a focus on evidence-gathering in the current period, followed by structured engagement and refinement. The Committee discussed the scale and complexity of the task and recognised that delivery would require prioritisation and difficult choices. The Committee highlighted the importance of focusing on transformational change rather than incremental service adjustments, particularly in the context of financial sustainability, workforce pressures and the need to shift care towards prevention and community-based models. The Committee supported the proposed direction of travel, including a pathway-based, clinically-led approach, endorsed the continued development of the Plan. The Committee **NOTED** the early stage of development of the Clinical Services Plan.
PPHPC 2702/12	**Deep dives on Place Based Care in Blaenau Gwent and Torfaen including key change issues** Lloyd Hambridge (LH), Divisional Director of Primary Care, Community Services & CHC, provided the Committee with an overview on the progression of the Place Based Care Programme, with a particular focus on Blaenau Gwent and Torfaen. The Committee was advised that over the preceding 12 months, significant work had been undertaken to develop a Place Based Care approach aligned to the Health Board's 10 year strategy. The programme had been mapped against strategic objectives and had evolved in response to changes in the national policy context, including increased emphasis on community-based and preventative models of care. LH advised the Committee that governance and leadership arrangements for the Place Based Care Programme had

	been strengthened. Clear reporting lines had been established between the Place Based Care Programme Board, the Executive Team, the Partnerships, Population Health and Planning Committee, and the Board, alongside alignment with local authority governance through the Integrated Service Partnership Board (ISPB) and the Regional Partnership Board (RPB). The Committee noted that a series of programme workstreams had been established to support delivery, including workforce, finance, digital and data, estates, engagement, and intelligence and evaluation. These workstreams were intended to enable consistent implementation and to address cross-cutting enablers of change. The Committee was advised that Blaenau Gwent and Torfaen had been selected as initial deep-dive areas due to high levels of deprivation, health inequality, and population need, alongside strong engagement and readiness within the local authorities. 8 defined "places" had been agreed across the two localities 4 in each, providing a clear geographic and community focus for implementation. The development of integrated neighbourhood teams was described as a core component of the Place Based Care model. These teams were intended to bring together professionals from health, local authority, housing, and the third sector to support individuals and families in a more coordinated way, reduce duplication, and simplify access to services. It was emphasised that the model aimed to support prevention, early intervention, and management of long-term conditions closer to home. The Committee was advised that work was underway to complete a baseline assessment of workforce, services, and resources within the defined places. LH advised that this exercise had proven complex due to the scale of staff and services involved, but was essential to inform the design of a consistent operational model and a realistic implementation plan. The key risks to delivery were highlighted, including workforce capacity and alignment, the current misalignment between some operational teams and place boundaries, and the impact of ongoing acute and urgent

	care pressures on organisational capacity to sustain transformation activity. Risks associated with clarity of accountability and delegation to the ISPB were also noted, with assurance provided that these issues were being progressed through existing governance routes. The Committee discussed the importance of ensuring alignment between Place Based Care, Neighbourhood Care Network (NCN) plans, and wider system priorities. LH advised the Committee that NCN plans had been shaped to support Place Based Care objectives and were expected to act as key delivery mechanisms at neighbourhood level. The Committee recognised the programme as a significant opportunity to shift the system towards prevention, improve population health outcomes, and address long-standing health inequalities. The importance of estates utilisation, including health and wellbeing centres and wider community assets, was also acknowledged as a key enabler of success. The Committee **NOTED** the progress made in developing the Place Based Care Programme in Blaenau Gwent and Torfaen.
PPHPC 2702/13	**Health Protection & Vaccination Programme Update** Eryl Powell (EP), Consultant in Public Health, provided the Committee with an update on the Health Board's Health Protection and Vaccination Programme. EP advised the Committee that the programme had focused on strengthening the system's capability to plan for, mitigate, and respond to communicable disease threats, environmental hazards, and other public health incidents. EP highlighted that the service had been established as a key legacy of the COVID-19 pandemic and now encompassed a broad portfolio. The Committee was advised that sustainable structures had been developed across the Health Board, supported by recurrent Welsh Government funding, and now brought together teams from the Gwent Public Health Team, Vaccination Services, and local authority public protection colleagues. This system-wide approach had strengthened recognition of health protection as a core Public Health function across Gwent.

	The Committee noted examples of recent operational activity, including the management of TB cases, blood-borne virus prevention work, sexual health initiatives, and the delivery of the seasonal vaccination campaigns. EP advised the Committee that the programme had placed significant emphasis on prevention and proactive Public Health measures, with particular attention to vaccine access and equity. The Committee was advised that the service had responded to several local incidents, including TB and scabies in care settings, and a Hepatitis A case requiring rapid vaccination of staff and children. EP advised that Public Health Wales had commended the speed and effectiveness of this response. EP advised the Committee that immunisation governance had been strengthened through the Vaccine Operational Group and the Strategic Immunisation Group. The Committee noted that the Cwmbran Vaccination Centre, opened in April, had enabled the delivery of a wide range of vaccinations in a single accessible location. EP advised the Committee that the Health Protection Service had participated in the recent Wales-wide pandemic simulation exercise. As a result, the pandemic plan and Public Health incident plan would be updated and exercised regularly. The Committee was advised that the service had received a Health Protection Hero Award at the UK Public Health Register Awards. In addition, the service had received positive feedback during its biannual review with Welsh Government. The Committee expressed their appreciation for the breadth and maturity of work undertaken. They noted particularly the strengthened vaccination performance and the improvement in staff flu vaccine uptake compared to the previous year. The Committee **NOTED** the update.
PPHPC 2702/14	**Regional Partnership Board Update** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, provided the Committee with an update on the Regional Partnership Board (RPB), advising that its

	purpose was to ensure consistent messaging between the RPB and the Health Board. The Committee was advised that the RPB had held a workshop to review and refine its priorities. As a result, 5 key priority areas had been identified. HE advised the Committee that once the agreed priorities and proposed outcomes were agreed these would be shared with Committee members. **Action: Director of Strategy, Planning and Partnerships.** HE advised the Committee that further work had been commissioned to review the structures that sat beneath the RPB, ensuring they were aligned with the revised priorities and able to support delivery. A workshop to progress this work had been scheduled. The task and finish Group had been established to examine the Section 33 agreements governing the regional frailty model, with particular focus on the financial and legal framework. A report on the work completed to date had been submitted to the RPB, along with the current position of the Health Board. HE advised the Committee that this work remained ongoing. The Committee was advised that the Health Board had provided the RPB with an update on the winter sprint activity and the accompanying impact assessment. This work would continue to be monitored through RPB mechanisms. The Committee **NOTED** the Regional Partnership Board update.
PPHPC 2702/15	**Public Services Board Update** Eryl Powell (EP), Consultant in Public Health, provided the update on Public Services Board (PSB), outlining a summary of the most recent PSB meeting, which had taken place on 11th December 2025. The Committee noted that the PSB had discussed its ongoing collaboration priorities and areas for joint working. EP advised the Committee that the PSB had expressed its intention to strengthen collaboration with the Regional

	Partnership Board (RPB)**.** The PSB had recognised the potential benefits of closer alignment, particularly in relation to areas where priorities overlapped. As a result, the PSB had agreed to explore opportunities for deeper joint working, including options for shared priority setting and consideration of shared structures where this would add value. The Committee noted that the PSB had also reflected on the wider strategic landscape, acknowledging the need to clarify its role and contribution within the broader system of partnerships operating across Gwent. To support this, the PSB had agreed to hold further discussions to define its future focus. The Committee **NOTED** the Public Services Board update.
PPHPC 2702/16	**Regional Planning Update** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, provided the Committee with an update on Regional Planning. The purpose of the report had been to provide the Committee with an overview of progress across a range of regional and South Wales planning programmes. The Committee was advised that Aneurin Bevan UHB, Cardiff and Vale UHB, and Cwm Taf Morgannwg UHB had remained committed to working collaboratively on major regional programmes to improve clinical service delivery, access, and sustainability across South East Wales. HE highlighted the Committee that the expectations from Welsh Government and the Regional Joint Committee (RJC) remained high, with the Planning Framework for 2026/27 setting out clear commitments around regional working. Regional planning teams, supported by corporate and clinical colleagues, were continuing to progress work aimed at addressing strategic challenges and strengthening regional clinical models. The Committee was advised that the phase one Full Business Case (FBC) for diagnostic services and the Outline Business Case (OBC) for the orthopaedic development had been submitted to Welsh Government and had recently been considered at the Infrastructure Investment Board (IIB). HE noted that the IIB had

	provided a detailed feedback matrix, and work had commenced across the region to address the points raised. HE advised the Committee that although revenue affordability remained a significant challenge for all 3 Health Boards, the IIB had acknowledged that the region collectively needed to resolve the resource gap given the substantial pressures in orthopaedic capacity. Work was underway to scope workforce models and operating arrangements for the new regional elective orthopaedic service. Clinical teams from across the region had been meeting regularly to agree potential options, including shared consultant capacity and job planning. The Committee was advised that the RJC had now met once and was expected to approve a regional work programme at an upcoming meeting in February. HE noted that work had been undertaken to define a supporting structure intended to ensure stronger collective oversight and alignment. The Committee **NOTED** the update and the progress being made across the regional planning portfolio.
PPHPC 2702/17	**Digital Strategy** John Frankish (JF), Interim Assistant Director Strategy, Planning & Design, provided the Committee with an update on the development of the Health Board's Digital Strategy. The Committee was advised that a first draft of the Digital Strategy had been completed in response to the Health Board's long-term organisational strategy, Gwent 35: Better Health, Better Care, Better Lives. The Digital Strategy had been designed to set out how digital, data and technology would support delivery of strategic objectives over a 10 year period. JF advised the Committee that the Strategy had been structured to align with national digital priorities and frameworks, including the NHS Wales Digital and Data Strategy, while also reflecting local organisational needs. The Strategy had been framed around the principle of "putting digital to work" for better health, better care and better lives, rather than digital being an end in itself. The Committee was advised that the Strategy articulated a clear digital vision and scope, setting out how digital

	capabilities would support patient care, workforce effectiveness, population health, service integration and organisational sustainability. The Strategy recognised current challenges, including fragmented digital systems, under-investment, workforce capacity and the need for improved data maturity and governance. 6 digital "missions" had been identified within the Strategy, covering digital health and care, data and analytics, workforce enablement, digital platforms and infrastructure, cyber resilience, and organisational capability and governance. The Committee was advised that each mission was supported by defined goals and enabling plans, intended to translate strategic ambition into deliverable actions over time. The importance of workforce capability and digital inclusion was emphasised. JF advised the Committee that the Strategy recognised the need to develop new digital skills across the organisation, alongside leadership development, governance, service design and user-centred approaches. The Committee discussed the need to grow internal capability rather than relying solely on external partners. The Committee was advised that implementation would be delivered through a phased approach, described as 3 delivery horizons, to balance foundational improvements with longer-term transformational change. The Committee noted that the Strategy acknowledged the risk of focusing solely on infrastructure and committed to demonstrating tangible improvements alongside foundational work. The role of strategic partnerships was outlined, including the proposal to work with external partners to accelerate delivery, build internal capability and reduce risk, while retaining organisational ownership and governance. The Committee noted that any investment would be subject to appropriate business case approval and financial scrutiny. The Committee was advised that a formal consultation on the draft Digital Strategy had commenced and that staff and stakeholders were being invited to provide feedback. The consultation period would inform refinement of the Strategy prior to further consideration at Board briefing and formal Board approval later in the year.

	The Committee welcomed the clarity of alignment with Gwent 35 and the focus on enabling clinical pathways, population health management and workforce effectiveness. The Committee emphasised the importance of ensuring the Strategy translated into measurable improvements and supported wider transformation activity across the system. The Committee **NOTED** the update.
PPHPC 2702/18	**Audit Wales Eye Care Report** The Audit Wales Eye Care report was provided to the Committee for information.
PPHPC 2702/19	**Review of Committee Programme Annual Programme of Business 2025/26** The review of Committee Programme of Business was provided to the Committee for information.
PPHPC 2702/20	**Cybersecurity Audit** The Cybersecurity Audit was provided to the Committee for information.
PPHPC 2702/21	**Items to be Brought to the Attention of the Board and Other Committees** There were no specific items to be identified for escalation to the Board or for referral to other Committees arising from the discussions held during the meeting.
PPHPC 2702/22	**Any Other Urgent Business** Neil Patrick (NP), Independent Member, advised the Committee that he had recently chaired the Gwent Armed Forces meeting and the outcome of the meeting was to strengthen governance arrangements relating to Armed Forces activity within the region and to develop a Terms of Reference (TOR) for the Gwent Armed Forces structure, ensuring clarity of purpose and alignment with broader partnership frameworks. Rani Dash (RD), Director of Corporate Governance, advised the Committee that Sarah Simmonds (SS), Director of Workforce & OD, could bring an update on Armed Forces matters to a future Committee meeting. **Action: Director of Workforce & OD**

	Rani Dash (RD), Director of Corporate Governance, highlighted to the Committee that this maybe Philip Robson (PR), Chair, last meeting and thanked him for his support to the Committee and Board.
PPHPC 2702/23	**Date of the Next Meeting** 7th April 2026

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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

Outstanding	Overdue: In Progress	Not Due	Completed	Transferred to another Committe

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
January 2026	**PPHPC 2702/14**	**Regional Partnership Board Update** Regional Partnership Board priorities and proposed outcome once agreed would be shared with Committee members.	Director of Strategy, Planning and Partnerships	April 2026	**Completed** <u>February update</u> The RPB priorities were shared with Committee members on 18/02/2026

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
January 2026	**PPHPC 2702/22**	**Any Other Urgent Business** An update on Armed Forces matters to a future Committee meeting.	Director of Workforce & OD	April 2026	**Completed** <u>May update</u> This action has been included on the agenda for June's meeting

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 June 2026
CYFARFOD O: **MEETING OF:**	Partnerships, Population Health and Planning Committee (PPHPC)
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Armed Forces Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sarah Simmonds, Executive Director of Workforce & OD
SWYDDOG ADRODD: **REPORTING OFFICER:**	Maisy Provan, Regional Armed Forces Lead

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

Er Gwybodaeth/For Information

This report is to provide an overview of the work being undertaken as part of the Armed Forces Portfolio at Aneurin Bean University Health Board.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This briefing paper provides a comprehensive update on the Armed Forces Portfolio led by Maisy Provan (Regional Armed Forces Lead), highlighting ongoing developments, strategic priorities, and achievements to support the Armed Forces community (both patients and staff).

The portfolio aligns with Aneurin Bevan University Health Board's Equality, Diversity, and Inclusion objectives, statutory obligations under the Armed Forces Covenant, Covenant Duty and Welsh Health Circular (2023) and commitment to being a Forces Friendly organisation.

The Committee is asked to: (As seen in the recommendation section)

1. Acknowledge the broad scope and progress of the Armed Forces Portfolio.
2. Endorse continued cross-departmental collaboration to maintain and expand our Forces Friendly approach.
3. Support sustained staff training and Armed Forces Staff Network development.

4. Recognise the significance of the Poppy Programme and the work of Patient Advice and Liaison Service (PALS) and frontline staff in delivering inclusive, compassionate care.

Cefndir / Background

The Armed Forces Covenant (2011) - The Armed Forces Covenant is a promise from the nation that those who serve or have served in the Armed Forces, and their families, are treated fairly. (This became legislation as part of the Armed Forces Act 2021.)

The Armed Forces Covenant Duty (2022) - The new Covenant Duty means that Local Authorities, NHS Trusts and other local bodies across the UK will have to consciously consider the principles of the Armed Forces Covenant when delivering key healthcare, housing and education services.

Who is included within the Armed Forces Community? Regular serving personnel (Royal Navy, RAF & Army), reservists, veterans and spouses/partners of those listed and their dependants.

Strategic Vision

The Armed Forces Portfolio at Aneurin Bevan University Health Board seeks to ensure that no member of the Armed Forces Community faces disadvantages in accessing healthcare and employment. Our vision is built on the following pillars:

- Integration of the Armed Forces Covenant into policy and practice.
- Equitable, personalised care for veterans, service leavers, reservists, and Armed Forces families.
- Promotion of Armed Forces awareness and cultural competence among staff.
- Strengthening community and cross-sector partnerships.

As an NHS provider the Health Board have a legal obligation to uphold our Armed Forces Covenant Duty and as an organisation, we need to ensure members of our Armed Forces Community do not face disadvantage when accessing healthcare of employment through our Health Board.

Asesiad / Assessment

Key Achievements and Areas of Impact

A. Accreditations and Recognitions

- Veteran Aware accreditation through the Veterans Covenant Healthcare Alliance (VCHA), achieved in June 2025.
- Awarded the Gold Employer Recognition Scheme (ERS) Award by the Ministry of Defence.
- Signatory of the Pride in Veterans Standard, promoting inclusion for LGBTQ+ veterans and service members.
- Commitment to Forces Friendly Employer status, including pledging to Step into Health, supporting career transition for service leavers and veterans.

B. Workforce and Staff Support

Launched and continue to develop the Aneurin Bevan University Health Board Armed Forces Staff Network, a dedicated space for reservists, veterans, and Armed Forces family members to connect, advocate, and contribute.

- A staff contact list has been developed to track and record all our Armed Forces staff members.
- Coffee mornings have been set up to allow staff members to come together in a safe space.
- Armed Forces Staff Pin Badges were designed and created to allow members of the network to easily identify each other in the Health Board.

Developed internal guidance to support staff who are members of the Armed Forces Community;

- A Reservist toolkit was created to sit alongside the All-Wales Reserve Forces Mobilisation Policy.
- Work has been undertaken to update the All-Wales Policy to reflect the changing use of the reserves and lengths of deployment, following the Strategic Defence Review 2025, this has been approved through NHS Employers and re-distributed across all Health Boards in Wales.
- A Line Manger's Guide for supporting Armed Forces Staff has also been created to provide additional support to both staff and their manager's.

Delivering Armed Forces Awareness Training across the Health Board, including a more in-depth session to all PALS staff, who assist with onward referrals to military third sector organisations.

- Offer of additional Continued Personal Development (CPD) Armed Forces Champions training.

Armed Forces engagement has incorporated into roadshows delivered across the main Health Board sites with Equality, Diversity and Inclusion and Welsh Language Teams, and in partnership with Occupational Health.

C. Armed Forces Identification and Patient Care – The Poppy Programme

The Poppy Programme Health Initiative has been implemented across Aneurin Bevan University Health Board to enhance the identification and support of patients from the Armed Forces Community:

- All patients are now asked: "Have you ever served in the British Armed Forces?"
- Responses are recorded in the Key Notes section of the Welsh PAS system.

The Health Board have requested for a digital change to be made to Clinical Workstation (CWS) and Symphony.

Identified patients are:

- Provided with an information leaflet outlining available support.
- Offered a poppy magnet to display at their bedside.

- Flagged to the PALS Team if additional support is required.

All PALS staff have received tailored training from Maisy Provan to ensure sensitive and effective support.

A specific Armed Forces Volunteer role has been approved through staff side and training sessions have been carried out with volunteers, who have been identified as part of the Armed Forces Community. Along with a pre-recorded session for any other volunteers to raise awareness of the Armed Forces Community.

- The Health Board currently have 3 people engaged in the process of becoming Armed Forces Volunteers.
- Work is on-going with Primary Care and managed practices to encourage signing up to the Health Education Improvement Wales (HEIW) Veteran Friendly Accreditation Scheme.
- Ensuring end to end pathways

D. Commemorative and Cultural Events

Aneurin Bevan University Health Board actively participates in and promotes national and local Armed Forces commemorations:

- VE Day.
- Armed Forces Week.
- Remembrance Day and Remembrance Week.

Events are delivered with inclusive participation from staff and public, celebrating the contributions of the Armed Forces while raising awareness across the Health Board.

E. Community and Multi-Agency Collaboration

Active members of the Gwent Armed Forces Forum, facilitating regional and cross-sector collaboration, alongside the development of relationships with social care partners and the utilisation of patient experience to inform work across the sector.

- The Health Board is leading the way to progress the utility of this forum by being the first in Wales to create a set Terms of Reference (ToR) and Key Performance Indicators (KPIs) ensuring a more structured approach to delivery and improved outcomes.

- Partnerships established with military charities and organisations, including Soldiers, Sailors, Airmen and Families Association (SSAFA), Royal British Legion, and Change Step.

- Ongoing alignment of Armed Forces initiatives with the broader EDI strategy, ensuring all protected characteristics are considered intersectionality.

Capacity to Deliver

The portfolio has one assigned member of staff who is also employed in CAVUHB in the same capacity and therefore represents on a Regional Southeast Wales basis.

Looking Ahead: Key Priorities

- Continue training roll-out to all departments, ensuring full staff engagement with the Poppy Programme.
- Enhance data collection and analysis to evaluate service outcomes and healthcare access for the Armed Forces population.
- Support the Step into Health Programme through HR and Recruitment initiatives.
- Expand Veteran-specific Care Pathways, especially where we are seeing an increasing number of veterans with service-related injuries: Orthopaedics, audiology etc.
- Sustain and grow Aneurin Bevan University Health Board's leadership in national Armed Forces Health and Inclusion Forums.

Risk Assessment

As a Health Board and NHS provider we are obligated under the Armed Forces Covenant Duty to ensure we consciously consider members of the Armed Forces Community when delivering health care and expedite those with service-related injuries under the Welsh Health Circular (2023). If we don't, we are breaching legal obligations and our duty responsibility of due regard.

We hold an ERS Gold status and therefore a failure to support our Armed Forces Staff members could risk this accreditation and result in potential reputational damage.

This is also true for our Veteran Aware VCHA accreditation.

This portfolio has implications on both staff and patient experience.

Argymhelliad / Recommendation

Recommendations

The Committee is asked to:

- Acknowledge the broad scope and progress of the Armed Forces Portfolio.
- Endorse continued cross-departmental collaboration to maintain and expand our Forces Friendly approach.
- Support sustained staff training and Armed Forces Staff Network development.
- Recognise the significance of the Poppy Programme and the work of PALS and frontline staff in delivering inclusive, compassionate care.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 4.2 Patient Information All Health & Care Standards Apply Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the wellbeing and engagement of our staff

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	Continued Personal Development (CPD) Clinical Workstation (CWS) Employer Recognition Scheme (ERS) Health Education Improvement Wales (HEIW) Key Performance Indicators (KPIs) Patient Advice and Liaison Service (PALS) Soldiers, Sailors, Airmen and Families Association (SSAFA) Terms of Reference (TOR) Veterans Covenant Healthcare Alliance (VCHA)
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) **Impact: (must be completed)**

Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Yes, outlined within the paper
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**Yes not yet available** **Armed Forces Representation now sits on the EQIA panels for the EIA.** 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. 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

ABUHB- Armed Forces Healthcare

Mikaela Swindon

Armed Forces & Equality Diversity & Inclusion Manager

ABUHB Board Brief
Context & Commitment

The Health Board remains committed to embedding the Armed Forces Covenant across its patient and staff experience. This update outlines our achievements, current initiatives and next steps to strength support for the Armed Forces Community

- 4.5% of the population in Wales are Veterans,
  - Blaenau Gwent- 3.09%
  - Caerphilly- 4.4%
  - Monmouthshire- 5.4%
  - Newport- 4.0%
  - Torfaen- 4.9%

Source: Office for National Statistics - Census 2021

- Armed Forces Staff: Currently have 121 registered on ESR

ABUHB Achievements to date

- Assigned Executive Champion and IM sponsor
- Signed the Armed Forces Covenant
- Accreditations
  - Employer Recognition Scheme Gold Award - Renewal Achieved
  - Signed up to Pride in Veterans Standards
  - Achieved Veteran Aware Status
- A dedicated member of staff in post to work on the portfolio who covers both ABUHB and CAVUHB

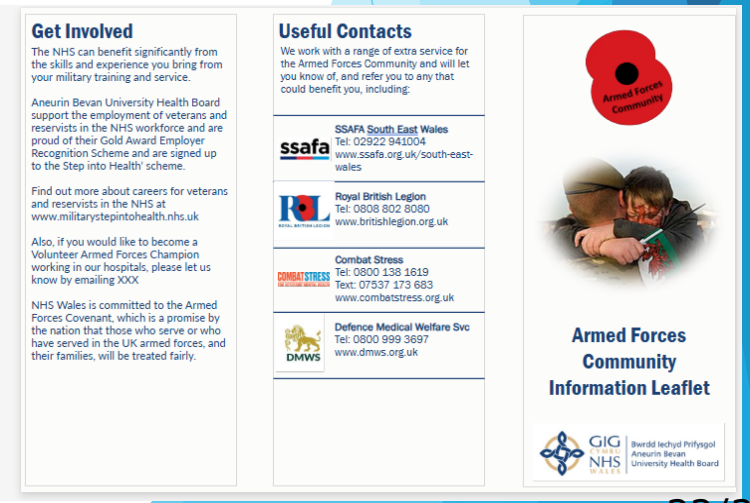
Improving the Armed Forces Community's access to care -Patient Side

- Identification piece
  - Poppy Programme- campaign to ensure patients from the AFC are identified & supported
  - Staff Training
  - Ability to record Veteran status on Welsh PAS and raised with digital to do the same for CWS & Symphony
- Implementing the Armed Forces Covenant & Welsh Health Circular
  - Service-related conditions/injuries
  - Armed Forces Community who have faced disadvantage
- Third sector support

PALS Team to complete onward referrals to military third sector and support groups

Poppy Programme

- Have you ever served in the **British** Armed Forces?
  - Part of the demographics collected- Welsh PAS
  - Poppy magnets on ward whiteboards
  - Patients to be given an Armed Forces Community Information Leaflet
  - Direct to PALS if patient needs further support
    - Email subject 'Armed Forces Community'



Importance of Primary Care

- Taken a proactive role in promoting the HEIW Veteran Friendly Accreditation Scheme

Why?

- End to end pathways
- Knowledge of what exists for these patients
- Role of social prescribing
  - Tackling loneliness & social isolation
  - Community integration
- Ease for referrals
- Having a point of contact

Becoming a Forces Friendly Employer -Staff Side

- Current work;
  - Step into Health
  - Employer Recognition Scheme Gold Award- plans to engage with other Gold Award holders
  - Recruitment of the Armed Forces Community- Estates held a stand at AF Day & the CTP jobs fair
- Armed Forces Staff Network
  - Informal network meetings/ Coffee Mornings
  - Armed Forces Staff Pin Badges
  - Creation of the Line Manager's Guide
- Reservists
  - Reserve Toolkit
  - Review and update of the All Wales Policy- interlinking with interested parties
  - Education sessions for line managers

Collaboration & Engagement

- Engagement with local units
  - Promotion of civilian/military opportunities- Ex Med Stretch, Team days with 203 (W) MMR
- Engagement with third sector
- Presence at events
  - Attendance and representation at cross-party group and Welsh Gov Expert Group
- Celebrating events in the Health Board
  - VE Day
  - Armed Forces Week
  - Remembrance
- Engaging with 160 Bde on a working group around transition

Questions

Further training links can also be found on the intranet

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 June 2026
CYFARFOD O: **MEETING OF:**	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Primary Care Sustainability Board
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lloyd Hambridge, Divisional Director for Primary Care, Community Services, Complex and Long Term Care

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the Committee regarding the progress of the Primary Care Sustainability Board, including setting out the current position of Independent Contractors across ABUHB, the challenges across Primary Care and the progress of the Primary and Community Care Academy as a key delivery vehicle for a sustainable workforce. This report will be adapted as required for onward submission to the Partnerships, Population Health and Planning Committee on 30 June 2026.

Cefndir / Background

Primary Care services continue to operate in a highly challenging environment, responding to rising levels of demand. At a population level, sustained growth and demographic change are key drivers of demand. The population is ageing, with older individuals typically requiring more frequent and complex health interventions. Alongside this, there has been a continued increase in the prevalence of long-term conditions such as diabetes, cardiovascular disease and respiratory illness, all of which require ongoing management and coordination within Primary Care. Increasing levels of multi-morbidity and frailty mean that individuals are presenting with more complex needs, often requiring longer consultations, more intensive care planning and input from multi-disciplinary teams (MDT). These pressures are further exacerbated by delays in Secondary Care pathways, resulting in patients remaining under the management of Primary Care services for longer periods and increasing the overall clinical workload.

Workforce constraints remain one of the most significant challenges to system sustainability. Recruitment and retention difficulties, compounded by burnout, workload pressures and early retirement, are reducing available capacity across all Primary Care settings. At the same time, financial constraints continue to limit the ability of independent contractors to expand services, invest in infrastructure or increase staffing levels. Broader economic pressures, including inflation and rising operational costs, are increasing the financial burden on providers, further challenging the sustainability of some contractor arrangements.

Primary Care Contracted Services – General Medical Services (GMS)

Sustained pressure and systemic challenges have persisted across GMS during 2025/26, as highlighted in the Senedd inquiry into *The Future of General Practice*.

The Health Board has directly managed 5 practices throughout 25/26 as a result of GMS contract resignations, one of which has successfully returned to independent contractor status. Due to further resignations, the Health Board is directly managing a further 3 GMS practices under hosting arrangements from the start of April 2026 (*table 1*), whilst a procurement process in undertaken. There has also been one practice merger and one branch surgery closure during 25/26 (*Appendix A*).

Table 1. Health Board Managed and Hosted Practices

Practice	Position	Effective date
Blaenavon Medical Practice	Divisional Directly Supported Practice	01/03/25
Brynmawr Medical Practice	Divisional Directly Supported Practice	01/03/25
Bryntirion Surgery	Divisional Directly Supported Practice	01/04/25
Tredegar Medical Practice	Divisional Directly Supported Practice	01/04/25
Aberbeeg Medical Practice	Full GMS contract award	01/01/26
Pontypool Medical Centre	Divisional Hosted Practice	01/04/26
Meddygfa Gelligaer Surgery	Divisional Hosted Practice	01/04/26
Lliswerry Medical Centre	Divisional Hosted Practice	01/04/26

Primary Care Contracted Services – General Dental Services

Welsh Government (WG) has introduced significant reform to NHS General Dental Services (GDS), following public consultation in Spring/Summer 2025. The resulting 2026 NHS GDS Regulations, implemented from 1 April 2026, replace previous activity-based models (UDAs/Contract Reform) with a segmented contract approach, linking delivery to agreed proportions of contract value.

These changes are intended to:

- Create a more equitable remuneration model;
- Strengthen prevention and align care with clinical need; and
- Enable greater flexibility for Health Boards to respond to local population needs.

However, transition to the new model has presented challenges, including:

- A reduction in GDS contracts locally;
- Increased workload and complexity for Primary Care Contracting Team (PCCT), including contract variations, terminations, and patient allocation; and
- Limited data visibility and system unpredictability, making financial and performance forecasting difficult during 2026/27.

To maintain access, the Health Board remains proactive and adaptive, with a focus on sustaining NHS dental provision across the population. Following 13 GDS contract terminations, 4 GDS variations and 2 PDS Emergency Dental Service terminations to date, between September 2025 and April 2026 (*table 2*), the Health Board plans to:

- Undertake a procurement process in early Autumn 2026;
- Seek to fully reinvest £5.4m of available funding into NHS dental services; and
- Consider alternative delivery models if full reinvestment cannot be achieved.

Delivery timelines for procurement are constrained by concurrent GMS procurement activity and capacity limitations within procurement and PCCT teams. Members are referred to the additional paper GDS – Contract Reform Updated Position for further detail.

Table 2. NHS GDS contract termination/variation configuration

Contract Change	Contract Type	Blaenau Gwent	Caerphilly	Newport	Monmouthshire	Torfaen	Totals
Terminations	GDS	0	2	5	1	5	13
	PDS	0	1	1	0	0	2
Variations	GDS	0	1	1	2	0	4
	PDS	0	0	0	0	0	0
							19

Primary Care Contracted Services – Community Pharmacy

Ongoing implementation of the Electronic Prescribing Service across the Health Board, with 95% of Community Pharmacies now live.

Limited changes to service experienced across Community Pharmacy, whereby 10 pharmacies reduced their opening hours, 2 changed their opening times with no reduction in hours and 3 pharmacies increased their opening hours.

During 2025/26, two pharmacies of the same provider, were notified of the Health Boards intention to remove them from the pharmaceutical list as a result of continued unauthorised closure and associated contractual breaches. A total of 235 breach notices were issued across these two pharmacies (236 in total for the whole of ABUHB in 25/26).

The provider of both pharmacies went into administration and they subsequently changed ownership, voiding the intention to remove notices. Both pharmacies have re-opened under new ownership and resumed delivery of services.

Community pharmacies participated in the Winter Incentive Scheme October 2025-March 2026, comprising of Participation in Common Ailment Service (CAS) Patient Reported Experience Measures- feasibility study, Participation in Help us Help You CAS Winter Campaign and the CAS Management of UTI and Sore Throat.

Primary Care Contracted Services – Wales General Ophthalmic Services (WGOS)

Continued development and implementation of WGOS pathways during 25/26, supporting the delivery of eye care services in the community, with the aim being to reduce demand on Hospital Eye Services. Increased demand and activity across all pathways (WGOS 1-5) during the year.

WGOS 4, the pathway for medical retina, glaucoma and hydroxychloroquine, continues to evolve. Across the Health Board, consideration remains ongoing regarding the safe and sustainable implementation of WGOS 4 Glaucoma Monitoring once national digital platforms are rolled out in 2026. This includes the Electronic Patient Record (EPR) and the Electronic Referral System which are essential to ensure the safe and effective management of this cohort of patients. Responsibility for their care will remain with Secondary Care until the EPR is implemented. During 2025/26, WGOS 4 prevented a total 2,249 referrals being made into Secondary Care.

The ABUHB Eye Health Needs Assessment published in April 2025, together with ongoing service monitoring and the introduction of a structured practice-visit programme, is helping to further embed WGOS delivery and guide future service development.

Alongside the expansion of the WGOS services, the Health Board will undertake a comprehensive review of all ophthalmic pathways, ensuring alignment with the Community by Design (CbD) programme/Placed Based Care (PBC). Focusing on prevention, accessibility, and community-centred models of care, the Health Board will strengthen local provision while ensuring pathways remain safe, efficient, and sustainable. This combined emphasis on service expansion, pathway redesign, quality assurance, and collaborative working with key stakeholders ensures WGOS remains effective, responsive, and equitable for the population of Gwent.

Primary Care Contracted Services - Funding

Primary Care contractors across continue to face significant financial and contractual pressures, with rising operational costs outpacing funding growth. While the WGs 2025/26 funding settlements introduce targeted uplifts, these are largely positioned as **stabilisation measures** rather than transformational investment, and do not fully offset sustained cost inflation or historical underinvestment.

These increases fall short of fully addressing the cumulative impact of rising operational costs and demand growth. As a result, financial and contractual pressures continue to constrain provider sustainability, limit investment in service transformation, and pose risks to access and equity within Primary Care.

GMS:

- The 2025/26 GMS contract includes £41.9m additional investment, including a 4% pay uplift and 1.77% expenses uplift.
- A further 5.8% recurrent uplift is committed from 2026/27, providing some medium-term certainty.
- £20m recurrent funding is explicitly framed as stabilisation funding to address

immediate pressures (£10m Workforce Fund - additionality, replaces Additional Capacity funding and £10m Change fund – support the DCS work).

This was welcomed by the profession as acknowledges cost pressures and improves short-term stability, however, uplifts remain below the cumulative impact of inflation and workload growth, limiting practices' ability to invest in workforce expansion, estates, and transformation. Many practices are considering the viability of ongoing delivery of optional supplementary services.

Community Pharmacy:

- The Community Pharmacy Contractual Framework (CPCF) 2025/26 delivers a 4% funding uplift.

The uplift provides short-term mitigation, but does not resolve structural issues including margin pressure, dispensing cost volatility, and workforce constraints in the context of sustained increased demand and workload. There remains significant financial strain with many providers highlighting cash flow challenges as a consequence of payment mechanisms.

WGOS:

- Contract envelope uplift of approximately £3m (% varies across pathways)

GDS:

- The 2025/26 settlement includes a 4% uplift to NHS dental contract values
- Sits alongside major contract reform, with the new regulations from April 2026.

While the uplift provides some financial support, systemic reform introduces uncertainty and transition risk, and overall funding levels continue to be cited as insufficient to ensure sustainability and NHS commitment.

Across all contracting areas, real-terms funding growth remains limited, given inflationary and workforce cost pressures. Consequently, from a contractual perspective, contractual uplifts continue to be modest and are consistent with WG settlements. Expectations continue to focus on improving access, standardisation of service delivery, and increased collaboration through Neighbourhood Care Network (NCN) models.

Primary Care Sustainability Board

Since its re-establishment in 2023, the Primary Care Sustainability Programme has demonstrated significant progress in both scope and maturity, evolving from an initial programme of work into a more embedded and system-wide approach to sustainability. Strategically, the Sustainability programme is fully aligned to WGs CbD framework, which promotes the principle that care should be delivered as close to home as possible, with strong emphasis on prevention, integration and MDT-based delivery. Locally, the programme is also closely aligned with the Health Board's PBC programme, ensuring that delivery is coordinated at neighbourhood level and supports integrated service models.

This direction is further reinforced by national policy commitments, including those set out within the new Programme for Government, which include a clear ambition to rebalance resource toward primary and community care. Specifically, increasing Health Boards budgets allocated to Primary Care by 0.5% annually from 2027/28 and commissioning research into reforming the GP funding formula. This policy context supports the need to strengthen Primary Care capacity and ensures that resources are aligned with demand across the system.

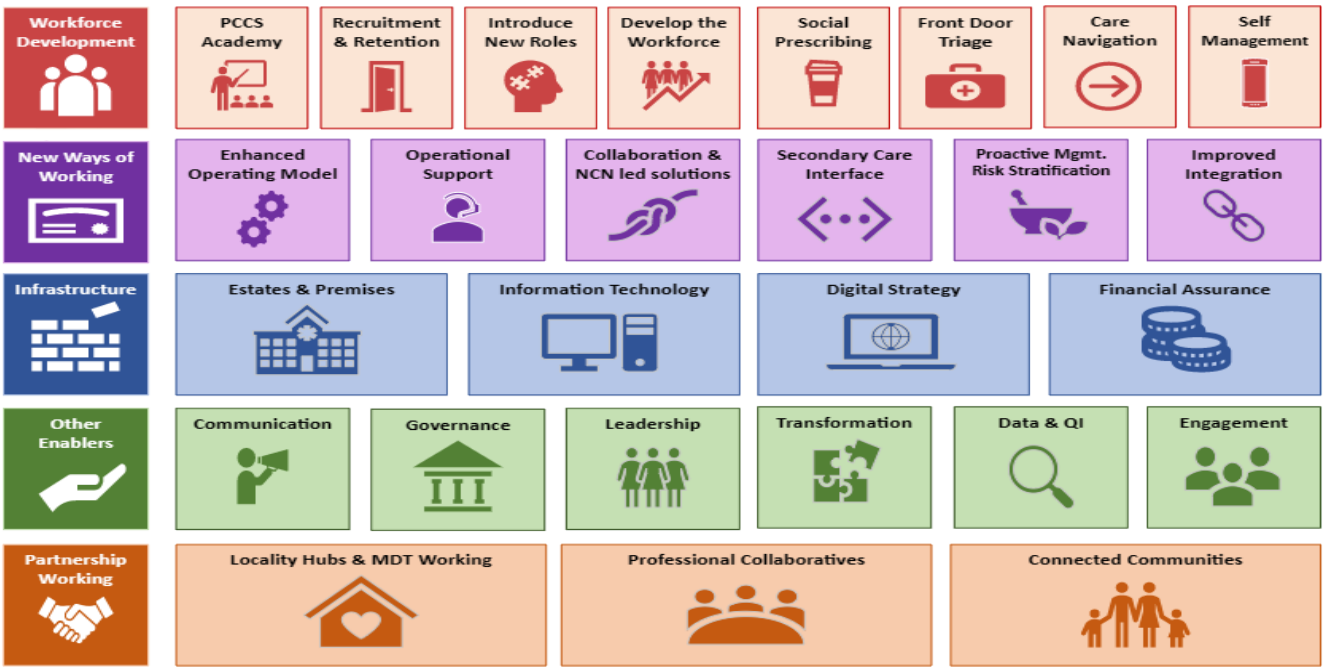
In addition, projects within the delivery programme aligned to the ambitions and commitments set out within the Gwent 35: 10 Year Strategy for ABUHB. The strategy

outlines a clear vision that by 2035 all residents will have the opportunity to live longer, healthier lives, underpinned by three core aims: Better Health, Better Care, and Better Lives (*figure 1*). The programme directly supports these aims by strengthening the resilience and capacity of primary and community care services, enabling a proactive shift towards prevention, early intervention, and care delivered closer to home. This includes enhancing MDT models, improving timely access, and reducing reliance on acute services, thereby delivering more person-centred care within communities. In doing so, the programme contributes to tackling health inequalities, improving population health outcomes, and supporting partnership-based delivery consistent with the strategy's emphasis on co-production and community engagement. Furthermore, by embedding sustainable workforce models and integrated NCN-based working, the plan reflects the Gwent 35 commitment to transforming the system to meet growing demand and demographic change, ensuring long-term service sustainability and a whole-system approach to improving health and wellbeing across Gwent

Figure 1. Strategic Aims of Gwent 35

At its outset, the Programme Board established a clear governance framework, endorsed by the Partnerships, Population Health and Planning Committee, with defined strategic functions and a structured programme of delivery focused on key priority areas including access, workforce, service transformation and enabling infrastructure (*figure 2*). This provided a robust foundation for coordinated action across Primary Care services and a mechanism for ongoing assurance through regular reporting and oversight.

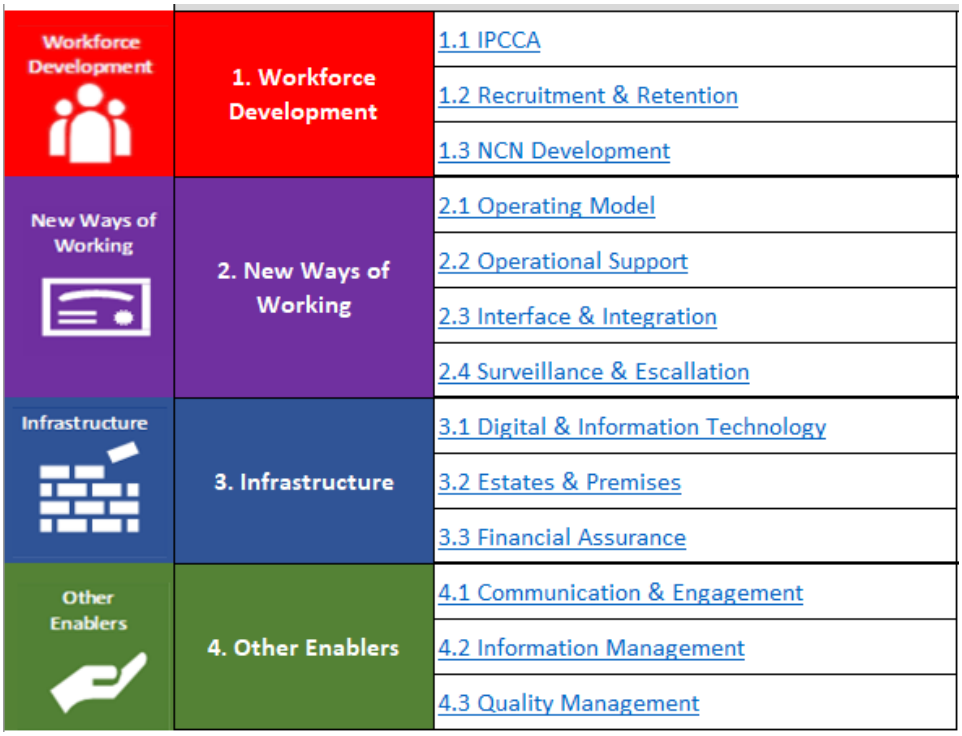
Figure 2. Original Hierarchical Priorities of the Sustainability Programme Board



Over the past two years, the programme has delivered a broad range of initiatives aligned to these priorities via 4 key workstreams (*figure 3*), supported by strengthened governance through the Programme Board and operational Steering Group. This has included enhanced oversight of contractor sustainability, improved horizon scanning

through the sustainability framework, and the development of system-level responses to risks identified through NCNs and contractor monitoring. The Programme has also played a central role in progressing key strategic developments, including the establishment of the Primary and Community Care Academy (PCCA), the expansion of MDT models, and the implementation of system enablers such as Single Point of Access.

Figure 3. Sustainability Programme Board workstreams 24/26



Audit Wales Review

The Committee should also note the findings of the recent Audit Wales (May 2026) review relating to the multi-GMS contract award procurement exercise. Whilst the proposed delivery model across multiple contracts did not progress as anticipated within ABUHB, the report recognised our organisation's intent to explore potentially transformational opportunities via alternative and innovative approaches to GMS delivery and confirmed that appropriate governance and procurement processes were followed. The work has provided important learning, which informs future commissioning approaches and reinforces the importance of robust governance frameworks when developing new service models.

In addition to the Audit Wales review, the Health Board has undertaken its own robust internal reflections to ensure lessons are fully understood and embedded within strengthened policies and processes, providing greater resilience and oversight in future arrangements.

A comprehensive Standard Operating Procedure (SOP) which outlines the procedural steps for contract letting of both vacant and Health Board managed practices, with clear roles and responsibilities identified has been developed to enhance and strengthen the Health Boards processes in relation to GMS Vacant Practice process and the awarding of GMS contracts. Encompassing lessons learnt, the SOP satisfies the recommendations from the Internal Audit report relating to Health Board Managed Practices, the Internal Audit Advisory Report and the Wales Audit Report, GMS Contract Challenges. The SOP and associated documentation also reflect the changes in Procurement Regulations.

The SOP contains;

- Updated existing Vacant Practice Policy reflecting 2025 procurement regulations;

- Operational processes aligned to procurement changes;
- Communications and Engagement plan;
- Scoring matrix;
- Enhanced Monitoring Framework with clear KPI's and triggers for escalation/de-escalation; and
- Strengthened financial due diligence check list including 3-year financial forecasts, back ground checks for all and stipulation regarding record retention.

Audit Wales also highlighted that the Welsh Government existing GMS guidance and contractual frameworks should be considered for review, as they date back to 2006. The Health Board supports this position and has already contributed to the review of Welsh Health Circular (2006) 063 through national primary care peer networks, drawing on its operational experience and learning.

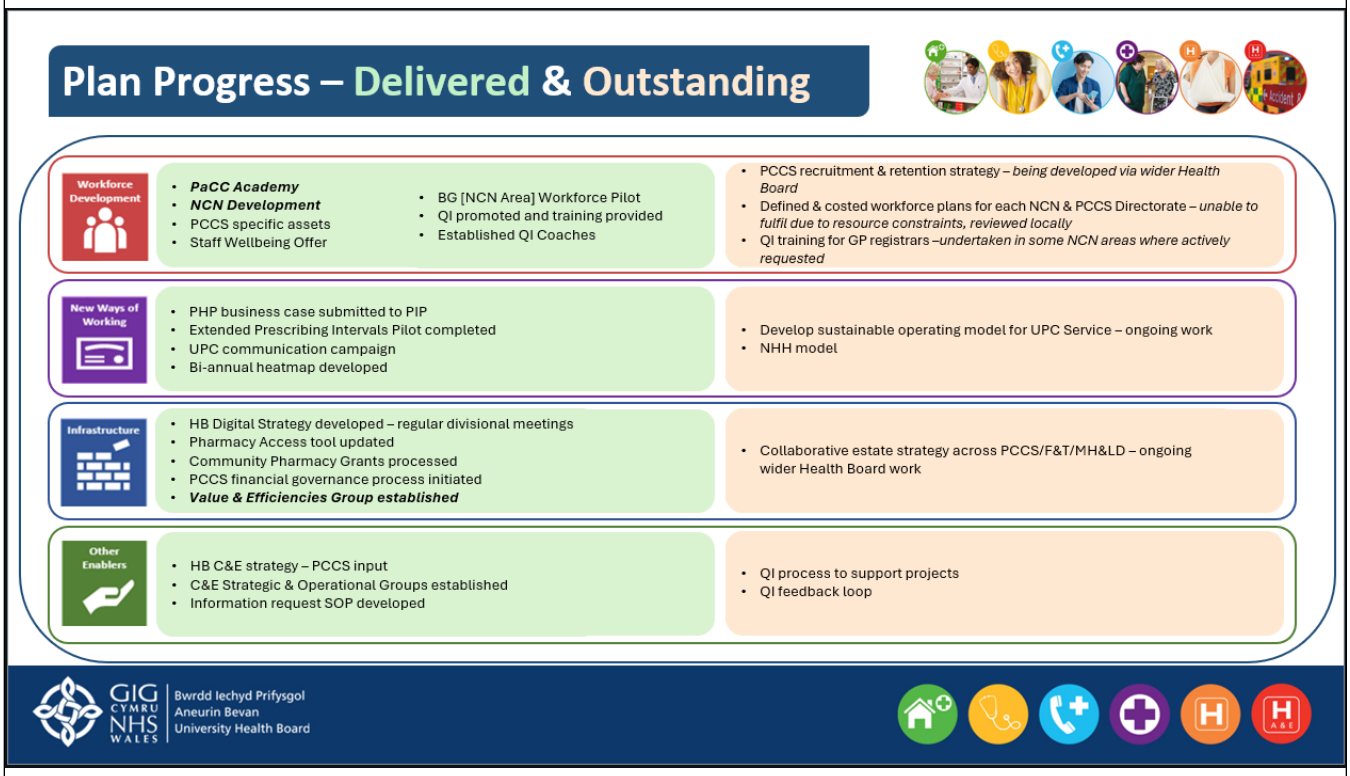
Asesiad / Assessment

Primary Care Sustainability Programme Board

The Primary Care Sustainability Programme Board continues to provide strategic leadership and oversight for Primary Care sustainability across the Division, maintaining a clear focus on identifying, monitoring and mitigating key risks while coordinating delivery across the core domains of access, workforce, service transformation and enabling infrastructure. During 2025/26, the Board has overseen continued and measurable progress against the Sustainability Plan. This includes strengthened contractor monitoring and support arrangements, enabling more proactive identification and management of risks to service continuity, alongside the continued development of NCNs and the embedding of MDT models (*Appendix B*). System enablers such as Single Point of Access and alternatives to admission pathways have progressed, complemented by ongoing work to strengthen workforce planning, recruitment and retention initiatives.

Through 2025/26, a review of the programme deliverables was undertaken as broadly, the main aspects of the original plan had been embedded and to ensure alignment with current priorities for both the Division and the Health Board. *Figure 4* reflects high level progress through 2025/26.

Figure 4. Sustainability Plan Progress 2025/26



As identified above, the majority of actions and projects identified within the Primary Care Sustainability Plan have now been delivered or substantially progressed, reflecting the maturity and integration of the programme over time. Remaining actions are being advanced either through wider Health Board programmes, incorporated into ongoing operational delivery, or aligned to broader strategic initiatives, ensuring that sustainability priorities continue to be taken forward within appropriate governance structures.

The delivery of Psychological Health Practitioners (PHPs) across NCNs has demonstrated an effective, evidence-based approach to addressing low-level and underlying mental health conditions within primary and community settings. By providing early intervention, preventative support, and improved access to psychological care, the model has contributed to enhanced patient outcomes and reduced escalation into more acute

services. Building on this emerging evidence and operational learning, a formal paper outlining the impact, benefits, and future investment case has been developed and submitted through the Pre-Investment Panel (PIP) and will be progressed as part of the phased multidisciplinary workforce implementation under the PBC programme.

A pilot programme to extend prescribing intervals has been successfully implemented through collaborative working between GP surgeries and community pharmacists, demonstrating a positive impact on both patient care and system efficiency. The initiative has supported improved continuity of care, reduced avoidable prescribing workload within Primary Care, and enhanced patient convenience through fewer prescription requests and collections. Early findings indicate increased alignment between clinical and pharmacy teams, improved medicines optimisation, and a reduction in administrative burden, providing a strong foundation for consideration of wider rollout.

Maintaining the pharmacy theme, the Sustainability Programme has delivered further system improvement through enhancement of the Pharmacy Access Tool, enabling users to readily identify services available within their locality and surrounding areas when seeking pharmacy support. This has improved accessibility, visibility, and utilisation of Community Pharmacy services. In parallel, to strengthen the resilience and capability of the independent Community Pharmacy sector, the programme has also administered the Welsh Government Improvement Grants process, supporting pharmacies to upgrade their premises and infrastructure. This investment has enabled improvements in the quality and range of services delivered, ultimately enhancing patient care and supporting the ongoing sustainability of community pharmacy provision.

The programme has established both strategic and operational communication and engagement groups to strengthen awareness and understanding of services across and beyond the immediate service area. These groups provide structured mechanisms to share key developments, promote service visibility, and ensure consistent messaging to stakeholders. In addition, they create valuable opportunities to capture and reflect public and stakeholder feedback, enabling this insight to directly inform service design, delivery, and future planning, thereby supporting a more responsive and person-centred approach.

The Primary and Community Care Academy (PCCA)

As the focal area of the Workforce Development workstream, the PCCA has delivered a comprehensive, multi-professional education and training programme aligned to divisional priorities and Health Education and Improvement Wales (HEIW) strategic objectives. Activity has been structured across six key themes: developing the Academy, supporting new starters, developing new roles, professional development, multi-professional learning, and future workforce planning, summarised below:

Strengthening Infrastructure and Access

- Implementation of digital platforms (Padlet, Pulse site, Medtribe) has improved visibility, access, and administration of training, with over 900 registered users.
- Introduction of standardised processes and a formal Quality Assurance framework has enhanced consistency and governance.

Supporting Workforce Entry and Early Development

- General Practice Nurse (GPN) programme continues to demonstrate strong retention (28 of 32 nurses retained in Primary Care).
- Journey of Excellence programme improved participant confidence significantly (6% to 54% "very confident").
- Delivery of induction and development programmes for Health Care Support Workers (HCSW), Internationally Educated Nurses (100% confidence post-programme), and foundation Pharmacists.
- £115k investment in Advanced Practice training with clear improvements in confidence, capability, and job satisfaction.

Developing New Roles and Skill Mix

- Pharmacy Technician programme supporting role integration in Primary Care,

improving patient safety and releasing Pharmacist capacity.
- Continued development of rotational Pharmacist training model across Community Pharmacy and General Practice.

Delivering Continuous Professional Development (CPD)
- 259 staff completed clinical skills training across core competencies.
- Expanded multidisciplinary CPD offer including Learn@Lunch webinars (up to 107 attendees) and targeted programmes (e.g. women's health, psychological therapies).
- Strengthened care home engagement, with 81 staff trained and a coordinated programme established across ~100 care homes.
- Delivery of non-clinical and operational training to support practice sustainability.

Multi-professional Learning and Engagement
- Successful delivery of Protected Learning Time (PLT) events on key clinical themes, with high engagement (800+ attendees per event).
- Strong cross-disciplinary participation supporting whole-system learning.

Future Workforce Development
- Expansion of undergraduate nursing placements to 9 GP practices.
- Ongoing engagement with schools and universities to promote careers in Primary and Community Care.

The key delivery priorities for the PCCA for the 26/27 financial year, reflecting organisational objectives, workforce needs, and system transformation priorities are:
- Introduce Falls training and recruit a dedicated Falls Lead;
- Sustain and expand GPN and Journey of Excellence programmes;
- Continue pharmacy workforce development, subject to funding;
- Prioritise Advanced Practice training within reduced HEIW funding envelope;
- Expand CPD and PLT programmes (including dental engagement);
- Strengthen training provision for care homes and operational staff;
- Progress leadership development (Practice Managers and Partners);
- Develop digital learning systems and align QA processes; and
- Support strategic priorities including PBC and CbD.

Under the Sustainability umbrella and workforce development, the PCCA continues to deliver a high-impact, scalable education and training offer, aligned to workforce and service priorities. Sustained success will depend on effective prioritisation, continued system alignment, and securing sustainable funding to meet growing demand.

Wider Sustainability Support Initiatives

A range of complementary programmes continues to underpin delivery and support the long-term sustainability of Primary Care. The *Values and Efficiencies Programme* promotes financial discipline and prioritisation, while targeted investment through the *Strategic Programme for Primary Care* (SPPC) has strengthened service improvement capacity, NCN development, and delivery of the All-Wales Diabetes Prevention Programme (AWDPP), albeit within the constraints of time-limited funding. The *Regional Integration Fund* (RIF) has further enabled the development of integrated, place-based models of care, including Integrated Wellbeing Networks (IWNs) and multidisciplinary approaches. Ongoing investment in NCNs is supporting local workforce solutions, innovation, and system resilience, collectively providing a coordinated framework for both immediate delivery and longer-term transformation.

Significant progress has been achieved across 2025/26, particularly through the NCN and Obesity (AWDPP) programmes, which have advanced integrated, preventative models aligned to neighbourhood and place-based working. MDT approaches are now established across most GP practices, with strengthened partnership working and expanded population health initiatives, including social prescribing and community-based wellbeing support. Approximately 3,000 patients have been reviewed through MDT forums over the

past year, supporting improved identification and management of complex and high-risk populations. In parallel, the AWDPP has demonstrated strong performance in patient engagement and clinical outcomes, contributing to reduced progression to diabetes and evidencing the impact of early intervention and prevention.

Collectively, these programmes have improved access, increased system capacity, and contributed to a shift toward prevention and community-based care, with emerging reductions in secondary care demand. However, sustainability remains a key risk due to reliance on short-term funding. Continued investment is required to maintain critical workforce, infrastructure, and partnership arrangements, particularly within the NCN and Obesity programmes. Without transition to recurrent funding, there is a significant risk that the progress achieved in system integration, prevention, and service transformation will not be sustained.

Workforce Optimisation and Service Planning

A small number of actions from the sustainability plan, specifically the development of fully costed workforce plans, have not been completed in full due to the current resource landscape and competing organisational priorities. However, the implementation of the Primary Care Workforce Intelligence System (PCWIS) provides a significant mitigating development. This system is expected to enhance workforce visibility, planning capability and modelling at scale, thereby addressing many of the original objectives of the workforce planning actions through a more sustainable and data-driven approach.

Further to the availability of national workforce intelligence tool, PCWIS, which provide valuable system-wide data and modelling capability, the Primary Care Division has undertaken an extensive and complementary local workforce modelling exercise to better understand service capacity and workforce pressures at practice level. This approach incorporates an assessment of minimum nursing and HCSW requirements (non-extended scope), based on a blended workforce model for GMS delivery, aligned to an assumed ratio of 1 clinical hour per 100 patients. The model also applies an equivalence assumption whereby one NERs is estimated at 0.65 of a GP, with consideration given to establishing a comparable ratio between Registered Nurses and HCSWs/phlebotomists. This methodology enables a weighted analysis of workforce capacity across GPs, NERs, nurses and HCSWs, providing an indicative vacancy factor by locality, NCN and practice thus supporting a more granular understanding of recruitment and workforce sustainability challenges across the health boards GMS landscape.

Table 3. Deficit comparison 2023 v 2025

	GP Deficit		NERS Deficit	
	Dec-23	Nov-25	Dec-23	Nov-25
Blaenau Gwent East	*2.98*	*4.38*	*7.31*	*4.4*
Blaenau Gwent West	*1.66*	*1.69*	*3.38*	*3.12*
Caerphilly East	*2.53*	*0.74*	*2.45*	*1.74*
Caerphilly North	*11.64*	*6.75*	*6.73*	*9.18*
Caerphilly South	*1.8*	*0.55*	*2.5*	*3.26*
Monmouthshire North	*0*	*1.86*	*1.27*	*1.27*
Monmouthshire South	*0*	*0*	*0*	*1.86*
Newport East	*10.19*	*5.41*	*7.58*	*6.99*
Newport West	*4.82*	*1.22*	*3.77*	*5.04*
Torfaen North	*2.37*	*3.54*	*4.79*	*6.14*
Torfaen South	*0.7*	*0.6*	*2.97*	*6.74*
Gwent Total	**38.69**	**26.74**	**42.75**	**49.74**

Table 3 demonstrates a clear improvement in the overall GP deficit across Gwent, reducing by 31% over the last 2 years, indicating that workforce and recruitment initiatives are having a positive impact. However, this progress is marginally offset by an increased NERS deficit, which has increased from 42.75 to 49.74 over the same period, suggesting that demand for services continues to outpace capacity. While notable gains have been achieved in areas such as Caerphilly North and Newport East for GP provision, these locations, alongside increasing vacancies in Blaenau Gwent, remain significant pressure points due to persistently high or increasing GP and/or NERS deficits. This intelligence allows the Division in collaboration with NCN Leads to progress a more integrated approach to demand and service planning.

In terms of service planning, it has become increasingly evident that many elements of the Sustainability Plan are now embedded within, or aligned to, wider Divisional and Health Board programmes and governance structures. Workstreams originally developed under the Sustainability Programme are now being delivered through established divisional priorities, including Place Based Care, NCN development and integrated delivery frameworks.

The programme has now reached a point of maturity where its original objectives and workstreams are increasingly embedded within wider Divisional and organisational delivery. Many initiatives established under the Sustainability Programme are now aligned with, or delivered through, existing divisional priorities and governance structures, particularly those associated with the Integrated Medium-Term Plan (IMTP) and PBC. While this reflects successful integration and mainstreaming of sustainability principles, it has also highlighted potential duplication within governance arrangements and a potential gap in clarity in relation to accountability where similar initiatives are being reported through multiple structures.

In response, a revised delivery model is proposed, which brings the Sustainability Programme fully into alignment with the Divisional IMTP. Under this approach, sustainability will be embedded as a core, cross-cutting principle across all services, rather than delivered through a parallel programme structure. The IMTP will continue to define the strategic direction (*figure 5*) and intended outcomes, with sustainability arrangements providing the operational delivery framework, performance oversight and enabling infrastructure required to support implementation. This shift will reduce duplication, strengthen accountability through established governance mechanisms, and enable more consistent and robust performance management and assurance.

Figure 5. Primary Care IMTP Objectives

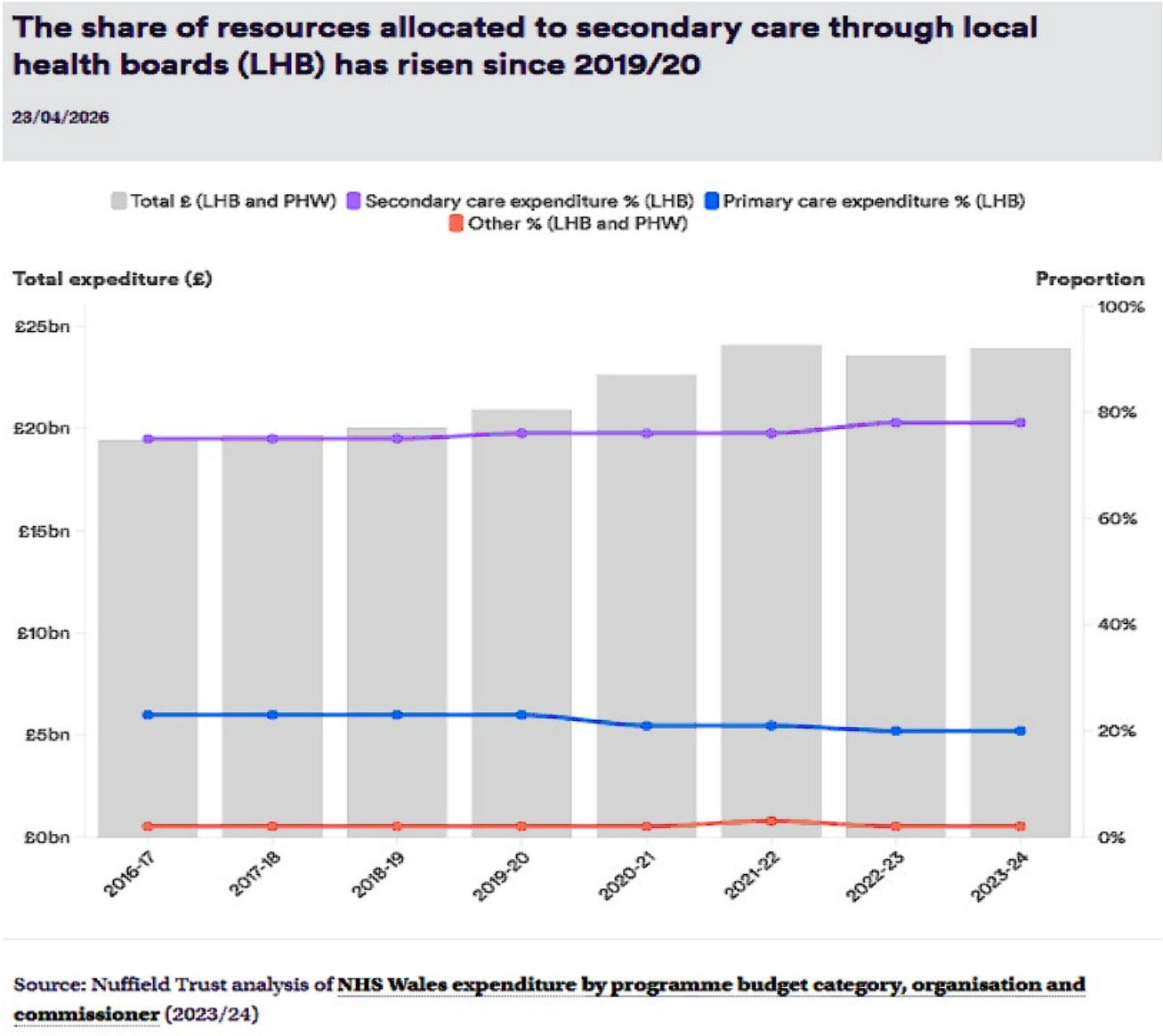
As identified above, the Division's long-term strategic objectives are framed across two complementary pillars: strengthening foundational capabilities and delivering system

transformation. The foundations prioritise sustainable services, value and efficiency, quality and patient safety, and modernised infrastructure, ensuring core services are resilient and effective. In parallel, system transformation focuses on advancing integrated neighbourhood teams, improving timely access to care, enhancing population health and prevention, and optimising interface pathways. Sustainability is embedded as a cross-cutting principle throughout both pillars, ensuring that all developments, whether reinforcing existing services or transforming models of care, support long-term operational, environmental, and financial resilience.

Financial Context

The financial context remains a significant consideration to sustainability. Primary care continues to operate within a constrained environment, with a marked imbalance in investment compared to Secondary Care Services. This investment imbalance is evident at a National (*figure 6*) and local level expenditure (*figure 7*) and persists despite the substantial contribution of Primary Care to overall system activity and performance (*figure 8*). This is combined with the Division delivering significant savings over recent years (*table 4*), contributing to almost a quarter of Health Board efficiencies. This position reinforces the need to rebalance investment toward community-based services, in line with national policy direction, which includes a clear commitment to increasing the proportion of funding allocated to Primary Care.

Figure 6. National Primary Care Investment 2016-2024



Source: Nuffield Trust analysis of **NHS Wales expenditure by programme budget category, organisation and commissioner** (2023/24)

Figure 7. ABUHB Expenditure 2016-2024

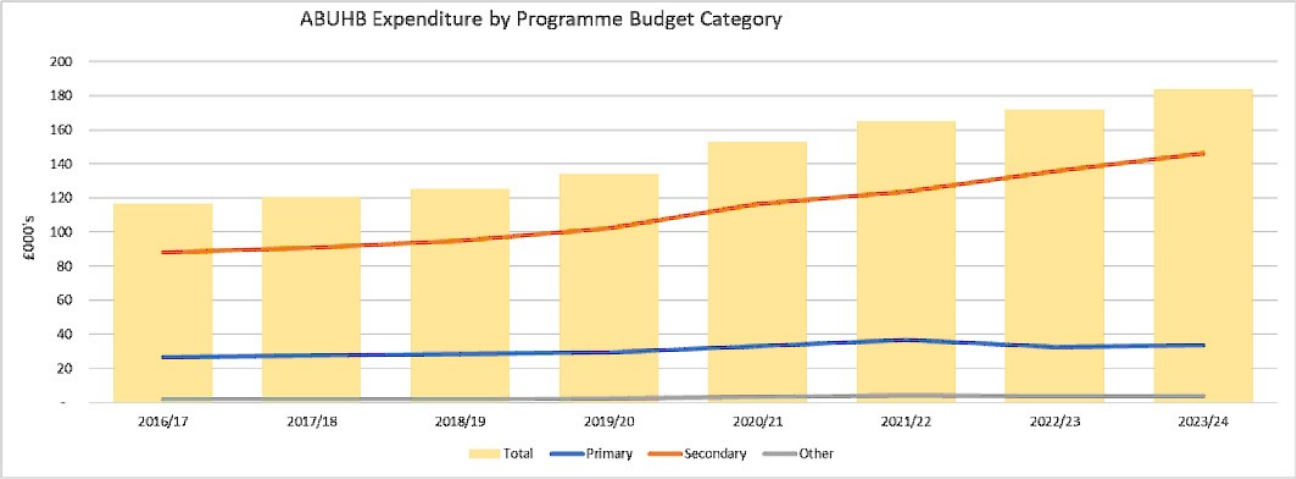


Figure 8. Indicative Activity Levels (2025)

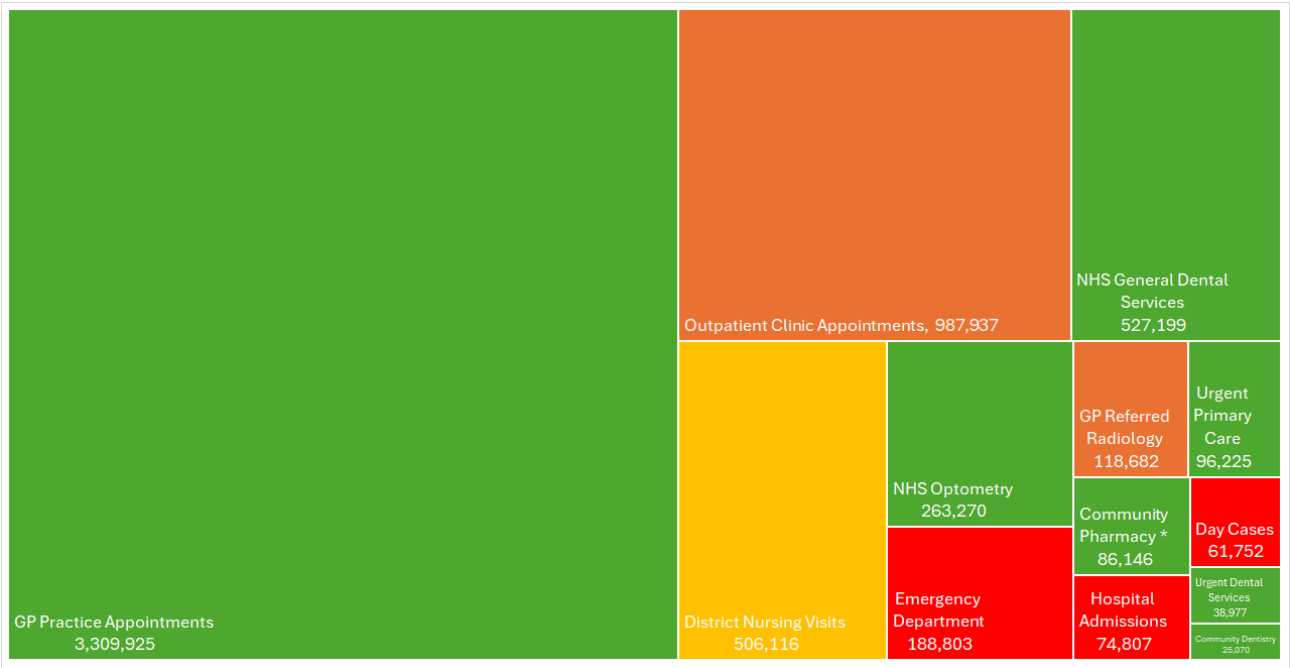


Table 4. Primary Care Divisional Savings and contribution to Health Board Efficiencies 2023 - 26

Financial Year	Divisional Saving Achieved (£m)	% of Overall HB Efficiencies
2023/24	9.49	22%
2024/25	12.002*	26%
2025/26	9.4*	22%
Total	**30.892**	**23%**

*Includes CHC

It is important to highlight the clear relationship between sustainability, deprivation, burden of disease and the inverse care law, alongside Plaid's commitment to review the General Medical Services funding formula to strengthen health equity. Our current approach is already aligned with this direction with the ring-fenced allocations for NCNs being weighted per NCN using the Welsh Index of Multiple Deprivation (WIMD), ensuring resources are directed to areas of greatest need. This demonstrates a practical commitment to proportionate universalism, a core principle of the Marmot approach adopted by the Health Board, by balancing universal service provision with targeted investment to improve outcomes in the most disadvantaged communities.

Future Direction of the Sustainability Programme Board

Looking forward, the programme will transition to a more integrated and strategically aligned model of delivery. Sustainability will be embedded within IMTP priorities and linked closely to PBC and CbD, ensuring a coherent system-wide approach. The role of the Programme Board will evolve accordingly, focusing on strategic oversight, risk identification and escalation, supported by strengthened governance through existing programme structures and Executive-led transformation boards. This approach will ensure that sustainability is fully integrated within core business, with a clear emphasis on outcomes, performance and long-term system resilience.

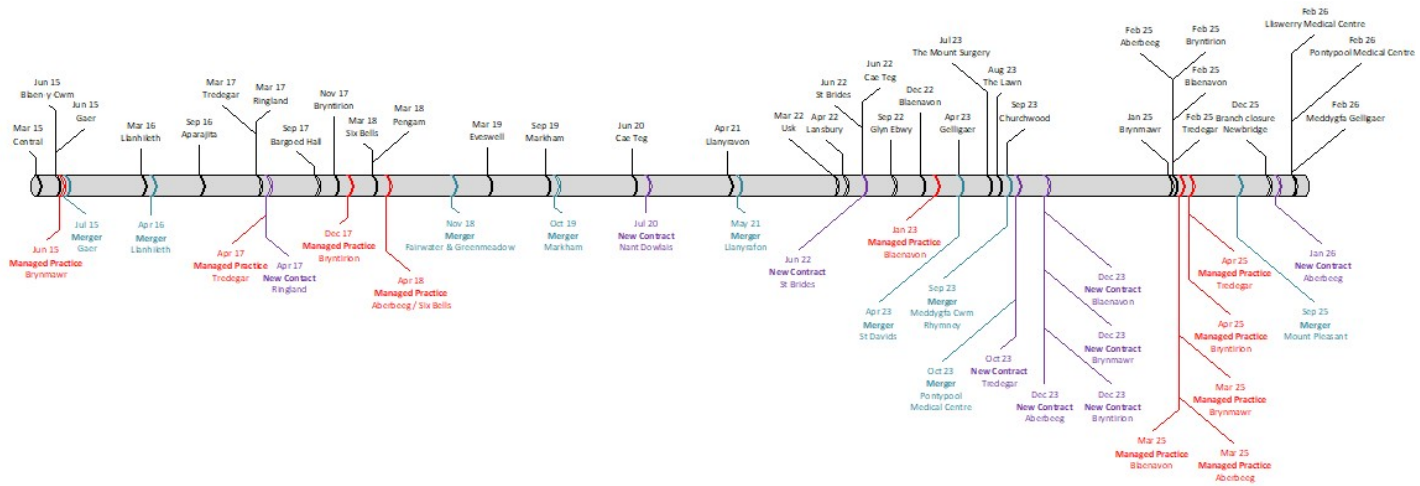
In summary, the Primary Care Sustainability Programme Board has continued to provide strong strategic leadership and oversight across 2025/26, maintaining a clear focus on risk management, service continuity and coordinated delivery across access, workforce, transformation and enabling infrastructure. Significant progress has been achieved, with the majority of Sustainability Plan actions now delivered or embedded within wider divisional and Health Board programmes, reflecting the maturity of the programme. Key developments include strengthened contractor oversight, expansion of MDT and neighbourhood-based models of care, and delivery of system enablers such as Single Point of Access and alternatives to admission. Workforce initiatives, led through the PCCA, have demonstrably improved capability, retention and multidisciplinary working, while targeted, funded programmes, including NCN development, obesity prevention and RIF funded projects have contributed to improved access, population health outcomes and system efficiency. However, continued reliance on time-limited funding presents a risk to sustaining progress. In response to increasing programme maturity, a proposed transition is underway to embed sustainability fully within the Divisional IMTP, ensuring streamlined governance, strengthened accountability and a clear focus on long-term system resilience, performance and person-centred outcomes.

Argymhelliad / Recommendation

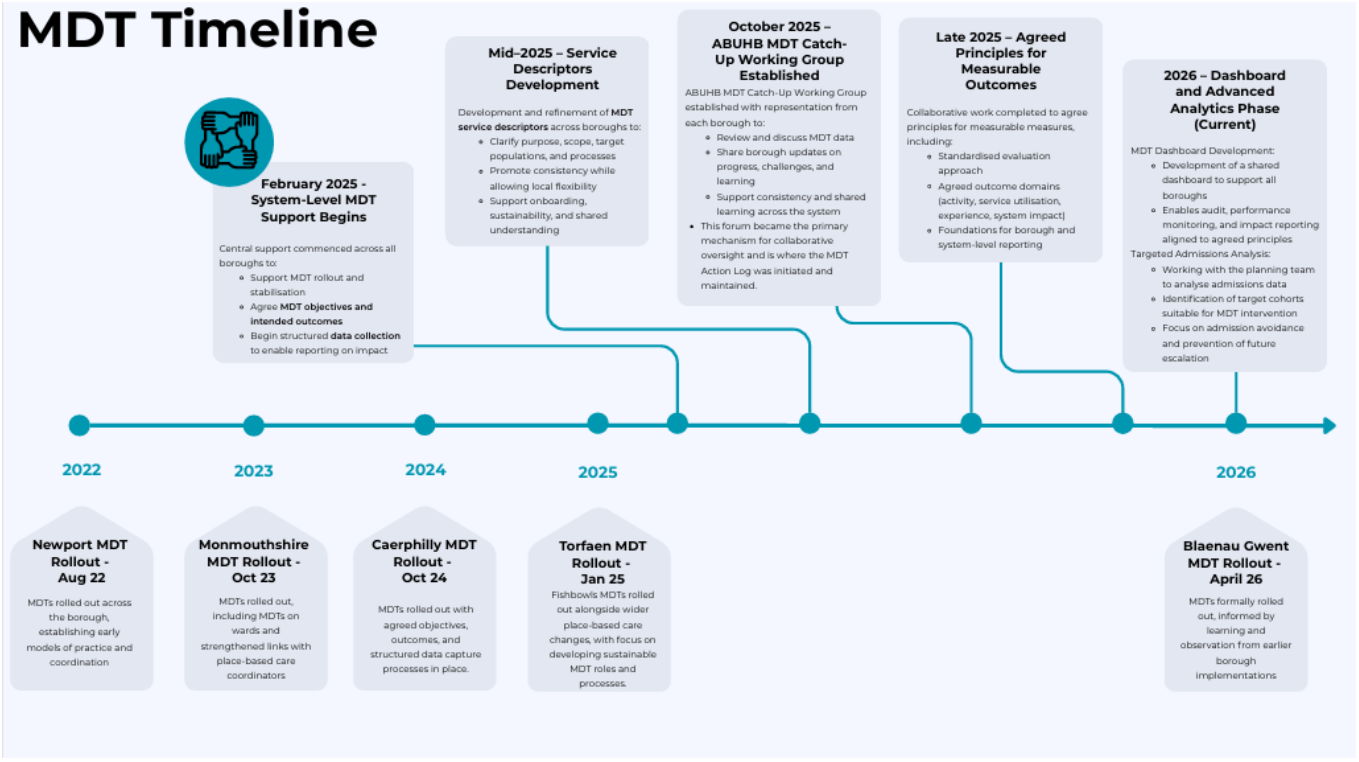
The Committee is asked to:

1. Note the progress of the Primary Care Sustainability Programme Board;
2. Note the ongoing system pressures facing Primary Care Contracted Services;
3. Note the breadth of programmes contributing to sustainability, including the progress of Primary and Community Care Academy as a key delivery vehicle for a sustainable workforce and the impact of short-term funding;
4. *Endorse the revised approach to developing the Sustainability delivery plan*, noting:
    - Sustainable services built in as foundational for the Divisional IMTP strategic objectives and aligned to Gwent 35 strategy; and
    - Successful implementation of Place Based Care and Community by Design is reliant on sustainable services as a solid foundation.

Appendix A – GMS Sustainability challenges



Appendix B – MDT Timeline



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):	3.2 Communicating Effectively 5. Timely Care 7. Staff and Resources Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

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

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

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN UNIVERSITY HEALTH BOARD**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 June 2026
CYFARFOD O: **MEETING OF:**	Partnerships, Population Health and Planning Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	General Dental Services (GDS) – Contract Reform Updated Position
ARWEINIOL: **LEAD:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lloyd Hambridge, Divisional Director for Primary Care, Community Services, Complex and Long-Term Care

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

The purpose of this report is to provide an update to the Partnerships, Population Health and Planning Committee regarding the implementation of the new National Health Service (NHS) (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026[1] and the Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (No.2) 2026[2] that came in to force from 1 April 2026 and the associated contractual changes that have occurred as a result. This report will be adapted as required for onward submission to the Partnerships, Population Health and Planning Committee on 30 June 2026.

Cefndir / Background:

In September 2025, the Primary Care, Community Services, Complex and Long-Term Care Division provided an overview to the Executive Committee and Board members on the General Dental Services Contract Reform position and planned regulatory changes (annex a &ai.).

In the subsequent months, the Primary Care Contracting Team (PCCT) continued to work collaboratively with key stakeholders, including NHS dental practices, Gwent Local Dental Committee (LDC), the British Dental Association (BDA) and Welsh Government (WG) to support and facilitate the implementation of the new National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026[1] (The 2026 Regulations).

The Health Board continues to commission NHS General Dental Services (GDS) throughout the Aneurin Bevan University Health Board area, from independent contractors. Also commissioning Emergency Dental Services (EDS), Domiciliary,

Orthodontic, Sedation and Oral Surgery Services via Personal Dental Services (PDS) contracts, which are time limited contracts. Additionally, GDS provision is also commissioned within HMP Usk and HMP Prescoed.

Since the inception of the 2006 NHS GDS contract, patients have not been registered with a dental practice, but access care through a contract based on individual courses of treatment. It is the patient's responsibility to ensure regular attendance at a dental practice to receive ongoing dental care. This position remains unchanged.

Urgent dental care also remains accessible for individuals that do not regularly attend a dental practice via the Health Boards Dental Helpline; Monday-Friday 9am-12.15pm and 1.15pm-4pm. Between 6.30pm-8am on weekdays, advice is available and during weekends and Bank Holiday's a limited number of urgent appointments are available and/or advice can be obtained.

Asesiad / Assessment

2025/26 End of Year Contract Management

Prior to 1 April 2026 NHS GDS was monitored and managed in accordance with the now revoked National Health Service (General Dental Services Contracts) (Wales) Regulations 2006[3] either by the delivery of Units of Dental Activity (UDA) or Contract Reform (CR) metrics.

Final 25/26 activity detail will be confirmed at the end of June 26, however, as at 31 March 2026:

- 69 dental practices delivering NHS dental services across the Health Board area:
  - 51 practices delivered dental services via UDA; and
  - 18 delivered dental services via CR.

Usual end of year (EOY) management process is in place with indicative individual EOY position communicated to contract holders at the beginning of April 2026, enabling practices up to 6 months to repay any monies owed due to underperformance. The final end of year position will be communicated to all NHS dental contract holders by the end of July 2026.

In addition to the usual contract performance management process, in December/January 2025/2026, communication was issued to all NHS dental practices advising that to receive the full annual Doctors and Dentist Review Body (DDRB) uplift of 4%, a number of actions were required:

- Undertake an antimicrobial audit, compare the findings to previous years audit and discuss with the practice team by 30 June and share its findings with the Health Board by 31 July 2026;
- Undertake urgent dental care audit between January – March 2026 and report the findings to the Health Board by 31 March 2026;
- Paediatric Referrals – General Dental Provider to attempt to treat a child on 2 occasions before a referral is made, clearly evidencing this on any referrals made; and
- Undertake a Did Not Attend audit – template for recording to be provided by Welsh Government *.

*To note, in the absence of a national audit tool NHS dental practices have not completed. Welsh Government are aware of the position.

Confirmation of completed actions by way of submitting a self-declaration is required by 30 June 2026.

Transition arrangements for 2025/26 under/overperformance

A key consideration for 2025/26 EOY is the fundamental change in the currency of performance management as the system transitions toward the new national model of delivery. Historically, EOY assessment has been based on numerical or percentage-based delivery of specific metrics. Under the new arrangements, any carry forward position, whether under deliver or over delivery, will need to be managed in monetary terms, rather than as units of activity or percentages achieved.

Therefore, the Divisional Senior Leadership Team agreed that in the event that a contract achieves between 95-105% at 25/26-year end, the contract holder will have the option to carry forward this activity to 2026/27 as a monetary value. For any increase or decrease in annual contract value (ACV) as a consequence of under or over performance, this applies to the determination of % segments, actual paid ACV remains the same, i.e. no additional funding will be awarded to practices during this process. Where a contract delivers more than 105%, this activity will be lost.

New NHS General Dental Services Regulations

As detailed in the previous paper (annex a), acknowledging the need to reform NHS GDS services, WG issued a consultation in Spring/Summer 2025. The outcome of that consultation was published on 23 September 2025. Subsequently, the new 2026 NHS GDS Regulations were laid on 11 February 2026[4] and came into force from 1 April 2026.

Communication

As the changes were regulatory in nature, implemented within the existing contractual framework, WG confirmed it was not necessary to issue new contracts to existing GDS contract holders. Instead, all practices were issued with transition communication (annex b and bi) dated 12 March 2026 for contract holders to confirm their acceptance to providing ongoing NHS dental services in accordance with the 2026 Regulations. WG have developed a model NHS General Dental Services contract which aligns to the 2026 Regulations to be issued for any new contracts commissioned from 1 April 2026.

Prior to any documentation shared with practices and to support the implementation of the 2026 Regulations, Gwent and Bro Taf LDC hosted an evening event with the profession on 26 November 2026. WG Chief Dental Officer and the Head of Dental Service were in attendance and provided an overview of the 2026 Regulations, offering practices the opportunity to raise queries regarding the changes. The event was well attended by practices across the region and Health Board Primary Care Contracting Teams.

Subsequently, WG developed a 'vignettes' document (annex c) and the final version was issued to Health Board Primary Care Contracting Teams and NHS GDS practices on 18 March 2026. This document aims to provide practices with an aide memoir for clinical and administrative teams to refer to for managing a variety of scenarios. It should be noted that this is not a contractual document.

Additionally, Health Board Primary Care Contracting Teams have collaborated with WG to develop a 'Frequently Asked Questions' (FAQs) document to support with local practice and contract management queries. This document remains live.

The Health Board appreciated that many NHS dental contract holders were anxious and unsure about whether or not to continue to provide NHS GDS under the 2026 Regulations and therefore the PCCT and the Divisions Dental Director hosted two evening engagement events for the profession to attend on 25 and 26 March 2026. An overview of the information available at that time was provided, setting out the contract requirements going into 26/27. This was followed by a question-and-answer session.

The event was well attended by practices across Gwent. A series of engagement events will continue over the year.

Implementation

This section outlines the key changes and the Health Board approach to implementation, ensuring service delivery is maintained, the GDS budget is maximised and the population can continue to access NHS dental care. A number of key areas were considered by the Divisional Senior Leadership Team, to ensure an agreed approach to implementation and interpretation. The attached paper provides further detail (annex d).

From 1 April 2026, NHS dental practices are required to deliver NHS dental care in a different way to how they have in previous years. Rather than deliver activity via UDAs or Contract Reform, they are now required to deliver the contract via segments which have an associated negotiated percentage of their annual contract value attached.

Health Boards can flex the percentage allocation for each segment based on local need and that these segmentations are flexible in their entirety, at practice, NCN, borough and/or Health Board level either at the request of a practice, to be agreed, or at the determination of the Health Board.

Following a full analysis of data/information available to the Health Board prior to 1 April 2026, the Divisional Senior Leadership team determined to flex the 2026/27 baseline segments as detailed below, noting these may change throughout the year. WG confirmed there would be no allocation for local/national priorities in year 1 and this is to transfer to care packages instead.

Segment	WG Allocation	ABUHB Allocation	Variance
Recall	3%	3%	0%
Urgent Treatment	7%	3%	-4%
New Patient Assessment	10%	3%	-7%
Care Packages	70%	86%	16%
Prevention	5%	5%	0%
Local/National Priorities	5%	0%	-5%
	100%	**100%**	

Table 1: Confirmed Health Board segmentation shown against WG baseline allocation

As outlined, one of the Health Board's priorities is to maintain patient access therefore the number of patients accessing urgent dental services was considered along with the number of new patients seen in previous years.

- ❖ New Urgent Patients

The table below provides a breakdown of the number of urgent patients seen within the Health Board area compared to the number of urgent patients that would require an appointment against the segment percentage as proposed by Welsh Government and the Health Board.

New Urgent Patient (NUP)	WG 7%	ABUHB 3%
Number of NUPs required across all NHS GDS Contracts	34256	14681
Monthly requirement per %	2854	1223
2025/26 available appointments (month)	1137	
Utilisation	952 (83%)	

Table 2: Urgent patient split between Welsh Government and Health Board percentage

In summary, the Health Board offers 1,137 urgent appointments per month (297 per week) to patients across all practices, and of this, 17% of these appointments are not utilised, therefore reducing the segment percentage from 7 to 3% ensures the Health Board is still meeting patient demand without compromising value for money.

As in 2025/26, the Health Board continues to facilitate urgent appointments, via the Dental Helpline and on a rota basis across all NHS General Dental Services practices, Monday to Friday (excluding Bank Holidays).

- ❖ New Patients

The table below provides a breakdown of the number of new patients that would need to be seen against the segment percentage as proposed by Welsh Government and the Health Board.

New Patient (NP)	WG 10%	ABUHB 3%
Number of NPs required across all NHS GDS Contracts	67455	20237

Table 3: new patient split between Welsh Government and Health Board percentage

As detailed further on, as at 23 April 2026, 21,143 patients have registered on the Dental Access Portal therefore the decision was made by the Primary Care, Community Services, and Complex and Long-Term Care Division to reduce the segment percentage.

Additionally, it is difficult to forecast the number of new patients that need to be seen for a contract negotiated ACV (segment contract value) as the level of remuneration a practice receives for a new patient is dependent on the patients' age:

- Under 1 year = £80
- 1-4 years = £75
- 5-12 years = £70
- 13-17 years = £60
- Over 18 years = £54.41

On this basis contract compliance will be monitored against the contracts negotiated ACV.

❖ Recalls

Practices will receive a fixed allocation of 3% of their ACV to cover all recall activity for low-need patients. This replaces the previous system in which practices were paid per individual examination and aligns with WG direction that no monetary value should be attributed to individual recalls for this cohort. In contrast, examinations for medium and high need patients will continue to attract a £50 fee per examination, ensuring resource is targeted to clinical need.

It is not possible to forecast how many patients will be treated within this segment across the Health Board in 2026/27. Recent contract years have shown that patient behaviour is influenced by legacy arrangements, with many patients returning annually to obtain the once-a-year historic patient credit and to complete the required Assessment of Clinical Oral Risks & Needs (ACORN) assessment. As the new model embeds, and as practices adjust recall intervals in line with NICE guidance, activity patterns are likely to change materially and unevenly across localities, limiting our ability to model volumes with confidence.

❖ Prevention

Practices will receive a fixed allocation of 5% of their ACV to ensure consistent delivery of evidence based preventive care. It focuses on full compliance with Delivering Better Oral Health[5] including fluoride application, prevention conversations, and -risk-based care planning. Rather than being tied to activity levels, this component will be monitored through audits and clinical software that records key preventive measures, such as fluoride varnish applications, fissure sealants, and tailored advice. Overall, the segment acts as an addition to core activity to strengthen and standardise prevention across patient pathways.

❖ Care Packages

The 86% care package segment forms the core of the contract and encompasses the full range of treatment activity delivered by practices. The revised valuation model provides a more appropriate and equitable remuneration structure than the former UDA system, meaning that practices may achieve their contract value more

quickly while delivering fewer total treatments. For practices serving high-needs populations, this may result in their care package allocation being exhausted earlier in the year, which could limit their ability to offer timely recall examinations or further courses of treatment.

A significant forecasting challenge for 2026/27 is the inability to accurately forecast care package delivery.

Annex e. Care Package title and description.

From April 2026, a patient can be eligible to receive one or multiple care packages as part of their course of treatment. Going forward practices will be able to report the start of a course of treatment with the expected packages included, these may change throughout a patient's treatment journey and will not be confirmed until the practice closes the course of treatment and submits their claim.

As this is the first year of operating under the 2026 Regulations, both practice behaviour and patient flow are highly uncertain. In addition, the gap created by the reduction in contracts (detailed later), despite plans for recommissioning, means there will be an unavoidable shortfall in activity that the Health Board cannot predict with confidence. For these reasons, forecasting delivery through care packages will not be feasible until the system has embedded and we have a clearer understanding of how practices respond to the new model.

Like all segment percentages, ongoing monitoring will continue during 2026/27 and if required further flexing will occur.

- ❖ Local/National Priorities

The 5% segment under the new regulations is intended to be a flexible area that Health Boards can use to focus on local priorities, emerging pressures, and systemwide improvement. Although the final process for selecting these priorities is still being developed by WG groups, the expectation is that this portion will incentivise activities such as quality improvement work, participation in new clinical pathways, and targeted interventions for specific patient groups.

Overall, the 5% is intended as a tool for Health Boards to encourage innovation, improve quality and consistency of care, and respond to local population needs while staying aligned with national aims. However, as this approach is not in place for 2026/27, it is instructed by WG that the 5% allocation be temporarily transferred into care packages, increasing the proportion that must be delivered through care packages for all contractors.

<u>2026 Regulations - Key Changes</u>

Key areas of change from April 2026:

- Mid-Year - historically, dental contracts must achieve at least 30%, this has changed to 40% and dental contract holders will be required to submit a mid-year report to the Health Board by 31 October each year.
- Termination – historically dental contract holders must provide at least three months' notice to the Health Board if they wish to terminate their agreement, this has changed to six months.

- Personal Dental Service provision – Services must align with the new regulations as the remuneration structure has changed for all services commissioned.

Accelerated Cluster Development

A requirement of 2026 Regulations is for Health Boards to develop dental collaboratives/clusters, aligned to wider primary care contracting areas.

Schedule 3, Part 9, Paragraph 83 of the 2026 Regulations makes provision for *"Duty of co-operation: cluster working".*

Additionally, the vignettes details:

42. Can you explain what I need to do regarding dental collaboratives?

"The 2026 contract is an opportunity to become involved with the Dental Professional Collaboratives and the Accelerated Cluster Development (ACD) programme by engaging with several structured entry points that the system now provides. This is a significant shift from the historic GP-led cluster model and creates new opportunities for dental teams to shape local planning, prevention priorities, and service development across Wales. As the 2026 GDS contract embeds prevention, complexity, and population-health principles, dentistry's contribution to ACD becomes central to integrating oral health into wider healthcare. Involvement ensures that dental needs are understood, funded, and integrated into the wider system. To support this ambition funding will be available to practices to enable a dentist from the practice to participate in professional collaborative meetings. The requirement will be to attend 4 meetings annually for a payment of £1,200. Failure to attend meetings will result in a pro rata reduction of that payment (£300 per meeting missed)."

The proportion of funding is paid to practices, via COMPASS (payment system) in 1/12th payments. However, failure to attend all or any of the collaborative meetings will result in payment being recovered at year end. It should be noted that there is no scope to transfer this funding in to segment funding. With this in mind the Health Board will be hosting 4 collaborative meetings during 2026/27 both face to face and virtually.

It is recognised that working on a cluster/collaborative basis is very much a new way of working for dental practices and therefore support from Health Board colleagues, and learning from existing cluster and collaborative leads in other areas, will be provided to practices during 2026/27.

It is anticipated that further information regarding the development of dental collaboratives will be shared by WG during 2026/27.

Practice Opening Hours

The vignettes document details that NHS GDS practices provide NHS dental services to patients between 9am – 5pm, Monday to Friday (excluding Bank Holidays), however, this is not stipulated within the 2026 Regulations.

Historically many practices close on a Friday afternoon. To ensure consistency and equitable access remains the Health Board has confirmed to all NHS GDS practices that they are expected to deliver NHS dental services between 9am – 5pm, Monday to Friday (excluding Bank Holidays). This is to ensure OOH and Emergency

Departments are not adversely impacted by a practice closing early. This approach is consistent with national aims to improve fairness, consistency, and continuity within the new contract framework.

However, it should be noted that OOH does not commence until 6:30pm weekdays, leaving a gap in service provision between 5-6:30pm.

Should a practice not be able to deliver NHS General Dental Services during these standardised hours, a contract holder can request to vary. Any hours the practice is not open, they will be required to have buddy arrangements in place to enable patients seeking urgent treatment to be seen in a timely manner, without presenting elsewhere in the system.

Digital Infrastructure

In November 2025, all practices utilising the computer software system, EXACT, were advised that the system would not be updated from April 2026 and therefore if the practice was intending to opt in to the new way of working, they would need to change their software system to Dentally.

Prior to 1 April 2026, 61% of dental practices in the Health Board utilised the system EXACT and therefore switching software systems may have caused some disruption to practices. It is unknown at this stage but the forced transition may have temporarily affected contract delivery for 2025/26 through factors such as system downtime of up to two weeks, the need to close off courses of treatment, data discrepancies during transfer, and time required for staff training.

To ensure fairness, a structured mitigation process will be considered by the Primary Care, Community Services, and Complex and Long-Term Care Division should any EXACT dental provider affected by the transition process raise an appeal following the end of year contract position being confirmed.

Due to the imposed changes some NHS contract holders made the decision to terminate or vary their existing NHS General/Personal Dental Services contracts with effect from 1 April 2026.

Since the implementation of the 2026 Regulations, there has been considerable concern raised by GDS practices that digital systems have not kept up with the changes, resulting in claiming issues and delays. WG and NHS Business Services Authority (BSA) colleagues are aware and working through these challenges, however, it is likely to have a significant impact on the availability and accuracy of data for both Health Boards and practices, at least during quarter 1 of 2026/27, making monitoring and forecasting almost impossible.

Dental Access Portal

The Dental Access Portal (DAP) was implemented within Aneurin Bevan University Health Board from February 2025 and as at 23 April 2026:

- 21,143 patients have registered on the Dental Access Portal; and
- 9,071 patients have been allocated to an NHS dental practice.

In accordance with the 2026 Regulations, all NHS dental practices must now accept all new patients from the DAP, with the exception of:

- children of active parents or grandparents can be accepted as a new patient to the practice and
- a new urgent patient seen can be accepted as a new patient, bypassing the DAP

	Blaenau Gwent	Caerphilly	Newport	Monmouthshire	Torfaen	Totals
Number of patients registered on DAP since February 2025	2,277	4,593	7,077	3,439	3,757	**21,143**
Number of patients allocated to an NHS dental practice since February 2025	2,091	3,410	2,205	797	568	**9,071**

Table 4: Number of patients registered on the Dental Access Portal v number of patients allocated to an NHS dental practice by borough as at 23 April 2026.

Due to the regulatory change, dental practices must not hold their own patient waiting lists, and in order for the Health Board to allocate patients to an NHS dental practice, patients must register their details onto the DAP.

The management of this process has so far been absorbed by the PCCT, however, as enrolment increases and capacity allows allocations, this will need to be kept under review to ensure there are no delays in the system as this would have a direct impact on a practice ability to fulfil their contract.

The PCCT continue to prioritise the allocation of children to dental practices, along with ensuring families are allocated together to a practice.

Additionally, recent contract terminations and variations have had an impact on children awaiting orthodontic care, in the instance where children require extractions before orthodontic treatment can commence and they no longer have an NHS dentist due to the referring dentist ceasing NHS provision, the PCCT is fast tracking these patients to an NHS practice so not to delay their orthodontic treatment.

To raise patient awareness of the DAP as the single route to access routine NHS GDS, the Health Board's Communication and Engagement Team is developing a public dental campaign to explain what is required and encourage sign up to the DAP in order to fully satisfy the NHS GDS new patient segment.

Contract Terminations/Variations (Reductions)

On 1 April 2025, the Health Board commissioned 72 NHS GDS contracts. By 1 April 2026, this reduced to 59 NHS GDS contracts, a reduction of 13 NHS GDS contracts.

Prior to 31 December 2025, the Health Board received notification of 3 NHS General Dental Services contract terminations or variations and these notifications were managed in accordance with notice periods in the now revoked National Health Service (General Dental Services Contracts) (Wales) Regulations 2006:

- Terminations – 3 months
- Variations – 14 days

Between January – March 2026, further notifications from NHS contract holders were received to either terminate or vary their NHS General Dental Services contracts. These notifications took effect from 1 April 2026 and were also managed in accordance with the now revoked 2006 Regulations, but by mutual agreement, an earlier termination or variation date was agreed.

The table below details the number of General Dental Services contract terminations and/or variations, by borough, during 2025/26.

Contract Change	Contract Type	Blaenau Gwent	Caerphilly	Newport	Monmouthshire	Torfaen	Totals
Terminations	GDS	0	2	5	1	5	13
	PDS	0	1	1	0	0	2
Variations	GDS	0	1	1	2	0	4
	PDS	0	0	0	0	0	0
							19

Table 5: NHS General Dental Services contract termination/variation configuration

Approximately £5.4m has been returned to the Health Board due to these contract changes. One of the Health Board's priorities is to maintain patient access, therefore, monies returned will be reinvested back in to NHS Dental Services, this is an expectation from WG, noting this will be in the context of the Health Boards financial position in relation to financial pressures associated with the legacy Patient Charge Revenue (PCR) target.

It is difficult to determine the total number of patients affected by these contract changes in the absence of patient registration, however, it is anticipated that approximately 60,000 patients may have been affected by these contract changes. This is yet to be reflected in DAP enrolment.

It is important to recognise that where contractual changes have occurred that have impacted on patients, the Health Board has also varied contracts to increase patient access. Prior to 1 April 2026, the Health Board commissioned a number of child and exempt only contracts, meaning fee paying patients were not able to access NHS dental care from these practices. With the implementation of the new regulations, these contracts have now been varied to ensure all patient groups can be accepted, ultimately, increasing patient access.

During any contractual change the PCCT work closely with the NHS dental practice to ensure due process is followed and patients are informed of any changes promptly. Additionally, all NHS dental practices are encouraged to inform patients of the Dental Access Portal as a place to register interest if requiring access to routine NHS dental care.

Next Steps

Contract and Activity Monitoring

Whilst the PCCT continues to engage with NHS dental practices to provide support, as yet the team is unable to monitor claiming and activity data. Due to the numerous system changes that have needed to occur as a result of the new regulations being implemented, it is anticipated that monitoring data will not be available until the end of quarter 1 of 2026/27.

It is recognised that contracts may not achieve the required 40% at mid-year and should a practice request to flex their contract during 2026/27, the PCCT may not be able to rationalise or justify the request in the absence of data. That said, ongoing discussions with WG and NHS BSA colleagues continue.

Any delay in activity being reported will impact the Health Board's ability to accurately predict how practices will operate and how services will be delivered

under the 2026 Regulations. The PCCT will closely monitor contract delivery on a monthly and quarterly basis and, in addition, a full review will be undertaken at mid-year and end of year.

The Health Board will need to observe a full year of implementation to understand delivery patterns and contractor behaviour under the new contractual framework. In addition, the reduction in contract numbers, despite plans to recommission, will create a gap in delivered activity, which will not only impact access but also further reduce the overall patient charge revenue.

The PCCT will continue to work closely with finance colleagues and:

- Increase contractor engagement - More frequent touchpoints with contractors, including an increase in face-to-face practice visits;
- Continue to Performance Manage **-** Monthly review of contractor delivery using available data, supported by quarterly and mid-year reporting. Updates will be provided through quarterly meetings, Senior Leadership Team, and Integrated Oral Health Group. Additionally, the Health Board may look to flex contracts further; and
- Manage end of year as stipulated in the new regulations 2026 **-** Preparation and oversight of the end of year process, including forecasting final delivery, confirming end-of-year positions, and communicating outcomes with both contractors and Senior Leadership Team.

<u>Recommissioning / Provider Selection Regime (PSR)</u>

The Health Board is committed to investing in NHS GDS services and over the coming weeks will be commencing a procurement exercise to recommission services that have either been terminated or reduced in accordance with The Health Services (Provider Selection Regime) (Wales) Regulations 2025 (PSR)[6].

Given the complexities surrounding the contract segmentation and the ability to flex based on local need, the PCCT are currently mapping areas of greatest need against data obtained via the DAP in order to inform and prioritise the re-provision, balanced against appetite to deliver.

It is anticipated that NHS General Dental Services will be recommissioned from Autumn 2026. Exploration of alternative methods of service delivery is ongoing, should consideration be required if the procurement process is not as successful as anticipated.

<u>Communication and Engagement</u>

In February 2026, WG launched the 'Accessing dental services' strand of the 2025/26 Help Us Help You campaign[7]. This sub-campaign focuses on informing and reassuring the public about the changes to NHS dental services in Wales from April 2026, explaining the DAP and promoting self-care and good oral health.

Between 1 January 2026 to 22 May 2026, the PCCT has received and responded to 21 informal concerns and 37 formal concerns (including MS/MP concerns) from patients seeking additional information on how to access NHS dental services and what the changes, in terms of the regulation change, mean for them as an NHS patient.

The PCCT will continue to work collaboratively with NHS Dental Practices, Gwent LDC, WG and other key stakeholders, including Llais to build on the information already available to practices and patients to support the implementation of the 2026 Regulations.

Additionally, further engagement will be undertaken with other local services such as the Community Dental Service and Secondary Care Dental Services to understand if there has been any impact on these services as a result of the new regulations being implemented, this will be fully explored as part of the Integrated Oral Health Group agenda.

Continued Professional Development

The Health Board is committed to supporting clinical professionals with professional development and in collaboration with Health Education and Improvement Wales and Gwent LDC, is developing a Continued Professional Development programme, with an event scheduled in the Autumn/Winter of 2026/27.

It has been communicated by Gwent LDC that this engagement is extremely positive and very much welcomed by the profession.

Summary

The implementation of the 2026 NHS GDS Regulations represents a significant change in the delivery of NHS dental care, creating a more equitable remuneration structure, strengthening prevention, directing resource based on clinical need and providing greater flexibility for Health Boards to respond to local need. However, the transition has also been met with a reduction in GDS contract numbers within the Health Board area.

For the Health Board, notably the PCCT, the changes have resulted in a marked increase in workload and complexity particularly in managing the implementation, contract variation and terminations, patient allocations via DAP and increased stakeholder engagement.

Limited visible data and unpredictability across a number of areas means forecasting delivery, performance and the financial position will remain challenging during 2026/27 and the PCCT will remain proactive and adaptive to ensure access to NHS dental care is maintained for the population of Aneurin Bevan University Health Board

In early Autumn, the Health Board will be undertaking a procurement process to recommission services lost as a consequence of the 13 contract terminations received to date. The Health Board intention is to fully reinvest the £5.4m available to ensure care can be re-provided for the approximately 60,000 patients impacted by the terminations. However, should this not be achieved then alternative methods of delivery will be explored. Procurement timescales are impacted by concurrent GMS procurement activity and capacity constraints within both the procurement team and PCCT. The Division has highlighted potential slippage due to the delay in procurement processes through the relevant governance routes and this will be managed in line with the expectations of Welsh Government on reinvestment/service provision.

Argymhelliad / Recommendation

The Committee is asked to:

- Consider the content of this report and associated documents;
- Acknowledge the potential implications and ongoing challenges resulting from the implementation of the 2026 Regulations; and
- Endorse the approach the Division has outlined in terms of its implementation, current contract management processes and recommissioning of routine NHS GDS provision.

Supporting Documents and Links

[1] The National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026

[2] Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (No.2) 2026

[3] The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 (revoked)

[4] Written Statement: New Contract to Improve Access to NHS Dentistry (11 February 2026) | GOV.WALES

[5] Delivering better oral health: an evidence-based toolkit for prevention - GOV.UK

[6] The Health Services (Provider Selection Regime) (Wales) Regulations 2025

[7] Welsh Government Communications Services Digital Toolkit

Annex a & ai – Executive Committee Report and Slide deck


Annex A - GDS Exec Report.docx


GDS Position September 2025 Boa

Annex b and bi – Transition and Guidance documentation


Annex B - ABUHB Transition Template


Annex Ba - Implementation Gui

Annex c – Vignettes


Annex C - Vignettes - Version 2 - Issued

Annex d- SLT paper


GDS Contract Segmentation Feb 2

Annex e – Care Package

Annex D - Care Package.docx

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy 2. Safe Care 3. Effective Care 5. Timely Care
Blaenoriaethau CTCI Link to IMTP	
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item. **Long Term –** ensures the ongoing access to NHS dental care. **Integration** – facilitates integrated working with independent contractors. **Involvement** –Involvement from the Local Dental Committee and Llais. **Collaboration** – Independent GDS Practices and cluster teams. Local Dental Committee and Llais.

	Prevention – this will ensure the ongoing provision of GDS services to patients.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	04 September 2025
CYFARFOD O: **MEETING OF:**	Executive Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	General Dental Services (GDS) – Contract Reform Overview and Current Position
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lloyd Hambridge, Divisional Director for Primary Care, Community Services, Complex and Long Term Care

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

The purpose of this report is to inform the Executive Committee of the existing NHS General Dental Services (GDS) commissioning arrangements for routine dental care within Aneurin Bevan University Health Board, to provide an update in relation to the recent Welsh Government consultation regarding NHS GDS Contract Reform and the proposed contractual arrangements from April 2026, associated risks and mitigations.

Cefndir / Background

The Health Board commissions General Dental Services (GDS) throughout Aneurin Bevan University Health Board from independent contractors, through The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006)[1]. There are currently 72 General Dental Contracts that are responsible for providing NHS dental care within the Health Board area.

Since the inception of the NHS GDS contract, patients have not been registered with a dental practice, but access care through a contract based on individual courses of treatment. It is the patient's responsibility to ensure regular attendance at a dental practice to receive ongoing dental care.

Individuals that do not regularly attend a dental practice and require urgent dental care can contact the Health Boards Dental Helpline; Monday-Friday 9am-12.15pm and 1.15pm-4pm. Between 6.30pm-8am on weekdays, advice is available and during weekends and Bank Holiday's a limited number of urgent appointments are available and/or advice can be obtained.

The Health Board also commissions Domiciliary Services, Orthodontic services, Sedation and Oral Surgery Services. In addition, GDS is also commissioned within HMP Usk for the populations of HMP Usk and HMP Prescoed.

Asesiad / Assessment

The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 sets out the framework for mandatory and additional services to be provided under NHS GDS contracts in Wales.

The GDS contract is based on substantiative activity targets known as Units of Dental Activity (UDA), a proxy for counting dental treatments. NHS dental treatment is categorised into bands, each with an associated UDA value:

- Band 1- Diagnosis, treatment and maintenance;
- Band 2- Treatment such as fillings, endodontics and extractions; and
- Band 3- Provision of appliances such as bridges, crowns and dentures.

Welsh Government (WG) acknowledged that the current contractual system needs reform. UDAs as a sole measure of contract performance, focusing on treatment activity only, does not encourage needs led care, provide a preventative focus, or make the best use of the skill mix within dental teams. In light of this, the Contract Reform Programme (CRP) commenced in 2017.

WG set the direction for GDS CR with the Dental Public Health Team taking forward the development. Some of the national policy drivers for change include *A Healthier Wales: The Oral Health and Dental Services Response*[2], *The National Oral Health Plan 2013-18*[3] and *Taking Oral Health Improvement and Dental Services Forward in Wales*[4]*.*

The CRP recognises that the implementation of Prudent Healthcare Principles, evidence-based prevention and the development of a culture of continuous improvement are key in ensuring NHS dental services are sustainable. Dental services also need to be an integral part of proactive and co-ordinated primary care to improve overall patient health and outcomes.

CR was initially developed and implemented in a phased approach and required a shift in focus of dental care delivery to improve the oral health of the population and contribute towards general health and wellbeing, reduce oral health inequalities and deliver improved patient experience and outcomes.

The initial CRP was focused on the needs and outcomes of individual patients through the Assessment of Clinical Oral Risk and Need (ACORN). Working with patients to co-produce care plans to improve outcomes, improve delivery of evidence-based prevention, introduce needs-led dental recall intervals and increase in the use of skill mix.

The CRP was delayed as a result of COVID-19, however, was re-established in 2022/23 and has continued to evolve in subsequent years.

It is important to understand that CR is implemented as a contract variation to the existing substantive NHS GDS Contract in accordance with the 2006 Regulations. Consequently, treatment provided remains categorised within the treatment bands.

NHS GDS – Contract Reform Programme (CRP)

Since April 2022, all NHS dental practices have had the opportunity to opt into CR or remain on the substantive UDA Contract. Those practices that have opted into CR, are required to deliver against a set of metrics derived by WG. Whilst the core metrics remain unchanged, their specific application is subject to annual review by WG annually:

- Complete and report **ACORN** (Assessment of Clinical Oral Risk and Needs assessment) findings;
- Accept a specified number of **new patients** per week (determined by Annual Contract Value (ACV));
- Accept a specified number of **new urgent patients** per week (determined by ACV);
- See a minimum number of **historical patients** per week (determined by ACV). A historical patient is defined as someone who a dentist has submitted a claim for in the previous four financial years;
- Apply Fluoride Varnish to a minimum % of all adult patients with risk of (amber), or active decay (red) and a minimum % of all child patients aged 3 and over as well as for child patients aged under 3 with a risk of caries (red or amber); and
- More recently, Quality Improvement cycles.

Each year the metrics and associated thresholds are set out as a standard offer, with a level of off-setting and transferability between each metric dependent upon the guidance and individual practice circumstances.

The Historic Patient (HP) metric proves the most challenging to achieve for practices working to CR, due to a number of reasons. The time to manage a new patient (NP) is invariably greater than a HP; they may not have been seen by a dental practice for many years and can often have complex oral health needs. Practices have also been dealing with a high number of urgent patients (NUP), again presenting with complex oral health needs. Both scenarios result in less capacity to re-call HP.

Practices have raised concerns in relation to HP attendance, citing costs, along with patient choice to attend other practices that have capacity and as such are being seen as a NP at an alternative practice rather than wait for capacity within their regular dental practice.

For those practices that remain with UDAs, they continue to provide dental services in accordance with The NHS (General Dental Services Contracts) (Wales) Regulations 2006.

All NHS GDS practices within the Health Board are monitored and managed in accordance with the 2006 Regulations, including mid-year reviews and the management of end-of-year (EOY) based on performance and delivery of activity against either the UDA target or CR metrics. Following the application of any agreed mitigation, financial recoveries are instigated in all instances where there is an underperformance identified.

NHS GDS Activity

Table 1 shows a summary of the number of practices within each borough that opted into the Contract Reform or remained on UDAs since 2022/23.

Borough	2022/23		2023/24		2024/25		2025/26	
	CR	UDA	CR	UDA	CR	UDA	CR	UDA
Blaenau Gwent	9	1	7	3	9	2	9	2
Caerphilly	13	13	13	16	13	12	17	8
Monmouth	11	1	5	8	9	3	7	2
Newport	13	2	9	6	10	4	10	4
Torfaen	9	7	7	6	11	3	10	3
Totals	**55**	**24**	**41**	**39**	**52**	**24**	**53**	**19**

Table 1. CR/UDA split by borough

The graph below shows the number of adults and children treated across both UDA and CR practices over the years to current date, demonstrating an overall increase year on year.

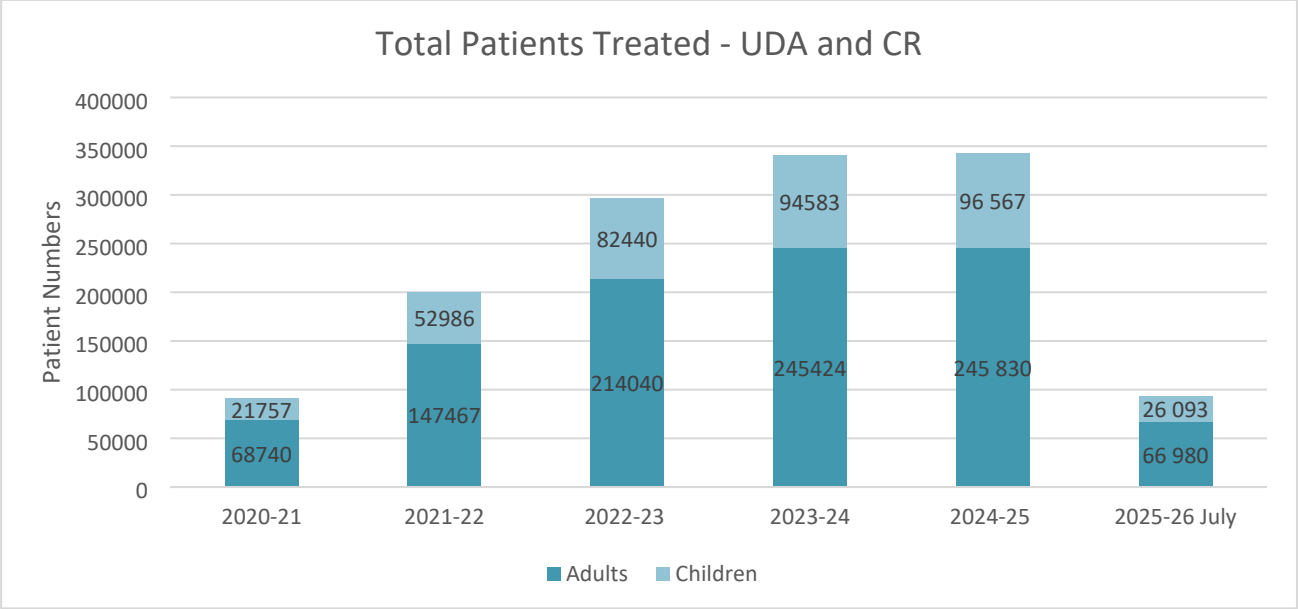


Fig 1. Adults and children treated - UDA and CR practices

Figure 2 shows the number of patients seen solely within CR practices, broken down by each metric. The reduction in numbers in 2023/24 is reflective of a number of practices reverting back to UDA delivery (table 1) for that period. Figure 1 demonstrates there was no overall reduction in the number of patients treated across all practices. 2024/25 CR figures returned to 2022/23 volumes.

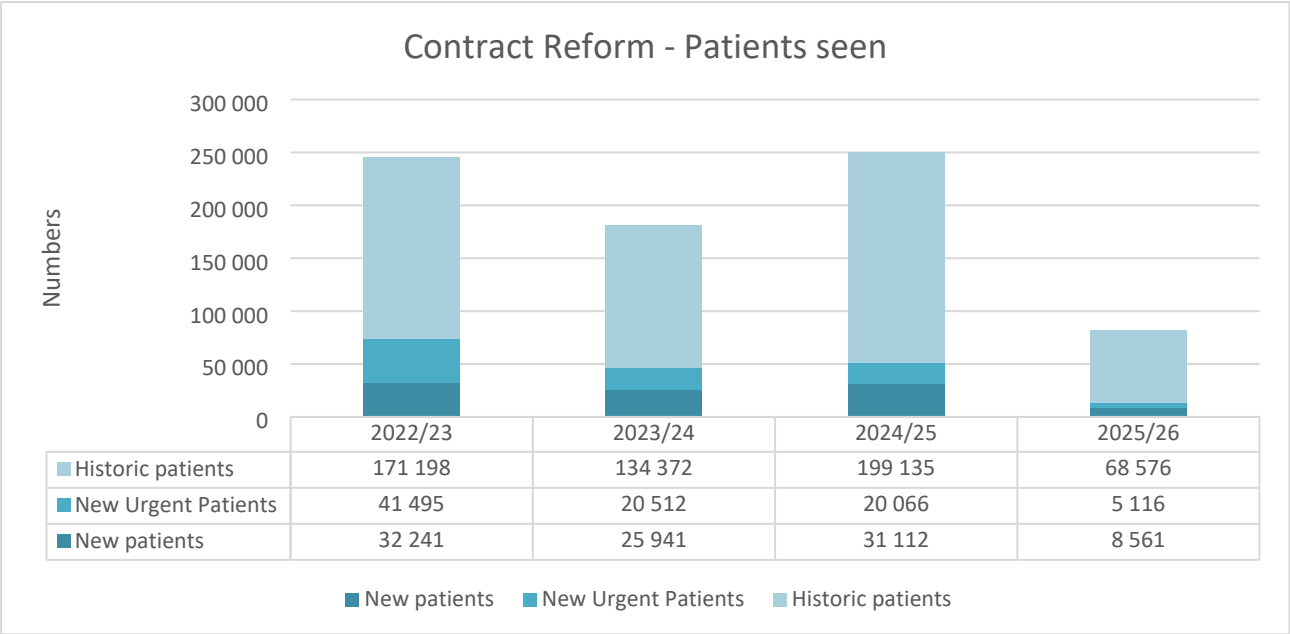


Fig 2. Patient figures across CR metrics

Emergency Dental Services (EDS)

Urgent access remains a key priority for the Health Board. From April 2025, the Health Board commissioned 87 core Emergency Dental Service (EDS) appointments per week with an additional 207 EDS appointments commissioned per week as a result of the Contract Reform requirements for 2025/26 (New Urgent Patients - NUP).

Over recent years, capacity within EDS has outweighed demand as a result of the CR NUP metric therefore, from 1 August 2025 the Health Board reduced the core EDS slots down to 71 appointments per week.

Table 2 is a summary of the number of EDS appointments provided per week, by borough:

Borough	**Contract Reform EDS appts per week**	**Core EDS appts per week**
Blaenau Gwent	33	19
Caerphilly	63	4
Monmouth	20	9
Newport	55	32
Torfaen	36	7
Totals	**207**	**71**

Table 2. EDS provision- core and CR

Figure 3 provides the breakdown of EDS utilisation for 2025/26 to date. The service continues to be monitored.

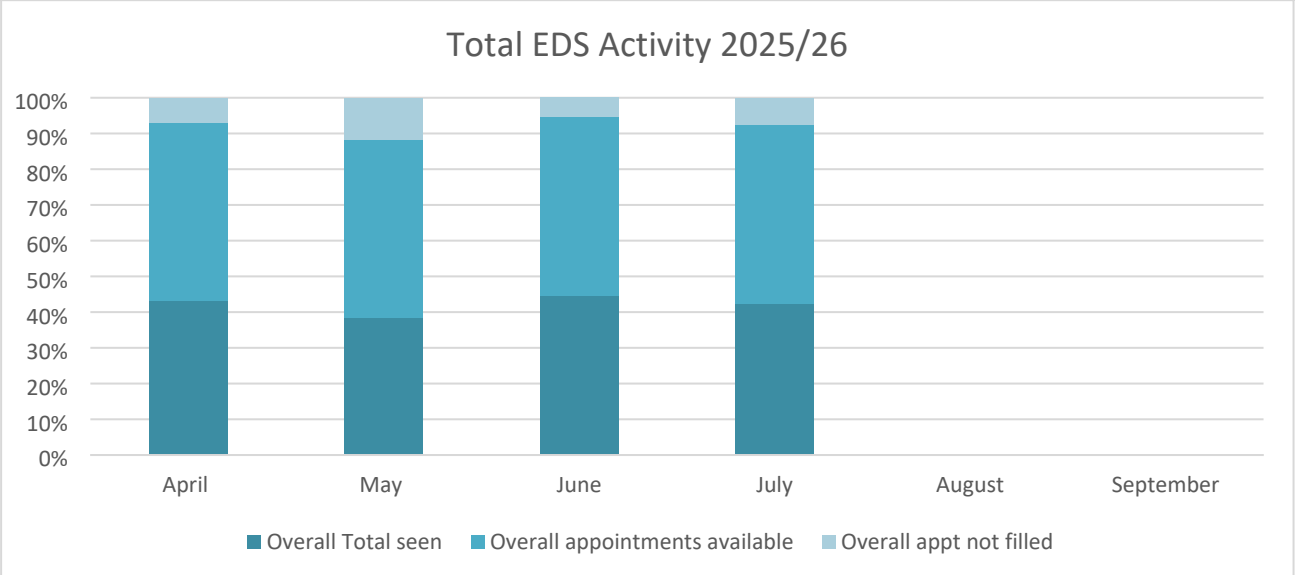


Fig 3. Total EDS activity 2025/26 - Core and CR

Dental Access Portal

Health Boards across Wales manage routine NHS GDS access differently with some patient lists being held by Health Boards and some held at individual practice level. Aneurin Bevan University Health Board has not historically held a central waiting list.

The absence of a consistent approach can lead to inequity in accessing routine NHS care across Wales and it is impossible to determine, either at Health Board level or Welsh Government level, the number of patients who are waiting to be assigned to a dentist or the length of time that patients might wait to access routine care.

In order to address these challenges, Welsh Government introduced a centralised digital platform for patients to register for routine NHS GDS provision.

The Dental Access Portal (DAP), designed and built by Digital Health Care Wales (DHCW), is a centralised, digital service that allows patients in Wales to access NHS dental services on a more equitable basis.

The full national roll out of the DAP commenced in November 2024 and Aneurin Bevan University Health Board went live in February 2025. There are currently 4,705 Health Board patients enrolled onto the DAP which is being actively managed within the Primary Care Contracting team, however patient allocations are dependent on practice capacity. It is expected that Health Boards may be monitored against the DAP in the future.

It is anticipated that the DAP will allow for better understanding of demand both locally and nationally, informing future service planning. It will also mean patients living in every area of Wales will, for the first time, be able to register their interest in receiving routine NHS care through one digital platform, making access simpler and fairer for everyone.

To be eligible to apply through the DAP, patients must:

- Be aged 16 or over (parents/guardians can apply for under 16s);
- Not have received routine dental treatment on the NHS in the last four years; and
- Live at an address in Wales for more than six months of the year or attend a Welsh GP practice.

Community Dental Service

The Community Dental Service (CDS) in Aneurin Bevan University Health Board is a salaried dental service providing oral healthcare services to vulnerable client groups in line with the Welsh Health Circular (2019)21; The Role of the Community Dental Service and Services for Vulnerable People[5].

The CDS provides dental care for vulnerable children and adults from 11 dental clinics as a core service and include programmes for children in special schools and units, Looked After Children, adults with learning disabilities, people who are homeless, those that misuse substance, asylum seekers and refugees and vulnerable older people.

Most of the Health Board clinics are equipped to provide special care dentistry and specialist paediatric dentistry. Six of the sites also offer dental sedation currently. The Health Board also has mobile dental units and provides a domiciliary service. CDS includes an Oral Health Promotion team that offers oral health promotion and advice for vulnerable adults and carers and works with teams supporting vulnerable adults. In addition, CDS also provides oral health prevention through the national programme Designed to Smile for children and Gwên am Byth. The CDS team comprises Dental Care Professionals who offer Direct Access and support the dentists in providing appropriate dental care.

The following provides a snap-shot of CDS activity across all Health Board clinics over time.

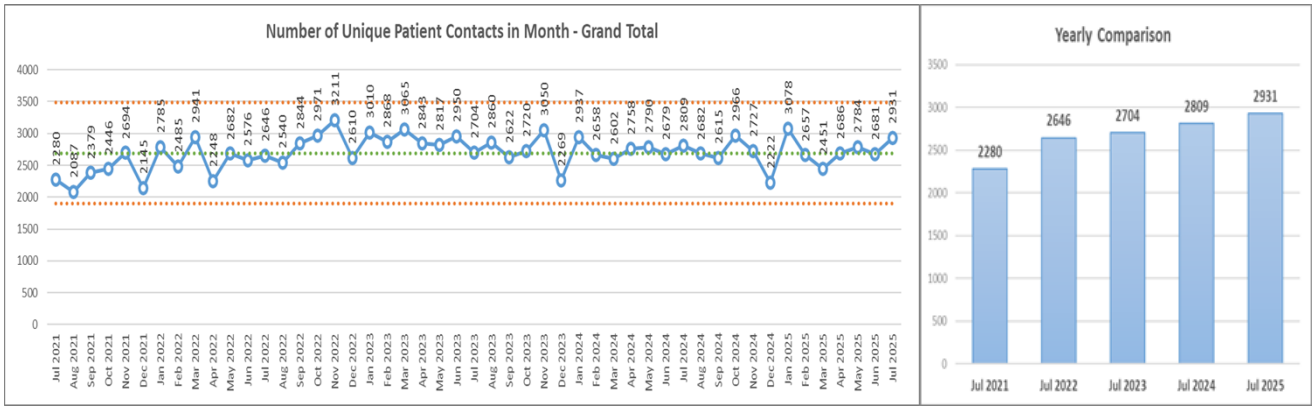


Fig 4. Unique patient contacts- CDS

There is integrated working with Primary Care GDS, Dental Public Health and Hospital Dental Services and with agreed care pathways for vulnerable adults in place. An established care pathway for Special Care Dentistry, paediatric dentistry,

GA triage for children, dental sedation and bariatric dentistry is in place as well as a central referral and triage system for domiciliary dental care that involves the GDS and CDS and supported by an Oral Health Improvement Practitioner.

The CDS also has the responsibility for the Health Boards dental Out of Hours and the Dental Helpline.

NHS Dental Services Consultation

WG issued a consultation on proposals to reform the delivery of NHS Dentistry through GDS contracts in Wales[6]. Responses to the consultation were required to be submitted by the 19 June 2025. Orthodontic and specialist services are not included in the proposals.

Recognising that reform is required, and following tripartite negotiations between September 2023 to October 2024, WG published an online consultation document to seek wider feedback on proposals from both the public and the dental profession.

It is proposed that a new national NHS GDS contract will be commissioned from April 2026 with the key changes to current working being:

- creating a single route of entry for people to access NHS dental services;
- the implementation of a different remuneration system that is fairer and more transparent;
- disincentivising unnecessary routine examinations;
- adjustment to patient charges due to changes in the remuneration system and a shift in how these charges are collected; and
- changes to contract terms and conditions, such as parental leave.

WG is expected to publish the outcome of the consultation in September 2025, with regulatory changes being made from February 2026 including:

- Revoking the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006;
- Revoking the National Health Service (Dental Charges) Regulations 2005; and
- The making of new versions of the above regulations and supporting directions.

Rationale for change

Building on the learning from the initial objectives of the CRP, WG set the vision for the future of NHS dentistry, seeking to:

- Improve population health, oral health, and general well-being through a greater focus on prevention, improve equitable access, experience, and quality of dental care for individuals and families;
- Enrich the well-being, capability, and engagement of the dental workforce; and
- Increase the value achieved from funding of dental services and programmes through improvement, innovation, use of best practice, and eliminating waste.

Within the consultation document, WG outline the intended outcomes and benefits for both patients and the profession[5] (p10).

For patients:

- ensure that every patient receives individualised advice and treatment where necessary for preventing tooth decay and gum disease;
- increase patient accountability for their own oral health;
- widen access so that there is greater capacity to provide treatment to those with disease;
- ensure that all treatment required to maintain oral health is available;
- change the way people with good oral health access services;
- establish new pathways that enable people with elevated levels of oral disease to receive treatment;
- improve the quality of dental services delivered; and
- ensure there is always capacity for new patients to get access for both urgent and routine care.

For dentists:

- Reduce administrative burden;
- Introduce a fairer and more transparent remuneration system;
- Encourage dentists to commit more of their time to providing NHS services;
- Enable skill mixing and making full use of the dental team; and
- Have clearer contractual controls to manage underperformance.

There are 14 issues detailed in the proposals, which are summarised below.

<u>Issue 1 – Contract Segmentation.</u>
Segmenting the Annual Contract Value (ACV) to ensure capacity for new patients requiring urgent and routine care as well as prevention and Quality Improvement (QI) activities.
Health Boards will have discretion to vary the % for each segment based on population need and practice profile.

<u>Issue 2 – Remuneration Model.</u>
Driven by a need to replace the current UDA model with a fairer and more transparent payment mechanism, the proposals outline a care package model offering remuneration for dental treatments based on complexity and time required. Detailed is the intention to set a maximum threshold on the number of high value treatments. Local flexibility will be allowed with prior agreement from the Health Board in areas with an evidence base for a disproportionately higher volume of complex treatments.

<u>Issue 3- End of Year reconciliation.</u>
Proposal to streamline the process and reduce the period for practice claim submissions from 62 days, after 31 March, to 20 days. Health Boards will then be expected to confirm the position within 28 days.

<u>Issue 4- Repair and Replacement.</u>
Under the new contract, the contractor will be responsible for providing a repair/replacement for any treatment that fails within 12 months for urgent treatment and 24 months for any treatment provided as part of a care package. These repair/replacements will not attract any additional payment and is a change from the current 12 months in any scenario.

Issue 5- Parental and Sickness Leave Absence.
Proposal to align to England in respect of applying a cap on payments for seniority, paternity, adoption, sick leave. The SFE does not currently make provision for this. Additionally, shared parental leave is to be included in the SFE.

Issue 6 – Urgent Care.
Expectations are strengthened in relation to the provision of urgent care. Practices will need to be open and available for urgent care Monday- Friday, 9am-5pm. Urgent appointments should include a full oral health assessment and any onward referral as appropriate. A long-term solution should be provided in order to provide relief from pain and/or further deterioration and should consist of permanent definitive treatment. Patients should be signposted to the Dental Access Portal (DAP) for accessing further routine care. Practices will be paid for any missed new urgent appointments providing they can evidence they have done everything possible to ensure the patients attendance.

Issue 7 – High Needs Patients.
High need patients i.e., those requiring ten or more interventions, are to be referred into a separate pathway. Health Boards are to determine locally if this is to be delivered through CDS or by commissioned services with GDS practices.
The care package remuneration model makes provision for a stabilisation course of treatment whilst referral is fulfilled. Once the high need course of treatment is complete, the patient is expected to re-join the DAP.

Issue 8 – Mandatory Services.
All level 1 treatment is to be carried out within the care package, in line with the guidance developed by the different specialities. Failure to do so will result in the rejection of onward referrals.

Issue 9 – Failure to Attend.
Work is ongoing to develop national guidance. The proposals outline that any patient allocated via the DAP/Health Board who fails to attend an initial assessment on two occasions will be returned to the DAP and will lose their positioning. Any patient in active treatment who misses 2 consecutive appointments or 3 within the care package will be returned to the bottom of the DAP.
Practices will be required to publish and display expectations of patients to attend appointments and the resulting consequences if they don't.

Issue 10 – Accelerated Cluster Development/Professional Collaboratives.
Participation in professional collaboratives will become a contractual requirement, with attendance at 4 meetings per year. Alignment with other primary care colleagues.

Issue 11- Contract Management.
Outlined is the intention to enable Health Boards to keep any performance related sanctions to a minimum through strengthened contractual levers.
Mid-year expected delivery will increase from 30% to 40% - failure to do so means that the Health Board can unilaterally implement a mid-year adjustment allowing reallocation of funding in year.

Full year activity – any achievement below 95% will result in a financial recovery, with the ability to apply the full underperformance up to 100%. Underperformance over two consecutive years and the Health Board can unilaterally apply a permanent reduction, via the Breach notice mechanism.
Activity achieved between 95% and 100% - associated underperformance may be carried over to the following financial year of recovery applied. If carried forward, the activity must be delivered in the first two months.
Activity between 100% and 105% - Health Board discretion applies to either carry forward with no financial increase or to pay for the over performance.
Activity exceeding 105% will be lost.
The notice period for any contract variation or termination will increase to 6 months.

Issue 12- Seniority Payment.
Proposal to remove the provision from the SFE, aligned to England.

Issue 13 – Patient Charge Revenue.
Proposal to introduce a centralised on-line payment system, managed by NHS Business Services Authority.
No proposals to change the exemption eligibility criteria.
Proposal to separate patient charge for dental appliances from the treatment charge with patients paying cost price for appliances directly to practices, and a set cap on the maximum treatment charge for patients at £384, aligned to other areas of the UK.

Issue 14- Patient Flow.
Patients are not currently registered at a dental practice, there is no proposed change to this. The DAP will be the primary access route into NHS dental care for all patients. Once a patient has been allocated to a practice via the DAP, attended for a 'check-up' they will either receive a care package from that practice, if clinically indicated or return to the DAP until their next routine check-up. Essentially this will extend patient recall periods to 18 months or more, however will be able to access urgent care from the assigned practice for 24 months.

Health Board response and anticipated impact

The Health Board has submitted a balanced and proportionate response to the consultation (annex a), in support of the rationale for change and a system which prioritises treatment based on risk and need, recognising that there are positive steps forward outlined in the proposals and acknowledging some distinct challenges and potential unintended consequences.

The positive support for the prioritisation of children and adults with high needs is welcomed. Greater clarity is needed on the detail regarding expected activity in relation to ACV to be able to fully assess the potential impact on routine access and access to treatment.

There is some concern regarding the extended recall intervals and current low risk patients and their ability to maintain good oral health in the interim and potential increased risk of not being able to identify more complex health issues early such as oral cancers.

As a Marmot Region, the Health Board appreciates and acknowledges the need to adapt to the needs of the population particularly in areas of higher need, however, flexibility and Health Board discretion can lead to a perception of unequal treatment of practices with a potential for a high degree of variance locally and across Wales.

Alignment to other primary care providers in areas such as cluster development is positive and supports the Health Board Place Based Care agenda. It is also felt that the additional provision in respect of contractual levers is helpful, as is the stipulation regarding urgent care provision.

The key areas for concern from the Health Boards perspective are:

- **Contract variations and terminations.** The Health Board is aware of significant concerns within the dental profession regarding the implications of the proposals with many indicating that their ongoing NHS commitment is under consideration. Ultimately, any contract variations or terminations have the potential to significantly reduce NHS access with implications for the wider system.
- **The lack of clarity** on the detail of the specifics.
- **Single route of access via the DAP** and implications for continuity of care and patients' confidence in the profession without the ability to build relationships. Subsequent extended waits to access routine care. The management of the DAP process is likely to become increasingly high in terms of administrational load for the Primary Care Contracting Team and may require additional resource.
- **Implications for CDS in respect of the high need pathway.** It is anticipated there will be additional funding for this element, however this will take significant management and resource. Any GDS provision in respect of this pathway will be dependent on providers coming forward as part of a procurement process.

Consideration of the application of the Health Services (Provider Selection Regime) (Wales) Regulations 2025[7] in respect of the commissioning of a new GDS contract is required. A national position is required to ensure consistency across Wales.

Through the Local Dental Committee (LDC) the profession has highlighted a number of concerns to the Health Board and to the British Dental Association (BDA) and have also submitted a response to the consultation.

Some of their concerns include complexities regarding the fee scale, the requirement to be available 9am-5pm Monday to Friday for urgent care, access via the DAP only, removal of seniority payments and the determination of laboratory fees for exempt patients. As a result, some of the profession feel that they are being disincentivised further from providing NHS care and fear that they will face additional recruitment challenges.

The Health Board is aware that this has led to a number of practices promoting private payment plans to existing NHS patients in anticipation of any change, with some details being mis-represented such as informing patients they will no longer be registered from the 1 April 2026. A small number of practices have approached

the Health Board for in-year reductions during 2025/26, to date there have been no notifications of contract terminations. However, it is impossible to predict at this stage what will come over the next few months and the publication of the consultation outcomes in September 2025 could result in an influx of practices providing the current 3-month notice period from January 2026, ahead of the implementation of a new contract in April 2026. Should this happen, the Health Boards ability to re-commission and maintain the same level of routine access will be severely impeded and the number of patients enrolled on the DAP and the length of time they remain on there is likely to significantly increase. Consideration will be required for alternative mechanisms for service delivery such as additional CDS resource, a distinct salaried model of delivery and/or increase in EDS provision. All of which have considerable financial and physical resource implications for the Health Board including estate and workforce. The Health Boards Integrated Oral Health Group will be a key enabler to these developments.

The GDS consultation and potential implications, should the proposals be implemented, are captured on the risk register and remains under review.

A further update will be provided to the Executive Committee and Board following the publication of the consultation and next steps.

In the interim period the Division and the Primary Care Contracting team will:

- Continue to manage and monitor all GDS contracts in accordance with the extant 2006 Regulations;
- Continue to liaise with practices and LDC to maintain relationships and work through individual contractual delivery;
- Apply usual processes for the management of any variations/terminations; and
- Develop and consider proposals through Integrate Oral Health Group for alternative models for service delivery for NHS GDS in anticipation of potential contract variations and terminations.

References/links

[1] The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006
[2] the-oral-health-and-dental-services-response.pdf
[3] TOGETHER FOR HEALTH: NATIONAL ORAL HEALTH PLAN FOR WALES 2013-18
[4] https://www.gov.wales/sites/default/files/publications/2019-04/taking-oral-health-improvement-and-dental-services-forward-in-wales.pdf
[5] the-role-of-the-community-dental-service-and-services-for-vulnerable-people.pdf
[6] Reform of NHS general dental services consultation
[7] The Health Services (Provider Selection Regime) (Wales) Regulations 2025

Annex a – Health Board Response

273373960.pdf

Argymhelliad / Recommendation

The Executive Committee is asked to:

- consider the content of this report and associated consultation documents;
- acknowledge the potential implications resulting from any NHS General Dental Services contract changes; and
- endorse the approach the Division has outlined in terms of its response, current contract management processes and the considerations in terms of risk mitigation.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy 2. Safe Care 3. Effective Care 5. Timely Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item. **Long Term –** ensures the ongoing access to NHS dental care. **Integration** – facilitates integrated working with independent contractors. **Involvement** –Involvement from the Local Dental Committee and Llais. **Collaboration** – Independent GDS Practices and cluster teams. Local Dental Committee and Llais. **Prevention –** this will ensure the ongoing provision of GDS services to patients.

General Dental Services: Contract Reform Overview and Current Position

Leanne Watkins
Chief Operating Officer
Lloyd Hambridge
Divisional Director for Primary Care, Community Services, Complex and Long Term Care

September 2025

General Dental Services (GDS)

- The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006
- 72 General Dental Contracts that are responsible for providing NHS dental care within the Health Board area
- Urgent dental care via the Health Boards Dental Helpline
- Additionally the Health Board commissions:
  - Community Dental Services, Domiciliary care, Orthodontics, Sedation, Oral Surgery, and GDS within HMP Usk for the populations of HMP Usk and HMP Prescoed
- Emergency Dental Services (EDS):
  - Personal Dental Services (PDS) contracts and Contract Reform (New Urgent Patients)
- Dental Access Portal (DAP):
  - Centralised digital platform that allows patients in Wales to access routine NHS dental services on a more equitable basis
  - Local implementation February 2025, 4700 patients currently active

GDS – Contract Reform

- Contract Reform Programme (CRP) – Commenced 2017:
  - A Healthier Wales: The Oral Health and Dental Services Response
  - The National Oral Health Plan 2013-18
  - Taking Oral Health Improvement and Dental Services Forward in Wales

- Sustainable NHS services based on:
  - Implementation of Prudent Healthcare Principles
  - Evidence-based prevention and
  - Development of a culture of continuous improvement

- Improve the oral health of the population, reduce oral health inequalities and deliver improved patient experience and outcomes

- Initial CRP - Assessment of Clinical Oral Risk and Need (**ACORN**):

- Delayed as a result of COVID-19, re-established in 2022/23 and has continued to evolve

GDS –Contract Reform

- ‘Opt-in’ since April 2022

- Metrics based on Annual Contract Value (ACV), specific application is subject to annual review by Welsh Government (WG)
  - **ACORN** (Assessment of Clinical Oral Risk and Needs assessment)
  - **New Patients**
  - **New Urgent Patients**
  - **Historical Patients**
  - **Fluoride Varnish**
  - More recently, **Quality Improvement** cycles

- UDA practices – performance against UDA activity only

- All NHS GDS practices are monitored and managed in accordance with the 2006 Regulations, financial recoveries are instigated in all instances where there is an underperformance identified

NHS Dental Services

- Welsh Government consultation on proposals to reform the delivery of NHS Dentistry through GDS contracts in Wales

- New national NHS GDS contract anticipated from April 2026. Key changes:
  - Creating a single route of entry for people to access NHS dental services via the DAP
  - Implementation of a different remuneration system that is fairer and more transparent
  - Disincentivising unnecessary routine examinations
  - Adjustment to patient charges due to changes in the remuneration system and a shift in how these charges are collected
  - Changes to contract terms and conditions, such as parental leave

- Regulatory changes required:
  - Revoking the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006
  - Revoking the National Health Service (Dental Charges) Regulations 2005
  - The making of new versions of the above regulations and supporting directions

- Indicative timeline
  - Consultation closed 19 June 2025
  - Publication of outcome - September 2025
  - Regulatory changes - February 2026
  - Implementation of new contract - April 2026

NHS Dental Services

- 14 separate issues detailed in the consultation:
  1. **Contract Segmentation Remuneration Model**
  2. **End of Year reconciliation**
  3. **Repair and Replacement**
  4. **Parental and Sickness Leave Absence**
  5. **Urgent Care**
  6. **High Needs Patients**
  7. **Mandatory Services**
  8. **Failure to Attend**
  9. **Accelerated Cluster Development/Professional Collaboratives**
  10. **Contract Management**
  11. **Seniority Payment**
  12. **Patient Charge Revenue**
  13. **Patient Flow**

Health Board Response

- Balanced and proportionate response, supportive of:
  - The rationale for change and a system which prioritises treatment based on risk and need
  - The prioritisation of children and adults with high needs
  - Alignment to other primary care providers in areas such as cluster development which supports the Place Based Care agenda
  - The additional provision in respect of contractual levers
  - The stipulation regarding urgent care provision

- The key areas for concern from the Health Boards perspective are:
  - Contract variations and terminations and reduced access. Indication that members of the profession are considering their ongoing NHS commitment
  - The lack of clarity on the detail of the specifics. Flexibility and Health Board discretion can lead to a perception of unequal treatment of practices with a potential for a high degree of variance locally and across Wales
  - Implications for CDS in respect of the high need pathway. Anticipated additional funding for this element. Any GDS provision in respect of this pathway will be dependent on providers coming forward as part of a procurement process.

Health Board Response

- Single route of access via the DAP
  - Implications for continuity of care and patients' confidence in the profession without the ability to build relationships.
  - Extended waits to access routine care,
  - Current low risk patients and their ability to maintain good oral health in the interim .
  - Potential increased risk of not being able to identify more complex health issues early, such as oral cancers.
  - The management of the DAP process is likely to become increasingly high in terms of administrational load.

- Local Dental Committee (LDC) has highlighted a number of concerns to the Health Board and to the British Dental Association (BDA) and have also submitted a response to the consultation:
  - Complexities regarding the fee scale
  - Requirement to be available 9am-5pm Monday to Friday for urgent care
  - Access via the DAP only
  - Removal of seniority payments
  - Determination of laboratory fees for exempt patients.

Outcomes and Mitigations

- High level of uncertainty regarding ongoing delivery of NHS GDS from April 2026
- Potential influx of contract terminations/reductions
- Consideration of alternative mechanisms for service delivery
- Risk Register inclusion
- Consideration of the application of the Health Services (Provider Selection Regime) (Wales) Regulations 2025 in respect of the commissioning of a new GDS contract. A national position is required to ensure consistency across Wales

Next Steps and

- The PCCS Division will:

  - Continue to manage and monitor all GDS contracts in accordance with the extant 2006 Regulations
  - Continue to liaise with practices and LDC
  - Apply usual processes for the management of any variations/terminations
  - Develop and consider proposals through Integrated Oral Health Group for alternative models for service delivery for NHS GDS in anticipation of potential contract variations and terminations

- The Board is asked to:

  - Consider the detail provided
  - Acknowledge the potential implications resulting from any NHS General Dental Services contract changes
  - Endorse the approach the Division has outlined in terms of its response, current contract management processes and the considerations in terms of risk mitigation

Statement: Reforming the Dental

Jeremy Miles MS, Cabinet Secretary for Health and Social Care
Oral Statement delivered in the Senedd Plenary - 23 September 2025

- Grateful for all contributions- 6,400 responses, broad support for contract reform
- Confirmation of new contract from April 2026 focused on prevention and individual patient oral health risk and need
- Centralised online payment system postponed to April 2027
- Retain existing exemption system
- Simpler dental charges for fee paying patients;
  - 50% of treatment package value (reduced from the proposed 55%)
  - maximum capped patient charge of £384, regardless of how much treatment required
- Acknowledged concerns regarding continuity of care- 'green' patients will not be required to re-join the Dental Access Portal
- Confirmation of Accelerated Cluster Development alignment with other Primary Care Contractors
- Development of high needs pathway over the coming months
- Capitation payment to practices; clinical judgement to base re-call intervals
- Focus on retaining and incentivising dental workforce
- Proposals regarding seniority payments and parental/sickness leave postponed

The Health Board awaits confirmation of the detail of the new GDS contract

12 March 2026

Provider Name
Practice Name
Practice Address

Dear Provider Name

RE: 2026 NHS GDS and Patient Charges (Wales) Regulations – Contract Transition xxxx

The purpose of this letter is to clarify the transitional arrangements associated with moving to The National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026 (The 2026 regulations) on 1 April 2026 and to notify you of Aneurin Bevan University Health Board's intention to vary the proportions of mandatory services.

Transition to the 2026 Regulations

A key feature of the 2026 Regulations is that they provide for the continuation and variation of existing contracts rather than their wholesale replacement. This approach has been deliberately adopted to provide stability and certainty for practices whilst modernising the contractual framework.

An "existing contract" (a contract entered into under the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 and in force immediately before 11 March 2026) has effect on and after 1 April 2026 as if entered into under the 2026 Regulations. This means that a current contract will continue without interruption, with the same financial value, automatically adapting to the new regulatory framework from 1 April 2026. No steps, such as issuing new contracts, will need to be taken to move to the new arrangements. Also, any bespoke contractual terms agreed between you and the Health Board will continue.

Notification of intent to vary – National Priorities

Under Regulation 17(7) of the 2026 Regulations, this letter confirms that the Health Board has determined that the 5% allocation for national priorities referred to in sub-paragraph (1)(f) is not required for the 2026/27 financial year in their area. The financial value associated with the element of contract will therefore be reallocated to the care packages element.

As set out in Regulation 17(7)(c) this reallocation is made without the need to consult.

Bwrdd Iechyd Prifysgol Aneurin Bevan
Is-adran Gofal Sylfaenol a Gwasanaethau Cymunedol
Ty Llanarth
Uned 1, Porth Trecelyn
Stryd y Bont
TRECELYN
NP115GH

Ffon: 01495 241200

Aneurin Bevan University Health Board
Primary Care and Community Services Division
Llanarth House
Unit 1, Newbridge Gateway
Bridge Street
NEWBRIDGE
NP115GH

Tel: 01495 241200

Notification of intent to vary proportions of mandatory services

Where an existing contract does not specify proportions of mandatory services in accordance with regulation 17, the standard proportions in regulation 17(1) apply from 1 April 2026.

Regulation 36(2) states that a Health Board may, before 16 March 2026, give notice to an existing contractor that different proportions apply. Aneurin Bevan University Health Board hereby gives notice that the proportions of mandatory service for contract number XXXXXXXX will be as follows from 1 April 2026:

- 3% for urgent treatment for new patients,
- 3% recall appointments between 18 and 24 months since the most recent appointment,
- 3% for new patient assessment,
- 86% to provide care packages,
- 5% for prevention services, and
- 0% for national priorities.

These proportions remain in place until otherwise agreed. You have 14 days to raise any concerns about this variation. Representations should be made in writing to Rachel Prangley, Head of Primary Care at rachel.prangley@wales.nhs.uk

Enclosed for your information is a copy of the Contract Implementation Guidance which provides further information on the changes included in the 2026 Regulations.

I would be grateful if you could sign the letter, as set out below, to confirm receipt and to confirm your continued provision of NHS Dentistry in line with the 2026 Regulations. All responses are required to be returned to ABB.PrimaryCareDepartment@wales.nhs.uk within 14 days of the date of this letter.

Yours sincerely,

Lloyd Hambridge
Divisional Director
Primary Care, Community Services, and Complex and Long-Term Care

Enc.

Signed on behalf of the Practice:
.....

Practice Name:
.....

Date:
.....

IMPLEMENTATION GUIDANCE FOR PROVIDERS OF GENERAL DENTAL SERVICES

The National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026

February 2026

Introduction

This guidance has been produced with the aim of supporting a consistent Wales-wide understanding of the operational aspects relating to the delivery of general dental services (GDS) following the introduction of the National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026 ("the 2026 Regulations").

The 2026 Regulations represent an evolution of the GDS contract framework rather than a complete replacement. Recognising the vital role that dental practitioners and practices play in the delivery of services across Wales, this guidance is intended to support a smooth transition to the new framework whilst maintaining service continuity and stability for both practices and patients.

Context

The GDS Contract is a legal contract between the respective Local Health Board and the GDS Contractor. The 2026 Regulations have been developed to modernise and clarify the contractual framework whilst preserving the fundamental structure of existing contractual arrangements.

The 2026 Regulations are made by the Welsh Ministers in exercise of the powers conferred by sections 57, 58, 59, 60, 61, 62, 63, 125, 126, 193 and 203(9) and (10) of the National Health Service (Wales) Act 2006 (the "2006 Act"). These powers provide the statutory foundation for the regulation of general dental services contracts, the prescription of required services, contract terms, payment directions, and patient charging arrangements.

Purpose

This guidance has been specifically produced to assist practitioners and practices in understanding and implementing the new contractual requirements, illustrating how the contractual changes are intended to work in practice at an operational level.

The guidance will be particularly relevant to Local Health Boards, persons who provide or may wish to apply to provide general dental services, persons who assist in the provision of general dental services or may wish to apply to assist in the provision of such services, and representative bodies.

The guidance provides clarity on aspects for immediate service implementation and on service changes that will take effect from 1 April 2026. In this respect, a lead-in time has been intentionally factored in, and the practice guidance summarised within this document is intended as a forward look, enabling practices and practitioners to prepare and make the necessary adjustments in a timely manner in advance of the legislative changes coming into force.

1. Variation of Existing Contracts: Continuity and Stability

1.1 The Fundamental Principle: Continuity Through Variation

A key feature of the 2026 Regulations is that they provide for the continuation and variation of existing contracts rather than their wholesale replacement. This approach has been deliberately adopted to provide stability and certainty for practices whilst modernising the contractual framework.

An "existing contract" (a contract entered into under the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 and in force immediately before 11 March 2026) has effect on and after 1 April 2026 as if entered into under the 2026 Regulations, and the parties may agree to vary an existing contract so that its terms conform with the 2026 Regulations before 1 April 2026. The Local Health Board is empowered to vary the contract in order to make it compliant with the new regulatory requirements upon giving notice (paragraph 57(2) of Schedule 3 to the 2026 Regulations).

This means that a current contract will continue without interruption, automatically adapting to the new regulatory framework from 1 April 2026. No steps will need to be taken to move to the varied contract.

1.2 Commencement and Transitional Provisions

The 2026 Regulations come into force on 11 March 2026, except for regulations 42 (revocation) and 43 (amendment) which come into force on 1 April 2026.

The transitional provisions are designed to ensure a smooth transfer to the new framework whilst recognising that practices and Local Health Boards require time to prepare. Importantly, where an existing contract does not specify the proportion of mandatory services in accordance with regulation 17, the standard proportions specified in regulation 17(2) will apply from 1 April 2026.

2. Legal Framework: Powers and Statutory Basis

2.1 Enabling Provisions in the 2006 Act

The 2006 Act provides the foundational legal architecture that enables the 2026 Regulations. Understanding these powers is important for appreciating how the regulatory framework operates and the extent of Local Health Boards' authority to manage contracts.

Section 57 (GDS Contracts): A Local Health Board may enter into a contract for the provision of primary dental services with a person who is a dentist or partnership of two or more persons at least one of whom is a dentist, called a "general dental services contract".

Section 58 (Prescribed Services): A general dental services contract must require the contractor to provide primary dental services of such descriptions as may be prescribed. This provision enables the Welsh Ministers through regulations to specify the mandatory services that must be delivered.

Section 60 (Payments): The Welsh Ministers may give directions as to payments under general dental services contracts, and a general dental services contract must require payments to be calculated, and to contain such other terms about payments, as may be determined in accordance with those directions.

Section 61 (Required Terms): Regulations may make provision as to the other terms and conditions which are to be included in a general dental services contract. Such regulations may make provision about standards of service, who is to perform services, variation (including provision about when a Local Health Board may impose a variation), termination, enforcement, and dispute resolution.

Section 62 (Dispute Resolution): Regulations may make provision for the resolution of disputes about terms of a proposed general dental services contract, including provision for reference of the matter to the Welsh Ministers or any other person for determination.

Sections 125 and 126 (Patient Charges): Regulations may provide for the making and recovery of charges for relevant dental services, including treatment provided under a general dental services contract. No charge may be made for relevant dental services provided to persons under 18, persons under 19 receiving full-time education, expectant mothers, or mothers who have given birth to a child in the previous 12 months.

2.2 Exercise of Powers in the 2026 Regulations

The 2026 Regulations exercise the powers conferred by sections 57, 58, 59, 60, 61, 62, 63, 125, 126, 193 and 203(9) and (10) of the 2006 Act. The Regulations provide comprehensive detail on contract terms, mandatory services, payment arrangements, patient charges, and the procedures by which Local Health Boards may vary contracts to reflect local population needs.

3. The New Service Framework: Mandatory Services and Proportions

3.1 Mandatory Services

A GDS contract must require the contractor to provide mandatory services, which comprise urgent treatment for new patients, 18 month plus recall appointments, new patient assessments via the Dental Access Portal, care packages, prevention services, urgent care for active patients, and a selection of national priorities as directed by Welsh Ministers.

This framework is designed to ensure that all practices provide a core set of essential services whilst allowing flexibility to respond to local population needs.

3.2 Standard Proportions

The standard proportions for mandatory services (other than urgent care for active patients) total 100% and comprise: 7% urgent treatment for new patients; 3% 18 month plus recalls; 10% new patient assessments; 70% care packages; 5% prevention; and 5% national priorities.

Urgent care for active patients must be delivered regardless of whether the regulation 17 proportions have been achieved and is not included in the overall percentage. This recognises that urgent care needs are unpredictable and must always be met.

3.3 Application to Financial Years

The proportions apply to each financial year, and where a contract begins on a date other than 1 April, to the remainder of that financial year and then to each financial year thereafter.

4. Flexibility: Local Health Board Power to Adjust Proportions

4.1 The Rationale for Adjustment

Recognising that population needs vary across Wales and even within Local Health Board areas, the 2026 Regulations provide Local Health Boards with the power to adjust, subject to consultation with affected contract holders, the standard proportions to ensure services are appropriately tailored to local circumstances. Going forwards this will require 28 days notice to be given to individual practices but initially this notice period is 14 days (i.e. adjustments before 1 April 2026).

A Local Health Board may depart from the standard proportions (within the overall 100%) if satisfied that different levels of need in its area require adjustment to ensure patients are properly provided for. Such adjustments may be made for the whole area, part of an area, or in relation to a single practice.

This power provides important flexibility whilst ensuring that any departures from the standard framework are justified by local population needs.

4.2 Standard Route: Adjustment for a Single Practice

Where a Local Health Board wishes to adjust proportions for a single practice (other than through the expedited national priorities reallocation route described below), procedural safeguards apply to ensure fairness and transparency.

Consultation Requirement: Before altering proportions for a single practice, the Local Health Board must consult the contractor and give at least 28 clear calendar days' notice.

Consideration of Representations: The Local Health Board must have regard to representations made by the contractor within the 28-day period (and need not have regard to representations made outside that period).

Dispute Resolution: If the contractor does not agree with the amended proportions imposed by the Local Health Board, the contractor may refer the dispute to the Welsh Ministers for determination under the dispute procedure set out in Schedule 3.

These provisions ensure that practices have the opportunity to be heard before adjustments are made and access to independent dispute resolution if agreement cannot be reached.

4.3 Expedited Route: Reallocation of National Priorities Proportion

The 2026 Regulations also provide an expedited mechanism for reallocating the national priorities proportion where it is not required for its intended purpose.

Where a Local Health Board determines that the 5% allocation for national priorities is not required (in whole or in part) for a specified period, it may reallocate the unused national priorities proportion to care packages for a specified period, for the whole area, part of an area, or one or more practices.

Importantly, where this reallocation route is used, the consultation requirements do not apply, but the Local Health Board must notify the affected contractor(s) in writing of the revised care package proportion, the period for which it applies, and the effective date, which must be at least 14 clear calendar days after notification.

This expedited route recognises that national priorities may vary over time and allows Local Health Boards to respond quickly to reallocate resources to care packages where appropriate.

5. Monitoring and Accountability: Delivery Reports and Financial Adjustments

5.1 Mid-Year Delivery Reports

To ensure that service delivery is monitored throughout the year and to enable early intervention where necessary, the 2026 Regulations require mid-year reporting.

Local Health Boards must provide mid-year delivery reports in a prescribed form, within a period not before the last day of month 6 and not later than the last day of month 7, reporting overall and category percentages over the relevant preceding 6 months.

If the mid-year reported total is below 40%, the Local Health Board may implement a mid-year financial adjustment reducing payments for the remainder of the year and must notify the contractor within 14 clear calendar days with reasons.

This mid-year checkpoint is designed to identify significant delivery issues early, allowing practices to take corrective action and Local Health Boards to provide support where needed.

5.2 Annual Delivery Reports

Local Health Boards must provide annual delivery reports in a prescribed format, with specific timing rules depending on contract type (including for contracts of standard duration type, not after the twentieth day of the fourteenth month).

The annual report triggers a range of potential consequences depending on performance levels:

Underperformance (below 95%): If annual delivery is below 95%, the Local Health Board may reduce payments for the next (and following) financial years and may apply financial recovery up to 100% of the underperformance but must give 14 clear calendar days' notice of intention and reasons before adjustment or recovery.

Performance between 100% and 105%: If annual delivery is between 100% and 105%, the Local Health Board must either reduce the next year's required activity back to 100% or remunerate the contractor for the additional work.

Performance over 105%: If delivery exceeds 105%, the Local Health Board must not increase required activity or remunerate unless there was prior written agreement dated at least 60 clear calendar days before year-end.

These provisions balance accountability with fairness, ensuring that underperformance is addressed whilst preventing practices from being financially penalised for reasonable variations in service delivery.

5.3 First Reporting Period (Transitional Arrangements)

Recognising that the introduction of the new framework requires transitional arrangements, specific timing modifications apply to the first reporting periods.

For contracts that started before 1 October 2025, the first mid-year delivery report must be provided after 30 September 2026 and no later than 31 October 2026. For contracts that started before 1 April 2026, the first annual delivery report must be provided after 31 March 2027 and no later than 30 April 2027.

These transitional timings allow practices to establish baseline delivery patterns under the new framework before full reporting obligations commence.

6. Step-by-Step Process for Adjusting Proportions

To assist practices and Local Health Boards in understanding how the proportions adjustment mechanism works in practice, the following step-by-step guidance is provided.

Note. Going forwards this will require 28 calendar day's notice to be given to individual practices but initially this notice period is 14 calendar days (i.e. adjustments before 1 April 2026).

Step 1: Identify the Standard Proportions

The baseline starting point is the standard proportions specified in regulation 17:

Service Category	Standard Proportion
Urgent treatment for new patients	7%
18 month plus recalls	3%
New patient assessments	10%
Care packages	70%
Prevention services	5%
National priorities	5%
Total	**100%**

Note: Urgent care for active patients is mandatory but not included in the percentage allocation.

Step 2: Determine Whether Adjustment is Justified

A Local Health Board considering adjustment must be satisfied that different levels of need in its area require the adjustment to ensure patients are properly provided for (regulation 17(3)).

Adjustments may reflect factors such as:

- Demographic characteristics of the registered population
- Prevalence of particular oral health conditions
- Access challenges in rural or underserved areas
- Workforce availability and practice capacity
- Alignment with local population health needs assessments

Step 3A: Standard Adjustment Route (Single Practice with Consultation)

3A.1 Consultation Notice (28 Clear Days): The Local Health Board must provide written notice to the contractor setting out the proposed adjusted proportions and giving at least 28 clear calendar days for consultation (regulation 17(5)).

3A.2 Contractor Representations: The contractor may make representations within the 28-day period. These representations should address:

- Whether the proposed proportions are appropriate to the practice's patient population
- Any practical difficulties in delivering the adjusted proportions

- Alternative proportion adjustments that might better meet local needs

3A.3 Local Health Board Consideration: The Local Health Board must have regard to representations made within the 28-day period (regulation 17(6)).

3A.4 Final Decision and Implementation: The Local Health Board determines the final proportions to apply, taking account of representations received.

3A.5 Dispute Resolution: If the contractor does not agree with the imposed proportions, the contractor may refer the matter to Welsh Ministers for determination under Schedule 3 (regulation 17(7)).

Step 3B: Expedited Route (National Priorities Reallocation)

3B.1 Determination: The Local Health Board determines that the national priorities allocation (or part of it) is not required for a specified period.

3B.2 Reallocation Decision: The Local Health Board decides to reallocate the unused national priorities proportion to care packages, specifying:

- The amount being reallocated
- The period for which the reallocation applies
- The geographic scope (whole area, part of area, or specific practices)

3B.3 Written Notice (14 Clear Calendar Days): The Local Health Board must notify affected contractor(s) in writing of:

- The revised care package proportion
- The period for which it applies
- The effective date (which must be at least 14 clear calendar days after notification)

(regulation 17(8))

3B.4 Implementation: The adjusted proportions take effect from the specified effective date.

7. Critical Timings: Preparing for 1 April 2026

7.1 Key Dates

Date	Event
11 March 2026	The 2026 Regulations come into force (except regulations 42-43)
Before 16 March 2026	Deadline for Local Health Boards to give notice of adjusted proportions to apply from 1 April 2026
1 April 2026	Existing contracts take effect under 2026 Regulations; standard proportions apply unless adjusted; regulations 42-43 come into force

7.2 Pre-1 April Adjustment Window

A particularly important transitional provision allows Local Health Boards to set adjusted proportions for existing contracts before the new framework fully comes into effect.

Before 16 March 2026, a Local Health Board may give notice to a contractor under an existing contract that proportions different from the standard proportions will apply from 1 April 2026.

If such notice is given, the contractor may make representations within 14 clear calendar days of receiving it, and the Local Health Board must have regard to any representations before determining the proportions to apply from 1 April 2026.

This abbreviated timeline reflects the transitional nature of the arrangements and the need to have proportions settled before the new framework takes effect on 1 April 2026.

7.3 What Happens if No Adjusted Proportions Are Set

Where an existing contract does not specify the proportion of mandatory services in accordance with regulation 17, the standard proportions specified in regulation 17(2) apply from 1 April 2026.

This default position provides certainty: in the absence of adjusted proportions, the standard framework automatically applies.

8. Transition Advice

8.1 Transitional Preparation

The pre-16 March deadline for Local Health Boards to give notice of adjusted proportions, combined with the 14-day representation period for contractors, means that decisions about proportions for 2026/27 need to be considered before the regulations are in force.

8.2 Recommended Actions for Local Health Boards

Conduct Needs Assessment: Review population health data, service delivery patterns, and local circumstances, including where recent contract terminations have been enacted, to determine whether the standard proportions are appropriate for your area or whether adjustments are justified.

Engage with Practices Early: Where you anticipate that adjusted proportions may be necessary, initiate informal discussions with affected practices before formal notice is given. Early engagement presents the best opportunity to support practices in understanding the rationale for adjustments and to reach agreement where possible.

Prepare Justification: Document the evidence base for any proposed adjustments, including population health data, service utilisation patterns, and how the adjusted proportions will ensure patients are properly provided for.

Meet the Deadline: Ensure that any notice of adjusted proportions is given before 16 March 2026 to enable the adjusted framework to take effect from 1 April 2026.

8.3 Recommended Actions for Practices

Review Your Service Delivery: Assess your current service mix and patient population needs. Consider whether the standard proportions are appropriate for your practice or whether adjusted proportions would better reflect your patient demographics and clinical caseload.

Engage with Your Local Health Board: If you believe adjusted proportions are necessary for your practice, initiate discussions with your Local Health Board now. Proactive engagement demonstrates professional responsibility and increases the likelihood of reaching mutually agreed arrangements.

Prepare Your Case: If you anticipate receiving notice of adjusted proportions from your Local Health Board, prepare your analysis and evidence in advance. This will enable you to make comprehensive and well-reasoned representations within the 14 calendar day period within which you must make your representations against the adjustments.

Plan for the Standard Framework: If adjusted proportions are not agreed, ensure you understand how to deliver against the standard proportions from 1 April 2026 and make any necessary operational adjustments to your service delivery model.

8.4 A Supportive Approach

The introduction of the proportions framework represents a significant evolution in how GDS services are structured and monitored. It is recognised that this change requires adaptation by both Local Health Boards and practices.

The transitional arrangements have been designed to allow time for preparation and adjustment. The approach is intended to be formative and supportive wherever possible, with monitoring and reporting mechanisms aimed at early identification of challenges and collaborative problem-solving rather than punitive intervention.

Early engagement between Local Health Boards and contractors presents the best opportunity to ensure the new framework operates effectively and sustainably from the outset, supporting service improvement and meeting patient needs.

9. Summary: Key Principles of the New Framework

The 2026 Regulations introduce a modernised GDS contract framework built on the following key principles:

Continuity: Existing contracts continue and take effect under the new Regulations from 1 April 2026, ensuring stability for practices and patients.

Statutory Basis: The framework is underpinned by clear legal powers in the 2006 Act, providing certainty about the scope and limits of regulatory requirements and Local Health Board authority.

Structured Service Delivery: The proportions framework provides structure and accountability whilst maintaining flexibility for Local Health Boards to adjust proportions based on local population needs.

Procedural Safeguards: Consultation requirements, representation rights, and dispute resolution procedures ensure fairness and transparency in the adjustment process.

Monitoring and Support: Mid-year and annual reporting enables early identification of delivery challenges and opportunities for support and intervention.

Proactive Preparation: The short transitional timeline requires both Local Health Boards and practices to continue communicating to support the preparation for implementation.

The overarching aim is to create a contract framework that supports high-quality dental services across Wales, reflects local population needs, and provides clarity and certainty for all parties.

10. Comparative Analysis: Key Differences and Continuities

The following table sets out the key differences between the 2026 Regulations and the 2006 GDS Contracts Regulations, as well as important areas of continuity.

Aspect	2006 Regulations	2026 Regulations	Nature of Change
Contract Continuity	Contracts entered into under 2006 Regulations	Existing contracts continue and take effect as if entered into under 2026 Regulations from 1 April 2026 (regulation 67)	**Continuity with transition**
Mandatory Services Framework	General requirement to provide primary dental services; specific services prescribed in Schedule 3	Structured framework of mandatory services with defined categories: urgent treatment for new patients, 18 month plus recalls, new patient assessments, care packages, prevention, urgent care for active patients, and national priorities (regulations 10-14)	**New structured approach**
Service Proportions	No prescribed proportions for service categories	Standard proportions totalling 100%: urgent treatment for new patients (7%), 18 month plus recalls (3%), new patient assessments (10%), care packages (70%), prevention (5%), national priorities (5%); urgent care for active patients mandatory but outside percentage allocation (regulation 17)	**New proportions framework**
Local Health Board Power to Adjust Proportions	No equivalent provision	LHB may depart from standard proportions if satisfied different levels of need require adjustment; may apply to whole area, part of area, or single practice (regulation 17(3)-(4))	**New flexibility mechanism**

Consultation on Proportion Adjustments	No equivalent provision	28 clear days' notice and consultation required for single practice adjustments (except national priorities reallocation); LHB must have regard to representations; dispute resolution available (regulation 17(5)-(7))	**New procedural safeguard**
National Priorities Reallocation	No equivalent provision	Expedited route: LHB may reallocate unused national priorities proportion to care packages with 14 clear days' notice, without consultation requirement (regulation 17(8))	**New expedited mechanism**
Mid-Year Delivery Reports	No equivalent provision	LHB must provide mid-year report (months 6-7) showing delivery percentages; if below 40%, LHB may reduce payments for remainder of year with 14 clear days' notice (regulation 18)	**New monitoring mechanism**
Annual Delivery Reports	No equivalent provision	LHB must provide annual report; consequences for under/over-delivery: below 95% may trigger payment reduction/recovery; 100-105% requires LHB to reduce next year's quantity or remunerate; over 105% requires prior agreement (regulation 18)	**New accountability framework**
Transitional Reporting Timings	N/A	Modified timings for first mid-year and annual reports for existing contracts (regulation 68)	**Transitional provision**
Pre-1 April Adjustment Window	N/A	LHB may give notice before 16 March 2026 of adjusted proportions to apply from 1 April 2026; contractor may make representations within 14 clear days (regulation 69)	**Transitional provision**
Payments	Determined in accordance with Welsh Ministers' directions under section 60 of 2006 Act	Determined in accordance with Welsh Ministers' directions under section 60 of 2006 Act (regulation 8)	**Continuity**
Dispute Resolution	Provision for disputes to be referred to Welsh Ministers (Schedule 3)	Provision for disputes to be referred to Welsh Ministers (Schedule 3)	**Continuity**
Contract Variation by LHB	LHB may vary without consent to comply with legislation/directions (Paragraph 60 of Schedule 3)	LHB may vary without consent to comply with legislation/directions (Paragraph 57, Schedule 3)	**Continuity**
Performer Lists	Provisions regarding dental performer lists	Provisions regarding dental performer lists maintained	**Continuity**
Dental Access Portal	No specific provision	New patient assessments must be via Dental Access Portal (Part 2 of Schedule 1)	**New digital requirement**
National Priorities Direction	No equivalent provision	Welsh Ministers may direct categories of treatment/care to be provided as national priorities (regulation 14)	**New strategic mechanism**

Areas of Fundamental Continuity

The following aspects remain **unchanged** and continue to apply under the 2026 Regulations:

- The fundamental nature of the GDS contract as a contract between Local Health Board and contractor under section 57 of the 2006 Act
- The requirement for payments to be determined in accordance with Welsh Ministers' directions
- Patient charging principles and exemptions (though presentation restructured)
- Dispute resolution procedures enabling referral to Welsh Ministers
- Contract variation procedures allowing LHB to impose variations to comply with legislation
- Termination grounds and procedures (though presentation restructured)
- Performer list requirements and procedures
- Core contractual obligations regarding clinical governance, record-keeping, information provision, and professional standards
- Patient registration and list management principles
- Regulatory oversight and enforcement mechanisms

Conclusion

The 2026 Regulations represent a considered evolution of the GDS contract framework, introducing greater structure and clarity through the proportions system whilst preserving the fundamental contractual architecture and ensuring continuity for existing contracts.

The new framework has been designed to balance accountability with flexibility, enabling Local Health Boards to tailor service proportions to local population needs whilst providing procedural safeguards and dispute resolution mechanisms to protect contractor interests.

With the 1 April 2026 implementation date approaching and the narrow pre-16 March window for adjustment notices, both Local Health Boards and practices are encouraged to engage proactively in assessing needs, preparing cases, and initiating dialogue to ensure the smoothest possible transition to the new framework.

The overall objective is to support the delivery of high-quality dental services across Wales that are responsive to local population needs, accountable through transparent monitoring, and delivered within a clear and stable regulatory framework.

Queries relating to the implementation of the 2026 Regulations should be directed to your Local Health Board in the first instance.

Wales NHS Dental Contract

Case Studies – Understanding the Segmented Contract

2026

The Remuneration Model

The 2026 NHS Wales GDS contract builds on the stability and fairness established since 2022, offering a clearer and more predictable framework for practices. It moves decisively away from the volatility of the historic UDA system, recognising clinical complexity, supporting prevention, and preserving the professional autonomy that practitioners value. Its components operate as a single, coherent model designed to reduce uncertainty, strengthen professional judgement, and ensure that practices serving high-need populations are not disadvantaged. Teams across Wales have already demonstrated the benefits of this approach; the 2026 framework consolidates that progress and provides the stability required for confident long-term planning.

A central focus of negotiations was the future remuneration model for NHS dentistry. NHS Wales, Welsh Government, and the Welsh General Dental Practice Committee shared a clear view that the UDA system should be replaced with a fairer and more transparent mechanism. Although fee-for-item (FFI) arrangements offer theoretical transparency and remain familiar to many within the profession, they inherently incentivise treatment rather than prevention. This makes FFI incompatible with a modern, risk-based preventive policy direction and unsuitable as a sustainable basis for improving population oral health.

Following detailed consideration of the interim arrangements and alternative weighted capitation models, there was agreement that a care-package approach—linking payment to the complexity and time associated with common treatments—provides the most balanced and future-proof solution. This document sets out the proposed fee structure and explains how the new contract operates at practice level.

The illustrative vignettes included here are intended to support clinical teams in planning care under the new model. They are guidance tools, not substitutes for national, evidence-based clinical standards. A separate patient-facing guide provides public transparency, while this document is designed to support professional understanding and confident implementation.

1 Care packages
Renumeration models

1. **Simple restorative care package (SRCP) £72.06**
   This includes permanent fillings, temporary/intermediate crowns, Hall crowns, and extractions up to a maximum of four teeth

2. **Extensive restorative care package (ERCP) £137.50**
   As per simple restorative care package (SCRP) for patients who need treatment on 5 to 8 teeth

   Note – For both restorative care packages composite material should be used for anterior teeth (canine to canine). Posterior teeth to use clinically appropriate materials, which include both amalgam and amalgam alternatives

   ***Note**: Once the treatment required exceeds four teeth, the extensive package is claimed, it is not permitted to claim multiple simple restorative care packages, for example a patient needing eight teeth treated would be managed under one extensive restorative package, not two simple caries packages. For nine teeth it would be one simple and one extensive. For sixteen teeth it would be two extensive packages and so on. Contemporaneous record keeping of the treatment required will be essential to evidence claiming.*

3. **New patient assessment £54.41**
   To include global health and clinical assessment (including soft tissue), intraoral radiography, special tests, and removal of plaque retentive factors.

   Prevention, as per Delivering Better Oral Health (DBOH) guidance to support patients that are ready to change

KEY POINTS

- The contract is no longer activity based, signaling the end of UDAs as a means for remunerating dental care.
- Care packages are additive - based on patient need – depending on the clinical assessment.
- The principle of care packages is based on time to deliver care, not activity.
- Prevention is integral to care packages and covered by a capitated 5% ACV payment.
- The segmented aspect of this contract will support skill mix.
- ACORN will continue to be the risk and need assessment tool, but the data points will be automatically generated to the NHSBSA.

their oral health behaviours and include:

- Improving oral hygiene (includes oral hygiene instructions and removal of plaque retentive factors)
- Optimising exposure to fluoride
- Reducing sugar intake and healthier eating
- Stopping smoking and tobacco use
- Reducing harmful alcohol consumption

Referral to appropriate services like Help Me Quit (if agreed by the patient) is also a part of the prevention.

Topical fluoride application, high concentration fluoride toothpaste prescription, and fissure sealants (for enamel caries) as appropriate.

***Note** - Following a new patient assessment, if treatment is identified an appropriate care package is claimed*

***Note** - A global oral health assessment refers to a comprehensive evaluation of oral health status, needs, and risk determinants (see q.35 on page 35). Please refer to DBOH toolkit for detailed guidance.*

4. Periodontal care package £97.06

Entry assessed on engagement from assessment, but patient must achieve satisfactory plaque scores by third OHE visit as advised by BSP guidance. To include plaque score and tailored Oral Hygiene Instructions, 6 Point Pocket Chart, Removal of Plaque Retentive Factors and Pocket debridement. The care package is for a single course of periodontal treatment. Up to two care packages can be claimed in a financial year per patient.

Contractor will be expected to follow national guidance on managing patients with periodontal disease: https://www.bsperio.org.uk/assets/downloads/Delivering_stepwise_Care_version_2_7th_August_2025.pdf

5. Denture care package £172.79

Excludes laboratory fees (which will be paid directly by the patient, unless exempt from NHS charges). Includes upper and lower dentures, including Cobalt Chrome dentures if clinically indicated. This includes all denture work provided in this care package and can be a

- 3% of the ACV is for recalling low need patients. Practices will be expected to recall 80% of their adult active patients who were given a recall of 18+ months at their previous visit. Failure to achieve could incur a financial sanction and/or a contractual breach notice.
- All decisions on Associate remuneration will continue to be the responsibility of the contract holder.
- There will be cases which may need to be extended over different financial years, which is allowable under the care package framework.
- Non-exempt patients will pay 50% of the care package fees up to a maximum of £384 (lab bills are in addition) per course of treatment.
- The amount of permanent crown, bridge, inlay, onlay and veneer care packages are capped at 10% of the ACV. Health Board permission must be sought and gained to go over this.

combination of metal and acrylic dentures.

All laboratory items such as special trays, study models should be included in the final laboratory bill. Dentures will be warranty for a period of 2 years at the point of fitting. Easing and adjustments will be free of charge for the 2-year period, and no care package will be claimable.

When fitting immediate dentures, only easing or adjustments for 2 months post fitting will be provided free of charge.

Lost and misplaced dentures will not be covered under the warranty period and replacement will be subject to the appropriate care package

Digital impression techniques are included in the care package

6. Stabilisation care package £150

For patients with unstable dental disease who present with 7+ carious teeth, where at least two of the teeth have caries extending to proximity or into pulp and the patient is keen to engage.

This will include extractions, Delivering Better Oral Health prevention, Glass Ionomer intermediate restorations, pulp extirpation, removal of plaque retentive factors.

7. Anterior root canal package £182.35

For up to two teeth (1-3) and includes any permanent restorations. For cases that require a laboratory made temporary crown the patient will be required to pay the laboratory bill to the practice. For exempt patients this will be re-imbursed using the tariff.

Clinicians will be expected to follow national guidelines, including placement of rubber dam. Deviation of the guidance will require clinical justification.

8. Posterior root canal package £365.44

Molar and pre-molar root canal package, for up to two teeth. This includes second molars if the tooth is

- 5% of the ACV is for adaptive commissioning. Health boards, by mutual agreement, will have the discretion to use this financial segment of the contract to commission a service. For example, a diabetic periodontal disease pathway, or in-practice quality improvement project.
- Failure to achieve a mutually agreeable use of the 5% will result in the funding being added to the ACV segments.

strategically necessary to maintain function (eg; patients who have a lack of posterior support, a medical reason to retain etc). Clinicians will be expected to follow national guidelines, including placement of rubber dam. Deviation of the guidance will require clinical justification recorded in the clinical notes.

For cases that require a laboratory made temporary crown then the patient will pay the appropriate laboratory fee. For exempt patients this will be reimbursed using the tariff.

NOTE: T*emporary chairside crowns, temporary and permanent fillings are included in the anterior and posterior root canal package. If a patient is reviewed at a subsequent visit and requires cuspal coverage (such as a crown) then an additional crown and bridge care package can be claimed. If a crown is placed within the endodontic care package no additional care package is claimable, but the laboratory bill is still applied for non-exempt patients (or re-imbursed for exempt patients).*

9. Recall examination £50 per visit

Patients having a recall examination will be put on a recall interval aligned to NICE guidance. The number of recall intervals should reflect the risk and need of the patient. A robust clinical monitoring process will take place to confirm that the patient is on the appropriate risk assessed recall package. The recall visit includes a full oral health assessment including a basic periodontal examination, radiographs, soft tissue, fluoride application, removal of plaque retentive factors, prevention etc where appropriate.

10. Permanent Crown, bridge, inlay, onlay, and veneer care package for permanent teeth £280.88

Up to a 3 unit bridge (unit is defined as retainer and pontic) or up to two crowns or, where a crown and bridge are both provided, a single cantilever bridge and single crown would count to a single care package. This package includes study models, diagnostic wax ups, face

bow recordings, posts and cores etc. A simple cantilever bridge and a single crown will generate a single care package. A four-unit bridge would count as two care packages and so on. The package will include all tooth preparation types necessary for the crown, bridge, inlay, onlay, and veneer that the patient has consented to. Excludes laboratory fees (which is patient funded, unless exempt). A comprehensive laboratory reimbursement tariff will be published, subject to annual DDRB uplift.

Digital impression techniques are included in the package.

All luting cements and techniques are included in the package.

Any clinical photos to determine shades are also included in the care package

11. Urgent care package £75

Urgent appointments will include an oral health assessment (including soft tissue) and onward referral where appropriate.

Urgent care should provide relief from pain and/or prevent significant deterioration of a particular problem, with an onward referral if required. This care should normally be done in a way that provides, whenever possible, a long-term solution.

Where appropriate, and with the patient's consent, urgent care should consist of permanent definitive treatment, including restorations. When definitive treatment is contraindicated or not possible, justification for any treatment or care provided will be recorded in the patient's clinical record.

For patients that do not currently have an existing relationship with the practice, the patient should be made aware of their responsibilities and requirement to seek further care to resolve the urgent issue or prevent a recurrence. When routine treatment is needed, they should be advised to enrol on the Dental Access Portal.

Treatment provided for new urgent patients under an urgent care slot is warranted for a period of 12 months from the initial appointment. A patient can directly contact the practice if they continue to have issues with the same tooth. No further care package or patient charge can be generated.

The urgent care package fee is only paid for patients who are not historic patients of the practice

The number of urgent slots agreed are calculated based on the £75 financial value.

12. Miscellaneous care package £50

For treatment and interventions for patients that fall outside a current care package or outside the warranty period ie;

- Denture repair/addition/re-line (see denture care package regarding immediate dentures) for dentures not provided by the contract holder in the last 2 years.
- Denture ease (up to two per financial year for dentures older than 2 years or made by another contract holder and for immediate dentures fitted more than 2 months ago)
- Study models (not part of another care package and one claim per year)
- Bite raising appliance (includes study models). A two-year warranty applies
- Biopsy per site (includes sutures, pathology report, follow up and post-operative complications/management)
- Repair/Recement of a crown, bridge, or veneer (one year warranty)
- Removal of sutures for procedures external to the practice (eg an extraction carried out by specialist services)
- Pericoronitis. Only one miscellaneous care package can be claimed relating to the same tooth per episode regardless of the number of visits
- ANUG per episode. Only one miscellaneous care package can be claimed per episode regardless

of the number of visits.

- Orthodontic urgent issues when the patient's own orthodontist is unavailable. Only one miscellaneous care package can be claimed within a 3-month period.
- Arrest of haemorrhage (for extractions carried outside of a care package, includes sutures and removal) regardless of the number of visits to manage the same site only one miscellaneous care package can be claimed
- Dry socket (for extractions carried outside of a care package). Regardless of the number of visits for the same site only one miscellaneous care package can be claimed
- Splinting of mobile teeth per episode of care (up to four teeth and warranted for 12 months)
- Trauma related injury (includes all necessary review appointments, pulp sensibility tests, radiographs, and all other necessary tests)

Note - Excludes any laboratory fee which is patient funded, unless exempt.

Note – sports gum shields / sports guards are not available under the NHS for any age group.

13. Child new patient assessment

- Under 1 £80
- Age 1-4 £75
- Age 5-12 £70
- Age 13-17 £60

Recall examination £55 (maximum of 4 per year or 3 following initial new patient assessment fee).

2 Care packages
Worked Examples

SCENARIO 1

Mr Jones is a new non-exempt patient and booked to see Dr A. Following an examination, he requires a molar root canal therapy and four fillings.

What care package(s) does this generate?

1. New patient assessment **£54.41**
2. Simple restorative care package **£72.06**
3. Posterior tooth endodontic care package **£365.44**

Mr Jones will be invoiced for his NHS dental charge (PCR) based on treatment provided.

What else can Mr Jones expect following his examination?
Dr A either himself or using an appropriately qualified member of his team will ensure that Mr Jones receives comprehensive preventive advice as detailed in Delivering Better Oral Health, under the 5% prevention capitated payment.

Mr Jones successfully completes his treatment and, following an oral health risk assessment, it is decided that he needs a 6-month recall.

Mr Jones returns 6 months later. This generates a **£50** recall payment. However, it is noted that the endodontically treated molar now needs a crown for cuspal coverage, which attracts an additional Crown care package of **£280.88**. Mr Jones will pay the crown laboratory bill direct to the practice. Mr Jones will be invoiced separately for his NHS dental charge (PCR)

In total for the year this generates a total practice payment of **£822.79**

Mr Jones unfortunately returns 2 months as one of his new fillings fallen out.

What care package(s) does this generate?
None - no further payment is allowable. Under the warranty the contract holder will need to fix the tooth.

SCENARIO 2

Mrs Evans is experiencing toothache; she doesn't have a regular dentist. She calls NHS111 (some health boards have a direct number) and explains her symptoms. 111 pass the details onto the health board who arrange an appointment for an urgent care package GDS at Dr A's practice.

Dr A sees Mrs Evans and identifies a grossly carious upper first premolar tooth and decides that the tooth needs to be extracted. The tooth is extracted.

What care package(s) does this generate?

Urgent care package **£75**

*If Mrs Evans fails to attend the appointment **£75** is still paid*

SCENARIO 3

Ms Lewis has swelling, and pain associated with a molar tooth. She doesn't have a dentist. She calls 111 and is directed to the health board who arrange a timely appointment at Dr A's practice via an available urgent slot.

Dr A examined Ms Lewis and identified that the tooth could not be saved. Unfortunately, due to the active infection present, he is unable to achieve adequate anaesthesia. Dr A prescribes antibiotics and arranges for Ms Lewis to return for a second appointment. On the second appointment Dr A removes the tooth successfully.

What care package(s) does this generate?

Urgent care patient care package **£75**

Dr A noticed that Ms Lewis would benefit from additional dental treatment which Dr A has identified as a priority. Ms Lewis is keen to improve her oral health. Instead of returning to the DAP, Dr A can ask the HB if he can accept Ms Lewis as a new patient outside the normal new patient DAP process.

SCENARIO 4

Dr A puts in a request for new patients to the health board. Mrs Owen has been on the DAP for 1 year and is notified that Dr A can offer her a routine examination appointment, she

accepts the offer and shortly afterwards is contacted by Dr A's dental practice with an appointment.

Mrs Owen has an examination and is identified has having active periodontal disease stage 2, grade B, with poor plaque control. She also has two carious teeth that are restorable. Mrs Owen is very engaged and wishes to improve her oral health and keep as many teeth as possible. Dr A, following initial treatment, concludes that a 3-month recall is appropriate based on his clinical opinion and risk factors.

What care package(s) does this generate?

New patient assessment **£54.41**
Simple restorative care package **£72.06**
Periodontal care package **£97.06 (maximum of 2 periodontal packages per financial year, *but each periodontal care package where clinically appropriate may be carried out over more than one visit*)**
Recall examination **£50 per visit**

How might this work in practice? (This is only an approximate example for payment purposes and should not be taken as clinical guidance - for further guidance and management please refer to the BSP guidance on managing periodontal disease – Appendix 3)

- Extensive preventive advice as per DBOH which is part of the **5% ACV** contract payment (capitation type arrangement). This could be delivered, for example, by the dental nurse trained in oral health education.
- Once plaque control is satisfactory the patient then has initial periodontal treatment, a more detailed assessment and possible restorative treatment.
- The Patient is put on a 3-month recall interval which will include further advanced periodontal treatment following re-assessment.
- Total payment **£273.53,** excluding capitation payment.
- The hygienist could carry out the periodontal package, or
- The dental therapist could carry out the periodontal package, 3 months recall visits and simple restorative package, or
- The preventive advice could be carried out by the dental nurse, hygienist, therapist, or dentist.

  Note: if further treatment is required excluding warranted interventions, then additional care packages are allowable, for example if a further tooth is identified as needing to be extracted, the patient will fall into an additional simple caries package.

- The segregation of packages allows a simple remuneration system to calculate relevant pay for the individual members of the dental team.
- It may be possible to provide remote preventive advice using secure digital technology or record such interactions allowing patients to watch the advice again.

SCENARIO 5

Mrs Kaur attends Dr A's practice for her routine 12-month recall and asks if she can arrange an appointment for her newborn son Harjinder who is 10 months old. Dr A welcomes Harjinder to the practice and the receptionist says that they have a 30 mins slot available now if that works for Mrs Kaur? Mrs Kaur accepts.

What care package(s) does this generate?

Harjinder is under 1 so **£80** is paid from the initial assessment care package for children

What is expected?

Full prevention and dietary advice as per Delivering Better Oral Health guidance. This should include a comprehensive discussion including relevant topics such as supervised toothbrushing, breast feeding, pacifiers, digit sucking, weaning and the oral health of other children in the family etc. It is estimated that this will take around 20 to 30 mins.

Who can provide this advice?

Dental nurse trained in oral health education, hygienist, dental therapist, or dentist. It may be possible to carry out this discussion at a separate appointment using digital technology.

In this instance there is concern about poor oral hygiene and diet and therefore Harjinder is put into the 6 months recall interval which, **this equates to £55 per recall examination visit.**

For a 12-month period the payment excluding the capitation element of prevention within the ACV will be **£190 (initial assessment care package plus two recall examinations)**.

SCENARIO 6

Dr A's practice makes a request to the health board for new patients. Steven Lewis is 15 years old, having just moved to Wales, and his parent is contacted to offer Steven a new patient appointment with Dr A's practice after being on the DAP for 2 months. Steven's parent accepts his appointment and attends Dr A's practice.

On examination, Steven needs seven fillings which are all restorable. Dr A advises that a 6-month recall is appropriate.

What care package(s) does this generate?

Initial new child patient assessment **£60**
Extended restorative care package **£137.50**

What is expected?

In addition to the examination, radiographs and restorative treatment, comprehensive prevention advice as per DBOH guidance is provided. As in previous examples this is paid in addition to the care package payments as part of the 5% capitation payment in the ACV. Remote digital prevention is acceptable by any qualified member of the dental team.

For 12 months including the next two examination recalls, the total payment generated is **£307.50**

SCENARIO 7

Mr Stokes is an active patient of Dr A's practice and needs an urgent appointment for toothache. He had received a simple restorative care package 9 months ago. Dr A arranges a timely appointment to see Mr Stokes. Mr Stokes is identified as needing another filling in a tooth that was not part of the previous simple restorative care package.

What care package(s) does this generate?
A simple restorative care package of **£72.06**

SCENARIO 8

James Roberts is 14 years old, a known patient at Dr A's practice. James had received a simple restorative package 6 months ago but has now fallen over and fractured his front tooth. James's mother phones the practice and Dr A arranges a timely appointment.

Following assessment James needs root canal therapy.

What care package(s) does this generate?
Anterior root canal package **£182.35**

Note: An urgent fee cannot be claimed as James was not placed into an urgent care appointment by the health board. However, if James is due for his 6 months recall it may be appropriate to claim the recall fee or defer.

SCENARIO 9

Ms Powell has broken her back molar tooth; she attended Dr A's practice 4 months ago and had a simple restorative care package. Ms Powell phones the practice and Dr A's practice arranges a timely appointment.

Dr A identifies that a crown is now needed and Ms Powell consents to treatment.

What care package(s) does this generate?
A crown and bridge care package is allowable **£280.88**

SCENARIO 10

Mr Levi is on a 9-month recall and attends Dr A's practice for his recall appointment. Following examination, it is identified that three of his upper anterior teeth have become nonvital. Mr Levi recalls banging his front teeth a few months ago but didn't see the need to get urgent care.

Mr Levi consents to three root canal treatments

What care package(s) does this generate?
As this exceeds the upper limit of two teeth within a single anterior root canals this would mean two anterior root care packages are claimable **£182.35 plus £182.35**
Plus, the 9 months recall fee **£50**

Total payment generated **£414.70**

SCENARIO 11

Unfortunately, Mr Levi from scenario 10 returns with acute pain and infection associated with one of the root fillings. He requests extraction and an immediate denture.

What care package(s) does this generate?
The extraction will not generate a fee as this will be covered as part of the warranty.
The denture care package is allowed generating a fee of **£172.79**. Mr Levi is not exempt so will need to directly pay the laboratory bill and any associated NHS patient charge

Total payment generated **£172.79**

SCENARIO 12

Ms Roundtree has lost a filling causing significant sensitivity/pain but does not have a regular dentist. She calls 111 who pass the information onto the relevant health board. The health board arrange for Ms Roundtree to see Dr A in 2 days' time as he has slots free that day and is the nearest practice.

Dr A examines Ms Roundtree and places a temporary filling into the tooth. He advises Ms Roundtree to place her name on the DAP if she wishes to receive ongoing NHS dental care.

What care package(s) does this generate?

New urgent patient care package **£75**

Total payment generated **£75**

SCENARIO 13

Ms Roundtree returns 5 weeks later as the temporary filling has fallen out.

What care package(s) does this generate?

If a filling should have been provided as definitive treatment at the urgent appointment as this was the most clinically appropriate treatment then no care package is claimable.

At the second visit Dr A decides to place a permanent restoration to reduce the chance of the patient returning for a third unpaid visit.

SCENARIO 14

Mr Cleverly attends for his 12 months recall to Dr A's practice. Following examination, a tooth with a large lost filling is discovered with little remaining tooth structure. Dr A advises that a crown is required, but Mr Cleverly only wishes a filling to be placed. In this scenario Dr A must clearly state the recommended treatment and be able to clinically justify that a crown was the best and sensible option. The notes should be clear for NHSBSA and other relevant clinical policy advisors to also come to the same conclusion, based on a reasonable average evidence-based opinion.

What care package(s) does this generate?

Recall examination fee **£50**

Simple restorative care package **£72.06**

Total payment generated **£122.06**

SCENARIO 15

Mr Cleverly's filling falls out 1 month later and he rings up Dr A's practice. Dr A arranges a timely appointment and explains again that the tooth ideally requires a crown. Dr A has the following options to consider:

1. If Mr Cleverly decides to go ahead with the crown, then Dr A can claim the crown and bridge care package **£253** (Mr Cleverly will pay the lab bill as not exempt, plus patient charge)
2. If Mr Cleverly wishes to have the tooth extracted, then Dr A cannot claim an additional care package as this comes under the 2-year warranty and is covered under the simple caries package. **No fee**
3. Attempt to restore the tooth **No fee** (repair/replace)

4. Option for treatment on a private basis outside the NHS (personal choice)

SCENARIO 16

Mr Hamilton returns for his 12-month recall in January to see Dr A. On examination it is identified that he needs the upper right premolar tooth crowned. Dr A is aware that he has reached 10% of the ACV value for high value care packages.

What care package(s) does this generate?

Crown and bridge care package **£280.80**
12 months recall examination fee **£50**
Total payment generated **£330.80**

Mr Hamilton would ideally like the crown done on the NHS and ASAP as his son is getting married in 2 months' time.

Possible options to consider (in order):

a) Dr A contacts the health board with a request for additional funding approval within the current financial year
b) Dr A defers treatment until the next financial year
c) Mr Hamilton pays privately for the crown

SCENARIO 17

Mrs Chan is a new patient allocated to Dr A's practice from the DAP. Dr A's reception staff books Mrs Chan for a routine examination.

Following examination Mrs Chan has extensive caries due to having eaten copious amounts of honey and using a non-fluoridated toothpaste once daily. Plaque levels are moderate. Mrs Chan clearly presents with unstable disease.

Dr A notes nine cavities with two requiring endodontic treatment. An additional two teeth require extractions. Mrs Chan is very keen and engaged to improve her oral health and follow advice.

What care package(s) does this generate?

New patient assessment **£54.41**
Stabilisation care package **£150**

Total payment generated (excluding prevention capitation payment) **£194.41**

What is expected for these care packages?

- Comprehensive preventive advice following DBOH guidance. This can be given by any member of the dental team who is suitably qualified, such as dental nurse with oral

health education, hygienist, dental therapist, and dentist. It may be possible to provide this using a digital platform, such as attend anywhere software.

- Mrs Chan will have her carious teeth stabilised using an appropriate temporary restorative material. Dr A may carry out extirpation and stabilisation of endodontically treated tooth if appropriate. In addition, extractions of the poor prognosis teeth are also allowable. Dr A may allocate Mrs Chan to his Foundation trainee (DFT) for the stabilisation phase as the practice would have this recognised against their contract.
- Once the team has completed the stabilisation and the patient shows compliance, and if suitable, Dr A can progress to definitive treatment using the care packages.

SCENARIO 18

Mr Turner is a new patient and attends Dr A's practice via the DAP allocation process with the health board.

On examination Mr Turner needs his last nine remaining loose teeth extracted, five in the upper arch and four in the lower arch. He agrees to extraction and immediate fitting of dentures.

What care package(s) does this generate?

New patient assessment **£54.41**
Extensive restorative package **£137.50**
Simple restorative package **£72.06**
Denture care package **£172.79**
Total payment generated **£436.76**

When Mr Turner returns for the 3-month examination, he may require new dentures or re-lining depending upon bone resorption post healing.

What care package(s) does this generate?

3 months recall fee £50

If a new denture is needed, a further denture care package is allowable
If a simple reline is needed, a miscellaneous package is allowable, if this is a laboratory reline then the patient pays the lab cost, or the practice receives the set fee for an exempt patient

SCENARIO 19

Mrs Robinson attends as a new patient to see Dr A. Dr A identifies two fillings and arranges a further appointment.

What care package(s) does this generate?

Patient assessment **£54.41**

Simple restorative care package **£72.06**

Unfortunately, Mrs Robinson fails to attend the filling appointment on two occasions. The simple restorative care package has not started and so only the new patient assessment can be claimed. If one of the fillings had been done, then the full care package is claimable.

Practices will be expected to follow the all-Wales DNAs policy and return Mrs Robinson to the DAP.

SCENARIO 20

Mrs Hughes, age 44, has not seen a dentist for 20 years and is embarrassed by the appearance of her teeth. She has enrolled on the DAP but developed severe toothache and contacted 111. The health board has allocated her to a vacant urgent care slot with Dr A. She is apprehensive but keen to not only be out of pain but also to improve her oral health.

On examination she has an unrestorable first premolar with an acute abscess and request an extraction. Dr A identifies that Mrs Hughes is likely to also require six non-complicated restorations, two simple extractions and one root elevation, a crown, basic periodontal therapy, and a partial denture.

What care package(s) does this generate?

Urgent care package, including an extraction **£75**

Dr A has capacity to accept Mrs Hughes as a new patient and seeks prior approval with the HB. Once approved Mrs Hughes is invited back for formal examination and assessment.
New patient assessment **£54.41**
High needs stabilisation care package **£150**
Extended restorative care package **£137.50**
Periodontal care package **£97.06**
Crown and Bridge care package **£280.88**
Denture care package **£172.79**

Total payment generated (excluding prevention capitation payment) **£967.64**

Note: The treatment clock stops once the initial treatment plan has been delivered in full. At this point the patient charge (for non-exempt patients) is calculated which in this case will be capped at £384 plus any laboratory items. Separate patient charges will apply for any future recall examinations or treatment.

SCENARIO 21 – New contract remuneration compared to the UDA contract

Mr Adams is offered a new patient appointment after being on the DAP for 5 months and is booked into to see Dr A's associate dentist called Dr B.

Dr B examines Mr Adams, carrying out a full examination and history including charting, BPE and soft tissue examination, he also takes two bite wing radiographs.

Mr Adams has average oral hygiene and frequently snacks on sugary foods.

Dr B reports on the radiographs and notes seven class two cavities which are not obvious to the patient. The UL5 is likely to be non-vital and so he carries out pulp sensibility tests and takes a periapical Xray confirming that the tooth is non vital. Dr B risk assesses Mr Adams as red for caries.

After a full discussion with Mr Adams, he consents to treatment.

Dr B asks the receptionist to book Mr Adams in with the dental nurse for comprehensive preventive advice, he also prescribes a high strength toothpaste to use in the meantime and applies duraphat varnish at the chairside.

At the next appointment Mr Adams sees the dental nurse through a video consultation and receives a 20 mins appointment aligned to delivering better oral health. He is clearly engaged and following a face-to-face review appointment with the dental nurse his oral hygiene is excellent, and the sugary snacks have been stopped. The dental nurse asks the receptionist to book Mr Adams in with Dr B for restorative fillings, after two visits all the fillings are complete, and Mr Adams is keen to save his premolar tooth.

Dr B arranges a further visit to carry out root canal therapy of the asymptomatic premolar tooth. Following a second visit the root canal therapy is completed.

Dr B advises a 6 month recall due to the initial risk factors, but factoring in the improvement in oral hygiene

Mr Adams attends 6 months later with the cusp fractured off the root filled molar tooth, his diet and oral hygiene remain good, and he is keen to keep the tooth. Following an examination with Dr B and a PA radiograph, the tooth is restorable and apical healing is satisfactory.

Mr Adams returns for his crown prep and a week later his crown his fitted. Mr Adams is not exempt and pays for the laboratory bill direct to the practice

Mr Adams books for a 6-month recall examination appointment

At the next recall appointment. Mr Adams has no problems, his oral hygiene is excellent, and diet remains healthy with little to no sugary snacks.

Dr B now explains to Mr Adams that their risk factors have reduced, and he can now be seen every 12 months. Mr Adams now goes into a 12-month care package.

Remuneration for the 12-months:

Claim 1 -

- Initial new patient assessment **£54.41**
- Extended restorative package **£137.50**
- Molar endodontic package **£365.44**
- Prevention included in the **5% ACV**

Claim 2

- Recall examination **£50**
- Crown and bridge package **£280.88**

Total payment generated (excluding capitation prevention) **£888.23**

Under the UDA contract with an average £30 UDA value, this would have generated:

- Band 2
- Band 3
- Band 1
- Band 1

Total £510 less the laboratory bill
Assuming the lab bill was £75, this would only have generated **£435**

Under the new contract the practice receives an additional £453.23. This figure is higher as the contract also contains 5% ACV for prevention.

SCENARIO 22: New contract remuneration compared to UDA model

Danielle is 14 years old; she attends Dr A's practice and sees Ms Smith the dental therapist under direct access. Following a full examination Ms Smith takes BW radiographs and diagnoses five small class 2 cavities all extending into dentine. Ms Smith discusses the finding with Danielle and her parents and explains that she will need two more appointments to complete the treatment, but first he needs to arrange an appointment with the practice dental

nurse for preventive advice. Danielles mother books two appointments to see Ms Smith and has a virtual preventive session booked with the dental nurse.

The dental nurse using video consultation software provides comprehensive preventive advice including toothbrush demonstration and follows the DBOH guidance. Two weeks later Danielle returns to have their fillings done with Ms Smith who reinforces the preventive advice and additionally applies fluoride varnish, Ms Smith also by mutual consent agrees to place fissure sealants on the posterior molars.

Danielle returns the following week to complete the fillings. Danielle is considered a risk for caries, and a file note is made that at the 6-month recall examination, Danielle will also receive a further fluoride application. Danielle returns for their recall appointment to see Ms Smith and no new cavities are detected; an application of fluoride is applied along with preventive advice.

Remuneration for the 12-month time period under the new contract:

- Initial new child patient assessment £60
- Extensive restorative care package £137.50
- Recall examination £55
- Prevention included in the 5% ACV

Total payment generated **(**excluding 5% ACV prevention) **£252.50**

Under the UDA contract with an average £30 UDA value, this would have generated:

- Band 1
- Band 2
- Band 1

Total £150

Under the new contract the practice receives an additional £102.50. This figure is higher as the contract also contains 5% ACV for prevention.

SCENARIO 23

Mr Hoffman attends and is booked in to see Dr A, he is a regular patient attending for his 9-month recall. He mentions to Dr A that his simple cantilever bridge is loose. Dr A pulls the bridge off and after cleaning the bridge and examining the retainer, he informs Mr Hoffman that he can simply recement the bridge.

What care package(s) does this generate?

Recall examination **£50**
Miscellaneous care package **£50**

Total payment generated **£100**

SCENARIO 24

Stephen is 5 years old and attends with his mother as a new patient to Ms Smith the dental therapist. Stephen's mother explains that he has a bad back tooth. Ms Smith notices that he has a carious LRE which would benefit from a stainless-steel crown.

Following radiographic assessment, she arranges for Stephen to return where he and his mother get comprehensive prevention advice, fluoride varnish, and acclimatisation. Stephen returns for a second visit and has the LRE restored with a stainless-steel crown.

What care package(s) does this generate?
Initial assessment fee 5-12 **£70**
Simple restorative package **£72.06**
Total payment generated **£142.06** (excluding 5% prevention ACV)

SCENARIO 25

Mr Christopher Thomas is booked into see Dr A, he is 8 years old and is a new patient at the practice. His father explains that he has a "bad" back tooth. Dr A can see that Christopher has a non-vital LRE with a sinus and cavities in his LRD and LLD. Dr A decides and obtains consent to extract the LRE and fill the LRD and LLD. His father says that he has had a baby tooth removed before and co-operates well.

Dr A arranges for Mr Christopher Thomas and his father to receive comprehensive prevention advice with one of his suitably qualified dental nurses and asks Mr Thomas to bring Christopher back for a further two appointments where he completes the treatment including fluoride varnish application.

What care package(s) does this generate?
Initial assessment fee **£70**
Simple restorative package **£72.06**
Total payment generated **£142.06**

When Christopher returns 6 months later, one of the fillings has fallen out.

What care package(s) does this generate?
6 months recall **£55**

The filling will need to be replaced by the practice as it will fall under the warranty period and was included in the original simple caries package

SCENARIO 26

Mrs Bragg is a new patient of the practice and attends for her initial assessment with Dr A. She has a full upper denture and a partial lower denture. She has a small amount of calculus and mentions that her lower denture has been rubbing recently. Dr A notices some ulceration related to the denture. He removes the plaque retentive factors, provides prevention advice, places some fluoride varnish on an early enamel lesion and eases the denture. He arranges for Mrs Bragg to return a week later to review the ulceration and is pleased to see that it has all resolved. Mrs Bragg is placed on a 12-month risk assessed recall interval. You may notice that the regulations refer to scale and polish, this can be interpreted as removal of plaque retentive factors including overhangs/calculus. You are not mandated to polish the teeth although this can be included at the clinician's discretion but no additional fee is generated

What care package(s) does this generate?

New patient assessment **£54.41**
Miscellaneous care package **£50**
Total payment generated **£104.41**

SCENARIO 27

Mr Conradi calls Dr A's practice explaining that the new front crown that was done last year has fallen off. The practice arranges a timely appointment for Mr Conradi who is also due his 9 months recall appointment. On examination Dr A observes that the tooth has fractured inside the crown and that the tooth is no longer restorable. He explains that the root will need to be removed. Mr Conradi doesn't want a gap and asks if he can have a denture.

Following an informed, shared decision-making, conversation Mr Conradi consents for an immediate partial denture which will also fill some pre-molar gaps.

Dr A at further visits removes the root and places an immediate denture.

What care package(s) does this generate?

Denture care package **£172.79**
Recall fee **£50**
Total payment generated **£222.79**

Note: *The extraction is included in the crown and bridge care package warranty*

SCENARIO 28

Mr Bold calls Dr A's practice explaining that his Lower right molar tooth has lost a filling. He was only in the practice last week for his routine 12-month recall and no treatment need was

identified at that appointment. As the tooth is currently asymptomatic, Dr A books him for 3 weeks' time.

Mr Bold attends his appointment and Dr A restores the tooth with composite. The tooth was last filled by Dr A 5 years ago

What care package(s) does this generate?

A simple restorative care package would be applied, (although filled 5 years ago this is outside the warranty period) **£72.06**

Total payment generated **£72.06**

SCENARIO 29

Mx Jones has pain from their erupting wisdom tooth; they call Dr A's practice, and they arrange to see them in a timely fashion.

Mx Jones is not due a recall visit and has never had any treatment at the practice. Dr A diagnoses acute pericoronitis and appropriately prescribes antibiotics, in addition he provides preventive advice. In this scenario the treatment provided comes under the miscellaneous care package.

What care package(s) does this generate?

Miscellaneous care package **£50**

Total payment generated **£50**

SCENARIO 30

Mrs Boon attends as a new patient to see Dr A. Dr A following a full examination including radiographs, explains that she needs five fillings, Mrs Boon would also like her old partial chrome denture replaced as its 15 years old. Dr A agrees that she would benefit from a new denture and that a chrome denture would be the optimum choice, however her tooth brushing needs to improve and although she has no significant periodontal disease, there is marked gingivitis, and it is obvious that the denture is being slept in.

Mrs Boon is very engaged and is booked in with the dental nurse for comprehensive prevention and fluoride varnish application, she then books an appointment with the dental therapist who removes all plaque retentive factors. On the third visit she again sees the dental therapist who starts the restorative treatment and notices the marked improvement in the brushing. Following a further visit she completes the last of her fillings and is booked in with Dr A for a new chrome denture.

What care package(s) does this generate?
New patient assessment **£54.41**
Extensive restorative care package **£137.50**
Denture care package **£172.79**
Total payment generated (excluding 5% ACV prevention) **£364.70**

Mrs Boon calls the practice a month later as the denture is rubbing. Dr A sees Mrs Boon and adjusts the denture.

What care package(s) does this generate?
No fee as comes under a denture care package. Mrs Boon is exempt from NHS dental charges. The practice will pay the laboratory direct and receive payment back through the ACV.

SCENARIO 31

Mrs Pole is an activec patient of Dr A. She was referred to oral surgery for a complex impacted 8. She had the tooth surgically removed yesterday and calls Dr A's practice because she thinks that the socket is bleeding. She is otherwise fit and well.

Dr A is happy to see Mrs Pole and on examination agrees that the socket is oozing and controls the bleeding with an additional suture and bite packs.

What care package(s) does this generate?
Miscellaneous care package **£50**
Total payment generated **£50**

SCENARIO 32

Mr Smyth had a tooth removed yesterday with one of Dr A's associates as part of a simple restorative care package. He calls the practice as he has noticed that the socket is bleeding despite using local measures. Dr A sees Mr Smyth and controls the bleeding using a suture and a haemostatic dressing,

What care package(s) does this generate?
No package because this comes under post-operative care within the simple restorative care package.

Packages are contract specific and are not dependant on the which clinician within the practice has carried out the treatment.

SCENARIO 33

Mr Lowe is a regular patient of Dr A; he is minimal risk for oral disease, and his risk profile is green. He attends for his 18-month routine recall.

What care package(s) does this generate?

At his last appointment Mr Lowe was classified as a Green low risk existing patient and given a recall appoint interval of 18 months. As such **No** recall fee is claimable as this is included in the 3% capitated ACV payment for green existing patients of the practice. However, should any treatment need be identified this would allow an appropriate care package to be claimed.

If the patient is non-exempt for NHS dental treatment, then the patient charge will be generated for a recall appointment (£25).

3 Worked Examples Using The Wider Team

Utilising the team considerations

The contract breaks treatment types into distinct packages of care. This unique system allows a contract holder to identify which team member has carried out each package of care.

SKILL MIX SCENARIO

A new patient is assessed by Dr A who identifies three fillings, and the need for a new crown. Dr A arranges for the patient to have the fillings done by the dental therapist and the associate does the crown. The dental nurse with extended duties training will take the radiographs and provide preventative advice based on Delivering Better Oral Health.
From a financial perspective the contract holder can easily see what remuneration is generated because of each member of the team's contribution to the patient's overall care:

- The dental therapist completes a **simple restorative** package **(£72.06)**
- The dental nurse contributes to the **5% prevention** element of the ACV
- The associate completes a **crown and bridge** care package **(£280.88)**
- Dr A completes a **new patient assessment** package **(£54.41)**

The recall package can then be assigned to an appropriate member of the team. If two members of the team complete an individual care package, it will still be possible to pro-rata the care package remuneration as appropriate.

SHARED CARE APPROACH SCENARIO

A 13-year-old patient is routinely reviewed by Dr A who identifies an orthodontic need. However, there is marginal gingivitis with moderate plaque control. There is also early cervical demineralisation but no active caries. Dr A advises a session with the oral health educator, and hygienist before referral to a local orthodontic specialist.

The dental nurse with OHE experience provides preventative advice based on delivering better oral health.

The hygienist arranges two sessions, with fluoride varnish applications, and is satisfied with the improvement in plaque control.

Meanwhile the orthodontist requests the extraction of first premolar teeth but notices a small occlusal cavity that needs a composite filling. Dr A has two part-time Associate Dentists working at the practice and to avoid deferring the start of the orthodontic treatment books the patient to see both Associates:

- Dr A completes a child 6-month review **(£55)**
- The dental nurse and hygienist contribute to the **5%** prevention element of the ACV
- One Associate completes the simple cavity*****
- The second Associate completes the orthodontic extractions*****

> ****Note**: This part of the segmented care package would generate an extensive restorative package fee of £137.50. The contractor would need to agree how this is divided between the two Associate Dentists.*

The recall package can then be assigned to any appropriate member of the team during the orthodontic therapy.

This illustrates that if two members of the dental team divide up different care packages during a single course of treatment it is feasible to pro-rata the care package fees to calculate the Associate payments.

THE TRAUMA PATIENT

Example 1

Mrs Browne has been hit playing a sport and notices one of her central incisors are loose and in an odd position. She doesn't have a dentist and calls NHS 111 and is directed to the HB who arrange a timely appointment at Dr A's practice via an available urgent slot.

Dr A examines Mrs Browne and identifies an extrusive luxation injury, following the relevant guidance Dr A repositions the tooth and applies a splint. Mrs Browne requires removal of this splint in 2 weeks and then subsequent follow ups in line with IADT/BSPD guidelines.

What care package(s) does this generate?
Urgent Care Package (includes splinting) ***£75***
Miscellaneous care package (trauma review) ***£50***

At the 12-week review Dr A identifies that the tooth has devitalised and now requires a root canal and composite build-up. Dr A contacts the HB to ask if they can accept Mrs Browne as a new patient outside the normal new patient DAP process.

What care package(s) does this generate?
New patient examination ***£54.41***
Anterior root canal package ***£182.45***

Example 2

Mr White is a known patient to Dr A's practice. He comes in for an urgent assessment following an accident that knocked his front tooth out. Mr White has only just had a routine examination done a few weeks ago and no treatment was identified

Dr A examines Mr White and identifies an avulsion, following the relevant guidance Dr A reimplants the tooth and applies a split. Mr White requires removal of this splint in 2 weeks and then subsequent follow ups in line with IADT guidelines.

What care package(s) does this generate?
Miscellaneous care package, splinting of tooth ***£50***
Miscellaneous care package, trauma ***£50***

> **NOTE:** Once he becomes due for his routine recall any additional recall fee can be claimed at the appropriate interval. If further treatment is required, then the appropriate care package is initiated. For laboratory made splints the laboratory bill is paid directly for non-exempt patients

4 Care packages Clarifications

1. **If a patient fails to complete all the treatment in a care package, do I get paid anything?**

   Yes, the care package is paid so long as treatment has commenced within the care package, excluding initial assessments and urgent care packages. New urgent patient slots are paid regardless of if a patient attends or not. If a patient subsequently returns any remaining treatment will be apportioned to the relevant care package and normal patient charges will be applicable. This means that patients who fail to attend and are managed according to all Wales DNA policy and are not exempt from dental charges may end up paying twice for the same care package. Alternatively, where appropriate and in line with the All-Wales DNA policy practices may wish to place the patient back onto the DAP.

2. **When can I claim a stabilisation care package?**
   For patients who present with 7+ carious teeth, where at least two of the teeth have caries in or within proximity to the pulp and the patient clearly has unstable disease. The patients should express a desire to engage and improve their oral health.

   The clinical notes should be sufficient to justify the claim in the event of a clinical record card audit. It is anticipated that this care package will be infrequent.

3. **What prevention should I do?**
   Prevention should be tailored to the needs of the individual patient; contract holders will be expected to follow best practice as provided by the Delivering Better Oral Health guidance. The contract receives a 5% ACV capitation payment to cover this. This will be monitored by health boards and the NHSBSA. Failure to provide prevention will result in a contractual breach.

4. **Can I claim multiple care packages?**
   Yes, where appropriate to do so, for example if a patient needs ten fillings, then an extensive and simple caries packages can be claimed. Please note that for the two

restorative packages (extensive and simple), the combination will be made up of the minimum number of combinations.

If a patient needs three crowns, then two crown and bridge packages could be claimed. A two-unit bridge and one crown will come under a single crown and bridge package.

5. **I am a contract holder and one of my dentists struggles with taking routine teeth out. Is it ok for them to refer to a specialist service?**
   The contractor holder is responsible for ensuring that all level 1 procedures are carried out within the practice, if none of the clinicians on the performers list working under the contract within the practice are capable of doing the level 1 procedure then a referral can be made in order to facilitate the care of the patient, however this could result in a breach of contract notice so an early conversation with the health board should be arranged to discuss how the contract holder can prevent the need to refer to specialist services for routine mandatory services.

6. **What happens if I run out of funding to provide care packages?**
   It is the responsibility of the contractor holder to ensure that their activity and funding is managed throughout the financial year. Any issues with predicted under or over delivery needs to be discussed with the health board, however there should be no expectation that additional funding can or will be made available.

7. **Is there a limit on what an NHS patient can pay for their lab bill?**
   Exempt patients will be remunerated at a nationally agreed maximum tariff (see page 38). Fee paying patient may decide on a lower laboratory bill or pay something more expensive. NHSBSA will audit laboratory bills to verify alignment between patient payments, reimbursements, and invoices. It is important that all relevant documentation (e.g., clinical records, laboratory invoices) are retained if audited by NHSBSA or the Health Board. Failure to produce information such as clinical records, laboratory invoices etc. will be taken seriously and maybe considered as a probity or professional issue.

8. **How will patient charges be collected?**
   There is no change to the method of patient charges at this stage. The practice will need to collect both the patient charge and laboratory fee elements.

9. **Can I claim anything if one of my fillings fails?**
   - Care package treatment is under warranty for **24 months**
   - Urgent care packages for **12 months**

   This applies for any treatment on a particular tooth completed within a care package, for example a filling done in a simple caries package that fails regardless of the reason (excluding trauma as described) within the 24-month period will be sorted at the practice expense and no care package is claimable. If the tooth requires treatment

that is covered in a separate care package, for example the tooth now requires endodontic treatment or a crown then a care package becomes applicable and can be claimed.

10. **Can I carry out preventive advice using remote digital technology?**
    Some patients may prefer this, and so long as appropriate consent and digital governance is in place this is acceptable. Contract holders will be able to tailor this advice to individual patient need.

11. **I don't understand why the initial assessment fee is so much for a newborn baby compared to an adult.**
    We know that if prevention is embedded at the start of a child's life though education and best practice prevention, we can prevent the main dental diseases. You will be expected to spend approximately 30 minutes with the new parent/guardian providing comprehensive advice covering everything in Delivering Better Oral Health. Good prevention improves population oral health in the longer term and is cost effective.

12. **What if a patient fails to attend for a new urgent appointment?**
    This will be recorded and will count as urgent activity. The contract holder will receive the payment regardless of if the patient attends or not.

13. **Can I have a children's only contract?**
    This will be a local health board decision

14. **Why can't I pick my own new patients?**
    To reduce inequality in access and align to the rest of healthcare, new patients will be supplied through the dental access portal from the health board. You will be able to ask your health board for new patients, and they will send you the details. Health boards will be prioritising children. **Practices must not keep their own new NHS patient waiting lists.**

15. **If I see a new urgent patient who <u>obviously needs</u> additional care can I see them as a new patient?**
    Yes, with prior approval of the health board. This will then attract a new patient fee plus the prescribed care packages. Health Boards will have the autonomy to decide how this is achieved, for example a Health Board could agree that up to a set number of new urgent patients could be taken directly without going through the DAP allocation process.

16. **Can I see new child patients who are in pain and walk into the practice without going through regular pathways?**
    If a child in pain is brought to the practice by a parent or guardian, then care can be provided without going through 111 or the health boards dental urgent line. The health board will need to be notified within 7 working days.

17. If a new adult patient turns up at the practice in pain, can I see them as a new urgent patient?

Under normal circumstances the patient should be instructed to telephone 111. There maybe a few clinical scenarios when a patient presents with a true dental emergency that it is ethically inappropriate to delay their care. If a new urgent patient is seen outside of the normal pathway, then the health board should be informed within 7 working days to ensure that appropriate remuneration against the contract is confirmed.

18. I keep underperforming more by more than 5%. What happens?

The new contract will allow health boards where justifiable to reduce a contract value. Normal appeal processes will still exist.

19. Can I still carry out private treatment on a patient?

Yes, through fully informed evidence based shared decision-making consent process. For laboratory work patients now pay directly for the types of crowns etc that were previously paid for on a private basis as the NHS is paying for the clinical time. Any NHS patient that opts for private treatment which is available on the NHS must have the reasons fully explained within the clinical records, the notes should provide total clarity if this comes under scrutiny such as a patient challenge or because of a clinical record card audit.

20. Can exempt patients pay for a top up on the laboratory bill.

Exempt patients will have the option to pay the difference between the NHS and private laboratory costs directly to the practice. The practice will claim the NHS portion through NHSBSA.

21. Can I stay on UDAs or contract variation?

No, the new contract will replace the 2006 GDS UDA based contract. All extant UDA contracts will end on 31 March 2026

22. What happens if a new patient fails to attend, do I still get paid?

No, it is for the contract holder as an independent business to ensure that the fail to attend rate is as low as possible. However new urgent patient slots arranged with the health board will be paid for regardless of whether the patient attends or not.

23. What happens if I have patients booked in after the 1st of April 2026 in the middle of treatment?

Patients will pay the charge at the time of opening the course of treatment, for example a patient needing a band 2 on the 3rd March for 2 fillings will pay the pre 1st April 2026 band 2 charge, when the treatment is completed post April 1st the practice will send off the new FP17W and claim the appropriate care packages in this case a recall examination and simple caries package.

24. When do I submit the FP17W?

At the end of a course of treatment. This would normally comprise the recall examination plus any care packages provided. However, an FP17w for a new patient assessment must be submitted separately to the FP17w for any subsequent care packages to enable the associated fees to be credited to the appropriate service line. This will change when Compass is replaced and further guidance will be issued.

25. Is there an All-Wales agreed failure to attend (DNA) policy?

Yes, based on the NHS Social Charter principles aimed at improving access for high-need patients, enhancing patient engagement and satisfaction, and aligning to prudent healthcare principles. This is supported within the new dental contract.

26. What if the health board runs out of new patients?

In this unlikely scenario, health boards will have the ability to mutually agree a way forward with individual contract holders.

27. Will specialist PDS contracts still be possible?

Yes, for the provision of specialist services. The commissioning of which will be determined by individual health boards.

28. What does the 5% local flexibility mean?

Health boards will be able to locally commission. National and local priorities are currently being determined. In year one this 5% will be added to the care packages

29. What will my opening hours be

The health board will advise on what their expected core hours will be, but this is likely to be Monday to Friday 9am till 5pm

30. Can I choose when I want to provide the urgent slots?

While we would always encourage a mutual agreement, health boards will ultimately decide what is reasonable for their urgent service based on their knowledge of demand patterns across the health board area.

31. Can I use amalgam?

Amalgam is being phased out due to worldwide environmental considerations. For most patients, a plastic restoration will be equal or superior to an amalgam filling and should be the preferred option. Amalgam should not be the default option even for posterior restorations. Patients should not be offered posterior composites as a private only alternative. Assuming amalgam is available, this should only be used in situations where it has a clinically justifiable advantage.

32. Can I refer children who are uncooperative?

Yes, subject to the paediatric dental referral acceptance criteria for patients who are level 2 and level 3 complexity. For patients who are simply non-compliant, it is

expected that the contract holder will make reasonable attempts to acclimatise a child before making the referral. This will be closely monitored by NHS BSA and health boards who will have contractual responsibility to action any necessary remedial action if inappropriate referrals are identified.

33. When can I claim the urgent care package?

This can be claimed for new urgent patients sent to the practice as part of the urgent slot component of the contract, it is not an additional payment for new urgent patients but is the fee used to calculate the number of urgent slots allocated to a contract holder. The urgent care package contains a description of what is expected to be provided in an urgent care package. The total fee paid for a new urgent patient seen at the practice is £75. For active patients, the clinician should claim the relevant care package including the use of the miscellaneous package. The miscellaneous package includes conditions such as pericoronitis, ANUG etc. The practice will determine the urgency of the appointment through their robust triage process and must justify the time period that the patient is expected to wait. Patients for example experiencing continuous pain would be expected to be seen within a 24 hour timeframe.

34. I am unsure what to claim, what should I do?

If you are unsure, then speak to the health board or the NHSBSA. It is sensible to document and record the advice received so that there are no misunderstandings.

35. What is expected from a 'global oral health assessment' when a new patient is allocated to my practice?

A global dental assessment within the NHS framework is a structured, evidence-based evaluation of a patient's oral health, designed to inform preventive, diagnostic, and therapeutic care. According to clinical and NICE CG19 guidelines, it encompasses:

- Patient history (medical, dental, lifestyle)
- Clinical examination (extraoral and intraoral)
- Risk assessments (caries, periodontal disease, oral cancer)
- Radiographic and diagnostic investigations
- Functional and aesthetic evaluation
- Preventive advice and health promotion
- Personalised care planning (including risk-based recall)
- Documentation and outcome measures (e.g. PROMs, PREMs)

This holistic, needs-based, approach supports prevention, early diagnosis, and tailored treatment planning. The emphasis is on shared decision making with the patient based on their needs and risk profile.

36. I constructed a new denture last year and the patient lost it. What happens next?

If they wish a replacement denture then the patient will have to have another care package and be subject to the appropriate charges. Exempt patients will not be reimbursed by the laboratory bill and will incur full laboratory cost.

37. I fitted a denture last month and the patient doesn't like the fit or colour of the teeth?

The denture is under the 2 year warranty and no denture care package can be claimed. It is up to the clinician to ensure that the fit and colour of the denture is satisfactory.

38. Can I change the ratio of new patients and new urgent patients?

The contract is designed to be segmented and at an early stage if you would prefer to see for example more new patients, then this will need a conversation between the health board and the contract holder. If you find that new patients require significant treatment and you think that you cannot see additional new patients, then you will need to contact the health board to discuss reducing the proportion of ACV allocated to new patient assessment and moving the funding to the care packages.

39. Will my software provider be aware of these changes?

While the NHS and WG cannot be responsible for your individual software systems as an independent contractor, the NHSBSA speak on a regular basis with the major software suppliers and have an understanding to provide the required information for software changes in advance of any new contract. The NHSBSA have a backup system to electronically submit FP17Ws for practices that do not use a software system and if the software companies do not make the necessary changes in a timely manner. Ultimately it is for the contract holder to ensure that their systems are ready for the new contract requirements.

40. I have a patient who has BPE scores of 2, but no significant pocketing, however they have a significant amount of calculus that will likely require two visits or an extended visit with possible local anesthetic. What can I claim?

It is understood that some patients present in this manner and in such scenarios a periodontal care package is allowable. It is advised that clinical notes are contemporaneous and ideally clinical photos or radiographs (if justified) are available to demonstrate the amount of calculus present.

41. After completing a course of treatment (care package), when does the treatment clock stop and patients need to pay a PCR for review appointments?

PCR is calculated at the end of a course of treatment. See scenario 20.

42. Can you explain what I need to do regarding dental collaboratives?

The 2026 contract is an opportunity to become involved with the Dental Professional Collaboratives and the Accelerated Cluster Development (ACD) programme by engaging with several structured entry points that the system now provides. This is a significant shift from the historic GP-led cluster model and creates new opportunities

for dental teams to shape local planning, prevention priorities, and service development across Wales.

As the 2026 GDS contract embeds prevention, complexity, and population-health principles, dentistry's contribution to ACD becomes central to integrating oral health into wider healthcare. Involvement ensures that dental needs are understood, funded, and integrated into the wider system. To support this ambition funding will be available to practices to enable a dentist from the practice to participate in professional collaborative meetings. The requirement will be to attend 4 meetings annually for a payment of £1,200. Failure to attend meetings will result in a pro rata reduction of that payment (£300 per meeting missed).

43. If I provide a temporary restoration, is that covered by the warranty?

For the active patient there are no care packages that cover temporary restorations, only definitive restorations. There are times for example when a clinician sees a new urgent patients and may decide to extirpate the pulp and place a temporary restoration and advises the patient to go back to the DAP/Seek a regular dental practice as the patient presented with a viable tooth and wished to attempt endodontic treatment in this scenario no warranty is available if the patient needed urgent care again they would need to go through the normal health board urgent slot process. However, if a patient wished to have an extraction but for clinical reasons it could not be done at that appointment and the pulp was extirpated and temporary dressing was placed, this scenario would be covered by the warranty for new urgent patients.

APPENDIX 1 – Laboratory charges

Item Description	Scope	Description	Maximum Reimbursement
Full acrylic dentures	Inclusive of special trays/models and whether upper/lower (per denture)	Prosthetics	£150
Partial acrylic dentures	Inclusive of special trays/models and whether upper/lower (per denture)	Prosthetics	£90
Chrome dentures	Inclusive of special trays/models or whether upper/lower (per denture)	Prosthetics	£200
Repairs	Including minor modifications for example addition of a strengthener and repairs of restorative laboratory items	Prosthetics/ Restorative	£66
Additions	Addition of a tooth	Prosthetics	£60
Relines	Includes both hard and soft liners	Prosthetics	£64
Bite Guard/Bruxism	Soft or hard construction	Restorative	£39
Orthodontic retainer	Not applicable	Orthodontics	£33
Single Crown	Including precious metal, Zirconia, Emax, post and core	Restorative	£110
Single onlay/inlay/veneer	Porcelain, ~~gold~~, composite	Restorative	£125
Fixed bridge per unit	Bonded/Zirkonia	Restorative	£57
Adhesive bridge per unit	Standard construction including wings and pontics	Restorative	£50
Temporary Crown	Free choice per unit	Restorative	£39
Temporary Bridge	Free choice per unit	Restorative	£39
Study models	When used in isolation and not part of a restorative or prosthetic treatment per model	Not applicable	£18
Post and core not used as part of bridge/crown treatment plan		Restorative	£28

APPENDIX 2 - FAQs

Recall Examination Fee

A care package can be claimed without a recall examination fee. The care packages will expect an assessment of the patient to diagnose their specific problem including any necessary radiographs and special tests. If a patient attends between their risk-based recall date for a problem, then a recall can only be claimed if the patient attends within a maximum of 5 weeks of their recall visit. A maximum of 4 recall examination fees can be claimed in any financial year or for the case of new patients 3 recall examination fees plus the initial new patient examination with a minimum separation of 12 weeks between each claim(appointment) apart from a patient who attends in between their recall date as described above.

Patients who are at low risk for oral disease and on an 18 to 24 month recall interval will be included in the 3% capitation payment, and no additional recall fee can be claimed. If the patient is identified as needing treatment, then the appropriate care package can be claimed. Fee paying patients will still pay the routine examination fee (50% of the recall fee).

How are active patients defined?

An adult patient becomes an active patient if they have received a banded course of treatment, a new patient examination, a recall examination or a care package in the last 3 years.

How has the New urgent slot been calculated?

7/100 multiplied by the ACV divided by 75 equals the number of urgent slots per year. The times and days that the service needs to be provided will be determined and agreed by the health board

How has the new patient slot been calculated?

10% ACV divided by new patient examination fee equals the number of new patients per year.

Patients on an 18 to 24 month recall capitated recall

Check-up appointments fall within the 3% capitation payment. Any treatment required will be part of a care package(s). If the patient is non-exempt a PCR charge is required.

Contract Monitoring and Accountability

Health Boards will employ a range of nationally agreed mechanisms to monitor the delivery of NHS dental contracts. These include the authority to request access to NHS clinical records where appropriate. The NHS Business Services Authority (NHSBSA)

will continue to support this process through data analysis and the implementation of clinical audit reviews.

Contract holders are expected to adhere to evidence-based clinical practice. Failure to comply with recognised guidance—such as *Delivering Better Oral Health*—may result in formal contractual breach and remedial action. If a breach notice is issued this may be accompanied by the imposition of financial sanctions, including the unilateral reduction of contract value by the Health Board.

Responsibilities of Contract Holders

Contract holders are accountable for the provision of Level 1 NHS dental services within their practice, regardless of whether they personally deliver care to individual patients. Performer List regulations will continue to apply in parallel with contractual obligations.

In summary, contract holders have a duty of care to ensure that all members of the dental team operate to the standards expected under the terms of the contract. The care packages have been designed to ensure that NHS patients receive high-quality, evidence-based care.

Clarification - Warranty exemptions

1. The need for endodontic treatment following placement of a crown or bridge where all reasonable tests had been done to determine the health of the pulp prior to fitting*

2. External trauma, such as a blow to the face, resulting in fracture of the tooth (does not include biting on something hard or parafunctional activities)*

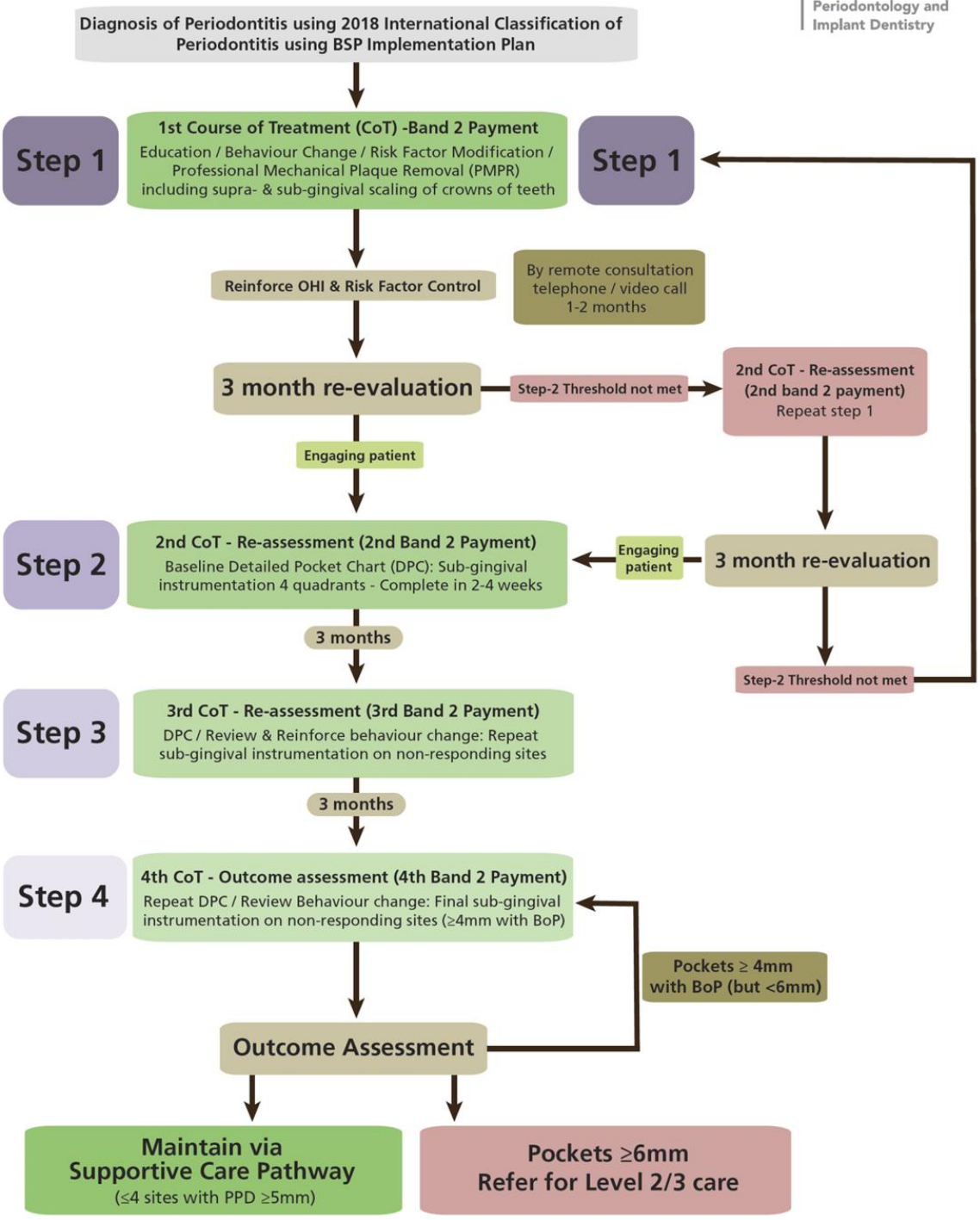
3. Temporary procedures for some new urgent dental patients (see example in FAQ 43.

* For such exemptions the appropriate care package can be claimed. Fee paying patients will be required to pay the charge. Contemporaneous notes should be recorded.

** The care package interventions are for definitive restorations and do not include restorations intended to be temporary in nature.

Stepwise Personalised Care Pathway in NHS General Dental Practice – Full Care Pathway adapted to UDA Banding

BSP British Society of Periodontology and Implant Dentistry



Notes:
Remote consultation by dentist / hygienist /therapist or oral health educator
Patients not at the step-2 threshold offered a 2nd band 2 STEP-1:
Attempt to engage, then 3/12ly Band 1 Step 1 until engage

Annex D – Care Package Title and Description

Care Package	Description
Simple Restorative Care Package	Includes fillings, temporary/intermediate crowns, Hall crowns and extractions up to a total of 4 teeth.
Extensive Restorative Package	As per simple restorative package for 5 to 8 teeth. Composite material for anterior teeth (canine to canine). Posterior teeth to use clinically appropriate materials, which include both amalgam and amalgam alternatives.
Periodontal Care Package (maximum of two per patient per year)	Entry assessed on engagement from assessment, but Patient must achieve minimum of 30% plaque score by 3rd Oral Health Education visit. Includes plaque score and tailored OHI, 6ppc, RPRF and Pocket debridement. Contract holders expected to follow guidance such as the British Periodontology guidance on managing Patients with periodontal disease.
Denture Care Package	Excludes laboratory fees (to be paid directly by the Patient, unless exempt from NHS charges). Includes upper and lower dentures, including Cobalt Chrome dentures if clinically indicated
Stabilisation Care Package	For Patients who present with 7+ carious teeth, where at least two of the teeth have caries extending to close proximity or into the pulp and the Patient is keen to engage. Includes extractions, DBOH prevention, Glass Ionomer intermediate restorations, pulp extirpation, removal of plaque retentive factors.
Anterior Root Canal Package	For up to two teeth 1-3, includes any permanent restorations.
Posterior Root Canal Package	Posterior and pre-molar root canal package, for up to two teeth. Includes Second molars if the tooth is strategically necessary to maintain dentition (e.g. Patients who have a lack of posterior support, a medical reason to retain etc.). Includes any cuspal coverage needed, excluding laboratory fee (paid by patients, unless exempt from NHS charges).
Crown Bridge, Inlay, Onlay and Veneer Care Package (limited to 10% of overall care package delivery)	Excludes temporary restorations. Up to 3 units, includes study models, posts and cores etc. Excludes laboratory fees.
Miscellaneous Care Package	For treatment and interventions for patients that fall outside a current care package or outside the guarantee period. Includes: Denture repair/addition/reline, Denture ease, Study models, Bite raising appliance, Biopsy, Repair/Recement of a crown, bridge or veneer, Removal of sutures, Pericoronitis, ANUG, Orthodontic urgent issues, Arrest of haemorrhage (for extractions carried outside of a care package), Dry socket (for extractions carried outside of a care package). Excludes any laboratory fee.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN UNIVERSITY HEALTH BOARD**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	03 March 2026
CYFARFOD O: **MEETING OF:**	Senior Leadership Team
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	The National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026
ARWEINIOL: **LEAD:**	Rachel Prangley- Head of Primary Care Mick Allen- Dental Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rachel McWilliams - Senior Primary Care Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the Senior Leadership Team (SLT) regarding the new National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026 Written Statement: New Contract to Improve Access to NHS Dentistry (11 February 2026) | GOV.WALES that will be implemented from 1 April 2026 and the related contractual requirements NHS dental practices must deliver against, including associated risks and mitigations the Health Board must be aware of and manage.

The revised contract model introduces a segmented approach, whereby each contracts Annual Contract Value (ACV) is earned through the delivery of defined components.

SLT are requested to consider a number of options outlined in the report and endorse the proposed approach.

Cefndir / Background:

Current Position

The Health Board commissions General Dental Services (GDS) throughout Aneurin Bevan University Health Board from independent contractors, through The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006) The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006. There are currently 69 General Dental Contracts that are responsible for providing NHS dental care within the Health Board area.

Since the inception of the NHS GDS contract, patients have not been registered with a dental practice, but access care through a contract based on individual courses of treatment. It is the patient's responsibility to ensure regular attendance at a dental practice to receive ongoing dental care.

Individuals who do not regularly attend a dental practice and require urgent dental care can contact the Health Boards Dental Helpline; Monday-Friday 9am-12.15pm and 1.15pm-4pm. Between 6.30pm-8am on weekdays, advice is available and during weekends and Bank Holiday's a limited number of urgent appointments are available and/or advice can be obtained.

The Health Board also commissions Domiciliary Services, Orthodontic Services, Sedation and Oral Surgery Services via Personal Dental Service (PDS) agreements The National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006. In addition, GDS is also commissioned within HMP Usk for the populations of HMP Usk and HMP Prescoed.

Further detail regarding the various NHS dental contract models can be found in the 'GDS contract Reform Overview and Current Position report' *(annex a).*

Since April 2022, participation in the Contract Reform Programme (CRP) has been on an opt-in basis for practices. Performance within the programme is assessed against a series of metrics aligned to each contract's ACV. These indicators currently include ACORN completion, new patient access, new urgent patient activity, care provided to historical patients, fluoride varnish application. Practices that remain on Units of Dental Activity (UDA) contracts continue to be monitored solely on UDA delivery, reflecting the more traditional activity-based model. There are currently 51 practices delivering against Contract Reform and 18 practices delivering against UDAs.

Table 1 shows a summary of the number of practices within each borough that opted into the CR or remained on UDAs since 2022/23.

Borough	2022/23		2023/24		2024/25		2025/26	
	CR	UDA	CR	UDA	CR	UDA	CR	UDA
Blaenau Gwent	9	1	7	3	9	2	9	2
Caerphilly	13	13	13	16	13	12	16	8
Monmouthshire	11	1	5	8	9	3	7	2
Newport	13	2	9	6	10	4	10	4
Torfaen	9	7	7	6	11	3	9	2
Totals	**55**	**24**	**41**	**39**	**52**	**24**	**51**	**18**

Table 1. CR/UDA split by borough since 2022/23.

ABUHB serves a population of approximately 600,000 to 640,000 people. The area covers Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen.

Figure 1 details the total number of patients treated in ABUHB since April 2020-December 2025 across all practices demonstrating an overall increase year on year – (number of UDAs delivered and number of claims for either NP, NUP or HP under Contract Reform).

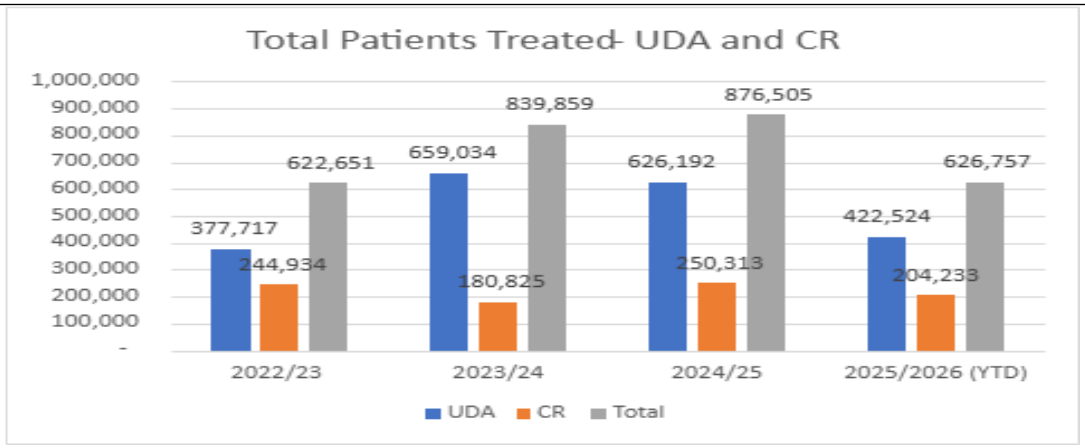


Fig 1. Total patients treated since 2020/21

Figure 2 shows the number of patients seen solely within CR practices, broken down by each metric. The reduction in numbers in 2023/24 is reflective of a number of practices reverting back to UDA delivery (table 1) for that period. Figure 2 demonstrates there was no overall reduction in the number of patients treated across all practices. 2024/25 CR figures returned to 2022/23 volumes.

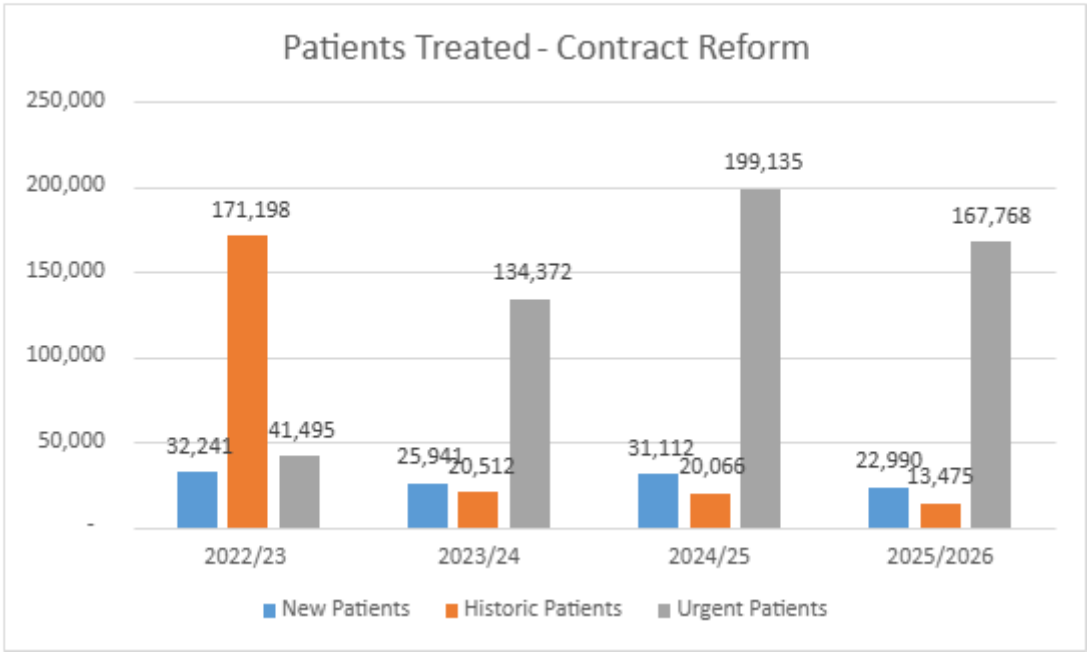


Fig 2. Patient figures across CR metrics

Dental Access Portal

Health Boards across Wales have historically managed patient access for routine NHS GDS services differently with some patient lists being held by Health Boards and some held at individual practice level. ABUHB has not historically held a central waiting list, however from February 2025, the Dental Access Portal was introduced within ABUHB. There are approximately 9,500 patients on the ABUHB DAP which is actively managed by the Primary Care Contracting Team. All CR practices are encouraged to accept new patients from the DAP; however patient allocations are dependent on a practice's capacity.

To date, 20 practices have requested patients from the DAP since February 2025.

Borough	Number of practices requesting (requested) patients from DAP
Blaenau Gwent	3
Caerphilly	8
Monmouthshire	1
Newport	6
Torfaen	2
Totals	**20**

Table 2. Number of practices within each borough accepting new patients from the DAP

To date, 5,345 patients have been successfully allocated to an NHS dental practice.

Borough	No Patients reg since Feb 25	Number of Patients still waiting	Number of allocated	Average wait per borough	Offers Declined
Blaenau Gwent	1336	258	1067	Jan 26	6
Caerphilly	2696	393	2293	Jan 26	4
Newport	4239	3114	1126	July 25	17
Monmouthshire	2431	1696	725	Aug 25	9
Torfaen	2266	2129	134	March 25	7
Totals	12978	7590	5345	NA	43

Table 3. Analysis of DAP by borough as at 6 February 2026

New NHS General Dental Services Regulations

Acknowledging the need to reform NHS GDS services, Welsh Government (WG) issued a consultation in Spring/Summer 2025 with responses to the consultation to be submitted by 19 June 2025. On 23 September 2025 the outcome of the consultation was published. Further information regarding the consultation can be found by accessing the following link: Reform of NHS general dental services | GOV.WALES

The consultation confirmed the use of segmented ACVs within GDS contracts, ensuring dedicated capacity for urgent and routine care to new and active patients, including prevention services. Health Boards will retain flexibility to adjust segment weightings based on local need and practice capacity.

The new NHS GDS Regulations 2026 have been laid (11 February 2026) and will come into force from 1 April 2026 Written Statement: New Contract to Improve Access to NHS Dentistry (11 February 2026) | GOV.WALES

To support the implementation of the new NHS GDS Regulations 2026, WG issued draft guidance to all Health Boards and NHS GDS practices by way of a Vignettes document *(annex b).* Within the vignettes it details the contractual requirements NHS GDS practices must deliver against to receive the total ACV, however it also advises that Health Boards can flex the percentage allocation for each segment based on local need. It should be noted that a final version of the vignettes will be issued to Health Boards and practices by 31 March 2026, along with a model NHS GDS contract.

Below is a breakdown of the baseline segments that must be delivered against from April 2026.

Segment	Allocation	Strategic Purpose
Recall (18+ months)	3%	Capitation-based continuity
Urgent Treatment	7%	Mandated access, paid regardless of DNA
New Patient Assessment	10%	Access via Dental Portal
Care Packages	70%	Core service delivery
Prevention	5%	DBOH compliance, tailored care
Local/National Priorities	5%	Annual negotiation

The table below details the standard proportions of segmented metrics proposed by WG and what that means for ABUHB in terms of patient numbers:

Segmentation of each metric	**7% of ACV for urgent treatment for new patients *(NUP)***	**3% of ACV for recalls of low-risk patients *(recall interval between 18 and 24 months)***	**10% for new patient assessments *(NP)***	**70% to provide care packages *(CP)***	**5% for prevention**	**5% for local or national priorities**
Number of patients required full GDS budget 2026/27	34256	NA	67455	NA	NA	NA 2026/27

Table 4. Baseline segments in comparison with the number of patients required to be seen as part of the full GDS budget allocation

From April 2026, practices must accept new patients (NPs) via the DAP and new urgent patients (NUPs) via the Dental Helpline. This in turn allows the NUP segment to be guaranteed, resulting in the practice receiving the full contract value for this segment. As in 2025/26, the Health Board must develop a NUP rota for 2026/27 to support practices with the delivery of NHS urgent dental provision.

Asesiad / Assessment

As we move through this transition period and beyond, there are a number of contractual processes that require consideration and an agreed Health Board approach to ensure service delivery is maintained, the GDS budget is maximised and patients can continue to access NHS dental care.

These areas include; End of Year management for 2025/26, software mitigation, re-procurement of contract terminations and variations, contract segmentation, opening hours and resource implications. Each one is appraised in turn.

- **2025/2026 End of Year**

A key consideration for 2025/26 is the fundamental change in the currency of performance management as the system transitions toward the new national GDS contract model. Historically, end of year assessments has been based on numerical or percentage-based delivery of specific metrics. Under the emerging arrangements, any carry forward position, whether under deliver or over delivery, will need to be managed in monetary terms, rather than as units of activity or percentages achieved.

This shift from activity-based metrics to a financial currency represents a substantial operational change. It will require Health Boards and providers to apply new processes for assessing year end performance, calculating financial adjustments, and ensuring that contract amendments are consistent with the new framework.

Welsh Government (WG) has confirmed that for 2025/26 end of year should be managed as follows for contract reform practices:

*"… for practices working under the GDS variation arrangements the mitigation formula for high needs remains in place for the 2025/26-year end. As a reminder the formula is that for every 1% increase above the Health Board **median** average for red ACORN with 4 or more interventions, the annual HP, NP and NUP targets can be decreased by 2%."*

The table below details the current end of year management for contractors:

Percentage Delivered	Action for Delivery
Activity achieved below 95%	the Health Board will apply a financial recovery. The Health Board reserves the right to recover the full underperformance, up to 100%, where a contract has underperformed in the previous financial year or where the practice has highlighted challenges with achieving the annual contracted target
Activity achieved between 95% to 100%	the Health Board may carry forward this underperformance or request a financial recovery
Activity 100% to 105%	this is managed at the discretion of the Health Board and a carry forward to the following financial year, with no contract value increase, may be applied. The Health Board also reserves the right to financially reward the practice instead of applying a carry forward
Activity achieved in excess of 105%	no adjustment will be made; activity will be lost

Table 5. Summary of EOY management process

Due to the changes from 1 April 2026, there are some specific considerations required for the 25/26 EoY process*;*

Option 1*:*

Manage EoY as confirmed by WG and manage underperformance as outlined above (table 5), converting underperformance between 95-100% to money and increasing the ACV for 2026/27 accordingly as 100% ACV has been awarded in 2025/26.

Manage EoY as confirmed by WG and manage overperformance as outlined above (table 5), converting overperformance between 100-105% to money and decreasing the ACV for 2026/27 accordingly as only 100% ACV has been awarded in 2025/26.

Option 2:

Manage EoY as confirmed by WG and manage underperformance as outlined above (table 5), converting underperformance between 95-100% to money and increase the care package % for 2026/27 accordingly as 100% ACV has been awarded in 2025/26.

Manage EoY as confirmed by WG and manage overperformance as outlined above (table 5), converting overperformance between 100-105% to money and reduce the care package % for 2026/27 accordingly as only 100% of the contracts ACV is awarded during any given financial year.

Option 3:

Manage EoY as confirmed by WG and manage underperformance as outlined above (table 5), converting underperformance between 95-100% to money and increasing the ACV for 2026/27 accordingly as 100% ACV has been awarded in 2025/26.

Manage EoY as confirmed by WG and manage overperformance as outlined above (table 5), financially rewarding practices where achievement is 100-105%, resulting in no carry forward being applied for 2026/27.

Option 4:

Manage EoY as confirmed by WG and manage underperformance as outlined above (table 5), converting underperformance between 95-100% to money and increase the care package % for 2026/27 accordingly as 100% ACV has been awarded in 2025/26.

Manage EoY as confirmed by WG and manage overperformance as outlined above (table 5), financially rewarding practices where achievement is 100-105%, resulting in no carry forward being applied for 2026/27.

Potential Overperformance Costs if Financially rewarded (based on January 2026 forecast, likely to increase)

- UDA Overperformance:
  Only one contractor is forecast to deliver over 100%, approximately 107% of its UDA activity. Estimated cost for up to 5% overperformance: £REDACTED.
- CR Overperformance:
  11 practices are projected to overperform on both NP and HP activity without the need for offsetting.
  Maximum cost exposure for up to 5% overperformance: £REDACTED, though the actual cost may be lower if practices do not fully reach the 5% threshold.

The Primary Care Contracting Team recommends option 1, this is supported by the Dental Director.

NB. For any increase or decrease in ACV as a consequence of under or over performance, this applies to the determination of % segments, actual paid ACV remains the same.

- **Software Mitigation**

In November 2025, all practices utilising the computer software system, EXACT, were advised that the system would not be updated from April 2026 and therefore if the

practice was intending to opt in to the new way of working, they would need to change their software system to Dentally *(annex c).*

42/69 ABUHB dental practices utilise the system EXACT and therefore switching software systems may cause disruption whilst a practice is working towards end of year and in many cases implementing the new regulations. This transition may temporarily affect contract delivery for 2025/26 through factors such as system downtime of up to two weeks, the need to close off courses of treatment (CoTs), data discrepancies during transfer, and time required for staff training.

To ensure fairness and maintain stability during the transition, a structured mitigation process should be considered.

In March 2018 practices were forced to close, due to extreme weather conditions, causing disruption to contract delivery. In 2017/18 Welsh Government in conjunction with the British Dental Association (BDA) reduced the contractual tolerance level from 95% to 94% due to the extreme weather conditions.

This section of the paper seeks SLT agreement in advance on a proactive approach to managing any appeals arising from software related disruption during 2025/26, specifically for contractors transitioning to the new dental system platform. The aim is to ensure fairness, consistency, and a manageable workload for the team by establishing a clear framework in advance.

Options for consideration;

Option 1:

Do nothing. It is the responsibility of the provider to manage their contract in order to achieve at least 95% at end of year.

Option 2:

Award a 1% tolerance to all EXACT providers who opt in to the new way of working from April 2026. This would be a Health Board decision only but would demonstrate support for the profession.

Option 3:

Apply a 1% tolerance to only those EXACT providers who request mitigation and are opting in to the new of working from April 2026. This would be a Health Board decision only but would demonstrate support for the profession. However, would not demonstrate equity.

Option 4:

Apply a 1% tolerance to only those EXACT providers who request mitigation and are opting in to the new of working from April 2026 by establishing a multi-disciplinary panel.

A similar approach has been adopted previously. This would be a Health Board decision only but would demonstrate support for the profession. A multi-disciplinary panel established to review mitigation appeals submitted by EXACT contractors. Providers would be required to demonstrate impact in key areas such as verified system discrepancies, workforce constraints directly linked to the software transition, or loss of clinical hours during system shutdown or migration. Evidence of delays in closing CoTs due to system limitations would also be considered.

The Primary Care Contracting Team recommend option 4, this is supported by the Dental Director.

- **Contract Terminations**

There are currently 69 NHS GDS contracts across ABUHB. However, since December 2025, the Health Board has received notification of 9 contract terminations (totalling 12 during 2025/26) plus 2 contract variations (reductions), one of which will take effect from April 2026.

The table below details the current number of GDS contracts in ABUHB as of February 2026, the name of the practices who have varied their contract to date and the number of practices that have given notice to terminate their contract as of 1 April 2026. Also included in the number of GDS contracts expected to deliver from 1 April 2026 onwards:

Redacted due to commercial sensitivity

Table 6. Contractual Information as at 24 February 2026

In line with other Health Boards across Wales, ABUHB wrote to all practices on 2 February 2026 to confirm that practices had until 16 February 2026 to confirm whether they will be continuing NHS GDS provision from April under the new regulations.

The Health Board has not been made aware of any further terminations or variations to date.

To maintain access to NHS dental services and maximise the GDS budget for NHS GDS provision, it is important that the Health Board reprocures investment returned via contract terminations at its earliest opportunity. Therefore, SLT are asked to consider the following options;

Option 1:

Do nothing, do not look to recommission services. This would have a significant impact on NHS GDS access and the wider healthcare system.

Option 2:

Undertake a full procurement exercise in accordance with the Provider Selection Regime (PSR) Regulations, with the aim being to secure multiple replacement GDS providers in order to maintain current access levels. At present, £3.7m to be procured.

Option 3:

Undertake a full procurement exercise in accordance with the Provider Selection Regime (PSR) Regulations on a partial basis. Proportion of investment to be confirmed by SLT.

The Primary Care Contracting Team recommends option 2, this is supported by the Dental Director.

- **April 2026 – Segmented Model**

Under the 2026 regulations, the segmentations are flexible, in their entirety, at practice level, NCN/ borough level and Health Board level either at the request of a practice, to be agreed, or at the determination of the Health Board in order to meet local need.

The Health Board has considered the WG baseline for contract segmentation and analysed local data to assess achievability and consequently calculated adjustments for 2026/27. Where a variance has been applied, this has been included in the Care Package %.

Segment	WG Allocation	ABUHB Allocation	Variance
Recall (18+ months)	3%	3%	0%
Urgent Treatment	7%	3%	-4%
New Patient Assessment	10%	3%	-7%
Care Packages	70%	86%	16%
Prevention	5%	5%	0%
Local/National Priorities	5%	0%	-5%
	100%	**100%**	

Fig 4. Details ABUHB allocation

The Health Board issued communication to all NHS GDS practices on 26 January 2026 outlining its indicative segmented percentage for each contract segments from April 2026 *(annex d).*

New Urgent Patients (NUP)

The Welsh Government's proposal for 2026/27 allocates 7% of the contract value specifically for providing urgent treatment to new patients (NUPs). Under this model, practices must deliver definitive urgent treatment at the first appointment. If this is not possible, they must offer a follow-up appointment to complete the urgent course of care.

Practices will need to provide urgent appointment slots at a frequency agreed and planned in advance with the Health Board. All NUP urgent appointments will be booked solely through the Health Board's dental helpline and therefore guaranteed, the urgent appointment fee will be paid to the contractor even if the patient does not attend.

As a result, this part of the contract is fully protected and achievable throughout the contract year.

Across the Health Board, 1,135 urgent appointments are available via PDS EDS and CR provision. The current uptake is 83%.

Prior to receiving information relating to the new regulations 2026, the PDS contracts have been extended to March 2029, in accordance with current regulations. Under current regulations, either the contractor or the Health Board may terminate a PDS contract providing three months' notice. Continuing with the existing PDS-delivered EDS model into 2026/27 will safeguard service provision whilst the Primary Care Contracting Team implement the new NHS GDS regulations 2026.

WG 7% baseline requirement would generate more capacity than current patient demand, it is therefore necessary to reduce the proportion of ACV currently allocated to NUP. Adjusting this percentage will help ensure that contract capacity more accurately reflects actual patient demand and supports a more efficient use of resources. However, it is important to note that if patient demand changes for urgent dental services, whether that be to decrease once terminated contracts are reprocured or increases due to additional terminations, the Health Board has the option to flex contracts according to support such change.

The following table details the number of NUPs practices would need to see based on WGs suggested percentage compared to the Health Board's varied percentage.

NUP	WG 7%	ABUHB 3%
Number of new urgent patients required for this metric across all GDS contracts	34,256	14,681
Monthly requirement per percentage April 2026	2,854	1,223
Current available appts (average per month across all providers)	1,137	
Total number of urgent appts utilised across all EDS/NUP providers	952 (83%)	

Table 8. Proportioned segmented percentage for NUPs

All contractor NUP targets will be used to calculate how many NUPs practices need to see each week, a rota will be prepared in advance, working closely with the contractors to ensure the allocated NUP days/times align with patient demand. The Primary Care Contracting Team will also work closely with the Dental Helpline.

The Primary Care Contracting Team will monitor NUP delivery on a month-by-month basis, undertaking a full review at mid-year and flex where/if required.

With regards to the PDS EDS agreements in place, these agreements will need to be varied to align with the new NHS GDS regulations 2026 from April 2026. Current agreements align to the UDA model and remuneration system. As there will be no allowance for UDAs from April 2026, current EDS agreements will be varied to reflect the NUP charge of £75. The Primary Care Contracting Team is currently modelling this.

<u>New Patients (NP)</u>

The WG baseline position for 2026/27 allocates 10% of the contract value specifically for providing treatment to new patients (NPs). Under this model new patients must be supplied through the Health Board's Dental Access Portal (DAP), with specific exceptions such as children whose parents are already NHS patients at the practice.

Since the launch of DAP in ABUHB in February 2025, the number of patients joining the system has varied significantly across the year. Using daily averages from selected weeks within this financial year, the indicative monthly volumes are as follows:

- Pre-termination period (October 2025): Based on two weeks of data, the daily average number of patients adding themselves to DAP equates to an estimated 806 new additions per month (assuming a 31-day month).

- Post-termination notices (January 2026): Following the issuing of contract termination letters to patients in January, the daily average increased substantially, projecting approximately 2,883 new additions per month, representing a 30% increase.
  This increase is expected to be temporary and reflects the spike caused by the notification of several contract terminations across ABUHB.

If the Health Board were to adopt the WG standard segmentation of 10%, there is a significant risk that the Health Board would not have sufficient new patients available on the DAP to allocate, meaning many practices would not achieve their NP requirements.

Current DAP data already demonstrates considerable variation between boroughs. The following table demonstrates the number of patients who have registered on the DAP by borough:

Borough	No Patients reg since Feb 25	Number of Patients still waiting	Number of allocated	Average wait per borough	Offers Declined
Blaenau Gwent	1336	258	1067	Jan 26	6
Caerphilly	2696	393	2293	Jan 26	4
Newport	4239	3114	1126	July 25	17
Monmouthshire	2431	1696	725	Aug 25	9
Torfaen	2266	2129	134	March 25	7
Totals	12978	7590	5345	NA	43

Table 9. Patient distribution by borough

This uneven distribution makes it increasingly challenging for all practices to meet current NP targets, and the situation would be significantly worsened under a higher WG-mandated percentage.

For these reasons, The Health Board has reduced the proportion of ACV allocated to NP assessments to 3%. This will apply across the whole Health Board initially, with the option to flex to the individual contractors need if required.

The table below details the segmentation for full GDS budget, broken down per borough in ABUHB (as of 27/01/2026):

NP	WG 10%	ABUHB 3%	Number of pts awaiting allocation on DAP as of 06/02/2026
Number of new patients required for metric across all GDS contracts	67,455	20,237	7,590
Blaenau Gwent	11,069	3,321	258
Caerphilly	21,136	6,341	393
Newport	17,978	5,393	3,114
Monmouthshire	6,912	2,076	1,696
Torfaen	10,353	3,106	2,129

Table 10. DAP patients required for each borough

DAP Challenges

A key challenge relates to the unpredictability of patient behaviour. It is the responsibility of the patient to register themselves to the DAP, and the Health Board cannot quantify how many patients will choose to register or when they will do so.

There appears to be a lack of public awareness of the DAP. Although WG have published communications assets and the Health Boards Communication and Engagement Team has

issued public communications, current levels of patient understanding and knowledge of the system and how to register remain low.

Another significant challenge is the potential inability of the Health Board to supply practices with the required number of new patients. While terminations will increase additions to DAP, which the Primary Care Contracting Team have seen in recent weeks, the requirement for practices to take *all* new patients exclusively from DAP means that shortages could quickly arise, particularly in boroughs where DAP numbers are already very low.

WG has recently confirmed that, as of January 2026, there are 81,000 patients on DAP across Wales.

Given these constraints, a pragmatic approach for 2026/27 may be to guarantee the NP percentage within contracts so that if the Health Board exhausts the available DAP pool, practices are still supported in meeting the metric which mandates all new patients are allocated from DAP. This may be considered in time.

Care Packages

The WG proposed 70% care-package segment forms the core of the contract and encompasses the full range of treatment activity delivered by practices. The revised valuation model provides a more appropriate and equitable remuneration structure than the former UDA system, meaning that practices may achieve their contract value more quickly while delivering fewer total treatments. For practices serving high-needs populations, this may result in their care-package allocation being exhausted earlier in the year, which could limit their ability to offer timely recall examinations or further courses of treatment.

A significant forecasting challenge for 2026/27 is the inability to accurately forecast care-package delivery.

Care Package	Description
Simple Restorative Care Package	Includes fillings, temporary/intermediate crowns, Hall crowns and extractions up to a total of 4 teeth.
Extensive Restorative Package	As per simple restorative package for 5 to 8 teeth. Composite material for anterior teeth (canine to canine). Posterior teeth to use clinically appropriate materials, which include both amalgam and amalgam alternatives.
Periodontal Care Package (maximum of two per patient per year)	Entry assessed on engagement from assessment, but Patient must achieve minimum of 30% plaque score by 3rd Oral Health Education visit. Includes plaque score and tailored OHI, 6ppc, RPRF and Pocket debridement. Contract holders expected to follow guidance such as the British Periodontology guidance on managing Patients with periodontal disease.
Denture Care Package	Excludes laboratory fees (to be paid directly by the Patient, unless exempt from NHS charges). Includes upper and lower dentures, including Cobalt Chrome dentures if clinically indicated
Stabilisation Care Package	For Patients who present with 7+ carious teeth, where at least two of the teeth have caries extending to close proximity or into the pulp and the Patient is keen to engage. Includes extractions, DBOH prevention, Glass Ionomer intermediate restorations, pulp extirpation, removal of plaque retentive factors.
Anterior Root Canal Package	For up to two teeth 1-3, includes any permanent restorations.
Posterior Root Canal Package	Posterior and pre-molar root canal package, for up to two teeth. Includes Second molars if the tooth is strategically necessary to maintain dentition (e.g. Patients who have a lack of posterior support, a medical reason to retain etc.). Includes any cuspal coverage needed, excluding laboratory fee (paid by patients, unless exempt from NHS charges).
Crown Bridge, Inlay, Onlay and Veneer Care Package (limited to 10% of overall care package delivery)	Excludes temporary restorations. Up to 3 units, includes study models, posts and cores etc. Excludes laboratory fees.
Miscellaneous Care Package	For treatment and interventions for patients that fall outside a current care package or outside the guarantee period. Includes: Denture repair/addition/reline, Denture ease, Study models, Bite raising appliance, Biopsy, Repair/Recement of a crown, bridge or veneer, Removal of sutures, Pericoronitis, ANUG, Orthodontic urgent issues, Arrest of haemorrhage (for extractions carried outside of a care package), Dry socket (for extractions carried outside of a care package). Excludes any laboratory fee.

Table 11. Care Package title and description.

From April 2026, a patient can be eligible to receive one or multiple care packages as part of their course of treatment. Whilst practices will be able to report the start of a course of treatment with the expected packages included, these may change throughout a patient's treatment journey and won't be confirmed until the practices close the course of treatment and submits their claim.

As this will be the first year of operating under the new regulations from April, both practice behaviour and patient flow are highly uncertain. In addition, the gap created by the reduction in contracts, despite plans for recommissioning, means there will be an unavoidable shortfall in activity that the Health Board cannot predict with confidence. For these reasons, forecasting delivery through care packages will not be feasible until the system has embedded over a full year and we have a clearer understanding of how practices respond to the new model.

For 2026/27 care packages will be supplemented where the Health Board has flexed other segments. Therefore, increasing the care package percentage from 70% to 86%.

Recalls

Practices will receive a fixed allocation of 3% of their ACV to cover all recall activity for low-need patients. This replaces the previous system in which practices were paid per individual examination and aligns with Welsh Government direction that no monetary value should be attributed to individual recalls for this cohort. In contrast, examinations for medium and high need patients will continue to attract a £50 fee per examination, ensuring resource is targeted to clinical need.

It is not possible to forecast how many patients will be treated within this segment across the Health Board in 2026/27. Recent contract years have shown that patient behaviour is influenced by legacy arrangements, with many patients returning annually to obtain the once-a-year historic patient credit and to complete the required ACORN assessment. As the new model embeds, and as practices adjust recall intervals in line with NICE guidance, activity patterns are likely to change materially and unevenly across localities, limiting our ability to model volumes with confidence.

Prevention

Practices will receive a fixed allocation of 5% of their ACV to ensure consistent delivery of evidence based preventive care. It focuses on full compliance with Delivering Better Oral Health (DBOH), including fluoride application, prevention conversations, and -risk-based care planning. Rather than being tied to activity levels, this component will be -monitored through audits and clinical software that records key preventive measures, such as fluoride varnish applications, fissure sealants, and tailored advice. Overall, the segment acts as an addition to core activity to strengthen and standardise prevention across patient pathways. Delivering better oral health: an evidence-based toolkit for prevention - GOV.UK

Local/National Priorities

The 5% segment under the new regulations is intended to be a flexible area that Health Boards can use to focus on local priorities, emerging pressures, and systemwide improvement. Although the final process for selecting these priorities is still being developed by Welsh Government groups, the expectation is that this portion will incentivise activities such as quality improvement work, participation in new clinical pathways, and targeted interventions for specific patient groups.

Overall, the 5% is designed as a tool for Health Boards to encourage innovation, improve quality and consistency of care, and respond to local population needs while staying

aligned with national aims. However, as this approach will not be in place for 2026/27, it is instructed by WG that the 5% allocation be temporarily transferred into care packages, increasing the proportion that must be delivered through care packages for all contractors.

Practice Opening Hours

The vignettes document (annex b) issued by WG to Health Board's and practices details that *'the Health Board will advise on what their expected core hours will be, but this is likely to be Monday to Friday 9am till 5pm'.* However, the new NHS GDS Regulations 2026 do not make reference to this.

Historically many practices close on a Friday afternoon. To ensure consistency and equitable access remains the Primary Care Contracting Team suggests that all NHS GDS practices should be expected to at least deliver NHS dental services, Monday to Friday between 9am – 5pm. This is to ensure OOH and Emergency Departments are not adversely impacted by a practice closing early. This approach is consistent with national aims to improve fairness, consistency, and continuity within the new contract framework.

However, it should be noted that OOH does not commence until 6:30pm weekdays, leaving a gap in service provision between 5-6:30pm.

Additionally, it should be noted that stipulating a practice's opening as Monday to Friday between 9am – 5pm may generate operational risks for smaller and single-handed practices, particularly where their ACV does not proportionately support the staffing levels or opening hours required to meet these obligations.

SLT are therefore asked to consider the following options and confirm its preferred option.

Option 1:

Do nothing. Practices to maintain current arrangements.

Option 2:

Standardise hours. All practices to open 9am–5pm, Monday to Friday

Option 3:

Standardise hours, Monday to Friday between 9am – 5pm but practices can request to vary. All practices to be advised that practice opening should be 9am–5pm, Monday to Friday but should a practice wish to vary these hours, this may be requested as per Part 8 of the new NHS GDS Regulations 2026. Any hours the practice is not open during this time, they will be required to have buddy arrangements in place to enable patients seeking urgent treatment to be seen in a timely manner, not putting additional pressures on alternative services.

The Primary Care Contracting Team recommends Option 3, this is supported by the Dental Director.

- **PDS Commissioning as part of a GDS Contract**

Child only & Exempt Patients

From April 2026, WG have advised that no new child only contracts can be commissioned by Health Boards unless approval is sought from WG.

ABUHB currently commissions child and exempt contracts from 3 providers.

Redacted

Table 12. Child and exempt contracts

It has been communicated by WG that existing child contracts can be varied to allow these contracts to continue from April 2026 as children can be allocated to practices from the DAP. However, exempt contracts cannot as the DAP does not collate a patients exemption status therefore patients are unable to be allocated to a practice based on their exemption status.

At present, those NP allocated form DAP in ABUHB, supports the traditional "family practice model" and ensures that access, recalls, and care planning reflect whole-household needs rather than separating patient groups.

The table below details the number of patients aged under 18 years registered on the DAP within each borough.

Borough	Caerphilly	BG	Torfaen	Newport	Monmouthshire	Total
No of patients age 18 and under awaiting allocation on DAP	67	30	403	714	377	1591

Table 13. Children registered on DAP within each borough as at 17 February 2026

SLT are therefore asked to consider the following options and confirm its preferred option.

Option 1:

Do Nothing.

All child and exempt contracts to be terminated, or vary to full GDS contracts, from April 2026. Current DAP data shows that there are insufficient numbers of children across all boroughs, which would create both operational and access challenges. Implementing a child only model would split families across different practices, requiring parents or guardians to travel separately for their children's appointments while continuing their own care elsewhere. In many areas, children may also need to travel significantly further due to the low volume of under-16s on DAP. This approach would run counter to the principles of the "family dentist" model and introduce inequity in access.

Option 2:

Vary to continue with child only contracts

This option carries the risk of unintentionally supporting or driving private dental care. Separating provision in this way would split families, potentially forcing parents or guardians to pay privately at practices where their children are seen as NHS patients. This creates both equity and financial concerns for households and may undermine the broader aims of NHS dental provision.

The Primary Care Contracting Team recommends Option 1, this is supported by the Dental Director.

Orthodontics / EDS

In some cases, ABUHB commissions PDS services via GDS contracts; Orthodontics (x 1 practice) and EDS (x 2 practices). WG has advised that this will not be viable from April 2026, therefore these practices will either need to terminate these services, convert ACV into overall ACV or split the contract to allow for a stand-alone contract to be commissioned.

The following should be noted where a variation to orthodontic services is required:

- practice may advise that they do not wish for the ACV to be separated and hold a stand-alone contract or they may wish for the ACV to be amalgamated with their GDS ACV – due to the nature of how orthodontic services are commissioned and delivered, transferring patient care to an alternative orthodontic practice, will pose significant financial pressure on the Health Board and may result in patient care being delayed.

The following should be noted where a variation to EDS services is required:

- should the practices wish to amalgamate their EDS ACV into the GDS ACV, it is not expected to cause significant risk to the Health Board or patients as NUPs are commissioned via all NHS GDS contracts from April and the Health Board has extended the PDS EDS contracts until 2029.

The table below details all PDS services within ABUHB for information.

REDACTED

Table 14. PDS agreements

- **NHS GDS Regulations 2026 – Changes**

Key areas of change from April 2026

- Mid-Year - currently practices must achieve at least 30%, this will change to 40% and contractors will be required to submit a mid-year report to the Health Board by 31 October each year.
- Termination – currently practices must provide at least three months' notice to the Health Board if the contractor is wishing to terminate their agreement, this will change to six months.
- PDS service provision – Services must align with the new NHS GDS regulations 2026, therefore the remuneration structure will change for all services commissioned
- Accelerated Cluster Development (ACD) - dental practices will be funded £1,200 per annum to attend 4 meetings per year. This funding will be top sliced from the contractors ACV.

<u>Patient Charge Revenue/Forecasting</u>

The Health Board is unable to accurately predict how practices will operate and how services will be delivered under the new regulations. The Primary Care Contracting Team will closely monitor contract delivery on a monthly and quarterly basis and, in addition, a full review will be undertaken at mid-year and end of year.

The Health Board will need to observe a full year of implementation to understand delivery patterns and contractor behaviour under the new contractual framework. In addition, the reduction in contract numbers, despite plans to recommission, will create a gap in delivered activity, which will further reduce the overall PCR.

The Primary Care Contracting Team will continue to work closely with finance colleagues and:

- Increase contractor engagement - More frequent touchpoints with contractors, including an increase in face-to-face practice visits.
- Continue to Performance Manage **-** Monthly review of contractor delivery using available data, supported by quarterly and mid-year reporting. Updates will be provided through quarterly meetings, SLT, and IOHG. Additionally, the Health Board may look to flex contracts further.
- Manage EoY as stipulated in the new NHS GDS regulations 2026 **-** Preparation and oversight of the end-of-year process, including forecasting final delivery, confirming end-of-year positions, and communicating outcomes with both contractors and SLT. This cycle will be repeated annually.

- **Resources**

The Primary Care Contracting Team recognises the need to manage and monitor all NHS GDS contracts from April very closely. The Primary Care Contracting Team will also be required to actively manage the supply of NPs from the DAP. Since April 2025, the team has worked closely with 20 practices accepting patients from the DAP. It is anticipated that this will increase to 60 from April 2026. The management of the DAP is a lengthy process and at present is being managed by the current workforce within the team, approximately 0.6wte.

Additionally, contract management will increase as the Health Board has discretion to commission up to 60 varying contract models at any point in the year, in accordance with the regulations (segments flexed differently for all contractors). This in turn will require up to 60 varying ways to contract manage, possibly varying multiple times throughout each financial year.

With regards to the wider reform programme, dental practices have not been included in ACD and will require support and direction whilst establishing this way of working along with identifying and delivering innovation.

Collectively, these changes represent a material increase in workload and administrative complexity, which cannot be absorbed within current staffing levels without creating operational risk.

The current workforce, in addition to HoPC and DHoPC, consists of:

- Band 8a - 1 WTE (shared Dental and Optometry role)
- Band 7- 1 WTE
- Band 6- 1 WTE
- Band 5 - 0.5 WTE (vacant - shared Dental and Optometry role)

To implement the new dental system and manage higher levels of patient allocation and communication through the DAP, it is likely that additional resource may be required. This is currently being scoped alongside the requirements of the wider Primary Care Contracting Team. the team will require additional administrative capacity. This includes:

Next steps

Following confirmation of the preferred options for the areas described in the report, a series of coordinated actions will be required to facilitate a smooth transition into the 2026/27 contract year. The immediate focus will be on clear communication with both the profession and patients, alongside internal preparation to manage pressures created by the revised model.

The steps below outline the key activities.

Key actions will include:

- Informing the profession of the agreed approach, including revised percentage allocations and expectations for NUP, NP and care-package delivery in 2026/27.
- Issuing patient-facing communications to reinforce how to access NHS dental care through the Dental Access Portal (DAP) and the DAP Helpline, ensuring consistent messaging across all boroughs.
- Revising workload within the existing team to support implementation of the new model, manage increased DAP-related activity and ensure sufficient capacity for contract oversight and monitoring.
- Preparing for the re-tendering process, ensuring that capacity lost through contract terminations is replaced and that new provision aligns fully with the urgent access model and revised percentage allocations.
- Preparing and update internal process/SOPs to support the changes detailed in the new regulations.

This approach ensures that contractors, patients, and internal teams are appropriately supported through the transition and that the Health Board is well positioned to deliver stable and equitable access during 2026/27.

Argymhelliad / Recommendation

Within this report SLT are asked to consider a number of options, all of which are detailed below:

2025/2026 EoY (page 5)

Preferred option - Option 1:

Manage EoY as confirmed by WG and manage underperformance as outlined above (table 5), converting underperformance between 95-100% to money and increasing the ACV for 2026/27 accordingly as 100% ACV has been awarded in 2025/26.

Manage EoY as confirmed by WG and manage overperformance as outlined above (table 5), converting overperformance between 100-105% to money and decreasing the ACV for 2026/27 accordingly as only 100% ACV has been awarded in 2025/26.

Software Mitigation (page 7)

Preferred Option 4:

Apply a 1% tolerance to only those EXACT providers who request mitigation and are opting in to the new of working from April 2026 by establishing a multi-disciplinary panel.

Contract Terminations (page 8)

Preferred Option - Option 2:
Undertake a full procurement exercise in accordance with the Provider Selection Regime (PSR) regulations on a full basis. At present, £3.7m to be procured.

Practice Opening Hours (page 16)

Preferred Option - Option 3:

Standardise hours, Monday to Friday between 9am – 5pm but practices can request to vary with buddy arrangements in place.

Child and Exempt (page 16)

Preferred Option - Option 1:

Do Nothing, all child and exempt contracts to be terminated, or vary to full GDS contracts, from April 2026.

Supporting Documents

Annex A- GDS Consultation Exec Cor

Annex b - Vignettes.docx

Annex c - Software.docx

Annex d - HB Comms.pdf

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):	Choose an item. Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI Link to IMTP	
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 June 2026
CYFARFOD O: **MEETING OF:**	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Regional Planning
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Executive Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Claire Nelson, Deputy Director of Strategy, Planning and Partnerships

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

1. Sefyllfa / Situation

This report provides a progress update on several ongoing regional and South Wales service planning programmes. All significant work and recent developments since the last update was given to the Partnerships, Population Health and Planning Committee in January 2026 are summarised in this paper.

2. Cefndir / Background

The Southeast Wales Health Boards (Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg) are committed to collaborating on several 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 and continued outlined commitments set out in the Planning Framework for 26/27. Health Board planning teams 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 Southeast Wales area.

- **Asesiad / Assessment**

An overview of current programmes is set out below:

3.1 Regional Ophthalmology

The Regional Ophthalmology Programme was awarded £16.5 million in non-recurrent funding by Welsh Government for Q2–Q4 of 2025/26, covering the period July 2025 to March 2026, with a specific mandate to outsource 11,000 cataract pathways to independent sector providers. This investment was supplemented by £7 million recurrent regional funding, which included provision for 1,492 cataract pathways to be outsourced during the same financial year. Together, these allocations created a total outsourcing target of 12,492 cataract pathways for delivery within a nine-month period.

The project successfully delivered 12,529 cataract surgeries across five external providers based in Newport, Cardiff, Bristol, Gloucester and Swansea. During the project over 17,000 patients were sent a letter inviting them for cataract surgery with the external providers. The letters included a questionnaire to assess willingness to travel and clinical suitability for the private providers and encourage patient participation in their care. Over 15,000 patients responded to the letters and over 13,000 patients were sent to private providers for treatment. Over 10,000 patients had an outpatient appointment, and 8,840 patients had eye surgery. 42% of patients had both eyes treated within the project resulting in the delivery of 12,529 cataract surgeries.

A small element of outsourcing as part of the 2026/27 recurrent regional funding has been approved and is due to start, concentrating in line with clinical guidance on the second eyes that require operating upon.

Aside from cataracts, there has been a focus on progressing several digital enablers with Open Eyes, an electronic patient record that works across primary and secondary care live in the Health Board since end of March 2026 although there is a risk that this only has central funding until early 2027. Work is also ongoing with DHCW (Digital Health Care Wales) on establishing a shared regional waiting list which is established for Ophthalmology could then be applied to other specialties. Clinically, Glaucoma is being focussed on with demand and workforce analysis being undertaken with the aim of streamlining the pathway which affects 4000 patients per year in Gwent.

3.2 Regional Orthopaedics

The Regional Orthopaedic Plan for primary arthroplasty and Full Business case (FBC) for Phase 2 of the Llantrisant Health Park (LHP) development which seeks to establish a new primary arthroplasty hub for additional capacity, are due to be finalised by 8th July. They will be presented at internal Health Board meetings and Board meetings at the end of July prior to submission to Welsh Government for funding consideration. The FBC will outline the latest demand and capacity and the work of pre-operative assessment, clinical advisory groups and digital workstreams that inform the delivery model.

An extraordinary Regional Project Board is due to take place on 23rd June with several Executive Directors primarily to share workforce and finance updates.

Slides will be presented at the PHPP meeting to provide the latest position on the FBC which is dynamic due to the upcoming deadline.

3.3 Regional Pathology

The Regional Pathology Programme has been established to oversee the identification, development and implementation of regional pathology solutions and standardisation of practice across south-east Wales (SEW). While the programme spans all pathology disciplines, the initial focus is on Cellular Pathology and exploring the potential for a centralised model of Cellular Pathology services to address regional shortfalls in workforce and estate. A dedicated working group has been established to develop the case for change, alongside an associated options appraisal of available NHS estate across the region.

To support this work, and to inform wider opportunities for standardisation in practice, a first region-wide Cellular Pathology benchmarking exercise has been completed, establishing a 2024–25 baseline dataset across key domains which is currently undergoing validation. A further iteration is planned to incorporate 2025–26 data, alongside refinements to data collection processes. In parallel, Digital Cellular Pathology (DCP) is progressing through formal procurement, with the tender published and a supplier award anticipated in autumn 2026. A dedicated programme board is being established to oversee implementation planning, rollout sequencing and clinical engagement, supporting the transition to digital reporting.

3.4 Regional Endoscopy

The contract for the Independent Sector Provider (ISP) who will deliver Endoscopy at LHP is being progressed with all inputs completed except for the lease arrangements which will follow. Whilst in September 2025 ABUHB Board endorsed the principle of commissioning endoscopy activity at LHP to the equivalent of five sessions based on demand and capacity requirements.

HEIW (Health Education and Improvement Wales) have submitted a business case for Phase 2 of their Endoscopy Plan (with Phase 1 funded from their existing allocation) to Welsh Government for funding of consisting of three elements:

- Establish a Training Academy Hub in LHP and regional training centres in SW Wales and North Wales
- introduce accelerated training
- appoint National Training Faculty to support delivery of both training centre and accelerated training

Due to uncertainty on the funding arrangements, a HEIW led workshop has recently been held with south-east Health Boards to outline the case, with further discussions ongoing.

3.5 Regional Joint Committee

The Regional Joint Committee (RJC) workplan is currently focussed on the following areas in addition to supporting the regional Orthopaedic work:

- Deep Dives on Digital and Data workplans across the region
- Working up the potential for a commonality of approach to Clinical Services assessment and planning across the region and beyond

- Procurement of a partner to develop Organisational Development in the RJC

3.6 Regional Communications and Engagement

A coordinated south-east Wales regional communications and engagement approach is being developed to support regional programmes, ensuring consistent and aligned engagement across the three Health Boards. This work is being progressed through the recently established SEW Regional Engagement Forum, bringing together communications, engagement and workforce leads to establish a shared approach.

The focus is on developing a clear regional "case for change" narrative and an integrated communications and engagement plan, enabling early engagement with the public and workforce, and providing a consistent framework to support programme development while allowing for local adaptation. This is being developed iteratively, with input from key stakeholders including Llais. The plan will be submitted to the Regional Development Group on 10th July and subject to approval, progressed through Health Board governance processes.

3. Argymhelliad / Recommendation

The Committee is asked **to note** the updates included in this report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	SRR001F SRR007A
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	
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 prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	LHP: Llantrisant Health Park RJC: Regional Joint Committee SEW: South-East Wales
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 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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives 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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 June 2026
CYFARFOD O: **MEETING OF:**	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Public Health Update Report**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Tracy Daszkiewicz, Executive Director of Public Health & Strategic Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	James Attwood – Population Health Management (PHM) Amy McNaughton – PSB Update Simon Hodson – Joint Strategic Assessment (JSA) & Gwent Indicator Framework (GIF) Will Beer – Vaccination Update Shareen Ali – Health Protection Update

Pwrpas yr Adroddiad **Purpose of the Report**
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report along with its detailed appendices provides an update to the committee on a number of Public Health priorities and partnerships, including:

- Population health management (appendix 1)
- Joint strategic assessment and Gwent indicator framework (appendix 2)
- Public Services Board (appendix 3)
- Health Protection and Vaccinations (appendix 4)

The Committee is asked to receive these papers for assurance and note respective recommendations with each of the attached appendices.

Population Health Management (PHM)

- The Gwent Population Health Management (PHM) programme remains at the proof-of-concept stage and has experienced significant delays due to Information Governance assurance processes and external dependencies relating to Primary Care data extraction and delivery.
- Internal DPIA and Data Sharing Agreement approvals have now been secured and Mount Pleasant Medical Practice has completed its governance approvals.

Three additional GP practices have also agreed to participate in the proof-of-concept with governance still outstanding with DHCW.

- Optum's EMIS X platform, which is required to facilitate Primary Care data extraction and delivery, is expected to become available from July 2026, creating an opportunity to progress implementation during 2026/27

Joint Strategic Assessment and Gwent Indicator Framework

- The Public Health team have recently published an annual update to the Gwent Joint Strategic Assessment (JSA) and the Gwent Indicator Framework (GIF). The 3rd edition of Gwent Joint Strategic Assessment was published in March 2026 and the 2nd edition of the Gwent Indicator Framework was published in May 2026. The Gwent Joint Strategic Assessment 2025/26 Edition - Aneurin Bevan University Health Board
- This edition of the JSA had significantly more input from partners across the Public Service Board (PSB). With their support the JSA was restructured to reflect 6 of the 7 Well-being of Future Generation goals, additional indicators were added that better reflected these goals and in some cases partners provided much of the descriptive text.
- The 2nd edition of the GIF required a considerable re-build of the architecture that sits behind the Microsoft Power Bi tool to be able to accommodate the much larger number of indicators. The number of separate measures in the GIF has increased by from 270 to over 1,600. Given the much larger set of measures the navigation of the GIF was also improved with the addition of a search option and and an easy to navigate set of selection buttons. A number of other additional features are now present in the GIF including a geographic map visualisation.

Public Services Board (PSB)

- 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. It last met on 26th March 2026

Health Protection and Vaccinations

- 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

Population Health Management (PHM)

- PHM aims to improve population health and reduce inequalities through the use of linked data to identify, segment and proactively support at-risk and rising-risk population cohorts.
- A Gwent PHM proof-of-concept was approved in 2024, initially focused on linking Primary and Secondary Care data for South Monmouthshire GP

practices to demonstrate the value of PHM and support proactive population-based interventions.
- National momentum for PHM continues to grow, including publication of Welsh Health Circular WHC/2026/012, which positions PHM as a key component of Community by Design and future NHS planning and delivery in Wales.

Joint Strategic Assessment and Gwent Indicator Framework

- The Gwent Joint Strategic Assessment (Gwent JSA) was initiated by Professor Tracy Daszkiewicz, Executive Director for Public Health & Strategic Partnerships, in July 2023.
- The aim of the Gwent JSA is to provide a publicly outward facing, centralised and comprehensive summary of the health and well-being of the people of Gwent. The JSA highlights key indicators across Population, Equity, Cohesive Communities, Culture, Health, Prosperous, Resilience. The GIF provides a much larger set of indicators and functions like an repository of indicators focused on the Gwent and Local Authorities within Gwent. With the first Gwent JSA published in February 2024, there is a commitment from the Gwent Public Health team to produce this annually.
- The GIF was created after the first JSA due to feedback that the style of the first JSA (a slide set) was appreciated, that many readers wanted more indicators and that other readers wanted a summary. The decision was taken to make the JSA a product that focused on key indicators and to create a much larger product that was better suited to the presentation of large lists of indicators.

Public Services Board (PSB)

- The work of Gwent PSB is guided by it's Wellbeing Plan and prioritises work around four Areas of Focus - That every child has the best start in life; That everyone lives in a place they feel safe; That everyone has the same economic chances; And that everyone lives in a climate-ready community where their environment is valued and protected.

Health Protection and Vaccinations

- 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.
- 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.
- There has been a steady decline vaccination uptake in Gwent and across Wales since the pandemic. Research shows that this is due to a combination of factors including barriers to access, lack of flexibility and convenience, misinformation as well as trust and confidence in vaccines.
- In terms of vaccination equity there is a correlation between uptake and areas of deprivation. The proportion of children up to date with their immunisations is lowest in the most deprived fifth of the population and the inequality gap increases as children increase in age.

Asesiad / Assessment

Population Health Management (PHM)

- Significant progress has been made in resolving governance, procurement and technical barriers; however, delivery remains dependent upon:
    - Completion of the Optum EMIS X contract and implementation.
    - Timely support from Health Board Digital, Information Governance and Cyber teams.
    - Establishment of a common pseudonymised identifier to enable linkage between Primary and Secondary Care datasets.
    - Progression of outstanding approvals relating to the additional GP practices.
- Continued delays risk loss of momentum, reduced GP engagement and postponement of the benefits that PHM could deliver in terms of prevention, health inequalities and population health outcomes.
- Emerging local and national developments may provide additional opportunities to support PHM delivery and data access arrangements

Joint Strategic Assessment and Gwent Indicator Framework

- Development and refinement of processes to ensure these indicators are kept up to date will be ongoing as part of the Gwent Public Health Intelligence strategy.

Public Services Board (PSB)

- The PSB continues to take forwards work informed by Marmot Principles and the Wellbeing of Future Generations Act. On 26th March the Board considered:
- Annual Report of the Director of Public Health: This years report focuses on The Big Gwent Vaccination Conversation and the importance of acting to reach herd immunity across our communities. Next years annual report will focus on Housing as a key determinant of health.
- Child Poverty Strategy & Cardiff Capital Region (CCR): The CCR are developing a new child poverty strategy for the region. The importance of considering the specific needs of Gwent's communities within the strategies development.
- Area of Focus - Best Start in Life: Progress has been made to strengthen governance arrangements, including establishment of a strategic leadership group. A BSiL Community of Practice has launched.
- Gwent Climate Change Risk Assessment: Report has been published on PSB website Understanding Climate risks: the process - Gwent Public Services Board Gwent Public Services Board

Health Protection and Vaccinations

- There have been several recent changes to the routine immunisation schedule. This has included:
    - Hib/MenC vaccine no longer being offered at the 1-year vaccination appointment. Instead, an extra dose of the 6-in-1 vaccine, which gives protection against Haemophilus influenzae type b (Hib), is offered at the 12-month or 18-month appointment.
    - Second dose of the meningococcal B (MenB) vaccination, previously offered at 16 weeks of age, was moved to 12 weeks.
    - MMRV vaccine has been introduced into the routine childhood immunisation schedule.
- There have been significant improvements in some vaccination programmes, however all fall short of target requirements. These improvements include:

    - Improvements in staff flu and MMR uptake, the latter has been driven by better documented evidence of immunity.
    - A more robust model for targeted BCG vaccination.
    - A more robust pathway for babies born to Hep b positive mothers, ensuring that all babies are accounted for.
- Based on available data and evidence vaccination priorities have been identified with a focus on improving uptake and reducing variation, these include:
    - MMR1 and MMR2 due to measles posing a significant risk in Gwent with cases and sporadic outbreaks being reported across Wales and the UK. An imported measles case into that area could, without appropriate control, initiate an outbreak of up to 2,220 cases across the area. By the age of 5 years, uptake of the full course of MMR vaccination is less that 85% in Newport and Torfaen North NCN area.
    - HPV as a primary prevention measure that drastically reduces the incidence of human papillomavirus (HPV) infections, which are responsible for virtually all cervical cancers and several other cancers. Uptake of the HPV vaccination by 15 years of age remains a challenge, with all NCN areas failing to achieve the national ambition of 90% uptake.
- The Health Board's Vaccine Equity Strategic Framework has been developed and agreed which outlines how ABUHB plans to build on the established work to address barriers amongst the population groups with sub-optimal vaccination uptake, aligned to the requirements of the National Immunisation Framework. Work is now ongoing to develop an appropriate delivery plan.
- There remains a number of operational challenges to effectively and efficiently deliver vaccination services following the update to The Human Medicines Regulations (2012). During the COVID-19 pandemic, National Protocols (Regulations 247A) were introduced as temporary legal mechanisms to allow different trained staff to undertake different stages of vaccination, including non-registered staff, however this has since been updated:
    - Non-registered healthcare workers are no longer able to clinically assess and obtain informed consent from patients under new Regulation 235A.
    - There are now limitations on the movement of vaccinations between providers under Regulation 19.

Operational adjustments are ongoing but the impact to the workforce specifically under 235A are currently under review.

- There are several areas of work in place to ensure that the Health Board and wider health protection system continues to build capabilities to prevent, respond to and recover from infectious diseases and environmental threats, which include:
    - Review of the Health Board's current public health incident response and pandemic plan, including creating plans for ongoing embedding and exercising.
    - High consequence infectious disease (HCID) preparedness planning including fit mask testing scale up, accelerating HCID pathway training and planned exercises.
    - Measles preparedness including review and development of testing pathways and the development of a robust outbreak response plan.

- Welsh Government has two key elimination targets relating to health protection: Eliminating Hepatitis B and C as a public health threat by 2030 and zero new transmissions of HIV by 2030.
    - There have been notable achievements regarding the success of the local Hepatitis b and c elimination plan including positive feedback from Welsh Government on progress. Planned objectives are identified and agreed by the Hepatitis B and C Elimination Implementation Group, which has oversight of the effective implementation of the local elimination plan.
    - Fast Track Gwent was established in July 2025, with a local multi-disciplinary steering group overseeing work to shape a future free of new HIV transmissions and to end stigma of those living with HIV.
- In lieu of a national TB elimination plan, work has commenced locally to develop a TB elimination strategy and accompanying delivery action plan for Gwent.
- The Health Board continues to be responsible for ensuring the mobilisation of an appropriate and proportionate response to acute health protection incidents across the region. Recent examples include:
    - the mobilisation of a response to the HSDU sterilisation incident. Following an assessment of risk by Microbiology colleagues there was a requirement for BBV screening and hep b post exposure prophylaxis to be offered to affected patients.
    - The health protection team and PC HeaRT remain responsible for the mobilisation of a response to TB cases and clusters. This includes providing additional workforce capacity to the TB service when required such as development of operational processes, providing phlebotomy trained staff and the implementation of enhanced case management for TB cases.
    - In autumn 2025 the health protection team were notified of a case of Hepatitis A affecting a school aged child in the ABUHB area. Request was made to mobilise an urgent response to offer post exposure prophylaxis and vaccinate 15 staff and 83 children of reception age in a timeframe of less than a week. More recently a follow up clinic was held at the school to offer a second dose of Hepatitis A vaccine. The clinic achieved 74% uptake with those absent indicating they would follow up the second dose with their own GP's.
    - Responding to incidents of national and international concern including an outbreak of invasive meningococcal disease (IMD) in Kent, that was later confirmed as the MenB strain, an outbreak of Hantavirus due to the Andes hantavirus Varian (ANDHV) on a Dutch cruise ship and the WHO declared 'public health emergency of international concern' due to an outbreak of Ebola disease in the Democratic Republic of the Congo and Uganda (caused by the Bundibugyo virus).
- Additional health protection funding investment for Local Authorities has continued to enable them to undertake health protection work beyond their statutory obligations, including but not exhaustive of, responding to and investigating cases of notifiable infectious diseases and food poisoning outbreaks, promoting vaccinations within schools and other educational settings as well as care homes as part of winter preparedness efforts and working across local authority boundaries to identify and implement novel projects such as improving standards within sunbed shops.

- An all-hazards approach to health protection continues to be taken. The public health team in partnership with emergency planning colleagues in recent months have been involved in the preparedness and response to a number of incidents of this nature, including supporting the recovery of a major flooding incident, providing advice and guidance during extreme weather events and ongoing preparedness efforts to respond to vector-bourne disease risks.

Argymhelliad / Recommendation

Population Health Management (PHM)

1. Note progress made in advancing the Gwent PHM proof-of-concept.
2. Reaffirm organisational commitment to the development and delivery of Population Health Management across Gwent.
3. Support establishment of appropriate programme governance arrangements to oversee delivery and escalation of issues.
4. Support continued collaboration across Public Health, Digital, Information Governance, Cyber and Primary Care partners to enable receipt and linkage of Primary Care data during 2026/27.
5. Support exploration of local and national opportunities that could accelerate delivery of PHM and associated data capabilities

Joint Strategic Assessment and Gwent Indicator Framework

1. The Gwent Public Health Intelligence team continue to allocate sufficient resource to develop and promote both the JSA and GIF.
2. Resources are allocated to continue developing the Gwent Public Health Data Warehouse infrastructure to act as a repository for the JSA and the GIF.
3. Partners are encouraged to use and support the production of the JSA and GIF.
4. That the JSA and the GIF are used to support evidence-based decisions.

Public Services Board (PSB)

1. Note the update on collective action to improve health and wellbeing in Gwent through the work of the PSB

Health Protection and Vaccinations

1. Provide scrutiny in relation to the 2025/26 Winter respiratory vaccination programme, vaccination service improvements and steps to improve vaccination equity.
2. Provide assurance to the Board that strategic priorities, changes to the routine immunisation schedule, and operational challenges are being managed effectively.
3. Receive the update and note the breadth of work being undertaken across the health protection system to strengthen its capabilities to plan for and respond to incidents and threats. This has only been possible through dedicated and sustained Welsh Government health protection funding.

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):	Governance, Leadership and Accountability 1. Staying Healthy 1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety
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	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 prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.

	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Not applicable to this report

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 June 2026
CYFARFOD O: **MEETING OF:**	Partnerships, Population Health and Planning Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Population Health Management (PHM) Update Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Professor Tracy Daszkiewicz, Executive Director for Public Health & Strategic Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	James Attwood, Health Intelligence Consultant

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 Gwent Population Health Management programme has been significantly delayed and is currently remains at the very start of the proof-of-concept stage.

1. **For much of 2024 the Gwent PHM proof-of-concept was awaiting resolution of the necessary levels of Health Board Governance assurance required for sign off. The DPIA (Data Protection Impact Assessment) and DSA (Data Sharing Agreement) were written and submitted internally for review in June 2024. Following a constructive, but longer than anticipated, period of challenges and subsequent responses internal assurance was reached in April 2025.**

2. **With the internal sign off complete, the DPIA and DSA were shared with both the Mount Pleasant Practice who were our original pathfinder GP Practice, and their private Data Protection Officer (DPO) in April 2025. All queries and outstanding Information Governance issues relating to the DPIA & DSA were quickly resolved with Mount Pleasant and their private DPO by June 2025.**

3. **During 2025 and early 2026 Optum (who own the EMIS Primary Care system) have been continuing to develop their extraction and delivery tool, EMIS X, that will facilitate delivery of Primary Care data from Mount Pleasant Practice to the Gwent Public Health Team. This platform is now ready and data from all GP Practices in Wales is being migrated on to EMIS X, with Mount Pleasant Practice data being migrated on to EMIS X in July 2026.**

   A contract is required between the health board and Optum for use of their EMIS X platform for delivery of the GP Practice data in to the Health Board.

   A quote for 1 year's use of EMIS X for the 4 x South Monmouthshire NCN GP Practices was received from Optum in April 2026 and is being funded from the core Gwent Public Health budget. The Health Board's Procurement team have been supporting Optum and the Gwent Public Health Team in getting this contract over the line through a direct award process, since Optum are the only organisation able to provide this data and service. This procurement process is ongoing but progressing well as at June 2026.

4. **In December 2025 the remaining 3 x GP Practices in the South Monmouthshire NCN also agreed to come on board for the proof-of-concept phase, as per the ambition in the DPIA. These GP Practices are Vauxhall Surgery, Town Gate Practice & Gray Hill Surgery. These GP Practices use DHCW as their Data Protection Officer. The DPIA & DSA were sent to DHCW for review by the Practices in March 2026. As at June 2026 there has been no response from DHCW.**

The time taken for internal assurance to solidify understanding and technical details resulted in a significant delay in the PHM project proof-of-concept's internal Health Board sign off. The additional delay with the EMIS X platform added another further delay that was out of the Health Board's control.

Further details

(1) There was a long period of time needed to reach internal Governance assurance through various challenges and technical queries.

A summary of key events relating to the DPIA sign off are provided below

- October 2023 - The Gwent Public Health Team began initial conversations with the health board's Information Governance team about an over-arching DPIA for all the planned future data flows relating to the Public Health Data

Warehouse including those for to PHM. The idea was that having one over-arching DPIA for all of our data flows meant not having to do a new DPIA each time we wanted to flow a new data set, making delivery of new initiatives streamlined, quick and less resource intensive.

- 9th April 2024 - This over-arching Gwent Public Health Data Warehouse DPIA was signed off and agreed by the Health Board's Information Governance team

- May 2024 - The Health Board's Information Governance team indicated that the over-arching DPIA previously signed off and agreed was not sufficient with regards to PHM. The Health Board's IG team communicated to the Gwent Public Health Team that additional assurance was needed through a Data Sharing Agreement (DSA) as it had not been assessed within the Warehouse DPIA. The IG team also highlighted that there would also need to be assurance from the Health Board's Cyber team.

- May 2024 - A DSA was completed by the Gwent Public Health Team and sent to the IG Team in late May 2024

- 26th June 2024 - The Health Board's Information Governance Team indicated to the Gwent Public Health Team that another DPIA would also be needed in addition to the DSA that had just been completed in order to cover the PHM proof of concept with Mount Pleasant Medical Practice and other GP practices wishing to flow their data to co-development of the PHM platform. This additional DPIA was written and sent to the Health Board's I.G. team in late June 2024.

- July & August 2024 - The Health Board's Cyber Team met with both the Gwent Public Health Team and representatives from Optum to discuss the proposed Primary Care data flow from GP Practices into the Gwent Public Health Data Warehouse.

- September 2024 – Following the previous meeting between the Health Board's Cyber Team, Optum and the Gwent Public Health Team it was highlighted that the Cyber Team hadn't fully understood the model and after clarification and discussions cyber assurance was agreed. It was then stated by the Health Board's IG team that there was one highlighted risk that the Health Board's DPO and SIRO were discussing.

- April 2025 – Email confirmation that the DPIA / WASPI documents had now been signed internally within the Health Board in support of the PHM proof of concept.

(2) To deliver Primary Care data from GP Practices in to the Gwent Public Health Team's Data Warehouse, Optum are developing an extraction and delivery tool to facilitate this. Optum are building this extraction and delivery tool in conjunction with DHCW to support the future population of the National Data Repository (NDR) with Primary Care data. The Gwent PHM proof-of-concept project is going to utilise that functionality to deliver Primary Care data into the Health Board for the purposes of PHM in Gwent.

Conversations between Optum and DHCW progressed well during 2025 in terms of contracts for data replication into the EMIS EXA data lake. Optum started on the development work at the back end of the summer 2025. The EXA data lake is now up and running with Mount Pleasant data due to be migrated on to this platform in July 2026.

When the data is landed in the Health Board, there will be a resource requirement from the Health Board's Digital Team to support in various ways. The Digital support will be needed for the following aspects

- To securely land the Mount Pleasant GP Practice data in to the health board from the Optum tool
- To facilitate a common linked pseudonymised identifier between Primary Care data and Secondary Care data, to enable linking patients between Primary and Secondary Care by the Gwent Public Health Team. Without this PHM is impossible.
- To deliver that pseudonymised data in to the Gwent Public Health Data Warehouse

In order to allocate Health Board Digital resource for the proof-of-concept

- The PHM proof-of-concept was logged on the Health Board's project register on 2nd February 2025 following a meeting with John Frankish
- A log was created on HALO to log the details of the future Digital support needed later in 2025.
- The Gwent Public Health Intelligence Team met with the health board's Chief Information Officer on 16th April 2025 to discuss and agree the support needed in more detail and to allocate and earmark resource for later in 2025
- Due to the delay in Optum's EMIS X platform the resource originally earmarked for late 2025 will be required in July-Sep 2026 and this paper seeks support for this.

Other Wider PHM Developments

During 2025 & 2026 other projects surfaced that are not directly related to the Gwent PHM proof-of-concept but may provide opportunities to unlock PHM aspects for the Gwent PHM proof-of-concept and they are listed below

1. PHM in Wales

- As part of the NHS Health Inequalities Group, the Population Health Management (PHM) subgroup made a number of recommendations to the NHS Leadership Board on the use of Population Health Management (PHM) in the NHS in Wales. This included recommending the Welsh Government to supplement the 2025-28 NHS Planning Framework and associated technical guidance with a WG policy framework which will:

    i. Provide a clear policy narrative to support action, setting out how PHM must drive service planning and delivery to embed prevention, reduce health inequalities and increase value-based care.
    ii. Mandate the NHS Executive to lead the development and roll out of a national digital tool to enable population segmentation and risk stratification, working with PHW and Health Boards

- A Task and Finish Group, chaired by the Deputy Chief Medical Officer for Wales, Dr Keith Reid, was convened in June 2025 to progress these recommendations. The Gwent Public Health Team were a part of this group which met for the first time at the end of June 2025. The Task & Finish Group found that the digital maturity and infrastructure within Wales was not at a level that supported delivery of the data flows needed for PHM at a national scale as yet and that it would take a number of years before that was even a possibility. Instead, in the interim, the Task and Finish Group supported and championed the ambition for local health boards to pursue their own PHM journeys, sharing ideas and best practice and informing a national PHM way forward at a later point in time. The Task and Finish Group was disbanded in late 2025.

- A PHM 'current data landscape' group including representatives of the 7 x Welsh Health Boards was created in late 2025 to understand where each Health Board currently is with their PHM journey and maturity. The Gwent Public Health Team was a part of this group.

- A Welsh Health Circular was issued on 02/04/2026, WHC Number – WHC/2026/012, titled '**Population Health Management in Wales**' and signed by Dr Keith Reid - Deputy Chief Medical Officer (Public Health) and Sioned Reese – Director, Public Health. This circular set out the purpose of population health management, its potential benefits and an agreed definition to support planning and delivery in Wales. Under the 'Adoption' heading the circular stated:

    '*A PHM approach is an integral part of the Community by Design programme aimed at accelerating the delivery of integrated services in the community and securing of improvements in health outcomes in*

Wales. It is envisaged that Clinicians (such as GPs, nurses, allied health professionals), planners, commissioners, analysts, public health practitioners, local authorities, health boards, wider NHS organisations (such as Public Health Wales), and wider public sector bodies will apply PHM approaches in their work.'

2. Local data flows
   - There is an emerging project within Gwent, external to the Health Board, that aims to link multiple different datasets including Primary Care data that has an ambition to create a population level record. Early discussions between the Gwent Public Health Team and this project have taken place and will continue to develop. This may be another route in to obtaining the data sources that are essential for delivering PHM.

Cefndir / Background

Population Health Management aims to improve population health by data driven planning and delivery of proactive care to achieve maximum impact for the health and wellbeing of the population working from a single dataset to provide one version of the truth to deliver proportionate universalism.

It uses linked data to segment, stratify and model local 'at risk' and 'rising risk' cohorts – then designing, targeting and personalising interventions to deliver proactive care to reduce health inequalities.

The initial concept of PHM was presented to Executives in December 2022, in January 2023 we commissioned a company called Sollis to link the data and run Population Health Management Development Programme. The GP managed practices took part in the programme but despite attending all of the workshops there was no resource to contact the cohort that had been identified for action. In August 2023 it was agreed that we would consider building our own capability and develop our own platform initially within the Gwent Public Health Team and this formed part of the primary care action plan for sustainability, reported at the Sustainability Steering Group and the IMPT reporting.

PHM involves linking many datasets and one of the key data sets is Primary Care. There are a number of GPs and GP Practices within Gwent willing to share Primary Care Data with the Gwent Public Health Team so that the Gwent Public Health Team can co-develop a PHM Platform that enables them to better manage cohorts of patients and improve health and well-being outcomes.

A proof of concept was agreed in March 2024 to initially use Primary Care data from Mount Pleasant practice in South Monmouthshire. The proposal was to flow their Primary Care data into the Gwent Public Health Data Warehouse during 2024 and for tailored reports to be developed, with the appropriate level of locked down

security, to enable Mount Pleasant GPs to improve patient outcomes for specific cohorts, through a better management approach using Primary and Secondary care intelligence. This would prove the art of the PHM possible and whet the appetite for stakeholders gaining buy-in for future phases of PHM development.

Optum/EMIS have already been commissioned by Digital Health and Care Wales (DHCW) to flow Primary Care data nationally when the national need and remit arises in the next few years. Due to this, Optum were consulted by the Gwent Public Health Team about providing the Primary Care data flow from the Mount Pleasant practice into the Gwent Public Health Data Warehouse. Optum confirmed that this process is feasible once they develop their Primary Care data extraction and delivery tool EMIS X. Originally this was anticipated to be available early in 2025 however Optum have been side-lined with other work and so this essential tool was delayed until 2026.

Asesiad / Assessment

The time taken to provide the necessary level of internal Health Board assurance, through necessary, thorough, constructive and informative dialogue combined with the ongoing delay with the EMIS data extraction and delivery tool mean that the PHM project is significantly delayed compared to its original anticipated delivery timescale.

Without clear and efficient processes and timelines for resolving current and future issues, the entire PHM programme risks ongoing significant and avoidable delays. These delays will, in turn, postpone the anticipated benefits that PHM could deliver to the health and well-being of the people of Gwent. Continued delays risk diminishing GP engagement and reducing the availability of Primary Care data, which is critical to the success of PHM.

The Welsh Government positive direction of travel with regards to PHM provides a potential opportunity to facilitate faster delivery of PHM within Gwent and explore other ways of acquiring the necessary datasets should the Optum/EMIS route fail to deliver within the required timescales.

Argymhelliad / Recommendation

To minimise further delays, the following recommendations are proposed:

1. It would be helpful for the Health Board to reaffirm its commitment to support the Gwent Public Health Team's Population Health Management programme.

2. It would be beneficial to create a PHM project board, lead by the Gwent Public Health Team, to support delivery of PHM across Gwent. This project board would provide governance, manage delivery, escalate outstanding

issues and ensure the Health Board's commitment to delivering PHM is carried out in a timely, safe and cost-effective manner

3. In a wider context, it would be good for the Health Board to commit to supporting and embracing the rapidly evolving PHM landscape both locally and nationally. Should the need arise for a revised Gwent approach or new Information Governance documentation such as new or revised DPIAs and DSAs then it is essential that these are not delayed by the lengthy internal processes that have been experienced so far.

4. It would be positive to reaffirm commitment from all relevant teams within the Health Board, including IG, Cyber, I.T. & B.I. to support the Gwent Public Health Team in delivering PHM in Gwent and with particular focus on enabling a flow of Primary Care data from Mount Pleasant practice into the Gwent Public Health Data Warehouse from Q2 2026/27. An essential aspect of this is a recommendation to reaffirm the commitment for the health board's Digital Team to work collaboratively with Optum and the Gwent Public Health Team to ensure a common linkable identifier exists across both the Primary Care data from EMIS X and the secondary care data relating to A&E Attendances, Admissions and Outpatient Appointments. PHM fails without this critical link.

5. It is suggested that the Health Board aim to be in a position ready to receive Primary Care data in July 2026 with the necessary internal support, outlined earlier, and resource made available when the Primary Care data is finally available on EMIS X and the contract with Optum is live.

6. A commitment would be welcomed from all relevant parties within the Health Board to support the Gwent Public Health Team in developing and delivering front-end Power BI reports back to Mount Pleasant GPs by the end of Q3 2026/27. These reports will provide intelligence that will include both Primary and Secondary care aspects. The GPs viewing these will only be able to see intelligence relating to patients that they are authorised for and that are under their care.

7. Any other local or national opportunities that could benefit delivery of PHM within Gwent should be explored such as the National PHM programme and the Gwent project referenced earlier in this document

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):	3.4 Information Governance and Communications Technology 1. Staying Healthy

	2.1 Managing Risk and Promoting Health and Safety 3. Effective Care
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 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	**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 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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 June 2026
CYFARFOD O: **MEETING OF:**	Partnerships Population Health and Planning Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Gwent Joint Strategic Assessment (Gwent JSA) and Gwent Indicator Framework (GIF) Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Professor Tracy Daszkiewicz, Executive Director for Public Health & Strategic Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Simon Hodsdon, Head of Public Health

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 Public Health team have recently published an annual update to the Gwent Joint Strategic Assessment (JSA) and the Gwent Indicator Framework (GIF). The 3rd edition of Gwent Joint Strategic Assessment was published in March 2026 and the 2nd edition of the Gwent Indicator Framework was published in May 2026.

The Gwent Joint Strategic Assessment 2025/26 Edition - Aneurin Bevan University Health Board

This edition of the JSA had significantly more input from partners across the Public Service Board (PSB). With their support the JSA was restructured to reflect 6 of the 7 Well-being of Future Generation goals, additional indicators were added that better reflected these goals and in some cases partners provided much of the descriptive text.

The 2nd edition of the GIF required a considerable re-build of the architecture that sits behind the Microsoft Power Bi tool to be able to accommodate the much larger number of indicators. The number of separate measures in the GIF has increased by from 270 to over 1,600. Given the much larger set of measures the navigation

of the GIF was also improved with the addition of a search option and and an easy to navigate set of selection buttons. A number of other additional features are now present in the GIF including a geographic map visualisation.

The JSA and GIF will become the foundation for the W

Cefndir / Background

The Gwent Joint Strategic Assessment (Gwent JSA) was initiated by Professor Tracy Daszkiewicz, Executive Director for Public Health & Strategic Partnerships, in July 2023.

The aim of the Gwent JSA is to provide a publicly outward facing, centralised and comprehensive summary of the health and well-being of the people of Gwent. With the first Gwent JSA published in February 2024, there is a commitment from the Gwent Public Health team to produce this annually.

The Gwent JSA endeavours to look beyond clinical health outcomes to include factors like housing, education, employment, environment, and social connections that influence health and well-being. The JSA highlights key indicators across Population, Equity, Cohesive Communities, Culture, Health, Prosperous, Resilience. The GIF provides a much larger set of indicators and functions like an repository of indicators focused on the Gwent and Local Authorities within Gwent. Together they serve as foundational tools for developing strategies and policies that improve health outcomes and address inequalities across Gwent, as well as being the 'one source of the truth'.

In July 2023 the Gwent Public Health Intelligence Team began the challenging task of searching for, and documenting, the data sources that would contribute to the first iteration of the Gwent JSA. This initial phase was a time-consuming task that took a number of months, eventually leading to a list of over 100 disparate indicators being acquired, downloaded into Excel and documented. Each year the list has grown and now is over 1,600 indicators.

The work to centralise all this data started in June 2024 and will continue to be a core ongoing part of the Gwent Public Health Intelligence strategy. Data timeliness and quality is essential and therefore it is critical to have an ongoing function to support this through updating data when new figures are published or to add in new data sets when they are released.

The GIF was created after the first JSA due to feedback that the style of the first JSA (a slide set) was appreciated, that many readers wanted more indicators and that other readers wanted a summary. The decision was taken to make the JSA a product that focused on key indicators and to create a much larger product that was better suited to the presentation of large lists of indicators.

Having an infrastructure that holds these key data sets and indicators forms the core underlying basis of intelligence for future Gwent JSAs, Health Needs Assessments and for the Gwent Public Health Intelligence strategy.

Another aspect of the Gwent Public Health Intelligence Team's strategy is to utilise market-leading visualisation tools to present engaging visuals to the reader. Microsoft's Power BI software has been used to create a Gwent Indicator Framework, which includes the vast array of collected indicators in an interactive format, allowing users easily to view and engage with results. Alongside this interactive dashboard, the Gwent JSA provides a summary of the key patterns in a user-friendly Canva presentational format.

To increase the value of the descriptive test in the JSA a Partnership meeting was set up in late 2025 with partners across the PSB. This group will continue to meet to make sure the JSA is useful to all partners.

The JSA will form the basis for the PSBs 2026/27 Wellbeing Assessment and the Regional Partnership Boards 2026/27 Population Needs Assessment.

Asesiad / Assessment

Development and refinement of processes to ensure these indicators are kept up to date will be ongoing as part of the Gwent Public Health Intelligence strategy.

Argymhelliad / Recommendation

It is recommended that

1. The Gwent Public Health Intelligence team continue to allocate sufficient resource to develop and promote both the JSA and GIF.

2. Resources are allocated to continue developing the Gwent Public Health Data Warehouse infrastructure to act as a repository for the JSA and the GIF.

3. Partners are encouraged to use and support the production of the JSA and GIF.

4. That the JSA and the GIF are used to support evidence-based decisions.

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):	1. Staying Healthy 1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 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 Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Gwent JSA – Gwent Joint Strategic Assessment GIF- Gwent Indicator Framework
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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 June 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:**	Amy McNaughton, Public Health Consultant, ABUHB 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 paper is to provide Board 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 26th March 2026. This meeting was Chaired by the Chair Cllr Anthony Hunt.

The main points from the meeting were as follows:

Annual Report of the Director of Public Health

The PSB received a presentation from Prof. Tracy Daszkiewicz on the 2025/26 DPH report '*The Big Gwent Vaccination Conversation'*. Key Points included:

- A general reticence around vaccination among communities in Gwent
- A lack of information on, and access to, vaccinations across the region
- Vaccination levels have dropped below those required to offer collective protection against a number of preventable diseases– known as 'herd immunity'

Areas for action discussed included:

- Increasing availability of consistent messaging and information across our communities

- Exploring the feasibility of single 'opt-in' consent from parents to streamline access to childhood vaccinations in schools
- Development of a vaccine equity framework and delivery plan
- Building as stronger focus on uptake of vaccines among older people into our approach to winter preparedness.

The Board are asked to note:
The associated SBAR on Health Protection and Vaccination.
The 26/27 DPH report will focus on housing as a key determinant of health and wellbeing.

Child Poverty Strategy & Cardiff Capital Region (CCR)

The CCR are developing a new child poverty strategy for the region. Child poverty has a significant immediate impact on children's health and wellbeing as well as impacts across the life course. Overall rates of child poverty are higher in south east Wales region than UK and Welsh averages.

PSB members highlighted the need for the strategy development process to consider: how the specific needs of Gwent are understood and addressed, the role of volunteering as a pathway to employment, importance of wealth creation as a focus within work of the CCR as a whole and importance of addressing child poverty coming through as a cross cutting theme across all CCR strategies.

Best Start in Life Area of Focus

Progress has been made to strengthen governance arrangements, including establishment of a strategic leadership group. Third sector representation was noted an outstanding gap to be addressed. Priorities within the area of focus are being developed and a lead for each priority will be needed.

PSB members discussed the importance of moving to focussed delivery, the critical role of consistent senior director engagement and the importance of a clear narrative on roles and responsibilities of RPB and PSB in BSiL space.

The Board are asked to note:
BSiL Community of Practice has launched

Gwent Climate Change Risk Assessment

The CCRA has been produced drawing together both quantitative data and qualitative insights from people with knowledge of climate change and it's impacts in Gwent. The assessment has identified 10 priorities and 12 recommendations. Report has been published on PSB website Understanding Climate risks: the process - Gwent Public Services Board Gwent Public Services Board

PSB members noted in their discussions that we are already seeing the impacts of climate change, particularly in relation to flooding and the immediate and longer-term impacts on health and wellbeing flooding has in our communities. Discussions also focussed on the need for clear, strong and sustained leadership across organisations to mitigate and adapt to the impacts of climate change.

Future Meetings

The next PSB meeting is scheduled to take place on 2nd July.

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 Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	None

Parties / Committees consulted prior to University Health Board:	

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

DYDDIAD Y CYFARFOD:	30 June 2026
CYFARFOD O: MEETING OF:	Partnerships, Population Health and Planning Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health Protection and Vaccination Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Tracy Daszkiewicz, Executive Director for Public Health and Strategic Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Will Beer, Consultant in Public Health Shareen Ali, Head of Public Health

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 and vaccinations 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.

The National Immunisation Framework paves the way for vaccination transformation in Wales, enabling exemplar delivery of vaccination and immunisation programmes with uptake and equity at the core.

Throughout the life course, individuals are eligible for routine childhood immunisation schedule, seasonal vaccinations (e.g. Influenza and COVID-19), and selective programmes (e.g. BCG, Mpox).

Within Gwent, vaccinations are delivered through different providers with GP Practices, Community Pharmacies, School Nursing Service, Occupational Health and the Vaccination Service all having a role in delivery.

There has been a steady decline vaccination uptake in Gwent and across Wales since the pandemic. Research shows that this is due to a combination of factors including barriers to access, lack of flexibility and convenience, misinformation as well as trust and confidence in vaccines. This is contributing to sub-optimal uptake across the life course.

In terms of vaccination equity there is a correlation between uptake and areas of deprivation. The proportion of children up to date with their immunisations is lowest in the most deprived fifth of the population and the inequality gap increases as children increase in age.

Asesiad / Assessment

1. Immunisations

Changes to the routine immunisation schedule
Over the last year, there have been several changes to the routine immunisation schedule.

Since 1st July 2025, the Hib/MenC vaccine has no longer been offered at the routine 1-year vaccination appointment. Instead, an extra dose of the 6-in-1 vaccine, which gives protection against Haemophilus influenzae type b (Hib), is offered at the 12-month or 18-month appointment. In addition, the second dose of the meningococcal B (MenB) vaccination, previously offered at 16 weeks of age, was moved to 12 weeks.

From August 2025, eligibility for a shingles vaccination has been expanded from all severely immunosuppressed individuals aged 50 years and over, to include all severely immunosuppressed adults aged 18 years and over.

Since 1st January 2026, the MMRV vaccine has been introduced into the routine childhood immunisation schedule.

From 1st April 2026, eligibility for RSV programme has been extended to all those aged 80 years and over (with no upper age limit) and all residents in care homes for older adults.

Winter respiratory vaccination programme
The Winter respiratory vaccination programme involved all providers across GP Practices, Community Pharmacies, School Nursing Service, Occupational Health and

the Health Board Vaccination Service. The table below shows that uptake across the vaccination programme was either in line with or slightly higher than the All Wales average for each eligible cohort (Table 1, below). In relation to the COVID-19 vaccination programme alone, a total of 48,396 vaccines were administered with 21,663 (45%) provided through the Health Board Vaccination Service and 26,733 (55%) given through commissioned service in primary care.

Table 1: Uptake across the different cohort during the 2025/26 Winter respiratory vaccination campaign

Vaccination Programme	**Cohort**	**ABUHB uptake**	**All Wales uptake**
Wales COVID-19 Autumn 2026	All eligible	60.42%	58.30%
RSV	75–79-year-olds	63.31%	63.29%
Flu Autumn 2026	2–3-year-olds	50.8%	47.0%
	65 years and older	73.9%	73.0%
	16 years to 64 years in a clinical risk group	43.8%	42.7%

Vaccination service improvements

During the 2025/26 Winter respiratory vaccination campaign the Public Health Team led the planning and implementation of the staff flu vaccination programme. Working in partnership with the Vaccination Service, Occupational Health and Flu Champions (Peer Vaccinators), the Health Board achieved its highest uptake since 2022/2023, obtaining 46.5%. This was the highest uptake amongst the Health Boards in Wales but remains significant lower that the Welsh Government target.

During July and August 2025, the Vaccination Service working alongside Maternity Service to offer RSV vaccinations opportunistically and through scheduled antenatal appointments. Trained immunisers from the Vaccination Service were deployed in antenatal clinics administering 234 vaccines during the pilot which increased uptake from around 48% between April and July to around 60% between September and December 2025. From an analysis of postcode data using the Welsh Index of Multiple Deprivation, the highest number of vaccinated individuals (n=90) resided in areas of greater deprivation. A poster presentation on the pilot was submitted to the Welsh Immunisation Conference in April 2026.

The Public Health Team and Occupational Health have also undertaken an ABUHB staff MMR campaign to ensure staff are protected and MMR status is recorded in their occupational health record. This has been an important area of focus because healthcare staff who are exposed to a confirmed or suspected measles case who lack documented immunity or two doses of the measles containing vaccine (or evidence of immunity) must be excluded from work from the 5th day after their first exposure until the 21st day after their final exposure. A recent review of occupational health records has shown that 45% of Health Board staff have MMR status recorded. In relation to high-risk clinical areas this was 92.5% in the Children's Emergency Assessment Unit; 66% in Acute Medical Assessment Units; and 65% in the Emergency Department.

The Health Board is implementing a new neonatal pathway for the small number of babies born to Hepatitis B infected mothers who require vaccination as post-exposure prophylaxis. While the initial vaccine dose is given through the Paediatric Department at birth, the 4-week vaccination follow-up sits outside of the routine child immunisation schedule, and a follow-up Hep B surface antigen test (Dry Blood Spot test) is also required at 12-18 months of age. Going forward the Primary Care Health Protection Clinical Response Team (PC HeaRT) will arrange the 4-week vaccination and facilitate the Dry Blood Spot test after 12 months.

Over the last six months the responsibility for offering the BCG vaccination to babies under 12 months of age who live with a parent or grandparent born in a country with a high incidence of TB, has moved from the School Nursing Service to the Vaccination Service. This is a key component of the emerging TB elimination strategy and delivery plan being led by the Public Health Team.

Current strategic priorities

Measles poses a significant risk in Gwent and Wales with cases and sporadic outbreaks being reported across Wales and the UK. PHW have undertaken modelling which shows that the biggest driver of risk for a measles outbreak in Gwent is young adults (18-24 years old) in the central area of Newport. By combining these areas within the model it is possible to consider this as an area with a population of 43,400 where there are 4,220 susceptible individuals. An imported measles case into that area could, without appropriate control, initiate an outbreak of up to 2,220 cases across the area.

By the age of 5 years, uptake of the full course of MMR vaccination is less that 85% in Newport and Torfaen North NCN area. Uptake is also less than 90% in Torfaen South and Blaenau Gwent East NCN areas.

The HPV vaccination is a primary prevention measure that drastically reduces the incidence of human papillomavirus (HPV) infections, which are responsible for virtually all cervical cancers and several other cancers. By preventing these persistent infections, the vaccine serves as a cornerstone of modern public health, aiming to completely eliminate preventable cancers.

Uptake of the HPV vaccination by 15 years of age remains a challenge, with all NCN areas failing to achieve the national ambition of 90% uptake. Only five NCN areas exceed 70% uptake, with highest uptake in Monmouthshire North NCN area at 76.7%.

Vaccine equity

The Health Board's Vaccine Equity Strategic Framework outlines how ABUHB plans to build on the established work to address barriers amongst the population groups with sub-optimal vaccination uptake, taking into consideration national and international evidence and alignment to the requirements of the National Immunisation Framework.

Key enablers for reducing vaccine inequity have been:

- Vaccination Centre, Cwmbran
- Nye BeVAN mobile outreach van
- The Big Gwent Vaccination Conversation

- Vaccination Brief Advice

The Vaccination Centre opened in April 2025 and provides access to the people of Gwent to receive life-saving vaccinations. The centre is open six days a week and experienced immunisers can administer a wide range of vaccinations for all age groups including COVID-19 boosters, influenza vaccines, human papillomavirus (HPV) and many others. They can also answer any questions or concerns about vaccination and residents are able to check their vaccine status and get help with eligibility guidance.

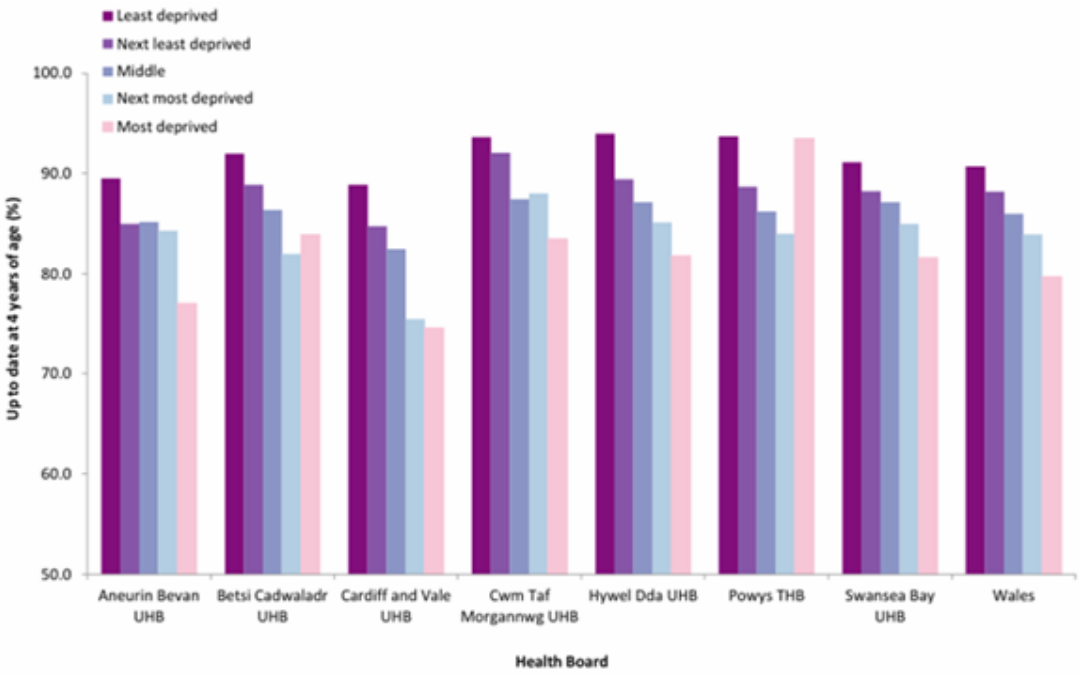
The Nye BeVAN commenced operation in September 2025. With the intention of taking services to our population, the unit has facilitated delivery of staff flu and MMR vaccinations; flu vaccinations for school-aged children; HPV vaccinations for students in areas of lower coverage and provided engagement and advocacy.

Delivered in October 2025, the 'Big Gwent Vaccination Conversation' 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. In addition to an event, focus groups and a public survey were undertaken to develop and inform the health board's vaccine equity agenda and vaccination campaign strategy.

Vaccination Brief Advice (VBA) training package has been developed and is being piloted and evaluated, before a comprehensive rollout. The training is intended for those who want to increase their confidence when having vaccination conversations or addressing vaccination hesitancy. The VBA package includes a 1-hour awareness and learning session with associated Padlet resources to use in clinical practice, during vaccination conversations. The package is evidence-based, using behaviour change frameworks such as the COM-B Model and brief intervention approach.

To consolidate the activity across the system, a vaccine equity action plan is being developed, initially focusing on MMRV coverage and immunisations in the Newport locality, where uptake across childhood immunisations is consistently below 90%. Vaccination surveillance data shows that the proportion of children in the Gwent area who are up to date with their immunisations by 4 age. Despite uptake in the most deprived fifth of the population being at its highest rate since 2022 there is still as significant variation in uptake (Figure 1, below). From a public health perspective, vaccination uptake by 4 years of age is important as it ensures children receive their routine pre-school vaccinations before entering nursery or school environments where outbreaks frequently occur.

Figure 1: Percentage of children who are up to date with routine immunisation by 4 years of age, by quintile (fifth) of deprivation of the LSOA in which they reside (Data presented is for children reaching their 4th birthday between 01/04/2025 and 31/03/2025)



[1] Completed '4 in 1' pre-school booster, the Hib/MenC booster and second MMR dose by four years of age.

Operational challenges

The Human Medicines Regulations 2012 underpin how vaccines are prepared, supplied and administered in the UK. During the COVID-19 pandemic, National Protocols (Regulations 247A) were introduced as temporary legal mechanisms to support rapid and safe vaccine deployment, allowing different trained staff to undertake different stages of vaccination. This lapsed on 1st April 2026 as was replaced by a new permanent legal mechanism (Regulation 235A) which allows authorized healthcare providers to supply and administer vaccines and establishes the legal basis for the use of Vaccine Group Directions (VGDs). VGDs permit some tasks within them, such as preparation and administration or record keeping, to be delegated to suitably trained and competent non-registered healthcare workers, but clinical assessment and obtaining informed consent cannot be delegated and must be carried out by the registered healthcare professionals authorised under the VGD.

In addition, Regulation 19 has allowed COVID-19 and influenza vaccines to be moved between different NHS service providers at the end of the supply chain by providers operating under NHS arrangements without the need for a wholesale dealer's licence. This has reduced vaccine wastage and enabled more timely access to vaccinations

These changes to the regulations have had a significant impact on operational delivery. Non-registered healthcare workers are no longer able to clinically assess and obtain informed consent from patients under new Regulation 235A and there are now limitations on the movement of vaccinations between providers under Regulation 19. Operational adjustments are ongoing but the impact to the workforce specifically under 235A are currently under review.

2. Infectious disease management: Preparedness, Elimination Plans and Response

Preparedness

Health Board 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 has informed the review of the Health Board's current public health incident response plan and pandemic plan. Once established, these documents will be embedded across the Health Board and exercised frequently. As well as leading the refresh of the current Health Board incident and pandemic plan, the health protection team, in partnership with the emergency planning team, have developed a Gwent Local Resilience Forum (LRF) Pandemic Response Plan. This plan has been shared with each LRF across Wales and provides the blueprint for each respective plan to ensure, where appropriate, a consistent response is mounted across Wales.

High Consequence Infectious Disease (HCID) Preparedness

The ABUHB HCID preparedness group continues to meet to discuss and agree required action in relation to emerging HCIDs as new information and public health threats emerge, ensuring that the Health Board remains prepared to respond if one or more suspected or confirmed HCID cases presented at a Health Board site.

The work already undertaken and that continues to progress, has been highlighted recently in response to the Hantavirus outbreak linked to cruise ship travel, as well as the WHO declaration of a public health emergency of international concern due to an outbreak of Ebola disease in the Democratic Republic of the Congo and Uganda (caused by the Bundibugyo virus). Whilst there have been no suspected or confirmed cases within Gwent there has been a requirement to scale up preparedness efforts. This has included but is not exhaustive of:

- Scaling up of fit mask and testing
- Accelerating HCID pathway training
- Reviewing pre-triage and triage questions
- Developing asymptomatic testing protocols for identified contacts
- Working closely with Local Authority colleagues to ensure end to end welfare and support pathways and packages are in place

Work in this area is ongoing with a planned HCID tabletop exercise is due to take place in the coming months that will test specific elements of the HCID pathway and provide valuable ongoing learning and reflection.

Measles Preparedness

The ABUHB Measles and MMR oversight Group, chaired by the Head of Public Health, has been re-established. The purpose of the group, acknowledging the established immunisation governance structures that are in place, is to receive assurance that progress is being made against the requirement to improve uptake and reduce variation in uptake of the MMRV1 and MMRV2 vaccinations as well as provide the oversight and governance that there are plans in place to ensure that an appropriate response can be mounted in the event of a measles incident or outbreak. Outputs of the group includes:

- Review of resources and communications to Primary Care and Secondary care (including the circulation of updated action cards outlining testing, reporting and PPE/ isolation precautions).
- Development and implementation of a measles community testing pathway and immunoglobulin pathway within the Primary Care Health Protection Response Team (PC HeaRT).

- A review of the secondary care triage and isolation pathway.
- Develop a robust response plan that can be enacted as part of an outbreak or surge response.
- Receive assurance and provide appropriate challenge in relation to:
    - Improving MMRV1 and MMRV2 vaccination uptake and reducing variation, in line with the anticipated requirements of the draft national Measles Elimination Plan.
    - Improving MMR vaccination uptake amongst Health Board staff and improving data quality mechanisms to understand Health Board staff uptake.

Elimination plans

Welsh Government has two key elimination targets relating to health protection: Eliminating Hepatitis B and C as a public health threat by 2030 and zero new transmissions of HIV by 2030. Whilst there has been an ambition by Welsh Government to eliminate Tuberculosis (TB) in Wales by 2030, a national plan is yet to be published. In lieu of a national plan, work has commenced locally to develop a TB elimination strategy and accompanying delivery action plan for Gwent. Progress against, and the ongoing development of, the key elimination plans and respective targets is being led and co-ordinated by the Gwent Public Health Health Protection Team.

<u>Hepatitis B and C</u>

There have been notable achievements regarding the success of the local Hepatitis b and c elimination plan including positive feedback from Welsh Government on progress. Planned objectives are identified and agreed by the Hepatitis B and C Elimination Implementation Group, which has oversight of the effective implementation of the local elimination plan.

This has included ongoing commitment to maximise efforts for those in greatest need in key community settings such as offering blood bourne virus testing and increasing needle and syringe exchange provision in pharmacies, substance misuse services, probation offices and prisons. The health protection team has previously provided funding to GDAS to purchase a Cepheid Xpert Point of Care BBV test machine to enhance access to hepatitis C testing and continues to fund 1 WTE clinical staff member (until March 2027) to support the project and facilitate the implementation and operation of the Orasure and Cepheid machine. The purpose of this is to support the ongoing increase in hepatitis case finding across the Gwent area. As well as targeted efforts the approaches have been developed to understand, prevent, identify and treat viral hepatitis infection across a range of population groups.

Data from PHW annual reporting, the BBV-PET (Blood Borne Virus Progress to Elimination Tool) and DOE-D (Diseases of Elimination-Dashboard) are monitored by members of the implementation group, included dedicated support from the data and intelligence team in the Gwent Public Health team. This information is used to monitor progress and inform ongoing learning and review of agreed actions.

<u>HIV</u>

In response to the national HIV Action Plan for Wales 2023-2026 and its 30 actions aimed at eliminating all HIV in Wales and achieving zero tolerance of HIV-related stigma by 2030, Welsh Government established Fast Track Cymru. The intention is

to provide capacity and strategic focus for stakeholders, community groups and decision makers through local fast track collaborations. Fast Track Gwent was established in July 2025, with a local multi-disciplinary steering group overseeing work to shape a future free of new HIV transmissions and to end stigma of those living with HIV.

The health board submits an annual audit to Welsh Government of its HIV services. Feedback received from Welsh Government noted a comprehensive return which more than adequately addressed all questions in the annual audit. Notably, the Health Board received positive feedback for:

- Provision of virtual and face-to-face PrEP clinics
- Promotion of PrEP awareness campaigns
- Testing provision in line with guidelines and subsequent pathways in place for those diagnosed
- Appropriate MDTs in place for children, young and pregnant people
- New cases of HIV are contacted within two weeks and signposted to support programmes.

Tuberculosis

Tuberculosis (TB) is a preventable and curable disease, yet it continues to affect individuals and communities across Gwent. Although Wales has historically experienced lower TB rates than many parts of the UK, recent increases in case numbers in Gwent has highlight the need for a renewed focus and coordinated action.

In the absence of a National TB elimination Strategy for Wales, ABUHB has commenced the development of a Gwent TB elimination strategy and delivery plan. This plan is being developed and led by the ABUHB public health and respiratory teams in partnership with a range of partners including wider ABUHB teams, Local Authorities, Public Health Wales, Housing and Third Sector Partners. It seeks to set out a structured, evidence-based approach to eliminate TB as a public health threat in Gwent by 2031, aligned with WHO and UK wide ambitions.

It outlines how we will prevent new infections, diagnose TB earlier, support people through treatment, and work with communities to reduce stigma and improve awareness through five cross cutting key themes:

1. Preventing TB, including targeted and universal BCG vaccinations
2. Testing for TB, including targeted latent TB case finding
3. Incident management and outbreak control optimisation
4. Education and communication for people and professionals
5. Clinical management of cases led by an appropriately resourced Health Board TB Service

Our approach is grounded in evidence, shaped by the needs of communities across Gwent, and aligned with national and international ambitions to eliminate TB as a Public Health threat. The Gwent Elimination strategy is currently in draft format, with an aim of seeking Executive approval to progress its implementation in the summer of 2026.

Failure to proactively address the rising TB incidence rates that are being observed across parts of Gwent risks increased community transmission, preventable illness and deaths and growing pressure on an already strained healthcare system.

Delayed proactive action will also lead to significantly higher long-term treatment costs and undermines progress toward TB elimination goals.

Acute Response

The Health Board continues to be responsible for ensuring the mobilisation of an appropriate and proportionate response to acute health protection incidents across the region. This includes providing specialist leadership, risk assessment and public health advice during outbreaks, environmental hazards and other health protection emergencies. This is done in partnership with stakeholders across health, local authorities, emergency services and the third sector to prevent and minimise harm to the population of Gwent.

Hospital Sterilisation and Decontamination Unit (HSDU) Incident

The health protection team were involved in the mobilisation of a response to the HSDU sterilisation incident whereby medical equipment was disinfected but did not then complete the final stage of sterilisation before being used on the next patient. Following an assessment of risk by Microbiology colleagues there was a requirement for BBV screening and hep b post exposure prophylaxis to be offered to affected patients. Actions undertaken to enable this to happen included:

- Establishment of a call centre and email contact for affected patients supported by call handler scripts and escalation routes
- Clinic schedules including the provision of home visits for some patients (facilitated clinically by PC HeaRT colleagues)
- Clinic and home visit standard operating procedures (SOP's) and proformas
- Patient and GP correspondence including results letters
- FAQ's
- Vaccine supply provision and storage
- Administrative support at clinics and central line list management

The response continues into August 2026 when the final testing will take place.

TB Response

The health protection team and PC HeaRT remain responsible for the mobilisation of a response to TB cases and clusters. This includes providing additional workforce capacity to the TB service when required such as development of operational processes, providing phlebotomy trained staff and the implementation of enhanced case management for TB cases via direct observation therapy and video observed therapy. This helps to ensure adherence and completion of TB treatment as well as reducing the risk of drug resistance due to erratic or incomplete treatment.

Teams have recently been involved in providing an appropriate response to two separate cases of TB. The first case in a health worker resulted in screening being facilitated by PC HeaRT for the staff of a care home and by Occupational Health for Health Board staff. With the assistance of the care home manager, uptake of screening was high with 34 out of 38 staff being screened.

The second case was extremely complex and involved a vulnerable homeless individual who had stayed in shared temporary accommodation during their infectious period. The response included partners from LA homelessness teams as well as GDAS and the probation service. Due to the accommodation being located within an area of very high incidence rate of TB it was considered proportionate to

offer screening to a large number of individuals with potential exposure. In partnership with PHW and the accommodation manager, a screening session was held at the temporary accommodation site to try to capture the possible contacts in a place they felt comfortable. Uptake of screening was sub optimal which is an ongoing problem in this cohort of patients but reinforces the need for establishing and enacting a robust TB Elimination Plan for Gwent.

Hepatitis A Response

In autumn 2025 the health protection team were notified of a case of Hepatitis A affecting a school aged child in the ABUHB area. Following an IMT a request was made to mobilise an urgent response to offer post exposure prophylaxis and vaccinate 15 staff and 83 children of reception age in a timeframe of less than a week.

In response vaccination clinics were held at the school over 2 days, delivered by PC HeaRT clinicians with staff from the wider ABUHB Health Protection service providing administrative and operational support. The clinic was very successful and delivered the following:

- 14 out of 15 staff vaccinated (93% uptake)
- 64 children out of 83 vaccinated (77% uptake)
- 78 vaccines total given across staff and pupils

More recently a follow up clinic was held at the school to offer a second dose of Hepatitis A vaccine. Whilst this was outside of the initial required public health management of the incident, it was an opportunity to offer longer term protection prior to any travel over the summer holidays especially pertinent as the original case was believed to have acquired the infection abroad. The clinic achieved 74% uptake with those absent indicating they would follow up the second dose with their own GP's.

Incidents of national and international concern

In March 2026 the UKHSA declared an outbreak of invasive meningococcal disease (IMD) in Kent, that was later confirmed as the MenB strain. This outbreak resulted in a high number of confirmed cases with two people sadly dying. The UKHSA led the response to the outbreak, including carrying out contact tracing and offering chemoprophylaxis to identified groups of individuals. Whilst the outbreak was in Kent, there was a requirement for an appropriate response to be mounted across other areas of the UK including in Gwent. The response was led by the Gwent health protection team and the purpose of which was to ensure the local system could cope with and respond to the significant increase in the number of queries from the public in a timely way as well as put in place measures to minimise the risk of cases occurring in Wales due to the outbreak in Kent. Action included:

- Developing quick reference guides for GP practices and reception staff as well as NHS 111 call handlers and clinical staff.
- Ensuring the existing vaccination service call centre had the capability to respond to MenB related calls, including writing call handler scripts and ensuring mechanisms for escalating queries and concerns were in place.
- Developing, publishing and monitoring public facing communications on behalf of the Executive Director for Public Health.

More recently in May 2026 an outbreak of Hantavirus due to the Andes hantavirus Varian (ANDHV) on a Dutch cruise ship in the Atlantic was declared. ANDHV is

classified as a High Consequence Infectious Disease (HCID) in the UK due to the high reported mortality rate of 35-50%. Due to the possible person-to person transmission of ANDHV contacts and cases were, and continue to be, followed up. In response to the outbreak there was a requirement for a Gwent Incident Management Team (IMT) to be convened, chaired by the Head of Public Health, that met daily. The IMT is made up of a multidisciplinary group to ensure the healthcare and wider public protection system could prepare for and respond appropriately to any suspected or confirmed cases, or contacts, linked to the outbreak.

During the Hantavirus outbreak response, the WHO declared a public health emergency of international concern due to an outbreak of Ebola disease in the Democratic Republic of the Congo and Uganda (caused by the Bundibugyo virus). In response to this the scope of the IMT was widened to ensure the local system was prepared to respond to a suspected or confirmed case of Ebola. Whilst the level of response in place locally has lowered the IMT continues to meet weekly and work is ongoing to continuously review HCID pathways across the system, with a particular focus on paediatrics and maternity. To support the testing of these pathways a virtual exercise, led by Public Health Wales, is being planned for summer 2026. This will provide an opportunity to explore and test our multi-agency response to a suspected and confirmed Ebola Virus Disease case in Gwent and build on the work already undertaken in response to the hantavirus outbreak.

3. Local authority public protection teams

Service level agreements (SLAs) are in place until 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.

The additionality of this investment has enabled local authorities to undertake health protection work beyond their statutory obligations. The work carried out by local authorities has included but is not exhaustive of:

- Being core members of Incidents Management Teams for a range of incidents and diseases
- Responding to and investigating hundreds of cases of notifiable infectious diseases and food poisoning outbreaks such as Salmonella, Campylobacter and Norovirus.
- Proactively and opportunistically promoting vaccinations within schools and other educational settings, as well as care homes as part of winter preparedness efforts.
- Proactive and reactive infection prevention and control advice and support within educational settings with the intended outcome of reducing levels of staff and pupil absence.
- Collaborative work across local authority areas to identify and implement novel projects such as improving standards and protecting customers of sunbed shops. This has recently resulted in the successful prosecution of a premises in Blaenau Gwent following a serious burn to a customer that required extensive follow up hospital treatment.

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.

The public health team in partnership with emergency planning colleagues in recent months have been involved in the preparedness and response to a number of incidents of this nature, including:

- Supporting the response and recovery of a major incident declared in Monmouth due to severe and widespread flooding across the town and surrounding communities. 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.
    - Monitor changes in gastrointestinal incidents
    - Ensuring appropriate advice for how to safely return home was shared with everyone affected.
- Ongoing involvement in preparedness exercises including a focus on vector-borne disease risks.
- Providing advice and signposting to guidance on how to stay safe during extreme weather events such as heatwaves and wildfires.
- Involvement in environmental incident management team meetings. Most recently this has involved providing local public health specialist advice regarding an odour being detected across the city of Newport. Advice included the development of appropriate public facing communications following an assessment of risk to the health of the public.

Argymhelliad / Recommendation

The PPHPC are asked to:

1. Provide scrutiny in relation to the 2025/26 Winter respiratory vaccination programme, vaccination service improvements and steps to improve vaccination equity.

2. Provide assurance to the Board that strategic priorities, changes to the routine immunisation schedule, and operational challenges are being managed effectively.

3. Receive the update and note the breadth of work being undertaken across the health protection system to strengthen its capabilities to plan for and respond to incidents and threats. This has only been possible through dedicated and sustained Welsh Government health protection funding.

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	Choose an item.
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.

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 June 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 2026/27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Governance Support Officer

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The 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 2026/27 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.

Deferred items on the forward work plan:-

- Committee Annual Report 2025/26, this was deferred from April's meeting due to being cancelled and was circulated to Committee members virtually.
- Emergency Planning Assurance Report was deferred from June's meeting to Octobers meeting.
- NHS Wales Emergency Preparedness, Resilience and Response (EPRR) Annual Report

Items deferred from April 2026 meeting due to cancelation: -

- Committee Risk Report;
- Transformation Programmes Deep Dive;
- Development of any plans and strategies aligned to the IMTP and Annual Plan;
- Primary Care Sustainability Report;
- Regional Partnership Board;
- Public Services Board;
- Regional Planning;
- Health Protection & Vaccination Programme Update;
- Update on Armed Forces matters.

Additional items added to the forward work plan:-

- Update and implications of new Welsh Government national GDS contract was included on the plan as an action from the Finance & Performance Committee;
- Regional Integration Fund audit report was included on the plan as an item for information and will be reported at June 2026 meeting;
- NHS Wales Emergency Preparedness, Resilience and Response (EPRR) Annual Report was included on the plan for information and will be reported at June 2026 meeting.

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 *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.

Annual Programme of Business for 2026-27

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 Gwent 35 Strategy and "Making it Happen", strategy deployment plan;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of Committee self-assessment for 2025/26
- 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 (including the NHS Wales Joint Commissioning Committee and the Regional Joint Committee); 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 07/04/26	QTR 2 July to Sept 30/06/26	QTR 3 Oct to Dec 13/10/26	QTR 4 Jan to Mar 09/01/27
Preliminary Matters						
Attendance and Apologies	Chair	**SI**	✓	✓	✓	✓
Declarations of Interest	All members	**SI**	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	**SI**	✓	✓	✓	✓
Committee Action Log	Chair	**SI**	✓	✓	✓	✓
Committee Governance						
Development of Committee Annual Programme of Business 2027/28	DoCG	**AN**				✓
Committee Annual Report 2025/26 • Annual Review of Committee Effectiveness 2025/26 • Outcome of Annual Review of Committee Effectiveness 2025/26 **Deferred from January meeting**	DoCG	**AN**	✓ D			
Committee Annual Report 2026/27	DoCG	**AN**				✓

• Annual Review of Committee Terms of Reference 2026/27 • Annual Review of Committee Effectiveness 2026/27 • Outcome of Annual Review of Committee Effectiveness 2026/27						
Review of Committee Programme of Business 2026/27	DoCG	**SI**	✓ D	✓	✓	✓
Committee Risk Report	DoCG	**SI**	✓ D	✓	✓	✓
Strategic Planning						
Annual Review of progress of the Long-Term Strategy	DoSP&P	**An**			✓	
Transformation Programmes Deep Dive	DoSP&P	**SI**	✓ D	✓ D	✓	✓
IMTP/Annual Plan Development	DoSP&P	**An**			✓	
Development of any plans and strategies aligned to the IMTP and Annual Plan	DoSP&P	**SI**	✓ D	✓ D	✓	✓
Emergency Planning Assurance Report	COO/ DoN	**An**		✓ D	✓	
Primary Care Sustainability Report	COO	**An**	✓ D	✓		
Place Based Care Development Progress Report	COO	**BI**		✓		✓
Estates Strategy Review	DoSP&P	**AN**			✓	

Nevil Hall Hospital Development Case	DoSP&P	**AN**			✓	
St Woolos Hospital rationalisation	DoSP&P	**AN**			✓	
Digital Strategy	DOD	**AN**				✓
Planning Maturity Matrix	DoSP&P	**AN**			✓	
Strategic Partnerships						
Regional Partnership Board	DoSP&P	**SI**	✓ D	✓	✓	✓
Public Services Board	DPH	**SI**	✓ D	✓	✓	✓
Regional Planning	DoSP&P	**SI**	✓ D	✓	✓	✓
Population Health						
Population Health Management Update Report	DPH	**An**		✓		
Joint Strategic Needs Assessment Update	DPH	**An**		✓		
Health Protection & Vaccination Programme Update	DPH	**Bi-An**	✓ D	✓		✓
Update on Armed Forces matters	DoWOD	**Action**	✓ D	✓		
Update and implications of new WG national GDS contract (Action transferred from FPC)	COO	**Action**		✓		
RIF Audit report (for information)	DoSP&P	**Add Hoc**		✓		
NHS Wales Emergency Preparedness, Resilience and Response (EPRR) Annual Report	DoSP&P	**Add Hoc**		✓		

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

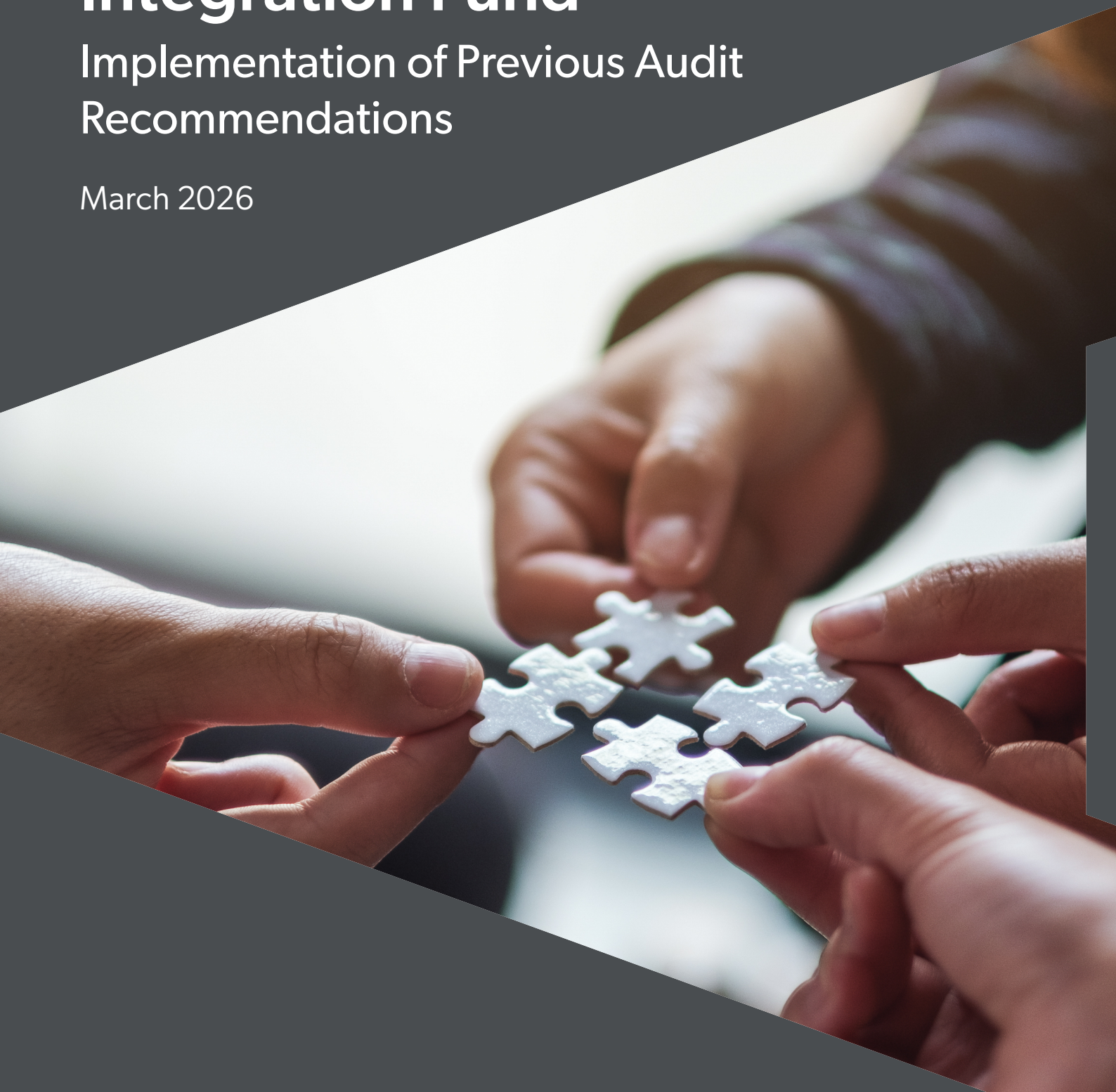
Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	!/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Archwilio Cymru
Audit Wales

Managing the Regional Integration Fund

Implementation of Previous Audit Recommendations

March 2026



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Audit Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

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Audit snapshot

What we looked at

1 In 2019, we published a Review of the Integrated Care Fund. The Welsh Government set up the Integrated Care Fund (ICF) in 2014 to enable regional partnerships to better integrate health, social care, and housing.

2 The review described the ICF's positive impact on improving integration and partnership working. However, it also identified weaknesses in the way the annual fund was managed. It made six recommendations for the Welsh Government which it accepted in full.

3 In April 2022, the Welsh Government replaced the ICF along with its Transformation Fund with the Health and Social Care Regional Integration Fund (RIF). The capital elements were replaced with a new Housing with Care Fund.

4 This report examines the extent to which the Welsh Government has implemented our recommendations through the rollout of the RIF, and to a lesser extent through the Housing with Care Fund.

Why this is important

5 The RIF is a key part of the Welsh Government's approach to achieving its long-term vision of integrated health and social care, set out in its 2018 strategy, A Healthier Wales. Through the RIF and Housing with Care Fund, along with the Integration and Rebalancing Capital Fund it aims to embed a preventative approach to population health and wellbeing, and delivery of seamless health and care support.

6 The RIF is the Welsh Government's main funding to support early intervention, integration, and partnership working through Regional Partnership Boards (RPBs). It is a five-year fund running from April 2022 to March 2027, with an annual budget of around £146 million.

What we have found

7 The Welsh Government's Regional Integration Fund is supporting regional working and developing seamless models of care. Now in its fourth year, the fund has had a positive impact on many people's lives. In 2024-25, it supported over 180,000 people to prevent their health and care needs escalating.

8 The Welsh Government has fully implemented five of our six previous recommendations and partly completed the remaining one. It has improved the timeliness of its decision-making and monitoring information, strengthened its oversight and supported RPBs to share learning. However, we found some minor gaps in the Welsh Government's oversight of RPB spending of the RIF. We also found that some shared learning networks are more effective than others.

9 Despite the Welsh Government's efforts to simplify RPB funding arrangements, those arrangements are still complex and could be better integrated. There are also concerns about longer-term funding to replace the RIF programme in 2027, particularly as RIF funding is being used to fund some services which are now embedded in the health and social care system.

10 We identified weaknesses in oversight by statutory organisations of RPB activities and how RIF funding is being used. Health boards and local authorities are responsible for ensuring appropriate oversight takes place. The Welsh Government could also do more to assure itself that those bodies comply with its guidance on oversight.

What we recommend

11 We are reissuing two of our previous recommendations, updated to reflect the current delivery context. These focus on further simplifying and aligning RPB funding streams and ensuring appropriate scrutiny of RPB decisions in the regional statutory organisations.

12 We are also making two new recommendations to improve the quality of the Welsh Government's oversight of RPB spending.

Auditor General's view

I am encouraged to see that the Welsh Government has taken the findings of my 2019 report on the ICF seriously and acted on my recommendations. The report has clearly driven improvements to the management of public money by the Welsh Government and RPBs.

The Welsh Government is increasingly allocating funds through RPBs, so it needs to continue working with partnership bodies to ensure they are overseeing spending that money wisely. The findings and further recommendations that I have set out in this follow up report will hopefully help shape that important work going forward.

Adrian Crompton
Auditor General for Wales

Key facts and figures

The Welsh Government has fully addressed **5 recommendations** from our 2019 review, and partly addressed the remaining one.

The RIF aims to create sustainable service change through **6 national integrated models of care.**

The Welsh Government has committed around **£146 million** annually for five years through the RIF.

From 2022-23 to 2024-25, RPBs have spent **£436.6 million** of RIF funding.

Partner organisations provided an additional **£174.2 million** of match funding over the first three years of the fund.

From 2022-23 to 2024-25, RPBs have spent **£125 million** of Housing with Care funding.

In 2024-25, **747,953** people used RIF funded projects*.

That support prevented levels of need escalating for **181,922** people.

Note * People may be counted more than once if they used more than one project.

Our findings

Allocating RIF funding

The Welsh Government has clearly designed the RIF to support longer-term planning and minimise late decision-making

13 In 2019, our report on the ICF found that changing Welsh Government expectations and issues with the timeliness of funding allocation processes hampered regional delivery. **Exhibit 1** shows that the Welsh Government has fully implemented our recommendation to improve the timeliness of guidance and decision-making.

Exhibit 1: the Welsh Government's implementation of recommendation 1 from our 2019 report

Recommendation 1

We recommended that the Welsh Government should:

- consider the impact of issuing guidance earlier on the timeliness of project funding decisions (**complete**); and
- consider whether any further improvements in the funding allocation process can be made (**complete**).

Source: Audit Wales

Development of the RIF

14 The Welsh Government has clearly learnt from our review and national evaluations of the ICF and Transformation Fund to develop its RIF programme. A key example of that learning is the Welsh Government's design of the RIF as a five-year programme to support longer-term planning and provide more certainty for RPBs.[1] The Welsh Government also expanded the Housing with Care Fund timespan to match the five-year term of the RIF.

15 Most RPB members we spoke to welcome the RIF's five-year timespan. However, one RPB member responding to our survey described it as restrictive, while others felt five years was not long enough:

> 5-year plans can of course bring a sense of continuation and stability but they also risk locking us into spending that is too hard to review and change, bringing a sense of inertia and complacency.
>
> RPB member survey respondent

> It's a positive development that we had a five year cycle. We hope that will be extended in order to make medium term decisions rather than short termism.
>
> RPB member survey respondent

> To create a mature partnership that can effectively develop and deliver long-term strategic plans that support fundamental transformation needs long term guaranteed funding.
>
> RPB member survey respondent

1 RPBs were set up in response to the Social Services and Well-being (Wales) Act 2014 and bring together health boards, local authorities, the third sector and independent providers to meet the care and support needs of their area.

16 The Welsh Government designed the RIF as a learning programme to inform the development of its Integrated Community Care System, and it is clear to see the evolution from the ICF to the RIF and then emerging care system plans. It continues to learn from delivery of the RIF through the communities of practice, and a series of national evaluations throughout the programme.[2] The Welsh Government aims to use the evaluations to develop 'blueprints' setting out revised national models of care by year five of the RIF (2026-27).

17 Welsh Government's RIF team (the RIF team) worked with RPB members over an 18-month period to develop the RIF. Some of those members criticised the Welsh Government for not implementing all their suggestions. However, most RPB members we spoke to said that early Welsh Government engagement laid the foundations for positive working relationships to deliver the programme.

18 The Welsh Government continues to engage RPB members as the programme evolves, adapting its arrangements in response to feedback. For instance, it removed its reduction or 'tapering' of RIF funding over time in recognition that the statutory partners within the RPBs were struggling to 'mainstream' successful RIF funded projects due to financial pressures. The RIF team's early and sustained engagement is an example of good practice in involving stakeholders in the design and delivery of Welsh Government programmes.

The timeliness of decision-making

19 The Welsh Government published the final version of its RIF guidance in February 2022, shortly before the programme started in April. It asked RPBs to submit RIF investment proposals for 2022-23 by the end of March 2022. Despite the publication timeframe, the Welsh Government had engaged regularly with RPBs before the programme started and agreed which projects previously funded by ICF and met the RIF criteria could move over to the RIF. The Welsh Government also used 2021-22 as a transition year to allow RPBs to plan and make the necessary changes from the ICF to the RIF.

2 Communities of practice are networks of professionals designed to share learning and make links between relevant Welsh Government national programmes.

20 Although the Welsh Government did not publish its Housing with Care Fund guidance until May 2022, it worked with RPBs beforehand to support their planning. The RPBs had capital investment plans in place to manage forthcoming and ongoing ICF capital projects. The capital investment plan arrangements rolled forward with the introduction of the Housing with Care Fund to include new capital projects and existing ICF commitments. **Exhibits 21 and 22** in **Appendix 2** set out Housing with Care Fund spending over time.

21 To date, the Welsh Government has looked to simplify arrangements for RPBs by avoiding making changes to its RIF guidance. Rather than revising the guidance, it wrote to RPBs about tapering changes in January 2024. Officials told us they are waiting for the outcome of our review to incorporate potential changes before updating the guidance.

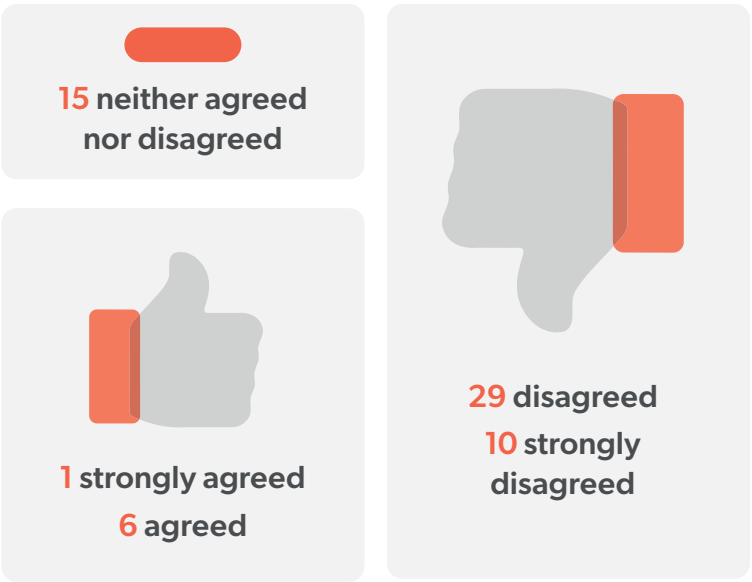
22 Some RPB members responding to our survey felt that the Welsh Government did not issue its guidance early enough to support effective planning. Given the steps the Welsh Government took to develop and embed its RIF guidance (see **paragraph 19**), survey respondents may have been referring to Welsh Government guidance for funds allocated to the RPBs other than the RIF. Many RPB members described difficulties responding to the Welsh Government's requirements for other funds, in particular where it provided those funds at short notice (see **paragraph 39**).

23 The Welsh Government provides a clear five-year funding commitment through the RIF. It also sets out annual allocations each December in its NHS budget letters to health boards, which should leave RPBs in no doubt about their funding allocations. The Welsh Government also issues annual RIF funding allocation letters for the next financial year to RPBs as a formality between January and March. It agrees in-year transfers between projects in routine meetings with RPB finance leads.

24 Despite those longer-term arrangements, many RPB members perceive the Welsh Government's funding decisions as late. The majority (39) of RPB members responding to our survey either disagreed or strongly disagreed that the Welsh Government made funding decisions early enough to support effective regional planning (**Exhibit 2**).[3]

3 63 RPB Members completed our survey.

Exhibit 2: number of respondents to our survey who agree or disagree with the statement 'the Welsh Government makes funding decisions early enough to support effective regional planning'



Source: Audit Wales Survey of RPB Members, 2025

25 Some RPB members described slow decision making from their regional partners rather than the Welsh Government. Several members of different RPBs told us that regardless of the Welsh Government's five-year timeframe, RPB planning follows an annual cycle. Despite being a formality, some members said that their RPB did not want to confirm funding for projects until receiving the Welsh Government's allocation letter.

The Welsh Government supports RPBs to use RIF funding flexibly to meet local need, but RPB funding is becoming increasingly complex

26 In 2019, we reported that RPBs were finding it difficult to align local population needs with the Welsh Government's indicative allocations for priority population groups within the ICF. At the time, RPB funding arrangements were complicated with multiple short-term Welsh Government funding streams focusing on the same priority population groups. Those funds often had different criteria which made it difficult for RPBs to combine them to address local need. **Exhibit 3** shows that the Welsh Government has fully implemented our recommendation to simplify RPB funding streams.

Exhibit 3: the Welsh Government's implementation of recommendation 2 from our 2019 report

Recommendation 2

We recommended that the Welsh Government review all short-term funding streams available to health, social care, and housing partners to ensure that funding streams:

- minimise duplication (**complete**);
- are complementary and that the collective allocations for specific groups of people align with local population needs as well as Welsh Government priority areas (**complete**); and
- can be combined to address local need (**complete**).

Source: Audit Wales

27 The Welsh Government has worked hard to simplify and align funding streams within the RIF. Nonetheless, funding arrangements are still over-complicated and some RPB members are confused about whether the Welsh Government still sets indicative allocations for priority population groups.

28 The Welsh Government developed the RIF programme to align to local population need and relevant policy areas. Its RIF guidance makes it clear that RPBs must demonstrate that RIF funded initiatives meet the needs of five target priority population groups through six national models of care (**Exhibit 4**).

Exhibit 4: RIF priority groups and models of care

Priority groups

- Older people including people with dementia
- Children and young people with complex needs
- People with emotional and mental health well-being needs
- Unpaid carers
- People with learning disabilities and neurodevelopmental conditions

Models of care

Community based care: **Prevention** and **community coordination**

Community based care: Complex care **closer to home**

Promoting good **emotional health** and **well-being**

Supporting families to **stay together safely**, and therapeutic support for **care experienced children**

Home from hospital

Accommodation based solutions

Source: Audit Wales analysis of Welsh Government information

29 The Welsh Government does not set indicative allocations for the priority population groups for the main RIF fund but sets aside specific ring-fenced funds within the RIF for key groups or services. RPBs can transfer funds from one priority population group to another in agreement with Welsh Government officials. The RIF also includes a ring-fenced annual £750,000 regional infrastructure fund for running costs (**Exhibit 5**).

Exhibit 5: the structure of the RIF

National Ringfenced Fund

To fund:

- The Integrated Autism Service
- Dementia projects
- Memory assessment services
- Unpaid carers hospital discharge engagement
- Short breaks for carers

Funding

100% Welsh Government funded

Regional Infrastructure Fund

To fund:

- RPB infrastructure to ensure they have sufficient resources to support their regional working

Funding

75% Welsh Government funded

RPBs must provide the remaining 25%

Core RIF Fund

To fund projects in line with the Welsh Government's models of care:

- Accommodation based solutions
- Complex care closer to home
- Home from hospital
- Promoting good health and emotional well-being
- Prevention and community coordination
- Supporting families

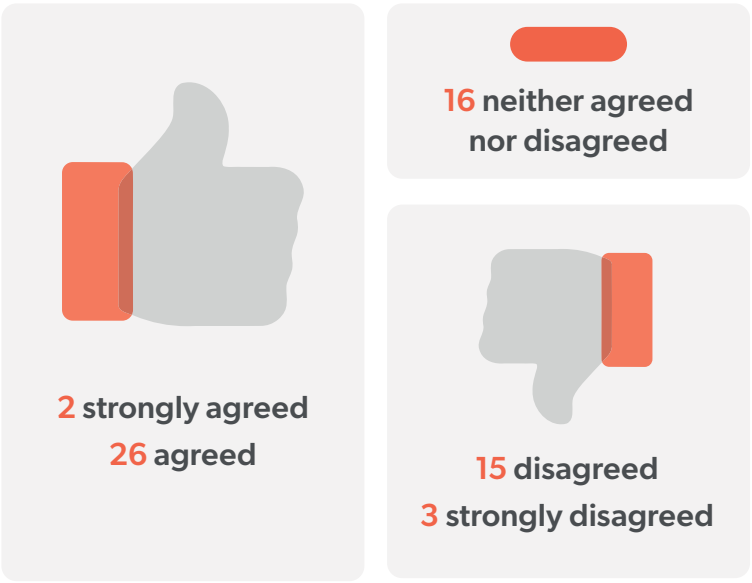
Funding

100% Welsh Government funded

Source: Audit Wales analysis of Welsh Government information

30 Just under half of the RPB members (28) responded positively to our survey question on the RIF's alignment to local need. However, over a quarter of respondents felt more negatively about that alignment, and a quarter gave a neutral response (**Exhibit 6**).

Exhibit 6: number of respondents to our survey who agree or disagree with the statement 'the RIF priority areas set by the Welsh Government are clearly aligned to local need'



Source: Audit Wales Survey of RPB Members, 2025

31 Some of the RPB members we spoke to misunderstand the Welsh Government's focus on priority population groups and asked for more flexibility to respond to local need. Some regional partners were already funding initiatives for some population groups with non-RIF funding. They mistakenly thought they are unable to move RIF funding for one population group to meet the needs of other groups.

32 Some of the misunderstanding about priority population allocation may stem from misinterpretation of information in Welsh Government allocation letters. For example, the 2022-23 letters set out its expectation that for the core RIF fund:

- at least 5% would be used to support unpaid carers (in addition to the ringfenced fund);
- at least 20% would be spent on delivery through partners delivering wider economic, social, or environmental benefits; and
- at least £20 million would be spent across Wales in services to support children who are care experienced or at the edge of care.

Integration of relevant funding streams

33 The Welsh Government designed its RIF to better integrate processes for existing funding streams into a single system. It consolidated several individual funding streams, providing ring-fenced allocations within the RIF (see **Exhibit 5**). It designed the RIF, Housing with Care Fund and Integration and Rebalancing Capital Fund as complementary programmes to support its longer-term vision for an Integrated Community Care System.

34 Between 2021-22 and 2026-27, RPBs will have had access to £1.45 billion Welsh Government funding spanning nine programme areas (see **Exhibit 17, Appendix 2**). Most of these funds started at the same time as the RIF or predated it. The Welsh Government introduced other short term funding streams after the RIF including Allied Health Professional, Further Faster, and 50-day Challenge funding.

35 The year one national evaluation of the RIF described the 'fast-changing policy context' as a challenge to integrating the RIF with other relevant funding programmes. The Welsh Government's RIF team recognised this challenge from the start and has taken steps to address it.

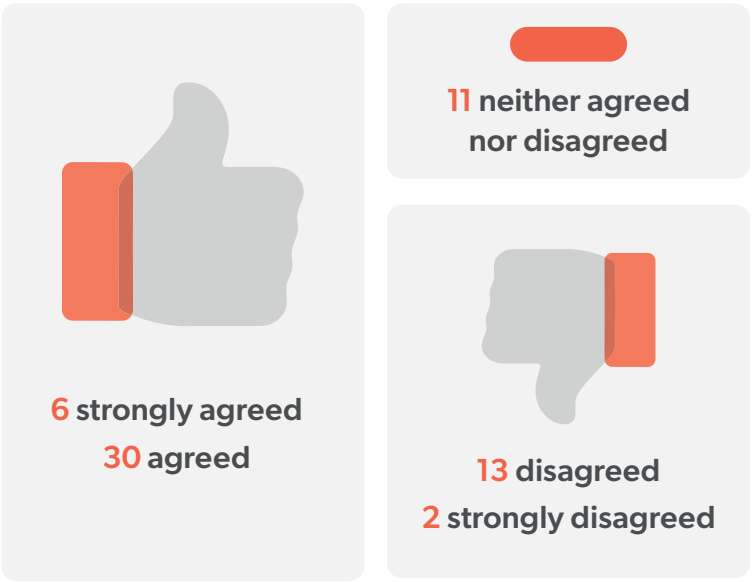
36 The RIF team hold regular meetings with policy leads for relevant programmes to improve integration and develop plans for the Integrated Community Care System.[4] These officials also sit on the RIF Assurance Board where we saw positive examples of information sharing.

37 As the RIF programme has evolved, the Welsh Government has better integrated reporting of key funding streams. For instance, the RIF annual report for 2023-24 was a joint progress report or 'position statement' for its Housing with Care Fund, Integration and Rebalancing Care Fund and RIF funds. The position statement also describes progress towards creating the Integrated Community Care System.

38 Just over half of the RPB members (36) responding to our survey were positive about the flexibility of the RIF funding criteria (**Exhibit 7**) and 27 found it easy to combine the RIF with other funding streams (**Exhibit 8**). However, RPB members and the Welsh Government's RIF team recognise that since the start of the RIF, funding allocated to RPBs has become increasingly complex.

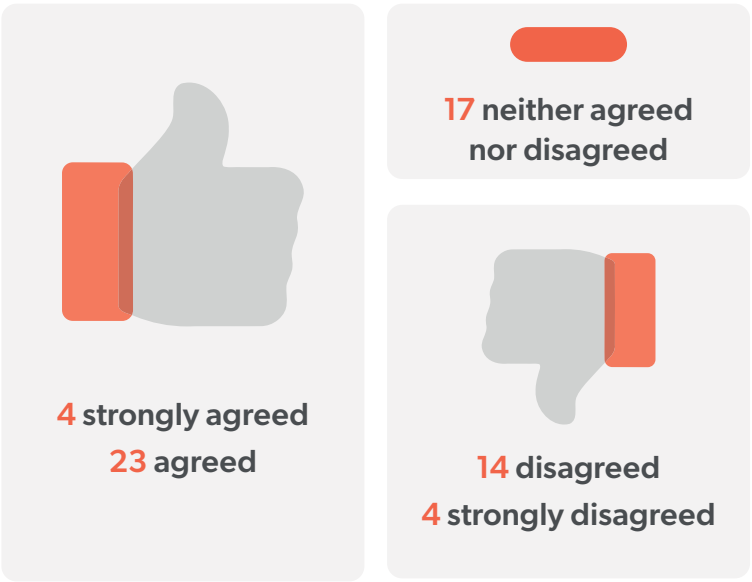
4 Including the Housing with Care Fund, the Six Goals Programme, and the Strategic Programme for Primary Care

Exhibit 7: number of respondents to our survey who agree or disagree with the statement 'the RIF funding criteria is flexible enough to support local decision-making'



Source: Audit Wales Survey of RPB Members, 2025

Exhibit 8: number of respondents to our survey who agree or disagree with the statement 'the Welsh Government has made it easy to combine the RIF with other funding streams'



Source: Audit Wales Survey of RPB Members, 2025

39 RPB members we spoke to were concerned about the complexity and sometimes short timeframes associated with new funding streams such as the 50-day Challenge and Further Faster funds. They told us that responding to the requirements of some initiatives (particularly the 50-day Challenge) puts pressure on RPB staff and members and diverts resources from other aspects of delivery.

40 The Welsh Government's 2024-25 RIF funding allocation letters list details of some other funds to provide an overview of funding to RPBs.[5] However, the Welsh Government still sends separate letters for those programmes in addition to its RIF letters. Also, the RIF letters do not list all relevant RPB funds. The number of funding letters may be contributing to RPB's perception that funding arrangements are overly complex.

41 The RIF, Housing with Care Fund and Integration and Rebalancing Capital Fund all end in 2027, presenting an opportunity to reflect on future arrangements. The Welsh Government has already started this reflection and has set up a cross sector working group to explore ways of aligning investment and delivery in relevant areas. Moving forward, it wants to better integrate funding streams through its Integrated Community Care System, recognising that future investment decisions depend on political priorities after the May 2026 Senedd election.

5 The letters list allocations of Further Faster, Allied Health Professionals and Integration and Rebalancing Capital funds.

The Welsh Government is identifying and sharing good practice, but some RPB members are unclear about aspects of the approach

42 Our 2019 report found little evidence that ICF funded projects had been 'mainstreamed' as part of core service delivery within partner organisations. We recommended that the Welsh Government increases its support for shared learning across RPBs with a particular focus on approaches to managing the fund and overcoming challenges to mainstreaming. **Exhibit 9** shows that the Welsh Government has fully implemented our recommendation on supporting shared learning.

Exhibit 9: the Welsh Government's implementation of recommendation 6 from our 2019 report

Recommendation 6

We recommended that the Welsh Government increases its support for shared learning across the RPBs with a particular focus on:

- approaches to managing the fund, in the context of the variation highlighted in this report (**complete**); and
- overcoming challenges to mainstreaming successful projects (**complete**).

Source: Audit Wales

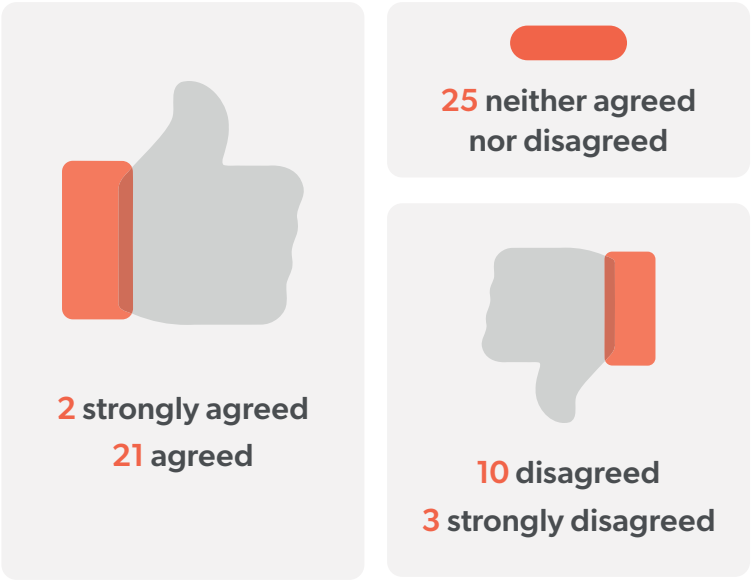
43 The Welsh Government provides formal and informal opportunities to share learning. Its formal arrangements include:

- capturing and sharing learning during its routine monitoring arrangements (see **paragraph 59**);
- highlighting good practice in its annual progress reports;
- conferences for RPBs to share learning; and
- 'communities of practice' to share learning on the national models of care to inform RIF projects and the development of the Integrated Community Care System. The communities, introduced in 2022, are networks of RPB members, Welsh Government officials and other stakeholders.

44 Welsh Government officials also share learning informally through the network of RPB leads. We found several examples where Welsh Government officials recognised strengths in one region and worked with that region to share examples amongst RPB leads.

45 Despite the positive examples we identified, RPB member responses to our survey were not clear about whether the opportunities provided by Welsh Government were supporting shared learning (**Exhibit 10**). One RPB member commented that the Welsh Government's support for shared learning was a recent development. Another described limited time to learn from others.

Exhibit 10: number of respondents to our survey who agree or disagree with the statement 'the Welsh Government provides opportunities for shared learning about other RIF funded projects'



Source: Audit Wales Survey of RPB Members, 2025

46 RPB members we spoke to explained that learning is shared regularly between regions, but that process is not always led by the Welsh Government. RPB leads have made their own arrangements to share learning through weekly meetings, which the Welsh Government has encouraged as a form of pro-active peer to peer sharing of good practice. In general, RPB members praised the RIF team's positive engagement and responsiveness.

47 The Welsh Government has established six communities of practice to support shared learning. These are sharing learning, policy developments and facilitating engagement with stakeholders in relevant sectors. Welsh Government officials acknowledged that some communities of practice are more effective than others in sharing good practice.

48 Some RPB members we spoke to were confused about the purpose of the communities of practice. Some RPB leads told us they had stopped attending meetings because they were time-consuming and unhelpful. The year three national evaluation of the RIF found that target membership is unclear and raised questions about the breadth of representation. It also recognised that the objectives of the communities of practice are not always clear to stakeholders. The Welsh Government is currently exploring ways to improve the effectiveness of the communities of practice, learning from those that are working well.

The RIF has supported partnership working and service improvement but there are concerns over long term funding arrangements

49 RPB members responding to our survey clearly value the RIF programme and responded positively to our survey questions about its contribution to regional partnership working and providing sustainable and improved services. Respondents also made comments about the impact of the RIF:

> The RIF has become instrumental in the development of new ways of working, many of which are embedded in the way services are now delivered.
>
> RPB member survey respondent

> Many councils and the NHS would strongly evidence that the fund has enabled a consistent added value to residents.
>
> RPB member survey respondent

50 However, due to broader financial challenges many RPBs also described a lack of progress mainstreaming successful projects. Several RPB members called for clarity about how the Welsh Government will replace RIF funding after 2026-27, saying it is currently being used to fund services which are now considered part of core provision.

> Mainstreaming was introduced but doesn't appear to have happened in practice as individual organisations face significant financial challenge.
>
> RPB member survey respondent

> RIF needs to be continued and consolidated as it is used to fund core services that have become essential elements of the health and care system. In the current financial climate, reducing or ceasing funding will result in the curtailing of services.
>
> RPB member survey respondent

51 There are considerable challenges associated with mainstreaming projects into core budgets. Nonetheless, partner organisations within RPBs have contributed their own funding to support the Welsh Government's RIF allocations using a combination of cash and other resources.[6]

52 RPB partners provided an additional £174.2 million of match funding over the first three years of the RIF. **Exhibit 11** shows that the proportion of funding provided by partner organisations varies considerably by region.[7] In particular, partner organisations within the North Wales Regional Partnership Board provided considerably higher levels of their own funding in 2022-23 and 2023-24 than other regions.

Exhibit 11: RPB RIF funding provided by partner organisations from 2022-23 to 2024-25, in £ millions and as a percentage of overall RPB income (shown in brackets)

RPB	2022-23	2023-24	2024-25
Cardiff and Vale	*	*	6.2 (24%)
Cwm Taf Morgannwg	6.1 (21%)	5.6 (20%)	5.0 (18%)
Gwent	7.3 (21%)	7.0 (20%)	5.5 (17%)
North Wales	23.5 (42%)	27.7 (46%)	55.0 (63%)
Powys	2.0 (24%)	0.4 (6%)	1.6 (19%)
West Glamorgan	*	*	6.2 (25%)
West Wales	2.5 (12%)	3.9 (17%)	8.7 (32%)

Source: Audit Wales analysis of Welsh Government information

Note: *Cardiff and Vale and West Glamorgan Regional Partnership Boards did not provide information on funding provided by their partners organisations in 2022-23 and 2023-24.

53 RPBs are also experiencing financial pressures associated with delivering RIF funded projects, particularly rising staff costs. The Welsh Government removed the tapering element of the RIF in recognition of mainstreaming challenges (see **paragraph 18**). It has not increased RIF funding to match inflation.

6 Such as staff, or premises not funded by the RIF.

7 Welsh Government officials told us that some of this variation could relate to differences in how RPBs capture match funding information. Officials are working with the RPBs to improve the quality and consistency of their data.

54 The Welsh Government's overall RIF allocation has increased slightly from £144.7 million in 2022-23 to over £146 million in 2023-24 and 2024-25. However, in real terms the Welsh Government's funding fell by 8% over the three years.[8] **Exhibits 18 to 20** in **Appendix 2** provide more analysis of RIF spending by type and RPB.

Welsh Government oversight

The Welsh Government has continued to work with RPBs to improve the quality and consistency of RIF monitoring information

55 In 2019, our ICF report described weaknesses in the Welsh Government's arrangements to assess the overall impact of its programme. It explained that RPBs were using different tools and processes to measure performance and found it difficult to measure project outcomes. **Exhibit 12** shows that the Welsh Government has fully implemented our recommendation to improve project monitoring.

Exhibit 12: the Welsh Government's implementation of recommendation 5 from our 2019 report

Recommendation 5

We recommended that the Welsh Government work with RPBs to:

- agree key outcome measures which are expected to be achieved, and monitored, for the different target groups in receipt of the fund. Where possible, these measures should align to wider outcome measures set out in national outcome frameworks already in place (**complete**);
- make clear how it is using the information gathered by RPBs (**complete**); and
- streamline the reporting requirements for revenue and capital projects, where practical to do so (**complete**).

Source: Audit Wales

8 Real terms figures are adjusted to take account of inflation. We used HM Treasury GDP deflators at market prices and money, June 2025.

Measuring outcomes and impact

56 The Welsh Government developed a RIF outcomes framework clearly setting out the outcomes and principles it wants to achieve for the wider health and social care system.[9] The Welsh Government provided separate guidance to support RPBs to use the framework. The framework is a positive step towards measuring the fund's impact, focussing on both person-centred and system outcomes (**Exhibit 13**). The Welsh Government continues to refine the approach as the programme progresses including developing ways to measure social return on investment.

9 The Welsh Government published the framework on page 42 of its RIF guidance.

Exhibit 13: key intended outcomes in the Welsh Government's outcomes framework

Overall system

Outcomes

- People are healthier and happier
- Health and care services are better and easier to access
- Health and care services are innovative and use latest technology
- Staff in health and social care are looked after and motivated

Principles

- Principles of co-production are embedded in the design, delivery and evaluation of models of care
- Models of care are preventative and provide early intervention solutions
- Care pathways are clear, equitable and accessible across the population groups
- Models of care demonstrate the impact of the benefits that they bring

Person-centred outcomes

- People feel more able to make their own decisions about what is important to and for them
- People have more voice in and control over their care and support needs
- People have greater awareness of what care and support services are available and local to them
- People have improved access to care and support at home or close to home

Two person-centred outcomes for each model of care. For instance, under 'accommodation based solutions', the outcomes are:

- people are more involved in the design of accommodation to meet their needs; and
- people have more choice about where they live and with whom

Source: Audit Wales analysis of Welsh Government information

57 The Welsh Government has different arrangements to measure the impact of its Housing with Care Fund. RPBs set out intended outputs and outcomes for individual projects in their respective 10-year capital investment plans. The Welsh Government's Health and Housing Team monitors delivery against the plans every six months.

RIF monitoring arrangements

58 The Welsh Government has worked hard to develop monitoring arrangements that provide robust information for effective oversight of its investment. It also provides £750,000 annually to each RPB to support their management of the RIF including reporting arrangements (see **paragraph 29**).

59 The Welsh Government has developed a clear monitoring schedule for RPBs based on:

- quarterly finance returns setting out forecast and actual spend, and delivery of projects to date, setting out risks to project delivery at quarters two and four; and
- six monthly impact reports demonstrating progress using the RIF outcomes framework, risks, and project learning.

60 The RIF team has good arrangements to scrutinise RPB finance and impact reports and discuss in quarterly meetings with the RPB leads. Officials consider RPB plans to manage project over or underspends and have clear arrangements to agree transferring funding between projects.

61 Officials told us that they initially planned to include routine 'spot-checks' on individual spending lines in the finance reports to check that funding allocated through RPBs is being spent appropriately. At the time of our review, the Welsh Government had not developed arrangements for those checks which are intended to be undertaken by its internal audit function.

62 For the Housing with Care Fund, the Welsh Government's Health and Housing Team discusses performance with RPBs in monthly meetings with RPB leads. Discussions focus on project delivery, finance, and risk, which feed into six-monthly progress reviews with the Welsh Government.

63 The Welsh Government worked with RPBs to develop monitoring tools in preparation for the introduction of the RIF and has continued to work with them to refine and develop new tools throughout the programme. We also found examples of the Welsh Government sharing good monitoring processes at one RPB to improve approaches elsewhere.

64 The RIF team has formally reported a risk associated with poor quality RPB monitoring information on the risk log it shares with its RIF Assurance Board. To mitigate the risk, the Welsh Government provides training for RPB leads, reporting templates and support through routine monitoring meetings. It also has a formal escalation process for late submissions. Those actions have reduced the residual score on the risk log, and the Welsh Government reviews the risk every six months.

65 We found the Welsh Government's monitoring requirements clear and proportionate. However, the majority of RPB members responding to our survey did not find it easy to provide the type of monitoring information the Welsh Government requests. Several RPB leads told us monitoring arrangements are an administrative burden, often requiring staff training. Some were using parallel monitoring processes where the Welsh Government's requirements differ from those of the RPB partner organisations. Some RPB leads were frustrated that the Welsh Government asked for information it already has, from previous RIF monitoring information or from other programmes.

> The reporting requirements via the RIF templates are significant, and the timescales are not always realistic, especially when gathering information from organisations who are being commissioned by the RPB.
>
> RPB member survey respondent

> Requests for data that Welsh Government already has access to is frustrating – especially as different agencies have different systems and we do not share data in a way that would support strategic planning and integration.
>
> RPB member survey respondent

66 Many of the RPB leads said that the Welsh Government's financial reporting template is difficult to use. Welsh Government officials recognised that there are opportunities to improve the template which they are working with RPBs to address.

67 Despite their concerns about responding to the Welsh Government's monitoring requirements, most RPB leads described significant improvements in monitoring requirements in 2024-25. One person explained that reporting requirements had reduced from about 500 pages in year one of the RIF to about 200. Welsh Government officials told us they had been confident to move to more 'light touch' monitoring from 2023-24 onwards because the strength of RPB performance information had improved considerably.

68 RPB members we spoke to had varying views on the level of feedback they get from the Welsh Government on their monitoring submissions. Some praised the clear and regular feedback whilst others felt that they would submit information to the Welsh Government but not receive any feedback from officials. Welsh Government officials told us that they provide robust feedback through the quarterly meetings with RPBs and in an annual 'score card' report. Not all RPB members are included in these meetings, so there is a possibility that not all members are sighted of feedback.

RIF reporting arrangements

69 The Welsh Government publishes annual reports on progress delivering the RIF on its website. The first report (2022-23) set out funding allocations, the number of projects and a description of outputs and outcomes for key projects for each region.

70 By its second year (2023-24), the Welsh Government's reporting of the RIF was more sophisticated, publishing some performance measures from the outcomes framework (see **paragraph 56**). The report set out information clearly and simply with output measures of 'how much we did' and outcomes measures of 'the difference we made for people'. The Welsh Government continued to use this approach for its third-year report (2024-25) (**Exhibit 14**).

Exhibit 14: outputs and outcomes from the Welsh Government's RIF annual report 2024-25

Outputs

747,953 individuals have accessed RIF projects in 2024-25

249,455 were accessing the projects for the first time

1,620,654 contacts were made (count multiple contacts per individual)

Outcomes

213,091 individuals felt less isolated

231,547 individuals were maintaining or improving their emotional health and well-being

175,953 individuals felt they were able to influence decision-making that impacted them

161,797 individuals feel more confident in accessing services following project support

207,931 individuals whose independence has improved or remained the same after the support of a project

181,922 individuals have received support that has prevented their level of needs from escalating

Source: Audit Wales analysis of information in the Welsh Governments annual report 2024-25

The Welsh Government's RIF Assurance Board provides good scrutiny, including challenge from outside the RIF team

71 In 2019, our ICF report found that the Welsh Government needed to strengthen central oversight of the fund. It also described the impact of limited Welsh Government staff capacity to support regular and timely oversight. **Exhibit 15** shows that the Welsh Government has fully implemented our recommendation to strengthen its project board arrangements.

Exhibit 15: the Welsh Government's implementation of recommendation 3 from our 2019 report

Recommendation 3

We recommended that the Welsh Government further strengthen its governance arrangements for the fund by reviewing the membership of its project board to include representation from outside of the departments directly involved in the fund to provide some independent challenge (**complete**).

Source: Audit Wales

72 The Welsh Government has addressed our recommendation by incorporating independent challenge into its RIF Assurance Board. The Board has broad membership including Welsh Government officials representing health, social care, and housing, and from the Bevan Commission.

73 The Board's terms of reference are clear, and the RIF team effectively supports Board oversight with clear and regular information on relevant areas. The Board also holds helpful 'deep dive' sessions focused on specific topics supported by relevant information from the RIF team. For instance, in February 2025 it held a deep dive on progress towards developing the Integrated Community Care System.

74 We identified some minor areas for improvement in the information that the RIF team shares for Board oversight. The team provides verbal summaries of financial and impact reports but could provide more clarity in its finance reports on spending variance against year-end forecasts. It could also analyse the information submitted by RPBs in their quarterly finance returns to understand overall progress in 'mainstreaming' RIF funded projects.

75 There was a gap of 10 months in the frequency of Board meetings due to staff vacancies. Meetings resumed in August 2024 when the new Head of RIF started work. We saw good scrutiny of performance and financial information from Board members outside the RIF team. We also saw examples of the Board acting as a forum for officials to share information and ideas across different parts of the Welsh Government.

76 In June 2025, the Welsh Government set up internal audit arrangements to provide assurance to the RIF Board Chair and Director General of Health and Social Services on the effectiveness of processes to oversee the RIF. The Welsh Government's internal audit team share quarterly observations to the Welsh Government's Health, Social Care and Early Years Group Audit and Risk Committee, and more formally, in an annual report.[10]

77 The Welsh Government's Housing with Care Fund Board oversees delivery of its Housing with Care programme. The Board is supposed to meet quarterly but at the time of our review, had not met for a year due to staff vacancies. During this time, the Housing with Care Fund panel continued to meet to approve funding applications but did not provide overall programme oversight. The programme lead also met regularly with the Deputy Director of Homes and Places to manage the gap in oversight. The Board resumed meetings from October 2025.

There are still weaknesses in health board and local authority oversight of RPB activity and use of the RIF, and the Welsh Government's understanding of that oversight

The status of RPBs

78 Our 2019 ICF report found that there was little scrutiny of RPB activity by health boards and local authorities. There was also a general lack of awareness across these organisations about how the fund was being used. We recommended that the Welsh Government works with NHS bodies and local authorities to ensure that appropriate scrutiny arrangements are in place for decisions made by the RPBs on behalf of those bodies. **Exhibit 16** shows that the Welsh Government has not gone far enough to implement our recommendation to improve RPB governance arrangements.

10 From July 2025 onwards, the Committee became the Health, Social Care and Early Years Assurance Board.

Exhibit 16: the Welsh Government's implementation of recommendation 4 from our 2019 report

Recommendation 4

We recommended that the Welsh Government works with NHS bodies and local authorities to ensure that appropriate scrutiny arrangements are in place for decisions made by the RPBs on behalf of those bodies (**partly complete**).

Source: Audit Wales

79 Health boards and local authorities established RPBs in response to the Partnership Arrangements (Wales) Regulations 2015.[11] RPBs are statutory governance bodies which limits their functions. In particular, they cannot employ staff or hold budgets.[12] They can only make recommendations but not decisions. Those decisions rest with the statutory partners and must be taken through each body's lawful decision-making procedures. Representatives of those partners sitting on RPBs may only take decisions within any delegated authority, and otherwise must seek Cabinet or Board approval.

80 In 2021, the Welsh Government consulted on its proposals to improve social care arrangements and strengthen partnership working in a White Paper on Rebalancing Care and Support. The paper set out its proposal to establish RPBs as legal entities. However, the Welsh Government chose not to change RPBs in this way in response to feedback from statutory partners including, local authorities, health boards and from RPB members. The Welsh Government revised its part 9 statutory guidance to clarify RPB membership and scrutiny arrangements (see **paragraph 83**).

11 Part 9 of the Social Services and Well-being (Wales) Act 2014 allowed Welsh Ministers to make regulations about partnership arrangements between health boards and local authorities.

12 RPB staff are employed by either health boards or local authorities depending on regional arrangements. RPBs can use the £750,000 annual RIF allocation for staff costs although some of those costs are met by partnership bodies.

Partner scrutiny

81 All funding allocated to RPBs is provided by Welsh Government funding streams. Health boards hold those funds on behalf of the RPBs.

82 The limitation of RPB functions (see **paragraph 79**) means it is essential that health boards and local authorities have robust oversight and governance arrangements. They must provide adequate scrutiny of RPB activity and the funds health boards hold on behalf of RPBs to ensure services and resources are used effectively and efficiently.

83 The Welsh Government's part 9 statutory guidance sets out its expectations that partnership bodies should be satisfied that RPBs have effective oversight and governance arrangements.[13] In addition, its RIF guidance requires RPBs to 'put in place a memorandum of understanding that sets out the agreed governance, accountability and decision-making processes including appropriate arrangements to enable scrutiny of investment decisions by relevant sovereign bodies'. However, the Welsh Government has not checked whether RPBs have complied with its requirement.

84 All RPBs have some form of terms of reference setting out their purpose and responsibilities. However, only four of the seven RPBs had a memorandum of understanding. None of the documents were clear enough about how health boards and local authorities will scrutinise RPB activity, including which information they will receive and which forum it will go to.

85 Despite these apparent gaps, RPB members responding to our survey were generally confident that their organisation has appropriate scrutiny arrangements in place to oversee RPB decisions on their behalf. The majority (41 respondents) also agreed or strongly agreed that their organisation has the right information to understand the impact of RIF funded projects.

86 We used our focus groups with RPB members to understand those positive responses in the light of the governance weaknesses we had identified. On closer examination, many members were unclear about health board and local authority arrangements to scrutinise RPB activity. Some were able to cite individual examples of RPB documents being scrutinised at council or health boards meetings. However, none of the RPB members we spoke to were clear about which information goes to those bodies and which forums it goes to.

13 Under part 9 of the Social Services and Well-being (Wales) Act 2014, health boards and local authorities must have regard to the Welsh Government's part 9 statutory guidance. The Welsh Government published an updated version of the guidance in April 2025.

87 Some RPB members told us that there is considerable variation in scrutiny arrangements at local authorities in their region. They said the variation makes it even harder to understand the regularity and focus of scrutiny at those organisations.

88 Some RPB members we spoke to raised broader questions about RPB governance arrangements. They recognised that RPB members had responded to the Welsh Government's 2021 consultation to say they did not want to become legal entities. However, we heard examples where RPB chairs were uncomfortable making decisions on behalf of partnership bodies.

Welsh Government oversight of partnership scrutiny

89 Partner bodies are responsible for providing effective oversight and governance arrangements (see **paragraph 83**). The Welsh Government requires RPBs to set out those arrangements in their annual reports. Officials also discuss compliance with the part 9 requirements with RPBs in quarterly meetings. The Welsh Government also requires RPBs to complete self-assessments of their performance every two years from 1 April 2025.[14] RPBs must also consider the effectiveness of their governance arrangements.

90 The Welsh Government ran a series of pilots with RPBs, Care Inspectorate Wales (CIW) and Healthcare Inspectorate Wales (HIW) from 2021 to 2024 to develop the self-assessment approach. For the pilot, all RPB members were invited to complete a self-assessment survey designed by the Welsh Government. The survey includes a specific question on whether RPB partner organisations have arrangements in place for organisations to be held to account for delivery of the RPB priorities. RPBs then took part in workshops to discuss the findings and develop improvement actions.

91 The Welsh Government asked RPBs to set out their actions to address issues from the pilot self-assessments in their 2024-25 annual reports. But it has not used the self-assessment results from the pilot or the improvement actions identified to understand the strengths and weaknesses of RPB arrangements. The Welsh Government recognises it could do more to oversee the effectiveness of RPB partner scrutiny including checking that memoranda of understanding are in place.

14 A requirement of the Welsh Government's amended Partnership Arrangements (Wales) Regulations in 2024.

4 Recommendations

92 We are re-issuing two of our previous recommendations, updated to reflect the current delivery context. We are also making three new recommendations.

Updated recommendations from our 2019 ICF review

R1 The Welsh Government should make further changes to simplify RPB funding arrangements and ensure they are aligned to local population needs. It should:

1.1 Work with RPBs to make sure they understand the flexibility of the RIF and their ability to transfer non-ring-fenced funds between projects where they clearly align to local need (**paragraphs 27 to 32**);

1.2 Work with RPBs to combine monitoring and reporting arrangements for different funds where possible (**paragraphs 33 to 41**); and

1.3 Build arrangements into its Integrated Community Care System to incorporate new funding streams that may emerge after it is established (**paragraphs 33 to 41**).

R2 The Welsh Government should work with health boards and local authorities to ensure they have appropriate scrutiny arrangements in place for delegated decisions made by the RPBs on behalf of those bodies. This should include ensuring RPBs have a memorandum of understanding in place **(paragraphs 81 to 91**).

New recommendations

R3 The Welsh Government should improve the finance reports it provides to the RIF Assurance Board to include information on:

- RPB spending variance against year-end forecasts; and
- RPB progress towards mainstreaming successful projects (**paragraph 74**).

R4 The Welsh Government should introduce spot–checks on RPB spending to ensure that RIF funding is spent appropriately (**paragraph 61**).

Appendices

1 About our work

2 Financial information

3 Key terms in this report

1 About our work

Scope of the audit

We have looked at how well the Welsh Government has addressed the recommendations in our 2019 review through the rollout of its RIF, and to a lesser extent the Housing with Care Fund. We have not reviewed the Welsh Government's management of the Integration and Rebalancing Care Fund.[15] We did not set out to evaluate the impact of the RIF or consider wider points beyond our 2019 recommendations.

Audit questions and criteria

Questions

Our audit focused on four specific questions:

- Does the Welsh Government have a coherent strategic approach to providing integrated health, social care, and housing funding via the Regional Integration Fund?
- Does the Welsh Government have appropriate arrangements to oversee delivery of its Regional Integration Fund?
- Has the Welsh Government worked with NHS bodies and local authorities to ensure that there are appropriate scrutiny arrangements of decisions made by RPBs?
- Does the Welsh Government ensure the sharing of good practice across regions?

15 We reviewed aspects of the Fund as one of our five case studies to inform our May 2025 report on the Wales Infrastructure Investment Strategy.

Criteria

In gathering evidence against the above questions, we were looking for the Welsh Government to demonstrate that it had made the expected progress in implementing our 2019 audit recommendations to address the issues and concerns identified in the original audit.

Methods

We undertook our field work during April and July 2025.

We used the following methods:

- Review of Welsh Government documents which shows the timeliness of decision making; guidance for the RIF and related funding streams; monitoring information on delivery of the RIF including progress reports on delivery outputs and outcomes; RIF project board papers; and information demonstrating how good practice is identified and shared.
- Review of some RPB documents including the terms of reference, memorandum of understanding and their scrutiny arrangements.
- High-level financial analysis of Welsh Government spending to date through the ICF, Transformation Fund and RIF.
- Interviews with Welsh Government officials responsible for managing and overseeing the RIF and similar funds associated with Welsh Government's national programmes on Planned Care, Urgent and Emergency Care and Primary Care.
- Focus groups involving all RPB leads and chairs in Wales.
- An online survey of all 196 RPB members which received a total of 63 responses. The survey was open for responses between the 2 May 2025 and 14 July 2025.
- An observation of a meeting of the Welsh Government's RIF Assurance Board which includes Welsh Government officials from various backgrounds to provide oversight of the RIF.

2 Financial information

Exhibit 17 shows all RPB funding streams available from 2021-22 to 2026-27. **Exhibits 18** to **20** set out RIF spending by type and from 2022-23 to 2024-25 by RPB. The Welsh Government publishes detailed analysis of RPB spending across population groups in its annual reports. **Exhibits 21** and **22** show Housing with Care Fund spending from 2022-23 to 2024-25 and by RPB.

Exhibit 17: RPB funding streams available during the period 2021-22 to 2026-27

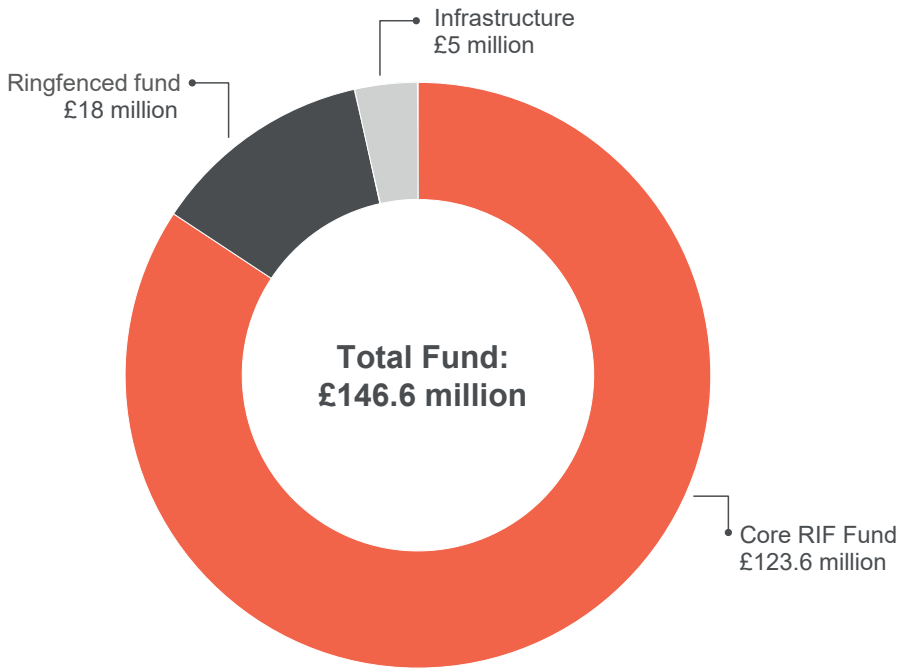
Funding programme	Value	Duration	Focus
Integration and Rebalancing Capital Fund	£320 million	2022-23 to 2026-27	Develop local community care hubs to co-locate frontline health and social care services
Integration and Rebalancing Capital Fund – revenue budget	£20 million	2022-23 to 2026-27	To resource RPBs for the strategic planning and coordination of the Integration and Rebalancing Capital Fund
Housing with Care Fund	£242 million	2022-23 to 2026-27	Provide supported housing and accommodation for vulnerable people with care and support needs
Regional Integration Fund (RIF)	£731 million	2022-23 to 2026-27	Create sustainable system change by developing six integrated models of care
Six Goals for Urgent and Emergency Care Programme	£100 million	2021-22 to 2025-26	Provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration
Strategic Programme for Primary Care	£7.6 million	2022-23 to 2023-24	Deliver national primary care priorities

Funding programme	Value	Duration	Focus
Allied Health Professionals Funding	£5 million	2023-24	Increase access to community-based care by increasing the number of NHS Allied Health Professionals and support workers
Further Faster Funding	£12 million	2023-24	Go ‘further, faster’ to strengthen community care capacity by developing an integrated community care system for Wales
50-day Challenge Funding	£19 million	2024-25	Help more people safely return from hospital and ease winter pressures on the health and social care system

Source: Audit Wales analysis of Welsh Government information

Note: The Six Goals Urgent and Emergency Care Programme is administered by NHS Wales Performance and Improvement. All other funds in the table are administered by the Welsh Government.

Exhibit 18: RIF spending by type, 2024-25



Source: Audit Wales analysis of Welsh Government information

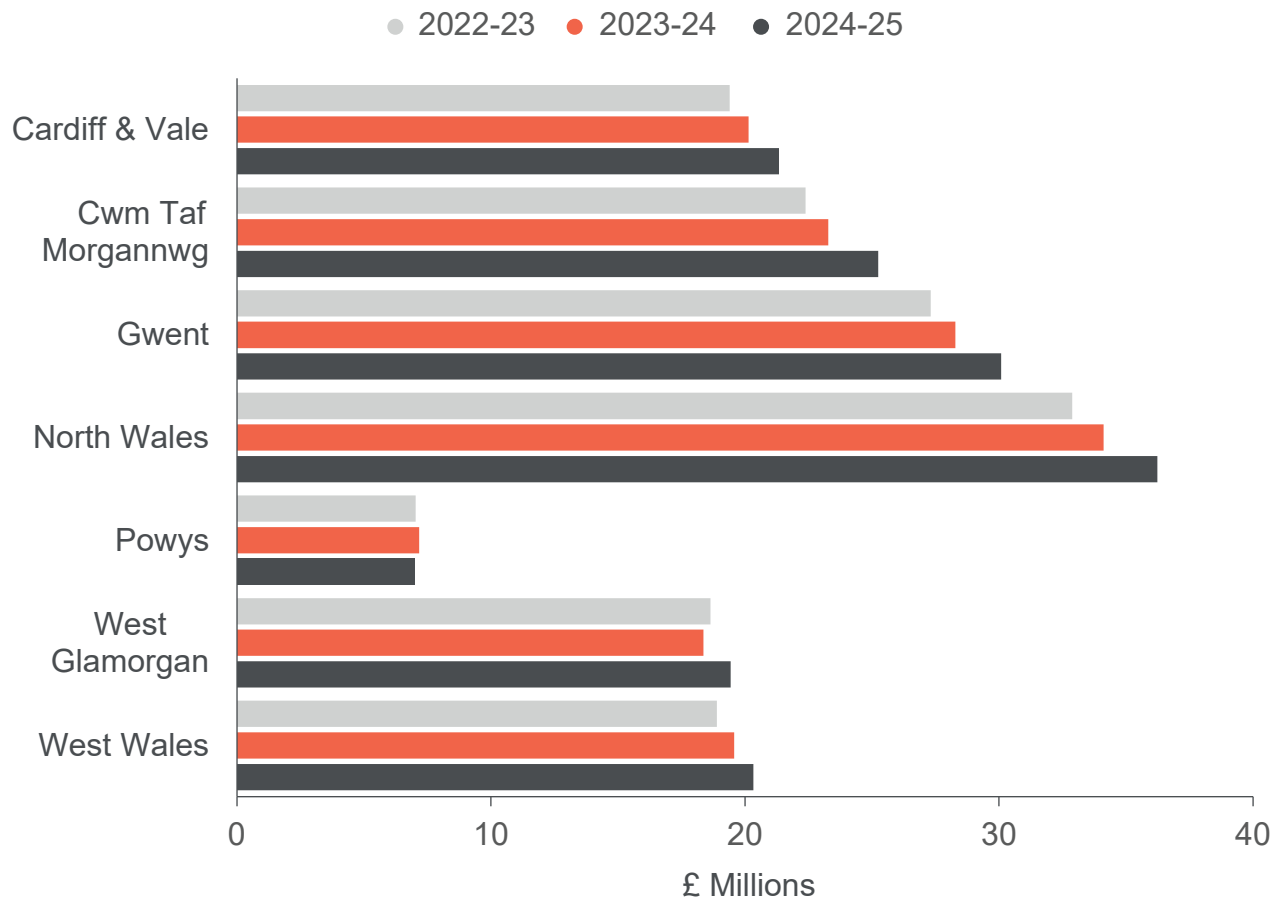
Note: Cwm Taf Morgannwg and Gwent RPBs did not spend their full allocation of £750,000 infrastructure funding in 2024-25.

Exhibit 19: core RIF spending by model of care, 2024-25

Model of care	£ millions
Home from hospital	35.6
Prevention and community coordination	30.8
Supporting families	22.7
Complex care closer to home	20.6
Promoting good health and emotional well-being	8.4
Accommodation based solutions	2.1
Project management costs	3.4

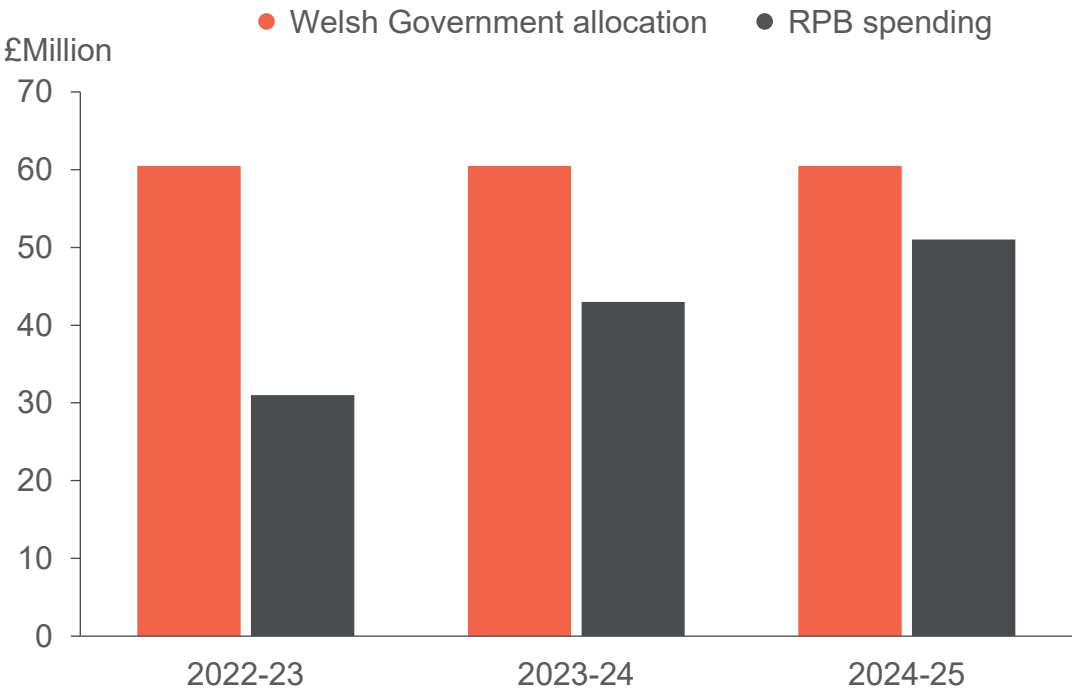
Source: Audit Wales analysis of Welsh Government information

Exhibit 20: total (core and non-core) RIF spending by RPB, 2022-23 to 2024-25



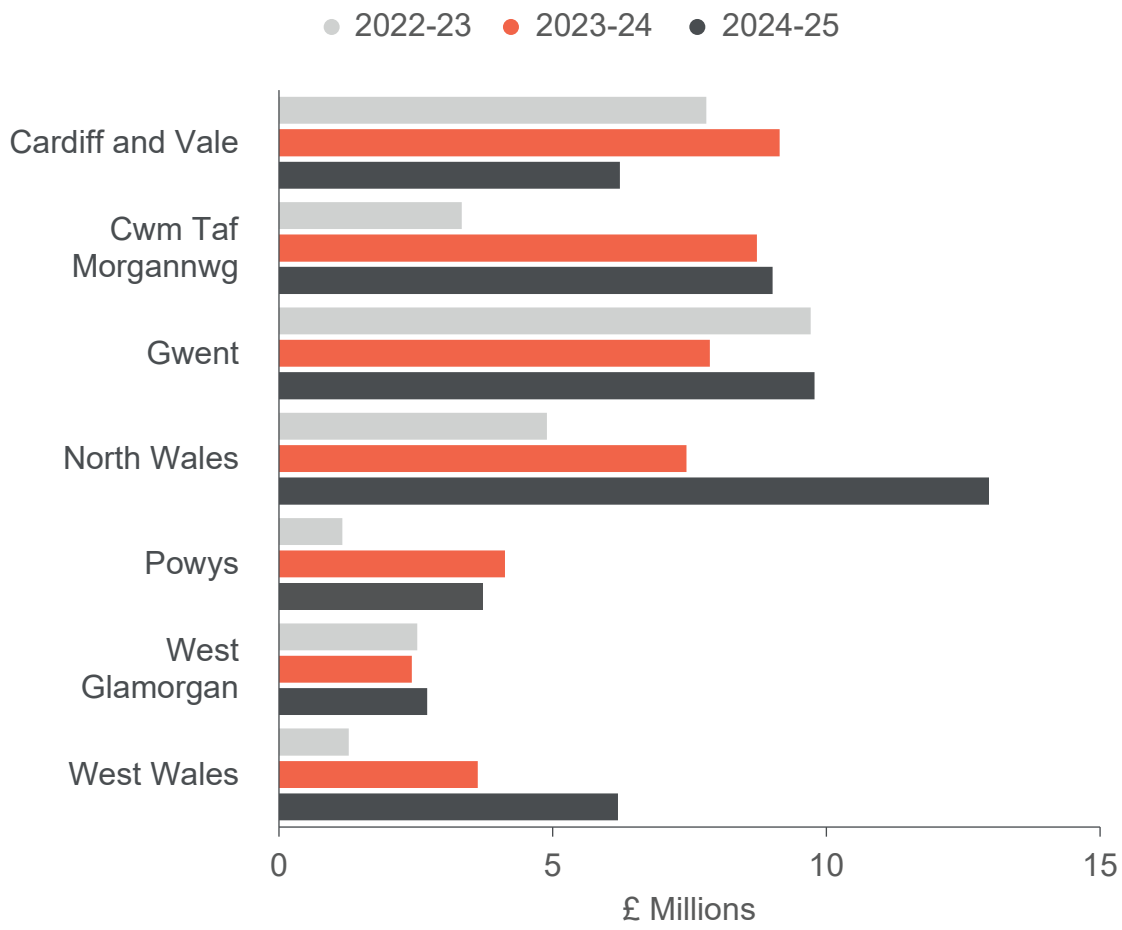
Source: Audit Wales analysis of Welsh Government information

Exhibit 21: Housing with Care Fund Welsh Government allocations and RPB spending, 2022-23 to 2024-25



Source: Audit Wales analysis of Welsh Government information

Exhibit 22: Housing with Care Fund spending by RPB, 2022-23 to 2024-25



Source: Audit Wales analysis of Welsh Government information

3 Key terms in this report

Term	Description
Allied Health Professionals funding	A Welsh Government fund for RPBs in 2023-24. The fund was aimed at increasing the number of community-based healthcare professionals and support workers.
Further Faster funding	A Welsh Government fund for RPBs in 2023-24. The fund was aimed at bringing together existing health and social care initiatives to start developing an integrated community care system.
Housing with Care Fund	A Welsh Government fund for RPBs from 2022-23 to 2026-27. The fund is aimed at providing supported housing accommodation for vulnerable people with care and support needs.
Integrated Community Care System	The Welsh Government's vision for providing seamless health and social care at or as close to home as possible through six models of care.
Integrated Care Fund (ICF)	A Welsh Government fund for RPBs from 2014-15 to 2021-22. The fund was aimed at encouraging collaboration between social services, health, housing, and the third and independent sector to improve the lives of the most vulnerable people in Wales. The Welsh Government introduced the fund in 2014 as the Intermediate Care Fund and renamed it the Integrated Care Fund in 2017.
Integration and Rebalancing Capital Fund	A Welsh Government fund for RPBs from 2022-23 to 2026-27. The fund is aimed at developing local community hubs to co-locate frontline health and social care and other services.

Term	Description
Mainstreaming	Mainstreaming refers to the process of embedding successful, innovative, or pilot initiatives into standard practice across health and social care systems.
NHS Wales Performance and Improvement	The Welsh Government set up the NHS Wales Executive in April 2023. The Executive changed its name in 2025 to NHS Wales Performance and Improvement. It aims to drive improvements in the quality and safety of care.
Regional Integration Fund (RIF)	A Welsh Government fund for RPBs from 2022-23 to 2026-27. The fund is aimed at supporting integrated health and social care initiatives at a regional level.
Tapering	A method used in social care funding where financial support gradually reduces over time. It allows projects to support themselves financially gradually, avoiding sudden loss of support and encouraging financial independence.
Transformation Fund	A Welsh Government fund for RPBs from 2019-20 to 2021-22. The fund was aimed at improving health and social care services by scaling up models that are successful and replacing less successful or outdated ones.
Six Goals for Urgent and Emergency Care Programme	An NHS Wales Performance and Improvement fund from 2021-22 to 2025-26. The fund is aimed at providing healthcare as close to home as possible and to improve service access and integration.
Social Services and Well-being (Wales) Act 2014	The Act came into force in 2016 in Wales. It promotes voice, control, prevention, co-production, and collaboration, giving individuals and carers more say in the support they receive.
50-day Challenge funding	A non-recurrent Welsh Government fund for RPBs in winter 2024-25. The fund was aimed at helping people safely return from hospital to ease winter pressures on hospitals.
Strategic Programme for Primary Care	The Welsh Government set up the Strategic Primary Care Programme in 2018 to implement its vision for primary care. The programme is now led by NHS Wales Performance and Improvement and no longer has a dedicated funding stream.

About us

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

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

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 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 January 2026, 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, and therefore 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.

It is important to note that **SRR 002A** and **002B** will require significant investment to achieve a material reduction in risk and are therefore likely to remain above the Board's risk appetite for some time. The Committee on behalf of the Board is asked to acknowledge and accept this position.

While the risks remain high/extreme due to the potential impact should they materialise, key controls are in place to maintain safety and mitigate the likelihood of occurrence.

Priority focus is being given to those areas of highest risk, with preventative controls established and actively managed. These arrangements provide a level of assurance that, notwithstanding the current risk ratings, the risk to safety in the most critical areas is being reduced as far as reasonably practicable.

Preventative controls are established and actively managed across all areas to mitigate risk and maintain safety. Whilst this is the case, priority focus is given to those areas with the highest safety risks. These arrangements provide a level of assurance that, notwithstanding the current risk ratings, risks to safety are being reduced as far as reasonably practicable.

SRR 004B – The current risk score acknowledges that Business Continuity plans are not yet consistently in place across all areas of the Health Board, and that not all areas have fully tested their business continuity and critical incident plans. However, it is recognised that key frontline services, including the Emergency Department and other critical clinical areas, do have established arrangements in place.

There is a continued and targeted focus on strengthening arrangements across all service areas, with particular emphasis on the development and testing of plans. This is being actively supported by the Emergency Planning Team, who are driving an increased programme of testing and assurance to improve overall preparedness and resilience.

Priorities for 2026/27

The focus for 2026/7 will be on strengthening overall risk maturity across the Health Board through:

1. **Refinement of Strategic Risks**
   Ensuring the Strategic Risk Register (SRR) is dynamic and responsive, reflecting current and emerging strategic challenges through horizon scanning, alignment with national and regional priorities, and ongoing review of organisational objectives to support delivery of the IMTP.

2. **Established Corporate Risk Register**
   Maintaining a robust Corporate Risk Register (CRR) that captures the key operational risks impacting the delivery of strategic priorities, ensuring clear alignment and traceability between operational pressures and strategic objectives within the IMTP.

3. **Strengthening Risk Management Across the Health Board**
   Developing a mature and consistent risk management framework across the

Health Board, with a focus on strengthening capability through targeted training, improving the quality and consistency of risk information, and ensuring clear connectivity between local, corporate and strategic risks to support informed decision-making.

4. **Increasing Visibility and Assurance**
   Enhancing governance, oversight and assurance arrangements to support delivery of the IMTP, including strengthened escalation processes, structured review cycles and comprehensive assurance mapping, enabling the Board and its Committees to have clear visibility of key risks, mitigating actions and the effectiveness of controls**.**

To support this, a comprehensive review of all strategic risk assessments is underway to ensure they accurately reflect the current operating environment. This includes evaluating existing controls to determine whether they are effectively reducing risks to within the organisation's risk appetite or preventing risks from materialising. In addition, consideration is being given to the assurances in place to evidence that these controls are operating effectively. Amendments to the risk assessment template will further strengthen and demonstrate a more robust and consistent approach to assurance.

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.

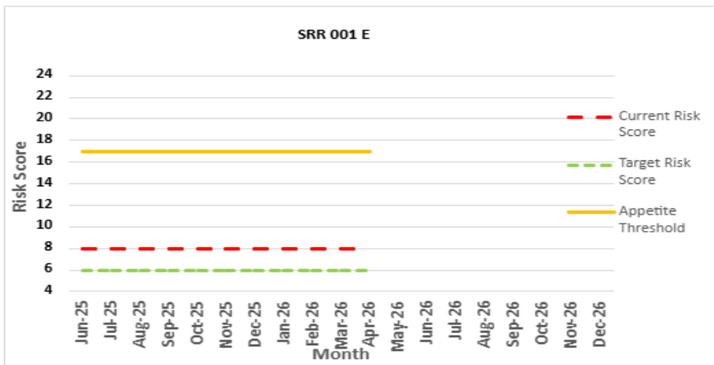
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee 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 ID and Description				IMTP Link	Risk Score												
					2	3	4	5	6	8	9	10	12	15	16	20	25
SRR 001	Director of Strategy, Planning and Partnerships.	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	e) Due to inadequate strategic plans which respond to population health and socio-economic needs	System Change					X	●					◊		
			f) Due to unsustainable service models						X				●		◊		
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 *(As a result of)*	**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 *(Consequences of the threat)*	**Patient** • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes	**Staff**	**Organisation** • 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** *(Unlikely)* x	**2** *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*	
Last Reviewed	May 2026	**Risk rating**	**= 8 *(Moderate)***	***= 6 (Moderate)***	
Next Review (Six monthly based on risk score)	November 2026				

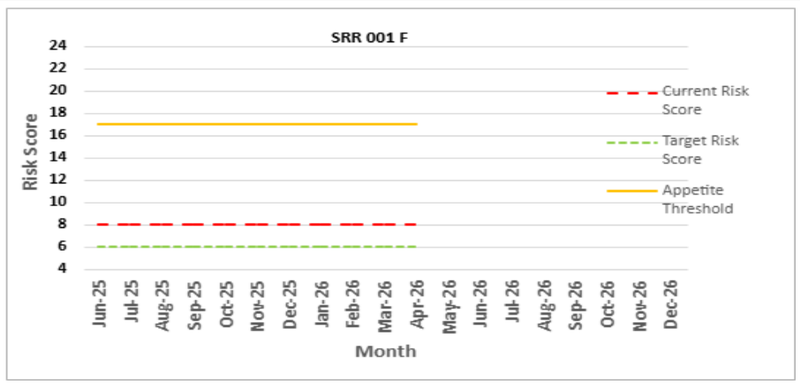


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short,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

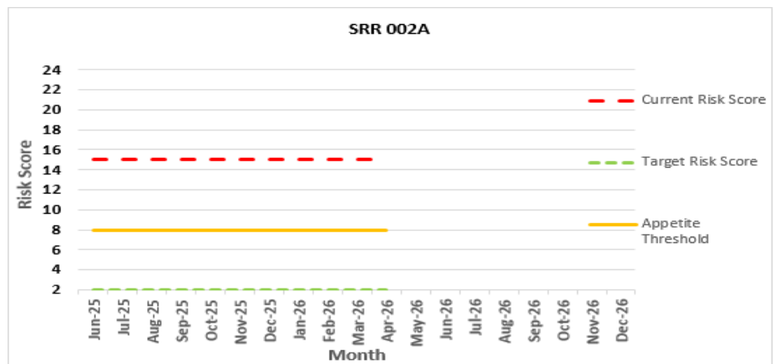
RISK THEME	**SERVICE DELIVERY**				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic Risk SRR 001 F	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**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 *(Consequences of the threat)*	**Patient** • Increased demand • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes	**Staff** N/A	**Organisation** • 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.	**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	May 2026	**Risk rating**	**= 8 (Moderate)**	***= 6 (Moderate)***	
Next Review (Six monthly based on risk score)	November 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 *(Executed by risk management and compliance functions)*		
• 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 *(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** • 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 (*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	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 *(As a result of)*	**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 *(Consequences of the threat)*	**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**		
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	June 2026	**Risk rating**	**= 15 (Extreme)**	**= 2 *(Low)***		
Next Review (Monthly based on risk score)	July 2026					

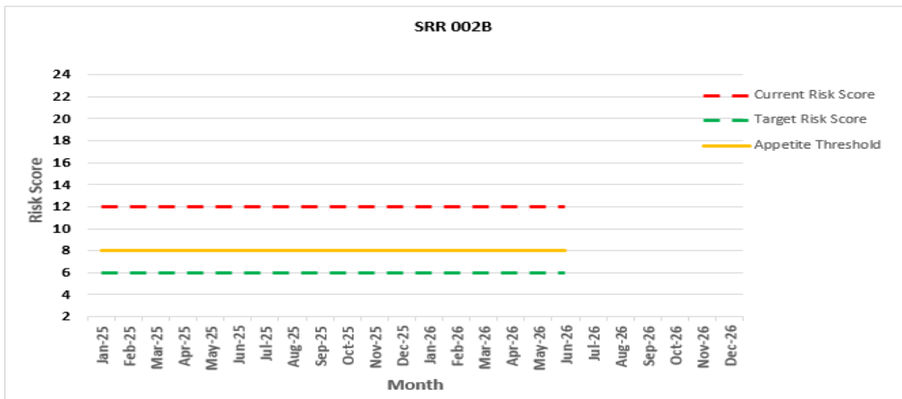
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, 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 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 2025

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)*		
• 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. • Latest report (received March 2026 has recommended additional works as well as a need to take more substantive actions proactively due to the duration of the presence of temporary steps previously taken •	Recommendations from latest report to be developed into proposals for action Recommendation is to now form the works as a capital scheme as opposed to a series of reactive works and this will be scoped for formal consideration through capital processes onto Executive Committee
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• 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 reissued 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, autumn 2025	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• 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 (*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	**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 *(As a result of)*	**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 *(Consequences of the threat)*	**Patient** • Harm or injury to patients/public • 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**
Monitoring Committee / Group	Partnerships, Health Protection & Planning Committee	**Likelihood**	**3** (Possible) x	**3** (Possible) x
Initial Date of Assessment	June 2023	**Impact**	***4** (Major)*	**2** (Minor)
Last Reviewed	April 2026	**Risk rating**	**= 12 (High)**	**= 6 (Moderate)**
Next Review (Quarterly based on risk score)	July 2026			



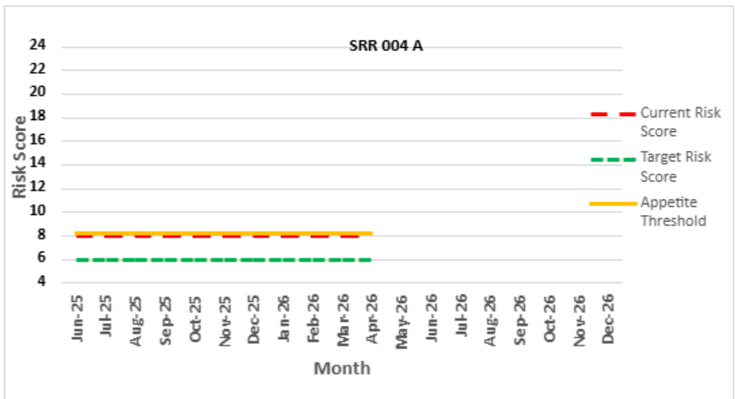
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• 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 2026/27 • 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). Discussions commencing with WG relating to any TEF monies for 27/28 and additional bids being submitted for additional monies for Mental Health in 2026/27 • Elements of St Woolos Hospital estate beien closed as part of the Board agreement to rationalise the site and remove use of old and poor estate. Business case for WG investment being developed to further rationalise the 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 *(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)*		
• 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 *(Executed by risk management and compliance functions)*		
• 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 February 2026 • Divisional Director Estates and Facilities presented to Committee on St Woolos Hospital project in October 2025.	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
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 • Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. • Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level	• 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 (*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	**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 *(As a result of)*	**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 *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings • Harm or injury to patients	**Staff** • Inability to respond to a major incident to meet needs of those affected • Harm or injury to staff	**Organisation** • 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**	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	June 2023	**Impact**	*4 (Major)*	3 (Moderate)
Last Reviewed	May 2026	**Risk rating**	**= 8 (Moderate)**	**= 6 *(Moderate)***
Next Review (Six-monthly based on risk score)	November 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 *(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)*		
• 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 *(Executed by risk management and compliance functions)*		
• 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 *(Implemented by both auditors internal and external independent bodies)*		
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.

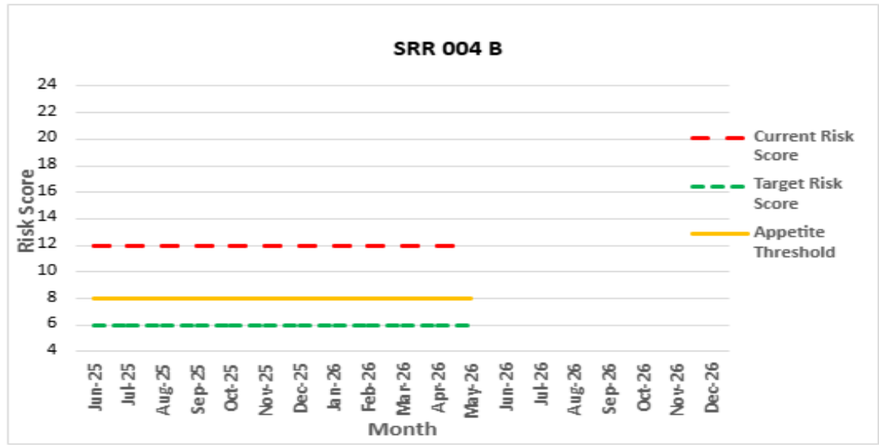
Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.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

RISK THEME	**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 (BC) incidents.**		**Publication Status**	**Public**
Threat *(As a result of)*	• **Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity (BC) or Critical Incident**			
Impact *(Consequences of the threat)*	**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	
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	March 2026	**Risk rating**	**= 12 (High)**	**= 6 (Moderate)**
Next Review (Quarterly based on risk score)	June 2026			

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.

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 and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



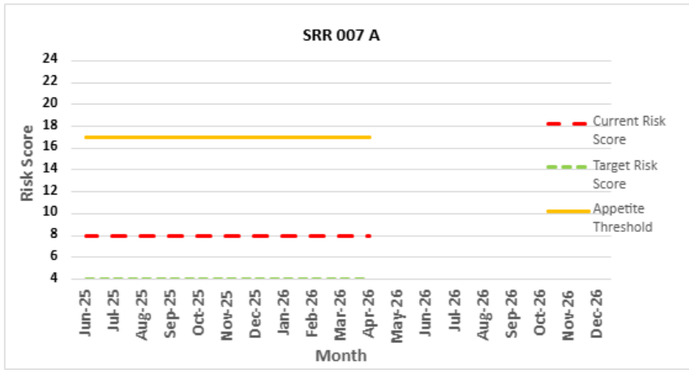
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Business Continuity Policy • Business Continuity Response Guidance • Business Continuity Template & guidance (reviewed and updated April 2025) • Divisional, Directorate & Service Business Continuity Plans across a number of key operational areas • Business Continuity Exercises • Business Continuity debrief learning. • Health Board and Local Resilience Forum (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. • Health Board 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	• Ongoing support to develop business continuity plans – BC templates & guidance has been reviewed to make them more user friendly and easier to access via the HB's sharepoint. • 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. The Health Board are part of the LRF group to develop a multiagency response plan for the critical themes – loss of power and loss of water supply – this will feed into the Health Boards estates planning. • 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.

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). • 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, Exercise Pegasus	• Services are being audited against the organisational BC dashboard – level of plans in place and the test/exercise of those plans. • We have delivered 2 BC exercises (loss of IT applications/networks) for service senior managers – further exercises are planned for 26/27 • Services will be required to have tested & exercised at least 2 key theme plans and the alert, coordinate & escalate procedures in 2026. • Creation of any BC lessons learned repository for services to populate and learn from. • Training Operational Management teams to enable them to respond to and coordinate BC incidents that are impacting patient flow/care. (This has commenced) • Work with the wider planning team to influence them to consider BC requirements when developing new processes, initiatives or the introduction of new technology.

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)*		
• 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 *(Executed by risk management and compliance functions)*		
• Report to the EPRR Group from debrief of incidents Reports to the PPHP Committee on Emergency Planning Preparedness (most recent Jan 2026)	• EPRR Thematic Risk Register	• Develop an EPRR Risk Register
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Review(s) Business Continuity Planning 2025-26 outcome report published – **Reasonable Assurance** • Outcome and feedback from national exercise	• Identification of recommendations to ensure the Health Board is prepared and has the capabilities to respond effectively.	• Implementation of the recommendations and subsequent management responses.

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	**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 *(As a result of)*	**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 *(Consequences of the threat)*	**Patient** • Unmet patient need resulting in harm	**Staff** N/A	**Organisation** • 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.
Lead Director	Director of Strategy, Planning, and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	**4** (Major)	**2** (Minor)
Last Reviewed	May 2026	**Risk rating**	**= 8 (Moderate)**	***= 4 (Moderate)***
Next Review (Six Months based on risk score)	November 2026			



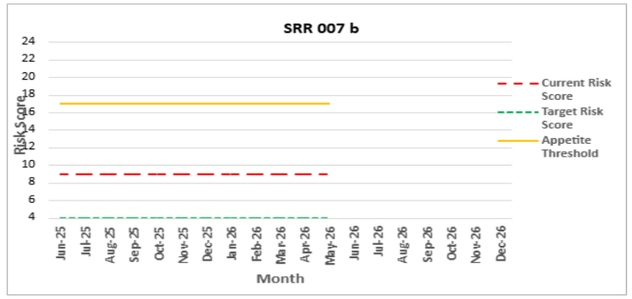
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
The Health Board 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 *(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)*		
• 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 *(Executed by risk management and compliance functions)*		
• Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board.	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
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 (*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	**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 regional health and care services for the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**The impact of service fragility across the regional footprint and health board systems which work autonomously of regional working**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • 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 • Variable partner alignment	**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	June 2026	**Risk rating**	**= 9 (High)**	***= 4 (Low)***	
Next Review (Quarterly based on risk score)	September 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)*
A robust South-east Wales regional planning infrastructure has been established with clear governance mechanisms including an agreed Terms of Reference in place. The Regional Joint Committee is attended by Health Board Chairs and Chief Executives on a bi-monthly basis. The Executive Management Group reports to the Regional Joint Committee and requires at least one Chief Executive and one Executive representative from each organisation to be present for quoracy. The Executive Management Group and the and Regional Development Group which provides the first line of assurance on progress of programmes , bring 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. • Whilst Cwm Taf Morgannwg UHB is the lead accountable organisation for the development of Llantrisant Health Park (LHP), it is a key regional infrastructure development and is therefore included in the Regional Joint Committee Governance model. The majority of service planning for the services that will operate from LHP will take place within the appropriate regional programme. • 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 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.	Following the first Regional Joint Committee, the following three Task & Finish groups were established to develop proposals to address cross cutting risks related to regional working: • Regional Contracting and Commissioning: developing a proposed framework for the region • Digital: Establish shared patient treatment lists with a minimum viable product being proof of concept for cataracts and lower limb arthroplasty • Digital: Ability for clinical teams to see patient records across health board boundaries Following support from ABUHB of the Regional Diagnostic and Treatment Centre Outline Business Case at Llantrisant Health Park (LHP) in November 2025, there is a requirement to regionally develop a full business case. This will include a clear outline strategy, comprehensive demand & capacity modelling for the proposed diagnostic services including an Endoscopy Academy, future development opportunities and programme governance arrangements. Given the challenges in delivering Cellular Pathology services, a Strategic outline case will be developed regionally to be taken through the regional governance structure and then onto Welsh Government. More widely, a consistent framework is to be developed and used across the region for assessing fragility of acute services. This will enable a common approach to scoring against a defined set of criteria which will lead to identifying service areas where regionalisation may provide a solution.

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)*		
• Service Divisions reporting to the Chief Operational Officer • Service attendance at regional operational meetings and workshops	• Alignment and effectiveness of partners to deliver integrated services	
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Executive Oversight of all Regional Developments at the monthly Internal Regional Planning Oversight Group. • 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 *(Implemented by both auditors internal and external independent bodies)*		

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**