# Aneurin Bevan University Health Board Public Board

*Wed 20 May 2026, 09:30 - 13:00*

**Conference Centre, St Cadoc's Hospital**

## Agenda

**09:30 - 09:30**
0 min

## 1. PRELIMINARY MATTERS

PB20260520_Board Consent Agenda.pdf (3 pages)

### 1.1. Welcome and Introductions

*Oral* *Chair*

### 1.2. Apologies for Absence for Noting

*Oral* *Chair*

### 1.3. Declarations of Interest for Noting

*Oral* *Chair*

**09:30 - 09:30**
0 min

## 2. CONSENT AGENDA BUSINESS

### 2.1. The Chair will ask if there are any items from the Consent Agenda (Item 7) that Board Members wish to bring forward to the Main agenda for discussion

*Chair*

**09:30 - 09:30**
0 min

## 3. EXPERIENCE STORY

### 3.1. Staff Story: First Gold Accredited Ward

*Attachment* *Director of Nursing*

**09:30 - 09:30**
0 min

## 4. CHAIR & CEO UPDATES

### 4.1. Update from the Chair

*Oral* *Chair*

### 4.2. Update from the Chief Executive

*Oral* *Chief Executive*

**09:30 - 09:30**
0 min

## 5. PERFORMANCE & DELIVERY

### 5.1. Urgent and Emergency Care Improvement and Stabilisation Plan

*Attachment* *Chief Operating Officer*

PB 20260520 Agenda Item 5.1 Urgent and Emergency Care Improvement and Stabilisation Plan.pdf (6 pages)
PB 20260520 Agenda Item 5.1 Urgent and Emergency Care Improvement and Stabilisation Plan Appendix A.pdf (36 pages)

### 5.2. Delivery Framework for the Annual Plan 2026/27

*Attachment* *Director of Strategy, Planning and Partnerships*

PB 20260520 Agenda Item 5.2 Delivery Framework for the Annual Plan 2026-27.pdf (7 pages)
PB 20260520 Agenda Item 5.2 Delivery Framework for the Annual Plan 2026-27 Appendix 1.pdf (24 pages)
PB 20260520 Agenda Item 5.2 Delivery Framework for the Annual Plan 2026-27 Appendix A.pdf (12 pages)

### 5.3. Board-Level Committee Governance Arrangements during Escalation

*Attachment* *Director of Corporate Governance*

PB 20260520 Agenda Item 5.3 Board-Level Committee Governance Arrangements during Escalation.pdf (5 pages)

### 5.4. 2025/26 Performance Reporting

*Attachment* *Executive Leads*

a. Integrated Performance Report

b. Financial Performance Report, Month 12

PB 20260520 Agenda Item 5.4a Integrated Performance Report.pdf (12 pages)
PB 20260520 Agenda Item 5.4a Integrated Performance Report Appendix A.pdf (79 pages)
PB 20260520 Agenda Item 5.4a Integrated Performance Report Appendix 1.pdf (14 pages)
PB 20260520 Agenda Item 5.4b Financial Performance Report, Month 12.pdf (24 pages)
PB 20260520 Agenda Item 5.4b Financial Performance Report, Month 12 Appendix A.pdf (38 pages)

**09:30 - 09:30**
0 min

## 6. ASSURANCE MATTERS

### 6.1. Key Matters from Committees of the Board

*Attachment* *Committee Chairs*

PB 20260520 Agenda Item 6.1 Key Matters from Committees of the Board.pdf (15 pages)

### 6.2. Executive Committee Chair’s report

*Attachment* *Chief Executive*

PB 20260520 Agenda Item 6.2 Executive Committee Chair’s report.pdf (6 pages)

### 6.3. Strategic Risk Report, May 2026

*Attachment* *Chief Executive*

PB 20260520 Agenda Item 6.3 Strategic Risk Report_May 2026.pdf (6 pages)
PB 20260520 Agenda Item 6.3 Strategic Risk Report Appendix A_Strategic Risk Dashboard & Assessments.pdf (44 pages)
PB 20260520 Agenda Item 6.3 Strategic Risk Report Appendix B_Annual Risk Activity.pdf (1 pages)

### 6.4. Report from Llais, Gwent Region

*Attachment* *Regional Director, Llais*

PB 20260520 Agenda Item 6.4 Report from Llais, Gwent Region.pdf (13 pages)

**09:30 - 09:30**
0 min

## 7. CONSENT AGENDA

### 7.1. FOR APPROVAL

### 7.1.1. Draft Minutes of the Health Board Meeting, held on 25th March 2026

*Attachment* *Chair*

PB 20260520 Agenda Item 7.1.1 Draft Minutes of the Public Board Meeting held on 25th March 2026.pdf (14 pages)

### 7.1.2. Report on Sealed Documents and Chair's Actions

*Attachment* *Chair*

PB 20260520 Agenda Item 7.1.2 Governance Matters.pdf (5 pages)

### 7.1.3. NHS Wales Joint Commissioning Committee Terms of Reference, Standing Orders and Standing Financial Instructions

*Attachment* *Director of Corporate Governance*

PB 20260520 Agenda Item 7.1.3 NHS Wales Joint Commissioning Committee Terms of Reference, Standing Orders and Standing Financial Instructions.pdf (8 pages)
PB 20260520 Agenda Item 7.1.3 NHS Wales Joint Commissioning Committee Terms of Reference, Standing Orders and Standing Financial Instructions Appendix 1.pdf (5 pages)
PB 20260520 Agenda Item 7.1.3 NHS Wales Joint Commissioning Committee Terms of Reference, Standing Orders and Standing Financial Instructions Appendix 2.pdf (44 pages)
PB 20260520 Agenda Item 7.1.3 NHS Wales Joint Commissioning Committee Terms of Reference, Standing Orders and Standing Financial Instructions Appendix 3.pdf (42 pages)
PB 20260520 Agenda Item 7.1.3 NHS Wales Joint Commissioning Committee Terms of Reference, Standing Orders and Standing Financial Instructions Appendix 4.pdf (16 pages)
PB 20260520 Agenda Item 7.1.3 NHS Wales Joint Commissioning Committee Terms of Reference, Standing Orders and Standing Financial Instructions Appendix 5.pdf (14 pages)
PB 20260520 Agenda Item 7.1.3 NHS Wales Joint Commissioning Committee Terms of Reference, Standing Orders and Standing Financial Instructions Appendix 6.pdf (11 pages)

## 7.2. FOR NOTING

### 7.2.1. Board Action Log with Updates

*Attachment* *Chair*

PB 20260520 Agenda Item 7.2.1 Board Action Log.pdf (1 pages)

### 7.2.2. Welsh Government, Accountability Interface Arrangements

*Attachment* *Chief Executive*

PB 20260520 Agenda Item 7.2.2 Welsh Government, Accountability Interface Arrangements.pdf (5 pages)
PB 20260520 Agenda Item 7.2.2 Welsh Government, Accountability Interface Arrangements.docx Appendix A.pdf (8 pages)

### 7.2.3. UK Covid-19 Inquiry, Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom

*Attachment* *Director of Corporate Governance*

PB 20260520 Agenda Item 7.2.3 UK Covid-19 Inquiry, Module 3, The impact of the Covid 19 pandemic on the healthcare systems of the United Kingdom.pdf (7 pages)

### 7.2.4. Strategic Partnership Updates

*Attachment* *Director of Strategy, Planning and Partnerships & Director of Public Health*

a. Regional Partnership Board

b. Public Service Board

PB 20260520 Agenda Item 7.2.4a Regional Partnership Board.pdf (8 pages)
PB 20260520 Agenda Item 7.2.4a Regional Partnership Board Appendix A.pdf (51 pages)
PB 20260520 Agenda Item 7.2.4a Regional Partnership Board Appendix B.pdf (15 pages)
PB 20260520 Agenda Item 7.2.4a Regional Partnership Board Appendix C.pdf (2 pages)

- PB 20260520 Agenda Item 7.2.4a Regional Partnership Board Appendix D.pdf (2 pages)
- PB 20260520 Agenda Item 7.2.4a Regional Partnership Board Appendix E.pdf (2 pages)
- PB 20260520 Agenda Item 7.2.4a Regional Partnership Board Appendix F.pdf (25 pages)
- PB 20260520 Agenda Item 7.2.4b Public Service Board.pdf (6 pages)

### 7.2.5. An overview of Joint and Partnership Committee Activity

*Attachment* *Chief Executive*

a. NHS Wales Joint Commissioning Committee

b. NHS Wales Shared Services Partnership Committee

- PB 20260520 Agenda Item 7.2.5a Joint Commissioning Committee.pdf (4 pages)
- PB 20260520 Agenda Item 7.2.5b NHS Wales Shared Services Partnership Committee.pdf (3 pages)
- PB 20260520 Agenda Item 7.2.5b NHS Wales Shared Services Partnership Committee Appendix A.pdf (5 pages)

### 7.2.6. Committee Annual Reports 2025/26 and Terms of Reference

*Attachment* *Director of Corporate Governance*

- PB 20260520 Agenda Item 7.2.6 Committee Annual Reports and Terms of Reference.pdf (4 pages)

**09:30 - 09:30**
0 min

## 8. OTHER MATTERS

### 8.1. Any Other Business

### 8.2. Date of the Next Meetings

24th June 2026

**09:30 - 09:30**
0 min

## 9. PRIVATE/IN COMMITTEE SESSION

**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*

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

**MEETING OF THE BOARD**

| AGENDA | | | |
|---|---|---|---|
| **Date and Time** | | **Wednesday 20th May 2026 at 9.30 am** | |
| | **Venue** | **Conference Centre, Headquarters, St Cadoc's Hospital** | |
| **Item** | **Title** | **Format** | **Presenter** |
| **1** | **PRELIMINARY MATTERS** | | |
| 1.1 | Welcome and Introductions | Oral | Chair |
| 1.2 | Apologies for Absence for Noting | Oral | Chair |
| 1.3 | Declarations of Interest for Noting | Oral | Chair |
| **2** | **CONSENT AGENDA BUSINESS** | | |
| 2.1 | The Chair will ask if there are any items from the Consent Agenda (Item 7) that Board Members wish to bring forward to the Main agenda for discussion | | Chair |
| **3** | **EXPERIENCE STORY** | | |
| 3.1 | Staff Story: First Gold Accredited Ward | Attachment | Director of Nursing |
| **4** | **CHAIR & CEO UPDATES** | | |
| 4.1 | Update from the Chair | Oral | Chair |
| 4.2 | Update from the Chief Executive | Oral | Chief Executive |
| **5** | **PERFORMANCE & DELIVERY** | | |
| 5.1 | Urgent and Emergency Care Improvement and Stabilisation Plan | Attachment | Chief Operating Officer |
| 5.2 | Delivery Framework for the Annual Plan 2026/27 | Attachment | Director of Strategy, Planning and Partnerships |
| 5.3 | Board-Level Committee Governance Arrangements during Escalation | Attachment | Director of Corporate Governance |
| 5.4 | 2025/26 Performance Reporting:<br>a. Integrated Performance Report<br>b. Financial Performance Report, Month 12 | Attachment | Executive Leads |
| **6** | **ASSURANCE MATTERS** | | |
| 6.1 | Key Matters from Committees of the Board | Attachment | Committee Chairs |

| | | | |
|---|---|---|---|
| 6.2 | Executive Committee Chair's report | Attachment | Chief Executive |
| 6.3 | Strategic Risk Report, May 2026 | Attachment | Chief Executive |
| 6.4 | Report from Llais, Gwent Region | Attachment | Regional Director, Llais |
| | **CONSENT AGENDA** | | |
| 7.1 | **FOR APPROVAL** | | |
| 7.1.1 | Draft Minutes of the Health Board Meeting, held on 25th March 2026 | Attachment | Chair |
| 7.1.2 | Report on Sealed Documents and Chair's Actions | Attachment | Chair |
| 7.1.3 | NHS Wales Joint Commissioning Committee Terms of Reference, Standing Orders and Standing Financial Instructions | Attachment | Director of Corporate Governance |
| **7.2** | **FOR NOTING** | | |
| 7.2.1 | Board Action Log with Updates | Attachment | Chair |
| 7.2.2 | Welsh Government, Accountability Interface Arrangements | Attachment | Chief Executive |
| 7.2.3 | UK Covid-19 Inquiry, Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom | Attachment | Director of Corporate Governance |
| 7.2.4 | Strategic Partnership Updates:<br>a) Regional Partnership Board<br>b) Public Service Board | Attachment | Director of Strategy, Planning and Partnerships & Director of Public Health |
| 7.2.5 | An overview of Joint and Partnership Committee Activity:<br>a. NHS Wales Joint Commissioning Committee<br>b. NHS Wales Shared Services Partnership Committee | Attachment | Chief Executive |
| 7.2.6 | Committee Annual Reports 2025/26 and Terms of Reference | Attachment | Director of Corporate Governance |
| **8** | **OTHER MATTERS** | | |
| 8.1 | Any Other Business | | |
| 8.2 | Date of the Next Meetings:<br>• 24th June 2026 | | |
| **9.** | **PRIVATE/IN COMMITTEE SESSION** | | |
| | **Motion to Exclude Members of the Public and the Press**<br>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."<br>*Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960* |

| | |
|---|---|
| GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board | **CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN**<br>**ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING** |

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Urgent and Emergency Care Improvement and Stabilisation Plan 2026/27 |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Leanne Watkins, Chief Operating Officer |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Matt Temby, Deputy Chief Operating Officer |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Trafodaeth/For Discussion |

| **ADRODDIAD SCAA**<br>**SBAR REPORT** |
|---|
| **Sefyllfa / Situation**<br><br>This paper outlines the background, delivery mechanisms and governance arrangements for the Urgent and Emergency Care Improvement and Stabilisation Plan which is included as Appendix 1.<br><br>The Plan is a response to Aneurin University Health Board's Urgent and Emergency Care challenges, setting out the actions being taking by the Health Board and partners to improve whole system flow, reduce harm and improve patient experience. It sets out the key workstreams for immediate improvement and sustaining this level of improved operational performance to provide system wide resilience. These actions also support meeting the requirements of Welsh Government escalation. |

The Board is asked to take:

**Assurance** from the Plan that it meets the requirements of the Welsh Government's escalation for Urgent and Emergency Care at the Grange University Hospital.

## Cefndir / Background

The challenges facing the Health and Care system are significant including:

- growing demand across urgent and emergency care pathways
- increasing patient acuity and complexity particularly with our frail and older populations
- workforce constraints across acute, community and social care
- ambulance handover delays and ongoing delays in patient flow
- variable performance and patient experience

A number of changes and investments including the development of a Transfer Lounge in the Grange University Hospital to support timely flow of discharges have been made over the last 12-18 months, but it is recognised that further progress is required which this Plan seeks to resolve.

The challenges that the Health Board is facing has resulted in the organisation being put into level 3 Enhanced Monitoring by Welsh Government for performance and outcomes related to Urgent and Emergency Care at the Grange University Hospital. This was escalated in December 2025 to Level 4 Targeted Intervention for performance and outcomes related to Urgent and Emergency Care alongside Level 4 for Finance, Strategy and Planning due to the rapidly deteriorating financial position.

A series of actions that the Health Board needs to take in response to this escalation and enable de-escalation were set out and this Improvement and Stabilisation Plan seeks to deliver against these.

## Asesiad / Assessment

The attached UEC Improvement and Sustainability Plan comprehensively set outs how the Health Board is responding to the challenges being faced within Urgent and Emergency Care within 2026/27 with a dedicated Programme of work in line with exemplar work from the National UEC Programme within NHS Wales Performance and Improvement and GIRFT (Get it Right First Time)

Five Urgent and Emergency Care workstreams are established with clear aims and objectives to support improved performance and delivery of the UEC Enabling actions in Welsh Government's 2025/28 Planning Guidance.

The refreshed UEC Programme consolidates the existing workstreams supporting UEC into a single unified structure with the following five key workstreams:

| Our Next Patient | Integrated Discharge | Older Persons Pathway | Acute Medical Model | Stroke Improvement |
|---|---|---|---|---|

The Plan sets out the purpose of each of the workstreams and outlines the projects under each of the workstreams including demand management and reducing delays in hospital stays under Our Next Patient and Single Point of Access and Falls within the Older Persons Pathway workstream.

The following three delivery phases of the Plan are outlined, with a targeted focus now as part of Stabilisation, on Ambulance Handovers within 45 minutes. Four key areas of work to support this have been established along with monthly improvement trajectories.

| **Phase** | **Timescale** | **Primary focus** |
|---|---|---|
| Stabilisation and H45 focus | 0-90 days | Operational grip and control; stepped improvement in ambulance handovers and flow |
| Recovery | 3-6 months | Delivery of operational projects to make performance improvement more reliable |
| Sustainability | 6-18 months | Implementation of strategic change and embedding of sustainable delivery arrangements |

The Plan describes the new Governance arrangements in place from May 2026 with a consolidated Urgent and Emergency Care Programme Board that will meet monthly chaired by the Chief Executive. This will report into the Finance and Performance Committee and then to the Board. The Programme Board will consist of a streamlined membership primarily made up on Director level colleagues from within the Health Board and a representative from the Local Authorities, Welsh Ambulance Services Trust and NHS Wales Performance and Improvement. The role of leadership and clinical leaders specifically is explicitly outlined, recognising their importance in leading sustainable change.

Each workstream sets out in the Plan the key projects that it seeks to deliver on, along with the Project Lead and how they are aligned to national metrics. Highlight reports from the five workstreams will be received by the UEC Programme Board along with performance against the agreed trajectories for the UEC measures agreed in the Annual Plan 2026/27 with agreed actions when/if performance falls below these.

Performance related to UEC against the six Quality Pillars which are reported to the Patient Quality, Safety and Outcomes Committee and include Patient

Experience and Feedback, Concerns and Complaints and Incidents and Patient Safety will also be presented.

Alignment with other of the Health Board's Priority Programmes: Mental Health and Place Based Care which are key pillars in the UEC Plan are described. Several of the initiatives that these Programmes are progressing such as further development of crisis management in the community and reducing unnecessary conveyances and attendances to the Emergency Department are critical enablers to improved and sustained UEC performance.

The importance of monitoring data in terms of the impact of UEC workstreams on Patient Safety, Quality and Experience and progress against key performance indicators is outlined along with the measures of improvement required and the timescales for achieving these. Trajectories are included for each of the KPIs with actual performance against these to be monitored through the previously described governance processes.

The UEC Programme risks identified to date along with the planned mitigations are included in the Plan, along with the process for management these through an over-arching Programme Risk Register and appropriate escalation to ensure transparency and further mitigation where required.

The approach to Stakeholder Engagement, Culture Change and Improvement is recognised as a critical component to embed cultural and behavioural transformation with investments in training including through establishing a UEC Academy key to this. Discussions on the draft UEC Plan has already begun with staff, the Trade Union Partnership Forum and key partners including members of the Regional Partnership Board and Llais.

**Argymhelliad / Recommendation**

The Board is asked to take **Assurance** from the attached Urgent and Emergency Care Improvement and Stabilisation Plan 2026/27.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | SRR001: Risk that the Health Board is unable to deliver and maintain high quality, safe and sustainable services that meet the needs of the population.<br>Score: 12 |

| | |
|---|---|
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 3. Effective Care<br>2. Safe Care<br>5. Timely Care<br>4. Dignified Care |
| Blaenoriaethau CTCI<br>IMTP Priorities<br>Link to IMTP | Choose an item. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Experience Quality and Safety |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br>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 |

| **Gwybodaeth Ychwanegol:**<br>**Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | GIRFT (Getting it Right First Time) |
| Rhestr Termau:<br>Glossary of Terms: | BCI: Business Continuity Incidents<br>ONP: Our Next Patient<br>SRO: Senior Responsible Officer<br>UEC: Urgent and Emergency Care |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | March 2026: First draft of Plan to Executive Committee |

| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |

| | |
|---|---|
| **Asesiad Effaith Cydraddoldeb**<br><br>**Equality Impact Assessment** (EIA) completed | **Yes not yet available**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br><br>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**<br><br>**Well Being of Future Generations Act – 5 ways of working**<br><br>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 |

# Urgent and Emergency Care Improvement and Stabilisation Plan 2026/27

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## 1. Introduction

This Urgent and Emergency Care (UEC) Improvement and Stabilisation Plan ("the plan") sets out the actions being taken by the Health Board and partners to improve whole-system flow, reduce harm and improve patient experience. Given the Health Boards recent escalation to Targeted Intervention for Urgent and Emergency care, a refreshed plan has been developed that encompasses the range of work programmes underway and the important enablers that have been implemented over the last number of months to improve the UEC position. This overarching plan sets out the key components that will enable improved and sustained operational performance and long-term system wide resilience.

## 2. Health Board Commitment

| | |
|---|---|
| **Health Board, Partners & Population** | The Health Board is driving improvements through the Gwent 35 Ten Year Strategy 'Better Health, Better Care and Better Lives'. The Strategy sets a clear direction for shifting the system forward through strengthened prevention, a focus on population health and enhanced community wellbeing to improve outcomes for the population |
| **The Board** | The Board commits to the Improvement and Stabilisation Plan associated with UEC and to continue to enable Divisions to deliver the required improvements through support, check and challenge |
| **Divisions** | The Divisions and their teams recognise the primary importance of a sustainable and improved UEC system and will commit to a continuous quality improvement approach to deliver sustained improvement |

## 3. Background

The Health Board continues to experience sustained, system-wide pressure across Urgent and Emergency Care (UEC), driven by increasing demand and complexity within the Gwent population. Pressures at the point of access particularly at the GUH are intrinsically linked to constrained

inpatient capacity and variable flow through acute and specialty pathways. These challenges are compounded by workforce constraints, rising levels of frailty and multi-morbidity. The impact is seen in extended waits, ambulance handover delays, and increased risk to patient safety, experience and outcomes.

Delayed discharge and limited step-down capacity remain key contributors to UEC pressure, restricting the release of beds for patients who are clinically ready to leave hospital and creating exit block across the system. Improving UEC performance is therefore a key priority for the Health Board and system partners, with delivery focused on strengthening flow, reducing delays, and improving patient outcomes. This is supported through the UEC Improvement and Stabilisation Plan, with a clear focus on operational grip, whole-system discharge, and sustained improvement in flow and capacity.

In January 2024, the Health Board was placed in Level 3 Enhanced Monitoring under the NHS Wales Escalation and Oversight Framework due to UEC performance and outcomes at the GUH. Despite a range of improvement actions, ongoing system pressures and performance challenges resulted in an escalation to Level 4 Targeted Intervention in December 2025. Welsh Government subsequently requested a strengthened UEC improvement and stabilisation response, with a clear focus on improving admission avoidance, reducing ambulance handover delays, strengthening internal patient flow, and ensuring robust and regular performance reporting.

The February 2026 Escalation Framework (**Appendix 1**) further required the Health Board to evidence that credible recovery and improvement plans are in place, underpinned by deliverable trajectories and measurable outcomes. This UEC Improvement and Stabilisation Plan brings together key actions and learning from the Six Goals Programme, the Our Next Patient (ONP) initiative, and insights from winter improvement sprints, alongside best practice from high-performing systems.

The plan is, however, being developed and delivered in the context of significant system-wide challenges. These include sustained high demand across emergency and urgent care pathways; increasing patient acuity and complexity, particularly within frail and older populations; workforce constraints across acute, community and social care services; and delays in patient flow. In addition, ambulance handover delays and variable internal flow processes continue to impact performance and patient experience.

To address both immediate stabilisation and longer-term sustainability, the plan also incorporates the system-wide transformation programmes, including the Acute Medical Model and the Older Person Pathway. These are fundamental to improving flow, reducing length of stay, and ensuring patients receive care in the most appropriate setting at the earliest opportunity. Together, this integrated approach aims to deliver both rapid improvement and sustainable transformation across the UEC system.

The UEC system in Gwent has seen a number of key changes and investments over the past 12-18 months including:

- Development of a Transfer Lounge in the GUH providing additional capacity to support timely flow of discharges and step downs.
- Delivery of Winter Sprints aligned to system pressures, supported by the Health Board Hospital to Home discharge service and the roll out of the Optimal Hospital Flow Framework (OHFF), improving timely discharge and patient flow.
- Expansion of waiting and assessment space in the Emergency Department (ED) in the GUH to improve patient experience in respect of waiting areas and increased assessment capacity.
- Increase in the number of ED consultants to increase capacity in rotas to better match UEC demand and to support improvements in the clinician waiting times.
- Development of Acute Frailty models across the system to improve timeliness and appropriateness of assessment for this cohort of population, including the Community Assessment Lounge at GUH.
- Launch of a Single Point of Access (SPoA) via a Community Clinical Desk in November 25 which is starting to yield positive impact.
- Strengthening of the Community Falls model in line with national framework

Notwithstanding this focus, the UEC system continues to be challenged and sustaining, spreading and amplifying the progress made underpins this UEC Improvement and Stabilisation Plan.

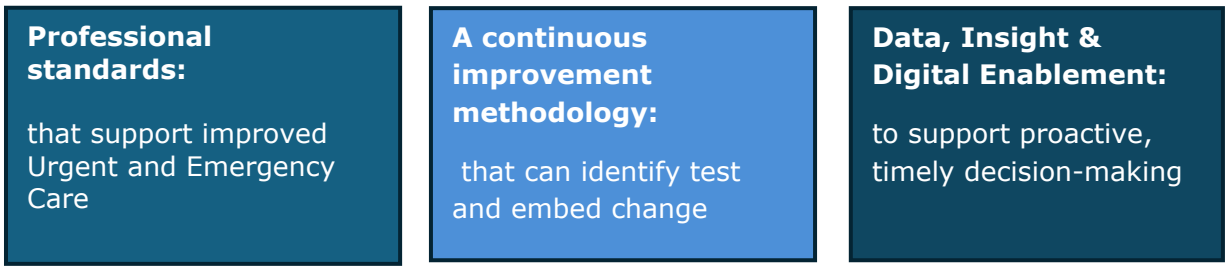
## 4. Aim and objectives and scope

The overall aim of the Plan is to sustainably improve **whole-system flow** to reduce harm and improve patient experience. The objectives to fulfil this aim are to:

- Increase delivery of **community-based care**, reducing reliance on emergency departments.
- Sustainably improve the time **patients wait for emergency care**.

- Deliver an effective and efficient **acute medicine model**.
- Implement and optimise the **older person pathway**.
- Increase **system-wide discharges** while reducing unwarranted variation reduction in length of stay
- Delivery of the optimal **Stroke pathway** ensuring patients receive timely and quality care.

Underpinning the delivery of the aim and objectives are the three programme pillars:




The scope of the programme consolidates all the existing workstreams supporting UEC improvement into a single unified structure. The Health Board has previously had in place the following:

1. Our Next Patient
2. Six Goals transformation workstreams
3. Integrated Discharge Board
4. Older Person Pathway Group

Under the refreshed programme the five key workstreams will be set as:

1. Our Next Patient
2. Integrated Discharge
3. Older Person Pathway
4. Acute Medical Model
5. Stroke Improvement

The purpose of each programme is described in the below table:

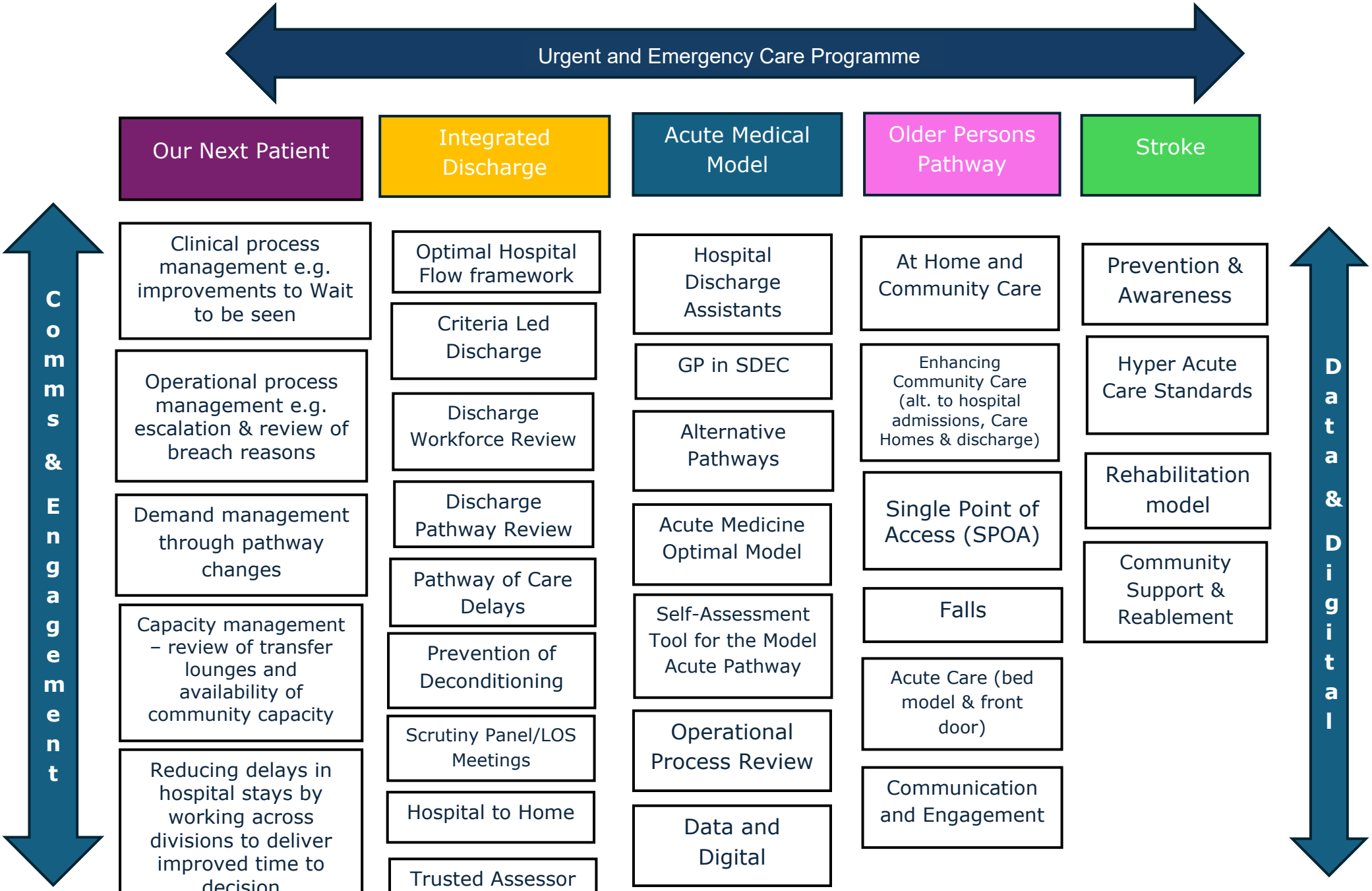
**Table 1: Programmes and Purpose**

| Programme | Purpose |
|---|---|
| **Our Next Patient** | Improvement projects that are operationally focused across all divisions and corporate teams. The number of initial projects focus on demand management, improving capacity availability and use and process management in the UEC space. |

| | |
|---|---|
| **Integrated Discharge** | The Integrated Discharge Board was established under the Six Goals Programme and brings together Local Authority partners with the health board to focus on the collective priorities to sustainably improve the pathways and models for discharge. The Discharge Programme will be where much of the system wide work with partners will be undertaken. This work will require a dual reporting line to the Regional Partnership Board and the Gwent Adult Strategic Partnership to ensure full engagement with key partners. |
| **Older Person Pathway** | Programme focuses on the Older Person Pathway aim to improve outcomes, experience, and quality of life for older people particularly those living with frailty through whole-system transformation of end-to-end pathway, spanning community services, intermediate care, access and navigation and acute hospital flow. |
| **Acute Medical Model** | The delivery of an optimal acute medical model focuses on providing high-quality, sustainable healthcare through a service approach designed to meet the needs of the Gwent population, supported by a sustainable and deliverable workforce model and the efficient, effective use of resources. This involves a full redesign of the acute medical service to generate system-wide efficiencies across the Health Board, strengthen workforce sustainability, and improve patient outcomes and flow. |
| **Stroke Improvement Programme** | The purpose of the Stroke Improvement Programme is to optimise and maintain standards in provision of timely access to emergency treatments (Scanning/thrombectomy/thrombolysis), specialist rehabilitation, and long-term, community-based support to maximise clinical outcomes, independence and quality of life for the population of Gwent, aligned to the National Quality Statement for Stroke and the National Stroke Standards. |

The national direction is to move away from the Six Goals Programme and to consider UEC improvement more widely. The Six Goals Programme will transition across the five workstreams.

**Diagram 1** below outlines the key projects within each of the workstreams. Comprehensive workstream delivery plans are included within the appendices and are referenced throughout this document.


Urgent and Emergency Care Programme
Our Next Patient
Integrated Discharge
Acute Medical Model
Older Persons Pathway
Stroke
Clinical process management e.g. improvements to Wait to be seen
Operational process management e.g. escalation & review of breach reasons
Demand management through pathway changes
Capacity management – review of transfer lounges and availability of community capacity
Reducing delays in hospital stays by working across divisions to deliver improved time to decision
Optimal Hospital Flow framework
Criteria Led Discharge
Discharge Workforce Review
Discharge Pathway Review
Pathway of Care Delays
Prevention of Deconditioning
Scrutiny Panel/LOS Meetings
Hospital to Home
Trusted Assessor
Hospital Discharge Assistants
GP in SDEC
Alternative Pathways
Acute Medicine Optimal Model
Self-Assessment Tool for the Model Acute Pathway
Operational Process Review
Data and Digital
At Home and Community Care
Enhancing Community Care (alt. to hospital admissions, Care Homes & discharge)
Single Point of Access (SPOA)
Falls
Acute Care (bed model & front door)
Communication and Engagement
Prevention & Awareness
Hyper Acute Care Standards
Rehabilitation model
Community Support & Reablement
Comms & Engagement
Data & Digital

Data, insight and digital will be central to a significant number of the projects delivered, but it should be noted that larger scale transformation in this area will be required to make improvements within the Health Board. Currently the focus is within the discharge and acute medical model programmes, however, early consideration will be required to focus on a whole health and care digital flow system.

## 5. Delivery phases

There are three phases of delivering the UEC Improvement and Stabilisation Plan set out as follows:

**Table 3: Delivery phases of the UEC Improvement and Stabilisation Plan**

| Phase | Timescale | Primary focus |
|---|---|---|
| Stabilisation and H45 focus | 0-90 days | Operational grip and control; stepped improvement in ambulance handovers and flow |
| Recovery | 3-6 months | Delivery of operational projects to make performance improvement more reliable |
| Sustainability | 6-18 months | Implementation of strategic change and embedding of sustainable delivery arrangements |

### 5.1 Stabilisation and Handover 45 focus (0-90 days)

The Health Board has not made sufficient progress against the Handover 45 (H45) protocol. NHS Performance and Improvement will be supporting the rapid implementation of the protocol across Wales, and the Health Board will be in the first tranche of organisations being reviewed.

To implement a H45 protocol by the Autumn of 2026, from May 2026 the stabilisation phase focuses on intensive operational management of the UEC pathway. There are four areas of work included:

1. Deliver a sustainable clinical model for SPOA and effectively manage demand through the Flow Centre
2. Reduce the Waiting To Be Seen (WTBS) in the ED
3. Increase discharges across the system through continued implementation of the Optimal Hospital Flow Framework
4. Work with Local Authorities to simplify the discharge process through initiatives such as Trusted Assessor

The below table outlines the trajectory for improvement in Ambulance handover rates **within** 45 minutes to support implementation of the H45 protocol by the Autumn.

**Table 4: Trajectories for Ambulance Handover Times**

| Milestone point | Ambulances handed over within 45 minutes | Numbers over 45 mins Health Board wide |
|---|---|---|
| **End of May 2026** | 60% | 740 |
| **End of June 2026** | 65% | 733 |
| **End of July 2026** | 70% | 604 |
| **End of August 2026** | 80% | 398 |

These trajectories are intentionally ambitious. Benchmarking suggests that maintaining such standards at all times is difficult, which is why the operational response includes twice-weekly review of variation and sprint projects to address recurrent causes of delay.

### 5.2 Recovery phase (3-6 months)

All projects in scope have been mapped as either operational change or strategic change. The recovery phase concentrates on operational projects that can secure improved reliability in day-to-day performance during the first half of 2026/27. A suite of standardised project documentation, delivery plans with milestones and reporting will be used across all workstreams to support consistency with the Transformation and Delivery Team approach. Examples of this can be found throughout the attached appendices.

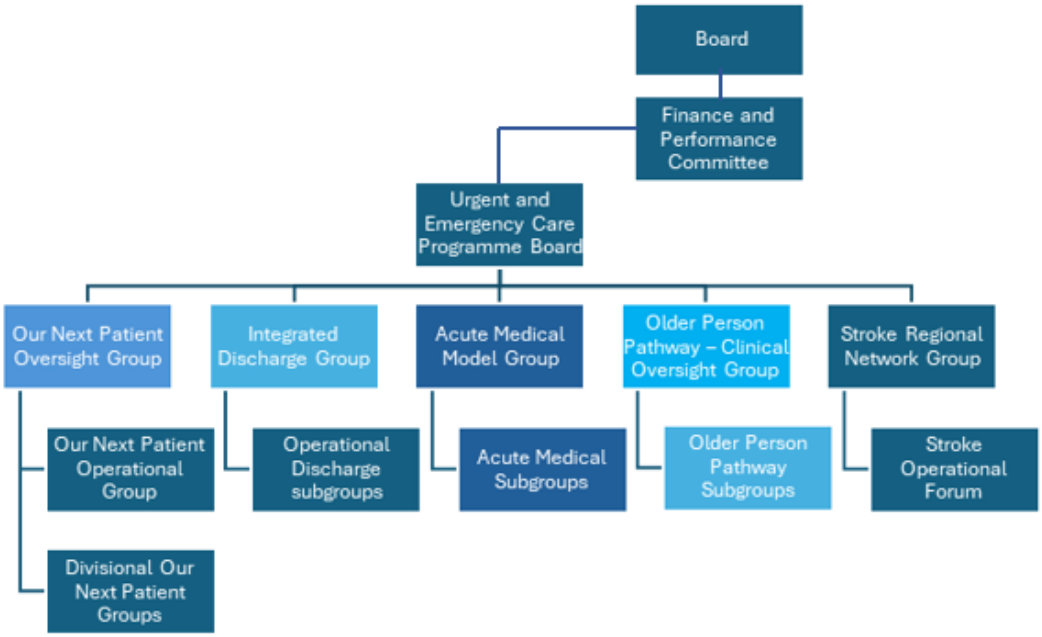
### 5.3 Sustainability phase (6-18 months)

The sustainability phase focuses on strategic change. Some projects will have implementation timescales extending beyond 12 months, but the expectation is that initial design decisions, mobilisation steps and early implementation milestones will be delivered within the year. Strategic reporting will align to existing quarterly transformation reporting arrangements.

## 6. Governance and Accountability

The Governance model consolidates the current UEC programmes of work under a single structure so that there is one clear route for assurance, escalation, support and challenge. The UEC Programme Board will provide overarching oversight, supported by programme management, operational and divisional groups covering the workstreams in each of the individual programmes. This structure is intended to eliminate duplication between previous arrangements and make Discharge, Our Next Patient, the Acute Medical Model and Older Person Pathway programmes and activities mutually effective.

**Diagram 2: UEC Programme Governance and Accountability structure**




The overarching UEC Programme Board will be held monthly to maintain oversight on key milestones. The Terms of Reference for the Programme Board are included in **Appendix 2**. The meetings within this governance structure are shown in Diagram 2 above, with aligned Executive Lead/Chair and Senior Responsible Officer (SRO) are listed below in Table 2. There are several identified subgroups supporting each of the workstreams to enable delivery.

**Table 2: Key UEC workstreams and the designated Leads/SROs**

| Group | Chair/Executive Lead | Senior Responsible Officer |
|---|---|---|
| Urgent and Emergency Care Programme Board | Chief Executive Officer | Chief Operating Officer |
| Our Next Patient Group | Chief Operating Officer | Deputy Chief Operating Officer |
| Integrated Discharge Board | Chief Operating Officer | Deputy Chief Operating Officer |
| Older Person Pathway | Chief Operating Officer | Divisional Director, Primary Care, Community Services and Complex and Long-Term Care |
| Acute Medical Model Task & Finish Group | Chief Operating Officer | Deputy General Manager for Medicine |
| Stroke Improvement | Executive Director of Allied Health Professionals & Health Science | Programme Director |

## 6.1 Role of Clinical Executives in Driving UEC Transformation

Strong, visible, and consistent clinical leadership is fundamental to the successful delivery of the UEC plan. Clinical Executives will play a pivotal role in shaping, championing, and embedding transformational change across all priority workstreams.

Clinical leadership is key to driving forward the change and will include:

- Setting clear clinical vision and direction aligned to "Our Next Patient" principles, ensuring care is delivered in the right place, first time
- Acting as senior clinical advocates for change, building credibility and engagement across multidisciplinary teams
- Leading pathway redesign including the Older Person Pathway using evidence, data and best practice to deliver improved outcomes and patient experience
- Championing a system-wide approach, working across organisational boundaries with primary care, community services, local authorities and third sector partners
- Supporting cultural change, moving from reactive care to proactive, anticipatory and person-centred models

- Ensuring clinical ownership and accountability for delivery, performance and quality within each programme area
- Providing visible leadership at operational and strategic forums, including programme boards and frontline engagement

## 7. Workstream Detail

The following section provides a more detailed view of the objectives of each of the five workstreams and within the appendices there is further supporting information available in terms of project timelines and outcomes.

### 7.1 Our Next Patient

**Purpose and oversight**

Continuous flow in urgent and emergency care refers to the seamless movement of patients through the healthcare system, from initial assessment to definitive treatment and discharge. The aim is to minimise delays, optimise resource utilisation, and ensure timely access to care. Effective continuous flow helps reduce overcrowding, enhances patient outcomes and experiences.

Successful continuous flow models depend on collaborative efforts across divisions. The Our Next Patient (ONP) initiative is designed to implement a continuous flow model within the Health Board.

ONP is overseen through two key approaches:

1. Weekly oversight group
2. Operational improvement meetings held twice a week

Additionally, system flow meetings occur twice daily to support continuous flow.

**Aim**

The aim of the ONP initiative is to implement a continuous flow model designed to facilitate prompt ambulance handovers, and reduced 12 hour stays in ED, thereby enhancing patient experience and outcomes. Additionally, this approach aims to mitigate risks present in community settings.

**Objectives**

Divisions will deliver change projects to:

- Improve ambulance handover performance

- Improve timeliness of assessment and treatment
- Increase delivery of care in community settings
- Improve outcomes for priority clinical pathways: deliver targeted improvement for agreed high-impact pathways to ensure timely assessment, treatment, rehabilitation and discharge
- Embed operational process to support continuous flow throughout the system
- Embed data, digital and improvement capability

**Our Next Patient workstream**

Currently, ONP encompasses sixteen projects that have been selected to deliver operational improvement opportunities throughout the entire system and all divisions. Each division is responsible for managing its respective projects and, upon completion, identifying subsequent opportunities for improvement.

The operational improvement meeting, held twice a week, serves as a community of practice where data is used to identify sprint projects that help sustain operational performance. Each sprint project is intended to be completed within two weeks.

The combination of operational projects and sprint improvements is designed to embed a continuous improvement approach to Urgent and emergency care.

The foundation for ongoing improvement is the use of digital and data. Over the past three months, enhancements have been made regarding the capture and availability of data related to constraints affecting continuous flow and discharge preparedness. This data is now utilized daily and weekly to identify areas for further improvement.

Project documentation has been established for all projects across the divisions. These projects will be managed at the divisional level, with ongoing oversight facilitated by the weekly ONP group meetings. The over-arching Project Plan for ONP is included as **appendix 3** and project documentation as **appendix 4.**

## 7.2 Integrated Discharge

**Purpose and oversight**

The Integrated Discharge Board (IDB) is a monthly, system wide forum chaired by the Interim Deputy Chief Operating Officer, bringing together senior partners across Gwent to improve safe, timely discharge and hospital flow in line with the national Urgent and Emergency Care Programme.

The work plan includes eleven integrated workstreams across health and social care, each with defined objectives and accountable clinical, operational and management leads. Delivery is supported through governance to monitor progress, manage risks and drive coordinated system-wide improvement, further detail on the scope and workstream metrics is outlined in **appendix 5.**

A six weekly meeting is also in place, bringing together the Interim Deputy Chief Operating Officer, Heads of Adult Services from the five Local Authorities, and representatives from the Regional Partnership Board. This forum progresses discharge pathway improvements at pace through a sprint-based methodology, identifying and addressing improvement opportunities at each stage of the pathway.

**Aims**

The Integrated Discharge Programme aims to:

- Ensure patients experience safe and timely discharge
- Deliver coordinated follow-on care
- Provide the right care, in the right place, at the right time
- Reduce avoidable delays in discharge
- Prevent deconditioning during and after hospital stay
- Minimise avoidable readmissions

**Objectives**

The **Health Board and Local Authorities** will work together to:

- Increase safe discharges, including weekday and weekend discharges
- Improve patient outcomes through coordinated, person-centred planning
- Reduce delays related to assessments, reablement, and packages of care
- Standardise escalation with Local Authorities and adopt the Trusted Assessor model
- Embed action-oriented site flow and strong daily operational grip
- Standardise length of stay reviews across all sites
- Strengthen joint working across health, social care, community, and voluntary partners
- Prevent readmissions through appropriate post discharge support

Delivery of the Integrated Discharge Programme relies on interdependent workstreams that require whole-system working across health, social care, community and voluntary partners to achieve sustainable, continuous improvement in discharge and hospital flow.

### 7.3 Acute Medicine Model

**Purpose and Oversight**

The Acute Medicine Model Group focuses on improving front-door assessment, clinical decision-making, and patient flow, while supporting the development of an optimal long-term acute medicine service model support the Health Board. This work forms part of a wider, longer-term transformation programme that will be delivered in phases over time.

The Acute Medicine work plan includes seven focused workstreams to drive forward service change, each supported by identified clinical and operational leads with clear accountability for delivery and improvement, further detail on the scope and workstream metrics is outlined in **appendix 6.**

Oversight is provided through a fortnightly meeting chaired by the Senior Responsible Officer, the Deputy General Manager for Medicine, supported by the Clinical and Medical Director with overall Executive leadership provided by the Chief Operating Officer.

**Aims**

The Acute Medicine Working Group aims to:

- Improve front door assessment, aligned to the NHS England Acute Model Pathway (2026)
- Strengthen early clinical decision-making
- Enhance patient flow
- Reducing avoidable admissions
- Optimising length of stay
- Developing a sustainable long-term acute medicine model
- Improve outcomes and patient experience across the system.

**Objectives**

- Deliver timely, high-quality assessment at the front door
- Increase early senior clinical decision making
- Expand ambulatory and same-day emergency care pathways
- Reduce avoidable admissions and unnecessary bed days
- Improve patient flow and reduce delays across the pathway
- Standardise acute medical processes and models of care

- Strengthen integration with frailty and community services
- Implement digital system to monitor, track and report performance in real time
- Use data, benchmarking and performance metrics to drive continuous improvement
- Support development of a sustainable, future acute medicine model.

## 7.4 Older Person Pathway

### Purpose and Oversight

The Older Person Pathway Oversight Group provides monthly strategic oversight of work to improve pathways for older people across the system. Chaired by the Chief Operating Officer and supported by the Medical Director and Senior Responsible Officer (Divisional Director for Primary Care, Community Services and Complex and Long-Term Care), the aim of the group is to drive timely, person-centred care, reduce avoidable admissions and length of stay, and promote safe discharge through aligned, data-driven system working. This work forms part of a wider, complex, long-term transformation programme delivered in phases over three years.

The work plan includes six workstreams spanning the pathway from community to acute care, with allocated clinical, nursing and managerial leads. Communication and engagement form a key cross-cutting workstream, aligned to supporting multidisciplinary delivery, further detail on the scope and workstream metrics is outlined in **appendix 7.**

### Aims

The Older Person Pathway Oversight Group aims to:

- Align with Place-Based Care to support prevention, community-based care, and reduced Health inequalities
- Development of a Single Point of Access, enabling timely triage, supporting admission avoidance for older people through rapid assessment, community support, and reduced emergency admissions.
- Improve front door assessment and identification of older people with complex needs
- Promote person-centred care that maintains independence and function
- Reduce avoidable admissions and unnecessary hospital stays
- Optimise flow and bed base utilisation for older patients
- Strengthen integration across acute, community, carers and social care services and third sector, across partnerships

- Use data and outcomes to drive continuous improvement in care and experience

**Objectives**

- Deliver timely identification and assessment of frail and older patients in the community and at the front door.
- Increase early senior and multidisciplinary decision-making
- Reduce avoidable admissions through alternative, community-based pathways and preventative support, enabling people to remain well at home.
- Optimise flow and bed base utilisation for older people
- Minimise length of stay through proactive care and early discharge planning
- Improve access to rehabilitation, reablement, and community support
- Enhance patient outcomes, experience, and maintenance of independence
- Collaborative working with Torfaen and Blaenau Gwent Local Authorities to expand reablement opportunities, supporting admission avoidance, care closer to home, and improved system flow
- Explore opportunities arising from new delivery mechanisms to sustain and enhance frailty service provision following the conclusion of Section 33 arrangements
- Use data and performance metrics to monitor delivery and drive improvement.

## 7.5 Stroke Improvement

**Purpose and oversight**

The purpose of the Stroke Improvement Programme is to optimise and maintain standards in provision of timely access to emergency treatments (Scanning/thrombectomy/thrombolysis), specialist rehabilitation, and long-term, community-based support to maximise clinical outcomes, independence and quality of life for the population of Gwent, aligned to the National Quality Statement for Stroke and the National Stroke Standards.

The work plan includes four workstreams across prevention, acute, rehabilitation and community services, each with allocated clinical and operational leads accountable for driving service improvement aligned to national best practice guidance, further detail on the scope and workstream metrics is outlined in **appendix 8.**

The Stroke Operational Forum provides strategic oversight of work to improve the steps within the Stroke Pathway.

**Aims**

The aims of the Stroke Improvement Programme fall under the following areas:

- Primary prevention – seek to prevent as many strokes as possible, by working to improve the detection and management of underlying risk factors for stroke.
- Awareness raising – work to understand public awareness of stroke symptoms, and the action required when they occur, and support the delivery of FAST campaigns.
- Hyperacute care – optimise initial scanning and delivery of thrombolysis and efficient transfer of those requiring a thrombectomy service, as well as timely access to stroke unit
- Rehabilitation & Reablement – Ensure the provision of high quality, holistic rehabilitation and reablement services that is person-centred, re-accessible, delivered in the appropriate setting with patient outcomes and experiences measured.

**Objectives**

The following objectives have been set across the Stroke pathway:

- Detection and management of underlying risk factors for stroke
- Ensuring stroke patients have timely access to stroke wards within national standards.
- Constraint Analysis and understanding of the limitations and challenges in meeting the national hyper acute standards
- Embedding Rehabilitation service model
- Optimise patient outcomes and experience
- Ensuring patients are supported within the community following acute admission
- Utilisation of the Sentinel Stroke National Audit Programme (SSNAP) to monitor performance and drive improvements.

## 8. Mental Health and UEC

Mental Health is alongside the UEC Programme, one of the Health Board's priority programmes for 2026/27. It includes within its objectives to support the UEC Programme in delivery of this Stabilisation and Improvement Plan which encompasses both physical and mental health. The two specific work-streams that it will report on to both the Mental Health Programme Board and the UEC Programme Board are:

- Development of the crisis model with a focus on appropriate links to the 111 press 2 service to ensure that where possible that crisis is managed in the community. Further to this the Mental Health Programme is looking to align the crisis response to community mental health teams and the assertive outreach team to ensure that there is sufficient capacity to respond to the crisis needs. The plan is to complete this work in a six-month timeline.
- Embedding the national priorities surrounding the red to green flow model in mental health (which is a visual management system identifying reducing wasted time (red days) and daily treatment that adds value towards discharge (green days)) and to develop a sustainable centralised bed management approach.

## 9. Place Based Care and UEC

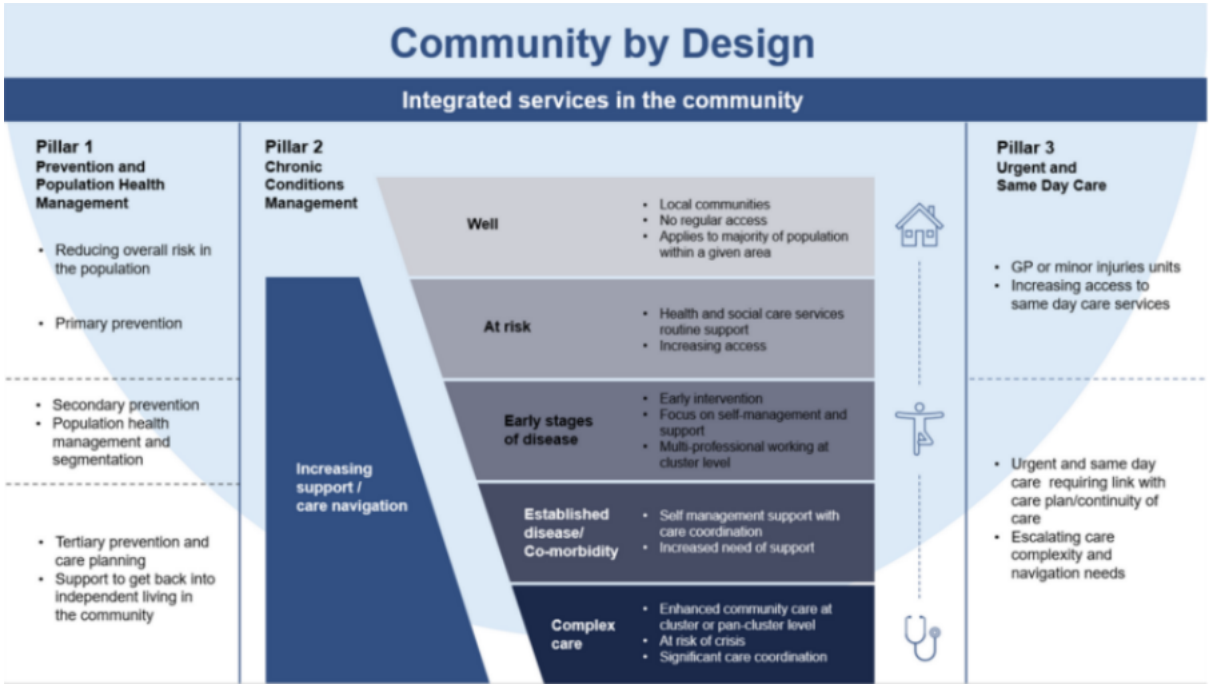
Place-Based Care (PBC) is a key transformation programme for the Health Board, aimed at fundamentally reshaping the health and care system to focus on prevention, reduce health inequalities, and strengthen partnerships across communities. The programme aligns with the Welsh Government's vision set out in A Healthier Wales, supporting the development of an Integrated Community Care System (ICCS) at a local level.

Governance is provided through a Programme Board led by the Executive Director of Public Health (Senior Responsible Officer), alongside the Director of Primary Care and the Divisional Director for Primary Care, Community Services, and Complex and Long-Term Care.

PBC also incorporates the Community by Design pillars which are outlined in Diagram 4 below, translating whole-system integration and prevention into practical action across Gwent's neighbourhoods. This approach is supported regionally by the Gwent Regional Partnership Board and Public Service Board, ensuring alignment with wider strategic priorities.

Internally, PBC is a key pillar of the UEC Stabilisation and Improvement Plan, with initiatives such as the SPoA acting as critical enablers to prevent avoidable conveyances and attendances at emergency departments.

**Diagram 4: Overview of the Community by Design pillars:**




## 10. Discharge and continuous flow

Continuous flow can only be sustained if reliable operational processes increase discharge activity consistently across the week and across the whole system. Recent changes aligned to the Optimal Hospital Flow Framework have strengthened daily decision-making and ward routines. The next step is to embed those principles consistently across all sites, reduce variation, and support timely discharge for patients who are clinically ready to leave hospital.

The system needs to move reliably towards an average of 115 discharges per day, Monday to Friday. Although total weekly discharge activity has improved over the last 18 months and variation has narrowed, current performance still typically ranges between 85 and 95 discharges per day. The below table sets out the trajectories for increasing the number of discharges per day over 2026/27.

**Table 9: 2026/27 Trajectories for the number of discharges per day**

| Step change | Discharges per day | Indicative compliance |
|---|---|---|
| **May 2026** | 95 | 55% |

| | | |
|---|---|---|
| **July 2026** | 105 | 85% |
| **March 2027** | 115 | 97% |

## 11. Resourcing principles

The Health Board has made significant investment across UEC pathways. As delivery progresses, organisational decisions will be needed about where care is best delivered and how resources should move in response. These decisions should be taken through existing governance structures based on evidence, benefits and affordability.

The Health Board's plan for 2026/27 maintains investment in UEC through the ONP programme, with recurrent revenue also identified for UPCC (Urgent Primary and Community Care) and SDEC (Same Day Emergency Care). These investments are expected to generate future efficiencies and support resource reallocation or efficiency. In the short to medium term, some targeted pump priming may still be required; where that is the case, proposals should be supported by explicit benefits plans.

The Regional Partnership Board, through the Integrated Discharge Board, is reviewing discharge pathways across the system to identify opportunities to streamline process, reduce duplication and target resources more effectively. Any efficiencies identified through that work should be used to support resource shifts that strengthen flow and ensures improved outcomes for patients.

## 12. Benefits Realisation Framework

Benefits realisation will use Welsh Government de-escalation criteria as the core performance framework, supplemented by the 2026/27 Plan trajectories and local programme metrics. A single verified data source should underpin ONP reporting, UEC reporting and benefits tracking so that progress can be monitored consistently and acted upon quickly. The below table sets out the main benefits and key metrics for monitoring realisation of these which will be reported to the Programme Board.

**Table 10: Benefits Realisation**

| Benefit | Patient Outcomes | Operational System Outcomes | Key Metrics |
|---|---|---|---|
| Earlier and more reliable discharge (including | Reduced length of stay, reduced deconditioning, | Improved bed availability and flow due to | 7-day & pre-midday discharge, LOS |

| | | | |
|---|---|---|---|
| weekends and pre-midday) | safer transitions of care | reduced length of stay. | |
| Reduced avoidable length of stay | Improved patient experience and reduced harm | Reduced bed days and variability | LOS 0–7 days, LOS 21+ |
| Faster progression to clinically optimised status | Timely decision-making and clearer plans | Reduced internal delays | LOS to clinically optimised |
| Clear daily clinical and operational focus (Red to Green, SAFER, D2RA) | Reduced delays in tests, decisions and actions | Improved ward-level grip and escalation | D2RA 4 measures |
| Improved MDT and system-wide working | Coordinated, person-centered care | Fewer delays between services | Pathways of Care Delays by reason code |
| Better identification and management of discharge barriers | More predictable discharge journeys | Targeted improvement at cause level | HB & LA delay attribution |
| Improved data quality and visibility | Safer discharge decisions | Evidence-based flow management | D2RA and LOS reporting |
| Released acute capacity | Reduced ED waits and cancellations | Improved flow from ED and electives | LOS, discharge timing |

## 13. Patient Quality, Safety and Experience

Delivery of this UEC Improvement and Stabilisation Plan will be underpinned by systematic monitoring of patient quality, safety and experience, ensuring that improvements in flow are achieved without unintended harm. Information generated through the programme will be triangulated with established quality and safety intelligence including incident reporting, complaints, patient feedback and clinical outcome data.

This will be collated within the UEC dashboard that will monitor performance throughout the governance structure.

Platforms such as Civica will be used to support consistent capture, analysis and reporting of quality and safety metrics, enabling timely identification of themes, risks and improvement opportunities. This intelligence will be reviewed through existing governance arrangements, including programme, divisional and executive forums, to ensure that learning is acted upon, mitigations are implemented, and patient experience and safety remain central to operational decision-making as performance improves and stabilises.

## 14. Data and Digital

### 14.1 Monitoring of data

The availability of timely data is a critical component across the UEC system to allow clinical and operational teams to anticipate demand, manage capacity, identify bottlenecks in the system so that resources can be targeted where most required.

The following table sets out the level of improvement required to achieve the Targeted Intervention de-escalation criteria and/or the other relevant performance measures included within the 2026/2027 Annual Plan and their respective improvement trajectories:

**Table 11: Key performance measures and timeframe for delivery**

| Metric | Measure Type | Level of improvement required | De-escalation/improvement timeframe |
|---|---|---|---|
| >45 minute handovers to GUH ED | **Targeted Intervention** and Ministerial Delivery Expectation | Staged improvement of 11% per month for 3 months (at 60 mins) | Based on the WG requirement of maintenance for at least 3 months September is the earliest de-escalation point |
| Ambulance lost hours at GUH ED | ABUHB Annual Plan | Reduce | Annual Plan trajectory seeks to reduce by 66.7% (baseline of 2,988, Q4 trajectory 768) |
| % greater than 12 hours in ED | **Targeted Intervention** | 7% or less | May 26 earliest point |

| | | | |
|---|---|---|---|
| >12hr EDMIU breaches | Ministerial Delivery Expectation | Reduce | Annual Plan trajectory seeks to reduce by 26.6% (baseline of 1,089, Q4 trajectory 799) |
| <4hr EDMIU compliance | ABUHB Annual Plan | Increase | Annual Plan trajectory seeks to increase by 3.7% (baseline of 73.3%, Q4 trajectory 77%) |
| Median Wait to be seen in ED | **Targeted Intervention** | 60 mins | March 2027 |
| Pathway of Care delays – by volume | **Targeted Intervention** and Ministerial Delivery Expectation | 156 | Earliest point to achieve based on 3 months maintenance is June 26 |
| Pathway of Care delays – by days delayed | Ministerial Delivery Expectation | Reduce | Annual Plan trajectory seeks to reduce by 37.7% (baseline of 6,165, Q4 trajectory 3,840) |
| Improve the percentage of pre noon Provider Spell discharges | ABUHB Annual Plan | Increase | Annual Plan trajectory seeks to increase by 1.5% (baseline of 15.6%, Q4 trajectory 17.1%) |

The Health Board's Annual Plan 2026/27 includes the below trajectories linked to the targeted intervention de-escalation criteria. Actual performance against the trajectories is reported monthly through the governance structure.

**Diagram 5: Number of ambulance handovers over 45 minutes by month in the GUH Emergency Department, actual and forecast**

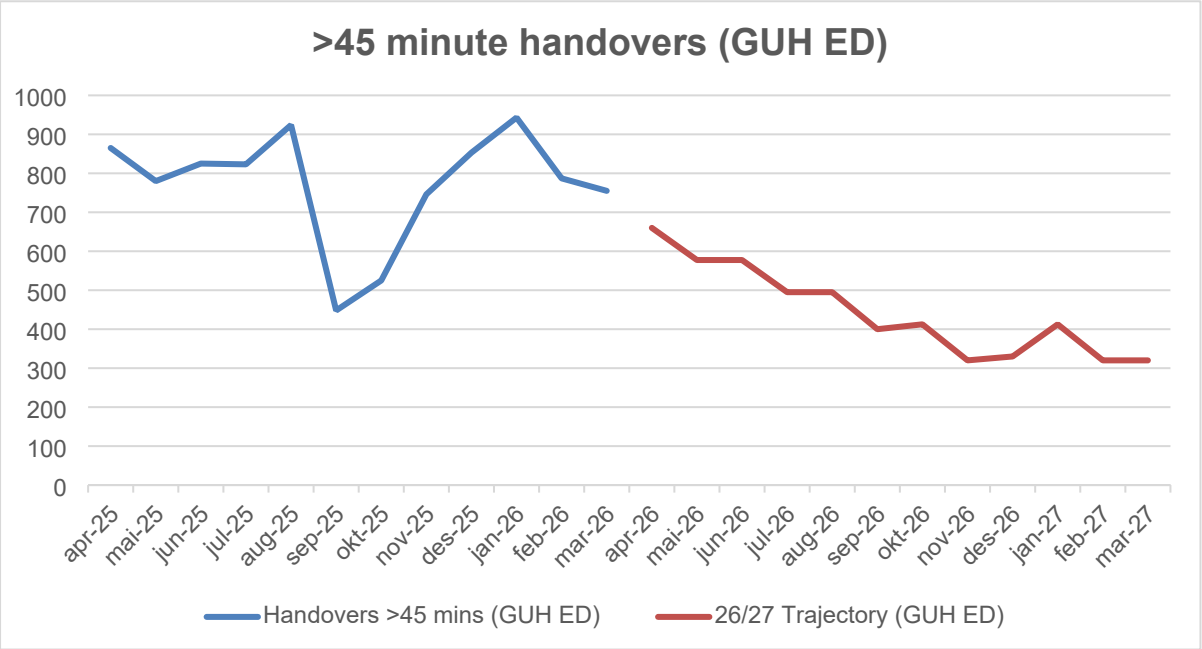



**Diagram 6: Number of over 12 hour breaches by month in the GUH Emergency Department and Minor Injuries Department, actual and forecast**

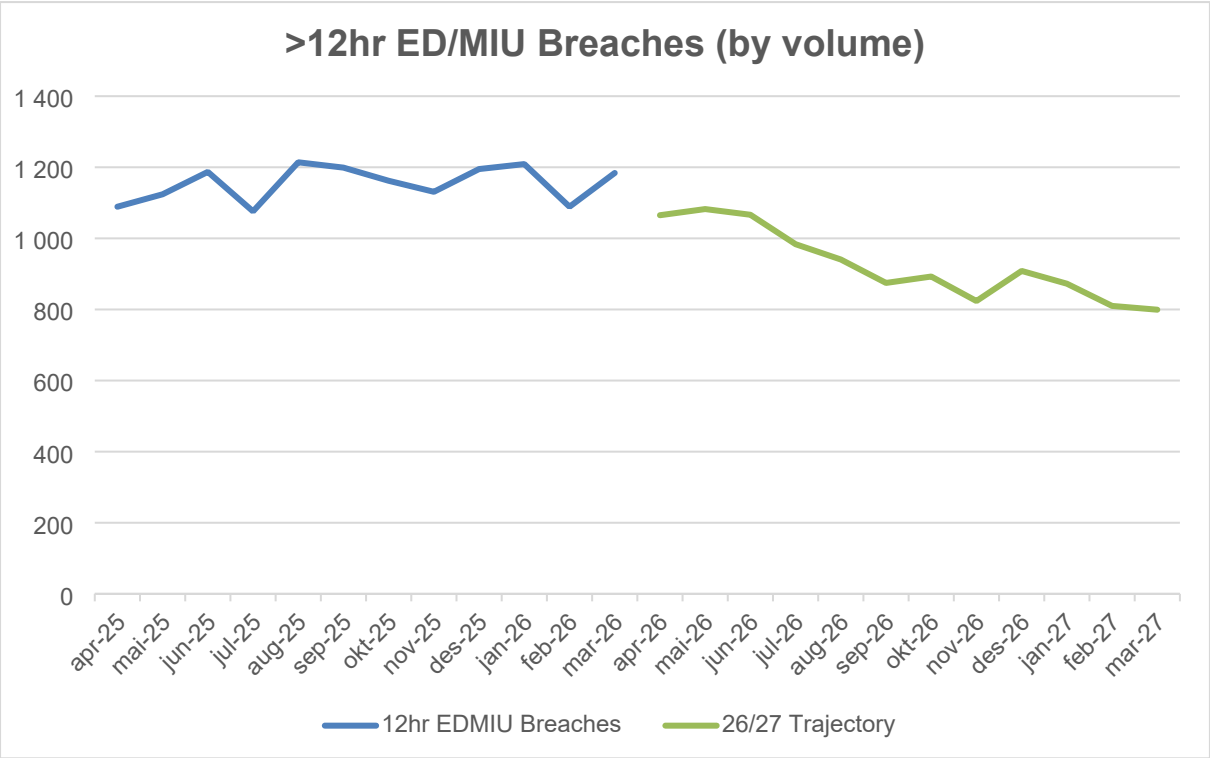



**Diagram 7: Historical compliance against the Emergency/Minor Injuries Departments 12 hour target and the 2026/27 Trajectory**

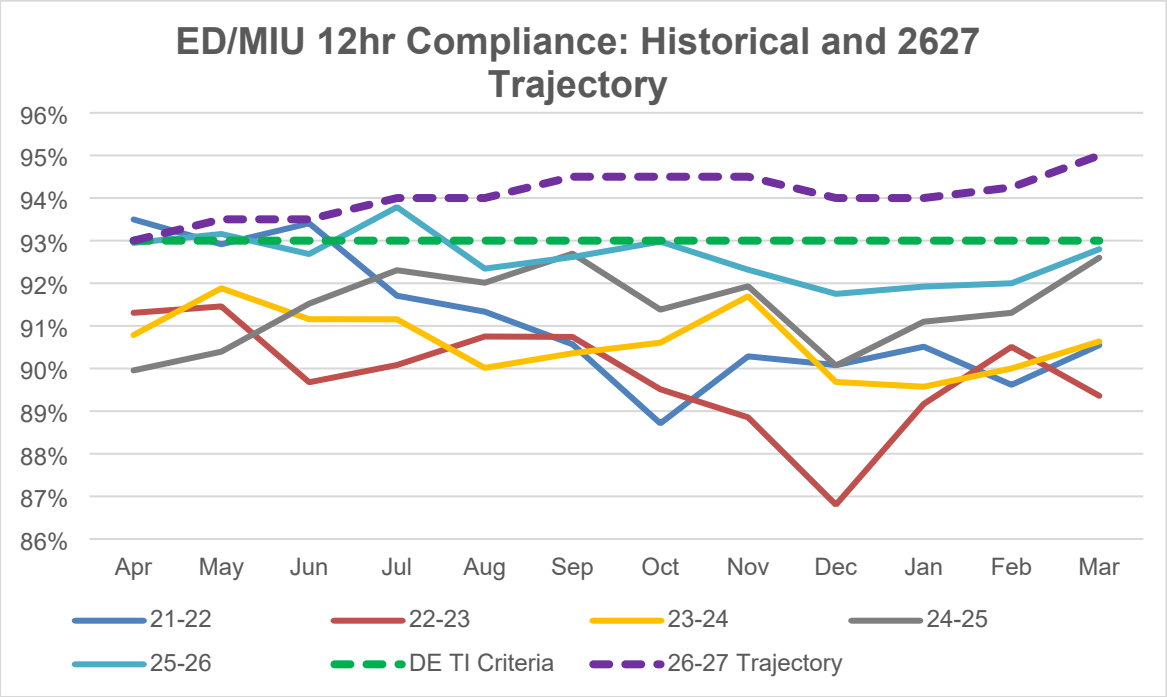



**Diagram 8: Median waiting time to be seen by a Senior Clinician in minutes by month, actual and forecast**

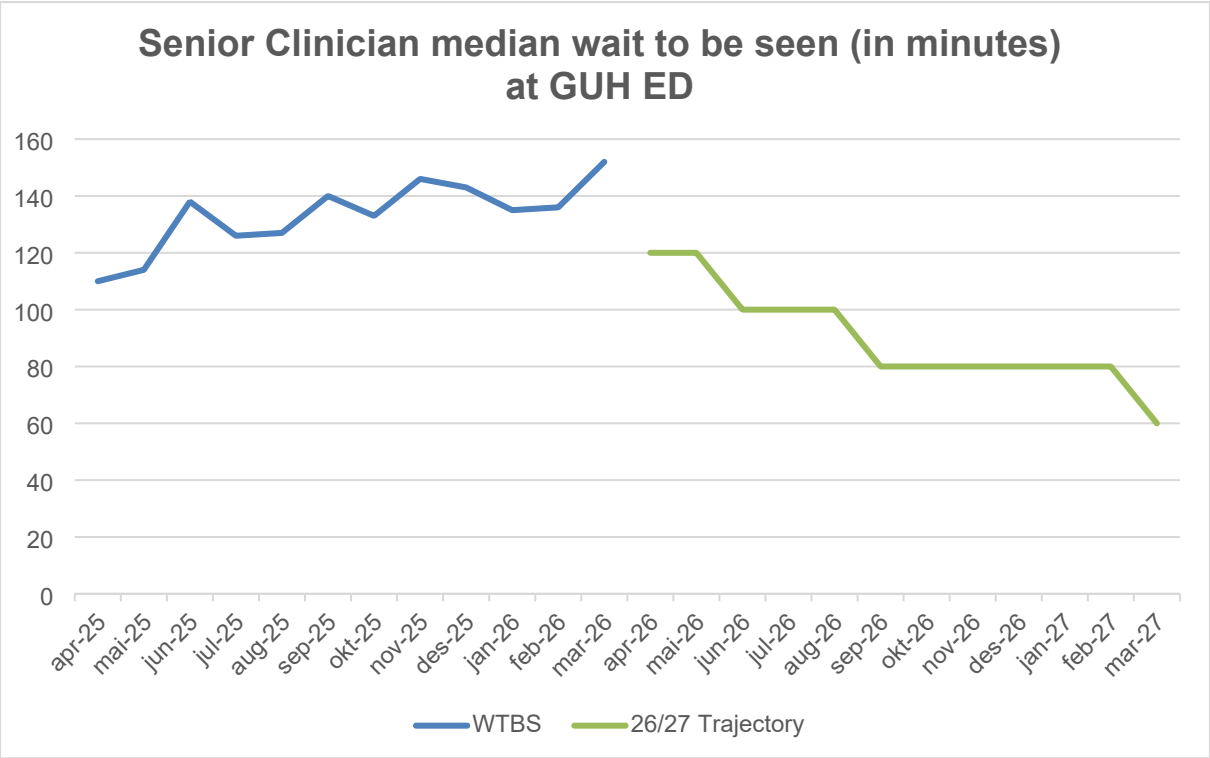
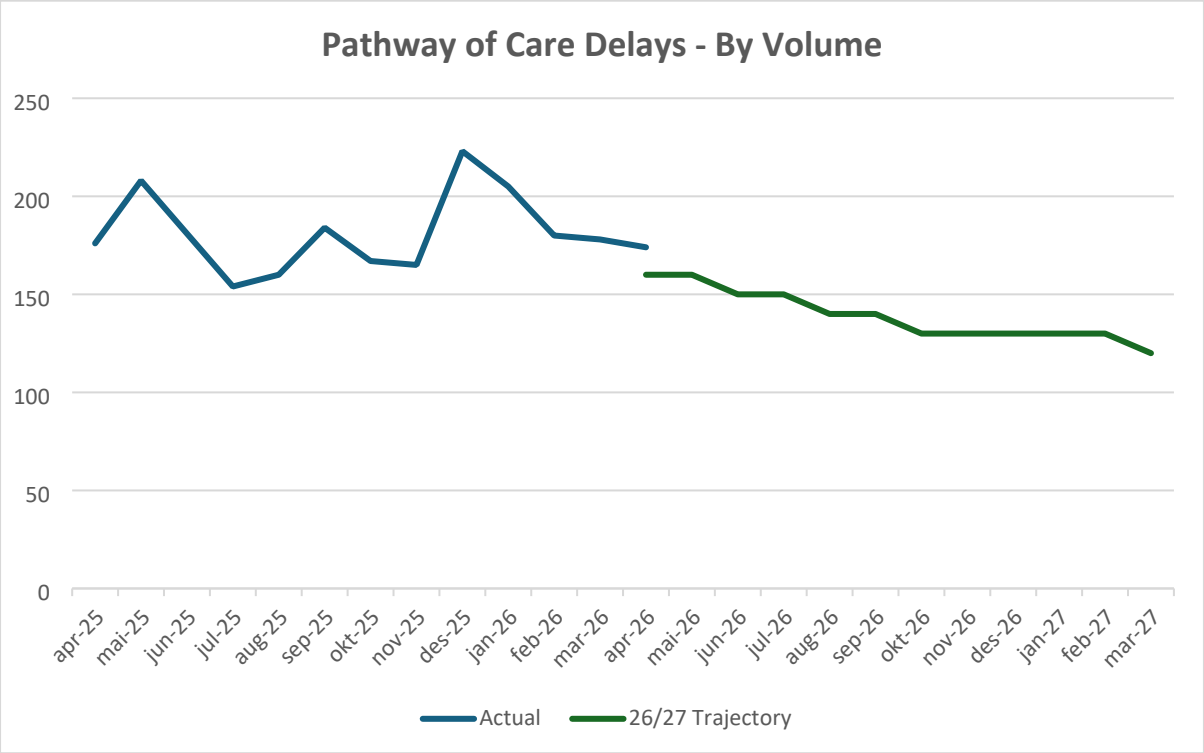



**Diagram 9: Number of Pathway of Care Delays by month, actual and forecast for 2026/27**



## 14.2 Digital Transformation

It is recognised throughout the Plan that digital transformation is central to improving the delivery of UEC across the Health Board by enabling faster, safer and more co-ordinated decision-making across the whole care pathway. Providing clinicians with timely access to accurate patient information and digital tools can reduce duplication, support better triage, improve patient flow and help patients receive care in the most appropriate setting whether that be in a patient's home for remote advice and management, in primary or community care or in the Emergency Department.

The Health Board's draft Digital Transformation Strategy which has recently been out to consultation sets out specific goals which support UEC improvement namely:

- *Goal 2: Support clinicians and care partners* through better information sharing, digitally enabled workflows and support tools to reduce avoidable admissions, help redesign care models and enable safe and timely discharge.
- *Goal 3: Building the Digital Platform for joined up services* so that there is real time visibility of data and over time extending the health and care record to include Local Authorities and Third Sector partners supporting whole system care and the ambitions of the Regional Partnership Board.

Further alignment between the Digital Strategy and the UEC Plan will be agreed prior to the final version of the Strategy is considered at Board in July 2026.

## 15. Programme, Risk Management and Quality Improvement

The purpose of the UEC Programme is to provide strategic oversight of a sustainable, whole system approach to improving patient experience and outcomes across UEC in Gwent.

This plan has established for the programme a clear direction and deliverables, and measure progress against agreed priorities for Urgent and Emergency Care across the system for the year ahead.

The Programme will ensure system-wide accountability through Chief Executive chaired UEC Programme Board, with membership to include Health Board Executives, Social Care, Welsh Ambulance Services NHS Trust (WAST) and NHS Performance & improvement.

The Programme Board will provide strategic leadership and decision-making authority.

To support the stabilisation and improvement, a dedicated Programme Management function will ensure connectivity across workstreams, coordination of delivery, milestone tracking, and proactive risk management. This approach will support consistency and assurance against national reporting requirements that include UEC National Programme reports, Ministerial Delivery and Enabling actions progress.

Recognising the interdependency between tactical (operational) and strategic change, particularly during periods of peak demand, the Programme will adopt a dual approach that supports immediate improvement in operational performance and flow, while delivering longer term strategic change to better meet the needs of the population and improve system resilience.

The programme will ensure decision making is evidence based utilising key daily operational dashboards to support real-time decision-making and improvement such as Estimated Date of Discharge (EDD) and Red Reason tracking. These will be complemented by system-level performance and health indicators aligned to strategic objectives, as outlined above.

Quality Improvement (QI) will be a key enabler of change within the organisation and leveraging QI expertise within the Health Board to provide coaching and practical support, build local capability in improvement methods and empower teams to design, test, and embed sustainable change will be essential.

An overarching Programme Risk Register will be maintained. Risks will be identified and scored at project and workstream level, with escalation to the Programme Board monthly where risk scores exceed agreed tolerance levels. This approach will ensure transparency, timely mitigation, and appropriate system-level oversight.

There are several identified risks in delivery of this UEC Stabilisation and Improvement Plan that should be initially noted:

**Table 11: Identified risks to date**

| System-level risk | Planned mitigation |
|---|---|
| Demand increases beyond modelled projections, resulting in poor performance against standards. | Use the ONP operational group to review metrics at least weekly, identify adverse trends and launch |

| | |
|---|---|
| | sprint improvement actions quickly. |
| Phase 2 ED development adversely impacts ED capacity during works. | Coordinate cross-divisional mitigation to protect flow and provide additional senior decision-maker capacity where required. |
| Implementation of the Welsh emergency care data set changes the definition of wait-to-be-seen performance. | Review impact promptly and, if required, seek discussion with Welsh Government on the implications for de-escalation criteria. |
| Ambulance demand rises while handover performance improves, placing additional pressure on the front door. | Review the effectiveness and scale of discharge and assessed-out targets if ambulance arrivals increase on a sustained basis. |
| Community capacity and local authority workforce pressures delay discharge. | Use the Discharge Improvement Programme, with local authorities and the Regional Partnership Board, to maintain oversight and remove barriers. |
| Digital readiness and data quality gaps slow real-time decision-making and benefits tracking. | Standardise data capture, improve data quality and accelerate roll-out of real-time dashboards using a single verified source. |
| Insufficient engagement from medical, nursing and therapy staff due to competing pressures. | Maintain visible executive and divisional leadership, reinforce programme priority, and continue the multidisciplinary engagement model used through ONP and winter response. |

## 16. Stakeholder Engagement, Culture Change and Improvement

Sustainable change within UEC is dependent on embedding behavioural and cultural transformation across services, the wider health and care system and the population of Gwent.

It is imperative that frontline staff are actively involved and empowered throughout both the design and implementation phases of the programme. Engaged staff will act as key drivers and champions of change, supporting the delivery and sustainability of improvements.

This approach must be underpinned by a strong commitment to professional standards, ensuring consistently safe, high-quality and compassionate care. A culture of accountability, continuous improvement

and evidence-based practice is essential, alongside strong multidisciplinary working and clinical leadership.

Investment in training, supervision and reflective practice will reinforce professional behaviours and support staff to respond to growing demand and complexity. Aligning cultural transformation with professional excellence will ensure sustainable improvements and better patient outcomes.

To achieve this, clinical teams will be represented across all workstreams, with ongoing engagement extended to wider staff groups, including Trade Union Partnership Forum (TUPF) representatives.

In addition, a UEC Academy will be established as a structured development offer to support the growth, capability and confidence of staff across the system. The Academy will provide a comprehensive programme focused on service improvement, quality improvement methodologies, and rapid cycle "sprint" approaches to testing and implementing change at pace.

The UEC Academy will be designed to equip multidisciplinary teams with practical tools and techniques, including improvement science, data-driven decision-making and pathway redesign, ensuring that staff are able to identify unwarranted variation, test solutions, and sustain improvements in their own areas.

Delivery will include a blended approach of formal training, action learning, coaching, and on the job application through live improvement projects aligned to UEC priorities. This will enable participants to immediately apply learning to real system challenges, fostering ownership and accelerating impact.

A key focus of the UEC Academy will be the development of local improvement leaders and champions at all levels, creating a distributed leadership model that supports continuous improvement and innovation. Through this approach, the Academy will help embed a culture of curiosity, collaboration, and accountability, where staff feel empowered to challenge existing practices and drive change.

Specific discussions will be ongoing with Llais to raise awareness of and ensure that the objectives of the plan are delivered in line with their 'People's Principles'.

## 17. Sustainable Delivery

Sustainable UEC delivery depends on embedding a consistent, evidence-based continuous improvement approach across the Health Board and with system partners. By strengthening data-driven decision-making, using

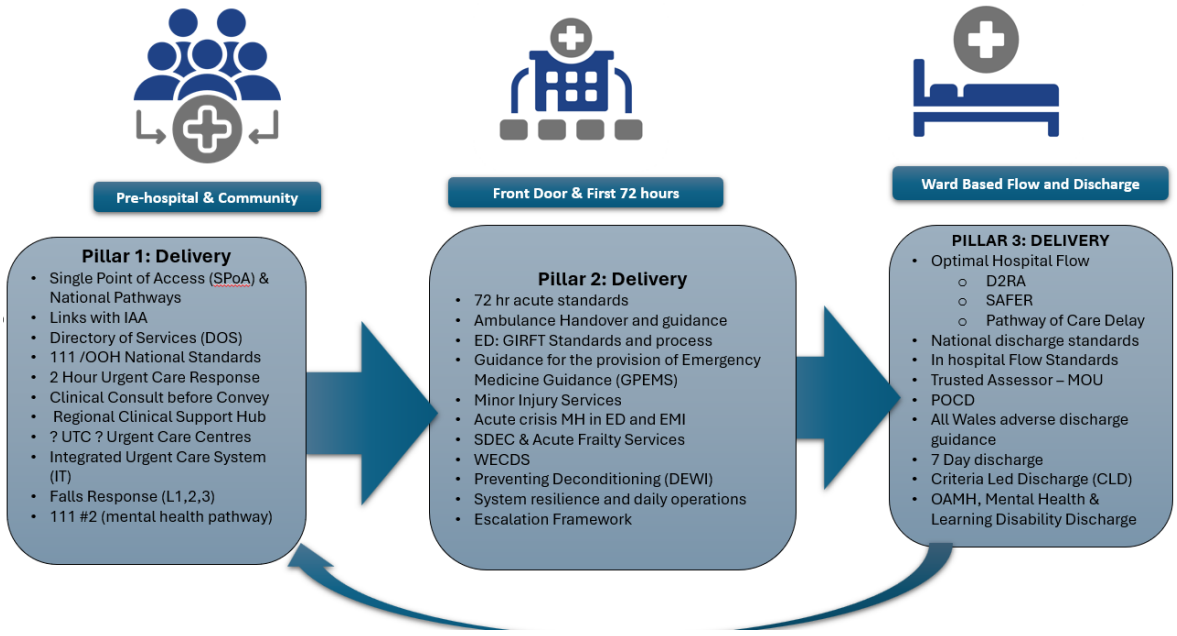
proven improvement methods and building capability in clinical and operational teams, the organisation can reduce unwarranted variation and make improvement a routine way of working rather than a time-limited initiative.

While the Health Board remains at its current escalation level, the governance structure described in this plan should remain in place. Following de-escalation, ongoing UEC programme oversight should continue through business-as-usual arrangements so that gains are maintained.

## 18. Alignment to National Strategy and Plan

The National UEC Programme's Plan for 2026/27 was shared across Health Boards at the Urgent and Emergency Care summit on the 27th of April 2026. The following diagram outlines the national approach in 2026/27:

**Diagram 10: National Urgent and Emergency care Programme Delivery pillars**




The Health Board has been engaging with NHS P&I colleagues to ensure that the plan in development is aligned with national expectations. To ensure that there are no significant gaps there has been a process of mapping the project and improvement work to the national pillars which evidenced close alignment of:

Pillar 1: Pre-hospital and Community to the 'Place Based Care' Programme

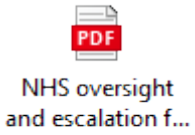
Pillar 2: Front Door and First 72 Hours to 'Our Next Patient' workstream and;

Pillar 3: Ward Based Flow and Discharge to the Integrated Discharge workstream

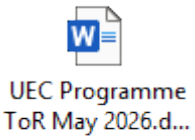
The feedback from NHS P&I is that the approach and plan outlined meets the expectations of the national team. There will be continual engagement with NHS P&I colleagues on the delivery of the plan and meeting the national programme's ongoing requirements.

## 19. Appendices

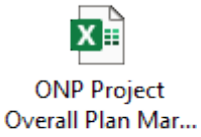
- **Appendix 1** - February 2026 Welsh Government Escalation Framework for the Health Board



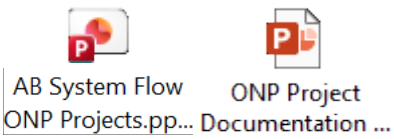

- **Appendix 2** - UEC Programme Board Terms of Reference



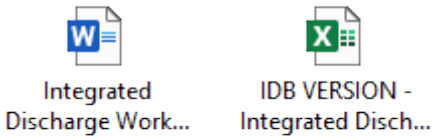

- **Appendix 3** - Overarching project plan for Our Next Patient



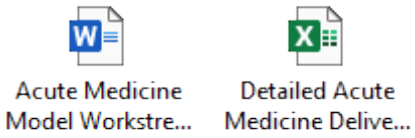

- **Appendix 4 –** Our Next Patient Workstream Documentation including blank example



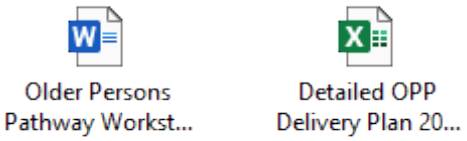

- **Appendix 5 –** Integrated Discharge Board Delivery Timeline



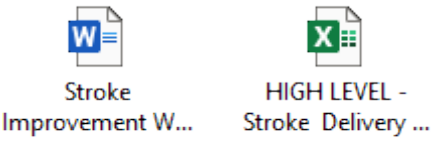

- **Appendix 6 –** Acute Medicine Delivery Timeline




- **Appendix 7 –** Older Person Pathway Delivery Timeline




- **Appendix 8 –** Stroke Delivery Timeline



| | |
|---|---|
| GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board | **CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN**<br>**ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING** |

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Annual Plan 2025/27 Delivery Framework |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Hannah Evans, Director of Strategy, Planning and Partnerships |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Claire Nelson, Deputy Director of Strategy, Planning and Partnerships |

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

| **ADRODDIAD SCAA**<br>**SBAR REPORT** |
|---|
| **Sefyllfa / Situation** |
| This paper sets out how delivery of Aneurin Bevan University Health Board's Annual Plan 2026/27 will be supported through six Priority Programmes each with clear delivery milestones and reporting structures as well as a refreshed Value and Sustainability portfolio of work. The paper identifies where there is overlap between these delivery mechanisms.<br><br>The Board is asked to take:<br><br>**Assurance** that the Priority Programmes alongside the Value and Sustainability Portfolio will support delivery of the Annual Plan 2026/27. |

## Cefndir / Background

In March 2026 the Board approved for submission to Welsh Government the 2026/27 Annual Plan. The Plan is framed against the strategic aims as set out in the Gwent 35 organisational strategy and serves as a key vehicle to drive strategy delivery. In addition, the plan responds to the NHS Planning Framework and sets out the commitments in response to the national requirements and the national priorities of Population Health & Prevention, Timely Access to Care (UEC and Planned Care and Cancer), Women's Health and Community by Design. A key part of the Plan is the milestones and deliverables associated with enablers including the underpinning financial plan which includes a significant savings requirement.

Plan delivery and execution in line with the commitments is key. Delivery of the plan is a key requirement of the Health Board's national escalation status framework. Plan execution is done via a number of inter-related means:

- Via the management structures through the Performance and Accountability Framework (PMF)
- Via whole system Priority Programmes
- Via the Value and Sustainability portfolio

## Asesiad / Assessment

**Performance and Accountability Framework (PMF)**

The PMF was updated in late 2025 (following initial launch in 2023) and is due to be fully deployed during 2026/27. As part of the PMF, all Executive Directors will receive Accountability Agreements which in effect are the relevant elements (financial, service change, performance etc) of the Annual Plan cascaded into their objectives in a transparent and explicit way. These Accountability agreements will be issued in May 2026. In turn, each Division will receive an Accountability agreement setting out the delivery expectations of Divisions across the breadth of plan commitments, these letters will be issued before the end of Q1. These expectations form the basis of the Assurance and Performance reviews throughout the year in line with the PMF. Chief Executive led reviews of each Division happens at the mid year and end of year point in line with the PMF with escalation levels are considered as a minimum after each cycle of reviews. The Integrated Performance Report tracks delivery against the trajectories as committed to in the plan and is presented to each Finance and Performance Committee and Board meeting. On a Quarterly basis the performance report includes progress against key non quantifiable deliverables.

**Value and Sustainability Portfolio**

Building on last year's approach, financial plan delivery will be supported and enabled via the Value and Sustainability Board (VSB) mechanism. Mirroring the

national approach, the key programmes supporting the identification and realisation of efficiencies are:

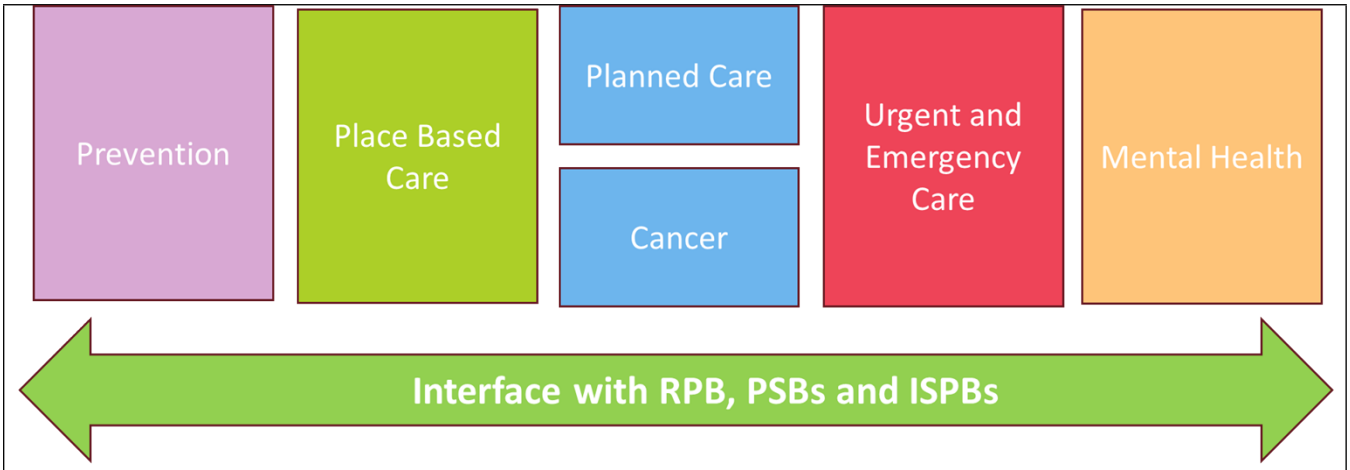
| **Saving project/workstream** | **Exec Lead** | **Delivery mechanism** |
|---|---|---|
| Right sizing bed base | COO – LW | Older persons pathway |
| Mental Health & LD service and estate transformation | COO -LW | Service transformation |
| Theatre Capacity - Rightsizing | DoP – HE | Theatre project group |
| Estates Opportunities | DoP – HE | Estates Strategy Group |
| Therapies Workforce review | DAHP – PC | tbc |
| Medicines Management | MD – SSr | Medicines Management Programme Board |
| Continuing Health Care (CHC) | COO – LW | CHC Programme Board |
| Workforce | WOD – Ssi | Workforce Group |
| Non-Pay | DOF – RH | Non-Pay Group |
| Evidence Based Interventions (EBI) | MD – SSr | tbc |
| Efficiency (Outpatients Programme) | COO – LW | tbc |
| Corporate | DOF – RH | Dependent on focus area |
| Commissioning - SLAs | DOF – RH | Non-pay Group |

Reports against the VSB overall will be via the progress reports to Finance and Performance Committee with additional supplementary papers and reports on areas as required.

**Priority Change programmes**

A programme approach is deployed to both support Divisions and corporate teams drive delivery across the organisation.

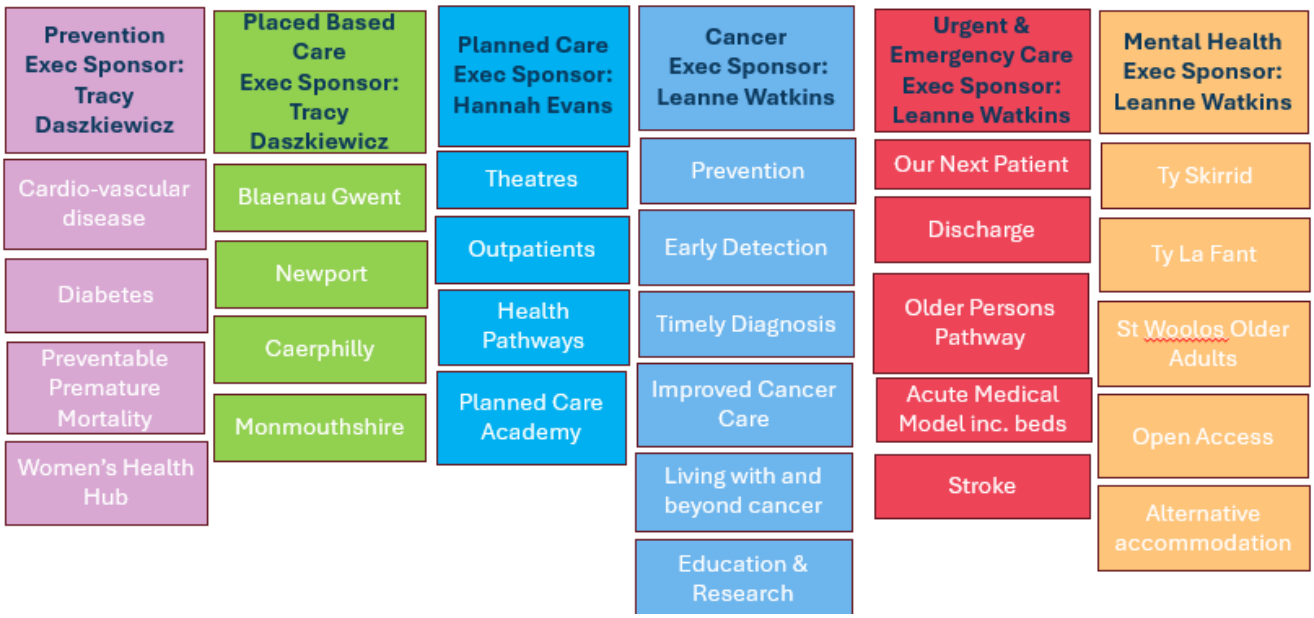
Following engagement with the Executive Team the following six Priority Programmes are established within the Health Board to support delivery of the Annual Plan 2026/27:




These priority programmes cover the priority areas set within the NHS Wales Planning Framework with the Urgent and Emergency Care Programme leading on Pathway of Care Delays, Place Based Care encompassing Population Health and Primary and Community Care and Women's Health featuring within the Prevention Programme. It is also recognised that cross programme working will be required to deliver a number of the priorities.

The Programmes each have an Executive Lead, SRO, Senior Programme Management support and identified Workforce and Finance Leads. Programme Boards are in place for five out of six Programmes with the remaining Programme due to have one established by the end of Q1.

The Programmes have the following priority workstreams within them.



As newly established Programmes, Placed Based Care and Prevention and the workstreams that sit within them are in the process of being finalised to ensure alignment between them and with other Programmes.

The 2026/27 Plan includes as part of the appendices a summary of each Programme. Whilst planning has moved on since time of submission, these are included in this report for completeness in appendix 1.

Each of the Programmes are supported by the Health Board's Transformation and Delivery team, and have clear reporting documentation of a programme on a page at the start of the year and monthly highlight reports.

The benefits to be realised by each Programme are set out in these documents to enable effective progress monitoring and if delivery is off track, the reasons for this and mitigation to return on track can be advised. The Programmes on the page are included as appendix 2. Due to scale of programme, the UEC programme has a Plan on page for each workstream. The workstreams have or will have underpinning more detailed project plans and supporting information.

**Reporting arrangements**

The Programmes will report to Executive Committee and then through to Planning, Populations Health and Partnerships Committee. Finance and Performance Committee will receive detailed updates on the UEC programme and financial performance as it directly aligns to national escalation levels.

**Deep Dives**

Annual Deep Dives on each of the Priority Programmes will be presented to the Public Board to provide additional assurance of the delivery of the changes noting that the individual Programme Boards will be the route for escalation for delivery. These are scheduled as follows:

**May:** Urgent and Emergency Care

**July:** Planned Care and Cancer

**September:** Prevention and Place Based Care

**November:** Mental Health

**Argymhelliad / Recommendation**

The Board is asked to take **Assurance** that the Priority Programmes alongside the Value and Sustainability Portfolio will support delivery of the Annual Plan 2026/27 and updates will be provided via Population Health, Planning and Partnerships committee, Finance and Performance Committee and the Integrated Performance report. This regular reporting will be supplemented via a series of Deep Dives through to Board.

## Atodiad / Appendix

Appx 1 Annual Plan 26-27 Appendices Pı

Appx 2 Priority Programmes Plan or

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | SSR01 Service Delivery, Score: 12 |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 3. Effective Care<br>5. Timely Care<br>7. Staff and Resources<br>1. Staying Healthy |
| Blaenoriaethau CTCI<br>IMTP Priorities<br>Link to IMTP | Choose an item. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Experience Quality and Safety |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br>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 |

| **Gwybodaeth Ychwanegol:**<br>**Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | GIRFT (Getting it Right First Time) |

| | |
|---|---|
| Rhestr Termau:<br><br>Glossary of Terms: | BCI: Business Continuity Incidents<br><br>ONP: Our Next Patient<br><br>SRO: Senior Responsible Officer<br><br>UEC: Urgent and Emergency Care |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br><br>Parties / Committees consulted prior to University Health Board: | March 2026: First draft of Plan to Executive Committee |

| **Effaith: (rhaid cwblhau)**<br><br>**Impact: (must be completed)** | |
|---|---|
| | Is EIA Required and included with this paper |
| **Asesiad Effaith Cydraddoldeb**<br><br>**Equality Impact Assessment** (EIA) completed | Yes not yet available<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br><br>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**<br><br>**Well Being of Future Generations Act – 5 ways of working**<br><br>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 |

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

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

# IMTP Appendices for Priority Programmes



## Mental Health

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

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

## Performance in 25/26

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

# IMTP Appendix 4: Mental Health Transformation Programme, Achievement 25/26 & Focus 26/27

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

**Programme Key Achievements in 25/26**

During 25/26 we delivered the following achievements:

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

## Focus for 26/27

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

## IMTP Appendix 4 Mental Health Delivery against Strategic Aims (26/27)

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

## IMTP Appendix 4 Mental Health Performance expectations and performance against enabling action

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

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

## Place Based Care

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

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

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

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

### Performance for 25/26

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

# Place Based Care Transformation Programme, Achievement 25/26 & Focus 26/27

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

## Programme Key Achievements in 25/26

During 25/26 we delivered the following achievements:

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

## Place Based Care Focus for 2026/27

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

## Delivery against Strategic Aims (26/27): Placed Based Care

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

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

## Place Based Care

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

## Urgent & Emergency Care

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

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

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

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

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

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

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

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

## Performance in 25/26: Urgent & Emergency Care

| Delivery Expectation | ABUHB commitment | In month performance against trajectory |
|---|---|---|
| Reduce the number of ambulance patient handovers over 1 hour | **500** Mar-26 | **687** Feb-26 (Feb-26 Trajectory: 578) |
| Reduce the number of ambulance crew hours lost at GUH ED (per month) | **2,500** Mar-26 | **2,302** Feb-26 (Feb-26 Trajectory: 2,750) |
| Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero | **750** Mar-26 | **1,089** Feb-26 (Feb-26 Trajectory: 731) |
| Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU | **80%** Mar-26 | **73.3%** Feb-26 (Feb-26 Trajectory: 80%) |
| Reduction in time from arrival to ED triage - no waits over 60 minutes | **200** Mar-26 | **343** Feb-26 (Feb-26 Trajectory: 250) |
| Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months. | **60** Mar-26 | **136** Feb-26 (Feb-26 Trajectory: 70) |
| Maintain the number of Urgent Primary Care contacts (inc. virtual) | **95,147** Mar-26 | **80,564** Jan-26 (Q4 Trajectory: 95,147) |
| % of patients directly admitted to an acute stroke ward <4hrs of clock start | **20%** Mar-26 | **1.2%** Q2 25/26 (Q2 Trajectory: 20.0%) |
| % of unique stroke patients given thrombectomy (all stroke types) | **6%** Mar-26 | **1.8%** Q2 25/26 (Q2 Trajectory: 6.0%) |
| % Assessed by OT within 24 hours | | **21.9%** Jan-26 |
| % Assessed by PT within 24 hours | | **18.8%** Jan-26 |
| % Assessed by SaLT within 72 hours | | **75.8%** Jan-26 |
| Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard | **160** Mar-26 | **180** Feb-26 (Feb-26 Trajectory: 170) |
| Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard | **6437** Mar-26 | **6,165** Feb-26 (Feb-26 Trajectory: 7,184) |
| Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment | **12** Mar-26 | **13** Feb-26 (Feb-26 Trajectory: 14) |
| Continuous reduction in the number of people admitted as an emergency who remain in hospital over 21 days since admission | **370** Mar-26 | **445** Jan-26 (Jan-26 Trajectory: 380) |

# Urgent & Emergency Care Transformation Programme, Achievement 25/26 & Focus 26/27

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

**Programme Key Achievements in 25/26**

During 25/26 we delivered the following achievements:

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

## Urgent and Emergency Care Focus for 26/27

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

## Delivery Against Strategic Aims 2026/27 Urgent & Emergency Care

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

| Performance Expectations 26/27 | | National Target | Meet Target? | Baseline | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard | MD | ↓ | Yes | 180 | 150 | 140 | 130 | 120 |
| Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard | MD | ↓ | Yes | 6,085 | 4,500 | 4,200 | 4,160 | 3,840 |
| Ensure no ambulance patient handover waits over 45 minutes - All Locations | MD | 0 | No | 1,471 | 733 | 455 | 374 | 364 |
| Ensure no ambulance patient handover waits over 45 minutes – Grange University Hospital Emergency Department | TI | 11% ↓ for 3 months | Yes | 943 | 578 | 400 | 330 | 320 |
| Reduce the number of ambulance crew hours lost – All Locations | | - | - | 3,556 | 1,949 | 1,250 | 1,031 | 960 |
| Reduce the number of ambulance crew hours lost – Grange University Hospital Emergency Department | | - | - | 2,653 | 1,559 | 1,000 | 825 | 768 |
| Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero | MD | 0 | No | 1,089 | 1,066 | 875 | 908 | 799 |
| Increase and maintain national target of the percentage of patients waiting <4 hours in Emergency Department/Minor Injury Units | | 95% | No | 73.5% | 75% | 76% | 76% | 77% |
| Reduction in time from arrival to Emergency Department triage: no waits over 60 mins | | - | - | 414 | 300 | 200 | 400 | 200 |
| Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three | TI | <60 mins | Yes | 135 mins | 100 | 80 | 80 | 60 |

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

## Planned Care & Cancer

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

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

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

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

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

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

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

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

## Performance in 25/26 Planned Care & Cancer

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

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

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

## Programme Key Achievements in 25/26

During 25/26 we delivered the following achievements:

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

## Planned Care Focus for 2026/27

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

## Cancer Focus for 26/27

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

## Delivery against Strategic Aims (26/27)

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

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

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

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

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

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

# Programmes Overview

| Programme | Executive Sponsor | SRO | SPM | Workforce Lead | Finance Lead | Workstreams |
|---|---|---|---|---|---|---|
| **Decarbonisation** | Robert Holcombe | James Hodgson | Terry Watkins | Cathy Brooks | Robert Jones | Facilities Group |
| | | | | | | Communications Group |
| | | | | | | Clinical Health Care Group |
| | | | | | | Resources Group |
| | | | | | | Waste Group |
| **End of Life Care** | Jennifer Winslade | Tracey Partridge-Wilson/ Tanya Strange | Jamie-Lee Cook (Service Improvement Manager) | TBC | Tristan Harris | Workforce Development and Capability |
| | | | | | | Integrated Clinical Delivery |
| | | | | | | Digital, Data and Quality Intelligence |
| | | | | | | Bereavement, Carer Support and Engagement |

# Value & Sustainability Board priorities

| Theme | Areas | QIA | Within Priority Programmes? |
|---|---|---|---|
| Capacity Reduction | Beds – Reset bed base, focus on medical and community | Closure of x2 Medicine wards<br>Closure/redesignation of Monnow Vale, 19 beds<br>Closure/redesignation of Redwood Unit, 12 beds | Yes |
| | Theatres – Delivery and consolidation of efficiencies to reduce capacity, do same through less | • Realignment of theatre model | Yes |
| Service Changes | Mental Health – OAMH reconfiguration (3 sites to 1) | N/A | Yes |
| | Redesign Acute Medicine<br>Redesign Frailty/COTE – Model to Execs/Board March 2026 | N/A | Yes |
| Estate | SWH Phase 1 Rationalisation complete<br>SWH Phase 2 Agree plan and implement | N/A | Partially |
| | MH Estate reduction footprint (linked with service change/YTC opportunity) | N/A | Yes |
| Digital | Use of digital to realise savings: RPA, Ambient AL, new O365 | N/A | N/A |
| Non-Clinical | Admin & Clerical/'back office' opportunities<br>Linked to digital enablers | N/A | N/A |

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

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

# Priority Programmes plan on a page



# Placed Based Care Programme on a Page 2026/27

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Programme Aims & Objective** | Build resilient and connected communities, reduce health inequalities, reduce preventable morbidity and mortality, provide care and support closer to home and streamline access to specialist care by bringing together members of the community, organisations, services and teams who are responsible for the health and well-being of the population/community within a place. | | | | | | | | |
| **Executive Lead** | Tracy Daszkiewicz | **SPM** | Kate Williams | **SRO** | Lloyd Hambridge | **Workforce Lead** | Cathy Brooks | **Finance Lead** | Chris Commins |

| Workstreams & Priorities | Key Deliverables | Intended Benefits *(include KPIs, Finance and Performance data)* | Interdependencies & Risks |
|---|---|---|---|
| To be confirmed | Establish Place-Based Care (PBC) and Population Health Management (PHM) operating model – Agreed and implemented across ISPBs and neighbourhoods, including linked health, social care and wider determinants datasets.<br><br>Core-funded neighbourhood workforce models – Decisions and implementation for IWN Leads, CIOs, Health Coaches, MDT Coordinators, PHPs and Diabetes Prevention Programme.<br><br>Single, accessible digital and community asset directory – A Gwent-wide platform providing clear routes to wellbeing support, social prescribing and community assets, co-maintained with Third Sector partners.<br><br>Strengthened community infrastructure and engagement model – IWN collaboratives embedded, community anchor organisations identified and supported, and residents actively shaping local priorities.<br><br>Development of new models of care for earlier access and prevention – Including Inclusion Health and peer support models, women's health at place level, and initial pathways (e.g. breathlessness) | Reduced health inequalities and preventable demand<br>– Targeted interventions in areas of greatest deprivation using PHM intelligence and local data.<br><br>Care delivered closer to home<br>– Improved access to prevention, assessment and support through neighbourhood MDTs, social prescribing and community services.<br><br>Improved system flow and reduced pressure on acute services<br>– Alignment with UEC Improvement and Stabilisation Plan, supporting earlier escalation prevention and timely discharge.<br><br>More efficient and sustainable use of resources<br>– Reduced duplication through consistent models, clearer workforce roles and shared digital infrastructure.<br>Stronger investment case for place-based prevention and early intervention<br><br>– Clear articulation of foundational, enabling and legacy roles supporting long-term population health outcomes. | Workforce funding and sustainability decisions<br>– Risk of delivery gaps if core funding decisions are delayed or inconsistent across 26/27 and 27/28.<br><br>Data availability, linkage and digital capability<br>– Dependency on timely access to high-quality linked datasets and functional digital platforms.<br><br>System alignment and governance clarity<br>– Risk of duplication or slowed delivery without clearly embedded governance across RPB, ISPBs and the PBC Programme Board.<br><br>Third Sector and community capacity<br>– Reliant on the capacity and resilience of community anchor organisations, particularly in deprived areas.<br><br>Implementation pressure and variable local implementation<br>– Risk of uneven delivery across Gwent if engagement, communication and support for places and neighbourhoods is inconsistent. |

**Q1/Q2 milestones**

- Review Governance Structure RPB, ISPB and Place Based Care Programme Board and Partnerships
- Establish a PHM operating model across the partnership.
- Use existing linked datasets within the data warehouse to identify cohorts at risk
- Blaenau Gwent/Torfaen ISPB to present PBC model to AB Execs
- Undertake a review to assess whether First Contact MSK model is being delivered equitably in Gwent

**Q3/Q4 milestones**

- Build or enhance a digital platform providing: Easy access to wellbeing and community information; Clear routes to request support/link worker contact
- Agree approach to a single, accessible directory of community assets, co-maintained with Third Sector partners
- Maintain and strengthen IWN collaboratives
- ISPBs identify existing and potential community anchor organisations, prioritising growth in deprived communities
- Use Public Health data/local intelligence to identify: Variations in community capacity between places; areas with the greatest inequality/ disadvantage

# Planned Care Programme on a Page 26/27

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Programme Aims & Objective** | The Planned Care Recovery Programme brings together 6 goals (**Outpatients, Theatres Maximisation, Keeping Well, Health Pathways, Planned Care Academy and Diagnostics**) in line with the WG national programme and planned care response. Progress in each of the workstreams is being made, which feed into the overall HB and national agenda. | | | | | | | | |
| **Executive Lead** | Hannah Evans | **SPM** | Catherine Pugh | **SRO** | Julie Poole | **Workforce Lead** | Angela Palfrey | **Finance Lead** | Greg Bowen |

## Workstreams & Priorities

- **Outpatients**
- **Keeping Well**
- **Theatres Maximisation**
- **Health Pathways**
- **Planned Care Academy**
- **Diagnostics**

**Priorities**

- Theatres Programme for 2026/27
- Ongoing exploitations of opportunities in CIN Optimisation Frameworks.
- Development of Validation plan
- Outpatients review of SOS and PIFU and retrospective application of pathways. Reduction in follow up waiting list.

## Key Deliverables

- Establishment of a Theatres Optimisation Programme with associated workstreams for 2026/27.
- Implement a consistent 8-hour full-day operating list model for all standard day elective theatres.
- Deliver priority HealthPathways for 2026/27 and plan beyond when national funding ceases.
- Development of a booking app for outpatient clinic departments to support increased utilisation of outpatient space.
- Development and implementation of validation plan.

## Intended Benefits

*(include KPIs, Finance and Performance data)*

| | Baseline (April 26) | Target (Mar 27) |
|---|---|---|
| **Theatres:** | | |
| Utilisation 83.10% | | 85% |
| Late Starts 37% | | 25% |
| Early finishes 30.70% | | 15% |
| **Referral Rates:** | | |
| Reduction in referral rate: 900 (per 100,000) | | 800 (per 100,000) |
| **Outpatient Transformation:** | | |
| 104 weeks: 21 | | 3,022 |
| 8 week diagnostic: 233 | | 0 |
| SOS & PIFU Rate 12.7% | | 15% |
| 100% past target follow ups 30,819 | | 23,606 |
| Finance savings assoc. with Theatres Optimisation programme | | £0.5m |

## Interdependencies & Risks

**Interdependencies**

- Cancer Programme
- UEC Programme
- Value and Sustainability
- Digital/Finance/Workforce

**Risks**

- Reduced capacity of HealthPathways team which may slow implementation and reduce benefits affecting ability to secure funding.
- E-advice – timescale of delivery may be delayed further due to competing priorities.
- Theatres Optimisation Programme: Support for reviewing job plans and implications of changes to long standing ways of working

## Key Milestones

**Q1/Q2**

- Implement additional 8 new HealthPathways each quarter.
- Drive improvements in late starts/early finishes & theatres.
- Implement Validation Strategy.
- Pilot of outpatient booking app in RGH.

**Q3/Q4**

- Evaluate impact of HealthPathways to determine ongoing commitment
- Further Did Not Attend/Can Not Attend deep dives.
- Roll out of booking app to NHH and YYF.

# Transforming Cancer Services Programme on a Page 2026/27

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Programme Aims & Objective** | The Planned Care Recovery Programme brings together 6 goals (**Outpatients, Theatres Maximisation, Keeping Well, Health Pathways, Planned Care Academy and Diagnostics**) in line with the WG national programme and planned care response. Progress in each of the workstreams is being made, which feed into the overall HB and national agenda. | | | | | | | | |
| **Executive Lead** | Leanne Watkins | **SPM** | Clare Small | **SRO** | Arvind Kumar | **Workforce Lead** | Cathy Brooks | **Finance Lead** | Phil Meredith |

| Workstreams & Priorities | Key Deliverables | Intended Benefits *(include KPIs, Finance and Performance data)* | Interdependencies & Risks |
|---|---|---|---|
| • Prevention<br>• Early Detection<br>• Timely Diagnosis<br>• Improved and Standardised Care<br>• Living well With & Beyond Cancer<br>• Improving our Knowledge of Cancer | • Development of the Gwent Cancer Plan 35 with KPIs, datasets, communication plans and full programme implementation plan for each of the work streams.<br>• Strengthened cancer prevention and early detection engagement model– developing collaborations with third sectors organisation, communications & engagement, and community resources.<br>• Support focused attention in raising awareness of lifestyle risk factors and supporting more vulnerable communities.<br>• Enable people to have their cancers picked up early<br>• Improving the number of people being diagnosed with cancer at an early stage.<br>• Help people living with, and after cancer to have access to advice and support tailored to their needs.<br>• Work along side Velindre Cancer Centre to develop SACT Outreach inline with the nVCC opening in 2027. | • Reduced cancer inequalities through the Cancer Pathway, including prevention and early detection interventions (Screening programmes) and equity through the SCP. Targeted interventions in areas of greatest deprivation using local data.<br>• Improved HPV Vaccination rates and Cervical Cancer screening uptake to support Wales approach to eliminate Cervical Cancer.<br>• Improved Screening uptake across, Bowel, Cervical and Breast Cancer Screening programmes.<br>• Care delivered closer to home – Improved access to cancer treatments for patients in Gwent via VCC Outreach facilities at ABUHB<br>• Improved system flow and reduced pressure on 62 day SCP and mproved patient experience | • Workforce funding and sustainability decisions – Risk of delivery gaps if core funding decisions (prehab/psychology) are delayed or inconsistent across 26/27 and 27/28.<br>• Data availability, linkage and digital capability – Dependency on timely access to high-quality linked datasets and functional digital platforms.<br>• Implementation pressure and variable local implementation – Risk of uneven delivery across Gwent, if local engagement with patients, primary care and third sector is variable.<br>• Financial sustainability to support engagement activity and resources. |

- Development of the Gwent 35 Cancer Plan: scoping, evaluation of previous strategy and workshops
- Identify gaps in screening uptake and methods for improving engagement in screening

- Development of engagement activity to support prevention and early detection messaging
- Delivery of the big Cancer Conversation to support community and third sector engagement in the development and delivery of the Gwent 35 Cancer Plan

*TIMELINES SUBJECT TO CHANGE

# GWENT CANCER PLAN 2035 DEVELOPMENT BY ABUHB*

**11 MARCH 2026**
Cancer Conference Launch of Cancer 2035 planning

Evaluation of workshop content

**SPRING 2026**
Evaluation of previous strategy

Gwent Caner Plan Workshop Preparation

**JUNE 2026**
Plan Proposal to Executive Board

**30 JUNE 2026**
ABUHB Cancer Plan Workshop **Pillar 1 Prevention & Pillar 2 Early Detection**

**2 JULY 2026**
ABUHB Cancer Plan Workshop **Pillar 3 Timley Diagnosis & Pillar 5 Living with and beyond cancer**

**6 JULY 2026**
ABUHB Cancer Plan Workshop **Pillar 4 Improved and standardised cancer care & Pillar 6 Improving our knowledge of cancer**

**SUMMER - WINTER 2026**
Engagement sessions with partners to develop actions for plan achievement

**JANUARY 2027**
Draft to Cancer Board

**10 MARCH 2027**
ABUHB Cancer Conference

**LAUNCH EVENTS SPRING 2027**
Partner Launch Event (tbc)

## Community Engagement for Gwent Cancer Plan 2035 development

BeVan

Working alongside current planned engagement events for Prevention and early detec

Linked to Gwent 2035 lifestyle timelines

Big Cancer Conversation TBC pending funding

Social Media & Stake holders

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# Mental Health & LD Transformation Programme on a Page 2026/27

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Programme Aims & Objective** | Deliver consistent, sustainable Models of Care to improve timely access and outcomes, reduce variation and inequalities and minimise avoidable admissions and out of area placements, ensuring delivery within existing workforce and estate capacity in the context of rising demand. | | | | | | | | |
| **Executive Lead** | Leanne Watkins | **SPM** | Sarah Parks-Jones | **SRO** | Louise Turner | **Workforce Lead** | Paula Michell | **Finance Lead** | Phillip Meredith |

| Workstreams & Priorities | Key Deliverables | Intended Benefits | Interdependencies & Risks |
|---|---|---|---|
| **Workstream 1 – Adult Mental Health (AMH)**<br>Improve access, reduce waits, and shift care to community-based models, reducing avoidable admissions.<br>**Workstream 2 – Learning Disabilities (LD)**<br>Improve equitable access and outcomes while reducing avoidable admissions and reliance on out-of-area placements through strengthened community alternatives.<br>**Workstream 3 – Older Adult Mental Health (OAMH)**<br>Improve timely diagnosis and care through reduced delays and stronger early intervention and strengthened pathways.<br>**Workstream 4 – Open Access**<br>Enable faster, simpler access with effective triage and navigation, reducing pressure on crisis services. | • Implement consistent, scalable Models of Care across MH & LD services<br>• Improve access standards and patient flow, reducing waiting times and backlogs.<br>• Reduce avoidable admissions and out-of-area placements.<br>• Shift care from inpatient to community settings where clinically appropriate.<br>• Align service delivery to workforce, estate and financial capacity.<br>• Delivery of **bed and estate efficiencies** through redesigned models of care aligned to the Annual Plan | • Faster access to assessment and treatment (reduced referral-to-assessment waits).<br>• Improved clinical outcomes and reduced inequalities.<br>• Reduction in avoidable admissions and out-of-area placements (MH & LD).<br>• Increased proportion of care delivered in community settings.<br>• Improved system flow, sustainability and delivery confidence.<br><br>(Indicative measures to be monitored through performance dashboards and IMTP reporting.) | **Interdependencies**<br>• Workforce availability, skill mix and productivity.<br>• Data and digital capability to support demand and capacity modelling, SPA and 111.<br>• Integration with primary care, third sector, local authorities and partner organisations.<br>• Estate capacity, optimisation and availability of alternative accommodation options.<br>**Risks**<br>• **Demand exceeding capacity:** Managed through phased implementation, demand modelling and prioritisation.<br>• **Backlog reduction slower than planned:** Focused pathway redesign and targeted backlog initiatives.<br>• **Open Access increasing demand beyond plan:** Controlled triage, clear thresholds and continuous monitoring.<br>• **Workforce recruitment and retention challenges:** Workforce redesign, skill mix optimisation and targeted recruitment.<br>• **Estate and funding constraints:** Estate optimisation and alignment to financial planning cycles |

| Q1/Q2 | Key Milestones | Q3/Q4 |
|---|---|---|
| • Open Access (SPA/111) embedded with agreed triage and governance.<br>• Demand and capacity modelling completed.<br>• Early access improvements implemented.<br>• Backlog reduction initiatives commenced. | • Models of Care implemented across pathways.<br>• Measurable reductions in waiting lists and avoidable admissions.<br>• Reduced reliance on out-of-area placements.<br>• Models embedded and performance stabilised. | |

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# Urgent and Emergency Care Programme:

# Priority workstreams plan on a page



# Our Next Patient Programme on a Page 2026/27

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Programme Aims & Objective** | The aim of the ONP initiative is to implement a continuous flow model designed to facilitate prompt ambulance handovers, and reduced 12 hour stays in ED, thereby enhancing patient experience and outcomes. Additionally, this approach aims to mitigate risks present in community settings. | | | | | | | | |
| **Executive Lead** | Leanne Watkins | **SPM** | Becky Goode | **SRO** | Matt Temby | **Workforce Lead** | Angela Palfrey | **Finance Lead** | Tristan Harris |

| Workstreams & Priorities | Key Deliverables | Intended Benefits *(include KPIs, Finance and Performance data)* | Interdependencies & Risks |
|---|---|---|---|
| • ONP encompasses 16 projects that have been selected to deliver operational improvement opportunities throughout the entire system and all divisions.<br>• Each division is responsible for managing its respective projects and, upon completion, identifying subsequent opportunities for improvement | Multiple Deliverables across 16 projects that include (but not limited to):<br>• Improve WTBS to ensure that every ED patient receives clinical assessment, within 60 minutes<br>• Meet the national standard of no ambulance waits longer than 45 minutes<br>• Implementing a safe, efficient direct streaming pathway from ED to SAU.<br>• streamline access to the Respiratory Ambulatory Care Unit (RACU)<br>• Streamlining and booking of transport via GUH lounge and increased usage of eLGH lounges<br>• Provision of Medical cover with CAL | • Ambulance handover staged improvement of 11% per month for 3 months (at 60 mins)<br>• An increase in the proportion of patients spending less than 4 hours in EDMIU by 3.7%<br>• A Reduction in ambulance lost hours at GUH ED by 66%<br>• A reduction in the proportion of patients spending over 12 hours in EDMIU by 7%<br>• An increase in the proportion of patient discharges pre-midday by 1.5% | • Interdependent UEC Programme Workstreams<br>• Place Based Care Programme<br>• Cross Divisional Accountability<br>• Operational Demand and Capacity<br>• Pathway of Care Delays<br>• Workforce Sustainability<br>• ED & Assessment unit capacity<br>• Community Capacity<br>• Digital Enablers & WECDS |

## Key Milestones

| Q1/Q2 | Q3/Q4 |
|---|---|
| • Implement ED Extension Phase 2 design and clinical Model<br>• Launch Quality improvement Project mapping exercise<br>• Roles & Responsibilities workshop to focus on level 1 process and patient movement<br>• Radiology prepare 'push ' model to reduce request to scan times | • Develop early-intervention pathways for COPD returning patients<br>• Diverting suitable patients to SAU in line with agreed streaming criteria<br>• Implement a clear pathway for Neck of Femur (NoF) patients, enabling direct ward blocking/authorisation rather than SAU transfer. |

# Acute Medicine Model - Programme on a Page 2026/27

| | |
|---|---|
| **Programme Aims & Objective** | Acute medicine model focuses on providing high-quality, sustainable healthcare through a service approach designed to meet the needs of the Gwent population, supported by a sustainable and deliverable workforce model and the efficient, effective use of resources. This involves a full redesign of the acute medical service to generate system-wide efficiencies across the Health Board, strengthen workforce sustainability, and improve patient outcomes and flow. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Executive Lead** | Leanne Watkins | **SPM** | Kate Fitzgerald | **SRO** | Christopher Heath | **Finance Lead** | Karen Archer | **Workforce Lead** | Helen Drew-Jones |

## Workstreams & Priorities

**1. Hospital Discharge Assistants** – Align HDA's to support AMU in GUH and timely flow, define the role required to support actions to facilitate timely discharge or progression to the next stage of the pathway.
**2. GP in SDEC** – Define the scope of the role, improve front door streaming and triage. Strengthen links between primary care & community services to avoid admission where appropriate and monitor impact using daily activity data.
**3. Alternative Pathways** – Align current and pathways under development to the new Older person pathway ensuring delivery timeframes knit together for seamless implementation, ensuring alignment with the SPOA.
**4. Acute Medicine Optimal Model –** Develop an options appraisal supported by detailed aligning to the older person pathway.
**5. Self Assessment Tool Model Acute Pathway** – Complete NHS England Self Assessment tool to inform, identify and prioritise areas for improvement.
**6. Operational Process Review** – Identify opportunities to streamline key operational processes such as clerking, assessment and documentation workflows. This piece of work will compliment the below workstream.
**7. Data and Digital –** Explore digital solutions such as symphony to support AMU and develop mapping and implementation plans to support In line with the above modelling.

## Key Deliverables

- Deliver timely, high-quality assessment at the front door
- Increase early senior clinical decision making
- Expand ambulatory and same-day emergency care pathways
- Reduce avoidable admissions and unnecessary bed days
- Improve patient flow and reduce delays across the pathway
- Standardise acute medical processes and models of care
- Strengthen integration with frailty and community services
- Implement digital system to monitor, track and report performance in real time
- Use data, benchmarking and performance metrics to drive continuous improvement
- Support development of a sustainable, future acute medicine model

## Intended Benefits

- Improve front door assessment, aligned to the NHS England Acute Model Pathway (2026)
- Strengthen early clinical decision-making
- Enhance patient flow
- Reducing avoidable admissions
- Optimising length of stay
- Developing a sustainable long-term acute medicine model
- Improve outcomes and patient experience across the system.

***Improvement can be tracked through:***

- Improvement in Handover 45
- Monitoring of activity
- SDEC – LOS/outcomes
- First 72-hours standards
- Preventing Deconditioning Tool usage

## Interdependencies & Risks

***Interdependencies:***

- Single Point of Access
- Older Person Pathway
- Place Based Care
- Planned Care
- Digital/workforce/finance

***Risks:***

- Acute Medicine Consultant Resource
- Scale of the change to be delivered
- Communication and engagement
- Estate to support reconfiguration
- Lack of digital solutions
- Seven day working

## Key Milestones

### Q1/Q2

- Continue to monitor impact of HDA role within AMU and implement deconditioning assessment tool (DEWI).
- Develop and sign off JD including governance and accountability framework. Start advertising and recruitment process.
- Review alignment of alternative pathways including DVT & Chest pain
- Undertake self assessment tool for the model acute pathway (England) with a view to identifying opportunity and feedback to UEC Board.
- Undertake tabletop exercise with key stakeholders, feedback findings to members and design a proposal of optimal model in readiness for discussion at divisional management team meeting.
- Undertake review of operational processes such as clerking, documentation etc.
- Engage with stakeholders to develop a subgroup for new electronic system and define key requirements of system inputs and outputs

### Q3/Q4

- Monitor and assess findings of deconditioning tool roll out as well as staff feedback.
- GPs to begin induction programme and embedding within core numbers to support winter pressures.
- Align reviewed pathways in line with older person pathway roll out.
- Following discussion at DMT, propose a plan to present to executive board in line with the development of the older person pathway.
- Begin to design an implementation plan in line with executive decision.
- Develop implementation plan including training, business change, comms and UAT testing.
- Follow up actions of go live date, roll out, stabilisation and full evaluation to be planned.

# Older Person Pathway - Programme on a Page 2026/27

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Programme Aims & Objective** | To improve outcomes for older people through prevention, early intervention and timely access to person centred care, supporting community and place-based care approaches, reducing avoidable admission and hospital stays and optimising flow and bed base utilisation for older patients | | | | | | | | |
| **Executive Lead** | Leanne Watkins | **SPM** | Kate Fitzgerald | **SRO** | Lloyd Hambridge | **Workforce Lead** | Paula Michell | **Finance Lead** | Tristan Harris |

## Workstreams & Priorities

- **At Home and Community** - Supporting people to remain well, independent, and safely managed within their own home environment to include community MDT, cluster/NCN teams and contracted services, virtual wards, diagnostics and remote monitoring
- **Enhanced Community Care** - Ensure older people receive timely, coordinated and clinically robust support at home, improving outcomes and reducing avoidable hospital conveyance. This includes NHS at Home, Care Home Programme and other intermediate care services
- **Single Point of Access** - Enabling system-wide coordination and the ability to direct individuals to the right service first time to include integration with urgent Primary Care, Local Authorities, WAST and community services
- **Falls** – Whole-system approach across pre-hospital, community, care home and acute settings, focusing on prevention, integrated support, and responsive pathways following a fall
- **Acute Care** – Ensuring efficient and safe flow through the hospital front door and optimising inpatient capacity to include optimal bed model and front door model
- **Communication & Engagement** - Providing targeted training and associated communication to include CFS module on ESR

## Key Deliverables

- Deliver **timely identification** and assessment of frail and older patients in the community and at the front door
- Increase early senior and **multidisciplinary decision-making**
- **Reduce avoidable admissions** through alternative, community-based pathways
- **Optimise flow and bed base** utilisation for older people
- **Minimise length of stay** through proactive care and early discharge planning
- **Improve access to rehabilitation, reablement**, and community support
- Enhance **patient outcomes, experience**, and maintenance of independence
- Collaborative working with **Torfaen and Blaenau Gwent** Local Authorities to expand reablement opportunities
- **Deliver Single Point of Access** to coordinate individuals to the right service and the right time.

## Intended Benefits

***Benefits:***

- Enables timely triage and admission avoidance via a Single Point of Access
- Improves early identification of older people with complex needs at the front door
- Promotes person-centred care that maintains independence and functional ability
- Reduces avoidable admissions and unnecessary hospital stays
- Optimises patient flow and bed utilisation for older people
- Strengthens integration across acute, community, social care, carers, and third sector partners
- Delivery of **bed efficiencies** through redesigned models of care aligned to the IMTP

***Metrics:***

- 2hr community response
- Single Point of Access
- Conveyance/non conveyance
- Acuity Frailty Standards
- First 72 hours standards

## Interdependencies & Risks

***Interdependencies:***

- Acute Medical Model
- Place Based Care
- Local Authorities & Locality Teams
- Regional Partnership Board
- Value & Sustainability
- Digital/workforce/finance

***Risks:***

- Scale and complexity of the change
- Pace of the change
- Increase in demand, frail population
- Lack of digital solutions
- Seven day working
- Enhanced community services
- Right sized bed base
- Variation across Local Authorities.

## Key Milestones

### Q1/Q2

- Optimal pathway sign off by Executive Committee and Board
- Delivery of Place Based Care implementation plan
- Modelling and costing of AFU and bed efficiencies through redesigned models ahead of Board in July
- Continue Care Homes Support Programme delivery including locality support in BG and Torfaen
- Complete service mapping for rapid frailty response
- Develop the SPoA aligned to the Older Person Pathway with senior frailty decision maker
- Communication and engagement campaign, reinforcing the importance of CFS to support effective decision

### Q3/Q4

- Delivery of AFU pilot as test of concept to inform next phase of pathway delivery
- Deliver bed efficiencies aligned to identified opportunities
- Enhanced SPoA through wider stakeholder integration, including Local Authority
- Improve Falls navigation and flow via the SPoA
- Strengthen care home support and expand locality support to all five local authorities
- Design of enhanced community model to support AFU and enable care closer to home
- Public communication campaign to support appropriate service use and promote 'home first' approach

# Discharge Improvement - Programme on a Page 2026/27

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Programme Aims & Objective** | To support safe and timely patient discharge ensuring co-ordinated follow up care, reduced delays, prevention of de-conditioning and minimising avoidable admissions. | | | | | | | | |
| **Executive Lead** | Leanne Watkins | **SPM** | Kate Fitzgerald | **SRO** | Matt Temby | **Workforce Lead** | Ruth Madine | **Finance Lead** | Tristan Harris |

## Workstreams & Priorities

- **Optimal Hospital Flow Framework –** embed red to Green, SAFER and D2RA principles
- **Criteria Led Discharge –** identify suitable patients for criteria led discharge
- **Discharge Workforce Review –** review discharge workforce capacity and coverage across the system
- **Discharge Pathway Review –** review of the end-to-end discharge pathway
- **Data and Digital –** Define and standardise core system and data set requirements for discharge and flow
- **Pathway of Care Delays –** reduce delays based off themes
- **Prevention of Deconditioning –**raise awareness of the risks of hospital acquired deconditioning
- **Scrutiny Panel/LOS Meetings -** Identify delays and actions to progress discharge and improve flow
- **Hospital to Home** – progress business case for sustained funding
- **Trusted Assessor -** Progress implementation of the model

## Key Deliverables

- Increase safe discharges, including weekday and weekend discharges
- Improve patient outcomes through coordinated, person-centred planning
- Reduce delays related to assessments, reablement, and packages of care
- Standardise escalation with Local Authorities and adopt the Trusted Assessor model
- Embed action-oriented site flow and strong daily operational grip
- Standardise length of stay reviews across all sites
- Strengthen joint working across health, social care, community, and voluntary partners
- Prevent readmissions through appropriate post discharge support

## Intended Benefits

***Benefits:***

- Ensure patients experience safe and timely discharge
- Deliver coordinated follow-on care
- Provide the right care, in the right place, at the right time
- Reduce avoidable delays in discharge
- Prevent deconditioning during and after hospital stay
- Minimise avoidable readmissions

***Metrics:***

- 7 day and by mid-day discharge
- Length of Stay (LOS) 0-7 days and 21 days+
- LOS to clinically optimised
- D2RA data:4 measures
- Pathways of Care Delays by reason code, HB and LA
- Preventing Deconditioning/ DEWI

## Interdependencies & Risks

***Interdependencies:***

- Older Person Pathway
- Place Based Care
- Local Authority
- Regional Partnership Board
- Value & Sustainability
- Digital/workforce/finance

***Risks:***

- Cultural change
- Lack of digital solutions
- Seven day working
- Community capacity to support discharge
- Hospital acquired deconditioning
- Variation across Local Authorities

## Key Milestones

### Q1/Q2

- Embed the principles of the Optimal Hospital Flow Framework
- Standardise Criteria Led Discharge protocols across all sites via SOP
- Review discharge workforce capacity and coverage across wide system
- Define and standardise core system and data set requirements for discharge and flow
- Implement monthly meetings with PCC DMT to review the POCD data and action improvement
- Evolve the existing monthly deconditioning group into a collaborative, encouraging and embedding QI methodology
- Progress with Business case to substantiate service to Executive Committee following PIP
- Draft and agree a trusted assessor memorandum of understanding (MoU)

### Q3/Q4

- Evaluation of the roll of the Optimal Hospital Flow Framework across the Health Board
- Implement a new workforce model to support safer and earlier discharge
- Develop digital tools and dashboards to support monitoring, assurance and improvement
- Reduce delays based off themes and learning and variation to support timely care in the most appropriate setting
- Roll out the deconditioning tool in assessment units
- H2H monitor existing key metrics at discharge group and IDB to support and promote usage of the service
- Progress implementation of the agreed Trusted Assessor model
- Scrutiny Panel focus on key learning and themes addressed by targeted learning events

# Stroke Improvement Programme on a Page 2026/27

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Programme Aims & Objective** | The purpose of the Stroke Improvement Programme is to optimise and maintain standards in provision of timely access to emergency treatments (Scanning/thrombectomy/thrombolysis), specialist rehabilitation, and long-term, community-based support to maximise clinical outcomes, independence and quality of life for the population of Gwent, aligned to the National Quality Statement for Stroke and the National Stroke Standards. | | | | | | | | |
| **Executive Lead** | Peter Carr | **SPM** | Simon Roberts | SRO | Neil Miles/TBC | **Workforce Lead** | Helen Drew-Jones | **Finance Lead** | Karen Archer |

| Workstreams & Priorities | Key Deliverables | Intended Benefits *(include KPIs, Finance and Performance data)* | Interdependencies & Risks |
|---|---|---|---|
| • Prevention & Awareness<br>• Hyper Acute Care Standards<br>• Rehabilitation Model<br>• Community Support & reablement | • Detection and management of underlying risk factors for stroke<br>• Ensuring stroke patients have timely access to stroke wards within national standards.<br>• Analysis and understanding of the limitations and challenges in meeting the national hyper acute standards<br>• Embed Rehabilitation service model<br>• Optimise patient outcomes and experience<br>• Ensuring patients are supported within the community following acute admission | • A minimum of 40% of patients having had a brain scan completed within 20 minutes of arrival to hospital<br>• A minimum of 20% of patients have received thrombolysis and ideally within 30 minutes of arriving to Hospital<br>• A minimum of 50% of patients admitted or transferred to a specialist stroke ward within 4 hours of arrival to Hospital<br>• Patients receiving specialist therapy assessment within 24 hours of arrival to hospital and 72 hours for Speech & Language therapy | • Interdependent UEC Programme Workstreams<br>• Place Based Care Programme<br>• Cross Divisional Accountability<br>• Population Engagement<br>• Operational Demand and Capacity<br>• Environmental constraints with rehab facilities<br>• Pathway of Care Delays<br>• Workforce Sustainability |

| Q1/Q2 | Q3/Q4 |
|---|---|
| **Key Milestones** | |
| • Assessment against national recommended staffing levels through acute, recovery, rehabilitation and community phases (medical, nursing and therapy)<br>• Action Plan development to ensure standards are met in the delivery of hyper-acute protocol including scanning and treatment plans for the management of blood clots<br>• Finalisation of location of inpatient rehabilitation services at Ysbyty Ystrad Fawr and associated plan for access, capacity, environment and workforce<br>• Delivery of pre-hospital video triage and links to arrival, diagnosis and treatment flows<br>• Constraint analysis and action plan development to improve performance related to access of specialist stroke unit within 4 hours of arrival to hospital | • Embedding of a consistent approach to outcome measures in addition to performance measures<br>• Development of investment case for 2027/29 IMTP/Annual Planning round to deliver and sustain highest service delivery standards |

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| GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board | **CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN**<br>**ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING** |

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Board-Level Committee Governance Arrangements during Escalation |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Rani Dash, Director of Corporate Governance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Rani Dash, Director of Corporate Governance |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

Aneurin Bevan University Health Board is currently operating under the NHS Wales Oversight and Escalation Framework at Level 4 – Targeted Intervention in some areas.

This report outlines the governance arrangements in place to ensure continued, effective oversight, assurance and accountability at a Board and Committee level during this period.

The Board is asked to approve the proposed approach and take assurance that appropriate governance arrangements are in place to support effective scrutiny of both routine business and escalation-related matters.

## Cefndir / Background

The Health Board has an established Committee structure, with delegated responsibilities set out through approved Terms of Reference, enabling the Board to discharge its duties in relation to governance, performance, risk and assurance.

The Finance and Performance Committee plays a central role in providing assurance to the Board regarding financial stewardship, performance management and delivery against strategic objectives. Terms of Reference for the Finance and Performance Committee are available for viewing on the Health Board's Internet.

In line with the NHS Wales escalation framework, additional arrangements are required to ensure targeted and sustained oversight of areas subject to escalation.

## Asesiad / Assessment

The Health Board remains under Level 4 (Targeted Intervention) escalation status for finance, strategy and planning, and performance and outcomes in relation to urgent and emergency care.

**Finance and Performance Committee - Enhanced Oversight during Escalation**

To reflect the Health Board's escalation status, the two key escalation areas of finance, strategy and planning, and performance and outcomes in relation to urgent and emergency care will be subject to enhanced, focused scrutiny through an additional monthly meeting of the Finance and Performance Committee.

The membership of this meeting will be drawn from the existing Finance and Performance Committee, ensuring continuity of expertise and alignment with the Committee's delegated responsibilities. The meeting will be chaired by the Chair of the Health Board.

This meeting of the Committee will therefore:

- Be chaired by the Chair of the Health Board
- Include membership aligned to the Finance and Performance Committee
- Provide focused, in-depth oversight of the escalation areas, including finance, strategy and planning, and urgent and emergency care performance and outcomes
- Enable timely escalation, challenge and decision-making to the Board where required
- Oversee achievement of de-escalation actions and monitoring against improvement trajectories.

As set out within the Delivery Framework for the Annual Plan 2026/27, both the Value and Sustainability Board and Urgent and Emergency Care Programme Board will report to the Finance and Performance Committee given the direct alignment with national escalation levels related to performance. These two management groups will therefore provide a structured approach to reporting assurance into this part of the Finance and Performance Committee.

Given the focus on finance, the following elements of the Finance and Performance Committee's Terms of Reference will be considered through the monthly meetings, as an integral part of achieving de-escalation:

- Financial management and financial performance (revenue, capital and savings delivery)
- Oversight of efficiency, productivity and value for money.

This approach will strengthen governance by separating routine assurance from escalation-focused scrutiny, ensuring sufficient time and focus is given to both.

**Finance and Performance Committee – Routine Business**

During this period, the Finance and Performance Committee will continue to meet in line with its agreed programme of meetings, maintaining oversight and seeking assurance in respect of its remaining remit, including:

- Performance management and accountability across directly provided and commissioned services
- Delivery of Ministerial priorities and monitoring delivery against the Board's priorities, national frameworks and performance targets
- Delivery, performance and compliance of Information governance, digital performance and IM&T systems
- Capital, estates and infrastructure performance and compliance.

This meeting will continue to be Chaired by the nominated Independent Member Chair and no changes to Committee membership will be made. The Chair of the Health Board will not attend this meeting of the Committee.

These arrangements will ensure continuity of business-as-usual governance and ongoing assurance to the Board.

**Duration of Arrangements**

These enhanced arrangements will remain in place for the duration of the Health Board's Level 4 escalation status and will be reviewed following de-escalation.

**Reporting Arrangements**

Both meetings of the Finance and Performance Committee (routine business and escalation oversight) will report to each meeting of the Board in-line with established committee reporting arrangements.

**Argymhelliad / Recommendation**

The Board is asked to:

- **APPROVE** the proposed approach for the Finance and Performance Committee during the period of Level 4 escalation
- Take **ASSURANCE** that appropriate governance arrangements are in place to support effective scrutiny of both routine business and escalation-related matters.
- **NOTE** that these arrangements will remain in place for the duration of the Health Board's escalation status and will be reviewed following de-escalation.

| **Amcanion: (rhaid cwblhau)**<br><br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br><br>Datix Risk Register Reference and Score: | • SRR 001G – Financial Sustainability<br>• SRR 001I – Performance Improvement<br>• SRR 006A, B & C – Digital Infrastructure and System Delivery<br>• SRR 011 – Climate Change / Green Health |
| Safon(au) Gofal ac Iechyd:<br><br>Health and Care Standard(s): | Governance, Leadership and Accountability<br><br>Choose an item.<br><br>Choose an item.<br><br>Choose an item. |
| Blaenoriaethau CTCI<br><br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br><br>Enabling Actions across the IMTP |
| Galluogwyr allweddol o fewn y CTCI<br><br>Key Enablers within the IMTP | Finance |
| Amcanion cydraddoldeb strategol<br><br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br><br>Choose an item.<br><br>Choose an item.<br><br>Choose an item.<br><br>N/A |

| **Gwybodaeth Ychwanegol:**<br><br>**Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br><br>Evidence Base: | N/A |
| Rhestr Termau:<br><br>Glossary of Terms: | N/A |

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

| **Effaith: (rhaid cwblhau)**<br><br>**Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb**<br><br>**Equality Impact Assessment** (EIA) completed | Choose an item.<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br><br>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**<br><br>**Well Being of Future Generations Act – 5 ways of working**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Choose an item.<br><br>Choose an item. |

| | |
|---|---|
| | **CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN**<br><br>**ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING** |
| **DYDDIAD Y CYFARFOD:**<br><br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br><br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br><br>**TITLE OF REPORT:** | Integrated Performance Report: May Board |
| **CYFARWYDDWR ARWEINIOL:**<br><br>**LEAD DIRECTOR:** | Hannah Evans, Director of Strategy, Planning and Partnerships<br><br>Sarah Simmonds, Director for Workforce and OD<br>Jennifer Winslade, Director of Nursing<br><br>Robert Holcombe, Director of Finance |
| **SWYDDOG ADRODD:**<br><br>**REPORTING OFFICER:** | Trish Chalk, Assistant for Director Planning and Performance<br><br>Paul Steynor, Head of System Planning and Performance<br><br>Marie-Claire Griffiths, Head of Strategic Planning |
| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br><br>**Purpose of the Report** (select as appropriate) | |
| Er Sicrwydd/For Assurance | |

| **ADRODDIAD SCAA**<br><br>**SBAR REPORT** |
|---|
| **Sefyllfa / Situation**<br><br>The purpose of this report is to provide the Board with an integrated overview of performance against the key Health Board and Ministerial Priorities throughout 2025/26, with performance figures including the most up-to-date, validated positions. In addition, delivery against the IMTP quarter 4 deliverables is also included. As part of Welsh Government requirements for 2025/26 a narrative update on progress with 'Enabling Actions' is included as an Appendix (noting the quantifiable enabling actions are embedded in the Performance report). |

The Board is asked to:

- **Note** the progress against key performance metrics as of the latest, available validated information,
- **Note** the progress against the IMTP quarter 4 deliverables
- **Note** the progress against the Enabling Actions as of Q4 (included as an Appendix)

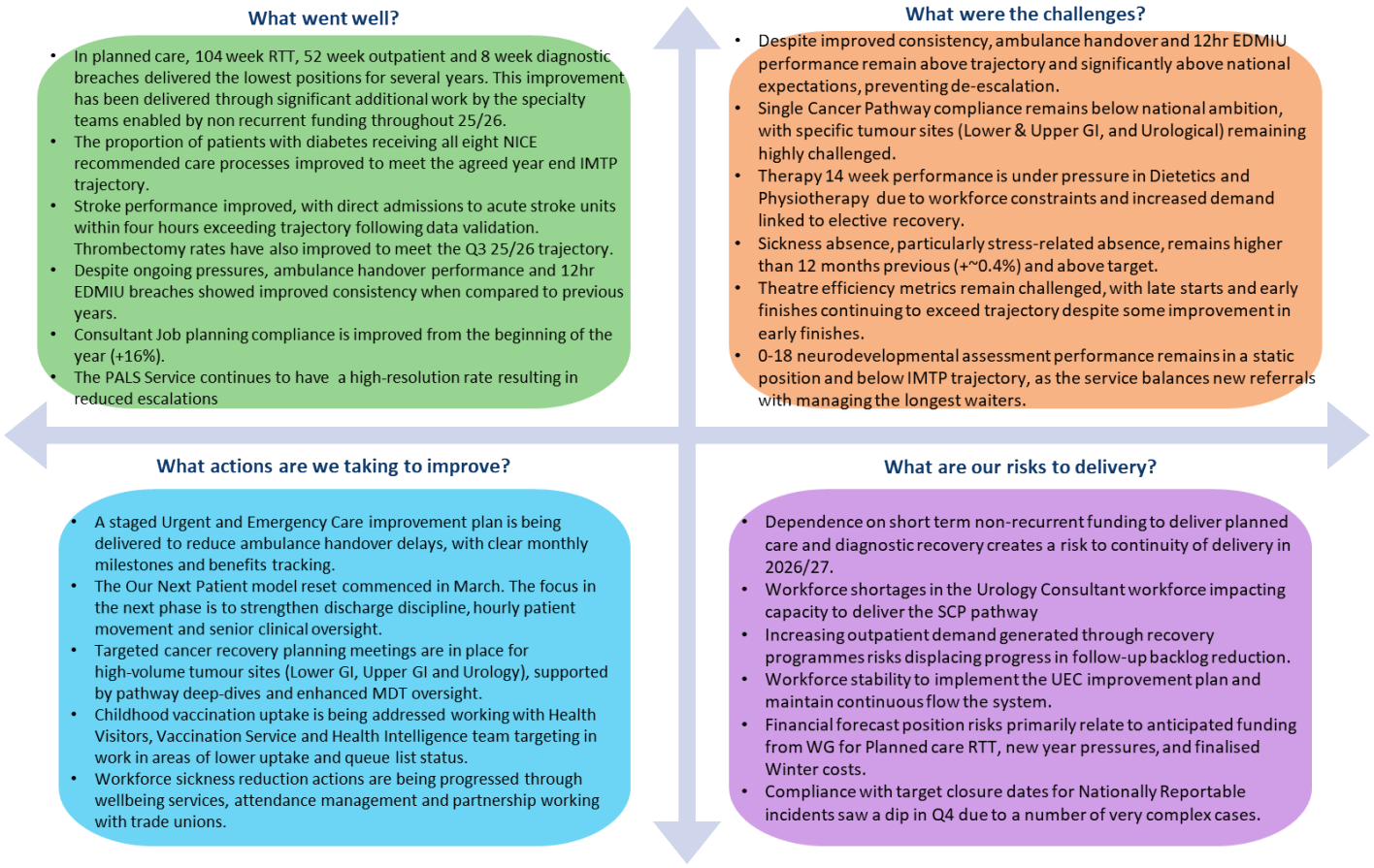
## Cefndir / Background

The report focusses on performance against the organisation's key priorities in line with the Heath Board's 2025/26 IMTP. The report (Appendix 1) is structured across the following sections:

| | |
|---|---|
| Section 1: | • Cabinet Secretary Priorities |
| Section 2: | • Our Performance & System Change Delivery<br>o Embedding Prevention and Population Health in all that we do<br>o Progressing place-based models of care and sustainability in Primary and Community Services<br>o Improving our Urgent & Emergency Care system focusing on experience, access and discharge pathways<br>o Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care<br>o Improving our Mental Health Services |
| | • Workforce |
| | • Quality & Patient Safety |
| | • Finance |
| Appendix1 | Enabling Actions Q4 Update |

## Asesiad / Assessment

Key summary messages from the report include:




Thematic headlines and insights from the report are provided below against the System Change Priorities drawing out areas where performance is on track and where there are areas of challenge:

## Prevention and Population Health

| Delivery Expectations - performance against (trajectory in month) | | |
|---|---|---|
| 4/11 on track | 3/11 off track within tolerance | 4/11 off track |

Delivery against this priority theme is mixed with some areas of challenge and other areas demonstrating progress. With regards to Vaccination rates across the range of adult programmes (COVID and flu) there have been improvements compared to last year and the Health Board has performed better than the all-Wales average in terms of take up. However, coverage and take up has still yet to meet the targets with COVID-19 spring booster reaching 56.5% coverage against a target of 75%, the autumn booster 60.4%, and flu shots for ages 65+ reaching 73.9%.

Whilst validated data is only available up to quarter 3, Childhood vaccination rates have improved albeit not achieving the targets. Rates at age five reached 83.8%, and HPV uptake improved by 3.9% in Q3 to 70.6% against a commitment of 90%. The report outlines ongoing efforts to boost childhood vaccinations, including targeted teams, improved reporting, digital consent pilots, and local outreach building on the

Director of Public Health's commitments and approach set out in her Annual Report and the Vaccination Equity Plan.

Due to the mixed progress against the smoking cessation measures (in quarter 3 Quit attempts have decreased whereas as the proportion of those who are CO validated has improved) a series of actions have been put in train including alignment of behaviour change practitioners with local teams, expansion community clinics, prioritisation of validated quits, and focus on high-risk groups.

Positively, Early years screening exceeded the targets with newborn hearing and six-week exams performance maintained, and eight-week checks improved to 92.7%. For chronic conditions, 47.3% of diabetes patients received all eight NICE care processes, meeting the IMTP trajectory.

**Primary and Community Services**

| Delivery Expectations - performance against (trajectory in month) | | |
|---|---|---|
| 4/8 on track | 3/8 off track within tolerance | 1/8 off track |

The report demonstrates the continued increasing contribution that primary care services are providing to the population and system as a whole. Provision of Community pharmacy services has grown substantially, with Pharmacist Independent Prescribing Service (PIPS) activity exceeding expectations reaching 157% of the annual target by March 26. The Common Ailment Scheme (CAS) activity exceeded the Q4 trajectory, with March seeing a record 9,510 consultations, mostly for urinary tract infection and sore throat testing. Optometry services were also ahead of trajectory seeing nearly 20,000 more patients (8%) than last year. Emergency dental care was slightly below trajectory, achieving 93% of the IMTP trajectory with monthly fluctuations. These services offer a significant and important alternative to GMS (General Practice) services in Primary and community care.

The volume of Community nursing contacts delivered 72% of its trajectory (92,343 weekend contacts against a commitment of 128,347), but in 2025/26 these has been a higher average monthly contacts compared to 2024/25. Enhanced Community Care referrals increased by nearly 25%, and Rapid Response and Emergency Care at Home operated with increased capacity. Palliative care reached 91% of planned trajectory due to demand and workforce challenges but improved towards year-end.

This progress will be further built on through the development of Integrated Network Teams as part of the place-based care programme of work.

**Urgent and Emergency Care**

| Delivery Expectations - performance against (trajectory in month) | | |
|---|---|---|
| 5/13 on track | 3/13 Off track within tolerance | 5/13 off track |

The information in the report shows that whilst the Urgent and Emergency care system continues to be under persistent pressure, there have been improvements in a number of metrics. The volume of ambulance handovers over 1 hour and the total volume of

ambulance lost hours have decreased by 100 and 1,000 respectively when compared to the same period last year. Although the IMTP trajectory was not consistently met (3 out of 12 months below target), handover performance in ED in the Grange improved overall during 2025/26, with March showing the best results since the 'Our Next Patient' period.

The proportion of patients waiting less than twelve hours in ED remained static for most of the year representing improved stability compared to the volatility of previous years. Whilst the de-escalation threshold of 93% waiting less than 12 hours was not met, overall compliance was above 92%. Four-hour performance was however more variable, particularly over winter, reflecting sustained demand, high bed occupancy and constraints in discharge.

Stroke performance showed positive improvement following a data correction with direct admissions to acute stroke units within four hours exceeding the IMTP trajectory of 20%. Thrombectomy rates met planned targets, up to 7.3% against a trajectory of 6% with national discussions underway to further improve commissioning and operating hours. Therapy standards improved, with more patients receiving physiotherapy and occupational therapy assessments within 24 hours, and speech and language therapy delivered within 72 hours.

Delayed care pathways fell for three months post-winter peak. March's figure of 178 is slightly above the planned trajectory of 160 but up 4% from last year. Patients staying over 21 days remained near the agreed trajectory.

A revised Urgent and Emergency Care Stabilisation and Improvement Plan has been developed bringing together key operational and transformational priorities together into a reset and refocused plan. This plan will be presented to the Board at its May meeting.

**Cancer and Planned Care**

| Delivery Expectations - performance against (trajectory in month) | | |
|---|---|---|
| 7/18 on track | 5/18 Off track within tolerance | 6/18 off track |

Performance within this theme has largely shown significant progress towards the end of 2025/26 although delivery of key Cancer standards remains below national expectations and the IMTP trajectory. Compliance with the Single Cancer Pathway rose to 63.1% in March (from 57.7% in February) but against a target of 75%. Targeted recovery action is continuing in Lower & Upper GI, and Urological tumour site Task and Finish Groups. The backlog of patients waiting over 62 days on the single cancer pathway fell to under 10% of the pathway list and longer waits beyond 104 days have remained stable, with further reduction targeted in 2026/27.

In Planned Care, the number of patients waiting over 104 weeks dropped to 23 by the end of 2025/26, the lowest since April 2020 and significantly supported by additional non recurrent monies. This was the third lowest of all health boards in Wales after Swansea Bay (0) and Hywel Dda (3). The volume of patients waiting over 52 weeks for

a new outpatient appointment also reduced, supported by the outpatient insourcing programme. In contrast, the number of patients waiting more than 100% beyond their follow-up target date remained above trajectory despite reductions during the final quarter, with strengthened use of see-on-symptom and patient-initiated follow-up pathways, and clinical review of long-wait cohorts.

In Diagnostics there was the lowest number of patients waiting over 8 weeks on record following the allocation of non-recurrent funding and operational delivery focus. By March 26 the Health Board delivered a reduction in over 8 weeks waiters, reducing from 1,557 in February to a year end position of 233.

Theatre session utilisation and day-surgery rates remained close to national standards with protected capacity consistently exceeding the national target of 90% and current performance at 95.4%.

**Mental Health**

| Delivery Expectations - performance against (trajectory in month) | | |
|---|---|---|
| 7/9 on track | 0/9 Off track within tolerance | 2/9 off track |

The high levels of performance against the Mental Health access standards have remained strong throughout 2025/26, with Adult and CAMHS Part 1a and 1b standards consistently achieved. Adult Part 2 compliance exceeded 90% from July 25 onwards. CAMHS Part 2 Care and Treatment Plan performance returned to above the national standard in the past four months. Specialist CAMHS Choice assessments stayed well above the 80% standard.

More challenging however is the performance in Psychological Therapies which decreased to 54% in March against a standard of 60%, primarily due to workforce vacancies impacting service capacity, compounded by historic data quality issues and RTT clock misalignment within the Mental Health Electronic Patient Record. Actions to address have been included in the revised Divisional recovery plan for 26/27.

Following a year of variation, Neurodevelopmental assessment performance stabilised at 57%. This was below trajectory noting the increasing rate of referrals, however the 52-week wait standard was maintained. Early 2026/27 projections show continued progress as the Neurodiversity Early Support Hub model is implemented across Gwent.

**Workforce**

Year-end workforce was stable at 13,724 WTE, with turnover positively below target set for the year, and over 14,000 staff retained. This has remained consistent in quarter 4, reflecting short-term movements linked to turnover rather than growth in funded establishments.

Sickness absence dropped to 6.31% in March, though remaining above the comparative position from the previous year. Long-term sickness made up two-thirds of absences, with anxiety, stress, depression and musculoskeletal issues as continuing to be the main causes contributing to 1.99% of all absence, a decrease from 2.10% reported in January.

A programme of workforce wellbeing and attendance management activity is in place, supported by health and wellbeing services, employee assistance arrangements and development of a joint improvement plan with trade unions to support sustained reduction in absence levels.

The focus on variable pay can be seen in the final quarter with Variable pay usage reduced. Contributing to this reduction, Bank usage dropped from 951 wte in January 26 to 881 wte in March 26. Similarly, Agency usage decreased in March 26 to 139 wte from 169 wte reported in January 26.

Job planning compliance improved modestly for consultants to 55.1% an increase from the 53.4% reported in January 2026 but remains below target for both consultant and SAS cohorts, with further action underway through divisional oversight, conditional vacancy approvals and strengthened governance arrangements.

**Quality, Safety & Experience**

The Patient Advice and Liaison Service (PALS) continue to deliver a high-resolution rate, which has contributed to a reduction in the number of cases requiring escalation. Early Resolution processes have consistently achieved compliance rates over 80% since January 2025, despite fluctuating volumes.

Formal complaints under Putting Things Right in January saw reduced compliance from 64% (Dec) to 52.8% due to higher complaint volumes and operational pressures and reduced capacity driven by legislative preparation. Improved systems in Mental Health and Family and Therapies divisions have led to better timescale adherence, while the Urgent Care Division sustained 80% compliance throughout the year.

In February 2026, there were 256 reported falls incidents, representing an 8% decrease compared to January 2026, which recorded 279 incidents. This reduction shows positive progress in the fall's prevention and management improvement work. Nationally Reportable incident closures reduced in Q4 due to complex cases requiring more resources.

**Finance**

The Health Board out-turn position (subject to audit) is £18.282m, which is in line with the forecast, but greater than the submitted plan. The deficit position is due to new in year pressures that include prescribing costs/acute drugs, CHC activity, winter pressures and ED pressures driving variable pay, and service pressures relating to Mental Health and cancer as well as unfunded national insurance costs. Delivery of this position is after achieving £43.4m of savings and full receipt of anticipated Welsh Government funding, including support for planned care RTT pressures.

Progress with the production of the 2025/26 Annual Accounts is in line with the agreed timetable and Welsh Government deadlines, with draft submissions completed in accordance with national requirements. The accounts are currently subject to external audit.

## Appendix 2- Enabling Actions Q4 update

As required by Welsh Government, the report for this quarter includes a more detailed appendix on delivery against the Enabling Actions (as per the NHS Planning Framework). It is in more narrative form as the metrics are already embedded in the performance report.

| Enabling Actions - progress Q4 | | |
|---|---|---|
| 21/34 adopted | 11/34 partially adopted | 2/34 off track |

**Operational Productivity & Efficiency (UEC)**

- The Level 1 Falls response improved to 40% from 35%, including a new response added in January 2026. Hospital conveyance for falls reduced to 39% and Gwent has now second lowest conveyance rate in Wales.
- The Community Clinical Desk assessed 320+ patients with 57% of those assessed remaining at home.
- Frailty/discharge pathways have been extended and the current performance showed that 76% patients were discharged home and there is now a 7-day therapies service at the Grange to support discharge pathways.
- Therapist support for falls navigation via Community Clinical Desk/SPOA will continue through Q4 as part of the SPOA initiative.
- Pre-noon discharges at The Grange have increased in quarter 4 from 12% om Q3 to 13%.
- Flow governance has been reinforced with the roll out of Optimal Hospital Flow Framework, scrutiny panels for the top 20 longest staying patients supported by an updated discharge policy.

**Operational Productivity - Planned Care and Cancer**

- The national Clinical Implementation Network (CIN) pathways have been mostly implemented (5/6)
- The requirement for Cataract direct listing has been completed.
- DNA/CNA rate has decreased to 4.9% the lowest since Apr 2019 and below the 5% national standard.
- Elective theatre protection year to date is 96.7%, with March at 95.4%.
- The performance for late start lists under the 15-minute measure has been relatively static, averaging 37.1% through the course of 25/26 and within a relatively tight range. March performance is currently 38%.
- With the 26/27 definition now clarified for early finished as a 60-minute measure is applied, March performance under this definition currently stands at 20.8%. Both measures have not met the improvement trajectory and will be the focus of the improvement plan for 26/27.
- The Day Surgery rates are above the national target with BADS rate The latest available position is Dec-25 under BADS definition, with performance at 76.1% and Performance through first 3 quarters of the year is averaging 78.7%.

**Workforce Productivity**

- Recruitment/retention have seen an improvement but have been challenged by urgent care demands over the winter and delivery of the 26-week outpatient targets.
- In 2025/26 Agency spend reduced by just over £4 million compared to 2024/25, a circa 14% reduction.
- Consultant job plan compliance is currently at 54% (Feb 2026) with 379/563 digital plans signed off. There remain a number of areas of dispute which is constraining progress.

**Maximising Value for Money**

- The Medicines management program leads in Wales for biosimilar uptake, generic apixaban and rivaroxaban as a % of direct oral anti coagulants (DOACs) (92% primary care, 96% WP10HP).
- The Health Board continues to conduct CHC eligibility reviews. Challenges with eligibility and enhanced care involving Local Authorities are being addressed through partnership meetings and workshops. The All-Wales digital solution is planned for 26/27 subject to Welsh Government confirmation.
- Estates rationalisation has been progressed by the Health Board against the expected timescales with the SOC for Nevill Hall submitted for review and the SOC development commencing for St Woolos Hospital.

**Improving Value, Optimising Outcomes, & Minimising Variation**

- National Optimal Pathways continue to be followed; however, timescale compliance remains at risk. January confirmed compliance was at 56.1%. The trajectory set for February was 71.2%.
- Recovery actions include additional colorectal theatre capacity, gynae pathology capacity actions, urology super lists, and Cancer Recovery Group meetings to review and progress improvement plans.
- The Bone Health pathway continues to perform against the plans, the number of fragility fracture patients has increased by 10.5%, with treatment improved to 70%. The service has been recognised nationally for the success of the programme in preventing fractures.
- For digital a number of key priorities have been achieved. The digital maternity platform has launched; NHS Wales App development is completed with further expansion proposed with a plan to support increased functionality for our patients.
- There are 180 live Health Pathways. Funding is decreased for 2026/27, reducing capacity from 1.2WTE to 0.5WTE. The team is focusing on integrating the platform via Clinical Interface Groups, Interface GPs, and e-advice.

**Argymhelliad / Recommendation**

The Board is asked to:

- **Note** the progress against key performance metrics as of the latest, available validated information,
- **Note** the progress against the IMTP quarter 4 deliverables
- **Note** the progress against the Enabling Actions as of Q4 (included as an Appendix)

| **Amcanion: (rhaid cwblhau)**<br><br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br><br>Datix Risk Register Reference and Score: | |
| Safon(au) Gofal ac Iechyd:<br><br>Health and Care Standard(s): | 1. Staying Healthy<br><br>5.1 Timely Access<br><br>1.1 Health Promotion, Protection and Improvement<br><br>7.1 Workforce |
| Blaenoriaethau CTCI<br><br>IMTP Priorities<br><br>Link to IMTP | Adults in Gwent live healthily and age well |
| Galluogwyr allweddol o fewn y CTCI<br><br>Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol<br><br>Strategic Equality Objectives<br><br>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<br><br>Gender and pay - Develop a fuller understanding of the reasons for any differences in pay and take the necessary action to address this<br><br>Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers<br><br>Choose an item. |

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

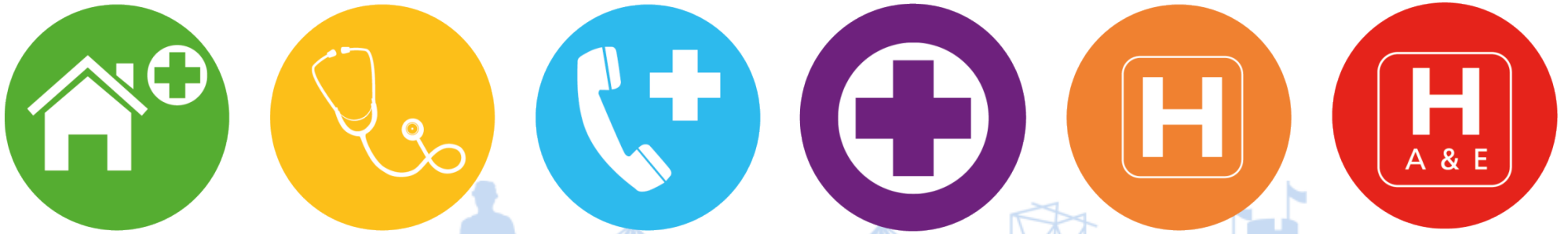
| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb**<br>**Equality Impact Assessment** (EIA) completed | **No does not meet requirements**<br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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**<br>**Well Being of Future Generations Act – 5 ways of working**<br>https://futuregenerations.wales/about-us/future-generations-act/ | Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves<br>Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives |

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

# ABUHB BOARD

## Integrated Performance Report

## May 2026 Board



## Performance Summary

### Section 1: Ministerial Delivery Expectations

The Cabinet Secretary for Health and Social Services has set out eighteen delivery expectations under five themes;

•Timely Access to Care
•Population Health & Prevention
•Building Community Capacity
•Mental Health Access (Adult and CAMHS)
•Women's Health

In the Integrated Medium-Term Plan 2025-28 the Health Board set performance expectations against all eighteen measures, agreeing to meet the national standard in all areas except Timely Access to Care.

### Section 2: Our Performance & System Change Delivery

The Performance Report section provides detail of Health Board performance across the quadruple aims and the system change themes identified in the Integrated Medium-Term Plan 2025-28. Detail on what is included under each quadruple aim is provided below.

A summary of performance is provided under each aim against the Health Board's priorities and corresponding performance ambitions, including detail of Integrated Medium Term Plan commitments. Performance against the relevant NHS Performance Frameworks measures is provided under each aim.

### Appendix 1: Enabling Actions

As part of the 2025/26 NHS Wales Planning Framework, the Welsh Government set out a number of Enabling Actions (focusing on productivity and efficiency) which NHS Wales Organisations need to adopt or justify. Delivery against these are tracked as part of our performance report, with the Q4 update provided as an appendix at to this report.

| Quadruple Aim | | Health Board's System Change Theme and Integrated Report |
|---|---|---|
| Aim 1 | People in Wales have improved health and well-being with better prevention and self-management. | • Embedding **Prevention** and Population Health in all that we do |
| Aim 2 | People in Wales have better quality and more accessible Health and Social Care Services, enabled by digital and supported by engagement. | • Progressing place based models of care and sustainability in **Primary and Community Services**<br>• Improving our **Urgent and Emergency Care System** focusing on experience, access and discharge pathways<br>• Continuing to prioritise **Cancer, Urgent and the longest waiting patients for Planned Care**<br>• Improving our **Mental Health** services |
| Aim 3 | The Health and Social Care workforce in Wales is motivated and sustainable. | Workforce and Culture |
| Aim 4 | Wales has a higher value Health and Social Care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes. | Quality, Safety and Experience<br><br>Financial Performance |

# Performance Summary

## What went well?

- In planned care, 104 week RTT, 52 week outpatient and 8 week diagnostic breaches delivered the lowest positions for several years. This improvement has been delivered through significant additional work by the specialty teams enabled by non recurrent funding throughout 25/26.
- The proportion of patients with diabetes receiving all eight NICE recommended care processes improved to meet the agreed year end IMTP trajectory.
- Stroke performance improved, with direct admissions to acute stroke units within four hours exceeding trajectory following data validation. Thrombectomy rates have also improved to meet the Q3 25/26 trajectory.
- Despite ongoing pressures, ambulance handover performance and 12hr EDMIU breaches showed improved consistency when compared to previous years.
- Consultant Job planning compliance is improved from the beginning of the year (+16%).
- The PALS Service continues to have  a high-resolution rate resulting in reduced escalations

## What were the challenges?

- Despite improved consistency, ambulance handover and 12hr EDMIU performance remain above trajectory and significantly above national expectations, preventing de-escalation.
- Single Cancer Pathway compliance remains below national ambition, with specific tumour sites (Lower & Upper GI, and Urological) remaining highly challenged.
- Therapy 14 week performance is under pressure in Dietetics and Physiotherapy  due to workforce constraints and increased demand linked to elective recovery.
- Sickness absence, particularly stress-related absence, remains higher than 12 months previous (+~0.4%) and above target.
- Theatre efficiency metrics remain challenged, with late starts and early finishes continuing to exceed trajectory despite some improvement in early finishes.
- 0-18 neurodevelopmental assessment performance remains in a static position and below IMTP trajectory, as the service balances new referrals with managing the longest waiters.

## What actions are we taking to improve?

- A staged Urgent and Emergency Care improvement plan is being delivered to reduce ambulance handover delays, with clear monthly milestones and benefits tracking.
- The Our Next Patient model reset commenced in March. The focus in the next phase is to strengthen discharge discipline, hourly patient movement and senior clinical oversight.
- Targeted cancer recovery planning meetings are in place for high-volume tumour sites (Lower GI, Upper GI and Urology), supported by pathway deep-dives and enhanced MDT oversight.
- Childhood vaccination uptake is being addressed working with Health Visitors, Vaccination Service and Health Intelligence team targeting in work in areas of lower uptake and queue list status.
- Workforce sickness reduction actions are being progressed through wellbeing services, attendance management and partnership working with trade unions.

## What are our risks to delivery?

- Dependence on short term non-recurrent funding to deliver planned care and diagnostic recovery creates a risk to continuity of delivery in 2026/27.
- Workforce shortages in the Urology Consultant workforce impacting capacity to deliver the SCP pathway
- Increasing outpatient demand generated through recovery programmes risks displacing progress in follow-up backlog reduction.
- Workforce stability to implement the UEC improvement plan and maintain continuous flow the system.
- Financial forecast position risks primarily relate to anticipated funding from WG for Planned care RTT, new year pressures, and finalised Winter costs.
- Compliance with target closure dates for Nationally Reportable incidents saw a dip in Q4 due to a number of very complex cases.

# Ministerial Delivery Expectations

| Theme | Delivery Expectation | ABUHB commitment | Plan meets National Standard | In month performance against trajectory |
|---|---|---|---|---|
| Population Health & Prevention | Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes | 47% Mar-26 | Yes | 47.3% Mar-26 (Mar-26 Trajectory: 47.0%) |
| | Achievement of vaccinations targets in the performance framework | Yes Mar-26 | Yes | Off Track 3 seasonal: 2 not met target, 1 borderline. 2 BCYP: 2 not meeting trajectory (Q3). |
| Building Community Capacity | Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard | 160 Mar-26 | Yes | 178 Mar-26 (Mar-26 Trajectory: 160) |
| | 100% of GP practices achieving all National Access Standards for In hours GMS | 100% Mar-26 | Yes | Reported Jun-26 |
| | Increase in number of people accessing PIPs for acute minor conditions and routine contraception services where the patient reports they would have otherwise visited their GP | 24,065 Mar-26 | Yes | 37,789 Mar-26 (Q4 Trajectory: 24,065) |
| | Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25 and greater where possible | 128,347 Mar-26 | Yes | 92,343 Mar-26 (Q4 Trajectory: 128,347) |
| | Increase in capacity of Enhanced Community Care to at least the required levels previously set for 2024/25 and greater where possible | 5,277 Mar-26 | Yes | 6,545 Mar-26 (Q4 Trajectory: 5,277) |
| Women's Health | Establishment of one Women's Health Hub in each health board area by March 2026 | Yes Mar-26 | Yes | Online hub established Mar-26 |

# Ministerial Delivery Expectations

| Theme | Delivery Expectation | ABUHB commitment | Plan meets National Standard | In month performance against trajectory |
|---|---|---|---|---|
| Timely Access to Care | Reduce the number of ambulance patient handovers over 1 hour –national target - zero | 500 Mar-26 | No | 666 Mar-26 (Mar-26 Trajectory: 500) |
| | Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero | 750 Mar-26 | No | 1,184 Mar-26 (Mar-26 Trajectory: 750) |
| | No patients waiting more than 104 weeks for referral to treatment. | 0* Mar-26 | No | 23 Mar-26 (Mar-26 EoY Trajectory: 0) |
| | 12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion building toward a national target of 80% by 31 March 2026. | 70% Mar-26 | No | 63.1% Mar-26 (Mar-26 Trajectory: 70.0%) |
| | No patients waiting more than 8 weeks for a specified diagnostic | 166* Mar-26 | No | 233 Mar-26 (Mar-26 EoY Trajectory: 166) |
| Mental Health Access (Adult and CAMHS) | 80% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral – Over 18s | 80% Mar-26 | Yes | 86.6% Mar-26 (Mar-26 Trajectory: 80.0%) |
| | 80% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS – Over 18s | 80% Mar-26 | Yes | 93.7% Mar-26 (Mar-26 Trajectory: 80.0%) |
| | 80% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral – Under 18s | 80% Mar-26 | Yes | 99.0% Mar-26 (Mar-26 Trajectory: 80.0%) |
| | 80% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS – Under 18s | 80% Mar-26 | Yes | 80.4% Mar-26 (Mar-26 Trajectory: 80.0%) |

# Progress Against our Integrated Medium-Term Plan

| | | | | |
|---|---|---|---|---|
| Embedding **Prevention** and Population Health in all that we do | Resilient Communities & Health Protection | Best Start in Life | Women's Health | Preventable Premature Mortality |
| Progressing place based models of care and sustainability in **primary and community services** | Rightsizing of Commissioned Care | Access & Sustainability | Focus on Community Pathways | Place Based Care |
| Improving our **Urgent and emergency care** system focusing on experience, access and discharge pathways | Admission Avoidance (Goal 1) | Integrated Front Door (Goals 2,3 &4) | Integrated Back Door (Goals 5&6) | Medical Service Redesign |
| Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care** | Single Cancer Pathway | Health Pathways | Theatre Maximisation | Outpatient Transformation |
| Improving our **Mental health** services | Quality Improvement | Ministerial Priority Performance | Neuro-developmental Services | Rightsizing Inpatient & Transforming Community Services |

Quality, Patient Safety & Experience

Workforce & Culture

Finance

# Embedding *Prevention and Population Health* in all that we do: Performance Summary

| Theme | Delivery Expectation | ABUHB commitment | In month performance against trajectory |
|---|---|---|---|
| Prevention and Population Health | % uptake of the COVID-19 vaccination for those eligible Spring Booster | 75% Sep-26 | 56.5% Q1 25/26 (Q1 Trajectory: 75%) |
| | % uptake of the COVID-19 vaccination for those eligible Autumn Booster | 75% Mar-26 | 60.4% Q4 25/26 (Q4 Trajectory: 75%) |
| | % uptake of the influenza vaccination amongst adults aged 65 years and over | 75% Mar-26 | 73.9% Q4 25/26 (Q4 Trajectory: 75%) |
| | % children up to date with vaccinations by age 5 | 95% Mar-26 | 83.8% Q3 25/26 (Q3 Trajectory: 92%) |
| | % of children receiving HPV vaccination 1 dose by the age of 15 | 90% Mar-26 | 70.6% Q3 25/26 (Q3 Trajectory: 85%) |
| | Percentage of adult smokers who make a quit attempt via smoking cessation services | 5% Mar-26 | 3.9% Q3 25/26 (Q3 Trajectory: 5%) |
| | Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks | 32% Mar-26 | 22.2% Q3 25/26 (Q3 Trajectory: 28%) |
| | Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks | 90% Mar-26 | 93.2% Jan-26 (Jan-26 Trajectory: 90.0%) |
| | Maintain physical examination at 6 weeks rates (Healthy Child Wales) | 90% Mar-26 | 94.5% Jan-26 (Jan-26 Trajectory: 90.0%) |

# Embedding Prevention and Population Health in all that we do: Performance Summary

| Theme | Delivery Expectation | ABUHB commitment | In month performance against trajectory |
|---|---|---|---|
| Prevention and Population Health | Increase weight and measurement at 8 weeks rates (Healthy Child Wales) | 80% Mar-26 | 92.7% Q3 25/26 (Q3 Trajectory: 76%) |
| | Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes | 47% Mar-26 | 47.3% Mar-26 (Mar-26 Trajectory: 47.0%) |

Embedding **Prevention** and Population Health in all that we do

Measure: % uptake of the COVID-19 vaccination for those eligible Spring Booster

Ministerial Delivery

Performance: 56.45% (10/07/25, end of campaign)
Trajectory: 75%
National target: 75%

| Region | Eligible population (n) | Vaccinated (n) | Coverage (%) | Of those vaccinated, number with no previous doses (n) |
|---|---|---|---|---|
| Aneurin Bevan University Health Board | 78,706 | 44,432 | 56.45 | 17 |
| Blaenau Gwent | 8,923 | 4,550 | 50.99 | 1 |
| Caerphilly | 22,595 | 12,326 | 54.55 | 2 |
| Monmouthshire | 16,160 | 10,820 | 66.96 | 7 |
| Newport | 18,261 | 9,796 | 53.64 | 4 |
| Torfaen | 12,767 | 6,940 | 54.36 | 3 |

Measure: % uptake of the COVID-19 vaccination for those eligible Autumn Booster

Ministerial Delivery

Performance: 60.4% (as of 19/02/26, end of campaign)
Trajectory: 75% (Q4 25/26)
National target: 95%

| Region | Eligible population (N) | Vaccinated (n) | Coverage (%) | Of those vaccinated, number with no previous doses (n) |
|---|---|---|---|---|
| Aneurin Bevan University Health Board | 79,788 | 48,211 | 60.42 | 92 |
| Blaenau Gwent | 9,124 | 4,848 | 53.13 | 4 |
| Caerphilly | 23,039 | 13,252 | 57.52 | 14 |
| Monmouthshire | 16,182 | 11,827 | 73.09 | 49 |
| Newport | 18,477 | 10,629 | 57.53 | 19 |
| Torfaen | 12,966 | 7,655 | 59.04 | 6 |

**Insight & Actions:**

- COVID-19 spring booster: ABUHB performance was higher than the all-Wales figure 53.18%, however this is short of the 75% target as per the ministerial delivery expectation.

- COVID-19 autumn booster: Campaign commenced on 1st October; performance data includes vaccinations given and recorded on the Welsh Immunisation System up to the end of 19/02/2026, with no further updates since that time indicating the end of the campaign. Performance of 60.4% puts ABUHB marginally higher than the all-Wales figure of 58.3% and is improved from the Spring campaign. Covid vaccination performance has been removed from the NHS Wales Performance Framework for 26/27.

Embedding **Prevention** and Population Health in all that we do

Measure: % uptake of the influenza vaccination amongst adults aged 65 years and over

Ministerial Delivery

Performance: 73.9% (as of 31/03/26, end of campaign)
Trajectory: 75% (Q4 25/26)
National target: 75%

| | | 65y and older | | |
|---|---|---|---|---|
| | | Immunised | Denominator | Uptake (%) |
| Aneurin Bevan UHB | Blaenau Gw.. | 10,717 | 15,118 | 70.9% |
| | Caerphilly | 28,539 | 38,978 | 73.2% |
| | Monmouths.. | 21,768 | 27,658 | 78.7% |
| | Newport | 20,917 | 29,012 | 72.1% |
| | Torfaen | 15,505 | 21,058 | 73.6% |
| | AB Total | 97,446 | 131,824 | 73.9% |
| Wales | Wales | 528,891 | 724,719 | 73.0% |

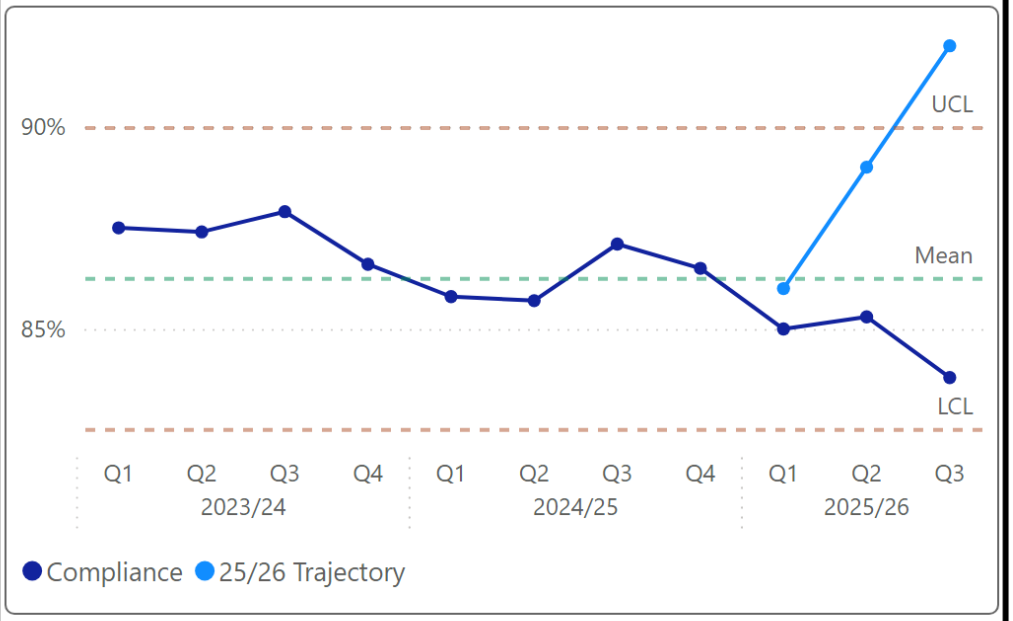
**Insight & Actions:**

- Influenza vaccination: ABUHB performance for residents aged 65 years and older 73.9% as of 31st March which represents the end of the campaign. This is an improvement from 24/25 performance (72.9%) and higher than the all Wales figure of 73%.

## Embedding **Prevention** and Population Health in all that we do

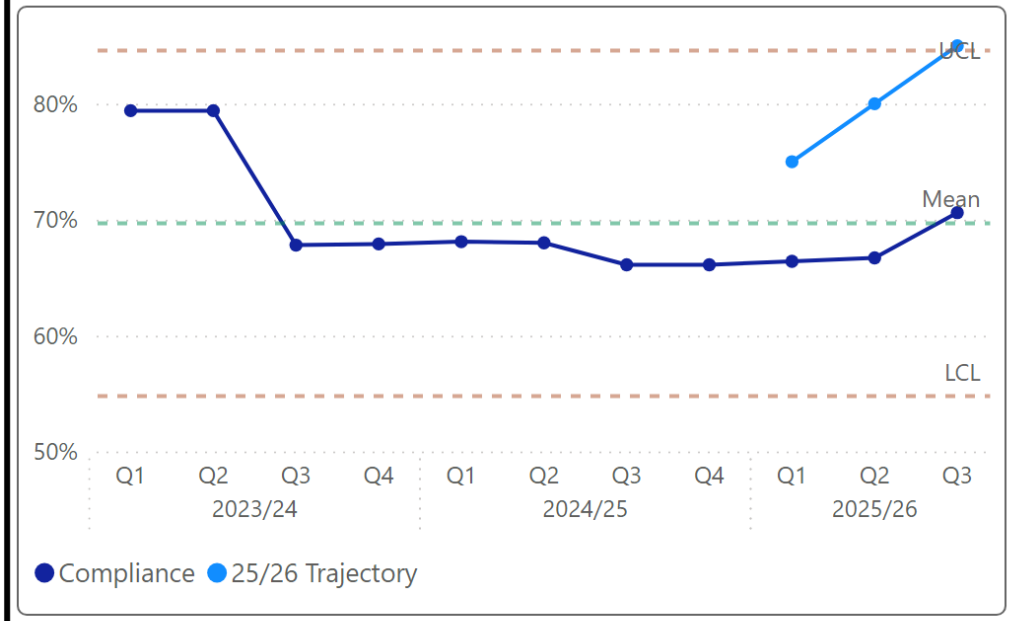
Measure: % children up to date with vaccinations by age 5
Performance: 83.8% (Q3 25/26)
Trajectory: 92.0% (Q3 25/26)
National target: 95.0%

**Ministerial Delivery**




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

**Ministerial Delivery**

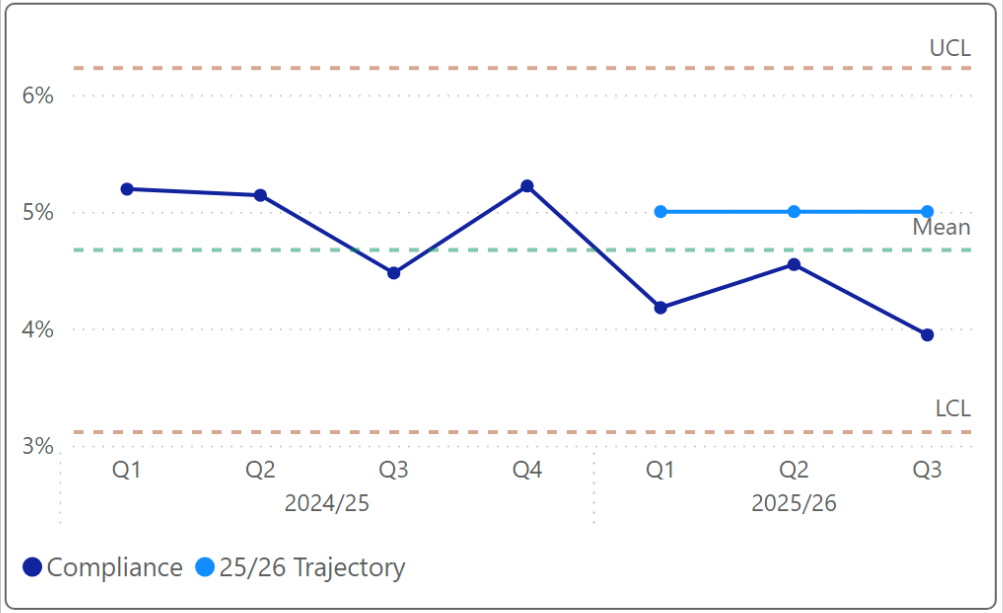



### Insight and Actions

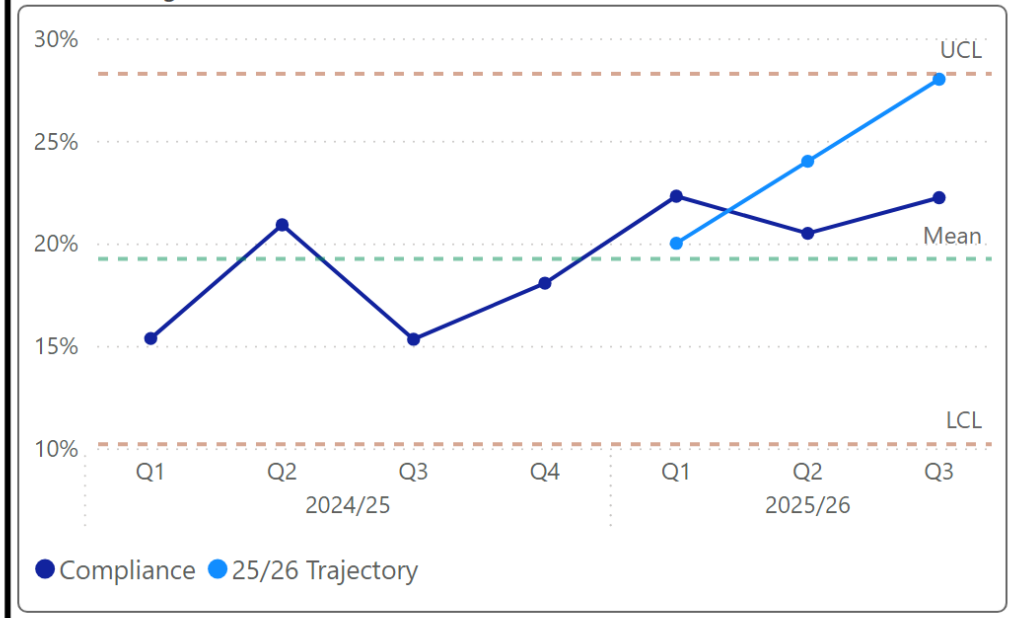
- Childhood vaccinations: Q3 performance decreased to 83.8%, below trajectory (92%). HPV: Q3 performance showed first significant improvement in some time, rising by 3.9% to achieve 70.6% compliance.
- For vaccinations by age 5, a task and finish group, led by Public Health Team and working with Health Visitors, Vaccination Service and Health Intelligence team will target work in areas of lower uptake. One key initiative is to work to develop a 'live' dashboard to understand if any of the interventions have a positive impact upon uptake. Initially this pilot will prioritise MMRV vaccination but will also utilise 'Making Every Contact Count' (MECC) approaches during contact with families. Colleagues involved will be offered to attend the new Vaccine Brief Advice Awareness Training that has been developed by the Health Protection Team – one of the recommendations from the Big Gwent Vaccination Conversation.
For HPV, work has progressed to enable wider digital consent for school-aged vaccinations piloting with a small number of schools for HPV Vaccination. Once the pilot has taken place, learning and improvements will be made as required with an intention to increase HPV Vaccination uptake across Gwent. In addition to the digital consent pilot, the utilisation of the mobile Nye BeVAN has commenced in areas where we have sub-optimal uptake to offer parents and young people an additional method and opportunity to receive vaccination.

## Embedding **Prevention** and Population Health in all that we do

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




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

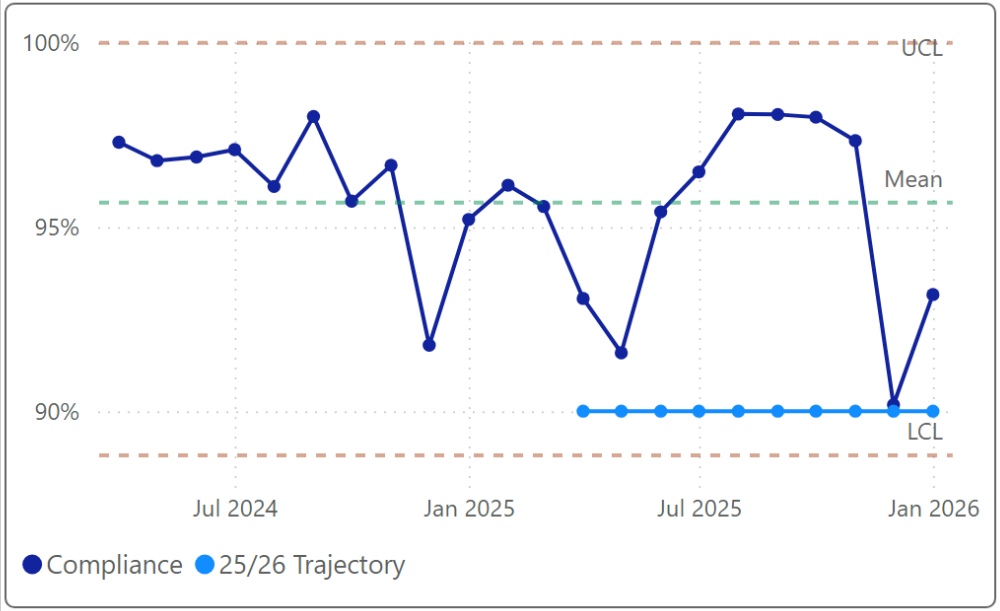



### Insight and Actions

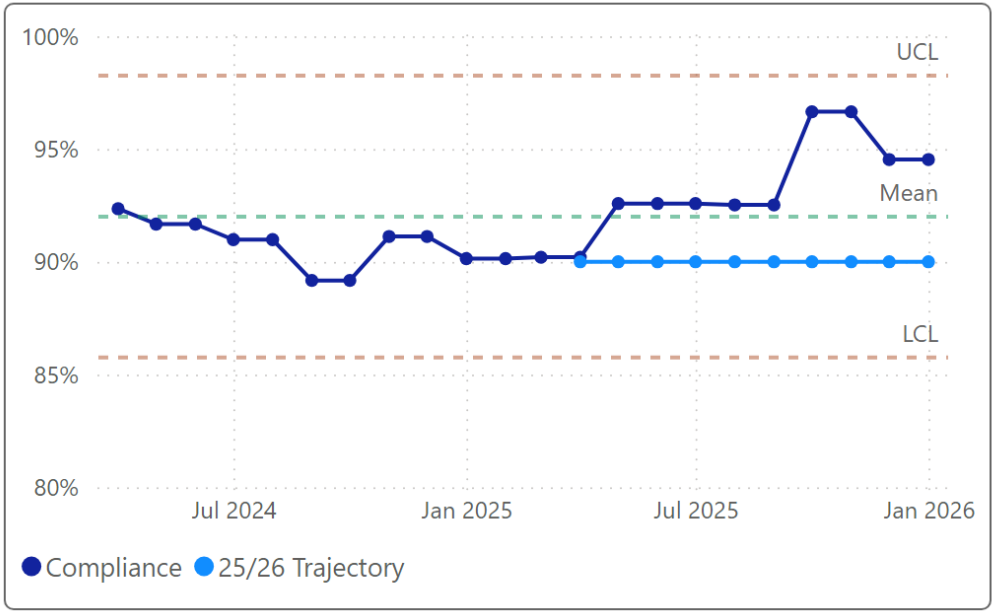
- Smoking cessation performance across the two measures are based on annualised targets, however, are presented here quarterly to give assurance on progress. Q3 quit attempt performance decreased to 3.9%, with cumulative performance through the first three quarters of the year now standing at 4.22%.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

Embedding **Prevention** and Population Health in all that we do

Measure: Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks
Performance: 93.2% (January 2026)
Trajectory: 90.0% (January 2026)
National target: 90.0%




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

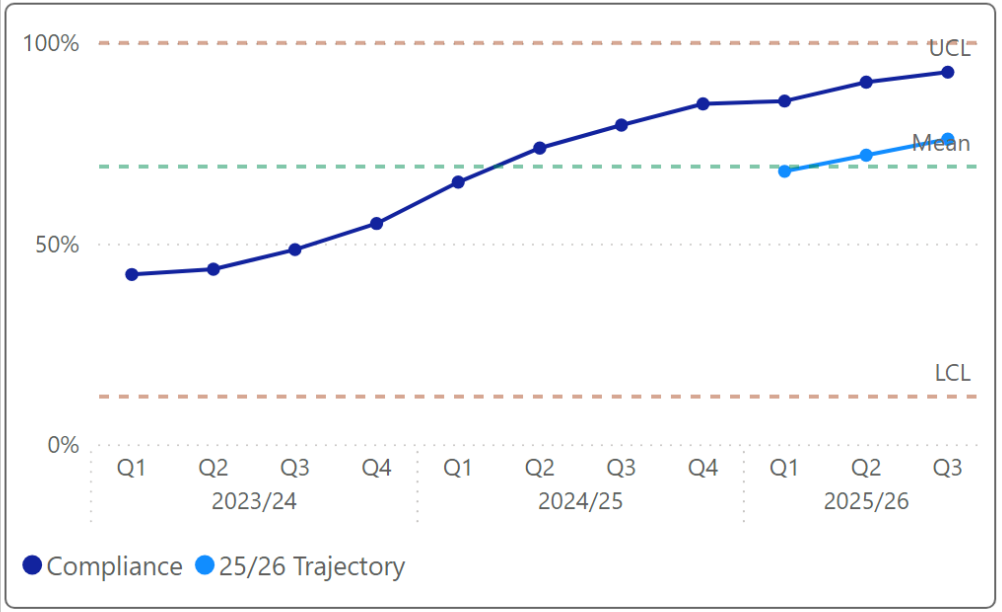



## Insight and Actions

- Performance for both the newborn hearing screening programme and the physical examination at 6 weeks remain above the national target through the course of 25/26 to date.

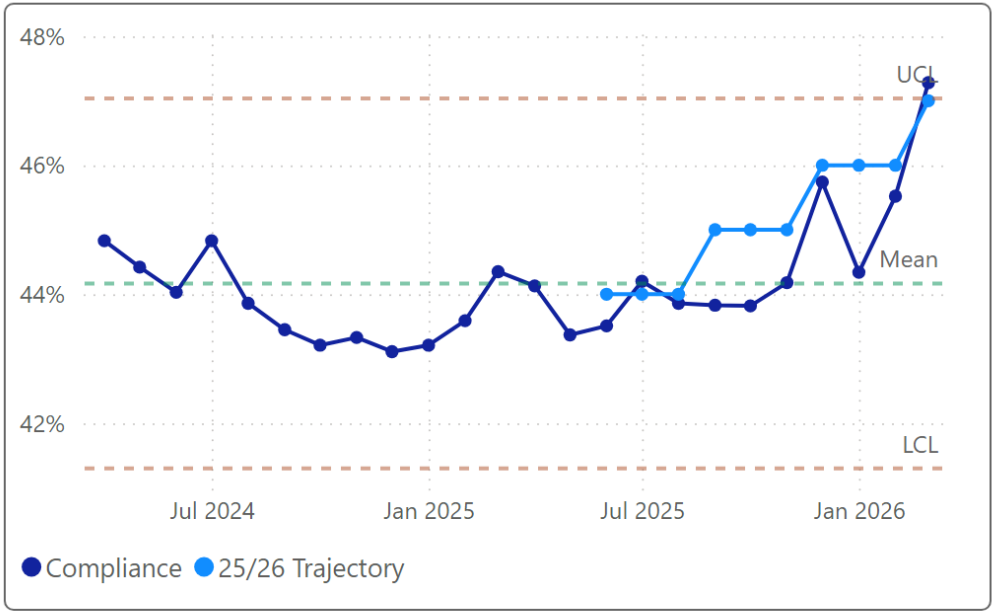
## Embedding **Prevention** and Population Health in all that we do

Measure: Increase weight and measurement at 8 weeks rates (Healthy Child Wales)
Performance: 92.7% (Q3 25/26)
Trajectory: 76.0% (Q3 25/26)
National target: None




Measure: Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes
Performance: 47.3% (March 2026)
Trajectory: 47.0% (March 2026)
National target: None

**Ministerial Delivery**




### Insight and Actions

- Weight and measurement at 8 weeks: Q3 performance saw a further increase to 92.7%, compounding consecutive quarterly improvement since 23/24.

- 8 Diabetes processes: March performance increased again to achieve 47.3% and thus meet the IMTP trajectory which is positive. The Urine ACR project is now entering its closure phase, with a detailed closure report and impact evaluation due at the end of April; while progress has been slightly delayed by limited GP data returns, early findings suggest a potential 4% improvement across ABUHB. The improvement programme has also published its findings to GMS collaboratives, highlighting high and low value activities across the screening pathway to support GP decision-making. The footcare project has continued to progress but has faced delays related to materials production and communications, resulting in an extension into Q2/Q3 of 26/27 to enable robust implementation and evaluation. Additionally, scoping work is underway to explore new opportunities in Gestational Diabetes and Transition to Adult Services in 26/27.

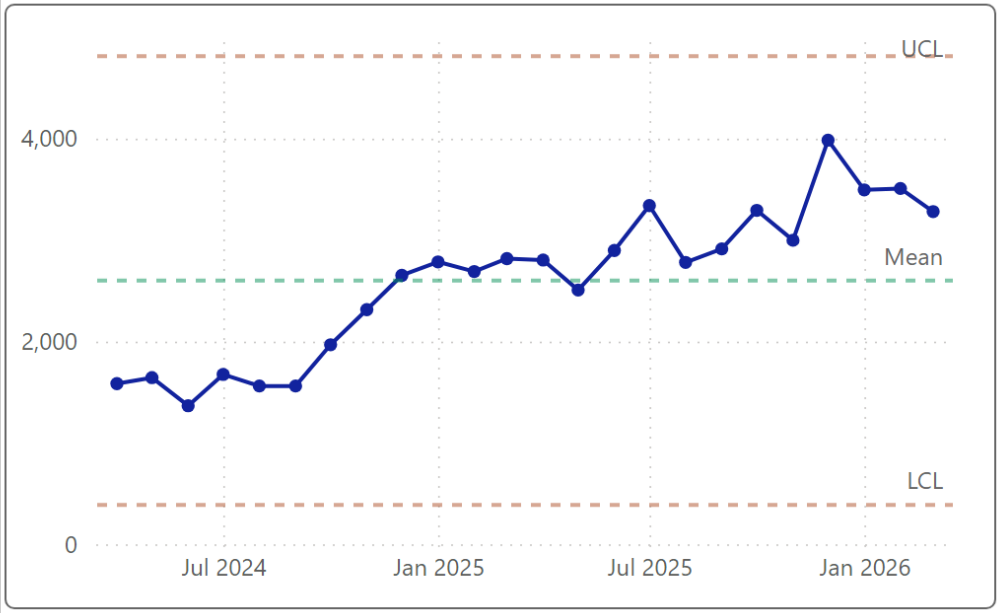
| Priority | Q4 Planned | Q4 Progress | Q4 Comments |
|---|---|---|---|
| **Resilient Communities & Health Protection** | Deliver the change in childhood immunisations | Complete/On schedule | The has been a change in the childhood immunisation schedule in January 2026 with the introduction of the varicella vaccine given as part of the existing MMR vaccine (MMRV). Children whose parents had previously declined the MMR vaccine were automatically added to the schedule because it is a new vaccine. This increased demand has seen an increase in the 'queue' lists held on the childhood immunisation system, Cypris. The child is added at birth and it holds their schedule of immunisations until they are 25. Queue lists are provided to GP's on a weekly basis who are contracted to deliver pre-school immunisations. GP's have been advised to review clinics to utilise capacity appropriately. |
| | Lead the implementation of vaccine equity strategy | Off track within tolerance | Task & Finish equity group underway to baseline measures of activity with a draft system wide delivery plan being developed for Q1 26/27. |
| **Best Start in Life** | Framework delivery plan is approved by Gwent PSB and actions are implemented by partners | Complete/On schedule | Draft priorities for improvement were shared with the Best Start in Life (BSiL) Leadership Group in Q4, with further refinement now underway through the Regional Management Group. Priorities include a focus on improving preconception, pregnancy planning support, and increasing breastfeeding in Gwent through promotion of the Pump Loan Scheme and Peer Support Groups. Work continues to review each priority, strengthen system mapping across the Gwent partnership, and develop the BSiL Community of Practice, which has launched its first newsletter, delivered a well attended webinar with partnership representation, and is planning a programme of future sessions. |
| **Women's Health** | Implement pathfinder Women's Health Hub by end of quarter | Complete/On schedule | The Women's Health discovery work has been translated into an action plan to inform development of the pathfinder hub and wider hub network business case. A Women's Health Conference was held in Q4, and work continues to develop the business case for both the initial pathfinder hub and a longer term sustainable model to improve women's health. |
| **Preventable Premature Mortality** | Commission an integrated model which amalgamates the Diabetes Prevention Programme and Hypertension Programme | Complete/On schedule | Quarterly monitoring continues, with ongoing work with primary care to improve data returns and prepare for the new 2026/27 CVD Risk Factor Management Service. Outputs include updated service materials, a new search strategy, and an electronic referral pathway are in development, with a practice webinar in place. The Diabetes Prevention Programme has secured short term funding and planning continues for its integration into the CVD service from September 2026. |

| Theme | Delivery Expectation | ABUHB commitment | In month performance against trajectory |
|---|---|---|---|
| Primary and community services | Increase in people accessing PIPs where they would have visited their GP | 24,065 Mar-26 | 37,789 Mar-26 (Q4 Trajectory: 24,065) |
| | Maintain the number of consultations undertaken by community pharmacy under CAS | 79,553 Mar-26 | 91,240 Mar-26 (Q4 Trajectory: 79,553) |
| | Maintain the number of patients accessing NHS Optometry Services | 246,133 Mar-26 | 266,125 Mar-26 (Q4 Trajectory: 246,133) |
| | Number of patients accessing urgent emergency services - Dental | 43,153 Mar-26 | 39,999 Mar-26 (Q4 Trajectory: 43,153) |
| | Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25 | 128,347 Mar-26 | 92,343 Mar-26 (Q4 Trajectory: 128,347) |
| | Increase in capacity of Enhanced Community Care to at least the required levels previously set for 2024/25 | 5,277 Mar-26 | 6,545 Mar-26 (Q4 Trajectory: 5,277) |
| | Maintain 95% of Palliative Care referrals assessed within 2 days | 95% Mar-26 | 94.0% Mar-26 (Mar-26 Trajectory: 95.0%) |
| | Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s | 8.5% Mar-26 | 7.0% Mar-26 (Mar-26 Trajectory: 8.5%) |

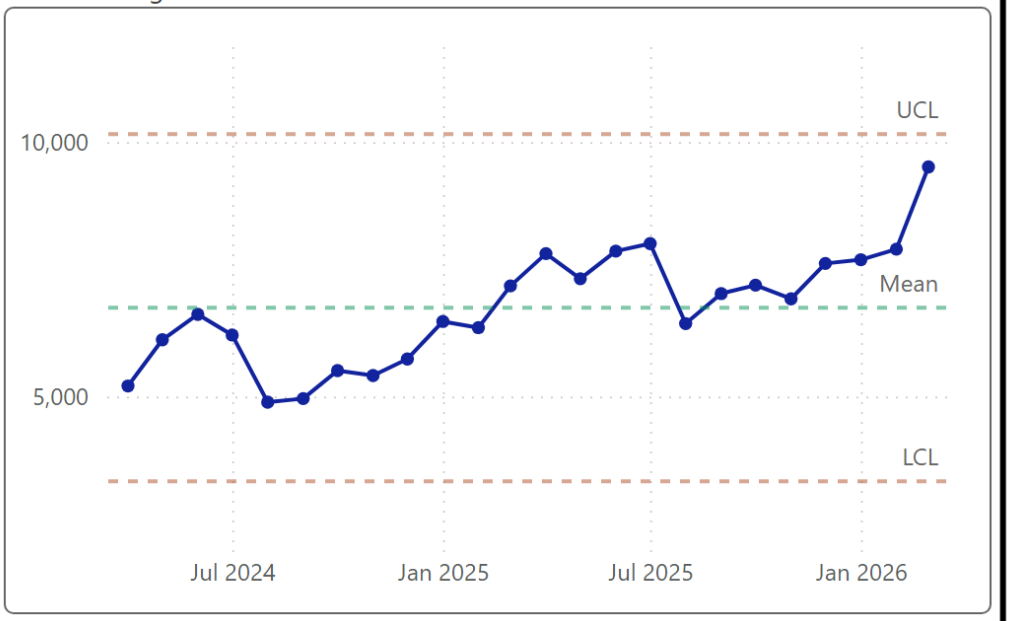
## Progressing place based models of care and sustainability in **primary and community services**

Measure: Increase in people accessing PIPs where they would have visited their GP
Performance: 37,789 (March 2026)
Trajectory: 24,065 (Q4 25/26)
National target: None

**Ministerial Delivery**




Measure: Maintain the number of consultations undertaken by community pharmacy under CAS
Performance: 91,240 (March 2026)
Trajectory: 79,553 (Q4 25/26)
National target: None



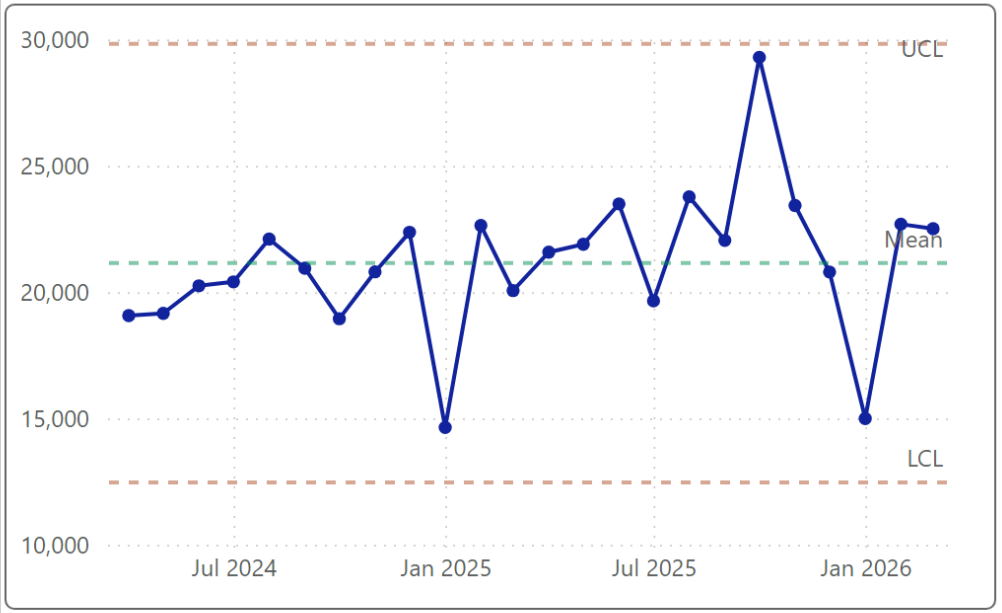

### Insight and Actions

- Pharmacist Independent Prescribing Service (PIPS): PIPs consultations for 2025/26 have delivered significantly above trajectory, with the March position representing 157% of the annualised target. The number of Community Pharmacies providing the PIPs service has also increased over the course of the year, from 49 in April to 67 in March (+18).
- Common Ailment Scheme (CAS): CAS claims have significantly exceeded the Q4 trajectory for 25/26, with the March position representing the highest number of consultations to date at 9,510. Uptake has continued to increase for the scheme's newest conditions, with UTI consultations having almost doubled from the first half of 25/26, now averaging just under 600 per month. While Sore Throat Test consultations display a seasonal trend with increased demand in the winter months, similar to the UTI consultations the number has almost doubled from Dec-Mar 24/25 to Dec-Mar 25/26, from ~650 per month to now over 1,000 a month.

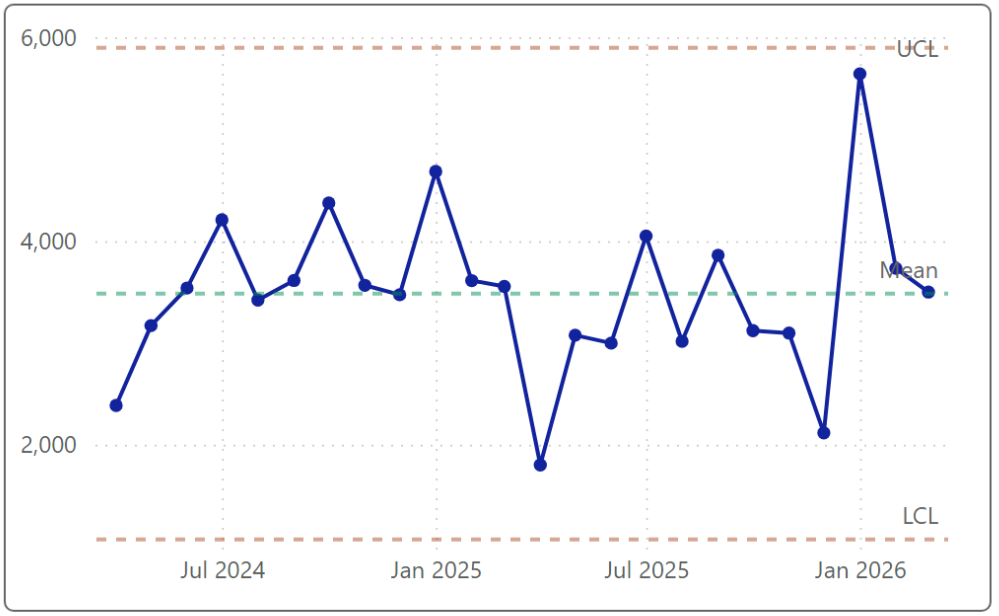
- PIPS and CAS contacts continue to increase following an extension to the clinical conditions feasibly managed by the service and a successful public awareness campaign. It is anticipated that activity will continue to grow but at a lower rate in the coming years as we approach the ceiling for CAS in particular.

## Progressing place based models of care and sustainability in **primary and community services**

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




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



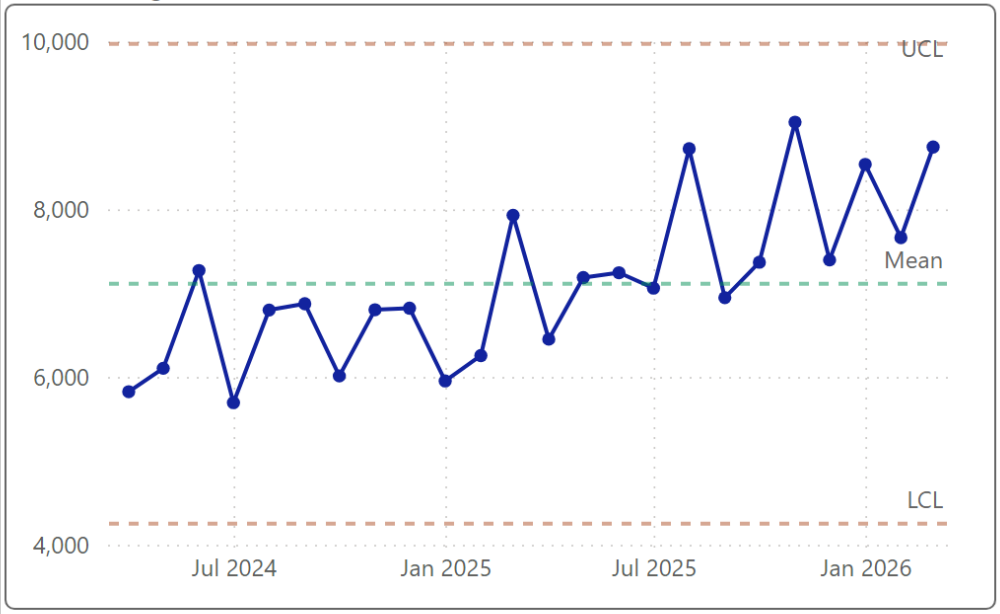

### Insight and Actions

- Optometry Services: Performance for 2025/26 has exceeded the IMTP trajectory by almost 20,000 patients (8%). Implementation of the new WGOS pathways has seen an increase in patients accessing optometry services in the community, with the total number of patients accessing services in 2025/26 exceeding the annual total from 2024/25. Performance displayed some marked variability over the year, notably a drop to just under 15,000 in January, a trend observed in January 2025, and a rise to an all-time high of 29,292 patients in October.
- Emergency Dental: Performance over the course of 2025/26 represent 93% of the total IMTP trajectory, as well as a reduction in the total number of patients accessing Emergency Dental Services compared to the previous year. Overall performance also showed more variability than the previous year, with lows in April and December, as well as an all-time high of 5,640 patients in January.

## Progressing place based models of care and sustainability in **primary and community services**

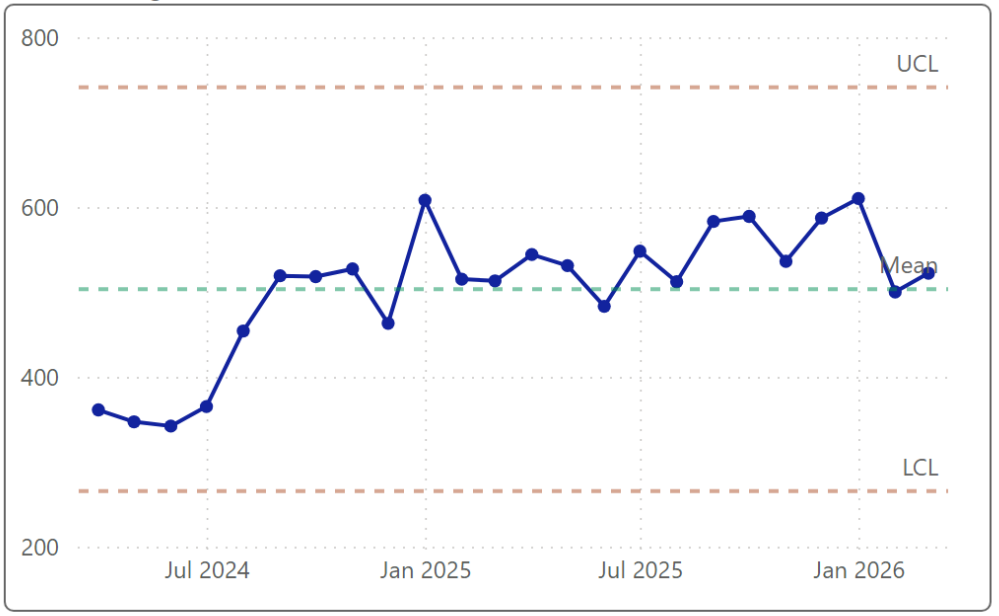
Measure: Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25
Performance: 92,343 (March 2026)
Trajectory: 128,347 (Q4 25/26)
National target: None

**Ministerial Delivery**




Measure: Increase in capacity of Enhanced Community Care to at least the required levels previously set for 2024/25
Performance: 6,545 (March 2026)
Trajectory: 5,277 (Q4 25/26)
National target: None

**Ministerial Delivery**

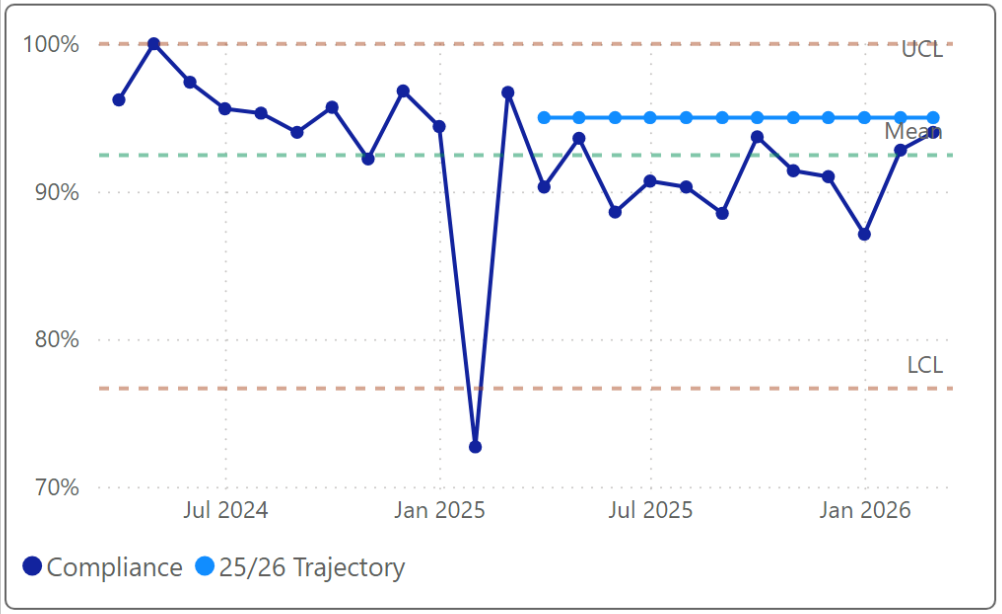



### Insight and Actions

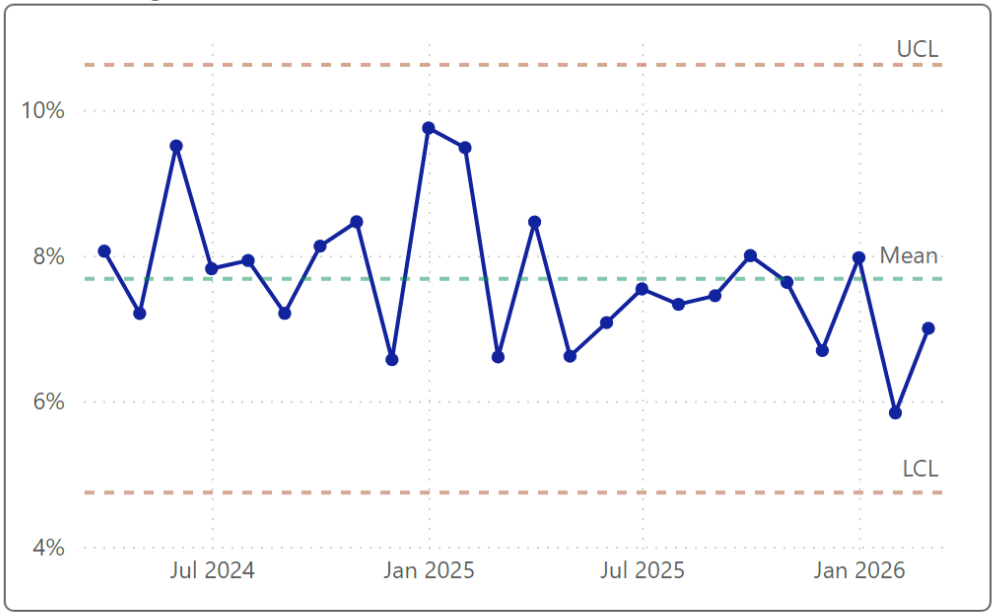
- Community Nursing: End of year performance has finished significantly behind the expected trajectory, with only 72% of the IMTP trajectory delivered. However, an upward trend can be seen over the past two years, with around 1,200 more monthly contacts on average in 2025/26 compared to 2024/25. Ministerial expectations set out that weekend activity reaches 80% of an average weekday level. Although weekend activity as a proportion of total activity is increasing and overall contacts are trending upwards as shown in the graph, achieving the ministerial measure from a volume perspective would demand a significant shift in service delivery towards weekends.
- Enhanced Community Care (ECC): Accepted ECC referrals for 2025/26 has exceeded the IMTP trajectory by almost 25%. While performance dropped in February and March, this was a trend seen in 2024/25, and for both years January represented the month with the most accepted referrals. The ABUHB services included within the national definition comprise Rapid Response across the five boroughs, the Ready to Go Ward at RGH, and Emergency Care at Home in Caerphilly.

Progressing place based models of care and sustainability in **primary and community services**

Measure: Maintain 95% of Palliative Care referrals assessed within 2 days
Performance: 94.0% (March 2026)
Trajectory: 95.0% (March 2026)
National target: 95.0%




Measure: Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s
Performance: 7.0% (March 2026)
Trajectory: 8.5% (March 2026)
National target: None




## Insight and Actions

- Palliative Care: Overall performance for 2025/26 has decreased by just under 2% compared to 2024/25, with values remaining relatively consistent around 91%. The IMTP trajectory of 95% hasn't been met for any month this year. This is a result of a significant increase in demand, as well as having to manage periodic workforce capacity constraints. However, an improvement in February (+5.7%) and again in March (+1.2%) has brought end of year performance to 94%, marginally below the 95% trajectory.
- GP referrals to Rapid Response: Performance over the past year has shown less variability than 2024/25, remaining stable with an average of 7.3%. However, this is an overall reduction on the average of 8.1% in 2024/25 and only April 25 met the IMTP trajectory this year. December performance decreased and was followed by recovery in January, which is an observable, seasonal trend. There was then a more pronounced drop in February and some improvement in March although only to just above December levels. As part of the UEC transformation programme (older people workstream), one of the outcomes of the Navigation Hub/Single Point of Access will be to reduce barriers for GPs to access Rapid Response services.

| Priority | Q4 Planned | Q4 Progress | Q4 Comments |
|---|---|---|---|
| **Rightsizing of Commissioned Care** | Implementation of outcomes from review of additional support contracts | Complete/On schedule | Community Health Care top 50 reviews have been completes and the associated actions have been taken forward resulting in efficiencies. The 25-26 identified saving targets have been met with £306k of full year savings achieved for top 50 placements and £305k full year savings for Funded Nursing Care assessment process |
| **Access & Sustainability** | Increase the number of pharmacies providing Pharmacist Independent Prescriber Service and services through Common Ailments Service (CAS) | Complete/On schedule | 65 pharmacies currently provide PIPs, with 7,002 consultations recorded to date for Q4 (awaiting March 2026 data) During Q4 there were 15,581 CAS consultations of these 1140 were for the new common ailment of Urinary Tract Infections (Awaiting March 26 data). |
| **Focus on Community Pathways** | Deliver actions within the Local Oral Health Plan for 2024-26 across Gwent | Off track within tolerance | The Local Oral Health plan is being revised in the context of the new General Dental Service Regulations, oversight will be led from the newly re-established Integrated Oral Health Group chaired by Dental Director. |
| **Place Based Care** | Actions plans in place to expand integrated neighbourhood teams to be fully multi-professional making the necessary shift in resources and decision making from acute settings into our communities building community resilience | Off track within tolerance | The concept of Integrated Network Teams have been agreed by all Integrated Service Partnership Boards as the key delivery units for Place Based Care. Visible senior sponsorship and permission is now required for practitioners within Integrated Neighbourhood Teams to established new ways of integrated working.<br>Integrated Wellbeing Network Leads are now active members of the Neighbourhood Care Networks embedding social prescribing to utilise community assets. Regular updates through to Populations Health, Partnerships and Planning Committee. |

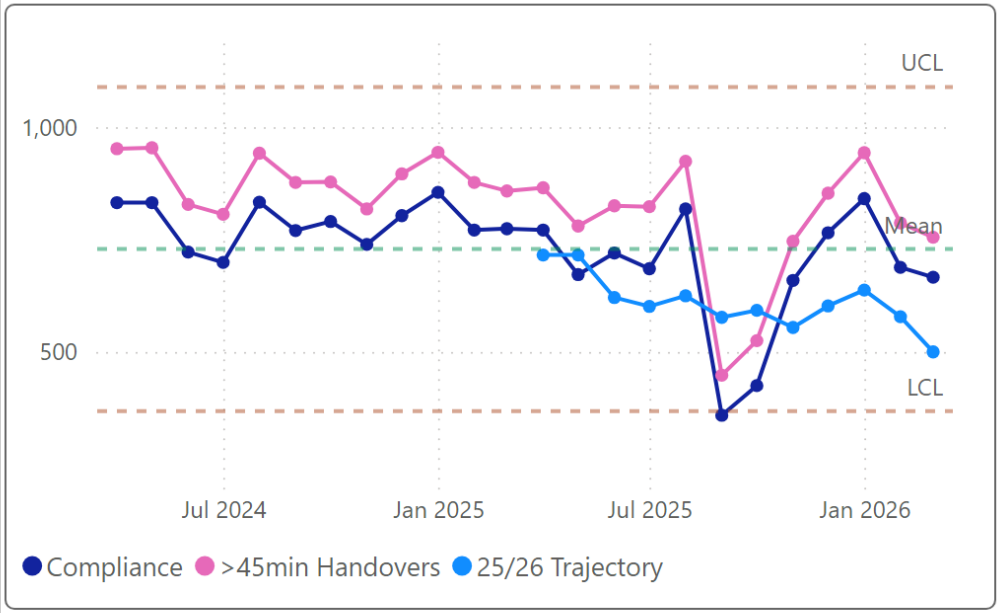
| Theme | Delivery Expectation | ABUHB commitment | In month performance against trajectory |
|---|---|---|---|
| Urgent and emergency care | Reduce the number of ambulance patient handovers over 1 hour | 500 Mar-26 | 666 Mar-26 (Mar-26 Trajectory: 500) |
| | Reduce the number of ambulance crew hours lost at GUH ED (per month) | 2,500 Mar-26 | 2,195 Mar-26 (Mar-26 Trajectory: 2,500) |
| | Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero | 750 Mar-26 | 1,184 Mar-26 (Mar-26 Trajectory: 750) |
| | Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU | 80% Mar-26 | 73.8% Mar-26 (Mar-26 Trajectory: 80%) |
| | Reduction in time from arrival to ED triage - no waits over 60 minutes | 200 Mar-26 | 528 Mar-26 (Mar-26 Trajectory: 200) |
| | Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months. | 60 Mar-26 | 152 Mar-26 (Mar-26 Trajectory: 60) |
| | Maintain the number of Urgent Primary Care contacts (inc. virtual) | 95,147 Mar-26 | 95,304 Mar-26 (Q4 Trajectory: 95,147) |
| | % of patients directly admitted to an acute stroke ward <4hrs of clock start | 20% Mar-26 | 21.1% Q3 25/26 (Q3 Trajectory: 20.0%) |
| | % of unique stroke patients given thrombectomy (all stroke types) | 6% Mar-26 | 7.3% Q3 25/26 (Q3 Trajectory: 6.0%) |

| Theme | Delivery Expectation | ABUHB commitment | In month performance against trajectory |
|---|---|---|---|
| Urgent and emergency care | % Assessed by OT within 24 hours | | **33.3%** Feb-26 |
| | % Assessed by PT within 24 hours | | **31.7%** Feb-26 |
| | % Assessed by SaLT within 72 hours | | **74.1%** Feb-26 |
| | Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard | **160** Mar-26 | **178** Mar-26 (Mar-26 Trajectory: 160) |
| | Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard | **6,437** Mar-26 | **4,543** Mar-26 (Mar-26 Trajectory: 6,437) |
| | Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment | **12** Mar-26 | **19** Mar-26 (Mar-26 Trajectory: 12) |
| | Continuous reduction in the number of people admitted as an emergency who remain in hospital over 21 days since admission | **370** Mar-26 | **385** Feb-26 (Feb-26 Trajectory: 380) |

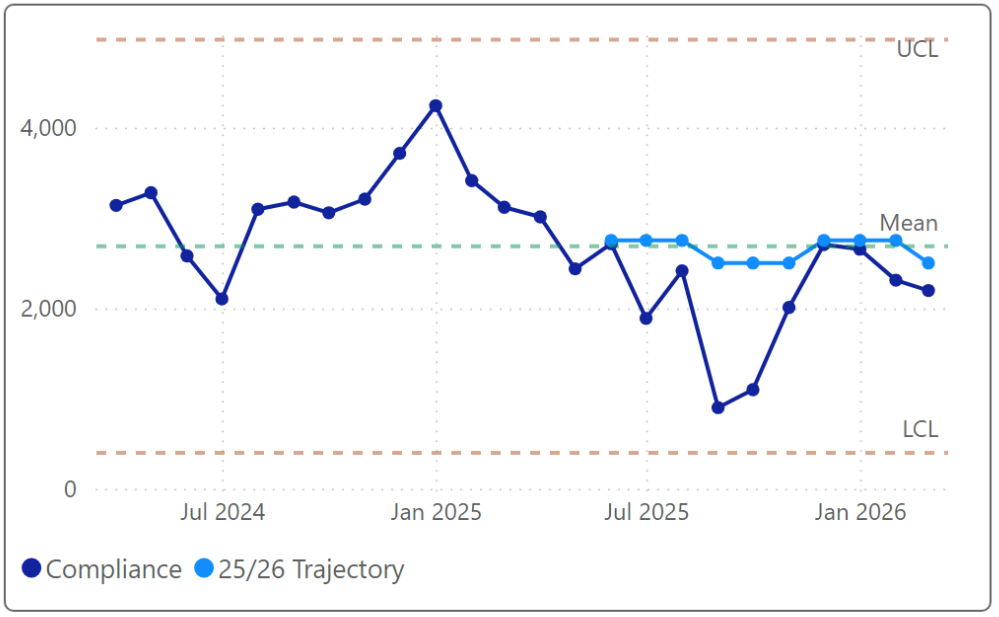
## Improving our **Urgent & emergency care** system focusing on experience, access and discharge pathways

Measure: Reduce the number of ambulance patient handovers over 1 hour
Performance: 666 (March 2026)
Trajectory: 500 (March 2026)
National target: 0

**Ministerial Delivery**




Measure: Reduce the number of ambulance crew hours lost at GUH ED (per month)
Performance: 2,195 (March 2026)
Trajectory: 2,500 (March 2026)
National target: None



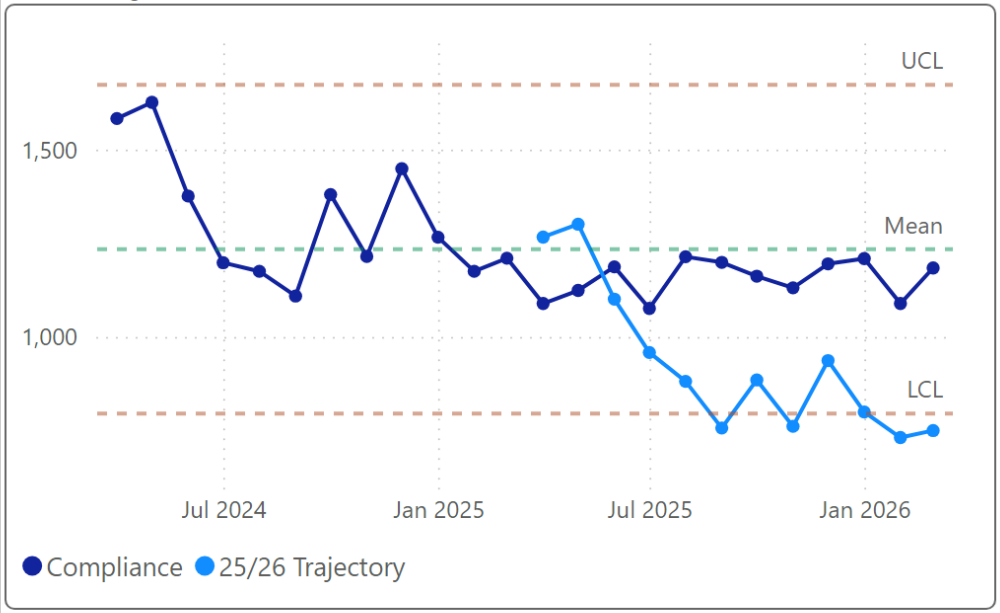

### Insight and Actions

- Ambulance handovers and lost hours: Ambulance handovers at GUH ED and the associated lost hours have improved throughout February and March, with lost hours still maintaining below trajectory performance and ambulance handovers continuing to track above trajectory. Ambulance handovers are reduced by ~100 and lost hours by ~1000 compared to the same period 12 months prior. For handovers, whilst not meeting the IMTP trajectory consistently (3/12 months below), performance at GUH ED has improved again in 25/26. Under both the >60min and >45min measures, March delivered the best performance of the year (outside of the Sep-Nov ONP launch months) at 666 and 755 breaches respectively. Again, outside of the Sep-Nov '25 period, this is the best performance on record since the first few months of GUH (Feb '21). Translating >45min performance into 45 min compliance, March performance of 52% again represents progress and is only marginally short of achieving the 55% target as outlined in the UEC improvement plan. The staged improvement plan sets out monthly targets for handover times and performance against the 45-minute standard, supported by clear actions to increase discharges and patient moves each hour. The plan includes an initial reset phase to re-establish standards and roles, followed by divisional ownership of delivery supported by clinical and executive leaders. All improvement projects are benefits-mapped to track how changes impact and improve system-wide gains in handover performance, flow, length of stay and patient experience.

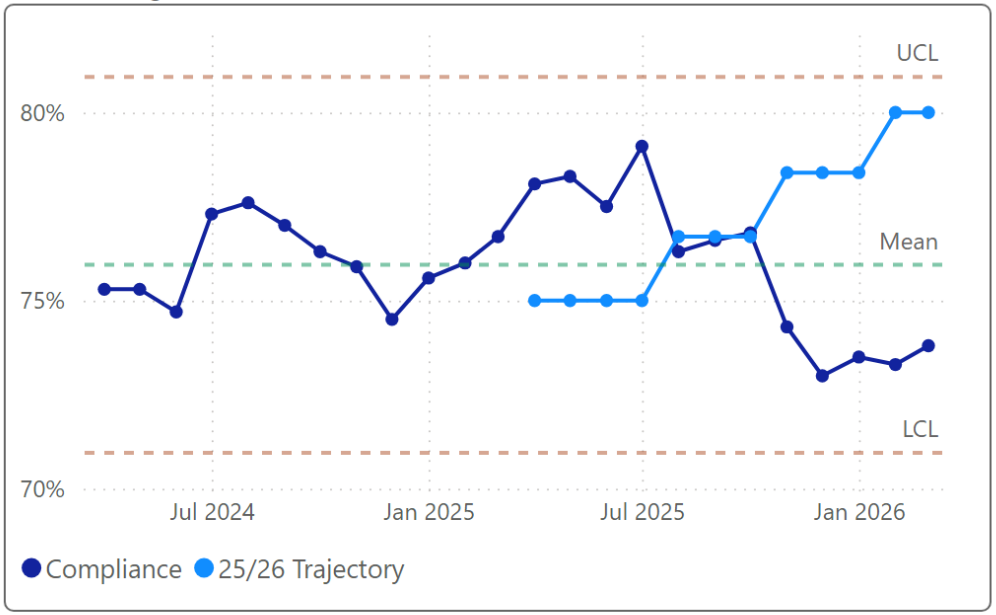
## Improving our **Urgent & emergency care** system focusing on experience, access and discharge pathways

Measure: Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero
Performance: 1,184 (March 2026)
Trajectory: 750 (March 2026)
National target: 0

**Ministerial Delivery**




Measure: Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU
Performance: 73.8% (March 2026)
Trajectory: 80.0% (March 2026)
National target: 95.0%

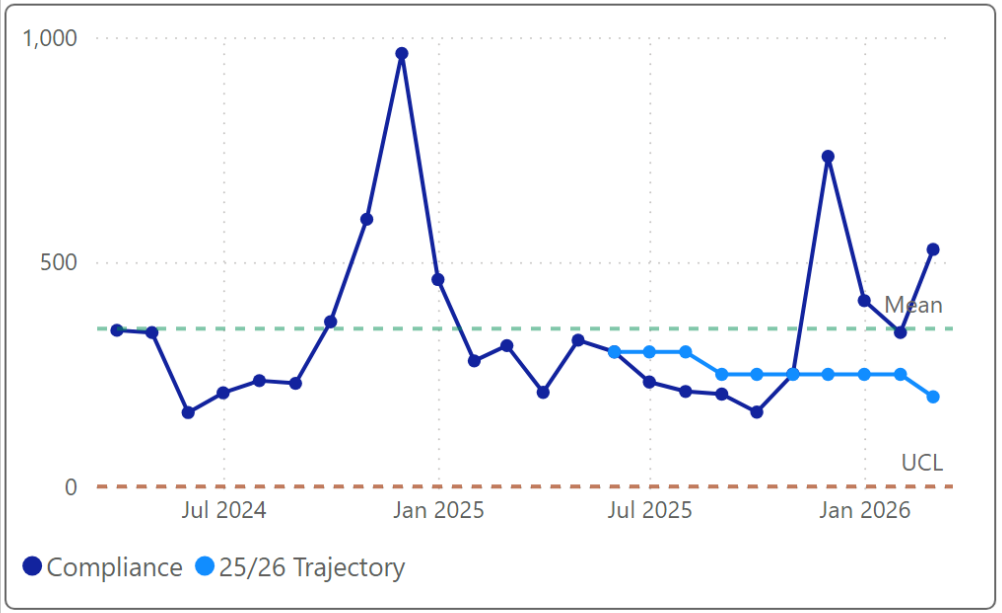



### Insight and Actions

- 12hr EDMIU and 4hr compliance: Whilst the 12hr EDMIU IMTP trajectory has not been realised for the most part (2/12 months below), performance through 25/26 has been improved from previous years. When looking at breaches by volume, performance has largely been in a steady state across the 12 month period with a tight range of just 138 (high of 1,214 in August and low of 1,076 in July). This is markedly different to previous years which had much greater volatility in performance. Looking at performance through the 12hr compliance lens, again there has been a marked improvement through 25/26 with compliance typically between 92.3% and 93.2%, with a post GUH opening record high outlier of 93.8% in Jul '25 and even the most challenged month of Dec '25 at the yearly low of 91.8% (but still the best December since GUH opened). 25/26 ended with 92.8%, just short of the Targeted Intervention de-escalation criteria (93%). Although this represents improved consistency compared to previous periods, weekly fluctuations continue, largely influenced by delays in specialty responses, high bed occupancy, and ongoing constraints on patient flow across the wider system. To achieve further reductions in breach volumes, sustained attention on earlier specialty moves, improved inpatient throughput, and maintaining continuous flow throughout the ED and downstream wards remains critical. This will all be supported by the ONP relaunch. 4hr compliance has been more challenged through the Winter period, as demand driven pressures on all parts UEC system impact the ability to enact timely reviews and moves.

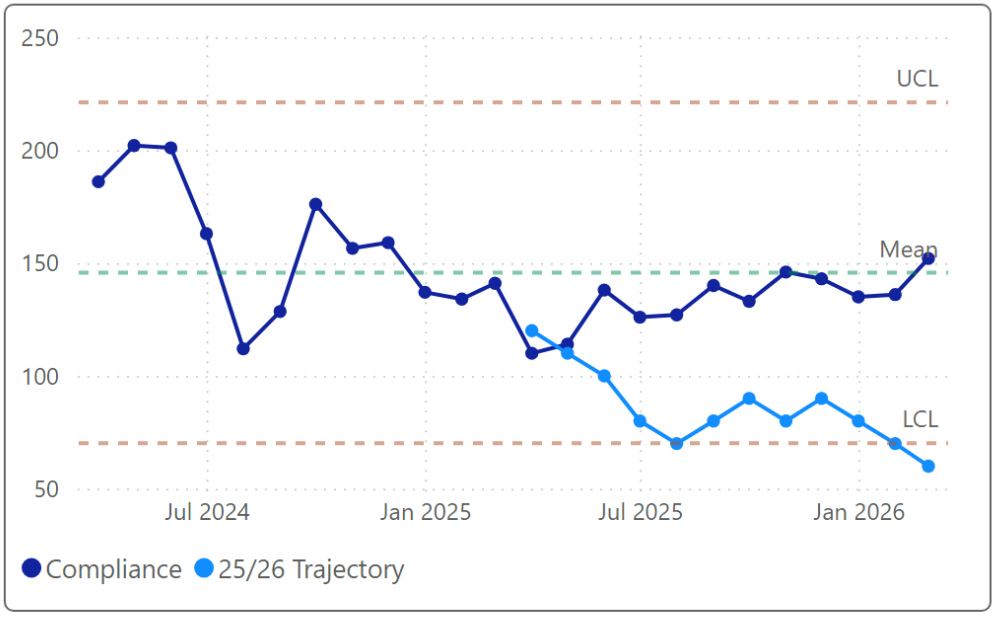
## Improving our **Urgent & emergency care** system focusing on experience, access and discharge pathways

Measure: Reduction in time from arrival to ED triage - no waits over 60 minutes
Performance: 528 (March 2026)
Trajectory: 200 (March 2026)
National target: None




Measure: Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months.
Performance: 152 (March 2026)
Trajectory: 60 (March 2026)
National target: 60

**Organisational Escalation**

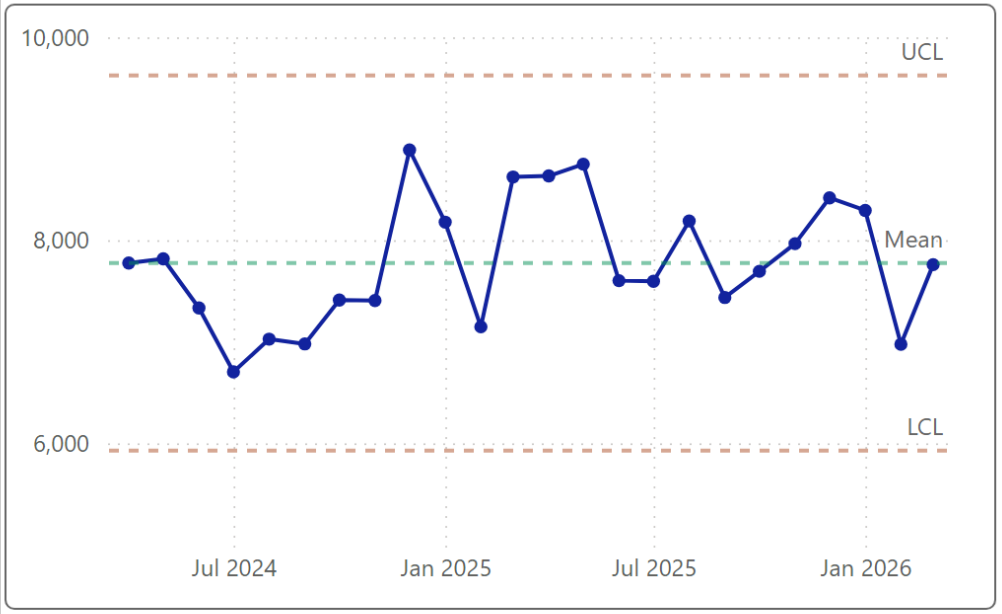



### Insight and Actions

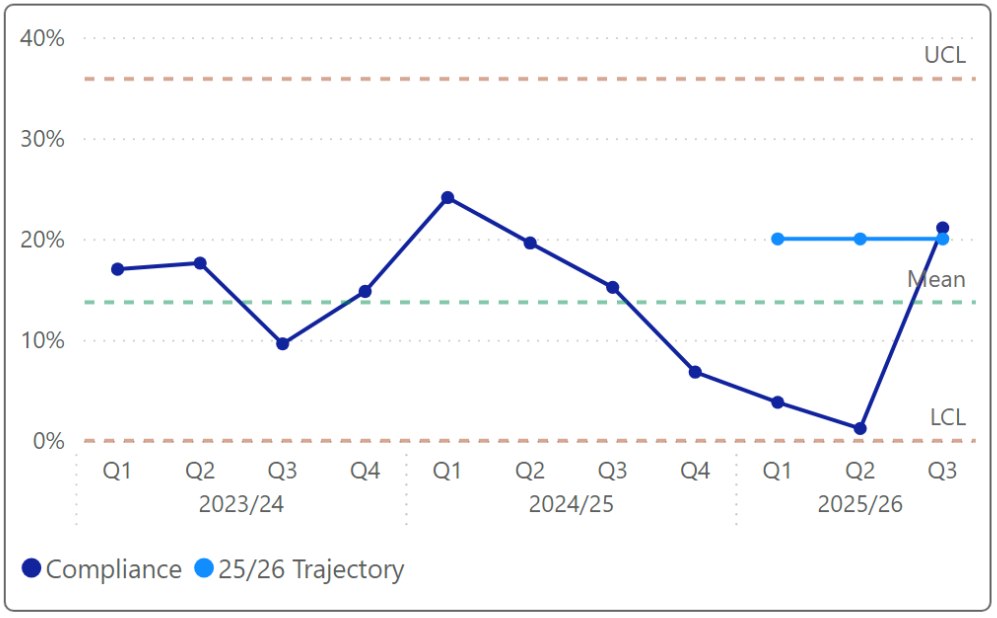
- Triage: Triage performance had been tracking below trajectory through the year to date, however there was a significant spike in December, and performance has yet to return to below trajectory, increasing again in March although reduced from the December peak. This is observable in the data in 2024 and 2022. 60-minute triage breaches since 24/25 are circa one third of the volume they were in the first two and half years of GUH. Triage improvement is included as a project within the ONP relaunch.
- Wait to be seen (WTBS): 25/26 performance is improved when compared to the previous few years and again has been much more stable, however it has trended upwards through the year, with the opening April position the lowest at 1h50mins and the closing March position the highest at 2h32mins. To embed sustained continuous-flow across the Emergency Department, daily huddles are being strengthened and used as a mechanism to improve early patient movement, helping to prevent congestion within majors and assessment areas. Improving daytime assessment capacity is also key, building on ongoing clinician role redesign and effective Senior Rapid Assessment & Treatment (SRAT) rostering. This ensures assessment spaces capacity is used to the maximum potential, reducing the delays that contribute to WTBS pressures. Finally, protecting cubicle availability overnight is essential, with enforcement of ONP escalation and adhering to boarding protocols so that clinical areas retain capacity, helping to avoid the deterioration in WTBS performance when overnight capacity is challenged.

Improving our **Urgent & emergency care** system focusing on experience, access and discharge pathways

Measure: Maintain the number of Urgent Primary Care contacts (inc. virtual)
Performance: 95,304 (March 2026)
Trajectory: 95,147 (March 2026)
National target: None




Measure: % of patients directly admitted to an acute stroke ward <4hrs of clock start
Performance: 21.1% (Q3 25/26)
Trajectory: 20.0% (Q3 25/26)
National target: 50.0%



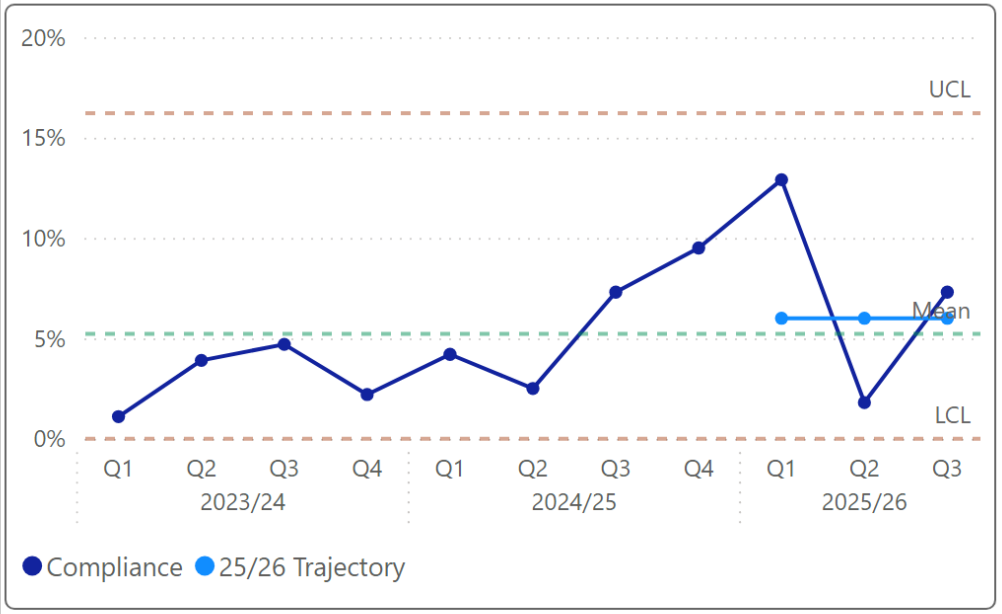

## Insight and Actions

- Urgent Primary Care (UPC): UPC contacts exceeded the Q4 trajectory. Higher monthly contacts were reported in December and January, demonstrating that service support increased in line with demand in the peak winter period.

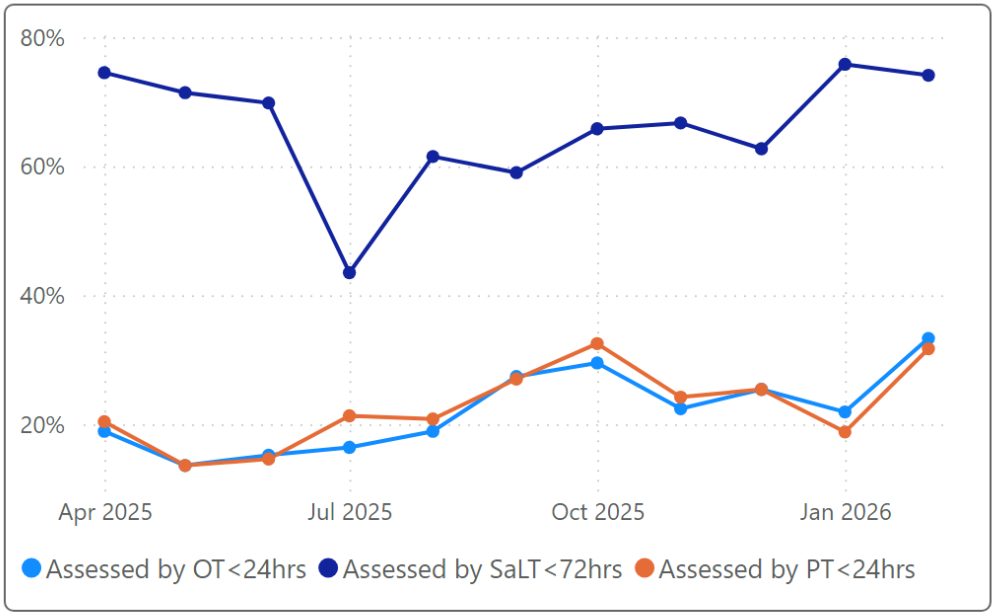
- Stroke 4hr target: Following the identification of the a data processing error which had depressed true performance, it is hugely encouraging that, following the publication of the Q3 SSNAP data, performance has exceeded the IMTP trajectory of 20%. Current analysis suggest the performance has at the least been maintained into Q4. The Stroke Regional Network Group is placing an increasing focus on performance in new Urgent & Emergency Care Improvement programme. Updated stroke improvement plan is in place to address outstanding GIRFT actions and new NHS Wales Stroke Quality statement, and standards along with an overview of monthly performance metrics will be provided to June 2026 Finance and Performance Committee.

## Improving our **Urgent & emergency care** system focusing on experience, access and discharge pathways

Measure: % of unique stroke patients given thrombectomy (all stroke types)
Performance: 7.3% (Q3 25/26)
Trajectory: 6.0% (Q3 25/26)
National target: 10.0%




Measure: % Assessed by OT <24hrs, PT <24hrs, SaLT <72hrs
Performance:
33.3% OT <24hrs, 31.7% PT <24hrs, 74.1%, SaLT <72hrs (February 2026)
Trajectory:
National target: None



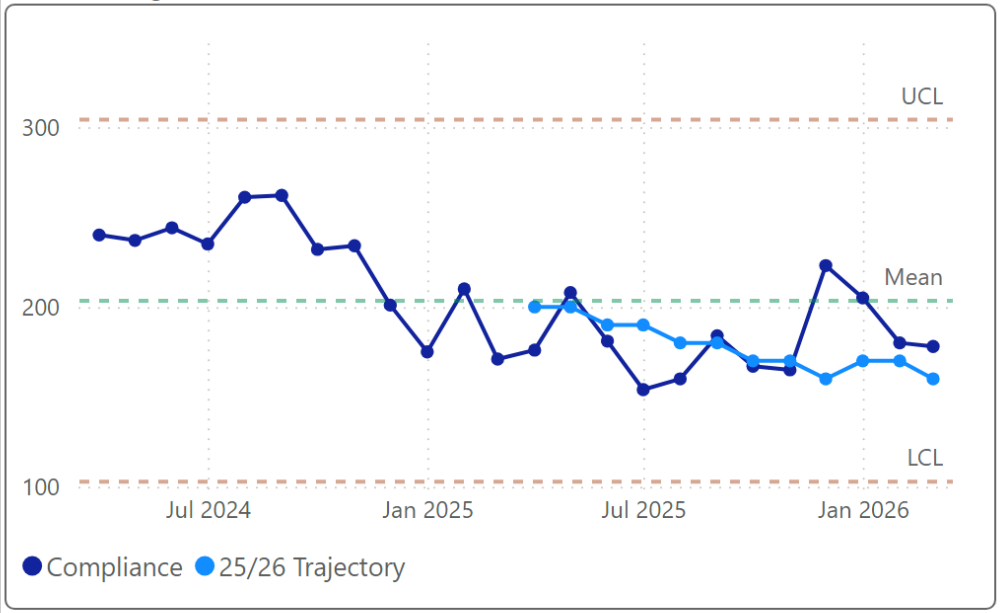

### Insight and Actions

- Stroke thrombectomy: Q3 SSNAP data also shows improvement in thrombectomy rates up to 7.3% and meeting the IMTP trajectory. -Thrombectomy commissioning and data capture has been discussed between ABUHB and NHS P&I. NHS P&I are liaising with the JCC around commissioning approach and particularly hours of service provided from Southmead (NBT), an extension to which could assist in improving rates further. The internal stroke improvement plan linked to improving thrombolysis rates is underway and will have linked benefit to thrombectomy where applicable.
- Stroke therapies: Physio and Occupational Therapy assessment within 24hrs improved as of the latest February data, with Speech and Language within 72hrs broadly maintaining it's improved performance since Q2. The inpatient rehabilitation engagement exercise has concluded. It has been confirmed that the service will remain at YYF, supported by Llais but subject to them receiving a service change proforma and a monitoring plan for improvements as outlined in an Executive Committee paper in March. Llais have been invited to join the Stroke Regional Network Board to oversea this going forward alongside other aspects of strategic service oversight.

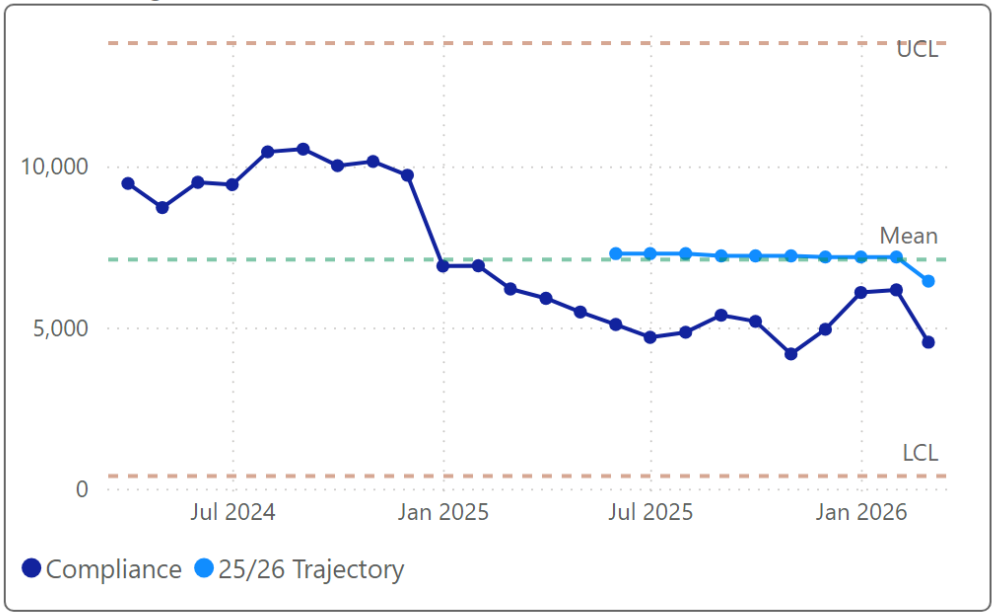
## Improving our **Urgent & emergency care** system focusing on experience, access and discharge pathways

Measure: Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard
Performance: 178 (March 2026)
Trajectory: 160 (March 2026)
National target: None

**Ministerial Delivery**




Measure: Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard
Performance: 4,543 (March 2026)
Trajectory: 6,437 (March 2026)
National target: None



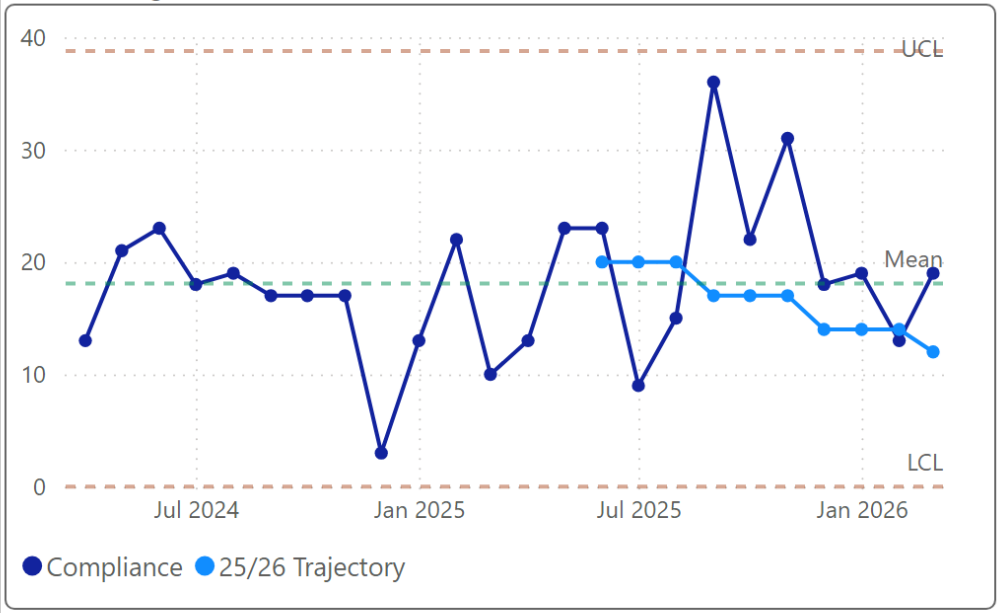

### Insight and Actions

- Pathway of Care Delays (POCDs): The total number of POCDs has seen three months of consecutive reduction after reaching a 2025/26 high in December. The March position of 178 is now slightly above the planned trajectory of 160. However, this still represents a 4% increase on the position a year ago (171). POCDs by days delayed remained stable from January to February but dropped dramatically in March to 4,543, the second lowest position since April '24 and a 27% drop on the position a year ago. Average days delayed has also decreased from 34 days in February to 26 days in March, reflecting the proportionally greater reduction in days delayed than total POCDs. Significant focus remains on reviewing the longest staying patients, as well as new processes in place across Divisions to improve the accuracy of Estimated Discharge Dates (EDDs) and the recording of reasons that are preventing patients moving to the next step of the discharge planning process.

## Improving our **Urgent & emergency care** system focusing on experience, access and discharge pathways

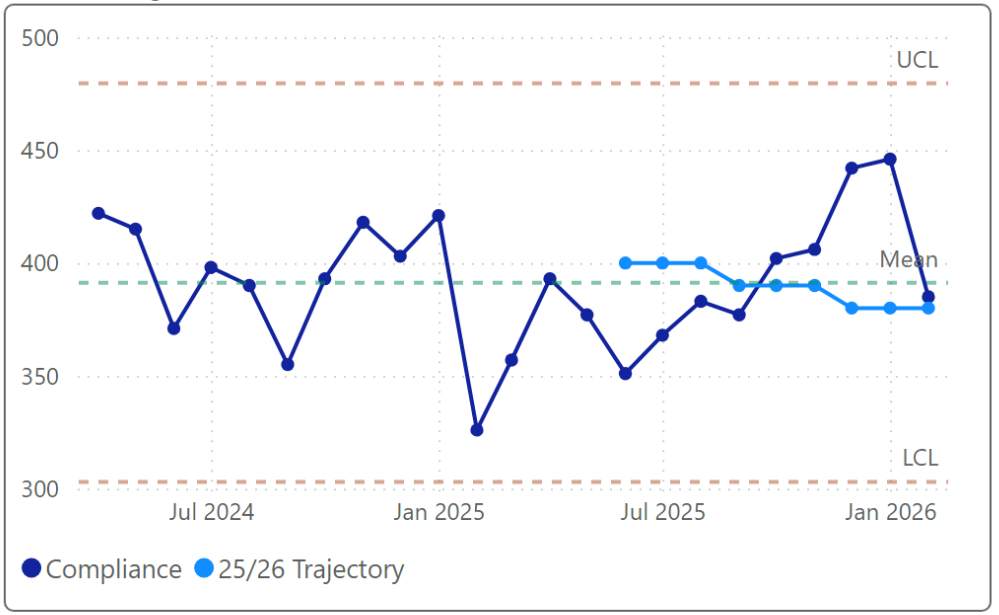
Measure: Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment
Performance: 19 (March 2026)
Trajectory: 12 (March 2026)
National target: None

**Organisational Escalation**




Measure: Continuous reduction in the number of people admitted as an emergency who remain in hospital over 21 days since admission
Performance: 385 (February 2026)
Trajectory: 380 (February 2026)
National target: None

**Organisational Escalation**




### Insight and Actions

- POCD subset: The POCD subset measure, which is a condition of UEC enhanced monitoring status, reached a peak in September and has been on a downward trend since, dropping below trajectory in February. March has seen an increase on this position, despite a small reduction in total POCDs (-2). Awaiting completion of Allied Health Professional assessment was amongst the top 5 most common delay reasons in March, having increased from 7 to 11. Delays related to awaiting completion of nursing assessment also rose from 3 to 7.
- 21 day+ Length of Stay: another measure as part of UEC enhanced monitoring status, performance trended upwards from June, reaching a peak in the winter months as would be anticipated, when considering seasonality and increases in acuity. While December and January cohorts were significantly above trajectory, this has reduced in February to just above trajectory at 385. Operational Length of Stay meetings have had a renewed focus through the Our Next Patient initiative and organisational focus on the need to effectively manage this patient cohort to enable whole system flow.

| Priority | Q4 Planned | Q4 Progress | Q4 Comments |
|---|---|---|---|
| **Admission Avoidance (Goal 1)** | Increase the number of care home residents with a robust Future Care Plan (FCP) in place expanding into new care homes | Complete/On schedule | The Future Care Plan (FCP) facilitators have delivered training to 14 care homes across Gwent, with further sessions consistently booked through to July 2026. 92 care homes staff (from the 14 homes) have been trained with 48 NHS staff.<br><br>To strengthen and sustain this work, a new Future Care Plan Standard Operating Procedure (SOP) has been developed to complete the loop. This SOP enables follow-up visits to homes that have already received training, supporting the ongoing development, consistency, and quality of residents' Future Care Plans. |
| **Integrated Front Door (Goals 2,3 & 4)** | Pilot of proposed Navigation Hub model | Complete/On schedule | Single point of access for health care professionals is well established with call handlers navigating urgent primary, secondary and community referrals. Work is on-going to simplify existing structures to improve outcomes.<br><br>A Frailty based MDT pilot implemented from November to March . Over 320 cases were reviewed during the pilot period to 1 March 2026, resulting in 57% of patients remaining at home and 85% avoiding conveyance to the Grange University Hospital when community hospital admissions were included as alternative pathways. |
| **Integrated Back Door (Goals 5 &6)** | Roll out of Optimal Ward Model across all Hospital Sites | Complete/On schedule | Optimal Hospital Flow Framework rolled out across all sites to support continuous flow model. The principles of the Framework need to be embedded consistently across site to reduce variation and support timely discharges. A target for the daily no. of discharges has been set with compliance against it monitored. |
| **Medical Service Redesign** | Continued implementation of new service model at RGH | Complete/On schedule | Scoping of new pathway completed and informing Older Persons service model. |
| | Confirm clinical intake model at NHH | Complete/On schedule | The rationale for capital investment at NHH is fundamentally to address significant structural risk from RAAC but the work would also enable the modernisation of clinical pathways and a sustainable enhanced Local General Hospital model and estate. A revised Strategic Outline Case (SOC) was submitted to Welsh Government in March. |
| | Finalise future service model for Frailty & Care of the Elderly onfiguration | Complete/On schedule | Update provided at Board Development in April 2026 which included the outcomes of the Desktop Review of each patient under the medical take in 24-hour period, undertaken by a range of clinicians to determine the most appropriate pathway based on the information available at the point of referral. Outlined proposed requirements and timelines. |

| Theme | Delivery Expectation | ABUHB commitment | In month performance against trajectory |
|---|---|---|---|
| Continuing to prioritise cancer, urgent and the longest waiting patients for planned care | 12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion | 70% Mar-26 | 63.1% Mar-26 (Mar-26 Trajectory: 70.0%) |
| | Reduction in backlog of patients waiting over 62 days (SCP) | 200 Mar-26 | 310 Mar-26 (Mar-26 Trajectory: 200) |
| | Reduction in backlog of patients waiting over 104 days (SCP) | 50 Mar-26 | 92 Mar-26 (Mar-26 Trajectory: 50) |
| | Increase in rate of treatments starting within 28 days of decision to treat | 75% Mar-26 | 87.7% Mar-26 (Mar-26 Trajectory: 75.0%) |
| | Numbers of patients waiting over 104 weeks (all stages) | 0* Mar-26 | 23 Mar-26 (Mar-26 EoY Trajectory: 0) |
| | Number of patients waiting over 52 weeks for Outpatients | 1,834* Mar-26 | 1,228 Mar-26 (Mar-26 EoY Trajectory: 1,834) |
| | Reduction in the number of patients waiting 100% past Outpatient follow-up target date | 27,275 Mar-26 | 30,850 Mar-26 (Mar-26 Trajectory: 27,275) |
| | Increase in the rate of See On Symptom and Patient Initiated Follow-ups | 13.5% Mar-26 | 12.6% Mar-26 (Mar-26 Trajectory: 13.5%) |
| | Monitoring DNA/CNA for every Outpatient clinic. When DNA >5%, overbooking to be implemented & monitored and reduction of CNA | 5% Mar-26 | 5.2% Mar-26 (Mar-26 Trajectory: 5.0%) |

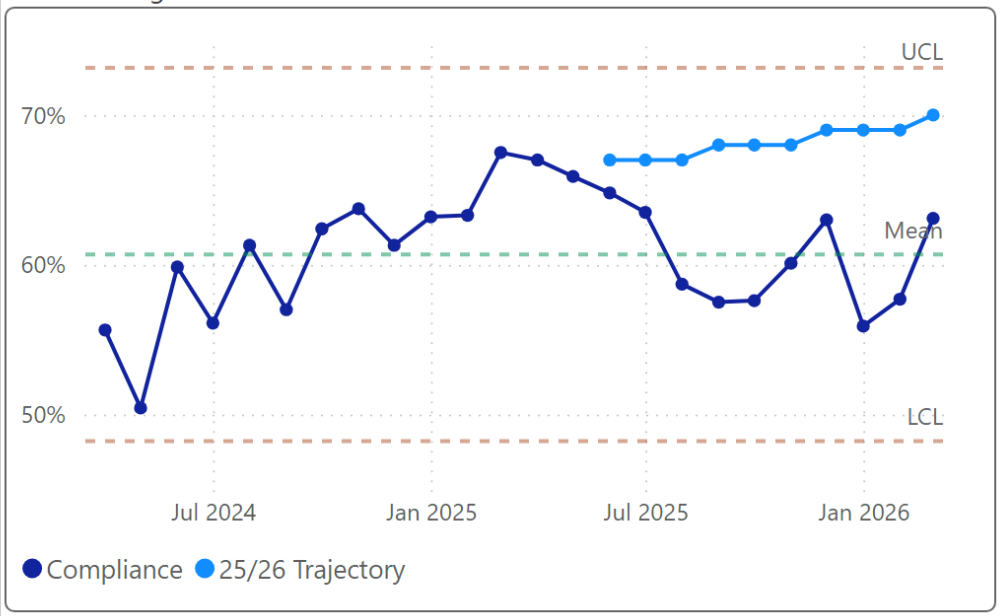
# Ministerial Delivery Expectations

| Theme | Delivery Expectation | ABUHB commitment | In month performance against trajectory |
|---|---|---|---|
| Continuing to prioritise cancer, urgent and the longest waiting patients for planned care | Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic | 166* Mar-26 | 233 Mar-26 (Mar-26 EoY Trajectory: 166) |
| | Number of adults waiting more than 14 weeks for all audiology pathways | 5,440 Mar-26 | 5,766 Mar-26 (Mar-26 Trajectory: 5,440) |
| | Number of children waiting more than 6 weeks for all audiology pathways | 3,630 Mar-26 | 780 Mar-26 (Mar-26 Trajectory: 3,630) |
| | No patient waiting more than 14 weeks for a therapeutic assessment | 105 Mar-26 | 350 Mar-26 (Mar-26 Trajectory: 105) |
| | On 90% of days planned care inpatient/daycase/theatre recovery capacity should be protected from pressures and outliers | 90% Mar-26 | 95.4% Mar-26 (Mar-26 Trajectory: 90.0%) |
| | Theatre Utilisation late starts to less than 20% | 25% Mar-26 | 38.2% Mar-26 (Mar-26 Trajectory: 25.0%) |
| | Theatre Utilisation early finishes to less than 10% | 25% Mar-26 | 40.8% Mar-26 (Mar-26 Trajectory: 25.0%) |
| | Theatre Utilisation session utilisation to 85% | 85% Mar-26 | 83.7% Mar-26 (Mar-26 Trajectory: 85.0%) |
| | Deliver improvements in day surgery rates, achieving a BADS daycase rate | 55% Mar-26 | 77.9% Feb-26 (Mar-25 Trajectory: 55.0%) |

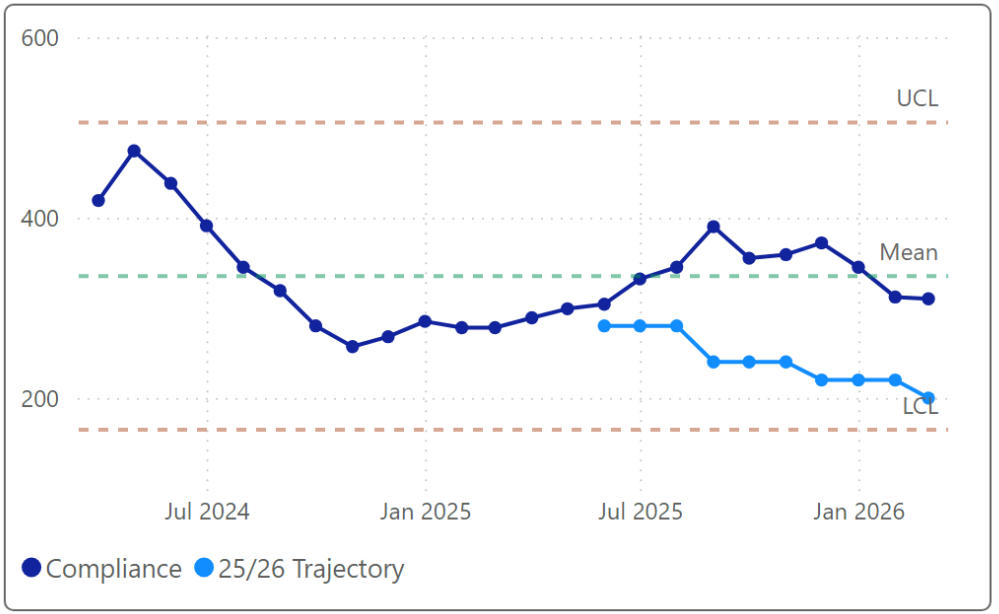
Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**

Measure: 12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion
Performance: 63.1% (March 2026)
Trajectory: 70.0% (March 2026)
National target: 80.0%

**Ministerial Delivery**




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

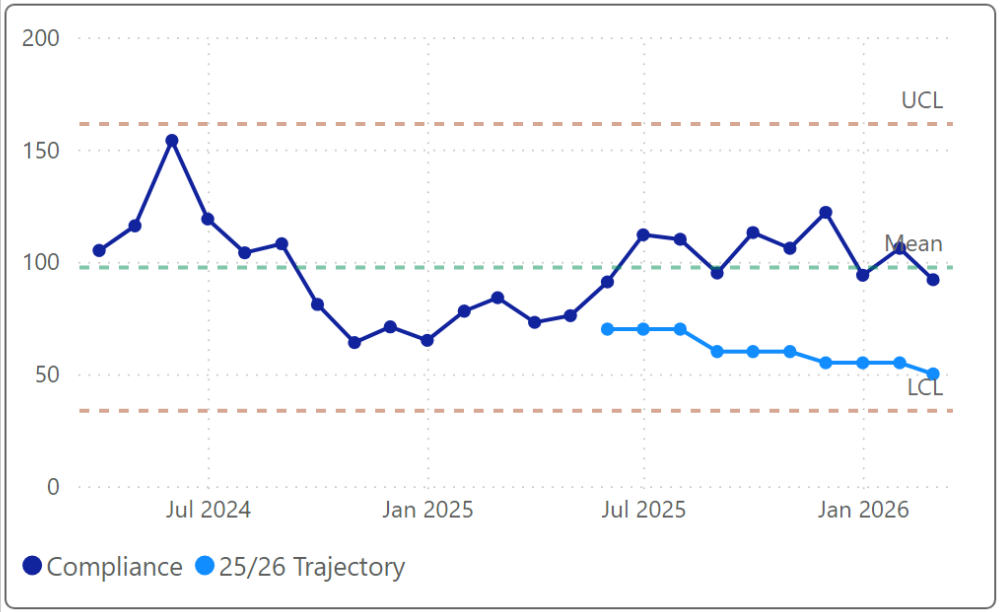



## Insight and Actions

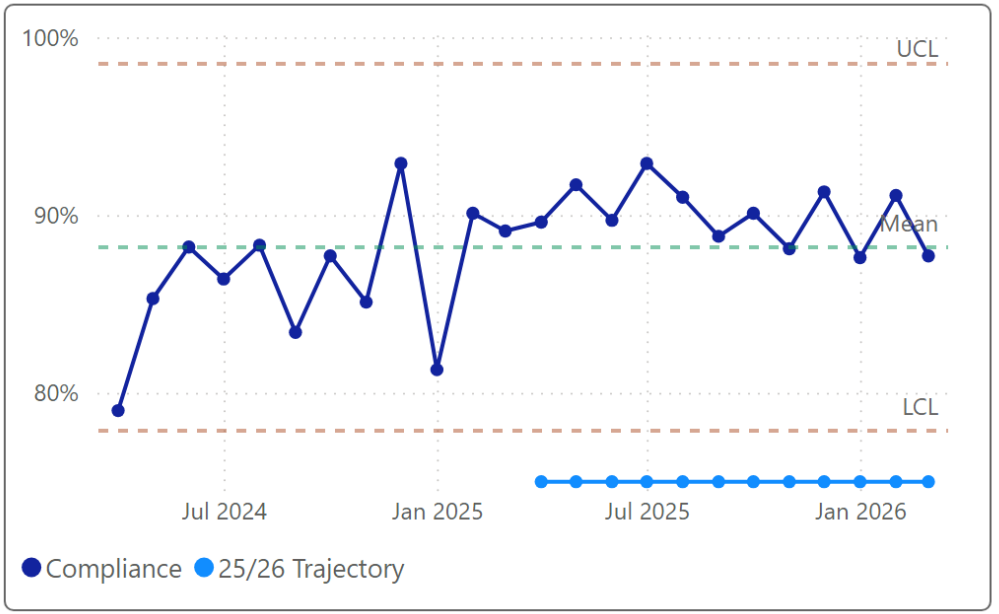
- SCP compliance: Continued increase in performance for the past two months, with March position at 63.1%. Recovery planning meetings have been established, chaired by the Cancer SRO and supported by Cancer Services. Weekly meetings have resumed in Head & Neck and a pathway deep-dive is underway, with the backlog already reducing. Recovery planning group meetings in gynaecological oncology are beginning to demonstrate a positive impact, with February SCP compliance rising to an in-year high of 73.3% in Feb-26 (37.5% in Nov-25), although the Mar-26 position has reduced to 36.4%. In colorectal services, a detailed action plan has been developed to support improvements in patient pathways and SCP compliance, supported by the establishment of a recovery action planning group to focus on key areas for improvement. A particular priority is addressing significant challenges at the first diagnostic stage of the pathway. The endoscopy service continues to experience high DNA and short-notice CNA rates, which are negatively impacting overall pathway compliance.
- 62 day backlog: The target for the 62 day backlog is to be ~10% of the SCP Census, which has increased through 25/26 reaching a high of ~3,900 in July. The PTL has continued to decrease and now sits at 3,232 as of March, and thus a backlog of 310 represents 9.6% of the total PTL. There remains a continued focus to reduce the backlog in the three tumour sites the make up over 75% of the entire 62 day backlog (Lower GI, Upper GI and Urology).

Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**

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




Measure: Increase in rate of treatments starting within 28 days of decision to treat
Performance: 87.7% (March 2026)
Trajectory: 75.0% (March 2026)
National target: None




## Insight and Actions

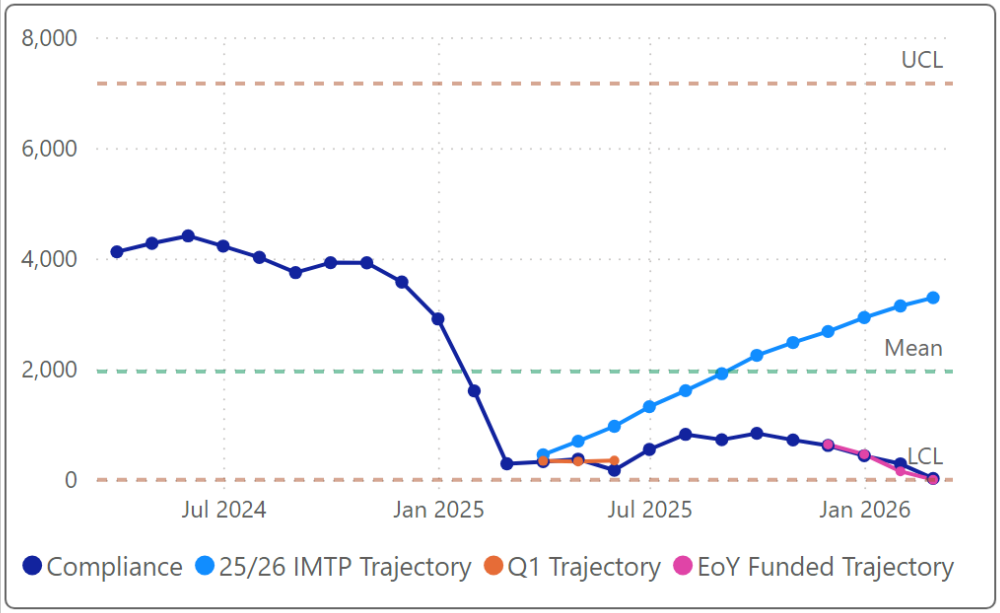
- 104 day backlog: The 104 day backlog has been largely stable over the past 6 months, even in the context of an SCP census that has been subject to significant fluctuation. The actions through the remainder of Q4 and into 26/27 will be focussed on reducing this backlog.

- 28 day treatment start rate from decision to treat (DTT): The percentage of treatments starting within 28 days of DTT have been relatively consistent through 25/26 to date, all within a range of 5.9% (86.9% - 92.8%), and the majority in excess of the mean performance.

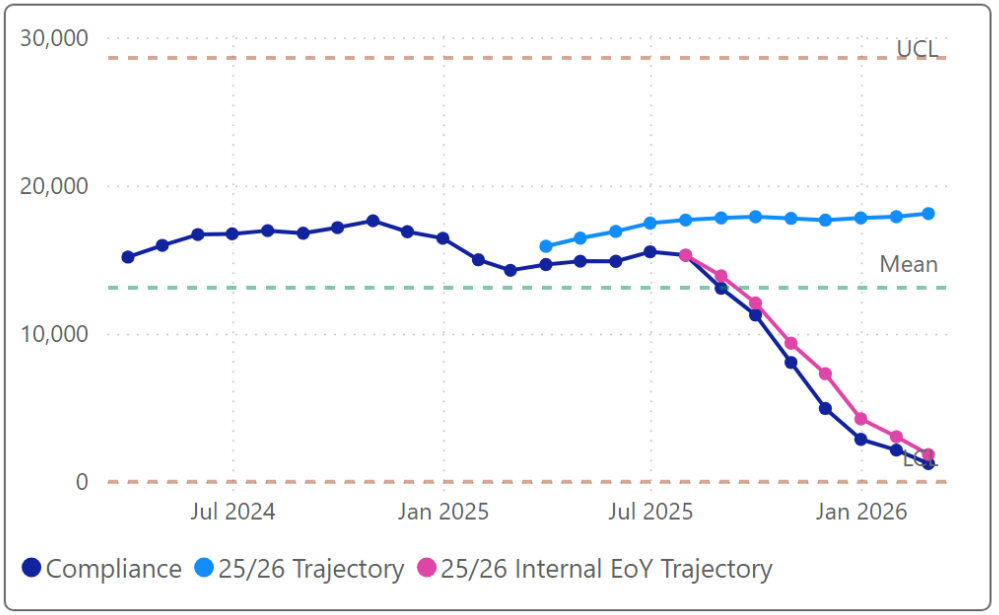
Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**

Measure: Numbers of patients waiting over 104 weeks (all stages)
Performance: 23 (March 2026)
Trajectory: 3,291 (March 2026)
National target: 0

**Ministerial Delivery**




Measure: Number of patients waiting over 52 weeks for Outpatients
Performance: 1,228 (March 2026)
Trajectory: 18,095 (March 2026)
National target: 0

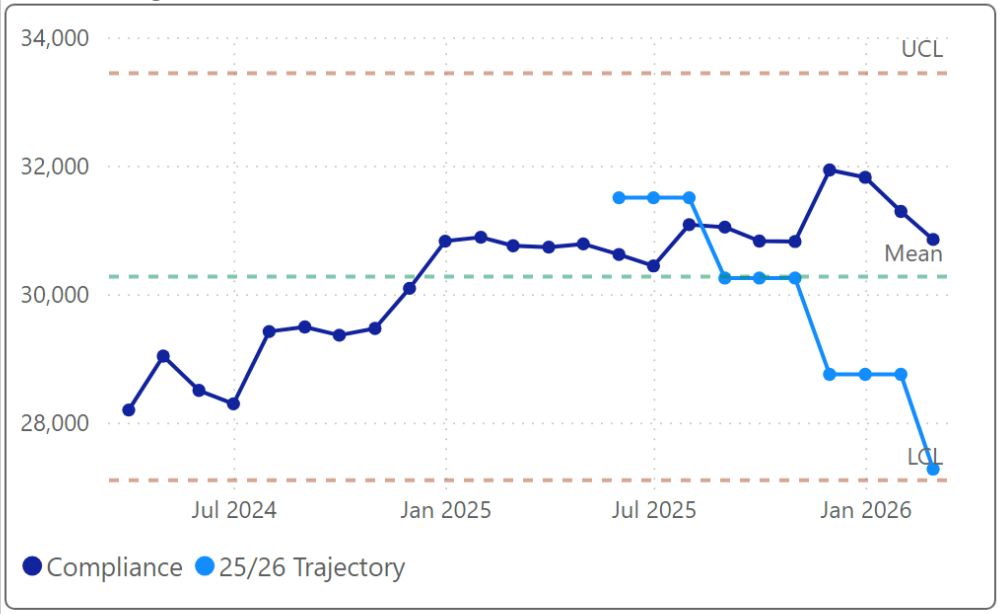



## Insight and Actions

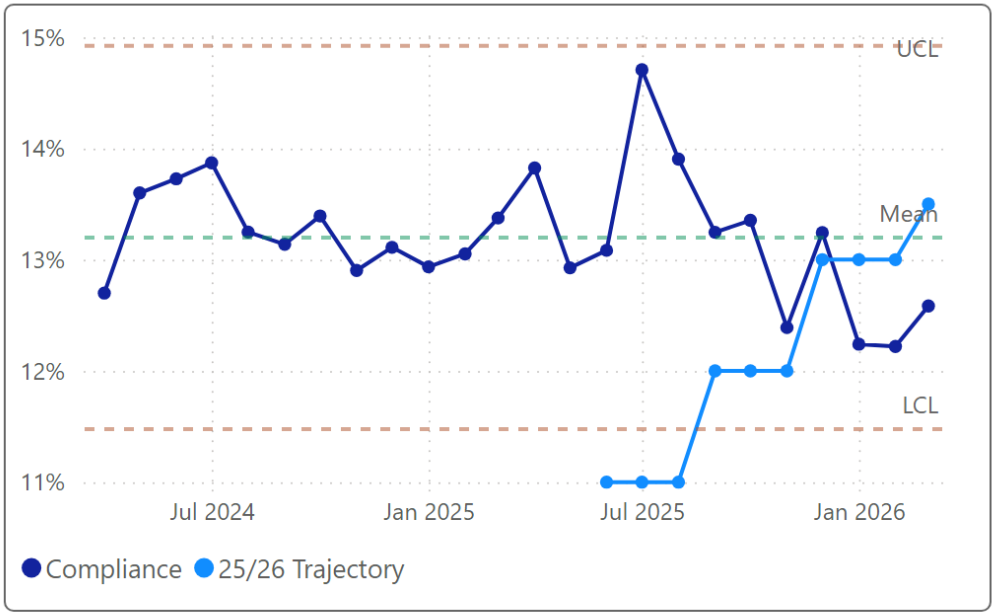
- 104 weeks RTT: The Health Board has delivered a significant achievement in reducing planned care wait overs 104 weeks to 23. This is the lowest number since April 2020. Enabled by additional, non recurrently funded schemes within the Division of Surgery, there was a vast amount of organisational focus on delivering against the end of year trajectory. Whilst this was aiming for zero, a risk position of 30-40 was highlighted in Orthopaedics so to close the year at 23 represents an excellent result. An enormous amount of credit is due to all of the teams involved in delivering against this objective.
- 52 week new Outpatient: The 26 week OP programme significantly impacted on the 52 week breach profile, as evidenced by the sustained reduction from the August position. The year end position of 1,228 was lower than the IMTP 26/27 planning assumption year end forecast of 1,834, and represents the Health Board's lowest 52 week OP position since August 2020. With regards to delivery against the 26 weeks outpatient insourcing programme, as of the latest available data the Health Board has delivered 33,203 against a planed total of 33,612. This variance of 409 equates to 98.8% contract delivery.

Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**

Measure: Reduction in the number of patients waiting 100% past Outpatient follow-up target date
Performance: 30,850 (March 2026)
Trajectory: 27,275 (March 2026)
National target: None




Measure: Increase in the rate of See On Symptom and Patient Initiated Follow-ups
Performance: 12.6% (March 2026)
Trajectory: 13.5% (March 2026)
National target: None



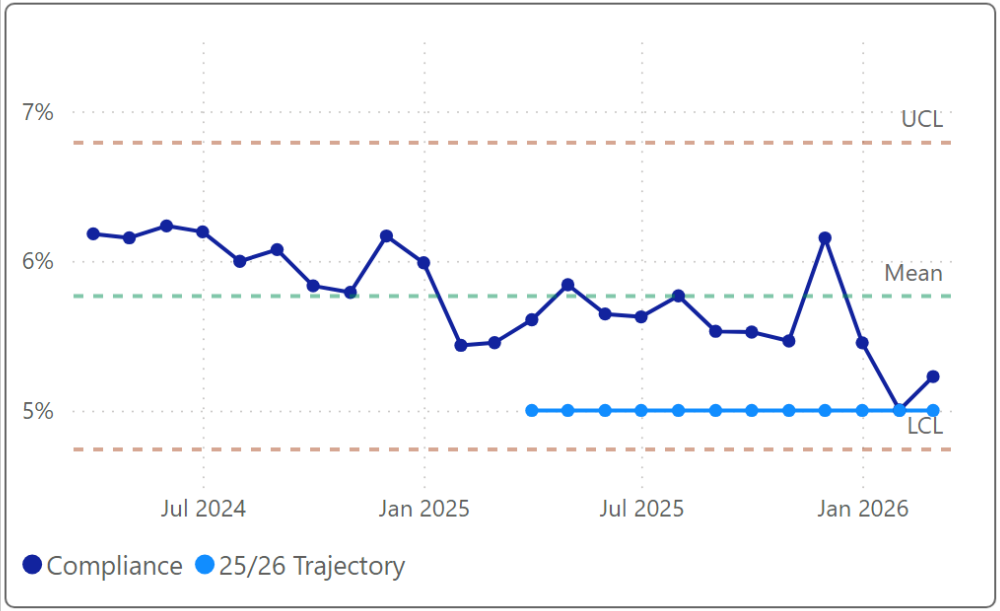

## Insight and Actions

- Following the increase in December for the number of patients waiting 100% past follow up target date, the volume has reduced through Q4 however remains higher than IMTP trajectory. For 26/27, the Health Board has committed to delivering against the national expectation of reducing the size of this list by 25%. SOS and PIFU rates are rose slightly in March to 12.6%, however this was slightly short of meeting the IMTP trajectory. The OPD Transformation Programme continues to monitor patients with the longest follow-up waits, working closely with Directorate teams to ensure patients are booked or appropriately clerically and clinically validated. There remains a strong focus on Straight to Discharge where appropriate, with the majority of CIN protocols embedded as standard practice. Local SOS and PIFU pathways are established, and during March and April work is being undertaken with Directorates to ensure consistent use of these pathways and to identify any new opportunities. Retrospective application of SOS/PIFU pathways is planned for 2026/27, aligned with the wider validation strategy, building on early implementation in a small number of areas. Clinical validation of the delayed follow-up list for ENT commenced in January 2026, resulting in patients being discharged or moved onto SOS/PIFU pathways where clinically appropriate.

Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**

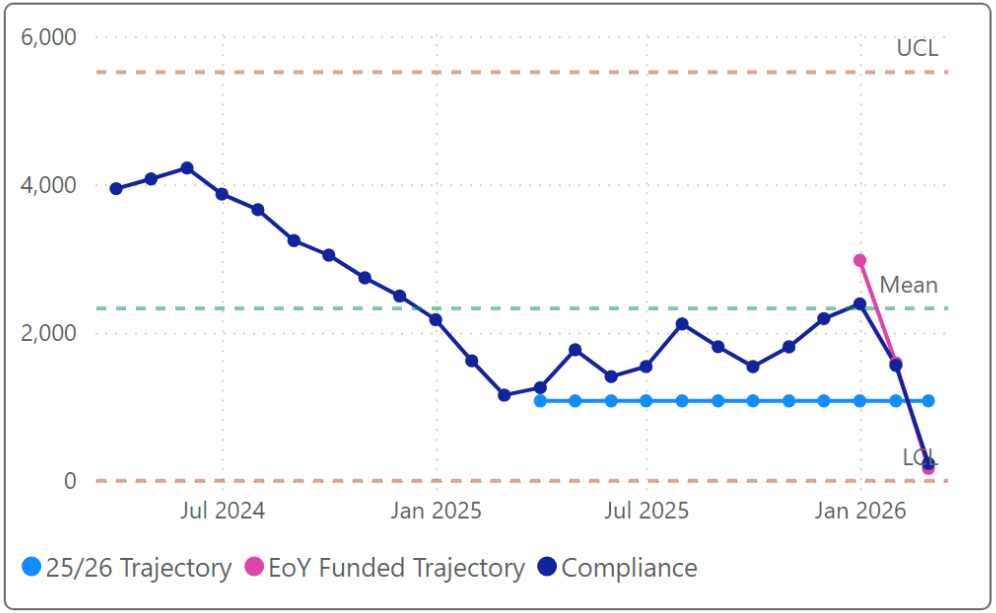
Measure: Monitoring DNA/CNA for every Outpatient clinic. When DNA >5%, overbooking to be implemented & monitored and reduction of CNA
Performance: 5.2% (March 2026)
Trajectory: 5.0% (March 2026)
National target: 5.0%

**Enabling Action**




Measure: Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic
Performance: 233 (March 2026)
Trajectory: 1,077 (March 2026)
National target: 0

**Ministerial Delivery**

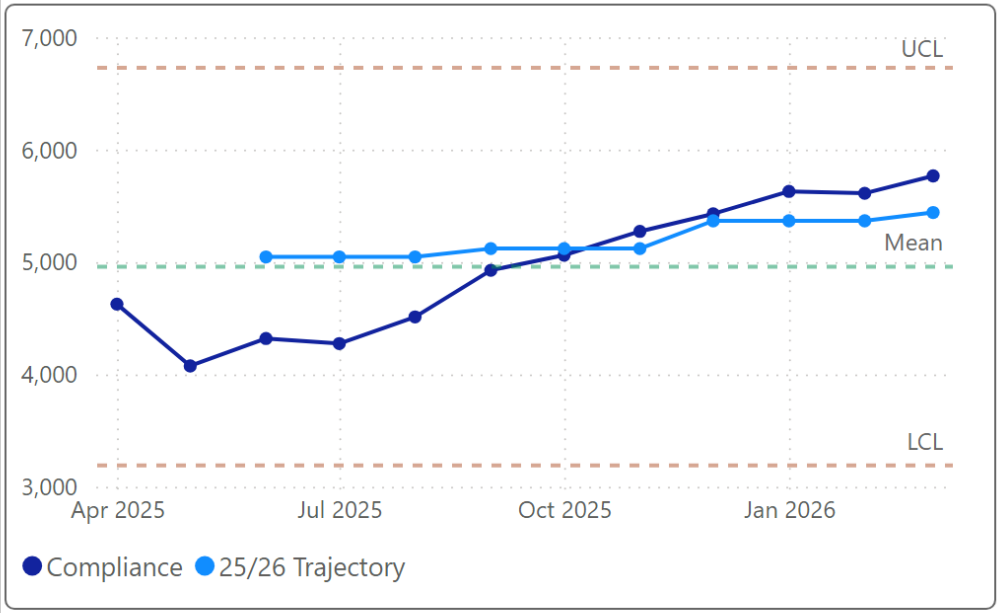



## Insight and Actions

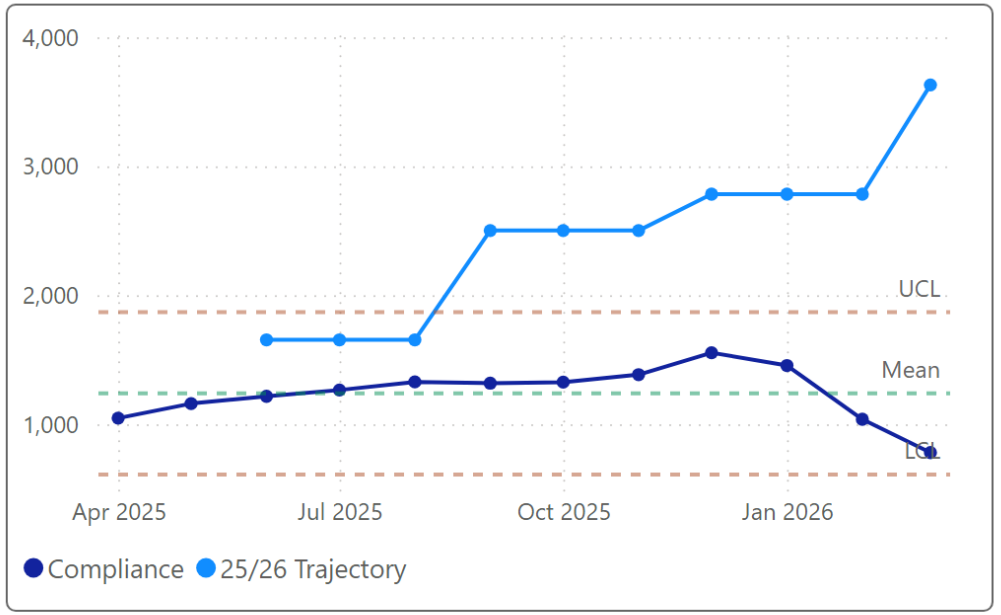
- DNA/CNA rates: Performance in February achieved a 2025/26 low of 4.9%, representing the lowest DNA rate on record (data available from April 2019). March performance increased slightly to 5.2% and marginally above the national target and IMTP trajectory, however the improvement delivered over the past 24 months is positive. A targeted approach continues to focus on areas with high DNA and short-notice CNA rates, supported by text message reminders which are now in place for the majority of clinics. Work has commenced with Public Health to better understand cohort-specific factors contributing to DNAs within COTE services.
- Diagnostics: The Health Board has had an intensive programme of work through Q4 to reduce 8 week diagnostic breaches, following the receipt of additional funding. March saw the Health Board deliver an extraordinary reduction in 8 weeks breaches, reducing from 1,557 in February to a year end position of 233. The initial assessment had been 166 breaches at year end, however delivering this additional level of activity set within the context of the supplementary diagnostic pressures created through the 26 week outpatient insourcing programme again represents a tremendous result for the Health Board, and there should be huge recognition and commendation of the efforts of an extensive number of teams involved in achieving this milestone in performance.

Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**

Measure: Number of adults waiting more than 14 weeks for all audiology pathways
Performance: 5,766 (March 2026)
Trajectory: 5,440 (March 2026)
National target: None




Measure: Number of children waiting more than 6 weeks for all audiology pathways
Performance: 780 (March 2026)
Trajectory: 3,630 (March 2026)
National target: None

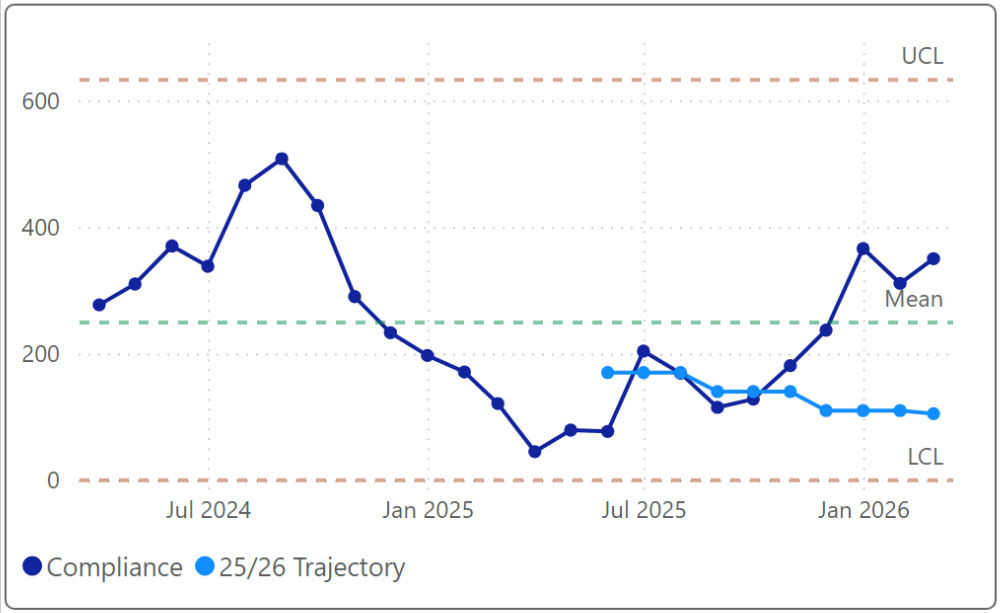



## Insight and Actions

- Audiology: For adult pathways, there has been additional demand placed on the service due to increased demand to the Adult Hearing New (AHN) and diagnostic pathways which is a result of the 26 week OP programme delivery in ENT. This has led to 14 week breach numbers being higher than planned in the IMTP trajectory as the service manages the surge in referrals within their existing capacity. For paediatric pathways, some additional, end of year funding has been received to reduce the breach profile with this resulting in the year end position now being lower than that at the beginning of 25/26 and well below the IMTP trajectory.

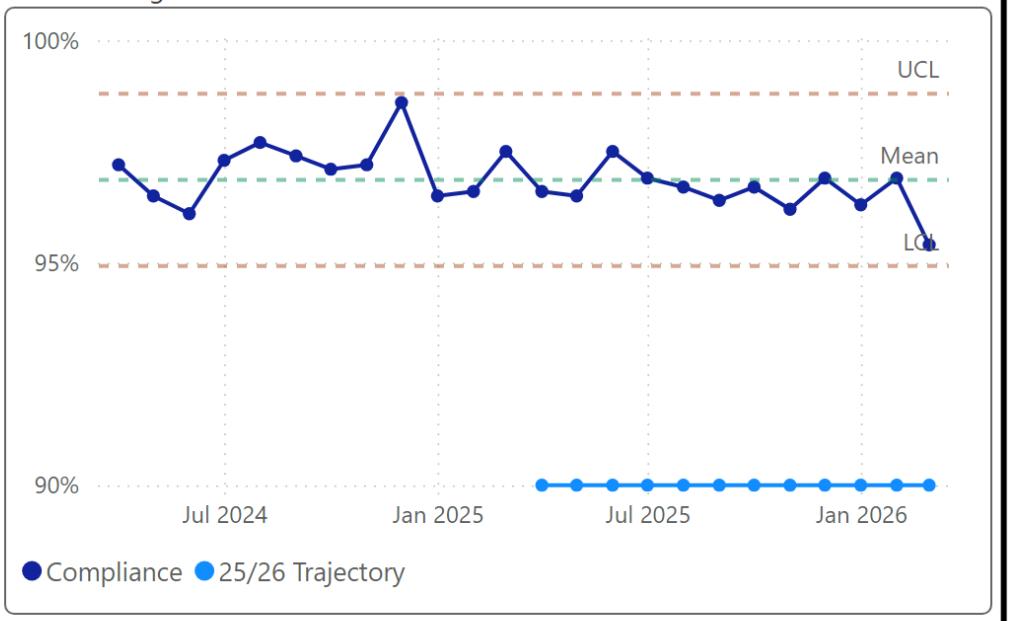
Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**

Measure: No patient waiting more than 14 weeks for a therapeutic assessment
Performance: 350 (March 2026)
Trajectory: 105 (March 2026)
National target: 0




Measure: On 90% of days planned care inpatient/daycase/theatre recovery capacity should be protected from pressures and outliers
Performance: 95.4% (March 2026)
Trajectory: 90.0% (March 2026)
National target: 90.0%

**Enabling Action**




## Insight and Actions

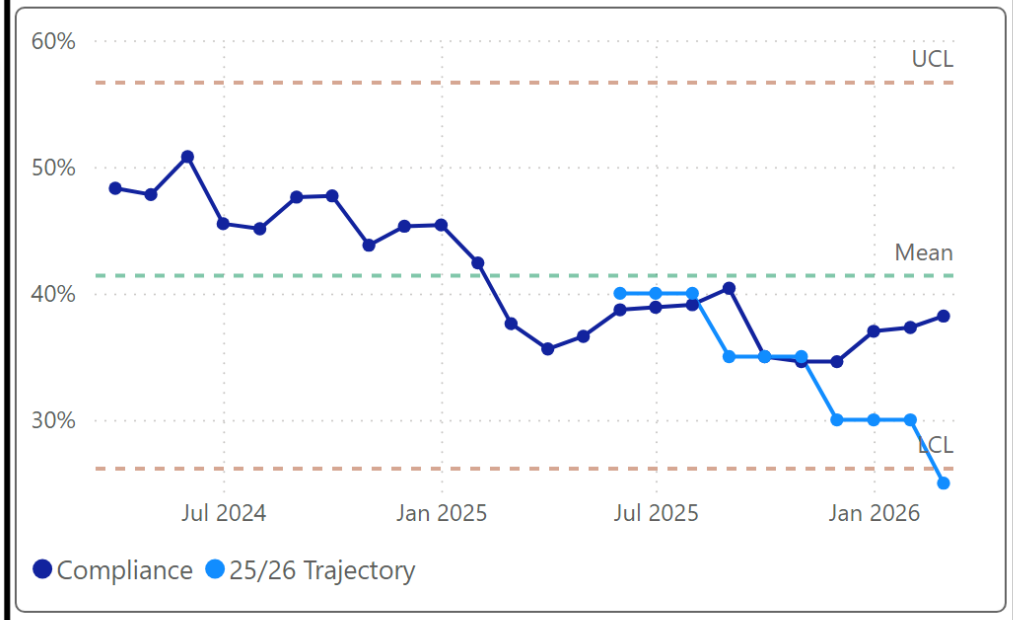
- Therapies: Therapies 14wk performance deviated from the IMTP trajectory in the second half of the year. For Dietetics there are ongoing capacity issues in Paeds and Gastro are limiting ability to meet demand. The service is working with the Value Team to prioritise activity based on clinical need. The forthcoming All-Wales Gluten Free Subsidy Card may further affect RTT performance, and a paediatric post is planned for recruitment in April 2026. Physiotherapy services are also experiencing increased pressure due to a substantial rise in spinal and knee referrals being redirected from Orthopaedics, linked to expanded triage activity. To support delivery of the 104 week delivery plan in Orthopaedics, MSK capacity has been reduced by 12 Nurse Practitioner slots per month, adding further strain to the physiotherapy waiting list.

- Elective theatre protection: Performance has remained compliant with this measure for the past 24 months. The NHS P&I definition of this measure is based on the number of individual days per month where emergency surgery is carried out on elective lists. However in lieu of national clarity on their construction of this metric, this local measure continues to be used.

Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**

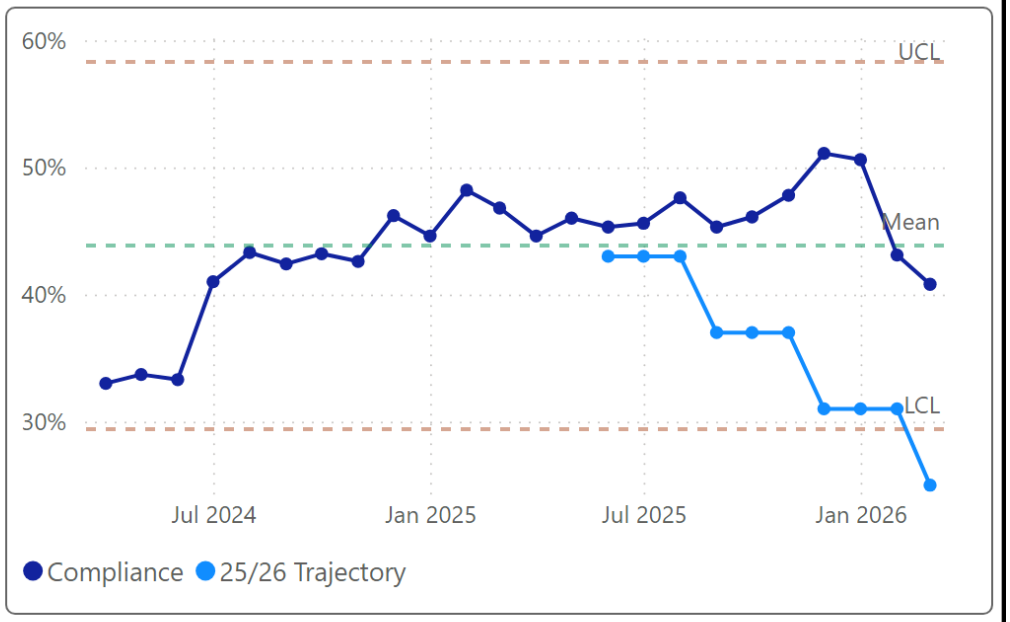
Measure: Theatre Utilisation late starts to less than 20%
Performance: 38.2% (March 2026)
Trajectory: 25.0% (March 2026)
National target: 20.0%

**Enabling Action**




Measure: Theatre Utilisation early finishes to less than 10%
Performance: 40.8% (March 2026)
Trajectory: 25.0% (March 2026)
National target: 10.0%

**Enabling Action**



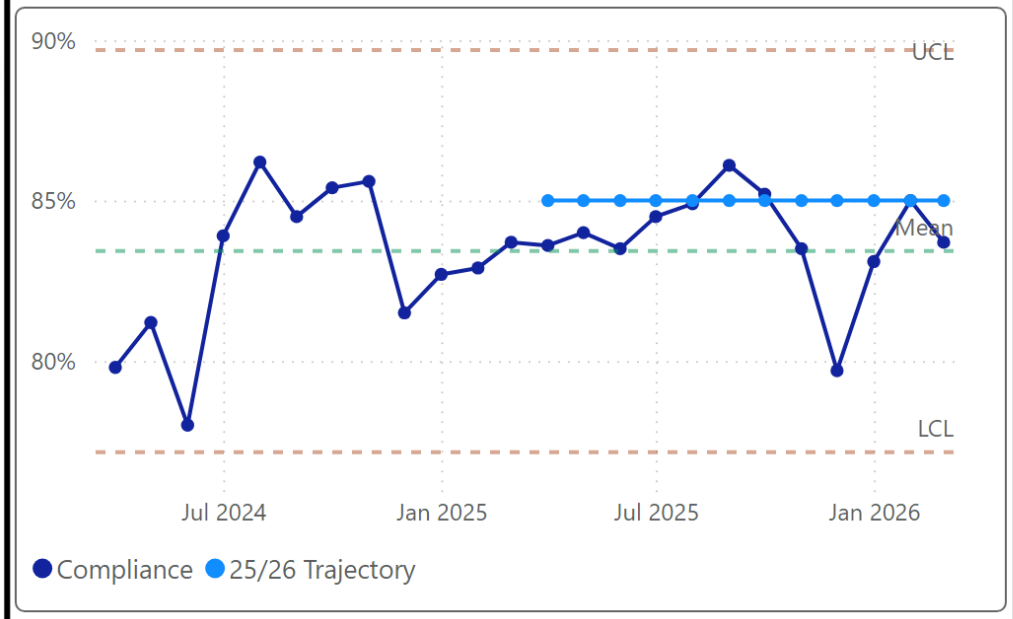

## Insight and Actions

- Theatres late starts & early finishes: Late start performance has improved over the past 24 months, although the planned improvement by through quarters 3&4 has not been realised. Autosend and golden patient initiatives are now in place at all sites, with ongoing analysis to understand the improvements that this delivers. Early finishes remain significantly behind the IMTP improvement trajectory, however, there has been a marked improvement in the final two months of the year, with the March value of 40.8% the lowest since June 2024. This metric is under the 30-minute measure, but from next year this will move to >60 minutes to bring in line with the WG definition that has been issued as part of the Planning Framework for 26/27. Theatres optimisation is a key organisational priority for 26/27 and improvement in efficiency indicators such as late starts and early finishes will be central to measuring success.

Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**

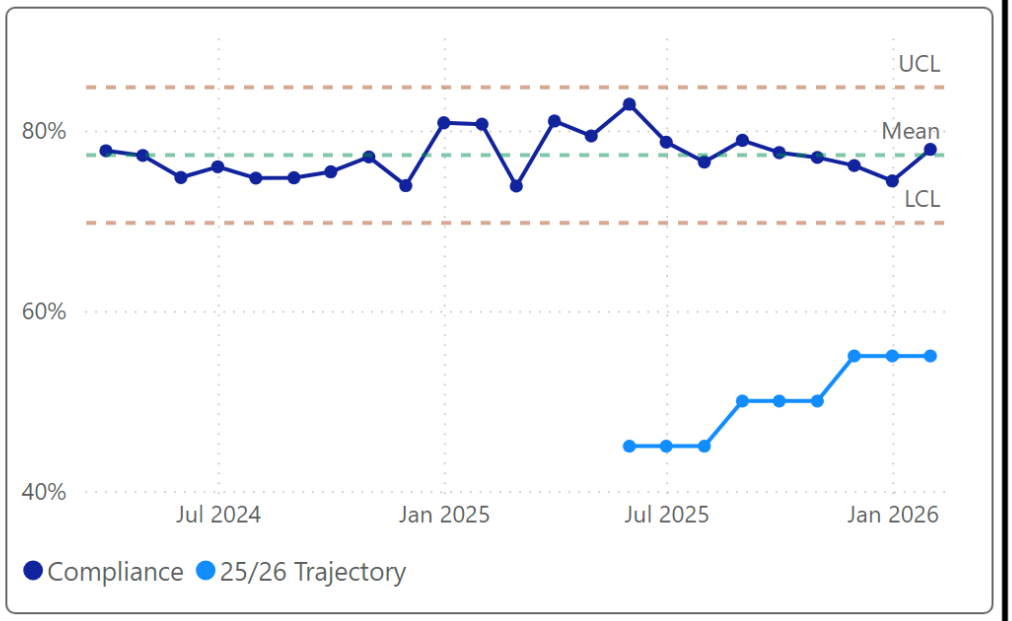
Measure: Theatre Utilisation session utilisation to 85%
Performance: 83.7% (March 2026)
Trajectory: 85.0% (March 2026)
National target: 85.0%

Enabling Action




Measure: Deliver improvements in day surgery rates, achieving a BADS daycase rate
Performance: 77.9% (February 2026)
Trajectory: 55.0% (February 2026)
National target: 80.0%

Enabling Action




## Insight and Actions

- Session utilisation: Performance had been relatively close to the national standard of 85% through the course of 25/26 to date, within a very tight range of 2.6% as of November (83.5% - 86.1%). December performance did reduce to 79.6%, however this is an observable, seasonal trend, and performance returned close to or above mean performance in the final quarter of the year and only marginally below the national standard. A 6-4-2 process has been implemented, where annual leave is finalised no less than 6 weeks in advance, lists are arranged 4 weeks in advance and then locked down 2 weeks before the date.

- British Association of Day Surgery (BADS) rates: BADS rates have also tracked closely to the national standard of 80% through the course of 25/26. Monthly Day Surgery Maximisation meetings remain in place to optimise day surgery delivery in NHH.

| Priority | Q4 Planned | Q4 Progress | Q4 Comments |
|---|---|---|---|
| **Single Cancer Pathway** | Make improvements in tumour site single cancer pathway with a focus on urology and gynaecology | Significantly off track | There have been significant improvements within Gynaecology, supported by the continuation of fortnightly Cancer Recovery Group meetings. Gynaecology exceeded its performance trajectory in February.<br><br>Urology performance remains fragile. Although the service is highly engaged, it continues to experience substantial workforce challenges, including a shortfall of four Consultants and ongoing unresolved staffing gaps. These issues are the primary drivers of continued non-compliance with Single Cancer Pathway (SCP) timescales. SCP compliance declined to approximately 30% in February (from 38% in January), though an improvement to around 45% is forecast for March. |
| | Improve straight to test compliance. | Complete/On schedule | The majority follow the Straight to Test (STT) compliance across the National Optimal Pathways (NOPs) and have continued to make good progress with the exception of colorectal. For all tumour sites, the detailed recovery plans are in place to drive improvement.<br>The Cancer Recovery Group meetings are in place to progress the National Optimal Pathways. These groups look across the whole pathway to understand any barriers and develop targeted actions plans to improve performance. |
| **Health Pathways** | Achieve additional 50 localised pathways live on Aneurin Bevan local site | Complete/On schedule | 84 pathways have been live since 1st April 2025, with 188 pathways live in total.<br><br>Page views are consistently high throughout the year supported by dedicated education sessions which have increased user traffic. Page views in March 26 were 9'335 which was the highest ever and 72,092 for the 25/26 financial year. |
| **Theatre Maximisation** | Keeping Well Service within the Health Board and seen as the Single Point of Contact for advice on Health and Wellbeing | Off track within tolerance | The Keeping Well service continues to support patients who are experiencing long waits for planned care with a pilot to expand the service to incoming calls for Gynaecology in the new financial year. |
| **Outpatient Transformation** | Ongoing monitoring of activity and opportunities for one-stop treatment pathways in the Outpatient Treatment Unit | Complete/On schedule | Attendances in Outpatient Treatment Unit 25-26 were 3921, this is an increase of 1120 compared to the previous year.<br><br>As part of the development of the one stop treatment pathways. The new one stop Gynae Heavy Menstrual Bleeding clinic is planned for 25-26 and scoping exercise is taking place for vasectomy procedures moving from daycase. |

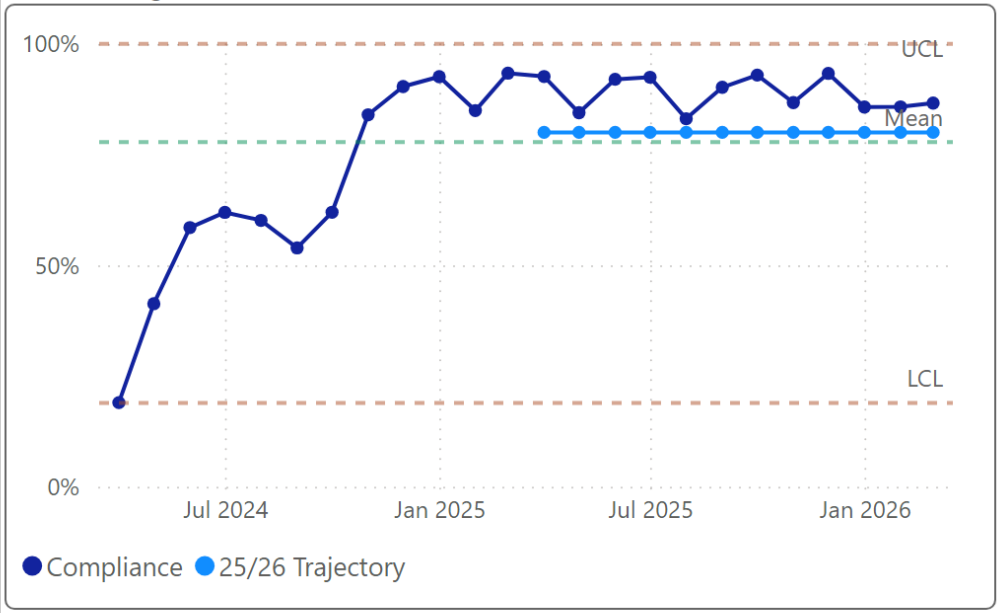
# Improving our Mental health services: Performance Summary

| Theme | Delivery Expectation | ABUHB commitment | In month performance against trajectory |
|---|---|---|---|
| Improving our Mental health services | Maintain Adults Part 1a to national target (assessment completed within 28 days) | 80% Mar-26 | 86.6% Mar-26 (Mar-26 Trajectory: 80.0%) |
| | Maintain Adults Part 1b to national target (interventions completed within 28 days) | 80% Mar-26 | 93.7% Mar-26 (Mar-26 Trajectory: 80.0%) |
| | Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan) | 90% Mar-26 | 91.3% Mar-26 (Mar-26 Trajectory: 90.0%) |
| | Maintain rate of psychological therapy received within 26 weeks | 60% Mar-26 | 46.9% Mar-26 (Mar-26 Trajectory: 60.0%) |
| | Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days) | 80% Mar-26 | 99.0% Mar-26 (Mar-26 Trajectory: 80.0%) |
| | Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days) | 80% Mar-26 | 80.4% Mar-26 (Mar-26 Trajectory: 80.0%) |
| | Maintain CAMHS Part 2 national target compliance | 90% Mar-26 | 95.0% Mar-26 (Mar-26 Trajectory: 90.0%) |
| | Improvement in Neurodevelopment waiting times compliance | 80% Mar-26 | 57.0% Mar-26 (Mar-26 Trajectory: 80.0%) |
| | Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral | 80% Mar-26 | 94.5% Mar-26 (Mar-26 Trajectory: 80.0%) |

## Improving our **Mental health** services

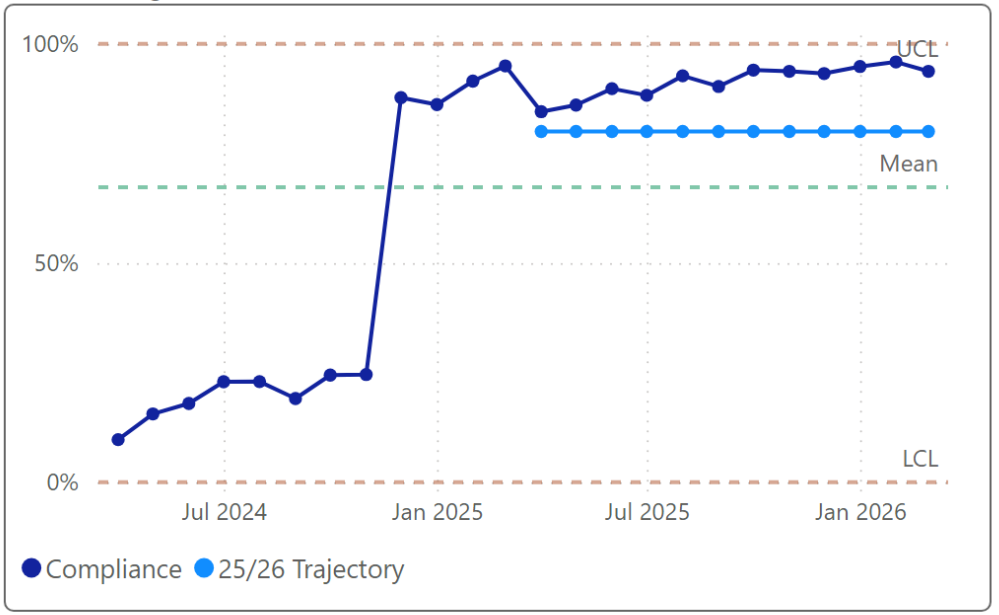
Measure: Maintain Adults Part 1a to national target (assessment completed within 28 days)
Performance: 86.6% (March 2026)
Trajectory: 80.0% (March 2026)
National target: 80.0%

**Ministerial Delivery**




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

**Ministerial Delivery**

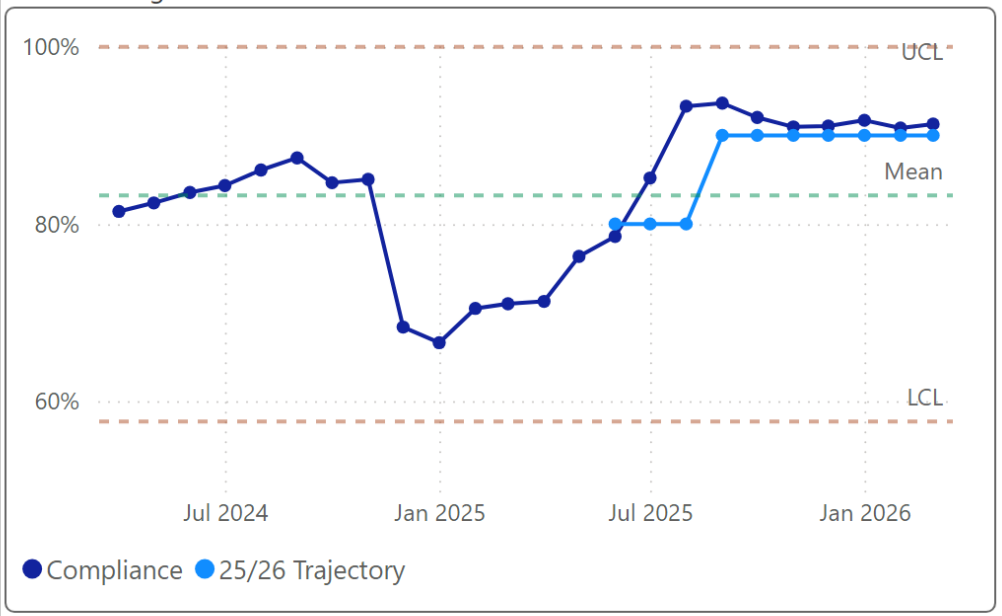



### Insight and Actions

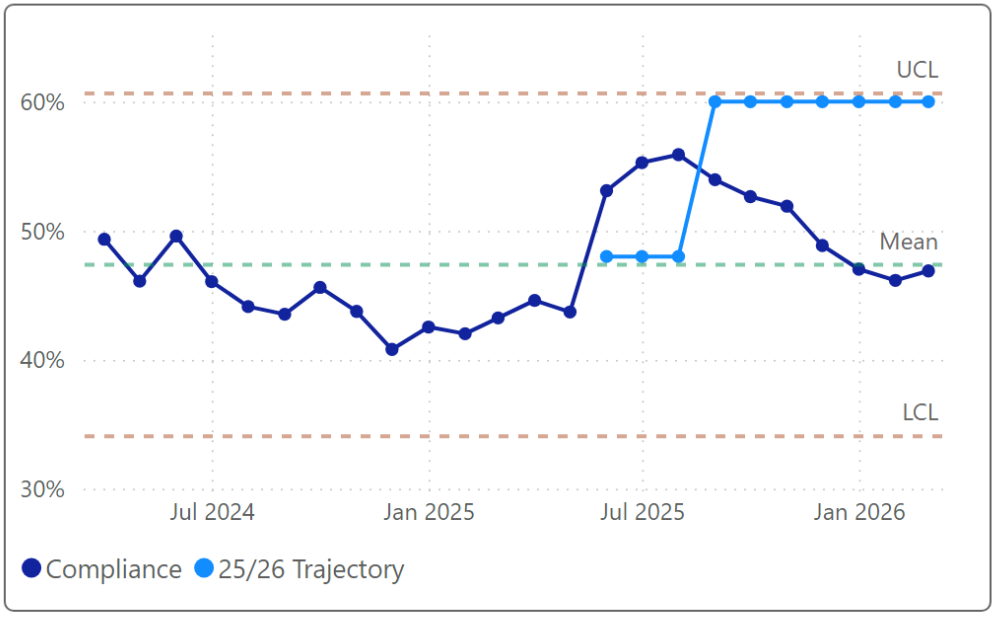
- Adults 1a & 1b: There are no issues with performance for these measures, with the service managing to balance both demand and capacity to ensure continued compliance with the national standard through the entirety of 2025/26.

## Improving our **Mental health** services

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




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



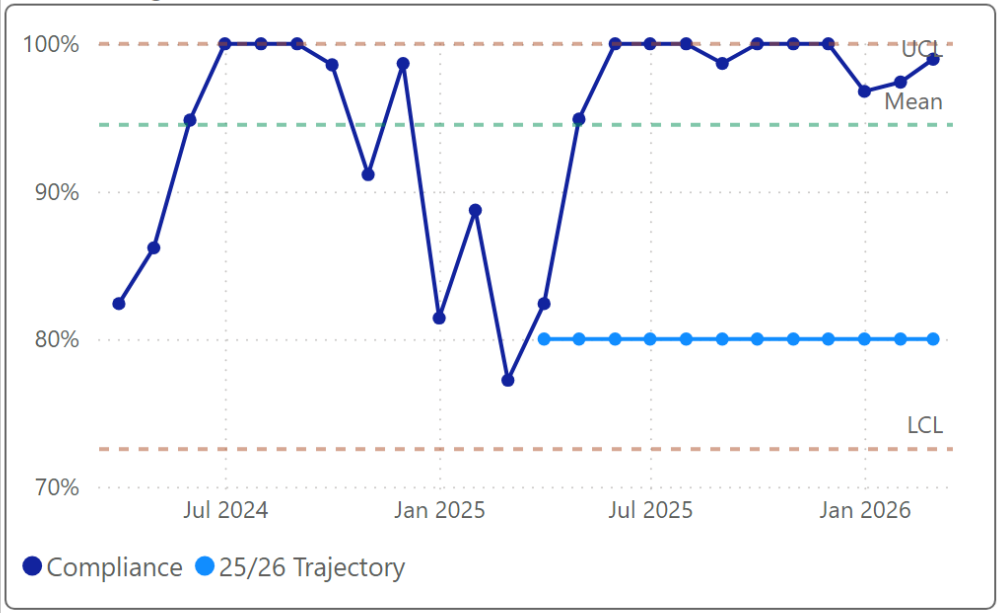

### Insight and Actions

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

## Improving our **Mental health** services

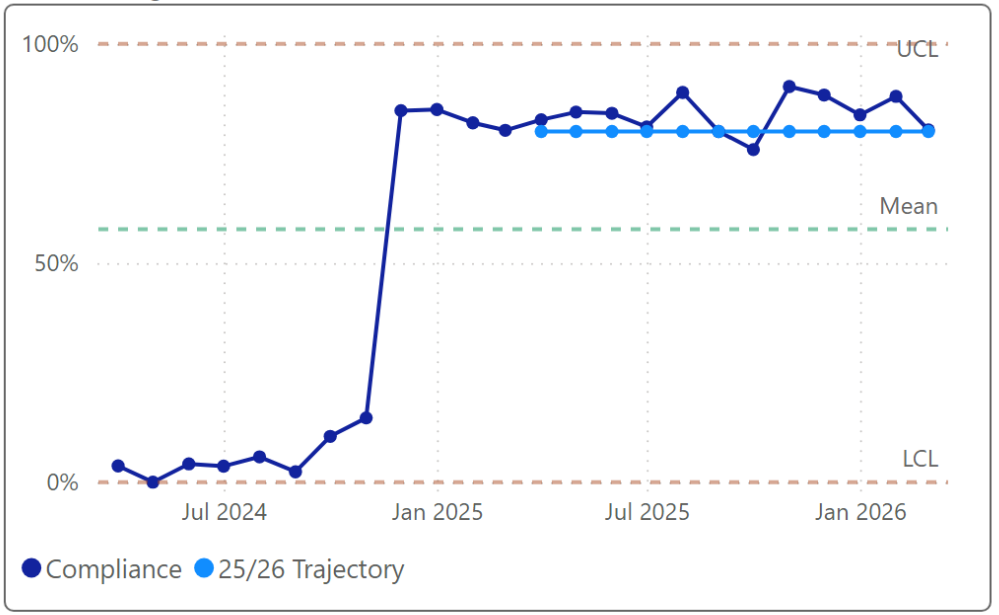
Measure: Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)
Performance: 99.0% (March 2026)
Trajectory: 80.0% (March 2026)
National target: 80.0%

**Ministerial Delivery**




Measure: Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)
Performance: 80.4% (March 2026)
Trajectory: 80.0% (March 2026)
National target: 80.0%

**Ministerial Delivery**

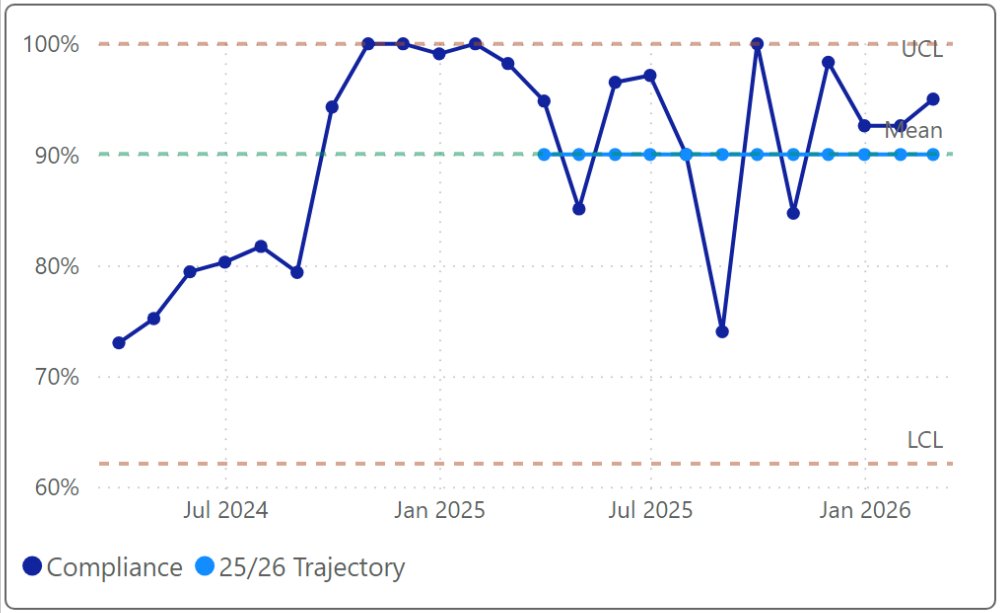



### Insight and Actions

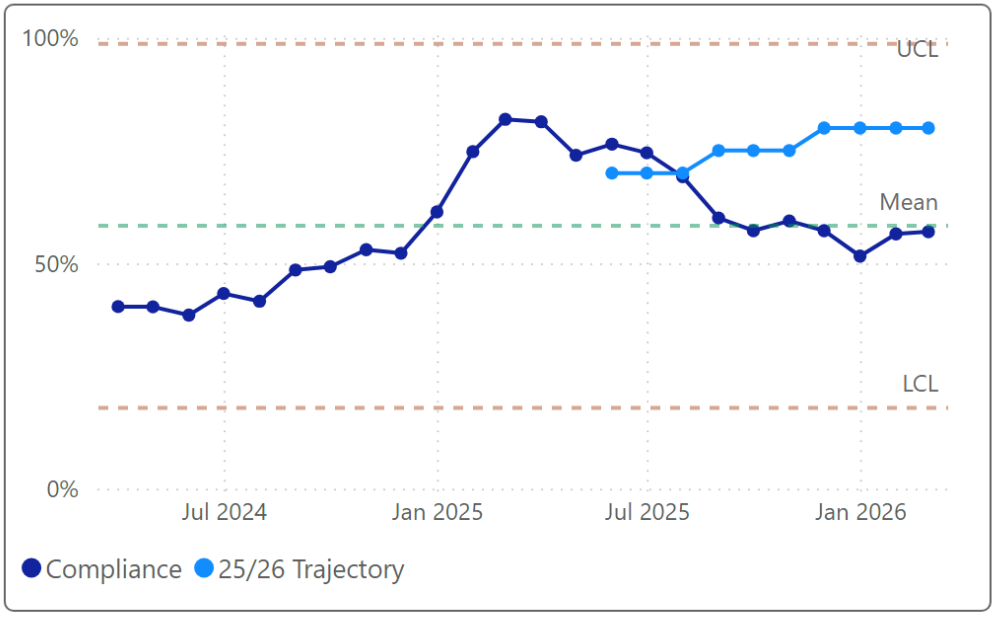
- CAMHS 1a & 1b: Like with Adults there are no issues with performance for these measures, with the service managing to balance both demand and capacity to ensure continued compliance with the national standard, with 1a having met the national standard for the entirety of 2025/26. There was a decrease in October performance to below the national standard in 1b, however this was the result of a data entry issue that adversely affected performance. In response, the Division provided education and training to the clinical staff these errors related to mitigate future repetition and have been compliant in the proceeding five months.

## Improving our **Mental health** services

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




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

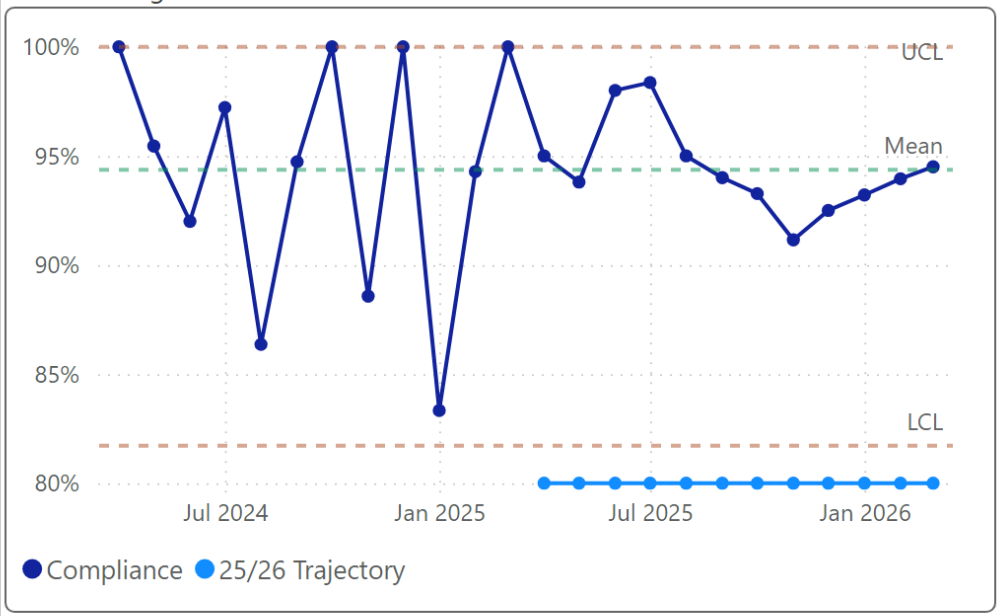



### Insight and Actions

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

## Improving our **Mental health** services

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




### Insight and Actions

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

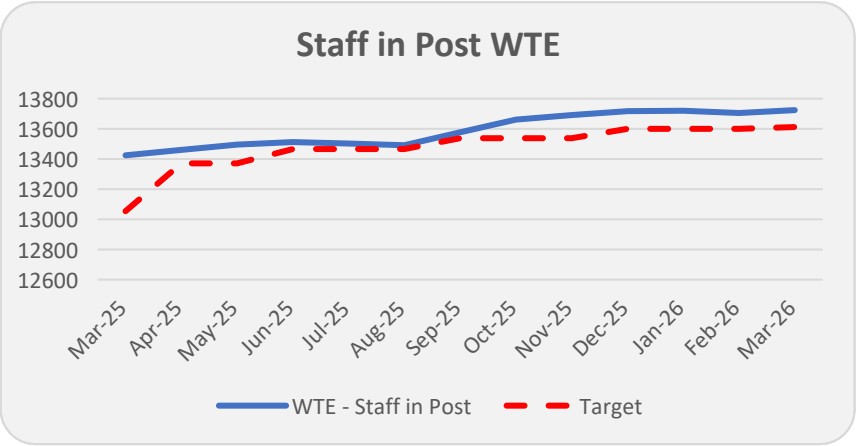
| Priority | Q4 Planned | Q4 Progress | Q4 Comments |
|---|---|---|---|
| **Quality Improvement** | Sustain progress of Part 1a and 1b for Adults | Complete/On schedule | Part 1a and Part 1b progress was maintained throughout 2025/26, with the service being consistently above the target of 80% in both Part1a (assessments completed within 28 days) and Part 1b (interventions completed with 28 days) |
| **Ministerial Priority Performance** | Sustain progress of Part 1a and 1b for Children | Complete/On schedule | Part 1A and 1B progress maintained throughout 2025/26, resulting in March compliance at 94.6% for part 1A and part 1b at 87%.<br><br>Increased triaging of referrals across Primary and Secondary CAMHS has supported a reduction in referrals. This has enabled capacity to be flexed to meet both the 1A and 1B and support the waiting list for interventions, despite having a significant rise in sickness absence. |
| **Neurodevelopmental Services** | Complete children's neurodevelopmental transformation programme | Significantly off track | The Children & Young People needs-led model is embedding across teams, evidenced by a shift from universal to targeted support and improved appropriateness of referrals entering the specialist pathway.<br><br>RTT increased slightly to 56.51% in February, indicating early signs of stabilisation despite rising demand with RIF funding secured for 2026/27, maintaining existing staffing and helping stabilise waiting times.<br><br>Website development and digital access pathways continue to progress as a key improvement action. |
| | Deliver Single Neurodevelopmental pathway for Adults | Significantly off track | Whilst National Funding for Adults ADHD service ceased in 25/26, plans have been put in place to manage the caseload and secure funding for ADHD for 2026/27. |
| **Rightsizing Inpatient & Transforming Community Services** | Initial review of service changes completed and initial outcomes in terms of patient care and reduction in variable pay | Off track within tolerance | An implementation plan is being developed which will inform actions needed in 26/27 to deliver the models of care programme for Adults, Older Adults and Community services. |

The Health Board's People Plan, 2025 -2023 supports our purpose and ambition by putting people at the heart of everything we do; creating the conditions for them to thrive, and enabling us to deliver outstanding, compassionate care while tackling health inequalities and building healthier futures for all.
A key part of our revised plan will be ensuring our people have the skills, confidence, and opportunities to support our communities in living healthier lives, embedding prevention as a core part of how we work and strengthening our role in reducing inequalities for future generation.

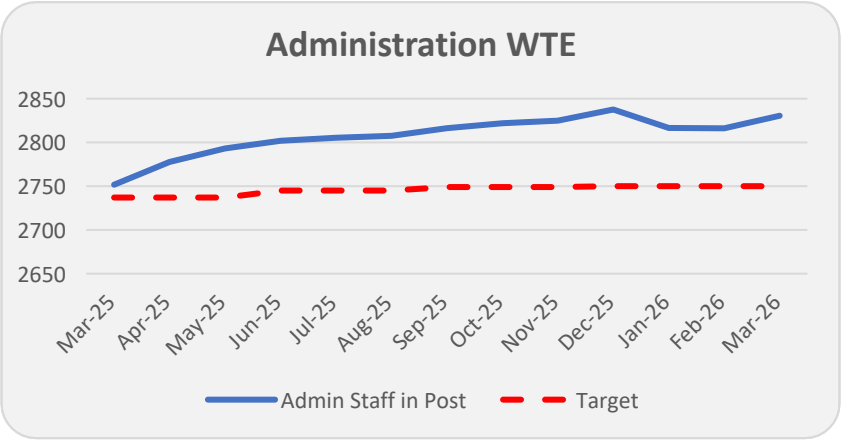
**Reporting Period end of March 2026**



**Staff in Post**




**Administration Staff in Post**




**Performance Summary**

Staff in post as of end of March 2026 totalled 13724.27 wte representing an overall increase of 4 wte since January 2026.
This marginal increase largely reflects short – term movements (turnover, rotations) rather than growth in funded establishments.

Changes by staff groups:

- Administration and Clerical increase of 14wte (to fill vacancies)
- Medical and Dental has increased by 15.34 wte. This reflects the appointment of 4 wte consultants to vacancies. The increase also includes a rise in speciality registrars, consistent with the numbers in post observed during the same period last year.
- Small reduction in Additional Clinical Services of 8.18 wte (linked with normal turnover variation)
- Small reductions across a number of other staff groups associated with turnover variation

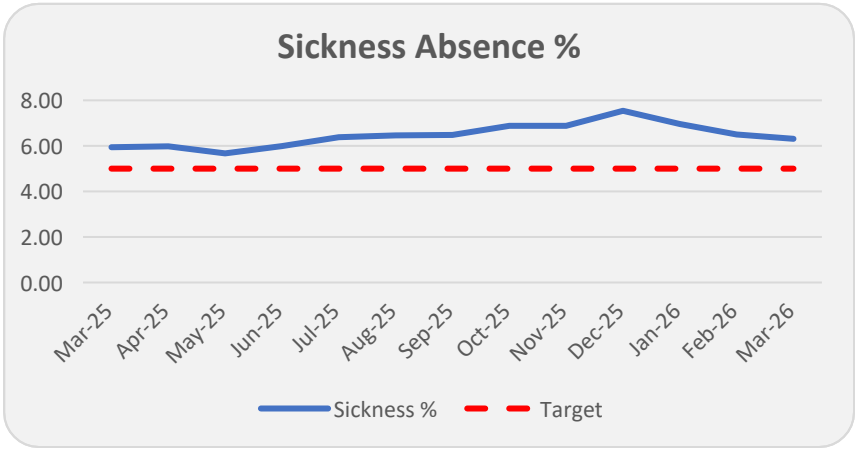
The target in graph was set as part of the IMTP performance framework for 25/26 and will reset for 2026/27.

**Performance Summary**

There has been an increase in 14 wte administration and clerical staff in post of since January 2026. This increase is largely attributable to fluctuations in turnover rather than growth in establishments. Turnover has reduced in this staff group over the past quarter resulting in few vacancies and a corresponding improvement in staff in post (SIP) figures.

The target in graph was set as part of the IMTP performance framework for 25/26 and will reset for 2026/27.

**Sickness** Enabling Action




**Performance Summary**

Sickness Absence had peaked in December and has dropped from 6.96% (955 wte) reported in January 2026 to 6.31% (866 wte). The rate is higher than the 5.85% absence rate reported in the same reference period last year.

Short term sickness has decreased from 2.73% to 2% and long term sickness (over 28 days) has reduced from 4.23% to 4.13% in the last quarter and attributes to 66% of overall sickness. The target of 5% in Graph was set as part of the IMTP performance framework 2025/26 and will be reset for 2026/27 in line with ministerial enabling targets.

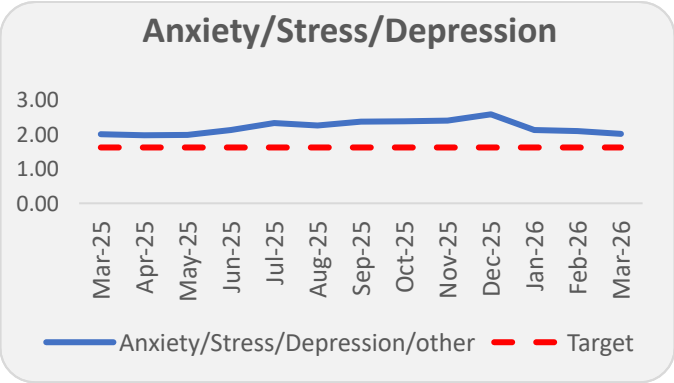
Key observations – 3 highest staff groups rate changes in the last quarter:

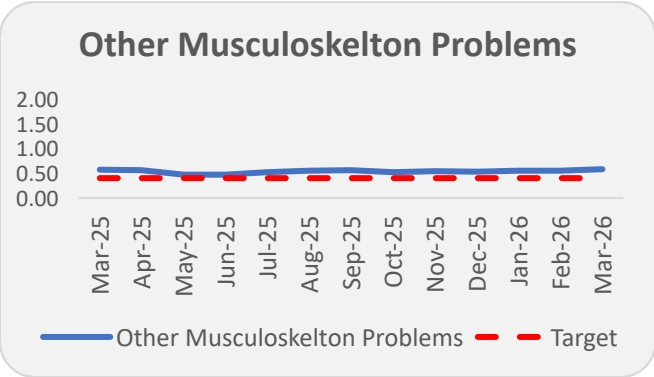
1. Additional Clinical Services (HCSWs) – 8.93% a decrease from 11.03%
2. Estates and Ancillary – 9.07% a decrease from 9.95%
3. Nursing and Midwifery – 6.81% remained the same

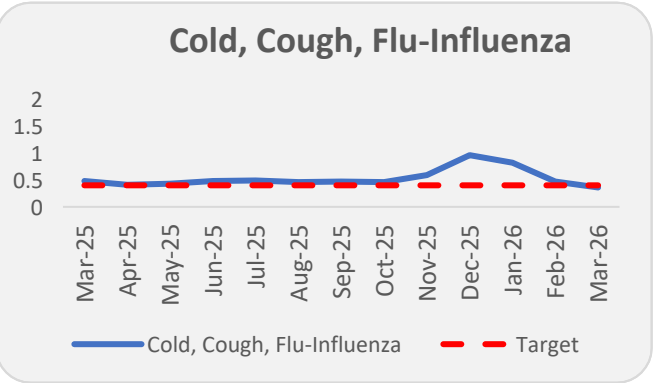
The target in graph was set as part of the IMTP performance framework for 25/26 and will reset for 2026/27.

A 12-month project plan in development (in partnership with TUs), in conjunction with the actions of our People Plan (2025-2030) to focus on main reasons for absence with the aim of supporting a sustainable reduction in absence.

**Top Sickness Reasons** Enabling Action



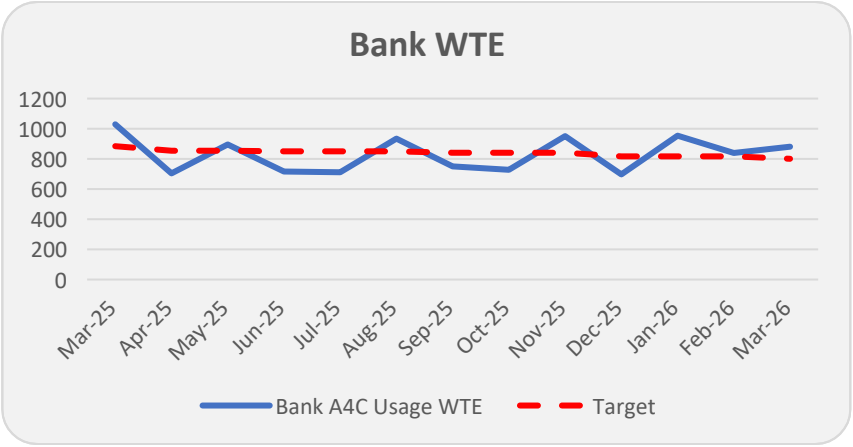

**Performance Summary**
**Of**
**Anxiety/Stress/Depression** remains the top reason for absence contributing to 1.99% of all absence, a decrease from 2.10% reported in January.

**Musculoskeletal Problems** remained relatively unchanged at 0.58% above the target of 0.4%.

**Cold, Cough and Flu- influenza as the 3rd highest reason** with a rate of 0.36% a decrease from 0.82% % reported in January and below the target of 0.4%

The Health and Wellbeing Service continues to increase the support options available for staff including psychological therapy, counselling and self-help guidance tools. In addition, our "Wellbeing Matters" Programme provides advice and support to those suffering with physical conditions (e.g. back problems). The Health Board have also introduced an Employee Assistance Programme to support access to wellbeing support, which has reduced waiting times for our internal staff wellbeing service.
The target in each graph was set as part of the IMTP performance framework for 25/26 and will reset for 2026/27.

**Variable Pay Bank** Enabling Action



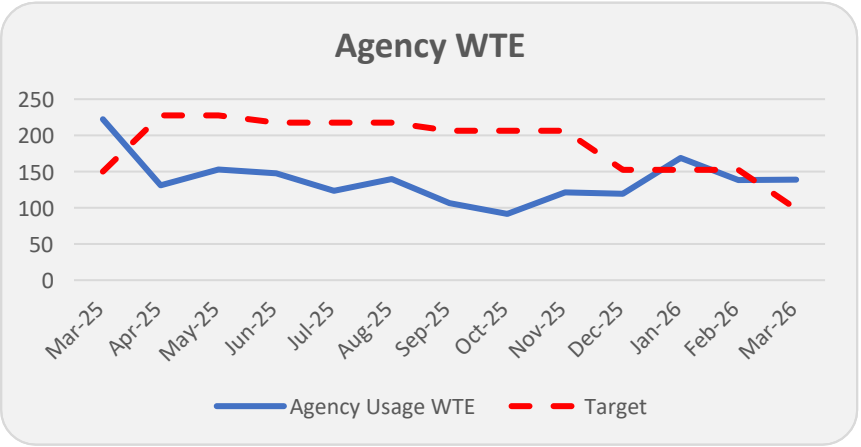

**Performance Summary**
The Variable Pay Programme, recognising the importance of recruitment and retention, continues to progress and explore opportunities to reduce variable pay.

In March bank usage reduced to 880.89 wte from 951wte reported for January 26.

In March 26 the three highest users were HCSW 446.53 wte (51%), Nursing & Midwifery 300.68 wte (34%) and Facilities 90.36 wte (10%). Highest reason for usage is Vacancies 299.96 wte (37%).

The target in graph was set as part of the IMTP performance framework for 25/26 and will reset for 2026/27.

**Variable Pay Agency** Enabling Action



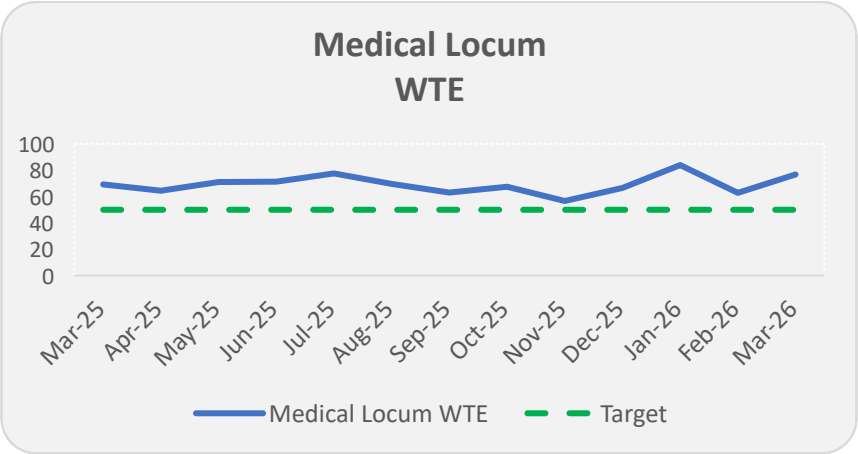

**Performance Summary**
Agency usage has decreased to 138.87 wte from thee 168.8 wte reported in January 26.

In March 26 22.82 wte (16%) were used for HCSW and 116.05 wte (84%) for Nursing and Midwifery. The top three reasons for Agency usage are Vacancies 32.35 wte (23%), Sickness 32.21 wte (23%) and Enhanced Care 25.84 wte (19%).

As part of our strategic workforce planning for 2025/26, we reset our agency workforce trajectory based on the March 2025 baseline of 227 WTE. The revised plan sets out a target to reduce agency usage incrementally each quarter, aiming to reach 98 WTE by March 2026. This approach aligns with our broader goals of zero agency contract, recruitment and general variable pay reduction.

The target in graph was set as part of the IMTP performance framework for 25/26 and will reset for 2026/27.

**Variable Pay Medical Locum** Enabling Action

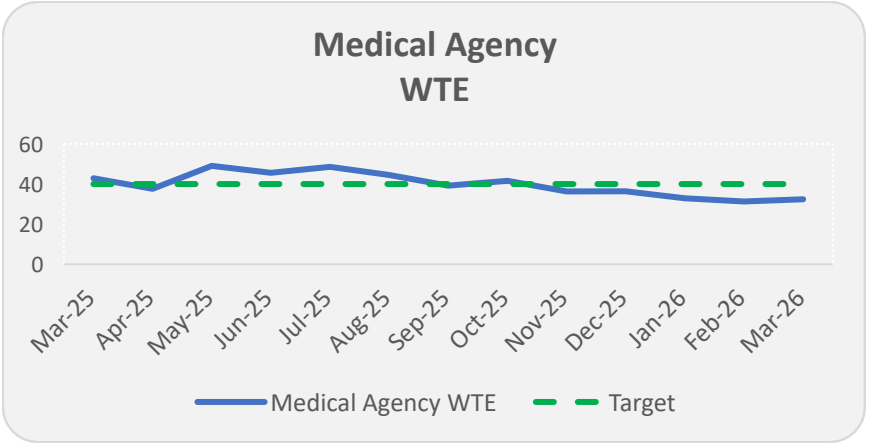



**Performance Summary**

Current locum usage has decreased to 76.81 wte from the 83.96 wte in January 2026.
The highest reason for combined locum and agency usage continues to be attributed to vacancies- 57.15 wte (51%).

There is ongoing work with the development of a Medical Workforce Strategy and the introduction of medical e-Systems to support reducing reliance on variable pay.
Target in graph was estimated as part of the IMTP performance framework 2025/26 and will be interchangeable with agency usage and will be reset for 2026/27.

**Variable Pay Medical Agency** Enabling Action

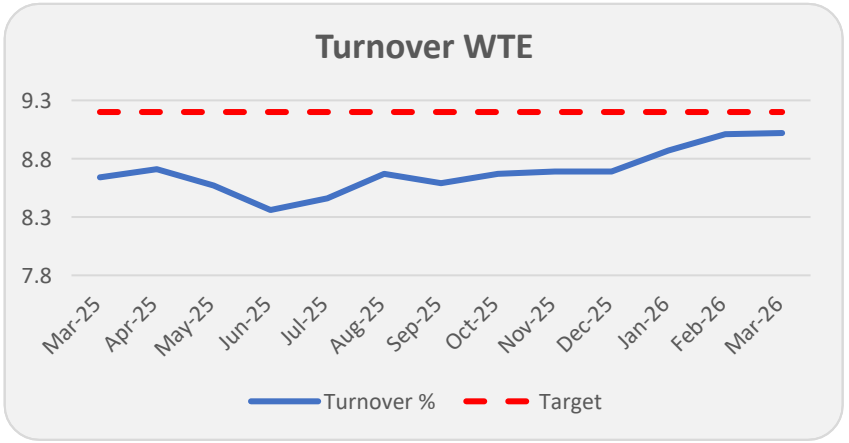



**Performance Summary**

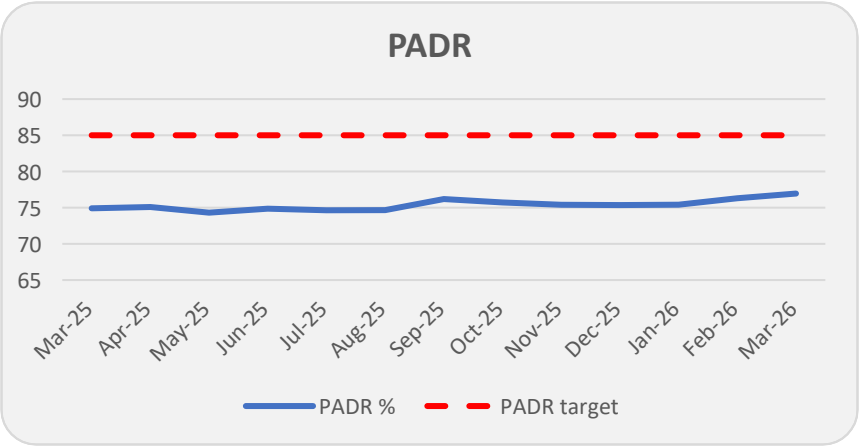
Medical Agency had a sustained reduction from October 2025 and in the last quarter has remained constant at 32 wte. There is ongoing work with the development of a Medical Workforce Strategy and the introduction of medical e-Systems to support this work.

Target in graph was set as part of the IMTP performance framework 2025/26 and will be interchangeable with Locum usage and will be reset for 2026/27.

**Turnover**




**PADR**




**Performance Summary**

Turnover rate has slightly increased in the last quarter from 8.87% to 9.02% following an overall sustained reduction in in the preceding year and remains below the target trajectory.

Nursing & Midwifery have the lowest turnover rate of 6.07% whilst Estates & Ancillary have the highest turnover rate of 12.15%. The Stability Rate is 91.72%, the Health Board has retained 14,385 staff.

The target in graph was set as part of the IMTP performance framework for 25/26 and will reset for 2026/27.

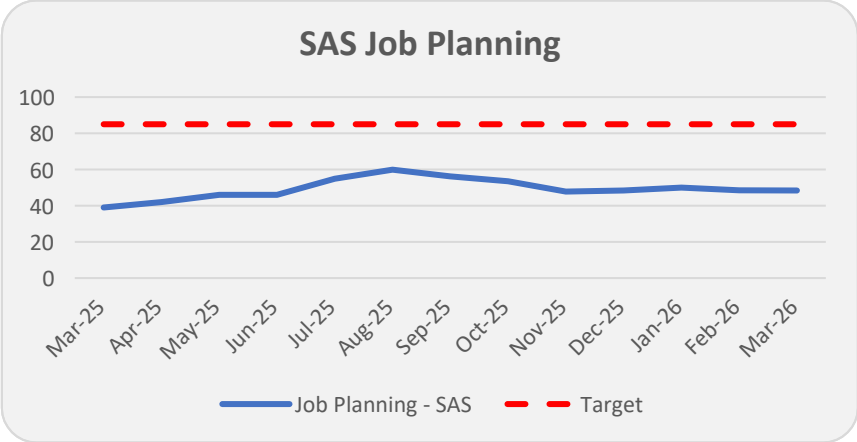
**Performance Summary**

PADR compliance has improved in March to 76.95% from the 75. 41% reported in January 26.

Work continue towards achieving 85% All Wales target through divisional reporting, renewed tools and training for managers.

**Job Planning** Enabling Action




**Performance Summary**

**Job Planning -** Job planning compliance for the consultant workforce is 55.1% an increase from the 53.4% reported in January 2026. A key factor is job plans falling out of the 12 month rolling period and ongoing complexities being worked through with directorates.

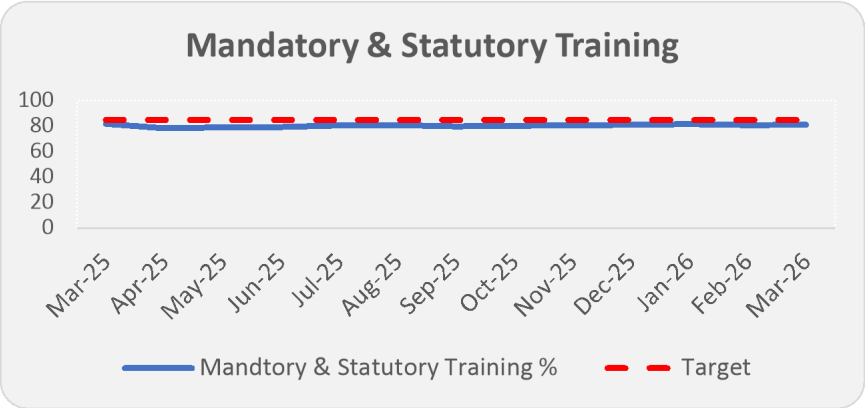
To support the targeted job planning compliance, key actions include integrating progress updates into Divisional Performance Reviews, conducting targeted deep dives, and withholding vacancy approvals until up-to-date consultant job plans are in place. Pay-impacting changes and study leave funding will also be restricted unless job plans are current or under appeal. Attendance at the Job Planning Consistency Group is now compulsory, and a formal reminder from the Medical Director and Chief Operating Officer will reinforce consultants' contractual obligations.
Deep dives with divisional management were undertaking in January 2026 to review compliance levels, action plans and support required.
The target in graph was set as part of the IMTP performance framework for 25/26 and will reset for 2026/27.

**Performance Summary**

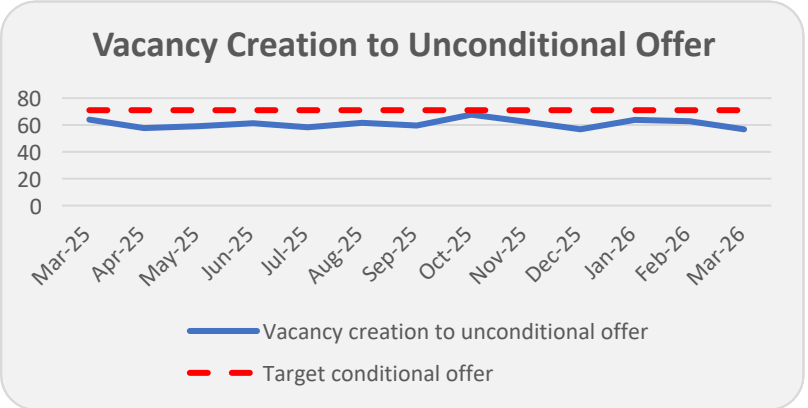
**Job Planning** – Job planning compliance is current 48.7% and has remained at that level since November 2025.

To support the targeted job planning compliance, key actions include integrating progress updates into Divisional Performance Reviews, conducting targeted deep dives, and withholding vacancy approvals until up-to-date consultant job plans are in place. Pay-impacting changes and study leave funding will also be restricted unless job plans are current or under appeal. Attendance at the Job Planning Consistency Group is now compulsory, and a formal reminder from the Medical Director and Chief Operating Officer will reinforce consultants' contractual obligations.
The Medical Workforce E-System Team remains actively engaged with directorates to support sustained improvements in compliance for consultant and SAS and to ensure that completed job plans are reviewed and updated as necessary prior to their expiry, maintaining continuity going forward.
The target in graph was set as part of the IMTP performance framework for 25/26 and will reset for 2026/27.

**Mandatory Training**




**Time to Hire**




**Performance Summary**

Mandatory & Statutory Training has remained level at 81% which is 4% off the target. There are 7 Divisions/Corporate Services that have reached/higher than the target of 85%.

As previously reported, new statutory and mandatory courses have created some variation to the previous benchmarking reporting rates.

**Performance Summary**

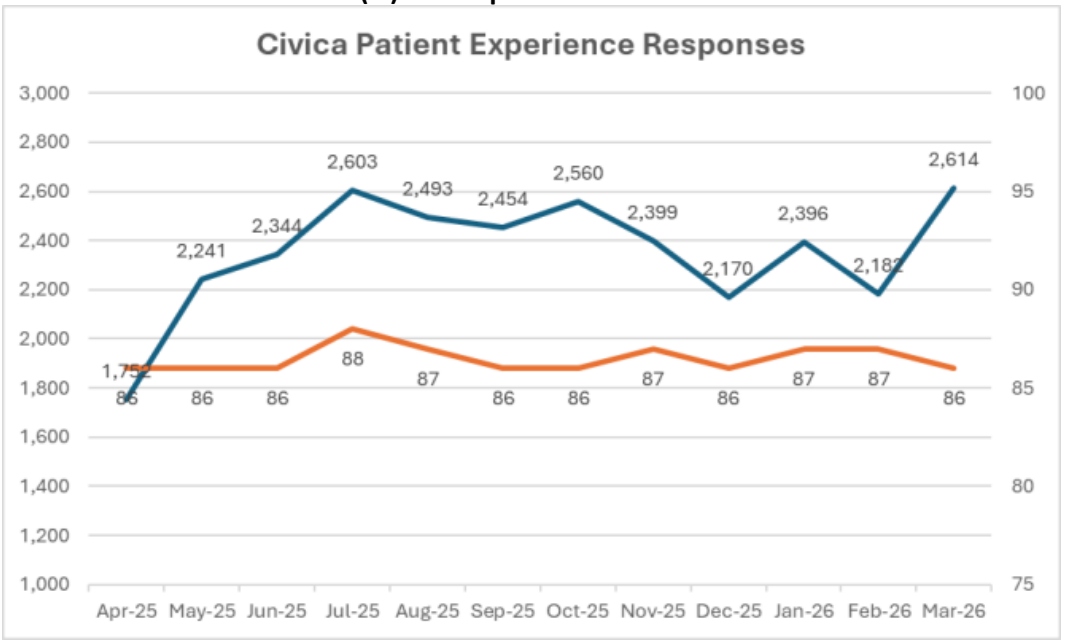
The All-Wales target for recruitment Time to Hire (the time interval between vacancy creation and successful candidate ready for start date) is 71 days and the Health Board is continues to improve and exceed the target at 56.8 days by 14.2 days

Conditional offer letter to completed PECS continues to improve and is now 18.4 days which is 6.6 days lower than the target.


6 Pillars of Quality
1
Patient and Staff Feedback, Complaints, Concerns & Compliments
2
Patient Safety
3
Clinical Effectiveness
4
Health, Safety, Security and Compliance
5
Infection Prevention and Control
6
Safeguarding

## Pillar 1 Patient and staff feedback, concerns, complaints and compliments- Patient Experience CIVICA

**Graph 1– Overview of CIVICA volumes and satisfaction score (%) from April 2025 to Mar 2026**




- **Civica Overall Satisfaction score** (Graph 1) for the 'Patient Experience Survey' has remained stable since its introduction in May 2025, with overall scores ranging between 86 to 88. The lowest scoring question remains 'Was the time you waited'.
- The **Overall response trend** (Graph 1) shows that 7,192 feedback responses for this period (Q4), compared with 7,129 in Q3, although responses are still coming through (especially from SMS).
- Preparing the All-Wales National Endoscopy Survey for April 2026, with launch via SMS to follow; work to launch All Wales Research Survey continues.
- Implementing the National Survey for the new Listening to People process for April 2026, including additional languages and BSL; developing an Easy Read version and continuing to address CIVICA SMS delays.

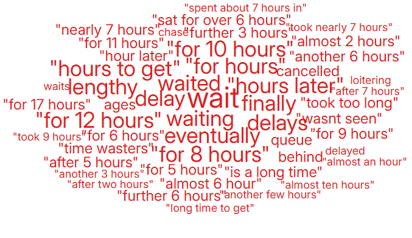
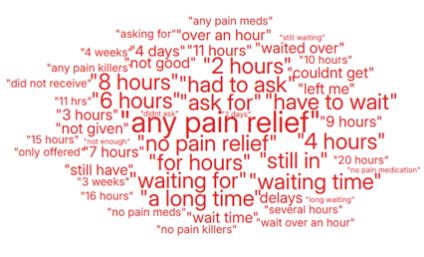
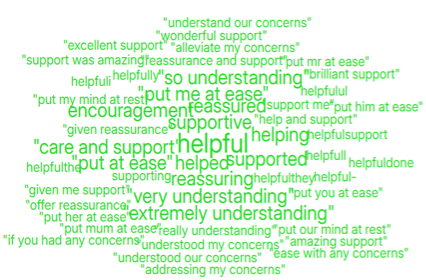
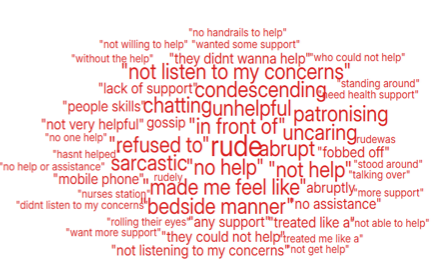
- **Listening & Learning: What we're doing**

- Reviewing and supporting areas with little or no feedback during 2025, and expanding rollout across all Divisions (including teams working across sites and within outpatient clinics).

- The new Cancer Treatment Survey (SMS) was launched on the 23rd February 2026 and continues to show a very positive response rate 28.61% (February and March combined).

## Pillar 1 Patient and staff feedback, concerns, complaints and compliments- Patient Experience CIVICA

### Positive and negative themes Q4 2025/26

| Positive Themes | Negative Themes |
|---|---|
| **Compassion (763)** | **Waiting** *(contains duplicate so not shown)* |
|  |  |
| **Professional and Competent (624)** | **Pain (216)** |
|  |  |
| **Emotional and Physical Support (611)** | **Emotional and Physical Support (197)** |
|  |  |

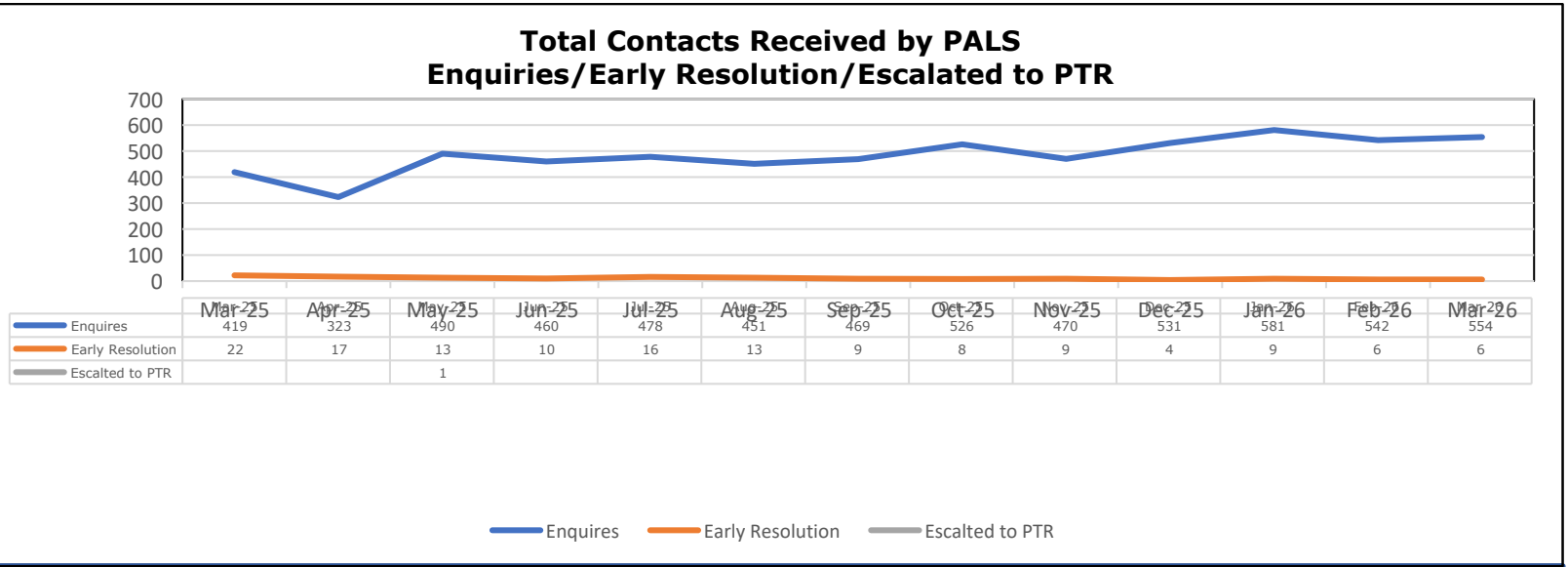
### Listening & Learning (Jan – March 2026, Q4): What we're hearing

- FFT (Friends and Family Test) 'How would you rate your overall experience?': overall FFT score for Q4 is 83% and the negative score remains 10% (unchanged from January and February).
- The PES question 'Was the time you waited' remains the lowest overall scored question for this period at 73, with a noted drop in March compared to January and February (see graph).

### Listening & Learning: What we're doing

- Preparing the All-Wales National Endoscopy Survey for April 2026, with launch via SMS to follow; work to launch All Wales Research Survey continues.
- Implementing the National Survey for the new Listening to People process for April 2026, including additional languages and BSL; developing an Easy Read version and continuing to address CIVICA SMS delays.

## Pillar 1 Patient and staff feedback, concerns, complaints and compliments- Patient Advice & Liaison Service (PALS)




| Themes | Count |
|---|---|
| Communication Issues (including Language) | 3165 |
| Access (to Services) | 1543 |
| Appointments | 444 |
| Clinical treatment/ Assessment | 237 |
| Patient Care | 235 |
| Discharge Issues | 140 |
| Post Death Issues | 103 |
| Complaints Handling | 79 |
| Record Keeping | 68 |
| Admissions | 40 |

The number of contacts received by PALS has increased in Q4 with 1677 enquires, up from 1526 in Q3.

**What the Data Tells Us**
- 6,437 cases managed
- 32% increase in March year-on-year
- 50% of enquiries = Communication issues
- Only 1 case escalated to PTR (0.01%)

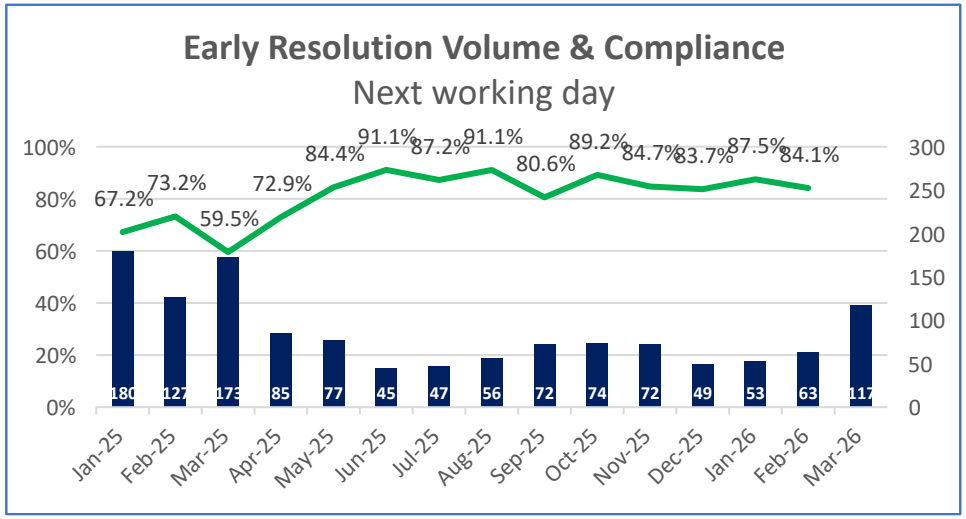
**Learning & Improvements**
- Proactive communication reduces anxiety
- Stronger links with clinical teams improve timeliness
- Advocacy supports vulnerable patients & families
- Clearer care plans achieved through PALS facilitation
- Training ongoing with British sign language level 1 for all PALS

**Successes**
- High resolution rate with almost no escalation
- Compassionate support for vulnerable patients
- Set up People's Participation Panel for Deaf community

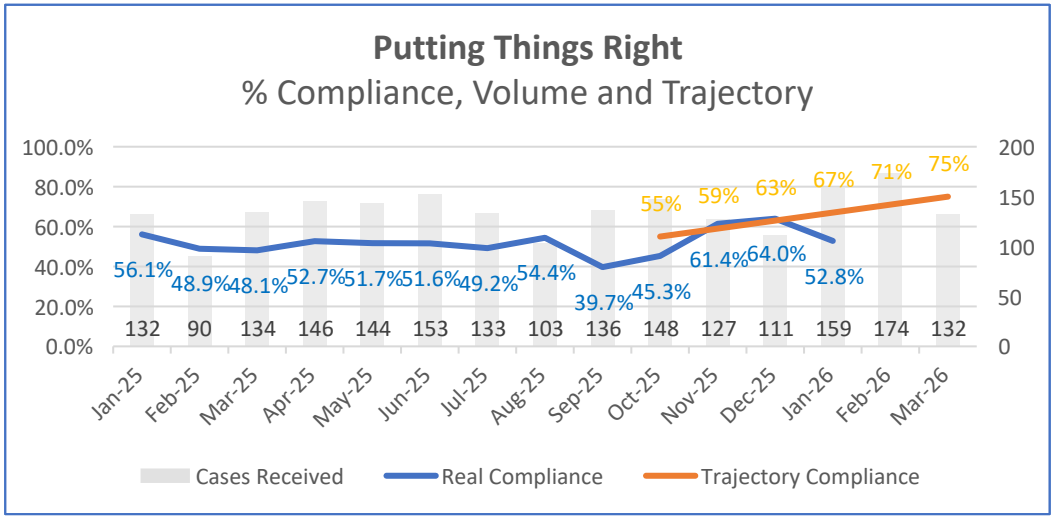
**Challenges**
- Communication breakdowns persist
- Call-handling & access issues drive demand
- Early Resolution work under-recorded due to system limits. Likely to change with new regulations (LTP)

## Pillar 1 Patient and staff feedback, concerns, complaints and compliments- Putting Things Right

**Graph 1- Early Resolution Performance**




**Graph 2 – Putting Things Right Performance**




**Graph 1** shows the Early Resolution volume and compliance since January 2025. It illustrates the compliance being maintained above 80% with variable volumes.

**Graph 2** shows the Putting Things Right (formal complaint) received, the compliance and the agreed improvement trajectory. January saw a decline in the compliance as a result of increased volumes, high operational pressures on divisional teams and the resource required to prepare for legislative changes.

**Key Themes and Learning** –

The main complaint themes in Q4 Clinical Treatment / Assessment (49%), Communication issues (12%) and Appointments (8%). Work has taken place with specific directorates to improve communication as a result of learning from complaints with improvements to letters to patients and template responses to improve efficiency.

**Improvements-**

Systems and processes have been refined in the Mental Health and Family and Therapies divisions making a notable improvement to compliance with timescales. Urgent Care continues to be the best performing division with compliance of 80% across the financial year.

Focused weekly sessions continue with the PTR management team to monitor and escalate where required cases approaching compliance deadline to ensure those which can be achieved within timescale are being driven by the concerns support officers.

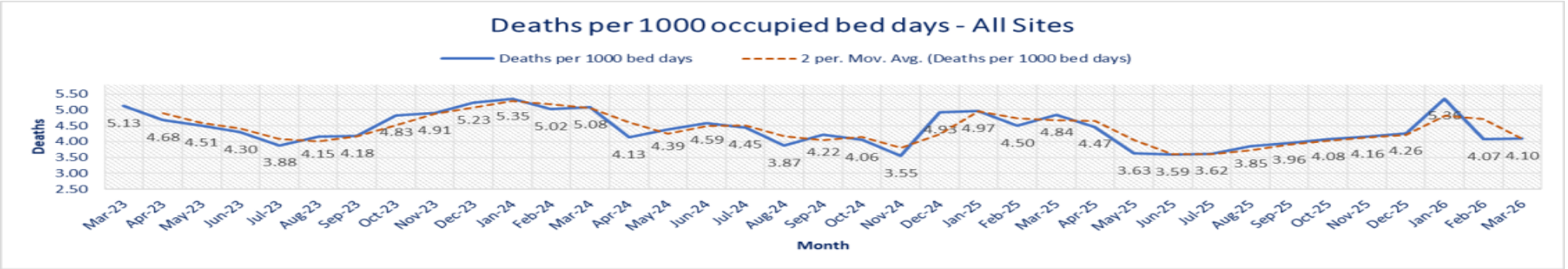
Focus has been directed towards preparing for the rollout of the LtP regulations, which means some resources have been allocated to ensure readiness for its implementation

## Pillar 2 – Patient Safety Including Incident Reporting - Mortality

**Graph 1 - Risk Adjusted Mortality Index (RAMI)**




**Graph 2 - Deaths per 1000 occupied bed days**

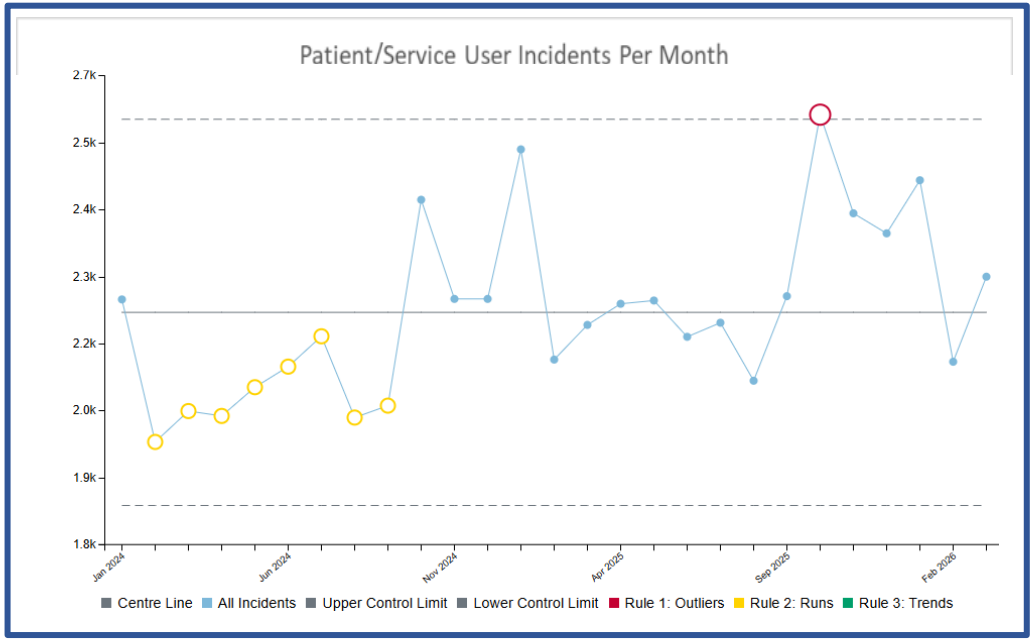


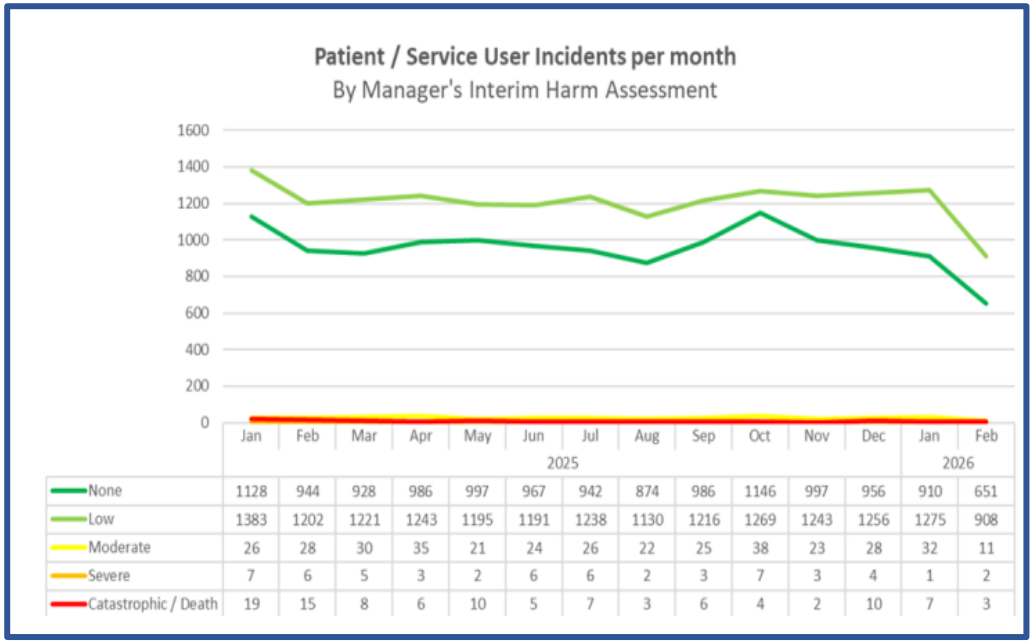

**Graph 1** - shows the Health Board's Risk-Adjusted Mortality Index (RAMI) for January is 119.2, (RAMI Q1-91, Q2-84, and Q3-92). The increase in in line with All Wales peers. RAMI adjusts for patient risk factors and co-morbidities, allowing meaningful comparisons across organisations. RAMI has improved year-on-year since 2023 indicating fewer observed deaths than expected. RAMI reliability depends on accurate clinical coding and timely updates to external systems. A standard 6–8-week delay in coding ensures completeness and accuracy. In January 2026, the Health Board ranked third among six members of the All-Wales peer group. Q4 complete data (February and March will be updated in due course).

**Graph 2** – crude mortality measures the number of deaths in a population over a set period, comparing current figures to the three-year average to identify trends. This data reflects all-cause mortality within the Health Board. The graph shows hospital deaths recorded by the Health Board. In 2025, deaths were on average 15% lower than previous years. Seasonal variation is evident, with consistent spikes in December and January each year.

**Learning and Improvement** – continue presenting the Learning from Death report to strengthen understanding of mortality reporting. This includes structured reviews and deep dives to interrogate RAMI data. Review mortality outliers through case-based notes analysis to identity learning opportunities and drive improvement. Collaborate with coding teams to improve depth and accuracy of clinical coding, enhancing the reliability of mortality metrics.

## Pillar 2 – Patient Safety Including Incident Reporting – RL Datix Incidents Overview




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2025 | | | | | | | | | | | | 2026 | |
| None | 1128 | 944 | 928 | 986 | 997 | 967 | 942 | 874 | 986 | 1146 | 997 | 956 | 910 | 651 |
| Low | 1383 | 1202 | 1221 | 1243 | 1195 | 1191 | 1238 | 1130 | 1216 | 1269 | 1243 | 1256 | 1275 | 908 |
| Moderate | 26 | 28 | 30 | 35 | 21 | 24 | 26 | 22 | 25 | 38 | 23 | 28 | 32 | 11 |
| Severe | 7 | 6 | 5 | 3 | 2 | 6 | 6 | 2 | 3 | 7 | 3 | 4 | 1 | 2 |
| Catastrophic / Death | 19 | 15 | 8 | 6 | 10 | 5 | 7 | 3 | 6 | 4 | 2 | 10 | 7 | 3 |

Incident Volume and Harm: Patient/Service user incidents in Q4 reached 6,888 which is similar to the 6,860 seen in Q4 24/25.

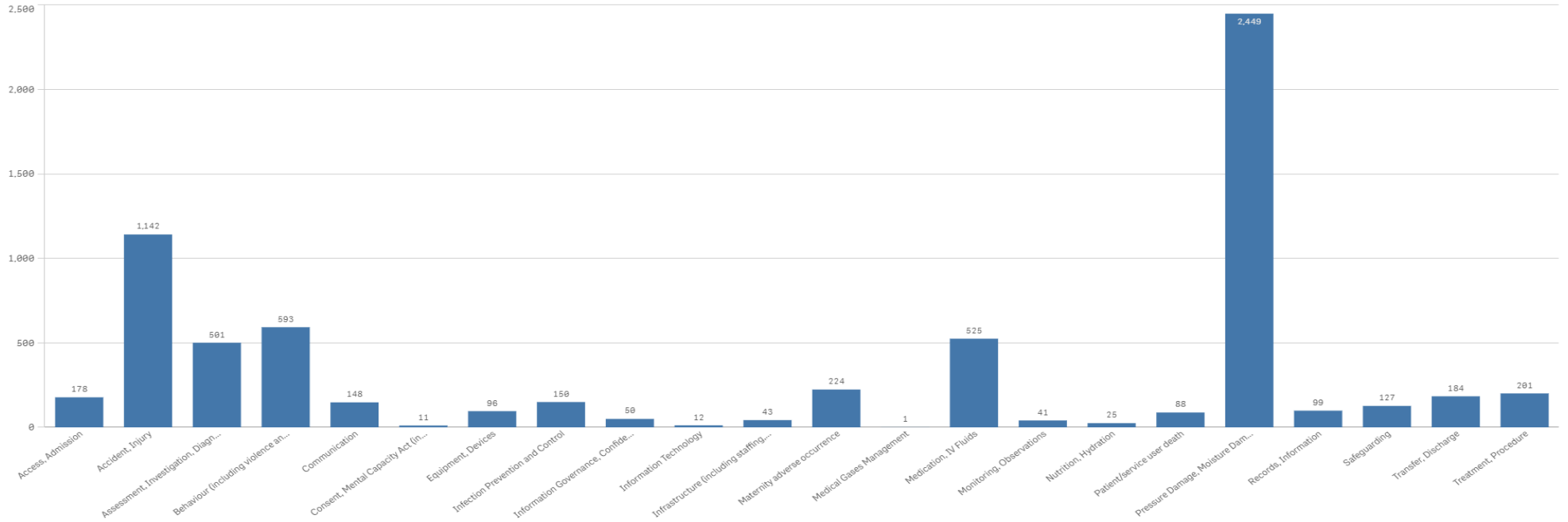
A notable decrease in the number of Catastrophic/Death incidents has been driven by work to improve the review and grading of incidents where patients have sadly died. The level of harm should be evaluated from the perspective of harm caused/contributed by Healthcare.

All incidents are investigated for identification of learning, themes and trends are collated and local actions or quality improvement programmes are developed as a result of the learning identified. These actions and quality improvement programmes may be delivered locally, divisionally and at Health Board level.

**Learning & Improvement -**

Development of the Health Board's Quality and Patient Safety Application is ongoing with phase one going live in Q4. This saw patient safety incidents and feedback modules being accessible to relevant teams. Divisional level monitoring is continuing at a monthly basis with statistically significant variations and trends being highlighted for investigation and improvement.

## Pillar 2 – Patient Safety Including Incident Reporting – RL Datix Incidents Overview Q4




**The data presented above is extracted from RL Datix and provides a high level overview of the most common 'Classification' of incidents. Classification, represents the highest tier of description, with 'category' and 'sub-category' providing a more granular description of an incident. The data presented is only for Q4 2025/26.**

'Pressure damage, moisture damage' incidents are the most common Datix incident, of which 73% relate to pressure ulcers present before admission, 27% relate to worsening pressure ulcers during their care, this is similar to the previous quarter (72% and 28% respectively). A dedicated slide on pressure ulcers explore the work being undertaken.

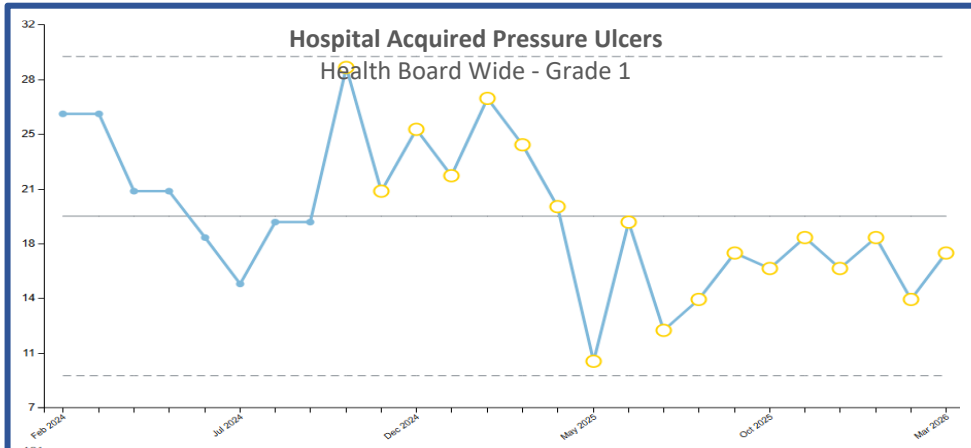
'Accident, Injury' incidents- 85% are related to 'slip, trips and falls'. A dedicated slide on patient falls will explores these incidents in more detail and the work ongoing to mitigate the risk and harm of patient's falling.

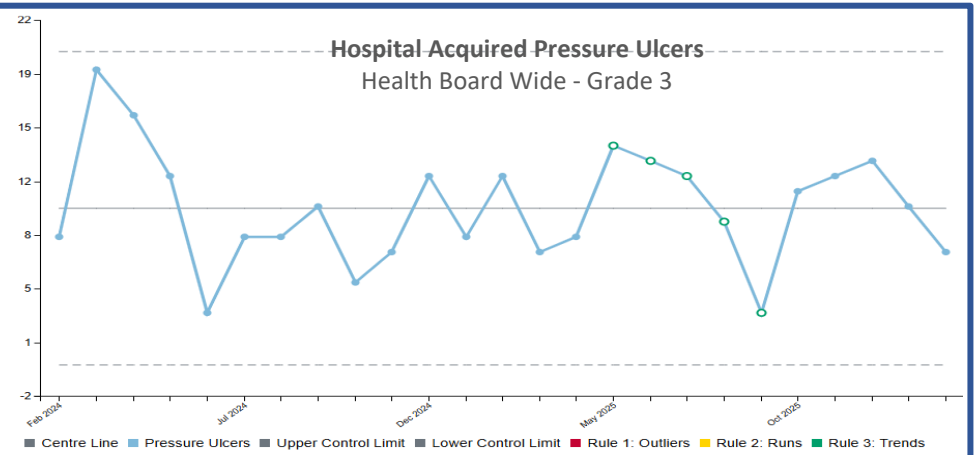
'Behaviour' incidents- 52% related to 'Self harm/injury', 13% relate to 'Restrictive practices' and 11% relate to 'absconding/missing patients. The overall number of these incidents notablely decreased from 756 in Q3 to 593 Q4, driven by improvement work within the Mental Health and Learning Disabilities Division.

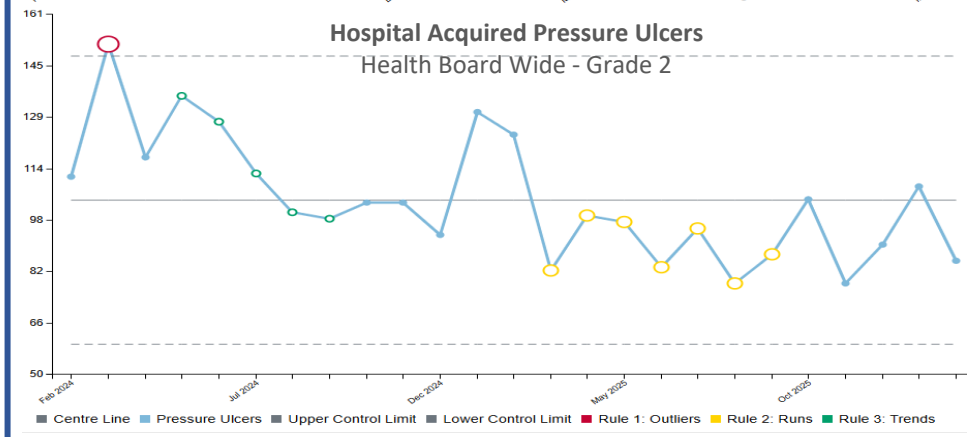
'Medication, IV Fluids' incidents- 42% relate to 'Administration errors' which would encompass delays, dose, strength, route of administration. 26% are 'Medication supply errors' and 17% are "Prescribing errors".

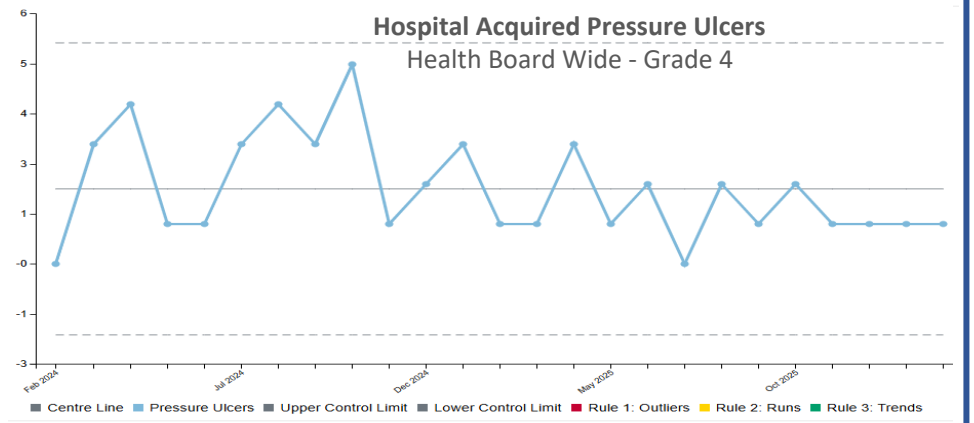
'Assessment, investigation, diagnosis' incidents- 62% are 'Diagnostic testing- Pathology', 23% are 'Clinical assessment/diagnosis' and 12% are 'Diagnostic testing – Radiology'.

# Pillar 2 – Patient Safety Including Incident Reporting – Pressure Ulcers



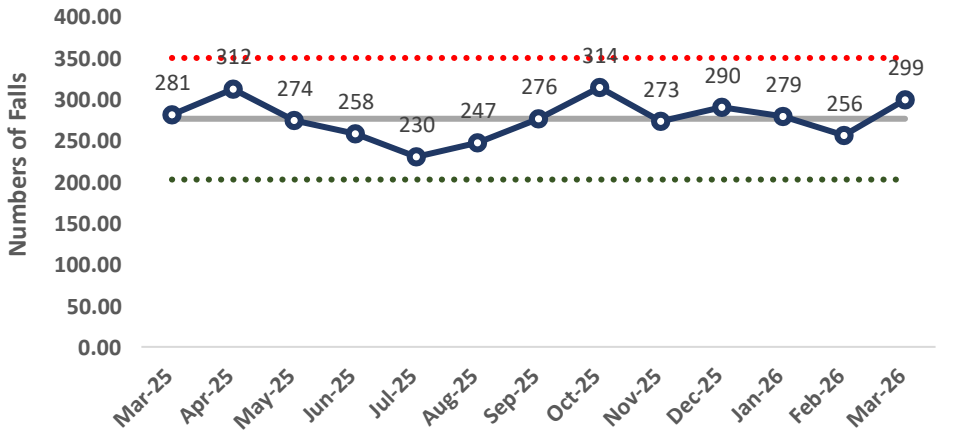



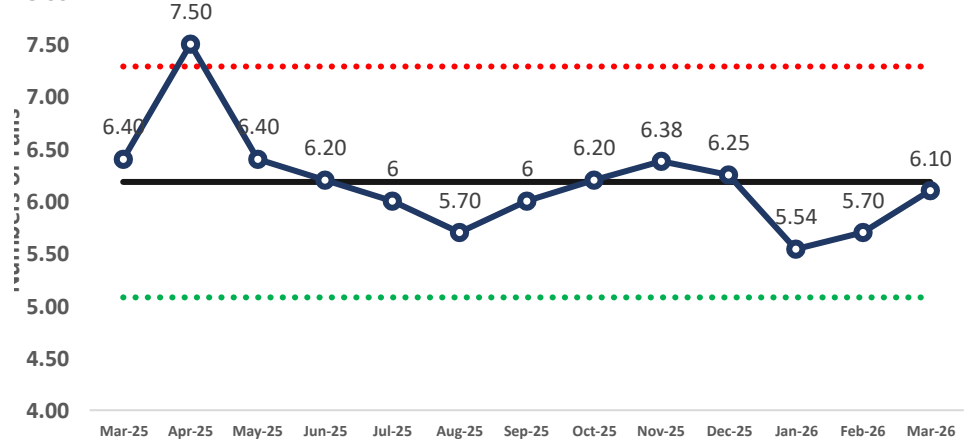




The majority of Pressure Ulcers recorded are category 2 (partial-thickness skin loss where the epidermis (outer layer of skin) or dermis (deeper layer of skin), or both, are damaged). Within Grade 1 HAPU there has been a shift with all months since April 2025 falling below the mean, which coincides with the Director of Nursing establishing a professional standards group. The expected trend of increases during winter months can be seen in both grade 1 & 2.

| Issue | Action | Learning and Improvement |
|---|---|---|
| Open "no value" incidents | Process reviewed by Complex Care relating to grade 1 and 2 pressure damage occurring within a non-commissioned service. | Number of cases reviewed monthly at the collaborative, contributing to a significant reduction in cases across the Health Board. |
| Non-standardised use of flow charts and guidance, and lack of clarity in recording certain categories of pressure damage | Review of policy and all guidance relating to pressure damage, alongside the development of standardised flow charts for use across the Health Board. | Improved understanding of processes and shared learning across divisions. Documentation to be agreed at the next collaborative and then submitted for sign-off. |
| Pressure damage not recorded prior to transfer of a patient to another clinical area | Datix process reviewed, with discussions held at the collaborative to increase staff understanding of requirements and processes. | Guides developed to promote understanding and compliance, with a planned re-launch of the Pressure Ulcer Passport to support learning and improvement in practice. |

## Pillar 2 – Patient Safety Including Incident Reporting – Falls



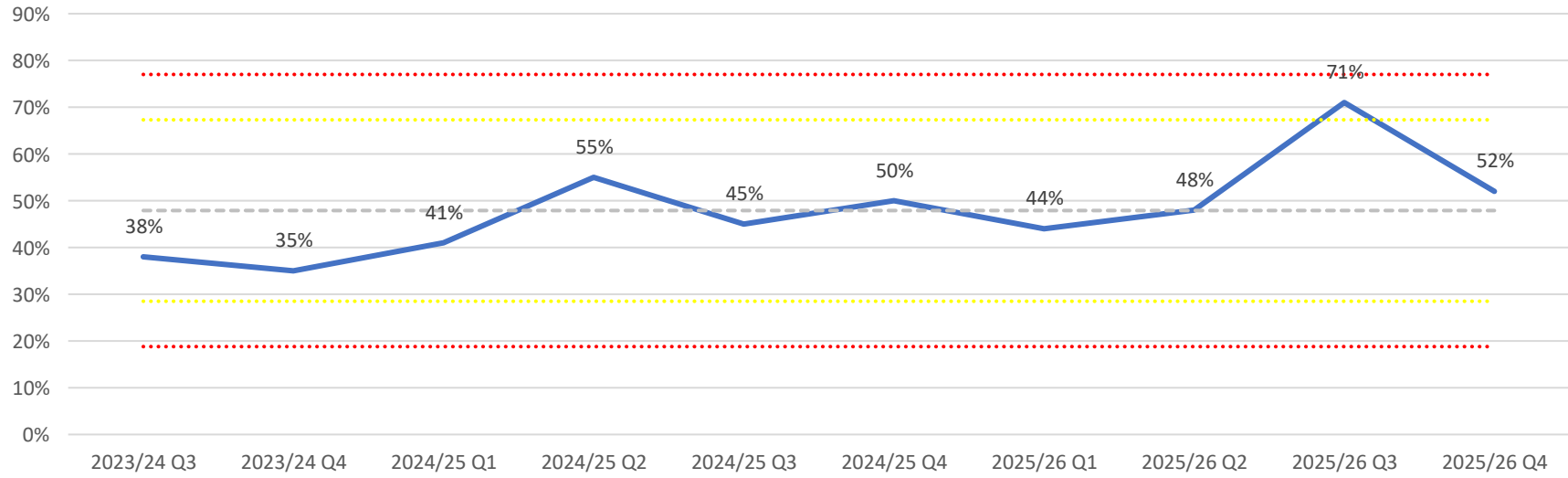

For the given period of analysis, the mean average value of fall incidents is 275 which represents a marginal decrease from 280 reported in January 2025-26.
February 2026 (256) has seen a 8% decrease in the numbers of reported falls incidents as compared to January 2026 (279).

At the time of reporting 93% of incidents for January 2026 were identified as no/ low harm. No incidents have been reported as a catastrophic outcome since November 2024.

Positive variation has been demonstrated for 10 consecutive months (May 2025 to February 2026) in which falls per OBD's have been below the National average.

For Q4 both January and February 2026 have been
11.5 % and 9% below the mean average value for the Health Board.

## Pillar 2 – Patient Safety Including Incident Reporting – Nationally Reportable Incidents




Compliance with target closure dates for Nationally Reportable incidents saw a dip in Q4 due to a number of very complex cases.

The number of cases overdue :
12 months is 2 (compared to 4 in Q3)
6-12 months is 3 (compared to 2 in Q3)
3-6 months is 3 (unchanged from Q3)
0-3 months is 8 (compared to 9 in Q3)

**Learning and Improvement:**

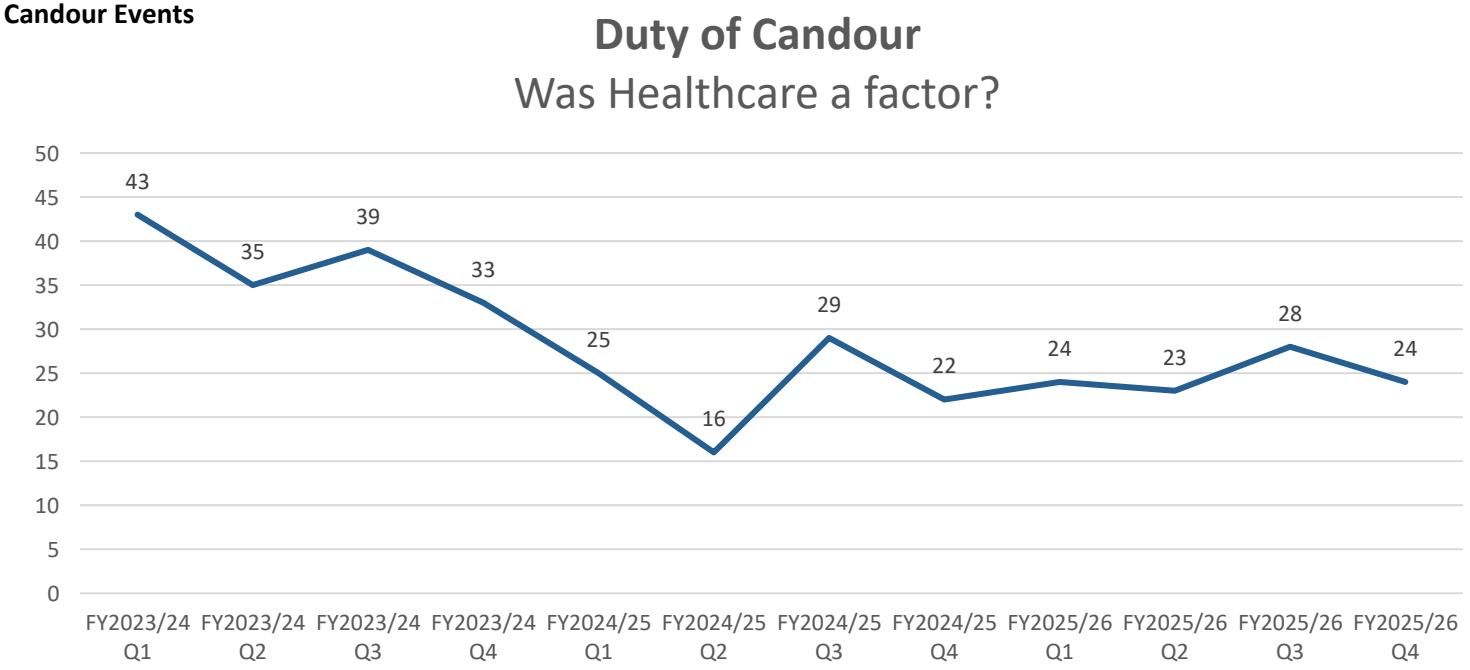
A recent PQSOC paper highlighted the notable improvements made in reducing the number of open overdue NRI cases in the Health Board. An improvement plan that will take place across 2026/27 which aims to address areas of improvement across all stages of the NRI process has been developed.

The corporate PSI team has undertaken a review of the PSI investigation process, with the aim of ensuring that quality patient safety and robust governance are embedded throughout the process; This has been presented to the clinical executive team and will be presented to QMG in March.

The corporate PSI Team has been meeting with the F+T Division to review their PSI process. This work is ongoing.

## Pillar 2 – Patient Safety Including Incident Reporting – - Duty of Candour

**Graph 1 – Duty of Candour Events**



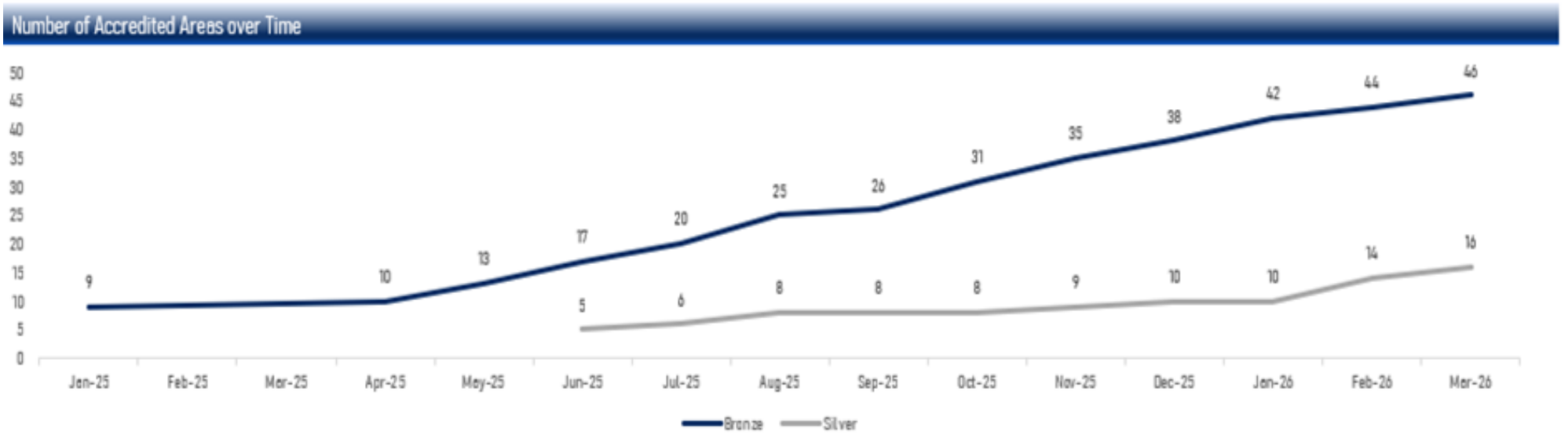

Duty of Candour information is extracted from RL Datix and represents an evolving picture; data correct as of 23 April 2026. The number of Duty of Candour (DoC) incidents remains low. Common Categories of Incidents: *Treatment or procedure issues, Clinical assessment / diagnosis, Slip, trip or fall and Pressure ulcer developing/worsening.*

**Actions:** Refreshed SoPs being finalised which will go alongside new digital resources on ABUHB intranet and Business Intelligence Software (QLIK) to allow real time monitoring of DoC cases.

**Learning and Improvement:** Mandatory training will strengthen understanding and statutory compliance. Patient and family feedback reinforces the need for timely, compassionate communication during DoC processes. Continuous monitoring of DoC application and training effectiveness. Collaboration with other Health Boards to share best practice and refine SOPs. Cultural shift towards openness and honesty as core principles.

## Pillar 3 Clinical Effectiveness – Ward Accreditation

**Graph 1- Ward accreditation status over time**



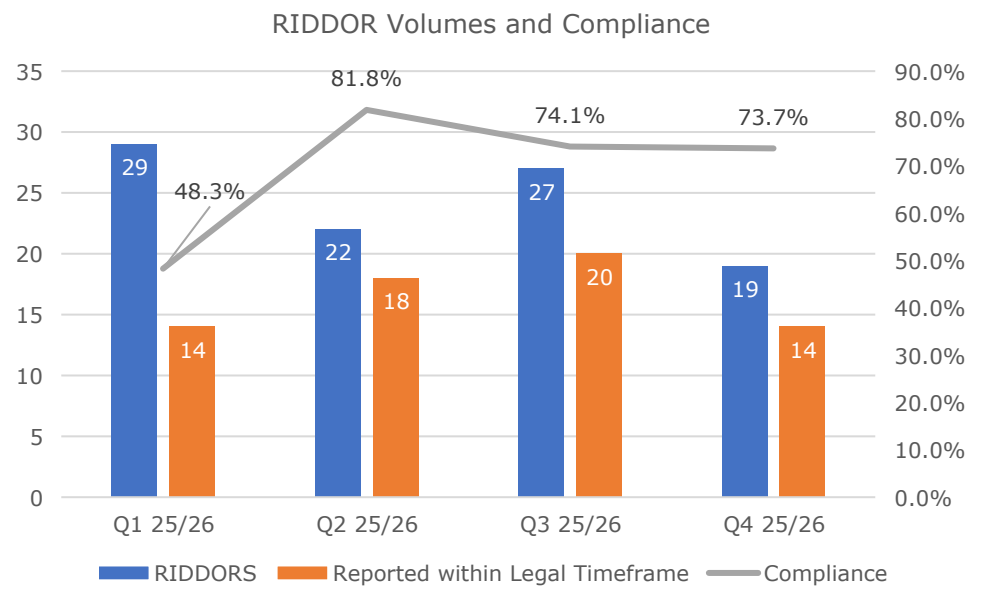

### Quality Improvement Projects through ward accreditation

8 more areas have achieved bronze accreditation and 7 more areas have reached silver in Quarter 4 2025/26.
More specialist areas are being accredited (theatres / clinics).
Winter pressures are slowing the wards' ability to progress their accreditation.
Roll out to district nursing / complex care and public health nursing in progress

| Issue | Action | Learning and Improvement |
|---|---|---|
| Resources to undertake independent reviews have been impacted by winter pressures.<br><br>Some reviews may be delayed slightly depending on availability of senior staff. | Shadowing senior nurses so they can use a peer review in clinic areas for bronze accreditation.<br><br>Widen scope of staff undertaking reviews : invites sent to QPS / IPAC / Safeguarding | Review of independent review process to streamline |
| | | |

## Pillar 4 - Health, Safety, Security and Compliance

### Graph 1- RIDDOR % Compliance




### Table 1 - Health and Safety Training Compliance

| Staff Health and Safety Incident Reporting | Q1 25/26 | Q2 25/26 | Q3 25/26 | Q4 25/26 |
|---|---|---|---|---|
| Health and Safety | 86.6% | 87.1% | 86.9% | 87.2% |
| Fire Safety | 82.2% | 82.3% | 82.4% | 82.7% |
| Manual Handling | 69.7% | 69.7% | 66.2% | 64.9% |
| Violence Prevention & Reduction | 86.3% | 86.3% | 85.7% | 85.3% |

### Table 2 – Violence and Aggression incidents

| Staff Health and Safety Incident Reporting | Q1 25/26 | Q2 25/26 | Q3 25/26 | Q4 25/26 |
|---|---|---|---|---|
| Physical assault | 266 | 203 | 262 | 276 |
| Contact with needles or medical sharps | 56 | 67 | 65 | 54 |
| Slip, trip or fall | 28 | 35 | 26 | 50 |
| Verbal assault | 46 | 25 | 45 | 46 |
| Manual handling | 18 | 19 | 19 | 16 |
| Sexual assault and/or sexually inappropriate behaviour | 19 | 11 | 19 | 14 |

| Issue | Action | | Learning and Improvement |
|---|---|---|---|
| Violence towards staff | Violence Prevention & Reduction Strategic Plan approved by Board<br><br>Successful recruitment of Violence, Prevention & Reduction Manager | Under-reporting and normalisation of abuse | The VPR Strategic Plan sets out objectives to improve reporting and culture |
| Needlestick & sharps | Reduction in number of injuries in Q4 2025/26 | Poor practice relating to safe disposal of sharps identified as a contributory factor to injuries | QI project to reduce needlestick and sharps injuries to commence in Q2 26/27 in conjunction with H&S, IPaC and Occupational Health |
| Winter slips, trips and falls | Winter falls thematic review conducted by Corporate Health & Safety | Slips, trips and falls in Q4 25/26 significantly above the quarterly average and data for the same period in Q4 24/25 | Areas for improvement identified within the thematic review to be shared with Facilities Division |
| RIDDOR reporting compliance with the legal timeframes | RIDDOR SOP revised | Timely reporting and investigation of incidents to determine an outcome on RIDDOR | RIDDOR Awareness eLearning Training to be implemented in Q2 26/27. Submission to Core Learning Committee in June 2026 to mandate this training for managers |
| Manual Handling Training | Manual handling training programme developed for 2026/27 | Backlog of staff requiring the 2-day People Handling Foundation Training | Focus on supporting Cascade Trainers (Transfer Specialists) to ensure update training is delivered locally |

## Pillar Five - Infection Prevention & Control

**Table 1 – Healthcare Associated Infections per 100,000 populations**

| | C. difficile | MRSA bacteraemia | MSSA bacteraemia | E. coli bacteraemia | Klebsiella sp bacteraemia | P. aeruginosa bacteraemia |
|---|---|---|---|---|---|---|
| Aneurin Bevan UHB | 41.99 | 1.51 | 24.86 | 64.83 | 20.49 | 5.21 |
| Wales | 42.03 | 2.09 | 25.53 | 68.1 | 23.7 | 5.12 |

**Table 2 – Healthcare Associated Infections Count of specimens**

| | C. difficile | MRSA bacteraemia | MSSA bacteraemia | E. coli bacteraemia | Klebsiella sp bacteraemia | P. aeruginosa bacteraemia |
|---|---|---|---|---|---|---|
| Aneurin Bevan UHB | 250 | 9 | 148 | 386 | 122 | 31 |
| Wales | 1330 | 66 | 808 | 2155 | 750 | 162 |

### C difficile infection

250 cases of C difficile reported from April 2025 to March 2026. This is **25 less** than the equivalent period 2024/25. This is a HB rate of 41.99 per 100,000 population

< than same period last FY
= same period last FY
> than same period last FY

### Staph Aureus blood stream infection

157 cases of Staph Aureus BSI reported from April 2025 to March 2026. This is **32 less** than the equivalent period 2024/25. This is a HB rate of 26.37 per 100,000 population

### E coli blood stream infection

386 cases of E coli BSI reported from April 2025 to March 2026. This is **10 more** than the equivalent period 2024/25. This is a HB rate of 64.83 per 100,000 population

### Klebsiella blood stream infection

122 cases of Klebsiella BSI reported from April 2025 to March 2026. This is **7 more** than the equivalent period 2024/25. This is a HB rate of 20.49 per 100,000 population

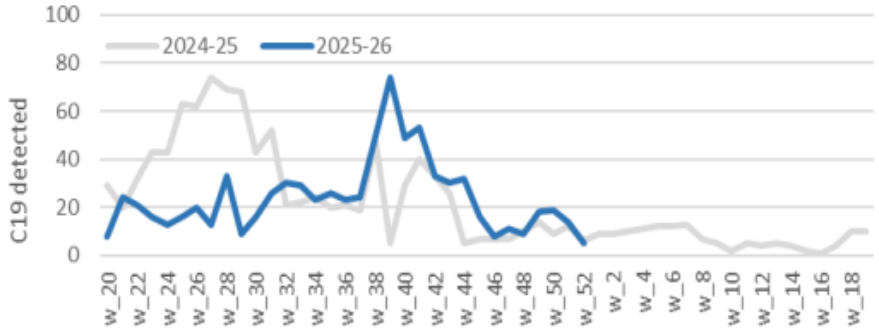
### Pseudomonas blood stream infection

31 cases of Pseudomonas BSI reported from April 2025 to March 2026. This is **11 less** than the equivalent period 2024/25. This is a HB rate of 5.69 per 100,000 population

## Pillar Five - Infection Prevention & Control

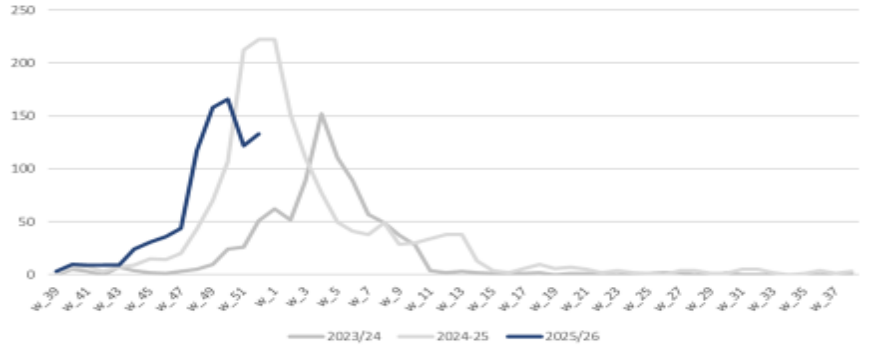
### Covid

COVID-19 remains stable at low levels in ABUHB and across Wales



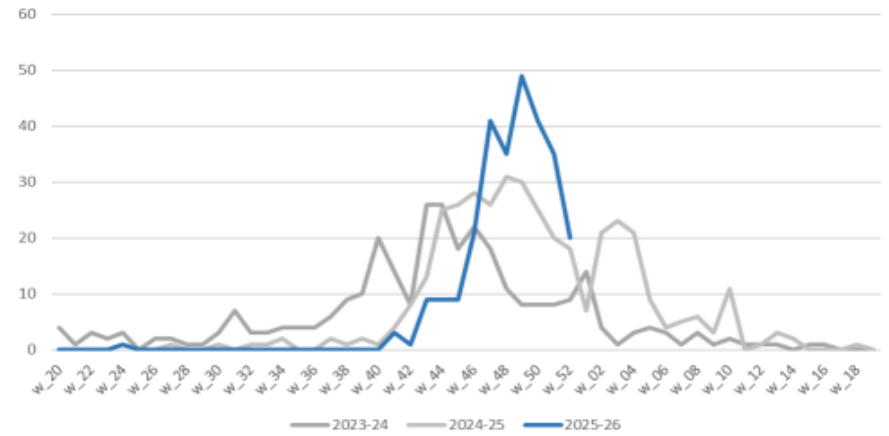

### Influenza

Influenza remains stable at medium intensity levels in ABUHB. Across Wales, influenza continues on an increasing trend – particularly numbers of new cases being hospitalised with confirmed influenza.




### RSV

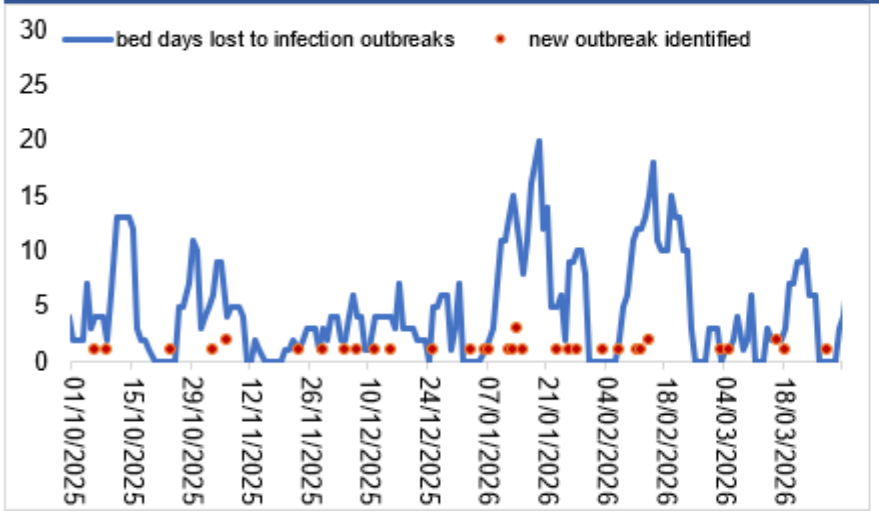
New RSV cases declined for a third consecutive week in ABUHB, suggesting we have passed the peak. Activity in adults increased, but numbers remain very small overall. Across Wales, RSV activity in children under 5 is still above high intensity level thresholds, but activity is declining



## Pillar Five - Infection Prevention & Control

**Table 1 – Ward Closures, Bed Days Lost & RAG Escalation (rolling 7 days)**

### Bed Days Lost to infection (Flu, Covid, C difficile & Norovirus)




| Organism | Number of ward closures |
|---|---|
| C difficile | 1 |
| Covid-19 | 1 |
| RSV | 1 |
| Norovirus | 26 (7 during March 2026) |

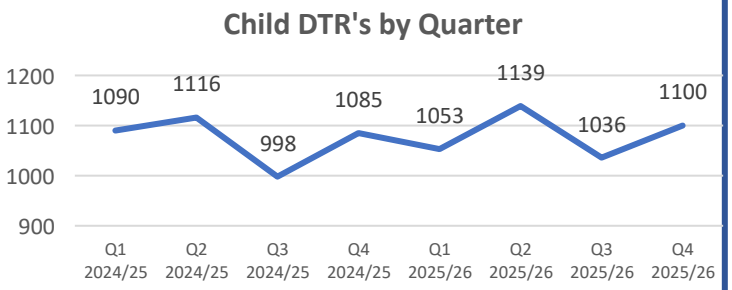
| TRIGGERS | 01/03/2026 | 02/03/2026 | 03/03/2026 | 04/03/2026 | 05/03/2026 | 06/03/2026 | 07/03/2026 | 08/03/2026 | 09/03/2026 | 10/03/2026 | 11/03/2026 | 12/03/2026 | 13/03/2026 | 14/03/2026 | 15/03/2026 | 16/03/2026 | 17/03/2026 | 18/03/2026 | 19/03/2026 | 20/03/2026 | 21/03/2026 | 22/03/2026 | 23/03/2026 | 24/03/2026 | 25/03/2026 | 26/03/2026 | 27/03/2026 | 28/03/2026 | 29/03/2026 | 30/03/2026 | 31/03/2026 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Number of covid positive in patients | 1 | 3 | 5 | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 3 | 2 | 3 | 4 | 3 | 3 | 4 | 1 | 1 | 3 | 4 | 4 | 6 | 8 |
| Total Number of flu positive in patients | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Number of RSV positive in patients | 3 | 4 | 2 | 3 | 2 | 3 | 2 | 1 | 0 | 1 | 2 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 0 | 1 | 0 | 1 | 1 | 1 | 0 |
| TOTAL ARI IN PATIENTS | 6 | 8 | 8 | 5 | 3 | 4 | 3 | 2 | 2 | 2 | 3 | 4 | 2 | 3 | 2 | 2 | 3 | 3 | 4 | 4 | 6 | 4 | 4 | 7 | 2 | 2 | 3 | 5 | 5 | 7 | 8 |
| Total number of full ward closures ARI | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Total number of full ward closures D&V Noro | 0 | 0 | 1 | 1 | 2 | 3 | 1 | 1 | 2 | 2 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 2 | 2 | 3 | 3 | 3 | 3 | 3 | 1 | 1 | 1 | 1 | 1 | 2 | 1 |
| Total number of pods/bays closed ARI/D&V Noro | 1 | 1 | 0 | 0 | 1 | 2 | 2 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 |
| TOTAL AREAS CLOSED | 1 | 1 | 1 | 1 | 3 | 5 | 3 | 2 | 2 | 3 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 3 | 2 | 3 | 3 | 3 | 3 | 3 | 1 | 1 | 1 | 2 | 2 | 3 | 1 |
| Number of patients ventilated in ICU c/o ARI | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Staff sickness % due to ARI | 0.7 | 0.73 | 0.7 | 0.7 | 0.65 | 0.65 | 0.64 | 0.65 | 0.64 | 0.62 | 0.61 | 0.69 | 0.7 | 0.62 | 0.59 | 0.67 | 0.66 | 0.71 | 0.62 | 0.63 | 0.56 | 0.56 | 0.61 | 0.56 | 0.61 | 0.56 | 0.64 | 0.53 | 0.5 | 0.56 | 0.52 |
| Number of Enclosed Settings in incidence | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ESCALATION LEVEL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total number of NOROVIRUS patients within 72 hours of symptomatic period | 0 | 0 | 0 | 0 | 20 | 30 | 30 | 27 | 17 | 13 | 9 | 6 | 0 | 0 | 0 | 0 | 1 | 9 | 13 | 19 | 21 | 23 | 22 | 17 | 10 | 7 | 7 | 4 | 4 | 4 | 11 |

## Pillar Five - Infection Prevention & Control

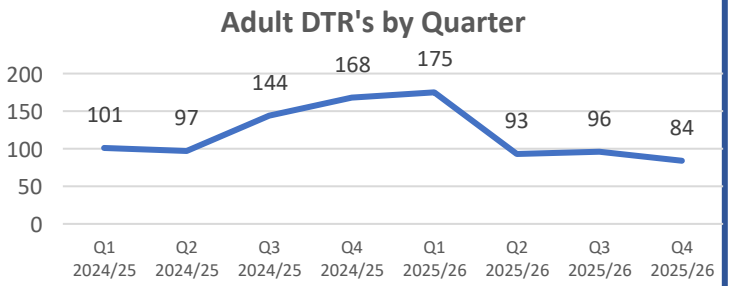
| Themes & Trends | Successes | Challenges | Learning & Improvement |
|---|---|---|---|
| **C difficile** | Four new clusters identified or periods of increased incidents confirmed gen- sequency in D5W<br><br>Quality improvement ongoing at RGH with a focus on near patient cleaning of equipment and communication | Antimicrobial pharmacist workforce currently shortage in team<br><br>Timely isolation at RGH and NHH due to limited isolation capacity<br><br>Norovirus impacting on incident finds of C difficile<br><br>Vacancies and sickness within facilities team | Local risk assessment for hospital cleaning due to limited workforce<br><br>Reduction in hospital acquired C difficile of 22% from 138 to 107 plus a 3% reduction in number of CAI cases compared to previous FY |
| **Staph Aureus blood stream infections** | Refreshed training package to interactive session for healthcare support workers with positive feedback<br><br>Reduction of 15% of hospital acquired MSSA/MRSA plus a 21% reduction in CAI *Staph aureus* BSI infections compared to previous FY | Line infection MSSA in critical care<br><br>ESR reporting re ANTT compliance | Refreshed PIC line guidance obtained from Velindre, local T&F group to be established to review line care generally across the HB<br><br>Promoted I DECIED for line access assessment tool |
| **Gram Negative blood stream infections** | Erase developed and published for urine dip stick UTI rate in care home lower than all Wales average<br>No device related BSI | Increase in E coli and Klebsiella Secondary infections linked to respiratory and biliary sepsis<br><br>7% increase in CAI Gram-negative BSI compared to previous FY | HAP audit planned for April |
| **Winter Viruses** | Escalation triggers within standard operating procedure includes norovirus<br><br>Respiratory virus impact declined to seasonal variation | High prevalence of community Norovirus Impact on Nevill Hall Hospital, YYF and RGH over the last 3 months | Shared facilities contributed Norovirus testing in assessment units help support system wide risk assessment and patient placement<br>Public coms messaging |

# Safeguarding

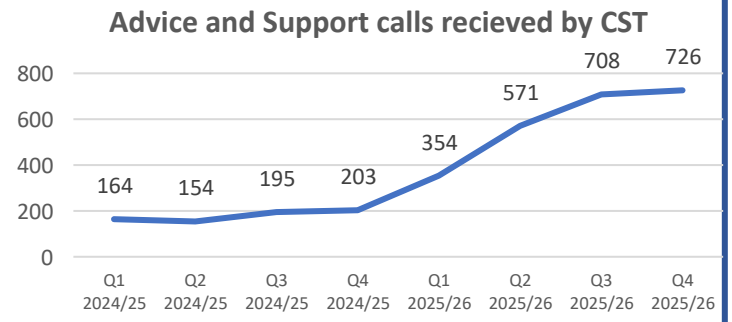
## Graph 1 – Child Duty to Report



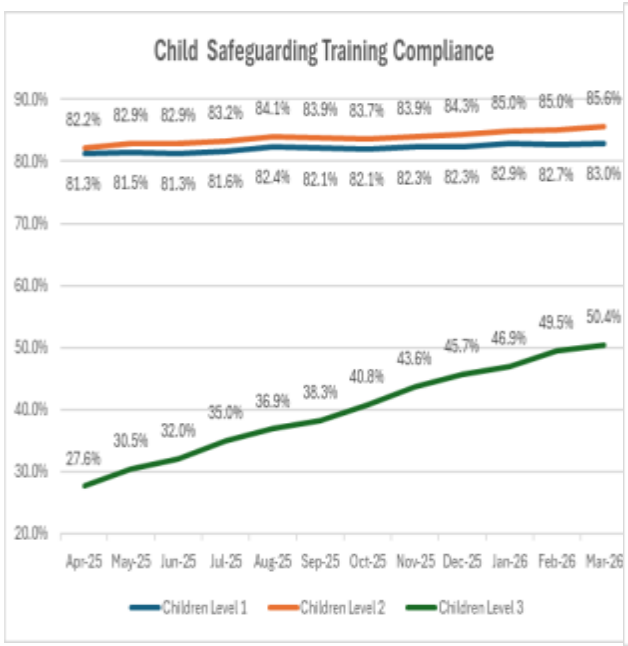

## Graph 2 – Adult Duty to Report

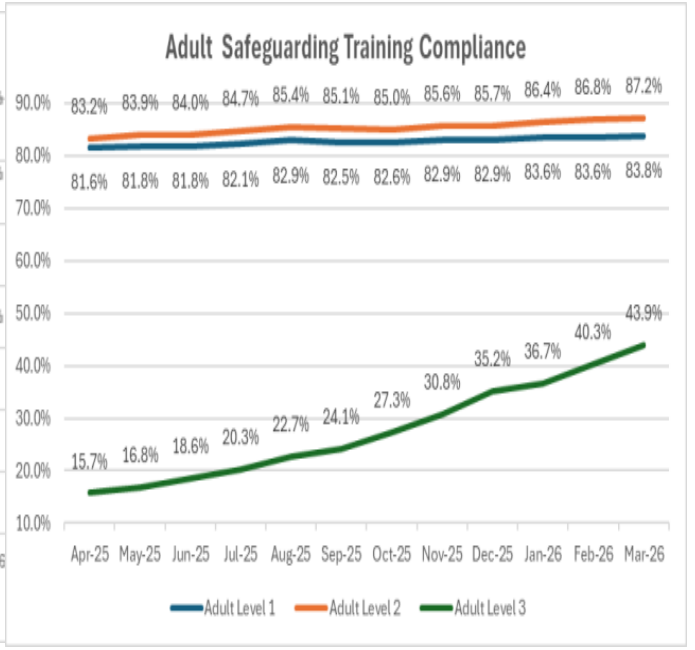



## Graph 3 – Advice & Support Calls to Safeguarding Service




## Table 1 - Child and Adult Safeguarding training compliance (levels 1, 2 & 3)




**Child Duty to Report:**
Child Duty to Report (DTR) activity shows mild quarter-on-quarter variation but remains largely stable, demonstrating continued vigilance by frontline staff. Despite this, the volume and complexity of cases continue to challenge Corporate Safeguarding capacity, reinforcing the need for sustained workforce capability and system resilience.

**Adult Duty To Report**
Adult Duty to Report (DTR) activity has stabilised over the past three quarters, reflecting the embedding of Level 3 safeguarding training into practice. While overall volumes remain steady, cases are often complex and involve multiple risk factors. Effective multi-agency working continues to support positive outcomes; however, the complexity of cases places ongoing pressure on safeguarding capacity and resources.

**Safeguarding Training:**
Compliance for Child Level 1 and 2 training remains broadly in line with the benchmark of 85%. Compliance with Adult and Child Level 3 training continues to improve and remains on track to achieve the agreed target by 31 March 2028. A key success has been the introduction of hybrid training delivery, which has proven effective for staff groups requiring both Adult and Child Level 3 training. However, attendance remains a challenge, with a persistently high number of staff booking onto sessions but failing to attend. In response, learning and improvement activity is focused on exploring alternative approaches to full-day training, with new methodologies currently being considered at a national level to improve accessibility, attendance, and overall compliance.

The 2025/26 financial performance is measured by comparing actual expenditure with the budgets as delegated and approved by the Board and CEO. The Health Board has statutory financial duties and other financial targets which must be met. The table below summarises these and the Health Board's performance against them.

**Feb-26**
**Performance against key financial targets 2025/26**
+Adverse / () Favourable

| Target | Unit | Current Month | Year to Date | Year-end Forecast | Movement |
|---|---|---|---|---|---|
| **Revenue financial target** To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.* | £'000 | (630) | 16,974 | **18,314** | ↓ |
| **Capital financial target** To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.* | £'000<br>£45,013 | 6,295<br>14% | 32,406<br>72% | **0** | ↔ |
| **Public Sector Payment Policy** To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number) | % | 97.9% | 97.1% | **>95%** | ↑ |

| **Performance against requirements 23/24** | | **22/23** | **23/24** | **24/25** | **3 Year Aggregate (22/23 to 24/25)** |
|---|---|---|---|---|---|
| Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue | x | **36,842** | **49,754** | **7,185** | **93,781** |
| Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital | ✓ | **(43)** | **(41)** | **(66)** | **(150)** |
| Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers | x | | | | |

| **Underlying Financial Position (Brought Forward ULP)** | **22/23** | **23/24** | **24/25** | **25/26 Forecast** |
|---|---|---|---|---|
| This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years. | **£89.6m Deficit** | **£81.4m Deficit** | **£27.2m Deficit** | **£38.2m Deficit** |

The 2025/26 financial year to date budget performance as at month 11 is an adverse variance of **£16.974m**. This position is £13m worse compared to the IMTP MDS and £1m better compared to the Month 10 MMR month 11 profile for 2025/26.

In Month 10 the forecast position remained the consistent which is **a reported forecast of £18.3m deficit**.

This position relies on savings achievement of £43.4m.

There remain risks associated with this forecast position, primarily relating to anticipated funding from WG for Planned care RTT and any new year pressures, including critical incidents, Winter, and full achievement of the savings schemes.

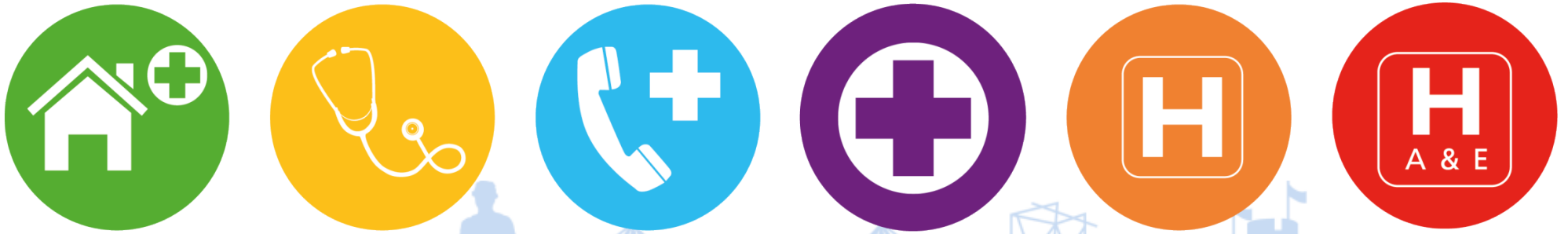
**ABUHB Mid Year Review 2025/26 (M11)**
**Forecast Deficit Analysis - outside of IMTP plan**

| Category | Issue | Value £m |
|---|---|---|
| National Issues (£2.9m) | National insurance > funding | 2.20 |
| | Theatres B2 to B3 grievance | 0.30 |
| | MS365 | 0.40 |
| Funding Ceased (£0.3m) | Fracture liaison service | 0.30 |
| Ministerial Priorities - Urgent & Emergency Care (£4.5m) | Winter Beds 24/25 | 0.80 |
| | Surge beds | 2.00 |
| | Emergency Department | 0.20 |
| | ITU capacity | 1.50 |
| Ministerial Priorities - Cancer (£2.5m) | Cancer | 2.00 |
| | Diagnostics growth | 0.50 |
| Growth above plan (£5.3m) | Drugs | 2.00 |
| | CHC | 2.50 |
| | Diabetes Pumps | 0.80 |
| Unavoidable Investments / Risk mitigations (£4.6m) | Mental health | 3.90 |
| | Thyroid loss of service | 0.50 |
| **Mid Year Review Forecast Deficit** | | **19.90** |
| Month 8 - 10 Movements | Winter 25/26 | 1.98 |
| | 45 Minute Handover | 1.38 |
| | NWSSP Rebate | (0.50) |
| | Bank Pay Award 2024/25 | (1.80) |
| | Additional Savings - from opps & new | (3.09) |
| | National Outpatient Insourcing (164 cohort). PP > £10.00 each | 1.05 |
| | Revised forecast sessional GP Ooh's (£0.6m),GMS (Global sum -£1.3m) | (0.60) |
| **25/26 Forecast as at Month 10** | | **18.32** |
| | National Outpatient Insourcing (164 cohort). PP > £10.00 each Funding | (0.96) |
| | Global sum correction to payments (per WG advised 10.03.26) | 0.95 |
| **25/26 Forecast as at Month 11 Final** | | **18.31** |

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

# Appendix 1

## Q4 25/26 progress against Enabling Actions



# Appendix 1: Enabling Actions

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Operational Productivity & Efficiency UEC | Community Based Falls Response | F | Plans in place to fully adopt with benefits tracking (6 Goals). | The Level 1 falls response has increased during Q4 at 40%, up from 35% in , with an additional L1 response initiated from January 2026 (winter additionality). Conveyance to hospital following a falls response was slightly reduced in Q4 down to 39%. Comparative analysis shows that Gwent has the second lowest conveyance rate for falls in Wales, just behind Powys. Therapist provision within Community Clinical Desk / SPOA is providing central support to falls navigation which is due to continue until the end of Q4 as part of the SPOA initiative. |
| | Remote clinical assessment services framework | P | Awaiting WG Issue, strong flow centre model expanding to MDT hub. | Community Clinical Desk Pilot implemented as planned from November 2025, based within the SPOA hub at Vantage Point House. The Community Clinical Desk is an MDT comprising a combination of General Practitioner, Occupational Therapist, Advanced Paramedic Practitioner and Frailty Specialist. As at the end of Q4, over 320 patients have been assessed through the pilot with 57% remaining at their normal place of residence thus avoiding conveyance/admission. Pilot will run to the end of Q4 with evaluation and options appraisal to follow. |
| | Acute frailty model at the Front Door | F | Plans in place to fully adopt with benefits tracking (6 Goals). | The Community assessment lounge has been extended to 31st March supporting our older population to return home following an ED attendance - currently at 76% discharge home rate. eLGH assessment units including SDEC at YYF continue to see a high proportion of over 65yr patients, same day assess-rates above 70%. Home First Team centralised to the Grange Hospital. 7 day coverage of front door therapies at The Grange with 5 day coverage at eLGH's sites. Older person programme established to identify the needs across sites, currently Frailty is a community based service with COTE clinicians based within eLGH's front doors, with therapies led service at GUH. |

# Appendix 1: Enabling Actions

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Operational Productivity & Efficiency UEC | Welsh Health Circular - Ambulance Handover Guidance | P | Improvement in performance expectations. | The next phase of Our Next Patient continues and the ED Extended footprint opened as of 17th Dec. ED attendances remain high, often reaching 280 per day. Pre-noon discharges rates at The Grange are up from 12% to 13% in Q4. Across eLGH's pre-noon discharges are stable for Q4 but have improved year on year (9% to 11%). The Transfer lounge at GUH is seeing around 134 patients per week compared to 91 in March 2025. Whilst there are still considerable improvements to be made, <45 minute handover compliance increased to 52% at the end of Q4, up from 48.1% at the end of Q3. <12 hour GUH ED compliance ended the year at 84.7%, up from 84.1% at Q3. |
| | Optimal Hospital Flow Framework | F | Plans in place to fully adopt with benefits tracking (6 Goals). | The roll out of the OHFF has been implemented across all sites, with the next steps to evaluate the implementations to assess the benefits, and to continue to embed the principles 2026/2027.<br><br>Divisional Nurse oversight is reported monthly via the Integrated Discharge Board, aligned with the POCD Action Plan. |
| | Maintaining the actions within the 50 Day challenge | F | Plans in place to fully adopt with benefits tracking (6 Goals). | A Weekly scrutiny panel is held to provide challenge and support with a focus on top 20 longest staying patients, evaluation to be undertaken post 12 months implementation to assess the benefits aligned to reduction in the longest staying patients. The Discharge Policy has been revised and signed off by the Integrated Discharge Board, and available on the intranet. |

# Appendix 1: Enabling Actions

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Operational Productivity Planned Care | Implement national guidelines with thresholds by Clinical Implementation Network (CIN). Including SOS and PIFU by default. | - | Current baseline is 13.4% in organisation. Baselines for each specialty known. Will continue to work with National team. | Ongoing monitoring by the OP transformation programme of the longest waiting patients on the follow up list.<br><br>The work with Directorate teams focuses on patients waiting to be booked/clerically validated/clinically validated. Continued focus on the implementation of straight to discharge pathways where appropriate.<br><br>5 out of 6 CIN protocols in place or now standard practice.<br><br>Local SOS/PIFU pathways implemented. Throughout March/April work is being undertaken with Directorates to confirm consistent use of all pathways and identify any new pathways.<br><br>Retrospective application of SOS/PIFU pathways to be undertaken in 2026/27 linked to validation strategy and clerical/clinical validation plan. Clinical validation of the delayed follow up list for ENT commenced Jan 26, with patients being discharged or moved to SOS/PIFU where appropriate. |
| | All new Cataract referrals should be direct listed to treatment stage of the pathway following an admin triage (end of Q2). | **P** | Baseline partial direct listing in place, plans to direct list all patients by end of Q4. | Action complete. |
| | Monitoring DNA/CNA for every Outpatient clinic. When DNA/CNA as a combined rate >5%, overbooking to be implemented & monitored. | **P** | DNA baseline 6%, CNA short notice baseline 4.5%.<br><br>. | Ongoing targeted approach within areas with high DNA/short notice CNA rates.<br><br>Text messages in place for majority of clinics to support timely communications. Work commenced with Public Health to understand patient cohort specific issues affecting DNA's for COTE.<br><br>Feb performance reached 25/26 low of 4.9%, which is also the lowest value on record (since Apr 2019) . March to date performance is 5.0%. |

# Appendix 1: Enabling Actions

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Operational Productivity Planned Care | Implementation of CIN follow up criteria both prospectively and retrospectively to established Follow-up waiting lists | - | Baselines known at specialty level – tracked in OP Group | Ongoing monitoring by the OPD transformation programme of the longest waiting patients on the follow up list linking with Directorate teams for patients to be booked/clerically validated/clinically validated. Continued focus of straight to discharge the implementation of straight to discharge pathways where appropriate. 5 out of 6 CIN protocols in place or now standard practice. Local SOS/PIFU pathways implemented. Throughout March/April work is being undertaken with Directorates to confirm consistent use of all pathways and identify any new pathways. Retrospective application of SOS/PIFU pathways to be undertaken in 2026/27 linked to validation strategy and clerical/clinical validation plan. Clinical validation of delayed follow up list for ENT commenced Jan 26, with patients being discharged or moved to SOS/PIFU where appropriate. |
| | On 90% of days planned care inpatient/daycase/theatre recovery capacity should be protected from pressures and outliers (end of Q1). | F | Baseline 97.6% | In lieu of a national definition, ABUHB have used a the locally defined measure: "% emergency surgery on elective lists" to track performance through the course of 25/26.<br><br>Year to date performance has averaged 96.7% elective protection, with current March performance at 95.4%. |
| | Reducing late starts to less than 20%; - Reducing early finishes to less than 10%; and - Increasing session utilisation to the GiRFT standard of 85% by March 2026. | F | Baselines are late starts 44%, early finishes 47%, theatre utilisation 83%. Plans to improve late starts & early finishes to 25%. | The performance for late start lists under the 15 minute measure has been relatively static, averaging 37.1% through the course of 25/26 and within a relatively tight range. March performance is currently 38%. Autosend and Golden Patient initiatives have now been rolled out at all sites.<br><br>A Theatres workshop ran on 26th March to review the theatre priorities for 2026/27 , the focus was on late starts, which will be a key priority for the programme of work going forward.<br><br>In lieu of national clarity at the start of the year, the 30-minute measure was used for early finishes in the IMTP. Performance deteriorated through the first 3 quarters, reaching a high of 51.1% in December. March to date is improved at 40.7%. With the 26/27 defined as a 60 minute measure, March performance under this definition currently stands at 20.8%. |

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Operational Productivity Planned Care | Deliver improvements in day surgery rates, achieving a BADS daycase rate of 70% (April 2025), then 80% (June 2025) | P | Baseline 50%. Plans to improve to 55%. Following a review of procedures to identify opportunities to increase day case rate, implementation will commence and further opportunities to be scoped ahead planning for NHH Day Case Centre of Excellence. | The latest available position is Dec-25 under BADS definition, with performance at 76.1%. Performance through first 3 quarters of the year is averaging 78.7%.<br><br>Monthly day surgery maximisation meetings which support planning of HVLC lists have continued. |
| | Consistent clerical and clinical validation should be in place on an ongoing basis and reported quarterly for impact. | F | In place reported through outpatient transformation. | Ongoing clerical validation centrally and locally for RTT patients and cohorts of long waiting validation patients. A validation plan is in progress for the end of March for RTT patients (core and additional hours). The plan consists of text message validation of patients in OPD stage 26 weeks by end of March, text message validation of patients in treatment stage up to 78 weeks by end of March, clerical pathway validation of patients in diagnostic and follow up stages 26 weeks by end of March. In addition there is development of Validation Strategy in progress, with a task and finish group established. |

# Appendix 1: Enabling Actions

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Workforce Productivity | Variable Pay & Agency Control Framework Welsh Health Circular | F | 2024/25 total agency spend has reduced to £43.2m compared to £805m in substantive workforce which has inc. from last year. | Extensive work has been completed in relation to recruitment campaigns and a focus on retention and sickness. The volume of additional workstreams across RTT 104wks and 26wk outpatient, as well as emergent 45 minute ambulance handover/whole system flow programme has meant resources have been prioritised against these urgent areas. |
| | Sustained reduction in agency expenditure, with a target 30% reduction in 2025/26 from 2024/25 outturn, and ensuring no off-contract expenditure. | P | 2024/25 agency reduction savings £11m. Total agency saving to achieve 30% reduction would need to be £7m. | The latest trend of financial spend demonstrates this reduction is unachievable this year due to previously identified pressures such as Planned Care, 45 minute handover, and winter. Reduction from 24/25 to 25/26 is 4.089 million (14%) |
| | Ensure a reduction in agency spend on HCSW, A&C, and E&A to zero by 30th Sept 2025 | P | 2024/25 spend is £1.05m; Plans to achieve total off-contract and HCSW agency removal by September 25. A&C and E&A, reduction in spend will be achieved but zero spend difficult within current recruitment market. | Extensive work in relation to recruitment campaigns and a focus on retention and sickness. Despite this, the volume of additional workstreams across RTT 104wks and 26wk outpatient, as well as emergent 45 minute ambulance handover/whole system flow programme has meant resources have been prioritised against these urgent areas. |
| | Ensure effective implementation of job planning policy, to include ensuring that > 90% of all Consultants have an agreed job plan in place at all times by 30 September 2025. | P | Baseline 38%. Monthly trajectory plan by division to achieve 90% compliance by September 25 and a positive number in progress. However progress will be in balance with benefits of new job planning system. | Consultant Job Planning performance has remained broadly stable, with compliance recorded at 54% in February 2026, representing a 0.6% decrease from January 2026. This reduction is primarily due to a number of job plans falling out of compliance as part of the rolling-year cycle. The Health Board remains committed to achieving 80% compliance within the 2026/27 IMTP, supported through a targeted, incremental improvement approach across services.<br><br>Progress continues to be constrained by several key issues, including formal disputes, ongoing discussions regarding paid breaks, and the allocation of SPA and DCC time for specific activities such as coroners' reports. Of the 563 job plans required to be completed digitally, 379 have been finalised although may not be signed off, with dedicated support in place to progress the remaining 74 plans to digital completion and sign off. |
| | Ensure a reduction in sickness absence in 2025/26 in comparison to 2024/25 | F | Baseline cumulative 12 month absence 6.53% in Jan 25 plans to reduce 25/26 in comparison to 24/25. | The National joint partnership group have undertaken benchmarking across Wales to inform options and approach. The existing National Sickness Absence Policy continues to be under review. |

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Maximising Value for Money | Non-Pay - ensure implementation of Value & Sustainability Board recommendations, which includes local implementation of clinically endorsed and mandated product choice to maximise market share and deliver best value. | F | In place reported through Value & Sustainability | Previous opportunities identified are either achieved or in progress, with close links to both local and national initiatives. All known opportunities have been considered for the 26-27 plan. |
| | Medicines Management - ensure full implementation of the high value medicines Value & Sustainability Board programme, which includes delivering opportunities against each of the four programme areas (maximise use of biosimilars, switch to generics, preferential use of medicines in primary care, restrict low value prescriptions) | F | In place reported through Value & Sustainability | 1. ABUHB continues to have the highest uptake of established biosimilars in Wales. For the newer biosimilars, a switch to aflibercept has been completed with golimumab and omalizumab in progress. Once the tender is announced for denosumab, this will commence.<br>2. A review of generic contract medicines has been undertaken. Discussions are taking place with Haematology regarding switch of eltrombopag from WP10HP to homecare to maximise the contract price.<br>3. ABUHB continues to see a growth of generic apixaban and rivaroxaban as a % of DOACs (92% primary care, 96% WP10HP).<br>4. ABUHB has the second lowest prescribing of bath and shower emollients in Wales (primary care ) WP10HP use is 4th lowest.<br>5. ABUHB has the highest performance of blood glucose strips <£10 (primary care 91.2%)<br>6. ABUHB has the second highest use in Wales of generic dapagliflozin of all SGLT2is (primary care 80.2% WP10 91.4%)<br>Blueteq business case and has been reviewed by Executive team with case going to PIP on 25/2/26 |

# Appendix 1: Enabling Actions

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Maximising Value for Money | CHC - ensure implementation of Value & Sustainability Board recommendations which include continued actions to improve clinical and financial effectiveness associated with packages of care. This includes implemented a standard digital solution to support effective intelligence capture on a national basis. | F | In place reported through Value & Sustainability | The Health Board continues with eligibility reviews. Issues remain with eligibility and enhanced care with Local Authorities and a series of partnership meetings and workshops are in place to address these collaboratively.<br>We have committed to the delivery of the All Wales digital solution within our IMTP for next year however the current overall position with Welsh Government across Wales is unsure. |
| | Estate - ensure ongoing actions to strengthen estate utilisation including the appropriate repurposing and disposal of under-utilised estate. | F | In place reported through Value & Sustainability | Ongoing work continues regarding the STW rationalisation to realise disposal opportunities. Anticipated SOC development end of Q2 26/27.<br><br>SOC submitted to Welsh Government for Nevill Hall Hospital which looks to reduce footprint of site and potentially rationalise the wider Health Board estate. Optimising utilisation across the Health Board through the development of Health and Well-Being Centre at Monmouth using an existing facility.<br><br>OBC anticipated 26/27.Significant progress made against the Extant Estates Strategy with work underway to progress the new 2028-2038 Strategy. |

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| **Improving Value, Optimising Outcomes, & Minimising Variation** | Ensuring full implementation of the nationally optimised pathways in the cancer recovery programme | **P** | Steps within pathways in place but timeframes now always with exception of Head and Neck where we have not fully implemented. | National Optimal Pathways continue to be followed, however timescale compliance remains at risk. January confirmed compliance = 56.1%. The trajectory set for February was 71.2% (372 treatments; no more than 107 breaches); whilst the Health Board delivered the correct number of treatments the capped number of breaches were exceeded (164). Early indications suggest February compliance will be similarly low. With the exception of Haematology, none of the tumour sites met their trajectory for January 2026. Referral demand has remained constant.<br>Of note:<br>• Colorectal compliance was less than 30%, however treatment numbers (52) were significantly higher than the rest of the year. There are plans for Colorectal to undertake additional work in theatres to address this. RGH has been identified as a focus area, with half the capacity of NHH and YYF Reviews are underway to of the additional capacity on other sites, First Task and Finish meeting held in February with good clinical engagement and clear actions for progression.<br>• Gynae continue to perform below trajectory and treatment numbers remain low, however traction is being made via the Cancer Recovery Group and there is an expectation we will begin to see some of this positive movement in February. Issues with Gynae Pathology (18 outstanding cases as at 03.03.26) have been highlighted as contributing to delays. Staff sickness has contributed to this. More robust communication to be implemented to ensure staffing shortages don't affect pathway timescales. Fortnightly Cancer Recovery Group meetings have been key to improving compliance due to the continued and consistent focus.<br>• Urology January compliance was the lowest it's been since March 2025 (37%). The service has consistently delivered considerably more than the trajectory, including January, however breaches remain high. The service has confirmed it will be undertaking a super list to improve compliance. Task and Finish group will be undertaking a reset (including re-developing the action plan) during Q4 as progress has stalled, Cancer SRO will also be attending.<br>• Skin remains below trajectory; however Cancer Services DM is reassured by the service that this will start to pick up again.<br>• The PTL is being maintained at a reasonable number, and housekeeping issues are now being resolved, by the end of April this is expected to be fully rectified due to new staff commencing in post. Backlog is reducing back down towards 10% with the expectation that this will improve further. Larger numbers on the backlog are in Urology and Colorectal. |

# Appendix 1: Enabling Actions

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Improving Value, Optimising Outcomes, & Minimising Variation | Ensuring full compliance with straight to test guidance | P | Head and Neck and Sarcoma only pathways outstanding, work ongoing to establish measures. | The capacity gaps reported in remain with plan in place to progress Sarcoma work from Q1. This will lead to an anticipated improvement in compliance following completion of key actions that include mapping the pathway and ensuring appropriate governance and ownership of the pathway. |
| | Ensure progress with the implementation of Value & Sustainability Board High Value High Impact pathway - Diabetes | F | Plans in place to fully adopt with benefits tracking through Value & Sustainability | Urine ACR project is now entering a closure state, this will include a detailed project closure report available at the end of Q4, containing an evaluation of the impacts of our work. Slight delays are being experienced due to a lack of data from GP practices, however, initial findings show a possible improvement of 4% across ABUHB. WS2 has also published its findings to the GMS collab groups indicating high and low value activities across the screening pathway for GP practices to consider and adopt or stop.<br><br>Whilst the footcare project has also progressed we have experienced a number of delays due to production and publication of the materials and delays with communications teams and printers. As a result we have extended the project into Q2/3 of next year to allow for a robust implementation and evaluation of impact to tack place. We also continue to explore new opportunities in Gestational Diabetes and Transition to Adult Services with scoping planned to be completed by the end of Q4. |

# Appendix 1: Enabling Actions

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Improving Value, Optimising Outcomes, & Minimising Variation | Ensure progress with the implementation of Value & Sustainability Board High Value High Impact pathway - Bone Health | F | Plans in place to fully adopt with benefits tracking through Value & Sustainability | ABUHB identified 2,890 fragility fracture patients in 2026, an increase from 2,614 in 2025, representing a 10.5% rise. In 2026, 77% of fragility fracture patients were identified and 70% received appropriate bone protection treatment, compared with 61% treated in 2025. The AB-FLS team was awarded the NHS Wales Leadership Award 2025 – "Let the First Fragility Fracture be the Last." AB-FLS has worked closely with national teams, contributing to the adoption of the Missed Opportunity measure within the FLS-DB. This aligns with the Royal Osteoporosis Society (ROS) National Osteoporosis Standards, based on the 80/50/80 rule: 80% of fragility fracture patients should be identified; 50% should receive bone protection treatment and 80% should be reviewed at 52 weeks. Based on expected activity of 3,755 fragility fracture patients, AB-FLS will be required to complete care plans and deliver guideline based treatment to approximately 1,200 patients to meet the standard. Historical missed opportunities for AB-FLS were: 1,003 in 2021; 1,013 in 2022; 936 in 2023 and 239 in 2024. By the time all 52 week follow ups for the 2025 cohort are completed in January 2027, AB-FLS aims to achieve zero missed opportunities. |
| | Ensure progress with the implementation of Value & Sustainability Board High Value High Impact pathway - Arthroplasty (Hip & Knee) | F | Plans in place to fully adopt with benefits tracking through Value & Sustainability | No active Programme. |
| | Ensure implementation of national digital priorities, specifically the implementation of the digital maternity system, and NHS Wales app. | F | Implementation of Maternity solution (Badgernet) completed and benefits presented to Ministerial Digital Summit. Procurement for Mental Health solution underway and continue to engage with Connected Care programme. E-Prescribing rollout continuing for the Health Board. | NHS Wales App - Expansion plan submitted.<br>Engagement continues with DHCW DSPP programme on future functionality.<br>Digital Maternity - this platfom is live in ABUHB. |

# Appendix 1: Enabling Actions

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| Improving Value, Optimising Outcomes, & Minimising Variation | Support the implementation and roll-out of the NHS Wales app for maximum impact and benefit to include the uptake of its use for repeat prescriptions. | F | Plans in place to fully adopt with benefits tracking through collaboration with DHCW and membership at the relevant governance groups. | To support increased usage of the NHS Wales app, an expansion plan including the onboarding of further appointments for clinical services has been shared with DHCW. The HB continues to work with the National Digital Services for Patients and the Public (DSPP) Team on the development of a roadmap for future features and implementation. |
| | Eradicate unsupported systems and devices, and ensure a clear cyber response plan for the organisation. | F | Cyber security improvement plan in place linked to recommendations from the Cyber Resilience Unit to achieve compliance against the Cyber Assurance Framework. | Project to remove Windows server 2016 and MS Sequel 2012, 2014 and 2016 are progressing. Extended support deadlines for the 8 remaining 2012 servers is being monitored. Projects completing within the next few months eliminate 2012 OS from the estate. Palo Alto implementation progressing. Cyber exercising planned quarterly for 2026. CRU NIS CAF Audit Assessment planned for June 2026. |
| | Progress implementation of the national approach to Interventions not normally undertaken (INNU) - Deliver the 8 priority procedures determined for implementation as part of Phase 1. | F | Work with AWCEG to implement the clinical criteria and monitor the activity data for each intervention. | Further discussion ongoing with DMCO to ensure engagement with Planning & Improvement Clinical Leads and allocation of work to small groups. Work also being undertaken to examine whether further coding input is required. |
| | Progress implementation of the national approach to Interventions not normally undertaken (INNU) - continue to implement ongoing recommendations throughout 2025/26 | F | Implement the criteria once reviewed from the AWCEG and monitor the activity data, reporting as requested. | Further discussion ongoing with DMCO to ensure engagement with Planning & Improvement Clinical Leads and allocation of work to small groups. Work also being undertaken to examine whether further coding input is required. |

# Appendix 1: Enabling Actions

| Delivery Area | Enabling Action | Adoption | Baseline | Progress this period |
|---|---|---|---|---|
| **Improving Value, Optimising Outcomes, & Minimising Variation** | Ensure delivery of effective referral management processes. This includes consistent implementation of Health Pathways (Pathway Alliance Programme) across all Health Boards with the rapid adoption of the 282 pathways within the programme. | **P** | Plan to increase will not meet 282 localised pathways. This would take financial investment without clear benefits realisation. | 180 pathways currently live. Decision to reduce funding into 2026/27 - CE capacity will reduce from 1.2WTE total to 0.5WTE total. Team continuing to focus on integrating the platform into the organisation through Clinical Interface groups, Interface GPs, and comms and engagement .Team meeting with Divisions to agree on pathway priorities for 2026/27. |

| | |
|---|---|
| | **CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN**<br>**ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING** |

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Finance Performance Report – March 2026 (2025/26 Month 12) |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Rob Holcombe - Director of Finance, Procurement & VBHC |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Suzanne Jones – Assistant Director of Finance |

## Pwrpas yr Adroddiad
## Purpose of the Report

Er Sicrwydd/For Assurance

This report sets out the following:

- The financial performance at the end of March 2026 and the forecast position against the statutory revenue and capital resource limits,
- The savings position for 2025/26,
- The revenue reserve position on the 31st March 2026,
- The Health Board's underlying financial position,
- The cash position, including the strategic cash support required,
- Public sector payment policy performance, and
- The Capital position.

A system link is included for the month 12 monitoring returns reported to Welsh Government.

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

This report sets out the financial performance of Aneurin Bevan University Health Board, as at the 31st March 2026 (Month 12) for the financial year 2025/26.

The 2025/26 financial performance is measured by comparing actual expenditure with the budgets as delegated and approved by the Board and CEO. The Health Board has statutory financial duties and other financial targets which must be met. The table below summarises these and the Health Board's performance against them.

**Mar-26**
**Performance against key financial targets 2025/26**
+Adverse / () Favourable

| Target | Unit | Current Month | Year to Date | Year-end Forecast | Movement |
|---|---|---|---|---|---|
| **Revenue financial target** To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.* | £'000 | 1,308 | 18,282 | **18,282** | ↓ |
| **Capital financial target** To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.* | £'000 | £13,213 | £45,619 | **(47)** | ↔ |
| | £45,666 | 29% | 100% | | |
| **Public Sector Payment Policy** To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number) | % | 97.4% | 97.1% | **>95%** | ↑ |

| Performance against requirements | | 23/24 £'000 | 24/25 £000 | 25/26 £000 | 3 Year Aggregate (23/24 to 25/26) £000 |
|---|---|---|---|---|---|
| Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue | x | 49,754 | 7,185 | 18,282 | 75,221 |
| Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital | ✓ | (41) | (66) | (47) | (154) |
| Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers | x | | | | |

| Underlying Financial Position (Brought Forward ULP) | 22/23 | 23/24 | 24/25 | 25/26 Outturn |
|---|---|---|---|---|
| This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years. | £89.6m Deficit | £81.4m Deficit | £27.2m Deficit | £38.2m Deficit |

The full-year budget performance at month 12 is a deficit of £18.3m, which is in line with the forecast, but greater than the submitted plan. The deficit position is due to new in year pressures that include prescribing costs/acute drugs, CHC activity, winter pressures and ED pressures driving variable pay, and service pressures relating to Mental Health and cancer as well as unfunded national insurance costs.

This position includes the delivery of savings plans greater than the IMTP plan (total achieved £43.4m, compared with £40.4m plan).

Public Sector Payment target for Non-NHS invoices was overachieved at 97% compared with the 95% target.

Cash holding was £5.5m, within the £6m best practice limit.

The Board continues to progress further opportunities to minimise operational and savings delivery risks and to reach and maintain a sustainable financial position.

The Health Board submitted the draft 2025/26 Annual Accounts to Welsh Government on the 1st May 2026 and these are currently being reviewed by Audit Wales.

## Cefndir / Background

The Board approved 2025/26 IMTP financial plan was ambitious with a high delivery risk to achieve financial balance with planned financial savings of £40.4m.

Through financial recovery actions the achievement of savings and mitigating actions has totalled £43.4m. However, the in-year cost pressures that the Health Board was unable to mitigate are listed in the table below:

| **ABUHB Full Year Review 2025/26**<br>**Forecast Deficit Analysis - outside of IMTP plan** | | |
|---|---|---|
| **Category** | **Issue** | **Value £m** |
| National Issues (£2.9m) | National insurance > funding | 2.20 |
| | Theatres B2 to B3 grievance | 0.30 |
| | MS365 | 0.40 |
| Funding Ceased (£0.3m) | Fracture liaison service | 0.30 |
| Ministerial Priorities - Urgent & Emergency Care (£4.5m) | Winter Beds 24/25 | 0.80 |
| | Surge beds | 2.00 |
| | Emergency Department | 0.20 |
| | ITU capacity | 1.50 |
| Ministerial Priorities - Cancer (£2.5m) | Cancer | 2.00 |
| | Diagnostics growth | 0.50 |
| Growth above plan (£5.3m) | Drugs | 2.00 |
| | CHC | 2.50 |
| | Diabetes Pumps | 0.80 |
| Unavoidable Investments / Risk mitigations (£4.6m) | Mental health | 3.90 |
| | Thyroid loss of service | 0.50 |
| **Mid Year Review Forecast Deficit** | | **19.90** |
| Month 8 - 10 Movements | Winter 25/26 | 1.98 |
| | 45 Minute Handover | 1.38 |
| | NWSSP Rebate | (0.50) |
| | Bank Pay Award 2024/25 | (1.80) |
| | Additional Savings - from opps & new | (3.09) |
| | National Outpatient Insourcing (164 cohort). PP > £10.00 each | 1.05 |
| | Revised forecast sessional GP Ooh's (£0.6m),GMS (Global sum -£1.3m) | (0.60) |
| **25/26 Forecast as at Month 10** | | **18.32** |
| | National Outpatient Insourcing (164 cohort). PP > £10.00 each Funding | (0.96) |
| | Global sum correction to payments (per WG advised 10.03.26) | 0.95 |
| **25/26 Forecast as at Month 11 Final** | | **18.314** |
| Month 12 Movements | | (0.03) |
| **25/26 Final Position** | | **18.282** |

As discussed at the Board meeting held on 10th September 2025, all options that were available to the Health Board to minimise the impact of the emerging pressures were discussed and agreed, with risks. The Health Board had limited ability to identify further mitigating actions without identification of further funding or cessation or reduction of services.

## Asesiad / Assessment

### Revenue Performance

A summary of the 2025/26 full-year financial performance is provided in the table below. The cost drivers causing the overspend position of £18.282m are related to those in the table within the section above. The full-year position by delegated area is:

| | Annual budget £000s | YTD Reported Variance £000s | Full-year Forecast at M12 £000s | Full-year Forecast at M11 £000s | Movement £000s |
|---|---|---|---|---|---|
| **Operational Divisions:-** | | | | | |
| Primary Care and Community | 331,973 | **1,273** | 1,273 | 1,824 | (550) |
| Prescribing | 125,639 | **1,499** | 1,499 | 1,235 | 264 |
| Community CHC & FNC | 76,136 | **2,298** | 2,298 | 2,276 | 22 |
| Mental Health & Learning Disabilities | 153,788 | **5,427** | 5,427 | 5,314 | 113 |
| **Total Primary Care, Community and Mental Health** | **687,537** | **10,498** | **10,498** | **10,648** | **(150)** |
| Surgery | 162,879 | **8,879** | 8,879 | 10,292 | (1,413) |
| Clinical Support Services | 141,561 | **1,138** | 1,138 | 2,645 | (1,508) |
| Medicine | 181,020 | **6,736** | 6,736 | 6,257 | 479 |
| Urgent Care | 43,825 | **1,291** | 1,291 | 1,162 | 129 |
| Family & Therapies | 152,918 | **3,116** | 3,116 | 3,016 | 99 |
| Estates and Facilities | 99,063 | **(2,817)** | (2,817) | (1,952) | (865) |
| Chief Operating Officer | 16,519 | **(685)** | (685) | (200) | (485) |
| **Total Chief Operating Officer** | **797,785** | **17,657** | **17,657** | **21,220** | **(3,563)** |
| **Total Corporate Divisions** | **161,996** | **(2,255)** | **(2,255)** | **(3,642)** | **1,387** |
| **Total Specialist Services** | **208,907** | **299** | **299** | **581** | **(282)** |
| **Total External Contracts** | **132,191** | **(4,543)** | **(4,543)** | **(4,153)** | **(389)** |
| **Total Capital Charges** | **45,986** | **49** | **49** | **0** | **49** |
| **Total Delegated Position** | **2,034,402** | **21,706** | **21,706** | **24,654** | **(2,948)** |
| **Total Reserves** | **3,424** | **(3,424)** | **(3,424)** | **(6,340)** | **2,917** |
| **Total Income** | **(2,037,825)** | **(0)** | **(0)** | **0** | **(0)** |
| **Total Reported Position** | **0** | **18,282** | **18,282** | **18,314** | **(31)** |

### Summary of key operational points for Month 12

Key points to note for month 12 include:

The financial position at the 31st March 2026 shows a £18.282m deficit. The key issues in the month are described in this report.

- Total pay expenditure for the Health Board in Month 12 amounted to £81.4m, excluding notional pension costs (9.4%). This represents an increase of £2.3m compared to the prior month (February £79.1m). This movement was due to the Band 2 to Band 3 uplift accrual for the year.

- Non-pay expenditure (excluding capital adjustments) totalled £118.1m, an increase of £22.1m compared to February. This increase was driven by JCC and Vertex pass through costs of £5.3m, Band 2–3 uplift costs (treated as a loss for accounting purposes) of £4.6m, and higher Month 12 CHC expenditure of £3.0m (reflecting the longer month in March, with package costs charged daily alongside additional IRP expenditure), Regional Partnership Board costs of £2.6m, Medical and Surgical Equipment £2.0m, GP IT Refresh expenditure of £2.0m, and increased spend on Planned Care £1.0m and Frailty £1.0m.

- Overall CHC costs presented as a financial pressure due to inflationary price uplifts and volume increases during the year, including an increase in Discharge to Assess placements and an increase in high cost CHC packages of care.

- Prescribing expenditure performed worse than planned, driven by an increase in the average item price between the estimate and final performance in 2024/25. Between April 25 and January 26, the average item price was £7.91, compared with the forecast price of £7.80. The January PAR was 12.6p higher than forecast £7.88 (actual) versus £7.75 (forecast). The YTD growth rate adjusted for prescribing days is -1.03% (an increase compared with 1.42% last month).

- On-going acute secondary care high-cost drugs prices and volume growth continue to be a pressure.

- Demand and flow pressures across the system continue to drive significant costs. In March, the number of in-patients fit for discharge at the Welsh Government data capture point decreased to 178 (from 180 in February). Of these, 31 were Health delays, 43 Social Care delays, and 104 Joint delays. The categories of reasons for delayed days are as follows:

| Reason | Number of Patients | % |
|---|---|---|
| Assessment Issues | 51 | 29% |
| Care Home placement arrangements | 42 | 24% |
| Disagreements/Legislation | 21 | 12% |
| Home care related issues | 20 | 11% |
| Stepdown to recover and assess | 18 | 10% |
| Home adaptation/equipment issues | 14 | 8% |
| Housing related issues | 7 | 4% |
| Funding Issues | 3 | 2% |
| Transfer related issues | 2 | 1% |
| | **178** | **100%** |

- The estimated cost for the year of continued blocked bed days for all reasons is c.£11.6m using a £200 cost per bed day (based on the number of in-patients for March). The demand and flow challenges drive surge bed capacity & increased demand in high-cost unfunded temporary staff.

**Outturn Position**

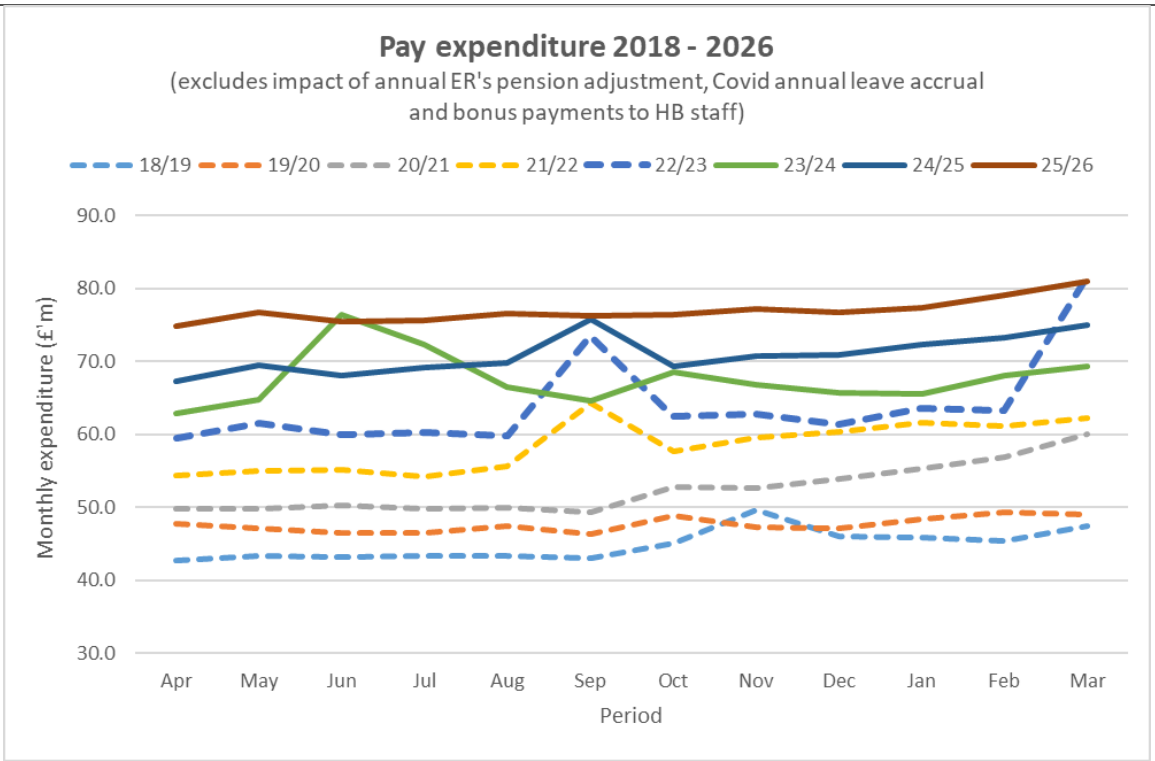
The plan financial forecast submitted following Board approval in March 2025 was a non-recurrent break-even position for 2025/26. The ABUHB IMTP financial plan was based on achieving IMTP savings (£40.4m) and through financial recovery actions the achievement of savings and mitigating actions is £43.5m.

The Board took the decision to change from the planned break-even financial forecast to a forecast £19.9m deficit due to the in-year pressures. The position improved in Month 8 to £18.3m due to Welsh Government confirmed funding to cover the A4C pay award for bank staff (for both the 2024/25 and 2025/26 uplifts) and NWSSP cost slippage. This forecast was maintained for the remainder of the year and is in line with the final outturn position.

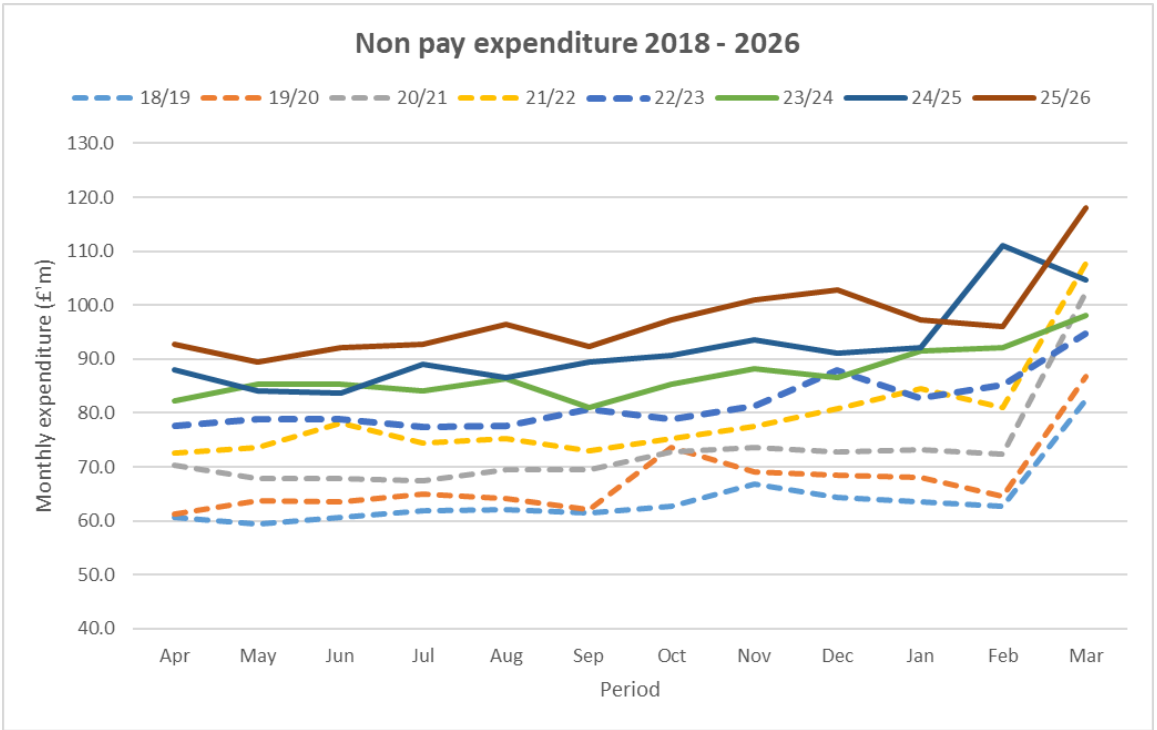
Welsh Government confirmed non recurrent payment for the increased Welsh Risk Pool premium (c£9.7m) which otherwise would have fallen to the Health Board to fund and non-recurrent coverage for the band 2–3 HCSW regrading costs for 2025/26 (£7.1m) which will include an element of backpay. Both areas will be cost pressures for 2026/27 onwards.

**Expenditure run-rates.**

Pay and Non-Pay expenditure run-rates for eight financial years are shown below; assuming the current level of income, the expenditure run-rates need to reduce for the Health Board to reach a sustainable financial position.




Total pay (excluding notional pensions) for 2025/26 was £923.007m, 2024/25 £850.736m and 2023/24 £811.894m.




Total non-pay (excluding capital / depreciation) for 2025/26 was £1,168.2m, 2024/25 £1,103.9m and 2023/24 £1,046.2m.

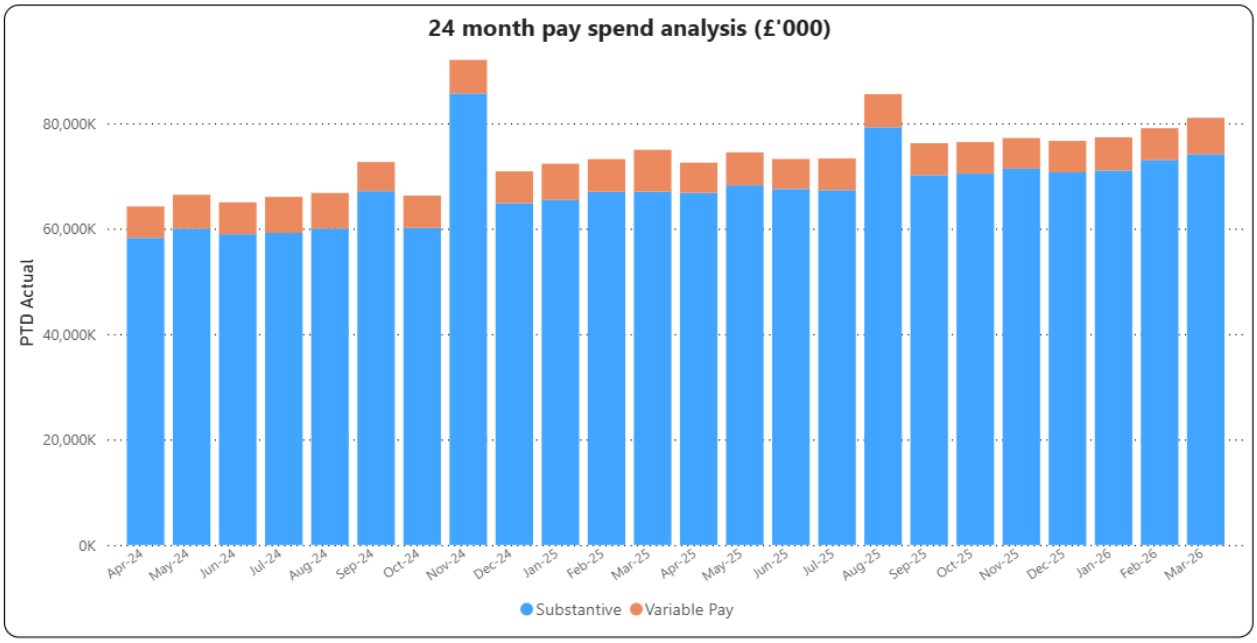
**Workforce**

The Health Board spent £81.0m in March on workforce (excluding notional pension costs of £56m).

| Workforce Costs | Current month £m | *Previous Month £m* | Year to Date 25/26 £m |
|---|---|---|---|
| Total Pay | 81.0 | 79.1 | 923.0 |
| Substantive Pay | 74.2 | 73.1 | 850.3 |
| Variable Pay | 6.9 | 6.0 | 72.7 |

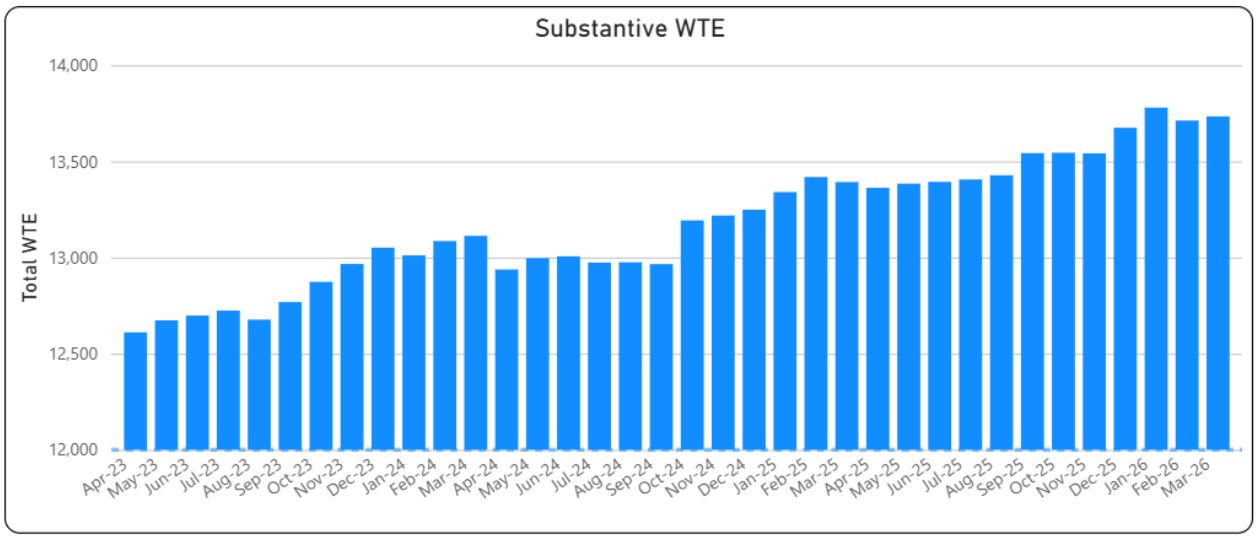
Operational pressures including Enhanced Care, sickness and vacant posts continued to cause a variable pay pressure on the Health Board position. The focus will remain on minimising variable pay with a range of operational actions and savings plans including recruiting to posts. Real terms whole time equivalent / head count total cost reduction will be the key indicator; currently variable pay reductions are not sufficient to create a net saving when substantive staff growth is considered.

Workforce expenditure trends are shown below differentiating between substantive and variable pay:



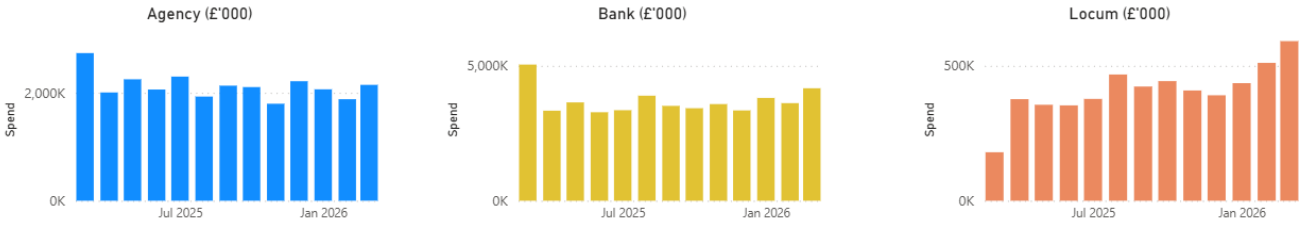

**Substantive staff**

Substantive pay was £74.2m in March, an increase of £1.1m on the previous month, due to the increase in costs for band 2-3 uplift offset by lower than February enhancements. Substantive WTE's were 13,734 compared with 13,713 for February.




## Variable pay

Variable pay (Agency, Bank and Locum) was £6.9m in March compared with £6.0m in February, a £0.9m increase.




| **Variable Pay Costs** | **Current month £m** | ***Previous Month £m*** | **Year to Date 25/26 £m** |
|---|---|---|---|
| Agency - Nursing | 0.8 | 0.7 | 8.2 |
| Agency – Medical & Dental | 0.7 | 0.6 | 10.5 |
| Agency - HCSW | 0.1 | 0.1 | 1.4 |
| Agency – Estates & Other | 0.5 | 0.5 | 4.7 |
| Bank | 4.1 | 3.2 | 47.2 |
| Locums | 0.6 | 0.5 | 5.1 |

**Enhanced Care** the notional calculated cost for March was £0.7m of expenditure using bank and agency registered nurses and health care support workers, for 26,293 hours worked.

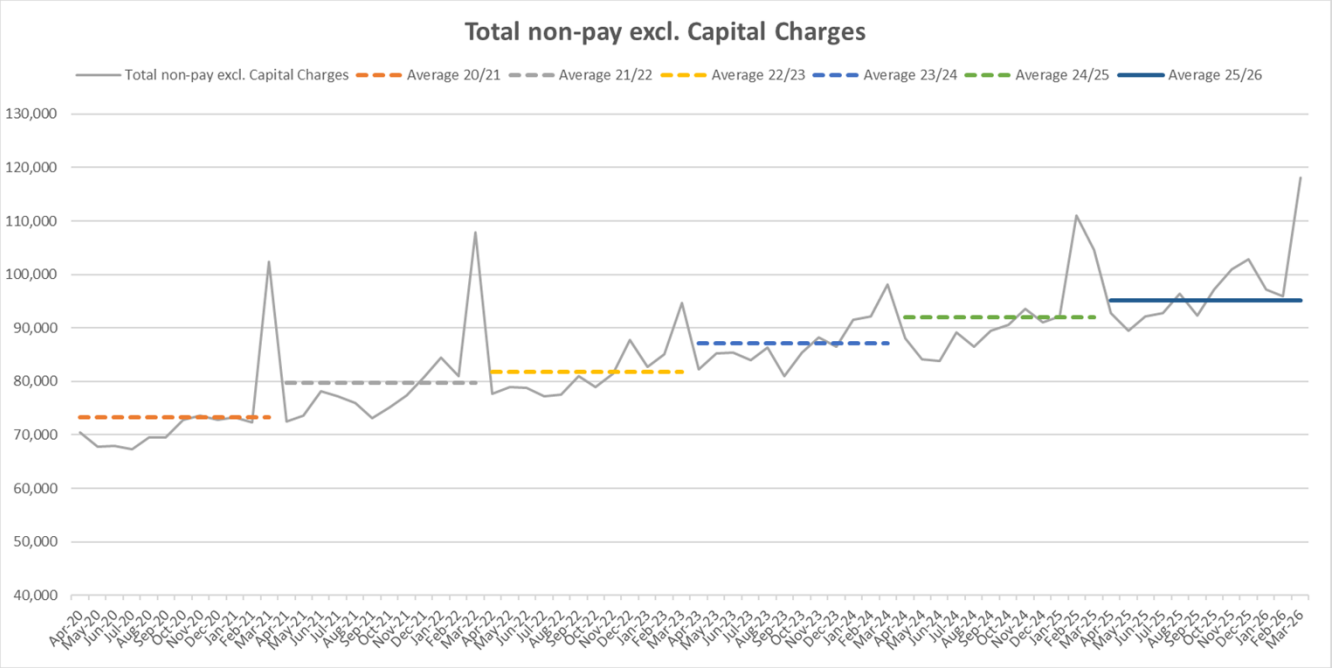
**Nursing vacancy cover** for March relating to vacancies is c.£1.1m for 40,355 hours worked for bank and agency hours for shifts where 'to cover vacancies' is provided as the reason for use.

**Nursing sickness cover** for March variable pay relating to sickness is c.£1.2m for 43,716 hours worked for bank and agency hours for shifts booked to cover sickness as input onto the e-roster system.

**Non-Pay**

Non-pay expenditure (excluding capital adjustments) totalled £118.1m, an increase of £22.1m compared to February. This increase was driven by JCC and Vertex pass through costs of £5.3m, Band 2–3 uplift costs (treated as a loss for accounting purposes) of £4.6m, and higher Month 12 CHC expenditure of £3.0m (reflecting the longer month in March, with package costs charged daily alongside additional IRP expenditure), Regional Partnership Board costs of £2.6m, Medical and Surgical Equipment £2.0m, GP IT Refresh expenditure of £2.0m, and increased spend on Planned Care £1.0m and Frailty £1.0m.

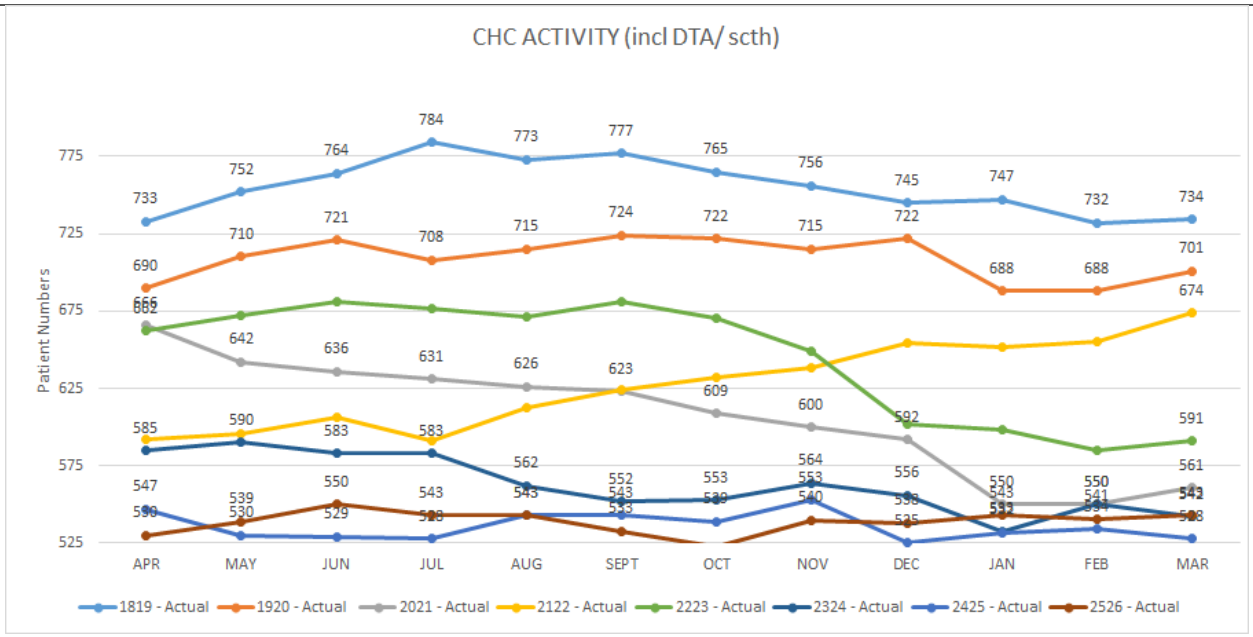
The graph below presents non-pay expenditure since April 2020 (it should be noted that the peaks are year-end adjustments and Month 12 items):




**CHC**

The Health Board spent £12.5m on CHC (all types) in March, a £2.2m increase on the prior month due to a longer (more days) month in March, with package costs charged daily, alongside (funded) additional IRP expenditure.

Adult Complex Care CHC activity over for 5 financial years is summarised in the chart below:




Children's packages are more volatile and may continue to present a risk in 2026/27 above plan assumptions. At month 12 there are 51 out of county packages of care, 5 of which are high value packages (cost more than £0.1m each p.a). Children's Community Nursing has 19 internal open packages of care, 3 of which are classified as high value packages.

Mental Health CHC patient numbers had a net increase of 5 in month 12 taking MH packages of care to 288. The number of Learning Disabilities (LD) packages remained unchanged with a total of 173. This results in 461 patients overall. MH packages are averaging £92k and LD £176k per annum.

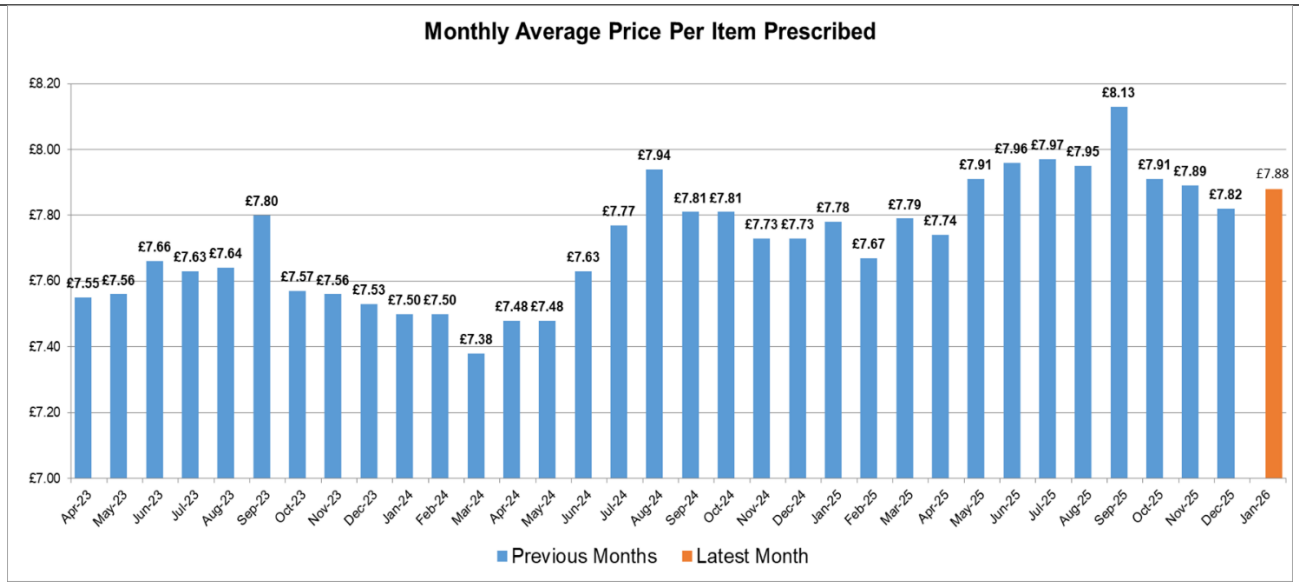
**Prescribing**

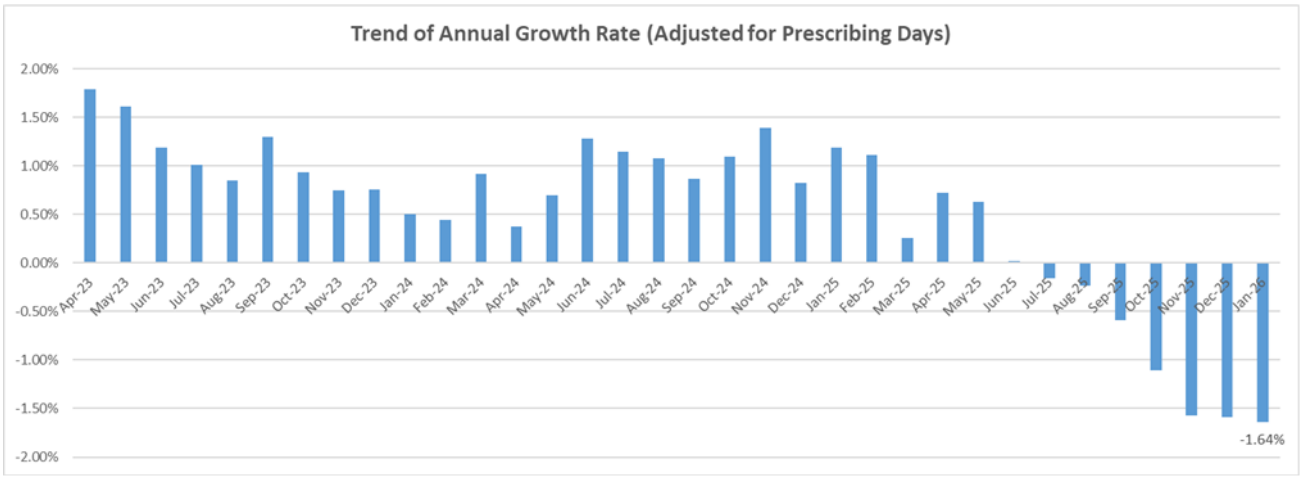
Primary Care prescribing spend for March was £11.3m, an increase of £0.5k compared with the prior month.

The January PAR saw a 12.6p increase in the average item price for the month to £7.88 compared to forecast. This has resulted in an increase of 3.0p in the full year forecast average item price (including estimates for February and March) to £7.91.

The YTD growth rate (based on January PAR) adjusted for prescribing days is -1.03% (an increase of -1.42% last month) compared to the same period last year. For month 12, which includes forecast assumptions for February and March PAR, the full year forecast growth has reduced to -0.85% from -0.70% at month 11, based on the latest information available.

The graphs below show the monthly average price per item and item growth: -




**For example the growth rate quoted in Jan-26 will be the growth in items for the 12-month period Feb-25 to Jan-26 compared with Feb-24 to Jan-25**

## Waiting Times Additional activity (104-week)

During 2025/26, the Health Board secured significant targeted investment to accelerate the reduction of 104-week waiting times across key specialties.

Initial funding of £1.5m in Quarter 1 supported the mobilisation of early initiatives, followed by £1.46m in Quarter 3, specifically targeted at improving the Orthopaedic 104-week position. In Quarter 4, a further £5.63m was deployed to support the elimination of remaining 104-week waits across ENT, Ophthalmology, General Surgery, Maxillofacial and Orthopaedic services. This included funding to accommodate the additional Orthopaedic activity delivered over and above the initial allocations in the earlier part of the year.

All Q4 schemes were mobilised from January, with delivery focused on high-impact insourcing, outsourcing and waiting list initiative (WLI) activity. Progress was temporarily impacted in February due to a national shortage of bone cement, which constrained arthroplasty throughput. Although this issue was subsequently resolved,

the disruption limited the ability to fully recover lost activity within the remaining time limit.

Overall, this phased, and specialty-led investment approach enabled a targeted and flexible delivery model, maximising available capacity and responding to operational challenges as they arose.

From a performance perspective, this investment has supported the achievement of a zero 104-week waiting position across all specialties, except for Orthopaedics. The year-end position for Orthopaedics was 23 patients, reflecting the impact of the bone cement shortage and the inability to fully mitigate this within the year.

104 Weeks Waiting Time Activity

| | | Q1 | | | |
|---|---|---|---|---|---|
| Specialty | Delivery Method | Funding £k | Actual Vol | Spend £ | Variance £ |
| ENT | Insourced | 300 | 464 | 224 | -76 |
| Non Cat Eyes | Outsourced | 152 | 63 | 72 | -80 |
| | Insourced | 28 | 50 | 12 | -16 |
| Orthopaedics | WLI / Backfill | 1,020 | 425 | 2,338 | 1,318 |
| Gen Surgery / Max Fax | WLI / Backfill | | | | 0 |
| **Total** | | **1,500** | **1,002** | **2,646** | **1,146** |

| | | Q2 | | | |
|---|---|---|---|---|---|
| Specialty | Delivery Method | Funding £k | Actual Vol | Spend £ | Variance £ |
| ENT | Insourced | 0 | 0 | 0 | 0 |
| Non Cat Eyes | Outsourced | 0 | 0 | 0 | 0 |
| | Insourced | 0 | 0 | 0 | 0 |
| Orthopaedics | WLI / Backfill | 0 | 210 | 1,329 | 1,329 |
| Gen Surgery / Max Fax | WLI / Backfill | | | | 0 |
| **Total** | | **0** | **210** | **1,329** | **1,329** |

| | | Q3 | | | |
|---|---|---|---|---|---|
| Specialty | Delivery Method | Funding £k | Actual Vol | Spend £ | Variance £ |
| ENT | Insourced | 0 | 0 | 0 | 0 |
| Non Cat Eyes | Outsourced | 0 | 0 | | 0 |
| | Insourced | 0 | 0 | | 0 |
| Orthopaedics | WLI / Backfill | 1,460 | 262 | 1,514 | 54 |
| Gen Surgery / Max Fax | WLI / Backfill | | | | 0 |
| **Total** | | **1,460** | **262** | **1,514** | **54** |

| | | Q4 | | | |
|---|---|---|---|---|---|
| Specialty | Delivery Method | Funding £k | Actual Vol | Spend £ | Variance £ |
| ENT | Insourced | 554 | 165 | 457 | -97 |
| Non Cat Eyes | Outsourced | 0 | 0 | 0 | 0 |
| | Insourced | 169 | 75 | 175 | 6 |
| Orthopaedics | WLI / Backfill | 3,687 | 325 | 2,174 | -1,513 |
| Gen Surgery / Max Fax | WLI / Backfill | 1,220 | 292 | 838 | -382 |
| **Total** | | **5,630** | **857** | **3,644** | **-1,986** |

| | | M12 YTD | | | |
|---|---|---|---|---|---|
| Specialty | Delivery Method | Funding £k | Actual Vol | Spend £ | Variance £ |
| ENT | Insourced | 854 | 629 | 681 | -173 |
| Non Cat Eyes | Outsourced | 152 | 63 | 72 | -80 |
| | Insourced | 197 | 125 | 187 | -10 |
| Orthopaedics | WLI / Backfill | 6,167 | 1,222 | 7,355 | 1,188 |
| Gen Surgery / Max Fax | WLI / Backfill | 1,220 | 292 | 838 | -382 |
| **Total** | | **8,590** | **2,331** | **9,133** | **543** |

Actual Planned care funding totalled £36.8m, of which £8.59m was for 104 week targets and £15.5m for the regional cataracts service which ABUHB lead. The balance of funding was used to improve waiting times across diagnostics, outpatients and other targeted initiatives, all additional costs were covered by WG funding.

**Long Term Agreements (LTA's)**

The Health Board has agreed and signed LTAs for all Welsh providers and commissioners for 2025/26.

The Health Board has agreed LTAs with all English providers reflecting the CUF Uplift/National tariff changes. During a review of these agreements, it has been identified that several of the individual tariff lines have been inflated by up to 14.7% which is significantly more than the current WG funding. The Health Board absorbed £0.7m of costs associated with this.

At Month 12 reporting, activity information to support LTA forecasts is based on Month 11 data but year-end settlements have been agreed with all providers and commissioners.

The final JCC overspend was £0.299m, containing spending within the agreed plan for 2025/26.

The Health Board expects to have signed agreements with all Providers in line with the deadline for 2026/27.

**Revenue Reserves**

Health Board reserves are held by the Board until such time as they agree their use or delegate this responsibility to the Chief Executive as Accountable Officer.

Reserves held on 31st March for 2025/26 total £3.4m and were retained in support of the financial position. All other reserves have been delegated to Divisions in line with the delegation authorisation process.

A summary of all Health Board reserves on 31st March can be found in the appendices.

**Underlying Financial Position (ULP)**

The Underlying (U/L) position brought forward into 2025/26 was a deficit of £27.2m with a forecast carry forward deficit into 2026/27 of £14m. This is per the plan submitted on the 31st March 2025.

| 2025/26 Opening underlying position | 24/25 Plan £m | 25/26 movement £m | 25/26 opening plan £m |
|---|---|---|---|
| Workforce & Variable Pay | 2 | 3.9 | **5.9** |
| CHC | 2.6 | 1 | **3.6** |
| Medicines management | 4.8 | 5 | **9.8** |
| JCC specialised services | 5 | 2.8 | **7.8** |
| **Total** | **14.4** | **12.7** | **27.2** |

The elements and cost drivers making up the underlying deficit are under regular review to ensure actions to address the growth/pressure are being progressed and may be updated in conjunction with the review of the forecast.

**The underlying position was reviewed and tested in depth for the IMTP, this resulted in a worsening position before savings at c£38.2m.** This is increased due to recurrent and full year effect of cost pressures and impacts of savings. This position was discussed with the Board and has been formally signed off as part of the IMTP.

Underlying Deficit by theme is shown in the table below:

| Underlying deficit c/f 2024/25 | Planned ULD closing 25/26 | 25/26 recurrent cost pressures into 2026/27 new in year | Opening Revised ULD 2026/27 |
|---|---|---|---|
| | £m | £m | £m |
| Workforce pressures | 2.0 | 13.4 | 15.4 |
| CHC | 2.6 | 2.5 | 5.1 |
| Medicines management (prescribing and acute drug costs) | 4.8 | 2.8 | 7.6 |
| WHSSC / EASC (service growth in excess of funded levels) | 5.0 | | 5.0 |
| Digital | | 5.1 | 5.1 |
| **Total** | **14.5** | **23.8** | **38.2** |

**Savings delivery**

The 2025/26 plan submitted by the Health Board to Welsh Government (March 2025), identified £40.4m as the required level of savings to support a breakeven forecast position for 2025/26. The savings schemes were shown as three categories:

- Identified savings schemes - £15.7m
- Identified Health Board level savings opportunities with work to be undertaken to attribute to specific schemes - £10.3m
- Pipeline opportunities not yet identified - £14.4m

Following financial recovery actions all savings and mitigating actions have been identified, albeit risk remains in their achievement.

**Total savings achievement for 2025/26 is £43.4m compared to planned savings for the year of £40.4m.**

The Health Board will continue to identify new schemes and to review performance on existing schemes to ensure full delivery of the 2026/27 savings shown in the IMTP, and to maximise the total achievement for the year. The Health Board Value & Sustainability Board will meet monthly to identify and monitor opportunities for new savings plans.

The table below presents the updated savings plan at a Divisional level (nb. The 'various' line were savings yet to be confirmed in the IMTP):

Savings YTD and forecast position (£'000)

| Division | % of total Plan | Annual Plan | YTD Plan | YTD Achieved | YTD Variance | Forecast | Forecast variance to Plan | % Achieved |
|---|---|---|---|---|---|---|---|---|
| Clinical Support Services | 3.6% | £1,438 | £1,438 | £4,712 | £3,275 | £4,712 | £3,275 | 327.8% |
| Complex Care | 1.9% | £781 | £781 | £1,031 | £251 | £1,031 | £251 | 132.1% |
| Contracting and Commissioning | 0.0% | £0 | £0 | £4,162 | £4,162 | £4,162 | £4,162 | |
| Corporate | 6.1% | £2,471 | £2,471 | £6,846 | £4,376 | £6,846 | £4,376 | 277.1% |
| Estates and Facilities | 7.4% | £3,000 | £3,000 | £5,256 | £2,256 | £5,256 | £2,256 | 175.2% |
| Families and Therapies | 1.7% | £682 | £682 | £2,800 | £2,118 | £2,800 | £2,118 | 410.5% |
| Medicine | 5.6% | £2,250 | £2,250 | £4,537 | £2,287 | £4,537 | £2,287 | 201.6% |
| Mental Health and Learning Disabilities | 2.3% | £946 | £946 | £1,732 | £786 | £1,732 | £786 | 183.1% |
| Prescribing | 5.6% | £2,252 | £2,252 | £5,579 | £3,327 | £5,579 | £3,327 | 247.8% |
| Primary Care and Community | 4.0% | £1,614 | £1,614 | £2,763 | £1,149 | £2,763 | £1,149 | 171.2% |
| Surgery | 6.1% | £2,448 | £2,448 | £3,357 | £909 | £3,357 | £909 | 137.1% |
| Urgent Care | 1.3% | £539 | £539 | £624 | £85 | £624 | £85 | 115.8% |
| Various | 54.4% | £21,980 | £21,980 | £0 | -£21,980 | £0 | -£21,980 | 0.0% |
| **Total** | **100.0%** | **£40,400** | **£40,400** | **£43,400** | **£3,000** | **£43,400** | **£3,000** | **107.4%** |

The table below shows the total savings performance achieved in 2026/27 by Value & sustainability category:

| Value & Sustainability category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to Plan | Full-year Annual Plan | Full-year Forecast savings | Full-year Variance to plan |
|---|---|---|---|---|---|---|---|
| CHC | 12 | £2,563 | £1,900 | -£663 | £2,563 | £1,900 | -£663 |
| Medicines Management | 54 | £4,520 | £9,557 | £5,037 | £4,520 | £9,557 | £5,037 |
| Procurement & Non-pay | 138 | £20,587 | £17,448 | -£3,139 | £20,587 | £17,448 | -£3,139 |
| Service redesign | 3 | £1,980 | £1,712 | -£268 | £1,980 | £1,712 | -£268 |
| Workforce | 91 | £10,750 | £12,782 | £2,032 | £10,750 | £12,782 | £2,032 |
| **Total** | **298** | **£40,400** | **£43,400** | **£3,000** | **£40,400** | **£43,400** | **£3,000** |

The table below demonstrates the 2025/26 achieved savings and the breakdown between recurrent and non-recurrent savings with the 2026/27 impact, by value & sustainability category. It shows that **43% of the savings are non-recurrent**. This adversely impacts the underlying position of the Health Board.

| V&S category | Number of Schemes | Annual Plan | Forecast savings | Variance to Plan | Non Recurrent forecast savings | Recurrent forecast savings | Forecast savings FYE |
|---|---|---|---|---|---|---|---|
| CHC | 12 | £2,563 | £1,900 | -£663 | £250 | £1,650 | £2,385 |
| Medicines Management | 54 | £4,520 | £9,557 | £5,037 | £743 | £8,814 | £15,118 |
| Procurement & Non-pay | 138 | £20,587 | £17,448 | -£3,139 | £9,530 | £7,918 | £9,163 |
| Service redesign | 3 | £1,980 | £1,712 | -£268 | £1,712 | £0 | £0 |
| Workforce | 91 | £10,750 | £12,782 | £2,032 | £6,489 | £6,293 | £9,057 |
| **Total** | **298** | **£40,400** | **£43,400** | **£3,000** | **£18,725** | **£24,675** | **£35,723** |

**Opportunities**

The ABUHB Value & Sustainability Board and relevant Divisions / Departments are actively engaged in the identification of opportunities to reach financial sustainability for ABUHB.

**Risks**

The reported position for 2025/26 remains subject to Audit adjustments (including any adjustments in relation to the final Prescribing PAR reports)

There continues to be a number of risks which will need to be managed or mitigated going into the new financial year (2026/27):

- Ensuring full delivery of the savings plans identified in the annual plan,
- Managing variable pay linked to workforce operational pressures,
- Delayed transfers of care due to LA service challenges,
- Funding for any wage award or change in terms and conditions,
- Additional revenue costs due to IFRS 16,
- Impact on service delivery and performance on waiting times because of savings required and
- Economic factors such as inflationary impacts beyond those assumed,
- Identifying sufficient savings and opportunities to deliver future break even.

**Capital**

The approved Capital Resource Limit (CRL) as at Month 12 totalled £45.666m including disposal proceeds totalling £0.361m. The outturn against the overall CRL for 2025/26 is an underspend of £0.047m.

The Health Board confirmed the CRL requirements for all All-Wales Capital Programme (AWCP) schemes at the end of October. Brokerage requests have been agreed with Welsh Government (WG) to deal with the AWCP slippage incurred after October totalling £2.021m. The brokerage with the Discretionary Capital Programme

(DCP) has been managed by accelerating forward schemes approved as part of the opening 2026/27 DCP approved in January 2026.

The NHH Satellite Radiotherapy scheme building handover took place on the 6th May 2025. After commissioning, the unit opened to patients on the 30th June 2025. The final account for the building works is being agreed with the contractor. A slippage request of £0.324m has been approved to allow associated smaller works and expenditure against the arts budget to continue in 2026/27.

Phase 1 works to the Grange University Hospital Emergency Department Extension were finalised and the unit opened to patients in December 25. The final account is now being agreed with the contractor. Phase 2 works will take place in 2026/27 with £0.300m approved as part of the opening DCP.

The Centralised Decontamination Unit at RGH works completed in month and the commissioning of the unit commenced. The reported underspend relates to the reimbursement to DCP for fees incurred in prior financial years (£0.139m). Slippage of £0.221m into 2026/27 has been approved to manage costs associated with the commissioning period.

The final spend during 2025/26 across all Targeted Estates Funding (TEF) schemes for 2025/26 was £7.913m. The two-year programme continues into 2026/27 with an approved allocation of £9.961m. Expenditure is expected to progress quickly in the new financial year as the majority of procurements have concluded and orders have already been placed.

A brokerage request totalling £0.413m was approved in relation to slippage on the Reinforced Aerated Autoclaved Concrete works at Nevill Hall. The slippage relates to works costs and fees that are now planned for 2026/27.

The Outline Business Cases (OBC) for Abervalley and Monmouth Health and Well-being Centres are not expected to complete until next financial year. As such, brokerage requests totalling £0.528m have been approved to carry the funding forward to 2026/27. A further £0.424m has also been approved for the Abervalley scheme in month to cover the increased costs required to complete the OBC.

The Health Board Discretionary Capital Programme (DCP) funding for 2025/26 (after agreed brokerage) is £8.948m at Month 12 made up of:

- 2025/26 DCP Funding - £12.875m
- Less 30% TEF contribution - (£2.862m)
- Less 2024/25 AWCP scheme brokerage - (£3.235m)
- Plus 2025/26 agreed AWCP brokerage - £2.021m
- Plus Disposal Proceeds 2025/26 - £0.149m

Final DCP expenditure for 2025/26 totalled £9.011m, an overspend of £0.063m. After reimbursement of the Centralised Decontamination unit fees incurred during

2024/25 (-£0.139m) and deducting other AWCP overspends that are required to be funded by DCP (£0.028m), the underspend against the overall 2025/26 CRL is £0.047m.

**Cash**

The cash balance at the 31st March is £5.551m, which is below the advisory figure set by Welsh Government of £6m. This includes receipt of strategic cash from Welsh Government.

**Public Sector Payment Policy (PSPP)**

The Health Board performance has achieved the target to pay 95% of the number of both NHS and Non-NHS creditors within 30 days of delivery of goods/services in the month of March 2026.

| Category | Invoices | In Mth % | YTD % |
|---|---|---|---|
| NHS | Value | 97.7 | 98.6 |
| | Number | 95.3 | 93.3 |
| Non NHS | Value | 96.2 | 96.9 |
| | Number | 97.4 | 97.1 |

Cumulatively, the HB has achieved the statutory 95% target for Non-NHS creditor invoices for the 2025/26 Financial Year, with a value of 97.1%.

However, the issues reported in previous months' have had an impact on the cumulative NHS target, which has not been achieved in 2025/26.

**Annual Accounts 2025/26**

Progress with the production of the 2025/26 Annual Accounts is in line with the agreed timetable and Welsh Government deadlines, with draft submissions completed in accordance with national requirements. The accounts are currently subject to external audit, which is progressing as planned, and regular updates are being provided through the Audit, Risk and Assurance Committee. Work continues to respond to audit queries, with no material issues identified at this stage that would prevent timely certification and submission of the final audited accounts by the required deadline.

**Argymhelliad / Recommendation**

**The Committee is asked to note for assurance:**

- The financial performance for the financial year 2025/26, and the outturn position against the statutory revenue and capital resource limits,

- The savings position for 2025/26,
- The revenue reserve position on the 31st March 2026,
- The Health Board's underlying financial position,
- The cash position,
- Public sector payment policy performance, and
- The capital position.

Note: the appendices attached providing further detailed information.

Board%20Finance%20Report%20Appen

March 2026 Monthly Monitoring Return:
Key Documents - Aneurin Bevan University Health Board

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Financial Sustainability |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 7. Staff and Resources<br>Governance, Leadership & Accountability<br>All Health & Care Standards Apply<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br>All IMTP priorities |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Finance |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Improve the Wellbeing and engagement of our staff<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| **Gwybodaeth Ychwanegol: Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | ABUHB efficiency compendium<br>Value & Sustainability Board |
| Rhestr Termau:<br>Glossary of Terms: | A&C – Administration & Clerical<br>A&E – Accident & Emergency<br>A4C - Agenda for Change<br>AME – (WG) Annually Managed Expenditure<br>AQF – Annual Quality Framework<br>AWCP – All Wales Capital Programme<br>AP – Accounts Payable<br>AOF – Annual Operating Framework<br>ATMP – Advanced Therapeutic Medicinal Products<br>B/F – Brought Forward<br>BH – Bank Holiday<br>C&V – Cardiff and Vale<br>CAMHS – Child & Adolescent Mental Health Services<br>C/F – Carried Forward<br>CHC – Continuing Health Care<br>Commissioned Services – Services purchased external to ABUHB both within and outside Wales<br>COTE – Care of the Elderly<br>CRL – Capital Resource Limit<br>Category M – category of drugs<br>CEO – Chief Executive Officer<br>CEAU – Children's Emergency Assessment Unit<br>CTM – Cwm Taf Morgannwg<br>D&C – Demand & Capacity<br>DCP – Discretionary Capital Programme<br>DHR – Digital Health Record<br>DNA – Did Not Attend<br>DOSA – Day of Surgery Admission<br>D2A – Discharge to Assess<br>DoLS - Deprivation of Liberty Safeguards<br>DoF – Director(s) of Finance<br>DTOC – Delayed Transfer of Care<br>EASC – Emergency Ambulance Services Committee<br>ED – Emergency Department<br>EDCIMS – Emergency Department Clinical Information Management System |

| | |
|---|---|
| | eLGH – Enhanced Local general Hospital<br>EFAB – Estates Funding Advisory Board<br>ENT – Ear, Nose and Throat specialty<br>EoY – End of Year<br>ETTF – Enabling Through Technology Fund<br>F&T – Family & Therapies (Division)<br>FBC – Full Business Case<br>FNC – Funded Nursing Care<br>GDS – General Dental Services<br>GMS – General Medical Services<br>GP – General Practitioner<br>GWICES – Gwent Wide Integrated Community Equipment Service<br>GUH – Grange University Hospital<br>GIRFT – Getting it Right First Time<br>HCHS – Health Care & Hospital Services<br>HCSW – Health Care Support Worker<br>HIV – Human Immunodeficiency Virus<br>HSDU – Hospital Sterilisation and Disinfection Unit<br>H&WBC – Health and Well-Being Centre<br>IMTP – Integrated Medium Term Plan<br>INNU – Interventions not normally undertaken<br>IPTR – Individual Patient Treatment Referral<br>I&E – Income & Expenditure<br>ICF – Integrated Care Fund<br>LoS – Length of Stay<br>LTA – Long Term Agreement<br>LD – Learning Disabilities<br>MH – Mental Health<br>MSK - Musculoskeletal<br>Med – Medicine (Division)<br>MCA – Mental Capacity Act<br>MDT – Multi-disciplinary Team<br>MMR – Welsh Government Monthly Monitoring Return<br>NCA – Non-contractual agreements<br>NCN – Neighbourhood Care Network<br>NCSO – No Cheaper Stock Obtainable<br>NI – National Insurance<br>NICE – National Institute for Clinical Excellence<br>NHH – Neville Hall Hospital<br>NWSSP – NHS Wales Shared Services Partnership<br>ODTC – Optometric Diagnostic and Treatment Centre<br>OD – Organisation Development<br>PAR – Prescribing Audit Report |

| | |
|---|---|
| | PCN – Primary Care Networks (Primary Care Division)<br>PER – Prescribing Incentive Scheme<br>PICU – Psychiatric Intensive Care Unit<br>PrEP – Pre-exposure prophylaxis<br>PSNC –Pharmaceutical Services Negotiating Committee<br>PSPP – Public Sector Payment Policy<br>PCR – Patient Charges Revenue<br>PPE – Personal Protective Equipment<br>PFI – Private Finance Initiative<br>RGH – Royal Gwent Hospital<br>RN – Registered Nursing<br>RRL – Revenue Resource Limit<br>RTT – Referral to Treatment<br>RPB – Regional Partnership Board<br>RIF – Regional Integration Fund<br>SCCC – Specialist Critical Care Centre<br>SCH – Scheduled Care Division<br>SCP – Service Change Plan (reference IMTP)<br>SLF – Straight Line Forecast<br>SpR – Specialist Registrar<br>STW – St.Woolos Hospital<br>TCS – Transforming Cancer Services (Velindre programme)<br>TEF – Targeted Estates Funding<br>T&O – Trauma & Orthopaedics<br>TAG – Technical Accounting Group<br>UHB / HB – University Health Board / Health Board<br>USC – Unscheduled Care (Division)<br>UC – Urgent Care (Division)<br>ULP – Underlying Financial Position<br>VCCC – Velindre Cancer Care Centre<br>VERS – Voluntary Early Release Scheme<br>WET AMD – Wet age-related macular degeneration<br>WG – Welsh Government<br>WHC – Welsh Health Circular<br>WHSSC – Welsh Health Specialised Services Committee<br>WLI – Waiting List Initiative<br>WLIMS – Welsh Laboratory Information Management System<br>WRP – Welsh Risk Pool<br>YAB – Ysbyty Aneurin Bevan<br>YTD – Year to date<br>YYF – Ysbyty Ystrad Fawr |

| | |
|---|---|
| | |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board: | Finance & Performance Committee |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment** (EIA) completed | **No does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working**<br><br>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<br>Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives |

# Aneurin Bevan University Health Board

## Finance Report – March (Month 12) 2025/26

## Appendices


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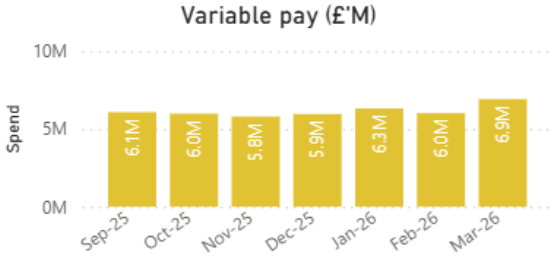
**Pay Summary (1) (excluding 9.4% Pension employer costs paid in March of each year):**

## Pay summary



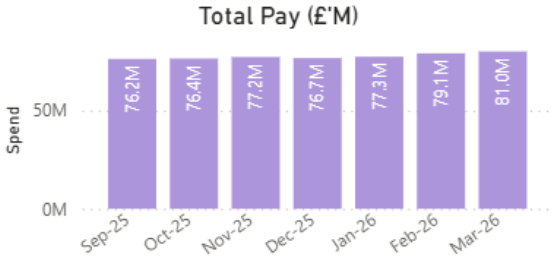

### Substantive (£'000)

| Pay category | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Change | % | Avg 24/25 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ADD PROF SCIENTIFIC AND TECHNICAL | 3,101 | 2,748 | 2,831 | 2,794 | 2,761 | 2,795 | 2,788 | 2,765 | -23 | -0.8% | 2,513 |
| ADDITIONAL CLINICAL SERVICES | 9,899 | 9,034 | 9,016 | 9,151 | 8,910 | 8,891 | 9,563 | 11,101 | 1,539 | 16.1% | 8,438 |
| ADMINISTRATIVE & CLERICAL | 12,609 | 11,219 | 11,256 | 11,396 | 11,350 | 11,258 | 11,476 | 11,439 | -37 | -0.3% | 10,110 |
| ALLIED HEALTH PROFESSIONALS | 5,425 | 4,782 | 4,824 | 4,880 | 4,907 | 4,888 | 4,982 | 5,074 | 92 | 1.8% | 4,361 |
| ESTATES AND ANCILLIARY | 3,794 | 3,476 | 3,498 | 3,658 | 3,527 | 3,514 | 3,923 | 3,732 | -191 | -4.9% | 3,208 |
| HEALTHCARE SCIENTISTS | 1,483 | 1,331 | 1,343 | 1,359 | 1,348 | 1,343 | 1,334 | 1,367 | 33 | 2.5% | 1,236 |
| MEDICAL AND DENTAL | 20,408 | 18,001 | 17,665 | 17,775 | 17,797 | 18,128 | 17,768 | 18,405 | 637 | 3.6% | 16,548 |
| NURSING AND MIDWIFERY REGISTERED | 22,515 | 19,557 | 20,014 | 20,392 | 20,104 | 20,220 | 21,219 | 20,246 | -972 | -4.6% | 18,058 |
| STUDENTS | 2 | 2 | -1 | 2 | 2 | 2 | 2 | 2 | 0 | 0.0% | 2 |
| **Total** | **79,237** | **70,149** | **70,448** | **71,406** | **70,707** | **71,038** | **73,054** | **74,131** | **1,077** | **1.5%** | **64,476** |




### Variable pay (£'000)

| Pay category | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Change | % | Avg 24/25 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Agency | 1,930 | 2,131 | 2,105 | 1,797 | 2,214 | 2,064 | 1,881 | 2,147 | 266 | 14.1% | 2,414 |
| Bank | 3,891 | 3,515 | 3,427 | 3,580 | 3,345 | 3,809 | 3,615 | 4,167 | 551 | 15.3% | 3,673 |
| Locum | 468 | 423 | 443 | 408 | 391 | 436 | 511 | 591 | 81 | 15.8% | 332 |
| **Total** | **6,289** | **6,069** | **5,975** | **5,786** | **5,950** | **6,309** | **6,007** | **6,905** | **898** | **14.9%** | **6,419** |

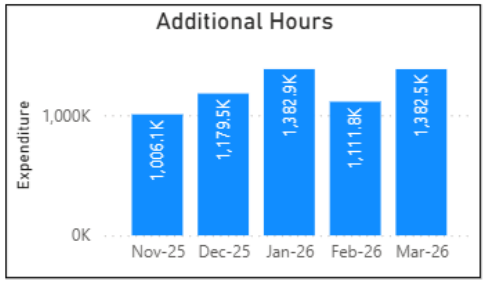


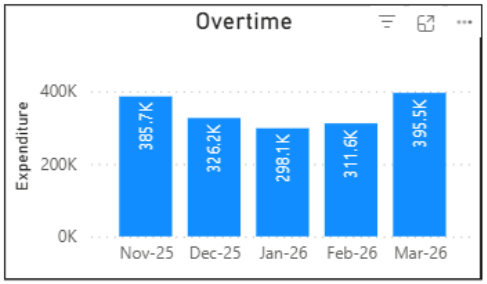

### Total pay (£'000)

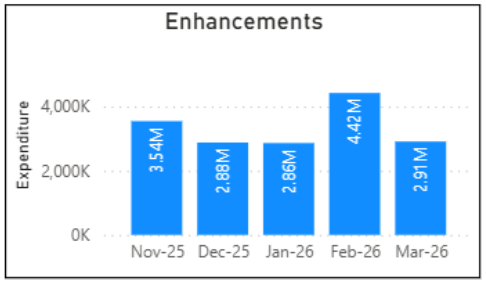
| | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Change | % | Avg 24/25 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Pay | **85,525** | **76,218** | **76,423** | **77,192** | **76,657** | **77,347** | **79,061** | **81,036** | **1,975** | **2.5%** | **70,895** |

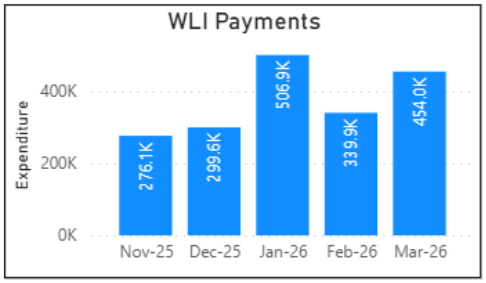
## Pay Summary (2): Substantive Pay: Additional pay element

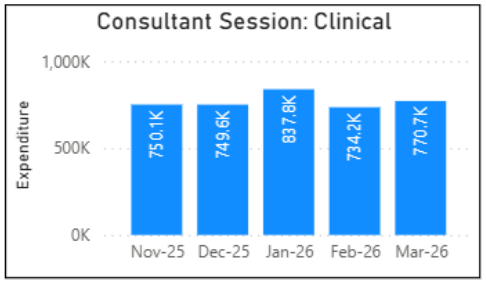
### Substantive staff additional pay by period and Division

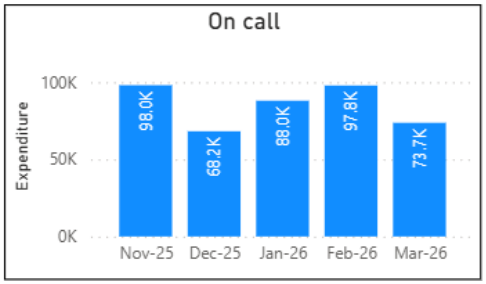


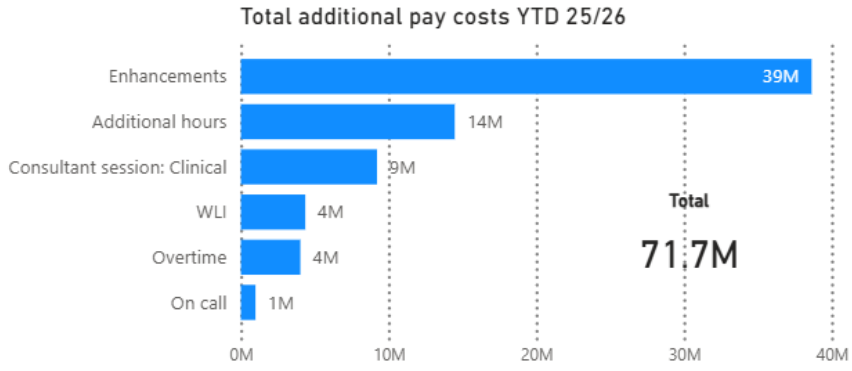




Total additional pay by Division (£'000)

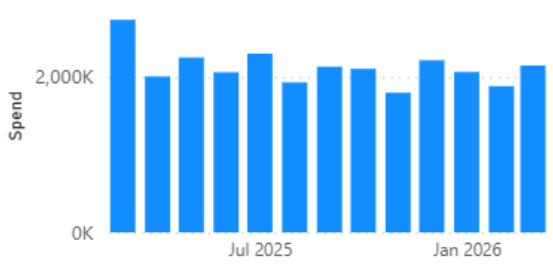
| Division | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Total |
|---|---|---|---|---|---|---|
| Medicine | 1,390 | 1,384 | 1,490 | 1,699 | 1,423 | **7,385** |
| Surgery | 881 | 865 | 1,002 | 1,033 | 986 | **4,767** |
| Clinical Support Services | 834 | 732 | 846 | 873 | 816 | **4,101** |
| Family and Therapies | 647 | 574 | 572 | 695 | 617 | **3,105** |
| Primary Care and Community | 549 | 471 | 503 | 732 | 549 | **2,805** |
| Urgent Care | 593 | 475 | 523 | 586 | 530 | **2,707** |
| Estates and Facilities | 531 | 454 | 429 | 633 | 452 | **2,499** |
| Mental Health and LD | 398 | 332 | 349 | 498 | 371 | **1,948** |
| CHC and FNC | 139 | 116 | 108 | 152 | 104 | **619** |
| Corporate | 96 | 98 | 151 | 113 | 137 | **596** |
| **Total** | **6,059** | **5,500** | **5,974** | **7,015** | **5,986** | **30,533** |



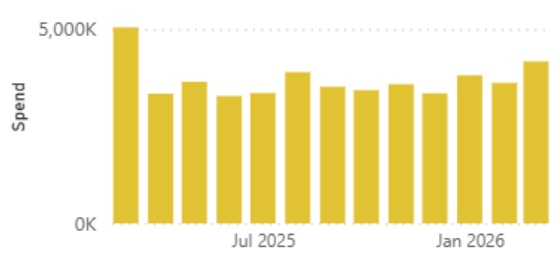
## Pay Summary (3): Variable Pay (£'k)

| Pay category | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Change | % | Avg 24/25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Agency** | | | | | | | | | | | | | | | | |
| Admin & Clerical Agency | 37 | 38 | 10 | 17 | 54 | 2 | 61 | 20 | 26 | 29 | 54 | 77 | 47 | -30 | -39.0% | 8 |
| Allied Health Prof Agency | 323 | 163 | 136 | 78 | 202 | 69 | 79 | 68 | 59 | 104 | 148 | 160 | 230 | 70 | 44.1% | 168 |
| Estates & Ancilliary Agency | 145 | 112 | 81 | 128 | 59 | 111 | 159 | 161 | 103 | 137 | 75 | 103 | 104 | 2 | 1.7% | 54 |
| Medical Agency | 1,038 | 858 | 1,156 | 945 | 991 | 883 | 903 | 1,015 | 736 | 972 | 725 | 609 | 735 | 127 | 20.8% | 968 |
| Nurse HCA/HCSW Agency | 202 | 115 | 172 | 189 | 197 | 95 | 84 | 98 | 40 | 126 | 96 | 97 | 129 | 32 | 32.6% | 74 |
| Other Agency | 98 | 91 | 68 | 135 | 96 | 137 | 150 | 97 | 181 | 113 | 90 | 138 | 112 | -26 | -18.5% | 77 |
| Registered Nurse Agency | 893 | 627 | 627 | 568 | 701 | 632 | 695 | 646 | 652 | 734 | 875 | 697 | 788 | 91 | 13.0% | 1,066 |
| **Total** | **2,735** | **2,005** | **2,249** | **2,060** | **2,300** | **1,930** | **2,131** | **2,105** | **1,797** | **2,214** | **2,064** | **1,881** | **2,147** | **266** | **14.1%** | **2,414** |
| **Bank** | | | | | | | | | | | | | | | | |
| Admin & Clerical Bank | 168 | 73 | 79 | 68 | 74 | 84 | 74 | 88 | 101 | 80 | 92 | 72 | 84 | 12 | 16.2% | 84 |
| Estates & Ancilliary Bank | 325 | 253 | 288 | 280 | 276 | 296 | 288 | 266 | 274 | 287 | 290 | 286 | 350 | 64 | 22.4% | 260 |
| Nurse HCA/HCSW Bank | 2,032 | 1,574 | 1,698 | 1,570 | 1,595 | 1,842 | 1,622 | 1,611 | 1,693 | 1,590 | 1,708 | 1,646 | 1,922 | 276 | 16.8% | 1,638 |
| Other Bank | 233 | 27 | 37 | 25 | 34 | 35 | 38 | 32 | 27 | 36 | 33 | 51 | 94 | 42 | 83.1% | 19 |
| Registered Nurse Bank | 2,287 | 1,408 | 1,541 | 1,336 | 1,375 | 1,634 | 1,492 | 1,429 | 1,485 | 1,352 | 1,686 | 1,560 | 1,718 | 157 | 10.1% | 1,672 |
| **Total** | **5,044** | **3,336** | **3,643** | **3,279** | **3,354** | **3,891** | **3,515** | **3,427** | **3,580** | **3,345** | **3,809** | **3,615** | **4,167** | **551** | **15.3%** | **3,673** |
| **Locum** | | | | | | | | | | | | | | | | |
| Medical Locum | 180 | 376 | 356 | 353 | 377 | 468 | 423 | 443 | 408 | 391 | 436 | 511 | 591 | 81 | 15.8% | 332 |
| **Total** | **180** | **376** | **356** | **353** | **377** | **468** | **423** | **443** | **408** | **391** | **436** | **511** | **591** | **81** | **15.8%** | **332** |
| **Total** | **7,959** | **5,718** | **6,248** | **5,692** | **6,031** | **6,289** | **6,069** | **5,975** | **5,786** | **5,950** | **6,309** | **6,007** | **6,905** | **898** | **14.9%** | **6,419** |

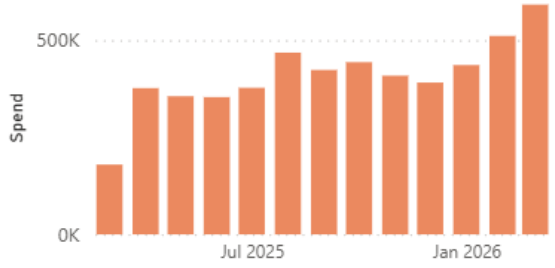
Agency (£'000)




Bank (£'000)

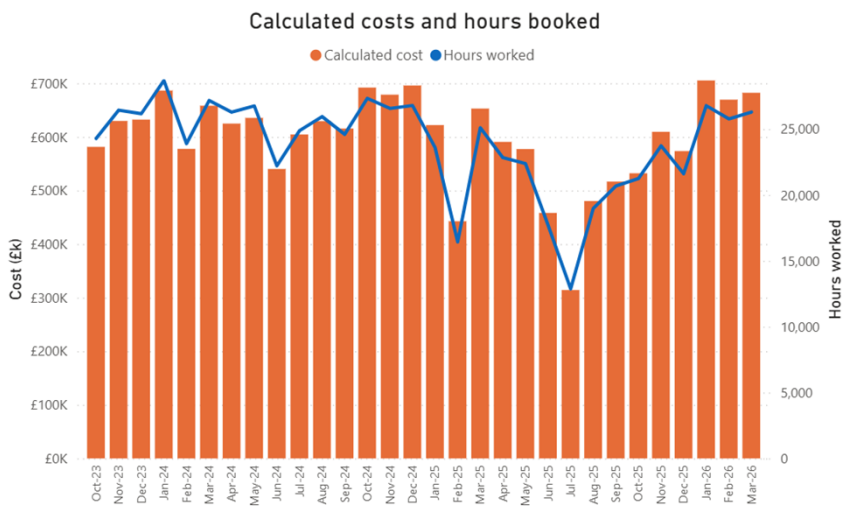



Locum (£'000)

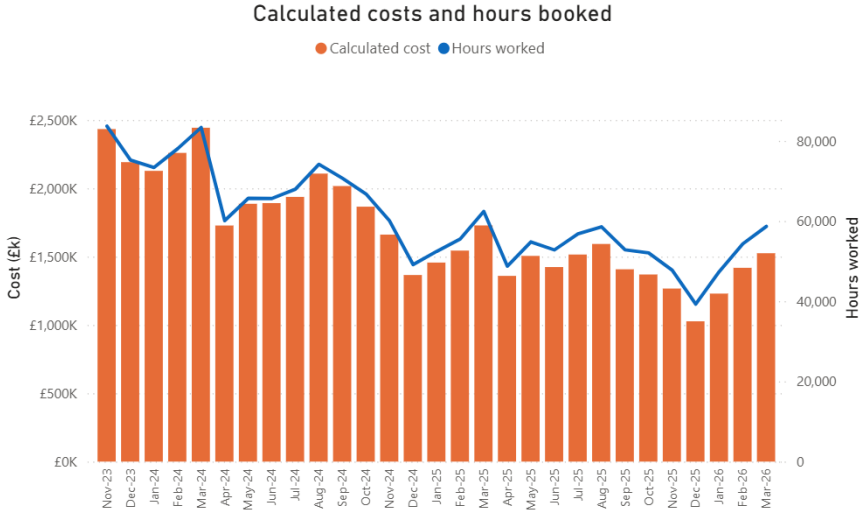


## Pay Summary (4): Nurse Bank & Agency Reason for Booking (£'k)

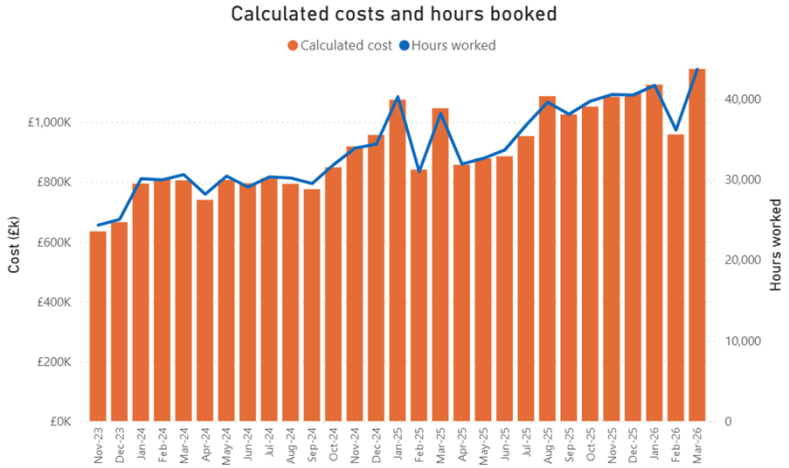
### Enhanced Care




### Established Vacancy Cover

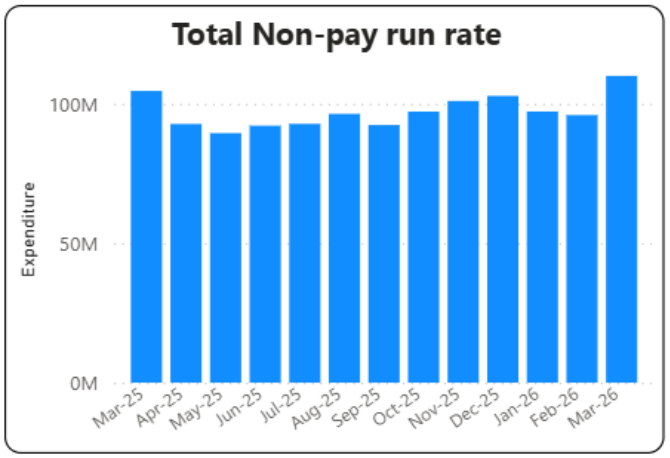


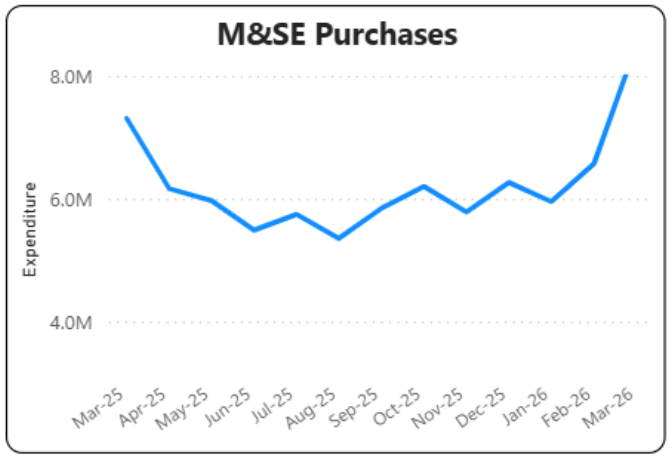

### Sickness Cover

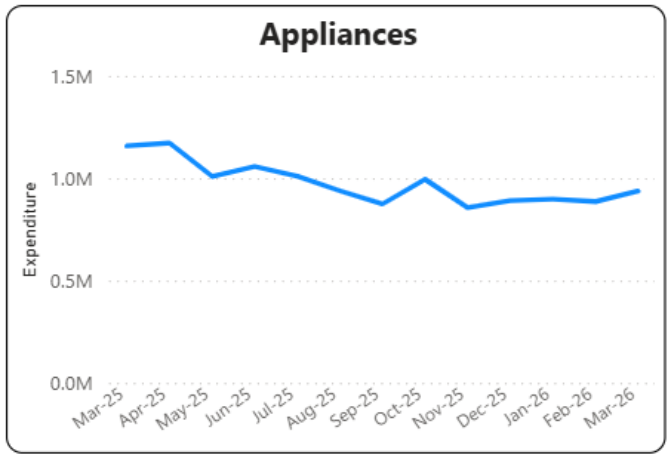


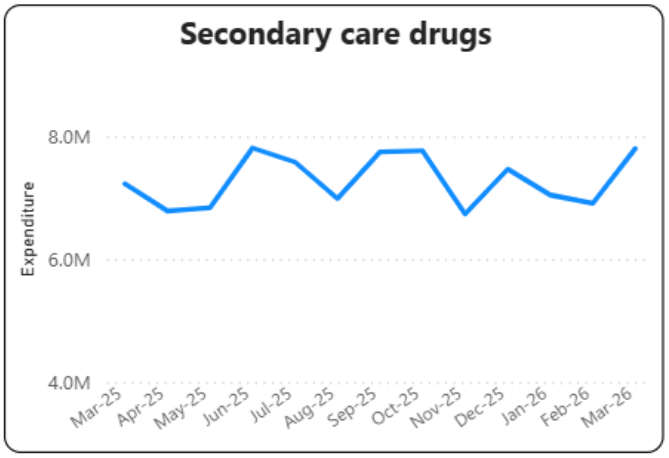

These graphs represent **'notional-calculated worth'** of these booking reasons for Bank and Agency - Registered Nurses and Healthcare Support Workers. This means assigning an average cost for the hours worked, per the reasons reported in e-roster.

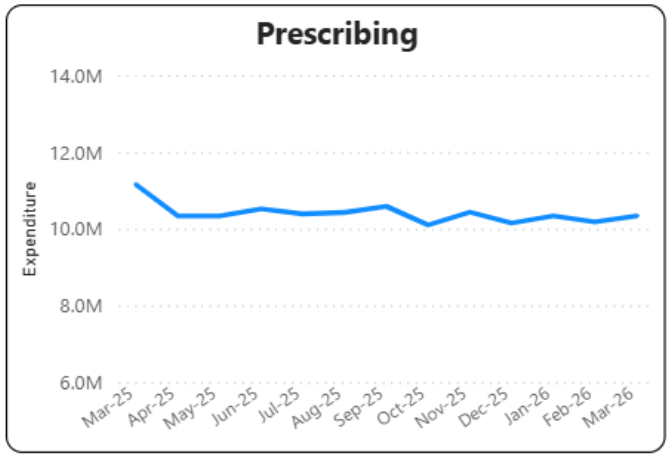
**Non-Pay Summary:**

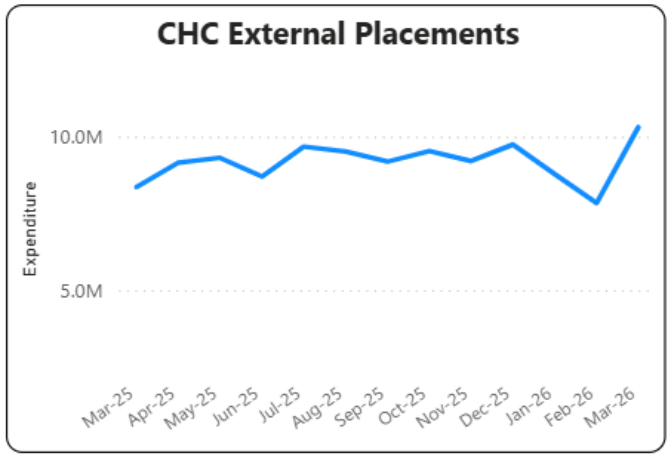


**CHC (Adult Community CHC): Activity and Spend - YTD & Forecast**

Activity has decreased by 3 cases when compared to the 2024/25 out-turn, spend has increased by £5.8m when compared to the 24/25 out-turn.

| Activity - Actual | Mar-26 | Feb-26 | Movement | Average 24/25 |
|---|---|---|---|---|
| D2A | 21 | 22 | -1 | 18 |
| CAHT | 45 | 47 | -2 | 50 |
| All Other EXT CHC | 476 | 469 | 7 | 462 |
| Discharge schemes (RIF) | 17 | 26 | -9 | 27 |
| **Total** | **559** | **564** | **-5** | 557 |

| Activity - Forecast | Mar-26 | turn | Movement |
|---|---|---|---|
| D2A | 27 | 18 | 9 |
| CAHT | 48 | 50 | (2) |
| All Other EXT CHC | 462 | 462 | 0 |
| Discharge schemes (RIF) | 17 | 27 | (10) |
| **Total** | **554** | **557** | **(3)** |

| YTD & Forecast £'000 | 2025/26 forecast as at M11 £'000 | 2025/26 full year M12 £'000 | Movement | 24/25 Out-turn | 23/24 Out-turn |
|---|---|---|---|---|---|
| D2A | 2,624 | 2,599 | 25 | 1,776 | 2,093 |
| CAHT | 10,284 | 10,284 | - | 10,147 | 10,932 |
| All Other EXT CHC | 47,184 | 46,714 | 470 | 42,341 | 41,053 |
| Discharge schemes (RIF) | 1,175 | 1,175 | - | 1,221 | 545 |
| **Total** | **61,267** | **60,772** | **495** | **55,485** | **54,623** |

**Referral to Treatment (RTT):**

- Elective Treatments for Mar '26 = 2,315 (Feb '26: 2,040, 25/26 total: 24,736, 2024/25 total: 25,658, 23/24 total: 24,688, 22/23 total: 22,327)

| Planned Treatments (M12) | | | | |
|---|---|---|---|---|
| Treatment | Core | Backfill | WLI | Total |
| N107-Dermatology | 198 | 0 | 12 | 210 |
| N147-ENT | 131 | 0 | 0 | 131 |
| N105-General Surgery | 263 | 4 | 0 | 267 |
| N146-Oral Surgery | 217 | 0 | 0 | 217 |
| N148-Ophthalmology | 320 | 0 | 0 | 320 |
| N115-Trauma & Orthopaedics | 459 | 19 | 16 | 494 |
| N106-Urology | 242 | 0 | 0 | 242 |
| | 1,830 | 23 | 28 | 1,881 |

| Actual Treatments (M12) | | | |
|---|---|---|---|
| Core | Backfill | WLI | Total |
| 220 | 0 | 0 | 220 |
| 151 | 0 | 0 | 151 |
| 335 | 27 | 8 | 370 |
| 251 | 0 | 0 | 251 |
| 373 | 0 | 0 | 373 |
| 555 | 49 | 93 | 697 |
| 253 | 0 | 0 | 253 |
| 2,138 | 76 | 101 | 2,315 |

| Treatment Variance (M12) | | | |
|---|---|---|---|
| Core | Backfill | WLI | Total |
| 22 | 0 | (12) | 10 |
| 20 | 0 | 0 | 20 |
| 72 | 23 | 8 | 103 |
| 34 | 0 | 0 | 34 |
| 53 | 0 | 0 | 53 |
| 96 | 30 | 77 | 203 |
| 11 | 0 | 0 | 11 |
| 308 | 53 | 73 | 434 |

- Outpatient activity for Mar '26 = 5,790 (Feb '26: 5,875. 2025/26 total: 74,754, 2024/25 total: 74,787, 23/24 total: 71,165, 22/23 total: 65,873)

| Planned Outpatients (M12) | | | | |
|---|---|---|---|---|
| Outpatient | Core | Backfill | WLI | Total |
| N107-Dermatology | 1,033 | 0 | 0 | 1,033 |
| N147-ENT | 504 | 0 | 0 | 504 |
| N105-General Surgery | 1,619 | 132 | 35 | 1,786 |
| N146-Oral Surgery | 244 | 0 | 0 | 244 |
| N148-Ophthalmology | 556 | 0 | 32 | 588 |
| N108-Rheumatology | 146 | 0 | 0 | 146 |
| N115-Trauma & Orthopae | 798 | 12 | 25 | 835 |
| N106-Urology | 481 | 0 | 15 | 496 |
| Total | 5,381 | 144 | 107 | 5,632 |

| Actual Outpatients (M12) | | | | |
|---|---|---|---|---|
| ACTUAL TYPE | Elective | Backfilled | WLI | |
| Outpatient | Core | Backfill | WLI | Total |
| N107-Dermatology | 1,234 | 0 | 0 | 1,234 |
| N147-ENT | 606 | 0 | 0 | 606 |
| N105-General Surgery | 1,708 | 0 | 0 | 1,708 |
| N146-Oral Surgery | 356 | 0 | 0 | 356 |
| N148-Ophthalmology | 577 | 0 | 0 | 577 |
| N108-Rheumatology | 135 | 0 | 0 | 135 |
| N115-Trauma & Orthopaed | 626 | 0 | 0 | 626 |
| N106-Urology | 544 | 0 | 4 | 548 |
| Total | 5,786 | 0 | 4 | 5,790 |

| Outpatient Variance (M12) | | | | |
|---|---|---|---|---|
| Outpatient | Core | Backfill | WLI | Total |
| N107-Dermatology | 201 | 0 | 0 | 201 |
| N147-ENT | 102 | 0 | 0 | 102 |
| N105-General Surgery | 89 | (132) | (35) | (78) |
| N146-Oral Surgery | 112 | 0 | 0 | 112 |
| N148-Ophthalmology | 21 | 0 | (32) | (11) |
| N108-Rheumatology | (11) | 0 | 0 | (11) |
| N115-Trauma & Orthopaedi | (172) | (12) | (25) | (209) |
| N106-Urology | 63 | 0 | (11) | 52 |
| | 405 | (144) | (103) | 158 |

- **Medicine Outpatients activity for Mar ’26 was 2,148 - (Feb ’26: 2,089. 2025/26: 25,932. 2024/25: 23,053. 2023/24: 22,708)**

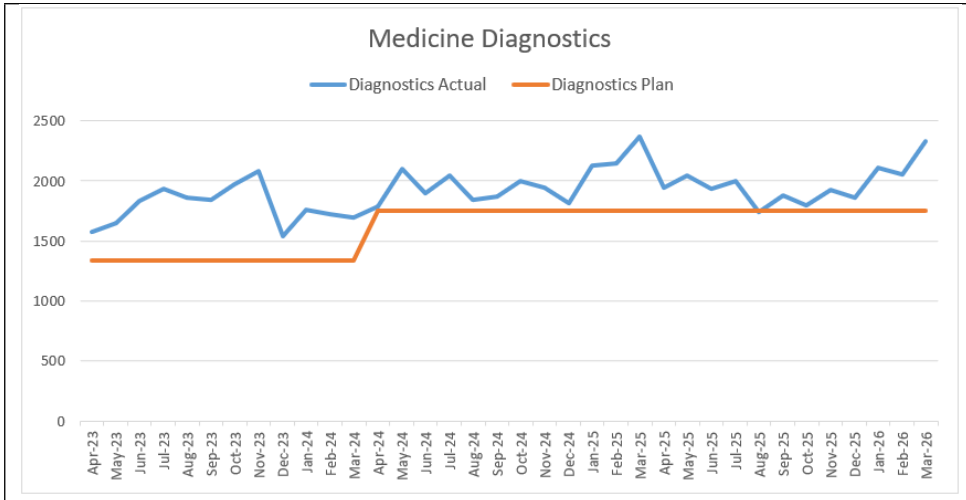
Mar-26

| | Assumed monthly activity | Actual activity | Variance |
|---|---|---|---|
| Gastroenterology | 475 | 483 | 8 |
| Cardiology | 430 | 441 | 11 |
| Respiratory (inc Sleep) | 455 | 407 | -48 |
| Neurology | 257 | 279 | 22 |
| Endocrinology | 186 | 229 | 43 |
| Geriatric Medicine | 313 | 309 | -4 |
| **Total** | **2116** | **2148** | **32** |

Mar-26

| YTD | YTD Plan | YTD Actual | Variance | Variance |
|---|---|---|---|---|
| Gastroenterology | 5700 | 5378 | -322 | -6% |
| Cardiology | 5160 | 4722 | -438 | -8% |
| Respiratory (inc Sleep) | 5460 | 4707 | -753 | -14% |
| Neurology | 3084 | 3756 | 672 | 22% |
| Endocrinology | 2232 | 2630 | 398 | 18% |
| Geriatric Medicine | 3756 | 3561 | -195 | -5% |
| **Total** | **25392** | **24754** | **-638** | **-3%** |

- **Medicine Diagnostics activity for Mar ’26 was 2,335 - (Feb ’26: 2,057. 2025/26: 23,628. 2024/25: 23,952. 2023/24: 21,466)**




| YTD Mar 26 | YTD Plan | YTD Actual | Variance | Variance |
|---|---|---|---|---|
| Endoscopy | 20988 | 23952 | 2964 | 14% |
| **Total** | **20988** | **23952** | **2964** | **14%** |

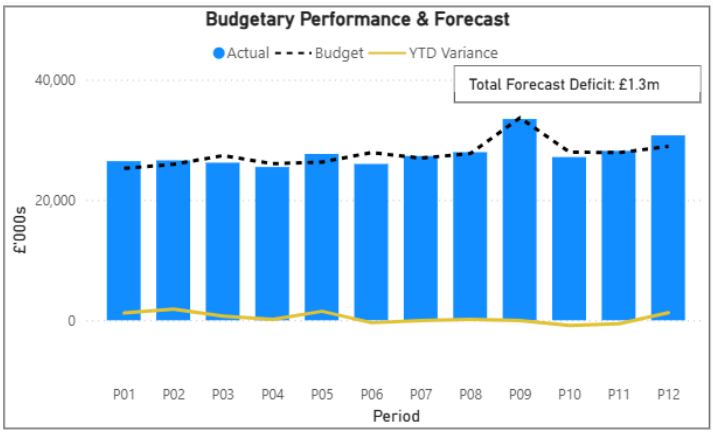
**RAG rating category definitions**

Savings schemes are categorised as *Red*, *Amber* or *Green* according to the certainty of the forecast achievement. Definitions for each rating are as follows:

- **Green scheme**: Started delivering in the current month or prior month and is expected to continue delivering for the remaining period.
- **Amber scheme**: Agreed plan in place and expected to deliver starting in a future month. Not yet started, therefore Amber due to the time factor risk.
- **Red scheme**: No plan in place and not expected to achieve.

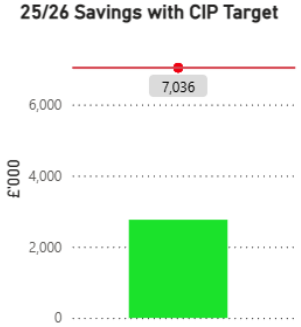
The definitions are consistent with Welsh Government guidance and have been communicated to Divisions.

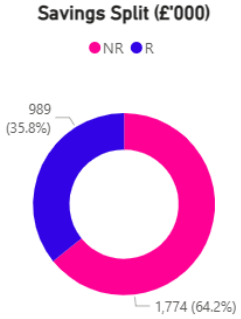
## Divisional analysis – Primary Care and Community




Key drivers of outturn deficit:

- £2.9m Community Wards
- (£0.6m) Contracts
- (£1.5m) Vaccines and Hospital Pharmacy
- (£0.6m) Primary Care Projects
- £0.6m Winter 24-26
- £1.0m Community COTE
- (£0.08m) other



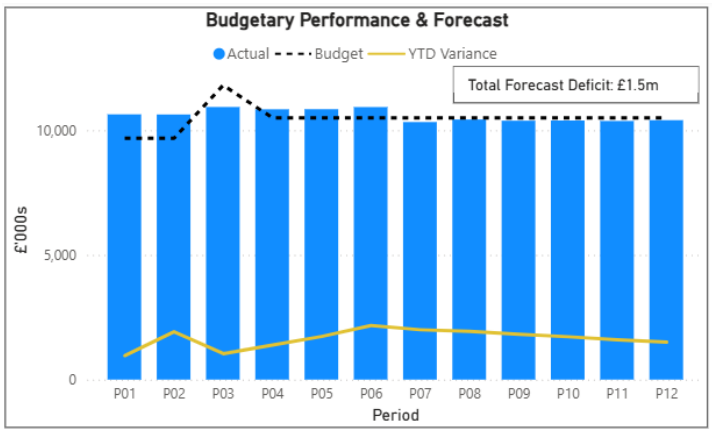

Savings summary (£'000)

| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| Medicines Management | 3 | 300 | 475 | 175 | 300 | 475 | 175 |
| Procurement & Non-pay | 17 | 832 | 1,749 | 917 | 832 | 1,749 | 917 |
| Workforce | 11 | 482 | 540 | 58 | 482 | 540 | 58 |
| **Total** | **31** | **1,614** | **2,763** | **1,149** | **1,614** | **2,763** | **1,149** |

| Savings Scheme Number | Scheme / Opportunity | R/NR | Annual Plan v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| PCC-01 | SLA's - Age Cymru & BHF | R | Month 1 | Green | 31 | 31 |
| PCC-03 | GMS - Improvement Grants | NR | Month 1 | Green | 100 | 100 |
| PCC-05 | 30% Reduction of B&A vs 24/25 plan | R | Month 1 | Green | 27 | 27 |
| PCC-06 | 6% Reduction of Non Pay across the area | R | Month 1 | Green | 14 | 14 |
| PCC-07 | Change the band 7 Discharge Liaison Nurse post [0.6wte £38K] to a band 4 administrative post [1.00wte £34k] | R | Month 1 | Green | 4 | 4 |
| PCC-08 | 10% Reduction of OAMH | R | Month 1 | Green | 15 | 15 |
| PCC-09 | ONN Vehicle Lease Cars (minus 6k early release fee) | R | Month 1 | Green | 25 | 25 |
| PCC-10 | BG Locality Bank & Agency reduction | R | Month 1 | Green | 1 | 1 |
| PCC-11 | Reduction in DN teams from 8 to 7 | R | Month 1 | Green | 10 | 10 |
| PCC-12 | Partial retirement savings non clinical staff | R | Month 1 | Green | 7 | 7 |
| PCC-13 | Stock review/control | R | Month 1 | Green | 1 | 1 |
| PCC-14 | Reduction/closure of boarding beds C5West and C5East | R | Month 1 | Green | 141 | 141 |
| PCC-15 | Closure of Victoria House | R | Month 1 | Green | 103 | 103 |

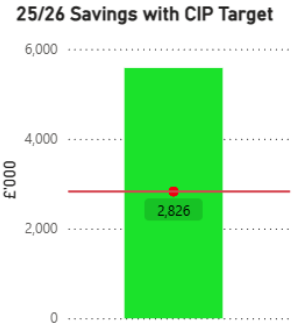
| Savings Scheme Number | Scheme / Opportunity | R/NR | Annual Plan v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| PCC-16 | Service provision at Trevethin | R | Month 1 | Green | 69 | 69 |
| PCC-17 | Reconfiguration of senior nurse posts DN/CRT | R | Month 1 | Green | 33 | 33 |
| PCC-18 | Non pay opportunities | R | Month 1 | Green | 13 | 13 |
| PCC-19 | Medicines Management - SSP Opportunities idenfied by procurement | R | Month 1 | Green | 300 | 300 |
| PCC-20 | Remove Emergency Dental Service (QIA) - commissioned Monday to Friday via GDS providers (in | R | Month 1 | Green | 58 | 58 |
| PCC-21 | Non-clinical staff review across core UPC / HP / SPA | R | Month 1 | Green | 65 | 65 |
| PCC-22 | Enhancements on Specialist rates | R | Month 1 | Green | 36 | 36 |
| PCC-23 | Administered COVID-19 Vaccines | NR | In Year | Green | 140 | 140 |
| PCC-23NRtoR | Administered COVID-19 Vaccines | R | In Year | Green | 35 | 35 |
| PCC-25 | Procurement - A4 paper switch saving | R | In Year | Green | 1 | 1 |
| PCC-38 | GMS Prior Year enhanced services accrual release | NR | In Year | Green | 614 | 614 |
| PCC-39 | GDS prior year clawback benefit | NR | In Year | Green | 108 | 108 |
| PCC-40 | Nursing non pay opportunities | NR | In Year | Green | 21 | 21 |
| PCC-41 | GDS NR saving from contract variation | NR | In Year | Green | 510 | 510 |
| PCC-42 | Respiratory - vacancies & maternity leave | NR | In Year | Green | 16 | 16 |
| PCC-43 | Optometry contract Prior year accrual release | NR | In Year | Green | 50 | 50 |
| PCC-44 | Uniform amnesty/recycling | NR | In Year | Green | 16 | 16 |
| PCC-45 | Early Winter Ward Closure | NR | In Year | Green | 200 | 200 |
| | | **Original CIP Target:** | | **7,036** | **2,763** | **2,763** |
| | | **Distance from target (over)/under** | | **4,273** | | |

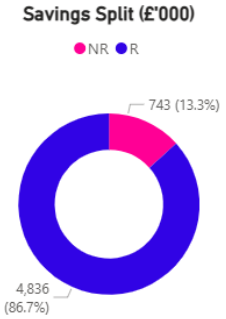
## Divisional analysis – Prescribing




Key drivers of outturn deficit:

- £1.1m prior year cost pressure due to 24/25 outturn
- £0.4m other net movements including reduced growth and increased price (including dapagliflozin Loss of exclusivity (LOE) price reduction)



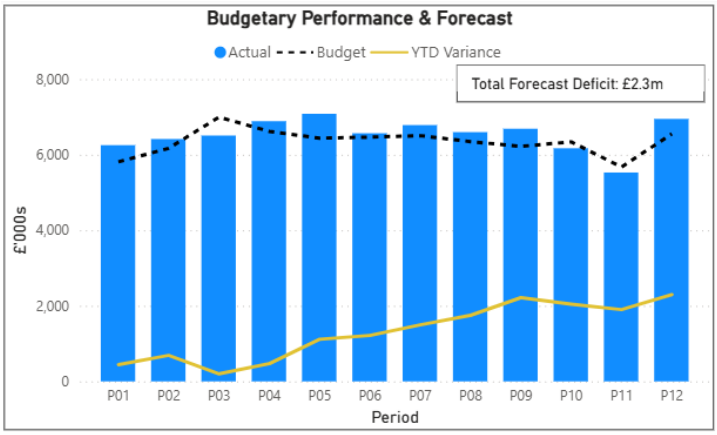




Savings summary (£'000)

| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| Medicines Management | 14 | 2,103 | 5,430 | 3,327 | 2,103 | 5,430 | 3,327 |
| Workforce | 1 | 149 | 149 | 0 | 149 | 149 | 0 |
| **Total** | **15** | **2,252** | **5,579** | **3,327** | **2,252** | **5,579** | **3,327** |

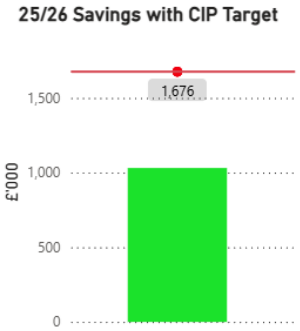
| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| PCC-02 | Stoma Team Phase 2 | NR | Month 1 | Green | 149 | 149 |
| PCC-04 | Medicines Management | R | Month 1 | Red | 0 | 0 |
| PCC-04A | Dietitians | R | In Year | Green | 71 | 71 |
| PCC-04B | Waste Reduction Scheme | R | In Year | Green | 282 | 282 |
| PCC-04C | Pharmacy Led Savings | R | In Year | Green | 202 | 202 |
| PCC-04D | Scriptswitch Acute | R | In Year | Green | 186 | 186 |
| PCC-04E | Scriptswitch Repeat | R | In Year | Green | 622 | 622 |
| PCC-04F | Liothyronine Formulation change | R | In Year | Green | 1 | 1 |
| PCC-04G | DOAC (Edoxaban) switch to Apixaban / Rivaroxaban | R | In Year | Green | 411 | 411 |
| PCC-04H | Bath & Shower Emollient Review | R | In Year | Green | 6 | 6 |
| PCC-04I | Chloral Hydrate Prescribing Review | R | In Year | Green | 0 | 0 |
| PCC-100 | Dapagliflozin LOE | R | In Year | Green | 2,984 | 2,984 |
| PCC-101 | Ticagrelor LOE | R | In Year | Green | 72 | 72 |
| PCC-102 | Denosumab LOE | R | In Year | Green | 0 | 0 |
| PCC-24 | Only Order What You Need | NR | In Year | Green | 594 | 594 |
| | | **Original CIP Target:** | | **2,826** | **5,579** | **5,579** |
| | | **Distance from target (over)/under** | | **(2,753)** | | |

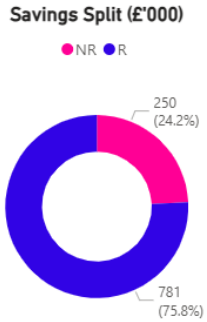
## Divisional analysis – Complex Care




Key drivers of outturn deficit:

- £2.24m CHC, DTA and FNC placements
- £0.22 Care at Home
- (£0.38m) Governance and Commissioning underspend
- Outturn includes £1.073m of database reviews



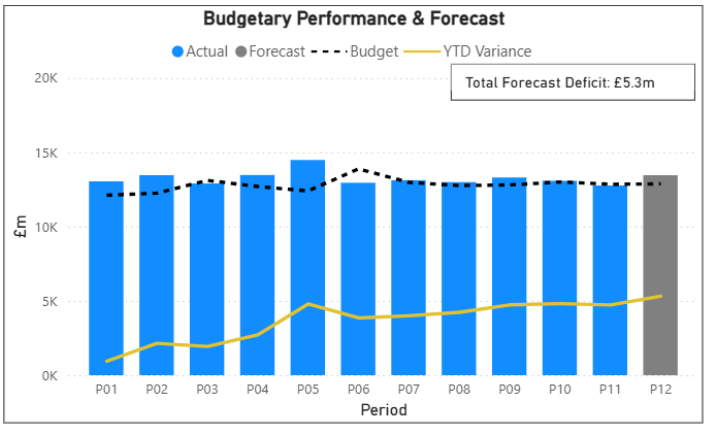




Savings summary (£'000)

| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| CHC | 6 | 763 | 1,013 | 251 | 763 | 1,013 | 251 |
| Workforce | 1 | 18 | 18 | 0 | 18 | 18 | 0 |
| **Total** | **7** | **781** | **1,031** | **251** | **781** | **1,031** | **251** |

| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| CHC-01 | Top 50 placement reviews | R | Month 1 | Green | 306 | 306 |
| CHC-02 | Management and reduction of commissioned enhanced care one to one in care homes | R | Month 1 | Green | 108 | 108 |
| CHC-03 | FNC Assessments | R | Month 1 | Green | 305 | 305 |
| CHC-04 | Care at Home Team | R | Month 1 | Green | 32 | 32 |
| CHC-05 | Rightsizing additional support | R | Month 1 | Green | 12 | 12 |
| CHC-06 | Enhancements on Specialist rates | R | Month 1 | Green | 18 | 18 |
| CHC-07 | Reduced growth chc | NR | In Year | Green | 250 | 250 |
| | | **Original CIP Target:** | | **1,676** | **1,031** | **1,031** |
| | | **Distance from target (over)/under** | | **645** | | |

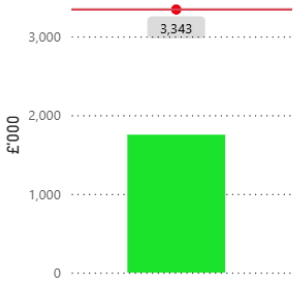
# Divisional analysis – Mental Health and Learning Disabilities



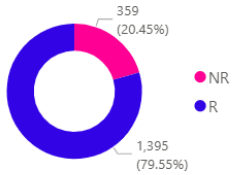

Key drivers of outturn deficit:

- £1.1m overspend for Commissioned placements
- £5.4m overspend on inpatients wards within Older Adult, Adult & Learning Disabilities, Enhanced Care and High Observations Driving the position
- £0.4m Drugs
- £0.8m overspend on Adult Medical Agency due to covering gaps
- (£2.3m) offset with underspends in relation to vacancies across Community teams, Older Adult Psychology vacancies

**25/26 Savings with CIP Target**




**Savings Split (£'000)**

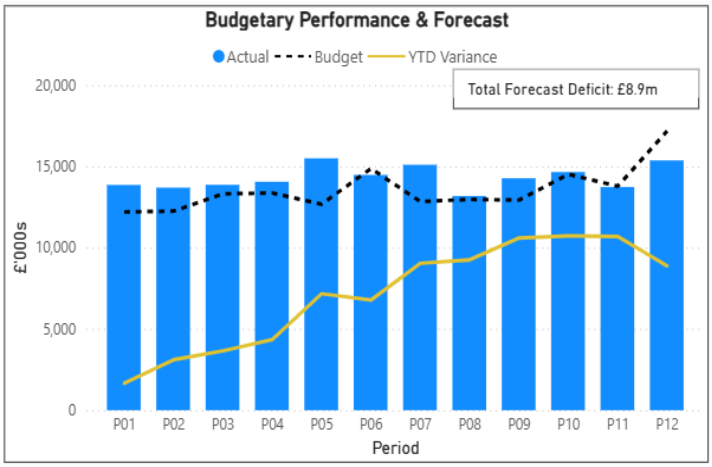



**Savings summary (£'000)**

| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| CHC | 5 | 683 | 738 | 55 | 700 | 887 | 187 |
| Medicines Management | 4 | 3 | 16 | 13 | 3 | 18 | 15 |
| Procurement & Non-pay | 2 | 0 | 361 | 361 | 0 | 394 | 394 |
| Workforce | 6 | 221 | 371 | 150 | 243 | 455 | 212 |
| **Total** | **17** | **907** | **1,486** | **579** | **946** | **1,753** | **807** |

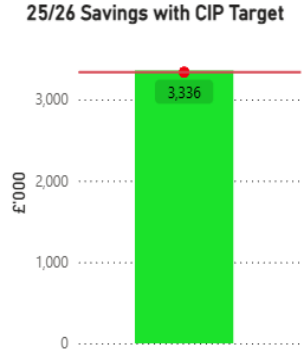
| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| MH-01 | Mitchell Close | R | Month 1 | Red | 0 | 0 |
| MH-02 | Aripiprazole drug switch | R | Month 1 | Green | 2 | 2 |
| MH-03 | Reduction to variable pay | R | Month 1 | Red | 0 | 0 |
| MH-04 | CHC Dispute CB Hammersmith & Fulham | NR | Month 1 | Red | 0 | 0 |
| MH-05 | CHC Transition Cases (x2) | R | Month 1 | Green | 207 | 207 |
| MH-06 | MH Framework Uplifts | R | In Year | Green | 344 | 344 |
| MH-07 | MH LD Adult / CAMHS Hospitals Framework Agreement | R | In Year | Green | 50 | 50 |
| MH-11 | CHC DB Repat In house services | R | In Year | Green | 366 | 366 |
| MH-13a | CHC Saving Eligibility Review | R | In Year | Green | 14 | 14 |
| MH-13b | CHC rightsize/change in need/step down | R | In Year | Green | 300 | 300 |
| MH-14 | Cedar temp closure | NR | In Year | Green | 157 | 157 |
| MH-15 | Older Adult Psychology Posts | NR | In Year | Green | 145 | 145 |
| MH-16 | Haloperidol tablets to liquid switch (cost difference) | R | In Year | Green | 16 | 16 |
| MH-17 | Variable Pay Reduction LD | NR | In Year | Green | 33 | 33 |
| MH-18 | National Priorities - Dapagliflozin generic | NR | In Year | Green | 1 | 1 |
| MH-19 | National Priorities - Ticagrelor generic | NR | In Year | Green | 0 | 0 |
| MH-14NRtoR | Cedar temp closure | R | In Year | Green | 97 | 97 |
| | | | **Original CIP Target:** | **3,343** | **1,732** | **1,732** |
| | | | **Distance from target (over)/under** | **1,611** | | |

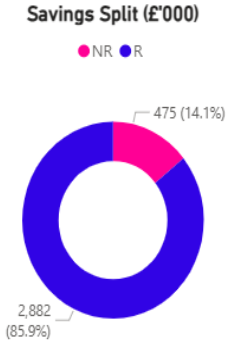
## Divisional analysis – Surgery




Key drivers of outturn deficit:

- £0.9m prior year savings plans across multiple themes that were unable to be achieved
- £2.4m Additional Backfill and WLI sessions above core to address Urgent and Cancer demand
- £0.9m Overperformance against its core activity, associated cost of this increased efficiency was calculated by applying specialty-specific variable cost rates (as per costing returns) to the excess activity delivered.
- £2.2m Historic gap between excess capacity and versus affordability in budget. A prior plan to reduce capacity by shifting more activity to a HVLC / Daycase setting was not implemented.
- £0.1m Additional Insourcing to address demands in ENT




Savings summary (£'000)

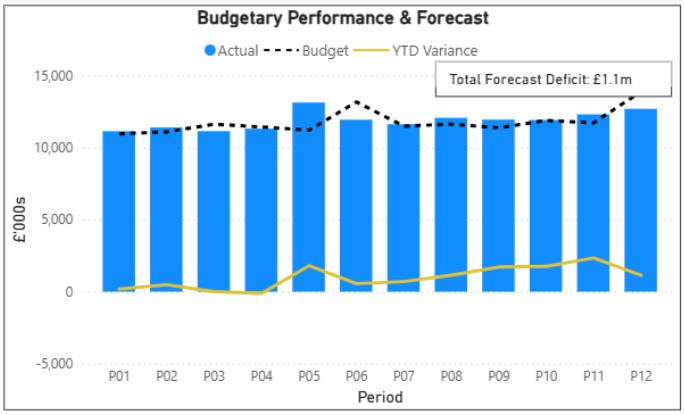
| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| Medicines Management | 8 | 963 | 1,620 | 657 | 963 | 1,620 | 657 |
| Procurement & Non-pay | 20 | 573 | 722 | 149 | 573 | 722 | 149 |
| Workforce | 14 | 912 | 1,015 | 103 | 912 | 1,015 | 103 |
| **Total** | **42** | **2,448** | **3,357** | **909** | **2,448** | **3,357** | **909** |

| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| SUR-01 | Haematology drugs wastage reduction | R | Month 1 | Red | 0 | 0 |
| SUR-02 | Robot buy out of lease (GB) | R | Month 1 | Green | 286 | 286 |
| SUR-03 | Divisional - Pump Giving Sets (Procurement) | R | Month 1 | Red | 0 | 0 |
| SUR-04 | General Surgery - Workforce - Net savings as a result of appointing two substantive consultants. | R | Month 1 | Green | 18 | 18 |
| SUR-05 | General Surgery - Medication - Switching IV Co-trimoxazole and metronidazole to oral in GUH | R | Month 1 | Red | 0 | 0 |
| SUR-06 | General Surgery - Pintuition seeds | R | Month 1 | Green | 65 | 65 |
| SUR-07 | Ear, Nose and Throat - Re-Usable Instruments | R | Month 1 | Green | 3 | 3 |
| SUR-08 | Ophthalmology - Workforce - Band 5 Orthoptist | R | Month 1 | Green | 10 | 10 |
| SUR-09 | Rheumatology - Workforce - Band 6 Rheumatology CNS | R | Month 1 | Green | 50 | 50 |
| SUR-11 | Trauma and Orthopaedics - Consolidation of maintenance contracts (Desoutter) | R | Month 1 | Green | 13 | 13 |
| SUR-12 | Trauma and Orthopaedics - Workforce - substantiate 1.2 WTE orthogeriatric ward doctor posts | R | Month 1 | Green | 26 | 26 |
| SUR-13 | Trauma and Orthopaedics - Workforce - Changes to on-call structures | R | Month 1 | Green | 3 | 3 |
| SUR-14 | Trauma and Orthopaedics - Workforce - 2 x consultant on-call cost replaced by 1x SAS on-call costs | R | Month 1 | Green | 3 | 3 |
| SUR-15 | Trauma and Orthopaedics - Bone Cleaning Device | R | Month 1 | Green | 69 | 69 |

## Surgery continued...

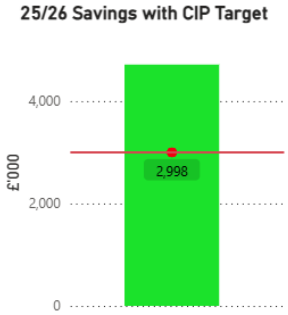
| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| SUR-16 | Trauma and Orthopaedics - Workforce - substantiate 2.5 WTE JCF over establishment for RGH/OSU ward cover | R | Month 1 | Green | 25 | 25 |
| SUR-17 | Urology - Cystoscopes - Disposable Cystoscopes | R | Month 1 | Green | 1 | 1 |
| SUR-18 | Urology - Medication - Switch to Dysport from BOTOX for N/Ps with Neuropathic Pain | R | Month 1 | Green | 0 | 0 |
| SUR-19 | Urology - Follow Up Patients - Spacing for follow Up Patients receiving BOTOX | R | Month 1 | Green | 2 | 2 |
| SUR-20 | Urology - Workforce - Associate Specialist Vacancy | R | Month 1 | Green | 24 | 24 |
| SUR-21 | Divisional Management - Medication - Sports Medicine review | R | Month 1 | Red | 0 | 0 |
| SUR-22 | Haematology - SLA - Bristol SLA | R | Month 1 | Green | 4 | 4 |
| SUR-23 | Haematology - Workforce - Admin team maternity leave | R | Month 1 | Green | 7 | 7 |
| SUR-24 | Haematology - Study - POLARIS-2; Study of Olverembatinib | R | Month 1 | Red | 0 | 0 |
| SUR-25 | Haematology - Workforce - Registrar to be recharged to another non surgical Directorate | R | Month 1 | Green | 15 | 15 |
| SUR-26 | Oral and Maxillofacial Services - Orthodontic Brackets - Reduce costs for Orthodontic brackets | R | Month 1 | Green | 4 | 4 |
| SUR-27 | Dermatology - IMF - ABUHB Pathology to delivery IMF (Indirect immunofluorescence) | R | Month 1 | Red | 0 | 0 |
| SUR-28 | Ear, Nose and Throat - Consumables - Review consumable usage for ENT treatment room | R | Month 1 | Green | 2 | 2 |
| SUR-29 | Trauma and Orthopaedics - Consumables - Review of generic theatre consumables charged to T&O | R | Month 1 | Green | 3 | 3 |
| SUR-30 | Ophthalmology - Workforce - 2X Consultant Posts | R | Month 1 | Green | 195 | 195 |
| SUR-31 | Ophthalmology - Workforce - Middle Grades starting which will remove agency usage from the service - | R | Month 1 | Green | 276 | 276 |
| SUR-32 | Ophthalmology - Medication - Conversion of 2mg Eyelea to 8mg to take advantage of lower price | R | Month 1 | Red | 0 | 0 |
| SUR-33 | Enhancements on Specialist rates | R | Month 1 | Green | 13 | 13 |
| SUR-34 | Medicines Management savings | R | Month 1 | Green | 924 | 924 |
| SUR-35 | Ophthalmology Visco Elastic Savings over the current financial year | R | In Year | Green | 11 | 11 |
| SUR-36 | Drugs | NR | In Year | Green | 0 | 0 |
| SUR-43 | All Wales standard and custom procedure packs | R | In Year | Green | 3 | 3 |
| SUR-44 | 5% Stryker hips and knees | R | In Year | Green | 56 | 56 |
| SUR-45 | Additional saving agreed Sept 26 | NR | In Year | Green | 125 | 125 |
| SUR-46 | Aflibercept (Eylea) 2mg Biosimilar (Mynzepli) | R | In Year | Green | 696 | 696 |
| SUR-47 | Trauma and Orthopaedics - Power Tools lease v purchase | R | In Year | Green | 17 | 17 |
| SUR-48 | Additional saving agreed Sept 26 SUR-45 NR to R | R | In Year | Green | 59 | 59 |
| SUR-49 | Planned Care Efficiency - Surg | NR | In Year | Green | 650 | 650 |
| | | **Original CIP Target:** | | **3,336** | **3,657** | **3,657** |
| | | **Distance from target (over)/under** | | **(321)** | | |

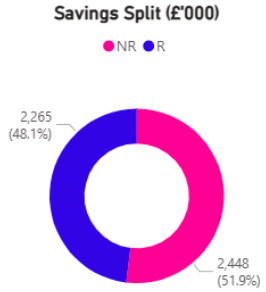
## Divisional analysis – Clinical Support Services




Key drivers of outturn deficit:

- £2.4m operational pressures in PACCT, Non-Pay in Theatres of circa £1m and £1.2 in Critical Care for Nursing Variable pay (mat leave, sickness & winter impact) and non-pay.
- £0.4 winter cost pressures
- (£1.3m) operational underspend in diagnostics (pathology & radiology) – vacancy, additional income & savings
- £0.4 other




Savings summary (£'000)

| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| Medicines Management | 7 | 16 | 14 | -2 | 16 | 14 | -2 |
| Procurement & Non-pay | 49 | 1,044 | 2,768 | 1,724 | 1,044 | 2,768 | 1,724 |
| Workforce | 15 | 378 | 1,931 | 1,553 | 378 | 1,931 | 1,553 |
| **Total** | **71** | **1,438** | **4,712** | **3,275** | **1,438** | **4,712** | **3,275** |

| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD | Full year |
|---|---|---|---|---|---|---|
| | | | | | Achieved £'000 | Forecast £'000 |
| CSS-01 | Sysmex Maintenance Savings | R | Month 1 | Green | 178 | 178 |
| CSS-02 | Siemens KPI review | R | Month 1 | Green | 50 | 50 |
| CSS-03 | Sysmex MSC KPIs | R | Month 1 | Green | 5 | 5 |
| CSS-04 | Factor 8 Repatriation | R | Month 1 | Green | 6 | 6 |
| CSS-05 | WBS Commercial Products | R | Month 1 | Green | 6 | 6 |
| CSS-06 | Restructure of Management Positions | NR | Month 1 | Green | 13 | 13 |
| CSS-08 | Enhancements on Specialist Rates | R | Month 1 | Green | 392 | 392 |
| CSS-10 | Critical Care HCSW Variable Pay | R | Month 1 | Green | 20 | 20 |
| CSS-11 | Hepzyme Repatriation | R | Month 1 | Green | 0 | 0 |
| CSS-12 | P3NP Repatriation | R | Month 1 | Green | 3 | 3 |
| CSS-13 | JCC funding for liver ablations | NR | Month 1 | Green | 162 | 162 |
| CSS-14 | IPFR income | NR | Month 1 | Green | 70 | 70 |
| CSS-15 | Ablation needles | R | Month 1 | Green | 5 | 5 |
| CSS-16 | Maintenance contracts for new DR equipment - NR | NR | Month 1 | Green | 30 | 30 |

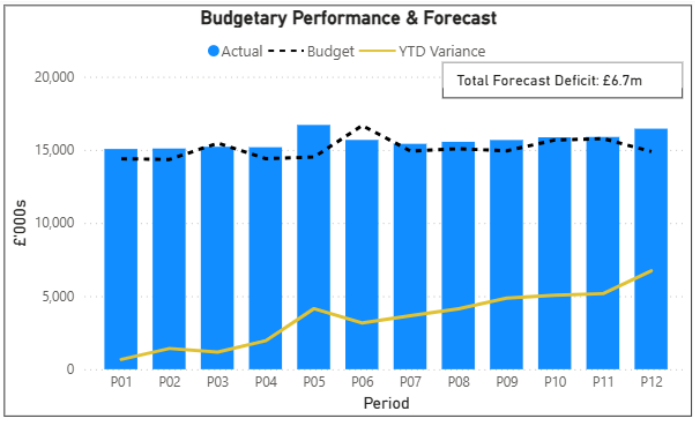
## Clinical Support Services continued...

| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD | Full year |
|---|---|---|---|---|---|---|
| | | | | | Achieved £'000 | Forecast £'000 |
| CSS-17 | Contrast bought in 24/25 | NR | Month 1 | Green | 200 | 200 |
| CSS-18 | Blood Products from 24/25 Year End | NR | Month 1 | Green | 100 | 100 |
| CSS-19 | Additional Everlight reporting in 24/25 | NR | Month 1 | Green | 46 | 46 |
| CSS-20 | Image Intensifier Maintenance | NR | Month 1 | Green | 16 | 16 |
| CSS-21 | Decomissioning of Fuji Equipment on current contracts | NR | Month 1 | Green | 22 | 22 |
| CSS-22 | C&V Ultrasound | NR | Month 1 | Green | 10 | 10 |
| CSS-23 | Cell Salvage income rebate | NR | Month 1 | Green | 47 | 47 |
| CSS-24 | Clariscan to Dotograf switch | R | Month 1 | Green | 8 | 8 |
| CSS-25 | Co-trimoxazole IV | R | In Year | Green | 1 | 1 |
| CSS-26 | Lumicare | R | In Year | Green | 25 | 25 |
| CSS-27 | Critical Care RN Variable Pay | R | In Year | Green | 596 | 596 |
| CSS-35 | Radiology Maintenance contracts | NR | In Year | Green | 153 | 153 |
| CSS-36 | Bis Monitoring - Supplier change | R | In Year | Green | 29 | 29 |
| CSS-37 | Recycled Paper | R | In Year | Green | 2 | 2 |
| CSS-38 | Medical Workforce - Intensity banding review | R | In Year | Green | 11 | 11 |
| CSS-39 | Medical Workforce Variable Pay Spend | R | In Year | Green | 33 | 33 |
| CSS-40 | Medicines Management - Green | R | In Year | Green | 15 | 15 |
| CSS-41 | Medical Workforce Variable Pay Spend (Consultant) | R | In Year | Green | 7 | 7 |
| CSS-42 | Medical Workforce Variable Pay Spend (Juniors/Middle Grades) | R | In Year | Green | 63 | 63 |
| CSS-43 | Additional IPFR Income (Powys) | NR | In Year | Green | 8 | 8 |
| CSS-44 | Outsourcing, linked to acute demand, Audit and deep dive. Reduce Forecast to match YTD run rate (8% | R | In Year | Green | 117 | 117 |
| CSS-45 | Mycology Testing (PHW) | R | In Year | Green | 11 | 11 |
| CSS-46 | Contract Funerals | R | In Year | Green | 5 | 5 |
| CSS-47 | Serosep Contract | R | In Year | Green | 16 | 16 |
| CSS-48 | Cessation of Weekend Enhancement Pay | R | In Year | Green | 17 | 17 |
| CSS-49 | Utilisation of Blood Bikes | R | In Year | Green | 6 | 6 |
| CSS-50 | Syphilis Repatriation | R | In Year | Green | 10 | 10 |
| CSS-51 | Leica Bond III Contract | R | In Year | Green | 30 | 30 |
| CSS-52 | Siemans MSC KPIs (Part 2) | NR | In Year | Green | 0 | 0 |

## Clinical Support Services continued...

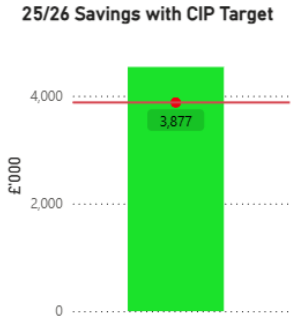
| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD | Full year |
|---|---|---|---|---|---|---|
| | | | | | Achieved £'000 | Forecast £'000 |
| CSS-53 | Reduction in Carriage Charges | R | In Year | Green | 1 | 1 |
| CSS-54 | Liver ablations | NR | In Year | Green | 258 | 258 |
| CSS-55 | Reduction in Health Protection testing | NR | In Year | Green | (0) | (0) |
| CSS-56 | New locum recruitment | R | In Year | Green | 10 | 10 |
| CSS-57 | Savings on additional hours by recruiting locum consultant | R | In Year | Green | 0 | 0 |
| CSS-58 | Reduction in Health Protection testing | NR | In Year | Green | 0 | 0 |
| CSS-59 | Risp reduced penalty | NR | In Year | Green | 312 | 312 |
| CSS-60 | Medical Illustration - Photo Materials | R | In Year | Green | 11 | 11 |
| CSS-61 | Staff Slippage | NR | In Year | Green | 29 | 29 |
| CSS-62 | RDC closure | R | In Year | Green | 42 | 42 |
| CSS-63 | Additional Out of Area IR income Powys | NR | In Year | Green | 14 | 14 |
| CSS-64 | Additional Out of Area IR income CTM | NR | In Year | Green | 66 | 66 |
| CSS-65 | Contrast switch Omnipaque to Optiray | R | In Year | Green | 6 | 6 |
| CSS-66 | BTW additional Income for increase in consultant sessions | R | In Year | Green | 69 | 69 |
| CSS-67 | Dart Support | R | In Year | Green | 2 | 2 |
| CSS-68 | Theatres Par Level Review - GUH | NR | In Year | Green | 46 | 46 |
| CSS-69 | Haloperidol Tablets to liquid switch | R | In Year | Green | 1 | 1 |
| CSS-70 | Omnipaque to Optiray | R | In Year | Green | 0 | 0 |
| CSS-71 | Release of Fuji Accrual | NR | In Year | Green | 150 | 150 |
| CSS-72 | Staff Slippage | NR | In Year | Green | 32 | 32 |
| CSS-73 | Cap of WLI's from 3 to 2 per week | R | In Year | Green | 40 | 40 |
| CSS-74 | National priorities - Dapagliflozin generic | R | In Year | Green | 1 | 1 |
| CSS-75 | National priorities - Ticagrelor generic | R | In Year | Green | 0 | 0 |
| CSS-76 | Dantrolene holding rationalisation (Waste prevention) | R | In Year | Green | 4 | 4 |
| CSS-77 | Delayed appointment to Deputy Head of Nursing post | NR | In Year | Green | 14 | 14 |
| CSS-78 | Siemans MSC KPIs (Part 2)NRtoR | R | In Year | Green | 12 | 12 |
| CSS-79 | Reduction in Health Protection testing | R | In Year | Green | 401 | 401 |
| CSS-80 | Planned Care Efficiency - CSS | NR | In Year | Green | 350 | 350 |
| | | | **Original CIP Target:** | **2,998** | **4,412** | **4,412** |
| | | | **Distance from target (over)/under** | **(1,415)** | | |

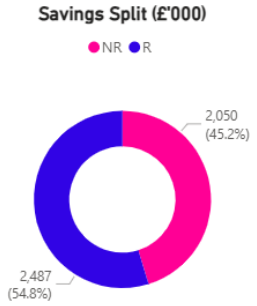
## Divisional analysis – Medicine




Key drivers of outturn deficit:

- Nursing variable pay (vacs, enh care, sickness) £2.837m
- Reduction in savings achievement from bed reconfiguration with regards to timing and number of beds £0.428m
- Drugs (Neuro, Gastro, Resp) £1.320m
- Maintenance Contracts (Gastro, Resp) £0.561m
- 45-minute ambulance handover (ONP) Oct - Mar £0.572m
- Winter ward 29/12/25 - 31/3/26 £0.668m
- Other winter pressures and critical incident £0.350m
- £0.3m Other winter pressures & critical incident




Savings summary (£'000)

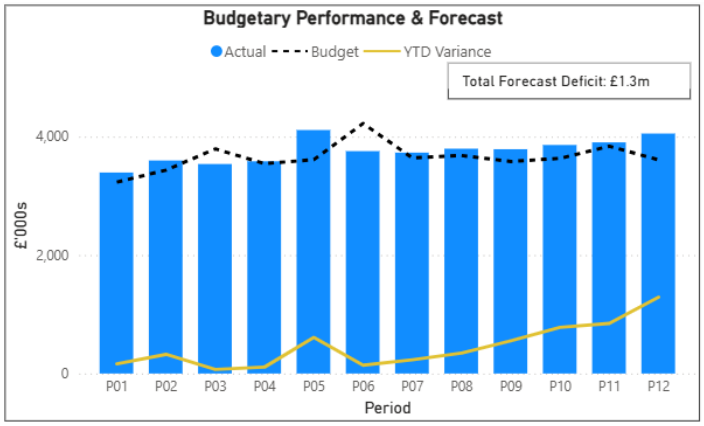
| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| Medicines Management | 13 | 1,072 | 1,938 | 866 | 1,072 | 1,938 | 866 |
| Procurement & Non-pay | 5 | 456 | 384 | -72 | 456 | 384 | -72 |
| Service redesign | 2 | 340 | 1,712 | 1,372 | 340 | 1,712 | 1,372 |
| Workforce | 3 | 382 | 503 | 121 | 382 | 503 | 121 |
| **Total** | **23** | **2,250** | **4,537** | **2,287** | **2,250** | **4,537** | **2,287** |

| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| MED-01 | Biologic Switch of Ustekinumab | R | Month 1 | Green | 850 | 850 |
| MED-02 | Enhancements on Specialist rates | R | Month 1 | Green | 382 | 382 |
| MED-03 | National priorities - Teriparatide generic switch | R | Month 1 | Green | 8 | 8 |
| MED-04 | National priorities - Dimethyl fumerate - Generic switch | R | Month 1 | Green | 409 | 409 |
| MED-05 | National priorities - Omalizumab - transitional contract | R | Month 1 | Green | 0 | 0 |
| MED-06 | National priorities/Best value Biosimilars - Ustekinumab vials | R | Month 1 | Green | 589 | 589 |
| MED-07 | Neurology - Idebenone Homecare Supply | R | Month 1 | Green | 10 | 10 |
| MED-08 | Annual purchase of insulin pumps at preferential rate | NR | Month 1 | Green | 5 | 5 |
| MED-09 | Use of 24/25 purchased CPAP's for 25/26 activity | NR | Month 1 | Green | 247 | 247 |
| MED-10 | Use of 24/25 purchased colon capsules for 25/26 activity | NR | Month 1 | Green | 63 | 63 |
| MED-11 | Use of 24/25 purchasesd equip (leads etc) for 25/26 activity | NR | Month 1 | Green | 23 | 23 |
| MED-12 | Delay in prescribing Budesomide | NR | Month 1 | Green | 1,712 | 1,712 |

## Medicine continued...

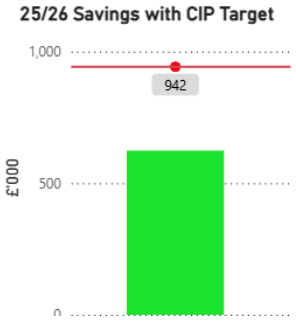
| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| MED-13 | COTE - Denosumab | R | In Year | Green | 0 | 0 |
| MED-14 | Co-trimaxazole IV | R | In Year | Green | 5 | 5 |
| MED-21 | National priorities/Best value Biosimilars - Rituximab biosimilar switch (Rixathon to Truxima) | R | In Year | Green | 1 | 1 |
| MED-22 | Reduction in locum consultants replaced with substantive x3 | R | In Year | Green | 14 | 14 |
| MED-23 | Reduction in RN agency | R | In Year | Green | 107 | 107 |
| MED-24 | Saving in sleep masks | R | In Year | Green | 46 | 46 |
| MED-25 | Switch Acute 30 bedded ward to Community ward | R | In Year | Red | 0 | 0 |
| MED-26 | Haloperidol tablets to liquid switch | R | In Year | Green | 16 | 16 |
| MED-27 | National priorities generic dapagliflozin | R | In Year | Green | 26 | 26 |
| MED-28 | National priorities generic ticagrelor | R | In Year | Green | 18 | 18 |
| MED-29 | National priorities/Best value Biosimilars - Ustekinumab vials Steqeyma | R | In Year | Green | 7 | 7 |
| | | **Original CIP Target:** | | **3,877** | **4,537** | **4,537** |
| | | **Distance from target (over)/under** | | **(660)** | | |

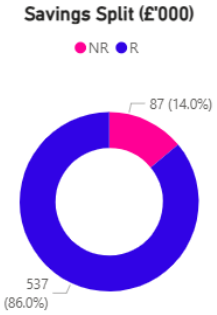
## Divisional analysis – Urgent Care




Key drivers of outturn deficit:

- £0.368m 45-minute ambulance handover
- £0.254m Paeds/CEAU Pilot
- £0.196m Interim Clinical Model due to ED Extension
- £0.146m SDEC Boarding & Triage Nurse Cover
- £0.148m Non-recovery of E-Triage income
- £0.116m 2 x 6 month FTC Consultants



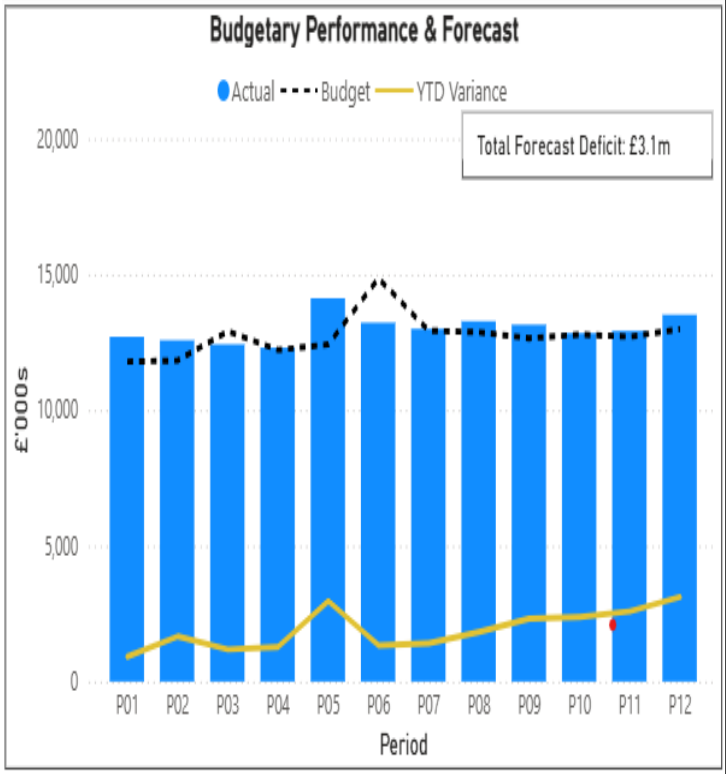




Savings summary (£'000)

| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| Medicines Management | 4 | 0 | 8 | 8 | 0 | 8 | 8 |
| Procurement & Non-pay | 5 | 19 | 21 | 2 | 19 | 21 | 2 |
| Workforce | 4 | 520 | 595 | 75 | 520 | 595 | 75 |
| **Total** | **13** | **539** | **624** | **85** | **539** | **624** | **85** |

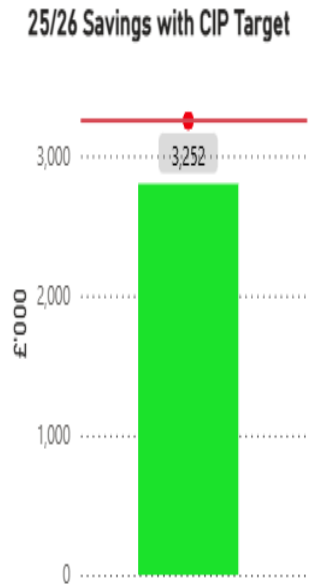
| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| URG-01 | Enhancements on Specialist rates | R | Month 1 | Green | 520 | 520 |
| URG-02 | Switch to a non-ported admin set with pump | R | Month 1 | Green | 2 | 2 |
| URG-03 | changing from the pre-made convenience FICB packs to individual items | R | In Year | Green | 7 | 7 |
| URG-10 | Switch from dual giving set ports to single port | R | In Year | Green | 8 | 8 |
| URG-11 | Close RGH & NHH Transfer Lounge | R | In Year | Amber | 0 | 0 |
| URG-12 | Close RGH MIU Over night | R | In Year | Amber | 0 | 0 |
| URG-13 | Delay Implementation of Medical Model in Flow Centre | NR | In Year | Green | 75 | 75 |
| URG-14 | Source E-Triage Funding | NR | In Year | Green | 0 | 0 |
| URG-15 | Switching to 1 Page Drug Charts | NR | In Year | Green | 4 | 4 |
| URG-16 | Fomeprizole Antidote Replacement | NR | In Year | Green | 6 | 6 |
| URG-17 | National priorities - Dapagliflozin generic | NR | In Year | Green | 0 | 0 |
| URG-18 | National priorities - Ticagrelor generic | NR | In Year | Green | 1 | 1 |
| URG-19 | Dantrolene holding rationalisation (Waste prevention) | NR | In Year | Green | 1 | 1 |
| | | **Original CIP Target:** | | **942** | **624** | **624** |
| | | **Distance from target (over)/under** | | **318** | | |

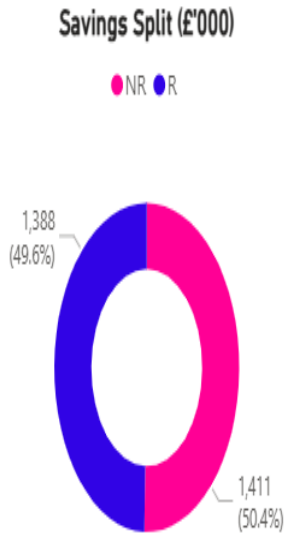
## Divisional analysis – Family & Therapies




Key drivers of outturn deficit:

- £2.0m Medical operational/workforce pressures within Gynae, Neonates, Paediatrics & CAMHS. Substantive Variance - £0.334m - maintaining Medical cover within Paediatrics (£0.674m) offset by Gynae Vacancies (£-0.321m). Variable Pay Variance (Patchwork)- £1.644m –additional costs to cover Sickness (£0.512m), Vacancies (£0.490m), Additional Activity (0.247m), Annual Leave (£0.164m), Restricted Duties £0.077m and CAMHS WLI's (£0.029m)
- £1.8m Maternity operational/workforce pressures, births in month 378, C-Section rate 46.3%Pay - £1.112m – Main reasons being costs of maintaining Maternity staffing cover (£0.757m substantive & £0.355m variable pay) – Maternity leave within Maternity currently around 15.4 wtes
- Non-Pay - £0.671m – Main reasons being increase in clinical supplies costs associated with C Section rates (£0.242m) and blood products costs for 2 patients on IVIG (£0.191m) – Average C Section rate for 25/26 – 44.2%
- £0.1m Winter cost pressures
- (£0.6m) F&T Divisional Manager (£-469k SARC and £-131k mixture of vacancies & non pay underspends), £-130k Diabetic pumps with the remaining £-54k being over other directorates.



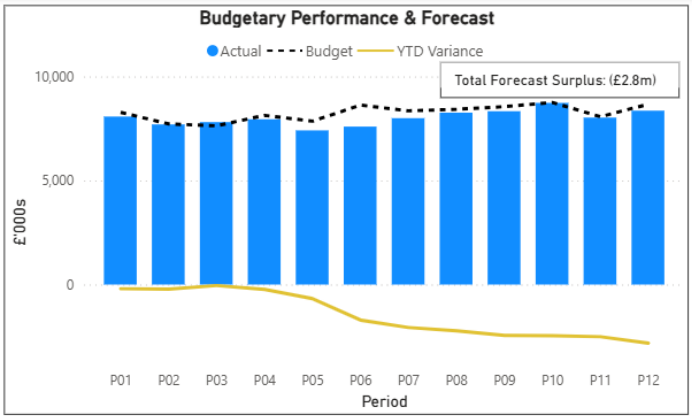




Savings summary (£'000)

| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| Medicines Management | 1 | 63 | 53 | -9 | 63 | 53 | -9 |
| Procurement & Non-pay | 11 | 362 | 1,250 | 888 | 362 | 1,250 | 888 |
| Workforce | 4 | 257 | 1,496 | 1,239 | 257 | 1,496 | 1,239 |
| **Total** | **16** | **682** | **2,800** | **2,118** | **682** | **2,800** | **2,118** |

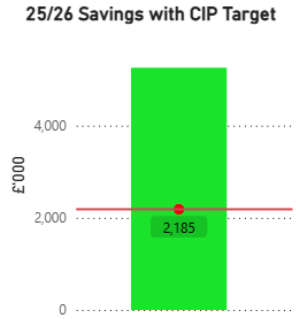
| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| F&T-01 | Divisional drugs savings target | R | Month 1 | Green | 53 | 53 |
| F&T-02 | Health Visiting - Reduction in Rental Charges due to relocation to 19 Hills Health & Wellbeing Centre, | R | Month 1 | Green | 11 | 11 |
| F&T-03 | Actim Prom and Partus | R | Month 1 | Green | 13 | 13 |
| F&T-04 | Non- renewal of Windmill Farm SLA with NPT LA for 25/26 | R | Month 1 | Green | 300 | 300 |
| F&T-05 | Enhancements on Specialist rates | R | Month 1 | Green | 257 | 257 |
| F&T-06 | Cessation of Tafarn Newydd S28A SLA with Torfaen LA | R | Month 1 | Green | 31 | 31 |
| F&T-07 | Giving Sets for Infusion Pumps | R | Month 1 | Green | 2 | 2 |
| F&T-08 | Bulk purchase of Medtronic 780G Diabetic pumps and sensors | NR | Month 1 | Green | 5 | 5 |
| F&T-09 | LYRECO BUDGET WHITE A4 PAPER 80GSM - BOX OF 5 REAMS (5 X 500 SHEETS OF PAPER) Move to Recycle | R | In Year | Green | 2 | 2 |
| F&T-16 | Financial recovery divisional scheme - pay R | R | In Year | Green | 257 | 257 |
| F&T-17 | Financial recovery divisional scheme - pay NR | NR | In Year | Green | 640 | 640 |
| F&T-18 | Financial recovery divisional scheme - Non-Pay R | R | In Year | Green | 99 | 99 |
| F&T-19 | Financial recovery divisional scheme - Non-Pay NR | NR | In Year | Green | 767 | 767 |
| F&T-20 | Financial recovery divisional scheme - Income | NR | In Year | Green | 0 | 0 |
| F&T-21 | The All Wales Standard & Custom Procedure Packs (MED-OJEU-56015) | R | In Year | Green | 20 | 20 |
| F&T-17NRtoR | Financial recovery divisional scheme - pay R | R | In Year | Green | 342 | 342 |
| | | **Original CIP Target:** | | **3,252** | **2,800** | **2,800** |
| | | **Distance from target (over)/under** | | **452** | | |

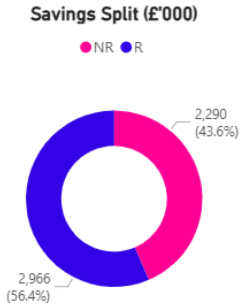
## Divisional analysis – Estates & Facilities




Key drivers of outturn deficit:

- (£1.4m) non-recurring savings linked to one off Utility benefits (£800k metering issues at GUH & £554k correction to prior year accruals)
- (£1.4m) non-recurring savings linked to vacancy slippages
- (£0.5m) Gas consumption below original forecast
- £0.5m inflationary uplift to water rates
- £0.2m backlog maintenance and replacement batteries on Mindray patient monitoring equipment
- £0.08m waste bins purchased to meet new national regulations



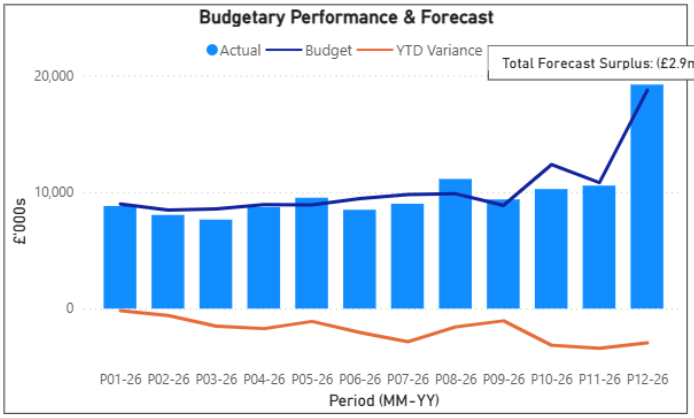




Savings summary (£'000)

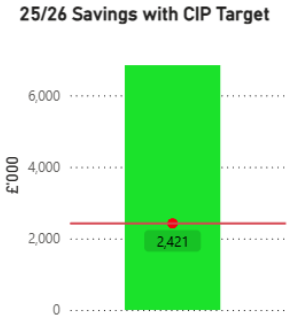
| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| Procurement & Non-pay | 8 | 3,000 | 4,592 | 1,592 | 3,000 | 4,592 | 1,592 |
| Workforce | 4 | 0 | 664 | 664 | 0 | 664 | 664 |
| **Total** | **12** | **3,000** | **5,256** | **2,256** | **3,000** | **5,256** | **2,256** |

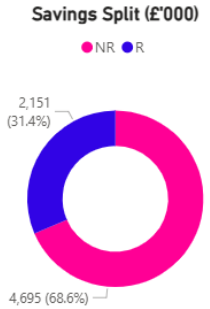
| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| FAC-01 | Chepstow Hospital Unitary Charge | R | Month 1 | Green | 500 | 500 |
| FAC-02 | ENERGY SAVINGS | R | Month 1 | Green | 1,850 | 1,850 |
| FAC-03 | Bed contract savings | R | Month 1 | Green | 250 | 250 |
| FAC-04 | Energy | R | Month 1 | Green | 250 | 250 |
| FAC-11 | Vacancies | NR | In Year | Green | 320 | 320 |
| FAC-11NRtoR | Vacancies | R | In Year | Green | 40 | 40 |
| FAC-12 | Rates rebates | NR | In Year | Green | 80 | 80 |
| FAC-13 | Kintra - Cost plus Credit | NR | In Year | Green | 108 | 108 |
| FAC-14 | Vacancies | NR | In Year | Green | 228 | 228 |
| FAC-14NRtoR | Vacancies | R | In Year | Green | 76 | 76 |
| FAC-15 | Accountancy gain - duplicate meter reading | NR | In Year | Green | 1,354 | 1,354 |
| FAC-16 | Utilities Efficiency | NR | In Year | Green | 200 | 200 |
| | | **Original CIP Target:** | | **2,185** | **5,256** | **5,256** |
| | | **Distance from target (over)/under** | | **(3,071)** | | |

## Divisional analysis – Corporate




- **COO** – Slippage £524k on 26wks/Gatekeeper with balance made up from vacancies/non pay
- **Litigation** - £702k overspend on legal fees
- **Digital** – £585k overspend, unfunded posts £247k, O365 and capital to revenue costs –cloud based systems that can no longer be capitalised £978k offset with underspend in Connecting Care income.
- **CEO** – £904k non-pay budget released to support winter pressures
- **PH** – £1,484k underspend £550k dilapidations accrual release, £185k LA accruals release, £295k underspend on hypertension model and staff underspend due to 2 x consultant vacancies full year staff slippages (-£0.5m)
- **FD** - £426k underspend due to Vacancies £100k and NWSSP Savings £500k, Chepstow PFI £600k offset with an increase in bad debt provision £430k
- **Planning** – £192k underspend vacancies & income from secondments




Savings summary (£'000)

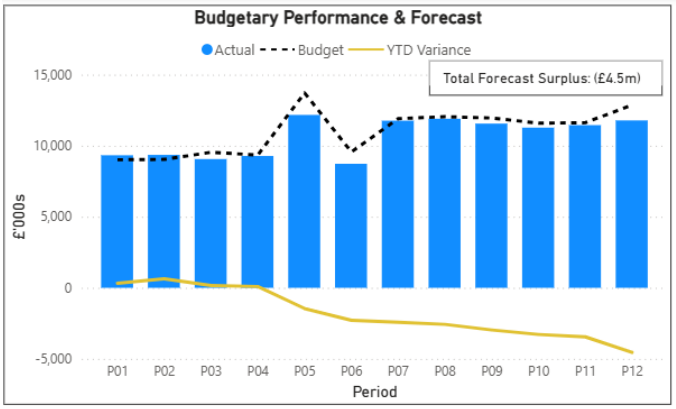
| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| Procurement & Non-pay | 8 | 301 | 1,906 | 1,605 | 301 | 1,906 | 1,605 |
| Workforce | 25 | 2,170 | 4,940 | 2,770 | 2,170 | 4,940 | 2,770 |
| **Total** | **33** | **2,471** | **6,846** | **4,376** | **2,471** | **6,846** | **4,376** |

| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| CORP-01 | Reduction in workforce costs - on call allowance | NR | Month 1 | Green | 70 | 70 |
| CORP-02 | Reduction in non-pay spend | NR | Month 1 | Green | 50 | 50 |
| CORP-03 | Opportunity | R | Month 1 | Green | 151 | 151 |
| CORP-04 | Scheme | NR | Month 1 | Green | 100 | 100 |
| CORP-05 | Opportunity | NR | Month 1 | Green | 100 | 100 |
| CORP-06 | Executive directorate strech target saving | R | Month 1 | Green | 152 | 152 |
| CORP-07 | Executive directorate strech target saving | R | Month 1 | Green | 103 | 103 |
| CORP-08 | Executive directorate strech target saving | R | Month 1 | Green | 149 | 149 |
| CORP-09 | Executive directorate strech target saving | R | Month 1 | Green | 102 | 102 |
| CORP-10 | Executive directorate strech target saving | R | Month 1 | Green | 180 | 180 |

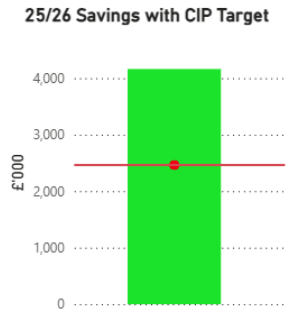
## Corporate continued ...

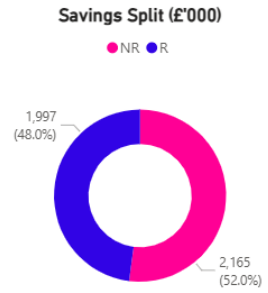
| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| CORP-11 | Executive directorate strech target saving | R | Month 1 | Green | 242 | 242 |
| CORP-12 | Executive directorate strech target saving | R | Month 1 | Green | 207 | 207 |
| CORP-13 | Executive directorate strech target saving | R | Month 1 | Green | 700 | 700 |
| CORP-14 | Executive directorate strech target saving | R | Month 1 | Green | 97 | 97 |
| CORP-15 | Executive directorate strech target saving | R | Month 1 | Green | 29 | 29 |
| CORP-16 | Executive directorate strech target saving | R | Month 1 | Green | 39 | 39 |
| CORP-84 | Accountancy gain- release study leave accrual | NR | In Year | Green | 0 | 0 |
| CORP-85 | Accountancy gain- dispute dilapidations | NR | In Year | Green | 200 | 200 |
| CORP-86 | Accountancy gain- Dispute H&SE fine | NR | In Year | Green | 400 | 400 |
| CORP-88 | Various Directors savings - non pay | NR | In Year | Green | 600 | 600 |
| CORP-89 | Various - slippage on spend plans - presentation to be reviewed | NR | In Year | Green | 405 | 405 |
| CORP-90 | Various Directors savings - vacancies | NR | In Year | Green | 100 | 100 |
| CORP-91 | Savings - Vacancies | NR | In Year | Green | 200 | 200 |
| CORP-92 | Various Directors savings - vacancies | NR | In Year | Green | 100 | 100 |
| CORP-93 | Various Directors savings - vacancies | NR | In Year | Green | 400 | 400 |
| CORP-94 | Various Directors savings - vacancies | NR | In Year | Green | 100 | 100 |
| CORP-95 | Various Directors savings - vacancies | NR | In Year | Green | 167 | 167 |
| CORP-96 | Various Directors savings - vacancies | NR | In Year | Green | 200 | 200 |
| CORP-97 | Various Directors savings - vacancies | NR | In Year | Green | 200 | 200 |
| Corp-98 | Public Health Savings | NR | In Year | Green | 400 | 400 |
| Corp-99 | Pathway Efficiency COO | NR | In Year | Green | 500 | 500 |
| | | **Original CIP Target:** | | **2,421** | **6,846** | **6,846** |
| | | **Distance from target (over)/under** | | **(4,425)** | | |

## Divisional Analysis - Contracting & Commissioning




- The outturn position against the annual budget is a favourable £4,543k. This is due to lower-than-expected contract expenditure, in particular at Velindre Trust, and some material favourable accountancy gains from previous year accruals , plus a benefit from the dispute with CTM for SDEC reporting.



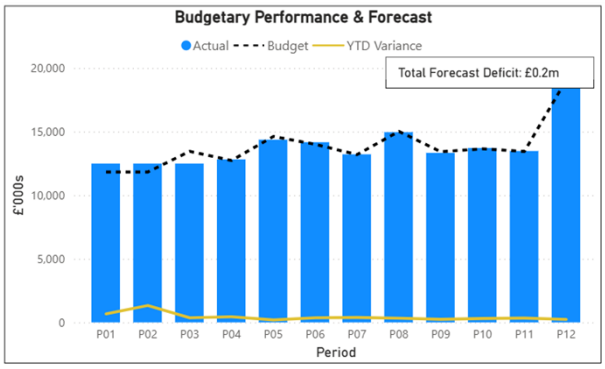




Savings summary (£'000)

| Value & Sustainability Category | Number of schemes | YTD Annual Plan | YTD savings achieved | YTD variance to plan | Full Year: Annual Plan | Full Year: Forecast | Full Year: Variance to Plan |
|---|---|---|---|---|---|---|---|
| Procurement & Non-pay | 11 | 0 | 3,662 | 3,662 | 0 | 3,662 | 3,662 |
| Workforce | 1 | 0 | 500 | 500 | 0 | 500 | 500 |
| **Total** | **12** | **0** | **4,162** | **4,162** | **0** | **4,162** | **4,162** |

| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| Con1 | Accountancy benefit of NHS England end of year position | NR | In Year | Green | 507 | 507 |
| Con10 | Accountancy benefit of NHS England end of year position | NR | In Year | Green | 102 | 102 |
| Con11 | Renegotiation of GH&C Contract Baseline | R | In Year | Green | 194 | 194 |
| Con-12 | Velindre, CTM, England - Commisioning | NR | In Year | Green | 500 | 500 |
| Con2 | Forecast reduced activity- Cardiff LTA | R | In Year | Green | 300 | 300 |
| Con3 | Forecast reduced activity- CTM LTA | R | In Year | Green | 500 | 500 |
| Con4 | Forecast Additional Provider Income | R | In Year | Green | 200 | 200 |
| Con5 | Accountancy benefit - service contracts | NR | In Year | Green | 410 | 410 |
| Con6 | Accountancy benefit - service contracts | NR | In Year | Green | 600 | 600 |
| Con7 | Forecast reduced activity- Velindre LTA | R | In Year | Green | 554 | 554 |
| Con8 | Forecast Additional Provider Income | R | In Year | Green | 250 | 250 |
| Con9 | Accountancy benefit of NHS England end of year position | NR | In Year | Green | 46 | 46 |
| | | **Original CIP Target:** | | **2,463** | **4,162** | **4,162** |
| | | **Distance from target (over)/under** | | **(1,699)** | | |

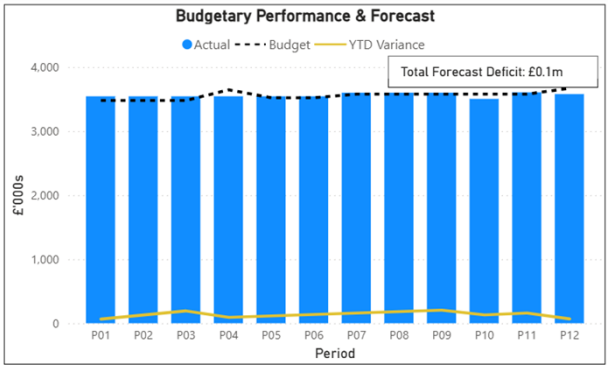
## Divisional Analysis – WHSCC




- Overspend is reflective of the JCC monthly reported position, it represents over performance against the IMTP

| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| | | | | | 0 | 0 |
| | | | | | 0 | 0 |
| | | **Original CIP Target:** | | **3,296** | **0** | **0** |
| | | **Distance from target (over)/under** | | **3,296** | | |

## Divisional Analysis – EASC




- Overspend is reflective of the agreed IMTP

| Savings Scheme Number | Scheme / Opportunity | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD Achieved £'000 | Full year Forecast £'000 |
|---|---|---|---|---|---|---|
| | | | | | 0 | 0 |
| | | | | | 0 | 0 |
| | | **Original CIP Target:** | | **936** | **0** | **0** |
| | | **Distance from target (over)/under** | | **936** | | |

## Reserves

The balance of reserves held as at 31st March is £3.4m, comprising a mixture of recurrent and non-recurrent balances.

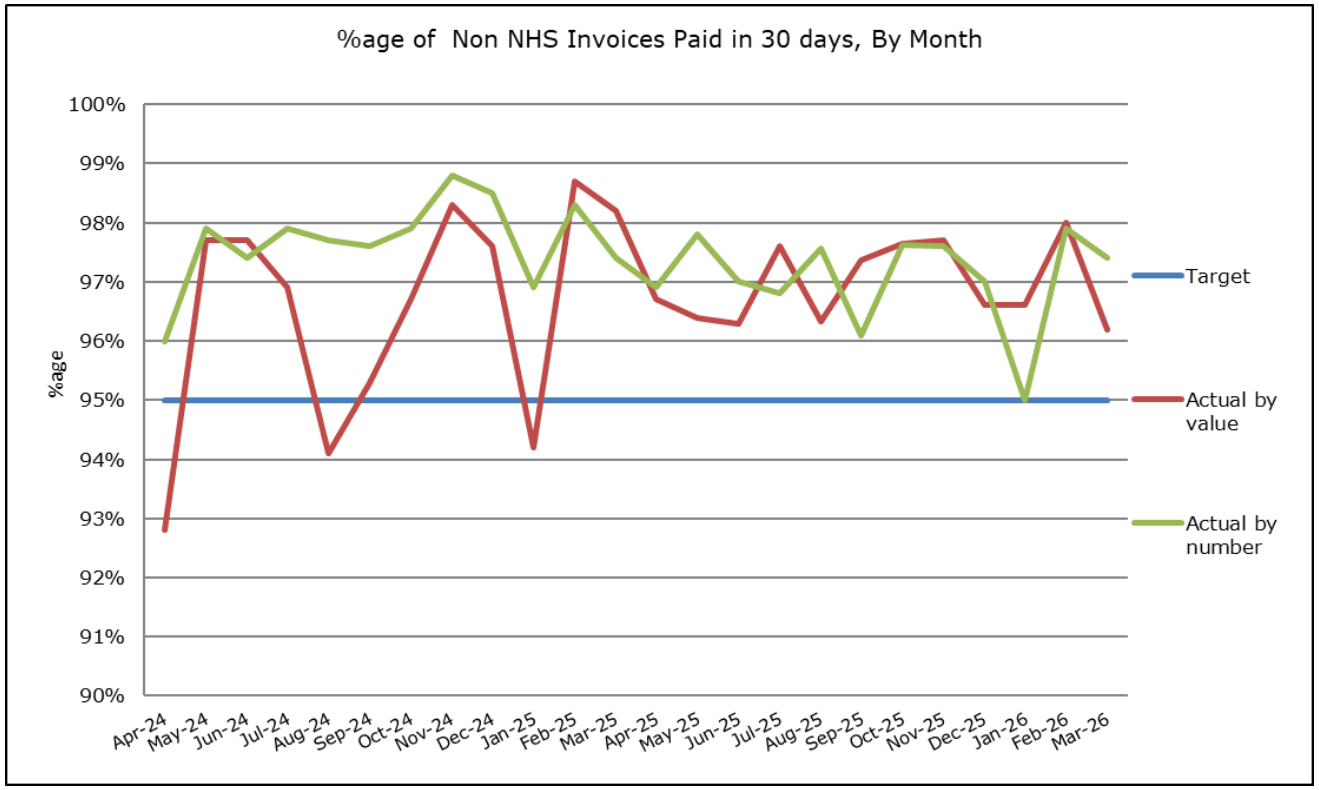
A recurrent value of £13.7m is being retained in reserves, will be allocated to divisions as part of the budget setting exercise in 26/27.

| Description | | | 25/26 |
|---|---|---|---|
| | | **Planned Care Phase 3** | |
| Confirmed | NR | Planned Care - Dermatology Minor Outpatient Procedures | 473,923 |
| Confirmed | | Phase 3 Additional Funding Support | 133,722 |
| Confirmed | | Diagnostic Ophthalmology | 199,420 |
| | | **Planned Care Phase 4 Diagnostics** | |
| Confirmed | NR | Planned Care 2025-2026 - Phase 4 Diagnostics | 104,125 |
| Confirmed | NR | Planned care - Plain film for oral surgery clinics funding anticipation | 13,319 |
| Confirmed | NR | Phase 4 Planned Care Diagnostics - Outpatient conversions | 416,346 |
| Confirmed | NR | Phase 4 diagnostics - additional allocation for 8 week waiters | (255,148) |
| | | **Planned Care Phase 5 104 weeks** | |
| Confirmed | NR | RTT WAITING TIMES Phase 5 Agreed Allocation £1.988m for General Surgery, ENT, Oral surgery, Max fax, and Urology qtr 3 and 4 | 946,235 |
| Confirmed | NR | RTT Waiting Times Phase 5 Agreed Allocation - Ophthalmology (non-Cataract) | 224,036 |
| Confirmed | NR | RTT Waiting Times Phase 5 Agreed Allocation - 104wks additional | 836,577 |
| Confirmed | | phase 5 orthopaedics | 3,770 |
| | | **Month 10 Finance Return Variance** | |
| Confirmed | | Month 10 Finance Return Variance | 684,720 |
| Confirmed | | Orthopaedics q1, q2 | (2,541,728) |
| **Total Commitments** | | | **1,239,317** |

| Description | 25/26 |
|---|---|
| | |
| IT Revenue to Capital April 25 | 29,664 |
| IT Revenue to Capital May 25 | 55,632 |
| IT Revenue to Capital June 25 | 48,690 |
| IT Revenue to Capital Jul, Aug, Sep & Oct 25 | 54,828 |
| IT Revenue to Capital Nov 25 | 20,840 |
| IT Revenue to Capital Dec 25 | 7,128 |
| IT Revenue to Capital Jan 26 | 4,444 |
| IT Revenue to Capital Feb 26 | 9,940 |
| IT Revenue to Capital Mar 26 | 10,684 |
| Recovery of E&F budget delegated for Portacabin - GUH Transfer Lounge | 387,000 |
| 2526 Wage Award Roundings and KCOR | 10,471 |
| Winter provision (m6) | 0 |
| RTT Waiting times Q1 25-26 (General Reserve) | 171,000 |
| RTT Waiting times Q1 25-26 (Infrastructure) | 132,000 |
| Planned Care - infrastructure (GREG) M10 | 66,347 |
| Planned Care - infrastructure (GREG) M11 | 66,957 |
| Winter | (806,594) |
| HCHS initial table roundings | 0 |
| GMS initial table roundings | 0 |
| Dental initial table roundings | 0 |
| NWSSP Savings Rebate | 591,000 |
| Medical training cohort balance of funding | 31,571 |
| Fracture liaison service - risky income assumed - WG confired not an allocat | (321,000) |
| 25/26 Physician Associates - risky income assumed - WG confired not an all | (59,000) |
| VSM/ESP Pay Award | 480 |
| Spinal Mega Clinics Clawback | (651) |
| Investment Reserve | 280,000 |
| Supporting Financial Position (Investment Reserve) | 1,000,000 |
| Balance of all wage awards / NIC 25/26 (exc bank) not delegated | 289,734 |
| National Insurance increase (Ers) 25-26 underfunded by 114k | (113,144) |
| 24/25 bank wage award (full amt is 1.819 but 503k was already anticpated | 294,078 |
| Band 8a+ 24/25 incremental changes - 25/26 & 26/27 impact | 322,000 |
| 25/26 wage award (636 returned for GP OOHs, 85.9 PHW 2627) | 635,542 |
| Core Cost and Demand uplift for 2026-27 (1.11%) | 0 |
| Core Cost and Demand uplift for 2026-27 (1.11%) Mental Health | 0 |
| PLANNED CARE JNL B07 | |
| PLANNED CARE M12 INFRASTRUCTURE | 144,613 |
| GMS IT Refresh | 543,000 |
| Year End m12 spend | (2,023,180) |
| 2526 PAACCS National Resource Adjustment | 143 |
| | 300,000 |
| | |
| **Total Supporting Financial position** | **2,184,217** |

**Cash Position**
The cash balance at the 31st March is £5.551m, which is below the advisory figure set by Welsh Government of £6m.

**Public Sector Payment Policy (PSPP)**
The HB has achieved the target to pay 95% of the number of both NHS and Non-NHS creditors within 30 days of delivery of goods/services in March 2026. Cumulatively, the HB has achieved the statutory 95% target for Non-NHS creditor invoices for the 2025/26 Financial Year. However, the issues reported in previous months' have had an impact on the cumulative NHS target, which has not been achieved in 2025/26.

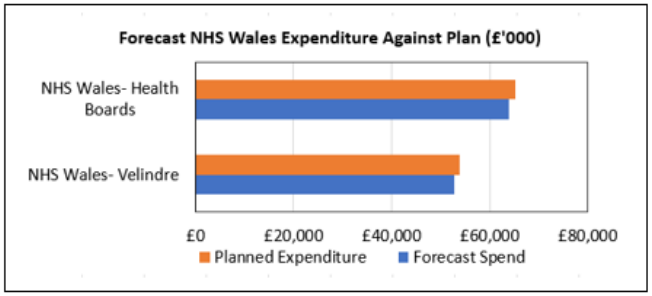


## Contracting and Commissioning – LTA Spend & Income

**Month/Financial Year:-** Month 12 (March) 2025-26

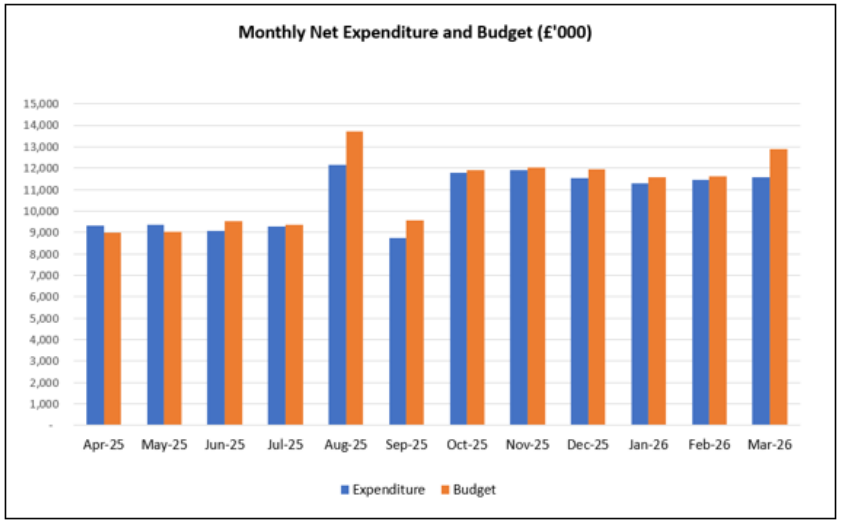
At Month 12 the year to date financial performance for Contracting and Commissioning is £4,543k underspend against the delegated budget.

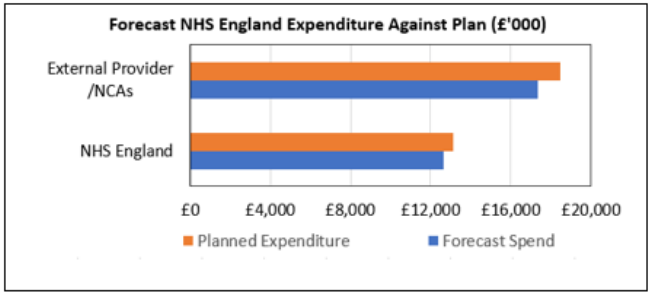
The key elements contributing to this position at Month 12 are as follows:




**NHS Wales Expenditure**

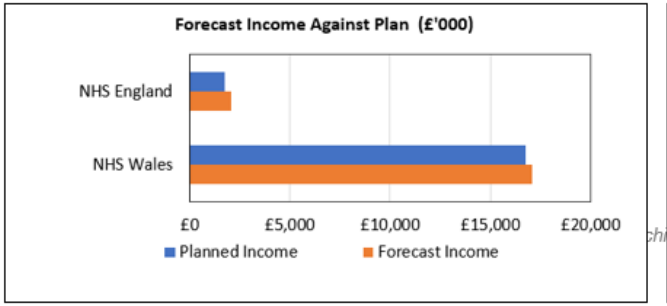
Expenditure in NHS Wales contracts is based on provider monitoring returns and is c£750k less than plan due to lower activity and recharged services at Cwm Taf and Cardiff and Vale and a further £1,100k less after receiving a revised lower forecast from Velindre Trust




**NHS England Expenditure**

Contract Expenditure with NHS England organisations is c£500k less than plan due to favourable settlements of 24/25 final balances following successful challenges by the commissioning team




**Provider Income**

Provider income is c£600k more than plan in 25/26 following higher activity levels in months 1-11 for Powys NHS England and other commissioners

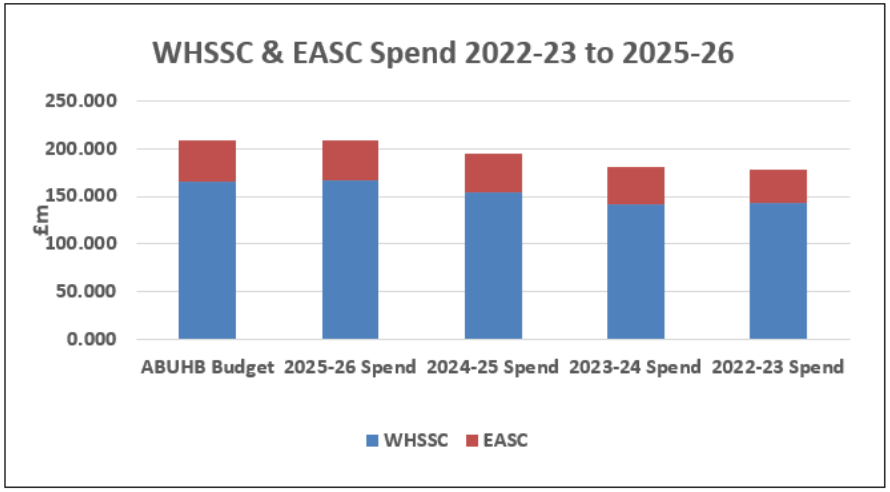
**Key Issues 2025-26**

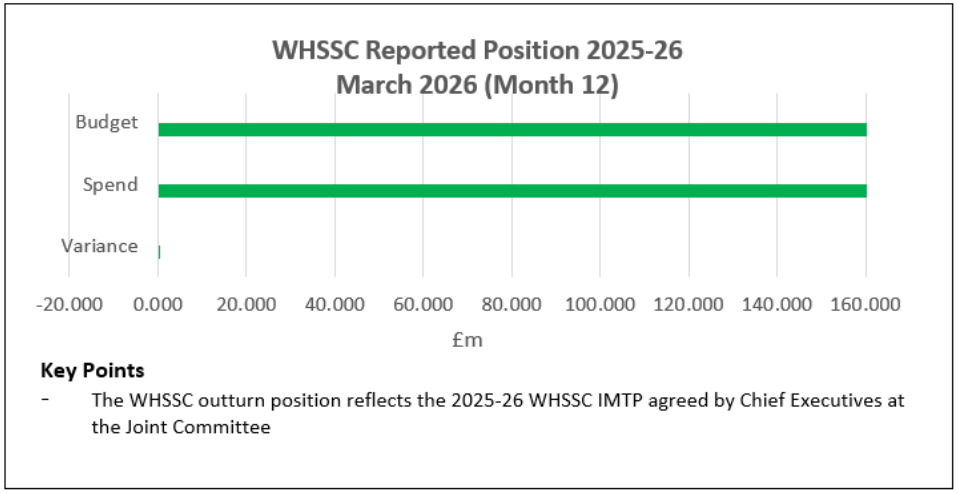
- All LTAs have been agreed ahead of the WG deadline and have been signed by ABUHB.
- A recurrent annual saving of £1.8m from 2024/25 LTA negotiations with Cwm Taf was achieved against a target of £300k which resulted in a £1.5m recurrent benefit within the 'underlying' HB position.
- The expenditure being forecast for cancer services at Velindre is in line with the provider monitoring return (c£2m growth on 2024/25)
- An additional c£3.5m budget was delegated from M3 and has been allocated across the contracts for M4 reporting in line with the IMTP submission
- Additional budget was received and anticipated relating to regional ophthalmology 2025/26 from month 5 on behalf of Cwm Taf, Cardiff and Aneurin Bevan Health Boards

**JOINT COMMISSIONING COMMITTEE (formerly WHSSC & EASC) Financial Position 2025-26**

**Period:** Month 12 2025-26

The Month 12 financial position for the JCC is a forecast overspend of £0.301m. The position reflects the agreed IMTP and the 2025-26 budget delegation for the Specialised Services (formerly WHSSC) and EASC elements.




**Key Points**

- The WHSSC outturn position reflects the 2025-26 WHSSC IMTP agreed by Chief Executives at the Joint Committee

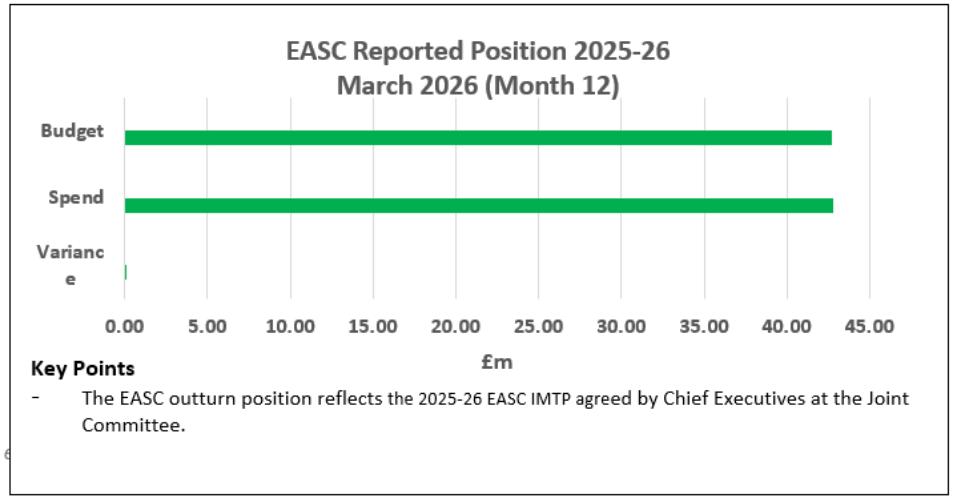
**Key Issues 2025-26**

**Specialised Services**

- The outturn position is based on the agreed IMTP and reported in year overperformance in respect of C&VUHB LTA performance, Individual Patient Treatments offset by slippage on developments

**EASC**

- The outturn position is based on the agreed IMTP and reported in year overperformance.




**Key Points**

- The EASC outturn position reflects the 2025-26 EASC IMTP agreed by Chief Executives at the Joint Committee.

## Balance Sheet

| Balance sheet as at 31st March 2026 | 2025/26 Opening balance £000s | 31st March 2026 £000s | Movement £000s |
|---|---|---|---|
| **Fixed Assets** | **945,668** | **1,003,597** | **57,929** |
| **Other Non current assets** | **111,489** | **143,072** | **31,583** |
| **Current Assets** | | | |
| Inventories | 10,433 | 9,794 | (639) |
| Trade and other receivables | 167,220 | 177,858 | 10,638 |
| Cash | 4,823 | 5,551 | 728 |
| Non-current assets 'Held for Sale' | 0 | 0 | 0 |
| Total Current Assets | **182,476** | **193,203** | **10,727** |
| **Liabilities** | | | |
| Trade and other payables | 221,140 | 232,094 | 10,954 |
| Provisions | 207,724 | 245,761 | 38,037 |
| | **428,864** | **477,855** | **48,991** |
| | **810,769** | **862,018** | **51,249** |
| **Financed by:-** | | | |
| General Fund | 610,494 | 612,791 | 2,297 |
| Revaluation Reserve | 200,275 | 249,226 | 48,951 |
| | **810,769** | **862,018** | **51,249** |

**General Fund:** This represents the difference in the year-to-date resource allocation budget and actual cash draw down including capital.

**Fixed Assets:-** The main movements since the end of 2024/25 relate to:

- Increase of £43.4m-capital prog. purchase additions, £0.2m Charitable Funds capital purchase.
- Increase of £93.8m upwards revaluations due to by Indexation for land and buildings.
- Decrease of £31.3m-impairment of assets under construction coming into use and written off.
- A decrease of £45.95m due to depreciation charged in year.
- A net decrease of £2.2m in renewals and depreciation for IFRS16 leased assets

**Other Non-Current Assets**: This relates to a significant increase in Welsh Risk Pool claims due in more than one year of £33.4m and a decrease in intangible assets of £1.9m since the end of 2024/25.

**Inventories:** The decrease in year relates to changes in stock held within the divisions following the annual stocktake

**Current Assets, Trade & Other Receivables:** Main movements since the end of 2024/25 relate to:

- A decrease in the value of debts outstanding on the Accounts Receivable of £2.5m
- A net increase in the value of both NHS & Non-NHS accruals of £3.1m, of which £2.8m relates to an increase Non-NHS accruals and £0.3m relates to a decrease in NHS Accruals.
- An increase in the value of Welsh Risk Pool claims due in less than one year totalling £6.9m
- A increase in VAT and other debtors since of the end of 24/25 of £0.3m
- An increase in the value of prepayments held £2.8m

**Cash:** The cash balance held at the end of March is £5.551m.

**Liabilities, Trade & other Payables:**
The movement since the end of 2024/25 relates to a number of issues, the most significant of which are:-

- An increase in Capital accruals (£1.3m)
- An increase in NHS Creditor accruals (£0.5m)
- A decrease in the level of invoices held for payment from the year end (£1.5m) offset by increase to GRNI (£3.7m)
- An increase in non NHS accruals (£6.3m)
- An increase in Tax & Superannuation (£3.9m)
- A decrease in other creditors (£1.3m)
- A decrease in the liability for lease payments (£2.01m)

**Provisions:**

- Due to an overall increase in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £36.6m and an increase in other provisions (including CHC) of £1.4m.

## Health Board Income
## WG Funding Allocations: £2.02bn

**Confirmed Allocations as at March 2026 (M12 2025/26)**

| | £'000 |
|---|---|
| HCHS | 1,820,096 |
| GMS | 126,273 |
| Pharmacy | 38,151 |
| Dental | 38,476 |
| **Total Confirmed Allocations - March 2026** | **2,022,996** |
| **Plus Anticipated Allocation - March 2026** | **-** |
| **Total Allocations - March 2026** | **2,022,996** |

## Other Income:

The HB received income from a number of sources other than WG, at the end of this financial year this totalled £125m. (£125m for 24/25). The majority of this income was delegated to budget holders and therefore netted against their delegated budget positions. The main areas for income are: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Full year funding (allocations & income) for the UHB this year totalled £2.15bn (£2bn for 24/25).

**WG Revenue Resource Limit : Anticipated Allocations (March)**

| Funding Type | Description | Value £'000 | Recurrent / Non Recurrent |
|---|---|---|---|
| | | | |
| | **Total Anticipated: Per Ledger** | - | |

| | |
|---|---|
| **Total Confirmed 2025/26 Allocations - May 2025** | **2,022,996** |
| **Total 2025/26 Allocations - March 2026** | **2,022,996** |

# Capital Planning & Performance Month 12 2025/26

| Summary Capital Plan Month 12 2025/26 | 2025/26 | | | | |
|---|---|---|---|---|---|
| | Original Plan £000 | Revised Plan £000 | Spend to M12 £000 | Final Outturn £000 | Variance £000 |
| **Source:** | | | | | |
| **Discretionary Capital:** | | | | | |
| Approved Discretionary Capital Funding Allocation | 12,875 | 12,875 | | 12,875 | 0 |
| Less Targeted Estates Fund Contribution | -3,762 | -2,862 | | -2,862 | 0 |
| Less AWCP Brokerage 2024-25 | -3,353 | -3,235 | | -3,235 | 0 |
| Add AWCP Brokerage 2025-26 | 0 | 2,021 | | 2,021 | 0 |
| NBV of Assets Disposed | 0 | 149 | | 149 | 0 |
| Grants / Donations | 0 | 0 | | 0 | 0 |
| **Total Approved Discretionary Funding** | 5,760 | 8,948 | | 8,948 | 0 |
| **All Wales Capital Programme Funding:** | | | | | |
| AWCP Approved Funding | 12,184 | 34,621 | | 34,621 | 0 |
| **Total Approved and Anticipated AWCP Funding** | 12,184 | 34,621 | | 34,621 | 0 |
| **IFRS16 Lease Funding:** | | | | | |
| Approved IFRS16 Lease Funding | 0 | 2,097 | | 2,097 | 0 |
| IFRS16 CRL reduction for Lease Asset Disposals | 0 | -212 | | -212 | 0 |
| NBV of IFRS16 Leased Asset Disposals | 0 | 212 | | 212 | 0 |
| **Total Approved IFRS16 Lease funding** | 0 | 2,097 | | 2,097 | 0 |
| **Total Capital Funding / Capital Resource Limit (CRL)** | **17,944** | **45,666** | | **45,666** | **0** |
| **Applications:** | | | | | |
| **Discretionary Capital:** | | | | | |
| Statutory Compliance Allocations | 964 | 1,250 | 1,216 | 1,216 | -34 |
| Other Commitments | 1,050 | 1,053 | 1,040 | 1,040 | -13 |
| Commitments b/f from 2024-25 | 544 | 813 | 1,092 | 1,092 | 279 |
| Divisional Priorities | 2,370 | 5,483 | 5,313 | 5,313 | -169 |
| Corporate Priorities | 0 | 350 | 350 | 350 | 0 |
| Remaining DCP Contingency | 832 | 0 | 0 | 0 | 0 |
| **Total Discretionary Capital** | **5,760** | **8,948** | **9,011** | **9,011** | **63** |
| **All Wales Capital Programme:** | | | | | |
| NHH Satellite Radiotherapy Centre | 1,991 | 926 | 926 | 926 | 0 |
| GUH ED Extension | 1,946 | 2,665 | 2,665 | 2,665 | 0 |
| Head Lease for Chepstow Community Hospital | 60 | 107 | 107 | 107 | 0 |
| 2nd MRI for Grange University Hospital | 2,500 | 2,201 | 2,161 | 2,161 | -40 |
| Centralised Decontamination Unit RGH | 3,925 | 3,778 | 3,639 | 3,639 | -139 |
| RGH – Block 1 and 2 Demolition and Car Park | 269 | 13 | 13 | 13 | 0 |
| Backlog Maintenance 2024-25 | 901 | 1,970 | 1,963 | 1,963 | -7 |
| EFAB - Infrastructure 2024-25 | 0 | 224 | 224 | 224 | 0 |
| YYF Breast Centralisation Unit | 0 | -219 | -219 | -219 | 0 |
| CAMHS Sanctuary Hub | 0 | 104 | 113 | 113 | 9 |
| Housing with Care Fund | 0 | 149 | 135 | 135 | -14 |
| Ty Gwent | 0 | 1 | 1 | 1 | 0 |
| Commercial Research Delivery Wales Equipment 2024-25 | 0 | 12 | 12 | 12 | 0 |
| Diagnostic Equipment and Medical Devices Funding 2024-25 | 0 | 11 | 3 | 3 | -8 |
| Digital Equipment 2024-25 | 0 | 53 | 61 | 61 | 8 |
| End of Year Funding 2024-25 | 0 | 77 | 73 | 73 | -4 |
| IRCF - Abervalley H&WBC | 592 | 132 | 132 | 132 | 0 |
| IRCF - Dixton H&WBC | 0 | 165 | 165 | 165 | 0 |
| Targeted Estates Fund (TEF) | 0 | 7,913 | 7,913 | 7,913 | 0 |
| DPIF - Electronic Prescribing and Medicines Administration (ePMA) | 0 | 920 | 920 | 920 | 0 |
| Non-Radiology Ultrasound Replacement Funding | 0 | 840 | 881 | 881 | 41 |
| DPIF - RISP | 0 | 448 | 448 | 448 | 0 |
| Mental Health Quality & Safety Schemes | 0 | 705 | 697 | 697 | -8 |
| Reinforced Aerated Autoclave Concrete Management, Nevill Hall Hospital | 0 | 393 | 393 | 393 | 0 |
| Hospital Helicopter Landing Site Improvements - 2025-26 | 0 | 28 | 25 | 25 | -3 |
| VAT Recovery Reimbursed to WG (Backlog & EFAB schemes) | 0 | -342 | -342 | -342 | 0 |
| Decarbonisation Project (REFIT) | 0 | 3,969 | 3,969 | 3,969 | 0 |
| DPIF - Connecting Care | 0 | 815 | 815 | 815 | 0 |
| End of Year Funding 2025-26 | 0 | 3,142 | 3,189 | 3,189 | 47 |
| Digital End of Year Funding 2025-26 | 0 | 3,371 | 3,369 | 3,369 | -2 |
| Entonox Cracking Devices | 0 | 11 | 16 | 16 | 5 |
| Generator (Speedboat Procedure) | 0 | 24 | 24 | 24 | 0 |
| VPAG Funding | 0 | 12 | 12 | 12 | 0 |
| Transfer from HEIW for National Programme Theatre Laptop | 0 | 3 | 3 | 3 | 0 |
| **Total AWCP Capital** | **12,184** | **34,621** | **34,510** | **34,510** | **-111** |
| **Total IFRS16 Lease Expenditure** | **0** | **2,097** | **2,097** | **2,097** | **0** |
| **Total Programme Allocation and Expenditure** | **17,944** | **45,666** | **45,619** | **45,619** | **-47** |
| **Underspend against Overall Capital Resource Limit** | | | | | **-47** |

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|---|---|
| **CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN<br>ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING** | |
| **DYDDIAD Y CYFARFOD:<br>DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:<br>MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:<br>TITLE OF REPORT:** | **Key Matters from Committees of the Board** |
| **CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR:** | Rani Dash, Director of Corporate Governance |
| **SWYDDOG ADRODD:<br>REPORTING OFFICER:** | Naomi Murtagh, Board Business Manager |

| **Pwrpas yr Adroddiad<br>Purpose of the Report** |
|---|
| Er Sicrwydd/For Assurance |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

In line with the Health Board's Standing Orders, a number of Board Committees and Advisory Groups have been established. This report provides, for assurance, an overview of the business undertaken by these committees during the reporting period, and highlights key matters for Board consideration, where required.

## Cefndir / Background

The Health Board's Standing Orders, approved in line with Welsh Assembly Government guidance, require that a number of Board Committees and advisory groups be established. The following Committees and advisory groups have been established:

- Audit, Risk and Assurance Committee
- Charitable Funds Committee
- Patient Quality, Safety and Outcomes Committee
- Mental Health and Learning Disabilities Committee
- People and Culture Committee
- Remuneration and Terms of Service Committee
- Partnerships, Population Health and Planning Committee
- Finance and Performance Committee

**Assurance Reporting**

The following Committee assurance reports for the period are included at Appendix 1:

- Mental Health and Learning Disabilities Committee – 24th March 2026
- Finance and Performance Committee – 21st April 2026
- Charitable Funds Committee – 22nd April 2026
- Audit, Risk and Assurance Committee – 28th April 2026
- Patient Quality, Safety and Outcomes Committee – 6th May 2026

**Asesiad / Assessment**

In receiving this report, the Board is contributing to the good governance practice of the organisation in ensuring that Committee business is reported to the Board and any key matters escalated, where appropriate.

**Argymhelliad / Recommendation**

The Board is asked to NOTE for assurance this report, and the updates provided from Health Board Committees.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not Applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br><br>There is no direct link to the Plan associated with this report, however the work of individual committees contributes to the overall implementation and monitoring of the IMTP. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item.<br><br>Not applicable |

| **Gwybodaeth Ychwanegol: Further Information:** | |
|---|---|
| Ar sail tystiolaeth: Evidence Base: | Not Applicable |
| Rhestr Termau: Glossary of Terms: | Included within the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board: | Committee Chairs |

| **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**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Choose an item.<br>Choose an item.<br><br>Not applicable to this specific report, however WBFGA considerations are included within committee's considerations |

| Aneurin Bevan University Health Board<br>Key Issues Report | | | | |
|---|---|---|---|---|
| **Board Date:** | | 20 May 2026 | | |
| **Date of Committee** | | 24 March 2026 | **Report of:** | Mental Health and Learning Disabilities Committee |
| **Quoracy met:** | | Yes | | |
| **1** | Agenda and papers | abuhb.nhs.wales/files/key-documents/mental-health-and-learning-disabilities-committee/mental-health-and-learning-disabilities-committee-final-boardbook-pdf/?ts=1775129922330 | | |
| **2a** | Matters referred to the attention of the Board | **Pressures and Trends in Section 136 Detentions**<br>The Committee highlighted continued pressure and emerging trends in the use of Section 136 detentions. Particular concern was noted in relation to repeat detentions and the increasing reliance on multi-agency response arrangements, which were placing sustained demand on services.<br><br>**Sustainability of Dementia Services Funding**<br>The Committee noted future funding sustainability risks associated with dementia services beyond the current funding period and recognised that uncertainty around longer-term funding could have implications for service continuity and the ability to maintain current levels of provision.<br><br>**Mental Health Digital Maturity**<br>The Committee considered the findings from the Mental Health Digital Maturity Assessment, which indicated limited digital maturity across services. The assessment highlighted the need for sustained investment at both national and local levels to support digital transformation.<br><br>**Impact of the Mental Health Act Bill**<br>The Committee discussed the emerging impacts of the Mental Health Act Bill, particularly in relation to increased workload pressures, workforce capacity challenges and future funding requirements. The Committee noted that further clarity would be required as implementation plans developed, but agreed that the Board | | |

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| | | should be made aware of the anticipated implications to support forward planning and assurance. |
| **2b** | Assurance | **Mental Health Act compliance**<br>The Committee noted improvements in training, documentation quality and reductions in rectifiable errors, alongside strengthened audit and monitoring arrangements.<br><br>**Mental health and CAMHS performance**<br>The Committee received assurance on the sustained compliance against national access standards (Parts 1A and 1B) despite increasing demand and system pressures.<br><br>**Dementia services**<br>The Committee received assurance where significant progress was reported against the All-Wales Dementia Standards, including operational dementia hubs, improved memory assessment pathways and strong workforce engagement.<br><br>**Quality and safety at Maindiff Court**<br>The Committee received a largely positive HIW inspection outcome report and received assurance that action plans were in place to address identified areas for improvement. |
| **2c** | Review of Risks | **Overview of Key Risks**<br>The Committee reviewed the risks within its remit and noted that the key risks remained consistent with those previously reported. These continued to relate primarily to service demand, workforce sustainability, service performance, quality and safety, and enabling infrastructure. The Committee was assured that these risks continued to reflect known pressures across the system.<br><br>**Risks Requiring Ongoing Oversight**<br>The Committee identified specific risks requiring ongoing oversight, including the sustainability of dementia service funding, levels of digital maturity, and the implications of legislative change arising from Mental Health Act reform. The Committee agreed that these areas merited continued monitoring due to their strategic importance and potential impact on service delivery and future planning. |

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| **2d** | Sharing of Learning | **Ensuring Appropriate Detentions**<br>The Committee noted learning and improvement activity arising<br>from ensuring appropriate detentions. These incidents had been addressed through targeted learning, enhanced training and the implementation of corrective actions aimed at preventing recurrence. The Committee<br>was assured that appropriate steps had been taken to embed learning into practice.<br><br>**Incidents, Complaints and Patient Feedback**<br>The Committee noted that incidents, complaints and patient feedback continued to inform service quality improvement across Mental Health services. This learning had contributed to strengthened incident review processes and supported a culture of continuous improvement and responsiveness to patient experience.<br><br>**Inspection Activity**<br>The Committee considered learning arising from inspection feedback, particularly from the Healthcare Inspectorate Wales (HIW) inspection at Maindiff Court. The Committee noted that areas of good practice were identified and commended, including strengths in relational security and ward leadership, providing assurance regarding the quality of care and leadership within the service. |
| **3** | Matters to be Shared with Other Committees | The Committee noted matters for wider consideration through governance arrangements, including:<br><br>Ongoing focus within forward work planning on learning disabilities, children and young people's services, digital maturity, and workforce risks. Continued monitoring and assurance through routine committee structures in relation to dementia service sustainability, digital transformation, and Mental Health Act implementation. |

| Aneurin Bevan University Health Board<br>Key Issues Report | | | | |
|---|---|---|---|---|
| **Board Date:** | | 20 May 2026 | | |
| **Date of Committee** | | 21<br>April 2026 | **Report of:** | **Finance and Performance Committee** |
| **Quoracy met:** | | Yes | | |
| **1** | Agenda and papers | Agenda and Papers | | |
| **2a** | Matters referred to the attention of the Board | The Committee noted continued improvement in planned care performance, including sustained reductions in long waits. Provisional year-end positions indicated that 104-week RTT waits and 52-week outpatient waits had reduced to their lowest levels since 2020, alongside record-low DNA rates. These improvements reflected sustained operational focus following winter pressures.<br><br>The Committee noted that some divisions remained in escalation, including five divisions for finance, Urgent Care for operational delivery and quality and safety, and Mental Health Services for quality and safety. While some improvement had been observed, particularly in ambulance handovers and patient flow, performance was not yet sufficient to support de-escalation.<br><br>The Committee highlighted ongoing financial pressures, including workforce affordability, reliance on non-recurrent measures, uncertainty around national income allocations, and cost growth within Continuing Healthcare.<br><br>The Committee confirmed that matters discussed at the meeting were being managed through established governance and assurance arrangements. | | |

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| **2b** | Assurance | **Performance and Escalation**<br>The Committee received assurance that the revised Performance Management and Accountability Framework strengthened escalation and de-escalation arrangements, clarified expectations for recovery planning, and improved routes for Board-level assurance, with full reassessment planned at year end.<br><br>**Service Performance**<br>The Committee received assurance that improvements in planned care performance were being sustained and that recovery actions were in place for areas of continued challenge, including Urgent Care, cancer performance, diagnostics and childhood immunisation.<br><br>**Finance**<br>The Committee received assurance that financial performance was being actively monitored and managed, with capital expenditure and cash management remaining within approved limits, and continued engagement with Welsh Government regarding income uncertainty.<br><br>**Information Governance**<br>The Committee received assurance that information governance arrangements remained effective, with no reportable incidents to the Information Commissioner's Office and emerging risks actively managed. |
| **2c** | Review of Risks | The Committee reviewed strategic and performance risks relating to sustained system pressures across Urgent and Emergency Care, diagnostics and workforce capacity, recognising that demand and national policy requirements continued to constrain recovery.<br><br>The Committee considered financial risks associated with workforce affordability, Continuing Healthcare cost growth, reliance on non-recurrent measures and uncertainty around national funding, noting that mitigation was being progressed through the Value and Sustainability Programme and IMTP delivery.<br><br>The Committee also reviewed information and digital risks, including cyber security and training compliance, and received assurance that controls remained in place. |

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| **2d** | Sharing of Learning | The Committee recognised the sustained improvement in planned care performance as demonstrating the impact of focused operational grip, productivity initiatives and strengthened performance oversight, alongside clearer escalation arrangements. |
| **3** | Matters to be shared to other Committees | There were no matters identified at this meeting that required referral to other Committees. |

| **Aneurin Bevan University Health Board<br>Key Issues Report** | | | | |
|---|---|---|---|---|
| **Board Date:** | | Wednesday 20th May 2026 | | |
| **Date of Committee** | | Wednesday 22nd April 2026 | **Report of:** | Charitable Funds Committee |
| **Quoracy met:** | | Yes | | |
| **1** | Agenda and papers | Agenda and Papers | | |
| **2a** | Matters referred to the attention of the Board | • **Investment Performance and Market Volatility:** The Committee noted a material unrealised investment loss of £314k at 31 March 2026, reflecting wider market volatility. While there was no immediate cash impact, The Committee agreed this required continued oversight and further assurance.<br>• **Request for Independent Investment Assurance:** The Committee agreed that the CCLA investment fund manager should attend a future meeting to provide assurance on investment performance, risk and asset allocation. Preparatory work would also commence to inform re-procurement of the investment management contract ahead of its expiry in March 2027.<br>• **Use of Surplus Reserves to Support Commitments:** To ensure delivery of previously approved bids, the Committee approved the transfer of £69k from surplus reserves to the general charitable fund. This was judged an appropriate and proportionate response to an over-committed position for 2026/27.<br>• **Learning from Oversight of Slow-Moving Funds:** Continued reductions in the number and overall value of funds with | | |

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| | | balances over £25k were noted. The Committee reinforced expectations regarding fundholder engagement and stewardship, highlighting the importance of timely use of funds in line with donor intent.<br>• **Positive Progress in Charity Profile and Governance:** The Committee noted successful registration with the Fundraising Regulator, introduction of a refreshed bilingual charity brand aligned to NHS values, and pilot use of digital donation boxes, strengthening public confidence and future fundraising capability. |
| **2b** | Assurance | • **Financial Position and Fund Accessibility:** The Committee received assurance that charitable funds remained accessible if required, including confirmation that investments could be liquidated where necessary. Planned drawdowns were in place to support approved commitments.<br>• **Management of Temporary Overdrawn Position:** While the general charitable fund was temporarily overdrawn at 31 January 2026, this was a planned position, with assurance received that anticipated 2025/26 investment income was expected to restore the balance, subject to year-end confirmation.<br>• **Robust Governance of Bids and Grants:** The Committee received assurance that all bids and grants were subject to strengthened scrutiny, including Executive Committee review to ensure alignment with charitable purpose and confirmation that funding did not replace core NHS provision.<br>• **Compliance and Legislative Assurance:** The Committee was assured that there were no new legislative or regulatory changes impacting the Charity and that operations continued to comply fully with charity law and regulatory requirements.<br>• **Financial Control and Governance Frameworks:** Assurance was received that the Financial Control Procedure was maintained as a live document, updated throughout the year, |

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| | | and aligned with operational practice and regulatory expectations. |
| **2c** | Review of Risks | • **Investment and Market Risk:** Ongoing market volatility presents a risk to future investment returns, particularly following the reported unrealised loss. Further assurance and contract re-procurement planning was identified as key mitigations.<br>• **General Fund Sustainability Risk:** The temporary overdrawn position of the general charitable fund posed a short-term sustainability risk, mitigated through planned investment income and the approved transfer from surplus reserves**.**<br>• **Slow-Moving Fund Risk:** Although improvements were evident, continued non-engagement by some fundholders could limit charitable impact and present stewardship and reputational risks if not addressed.<br>• **Capacity and Delivery Risk:** The Committee recognised the need to balance increasing charitable activity and ambition with available governance and operational capacity to ensure effective oversight and delivery. |

| **Aneurin Bevan University Health Board<br>Key Issues Report** | | | | |
|---|---|---|---|---|
| **Board Date:** | | Wednesday 20th May 2026 | | |
| **Date of Committee** | | Tuesday 28th April 2026 | **Report of:** | Audit, Risk and Assurance Committee |
| **Quoracy met:** | | Yes | | |
| **1** | Agenda and papers | abuhb.nhs.wales/files/key-documents/audit-risk-and-assurance-committee/arac-20260428-final-boardbook-2-pdf/?ts=1777446912992 | | |
| **2a** | Matters referred to the attention of the Board | **Strong financial governance maintained:** The Committee noted that all financial policies are within review cycles, no reportable losses were identified, and the Health Board continues to be the top | | |

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| | | performer in Wales against the Public Sector Payment Policy.<br><br>**Progress in closing audit recommendations:** The Committee noted that 29 recommendations have been completed; however, this is offset by 80 remaining live recommendations.<br><br>**Concern regarding delayed and long-outstanding actions:** The Committee expressed concern about the volume of older and repeatedly deferred recommendations, particularly high-priority actions, highlighting a need for stronger delivery planning and pace of improvement.<br><br>**Digital transformation learning:** The Committee noted that external audit work identified progress but also highlighted the need to strengthen governance, oversight, cyber assurance, and digital workforce capacity.<br><br>**Limited assurance areas (private session):** The Committee considered reviews with limited assurance ratings (Speaking Up Safely and Emergency Department Extension), highlighting areas of ongoing concern and the need for sustained management action and follow-up. The Committee also received the Audit Wales General Medical Services (GMS) Contract Challenges report. |

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| **2b** | Assurance | The Committee was able to take a **reasonable level of assurance** in the following areas:<br><br>**Annual accounts preparation:** Progress remains on track, with no current concerns raised by Audit Wales.<br><br>**Internal audit programme:** Delivery is largely complete, with multiple areas assessed as providing reasonable assurance, and a draft overall opinion of reasonable assurance anticipated.<br><br>**External audit planning:** Audit Wales confirmed that planned work is progressing as expected, with no significant issues identified at this stage.<br><br>**Counter fraud arrangements:** An approved, risk-based work plan is in place, aligned to national strategy and legislation. |
| **2c** | Review of Risks | The Committee reviewed key areas of risk and noted the following:<br><br>**Delivery risk relating to audit recommendations:** A significant number of outstanding and deferred recommendations presents a risk to timely improvement and mitigation of known control weaknesses.<br><br>**Records management:** Continued weaknesses following previous limited assurance, with reliance on longer-term digital solutions, present an ongoing risk requiring sustained oversight.<br><br>**Digital transformation and cyber assurance:** External audit findings identified gaps in governance, oversight, and workforce capability, representing strategic delivery risks.<br><br>**Workforce capacity risks:** Internal audit work, particularly in Occupational Health, highlighted ongoing pressures affecting service resilience and sustainability.<br><br>**Emerging fraud risks:** Increasing sophistication of fraud, including AI-enabled |

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| | | recruitment risks, requires continued strengthening of preventative controls and awareness. |

| Aneurin Bevan University Health Board<br>Key Issues Report | | | | |
|---|---|---|---|---|
| **Board Date:** | | Wednesday 20th May 2026 | | |
| **Date of Committee** | | Wednesday 6th May 2026 | **Report of:** | Patient, Quality, Safety and Outcomes Committee |
| **Quoracy met:** | | Yes | | |
| **1** | Agenda and papers | Agenda and Papers | | |
| **2a** | Matters referred to the attention of the Board | **Quality Intelligence and Qlik Analytics Platform:** The Committee received an update on the development of the Qlik analytics platform as part of the Health Board's Quality Strategy. The system brings together multiple data sources, including incident reporting, complaints and patient feedback, into a single analytics environment, enabling enhanced intelligence, trend analysis and identification of variation. The Committee recognised the significant benefits in moving from retrospective reporting to proactive intelligence-led quality management, supporting improved oversight at organisational, divisional and ward level. The Committee noted that the platform remained in development, with further work required to validate data and refine Board-level reporting. | | |
| **2b** | Assurance | **Mortality Governance and Patient Safety:** The Committee received strong assurance from the Learning from Deaths report that mortality outcomes did not indicate hidden clinical risk or unsafe care. Structured case note reviews, including 270 cases across key specialties and a further Public Health surveillance review, demonstrated a consistently high standard of care, with only minor issues identified that did not impact patient outcomes. The | | |

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| | | Risk Adjusted Mortality Index and other mortality indicators were reported as stable and performing in line with or better than national peers, providing robust assurance regarding patient safety and clinical effectiveness. |
| **2c** | Review of Risks | **Emerging Risks and Areas for Ongoing Monitoring:** The Committee noted that the Qlik analytics platform remains in development, with risks relating to data validation, system maturity and readiness for Board-level reporting. These risks were being managed through phased implementation, user acceptance testing and ongoing refinement of the system. The Committee also noted an emerging operational risk relating to delays in completion of discharge death notifications, with a corporate audit proposed to further understand the issue and inform improvement actions. |

| Aneurin Bevan University Health Board<br>Key Issues Report | | | |
|---|---|---|---|
| **Board Date:** | 20th May 2026 | | |
| **Period of:** | 05 March 2026 through to 23 April 2026 | **Report of:** | The Executive Committee |
| **Quoracy met:** | N/A | | |

The Executive Committee meets on a weekly basis and focusses on the breadth of the organisation's business. These formal meetings are supplemented by:

- Informal Executive Team Sessions, which are used to focus on strategic developments, information sharing and Executive Team engagement.
- A weekly formal meeting which enables the Executive Team to oversee implementation of the Board's strategic priorities, take decisions and resolve issues which may be impacting delivery.
- A monthly Executive Committee Performance Meeting, which enables the Executive Team to monitor the Health Board's integrated performance to enable a focus on quality, workforce, activity and financial performance.
- Regular Executive Team development sessions focussing on the effectiveness of the Executive Team and its way of working.

Much of the business of the Executive Committee informs onward reporting to the Board's assurance committees, providing assurance to the Board on the effective management of the organisation and achievement of the Board's strategic objectives. The Executive Committee's business also informs much of the Board's formal meeting agendas, given the Executive Team's responsibility for strategy development and its implementation.

The Workplan of the Executive Committee is based on five key areas to ensure appropriate focus, oversight of the organisation's business, and enable the Chief Executive Officer and Executive Team members to discharge their responsibilities effectively:

- Quality, Safety and Culture
- Delivery, Performance and Efficiencies
- Strategic Planning and Service Development
- Strategic Partnership Arrangements

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| • Transformational programmes.<br><br>During the period 05 March 2026 through to 23 April 2026, the following matters were some of the issues considered by the Executive Committee. | | |
| **1** | Quality, Safety and Culture | **Quality and Safety Oversight**<br><br>The Executive Committee maintained close oversight of quality and safety through standing Safety Briefings and established quality surveillance arrangements. The Committee was assured that reporting culture continued to strengthen.<br><br>**Maternity and Neonatal Quality**<br><br>Oversight of Maternity and Neonatal services was strengthened through detailed scrutiny of unplanned caesarean section data and consideration of National Reportable Incidents. Assurance was provided regarding data accuracy and alignment with MBRACE reporting, pending national clarification on reporting thresholds.<br><br>**Mental Health and Learning Disabilities Services**<br><br>The Committee held significant discussions focused on Mental Health and Learning Disabilities services, with recognition of mixed performance and agreement that closer alignment with organisational violence prevention and workforce governance arrangements was required to strengthen assurance.<br><br>**Welsh Risk Pool Compliance**<br><br>The Committee reviewed Welsh Risk Pool penalties and compliance with learning requirements. The Committee agreed that a standard operating procedure would be developed as a priority, supported by Divisional improvement plans, in order to strengthen accountability and compliance.<br><br>**Staff Culture and Wellbeing**<br><br>The Committee considered staff culture and wellbeing, including confidence in raising concerns, learning from internal incidents and staff recognition initiatives. The Committee emphasised the importance of visible leadership, transparent communication and consistent escalation |

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| | | routes. A focussed session with the Board is planned for 17 June 2026.<br><br>**Patient Experience and Feedback**<br><br>The Committee received comprehensive assurance in relation to patient experience. Patient experience remained stable and above All-Wales benchmarks. Performance in early resolution and complaint handling was largely maintained; however, a temporary dip in January was noted, attributable to workforce pressures, with improvement anticipated in subsequent months.<br><br>**Patient Safety, Incidents and Regulation**<br><br>The Committee reviewed patient safety incidents, serious incidents, safeguarding matters and inquests. Areas requiring continued focus were identified, including medication and intravenous fluid incidents and infection prevention and control performance, which remained below All-Wales averages, although improvement actions are in place and progress is being monitored through established governance arrangements. Assurance was provided that mitigation and improvement actions were progressing through established governance arrangements. Oversight of National Reportable Incidents and Never Events continued, with investigations underway and compliance improving. |
| **2** | Delivery, Performance and Efficiencies | **Urgent and Emergency Care Performance**<br><br>Urgent and Emergency Care remained a standing priority across all meetings. The Committee noted ongoing volatility in performance, particularly in relation to discharge, patient flow, ambulance handovers and emergency department waiting times. Assurance was sought that contingency planning, escalation arrangements and short-term capacity measures were in place to mitigate patient safety risk, including periods of anticipated peak demand.<br><br>**Planned Care Delivery and Diagnostics**<br><br>Planned care performance was reviewed in detail, including progress in relation to 104-week waits and diagnostics. The Committee acknowledged that continued active pursuit of the 104-week target was neither affordable nor sustainable |

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| | | within the current context and the Committee supported a revised approach focused on maximising core capacity, safeguarding patients waiting the longest and setting out a clear and honest narrative within planning documentation. Diagnostic backlogs were recognised as an ongoing quality and safety risk requiring close monitoring.<br><br>**Workforce Performance and Capacity**<br><br>Workforce performance remained broadly stable , with some improvements in sickness absence noted. Ongoing risks relating to agency usage, mandatory training compliance and cultural improvement were noted. The Committee supported stronger controls on agency usage and the introduction of enhanced governance through student streamlining and workforce modelling arrangements. |
| **3** | Strategic Planning and Service Development | **Integrated Medium Term Plan (IMTP)**<br><br>Development of the Integrated Medium Term Plan remained a central focus. The Executive Committee scrutinised planning assumptions, trajectories and risks, recognising the challenge of balancing affordability, credibility and deliverability. Assurance was sought that planning remained aligned with national expectations, with further work required to strengthen outcome measures and delivery assurance.<br><br>**Nevill Hall Hospital Strategic Outline Case**<br><br>Updates were received on the Nevill Hall Hospital Strategic Outline Case, noting Welsh Government's decision not to support the proposal in its current form. The Committee supported reframing the approach to progress a shortlist of options into Outline Business Case development and emphasised the importance of a clear, consistent and aligned narrative.<br><br>**Nursing and Midwifery Strategy**<br><br>The Committee received an update on the delivery of the Nursing and Midwifery Strategy, which demonstrated substantial progress across leadership development, professional standards, quality improvement, research and workforce innovation. A refreshed Nursing, Midwifery and Specialist Public Health Nursing Plan for 2026–2030 was |

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| | | presented and noted as subject to further engagement and subsequent Board approval. |
| **4** | Strategic Partnership Arrangements | **System Leadership and Partnership Working**<br><br>The Executive Committee considered a number of issues requiring effective system leadership and partnership working, particularly in relation to discharge delays, urgent and emergency care flow and community capacity. Engagement with local authorities, Welsh Government and national partners continued across planning, capital, workforce and service priorities.<br><br>Specific partnership risks were identified, including Section 117 aftercare arrangements, with Executive-level escalation agreed and interim mitigations put in place to manage patient risk. Engagement with Llais and under-represented groups was also discussed, with agreement that strengthened and coordinated governance arrangements were required. |
| **5** | Transformational programmes | **Digital Transformation and Enablement**<br><br>Digital transformation was considered in relation to EPMA, urgent and emergency care flow and the proposed extension of the Signal for Noise contract. The Committee supported extending the contract to avoid loss of critical functionality, while emphasising the need for strengthened oversight and independent assurance.<br><br>**Workforce Transformation**<br><br>Workforce transformation was progressed through consideration of student streamlining and undergraduate commissioning. The Committee agreed preferred scenarios aimed at reducing variable pay, sustaining workforce capacity and strengthening deployment governance. |
| **6** | Other Formal Business | As standing agenda items, the Executive Committee receives:<br>• Quality and Safety Performance Report<br>• Workforce Performance Dashboard<br>• Strategic Risk Report |

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| | | • Financial Performance Report<br>• Activity & Performance Report, including Ministerial Priorities<br><br>In this reporting period Routine business was noted, including Managed Practice updates and Safety Briefings. |

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

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | **Strategic Risk Report, May 2026** |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Chief Executive Officer |
| **SWYDDOG ADRODD:**<br>**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 Strategic Risk Report provides the Board with an overview of the key strategic risks facing the Health Board, aligned to the priorities and objectives within the 2025–28 Integrated Medium-Term Plan (IMTP).

It seeks to provide assurance that these risks are being identified, monitored, and managed effectively, with proportionate actions in place to mitigate potential impacts on service delivery, financial sustainability, and patient safety.

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

This report provides the Board with an updated assessment of the Health Board's strategic risk profile and the principal risks that may impact delivery of the IMTP 2025–2028 and wider organisational objectives.

The Strategic Risk Register (SRR) comprises nine strategic risks and 21 supporting sub-risks, which continue to be actively monitored through the established governance framework.

The overall risk profile remains broadly stable; however, the operating environment continues to present sustained pressures across key domains including financial sustainability, system performance, estate resilience and enabling infrastructure.

## Cefndir / Background

The SRR is the primary mechanism through which the Board receives assurance on the identification, assessment and management of principal strategic risks.

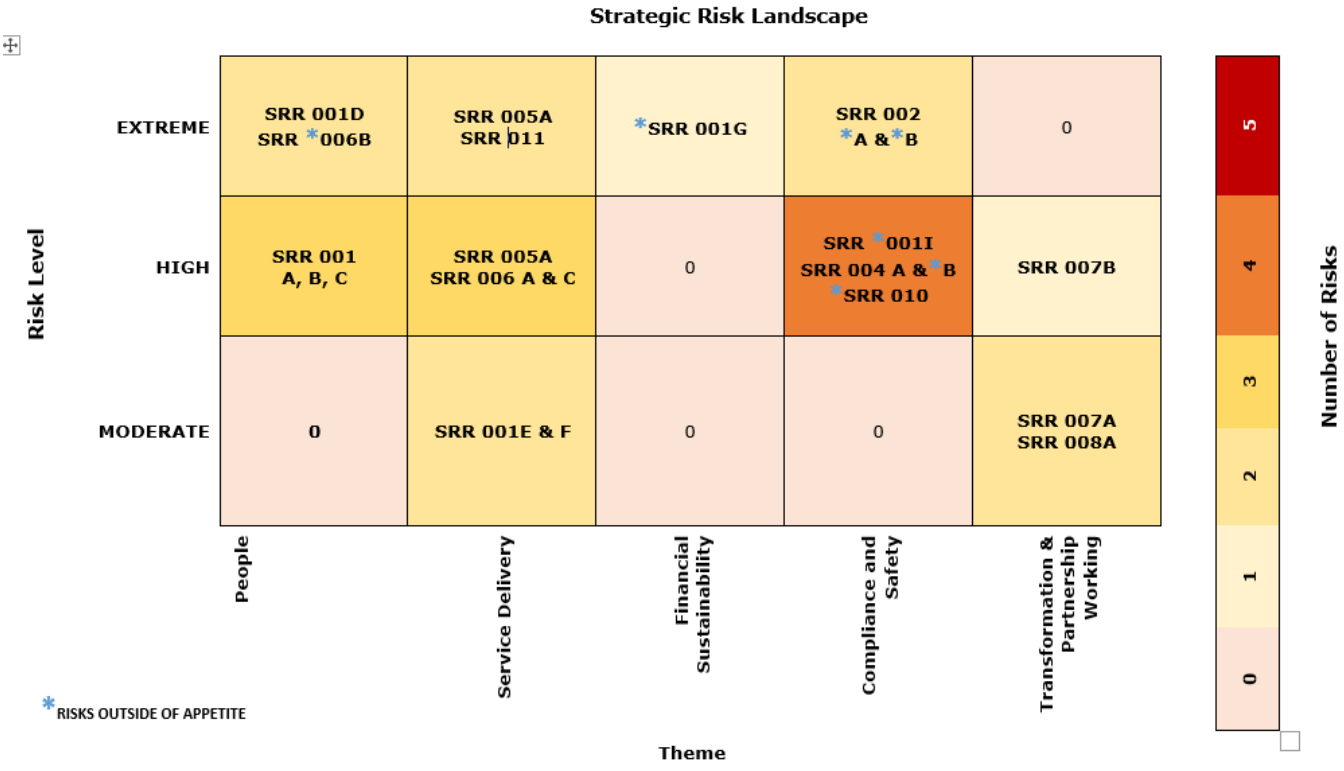
The risk register is aligned to delivery of the IMTP and captures risks that may impact the organisation's ability to deliver safe, high-quality and sustainable services. Each risk is assigned to an Executive Director, with accountability for ensuring that appropriate controls, mitigating actions and assurance mechanisms are in place and operating effectively.

Strategic risks are subject to regular review through the governance structure, including Board and committee oversight, providing a defined framework for escalation, scrutiny and assurance.

## Asesiad / Assessment

The Health Board's strategic risk profile has remained stable since the previous report, with no changes to the principal risks under Board oversight. Detailed information is provided in **Appendix A** (Strategic Risk Assessments).

The Heat Map below illustrates the current distribution and relative severity of the Health Board's strategic risks, while **Appendix B** provides a visual overview of the movement in risk exposure over a 12-month period.




The Heat Map also highlights the risk outside of appetite, of which six out of the 21 strategic sub-risks remain outside the defined risk appetite, indicating areas of continued exposure requiring enhanced management and scrutiny.

These relate to critical aspects of organisational resilience, including financial sustainability, performance delivery, estate resilience, business continuity, and governance and legislative compliance, as set out in Table 1 below.

*Table 1*

| Risk ID & Score Threshold | Sub Risk Description | Current Score | Management of the Risk |
|---|---|---|---|
| **SRR 001G** Score 12 and below | Due to the failure to deliver a sustainable financial position and longer-term financial plan. | **20** | The residual risk is being **treated** through strengthened financial controls, while **opportunities are being taken** to redesign services for long-term sustainability. |
| **SRR 001I** Score 8 and below | Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance. | **12** | The residual risk is being **treated** and opportunities taken to strengthen services and accountability structures. |
| **SRR 002A** Score 8 and below | Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures | **15** | The risk is being **tolerated** pending completion of remediation plans. |
| **SRR 002B** Score 8 and below | Due to significant levels of backlog maintenance and structural impairment. | **12** | The risk is being **treated** through proactive estate investment and maintenance planning. |
| **SRR 004B** Score 8 and below | Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident | **12** | The risk is being **treated** through the development, standardisation, and testing of business continuity and incident response plans. |
| **SRR 010** Score 8 and below | Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Health and Safety Act. | **12** | The risk is being **treated** through strengthening governance and **taking the opportunity** to enhance staff safety culture. |

Mitigating actions are in place across all risks, and there is evidence of active management and oversight. However, the persistence of risks above appetite reflects the scale and complexity of the challenges faced and reinforces the need for sustained focus at Executive and Board level.

The Board can take assurance that:

- Strategic risks are clearly defined and owned;
- Governance arrangements support regular review and escalation;
- Controls and mitigation plans are in place and monitored, with risk assessments being further reviewed to ensure controls and sources of assurance are clearly aligned, enabling the Board to determine the effectiveness of those controls.

Internal Audit has provided reasonable assurance that the Health Board's arrangements for strategic risk and assurance are fundamentally sound. However, the review identified opportunities to strengthen the quality, consistency and strategic focus of assurance, particularly in relation to Executive oversight, alignment to long-term strategy, and the clarity of SRR reporting.

**Look Ahead - Strengthening Strategic Risk and Assurance** (Next 3–6 Months)

To enhance the depth and reliability of assurance to the Board, a focused programme of improvement will be delivered over the next 3–6 months, aligned to the Internal Audit findings from the Strategic Risk and Assurance Report.

This will focus on four key areas:

- **Strengthened Executive Assurance**
  Formalising routine, structured scrutiny of the SRR by the Executive Committee to ensure consistent challenge of risk exposure, assurance gaps and delivery of mitigating actions prior to Board reporting.

- **Clear Strategic Alignment of Risk**
  Refreshing the SRR to align explicitly with the *Gwent 35* strategy and IMTP, ensuring a clear distinction between strategic and operational risk and strengthening focus on principal threats to delivery.

- **Improved Quality and Transparency of Reporting**
  Enhancing the SRR framework, template and guidance to ensure consistent and robust articulation of controls, assurances, gaps and actions, supported by targeted training and risk-focused deep dives.

- **Stronger Evidence of Risk Mitigation Effectiveness**
  Strengthening the definition and tracking of controls and actions to ensure they are measurable, outcome-focused, and demonstrably reducing risk exposure over time.

Collectively, these actions will enhance the integrity, transparency and strategic focus of risk reporting, providing the Board with stronger and more reliable assurance that key risks are being effectively managed.

**Argymhelliad / Recommendation**

The Board is requested to:

- **CONSIDER** whether it has sufficient assurance that strategic risks are being appropriately identified, assessed and managed; and

- **NOTE** the programme of work underway to strengthen the quality and depth of assurance over the next 3–6 months.

**Amcanion: (rhaid cwblhau)**
**Objectives: (must be completed)**

| | |
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| Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate 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<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br>Choose an item.<br>The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Not Applicable<br>Choose an item.<br>Choose an item.<br>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)** | |
|---|---|
| **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 |

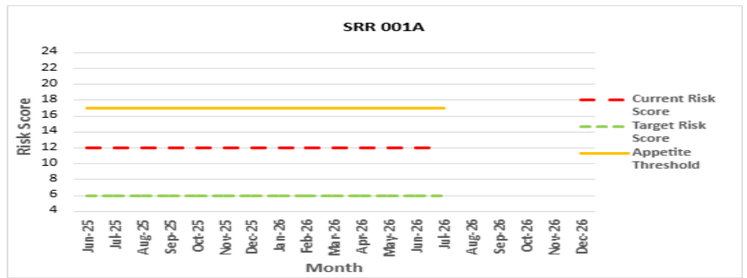
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| **Asesiad Effaith Cydraddoldeb Equality Impact Assessment** (EIA) completed | **No  does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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**<br>**Well Being of Future Generations Act – 5 ways of working**<br><br>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<br>Choose an item. |

| 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 workforce and OD | There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population | a) Due to an inability to recruit and retain staff across all disciplines and specialities. | Workforce & Culture | | | | | X | | | | ● | | ◊ | | |
| | | | b) Due to a deterioration in, and a failure to improve, the well-being of our staff | | | | | | | | × | | ● | | ◊ | | |
| | | | c) Due to insufficient and ineffective leadership levels throughout the organisation. | | | | | | X | | | | ● | | ◊ | | |
| | | | d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level | | | | | | | X | | | | | ◊ ● | | |
| | Director of Strategy, Planning and Partnerships. | | 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 | | | | ● | | ◊ | | |
| | Director of Finance and Procurement | | g) Due to the failure to deliver a sustainable financial position and longer-term financial plan | Finance | | | | | | X | | | ◊ | | | ● | |
| | Director of Strategy, Planning and Partnerships. | | I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance. | Performance Expectations & Workforce & Culture | | | | | | X ◊ | | | ● | | | | |
| SRR 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 005 | Chief Operating Officer | There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system | a) Due to inadequate arrangements to support system-wide patient flow | System Change | | | | | | | X | | | | ● ◊ | | |
| SRR 006 | Director of Digital | There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery | a) Due to the full or partial failure of existing digital infrastructure and systems | Digital, Data & Technology | | | | | | X | | | | | ● ◊ | | |
| | | | b) Due to an adverse impact on service delivery in the implementation of new digital systems | | | | | | X | | | | | | ◊ | ● | |
| | | | c) Due to a failure to develop digital solutions that are sustainable and fit for the future | | | | | | | X | | | ● | | ◊ | | |
| SRR 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 | | | | ● | | ◊ | | | | |
| SRR 008 | Director Of Nursing | There is a risk that the Health Board fails to build positive relationships with patients, staff and the public | a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement | Quality | | | X | | | ● | | | | | ◊ | | |
| SRR 010 | Director of Allied Health Professions and Health Science | There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974 | a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments. | Quality & Workforce & Culture | | | | | X | ◊ | | | ● | | | | |
| SRR 011 | Director of Finance and Procurement | There is a risk that the Health Board does not adequately anticipate, plan for, and respond to the impacts of climate change, green health requirements, and the need to adapt and decarbonise its services, estate and infrastructure. | a) Due to an ageing and complex estate, competing capital and revenue pressures, climate-related service demand and the absence of an organisation-wide climate adaptation approach. | Green Health | | | | | | X | | | | | ● ◊ | | |

| Key | |
|---|---|
| Current Score | ● |
| Target Score | × |
| Appetite Threshold | ◊ |

| | | | | |
|---|---|---|---|---|
| **RISK THEME** | **PEOPLE** | | | |
| **LINK TO IMTP** | **SECTION 4: ENABLER – WORKFORCE AND CULTURE** | | | |
| **Strategic - SRR 001 A** | **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 an inability to recruit and retain staff across all disciplines and specialties.** | | **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**<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings | **Staff**<br>• Non-compliance with safe staffing principles and standards.<br>• Increased Workload | **Organisation**<br>• Operational Disruptions<br>• Quality of Services<br>• Reputational Damage<br>• Financial strain – use of agency and bank staff | **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.<br>**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 Workforce & Organisational Development | **Risk Exposure** | **Current Level** | **Target Level** |
| **Monitoring Committee / Group** | People & Culture Committee | **Likelihood** | **3** *(Possible)* | **3** *(Possible)* |
| **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)* |
|---|---|
| • Monitoring Framework to support roll-out of the People Plan.<br>• Workforce Dashboard to track activity – recruitment, turnover, sickness absence.<br>• Supply and demand tracker (Nursing and HCSW).<br>• People Plan tracker to support delivery of actions within the People Plan 2025-2030<br>• Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board.<br>• Management of attendance through All Wales Management Attendance at Work Policy.<br>• Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture.<br>• Nurse Staffing Levels (Wales) Act 201625b/25c.<br>• Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP.<br>• Workforce planning supported by Compendium of new roles to support innovative workforce models.<br>• Recruitment KPI's.<br>• IMTP (Integrated Medium-Term Plan) Educational Commissioning.<br>• Workforce Establishment controls national working group has been instigated and will be launching dashboard in April 2026<br>• Value and Sustainability Board.<br>• Implementation of the Collective Agreement (Non-Pay Deal) 2022/24.<br>• Real Living Wage Employer.<br>• Workforce Supply Oversight Group (WSOG) established led by HEIW with HB executive membership<br><br>• **Recruitment**<br>• Engagement with national recruitment campaigns such ~~as BAPIO,~~ M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Resident Doctor.<br>• Annual programme of Apprentice and RCN Connect recruitment.<br>• Overseas Nursing (All Wales Recruitment programme).<br>• Nursing Workforce Strategy 2023 – 2026 | **Recruitment**<br>• Approval to overrecruit to newly qualified nurses in September 2025, March 2026 and September 2026 resulting in zero forecasted RN vacancies in rostered areas.<br>• Flexible RN training routes circa 35 predicted to complete training each year<br>• Exploring potential of Overseas clinical attachments in other Divisions at both Junior and Senior grades (currently only Medicine) offering NHS experience to IMGs and provides a pipeline of suitable candidates to fill vacancies in future, particularly senior grades.<br>• Working closely with HEIW for earlier notification of unfilled and part-time training posts.<br>• Expand talent pools into areas with high turnover such as Facilities and Health Records.<br>**Retention**<br>• Development of career pathways (e.g., non-clinical to clinical).<br>• Implementation of Talent Management and succession planning workshops.<br>• NHS Wales Nurse Retention Plan quarterly updates being reviewed, submission update in September 2025.<br>• HCSW retention plan developed in collaboration with Nursing focusing on areas of high turnover being reviewed monthly.<br>• Introduction of new starter surveys in collaboration with Nursing and Midwifery directorate<br>• Over 50 positive retention stories across all divisions collated and on the intranet.<br>• Organisational turnover and exit reviewed and analysed leading to an initial deeper dive into estates and facilities.<br><br>**Variable Pay Reduction**<br>• Development of action plan based on WHC to support the reduction in bank and agency usage.<br>**E- Systems**<br>• Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas.<br>• Roll out of medical rostering will resume in October 2025. This will help to predict junior doctor gaps and look for alternative ways to fill. |

- Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022)
- Partnerships with employability schemes and FE/HE to widen access.
- Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board.
- Working with partners to improve visibility and attraction.
- DBS Policy in place with DBS risk assessment form November 2024.
- Recruitment & Selection Policy published September 2025.
- Introduced centralised HCSW talent pools from September 2023.
- Future Nurse Academy introduced in January 2024.
- Fixed term Rotational posts for Registered Nurses to be introduced March 2026
- Internal Lateral Transfer Scheme for B5 Registered Nurses introduced January 2026

**Retention**

- Retention lead appointed with programme action plan in place for the next two years.
- Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts.
- Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return.
- Development of HCSW skills matrix and career framework has commenced.
- Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee.
- Career conversations and succession planning resources designed; Talent management succession planning workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked**.** Further workshops planned until the end of the year.
- All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline.
- Launch and support of the NHS Wales Staff Survey (October and November 2025).

**Variable pay reduction**

- Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board.

**E- Systems**

- Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all 'live' and rolled out within the Health Board.
- Medical E-Rostering roll out is still not fully rolled out due to some development delays with the provider, but the first areas should be live by Summer of 2026

**Development of Alternative and New Roles**

- Development of alternative and new roles.
- A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care.
- Mental Health Workforce plan development in line with new Models of Care.

**Training**

- The HEIW Education & Training Plan 2025/26 continues the investment in education and training in Wales that has been increasing over past years.
- The 2025/26 education training plan demonstrated increases in a number of medical training places in medical, surgical, diagnostics and mental health specialities. This is to support areas of high vacancies, population health predictions and Welsh Government Priorities. The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing (adult, health visiting, practice. Training numbers in Therapies and Health Care Science programmes will remain static at previous year's numbers.
- HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience.
- Ongoing investment in the Primary and Community Care Academy Network will be a key enabler to delivering innovation and transformation through the Strategic Workforce Plan for Primary Care and the Strategic Programme for Primary Care.
- Flexible routes to RN training in place through USW and Open University
- Cadet Nursing programme in place – 16 candidates attended for the 2024 induction and work is ongoing to support all 16 to achieve accreditations. - 16 RCN cadets attending All Wales HCSW Clinical Skills Induction, currently 12 active.
- K102 bridging model now being offered to support HCSW pathways into registered nursing.
- Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx). Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024 with cohort 2 launching June 2025. Nursing and Midwifery Academy for senior level nurses and midwifes, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff per year.
- Delivery of workforce planning training.

**Vacancy Numbers and establishment control**

- Quarterly reporting of vacancy numbers have improved from 442wte to 330wte vacancies as of September 25 (all staff groups)

- Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision.
- E-Job Planning compliance has remained static, and February's compliance was 54%. A Revised trajectory has been commissioned by the Medical Director for improvement to 80% in 26/27.
- Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles.
- Due to delays in development to allow for roll out of live rosters for Medical and Dental, a contract improvement notice has been issued to Patchwork.

**Development of alternative and new roles**

- Continued implementation and increase in new roles such as ~~Physician Associates~~, CAAPs, Enhanced and Advanced,consultant roles to support workforce skills gaps in line with IMTP.
- Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal.
- Looking to increase Assistant band 4 in Community/Mental Health and areas such as Cardiology Physiology.
- Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity.
- Increasing consultant therapy and nurse practitioners.
- RCN introduction of Registered Nursing Associate role to help build the capacity of the nursing workforce with placements from September 2027.
- Development of new roles and career pathways to support hard to fill roles in Health Visiting.
- Re-design of the Health Board's work experience programme with 246 applicants since March 2024 and 75 placements confirmed
- Development of Medical & Dental Recruitment & Retention Strategy 2025 – 2030.
- Looking to further widen access by partnering with DWP to offer 12-week unpaid placements to the unemployed with a view to offering training, support and guaranteed interviews – further promoting ABUHB as an employer of choice at entry level roles. This programme attracts £1000* per candidate and there is a maximum of 50 candidates we can support per year *(*as at July 2025).*
- Regional planning supporting a number of strategic workforce plans (Orthopaedics, Endoscopy, Women's Health Units, Vascular).

**Workforce Supply and Demand Modelling**

- 10-year draft predictions undertaken for future workforce requirements based on previous trends and training pipelines.
- HEIW leading several workforce initiatives to improve supply and demand modelling.

**Training**

- HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy.
- Workforce planning training prospectus of local and online training launched May 2025 and HEIW Workforce Planning Hub launched June 2025 with dates for 2026.
- Development opportunity being scoped for Business support staff.
- Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR.
- Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire.
- Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies.
- A review and action plan underway to consider how to address instances where nurse streamlining preferences for specific posts exceed the number of vacancies available, to promote recruitment and retention.
- 31 staff enrolled on workforce planning online training modules level 1. 15 managers enrolled on level 2 training delivered locally March 2025. A capacity and capability workforce planning action plan are being developed to support 25/26 programme of activity.
- Launch of Admin Together staff network (now at 100 members) supporting administrative staff to connect, develop and address organisational challenges. Continued support of all staff networks.

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| • Development of ESR establishment control model commenced. Local delivery action plan has been agreed by the Executive Committee with expected 90% roll out completed by 31 October 2025. Dashboard to be launched late April 2026 A bespoke model will be developed to support medical staffing.<br>**Staff attendance**<br>• Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work.<br>• "Hot spot" areas identified and plans in place to support.<br>**Band 2/3**<br>• Implementation of the national Health Care Support Worker Job Description Framework has commenced and 98% completed for staff in post as 1st January 2026. This will re-band many Band 2 staff in nursing, maternity, and theatres to Band 3, improving engagement, retention, and recruitment. | |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(What further evidence is required to provide the effectiveness of controls)* |
|---|---|---|---|
| **Level 1 Operational** *(Implemented by the department that performs daily operation activities)* | | | |
| • Workforce reports to the Nurse Strategic Workforce Group.<br>• Monthly sickness monitoring reports.<br>• Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN.<br>• Medical Staffing Co-ordinator review of medical rotas.<br>• Cross site operational calls. | • Occupational Health and Wellbeing dashboards report KPIs.<br>• Recruitment KPIs<br>• Medical & Dental and Student Streamlining fill rate reports | | |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | | |
| • Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25<br>• Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board.<br>• Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation.<br>• Measurements of Wellbeing through the ABUHB | • (Aneurin Bevan University Health Board) Staff Survey<br>• Routine Reporting against nurse staffing levels.<br>• Variable Pay Programme Board reporting to Value and Sustainability Board<br>• Resident Doctor Contract Reform Steering Group | • Governance processes<br>• risk management input (register, risk assessment) | |
| **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* | | | |
| • Internal Audit Reviews 2023 -24<br>• Long Term Sickness Absence Management (Q4)<br>• Flexible Working (Q4)<br>• External quarterly vacancy reporting to WG<br>• National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges. The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative. | • External reporting on Nursing Staffing Levels<br>• National Acuity Audits (Nursing)<br>• Workforce planning external audit action plan 2024 and Structured Assessment Response August 2025<br>• Resident Doctor Contract Reform | • Latest local survey saw a reduction in staff wellbeing<br>• Resident Doctor Contract Reform – element still in negotiation with BMA<br>• 1000 new trainee posts in NHS England to commence in August 2026 which may impact on NHS Wales and the additional capacity required as a result of the new Resident Doctor Contract Reform | • Internal Audit Staff Culture Q3 2024/25<br>• Audit on Right to Work and International recruitment processes April 2026 |

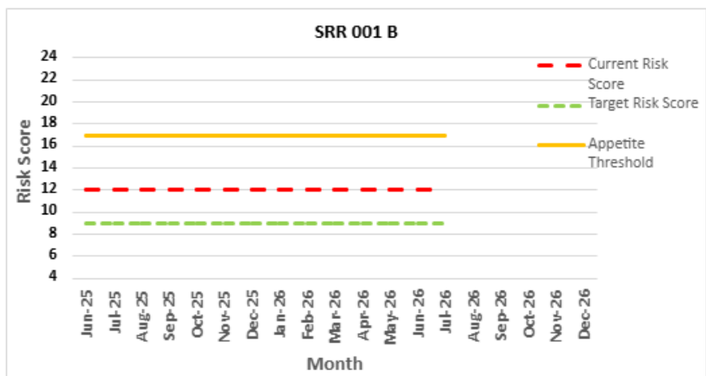
| **Assurance Rating** (*Overall Assessment of controls and assurances)* *Guidance* | | | |
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| **Negative –** Insufficient evidence that the controls | **Reasonable -** adequate evidence that the controls in place are working effectively. | **Positive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

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| **RISK THEME** | **PEOPLE** | | | |
| **LINK TO IMTP** | **SECTION 4: ENABLER – WORKFORCE AND CULTURE** | | | |
| **Strategic - SRR 001 B** | **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 a deterioration in, and a failure to improve, the well-being of staff.** | | | |
| **Impact** *(Consequences of the threat)* | **Patient**<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings | **Staff**<br>• High absence levels, with some sustained long periods<br>• Non-compliance with safe staffing principles and standards | **Organisation**<br>• Reputational damage to the health board as an employer<br>• Work-related claims<br>• Financial Implications | |
| **Lead Director** | Director of Workforce & Organisational Development | **Risk Exposure** | **Current Level** | **Target Level** |
| **Monitoring Committee / Group** | People & Culture Committee | **Likelihood** | **3** *(Possible)* *x* | **3** *(Possible)* x |
| **Initial Date of Assessment** | June 2023 | **Impact** | **4** *(Major)* | **3** *(Moderate)* |
| **Last Reviewed** | April 2026 | **Risk rating** | **= 12** ***(High)*** | **= 9** ***(High)*** |
| **Next Review** (Quarterly based on risk score) | July 2026 | | | |

**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.

**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.



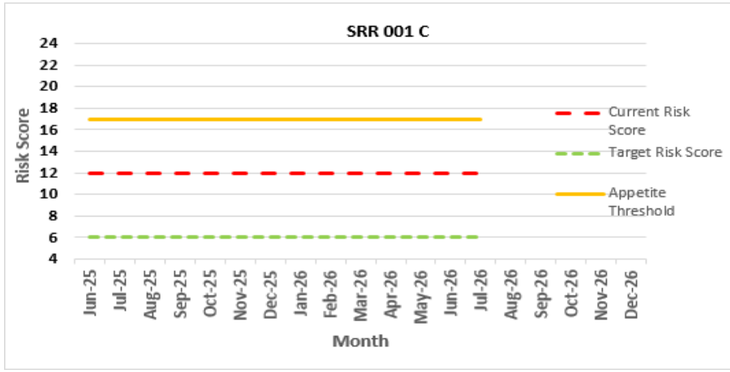

| **Current Key Controls**<br>*(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control**<br>***What further controls are required to reduce the risk exposure to within a tolerable range?***<br>*(Short, Medium, and Long-Term Plans need to be included)* |
|---|---|
| **General**<br>• Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard<br>• Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity<br>• Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority<br>• Strategic Equality Plan<br>• Rest and Facilities Charter – monitoring and compliance<br>• Staff related policies<br>• National Staff Survey outcomes<br>• External Employee Assistance Programme<br>• Speaking up Safely Action Plan<br>• Race/LGBT groups<br>• Wellbeing resources<br>• Staff diversity networks<br>• Regular Schwartz rounds arranged across the Health Board<br>• Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own<br>• Close links with the Arts in Health programme<br>• Chaplaincy service for staff<br>• Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being<br>Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate<br>• Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management.<br>• An externally commissioned SUS hotline | **General**<br>• Increase wellbeing initiatives, including long term strategic programmes within large departments (e.g., Maternity)<br>• Identify, training and develop Respect and Resolution advocates (like Mental Health first aiders)<br>• Take a data-based approach to improve our approach to Respect and Resolution processes, and supporting resources<br>• Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues<br>• Trained mediators so there is team and organisational resilience and network<br>• Enhanced our financial well-being offer<br>• Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate<br>• Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management<br>• The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has consistently resulted in a 60-70% reduction in investigations and a wide range of other organisational benefits over 3 years. The next phase of this programme will involve transferring the benefits to Respect and Resolution processes.<br>• Implement, develop and embed the Speaking up Safely process in line with the Welsh Government Framework<br>• We are planning a series of events to celebrate 10 Years of Schwartz Rounds within ABUHB<br>• 'Safe atmospheres' training has been piloted to support the ongoing psychological safely focused work taking place in theatres and linked to 'never events' and team debriefing<br>• Working with trade union and national partners to improve attendance at work and prevent absence through a variety of initiatives including Wellbeing Passport, alternative roles and health promotion.<br><br>**Occupational Health.**<br>• Regional occupational health partnership working being explored with Cardiff and Vale and also Cwm Taff, Phase 1 collaborative physician procurement process completed and implemented<br>• Support equality and diversity of workforce |

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| • An external Employee Assistance Programme (Vivup) has been commissioned for a further 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative<br><br>**Occupational Health**<br>• Additional occupational health resources secured to reduce waiting times<br>• Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes<br>• SEQUASH accreditation applied for QTR 4 2025/2026.<br><br>**Other**<br>• Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC | • Review of staff diversity networks<br>• Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms<br>• Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing<br><br>**Staff Survey Action Plan**<br>• Findings from the staff survey 2024/25 indicate improvements with culture and diversity<br>• An ABUHB action plan has been developed to address staff engagement, work related stress and to improve retention of staff<br>• Planning for 2026 staff survey underway to improve compliance and value of outcomes |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(What further evidence is required to provide the effectiveness of controls)* |
|---|---|---|
| **Level 1 Operational** *(Implemented by the department that performs daily operation activities)* | | |
| • Dashboard reporting<br>• Reporting to monitor the rollout of the People Plan 22-25<br>• Reporting to monitor of demand on wellbeing services | • Understand if support is reaching all staff | • Meetings with Divisions ongoing to ensure all areas are aware of what's available. |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |
| • People and Culture Committee reports (People Plan 22-25)<br>• Local wellbeing surveys<br>• LNC – reporting of compliance of BMA Rest and<br>• Facilities | | |
| **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* | | |
| • National workforce surveys<br>• Monitoring and compliance of BMA Rest and Facilities via NHS Employers<br>• Staff Welfare Charter<br>• Sickness Absence Audit 2023/24 – Outcome: Reasonable Assurance | • Latest local survey saw a reduction in staff wellbeing | • Internal Audit Staff Culture Q3 2024/25 |

| **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. | **POSITIVE ASSURANCE** |

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| **RISK THEME** | **PEOPLE** | | | | |
| **LINK TO IMTP** | **SECTION 4: ENABLER – WORKFORCE AND CULTURE** | | | | |
| **Strategic - SRR 001 C** | **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 insufficient and ineffective leadership levels throughout the organisation** | | | **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**<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings; | **Staff**<br>• Adverse impacts on staff recruitment and retention | **Organisation**<br>• Failure to deliver health board priorities, required improvements and achieve sustainability;<br>• Poor levels of accountability and delivery;<br>• Reputational damage to the health board as an employer; | **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**<br>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 Workforce & Organisational Development | **Risk Exposure** | **Current Level** | **Target Level** | |
| **Monitoring Committee / Group** | People & Culture Committee | **Likelihood** | **3** *(Possible)* | **3** *(Possible)* | |
| **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 | | | | |



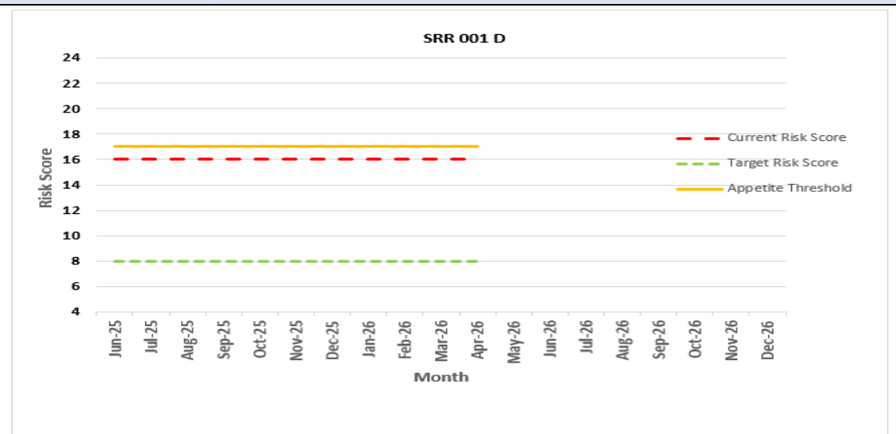

| **Current Key Controls**<br>*(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control**<br>***What further controls are required to reduce the risk exposure to within a tolerable range?***<br>*(Short, Medium, and Long-Term Plans need to be included)* |
|---|---|
| • Talent and Succession Planning framework published<br>• Monitoring Framework to support roll out of the People Plan – Focus on Talent and Succession Planning.<br>• Monitoring Frameworks with HEIW<br>• HEIW leadership programmes including for aspiring Directors and CEOs<br>• Leadership journey and programmes mapped, variety of programmes and resources available ranging from aspiring to senior leaders. Including bespoke for Leading people and staff groups including Clinical Directors, Directorate Managers and Administrative Network.<br>• Nursing Leadership Academy well established<br>• Learning masterclasses have been designed and developed for the organisation addressing ley themes such as giving feedback, developing team and having courageous conversations.<br>• OD and training available for local management levels as well as corporate organisational wide programmes. | **Talent and Succession Planning**<br>• Development workshops being rolled across the Health Board, open for all leaders to attend. Ongoing and planned throughout 2026/27<br>• Designated Talent and Management succession planning resources available on ABUHB intranet and updated regularly.<br><br>**Development leadership capabilities**<br>• Currently exploring leadership funding options with USW to maximise Governmental Grants and utilisation of the apprentice levy.<br>• Continued commitment to NHS graduate schemes.<br>• Continued bespoke development and support for senior management teams in clinical and non-clinical settings focusing on leadership, team dynamics and thriving.<br>• Working with HEIW to inform a national development programme for managers<br>• Engagement with the management competency framework which will be adopted in Wales (following implementation in NHS England).<br>• Review of current leadership journey and training with planning starting to develop a very senior leadership development programme in 2026/27<br>• Specific leadership and culture work starting in MHLD division with methods being developed to scale across the Health Board in 2026. |

| Sources of Assurance<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | Gaps in Assurance<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | Actions to Address Gaps<br>*(What further evidence is required to provide the effectiveness of controls)* |
|---|---|---|
| **Level 1 Operational** *(Implemented by the department that performs daily operation activities)* | | |
| • WOD Divisional reporting<br>• Evaluation of internal leadership programmes and regular review of our internal offer | | |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |
| • Reporting to People and Culture Committee - progress against People Plan 22-25 / 2025 – 2028. | | |
| **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* | | |
| • Internal Audit Review<br>• Talent and Succession Board | | |

| **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. | **POSITIVE ASSURANCE** |

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| **RISK THEME** | **PEOPLE** | | | |
| **LINK TO IMTP** | **SECTION 4: ENABLER – WORKFORCE AND CULTURE** | | | |
| **Strategic - SRR 001 D** | **There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.** | | **Publication Status** | **Public** |
| **Threat** *(As a result of)* | **Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level** | | **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**<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings | **Staff**<br>• Non-compliance with safe staffing principles and standards | **Organisation**<br>• Litigation & Financial Penalties<br>• Reputational damage to the health board 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**<br>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 Workforce & Organisational Development | **Risk Exposure** | **Current Level** | **Target Level** |
| **Monitoring Committee / Group** | People & Culture Committee | **Likelihood** | **4 (Likely)** | 2 *(unlikely)* |
| **Initial Date of Assessment** | June 2023 | **Impact** | **4** *(Major)* | **4** *(Major)* |
| **Last Reviewed** | April 2026 | **Risk rating** | **= 16** ***(Extreme)*** | **= 8** ***(Moderate)*** |
| **Next Review** (Monthly based on risk score) | May 2026 | | | |




| **Current Key Controls**<br>*(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**<br>***What further controls are required to reduce the risk exposure to within a tolerable range?***<br>*(Short, Medium, and Long-Term Plans need to be included)* |
|---|---|
| • All Wales Industrial Action Planning Group.<br>• Local Health Board planning arrangements.<br>• Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and<br>• CODE OF PRACTICE Industrial Action Ballots and Notice to Employers.<br>• Business Continuity Plans<br>• Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture.<br>• Effective derogation processes including Christmas Day cover definition.<br>• Local Negotiating Committee (LNC) and Trade Union Partnership Forum (TUPF)<br>• Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. All Wales training sessions provide by legal and risk to support industrial action.<br>• Picketing guidance supported and agreed.<br>• Workforce Peer Networks – WOD's and DEWOD's.<br>• Resident Doctor Contract agreed and implementation plan issued<br>• Living Wage uplift to be applied from April 2026 as per WHC<br>• Band 2/Band 3 assessments initiated<br>• AFC pay award for 2026/27 announced for Agenda for change and Medical and Denral staff. | • Issue of WHC AFC non pay elements of collective agreement 2022-24.<br>• .<br>• Early notification of consultative ballot outcomes via NHS Employers/WG.<br>• Local negotiation and response to grievances related to band 2/band 3 job descriptions for HCSWs.<br>• Awareness of national TU ballot responses regarding pay dispute – early notification ahead of any strike action ballots for planning purposes.<br>• Resident Doctor contract reform planning structure in place in conjunction with Medical Director.<br>• CPD/Statutory and Mandatory training review in progress with TU colleagues.<br>• Review of Health Visitor Job Description in partnership with Tus<br>• Contribution to national Health Visitor working group<br>• Resident Doctor contract implementation readiness assessment Contractual reviews/disputes supported with guidance from NHS Wales Employers |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(What further evidence is required to provide the effectiveness of controls)* |
|---|---|---|
| **Level 1 Operational** *(Implemented by the department that performs daily operation activities)* | | |
| • Local Staff re-deployments assessment<br>• Divisional engagement and service planning arrangements in place<br>• Local Negotiating Committee (LNC)<br>• Trade Union Partnership meetings<br>• Established processes and tools used for previous industrial action. | | Further industrial action |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |
| • Reporting to Executive team<br>• Business Continuity groups<br>• Command and control structure in place to be implemented as required | | |
| **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* | | |
| • All Wales IA group and Welsh Government planning group.<br>• Debriefing session planned to reflect and capture learning for any potential future action<br>• Resident Doctor Contract Reform<br>• Band 2/3 Implementation Framework – DRAFT, subject to Cabinet Secretary review/approval | | |

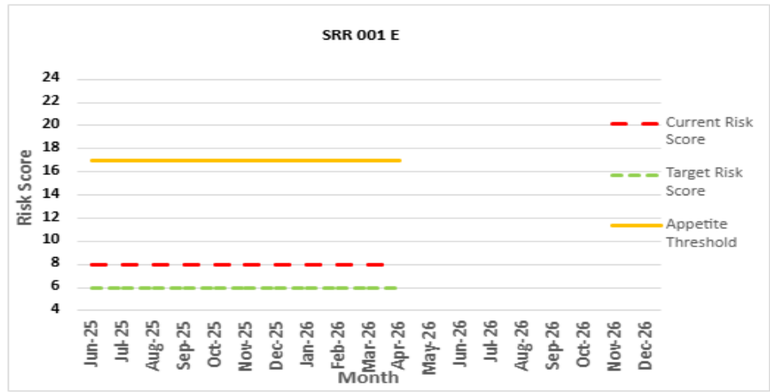
| **Assurance Rating** (*Overall Assessment of controls and assurances*) *Guidance* | | | |
|---|---|---|---|
| **Negative –** Insufficient evidence that the controls | **Reasonable -** adequate evidence that the controls in place are working effectively. | **Positive -** robust evidence that the controls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

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|---|---|---|---|---|
| **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.** | | | |
| **Impact** *(Consequences of the threat)* | **Patient**<br>• Increased patient acuity levels<br>• Worsening of health inequalities<br>• Worsening of health outcomes | **Staff** | **Organisation**<br>• Failure to train teams in multi-morbidity management<br>• Failure to comply with the Wellbeing of Future Generations Act (Wales)<br>• Reputational damage and loss of public confidence<br>• Increased demand | |
| **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)*<br>x | **2** *(Unlikely)*<br>x |
| **Initial Date of Assessment** | June 2023 | **Impact** | ***4*** *(Major)* | **3** *(Moderate)* |
| **Last Reviewed** | November 2025 | **Risk rating** | **= 8**<br>***(Moderate)*** | ***= 6***<br>***(Moderate)*** |
| **Next Review** (Six monthly based on risk score) | May 2025 | | | |

**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.

**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.

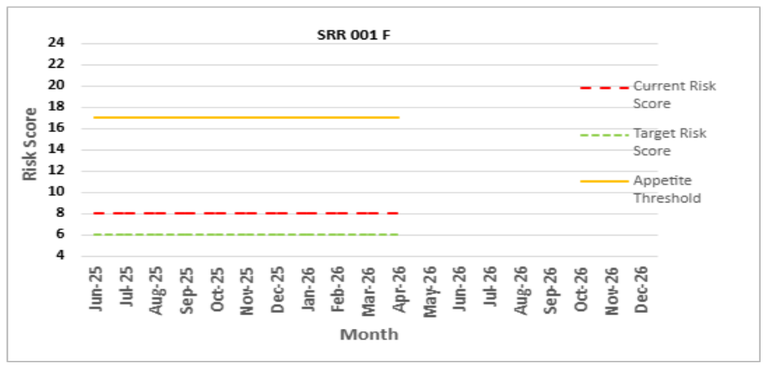



| **Current Key Controls**<br>*(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control**<br>***What further controls are required to reduce the risk exposure to within a tolerable range?***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

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(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<br>• SFN – performance information | | • Effectiveness of the plans in delivering improvements |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |

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| • IMTP Delivery and Outcomes Reporting to Board<br>• Marmot Region Programme<br>• 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**<br><br>• IMTP Planning (Q1) Outcome – Reasonable Assurance<br><br>**Internal Audit Reviews 2024-25**<br><br>• 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 ASSURNACE** |

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|---|---|---|---|---|---|
| **RISK THEME** | **SERVICE DELIVERY** | | | | |
| **LINK TO IMTP** | **SECTION 3: SYSTEM CHANGE** | | | | |
| **Strategic Risk**<br>**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**<br>*(As a result of)* | **Due to unsustainable Service Models** | | | **Risk Appetite Level – OPEN**<br>Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure. | |
| **Impact**<br>*(Consequences of the threat)* | **Patient**<br>• Increased demand<br>• Increased patient acuity levels<br>• Worsening of health inequalities<br>• Worsening of health outcomes | **Staff**<br>N/A | **Organisation**<br>• Failure to train teams in multi-morbidity management<br>• Failure to comply with the Wellbeing of Future Generations Act (Wales)<br>• Reputational damage and loss of public confidence | **Risk Appetite Threshold – SCORE 17 AND BELOW**<br>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**<br>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)<br>x | **2** (Unlikely)<br>x | |
| **Initial Date of Assessment** | June 2023 | **Impact** | ***4** (Major)* | **3** (Moderate) | |
| **Last Reviewed** | November 2025 | **Risk rating** | **= 8**<br>**(Moderate)** | ***= 6***<br>***(Moderate)*** | |
| **Next Review**<br>(Six monthly based on risk score) | May 2026 | | | | |

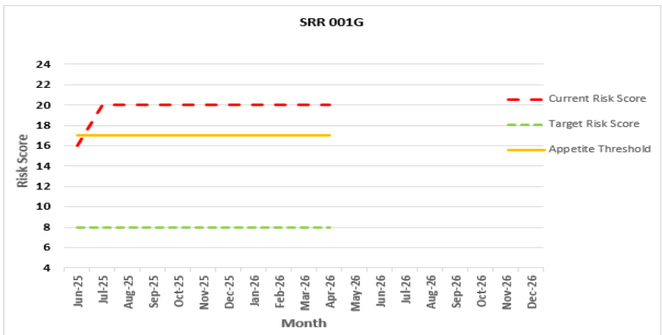



| **Current Key Controls**<br>*(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control**<br>***What further controls are required to reduce the risk exposure to within a tolerable range?***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

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(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.<br>• Qliksense – performance information | | • Evidence of individual arrangements in place to deliver service plans. |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |

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| • IMTP delivery and outcomes reporting to Board.<br>• RPB reporting to Board and Population Health, Planning and Partnerships Committee.<br>• Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. | • Regional Planning reporting to Population Health, Planning and Partnerships Committee.<br>• 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**<br><br>• IMTP planning Q1. Outcome – Reasonable Assurance.<br><br>**Internal Audit Reviews 2024-25**<br><br>• IMTP – Service Plans (Q2) – Outcome - Reasonable Assurance<br>• 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 ASSURNACE** |

| RISK THEME | FINANCIAL SUSTAINABILITY | | | | |
|---|---|---|---|---|---|
| LINK TO IMTP | SECTION 4: ENABLER - FINANCE | | | | |
| **Strategic - SRR 001 G** | **There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.** | | | **Publication Status** | **Public** |
| **Threat** *(As a result of)* | **Due to the failure to deliver a sustainable financial position and longer-term financial plan.** | | | **Risk Appetite Level – CAUTIOUS** Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls | |
| **Impact** *(Consequences of the threat)* | **Organisation**<br>• Breach of statutory duty to breakeven over 3 years.<br>• Instigation of NHS Wales Escalation & Intervention Arrangements.<br>• Non–delivery of Health Board priorities, required improvements, and achieving longer-term sustainability.<br>• Prioritisation and possible disinvestment in service delivery.<br>• Reputational damage and loss of public confidence. | | | **Risk Appetite Threshold – Score 13 and Below** Risks relating to all aspects of the Health Board's financial performance and its ability to manage cost and efficiencies. | |
| | | | | **SUMMARY** The current risk level is **OUTSIDE** of target and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold. | |
| **Lead Director** | Director of Finance and Procurement | Risk Exposure | **Current Level** | **Target Level** | |
| **Monitoring Committee / Group** | Finance and Performance Committee | **Likelihood** | **5 (Almost certain)** x | 2 (Unlikely) x | |
| **Initial Date of Assessment** | June 2023 | **Impact** | ***4** (Major)* | **4** (Major) | |
| **Last Reviewed** | April 2026 | **Risk rating** | **= 20 (Extreme)** | ***= 8*** **(Moderate)** | |
| **Next Review** (Monthly based on risk score) | May 2026 | | | | |




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

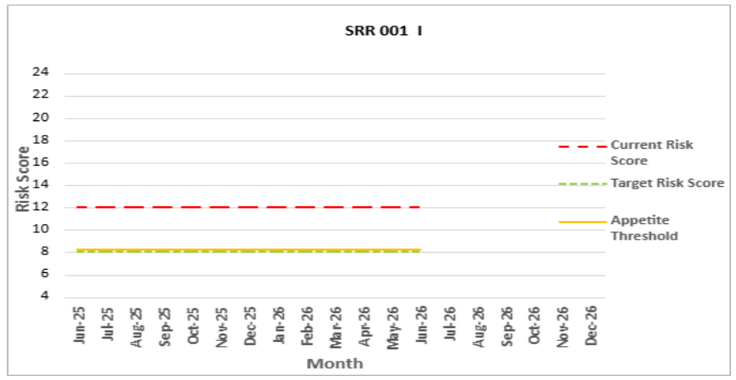
| | |
|---|---|
| • Enhanced forecasting and planning processes | |

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

**Assurance Rating** (*Overall Assessment of controls and assurances*) *Guidance*

| | | | |
|---|---|---|---|
| **Negative –** Insufficient evidence that the controls | **Reasonable -** adequate evidence that the controls in place are working effectively. | **Positive -** robust evidence that the controls in place are working effectively. | **REASONABLE ASSURNACE** |

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|---|---|---|---|---|---|
| **RISK THEME** | **COMPLIANCE AND SAFETY** | | | | |
| **LINK TO IMTP** | **SECTION 2: DRIVERS – PERFORMANCE EXPECTATIONS** | | | **SECTION 4: ENABLERS – WORKFORCE & CULTURE** | |
| **Strategic Risk**<br>**SRR 001 I** | **There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, sustainable services that meet the needs of the population.** | | | **Publication Status** | **Public** |
| **Threat**<br>*(As a result of)* | **Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Leadership, Corporate Governance, Operational Performance and Delivery, and Finance.** | | | **Risk Appetite Level – MINIMAL**<br>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**<br>*(Consequences of the threat)* | **Patient**<br>• Unintended Patient Harm.<br>• Negative Public/Patient Experience. | **Staff**<br>• Reduced Staff Morale leading to potential absence from work. | **Organisation**<br>• Loss of patient/public trust and confidence.<br>• Scrutiny from external organisations.<br>• Adverse publicity.<br>• Punitive Actions.<br>• Financial implications. | **Risk Appetite Threshold – SCORE 8 AND BELOW**<br>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**<br>The current risk level is **OUTSIDE** of target and 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** | Finance and Performance Committee. | **Likelihood** | 3 (Possible)<br>x | **2** (Unlikely<br>x | |
| **Initial Date of Assessment** | April 2024. | **Impact** | ***4*** *(Major)* | **4** (Major) | |
| **Last Reviewed** | March 2026 | **Risk rating** | **= 12**<br>**(High)** | **= 8**<br>**(Moderate)** | |
| **Next Review**<br>(Quarterly based on risk score) | June 2026 | | | | |

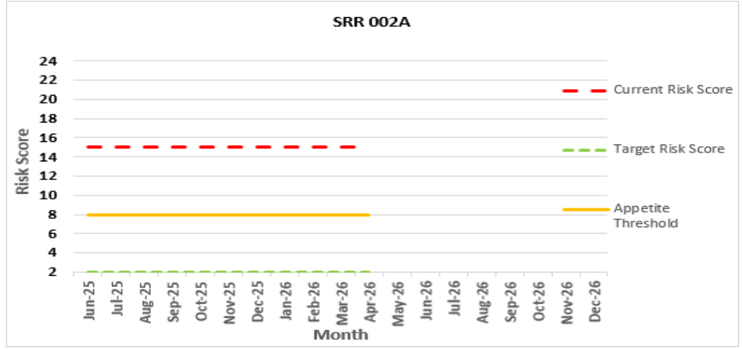



| **Current Key Controls**<br>*(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control**<br>***What further controls are required to reduce the risk exposure to within a tolerable range?***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

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

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

| | | | | | |
|---|---|---|---|---|---|
| **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**<br>• Harm or injury to patients<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings | **Staff**<br>• Harm or injury to staff | **Organisation**<br>• Litigation & Financial Penalties<br>• Loss of estate | **Risk Appetite Threshold –** Score 8 and below<br>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**<br>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)<br>x | **1** (Rare)<br>x | |
| **Initial Date of Assessment** | June 2023 | **Impact** | ***5*** *(Catastrophic)* | **2** (Minor) | |
| **Last Reviewed** | April 2026 | **Risk rating** | **= 15 (Extreme)** | **= 2 *(Low)*** | |
| **Next Review** (Monthly based on risk score) | May 2026 | | | | |




| **Current Key Controls** *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)* |
|---|---|
| • 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)<br>• 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.<br>• 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<br>• Remediation work to areas of high-risk areas undertaken<br>• Controlled access to roof areas which is being enhanced with proposals around cameras and designated walkways<br>• Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present.<br>• Ongoing engagement with expert surveyor<br>• Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management<br>• 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<br>• Links with NHS England and other Health Boards in Wales for shared learning.<br>• Regular dialogue with Welsh Government and Shared Services Estates.<br>• 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<br>• Management Strategy and the Management Plan are completed and was approved at the Health & Safety Committee in April 2025 |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(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<br>• Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection)<br>• Review of existing arrangements in place supported by external body | • Ongoing management of the issues.<br>• 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<br>• | 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<br>• risks and issues associated with any remedial measures implemented.<br>• 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<br>• Formal reporting to the Board/Committees in place<br>• 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.<br><br>• 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<br><br>**Internal Audit 2024/25 Plan**<br>• Implementation of the management responses to close off recommendations been concluded. |

**Assurance Rating** (*Overall Assessment of controls and assurances*) *Guidance*

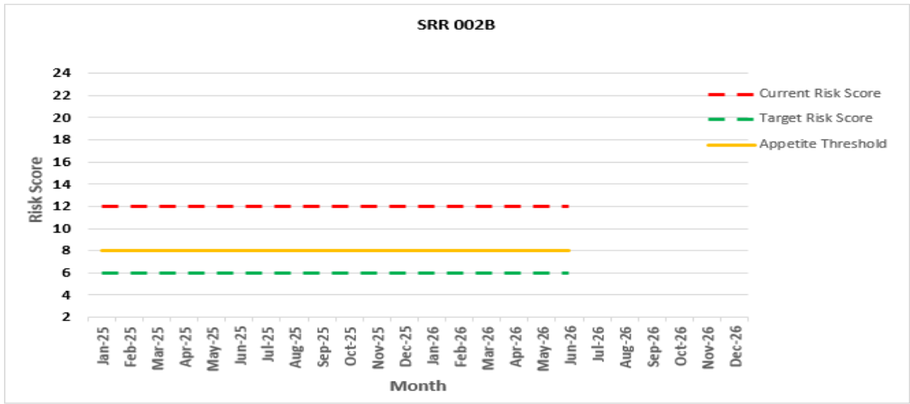
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| **Negative –** Insufficient evidence that the controls | **Reasonable -** adequate evidence that the controls in place are working effectively. | **Positive -** robust evidence that the controls in place are working effectively. | **REASONABLE ASSURNACE** |

| | | | | |
|---|---|---|---|---|
| **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.** | | | |
| **Impact** *(Consequences of the threat)* | **Patient**<br>• Harm or injury to patients.<br>• Adverse impacts on the delivery of care to patients across acute and non-acute settings. | **Staff**<br>• Harm or injury to staff. | **Organisation**<br>• Non-compliance with health and safety legislation.<br>• Litigation and financial penalties.<br>• Loss of estate | |
| **Lead Director** | Chief Operating Officer | **Risk Exposure** | **Current Level** | **Target Level** |
| **Monitoring Committee / Group** | Partnerships, Health Protection & Planning Committee | **Likelihood** | **3** (Possible)<br>x | **3** (Possible)<br>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 | | | |

**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.

**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.




| **Current Key Controls**<br>*(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**<br>***What further controls are required to reduce the risk exposure to within a tolerable range?***<br>*(Short, Medium, and Long-Term Plans need to be included)* |
|---|---|
| • Health Board Estates Rationalisation Strategy<br>• Health Board Estates Strategy<br>• Health Board policies and procedures related to the maintenance of Health Board estate.<br>• 6 Facet survey completed in 2019.<br>• Divisional Risk Register<br>• Multiple policies and SOPs published and communicated to staff.<br>• A robust internal training programme in place covering all aspects of estate management including food hygiene.<br>• Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director)<br>• Asbestos reinspection programme (over the next 3 years)<br>• Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation<br>• HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants | • Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance.<br>• 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.<br>• Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance.<br>• Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM.<br>• Drive clinical service engagement in compliance meetings where engagement is low.<br>• Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.<br>• Continuation of the additional £500k backlog maintenance allocation by the Board to the Estates and Facilities Division in 2026/27<br>• 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<br>• 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<br>• Condition survey (commonly referred to as 6 facet) being scoped for completion in early 2026/27 to inform the estates strategy |

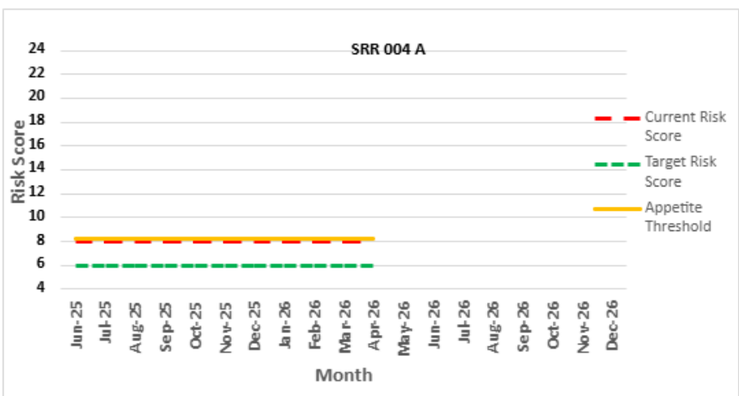
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| • A clear approach to compliance monitoring and escalation of AE reports has been implemented | |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(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<br>• 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.<br>• Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee.<br>• Divisional Director Estates and Facilities presented to Committee in December 2024 and February 2026<br>• 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**<br>• Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and<br>• Finance and Performance Committee<br><br>Internal Audit Plan 2024-25<br>• Estates Assurance – Energy Management (Q2) Outcome = Reasonable Assurance. Reported to the November ARA<br><br>• Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes.<br><br>• 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**<br>• Implementation of the management responses to close off recommendations<br>• Audit Wales completing an all-Wales audit on estate condition in Q4 2025/26 |

**Assurance Rating** (*Overall Assessment of controls and assurances*) *Guidance*

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|---|---|---|---|
| **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 ASSURNACE** |

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|---|---|---|---|---|---|
| **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**<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings<br>• Harm or injury to patients | **Staff**<br>• Inability to respond to a major incident to meet needs of those affected<br>• Harm or injury to staff | **Organisation**<br>• Health Board breaches statutory duties under the Civil Contingencies Act 2004<br>• Litigation & Financial Penalties<br>• 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** | November 2025 | **Risk rating** | **= 8 (Moderate)** | **= 6 *(Moderate)*** | |
| **Next Review** (Six-monthly based on risk score) | May 2026 | | | | |




| **Current Key Controls** *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)* |
|---|---|
| • Local/Divisional action cards are in place in key areas<br>• Training undertaken service-specific relating to local response.<br>• 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<br>• Internal strategic on call training<br>• Executive Team attending 2-day strategic training.<br>• Loggist training is provided and accessed regularly<br>• New all Wales logbooks are in place for use<br>• Regular liaison with Gwent Local Resilience Forum (Strategic and tactical)<br>• Joint Planning and Training with LRF and across Wales.<br>• Ongoing Participation in exercises UK, Wales, LRF and HB.<br>• 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) | • Continue to deliver training programmes to support staff preparedness to response to an incident.<br>• Additional 'local' team and intra team exercises to take place for areas to practice and embed their response to a major incident together<br>• Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational.<br>• 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.<br>• National pandemic exercise Pegasus Autumn 2025<br>• Development of a pan plan to support pandemic pathways (HCIDs e.g., MPOX) |

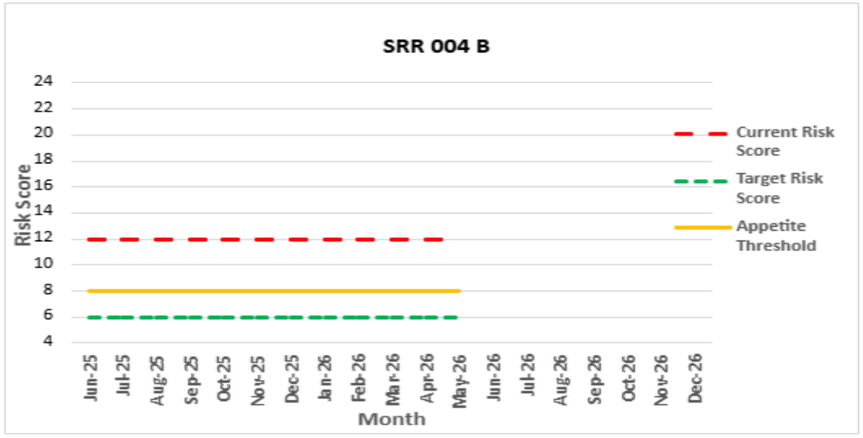
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| • Continuing to work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner<br>• LRF Pandemic Solaris undertaken | |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(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.<br>• Training records<br>• Plans and action cards in place and up to date<br>• 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<br>• 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)**<br>• Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response - **Reasonable Assurance**<br>• 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 ASSURNACE** |

| | | | | |
|---|---|---|---|---|
| **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** | | | **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**<br>• Harm or injury to patients<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings | **Staff**<br>• Staff absence (injury, wellbeing)<br>• Harm or injury to staff | **Organisation**<br>• Operational flow if services fail to prepare BCPs against the 5 key themes<br>• Loss of infrastructure;<br>• Financial implications due to staff absence<br>• Health Board breaches statutory duties under the Civil Contingencies Act 2004;<br>• Litigation & Financial Penalties;<br>• 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 and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold. |

| | | | | |
|---|---|---|---|---|
| **Lead Director** | Director of Strategy, Planning and Partnerships | Risk Exposure | **Current Level** | **Target Level** |
| **Monitoring Committee / Group** | Partnerships, Public Health & Planning Committee | **Likelihood** | 3 (Likely)<br>x | 2 (Unlikely)<br>x |
| **Initial Date of Assessment** | 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 | | | |




| **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<br>• Business Continuity Response Guidance<br>• Business Continuity Template & guidance (reviewed and updated April 2025)<br>• Divisional, Directorate & Service Business Continuity Plans across a number of key operational areas<br>• Business Continuity Exercises<br>• Business Continuity debrief learning.<br>• Health Board and Local Resilience Forum (LRF) Plans.<br>• 3C (Command/Control, Communication) structure in place to respond to incidents.<br>• 1-2-1 training with Divisional BC leads and delivering BC workshops for services.<br>• Health Board EPRR Group Established.<br>• Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies.<br>• Awareness raising of the requirement for BC across the Health Board through various training programmes<br>• Infectious Diseases plan<br>• Joint plan with PH in response to infectious diseases and public health incidence response overall<br>• Internal strategic on call training<br>• Executive Team attending 2-day strategic training.<br>• Regular liaison with Gwent Local Resilience Forum (Strategic and tactical)<br>• Joint Planning and Training with LRF and across Wales.<br>• Ongoing Participation in exercises UK, Wales, LRF and HB. | • 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.<br>• 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.<br>• Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational.<br>• 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.<br>• 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.<br>• Development of a business continuity dashboard that enables divisions & directorates to manage, RAG rate and provide assurance of their BC planning arrangements.<br>• Joint working with partners – Exercise Pegasus<br>• 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.<br>• Develop an off the shelf BC exercise for divisions, directorates & services.<br>• 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. |

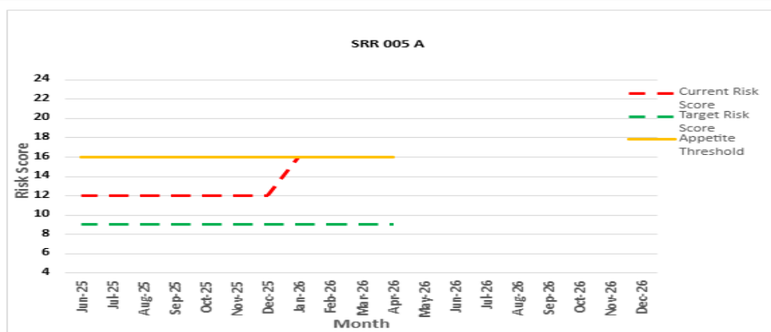
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| • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).<br>• Ability to warn & inform the organisation of critical BC incidents via the Health Board communications team.<br>• Health Board service BC supporting plan – to provide a generic response framework if they have no specific plans are in place.<br>• A dedicated business continuity lead for IT applications and networks to reduce the highest key theme risk.<br>• The introduction of a business continuity Incident Response Group in the event that a BC incident that escalates to critical.<br>• 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.<br>• We have delivered 2 BC exercises (loss of IT applications/networks) for service senior managers – further exercises are planned for 26/27<br>• Services will be required to have tested & exercised at least 2 key theme plans and the alert, coordinate & escalate procedures in 2026.<br>• Creation of any BC lessons learned repository for services to populate and learn from.<br>• Training Operational Management teams to enable them to respond to and coordinate BC incidents that are impacting patient flow/care. (This has commenced)<br>• 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**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(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.<br>• Div/Service BC risk registers<br>• Service BC training records<br>• Departmental debrief following an incident to inform learning and enhance controls.<br>• 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<br>• Reports to the PPHP Committee on Emergency Planning Preparedness (most recent Jan 2026)<br>• | • 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)**<br>Business Continuity Planning 2025-26 outcome report published –<br>**Reasonable Assurance**<br><br>• 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 ASSURNACE** |

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|---|---|---|---|---|
| **RISK THEME** | **SERVICE DELIVERY** | | | |
| **LINK TO IMTP** | **SECTION 3: SYSTEM CHANGE** | | | |
| **Strategic Risk**<br>**SRR 005 A** | **There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system** | | **Publication Status** | **Public** |
| **Threat**<br>*(As a result of)* | **Due to inadequate arrangements to support system-wide patient flow** | | | **Risk Appetite Level – OPEN**<br>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**<br>*(Consequences of the threat)* | **Patient**<br>• Avoidable deaths and significant harm.<br>• Delayed discharges from acute and non-acute settings resulting. in deteriorating patients.<br>• Delays in releasing ambulances from hospital sites back into the community. | **Staff**<br>• Increased workload<br>• Fatigue & burnout | **Organisation**<br>• Litigation & Financial Penalties<br>• Reputational damage and loss of public confidence | **Risk Appetite Threshold – OPEN SCORE 17 AND BELOW**<br>Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. |
| | | | | **SUMMARY**<br>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** | Chief Operating Officer | Risk Exposure | **Current Level** | **Target Level** |
| **Monitoring Committee / Group** | Patient Quality, Safety and Outcomes Committee | **Likelihood** | **4** (Possible)<br>x | 3 (Possible)<br>x |
| **Initial Date of Assessment** | June 2023 | **Impact** | ***4** (Major)* | 3 (Moderate) |
| **Last Reviewed** | April 2026 | **Risk rating** | **= 16**<br>**(Extreme)** | ***= 9***<br>***(High)*** |
| **Next Review**<br>(Monthly based on risk score) | May 2026 | | | |




| **Current Key Controls**<br>*(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**<br>***What further controls are required to reduce the risk exposure to within a tolerable range?***<br>*(Short, Medium, and Long-Term Plans need to be included)* |
|---|---|
| • Escalation Policy.<br>• Performance and Accountability Framework<br>• Operational Framework<br>• Major incident Procedures<br>• Daily ONP flow meetings - Twice daily ONP calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks.<br>• Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team.<br>• Weekly system safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Data driven. action focussed and task driven.<br>• Enhanced monitoring in place for U&EC – level 4<br>• Range of performance measures/metrics in place<br>• Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards.<br>• Maximum Capacity Plan – Executive team agreed maximum capacity (including risk assessed boarding) plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. Full Capacity Protocol is in place.<br>• Planned care delivery plan agreed and recovery meetings with the NHS execs to support activity.<br>• 26-week OP programmehas finished, and HB is exceeded numbers for first outpatient appoints.<br>• Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls.<br>• WG – IQPD meetings to review areas of focus<br>• Regular meetings with Local Authorities to review POC delays and LOS concerns. | ➢ **Continue Refocus on Our New Patient and key pieces of work: -**<br>**Discharge Acceleration:**<br>➢ Daily board rounds identify definite and potential discharges early to free up beds before peak demand<br>➢ Weekend discharge lists are shared proactively to maintain flow across all sites.<br>**Full Capacity Protocol:**<br>➢ Boarding continues across sites under strict risk assessment, with escalation to use dayrooms or therapy spaces only as a last resort.<br>➢ Red lines for boarding (e.g., avoiding high-risk patients) are reinforced in SOP discussions.<br>**Step-Down Coordination:**<br>➢ Flow Centre actively books and allocates step-downs; priority is given to patients who can safely move to community beds or lower-acuity settings.<br>➢ Community bed usage is maximized, with reablement teams engaged to expedite transfers.<br>➢ Contingency for Delays - where step-downs stall, escalation includes opening additional community beds and using SDEC for low-acuity patients.<br>**Rapid Offload Strategy:**<br>➢ Flow Centre monitors ambulance waits and redistributes crews to minimise delays.<br>➢ Plans include prioritizing high-risk patients for cubicles and using lounges for temporary placement.<br>**Standard Operating Procedure (SOP):**<br>➢ A simplified SOP is being finalised to standardise escalation pathways, boarding criteria, and discharge prioritisation across divisions.<br>➢ Divisional “red lines” (e.g., elective bed protection, infection control limits) are being formalised for consistent decision-making.<br>**Data-Driven Oversight:**<br>➢ Flow Centre dashboards and live trackers are used to monitor patient movement, discharge progress, and capacity in real time.<br>➢ Development of new dashboards to track EDDs and Red Reasons to inform system flow decisions.<br>➢ New ED extension opened on the 17th December with phase 2 to start in the new financial year<br>➢ Additional ED consultants in place |

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| | ➢ New expanded transfer lounge is progressing well, supporting with transport booking and supporting early movement of patients.<br>Focus Areas for the next month:<br>➢ Develop Our Next Patient UEC recovery plan – Board Development Session April 2026<br>➢ Programme of work has Divisional projects across the system to support flow<br>➢ Work with social care and PCC division on joint assessment and community bed delays to consistently improve discharge reliability.<br>➢ Reset regularly — ONP highlights the need for routine reset days/fortnights to correct worsening patterns in flow, WTBS, and handovers. |

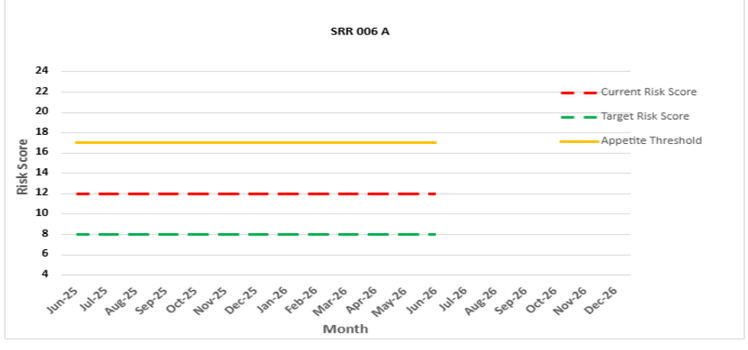
| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(What further evidence is required to provide the effectiveness of controls)* |
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| **Level 1 Operational** *(Implemented by the department that performs daily operation activities)* | | |
| • The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services.<br>• Performance report against measures/metrics<br>• Regular ONP meetings to review flow<br>• S2S meeting - creates a consistent, standardised process for assessing readiness, escalating issues, and agreeing collective plans, fostering clear accountability from ward to board level.<br>• Weekly weekend planning meetings in place to plan for the weekend capacity | • Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan.<br>• The impact of the Performance and Accountability framework in improving patient flow<br>• Outputs and progression of actions from ONP and S2S meetings to sustain system flow | • Close monitoring and reporting of the frameworks in practice to support learning and improvements. |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |
| • Monthly Divisional Assurance reviews.<br>• Mid and EoY Reviews for Divisions<br>• Performance against measures/metrics reported to the Executive Committee<br>• Planning and Performance Committee<br>• Cross Divisional Meetings – cross divisional thinking, learning and sharing best practice | • The Operational Framework is being developed to define how individual services meet demand and outline the actions required during escalation. This framework is currently under refinement through the Our Next Patient (ONP) work. | • The Operational Framework process commenced in November 2024, initiating a series of in-depth reviews across specific services. This is an iterative approach designed to remain active and adaptable, ensuring it continues to meet the evolving needs of the services. |
| **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* | | |
| Independent Reviews<br><br>• Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024.<br>• External inspections/visits.<br>• IQPD Monthly Meetings focus on key areas<br>• GIRFT visit Report<br>• Accelerated Design Event / Programme of work<br>• Winter Sprint – December 2025 and January 2026<br>• MAG Report - focus areas for ABUHB | • **Clinical Leadership & Patient Experience:** Strong emphasis on clinically led, data-driven change, with patient stories highlighting the real-world impact of delays.<br>• **Mandated Targets:** The 45-minute ambulance handover target is to be mandated, with an ambition to reach a 15-minute standard for patient safety.<br>• **System-Wide Responsibility:** Improvement requires engagement across all sectors—ED, primary care, community, acute medicine, surgery, and ambulance services.<br><br>Improving Performance Together (MAG Report)<br>• 45 min hand overs,<br>• Clarity over fragile services asks and delivery<br>• Accountability for regional working in our region<br>• Asks around data sharing and use of comparative data sets – definitions are still work in progress<br>• Indicates population health management tools will be available – Alignment locally<br>• Breathlessness and lung cancer alignment with our own plans<br>• Integrated care hubs<br>• Define the funding and delivery shift from Secondary to Primary Care– with a plan | N/A |

**Assurance Rating** (*Overall Assessment of controls and assurances)* *Guidance*

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| **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 ASSURNACE** |

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

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| **Lead Director** | Director of Digital | Risk Exposure | **Current Level** | **Target Level** |
| **Monitoring Committee / Group** | Finance and Performance Committee | **Likelihood** | 3 (Possible)<br>x | 2 (Unlikely)<br>x |
| **Initial Date of Assessment** | June 2023 | **Impact** | *4 (Major)* | 4 (Major) |
| **Last Reviewed** | April 2026 | **Risk rating** | **= 12 (High)** | ***= 8 (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)* |
|---|---|
| • Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jun 2025. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed regularly.<br>• Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained.<br>• Information Governance and Cyber Security governance and assurance processes reviewed and implemented.<br>• Governance group terms of reference agreed. Meetings started in November 2023.<br>• Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff<br>• Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report.<br>• Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report and presented at monthly Service Delivery Management Group.<br>• Work with Information Governance around implementing the controls required to align DDaT to the ISO27001 standard.<br>• Battle tested ABUHB cyber incident response, communication cascade and reporting to Cyber Resilience Unit.<br>• Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed to failover in a seamless fashion from one DC to the other with no service impact.<br>• Microsoft Defender provides inspection and protection from malicious links embedded within emails using telemetry from the whole NHS Wales tenant.<br>• Microsoft Sentinel security event and incident management tool in use to analyse systems and provide alerts. | • Cyber Resilience Unit (CRU) Audit undertaken in June 2025 showed an overall improvement. Progress continues with finding outcomes from past audits. Bi-Monthly meetings (NIS Assurance Group) with the responsible action owners to provide updates against the findings, some key recommendations such as incident management testing have been actioned. The next NIS CAF Audit is scheduled for June 2026.<br>• Work with Information Governance around implementing the controls required to align DDaT to the ISO27001 standard, implement NIS CAF controls, and CIS (Centre for internet security) benchmarks for operating systems.<br>• Internal Audit review on Shadow IT scheduled for 2026.<br>• Daily firewall reports on suspicious traffic, internet usage. Stats and trends reported monthly to the Service Delivery Management Group (SDMG)<br>• Improvements to Vulnerability Management Service (VMS) to identify vulnerable 3rd party applications<br>• Internet of Things reporting to show device security posture now being developed as new firewalls are being deployed.<br>• Ingest NHS England Security Operations Centre (SOC) Indicators of compromise (IOC) feed into the Health Boards security tooling to provide additional early warnings.<br>• Improvements in mandatory training compliance for Information Governance and Cyber Security.<br>• Monthly Phishing simulations have identified colleague susceptibility and additional training and awareness needs. requirements - a Phishing simulation tool with inbuilt cyber training has been procured to support this<br>• Incident management; |

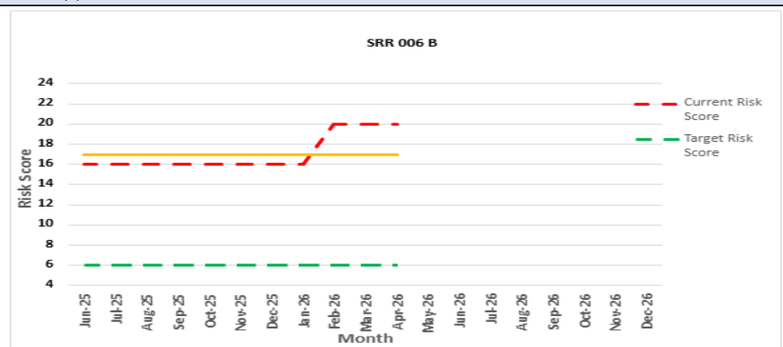
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| • At least monthly simulated phishing emails to check email security awareness among staff.<br><br>Scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber to run quarterly exercises. | ○ 2x members of Cyber security now CIPR (Cyber Incident Panning & response) accredited<br>○ Cyber attend regular NHS England hosted Immersive labs tabletop exercises.<br>○ 2x tabletop exercises for technical teams conducted in 2025 by Tarian (SW Police Cyber unit)<br>○ Rubrik hosting a "Save the data" tabletop exercise planned for April 2026<br><br>Quarterly inhouse scenario-based tabletop exercises hosted by Cyber for technical teams and wider responders – 2 exercises have been conducted as of April 2026, one regarding a malware incident on CWS and one around a senior finance manager account compromise |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(What further evidence is required to provide the effectiveness of controls)* |
|---|---|---|
| **Level 1 Operational** *(Implemented by the department that performs daily operation activities)* | | |
| • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans.<br>• Single directorate risk registers now in place. | • None | • N/A |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |
| • Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan.<br>• Annual Senior Information Risk Owner report. | • None | • N/A |
| **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* | | |
| • Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2024/25<br>• DHCW CRU NIS CAF Audit June 2026<br>• Oversight from NHS Wales Cyber Resilience Unit.<br>• Infrastructure and Network controls Audit by Audit Wales. | • None | • N/A |

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

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

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




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

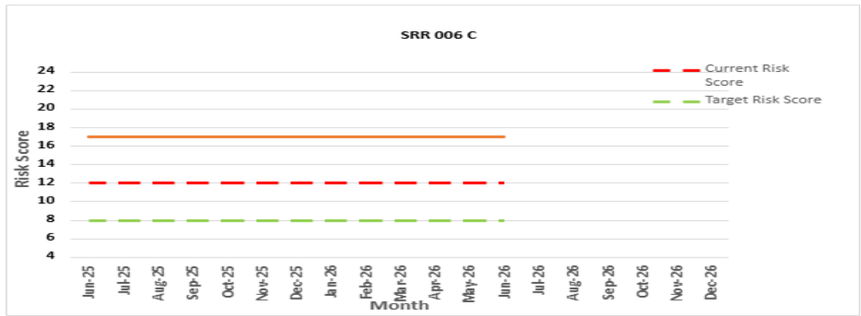
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| • Digital transformation development programme provided to the Board in January 2026.<br>• Welsh Government strengthening national governance with the introduction of a DDaT Leadership Board and supporting groups.<br>• Regular reporting now in place to Chief Executive Management Team and Welsh Government DDAT Leadership Board due to concerns over timescales and deliverability to LIMS and RISP.<br>• Local project tolerance levels changed to zero for both RISP and LIMS to ensure immediate escalation processes are enacted for risks or issues impacting delivery / timelines. | |

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

**Assurance Rating** (*Overall Assessment of controls and assurances*) *Guidance*

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|---|---|---|---|
| **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 ASSURNACE** |

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|---|---|---|---|---|---|
| **RISK THEME** | **SERVICE DELIVERY** | | | | |
| **LINK TO IMTP** | **SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY** | | | | |
| **Strategic Risk**<br>**SRR 006 C** | **There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.** | | | **Publication Status** | **Public** |
| **Threat**<br>*(As a result of)* | **Due to failure to develop digital solutions that are sustainable and for the future.** | | | **Risk Appetite Level – OPEN**<br>Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure. | |
| **Impact**<br>*(Consequences of the threat)* | **Patient**<br>• Unintended harm or injury to patients.<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings | **Staff**<br>• Unintended harm or injury to staff. | **Organisation**<br>• Data breaches<br>• Litigation & Financial Penalties<br>• Reputational damage and loss of public confidence | **Risk Appetite Threshold – Score 17 and Below**<br>Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. | |
| | | | | **SUMMARY**<br>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 Digital | Risk Exposure | **Current Level** | **Target Level** | |
| **Monitoring Committee / Group** | Finance and Performance Committee | **Likelihood** | **3** (Possible)<br>x | **2** (Unlikely)<br>x | |
| **Initial Date of Assessment** | June 2023 | **Impact** | ***4*** *(Major)* | **4** (Major) | |
| **Last Reviewed** | April 2026 | **Risk rating** | **= 12**<br>**(High)** | ***= 8***<br>***(Moderate)*** | |
| **Next Review**<br>(Quarterly based on risk score) | July 2026 | | | | |



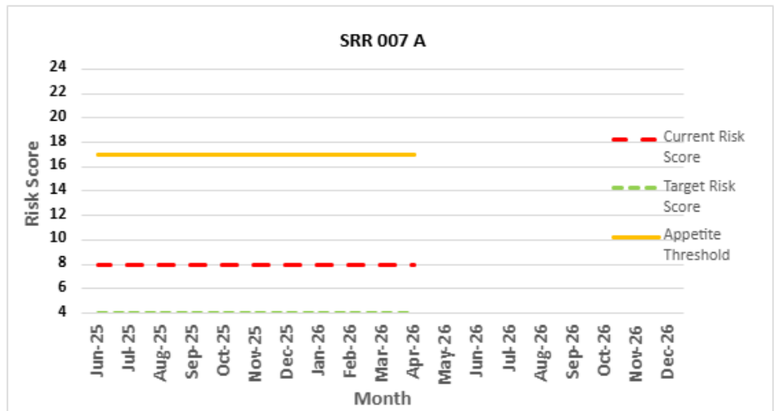

| **Current Key Controls**<br>*(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control**<br>***What further controls are required to reduce the risk exposure to within a tolerable range?***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

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

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

| | | | | |
|---|---|---|---|---|
| **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**<br>• Unmet patient need resulting in harm | **Staff**<br>N/A | **Organisation**<br>• Ineffective use of combined resource Delayed decision making<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings<br>• Failure to deliver health board priorities, required improvements and achieve longer-term sustainability<br>• 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. |

| | | Risk Exposure | Current Level | Target Level |
|---|---|---|---|---|
| **Lead Director** | Director of Strategy, Planning, and Partnerships. | | | |
| **Monitoring Committee** | Partnerships, Public Health & Planning Committee | **Likelihood** | **2** (Unlikely) x | **2** (Unlikely) x |
| **Initial Date of Assessment** | June 2023 | **Impact** | **4** (Major) | **2** (Minor) |
| **Last Reviewed** | November 2025 | **Risk rating** | **= 8 (Moderate)** | ***= 4 (Moderate)*** |
| **Next Review** (Six Months based on risk score) | May 2026 | | | |



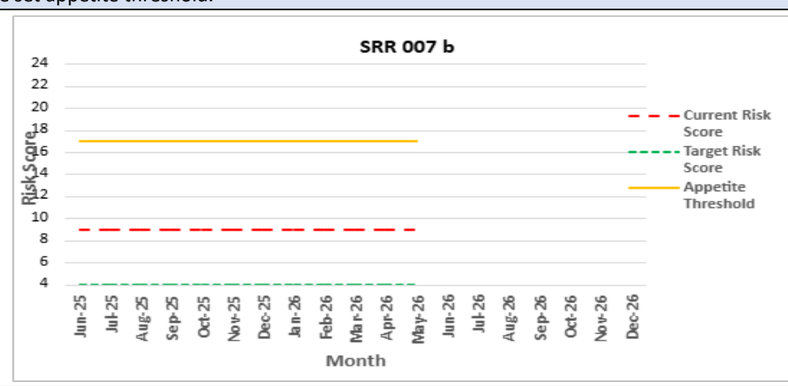

| **Current Key Controls** *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)* |
|---|---|
| The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including:<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• Renewed Strategy for strategic partnership Capital in place and revised governance processes.<br>• New Long-Term Strategy for Health Board to focus on Partnership approach. |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(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.<br><br>• Regional Leadership Group Reporting | • Systematic reporting of outcomes<br>• Systematic evaluation of schemes<br>• Governance of financial control arrangements | • Implementation plan to be developed following RPB governance review.<br><br>• 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.<br><br>• 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**<br><br>• RPB Governance Review (Q4) – **Outcome = Limited Assurance.** Reported to ARAC September 2024<br>• 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*

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|---|---|---|---|
| **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 ASSURNACE** |

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|---|---|---|---|---|---|
| **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**<br>• Unmet patient need resulting in harm<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings | **Staff**<br>N/A | **Organisation**<br>• Failure to deliver health board priorities, required improvements and achieve longer-term sustainability<br>• Reputational damage and loss of public confidence<br>• Ineffective use of combined resources<br>• Delayed decision making<br>• 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)<br>x | **2** (Unlikely)<br>X | |
| **Initial Date of Assessment** | January 2024 | **Impact** | ***3** (Moderate)* | **2** (Minor) | |
| **Last Reviewed** | March 2026 | **Risk rating** | **= 9 (High)** | ***= 4 (Low)*** | |
| **Next Review** (Quarterly based on risk score) | June 2026 | | | | |

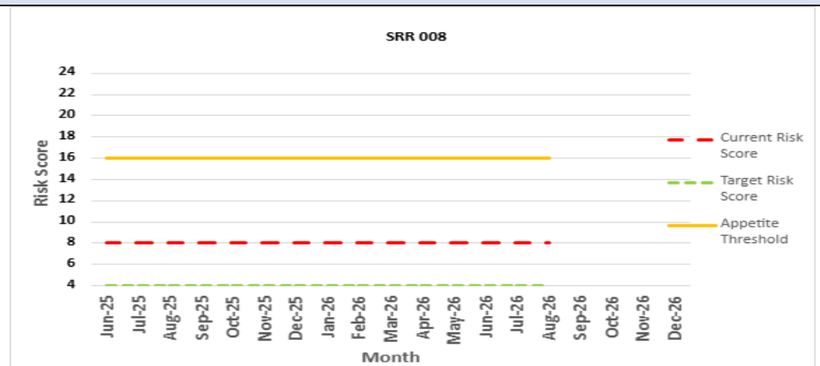



| **Current Key Controls** *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(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:<br><br>- to review all regional service projects<br>- to assess progress against agreed timelines and;<br>- to agree additional measures / escalations in the event of identified issues and risks.<br><br>• 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.<br><br>• Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all.<br><br>• 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.<br><br>• 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. | 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:<br><br>• Regional Contracting and Commissioning: developing a proposed framework for the region<br>• Digital: Establish shared patient treatment lists with a minimum viable product being proof of concept for cataracts and lower limb arthroplasty<br>• Digital: Ability for clinical teams to see patient records across health board boundaries<br><br>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.<br><br>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.<br><br>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. |

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| • 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. | |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(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<br>• 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.<br>• Assurance reporting to the Population Health, Partnerships, and Planning Committee.<br>• Assurance reporting to the Board.<br>• 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 ASSURNACE** |

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|---|---|---|---|---|---|
| **RISK THEME** | **TRANSFORMATION AND PARTNERSHIP WORKING** | | | | |
| **LINK TO IMTP** | **SECTION 4: ENABLER - QUALITY** | | | | |
| **Strategic Risk SRR 008** | **There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.** | | | **Publication Status** | **Public** |
| **Threat** *(As a result of)* | **Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.** | | | | **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**<br>• Unmet patient needs resulting in patient harm.<br>• Ineffective use of combined resources<br>• Delayed decision making<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings<br>• Negative experience of care<br>• Distress and frustration.<br>• Carer stress. | **Staff**<br>Staff dissatisfaction<br>Frustration<br>Increased absence.<br>Loss of confidence. | **Organisation**<br>• Failure to deliver health board priorities, required improvements and achieve longer-term sustainability<br>• Reputational damage and loss of public confidence | | **Risk Appetite Threshold – OPEN 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 but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold. |
| **Lead Director** | Director of Nursing | **Risk Exposure** | **Current Level** | **Target Level** |  |
| **Monitoring Committee** | Patient Quality, Safety and Outcomes Committee | **Likelihood** | **2** (Unlikely) x | **2** (Unlikely) x | |
| **Initial Date of Assessment** | June 2023 | **Impact** | ***4** (Major)* | **2** (Minor) | |
| **Last Reviewed** | March 2026 | **Risk rating** | **= 8 (Moderate)** | ***= 4 (Low)*** | |
| **Next Review** (Six monthly based on risk score) | September 2026 | | | | |



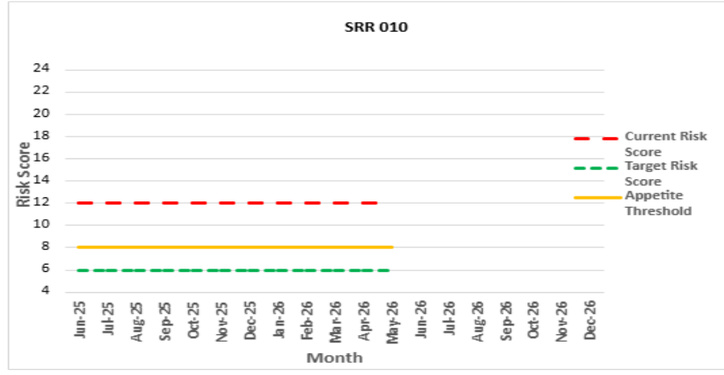
| **Current Key Controls** *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)* | **Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)* |
|---|---|
| • Corporate Engagement Team<br>• Patient Experience and Involvement Strategy- organisational ownership<br>• Person Centred Care (PCC) Surveys and National surveys via CIVICA<br>• PCC KPI's (support PCC Quality pillar)<br>• 'You said…… we did' public facing information for service areas.<br>• PLO service at GUH<br>• Introduction of PALS Service (Oct 23)<br>• Volunteer Patient Experience Feedback<br>• Collaboration to recruit community listeners to support Dementia Awareness<br>• Digital patient stories to support listening and learning.<br>• DATIX<br>• Oversight of Medical Examiner reports to determine patient experience actions<br>• Public Engagement- Big Conversation Bereavement held 20th March 2024, Big Conversation Sepsis Sept 2025 and Big Conversation Care Homes December 2025<br>• People Participation Panel ED in Progress, PPP for Deaf People established<br>• Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.<br>• Dementia Person centred Care team dedicated e mail address. | • Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress.<br>• PCCT staff training to support Civica data entry and retrieval in progress. Short Term grant funding for Band 2 data entry support<br>• Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners.<br>• Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to Quality Management Group and IQPD<br>• Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. SMS provision to be implemented in Feb 2025 across ED and all MIU's. 5 National Maternity Surveys launched via SMS 1st Sept 2025<br>• National directives around new national surveys that need to be managed additional to internal roll out programme – National People's Experience Survey live 1st May 2025 and default survey for majority of live areas. Continued participation in national meetings<br>• Volunteer feedback to be reviewed to identify themes. This happens weekly<br>• End of Life and Bereavement models published and meets Bereavement Standards.<br>• EOLCB refresh completed to meet National Palliative and End of Life Care Specification and National Competency Framework<br>• Community of Practice for Patient Experience and People Participation Panels (PPP) now agreed and to be progressing. BSL version of PPP leaflet secured. |

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| • Dementia Information and signposting through webpages.<br>• Patient feedback on the agenda for each of the dementia workstream meetings.<br>• Dementia - QR code for feedback at each training event and session.<br>• Dementia Thematic review from CIVICA team requested to inform actions and improvements in care.<br>• Dementia - Multi agency partnership workstreams measuring impact of service.<br>• Graces places set up across all 5 boroughs | • Dementia community hubs in each borough of Gwent enable accessible opportunities for feedback and signposting, plans to increase hubs in more areas of Gwent. Annual Dementia Report scheduled for Board March 2026 |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(What further evidence is required to provide the effectiveness of controls)* |
|---|---|---|
| **Level 1 Operational** *(Implemented by the department that performs daily operation activities)* | | |
| • Concerns are fed back to divisional teams when identified.<br>• Outcome of the volunteer feedback to drive improvements.<br>• Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024<br>• Immediate feedback and escalation to clinical teams following PALS queries and concerns<br>• Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly.<br>• Bereavement survey built with CIVICA – Nov 2024<br>• CIVICA SMS launched 3rd March 2025 across ED and MIU'S<br>• People Participation Panels<br>• Bespoke Big Conversations | • Currently there is limited SMS provision to increase the number of surveys.<br>  • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. This is being reviewed in light of the new Listening to People framework<br>  • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.<br>  • CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / 'you said, we did' / quality improvement projects. | • SMS provision for patient experience feedback launched in ED and all MIU's in February 2025. Civica lead in regular contact with National Leads and risks identified through Director of Nursing Meetings/SBARs<br>• PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms.<br>• PALS and Chaplaincy Team undertaking BSL training to support Deaf Community<br>• Patient experience KPI's and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys have been built into ward accreditation.<br>• Development of a ABUHB bereavement survey has been built within CIVICA and tested. This is being reviewed to better align with the national Patient Experience Survey- anticipated to go live from April 2026<br>• Community of Practice for Patient Experience commencing March 2026. Topics will include supporting teams to publicise 'You Said/We Did'. |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |
| • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO)<br>• Listening and Learning reported through QPSOG/ Outcomes Committee<br>• Implemented PALS DATIX Module | None | N/A |
| **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* | | |
| • Bi-monthly LLais Reports<br>• HIW inspections<br>• Advocacy reports | None | N/A |

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

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|---|---|---|---|---|---|
| **RISK THEME** | **COMPLIANCE AND SAFETY** | | | | |
| **LINK TO IMTP SECTION 4: ENABLER** | **QUALITY** | | | **WORKFORCE & CULTURE** | |
| **Strategic Risk: SRR 010** | **There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974** | | | **Publication Status** | **Public** |
| **Threat** *(As a result of)* | **Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements** | | | **Risk Appetite Level – MINIMAL** Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below. | |
| **Impact** *(Consequences of the threat)* | **Patient**<br>• Unintended physical harm to patients<br>• Psychological trauma | **Staff**<br>• Unintended physical harm to staff<br>• Psychological trauma<br>• Increased levels of staff sickness | **Organisation**<br>• Punitive actions from the Health and Safety Executive (HSE)<br>• Loss of estates due to unsafe environments<br>• Financial implications<br>• Adverse publicity<br>• Reputational damage. | **Risk Appetite Threshold – SCORE OF 8 or Below** 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. | |
| | | | | **SUMMARY** The current risk level is **OUTSIDE** of target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold. | |
| **Lead Director** | Director of Allied Health Professions and Health Science | **Risk Exposure** | **Current Level** | **Target Level** | |
| **Monitoring Committee** | Patient Quality, Safety and Outcomes Committee | **Likelihood** | 3 (Possible) x | 2 (Unlikely) x | |
| **Initial Date of Assessment** | December 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 | | | | |




| **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)* |
|---|---|
| • Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices.<br>• Health and Safety Policies and Procedures<br>• Dedicated Health and Safety site on ABPULSE<br>• Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'.<br>• Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression)<br>• Partial Programme of Health and Safety Monitoring (Active & Reactive)<br>• Corporate and Directorate Health and Safety Risk Register established.<br>• Board Training /development (Completed 24 April 2024)<br>• Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern.<br>• Health and Safety Governance and reporting arrangements (Health and Safety Committee) | • Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System<br>• Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments)<br>• Consultation and communication with the workforce regarding compliance with the Act<br>• New ways of working with Divisions to ensure accountability for health and safety is recognised.<br>• Implement key performance indicators to monitor health and safety compliance.<br>• Review the governance arrangements for the Health & Safety Committee<br>• Health and Safety Policies and Procedures to be reviewed.<br>• Onboard further Manual Handling trainers across the organisation to improve compliance.<br>• Scope for training non-Health Board staff<br>• Learning from events to be documented and communicated to the organisation. |

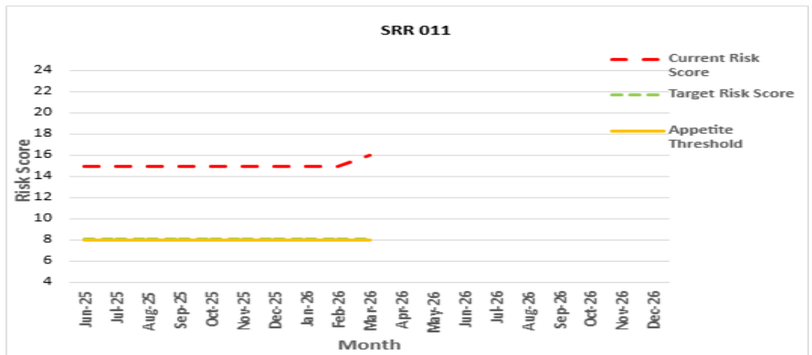
| Sources of Assurance<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | Gaps in Assurance<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | Actions to Address Gaps<br>*(What further evidence is required to provide the effectiveness of controls)* |
|---|---|---|
| **Level 1 Operational** *(Implemented by the department that performs daily operation activities)* | | |
| Health and Safety compliance data extracted from ESR and Datix and reported<br>Statutory reporting data reports and dashboards | • Implementation of a health and safety performance report<br>• Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act<br>• Compliance on completion of risk assessments and mitigating actions<br>• Consistent adherence and application of policies | • Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework.<br>• Review the membership and ToRs of the Health and Safety Committee<br>• Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |
| • Established monitoring of H&S at the Executive Committee<br>• Corporate H&S Team report risk and assurance to the Health and Safety Group<br>• Health and Safety Annual Report<br>• Health and Safety Improvement Plan<br>• Established monitoring of H&S at the PQSO Committee | • Thematic Risk Register | • Development of a thematic risk register |
| **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* | | |
| **Internal Audit 2024/25 Plan**<br>• Health and Safety Internal Audit – **Concluded Limited Assurance**<br><br>• Performance reviews at All Wales Health and Safety Management Steering Group<br>• South Wales Fire & Rescue Service fire safety audit programme.<br><br>Health and Safety Executive reviews/inspections. | • Recommendations from the 2024/25 Internal Audit | • Implement actions to address the findings and recommendations set out in the Limited Assurance Internal Audit Report |

**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 ASSURNACE** |

| | | | | |
|---|---|---|---|---|
| **RISK THEME** | **SERVICE DELIVERY** | | | |
| **LINK TO IMTP** | **SECTION 4: ENABLER – GREEN HEALTH** | | | |
| **Risk** (reframed)<br>**SRR 011** | **There is a risk that the Health Board does not adequately anticipate, plan for, and respond to the impacts of climate change, green health requirements, and the need to adapt and decarbonise its services, estate and infrastructure.** | | **Publication Status** | **Public** |
| **Cause**<br>*(As a result of)* | **Due to an ageing and complex estate, competing capital and revenue pressures, climate-related service demand and the absence of an organisation-wide climate adaptation approach.** | | **Risk Appetite Level – OPEN:** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure | |
| **Impact**<br>*(Consequences of the threat)* | **Patient / population**<br>• Increased safety risks to patients arising from inadequately adapted buildings and infrastructure.<br>• Reduced access to clinical services<br>• Poor patient experience | **Staff**<br>• Increased safety risks to staff arising from inadequately adapted buildings and infrastructure.<br>• Low morale<br>• Increased workload from staff absences | **Organisation**<br>• Disruption to clinical services and business continuity<br>• Greater demand on healthcare services<br>• Non-compliance with Welsh Government policy and statutory duties under the Well-being of Future Generations (Wales) Act.<br>• Increased operational and capital costs due to reactive rather than planned interventions.<br>• Reputational damage<br>• Missed opportunities to improve population health and prevention through green health approaches. | **Risk Appetite Threshold – SCORE 17 AND BELOW.**<br>Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. |
| | | | | **SUMMARY**<br>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. |

| | | Risk Exposure | Current Level | Target Level |
|---|---|---|---|---|
| **Lead Director** | Director of Finance and Procurement | | | |
| **Monitoring Committee / Group** | Finance and Performance Committee | **Likelihood** | 4 x Likely | 4 x Likely |
| **Initial Date of Assessment** | November 2025 | **Impact** | 4 Moderate | 2 Minor |
| **Last Reviewed** | April 2026 | **Risk rating** | **= 16 Extreme** | **= 8 Moderate** |
| **Next Review**<br>(Monthly based on risk score) | May 2026 | | | |




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

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

**Assurance Rating** (*Overall Assessment of controls and assurances*) *Guidance*

| | | | |
|---|---|---|---|
| **Negative –** Insufficient evidence that the controls | **Reasonable -** adequate evidence that the controls in place are working effectively. | **Positive -** robust evidence that the controls in place are working effectively. | **REASONABLE ASSURNACE** |


All 21 Risks: Monthly Scores (Apr 2025 – Apr 2026)
Risk Score
20
18
16
14
12
10
8
Apr-2025
May-2025
Jun-2025
Jul-2025
Aug-2025
Sep-2025
Oct-2025
Nov-2025
Dec-2025
Jan-2026
Feb-2026
Mar-2026
Apr-2026
Month
SRR 006 B
SRR 00 1 G
SRR 005 A
SRR 001 D
SRR 011 A
SRR 002 A
SRR 002 B
SRR 00 1 I
SRR 001 C
SRR 001 B
SRR 001 A
SRR 004 B
SRR 006 A
SRR 006 C
SRR 010 A
SRR 007 B
SRR 004 A
SRR 008 A
SRR 007 A
SRR 00 1 F
SRR 00 1 E

LLAIS

Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care

# Llais Gwent Region – Report for Aneurin Bevan University Health Board, Public Board Meeting.

## May 2026



To inform Aneurin Bevan University Health Board of current issues of concern, and positive observations, or public feedback being addressed by Llais Gwent Region in relation to the planning and delivery of health and social care services.

# Accessible formats

This report is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us.

You can download it from our website or ask for a copy by contacting our office.

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Holding It Together: Carers Speak About Their Journey 10

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# About Llais

We believe in a healthier Wales where people get the health and social care services they need in a way that works best for them.

We are here to understand your views and experiences of health and social care, and to make sure decision-makers use your feedback to shape your services.

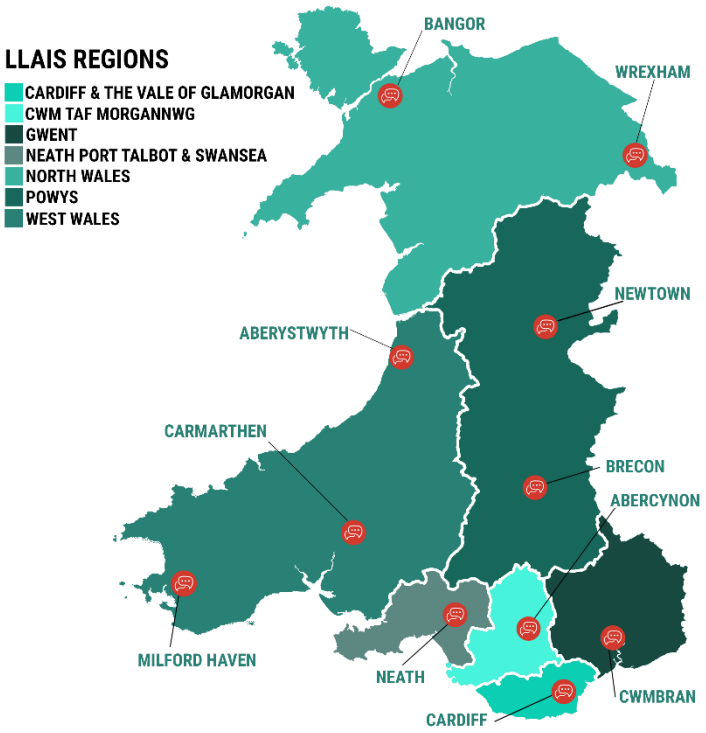
We seek out both good and bad stories so we understand what works well and how services may need to get better. And we look to particularly talk to those whose voices are not often heard.

We also talk to people about their views and experiences by holding events in your local communities or visiting you wherever you're receiving your health or social care service.

We also work with community and interested groups and in line with national initiatives to gather people's views.

And when things go wrong, we support you to make complaints.

There are 7 Llais Regions in Wales. Each one represents the "patient and public" voice in different parts of Wales.



# Introduction

The purpose of this report is to inform Aneurin Bevan University Health Board of current issues of concern and positive observations, and public feedback being addressed by Llais Gwent Region in relation to the planning and delivery of health and social care services.

Llais continues to work in respect of engaging with the population, scrutinising, and offering independent challenge to the NHS and social care, to monitor and consider routine and urgent service changes. We also continue to provide independent Complaints Advocacy Service.

# Our Strategic Focus 2026-27



We will continue to work to deliver the 5 priorities set out in our Strategic Plan:

1) Drive a national conversation about the future of health and social care services
2) Push for services that meet everyone's needs.
3) Work together better.
4) Help people and services to use technology in ways that work for them.
5) Grow and improve as an organisation.

This year, we will focus on[1]:

- Engaging effectively with people in communities with poorer health and wellbeing, and children and young people.
- Learning from complaints and lived experience, to make meaningful representations that lead to positive change.
- Demonstrating change through follow-up and reporting.
- Embedding the People's Principles as a public accountability standard that's used to frame the way services are planned, designed and delivered.

Alongside these priorities, we will continue to deliver our core statutory functions and day-to day work, listening to people across Wales. This includes supporting people to have their voices heard through our enquiries and complaints advocacy services, gathering insight through engagement and lived experience, and working with partners and communities to ensure that people's views inform decisions about health and social care.

Equity, diversity and inclusion will continue to underpin all of our work. We will deliver the commitments set out in our Strategic Equality Plan so that no one is left behind, and that the voices of people whose experiences are often heard less are reflected in our engagement, insight and influence.

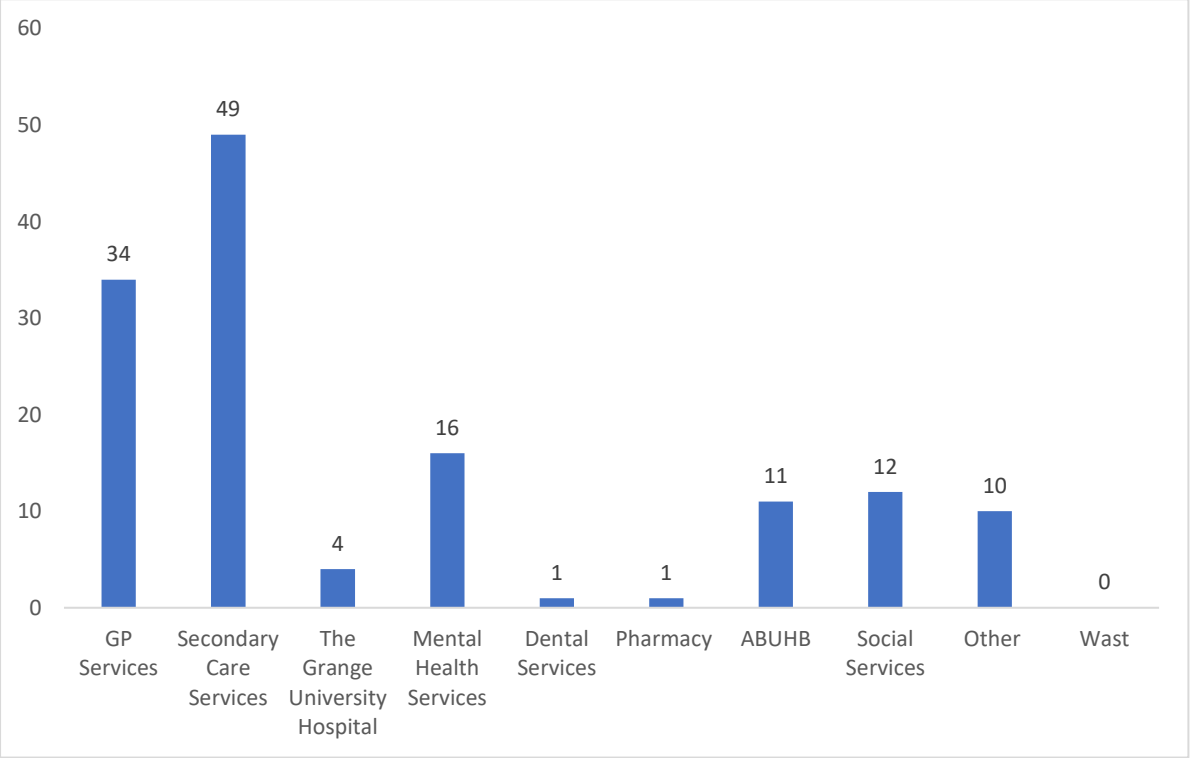
[1] https://www.llaiswales.org/news-and-reports/reports/llais-annual-plan-2026-2027

## Local insights and engagement:

### Gwent Advocacy Service

There were 138 contacts between March and April. 63 were formal concerns and 75 were enquiries that required early resolution or where we are awaiting consent.

Of the 138 contacts, 31 have now been resolved and 107 are still active.




**Key Observations:**

- **GP Services:** 34 contacts highlighting concerns such as missed or unsent referrals, failure to diagnose, staff and GP conduct, lack of care and support and limited appointment availability.
- **Secondary Care Services**: 49 contacts raising issues including failure to diagnose, long waiting times, wrongly being removed from waiting lists, lack of follow up, referrals not being sent, availability of beds and appointments being cancelled.

- **Mental Health**:16 contacts raising concerns about long delays to get a diagnosis, referrals not being sent, access to ADHD medication and unable to access help and support.

## - Implementation of "Listening to People" Regulations

Since the introduction of the Listening to People (LTP) regulations on 1st April 2026, Llais have established a positive and open working relationship, to share early learning, clarify expectations, and ensure patients have an early offer of advocacy support.

There is a clear, mutual commitment to keeping the person at the centre ensuring individuals feel heard, supported, and able to explore their concerns in a way that meets their needs.

Llais has raised concerns Nationally regarding engagement and implementation of LTP across Primary Care providers.

## Engagement and Insights:

### Same Day Urgent Care

Following our March 2026 report and subsequent escalation, a formal update is pending from the health board on their Urgent and Emergency Care Plan, including workstreams reviewing the Older Persons Pathway and the Acute Medical model.

### Royal Gwent Hospital

Llais were made aware by the health board and given assurance that the use of unsterilised equipment during orthodontic procedures was an isolated incident and wider systems remain safe.

Following the cancellation of Ophthalmology procedures due to an error in ordering equipment for theatre use, Llais has requested an update.

## - Children and Young People

Criw Llais is part of the wider Llais brand family, designed specifically to connect with children and young people through vibrant and visually engaging communications. This new approach strengthens how we reach and involve younger audiences, ensuring they feel recognised, included and empowered to share their experiences.

During April, we brought this approach to life through continued engagement activity across Gwent, with a particular focus on hearing directly from young people about their experiences of accessing health and social care services. As part of this work, we attended five college health and wellbeing events, speaking with 675 young people.

This engagement reflects our ongoing commitment to ensuring that the views of children and young people - particularly those whose voices are less often heard, are captured, understood and used to inform service planning, improvement and decision-making.

**Key Themes from Young People:**

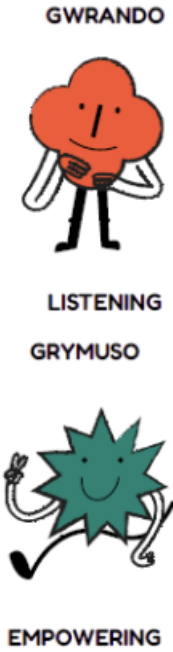
<u>Access to services</u>

- Long waiting times for GP appointments
- Difficulty understanding what health and care services exist and how to access them when they need them
- There was a call for simpler, more flexible health care access, including online booking, same-day options, text services, and clear signposting.
- Dental care access




<u>Wider health determinants</u>

- Worry about money pressures
- Anxiety about the health and care of family members.




Feeling listened to

A recurring message was the importance of being believed, listened to, and respected. Young people shared that when concerns are dismissed or delayed, they may disengage from services altogether.

Mental health and wellbeing

- Long waits for Child and Adolescent Mental Health Services (CAMHS)
- Challenges navigating mental health support

**Llais will…**

Pilot a whole-school approach to hear louder and stronger voices from children and young people.

## - Holding It Together: Carers Speak About Their Journey

We engaged with carers across Gwent to understand their experiences of supporting family members and loved ones to access health and social care services, particularly in relation to dementia, stroke, and long-term conditions.

The findings from this engagement are set out in our report.

**What We Did**

We engaged with carers over several months through community-based conversations, including visits to local groups and discussions with carers and families living with dementia. We also listened to carers' experiences following diagnosis, hospital discharge, and changes in service provision. This approach enabled open discussion in familiar settings and reduced barriers to participation, allowing us to hear directly from carers with lived experience, alongside insights from organisations supporting carers across Gwent.

Alongside this local work, we contributed at a national level by responding to the Welsh Government's Draft National Strategy for Unpaid Carers 2026. Our response drew on what carers told us locally

and nationally through engagement activity and complaints advocacy, ensuring lived experience directly informed national policy development.

**Good Practice Identified**

Carers shared examples of positive practice where services were proactive, compassionate, and communicative. Some described supportive relationships with memory clinics, therapy services, and community-based teams, particularly where carers were included in discussions and felt listened to.

Where follow-up contact was offered, such as clear points of contact or check-in calls, carers felt more reassured and less isolated. Partnership working with voluntary and community organisations was also recognised as an important source of emotional and practical support.

**Key Themes**

Carers frequently described feeling overwhelmed, invisible, and close to breaking point, often reluctant to seek help due to uncertainty about what support is available or not wanting to burden others.

Many shared that receiving large volumes of information at the point of diagnosis felt overwhelming, with a clear need for staged information and structured follow-up once there had been time to process what was happening.

A strong theme was the importance of carers being listened to and recognised as partners in care, particularly during appointments, transitions, and discharge planning. Difficulties accessing respite, day services, and practical support were also raised, with carers highlighting inconsistencies across areas and the cumulative impact of caring on their own health and wellbeing.

**Llais will…**

Continue to amplify carers' voices locally and nationally, ensuring their experiences inform policy and service delivery. We will build on the responses received from Aneurin Bevan University Health Board and local authority partners and continue to use engagement and collaboration to promote more consistent and accessible support for unpaid carers across Gwent.

- ## Breaking Barriers: Continuing to Learn from Deaf Voices

Llais has continued to work closely with Aneurin Bevan University Health Board (ABUHB), RNID, the British Deaf Association, Action Deafness Cymru, and SENSE to ensure this programme of work remains informed by Deaf lived experience and specialist expertise.

Concerns raised through engagement and the Patient Participation Panel (PPP) - including lack of access to interpreters at critical points in care, families being asked to interpret, exclusion from key clinical discussions, and inaccessible appointment letters have been escalated and formally requested to be recognised as safeguarding triggers within relevant Health Board processes.

Llais has supported members of the Deaf community to provide direct feedback on Health Board appointment letters. This feedback has identified specific barriers within written communications and has informed improvements to wording, format, and overall accessibility, helping to ensure communications better meet the needs of Deaf BSL users.

Overall, this work demonstrates a continued shift from listening to action and reflects progress towards a more consistent, inclusive, and person-centred approach to care for Deaf BSL users across Gwent.

# Thanks



We thank everyone who took the time to share their views and experiences with us about their health and social care services and sharing their ideas with us.

# Feedback

We'd love to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.

# Contact details


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Facebook: @gwentllais
twitter: Llais_wales

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

| MINUTES OF MEETING HELD | | |
|---|---|---|
| **Date and Time** | **Wednesday 25th March 2026 at 09:30am** | |
| **Venue** | **Conference Centre, St Cadoc's Hospital and Microsoft Teams** | |
| | | |
| **PRESENT** | Ann Lloyd | Chair |
| | Phil Robson | Vice Chair |
| | Paul Deneen | Independent Member (Community) |
| | Dafydd Vaughan | Independent Member (Digital) |
| | Iwan Jones | Independent Member (Finance) |
| | Neil Patrick | Independent Member (Community) |
| | Penny Jones | Independent Member (Community) |
| | Akmal Hanuk | Independent Member (Third Sector) |
| | Helen Sweetland | Independent Member (University) |
| | Helen Cunningham | Independent Member (Local Authority) (From Item 6.3) |
| | Nicola Prygodzicz | Chief Executive |
| | Tracy Daszkiewicz | Director of Public Health |
| | Jennifer Winslade | Director of Nursing |
| | Rob Holcombe | Director of Finance & Procurement |
| | Paul Solloway | Director of Digital |
| | Hannah Evans | Director of Strategy, Planning and Partnerships |
| | Peter Carr | Director of AHPs and Health Science |
| | Sarah Simmonds | Director of Workforce and OD |
| | Dr Seema Srivastava | Medical Director |
| **IN ATTENDANCE** | Rani Dash | Director of Corporate Governance |
| | Karen Newman | Assistant Director of Communications and Engagement |
| | Bryony Codd | Head of Corporate Governance |
| | Naomi Murtagh | Board Business Manager |
| | Lisa Charles | Regional Director, Llais Cymru |
| | Nadia Lovell | Head of Advocacy and Engagement, Llais Cymru |
| | Tracey PartridgeWilson | Deputy Director of Nursing |
| | Amanda Whent | Lead Nurse for Dementia (Item 4.1) |
| | Matthew Temby | Interim Deputy Chief Operating Officer |
| | Polly Frazer | Aspiring Board Member |
| | Thokozani Owino | Aspiring Board Member |

| | | |
|---|---|---|
| **APOLOGIES** | Vivek Goel<br>Leanne Watkins | Independent Member (Trade Union)<br>Chief Operating Officer |

| | **PRELIMINARY MATTERS** |
|---|---|
| **ABUHB 2503/01** | **Welcome and Introductions**<br><br>The Chair welcomed everyone to the meeting, in particular members of the public who had joined the meeting to observe.<br><br>It was noted that the meeting would be livestreamed and published on the Health Board's website following the meeting. |
| **ABUHB 2503/02** | **Declarations of Interest for Noting**<br><br>There were no declarations of interest raised. |
| **ABUHB 2503/03** | **Consent Agenda**<br><br>The Chair introduced the Consent Agenda and asked if there were any items to be brought forward for discussion. There were no requests made. |
| **ABUHB 2503/04** | **Report from the Chair**<br><br>Ann Lloyd (AL), Chair, provided her verbal report, with a focus on the following areas:<br>• The Chair advised that she had met with Members of Parliament regarding the North Gwent Children's Centre. Discussions on the future of children's services in North Gwent were ongoing and were being progressed through the Regional Partnership Board (RPB).<br>• The Chair updated the Board on recent multi agency discussions and meetings of the Chairs' Peer Group, noting that discussions had focused on the draft operating and accountability framework. Chairs had welcomed proposals to standardise and streamline meetings and information flows and supported the simplification of the escalation and intervention framework.<br>The Chair reported that Chairs had sought clarity on the role and offer of NHS Performance and Improvement (NHS P&I), including assurance on the support it would provide to Health Boards. Concerns had also been raised regarding regional and collective accountability for proposals and projects, particularly where organisations were non-statutory.<br>The Chair confirmed that concerns relating to the accountability of Boards and Chairs had been raised, where early drafts of the framework implied arrangements not aligned with statutory instruments. Assurance had since been provided that statutory |

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|---|---|
| | accountability arrangements would apply and that the guidance had been amended accordingly.<br>The Chair highlighted discussions regarding the rising cost of Continuing Healthcare (CHC), including the impact of direct payments. The Chair advised that increasing CHC costs represented a significant emerging risk locally and nationally. A paper adopted by Chief Executives and Chairs had been developed, with joint representations to Welsh Government to be progressed.<br>• The Chair reported on a recent meeting of the Regional Joint Committee (RJC), noting progress in relation to Llantrisant Health Park while emphasising the importance of maintaining momentum in other areas. Current challenges in vascular surgery had been acknowledged, with collaborative mitigation in place.<br>• The Chair advised that the RPB had met recently and was considering its future role and funding arrangements, while continuing to progress current work programmes.<br>• The Chair informed the Board that she had contributed to the induction programme for new Board members, sharing reflections on Board membership, the role of the Chair and the importance of effective collective decision-making.<br><br>The Chair thanked Board members and Executive colleagues for their support and guidance during a demanding period for the organisation.<br><br>Phil Robson (PR), Vice Chair, formally acknowledged that this was AL's final Board meeting as Chair, paying tribute to her leadership, resilience and contribution over nine years, including her stewardship during challenging periods.<br><br>Nicola Prygodzicz (NP), Chief Executive, echoed these sentiments, recognising AL's integrity, commitment to governance and patient care, and her role as a mentor and source of stability for the organisation.<br><br>The Board **NOTED** the Chair's updates. |
| **ABUHB 2503/05** | **Report from the CEO**<br><br>Nicola Prygodzicz (NP), Chief Executive, provided her verbal report, with a focus on the following areas:<br>• NP provided an update on organisational activity over the preceding period, noting that it had been particularly busy, with a strong focus on preparation of the Annual Plan, which was a key item on the agenda.<br>• NP highlighted cancer services as a continued priority and reported on her attendance at a Cancer Services Conference, which reflected on delivery against the five-year cancer strategy. |

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| | NP noted the positivity around shaping priorities for the next phase and advised that she had visited the new Velindre Cancer Centre, recognising its significance for Aneurin Bevan University Health Board residents and regional collaboration.<br>• NP advised that women's health had been a key focus during the period. She reported on a successful women's health conference and a visit from the Minister, who had welcomed the opportunity to see the women's ambulatory unit at Nevill Hall Hospital and the progress being made in this area.<br>• Primary and Community Care had also been a focus, with NP reporting on continued development of the Community by Design national programme. NP reflected on visits to a community pharmacy in Abergavenny and Chepstow Hospital, which demonstrated effective integrated working between GPs, district nurses and community teams and the potential to strengthen community based models of care.<br>• NP informed the Board that the national maternity and neonatal review report had been published and that a paper setting out the Health Board's assessment would be considered later on the agenda. NP also reported on a visit to the Grange University Hospital maternity unit, noting both the quality of care being delivered and opportunities for continued improvement.<br>• NP advised that staff survey results had been received and that response rates and overall engagement scores had improved. NP noted that, while the headline results were relatively positive, the detailed feedback would be used to identify areas requiring further focus and improvement, with work ongoing to review the findings in detail.<br><br>NP acknowledging the significant contribution of staff and teams across the organisation during a challenging period and thanked colleagues for their continued commitment and effort.<br><br>The Board **NOTED** the Chief Executive's updates. |
| **ABUHB 2503/06** | **Patient Experience Story & Dementia Annual Report**<br><br>Amanda Whent (AW), Lead Nurse for Dementia, presented the Patient Experience Story alongside the Dementia Annual Report.<br><br>AW introduced the Patient Experience Story and explained that the presentation would focus on key aspects of the programme, with particular emphasis on dementia care in hospital settings. AW outlined the All-Wales Dementia Standards of Care and described the Health Board's delivery model, structured around five workstreams covering community engagement, memory assessment and support, dementia connector roles, dementia-friendly environments and hospital care, and learning, development and monitoring. AW highlighted progress in staff education and training, noting increased completion of mandatory |

dementia awareness training and the availability of additional learning resources to support staff across all roles and settings.

The presentation focused on the Dementia Friendly Hospital Charter, which had been introduced to improve the experience of people living with dementia when admitted to hospital. AW outlined the refreshed three-year improvement plan and the key priorities underpinning this work, including accessibility, communication, timely and needs-based assessment, person-centred care planning, carer involvement, meaningful engagement, coordinated discharge planning and learning from feedback.

As part of the Patient Experience Story, the Board viewed a recorded account from a patient, Ken, who shared his experience of his wife's hospital admission while living with advanced dementia. The account highlighted significant concerns regarding communication, dignity, compassion, staff awareness, supervision, nutrition and hydration, discharge decision-making and future care planning. AW explained that this experience had been used as a catalyst for learning and improvement across services.

Board members thanked Ken for sharing his experience and acknowledged the distressing nature of the account. Ann Lloyd (AL), Chair, reflected on the importance of learning from lived experience and sought assurance regarding how dementia care was being supported beyond hospital settings, including in community services and for people living in their own homes. AW confirmed that dementia training and support extended across community services, care homes and partner organisations, and that work continued through dementia-friendly communities and engagement programmes.

Jennifer Winslade (JW), Director of Nursing, emphasised that the dementia programme was delivered through a whole-system approach involving health, social care, third sector partners, patients and carers. She highlighted the importance of "What Matters" conversations, person-centred care and effective communication in maintaining dignity and safety.

Nicola Prygodzicz (NP), Chief Executive, reflected that the experience illustrated issues relating both to dementia□specific care and to wider fundamentals of care and organisational values. She highlighted the role of ward accreditation and quality assurance systems in Improving the quality of care to patients and families.

Board members raised questions regarding monitoring impact, workforce training, preventative approaches and future sustainability of the programme. AW explained that progress was monitored through local and national dementia audits, action plans and reporting mechanisms, noting that increased reporting of experiences could

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| | reflect greater awareness and engagement rather than deterioration in care. She also highlighted the importance of performance measures in supporting future funding discussions.<br><br>The Board expressed pride in the dementia team's work and acknowledged the contribution of volunteers. The importance of securing future funding beyond current arrangements was emphasised, alongside continued engagement with Welsh Government and regional partners.<br><br>The Board **NOTED** the Patient Experience Story and **NOTED** the Dementia Annual Report. |
| **ABUHB 2503/07** | **Report from Llais, Gwent Region**<br><br>Lisa Charles (LC), Regional Director, Llais Cymru, presented Llais' report which set out current issues of concern and positive observations, and public feedback being addressed by Llais Gwent Region.<br><br>LC acknowledged that it was Ann Lloyd's (AL), Chair, final Board meeting and thanked her for her ongoing engagement with Llais Cymru. LC recognised AL's commitment to listening meaningfully to people's experiences, including where conversations had been difficult, and highlighted the positive impact this had had on improving services and outcomes for citizens across Gwent.<br><br>Board members welcomed the report and thanked LC and her team for their work. Helen Sweetland (HS), Independent Member, asked about the next steps following the recent discharge summit and how learning would be taken forward across organisations. LC explained that this work would be progressed primarily through the RPB, with clear actions and accountability, and that early discussions with system leaders had demonstrated strong appetite to act on the findings.<br><br>Further assurance was provided that insights would be fed into existing structures, including the Integrated Discharge Board, rather than creating additional governance layers. Board members also discussed the importance of digital enablers, trusted assessment processes and joint funding arrangements in supporting system-wide improvement.<br><br>AL thanked LC and the Llais Cymru team for their contribution, recognising their role as a critical conduit for patient and citizen voices and for supporting learning and improvement across the system.<br><br>The Board **NOTED** the Llais Gwent Region Report and welcomed continued engagement and feedback from Llais Cymru to inform system improvement and partnership working. |

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| **ABUHB 2503/08** | **Integrated Medium-Term Plan 2025-2028**<br><br>Hannah Evans (HE), Director of Strategy, Planning and Partnerships, presented the Integrated Medium-Term Plan (IMTP) 2025–2028 for Board consideration and approval for submission to Welsh Government.<br><br>HE explained that the Plan had been developed in line with the NHS Wales Planning Framework and reflected the Health Board's strategic direction, Gwent 35. She advised that the IMTP set out clear priorities, delivery commitments and measures of impact across the themes of Better Health, Better Care and Better Lives, while recognising the organisation's current escalation status and challenging operational and financial context.<br><br>HE highlighted key areas of strategic service change, including place-based care, older people's pathways, acute and mental health service transformation, women's health, and continued regional collaboration. Delivery of the Plan was supported by enabling programmes covering quality and assurance, workforce, estates and digital transformation. HE noted that the Plan was transparent about where national targets could be met and where progress would be achieved through improvement trajectories and de-escalation criteria.<br><br>Rob Holcombe (RH), Director of Finance and Procurement, outlined the financial position within the IMTP, including the savings requirement and forecast deficit. RH highlighted key assumptions and risks, including Continuing Healthcare, prescribing costs and savings delivery, the Welsh Risk Pool, and confirmed that work would continue to identify efficiencies and mitigate financial pressures.<br><br>Nicola Prygodzicz (NP), Chief Executive, acknowledged the significant work involved in developing the Plan and confirmed that it provided a credible basis for delivery, while recognising ongoing risk. She advised that further work would continue on recovery planning and assurance.<br><br>Board members welcomed the Plan and discussed a range of issues including performance delivery, workforce assumptions, funding allocation and financial risk.<br><br>Akmal Hanuk (AH), Independent Member, referred to the Plan's assessment against ministerial delivery expectations and sought clarification on how areas not expected to meet national targets would impact the Health Board's de-escalation objectives. Hannah Evans (HE), Director of Strategy, Planning and Partnerships, explained that the Plan prioritised delivery of de-escalation criteria and improvement trajectories where national standards could not immediately be met. |

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| | Iwan Jones (IJ), Independent Member, raised questions regarding workforce growth, vacancies and assumptions built into the Plan. HE and Sarah Simmonds (SS), Director of Workforce and OD, provided assurance on workforce projections, recruitment priorities, vacancy management and actions to improve workforce efficiency and reduce variable pay.<br><br>Ann Lloyd (AL), Chair, emphasised the importance of transparency in setting out assumptions and risks, ongoing engagement with Welsh Government, and robust monitoring of delivery and financial position throughout the year.<br><br>The Board **APPROVED** the Annual Plan (IMTP) 2026-27 for submission to Welsh Government, noting that final numerical checks would be completed prior to submission. |
| **ABUHB 2503/09** | **Budget Delegation Proposal 2026/27**<br><br>Rob Holcombe (RH), Director of Finance and Procurement, presented the Budget Delegation Proposal for 2026/27 for Board approval.<br><br>RH advised that the report set out the proposed delegation of budgets for the forthcoming financial year, in line with the Health Board's Standing Financial Instructions and the assumptions within the Integrated Medium-Term Plan. He explained that the proposal reflected the anticipated funding envelope, including recurrent budget rollovers for existing budget holders and the application of directed funding uplifts, while recognising the absence of a contingency reserve in the context of the Health Board's forecast financial position.<br><br>RH confirmed that delegated budgets would provide operational teams with clarity on their financial responsibilities for the year ahead and would be supported by existing financial control frameworks, including routine budget monitoring, variance reporting and escalation arrangements. He advised that, should financial pressures increase, additional controls could be implemented to ensure grip and control over expenditure.<br><br>Board members considered the proposal and sought assurance on how delegated budgets would be managed in practice. Akmal Hanuk (AH), Independent Member, queried how overspending would be prevented in the absence of contingency funding and what mechanisms were in place to support budget holders to remain within their allocations. RH responded by outlining the Health Board's established governance arrangements, including accountability of budget holders, monthly financial reporting, and the ability to strengthen expenditure controls where required. |

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| | Iwan Jones (IJ), Independent Member, asked how the Board would be assured that delegated budgets were being adhered to throughout the year. RH confirmed that financial performance would continue to be monitored through regular reporting to the Board and Committees, with clear escalation where variances emerged, and that the delegation framework aligned with the financial assumptions approved within the IMTP.<br><br>The Board noted that the proposed budget delegations were consistent with the agreed financial strategy and reflected a prudent approach in a challenging financial environment.<br><br>The Board **APPROVED** the Budget Delegation Proposal for 2026/27. |
| **ABUHB 2503/10** | **Strategic Equality Plan Annual Report**<br><br>Sarah Simmonds (SS), Director of Workforce and Organisational Development, presented the Strategic Equality Plan (SEP) Annual Report, which provided an update on progress against the Health Board's equality objectives and sought approval for publication in line with statutory requirements.<br><br>SS advised that the report set out performance against the delivery of the Strategic Equality Plan and demonstrated how equality, diversity and inclusion considerations continued to be embedded across the organisation's policies, workforce practices and service delivery. She explained that the report drew on a range of evidence, including workforce data, staff survey findings, engagement activity and feedback, and outlined progress made during the reporting period.<br><br>SS highlighted key areas of activity, including work to promote equality and inclusion within the workforce, targeted actions to address health inequalities, and ongoing engagement with staff networks and communities. She confirmed that the Health Board continued to meet its statutory duties under equality legislation and that the Annual Report had been developed to meet the required publication deadline.<br><br>Board members welcomed the report and discussed aspects of equality monitoring and workforce experience. Akmal Hanuk (AH), Independent Member, queried how issues relating to race equality and staff experience were captured and monitored, including through staff survey data. SS responded by outlining the range of mechanisms used to understand workforce experience, including survey insights, staff networks and engagement activity, and confirmed that learning from these sources informed ongoing actions.<br><br>Iwan Jones (IJ), Independent Member, sought further clarification on aspects of delivery and assurance. SS provided additional explanation |

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| | on governance arrangements and how progress against equality objectives was monitored and reported.<br><br>The Board acknowledged the importance of the Strategic Equality Plan in supporting an inclusive culture, fair access to services and compliance with statutory requirements.<br><br>The Board **NOTED** the Strategic Equality Plan Annual Report and approved its publication by the statutory deadline of 31 March 2026. |
| **ABUHB 2503/11** | **Maternity and Neonatal National Assurance Assessment**<br><br>Seema Srivastava (SSr), Medical Director, introduced the Maternity and Neonatal National Assurance Assessment report, which set out the findings from the national review and the Health Board's initial assessment and response.<br><br>SSr advised that the assessment had been undertaken as part of a national programme led by Professor Sally Holland, Chair of the Maternity and Neonatal National Assurance Assessment Independent Oversight Panel, and provided an independent evaluation of maternity and neonatal services. She explained that the report outlined areas of good practice alongside priority actions for improvement and provided a framework for ongoing assurance and monitoring.<br><br>SSr emphasised the importance of learning from the findings to strengthen safety, quality and experience within maternity and neonatal services.<br><br>Jennifer Winslade (JW), Director of Nursing, provided further detail on the Health Board's preliminary assessment against the national findings, including how actions would be prioritised, monitored and reported through existing governance arrangements.<br><br>Board members welcomed the report and acknowledged the importance of the assurance process. Ann Lloyd (AL), Chair, referred to the significance of effective stakeholder engagement and the need to ensure that learning from the assessment was shared transparently and acted upon.<br><br>The Board discussed the importance of continued focus on improvement, learning and assurance, including workforce engagement, quality oversight and alignment with national programmes.<br><br>The Board **NOTED** the findings and priority actions arising from the Maternity and Neonatal National Assurance Assessment and **NOTED** the Health Board's preliminary assessment and proposed monitoring arrangements. |

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| **ABUHB 2503/12** | **Integrated Performance Report**<br><br>Hannah Evans (HE), Director of Strategy, Planning and Partnerships, presented the Integrated Performance Report, which provided an overview of organisational performance at the end of Quarter 3 2025/26.<br><br>HE highlighted the key areas of performance covered within the report, including delivery against the Integrated Medium-Term Plan, national priorities and escalation criteria. She advised that progress had continued in several areas, including childhood vaccination uptake and ambulance handover performance, and noted sustained improvement in four-hour emergency department performance. However, HE acknowledged ongoing challenges, particularly in relation to twelve-hour waits in emergency departments and overall system pressures.<br><br>Matthew Temby (MT), Interim Deputy Chief Operating Officer, provided an operational update, outlining actions being taken to manage demand, improve patient flow and support safe care delivery. He advised that changes to operational arrangements were being progressed to address pressures and support improvement trajectories.<br><br>On planned care and cancer performance, HE noted that performance against the cancer standard had dipped below the 56% threshold in January. She explained that this reflected demand and capacity pressures and confirmed that recovery actions were in place. The report also set out performance against efficiency metrics and highlighted areas requiring continued focus.<br><br>Nicola Prygodzicz (NP), Chief Executive, provided additional context on performance delivery, including the impact of reduced activity levels on certain performance measures. She emphasised the importance of maintaining momentum on improvement while recognising the operational challenges faced.<br><br>Ann Lloyd (AL), Chair, highlighted concerns regarding stroke performance and sought clarification on the causes of recent deterioration. Peter Carr (PC), Director of Allied Health Professionals and Health Science, outlined the contributory factors and actions being taken.<br><br>Sarah Simmonds (SS), Director of Workforce and Organisational Development, provided an update on workforce performance, including current staffing challenges, vacancy management and actions being taken to support workforce sustainability. SS outlined ongoing work to strengthen recruitment and retention, reduce reliance |

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| | on variable pay, improve workforce efficiency and support staff wellbeing, and confirmed that workforce risks continued to be monitored through established governance arrangements.<br><br>Jennifer Winslade (JW), Director of Nursing, presented the quality and safety elements of the report, including safeguarding performance. She confirmed that compliance with Level 2 safeguarding training remained strong and provided assurance on continued oversight of quality, safety and safeguarding through routine monitoring and escalation processes.<br><br>The Board **NOTED** the Integrated Performance Report and received assurance on performance against key priorities and improvement actions. |
| **ABUHB 2503/13** | **Financial Performance Report, Month 10**<br><br>Rob Holcombe (RH), Director of Finance and Procurement, presented the Financial Performance Report for Month 10, which provided an update on the Health Board's financial position.<br><br>RH advised that the report set out the in-year financial performance against plan and highlighted the key drivers impacting the overall position. He outlined the headline position, including performance against revenue forecasts, and provided commentary on areas of pressure and mitigation. RH noted that ongoing cost pressures continued to be driven by factors such as Continuing Healthcare, prescribing and operational demand, while work remained underway to manage expenditure and deliver planned efficiencies.<br><br>RH highlighted progress in relation to payment performance, confirming that payments to non-NHS providers within 30 days continued to be closely monitored. He also provided assurance on the robustness of financial controls and governance arrangements in place to support grip and control, including regular monitoring, escalation of variances and alignment with the assumptions set out in the Integrated Medium-Term Plan.<br><br>RH outlined the actions being taken to mitigate financial risk. He highlighted strengthened financial oversight arrangements, a continued emphasis on efficiency, productivity and cost control, and ongoing engagement with Welsh Government and national partners to address system-wide financial pressures.<br><br>The Board acknowledged the scale of the financial challenge and emphasised the importance of continued transparency, robust monitoring and timely escalation of emerging risks.<br><br>The Board **NOTED** the Financial Performance Report for Month 10 and |

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| | received assurance on the Health Board's financial position and control arrangements. |
| **ABUHB 2503/14** | **Strategic Risk Report, March 2026**<br><br>Nicola Prygodzicz (NP), Chief Executive, presented the Strategic Risk Report for March 2026.<br><br>NP advised that the report set out the Health Board's current strategic risk position and the closing position for 2025/26. She highlighted that the Board was asked to consider whether it had sufficient assurance that strategic risks were being appropriately identified, assessed and managed.<br><br>NP drew attention to a proposed increase in risk exposure for Strategic Risk SRR 006B, advising that this reflected a reassessment of the level of risk. She also outlined the proposed reframing of Strategic Risk SRR 011, explaining that this would provide a clearer articulation of the risk.<br><br>The Board **NOTED** he 2025/26 closing position and **ACCEPTED** the increase in risk exposure for Strategic Risk SRR 006B. |
| **ABUHB 2503/15** | **Key Matters from Committees of the Board**<br><br>Committee Chairs provided an update on key matters arising from recent meetings of the Health Board's Committees.<br><br>Penny Jones (PJ), Independent Member and Chair of the Mental Health and Learning Disabilities Committee, provided an update on matters considered by the Committee, highlighting ongoing oversight of Mental Health and Learning Disabilities services and the Committee's continued focus on quality, safety and service improvement.<br><br>Iwan Jones (IJ), Independent Member and Chair of the Audit, Risk and Assurance Committee, summarised key areas of assurance considered by the Committee, including audit activity, risk management and governance arrangements, and confirmed that the Committee continued to provide assurance to the Board on the effectiveness of internal control and risk management processes.<br><br>Paul Deneen (PD), Independent Member and Chair of the People and Culture Committee, updated the Board on workforce-related matters, including staffing, organisational culture and people priorities, and confirmed that the Committee continued to monitor workforce risks and improvement actions. |

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| | Helen Sweetland (HS), Independent Member and Chair of the Patient Quality, Safety and Outcomes Committee, reported on the Committee's recent focus on patient safety, quality of care and outcomes, including review of quality indicators and assurance on improvement activity.<br><br>Neil Patrick (NPt), Independent Member and Chair of the Finance and Performance Committee, provided an update on financial and performance matters considered by the Committee, including oversight of financial position, performance delivery and efficiency.<br><br>The Board **NOTED** the updates provided and acknowledged the role of Committees in supporting effective governance, assurance and oversight. |
| **ABUHB 2503/16** | **CONSENT AGENDA** |
| | The Board **APPROVED** the Draft Minutes of the Health Board Meeting, held on 28th January 2026 |
| | The Board **APPROVED** the Report on Sealed Documents and Chair's Actions. |
| | The Board **APPROVED** the Violence Prevention & Reduction Strategic Plan. |
| | The Board **NOTED** the Board Action Log with Updates |
| | The Board **NOTED** the Pay Gap Reports 2025:<br>a) Ethnicity Pay Gap<br>b) Gender Pay Gap |
| | The Board **NOTED** the Strategic Partnership Updates:<br>a. Regional Partnership Board |
| | The Board **NOTED** the Executive Committee Chair's report |
| | The Board **NOTED** the overview of Joint and Partnership Committee Activity<br>a. NHS Wales Joint Commissioning Committee<br>b. NHS Wales Shared Services Partnership Committee<br>c. Regional Joint Committee |
| | **OTHER MATERS** |
| **ABUHB 2503/17** | **Any Other Business**<br><br>There were no further items raised for discussion. |
| **ABUHB 2503/19** | **Date of the Next Meeting:**<br><br>Wednesday 20th May 2026 |

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

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| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | **Governance Matters: Report on Sealed Documents and Chair's Actions** |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Rani Dash, Director of Corporate Governance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Bryony Codd, Head of Corporate Governance |

## Pwrpas yr Adroddiad
## Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

This report is presented for compliance and assurance purposes to ensure the Health Board fulfils the requirements of its Standing Orders in respect of documents agreed under seal and situations where Chair's Action has been used for decisions.

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

This paper presents for the Board a report on the use of Chair's Action and the Common Seal of the Health Board between 11th March and 6th May 2026

The Board is asked to note that one (1) document required the use of the Health Board's seal during the above period.

Chair's Action in Standing Orders requires approval by the Chair, Chief Executive and two Independent Members, with advice from the Board Secretary (the Director of Corporate Governance). All Chair's Actions require ratification by the Board at its next meeting.

During the period 11th March and 6th May 2026 three (3) Chairs Actions were agreed.

### Cefndir / Background

**1. Sealed Documents**

The common seal of the Health Board is primarily used to seal legal documents such as transfers of land, lease agreements and other contracts. The seal may only be affixed to a document if the Board or Committee of the Board has determined it should be sealed, or if the transaction has been approved by the Board, a Committee of the Board or under delegated authority.

Under the provisions of Standing Orders, the Chair or Vice Chair and the Chief Executive or Deputy Chief Executive must seal documents on behalf of the Health Board. One document was sealed between the 11th March and 6th May 2026, as outlined below.

| Date | Title |
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| 15/04/2026 | Back to back agreement – ICF GWE 34 – Independent Living. ABUHB and Codi Homes and Communities Limited. |

## 2. Chair's Action

Chair's Action is defined by the Health Board's Standing Orders as: Chair's action on urgent matters: There may be circumstances where decisions which would normally be taken by the Board need to be taken between scheduled meetings, and it is not practical to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

The Chair's Actions approved between 11th March and 6th May 2026 are summarised below:

| Date | Title |
|---|---|
| 19/03/2026 | **Insourcing of Bowel Screening and General Endoscopy Services at ABUHB.** Contract award for two years (including extension option) to provide an essential insourced service to the Health Board in terms of diagnosing and staging of suspected/confirmed cancer and positive bowel screening results, providing follow up for patients with prior diagnosis and delivering interventional treatment, thus delivering both therapeutic and diagnostic services.<br><br>Contract Value:<br>£1,365,001 – General Endoscopy<br>£632,783 – Bowel Screening<br><br>**Total contract value – two years - £1,997,784 (VAT exempt)** |
| 02/04/2026 | **Welfare Advice Service – Newport Citizens Advice and Rainbow Connectors Service – Growing Space:** The Health Board requires a contract for the provision of Mental Health and Learning Disabilities Services, divided in to two Lots:<br>Welfare Advice Service – to ensure people in contact with our services, and those close to them (carers) have appropriate expertise to ensure financial inclusion - **£198,193.12**<br>Rainbow Connector Service – To support recovery and social inclusion for people with mental health and learning disability needs **- £102,505.60**<br><br>**Total Contract Value:**<br>Initial Term: 1/5/26 – 30/4/27<br>Extensions: 1/5/27-30/4/28 and 1/5/28-30/4/29 |

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| | Total Value of Contract, including extensions: **£902,096.16** |
| 19/03/2026 | **Cisco Enterprise agreement:** This contract aims to simplify the management of software and associated licensing across selected products. By consolidating several separate software agreements into a single, unified contract, all relevant assets can be managed under one comprehensive framework. This approach reduces administrative overhead, improves visibility of entitlements, and ensures more efficient lifecycle and compliance management.<br><br>**Total Value of New Contract:**<br>1st April 2026 -31 March 2031 (5years)<br>**£2,148,374.76 ex Vat** |

### 3. Clinical Negligence Claims

In line with the Scheme of Delegation, all clinical negligence claims over £1m are agreed between the Chair, Chief Executive, and two Independent Members (following recommendation from 2 clinical executives) outside of formal Board meetings. During the period 11th March and 6th May:

| **Number of Clinical Negligence Claims over £1m** | **Total value** |
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| Three | Up to £43,325,000 |

**Asesiad / Assessment**

In endorsing this report the Health Board will comply with its own Standing Orders.

**Argymhelliad / Recommendation**

The Board is asked to NOTE the documents that have been sealed and to RATIFY the action taken by the Chair on behalf of the Board.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
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| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | N/A |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |

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| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br><br>Enabler |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item.<br><br>Not applicable to this report |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | N/A |
| Rhestr Termau:<br>Glossary of Terms: | None |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | None |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
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| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment** (EIA) completed | **No  does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working** | Choose an item.<br>Choose an item.<br><br>Not applicable to this report |

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

| Agenda Item |
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| 7.13 |

# Joint Commissioning Committee

## Joint Commissioning Committee Governance Framework

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| **Dyddiad y Cyfarfod / Date of Meeting** | 20/05/2026 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public |
| **Awdur yr Adroddiad / Report Author** | Aaron Fowler, Committee Secretary NWJCC |
| **Cyflwynydd yr Adroddiad / Report Presenter** | Aaron Fowler, Committee Secretary NWJCC |
| **Noddwr yr Adroddiad / Report Sponsor** | Ian Green, Chair of the NWJCC |

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| **Pwrpas yr Adroddiad / Report Purpose** | For Approval |

| **Engagement (internal/external) undertaken to date (including receipt /consideration at Committee/Group)** | | |
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| **Committee/Group/Individuals** | **Date** | **Outcome** |
| **ToR - Quality Safety and Outcomes (QSOC) Sub-Committee** | 23 February 2026 | Endorsed<br>Feedback assisted in developing the drafts |
| **ToR - Planning Performance and Finance (PPF) Sub-Committee** | 26 February 2025 | Endorsed<br>Feedback assisted in developing the drafts |
| **PPF and QSOC ToR - Joint Commissioning Committee** | 17 March 2026 | The JCC Endorsed the updated ToR |
| **Senior Leadership Team NWJCC and HB Director of Corporate Governance Draft Standing Orders and Standing Financial Instructions** | 13 April 2026 | Feedback received and assisted in finalising the documents |
| **Joint Committee - Draft Standing Orders and Standing Financial Instructions** | 26 May 2026 | To be Approved |

## 1. SITUATION

The purpose of this report is to present the NHS Wales Joint Commissioning Committee's (JCC) updated governance framework. In accordance with the JCC scheme of delegation and reservation of powers, approval of the Joint Committees governance framework is reserved to Local Health Boards (LHBs).

## 2. BACKGROUND

The Governance Framework for the JCC contains several key components which, combined, set out the legislative framework, constitution and ways of working for the JCC in its operations and handling of business. These documents are an integral part of the wider governance framework of LHBs and have been developed within that context.

The Governance Framework of the JCC contains the following.

Figure 1 – JCC Governance Framework



## 2.1 Standing Orders and Standing Financial Instructions

The Seven LHBs approved the JCC Standing Orders (SOs) and Standing Financial Instructions (SFIs) in March 2024. There were subsequently adopted by the Joint Committee at its inaugural meeting on 8 April 2024 following which they were included as a schedule to each of the Health Boards (HBs) own SOs and have effect as if incorporated within them.

During October 2025, WG issued updated Model Standing Orders for the NWJCC. The purpose of these amendments was to ensure consistency relating to the timescales for the publication of board and committee agendas and papers. Updates to the JCC's Standing Orders to incorporate these changes were approved at the November 2025 Joint Committee meeting.

A further review of the NWJCC Governance Framework commenced during Q3 of 2025-2026. Attached at **Appendix 1** is a table of the proposed amendments to the Standing Orders. The changes are largely administrative in nature and seek to either re-format or re-define the content of each document, or update sections to reflect operational reality. The changes to the Standing Financial Instructions are also mainly administrative. The more substantial updates include the following.

- Section 11 (highlighted in blue) replaced for the updated Procurement Regulations (including Schedule 1) and updated references for NWJCC/JCCT.
- Addition of a debt recovery paragraph in section 9 to reflect current processes.

Attached as **Appendices 2 and 3** are tracked changes versions of the Standing Orders and Standing Financial Instructions for approval.

## 2.2 Scheme of Delegation and Reservation of Powers

The NWJCC's Scheme of Reservation and Delegation of Powers forms an annex to the NWJCC's SOs, which form a schedule to each HBs own SOs and have effect as if incorporated within them. The Scheme of Delegation and Reservation of Powers, sets out in the context of the NWJCC's business:

- Those matters reserved for HBs;
- Those matters delegated from HBs and reserved for the NWJCC; and
- Those matters further delegated from the NWJCC to the Chief Commissioner (and other Officers as appropriate).

The Scheme of Delegation was approved by the JCC in May 2025 and was subsequently approved by Health Boards in July 2025. At present no changes are proposed to these documents.

## 2.3 The Hosting Agreement (HA) and memorandum of Agreement (MoA)

The Hosting Agreement (HA) and the Memorandum of Agreement (MoA) were endorsed by the Joint Committee on 17 September 2024 and were approved by the seven HBs at their September 2024 Board meetings. The governance arrangements within the Hosting arrangement have been working effectively. There is regular dialogue between the JCC and officers at Cwm Taf University Health Board (CTMUHB), complemented by more formal meetings between the two Accountable Officers where the Hosting Arrangements are discussed.

A formal review of the Hosting Agreement is scheduled during Q1 of 2026/27.

## 2.4 Accountability Map and Guidance on the Handling of Interests

The Accountability Map outlining the formal accountabilities and relationships between Welsh Government, LHBs, CTMUHB (as the JCC Host Body), the JCC and its Team; and the Guidance on the Handling of Interests which sets out the arrangements for the appropriate handling of declarations of interests within the NWJCC's business, were both received by the Joint Committee at its inaugural meeting on 8 April 2024. The Guidance on the Handling of Interests has been updated and minor changes have been proposed in track and attached at **Appendix 4.** No changes are proposed to the Accountability Map.

**Appendices 1-4** will be presented to the May 2026 JCC meeting for endorsement.

## 2.5 JCC SUB-COMMITTEE STRUCTURE

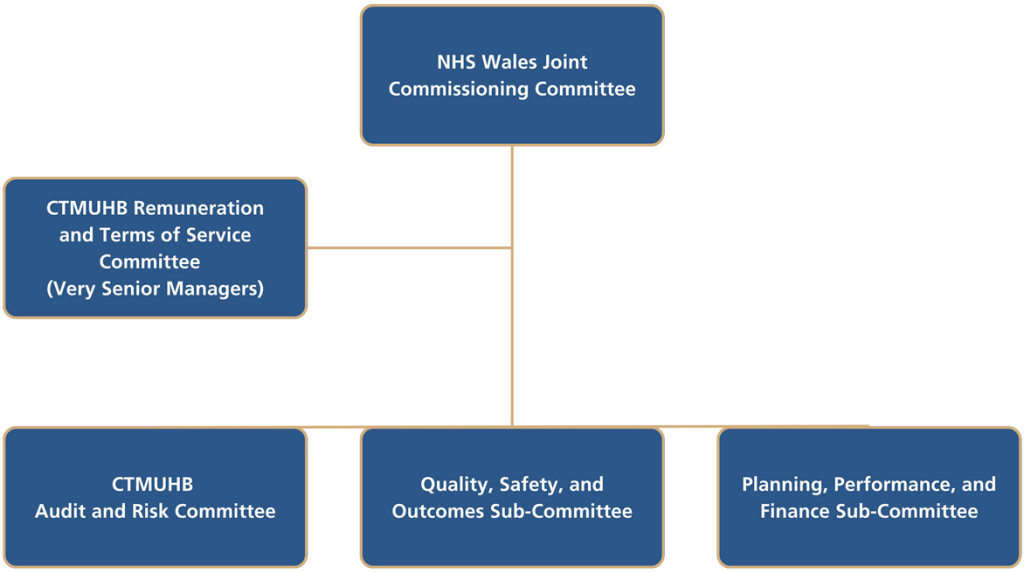
Paragraph 5.5 of the NWJCC Standing Orders states that the Joint Committee shall determine, for agreement by Health Boards, a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent Health Boards.

Paragraph 5.8 of the Standing Orders states that "As a minimum, it shall ensure that there are joint sub-Committee arrangements which cover the following aspects of Joint Committee business:

- Audit and Risk
- Quality, Safety and Outcomes
- Planning and Performance"

The NWJCC Sub-Committee structure was established in January 2025 with the introduction of the Quality, Safety and Outcomes (QSOC) and Planning, Performance and Finance (PPF) Sub-Committees. The NWJCC's Audit and Risk assurance arrangements are serviced by the CTMUHB Hosted Bodies Audit, Risk and Assurance Committee.

Figure 2 –JCC Sub-Committee Structure




Sub-Committee Terms of Reference are subject to annual review (Para 16.1 of the respective ToR). Following a full year of operation, consideration has therefore been given to the content of the QSOC and PPF ToR, and how they align with the NWJCC's governance framework and operational structure.

Updated QSOC and PPF ToR are presented at **Appendix 5** and **Appendix 6** for final approval, having previously been endorsed by the NWJCC Sub-Committees and Joint Committee. Proposed changes are detailed in track.

## 3. ASSESSMENT

| Objectives / Strategy | |
|---|---|
| **Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s)** | Ensure Quality |
| | |
| **Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals** *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)* | A Resilient Wales |
| | If more than one applies please list below:<br>A Healthier Wales<br>A More Equal Wales |
| **Dolen i Hwyluswyr Ansawdd** *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))* | Whole-systems Perspective |
| | If more than one applies please list below: |
| **Dolen i Feysydd Ansawdd** *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))* | Effective |
| | If more than one applies please list below:<br>Person Centred<br>Timely<br>Safe |
| **Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)** | No - Not Applicable |
| | If more than one applies please list below: |

| Impact Assessment | | |
|---|---|---|
| **Ansawdd**<br>*Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /*<br>**Quality**<br>*Have you undertaken a Quality Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome: | If no, please include rationale below:<br><br>N/A |
| **Cydraddoldeb**<br>*Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /*<br>**Equality**<br>*Have you undertaken an Equality Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome: | If no, please include rationale below:<br><br>N/A |
| **Cyfreithiol / Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | | |
| **Enw da / Reputational** | There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report. | |
| | | |
| **Effaith Adnoddau**<br>*(Pobl /Ariannol) /*<br>**Resource Impact**<br>*(People / Financial)* | There is no direct impact on resources as a result of the activity outlined in this report. | |
| | | |

## 4. RECOMMENDATIONS

Board Members are asked to **Approve:**

- the updated Standing Orders for the JCC (**Appendix 2**), subject to formal approval by the NWJCC at the Joint Committee meeting of the 26 May 2026.
- the updated Standing Financial Instructions (SFIs) for the JCC (**Appendix 3**), subject to formal approval by the NWJCC at the Joint Committee meeting of the 26 May 2026.
- the updated Guidance on the Handling of Interests (**Appendix 4**).
- the updated terms of reference (ToR) for the JCC Quality, Safety and Outcomes Sub-Committee (**Appendix 5**); and
- the updated terms of reference (ToR) for the JCC Planning, Performance & Finance Sub-Committee (**Appendix 6**).

## 5. NEXT STEPS

Following approval, the revised JCC Governance Framework will be published on the NWJCC website, and all hyperlinks within the associated documents will be updated to reference these approved materials.

***Appendix 1***

NWJCC Standing Orders

Suggested changes to version 2.1 Draft 13 October 2025

| Organisation | Details of the provision including reference to para | Impact or risk associated with the current arrangement | Proposal for an appropriate and reasonable amendment |
|---|---|---|---|
| NWJCC | Paragraph 1.3 | Nil | Removal of spare bullet point. |
| | Paragraph 1.7 | Nil | Link to be updated, formatting of paragraphs to be changed (space between paras one and two). |
| | Para 2.22 | Nil | Formatting of text and a gap to 2.23. |
| | Para 3.1 – Bullet point 1 | Nil | At the end of bullet point 3 – add in (as set out at Annex 1)<br><br>Please add Annex 1 to the Scheme of Delegation also. |
| | Paras 6.1 to 6.4 | Nil | Spacing of paragraphs |
| | Para 6.3 | Nil | Remove: [known as Lay Members]. This detail is referred to in the paragraph. |
| | Para 6.3 – | Nil | Delete<br>Note: At the time of preparing these Standing Orders 3 Lay Member have been appointed. |
| | Para 6.11 and 6.12 | Nil | Spacing |

| | | |
|---|---|---|
| Para 6.13 | Nil | Paragraph Spacing |
| Para 6.14 | Nil | Documents alignment – 'Vice Chair' to drop to the next page. |
| Para 6.15 | Nil | Formatting - Para 5 to be justified |
| Para 7.3 | Nil | Fifth word – the 't' in 'not' to have the strikethrough removed. |
| Para 7.5? 7.4? | Nil | Formatting – Paragraph spacing. |
| Para 7.5 – Page 21 of 37 | Nil | Inconsistency with Paragraph 7.12 as approved in recent WHC.<br><br>Amend 7 calendar days to 5 |
| Para 7.8 – final paragraph. | Nil | Confusing as this was a statement inserted when the first version was approved and was required as part of a transition in the first year<br><br>Delete from "for the forthcoming year by the end of May 2025, and for subsequent years" |
| Para 7.11 and 12 | Nil | Inconsistency with Paragraph 7.11 and 12<br><br>Amend 7 calendar days to 5 |
| Para 7.11 | Nil | To be updated as per WHC and November Board approval. |

| | | |
|---|---|---|
| Para 7.13 – para 5 | Nil | Formatting. Add space between paragraphs. |
| Para 7.15 – Amendments | Nil | Formatting. Add space between paragraphs. |
| Para 7.21 | Nil | Line 3 – Update to 'minutes' |
| Para 8.1 | Nil | Update the second paragraph to:<br><br>The Joint Committee adopts the Standards of Behaviour Policy of the Host Body which will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, JCC Team officers and others, as appropriate. The framework adopted by the Joint Committee is the Standards of Behaviour Policy which will form part of the JCC SOs. |
| Para 8.2 | Nil | Para 3 please add "(Annex 2)" after Guidance on Handling of Interests. |
| Para 8.8 | Nil | Space to be added between 7 and LHBs – Last line. |
| Para 10.1 | This paragraph is not reflective of current practice. | Proposed update as follows: |

| | | | |
|---|---|---|---|
| | | | The Joint Committee shall set out explicitly, within a ~~Risk and~~ Joint Committee Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.<br><br>The Joint Committee shall provide assurance on the processes in place to support this to the Host Body's Audit Risk and Assurance Committee ~~ensure that its assurance arrangements are operating effectively, advised by the~~ |

| | | | |
|---|---|---|---|
| | | | ~~Joint Committee's Audit Committee~~. |
| | PAGE 41 - | Nil | Below C4 there is an empty row to be deleted. |
| | Page 41 – Annex 1(D) | For detail | We need to update this table to confirm that this will be kept under review during 2026/27. |

**Appendix 2**

# STANDING ORDERS FOR THE NHS WALES JOINT COMMISSIONING COMMITTEE

**This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders**

Adopted from the Model Standing Orders issued by Welsh Government on 13 October 2025.

| | |
|---|---|
| **Date endorsed:** | |
| **Endorsed by:** | JCC |
| **Date approved:** | |
| **Approved by:** | Health Boards |
| **Review date:** | Annual |
| **Version:** | 2.1 |
| **Responsible Director:** | Committee Secretary |

| | | |
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## 1. INTRODUCTION

### Foreword

1.1 Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. When agreeing Standing Orders Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the NHS Wales Joint Commissioning Committee's (JCC) proceedings and business to form part of each LHBs Standing Orders.

1.2 These JCC Standing Orders form a schedule to each LHBs own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024 and LHB Standing Order, paragraph 3.2 into day to day operating practice.

Together with the adoption of a Schedule of Powers reserved to the Joint Committee; a Scheme of Delegation to officers and others; and Standing Financial Instructions (SFIs), they provide the framework for the business conduct of the Joint Committee.

1.3 These documents, together with the following, are designed to ensure the achievement of the standards of good governance set for the NHS in Wales:

- Memorandum of Agreement which defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executive Officer of the constituent LHBs as individual members of the Joint Committee;
- Hosting Agreement which outlines the accountability arrangements and resulting responsibilities for Cwm Taf Morgannwg University Health Board (the Host Body) and the other 6 LHBs; and
- Cwm Taf Morgannwg University Health Board's Values and Standards of Behaviour Framework.

1.4 All LHB Board members (and employees where appropriate), Joint Committee members, and the NHS Wales Joint Commissioning Committee Team (JCCT) must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements for the Joint Committee. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/a-wp/governance-e-manual/

1.6 As a joint committee of the LHBs, the JCC is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf.
Ultimately, the 7 LHBs remain accountable for planning, securing and delivering health services to their respective populations.

1.7 Cwm Taf Morganwwg University Health Board is appointed as the Host Body under Ministerial Direction and is accountable for the delivery of the functions of host body, as required by the NHS Wales Joint Commissioning Committee (Wales) Directions 2024 (the JCC Directions). As the host body they are required to provide administrative support for the operation of the JCC and establish the JCCT.

The Board of the Host Body will not be responsible or accountable for the planning, funding and securing of those services delegated to the JCC by the 7 LHBs, or as directed by Welsh Ministers, save in respect of residents within the areas served.

## 2. CONSTITUTION AND PURPOSE

**Statutory Framework**

2.1 The NHS Wales Joint Commissioning Committee (JCC) (the Joint Committee) is a joint committee of each LHB in Wales, established under the NHS Wales Joint Commissioning Committee (Wales) Directions 2024 (the JCC Directions).

The functions and services of the Joint Committee are listed in Section 3(2) of the JCC Directions.

2.2 The principal place of business of the JCC is Unit G1, The Willowford, Treforest Industrial Estate, Pontypridd CF37 5YL.

2.3 All business shall be conducted in the name of the NHS Wales Joint Commissioning Committee (JCC) on behalf of LHBs.

2.4 LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the NHS (Wales) Act 2006 which is the principal legislation relating to the NHS in Wales.

Whilst the NHS Act 2006 applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

2.5 Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions.

2.6 LHBs must act in accordance with those directions. Most of the LHBs' statutory functions are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009.

However, in some cases the relevant function may be contained in other legislation.

2.7 Each LHBs functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and tertiary services for the citizens in their respective areas. The JCC Directions provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning, securing and commissioning of services delegated to it and will establish the Joint Committee for the purpose of jointly exercising those functions.

2.8 Under powers in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006 the Minister has made the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024 (the JCC Regulations) which set out the constitution and membership arrangements of the Joint Committee.

Certain provisions of the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (the Constitution Regulations) will also apply to the operations of the Joint Committee, as appropriate.

2.9 In addition to directions, the Welsh Ministers may from time to time issue guidance relating to the activities of the Joint Committee which LHBs must take into account when exercising any function.

2.10 The Host LHB shall issue an indemnity to the Chair and Lay Members, on behalf of the LHBs.

**NHS Framework**

2.11 In addition to the statutory requirements set out above, the Joint Committee, on behalf of each of the LHBs, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery.

The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

2.12 Adoption of the principles will better equip the Joint Committee to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

2.13 The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; and Standing Financial Instructions, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

2.14 The Welsh Ministers, reflecting their constitutional obligations and legal duties under the Well-being of Future Generations (Wales) Act 2015, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

2.15 The Well-being of Future Generations (Wales) Act 2015 also places duties on LHBs, NHS Trusts and Special Health Authorities in Wales and therefore is extended to the activity of the JCC. Sustainable development in the context of the act means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

2.16 The Health and Social Care (Quality and Engagement) (Wales) Act 2020 places requirements to:

- Ensure NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality); and
- Ensure NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour).

LHBs will need to ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance. These requirements therefore extend to the activity of the JCC, where relevant as set out within the JCC Scheme of Delegation.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

2.17 Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Ministers' Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at: https://nwssp.nhs.wales/a-wp/governance-e-manual/

Directions or guidance on specific aspects of Joint Committee/LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

**Purpose and Delegated functions**

2.18 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the planning, securing and commissioning of:

- specialised services for:
  - cancer and blood disorders
  - cardiac conditions
  - mental health and vulnerable groups
  - neurosciences, and
  - women and children.
- services where there is agreement between the Local Health Boards that they should be arranged on a regional or national basis
- emergency medical services
- non-emergency patient transport services
- emergency medical retrieval and transfer services
- NHS 111 services
- sexual assault referral centres, and
- other services as directed by the Welsh Ministers.

2.19 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of services identified in 2.18 for residents within their area.

**Role of the Joint Committee**

2.20 The Joint Committee's role is to:

- Determine a long-term strategy for the commissioning of services delegated to the JCC
- Produce an Integrated Medium-Term Plan which describes how these services will be delivered on behalf of LHBs through clear 'commissioning intentions' which informs and compliments the LHBs Integrated Medium-Term Plans (IMTPs)
- In commissioning services, the JCC will act in accordance with the Directions and Scheme of Delegation of the health boards and will, for the relevant functions:
    - Identify and evaluate existing, new and emerging services and treatments and advise on the way in which these services should be delivered
    - Develop policies for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC
    - Determine annually those services that should be commissioned on a regional or national basis
    - Determine the appropriate level of funding for the commissioning of directed and delegated services at a regional or national level and determine the contribution from each LHBs for those services (which will include the running costs of the JCC and the Joint Commissioning Team) in accordance with any specific directions set by the Welsh Ministers
    - Secure the provision of services delegated at a regional and national level including those to be delivered by providers outside of Wales
- Ensure the JCC operates within an appropriate governance framework.

2.21 To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making delegated to the Chief Commissioner and others undertaken at the direction of the Joint Committee.

2.22 The Joint Committee must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Where LHBs have delegated decisions to the JCC, each **LHB shall be bound by the decisions of the Joint Committee in accordance with the Schedule of Powers reserved for the Joint Committee.**

In the event that the Joint Committee is unable to reach agreement, the dispute process set out within the Memorandum of Agreement should be followed.

2.23 The Joint Committee shall work with all its partners and stakeholders in the

best interests of the population of Wales.

## 3. SCOPE AND DUTIES

**Joint Committee Framework**

3.1 The specific governance and accountability arrangements established for the Joint Committee are set out within:

- These JCC Standing Orders and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation to others (as set out in **Annex 1)**
- The JCC Standing Financial Instructions (SFIs)
- JCC Accountability Map
- A Memorandum of Agreement which defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executive Officer of the constituent LHBs as individual members of the Joint Committee;
- A Hosting Agreement which outlines the accountability arrangements and resulting responsibilities for Cwm Taf Morgannwg University Health Board (the Host Body) and the other 6 LHBs; and
- Guidance on the Handling of Interests.

3.2 **Annex 2** to these Standing Orders provides details of the key documents that, together with these SOs, make up the Joint Committee's governance and accountability framework.

3.3 The Joint Committee may from time to time agree operating procedures which apply to Joint Committee members.

The decisions to approve these operating procedures will be recorded in an appropriate Joint Committee minute and, where appropriate, will be included in Annex 2 of these JCC SOs.

**Applying JCC Standing Orders**

3.4 The JCC SOs (together with the JCC SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any joint sub-Committees established by the Joint Committee, including any Advisory Groups.

The JCC SOs may be amended or adapted for the joint sub-Committees or Advisory Groups as appropriate, with the approval of the LHB Boards. Further details on joint sub-Committees and Advisory Groups may be found **in Annexes 3 and 4** of these JCC SOs, respectively.

3.5 Full details of any non-compliance with these JCC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit Committee to formally consider the matter and make proposals to the Joint Committee on any action to be taken. LHB Boards should be notified of any material non-compliance and the action taken, as determined by the

Committee Secretary.

All Joint Committee members and Joint Committee Team officers have a duty to report any non-compliance to the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported. Ultimately, failure to comply with JCC SOs is a disciplinary matter.

**Variation and amendment of JCC Standing Orders**

3.6 Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the Joint Committee determines that it is necessary to vary or amend the SOs during the year.

In these circumstances, the Chair of the Joint Committee, advised by the Committee Secretary, shall submit a formal report to each LHB Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the seven LHBs are in favour of the amendment, and
- Where the Welsh Ministers agree if it relates to part of the Standing Orders issued under direction, or
- In the event that agreement cannot be reached, Welsh Ministers determine that the amendment should be approved.

**Interpretation**

3.7 During any Joint Committee meeting where there is doubt as to the applicability or interpretation of the JCC SOs, the Chair of the Joint Committee shall have the final say, provided that the decision does not conflict with rights, liabilities or duties as prescribed by law.

In doing so, the Chair should take appropriate advice from the Committee Secretary.

3.8 The terms and provisions contained within these SOs aim to reflect those covered within all applicable legislation. The legislation takes precedence over these JCC SOs when interpreting any term or provision covered by legislation.

**Relationship with LHB Standing Orders**

3.9 The JCC SOs form a schedule to each LHBs own SOs, and shall have effect as if incorporated within them.

## 4. DELEGATED POWERS

4.1 Each LHB will have appropriate arrangements to equip their respective Chief Executive to represent the views of the individual Board and discharge their delegated authority appropriately.

**Reservation and Delegation of Joint Committee Functions**

4.2 Within the framework approved by each LHB Board and set out within these JCC SOs and subject to any directions that may be given by the Welsh Ministers; the Joint Committee may make arrangements for certain functions to be carried out on its behalf, so that the day-to-day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives.

In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made.

4.3 The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

1. Schedule of matters reserved to the Joint Committee
2. Scheme of delegation to joint sub-Committees and others, and
3. Scheme of delegation to the Chief Commissioner and others as appropriate

all of which must be formally adopted by the Joint Committee and approved by LHB Boards as a schedule to their own SOs.

4.4 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

**Chair's action on urgent matters**

4.5 There may, occasionally, be circumstances where decisions which would normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee. In these circumstances, the Joint Committee Chair and one Officer Member (CEO of an LHB) will take a decision after consulting with the Chief Commissioner, supported by the Committee Secretary.

The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

The Committee Secretary will determine a process for the use of Chair's action on urgent matters, ensuring that the requirements outlined within these SOs are achieved.

4.6 Chair's action may not be taken where either the Joint Committee Chair or the Officer Member (CEO of an LHB) has a personal or business interest in an urgent matter requiring decision, on the advice of the Committee

Secretary.

In this circumstance, a Lay Member acting as the Vice-Chair will take a decision on the urgent matter, as appropriate. In terms of the officer member, an alternate officer member would need to be sought.

These arrangements will cease if the Chair is suspended in accordance with Regulation 9 of the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024. Reference should be made to Regulation 11 of these Regulations and advice should be sought from Welsh Government.

## 5. AUTHORITY

**Committee Authority**

5.1 Approve those policies relevant to the business of the Committee as delegated by the LHBs or the host Board.

5.2 Each LHB Board may agree that designated board members or LHB officers shall be in attendance at Joint Committee meetings. The Joint Committee Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the relevant LHB Chair.

5.3 The LHBs jointly shall determine the arrangements for any meetings between the Joint Committee and LHB Boards.

5.4 As a Joint Committee of LHBs, the Joint Committee Chair will have a bi-lateral relationship with each of the Chairs of the 7 LHBs, in respect of the JCC's role carried out on their behalf and to ensure that the JCC's governance framework remains appropriate to the overarching governance framework of the 7 LHBs.

The Joint Committee Chair will have a relationship with the Host Body's CEO given their respective accountability arrangements with regard to their role in holding a shared accountability for the Chief Commissioner. The arrangements to support the relationship between the Joint Committee Chair and the Host Body CEO are further detailed in the Hosting Agreement.

**Sub Committees**

5.5 The Joint Committee may and, where directed by the LHB Boards jointly, or the Welsh Ministers must, appoint joint sub-Committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

The Joint Committee shall determine, for agreement by the LHBs, a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.

5.6 These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies, to be set out within agreed Terms of Reference and Operating Arrangements.

The membership of any such joint sub-Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers, and set out in respective Terms of Reference and Operating Arrangements for LHB Boards for approval.

5.7 Full details of the joint sub-Committee structure requirements determined by the Joint Committee, including detailed terms of reference for each of these joint sub- Committees are set out in **Annex 3** of these JCC SOs.

5.8 As a minimum, it shall ensure that there are joint sub-Committee arrangements which cover the following aspects of Joint Committee business:
- Audit and Risk
- Quality, Safety and Outcomes
- Planning and Performance.

The Joint Committee may make arrangements to receive and provide assurance to others through the establishment and operation of its own joint sub-Committees or by placing responsibility with the host LHB or other designated LHB. Where responsibility is placed with the host LHB or other designated LHB, the arrangement shall be detailed within the Hosting Agreement between the Joint Committee and the host LHB or the Memorandum of Agreement between the seven LHBs (as appropriate).

The LHBs shall agree the delegation of any of its functions to joint sub-Committees or others (including networks), setting any conditions and restrictions it considers necessary and following any directions of the Welsh Ministers.

The Health Boards shall agree and formally approve the delegation of specific powers to be exercised by joint sub-Committees which it has formally constituted on to others.

Full details of the joint sub-Committee structure established by the Joint Committee, including detailed Standing Orders for each of these joint sub-Committees are set out in **Annex 3** of these JCC SOs

5.9 Each joint sub-Committee established by or on behalf of the Joint Committee must have its own Terms of Reference and operating

arrangements, which must be formally endorsed by the Joint Committee for approval by LHB Boards.

These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority)
- Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum
- Meeting arrangements
- Communications
- Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups)
- Any budget, financial and accounting responsibility
- Secretariat and other support
- Training, development and performance
- Reporting and assurance arrangements.

In doing so, the Joint Committee shall specify which aspects of the JCC SOs are not applicable to the operation of the joint sub-Committee, keeping any such aspects to the minimum necessary.

## 6. MEMBERSHIP

**Membership of the Joint Commissioning Committee**

6.1 The membership of the Joint Committee is provided for within the Joint Committee Directions and the Joint Committee Regulations. It shall be 11-13 voting members and one associate member as detailed below.

**Chair**

6.2 The Chair is responsible for the effective operation of the Joint Committee and is appointed by the Welsh Ministers through the Public Appointments process.

**Non-Officer Members ~~[known as Lay Members]~~**

6.3 Up to 5 non-officer members, to be referred to as Lay Members, appointed by the Welsh Ministers through the Public Appointments process.

~~Note: At the time of preparing these Standing Orders 3 Lay Member have been appointed.~~

**Officer Members**

6.4 A total of 7, drawn from each Local Health Board in Wales (the Chief Executive Officer of each).

**Associate Member**

6.5 The Chief Commissioner of the JCC Team will be appointed as an Associate Member of the Joint Committee attending meetings on an ex-officio basis, without voting rights.

6.6 Where a post of Chief Commissioner is shared between more than one person because of their being appointed jointly to the post, either or both persons may attend and take part in a Joint Committee meeting.

**In attendance**

6.7 The Joint Committee should, at appropriate times, invite other members of the JCC team and key providers of services commissioned by the JCC to attend all or part of a meeting on an ex-officio basis to assist the Joint Committee in its work. Representatives from Llais may also be invited to meetings as required (Section 7.7).

In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Llais) and to demonstrate openness and transparency in the conduct of business.

**Member Responsibilities and Accountability**

6.8 The Joint Committee will function as a decision-making body, all voting members being full and equal members and sharing responsibility for all the decisions of the Joint Committee.

The JCC must discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must be acting clearly in the interests of the JCC and of the population of Wales, rather than furthering direct or indirect financial, personal, professional or organisational interests.

6.9 Members who are appointed to the Joint Committee must act in a balanced manner, ensuring that any opinion expressed is impartial and based upon the best interests of the population of Wales.

6.10 All members must comply with the terms of their appointment to the Joint Committee. They must equip themselves to fulfil the breadth of their responsibilities on the Joint Committee by participating in relevant personal and organisational development programmes, engaging fully in the activities of the Joint Committee and promoting understanding of its work.

6.11 The Joint Committee may also co-opt additional independent external members from outside the LHBs or the JCCT to provide specialist skills, knowledge and experience. These individuals would attend in an ex-officio capacity.

**The Chair**

6.12 The Chair is responsible for the effective operation of the Joint Committee:

- Chairing Joint Committee meetings
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Joint Committee business is conducted in accordance with JCC SOs
- Developing positive and professional relationships amongst the Joint Committee's membership and between the Joint Committee and each LHBs Board.

Supported by the Committee Secretary, the Chair shall ensure that key and appropriate issues are discussed by the Joint Committee in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

The Chair, shall be appointed by the Minister for Health and Social Services for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. The Chair may be reappointed but may not serve a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

The Chair is accountable to the Minister for Health and Social Services in respect of their performance as Chair of the JCC, upholding the values of the NHS and promoting the confidence of the public and partners. The Minister for Health and Social Services undertakes a performance appraisal of the Joint Committee Chair and sets objectives accordingly.

In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of and NHS body in Wales whilst also serving as the Chair of the Joint Committee.

**Lay Members**

6.13 On a day-to-day basis, Lay Members are responsible to the Committee Chair for discharging their roles as Lay Members of the JCC (and any subsequent sub-Committee). The Committee Chair will undertake performance appraisals of Lay Members on behalf of the Minister for Health and Social Services.

The Committee Lay Members are appointed by, and are accountable to, the Minister for Health and Social Services in respect of their performance as Lay Members of the JCC, upholding the values of the NHS and promoting the confidence of the public and partners.

In addition to the eligibility, disqualification, suspension and removal

provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of an NHS body in Wales whilst also serving as a Lay Member.

**Vice Chair**

6.14 The members of the Joint Committee may appoint one of the non-officer members, other than the chair, to be vice-chair for such period, not exceeding the remainder of that person's term as a member, as they may specify on the appointment.

They may, at any time resign from the office of vice-chair by giving notice in writing to the chair or, if the office of chair is vacant, to the members.

The appointment will cease if the Chair were to be suspended and advice should be sought from Welsh Government and reference made to Regulation 11 of the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024.

**Chief Commissioner**

6.15 The Joint Committee will delegate certain functions to the Chief Commissioner. For these aspects, the Chief Commissioner, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Commissioner will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

This must be considered and approved by the Joint Committee (subject to any amendment agreed during the discussion). The Chief Commissioner may periodically propose amendment to the Scheme of Delegation and any such amendments must also be considered and approved by the Joint Committee.

The Chief Commissioner is accountable to the Committee Chair in relation to discharging the role and functions delegated by the Joint Committee, on behalf of the 7 LHBs, to the Commissioning Team for the planning, securing and commissioning of the relevant services, by the Joint Committee, on behalf of the 7 LHBs.

In respect of personal performance this will include an annual performance review undertaken by the Committee Chair. This will take into account those functions delegated from the host, as set out within the Hosting Agreement, and will therefore be informed by the Chief Executive of the Host Body. Feedback from other Joint Committee members will also be sought in informing the appraisal of the Chief Commissioner.

As an employee of the Host Body, the Chief Commissioner will be accountable to the Chief Executive of the Host Body in respect of the

responsibilities delegated to the Chief Commissioner set out within the Hosting Agreement. As the employer, the Host Body is responsible for the Terms of Conditions and employment matters associated with the Chief Commissioner, informed by the Committee Chair.

As a Joint Committee of LHBs, the Chief Commissioner will have a relationship with the Chief Executive Officers and Executive Teams of the 7 LHBs, in respect of the role and functions delegated to the Commissioning Team by the Joint Committee, on behalf of the 7 LHBs.

**The Committee Secretary**

6.16 The role of the Committee Secretary is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee, and is a key source of advice and support to the Chair and Joint Committee members.

Independent of the Joint Committee, the Committee Secretary acts as the guardian of good governance within the Joint Committee:

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, its joint sub-Committees and Advisory Groups
- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role
- Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of a committee culture that embodies NHS values and standards of behaviour; and
- Monitoring the Joint Committee's compliance with the law, JCC SOs and the framework set by the LHBs and Welsh Ministers.

The Committee Secretary is accountable to the Joint Committee Chair for all matters in relation to the responsibilities delegated in respect of the JCC's Governance Framework, within the context of the overarching Governance Framework of the 7 LHBs. The Committee Secretary is accountable to the Chief Commissioner for their performance as an employee of the Host Body and a member of the JCC Commissioning Team.

As a Joint Committee of LHBs, the Committee Secretary will have a relationship with the Directors of Corporate Governance of each of the 7 LHBs, in respect of the overarching governance framework of the 7 LHBs. As an employee of the Host Body (CTMUHB), the Committee Secretary will also have a relationship with the Host Body's Director of Corporate

Governance with regard to the governance of those functions delegated to the JCC Team via the Hosting Agreement.

The Committee Secretary will have a relationship with the Head of NHS Governance within Welsh Government, as a Senior Governance Professional within NHS Wales

## 7. COMMITTEE MEETINGS

**Chairing Joint Committee meetings**

7.1 The Chair of the Joint Committee will preside at any meeting of the Joint Committee unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the vice-chair, if appointed, shall preside. If the Vice-Chair is also absent or disqualified, the Lay Members present shall elect one of them to preside.

The Chair must ensure that the meeting is handled in a manner that enables the Joint Committee to reach effective decisions on the matters before it. This includes ensuring that Joint Committee members' contributions are timely and relevant and move business along at an appropriate pace.

In doing so, the Joint Committee must have access to appropriate advice on the conduct of the meeting through the attendance of the Committee Secretary. The Chair has the final say on any matter relating to the conduct of Joint Committee business.

**Quorum**

7.2 Quorum will be met if at least 6 voting members, 4 of whom are Officer Members (LHB Chief Executives) and 2 are the Chair, Vice-Chair or Lay Members, are present to allow any formal business to take place at a Joint Committee meeting.

If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a deputy to attend on their behalf. The nominated deputy must be an Executive Director (and hold office in accordance with regulation 3(2) of the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009) of the same organisation who can fully engage and take decisions in the absence of the CEO.

Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

If the Chief Commissioner is unable to attend a Joint Committee meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting.

The quorum must be maintained during a meeting to allow formal business

to be conducted, i.e., any decisions to be made. Any Joint Committee member or their deputy disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

**Frequency of Meetings**

7.3 Meetings shall be held nott~~t~~ less than six times a year and otherwise as the Chair of the Committee deems necessary.

**Meeting arrangements**

7.4 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of each LHB, including any views expressed formally.

7.5 **Circulation of Papers**

The Committee Secretary will ensure that all papers are distributed at least 5~~7~~ calendar days in advance of the meeting.

**Putting Citizens first**

7.6 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities
- The selection of accessible, suitable venues for meetings
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read, where requested or required, and in electronic formats
- Requesting that attendees notify the Committee Secretary of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings, and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh, in accordance with legislative requirements, e.g. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

**Working with Llais (Citizen Voice Body for Health and Social Care Wales)**

7.7 The Joint Committee shall ensure arrangements are in place to engage and co-operate with representatives of Llais as appropriate.

Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs and Trusts in relation to the engagement and involvement of Llais in their operations, which are extended to the activities of the JCC.

The 2020 Act places a statutory duty on LHBs and Trusts to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

The 2020 Act also places a statutory duty on LHBs and NHS Trusts to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions.

Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. LHBs and Trusts must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant).

The Code of Practice on Access to Premises and Engagement with Individuals can be found at: https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

The LHBs and Joint Committee will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning, developing, considering proposals for service change and commissioning services.

**Annual Plan of Committee Business**

7.8 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall appear on every Joint Committee agenda.

The plan shall set out the arrangements in place to enable the Joint

Committee to meet its obligations to its citizens as outlined in Section 7.7 whilst also allowing Joint Committee members to contribute in either English or Welsh languages, where appropriate.

The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of joint sub-Committees, Expert Panels and Advisory Groups.

The Joint Committee shall agree the plan ~~for the forthcoming year by the end of May 2024, and for subsequent years~~ by the end of March, and this plan shall be published on the Committee's website.

**Calling Meetings**

7.9 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time.

Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

If the Chair does not call a meeting within seven days after receiving such a request from Joint Committee members, then those Joint Committee members may themselves call a meeting.

**Preparing for Meetings**

7.10 **Setting the agenda**

The Joint Committee Chair, in consultation with the Committee Secretary and the Chief Commissioner, will set the agenda.

In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from joint sub-Committees and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

Any Joint Committee member may request that a matter is placed on the agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting.

The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12-day notice period if this would be beneficial to the conduct of Joint Committee business.

7.11 **Notifying and equipping Joint Committee members**

Joint Committee members should be sent an Agenda and a complete set of supporting papers at least 5~~7~~ calendar days before a formal Joint Committee meeting. This information may be provided to Joint Committee members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration.

Impact assessments shall be undertaken, as appropriate, when planning, securing or commissioning those services delegated to the Joint Committee. They will also be completed on all new or revised policies, strategies, guidance and / or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

In the event that at least half of the Joint Committee members do not receive the agenda and papers for the meeting as set out above, the Joint Committee Chair must consider whether or not the Joint Committee would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Joint Committee Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

In the case of a meeting called by Joint Committee members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

7.12 **Notifying the public and others –** Except for meetings called in accordance with SOs, at least 10 calendar days before each meeting of the Joint Committee, a public notice of the time and place of the meeting shall be displayed bilingually (in English and Welsh):

- On the JCC's website;
- Each LHBs website shall link to the JCC website; as well as through other methods of communication as set out in the JCC's communication strategy.

When providing notification of the forthcoming meeting, the committee shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g., as Braille, large print, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Committee.

**Conducting Joint Committee Meetings**

7.13 **Admission of the public, the press and other observers**

The Joint Committee shall encourage attendance at its formal Joint Committee meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the Joint Committee. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility.

The Joint Committee shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter affecting a JCC Member or a patient.

In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee shall resolve:

- *That representatives of the press and other members of the public 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 [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].*

In these circumstances, when the Joint Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Joint Committee in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Joint Committee meeting held in public session.

The Committee Secretary, on behalf of the Joint Committee Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

In encouraging entry to formal Joint Committee Meetings from members of the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

Unless the Joint Committee has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

**Dealing with motions**

7.14 In the normal course of Joint Committee business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g., where an aspect of service delivery is a cause for particular concern, a Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken.

The Committee Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Joint Committee unless moved by a Joint Committee member and seconded by another Joint Committee member (including the Joint Committee Chair).

7.15 **Proposing a formal notice of Motion**

Any Joint Committee member wishing to propose a motion must notify the Joint Committee Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out.

Where sufficient notice has been provided, and the Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

The Joint Committee Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Joint Committee business.

**Amendments**
Any Joint Committee member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Joint Committee alongside the motion.

If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

7.16 **Motions under discussion**
When a motion is under discussion, any Joint Committee member may propose that:

- The motion be amended
- The meeting should be adjourned
- The discussion should be adjourned and the meeting proceed to the next item of business
- A Joint Committee member may not be heard further
- The Joint Committee decides upon the motion before them
- An ad hoc committee should be appointed to deal with a specific item of business, or
- The public, including the press, should be excluded.

7.17 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.18 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Joint Committee Chair.

7.19 **Motion to rescind a resolution –** The Joint Committee may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Joint Committee members.

A Motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a joint sub-Committee/Chief Commissioner to which a matter has been referred.

**Voting**

7.20 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require a secret ballot or recorded vote if the majority of voting Joint Committee members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted.

In order to ensure balanced and collective decision, Members are not permitted to abstain during voting, given that the JCC must discharge its collective duty for the population of Wales.

The Associate Member may not vote in any meetings or proceedings of the Joint Committee.

In determining every question at a meeting, the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales. Such views may be presented to the Joint Committee through the LHBs utilising their formal Board Advisory Fora (Stakeholder Reference Group and Healthcare Professionals' Forum).

The Joint Committee will make decisions based on a majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

A nominated deputy of an LHB Chief Executive may vote. Absent Joint Committee members, who have no nominated deputy present, may not vote by proxy. Absence is defined as being absent at the time of the vote.

**Record of Proceedings**

7.21 A record of the proceedings of formal Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence and shall be submitted for agreement at the next meeting of the Joint Committee, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

**Confidentiality**

7.22 All Joint Committee members (including the Associate Member), together with members of any joint sub-Committee, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee

and/or LHB officials must respect the confidentiality of all matters considered by the Joint Committee in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Joint Committee Chair or relevant chair of a joint sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Standards of Behaviour Framework (including Gifts and Hospitality) Policy or legislation such as the Freedom of Information Act 2000, etc.

Committee members and attendees must not disclose any matter dealt with by or brought before the JCC in confidence without the permission of the Committee's Chair.

**Expert panel and other groups**

7.23 Where delegated by LHBs, the Joint Committee may also establish other groups to help it in the conduct of its business. The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers, must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed Standing Orders are set out in Annex 4 of the JCC SOs.

Any Expert Panel or Advisory Group established by the Joint Committee must have its own Standing Orders and operating arrangements, which must be formally approved by the Joint Committee. These must establish its governance and ways of working, setting out, as a minimum in the same way as for sub committees (section 7.5).

In doing so, the Joint Committee shall specify which aspects of the JCC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements or directions agreed by the LHBs or the Welsh Ministers, and set out in respective Terms of Reference and Operating Arrangements.

The Joint Committee shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the Joint Committee on their activities. Expert Panel or Advisory Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

Any Expert Panel or Advisory Group shall also submit an annual report to

the Joint Committee through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

**Reporting activity to the Joint Committee**

7.24 Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the Joint Committee on their activities.

Joint sub-Committee Chairs' shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

Each joint sub-Committee shall also submit an annual report to the Joint Committee through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

## 8. VALUES AND STANDARDS OF BEHAVIOUR

**Values and Standards of Behaviour**

8.1 The Joint Committee must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour framework.

~~These values and standards of behaviour will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, JCC Team officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the JCC SOs.~~The Joint Committee adopts the Standards of Behaviour Policy of the Host Body which will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, JCC Team officers and others, as appropriate. The framework adopted by the Joint Committee is the Standards of Behaviour Policy which will form part of the JCC SOs.

**Declaring and recording Joint Committee members' interests**
**Declaration of interests**

8.2 It is a requirement that all Joint Committee members should declare any personal or business interests they may have which may affect, or could be perceived to affect the conduct of their role as a Joint Committee member.

This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Joint Committee's business. Joint Committee members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations.

The JCC's Guidance on the Handling of Interests **(Annex 2)** provides further detail on the requirements of Joint Committee members.

The Committee Secretary will provide advice to the Joint Committee Chair and the Joint Committee on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour Framework. If individual Joint Committee members are in any doubt about what may be considered as an interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

**Register of interests**

8.3 The Committee Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Joint Committee members through the following processes:

The recording of JCC members' interests will be recorded as follows:

- JCC Chair – via the Host Body's policy and process for declaring and recording interests;
- JCC Lay Members - via the Host Body's policy and process for declaring and recording interests;
- JCC Officer Members – via their respective Health Board's policy and process for declaring and reporting interests; and
- Chief Commissioner - via the Host Body's policy and process for declaring and recording interests.

The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, working with LHBs in respect of Officer Members, through which Joint Committee members will be required to confirm the accuracy and completeness of the register relating to their own interests.

In line with the Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This may include publication on the Joint Committee's website.

**Publication of declared interests in Annual Report**

8.4 Joint Committee members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each LHB Board's Annual Report.

**Dealing with Members' interests during Joint Committee meetings**

8.5 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it is taken in an open, balanced, objective and unbiased manner.

In turn, individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales.

The JCC must discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must act in accordance with this principle, rather than furthering direct or indirect financial, personal, professional or organisational interests. This also includes ensuring that Officer Members do not seek to achieve a greater benefit for the population of their respective Local Health Board over and above that of others.

Where individual Joint Committee members identify an interest in relation to any aspect of Joint Committee business set out in the Joint Committee's meeting agenda, that member must declare an interest at the start of the Joint Committee meeting. Joint Committee members should seek advice from the Joint Committee Chair, through the Committee Secretary, before the start of the Joint Committee meeting if they are in any doubt as to whether they should declare an interest at the meeting.
All declarations of interest made at a meeting must be recorded in the Joint Committees minutes.

It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may vary dependent on the type of interest declared and further detail on the options takes are set out within the JCC's Guidance on the Handling of Interests.

For the purpose of the JCC's business, interests fall into the following categories with further detail set out within the JCC's Guidance on the Handling of Interests:

1. Personal Financial Interests
2. Non-Financial Personal Interests
3. Non-Financial Professional Interests
4. Indirect Interests
5. Provider Organisation Interests

In extreme cases, it may be necessary for the individual member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

Where the Joint Committee Chair is the individual declaring an interest, any decision on the action to be taken shall be made by a lay members acting as the Vice-Chair, on behalf of the Joint Committee.

In all cases the decision of the Joint Committee Chair (or the Vice-Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take advice from the Committee Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

**Members with pecuniary (financial) interests**

8.6 Where a Joint Committee member, or any person they are connected with has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it.

The Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

8.7 The Local Health Boards (Constitution, Membership and Procedures) Wales Regulations 2009 define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The JCC SOs must be interpreted in accordance with these definitions.

**Reviewing how interests are handled**

8.8 The Joint Committee will ensure that arrangements of the Handling of Interests relating to the JCC are reviewed through the Host Body's assurance arrangements as required within the Hosting Agreement and Memorandum of Agreement between the 7 LHBs.

**Dealing with offers of gifts, hospitality and sponsorship**

8.9 The Host Body's Standards of Behaviour Policy (Incorporating Declarations of Interest, Gifts, Hospitality, Sponsorship and Honoraria) applies to the Joint Committee's Chair, Lay Members and Chief Commissioner, and prohibits Joint Committee members from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

Gifts, benefits or hospitality must never be solicited. Any Joint Committee member who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Joint Committee member or JCC Team member. Failure to observe this requirement may result in disciplinary and/or legal action.

In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Committee Secretary as appropriate.

The Committee Secretary will ensure the recording of gifts, hospitality and sponsorship for the JCC's Chair, Lay Members and Chief Commissioner is embedded into the recording and reporting requirements of the Host Body.

The recording of gifts, hospitality and sponsorship for the JCC's Officer Members will be undertaken in accordance with the respective LHB's Standards of Behaviour Policy and reporting arrangements.

## 9. REPORTING AND ASSURANCE ARRANGEMENTS

**Reporting to Health Boards**

9.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the LHB Boards on the Committee's activities
- This includes written submission of Chair summary or highlight reports throughout the year and an in-person attendance at every LHB, meeting annually with Board Members
- Bring to the Board's specific attention any significant matters under consideration by the Committee
- Ensure appropriate escalation arrangements are in place to alert the Members, NHS Wales Chairs or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of NHS Wales.

**Annual Reporting Requirements**

9.2 The Committee shall provide a written, annual report to the host body on its work in support of the Annual Governance Statement.

The LHBs may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate.

The Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

## 10. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

**Risk and Assurance**

10.1 The Joint Committee shall set out explicitly, within a ~~Risk and~~Joint Committee Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks

**Commented [AF1]:** To be shared at the July 2026 JC meeting for approval.

in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

The Joint Committee shall ~~ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit Committee.~~ provide assurance on the processes in place to support this to the Host Body's Audit Risk and Assurance Committee.

10.2 **The role of Internal Audit in Providing independent internal assurance.**
The Host Body shall ensure the effective provision of an independent internal audit function for the Joint Committee as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Ministers.

10.3 **Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups**
The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its joint sub-Committees, Expert Panels and any other Advisory Groups.

Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

Each joint sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair to align with the LHBs annual reporting cycle, setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes
- Its Joint Committee Development Programme, as part of an overall Organisation Development framework, and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

10.4 **External Assurance**
The Joint Committee shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the Joint Committees operations, e.g., the Auditor General for Wales and

Healthcare Inspectorate Wales.

The Joint Committee may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Joint Committee itself may commission specifically for that purpose.

The Joint Committee shall keep under review and ensure that, where appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd's Public Accounts and Public Administration Committee and other appropriate bodies.

The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

## 11. DEMONSTRATING ACCOUNTABILITY

### 11.1 Accountability

Taking account of the arrangements set out within these JCC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the citizens it serves, its officers and healthcare professionals.

The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

### 11.2 Support to the Joint Committee

The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee
- Co-ordinating and facilitating appropriate induction and organisational development activity
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others
- Ensuring the provision of secretariat support for Joint Committee meetings

- Ensuring that the Joint Committee receives the information it needs on a timely basis
- Ensuring strong links to communities/groups
- Ensuring an effective relationship between the Joint Committee and the Host Body, and
- Facilitating effective reporting to each LHB enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

## 12. REVIEW

12.1 The JCC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in JCC SOs, including the appropriate impact assessment.

**Annex 1**

## NHS WALES JOINT COMMISSIONING COMMITTEE

## SCHEME OF DELEGATION AND RESERVATION OF POWERS

| **A. MATTERS RELATING TO THE JCC, RESERVED FOR HEALTH BOARDS** | | |
|---|---|---|
| REF. | AREA | MATTER |
| A1. | Operating Arrangements | Approval of the Joint Committee's Governance Framework, including:<br>• JCC Standing Orders<br>• JCC Standing Financial Instructions<br>• JCC Scheme of Delegation and Reservation of Powers<br>• JCC sub-Committee Terms of Reference |
| A2. | Strategy & Planning | Endorse the long-term strategic plan for the development of those functions delegated to the NHS Wales Joint Commissioning Committee (the Joint Committee), as agreed by the Joint Committee |
| A3. | Strategy & Planning | Endorse the JCC Integrated Medium-Term Plan, as agreed by the Joint Committee for inclusion in LHB Integrated Medium-Term Plans |
| A4. | Strategy & Planning | Endorse the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure), as agreed by the Joint Committee |

| **B. MATTERS RELATING TO THE JCC, DELEGATED FROM HEALTH BOARDS AND RESERVED FOR THE JOINT COMMITTEE** | | |
|---|---|---|
| REF. | AREA | MATTER |
| B1. | Operating Arrangements | Develop, vary, and amend the Joint Committee's Governance Framework for LHB approval, including:<br>• JCC Standing Orders<br>• JCC Standing Financial Instructions<br>• JCC Scheme of Delegation and Reservation of Powers<br>• JCC sub-Committee Terms of Reference |
| B2. | Operating Arrangements | Develop and approve arrangements for the handling of Interests declared by Joint Committee members, in alignment with the Host Body's Values and Standards of Behaviour Framework |
| B3. | Operating Arrangements | Develop and approve the Terms of Reference and Operating Arrangements for the following which are deemed necessary to provide the JCC with advice in |

| | | |
|---|---|---|
| | | the exercise of its functions:<br>• Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field.<br>• Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue. |
| B4. | Strategy & Planning | Develop and approve the long-term strategic plan for the development of those functions delegated to the NHS Wales Joint Commissioning Committee (the Joint Committee) |
| B5. | Strategy & Planning | Develop and approve the JCC's Integrated Medium-Term Plan, for LHB approval |
| B6. | Operating Arrangements | Ratify any urgent decisions taken by the Chair, in-line with JCC Standing Order requirements |
| B7. | Operating Arrangements | Receive report and proposals, after consideration by the appropriate Audit Committee, regarding any non-compliance with JCC Standing Orders (and schedules contained within), and where required ratify in public session any action required in response to failure to comply with JCC SOs for onward reporting to LHBs |
| B8. | Operating Arrangements | Adopt the Host Body's Values and Standards of Behaviour Framework for the JCC |
| B9. | Strategy & Planning | Determine and approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure) |
| B10. | Operating Arrangements | Approve the Joint Committee's Risk and Assurance Framework, ensuring alignment with the Host Body |
| B11. | Operating Arrangements | Approve the Joint Committee's Performance Management Framework |
| B12. | Performance & Assurance | Receive reports from the Chief Commissioner on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans |
| B13. | Performance & Assurance | Receive assurance reports from the Joint Committee's sub-Committees and groups on the performance of those services commissioned by the JCC, and approve action required, including improvement plans, where required |

| | | |
|---|---|---|
| B14. | Performance & Assurance | Receive reports produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-Committees (as appropriate) |
| B15. | Performance & Assurance | Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required |
| B16. | Performance & Assurance | Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Commissioner, set out in the JCC's SFIs, and in-line with any requirements of the Host Body |
| B17. | Performance & Assurance | Approve the Joint Committee's audit and assurance arrangements, in-conjunction with the Host Body as the provider of an internal audit function |
| B18. | Performance & Assurance | Receive assurance regarding the Joint Committee's performance against the Health and Care Quality Standards 2023 and the Duty of Quality and the arrangements for approving required action, including improvement plans, to provide onward assurance to LHBs and the Host Body. |
| B19. | Strategy & Planning | Approve policies for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC |
| B20. | Strategy & Planning | Approve the JCC's key plans and programmes required to exercise its functions relating to the planning, securing and commissioning of those services delegated to it (excluding the Integrated-Medium Term Plan [B5]). |

| **C. MATTERS RELATING TO THE JCC, DELEGATED FROM THE JOINT COMMITTEE TO THE CHIEF COMMISSIONER** | | |
|---|---|---|
| REF. | AREA | MATTER |
| C1. | Performance & Assurance | Responsibility for the leadership and overall delivery of the JCC's:<br>• Integrated Medium-Term Plan; and<br>• Budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure) |
| C2. | Performance | Responsibility for the framework for planning and |

| | | |
|---|---|---|
| | & Assurance | securing those services delegated to the JCC from LHBs, in-line with the approved Integrated Commissioning Plan (title to be confirmed) |
| C3. | Performance & Assurance | Responsibility for ensuring the Health and Care Quality Standards 2023 and the Duty of Quality is embedded within Joint Committee Team's activity |
| C4. | Performance & Assurance | Responsibility for implementing those policies approved by the JCC in relation to the planning and securing of those services delegated to the JCC from LHBs |

| **D. MATTERS RELATING TO THE JCC, DELEGATED FROM THE JOINT COMMITTEE TO SUB-COMMITTEE AND OTHERS (INCLUDING INIDVIDUAL LAY MEMBERS)** | | |
|---|---|---|
| REF. | AREA | MATTER |
| | | |
| | *To be reviewed during 2026/2027* | |
| | | |

**Annex 2(a) NWJCC Standing Financial Instructions**

The document can be accessed here

**Annex 2(b) Hosting Agreement**

The document can be accessed here

**Annex 2(c) Memorandum of Agreement (MOU)**

The document can be accessed here

**Annex 2(d) Guidance on Handling Interests**

The document can be accessed here

**Annex 2(e) Accountability Map**

The document can be accessed here

**Annex 3**

**Sub-Committee Terms of Reference**

Quality Safety and Outcomes Sub-committee Terms of Reference can be accessed here.

Planning, Performance and Finance Sub-committee Terms of Reference can be accessed here.

## Annex 4 -– Advisory/Expert Groups

Not applicable.

# Annex 2.1

## STANDING FINANCIAL INSTRUCTIONS FOR THE NHS WALES JOINT COMMISSIONING COMMITTEE

**This Annex forms part of, and shall have effect as if incorporated in the NHS Wales Joint Commissioning Committee Standing Orders and the Local Health Board Standing Orders (incorporated as Schedule 2.1 of SOs).**

# Foreword

These Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Each Local Health Board (LHB) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of the NHS Wales Joint Commissioning Committee's ( the 'JCC') financial proceedings and business.

These JCC Standing Financial instructions (JCC SFIs) are an annex to the JCC Standing Orders (JCC SOs) which form a schedule to each LHBs own Standing Orders and have effect as if incorporated within them. They are designed to translate statutory and Welsh Government financial requirements for the NHS in Wales into day-to-day operating practice. Together with the adoption of a schedule of decisions reserved to the JCC; a scheme of delegations to officers and others; and JCC Standing Orders, they provide the regulatory framework for the business conduct of the JCC.

These documents, together with the following, are designed to ensure the achievement of the standards of good governance set for the NHS in Wales:

- Memorandum of Agreement which defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executive Officers of the constituent LHBs as individual members of the Joint Committee;
- Hosting Agreement which outlines the accountability arrangements and resulting responsibilities for Cwm Taf Morgannwg University Health Board (the Host Body) and the other 6 LHBs; and
- Cwm Taf Morgannwg University Health Board's Values and Standards of Behaviour Framework.

All JCC members, Hhost ~~LHB~~ Body and the Joint Commissioning Committee Team (JCCT) staff must be made aware of these JCC Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The JCC's Committee Secretary or the ~~Director of Finance~~Director of Finance and Value will be able to provide further advice and guidance on any aspect of the JCC SFIs or the wider governance arrangements for the JCC. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

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# NHS Wales Joint Commissioning Committee

## 1. INTRODUCTION

### 1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Each Local Health Board (LHB) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of the NHS Wales Joint Commissioning Committee's (the 'JCC') financial proceedings and business. The Standing Financial Instructions shall apply equally to members off the Joint Commissioning Committee (JCC) and staff of the JCC Team.

1.1.2 **These SFIs shall have effect as if incorporated in the JCC Standing Orders (SOs) (incorporated as Annex 2 of SOs), and both should be used in conjunction with the Hh~~h~~ost Bb~~b~~ody SOs and SFIs.**

1.1.3 These SFIs detail the financial responsibilities, policies and procedures adopted by the JCC. They are designed to ensure that the JCC's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of matters reserved to the JCC and the Delegation of Powers and Scheme of Delegation to others.

1.1.4 These SFIs identify the financial responsibilities which apply to members of the JCC, including its joint sub-Committees and the JCCT staff. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and Financial Control Procedure notes.

1.1.5 The general principle is that financial control procedures used by the JCC and the JCCT will normally be those of the Hh~~h~~ost Body unless otherwise approved by the appropriate process. In some cases, the financial control procedures of the Host Body may need to be amended to take into account the nature of the business of the JCC. In these exceptional circumstances, the financial control procedures must be scrutinised and recommended by the ~~Director of Finance~~Director of Finance and Value of the JCCT (as referred to as the ~~Director of Finance~~Director of Finance and Value within these SFIs) for approval by the Audit and Risk Committee that deals with the JCC matters. Prior to consideration by the Audit and Risk Committee, the ~~Director of Finance~~Director of Finance and Value will discuss any proposed changes to Financial Control Procedures with the Director of Finance of the Host Body.

1.1.6 Should any difficulties arise regarding the interpretation or application of these SFIs the advice of the Committee Secretary or ~~Director of Finance~~Director of Finance and Value must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the JCC's SOs.

**1.2 Overriding Standing Financial Instructions**

Full details of any non-compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the ~~Director of Finance~~Director of Finance and Value and the Committee Secretary, who will ask the Audit and Risk Committee that deals with the JCC matters to formally consider the matter and make proposals to the JCC on any action to be taken. LHB Boards should be notified of any material non-compliance and the action taken, as determined by the Committee Secretary.

1.2.1 All JCC members, members of joint sub-Committees and the JCCT staff have a duty to report any non-compliance to the ~~Director of Finance~~Director of Finance and Value and the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported.

1.2.2 Ultimately, failure to comply with JCC SFIs is a disciplinary matter.

**1.3 Financial provisions and obligations of LHBs and the JCC**

1.3.1 The financial provisions and obligations for LHBs are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The JCC exists for the purpose of jointly exercising those functions relating to the planning and securing a defined range of services on a national All-Wales basis, on behalf of each of the seven LHBs in Wales. Each LHB shall be bound by the decisions of the JCC in the exercise of its delegated functions. The JCC must agree an appropriate level of funding for the provision of these services and determine the contribution from each LHB to allow the JCC to plan and secure those services, including the running costs of the JCCT. The JCC will prepare an Integrated Medium-Term Plan (IMTP) which shall outline the funding requirements in relation to the relevant services. The JCC will also be responsible for developing a risk sharing framework which sets out the basis on which each LHB will contribute to the IMTP and any variation from the agreed IMTP.

## 2. RESPONSIBILITIES AND DELEGATION

**2.1 The JCC**

2.1.1 The JCC exercises financial supervision and control by:

a) Formulating and approving the Medium-Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium-Term Plan (IMTP)

b) Requiring the submission and approval of balanced budgets within approved allocations/overall funding
c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability), and
d) Defining specific responsibilities placed on JCC members and the Chief Commissioner, and joint sub-Committees, as indicated in the JCC's Scheme of Delegation and Reservation of Powers.

2.1.2 The JCC has adopted the JCC SOs and resolved those certain powers and decisions may only be exercised by the JCC in formal session. The JCC, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day-to-day business of the JCC may be carried out effectively, and in a manner that secures the achievement of the JCC's aims and objectives.

2.1.3 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of services for residents within their area.

## 2.2 The Chief Commissioner and ~~Director of Finance~~Director of Finance and Value

2.2.1 The Chief Commissioner and ~~Director of Finance~~Director of Finance and Value will, as far as possible, delegate their detailed responsibilities, but they remain ultimately responsible for financial control.

2.2.2 The Joint Committee will delegate certain functions to the Chief Commissioner. For these aspects, the Chief Commissioner, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Commissioner will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

2.2.3 The Chief Commissioner is accountable to the Committee Chair in relation to discharging the role and functions delegated by the Joint Committee, on behalf of the 7 LHBs, to the Commissioning Team for the planning, securing and commissioning of the relevant services, by the Joint Committee, on behalf of the 7 LHBs.

2.2.4 As an employee of the Host Body, the Chief Commissioner will be accountable to the Chief Executive of the Host Body in respect of the responsibilities delegated to the Chief Commissioner set out within the Hosting Agreement. As the employer,

the Host Body is responsible for the Terms of Conditions and employment matters associated with the Chief Commissioner, informed by the Committee Chair.

2.2.5 The Chief Commissioner will hold Accountable Officer status for certain elements of their role, namely the propriety and regularity for public finances delegated to them by the LHBs and will be accountable to the Director General/NHS Wales Chief Executive in this regard. Further detail on this accountability relationship is set out in an Accountable Officer Memorandum and an Interface Agreement between the Chief Commissioner and the Chief Executive of the Host Body.

2.2.6 The Chief Commissioner is responsible for ensuring that financial obligations and targets are met, and has overall responsibility for the JCCT's system of internal control.

2.2.7 It is a duty of the Chief Commissioner to ensure that JCC and JCCT members, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

**2.3 The ~~Director of Finance~~Director of Finance and Value**

2.3.1 The ~~Director of Finance~~Director of Finance and Value is responsible for:

a) Implementing the JCC's financial policies and for co-coordinating any corrective action necessary to further these policies

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions

c) Recommending to the relevant Audit and Risk Committee any Financial Control Procedures for the JCC, where the Host Body's cannot be applied, for approval

d) Ensuring that sufficient records are maintained to show and explain the JCC's transactions, in order to disclose, with reasonable accuracy, the financial position of the JCC at any time, and

e) Without prejudice to any other functions of the JCC, and employees of the ~~h~~Host Body~~LHB~~ and JCCT, the duties of the ~~Director of Finance~~Director of Finance and Value include:

(i) ~~–~~The provision of financial advice to members of the JCC, joint sub-~~Committees,~~ Committees, Advisory Groups and the JCCT

(ii) The design, implementation and supervision of systems of internal financial control, and

(iii) The preparation and maintenance of such accounts, certificates, estimates, ~~records~~records, and reports as the JCC may require for the purpose of carrying out its delegated responsibilities.

2.3.2 The ~~Director of Finance~~Director of Finance and Value is responsible for ensuring

an ongoing training and communication programme is in place to affect these SFIs.

**2.4 JCC members and Team, and joint sub-Committees**

2.4.1 All members of the JCC, its joint sub-Committees, (including those employed to perform JCCT functions), severally and collectively, are responsible for:

a) The security of the property of the JCC and ~~host~~ Host Body~~LHB~~ where these are used by the JCCT
b) Avoiding loss
c) Exercising economy and efficiency and sustainability in the use of resources, and
d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of Delegation and Reservation of Powers.

2.4.2 For all JCC members and JCC Team staff, and joint sub-Committees who carry out a financial function, the form in which financial records are kept and the manner in which members of the JCC, joint sub-Committee and JCCT discharge their duties must be to the satisfaction of the ~~Director of Finance~~Director of Finance and Value.

**2.5 Contractors and their employees**

2.5.1 Any contractor or employee of a contractor who is empowered by the ~~host~~ Host Body~~LHB~~ to commit the JCC to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Commissioner to ensure that such persons are made aware of this.

**3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT**

**3.1 Audit and Risk Committee**

3.1.1 An independent Audit and Risk Committee is a central means by which the JCC ensures effective internal control arrangements are in place. In addition, the Audit and Risk Committee that deals with JCC matters provides a form of independent check upon the Team supporting the JCC.

3.1.2 The governance and issues relating to the hosting of the JCC will be incorporated into the standard business of the existing Host Body's Audit and Risk Committee. Assurance on the governance and issues relating to the hosting of the JCC will be reported to the Host Body's Board.

3.1.3 Issues relating to the functions of the JCC delegated from LHBs will be reported into a separate Host Body Audit and Risk Committee for the JCC specifically, operating within its own work cycle as required. The assurance from this will be reported to the LHB Boards. Detailed terms of reference and operating arrangements for this are set out in Annex 3 to the JCC's SOs. This Audit and Risk Committee will follow the guidance set out in the NHS Wales Audit and Risk

Committee Handbook.



NHS Wales Audit
Committee Handbook

3.2 **Chief Commissioner**

3.2.1 The Chief Commissioner is responsible for ensuring arrangements are in place within the JCCT to review, evaluate and report on the effectiveness of internal control, in line with the requirements of the Host Body's audit arrangements, as set out within the Hosting Agreement.

**3.2 Chief Executive of the Host BodyLHB**

The responsibilities of the Chief Executive of the Hhost LHB Body are set out within the Host Body's SFIs (add link),

3.2.1 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
b) Access at all reasonable times to any land or property owned or leased by the host Host BodyLHB.
c) Access at all reasonable times to JCC members and the JCCT
d) The production of any cash, stores or other property of the host Host BodyLHB under a JCC member or a member of the JCCT's control, and
e) Explanations concerning any matter under investigation.

**3.3 Internal and External Audit**

3.3.1 CTMUHB, as the Host Body, has responsibility for ensuring that appropriate internal and external audit of the activities of the JCC are in place. Details of these arrangements will be further set out within the Hosting Agreement.

**3.4 Fraud and Corruption**

3.5.1 In line with their responsibilities, the Chief Commissioner and Director of FinanceDirector of Finance and Value shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The Chief Commissioner and Director of FinanceDirector of Finance and Value shall report to the JCC and the host Host Body'sLHBs Local Counter Fraud Specialist any matters relating to fraud or corruption.

3.5.3 More detailed information about counter fraud can be found in section 3.5 of the host Host Body'sLHBs SFIs.

### 3.5 Security Management

3.5.1 The Chief Executive of the ~~host~~ Host Body~~LHB~~ has overall responsibility for controlling and coordinating security. The Chief Commissioner will ensure that adequate processes are in place to comply with the requirements.

3.5.2 In line with their responsibilities, the Chief Executive of the ~~host~~ Host Body~~LHB~~ will monitor and ensure compliance with Directions issued by Welsh Ministers on NHS Security management.

## 4. FINANCIAL DUTIES

### 4.1 Legislation and Directions

4.1.1 Whilst the JCC is not a statutory body the JCC exists for the purpose of jointly exercising functions on behalf of each of the seven LHBs in Wales which means it must operate in a way which supports delivery of the Local Health Boards two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. Those duties are then set out and retained in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts."

WHC/2016/054 - English and Welsh Versions


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4.3.2 To support the LHB's statutory duty the JCC is required to prepare an Integrated Medium-Term Plan. The Integrated Medium-Term Plan (IMTP) must reflect longer-term planning and delivery objectives for the ongoing development of those services commissioned on behalf of the seven health boards, in conjunction with the Welsh Ministers. The Integrated Medium-Term Plan should be continually reviewed based on latest Welsh Government policy and national and local priority requirements. The Integrated Medium-Term Plan, produced and approved annually, will be 3 year rolling plans. In particular, the Integrated Medium-Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

4.3.3 The NHS Planning Framework directs health boards and trusts to develop, approve and submit an Integrated Medium-Term Plan (IMTP) for approval by Welsh Ministers. Whilst there is not a statutory duty upon the JCC to develop an IMTP it is a requirement. The plan must:

- describe the context, including population health needs, within which the JCC will deliver key policy directives and operational targets from Welsh Government

- demonstrate how the JCC are:
  a) delivering their well-being objectives, including how the five ways of working have been applied,
  b) contributing to the seven Well-being Goals,
  c) establishing preventative approaches across all care and services,
- demonstrate how the JCC will utilise its existing commissioned services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to the quality and efficiency of services
- demonstrate how financial breakeven is to be achieved over a rolling three-year period.

4.3.4 Integrated Medium-Term Plans should be based on a reasonable expectation of future service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium-Term Plan (including a balanced Medium-Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium-Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium-Term Plan will incorporate the balanced Medium-Term Financial Plan and will incorporate the JCC's response to delivering the

- NHS Planning Framework
- Quality, governance and risk frameworks and plans, and
- Outcomes Framework.

4.3.6 The Integrated Medium-Term Plan will be developed in line with the Integrated Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based
- Details of major changes in activity, commissioned service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans
- Profiled activity, service, quality, workforce and financial schedules
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures.

4.3.7 The JCC will, in respect of those functions delegated to it by LHBs:

a) Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services
b) Develop national policies for the equitable access to safe and sustainable, high quality services across Wales, whether planned, funded and secured at national, regional or local level, and

c) Agree annually those services that should be planned on a national basis and those that should be planned locally.

4.3.8 The Chief Commissioner is responsible for the development of the plan and submission to the JCC, on an annual basis, the rolling 3 year Integrated Medium-Term Plan. The JCC's approved Integrated Medium-Term Plan will be submitted to Local Health Boards and Welsh Government in line with the requirements set out in the NHS Planning Framework.

4.3.9 The JCC will:

a) Approve the Integrated Medium-Term Plan prior to the beginning of the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Committee approval, the Plan will be submitted to Local Health Boards and Welsh Government prior to the beginning of the financial year of implementation
b) Approve a balanced Medium-Term Financial Plan as part of the Integrated Medium-Term Plan, which meets all financial duties, probity and value for money requirements
c) Agree the appropriate level of funding for the provision of those services delegated to the JCC , and determining the contribution from each LHB for those services (which will include the running costs of the JCC and the JCCT) in accordance with any specific directions set by the Welsh Ministers
d) Prepare and agree with the Local Health Boards a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Committee plan is not in place or in balance.

## 5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

### 5.1 Budget Setting

5.1.1 Prior to the start of the financial year the ~~Director of Finance~~Director of Finance and Value will, on behalf of the Chief Commissioner, prepare and submit budgets for approval and delegation by the JCC. Such budgets will:

a) Be in accordance with the aims and objectives set out in the JCC Integrated Medium-Term Plan, and Medium-Term Financial Plan, and focussed on delivery of improved population health, safe patient centred quality services
b) Be in line with Revenue, Capital, Commissioning, Activity, Service, Quality, Performance, and Workforce plans contained within the JCC approved balanced IMTP
c) Take account of approved business cases and associated revenue costs and funding
d) Be produced following discussion with appropriate Directors and budget holders
e) Be prepared within the limits of available funds
f) Take account of ring-fenced, specified and non-recurring allocations and

funding

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents)
h) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and
i) Identify potential risks and opportunities.

**5.2 Budgetary Delegation**

5.2.1 The Chief Commissioner may delegate the management of a budget to permit the performance of a defined range of activities,. This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget
b) The purpose(s) of each budget heading
c) Individual or committee responsibilities
d) Arrangements during periods of absence
e) Authority to exercise virement
f) Achievement of planned levels of service, and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Commissioner, ~~Director of Finance~~Director of Finance and Value and delegated budget holders must not exceed the budgetary total or virement limits set by the JCC.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Commissioner, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Commissioner, as advised by the ~~Director of Finance~~Director of Finance and Value.

5.2.5 All budget holders must provide information as required by the ~~Director of Finance~~Director of Finance and Value to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The ~~Director of Finance~~Director of Finance and Value has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist

budget holders managing their budgets successfully.

### 5.3 Financial Management, Reporting and Budgetary Control

5.3.1 The ~~Director of Finance~~Director of Finance and Value shall monitor financial performance against budget and plans and report the current and forecast position on a monthly basis and at every JCC meeting. Any significant variances should be reported to JCC as soon as they come to light and the JCC shall be advised on any action to be taken in respect of such variances.

5.3.2 The ~~Director of Finance~~Director of Finance and Value will devise and maintain systems of financial management performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital (where applicable), to the JCC in a form approved by the JCC containing sufficient information for the JCC to:

- Understand the current and forecast financial position.
- Evaluate risks and opportunities.
- Use insight to make informed decisions.
- Be consistent with other JCC reports, and as a minimum the reports will cover:
  - Details of variations from the Medium-Term Financial Plan showing the contributions to be made by each LHB under the risk sharing framework.
  - Actual income and expenditure to date compared to budget and showing trends and run rates.
  - Forecast year end positions.
  - A statement of assets and liabilities, including analysis of cash flow and movements in working capital
  - Explanations of material variances from plan
  - Capital expenditure and projected outturn against plan (where applicable)
  - Investigations and reporting of variances from financial, activity and workforce budgets.
  - Details of any corrective action being taken as advised by the relevant budget holder and the Chief Commissioner's and/or ~~Director of Finance~~Director of Finance and Value's view of whether such actions are sufficient to correct the situation.
  - Statement of performance against savings target
  - Key workforce and other cost drivers
  - Income and expenditure run rates, historic trends, extrapolation, and explanations, and
  - Clear assessment of risks and opportunities.
- Provide a rounded and holistic view of financial and wider JCC performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible

c) An accountability and escalation framework to be established for the JCC to

formally address material budget variances

d) Investigation and reporting of variances from financial, activity and workforce budgets.
e) Monitoring of management action to correct variances.
f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will:

- be held to account for managing services within the delegated budget.
- investigate causes of expenditure and budget variances using information from activity, workforce, and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Commissioner subject to the JCC's scheme of delegation;
b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement; and
c) No permanent employees are appointed without the approval of the Chief Commissioner other than those provided for within the available resources and workforce establishment as approved by the JCC.

5.3.5 The Chief Commissioner is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Integrated Medium-Term Plan and Medium-Term Financial Plans.

**5.4 Capital Financial Management, Reporting and Budgetary Control**

5.4.1 The JCC is not normally allocated any capital expenditure. In the event that there is an allocation the general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers and ~~host~~ Host Body's procedures and processes.

**5.5 Reporting to Welsh Government - Monitoring Returns**

5.5.1 The Chief Commissioner is responsible for ensuring that the appropriate monitoring returns for the JCC are submitted to the Welsh Ministers in accordance with published guidance and timescales.

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the ~~Director of Finance~~Director of Finance and Value and Chief Commissioner. This commentary should also highlight and quantify any significant risks with an

assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the JCC. There must be consistency between the Medium-Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly JCC reports.

## 6. ANNUAL ACCOUNTS AND REPORTS

6.1 The JCC is not a corporate body and does not therefore have a statutory duty to prepare annual accounts and reports.

6.2 However, the JCC is hosted by the ~~host~~ Host Body~~LHB~~ and therefore the Chief Executive of the H~~h~~ost Body~~LHB~~ is required to ensure that the financial results of the JCC are consolidated into its own financial statements and disclosed as appropriate. Details of what is required is set out in the Hosting Agreement and will be communicated to the JCC and JCCT by the Executive Director of Finance~~Director of Finance~~ of the Host Body.

## 7. BANKING ARRANGEMENTS

### 7.1 General

7.1.1 The JCC is legally hosted by the ~~host LHB~~Host Body and therefore all banking arrangements are the responsibility of the ~~host LHB~~Host Body. Further details of the banking arrangements can be found in section 7 of the ~~host LHBs~~Host Body's SFIs.

## 8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1.1 The JCC is generally only an expenditure incurring segment of the ~~host LHB~~Host Body. Any cash requirements for the JCC ~~is~~are likely to be incidental to its main activities.

8.1.2 All aspect relating to the recording, handling and collection of cash will be the responsibility of the ~~host LHB~~Host Body.

8.1.3 Further details of the processes and responsibilities can be found in section 8 of the ~~host LHB~~Host ~~s~~Body's SFIs.

## 9. INCOME, FEES AND CHARGES

### 9.1 General

9.1.1 The JCC is generally only an expenditure incurring segment of the ~~host LHB~~Host Body. Any income generated by the JCC is likely to be incidental to its main

activities, including recovery of contract underperformance or the cost of drug therapies under agreed rebate arrangements.

9.1.2 The main ~~All~~ aspects relating to the recording, handling and collection of income will be the responsibility of the ~~host LHB~~Host Body. The recovery of any overdue debt arising from invoiced income will remain the responsibility of the JCCT unless the debt requires referral to the Host Body's debt collection agency.

9.1.3 Further details of the processes and responsibilities can be found in section 9 of the ~~host LHB~~Host ~~s~~Body's SFIs.

## 10. NON PAY EXPENDITURE

### 10.1 Scheme of Delegation, ~~Non Pay~~Non-Pay Expenditure Limits and Accountability

10.1.1 The Chief Commissioner will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the JCC's Scheme of Reservation and Delegation of Powers.

10.1.2 The Chief Commissioner will set out in the operational scheme of delegation and authorisation:

a) The list of managers who are authorised to place requisitions for the supply of goods and services, and
b) The maximum level of each requisition and the system for authorisation above that level.

### 10.2 The ~~Director of Finance~~Director of Finance and Value's responsibilities

10.2.1 The ~~Director of Finance~~Director of Finance and Value will:

a) Advise the JCC regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs
b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay ~~expenditure~~expenditure.
c) Ensure systems are in place for the authorisation of all accounts and claims
d) Ensure Directors and officers (staff) strictly follow NHS Wales' system and procedures of verification, recording and payment of all amounts payable
e) Maintain a list of Directors and officers (including specimens of their signatures) authorised to certify ~~invoices~~invoices.
f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been ~~agreed~~agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs, and
h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures.

### 10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the ~~Director of Finance~~Director of Finance and Value and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the ~~Director of Finance~~Director of Finance and Value in advance of both any commitment being made and NWSSP Procurement Services being ~~engaged~~engaged.
b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public ~~procurement~~procurement.
c) Contracts above specified thresholds are approved by Welsh Ministers prior to any commitment being made
d) goods have been duly received, examined and are in accordance with specification and ~~order~~order.
e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are ~~correct~~correct.
f) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to JCC members, members of the Host Body or any employee of the Host Body, other than:
   (i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
   (ii) Conventional hospitality, such as lunches in the course of working visits.

   **This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7. of the ~~host LHB~~Host ~~s~~Body's Standing Orders and the JCC's Standing Order 8.9.**

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the ~~Director of Finance~~Director of Finance and Value on behalf of the Chief Commissioner.
h) All goods, services, or works are ordered on official orders except works and services executed in accordance with a contract and purchases from petty cash.

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds.

j) Goods are not taken on trial or loan in circumstances that could commit the JCC to a future uncompetitive purchase.

k) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the ~~Director of Finance~~Director of Finance and Value.

10.3.2 The Chief Commissioner and ~~Director of Finance~~Director of Finance and Value shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the scheme of delegation.

**10.4 Departures from SFI's**

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. The JCC must consult with NWSSP Procurement Services, ~~Host Body~~the Executive Director of Finance of the Host Body, ~~Director of Finance~~Director of Finance and Value and Committee Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Scheme of Delegation.

**10.5 Accounts Payable**

10.5.1 NWSSP Finance, shall on behalf of the JCC, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable.

**10.6 Prepayments**

10.3.1 Prepayments should be ~~exceptional, and~~exceptional and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where ~~e~~ieither:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%)
- It is the industry norm e.g. courses and conferences.
- It is in line with requirements of Managing Welsh Public Money
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.
- The prepayment is part of the routine cash flow system agreed by the Directors of Finance.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate JCCT Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out

the effects on the ~~host LHB~~Host Body or JCC if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments.

b) The ~~Director of Finance~~Director of Finance and Value will need to be satisfied with the proposed arrangements before contractual arrangements proceed (~~taking into account~~considering the Public Contracts Regulations where the contract is above a stipulated financial threshold), and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Commissioner if problems are encountered.

## 11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

### General Information

### 11.1 Procurement Services

11.1.1 While the Chief Commissioner is responsible for procurement, as delegated by the Host Body, the service is delivered by NWSSP Procurement Services.

11.1.2 Procurement staff are employed by NHS Wales Shared Services Partnership (NWSSP) and provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Host ~~Health Board~~Body. Where the term Procurement staff or department is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of NWSSP Procurement Department, for example pharmacy and works who undertake procurement on a devolved basis.

### 11.2 Policies and Procedures

11.2.1 NWSSP Procurement Services shall, on behalf of the Host Body maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Revised General Consent to enter Individual Contracts.

11.2.2 The Chief Commissioner is ultimately responsible for ensuring that the JCC Members and JCCT staff strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures:

- Are kept up to date.
- Conform to statutory requirements and regulations.
- Adhere to guidance issued by the Welsh Ministers
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

**11.3 Legislation Governing Public Procurement**

11.3.1 Legislation governs public sector procurement in the UK. From the 24 February 2025, the Procurement Act 2023 and associated subordinate instruments (together "**the 2023 Act**") and the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and associated subordinate instruments (together "**the PSR Wales Regulations**") are the key pieces of legislation which governs public sector procurement in the UK. The PSR Wales Regulations only apply to certain health services ("**In-Scope Health Services**") and further detail these can be found in the Welsh Government's statutory guidance titled "Health service procurement: statutory guidance". Goods and services which are not In-Scope Health Services ("**Goods and Non-Health Services**") fall within the scope of the 2023 Act. `

11.3.2 Where specific instruction relates only to procurements undertaken under the PSR Wales Regulations, the words **'In-Scope Health Services Only'** will appear at the start of the instruction paragraph. Where specific instruction relates only to procurements undertaken under the Act, the words **'Goods and Non-Health Services Only'** will appear at the start of the instruction paragraph. If such references do not appear at the start of the instruction paragraph, all information detailed is applicable to the procurement regimes under both the PSR Wales Regulations and the 2023 Act, save for any bracketed instruction reference following a phrase to either regimes applicability.

11.3.3 **'Goods and Non-Health Services Only'** The Act governs the procurement of Goods and Non-Health Services. The Welsh Government's Policy Framework and the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act also govern this area. A key objective of the legislation is to establish a flexible, ~~accessible~~accessible, and equitable framework for public procurement in Wales that maximises social, economic, environmental and cultural outcomes for communities across Wales. Legislation, policy, and guidance setting out procedures and requirements for awarding all forms of regulated contracts shall have effect as if incorporated in the ~~LHB~~JCCs SFIs. **In the event of any conflict between what is contained in the 2023 Act and the ~~LHB~~JCC's SFIs, the former shall prevail.**

11.3.4 **'In Scope Health Services Only'** The PSR Wales Regulations governs the procurement of In-Scope Health Services. Under this legislation, relevant

organisations to which the PSR Wales Regulations apply must also have regard to the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act. They must also have regard to the statutory guidance issued by the Welsh Government which sets out how the PSR Wales Regulations should be adopted. One of the key objectives of this legislation is to ensure there is more flexibility when selecting providers for health services, with competitive tendering being one tool for the ~~LHB~~JCC to use when it is of benefit; alongside other routes that may be more proportionate, and which better enable the development of stable partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the ~~LHB~~JCC's SFIs. **In the event of any conflict between what is contained in the PSR Wales Regulations and the ~~LHB~~JCC's SFIs, the former shall prevail.**

11.3.5 ~~All Directors and their~~ The Chief Commissioner, JCC members and all JCCT staff are responsible for ensuring that all legal requirements ~~in the area of~~in public procurement are understood and fully complied with. The provisions set out in the 2023 Act, the PSR Wales Regulations, Welsh Procurement Policy Notices and all associated subordinate instruments are the model upon which all procurement exercises should be based.

11.3.6 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the Chief Commissioner (JCCT) ~~LHB~~ and Procurement Services e.g., engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.3.7 All other relevant legislation, guidance and policy documents must also be observed, including but not limited to the following:

- Social Partnership and Public Procurement (Wales) Act 2023
- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'

- The Welsh Government Procurement Policy Framework, including: Wales Procurement Policy Notes (extant at the time of undertaking the procurement exercise)
- The Wales Procurement Policy Statement (WPPS) (section 14 of the Procurement Act 2023)

**11.4 Procurement Principles and Objectives**

11.4.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the JCCT~~LHB~~ to perform its functions, and furthermore embrace all building, equipment, consumables, and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.4.2 **'Goods and Non-Health Services Only'** The legal and governing principles guiding 'covered procurement' under the 2023 Act, and incorporated into these SFIs include but are not limited to the following:

- Having regard to the objectives of delivering value for money; maximising public benefit; sharing information for the purpose of allowing suppliers and others to understand the authority's procurement policies and decisions; acting, and being seen to act, with integrity; and removing or reducing the barriers faced by SMEs. Ensuring equal treatment by treating suppliers the same, unless differences between the suppliers justify different treatment (and where different treatment of suppliers is justified, to take all reasonable steps to make sure the different treatment does not put a supplier at an unfair advantage or disadvantage).

11.4.3 **'In Scope Health Services Only'** The legal and governing principles guiding procurement of In-Scope Health Services under the PSR Wales Regulations, and incorporated into these SFIs include but is not limited to the JCCT~~LHB~~ doing the following: Making decisions in the best interests of people who use the service by acting with a view to (1) securing the needs of the people who use the services; (2) improving the quality of the services; (3) improving efficiency in the provision of the services;

- Acting transparently, fairly, and proportionately;
- Having regard to the Welsh Government's Health Service Procurement: Statutory Guidance; and
- having regard to the Wales Procurement Policy Statement published under section 14 of the 2023 Act.

**11.5 Procurement Procedures**

11.5.1 To help towards ensuring that the JCCT~~LHB~~ is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers' guidance and policy, the Host Body ~~LHB~~ shall, through Procurement Services, ensure that it shall have procedures that set out:

- requirements for, and exceptions to, formal competitive tendering (**'Goods and Non-Health Services Only'**);
- tendering processes including post tender ~~discussions;~~discussions.
- requirements and exceptions to obtaining quotations (**'Goods and Non-Health Services Only'**);
- evaluation and scoring methodologies; and
- approval of firms for providing goods and services.

11.5.2 All procurement procedures must comply with all relevant legislation, the Welsh Ministers' guidance and the JLHBCC's delegation arrangements and approval processes.

**11.6 Notification to Welsh Government and consent from the Welsh Ministers**

11.6.1 **Schedule 1** details the requirement and notification process for entering into contracts.

11.6.2 The provisions of Schedule 1 do not remove the requirement for ~~the LHB's~~ the JCCT to comply with Standing Orders, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

***Planning***

**11.7 Sustainable Procurement**

11.7.1 To further nurture the Welsh economy and in support of social, environmental, economic, and cultural goals in Wales, the JCCT~~LHB~~ must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible and within the legislative framework. The principles of the Well-being of Future Generations (Wales) Act 2015 ("**the WBFG Act 2015**") should be adopted at the earliest stage of procurement planning.

11.7.2 For example, the WBFG Act 2015 requires affected public bodies to act in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. The WBFG Act 2015 also provides for a shared purpose through seven well-being goals for Wales which are indivisible from each other and explain what is meant by the well-being of Wales.

11.7.3 The seven well-being goals are:

- a prosperous Wales.;
- a resilient Wales.;
- a healthier Wales.;
- a more equal Wales.;
- a Wales of cohesive communities.;

- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

11.7.4 The WBFG Act 2015 puts in place a "sustainable development principle" which tells relevant public bodies how to go about meeting their well-being duty. Such bodies need to make sure that when making their decisions they take into account the impact they could have on people living in Wales now and in the future. The WBFG Act 2015 includes five principles that those public bodies need to think about to show they have applied the sustainable development principle, which by way of ~~brief summary~~summary are as follows:

- **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
- **Integration**: considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies.~~;~~
- **Involvement**: the importance of involving people with an interest in achieving the well-being goals and ensuring that those people reflect the diversity of the area which the body serves.~~;~~
- **Long term**: the importance of balancing short-term needs with the need to safeguard the long-term needs; and
- **Prevention**: how acting to prevent problems occurring or getting worse may help public bodies meet their objectives.

11.7.5 The JCCT~~LHB~~ is required to consider the Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains and the Code of Practice on ethical employment in supply chains which includes aims to commit public, private and third sector organisations to a set of actions designed to eliminate modern slavery and support ethical employment practices.

11.7.6 The JCCT ~~LHB~~ shall make use of the tools developed by Welsh Government Commercial Delivery team in implementing the principles of the WBFG Act 2015. The JCCT~~LHB~~ shall benchmark its performance against the WBFG Act 2015. As detailed in WPPN 005, for the procurement of all contracts over £25,000, ~~LHBs are required to~~ the JCCT shall take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the Sustainable Risk Assessment Template

**11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)**

11.8.1 In accordance with the 'covered procurement' objectives in the 2023 Act, Welsh Government's commitments are set out in Welsh Government's 'technical guidance for covered procurement' and the current and subsequent versions of the

Wales Procurement Policy Statement (WPPS). The JCCTLHB shall ensure that it provides opportunities for SMEs, TSOs and SFBs to quote or tender for contracts.

**11.9 Planning Procurements**

11.9.1 The Chief CommissionerLHB must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks and requirements governing public procurement.

11.9.2 A process of planning all procurement exercises must be undertaken with the Procurement Services and an appropriate representative from the service and other appropriate stakeholders, (depending on the value, risk, and complexity of the procurement). The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost.;
- the likely 'route to market' which will consider the legislative and policy framework set out above.;
- the availability of funding to be able to award a contract following a successful procurement process; and
- that the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the four principles of prudent healthcare:

- equal partners through co-production;production.
- care for those with the greatest health need first;first.
- do only what is needed; and
- reduce inappropriate variation.

For **'Goods and Non-Health Services Only'** Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position.

For **'In Scope Health Services Only'** Value Based Healthcare should be considered under the Key Criteria 'Value' where this is appropriate and applicable. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement (and is also a core objective of the 2023 Act).

11.9.4 Where free of charge services are made available to the JCCTLHB, Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the LHBHost Body does not unintentionally commit itself to a single provider or longer-term commitment. Regular reports on free of charge services provided to the JCCTLHB

should be submitted to the Host Body's Audit and Risk Committeeby the LHB Board Secretary to the Audit Committee.

11.9.5 The JCCLHB is required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

**Joint or Collaborative Initiatives**

11.9.6 Specialist advice should be obtained from Welsh Government's Health and Social Care Finance Department, and the opinions of Procurement Services and NWSSP Legal and Risk prior to external opinion being sought, where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

**11.10 Procurement Process**

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Host Body'sLHB's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those provided by the Welsh Government's Commercial Delivery team, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks (where access is permissible) shall take precedence over frameworks led by public sector bodies located outside of Wales.

11.10.2 **'Goods and Non-Health Services Only' -** In the absence of an existing suitable procurement framework to source the required item, a competition must be operated in accordance with the 2023 Act and the table below. The Chief CommissionerLHB must ensure the value of their requirement considers cumulative spend across the LHB for like requirements and opportunity for collaboration with other NHS Wales Organisations.

| Goods/Services/Works Whole Life Cost Contract value (excl. VAT) | Minimum competition[1] | Form of Contract |
|---|---|---|
| <£5,000 | Evidence of value for money has been achieved | Purchase Order |
| >£5,000 - <£25,000 | Evidence of 3 written quotations | Simple Form of Contract/Purchase Order |
| >£25,000 – Prevailing OJEU threshold | Advertised open call for competition. Minimum of 4 tenders received if available. | Formal contract and Purchase Order |

| | | |
|---|---|---|
| >OJEU threshold | Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route. | Formal contract and Purchase Order |
| Contracts above £1 million | Welsh Government approval required[2] | Formal contract and Purchase Order |

[1] subject to the existence of suitable suppliers
[2] in accordance with the requirements set out in SFI 11.6.3.

11.11.1 Advice from the Procurement Services must be sought for all requirements in excess of £5,000.

11.11.2 The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Host Body to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.3 Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 and require competition.

**11.12 Designing Competitions**

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- Required timescales are achievable.
- Specifications are drafted which:
  - are fit for inclusion in competition documents.
  - are drafted in a manner encouraging innovation by the market
  - are capable of being responded to and do not narrow competition.
  - deliver in line with legislative and policy frameworks.
  - include robust performance measures to effectively measure and manage supplier performance, and
  - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the JCC and ultimately the improvement of patient outcomes and wider health and social care communities.

11.12.3 Criteria for selecting suppliers and achieving an award recommendation must:

- be appropriately weighted in consideration of quality/price
- consider cost of change where relevant
- be transparent and proportionate.
- deliver value for money outcomes.

- fully explore complexity/risk, and
- consider whole life cost.

**11.13 Single Quotation Application or Single Tender Application**

11.13.1 In exceptional circumstances, there may be a need to secure goods / services / works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition)
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause.
- a need to retain a particular contractor for genuine business continuity issues (not just preferences) or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an ~~all-Wales~~all-Wales competition / national strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The ~~Director of Finance~~Director of Finance and Value must approve such applications up to £25,000. The ~~Host Body's~~ Chief Executive of the Host Body is required to approve applications exceeding £25,000, in-line with the Host Body's Standing Financial ~~Instructions .~~Instructions. The recording and reporting of applications will be in-line with the Host Body's Standing Financial Instructions and governance arrangements.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Commissioner and ~~Director of Finance~~Director of Finance and Value, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided.
- A value for money test has been undertaken.
- No bias towards a particular supplier
- Future competitive processes are not adversely affected.
- No distortion of the market is intended.
- An acceptable level of assurance is available before presentation for approval in line with the JCC Scheme of Delegation, and
- An 'or equivalent' test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA

/ STA, where the JCCT has already entered into an arrangement directly.

11.13.2 The recording and reporting of SQA and STA will be in-line with the Host Body's Standing Financial Instructions and governance arrangements.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition is not possible.

11.13.8 For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA/STA's not endorsed by Procurement or any exceptional matters.

**11.14 Disposals**

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Health Board making use of any agreements covering the disposal of such items.

11.14.3 Disposals will be undertaken in-line with the requirements set out within the Host Body's Standing Financial Instructions.

**Approval & Award**

**11.15 Evaluation, Approval and Award**

11.15.1 The evaluation of competitions via quotation or tender, must be undertaken by a minimum of 2 evaluators from within the JCCT. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the JCC's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be

managed by the Procurement Service.

**Implementation & Contract Management**

**11.16 Contract Management**

11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, ~~in order to~~to deliver the business and operational objectives required by the contract and in particular, to achieve value for money.
The relevant budget holder~~,~~ shall oversee and manage each contract on behalf of the JCCT ~~so as to~~to ensure that these implicit obligations are met. This contract management will include:

- Retaining accurate records
- Monitoring contract performance measures
- Engaging suppliers to ensure performance delivery.
- Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services, and
- Permitting stage payments as part of a formally agreed implementation / delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

**11.17 Extending and Varying Contracts**

11.17.1 Extending, modifying, or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the JCCT

and the local Head of Procurement. The JCC Team must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The JCCT must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The JCC Team must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

**Transactional Processes**

**11.18 Requisitioning**

11.18.1 In choosing the item to be supplied (or the service to be performed) the JCCT shall always obtain the best value for money. The JCCT will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract the JCCT shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with SFI 11.11 thresholds.

11.18.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

**11.19 No Purchase Order, No Pay**

11.19.1 The JCCT will ensure compliance with the 'No Purchase Order, No Pay' policy, the ~~All Wales~~All-Wales policy which was introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

**11.20 Official orders**

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered.
b) State the terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the JCCT by NWSSP Procurement Services.

## 12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

### 12.1 Health Care Agreements

12.1.1 The JCC will commission healthcare services for the resident population of all Local Health Boards, both from the LHB provided services and from Trusts and other providers. The Chief Commissioner is responsible for ensuring the JCC enters into suitable Health Care Agreements, Individual Patient Commissioning Agreements and Contracts with service providers for health care services. These agreements will be entered to in the name of the Host ~~Body, and~~Body and authorised in line with the Host Body's Scheme of Delegation.

12.1.2 All Health Care Agreements, Individual Patient Commissioning Agreements and Contracts should aim to implement the agreed priorities contained within the Integrated Medium-Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Commissioner should ~~take into account~~consider:

- The standards of service quality expected.
- The relevant quality, governance and risk frameworks and plans
- The relevant national service framework (if any)
- The provision of reliable information on quality, volume, and cost of service and
- That the agreements are based on integrated care pathways.

All agreements must be in accordance with the functions delegated to the JCC by the Welsh Ministers.

### 12.2 Statutory provisions

12.2.1 The National Health Service (Wales) Act 2006 (c.42) enables Health Boards to commission certain healthcare services. The JCC commissions services on behalf of the seven health Boards, and the H~~h~~ost Body~~LHB~~ enters into these contracts. Further information is available in paragraph 12.2 of the Local Health Board SFI's and these provisions may extend to the JCC with regard to those services delegated to the JCC.

### 12.3 Reports to Committee on Health Care Agreements (HCAs)

12.3.1 The Chief Commissioner will need to ensure that regular reports are provided to the JCC detailing performance, quality and associated financial implications of all health care agreements. These reports will be linked to, and consistent with, other Committee reports on commissioning and financial performance.

### 12.4 Tendering for supply of health care services

12.4.1 Where the JCC is required or elects to invite quotes or tenders for the supply of healthcare services, the Hhost Body'sLHBs SFIs in relation to procurement shall apply in relation to such competitive exercises.

12.4.2 The procurement arrangements surrounding the provision of healthcare services is a complex area and as such legal advice must be secured where there is doubt over the applicability or not of applying competitive processes. Further guidance is provided in the Hhost Body'sLHBs SFI, Annex A.

## 13. GRANT FUNDING

### 13.1 Policies and procedures

13.1.1 The Hhost BodyLHB shall be responsible for all aspects of the grant funding process on behalf of the JCC. Further details can be found in section 13 of the Hhost LHBs Body's SFIs.

## 14. PAY EXPENDITURE

### 14.1 Appointments and Remuneration

14.1.1 Appointments to the JCC shall be in accordance with section 1.4 of the JCC SOs and the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024.

14.1.2 All other appointments or recruitments to the JCCT (including the Chief Commissioner) and any remuneration or employment contract related matters shall be dealt with by the hHost BodyLHB on behalf of the JCC in accordance with the Hhost LHBs Body's own SOs and SFIs.

14.1.3 Further details of the Hhost LHBs Body's responsibilities can be found in section 14 of the hHost LHBs Body's SFIs.

## 15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

### 15.1 General

15.1.1 The funding delegated by the JCC is mostly revenue in nature, however in the event thatif it is required all Capital plans, and annual capital programmes, must be approved by the JCC before the commencement of a financial year and should

be in line with the objectives set out in the approved Integrated Medium-Term Plan (IMTP) for the organisation. The actual capital plan and programmes must be delivered within capital finance resource limits.

15.1.2 Any capital plans, and capital investment and expenditure incurred, by the JCC or the JCCT shall be dealt with in accordance with section 15 of the Hhost ~~LHBs~~ Body's SFIs. This includes the recording and safeguarding of assets.

## 16. LOSSES AND SPECIAL PAYMENTS

### 16.1 Losses and Special Payments

16.1.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

16.1.2 The ~~Director of Finance~~Director of Finance and Value is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

16.1.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Commissioner and/or the ~~Director of Finance~~Director of Finance and Value or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the ~~Director of Finance~~Director of Finance and Value and/or the Chief Commissioner.

16.1.4 Where a criminal offence is suspected, the ~~Director of Finance~~Director of Finance and Value must liaise with the Executive Director of Finance of the Hhost and the Hhost ~~LHB's~~ Body's Counter Fraud Service to determine the next immediate action including when to inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the ~~Director of Finance~~Director of Finance and Value must inform the Hhost ~~LHBs~~ Body's Local Counter Fraud Specialist (LCFS) and the Counter Fraud Service (CFS) Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

16.1.5 The ~~Director of Finance~~Director of Finance and Value or the Hhost Body's LCFS must notify the Audit and Risk Committee dealing with JCC matters, the Auditor General for Wales' representative and the fraud liaison officer within the Welsh

Government's Health and Social Services Group Finance Directorate of all frauds.

16.1.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the ~~Director of Finance~~Director of Finance and Value must notify:
a) The Audit and Risk Committee on behalf of the JCC,
b) The ~~h~~Host Bb~~b~~ody Executive Director of Finance and LCFS, and
c) An Auditor General for Wales' representative.

16.1.7 The ~~Director of Finance~~Director of Finance and Value shall be authorised to take any necessary steps to safeguard the JCC's and the H~~h~~ost ~~LHBs~~ Body's interests in bankruptcies and company liquidations.

16.1.8 The ~~Director of Finance~~Director of Finance and Value shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.). The ~~Director of Finance~~Director of Finance and Value must consult with and notify the Executive Director of Finance of the Host Bb~~b~~ody on all losses and special payments.

16.1.9 The Host Body's Audit and Risk Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in in Annex 3 of the JCC SOs.

16.1.10 For any loss or special payments, the ~~Director of Finance~~Director of Finance and Value should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

16.1.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Executive Director of Finance of the Host Body and the Health and Social Services Group's Director of Finance.

16.1.12 All novel, contentious and repercussive cases must be notified to the Executive Director of Finance of the Host Body and referred to the Welsh Government's Health and Social Services Group's Finance Directorate, irrespective of the delegated limit.

16.1.13 The reporting of all losses and special payments will be in-line with the Host Body's Standing Financial Instructions and governance arrangements.

16.1.14 The JCC must obtain approval of the Executive Director of Finance of the Host Body and the Health and Social Services Group Director General's approval for

special severance payments.

16.1.15 The Host Body ~~LHB~~ must notify the JCCT of any changes to the reporting and approval requirements in respect of losses and special payments in order to facilitate full compliance with the Host Body's ~~hosts~~ SFIs.

~~16.1.16~~

## 17. DIGITAL, DATA and TECHNOLOGY

### 17.1 Digital Data and Technology

17.1.1 The JCC and the JCCT shall operate within the guidance set out in section 18 of the H~~h~~ost ~~LHBs~~ Body's SFIs.

## 18. RETENTION OF RECORDS

### 18.1 Responsibilities of the Chief Commissioner and ~~Host~~ Chief Executive of the Host Body

18.1.1 The ~~Host~~ Chief Executive of the Host Body is the accountable officer for the retention of records and the associated statutory duties. The Chief Commissioner is responsible to the ~~Host~~ Chief Executive of the Host Body in respect of retention of records ~~in order for~~for the ~~Host~~ Chief Executive of the Host Body to discharge their statutory body accountability for this function.

18.1.2 The Chief Commissioner shall have delegated responsibility from the Host Body in respect ~~of maintaining~~of maintaining archives for all records. in respect of JCC matters, in-line with the Host Body's Policy on Records Management.

18.1.3 The records held in archives shall be capable of retrieval by authorised persons.

18.1.4 Records held in accordance with regulation shall only be destroyed in-line with the Host Body's Policy on Records Management and Schedule for the Retention and Destruction of Records.

## SCHEDULE 1

## GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

This schedule included as "General Consent to enter individual contracts" replaces all previous versions of Schedule 1 and should be read in conjunction with the revised Model Standing Financial Instructions (SFI's) issued in relation to Chapter 11 for Local Health Boards and NHS Trusts and Chapter 12 for Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW).

### PROCESSES FOR NHS WALES CONTRACTS, AND INTERESTS IN PROPERTY

Paragraph 13 of Schedule 2 to the National Health Service (Wales) Act 2006 states as follows:

*"(1) Subject to sub-paragraph (3), a Local Health Board may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.*

*(2) In particular it may—*

*(a) acquire and dispose of property,*

*(b) enter into contracts,*

*(c) accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the JCCT or for any purposes relating to the health service).*

(3) A Local Health Board may not do anything mentioned in sub-paragraph (2) without the consent of the Welsh Ministers (which may be given in general terms covering one or more descriptions of case)."

Section 10.1 of the NHS Wales Infrastructure Investment Guidance issued on 22 October 2018 ("**the Investment Guidance**") includes the following in relation to Local Health Boards:

*"Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.*

*Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process are included in Welsh Health Circular WHC(2015)031. Organisations should*

*ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements."*

**This is also to be regarded as being applicable to HEIW and DHCW, which were both established after the two WHC's mentioned above were issued.**

Section 10.2 of the Investment Guidance includes the following in relation to Trusts:

*"Whilst formal Cabinet Secretary consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above."*

Section 11 of the Investment Guidance also includes provision as to disposals and property protocols.

Welsh Health Circular WHC (2015) 031 issued 22 June 2015 includes arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process.

**That WHC is also to be regarded as being applicable to HEIW and DHCW in the same way as it applies to LHBs.**

**Entering into contracts**

This schedule confirms to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisition or disposal of a lease or any interest in property are delegated to the Director General, Health Social Care and Early Years.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Cabinet Secretary for Health and Social Care on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly, any issues relevant to the exercise of the Cabinet Secretary for Health, and Social Care's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

• All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSCEY prior to tendering for the contract;

• All eligible LHB and HEIW and DHCW contracts >£1m in total to be submitted to the Director General HSCEY for consent prior to award;
• All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSCEY for notification prior to award; and
• All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSCEY for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

i) Contracts of employment between LHBs, HEIW, or DHCW and their staff;

ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs, HEIW, or DHCW;

iii) Out of Hours contracts;

iv) All NHS contracts; that is where one health services body contracts with another health service body;

(v) Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Cabinet Secretary e.g. annual education and training commissioning also do not require further Ministerial notification or consent; and

(vi) Contracts between £500k - £1 million (for noting) and £1 million + (for approval).

a) Wales Public Sector Framework Agreements e.g., Frameworks established by the Welsh Government's Commercial Delivery team or NWSSP (not exhaustive) – no written approval required to award contracts under these Frameworks through a direct award or mini competition.

b) Third-Party Public-Sector Framework Agreements e.g., Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through minicompetition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

For non-capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

# NHS Wales Joint Commissioning Committee

# Guidance for the Handling of Interests

**MayApril 2026**4

## 1. Context

1.1 The NHS Wales Joint Commissioning Committee (JCC) ~~(the Joint Committee)~~ is a joint committee of each Local Health Boards (LHB) in Wales, established under the NHS Wales Joint Commissioning Committee ~~(JCC)~~ (Wales) Directions 2024 (the JCC Directions). The JCC is hosted by the Cwm Taf Morgannwg ~~L~~University Health Board~~HB~~ (the Host Body) on behalf of each of the seven LHBs.

1.2 The specific governance and accountability arrangements established for the JCC are set out within:

- The JCC Standing Orders (SOs) and the Schedule of Powers reserved for the JCC and the Scheme of Delegation to others,
- The JCC Standing Financial Instructions (SFIs),
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A Hosting Agreement between the JCC ~~LHBs~~ and the Host Body~~the host LHB~~ in relation to the provision of administrative and any other services to be provided to the JCC.

Up to date Copies of these agreements can be found here.

1.3 As set out within the JCC SOs, the JCC must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour Framework. This will be set within the context of the Host Body's Values and Standards of Behaviour Framework (~~Standards of Behaviour Policy (nhs.wales)~~Standards of Good Governance and Probity (in Public Service Roles) Policy) (It should be noted that all references to Independent Members and Board Members and Board Level Directors in this policy are interpreted as references to JCC Lay Members and Senior Leadership Team Directors).

1.4 The Welsh Government's Citizen-Centred Governance Principles apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales. "Public service values and associated behaviours are and must be at the heart of the NHS in Wales"

1.5~~4~~ The JCC is strongly committed to being value-driven, rooted in the Nolan principles (See 1.6 below) and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

1.5~~6~~ The JCC and its members are expected to practice high standards of corporate and personal conduct, based on the recognition that the needs of patients must come first. The "Seven Principles of Public

Life", or the "Nolan Principles" form the basis of the Standards of Behaviour requirements of the JCC. These are:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;
- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;
- **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and
- **Leadership** – Individuals should promote and support these principles by leadership and example.

1.~~6~~7 In support of these principles, the JCC must be impartial and honest in the way that it fulfils its duties. The JCC must remain beyond suspicion at all times. The JCC, and its members, will achieve the "Seven Principles" set out above by:

- Ensuring that the interests of patients remain paramount;
- Being impartial and honest in the conduct of its official business;
- Using public funds to the best advantage of the service and the patients, always seeking to ensure value for money;
- Not abusing individual~~'s~~ or collective official positions for personal gain or to benefit family or friends;
- Not seeking to advantage or ~~to~~ further private business or other interests in the course of their official duties;
- Not seeking or knowingly accepting, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the JCC.

## 2. Purpose

2.1 The aim of this guidance is to set out arrangements for the appropriate handling of declarations of interests within the JCC's business, ensuring that the JCC operates within its SOs and the Host Body's Values and Standards of Behaviour Framework ~~Standards of Behaviour Framework set by the Host Body~~.

2.2 The Host Body's Values and Standards of Behaviour Framework ~~Host Body's Standards of Behaviour Policy~~ aims to ensure that arrangements are in place to support employees to act in a manner that upholds Host Body's Values and Standards of Behaviour Framework ~~the Standards of Behaviour Framework~~ as well as setting out specific arrangements for the appropriate declarations of interests and acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that the ~~Health Board~~JCC can be seen to have exemplary practice in this regard.

2.3 The JCC will discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must act in accordance with this principle, rather than furthering direct or indirect financial, personal, professional or organisational interests. This also includes ensuring that Officer Members do not seek to achieve a greater benefit for the population of their respective Local Health Board over and above that of others.

## 3. Scope

3.1 The membership of the JCC Joint Committee (JC) comprises the Chair and Lay Members appointed by Welsh Ministers, the Chief Executives of all seven Local Health Boards in Wales and the Chief Commissioner who is employed by the Host Body.

3.2 This guidance is intended to support the handling of declarations within the business of the JCC. In particular dealing with Members' interests during ~~Joint Committee~~JC meetings, in-line with the JCC SOs.

3.3 JC~~C~~ members should declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a ~~Joint Committee~~JC member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the ~~Joint Committee's~~JC's business.

3.4 The recording of JCC members' interests will be recorded as follows:

- JCC Chair – via the Host Body's policy and process for declaring and recording interests;
- JCC Lay Members - via the Host Body's policy and process for declaring and recording interests;
- JCC Officer Members (Chief Executive of the seven LHBs) – via their respective Health Board's policy and process for declaring and reporting interests, acknowledging that external auditors may, from time to time, request declarations of interest prepared specifically for the JCC; and
- Chief Commissioner - via the Host Body's policy and process for declaring and recording interests.

3.5 The scope of this guidance does not apply to the JCC Team. As employees of the Host Body, the Host Body's Values and Standards of Behaviour Framework ~~Host Body's Standards of Behaviour Policy~~ and process for the declaring and recording of interests will apply.

3.6 The Committee Secretary will ensure annual reporting of declaration of interests for all JCC Members (utilising the processes set out in 3.4) is reported through the JCC to inform annual reporting to the Host Body.

## 4. Handling of Interests in JCC Meetings

~~4.1 The JCC must discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must act in accordance with this principle, rather than furthering direct or indirect financial, personal, professional or organisational interests. This also includes ensuring that Officer Members do not seek to achieve a greater benefit for the population of their respective Local Health Board over and above that of others.~~

Commented [AF1]: Duplication with section 2.3

4.1 It is a requirement that at the beginning of every meeting of the JCC that members be invited to declare their interests in relation to any items on the agenda. Where an actual or potential conflict is declared, the Chair with the advice of the Committee Secretary, will consider the appropriate action to be taken using the guidance attached at **Annex A**.

4.2 The actual or potential conflict and the action taken will be recorded in the minutes of the meeting and the relevant Register of Interests will be updated if required.

4.3 Where it becomes evident part way through a meeting that there may be a potential conflict the JCC member must declare their interest

immediately. The Chair with the advice of the Committee Secretary, will consider the appropriate action to be taken using the guidance attached at **Annex A**.

## 5. Categories of Interests

5.1. An Interest is defined as "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold"1.

5.2 For the purpose of the JCC's business, interests fall into the following categories:

1. Personal Financial Interests
2. Non-Financial Personal Interests
3. Non-Financial Professional Interests
4. Indirect Interests
5. Provider Organisation Interests

**Annex A** sets out the definitions of each of the 5 categories above, along with examples of where these interests may arise, and the actions available to the Chair in mitigating any actual or perceived interests that arise.

## 6. Role of the Chair and Committee Secretary

6.1 The Chair is responsible for the effective operation of the JCC, including:

- Chairing Joint Committee meetings
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all JCC business is conducted in accordance with JCC SOs and Host Body's Values and Standards of Behaviour Framework~~its Standards of Behaviour Framework~~; and
- Developing positive and professional relationships amongst the JCC's membership and between the JCC and each LHBs Board.

6.2 In respect of the Handling of Interests in JCC meetings, the Chair will need to consider the action to be taken and to what extent this affects the balance of the JCC's discussion and decision-making process. In doing so the Chair should ensure that conflicts and potential or

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perceived conflicts of interest do not, or do not appear to, affect the integrity of the JCC's decision-making processes.

6.3 The Committee Secretary is the guardian of good governance within the JCC and in doing so will include matters such as:

- Providing advice to the JCC as a whole and to individual JCC members on all aspects of governance;
- Facilitating the effective conduct of JCC business;
- Ensuring that in all its dealings, the JCC acts fairly, with integrity, and without prejudice or discrimination; and
- Contributing to the development of a culture that embodies NHS values and standards of behaviour.

6.4 The Committee Secretary has delegated responsibility for ensuring that the JCC is provided with competent advice and support regarding the effective and appropriate application of the Host Body's Standards of Behaviour Framework and the handling of interests.

**ANNEX A**

| **An Interest** "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold". | | | |
|---|---|---|---|
| **Category** | **Description** | **Examples** | **Action for consideration in handling declared interests** |
| 1<br>Personal Financial Interests | This is where an individual could or may get direct financial benefit from the consequences of a decision that they are involved in making.<br><br>A benefit may arise from the making of gain or avoiding a loss. | Where an individual may get direct financial benefits from the consequences of a decision that they are involved in making. This could include:<br>• A director (including a non-executive director) or senior employee in another organisation which is, or is likely to do business with an organisation in receipt of NHS funding<br>• A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding<br>• Outside employment<br>• A secondary income<br>• Receipt of a grant(s) | Where a JCC member has a direct pecuniary interest in any matter being considered by the JCC, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. This requirement is absolute as set out in *The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (Regulation 17)*.<br><br>The JCC Chair may determine that the JCC member concerned shall be excluded from that part of the meeting. |

| **An Interest** "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold". | | | |
|---|---|---|---|
| **Category** | **Description** | **Examples** | **Action for consideration in handling declared interests** |
| | | • Receipt of sponsored research<br>• Receipt of other payments (e.g., honoraria, day allowances, travel or subsistence for attendance at an event)<br>• Holding of patents and other intellectual property rights (either individually, or by virtue of their association with a commercial or other organisation). | |
| 2<br>Non-Financial Personal Interests | This is where an individual may benefit (or be perceived to benefit) personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions that they are involved in making. | Where an individual may benefit personally from a decision that they are involved in making, in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. | If a member has an actual, potential or perceived interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:<br>• Requiring the member to not attend the meeting |

| **An Interest** "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold". | | | |
|---|---|---|---|
| **Category** | **Description** | **Examples** | **Action for consideration in handling declared interests** |
| | A benefit may arise from the making of gain or avoiding a loss. | This could include, for example, where the individual is:<br><br>• A member of a voluntary sector/not for profit board or has a position of authority within a voluntary sector/not for profit organisation<br>• A member of a lobbying or pressure group with an interest in health and care<br><br>It is also important to consider an interest that a member of the public, who knew the relevant facts would reasonable consider to be so significant that it is likely to prejudice the JCC members judgment of what is in the public interest | • Ensuring that the member does not directly receive any confidential meeting papers relating to the nature of their interest<br>• Requiring the member to not attend all or part of the discussion and/or decision on the related matter<br>• Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate fully<br>• Removing the member from the group or process altogether. |

| **An Interest** "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold". | | | |
|---|---|---|---|
| **Category** | **Description** | **Examples** | **Action for consideration in handling declared interests** |
| 3<br>Non-Financial Professional Interests | This is where an individual may obtain a non-financial professional benefit from the consequences of a decision that they are involved in making, such as increasing their professional reputation or status or promoting their professional career.<br><br>A benefit may arise from the making of gain or avoiding a loss. | Where an individual may obtain a non-financial professional benefit from the consequences of a decision that they are involved in making, such as increasing their professional reputation or status or promoting their professional career.<br><br>This could include situations where the individual is:<br><br>• An advocate for a particular group of patients<br>• A clinician with a special interest.<br>• An active member of a particular specialist body, e.g. Royal Colleges<br>• An advisor for the Healthcare Inspectorate Wales, Care Quality | If a member has an actual, potential or perceived interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:<br>• Requiring the member to not attend the meeting<br>• Ensuring that the member does not directly receive any confidential meeting papers relating to the nature of their interest<br>• Requiring the member to not attend all or part of the discussion and/or decision on the related matter<br>• Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate fully<br>• Removing the member from the group or process altogether. |

| **An Interest** "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold". | | | |
|---|---|---|---|
| **Category** | **Description** | **Examples** | **Action for consideration in handling declared interests** |
| | | Commission or National Institute of Health and Care Excellence.<br>• Is undertaking a research role. | |
| 4<br>Indirect Interests | This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.<br><br>A benefit may arise from the making of gain or avoiding a loss. | Where an individual has a close association with another individual e.g., a close family member, close friend, associate or a business partner, who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision that they are involved in making.<br><br>This would include the examples above for personal financial, personal and professional non-financial interests. | If a member has an actual, potential or perceived interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:<br><br>• Requiring the member to not attend the meeting<br>• Ensuring that the member does not directly receive any confidential meeting papers relating to the nature of their interest<br>• Requiring the member to not attend all or part of the discussion and/or decision on the related matter<br>• Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate fully<br>• Removing the member from the group or process altogether. |

| **An Interest** "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold". | | | |
|---|---|---|---|
| **Category** | **Description** | **Examples** | **Action for consideration in handling declared interests** |
| | | | Where a JCC member declares an indirect pecuniary interest in any matter being considered by the JCC, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. This requirement is absolute as set out in *The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009.*<br><br>The JCC Chair may determine that the JCC member concerned shall be excluded from that part of the meeting. |

| **An Interest** "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold". | | | |
|---|---|---|---|
| **Category** | **Description** | **Examples** | **Action for consideration in handling declared interests** |
| 5<br>Provider Organisation Interests[2]<br>(relevant to JCC Officer Members only given their role as a Chief Executive of one of the 7 LHBs in Wales) | This is where an individual's employing organisation, as a provider of services, may or be perceived to directly benefit financially because of decisions that they are involved in making.<br>A benefit may arise from the making of gain or avoiding a loss.<br><br>A benefit may arise from the making of gain or avoiding a loss. | Where a provider organisation (one of the 7 LHBS) may get direct financial benefits from the consequences of a decision that they are involved in making.<br><br>This could include:<br>• award of contracts as a single provider<br>• award of contracts as a cohort of providers<br>• agreement of financial uplifts. | The JCC must discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must act in accordance with this principle, rather than furthering direct or indirect financial, personal, professional or organisational interests. This also includes ensuring they do not seek to achieve a greater benefit for the population of their Local Health Board over and above that of others.<br><br>In taking any actions to mitigate actual, potential or perceived conflicts of interest, the JCC Chair should act **proportionately** and should seek to preserve the spirit of collective decision-making, whilst balancing the benefits of having a particular individual involved.<br><br>In looking at mitigations, the Chair may need to take account of a range of factors in order to determine what the risks are of including an individual with an actual or perceived conflict in |

2 Informed by guidance to Integrated Care Board in NHS England: conflicts-of-interest-nhsp-advice-from-mwe-jun23.pdf (nhsproviders.org)

| **An Interest** "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold". | | | |
|---|---|---|---|
| **Category** | **Description** | **Examples** | **Action for consideration in handling declared interests** |
| | | | the decision-making process and how that may be perceived or challenged.<br><br>Where a JCC Officer Member declares an actual, potential or perceived Provider Organisation Interest, the Chair should determine whether this declaration could result in a material[3] benefit to the provider organisation and could therefore be deemed to influence the individual in decision-making.<br><br>If a material interest is declared, the Chair will need to consider to what extent this affects the balance of the JCC's discussion and decision-making process, and in doing so the Chair should ensure that conflicts and potential or perceived conflicts of interest do not, or do not appear to, affect the integrity of the JCC's decision-making processes.<br><br>If so, the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records: |

3 NHSE, Managing Conflicts of Interest Guidance describes a material interest as 'one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision'.

| **An Interest** "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold". | | | |
|---|---|---|---|
| **Category** | **Description** | **Examples** | **Action for consideration in handling declared interests** |
| | | | • Requiring the Officer Member to not attend the meeting<br>• Ensuring that the Officer Member does not directly receive any confidential meeting papers relating to the nature of their interest<br>• Requiring the Officer Member to withdraw from any decision or vote, but they may continue to participate in discussion recognising their role as a commissioner;<br>• Requiring the member to not attend all or part of the discussion and/or decision on the related matter;<br>• Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate fully, requesting clarity on any contributions made to be clear as to whether they are made as a provider or a commissioner of services |

Cyd-bwyllgor Comisiynu Joint Commissioning Committee

**Appendix 4**

# QUALITY SAFETY AND OUTCOMES SUB-COMMITTEE (QSOC)

Terms of Reference & Operating Arrangements
(Schedule 3.1 of the Standing Orders)

| | |
|---|---|
| **Document Author:** | Committee Secretary |
| **Lead Director** | Director of Nursing and Quality |
| **Endorsed By** | ~~Joint Commissioning Committee 17 September 2024~~ Joint Commissioning Committee 17 March 2026 |
| **Approved By** | ~~Health Boards – 25 and 26 September 2024 Board Meetings~~ Health Boards – May 2026 |
| **Issue Date** | ~~4 February 2025~~ 26 May 2026 |
| **Review Date** | ~~12 January 2025~~ March 2027 |
| **Version** | 4 |

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## Version Control

| Version | Issued To | Date | Outcome | Next Review Date |
|---|---|---|---|---|
| Version 1 | Health Boards | 17 September 2024 | Approved at LHB September Board meetings | 1 June 2025 |
| Version 2 | NWJCC Joint Commissioning Committee (JCC)~~CC~~ | 21 January 2025 | Endorsed | 12 January 2025 |
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| Version 3.2 | JCC | 17 March 2026 | Endorsed | March 2027 |
| Version 4 | Health Boards | May 2026 | | March 2027 |

**Sub-Committee Arrangements:**

This schedule forms part of and shall have effect as if incorporated in the NHS Wales Joint Commissioning Committee Standing Orders.

## 1. Introduction & Constitution

1.1 In accordance with NHS Wales Joint Commissioning Committee (NWJCC) Standing Order 5.5, the ~~NHS Wales Joint Commissioning Committee (JCC – the~~ NWJCC Joint Committee~~)~~ (the JC) ' may and, where directed by the Local Health Board (LHB) Boards jointly, or the Welsh Ministers must, appoint joint sub-committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee or on behalf of the Joint Committee to each LHB Board and/or its other committees). The Joint Committee shall determine, for agreement by the LHBs, a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.

1.2 In accordance with Standing Orders (SOs) (and the NWJCC Scheme of Delegation), the ~~Joint Committee~~JC shall nominate annually a sub-committee to be known as the **Quality, Safety and Outcomes Sub-Committee**. The detailed terms of reference and operating arrangements set by the ~~Joint Committee~~JC in respect of this sub-committee are set out below.

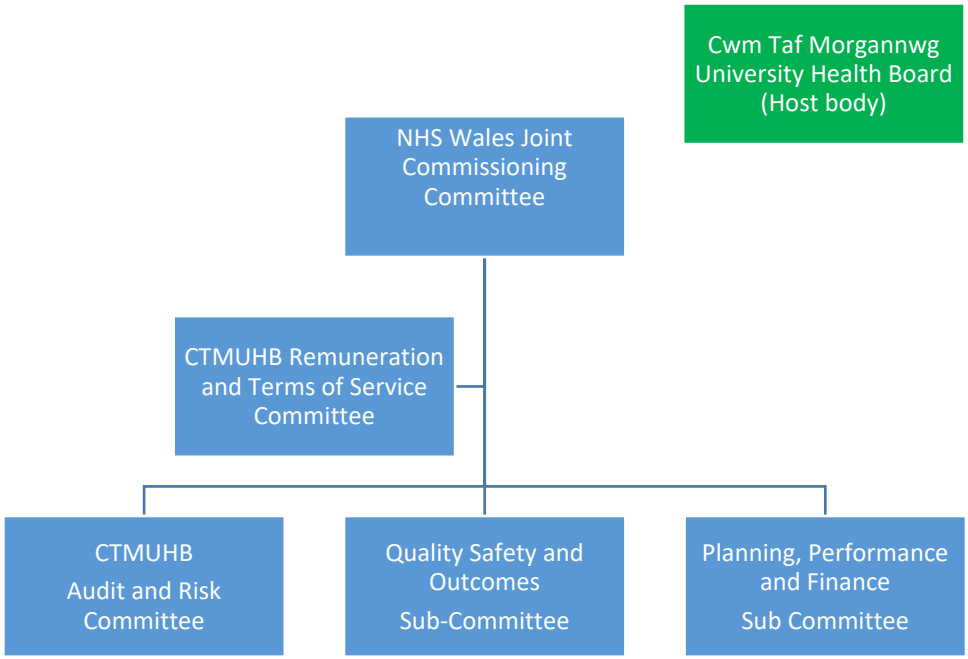
## 2. Purpose

2.1 The purpose of the Quality, Safety and Outcomes Sub-Committee "the Sub-Committee" is to be assured that the ~~Joint Committee~~JC is commissioning appropriate, high quality and safe services from providers (Local Health boards, Trusts and private sector providers) on behalf of ~~health boards~~LHBs in Wales.

This will be achieved by:

- Providing scrutiny and assurance to the Joint Committee for the Quality Safety and Outcomes of services commissioned from providers including local health boards, NHS Trusts and private providers who are accountable for the provision of safe, quality services~~)~~
- Reporting to and providing advice to the ~~Joint Committee~~JC, including escalation of issues that require urgent consideration and action by the J~~C~~C
- Addressing concerns delegated by the ~~Joint Committee~~JC ensuring that individual LHB Quality and Patient Safety Committees are informed of any issues relating to their population recognising that concerns of the services commissioned may impact on primary and secondary and vice versa (whole pathway) and contribute to the achievement of the Duty of Candour; and
- Providing assurance to the ~~Joint Committee~~JC in relation to improving the experience of patients, carers, citizens and those that come into contact with the services commissioned by the NWJCC.

Figure 1 – NWJCC Sub-Committee Structure




## 3. Scope and Duties

3.1 The Sub-Committee will provide scrutiny and assurance to the JC and LHBs in relation to the duties below ~~and will, in respect of its provision of advice to the Joint Committee~~:

- Monitor and support the development and implementation of the Commissioning Assurance Framework ensuring that there is continuous improvement in the commissioning of safe, effective and sustainable services for the people of Wales
- Consider the quality, patient safety and outcome implications arising from the development of commissioning strategies, including developments outlined in the agreed NWJCC Integrated Medium Term Plan (IMTP)
- Ensure that all aspects of commissioning activity, through regular reporting to the sub-committee consider quality, safety and outcomes as part of the commissioning of services
- Receive, when required, items for urgent consideration and escalation
- Ensure a robust process is in place for the development and approval of evidence-based service specifications, focussed on quality and safety of service provision, for all services commissioned by the NWJCC

- Have responsibility for the commissioning risks designated to the Sub-Committee for monitoring ensuring that quality, safety and outcomes of services commissioned are a priority for the organisation
- Monitor and scrutinise risk management and assurance arrangements for the risks designated to the Sub-Committee for monitoring from the perspective of clinical and patient safety risks
- receive assurance from provider organisations that concerns management arrangements are robust and reported through the appropriate governance routes; and
- Receive assurance that patient safety incidents, complaints and claims (relating to the services commissioned by the JCC) are routinely monitored and are considered a critical part of the evaluation of services in the JCC commissioning cycle.

**Sub-Committee Programme of work**

3.2 Each year the ~~Joint Committee~~JC will determine the Sub-Committee's priorities for its annual programme of work, based on the Joint Committee's Commissioning Assurance Framework (once approved) and Organisational ~~Corporate~~ Risk Register. This approach will ensure that the Sub-Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Sub-Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Sub-Committee's programme of work will be dynamic and flexible to meet the needs of the ~~Joint Committee~~JC throughout the year.

3.3 The Sub-Committee will provide onward assurance to the JC on all matters relating to its annual programme of work, as delegated.

## 4. Membership

**Members**

4.1 The Membership of the QS&O Sub-Committee is as follows:

| | |
|---|---|
| Chair | Lay (Independent) Member of the Joint Committee |
| Vice Chair | Lay (Independent) Member of the Joint Committee |
| Member | One further Lay (Independent) Member of the Joint Committee |
| Member | ~~One~~ Two LHB ~~representative~~ Chief Executive representatives, who shall alternate attendance, or designated nominated deputy who must be an Executive Director from a health board (and would be fully briefed on the issues to be discussed) |

4.2 The membership of the Sub-Committee shall be determined by the ~~Joint Committee~~JC, based on the recommendation of the Chair of the ~~Joint~~

~~Committee~~JC and lay members, taking account of the balance of skills and expertise necessary to deliver the subcommittee's remit and subject to any specific requirements or directions made by Ministers or the Welsh Government.

~~4.3 The Chair of the Joint Committee and the Chair of the Sub-Committee, receive from nominations from the CEOs of Local Health Boards~~

~~4.4~~4.3 The Membership will be reviewed annually.

**Support to Sub-Committee Members**

~~4.5~~4.4 The Committee Secretary, on behalf of the Sub-Committee Chair, shall:

- Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role, and
- Co-ordinate the provision of a programme of organisational development for Sub-Committee members as part of the overall JCCs Organisational Development programme.

~~4.6~~4.5 **In Attendance**

| |
|---|
| JCC Director of Nursing and Quality (Lead Director for the Committee) |
| JCC Medical Director |
| JCC Director of Commissioning for Specialised Services |
| JCC Director of Commissioning for Ambulance and 111 |
| JCC Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MH, LD & VG) |
| Committee Secretary or representative who will routinely attend meetings ensuring governance support and advice is available to the Committee Chair |
| Llais Representative |

Directors may on occasion nominate a suitably senior deputy to attend the Sub-Committee on their behalf but should ensure that they are fully aware and briefed on the issues to be discussed.

**By Invitation:**

~~4.7~~4.6 The Chief Commissioner, and other directors / senior managers may be invited to attend when the Sub-Committee is discussing areas of risk, audit/review findings or matters that are the responsibility of that Director / member of staff.

~~4.8~~4.7 The Sub-Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

**Member Appointments**

4.8 The membership of the Sub-Committee shall be determined by the Chair of the ~~Joint Committee~~JC, taking account of the balance of skills and expertise necessary to deliver the committee's remit and subject to any specific requirements or directions made by the Welsh Government.

## 5 Quorum & Attendance

5.1 A quorum shall be at least two members comprising of two Lay (Independent) Members.

5.2 For effective governance, at least two JCC Team directors, one of which must be a Clinical Director should be in attendance at the meeting.

## 6 Meeting Secretariat

6.1 The ~~JCC~~ Committee Secretary will determine the secretarial and support arrangements for the Sub-Committee.

## 7 Frequency of Meetings

7.1 The Meetings shall meet no less than 6 times a year, and otherwise as deemed necessary by the Chair of the Joint Committee.

7.2 Additional meetings may be called as appropriate with agreement of the Sub-Committee Chair.

7.3 Additional meetings may be held with the chairs of the LHBs Quality and Safety Committees where there is requirement.

7.4 Members will be ~~required~~ expected to attend a minimum of 75% of all meetings. Attendance will be monitored and reported to the Joint Committee through the Sub-Committee's Annual Report.

7.5 The Sub-Committee will arrange meetings and align with key statutory requirements during the year consistent with the Joint Committee's annual plan of Committee Business.

## 8 Withdrawal of Individuals in Attendance

8.1 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of ~~particular~~ specific matters.

## 9 Circulation of Papers

9.1 All papers will be distributed at least 5~~7~~ clear ~~calendar~~ days in advance of the meeting.

9.2 The Committee Secretaryiat will ensure that the draft minutes will be provided to the Sub-Committee Chair within ten working days following the meeting.

9.3 The JCC Committee Secretaryiat will ensure that a Sub-Committee highlight report is provided for presentation by the Sub-Committee Chair to the next Joint Committee meeting.

9.4 The Sub-Committee highlight report will also be shared with members and LHB Directors of Corporate Governance / Board Secretaries.

## 10 Access

10.1 The Chair of the Quality, Safety and Outcomes Sub-Committee shall work closely with the Director of Nursing and Quality and have reasonable access to the NWJCC Directors and other relevant senior staff within the NWJCC Team.

## 11 Accountability, Responsibility & Authority

11.1 Although health boardsLHBs have delegated authority to the Joint CommitteeJC and subsequently to this Sub-Committee for the exercise of certain functions as set out within these terms of reference, each healthLHBboard retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their organisation.

11.2 This Sub-Committee is responsible for providing scrutiny and assurance to the JCJoint Committee that Quality, Safety and Outcomes are being managed appropriately within the services commissioned by the NWJCC.commissioning cycles.

**Authority**

11.3 The Sub-Committee is authorised by the Joint CommitteeJC to investigate, or have investigated, any activity within its terms of reference.

11.4 The Sub-Committee is authorised by the Joint CommitteeJC to obtain outside legal or other independent professional and clinical advice and to secure the attendance of relevant external expertsoutsiders with relevant experience and expertise if it considers it necessary to support the Sub-Committee in the discharge of its duties. ,Such advice will be sought in accordance with the NWJCCs procurement, budgetary and other procedural and policy requirements.

11.5 The Sub-Committee will ensure that it is aware of and receives relevant reports on the activities and reports of external independent regulators and agencies, such as Healthcare Inspectorate Wales, Care Quality Commission,

National Audit Office and Audit Wales, that relate to the commissioning of services.

**Sub Groups**

11.6 The Sub-Committee may, subject to the approval of the ~~Joint Committee~~JC establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business.

**Strategy**

11.7 Oversee and monitor the development and implementation of the NWJCCs Strategies for patient quality, safety and outcomes:

- **Patient Quality, Safety and Outcomes**
  - Provide assurance to ~~Joint Committee~~JC on implementation of the Quality aspects within the Integrated ~~Medium Term~~Medium-Term Plan (IMTP) ~~for the Joint Committee~~
  - Provide support for the development and implementation of the Commissioning Assurance Framework and to subsequently provide assurance to the J~~oint Committee~~C in relation to the Commissioning Assurance Framework.
  - Contribute to and oversee the development of effectiveness of the Joint Committee's Annual Quality Statement and the Annual Governance Statement
  - Monitor quality via the Quality Dashboard.

- Monitor and receive reports on the organisation's progress with embedding and implementing the Health & Care Quality Standards
- Ensure arrangements are in place to review and act on clinical audit activity which responds to national and local priorities applicable to the business and services commissioned by the JCC as part of the commissioning cycle.
- Receive recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response.

**Corporate Organisational Risk**

11.8 Regularly review and provide assurance to the ~~Joint Committee~~JC on the risks included on the organisational Risk Register and assigned to the Sub-Committee by the Joint Committee.

**Quality Improvement activities**

11.9 ~~The Commissioning Assurance Framework provides the framework for quality improvement projects supporting compliance with the Duty of Quality.~~ The ~~Quality, Safety and Outcomes~~ Sub-Committee will:

- Provide scrutiny and assurance to the Joint Committee that priorities relating to quality, safety and outcomes are progressing.

11.10 **Patient Experience**

- Receive and review progress reports relating to Patient Experience and the emerging themes and trends identified in the performance management of providers and the NWJCC's escalation processes.~~requirements identified in the Commissioning Assurance Framework~~
- Ensure that the JCC engages with and co-operates with representatives of Llais as appropriate on ongoing patient engagement or major service change. (S.O. 7.7)

11.11 **Concerns**

- Receive~~ as presented within the quarterly quality report~~, reports on Concerns relating to the services commissioned by the NWJCC (reported patient safety incidents, complaints, compliments, clinical negligence claims and inquests) including reporting trends, with emphasis placed on ensuring that lessons are learnt and are built into the evaluation of services as part of the NWJCC's commissioning cycles.
- Receive assurance of effective and timely management of concerns (including incidents, complaints & claims) relating to commissioned services from across NHS Wales, in accordance with the legislation under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- Receive assurance of effective and timely management of concerns (including incidents, complaints & claims) contributing to LHB approaches providing information related to the services commissioned by the NWJCC to support them in complying with their ~~have~~ own legal and contractual requirements.

**Delegated Powers**

11.12 Although the ~~Joint Committee~~JC has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, the~~it~~ JC retains overall responsibility and accountability for ensuring the quality and safety of the services it commissions.~~,~~ ~~albeit~~Notwithstanding this, each LHB retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their ~~healthcare for its citizens through the effective governance of its~~ organisation.

11.13 This Sub-Committee is responsible for providing scrutiny and assurance to the ~~Joint Committee~~JC that Quality, Safety and Outcomes are being managed appropriately within the evaluation of services as part of the NWJCC's commissioning cycles.

The Sub-Committee will:

- Support the development of and sSeek assurance that the NWJCC's **Commissioning Assurance Framework** isremains appropriate, and is aligned to the Duty of Quality and ensuring that the duty is embedded in practice.
- Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:

    - Seeking assurance on the delivery of the NWJCC's Patient Experience Plan within the Commissioning Assurance Framework; and
    - Contributeing information from thea commissioning perspective to LHBs in their implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned through the commissioned service lens.

- Seek assurance that arrangements for the **provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:
    - the Commissioning Assurance Framework arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services
    - the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities
    - the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response
    - the development of the NWJCCJoint Committee's Annual Quality Statement including annual quality priorities; and
    - performance against key quality focussed performance indicators and metrics.

- Seek assurance on the arrangements in place to support **improvement and innovation**, including:
    - an overview of the research and development activity for commissioning within the organisation
    - alignment of the commissioning of services with the national objectives published by Health and Care Research Wales (HCRW);
    - an overview of the quality improvement activity for commissioned services within the organisation.

- Seek assurance that arrangements for commissioned services are **compliant with mental health legislation** are sufficient, effective and robust, including:
    - the Mental Health Act 1983
    - Mental Health Act Code of Practice for Wales and associated regulations (2016);
    - the Mental Capacity Act 2005 Code of Practice and associated regulations;
    - the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and associated regulations; and
    - the Mental Health Measure (Wales) 2010.

11.14 The Sub-Committee will seek assurances on the management of strategic risks delegated to the Sub-Committee by the Joint Committee, from the NWJCC Organisational Risk Register.

**Dealing with Members interests during meetings**

11.15 Declarations of interest will be a standing agenda item for all meetings.

11.16 Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for a meeting.

11.17 Interests declared at the start of, or during a meeting will be managed in accordance with section 8.2 of the NWJCC Standing Orders.

## 12 Reporting

12.1 The Sub-Committee Chair shall:

- Report formally, regularly and on a timely basis to the ~~Joint Committee~~JC on the Committee's activities. This includes:
  - Assurance that Quality, Safety and Outcomes are being managed appropriately
  - oral updates on recent activity
  - submission of written Sub-Committee highlight reports throughout the year
  - to receive annual reports, which will incorporate key information on quality, safety and outcomes.
- Bring to the ~~Joint Committee's~~JC's specific attention any significant matters under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the J~~Coint Committee~~ Chair, Chief Commissioner, LHB Chief Executive or Chairs of other relevant Sub-Committees of any urgent/critical matters that may affect the operation and/or reputation of the NWJCC and LHBs.

12.2 The Sub-Committee shall provide a written, annual report to the ~~Joint Committee~~JC on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Sub-Committees self-assessment and evaluation.

~~12.3 The Sub-Committee shall provide a highlight report to each HB after each meeting providing assurance that Quality, Safety and Outcomes are being managed appropriately, for inclusion on suitable HB Committee agendas.~~

~~12.4~~12.3 The ~~Joint Committee~~ JC may also require the Sub-Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Sub-Committee's assurance role relates to a joint or shared responsibility.

~~12.5~~12.4 The NWJCC Committee Secretary, on behalf of the J~~C~~oint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation.

**Relationship with the Joint Committee and its Sub-Committees / Groups**

~~12.6 Although the Joint Committee has delegated authority to the sub-committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and outcomes of healthcare for its commissioned services through the effective governance of its organisation.~~

~~12.7~~12.5 The Sub-Committee is directly accountable to the ~~Joint Committee~~ JC for its performance in exercising the functions set out in these Terms of Reference.

~~12.8~~12.6 The Sub-Committee, through the Sub-Committee Chair and members, shall work closely with the ~~Joint Committees~~NWJCC's other Sub-Committees to provide advice and assurance to the J~~C~~C through the:

- joint planning and co-ordination of JC~~Joint Committee~~ business; and
- sharing of information.

~~12.9~~12.7 In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the NWJCCs overall risk and assurance arrangements.

~~12.10~~12.8 The Sub-Committee, through its Chair and members, shall work closely with LHB Quality and Safety Committees to ensure that LHB Boards are informed of any issues relating to their population, recognising that concerns of the services commissioned by the JCC may impact on primary and secondary services and vice versa (i.e. the whole pathway). The Sub-Committee shall embed the JCC's standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

~~12.11~~12.9 The Sub-Committee shall embed the organisational values and strategic objectives through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

## 13 Applicability of Standing Orders to Sub-Committee Business

13.1 The requirements for the conduct of business as set out in the NWJCC Standing Orders are equally applicable to the operation of the Sub-Committee, except in the area relating to the quorum.

13.2 This Sub-Committee is a scrutiny and assurance sub-committee and therefore where a decision is required the matter will be referred to the NWJCC Senior Leadership Team or JC~~oint Committee~~, as appropriate.

## 14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the NWJCC Committee Secretary as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with one other Lay (Independent) Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Sub-Committee for consideration and ratification.

14.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

## 15 In Committee (Private Meeting)

15.1 The Sub-Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

## 16 Review

16.1 These Terms of Reference shall be adopted by the Sub-Committee at its first meeting and subject to review at least on an annual basis thereafter, with endorsement ~~ratified~~ by the ~~Joint Committee~~JC for onward approval by Health Boards.

Cyd-bwyllgor Comisiynu Joint Commissioning Committee

**Appendix 5**

# PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE (PPF)

Terms of Reference & Operating Arrangements
(Schedule 3.1 of the Standing Orders)

| | |
|---|---|
| **Document Author:** | Committee Secretary |
| **Lead Directors** | Director of Finance and Value ~~Director of Finance and Information~~ Director of Corporate Strategy and Planning~~Director of Planning and Performance~~ |
| **Endorsed By** | Joint Commissioning Committee ~~21 January 2025~~ 17 March 2026 |
| **Approved By** | Health Boards – ~~January 2025~~ May 2027 |
| **Issue Date** | ~~4 February 2025~~ 26 May 2026 |
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| **Version** | 4 |

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| Version | Issued To | Date | Outcome | Next Review Date |
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| Version 1 | Health Boards | 17 September 2024 | Approved at HB September Board meetings | 1 June 2025 |
| Version 2 | NWJCC Joint Commissioning Committee ~~JCC~~ | 21 January 2025 | Endorsed | 12 January 2025 |
| Version 3 | Health Boards | 21 January 2025 | Approved at HB Board meetings – with staff side rep removed. | 12 January 2026 |
| Version 3.1 | PPF | 26 February 2026 | Endorsed at PPF subject to minor updates – added in commissioning Directors to regular attendees – 4.5 and wording of 4.7 amended to expected rather than required | - |
| Version 3.2 | JCC | 17 March 2026 | Endorsed | - March 2027 |
| Version 4 | Health Boards | May 2026 | | - March 2027 |

**Sub-Committee Arrangements:**
This schedule forms part of, and shall have effect as if incorporated in the NHS Wales Joint Commissioning Committee Standing Orders.

## 1. Introduction & Constitution

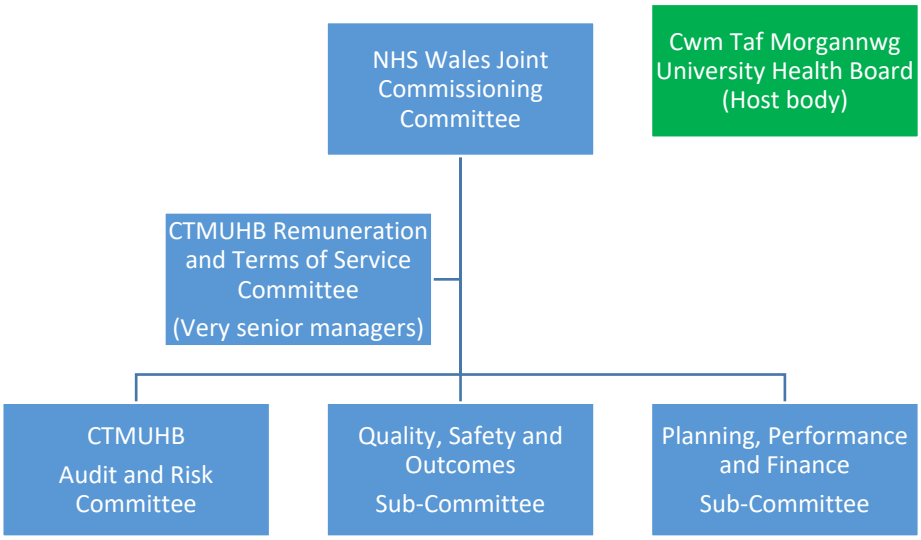
1.1 In accordance with NHS Wales Joint Commissioning Committee ("NWJCC") Standing Order 5.5, the ~~NHS Wales Joint Commissioning Committee (JCC – the~~ NWJCC Joint Committee~~)~~ (the "JC") may and, where directed by the Local Health Boards ("LHB") ~~Boards~~ jointly, or the Welsh Ministers must, appoint joint sub-committees of the NWJCC either to undertake specific functions on the NWJCC's behalf or to provide advice and assurance to others (whether directly to the NWJCC or on behalf of the NWJCC to each LHB Board and/or its other sub-committees). The NWJCC shall determine, for agreement by the LHBs, a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.

1.2 In accordance with Standing Orders (SOs) (and the NWJCC Scheme of Delegation), the JC~~Joint Committee~~ shall nominate annually a sub-committee to be known as the **Planning, Performance and Finance Sub-Committee**. The detailed terms of reference and operating arrangements set by the JC~~Joint Committee~~ in respect of this sub-committee are set out below.

## 2. Purpose

2.1 The purpose of the Planning, Performance and Finance Sub-Committee ("the Sub-Committee") is to be assured that the JC~~Joint Committee~~ is effectively managing the strategic planning, performance and financial duties outlined in the NWJCC's~~Joint Committees~~ SOs and Standing Financial Instructions (SFIs) relating to planning, securing and commissioning the services delegated to the NWJCC on behalf of LHBs in Wales.

Figure 1 – NWJCC Sub Committee Structure




## 3. Scope and Duties

The Sub-Committee will provide scrutiny and assurance in relation to the duties below:

### 3.1 Planning

- Monitor the process for the development of the Integrated ~~Medium Term~~Medium-Term Plan (IMTP) in line with the relevant SOs, SFIs and the NHS Wales Planning Framework
- Receive assurance on the delivery of the IMTP
- Scrutinise the alignment of service, workforce, digital and financial commissioning plans in the IMTP (as appropriate to the business of the NWJCC)
- Scrutinise the development and delivery of strategic or major service plans through the agreed Service Transformation Programme in the IMTP.

### 3.2 Performance

- Advise on and assure the development and implementation of the NWJCC's Performance Management Framework
- Monitor in-year performance against the financial plan and activity targets that support the relevant metrics agreed by the JC~~Joint Committee~~
- Monitor overall performance of commissioned services against the NWJCC's IMTP and the national targets for NHS Wales (Ministerial Priorities).

### 3.3 Organisational Risk Register

- Regularly review and scrutinise the planning, performance and finance risks included on the NWJCC Risk Register and assigned to the Sub-Committee by the NWJCC.

### 3.4 Finance

- Monitor delivery of financial plans and savings programmes
- Monitor risk to financial delivery including mitigating actions to appropriately manage the risks
- Robustly challenge and support progress against delivery of savings plans including consideration of impact on services
- Scrutinise investments in line with the Standing Financial Instructions (SFIs) and the Scheme of Delegation prior to submission to the JC~~Joint Committee~~ for approval
- Monitor activity and productivity including operational efficiency and effectiveness
- Report on significant financial variances and issues, including potential mitigation decisions.

3.5 **Sub-Committee Programme of work**

Each year the JC~~Joint Committee~~ will determine the Sub-Committee's priorities for its annual programme of work, based on the NWJCC's~~Joint Committee's~~ IMTP and Organisational ~~Corporate~~ Risk Register. This approach will ensure that the Sub-Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Sub-Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Sub-Committee's programme of work will be dynamic and flexible to meet the needs of the JC ~~Joint Committee~~ throughout the year.

3.6 The Sub-Committee, in monitoring and scrutinising the above areas, will discuss and recommend corrective action where necessary. This will include the transformation, recommissioning and value in health care approach.

3.7 The Sub-Committee will monitor the development of appropriate Key Performance Indicators (KPIs) across all parts of the organisation.

3.8 Where necessary, the Sub-Committee will undertake detailed "deep dives" of specific areas. These reviews will be supported by appropriate benchmarking information to ensure all of the NWJCCs commissioned services are striving to achieve "best in class" in relation to planning, performance and finance.

~~3.8~~3.9 The Sub-Committee will provide onward assurance to the JC on all matters relating to its annual programme of work, as delegated.

## 4. Membership

**Members**

4.1 The Membership of the PPF~~SC~~ Sub-Committee is as follows:

| | |
|---|---|
| Chair | Lay (Independent) Member of the JCC |
| Vice Chair | Lay (Independent) Member of the JCC |
| Member | One further Lay (Independent) Member of the JCC |

| | |
|---|---|
| Health Board Member | Two ~~One~~ LHB ~~representative~~ Chief Executive representatives, who shall alternate attendance, or designated nominated deputy who must be an Executive Director from a health board (and would be fully briefed on the issues to be discussed) |

4.2 The membership of the Sub-Committee shall be determined by the JC ~~Joint Committee~~, based on the recommendation of the Chair of the JC~~Joint Committee~~ and lay members, taking account of the balance of skills and expertise necessary to deliver the sub-committee's remit and subject to any specific requirements or directions made by Ministers or the Welsh Government.

~~4.3 The Chair of the Joint Committee and the Chair of the Sub-Committee, will receive a nomination from the CEOs of Local Health Boards as outlined below.~~

~~4.4~~4.3 The Membership will be reviewed annually.

**Support to Sub-Committee Members**

~~4.5~~4.4 The Committee Secretary, on behalf of the Sub-Committee Chair, shall:

- Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role, and
- Co-ordinate the provision of a programme of organisational development for Sub-Committee members as part of the overall JCCs Organisational Development programme.

~~4.6~~4.5 **In Attendance**

| |
|---|
| Director of Corporate Strategy and Planning ~~JCC Director of Planning and Performance~~ (co-lead JCC Director) |
| Director of Finance and Value ~~JCC Director of Finance & Information~~ (co-lead JCC Director) |
| JCC Director of Commissioning for Specialised Services |
| JCC Director of Commissioning for Ambulance and 111 |
| JCC Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MH, LD & VG) |
| Committee Secretary or representative who will routinely attend meetings ensuring governance support and advice is available to the Sub-Committee Chair |

Directors may on occasion nominate a suitably senior deputy to attend the Sub-Committee on their behalf but should ensure that they are fully aware and briefed on the issues to be discussed.

**By Invitation:**

~~4.7~~4.6 The Chief Commissioner, and other directors / senior managers may be invited to attend when the Sub-Committee is discussing areas of risk,

audit/review findings or matters that are the responsibility of that Director / member of staff.

4.84.7 The Sub-Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

**Member Appointments**

4.94.8 The membership of the Sub-Committee shall be determined by the Chair of the JCJoint Committee, taking account of the balance of skills and expertise necessary to deliver the sub-committee's remit and subject to any specific requirements or directions made by the Welsh Government.

## 5 Quorum & Attendance

5.1 A quorum shall be at least two members comprising of two Lay (Independent) Members.

5.2 For effective governance, the Director of Finance and Value Information and the Director of Corporate Strategy and Planning Director of Planning and Performance are required expected to attend all meetings.

## 6 Meeting Secretariat

6.1 The JCC Committee Secretary will determine the secretarial and support arrangements for the Sub-Committee.

## 7 Frequency of Meetings

7.1 The Meetings shall meet no less than 6 times a year, and otherwise as deemed necessary by the Chair of the Joint Committee.

7.2 Additional meetings may be called as appropriate with agreement of the Sub-Committee Chair.

7.3 Additional meetings may be held with the chairs of the LHBs Planning, Performance and Finance Committees where there is requirement.

7.4 Members will be expected required to attend a minimum of 75% of all meetings. Attendance will be monitored and reported to the Joint Committee through the Sub-Committee's Annual Report.

7.5 The Sub-Committee will arrange meetings and align with key statutory requirements during the year consistent with the Joint Committee's annual plan of Business.

## 8 Withdrawal of Individuals in Attendance

8.1 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of specific matters.

## 9 Circulation of Papers

9.1 All papers will be distributed at least 57 ~~calendar~~ clear days in advance of the meeting.

9.2 The Committee Secretary~~iat~~ will ensure that the draft minutes will be provided to the Sub-Committee Chair within ten working days following the meeting.

9.3 The ~~JCC~~ Committee Secretary~~iat~~ will ensure that a Sub-Committee highlight report is provided for presentation by the Sub-Committee Chair to the next Joint Committee meeting.

9.4 The Sub-Committee highlight report will also be shared with members and HB Directors of Corporate Governance / Board Secretaries.

## 10 Access

10.1 The Chair of the Planning, Performance and Finance Sub-Committee shall work closely with the Director of Finance and Value ~~Information~~ and the Director of Corporate Strategy and Planning ~~Director of Planning and Performance~~ and have reasonable access to the NWJCC Directors and other relevant senior staff within the NWJCC Team.

## 11 Accountability, Responsibility & Authority

11.1 Although LHBs ~~health boards~~ have delegated authority to the JC~~Joint Committee~~ and subsequently to this Sub-Committee for the exercise of certain functions as set out within these terms of reference, each LHB~~health board~~ retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their organisation.

11.2 This Sub-Committee is responsible for providing scrutiny and assurance to the JC~~JCC~~ that Planning, Performance and Finance are being managed appropriately within the commissioning cycles for the services commissioned by the NWJCC.

**Authority**

11.3 The Sub-Committee is authorised by the JC~~Joint Committee~~ to investigate~~,~~ ~~or have investigated,~~ any activity within its terms of reference.

~~11.3~~11.4 The Sub-Committee is authorised by the JC~~Joint Committee~~ to obtain outside legal or other independent professional and clinical advice and to secure the attendance of relevant external experts~~outsiders with relevant experience and expertise~~ if it considers it necessary to support the Sub-

Committee in the discharge of its duties. Such advice will be sought ~~,~~ in accordance with the NWJCCs procurement, budgetary and other procedural and policy requirements.

### Sub Groups

~~11.4~~11.5 The Sub-Committee may, subject to the approval of the JC~~C~~ establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business.

### Delegated Powers

~~11.5~~11.6 Although the JC~~Joint Committee~~ has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, ~~it~~ the JC retains overall responsibility and accountability for ensuring the quality and safety of the services it commissions. ~~,~~ Notwithstanding this,~~albeit~~ each LHB retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their ~~its citizens~~ through the effective governance of their ~~its~~ organisation.

### Dealing with Members interests during meetings

~~11.6~~11.7 Declarations of interest will be a standing agenda item for all meetings.

~~11.7~~11.8 Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for a meeting.

~~11.8~~11.9 Interests declared at the start of, or during a meeting will be managed in accordance with section 8.2 of the NWJCC Standing Orders.

## 12 Reporting

12.1 The Sub-Committee Chair shall:

- Report formally, regularly and on a timely basis to the JC~~Joint Committee~~ on the Sub-Committee's activities. This includes:
  - Assurance that Planning, Performance and Finance matters are being managed appropriately
  - oral updates on recent activity
  - submission of written Sub-Committee highlight reports throughout the year
  - to receive annual reports, which will incorporate key information on planning, performance and finance
- Bring to the JC's~~Joint Committee's~~ specific attention any significant matters under consideration by the Sub-Committee; and
- Ensure appropriate escalation arrangements are in place to alert the JC~~Joint Committee~~ Chair, Chief Commissioner, LHB Chief Executive or Chairs of other relevant Sub-Committees of any urgent/critical matters that may affect the operation and/or reputation of the NWJCC and LHBs.

12.2 The Sub-Committee shall provide a written, annual report to the JCJoint Committee on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Sub-Committees self-assessment and evaluation.

12.2 The Sub-Committee shall provide a highlight report to each HB after each meeting providing assurance that Planning, Performance and Finance are being managed appropriately, for inclusion on suitable HB Sub-Committee agendas.

12.3 The JCJoint Committee may also require the Sub-Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Sub-Committee's assurance role relates to a joint or shared responsibility.

12.4 The NWJCCJCC Committee Secretary, on behalf of the JCJoint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation.

**Relationship with the Joint Committee and its Sub-Committees / Groups**

12.5 Although the Joint Committee has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the effective planning, performance and financial management of healthcare for commissioned services through the effective governance of its organisation.

12.612.5 The Sub-Committee is directly accountable to the JCJoint Committee for its performance in exercising the functions set out in these Terms of Reference.

12.712.6 The Sub-Committee, through the Sub-Committee Chair and members, shall work closely with the JCJoint Committees other Sub-Committees to provide advice and assurance to the JCC through the:

- joint planning and co-ordination of JCC and Committee business; and
- sharing of information.

12.812.7 In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the NWJCCs overall risk and assurance arrangements.

12.912.8 The Sub-Committee, through its Chair and members, shall work closely with LHB Planning, Performance and Finance Committees to ensure that LHB Boards are informed of any issues relating to their population, recognising that concerns of the services commissioned by the NWJCC may impact on primary and secondary services and vice versa (i.e. the whole pathway). The Sub-Committee shall embed the NWJCC's standards,

priorities and requirements e.g. equality and human rights, through the conduct of its business.

~~12.10~~12.9 The Sub-Committee shall embed the organisational values and strategic objectives through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

## 13 Applicability of Standing Orders to Sub-Committee Business

13.1 The requirements for the conduct of business as set out in the NWJCC Standing Orders are equally applicable to the operation of the Sub-Committee, except in the area relating to the quorum.

13.2 This Sub-Committee is a scrutiny and assurance sub-committee and therefore where a decision is required the matter will be referred to the NWJCC Senior Leadership Team or JC~~Joint Committee~~, as appropriate.

## 14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the NWJCC Committee Secretary as appropriate, may deal with the matter on behalf of the Sub-Committee, after first consulting with one other Lay (Independent) Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

14.2 Chair's urgent action may not be taken where the sub-committee Chair has a personal or business interest in the urgent matter requiring decision.

## 15 In Committee (Private Meeting)

15.1 The Sub-Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

## 16 Review

16.1 These Terms of Reference shall be adopted by the Sub-Committee at its first meeting and subject to review at least on an annual basis thereafter, with endorsement ~~ratified~~ by the JC~~Joint Committee~~. for onward approval by Health Boards.

# CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
# ANEURIN BEVAN UNIVERSITY HEALTH BOARD
# ACTION LOG

| Outstanding | In Progress | Not Due | Completed | Transferred to another Committee |
|---|---|---|---|---|

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
|---|---|---|---|---|---|
| **There are no actions outstanding as at 20/05/2026** | | | | | |
| | | | | | |

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

**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN**

**ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Welsh Government, Accountability Interface Arrangements |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Nicola Prygodzicz, Chief Executive Officer |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Rani Dash, Director of Corporate Governance |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Trafodaeth/For Discussion |

**ADRODDIAD SCAA**

**SBAR REPORT**

## Sefyllfa / Situation

Welsh Government has set out a new approach to accountability, oversight and interface arrangements between Welsh Government, NHS Wales organisations and NHS Performance & Improvement (NHS P&I). These arrangements are intended to simplify existing mechanisms, strengthen clarity of accountability, and align assurance activity to organisational risk and escalation status.

This report is brought to the Board to support discussion of the revised arrangements, understand the changes to Welsh Government interfaces

(including the removal of IQPD and JET meetings), and consider the governance and assurance implications for Aneurin Bevan University Health Board.

## Cefndir / Background

On 16 March 2026, Welsh Government issued a letter to all NHS Chairs and Chief Executive Officers outlining revised accountability interface arrangements for NHS Wales. The changes respond to recommendations from the Ministerial Advisory Group (MAG) reviews on accountability and on performance and productivity.

The new approach introduces a streamlined, risk-based framework which aligns oversight meetings and reporting requirements to the Welsh Government Oversight and Escalation Framework. NHS Performance & Improvement will act as the single operational assurance interface between Welsh Government and NHS organisations, supported by a single common reporting pack and risk-based CEO/Executive Review meetings with the NHS Wales CEO.

The new arrangements are being implemented from Q1 2026/27.

The legal and statutory accountability framework remains unchanged: Boards and Chairs remain accountable to Welsh Ministers, and Chief Executives remain accountable to their Boards through their Chairs.

## Asesiad / Assessment

The revised accountability interface represents a significant change in how assurance and performance oversight is conducted across NHS Wales. Successful implementation will require clear internal alignment to the national reporting pack and ongoing oversight of how assurance provided through NHS P&I interfaces supports, rather than replaces, Board assurance. Key implications for the Health Board include:

- **Governance and reporting:** Increased reliance on a single, standardised performance and assurance pack used consistently within Board papers and discussions, supporting the principle of "one version of the truth".
- **Assurance cadence:** The removal of IQPD and JET meetings and their replacement with risk-based CEO/Executive Review meetings aligned to escalation status.
- **Role clarity:** NHS P&I acting as the single operational interface, providing consolidated assurance across quality, workforce, finance and performance, while statutory accountability relationships remain unchanged.
- **Earned autonomy:** Greater proportionality in oversight, with lighter-touch arrangements for organisations demonstrating sustained performance and stronger intervention where risks are identified.

- **Transparency:** Clearer escalation and de-escalation criteria, aligned to the national framework, supporting consistent and transparent accountability.

Overall, the approach is intended to reduce duplication, sharpen focus on outcomes, and strengthen system-wide assurance. Successful implementation will depend on alignment with existing Board governance arrangements and consistent use of the shared reporting framework. The revised accountability interface does not change the Health Board's statutory duties, Standing Orders, committee structures or internal governance arrangements. Board and committee assurance processes will continue to operate as the primary mechanisms through which the Board discharges its responsibilities, with alignment to the common national reporting pack expected to strengthen consistency.

**Argymhelliad / Recommendation**

The Board is asked to:

- **Discuss** the Welsh Government Accountability Interface Arrangements and the implications for Board governance, assurance and oversight.
- **Note** that the statutory accountability framework is unchanged.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | N/A |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| | |
|---|---|
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Choose an item. |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item. |

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

| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb**<br>**Equality Impact Assessment** (EIA) completed | **No does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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**<br>**Well Being of Future Generations Act – 5 ways of working**<br><br>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<br>Choose an item. |

## A NEW OPERATING & ACCOUNTABILITY INTERFACE - NHS WALES

### 1. Introduction

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

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

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

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

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

### 2. Oversight and Assurance

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

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

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

Design Principles

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

## 3. Scope and Roles

### 3.1 Welsh Government (HSCEY Group)

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

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

### 3.2 NHS Performance & Improvement (NHS P&I)

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

### 3.3 NHS Organisations (Health Boards, Trusts, SHAs)

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

## 4. Data and Reporting: "One Version of the Truth"

### 4.1 Shared Performance Pack

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

### 4.2 Access for WG Policy Officials

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

## 5. Escalation Alignment

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

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

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

### 6.1 System-level

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

### 6.2 Organisation-level

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

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

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

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

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

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

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

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

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

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

## 7. Earned Autonomy, Rewards and Consequences

### 7.1 Earned Autonomy (Rewards)

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

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

### 7.2 Consequences

Where performance or assurance falls short:

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

### 7.3 Accountability Mechanisms

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

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

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

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

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

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

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

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

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

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

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

## 9. Delivery Expectations and Tracking

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

How this aligns with the current framework?

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

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**Foundation domain: Leadership (Well-led)**
Definition: Boards and senior leaders set clear purpose and strategy, role-model the values and behaviours required for high-quality care, nurture an open, fair culture, ensure strong integrated governance across quality, finance and operations, and drive continuous improvement and system working. This domain will be assessed using a framework inclusive of self-assessment and evidence.
Leaders evidence: (i) clear shared direction and culture; (ii) effective governance and risk management; (iii) transparent use of data and insight; (iv) compassionate, inclusive people leadership; (v) visible improvement capability; and (vi) constructive system relationships that support delivery at pace.

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

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**Pillar 1: Quality**
Definition: The safety, effectiveness and experience of care — including compliance with quality standards, learning from incidents, clinical outcomes, and reduction of unwarranted variation.
Evidence base: National quality measures and statements, triangulated with the National Quality Management System, patient experience feedback and external assurance (Healthcare Inspectorate Wales, Audit Wales). Fragile or high-risk services (for example, maternity and neonatal) are captured here and, where relevant, in Delivery/Performance.
Expectations: Sustained compliance with agreed quality standards and trajectories; evidence of learning translating into improved outcomes and reduced harm.

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**Pillar 2: Workforce**
Definition: A safe, sustainable and engaged workforce with the right capacity, capability and culture to deliver plans — encompassing recruitment, retention, sickness, wellbeing, turnover, and productivity enablers.
Evidence base: People-measures within the national oversight approach (for example, staffing, skill mix, rota fill, training compliance, wellbeing indicators), supported by qualitative insights from staff surveys and speaking-up data.
Expectations: Delivery of safe staffing plans and trajectories; improved stability and engagement; demonstrable impact of workforce actions on quality and operational performance.

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**Pillar 3: Finance**
Definition: In-month and year-to-date financial position, medium-term sustainability, savings delivery and use of resources, with credible, triangulated plans that balance quality, activity and workforce. Strategy and planning considerations sit here where they materially affect financial sustainability.
Evidence base: Monthly monitoring returns, integrated performance and finance reports, and assurance over financial governance and control. Deeper review where there is a significant underlying deficit or gaps to plan.
Expectations: Sustained delivery against the agreed financial trajectory; strengthened financial controls; approved and deliverable medium-term plan demonstrating recurrent balance.

---

**Pillar 4: Delivery/Performance**
Definition: Delivery against nationally agreed priorities and the Performance Framework — including urgent and emergency care, planned care and cancer, diagnostics, mental health, and other access standards — supported by credible recovery plans and trajectories.
Evidence base: The single performance pack and published performance measures, trend analyses, risks and mitigations. Where quality or fragile-service risks are operational in nature (for example, patient flow, access backlogs), they will also be tracked here.
Expectations: Sustained delivery of agreed milestones and outcomes; variance managed within agreed tolerances; performance maintained without disproportionate negative impact on quality, workforce or finance.

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### 9.1 Applying escalation within the pillars

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

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

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

### 9.2 Mapping from legacy domains to the new structure

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

### 9.3 Measurement and reporting

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

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

## 10. Information Governance and Transparency

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

| | |
|---|---|
| GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board | **CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN<br>ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING** |

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:<br>DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:<br>MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:<br>TITLE OF REPORT:** | **UK Covid-19 Inquiry Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom** |
| **CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR:** | Rani Dash, Director of Corporate Governance |
| **SWYDDOG ADRODD:<br>REPORTING OFFICER:** | Dan Davies, Chief Business Officer |

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

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

The UK Covid-19 Inquiry has published its Module 3 Report (March 2026), examining the impact of the pandemic on the four UK healthcare systems. The report sets out the exceptional pressures experienced by the NHS, the systemic weaknesses exposed by the pandemic, and 10 recommendations intended to strengthen preparedness and resilience for future pandemics.

All reports published by the UK Covid-19 Inquiry to date can be viewed on its website at the following link: Inquiry Module Reports - UK Covid-19 Inquiry

This paper summarises the key findings and recommendations, with a particular focus on national actions agreed for NHS Wales, the governance arrangements through NHS Wales Leadership Board, and the implications for this Health Board.

### Background

Module 3 follows earlier Inquiry reports, including Module 2 (decision-making and political governance). The Welsh Government published its formal response to Module 2B in March 2026, and the Board has previously been briefed on the themes and actions arising from that response.

Whereas Module 2 focused primarily on national governance and decision-making structures, Module 3 shifts attention to the delivery and resilience of healthcare systems. As with earlier modules, Welsh

Government has confirmed a single, coordinated NHS Wales response, rather than individual Health Board submissions.

Module 3 of the UK Covid-19 Inquiry provides the most comprehensive assessment to date of how healthcare systems across the UK coped during the Covid-19 pandemic. The report concludes that healthcare systems "*coped, but only just*", and that system failure was narrowly avoided through the extraordinary efforts of staff, rather than through inherent resilience in healthcare structures.

The report is of relevance to Health Boards as it focuses on how policies, guidance and capacity translated into operational delivery, and how pre-existing fragilities in workforce, estates and services shaped the ability of local systems to respond.

**Asesiad / Assessment**

The Inquiry finds that healthcare systems entered the pandemic from a position of limited resilience. Across the UK this was characterised by high bed occupancy, insufficient critical care capacity, workforce shortages, ageing estates and constrained surge capability. For Health Boards in Wales, this meant that the pandemic response was delivered against a backdrop of already-stretched services, leaving limited capacity to absorb sustained or escalating demand. The report is explicit that this starting position materially affected outcomes, particularly during successive waves, and that reliance on emergency measures masked deeper structural weaknesses rather than addressing them.

Key Findings from Module 3

A summary of the key findings in Module 3 is set out below:

- A central theme of Module 3 is the impact on the healthcare workforce. Staff experienced prolonged periods of intense pressure, repeated redeployment, exposure to infection risk, and moral injury linked to difficult clinical decisions and visiting restrictions. The Inquiry highlights widespread evidence of burnout, psychological harm, and loss of experienced staff during and after the pandemic.
- The Inquiry is critical of how infection prevention and control (IPC) guidance was developed and applied. It concludes that IPC decision-making lacked clear ownership and sufficient multidisciplinary input. At organisational level, Health Boards were required to implement and interpret guidance that evolved rapidly and sometimes inconsistently, contributing to variation in practice. The report emphasises that future arrangements must provide clearer structures, stronger expertise and more transparent rationale, so that local organisations are not placed in the position of managing uncertainty alone.
- Module 3 documents how hospitals came close to being overwhelmed, particularly in critical care. The expansion of capacity relied heavily on redeployment, cancellation of elective activity, use of temporary facilities and extraordinary staff effort. While these measures were effective in the short term, the Inquiry concludes that they were reactive rather than planned. For Health Boards, the key message is that future preparedness must include tested, realistic plans for scaling hospital and critical care capacity, rather than relying on ad-hoc escalation during a crisis. This includes estates, workforce, oxygen supply, equipment and operational readiness.
- The Inquiry highlights sustained pressure on urgent and emergency care services, including ambulance services, emergency departments and NHS 111. Staff shortages, increased demand and discharge delays compounded pressures across the system, with knock-on

impacts for patient outcomes and staff wellbeing. Health Boards will recognise many of these challenges as continuations of pre-pandemic issues, which the pandemic intensified rather than created. The report reinforces the need for future surge planning to encompass the whole urgent care pathway, not solely hospital beds.

- Visiting restrictions are identified as one of the most distressing aspects of the pandemic for patients, families and staff. While acknowledging the infection control rationale, the Inquiry finds that restrictions were often applied inconsistently, sometimes without sufficient flexibility for vulnerable patients, carers or those receiving end-of-life care. For Health Boards, the findings underline the importance of clear national guidance combined with local discretion, and of recognising carers and family members as partners in care, not simply visitors.
- The Inquiry documents significant harm arising from disruption to non-Covid care, including delayed diagnoses, cancelled treatment, worsening long-term conditions and increased mortality. The impact on cancer pathways, elective care and long-term condition management is highlighted as a major consequence of the pandemic response.
- Module 3 also recognises Long Covid as a lasting legacy of the pandemic, affecting both patients and healthcare workers. The report highlights challenges in recognition, diagnosis, service provision and workforce impact, noting variation in access and understanding across the UK.

Taken together, the Inquiry's findings emphasise that future pandemic preparedness cannot rely solely on national decision-making or emergency measures. Health Boards sit at the point where policy becomes practice, and the report makes clear that system resilience, workforce capacity, clarity of guidance and ethical frameworks all materially affect local outcomes. While the Inquiry does not expect individual Health Boards to respond independently, its findings strongly reinforce the need for nationally led, locally deliverable actions that reflect the realities of healthcare delivery on the ground.

Inquiry Recommendations

In light of these findings, the Module 3 Report sets out 10 formal recommendations to strengthen preparedness and resilience ahead of future pandemics. These recommendations, as set out in the Inquiry report, are:

1. Ensure that decision-making on infection prevention and control is underpinned by clear structures and a cautious approach to transmission risk.
2. Guidance for visiting restrictions.
3. Better preparation for fit testing.
4. Improve data systems to identify individuals at high risk during a pandemic.
5. Prepare to scale up urgent and emergency care capacity.
6. Prepare for and test the ability to scale up hospital capacity.
7. A framework to guide the allocation of intensive care resources in the extreme event of saturation.
8. Systematically record and publish healthcare worker deaths.
9. A standardised process for advance care planning across the UK.
10. Psychological and emotional support for healthcare workers.

Approach to Responding in Wales

Welsh Government has confirmed that the response to the Module 3 recommendations will be taken forward through a single, coordinated NHS Wales approach, rather than through individual Health

Board responses. The response will set out how each of the 10 recommendations will be addressed, including where actions are already underway, where further policy or system development is required, and where delivery will be longer-term.

For each recommendation, national-level recommendation owners have been identified to lead development of the response. These leads are responsible for coordinating input across the system, assessing existing arrangements, identifying gaps, and setting out clear actions or commitments where further development is required. This work will draw on expertise from relevant NHS Wales clinical and operational colleagues, who are currently being identified.

Recognising that some recommendations have UK-wide relevance, Welsh Government has confirmed that four-nations working will be undertaken where appropriate, particularly in areas where alignment across health systems adds value, such as ethical frameworks, data approaches and workforce learning. In these areas, the Welsh response will reflect devolved responsibilities while contributing to shared UK-wide learning.

The NHS Wales Leadership Board will receive updates on progress, provide strategic oversight of recommendations that directly impact healthcare delivery, and consider the draft Welsh Government response prior to Ministerial clearance.

Based on the approach described above, Health Boards, including Aneurin Bevan University Health Board, are not expected to submit separate responses to the Inquiry. Instead, their role is to support Welsh Government and national recommendation owners where local insight, engagement or operational input is required and to ensure that local planning, improvement and recovery activity remains aligned with nationally agreed actions as these are developed.

The Module 3 Report was published in March 2026, and Welsh Government is required to submit its response within six months, by September 2026. The Board will be provided with a further update once the Welsh Government response is available.

Remaining Modules and Indicative Timings

The UK Covid-19 Inquiry is structured around ten thematic modules, each examining an aspect of the UK's preparedness for, and response to, the Covid-19 pandemic. While public hearings for all modules are now complete, the Inquiry has confirmed that reports and recommendations will continue to be published on a rolling basis during 2026 and into early 2027.

The Inquiry has formally set out its 2026 publication schedule, confirming the following timetable:

| Inquiry Module | Subject Area | Publication Timing (as indicated by the Inquiry) | Summary Scope |
|---|---|---|---|
| Module 3 | Healthcare Systems | Published on 19 March 2026 | Impact of Covid-19 on UK healthcare systems, including workforce, capacity, resilience and service delivery. |
| Module 4 | Vaccines and Therapeutics | Published on 16 April 2026 | Development, approval and deployment of vaccines, therapeutics and antivirals across the UK. |
| Module 5 | Procurement | Scheduled for Summer 2026 | Procurement of goods and services during the pandemic, including PPE and supply chain arrangements. |
| Module 6 | The Care Sector | Due later in 2026 | Impact on adult social care, care homes and the interface with health services. |
| Module 7 | Test, Trace and Isolate | Due later in 2026 | Design, governance and delivery of testing, tracing and isolation systems. |

In addition, the Inquiry held its final public hearings for Module 10 (Impact on Society) by March 2026. The report arising from Module 10, alongside the remaining reports including Module 8 (Children and Young People) and Module 9 (Economic Response), is expected to be published in the first half of 2027.

As further module reports are published, Welsh Government will consider their implications and determine whether coordinated NHS Wales responses are required. The Board will be provided with updates on any additional reports of relevance to healthcare systems and on any emerging expectations for Health Boards arising from future Inquiry findings.

**Argymhelliad / Recommendation**

It is recommended that the Board:

- Notes the publication of the UK Covid-19 Inquiry Module 3 Report and the key findings and recommendations relevant to healthcare systems.
- Notes the approach being taken by Welsh Government and NHS Wales in responding to the Module 3 recommendations.
- Notes the implications for Aneurin Bevan University Health Board, including the expectation to support national activity where required and to align local planning, improvement and recovery activity with nationally agreed actions as these are developed.

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: | Not applicable |

| | |
|---|---|
| Corporate Risk Register Reference and Score: | |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>3.2 Communicating Effectively<br>2.1 Managing Risk and Promoting Health and Safety<br>3.5 Record Keeping |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Not Applicable |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Improve the Wellbeing and engagement of our staff<br><br>Choose an item. |

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

| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** | |
|---|---|
| **Resource Assessment:** | A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: |
| • **Workforce** | Not Applicable |
| • **Service Activity & Performance** | Yes, outlined within the paper |
| • **Financial** | Not Applicable |
| **Asesiad Effaith Cydraddoldeb**<br>**Equality Impact Assessment** (EIA) completed | Choose an item.<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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**<br>**Well Being of Future Generations Act – 5 ways of working**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Not Applicable<br>Choose an item. |

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

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Regional Partnership Board Update |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Hannah Evans – Executive Director of Strategy, Planning and Partnerships |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Amy Dolben – Assistant Director of Partnership & Integration<br>Rebecca Stanton – Regional Children & Families Transformation Lead |

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

## 1. Sefyllfa / Situation

The Social Services and Wellbeing Act 2014 sets out the requirement for Local Authorities and Local Health Boards to establish Regional Partnership Boards (RPBs), to manage and develop services to secure strategic planning and partnership working. RPBs need to work with wider partners such as the third sector and providers to ensure care and support services are in place to meet the needs of their respective populations.

## 2. Cefndir / Background

This report is provided to the Board for information only to ensure consistent messaging and updates between the RPB and the Health Board.

### 2.1. Welsh Government policy: Regional Integration Fund Audit

Audit Wales has reviewed the Welsh Government's progress in transitioning from the Integrated Care Fund (ICF) to the Regional Integration Fund (RIF). Of the six recommendations related to Welsh Government's management of the ICF made in 2019, five have been fully implemented and one partly completed. The report identifies that the RIF has strengthened long-term planning, improved governance, and supported more consistent monitoring and shared learning across RPBs. However, funding arrangements remain complex, and scrutiny of RPB decisions is still inconsistent – particularly among statutory partners.



The new Audit Wales report concludes that whilst the Welsh Government has made substantial progress, further action is needed to simplify funding, strengthen oversight, and improve financial reporting. Four new recommendations have been issued to address these areas. The full report can be found in **Appendix A.**

## 3. Asesiad / Assessment

### 3.1. Memorandum of Understanding for Trusted Assessor

Following the conclusion of a national Trusted Assessor Audit, Welsh Government requested that all RPBs establish a Memorandum of Understand (MoU) to support the Home First approach to hospital discharge arrangements, including D2RA and Trusted Assessor arrangements by 20 February 2026. An MoU was collaboratively drafted by health and local authority colleagues. Following review of this draft by Welsh Government, the MOU was strengthened in a number of areas including the addition of where Trusted Assessor models are currently in use in Gwent. Work continues within the partnership to further strengthen the opportunities of Trusted Assessor models. The updated version can be found in **Appendix B.**

### 3.2. Youth Board Development

An engagement session was held in March to shape an action plan for establishing an RPB Youth Board for the Children & Families portfolio. The group was clear that the Board should represent more than tokenism, and should provide genuine influence over partnership decisions. The group agreed that next steps would include developing a full action plan, Youth Board Charter and Youth-friendly job descriptions in a summer session to test proposals ahead of a January 2027 plan.

### 3.3. Revenue Portfolio: Updates

A recent impact assessment process identified key outcomes for projects, including development of project initiation documents (PID) or business cases (BC) dependent on funding quantum, or transition plans for post-RIF. Projects have now submitted their PIDs and BCs. The RPB PMO team is reviewing submissions and providing feedback. The next phase will focus on initiating transition planning. The list of projects hosted by the health board, along with the actions required is attached in **Appendix C.**

### 3.4. Neurodivergence Improvement Programme (NDIP) Fund

The RPB has now received the indicative funding allocations for the Neurodivergence Improvement Fund (NDIP). The fund is intended to continue elimination of three-year waits for Children's Neurodevelopmental assessments, with flexibility for health boards already sustaining waits under two years to invest in wider system improvements. ABUHB's allocated amount is £568,536 based on current waiting-time performance, forecast risk, population need and assessment costs. A proposal has been drafted by the Children's Neurodevelopmental Team and will be shared for approval via the RPB prior to allocation. This will seek to maintain the maximum wait of 52 weeks as has already been delivered . The full letter can be found in **Appendix D.**

### 3.6 Revenue Portfolio: 2026/27 Investment Update

Following indicative confirmation of the NDIP, the total RPB revenue allocation for 2026/27 is £31,729,509. This is detailed in full in **Appendix E.**



All RPB funds have been allocated for investment except for those in the following table.

Whilst Unpaid Carers and Dementia will be subject to decision from the relevant Strategic Partnership, due to the value of the NDIP award and in line with RPB governance, RPB will give final signoff.

| **Unallocated Ring-Fenced Funds** | **Total £** |
|---|---|
| Unpaid Carers (Hospital Admission and Discharge) | 2,995 |
| Dementia | 1,195 |
| NDIP *Indicative | 568,536 |
| **Total** | **568,536** |

### 3.7. Capital Portfolio: Housing with Care Fund

There was £12.359m of Housing with Care Fund (HCF) allocated to Gwent in 2025/26, including an additional £750k uplift for Disabled Facilities Grants. In 2025/26, £8.572m of approved schemes were delivered, representing 69% utilisation, primarily impacted by slippage within larger housing schemes and external dependencies such as planning and approvals.

Welsh Government has calculated an allocation of £11.640m for 2026/27 as per the following table. As this is the last year of the fund, payment will be in arrears only.

| **2026/27 Allocation** | **Existing Commitments** | **Pre-payment Commitments** | **Unallocated Budget** |
|---|---|---|---|
| 11,640,000 | 7,672,321 | 1,865,675 | 2,102,004 |

### 3.7.1. HCF Majors

The following tables outlines Health Board projects which have been approved for investment in 2026/27 for the Majors funding.

| **ABUHB-led schemes** | | | |
|---|---|---|---|
| **Division** | **Scheme Name** | **2026/27 Approvals** | **Comments** |
| Family & Therapies | Ty Fforest Crisis Sanctuary Accommodation | £3.04m | ABUHB-led scheme delivering crisis and prevention provision for children and young people. |
| **Status:** | On site and progressing. | **Risk:** | Moderate – linked to additional works and funding alignment. |

| **Schemes in which another organisation is the lead delivery partner** | | | |
|---|---|---|---|
| **Division** | **Scheme Name** | **2026/27 Approvals** | **Comments** |
| Led by Codi Group with input from Mental Health & | Mental Health Step Down Accommodation (MH&LD) | Est HCF approved costs **£594,721** | Development of step-down accommodation to support Mental Health pathways. Scheme progressing through early development stages.<br>Supports ABUHB's strategy.<br>Individuals are provided by ABUHBs core service support. |



| | | | |
|---|---|---|---|
| Learning Disabilities | | | |
| Led by First Choice with input from Mental Health & Learning Disabilities | Ardwyn Supported Living Scheme (MH&LD) | Est HCF approved costs **£1,160,408** | Supported living provision linked to ABUHB placement planning. Accommodation for 6 tenants with LD, with 24-hour support.<br>Scheme progressing, with some risk to delivery timelines and funding drawdown. |

Delivery risk remains contained to a small number of schemes and is primarily associated with timing of approvals, funding alignment and cross-partner dependencies.

### 3.7.2. HCF Minors

The following table highlights a subset of schemes progressing in 2026/27. ABUHB is delivering a portfolio of minor capital schemes focused on targeted estate improvements, clinical environments and prevention-based interventions.

These schemes support service resilience, enable care closer to home and provide specialist equipment to reduce admission and support discharge pathways.

### HCF Minors Health Board projects in 2026/27

| Division | Scheme Name | 2026/27 Approvals | Comments |
|---|---|---|---|
| Family & Therapies | Specialist Children's Beds (ABUHB) | £2000 | Provision of specialist equipment, including beds, to support care at home. Scheme approved and progressing. |
| Mental Health & Learning Disabilities | Adferiad Ward Extra Care Area | £100,000 | |
| | Older Adult Mental Health- AT | £20,000 | |
| **Total** | | **122,000** | |

Risk across the Minors programme is low, with activity largely within ABUHB control and limited exposure to external dependencies.

### 3.8. Capital Portfolio: Integration and Rebalancing Care Fund

### 3.8.1. IRCF Capital

There is £70m of Integration and Rebalancing Care Fund (IRCF) monies available across Wales – this is allocated on an individual business case basis rather than split between regions.

ABUHB is leading the development of integrated health and wellbeing hubs across Gwent, with schemes currently progressing through business case and development phases. The following table outlines ABUHB capital projects which have been approved for IRCF investment in 2026/27.

| Division/ Lead | Scheme Name | 2026/27 Approvals | Status | Comments |
|---|---|---|---|---|
| Primary & Community | Monmouth Health & Wellbeing | £184,605 | Business case development | Dependency: ABUHB strategic estate and service model alignment<br>Risk: Early stage (site and business case) |



| | | | | |
|---|---|---|---|---|
| Care Services | Centre & Dixton Surgery | | | |
| | Aber Valley Health & Wellbeing Centre | £115,000 | Development progressing | Dependency: Integrated delivery model across partners<br>Risk: Site and delivery considerations |
| **Total** | | **£299,605** | | |

### 3.8.2. IRCF Revenue

Welsh Government allocates £250k of IRCF Revenue investment per year to the RPB to support the coordination and development of integrated health and social care hubs through feasibility studies and enabling resources. The following table outlines ABUHB schemes which have been approved for IRCF Revenue funding in 2026/27.

| Division/ Lead | Scheme Name | 2026/27 Approvals | Comments |
|---|---|---|---|
| Family & Therapies | Seren Lodge Feasibility | **£67,110** | Purpose-built perinatal unit in Cheshire, North Wales, dedicated support for new mothers with mental health needs. This piece of work would be looking at potential venues/spaces in Gwent that are being underutilised or would have the potential to adopt a similar model. |
| Mental Health & Learning Disabilities | Project Manager | **£72,000** | Project Manager role would initially, prioritise, looking specifically at the Learning disability market and how innovative projects can be developed with not-for-profit partners. |
| Primary & Community Care Services | Hub Coordinator | **£38,953** | The Hub Coordinator will work across organisation boundaries so that services and teams are able to work in a more holistic way, particularly for people with complex needs or specific vulnerabilities. |
| **Total** | | **£178,063** | |

### 3.9. Strategic Capital Plan (SCP)

Since 2022, the RPB has been required to develop a ten-year SCP that brings together key partners to develop integrated service delivery facilities and integrated accommodation-based solutions across the region. The SCP is subject to annual review and resubmission to Welsh Government. In 2025/26, the SCP was updated to reflect current and emerging regional needs in order to enable targeted investment decisions across Gwent. The SCP refresh followed a structured, evidence-led process supported by the RPB's Strategic Partnerships.

The revised SCP, which is included in **Appendix F**, has identified key opportunities for future capital development across the RPB's key population groups as per the following 'Plan on a Page.'

## 4. Argymhelliad / Recommendation

The Board is asked to note the updates included in this report.

| Appendices | |
|---|---|
| | Appendix A: RIF Audit Report<br>PDF<br>Managing-the-Regional-Integration-Fu |



| | |
|---|---|
| | Appendix B: Gwent Memorandum of Understanding<br><br>Gwent Memorandum of Understanding v0.4<br><br>Appendix C: Revenue Portfolio for Health Board<br><br>Appendix C Health Board hosted RIF pr<br><br>Appendix D: NDIP allocation letter<br><br>ABUHB - Allocation Letter_Eng_Final.pdf<br><br>Appendix E: RPB revenue allocation<br><br>Appendix E RPB whole revenue alloc<br><br>Appendix F: SCP Draft<br><br>SCP DRAFT 004.docx |

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | All Health & Care Standards Apply<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Every Child has the best start in life<br>Getting it right for children and young adults<br>Adults in Gwent live healthily and age well<br>Older adults are supported to live well and independently<br>Dying Well as part of life |



| | |
|---|---|
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Partnership First |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers<br>Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services<br>Choose an item.<br>Choose an item. |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | |
| Rhestr Termau:<br>Glossary of Terms: | **HCF** Housing with Care Fund<br>**ICCS** Integrated Community Care System<br>**ICF** Integrated Care Fund<br>**IRCF** Integration and Rebalancing Care Fund<br>**RIF** Regional Integration Fund<br>**RLG** Regional Leadership Group<br>**RPB** Regional Partnership Board<br>**SCP** Strategic Capital Plan |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment** (EIA) completed | **No does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies<br>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<br>Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs<br>Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves |

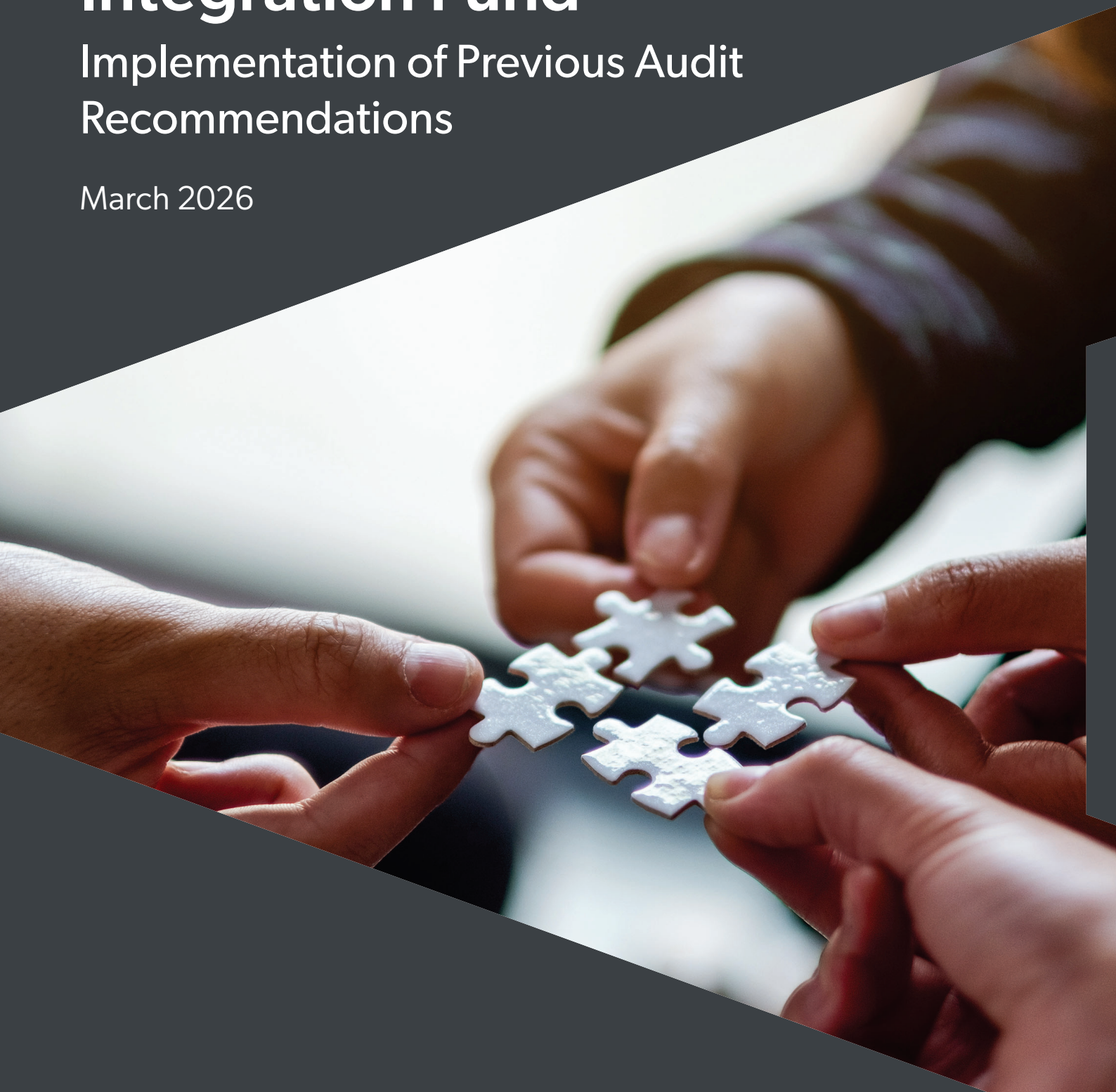


Archwilio Cymru
Audit Wales

# Managing the Regional Integration Fund

## Implementation of Previous Audit Recommendations

March 2026



# 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.

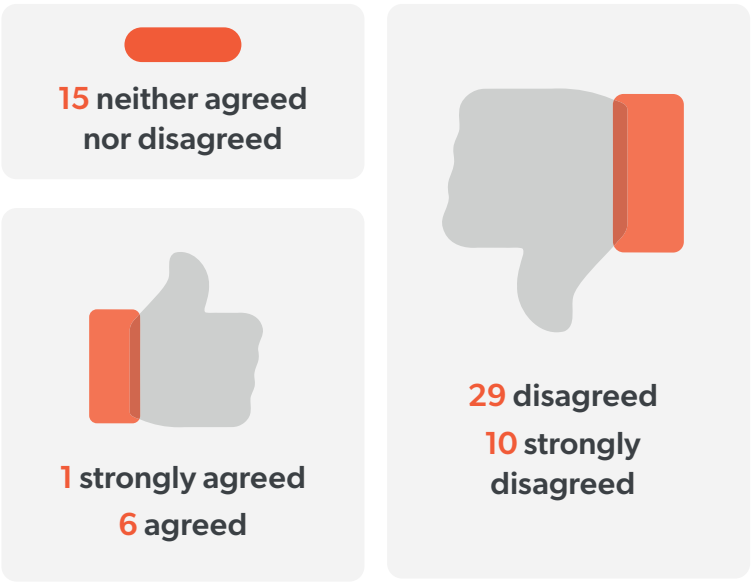
22 Some RPB members responding to our survey felt that the Welsh Government did not issue its guidance early enough to support effective planning. Given the steps the Welsh Government took to develop and embed its RIF guidance (see **paragraph 19**), survey respondents may have been referring to Welsh 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

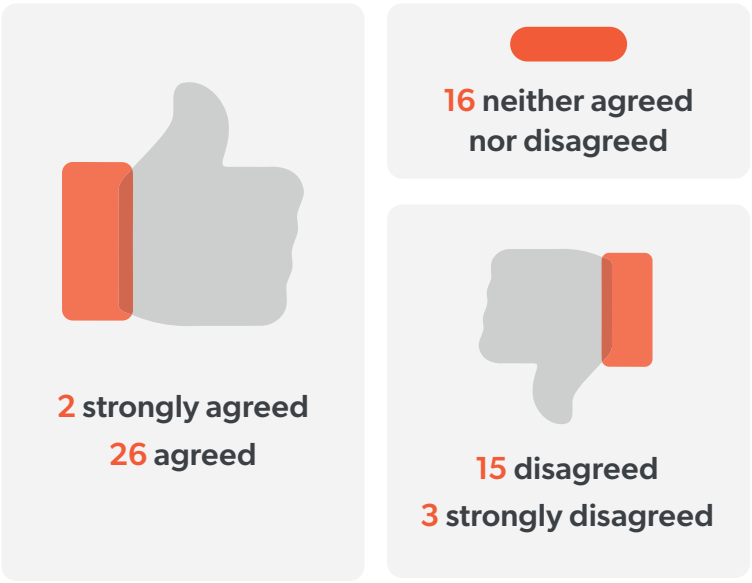
**Funding**

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.

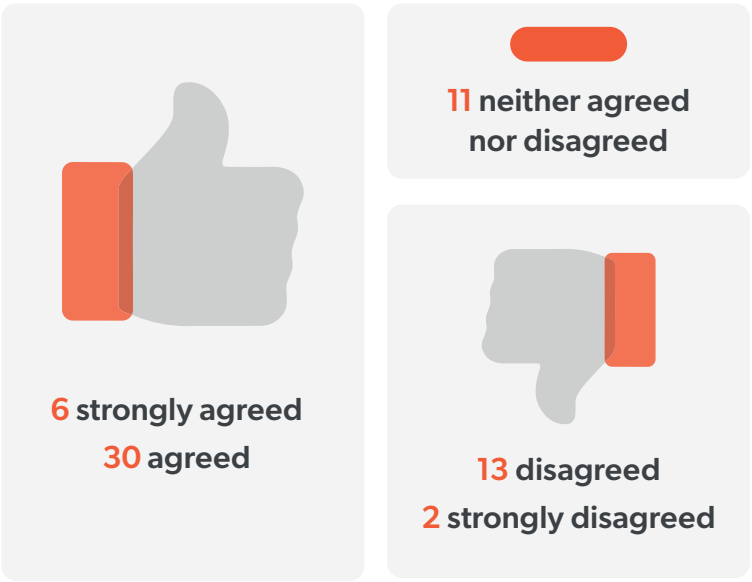
36 The RIF team hold regular meetings with policy leads for relevant programmes to improve integration and develop plans for the Integrated Community Care System.[4] These officials also sit on the RIF Assurance Board where we saw positive examples of information sharing.

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.

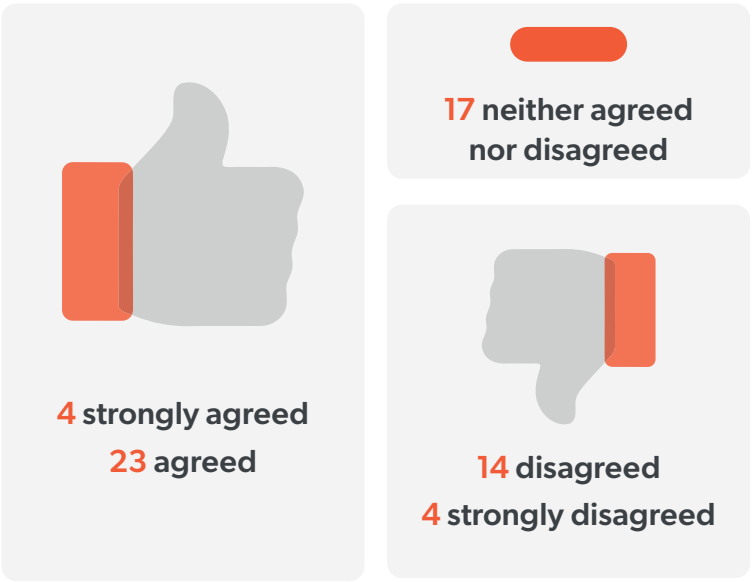
4 Including the Housing with Care Fund, the Six Goals Programme, and the Strategic Programme for Primary Care

**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

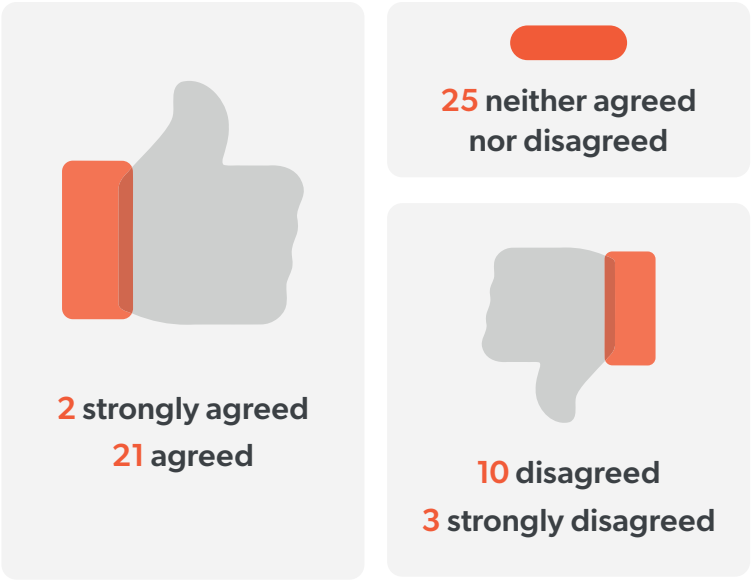
43 The Welsh Government provides formal and informal opportunities to share learning. Its formal arrangements include:

- 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**

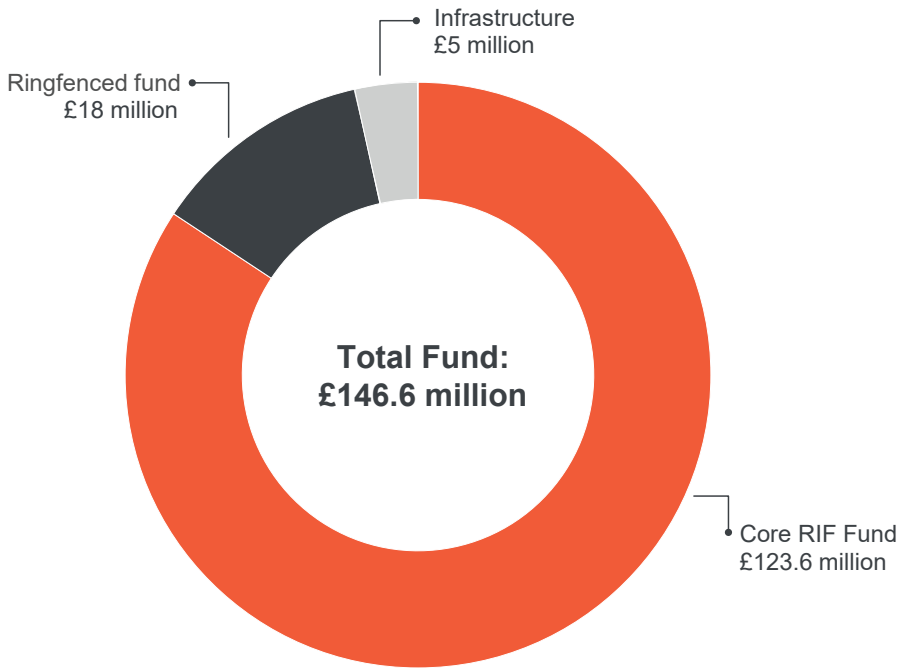
| Funding programme | Value | Duration | Focus |
|---|---|---|---|
| Integration and Rebalancing Capital Fund | £320 million | 2022-23 to 2026-27 | Develop local community care hubs to co-locate frontline health and social care services |
| Integration and Rebalancing Capital Fund – revenue budget | £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

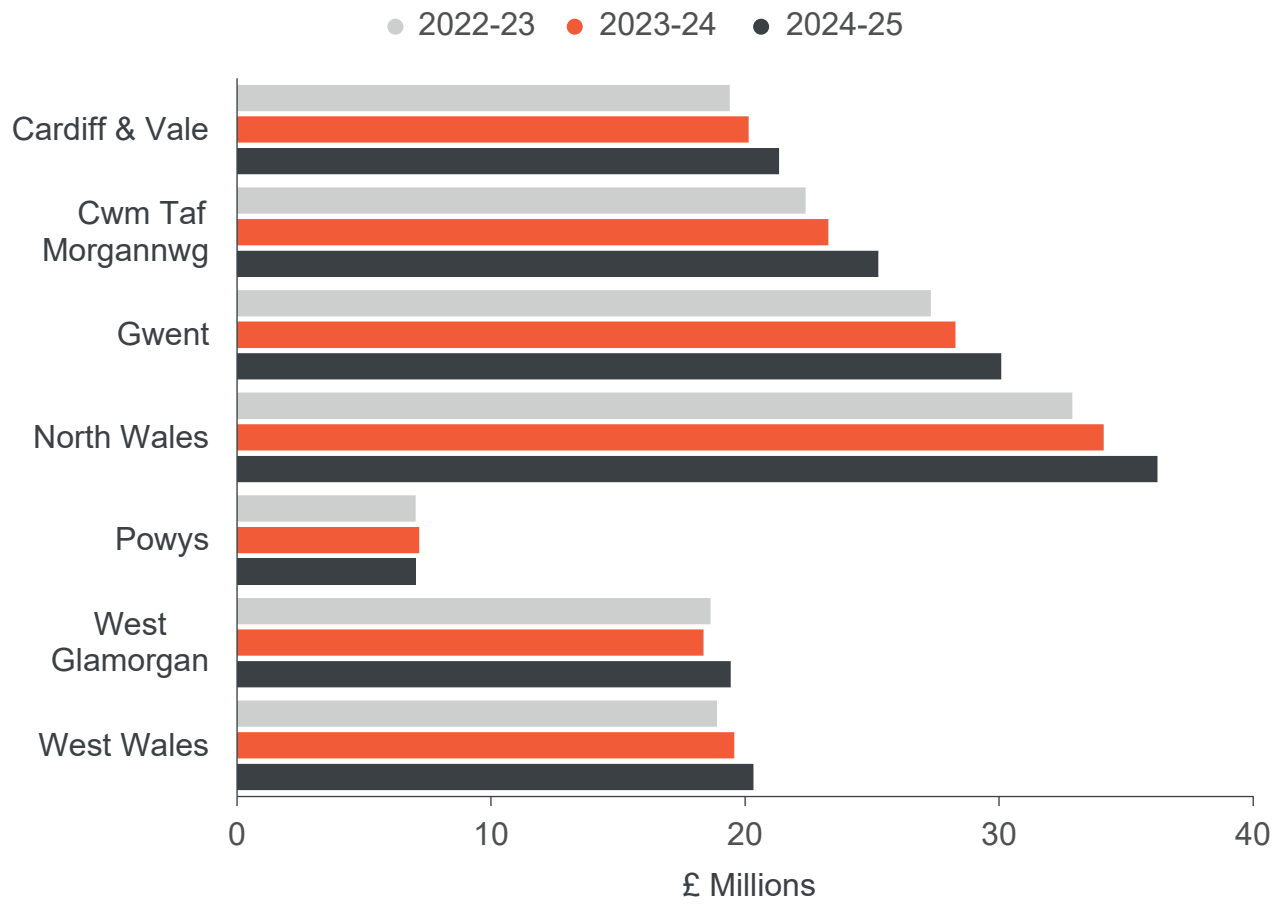
Note: Cwm Taf Morgannwg and Gwent RPBs did not spend their full allocation of £750,000 infrastructure funding in 2024-25.

**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 |

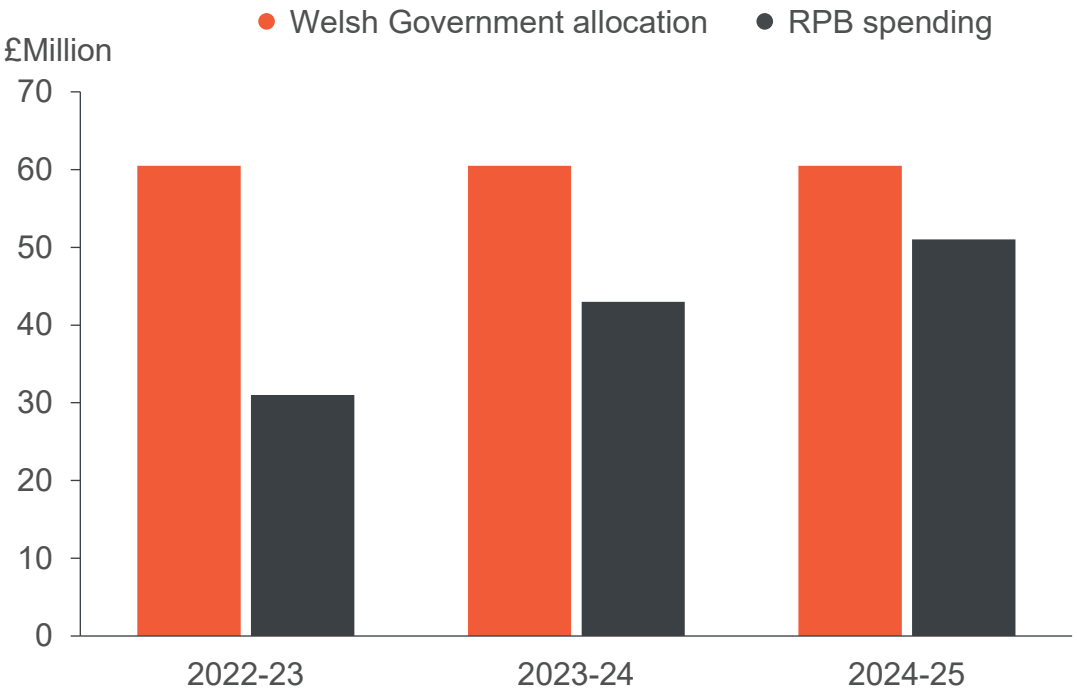
Source: Audit Wales analysis of Welsh Government information

**Exhibit 20: total (core and non-core) RIF spending by RPB, 2022-23 to 2024-25**



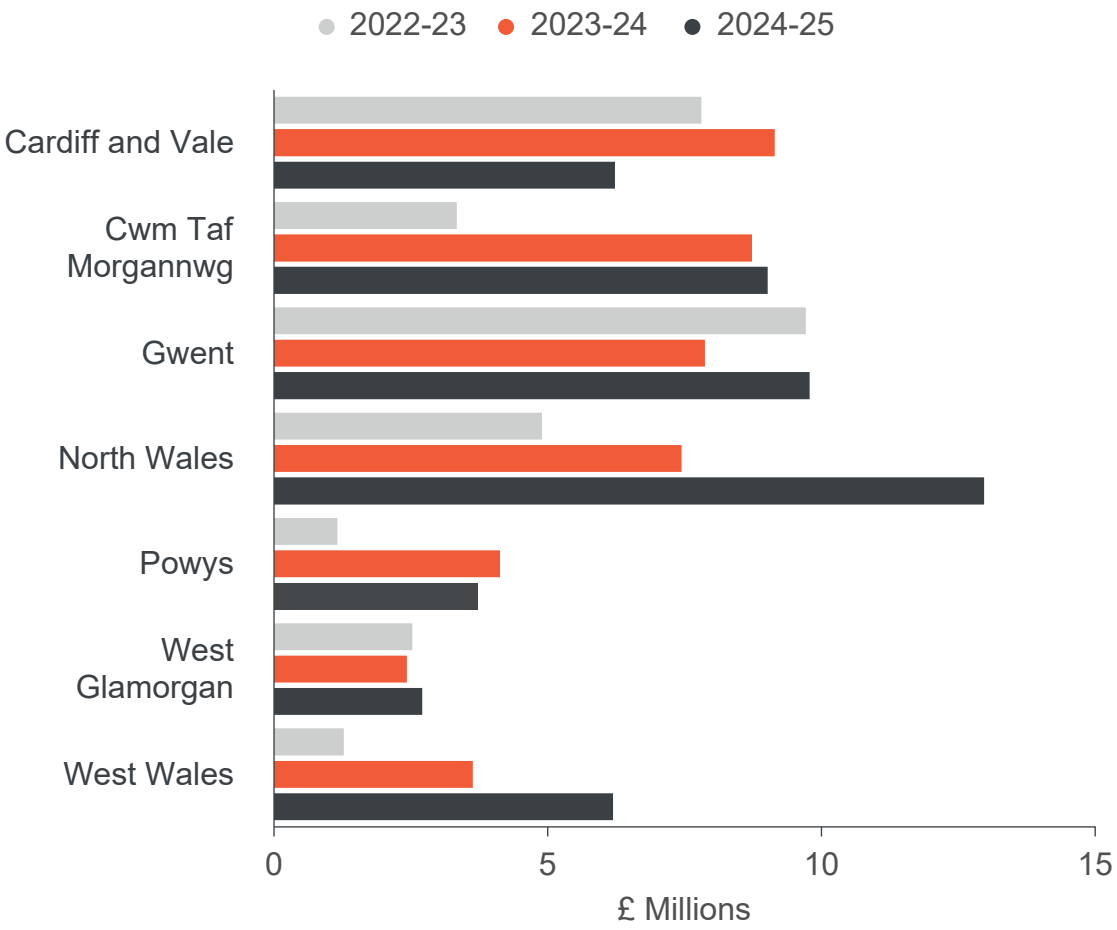

Source: Audit Wales analysis of Welsh Government information

**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. |

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

# Memorandum of Understanding (MOU) for Hospital Discharge in Gwent

## 1. Purpose and Scope

This MOU is established between:

- Aneurin Bevan University Health Board
- Blaenau Gwent County Borough Council
- Caerphilly County Borough Council
- Monmouthshire County Council
- Newport City Council
- Torfaen County Borough Council.

This MOU is intended to support timely, person-centred hospital discharge in Gwent, in line with national guidance and audit recommendations, as well as a key Regional Partnership Board (RPB) priority to improve discharge for our population. People and unpaid carers will be involved in discharge planning with access to advocacy where appropriate, in line with the Social Services and Well-being (Wales) Act. All partners are committed to ensuring that people across Gwent experience the best possible outcomes through high-quality, person-centred discharge processes, with equitable access to services and support regardless of where they live.

## 2. Strategic Context

This MOU supports integrated, person-centred discharge planning across partner organisations through alignment with key national models and policy drivers as per Sections 2.1. to 2.3. Partners are jointly committed to working together to deliver the outcomes set out in national programmes and legislation in Wales, including the Six Goals for Urgent and Emergency Care, the Integrated Community Care System, and the Social Services and Well-being (Wales) Act, ensuring a coherent and consistent approach across the region.

### 2.1. Home First

The Home First model emphasises timely discharge to an individual's home or intermediate care setting once medical treatment has concluded. The model seeks to facilitate a recovery in familiar surroundings, promote continued independence, and mitigate the serious risks associated with extended hospital stays.

In Gwent, the flagship Home First service provides support at the Grange University Hospital (GUH) 'front door' to prioritise early assessment. The service also provides a designated social worker for each local authority to collaborate with acute and community teams – further detail relating to specific roles is provided in 2.3.

### 2.2. Discharge to Recover then Assess (D2RA)

The D2RA model provides four pathways to facilitate timely discharge and ongoing support, ultimately enhancing independence and quality of life for individuals discharged from hospital:

- Pathway 0: No additional support required for discharge
- Pathway 1: Supported home first
- Pathway 2: Short-term supported facility for rehabilitation and reablement
- Pathway 3: Complex support in a bedded facility and a person's own home.

In Gwent, D2RA brings together intermediate care services, rapid response teams, common access points, and third sector support to provide seamless transitions of care and to maximise recovery.

### 2.3. Trusted Assessor

The Trusted Assessor approach is built on principles of proportionality, shared confidence, and professional trust. It enables appropriately skilled practitioners to carry out assessments on behalf of the wider multidisciplinary system, reducing duplication and ensuring decisions are made at the earliest appropriate point.

The approach provides clarity of roles, consistent standards, and transparent communication so that assessments are accepted across teams and organisations. By focusing on functional needs rather than professional boundaries, the approach supports timely, safe and patient-centred discharge planning.

In Gwent, all partners support the principles underpinning the Trusted Assessor function. Across the region, key roles across several workstreams support Trusted Assessor activity as outlined in the following table.

| Locality | Workstream | Description |
|---|---|---|
| **Pan Gwent** | Home First | Home First provides a single point of access for referrals and a single social care team to oversee and determine discharge pathways for patients from all localities at the Grange University Hospital (GUH). |
| **Pan Gwent** | Community Admission Avoidance Therapy Team (CAATT) | CAATT supports hospital and community services through the provision of equipment to enable admission avoidance and timely discharge. |
| **Pan Gwent** | Reablement | Occupational Therapists (OTs) develop reablement plans on behalf of both health and social care partners to support recovery and independence. |
| **Pan Gwent** | GWICES | OTs prescribe complex equipment on behalf of all partners via the Gwent Wide Integrated Community Equipment Service (GWICES). |
| **Pan Gwent** | Balancing Rights and Responsibilities | Partners apply agreed principles to balance individual choice, risk and system responsibilities in discharge decision-making. |
| **Pan Gwent** | Stroke | Health Board stroke services are based at Ysbyty Ystrad Fawr. Social work assistant |

| | | |
|---|---|---|
| | | posts are attached to stroke beds, working on behalf of the five local authorities to support discharge planning. |
| **Pan Gwent** | Acute Frailty Response Unit (AFR) | Advanced Nurse Practitioners operate at the GUH front door alongside CAATT and Home First, applying Trusted Assessor principles to support rapid decision-making. |
| **Pan Gwent** | Facilitating Early Discharge | Complex healthcare assessors undertake rapid assessments to support transfer of Decision Support Tool (DST) processes into the community. |
| **Blaenau Gwent** | Age Cymru | Age Cymru is commissioned to undertake low-level assessments to support timely discharge from hospital. |
| **Monmouthshire & Caerphilly** | Community Resource Team (CRT) | Monmouthshire and Caerphilly operate an OT-led Community Resource Team (CRT) in-reach model to support discharge planning within hospital settings. |
| **Monmouthshire, Newport & Torfaen** | Hospital to Home | Hospital to Home services support individuals following discharge through short-term, community-based interventions. |
| **Torfaen** | Integrated OT Team | The Integrated OT Team supports the provision of equipment and minor adaptations to facilitate safe discharge home. |

## 3. Core Principles

Partners commit to the following principles:

- **Home First, Always:** Independence is the default, with avoidable admissions prevented through early intervention, and discharge planning starting at admission in order to support timely return home or usual place of residence wherever safe.

- **Person at the Centre:** Discharge decisions are shaped around the person's needs, place and existing support system, with a focus on strengths.
- **One Shared Understanding:** Everyone works from the same information using consistent meeting formats and shared data set to support decision-making.
- **Clear Roles and Accountability:** Escalation routes and responsibilities are defined to ensure timely, coordinated action with assessment to take place in the community wherever possible and intervention and / or services to be considered as a last resort.
- **Whole-System Approach:** A single discharge approach applies across all services and for all population groups.

## 4. Roles and Responsibilities

### 4.1. Health Board responsibilities

The Health Board will:

- **Lead Clinical Decision Making:** Determine medical fitness for discharge and ensure timely documentation of expected discharge dates (EDDs), consistent with operational expectations around accurate EDD reporting.
- **Coordinate Multidisciplinary Discharge Planning:** Ensure ward and community teams follow agreed discharge processes, including specialist assessments, liaison with therapy services, and continuity of care. Provide updated clinical information, risk assessments, and treatment summaries, following standards in the Transfer and Discharge of Care Protocol.
- **Ensure Timely Communication:** Share required documentation with Adult Social Care early in the discharge pathway (e.g., referral forms, clinical summaries, risk assessments). Notify Adult Social Care of changes in a person's condition that may affect discharge arrangements.
- **Support Flow & Escalation:** Work with Adult Social Care to address delays in accordance with the Escalation Framework (as per Appendix 1), including through daily discharge reviews and system wide escalation where needed.

- **Safeguarding & Legal Duties:** Ensure compliance with safeguarding, Mental Capacity Act requirements, and best interest processes.

### 4.2. Adult Social Care responsibilities

Adult Social Care will:

- **Assess Social Care Needs Promptly:** Complete assessments where there appears to be a need for care and support, in line with statutory duties and within timescales needed to support timely discharge.
- **Lead on Social Care Provision:** Take primary responsibility for arranging appropriate ongoing social care support following discharge, ensuring that post-discharge plans reflect the individual's needs and preferences.
- **Provide Timely Communication & Participation:** Participate in discharge planning meetings either remotely or in person and contribute to clear decision making for people. Escalate delays or barriers through agreed processes.
- **Support Risk Management Discussions:** Engage in addressing risks of delayed discharge, including reluctant or disputed discharges, consistent with expectations for local authority involvement in resolving such cases.
- **Safeguarding & Legal Duties:** Fulfil all statutory safeguarding responsibilities and support joint risk management frameworks.

### 4.3. Joint responsibilities

All statutory partners will:

- **Undertake Early Discharge Planning:** Begin discharge planning from the point of admission to ensure that expectations, actions, and required support are identified as early as possible, enabling timely and coordinated discharge.
- **Share Information Lawfully and Securely:** Provide all relevant information to partners in line with legal, governance, and data sharing requirements, ensuring that timely and accurate details support safe and effective discharge decisions.

- **Maintain Clear Documentation:** Record all decisions, actions, and assessments consistently within organisational systems to ensure shared understanding, reduce duplication, and support continuity of care across the discharge pathway.
- **Ensure Staff Awareness of Protocols:** Equip staff with the knowledge and confidence to follow agreed discharge processes, supported by joint training and development where required to promote consistent practice across organisations.
- **Resolve Disputes Promptly:** Address delays or disagreements quickly through named operational leads, ensuring that challenges are escalated appropriately and resolved without impacting patient safety or flow.
- **Review Discharge Pathways Regularly:** Monitor and evaluate discharge processes on an ongoing basis to identify improvement opportunities, enhance efficiency, and optimise the experience and outcomes for individuals.
- **Plan for Contingency and Surge Pressures:** Work collectively during periods of system pressure, including winter and surge events, with agreed triggers and coordinated actions.

### 4.4. RPB responsibilities

The RPB will:

- **Provide Governance and Oversight:** Lead the strategic governance of the MOU by monitoring implementation, ensuring accountability across partners, and overseeing progress against agreed priorities to support consistent and effective delivery.

## 5. Governance and Oversight

The Gwent Adults Strategic Partnership (GASP) will provide overall system oversight of the implementation of this Memorandum of Understanding (MOU). GASP will be responsible for monitoring progress against agreed outcomes, managing system-level risks, and ensuring accountability across partners. GASP will report routinely through the Regional Partnership Board (RPB) governance arrangements and, where required, through individual statutory partners' internal governance processes.

At the commencement of this MOU – and refreshed on an annual basis – partners have collectively agreed on a single joint work plan, which is the Pathway of Care Delays (POCDs) Action Plan, setting out shared priorities and system improvement activity. The plan will be operationally managed through the Integrated Discharge Board (IDB), with strategic oversight and assurance from GASP and reported onward to the RPB, as well as individual partner governance mechanisms. The table below provides a high-level overview of the key improvement priority within the joint work plan for the next year.

| | |
|---|---|
| **Key Priority: Community Assessments** | Building on the learning from Caerphilly the ambition is for registered professionals to undertake proportionate assessments in hospital to facilitate discharge to a community based assessment service,<br><br>Key performance measures: reduction in assessment delays for both health and social care, decreased length of stay. |

The Integrated Discharge Board (IDB) will routinely monitor delivery of the joint plan against an agreed suite of key performance indicators (KPIs). Review of performance will be a standing agenda item at each IDB meeting. Performance reports will be shared regularly with the Gwent Adults Strategic Partnership (GASP) and escalated, where appropriate, through the Regional Partnership Board (RPB) governance arrangements as well as individual partner escalation routes to provide assurance, identify system risks and support timely corrective action.

The core performance metrics will be drawn from the POCD Census dataset, enabling consistent system-wide monitoring and comparison. These metrics will include:

- POCDs by delay owner
- POCDs by hospital site
- POCDs by locality
- POCD reason categories by delay owner

The POCD dataset will be reviewed periodically to ensure it remains aligned with agreed priorities and supports continuous improvement across the system.

## 6. Operational Framework

Partners commit to using the agreed tools, documentation and workstreams set out in the followng table to support consistent, multidisciplinary working across the Gwent health and social care system. These tools and workstreams define the expected operational approach to hospital flow, discharge planning, lengths of stay, prevention of deconditioning and hospital-to-home pathways. They will be used routinely by frontline services, managers and system leaders, unless an alternative approach is formally agreed through the governance arrangements set out below.

| **Tools and Documentation** | **Workstreams (including Six Goals for Urgent and Emergency Care Goals 5 and 6 and Stay Well at Home)** |
|---|---|
| • Hospital Discharge Policy<br>• Care Home Choice Policy<br>• Criteria Led Discharge Protocol<br>• Management Reluctant Discharge Transfer of Care to a More Appropriate Care Setting Guidance (All Wales) Policy<br>• Standard Operating Procedure Length of Stay Meeting<br>• Standard Operating Procedure Complex List<br>• Optimal Hospital Flow Tools, including D2RA, Red to Green, SAFER and preventing deconditioning | • Optimal Hospital Flow Framework<br>• Criteria Led Discharge<br>• Prevention of Deconditioning<br>• Data and Digital<br>• End of Life Care<br>• Pathway of Care Delays / Action Planning<br>• Hospital to Home<br>• Length of Stay Review Meetings / Scrutiny Panel |

Partners will operationalise this Framework through joint Health Board and local authority leadership of the relevant workstream within the IDB governance structure.

Partners acknowledge that, on occasion, there will be differences of professional or organisational judgement in applying the Operational Framework.

Where disagreements arise:

- **Operational resolution:** Issues should first be addressed at the appropriate operational forum (e.g. MDT, Length of Stay Review Meeting, Scrutiny Panel) using agreed policies and tools.
- **Managerial escalation:** If unresolved, the matter will be escalated to the relevant system or workstream lead for resolution within an agreed timeframe.

Decisions will be guided by the Core Principles outlined in Section 3 and will follow the Escalation Framework included in Appendix 1.

## 7. Information Sharing

Information will be shared in compliance with GDPR and data-sharing agreements, using secure systems and consent-based protocols.

Partners acknowledge the current limitations in sharing electronic records across organisations and commit to collectively identifying and implementing solutions to improve information accessibility and interoperability.

## 8. Workforce Development

Partners will deliver joint training programmes, promote cross-sector understanding, and support staff wellbeing and capacity.

This includes continuing to support workforce development on care homes, joint training for Community Resource Teams, and focused development on areas such as falls prevention.

## 9. Funding and Resources

Partners will continue to honour their existing financial commitments, with funding schedules reviewed through established programme workstreams to ensure the delivery of integrated services. Future financial planning will be informed by demand and capacity analysis. Opportunities to secure efficiency savings will be actively pursued, with any realised savings reinvested.

While the Regional Integration Fund (RIF) currently provides essential support for several community and intermediate care services, partners recognise the significant risk associated with planned cessation of funding on 31 March 2027. The withdrawal of RIF could create a substantial financial gap, jeopardising the sustainability of services that underpin hospital flow, prevention, and community resilience. As such, partners commit to proactively assessing the scale of this risk, exploring alternative funding options, and planning mitigations to safeguard critical services should RIF support cease.

## 10. Communication and Engagement

Internal communication will ensure staff awareness. External communication will inform patients and carers, as well as key external partners, including Welsh Government. Feedback mechanisms will support service improvement.

At the outset of the MOU (and updated annually), a structured communication plan will be developed to support consistent and timely messaging across the system.

## 11. Risks and Mitigation Strategies

| Risk | Mitigation Strategy |
|---|---|
| **Lack of engagement** | • Involving operational teams at the earliest opportunity<br>• Developing and implementing a communications plan for internal and external stakeholders |
| **Data sharing issues** | • Ensuring adherence to GDPR-compliant protocols<br>• Identifying and implementing solutions to improve information accessibility and interoperability |
| **Funding gaps, including RIF** | • Developing and implementing contingency plans to prepare for potential reductions in funding, including modelling the impact of the RIF ending and |

| | |
|---|---|
| | identifying priority services that require sustained investment.<br>• Undertaking joint advocacy across partners to secure alternative funding streams and influence national discussions |
| **Role confusion** | • Clarifying and documenting roles and responsibilities via a communications plan to ensure a shared understanding across partners, reducing duplication and strengthening accountability throughout the discharge pathway<br>• Continuing to support workforce development to embed consistent practice, improve cross□sector understanding, and reinforce the shared operating model |
| **Cultural misalignment** | • Promoting the shared values and principles outlined in 3. to build alignment in expectations and approaches across organisations, enabling smoother multidisciplinary working |

## 12. Review and Evaluation

This MOU shall commence in February 2026. For clarity, partners may treat 20 February 2026 as the formal start date of the agreement (or another specific date in February 2026 as mutually confirmed in writing).

The MOU will be reviewed following six months of implementation, and thereafter will be reviewed annually. All partners will review this MOU in September 2026 through GASP. The review will assess the outcomes of the collaboration, the continued relevance of the objectives, and whether any changes to partnership arrangements are needed.

The status of the MOU is as follows:

- **Nature of Agreement:** This document is a statement of intent to work in partnership. It is not a legally binding contract. The MOU does not create legal obligations or enforceable rights for any partner. Instead, it outlines how the partners intend to collaborate and coordinate their efforts.
- **Good Faith Commitment:** Although not legally binding, all partners enter into this MOU in good faith and intend to honour all their commitments. The success of this collaboration relies on mutual trust and partners' dedication to follow through on agreed actions.
- **Governing Law:** This MOU, as a voluntary understanding, is not governed by any specific contractual law. However, partners acknowledge that they are each subject to the laws and regulations applicable to their operations. Partners will ensure that their collaborative activities under this MOU conform to all applicable laws, including those relating to data protection, equality, and health and safety.
- **Resolution of Differences:** Any differences in interpretation of this MOU or disputes arising from it will be resolved amicably through discussion between partners. Partners are committed to working together to overcome any disagreements in the spirit of cooperation and the shared goals of this MOU.

## 13. Signatories

| Organisation | Name | Role |
|---|---|---|
| Aneurin Bevan University Health Board | | CEO |
| | | Director of Nursing |
| Blaenau Gwent County Borough Council | | CEO |
| | | Director of Social Services |
| Caerphilly County Borough Council | | CEO |
| | | Director of Social Services |
| Monmouthshire County Council | | CEO |
| | | Director of Social Services |
| Newport City Council | | CEO |

| | | |
|---|---|---|
| | | Director of Social Services |
| Torfaen County Borough Council | | CEO |
| | | Director of Social Services |

Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

## Appendix 1: Escalation Framework



Escalation Framework.docx

# Appendix C: Summary of RIF revenue Health Board hosted projects

| Summary of RIF revenue Health Board-hosted projects for 2026/27 | | | |
|---|---|---|---|
| **Division** | **Scheme** | **Action** | **Gwent RPB Allocation 2026/27** |
| Corporate Services (Chief Operating Officer) | PTCS (Patient Transport Clinical Support) | Transition Plan | £209,057 |
| Corporate Services (Nursing) | Infection Prevention & Control - Care Home In-reach | Transition Plan | £267,500 |
| Corporate Services (Planning) | Unpaid Carers Project Resource | PID/BC | £70,000 |
| Corporate Services (Public Health) | Gwent Emotional and Mental Wellbeing Programme | Transition Plan | £150,250 |
| | Integrated Wellbeing Networks (IWN) | Transition Plan | £656,426 |
| Estates & Facilities | Transport to Health Scheme | SP Discussion | £109,200 |
| Family & Therapies | SPACE Wellbeing | Transition Plan | £111,423 |
| | Family Intervention Team (FIT) | PID/BC | £154,200 |
| | Children's Centre Psychology | Transition Plan | £174,414 |
| | Speech & Language Therapy Community Capacity | Transition Plan | £180,518 |
| | Development of an Early Help Neuro-Diversity Team | Transition Plan | £199,998 |
| | Intensive Positive Behavioural Support (IPBS) | Transition Plan | £200,000 |
| | Expansion of Gwent Attachment Service (GAS) | Transition Plan | £200,871 |
| | Integrated Assessment And Planning (ISCAN / IAP Pilot) | Transition Plan | £269,589 |
| | Neuro-Community Service | PID/BC | £701,991 |
| Mental Health & Learning Disabilities | Reducing Health Inequalities | Transition Plan | £155,272 |
| | Mapping, Education and Carers Service (MECS) | Transition Plan | £205,579 |
| Primary Care & Community Services | Additional support for primary care mental health team | Transition Plan | £45,000 |
| | Hospital Admission Avoidance Project (HAAP) | Transition Plan | £68,000 |
| | D2RA – Newport | Transition Plan | £95,200 |
| | Step Up-Down Beds – Caerphilly | PID/BC | £117,629 |
| | D2RA - Blaenau Gwent | Transition Plan | £123,877 |
| | D2RA – Torfaen | Transition Plan | £124,800 |
| | Compassionate Communities Hub Capacity - Newport | Transition Plan | £207,805 |
| | Health Inclusion Service | Transition Plan | £217,084 |
| | GP Alignment & HRAC delivery | Transition Plan | £256,054 |
| | Patient Flow – ABUHB | Transition Plan | £258,004 |
| | Grange University Hospital (GUH) Discharge Team | Transition Plan | £303,282 |
| | CRT Pharmacy Project | Transition Plan | £639,126 |
| | Falls Response Unit | PID/BC | £854,429 |
| | Fast Track / End of Life Dom Care | Transition Plan | £66,205 |
| | Hospital to Home (H2H) | Transition Plan | £1,006,809 |
| Urgent Care | ED Wellbeing and Home Safe Service at GUH | Transition Plan | £247,319 |
| **TOTAL** | | | **£8,646,911** |

# Appendix C: Summary of RIF revenue Health Board hosted projects

| Summary of other RPB revenue funded Health Board-hosted projects for 2026/27 | | | | |
|---|---|---|---|---|
| **Division** | **Scheme** | **Funding Stream** | **Required Actions** | **Gwent RPB Allocation 2026/27** |
| Corporate Services (Nursing) | Regional Dementia Programme Manager | Dementia Ring-Fenced | PID/BC | £55,548 |
| | Weekend/Bank Holiday Specialist Palliative & End of Life Care Nursing | Further Faster | Further Faster not assessed | £140,000 |
| Corporate Services (Planning) | Regional Support Team PMO | Regional Infrastructure Fund (plus £280,782 RIF revenue) | Infrastructure Fund not assessed | £442,816 |
| Corporate Services (Public Health) | Intelligence Function | Regional Infrastructure Fund | Infrastructure Fund not assessed | £186,800 |
| Mental Health & Learning Disabilities | Dementia Connectors | Dementia Ring-Fenced | PID/BC | £100,000 |
| | Mapping, Education and Carers Service (MECS) | Dementia Ring-Fenced | Transition Plan | £117,271 |
| | MAS: Consultant Capacity | MAS Ring-Fenced | PID/BC | £149,712 |
| | Memory Rehabilitation | Dementia Ring-Fenced | Transition Plan | £261,330 |
| | MAS: Advance Nurse Practitioners | MAS Ring-Fenced | PID/BC | £315,325 |
| | Integrated Autism Service | IAS Ring-Fenced | Transition Plan | £571,286 |
| Primary Care & Community Services | CRT Monmouthshire | Further Faster | Further Faster not assessed | £366,556 |
| | Weekend Community Nursing | Further Faster | Further Faster not assessed | £550,000 |
| | Acute Frailty Response/ CRT | Further Faster | Further Faster not assessed | £873,528 |
| Surgery | MAS: Audiology MDT approach | MAS Ring-Fenced | PID/BC | £99,962 |
| **TOTAL** | | | | **£4,230,134** |

Llywodraeth Cymru
Welsh Government

To: CEO  AB University Health Board
Cc: Chair Regional Partnership Board

*Ref: MA/SM/0742/26*

March 2026

Dear colleagues,

Following my recent letter setting out priorities and expectations for the Neurodivergence Improvement Programme (NDIP) in 2026-27, I am writing to confirm the indicative funding allocations.

As outlined previously, a total of £5.6m will be made available in 2026-27 to support the maintenance of the elimination of three-year waits for children's neurodevelopmental assessments, while providing flexibility for health boards sustaining waits of less than two years to invest in wider system improvement.

The indicative allocation for 2026-27 is as follows:

| **Health Board** | **Allocation** |
|---|---|
| ABUHB < 52 weeks | 568,536 |

This allocation reflects current waiting-time positions, forecast risk, and the need to balance national performance protection with fairness to health boards that have already delivered sustained improvement. The allocations for 2026-27 are based upon the total amount available against the population waiting X the cost of an assessment and local information to ensure that the funding envelope is maximised.

Funding is provided on the expectation that health boards will continue to:

- Ensure no child waits more than three years for assessment.
- sustain two-year waits where these have already been achieved; and
- deliver agreed efficiency and pathway improvements, supported by clear delivery plans and ongoing engagement with NHS Performance and Improvement.

The approach taken is intended to support greater parity and equity for all children who need a neurodevelopmental assessment, helping to reduce unwarranted variation across Wales.

I recognise that this is an ambitious expectation and will require health boards to continue to look creatively and pragmatically at how they maximise efficiency, make best use of available capacity, and streamline pathways within existing resources.

If you have any questions about the allocations or the expectations set out, officials would be happy to discuss these with you.

Yours sincerely



Signed by:
**Shelley Davies**
**Deputy Director Future & Integration**
Health, Social Care and Early Years
under authority of the Cabinet Secretary for Health and Social Services one of the Welsh Ministers.

## Appendix E: RPB Total Revenue allocation

| Funding Stream | 2026/27 Funding | Notes |
|---|---|---|
| RIF Core Funding | £23.28m | |
| Ring-Fenced Funding | £3.28m | These funding streams are as follows:<br>• **Integrated Autism Service (IAS):** To provide multi-agency specialist autism service and funds IAS within the Health Board<br>• **Dementia, MAS, Community Connectors:**<br>• **Unpaid Carers (Hospital Admission and Discharge:** To provide ringfenced RIF funding for unpaid carers<br>• **Short Breaks for Carers:** To provide additional opportunities for unpaid carers to have a break from their caring role and has funded Bridging the Gap Gwent.<br>• **Integrated Autism Service (IAS):** To provide multi-agency specialist autism service and funds IAS within the Health Board<br>• **Dementia, MAS, Community Connectors:**<br>• **Unpaid Carers (Hospital Admission and Discharge:** To provide ringfenced RIF funding for unpaid carers<br>• **Short Breaks for Carers:** To provide additional opportunities for unpaid carers to have a break from their caring role. |
| RIF Regional Infrastructure Fund | £0.75m | To ensure the RPBs are sufficiently resourced to deliver against statutory duties.<br><br>Partly funds Regional Partnership Team, Regional Support Team PMO and Intelligence Function. |
| **Total RIF and Ring-Fenced Funding** | **£27.32m** | |
| Further Faster Funding | £2.29m | To support three service areas:<br><br>1. Weekend Community Nursing<br>2. Future Care Planning for 0.5% people most at risk of Urgent Care<br>3. Community capacity. |
| Neurodivergence Improvement Programme (NDIP) | £0.57m | To:<br>• Ensure no child waits more than three years for assessment<br>• Sustain two-year waits where these have already been achieved.<br><br>Deliver agreed efficiency and pathway improvements, supported by clear delivery plans and ongoing engagement with NHS Performance and Improvement. |
| **Total RIF and Ring-Fenced Funding (including Further Faster)** | **£30.18m** | |
| Allied Health Professional (AHP) Funding | £0.85m | To increase community and primary care based AHP posts and the capacity of AHPs as an integral, but underutilised, part of community teams.<br><br>Made available to health boards and awarded directly to ABUHB. |
| IRCF Revenue | £0.45m | To build regional capacity to support the development of integrated health and social care hubs and implementation of IRCF. |

## Appendix E: RPB Total Revenue allocation

| | | |
|---|---|---|
| | | Aligned to capital activity and subject to approval by RPB in March 2026. |
| Regional Innovation Co-ordination Hubs | £0.25m | To support regional capacity and allow RPBs to deliver a coordinated programme of innovation activity that aligns with and delivers against the strategic ambition of Wales Innovates: Creating a Stronger, fairer, Greener Wales and develops an innovation ecosystem for health and social care that operates at the regional and national levels.<br><br>Funds the Gwent Regional Innovation Coordination Hub within ABUHB. |
| **Total RPB Funding Allocation** | **£31.73m** | |

# STRATEGIC CAPITAL PLAN 2024–34

Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

## 2026/27 UPDATE

STRATEGIC CAPITAL PLAN

# PLAN ON A PAGE

Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

## VISION FOR GWENT

Integrated health, social care and housing infrastructure, enabling people to live independently and receive care close to home.

### CHILDREN & YOUNG PEOPLE

- Small therapeutic homes
- Respite and short-break accommodation
- Care-leaver supported housing

### ADULTS (MH&LD, ND, COMPLEX NEEDS)

- Supported living schemes
- Crisis accommodation
- Specialist neurodiversity environments

### OLDER ADULTS & DEMENTIA

- Extra care housing
- Dementia-friendly environments
- Adaptations and technology-enabled homes

### INTEGRATED HUBS

- Prevention and early intervention
- Multidisciplinary neighbourhood services
- Carer support and wellbeing services
- Community mental health and therapy services

### ANTICIPATED IMPACT

- Stronger early intervention, less crisis escalation
- Reduced out-of-area spend and improved market stability
- Improved access, equity and service integration
- Modern, future-proofed estate aligned to long-term need

### IMMEDIATE (0–1 YEARS)

- Pilot 1–2 bed children's homes
- Adaptation programmes
- Initial community hubs

### MEDIUM TERM (2–4 YEARS)

- Supported living expansion
- Step-up / step-down environments
- Extra care schemes

### LONG TERM (5–10 YEARS)

- Full hub network
- Major integrated developments
- Expanded residential capacity

**Abbreviations**

| | |
|---|---|
| **ALN/SEN** | Additional learning needs or special education needs |
| **HCF** | Housing with Care Fund |
| **IRCF** | Integration and Rebalancing Capital Fund |
| **LPMHSS** | Local Primary Mental Health Support Services |
| **RPB** | Regional Partnership Board |
| **SCP** | Strategic Capital Plan |
| **SP** | Strategic Partnership |
| **SSWBA** | Social Services and Wellbeing (Wales) Act 2014 |

## 1. Introduction

Regional Partnership Boards (RPBs) have been identified as critical vehicles to lead the development of a joined-up approach to planning health, social care and housing capital investment that can enable seamless service delivery closer to home.

RPBs were established under the Social Services and Wellbeing (Wales) Act 2014 (SSWBA) to facilitate the strategic partnership arrangements between a local health board and one or more local authorities. *A Healthier Wales*, the Welsh Government's Long-term Plan for Health and Social Care, positions RPBs in a key leadership role to drive forward health and social care integration.

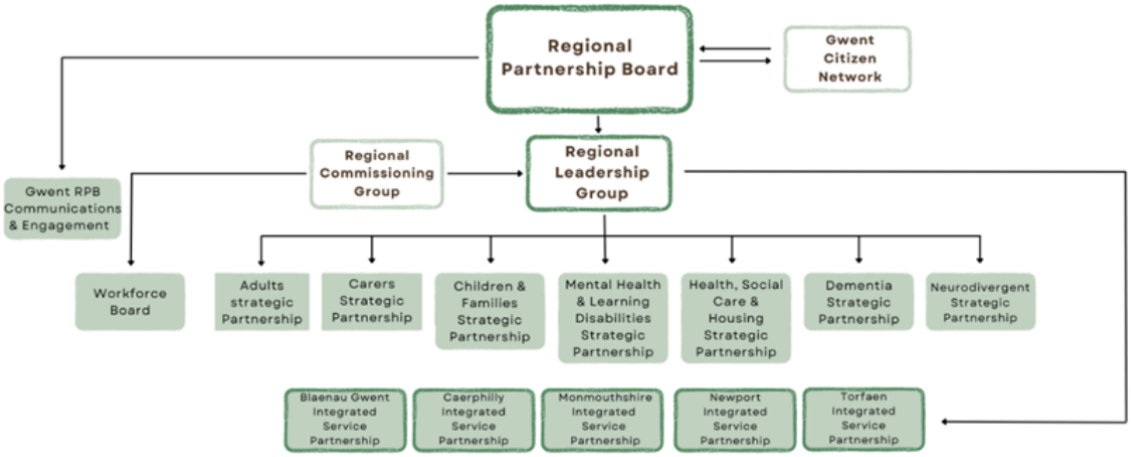
The Gwent Regional Partnership Board (RPB) is made up of Aneurin Bevan University Health Board, Blaenau Gwent County Borough Council, Caerphilly County Borough Council, Monmouthshire County Council, Newport City Council, Torfaen County Borough Council Welsh Ambulance Services NHS Trust, housing, third and independent sectors and carer representatives. We work together for a healthier Gwent with the aim of ensuring that our population receives the right care and support, in the right place, at the right time.

We do this through strategically planning, managing, and developing effective care and support services to improve the outcomes and well-being of priority population groups identified in the SSWBA. We facilitate cross-sector strategic planning around capital investment for health and social care related-services and facilities, as well as the broader co-location of key services.

Within this context, the Strategic Capital Plan (SCP) sets out a shared ten-year vision for capital investment in Gwent. It provides the strategic framework for planning and prioritising capital investment in accommodation, community facilities, integrated hubs, adaptations and enabling infrastructure – with the aim of supporting integrated ways of working that enable people to remain at home or as close to home as possible. The SCP provides a shared commitment across RPB partners to increase in-region provision, eliminate profit through expansion of local authority/not-for-profit capacity, and develop population-specific integrated hubs.

### *1.1. Developing the Refreshed SCP*

In 2025/26, the SCP was updated to reflect current and emerging regional needs in order to enable targeted investment decisions across Gwent. The SCP refresh followed a structured, evidence-led process supported by the RPB's Strategic Partnerships (SPs) – these are aligned to priority population groups within the SSWBA and sit within the RPB governance structure.




As experts in the needs of their population groups and with representation from key partner organisations, SPs first reviewed statutory assessments to establish a shared baseline. Comprehensive mapping was then undertaken with SPs and citizens to identify existing assets, gaps and opportunities across priority population groups. Intelligence was aligned and synthesised to highlight cross-cutting needs and inform population-specific gap analyses.

In addition to the population-specific SPs, the dedicated Health, Social Care and Housing SP provides a forum for partners across local authorities, the Health Board, housing providers and the voluntary sector to consider the wider accommodation system that supports health and care needs across Gwent. Through this partnership, a number of cross-cutting issues have been identified that influence the availability, sustainability and effectiveness of accommodation models across the region. These include increasing demand for supported housing, pressures within the care and housing market, and challenges in aligning capital investment with revenue funding and workforce capacity. The insights from this partnership provide an important system perspective that complements the population-specific analyses.

### *1.2. Our Strategic Context*

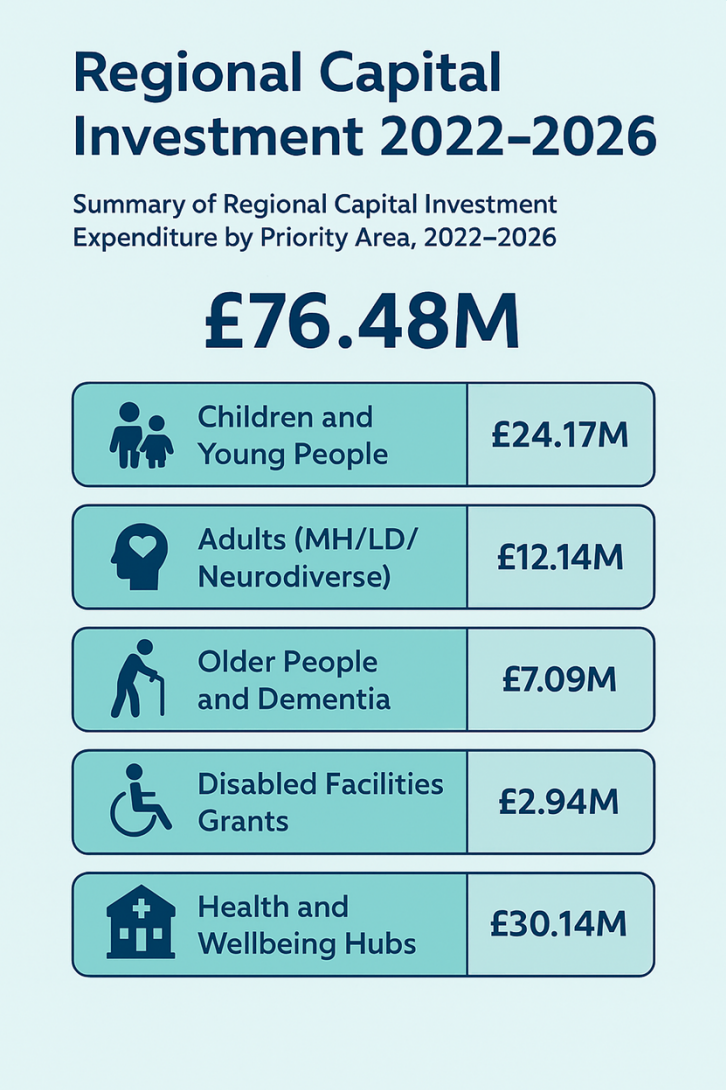
The SCP is shaped by a clear national direction that prioritises integration, prevention and sustainable, community-based care. The SSWBA, the Wellbeing of Future Generations Act and A Healthier Wales provide partners with a vision to work collectively to design seamless models of support grounded in shared evidence and long-term planning.

Regionally, the Population Needs Assessment, Joint Strategic Needs Assessment and Gwent Area Plan provide a robust foundation for understanding demographic change, service pressures and market capacity. These documents and datasets provide us with an understanding of existing and emerging needs across Gwent, and have helped us to develop of strong evidence-base for future capital investment in the region.

This evidence base underpins the development of an Integrated Community Care System and strengthens our commitment to place-based care. Through adopting a place-based approach, we can ensure that capital investment delivers modern, co-located facilities that support independence, improve access and enable people to remain as close to home as possible.

### *1.3. Current Regional Capital Investment*

Over the 2022–2026 period, the region has delivered a sustained programme of capital investment aligned to strategic for priority population groups alongside cross-cutting accommodation models. This has been supported through the Housing with Care Fund (HCF), Integration and Rebalancing Capital Fund (IRCF) and complementary capital funding streams.




**Children and Young People:** £24.17m
Investment in this area has formed the largest proportion of spend, reflecting a sustained focus on expanding local residential capacity, developing specialist provision, reducing reliance on out-of-area placements, and supporting progression toward not-for-profit models.

**Adults (Mental Health, Learning Disability and Neurodiverse Services):** £12.14m
Spend has remained relatively stable year-on-year, with minor variations reflecting project timing rather than changes in strategic emphasis. Schemes have targeted supported accommodation, community-based alternatives to hospital escalation, and specialist environments designed around complex needs.

**Older People and Dementia:** £7.09m
Investment has largely supported targeted accommodation solutions – community-based models, refurbishment, respite environments, and schemes that promote independence and reduce avoidable admission to long-term care or acute settings.

**Disabled Facilities Grant (Top-Ups):** £2.94m
Ongoing investment has enabled timely delivery of essential home adaptations, supporting people to remain safely at home and reducing unnecessary escalation into health and social care.

**Health Centres, Wellbeing Hubs and Feasibility Work:** £30.14m
A significant portion of this investment relates to the development of new integrated community facilities, including 19 Hills Health & Wellbeing Centre. Capital has also supported feasibility studies, design development and early enabling works that provide the foundation for future business cases within the SCP.

## 2. Opportunities and Strategic Priorities for Frontline Service Delivery and Accommodation-Based Solutions

In this chapter, we explore the regional context for cross-cutting accommodation-based solutions, alongside strategic priorities for capital investment for priority population cohorts supported by the RPB. Appendix 1 provides an overview of pipeline schemes.

### *2.1. Cross-Cutting Accommodation-Based Solutions*

Across Gwent there is increasing demand for accommodation models that combine housing with care and support. Extra Care housing and supported accommodation are widely recognised as important components of a preventative system, enabling individuals to maintain independence while receiving appropriate support.

However, there are key challenges and pressures which limit the expansion of these models across Gwent – these challenges are described in the following table.

| Theme | Key Issues |
|---|---|
| **Demand Outpacing Supply** | Demand for supported accommodation models continues to exceed available capacity |
| **Higher Acuity Needs in Community Settings** | Providers now support individuals with higher levels of need in community settings<br><br>Existing accommodation models were not built for these levels of acuity |
| **Changing Market Dynamics** | Private organisations purchasing care homes and supported accommodation in some Gwent area<br><br>Local authorities and not-for-profit providers struggling to expand provision at sufficient pace to meet demand |
| **Ageing Sheltered Housing Stock** | Some schemes are outdated and do not align with modern care models<br><br>Many properties need substantial investment to meet Welsh Housing Quality Standards or decarbonisation standards |
| **Lack of Suitable Accommodation for Complex Needs** | Insufficient provision for people with mental health conditions, substance misuse issues or co-occurring needs<br><br>Inappropriate environments delay hospital discharge |
| **Pressure on Temporary Accommodation** | Temporary accommodation is under strain across the region<br><br>Placement breakdowns lead to re-presentation in crisis |
| **Need for Adaptable Accommodation Models** | Growing variety of needs across population<br><br>Current models lack flexibility over time |

These challenges reinforce the need for coordinated capital investment across housing, health and social care systems. Future investment should focus on strengthening preventative accommodation models that reduce pressure on hospital and crisis services, while also ensuring sufficient capacity exists for individuals with more complex needs.

Key priorities identified include:

- Strengthening coordination between capital and revenue planning to ensure new accommodation models are sustainable
- Supporting the expansion of not-for-profit accommodation providers, including local authorities and registered social landlords
- Developing housing models that can adapt to changing care needs over time, including “lifetime homes”
- Improving governance and oversight of regional capital investment to support strategic decision-making
- Strengthening preventative accommodation models that support earlier intervention and reduce escalation into crisis services.

Improved collaboration between partners, supported by shared data and coordinated investment planning, will be essential to ensure that future accommodation developments are aligned with population need and capable of delivering sustainable models of care.

### *2.2. Children and Young People*

Across the region, partners have identified the need to strengthen local provision, expand preventative services and reduce reliance on out-of-region or crisis placements. The following table summarises the key cohorts where capital investment will play an important role in supporting children and families.

| Cohort | Identified Need | Current Provision | Demand / Evidence | Implications for Capital Investment |
|---|---|---|---|---|
| **Children with a Disability** | Expand respite and short-break provision<br><br>Develop specialist environments for complex needs | 10 respite beds regionally:<br><br>6 in Caerphilly<br><br>4 in Monmouthshire | Nationally:<br><br>21% of children receiving care / support are disabled<br><br>11.2% of pupils have additional learning needs or special education needs (ALN)<br><br>40.9% of those with ALN are supported via an individual development plan (Sept 25 figures will be 100%). | Current capacity is insufficient to meet existing or future need<br><br>Additional specialist respite accommodation is required |
| **Children with Emotional &** | Create small, therapeutic homes to provide | One 5-bed specialist respite unit in Newport | Nationally: | Significant shortfall in |

| | | | | |
|---|---|---|---|---|
| **Behavioural Needs** | stabilisation and prevent escalation to residential or hospital care | Most support via general/mixed settings | 1,179 under-18 referrals to Local Primary Mental Health Support Services (LPMHSS) per month<br><br>Rising complexity and great frequency of crisis presentations | therapeutic environment<br>Need for specialist residential and stabilisation spaces |
| **Children on the Edge of Care** | Develop dedicated preventative spaces for intensive family work, crisis support and short-term stabilisation | No dedicated preventative residential estate<br><br>Early-intervention delivered from general offices/shared spaces | Nationally:<br><br>1,957 children became looked after in Wales in 2024/25<br><br>Abuse/neglect most common reason for children becoming looked after | Lack of suitable environments increases risk of escalation<br><br>Strong case for family hubs and crisis-focused facilities |
| **Children Looked After (Residential Sufficiency)** | Increase in-region residential capacity<br><br>Expand public/not-for-profit provision | 149 bedspaces<br><br>173 units<br><br>75% private sector<br><br>46 registered homes across Gwent | Nationally:<br><br>7,198 children looked after on 31 March 2024<br><br>34% placed out of area<br><br>Gwent:<br><br>123 children in placements | Need for ~60 repatriation placements and ~103 new public/not-for-profit units<br><br>Emphasis on local, suitable, sustainable provision |
| **Care Experienced Young People (Transitions)** | Develop supported and semi-independent accommodation for young people leaving care. | 15 supported units delivered by United Welsh Housing Association<br><br>8 units delivered by Pobl Housing Group<br><br>171 supported and 161 independent placements<br><br>18 young people in bed and breakfast accommodation | Nationally:<br><br>586 young people leave care annually<br><br>Care experienced young people are at higher risk of homelessness or housing instability than their peers | Requires 67–100 new placements<br><br>Need for dedicated, high-quality transition accommodation with appropriate support |

The evidence indicates that whilst some specialist estate exists across the region, it is often limited in scale, not purpose-built, or not aligned to the complexity of current demand. The Cabinet Secretary for Education has said that they want RPBs to be more involved in Additional Learning Needs (ALN) work and this is suitable in the collaboration between Health and Education that is often part of the work. Whilst there are currently few if any capital needs in this area it is an important one with the full implementation of ALN in its early stages. Several areas show a clear mismatch between that availability of suitable environments and level of needs these include respite services for disabled children, therapeutic environments for children with emotional and behavioural needs, preventative support for families on the edge of and supported accommodation for care-experienced young people.

Future capital investment across children and young people's services should therefore prioritise:

- Expanding respite and short breaks developing small, therapeutic residential homes, strengthening preventative and family support hubs, and early intervention environments
- Expansion of supported and semi-independent accommodation for care leavers.
- Increased provision of suitable accommodation for children with complex ND/behavioural needs, including short breaks for family support
- Stronger integration between ALN education environments and ND-friendly community services
- Address gaps in specialist provision for autistic women, girls and non-binary people
- Improve access to ND informed temporary accommodation for young people i.e., crisis house with dedicated support.

Targeted investment in these areas will support the regional ambition to keep children closer to home, reduce reliance on out-of-county placements, and develop a more sustainable, community-based model of care.

### *2.3. Adults with Learning Disabilities, Mental Health Conditions and / or Complex Needs*

Across the region, partners have identified increasing demand for accommodation and community-based environments that support independence while reducing reliance on crisis services, hospital admission and out-of-county placements.

The following table summarises the key adult cohorts where capital investment will play an important role in strengthening local provision.

| Cohort | Identified Need | Current Provision | Demand / Evidence | Implications for Capital Investment |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **Adults with Mental Health Conditions** | Expand local accommodation<br><br>Increase residential/nursing capacity<br><br>Develop step-up/step-down provision | 81 supported housing units<br><br>4 supported housing projects in Newport<br><br>122 out-of-county placements in March 2025 | Nationally:<br><br>4,922 adult LPMHSS referrals in one month<br><br>Only 76.8% of these assessed in 28 days<br><br>17,759 adults in secondary mental health services | Strong need for expanded supported accommodation, recovery environments and transitional (step-up/step-down) pathways to reduce out-of-county reliance |
| **Adults with Learning Disabilities (LD)** | Increase local residential and supported living options<br><br>Expand respite Broaden community-based models | 138 registered social landlord (RSL) units<br><br>2,216 people known to services – 1,096 whom live with parents<br><br>490 people with LD in lodgings/supported living | Estimated 6,500 people may have LD<br><br>Population growth, increased identification and longer life expectancy are expected to increase demand for supported living and respite accommodation over time | Requires expansion of supported living, respite and diverse housing options to reduce out-of-county placements and meet future need |
| **Adults with Physical Disabilities / Sensory Impairments** | Enhance independence through accessible housing, adaptations and assistive technology | 22 identified accessible units:<br><br>18 reported by RSLs<br><br>4 reported by Caerphilly County Borough Council<br><br>Overall accessible housing likely underreported | Nationally:<br><br>21.1% of people are disabled<br><br>49.3% of adults with care plans have a disability<br><br>~480,000 people are deaf/hard of hearing. | Significant need for scalable investment in accessible homes, adaptations and technology-enabled care to meet rising demand |
| **Adults with a Hoarding Disorder** | Multi-agency support environments<br><br>Coordinated interventions to maintain safety at home | No dedicated estate required<br><br>Pressure borne by existing housing/support services | Gwent:<br><br>Based on a 1.5% prevalence, ~8,700 people are estimated to be living with a hoarding disorder | Integrated community hubs and multi-agency spaces |

Across adult services, the evidence suggests that demand for accommodation and community-based environments is increasing across multiple cohorts. While some supported housing and specialist accommodation already exists across the region, the current estate is insufficient to fully meet current and projected demand,

particularly for individuals whose needs fall between independent living and institutional care.

Future capital investment across adult services should therefore prioritise:

- Expansion of supported accommodation for people with mental health needs
- Development of additional residential and supported living provision for adults with learning disabilities
- Investment in adaptable housing, assistive technology and accessible environments for people with physical or sensory impairments
- Strengthening integrated community hubs that support coordinated responses for individuals with complex needs.

Targeted investment in these areas will help reduce reliance on out-of-county placements, support independence and strengthen community-based models of care across the region.

### *2.4. Adults with Autism and Neurodevelopmental Disorders*

Across the region, partners have identified increasing demand for specialist environments that can support neurodivergent people whose needs are not adequately met within generic services. Current provision is often fragmented and delivered from environments that were not designed with sensory, communication or environmental needs in mind.

The Strategic Capital Plan therefore identifies opportunities to develop specialist supported accommodation, inclusive community hubs and crisis alternatives that enable people to remain within their communities while reducing escalation into hospital admission or high-cost placements.

There is a growing recognition of the need for high-quality, specialist support for neurodivergent individuals**,** particularly those with co-occurring conditions whose needs fall between traditional service pathways.

Across Gwent current provision is limited, fragmented, and often unable to meet individual sensory, social communication, or environmental needs. Key gaps identified through stakeholder engagement and service reviews include:

- Limited specialist supported housing designed around sensory and environmental needs.
- Insufficient short-term accommodation for crisis prevention or step-down support.
- Transitional support deficits for young neurodivergent people entering adulthood or leaving institutional care.
- Variable access to diagnostics and post-diagnostic support (e.g., sustainability challenges within NESH).

- Insufficient accessible public spaces and service hubs that meet neurodevelopmental-friendly design standards.

These gaps drive escalation into high-cost crisis services, hospital admissions, or high-cost out-of-area placements where appropriate local environments are not available.

The following table summarises the key delivery models required to support people with ND in Gwent.

| Models | Identified Need | Current Provision | Demand / Evidence | Implications for Capital Investment |
|---|---|---|---|---|
| **Specialist Accommodation & Support Models** | Develop small-scale, community-based supported living (4–6 units) designed using neurodevelopmental-informed principles | No dedicated specialist ND accommodation identified<br><br>Current provision relies on generic supported living or out-of-area placements | Growing recognition that ND individuals require environments with sensory-appropriate design<br><br>Current estate not designed around sensory or environmental needs | Opportunities to develop clusters of self-contained units with sensory-appropriate design (soundproofing, neutral finishes, flexible lighting, regulation spaces, assistive tech, quiet outdoor areas). Helps reduce reliance on institutional placements. |
| **Prevention, Crisis Support & Community Infrastructure** | Crisis-prevention environments, short-break accommodation, transitional support, and sensory-friendly community infrastructure | No specialist ND crisis accommodation<br><br>Community spaces often overstimulating or inaccessible | Increasing need for alternatives to hospital admission<br><br>Community-based “crisis house” models are effective for stabilisation close to home<br><br>Many community buildings not ND-friendly | Investment needed in crisis houses, short-break units, and adapted community hubs with predictable layouts, improved acoustics, low-arousal spaces and integrated multi-agency working environments |

The evidence indicates a growing need for specialist environments that better reflect the sensory, communication and support needs of ND individuals. Current provision across the region remains limited, with many services delivered from buildings that were not designed with neurodevelopmental in mind. This can contribute to escalation into crisis services or hospital admission where appropriate community-based support environments are not available.

Future capital investment should therefore prioritise:

- Development of specialist supported accommodation for neurodivergent individuals
- Creation of short-term crisis and stabilisation environments
- Development of transition-focused accommodation for young people moving into adulthood
- Adaptation of community hubs and public buildings to support neurodevelopmental-friendly environments
- Strengthening integrated community infrastructure that enables coordinated multi-agency support.

Targeted investment in these areas will support the wider ambition of enabling neurodivergent individuals to live independently within their communities while reducing reliance on institutional care and crisis interventions.

### *2.5. Older Adults, Including Those with Dementia*

Across the region, population ageing and increasing complexity of need are expected to place growing pressure on health, social care and housing services. While residential and nursing care provision remains an important part of the system, the strategic direction across Gwent is to support independence for as long as possible through preventative models of care, adaptable housing and community-based support.

Capacity modelling undertaken as part of the SCP indicates that demand for residential and nursing care is expected to increase significantly over the next decade. Modelling suggests that nursing care capacity requirements could increase from 60 additional units in 2023 to approximately 296 units by 2033. While residential care capacity may increase from 52 additional units to around 340 over the same period.

This projected growth reflects wider demographic changes, including an ageing population and increasing levels of frailty and complex health conditions. The strategic ambition across the region is not solely to expand traditional residential care. Partners have identified the need to develop a broader range of accommodation models that enable older people to remain independent for longer.

This includes expanding extra care housing, housing-with-care schemes and adaptable accommodation, alongside repurposing suitable sheltered housing where appropriate.

The following table summarises the key delivery models required to support older people, including those living with dementia, in Gwent.

| Model | Identified Need | Current Provision | Demand / Evidence | Implications for Capital Investment |
|---|---|---|---|---|
| **Dementia Friendly Provision** | Supportive environmental design<br><br>Integrated community-based support | Current estate not consistently designed to meet dementia-specific needs<br><br>Limited dementia-friendly layouts and environments | Prevalence expected to rise significantly with ageing population<br><br>Many people can remain at home with adaptations, technology and community services | Need for dementia-friendly design in new developments<br><br>Investment in community hubs and integrated spaces<br><br>Ensure equitable access across the region |
| **Independence, Prevention & Community Support** | Delivered through adaptations, accessible homes and assistive technology<br><br>Integrated community infrastructure to prevent escalation | Adaptations and technology in use but not consistently or at sufficient scale<br><br>Community facilities variable across Gwent | Preventative housing interventions delay residential care, improve quality of life and reduce system pressure<br><br>Early intervention and multi-agency models improve outcomes | Expanded accessible housing, technology-enabled care, and multi-agency community hubs<br><br>Region-wide distribution needed to reduce geographic variation |

Across services for older people and people living with dementia, the evidence indicates that demand for accommodation and community-based support will continue to increase over the lifetime of the Strategic Capital Plan.

While residential and nursing care capacity will need to expand to meet projected demand, the long-term strategic direction across Gwent is to support independence through preventative models of care and housing.

Future capital investment should therefore prioritise:

- Expansion of extra care housing and housing-with-care provision
- Investment in adaptations and assistive technology to support independent living
- Development of dementia-friendly environments and integrated community hubs and/or refurbish existing dementia friendly hubs incorporating known dementia specific focal points
- Repurposing and modernisation of existing accommodation where appropriate
- Emphasizing the need of suitable spaces within hubs/accommodation for training, reablement, carers advice etc
- Ensuring equitable access to services across the region.

These priorities support the regional ambition to enable older people and people living with dementia to remain independent for as long as possible while ensuring that appropriate accommodation and care provision is available when required.

## 3. Integrated Health and Social Care Hubs

Across Gwent, there is increasing demand for accessible community-based environments that support prevention, early intervention and co-ordinated care. This demand is driven by demographic change, rising prevalence of long-term conditions, increasing understanding of neurodevelopmental, and pressures on families and carers.

The IRCF has supported the development of a regional hub programme aligned with the SCP, the programme aims to:

- Deliver care closer to home through multi-disciplinary neighbourhood hubs
- Strengthen prevention**,** early intervention, rehabilitation, and recovery
- Integrate health, social care, wellbeing, and the third sector
- Support market rebalancing, shifting provision toward not-for-profit and local authority-delivered models
- Modernise the public estate, unlocking underused or obsolete buildings
- Reduce reliance on acute settings, crisis responses and institutional care
- Provide accessible community spaces aligned with Net Zero, digital first, and inclusive design principles.

These developments form part of a broader shift toward community-based infrastructure that supports more sustainable models of care.

Several hub developments have been identified across the region through the IRCF programme. Together these projects form a diverse network of community infrastructure supporting different population groups and service pathways.

The following table summarises plans for future hub developments in Gwent.

| Year | Proposed Hub | Description / Purpose | Core Functions | Intended Impact | Readiness | Key Dependencies |
|---|---|---|---|---|---|---|
| **0–1 years (FY26–27) — Immediate Deliverables** | **Newport Carers Hub** | Repurposing city-centre space to provide a dedicated hub for unpaid carers | Identification and assessment<br><br>Information, advice and assistance<br><br>Support groups<br><br>Direct access (“one front door”) to health and social care services | Strengthens support for unpaid carers<br><br>Improves visibility and access<br><br>Enables earlier intervention | **Amber** | Revenue gap finalisation |
| | **Youth Justice Hub / Alternative Education Centre** | Redevelopment of a local authority building into a multi-agency hub for | Youth justice services<br><br>Alternative education | Reduces risk of escalation<br><br>Enhances early intervention | **Amber** | Early stage, design<br><br>Business case required |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | vulnerable young people | Specialist support<br><br>Multi-agency intervention | Provides stable, accessible support for at-risk young people | | Revenue finalisation |
| | **Newport Community Hubs Programme** | Upgrading three community centres to support delivery of integrated preventative services | Community connectors<br><br>Integrated community care teams<br><br>Health Board outreach<br><br>Local wellbeing activities | Expands place-based care<br><br>Improves access to early help<br><br>Brings services closer to communities | **Amber/Red** | ABUHB capital match funding<br><br>IRCF eligibility |
| **2–3 years** | **Older Persons Hub** | Expansion of a voluntary-sector centre into a specialist hub for older people | Dementia support<br><br>Carer services<br><br>Community clinics<br><br>Social prescribing<br><br>Voluntary-sector wellbeing support | Enhances dementia and carer support<br><br>Improves access to preventative services<br><br>Increases voluntary-sector role in early intervention | **Red** | Scope definition<br><br>Phased plan |
| | **Wellbeing Hub @ Sports Village** | Addition of more clinic spaces for ABUHB physiotherapy as well as more office space for other HB services, that support their current hub services. | Multi agency<br><br>Physiotherapy Hub<br><br>Post surgery rehab<br><br>Social prescribing<br><br>Local Wellbeing services<br><br>Physical Disability support functions | Improved access to physiotherapy services<br><br>Better space utilisation<br><br>Additional HB services to access space<br><br>Reduce requirement at primary sites | **Amber** | Business Case to be developed<br><br>Clear options appraisal to be drafted with deliverability a key measure<br><br>Scoping exercise to be undertaken |
| **3–5 years** | **Cwm Health Park Redevelopment** | Redevelopment of an existing health park into an integrated health, social care and wellbeing hub in a deprived area | Co-location of primary care, community mental health, therapies, social care teams, and wellbeing/preventative services | Strengthens preventative infrastructure<br><br>Improves access to integrated care | **Green** | Lease agreement<br><br>Minor capex |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | Reduces fragmentation of services | | |
| | **Neurodevelopmental & Learning Disability Hub – St Cadocs** | Refurbishment of a vacant hospital ward to establish a specialist ND & LD hub | Diagnostic services<br><br>Therapy<br><br>Multidisciplinary support<br><br>Potential short-stay crisis beds | Provides local specialist assessment and support<br><br>Reduces crisis escalation<br><br>Increases in-region capacity for ND/LD pathways | **Amber** | Clarity on Clytha relocation<br><br>HCF alignment |

## 4. Governance and Delivery

In this section, we outline key governance and delivery mechanisms.

### *4.1. Governance Arrangements*

Delivery of the Strategic Capital Plan will be coordinated through the Regional Partnership Board's established governance framework, supported by the Capital Regional Support Team PMO. The PMO will be responsible for oversight, programme management and assurance. Appendix 2 outlines the Gwent RPB governance arrangements.

Each scheme will progress through the HM Treasury Five Case Model, with Project Boards overseeing feasibility, design, procurement, risk and benefits realisation. Readiness assessments – covering site availability, revenue sustainability, workforce, digital requirements and dependencies – will determine sequencing within the pipeline.

Modern Methods of Construction, standardised design templates and regional procurement frameworks will be used to accelerate delivery and ensure value for money. Annual programme reviews will maintain alignment to need, affordability and strategic priorities.

### *4.2. Engagement with Key Stakeholders*

The programme commits to co-production with people with lived experience and statutory consultation duties across partners. Engagement is tailored to each project using existing mechanisms and bespoke approaches to ensure voice and control are embedded in service design.

### *4.3. Skills and Capacity Building*

Effective delivery of the SCP requires sustained investment in regional skills, technical capability and workforce capacity. The Capital Regional Support Team PMO will provide specialist expertise in support capital developments, ensuring partners have access to consistent, high-quality support.

There is also opportunity to build further capacity in collaboration with existing programmes of work managed by the Regional Workforce Board. This will ensure coordinated workforce development and alignment with emerging service and accommodation models.

### *4.4. Key risks and mitigations*

| Risk | Summary | Mitigation |
|---|---|---|
| **Workforce shortages** | Limited availability of clinical, estates, digital and project staff may delay scheme development | Integrated workforce models<br><br>Coordinated multi-agency workforce planning<br><br>Skills development pipelines |

| | | |
|---|---|---|
| **Insufficient capacity to develop schemes** | Lack of internal expertise or resource to design, cost and manage capital proposals | PMO support<br><br>External specialist input with skills transfer<br><br>Regional shared resource pool |
| **Revenue consequences of capital projects** | New or improved assets may create unaffordable running costs | Robust financial modelling<br><br>Invest-to-save approach<br><br>Whole-life costing |
| **Eliminating profit from provision** | Challenges shifting from profit-driven models to not-for-profit provision | Planning with rsls<br><br>Phased reprovision<br><br>Ongoing WG engagement |
| **Poor data quality/availability** | Gaps or inconsistencies in data across partners limiting prioritisation and modelling | Data-sharing protocols<br><br>Regional data platform<br><br>Common definitions |
| **Land/buildings availability** | Difficulty securing suitable sites or assets to meet service needs | Asset transfers<br><br>Early RSL/third-sector involvement<br><br>Long-term estate planning |
| **Siloed bids** | Uncoordinated submissions creating duplication or misaligned priorities | Strengthened RPB governance<br><br>Shared capital pipeline<br><br>Collective annual review |

## 5. Approach to Decarbonisation

All new developments will meet Net Zero standards, with opportunities to decarbonise retained assets. Design principles include optimising site potential and energy use, conserving water, optimising materials, enhancing indoor environmental quality, and optimising operations and maintenance.

## 6. Summary of Our Strategic Capital Plan

The 10-Year Strategic Capital Plan sets out a coordinated regional programme of capital investment across Gwent, covering accommodation, community hubs, preventative environments and specialist facilities. The plan includes 21 major project types across the key RPB priority population groups.

The programme includes:

- Development of small children's homes and therapeutic environments
- Supported living schemes for adults with MH, LD and ND needs
- Extra Care and dementia-friendly accommodation
- Crisis alternatives and step-up/step-down provision
- Integrated community hubs enabled through the IRCF
- Refurbishment and repurposing of existing estate
- Digital, assistive technology and adaptation infrastructure

Based on indicative capital ranges in the SCP, the total estimated value of the 10-year plan sits between £95m–£140m, excluding inflationary adjustments, subject to feasibility/business case refinement, funding availability and Welsh Government approvals.

A high-level delivery timeline is phased across Immediate (0–1 years), Medium (1–4 years) and Long-term (5–10 years) periods, reflecting readiness assessments, revenue dependencies and estate complexity.

On this basis, the following tables summarise Gwent RPB's planned strategic capital investment over the next ten years.

| Project Type | Estimated Number (10-year window) | Notes |
|---|---|---|
| **Children's Residential Homes (1–2 bed pilots / 4–6 bed homes)** | 10–14 | Supports +60 in-region placements and +103 not-for-profit capacity |
| **Children's Respite / Short Break Facilities** | 2–3 | Addresses gaps for disabled children and crisis stabilisation |
| **Therapeutic / Emotional & Behavioural Homes** | 3–4 | Small-scale specialist units |
| **Care Leaver Accommodation** | 4–5 schemes | Supports 67–100 placements |
| **Mental Health Residential & Supported Living** | 4–6 schemes | +40 residential/nursing & +5 SL units |
| **Learning Disability Supported Living** | 5–7 schemes | +64 residential & +23 SL units |
| **Physical Disability / Sensory Impairment – Accessible Housing & Adaptation Programmes** | Ongoing | Investment in accessible design and tech-enabled independence |
| **Hoarding Disorder Multi-Agency Infrastructure** | 1–2 (non-accommodation) | Community hub spaces, integrated responses |
| **Extra Care / Housing-with-Care** | 3–5 | Scaled over medium/long-term |

| | | |
|---|---|---|
| **Dementia-Friendly Hubs & Adapted Environments** | 3–4 | Integrated community settings |
| **Community Hubs (IRCF)** | 6 hubs | Newport Carers Hub, Newport Community Hubs, Age Connects, Cwm Health Park, St Cadocs ND/LD Hub, Youth Justice Hub |
| **Crisis House / Step-Up–Step-Down Environments** | 2–3 | For MH/ND stabilisation |
| **Refurbishment / Repurposing Projects** | 8–12 | Smaller schemes across LA/Health estate |

| Population Group | Immediate (0–1y) | Medium (1–4y) | Long (5–10y) | Notes |
|---|---|---|---|---|
| **Children & Young People** | Pilot 1–2 bed homes<br><br>Identify sites<br><br>Business Justification Cases | Deliver +60 in-region & +103 in-house<br><br>Expand respite<br><br>First hubs | Reprovision/modernise<br><br>Hub network complete | Counts from SCP v0.4<br><br>Costs TBD |
| **Adults with MH&LD, ND and/or Complex Needs** | Framework for adaptations<br><br>Site pipeline for +40 MH/+64 LD<br><br>Pilot step-up/down | Phased delivery incl. +5 MH SL & +23 LD SL<br><br>Expand rehab | Optimise<br><br>Reprovision supported living as needed | Counts from SCP v0.4<br><br>Costs TBD |
| **Older Adults, including those with Dementia** | Fast-track adaptations<br><br>Identify 5–11 respite sites<br><br>Capacity modelling | Phased nursing/residential builds<br><br>Expand extra-care | Optimise/modernise<br><br>Dementia hubs scaled | Indicative adds per SCP v0.4<br><br>Costs TBD |

| Project Category | Indicative Cost Range (from SCP assumptions) |
|---|---|
| **Small 1–2 bed children's homes** | £0.8m–£1.4m |
| **4–6 bed children's homes** | £1.6m–£3m |
| **Supported living clusters (4–6 units)** | £1.0m–£2.2m |
| **Extra Care / Housing-with-Care** | £12m–£22m per scheme |
| **Community hubs (IRCF)** | £1.5m–£4m |
| **Refurbishment / Repurposing** | £0.1m–£1m |

## Appendices

### Appendix 1: Capital Pipeline

Pipeline (HCF)

### Appendix 2: Governance Structure

Governance Structure

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

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Gwent Public Services Board Update |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Professor Tracy Daszkiewicz, Executive Director for Public Health & Strategic Partnerships |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Professor Tracy Daszkiewicz, Executive Director for Public Health & Strategic Partnerships. |

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

Ar Gyfer Trafodaeth/For Discussion

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

This paper provides an update to Board members on key developments and discussions from the Gwent Public Services Board, which took place on 26 March 2026, including progress across Areas of Focus and key strategic partnership developments.

## Cefndir / Background

The Gwent PSB continues to deliver against its Well-being Plan, with four Areas of Focus:

- Best Start in Life
- Safe Communities
- Economic Chances
- Climate Ready Communities

The March meeting included:

- Strategic input from the Director of Public Health Annual Report
- Regional Child Poverty Strategy development
- Progress updates on Best Start in Life
- Deep dive on Climate Change Risk Assessment
- A development proposal on Marmot in Action

## 1. Child Poverty Strategy (Cardiff Capital Region)

The PSB considered the emerging **regional Child Poverty Strategy** led by Cardiff Capital Region (CCR), which has a statutory duty to contribute to the eradication of child poverty.

The Strategy is structured around three draft priorities:

- Good Work & Good Pay
- Access to Opportunity
- Conditions for Shared Prosperity

There is clear alignment with Welsh Government objectives, including reducing costs, increasing income, improving wellbeing and tackling stigma.

From a public health perspective, poverty is recognised as a **key upstream determinant of health and inequalities**, reinforcing the importance of partnership action across income, housing, education and employment.

There is a strong opportunity for the PSB to ensure regional strategy aligns with local wellbeing plans and delivers measurable impact on health inequalities.

## 2. Best Start in Life (BSiL) – Progress Update

The PSB received a substantive progress report on the **Best Start in Life Area of Focus**.

**Key progress:**

- Establishment of governance (Leadership Group and Regional Management Group).
- Agreement of scope, age range (0–7 years) and regional definition of BSiL
- Development of draft priority areas including:
    - Pregnancy and early years
    - Mental health and wellbeing
    - Child development and education
    - Housing and income
    - Employment and childcare

Current delivery is fragmented across partnerships with limited coordination, highlighting the need for a stronger whole-system model:

- Launch of a community of practice and regional engagement activity.
- Secured funding for school readiness pilot ("Ready to Learn, Ready to Grow").
- New funding bids submitted, including:
    - Early bonding and communication programme
    - Starting with Nature early years programme

There is a clear shift towards a whole-system, prevention-focused early years model, aligned to Marmot and the Early Years Framework for Action.

The PSB considered a proposal for Starting with Nature Gwent, a regional programme connecting young children and families with nature.

- Focus on under-5s, particularly in disadvantaged communities.
- Combines child development, parental wellbeing and community resilience.
- Delivered through community hubs and co-produced with families.

**Intended outcomes:**

- Improved early child development and learning
- Better parental mental health and reduced isolation
- Stronger family relationships
- Reduced inequalities in access to nature and early years support

This represents a strong example of place-based, Marmot-aligned prevention, linking health, environment and early years.

3. **Climate Change Risk Assessment (CCRA)**

The PSB undertook a deep dive on the Gwent Climate Change Risk Assessment.

Key points:

- The CCRA is nearing completion and will inform a regional Climate Adaptation Plan (2026–2030).
- Developed collaboratively across partners with workshops, leadership seminars and specialist input.
- Focus on risks including flooding, heatwaves, drought and their impact on infrastructure, services and population health

The work strengthens the PSB's ability to plan for climate resilience and protect population health, forming an important evidence base for the next wellbeing assessment.

**4. Marmot in Action – Story & Impact Exchange Proposal**

The PSB considered a proposal to establish a Gwent Marmot Story & Impact Exchange.

Purpose:

- Shift the PSB from a reporting forum to a learning and action system.
- Capture and share practice aligned to Marmot principles.
- Support scaling and system-wide improvement.

Core components:

- Standardised "practice story" template
- Light-touch curation panel

- Regular "Story from Place" agenda item
- Shared digital learning repository

**Implication:**
This is a significant opportunity to strengthen impact, shared learning and system leadership on inequalities.

**Opportunities for ABUHB**

The developments outlined here have significant strategic opportunities for Aneurin Bevan University Health Board, reinforcing the need to strengthen its role as a system leader in prevention, inequalities and partnership delivery. The emerging regional Child Poverty Strategy and Best Start in Life programme require the Health Board to align more explicitly its services, commissioning and workforce towards upstream action on the wider determinants of health, particularly income, early childhood development and family wellbeing. The shift towards whole-system, Marmot-aligned approaches presents an opportunity for ABUHB to embed prevention at scale, but also highlights the need for stronger coordination across partner organisations and internal services to maximise impact. The Climate Change Risk Assessment further underscores the Board's responsibility to integrate climate resilience and health protection into planning, recognising the direct risks to population health and service delivery. Finally, the proposed Marmot Story and Impact Exchange offers a practical mechanism for ABUHB to contribute to and benefit from shared learning, supporting continuous improvement and demonstrating measurable progress in reducing health inequalities across Gwent

**Argymhelliad / Recommendation**
The Board is asked to:

Note the progress across PSB Areas of Focus
Recognise the strengthening system approach to prevention, early years and inequalities

Support continued alignment between PSB priorities and Health Board strategic objectives, particularly in relation to:

- Child poverty reduction
- Early years system transformation
- Climate resilience and health protection

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | N/A |

| | |
|---|---|
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 1. Staying Healthy<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Adults in Gwent live healthily and age well |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Partnership First |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Gwent well-being plan<br>https://www.gwentpsb.org/en/well-being-plan/gwent-well-being-plan/<br>Gwent Joint Strategic Assessment<br>https://abuhb.nhs.wales/health-advice/gwent-joint-strategic-assessment/ |
| Rhestr Termau:<br>Glossary of Terms: | N/A |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | None |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment** (EIA) completed | **No does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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**<br>**Well Being of Future Generations Act – 5 ways of working**<br><br>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<br>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**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | **NHS Wales Joint Commissioning Committee (JCC) Update Report – March 2026** |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Nicola Prygodzicz, Chief Executive Officer |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Rani Dash, Director of Corporate Governance |

**Pwrpas yr Adroddiad**
**Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the NHS Wales Joint Commissioning Committee (JCC) as a Joint Committee of the Board.

## Cefndir / Background

The JCC is a Joint Committee of all Health Boards in NHS Wales. Membership of the JCC consists of the Chief Executive Officer of each Local Health Board; an Independent Chair (the Chair); and not more than five Non-Officer Members (NOMs). The Chair and NOMs (to be known as Lay Members) are appointed by the Welsh Ministers. The JCC's membership also includes an Associate Member, who shall have no voting rights, who will be the Chief Commissioner of the Joint Commissioning Committee Team (JCCT). The Chief Commissioner is employed by CTMUHB as the Host Body and this individual holds the Accountable Officer status, as delegated by Welsh Government, for certain elements of their role, namely the propriety and regularity for public finances as delegated to them through the JCC from Local Health Boards.

Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of services as identified below for residents within their area.

- specialised services for: · cancer and blood disorders

- cardiac conditions
- mental health and vulnerable groups · neurosciences, and · women and children.
- services where there is agreement between the Local Health Boards that they should be arranged on a regional or national basis
- emergency medical services
- non-emergency patient transport services
- emergency medical retrieval and transfer services
- NHS 111 services
- sexual assault referral centres, and
- other services as directed by the Welsh Ministers.

**Asesiad / Assessment**

The Joint Committee last met on 17th March 2026, with an extra ordinary meeting held on 23rd March 2026. The papers for this meetings are available at Meeting Dates and Papers - NHS Wales Joint Commissioning Committee.

The Committee's Assurance Report from these meetings will be circulated once received.

The Committee is due to next meet on 26th May 2026, papers for which can also be accessed at the link above. The assurance report from this meeting will be presented to the Board once made available.

**Argymhelliad / Recommendation**

The Board is asked to RECEIVE this report by way of an update on NHS Wales Joint Commissioning Committee (JCC) Committee activity.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | N/A |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| | |
|---|---|
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item. |

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

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment** (EIA) completed | **No  does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working**<br><br>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<br>Choose an item. |

**Glossary of Terms**

- EASC – Emergency Ambulance Service Committee
- WAST – Welsh Ambulance Service Trust+

- SDEC- Same Day Emergency Care
- ICAP – Integrated Commissioning Action Plan
- ROSC – Return of spontaneous circulation
- CHARU- Cymru High Acuity Response Units
- NEPTS- Non-Emergency Patient Transport Service
- EMRTS Cymru – Emergency Medical Retrieval and Transfer Service
- CASC – Chief Ambulance Services Commissioner
- BCUHB – Betsi Cadwalader University Health Board
- CTMUHB – Cwm Taf Morgannwg University Health Board
- C&VUHB – Cardiff and Vale University Health Board
- HDUHB – Hywel Dda University Health Board
- SBUHB – Swansea Bay University Health Board
- DHCW – Digital Health and Care Wales
- SEDC – Same Day Emergency Care
- SPC – Statistical Process Control

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

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | **NHS Wales Shared Services Partnership Committee (NWSSP) Update Report – January 2026** |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Nicola Prygodzicz, Chief Executive Officer |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Rani Dash, Director of Corporate Governance |

**Pwrpas yr Adroddiad**
**Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the NHS Wales Shared Services Partnership Committee as a Joint Committee of the Board.

## Cefndir / Background

NHS Wales Shared Services Partnership Committee (NWSSP) was established in November 2010 and became operational in April 2011 and through its work delivers economies of scale; efficiencies and consistency of quality and process for the business and professional services that are directly managed and delivered by local NHS bodies.

The membership is comprised of representatives from each NHS organisation that use the services and from Welsh Government in an observer capacity. The NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General / CEO NHS Wales and Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by an Independent Member, Professor Tracy Myhill OBE.

## Asesiad / Assessment

The Joint Committee last met on 19th March 2026 and the papers for the meetings are available at Committee Schedule and Papers - NHS Wales Shared Services Partnership . The Committee Chair's Assurance Report from this meeting is attached at **Appendix A**.

The Committee is next due to meet on 14th May 2026. The assurance report from this meeting will be reported to the Board once made available.

## Argymhelliad / Recommendation

The Board is asked to RECEIVE this update report on NHS Wales Shared Services Partnership Committee activity.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | N/A |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br>N/A |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | N/A |
| Rhestr Termau:<br>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)<br>Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment** (EIA) completed | **No  does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working**<br><br>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<br>Choose an item. |

**ASSURANCE REPORT**
**NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE**

| | |
|---|---|
| **Reporting Committee** | **Shared Services Partnership Committee** |
| **Chaired by** | Professor Tracy Myhill OBE, NWSSP Chair |
| **Lead Executive** | Neil Frow OBE, Managing Director, NWSSP |
| **Author and Contact Details** | Roxann Davies, Corporate Services Manager and James Quance, Assistant Director of Corporate Services |
| **Date of Meeting** | 19 March 2026 |

**Summary of key matters including achievements and progress considered by the Committee and any related decisions made**

**Chair's Report** - The Chair updated the Committee on her activities since the meeting held on 22 January 2026. This included attendance at Chairs' meetings in January and February, with detailed discussion at the February meeting on the Welsh Risk Pool and its associated financial challenges. She also reported progress on the Governance and Accountability Review, attendance at Welsh Risk Pool meetings, and her contribution to Welsh Government work to develop a procedure for the performance management, removal and suspension of non-officer members across NHS Wales, drawing on her HR expertise. Additional activity included attendance at the NWSSP Audit Committee with Velindre, engagement with Welsh Government, Velindre and NWSSP on the Review Implementation Group, one-to-one meetings with the Chief Executive, and participation in the NWSSP Health and Wellbeing Conference, where she spoke on resilience. Forthcoming commitments were outlined, including further Chairs' and governance meetings and a joint session with Chairs, Chief Executives and the Director General.

Chair reflected on her 4.5-year tenure and thanked the Committee, Vice Chair, Senior Leadership Group and colleagues for their support and constructive challenge. She highlighted a number of key achievements and NWSSP's contribution during and beyond the COVID-19 pandemic, confirmed her intention to continue supporting NHS Wales in a different capacity, and expressed confidence in NWSSP's future. Committee Members formally recorded their thanks, noting the Chair's leadership, partnership working and the positive culture established during her tenure.

The Committee **NOTED** the Chair's Report.

**Chair's Action – Ratification of All Wales e-Rostering Solution** - The Committee **RATIFIED** the Chair's Urgent Action taken between meetings to approve the expansion of the All Wales e-Rostering contract to include Cardiff and Vale University Health Board medical and dental staff. It was confirmed that the action was taken in line with the Scheme of Delegation, that all necessary approvals had been secured, and that appropriate governance processes had been followed. For assurance, it was noted that Velindre Trust Board approval had also been sought and would be ratified via Chair's Action at the Trust Board meeting on 26 March 2026, and that a further paper would address the on-boarding of additional Health Boards.

**Managing Director Update -** The Managing Director presented a comprehensive update on key developments across NWSSP since the previous meeting. This included progress on the Governance and Accountability Review, with the Implementation Group meeting regularly and the review confirming the governance framework as fundamentally sound, with recommendations in hand to strengthen assurance. An update was provided on the Welsh Risk Pool, noting that the £49m Welsh Government support for 2025–26 is non-recurrent, creating future financial pressure. Work is underway to strengthen forecasting, data quality, transparency and mitigation, alongside a renewed focus on prevention, clinical learning and reducing patient harm as the root cause of risk. Committee Members emphasised the need for clearer response planning, improved intermediate-level intelligence and stronger system learning, with assurance provided on actions underway to address these issues.

Updates were also provided on the implementation of the Resident Doctor contract, highlighting complexity and risk, with a comprehensive update and future deep dive scheduled; workforce streamlining and supply challenges, including data gaps and funding constraints, with coordinated oversight in place; recent senior leadership appointments for the Medical Director and the Director of Pharmacy Technical Services; emerging work on the future hosting of NHS Employers; and accommodation challenges linked to the TrAMS programme, with a proposal submitted to Welsh Government.

The overarching report provided the Committee with updates across a range of service areas, including Transforming Access to Medicines (TrAMs), Radiopharmacy and the Hub Programme; the NHS Wales Influenza Vaccination Programme; a Procurement Services overview (including the potential impact of the Middle Eastern conflict and issues relating to Hi-Fatigue G bone cement); Primary Care Services and the Medical Examiner Service (including the Workforce Intelligence System and misdirected mail); Laundry Services; decarbonisation and adaptation activity; accommodation; engagement and leadership activity; and awards and recognition.

The Committee **NOTED** and **DISCUSSED** the Managing Director's Report.

**Items for Approval**

**Chair's Recruitment -** The Committee **APPROVED** the recruitment arrangements for the appointment of the next NWSSP Chair by the SSPC, informed by the Governance and Accountability Review and ongoing engagement with Welsh Government, and Velindre as host. It was noted that further discussions had resulted in a revised and proportionate approach that aligns with a public appointment process, whilst remaining deliverable within the required timescales. The Committee agreed to proceed with Option 3, including the proposed composition of the appointment panel, the establishment of a stakeholder panel, and the progression of a minor amendment to the SSPC Standing Orders in collaboration with Velindre colleagues. It was confirmed that the recommendation of the appointment panel would return to the full Committee, for discussion.

**All Wales e-Rostering System** - The Committee **APPROVED** the award relating to the expansion of the All Wales e-Rostering contract to include Medical and Dental staff and to novate current local Medical and Dental contracts for Betsi Cadwaladr, Cwm Taf Morgannwg, Hywel Dda and Swansea Bay University Health Boards. It was noted that other NHS organisations may join the arrangements at a future point in time, requiring a Change Control Notice. Assurance was provided that the expansion aligns with the implementation of the Resident Doctor contract, is anticipated within the original procurement, complies with contractual and governance requirements, presenting no financial risk to NWSSP or Velindre, with corresponding approval to be sought from the

Velindre Trust Board.

**Oversight Arrangements for NHS Wales Energy Procurement and Contract Management -** The Committee **APPROVED** the revised Terms of Reference for the Wales Energy Group (WEG) and Wales Energy Operational Group (WEOG), following a review requested by the Committee to ensure proportionate and effective oversight. Assurance was provided that the arrangements are streamlined, reflect mature procurement and contract management processes, retain flexibility to respond to market volatility, and that arrangements had been supported by Directors of Finance.

**Overarching Service Level Agreement (SLA) for 2026–27 -** The Committee **APPROVED** the annual update to the overarching SLA for 206-27, noting that it had been reviewed by NWSSP Legal and Risk Services and that no fundamental changes were proposed. Assurance was provided that amendments were limited to clarification and incremental improvements, and that the SLA had been uplifted by 1.1% in line with the unequivocal pass-through expectation set by Welsh Government, reflecting ongoing engagement with Service Leads throughout the year, alongside end-of-year clarification.

**All Wales Laundry Services Service Level Agreement (SLA) for 2026–27 -** The Committee considered **APPROVED** revised All Wales Laundry Services SLA, noting that it provides the operational framework and performance metrics for the service. Assurance was provided that the document had been developed through stakeholder consultation, remains broadly consistent with the previous SLA, includes targeted amendments to improve clarity and alignment with standards, and had received positive feedback from customers.

**Provision of Radiopharmaceutical Products Service Level Agreement (SLA)for 2026–29 -** The Committee **APPROVED** the SLA for the provision of radiopharmaceutical products from NWSSP Pharmacy. Assurance was provided that the SLA had been developed through extensive stakeholder engagement and multi-stage review, sets out service scope, quality, performance and pricing arrangements, and supports readiness for service go-live in summer 2026, including transition arrangements with Swansea Bay University Health Board.

**Items for Noting and Discussion**

**NWSSP Integrated Medium-Term Plan (IMTP) 2026–2029 – Financial Position Update** - The Committee received the update to the financial position underpinning the NWSSP IMTP, relating to the underlying £0.744m deficit arising from unfunded employer national insurance costs had now been fully mitigated through the identification of recurrent savings. Assurance was provided that the IMTP has been updated to reflect a balanced position, with no other changes from those previously agreed, and remains on track for submission in line with planning deadlines. Opportunities to further support NHS Wales through an opportunities pipeline will be developed and brought back as part of the 2026–27 work plan. The Committee **NOTED** the amendments and continued to **ENDORSE** submission of the IMTP to Welsh Government.

**Future NHS Workforce Solution Briefing -** The Committee received an update on progress with the Future NHS Workforce Solution, noting confirmation of early adopter status for NWSSP alongside DHCW, Hywel Dda and HEIW, intended to ensure strong Welsh influence over system design. Committee Members noted ongoing risks and challenges associated with data quality, system design and delivery, and the scale of change involved. Assurance was provided that governance, reporting and escalation arrangements are in place, with continued engagement at national level and further detailed updates

scheduled. The Committee **NOTED** the progress made and **ENDORSED** the early adopter status for NWSSP.

**Transforming Access to Medicines Services (TrAMS) Programme and Service Management Board Update -** The Committee **NOTED** the update provided, noting the six-month review of the Programme Board Terms of Reference and confirmation that full representative membership from across NHS Wales is now in place. It was noted that no further changes are planned at this stage, with the next review aligned to the phased opening of the South-East Radiopharmacy and the establishment of a Service Management Board to oversee delivery and performance.

**Finance, Performance, People, Programme and Governance Updates**

**Finance Report** – The Committee noted the financial position as break-even at the end of February 2026, with the full-year forecast also at break-even following agreed distributions of £6m and the offsetting of the National Insurance savings. Capital expenditure remains within the approved allocation and agreed with Welsh Government, with minor in-year profile adjustments for Radiopharmacy and TrAMS schemes. An update on the Welsh Risk Pool confirmed the forecast position at £194.5m, requiring the full £49m Welsh Government allocation, with the risks at the upper end of the range not yet having materialised. The focus was now on year-end closure and review of the position for 2026–27.

**People and Organisational Development (POD) Report** – The Committee noted the latest workforce position as at February 2026. The report confirmed staff turnover remains slightly above the NHS Wales average, with further analysis underway, sickness absence remains stable, and progress continues across wellbeing, inclusion, leadership development and employee experience initiatives.

**Performance Information Report** – The Committee noted strong performance against agreed KPIs from October 2025 to January 2026, with two indicators below target and appropriate explanations and improvement actions in place. Committee Members welcomed the positive performance position while challenging whether current targets remain sufficiently ambitious, with assurance provided that this will be reviewed to ensure measures continue to drive improvement and value.

**Outcome Measures Report** – The Committee noted the report focused on outcomes aligned to NWSSP's strategic objectives across services, people and value, continuing to demonstrate NWSSP's value and impact. Strong performance across customer satisfaction, workforce engagement, professional influence and decarbonisation was reported. Committee Members noted enhancements to reporting and confirmed that outcome measures will continue to evolve, including greater benchmarking and trend analysis in future reports.

**Transformation Management Office (TMO) Update Report** – The Committee noted the update on the breadth of programme activity underway within the TMO. Oversight of a portfolio of 20 live initiatives was reported and generally positive delivery status across major programmes. Improvements in project RAG status were noted, alongside the addition of new projects. Committee Members reiterated the need to ensure delivery pace and challenge remain appropriate given the consistently positive position.

**Integrated Medium-Term Plan (IMTP) Quarter 3 of 2025–26 Update** - The Committee noted the latest progress update for quarter 3 of 2025-26, providing assurance on delivery of the plan and the effectiveness of quarterly monitoring arrangements. Most

objectives remain on track, with a small number at risk due to capacity or external factors. Committee Members highlighted the need for greater pace in specific areas, including Scan4Safety, with further benchmarking and costing work underway to inform future planning.

**NWSSP Corporate Risk Register** – The Committee noted the latest update with the current risk profile, including six red-rated risks relating to cyber security, pharmaceutical supply, TrAMS and Radiopharmacy delivery, financial and workforce pressures, the Future Workforce Solution and Welsh Risk Pool forecasting. It was noted that several risks are stable or reducing, due to management actions, with one new risk escalated relating to Resident Doctor terms and conditions.

The Committee **DISCUSSED** and **NOTED** the above Reports.

**Items for Information**

The Committee received the following items for information:

- Finance Monitoring Returns (Months 9, 10 and 11)
- Personal Protective Equipment (PPE) Report
- NWSSP Audit Committee Assurance Report from 10 February 2026
- SSPC Forward Plan 2026-27

**Part B - Private**

The Committee **APPROVED** the proposals for Future Workforce Solution Charges, Linen Products and Microsoft Enterprise Agreement.

**Matters requiring Board/Committee level consideration and/or approval**

The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.

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|---|---|
| **Date of Next Meeting** | Thursday 14 May 2026, 10.00am to 12.00pm |

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

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 20 May 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Board |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | **Committee Terms of Reference Review and Annual Reports 2025-26** |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Director of Corporate Governance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Board Business 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**

This paper presents to the Board the revised Terms of Reference and Annual Reports 2025/26 for the Committees of the Board.

**Cefndir / Background**

Aneurin Bevan University Health Board's Standing Orders state that: "*The Board may and, where directed by the Welsh Ministers must, appoint Committees of ABUHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business: Quality and Safety; Audit; Information governance; Charitable Funds; Remuneration and Terms of Service; and Mental Health Act requirements*."

In line with the above, the Health Board has established the following Committees:

- Audit, Risk and Assurance Committee
- Charitable Funds Committee
- Patient Quality, Safety and Outcomes Committee
- Mental Health and Learning Disabilities Committee
- People and Culture Committee
- Remuneration and Terms of Service Committee

- Partnerships, Population Health and Planning Committee
- Finance and Performance Committee

Committees of the Board are required to develop an Annual Report and review their Terms of Reference on an annual basis.

Due to the confidential nature of the issues discussed at the Remuneration and Terms of Service Committee it is not appropriate to publish an Annual Report for this Committee.

## Asesiad / Assessment

**Terms of Reference**
The Terms of Reference (ToR) for each Committee have been reviewed by individual Committees and the final versions are provided in the supplementary papers. There have been minor changes to titles and dates but there were no material amendments to the Terms of Reference.

The Board is asked to approve the Terms of Reference.

**Annual Reports**
Each Committee is responsible for developing an annual report for submission to the Board, setting out its activities during the year and including the review of its performance.

The Annual Reports seek to provide a comprehensive evaluation of the business undertaken by the Committee throughout the 2025-26 financial year including any issues, and gaps in assurance that have required escalation to the Board.

The Annual Reports have been endorsed by each Committee and are presented to the Board for approval prior to publication.

As part of the Health Board's statutory requirements, each Committee of the Board is required to conduct an annual self-evaluation of committee effectiveness. All Board Members are required to complete a self-assessment for each Committee on which they are a member, to determine its effectiveness and ability to carry out its responsibilities. A summary of the outcomes of these self assessments are included within the Annual Report for each Committee.

The outcome of the assessment will enable the Committee to identify areas of development and focus for the coming year, such as any training and development, as well as changes to processes and procedures.

## Argymhelliad / Recommendation

The Committee Board is asked to APPROVE the Terms of Reference and Annual Reports 2025/26 for the Committees of the Board.

## Amcanion: (rhaid cwblhau)

| Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score: | Failure to agree the reports would mean that the Health Board would not comply with Welsh Government and HM Treasury requirements. |
| Safon(au) Gofal ac Iechyd: Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br>Choose an item.<br>The objectives will be referenced to the IMTP. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Not Applicable<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| Gwybodaeth Ychwanegol: Further Information: | |
|---|---|
| Ar sail tystiolaeth: Evidence Base: | N/A |
| Rhestr Termau: Glossary of Terms: | Explained within the report. |
| 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 |

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| • **Financial** | Not Applicable |
| **Asesiad Effaith Cydraddoldeb Equality Impact Assessment** (EIA) completed | **No does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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**<br>**Well Being of Future Generations Act – 5 ways of working**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Choose an item.<br>Choose an item.<br><br>Not applicable to the report, however, considerations will be included in considering how the business of the Committee aligns to the Well Being of Future Generations Act. |