

Aneurin Bevan University Health Board Public Board

Wed 26 November 2025, 09:30 - 16:00

Conference Centre, St Cadoc's Hospital

Agenda

09:30 - 09:30 1. PRELIMINARY MATTERS

0 min

 PB20251126_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 2. CONSENT AGENDA BUSINESS

0 min

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

Oral *Chair*

09:30 - 09:30 3. KEY UPDATES

0 min

3.1. Update from the Chair

Oral *Chair*

3.2. Update from the Chief Executive

Oral *Chief Executive*

09:30 - 09:30 4. PATIENT EXPERIENCE AND PUBLIC ENGAGEMENT


0 min

4.1. Diabetes Management:

Presentation *Director of Public Health*

- a. Patient Experience Story
- b. Diabetes Services Annual Report



 PB 20251126 Agenda Item 4.1b Diabetes Services Annual Report.pdf (7 pages)

 PB 20251126 Agenda Item 4.1b Diabetes Services Annual Report Appendix 1.pdf (27 pages)

09:30 - 09:30 5. ITEMS FOR DECISION



5.1. Digital Community Programme Business Case

Attachment *Director of Digital*

-  PB 20251126 Agenda Item 5.1 Digital Community Programme Business Case.pdf (16 pages)
-  PB 20251126 Agenda Item 5.1 Digital Community Programme Business Case Appendix 1.pdf (150 pages)




5.2. Nevill Hall Hospital Strategic Outline Case

Attachment *Director of Strategy, Planning and Partnerships*

-  PB 20251126 Agenda Item 5.2 Nevill Hall Hospital Strategic Outline Case.pdf (8 pages)
-  PB 20251126 Agenda Item 5.2 Nevill Hall Hospital Strategic Outline Case Appendix 1.pdf (152 pages)

5.3. Better Health, Better Care, Better Lives - 10-Year Strategy, Deployment Plan




Attachment *Director of Strategy, Planning and Partnerships*

-  PB 20251126 Agenda Item 5.3 Better Health Better Care Better Lives -10-Year Strategy, Deployment Plan.pdf (11 pages)
-  PB 20251126 Agenda Item 5.3 Better Health, Better Care, Better Lives -10-Year Strategy, Deployment Plan Appendix 1.pdf (43 pages)
-  PB 20251126 Agenda Item 5.3 Better Health, Better Care, Better Lives -10-Year Strategy, Deployment Plan Appendix 2.pdf (7 pages)

5.4. Regional Planning:

Attachment *Director of Strategy, Planning and Partnerships*

a) Orthopaedics OBC

-  PB 20251126 Agenda Item 5.4 Regional Planning Orthopaedics OBC.pdf (5 pages)
-  PB 20251126 Agenda Item 5.4 Regional Planning Orthopaedics OBC Appendix 1.pdf (133 pages)
-  PB 20251126 Agenda Item 5.4 Regional Planning Orthopaedics OBC Appendix 2.pdf (3 pages)

09:30 - 09:30

0 min

6. ITEMS FOR DISCUSSION


6.1. Women's Health Update Report

Attachment *Director of Public Health*

-  PB 20251126 Agenda Item 6.1 Women's Health Update Report.pdf (13 pages)



6.2. Feedback on the Respiratory Reconfiguration and the General Medicine Model at the Grange University Hospital

Attachment *Chief Operating Officer*

-  PB 20251126 Agenda Item 6.2 Feedback on the Respiratory Reconfiguration and the General Medicine Model at the Grange University Hospital.pdf (12 pages)

6.3. Health, Safety & Fire Annual Report

Attachment *Director of Allied Health Professions & Health Science*

-  PB 20251126 Agenda Item 6.3 Health, Safety & Fire Annual Report.pdf (5 pages)
-  PB 20251126 Agenda Item 6.3 Health, Safety & Fire Annual Report Appendix A.pdf (40 pages)

6.4. 2025/26 Performance Reporting:

Attachment *Executive Leads*

- a. Integrated Performance Report
- b. Financial Performance Report, Month 06

-  PB 20251126 Agenda Item 6.4a Integrated Performance Report.pdf (10 pages)

- 📄 PB 20251126 Agenda Item 6.4a Integrated Performance Report Appendix A.pdf (74 pages)
- 📄 PB 20251126 Agenda Item 6.4b Financial Performance Report, Month 06.pdf (26 pages)
- 📄 PB 20251126 Agenda Item 6.4b Financial Performance Report, Month 06 Appendix A.pdf (29 pages)

6.5. Public Services Ombudsman for Wales (PSOW) Annual Letter

Attachment *Director of Nursing*

- 📄 PB 20251126 Agenda Item 6.5 Public Service Ombudsman for Wales (PSOW) Annual Letter.pdf (4 pages)
- 📄 PB 20251126 Agenda Item 6.5 Public Service Ombudsman for Wales (PSOW) Annual Letter Appendix A.pdf (3 pages)

6.6. Nurse Staffing Level (Wales) Act, Annual Presentation

Attachment *Director of Nursing*

- 📄 PB 20251126 Agenda Item 6.6 Nurse Staffing Level (Wales) Act Annual Presentation.pdf (14 pages)
- 📄 PB 20251126 Agenda Item 6.6 Nurse Staffing Level (Wales) Act Annual Presentation Appendix 1.pdf (19 pages)

6.7. Strategic Risk Report, November 2025

Attachment *Chief Executive*

- 📄 PB 20251126 Agenda Item 6.7 Strategic Risk Report November 2025.pdf (7 pages)
- 📄 PB 20251126 Agenda Item 6.7 Strategic Risk Report November 2025 Appendix A.pdf (45 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 24th September 2025

Attachment *Chair*

- 📄 PB 20251126 Agenda Item 7.1.1 Draft Minutes of Public Meeting Held on 24 September 2025.pdf (17 pages)

7.1.2. Report on Sealed Documents and Chair's Actions

Attachment *Chair*

- 📄 PB 20251126 Agenda Item 7.1.2 Report on Sealed Documents and Chairs Actions.pdf (5 pages)

7.1.3. NHS Standing Orders and Standing Financial Instructions Updates

Attachment *Director of Corporate Governance*

- 📄 PB 20251126 Agenda Item 7.1.3 NHS Standing Orders and Standing Financial Instructions Updates.pdf (25 pages)

7.2. FOR NOTING

7.2.1. Board Action Log with Updates

Attachment *Chair*

- 📄 PB 20251126 Agenda Item 7.2.1 Board Action Log.pdf (1 pages)

7.2.2. Strategic Partnership Updates:

Attachment *Director of Strategy, Planning and Partnerships*

a) Regional Partnership Board

- 📄 PB 20251126 Agenda Item 7.2.2a Regional Partnership Board.pdf (5 pages)
- 📄 PB 20251126 Agenda Item 7.2.2a Regional Partnership Board Appendix 1.pdf (3 pages)
- 📄 PB 20251126 Agenda Item 7.2.2a Regional Partnership Board Appendix 2.pdf (2 pages)

7.2.3. Executive Committee Chair's report

Attachment Chief Executive

 PB 20251126 Agenda Item 7.2.3 Executive Committee Chair's report.pdf (10 pages)

7.2.4. Key Matters from Committees of the Board

Attachment Committee Chairs

 PB 20251126 Agenda Item 7.2.4 Key Matters from Committees of the Board.pdf (18 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

 PB20251126_Agenda_Item_7.2.5 a_Joint Commissioning Committee.pdf (4 pages)

 PB20251126_Agenda_Item_7.2.5 a JC Highlight Report - 16 Sept 2025.pdf (6 pages)

 PB20251126_Agenda Item 7.2.5 b NHS Wales Shared Services Partnership Committee.pdf (3 pages)

 PB20251126_Agenda_Item_7.2.5 b SSPC Assurance Report 30 September 2025.pdf (6 pages)

09:30 - 09:30 8. OTHER MATTERS

0 min

8.1. Any Other Business

8.2. Date of the Next Meeting

28th January 2025

09:30 - 09:30 9. PRIVATE/IN COMMITTEE SESSION

0 min

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

AGENDA

Date and Time		Wednesday 26th November 2025 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	KEY UPDATES		
3.1	Update from the Chair	Oral	Chair
3.2	Update from the Chief Executive	Oral	Chief Executive
4	PATIENT EXPERIENCE AND PUBLIC ENGAGEMENT		
4.1	Diabetes Management: a. Patient Experience Story b. Diabetes Services Annual Report	Presentation	Director of Public Health
4.2	Report from Llais, Gwent Region	Attachment	Regional Director, Llais
5	ITEMS FOR DECISION		
5.1	Digital Community Programme Business Case	Attachment	Director of Digital
5.2	Nevill Hall Hospital Strategic Outline Case	Attachment	Director of Strategy, Planning and Partnerships
5.3	Better Health, Better Care, Better Lives - 10-Year Strategy, Deployment Plan	Attachment	Director of Strategy, Planning and Partnerships
5.4	Regional Planning: a) Orthopaedics OBC	Attachment	Director of Strategy, Planning and Partnerships
6	ITEMS FOR DISCUSSION		

6.1	Women's Health Update Report	Attachment	Director of Public Health
6.2	Feedback on the Respiratory Reconfiguration and the General Medicine Model at the Grange University Hospital	Attachment	Chief Operating Officer
6.3	Health, Safety & Fire Annual Report	Attachment	Director of Allied Health Professions & Health Science
6.4	2025/26 Performance Reporting: a. Integrated Performance Report b. Financial Performance Report, Month 06	Attachment	Executive Leads
6.5	Public Services Ombudsman for Wales (PSOW) Annual Letter	Attachment	Director of Nursing
6.6	Nurse Staffing Level (Wales) Act, Annual Presentation	Attachment	Director of Nursing
6.7	Strategic Risk Report, November 2025	Attachment	Chief Executive
7	CONSENT AGENDA		
7.1	FOR APPROVAL		
7.1.1	Draft Minutes of the Health Board Meeting, held on 24 th September 2025	Attachment	Chair
7.1.2	Report on Sealed Documents and Chair's Actions	Attachment	Chair
7.1.3	NHS Standing Orders and Standing Financial Instructions Updates	Attachment	Director of Corporate Governance
7.2	FOR NOTING		
7.2.1	Board Action Log with Updates	Attachment	Chair
7.2.2	Strategic Partnership Updates: a) Regional Partnership Board	Attachment	Director of Strategy, Planning and Partnerships
7.2.3	Executive Committee Chair's report	Attachment	Chief Executive
7.2.4	Key Matters from Committees of the Board	Attachment	Committee Chairs
7.2.5	An overview of Joint and Partnership Committee Activity: a. NHS Wales Joint Commissioning Committee b. NHS Wales Shared Services Partnership Committee	Attachment	Chief Executive
8	OTHER MATTERS		
8.1	Any Other Business		

8.2	Date of the Next Meetings: <ul style="list-style-type: none"> • 28th January 2025
9.	PRIVATE/IN COMMITTEE SESSION
	<p>Motion to Exclude Members of the Public and the Press</p> <p>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:</p> <p>“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.”</p> <p><i>Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960</i></p>

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Diabetes Annual Report 24/25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Tracy Daszkiewicz - Executive Director for Public Health & Strategic Partnerships.
SWYDDOG ADRODD: REPORTING OFFICER:	Tracy Daszkiewicz – Executive Director of Public Health & Strategic Partnerships.

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Diabetes is a national priority in Wales because of its high and rising prevalence, significant health complications, and high cost to the NHS.

Public Health and Economic Drivers

- **High prevalence:** Approximately 8% of the population in Wales has diabetes, which is the highest rate in the UK.
- **Rising rates:** The number of diagnoses is increasing, particularly for type 2 diabetes, with projections estimating that this will affect 10% of the population by 2035.
- **Significant health complications:** Diabetes is a leading cause of complications such as blindness, kidney failure, heart attacks, and strokes.
- **Economic impact:** The treatment of diabetes, especially type 2, represents a large portion of the NHS budget, with treatment and management costing around 10% of the annual budget.

Health inequality and prevention

- **Health inequalities:** Diabetes prevalence is higher in more deprived areas and amongst minority ethnic communities, making it a key issue for reducing health inequalities.

- **Preventable cases:** Unlike type 1 diabetes, type 2 can be prevented through lifestyle changes, which is a major focus of prevention programmes.
- **Preventative investment:** The Welsh Government has investing in programmes like the All Wales Diabetes Prevention Programme (AWDPPP) to help those at high risk make lifestyle changes, such as dietary improvements and increased physical activity. (This funding will end March 2026)

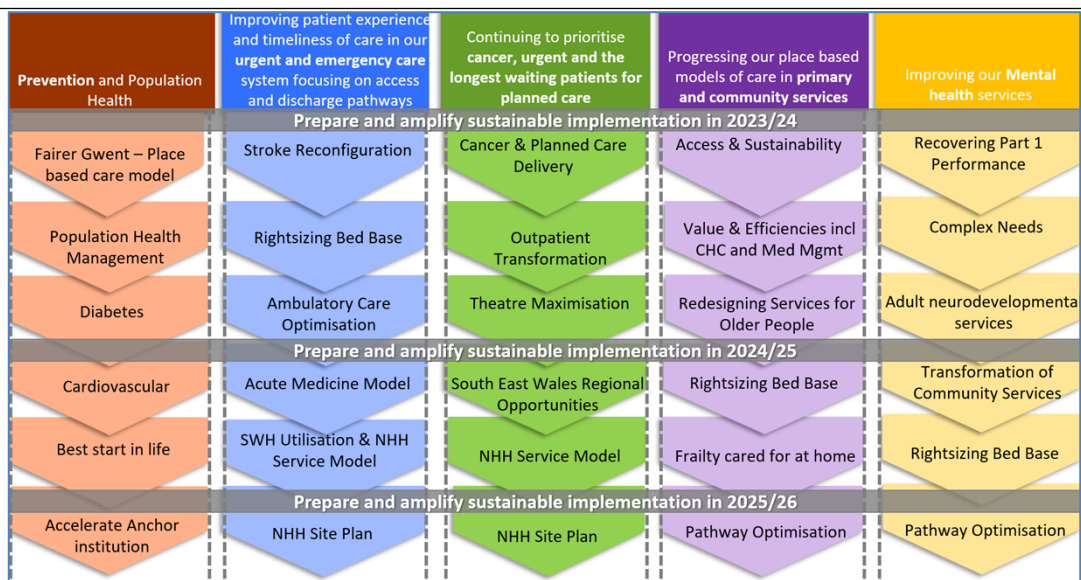
The 2024 DPH Annual Report [We are Gwent Annual Director of Public Health Report 2024h](#) set out the scale and impact of preventable premature mortality, and a need to accelerate progress in the prevention and treatment of Diabetes. Diabetes is also a strategic priority in the ABUHB 10 year strategic plan.

Diabetes is a growing health and equity challenge in Wales, with Aneurin Bevan University Health Board (ABUHB) experiencing rising prevalence, increasing demand on services, and widening inequalities.

- **Prevalence:** Over 8% of the adult population in Gwent and Wales live with diabetes and estimates suggest the prevalence of diabetes may rise to 10% of the population by 2035. Whilst Type 1 diabetes affects around 3,400 people in Gwent (and 16,000 people in Wales) and cannot be prevented, around 42,300 people in Gwent (and more than 190,000 people in Wales) have type 2 diabetes, which can be prevented or delayed.
- **Inequalities:** Higher burden in deprived communities, minority groups, and obese populations (8.2% prevalence vs 3.6% in non-obese adults).
- **Financial impact:** At least 10% of NHS Wales' expenditure relates to diabetes, with most costs linked to preventable complications and emergency admissions.
- **Capacity pressures:** Rising outpatient referrals, longer waiting lists, and fragile specialist services in both diabetes and endocrinology.
- **Service gaps:** Insufficient sustainable funding for Hybrid Closed Loop (HCL) systems, prevention programmes, and digital platforms.

Cefndir / Background

Diabetes remains a key area of focus in the Prevention and Population Health element of the ABUHB transformational and development priorities as set out in the 2023/24 summary in Fig 1 below



Diabetes remains a key global national, regional and local priority and as set out in the report requires co-ordinated deliver across a wider range of prevention and care delivery workstreams across the Health Board, community and partners.

ABUHB Diabetes Annual Plan 2024-25 set out the two strategic priorities:

Priority 1

Develop a diabetic centre for patients to have a one stop service experience

Priority 2

Implement the five year plan for delivery of effective diabetes technology (hybrid closed loop systems) to children, young people and Adults with type 1 diabetes to prevent the short term and long term complications of Diabetes

This annual report describes the progress the Health Board has made in relation to these priorities in the last 12 months.

Asesiad / Assessment

Progress against the two priorities:

Priority 1: The Diabetes Centre has been established at Nevill Hall Hospital. It focuses on the management and treatment of diabetes, offering comprehensive care including patient education, monitoring, and support.

Priority 2: In November 2024, a partial recurrent funding was identified to support the implementation of hybrid closed system for adult patients. This funding secured three diabetic specialist nurses (one B7 and two B6). The Health Board also allocated additional recurrent funding to implement the hybrid closed loop system for paediatric (aged <17 years) patients. This funding secured one B6 Diabetes Specialist Nurse, two dietitians at B7 and B6 levels, a B8A psychologist, and a B4 assistant practitioner. The hybrid closed loop pathway for paediatric patients (aged <17 years) has been redesigned. The updated pathway is achieving a 75% uptake rate and is resulting in HbA1c outcomes that are consistent with national averages.

Overview of diabetes services in the ABUHB

- There are 68 GP Practices across the Aneurin Bevan University Health Board foot print servicing a GP Practice population of 632,314 people.
- Approximately 80% of patients with diabetes are managed and monitored within primary care.
- Primary care performs the annual eight care processes recommended by NICE, to monitor diabetes, detect and prevent complications like heart disease, kidney disease, stroke, and diabetic foot, and ensure patients meet treatment targets. Health Board's overall compliance of eight care processes is 44%. Two lowest recorded care processes' compliance are albumin urine test and foot checks. ABUHB Value-Based Health Care team has developed a pilot project to improve the uptake these two care process in ten participating practices.
- Value-Based Health Care team has already been working on two projects.
 - Diabetic Inpatient Care and Education (DICE): DICE team provides targeted patient care and implements a structured staff education programme.
 - Cardio-Renal Optimisation Project: A multidisciplinary team screen and assess adults with type 2 diabetes; and it initiates SGLT2 inhibitors therapy, to regulate blood glucose levels.
- The Health Board provides access to the self-management resources for diabetic patients including MyDESMOND and SEREN (for paediatrics with type 1 diabetes).
- The Health Board provides structured education programmes including DAFNE (Dose Adjustment For Normal Eating) and XPERT Structured education programme.
- The diabetes and endocrinology secondary care services have seen an increase in outpatient referrals, new outpatient waiting lists and follow-up waiting lists.
- All-Wales Diabetes Prevention Programme was launched in July 2022 and currently rolled out across Caerphilly, Blaenau Gwent and most recently Newport. The funding for this programme will end in March 2026.
- The Health Board provides a range of services to reduce the lifestyle risk factors attributable to diabetes. These services offer opportunities for people to change their behaviour to reduce their risk of developing type 2 diabetes.

Conclusion

Diabetes poses an escalating clinical, financial, and equity challenge to the Health Board. Rising Type 2 diabetes prevalence, persistent Type 1 diabetes impacts, and widening inequalities require a coordinated, system-wide response, that includes

the social determinants of health. Investing in prevention, digital solutions, and routine care offers strong returns by lowering costly complications.

Strategic Priorities 2025 - 2030

1. To identify proactively the patients at risk of developing diabetes (prediabetics) and prevent them from developing diabetes by offering behavioural change interventions.
2. To provide specialist secondary care diabetes service to priority patients group including those with Type 1 Diabetes, those needing insulin pumps, the young persons with diabetes, antenatal diabetes, renal disease stage 4 or 5, active diabetes foot disease, pancreatic diabetes (type 3c), Latent Autoimmune Diabetes in Adults and complex clinical situation.
3. To implement hybrid closed loop systems for managing blood glucose levels in type 1 diabetes five-year plan.
4. To improve the quality of diabetes care (focussing on eight care processes, treatment targets and structured education) to prevent the onset or worsening of diabetes complications.
5. To educate, enable and empower patients to take control of their diabetes care encouraging self-management.
6. To reduce the referrals to specialist secondary care diabetic service.
7. To provide mental health and wellbeing support to patients living with diabetes.
8. To reduce health inequalities across diabetes services.
9. To improve access to the type2 diabetes remission programme.

Argymhelliad / Recommendation

Diabetes remains one of the most significant challenges facing ABUHB, with rising prevalence, widening inequalities, and unsustainable demand pressures. While strong progress has been made in prevention, service redesign, and technology uptake, substantial risks remain around funding, workforce, and digital sustainability.

The establishment of dedicated programme management to develop the Health Board's approach to developing the Diabetes Delivery Framework, incorporating a clear vision, defined pathways, and aligned to national priorities to facilitate a comprehensive understanding of the inequalities, risks, associated harms and

funding gap. This includes capacity and demand modelling across diabetes, endocrinology, and antenatal diabetes care pathways.

A strategic, system-wide approach is required, focused on prevention, early intervention, equity, and sustainable delivery of high-quality care.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

<p>Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:</p>	
<p>Safon(au) Gofal ac Iechyd: Health and Care Standard(s):</p>	<p>Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.</p>
<p>Blaenoriaethau CTCI IMTP Priorities Link to IMTP</p>	<p>Getting it right for children and young adults</p>
<p>Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP</p>	<p>Research, Innovation, Improvement, Value</p>
<p>Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24</p>	<p>Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.</p>

Gwybodaeth Ychwanegol:

Further Information:

<p>Ar sail tystiolaeth: Evidence Base:</p>	
<p>Rhestr Termau: Glossary of Terms:</p>	
<p>Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:</p>	

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

Aneurin Bevan University Health Board

Diabetes Annual Report

2024-25



Some of the amazing people who shared their stories of living with diabetes.



What is Diabetes?

Diabetes is a serious condition where your blood glucose level is too high. It can happen when your body doesn't produce enough insulin or the insulin it produces isn't effective. Or, when your body can't produce any insulin at all.

There are two main types of diabetes: type 1 and type 2.

When you've got type 1 diabetes, you can't make any insulin at all. If you've got type 2 diabetes, which is the most common, it's a bit different. The insulin you make either can't work effectively, or you can't produce enough of it. They're different conditions, but they're both serious.

There are lots of other types of diabetes. They include gestational diabetes, which some women may go on to develop during pregnancy, type 3c, MODY and Latent Autoimmune Diabetes in Adults (LADA).

In all types of diabetes, glucose can't get into your cells properly, so it begins to build up in your blood. And too much glucose in your blood causes a lot of different problems. To begin with, it may lead to diabetes symptoms.



Lynette's Story

After living with Type 2 diabetes for over 20 years, Lynette , decided to take control of her health. In 2022, she joined Slimming World, adopted a balanced diet, and started running - eventually losing an incredible 7 stone! 🎉 Her blood sugar returned to normal levels, and by last summer, Lynette was no longer insulin dependent.

Donna's Story

"I don't 'suffer from diabetes.' I live with it. It's part of who I am." Meet Donna, who has lived with Type 1 diabetes for 33 years. Donna manages her Diabetes and stays well by taking part in her local parkrun with her daughter.



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Background

The Aneurin Bevan University Health Board has set Diabetes as one of its priorities in the Health Board 10-year Strategy. This is to ensure there is a sharper focus on tackling the linked and causal inequalities and reducing the risk and associated harms of Diabetes. This Annual Report provides an opportunity to bring together all aspects of Diabetes prevention and care into a single document to look back on the work already taken place and currently underway. This will inform a baseline to deliver the ambitions set out in the 10-year strategy and will form a priority area of focus in the Preventing Premature Mortality & Morbidity Delivery Framework currently being developed.

Diabetes is a common health condition affecting all age groups. Diabetes can cause serious long-term complications such as heart attacks, strokes, kidney disease,



retinopathy (leading to vision loss), nerve damage, and diabetic foot (leading to ulcers or amputation). Short-term complications include low blood sugar (hypoglycaemia), high blood sugar (hyperglycaemia) and diabetic ketoacidosis (DKA). Managing diabetes and its complications in Wales accounts for 10% of the annual NHS Wales budget and costs approximately £500m per year, [Tackling diabetes together is key to people living longer, healthier lives in Wales - Public Health Wales](#) with much of this linked to avoidable complications and emergency admissions. Early diagnosis, the eight care processes, diabetes eye screening and effective self-management support lead to better outcomes and reduced demand on services. Regular monitoring will help reduce mortality, emergency admissions amputations and diabetic retinopathy [Diabetes is Serious Report Digital_0.pdf](#).

National Priority

Diabetes is a national priority in Wales because of its high and rising prevalence, significant health complications, and high cost to the NHS. Wales has the highest prevalence of diabetes in the UK, affecting around 8% of the population, with projections suggesting this will rise to 10% by 2035. The condition contributes to serious health problems like sight loss, kidney failure, heart attacks, and strokes, and the cost of treating type 2 diabetes accounts for about 10% of the annual NHS budget

Public Health and Economic Drivers

High prevalence: Approximately 8% of the population in Wales has diabetes, which is the highest rate in the UK.

Rising rates: The number of diagnoses is increasing, particularly for type 2 diabetes, with projections estimating that this will affect 10% of the population by 2035.

Significant health complications: Diabetes is a leading cause of complications such as blindness, kidney failure, heart attacks, and strokes.

Economic impact: The treatment of diabetes, especially type 2, represents a large portion of the NHS budget, with treatment and management costing around 10% of the annual budget.

Health inequality and prevention

Health inequalities: Diabetes prevalence is higher in more deprived areas and amongst minority ethnic communities, making it a key issue for reducing health inequalities.

Preventable cases: Unlike type 1 diabetes, type 2 can be prevented through lifestyle changes, which is a major focus of prevention programmes.

Preventative investment: The Welsh Government is investing in programmes like the All Wales Diabetes Prevention Programme (AWDPP) to help those at high risk make lifestyle changes, such as dietary improvements and increased physical activity.

Prevalence

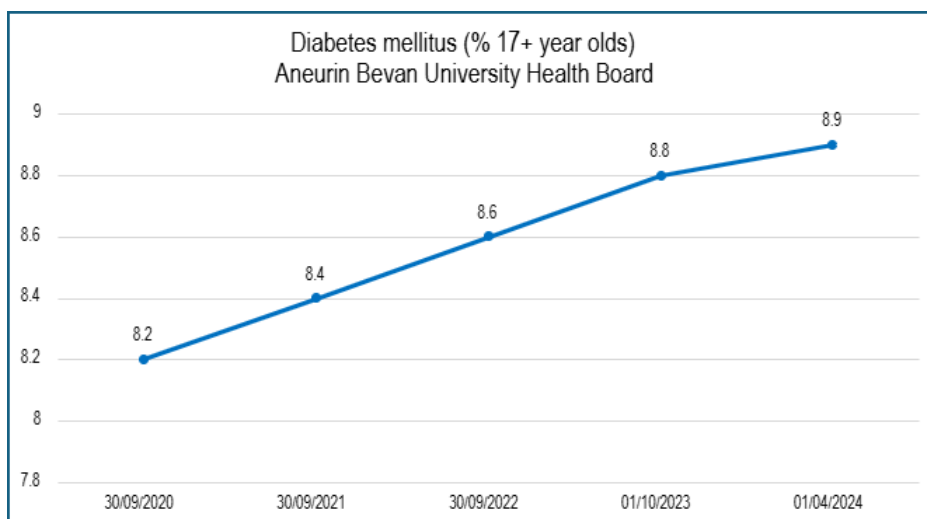
Gwent prevalence is in line with the Wales national average with prevalence at just over **8%** of the adult population living with diabetes and estimates suggest the prevalence in Gwent of diabetes may rise to 10% of the population by 2035 in line with national predictions. Whilst Type 1 diabetes affects around 3,400 people in Gwent (and 16,000 people in Wales) and cannot be prevented, around 42,300 people in Gwent (and more than 190,000 people in Wales) have type 2 diabetes, which can be prevented or delayed, [New approach to tackle diabetes and improve care unveiled | GOV.WALES.](#), ([Disease registers by local health board, cluster and GP practice](#)).

Prevalence continues to rise year-on-year, and estimates suggest the prevalence of diabetes may rise to 10% of the population by 2035 with one in 11 adults in Wales developing T2 diabetes. [Diabetes prevalence – trends, risk factors, and 10-year projection – Public Health Wales](#)

Risk Factors

Risk of developing diabetes is increased with age. Individuals who are white and over 40 years are at a higher risk, yet those over 25 are a greater risk if they are African Caribbean, Black African or South Asian. The risk is increased by 2 to 6 times in developing Type 2 diabetes if your parent, brother, sister or child has diabetes. There are certain health conditions that increase risk of developing diabetes including high blood pressure, coronary heart disease, and stroke. Individuals who suffer from mental ill health are at a greater risk of developing diabetes, such as people who have schizophrenia, bipolar illness or depression, or if you are receiving treatment with antipsychotic medication. Women who have polycystic ovaries, gestational diabetes or a baby weighing over 10 pounds also have an increased risk of developing the disease.

Chart 1 – Diabetes percentage 17+ years 2020-2024

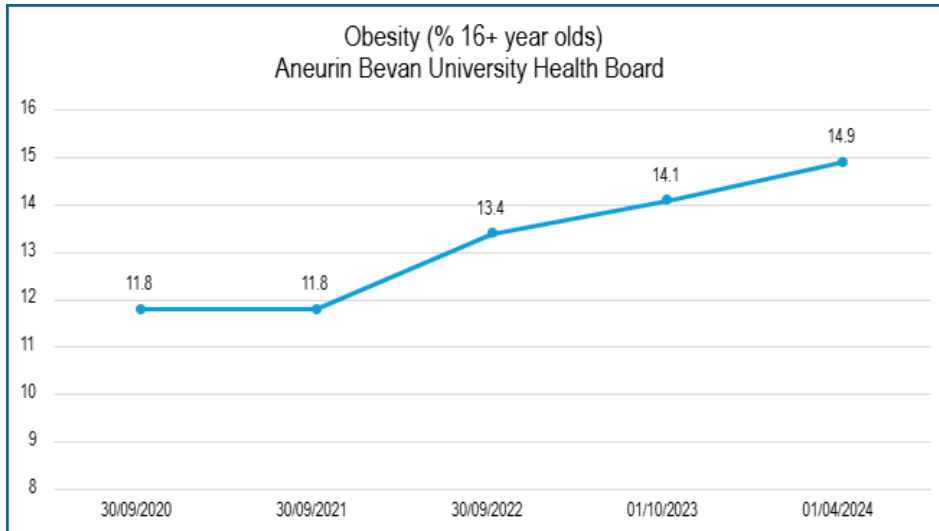


Source: [Disease registers by local health board, cluster and GP practice](#)

Those in deprived areas and minority groups face greater risks and poorer outcomes. Obesity (BMI 30+) more than doubles the risk, with 8.2% of obese adults having diabetes, compared to 3.6% of non-obese (National Survey for Wales, 2022/23).



Chart 2 – Obesity percentage 16+ years 2020 - 2024



Source: [StatsWales, Disease registers by local health board, cluster and GP practice](#)

Chart 2 demonstrates the sharp rise in recorded obesity in 16 years + across the Health Board. Obesity is a major factor in T2 diabetes and demonstrates a similar increase as diagnosis rates. The prevalence continues to rise, placing a substantial financial burden on the Health Board. It should be noted that GP registers tend to understate the true prevalence of obesity. The population prevalence of overweight and obesity in adults in Gwent is 65% that equates to 237,000 adults.

Social determinants of health, such as income, education, employment, and housing, significantly influence diabetes risk, progression, and outcomes. Socioeconomic disadvantage, food insecurity, and deprivation increase Type 2 (T2) diabetes prevalence, while limited access to healthy options hinders management.

Effective monitoring and control of risk factors can reduce morbidity and mortality associated with diabetes. Evidence suggests that, by supporting people to make lifestyle changes such as healthy diet, exercise, stop smoking, and reducing alcohol consumption, over half of type 2 diabetes cases could be prevented.

Addressing diabetes aligns with national prevention and health improvement agendas, across Welsh Government, Public Health Wales and NHS Wales Performance and Improvement. The National Strategic Clinical Network for Diabetes has six key long-term outcomes to guide delivery of the

<p>Self-management tools for people living with diabetes</p>	<p>Good early effective care for people living with type 1 diabetes</p>	<p>Good early effective care for people living with type 2 diabetes</p>
<p>Tackling inequalities</p>	<p>Preventing, detecting and managing complications</p>	<p>Diabetes in special circumstances (young children, pregnancy and diabetes care in inpatient care setting where serious harm and death have occurred)</p>

Vision

To improve the lives of all people across Gwent living with or at risk of developing diabetes. It will contribute to the ambition laid out in the Health Board 10 year strategy for 2035 of Better Health: Together we will support people to be healthy, active and happy.

Strategic Priorities 2024-25

Diabetes Annual Plan 2024-25 (Appendix 2, slide 6) set out the two strategic priorities:

Priority 1

Develop a diabetic centre for patients to have a one stop shop experience

Priority 2

Implement the five year plan for delivery of effective diabetes technology (hybrid closed loop systems) to children, young people and Adults with type 1 diabetes to prevent the short term and long term complications of Diabetes

Progress So Far

Priority 1

The Diabetes Centre has been established at Nevill Hall Hospital. It focuses on the management and treatment of diabetes, offering comprehensive care including patient education, monitoring, and support. There is a new multidisciplinary foot clinic at Nevill Hall Hospital (vascular, podiatry, medical) to join the established clinic at Royal Gwent Hospital. This development was made possible through the creation of the Diabetes Centre at Nevill Hall, which facilitates multidisciplinary collaboration and brings the team together in a single location to improve care for individuals with diabetes in the North Gwent. There is still no provision for joint working with renal including input for dialysis patients who are the "lost tribe" unable to attend appointments due to dialysis. There is a need for joint renal diabetes clinics working alongside renal colleagues for those with diabetes and renal disease who are pre dialysis.

Priority 2

Hybrid Closed Loop System for Adults

A business case for hybrid closed loop systems was developed and approved in 2022, it included a five-year implementation plan. But no funding could be secured. In November 2024, a partial recurrent funding was identified and this secured three diabetic specialist nurses (one B7 and two B6). The table on the left below shows the revised staffing requirements in the SBAR and the last column on the right demonstrates staff in post May 2025 and the difference from target for year 4 of the implementation plan.



Category	Target as per Business Case						ABUHB Current		Difference from Year 4 Target
	Required	Year 1	Year 2	Year 3	Year 4	Year 5	2024/25	May-25	
Patients - Target	185	264	343	422	528	660	380	407	-121
Diabetes Specialist Nurse (DSN)	1	2	3	3	3	4		3	0
Dietitian	1	1.9	2.4	2.8	3.5	4.3		2.4	-1.1
Consultant	0.3	0.3	1.3	1.3	1.3	1.3		0	-1.3
Psychologist	0.4	1.6	1.6	1.7	2.2	2.8		0	-2.2
Co-ordinator Band 4	1	1	1	1	1	1		0	-1
Admin Band 3	0	0	0	0.5	1	1		0	-1
Admin Band 2 (Nursing)	0	0.2	0.2	0.2	0.2	0.2		0	-0.2
Secretary	0	0.3	0.3	0.3	0.6	0.6		0	-0.6
Total WTE	3.7	7.3	9.8	10.8	12.8	15.2		5.4	-7.4

The current level of adult insulin pump service delivery is not sustainable at these volumes. The majority of consultants in these roles divide their time equally between diabetes and endocrinology, and the interdependencies between these services have affected both new outpatient and follow-up wait times. The impact of this requires further investigation, (see later section Priorities and Plans 2025/26). Funding for additional staff to support the hybrid closed-loop system will enhance capacity for both diabetes and endocrinology services.

Hybrid Closed Loop System for children and young people

Closed-loop systems for children and young people are important for improving glycaemic control and quality of life in children with type 1 diabetes by automatically adjusting insulin delivery based on real-time continuous glucose monitoring (CGM) readings. There has been considerable progress in staffing, service redesign, patient uptake, education, and clinical outcomes. Following the allocation of additional recurrent funding for one B6 Diabetes Specialist Nurse, two dietitians at B7 and B6 levels, a B8A psychologist, and a B4 assistant practitioner, the hybrid closed-loop pathway for paediatric patients (<17 years) has been redesigned. The updated pathway is achieving a 75% uptake rate and is resulting in HbA1c outcomes that are consistent with national averages.

The children's pump service will need to expand to accommodate the typical increase in newly diagnosed cases of T1 diabetes during childhood. There are financial pressures related to the procurement of pumps in the paediatric department. For the year 2024/25 up to month 12, the allocated budget was £1,178,563, while the actual expenditure amounted to £1,446,648, resulting in an overspend of £268,085. Similarly, for the period up to April 2025/26, the year-to-date budget was £392,852, with actual spend reaching £522,785, resulting in a cumulative variance of £129,933. These figures demonstrate a consistent trend of overspending against the planned budget, predominantly driven by pump-related costs, with a minor contribution from endocrinology consumables. This highlights ongoing financial challenges in managing these costs. When individuals reach 16 years of age or older, they transition to adult services. Although additional funding has been allocated, the adult insulin pump service remains unsustainable in its current form. Barriers remain in adult services due to the lack of sustainable funding for pump therapy, with a freeze on new pump starts (except urgent cases) due to capacity limits. These limitations are primarily caused by



psychological support needs and insufficient administrative time, which further impact the resource availability of Diabetes Nurse Specialists and consultants.

Aneurin Bevan University Health Board Diabetes Services

The Health Board has several different programmes across the pathway, a draft version of diabetes interventions across the domains and life course is at appendix 1.

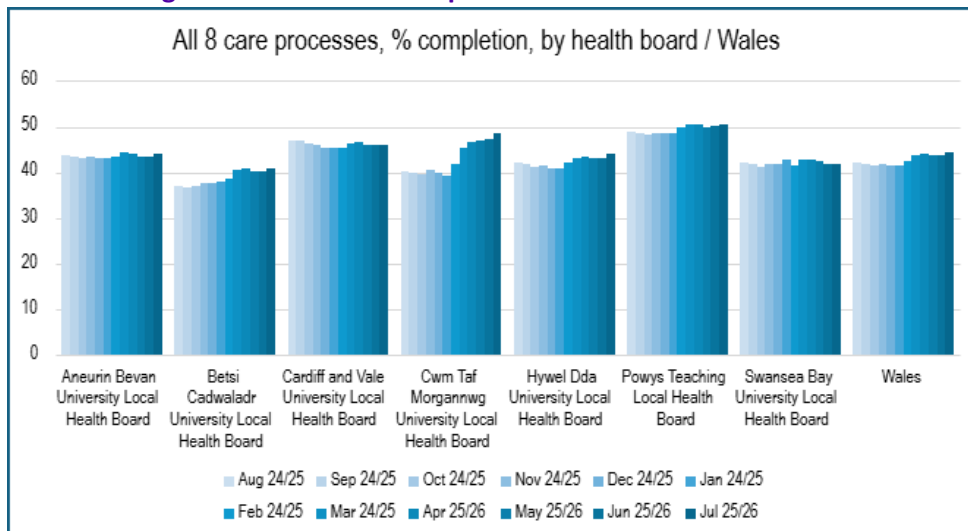
Managing and Monitoring Diabetes in Primary Care

There are 68 GP Practices across the Aneurin Bevan University Health Board foot print servicing a GP Practice population of 632,314 people. General practitioners and their primary care teams undertake most of the monitoring and management of patients with diabetes, particularly for those with Type 2 disease. Approximately 80% of patients are managed and monitored within primary care and will not require secondary care intervention. Primary care performs the **annual eight care processes** as outlined above. The eight diabetes care processes (depicted below) are an annual health check, recommended by NICE, to monitor health, detect and prevent complications like heart disease, kidney disease, stroke, and diabetic foot, and ensure patients meet treatment targets. These key annual checks will improve long-term outcomes.



Progress against the Eight Care Processes is monitored monthly via the Diabetes Insights and Variation Altas to support identification of variation and the Primary Care Portal.

Chart 3 – Eight Care Processes compliance across all Health Boards 2024-2006



As shown in the chart above, the percentage of T1 and T2 patients with a recorded completion within the past 15 months of all eight care processes has remained broadly level in ABUHB over the past year (43.9% in Aug 2024, 44.2% in Jul 2025). This contrasts with increases seen in Betsi Cadwaladr (3.9 percentage point increase) and Hywel Dda (2 pp), and the more obvious increase beginning in March 2025 in Cwm Taf Morgannwg (8.3 pp over the year, from 40.3% in Aug 2024 to 48.6% in Jul 2025).

Chart 4 – Individual percentage completion care process 08/24 – 07/25

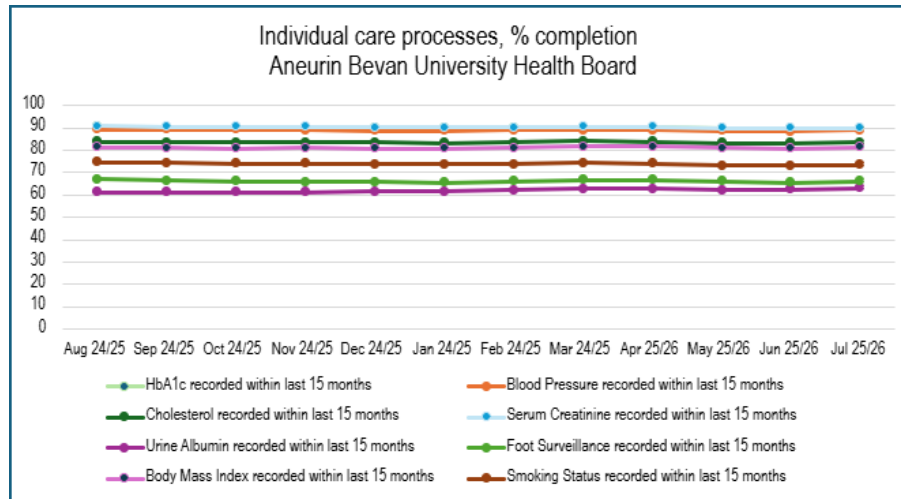


Chart 4 shows the percentage of T1 and T2 ABUHB patients with a recorded completion within the past 15 months of each individual care process. As with the combined data, the trend has remained mostly flat, with variations of less than one percentage point over the year on six of the eight metrics.

Chart 4 above demonstrates that urine albumin, to check kidney function, and foot surveillance are the lowest recorded care process. VBHC will be supporting the initial implementation of urine albumin testing by engaging ten practices. Variance has been established across all ten with best practice identified, the selected practices represent a diverse range of performance levels, patient engagement including in person and survey-based feedback has been received. The VBHC will be launching new communication and advice on Urine ACR testing (see Appendix 2). The ten practices will be distributing patient activation letters, information leaflets, and urine collection bottles to patients who have not undergone urine albumin testing within the past 12 months. Additionally, urine albumin testing will be incorporated into the GMS Chronic Kidney Disease Quality Improvement Project for the 2025/26 period.

The data utilised for national performance monitoring of the eight care processes is derived from primary care records. However, as management of type 1 diabetes primarily occurs within secondary care settings, this data source exhibits limited coverage, leading to a compliance rate of only 24%. Secondary care records are maintained in narrative (free text) format, which impedes automated data extraction and necessitates manual transfer by primary care personnel into the T1 diabetes portal. Recent sample case-mix audits undertaken across different clinics and locations, focusing on urine albumin and foot surveillance, by the VBHC team, do show much higher



compliance. Due to the free-text format the audits were resource intensive and not a sustainable method of measuring compliance in the future. There is national roll-out of the WISDM-diabetes database however the timescales for this are not clear. However, considering the number of primary care patients with T2 diabetes, the most significant opportunity for improvement is increasing the rate of annual urine albumin testing, an initiative supported by the VBHC project.

To support more complex patients with T2 diabetes, there is a dedicated **primary care specialist nursing team** led by a GP specialist, which serves as a bridge between primary and secondary care with one session per week. The referrals to this team may indicate a need for expansion.

Managing and Monitoring Diabetes in Secondary Care

The secondary care provides specialist diabetes for both type 1 and type 2 diabetes patients. Referrals into **secondary care** are focused around the "Super 7", a framework for categorising and delivering specialist (secondary care) diabetes services, to address complex cases not managed in primary care. This includes inpatient diabetes, antenatal diabetes (high risk pregnancy, antenatal care with diabetes and preconception planning), children, diabetic foot care, diabetic nephropathy (renal dialysis), insulin pumps, T1 diabetes (including young people). The diabetic service collaborates closely with the endocrinology department.

Gestational Diabetes: A Diabetes Specialist Midwife was put into post April 2024 and provides specialist care for gestational diabetes to ensure the Consultant Obstetrician cares for complex pregnancies. The Ante Natal Clinics across the hospitals carry out all OGTT tests. Due to demographic shifts, managing various types of diabetes in pregnancy has become increasingly complex. The rising prevalence of T2 diabetes has led to a corresponding increase in the number of patients with this condition receiving antenatal care. Currently, the service remains fragile, with only one Diabetes Specialist Midwife in post.

Type 2 Diabetes Remission Service

Aneurin Bevan University Health Board was one of four pilots, trialling the **Type 2 Diabetes Remission Service** that provides structured, low-calorie weight management programmes to help individuals achieve T2 diabetes remission, with a focus on a short-term, very low-calorie diet to lose weight and maintain it long-term. The All-Wales pilot funding concluded in March 2025, and as a result, this service is no longer accepting new patients. Currently, the Health Board does not offer a diabetes remission program for patients. This is particularly notable given the published data from the DiRECT study, ([The Diabetes Remission Clinical Trial \(DiRECT\): protocol for a cluster randomised trial](#)) which demonstrated that a substantial proportion of participants following a Very-Low-Calorie Diet achieved and maintained diabetes remission at one year (46%) and two years (36%).



Value-Based Healthcare Projects

Value-Based Healthcare (VBHC) in Wales is rooted in the [Prudent Healthcare](#) philosophy, focusing on four key principles: coproduction, equity, intervening gently and effectively, and reducing unwarranted variation. This approach emphasises delivering what matters to patients by collecting Patient-Reported Outcome Measures (PROMs) and [Patient-Reported Experience Measures \(PREMs\)](#), fostering data-driven decisions, and ensuring patients and clinicians work together to improve care and outcomes while using resources efficiently. Over the last 12 months VBHC have undertaken two projects DICE and Cardio Renal Optimisation, and are currently supporting improvement in two of the eight care processes (Urine Albumin, to check kidney function, and foot surveillance).

Diabetic Inpatient Care and Education (DICE) VBHC project facilitated the establishment of a permanent consultant-led DICE team, based at Grange University Hospital. DICE team actively case manage in-patients with diabetes to reduce length of stay by working with primary care to facilitating earlier discharge by linking with the primary care specialist nursing team. The team provides targeted patient care and implements a structured staff education programme. Given that one in six hospital admissions have diabetes, the team has achieved a reduction in the length of stay for patients with diabetic foot infections by 1.91 days. Additionally, 7.7% of patient reviews conducted by the team at the front door, have successfully avoided hospital admissions (based on 3-month audit 2024). Formal educational sessions have been delivered to over 100 nursing staff and 136 clinical staff during targeted drop-in sessions. The additional funding has enabled a new dedicated Diabetic Specialist Nurse team which allowed the existing Diabetic Specialist Nurses to be repatriated to provide care in outpatients and DICE across the enhanced local general hospital sites.

Cardio-Renal Optimisation VBHC project aims to mitigate the substantial disease burden associated with diabetes, thereby reducing the occurrence of long-term complications. A multidisciplinary team comprised of primary care pharmacists, a technician and an admin support have screened over 12,000 patients. Among these, 1,500 patients have completed comprehensive face-to-face holistic assessments, and of these, over 1000 individuals have initiated therapy with SGLT2 inhibitors, to regulate blood glucose levels in adults with type 2 diabetes. In addition, over 1,200 patients have been informed of their Kidney function and CV risk, with 40 patients referred onto 'Help me Quit', structured education programmes and informed of many other important factors to support their management of diabetes, including 'Sick day rules' (nearly 1,200 patients were previously unaware).

VBHC will has prioritised **albumin urine testing and foot surveillance projects** working with the ten identified practices. Public health has provided the initial funding for the project, enabling the dissemination of communications and the distribution of urine collection pots to patients prior to their appointments. This intervention is grounded in successful outcomes previously achieved within Cwm Taf Morgannwg University Health Board. VBHC recognises the potential risks associated with maintaining engagement with the ten practices, as well as the importance of understanding the activities of other practices that may be influencing urine albumin testing rates. The project will cease in



March 2026 and will operate on a six-week continuous improvement cycle. Lessons learned from the urine albumin testing will be integrated into the foot surveillance programme. Additionally, an assessment of the costs associated with the rollout across all practices will be necessary should the initiative prove successful.

Self-management

Self-management is essential for effective diabetes control, and individuals living with the condition can benefit from a range of resources, including **MyDESMOND** and **SEREN** (for paediatrics with T1 diabetes).

The MyDESMOND is available for anyone with a diagnosis of T2 diabetes over the age of eighteen. It is an online platform which remains nationally commissioned until 2026/27, with initiatives in place to increase uptake via primary care QR code access and user feedback. However, uptake of MyDESMOND remains low, with feedback indicating usability issues. SEREN continues to support young people with T1 diabetes moving between paediatric to adult diabetes services.

Structured Education Programmes

DAFNE (Dose Adjustment For Normal Eating) is the structured education program for adults with T1 diabetes. It is complemented by Diabetic Nurse Specialist education and covers all aspects of managing living with T1 diabetes. The programme is available to all individuals with T1 diabetes, with evidence demonstrating improvements in HbA1c levels, reductions in hypoglycaemic episodes, and enhanced quality of life. DAFNE courses are conducted in groups of up to nine participants, both in person and virtual groups with approximately ten courses scheduled annually across the Health Board. The programme is resource-intensive, requiring the dedicated involvement of one Diabetes Nurse Specialist and one dietitian over five days per course. DAFNE serves as a precursor to insulin pump therapy, is recognised as the national standard, and is an All Wales recommended course. The objective is to offer this programme within six months of diagnosis. It must be provided within six months of a new diagnosis and is also available to individuals with pre-existing T1 diabetes. Whilst DAFNE delivery has increased with the additional staffing resources for year 1 hybrid closed loop business case, capacity remains insufficient and access is delayed, resulting in a current waiting list of 332 patients. This poses a barrier to timely initiation of insulin pump therapy. Digital health interventions still present an opportunity to improve education at scale.

The **XPERT Structured education programme** constitutes a six-week group-based course comprising (2.5-hour sessions) designed to support individuals with T2 diabetes. The primary objective of the programme is to facilitate the acquisition of knowledge, skills, and understanding necessary for effective management of type 2 diabetes, thereby enabling participants to regulate their blood glucose levels more efficiently and make relevant behavioural change to manage cardiovascular risk factors. The course is delivered by a multidisciplinary team across the Health Board. Attendance lists are forwarded to primary care for record-keeping purposes. Although feedback regarding the course has been highly positive, there is presently no formal mechanism in place to

assess the programme's impact or to correlate it with subsequent complications, thereby limiting assurances regarding its effectiveness in reducing adverse outcomes. The number of referrals to the programme is substantial; however, this does not correspond to the proportion of individuals who complete it. The programme's design necessitates considerable resources for both its organisation and delivery. Gaining a comprehensive understanding of the resources allocated in relation to the long-term outcomes of the programme would support the principles of a VBHC approach.

Dietetics offers a **Carbohydrate Counting Refresher** course, consisting of two virtual group sessions designed to help patients update and refine their carbohydrate counting skills to improve glycaemic control. There is also a one-off **Diabetes Awareness Session (DAS)** for those with T2 Diabetes within 3 years of diagnosis. DAS is run by Dietetics and referrals are made via the Diabetes Education referral route, with those that meet the criteria being forwarded to Dietetics for the group to be offered.

Preventing Diabetes

All Wales Diabetes Prevention Programme

The [All-Wales Diabetes Prevention Programme](#) (launched in 2022) is a Welsh Government funded Public Health Wales-led initiative to prevent the development of T2 diabetes by supporting at-risk individuals with lifestyle changes, such as diet and physical activity. This is delivered by Dietetics as part of the All-Wales project with fixed term funding until March 2026 and currently rolled out across Caerphilly, Blaenau Gwent and most recently Newport. The total funding allocation for the programme across the seven clusters is £337,000, sourced from two funding streams: the Strategic Programme for Primary Care (£220,000) and Welsh Government (£117,000). Both funding sources are scheduled to conclude in March 2026. The programme uses blood tests (HbA1c that measures a person's average blood sugar levels over the past two to three months) to identify eligible people in the pre-diabetes range (with HbA1c between 42 to 47mmol/mol), who then receive a consultation with a trained Lifestyle Support Workers or Dietitians. These consultations provide personalised advice and may refer participants to additional resources to help manage weight, increase physical activity, and learn more about T2 diabetes. Further information about All Diabetes Prevention Programme is available here [All Wales Diabetes Prevention Programme - Public Health Wales](#)

A recent (June 2025) national evaluation of the AWDPP, provides initial evidence of the programme's effectiveness, showing that the risk of progressing to living with diabetic blood glucose levels was reduced by 23% among those who were identified as having pre-diabetes and took part in the diabetes prevention programme. (phw.nhs.wales/news/nhs-wales-diabetes-prevention-programme-cuts-risk-of-developing-type-2-diabetes-by-nearly-a-quarter/outcome-evaluation-of-the-all-wales-diabetes-prevention-programme/). Locally since June 2022 through March 2025, a total of 7,150 eligible individuals has been identified; of these, 2,778 (38.8%) have participated in the programme. 454 individuals, who participated in a follow-up assessment, 233 exhibited either a reduction in risk status or had exited the at-risk classification entirely, while twenty-six individuals progressed to a diagnosis of diabetes, the remainder stayed the same. This represents 5.7% of pre-diabetic patients developing diabetes which is lower than the expected development rate of approximately 25% with no intervention ([Global epidemiology of prediabetes - present](#)



[and future perspectives | Cardiovascular Diabetology – Endocrinology Reports | Full Text](#)).

Due to the temporary nature of the funding for the Diabetes Prevention Programme and the reliance on 1-year fixed-term contracts since its inception, staffing has been challenging. This has resulted in limited team capacity and a reduced ability to fully explore and capitalise on the opportunities the programme presents. There is variation between the number of eligible patients and those who attend; the public health team used behavioural science to reword the invitation letter for appointments to increase uptake, and this will be measured during 2025/26. A service exit plan is currently being developed in response to funding uncertainties for 2026/27 and referrals will cease in October 2025.

Managing Lifestyle Risk Factors

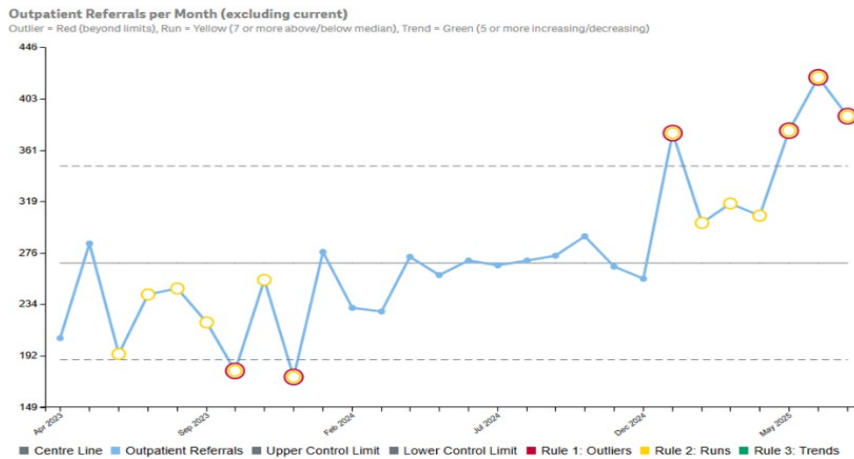
The Health Board provides a range of services to reduce the lifestyle risk factors attributable to diabetes. These services offer behavioural change support to adopt and maintain healthy life style choices. These services include:

- Stop Smoking Service
- Substance Misuse Service
- Weight Management Services
- National Exercise Referral Scheme
- Mental Health and Wellbeing Support (MELO)

Diabetes and Endocrinology Capacity and Demand

The diabetes and endocrinology secondary care services have seen an increase in outpatient referrals, new outpatient waiting lists and follow-up waiting lists. The Endocrinology New Outpatient Waiting List has fallen but current staffing levels are insufficient to sustain previous throughput and is likely to increase. There is a need to assess the interdependencies between diabetes and endocrinology services in terms of capacity and demand to support effective workforce planning across both specialties and the wider multi-disciplinary teams. Planning will be supporting the directorates. It is anticipated that the capacity and demand for diabetes and endocrinology services will be finalised by the end of November 2025 through the annual planning process for 2025/26.

Chart 5 - Diabetic Medicine Outpatient Referrals per month (Apr 23 – Jul 25)

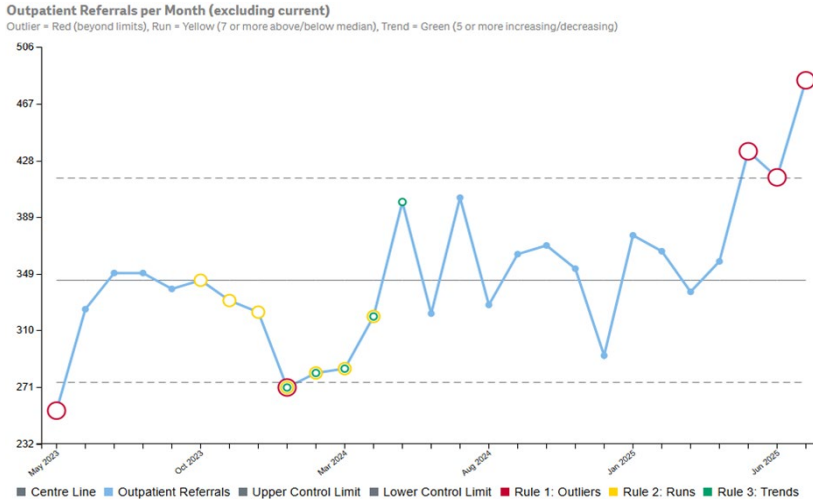


Outpatient referrals per month:
 Apr 23 position: 206
 Jul 25 position: 389

Referrals to diabetic outpatients have been steadily rising since December 2024 as demonstrated in Chart 5 above. Referrals have steeply increased over the last 3-months. This increase is likely due to the sickness absence within the specialist diabetic primary care nursing team, medication shortages of GLP1 analogues and release of Mounjaro. It is anticipated that the Level 3 weight management service will suspend routine referrals for Mounjaro, while still accepting urgent referrals. If Mounjaro is required and the patient is part of the weight management service with prediabetes the current budget permits initiation for up to 25 patients annually. Endocrinologists may prescribe Mounjaro to patients with diabetes. However, many individuals within the weight management service who have diabetes or prediabetes are not under the care of endocrinology and may face barriers to accessing the medication due to budget limitations. The existing budget does not adequately support the overall demand for the medication.

The Welsh Government has recommended a new national hub-and-spoke model, and while the primary care specialist team provides a solid foundation for implementing this model, it is highly probable that there will be a workforce gap to address. Primary care has arranged a gap analysis workshop taking place in the third quarter. The national model necessitates the allocation of psychological services, presenting an opportunity to develop this provision concurrently with the implementation of the hybrid closed-loop system. If implemented the national model should reduce referral to secondary care across T1 and T2 (national model is based on Cardiff model and reductions in referrals have been achieved).

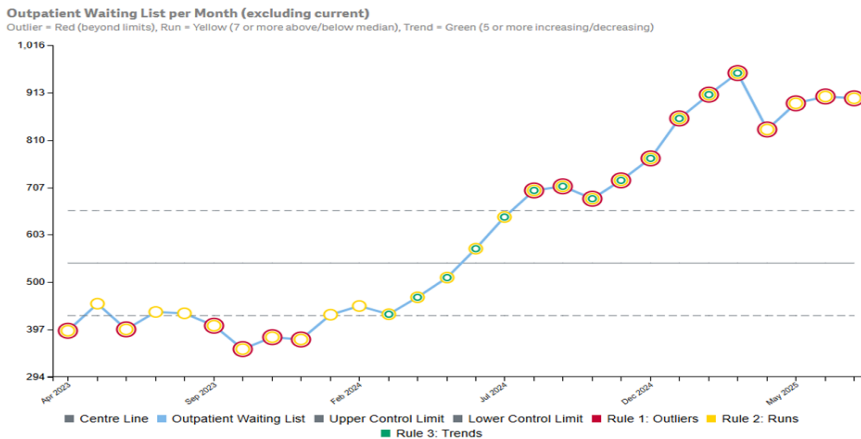
Chart 6 - Endocrinology Outpatient Referrals per month (May 23 – Jul 25)



Outpatient referrals per month:
May 23 position: 255
Jul 25 position: 483

Chart 6 above demonstrates the step change in increase of referrals into endocrinology from April 2024 reaching the highest numbers of referrals July 2025.

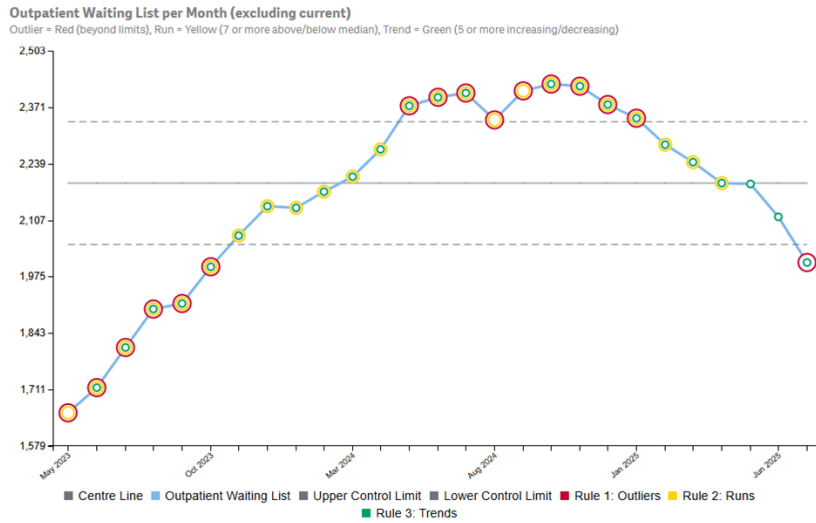
Chart 7 - Diabetic Medicine New Outpatient Waiting List (Apr 23 – Jul 25)



Outpatient referrals per month:
Apr 23 position: 394
Jul 25 position: 901

Chart 7 illustrates that the diabetic outpatient waiting list has exhibited a sustained upward trend since March 2024, surpassing the upper control limit in August 2024. A marginal decrease was observed in October 2024, followed by a pronounced increase between December 2024 and March 2025. A reduction of approximately 100 patients was recorded in April 2025. An analysis of workforce capacity and demand is required to assess whether the deployment of the DICE model has contributed to reduced outpatient clinic capacity, thereby elevating wait times. The anticipated impact of two retirements suggests that performance may decline in the forthcoming months due to constrained clinic capacity.

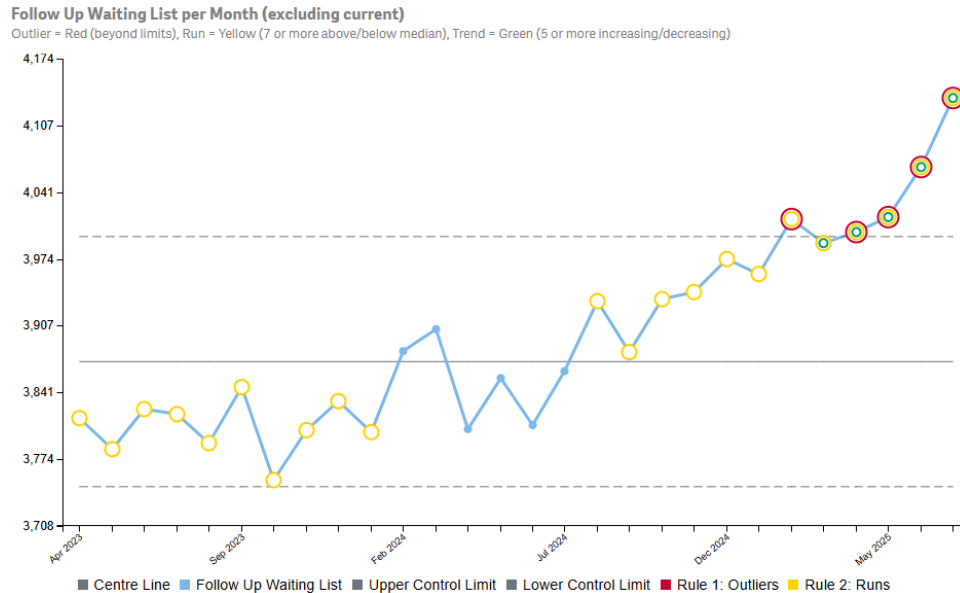
Chart 8 - Endocrinology New Outpatient Waiting List (May 23 – Jul 25)



Outpatient referrals per month:
May 23 position: 1,656
Jul 25 position: 2,008

Chart 8 illustrates an upward trend in the endocrinology new outpatient waiting list from May 2023 through December 2024. The recent decline in waiting times was attributable to dedicated consultant oversight of endocrinology outpatient clinics and dedicated funding for a registrar conducting three clinics weekly. The retiring of the consultant and departure of the registrar have reduced capacity, and current staffing levels are insufficient to sustain previous throughput, suggesting that wait times are likely to increase moving forward.

Chart 9 - Diabetic Medicine Follow Up Waiting List (Apr 23 – Jul 25)



Outpatient referrals per month:
Apr 23 position: 3,815
Jul 25 position: 4,135

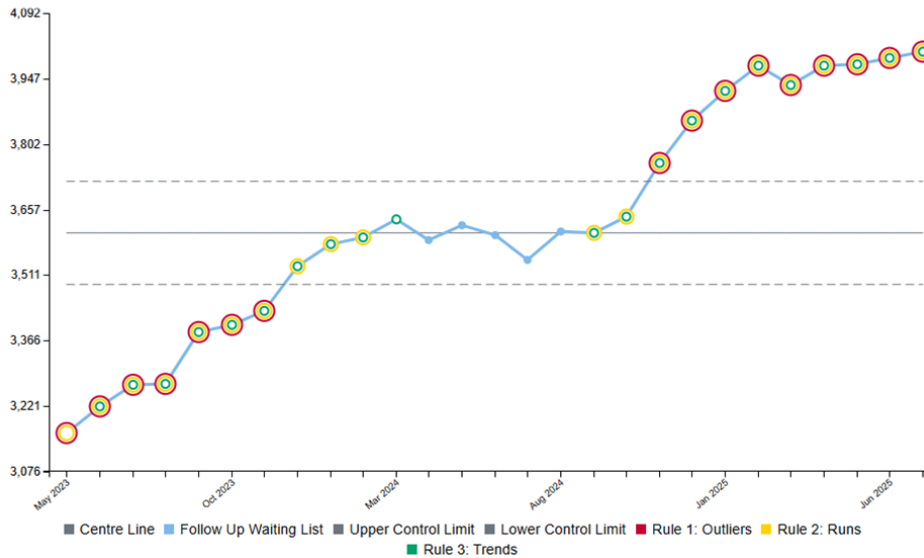
Chart 9 demonstrates that the diabetic Medicine Follow Up Waiting List has been increasing since May 2025.



Chart 10 - Endocrinology Follow Up Waiting List (May 23 – Jul 25)

Follow Up Waiting List per Month (excluding current)

Outlier = Red (beyond limits), Run = Yellow (7 or more above/below median), Trend = Green (5 or more increasing/decreasing)



Outpatient referrals per month:
May 23 position: 3,161
Jul 25 position: 4,007

Chart 10 above illustrates the follow-up waiting list for endocrinology has been increasing since May 2023 and further increased in October 2024.

Strategic Priorities 2025 - 2030

The Diabetes Strategic Group has outlined its draft priorities for the next five years 2025-20230, aligning them with the priorities established by the National Diabetes Network for 2025/26.

- To proactively identify the patients at risk of developing diabetes (prediabetics) and prevent them from developing diabetes by offering behavioural change interventions.
- To provide specialist secondary care diabetes service to priority patients group including those with Type 1 Diabetes, those needing insulin pumps, the young persons with diabetes, antenatal diabetes, renal disease stage 4 or 5, active diabetes foot disease, pancreatic diabetes (type 3c), Latent Autoimmune Diabetes in Adults and complex clinical situation.
- To implement hybrid closed loop systems for managing blood glucose levels in type 1 diabetes five-year plan.
- To improve the quality of diabetes care (focussing on eight care processes, treatment targets and structured education) to prevent the onset or worsening of diabetes complications.
- To educate, enable and empower to patients to take control of their diabetes care encouraging self-management.
- To reduce the referrals to specialist secondary care diabetic service.
- To provide mental health and wellbeing support to patients living with diabetes.
- To reduce health inequalities across diabetes services.
- To improve access to the type2 diabetes remission programme.

The table in Appendix 3 correlates the eight High Value, High Impact metrics with these draft priorities. The group is currently developing associated actions, and a preliminary diabetes delivery plan is being created, which will form a theme in the Preventable Premature Mortality and Morbidity Framework currently being developed. Ongoing work includes mapping diabetes interventions across various domains and throughout the life course (Appendix 1).

Risks

The risk assessment (appendix 4) highlights significant pressures on diabetes care, including data sourcing issues, funding gaps for new technologies, workforce shortages, uneven service coverage, uncertainty of national funding for prevention and misalignment between guidance and available resources. Rising demand, financial sustainability concerns, and pressures from implementing national models further add to the challenge. Mitigations focus on national oversight and phased rollouts, strengthened business cases, targeted resource allocation, capacity planning, and the development of sustainable multidisciplinary models. Financial and service risks are being managed through evaluation of cost-effectiveness, use of digital alternatives, and active lobbying for resources, ensuring that both current gaps and future demands are systematically addressed.

There is a significant funding gap across diabetes services within ABUHB, including the lack of confirmed long-term investment for the **Hybrid Closed Loop (HCL) pathway**, full rollout and investment beyond March 2026 of the **All-Wales Diabetes Prevention Programme (AWDPP)**, the re-commissioning of the **Diabetes remission programme** to meet current demand, the continuation of **MyDESMOND digital self-management platform** beyond 2027/28, and anticipated resource requirements for the **National Hub & Spoke multidisciplinary model**. There is a need to assess the capacity and demand for **antenatal diabetes care** and **endocrinology services** to identify any resource gaps.

Conclusion

Diabetes poses an escalating clinical, financial, and equity challenge for our Health Board. Rising Type 2 prevalence, persistent Type 1 impacts, and widening inequalities require a coordinated, system-wide response, this needs to be informed by an understanding of and the embedding of the social determinants of health, to provide the best opportunity of primary prevention of T2D and secondary prevention of associated risks of associated harms in T1D and T2D. Despite progress with prevention initiatives, VBHC projects, and new technologies, gaps in funding, workforce, education, and digital sustainability remain. Addressing these is vital to reduce preventable mortality, morbidity, and ensure equitable, high-quality care. Investing in prevention, digital solutions, and routine care offers strong returns by lowering costly complications. Targeted efforts in deprived and minority communities are essential to reduce health inequalities.

Recommendations

Service Development, Strategy and Programme Development

Develop dedicated project management for diabetes programme to support the Diabetes Strategic Group, develop a diabetes workplan and support the recommendations in this plan.

Deliver a Health Board-wide Diabetes Strategy through facilitated workshops, supported by VBHC and Business Intelligence, to set out vision, ambition, and clear priorities.

Finalise clinical pathways across primary, community, and secondary care to facilitate seamless transitions between services and align with national pathways work. Develop both current and aspirational pathways concurrently to support comprehensive gap analysis.

Funding and Sustainability

Understand total funding gap across diabetes pathways.

Secure long-term, sustainable funding for key programmes including Hybrid Closed Loop (HCL) systems, MyDESMOND beyond 2027/28, the All-Wales Diabetes Prevention Programme, and the national hub-and-spoke MDT model.

Update Hybrid Closed loop workforce gaps to reflect 25/26 A4C costs.

Workforce Planning

Undertake a comprehensive capacity and demand review across diabetes and endocrinology, with specific focus on consultant and psychology provision and any associated multi-disciplinary team support.

Undertake capacity and demand modelling for ante natal diabetes care including the rising number with gestational diabetes and type 2 diabetes.

Undertake gap analysis of National multi-disciplinary hub and spoke model.

Prevention and Inequalities

Expand targeted rollout of the Diabetes Prevention Programme to Torfaen and Monmouthshire, prioritising high-prevalence and deprived populations.

Implement a preventable premature mortality framework to track progress in reducing inequalities in diabetes and CVD outcomes.

Structured Education and Digital Innovation

Evaluate the impact, costs, and long-term outcomes of structured education programmes, ensuring scalability and alignment with Value-Based healthcare principles.

Explore alternative or complementary digital platforms to ensure sustainable, patient-centred self-management support beyond current contracts.

Monitoring, Data and Outcomes

Improve accuracy of Type 1 diabetes data reporting by developing sustainable data capture solutions between secondary and primary care.

Comprehensive understanding of the data needed to measure and evaluate diabetes care across the whole pathway.

Appendix 1 – Diabetes across the intervention and life course



Socio-economic factors and environmental supports	This tier focuses on addressing the root causes of diabetes, such as poverty, lack of access to healthy food and environments
Population based interventions	These interventions target large groups with the goal of improving overall health and reducing risk for diabetes
Preventive measures and early detection	Focuses on identifying on individuals at high risk of developing diabetes and implementing preventive measures
Clinical management of Diabetes	This tier focuses on managing diabetes in those individuals who have been diagnosed with the condition
Management of Diabetes Complications	This tier focuses on treating complications of diabetes such as kidney diseases

Appendix 2 – Diabetes Annual Plan 2024/25



2425 Diabetes Annual Plan Pack.ppt

Appendix 3 – VBHC Posters, produced by Public Health Communications, to promote urine albumin tests.

Protect your kidneys
Return your sample

When you have diabetes, your kidneys are at risk. Even if you feel fine, damage can build up silently over time.

Your kidneys do vital work, if they stop functioning properly, it can impact your health and wellbeing.

In severe cases kidney failure can be life-threatening.

A simple urine test is vital to identify warning signs that might require treatment.



Damaged kidney Healthy kidney

Act Early, Test Yearly.

With thanks to our patients for supporting the co-production of these materials and to the charities Kidney Wales and Diabetes UK for facilitating the focus groups

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

Living with Diabetes?

Have you had a urine test in the last 12 months?

2 in 5 people miss this simple check.



Not had one? Pop along to, or call your GP and:

1. Pick up a sample pot
2. Pee in it
3. Pass it back to the practice

It is very important to have your urine tested at least once a year as protein in the urine is the first sign of kidney damage.

Picking this up early means you can start treatment that can protect your kidneys from long term damage.



Act Early, Test Yearly.

With thanks to our patients for supporting the co-production of these materials and to the charities Kidney Wales and Diabetes UK for facilitating the focus groups

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







Appendix 4 – High Value, High Impact Metrics - Value & Finance Leadership Group mapped to Diabetes Strategic Group Draft priorities.

	Metric descriptor	Priorities 2025-2030	Baseline using Diabetes. Insights and Variation Atlas v3 Accessed September 2025
1	Number and % of people at high risk (HBA1c 42- 27 mmol/mol) of developing type 2 diabetes who are invited to All Wales Diabetes Prevention Programme.	<ul style="list-style-type: none"> To proactively identify the patients at risk of developing diabetes (prediabetics) and prevent them from developing diabetes by offering behavioural change interventions. 	Patients with prediabetes diagnosis 3.69%
2	Change in prevalence of people diagnosed with T2D diagnosed over time (adults and paediatrics).	<ul style="list-style-type: none"> To improve access to the type2 diabetes. 	Population Prevalence (T1)






			and T2 combined) 9.01%
3	Compliance with T1 pathway for first year after diagnosis (Adults and Paediatrics).	<ul style="list-style-type: none"> To improve the quality of diabetes care (focussing on eight care processes, treatment targets and structured education) to prevent the onset or worsening of diabetes complications. 	Compliance with care processes T1 24.16
4	% adherence to the bundle of 8 care processes plus DESW (7 for paediatrics).	<ul style="list-style-type: none"> To improve the quality of diabetes care (focusing on eight care processes, treatment targets and structured education) to prevent the onset or worsening of diabetes complications. To provide mental health and wellbeing support to patients living with diabetes. 	Compliance with care processes T2 45.77%
5	% of established people achieving HbA1c treatment target (<58 mmol/mol) when appropriate.	<ul style="list-style-type: none"> To educate, enable and empower to patients to take control of their diabetes care encouraging self-management. To reduce the referrals to specialist secondary care diabetic service. To provide mental health and wellbeing support to patients living with diabetes. 	People with T2D with HbA1c <58mmol/mol 55.86%
6	Is there a plan for roll out hybrid closed loop monitoring technology? Y/N	To implement hybrid closed loop systems for managing blood glucose levels in type 1 diabetes five-year plan.	
7	LoS for emergency and elective diabetes admission vs no diabetes patients.	To reduce emergency hospital admissions for diabetes.	Spells and inpatients per 1k registered people with Diabetes 612/1k Inpatients 293/1k
8	<p>Do health board have plans to identify, monitor and mitigate inequalities of care in your health board? Y/N</p> <p>Which of these groups/ characteristics have specific strategies in places? Care homes, ethnicity, poverty, learning disabilities diabetes pts, LAC Diabetes pts, asylum seekers, homeless pts, prison pts, other specify.</p>	<ul style="list-style-type: none"> To provide specialist secondary care diabetes service to priority patients group including those with Type 1 Diabetes, those needing insulin pumps, the young persons with diabetes, antenatal diabetes, renal disease stage 4 or 5, active diabetes foot disease, pancreatic diabetes (type 3c), Latent Autoimmune Diabetes in Adults and complex clinical situation. To reduce health inequalities across diabetes services. To provide mental health and wellbeing support to patients living with diabetes. 	

Appendix 5 – Register of risks for diabetes.

Risk ID	Risk Description	Likelihood	Impact	Overall Risk	Mitigation
R1	Funding Gap – Hybrid Closed Loop (HCL) Pathway – No Welsh Government funding for HCL	High	High	 High	Costed business case with WG (Nov 24); phased implementation plan being rolled out, prioritisation criteria for existing cases.
R2	Workforce Shortages – Insufficient consultant and psychology hours impact across T1, T2 and endocrinology.	High	High	 High	Costed business case with WG (Nov 24); PIP business case approved (2022) Recommendation of capacity and demand modelling across service.
R3	Inequitable Coverage of AWDPP – Programme not operating across Torfaen and Monmouthshire, driving inequalities. A service exit plan is being developed for implementation from October 25 onwards	High	High	 High	Design new model / Secure sustained funding; prioritise rollout to deprived areas; align with WIMD targeting.
R4	Rising Demand – Growing prevalence of diabetes (esp. gestational and Type 2), straining secondary and primary care capacity.	High	High	 High	Development of national hub and spoke multi-disciplinary model. Roll out of pre-diabetes programme. Capacity and demand work needed across localities to understand demand in gestational diabetes.
R5	National Model Pressures – Implementation of hub & spoke diabetes MDT model likely to require additional unfunded posts.	High	Medium	 High	Undertake gap analysis; phased implementation; lobby for WG resource allocation.
R6	Service Gap - ABUHB currently has no diabetes remission programme available for patients	High	High	 High	The pilot was conducted on a small scale, resulting in approximately 40 referrals annually. Of



Risk ID	Risk Description	Likelihood	Impact	Overall Risk	Mitigation
	following the cessation of the All-Wales Remission project in March 2025.				these, only about 25%—equating to approximately 10 individuals per year—were deemed suitable to initiate the program. Consequently, the limited scope of the pilot would not be expected to generate significant population-wide impact.
R7	Data Gaps – Type 1 diabetes national data is sourced via primary care. All care for T1 is carried out at secondary care but data for national performance is taken from secondary care. This means performance is not accurately recorded.	High	Medium		National team state they will add a 'caution' to the graph. Understanding other Health Boards data transfer into primary care Investigating how 24% of care processes are recorded at primary care for T1. The majority testing is undertaken on T2s in primary care. Increasing provision of tests in primary care will improve performance.
R8	NICE Guidance Misalignment – Changes in NICE guidance for HCL not aligned with current local capacity/funding set out in original business case in 2022.	Medium	Low	 Medium	Advances in technology in HCL system mean that if business case was fully funded would cover additional requirements in current NICE guidance
R9	Financial Sustainability – Requirement to absorb costs of MyDESMOND platform into IMTP from 2027/28.	Medium	Medium	 Medium	Evaluate cost-effectiveness and take-up of MyDESMOND. Undertake review across Health Board of all educational offers and explore digital platform alternatives.



Aneurin Bevan University Health Board

Diabetes Annual Report

2024-25

Diolch | Thank You

For further information on this
report please contact:
Scott.Wilson-Evans@wales.nhs.uk.



DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Digital Community – Mental Health and Learning Disabilities Electronic Patient Record
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Paul Solloway – Director of Digital
SWYDDOG ADRODD: REPORTING OFFICER:	Paul Solloway – Director of Digital

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

This report accompanies the Full Business Case for a replacement of the current Mental Health & Learning Disabilities (MH&LD) electronic patient record (EPR), the Welsh Community care Information System (WCCIS).

The report is intended to support informed decision-making by setting out why a new EPR is required, how the preferred solution aligns with local, regional and national strategies and the measurable benefits it will deliver for patients, staff and the wider health and care system.

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

This business case proposes the procurement and implementation of an integrated MH&LD EPR system for use within the Health Board. This system will align with national efforts in delivering a Shared Care Record (SCR), enabling streamlined communications and data interoperability, as well as with wider healthcare, social care and third-sector providers.

The overarching objective is to ensure a seamless migration from the existing digital platform and infrastructure to a unified, scalable EPR solution. The existing WCCIS platform will become subject to several end-of-life issues over the period January 2026 to March 2027.

This period will see various components of the technology stack become end of life (software components, database and server operating systems). In addition, the



overarching Master Service Agreement (MSA) will reach the end of its extended term in March 2027 and cannot be extended. The MSA provides the premise for the contractual terms and conditions that govern each subsequent deployment order, held directly between organisations and the supplier of the WCCIS platform.

Considering these arising issues, all organisations utilising the WCCIS platform are required to offboard to successor solutions by no later than March 2027. The March 2027 date provides a hard stop deadline for migration off the existing platform due to full de-support and decommission of the WCCIS product immediately after that date.

The risks associated with WCCIS contractual end of life are both significant and unavoidable. These risks place a clear obligation on the Health Board to proceed at pace with the procurement and implementation of a successor EPR. Failure to act decisively within the fixed window exposes the Health Board to serious contractual, financial, operational harm.

Cefndir / Background

The Health Board previously engaged with the national Connecting Care programme, led by Digital Health and Care Wales (DHCW) in response to the end-of-life challenges associated with WCCIS. However, the programme presented significant challenges, including issues with engagement models, strategic alignment, timelines and competing priorities.

Consequently, the Health Board chose to pursue the procurement and implementation of a successor solution, initially focused on MH&LD services. This approach was considered the most effective means of ensuring a timely transition from WCCIS, while maintaining and potentially improving upon the current levels of digital EPR adoption.

The Health Board issued a tender on 12 December 2024 via the London Procurement Partnership (LPP) Framework, specifically designed for mental health services. Four suppliers submitted bids, all of whom passed initial pre-qualification checks focusing on cyber security and data management.

An evaluation panel comprising of representatives from Child and Adolescent Mental Health Services (CAMHS), Child Psychology, Adult MH&LD Services, Assurance and Digital, Data and Technology (DDaT) assessed 321 written responses from each supplier. Two suppliers were disqualified due to critical failures. The remaining two progressed to system demonstrations to validate their written submissions. Final consensus scoring considered social value, quality and cost.

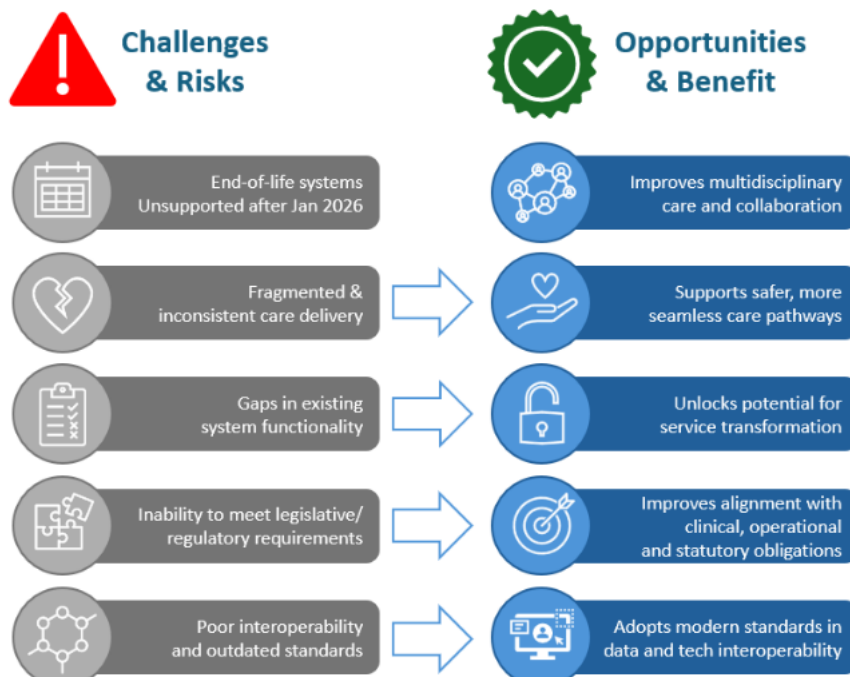
The Access Group's Rio solution has been identified as the preferred system, demonstrating strong alignment with clinical and operational needs, national digital priorities and the Gwent region's Local Authorities who have already contracted with the Access Group on their Social Care platform - Mosaic.

The primary purpose of this business case is to outline the necessity and benefits of transitioning to a modern, comprehensive and fit for purpose EPR (Rio) as a replacement to WCCIS.



By creating a single unified patient record, the system will improve real-time access to patient data across all care pathways in MH&LD, significantly enhancing care coordination and reducing duplication of effort. Rio will aid in health management, enable advanced reporting and improve analytics capabilities to inform both clinical and operational decision-making.

The proposed implementation of Rio will provide opportunities to integrate seamlessly with the chosen regional social care solution across Gwent, as well as any potential national SCR initiative. Aligning local, regional and national standards for data sharing, architecture and security will enable cross-sector collaboration across health, social care and third-sector organisations, supporting individuals with MH&LD while ensuring compliance with national digital health mandates. Greater information sharing and communication between stakeholders will help close the gaps in care coordination and lead to better patient outcomes for some of the most vulnerable populations in society.



Asesiad / Assessment

Why a new EPR is required?

- Technical expiry - software platform, database and server operating system are unsupported from Jan 2026.
- Contractual expiry - MSA ends March 2027 with no extension possible.
- Supplier exit – WCCIS Supplier leaving the market; development ceased.
- Functionality gaps (e.g. referral management, scheduling, data quality) compromising service delivery.
- Poor integration with health and social care, leading to duplication and delays.
- Inability to consistently meet Mental Health Measure (MHM) and Mental Health Act (MHA) reporting requirements.
- Reversion to paper/manual processes if no successor is adopted – unsafe, inefficient and regressive.

Options Appraisal

Option 1 – Do Nothing: An unmanaged return to alternative digital solutions and ways of working.

- **Description:** Allow WCCIS to lapse without structured replacement. Services would revert to paper, spreadsheets, Office 365 and other existing digital systems.
- **Benefits:** Less costly than an EPR procurement.
- **Risks:**
 - High clinical risk due to fragmented, inaccessible records.
 - Loss of statutory compliance (MHM, MHA, Referral to Treatment (RTT)).
 - Increased admin burden, duplication and errors.
 - Service regression and reputational damage.
 - Staff disengagement, recruitment/retention difficulties.
- **Assessment:** Unsafe, unsustainable, not aligned with digital or clinical strategies.

Option 2 – Do Minimum: A managed return to alternative digital solutions and ways of working

- **Description:** Structured withdrawal from WCCIS with governance, comms, training and temporary manual/digital solutions.
- **Benefits:**
 - More controlled transition than Option 1.
 - Staff supported with training and comms.
 - Less costly than an EPR procurement.
- **Risks:**
 - Fragmented Clinical Information
 - Patient Safety and Quality Risk
 - Unsustainable Use of Office 365 as a Clinical Platform



- Excessive Operational and Administrative Burden
- Programme and Project Resource Drain
- Inconsistent Processes and Data Standards
- Business Continuity and Knowledge Dependency
- Technical Obsolescence and Cyber Risk
- Strategic Misalignment and Reputational Impact
- Unknown Financial and Opportunity Costs
- **Assessment:** Under this option, services would continue to operate through a combination of existing digital systems, locally developed solutions (such as CWS / WPAS as well as Office 365 tools i.e. SharePoint lists, Excel trackers and Word templates) and non-digital processes such as paper-based documentation.

This approach would seek to maintain continuity of service delivery while avoiding major investment. However, it would not achieve the integration, consistency or sustainability associated with a single, clinically led EPR.

Key Considerations (applicable to Options 1 and 2):

- Clinical management: Fragmented, multiple systems mean duplicated effort, poor data quality and weaker clinical decisions.
- Programme management: Focus on troubleshooting could drain resources and stall digital transformation.
- Product support: Local tools become 'mini products' - creating duplication, knowledge silos and compliance risks.
- Strategic alignment: A hybrid model undermines national strategy, efficiency and long-term sustainability.

Option 3 – Do Maximum: Proceed with recommended procurement outcome to implement the RIO MH&LD EPR Solution

- **Description:** Implement a modern, interoperable MH&LD EPR following procurement outcome.
- **Benefits:**
 - Continuity & safety: mitigates WCCIS end-of-life risks.
 - Efficiency:
 - Referral processing reduced from 7.65 days → 0.5 days.
 - 50% fewer referral queries.
 - 52,000 admin hours saved over 5 years.
 - Clinician time savings ≈ £1.53m over 5 years.
 - Data quality & compliance: structured data, automated error reduction, statutory compliance maintained.
 - Staff experience: mobile/offline access, streamlined workflows, hybrid working supported.
 - Patient experience: portal for appointments, care plans, secure messaging; real-time risk alerts improve safety.
 - Integration: with Mosaic and regional care systems, supporting Once for Wales and Shared Care Record ambitions.



- Future-proof: enables AI tools, social prescribing modules, advanced analytics.
- **Risks:**
 - Complex programme requiring significant business change.
 - Resource-intensive, with high upfront costs.
 - Dependent on robust implementation and change management.
- **Assessment:** The only sustainable, strategic option. Benefits outweigh risks when well governed.

Comparative Summary

Criteria	Option 1: Unmanaged withdrawal	Option 2: Managed withdrawal	Option 3: Rio EPR
Strategic fit	Misaligned, regressive	Tactical, not strategic	Fully aligned
Benefits	None	Limited, transitional	Clear, measurable
Risks	High, unmanaged	Moderate, still regressive	Complex but manageable
Costs	Minimal but wasted effort	Transition costs, no legacy	Higher cost but long-term value
Sustainability	Not viable	Temporary only	Sustainable, future-proof

Staff in MH&LD services continue to face major challenges with WCCIS. Despite ongoing development, it remains inefficient, difficult to use, and poorly suited to clinical workflows. Referrals outside Primary Care Mental Health Support Services (PCMSS) are mostly manual, with information received by phone, email or post then uploaded to WCCIS. Electronic referrals within or across teams are limited due to system complexity, creating delays, duplication and reliance on local trackers.

Administrative staff spend excessive time entering and validating data, while clinicians must navigate multiple screens to find key information. Mobile working is restricted by the lack of a functional app, poor tablet optimisation and no offline access, forcing staff to return to base to complete notes.

Reporting is labour-intensive and dependent on manual data extraction and cleansing in excel, limiting timeliness and accuracy. Non-mandatory fields and poor data quality compound these issues.

Staff feedback consistently cites slow performance, frequent errors and poor usability, leading to inefficiency, data inaccuracy and increased workload in already pressured services.

The shortlisted suppliers were required to submit financial bids comprising of two components:

1. A core pricing schedule



2. A separate schedule for optional functionality

For evaluation purposes, only the costs included in the core pricing schedule were assessed and compared. This approach reflected the Health Boards use of a priority rating system within the tender, designed to clearly indicate which requirements were considered critical for Day 1/Minimum Viable Product (MVP) capability.

The Rio system, provided by The Access Group (TAG), emerged as the preferred solution due to its strong fit with clinical workflows, operational requirements and national digital objectives. The Access Groups involvement with Gwent Local Authorities, via the Mosaic social care platform, also supports opportunities for greater regional integration and continuity of care.

The implementation of Rio allows for:

- **Continuity and Stability of Service Delivery** - Ensures timely transition away from WCCIS ahead of its end-of-life and contractual expiry, safeguarding against operational disruption and compliance risk.
- **Implementation of a Modern, Fit-for-Purpose EPR Platform** - Replaces outdated, fragmented systems with a robust, future-ready digital platform tailored to MH&LD service needs and workflows.
- **Improved Clinical Documentation and Real-Time Information Access** - Supports real-time data entry and access at the point of care, reducing duplication, enhancing accuracy and enabling safer, more responsive clinical decision-making.
- **Enhanced Data Quality, Reporting and Statutory Compliance** - Enables automated, structured data capture and integrated dashboards to support statutory targets (e.g. MHM, MHA), with customisable reporting aligned to national standards and local priorities.
- **Increased Operational Efficiency and Reduction of Workarounds** - Eliminates reliance on manual processes, spreadsheets and disconnected reporting tools, freeing up staff time and reducing the risk of error and information loss.
- **Improved Care Coordination and Service Integration** - Facilitates timely information sharing across multidisciplinary teams, enhancing joint working and reducing fragmentation in care delivery.
- **Support for a Fully Mobilised, Agile Workforce** - Enables staff to access and update records from any location, supporting flexible and community-based models of care aligned with the Health Boards agile working policy.



- **Improved Patient Experience and Engagement** - Empowers clinicians to deliver personalised, coordinated care in the settings that matter most to service users, enhancing communication, continuity and outcomes.
- **Strengthened Governance, Risk Management and Auditability** - Embeds mandatory fields and structured data capture to improve accuracy, ensure accountability and support regulatory compliance.
- **Support for Service Transformation and Digital Maturity** - Provides the digital foundation to deliver sustainable, scalable models of care in line with the Health Boards 10-year strategy, Integrated Medium Term Plan (IMTP) and national policies such as *A Healthier Wales* and the *Mental Health and Wellbeing Strategy*.
- **Improved Workforce Experience and Staff Retention** - Offers intuitive, modern digital tools that align with staff expectations and professional standards, supporting recruitment, retention and wellbeing.
- **Timely Support for Performance Improvement and Demand Management** - Enables advanced analytics and forecasting capabilities to identify bottlenecks, optimise resource allocation and demonstrate service effectiveness to local and national stakeholders.

Strategic Alignment

This investment ensures clear alignment with both local and national strategic priorities, enabling the Health Board to meet its operational objectives and long-term ambitions through improved interoperability, data quality and service integration. The following priorities and strategies have been considered.

Mental Health and Learning Disabilities Divisional Strategies and Priorities

- **Divisional Priorities (IMTP Aligned)** - supports divisional IMTP priorities by modernising care, strengthening partnerships and enabling digital transformation across MH&LD and CAMHS

The Health Boards Organisational Strategies and Priorities

- **10-year strategy** – supports the 10-Year Strategy by enhancing early intervention, community access and integrated, sustainable mental health care.
- **IMTP 2025-2028**- underpins the Health Boards IMTP by transforming mental health services in line with the Mental Health Strategy, providing the digital foundations for new place-based care models and enhancing staff experience through reduced burden and improved workforce resilience.



- **Digital Strategy** - delivers on all four pillars of the Digital Strategy, enabling mobile care, integrated data use, community models and modern infrastructure.
- **Six Goals** - supports the Six Goals by enabling early risk detection, coordinated discharge and a “home first” approach.
- **People Plan 2022-2025** - enables a sustainable, inclusive workforce through improved digital tools that reduce burden and support agile, transformative working.
- **2024/27: Annual Plan three-year intent** - drives digital transformation to meet mental health demand, improve MHM compliance and support sustainable, mobile-enabled services.
- **All Wales Flexible Working Policy in conjunction with Health Board Agile/Hybrid Working Framework** - supports mobile and remote working models, aligning with flexible workforce policies and sustainability goals.

National Strategies and Priorities

- **Connecting Care Programme (DHCW)** - directly supports and aligns with DHCW’s Connecting Care Programme - a ministerial priority, by enabling safe, seamless and integrated digital care for people across Wales.
- **Once for Wales** - meets Once for Wales Tier 1 requirements by ensuring national compliance, interoperability and standards-based local configuration.
- **Mental Health and Wellbeing Strategy 2025-2035 and the Mental Health and Wellbeing Strategy Delivery Plan 2025-2028** - enables person-centred, trauma-informed and digitally driven care aligned with the national mental health vision.
- **National Data Resource (NDR) – Mental Health Dataset** - supports NDR compliance through standardised data capture and reporting for improved service visibility.
- **A Healthier Wales** - advances the A Healthier Wales vision by enabling integrated, outcome-based and person-focused digital health and care.
- **Prudent Health Care** - aligns with Prudent Healthcare by enabling efficient, needs-based, co-produced and evidence-led digital mental health care.

Forecast Benefits:

Fewer requests for further information when managing referrals



- The referral process will be fully digitised, removing the need for unstructured data capture via email, phone or letter and delivering a 50% reduction in further information requests — decreasing from 8,718 to 4,359 per year.

Increase in time available for administrative staff to reinvest into supporting daily operations and other improvement activities

- A Combined saving of 51,969 admin hours, or the equivalent of 6,929 working days over 5 years. This equates to 1,386 days per year across a number of administrative staff, supporting 137 Teams.
- This results in a forecasted non-cash releasing benefit of £176,591.22 per annum or £882,956 over 5 years across all teams.
- While no whole time equivalent (WTE) savings are expected, the efficiencies achieved will be reinvested into an improved ability to support daily operations of teams, letter writing, updating service information and service improvements.

Faster referral processing

- Average time cut from 7.65 days to just 0.5 days to process a referral which will result in patients receiving more timely initial assessments.

Increase in time available for clinical staff to reinvest time into core clinical duties

- 3 minutes saved per appointment on searching and documenting of information, equating to 15 minutes saved per clinician per day. This results in forecasted non-cash releasing benefit of £306,216.27 per annum, or £1,531,081.37 over 5 years across all teams.
- While no WTE savings are anticipated, the efficiencies achieved will allow staff to reinvest time into core clinical activities such as direct patient care including Care and Treatment Planning (CTP), Occupational Therapy group sessions, Discovery Through Activity (DTA) and reporting.

More timely management of diaries

- Appointments created after their due date fall to 25% (from current levels).
- Outlook integration eliminates the need for staff to manage multiple diaries, which in turn provides managers with clear visibility of team workloads to support more effective planning. This improved coordination reduces missed appointments and enhances the timeliness of patient care.

Increase in time available for performance and service improvement related duties because of reduction in time required to produce reports

- Outpatient error reporting cut by 25% (Saving 15 minutes per month)
- Crisis Resolution and Home Treatment (CRHT) reporting automated (saving 2 hours per month)
- Psychology waiting list reporting being automated (saving 20 minutes per month)
- Wider statutory reporting including MHM, inpatient metrics and Memory Assessment Service (MAS) cut by 75% (saving 11.25 hours per month)



- A combined benefit of 830 hours over five years — equivalent to 22 working days per year — delivering a forecasted non-cash-releasing benefit of £5,635.70 per annum (£28,178.50 over five years) across all teams, including information and performance team. These efficiencies enable staff to reinvest this time into other performance-related duties and service improvements.

Increased time available for performance and service improvement related duties because of reduction in time managing data errors

- Outpatient errors reduce by 25% saving 78 Hours 11 Minutes per annum.
- Admitted patient care errors reduce by 25% saving 5 Hours 20 minutes per annum.
- ICD10 (inpatient discharges) will be eliminated entirely; 94 Hours and 39 minutes per annum.
- A combined benefit of 890.8 hours over five years — equivalent to 24 working days per year — delivering a forecasted non-cash-releasing benefit of £6,048.60 per annum (£30,243.08 over five years) across all teams including information, performance and clinic support services such as ward clerks. These efficiencies enable staff to reinvest this time into other performance related duties and service improvements.

Mental Health Measure compliance consistently achieved without the need for manual data cleansing

- Mental Health Measure Part 1 consistently achieving target of above 80% (currently yearly average is 82.6% Adults and 92.3% Children and Young People (CYP)).
- Mental Health Measure Part 2 consistently achieving target of above 90% (current yearly average is 78.4%)
- These will be achieved more consistently and efficiently, with less need for manual data cleansing.
- Patients will be seen more promptly, improving experience and enabling monitoring of compliance to be maintained without additional manual effort.
- Triggers and enhanced dashboards will alert staff to when Care and Treatment Plans are due to be reviewed.

Staff and Patients will report a better experience

- Staff experience will improve through simplified tasks and workflows, reducing duplication and having a reduced need to work additional hours unpaid. Mobile access reduces the need for staff working in the field to return to base to just complete documentation, while proven system reliability supports a more efficient and satisfying working environment.
- Patients will report that they more frequently have a better experience with the service.
- Patient experience will improve through the introduction of a patient portal, which enables appointment access, secure messaging and personalised tools such as symptom tracking and mood journaling. This promotes transparency, engagement and self-management, while system efficiencies free clinicians to



spend more time delivering personalised care. The portal also aligns with national priorities and future integration with the NHS Wales App.

Financial Summary

Net Annual Investment

The table below outlines the investment requested from the Health Board to fund the revenue and capital gap. It presents costs for contracting, implementation, deployment and transition from 2025–2029, followed by average annual business-as-usual costs for RIO support and maintenance from 2029–2032.

Cost summary	2025/26	2026/27	2027/28	2028/29	2029/32 (3 year avg.)
	£'s	£'s	£'s	£'s	£'s
ABUHB Revenue Funding	0	2,010,810	1,088,448	562,072	77,847
ABUHB Capital Funding	0	147,900	0	0	0

Total 7 Year Funding Gap (Revenue):

The table below outlines the total investment requested from Aneurin Bevan University Health Board to fund the revenue gap across the full seven years of the business case. It separates the investment into both pay and non pay costs for contracting, implementation, deployment, and transition from 2025–2032.

Revenue	£'s
Staff (a)	299,050
Non-Staff (b)	4,143,734
Income (c)	870,034
Total (a+b)-c	3,572,750

Total Funding Gap (Capital):

The table below outlines the total investment requested from Aneurin Bevan University Health Board to fund the capital gap across the full seven years of the business case.

Capital	£'s



Argymhelliad / Recommendation

The proposed implementation of the Rio EPR presents a clear opportunity to address the longstanding limitations of WCCIS and deliver transformational change across services within the Health Board. Many of the planned benefits attributed to the WCCIS implementation have remained unrealised due to non-delivery of functionality, resulting in the service’s reliance on significant workarounds. The benefits of the proposed Rio EPR span operational efficiency, data quality, staff experience, patient engagement, safety, sustainability and compliance.

The Board is asked to approve the business case for the award of contract to the preferred supplier for the implementation of the Rio solution. This will enable the commencement of procurement and implementation activities, in accordance with the strategic priorities of the Health Board and the Welsh Government’s Connecting Care Programme.

The Board is further requested to endorse the allocation of the requisite financial resources, as detailed in the business case, to support the successful delivery of the programme. Funding discussions will continue with Welsh Government and inform the IMTP plan for 2026/27

**Amcanion: (rhaid cwblhau)
Objectives: (must be completed)**

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care 3.1 Safe and Clinically Effective Care 5. Timely Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Digital, Data, Intelligence
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.



Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth:
Evidence Base:

Rhestr Termau:
Glossary of Terms:

CAMHS – Child and Adolescent Mental Health Services
CRHT - Crisis Resolution and Home Treatment
DDaT – Digital Data & Tchnology
DHCW – Digital Health & Care Wales
EPR – Electronic Patient Record
IMTP – Integrated Medium Term Plan
MAS – Memory Assessment Service
MHA – Mental Health Act
MH&LD – Mental Health & Learning Disabilities
MHM – Mental Health Measure
NDR – National Data Resource
LPP – London Procurement Partnership
MSA – Master Services Agreement
PIP – Pre-investment Panel
RTT – Referral to Treatment
SCR – Shared Care Record
WCCIS – Welsh Community Care Information System

Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:
Parties / Committees consulted prior to University Health Board:

Digital Community Programme Board
DPPSG – Digital Portfolio Progress Sub Group
Andrew George – Finance Business Partner
Accountant



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

	Is EIA Required and included with this paper
<p>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</p>	<p>No does not meet requirements</p> <p>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk</p>
<p>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</p> <p>https://futuregenerations.wales/about-us/future-generations-act/</p>	<p>Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs</p> <p>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</p>



Full Business Case

This template should be used when bringing new cases for investment to the Pre-Investment Panel (value greater than £75,000)

Title of business case:	Digital Community – Mental Health and Learning Disabilities Electronic Patient Record
Division / Directorate	Digital, Data and Technology
Case sponsor	Janice Jenkins, Assistant Director of Digital Transformation, DDaT
Executive sponsor	Paul Solloway, Director of Digital, DDaT
Finance business partner supporting the case	Andrew George, Business Partner Accountant, Corporate
Workforce business partner supporting the case	Cara Bradley / Rhys Edwards
Planning lead supporting the case (if applicable)	Amy Dowden
Approval by Divisional Manager / DMT	Louise Turner (MH&LD) / Sara Garland (F&T - CAMHS)

Drafting and Approvals Status Record

Version No.	Date Issued	Amendment History	Accountable Manager
V0.1	26/05/2025	Initial Draft	Portfolio Manager
V0.2	16/06/2025	Edits from meeting with Jan Jenkins	Portfolio Manager
V0.3	19/06/2025	Edits following programme and business change review	Portfolio Manager
V0.4	21/07/2025	Edits following programme and business change review	Portfolio Manager
V0.5	29/07/2025	Edits following Jan Jenkins review	Portfolio Manager
V0.6	28/08/2025	Edits following financial Reviews and wider assurance feedback across DDaT and compliance functions.	Portfolio Manager

V0.7	03/09/2025	Edits following further financial Reviews and agreements with SRO on changes needed.	Portfolio Manager
V0.8	18/09/2025	Final draft review amendments and inclusion of final financial position	Portfolio Manager
V1.0	18/09/2025	Final version approved for submission to PIP	Portfolio Manager
V1.1	01/10/2025	PIP recommended updates and strengthening	Portfolio Manager
V1.2	10/10/2025	Strengthening and amendments following Executive Committee feedback and comments.	Portfolio Manager

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Glossary Of Terms

Acronym / Term	Full title	Description
ABUHB	Aneurin Bevan University Health Board	The NHS Health Board responsible for planning and delivering healthcare services across Gwent, Wales.
AICP	Access Integrated Care Platform	A solution from The Access Group enabling integration across health and social care systems.
API	Application Programming Interface	A set of tools and protocols that allow different software systems to communicate and exchange data.
CAB	Change Advisory Board	A governance forum that reviews and approves proposed changes to systems and services.
CAMHS	Child and Adolescent Mental Health Services	Specialist NHS services that assess and treat children and young people with emotional, behavioural, or mental health difficulties.
CDR	Clinical Data Repository	A secure, centralised database that stores patient information for access by healthcare professionals across systems.
COTS	Commercial Off-the-Shelf	Standardised software available for purchase and configuration rather than bespoke development.
CWS	Clinical Workstation	An ABUHB system that provides clinicians with access to patient information and results.
DHCW	Digital Health and Care Wales	The national body responsible for digital health services and infrastructure across NHS Wales.
DNAs	Did Not Attend	Patients who miss their scheduled appointments without prior notice.
EPEX	Electronic Patient Record System (legacy)	A previous clinical system used by some Welsh services before WCCIS.
EPR	Electronic Patient Record	A digital version of a patient's health and care information, designed to be accessible by authorised NHS professionals across care settings. It includes clinical notes, assessments, medications, test results, care plans, and treatment histories.
FHIR	Fast Healthcare Interoperability Resources	An international standard describing data formats and APIs for exchanging electronic health records.
GP	General Practitioner	A community-based doctor providing primary care services.
HCC Envoy	Healthcare Communications Envoy	A corporate patient communications platform for sending digital letters, SMS, and emails.

HL7	Health Level Seven	International standards for the exchange, integration, sharing, and retrieval of electronic health information.
IG	Information Governance	The framework ensuring patient data is handled legally, securely, and effectively.
IMTP	Integrated Medium-Term Plan	A statutory planning document used by NHS Wales to set out service and financial priorities over a 3-year period.
LCDR	Local Clinical Data Repository	The Health Board's source of truth for storing and sharing patient clinical data.
MAS	Memory Assessment Service	A specialist service that supports patients with memory problems, including dementia assessment and diagnosis.
MDT	Multidisciplinary Team	A team of healthcare professionals from different specialties working together to provide patient care.
MH&LD	Mental Health & Learning Disabilities	Division of the Health Board providing mental health and learning disability services.
MSP	Managing Successful Programmes	A framework for programme management, providing principles and governance structures.
PAS	Patient Administration System	An NHS system used to manage patient demographics, appointments, and admissions.
PCMHSS	Primary Care Mental Health Support Services	NHS Wales service providing early intervention, assessment, and support for individuals with mild-to-moderate mental health issues.
PMF	Project Management Framework	ABUHB's structured methodology for managing digital projects.
PROMs	Patient Reported Outcome Measures	Standardised tools used to capture patients' views on their health and quality of life.
PRINCE2	Projects in Controlled Environments (version 2)	A structured project management methodology widely used in the public sector.
RCOT	Royal College of Occupational Therapists	The professional body and trade union for occupational therapists in the UK.
RIF	Regional Integration Fund	Welsh Government funding stream to support health and care transformation through Regional Partnership Boards.
RPA	Robotic Process Automation	The use of software "robots" to automate repetitive tasks and processes.
SCR	Summary Care Record	A national electronic record containing key patient information, used to support safe care delivery.
SIM	Subscriber Identity Module	A card used in mobile devices to enable connectivity to mobile networks for data and communication.
SRO	Senior Responsible Owner	The individual accountable for successful delivery of the programme or project.
SMS	Short Message Service	A text messaging service used for communication with patients.
SNOMED	Systematized Nomenclature of Medicine – Clinical Terms	A standardised, multilingual vocabulary of clinical terminology used globally in electronic health records.

SOC/OB C/FBC	Strategic Outline Case / Outline Business Case / Full Business Case	HM Treasury's three-stage model for developing business cases to support investment decisions.
TRG	Technical Reference Group	A governance group providing expert assurance on technical design, architecture, and cyber security.
UAT	User Acceptance Testing	A testing process where end-users validate that the system meets their requirements and is ready for go-live.
WCCIS	Welsh Community Care Information System	The legacy system used across social care and some NHS Wales health boards for community and mental health services.
WCP	Welsh Clinical Portal	A national NHS Wales system providing access to test results, discharge summaries, and clinical documents.
WCRS	Welsh Care Record Service	A national NHS Wales service enabling the storage and sharing of care records.
WG	Welsh Government	The devolved government for Wales, responsible for health and care policy and funding.

Executive Summary

Subject:

This business case proposes the procurement and implementation of an integrated Mental Health and Learning Disabilities (MH&LD) Electronic Patient Record (EPR) system for use within Aneurin Bevan University Health Board (ABUHB). This system will align with national efforts in delivering Shared Care Record (SCR), enabling streamlined communications and data interoperability across ABUHB, as well as with wider healthcare, social care, and third-sector providers.

End of Life

The overarching objective is to ensure a seamless migration from the existing digital platform and infrastructure to a unified, scalable EPR solution. The existing Welsh Community Care Information System (WCCIS) platform, used by ABUHB in the management of MH&LD patients and referrals, will become subject to several end-of-life issues over the period January 2026 to March 2027.



This period will see various components of the technology stack become end of life (CRM solution, database and server operating systems).



In addition, the overarching Master Service Agreement (MSA) will reach the end of its extended term in March 2027 and cannot be extended. The MSA provides the premise for the contractual terms and conditions that govern each subsequent deployment order, held directly between organisations and the supplier of the WCCIS platform.

Considering these arising issues, all organisations utilising the WCCIS platform are required to offboard to successor solutions by no later than March 2027. The March 2027 date provides a hard stop deadline for migration off the existing platform due to full de-support and decommission of the WCCIS product immediately after that date.

Note: there is a current risk emerging around the WCCIS exit negotiations where the incumbent supplier is pursuing exit costs more than previously forecasted amounts, in line with deployment order dates and minimum term contract of 8 years. For ABUHB this means the ONEAdvanced as the supplier of WCCIS is seeking to recover full costs of the ABUHB deployment order, through to March August 2030 (2030/2031 financial year). Submitted calculations from ONEAdvanced, places those costs in the region of £1.9 million.

Work is ongoing through the exit strategy and negotiation group to fully mitigate these costs for all organisations currently using WCCIS and subject to this risk.

Contractual End of Life Risks

The risks associated with WCCIS contractual end of life are both significant and unavoidable. The Master Service Agreement (MSA) that underpins all deployment orders expires in March 2027 with no option for extension. At that point, the supplier will fully de-support and decommission the WCCIS platform. This represents a non-negotiable hard stop, after which the system will be legally and operationally unviable for ABUHB.

In addition to the technical end-of-life of critical components (CRM solution, database, and server operating systems), the contractual risks are severe:

- Unavoidable Exit Deadline – By March 2027, ABUHB must be fully migrated off WCCIS. Failure to do so would leave services without a legally supported digital patient record,

directly jeopardising clinical safety, statutory compliance (Mental Health Measure and Mental Health Act) and data governance.

- No Extension or Mitigation Option – Unlike other contracts where extensions or transitional support can be negotiated, the WCCIS MSA provides no legal or contractual mechanism for continuation. Post-March 2027, ABUHB would be operating outside of contract, with no vendor support and escalating risks of service interruption.
- Operational and Clinical Risks – Any delay in procurement or implementation of a successor system would result in service fragmentation, reversion to paper/manual processes and unacceptable risks to patient safety and service continuity.

These risks are time-critical, non-deferrable and strategically unavoidable. They place a clear obligation on the Health Board to proceed at pace with the procurement and implementation of a successor EPR. Failure to act decisively within the fixed window exposes ABUHB to serious contractual, financial, operational and reputational harm.

Purpose:

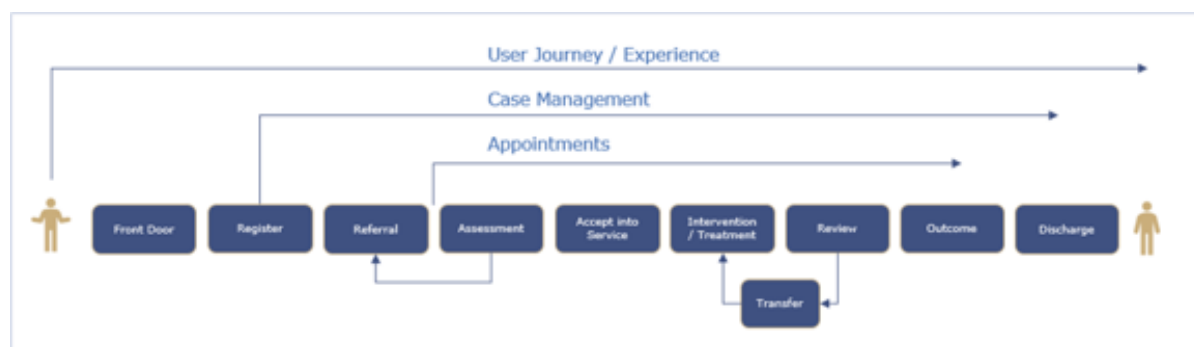
Context/Background

ABUHB previously engaged with the national Connecting Care programme, led by Digital Health and Care Wales (DHCW) in response to the end-of-life challenges associated with WCCIS. However, the programme presented significant challenges for ABUHB, including issues with engagement models, strategic alignment, timelines, and competing priorities.

Consequently, ABUHB elected to pursue a procurement and implementation of a successor solution, initially focused on MH&LD services. This approach was considered the most effective means of ensuring a timely transition from WCCIS, while maintaining — and potentially improving upon — the current levels of digital EPR adoption.

Requirements

Service led workshops were held to draft a market ready set of functional and non-functional requirements. Requirements were organised against themes and principles that align to and enable the MH&LD patient journey (below). A comprehensive validation process was followed (with key ABUHB stakeholders) to ensure alignment with patient needs, service delivery, and future scalability.



Procurement & Evaluation

ABUHB issued a tender on 12 December 2024 via the London Procurement Partnership (LPP) Framework, specifically designed for mental health services. Four suppliers submitted bids, all of whom passed initial pre-qualification checks focusing on cyber security and data management.

An evaluation panel comprising of representatives from Child and Adolescent Mental Health Services (CAMHS), Child Psychology, Adult MH&LD Services, Assurance, and Digital, Data and Technology (DDaT) assessed 321 written responses from each supplier. Two suppliers were disqualified due to critical failures. The remaining two progressed to system demonstrations to validate their written submissions. Final consensus scoring considered social value, quality, and cost.

Procurement Outcome

The Access Group's *Rio* solution has been identified as the preferred system, demonstrating strong alignment with clinical and operational needs, national digital priorities and the Gwent region's Local Authorities who have already contracted with the Access Group on their Social Care platform - *Mosaic*.

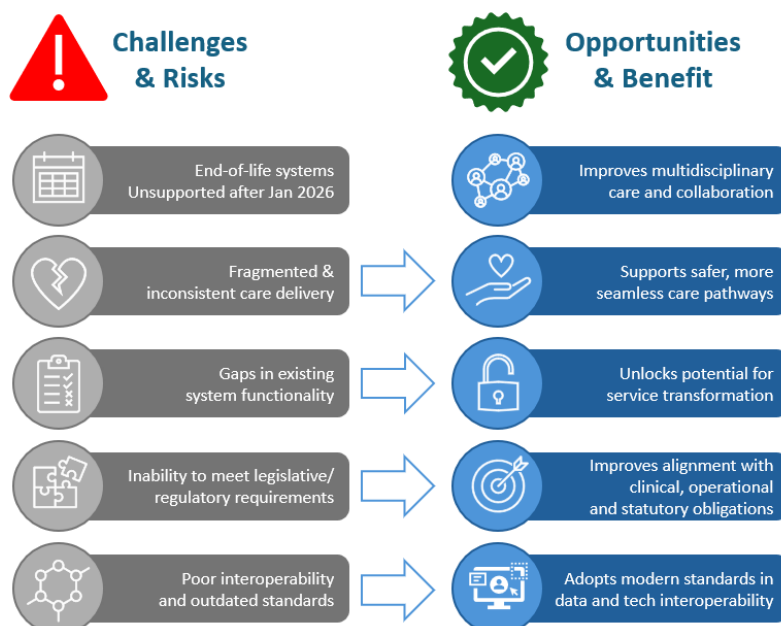
Business Case

The primary purpose of this business case is to outline the necessity and benefits of transitioning to a modern, comprehensive and fit for purpose EPR (*Rio*) as a replacement to WCCIS.

By creating a single unified patient record, the system will improve real-time access to patient data across all care pathways in MH&LD, significantly enhancing care coordination and reducing duplication of effort. *Rio* will aid in health management, enable advanced reporting, and improve analytics capabilities to inform both clinical and operational decision-making.

The proposed implementation of *Rio* will provide opportunities to integrate seamlessly with the chosen regional social care solution across Gwent, as well as any potential national SCR initiative. Aligning local, regional, and national standards for data sharing, architecture, and security will enable cross-sector collaboration across health, social care, and third-sector organisations, supporting individuals with MH&LD while ensuring compliance with national digital health mandates. Greater information sharing and communication between stakeholders will help close the gaps in care coordination and lead to better patient outcomes for some of the most vulnerable populations in society.

This migration strategy is designed to mitigate the risks associated with system downtime, data integrity and clinical safety that could arise from continuing with the current systems beyond their supported life. The proposed approach seeks a successor platform to WCCIS that aims to address:

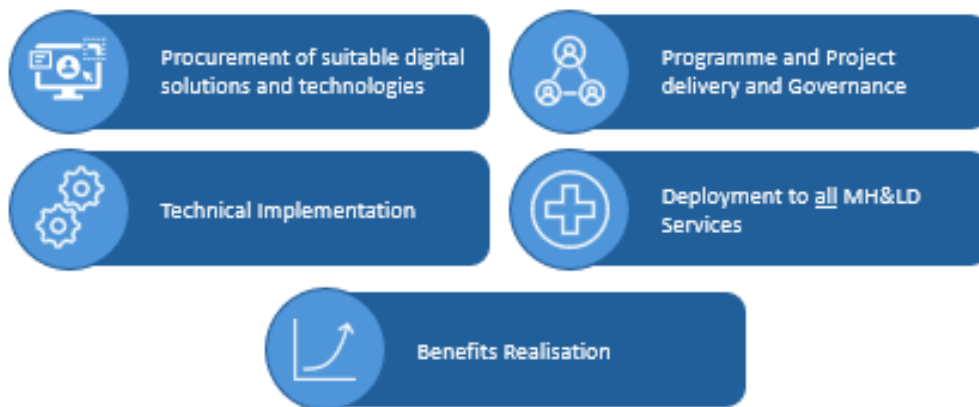


It will provide an opportunity for service transformation to take advantage of advancements and trends in technology, data, analytics and health care delivery to offer more personalised and proactive care management. Rio provides transformational opportunities to modernise ways of working with a shift towards more agile approaches.

In summary, this business case seeks to secure approval and funding for the timely and efficient migration to a new EPR system by Q4 of the 2026/2027 financial year.

Scope

The investment proposal and its scope are set out to ensure a safe and successful migration from existing systems, ahead of end-of-life challenges, with full operational integration and deployment by March 2027. The scope of this business case for a proposed MH&LD EPR system covers five core areas:

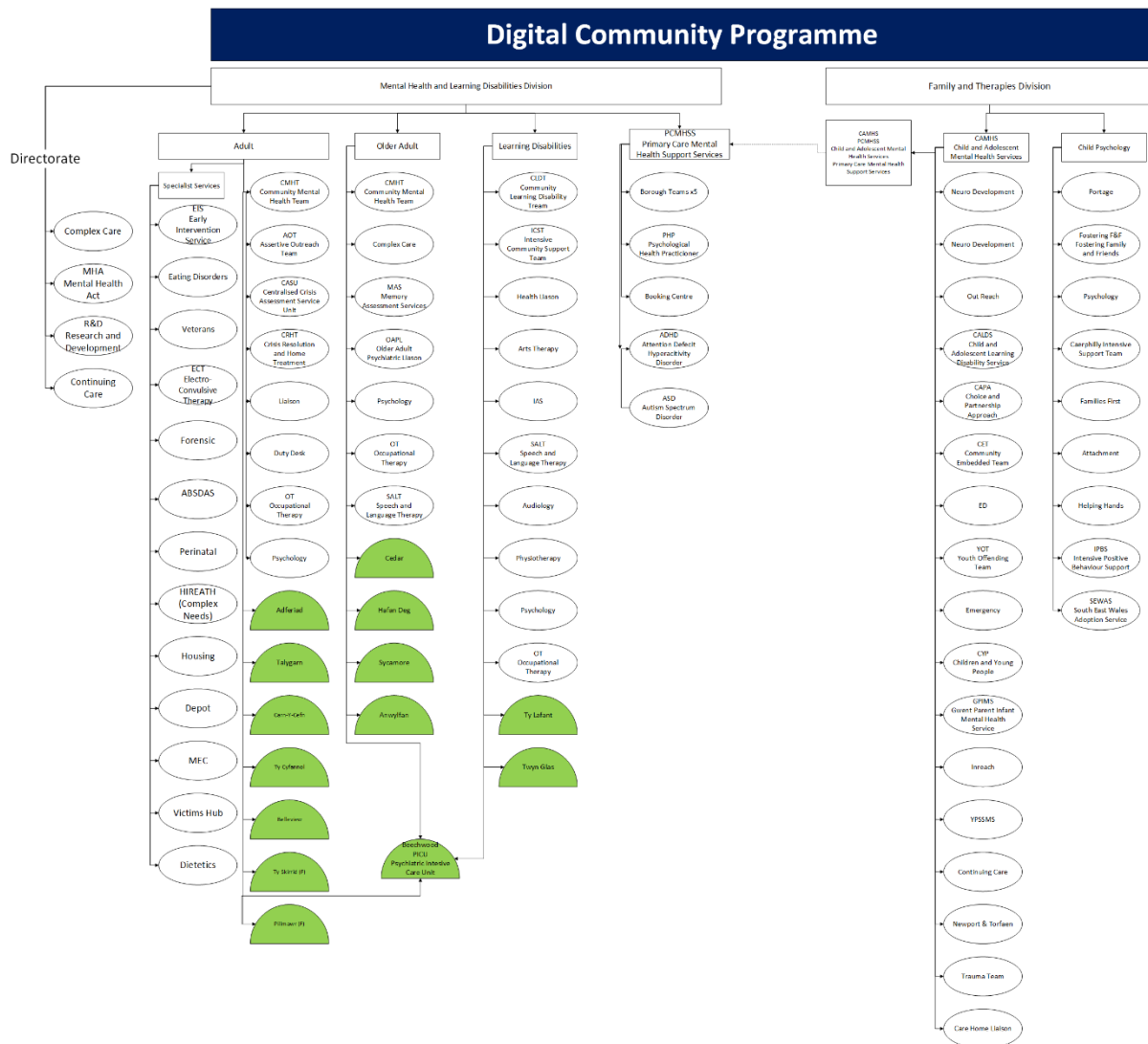


Reach Across Services

The system will cover the **full spectrum** of MH&LD services for both adults and children across:

- Primary Care
- Community Services
- Crisis Services
- Inpatient Services
- Mental Health Act Administration
- Commissioning Services
- Specialist Services
- Third Sector and Social Care Providers (*Enabling seamless collaboration across organisational boundaries with, health care providers, voluntary organisations, and social care.*)

Included in the scope above from the Health Board perspective are circa 2250 end users, working across 194 Teams, within 68 services, across 7 directorates and 2 divisions. Included below is a visual that depicts that structure to a service level.



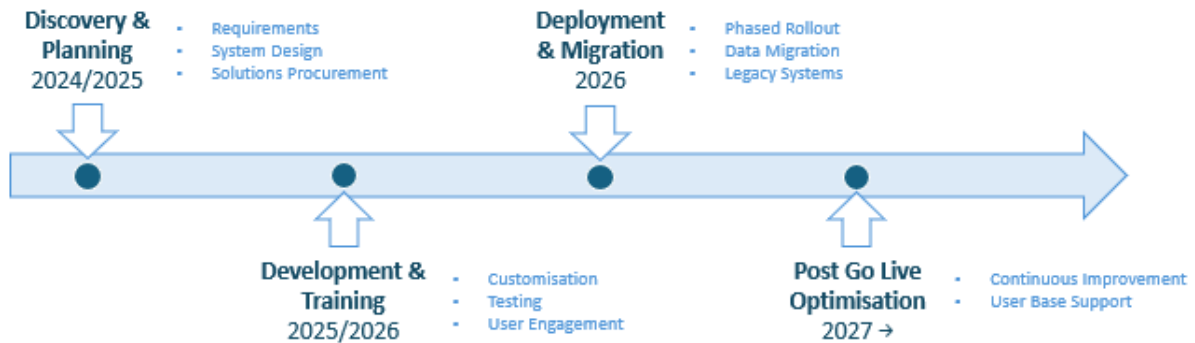
Furthermore, through integration, the RIO platform will enable enhanced information sharing, care coordination, and patient health management across regional Integrated Care Systems (ICSs) and wider national organisations.

Programme & Project Delivery

The Programme and its constituent projects will be governed by dedicated programme and project boards involving key stakeholders from clinical, operational, and digital teams, ensuring strategic alignment with service needs and national standards.

The programme and projects will be delivered using a combination of MSP (Managing Successful Programmes) and PRINCE2 (Projects in Controlled Environments) methodologies, that will provide the framework approach for controlling the managed delivery of the interrelated projects and providing an approach for overarching governance that is aligned to the Health Boards digital project management framework (PMF). The Health Boards approach to delivering the programme will be blended with tried and trusted blueprints for delivery from the suppliers of the new solution, to ensure that overall delivery is aligned to the Health Boards needs whilst adopting successful supplier experiences.

The delivery of the Programme will follow a structured, phased approach:



A robust risk management framework will be in place, addressing challenges such as system downtime, data integrity, and change management, ensuring the project remains on time, within budget and to set quality expectations.

Implementation

The EPR will be a **cloud-based**, fully integrated platform designed to support the specific needs of MH&LD services. It will ensure full interoperability with national Shared Care Record, enabling real-time information exchange across healthcare, social care, and third-sector providers. The system will meet all regulatory standards, including GDPR and NHS Data Security protocols, ensuring secure and compliant data management.

A phased implementation has been identified as the most appropriate approach, primarily informed by lessons learned from the WCCIS implementation. This approach seeks to partially mitigate or reduce the logistical complexities and service pressures associated with a Big Bang deployment.

Given the fixed programme timeline, largely dictated by the WCCIS end-of-life (EOL) risks, a phased rollout will be adopted at service level. The implementation will commence with CAMHS (inc. Child Psychology), followed by Adult MH&LD Services. This sequence is based on:

- **Risk Minimisation** – Deploying first to a service with a lower volume of users reduces the potential impact of unforeseen issues.
- **Service Transition Management** – Implementing CAMHS first helps streamline the transition process for patients moving from CAMHS into Adult Services.

Key Considerations under the proposed approach to implementation and deployment are:

- **Contingency for a Big Bang Implementation** - While a phased approach is preferred due to its clear advantages, unforeseen delays may necessitate a shift to a Big Bang approach if the available deployment window narrows.
- **Timeline Risks** - The programme assumes a six-month deployment window, concluding by the end of 2026. Any significant delays in the CAMHS rollout will compress the timeline for the Adult Services phase. Given the fixed deadline, if substantial issues arise during Phase 1, a Big Bang implementation may become necessary to ensure overall programme success.
- **Prioritisation of Critical Functionality** - Applying a clear priority rating (Critical, Expected, Important, Desirable) to both functional and non-functional requirements provide a structured approach to delivery that safeguards success at go-live and beyond. By ensuring that critical and expected requirements are fully met as a baseline, the programme minimises

operational risk and underpins safe, effective care from day one. Important and desirable requirements are then phased appropriately, allowing continuous improvement, user engagement, and system optimisation over time. This approach ensures that the solution is both immediately fit for purpose and adaptable to future needs.

To manage the risks associated with the preferred approach, key decision points will be embedded into the programme timeline. These checkpoints (linked to key programme milestones) will assess the ongoing feasibility of the phased approach and allow for course correction if needed. It is to be noted that such a decision needs to be constantly appraised throughout the programme around the eventuality of any type of delay to the delivery timeline. The key decision points represent key activities that need to happen by a finite point with any delay triggering a need to review.

Out of Scope

By clearly defining what is out of scope, the project will maintain a focused and efficient approach to delivering the EPR system, ensuring timely migration from legacy systems and a smooth transition without being impeded by additional, non-essential developments.

While the proposed MH&LD EPR system is designed to cover a wide range of functionalities and services, certain elements will remain out of scope for this project to ensure a focused, timely, and cost-effective delivery. The following areas are considered out of scope:

- 1. Integration with Non-Health Systems** - Non-health-related systems (such as financial management and procurement systems) are not included in this EPR implementation.
- 2. New Clinical Services or Care Pathways** - The project will focus on improving, standardising, and integrating existing Mental Health and Learning Disabilities (MH&LD) services that have been confirmed as in scope at the point of final agreement on implementation and deployment. The development, configuration, or integration of entirely new clinical services, pathways, or specialties that are not currently delivered by the organisation at that time will be considered out of scope.

While the agreed position is that newly established services, pathways, or specialties remain out of scope, any such developments arising during the implementation period will be reviewed on a case-by-case basis. Inclusion may be considered where there is a clearly defined clinical and/or operational risk, subject to governance oversight and impact assessment.

- 3. Extensive Customisation Requirements Beyond initial agreements** - While some customisation of the EPR is expected to meet the specific needs of MH&LD, significant customisation that goes beyond those agreed at the outset of implementation will be excluded as out of scope.
- 4. Legacy Systems Enhancements** - No further enhancements or upgrades will be made to the WCCIS that is end of life by January 2026. The focus is solely on the transition to the new EPR system. Maintenance will be minimal to ensure basic functionality until the migration is complete.

Product Delivery

The scope for implementation of the proposed EPR will include a full product delivery inclusive of supporting infrastructure, software, hardware, configuration, integrations, testing, training, programme support and the establishment of a new digital service.

Once the implementation of proposed EPR is complete, the programme will transition to a Product Delivery team for management of the day-to-day delivery and for the ongoing continuous improvement and optimisation of the platform. Successful transition from project implementation to product delivery requires a collaborative effort from multidisciplinary teams to ensure the product continues to meet user expectations and evolves to meet changing healthcare industry standards.

It is anticipated that the project will transition to product delivery during FY 2028/2029. ***The current expected roles are set out in Appendix 5.***

Key stakeholders

There has been engagement with all services across ABUHB in areas of MH&LD.

Alongside those direct clinical engagements there has also been extensive engagement with other external stakeholders including DHCW, the current WCCIS supplier, potential future suppliers and existing WCCIS users in other organisations, such as Social Care.

Assurance functions of the Health Board have been extensively engaged, including Clinical and wider assurance, to establish, review and endorse the benefits set out in this business case, determining the requirements for ABUHB and for the evaluation of the different systems available that could ensure the needs of services are met.

Engagement with Technical Subject Matter Experts across Digital Data and Technology (DDaT) services has been undertaken to determine the technical requirements for a MH&LD EPR solution, for supplier evaluation and contribution to the case for change.

Numerous key stakeholders have been involved in the development and review of this business case in other key assurance areas including Health Records, Information Services, Welsh Language, Equality and Diversity and Finance.

A full stakeholder list can be found in Appendix 1.

Strategic Alignment

The procurement of a modern EPR system for MH&LD will support ABUHB in delivering safe, effective, and person-centred care, while strengthening digital maturity across mental health services. This investment ensures clear alignment with both local and national strategic priorities, enabling the Health Board to meet its operational objectives and long-term ambitions through improved interoperability, data quality, and service integration. The following priorities and strategies have been considered:

Mental Health and Learning Disabilities Divisional Strategies and Priorities

- ✓ **Divisional Priorities (IMTP Aligned)** - supports divisional IMTP priorities by modernising care, strengthening partnerships, and enabling digital transformation across MH&LD and CAMHS

Aneurin Bevan University Health Board Organisational Strategies and Priorities

- ✓ **10-year strategy** - advances ABUHB's 10-Year Strategy by enhancing early intervention, community access, and integrated, sustainable mental health care.

- ✓ **IMTP 2025-2028**- underpins ABUHB’s IMTP by transforming mental health services in line with the Mental Health Strategy, providing the digital foundations for new place-based care models, and enhancing staff experience through reduced burden and improved workforce resilience.
- ✓ **Digital Strategy** - delivers on all four pillars of ABUHB’s Digital Strategy, enabling mobile care, integrated data use, community models, and modern infrastructure.
- ✓ **Six Goals** - supports the Six Goals by enabling early risk detection, coordinated discharge, and a “home first” approach.
- ✓ **ABUHB People Plan 2022-2025** - enables a sustainable, inclusive workforce through improved digital tools that reduce burden and support agile, transformative working.
- ✓ **2024/27: Annual Plan three-year intent** - drives digital transformation to meet mental health demand, improve MHM compliance, and support sustainable, mobile-enabled services.
- ✓ **All Wales Flexible Working Policy in conjunction with ABUHB Agile/Hybrid Working Framework** - supports mobile and remote working models, aligning with flexible workforce policies and sustainability goals.

National Strategies and Priorities

- ✓ **Connecting Care Programme (DHCW)** - The Mental Health EPR replacement programme directly supports and aligns with DHCW’s Connecting Care Programme - a ministerial priority, by enabling safe, seamless, and integrated digital care for people across Wales.
- ✓ **Once for Wales** - meets Once for Wales Tier 1 requirements by ensuring national compliance, interoperability, and standards-based local configuration.
- ✓ **Mental Health and Wellbeing Strategy 2025-2035 and the Mental Health and Wellbeing Strategy Delivery Plan 2025-2028** - enables person-centred, trauma-informed, and digitally driven care aligned with the national mental health vision.
- ✓ **National Data Resource (NDR) – Mental Health Dataset** - supports NDR compliance through standardised data capture and reporting for improved service visibility.
- ✓ **A Healthier Wales** - advances the A Healthier Wales vision by enabling integrated, outcome-based, and person-focused digital health and care.
- ✓ **Prudent Health Care** - aligns with Prudent Healthcare by enabling efficient, needs-based, co-produced, and evidence-led digital mental health care.

The case for change section sets out in detail how the delivery of the MH&LD EPR solution, in line with this business case will align to the specific and applicable objectives of each strategy.

Options Outline

The following three options are the final set of options that are under consideration by ABUHB as providing potential solutions within the timescales required for transition. Further options were considered as part of a strategic outline case and full options appraisal in November 2023. Subsequent

withdrawal from the national programme has further reduced the range of options to only those that can be viably delivered locally.

Option One: Unmanaged Return to Alternative Digital Solutions and/or Non-Digital Services (Hybrid)

Cease using the WCCIS digital EPR system and allow MH&LD services to revert to paper-based, alternative manual processes and/or fragmented digital solutions (e.g. Microsoft Office 365) without a coordinated transition plan. This option does not include any investment in alternatives or structured change management. It represents a withdrawal from the digital strategy and a return to pre-digitisation working practices.

Option One Summary

- **Description:** Allow WCCIS to lapse without structured replacement. Services would revert to paper, spreadsheets, Office 365.
- **Benefits:** None.
- **Risks:**
 - High clinical risk due to fragmented, inaccessible records.
 - Loss of statutory compliance (MHM, MHA, RTT).
 - Increased admin burden, duplication, and errors.
 - Service regression and reputational damage.
 - Staff disengagement, recruitment/retention difficulties.
- **Assessment:** Unsafe, unsustainable, not aligned with digital or clinical strategy.

Option Two: A Managed Return to Alternative Digital Solutions and/or Non-Digital Services (Hybrid)

This option involves a structured and planned withdrawal from the WCCIS digital EPR system, with MH&LD services transitioning to paper-based, alternative manual processes and/or fragmented digital solutions (e.g. Microsoft Office 365). The transition would be supported by formal project governance, change management, communications, staff training, and temporary solutions to ensure continuity of care and minimise operational and clinical risk.

Option Two Summary

- **Description:** Structured withdrawal from WCCIS with governance, comms, training, and temporary manual/digital solutions.
- **Benefits:**
 - More controlled transition than Option 1.
 - Staff supported with training and comms.
- **Risks:**
 - Fragmented Clinical Information
 - Patient Safety and Quality Risk
 - Unsustainable Use of Office 365 as a Clinical Platform
 - Excessive Operational and Administrative Burden
 - Programme and Project Resource Drain
 - Inconsistent Processes and Data Standards
 - Business Continuity and Knowledge Dependency
 - Technical Obsolescence and Cyber Risk
 - Strategic Misalignment and Reputational Impact
 - Hidden Financial and Opportunity Costs

Assessment: Under this option, services would continue to operate through a combination of existing digital systems, locally developed solutions (including the use of existing ABUHB assets - such as CWS / WPAS as well as Office 365 tools - such as SharePoint lists, Excel trackers and Word templates) and non-digital processes such as paper-based documentation.

This approach would seek to maintain continuity of service delivery while avoiding major capital investment. However, it would not achieve the integration, consistency or sustainability associated with a single, clinically led EPR.

Key Considerations

- **Clinical management impacts:**
Clinicians and team managers would need to navigate multiple systems and manual processes to record and retrieve patient information. The duplication of data entry, increased administrative workload and reduced visibility of complete care histories would compromise efficiency and clinical decision-making. The lack of standardised, structured data would also reduce the quality and timeliness of information available for performance management, risk monitoring and national reporting.
- **Programme management impacts:**
Sustaining a hybrid model would require ongoing coordination, configuration and user support. Without a single system roadmap, programme and project resources would be tied up maintaining multiple local solutions rather than delivering transformation. The administrative overhead of managing disparate systems combined with the need for repeated user training and troubleshooting would divert scarce programme capacity away from strategic digital priorities.
- **Product support impacts:**
Each locally developed Office 365 or legacy system effectively becomes its own “product,” requiring dedicated maintenance, permissions management and version control. This decentralised approach introduces duplication, creates dependency on individual staff knowledge and increases business continuity risk when key personnel change roles. Moreover, Office 365 is not designed or accredited as a clinical system, presenting risks related to data integrity, auditability and compliance with clinical safety and information governance standards.
- **Strategic alignment and sustainability:**
This approach would diverge from national and regional digital strategies including the Digital Priorities for Wales and the National Data Resource roadmap, which advocate for standardisation, interoperability and single patient records. While the hybrid model might limit immediate expenditure, it would embed inefficiency, increase long-term operational costs and erode digital maturity.

While this option would maintain short-term continuity and avoid significant upfront investment, it represents a resource-intensive and high-risk approach that undermines clinical, operational and strategic objectives.

When assessed against the preferred option (procurement and implementation of a unified MHL D EPR), the hybrid approach scores significantly lower in terms of benefit realisation, risk profile, and strategic fit. Although it avoids major initial capital costs, the cumulative operational burden and inefficiency across clinical, programme and product support functions would result in higher total cost of ownership over time.

Option Three: Proceed with ABUHB procurement outcome for the acquisition and implementation of the RIO Solution

This option reflects Aneurin Bevan University Health Board having undertaken a procurement process to source a new EPR system for Mental Health and Learning Disabilities services, separate from the national programme led by DHCW. Following the successful completion of a tender process which identified The Access Group’s Rio solution as a preferred option, this option would include establishing a local programme board, defining specific local requirements, engaging suppliers directly, and managing the procurement, implementation, and post-go-live support internally.

Option Three Summary

- **Description: Implement a modern, interoperable MH&LD EPR following procurement outcome.**
- **Benefits:**
 - Continuity & safety: mitigates WCCIS end-of-life risks.
 - Efficiency:
 - Referral processing reduced from 7.65 days → 0.5 days.
 - 50% fewer referral queries.
 - 52,000 admin hours saved over 5 years.
 - Clinician time savings ≈ £1.53m over 5 years.
 - Data quality & compliance: structured data, automated error reduction, statutory compliance maintained.
 - Staff experience: mobile/offline access, streamlined workflows, hybrid working supported.
 - Patient experience: portal for appointments, care plans, secure messaging; real-time risk alerts improve safety.
 - Integration: with Mosaic and regional care systems, supporting Once for Wales and Shared Care Record ambitions.
 - Future-proof: enables AI tools, social prescribing modules, advanced analytics.
- **Risks:**
 - Complex programme requiring significant business change.
 - Resource-intensive, with high upfront costs.
 - Dependent on robust implementation and change management.
- **Assessment:** The only sustainable, strategic option. Benefits outweigh risks if well governed.

Options Summary Appraisal

Key	
	Clear Risk
	Managed Risk
	Compromised Outcome
	Potential Benefit
	Clear Benefit

Criteria	Option One: Unmanaged Return to Alternative Digital Solutions &/or Non-Digital Services (Hybrid)	Option Two: A Managed Return to Alternative Digital Solutions &/or Non-Digital Services (Hybrid)	Option Three: Proceed with ABUHB procurement outcome for the acquisition and implementation of the RIO Solution
Description	Allow WCCIS use to lapse without structured transition or support	Structured withdrawal from WCCIS with formal	Procurement and implementation of a local EPR solution

		transition and risk mitigation	
Strategic Fit	Regressive and misaligned with digital transformation agenda	Tactical fit but lacks long-term strategic value	Aligned locally but only a limited alignment with national strategy
Benefits	No identifiable benefit	Controlled process, staff support	system, local control, innovation potential
Dis-Benefits	Disruption, clinical risk, fragmentation of records	Still regressive, but better managed	Costly, potential isolation
Costs (Pay)	No formal programme resources to fund	Requires transition project team	Full local programme team and SME engagement
Costs (Non-Pay)	Minimal investment	Paper-based systems, comms, training	Procurement, licences, integrations
Advantages	Quick, minimal effort	Controlled, safer transition, better optics	Agile, innovative, locally aligned
Disadvantages	Unsafe, unplanned, risk to care and data	Still regressive, costly for temporary value	Isolated, complex, resource-intensive
Risk Level	High operational and clinical risk	Better mitigated, but still risky	Complex but manageable with strong planning
Sustainability	Not viable or safe long-term	Temporary only, risk of digital stagnation	Sustainable if well-governed, but dependent on wider context

Proposal – preferred option

Option 3 has been identified as the preferred option following a comprehensive evaluation process. This option offers the best balance of functionality, strategic alignment, and value for money in meeting the Health Board’s requirements. The costs outlined below represent known and validated figures based on supplier bid submissions received through the procurement process.

The Access Group (RIO) vs CIVICA (Paris) Analysis

Suppliers were required to submit financial bids comprising two components:

1. A core pricing schedule
2. A separate schedule for optional functionality

For evaluation purposes, only the costs included in the core pricing schedule were assessed and compared. This approach reflected ABUHB’s use of a priority rating system within the tender, designed to clearly indicate which requirements were considered critical for Day 1 / Minimum Viable Product (MVP) capability.

Full Priority Rating:

Critical	Critical for Go-Live Includes all requirements that are essential for the successful implementation of the project. These are non-negotiable elements that provide the minimum usable subset of mandatory requirements.
Expected	Mandatory for Post Go-Live Includes all requirements that are essential for the safe and successful provision of care. These requirements detail mandatory functionality and

Important	<p>will ideally be available for go-live but is not deemed critical for Day 1. These requirements, whilst not critical, detail functionality that underpins the health board's strategic view.</p> <p>Functionality adding Value</p> <p>Includes all requirements that detail features or capabilities that are highly desirable and provide significant value - <u>but are not strictly required for the core solution to function effectively.</u></p>
Desirable	<p>Blue Sky</p> <p>Includes all requirements that detail nice-to-have enhancements or innovative features that are recommended, could provide added value or differentiation but are not expected or required.</p>

Financial Bid Evaluation

The core pricing schedule covered the full cost of delivering all Critical and Expected functionality. Submitted costs included:

- One-off implementation costs
- Initial setup charges
- Recurring costs (calculated per user)

Bids were based on 1,847 users. ABUHB has since confirmed a more accurate view of 1,975 users, aligned with the current live WCCIS user base. As pricing is user-dependent, total costs increase accordingly.

	1,847 users (submitted cost)	1,975 users (contractual premise)
The Access Group (TAG)	£5,393,256.75	£6,138,397.16
CIVICA	£7,100,008.22	£7,526,628.56

The final business case - based on the recommendation to procure and implement TAG's RIO platform - reflects the higher user numbers and includes selected optional functionality to strengthen ABUHB's strategic position.

In contrast, CIVICA's submission provided minimal detail linking their financial bid to system functionality. This lack of transparency suggests that additional costs would likely arise (c.£400k) if the CIVICA bid were pursued, as inferred from their written tender responses referencing implementation and development of the Paris platform e.g.

CIVICA propose a solution architecture drawing on several third-party components and associated licensing models covering:

- Integration and Interoperability
- Access and Hosting
- Database Technologies
- Mobile Solution
- Reporting Tools

Functional Analysis

Civica's responses consistently demonstrated weaker alignment with the Health Board's specified requirements compared to TAG, primarily due to a lack of clarity, completeness and evidence of proven functionality. Across multiple domains—including patient self-service, extended health records, and case management - Civica's submissions frequently acknowledged unmet criteria or the

need for further development, suggesting that several features remain conceptual rather than embedded within a mature, deployable system. This uncertainty undermines confidence in Civica's readiness to deliver a fully functional Mental Health and Learning Disabilities EPR aligned to NHS Wales' operational and clinical expectations.

In contrast, TAG's responses provided clearer, more direct evidence of capability, backed by demonstrable functionality and adherence to the specified criteria. Civica's narrative approach often described high-level intentions or generalised system capabilities without explicitly mapping them to the tender's defined requirements, making it difficult for evaluators to verify compliance. Consequently, TAG's submissions were perceived as more complete, robust, and implementation-ready, whereas Civica's responses reflected developmental gaps and limited assurance of immediate suitability for the Health Board's needs.

The Rio system, provided by The Access Group, emerged as the preferred solution due to its strong fit with clinical workflows, operational requirements, and national digital objectives. The Access Groups involvement with Gwent Local Authorities, via the Mosaic social care platform, also supports opportunities for greater regional integration and continuity of care.

The Access Group is a highly established UK software provider with strong financial resilience and a proven track record in health and social care. Its Rio EPR platform offers a scalable, future-proof solution aligned with national standards and local transformation priorities.

Key Points:

Supplier Strength & Stability

- One of the UK's largest providers: 7,000–8,000 staff, 100,000+ organisations served.
- Net assets >£2.5bn (FY2023) – strong financial foundation.
- Trusted by 45+ NHS Trusts and numerous local authorities.

Proven Platform

- Rio EPR widely deployed across NHS; G-Cloud listed for compliance and security.
- Used by 150,000+ clinicians in mental health, community, and child health.

Innovation & Future-Proofing

- R&D investment: £137m in 2023 (+52% YoY).
- Rio Reimagined: modern UX, mobile-first, offline capability.
- £6–8m invested in integrated care solutions linking Rio, Mosaic, EMIS.

Scalability & Interoperability

- Potential for further opportunities for wider deployment across the health board.
- Modular design enables reuse of assets, reducing duplication and cost.

Access Group's financial strength, innovation pipeline and interoperability roadmap provide confidence in a sustainable, scalable digital partnership for ABUHB over the next decade and beyond.

Investment Summary (ABUHB only)

The table below, illustrates the investment requested from Aneurin Bevan University Health Board to fund both the revenue and capital gap. It shows the initial 4 years costs associated with contracting, implementation, deployment and transition covering the period 2025 through 2029. After this period it shows the business as usual costs associated with ongoing support and maintenance of the RIO platform, shown as an average cost over three years covering the period 2029 through to 2032.

Cost summary	2025/26	2026/27	2027/28	2028/29	2029/32 (3 year avg.)
	£'s	£'s	£'s	£'s	£'s
ABUHB Revenue Funding	0	2,010,810	1,088,448	562,072	77,847
ABUHB Capital Funding	0	147,900	0	0	0

Investment Breakdown (Total Investment ABUHB and Welsh Government)

The table below, illustrates the total investment requested from both Aneurin Bevan University Health Board and DHCW to fund both the revenue and capital gap. It shows the initial 4 years costs associated with contracting, implementation, deployment and transition covering the period 2025 through 2029. After this period it shows the business-as-usual costs associated with ongoing support and maintenance of the RIO platform, covering the three year period 2029 through to 2032.

Cost summary	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	TOTALS
	£'s	£'s	£'s	£'s	£'s	£'s	£'s	£'s
ABUHB Revenue Funding	-322,122	2,010,810	1,088,448	562,072	55,915	77,745	99,882	3,572,750
WG Revenue Funding	870,034	0	0	0	0	0	0	870,034
ABUHB Capital Funding	0	147,900	0	0	0	0	0	147,900
WG Capital Funding	757,810	0	0	0	0	0	0	757,810
Total	1,305,722	2,158,710	1,088,448	562,072	55,915	77,745	99,882	5,348,494

Costs Summary

The table below shows a summary of the costs associated with delivery of the programme over a Seven-year period, for both pay and non-pay costs. It also accounts for known and identified cash releasing savings and income / funding provisions, providing a revised net total for the cost of delivering the programme.

Cost summary	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	Totals
	£'s	£'s	£'s	£'s	£'s	£'s	£'s	£'s
Revenue Costs								
Staff	286,808	1,379,045	1,127,656	730,409	210,301	217,661	225,279	4,177,159
Non-Staff	54,820	159,670	153,670	153,670	153,670	153,670	153,670	982,840
RIO Licence, support & Maintenance	209,269	556,014	571,206	557,827	572,553	587,825	603,174	3,657,868
RIO Implementation and Delivery	191,275	382,550	0	0	0	0	0	573,825
RIO Integration Costs	0	115,000	115,000	0	0	0	0	230,000
WCCIS System Costs	99,601	322,707	0	0	0	0	0	422,308
Sub Total	841,773	2,914,986	1,967,532	1,441,905	936,523	959,157	982,124	10,044,000
Capital Costs								
Hardware (Devices)	757,810	147,900	0	0	0	0	0	905,710
Sub Total	757,810	147,900	0	0	0	0	0	905,710
Income / Budget								
External Funding (Revenue)	870,034	0	0	0	0	0	0	870,034
External Funding (Capital)	757,810	0	0	0	0	0	0	757,810
Existing Budget	293,861	904,177	879,084	879,833	880,609	881,411	882,242	5,601,216
Sub Total	1,921,705	904,177	879,084	879,833	880,609	881,411	882,242	7,229,060
Savings								
Benefits	0	0	0	0	0	0	0	0
Sub Total	0	0	0	0	0	0	0	0
Total (Rev + Cap – Income - Savings)	-322,122	2,158,710	1,088,448	562,072	55,915	77,745	99,882	3,720,650

Hardware & Devices implications (Capital)

Costs of hardware procurement

Note: The capital costs of hardware and device purchases has only accounted for the initial purchase of the devices. These numbers of devices will have to be added to the organisational capital refresh programme for any future refresh of these devices. Typical life expectancy of the chosen devices is 5 years with the refresh due in the 2031/2032 and 2032/2033 financial years.

CAPITAL (£'s)	Year 1 - FYE (2025/2026)	Year 2 - FYE (2026/2027)	Year 3 - FYE (2027/2028)	Year 4 - FYE (2028/2029)	Year 5 - FYE (2029/2030)	Year 6 - FYE (2030/2031)	Year 7 - FYE (2031/2032)	Total
Capital Costs								
Hardware & Devices (Laptops & Tablets for 797 staff)	757,810	147,900	0	0	0	0	0	905,710
Total Costs	757,810	147,900	0	0	0	0	0	905,710
Capital Income								
DHCW National Funding (Capital)	757,810	0	0	0	0	0	0	757,810
ABUHB Capital Funding	0	147,900	0	0	0	0	0	147,900
Total Income	757,810	147,900	0	0	0	0	0	905,710
Total Net Costs (Costs – Income)	0	0	0	0	0	0	0	0

Depreciation of assets

Depreciation summary	25/26	26/27	27/28	28/29	29/30	30/31	31/32
	£'s	£'s	£'s	£'s	£'s	£'s	£'s
Initial Purchase Costs	757,810	147,900	0	0	0	0	
Depreciation							
25/26	50,521	0	0	0	0	0	0
26/27	151,562	29,580	0	0	0	0	0
27/28	151,562	29,580	0	0	0	0	0
28/29	151,562	29,580	0	0	0	0	0
29/30	151,562	29,580	0	0	0	0	0
30/31	101,041	29,580	0	0	0	0	0

31/32	0	0	0	0	0	0	0
Revised Total	757,810	147,900	0	0	0	0	0

Vacancy value

Vacancy value is a factor that is set against the direct pay elements of the programmes resource cost model, set against the baseline costs set in in the projected resource model. It is to account for vacant posts that may exist at points during programme delivery, where staff are not in post and therefore there are no salary commitments for any period that a post is vacant.

It is anticipated that there will be an element of staff turnover during the implementation and delivery of the Digital Community programme and as such a vacancy factor of 5% has been set. Estimated vacancy values have been calculated, for the term of the programme delivery, taken as Seven years and are identified as below:

Cost summary	25/26	26/27	27/28	28/29	29/30	30/31	31/32	Total
	£'s	£'s	£'s	£'s	£'s	£'s	£'s	£'s
Revenue Income - Staff Pay Costs (Vacancy Value)	12,955	62,955	50,176	36,520	10,515	10,883	11,264	195,268

Funding Source

It is recommended that the Health Board fully funds the MH&LD EPR Programme, covering all system acquisition, licensing, implementation, and internal resource costs. This approach provides financial certainty and ensures timely migration from WCCIS to a new platform by the fixed deadline of March 2027. Delays in funding decisions would represent a risk to the safe and timely transition from WCCIS to the RIO Platform.

While a range of external funding opportunities exist, these sources are not guaranteed due to changing national priorities. Therefore, the Health Board should proceed based on full self-funding, while actively pursuing external funding to offset internal financial pressures as opportunities arise.

External funding opportunities that exist are:

- Welsh Government funding via the DHCW Connecting Care Business Case.
- Regional Partnership Board (RPB) streams such as the Regional Integration Fund.

Benefits and Risks of Preferred Option

Implementation of Rio will enable the realisation of benefits that the WCCIS programme was unable to deliver. Rio will deliver significant efficiencies, free up valuable clinical and administrative time, and improve patient and staff experience. However, it must be noted that none of these benefits are cash releasing. Its a reinvestment in terms of time for staff to be able to reinvest in to other duties and service improvements.



The forecasted benefits are clear and measurable:

- **Fewer requests for further information when managing referrals:** 50% reduction dropping from 8,718 a year to 4,359 per year.
- **Reduction in administrative time when managing referrals:** Combined saving of 51,969 admin hours over 5 years — equivalent to 6,929 working days (1,386 per year across 137 Teams) — delivering a £882,956 non-cash releasing saving over 5 years, with time reinvested into supporting clinicians, letter writing and updating service information.
- **Faster referral processing:** Average time cut from 7.65 days to just 0.5 days to *process* a referral – over a week faster.
- **Clinician time released:**
 - 1 minute saved per appointment on searching for information.
 - 2 minutes saved per appointment on documenting information.
 - Resulting in a non-cash releasing saving of £1,531,081.37 over 5 years. Equates to an average of 14.92 working days per year per team.
 - The efficiencies achieved will enable staff to reinvest time into other duties and service improvements. This includes activities such for Psychology teams - Care and Treatment Planning (CTP), as well as direct clinical work for Occupational Therapy, including group sessions, Discovery Through Activity (DTA), and reporting repeating outcome measures.
- **More timely management of diaries:** Appointments created after their due date fall to 25% (from current levels).
- **Reduction in administrative time and an increase in reporting data quality**
 - Outpatient error reporting cut by 25% (Saving 15 minutes per month)
 - CRHT reporting automated (Saving 2 hours per month)
 - Psychology waiting list reporting automated (Saving 20 minutes per month)
 - Wider statutory reporting including MHM, Inpatient metrics and MAS cut by 75% (Saving 11.25 hours per month)
 - Combined saving of 830 hours over 5 years across ALL teams which equates to 22 working days per year and a non-cash releasing saving of £28,178.50 over 5 years.
 - The efficiencies achieved will enable staff to reinvest time into other performance related duties and service improvements.
- **Reduction in administrative time managing data cleaning errors**
 - Outpatient errors reduce by 25% saving 78 Hours 11 Minutes a year
 - Admitted patient care errors reduce by 25% saving 5 Hours 20 minutes a year

- o ICD10 (inpatient discharges) will be eliminated entirely 94 Hours and 39 minutes a year.
- Combined saving of 890.8 hours over 5 years across ALL teams which equates to 24 working days per year and a non-cash releasing saving of £30243.08 over 5 years enabling staff to reinvest this time into other performance related duties and service improvements.
- **Compliance maintained and improved without the need for manual data cleansing.**
 - o Mental Health Measure Part 1 consistently achieving target of above 80% (currently yearly average is 82.6% Adults and 92.3% CYP)
 - o Mental Health Measure Part 2 consistently achieving target of above 90% (current yearly average is 78.4%)
- **Experience Improved**
 - o Staff and patients will report a better experience.

The programme, in consultation with colleagues across the MHL service, recognises that the efficiencies delivered through the implementation of *Rio*, will represent the most significant source of benefit and will result in an improvement to staff and patient experience. This will be enabled through features such as shorter, automated, and role-specific forms, enabling real-time editing and reducing duplication. Fields such as date, time, location, and author are auto populated, improving accuracy and saving time. Referrals will be completed electronically, *eliminating* the reliance on unstructured emails, paper referral forms and other methods.

Where efficiency savings are realised, there is no expectation that these will translate into reductions in whole-time equivalent (WTE) posts. Instead, the efficiencies will create opportunities for teams to redirect time towards other priority duties, enhance service delivery, spend more time with patients to build stronger relationships, and support staff in reducing the need to work beyond contracted hours.

The introduction of *Rio* will see the realisation of benefits associated with the referral process across the MHL service, enabling patients to receive more timely access to care. Within Primary Care Mental Health Services (PCMHSS), Robotic Process Automation (RPA) has been utilised to support referral management, and the data obtained has provided a strong evidence base on which to forecast improvements across other aspects of referral handling. This includes anticipated reductions in return of referrals due to incomplete/incorrect information, improved compliance and faster progression of patients through to assessment and treatment. Average referral processing times will significantly reduce resulting in the organisation to consistently meet the national target of 80%.

These improvements alongside the real-time access and documentation at the point of care, mobile-optimised features, offline access, and improved compatibility alongside SIM-enabled devices will all support to improve staff experience. This will lead to an increase in job satisfaction, with digital tools that enable them to deliver a high quality of care our patients need.

Ultimately, the system will improve the patient experience when interacting with our organisation. Providing patients the tools where appropriate to self-manage their health through the patient portal, integrated with the NHS Wales App. This will allow them to view appointments, access care plans, receive updates, and securely message their care team providing greater transparency, patient empowerment to engage in their care, and improved treatment adherence—especially for those with long-term or complex needs. Aligning with national priorities around digital inclusion and person-centred care.

Additional benefits identified include:

- Increase in staff and patient safety by providing real-time, secure access to essential clinical information and alerts at the point of care. Staff will be able to view risk history, legal status, and care plans from any location, supporting safer, more informed decision-making.
- Increased visibility of appointments booked leading to reduction in patients being missed and not being seen in a timely manner. Appointment scheduling will be streamlined through integrated digital calendars and Outlook sync.

Following a series of workshops with service leads, the identified benefits have been confirmed as deliverable when assessed against the current functionality, the proposed functionality within Rio, and business change initiatives to be implemented. All benefits are owned by the services within Mental Health and Learning Disabilities Division and the Family and Therapies Division as identified in the benefit plan in Appendix 2.

Appendix 2 sets out the full details of the forecasted benefits.

Risks

Identified Issue or Risk (WCCIS)	Mitigation (Rio)	Associated Benefit
Staff rely on fragmented systems (WCCIS, paper, spreadsheets, disconnected systems) causing inefficiencies and data duplication	A single, integrated EPR offering consolidated workflows and real-time updates across disciplines	MHLD4 Reduction in clinical time spent per shift finding patient information relating to patient care.
Long forms requiring excessive clicks to complete notes, leading to fatigue and reduced productivity	Streamlined forms, role-based views, auto-populated fields (e.g. time, user) reduce clicks and improve usability	MHLD5 Reduction in clinical time spent per shift recording patient information related to patient care
Current system does not support fast access to information in the field, especially in poor connectivity areas	Mobile-optimised platform with offline functionality and automatic sync once reconnected	MHLD11 Timely access to information when in the community due to the ability to update and view information in real time
Lack of visibility and alerts for key safety information (e.g. allergies, safeguarding, risk history) exposing staff and patients to potential harm	Real-time access to structured alerts and patient risk information regardless of location or device	MHLD11 Increase in patient and staff safety
No current patient portal: patients have no digital access to view or manage appointments or care plans	Patient portal enabling access to appointments, updates, and secure messaging	MHLD16 Increase in patient experience
Inpatient clinicians unable to document at bedside due to WCCIS not working properly on tablets/iPads. Community workers having to return to base to upload documentation	Compatibility with sim enabled laptops; point-of-care recording supported by structured forms and offline mode	MHLD13 Improved staff experience by enabling staff to work in a hybrid way of working

as unable to complete in the field.		
Staff regularly travel back to base to upload notes, causing lost time, unnecessary travel, and increased carbon output	Ability to document care on the go; offline recording with sync functionality; mobile devices with SIM/Wi-Fi connectivity	MHLD13 Improved staff experience by enabling staff to work in a hybrid way of working.
Manual and duplicate entry of clinical information across Outlook and WCCIS causes frustration and errors in scheduling	Outlook integration and digital calendars to streamline appointment management, avoid duplication, and improve coordination	MHLD10 More efficient scheduling of clinical time
Service unable to forecast or report accurately due to poor data quality, free-text fields, and incomplete records	Validated, structured data capture with reporting-ready formats, improving auditability and forecasting	MHLD6 Improved data quality to inform reporting and forecasting.
Limited scheduling functionality and no recurring appointments impact therapy groups and discharge planning. Staff having to rely on numerous appointment systems.	Advanced scheduling tools including recurrence settings, shared calendars, and caseload visibility with outlook integration	MHLD7 Increased visibility of appointments booked leading to reduction in patients being missed and not being seen in a timely manner.
Poor performance and frequent outages of WCCIS impact clinical documentation and increase stress	Stable, resilient cloud-hosted solution with improved uptime and business continuity procedures	MHLD17 Better staff experience by more efficient management of workload MHLD12 Increase in patient and staff safety.
Limited shared view between health and social care teams, requiring manual updates and phone calls	Interoperability with social care systems (e.g. Mosaic), and shared care records across sectors	MHLD4 Reduction in clinical time spent per shift finding patient information relating to patient care.
No mechanisms to enable hybrid or flexible working; office presence often required to complete tasks	Mobile-enabled system supporting hybrid models; documentation can be completed in the field or remotely with full functionality	MHLD13 Improved staff experience by enabling staff to work in a hybrid way of working

Business Change Scaling

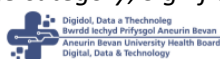
The implementation of the Rio EPR will demand a substantial programme of transformational change, requiring strong commitment from the MH&LD division, as well as CAMHS within the Family and Therapies Directorate.

A Business Change Scaling Assessment has confirmed that, due to the complexity of the Digital Community Programme, a **SIGNIFICANT** level of business change (total complexity score of 27) will be essential to ensure successful delivery and adoption.

- The change will impact over 80% of the staff within the service (5)
- Extensive stakeholder engagement is required with a range of stakeholders (5)
- There is a significant change which will affect a large range of processes that are complex and significantly different from the current processes (4)
- Due to Advance exiting the market, there is a limited time available to make the change (4)
- This change has been done before with the implementation of WCCIS (3)
- The work involved will involve some organisational/cultural change, mainly around mobile ways of working (3)
- Clinical leads and/or other managers have some adequate control or influence to deliver the required business change (3)

Although there are fewer than 2,000 clinical users, the total number of users—including those with read-only or edit access—exceeds 2,000. Additional services will also be onboarded to Rio, as they were previously unable to use WCCIS due to its inability to meet their specific requirements.

When combined, the size and complexity of the change required has been deemed in the highest change category; Significant, as detailed in the matrix below.



Business Change Scaling - Scoring Matrix

Complexity of the Change	Significant (30-35)	3	4	4	5	5
	High (25-29)	2	3	4	4	5
	Medium (19-24)	2	2	3	4	4
	Moderate (13-18)	1	2	2	3	4
	Low (7-12)	1	1	2	2	3
		< 100 users	100 to 500 Users	500 to 1000 Users	1000 to 2000 Users	> 2000 Users
Size of the Change						

Scale of the Change - Outcome

1. Low	2. Moderate	3. Medium	4. High	5. Significant
Business Change Scale of the Change				5. Significant

Conclusion & Recommendation

The proposed implementation of the Rio EPR presents a clear opportunity to address the longstanding limitations of WCCIS and deliver transformational change across services within the health board. Many of the planned benefits attributed to the WCCIS implementation have remained unrealised due to non-delivery of functionality, resulting in the service's reliance on significant workarounds. The benefits of the proposed Rio EPR span operational efficiency, data quality, staff experience, patient engagement, safety, sustainability and compliance.

The Rio EPR offers a modern, mobile-enabled, and interoperable platform that aligns with strategic priorities. Critically, it enables real-time, structured data capture and access across settings, reduces duplication, supports point-of-care documentation, and enhances both clinical and patient communication through integrated portals and scheduling.

A comprehensive risk-benefit analysis demonstrates that Rio directly mitigates key challenges identified with WCCIS while unlocking measurable intermediate and end benefits, as mapped against the benefit statements.

However, the change is substantial. A Business Change Scaling Assessment has classified the programme as requiring a significant level of transformational change, with high complexity, broad process impact, and extensive stakeholder engagement required. Success will therefore depend not only on technical implementation but on robust change management, strong clinical leadership, and committed divisional ownership across all affected services.

The recommendation is to proceed with the implementation of the Rio EPR as the preferred option. The case for investment is well-founded, offering a future-ready solution capable of supporting modern, integrated, and person-centred care. To maximise benefit realisation and mitigate risks, it is recommended that the programme is accompanied by a comprehensive business change strategy, targeted support for staff, and continuous monitoring to ensure successful adoption and long-term impact.

The Case for Change

Investing in a modern EPR for MH&LD services will enable the transformation of how care is delivered across MH&LD services in ABUHB. It will enable far-reaching improvements across clinical workflows, data quality, service integration, workforce mobility, and the patient experience. It will support a fully mobilised workforce, enabling real-time documentation at the point of care and empowering professionals to deliver responsive, flexible care in the community, where it is often needed most.

The rationale for investment is underpinned by both the challenges posed by existing systems and the significant opportunities for transformation. This case focuses on the core, interdependent elements that the programme seeks to improve—delivering meaningful benefits for ABUHB, its service users, and the wider NHS Wales system through the introduction of a fit-for-purpose, future-ready digital platform. Through the implementation of the EPR, we will drive improvements across key areas including:

- **Improved Reporting, Data Quality and Compliance:** Data will be captured more accurately and consistently through structured, role-specific forms, removing the need for retrospective validation. Alerts will flag emerging compliance risks, enabling timely action. This will strengthen adherence to national and local standards, including the Mental Health Measure (MHM), the Mental Health Act (MHA), and Referral to Treatment (RTT) targets. Consistent outcome tracking will also support data-driven service improvement and strategic planning.
- **Improved Operational Efficiency:** Time spent on administrative tasks—such as searching for information, completing documentation, and managing referrals—will be significantly reduced, allowing clinicians to focus more on direct patient care. Referral processes will be streamlined, duplication across services minimised, and communication between multidisciplinary teams strengthened. Improvements to task management and coordination will support more efficient, integrated services, enhancing staff experience.

- **Enhanced engagement and communication with patients:** A patient portal will provide patients and carers with more timely and transparent access to care information, supporting a more informed and engaged experience.
- **Increase in staff experience and satisfaction:** Rio will directly improve the day-to-day experience of staff by enabling documentation and record access at the point of care. Clinicians will no longer need to rely on delayed updates or fixed infrastructure, as the system supports mobile and agile working across a range of community and inpatient settings. This will improve the immediacy and accuracy of clinical information while supporting care delivery closer to home. Staff will be able to reinvest time saved on administrative tasks into higher-value activities such as direct care, innovation, and service development, enhancing job satisfaction and work–life balance.
- **Provide the foundations for future digital transformation:** As the world looks to AI (Artificial Intelligence) to improve efficiencies around working processes and practices, healthcare is no different. Smart Notes is Access Group’s AI product that supports with digital dictation and note summaries. Additionally, as we understand more about the benefits of social prescribing to better address our communities social and non-clinical needs, Access Group has an associated module that can be implemented at additional cost. Whilst not included in the scope of this business case, having the associated EPR in place would enable the service to develop and take advantage of these opportunities easily if required, to support future ways of working.

Whilst the case for change outlines the opportunities a new EPR will bring, it must also acknowledge the significant risks of not replacing WCCIS, which is approaching end-of-life.

The supplier of WCCIS, Advanced, has formally confirmed its withdrawal from the market, with core elements of the system due to become unsupported by January 2026. With the Master Service Agreement (MSA) ending in March 2027 and no option for extension, the system is rapidly approaching the point of being operationally unviable. Advanced has ceased any new developments to WCCIS. This creates a pressing need to transition to a modern, fit-for-purpose EPR.

WCCIS offers functionalities such as patient registration and demographics, referrals and case management, appointment scheduling, clinical documentation, MHA integration, risk management, activity tracking, and information governance. However, several of these functionalities have limitations that hinder efficient service delivery. At full maturity, Rio will become the central platform for community and inpatient based care delivery across all in scope services, forming a foundational component of ABUHB’s wider digital health architecture and enabling alignment with local and national strategies.

Without investment in a modern system, services would revert to fragmented, outdated practices—relying on paper records, scattered spreadsheets, and improvised tools unsuited to delivering safe, multidisciplinary care. These workarounds lack coherence, slow down workflows, and increase the risk of errors. Staff would waste time searching for information and duplicating effort, rather than focusing on patient care. Data governance would be compromised, with disconnected systems undermining auditability, accuracy, and timely access to information for reporting.

Without a fit for purpose digital platform, operational inefficiencies would grow, collaboration would suffer, and teams would struggle to scale or innovate. Shadow IT, increased storage costs, and inconsistent local practices would further erode service quality and consistency.

The digital system enables services to work in a coordinated way, facilitating rapid information sharing and real-time risk assessment. Clinicians can immediately see which services are involved with each

client, allowing for joined-up, timely interventions. Reverting to paper would abolish the coordinated efforts that it has already established, sending services to work separately and creating further risk to patients and clinicians.

Critically, this would represent a backwards step in digital maturity directly impacting service delivery for patients. Staff who have embraced digital ways of working would be forced to return to paper-based processes, risking disengagement and impacting recruitment and retention. Staff expect modern, interoperable systems aligned with the wider NHS digital agenda.

Evidence reinforces this risk: the Journal of Medical Internet Research links high digital maturity with better patient safety and lower infection rates. In contrast, organisations lacking digital capability face poorer data access and clinical decision-making, directly affecting care quality.

The Scale

The investment will support over 2000 staff (as of June 2025) across:

- Adult (including specialist services)
- Older Adult
- Learning Disabilities
- CAMHS (Child and Adolescent Mental Health Services)
- PCMHSS (Primary Care Mental Health Support Services)
- Psychology within Family and Therapies
- Adult Psychology Services
- Mental Health Act
- Commissioners

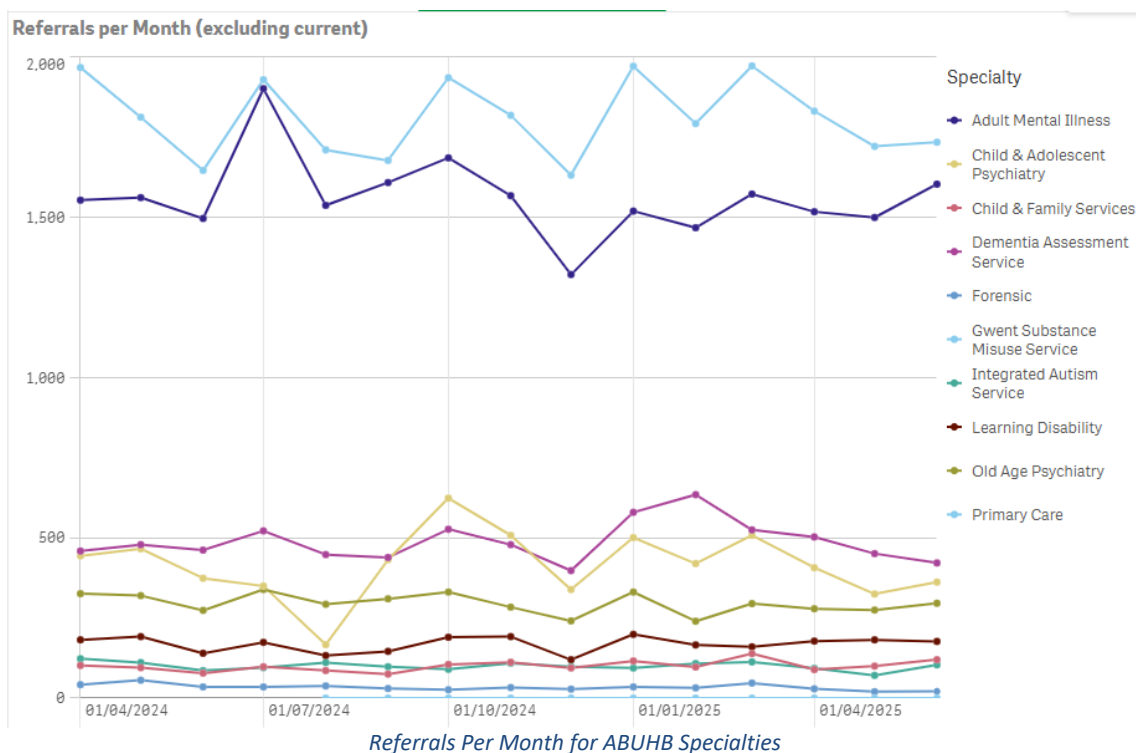
It will replace the WCCIS used to manage and co-ordinate the care for thousands of service users within Gwent across a wide range of pathways.

The neurodevelopment team within the CAMHS service, who are currently using paper-based processes will transition to the new EPR.

WCCIS is utilised by various clinical and non-clinical staff, including Registered Mental Health Nurses, Health Care Support Workers, Medics, Psychologists, Psychological Therapists, Occupational Therapists, Speech and Language Therapists, Mental Health Social Workers, Administrators, Team Managers, Service Improvement Managers, Peer Support Workers, Psychology Assistants, Allied Mental Health Professionals, Art Therapists and leadership team.

Current Service Performance, Demand and Capacity

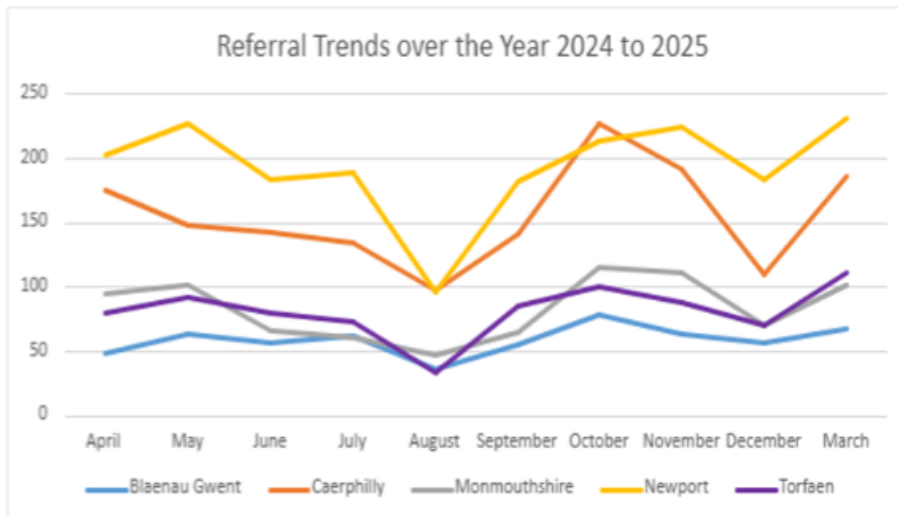
Demand for services across all areas remains consistently high as shown in the data below.



CAMHS Services

An increasing number of children and adolescents are presenting with mental health needs influenced by broader societal factors, including economic hardship, social isolation, and the long-term impact of the COVID-19 pandemic.

Within the SPACE service—a multi-agency initiative involving all five local authorities that coordinates both early intervention and specialist support for children’s mental health and emotional wellbeing—referral volumes have increased steadily across the year, with a clear upward trend and notable seasonal patterns—lower activity during summer (Q2) and peaks in autumn and winter, particularly in Q4. Newport consistently recorded the highest number of referrals, peaking in January 2025. Caerphilly and Blaenau Gwent experienced sharp increases in October and January, while Monmouthshire and Torfaen maintained lower but stable referral rates.



The graph shows referral trends from April 2024 to March 2025 for SPACE Wellbeing.

The data shows that service demand is increasing, especially for Neurodevelopmental support. Between April 2024 and March 2025, seven Gap Analyses highlighted significant service limitations.

Many referrals could not be actioned due to services being unavailable, at capacity, or restricted by funding. Consequently, "best effort" support packages were created to provide alternative support in several instances.

Services like Newport Mind and Family Intervention Team (FIT) were identified but often closed to new referrals. Where no suitable service existed, especially for complex or very young cases, alternative options such as Emotional Literacy Support Assistant (ELSA), Talking Zone, and external signposting are having to be offered.

The ABUHB 2024–2027 Annual Plan – Three-Year Intent highlights a projected threefold rise in demand for mental health services over the next 3 to 5 years, with significant growth expected in presentations involving severe anxiety and depression.

In April 2025 alone, there was a total of 2996 calls to the ABUHB NHS 111 Press 2 service, which provides urgent mental health support in Wales.

In addition to consistently high demand, services are also seeing a notable increase in the complexity of cases (patients appearing on multiple waiting lists concurrently). This is accompanied by higher expectations for early intervention and prevention, alongside a growing requirement for personalised, flexible care pathways. Due to the limitations of the WCCIS system, it remains challenging to quantify and report these trends accurately. However, service leads have provided narrative evidence that illustrates the scale and nature of these pressures.

Current Performance measures

WCCIS presents several significant challenges in meeting the requirements of statutory targets. WCCIS does not have many tools built into the system to support performance measures, so there have had to be frequent workarounds and cleansing work completed by performance teams to ensure compliance is met.

To support statutory compliance, Rio has pledged to implement all required Welsh data standards by December 2025. This ensures that, by the time the contract is in place, ABUHB will have access to a fully compliant reporting framework.

Mental Health Measure

Part 1 and 2

The division is now achieving its performance targets for Mental Health Measures Part 1 and near to compliance for part 2, across both adult services and services for children and young people. The challenge is maintaining compliance going forward.

A significant amount of time is spent compiling information for reports, and teams face ongoing challenges accessing up-to-date care plans quickly and easily. While WCCIS dashboards are designed to alert staff to Care and Treatment Plan (CTP) review dates, these are often unreliable. This is because the review date field is not mandatory in WCCIS, meaning it is frequently left blank, resulting in inaccurate or incomplete dashboard data.

Similarly, the absence of mandatory fields for recording Care Coordinators means this information is not consistently captured, or it is entered in different and unclear areas of the system. This can make it difficult and time-consuming for staff to identify who is responsible for a patient's care.

These limitations affect both compliance and service quality, as clinicians must manually track key information, increasing the risk of missed reviews, delayed interventions, and fragmented care planning.

Part 3

A requirement of Part 3 is for individuals to receive an outcome assessment report within 10 days of a part 3 assessment. Due to WCCIS incompatibility, the reporting team are having to put in system workarounds to track and monitor part 3 compliance. Within Rio, these reports can be pulled from the system, and not from disjointed reporting systems.

Mental Health Act (MHA)

There is an ongoing issue between Local Authorities and the Health Board regarding data entry responsibilities. While ABUHB is responsible for collating mental health act information, some Local Authority teams are entering data.

This has resulted in inaccuracies, such as incorrect detention dates being recorded (e.g., capturing the date of detention rather than the date the paperwork was signed). If errors occur, they can result in fines and patients remaining on sections when they should have been discharged.

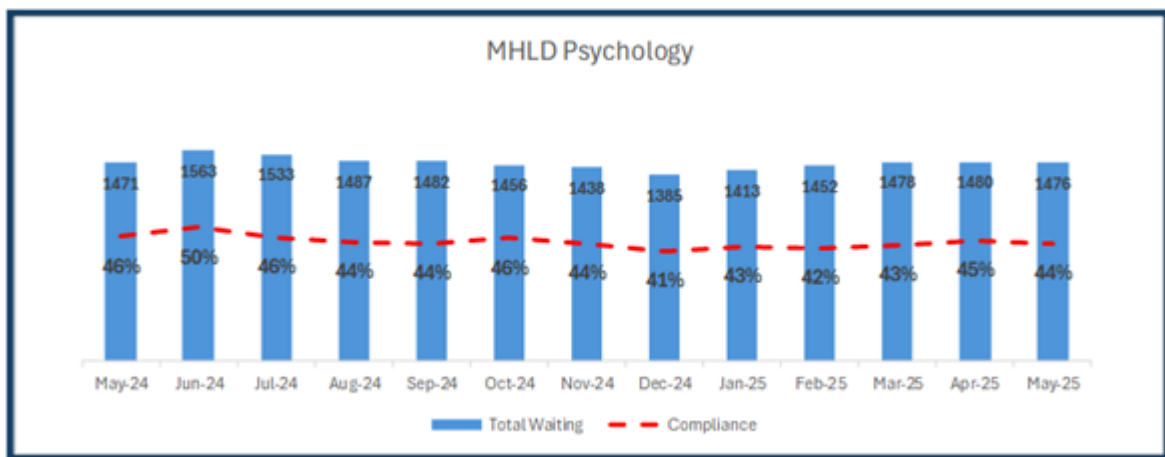
With the new EPR split between Rio (Health) and Mosaic (Social Care) in Gwent, Mosaic will not include a Mental Health Act (MHA) module. While it may be possible to configure some MHA sections against a person, this will lack the essential functionality to manage key processes such as review dates, tribunals, and renewals—reducing the risk of inappropriate or unsafe duplication of records and ensuring that MHA workflows are managed solely within the appropriate clinical system (Rio).

Under section 117 aftercare, patients should be reviewed as a minimum, on an annual basis. Similarly to care and treatment planning, dashboards are not showing accurate review data linked to health forms. This can mean patients can be missed.

Psychological Services

The Health Board is not meeting its targets for Psychological Services. The RTT target for psychological services is 26 weeks. Total patient waiting for psychological therapy is 1494 as of 30th June 2025.

As of June 2025, 434 patients have been waiting under 11 weeks, 190 have been waiting between 12-17 weeks. These are all within target. However, 160 patients have been waiting between 25-35 weeks, 198 patients have been waiting between 36-51 weeks, and 339 have been waiting longer than 52 weeks.



Across the services there are significant vacancies for Psychologists which is impacting waiting lists.

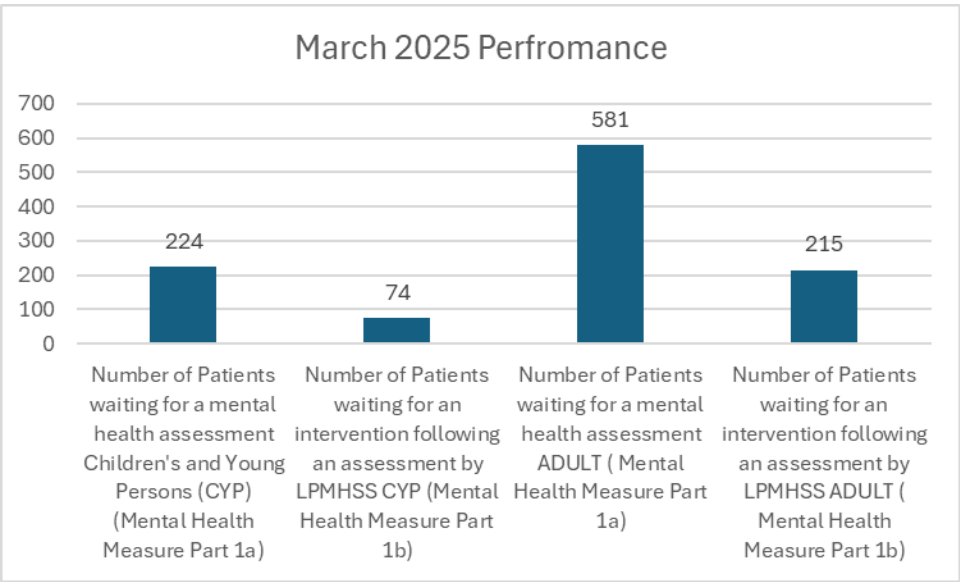
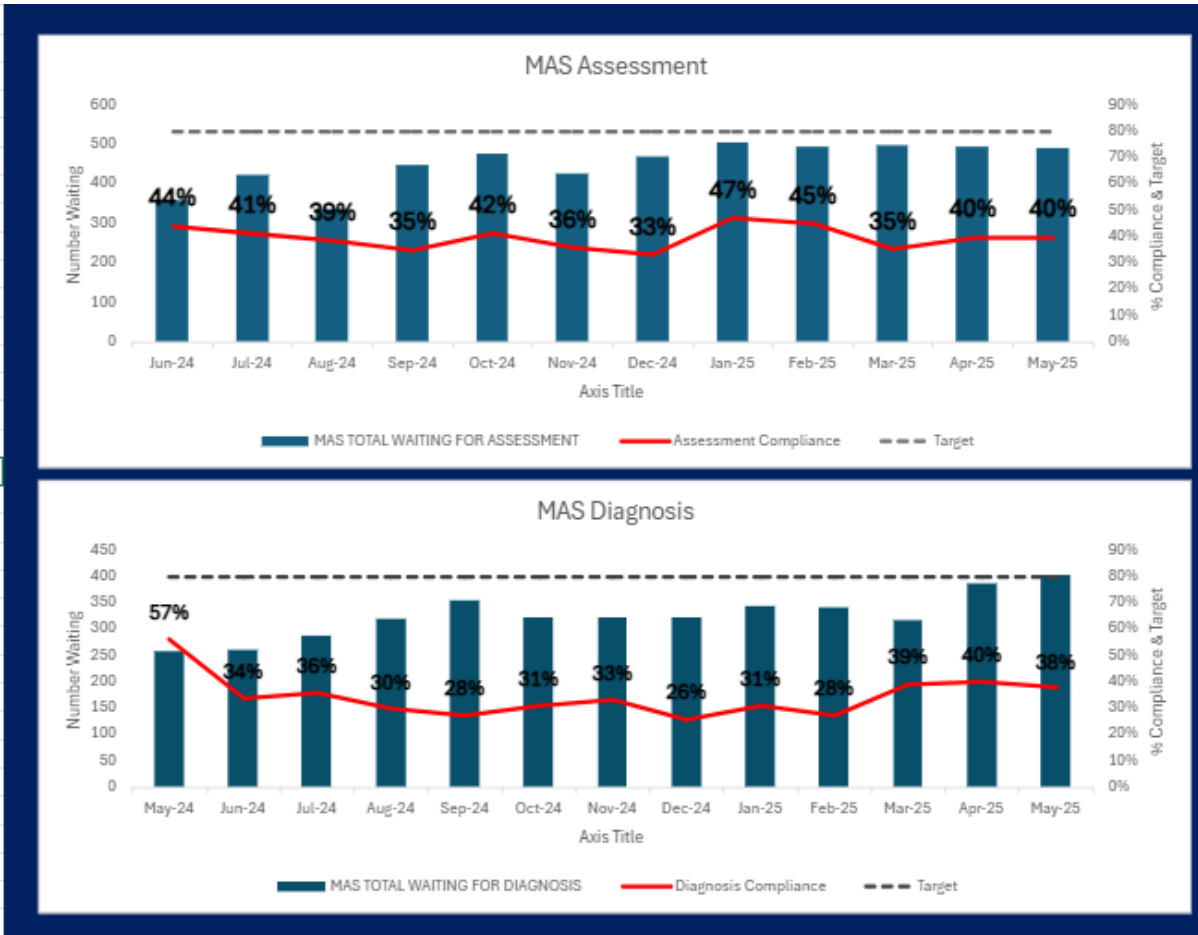
Additional funding for psychological services was agreed in December 2024 to reduce waiting lists. £33000 was claimed for psychological therapies waiting times to be spent between December 2024 and March 2025.

The funding was to be used for 50 new patients (adult) and 10 patients (LD) to receive treatment by agency staff. Other issues such as psychological processes, clock issues and data migration issues from EPEX to WCCIS are all contributing to waiting list challenges.

Memory Assessment Services

Targets are not being met for either referral to assessment, or referral to diagnosis. There has been significant work done with processes and dashboards, but workarounds have still needed to be completed and migration errors from EPEX to WCCIS still exist in the system, affecting performance.

Memory Assessment Service Data June 2024-May 2025



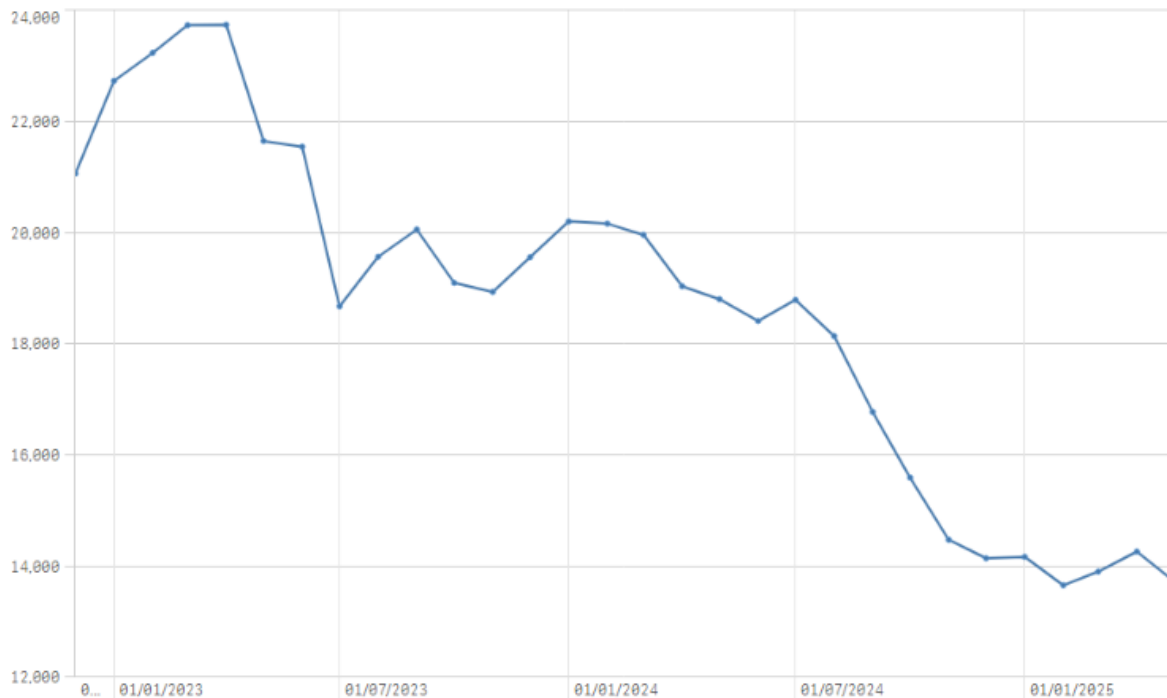
The inconsistent use of digital and paper forms—undermines data quality, validation, and compliance. Key information often must be manually extracted from narrative case notes, increasing the risk of errors and placing additional burden on already stretched teams.

A recent example includes the identification and auditing of 1,046 records flagged as non-compliant in relation to care co-ordinators being accurate. To resolve this, a full-time medical secretary had to

be reassigned solely to support this task. This task has had to be recently repeated with 117 patients across all 5 local authorities, not just ABUHB.

Waiting List per Month (excluding current)

Decrease in Period = -15,880 (29,686 - 13,806) * statistically significant



While the graph indicates a reduction in waiting lists, much of this improvement is attributed to the extensive data cleansing undertaken by performance managers within the MHL service to ensure more accurate reporting.

A further challenge is the fragmentation of data across systems. Reporting often requires pulling information from both WCCIS and Qlik, manually merging it in Excel, and applying custom formulas—taking up to 30 minutes per report. Only users with advanced skills and dual-system access can perform this, making real-time reporting inaccessible to frontline staff. Services not in scope for some reports need to be manually excluded from reports, adding to delays and increasing the risk of error.

Since the introduction of WCCIS, addiction services in Wales have faced significant challenges in meeting statutory reporting requirements to Area Planning Boards and Welsh Government (WG). These reports, which include data on referrals, discharges, drug use, waiting lists, and service demand, were previously compiled using EPEX, Grape reports, and local due diligence processes. However, WCCIS has severely limited the ability to extract and submit this information accurately or on time.

A key issue is WCCIS's tendency to incorrectly link current referrals with closed pathways—sometimes due to human error, but often as a result of flawed system algorithms. These errors require manual correction, yet staff often lack the necessary access or understanding to resolve them effectively. In many cases, those with access do not have insight into the service's operational context or reporting requirements. As a result, monthly data submissions from ABUHB addiction services have frequently been delayed or missed entirely, with some reports likely not submitted since 2022.

This has had a direct impact on the Health Board's ability to demonstrate the work being done, compare outcomes across regions, and secure appropriate funding. Incomplete or inaccurate data prevents Area Planning Boards and WG from identifying service trends or forecasting future needs, ultimately risking underinvestment in services that support some of the most vulnerable populations.

Specialist services have been disproportionately affected. The current system has compromised reporting, transparency, and strategic planning.

Rio will significantly improve data quality, ensuring key information is captured consistently at the point of entry. All User Defined Fields (UDFs) in Rio are automatically reportable, removing the need for workarounds or manual data extraction.

In addition, real-time reporting capabilities will allow users to generate reports directly from the live system using custom filters, eliminating the need for post-extraction data cleansing. Performance teams can pull SQL reports directly from Rio reports. This will reduce the time performance teams currently spend correcting incomplete or inconsistent data, improve overall data accuracy, and provide timely, accessible insights to both frontline staff and decision-makers.

Current Service Provision

This business case outlines not only the need to replace the existing digital infrastructure with a fit-for-purpose EPR, but also the wider system and the transformational change required to support modern, integrated and mobile models of care. It reflects a shift away from fragmented, inefficient processes toward a unified digital approach that better enables safe, responsive, and coordinated service delivery.

Current Challenges

Since its implementation, WCCIS has presented persistent and widespread issues. The following outlines some of the most significant challenges experienced across ABUHB:

Reliance on Digital Health and Care Wales (DHCW)

WCCIS is predominantly used by Social Care rather than Health. ABUHB stands alone in using it as the principal clinical system for mental health services. At the National Change Advisory Board (CAB), ABUHB have found difficulties prioritising the Health Board requirements. Requests submitted by ABUHB have often been deprioritised or rejected outright in favour of development priorities focused on Social Care. There was a significant disparity between health and social care members at CAB which has led to direct and ongoing consequences for clinical safety and workflow.

Example 1:

The enablement of automatic closure of referrals upon a patient's date of death was rejected on the basis that local authorities require patient records to remain open for financial reconciliation. The result is that clinicians must now manage and manually close referrals for deceased patients—leading to distress for relatives and confusion within care teams. Within ABUHB, there have been circumstances of letters being sent to patients who have deceased causing significant distress to family members.

Example 2:

ABUHB proposed changes to ensure that key MH&LD information would be immediately visible when a clinician accesses a patient's record on the patient summary screen. This functionality was rejected, as it conflicted with the preferred layout used in Local Authority settings. Consequently, mental health staff must manually locate and select the correct screen from a list—delaying access to critical information and disrupting clinical flow.

Example 3:

A request to change the column order of the appointment screen in WCCIS, so users do not have to scroll to the end of the screen to view an appointment outcome was never actioned despite this being considered a basic configuration change. This continues to cause significant operational issues.

ABUHB can no longer continue with a one-size-fits-all solution. WCCIS, as a system designed to meet the broad and often conflicting needs of both Health and Social Care sectors across Wales, has resulted in significant compromises. Its generic design limits the Health Board's ability to configure the system around the specific clinical and operational needs of our services.

Our ability to evolve the product to fit the needs of the service was also hindered by the fact that WCCIS was built on a CRM product. This lack of flexibility has hindered service innovation, restricted the development of workflows aligned with best practice, and prevented the adoption of digital tools that match the complexity of modern community healthcare delivery. The national model has ultimately constrained the Health Board's ability to deliver care the way we desire.

To address these limitations, ABUHB must now move forward with a dedicated EPR—one that is purpose-built to support our services, reflect our clinical priorities, and enable integrated, multi-disciplinary working.

Sharing of information with Social Cared Teams

The ambition of delivering fully integrated care between health and social care through WCCIS has not been realised in practice.

In many cases, health professionals can only access high-level, read-only information through a shared dashboard or via the 'break glass' function—an approach that requires additional steps, permissions, and often causes delays. These delays frequently occur at critical points in the patient journey. For example, when an individual known to social care is admitted to hospital, clinicians cannot view their social care history in real time, limiting their ability to make informed decisions. This compromises continuity of care and can impact both patient outcomes and staff confidence in the system. This means that patients must relay the same information multiple times to multiple sources.

WCCIS not enabling information to be shared easily has made access to information across the Gwent Region fragmented and unreliable, placing a burden on staff who are left to rely on phone calls, emails, or manual escalation routes to access essential background information.

These limitations affect both health and social care teams. Requests for information can be duplicated or missed, and the lack of real-time visibility leads to repeated assessments, delays in service handovers, and inefficiencies in multi-agency working.

The situation is further complicated by inconsistent local authority engagement. Four out of five local authorities fully adopted WCCIS, however, Monmouthshire did not, with the exception of a single integrated Learning Disability team. With all five Gwent local authorities now commissioning Mosaic, and ABUHB's preferred EPR, Rio, supplied by the same supplier, a more robust and modern approach to integration is being developed. Mosaic and Rio already support cross-system access through dedicated read only viewers.

This being further enhanced through the Access Group's Integrated Care Platform (AICP) which offers a unified, real-time view of patient information by integrating data from both health and social care systems.

This new model of integration will not only replace what WCCIS failed to deliver but will offer a far more flexible, scalable, and standards-based solution.

The approach supports broader interoperability through Care Connect APIs and national shared care record initiatives. Rather than diminishing connectivity, this presents a clear opportunity for ABUHB to take a deliberate step towards a more integrated environment for delivering coordinated care across health and social services.

Navigation Challenges

A key intended benefit of WCCIS was to increase the time available for patient care by enabling real-time documentation and reducing administrative burden (WCCIS01). However, this benefit remains largely unmet.

"WCCIS causes loss of clinical hours which are used to complete tasks within the system. It is stress-inducing and creates unnecessary delays."
MHL D Clinician quote taken from a staff survey.

Staff consistently report that WCCIS is not intuitive and significantly hinders day-to-day clinical tasks. Its complex structure and lack of user-friendly design contribute to inefficiencies, frustration, and excessive time spent searching for and documenting patient information. These usability issues are not minor inconveniences—they directly impact clinical time, workflow, and patient care.

*"The system is not intuitive. There are too many steps to input and find information, and data can be stored in multiple places, making it hard to locate."
Registered nurse working in MHL D services within Aneurin Bevan University Health Board*

One of the most frequently cited challenges is the system's confusing architecture. WCCIS separates similar types of information between person-level and referral-level views, making it unclear where key details—such as previous referrals, risk assessments, or patient history—can be found. Staff need to open multiple tabs and search across several sections, often without success. The timeline summary view does not give a complete picture of patient care as not all information is pulled from the different views within the system. Rio's Patient Timeline provides a structured, chronological view of each patient's journey—from referral to follow-up—automatically capturing key events such as appointments, cancellations, and contact attempts. This enables clinicians to spot delays and gaps in care with ease.

Often users end up completing the same tasks in different ways, with some taking significantly longer than others. For example, a resident doctor accessing a patient's notes from the ward overview was observed completing 13 individual clicks, and recording a single case note in 14 clicks. In contrast, other users complete the same actions in fewer steps, highlighting the system's lack of streamlined workflows. These are routine tasks repeated throughout the day, yet the unnecessary number of steps and confusing architecture introduces delays and contributes to digital fatigue.

Managers are unable to view the caseloads of staff they oversee, making it difficult to ensure safe caseload management or reallocate work when staff are absent due to sickness or leave. While individuals can see their own caseloads, there is no visibility of those beneath them. Professional leads covering multiple boroughs also face challenges, as there is no dashboard available to support caseload oversight across teams.

The proposed Rio EPR is designed around usability and efficiency. Its clean, modern interface gives staff seamless access to patient records, documentation, and key functions via a single dashboard—

eliminating the need to navigate across multiple screens or systems. This can be achieved using dashboards, smart banners and favourite pages, while embedded help text tailored to each role supports confident system use. Dashboards will enable safe case load management for managers.

Patient Name	Team	Post Code	Start Date	Next Review	Inpatient Location	Referral Urgency	Next Appointment	Pathway Status	Waiting List
BROWN, Alice	Community Mental Health Team	WT12 4TC	19 Mar 2025	-	-	Routine (16 Weeks)	-	✓	1
CROFT, Alistair	Community Mental Health Team	WT6 4RG	19 Mar 2025	-	-	Routine (16 Weeks)	-	✓	1
CROFT, Alistair	Community Mental Health Team	WT6 4RG	9 Apr 2025	-	-	Emergency	-	✓	1
CROFT, Alistair	Community Mental Health Team	WT6 4RG	2 Jun 2025	-	-	Urgent (4 Weeks)	-	✓	1
LLEWELYN, Cerys (Mrs)	Community Mental Health Team	WT12 4RT	22 Apr 2025	-	-	Routine (16 Weeks)	-	✓	1
MAXCMBE, Gordie	Community Mental Health Team	WT15 2RT	19 Mar 2025	-	-	Routine (16 Weeks)	-	✓	1
MILNER, Roy (Mr)	Community Mental Health Team	WT9 5TT	27 Mar 2025	-	Adult Male A	Emergency	-	✓	1
MILNER, Roy (Mr)	Community Mental Health Team	WT9 5TT	9 Apr 2025	-	Adult Male A	Emergency	-	✓	1
MOORE, David (Mr)	Community Mental Health Team	WT6 7FG	27 Mar 2025	-	-	Urgent (4 Weeks)	-	✓	1
MOORE, David (Mr)	Community Mental Health Team	WT6 7FG	31 Mar 2025	-	-	Routine (16 Weeks)	-	✓	1
RYAN, James	Community Mental Health Team	WT6 7YT	19 Mar 2025	-	Adult Male A	Routine (16 Weeks)	-	✓	1
RYAN, James	Community Mental Health Team	WT6 7YT	9 Apr 2025	-	Adult Male A	Emergency	-	✓	1
SAMSON, Jason (Mr)	Community Mental Health Team	WT6 8UV	19 Mar 2025	-	-	Routine (16 Weeks)	-	✓	1
SIMS, Brian (Mr)	Community Mental Health Team	WT15 7YH	12 Feb 2025	-	Adult Male A	Routine (16 Weeks)	-	✓	1

The dashboards display a user's caseload, providing a range of valuable information not available in WCCIS — including patient waiting list details. The dashboard also features hyperlinks that allow users to navigate directly to other relevant areas of the system.

Together, these changes will lead to improved staff satisfaction and support the realisation of key benefits. By reducing administrative burden and streamlining workflows, clinicians will have more time to focus on patient care—improving quality, enhancing patient experience, and increasing clinical capacity within existing resources.

Despite comprehensive training, staff frequently save documents in incorrect sections due to the unintuitive layout and limitations of WCCIS. This results in inconsistent records and poses a risk if staff cannot access essential documentation when required. There have also been issues with staff not adding attachments which has resulted in records being lost posing significant risks to data integrity and record completeness.

WCCIS compromises the quality and safety of care, hinders timely decision-making, and disrupts continuity—particularly during clinical handovers and multidisciplinary team discussions. The reliance on retrospective data entry also increases the likelihood of omissions, inaccuracies, or miscommunication of key clinical details.

Within WCCIS, forms are often overly lengthy and user-defined fields are not tailored to specific roles—sometimes due to how requirements have been interpreted or implemented—forcing staff to navigate large volumes of irrelevant information. Basic fields such as date, time, site and staff name do not auto-populate, resulting in inconsistent or incomplete records.

Furthermore, WCCIS allows multiple patient records to open simultaneously in separate windows. This increases the risk of documenting in the wrong patient's record—a risk realised in practice, with 236 support tickets raised in the past year to correct such errors. Rectifying mistakes requires ICT support to reopen case notes so users can manually strike through entries, adding delay.

The Health Inspectorate Wales inspected Maindiff Court Hospital in November 2022. WCCIS was specifically called out in their report.

“We found care records systems and documentation to be difficult to navigate due to being located across various paper and electronic systems. There were also some concerns expressed to us from staff regarding timely access to the recently implemented WCCIS system. The health board / local authority must ensure continue efforts to streamline its systems. WCCIS training needs and system issues must also be identified and escalated as appropriate.”

Another Health Inspectorate Wales inspection was carried out on Talygarn Ward in February 2024, and there were similar findings.

Due to these limitations, staff have resorted to using paper or alternative systems such as SharePoint to save completed documentation. In many cases, information is created outside of WCCIS and uploaded later as an attachment and not using the form within WCCIS, which could potentially result in Information Governance risk, demonstrating how difficult and inefficient the system has become for standard tasks.

Rio will reduce the inefficiencies and frustrations associated with current documentation practices. It enables faster, more accurate data entry through predictive text and customised lookup values tailored to each team’s needs—reducing time spent searching irrelevant fields.

With seamless integration to digital dictation solutions and a powerful form builder, Rio allows services to digitise existing paper forms, enforce mandatory fields, and capture structured information that reflects real clinical workflows. User-defined fields can also be configured to capture local requirements directly within the record, improving data quality and consistency.

Multi-window functionality allows clinicians to work across different areas of a patient’s record simultaneously enhancing visibility and reducing the need to jump between screens. Together, these features eliminate the need for workarounds like SharePoint or scanned uploads, making documentation faster, simpler and more reliable.

These changes will mean that clinicians will have more time to spend with their patients and will reduce the need to stay after shift to complete documentation leading to better staff experience.

Integration

WCCIS was originally procured with a wide-ranging integration roadmap, aiming to connect with 13 distinct systems and enable 21 functional capabilities. However, in practice, only 4 of these integrations were successfully delivered. Integrations promised but not delivered include Welsh Clinical Communications Gateway (WCCG), Welsh Care Record Service (WCRS) and Patient Administration System (PAS) Notifications.

This shortfall has left services facing persistent digital and information gaps that affect the quality, safety, and efficiency of care. WCCIS has limited interoperability and cannot reliably or securely exchange patient information with key systems, such as Welsh Care Record Service (WCRS) and Clinical Workstation (CWS). Additionally, system fragmentation means that staff must navigate multiple disconnected platforms, resulting in information silos, duplicated effort, and missed opportunities for timely and informed decision-making. Several benefits for WCCIS were in relation to integration with other systems, e.g. if a patient is admitted to a general hospital ward, staff would receive a notification and not undertake their community visit.

Advanced integration capabilities, enabled via the Rio Integration Hub, will ensure seamless interoperability with the Local Clinical Data Repository (LCDR) as the Health Board's source of truth for core information such as Allergies, Observations and Conditions. The LCDR will in turn synchronise with the National CDR to support cross-border data sharing and future integration with the Summary Care Record (SCR). In addition, Rio will provide direct access to key national systems and datasets—including Clinical Work Station (CWS), Welsh Care Record Service (WCRS), Welsh Clinical Portal (WCP), test results, discharge summaries, and the Welsh GP Record—without leaving the Rio environment. Looking ahead, functionality such as embedding a WCRS viewer directly into the patient record will further streamline workflows and reduce system switching.

It is planned for Rio to integrate with ABUHB's approved electronic prescribing system (Better Meds), replacing paper drug charts with a complete digital medication history with the ability to see the full record in one place—enhancing safety, accuracy, and continuity of care.

Referrals and Manual Workarounds

WCCIS does not meet the operational requirements of MHLDS services when it comes to managing referrals and waiting lists.

These issues directly impact performance against RTT targets. RTT performance and reporting is undermined by the current system's inability to support efficient scheduling, real-time information access, and reliable referral tracking and data capture resulting in delayed interventions and avoidable administrative burden.

Services have been forced to implement fragmented, manual workflows that are inconsistent across teams. This includes reliance on emails, Microsoft Forms, and standalone spreadsheets to manage patient referrals—none of which are integrated into the core clinical record.

Electronic referrals

Due to a lack of integration with WCCG, electronic referrals are not available. These disjointed processes increase the risk of referrals being misrouted, delayed, or rejected, and require frequent administrative follow-ups to resolve missing or incorrect information. For staff, this contributes to mounting frustration; for patients, it results in longer waits, poorer continuity of care, and delays in accessing timely support. Electronic referrals will be implemented with the Rio platform, which will save time and reduce the issues identified above.

To address some of the limitations of WCCIS, Primary Care Mental Health Support Services (PCMHSS) introduced a Robotic Process Automation (RPA) tool to streamline the referral handling process. This automation enabled the extraction and routing of key referral data with minimal manual intervention, significantly reducing administrative workload and saving time.

Within PCMHSS alone, the implementation of RPA has delivered efficiency gains equivalent to 3.0 Whole Time Equivalent (WTE) Band 2 roles. Referral processing times reduced dramatically—from 35 days to just 0.5 days.

However, this remains a temporary workaround. The RPA tool is not integrated into the core clinical system and is only available to a single service area. Other teams continue to rely on manual, time-consuming processes. The fact that external automation had to be introduced to overcome fundamental system shortcomings underlines the urgent need for a modern, purpose-built Electronic Patient Record.

For all other services outside of PCMHSS, approximately 50% of referrals originate from GPs. Over the past *three* years, this has amounted to over 111,000 referrals—each requiring manual entry. With system integration, referrals could be processed more efficiently, enabling patients to be seen more quickly.

Once a referral is accepted, Rio provides built-in scheduling and tracking tools, offering real-time visibility of referral pipelines, appointment statuses, and service capacity. This functionality will directly support services in maintaining critical RTT targets, such as the 28-day and 26-week standards, by enabling earlier intervention and reducing bottlenecks.

In addition, Rio introduces integrated waiting list functionality, allowing services to manage multiple concurrent waiting lists across assessment, intervention, and therapy stages. This is particularly important for patients accessing multiple services, such as CAMHS and Learning Disabilities, ensuring that no patient is inadvertently overlooked.

By supporting real-time case management and highlighting outstanding actions or deadlines, Rio enables staff to intervene earlier and manage caseloads more proactively minimising delays and improving flow through the system.

The system also includes detailed reporting capabilities, enabling teams to monitor performance metrics such as waiting times, RTT breaches, and appointment outcomes.

Task Management & Workflow

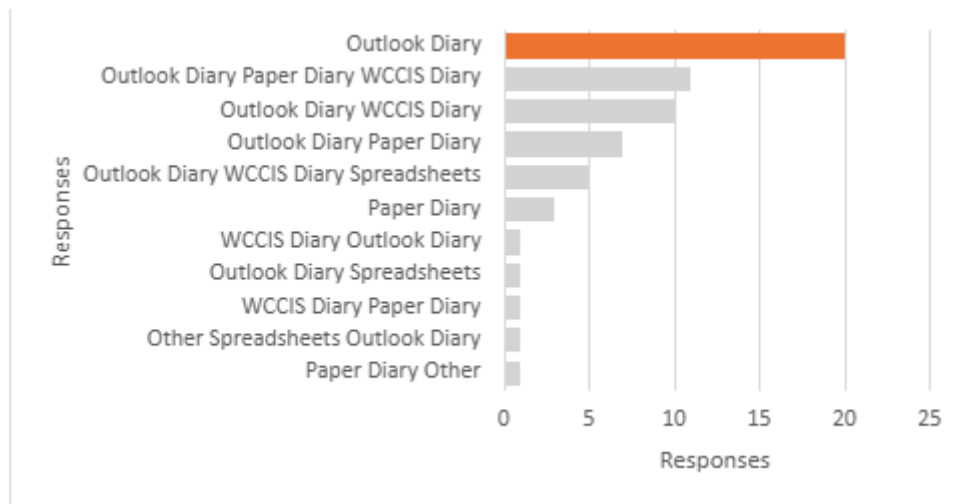
Within WCCIS, the task management functionality didn't deliver what is required for operational teams due to limitation with the task management functionality. This left clinical and operational teams without a dependable mechanism for tracking urgent actions, follow-ups, or assigned responsibilities within the system.

The new EPR will significantly improve this by introducing integrated, real-time alerts and embedded task management. Alerts will be delivered through Microsoft Outlook, Teams and SMS, ensuring staff are immediately notified of important events such as patient record updates, overdue actions, or new reports in real time, all of which are auditable.

For managers, this means better oversight of outstanding actions without needing to rely on separate systems or email trails. The overall result is a safer, more responsive, and better-organised approach to care delivery.

Appointment Scheduling and Management

Scheduling clinical time is a significant challenge, especially in community services where coordination and flexibility are crucial. The current WCCIS system does not integrate with outlook, meaning staff must rely on paper diaries, spreadsheets, or separate digital calendars, leading to duplicated effort, increased risk of scheduling errors, and limited visibility of team availability. Although outlook integration was originally planned, it was later descope due to technical limitations.



A poll was shared with MHL and CAMHS staff asking, 'How do you currently manage scheduling patient appointments, select more than one if you use more than one method?'. The results indicate that most users rely solely on Outlook, while others use a combination of diary systems, leading to duplication of effort.

WCCIS also lacks essential functionality, such as the ability to schedule recurring appointments beyond a 30-day period—an important feature for managing group sessions or ongoing interventions. Staff have reported that diary management can take up to an hour each week, time that could otherwise be spent delivering patient care.

Other limitations include the inability for joint appointments to appear in both clinicians' diaries, leading to incomplete performance data and gaps in service reporting. Attendance tracking is also manual, requiring case notes to record DNAs or cancellations, making accurate reporting difficult and time-consuming. All these challenges have resulted in 57.3% of appointments being created before the appointment date, against 42.7% being created after the appointment date (suggesting retrospective documentation or delays in scheduling). It is acknowledged that some level of retrospective appointment entry will always be necessary for certain services, such as crisis teams, due to the nature of their unplanned and responsive work.

The Rio EPR addresses these issues with modern, integrated scheduling tools designed for community-based care. Recurring appointments can be set up easily with no date limit, reducing administrative burden and improving consistency. Integration with Microsoft Outlook allows real-time diary synchronisation, ensuring staff have a single, reliable calendar view and eliminating the need for multiple systems.

Together, these features will improve efficiency, reduce administrative workload, and provide accurate, real-time data to support patient care and service planning.

Patient Communication

Patient communication within the current WCCIS system is highly limited. It lacks any functionality for digital interaction with patients, and the built-in letter generation tool is widely considered unfit for purpose. The system does not offer Easy Read formats, placing patients with learning disabilities or low literacy at a disadvantage, and printed outputs are often poorly formatted and unprofessional in appearance.

As a result, staff often resort to manually creating letters in Microsoft Word, printing them on headed paper, and uploading them to the system. This workaround adds to the administrative burden and introduces safety and information governance risks. In one case, a letter was sent to the wrong

address due to a typographical error, resulting in a breach—highlighting the risks of not having a secure, integrated communication process.

Functionality to notify patients of appointments by SMS or email was not adopted within WCCIS, as there was not a specific field to capture a telephone number for text messaging.

Staff must rely on in-person or postal communication, a process that is inconsistent, inefficient, and contributes to higher rates of non-attendance. Around 5.1% of appointments are currently cancelled, with long waits and fragmented communication compounding the issue.

Rio EPR offers a fully integrated communication suite designed to improve safety, efficiency, and accessibility. There is functionality to do this natively, but the preferred option is the digital patient communication integration.

Clinicians can send messages via SMS, email, or post directly from within the system, with automated appointment reminders scheduled from key modules such as calendars and waiting lists—helping reduce non-attendance.

Referral and discharge letters can be generated and sent automatically, eliminating delays and reducing reliance on manual document creation. Rio also supports Easy Read formats to ensure communications are accessible and inclusive. Templates can be created and edited within Rio using Microsoft Word integration. The preferred method for delivery for digital letters will be via integration with the corporate digital patient communications platform, HCC Envoy. Where patient letters will be output from RIO and sent via the HCC platform. This is supported by the supplier of RIO.

A built-in audit trail tracks the status of all communications, enabling timely follow-ups and reinforcing information governance. Together, these features represent a significant step forward in delivering consistent, secure, and patient-centred communication.

Patient Engagements

Currently, MH&LD services lack access to a patient portal. The introduction of the Rio Patient Portal addresses this gap by offering a secure, auditable, and user-friendly platform for patient engagement. All communication is encrypted and access-controlled, ensuring compliance with data protection standards and removing the need for informal channels.

The portal empowers patients to take an active role in their care, with tools for symptom tracking, medication monitoring, and daily mood check-ins. Features like personal journaling support reflection and enable individuals to share insights with their care teams, helping shape personalised treatment plans.

Importantly, the Rio Patient Portal will integrate with the NHS Wales App, giving patients seamless digital access to appointments, care plans, updates, and secure messaging with their care team. This alignment with national priorities around digital inclusion and person-centred care ensures greater transparency, empowers patients to engage in their treatment, and supports improved adherence—particularly for those with long-term or complex needs.

By creating a trusted, secure space for communication and information-sharing, enhanced through integration with the NHS Wales App, the portal strengthens safety, improves accessibility, and deepens the therapeutic relationship between patients and clinicians.

Ongoing performance issues

WCCIS continues to suffer from persistent performance issues. Although 23 performance-related incidents were formally logged via Halo over the past 12 months, this figure likely underrepresents the true extent of the issue. Performance problems are widely underreported, with many staff choosing to work around the system rather than raise formal tickets—reflecting normalised frustration and low confidence in the system’s reliability.

Staff feedback from a recent survey reinforces the scale of these challenges:

"It feels like I spend more time watching the circle spin on my devices or it saying 'connecting...' than actually doing my work."

"There have been multiple periods where WCCIS is extremely slow - to the point it is unusable, this is a huge challenge when we only have limited times available to complete entries."

"Severe lack of faith in the system that notes recorded will actually remain and not disappear. This has legal implications for all of our practice and the standard of patient care. Time is wasted having to create duplicate documents to record clinical notes."

Performance data from other health boards using Rio demonstrates consistently high system responsiveness, supporting efficient clinical workflows and reducing frustration among users. Routine functions are completed almost instantaneously—99% of user logins occur in under 0.5 seconds, 92% of patient alerts and Progress Notes are displayed within one second, and 95% of core actions, such as referrals and admissions, are completed in under four seconds.

To maintain user awareness and reduce disruption, the system provides real-time visual feedback for any process exceeding 2.5 seconds. For longer-running tasks, Rio offers clear progress indicators and safe cancellation options where appropriate—ensuring users remain informed and in control. Importantly, Rio also offers robust offline functionality. In the event of connectivity loss, clinicians can continue to record notes locally. Once the connection is restored, the information is automatically synced with the patient’s record, eliminating the need for manual re-entry and preserving the accuracy and timeliness of clinical documentation.

Access Group has confirmed that no clinical incidents related to Rio's system performance have been reported across its customer base in the past two years. This reflects the platform’s strong reliability and mature clinical safety architecture.

Community Context and Mobility Challenges

WCCIS has failed to deliver the agile and mobile working functionality that was central to its original business case—most notably, the intended benefit of a reduction in travel cost and time remains unachieved. Despite a large investment in mobile hardware—including 952 iPads issued across ABUHB, the mobile application originally promised as part of WCCIS was never delivered.

Clinicians were left to rely on the browser-based version, which is not optimised for use on iPads or other mobile devices. The platform's design presents several mobility barriers:

- Poor compatibility with mobile screen sizes
- No offline access for community-based work, and limited 4G and 5G access across some rural areas of Gwent such as Monmouthshire, Blaenau Gwent and parts of Torfaen
- Cumbersome workflows, such as multiple open browser tabs and long forms requiring keyboard input on a small device.

These issues meant that the mobile devices were not being used. At its peak, ABUHB was spending £15,000 per month on data SIMs to support mobile working. By 2024, this had dropped to around £3,500—not due to reduced need, but due to decreased use, driven by the impracticality of WCCIS on mobile devices. Many iPads were ultimately underutilised or repurposed for non-clinical use. After review, data sim contracts were also swapped from Gamma to Vodafone and EE.

Based on the latest data from Ofcom's Connected Nations Wales reports, mobile signal strength and coverage vary across the regions of Newport, Caerphilly, Blaenau Gwent, Torfaen, and Monmouthshire:

- **Newport:** Urban area with strong mobile coverage (99%+ from all major operators)
- **Caerphilly:** Generally good coverage, though less detailed in Ofcom reports
- **Blaenau Gwent:** Variable coverage with areas of limited signal strength
- **Torfaen:** Moderate coverage, weaker in rural parts
- **Monmouthshire:** Predominantly rural with mobile coverage challenges, especially in remote areas

While mobile connectivity has improved in recent years, significant gaps remain—particularly in rural areas. According to Ofcom's *Connected Nations Wales* report, approximately 90% of Wales' landmass has 4G coverage from at least one mobile operator. However, only 62% of the country benefits from 4G coverage provided by all four major networks, highlighting ongoing limitations in universal access.

5G coverage, although expanding, remains inconsistent and is largely confined to more urban or densely populated areas. In rural regions, coverage outside of premises ranges from just 10% to 46%, based on Ofcom's high-confidence estimates. These limitations continue to pose challenges for mobile working, particularly for community-based health and care services operating across geographically diverse areas like those within Aneurin Bevan University Health Board.

The current arrangement is with EE and Vodafone, with users allocated a data SIM based on their geographical area and whichever provider offers the strongest coverage in that location and that will continue with the introduction of Rio.

The limited mobile functionality of WCCIS has adversely affected community-based clinicians. To better understand the scale of this impact, a survey was distributed to all MH&LD community staff:

- 63% reported being unable to access WCCIS in the community.
- 24% could not communicate effectively with colleagues using current devices.
- Nearly 1 in 4 stated they “often” or “always” had to contact office-based staff to input or retrieve information.
- 80%+ preferred alternative devices (e.g. data sim enabled laptop to come out on top)
- 35% report that the devices available to them do not allow timely access to information needed for informed decision-making in patient care.
- 16.5% of staff start their working day from home, and 25% finish their day at home—highlighting untapped potential for increased remote and flexible working.

Clinicians require devices that provide seamless access to all of the systems they use daily. The previous procurement of iPads was limited in this respect.

This programme presents an opportunity for genuine transformational change. In collaboration with the EPMA programme, we are ensuring that the devices procured will support not only EPMA but also the wider range of clinical and supporting systems essential for clinicians to perform their duties.

To enable this, the business case requests the replacement of 727 existing devices with new laptops that are SIM-enabled, ensuring continuity of provision while enhancing mobility and connectivity for staff. Clinicians have consistently highlighted the need for a single device that delivers comprehensive access to the required applications and clinical systems. A SIM-enabled laptop will provide this capability, allowing staff to use Outlook, Microsoft Teams, Clinical Workstation, and Welsh Clinical Portal without the burden of managing multiple devices. This will also remove the inefficiency of returning to the office solely to input or retrieve information, thereby improving productivity and supporting mobile, flexible working.

Mobile appointment management is also fully enabled in Rio, allowing staff to outcome, cancel, reschedule, or create appointments directly from their device. Real-time access to demographic details, risk assessments, tasks, and follow-up plans ensures that clinicians can work efficiently and safely while in the field.

Its mobile capabilities are purpose-built to support clinicians working across diverse settings, including areas with limited connectivity. Rio has offline working, so clinicians can view, complete and save forms or case notes without a connection, and data syncs automatically when connectivity is restored. If staff are working in areas of low signal, they can download forms and documents before entering those areas.

Staff will no longer need to be tied down to an office base, they will be able to start and finish their working days in the community, where appropriate. However, it is recognised that there will always be a need for staff to return to base periodically to engage in face-to-face discussions with peers and managers, particularly regarding patient contacts and collaborative decision-making.

Inpatient Context

WCCIS has been implemented within all Mental Health wards across ABUHB. Staff in inpatient settings experience many of the same frustrations seen across other services, but these are often intensified by the high-pressure, 24/7 nature of the inpatient environment.

Inpatient teams are frequently required to activate business continuity procedures due to both planned maintenance and unexpected outages. These disruptions are particularly problematic in inpatient settings, where maintenance often takes place over weekends—a typically high-demand period—exacerbating the impact. During these downtimes, WCCIS becomes a static, read-only system, preventing clinicians from recording care in real time. Instead, they must rely on manual notes that are later transcribed, often by administrative staff unfamiliar with the clinical context. This process introduces significant operational and clinical risks, including delays in decision-making, duplication of effort, and a heightened risk of transcription errors, omissions, and inaccuracies—all of which threaten the continuity and safety of care.

A small file of core documentation was initially created for business continuity purposes, but due to the challenges described, it has since been expanded and is now more heavily relied upon. While some paper-based records—such as Do Not Resuscitate (DNR) forms or Mental Health Act documentation requiring wet signatures—will always be necessary, the volume of printed material has grown beyond what is operationally efficient.

Due to a lack of suitable or available equipment staff often complete documentation manually at the bedside and then scan or re-enter it later into the system. Competing demands for equipment reduce staff access to WCCIS for real-time documentation, forcing further duplication of effort and delays in recording critical information. This diversion of clinical time away from direct patient care places additional strain on staff and reduces the overall efficiency of the service.

Compliance with statutory legislation, such as the Mental Health Act, is essential across all service areas. While WCCIS does include some functionality to support this, adoption has been limited due to wider challenges with system workflows and the impact on performance. For example, there are no routinely used automated reminders for critical dates related to Mental Health Act sections, consent to treatment reviews, or leave form expiry. This makes it particularly difficult for staff working in busy inpatient environments, where the fast-paced nature of care increases the risk of missing key deadlines without system prompts or safeguards in place. To support this, ward managers have introduced manual daily checklists.

Rio supports compliance with legal requirements through automated prompts, a comprehensive task list, and intuitive dashboards. These features provide healthcare professionals with clear visibility of upcoming tasks and deadlines, helping ensure timely and appropriate action. This promotes lawful, consistent, and respectful care for individuals within mental health services. An integral aspect of patient safety and compliance within Rio is the prevention of discharges for patients detained under formal detentions, both under the Mental Health Act (MHA) and the Mental Capacity Act (MCA). Rio is designed to enforce this restriction effectively, ensuring that no patient can be discharged from a bed, ward, or hospital while under formal detention.

Ward clerks spend a significant proportion of time scanning handwritten documentation, due to a lack of functionality, including patient observation charts which currently remain on paper, into the system. This not only increases administrative burden but also creates challenges for auditability and data integrity.

Another frequent problem is if a bank or agency worker leaves a clinical note open at the end of their shift, WCCIS prevents the patient from being discharged until that note is completed. This delay prevents staff from updating the bed state, meaning a new patient cannot be admitted to that bed. As a result, staff are often forced to either move the patient to an alternative empty bed or incorrectly record the new admission as returning from leave, leading to inaccurate records.

Rio offers high availability, with a 99.5% uptime commitment. While periodic maintenance for updates and security is unavoidable, its underlying architecture significantly reduces both the frequency and disruption of these events. During planned maintenance windows, a read-only version of Rio remains available to ensure continued access to clinical information. The system also supports offline working, allowing staff to continue recording information when connectivity is lost, with data automatically re-synchronised once a connection is re-established. As a result, services can reduce reliance on paper and retain only essential hard copies—such as Mental Health Act documentation—or print selectively during planned downtime.

Rio will enable a patient timeline which will clearly show a patient's interaction with services to show any previous admissions. Inpatient areas will be equipped with fit-for-purpose, portable devices that support real-time documentation at the point of care, reducing the need to print, transcribe, or complete records retrospectively. This will minimise reliance on scanning and free up both administrative and clinical time, allowing staff to focus more on direct patient care. Having enough devices will support the compliance of time driven targets where inpatient areas are currently falling short of the target.

Primary Care Mental Health Support Services Context

Within PCMHSS, there are significant challenges in managing waiting lists. Waiting lists are currently managed through spreadsheets for each team and not on WCCIS. This then makes it difficult to see if

patients are on waiting lists, meaning clinicians need to speak to other clinicians such as Psychologists and Occupational Therapists to understand if they are on their waiting list or not. This also makes it difficult to see how many days someone has been waiting on a list.

Service Demand Analysis

The main strategic driver for this change is that WCCIS is reaching end of life. This necessitates an urgent transition to a modern, fit-for-purpose Digital Community Electronic Patient Record (EPR).

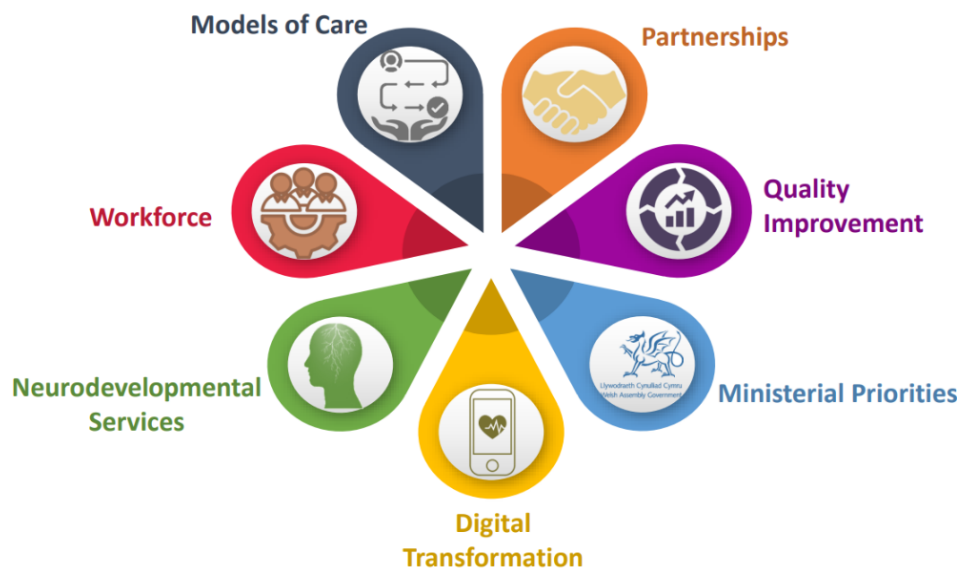
However, this extends beyond immediate operational needs—it presents a strategic opportunity to realise the transformational ambitions first envisioned in the original WCCIS business case. While those ambitions were not fully realised through WCCIS, the proposed solution is significantly better positioned to achieve them, particularly in the context of increasing demands on services to demonstrate compliance and meet evolving reporting requirements, which are only expected to intensify over time. ABUHB has made a deliberate decision to pursue a custom-configured solution—one that aligns with our services, workforce needs, and strategic goals—rather than adopting a generic, national model.

Divisional Context and Reasons why

Alignment with MHL Division Priorities 2025/26.



MHL Division Priorities 2025/26



The programme recognises and is fully aligned with the significant transformation initiatives already underway across the Mental Health and Learning Disabilities (MHL) Division. To maximise impact, avoid duplication, and enable cohesive, system-wide improvement, it is essential that the development and implementation of the new EPR is strategically integrated with these wider priorities.

Digital transformation is a critical enabler in this landscape, providing the infrastructure and capability to support and sustain change across the division. One of the most prominent initiatives is the Models of Care programme, which is focused on redesigning service delivery to ensure it meets the evolving needs of both service users and staff. The existing WCCIS platform lacks the flexibility, interoperability,

and scalability to adapt to these changes. It is unable to accommodate increasing demand, integrate emerging technologies, or support new, person-centred models of care delivery.

In contrast, the proposed Rio platform for MH&LD is being designed to directly align with and support the Division's 2025/26 priorities:

- **Models of Care:** Rio will support the delivery of redesigned pathways through customisable workflows, improved data capture, and real-time access to information, enabling more responsive and proactive care.
- **Partnerships:** Rio will enable partnership with local authorities via semi-interoperability through Mosaic and Access
- **Quality Improvement:** Rio will enable better data visibility and reporting, empowering teams to monitor outcomes, identify areas for improvement, and drive evidence-based service enhancements.
- **Workforce:** A modern, intuitive system will reduce administrative burden, improve staff experience, and support recruitment and retention by enabling clinicians to spend more time on direct patient care and less time navigating inefficient systems.
- **Neurodevelopmental Services:** Rio will support multidisciplinary working through shared records, custom assessments, and clear tracking of care plans, helping to address long-standing challenges in service access and coordination.
- **Digital Transformation:** As a core enabler, the new EPR represents a step-change in digital capability—laying the foundation for further innovations such as mobile working, patient portals, automated alerts, and advanced analytics.

By aligning with these strategic priorities, the new EPR will not only replace an ageing system but act as a catalyst for broader transformation—supporting the Division to deliver more connected, efficient, and person-centred care.

Local Context and reasons why

The main local policy and strategic drivers include:

Aneurin Bevan University Health Board's Integrated Medium-Term Plan (IMTP) 2025-2028 Improving Mental Health Services

The new IMTP continues to place improving mental health services at the forefront, with commitments to deliver the Mental Health Strategy, redesign care pathways, and maintain statutory performance against the Mental Health Measure.

The Business Case underpins these priorities by replacing WCCIS with Rio, a modern EPR that improves statutory compliance, enables integrated mental health pathways, and supports timely, data-driven care decisions across CAMHS and adult services.

Digital, Data and Technology as Key Enablers

The IMTP identifies digital transformation, interoperability with the National Data Resource, and robust data flows as critical enablers of safe, efficient, and integrated care.

The Business Case aligns directly by introducing Rio as a nationally compliant system that supports mobile and flexible working, ensures seamless data exchange, and provides real-time analytics to strengthen reporting, assurance, and performance management.

Workforce Sustainability and Experience

The IMTP highlights the need to strengthen workforce resilience, retention, and wellbeing through reduced administrative burden and improved digital tools.

The Business Case responds by replacing an outdated system with a user-friendly, intuitive EPR. Rio reduces duplication, streamlines documentation, and empowers staff with modern tools that improve morale, productivity, and job satisfaction.

Integrated and Place-based Models of Care

The IMTP commits to the roll-out and embedding of Integrated Neighbourhood Teams (INTs) to deliver place-based, multidisciplinary care in local communities.

Rio directly supports this by enabling mobile and offline working, integrating health and social care platforms (Rio and Mosaic), and ensuring staff have real-time access to patient records across community settings, underpinning new ways of delivering care closer to home.

Quality, Safety, and Performance Improvement

Quality and safety remain central to the IMTP, with a focus on strengthening governance, assurance, and continuous improvement.

The Business Case contributes directly by enabling structured, reliable data capture through Rio. This improves clinical safety, enhances risk management, and strengthens audit and compliance, supporting sustained improvement against quality and performance measures.

ABUHB 10-year strategy

The implementation of a new Digital Community EPR for MH&LD is a strategic enabler for delivering the ABUHB 10 Year Strategy

- **Better Health: Together we will support people to be healthy, active and happy.**
 - **Mental Health:** Rio enables early identification and proactive care through better data and alerts—supporting improved mental health and reduced preventable illness.
 - **Prevention:** Real-time data and structured documentation support targeted health interventions, aligning with goals to keep people well and reduce health inequalities.
 - **Accessible Care:** Mobile working and community-based delivery reduce barriers to access, supporting equitable care across Gwent.

- **Better Care: Together we will deliver what matters to people, supporting our staff to thrive and achieving quality, kind and sustainable care.**
 - **Coordinated, Person-Centred Care:** Real-time access to information improves continuity, speeds up referrals, and supports what matters to patients.
 - **Staff Empowerment:** Streamlined workflows and reduced admin free up time for direct care—improving job satisfaction and care quality.
 - **Digital First:** Rio supports digital services, online access, and modernised processes—meeting the strategy’s vision for digitally enabled, sustainable care.

- **Better Lives: Together we will create strong, safe and connected communities**
 - **Integrated Working:** Rio and Mosaic integration supports joined-up care across health and social services.
 - **Patient Empowerment:** The patient portal and accessible communication tools enhance involvement, inclusion, and trust.
 - **Sustainable Working:** Mobile, remote access reduces travel, supports hybrid working, and frees up NHS estate—aligning with goals for resilient, connected communities.

2024/27 Annual Plan: Three-Year Intent.

The implementation of Rio is a strategic enabler for delivering the priorities outlined in the ABUHB 2024–2027 Annual Plan, particularly in transforming mental health services. The Plan identifies a significant projected rise in demand, emphasises a shift towards community-based care, and sets ambitious targets for improving access and compliance under the Mental Health Measure.

Rio directly supports these aims by enabling scalable, efficient clinical workflows, real-time and mobile access to records, and enhanced tracking of care and treatment plans. It facilitates the maintenance of performance against Part 1 and Part 2 of the Mental Health Measure, supports psychological therapy access targets, and underpins the development of new models for complex and community-based care. Furthermore, it contributes to workforce wellbeing and service sustainability by reducing administrative burden, improving usability, and supporting agile working—key commitments within the Annual Plan.

By aligning digital infrastructure with clinical strategy, the EPR ensures ABUHB is equipped to meet rising mental health needs with safe, person-centred, and digitally enabled care.

ABUHB Digital Strategy: Transformation Through Digital

The implementation of Rio is fully aligned with the Health Board’s Digital Strategy, *Transformation through Digital*. The strategy sets out a vision to enhance care delivery, empower staff, and improve population health through the strategic use of digital tools—principles which are embedded throughout this Case for Change.

The new EPR directly supports the four strategic pillars of the Digital Strategy:

- **Digital Organisation:** It enables clinicians to deliver safe, joined-up, and holistic care through mobile, real-time access to patient records—addressing long-standing inefficiencies in the current system and supporting flexible, agile working models.
- **Digital Community:** By enabling care closer to home, supporting virtual consultations, and increasing patient engagement, the EPR underpins a community-focused model of service delivery—central to the Health Board’s Clinical Futures vision.
- **Digital Data and Intelligence:** The system will provide accurate, timely data to support evidence-based care, outcome tracking, service improvement, and operational decision-making—addressing a core aim of the strategy to harness data for quality and planning.
- **Digital Foundations:** The EPR replaces an obsolete and fragmented platform with a secure, interoperable, and scalable system that meets current and future digital infrastructure standards.

All Wales Flexible Working Policy in conjunction with ABUHB Agile/Hybrid Working Framework

A key element of the Health Board’s direction is to modernise our working culture through agile, hybrid, and flexible models of care delivery, as outlined in the All-Wales Flexible Working Policy and the Agile/Hybrid Working Framework.

Investing in Rio supports this direction by:

- Empowering the workforce to work flexibly across settings, enhancing wellbeing, productivity, and retention.
- Enabling inclusive and diverse working patterns, helping the Health Board attract and retain staff with varying needs and life circumstances.
- Reducing unnecessary travel and office dependency, supporting environmental goals and better use of estate.
- Aligning with governance expectations, including data security, lone working protocols, and safe agile practice.
- Enabling new models of care, such as virtual reviews, outreach, and multidisciplinary collaboration—key pillars of mental health, learning disability, and CAMHS transformation.

ABUHB People Plan 2022-2025

The implementation of Rio is a direct enabler of the priorities set out in the ABUHB People Plan, which aims to build a sustainable, healthy, and inclusive workforce. At its core, the People Plan focuses on three strategic themes: staff health and wellbeing, becoming an employer of choice, and creating a sustainable workforce.

Firstly, Rio will improve staff wellbeing by addressing the daily frustrations and inefficiencies caused by the current WCCIS system. It reduces duplication, delays, and the need for manual workarounds, while supporting more flexible, mobile, and autonomous ways of working. These improvements align directly with the People Plan’s commitment to a “healthy working day” and the creation of positive working environments where staff feel empowered and supported.

Secondly, the investment in a future-ready, digitally enabled platform reflects the Health Board’s ambition to become an employer of choice. Rio will modernise the working experience across the division, supporting agile roles, enhancing digital skills, and enabling new career pathways. This is consistent with the Plan’s focus on creating a digitally capable, skilled, and valued workforce that is equipped to deliver high-quality care in a changing environment.

Finally, Rio plays a key role in enabling workforce transformation and sustainability. It provides the digital foundation required to support integrated multidisciplinary working, flexible deployment models, and real-time decision-making across settings. These capabilities are essential for building a resilient workforce that can meet rising service demand, embrace new care models, and deliver services closer to home

Six Goals for Urgent and Emergency Care

- **Goal 1: Co-ordination planning and support for populations at greater risk of needing urgent or emergency care.**
Rio supports earlier identification of risk and enables proactive care planning through real-time visibility of structured assessments and patient history—particularly for those with complex or recurring needs.
- **Goal 5: Optimal hospital care and discharge practice from the point of admission.**
By enabling discharge planning to begin at admission, Rio improves information flow between hospital and community teams, helping to reduce delays and support timely, safe discharge.
- **Goal 6: Home first approach and reduce the risk of readmission.**
Rio gives community teams immediate access to discharge summaries, care plans, and follow-up tasks—supporting continuity of care at home and reducing the likelihood of avoidable readmissions.
- **Goals 2, 3, and 4:** These goals focus on triage, emergency alternatives, and rapid crisis response—areas where Rio provides indirect digital infrastructure benefits but is not a primary delivery mechanism.

National Context and Reasons Why

The main National policy and strategic drivers include:

Mental Health and Wellbeing Strategy 2025-2035 and the Mental Health and Wellbeing Strategy Delivery Plan 2025-2028

The transition to a modern Digital Community Electronic Patient Record (EPR) is directly aligned with the national strategic intent articulated in the Mental Health and Wellbeing Strategy for Wales (2025–2035) and its accompanying Delivery Plan (2025–2028). These documents set out an ambitious vision

to create a connected, person-centred mental health system that supports wellbeing at every stage of life. Rio is a critical enabler for delivering this vision, supporting the shift towards digitally enabled, integrated, and community-based care across NHS Wales.

- **Enabling Seamless, Needs-Led Mental Health Services**
The Strategy's **Vision Statement 4** emphasises the creation of *seamless, person-centred mental health services guided to the right support first time, without delay*. Rio directly supports this by improving the timeliness, accuracy, and accessibility of clinical information across pathways. It replaces the fragmented digital infrastructure of WCCIS with a unified platform that enables clinicians to deliver joined-up care, regardless of setting or profession.
- **Supporting a Connected, Multidisciplinary System**
In line with **Vision Statement 3**, which calls for *a connected system where all people receive the appropriate level of support wherever they reach out for help*, Rio will strengthen interoperability, clinical communication, and information sharing across services. The system's ability to integrate with wider digital platforms (e.g., primary care, social care, and specialist services) will enhance continuity and coordination, especially for those with complex or multi-agency needs.
- **Promoting Early Intervention and Whole-Person Care**
The Strategy and Delivery Plan prioritise early intervention, prevention, and whole-system collaboration—principles central to Rio's functionality. By enabling real-time clinical insights and decision support tools, the system will allow earlier identification of risk, proactive care planning, and shared management across health and care providers. This approach is consistent with the Strategy's goal to *prevent escalation and reduce crisis* through timely, needs-based responses.
- **Embedding a Trauma-Informed and Rights-Based Approach**
The Delivery Plan also underscores the importance of trauma-informed practice (Vision 3.6) and ensuring equity for neurodivergent individuals and those with learning disabilities (Vision 3.10–3.11). Rio will support these aims by embedding structured risk tools, alerts, and safeguarding flags to inform safe, tailored care. It also provides a digital foundation for inclusive service delivery, aligned with the broader national agenda for equitable mental health provision.
- **Strengthening Quality, Evidence and Outcomes**
A modern digital system underpins the Strategy's call for *robust data to inform continuous improvement*. Rio will support this by enabling the consistent capture of structured outcomes data, facilitating audit, performance reporting, and service evaluation. This aligns with overarching actions in the Delivery Plan (e.g., development of an outcomes framework, VS 1.1), ensuring NHS Wales has the intelligence needed to improve population-level mental wellbeing.
- **Empowering Staff and Supporting Workforce Wellbeing**
Finally, the Strategy commits to *creating environments where mental wellbeing is protected, and workforce needs are recognised* (Vision 2.5). Rio contributes directly to this by reducing digital burden, streamlining administrative processes, and enabling flexible, mobile working. These improvements support not only staff wellbeing and retention but also reflect best practice in compassionate, digitally supported mental health delivery.

A Healthier Wales (2018)

The implementation of Rio is directly aligned with the Welsh Government’s vision in A Healthier Wales for a seamless, person-centred health and social care system. The strategy calls for whole-system integration, early intervention, and digitally enabled services—all of which are supported by the core functionality of the proposed EPR.

The system enables real-time data sharing across services, improving coordination and continuity of care—particularly for people with complex needs who require support from multiple teams. It supports mobile working and timely access to information at the point of care, facilitating care closer to home and reducing reliance on hospital-based services.

A Healthier Wales also promotes a shift toward value-based care and a stronger focus on outcomes. Rio provides tools to capture and analyse meaningful outcome measures, including PROMs, enabling services to monitor impact, reduce unwarranted variation, and use data to drive improvement.

Finally, Rio supports the workforce by streamlining processes, reducing duplication, and enabling more efficient caseload management. This contributes to the creation of sustainable, digitally enabled services—central to delivering on the long-term vision set out in A Healthier Wales.

Prudent Healthcare

The proposed Rio EPR is well aligned with the Welsh Government’s Prudent Healthcare: Securing Health and Well-being for Future Generations strategy by directly enabling its core principles:

- **Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production:** The system empowers individuals to access and contribute to their care through features like patient portals, supporting shared decision-making.
- **Care for those with the greatest health need first, making the most effective use of all skills and resources:** Real-time dashboards and caseload visibility help staff target those with the most complex or urgent needs, supporting fair and effective use of resources.
- **Do only what is needed, no more, no less; and do no harm:** Standardised forms and clinical prompts reduce duplication and help ensure interventions are necessary, evidence-based, and safe.
- **Reduce inappropriate variation using evidence-based practices consistently and transparently:** Consistent templates and national data standards promote evidence-based practice and reduce unwarranted variation in care delivery.

Rio directly supports the delivery of prudent healthcare in practice—enabling safer, more consistent, personalised, and efficient care across ABUHB.

Once for Wales

The proposed Digital Community EPR for MH&LD aligns closely with the Once for Wales strategy by fulfilling its Base Tier requirement of compliance with national architecture—ensuring interoperability, data accessibility, and secure sharing across systems. While not adopting a single national system, the approach reflects the Once for Wales principle of flexibility within a shared framework—leveraging national standards while allowing local configuration tailored to ABUHB’s operational and clinical needs. This ensures strategic alignment without compromising service-specific functionality.

National Data Resource (NDR) – Mental Health Dataset

The Rio EPR will align with the National Data Resource (NDR) – Mental Health Dataset and is currently working with other Welsh Health Boards, including Swansea Bay University Health Board, to ensure consistency, interoperability, and national alignment across mental health services. This includes

supporting robust data capture and reporting to enable compliance with statutory requirements such as the Mental Health (Wales) Measure and Referral to Treatment (RTT) targets.

Service Capacity Analysis

The Welsh Governments plan 'A Healthier Wales' highlights the need to address current and future demand in the health system.

A key lesson from the WCCIS implementation is the need for clearly defined roles to drive adoption locally. Four Senior Clinical Users (SCU's), a registered nurse, a medic, an occupational therapist and a psychologist have been recruited 1 day a week as designated leaders of change. These individuals will guide local configuration, support adoption, provide guidance and act as a vital link between front-line users and the programme team.

We will also establish a network of Superusers embedded within teams to provide peer-to-peer support and act as the first line of assistance for colleagues.

Nursing Context

Nursing remains a cornerstone of the NHS workforce in Wales, accounting for approximately 40% of all NHS Wales staff. Within ABUHB, nurses work across a broad spectrum of roles within MH&LD and CAMHS services, spanning community, inpatient, and clinic settings. Their responsibilities are wide-ranging and include specialist areas such as substance misuse. As frequent users of WCCIS, nurses are significantly impacted by many of the challenges outlined in the Case for Change.

The Strategic Nursing Workforce Plan for Wales 2025–2030 places strong emphasis on mental health nursing, embedding it within key priorities such as advanced education, community-focused care, dual registration routes, and workforce transformation. It recognises mental health nursing as a central component of wider, system-level reforms across the nursing profession in Wales.

Despite this progress, workforce distribution remains uneven. As of September 2023, there were 3,320 full-time equivalent (FTE) Mental Health nurses in Wales, representing 13.8% of the four main nursing fields. In contrast, Learning Disability nurses accounted for just 468 FTE roles—only 1.95% of the total.

With such low numbers for MH&LD nurses within Wales, it's important to make the profession as attractive as possible to work in. The current digital landscape does not support this. In line with the Strategic Nursing Workforce Plan 2025, it is not only vital to grow the workforce but also to reduce the administrative burden on nurses by automating routine tasks. This will allow nurses to focus on the unique clinical expertise they bring to multidisciplinary teams.

The shift from traditional hierarchical or delegated care models to more distributed team-based approaches is also key. Enabling nurses to work autonomously and at the top of their licence will support better outcomes and improve workforce retention.

The introduction of Rio will directly support these priorities. It will provide nurses with mobile access to patient information in real time, reducing reliance on paper and duplicated documentation. Standardised forms, clinical dashboards, and automated alerts will streamline administrative tasks, enabling more time for patient care. Integrated workflows will enhance multidisciplinary collaboration, while improved data visibility will support clinical decision-making and accountability. Ultimately, Rio will help unlock the full potential of the nursing workforce by reducing digital friction and enabling nurses to work more efficiently and flexibly.

Psychologist Context

Health Education and Improvement Wales (HEIW) undertook a review of education and training services delivered to NHS Wales health professionals to ensure they were aligned with current and future workforce needs. This work was driven by the Together for Mental Health Delivery Plan 2019–2022, which set out a clear commitment for Welsh Government to collaborate with HEIW, Social Care Wales (SCW), and wider partners to develop a robust, long-term workforce plan for mental health services. In response to growing demand, workforce shortages, and increasing service complexity, HEIW commissioned additional education and training provision for psychological professions, with the aim of strengthening workforce sustainability and service resilience. Contracts were subsequently awarded to Cardiff University and Bangor University to support the delivery of these programmes. At Cardiff University, by 2025/26 the number of clinical psychology training places commissioned will have increased by 100% since 2019.

Within ABUHB, Psychologists, Psychological Practitioners, and Assistant Psychologists operate across a wide range of teams and settings. While most of these teams are multi-disciplinary, some are psychology-led, or receive input from senior Psychologists on an ad hoc basis. This diverse spread of staff proves problematic for WCCIS with regards capturing different types of interventions.

WCCIS uses a diary for appointments to be created and then actioned. These appointments are linked to open psychology referrals. However, not all psychological interventions, such as consultations, or input on psychiatric inpatient settings, have psychology referrals. This makes it problematic to accurately capture the work Psychology staff are doing, and the outcomes of these interventions.

In relation to group interventions, the process for setting these up in WCCIS is time-consuming. As the system does not support recurring group sessions, each group must be created manually on a weekly basis. Even once a group activity is set up, individual entries still need to be added and actioned separately for each participant's referral. This makes the process laborious and inefficient, increasing the risk of data being lost or omitted due to delays in completing WCCIS entries after the intervention.

Given the significant pressures associated with waiting lists, every minute is critical when managing the administrative demands of seeing clients or patients. Unfortunately, the time-consuming nature of writing case notes and navigating WCCIS processes often results in Psychology staff completing their documentation outside of working hours.

Rio will address these challenges by offering a modern, fit-for-purpose system that enables streamlined documentation, supports recurring group interventions, and allows for the accurate recording of all psychological activity—including work that occurs outside of traditional referral pathways—reducing administrative burden and improving visibility of service delivery across the workforce.

Medical Context

In 2024, there were 14,594 doctors on the medical register in Wales—representing 3.7% of all UK doctors and a 2.9% increase from 2023. Of these, 3,325 were doctors in training. While the growth is encouraging, doctors continue to report persistent and systemic challenges that affect their ability to deliver care and remain within the NHS in Wales.

Workload pressures and administrative burden are key concerns. In 2024 in the Our Work in Wales 2024 report, **65%** of doctors in Wales cited excessive workload, and **61%** cited time spent on bureaucracy as barriers to delivering good patient care. Across the UK, one in three doctors reported regularly working beyond rostered hours and feeling unable to cope with their workload. Notably,

16% of doctors in 2023 had taken concrete steps to leave UK practice—a trend that continues to rise year-on-year.

These concerns are often rooted in poor infrastructure and outdated digital systems. The GMC’s 2024 report on workplace experience states:

“Poor overall infrastructure in medicine, such as insufficient and outdated IT equipment, estates, and facilities, is affecting the ability of doctors to physically carry out their roles efficiently and safely.”

WCCIS is a clear example of this failing infrastructure. In feedback provided to ABUHB, one Resident Doctor described:

“Unfortunately I find WCCIS to be, by far, the worst EPR software I have used in my career. The poor design of clinical software in ABUHB (and Wales in general) is a strong “push” factor for me; when I consider where I would like to continue my higher training/apply for substantive posts in future, I consider leaving Wales for a region where the IT is more user friendly and allows me to get on with the job.”

Resident Doctor working with Mental Health in Aneurin Bevan University Health Board

Medics face specific challenges with WCCIS, particularly in maintaining oversight of large patient caseloads. The system does not provide a centralised dashboard view, limiting them to only seeing patients directly assigned to them, rather than all patients under their clinical oversight.

The implementation of Rio presents a meaningful opportunity to address many of the longstanding frustrations doctors have expressed with current systems. Designed with clinicians in mind, Rio offers a modern, responsive interface and functionality that directly supports medical workflows.

A key improvement is the ability for doctors to view and manage all patients under their clinical oversight through configurable dashboards—overcoming one of the most significant limitations of WCCIS. This not only improves clinical safety but also enables more efficient care coordination.

Occupational Therapy Context

The Occupational Therapy service supports people to live well supporting them to engage in meaningful and purposeful activities (occupations) that can help restore a sense of self-esteem, confidence and self-belief. Within Aneurin Bevan University Health Board, the service, spans across the division and has a presence in all four directorates. All Occupational Therapy staff are based within multi-disciplinary teams supporting the generic roles of the teams, whilst also providing specialist occupational therapy assessments, interventions and advice to the population we serve. The current digital systems do not adequately support their work.

WCCIS, does not allow for the clear creation of OT-specific waiting lists, nor does it provide a way to monitor OT referrals or caseloads in real-time. In response, the performance team has had to create “virtual teams” to work around this limitation. This is inefficient, misrepresents actual team structures, and adds to the administrative burden already facing overstretched services.

These local digital challenges reflect and exacerbate national workforce pressures. According to the Royal College of Occupational Therapists (RCOT) 2023 Workforce Survey, the OT profession is under unprecedented strain. The majority (86%) of OTs report increased demand for services, while 79% are dealing with more complex cases due to delayed intervention. Despite this, 78% state that their team is not large enough to meet demand, and 63% feel too busy to provide the standard of care they aspire to.

Recruitment and retention issues are compounding these pressures. Over half (55%) of respondents reported that longstanding difficulties with recruitment have directly impacted their ability to meet service needs. Alarming, over a third of all OTs surveyed intend to leave their current role within the next two years, with the most cited reasons being work-related stress (48%), feeling undervalued (47%), being unable to provide the quality of care they would like (46%), and unsustainable staffing levels (40%).

One of the most significant contributors to this dissatisfaction is the burden of administrative work. Over half of OTs say they spend too much of their time on non-OT duties, and 63% say they are simply too busy to deliver the level of care expected. High levels of work-related stress (with 59% rating their stress level as 7 out of 10 or higher) are driving poor morale and workforce attrition.

If the new system fails to address the structural issues of WCCIS — including the inability to clearly capture OT data, track waiting lists, and streamline day-to-day processes — the same problems will persist.

The Implementation of *Rio* will:

- Enable accurate recording and visibility of OT referrals, waiting lists, and caseloads without requiring artificial team structures.
- Streamline documentation and care planning processes to reduce time spent on non-clinical tasks.
- Support data collection that demonstrates OT demand, activity, and outcomes — essential for service planning, workforce modelling, and funding justification.
- Be intuitive and easy to use, minimising unnecessary complexity that could add to workforce stress.
- Enable Managers/leads and supervisors to see the caseloads for the staff they manage/supervise. This would ensure safe case load management and oversight if staff were off work.

Failure to deliver these capabilities risks reinforcing the same inefficiencies, increasing work-related stress, and contributing to further workforce attrition. If implemented correctly, however, a modern EPR can serve as a critical enabler — improving the visibility, efficiency, and sustainability of OT services at a time when they are under immense pressure.

Clinical Evidence

The implementation of the RIO system will provide significant strides forward, in terms of improved safety and compliance with clinical standards.

1. Safer discharge: Through alerts and notification within RIO, staff will be prompted to follow patients discharged from mental health wards within 72 hours in line with the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) recommendations. This is due to 14% of post-discharge suicides occurring within the first weeks of leaving hospital, with the highest number occurring on day 3 after leaving hospital.
2. Improved monitoring: RIO will support services to ensure that appropriate monitoring takes place at the correct intervals for medication and physical health reviews. Staff will be prompted by alerts and notifications in RIO which will support the management of mental health and comorbidities, for example, ensuring annual physical health checks for those with Learning Disabilities (NICE guideline - Mental Health problems in people with learning disabilities) and ensure medication reviews at the correct intervals, for those being prescribed

long-acting antipsychotics etc (NICE guideline - Psychosis and schizophrenia in adults: prevention and management)

3. Real time record keeping: Agile working and improved timely record keeping will improve access to information for clinical decision making and enable improved compliance with Aneurin Bevan University Health Board, Nursing and Midwifery, Royal College of Psychiatrists, Health and Care Standards and other professional record keeping standards.
4. Clinicians and the organisation have a duty to comply with the Mental Health Act, therefore Non-compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DOLs) can lead to decisions that are not in the best interests of the individual, potentially causing harm. Rio incorporates essential assessments that are directly related to the provisions outlined in the Mental Capacity Act. RIO will enable health care professionals to make timely, informed decisions aligned to the legislation.
5. Collaborative care planning: In line with the Mental Health Measure (2012), RIO will identify those patients who do not have an identified care coordinator. It will prompt care plan reviews to support with ensuring that all patients have a current care and treatment plan developed within the last 12 months. Improved involvement of patients and their families in the development of care and treatment plans through improved planning of reviews and being able to more easily identify which patients want involved in their care will support an improved patient experience (NICE Quality Standards – Service User experience in adult mental health services). There will also be improved sharing of care plans with the referrer through the ability to send documents electronically to GP's (Nice guidance - Psychosis and schizophrenia in adults: prevention and management)
6. Personalised risk management: The system will support the development and review of risk assessments. By having all information in one place that can be easily accessed RIO will support personalised risk planning in line with NCISH recommendations.
7. Improved information available for clinical audit: As a result of having an increased amount of clinical data, which can be easily extracted and located within RIO, and a reduction in the use of paper records, there will be an improved ability to audit and ensure maintenance of and compliance with clinical standards. This has previously been identified in Health Inspectorate Wales inspections as an area for improvement.
8. Transition from Children's to adults' services – The new system will improve the coordination of transition of children by providing easier access to information for the services involved. (NICE quality standard – Transition from children's to adults' services)

In conclusion, the introduction of RIO will provide significant strides forward for the services in scope in terms of safety, care planning, information sharing and record keeping. Through the notifications and alerts in the system staff will be prompted to ensure that reviews in relation to care planning, risk and monitoring are undertaken at required creating a safer process where patients have an improved experience.

User Stories

There are several different user stories for mental health professionals, below describes the top two use cases:

Use Case 1 – For inpatient services: A qualified mental health nurse can create an admission, transfer and discharge record for a patient. They can document the admission process, capture clinical case notes and assessments and other documentation within the system. They can record periods of leave from the ward (both informal and Section 17 leave) and capture enhanced observations.

Use Case 2 – Community Practitioners: Qualified community professionals can manage emergency, urgent and routine referrals of patients. They can book appointments and capture the outcomes of patients so that they are appropriately followed up through the patient pathway. They can document case notes and complete assessments and other documentation. They can capture their involvement in the persons care, including Care Coordination responsibilities, so that they can manage their caseload effectively.

Financial Position:

Current Budget

Item	25/26	26/27	27/28	28/29	29/30	30/31	31/32	Total
	£'s	£'s	£'s	£'s	£'s	£'s	£'s	£'s
Capital								
Pay	0	0	0	0	0	0	0	0
Non-Pay	0	0	0	0	0	0	0	0
Income	0	0	0	0	0	0	0	0
Total (Cap)	0	0	0	0	0	0	0	0
Revenue								
Pay	196,981	611,625	612,349	613,098	613,874	614,676	615,507	3,878,110
Non-Pay	96,880	292,552	266,735	266,735	266,735	266,735	266,735	1,723,107
Income	0	0	0	0	0	0	0	0
Total (Rev)	293,861	904,177	879,084	879,833	880,609	881,411	882,242	5,601,216
TOTAL (Cap+Rev)	293,861	904,177	879,084	879,833	880,609	881,411	882,242	5,601,216

Forecast Spend

Item	25/26	26/27	27/28	28/29	29/30	30/31	31/32	Total
	£'s	£'s	£'s	£'s	£'s	£'s	£'s	£'s
Capital								
Pay	0	0	0	0	0	0	0	0
Non-Pay	757,810	147,900	0	0	0	0	0	905,710
Total (Cap)	757,810	147,900	0	0	0	0	0	905,710
Revenue								
Pay	286,808	1,379,045	1,127,656	730,409	210,301	217,661	225,279	4,177,159
Non-Pay	554,965	1,535,941	839,876	711,497	726,223	741,495	756,844	5,866,841

Total (Rev)	841,773	2,914,986	1,967,532	1,441,905	936,523	959,157	982,124	10,044,000
TOTAL (Cap+Rev)	1,599,583	3,062,886	1,967,532	1,441,905	936,523	959,157	982,124	10,949,710

Forecast Funding Gap

Item	25/26	26/27	27/28	28/29	29/30	30/31	31/32	Total
	£'s	£'s	£'s	£'s	£'s	£'s	£'s	£'s
Capital								
Pay	0	0	0	0	0	0	0	0
Non-Pay	757,810	147,900	0	0	0	0	0	905,710
Income	757,810	0	0	0	0	0	0	757,810
Total (Cap)	0	147,900	0	0	0	0	0	147,900
Revenue								
Pay	286,808	1,379,045	1,127,656	730,409	210,301	217,661	225,279	4,177,159
Non-Pay	554,965	1,535,941	839,876	711,497	726,223	741,495	756,844	5,866,841
Funding	1,163,895	904,177	879,084	879,833	880,609	881,411	882,242	6,471,250
Total (Rev)	-322,122	2,010,810	1,088,448	562,072	55,915	77,745	99,882	3,572,750
TOTAL (Cap+Rev)	-322,122	2,158,710	1,088,448	562,072	55,915	77,745	99,882	3,720,650

Outcomes and Benefits Realisation Plan

Objectives

The desired objectives of implementing an EPR in MH&LD is:

- Ensure continuity of safe and effective digital services beyond the expiry of WCCIS
- Deliver a sustainable electronic patient record covering MHL, CAMHS, PCMHSS and Child Psychology
- Enhance system interoperability and enable future integration opportunities
- Improve patient access to information and engagement tools
- Increase workforce productivity through the use of digital solutions
- Provide secure mobile and remote access to support flexible care delivery
- Act as a strategic enabler for transformation across MH&LD services
- Ensure alignment with regional and national priorities for integrated health and social care

The introduction of Rio will see the realisation of many benefits. **Appendix 2 contains a full list of the benefits that have been identified as achievable.**

Benefits

The following benefits have been validated and signed off by service leads as being realistic and achievable. It is recognised that the main measurable benefits of the introduction of Rio will be centred around referral times, compliance targets and clinical efficiencies.

Increase in patients seen in a timely manner due to a more efficient referral process

Currently, apart from PCMHSS, referral management is a manual process: referrals arrive by phone, email, post, or form and must be uploaded into WCCIS along with any associated attachments. Within-team referrals cannot be completed electronically, and while cross-team referrals could be processed digitally, this is rarely done due to system complexity. Additionally, teams spend a considerable amount of time managing referrals where insufficient or incorrect information is given, this requires the team to go back to the original referrer and delays the patient's journey through the referral process.

Based on our current baselines and our knowledge of the system at this early stage we anticipate the following savings:

- Between August 2024 and July 2025, a total of 8718 requests for further/clarification of information relating to referrals were reported. While we do not expect to completely eliminate the need for additional information on referrals, we anticipate reducing this need by at least 50%. This reduction will be achieved by completing all referrals electronically, thereby eliminating the reliance on unstructured emails, paper referral forms and other methods. This means we would expect to see in the region of 4359 requests following implementation.
- The manual management of a referral including the management of multiple points of access i.e. paper forms take on average 14 minutes. The process will be eliminated with Rio. Between July 2024 and August 2025, 44,545 referrals were recorded, equating to a forecasted reduction of 51,969 administrative hours — equivalent to 6,929 working days (7.5 hrs/day) or 1,386 working days per year across 137 teams. This represents a non-cash releasing saving of £882,956.14 over 5 years*
- The overall processing of a referral from start to finish across all teams above 0.5 days is 7.65 days. With the introduction of Rio, GP referrals (via EMIS/WCCG), internal hospital-to-community referrals via an Integration, and referrals between Rio-using teams will be enabled to feed directly into managed dashboards. Based on similar automation that has been implemented within PCMHSS recently we would expect this to reduce to 0.5 days to process a referral end to end. Meaning on average this would reduce the delay between referral being documented to being actioned by 7.15 days. **

**At team level, savings range from less than half a day per month up to ten days per month. While no full FTE savings are expected, this will allow staff to reinvest time into other duties and service improvements such as supporting clinical staff, letter writing and updating key service information.*

***Across the teams currently above the 0.5 day target it averages from 0.54 to 27.75 days to process a referral therefore, for each of these areas we would expect a reduction between 0.4 to 27.25 days dependant on team. A full breakdown can be seen in the benefit register. Savings will not be seen in PCMHSS or teams currently under 0.5 days.*

Reduction in clinical time spent finding and documenting patient information.

Clinicians currently lose valuable time navigating multiple sections within WCCIS—such as Patient and Referral screens, switching between disconnected systems to locate essential patient information. They also currently spend disproportionate amounts of time documenting care because WCCIS is not intuitive and requires an excessive number of clicks to complete tasks.

By having streamlined access to information, staff will spend less time navigating the EPR and other systems to find the information that they need. Functionality such as smart banners, and intuitive search functionalities such as 'sound like' search will quicken the process for finding information. Rio also provides a more intuitive documentation process. The new EPR streamlines documentation

through shorter, automated, and role-specific forms, enabling real-time editing and reducing duplication. Fields such as date, time, location, and author are auto populated, improving accuracy and saving time.

A study was undertaken comparing the time it currently takes users to complete specific tasks on WCCIS, against how long those tasks took as part of a demo with The Access Group demonstrating Rio.

	Rio Demonstration	WCCIS	Time Saved
Searching a patient	17 Seconds	29 Seconds	12 Seconds
Finding a document	34 Seconds	1 Minute 20 Seconds	46 Seconds
Creating a care Co-Ordinator	33 Seconds	1 Minute 38 Seconds	1 Minute 5 Seconds
Creating an appointment from a waiting list	2 Minutes 02 Seconds	3 Minutes 19 Seconds	1 Minute 17 Seconds

Time in motion studies have been taken on how long it takes to find patient information, and how long it takes to document patient information. Once we have access to the system, this activity will be rerun to give an accurate baseline.

Based on our knowledge current of the system at this early stage we anticipate the following savings*:

- We anticipate finding patient information will reduce by 1 minute per patient appointment.
- We anticipate documenting patient information will reduce by 2 minutes per patient appointment.
- **For both searching and documenting information, this results in a non-cash releasing saving of £1,531,081.37 over 5 years. This is an estimated saving of 14.92 working days (7.5/hr days) per year per team.****

* The forecast is based on appointments only. This approach is deliberately conservative, as we recognise that system interventions also occur on patient case notes, but these have not been included to avoid double-counting alongside appointments. This does not include inpatient interventions.

**While no full FTE savings are anticipated, the efficiencies achieved will enable staff to reinvest time into other duties and service improvements. This includes activities such for Psychology teams - Care and Treatment Planning (CTP), as well as direct clinical work for Occupational Therapy, including group sessions, Discovery Through Activity (DTA), and reporting repeating outcome measures. This also relates to benefit MHL15 regarding staff experience and management of workload which can be found in Appendix 2.

Upon initial conversations with the service, it has been noted that this could enable more patients to be seen within existing resources and be able to spend more time with patients. However, until the time efficiencies are confirmed through supplier engagement this is not something that can be reliably forecasted.

Increased visibility of appointments booked, leading to a reduction in patients being missed and not being seen in a timely manner.

Current scheduling is fragmented, with staff relying on paper diaries and disconnected systems, leading to no visibility on whether patients are being seen in accordance with timelines until after the

fact. The new MHL D EPR will streamline scheduling through integrated digital calendars and Outlook sync, reducing duplication and improving visibility of availability.

Based on our current baselines and our knowledge of the system at this early stage we anticipate the following savings:

- Currently 42.7% are recorded after the appointment date (reflecting retrospective documentation or delays in scheduling). This is driven by staff relying on multiple, disconnected systems: 35% use one method, 31% use two, and 24% use three (most commonly Outlook, WCCIS, and paper diaries). This duplication contributes directly to inefficiency and retrospective entry. We anticipate that appointments created after the date reducing to 25%. *

**Please note, for specific teams such as crisis there will always be a need to add appointments and documentation retrospectively this has been taken into account within our forecasting.*

We anticipate there to be a time saving for admin staff scheduling appointments, however without supplier engagement we have been unable to quantify this.

Improved data quality to inform reporting and forecasting

Currently reporting through the WCCIS can be difficult due to the data not always being in the right format, place or missing entirely. This means that teams must manually cleanse the data through pulling of reports through multiple systems which is a time-consuming task.

Rio will enhance the accuracy and consistency of clinical and operational data by enforcing mandatory fields at the point of entry and reducing errors. Integrated scheduling tools will improve visibility of appointments, caseloads, and service demand. Services will be able to have their own reports built into the system, reducing the reliance on information teams and increasing accuracy by having reports available to them in real time. This will strengthen reporting, support accurate forecasting, and reduce reliance on manual data correction—improving efficiency and confidence in decision-making.

Based on our current baselines and our knowledge of the system at this early stage for reporting data we anticipate the following savings will be made within Information Services:

- Outpatient errors (“Dummy runs” – OPMDS, OPR, APC): Currently take 1 hour per month to run, pivot, and send to the service. We anticipate that with automated reports within the new system, the requirement for dummy runs will be significantly reduced, equating to a reduction of 15 minutes per month, taking the service only 45 minutes going forward.
- CRHT data collection and submission: Currently requires 1 hour to prepare North/South/West templates and send to service, plus 1 hour to combine and submit returned templates to NHS Wales. We anticipate this process will be automated through electronic CRHT recording, eliminating the requirement by 2 hours per month.
- Psychology waiting list submission to WG: Currently takes 20 minutes to collate data and populate the template. With built-in reporting within the new system, this will be automated, removing the need for manual data handling. This will equate to a saving of 20 minutes per month.
- Statutory Reporting includes Mental Health Measure reporting (Parts 1, 2 and 3), Inpatient Metric Reporting, and Memory Assessment Service reporting, along with associated charts and preparatory papers for DMT. This process currently requires 15 hours per month. It is expected that this will be reduced by 75 per cent to 11.25 hours. This will equate to a saving of 3.75 hours per month.

Overall time saving per month = 4 Hours 30 Minutes which equates to a non-cash releasing saving of £28,178.50 over 5 years. This is estimated at 22.13 working days per year in savings across ALL teams.

Based on our current baselines and our knowledge of the system at this early stage for cleansing data we anticipate the following savings within the performance and service improvement teams:

- The amount of **outpatient referral errors** recorded from April 2024 to March 2025 was 2085. Examples include invalid dates of birth, NHS numbers, and postcodes. These will have to be worked through manually by the performance and service improvement teams. We anticipate due to the new systems data validation capability there will be a reduction of 25% which equates to 521.25 reduced errors. *
- The amount of admitted patient care errors recorded for April 2024-March 2025 was 142. These will have to be worked through manually by the performance and service improvement teams. We anticipate due to the new systems data validation capability there will be a reduction of 25% (35.5 errors), excluding the ICD10 code errors.
- The number of ICD10 codes errors recorded (discharge patients from a ward) recorded for April 2024-March 2025 was 631. These will have to be worked through manually by the performance and service improvement teams. We anticipate due to the new systems data validation capability the need for data cleansing for these errors will be eliminated.

Overall time saving per year (based on an average 9 minutes per error) = 178.16 Hours (Estimated at 24 Working days per year) non-cash releasing saving of £30243.08 over 5 years
**

**There will always be some cleansing required due to scenarios such as NHS numbers not being known at time of treatment or other patient details. This data is also cleansed by service improvement managers and ward staff depending on demand.*

*** While no full FTE savings are expected, this will allow staff to reinvest time into other performance related duties and service improvements.*

Patients being seen in a timely manner leading a maintenance of compliance with part 1 of the Mental Health Measure (RTT)

Due of the new functionality surrounding data quality and processing, Rio will ensure referrals are ready to be triaged immediately, reducing unnecessary delays for patients. This will improve patient experience as they will be seen more promptly and will enable compliance scores to be maintained, without the extra manual work which needs to be undertaken currently to achieve this.

Based on our current baselines and our knowledge of the system at this early stage we anticipate the following:

- Currently the average compliance for part 1a within the service for August 2024 to July 2025 is
 - Adult – 82.6%
 - Children and Young People – 92.3%

With the above improvements we would expect this to maintain the current compliance and to exceed the national target of 80%. Additionally, we would expect this improvement to be maintained consistently and more efficiently by reducing the need for manual data cleansing.

Increase in ability to monitor and track care co-ordination outcomes resulting in maintaining compliance with part 2 of the Mental Health Measure.

Tracking care coordination in WCCIS is difficult due to the absence of live dashboards, lack of alerts, and the reliance on complex reporting methods to obtain accurate compliance data.

The new functionality within Rio, including alert and trigger management of care plans and enhanced dashboards, will ensure that care plans are created and recorded promptly. This will mean patients receive the right support at the right time, improving the quality and consistency of their care. In turn, this is expected to drive an increase in compliance with Part 2 of the Mental Health Measure, ensuring patients experience more timely, coordinated, and person-centred care

Based on our current baselines and our knowledge of the system at this early stage we anticipate the following:

- Currently the average compliance for part 2 within all services for August 2024 to July 2025 is 78.4%.

With the above improvements, compliance is expected to consistently reach the national target of 90%. Additionally, we would expect this level of performance to be sustained more efficiently through a reduced reliance on manual data cleansing.

Staff Experience

The current WCCIS system impacts upon several activities clinicians need in order to do their job effectively. This includes the amount of time spent on administrative tasks due to inefficient systems, duplicated processes, and poor usability. This contributes to increased workload pressure, frustration, and reduced job satisfaction. This can be seen in the time efficiency benefits above alongside results from the ABUHB Wellbeing Survey 2023 which indicate that over 50% of staff are working over and above their contracted hours – unpaid. From the feedback received we believe administrative duties play a part in this and a reduction in this figure should be seen based on the efficiency savings above.

This is also seen prominently in the community settings and includes facing delays due to limited mobile access, poor connectivity and device compatibility issues, alongside having to contact an office for additional information relating to patients where network coverage is unavailable. This also can impact upon staff safety by not having access to alerts or patient risks in a timely manner. When surveyed 56% of respondents indicated inconsistent or limited access to sufficient information or alerts to support safe clinical decision-making (e.g., risk, allergy warnings, safeguarding concerns), when working in the community. We seek to improve this through Rio's real-time access and documentation at the point of care, with mobile-optimised features, offline access, and improved compatibility alongside SIM-enabled devices, enabling staff to document care at the point of delivery. Appointments will be managed directly through the system, reducing the burden on staff of maintaining multiple diaries, with full integration into Outlook.

Due to the external factors on survey responses a forecast for these benefits has not been quantified however, we have baseline measures outlined in Appendix 2 and would expect to see an improvement in these baselines post implementation.

Patient Experience

The current WCCIS system offers no patient portal or digital access. Rio will introduce a dedicated portal, allowing patients to view appointments – enabled by staff scheduling appointments, access care plans, receive updates, and securely message their care team.

This functionality will support greater transparency, empower patients to engage in their care, and improve treatment adherence—especially for those with long-term or complex needs. Aligning with national priorities around digital inclusion and person-centred care e.g. integration with the NHS Wales App.

We anticipate the system usability and efficiencies from a staff perspective will have impacts to patient experience with the expectation that this will enable clinicians to dedicate more time to engaging with patients, building therapeutic relationships, and delivering more personalised, responsive care. Over time, we anticipate this will improve patient experience.

Due to the external factors on survey responses a forecast for these benefits has not been quantified however, we have baseline measures outlined in Appendix 2 and would expect to see an improvement in these baselines post implementation.

Forecasting considerations

Due to having limited access to the supplier due to procurement timescales we have been unable to ratify forecasts and have therefore agreed with the service to forecast at the conservative scenario reductions. Once we have access to the system it is anticipated that there will be greater benefit than it has been possible to forecast at this early stage.

Where efficiency savings are realised, there is no expectation that these will translate into reductions in whole-time equivalent (WTE) posts. Instead, the efficiencies will create opportunities for teams to redirect time towards other priority duties, enhance service delivery, and support staff in reducing the need to work beyond contracted hours.

Disbenefit

There is a potential disbenefit and associated risks with the Gwent Local Authorities and the Health Board operating on separate systems (Rio and Mosaic). The supplier for both systems is the same (The Access Group) and has developed integrated care access solutions that sit over the top of both the health and social care systems providing an aggregated view of Health and Social Care records. The Gwent Social Care region has not acquired the necessary plugins for the Mosaic product to present its records to that integrated care access solution. Discussions are under way to resolve this across the Social Care region whilst the cost of the Rio plugin has been incorporated into the business case.

Emergent Benefits

All other benefits have been categorised as emergent. These will be monitored as the programme progresses to determine and quantify the benefit expected prior to implementation:

Timely

- Increased clinical capacity through more efficient use of staff time, enabling more patients to be seen within existing resources.

Effective

- Increase ability to manage the Mental Health Act administration through increased health data control instead of local authority control.

The realisation of benefits will be managed through a benefits realisation register. This document will specify who will receive the benefits, who will own the benefits and be responsible for the monitoring and reporting of the realisation of the benefits identified.

It must be noted that given the significant change delivered, some of the identified benefits will not be realised until the programme has transitioned to Business as Usual (BAU), as detailed in Appendix 2.

The identification, baselining, forecasting and realisation of benefits will continue to be undertaken throughout the duration of the programme. The Business Change Manager for the digital community programme will oversee benefits realisation even after programme closure.

Progress will be tracked through the Benefits Plan, monitored by the Business Change Manager with regular reports to the Programme Board. All benefits are owned by the services within the Mental Health and Learning Disabilities Division and the Family and Therapies Division.

Option Appraisal

This section outlines the key options considered for the future of digital record-keeping within MH&LD services across ABUHB. The options have been developed and assessed in response to the current digital gap created by the need to replace the existing Electronic Patient Record (EPR) system.

Option One: Unmanaged Return to Alternative Digital Solutions and/or Non-Digital Services (Hybrid)

Description:

Cease using the WCCIS digital EPR system and allow Mental Health and Learning Disabilities services to revert to paper-based or other manual processes without a coordinated transition plan. This option does not include any investment in alternatives or structured change management. It represents a withdrawal from the digital strategy and a return to pre-digitisation working practices.

Benefits:

- ✓ Perceived short-term reduction in digital system-related frustration among some users.
- ✓ Immediate cessation of licensing and support costs related to WCCIS.
- ✓ Minimal requirement for digital training and change management in the short term.

Dis-Benefits:

- × Loss of real-time access to patient information across services and teams.
- × Fragmentation of care delivery and reduced ability to support integrated or multidisciplinary working.
- × Increased administrative burden on clinical and admin staff.
- × Loss of auditability, oversight, and data-driven decision-making capabilities.
- × Reputational damage due to perceived regression in service modernisation.

Advantages:

- ✓ Minimal immediate effort required.
- ✓ No reliance on digital system performance or support.
- ✓ Perceived “quick fix” for frustrations related to the current digital solution.

Disadvantages:

- × Elevated risk to clinical safety and operational efficiency due to fragmented and delayed information sharing.
- × Dissatisfaction and low morale among staff who rely on integrated access to records.
- × Potential impacts on service quality, continuity of care, and multidisciplinary collaboration.
- × May lead to long-term increases in operational costs and burden.
- × Weakens alignment with Welsh Government digital transformation objectives.

Costs:

Pay:

- Increased staff time required for manual documentation, duplication of effort, and information retrieval.
- Potential need for additional administrative support to manage paper records.

Non-Pay:

- Increased printing, stationery, and physical storage costs.
- Potential costs associated with future re-investment in digital solutions.
- Inefficiencies leading to indirect financial impacts (e.g., missed appointments, repeat assessments).

Risks:

Description	Consequence	Impact	Mitigation / Action Plan
Loss of access to integrated patient data and audit trails	Clinical safety risks, inconsistent care, reduced continuity, difficulty auditing care decisions	High	No effective mitigation without digital systems; rely on thorough documentation and manual audit processes
Operational inefficiency due to manual processes	Increased admin burden, slower workflows, reduced staff time with service users	High	Consider hiring more admin staff; redesign some processes to simplify paper workflows
Reputational and strategic misalignment with national digital health strategy	Potential scrutiny from Welsh Government and NHS Wales; perceived failure to modernise	Medium	Transparent communication of the rationale; develop a roadmap for future re-engagement with digital options
Loss of interoperability with partner services (e.g., Local Authorities)	Inability to share timely information, impacting joint care planning and safeguarding	High	Develop paper-based or email communication protocols, but these are inefficient and prone to error
Decline in data quality and reporting capability	Inability to support service planning, performance monitoring, regulatory reporting	High	Manual data collation from paper forms, but this is resource-intensive and less accurate
Increased risk of information governance breaches	Physical documents may be lost, misfiled, or accessed inappropriately	Medium-High	Improve physical document storage protocols, increase staff training, and assign IG leads to oversee records
Staff dissatisfaction and burnout	Paper systems increase duplication, cognitive burden, and reduce ability to deliver safe, effective care	High	Provide staff support, reduce non-essential paperwork, and plan for longer-term digital reintroduction

Risk of digital skill atrophy in workforce	Loss of familiarity and confidence in digital working, setting back digital maturity	Medium	Offer digital literacy maintenance programmes or optional digital tools training
Unintended inequity between digitally-enabled and non-digital teams	Teams using paper will have slower access to information and fewer insights, reducing standardisation of care	Medium	Develop internal SLAs for information sharing between services, consider hybrid pilots in higher-risk areas
Legal/regulatory non-compliance	Failure to meet HIW or DHCW expectations around digital maturity and data governance	Medium	Engage with regulators to clarify expectations and share plans for future compliance

Summary

Strategic Fit	Misaligned with national and local digital strategies.
Benefits	Very limited and short-term perceived benefit only.
Risks	Significant risks to safety, governance, and service quality.
Workforce Impact	Negative impact on efficiency and morale over time.
Patient/Service User Impact	Detrimental to care quality and safety.
Financial Impact	Short-term savings outweighed by long-term inefficiencies.
Deliverability	Technically possible but operationally harmful.
Sustainability	Not a viable long-term option.

Option Two: A Managed Return to Alternative Digital Solutions &/or Non-Digital Services (Hybrid)

Description:

This option involves a structured and planned withdrawal from the WCCIS digital EPR system, with Mental Health and Learning Disabilities services transitioning to paper-based or alternative manual processes. The transition would be supported by formal project governance, change management, communications, staff training, and temporary solutions to ensure continuity of care and minimise operational and clinical risk.

Benefits:

- ✓ Controlled and supported transition reduces immediate clinical and operational risks.
- ✓ Greater flexibility for services to tailor manual processes to local needs.
- ✓ Temporary relief from using a system perceived as unfit by some teams.
- ✓ Opportunity to reassess digital requirements and plan for better-aligned future procurement.

Dis-Benefits:

- × Investment in managing a transition to non-digital processes offers no long-term value.
- × Temporary or permanent loss of digital capabilities, including data sharing and interoperability.
- × Disruption to service continuity during the transition phase.
- × Risk of becoming stuck in manual processes without a clear reinvestment plan.

Advantages:

- ✓ Planned approach with risk mitigation and support for staff.

- ✓ Retains local service control and flexibility.
- ✓ Better perception among staff compared to an unmanaged withdrawal.
- ✓ More acceptable to regulators and stakeholders if framed as temporary.

Disadvantages:

- × **Fragmented Clinical Information**
Clinical records remain dispersed across multiple systems, Office 365 tools and paper files, increasing the risk of incomplete or inaccurate patient information at the point of care.
- × **Patient Safety and Quality Risk**
Lack of a single source of truth undermines care coordination, clinical decision-making and risk management, increasing the likelihood of adverse events and governance breaches.
- × **Unsustainable Use of Office 365 as a Clinical Platform**
Continued reliance on Excel, SharePoint and Word for clinical documentation introduces risks related to data integrity, version control, auditability and compliance with clinical safety and information governance standards.
- × **Excessive Operational and Administrative Burden**
Clinicians and service managers must duplicate data entry across systems and manual trackers, reducing productivity, increasing workload and diverting time from direct patient care.
- × **Programme and Project Resource Drain**
Ongoing effort required to maintain, configure and support multiple local solutions will consume scarce programme management and digital resources, limiting capacity for strategic transformation.
- × **Inconsistent Processes and Data Standards**
Variation in locally developed templates and processes leads to poor data quality, unreliable reporting and reduced ability to meet statutory, regulatory and performance reporting requirements.
- × **Business Continuity and Knowledge Dependency**
Locally developed tools often depend on individual staff knowledge with limited documentation, creating vulnerability to disruption when key personnel leave or are unavailable.
- × **Technical Obsolescence and Cyber Risk**
Continued use of unsupported legacy systems and non-clinical Office 365 solutions exposes the organisation to increasing cyber security and system reliability risks.
- × **Strategic Misalignment and Reputational Impact**
This option diverges from national and regional digital strategies that prioritise integrated records and standardisation, potentially weakening stakeholder confidence and eligibility for future digital funding.
- × **Hidden Financial and Opportunity Costs**
While capital expenditure may be avoided initially, the cumulative cost of duplication, manual workarounds and inefficiency will increase total cost of ownership and reduce value for money over time.

Costs:

Pay:

- Project team resources to manage the transition.
- Staff time for training, redesign of workflows, and increased administrative tasks.
- Potential recruitment of additional administrative staff.

Non-Pay:

- Physical storage solutions, stationery, and printing.
- Change management and communication materials.
- Potential investment in interim data capture tools (e.g., spreadsheets, local databases).

Risks:

Description	Consequence	Impact	Mitigation / Action Plan
Information fragmentation post-WCCIS withdrawal	Reduced ability to share data across services, impairing joint working and continuity of care	High	Establish standardised paper documentation and protocols for communication between teams
Clinical risk due to delayed access to information	Potential delays in decision-making and increased risk of errors due to lack of real-time access to patient records	Medium-High	Ensure clear handover protocols and regular case discussions; assign care coordinators
Operational inefficiencies in a manual workflow	Slower processes, duplication of work, increased staff time spent on administration	High	Map and optimise key processes; consider short-term digital tools to support workflow
Staff resistance or disengagement	Staff morale may be affected by perceived regression; risk of increased turnover or dissatisfaction	Medium	Engage staff throughout, provide reassurance on temporary nature, offer support and feedback channels
Increased risk of information governance incidents	Paper records are vulnerable to loss, theft, or misfiling	Medium	Implement robust paper IG policies, storage solutions, and training
Inequity between Mental Health and Learning Disabilities and other digitally enabled services	Mental Health and Learning Disabilities may fall behind in data quality, access, and service agility	Medium	Clearly define scope of return and communicate the rationale; prioritise re-engagement in future digital plans
Loss of auditability and business intelligence	Decreased ability to extract data for assurance, reporting, and planning	High	Design manual reporting templates and ensure regular local data collection
Reputational risk to Health Board and wider system	Stakeholders may perceive this as a step backwards, undermining confidence	Medium	Position the return as temporary and part of a managed reset toward better-aligned digital solutions
Transition complexity and costs	Coordinated planning, comms, training, and temporary solutions may	Medium	Time-bound project team, budget envelope,

	strain capacity and budgets		and clear governance structure
Risk of digital skill attrition among staff	Staff may lose familiarity with digital systems and become less prepared for future implementations	Low-Medium	Maintain digital skills training sessions or “digital champions” network even while non-digital

Summary:

Strategic Fit	Misaligned with long-term digital strategy but may offer tactical reset opportunity.
Benefits	Short-term relief and better staff engagement than an unmanaged approach.
Dis-Benefits	Functional, clinical, and operational setbacks compared to digital maturity goals.
Pay Costs	Staff time, training, potential additional admin support.
Non-Pay Costs	Printing, storage, change management resources.
Advantages	Planned, supported, and less risky than unmanaged option.
Disadvantages	Still regressive and resource-intensive without delivering long-term value.
Overall Risk Level	Risks are better mitigated than in an unmanaged return but still substantial.
Sustainability	Not viable long-term; must be time-limited with a clear digital reinvestment plan.

Option Three: Proceed with ABUHB procurement outcome for the acquisition and implementation of the RIO Solution

Description:

This option involves Aneurin Bevan University Health Board proceeding with the in-flight procurement process to source a new EPR system for Mental Health and Learning Disabilities services, separate from the national programme led by DHCW. It would include establishing a local programme board, defining specific local requirements, engaging suppliers directly, and managing the procurement, implementation, and post-go-live support internally.

Benefits:

- ✓ Fit for purpose solution that meets the specific clinical, operational, and strategic needs of Mental Health and Learning Disabilities services in Aneurin Bevan University Health Board.
- ✓ Greater control over timelines, scope, and supplier engagement.
- ✓ Opportunity to fast-track digital transformation locally, rather than waiting for a national procurement outcome.
- ✓ Potential to innovate and align digital strategy directly with Mental Health and Learning Disabilities service models.

Dis-Benefits:

- × Loss of consistency and interoperability with national systems and other Health Boards.
- × Duplication of effort and potential inefficiency if a national solution is later mandated.
- × Less bargaining power and economies of scale compared to a collective national procurement.
- × Increased governance, technical, and financial risk assumed locally.

Advantages:

- ✓ Local control and agility; the solution can be aligned with local priorities and clinical pathways.
- ✓ Faster timelines if procurement is well resourced and focused.
- ✓ Stronger sense of ownership and buy-in from local clinical and operational teams.
- ✓ Opportunity to define modern and fit-for-purpose requirements based on learning from previous systems (e.g., WCCIS).
- ✓ Improved view of digital as a solution that helps support effective and safe practice.

Disadvantages:

- × Risk of isolation from national digital direction and potential for future misalignment.
- × May increase variation and fragmentation across Wales' Mental Health and Learning Disabilities digital landscape.
- × High cost of delivery and potential duplication of functionality already under development nationally.
- × Complex procurement and implementation process requiring significant local expertise and capacity.

Costs:

Pay:

- Dedicated local programme team including project managers, digital analysts, procurement specialists, and clinical leads.
- Backfill costs for clinical and operational engagement during procurement and implementation.

Non-Pay:

- Procurement, licensing, infrastructure (if applicable), implementation, and support costs.
- Costs associated with integration, data migration, and user training.
- Ongoing vendor relationship management and system maintenance.

Risks:

Description	Consequence	Impact	Mitigation / Action Plan
Misalignment with national DHCW digital roadmap	Risk of incompatibility or future non-compliance with national architecture and strategy	Low	Engage DHCW throughout Design system with open standards and future interoperability in mind Adherence to Tier One of the national "Once for Wales" strategy
Local programme lacks capacity or capability	Poor delivery, delays, or procurement failure	Medium-High	Invest in experienced digital leadership, secure national or regional secondments or external support
High financial burden of local implementation	Budget pressure may limit scope or sustainability	Medium	Build robust business case with benefits realisation; explore partnerships or regional collaboration

Vendor lock-in or inflexible solution	Long-term limitations and risk of system not evolving with service needs	Medium	Ensure open APIs, modular design, and strong contractual governance in procurement
Loss of national integration or data flow	Fragmented care coordination with services still using national systems (e.g. LA, other HB services)	Medium-High	Prioritise integration; negotiate data-sharing agreements; implement interface engines
Resistance from national stakeholders	May face political and reputational challenges	Low-Medium	Ensure transparent communication and alignment with broader strategic goals
Clinical and operational disengagement due to poor system choice	System fails to meet expectations, reducing adoption	Medium	Deep engagement with Mental Health and Learning Disabilities clinicians and operational leads during specification and supplier selection
Delays in procurement due to complexity and governance	Project timeline extended, creating risk of gap in digital capability post-WCCIS	Medium	Adopt phased procurement and implementation; begin planning while still using WCCIS
Data migration issues	Loss of critical patient history or poor data quality in new system	Medium	Undertake early data quality audits; invest in professional data migration tools and testing
Overlap with future national system	Resources may be duplicated if national solution eventually supersedes local system	Medium	Maintain ongoing dialogue with DHCW; negotiate transition pathways if needed

Summary:

Strategic Fit	Alignment with the national programme in accordance with the “Once for Wales” strategy, whilst retaining alignment to local strategies, digital ambitions.
Benefits	Tailored system, control, innovation potential.
Dis-Benefits	Duplication risk, possible future redundancy.
Pay Costs	Requires full in-house programme team and SME backfill.
Non-Pay Costs	Procurement, licences, infrastructure, implementation, support.
Advantages	Agility, ownership, and local optimisation.
Disadvantages	Cost, isolation, and increased programme risk.
Overall Risk Level	Manageable with strong planning but dependent on capacity and governance.
Sustainability	Sustainable if planned well, but vulnerable to national direction shifts.

Preferred Option

Option Three: Proceed with ABUHB procurement outcome for the acquisition and implementation of the RIO Solution

Following a comprehensive options appraisal and risk assessment, it is recommended that the Health Board proceed with the local procurement and implementation of a replacement EPR system for MH&LD services, independent of but aligned to the national DHCW programme.

This recommendation builds on the completion of a procurement process, which identified The Access Group's Rio system as the preferred solution. The next phase would involve establishing a local programme board, defining specific service requirements, directly engaging with the supplier, and managing implementation and post-go-live support internally. This approach offers a timely, structured response to the current digital gap, enabling ABUHB to adopt a solution aligned with local clinical pathways, service models, and strategic priorities—while avoiding the risks associated with reverting to paper-based processes or awaiting a delayed or unsuitable national alternative.

The implementation of *Rio* allows for:

- **Continuity and Stability of Service Delivery**
Ensures timely transition away from WCCIS ahead of its end-of-life and contractual expiry, safeguarding against operational disruption and compliance risk.
- **Implementation of a Modern, Fit-for-Purpose EPR Platform**
Replaces outdated, fragmented systems with a robust, future-ready digital platform tailored to MH&LD service needs and workflows.
- **Improved Clinical Documentation and Real-Time Information Access**
Supports real-time data entry and access at the point of care, reducing duplication, enhancing accuracy, and enabling safer, more responsive clinical decision-making.
- **Enhanced Data Quality, Reporting and Statutory Compliance**
Enables automated, structured data capture and integrated dashboards to support statutory targets (e.g. Mental Health Measure, MHA), with customisable reporting aligned to national standards and local priorities.
- **Increased Operational Efficiency and Reduction of Workarounds**
Eliminates reliance on manual processes, spreadsheets, and disconnected reporting tools, freeing up staff time and reducing the risk of error and information loss.
- **Improved Care Coordination and Service Integration**
Facilitates timely information sharing across multidisciplinary teams, enhancing joint working and reducing fragmentation in care delivery.
- **Support for a Fully Mobilised, Agile Workforce**
Enables staff to access and update records from any location, supporting flexible and community-based models of care aligned with ABUHB's agile working policy.

- **Improved Patient Experience and Engagement**
Empowers clinicians to deliver personalised, coordinated care in the settings that matter most to service users, enhancing communication, continuity, and outcomes.
- **Strengthened Governance, Risk Management and Auditability**
Embeds mandatory fields and structured data capture to improve accuracy, ensure accountability, and support regulatory compliance.
- **Support for Service Transformation and Digital Maturity**
Provides the digital foundation to deliver sustainable, scalable models of care in line with ABUHB's 10-year strategy, IMTP, and national policies such as *A Healthier Wales* and the *Mental Health and Wellbeing Strategy*.
- **Improved Workforce Experience and Staff Retention**
Offers intuitive, modern digital tools that align with staff expectations and professional standards, supporting recruitment, retention, and wellbeing.
- **Timely Support for Performance Improvement and Demand Management**
Enables advanced analytics and forecasting capabilities to identify bottlenecks, optimise resource allocation, and demonstrate service effectiveness to local and national stakeholders.
- **A Tailored, Locally-Driven Solution Aligned with ABUHB Priorities**
Reflects a deliberate, strategic choice to implement a solution aligned with local clinical models and governance frameworks, rather than waiting for a delayed or generic national alternative.

As a supplier, The Access Group, is one of the UK's largest and most established software providers, employing around 7,000–8,000 staff and serving over 100,000 organisations across the public, private and third sectors. They have over 20 years' experience delivering systems across Wales. Following its acquisition of Servelec in 2021, The Access Group significantly expanded its presence within health and social care, becoming a trusted partner to more than forty-five NHS trusts and numerous local authorities across the UK. The Group reported net assets exceeding £2.5 billion (FY2023), demonstrating a strong financial foundation and long-term stability. This level of maturity and financial resilience contrasts with the challenges previously experienced in Wales with WCCIS and provides assurance that the chosen supplier has the capability and commitment to deliver and sustain a long-term digital partnership.

The Rio Electronic Patient Record (EPR) is a proven, NHS-deployed platform that is listed on the UK Government's G-Cloud framework, confirming compliance with national standards for security, interoperability, and data governance. The system is already in widespread operational use, being the largest EPR provider across the UK, with Access reporting that over 150,000 clinicians use Rio across mental health, community and child health services.

Access continues to make significant investments in innovation, with research and development expenditure increasing from £90 million in 2022 to £137 million in 2023. This commitment includes the Rio Reimagined programme, which has received over £2 million in investment during the past 24 months to modernise the user experience, enhance functionality, and strengthen system integration capabilities. As part of supplier demonstrations, The Access Group has pledged to work in partnership with ABUHB to support this development. Their commitment encompasses delivering an

intuitive design that enables completion of core tasks in no more than three clicks or touches, ensuring a mobile-first and responsive interface optimised for smartphones and tablets at the point of care, and providing both offline and online functionality to maintain performance in areas with limited connectivity, such as rural locations or older mental health facilities.

The Access Group is investing between £6 million and £8 million in developing integrated care solutions that connect the Rio (Health) and Mosaic (Social) systems, alongside EMIS and other system vendors. Given that the Gwent Local Authority Region has adopted Mosaic, this presents a significant opportunity for us to benefit from enhanced interoperability and streamlined care delivery.

This investment provides a future-proof digital platform that will evolve in line with both national strategy and local service transformation. The Rio EPR offers a clearly scalable solution, that provides potential opportunities for extended use across wider health board services, as well as being adapted for more extensive use within MHL D itself should additional services be brought into scope or divisional structures change. Its modular, interoperable architecture allows the Health Board to reuse configuration, infrastructure, and training assets, maximising value, reducing duplication, and “sweating” the initial investment.

Together, these factors provide confidence in the supplier’s capability, financial strength, and ongoing commitment to product development, giving assurance that this partnership will deliver a sustainable, scalable digital solution for Aneurin Bevan UHB over the next decade and beyond.

Strategic Alignment

The procurement of a modern Mental Health Electronic Patient Record (EPR) system will support Aneurin Bevan University Health Board in delivering safe, effective, and person-centred care, while strengthening digital maturity across mental health services. This investment ensures clear alignment with both local and national strategic priorities, enabling the Health Board to meet its operational objectives and long-term ambitions through improved interoperability, data quality, and service integration. The following priorities and strategies have been considered.

Mental Health and Learning Disabilities Divisional Strategies and Priorities

- ✓ **Divisional Priorities (IMTP Aligned)** - supports divisional IMTP priorities by modernising care, strengthening partnerships, and enabling digital transformation across MH&LD and CAMHS

Aneurin Bevan University Health Board Organisational Strategies and Priorities

- ✓ **10-year strategy** - advances ABUHB’s 10-Year Strategy by enhancing early intervention, community access, and integrated, sustainable mental health care.
- ✓ **IMTP 2025-2028**- underpins ABUHB’s IMTP by transforming mental health services in line with the Mental Health Strategy, providing the digital foundations for new place-based care models, and enhancing staff experience through reduced burden and improved workforce resilience.
- ✓ **Digital Strategy** - delivers on all four pillars of ABUHB’s Digital Strategy, enabling mobile care, integrated data use, community models, and modern infrastructure.

- ✓ **Six Goals** - supports the Six Goals by enabling early risk detection, coordinated discharge, and a “home first” approach.
- ✓ **ABUHB People Plan 2022-2025** - enables a sustainable, inclusive workforce through improved digital tools that reduce burden and support agile, transformative working.
- ✓ **2024/27: Annual Plan three-year intent** - drives digital transformation to meet mental health demand, improve MHM compliance, and support sustainable, mobile-enabled services.
- ✓ **All Wales Flexible Working Policy in conjunction with ABUHB Agile/Hybrid Working Framework** - supports mobile and remote working models, aligning with flexible workforce policies and sustainability goals.

National Strategies and Priorities

- ✓ **Connecting Care Programme (DHCW)** - The Mental Health EPR replacement programme directly supports and aligns with DHCW’s Connecting Care Programme - a ministerial priority, by enabling safe, seamless, and integrated digital care for people across Wales.
- ✓ **Once for Wales** - meets Once for Wales Tier 1 requirements by ensuring national compliance, interoperability, and standards-based local configuration.
- ✓ **Mental Health and Wellbeing Strategy 2025-2035 and the Mental Health and Wellbeing Strategy Delivery Plan 2025-2028** - enables person-centred, trauma-informed, and digitally driven care aligned with the national mental health vision.
- ✓ **National Data Resource (NDR) – Mental Health Dataset** - supports NDR compliance through standardised data capture and reporting for improved service visibility.
- ✓ **A Healthier Wales** - advances the A Healthier Wales vision by enabling integrated, outcome-based, and person-focused digital health and care.
- ✓ **Prudent Health Care** - aligns with Prudent Healthcare by enabling efficient, needs-based, co-produced, and evidence-led digital mental health care.

The case for change section sets out in detail how the delivery of the MH&LD EPR solution, in line with this business case will align to the specific and applicable objectives of each strategy.

Options Appraisal Conclusion

This option enables the Health Board to take ownership of its digital future, addressing the critical need for a sustainable EPR solution for MH&LD services. It balances local autonomy with strategic foresight, ensuring the digital maturity and service transformation required to meet the needs of service users and staff alike. While the financial and delivery burden is higher than other options, the value derived in terms of clinical effectiveness, patient safety, operational continuity, and service user experience makes this a justifiable and prudent investment.

It also offers a strategic and pragmatic approach, empowering ABUHB to procure a tailored solution. This option maximises the likelihood of successful outcomes while restoring confidence and engagement among stakeholders, whilst remaining aligned to the base tier of the Once for Wales definition.

Impact Assessment, Workforce Implications and Affordability of Preferred Option

Workforce Implications

The implementation of Rio will have a significant impact across the workforce. As of June 2025, over 2000 staff across 194 teams, 68 services, and 7 directorates will be directly affected by the transition from WCCIS to the new EPR.

This workforce spans a wide range of professional groups, including but not limited to:

Registered Mental Health Nurses

- Medics
- Psychologists and Psychological Therapists
- Occupational Therapists
- Speech and Language Therapists
- Peer Support Workers and Psychology Assistants
- Mental Health Social Workers
- Health Care Support Workers
- Administrative staff
- Team Managers and Clinical Leads

Due to the reasons outlined in the Case for Change, there have been some adoption challenges with the current system, leading to continued use of fragmented digital and paper-based tools by some staff and services. This has resulted in inefficiencies, increased risk, and a suboptimal experience for professionals. The introduction of a modern, fit-for-purpose EPR will significantly alter the way these teams operate—enabling real-time access to records, improved collaboration, and mobile working.

The resource plan for this programme spans a Seven-year period and includes dedicated funding for:

- Programme and project delivery
- Clinical reference groups
- Technical and compliance support
- Product delivery teams
- ICT, infrastructure, training, integration, and analytical support

A total of £4.14 million in staff resource costs has been allocated from 2025–2031, with roles being drawn primarily from existing resources wherever possible. The programme remains engaged and aligned with DHCW/the Connecting Care Programme to secure funding from Welsh Government. A 5% vacancy factor has been applied to account for anticipated turnover during delivery, expected to generate in the region of £207k in underspend against staffing costs.

The implementation of the EPR will require a significant programme of business change, with the Business Change Scaling Assessment confirming a total complexity score of 27. Over 80% of staff will be impacted, and extensive stakeholder engagement will be required to ensure successful adoption. This includes a cultural shift towards mobile and hybrid working, with training and support tailored to different staff groups and service areas.

Lessons learned from the implementation of WCCIS and benchmarking with other health boards have informed the design of the resource model. Unlike WCCIS, which introduced several unanticipated burdens to the workforce, Rio is designed to reduce administrative overhead, streamline documentation, and improve staff satisfaction by aligning functionality with clinical workflows.

The resource plan is reflective of and will enable the successful delivery of the programme, as set out in the planned implementation timeline (see section Implementation Plan).

Potential Service Impacts

The implementation of Rio will have wide-reaching impacts on service users and system partners. Engagement to date has included clinicians, operational leads, support services, digital teams and local authorities. Following approval of this business case, further engagement will be undertaken to ensure a full impact assessment is developed with each group.

Patients, Carers or the Public

Pros:

- ✓ Improved patient experience through faster, safer, and more joined-up care.
- ✓ An integrated digital record enables better continuity across services and fewer instances of patients having to repeat their history.
- ✓ Increased transparency and future potential for patient access to elements of their own records.
- ✓ Improved accessibility, including options to support Easy Read and inclusive communication.

Cons:

- × Concerns over data privacy, digital literacy, and accessibility may need to be addressed through proactive communication and support.

Clinical Support Services (e.g. Psychology)

Pros:

- ✓ More reliable and timely access to clinical information to support informed decision-making.
- ✓ Reduced duplication of documentation across systems.
- ✓ Greater ability to support MDT working through shared access to notes and care plans.

Cons:

- × Initial learning curve and adjustment period required for clinical teams adapting to a new system.
- × Potential for short-term delays or disruptions during the transition and data migration phase.

Non-clinical Support Services and Facilities Management

Pros:

- ✓ Improved coordination between clinical and non-clinical teams through shared task management and digital handovers.
- ✓ Reduced reliance on paper processes, resulting in efficiencies in printing, filing, and records management.

Cons:

- × Some administrative roles may require new training or reallocation of tasks as digital workflows are embedded.

Patient Transport

Not Applicable

Works and Estates

Pros:

- ✓ Reduction in paper-based storage requirements.
- ✓ Opportunity to streamline workspace layouts through digitisation.

Cons:

- × Potential minor refurbishment to accommodate IT requirements in community settings.

Equipment and ICT / Digital, Data and Technology

Pros:

- ✓ Modernisation of clinical infrastructure and rationalisation of legacy systems.
- ✓ Improved interoperability between services and systems.
- ✓ Enhanced data quality and availability to support service planning and patient care.

Cons:

- × Upfront investment required in devices, network upgrades, and user support.
- × High dependency on stable connectivity across community sites; inconsistent Wi-Fi remains a risk in some areas.
- × Ongoing demand on digital support services during rollout and early life support.

Primary and Community Services

Pros:

- ✓ Shared access to information improves continuity of care across service boundaries.
- ✓ Supports delivery of more integrated, person-centred care aligned to national models.
- ✓ Reduces need for paper referrals and improves real-time decision-making.

Cons:

- × Will require upskilling and support for community-based staff unfamiliar with new system.
- × Risk of increased short-term pressure as digital processes are embedded alongside existing demands.

Local Authority Services

Pros:

- ✓ Improved interface with NHS services through clear role demarcation and case coordination.
- ✓ Opportunities for more effective joint planning, safeguarding, and communication in shared care scenarios.

Cons:

- × Where local authority staff access is required, agreements on data sharing and access governance will need to be refreshed.
- × Not all services currently have the infrastructure in place to adopt the same digital workflows.

Third Sector Agencies

Pros:

- ✓ Increased visibility of care plans and patient needs can support more informed, coordinated support from third sector providers.
- ✓ Potential for integrated referral pathways and digital updates on patient status.

Cons:

- × Third sector agencies may require support or training to engage with any new digital interfaces.
- × Digital equity challenges must be considered, particularly for voluntary services with limited resources.

External Commissioning

Pros:

- ✓ Improved data quality and timeliness to support commissioning decisions and contract monitoring.
- ✓ Potential for automated reporting and improved outcome measurement aligned with Value-Based health care.

Cons:

- × Minimal direct operational impact anticipated but will require updated expectations in contract performance and reporting.

Further impact assessment work is scheduled to take place during implementation planning, including targeted workshops, digital readiness assessments, and service-specific change impact reviews. This will be aligned to the Business Change strategy and Programme Delivery Plan.

Funding

Proposed Funding Source

It is proposed and recommended that the Health Board seeks to fully fund the delivery of the programme inclusive of system costs for acquisition, licensing and implementation, as well as the costs associated with the internal resources required to deliver the implementation and deployment of the chosen system.

This approach will provide a sustainable and assured funding position for the programme to deliver the required migration from WCCIS to the RIO platform within the imposed deadline of March 2027. It must be noted that the March 2027 deadline is immovable and any delays in agreements on funding would impact on the ability of the Health Board to safely transition Mental Health and Learning Disabilities services to the replacement WCCIS platform ahead of hard stop end of life and switch off for WCCIS, on 31st March 2027.

There are multiple funding opportunities that have been explored as being available to the Health Board to acquire financial support across different facets of programme delivery. The landscape for such funding opportunities is currently volatile to change and cannot be relied upon to provide a guaranteed and consistent funding outcome that ensures the programme can be delivered within the requisite timescales. This is largely due to shifting priorities in the political arena that surrounds digital priorities both within the national mental health context but also in the wider context and priorities around “once for Wales” and “integrated health and social care”.

It is proposed that the Health Board seeks to fully fund the programme whilst pursuing the full range of external funding opportunities. Anything that arises from those routes would then come back into the Health Board to ease the financial pressures created from this programme.

Funding opportunities

Outlined below are the range of funding opportunities that continue to be explored for availability to the Health Board to provide financial support to the programme.

DHCW Connecting Care Outline Business Case

An option for ABUHB to submit costs via the DHCW national outline business case to Welsh Government to ask for funding to be issued to the Health Board via the DHCW route.

The ask would be for a fully funded business case in key areas of programme resourcing for the purposes of procurement, implementation and deployment as well as consideration for support and assistance with the transformational costs from suppliers and the inevitable double handling of WCCIS and new system costs.

Further consideration could be given to capital funding for the provision of hardware assets that support and enable mobile ways of working.

ABUHB submitted costs to DHCW and will now be represented in the wider DHCW connecting care business case which will be submitted to WG. An outcome decision has been reported that provides the health board with revenue funding of £870,034, ONLY for the 2025/2026 financial year. There is no commitment from Welsh Government to future years of the national business case.

Discussions are ongoing around capital funding settlements for the 2025/2026 financial year but the Health Board has been provided with an indicative minimum figure of £757,810 for the 2025/2026 financial year only.

Regional Partnership Board

The following funding streams are available via the Regional Partnership Board (RPB) and may provide financial support for components of the digital community programme:

Regional Integration Fund (RIF)

Supports long-term transformation of health and care services, especially where they are integrated or community focused. Administered by Welsh Government via the RPBs.

RIF supports projects aligned to:

- Community MH&LD transformation
- Integrated digital working between health and social care
- Prevention and early intervention
- Seamless services across organisational boundaries

Potential use cases for the Digital Community Programme:

- Co-designed digital workflows between MH and social care staff
- Enhancing community-based records or EPR modules
- Patient/carer-facing tools for care planning
- Proof of concept for integrated MDT working across sectors

The programme team has discussed this funding opportunity with the ABUHB Planning team. The outcome of those discussions identified that there are currently no opportunities to include this programme in the profiling if RIF funding. Furthermore, the RIF fund is due to end March 2027, with no commitment to a replacement fund currently known. As a result it is considered that there is no further opportunity via RPB at this point in time.

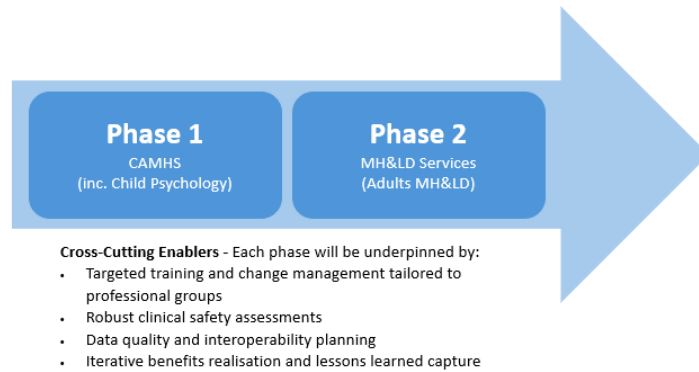
Implementation Plan and Measurement of Success

Utilising a phased delivery approach can support successful implementation of Rio. It enables a structured approach to delivering short term tactical objectives for MH&LD services whilst enabling a more strategic and structured approach for wider services across Community and Allied Health Professionals.

This approach is primarily informed by lessons learned from the WCCIS implementation and ensures that capabilities are delivered in a structured and manageable way, aligned to the needs, digital maturity, and readiness of each service group.

Given the fixed programme timeline, a phased rollout will be adopted at the service level. The implementation will commence with **CAMHS (inc. Child Psychology)**, followed by **Adult Services**. This sequence is based on:

1. **Risk Minimisation** – Deploying first to a service with a lower volume of users reduces the potential impact of unforeseen issues.
2. **Service Transition Management** – Implementing CAMHS first helps streamline the transition process for patients moving from CAMHS into Adult Services.



Key Considerations

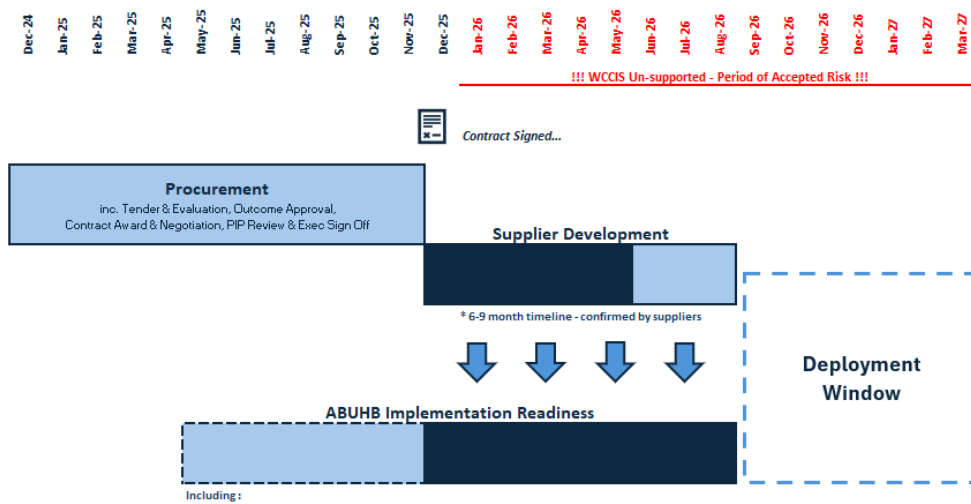
- **Contingency for a Big Bang Implementation**
While a phased approach is preferred due to its clear advantages, unforeseen programme delays may necessitate a shift to a Big Bang approach if the available deployment window narrows.
- **Timeline Risks**
The programme assumes a **six-month deployment window**. Any significant delays in the CAMHS rollout will compress the timeline for the Adult Services phase. Given the **fixed deadline**, if substantial issues arise during Phase 1, a Big Bang implementation may become necessary to ensure overall programme success.

*** Decision Points**

To manage this risk, key decision points will be embedded into the programme timeline. These checkpoints (linked to key programme milestones) will assess the ongoing feasibility of the phased approach and allow for course correction if needed.

A phased approach enables the programme to balance ambition with realism, ensuring that each service group receives the right support at the right time, while maintaining momentum and delivering tangible improvements in care quality, efficiency, and staff satisfaction.

Timeline



ID	Task Description	Named Lead	Estimated Start Date (ESD)	Estimated Finish Date (EFD)	Predecessor(s)	Status
1	Tranche 1 Programme Start Up and MH&LD Requirements	Michael Pugh Digital Programme Manager	26/08/2024	13/12/2024		Complete
2	Tranche 2 Programme Initiation & Procurement	Michael Pugh Digital Programme Manager	14/10/2024	13/06/2025	1	Complete
3	Tranche 3 Project Start Up, Initiation & Planning	Michael Pugh Digital Programme Manager	06/01/2025	17/10/2025	1, 2	Live Under Review*
4	All Projects Milestone 1 (Start Up & Initiation)	Technical Delivery - Paul McDonald; Mobility - Nadia Brookes; MH&LD - TBC	06/01/2025	17/10/2025	1, 2	Live Under Review*
5	Tranche 4 Scrutiny, Diligence, Business Case, Contracting	Michael Pugh Digital Programme Manager	02/06/2025	17/10/2025	2	Live
6	Tranche 5 Implementation Readiness, Development, Configure and Build	Michael Pugh Digital Programme Manager	06/10/2025	26/06/2026	5	On Track
7	All Projects Milestone 2 (Planning & Readiness)	Technical Delivery - Paul McDonald; Mobility - Nadia Brookes; MH&LD - TBC	27/04/2025	31/10/2025	4, 5	Live Under Review*
8	Tranche 6 Implementation and Deployment - Phase 1 & 2 (MH&LD / PCMHSS / CAMHS / CP)	Michael Pugh Digital Programme Manager	01/06/2026	31/03/2027	6	On Track
9	All Projects Milestone 3 (Delivery)	Technical Delivery - Paul McDonald; Mobility - Naadia Brookes; MH&LD - TBC	02/11/2025	26/06/2026	7, 8	On Track
10	All Projects Milestone 4 (Go Live)	Technical Delivery - Paul McDonald; Mobility - Nadia Brookes; MH&LD - TBC	28/06/2025	31/03/2027	8, 9	On Track
11	All Projects Milestone 5 (Closure)	Technical Delivery - Paul McDonald; Mobility - Nadia Brookes; MH&LD - TBC	06/12/2026	31/12/2027	8, 10	On Track
12	Tranche 7 MH&LD Programme Transition. Embed and Closure	Michael Pugh Digital Programme Manager	06/12/2026	31/12/2027	8, 11	On Track
* Activity 'Under Review' as milestone documentation being prepared retrospectively - due to the transition from Programme level activity to Project Start Up						

Key Roles & Responsibilities

RACI Matrix

For the all ages MH&LD EPR solution a RACI matrix has been provided for the key roles associated with the delivery of the programme. RACI is defined as per the below table:

Letter	Meaning	Description
R	Responsible	The person(s) who do the work to complete the task or activity.
A	Accountable	The person who is ultimately answerable for the activity. One per task.
C	Consulted	Those who are consulted for input before or during the work.
I	Informed	Those who are kept updated on progress or decisions.

The below table provides a RACI matrix for the key roles associated with the delivery of the All ages MH&LD EPR programme.

Role	Vision & Blueprint	Governance	Benefits Mgmt	Change Design	Stakeholder Engage	Planning	Delivery	Risk (Prog)	Risk (Proj)	Training	Adoption	Comms
Programme Management	R	R	R	C	A	A	A	A	C	A	I	A
Business Change Management	R	R	A	A	A	C	C	C	C	C	A	A
Project Management	I	R	R	C	R	R	R	R	A	R	C	R
Senior Responsible Owner	A	A	A	C	A	C	I	R	I	I	I	A
Senior Product Owner	C	R	R	R	R	C	C	R	C	C	R	R
Senior Clinical User	C	C	C	C	R	I	C	R	C	C	R	R
System Manager	I	I	I	I	C	I	R	R	R	C	R	I
Product Specialist	I	I	I	I	C	I	R	R	R	C	R	I
Trainer / Tester	I	I	I	I	I	I	R	R	R	R	R	I

Resourcing for the programme will be delivered through a multi layered approach. Each layer comprising several roles, with each role either operating directly under the umbrella of the programme or being made available to the programme on a temporary basis to provide advice, guidance or deliver task and finish work items.

The resourcing layers are described as follows:

Programme / Project:

The programme team provides leadership, coordination, and strategic oversight across related projects, ensuring alignment with organisational priorities and effective stakeholder engagement. It manages interdependencies, scope, resources, and risks, and acts as the main liaison with executive sponsors and assurance bodies.

Project teams operate within the programme structure, delivering specific products or capabilities. They manage day-to-day planning, design, testing, deployment, and local risks, working closely with subject matter experts and service users to ensure fit-for-purpose solutions.

Together, programme and project teams translate strategy into delivery, ensuring effective governance, engagement, and benefit realisation.

Clinical Reference Group:

Clinical Reference Groups (CRGs) provide expert clinical leadership and assurance to ensure digital initiatives are safe, evidence-based, and aligned with clinical practice. They bridge frontline teams and programme delivery to reflect real-world care.

CRGs support co-production, validate workflows, and define clinically sound, person-centred requirements that maintain or improve care quality and safety.

Technical Reference Group:

The Technical Reference Group (TRG) provides expert assurance on technical design, ensuring digital solutions are secure, interoperable, and standards compliant.

Bringing together experts in architecture, infrastructure, cyber security, and more, the TRG validates technical requirements, assesses risks, and ensures alignment with digital strategy and enterprise architecture.

It supports solution integration, legacy system alignment, and long-term technical sustainability.

Compliance Reference Group:

The Compliance Reference Group ensures adherence to legal, regulatory, and organisational standards across all digital initiatives.

Drawing expertise from data protection, governance, equality, and finance, the group reviews plans, identifies risks, and supports statutory artefacts (e.g., DPIAs, Equality Impact Assessments, Clinical Safety Cases).

It embeds compliance into programme governance to ensure transformation is lawful, ethical, and inclusive.

Product Support and Delivery:

Once the implementation of proposed EPR is complete, the programme will transition to a Product Delivery team for management of the day-to-day delivery and for the ongoing continuous improvement and optimisation of the platform. Successful transition from project implementation to product delivery requires a collaborative effort from multidisciplinary teams to ensure the product continues to meet user expectations and evolves to meet changing healthcare industry standards.

The product delivery model will include dedicated product delivery roles, inclusive of clinicians, product management and product support to manage, enhance and optimise the product to ensure ABUHB realises the benefits identified. The product delivery resource will work together to:

- Identify and prioritise features based on user needs, regulatory requirements, and user/service demands

- Implement rigorous testing processes to ensure the product's reliability, security, and compliance with healthcare standards
- Stay informed about updates and changes in regulatory requirements and make necessary adjustments to the product, ensuring compliance with relevant healthcare regulations and standards
- Ongoing development of training and support materials such as documentation, to address user queries and issues
- Assess and optimise the solution's scalability to accommodate a growing user base and increased data volume
- Continuously monitor and improve system performance to ensure a seamless user experience
- Conduct regular security audits and updates to address potential vulnerabilities to protect patient data and ensure compliance with data privacy regulations
- Establish procedures for handling software updates and patches
- Establish a feedback mechanism to collect input from users and stakeholders to address any issues with the product and prioritise future enhancements
- Develop comprehensive documentation for end-users and administrators e.g. user manuals, system architecture documentation, and release notes
- Develop a marketing strategy to promote the proposed EPR platform and ensure effective use of the product
- Establish a process for continuous improvement based on user feedback, technological advancements, and best practice
- Plan regular updates and releases to enhance the product's capabilities.

It is anticipated that the project will transition to product delivery during FY 2029/2030. ***The current expected roles are set out in Appendix 5.***

Dependencies

There are several dependencies that need to be considered in the delivery of such a programme. A full list of dependencies, with enhanced detail, will be maintained by the programme and project team throughout via the dependency register. However, key dependencies are identified below.

Software Design and Development

The success of the MH&LD EPR Programme is dependent on the expertise and capacity of the internal Software Design and Development function, which plays a critical enabling role in the integration, configuration, and optimisation of digital solutions.

Although the programme is procuring a commercial off-the-shelf (COTS) product, significant technical work is required to ensure that the EPR integrates seamlessly with a range of legacy and modern systems across the organisation. This includes bespoke development of interfaces, APIs, middleware

components, and data exchange mechanisms to support safe, real-time, and standards-compliant interoperability.

Key dependencies include:

- **Interface development and management:** Connects the EPR with systems such as PAS, laboratory systems, clinical portals, the local data repository, document store, wider digital platform, and community health solutions.
- **Data transformation and mapping:** Supports accurate and secure migration and exchange of structured and unstructured information between platforms.
- **Adherence to technical and data standards:** Such as HL7, FHIR and SNOMED, requiring the internal function to ensure compliance and alignment with national interoperability frameworks.
- **Ongoing configuration and customisation:** of software components to reflect local workflows, user requirements, and clinical safety standards.
- **Technical assurance and risk mitigation:** with the internal team contributing to design reviews, integration testing, and resolution of software defects or limitations identified during implementation.

This dependency is both strategic and operational, requiring close collaboration throughout the programme lifecycle. The internal team provides vital continuity between procurement, implementation, and live operations, ensuring that the digital ecosystem is coherent, future-proof, and capable of supporting integrated, person-centred care.

Information Services

The MH&LD EPR Programme is critically dependent on the expertise and capacity of the organisation's Information Services teams to support data quality, reporting, performance monitoring, and statutory returns throughout the lifecycle of the programme.

As the programme introduces a new digital platform, Information Services play a vital role in ensuring continuity of data flows, safeguarding reporting obligations, and enabling the extraction of meaningful insights from the new system. This dependency is particularly important given the complexity of mental health and learning disabilities services, which rely on accurate and timely data to support both operational delivery and strategic planning.

Key dependencies include:

- Design and development of reporting solutions to replace or replicate existing reports, dashboards, and performance metrics using new data structures from the EPR.
- Data validation and assurance during system implementation and migration to ensure data integrity, continuity, and clinical safety.
- Support for national and local reporting requirements, including mandatory datasets (e.g. the Mental Health Core Dataset), audit returns, and quality indicators.
- Collaboration in defining business intelligence (BI) requirements, supporting operational teams with actionable insights and enabling real-time decision-making.
- Facilitating interoperability with wider data platforms, such as the National Data Resource (NDR), through structured data extraction, transformation, and loading processes.

Information Services teams also provide ongoing analytical support post-implementation, ensuring the new EPR system continues to deliver value through data-driven insights and supports continuous improvement, population health management, and service transformation.

This dependency is essential to ensuring that the EPR is not just a clinical system, but a foundational tool for strategic intelligence, performance management, and person-centred care.

MH&LD services

The MH&LD EPR Programme is fundamentally dependent on the active engagement, time, and expertise of frontline MH&LD services and operational teams across all care settings. These teams play a central role in ensuring the successful design, configuration, testing, and adoption of the new EPR system.

This dependency spans the full lifecycle of the programme—from discovery and design through to implementation and embedding—and is essential to ensuring the system is clinically safe, operationally viable, and aligned with service delivery models.

Key dependencies include:

- Subject matter expertise to define requirements, validate workflows, and co-design system configurations that reflect the needs of service users and professionals.
- Participation in testing and assurance activities, including user acceptance testing (UAT), clinical safety reviews, and pathway validation exercises.
- Involvement in training and change management, helping to shape learning materials, act as champions, and support local adoption across teams.
- Resource availability to attend workshops, provide feedback, and contribute to working groups—balanced against ongoing service pressures and workforce constraints.
- Support for data migration and cleansing, ensuring that legacy data is accurate, relevant, and safe to transition into the new system.
- Benefits realisation, by helping to identify, track, and evidence improvements in care quality, efficiency, compliance, and staff and patient experience, and embedding new ways of working to ensure benefits are achieved and sustained.

These teams are not just stakeholders—they are co-creators of the future digital landscape. Their input ensures that the EPR supports integrated, person-centred care, reduces duplication, and enhances communication and coordination across multidisciplinary teams.

Sustained engagement from MH&LD services is therefore a critical success factor for the programme, requiring careful planning, flexible resourcing, and clear communication to enable participation without disrupting day-to-day care.

DHCW

The MH&LD EPR Programme is significantly dependent on the expertise, infrastructure, and support provided by Digital Health and Care Wales (DHCW). As the national body responsible for digital services across NHS Wales, DHCW plays a vital role in ensuring that the programme aligns with national architecture, data standards, and interoperability frameworks.

This dependency reflects the need for close collaboration across a range of DHCW functions, ensuring that the new EPR can operate effectively within the broader digital ecosystem and contribute to national priorities such as the National Data Resource (NDR) and Once for Wales service models.

Key dependencies include:

- Technical and architectural assurance, ensuring the EPR aligns with national digital infrastructure, cloud hosting standards, cyber security protocols, and architectural governance.

- Support for systems integration, particularly with national platforms such as the Welsh Clinical Portal, Welsh Care Records Service (WCRS), the Master Patient Index, and the NHS Wales Directory Service (Nadex).
- Facilitation of data exchange and analytics, supporting access to shared data environments and ensuring compliance with national coding standards (e.g. SNOMED CT, HL7, FHIR).
- Provision of identity, access management, and infrastructure services, including user account provisioning, authentication, and network support.
- Collaboration on information governance and compliance, particularly where the EPR interacts with national datasets or shared care records.
- Ongoing support and service management, particularly as the EPR moves into live service and requires integration into existing national support models.

The programme's success relies on proactive and sustained engagement with DHCW at both strategic and operational levels. Early alignment and collaborative planning are essential to manage technical dependencies, mitigate risks, and maximise opportunities for shared digital capabilities across Wales.

Suppliers

The MH&LD EPR Programme has a critical dependency on the selected supplier's services and teams to deliver a high-quality, fit-for-purpose digital solution that meets the needs of mental health and learning disabilities services. As a commercial partner, the supplier is central to delivering core system capabilities, ensuring technical integration, and supporting successful implementation across diverse clinical and community settings.

In addition to the supplier of the MH&LD EPR solution, there will also be several critical dependencies on other third-party suppliers of other incumbent local and national health solutions. These dependencies will exist around support for delivering key integrations where the relationships to develop such solutions will sit directly between those third-party suppliers.

This dependency spans the full programme lifecycle and encompasses both technical delivery and strategic collaboration, requiring a responsive and capable supplier team with clear roles, responsibilities, and service commitments.

Key dependencies include:

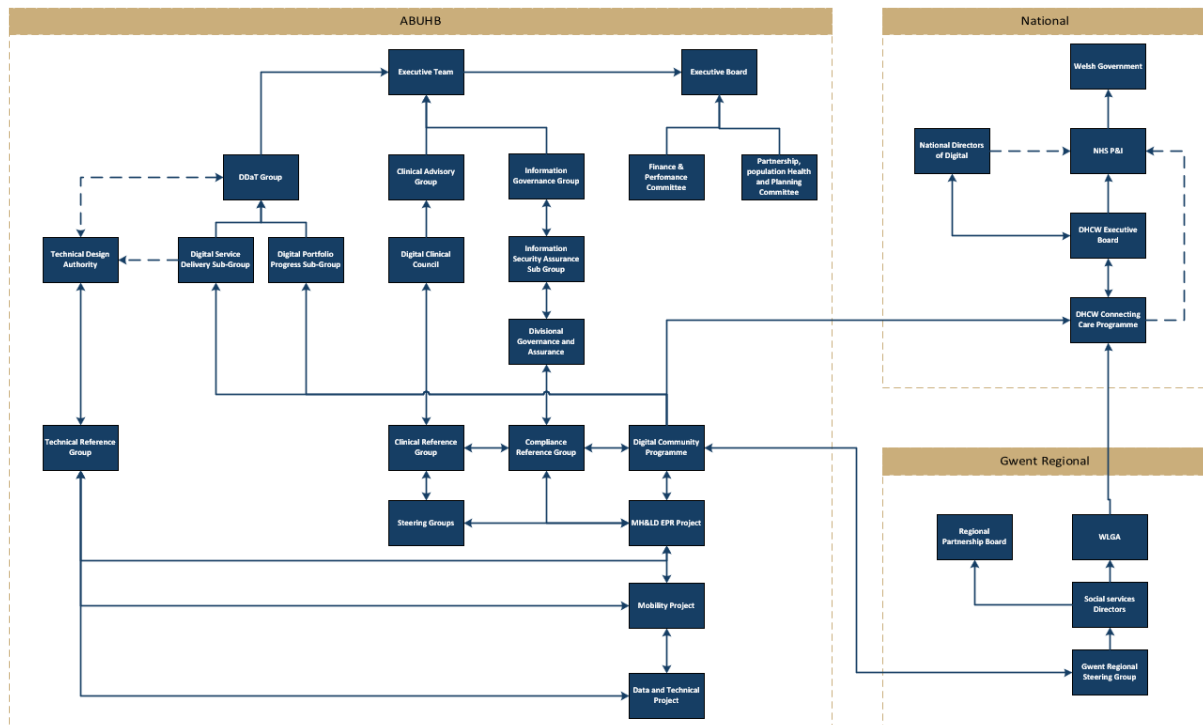
- System configuration and product delivery, including tailoring the core solution to local requirements, workflows, and care pathways through agreed build and design processes.
- Integration with local and national systems, particularly through the delivery of robust APIs, bespoke interfaces, and support for interoperability standards (e.g. FHIR, HL7, SNOMED CT).
- Support for data migration, working closely with internal teams to map, transform, and validate legacy data to ensure safe and accurate population of the new system.
- Provision of technical documentation and assurance artefacts, including architecture diagrams, safety cases, testing frameworks, and audit trails to support governance and compliance.
- Participation in collaborative testing, training, and change management activities, ensuring that the system is safe, usable, and ready for operational adoption.
- Ongoing support and service management, including incident handling, release management, and continuous improvement through a structured service level agreement (SLA).

A strong and effective partnership with the supplier is a key enabler of programme success. It requires shared accountability, clear communication, and a commitment to flexibility and problem-solving—

particularly where integration with legacy systems, bespoke configurations, or evolving clinical requirements arise.

Governance

The governance structure for the Digital Community Programme, encompasses the MH&LD EPR delivery, is designed to ensure strategic alignment, robust assurance, operational oversight, and stakeholder engagement across all levels of programme delivery. The illustration below shows a summary view of the main points of governance across the programme at a local, regional and national level.



Programme Oversight and Executive Leadership

At the apex of the Health Boards governance sits the Executive Board, supported by the Executive Team, providing corporate sponsorship and strategic alignment. The programme aligns with national direction through reporting to the DHCW National Connecting Care Programme which in turn, interfaces with Senedd structures, including the Welsh Government, NHS Performance and Innovation, and Social Services Directorate.

Core Programme Governance

The programme is governed operationally through the Health Board Digital Community Programme, led by the Health Board's DDAT Digital Senior Responsible Owner (SRO), supported by a Programme Manager, Business Change Manager, and Programme Support Officer. This structure ensures day-to-day delivery, integration of change management, and administrative governance.

Project Governance

Underneath the core programme structure lies a series of Digital Community Projects, each with its own governance arrangements:

- Mental Health and Learning Disabilities Project Board and Community Health (CH) Project Board provide oversight of respective domains.

- Project boards are supported by dedicated Senior Project Officers (SPOs) across key service areas: Mental Health and Learning Disabilities, CAMHS, Community Paediatrics (CP), Adult Mental Health (AMH), and Community Health (CH).
- Delivery is driven by Project Teams, Project Workstreams, and underlying Work Packages, enabling focused operational execution.

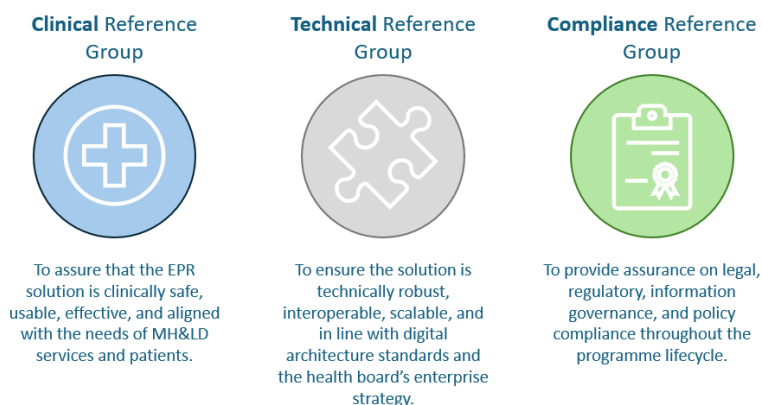
Assurance Functions

Robust assurance is provided through:

- Digital, Data and Technology (DDaT) Assurance, comprising:
 - Digital, Data and Technology Group
 - Digital Portfolio Progress Sub Group
 - Digital Service Delivery Sub Group
 - Technical Design Authority
 - DDaT Change Authority Board
 - Digital Portfolio Progress Sub Group
- These groups collaborate with enabling functions such as Cyber Security, Infrastructure Services, Information Governance, and Architecture, Design & Development to ensure compliance, risk management, and technical integrity.

Reference and Advisory Groups

Three key reference groups provide subject matter advice and expert guidance:



- Clinical Reference Group, including a Clinical Assurance Group, Clinical Council, and aligned Steering Groups, ensures clinical safety and alignment with care models.
- Organisational Assurance, encompassing domains such as Health Records, Finance, Values-Based Healthcare, Welsh Language, and Equality, Diversity & Inclusion, ensures organisational compliance and cultural alignment.
- Technical Reference Group, including areas like Software Design, Mobility Services, and Service Delivery, provides technical oversight and consistency across digital delivery.

Stakeholder Engagement

The programme is underpinned by stakeholder engagement, with input from:

- Mental Health and Learning Disabilities Service Workshops and steering groups, ensuring co-production and service user voice.
- Gwent Regional Governance, including:
 - Social Services Directors
 - Regional Steering and Operating Groups

- Shared Resource Service (SRS)
- Local Government Project Teams

These groups align the programme with the broader regional transformation agenda and integrated care models.

National Alignment

The governance structure connects with national transformation via:

- DHCW governance, including the Executive Committee and Connecting Care Programme Board
- Engagement with the Connecting Care Project Boards for Health and Social Services to ensure alignment with national programmes and interoperability standards.

Assurance

Robust, continuous, and transparent assurance is critical to the success of the Digital Community Programme. As a complex transformation initiative replacing legacy systems with strategic digital capabilities, the programme must maintain confidence among its stakeholders, particularly service users, clinicians, operational leaders, and regulatory bodies.

The Assurance Approach outlined here enables timely identification of risks, validation of progress, alignment with standards, and assurance of delivery outcomes. It is integrated across all programme layers, aligned to MSP's "Assure" principle and PRINCE2's "Continued Business Justification" and "Manage by Exception" principles, and informed by Jenner's Benefits Management methodology to ensure benefits are clearly defined, actively managed, and demonstrably realised.

Objectives

This assurance framework will:

- Provide independent and objective oversight of programme delivery and risks
- Ensure that clinical, technical, and compliance standards are met
- Validate that implementation plans are safe, achievable, and benefits-focused
- Support informed decision-making and maintain stakeholder trust
- Align programme outputs to strategic direction and national frameworks

Assurance Layers and Framework

The MH&LD EPR Programme will operate a multi-tiered assurance model, blending internal controls, stakeholder validation, and external assurance.

- **Internal Assurance** - Built into programme governance structures, delivery reporting, stage gates, and quality control processes. Led by the Programme Board and supported by PMO
- **Stakeholder Reference Group Assurance** - Provided by dedicated Clinical, Technical, and Compliance Reference Groups. These groups offer subject matter expertise, represent stakeholder communities, and validate key deliverables
- **External Assurance** - Includes national digital assurance gateways (e.g. DPIF, DHCW), internal audit, and regulatory checks (e.g. IG, cyber, clinical safety)

Key Assurance Activities

Phase	Activity	Lead Group(s)
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Discovery	Baseline clinical workflows, assess existing digital estate, identify compliance gaps	Clinical, Technical, Compliance
Procurement	Evaluate supplier responses and demos against assurance requirements	All groups
Design	Review configuration proposals, clinical pathways, architecture	Clinical, Technical
Configuration and Build	Review and agree updated workflows, dashboards, and forms	All groups
Testing	Witness acceptance testing, evaluate fail/pass criteria	Technical, Clinical
Go-Live	Contribute to Go/No-Go readiness checklists	All groups
Post-Go-Live	Validate clinical effectiveness, technical stability, compliance evidence	All groups

External Assurance

The programme will participate in external assurance activities, aligned to DPIF and Digital Assurance Framework timelines. Where applicable, the programme will commission or respond to:

- Internal Audit reviews
- NHS Wales Shared Services Procurement Assurance
- Digital Health and Care Wales (DHCW) interoperability assessments
- Digital Health and Care Wales (DHCW) data standards assessments
- Cyber Security assessments
- Independent Clinical Safety Reviews

Documentation and Reporting

All assurance-related findings and outputs will be:

- Logged in a central Assurance Register
- Presented to Programme Board with RAG status and recommendations
- Used to inform decision gates, re-baselining decisions, and change requests
- Stored in SharePoint with document control and access permissions

Outcomes and Benefits

A strong assurance framework will:

- Build confidence in programme delivery and governance
- Safeguard clinical safety and protect service users
- Align delivery with national and local strategies
- Minimise avoidable risks, delays, and costly rework
- Embed quality and compliance throughout every stage of the programme
- Provide transparent evidence of progress and value for money
- Support informed decision-making through timely insight and reporting
- Foster a culture of accountability, learning, and continuous improvement
- Ensure that intended benefits are not only achieved but sustained over time

Performance Management

To manage and measure the performance of Digital Community Programme, a structured framework that aligns with MSP and PRINCE2 principles is required, while also being tailored to the complexity and strategic goals of the organisation and transformation.

Benefits Realisation & Strategic Alignment

Focus Area	Performance Measures
Benefits tracking and realisation	% of planned benefits realised.
Alignment to strategic goals (local and national)	% of benefits realised that are linked to key strategic priorities.
Outcome measures	Aligned to delivery of benefits realisation and change plans

Clinical & Operational Adoption

Focus Area	Performance Measures
User adoption and uptake	% of users actively using the new system within X weeks of go-live
User satisfaction	Staff feedback (via survey) and training satisfaction
Clinical safety and effectiveness	Clinical users are using functionality within the system as trained such as case notes, forms
Conversion of non-digital services	Increase in adoption for users/services not currently utilising WCCIS

Programme Delivery Performance

Focus Area	Performance Measures
Delivery to time	% of milestones met within agreed timelines; deviation from baseline plan
Delivery to budget	Forecast vs actual spend by stage
Stage gate compliance	% of gateway reviews passed on first attempt
Issue & risk resolution	Number of open/high-priority risks/issues; average time to resolution
Delivery Quality	Programme delivery alignment to benefit realisation; Programme delivery alignment to change plan, Programme delivery of critical and essential criteria enabling transformational change

Technology & System Performance

Focus Area	Performance Measures
System availability and reliability	% uptime; number of unplanned outages; system performance SLAs met
Data migration quality	% of records migrated successfully, post-migration data quality audit scores. Exception management – volume and resolution rate
Interoperability success	Number of successful API/data flows with external systems (WCCIS, WCP, GP, NII, etc.)
Cybersecurity and IG compliance	Penetration test results; audit trail completeness; number of IG breaches (target: zero)

Training, Engagement & Change Readiness

Focus Area	Performance Measures
Staff training completion	% of staff trained in readiness of agreed Go Live date
Change readiness and confidence	Readiness assessment scores pre-go-live; feedback from engagement sessions

Communications effectiveness	Engagement metrics (e.g., SWAY Newsletter views, event attendance, feedback volume)
Change Acceptance management	Number of adoption concerns raised and addressed.

Programme Governance & Assurance

Focus Area	Performance Measures
Effectiveness of governance structures	Regularity and effectiveness of Clinical, Technical, Compliance & Steering Groups through meeting regularly, discussion focused and objective, attendance of core stakeholders
Decision-making efficiency	Time from issue escalation to resolution; number of deferred decisions
Assurance coverage	Relevant programme deliverables reviewed by appropriate internal/external assurance bodies, evidenced by go live assurance matrix

Sustainability & Future Readiness

Focus Area	Performance Measures
Post go-live support and service maturity	First-time fix rate; support ticket volume trends; handover quality and successful service transition
Continuous improvement pipeline	Number of improvement ideas logged, prioritised, delivered post go-live
System scalability and modularity	Ability to onboard new services, teams and users
Data insights and intelligence use	Number of users engaging with dashboards/reports; % of services using BI for planning and decision making

Success Measures

There are a range of success measures that are available to apply to the Digital Community Programme, aligned to MSP and PRINCE2 methodologies and support the programme's vision of safe transition, digital transformation, and future-proofing care delivery.

Strategic Success Measures

Success Area	Measures of Success
Strategic alignment	Programme demonstrably supports delivery against strategic objectives; local, regional and national strategic priorities
Focus on benefits	Benefits will be realised in line with the dates agreed on the benefit register
Learn from experience	Lessons captured and embedded across tranches; post-implementation review and feedback loop complete
End of life system replacement	All legacy systems decommissioned safely before March 2027 with no critical functionality lost
Future-ready foundation	Core platform has extensibility to support the ability to onboard new services, teams and users within the MH&LD services
Partnership and integration	Measurable collaboration with social care and third sector through implementation of shared care records, aligned processes, or data exchange

Clinical and Operational Success

Success Area	Measures of Success
Clinical adoption	>90% of clinical staff in-scope services actively using the system in daily practice within 3 months of go-live

Digital and Technical Success

Success Area	Measures of Success
System performance and availability	99.9% uptime post go-live; user response time under 3 seconds for key transactions
Data quality and integrity	>98% successful migration rate for priority clinical and demographic data; zero critical data loss
Cybersecurity and privacy	No major IG breaches post go-live; full compliance with local cyber policies, Successful PEN test outcomes, Remediation of PEN test failures within agreed timescales
Interoperability	Functioning APIs and data exchange methods delivered and implemented across the full extent of expected integrations.

User, Stakeholder, and Community Success

Success Area	Measures of Success
User satisfaction	>80% of staff report that the system improves their ability to deliver care (survey)
Engagement and co-design	Stakeholder groups (clinical, technical, patient/carer) are involved in all major design/decision phases.
Training and support readiness	80% of in-scope staff trained prior to go-live.
Equity and access	System supports diverse needs of MH&LD service users, including accessibility, easy-read, or assisted interface features. Tailored training will be provided for users with additional needs such as Dyslexia. Alignment to and delivery against standards set out against in WCAG 2.2
Welsh Language Standards	Alignment to and delivery against Welsh language standards as set out in the Welsh Language Act

Programme Delivery Success

Success Area	Measures of Success
Delivery to time and budget	Programme delivered within agreed tolerances of scope, time, and cost
Risk and issue containment	All high-rated risks that develop into issues are addressed or mitigated without minimal acceptable impact to go-live or safety
Governance and assurance	All programme stages successfully pass internal and external assurance (e.g., Gateway Reviews, audit checkpoints)
Stakeholder confidence	Clinical, executive, and strategic partners satisfaction with outcomes evidenced by feedback
Delivery Quality	Alignment of Programme outcomes to benefits and delivery of MVP

Innovation and Transformation Success

Success Area	Measures of Success
Enablement of new models of care	Evidence that digital tools have enabled and supported new or improved care delivery models (e.g., Single Point of Access, virtual wards, community triage)

Use of analytics and intelligence	Clinical and operational leaders use dashboards/reports for decision-making and planning
Platform extensibility within MH&LD	Capability in place for expansion to other services.
Citizen empowerment (future-facing)	Plan in place for EPR extension to patients, families and carers

Conclusion and Recommendation

Conclusions and Rationale

This Full Business Case demonstrates that the Welsh Community Care Information System (WCCIS) is no longer fit for purpose for Mental Health and Learning Disabilities (MH&LD) services. Despite significant investment, the system has failed to deliver key functionality, has become increasingly unstable, and will reach contractual and technical end-of-life in March 2027.

The risks associated with WCCIS contractual end of life are both significant and unavoidable. The Master Service Agreement (MSA) that underpins all deployment orders expires in March 2027 with no option for extension. At that point, the supplier will fully de-support and decommission the WCCIS platform. This represents a non-negotiable hard stop, after which the system will be legally and operationally unviable for ABUHB.

A decision not to invest in the proposed recommendation of this business case will result in reverting to fragmented digital and paper-based processes with increased reliance on business continuity arrangements, only intended to provide short term service delivery coverage. This would introduce unacceptable risks: compromised statutory compliance, increased clinical and operational inefficiencies, negative impact on staff morale, an overall regression in digital maturity and have a significant impact on patient experience and referral to treatment times for patients.

Staff (WCCIS users) have specifically cited concerns with the accessibility, usability and fragmentation of WCCIS, noting the risk this poses to timely decision-making, continuity of care, and patient safety. These subsequent findings reinforce the case for urgent replacement with a fit-for-purpose system that supports clinical workflows, reduces duplication, and enables safe, integrated, and timely access to information.

The case for change also evidences a growing demand and complexity in MH&LD services, alongside clear requirements to meet statutory duties under the **Mental Health Act** and the **Mental Health Measure**. The limitations of WCCIS actively hinder compliance, requiring extensive manual workarounds, retrospective data cleansing, and significant administrative effort. Without a modern replacement, compliance will remain fragile and resource intensive, putting both service delivery and regulatory assurance at risk.

By adopting The Access Group's Rio platform, Aneurin Bevan University Health Board will address these risks and unlock measurable benefits across four areas:

- **Operational efficiency:** Elimination of manual workarounds, streamlined referrals, real-time scheduling, and integrated task management will release thousands of clinical hours annually, allowing more time to spend on other clinical duties.

- **Improved data quality and statutory compliance:** Structured data capture and reporting-ready formats will enable accurate, timely monitoring of MHA, MHM and RTT standards, removing reliance on error-prone manual processes.
- **Enhanced patient engagement:** A patient portal will give patients and carers secure access to care plans, appointments, and communications, improving transparency and shared decision-making.
- **Staff experience and workforce sustainability:** A modern, mobile-enabled platform will reduce digital fatigue and support hybrid working.

The options appraisal confirms that the **procurement and implementation of Rio** offers the best balance of functionality, affordability, and sustainability. Withdrawal from WCCIS without a successor solution – managed or unmanaged – would not only compromise quality and safety but also represent a clear step backwards against both organisational and national digital strategies. The impact assessment acknowledges the **scale of transformation**, with over 2,200 users across multiple directorates affected and a significant programme of business change required. However, with phased implementation, strong clinical leadership, and robust change management, these challenges are manageable, and the benefits will be realised progressively across services.

Financial Modelling

The financial case sets out a **gross seven-year investment requirement of £10.95M with a net funding gap of £3.72m**, covering both revenue and capital - for devices, supplier costs, licences and internal resourcing. Aneurin Bevan University Health Board is a contributor to the national Connecting Care Programme business case, led by Digital Health and Care Wales, which seeks to secure Welsh Government funding. However, it is unlikely that such funding will cover the full lifetime costs of this project at this time. Consequently, the prudent assumption is that the Health Board will need to self-fund the programme in full to ensure certainty of delivery. External funding opportunities will continue to be actively pursued, but financial planning must proceed based on Health Board funding to safeguard delivery ahead of the immovable March 2027 deadline. Failure to approve and commit funding now significantly increases the risk of service disruption, operational inefficiency, and regulatory non-compliance by 2027.

Strategic Alignment

The Rio programme is fully aligned to ABUHB's strategic and national priorities:

- Supports the IMTP and 10-Year Strategy by enabling early intervention, digitally enabled community care, and improved access to sustainable services.
- Delivers on all four pillars of the ABUHB Digital Strategy, including mobile care, integrated data, modern infrastructure, and community-first models.
- Advances the ABUHB People Plan 2022–2025, providing tools that reduce burden, support flexible working, and strengthen workforce resilience.
- Enables compliance with the Mental Health and Wellbeing Strategy 2025–2035 and contributes directly to national programmes including Connecting Care and the Once for Wales digital agenda.
- Creates interoperability with regional partners through integration with Mosaic, enabling more joined-up health and social care across the Gwent region.

This confirms that the Rio EPR is not simply an IT replacement, but a strategic enabler of transformation across MH&LD services, underpinning safer, more responsive, and person-centred care in line with local, regional, and national objectives.

Recommendation

It is recommended that the Health Board:

1. **Approve this Full Business Case** and endorse the procurement and implementation of the Rio MH&LD EPR as the preferred option.
2. **Commit the necessary resources and investment** to deliver the programme at pace, ensuring safe migration ahead of hard-stop deadlines associated with definitive end-of-life of WCCIS in March 2027.
3. **Support the significant business change programme** required, recognising that successful adoption will depend on robust staff engagement, training, and clinical leadership.
4. **Mandate active monitoring of benefits realisation**, assuring measurable improvements in operational efficiency, patient safety, staff experience and compliance are achieved.

This is a critical and time-sensitive investment. Without it, the Health Board faces a hard stop in continued use of WCCIS beyond March 2027, introducing growing operational risk and deteriorating service performance. With investment, ABUHB can secure a modern, interoperable and future-ready platform that will transform MH&LD services, improve outcomes for some of the most vulnerable populations, and strengthen digital maturity across the organisation.

APPENDIX 1 – Full stakeholder analysis

Digital Community Programme - Stakeholder Analysis												
Stakeholders						Influence/Interest					Engagement	
Ref	Name/ Stakeholder Group	Organisati on	Role in Organisation	Role within Project/Programm e	Contact Details/Email	Subjec t Matter Expert (Yes/N o)	Decisi on Author ity (Yes/N o)	Level of Influen ce	Level of Inter est	Stakeholder Status	Programme/ Project Board (Yes/No)	Steering Group
	Scott Davies	ABUHB	Nurse	Senior Clinical User / Assurance	Scott.D.Davies@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	No	Yes
	Carmen Lewis	ABUHB	Occupational Therapist	Senior Clinical User / Assurance	Carmen.Lewis@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	No	Yes
	Hayley Griffiths	ABUHB	Psychologist	Senior Clinical User / Assurance	Hayley.Griffiths4@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	No	Yes
	Rahim Safeer	ABUHB	Medic	Senior Clinical User / Assurance	Rahim.Safeer@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	No	Yes
	Lorna Alcock	ABUHB	Performance and Service Improvement Manager	Divisional Senior Responsible Officer Digital	lorna.allcock@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	Yes	No
	Joanne Brown	ABUHB	Service Development Manager	Senior User	joanne.brown3@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	N	Yes
	Sara Newnes	ABUHB	MH Project Manager - Models of care Adult	Work could impact programme	Sara.Newnes@wales.nhs.uk	Yes	No	Low	Medium	KEEP INFORMED	No	No

Debra Hammett	ABUHB	Service Improvement Manager - Adult	Senior User	Debra.Hammett@wales.nhs.uk	Yes	No	Medium	High	ACTIVE CONSULTATION	No	Yes
Ruth Edwards	ABUHB	Service Improvement Manager - CAMHS	Senior User	Ruth.Edwards5@wales.nhs.uk	Yes	No	Medium	High	ACTIVE CONSULTATION	No	Yes
Kieran Sharatt	ABUHB	Business and Service Improvement Manager	Senior User	Kieran.Sharratt@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	Yes	No
Lauren Watkins	ABUHB	Service Improvement Manager - Learning Disabilities	Senior User	Lauren.Watkins7@wales.nhs.uk	Yes	No	Medium	High	ACTIVE CONSULTATION	No	Yes
Kally Richards	ABUHB	Service Improvement Manager - Older Adult	Senior User	Kally.Richards@wales.nhs.uk	Yes	No	Medium	High	ACTIVE CONSULTATION	No	Yes
Robert Callen-Davies	ABUHB	Directorate Manager PCMHSS (Primary Care Mental Health Services)	Assurance	Robert.Callen-Davies@wales.nhs.uk	Yes	Yes	Medium	High	ACTIVE CONSULTATION	No	Yes
Jade Robinson	ABUHB	Business Support Manager PCMHSS (Primary Care Mental Health Services)	Assurance	Jade.Robinson2@wales.nhs.uk	Yes	No	Medium	High	ACTIVE CONSULTATION	No	Yes
Rachel Stephens	ABUHB	Senior Management Team Administrator	Senior User	Rachael.Stephens@wales.nhs.uk	Yes	No	Medium	High	ACTIVE CONSULTATION	No	Yes
Hayley Jones	ABUHB	Performance Analyst & Information Support Officer	Senior User	Hayley.Jones5@wales.nhs.uk	Yes	No	Medium	High	ACTIVE CONSULTATION	No	Yes

	Tracey Smith	ABUHB	Interim Children's Centre Manager & Space Wellbeing Team Manager	Assurance - CAMHS Representative	Tracey.Smith5@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	Yes	No
	Janice Jenkins	ABUHB	Senior Responsible Officer (SRO)	Senior Responsible Officer	Janice.Jenkins2@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	Yes	No
	Emma Jayne Lewis	ABUHB	Directorate Manager for Therapy Services	Assurance	Emma-Jayne.Lewis@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	Yes	No
	Simon Line	ABUHB	Portfolio Manager	Portfolio Manager	Simon.Line@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	Yes	No
	Michael Pugh	ABUHB	Programme Manager	Programme Manager	Michael.Pugh@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	Yes	No
	Paul McDoanld	ABUHB	Senior Project Manager - Technical	Project manager technical	Paul.McDonald@wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	Yes	Yes
	Nadia Brooks	ABUHB	Senior Project Manager - Mobile	Project manager mobility	Nadia.Brooks@Wales.nhs.uk	Yes	Yes	High	High	KEY PLAYER	Yes	Yes
	Shane Morris-Podmore	ABUHB	Business Change Manager	Business Change and Benefits Activities	Shane.morris-podmore@wales.nhs.uk	No	Yes	High	High	KEY PLAYER	Yes	Yes
	Stacey John	ABUHB	Business Change Facilitator	Business Change and Benefits Activities	Stacey.john@wales.nhs.uk	No	No	Low	High	KEY PLAYER	Yes	Yes
	Bethan Simmonds	ABUHB	Business Change Facilitator	Business Change and Benefits Activities	Bethan.simmonds@wales.nhs.uk	No	No	Low	High	KEY PLAYER	Yes	Yes
	Anne McDonnell	ABUHB	Deputy Head of Health Records - DHR	Assurance	Anne.McDonnell@wales.nhs.uk	Yes	No	Low	Low	KEY PLAYER	Yes	No
	Rachel Hughes	ABUHB	Information	Assurance	Rachel.L.Hughes@wales.nhs.uk	Yes	No	Low	Low	ACTIVE CONSULTATION	Yes	No
	Gareth Moran	ABUHB	Head of Informatics Service Management	Assurance	Gareth.Moran@wales.nhs.uk	Yes	No	Low	Low	ACTIVE CONSULTATION	Yes	No

James Trueman	ABUHB	Health Records Service Manager	Assurance	James.Trueman@wales.nhs.uk	Yes	No	Low	Low	KEY PLAYER	Yes	No
Sarah Humphries	ABUHB	Head of Business Assurance	Procurement/ Technical requirements	Sarah.Humphries@wales.nhs.uk	Yes	No	Low	Low	ACTIVE CONSULTATION	Yes	No
Alex Sheffield	ABUHB	Programme Support Officer	Secretariat	Alex.Sheffield@wales.nhs.uk	No	No	Low	Low	KEY PLAYER	Yes	No
Samson Ossai	ABUHB	CSO	Assurance	Samson.Ossai@wales.nhs.uk	Yes	No	Low	Medium	KEY PLAYER	Yes	As required
Kelly Griffiths	ABUHB	Digital Portfolio Benefits Manager	Assurance	Kelly.Griffiths6@wales.nhs.uk	Yes	High	High	High	KEY PLAYER	Yes	No
Bryony Hope	ABUHB	Digital Change Lead	Assurance	Bryony.Hope2@Wales.nhs.uk	Yes	High	High	High	KEY PLAYER	Yes	No
Andy Warburton	ABUHB	Software Development & Enterprise Design Architect	Assurance	Andy.Warburton@wales.nhs.uk	Yes	No	Low	Low	ACTIVE CONSULTATION	Yes	No
Paul Soloway	ABUHB	Director of Digital	N/A	paul.soloway@wales.nhs.uk	Yes	Yes	High	Medium	MAINTAIN INTEREST	No	No

APPENDIX 2 - Detailed Benefits Realisation Plan

All benefits are owned by the services within Mental Health and Learning Disabilities Division and the Family and Therapies Division as identified below.

Benefit ID	Desired Objective	Benefit		Current State – Baseline	Target Future State Forecast	Timescale	Category
MHLD1	Reductions in return of referrals due to incomplete/incorrect information	<p>Teams spend a considerable amount of time managing referrals where insufficient or incorrect information is given, this requires the team to go back to the original referrer and delays the patient's journey through the referral process.</p> <p>Rio would involve mandated fields and information boxes, and the ability to eliminate paper referrals, ensuring that all pertinent information is collected first time, reducing the need for information to go back to the original referrer and reducing the delay of the patient's journey through the referral process. This will enable better quality information being captured and a potential reduction in DNA rates as decisions will be able to be made more quickly.</p>		<p>Between August 2024 and July 2025, a total of 8718 requests for further/clarification of information relating to referrals were reported.</p> <p>(We know this is an undercount, due to the status on WCCIS being changed once resolved)</p>	<p>Conservative scenario</p> <p>50% reduction in return of referrals: Approximately 4359 returned referrals would be prevented per year, with a similar number (4359) still occurring.</p>	1 Year Post Go Live	Equity
MHLD2	Reduction in administrative time due to a more efficient referral process	<p>Rio enable GP referrals (via EMIS/WCCG), internal hospital-to-community referrals via an Integrations, and referrals between Rio-using teams to feed directly into managed dashboards. Third-party referrals will continue to be added manually, with future opportunities (e.g. prison services) under consideration via Integrations.</p> <p>For PCMHSS, RPA will bridge the gap until they transition, although they will not realise the same benefits as they already have automation in place.</p> <p>Importantly, the introduction of Rio will facilitate of Single Point of Access (SPOA). This will increase the accuracy of referrals, save staff time by needing to manage separate inboxes and reduce missing referrals.</p>		<p>Time in motion studies: average time to process a referral -14 minutes</p> <p>Between July 2024-August 2025 44545 referrals were recorded excluding PCMHSS.</p> <p>Total admin time: 623,630 Minutes</p> <p>Total admin time:</p> <ul style="list-style-type: none"> 154700 Minutes 10,393 hours 50 minutes. 1,386 working days (at 7.5 hrs/day) 	<p>Elimination of 1,386 working days (at 7.5 hrs/day).</p> <p>10,393 hours 50 minutes saved across ALL teams.</p>	1 Year Post Go Live	Non-Cash Releasing Efficiency
			Total Non-Cash Release	<p>Equates to a saving of £882,956.14 over 5 years.</p> <p>Equates to a saving of 6929.2 Working days (at 7.5 hrs/day) over 5 years.</p> <p>1,386 working days (at 7.5 hrs/day) over a year.</p>			

			Saving (5 Years)	The full break down by team level is located within the benefit register. *At team level, savings range from less than half a day per month up to ten days per month. While no full FTE savings are expected, this will allow staff to reinvest time into other duties and service improvements such as supporting clinical staff, letter writing and updating key service information.			
MHLD3	Reduced delays in the processing of referrals	Patients will be ready to be triaged straight away, instead of unnecessarily sitting on lists or in email inboxes ready to be processed. This in turn will reduce the need for patients to wait unnecessarily		The overall processing of a referral from start to finish across all teams currently above 0.5 days takes 7.65 days.	Based on similar automation that has been implemented within PCMHSS recently we would expect this to reduce to 0.5 days to process a referral end to end. Meaning on average this would reduce the patient delay by 7.15 days. Across the teams currently above the 0.5 day target it averages from 0.54 to 27.75 days to process a referral therefore, for each of these areas we would expect a reduction between 0.4 to 27.25 days dependant on team. A full breakdown can be seen in the benefit register. Savings will not be seen in PCMHSS or teams currently under 0.5 days.	1 Year Post Go Live	Equity
Finding MHLD4 Documenting MHLD5	Reduction in clinical time spent finding and documenting patient information.	Clinicians currently lose valuable time navigating multiple sections within WCCIS—such as Patient and Referral screens, switching between disconnected systems to locate essential patient information. They also currently spend disproportionate amounts of time documenting care because WCCIS is not intuitive and requires an excessive number of clicks to complete tasks. By having streamlined access to information, staff will spend less time navigating the EPR and other systems to find the information that they need. Functionality such as smart banners, and intuitive search functionalities such as ‘sound like’ search will quicken the process for finding information. Rio also provides a more intuitive documentation process. The new EPR streamlines documentation through shorter, automated, and role-specific forms, enabling real-time editing and reducing duplication. Fields such as date, time, location, and author are auto populated, improving accuracy and saving time.	Finding	Time in motion studies: Comparison was completed from WCCIS, and the Rio demo Number of appointments (July2024-August 2025) - All teams 270868	Save an average of 1 minute when searching for information on a patients record per appointment Forecast of 270,868 minutes per year	1 Year post Go Live	Efficiency (Non-Cash Releasing)

			Documenting	Time in motion studies: Comparison was completed from WCCIS, and the Rio demo Number of appointments (July-August 2025) - All teams 270868	Save an average of 2 minute when documenting information on a patients record per appointment Forecast 541,736 minutes per year		
			Total		Forecast saving of 812604 minutes per year which equates to 13,543 hours 24 minutes per year		
			Total Non-Cash Release Saving (5 Years)	Equates to a saving of £1,531,081.37 over 5 year 15 Minutes saved per clinician per day (Average of 5 appointments a day) These savings relate to all in scope teams. While no full FTE savings are anticipated, the efficiencies achieved will enable staff to reinvest time into other duties and service improvements. This includes activities such for Psychology teams - Care and Treatment Planning (CTP), as well as direct clinical work for Occupational Therapy, including group sessions, Discovery Through Activity (DTA), and reporting repeating outcome measures.			
MHLD6	Improved data quality to inform reporting and forecasting - Information and Performance Team	Currently reporting through the WCCIS can be difficult due to the data not always being in the right format, place or missing entirely. This means that teams must manually cleanse the data through pulling of reports through multiple systems which is a time-consuming task. Rio will enhance the accuracy and consistency of clinical and operational data by enforcing mandatory fields at the point of entry and reducing errors. Integrated scheduling tools will improve visibility of appointments, caseloads, and service demand. Services will be able to have their own reports built into the system, reducing the reliance on information teams and increasing accuracy by having reports available to them in real time. This will strengthen reporting, support accurate forecasting, and reduce reliance on manual data correction—improving efficiency and confidence in decision-making.	Outpatient error reports	Average of 1 hour per month for collation and submission.	Forecast 25% time saving (equivalent to 15 minutes saving per month), with reports reduced from 60 minutes to 45 minutes.	1 Year Post Go Live	Efficiency (Non-Cash Releasing)
			CRHT reporting (Purely information services. The service also handles this data, but this will be explored when we have access to the system)	Average of 2 hours per month for collation and submission.	Forecast 100% time saving (equivalent to 2 hours per month).		
			Psychology	Average of 20 minutes per month.	Forecast 100% time saving (equivalent to 20 minutes per month).		

			waiting list submission					
			All other statutory reporting (including MHM Parts 1, 2 and 3, Inpatient metrics, and MAS services)	Average of 15 hours per month.	Forecast 75% time saving (equivalent to 11.25 hours per month), reducing reporting time to 3.75 hours.			
			Total	18 hours 20 minutes per month	4 hours 30 minutes per month	Forecast saving of 166 Hours per year		
			Total Non-Cash Release Saving (5 Years)	<p>Forecast saving of £28,178.50 over 5 years.</p> <p>Forecast saving of 22.13 working days per (7.5 /hr working day) across ALL teams per year</p> <p>Forecast saving of 110.66 working days over 5 years (7.5/hr working day)</p> <p>These savings relate to all in scope teams. While no full FTE savings are anticipated, the efficiencies achieved will enable staff to reinvest time into other performance related duties and service improvements.</p>				
MHLD7	Improved data quality to inform reporting and forecasting -Data Cleansing	Currently reporting through WCCIS can be difficult due to the data not always being in the right format, place or missing entirely. This means that teams must manually cleanse the data through pulling of reports through multiple systems which is a time-consuming task.	Outpatient Referral Error	Average of 9 Minutes per error April 2024 – March 2025	Outpatient errors reduce by 25% → 4,691 minutes (78.2 hours) per year		1 Year Post Go Live	Efficiency (Non-Cash Releasing)
			Admitted Patient Care Errors	Admitted patient care errors: 142 errors × 9 min = 1,278 minutes	Admitted patient care errors reduce by 25% → 320 minutes (5.3 hours) per year			

		Rio will enhance the accuracy and consistency of clinical and operational data by enforcing mandatory fields at the point of entry and reducing errors. Integrated scheduling tools will improve visibility of appointments, caseloads, and service demand. Services will be able to have their own reports built into the system, reducing the reliance on information teams and increasing accuracy by having reports available to them in real time. This will strengthen reporting, support accurate forecasting, and reduce reliance on manual data correction—improving efficiency and confidence in decision-making.	<table border="1"> <tr> <td>ICD10 Errors</td> <td>ICD-10 errors: 631 errors × 9 min = 5,679 minutes</td> <td>ICD-10 (inpatient discharges) eliminated entirely → 5,679 minutes (94.7 hours) per year</td> </tr> <tr> <td>Total</td> <td>Total: 25,722 minutes per year</td> <td>Total: 10,690 minutes per year = 178.16 hours = 23.75 working days</td> </tr> <tr> <td>Total Non-Cash Release Saving (5 Years)</td> <td colspan="2"> ~890.8 hours (118.8 working days) £30,243.08 Estimated at 23.752 Working days per year saving across all teams per year These savings relate to all in scope teams. While no full FTE savings are anticipated, the efficiencies achieved will enable staff to reinvest time into other performance related duties and service improvements. </td> </tr> </table>	ICD10 Errors	ICD-10 errors: 631 errors × 9 min = 5,679 minutes	ICD-10 (inpatient discharges) eliminated entirely → 5,679 minutes (94.7 hours) per year	Total	Total: 25,722 minutes per year	Total: 10,690 minutes per year = 178.16 hours = 23.75 working days	Total Non-Cash Release Saving (5 Years)	~890.8 hours (118.8 working days) £30,243.08 Estimated at 23.752 Working days per year saving across all teams per year These savings relate to all in scope teams. While no full FTE savings are anticipated, the efficiencies achieved will enable staff to reinvest time into other performance related duties and service improvements.			
ICD10 Errors	ICD-10 errors: 631 errors × 9 min = 5,679 minutes	ICD-10 (inpatient discharges) eliminated entirely → 5,679 minutes (94.7 hours) per year												
Total	Total: 25,722 minutes per year	Total: 10,690 minutes per year = 178.16 hours = 23.75 working days												
Total Non-Cash Release Saving (5 Years)	~890.8 hours (118.8 working days) £30,243.08 Estimated at 23.752 Working days per year saving across all teams per year These savings relate to all in scope teams. While no full FTE savings are anticipated, the efficiencies achieved will enable staff to reinvest time into other performance related duties and service improvements.													
MHLD8	Patients being seen in a timely manner leading a maintenance of compliance with part 1 of the Mental Health Measure (RTT)	Due of the new functionality surrounding data quality and processing, Rio will ensure referrals are ready to be triaged immediately, reducing unnecessary delays for patients. This will improve patient experience as they will be seen more promptly and will enable compliance scores to be maintained, without the extra manual work which needs to be undertaken currently to achieve this. The work needed to report compliance includes -		<p>Currently the average compliance rate for Part 1a within the service for August 2024 to July 2025</p> <p>Adults 82.6%</p> <p>Children and Young People 92.3%</p>	Reporting improvements would mean a maintenance to compliance of at least 80% without the extra manual interventions.	1 Year Post Go Live	Effective							
MHLD9	Increase in ability to monitor and track care coordination outcomes resulting in maintaining compliance with part 2 of the Mental Health Measure.	Tracking care coordination in WCCIS is difficult due to the absence of live dashboards, lack of alerts, and the reliance on complex reporting methods to obtain accurate compliance data. The new functionality within Rio, including alert and trigger management of care plans and enhanced dashboards, will ensure that care plans are created and recorded promptly. This will mean patients receive the right support at the right time, improving the quality and consistency of their care. In turn, this is expected to drive an increase in compliance with Part 2 of the Mental Health Measure, ensuring patients experience more timely, coordinated, and person-centred care		Currently the average compliance for part 2 within all services for August 2024 to July 2025 is 78.4%.	compliance is expected to consistently reach the national target of 90%. Additionally, we would expect this level of performance to be sustained more efficiently through a reduced reliance on manual data cleansing.	1 Year Post Go Live	Effective							
MHLD10	Increased visibility of appointments booked leading to reduction in patients being	Current scheduling is fragmented, with staff relying on paper diaries and disconnected systems, leading to no visibility on whether patients are being seen in accordance with timelines until after the fact.		Currently 42.7% are recorded afterwards (reflecting retrospective documentation or delays in scheduling).	We anticipate that appointments created before the date will increase to 75%, with after-date recording reducing to 25%. *	1 Year Post Outlook Integration	Effective							

	missed and not being seen in a timely manner.	Rio will streamline scheduling through integrated digital calendars and Outlook sync, reducing duplication and improving visibility of availability.		This is driven by staff relying on multiple, disconnected systems: 35% use one method, 31% use two, and 24% use three (most commonly Outlook, WCCIS, and paper diaries). This duplication contributes directly to inefficiency and retrospective entry.	*Please note, for specific teams such as crisis there will always be a need to add appointments and documentation retrospectively this has been considered within our forecasting.		
MHLD11	Timely access to information when in the community due to the ability to update and view information in real time	<p>Access to up-to-date clinical information is essential for safe, effective care—particularly in fast-paced community and inpatient settings. Currently, staff face delays due to limited mobile access, poor connectivity, and device compatibility issues. This leads to duplicated effort, delayed decision-making, and increased clinical risk.</p> <p>Rio will enable real-time access and documentation at the point of care, with mobile-optimised features, offline access, and improved compatibility. Clinicians will be able to view and update records instantly, reducing administrative burden and improving the safety, continuity, and quality of care.</p>		<p>Mobility Survey sent to all clinicians who deliver care in the community</p> <p>Older Adult</p> <p>63.6% of respondents report occasionally needing to contact an office.</p> <p>31.8% report this occurs often, and a further</p> <p>4.5% always do.</p> <p>No respondents reported never needing to contact an office.</p> <p>Adult Services</p> <p>A combined 84.9% of staff reported occasionally (60.6%) or often (15.2%) needing to contact an office, with an additional 9.1% reporting always.</p> <p>Only 15.2% said they never needed to.</p>	<p>Staff report that they need to contact an office less frequently for information relating to patient care.</p> <p>It is expected that there may be times where contact with an office may be required for a specific patient case so this will only be reduced rather than eliminated entirely.</p>	1 Year Post Go Live	Timely

				<p>Learning Disability</p> <p>61.5% of clinicians reported occasionally needing to contact the office, with 15.4% stating often.</p> <p>Only 23.1% said they never needed to, and none reported always.</p> <p>CAMHS</p> <p>62.5% said they occasionally need to contact an office, with 21.9% reporting this often.</p> <p>Only 15.6% of respondents said never.</p> <p>No respondents reported always.</p> <p>Child Psychology</p> <p>64.3% reported occasional need to contact the office, and 35.7% said never.</p> <p>No respondents reported often or always.</p>			
MHLD12	Increase in patient and staff safety	Patient and staff safety is currently impacted by limited access to key information—such as risk alerts, safeguarding concerns, and allergy warnings—when working in the community. Clinicians often rely on memory, paper notes, or calls to base, leading to delays and increased risk of error.		<p>Mobility Survey</p> <p>Question - As a clinician, when working in the community, do you feel that you have access to</p>	Staff report that they have better access to sufficient information or alerts to support safe clinical decision-making less frequently for information relating to patient care.	1 Year Post Go Live	Safety

		RIO will improve safety by providing real-time, secure access to essential clinical information and alerts at the point of care. Staff will be able to view risk history, legal status, and care plans from any location, supporting safer, more informed decision-making.		sufficient information or alerts to support safe clinical decision-making (e.g., risk, allergy warnings, safeguarding concerns), whether through WCCIS or other means? 44% of respondents reported having sufficient access to critical clinical information always or most of the time, while 56% indicated inconsistent or limited access ('sometimes', 'rarely', or 'never')			
MHLD13	Improved staff experience by enabling staff to work in a hybrid way of working	The introduction of Rio will support hybrid working through offline capability and SIM-enabled devices, enabling staff to document care at the point of delivery. This will improve work-life balance and enhance job satisfaction and retention.		Mobility Survey During a mobility survey, 16.7% of staff said they started their working day at home. During a mobility survey, 17.7% of staff said they ended their working day at home.	Staff report an increase of in being able to start their working day and end their working day at home	1 Year Post Go Live	Staff Experience
MHLD14	Increased proportion of clinical time spent with patients	Clinicians currently spend a significant proportion of their time completing administrative tasks. This reduces the time available for direct patient care and face-to-face interaction – a critical factor in delivering safe, effective, and compassionate care. Rio will reduce time spent on administration. These efficiencies will enable clinicians to dedicate more time to engaging with patients, building therapeutic relationships, and delivering more personalised, responsive care. Over time, this will improve patient experience.		Baseline – Post Rio rollout	Staff report an improvement in the amount and quality of time they can spend with patients following implementation of Rio.	1 Year Post Go Live	Patient Experience
MHLD15	Increase in patient engagement and involvement in their care	The current WCCIS system offers no patient portal or digital access. RIO will introduce a dedicated portal, allowing patients to view appointments, access care plans, receive updates, and securely message their care team.		Civica person centred and Peoples Experience Survey	Patients report that they more frequently have a better experience with the service.	1 Year Post Portal integration	Patient Experience

		This functionality will support greater transparency, empower patients to engage in their care, and improve treatment adherence—especially for those with long-term or complex needs. It aligns with national priorities around digital inclusion and person-centred care.		Primary Care Mental Health Overall score 80 Adult Mental Health and Specialist Services Overall Score 75			
MHLD16	Increase in patient experience	Rio will improve patient experience by enabling more personalised, coordinated, and accessible care. Features such as a dedicated patient portal, real-time appointment visibility, and improved care plan access will empower patients and carers to play a more active role in their care. Clinicians will have faster access to relevant information, reducing delays, improving continuity, and enabling more responsive support. These enhancements will reduce frustration, increase transparency, and support shared decision-making, particularly for individuals with long-term or complex needs		Civica person centred and Peoples Experience Survey Primary Care Mental Health Overall score 80 Adult Mental Health and Specialist Services Overall Score 75	Patients report that they more frequently have a better experience with the service.	1 Year Post Go Live	Patient Experience
MHLD17	Better staff experience by more efficient management of workload	Staff currently spend a disproportionate amount of time on administrative tasks due to inefficient systems, duplicated processes, and poor usability. This contributes to increased workload pressure, frustration, and reduced job satisfaction. Rio will streamline clinical workflows, reduce duplication, and improve access to information, allowing staff to manage their workload more efficiently. By freeing up time and simplifying daily tasks, the system will support a more positive working environment, improve staff wellbeing, and contribute to better retention and morale.		ABUHB Wellbeing Survey 2024 'On Average, how many additional unpaid hours do you work per week for this organisation, over and above your contracted hours' CAMHS 0 Hours – 30% Up to 5 Hours – 56.7% 6-10 Hours – 10% 11 or more hours – 3.3% MHLD 0 Hours – 44.2% Up to 5 Hours – 40.5%	Staff will report that they do less unpaid overtime	1 Year Post Go Live	Staff Experience

				6-10 Hours – 9.2%			
				11 or more hours – 6.1%			

APPENDIX 3 - Financial Schedule

The finances included in the below tables set out the projected investment costs required to acquire, implement, deploy and maintain the proposed RIO solution for both the life expectancy the minimum contract period as well as continued product team delivery up to the maximum life of the contract.

Notes

1. All costs and budgets are baselined against the 2025/2026 financial year.
2. Year on year staff costs are inclusive of what is considered an average uplift of **3.5%** as recommended for use in budget planning.
3. Year on year staff costs are compounded over the 7 years of the business case, utilising the previous years' salary as the baseline for the **3.5%** uplift.
4. All forecasted staff costs for future years have been baselined utilising the Health Boards default of mid-point salaries taken from the 2025/2026 AfC pay scales, inclusive of pay award uplift.
5. System costs for the future MH&LD EPR platform have been indexed year on year at an average of **8.0%** as informed by market research to establish a realistic average.
6. The current costs for the regional team are currently included in the budget allocated to the existing cost centre for the WCCIS programme. For the purposes of this business case the regional team are out of scope and as such have removed from all costs and associated budgets adjusted accordingly.
7. Costs for Year 1 (2025/2026 FYE) have been reflected as pro rata costs for 4 months of the full year. This is to reflect that the incurring of costs is not expected to commence until December 2025, post business case approval and contract commencement.

Appendix 3a – Implementation Cost Summary

Cost summary	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	Totals
	£'s	£'s	£'s	£'s	£'s	£'s	£'s	£'s
Revenue Costs								
Staff	286,808	1,379,045	1,127,656	730,409	210,301	217,661	225,279	4,177,159
Non-Staff	54,820	159,670	153,670	153,670	153,670	153,670	153,670	982,840
RIO Licence, support & Maintenance	209,269	556,014	571,206	557,827	572,553	587,825	603,174	3,657,868
RIO Implementation and Delivery	191,275	382,550	0	0	0	0	0	573,825
RIO Integration Costs	0	115,000	115,000	0	0	0	0	230,000
WCCIS System Costs	99,601	322,707	0	0	0	0	0	422,308
Sub Total	841,773	2,914,986	1,967,532	1,441,905	936,523	959,157	982,124	10,044,000
Capital Costs								
Hardware (Devices)	757,810	147,900	0	0	0	0	0	905,710
Sub Total	757,810	147,900	0	0	0	0	0	905,710
Income / Budget								
External Funding (Revenue)	870,034	0	0	0	0	0	0	870,034
External Funding (Capital)	757,810	0	0	0	0	0	0	757,810
Existing Budget	293,861	904,177	879,084	879,833	880,609	881,411	882,242	5,601,216
Sub Total	1,921,705	904,177	879,084	879,833	880,609	881,411	882,242	7,229,060
Savings								
Benefits	0	0	0	0	0	0	0	0
Sub Total	0	0	0	0	0	0	0	0
Total (Rev + Cap – Income - Savings)	-322,122	2,158,710	1,088,448	562,072	55,915	77,745	99,882	3,720,650

Appendix 3b – Investment Breakdown Summary

Cost summary	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	TOTALS
	£'s	£'s	£'s	£'s	£'s	£'s	£'s	£'s
ABUHB Revenue Funding	-322,122	2,010,810	1,088,448	562,072	55,915	77,745	99,882	3,572,750
WG Revenue Funding	870,034	0	0	0	0	0	0	870,034
ABUHB Capital Funding	0	147,900	0	0	0	0	0	147,900
WG Capital Funding	757,810	0	0	0	0	0	0	757,810
Total	1,305,722	2,158,710	1,088,448	562,072	55,915	77,745	99,882	5,348,494

Appendix 3c – Full Investment Breakdown

Revenue (£'s)	Position details			Future Costs								Notes / Comments
	WTE	Fixed Term / Permanent	Band / Scale	Year 1 - FYE (2025/2026)	Year 2 - FYE (2026/2027)	Year 3 - FYE (2027/2028)	Year 4 - FYE (2028/2029)	Year 5 - FYE (2029/2030)	Year 6 - FYE (2030/2031)	Year 7 - FYE (2031/2032)	Total	
(A) Pay Costs												
Programme Manager	1.00	Permanent	8a	25,448	79,016	81,782	84,644	0	0	0	270,890	Existing permanent / establishment staff covered under WCCIS budget 8096)
Programme Support Officer	1.00	Permanent	5	14,466	44,918	46,490	48,117	0	0	0	153,992	Existing permanent / establishment staff covered under WCCIS budget 8096)
Business Change Manager	1.00	Permanent	7	21,842	67,818	70,192	72,649	0	0	0	232,501	Existing permanent / establishment staff covered under WCCIS budget 8096)
Business Change Facilitator	1.00	Permanent	6	17,689	54,925	56,848	58,837	0	0	0	188,300	Existing permanent / establishment staff covered under WCCIS budget 8096)
Business Change Facilitator	1.00	Permanent	6	17,689	54,925	56,848	58,837	0	0	0	188,300	Existing permanent / establishment staff covered under WCCIS budget 8096)
Senior Project Manager - MH&LD	1.00	Permanent	7	21,842	67,818	70,192	72,649	0	0	0	232,501	Existing permanent / establishment staff covered under WCCIS budget 8096)
Senior Project Manager - Technical Delivery	1.00	Permanent	7	21,842	67,818	70,192	72,649	0	0	0	232,501	Existing permanent / establishment staff covered under WCCIS budget 8096)
Project Manager - Mobility	1.00	Permanent	6	17,689	54,925	56,848	58,837	0	0	0	188,300	Existing permanent / establishment staff covered under WCCIS budget 8096)
Project Manager - Technical Delivery	1.00	Fixed Term to April 2026 to March 2028	6	8,845	54,925	56,848	0	0	0	0	120,618	New post. To Be recruited.
Senior Clinical User_ Medic - MH&LD	0.20	Fixed Term to March 2028	8c	7,126	22,126	22,900	0	0	0	0	52,152	Existing permanent / establishment staff covered under WCCIS budget 8096)
Senior Clinical User_ Senior Nurse - MH&LD (All Services)	0.20	Fixed Term to March 2028	7	4,368	13,564	14,038	0	0	0	0	31,970	Existing permanent / establishment staff covered under WCCIS budget 8096)
Senior Clinical User_ OT - MH&LD	0.20	Fixed Term to March 2028	7	4,368	13,564	14,038	0	0	0	0	31,970	Existing permanent / establishment staff covered under WCCIS budget 8096)
Senior Clinical User_ Psychologist - MH&LD	0.20	Fixed Term to March 2028	8b	5,981	18,571	19,221	0	0	0	0	43,773	Existing permanent / establishment staff covered under WCCIS budget 8096)
Senior Clinical User_ F&T Nursing	0.20	Fixed Term to March 2028	7	4,368	13,564	14,038	0	0	0	0	31,970	New post. To Be recruited.
System Manager (RIO)	1.00	Permanent	6	0	54,925	56,848	58,837	60,897	63,028	65,234	359,770	New post. To Be recruited.
Product Specialist (RIO)	1.00	Permanent	5	0	44,918	46,490	48,117	49,801	51,544	53,348	294,220	New posts. To Be recruited.
Product Specialist (RIO)	1.00	Permanent	5	0	44,918	46,490	48,117	49,801	51,544	53,348	294,220	New posts. To Be recruited.
Product Specialist (RIO)	1.00	Permanent	5	0	44,918	46,490	48,117	49,801	51,544	53,348	294,220	New posts. To Be recruited.
Trainers	1.00	Fixed Term to April 2026 to March 2028	4	0	40,378	41,792	0	0	0	0	82,170	New posts. To Be recruited.
Trainers	1.00	Fixed Term to April 2026 to March 2028	4	0	40,378	41,792	0	0	0	0	82,170	New posts. To Be recruited.

Trainers	1.00	Fixed Term to April 2026 to March 2028	4	0	40,378	41,792	0	0	0	0	82,170	New posts. To Be recruited.
Trainers	1.00	Fixed Term to April 2026 to March 2028	4	0	40,378	41,792	0	0	0	0	82,170	New posts. To Be recruited.
Desktop Services Technician	1.00	Fixed Term to April 2026 to March 2027	5	14,466	44,918	0	0	0	0	0	59,384	New post. To Be recruited.
Information Officer	1.00	Fixed Term to April 2026 to March 2028	6	0	54,925	56,848	0	0	0	0	111,773	New post. To Be recruited.
Information Officer	1.00	Fixed Term to April 2026 to March 2028	6	0	54,925	56,848	0	0	0	0	111,773	New posts. To Be recruited.
System Manager (WCCIS)	1.00	Permanent	6	17,689	54,925	0	0	0	0	0	72,615	Existing permanent / establishment staff covered under WCCIS budget 8096). Staff not required from 2027/2028 following decommission of WCCIS
System Manager (WCCIS)	1.00	Permanent	6	17,689	54,925	0	0	0	0	0	72,615	Existing permanent / establishment staff covered under WCCIS budget 8096). Staff not required from 2027/2028 following decommission of WCCIS
Product Specialist (WCCIS)	1.00	Permanent	5	14,466	44,918	0	0	0	0	0	59,384	Existing permanent / establishment staff covered under WCCIS budget 8096). Staff not required from 2027/2028 following decommission of WCCIS
Product Specialist (WCCIS)	1.00	Permanent	5	14,466	44,918	0	0	0	0	0	59,384	Existing permanent / establishment staff covered under WCCIS budget 8096). Staff not required from 2027/2028 following decommission of WCCIS
Product Specialist (WCCIS)	1.00	Permanent	5	14,466	44,918	0	0	0	0	0	59,384	Existing permanent / establishment staff covered under WCCIS budget 8096). Staff not required from 2027/2028 following decommission of WCCIS
Total Pay	26.00			286,808	1,379,045	1,127,656	730,409	210,301	217,661	225,279	4,177,159	
(B) Non- Pay Costs				Year 1 - FYE (2025/2026)	Year 2 - FYE (2026/2027)	Year 3 - FYE (2027/2028)	Year 4 - FYE (2028/2029)	Year 5 - FYE (2029/2030)	Year 6 - FYE (2030/2031)	Year 7 - FYE (2031/2032)	Total	Notes / Comments
Mobile SIMS				47,820	152,670	152,670	152,670	152,670	152,670	152,670	963,840	Increase in data SIM costs to account for increased user numbers and increased data SIM contract costs for required data packages.
Marketing, Promotion & Training				5,000	5,000	0	0	0	0	0	10,000	Costs of training, marketing and promotion activities and materials.
Travel & Subsistence				2,000	2,000	1,000	1,000	1,000	1,000	1,000	9,000	Increase on current budget for the first two years due to forecasted increase in staff activity, resulting in additional claims.

RIO System – Licensing, Support & Maintenance				209,269	556,014	571,206	557,827	572,553	587,825	603,174	3,657,868	Annualised RIO costs submitted in the suppliers commercial bid.
RIO System - ABUHB Implementation & Delivery				191,275	382,550	0	0	0	0	0	573,825	One off implementation costs spanning financials years 25/26 and 26/27
RIO System - Integration costs				0	115,000	115,000	0	0	0	0	230,000	One off integration costs associated with key deliverables, profiled over the two year implementation window 26/27 to 27/28
WCCIS Annual Licensing, Support & Maintenance				99,601	322,707	0	0	0	0	0	422,308	Costs of WCCIS to the end of contract in March 2027. Represents the double handling of costs for the provision of MH&LD EPR solutions.
Total Non -Pay				554,965	1,535,941	839,876	711,497	726,223	741,495	756,844	5,866,841	
Total Gross Future Costs (A+B)				841,773	2,914,986	1,967,532	1,441,905	936,523	959,157	982,124	10,044,000	
(C) Income / Funding / Available Budget				Year 1 - FYE (2025/2026)	Year 2 - FYE (2026/2027)	Year 3 - FYE (2027/2028)	Year 4 - FYE (2028/2029)	Year 5 - FYE (2029/2030)	Year 6 - FYE (2030/2031)	Year 7 - FYE (2031/2032)	Total	Notes / Comments
Funding - DHCW National Business Case (Revenue)				870,034	0	0	0	0	0	0	870,034	Guaranteed funding from national DHCW OBC only currently allocated for 25/26 FY.
Budget - Current WCCIS Revenue - Pay (8096)				196,981	590,942	590,942	590,942	590,942	590,942	590,942	3,742,633	Current £210k RIF funding only for 2025/2026. Future budget reduced by £210k to reflect lack of guarantees around further funding.
Budget - Current WCCIS Revenue - Non-Pay (8096)				16,500	49,500	49,500	49,500	49,500	49,500	49,500	313,500	This is the current budget on 8096 for data SIMS and travel and subsistence. £48.5k SIMS and £1k T&S
Budget - Current WCCIS - System (8224)				72,412	217,235	217,235	217,235	217,235	217,235	217,235	1,375,822	This is the current budget on 8224 for the existing WCCIS system
3.5% Assumed Pay Award - 8096 Pay Budget (compound)				0	20,683	21,407	22,156	22,932	23,734	24,565	135,477	These have been added in as future budget that will be allocated to cover increases in staff pay in line with cost of living
8% Assumed Indexation for WCCIS Systems costs (compound)				7,968	25,817	0	0	0	0	0	33,785	These have been added in as future budget to provide coverage for system uplift costs in line with contract indexation.
Total Future Income (C)				1,163,895	904,177	879,084	879,833	880,609	881,411	882,242	6,471,250	
Net Future Costs (A+B-C)				-322,122	2,010,810	1,088,448	562,072	55,915	77,745	99,882	3,572,750	

(D) Savings				Year 1 - FYE (2025/2026)	Year 2 - FYE (2026/2027)	Year 3 - FYE (2027/2028)	Year 4 - FYE (2028/2029)	Year 5 - FYE (2029/2030)	Year 6 - FYE (2030/2031)	Year 7 - FYE (2031/2032)	Total	Notes / Comments
Benefits (Cash Releasing)				0	0	0	0	0	0	0	0	There are no identifiable cash releasing benefits
Benefits (Cost Avoidance)				0	0	0	0	0	0	0	0	There are no identifiable cost avoidance benefits
Total Savings (D)				0	0	0	0	0	0	0	0	
Total Net Future Costs (A+B-C-D)				-322,122	2,010,810	1,088,448	562,072	55,915	77,745	99,882	3,572,750	

CAPITAL (£'s)	Year 1 - FYE (2025/2026)	Year 2 - FYE (2026/2027)	Year 3 - FYE (2027/2028)	Year 4 - FYE (2028/2029)	Year 5 - FYE (2029/2030)	Year 6 - FYE (2030/2031)	Year 7 - FYE (2031/2032)	Total
Capital Costs								
Hardware & Devices (Laptops & Tablets for 797 staff)	757,810	147,900	0	0	0	0	0	905,710
Total Costs	757,810	147,900	0	0	0	0	0	905,710
Capital Income								
DHCW National Funding (Capital)	757,810	0	0	0	0	0	0	757,810
ABUHB Capital Funding	0	147,900	0	0	0	0	0	147,900
Total Income	757,810	147,900	0	0	0	0	0	905,710
Total Net Costs (Costs – Income)	0	0	0	0	0	0	0	0

Revenue Profile Year 1 (£'s) – 2025/26

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Pay Spend (+)	0	0	0	0	0	0	0	0	71,702	71,702	71,702	71,702	286,808
Non Pay Spend (+)	0	0	0	0	0	0	0	0	138,741	138,741	138,741	138,741	554,965
Income (-)	0	0	0	0	0	0	0	0	290,973	290,973	290,973	290,973	1,163,895
Savings (-)	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Revenue Expenditure	0	0	0	0	0	0	0	0	-75,006	-75,006	-75,006	-75,006	-322,122

Capital Profile Year 1 (£'s) – 2025/26

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
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Pay Spend (+)	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Pay Spend (+)	0	0	0	0	0	0	0	0	0	0	0	757,810	757,810
Income (-)	0	0	0	0	0	0	0	0	0	0	0	757,810	757,810
Savings (-)	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Capital Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0

Appendix 3d – Product Delivery Team

Revenue (£'s)	Position details			Future Costs						
(A) Pay Costs	WTE	Fixed Term / Permanent	Band / Scale	Year 8 - FYE (2032/2033)	Year 9 - FYE (2033/2034)	Year 10 - FYE (2034/2035)	Year 11 - FYE (2035/2036)	Year 12 - FYE (2036/2037)	Total	Notes / Comments
System Manager (RIO)	1	Permanent	6	67,517	69,880	72,326	74,858	77,478	362,059	New post. To Be recruited.
Product Specialist (RIO)	3	Permanent	5	165,647	171,445	177,445	183,656	190,084	888,276	New posts. To Be recruited.
Total Pay	24			233,164	241,325	249,771	258,513	267,561	1,250,335	

Appendix 3e – Ongoing RIO Costs (Optional Extensions)

Revenue (£'s)			Future Costs						
(A) Non- Pay Costs			Year 8 - FYE (2032/2033)	Year 9 - FYE (2033/2034)	Year 10 - FYE (2034/2035)	Year 11 - FYE (2035/2036)	Year 12 - FYE (2036/2037)	Total	Notes / Comments
RIO Licence, support & Maintenance			619,077	635,302	652,325	668,633	685,349	3,260,687	Ongoing system costs for period of optional extensions
Total Pay	23.8		619,077	635,302	652,325	668,633	685,349	3,260,687	

Appendix 3f – Depreciation of Capital Assets

Depreciation summary	25/26	26/27	27/28	28/29	29/30	30/31	31/32
	£'s	£'s	£'s	£'s	£'s	£'s	£'s
Initial Purchase Costs	757,810	147,900	0	0	0	0	
Depreciation							
25/26	50,521	0	0	0	0	0	0
26/27	151,562	29,580	0	0	0	0	0
27/28	151,562	29,580	0	0	0	0	0
28/29	151,562	29,580	0	0	0	0	0
29/30	151,562	29,580	0	0	0	0	0
30/31	101,041	29,580	0	0	0	0	0
31/32	0	0	0	0	0	0	0
Revised Total	757,810	147,900	0	0	0	0	0

APPENDIX 4 – Resourcing Impacts

Grouping	Role	Fixed Term / Permanent	Direct / Indirect costs	Est / Prog	WTE	NHS Banding
Programme & Project Delivery	Programme Manager	Permanent	Direct	Establishment	1.00	8a
	Programme Support Officer	Permanent	Direct	Establishment	1.00	5
	Business Change Manager	Permanent	Direct	Establishment	1.00	7
	Business Change Facilitator	Permanent	Direct	Establishment	2.00	6
	Senior Project Manager - MH&LD	Permanent	Direct	Establishment	1.00	7
	Senior Project Manager - Technical Delivery	Permanent	Direct	Establishment	1.00	7
	Project Implementation Manager - MH&LD Support / Mobility	Permanent	Direct	Establishment	1.00	6
	Project Implementation Manager - Technical Delivery Support	Fixed Term	Direct	Programme	1.00	6
	Senior Responsible Owner	Fixed Term	Direct	Programme	0.10	8d
	Senior Product Owner - MH&LD (CAMHS)	Fixed Term	Indirect	Establishment	0.20	8a
	Senior Product Owner - MH&LD (Child Psychology)	Fixed Term	Indirect	Establishment	0.20	8a
	Senior Product Owner - MH&LD (Adults / Inpatients / PCMHSS)	Fixed Term	Indirect	Establishment	0.20	8a
Senior Product Owner - MH&LD (AHP)	Fixed Term	Indirect	Establishment	0.20	8a	
Totals					9.90	
Clinical Reference Group	Senior Clinical User_ Medic - MH&LD	Fixed Term	Direct	Programme	0.20	8c
	Senior Clinical User_ Senior Nurse - MH&LD (All Services)	Fixed Term	Direct	Programme	0.20	7
	Senior Clinical User_ OT - MH&LD	Fixed Term	Direct	Programme	0.20	7
	Senior Clinical User_ Psychologist - MH&LD	Fixed Term	Direct	Programme	0.20	8b
	CxIO	Fixed Term	Indirect	Establishment	0.05	8c
	CCIO	Fixed Term	Indirect	Establishment	0.05	8c
	CSO	Fixed Term	Indirect	Establishment	0.10	7
Totals					1.00	
Product Support & Delivery Team	System Manager	Fixed Term	Direct	Establishment	1.00	6
	Product Specialist	Fixed Term	Direct	Establishment	3.00	5
	Trainer / Tester	Fixed Term	Direct	Programme	4.00	4
	Mobility Technician	Fixed Term	Indirect	Establishment	0.20	4
	Desktop Services Technician	Fixed Term	Indirect	Establishment	1.00	4
	Information Officer	Fixed Term	Direct	Establishment	2.00	6
	SD - Functional Analyst	Fixed Term	Indirect	Establishment	0.40	6
	SD - Lead Developer	Fixed Term	Indirect	Establishment	0.40	7
	SD - Senior Developer	Fixed Term	Indirect	Establishment	0.40	6
	SD - Lead Test Analyst	Fixed Term	Indirect	Establishment	0.40	7
	SD - Senior Test Analyst	Fixed Term	Indirect	Establishment	0.40	6
Totals					12.00	
Technical Reference Group	SD - Design & Architect Lead	Fixed Term	Indirect	Establishment	0.20	8a
	Mobility Analyst	Fixed Term	Indirect	Establishment	0.10	7
	Desktop Services Analyst	Fixed Term	Indirect	Establishment	0.10	7
	Information Services Lead	Fixed Term	Indirect	Establishment	0.10	8a
	Infrastructure Analyst	Fixed Term	Indirect	Establishment	0.10	8a
	IG Lead	Fixed Term	Indirect	Establishment	0.10	8a
	Cyber Lead	Fixed Term	Indirect	Establishment	0.05	7
	Service Management Lead	Fixed Term	Indirect	Establishment	0.10	8b
Totals					0.85	
Compliance Reference Group	Commercial Team (Procurement & Legal)	Fixed Term	Indirect	Establishment	0.40	8a
	Commercial Team (Finance)	Fixed Term	Indirect	Establishment	0.10	6
	Welsh Language	Fixed Term	Indirect	Establishment	0.05	5
	Equality Assurance	Fixed Term	Indirect	Establishment	0.05	7
	Health Records Assurance	Fixed Term	Indirect	Establishment	0.10	7
	Value Based Healthcare	Fixed Term	Indirect	Establishment	0.05	8b
	Finance & Accounting	Fixed Term	Indirect	Establishment	0.05	8a
Totals					0.80	

APPENDIX 5 – Roles and Responsibilities

RACIS Matrix

For the all ages MH&LD EPR solution a RACIS matrix has been provided for the key roles associated with the delivery. A RACIS matrix is an extended version of the more common RACI matrix used in project and programme management. RACIS is defined as per the below table:

Letter	Meaning	Description
R	Responsible	The person(s) who do the work to complete the task or activity.
A	Accountable	The person who is ultimately answerable for the activity. One per task.
C	Consulted	Those who are consulted for input before or during the work.
I	Informed	Those who are kept updated on progress or decisions.
S	Supportive	Those who support the responsible person by providing resources or help.

The use of RACIS instead of RACI has the following advantages:

- Can be used in complex programmes where multiple roles assist with execution but aren't directly responsible.
- To differentiate between supporting roles and direct responsibility.
- In resource-heavy or multi-team projects, where understanding support roles improves clarity and planning.

The below table provides a RACIS matrix for the key roles associated with the delivery of the All ages MH&LD EPR programme.

Role	Vision & Blueprint	Governance	Benefits Mgmt	Change Design	Stakeholder Engage	Planning	Delivery	Risk (Prog)	Risk (Proj)	Agile Delivery	Training	Adoption	Comms
Programme & Project Delivery													
Programme Manager	A	A	R	C	C	A	I	A	C	I	I	I	C
Programme Support Officer	S	S	S	S	S	S	S	S	S	S	S	S	S
Business Change Manager	C	C	C	A	A	C	I	C	I	C	C	A	C
Business Analyst	S	-	S	R	S	R	R	I	R	R	I	I	I
Business Change Facilitator	I	I	S	S	R	S	S	I	I	I	R	R	R
Senior Project Manager	I	C	I	C	C	A	A	I	A	A	C	C	C
Project Manager	I	I	I	C	C	R	R	I	R	R	C	R	C
Senior Responsible Owner	A	A	A	C	A	C	I	A	I	I	I	I	A
Senior Product Owner	C	I	C	R	R	C	R	I	R	A	C	C	C
Clinical Reference Group													
Senior Clinical User	I	I	C	C	A	I	C	I	C	C	C	C	C
CxIO	C	C	I	I	I	I	I	C	C	C	I	I	C
CCIO	C	C	C	C	A	I	C	C	C	C	I	I	C
CSO	C	C	I	C	C	I	I	C	C	I	I	I	I
Product Support and Delivery													
System Manager	I	I	I	I	C	I	R	I	R	C	C	C	I
Product Specialist	I	I	I	I	C	I	R	I	R	C	C	C	I
Training Manager	I	I	I	I	I	I	I	I	I	I	A	R	I

	Trainer / Tester	I	I	I	I	I	I	I	I	I	R	S	I	
	Software Dev – Functional Analyst	I	I	I	I	I	C	R	I	R	R	I	I	
	Software Dev – Lead Developer	I	I	I	I	I	I	A	I	A	R	I	I	
	Software Dev – Senior Developer	I	I	I	I	I	I	R	I	R	R	I	I	
	Software Dev – Lead Test Analyst	I	I	I	I	I	I	A	I	A	R	I	I	
	Software Dev – Senior Test Analyst	I	I	I	I	I	I	R	I	R	R	I	I	
	Desktop & Mobility Technicians	I	I	I	I	I	I	R	I	R	R	I	I	
	Information Officer	I	I	I	I	I	I	C	I	C	I	I	I	
Technical Reference Group														
	Software Dev – Lead Design & Architect	C	I	I	I	I	C	A	C	A	R	I	I	I
	Infrastructure Analyst	I	I	I	I	I	C	R	I	R	R	I	I	I
	Mobility Analyst	I	I	I	I	I	C	R	I	R	R	I	I	I
	Desktop Services Analyst	I	I	I	I	I	C	R	I	R	R	I	I	I
	Information Services Lead	I	C	I	I	I	I	C	C	C	C	I	I	I
	IG Lead	I	C	I	I	C	I	I	A	I	I	I	I	C
	Cyber Lead	I	C	I	I	I	I	I	C	C	I	I	I	I
	Service Management Lead	I	I	I	I	I	I	C	I	C	I	I	I	I
Compliance Reference Group														
	Commercial Team – Procurement & Legal	I	C	I	I	I	C	I	C	C	I	I	I	I
	Commercial Team – Finance	I	C	C	I	I	C	I	C	C	I	I	I	I
	Welsh Language	I	I	I	I	I	I	I	I	I	I	I	C	C
	Equality Assurance	I	I	I	I	I	I	I	I	I	I	I	C	C
	Health Records Assurance	I	I	I	C	C	I	C	C	C	I	I	C	C
	Value Based Healthcare	C	I	C	I	C	I	C	I	I	I	I	I	I
	Regional Systems Lead	I	C	C	C	A	C	C	C	C	I	C	C	C

APPENDIX 6 – Prioritisation Matrix

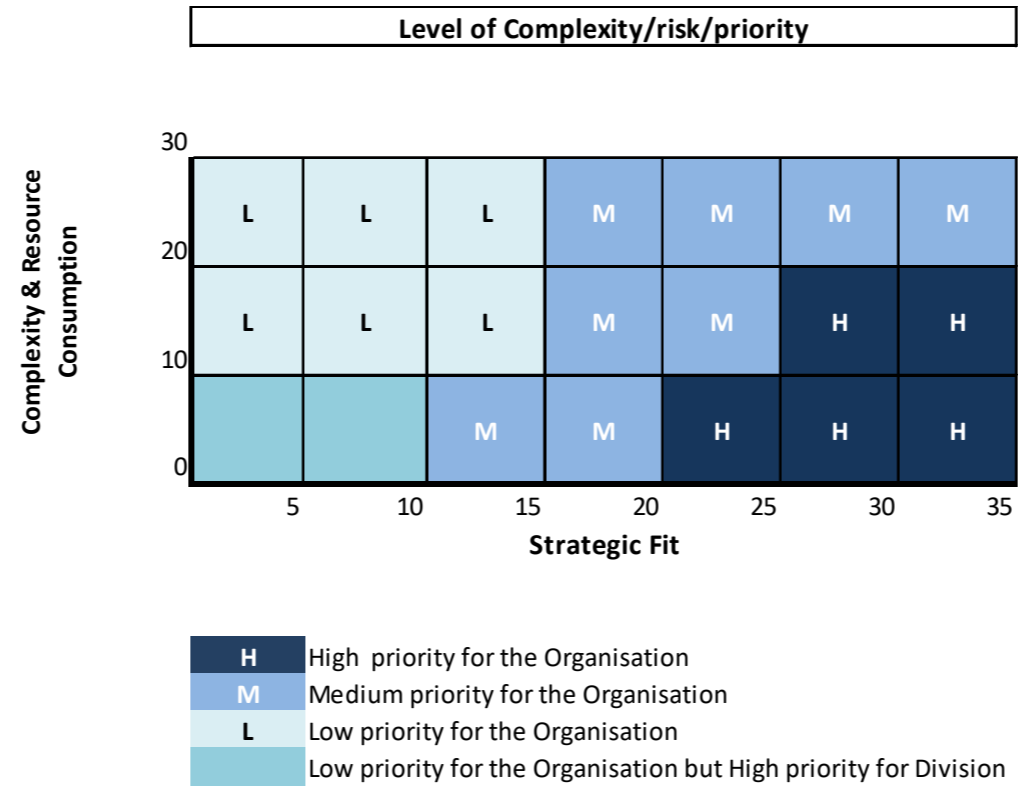
This is a 2-part matrix to assess the scale of your project, i.e. complexity, risk, capacity, support required, and its priority status against operational and strategic objectives.

Score for Complexity and Resource Consumption Criteria (Part 1)						
Criteria	1	2	3	4	5	Score
Scope	One main deliverable		Multiple deliverables		Complex and vague. Dynamic dependencies.	5
Costs	Resource neutral.	May involve some costs within departmental Scheme of Delegation i.e. <£50k.	Investment required <£100k. Executive approval.	Investment required £100-£250k	Investment required >£250k	5
Workforce Dependencies	No changes to workforce.	Workforce impact involves changing practice and procedures. Provision of short training programmes provided through in house. May require recruitment but no current skills shortages and no risk of the use of agency or high-cost variable pay.	Workforce changes effect small number of staff and involve changes to base or rotas only (potential short-term protection), which may require formal consultation under OCP or Requires provision of in house or external training or Will require recruitment but no current skills shortages identified and low risk that failure to recruit will require agency or high-cost variable pay.	Workforce changes impact staff and involve reduction of staff in post &/or changes to roles by 2 thirds &/or changes to bases &/or rotas (Potential long term and short-term protection through formal OCP or Requires provision of external training and backfill of posts). Will require recruitment of skills already in short supply, & Likely risk of failure to recruit which will require agency usage or high-cost variable pay.	Significant workforce changes effecting a whole service, function or ward and involving reduction of staff in post &/or changes to roles by 2 thirds &/or changes to bases &/or rotas (potential long term and short-term protection through formal OCP) or Requires external training and backfill of posts. Will require recruitment of skills where there are already significant vacancies and skills on occupational shortage lists and and will require agency usage or high cost pay to provide the level of resource requirements/or internal recruitment creates vacancies and high-cost variable pay or other parts of the service.	3
Indicative Capital Requirements* * It is recognised that capital requirements may not be clear at the scoping stage, so if you are unsure about how to score this, please contact Capital Team for advice.	No capital requirements	Small scheme <£100k ABHB CEO / Dep. CEO approval required.	£100k to £500k ABHB Executive Team approval required.	£500k - £1m ABHB Board level approval required	>£1m External capital funding and approval required.	4
Stakeholder Involvement & Consultation	Needs only internal staff (or 'free' resources) to do the work and consuming very low effort Informal internal discussion with staff only.	Involves working across 2 or more service areas. Informal discussions with stakeholders such as CHC, patients and staff required. HR and Trade Union support may be required.	Involves working across 2 or more service areas, and external partners or bodies. Some corporate support may be needed. Informal discussions with Trade Unions, HR, CHC and patients. Formal workforce consultation required.	Formal discussions with Trade Unions, HR, CHC and patients advised. Executive or Board level approvals required. Needs close working with other Divisions and/or corporate support to do the work. Requires some dedicated staff to do the work.	Requires dedicated staff resources and its own budget to deliver. Formal public consultation required. Potential political interest. Likely stakeholder opposition.	5
Project Duration	Very short-term – <3 months	Short- term – 3-8 months	Medium 9-<12 months	Med-Long term 12-18 months	Long term >18 months	5
Score for Complexity and Resource Consumption Criteria (Max score 30)					Total Score	27

Score for Complexity and Resource Consumption Criteria	Outcome
< = 10	Low level consumption
11 – 20	Moderate level consumption
>20	High level consumption

Score for Strategic Fit (Part 2)						
Criteria	1	2	3	4	5	Score
IMTP Strategic Priority: Degree of Alignment	Local priority e.g. improves efficiency, resolves local difficulty.	Key to delivery of Divisional objectives, e.g. financial or annual plans.	Key to delivery of ABUHB corporate objectives, e.g. financial balance, Clinical Futures	Key to delivery of a national priority e.g. target or strategy.	Delivers more than one national or regional or legislative directives	5
IMTP Strategic Priority: Health Inequalities	No/neutral impact on health inequalities.	Some small evidence that narrows gap in life or healthy life expectancy for small % of target Pop.	Some evidence of positive impact on moderate % of target Pop.	Good evidence of positive impact on significant % of target Pop.	Robust and convincing evidence on large % target Pop.	5
Organisational Risk Profile	Very low risk, if any. Failure not mission critical.	Low risk, modest changes, failure a local difficulty	Moderate risk profile (Amber). Major changes. Failure would have significant impact on business or operations.	Major changes. Failure would have major impact on strategic objectives and/or reputation.	High risk profile or mandatory compliance issue Red-rated risk on ABUHB Corporate Risk Register. Failure potentially catastrophic.	5
Evidence of Effectiveness	No evidence will have intended impact.	Limited amount of evidence predominantly from descriptive case studies, surveys or expert opinion.	Some evidence from non-comparative cross-sectional, or before and after studies, e.g. case control and cohort studies.	Moderate evidence from randomised and non-randomised comparative studies.	Strong evidence of effectiveness (well-conducted systematic reviews/meta-analyses).	5
Benefits/Value: Financial	Small financial benefit.		Makes a moderate contribution to the division's /organisation's savings target.		Makes a significant contribution to the division's/ organisation's savings target.	1
Benefits/Value Non-financial (inc QPS & EQIA)	Outcomes – capture of PROMS	Outcomes – capture of PROMS and clinical outcomes	Outcomes & Costing – transforming element of a pathway	Outcomes & Costing - transforming and capturing over a complete pathway	Full Integrated Practice Unit	5
Sustainability	Does not support Well Being Future Gens' – Long term way of working or other ABUHB sustainability objectives, e.g. Clinical Futures.		Partially supports achievement		Fully supports achievement including impact on other services and the overall health and social care system.	5
Score for Organisational Priority (Max score 35)					Total Score	31

Score for Strategic Fit	Outcome
< = 10	Low Priority for Organisation
11 - 20	Moderate Priority for Organisation
>20	High Priority for Organisation



The prioritisation level for the Preferred Option in this business case is: **Medium**

APPENDIX 7 – Risks & Issues

Risk Title	Cause	Event	Effect	Current Scoring		
				likelihood	Impact	Risk Score
CareDirector (WCCIS) - End Of Life						
CareDirector (WCCIS) EoL - Data Breach	End of life for Microsoft dynamics CRM 2016, SQL Server 2016 and Windows Server 2016, from January 2026	Risk of data breaches occurring	Data breaches can result in the unauthorised disclosure of sensitive personal and health information. These incidents can lead to identity theft, financial, fraud and a significant loss of patient trust with reputational damage. Patients whose data has been compromised may experience anxiety, stress and other psychological symptoms and consideration needs to be given to this as the system holds extremely sensitive mental health information. Compromise of patient confidentiality, leading to a loss of trust and potential distress for patients. Could lead to a reluctance for patients to share information in the future. Responding to a breach would take significant time and effort, as well as the emotional toll in the aftermath. Staff may face disciplinary action fines or even criminal charges if they are found to be negligent in protecting patient data. The impact felt by employees as a result of breaches would also be significant. Although encrypted, data can be stored for years until decryption tools are available to access breached data	3	4	12
CareDirector (WCCIS) EoL - Unauthorised Access	End of life for Microsoft dynamics CRM 2016, SQL Server 2016 and Windows Server 2016, from January 2026	Potential risk cyber attack	Unpatched, Unsupported and unmaintained technology platforms can provide an entry point for cybercriminals to exploit which can attack many more systems and render these inaccessible. This can cause major service disruption and cost millions in ransom and recovery expenses. Record tampering or data loss could lead to misdiagnosis and medical errors as a result of incomplete or inaccurate records.	2	4	8
CareDirector (WCCIS) EoL - Cyber & IG Compliance	End of life for Microsoft dynamics CRM 2016, SQL Server 2016 and Windows Server 2016, from January 2026	Non-compliance with regulatory standards and policies due to unsupported software.	Legal fees and settlement costs can be substantial. Under GDPR, fines can reach £17.5 million or 4% of annual turnover, whichever is higher. These fines reduce funds for new equipment or staffing and erode trust among patients and employees. Non-compliance can disrupt services, leading to system shutdowns or restricted functionality, causing delays in treatment, miscommunication, and limited access to vital patient health records, jeopardising patient safety.	3	4	12

CareDirector (WCCIS) EoL - Availability of Systems & Data	End of life for Microsoft dynamics CRM 2016, SQL Server 2016 and Windows Server 2016, from January 2026 - Lack of technical support for troubleshooting, bug fixes, and performance issues. Outdated systems become slower and less efficient, increasing the risk of crashes, performance issues, and data loss. Increased likelihood of system outages, degraded performance, and potential data loss, impacting service delivery.	Unavailability of systems and data	System disruptions can prevent access to critical patient records, jeopardizing the integrity of health records which will hinder the delivery of safe patient care and put patients and employees at risk. Performance issues and system crashes as a result of an outdated system will force employees to avoid using the system all together and complete some tasks manually leading to an increase of paper records. Should the system be completely inaccessible, users would need to revert to full Business Continuity for an indefinite period. Where performance is poor in a particular area of the system, the users may revert to other solutions and fragment the record i.e. utilising local electronic folders rather than using the system. This will also impact on employee morale and collaboration over time if they are constantly dealing with technical issues.	3	4	12
CareDirector (WCCIS) EoL - Compatibility	End of life for Microsoft dynamics CRM 2016, SQL Server 2016 and Windows Server 2016, from January 2026	Incompatibility with new software, applications, and hardware.	Challenges in integrating new solutions, potential for increased costs, and delays in the implementation of new systems. This would also be disruptive to pre-existing integrations with other solutions. This could erode any business benefits and prevent return of investment associated with that integration/solution.	3	3	9
CareDirector (WCCIS) EoL - Authentication	NHS Wales is on ADFS v4.0 however some WCCIS tenants are still on ADFS v3.0 / Microsoft Server 2016 which is EOL January 2027.	Users unable to authenticate	Failure to move all tenants to v4.0 by this date would leave the system vulnerable. Potential for authentication failures, access issues, and additional security vulnerabilities.	2	4	8
CareDirector (WCCIS) EoL - Legal & Statutory records	End of life for Microsoft dynamics CRM 2016, SQL Server 2016 and Windows Server 2016, from January 2026	The continued use of an unsupported electronic patient record system is in direct breach of current legal and statutory obligations and best practice and processes for records management.	Failure to meet legal and regulatory requirements could potentially lead to huge fines, legal action and reputational damage. Inability for the health board to respond fully to FOI and SAR submissions should the electronic data become inaccessible.	3	4	12
WCCIS EoL Technology (unsupported systems)	A number of components of the WCCIS technology stack will become end of life between January 2026 and January 2027, leaving the WCCIS solution with a number of technical vulnerabilities and in a position where it is no longer supportable or maintainable for security and integrity purposes	this will leave the solution vulnerable to malicious attacks, potential compromise of data or systems unavailability	this would result in risks to patient safety, service delivery, data security and integrity, cyber security of the immediate system environment and the broader integrity of other ABUHB networks, systems and data	4	4	16
WCCIS Contract Exit Penalty Costs	As a result of the early contract exit negotiations aiming to co-terminate for all WCCIS users on 31st March 2027, in line with termination of the MSA.	There is a risk that OneAdvanced seek to recover contractual costs from each individual organisation, up to the end date of each respective deployment order.	Resulting in ABUHB being pursued for a maximum residual contract value of £1.9m as penalty costs for early exit ahead of the original September 2030 end date for the minimum contractual term under the ABUHB deployment order.	2	5	10

Implementation

New system not implemented by co-terminus date of both Master Services Agreement and Deployment Order	Non-renewal of Master Service Agreement which then terminates ABUHB Deployment Order. No opportunity to extend the contract due to Advanced leaving the market.	Master Service Agreement expires March 2027	System is unsupported by Advanced.	3	4	12
Successful supplier could be contracted with multiple orgs with the Welsh market	HBs and LAs across Wales are procuring simultaneously and individually	Supplier resource impacted by multiple procurements	Resource constraints may result in product delivery delays and conflicting requirements from different orgs.	5	3	15
No Suitable Staging Server to enable ABUHB Data Migration from WCCIS to new platform	As a result of the Inability to commission a timely and adequately resourced staging server for the Data Migration process by the WLGA and DHCW.	Execution of the ABUHB Data Migration Project will be severely delayed	Achieving the Digital Community's deadline for migration and associated terminus of the WCCIS service in March 2027 will be delayed and lead to severe disruption to the MH & LD Service with the potential for medium term business continuity measures.	3	4	12
Resource Demand for Single Migration (Big Bang)	As a result of ... Undertaking a single all encompassing data migration (Big Bang) from WCCIS to its successor application.	There is a risk that ... Resources in Programmes, Business Change and the MH&LD Service become overstretched, overwhelmed and consumed by implementation activities such as Testing, Training and user support.	Which will lead to ... delayed implementation and poor acceptance of the product with the potential for business continuity measures.	2	3	6
User adoption challenges for single migration (Big Bang)	As a result of ... Undertaking a single all encompassing single data migration (Big Bang) from WCCIS to its successor application.	There is a risk of... Resistance from staff unfamiliar with digital systems.	Which will lead to ...to potential disruption in patient safety and service delivery.	2	3	6

APPENDIX 8 – Lessons Learned

Theme	Key Lessons Learned
Benefits Management	<p>Lesson : Could have gone live earlier, and achieved some benefits whilst waiting for the other benefits (Integration and Mobile App)</p> <p>Recommendation : Go live as soon as the service can safely even if some benefits need to be deferred.</p>
Business Change	<p>Lesson : Lack of engagement with the service or changes within the service made engagement at times challenging</p> <p>Recommendation : Create a network of named AHP who work alongside Programmes/ Informatics on related projects to their areas</p>
Data Migration	<p>Lesson : Dirty data causing a lot of pressure and using up a lot of resource - impacting dashboards in new systems as staff are not seeing a clean/clear dashboard.</p> <p>Recommendation : Ensure data cleansing is planned for and resourced</p>
Business Change	<p>Lesson : Named resource from Advanced left, there was no person to replace his role and support. A key contact/ link was missing</p> <p>Recommendation : Have a confirmed key contact with the supplier for duration of Implementation even if not named it should be added to the contract - check with procurement at contract stage</p>
Business Processes	<p>Lesson : Working with the service to joint facilitate workshops/meetings helps drive the meetings in the right direction.</p> <p>Recommendation : Co-facilitate meetings with someone from the service/ scope area</p>
Business Processes	<p>Lesson : Stakeholder engagement has been invaluable e.g. the System Development Team going out to meet the teams, providing demo's to the service and signing off forms/ letters with them, BCM's Awareness sessions with teams, visiting them and having small informal</p> <p>Recommendation : Continue engagement with the teams. Make sure you know where decisions can be made and use the appropriate forum. Manage expectations of staff.</p>
Communication	<p>Lesson : We often found it difficult to get important messages through to the service which resulted in important messaging and requirements being lost.</p> <p>Recommendation : Strengthen communication and engagement between project team and the service and vice versa</p>
Communication	<p>Lesson : Use of MS Teams to create collaborative channels in one place really helped communication across a spread out team. Having a Back Office Support Team group chat was useful - although it might have been better to have used a private channel with in the mai</p> <p>Recommendation : Maximise use of MS Teams fully - multiple focused channels - systems team, product specialist, call list support etc</p>
Communication	<p>Lesson : Having office space to act as a central 'hub' for Go Live Team was a great way to bring every one together, even if on a drop-in basis</p> <p>Recommendation : Ensure there is a dedicated 'Go Live Hub' space available for staff to gather</p>
Communication	<p>Lesson : Although SU role was defined and explained there was a lack of uptake of this across the directorate which at times lead to some SU's not being appropriate for the role as they were pushed into the roles and were a link to a team rather than what the SU role required. They were also not given the time to devote to the preparation required for the role.</p> <p>Training bookings were a challenge due to lack of a lead contact within the service to drive it forward at service level.</p> <p>Recommendation : Options to consider: - Smaller numbers of SU's across the division - SU Lead/ Main contact within the division (a training lead) - Allowed the SU's dedicated time to learn and apply the system throughout the implementation (before, during and after Go LIVE)</p> <p>SU Training Lead to be responsible for ensuring team members book onto and attend training etc. - should not be responsibility of Project Team.</p>

Mobile & Devices	<p>Lesson : Without an effective asset management system, it is very difficult to track the location of valuable assets.</p> <p>Recommendation : Work with ICT Configuration Manager/DHCW (if appropriate) to explore how this can be improved.</p>
Mobile & Devices	<p>Lesson : Consider all possible outcomes and risks when deciding to issue devices early.</p> <p>Recommendation : Due to delays in taking the system live, we could potentially have recalled the devices. Consider potential for delay versus benefits of handing out early. Consider all options and mitigations.</p> <p>If devices are given out it is for the service to ensure that the process change is embedded (with help from the Project Team or ICT)</p>
Data Migration	<p>Lesson : No Data Migration lead, no training lead identified</p> <p>Recommendation : Ensure there is a lead identified from within the Service early to ensure engagement</p>
Project Management	<p>Lesson : PCMHSS teams have a rolled implementation team by team and this has worked really well especially in terms of support for each of the teams</p> <p>Recommendation : Where possible a team by team approach to a go live is beneficial. Implement the lessons from each stage as you rollout.</p>
Project Management	<p>Lesson : As there was limited feedback and responses in Steering Group, it may have been better to have smaller specialised Steering Groups for each of the Service areas rather than having one Steering Group across the whole division. Important to maintain engagement by ensuring agenda items are relevant to those attending. This would have resulted in the impact of the implementation being more fully appreciated by decision makers.</p> <p>Recommendation : Investigate the options of creating sub-groups of steering group or even create 6 individual steering groups to try and get better engagement from the different services.</p> <p>Making the meetings more relevant when meeting with stakeholders with different needs - consider the frequency of the meetings.</p> <p>Ensure membership of any Steering Group has several senior Directorate Managers involved and a full impact analysis of the implementation is carried out.</p>
Project Management	<p>Lesson : Infrastructure reviews (I.e. Network speed/ capacity, wi-fi availability, hardware checks and additional requirements) are crucial as part of the implementation readiness work this needs to be started early.</p> <p>Recommendation : Network, wi-fi and hardware assessments should be undertaken as early as possible as part of the readiness stage of the project.</p>
Project Management	<p>Lesson : Including a buffer figure into the device roll-out plan helped to manage changes in team numbers where staff had been missed from the information originally sent in from the service. Project Team could manage this without involving the Programme Manager o</p> <p>Recommendation : Include a buffer figure to allow for mistakes in initial allocation which is easy to do with the size of these services. Consideration needs to be given to size of the buffer so there isn't too risk of an over surplus amount of devices</p>
Data Migration	<p>Lesson : When we had the second data migration work shop the scope of the migration had not been fully agreed. This did not hold up the data migration work but it became apparent that decisions needed to be made in order to keep on track to hit DM 1</p> <p>Recommendation : The DM Scope should be looked at and agreed as early as possible as a priority for the project. This then needs to be communicated and signed off by the service</p>
Project Management	<p>Lesson : Supplier needs to be given a high level of detail when delivering changes. It is important to ensure there is sufficient detail in the use case which articulates the vision of the client. Screenshots are useful. Sprint calls have demonstrated the changes were not fully understood in all cases by the supplier.</p> <p>Recommendation : To ensure that the correct functionality is developed, use screenshots and write clear detailed use cases to outline the change required</p>
Software Development	<p>Lesson : There are aspects of use cases that you cannot articulate in writing and intricacies that a developer may miss just by just reading a use case, this is where regular reviews are crucial and will avoid mistakes in interpretation.</p>

	<p>Recommendation : Following the drafting of the initial use case the development of use cases should be involved in ongoing regular reviews as the development progresses</p>
Staff Resources	<p>Lesson : It was not always clear who was best to refer specific queries to. By knowing who is primarily working on specific areas such as forms, dashboards, diaries etc. would help with the allocation of calls and as some calls may be similar it could reduce duplication.</p> <p>The lack of an implementation consultant from the supplier has meant that they have not been on the ground to see the daily issues staff are facing.</p> <p>Recommendation : Early consideration of Service Management transition. Clear roles and responsibilities defined for GoLive. Analysis of expected call volumes</p> <p>Allocate specialties to work on specific types of queries/areas e.g. forms, dashboards. Have clear lines of responsibility during the early go-live period.</p> <p>Clear overview of specific roles & responsibilities of all the team, not only in the Programme generally, but specifically during the Go Live period</p> <p>Supplier presence at initial go-live.</p>
Staff Resources	<p>Lesson : Clinical lead did not always have the correct reach to cover all aspects of the service.</p> <p>Recommendation : Consider need for multiple clinical leads for each project/Programme of work.</p>
Staff Resources	<p>Lesson : When bringing users into the programme there are competency issues prevent them from fully onboarding with the change and have the requirement competencies.</p> <p>Recommendation : Complete TNAs and ensure users are enrolled onto the appropriate training as required.</p>
Training	<p>Lesson : We received some feedback that the training was not fit for purpose in some areas due to differences in process.</p> <p>Recommendation : Test each course with suitable representatives before commencing.</p>
Training	<p>Lesson : Some staff with dyslexia/dyspraxia for example could not deal with training in the training room with other trainees</p> <p>Recommendation : Always build this into any TNA.</p>
Training	<p>Lesson : Now that we have received additional training from Careworks we are in a better position to progress various aspects of the project. It's really difficult to move things forward and get involved in National "debates" when you don't understand the system.</p> <p>Recommendation : Try to source training for the supplier at the earliest point possible</p>
Training	<p>Lesson : Increase accountability for self-learning</p> <p>Recommendation : Remind users in training, via intranet pages, newsletters, online help and via SU community.</p>
Training	<p>Lesson : Trainers added questions to a log which was reviewed and answered by Business change. Appropriate responses to specific queries gave reassurance and support that the system will work from them. Trainers had answers if asked the same question again.</p> <p>Recommendation : Continue, especially if the trainers are not particularly knowledgeable of all processes</p>
Training	<p>Lesson : Initially provided UAT training to SUs before asking them to test remotely using a script. Users struggled to use the system without f2f support. They found the script difficult to follow resulting in poor engagement and the exercise was unsuccessful</p> <p>Recommendation : Continue, especially if the trainers are not particularly knowledgeable of all processes</p>
Training	<p>Lesson : Local considerations for implementation were identified and additional areas to include in the Operational Guide. Security model, DM, practice for users. Quality of testing was improved and engagement was improved. Themes emerged from the testing.</p>

	<p>Recommendation : Replicate for later phases. Avoid script testing.</p>
Training	<p>Lesson : Alongside various training refresher sessions and e-learning and guides, short videos were produced to show a specific process</p> <p>Recommendation : Staff have reported that these have been useful as they are short targeted videos to help them understand and follow the process without having to review a 2 hour long virtual refresher video</p>
Training	<p>Lesson : The accessibility and capacity of training facilities within the HB are limited</p> <p>Recommendation : Identify requirements early so that issues can be escalated in a timely manner.</p>
Training	<p>Lesson : Management need to appreciate the extra responsibility around being a super user and the need to adapt to the substantive role</p> <p>Recommendation : Ensure this is addressed early in the readiness when engaging with senior management within the service</p>

APPENDIX 9 – Use Cases, User Stories and Scenarios

UC ID	Use Case	US ID	User Story
UC01	Appointments	UC01-US01	As a clinician, I want to book and update appointments in the system, so that patient journeys can be tracked, outcomes recorded, and information accessed in real time, including while working in the community.
		UC01-US02	As a health professional, I want to record patient interactions (face-to-face, virtual, or telephone), so that patient history is accurate and supports service capacity planning.
		UC01-US03	As a service, I want a central view of team appointments, so that times, dates, and staff allocation can be adjusted according to capacity.
		UC01-US04	As a service, I want to plan clinic contacts in advance, even when a specific clinician is not yet allocated, so that booking slots can still be reserved.
		UC01-US05	As a user, I want to book group appointments across different boroughs, so that efficiency is improved.
		UC01-US06	As a scheduler, I want live visibility of appointment cancellations, so that resources can be reallocated in real time.
UC02	Assessments	UC02- US02	As a crisis team member, I want to prioritise referrals, record outcomes, and arrange planned or immediate appointments, so that patients receive the right care at the right time.
		UC02- US03	As a clinician, I want access to standardised electronic assessment templates that can be saved in stages and pre-populate with existing patient data, so that assessments are consistent and efficient to complete in the community.
		UC02- US04	As a clinician, I want statutory forms (e.g., WARRNs, CTPs) available electronically, so that time and paper are saved compared to printing, scanning, and re-uploading.
UC03	Case Notes	UC03 – US01	As a clinician, I want to add secure case notes for all patient interactions and updates, so that information is accurate, shared appropriately across health and local authority teams, and data entry is not duplicated.
UC04	Diagnosis	UC04 – US01	As a clinician, I want to record both provisional and confirmed diagnoses, so that patients with evolving conditions are documented appropriately.
UC05	Duty Desk	UC05 – US01	As a duty worker, I want a quick search function to locate or create patient records in real time, so that I can respond promptly to calls with minimal clicks.
UC06	Mental Health Act (MHA) & Inpatient Wards	UC06 – US01	As a health professional, I want to conduct a Mental Health Act assessment, so that I can determine whether admission or discharge is required.
		UC06 – US02	As a clinician, I want to admit patients into beds using a central bed management function, so that inpatient information is visible to relevant users.
		UC06 – US03	As a clinician, I want to record a patient’s legal status in their record, so that colleagues have accurate MHA information.
		UC06 – US04	As a clinician, I want to discharge patients from beds, so that new admissions can be managed promptly.
		UC06 – US05	As a clinician, I want to record section information in the system, so that it is instantly available to the MHA team.
		UC06 – US06	As a ward clerk, I want to scan signed legal documents into the system, so that originals are available to the MHA team.
		UC06 – US07	As a clinician, I want to assign tasks to colleagues, so that responsibilities can be shared and picked up by others.
		UC06 – US08	As a user, I want to set tasks for others with timeframes, so that time-sensitive actions are completed.
		UC06 – US09	As an AMHP, I want to view and edit MHA information, so that legal requirements are met.
		UC06 – US10	As an MHA administrator, I want to review and update legal statuses and send tasks to medics, so that administrative and medical scrutiny are completed.
		UC06 – US11	As an MHA administrator, I want to inform responsible clinicians and nearest relatives of section details, so that records are accurate and communication is maintained.
		UC06 – US12	As an AMHP, I want to see when a patient is placed on a section that requires S117 aftercare, so that I can ensure they receive appropriate community support.

UC07	Mobile & Community Services	UC07 – US01	As a clinician, I want to see what other services are involved in a patient's care and view referral statuses, so that I can make informed decisions.
		UC07 – US02	As a clinician, I want to access patient records in community settings, so that I can provide care outside of the office.
		UC07 – US03	As a clinician, I want to dictate notes in the community and edit them later, so that I can document effectively when typing is difficult.
		UC07 – US04	As a clinician, I want offline access to key patient information and the ability to upload notes once back online, so that work continues even in areas with poor signal.
		UC07 – US05	As a clinician, I want visibility of CTOs, Section 136 assessments, and admission/discharge details, so that I have a full picture of patient status.
		UC07 – US06	As a clinician, I want to record details of carers, relatives, and support networks (e.g., next of kin, emergency contact, daily living support), so that I know who to contact if needed.
		UC07 – US07	As a clinician, I want full access to all patient documents, forms, and case notes, so that I can create holistic treatment plans.
		UC07 – US08	As a clinician, I want visibility of other services' involvement and referral statuses (including waiting times), so that duplication is avoided and planning is informed.
		UC07 – US09	As a clinician, I want to search for patients during unplanned calls in the community, so that I can respond immediately without returning to base.
		UC07 – US10	As a clinician, I want to refresh or sync data, so that I know I am working with the most up-to-date records.
		UC07 – US11	As a clinician, I want indicators showing if a patient is an inpatient (MHLA or general wards), so that I can adapt my visit plans accordingly.
		UC07 – US12	As a clinician, I want a chronological list of all patient contacts (community and clinic, including DNAs), so that I understand care history.
		UC07 – US13	As a clinician, I want access to key case details offline, even if not the full document, so that I can review essential information.
		UC07 – US14	As a clinician, I want visibility of information from social services and other agencies, so that I understand the full support in place.
		UC07 – US15	As a clinician, I want to log visit outcomes (attended, cancelled, DNA), so that patient records remain accurate.
		UC07 – US16	As a clinician, I want to set estimated timescales for next appointments and add patients to waiting lists or request MDT input, so that care is coordinated.
		UC07 – US17	As a clinician, I want to update demographic details (address, contact, GP) during visits, so that records remain current.
		UC07 – US18	As a clinician, I want to add case notes directly on my device, so that the system is always live and up to date.
		UC07 – US19	As a clinician, I want to create and update assessments and documents in the community, then refine them later on a laptop, so that paperwork is reduced.
		UC07 – US20	As a clinician, I want patients to be able to sign care plans electronically, so that paper processes are avoided.
		UC07 – US21	As a clinician, I want to make and receive calls on my work device, so that I do not need to carry both a mobile and a tablet.
		UC07 – US22	As a clinician, I want to record and update allergies, risks, height, and weight directly in the system, so that patient records are accurate and immediate.
		UC07 – US23	As a clinician, I want alerts if a patient has been admitted to a ward, so that I avoid unnecessary home visits.
		UC07 – US24	As a clinician, I want to create personal tasks or reminders in the system, visible to colleagues, so that work is organised and transparent.
UC08	Reporting	UC08 – US01	As a health board, I want accurate reporting of MHM Part 2 (Care and Treatment Planning), so that compliance is assured.
			As a health board, I want accurate reporting of MHM Part 3, so that compliance is assured.

			As a health board, I want accurate reporting of psychological therapy waiting lists (clock start and finish), so that activity is monitored.
			As a health board, I want to submit the annual KP90 dataset, so that statutory requirements are met.
UC09	Referrals	UC09-US01	As a user, I want to view referral details in one place and easily add patients to waiting lists, book appointments, or forward referrals, so that workflows are efficient.
			As a service, I want referral status options (accepted, rejected, pending further info, MDT review), so that decisions are clearly documented.
			As a SPACE team member, I want to manage cross-service referrals, so that patients move seamlessly between health and social care.
UC10	Risks	UC10-US-01	As a clinician, I want to access and manage patient risks (including those recorded by local authorities), so that they can be reviewed and updated in the community.
UC11	Referral to Treatment (RTT)	UC-11-US01	As a service, I want to record referral dates and track progress at every stage, so that compliance with Welsh Government RTT guidelines is maintained and reporting is accurate.
UC12	Safeguarding	UC12-US01	As a clinician, I want access to safeguarding records across agencies, so that I understand risks for patients and families.
UC13	Student Entries	UC13-US01	As a supervisor, I want to view and countersign student notes, so that quality and training standards are met.
UC14	Waiting Lists	UC14-US01	As a service, I want to capture multiple waiting lists (including MDT and specialty lists), so that patient demand is managed accurately.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Nevill Hall Hospital Strategic Outline Case
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans - Director of Strategy, Planning & Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Hannah Capel – Assistant Director, Strategic Capital

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

Ar Gyfer Penderfyniad/For Decision

The purpose of this paper is to:

- Gain approval to submit the Strategic Outline Case (SOC) to Welsh Government for an estimated investment of **£474.4m** for Nevill Hall Hospital. The investment will remove the significant presence of Reinforced Autoclaved Aeriated Concrete (RAAC), whilst rationalising the current footprint in order to deliver fit for purpose modern estate in line with the Health Board’s strategic direction.
- Set out the initial revenue implications of the development, noting the further work required as part of OBC development to test the assessment and seek opportunities to reduce further.
- Set out the feedback from the engagement exercise to support SOC development.

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Strategic Outline Case (SOC) sets out the rationale and case for change for investment at the Nevill Hall hospital site to create a modern, safe, and sustainable facility aligned with the Health Board’s clinical model. Whilst investment into Nevill Hall has featured as part of the Health Board’s extant Estates strategy, the significant presence of Reinforced Autoclaved Aeriated Concrete (RAAC) has



increased the priority for investment into this estate. Whilst primarily required to manage the risks associated with RAAC, investment into the site and estate will provide an opportunity to refine the capacity and services following the opening of the Grange Hospital recognising NHH key role in providing a core set of services.

The clinical models have been reviewed and considered from a whole system perspective, which has resulted in a requirement for a reduction in the overall footprint at Nevill Hall Hospital through the delivery of services to reflect population needs and increased efficiency. This supports the rationalisation of estate, considers opportunities which may arise in relation to working with AB's neighbouring Health Boards. Critical to this consideration is the presence on the NHH site of the new Velindre @ Nevill Hall Radiotherapy Centre Unit which is of strategic importance to the region and demands a level of clinical and nonclinical service presence in NHH.

Cefndir / Background

Under the Health Board's current clinical model and extant Estates Strategy, Nevill Hall is recognised as key site in the hospital system network both as a provider of services for the local catchment but also as a key part of health the network in terms of capacity and flow. Whilst work on reviewing and developing the clinical services plan for the Health Board, NHH is considered a fixed point in the hospital network due to:

- Its role in supporting the wider urgent and emergency care system in terms of local MIU and UPC services.
- Supporting the step-down model from the Grange University Hospital,
- In line with national policy, supporting care closer to home for low risk elective services such as outpatients, diagnostics and day surgery,
- Provision of care to families, children and women via the Children's centre, gynaecology ambulatory care and the emerging AB Women's Health Hub
- Its strategic location for the region as identified through travel times analysis for the satellite radiotherapy centre and recently as a north hub for south east Wales for cataracts for the region
- In addition, NHH site has a key role in the provision of staff residence, multi disciplinary education and management and administrative bases.

In February 2023 an alert was received from Welsh Government in relation to Reinforced Autoclaved Aeriated Concrete (RAAC), requesting that all Health Boards undertake a desktop review to determine whether or not there was any RAAC present within the Health Board's estate. This exercise identified Nevill Hall Hospital as the only site within the Health Board with RAAC present. Working alongside professional advisors Mott MacDonald detailed surveys and assessments have been undertaken. This has identified that RAAC panels are located across circa 19,010 m² of roof space within the NHH estate with a total number of panels of approximately 7,816. This is a significant number in comparison with other RAAC installations across the UK and Nevill Hall is considered a "whole RAAC hospital" for this reason. Whilst the risks associated with RAAC are being proactively managed and mitigated in the short to medium term, the only way to



eliminate fully the risk is to remove RAAC or decommission those spaces affected. This risk cannot be removed unless the RAAC panels are removed.

The Health Board is working with its professional advisors to continue to manage and monitor the presence of RAAC in line with latest IStructE guidance and are inspecting and propping areas where identified. However this is not a sustainable solution in the long term.

Asesiad / Assessment

The SOC sets out the case for change for investment into NHH based on the presence of RAAC and the emerging direction on service models, estates options and potential phasing.

Based on this work, the SOC proposes a “preferred way forward” as a reconfiguration of the NHH site that:

- Will provide new-build and right sized accommodation, providing capacity (only as required) for the services that currently sit in RAAC areas
- Allows for the refurbishment of the retained “H” Blocks (ward blocks where there is no RAAC),
- In a reduced footprint compared with current estate,
- Will provide more effective use of clinical space and agile working space in North Gwent.
- Provides for, as a potential future phase, the potential for integration of the services currently on Maindiff Court onto NHH site, thus reducing the overall size of the AB estate.

Acknowledging the challenges of availability and affordability of capital, the proposal requires funding for Phase 1 of capital investment of an estimated £474.4 million to redevelop the Nevill Hall Hospital (NHH) site and ultimately address the significant risk posed by the presence of RAAC. This figure represents the total anticipated investment required to deliver the scheme based on current cost modelling and assumptions. Support for the SOC will enable further option refinement, full affordability modelling, and continued engagement with stakeholders to confirm the preferred option at Outline Business Case (OBC) stage.

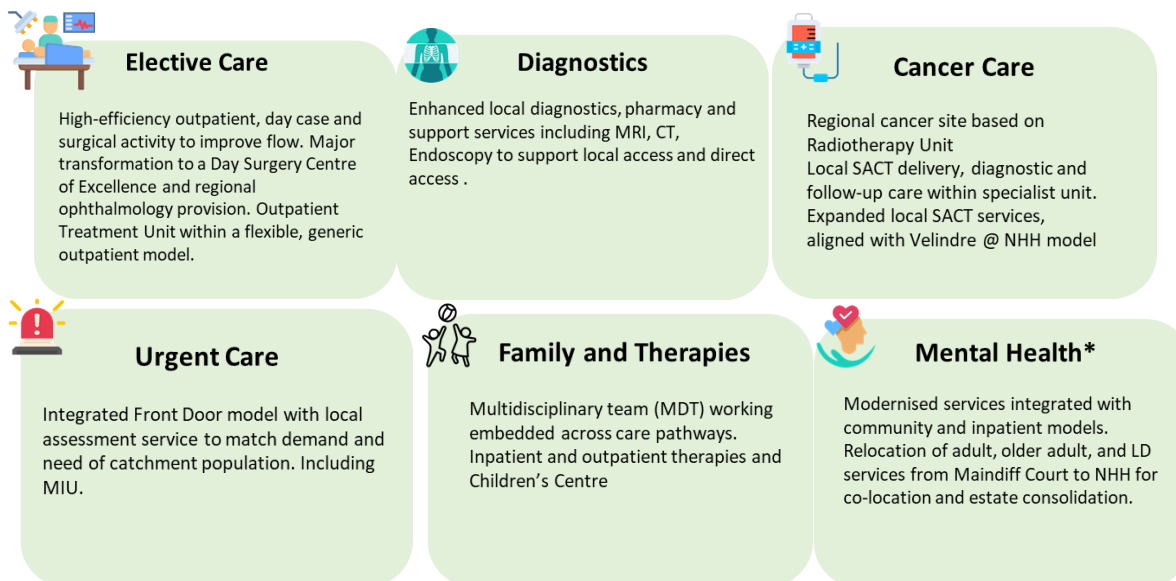
As outlined above, further benefits could be realised via future phases of investment that see the option of Maindiff court services being brought on to the NHH site. However the priority remains the removal of the RAAC risk.

The SOC is set out against the 5 case model with key messages from each case set out below:

The strategic case sets out the case for change in line with the above. It sets out the policy context and the assessment of risk associated with RAAC.

In terms of the emerging clinical model the infographic below gives an overview of services and capacity that is being assumed at this SOC stage, recognising greater levels of planning is required in the next stage of the business case process - the Outline Business Case (OBC).

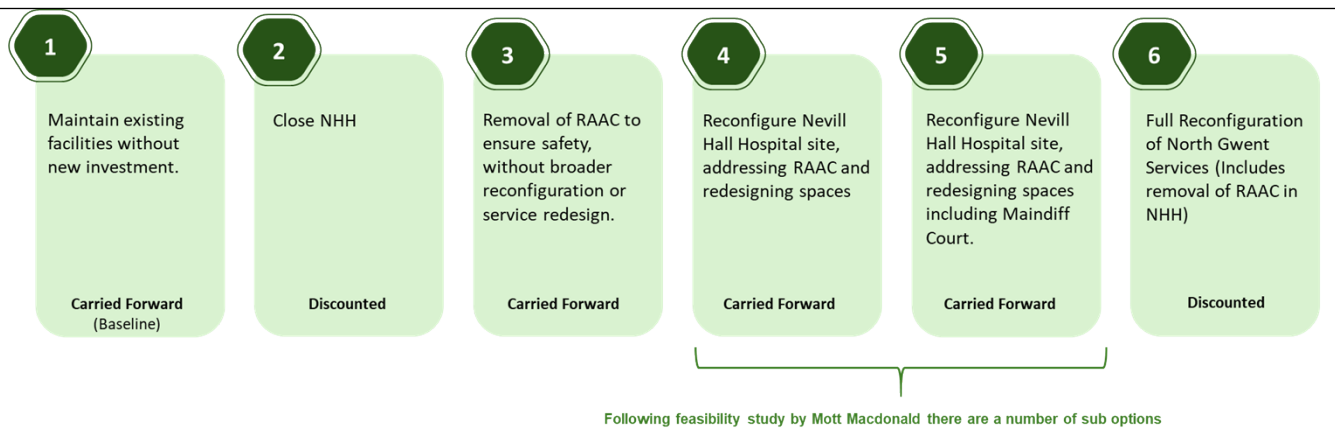




The **Economic Case** demonstrates that the Health Board has applied a rigorous and transparent approach to identifying a value-for-money solution that meets strategic and clinical objectives. A comprehensive long list of options was developed across six categories: service scope, service solution, service delivery, implementation, funding, and estate solution; and appraised against agreed Investment Objectives and Critical Success Factors.

IO1: Quality	To provide a model of care for the NHH site that is sustainable, removes RAAC, and is flexible to respond to future needs and workforce changes.
IO2: Sustainability	Develop a model of care for the NHH site that supports improved efficiency in service delivery and optimising resource use
IO3: Efficiency	Deliver an operationally efficient model of care at the NHH site that reduces unnecessary complexity and streamlines care processes and enables decarbonisation
IO4: Economy	Maximise the use of available resources at the NHH site, ensuring services align with Clinical Futures and provide cost-effective healthcare
IO5: Effectiveness	Provide a model of care for the NHH site that delivers patient care in line with best practice, meeting the needs of patients, carers, and staff.

From this process 4 key options were taken forward for detailed consideration as set out in the SOC.



The options appraisal will be revisited and thoroughly tested against a greater level of granular service model detail as part of the OBC economic case development in order to determine a preferred option.

From a **Commercial case** perspective, the Health Board will seek to appoint a Supply Chain Partner through the appropriate procurement frameworks, along with the necessary external advisors to support project delivery. In line with the national process, this step typically happens following Welsh Government support for SOC. This approach will ensure access to experienced suppliers, reduce procurement risk, and support timely delivery. Opportunities to embed Modern Methods of Construction (MMC), Net Zero Carbon principles, and digital infrastructure will be explored further to align with Welsh Government policy and sustainability goals.

If approved, the scheme is expected to be funded through the All-Wales Capital Programme (AWCP), and the Health Board will ensure that the commercial strategy supports value for money, compliance, and deliverability throughout the next stages of business case development.

The **Financial Case** sets out the indicative capital and revenue implications of the redevelopment proposals for Nevill Hall Hospital and provides an early view of affordability. A detailed feasibility study has been completed, which provides an initial assessment of the likely capital requirements and estate solutions. This SOC presents indicative costs based on that feasibility work. While detailed modelling will be undertaken at Outline Business Case (OBC) stage, the SOC presents an initial financial assessment to inform decision-making. The initial indicative recurrent revenue cost of the short-listed options range from c.£3.1m to c.£2.1m, with the preferred way forward delivering the lowest net cost through:

- Increased throughput in day case and outpatient activity.
- Rationalisation of estate, including the Phase 2 relocation of services from Maindiff Court
- Operational and clinical efficiencies from revised service models.

Engagement on Case for change for NHH

In line with best practice and guidance, ongoing engagement with staff and communities as part of service change is a key obligation for health organisations. As part of SOC development, a two phased comprehensive engagement approach



was developed ensuring inclusive participation to shape the future of NHH and the wider hospital system. This approach was agreed with Llais. Phase 1 was an eight-week period between June and August focussing on the case for change for NHH (setting out the reasons why arrangements in NHH cannot remain as currently configured), principles underpinning the plans, and emerging thinking on service models. Phase 2 has recently commenced and focusses on specific and concrete proposals, e.g. the long-term model for stroke rehabilitation.

In terms of Phase 1 engagement, engagement activity can be summarised below:

- A total of 437 responses were received from the on-line survey
- The web page covering the engagement information received a total of 3354 views over the eight weeks, representing 3167 unique users. The top three sources of traffic were Facebook (1464), AB Pulse (557), ABUHB Website (284).
- In person attendance at the nine public events was variable, with the greatest interest unsurprisingly at events within the Nevill Hall Hospital catchment area. A total of 91 people attended the public engagement events.
- During the eight-week period, a total of 32 community engagement sessions took place and conversations held with 406 people
- Eleven posts were shared on Facebook which had a total reach of just over 300,000. A total of 436 comments were received and there were 305 shares
- Three updates were shared on the Health Board's WhatsApp channel which has 427 followers.
- Three bespoke responses from wider stakeholders e.g. via e-mail and phone were received
-
- Bespoke session with Monmouthshire Council

Key findings and themes from the process were as follows:

- Understanding of case for change and RAAC situation
- Support for the principles proposed
- Desire to return more services to NHH, for example some of those that moved to the Grange,
- Desire for more information regarding services available and how to access them,
- Desire for straightforward contacts e.g. outpatient appointments to be available closer to home
- Importance of public and other transport links between hospitals



Many of the themes identified from the engagement exercise can be addressed as part of current plans and are not reliant on development at NHH.

The Health Board and project is committed to ongoing engagement with staff and stakeholders and as part of the OBC process more detailed engagement will be undertaken on the confirmed service models.

Argymhelliad / Recommendation

The Strategic Outline Case for NHH sets out the case for change and the need to response to the RAAC risks. As would be expected we have taken the opportunity to consider service models and further opportunities offered by the NHH site as part of the SOC development, noting that it is a site of regional strategic importance.

The Board is asked to:

- Support the Strategic Case for Change as set out in the SOC
- Approve submission of the Strategic Outline Case to Welsh Government to support the redevelopment of the Nevill Hall site in order to remove the risk which is posed by the presence of RAAC with an estimated potential capital cost of £474.4m
- Note the current assessment of potential revenue consequences of the development, acknowledging that there is further work to test and reduce
- Note the emerging thinking on service models, noting further work to fully test and refine
- Note the outcome of the engagement as part of SOC and the commitment to continue to engagement with staff, communities and stakeholders through the next phases of development
- Support the development of the Outline Business Case following Welsh Government approval of the SOC

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination 3.1 Safe and Clinically Effective Care 3. Effective Care
Blaenoriaethau CTCI IMTP Priorities	Choose an item.
Link to IMTP	



Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.



STRATEGIC OUTLINE CASE

Project Name: Nevill Hall Hospital Development Project

Authors:	Leigh-Anne Challenger Senior Programme Manager Hannah Capel Assistant Director of Strategic Capital Trish Chalk Assistant Director of Planning and Performance
Owner:	Hannah Evans Executive Director of Strategy, Planning and Partnerships
Document Number:	Version 0.12

i. Document Control

Version History

Amended By	Version	Status	Date	Summary of Changes
Leigh-Anne Challenger	0.1	Draft	23/10/24	Rough draft
Leigh-Anne Challenger	0.2	Draft	21/1/25	Working draft
Leigh-Anne Challenger	0.3	Draft	14/5/25	Working draft
Project Team	0.4	Draft	16/5/25	Project Team incorporated updates into live working document
Leigh-Anne Challenger	0.5	Draft	20/6/25	Updated for review by SRO, Project Lead, and Project Director ahead of PIP and Executive Committee submission
Leigh-Anne Challenger	0.6	Draft	23/6/25	Updated following comments from SRO
Leigh-Anne Challenger	0.7	Draft	24/6/25	Updated following comments from PIP and Project Board
Leigh-Anne Challenger	0.8	Draft	2/7/25	Editable version held following submission to EC
Leigh-Anne Challenger	0.9	Draft	13/8/25	Financial Case updated and updated capital costs
Leigh-Anne Challenger	0.10	Draft	24/9/25	Nomenclature changed from day centre of excellence to Day Case and Treatment Centre
Trish Chalk	0.10	Draft	3/11/25	Updates to Clinical Model section
Hannah Capel	0.10	Draft	3/11/25	Updates to Executive summary
Leigh-Anne Challenger	0.10	Draft	4/11/25	Updated Table of Contents, tables and figures; Outline plan updated
Leigh-Anne Challenger	0.11	Draft	11/11/25	Additional narrative in Strategic Context
Hannah Capel	0.12	Draft	19/11/25	Changes to some narrative for November Board version

Approvals

This document has been approved by:

Name	Date	Version

Distribution

This document has been distributed to:

Name	Date	Version
NHH Development Project Team	16/5/25	0.3
NHH Development Project Team	22/5/25	0.4
Project Lead, SRO, Project Director, Service Design Lead	20/6/25	0.5
NHH Development Project Board	23/6/25	0.5
NHH Development Project Board	24/6/25	0.6
NHH Service Design Group	24/6/25	0.6
Pre-Investment Panel	24/6/25	0.6
Executive Committee	2/7/25	0.7
SRO, Project Director	4/11/25	0.10
SRO, Project Director	11/11/25	0.11

ii. Executive Summary

The Strategic Outline Case (SOC) sets out the rationale and case for change for investment at the Nevill Hall hospital site to create a modern, safe, and sustainable facility aligned with the Health Board's clinical model. Whilst investment into Nevill Hall has featured as part of the Health Board's extant Estates strategy, the significant presence of Reinforced Autoclaved Aeriated Concrete (RAAC) has urgently increased the priority for investment into this estate. Whilst primarily required to manage the risks associated with RAAC, investment into the site and estate will provide an opportunity to rightsize the capacity and services post the Grange Hospital opening recognising NHH key role in providing a core set of capability and capacity.

The clinical models have been reviewed and considered for NHH from a whole system perspective, which has resulted in a requirement for a reduction in the overall footprint at Nevill, by right-sizing of services to reflect population needs and increased efficiency. This supports the rationalisation of estate, considers opportunities from working not only on a regional basis, but also any opportunities which may arise in relation to working with AB's neighbouring Health Boards. Critical to this consideration is the presence on the NHH site of the new Velindre @ Radiotherapy Centre Unit which is of strategic importance to the region and immediately demands a level of clinical and non clinical service presence in NHH

Strategic Outline Case:

Nevill Hall Hospital Development Project

This SOC proposes a “preferred way forward” as a reconfiguration of the NHH site that:

- Will provide new-build and right sized accommodation, providing capacity (only as required) for the services that currently sit in RAAC areas
- Refurbishment of the retained “H” Blocks (ward blocks where this is no RAAC),
- All in a reduced footprint compared to current estate,
- More effective use of clinical space and agile working space in North Gwent.
- And, as a potential future phase the integration of the services currently on Maindiff Court onto NHH site, thus reducing overall AB estate.

Acknowledging the challenges of availability and affordability of capital, the proposal is for funding for Phase 1 of capital investment of an estimated £474.4 million to redevelop the Nevill Hall Hospital (NHH) site and ultimately address the significant risk posed by the presence of RAAC. This figure represents the total anticipated investment required to deliver the scheme, including optimism bias, based on current cost modelling and assumptions. Support for the SOC will be able to further refine options, full affordability modelling, and continued engagement with stakeholders to confirm the preferred option at Outline Business Case (OBC) stage.

Strategic Case

The strategic case sets out the policy context and the assessment of risk associated with RAAC. Under the Health Board’s current clinical model and extant Estates Strategy, Nevill Hall is recognised as a key site in the hospital system network both as a provider of services for the local catchment but also as a key part of the network in terms of capacity and flow. Whilst work on reviewing and developing the clinical services plan for the Health Board, NHH is considered a fixed point in the hospital network due to:

- Its role in supporting the wider urgent and emergency care system in terms of local MIU and UPC services through to supporting the step-down model from the Grange University Hospital,
- In line with national policy, supporting care closer to home for low risk elective services such as outpatients, diagnostics and day surgery,
- Provision of care to families, children and women via the Children’s centre, gynae ambulatory care and the emerging AB Women’s Health Hub
- Its strategic location for the region as identified through travel times analysis for the satellite radiotherapy centre and recently as a north hub for south east Wales for cataracts for the region
- In addition, NHH site has a key role in the provision of staff residence, multi disciplinary education and management and administrative bases.

This SOC outlines the strategic case for change and rationale for investment at NHH, driven by these key factors:

Structural Risk and Estate Condition: The presence of Reinforced Autoclaved Aerated Concrete (RAAC) presents a significant risk and

Strategic Outline Case:

Nevill Hall Hospital Development Project

challenge with the existing concrete structural frame and a high-risk maintenance backlog pose ongoing safety and operational risks.

Alignment with clinical strategy: As a designated enhanced Local General Hospital (eLGH), NHH is vital to the delivery of general and routine care closer to home, supporting whole-system flow from the Grange University Hospital and across the network of hospitals and underpinned by strong and effective “place based” care models in the communities of north Gwent.

Modernisation of the Service Model: The current layout and service model requires reconfiguration to improve efficiency, better integrate services, and meet population health needs, particularly through the consolidation of activity across NHH and Maindiff Court.

Decarbonisation and Estate Rationalisation: Replacing outdated infrastructure will help meet NHS Wales decarbonisation targets and ensure long-term sustainability of the estate.

Workforce Sustainability: The redevelopment will support modern workforce models, promote agile working, and improve staff wellbeing and recruitment.

These drivers have informed the agreed investment objectives, which provide a robust framework for appraising the preferred way forward.

Economic Case

The Economic Case demonstrates that the Health Board has applied a rigorous and transparent approach to identifying a value-for-money solution that meets strategic and clinical objectives. A comprehensive long list of options was developed across six categories: service scope, service solution, service delivery, implementation, funding, and estate solution; and appraised against agreed Investment Objectives and Critical Success Factors.

Based on this work, the SOC proposes a “preferred way forward” as a reconfiguration of the NHH site that:

Will provide new-build and right sized accommodation, providing capacity (only as required) for the services that currently sit in RAAC areas

Refurbishment of the retained “H” Blocks (ward blocks where this is no RAAC),

All in a reduced footprint compared to current estate,

More effective use of clinical space and agile working space in North Gwent.

And, as a potential future phase the integration of the services currently on Maindiff Court onto NHH site, thus reducing overall AB estate.

Acknowledging the challenges of availability and affordability of capital, the proposal is for funding for Phase 1 of capital investment of an estimated £474.4 million to redevelop the Nevill Hall Hospital (NHH) site and ultimately address the significant risk posed by the presence of RACC. This figure represents the total anticipated investment required to deliver the scheme, including optimism bias,

Strategic Outline Case:

Nevill Hall Hospital Development Project

based on current cost modelling and assumptions. Support for the SOC will be able to further refine options, full affordability modelling, and continued engagement with stakeholders to confirm the preferred option at Outline Business Case (OBC) stage.

Commercial Case

The Commercial Case outlines the intended procurement approach. Subject to approval of this SOC, the Health Board will seek to appoint a Supply Chain Partner via the appropriate procurement frameworks, along with the necessary external advisors to support project delivery. This approach will ensure access to experienced suppliers, reduce procurement risk, and support timely delivery. Opportunities to embed Modern Methods of Construction (MMC), Net Zero Carbon principles, and digital infrastructure will be explored further to align with Welsh Government policy and sustainability goals.

If approved, the scheme is expected to be funded through the All-Wales Capital Programme (AWCP), and the Health Board will ensure that the commercial strategy supports value for money, compliance, and deliverability throughout the next stages of business case development.

Financial Case

The Financial Case sets out the indicative capital and revenue implications of the redevelopment proposals for Nevill Hall Hospital and provides an early view of affordability. A detailed feasibility study has been completed, which provides an initial assessment of the likely capital requirements and estate solution. This Strategic Outline Case presents indicative costs based on that feasibility work. While detailed modelling will be undertaken at Outline Business Case (OBC) stage, this Strategic Outline Case presents an initial financial assessment to inform decision-making.

The Health Board is operating within a challenging financial environment, with limited flexibility for revenue growth. However, strategic investment remains a priority where it supports long-term sustainability, improves service efficiency, and reduces risk.

Four short-listed scope options (Options 1, 3, 4, and 5) have been assessed for both capital and revenue impact. Initial capital cost estimates include allowances for optimism bias in line with HM Treasury guidance. The initial indicative recurrent revenue cost of the short-listed options range from **c.£3.1m to c.£2.1m**, with the preferred way forward (Option 5) delivering the lowest net cost through:

- Increased throughput in day case and outpatient activity.
- Rationalisation of estate, including the relocation of services from Maindiff Court.
- Operational and clinical efficiencies from revised service models.

Revenue assumptions will be further refined at OBC stage, including operational commissioning, digital costs, energy savings, and service transitions. The

Strategic Outline Case:

Nevill Hall Hospital Development Project

affordability of any uplift will be considered alongside the Health Board's Integrated Medium-Term Plan (IMTP), with a clear focus on cost containment and long-term value for money.

The Financial Case demonstrates that, with appropriate external capital funding and a robust service model, the preferred option can support sustainable healthcare delivery while optimising public investment.

Management Case

The project will be delivered in accordance with national frameworks and PRINCE2 methodology. A dedicated NHH Development Project Board, chaired by the Director of Strategy, Planning and Partnerships, has been established and reports to the Executive Committee. The governance structure sets out clear roles and responsibilities, with the Senior Responsible Owner (SRO) and Project Director accountable for delivery.

An outline project plan has been developed, subject to SOC approval. A formal risk management framework is in place, and a benefits realisation plan will be implemented to track delivery of key outcomes. A post-project evaluation will be undertaken within 12 months of completion to assess impact and capture learning for future investment.

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iii. Structure of Document

This SOC has been prepared using the agreed standards and format for Business Cases, as set out in:

- HM Treasury Guide to Developing the Project Business Case 2018
- NHS Wales Infrastructure Planning Guidance (2015)
- HM Treasury, the Green Book: Appraisal and Evaluation in Central Government: Treasury Guidance (2003).
- Public Sector Business Cases using the Five Case Model: A Toolkit Guidance and Templates (2007)

The approved format is the 5 Case Model, which comprises of the following key components:

- **The Strategic Case** which sets out the Strategic Context and the Case for Change, together with the supporting investment objectives for the Scheme.
- **The Economic Case** which demonstrates that ABUHB has selected a Value for Money approach whilst recognising the limited options available to meet the current need of the service.
- **The Commercial Case** which outlines the potential procurement strategy.
- **The Financial Case** which addresses the capital and revenue implications and the issue of affordability.
- **The Management Case** which demonstrates that the scheme is achievable and can be successfully delivered in accordance with accepted best practice.

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1. STRATEGIC CASE

1.1 Strategic Context

1.1.1 Organisational Overview

Aneurin Bevan University Health Board was established in October 2009 and achieved 'University' status in December 2013. The Health Board's principal role is to ensure the effective planning and delivery of our local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for our citizens, and in a manner that promotes human rights. To fulfil this role, we are required to work with our partners and stakeholders in the best interests of the population we serve.

As a Health Board, the organisation serves the population of Gwent which reflects the five local authority areas: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The demographics of Gwent are varied and include rural countryside areas, urban centres and the most easterly of the South Wales valleys.

The Population Needs Assessment for the region can be found here: [Gwent Joint Strategic Assessment - Aneurin Bevan University Health Board](#)

We employ 13,238 WTE (15,395 people; December 2024) and are the largest employer in Gwent. The workforce is ageing, as is the demographic profile of our population and the health inequalities of our population are also found within our workforce and 80% of our staff live within our communities. Therefore, it is essential that staff health and wellbeing is a key priority and a feature of our preventative plans.

The Health Board has an annual budget from the Welsh Government of just over £1.7 billion per year from which the organisation plans and delivers services for the population of Gwent. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being (Wales) Act 2014 and the Well Being of Future Generations (Wales) Act 2015.

Services - The Health Board provides a comprehensive range of acute hospital based, Community based, Mental Health and Primary Care services via a large and complex estate consisting of the following:

- 4 Acute Hospitals – Grange University Hospital, Royal Gwent, Nevill Hall, Ysbyty Ystrad Fawr
- 5 Community Hospitals - County, Ysbyty Aneurin Bevan, St Woolos, Chepstow and Monnow Vale
- 4 Mental Health Hospitals - St Cadoc's, Llanfrechfa, Maindiff Court, Ysbyty Tri Chwm

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8 Locality based Mental Health Units and 1 Residential Unit on LGH site, 4 unoccupied units across Gwent.
30 Locality based Community clinics

The University Health Board contracts with independent practitioners in respect of primary care services which are delivered by General Practitioners, Opticians, Pharmacists and Dentists. Outside of normal practice hours the University Health Board has responsibility for and provides an Out of Hours Primary Care Service. There are 281 WTE General Practitioners and Salaried GPs providing general medical services from 72 General Practices. Supporting these are 194.8 WTE practice nurses, 156.8 health care support workers 689.7 WTE administrative staff, including practice managers, receptionists, secretaries and IT officers. Around 375 General Dental Practitioners provide general dental services from 79 practices. There are 131 Community Pharmacies and 69 Optometry premises across the University Health Board.

A wide and growing range of community-based services are increasingly being delivered in patient's homes, through community hospitals, health centres and clinics. There are several smaller community hospitals, integrated health and social care centres, and health centres providing important clinical services to our residents closer to home.

The Health Board also provides comprehensive Mental Health and Learning Disabilities services in both hospital and community settings to the population of Gwent and South Powys

1.2 Business Strategy and Aims

1.2.1 National Policy /Service Context

'**A Healthier Wales**' sets out a long term, future vision of a whole system approach to health and social care which is focussed on health and wellbeing and on preventing illness. The ambition is for the continued development of a seamless, integrated system of health and social care, predicated on a place-based approach to service delivery, to improve service sustainability, quality and safety and to improve population wellbeing.

The Social Services and Wellbeing (Wales) Act and Wellbeing of Future Generations (Wales) Act 2015 provide an enabling legislative framework which requires the Health Board and partners to work collaboratively in an integrated way across the whole system, involving the public in developing long term solutions to prevent avoidable illness and provide sustainable services in the future.

The Wellbeing of Future Generations (Wales) Act established 7 National goals and places a Well-being duty on Welsh Public Bodies. The legislation requires the Health Board to carry out Sustainable Development by acting in accordance with the Sustainable Development Principle through applying five ways of working to its decision making, namely:

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- Long term thinking (where consideration should be given to the balance between current demands and longer-term impacts over a 25-year period).
- An Integrated approach (how wellbeing objectives impact upon each other and in turn on the objectives of other public bodies and then how decisions impact on supporting the 7 national well-being Goals).
- Preventative Action (deploying resources now to prevent problems occurring or getting worse).
- Collaboration (acting collaboratively with other bodies or with other parts of the Health Board to assist in the achievements of the objectives of all).
- Involvement (involving the people and communities whose well-being is being considered and engaging them and others in finding sustainable solutions).

By applying these ways of working the Health Board will bring about the organisational culture change needed to deliver on the ambition of 'A Healthier Wales'.

1.2.2 Regional Context

There is an ongoing requirement for co-ordinated service planning and delivery at a regional level to ensure the provision of safe, sustainable, and high-quality care across Southeast Wales. The Health Board continues to play an active role in strengthening regional planning in collaboration with neighbouring Health Boards and NHS Trusts. This includes:

Collaboration with Velindre NHS Trust and Powys, CTM and Cardiff & Vale LHBs on the development of a Satellite Radiotherapy Unit at Nevill Hall Hospital, which will enhance accessibility to cancer treatment for the populations of South East Wales and support broader system resilience.

Development of the Regional Ophthalmology Service a hub and spoke model with some regional cataract services based at Nevill Hall Hospital. This model, utilising shared theatre and outpatient capacity, forms part of a wider regional eye care pathway. It responds to increasing demand for high-volume, low-complexity procedures and is being developed in line with regional strategic priorities. Further expansion of this service is anticipated but is subject to a business case for sustainable cataract services.

Ongoing engagement in the Llantrisant Health Park (LHP) development, led by Cwm Taf Morgannwg University Health Board. As a proposed regional centre for planned care, LHP's evolving role has direct interdependencies with Nevill Hall Hospital's service configuration. The services to be provided in LHP are being modelled on the assumption of additionality to existing capacity, including that in NHH. Continued regional dialogue will be essential to ensure alignment, minimise duplication, and maximise system-wide efficiency.

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At this stage, whilst the Strategic Outline Case focuses primarily on the strategic need and case for change within Aneurin Bevan University Health Board, active consideration has been given to how it can align services with neighbouring Health Boards specifically in relation to regional working opportunities. This review will continue as we move forward through the Outline and Full Business Case stages and onto the operationalisation of the hospital.

1.2.3 Strategic Regional Fit

The Nevill Hall Hospital Development Project has been designed to complement, not duplicate, regional service developments. It has been shaped through regional dialogue and is aligned with existing and emerging models across South East Wales. The case recognises the importance of avoiding fragmentation and duplication and ensures that the services proposed for Nevill Hall are targeted, appropriate to local need, and coordinated with neighbouring health systems. This strategic fit underpins the role of Nevill Hall as a key component of a balanced, regionally integrated healthcare system.

1.2.4 Local Policy Context

The Health Board's Integrated Medium-Term Plan for the next three years 2025-2028 is a statement of the Health Board's ambition to improve the health and wellbeing of the population through services delivered closer to home. The plan sets out the change we will deliver against five themes:

1. Embedding prevention and population health in all that we do
2. Progressing place-based models of care and sustainability in primary and community services
3. Improving our urgent & emergency care system focusing on experience, access and discharge pathways
4. Continuing to prioritise cancer, urgent and the longest waiting patients for planned care
5. Improving our mental health services

Our plan sets out how we will purposefully advance our prevention priorities including, population health management and place-based care starting in deprived communities. This will be demonstrated through our continued partnership working across Gwent.

Our plan for next year will focus on:

- ✓ Further step towards financial sustainability through three-year route map
- ✓ Drive quality of care and improving health outcomes
- ✓ Delivery of improved performance in line with ministerial priorities and enabling actions
- ✓ Targeted actions to support organisation de-escalation in Urgent and emergency Care

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- ✓ Purposefully advancing our prevention priorities including, population health management and place-based care starting in deprived communities
- ✓ Supporting our staff and resilience of our workforce models

Our plan responds to several UK wide, National, Regional and Local drivers that form the strategic context we are delivering within. In addition, it's important we reflect the national legislation and framework that guides our focus over the next three years to deliver sustainable services, Value-Based interventions, improvement of care and outcomes that matter for our population. Throughout the plan we have evidenced our commitment to the duties of quality and candour including implementation of quality statements which have informed our delivery plan development.

The development of our new strategy **Gwent 2035** champions population health and puts the Wellbeing of Future Generations at the heart of everything we do to improve the health of our population through partnerships.

The Gwent Joint Strategic Assessment provided the evidence base and case for change highlighting the health inequity experienced by our population. Therefore, it was timely that the Health Board considered a new long-term strategy which articulates its joint commitments with the population of Gwent through to 2035. The development of a new strategy has provided a unique opportunity to look to the future with communities to determine what matters to them; and how we can work in partnership to improve wellbeing through place-based care.

The development of the strategy from 2025 to 2035 has ensured a comprehensive evidence base that has included an extensive horizon scanning library, engagement with staff, partners and population and significant data analysis from a range of sources including the Gwent Joint Strategic Assessment. Through thousands of rich and meaningful conversations, we have developed a better understanding of what is important for our population to feel healthy and have used themes from this public engagement to shape a new strategic framework of the organisation.

The Health Board has developed the strategy due to be considered by the Board in July entitled Gwent 2035: Better Health, Better Care, Better Lives'. The strategy sets out our purpose to Improve the health of our population achieving equity for all and our ambition that by 2035 everyone has the same chance to live a long healthy life

Under the Wellbeing of Future Generations Act (2015) we have a statutory responsibility to set and publish wellbeing objectives, and these are proposed to be our new strategic aims as set out below:

Our Aims	
Better Health	Together we will support people to be healthy, active and happy.
Better Care	Together we will deliver what matters to people, supporting our staff to thrive and achieving quality, kind and sustainable care.

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**Better
Lives**

Together we will create strong, safe, and connected communities.

These aims will enable us to improve the health of our population achieving equity for all working across the whole system. This can only be achieved by acting as an anchor institution and influencing all the factors that make people live healthy lives.

1.2.5 Clinical Futures Service model and The Grange University Hospital

The Clinical Futures programme set out a whole-system model of care built on the principle of providing safe, high-quality services in the most appropriate setting, delivering specialist and critical care in a specialist critical care centre, while supporting access to general and routine care as close to home as possible.

A major milestone in delivering this vision was the opening of the Grange University Hospital (GUH) in November 2020. As a purpose-built centre for specialist and emergency care, GUH consolidated complex and high-acuity services into a single site, allowing other acute hospitals, including Nevill Hall Hospital, to focus on the delivery of enhanced Local General Hospital (eLGH) functions. These include elective surgery, diagnostics, outpatient care, medical support, therapies, and rehabilitation.

The implementation of Clinical Futures and the opening of GUH have delivered measurable improvements in system flow, access to specialist care, and the ability to manage high-risk patients in dedicated environments. This is set out in the Hospital System Report presented to the Board in November 2024. There have been significant achievements since the reconfiguration in 2020 against the original objectives of the Clinical Futures FBC:

- ✓ Improved outcomes for the most seriously unwell
- ✓ Improved quality and safety
- ✓ Greater staffing sustainability in core services such as critical care and maternity
- ✓ Separation of planned and emergency activity
- ✓ Improved staffing and recruitment for essential specialties
- ✓ Greater resilience in services
- ✓ Ability to innovate within the system model

The Full Business case for the GUH was based on a set of demand assumptions using 2015 as a baseline. Annual demand since 2015 had been above predicted levels with significant pressures across the health and social care system. New modelling had been undertaken as part of the refreshed planning post FBC approval. The impact of the pandemic further compromised the modelling assumptions which have seen unpredictable patterns of demand as we have moved through the different phases of the pandemic.

There continues to be annual increases in the demand across most services including primary care and community services, urgent and emergency care,

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planned care, cancer services, Mental Health Services, women and children services and therapy services and diagnostics. The challenges that this presents is significant at a time when the organisation is trying to address the backlog of waiting lists, increasing acuity and public expectations. As well as increased demand the Office for National Statistics forecasting that by 2035 there will be 18% less 18-year-olds entering the workforce.

Most people who work for the Health Board also live in the Gwent area, so with forecasts of fewer 18-year-olds starting work by 2035 there will be fewer younger people starting their career in healthcare. Now, just 15% of our staff are aged between 21 and 30, while 36% are over the age of 50. Therefore, the organisation cannot continue to staff its services in the way it does now.

There are several areas to consider:

Workforce and service fragility: Whilst the opening of the GUH has strengthened workforce resilience in several critical services, it has stretched resources over additional sites. The full delivery of the proposed model set out in the FBC has not been achieved and there remains a higher number of beds open in the health boards system, stretching workforce in several areas. The demographic changes mean it is unlikely to be able to provide sustainability in the current model of care.

Estate mismatch: Many facilities, including those at Nevill Hall Hospital, were not originally designed for the revised model of care set out in the clinical futures FBC. This has resulted in inefficiencies, poor patient flow, and limitations on service modernisation. The GUH has delivered significant improvement in Infection Prevention Control (as set out in the [Hospital System Report](#)) via the building design which have not been achieved on other eLGH sites.

System interdependencies: The success of GUH relies on eLGH sites operating effectively as part of the whole system. Delays or limitations in day surgery, diagnostics, outpatient pathways and patient discharge at sites like Nevill Hall have a direct impact on overall system performance. In essence the eLGH sites support the operational function of the GUH and wider system.

Need for proactive investment: The initial success of GUH highlighted the importance of delivering estate improvements and clinical model alignment in tandem. Retrofitting changes after operational go-live can limit the effectiveness of transformation.

Stakeholder engagement: The proactive identification of stakeholders was key to the successful delivery of GUH, this included public engagement and engagement with Llais. Recent service change at NHH reinforces the proactive and early engagement of stakeholders as a core part of the project plan.

The Nevill Hall Development Project represents a critical opportunity to consolidate these learning points and ensure the next phase of the Health Board's transformation programme delivers a fully integrated, future-proofed

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model of care based on population need. The project will address the estate and service limitations currently faced at Nevill Hall, enable sustainable efficient workforce and service models aligned to need to support the long-term success of the Gwent region.

1.3 Case for Change

The redevelopment of Nevill Hall Hospital is essential to ensure safe, sustainable, and high-quality healthcare for the North Gwent population. The case for change is now primarily driven by the significant structural risk due to the presence of Reinforced Autoclaved Aerated Concrete (RAAC), a growing backlog of maintenance, and outdated infrastructure that no longer meets modern standards of care. At the same time, services must adapt to meet the changing needs of patients, deliver care closer to home, and support the wider clinical model development. This project provides a unique opportunity to rationalise and modernise the estate, align with regional service plans, and create an environment that supports future workforce models, improved patient outcomes, and long-term value for money.

The Health Board is now just over five years into the implementation of a significant change to the clinical model, following the opening of the Grange University Hospital in November 2020. The enhanced Local General Hospital (eLGH) sites are a key component of the ABUHB model supporting the operational function of the Grange University Hospital and the wider system. NHH is a key site that provides opportunities to further support the GUH and provide patient care close to home for the population of north Gwent while also providing regional specialist service such as ophthalmology and radiotherapy.

The NHH Development Project forms part of the Clinical Redesign Programme. The Clinical Redesign Programme is one of the Health Board's key priority transformation programmes, established to take forward clinical reconfiguration opportunities and service redesign aligned to the Health Board's Clinical Futures Strategy, with the overall aim of reducing health inequality and improving population health. The consolidation of the Stroke rehabilitation service and the Respiratory services provide examples of recent clinical redesign at NHH which aimed to deliver improved patient care and sustainable service delivery.

The purpose of the Nevill Hall Development Project is to establish an open process for identifying and confirming the preferred future model of care for Nevill Hall Hospital (NHH). This model aims to deliver quality, patient-centred care, ensure workforce stability, and optimise services to enhance patient outcomes and experiences, creating a future-proof model of care. The objectives are:

- Address the presence of Reinforced Autoclaved Aerated Concrete (RAAC) within the existing estate through the delivery of a long-term, sustainable infrastructure solution that mitigates structural risk and avoids ongoing monitoring and reactive maintenance
- Right size our key services to match capacity with anticipated demand

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- Rationalise the Health Board Estate
- Ensure that as many services as possible are provided close to home, whilst also recognising that where more complex acute care is required, this is provided according to best practice and the highest clinical standards
- Ensure service delivery is aligned with patient need for the north of Gwent
- Ensure all services are efficient and sustainable (this will help us to improve patient experience and reduce length of stay)
- Optimise the flow of patients through the system
- Match workforce resource to demand

1.3.1 Reinforced Autoclaved Aerated Concrete (RAAC)

Reinforced Autoclaved Aerated Concrete (RAAC) is a lightweight, precast concrete material used in construction between the 1950s and 1990s. It consists of steel reinforcement, high-temperature steam curing, and aerated concrete with air bubbles formed through a chemical reaction, additionally -

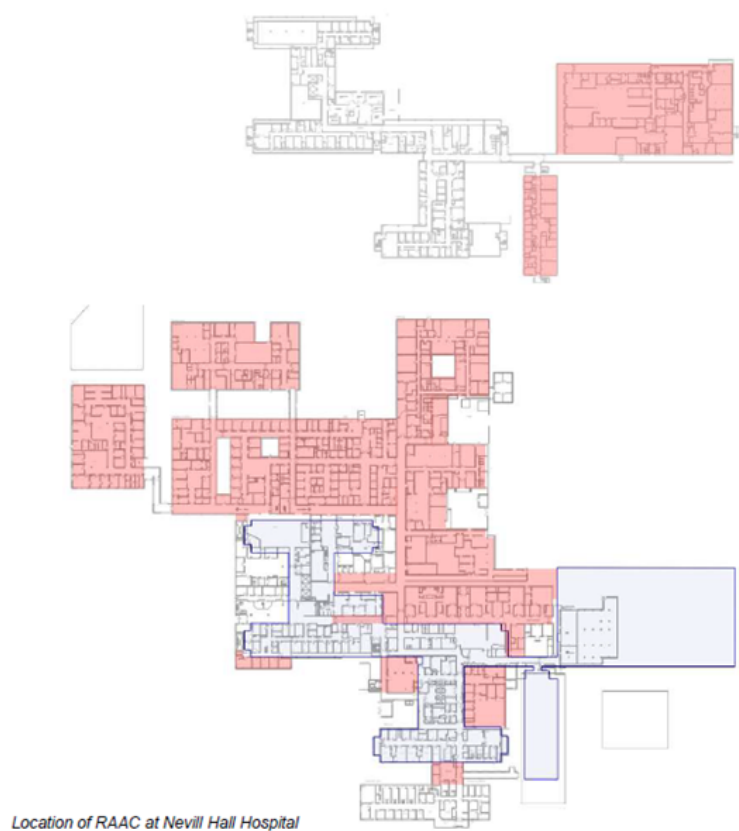
- It was widely used in the UK the 1950s to the 1990s, particularly in flat roofs, floors, and wall panels in public buildings, including hospitals, schools, and offices.
- Unlike traditional concrete, RAAC is more porous and weaker.
- Over time, it can degrade, especially when exposed to moisture.
- RAAC has a design life of around 30 years

RAAC panels are less dense and have lower compressive strength compared to traditional concrete. They are commonly used in roof structures, but also in floors and walls. However, RAAC has significant structural issues, including poor end-bearing, susceptibility to water damage, and potential for sudden failure, leading to concerns about its longevity and safety in buildings. RAAC panels are located across circa 19,010 m² of roof space within the NHH estate. The total number of panels is approximately 7,816. This excludes areas that have been demolished as of the date of the most recent inspection. This is a significant number in comparison to other RAAC installations across the UK. Nevill Hall is considered a whole RAAC hospital for this reason. The presence of RAAC can compromise the safety of healthcare buildings. This risk cannot be removed unless the RAAC panels are removed.

The installation consists of mainly flat roof panels, although some pitched roof panels exist above the theatre plant room space. There are a few instances of wall panels across the site, which are non-load bearing. There is a RAAC management strategy in place which has been developed alongside the Health Boards professional advisors and is adapted in line with the latest guidance as it is updated.

The following diagram indicates the extent of the presence of RAAC in NHH, which is highlighted in pink -

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1.3.2 Contribution to Whole-System Resilience

The redevelopment of Nevill Hall Hospital plays a pivotal role in enhancing the resilience of the Health Board's elective, routine, and diagnostic activity. By maximising day surgery and outpatient capacity at NHH, the scheme alleviates pressure on elective services currently at the Royal Gwent Hospital (RGH) and aligns with the Health Boards IMTP as a key enabler to meeting the GIRFT (Getting It Right First Time) recommendations, protecting elective capacity and flexible theatre and treatment room capacity. This, in turn, strengthens system-wide resilience by preserving emergency capacity at the Grange University Hospital (GUH), which is dedicated to acute and complex care. RGH currently hosts a Surgical High Care Unit (SHCU) enabling it to treat higher-acuity elective patients who would otherwise require intervention at GUH. By enabling lower-acuity elective activity to be delivered at NHH, the Health Board can safeguard RGH capacity for those higher-acuity cases. This redistribution of activity improves patient flow, reduces elective backlogs, and supports a more sustainable, whole-system model of care.

NHH is a key site supporting patient flow across the system, following an acute period of care, patients may be required to step down to an eLGH from the GUH to receive further care or while awaiting the next step in their patient pathway. This is the model of care implemented following the opening of GUH in November 2020, the eLGH sites including NHH support whole system following ensuring the patient receives the right care in the right place first time. The bed base at NHH supports care close to home and improved patient flow ensuring

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patients receive discharge planning support from local team supporting timely patient discharge and reduced length of stay.

1.3.3 Summary of Key Drivers

To guide investment decisions, six key strategic drivers have been identified (Figure 1). These reflect the core challenges and opportunities underpinning the case for change and will shape both the preferred solution and assessment of options.

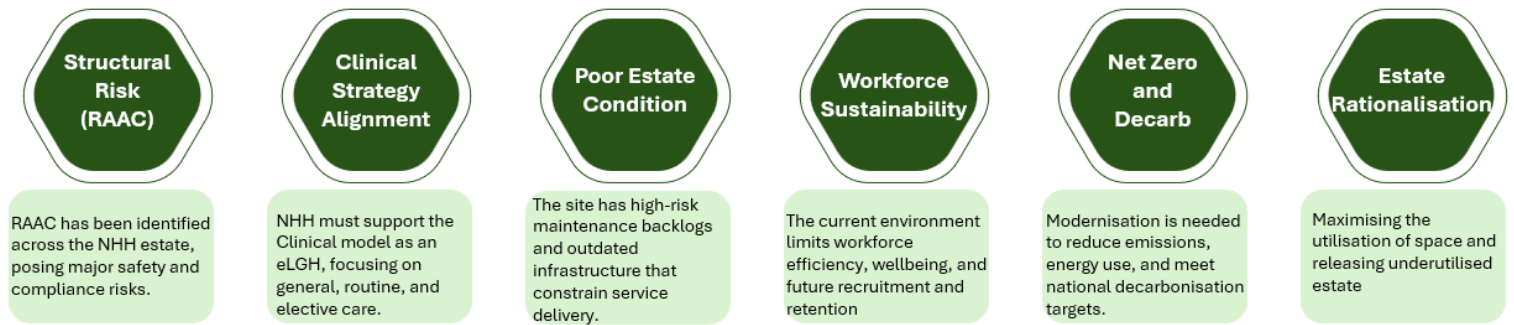


Figure 1: Summary of Key Drivers

The key drivers outlined above set the context for this investment, capturing the strategic, clinical, and operational challenges the scheme must address. These drivers have directly informed the development of investment objectives, which will be used to evaluate options and guide the design of a sustainable, future-focused solution for Nevill Hall Hospital.

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1.3.4 Investment Objectives

The following Investment Objectives have been established to provide a clear framework for evaluating and selecting options for the project. These objectives focus on delivering measurable outcomes that align with the Health Board's strategic priorities, ensuring each option contributes to the project's overarching goals. The Investment Objectives serve as benchmarks for assessing the potential impact, effectiveness, and sustainability of each option, helping to identify solutions that will drive long-term benefits, meet patient and service needs, and support organisational growth and resilience. The agreed Investment Objectives for this project are as follows:

	Investment Objective	Investment Theme	Specific	Measurable	Achievable	Relevant	Timebound
1	To provide a sustainable and high quality eLGH model of care on the NHH site	Economy	Allocate resources effectively at NHH to enhance service delivery and comply with strategic objectives, focusing on reducing costs and avoiding waste.	Track and report costs and resource utilisation	Conduct regular resource audits to identify areas for reallocation or efficiency improvements.	Ensures alignment with strategic goals and supports financial sustainability	Achieve targeted resource efficiency by 1 year following opening.
2	Provide a model of care for the NHH site that delivers patient care in line with best practice, meeting the needs of patients, carers, and staff.	Effectiveness	Implement a care model at NHH that adheres to national best-practice standards, ensuring all specialties deliver high-quality, consistent care.	Compliance with best-practice guidelines across specialties and maintain patient satisfaction scores	Engage multidisciplinary teams in developing model of care	Aligns with the Health Board's goal to improve health outcomes and enhance patient experience through reliable, evidence-based care.	Complete model implementation within 6 months of opening.

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3	To provide a safe and fit for purpose estate and environment that removes the risks associated with RAAC and aligns with the decarbonisation agenda and the principles of the Well-being of Future Generations (Wales) Act.	Quality	Develop a care model at NHH that supports adaptability for evolving clinical practices, patient demographics, and workforce structures, while removing all RAAC to ensure long-term safety.	Completion of RAAC removal and the development of a care model evidenced by approval of final plans by stakeholders	Aligns with the Health Board's Clinical Futures strategy, ensuring NHH remains fit-for-purpose in a changing healthcare environment and adheres to safety standards.	Aligns with the Health Board's Clinical Futures strategy, ensuring NHH remains fit-for-purpose in a changing healthcare environment.	Complete RAAC removal and decarbonisation upgrades by completion of build.
4	Deliver a model of care for the NHH site that supports improved efficiency in service delivery and optimising resource use.	Sustainability	Implement care pathways at NHH that shift focus from high-cost inpatient services to efficient outpatient and community-based care.	Achieve target efficiency metrics in care delivery	Utilise evidence-based practices incorporating technology and alternative care settings.	Supports the Health Board's goal for sustainable service models, enhancing patient outcomes and reducing operational costs.	Target efficiency improvements to be fully operational by 1 year following opening.
5	To deliver models of care and infrastructure that supports sustainable workforce models	Efficiency	Redesign care processes at NHH to minimise redundancy and reduce wait times, using integrated systems and streamlined workflows.	Monitor KPIs efficiency metrics in care delivery	Collaborate with clinical teams to introduce process improvements, technology, and training for streamlined care	Essential for maintaining high-quality care standards while optimising operational efficiency.	Complete efficiency improvements and achieve targeted reductions by 1 year following opening.

Table 1: Investment Objectives

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Together, these investment objectives provide a clear and measurable framework to guide the development and appraisal of options. They ensure that any proposed solution not only addresses the structural and clinical challenges currently facing the site, but also supports the delivery of high-quality, sustainable services aligned with the clinical strategy. The objectives will be used to evaluate the economic case and determine which option offers the best value for money while delivering the intended outcomes for patients, staff, and the wider health system.

1.3.5 Existing Arrangements

Nevill Hall Hospital

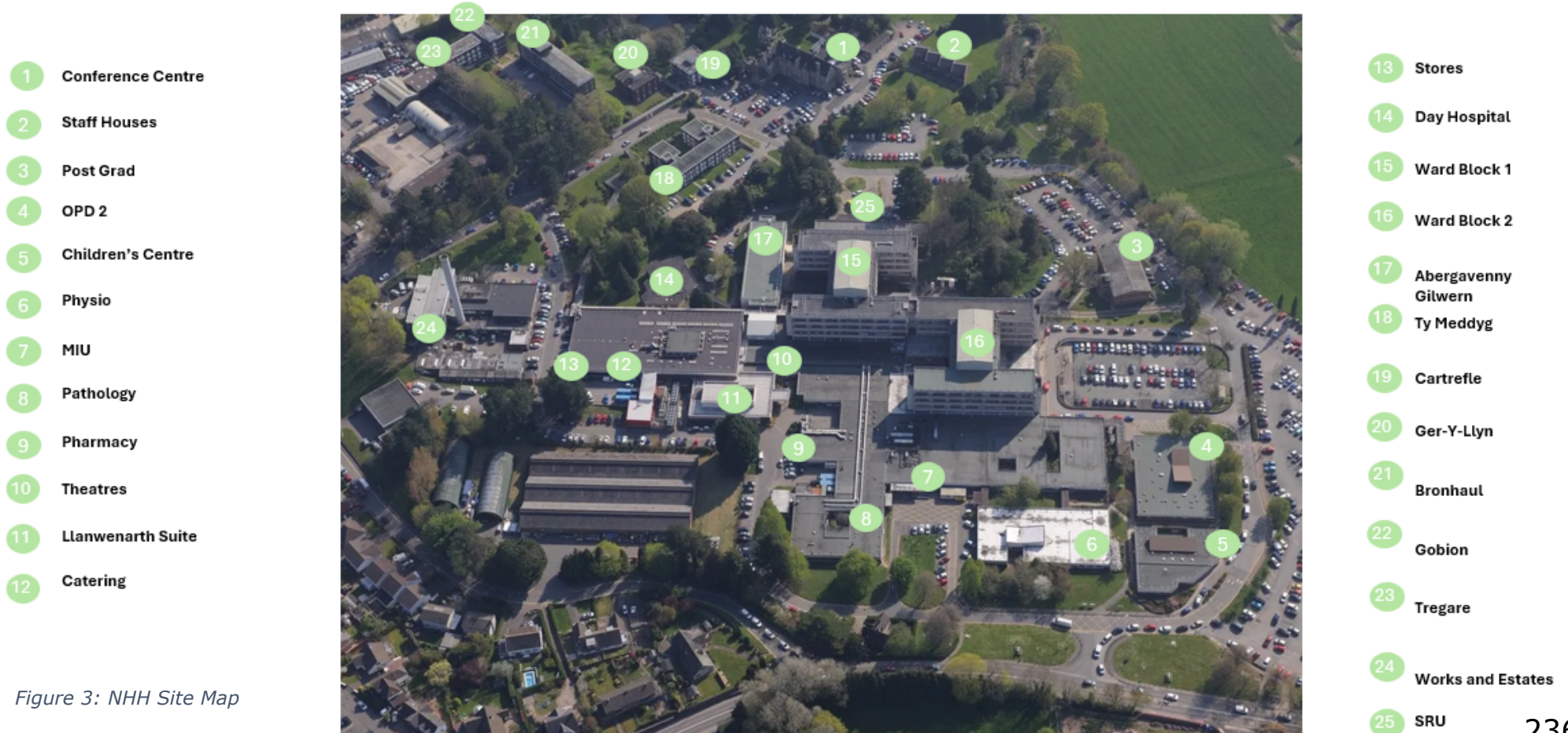


Figure 3: NHH Site Map

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1.3.6 Site Location and Description

Nevill Hall Hospital is in Abergavenny, Monmouthshire. The hospital serves as a key site within the Health Board's acute portfolio and currently accommodates a range of clinical services. The aerial image above illustrates the scale and complexity of the Nevill Hall Hospital (NHH) site, which comprises a mix of patient-facing clinical facilities and non-clinical areas distributed across multiple buildings. While the main hospital block remains the central hub for acute care delivery, the wider estate includes numerous peripheral structures that support a variety of operational functions. The dispersed layout, combined with varying building age and condition, contributes to ongoing challenges in space utilisation, wayfinding, and service integration.

The site was originally home to Nevill Hall, a Grade II listed country house that was repurposed as a hospital in the 1920s. In response to increasing service demand, a new hospital facility was constructed on the grounds in the late 1960s, with the main building officially opening in 1970. The hospital comprises a four-storey tower block positioned above a single-storey podium level. The primary structure is formed using a concrete frame, with in-situ cast waffle and ribbed concrete slabs for the tower and a precast concrete frame for the podium. The podium features infill panels formed from Reinforced Autoclaved Aerated Concrete (RAAC), creating a flat roof construction.

Over time, additional buildings have been developed on the site to accommodate service expansion, including the Abergavenny and Gilwern Ward, Day Hospital, Clinical School, Children's Centre, and the Llanwenarth Suite. Construction of a new Satellite Radiotherapy Unit (SRU) has recently been completed, with full operation commencing in summer 2025.

Despite its strategic importance, the hospital site faces several operational challenges:

Presence of Reinforced Autoclaved Aerated Concrete (RAAC):

presents known structural risks and requires active monitoring. Its presence is a key driver for long-term site redevelopment and risk mitigation. The precast concrete frame of the podium buildings has been found to have structural issues, which require further investigation, and may require further remediation.

Underutilisation of the Site: Since the opening of the Grange University Hospital (GUH), several services have relocated, resulting in large parts of the estate being underutilised. The current configuration no longer reflects the service delivery needs of a post-GUH model and does not make best use of available space.

Inefficient Layout: The estate has not been designed to maximise clinical efficiency. Key adjacencies between services are suboptimal, limiting the ability to streamline patient pathways and optimise staff productivity.

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Estate Condition: The overall condition of the hospital infrastructure is poor, contributing to high levels of backlog maintenance. Backlog is currently estimated at £54.6 million (excluding RAAC remediation costs).

The redevelopment of Nevill Hall Hospital provides an opportunity to address these issues through a comprehensive reconfiguration and investment in modern, sustainable infrastructure.

1.4 Service Overview

The plan for Nevill Hall hospital, as part of the Clinical Futures Strategy was delivery of the majority of hospital services focusing on general and routine care (elective, sub-acute, rehab, palliative, therapies, outpatients, investigations)

- Emergency care available 24/7 – with link to the Grange University Hospital
- Proposed Cancer Centre & Satellite Radiotherapy Unit
- Surgical Day Centre
- Care of the Elderly COTE – Elderly Frail Unit (EFU)
- Enhanced services available including MRI, CT, medical assessments from 8:00-20:00
- Reconfiguration of the site to keep it updated including proposed refurbished single 'front door'
- A dedicated, purpose designed Children's Outpatient Department providing dedicated waiting areas and play area; Clinic rooms and counselling facilities; Family room; and children's centre for children with disabilities
- Consultant and midwife antenatal and postnatal care
- Midwifery led birthing unit for women who are likely to have normal deliveries, with single en-suite delivery and aftercare rooms and water birth facilities

The current clinical model at NHH includes:

Minor Injuries Unit (MIU): Offers urgent care for minor injuries and illnesses (Open from 7.00am to 1.00am, seven days per week)

Main Outpatients Department: Provides a wide range of specialist outpatient clinics for consultations, follow-up care, and minor treatments.

Day Surgery Unit: Performs surgical procedures, enabling patients to undergo surgery and return home on the same day.

Diabetes Centre: Focuses on the management and treatment of diabetes, offering comprehensive care including patient education, monitoring, and support.

Children's Centre: Delivering specialised services to address the health needs of children.

Diagnostic Services: including radiology and pathology services, for accurate and timely diagnosis of medical conditions.

Gynaecology Ambulatory Care: Provides specialised outpatient care for gynaecological conditions, emphasizing non-emergency and ambulatory services.

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Haematology Day Unit: Delivers day treatments for blood disorders, such as chemotherapy and transfusions, for patients requiring ongoing haematological care.

Medical Inpatient Wards: Offers inpatient care for patients with a variety of medical conditions, ensuring continuous monitoring and treatment.

Orthogeriatric Step Down Ward: Provides specialised care for elderly patients recovering from orthopaedic surgery or injuries, facilitating their transition from acute care to home or other care settings.

Day Hospital: Offers specialised services including rheumatology clinics and other specialist outpatient services.

Pharmacy: Delivers comprehensive pharmaceutical care, including medication dispensing, management, and advice.

Research and Delivery: Facilitates the delivery of clinical research and trials, supporting innovation and evidence-based improvements in patient care.

Endoscopy services: diagnostic and therapeutic endoscopic procedures for a range of gastrointestinal conditions.

Urgent Primary Care: Provides urgent primary care services and GP out-of-hours care for patients needing immediate attention.

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1.4.1 Summary of Services across North Gwent

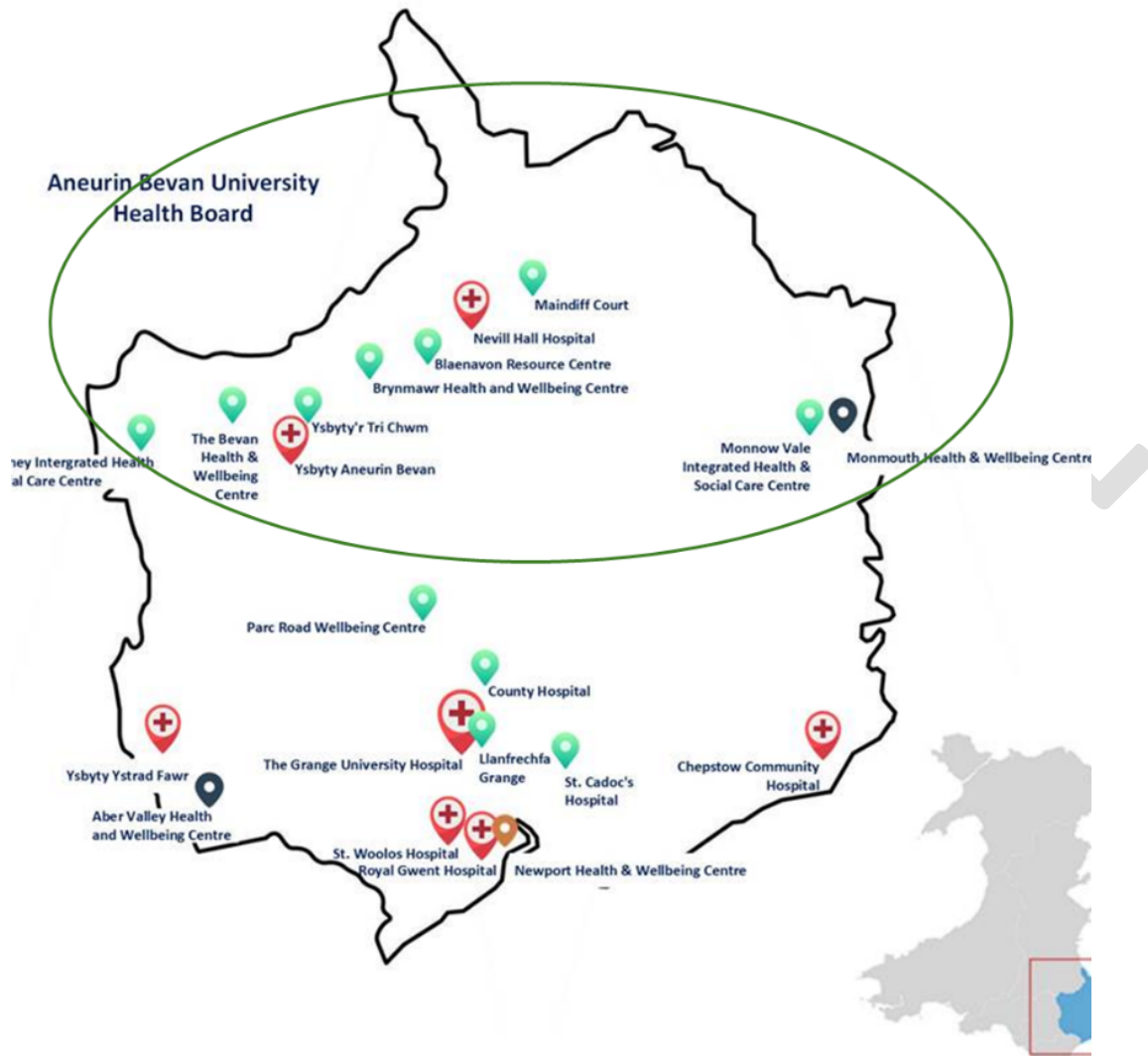


Figure 4: Maps of ABUHB Sites

The role of Nevill Hall Hospital is central to the delivery of the North Gwent service model, which is made up of a network of interconnected community hospitals, health and wellbeing centres, and specialist mental health facilities. Table 2 below provides a summary of the key services delivered across North Gwent:

Site	Services
Nevill Hall Hospital, Abergavenny	<ul style="list-style-type: none"> • Day surgery • Outpatients • Gynaecology ambulatory care • Haematology Unit • Diabetes Centre • Minor Injuries Unit • Medical Inpatient Ward • Orthogeriatric Step down • Day Hospital • Pharmacy • Diagnostics • Children's centre • Maternity ANC • Health Visiting • School Nursing

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Maindiff Court, Abergavenny	<ul style="list-style-type: none"> • MH&LD Outpatients and ECT • Adult Community Mental Health Team • Older Adult Mental Health • Primary Care Mental Health • Adult Mental Health Rehabilitation ward • Mental Health Residential Units 	<ul style="list-style-type: none"> • Learning Disabilities Service • Substance Drug and Alcohol Service • Veterans Service • Eating Disorder Service • Health Visiting • School Nursing
Ysbyty Aneurin Bevan, Ebbw Vale	<ul style="list-style-type: none"> • Adult Acute Mental Health Ward • Adult Community Mental Health Team • Minor Injuries Unit • Radiology Department • Outpatient Department 	<ul style="list-style-type: none"> • Maternity Birthing Pool • Physiotherapy Department • Podiatry • Diagnostic Imaging • Family & therapies • Children's department
Ysbyty Tri Cwm, Ebbw Vale	<ul style="list-style-type: none"> • Mental Health Inpatient ward (Dementia Assessment Unit) • Older Adult Community Mental Health Team • Older Adult Memory Assessment Service 	<ul style="list-style-type: none"> • MH&LD ADHD Service • Primary Care Mental Health Support Service • Older Adult Mapping • Education and Carers Service
Brynmawr Health & Wellbeing Centre	<ul style="list-style-type: none"> • GMS Services • Pharmacy • Dental • Memory Assessment Clinic 	<ul style="list-style-type: none"> • AAA • District Nurses • Psychology • Diabetic eye screening • Family and Therapy clinics
The Bevan Health and Wellbeing Centre, Tredegar	<ul style="list-style-type: none"> • GMS Services • Pharmacy • GDS • Health Visitors • District Nurses • Midwifery • Lymphoedema • Diabetic Eye Screening • Gwent Specialist Substance Misuse Service • CAMHS • Adult Mental Health Psychology Service • Podiatry • Audiology 	<ul style="list-style-type: none"> • Perinatal Mental Health • Children's Weight Management Clinic • Community S&LT • Lac / School Nursing Team • Eating Disorder Service • All Wales Diabetes Prevention Programme • Child and Family Psychology • Smoking Cessation • Veterans Service • Occupational Therapy: Blaenau Gwent Community Mental Health Team • Flying Start Breast Feeding Support Group • Expert Patient Programme – GAVO (Gwent Association of Voluntary Organisation) • Family Therapy

Table 2: Summary of North Gwent Services

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1.5 Business Needs – Current and Future

The Nevill Hall Hospital (NHH) development project seeks to address service gaps and operational challenges, ensuring that NHH is fit for purpose to meet the current and future needs of the local population. Since the opening of Grange University Hospital, the Health Board has faced several key challenges, which highlight the need for service improvements at NHH:

- Many of our services are under severe pressure and not always set up in such a way as to ensure efficiency and effectiveness
- The Health Board is under significant financial pressure, affecting our ability to invest in priority service areas
- Additional beds were added to the system during COVID-19, exceeding the capacity initially planned under the Clinical Futures strategy. This increased bed count is unsustainable due to staffing and financial limitations, highlighting the need for a more efficient model of care.

These issues, coupled with the presence of RAAC and a backlog of high-risk maintenance, reinforce the urgent need for a more effective, sustainable model of care at NHH. To ensure effective system operation and sustainability, the enhanced Local General Hospital (eLGH) sites, including NHH, must be designed with a fit-for-purpose and sustainable workforce model. This model should be capable of delivering high-quality, accessible care that meets the evolving needs of the local community.

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1.6 Potential Scope and Service Requirements

The scope of the Nevill Hall Hospital redevelopment has been shaped through extensive clinical engagement, feasibility testing, and alignment with key strategic drivers. To support decision-making and future design development, requirements have been grouped into three categories: Core (Essential), Desirable, and Optional, based on their contribution to safety, compliance, service sustainability, and long-term transformation goals (Table 3: Scope Options).

While the current business case is focused on addressing critical estate and service needs, most notably the removal of RAAC and delivery of a sustainable eLGH model, there are broader opportunities for the Nevill Hall site that could be explored as part of a longer-term Development Control Plan. These include the potential for integrated primary care provision, such as a co-located GP surgery, and the development of staff accommodation in partnership with housing providers to support workforce sustainability. While these opportunities are not within the immediate scope of this investment, they remain important strategic considerations that can be developed further once the core infrastructure and service model are secured.

Requirement Level	Definition	Description
Core / Essential	<i>These are non-negotiable elements that must be included in the project to meet fundamental goals, such as safety, compliance, and the immediate healthcare needs of the community. Core requirements directly impact the hospital's ability to operate effectively and sustainably.</i>	<ul style="list-style-type: none">• Removal of Reinforced Autoclaved Aerated Concrete (RAAC), and repair of the precast frame, to address structural risk and ensure ongoing compliance.• Refresh of clinical model to deliver a fit-for-purpose eLGH model, including inpatient wards, day surgery, diagnostics, outpatient care, rehabilitation, family and therapies and appropriate supporting clinical and non-clinical functions to support.• Establishment of a sustainable workforce and finance model, supported by an environment that enables agile, multidisciplinary working.• Incorporation of decarbonisation measures, improved patient flow, and modern estate design aligned with NHS Wales standards.• Integration of digital infrastructure and capability to support agile working, digital-first care models
Desirable	<i>These elements add significant value to the project but are not strictly</i>	<ul style="list-style-type: none">• Refurbishment of ward block (H Blocks)• Rationalise Maindiff Court as part of an efficient use of resources within the Health Board's estate.

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	<p><i>required to meet the minimum operational standards. Desirable requirements aim to enhance service delivery, patient experience, and operational efficiency. They support long-term goals.</i></p>	<ul style="list-style-type: none"> • Provide an administrative hub for staff to maximise clinical spaces and meet the demand for non-clinical spaces within the hospital
<p>Optional</p>	<p><i>These are additional features that provide added benefits but do not impact the project's core functionality or primary objectives. Optional requirements may be included if resources permit and can enhance the overall patient experience and community support.</i></p>	<ul style="list-style-type: none"> • Consider Ysbyty Tri Chwm (YTC), which has a mental health ward, as an option to support broader care needs by relocating the mental health ward to NHH and repurposing YTC for community use.
<p>Future Opportunities</p>	<p><i>These are potential future developments or service enhancements that are not currently included within the scope of this business case but align with long-term strategic goals. They may be considered in future phases or aligned programmes, subject to funding availability,</i></p>	<ul style="list-style-type: none"> • Development of a primary care hub or co-located GP surgery to support integrated out-of-hospital care models. • Staff accommodation delivered in partnership with local housing associations • Opportunities to further consolidate community services • Maggie's Centre <p>While outside the immediate scope of this business case, these future opportunities are strategically important and may be considered as part of a future Development Control Plan.</p>

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	<i>partnership development, or wider system planning.</i>	
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Table 3: Scope Options

1.6.1 Scope Options to Address the Case for Change

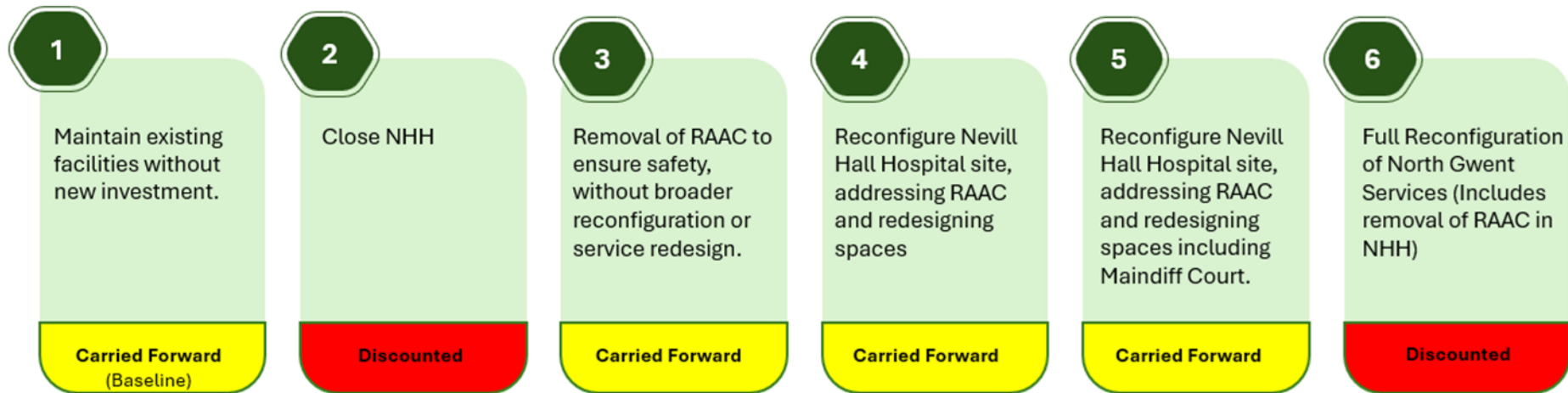


Figure 5: Diagram of Scope Options

In response to the challenges outlined, including ageing infrastructure, the presence of Reinforced Autoclaved Aerated Concrete (RAAC), suboptimal clinical adjacencies, and the need for a modernised service model 6 scope options were identified (Figure 5).

Option 1: Maintain existing facilities without new investment – RAAC mitigation only

Option 2: Close NHH – Discounted due to unacceptable impact on access, acute resilience, and local service provision.

Option 3: Remove RAAC only – Carried forward due to the urgent need to mitigate structural risk, although it does not address wider service or estate inefficiencies.

Option 4: Reconfigure NHH site (RAAC removal + redesign) – Carried forward as a feasible option delivering improved safety, service flow, and modern infrastructure.

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Option 5: Reconfigure NHH including Maindiff Court – Carried forward as it supports rationalisation of the estate and integrated service delivery.

Option 6: Full reconfiguration of North Gwent services – Discounted at this stage due to the scale and complexity of the option, the significant funding and time required to develop a business case, and the urgent need to address RAAC risks at Nevill Hall Hospital. While outside the immediate scope of this business case, these future opportunities are strategically important and may be considered as part of a future Development Control Plan.

The [Economic Case](#) provides a detailed appraisal of the long list of options.

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1.7 Enabling Capabilities

To address the challenges outlined in the Business Needs section, and in alignment with the project scope options, the NHH Development Project aims to enable a set of core capabilities aligned with the Health Board’s strategic priorities. These reflect the new ways of working required to deliver safe, sustainable, and high-quality care, and form the foundation for the project’s expected benefits.

Enabling capabilities are the key systems, functions, and ways of working that must be in place to support delivery of the project’s objectives. Table 4 outlines the enabling capabilities required to support delivery of the project’s objectives. These capabilities are aligned with the Health Board’s strategic priorities and underpin the transformation needed to deliver safe, sustainable, and high-quality care.

Capability	Description
Refreshed Clinical Model	Standardised operating procedures, improved patient pathways, generic outpatient and treatment spaces, and purpose-built facilities to support integrated, multidisciplinary care. Includes the rightsizing of services aligned to population need, ensuring services are designed based on evidence and demand, improving access and outcomes for the north Gwent population.
New Development at the NHH Site	Delivery of a modern estate with improved layout, low-carbon infrastructure, enhanced patient access (e.g. drop-off zones, signage), and more efficient use of space.
Sustainable Workforce and Financial Model	Workforce model that supports agile/hybrid working, improves staff wellbeing and retention, and reduces reliance on temporary staffing, underpinned by cost-effective resource use.

Table 4: Enabling Capabilities

1.8 Refreshed Clinical Model

The new clinical service model will be developed embedding the following principles (Figure 6):



Figure 6: Design Principles

1.8.1 Clinical Model

The Nevill Hall Development Project is centred on delivering high-quality, sustainable care through a modernised, integrated clinical model. Aligned with the Clinical Futures strategy and wider system needs, the proposal positions NHH as an enhanced Local General Hospital (eLGH), supporting general and routine care closer to home. It enables best practice through:

The future model is designed around:

- **Integrated, system-wide pathways** supporting early intervention and whole-system flow.
- **Diagnostics and Treatment Services** to improve access and reduce delays.
- **Local Assessment Services** that minimise unnecessary admissions.
- **Non-clinical enablers** (digital, workforce, estates) that underpin safe, agile care.
- Delivery of **children's services** through the existing Children's Centre

1.8.2 Proposed Clinical Model – Summary Overview

Table 5 provides a summary overview of the proposed clinical model, highlighting the key focus areas and planned transformations across both clinical and non-clinical service model.

Model	Model Focus and Key Transformation
Elective Care	High-efficiency outpatient, day case and surgical activity to improve flow. Day Surgery and treatment centre , with increased HVLC throughput and regional ophthalmology provision. Outpatient Treatment Unit within a flexible, generic outpatient model.
Diagnostics	Enhanced local diagnostics , pharmacy and support services to enable effective treatment.
Urgent & Emergency Care	Integrated Front Door model with local assessment and medical inpatient services. New assessment model and inpatient bed base , aligned to system demand.
Cancer Care	Local SACT delivery , diagnostic and follow-up care within specialist unit. Expanded local SACT services, aligned with Velindre @ NHH model
Family & Therapies	Multidisciplinary team (MDT) working embedded across care pathways. Inpatient and outpatient therapies and Children’s Centre
Mental Health	Modernised services integrated with community and inpatient models. Relocation of adult, older adult, and LD services from Maindiff Court to NHH for co-location and estate consolidation.
Non-Clinical Services	Safe, sustainable support services and infrastructure enabling effective clinical care. Adoption of agile working model and admin hub . Catering transitions to regeneration model. Infrastructure upgrades support digital, estates, and FM functions.

Table 5: Summary of Clinical Model

The clinical model has been approached from a whole-system perspective and the interdependencies across the Health Board’s acute and community sites. The modelling undertaken has recognised the Health Board Strategies, e.g. Place Based Care ensuring the optimal location of activity across the estate to improve patient flow, maximise the use of existing assets, and align activity to the appropriate level of acuity. This ensures that services are delivered in the most efficient and effective setting, supporting system-wide sustainability and improved patient outcomes. Future stages of the business case will continue to test and refine this approach in collaboration with regional partners to ensure alignment with broader service models and population health need

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Strategic Fit

- **Aligned with National Policy Direction:** including, GIRFT, and sustainability agendas: the model supports national priorities including *Getting It Right First Time (GIRFT)*
- **Supports Whole-System Flow and Resilience:** NHH, as an enhanced Local General Hospital (eLGH), plays a critical role in supporting flow from the Grange University Hospital (GUH) and maintaining capacity across the wider health system, enabling right care, right place, first time.
- **Enables Workforce Sustainability:** Modernised clinical environments, integrated team models, and agile working infrastructure help retain and attract staff, improve efficiency, and support new ways of working.

A summary of the proposed changes to the model of care at Nevill Hall Hospital (NHH) as part of the NHH Development Project, categorised by service type and transformation approach.

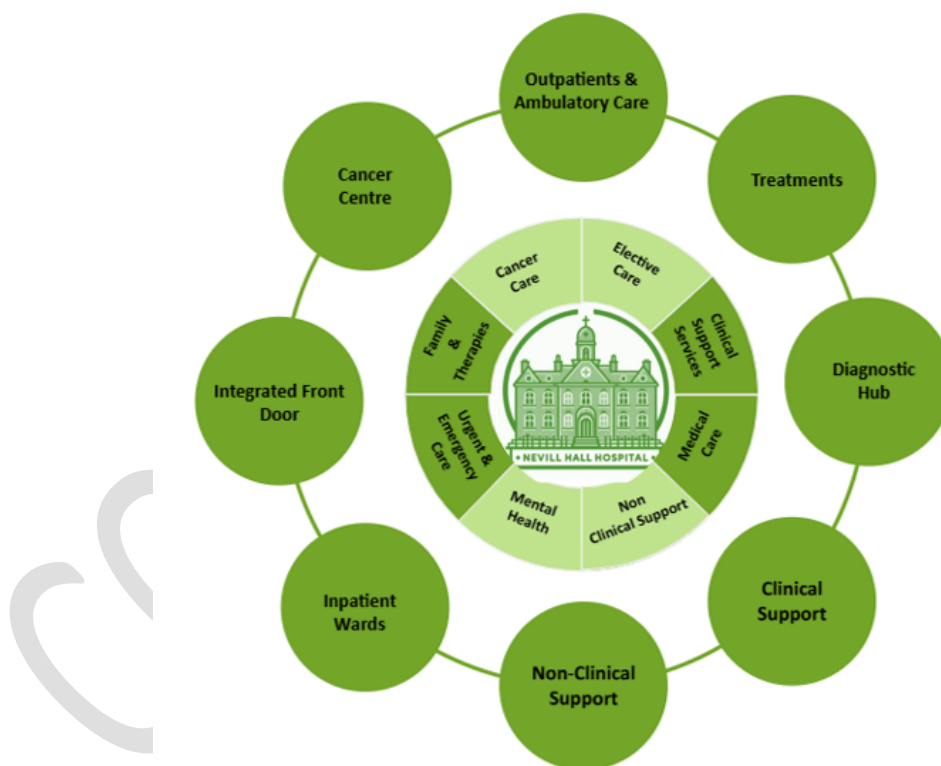


Figure 7: Clinical Model Diagram

The tables below outline the service model across the following key models:

- **Elective Care**
- **Diagnostics**
- **Urgent Care – Assessment and Inpatient**
- **Family and Therapies**
- **Mental Health**

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- **Cancer**
- **Non-Clinical Services**

The following definitions provide clarity on key terms used throughout the table:

Proposed Change Levels

No Change – The service remains in its current form with no modifications.

Minor Change – Small-scale adjustments to improve efficiency or patient experience, with minimal impact on service delivery.

Moderate Change – More substantial changes, such as service reconfiguration, pathway redesign, or relocation within the existing hospital footprint.

Major Change – Significant transformation, such as merging services, expanding capacity, or restructuring clinical functions. While new estate may be built to improve pathways and patient flow, this does not necessarily indicate a major change to clinical pathways. A major change would involve fundamental transformations in the way a service is delivered, impacting clinical pathways, workforce structures, or patient access.

New Service – A service that is being introduced to enhance patient care and address emerging healthcare needs.

Relocation - The service will be moved within NHH or to another site within the Health Board to improve access, optimise space, or align with strategic priorities.

Decommissioned – Services that will no longer be provided

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1.8.3 Elective Care Model

Table 6 provides a detailed summary of proposed changes across elective care services, including day surgery, outpatients, and associated specialist functions.

Elective			
Area	Service	Level of proposed Change	Summary of proposed change
Day Surgery and treatment centre	Theatres All surgical specialties	Major Change	<p>The day surgery model will undergo major change, with a shift towards a bespoke day case model based on best practice (Getting it Right First Time – GIRFT accreditation).</p> <p>Dedicated theatre space for elective No. Theatres 4 – up to 2 Laminar Flow, 4 treatment rooms Plus (Regional) Ophthalmology – 2 Theatres, based on Exeter.</p> <p>There will be a dedicated Ophthalmology unit based on the Exeter model</p> <p>Opportunity to increase in throughput of day cases increasing BADS (British Association of Day Surgery) overall delivery from 65% to 70%.</p> <p>Introduction of a bespoke day case model, focus on HVLC (High Volume Low Complexity) procedures, requires new pathways, workflows,</p>

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			<p>and infrastructure adjustments in line with GIRFT recommendations</p> <p>DSU with extended hours to accommodate some intermediate procedures who require longer than a standard day surgery admission but do not require an overnight stay</p>
Anaesthetics	Anaesthetics	Major change	<p>The anaesthetic model will evolve in line with changes to the day case service.</p> <p>Staffing and resource allocation will be adjusted to meet the demands of the updated day case pathway.</p>
Regional Ophthalmology	Regional Ophthalmology	Major change	<p>The regional ophthalmology service is an existing service</p> <p>Regional ophthalmology will be utilising Llanwenarth Suite as a dedicated theatre from end of March 25; core ophthalmology will also utilise this space for 3 core sessions per week. There is an assumption that this will not change.</p> <p>It is expected that regional work will need to expand to meet increasing demand and is therefore considered a major change. The preferred model is to incorporate back-to-back theatres, which would allow for greater efficiency in surgical throughput. This would be subject to a business case for the regional for sustainable cataracts service.</p>

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<p>Outpatients</p>	<p>General Surgery Dermatology Max Fax Eyes Orthopaedics ENT (Ears, Nose and Throat) Audiology Community Dentistry Gynaecology General Medicine Gastro Respiratory Sleep COTE (Care of the Elderly) Cardiology Neurology Stroke Rheumatology (GOPD) MS (Multiple Sclerosis) Infusions Anaesthetics ITU Nephrology Neurophysiology Endocrinology Speech and Language Therapy Plastic surgery Medical Genetics Bladder and Bowel Psychology Tissue Viability Nurse Paediatric</p>	<p>Minor Change & new service</p>	<p>Outpatient services will transition to a flexible, generic space model, with consultation and examination rooms designed to support multiple specialties, maximising occupancy, utilisation, and future-proofing the estate. Specialty-specific rooms will be provided only where necessary. To support this model, a standardised room booking and scheduling platform will be required.</p> <p>Virtual Appointments – Dedicated spaces for clinicians near clinical rooms to support virtual consultations while ensuring clinical spaces remain prioritised for face-to-face care. Optimisation frameworks being implemented to facilitate in space for ‘mega clinics’</p> <p>A new outpatient treatment service will be introduced at Nevill Hall Hospital, replicating the existing model currently operational at Royal Gwent Hospital. The specific procedures to be delivered are to be confirmed.</p> <p>Maindiff Court outpatient activity provided in bespoke space appropriate for the needs of these patients.</p>
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	Outpatients Treatment Unit		
Ophthalmology OPD	Ophthalmology	No Change & Potential New Service	The service currently delivers diagnostics, laser, outpatients and orthoptics. While core Ophthalmology OPD services will remain unchanged, there is potential for a service reconfiguration and expansion into a full diagnostic hub, contingent on estate availability. This would involve pathway redesign, space reallocation, and service integration
Cardiology Centre	Cardiology	Minor Change	Service currently provide Cardiac rehabilitation and cardiology centre on level 1.
Rheumatology Day Unit	Rheumatology	No change	Rheumatology Day Unit incorporated in the Outpatient Unit to remain as there is no suitable site on any other HB site.
Diabetes Centre	Diabetes	No change	Diabetic Day centre currently on level 1
Respiratory	Respiratory	No change	Respiratory services, including the sleep service and bronchoscopies currently in Llanwenarth Suite Respiratory specialist nurses, physiologists, and chest clinic area. These services would have dedicated specialist space where needed and incorporated in the Outpatient Unit where appropriate
Inpatient Ward - Surgical	Orthogeriatric	No Change	Orthogeriatric ward model will remain unchanged (25 beds)
	Clinical Photography	No change	No fundamental changes to the clinical photography model are planned. The service will need to be positioned near the Outpatients Department to support operational efficiency and patient accessibility.

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Research & Delivery	Research and Delivery	No change	A dedicated research office allows for storage of active trials, clinical workspace and designated lab is required.
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Table 6: Elective Model

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1.8.4 Diagnostic Model

Table 7 provides a detailed summary of the proposed changes across diagnostic services, including endoscopy, radiology, pathology, and pharmacy.

Diagnostics			
Area	Service	Level of proposed Change	Summary of proposed change
Endoscopy	Endoscopy	Minor	<p>The service will be for routine elective cases as per current model however will include some inpatient slots to prevent inpatients from requiring unnecessary transfer to GUH.</p> <p>There will be no emergency endoscopy service at NHH in line with current provision.</p> <p>There is a need for further expansion to meet ongoing service demands, screening changes and achieve cancer RTT targets. Additionality will be driven through efficiencies, expansion at RGH to 7 days (subject to funding) and access to LHP (subject to funding)</p> <p>The service proposes it requires a 2-theatre unit at NHH, similar to the development, as a standalone unit.</p>
Radiology	Radiology MR CT Plain / US Dental Imaging	Minor plus new service	<p>Radiology services at NHH currently include X-ray, CT, MRI, Mammo, Ultrasound, Vascular Ultrasound, and Nuclear Medicine. These services are proposed to remain on site, with the space to add a second MRI</p>

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	<p>Nuclear Medicine Vascular Ultrasound Option for PET and 2nd MRI</p>		<p>scanner to enhance diagnostic capacity and meet growing demand. The model is in alignment with regional planning for Community Diagnostic Centres (CDCs) via an in-house management model</p>
<p>Pathology</p>	<p>Pathology Haematology Blood Transfusion Biochemistry Phlebotomy POCT Andrology CADT / Body store ETR</p>		<p>Blood Bank: On-site service, Mon–Fri, 9–5, with 24/7 emergency blood collection. Includes product storage, batch cupboard, emergency fridge, and staff desk area. Point of Care Testing (POCT): Maintained for rapid testing where laboratory services are unavailable. Includes staff desk space, cold and room temp storage, and connection to Blood Bank.</p> <p>Body Store: 5 spaces with vehicular access, wash facilities, and admin area. No family viewing: reduced capacity will need to be offset elsewhere.</p> <p>Andrology: To be relocated offsite to another Health Board location, co-located with required facilities.</p> <p>Stores: Supplies for primary and secondary care to be managed at IP5 site by Shared Services.</p> <p>Administration:</p>

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			All admin and office functions to move offsite, including hot desks, supervisor and manager bases, and consultant rooms.
Pharmacy	Pharmacy	No change	<p>The pharmacy service will continue operating as it currently does, with no planned changes to its core functions.</p> <p>The existing pharmacy robot at NHH requires replacement; it currently provides an income stream, and there is a special licence linked to the service.</p> <p>NHH holds a Wholesale Distributor Authorisation (WDA) with MHRA, allowing it to supply medications to external entities such as PTHB (Stocklines), WAST, and St David's Hospice.</p> <p>NHH is also registered with the General Pharmaceutical Council (GPhC) to dispense named patient lines to PTHB.</p>

Table 7: Diagnostic Model

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1.8.5 Urgent Care Model

Table 8 summarises the proposed changes for urgent care and inpatient services at Nevill Hall Hospital, including current planning assumptions and areas where further work is required.

Urgent Care – Assessment and Inpatient			
Area	Service	Level of proposed Change	Summary of proposed change
Integrated Front Door	Intake Model UPC (Urgent Primary Care) MIU (Minor Injuries Unit) Assessment Unit Operation Hub – admin and consultant space available in dept. Discharge lounge	tbc	<p>There will need to be an assessment facility and service at NHH in the future to respond to population needs and support the wider urgent and emergency care system.</p> <p>The service will need to be sustainable from a demand and workforce perspective</p> <p>Further work in ongoing to fully design, test and agree the model. This will emerge as part of the 2025/26 HB plan.</p> <p>Planning assumptions at this stage is that MIU and UPC will be on NHH site.</p>
Inpatient Ward	COTE / Gen Med	tbc	<p>There will be a requirement for inpatient beds to support the wider hospital network and to respond to the front door assessment model.</p> <p>Assumption for SOC is for Bed base to return to Clinical Futures agreed numbers (157 medical beds plus 24 spaces on AMU)</p>

Table 8: Urgent Care Model

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			Exact designation of beds will be determined as part of OBC planning
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1.8.6 Family and Therapies Model

Table 9 provides a summary of proposed changes across family and therapy services, outlining the anticipated scale of change and key service dependencies.

Family and Therapies			
Area	Service	Level of proposed Change	Summary of proposed change
Therapy & Rehabilitation Inpatient Model	Physiotherapy Occupational Therapy Speech and Language Dietetics	tbc	<p>Inpatient models will influence therapy service delivery, workforce planning, and space requirements, therapy space will be incorporated into refurbishment of inpatient ward areas.</p> <p>Physiotherapy (Inpatient) Currently lacks dedicated ward-based rehab space; relies on main physiotherapy department. Future model requires improved proximity to wards, safe stair access for assessments, and enhanced rehab facilities.</p> <p>Occupational Therapy (Inpatient) needs to remain onsite to support hospital discharge. Requires dedicated facilities for assessments/interventions aligned with future ward configuration.</p> <p>Speech & Language Therapy (Inpatient) delivered via in-reach model; future provision</p>

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			<p>depends on which specialties (e.g., Care of the Elderly, Cancer Centre) remain on site.</p> <p>Dietetics (Inpatient) services depend on the type of inpatient care retained at NHH (e.g., elderly care, trauma). Future staffing and location plan dependent on clarity regarding inpatient specialties.</p>
<p>Children Centre</p>	<p>Maternity & Community Midwifery Health Visiting, School Nursing, Looked After Children Services Children with Disabilities (Therapies, Community Paediatrics, Psychology) Child & Family Psychology Paediatric Outpatients (General & Sub-specialty) CAMHS (Primary, Secondary, Neurodevelopmental services) Dietetics & Speech & Language Therapy (Paediatrics) Podiatry & Orthotics (Paediatric services)</p>	<p>Major Change</p>	<p>Services currently delivered for children with complex and additional learning needs will be enhanced through modern, up-to-date facilities, with clear links to interdependent services including maternity, paediatrics, and CAMHS.</p> <p>The centre will bring together maternity services, specialist services for children with additional and complex needs, and adolescent services (including transition) under one roof – ensuring a consistent and coordinated patient journey from birth through to the age of 25.</p> <p>Further discussion is needed to define the specific clinical models for each of the services currently supporting children with complex and additional learning needs.</p> <p>This integrated model cannot be delivered within the footprint of the existing Children’s Centre</p>

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Outpatient Centre	Physiotherapy (Inpatient & Outpatient – MSK, Neuro, Respiratory, Pelvic Health) Occupational Therapy (Inpatient and Long-Term Conditions) Speech & Language Therapy (Adult services) Dietetics & Weight Management (Adult services) Podiatry & Orthotics (including workshop space) Symptom Management Service (Adferiad/Chronic Fatigue, Fibromyalgia, Persistent Pain)	Major Change	<p>Outpatient model to be revisited in line with the emerging rehab strategy and community partnership model</p> <p>Inpatient model aims would be to co-locate as many rehabilitation services as possible on site, with better access to wards and improved storage facilities.</p> <p>Co-location of therapy teams will support efficient multidisciplinary working and improved patient flow.</p> <p>The Physiotherapy Outpatient services model is to be reviewed in line with community delivery delivered from NHH Physiotherapy Outpatient department includes MSK, Respiratory, Neurology & Pelvic Health. Staff are also based in the department that supports Cardiac Rehab provision which is provided at a different location on the site. The department also houses GWICES peripheral store for inpatient and outpatient equipment.</p> <p>The GWICES peripheral store for inpatient and outpatient equipment, currently located in the physiotherapy department, must also be accommodated within the new centre. Suitable hotdesking through the administration hub and group rooms are needed for flexible working and outreach service delivery. Currently, group delivery is limited due to</p>
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			space constraints, particularly because of RAAC and asbestos risks.
Women's Health Centre within Day Case and Outpatient Centre	Gynaecology Ambulatory Care Unit Sexual & Reproductive Health Services Bladder & Bowel Services	Major Change	Expanded clinical space for cancer diagnostics and treatment. Increased theatre use and extended hours for day case procedures. Hub-and-spoke model maintained (NHH as hub; Caldicot as spoke). Flexibility for multi-use procedure rooms Maintain and build on the work being undertaken at the Gynaecology Ambulatory Unit (GAU) – Since opening in 2020, the number of women's health procedures and services delivered at the GAU has continued to increase. We need to ensure expansion of the service is possible at Nevill Hall, ensuring that Sexual & Reproductive Health and Bladder & Bowel services also continue to be delivered on site (Bladder & Bowel to remain separate from Women's Health Unit).
Community Services	Health Visiting Community Midwifery	Major Change	There are a range of services including Health Visiting and Community Midwifery that are in and around the Abergavenny area including at GP premises. There have been increased instances of our services needing to vacate such venues at short notice. Delivering services at a dedicated centre at Nevill would provide a certain future to our services who rely on clinic venues to deliver a significant proportion of their models. In addition, data shows that attendance for Health Visiting

Strategic Outline Case:
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			appointments is higher at hospital sites than at community venues.
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Table 9: Family and Therapies Model

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1.8.7 Mental Health Model

Table 10 outlines the proposed changes across Mental Health services, summarising the key relocations planned as part of the Nevill Hall Hospital redevelopment.

Mental Health			
Area	Service	Level of proposed Change	Summary of proposed change
Older Adult	ECT (Electroconvulsive Therapy) Older Adult Monmouthshire CMHT (Community Mental Health Team)	Relocation	Relocation from Maindiff Court
Adult Mental Health	Eating Disorders Service Veteran Service North Monmouthshire Adult CMHT ABSDAS (Aneurin Bevan Specialist Drug and Alcohol Service) PCMHSS (Primary Care Mental Health) Ty Skirrid – Forensic Rehab Ward (16 beds)	Relocation	Relocation to Nevill Hall from Maindiff Court
Learning Disabilities	Monmouthshire CLDT (inc. Local Authority) Community Learning Disabilities Team	Relocation	Relocation to Nevill Hall from Maindiff Court

Table 10: Mental Health Model

1.8.7.1 Cancer Model

Table 11 summarises the proposed developments across cancer services, highlighting those that will remain stable and those that require regional planning or expansion.

Cancer			
Area	Service	Level of proposed Change	Summary of proposed change
Haematology Unit	Haematology Unit	No change	Based on ward 2/4 model Development of ways of working in line with developments of Velindre @ model (radiotherapy and SACT)
Satellite Radiotherapy Unit	Velindre @ Nevill Hall Radiotherapy Unit	No Change	Service to develop in line with SRU FBC – noting future phases for additional tumour sites likely subject to future planning across region
Outpatients	Systemic Anti-Cancer Therapy (SACT)	Major Change	In line with clinical model in the new Velindre Cancer Centre business case, the strategic direction of travel is for more SACT service to occur closer to home (and less in Velindre) Currently 3-day service from Windsor suite (7 chairs). Future planning with Velindre required to scope opportunities and requirements in NHH (and other AB sites)
Supporting patients with cancer			MDT meeting and hot desk space ABUHB / VCC Research hub Welfare and Benefits, inc. outreach from

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			ABUHB and Outreach Cancer Services Maggie's Centre is a future opportunity
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Table 11: Cancer Model

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1.8.8 Non-Clinical Services Model

Table 12 summarises the proposed changes and continuities across non-clinical services, including support functions, estates and administration

Non-Clinical Services			
Area	Service	Level of proposed Change	Summary of proposed change
Informatics	Medical Records	No change	Active scanning and destruction processes ongoing, but space needs remain high in the short to medium term. Future estates planning must consider appropriate, compliant, and secure storage environments for physical records and office accommodation for staff
Facilities Management (FM)	Catering Restaurant	Major Change	<p><u>Catering</u> Current patient catering model (Cook-Serve): Meals are freshly prepared, cooked in a central kitchen, and then distributed directly to patients for immediate consumption. New Model (Regen): Meals are pre-prepared, chilled or frozen, and then regenerated (reheated) at central kitchen before serving.</p> <p><u>Restaurant</u> Staff, patient and visitor restaurant / canteen with a hybrid approach with regen and traditional cook.</p>

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Facilities Management (FM)	Endoscopic Decontamination	No change	The fundamental service model will remain unchanged, but the decontamination unit is likely to be relocated within the hospital footprint to align with future operational and spatial planning. Maintaining proximity to the endoscopy unit is a key requirement to minimise transit time and enhance departmental communication. Surgical decontamination from Day Surgery Unit to be transferred to HSDU GUH as per current model
Facilities Management	Portering Cleaning Waste General Office Site Security Stores	No change	The facilities management model will remain unchanged, with portering, cleaning, waste, and general office services continuing as core functions.
Administration Accommodation	Quality and Patient Safety Overseas visitors Health and Safety Informatics Medical staffing Older adult psych liaison Palliative Care Infection control Primary care Mental Health Primary Care Volunteers	Relocation	As part of the Health Board's adoption of an agile working model, several non-clinical functions currently occupying office space within the hospital are proposed to be relocated. This aligns with the broader strategy of optimising clinical and patient-facing areas while supporting flexible and efficient working practices. The vision is for there to be a centralised staff admin hub where most admin activities will take place.

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	<p>Medical Secretaries Inpatient scheduling Outpatient booking Radiology booking Cancer Service - AOS Medicine Management Team (site lead, medical staffing, and senior nurses) nurse specialists and medical secretaries across multiple specialties Occupational Therapy Family and Therapies Management Team Eating Disorders Service Veterans Service North Mon Adult CMHT ABSDAS Learning Disabilities - Mon CLDT PCMHSS Health Visitors School Nursing CCNS PHN Consultants</p>		<p>Teams from Maindiff Court that do not require clinical space to be relocated to the administration centre.</p>
Medical Education	Medical Education	No change	Existing facilities and functions remaining unchanged
Works and Estates	Works and Estates	No change	Works and Estates service will remain unchanged, but it will require a defined footprint on-site to continue supporting the hospital's operational and maintenance needs effectively and adequate space for fleet car to support community sites.
Residential	Staff residence	No change	Residential accommodation is to be considered as part of future opportunities and a development plan for the site. It

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			remains unchanged within the scope of this case.
Chaplaincy	Chapel	No change	Service expected to continue with a chapel remaining on site to offer space for prayer and / or quiet reflection spiritual and pastoral care for patients, staff, and visitors
Creche	Crèche (non-HB service)	No change	The crèche is currently provided by a third-sector organisation occupying Health Board accommodation.

Table 12: Non-clinical Service Model

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1.8.9 Demand and Capacity

The SOC focuses on the investment associated with delivering more effective care and estate at NHH. A large majority of services currently provided at NHH will remain on the site. The changes afforded by the development will facilitate a modern estate that will enable co-location of services and increased efficiency with the ability to respond to changes in the population and future technological developments.

It is important to stress at this stage are based on high level estimates derived from demand and capacity modelling of service requirements and the scale of change proposed. These will be further refined at the OBC stage.

The NHH Development Project forms part of the Clinical Redesign Programme, one of the Health Board's key priority transformation programmes. The objectives of the programme are to:

- Right-size key services
- Ensure as many services as possible are delivered closer to home
- Ensure services are efficient and sustainable
- Optimise flow
- Match workforce resource to demand

This Programme includes several changes and interdependencies which affect multiple pathways and sites across the Health Board not just NHH, the work is ongoing and includes:

- Medical and Inpatient model
- Therapies: Rehabilitation Strategy and model
- Mental Health: Future Models of Care
- Theatres: Daycase and treatment centre and regional delivery model
- Women's Health Plan

Many services will remain at NHH; however, a more in-depth exercise has been undertaken to determine the future anticipated demand and capacity requirements for elective procedures, in line with the existing Planned Care Programme, Theatre Maximisation Programme, and Regional Programmes including Endoscopy and Ophthalmology.

There is further work planned as part of the Planned Care Programme and Theatre Maximisation Programme aligned with benchmarking opportunities identified to increase efficiencies and utilisation based on the current models and anticipated from the reconfiguration. This will include new ways of working such as extended working, digital integration to improve pathways or new models of care.

The service requirements are outlined below in terms of the following patient pathways:

- **Elective Care**
- **Diagnostics**
- **Urgent Care – assessment and inpatient**
- **Cancer Care**
- **Family and Therapies**
- **Mental Health**

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1.8.9.1 Summary of Planning Intentions and Assumptions

1.8.9.2 Elective Care

- Theatre provision reflecting national policy and planning requirements for improved daycase throughput and high-volume low complexity activity and recommendation from the 2025 Ministerial Advisory Group
- Provision of outpatients offering opportunity for one stop shop models, mega clinics, tele health and virtual and outpatient treatments.

1.8.9.3 Diagnostics

- The provision of services reflecting the current throughput, with the space to add a planned 2nd MRI to support the regional diagnostics programme, and the opportunity to future proof for PET is also provided.
- The development of Llantrisant Health Park will complement the development at NHH with maintenance of Endoscopy at current levels providing access to services in North Gwent.

1.8.9.4 Urgent Care and Emergency Care

- Providing an integrated front door model based on current activity, with added provision for a Frailty SDEC. (Frailty SDEC is indicative and may be subject to change as the pathway is refined.)
- Inpatient model and take based on the Clinical Futures bed base and current site provision.

1.8.9.5 Cancer Care

- A Southeast Wales hub for cancer services responding to population needs, addressing equity of provision and improving outcomes. Colocation of services and delivery of Outreach SACT to meet demand for 2030.

1.8.9.6 Family and Therapies

- The Children's Centre future scope is based on current service models and activity levels and is to remain on site.
- The Women's Health Hub to be located on site with ambulatory care and centralization of services.
- Therapies inpatients services remain based on current activity levels and outpatients will be incorporated within the Outpatients Department.

1.8.9.7 Mental Health

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- Maindiff Court & Mental Health OPD Cluster services located at Maindiff Court in scope for this project with capacity requirements to be based on current activity levels.

1.8.9.8 Non-Clinical Support

- The non-essential admin from OPD will be carried out in the central Admin block, however, this will need to be reviewed/confirmed by workforce. This facility is to include agile working and to accommodate staff from Maindiff Court

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1.8.9.9 Elective Care

Focused on planned procedures, outpatient treatment, and day surgery, designed to optimise efficiency and flow., including Outpatients, Theatres, Endoscopy

1.8.9.10 Outpatients

1.8.9.11 Current Activity

Outpatient activity has increased since the beginning of 21/22 (~8,000 appts per month) through to peaks of over 12,000 since 23/24 (Figure 8). This increase in growth in appointments delivered has stabilised since the end of 23/24 and has been used for forward assumptions.

The trend of face-to-face appointments is analogous to that of overall demand, with virtual appointments relatively now relatively static in the post, peak pandemic era.

Year-on-year outpatient activity by specialty is summarised in Table 13, demonstrating both high-volume areas and emerging service demand.

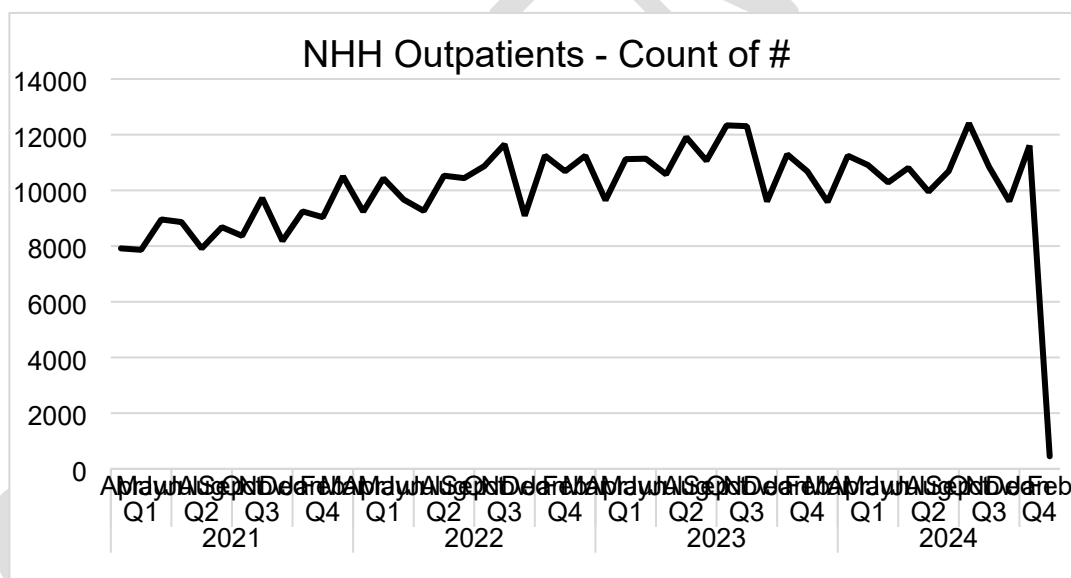


Figure 8: NHH Outpatients – Monthly Appointment Count by Quarter (Apr 2021–Feb 2025)

Specialty	2021	2022	2023	2024
Anaesthetics	3546	4857	153	162
Cardiac Rehab	0	0	1125	2315
Cardiology	9232	12113	13685	8582
Care Of the Elderly	1874	1767	1806	1688
Clinical Haematology	11172	12201	14246	11942
Clinical Microbiology	860	935	789	611
Critical Care Medicine	0	0	0	60
Dermatology	2172	3565	3909	3300
Diabetes & Endocrinology	2750	3058	51	0

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Diabetic Medicine	0	0	1711	1435
Diagnostic Imaging	0	201	165	632
Dietetics	62	379	490	364
Ear Nose & Throat	2789	3240	3210	3302
Endocrinology	0	0	1223	1435
Fostering and Adoption	0	0	12	137
Gastroenterology	1959	1433	1711	1482
General Surgery	9881	8757	9005	3361
Gynaecology	8838	8958	10015	8784
Infectious Diseases	159	192	259	209
Maternal Weight Management	0	11	63	0
Maxillo-Facial	1626	1503	1359	1148
Medical Virology	2300	650	0	0
Midwife Led Care	1666	1744	2942	3191
Nephrology	1314	1349	1769	1725
Neurology	527	560	654	554
Neurophysiology	0	0	0	268
Nursing Activity	4	4	11	0
Obstetrics	1300	1212	1100	2209
Obstetrics Ante Natal	3127	2584	1692	144
Occupational Therapy	198	464	654	551
Ophthalmology	4497	4913	5180	3879
Optometry	0	0	0	99
Orthodontics	713	719	769	648
Orthoptic - Medical Eyes	1304	1514	1718	960
Orthotics	108	73	1002	825
Pain Management	0	1	0	0
Palliative Care	68	46	26	11
Physiotherapy	7064	9075	10338	9134
Podiatry	0	0	0	723
Respiratory	4723	5386	5453	4501
Respiratory Physiology	2743	3099	3649	3841
Rheumatology	4426	4823	5429	5119
Sleep Medicine Service	0	0	0	44
Speech & Language Therapy	364	903	610	684
Stroke	102	326	288	206
Transient Ischaemic Attack	0	22	234	158
Trauma & Orthopaedic	4089	14915	16757	13870
Urology	0	0	0	137
Vascular Surgery	57	657	125	152
Total	97614	118209	125387	104582

Table 13: Outpatient activity by specialty, by year

1.8.9.12 Future assumptions

The planning assumptions are based current activity levels and growth in face to face assumed at 10% accommodated through some shift in appropriate activity and assumed uplift in digital/tele consultation and consolidation of patients' consultations,

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diagnostic testing (e.g., imaging, blood tests), and minor procedures in a single visit through one stop clinics and 90% utilisation.

1.8.9.13 Regional Ophthalmology

The regional ophthalmology service outpatients subject to an approved Business Case will be provided in a single unit linked to the Theatres, based on the Exeter model located in Llanwenarth Suite.

To provide enough patients for the 1955 surgeries, 1796 outpatient slots are required as follows:

- 7.5 patients per session (8 in the morning and 7 in the afternoon)
- 6 sessions per week
- 42 weeks per year
- 95% efficiency

Interdependencies

- Outpatient booking system.
- One stop shop – outpatient, pre-assessment and treatment all in one day
- Flow between outpatient/ambulatory/day case unit.
- Consolidation of Outpatients into one area
- Regional Ophthalmology sustainable business case
- Admin accommodation

1.8.9.14 Theatres - Day Case and Treatment Centre

1.8.9.15 Current Activity

Day case activity at NHH has stabilised through 22/23 and 23/24 (~3,800), however there has been a slight increase in 24/25 YTD with 3,780 by the end of M10. The specialty split is utilized between General Surgery, Gynaecology and T&O. In 24/25 YTD there has been a significant increase in activity for Ophthalmology which is expected to be maintained and grow in line with regional services (Figure 8).

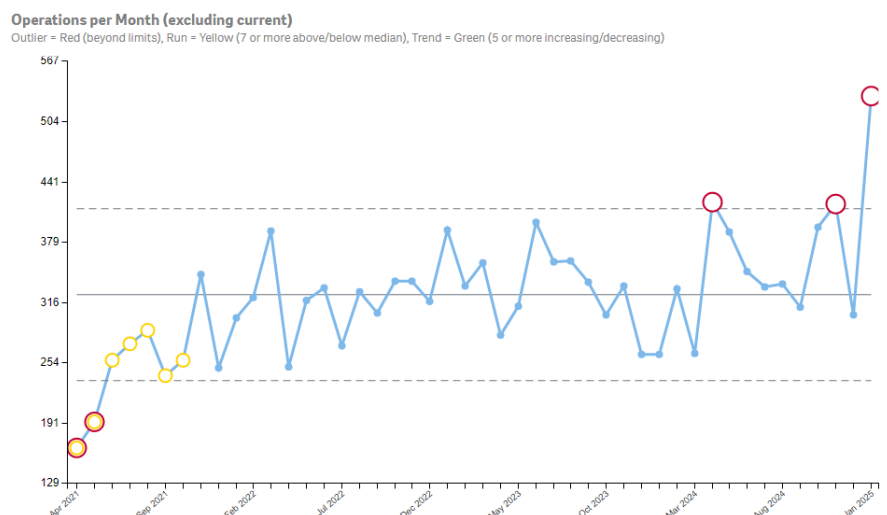


Figure 9: Monthly Day Case Activity at NHH

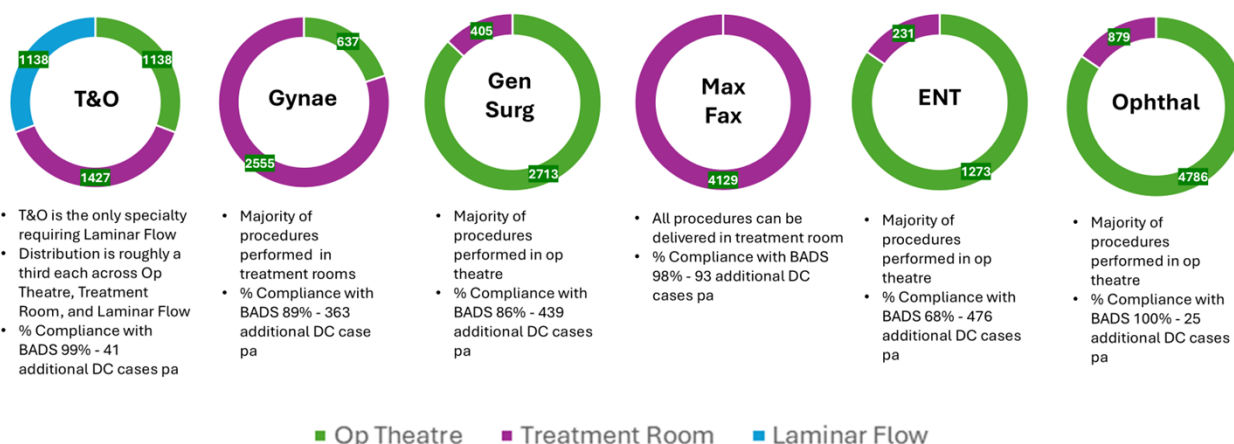
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1.8.9.16 Future Assumptions

As part of the options development, a series of options for theatre provision/configuration was assessed reflecting the ambition of the health board to increase high volume low complexity and increase activity up to ~ 15,000 procedures per annum. Demographic growth estimated at a 10% increase.

The capacity requirement assumptions were based on, a conservative utilisation rate of 75%, acknowledging that current utilisation levels will be improved and ~ 11,000 procedures at 60 minutes each and in line with GIRFT recommendations. This translates to ~6 theatres, 5.5 days/week, 10 hours/day, at 75% utilisation

Day Case Procedures Distribution and BADS Compliance

If BADS recommendations were fully achieved, a total of **1,437 procedures per year** could be converted to day case across all specialties.



Data is based on procedures identified as suitable for day case by specialty. A clinical review informed space suitability (Op Theatre, Treatment Room, Laminar Flow). Some clinical exceptions may still require alternative spaces despite this modelling. Some clinical exceptions and practical limitations (e.g. equipment and travel) may still prevent full compliance despite this modelling.

Figure 10: Day Case Procedures Distribution by specialty

Table 14: Day Case Procedure Activity, BADS Compliance by Specialty and Location

Specialty	Number of procedures done as DC	Potential number of procedures as DC if BADS recommendation followed	% Compliance with BADS	Count of Procedure Type in Op theatre	Count of Procedures in Op Theatre	Count of Procedure Type in Trx Room	Count of Procedures in Trx Room	Count of Procedure Type in Laminar flow	Count of Procedures in Laminar Flow
T&O	2777	2818	99%	4	1138	7	1427	4	1138
Gynae	2829	3192	89%	9	637	5	2555	0	0
Gen Surg	2679	3118	86%	10	2713	2	405	0	0
Max Fax	4036	4129	98%	0	0	26	4129	0	0
ENT	1028	1504	68%	14	1273	3	231	0	0

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Ophth	5661	5686	100%	9	4786	3	879	0	0
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1.8.9.17 Ophthalmology: Regional and Health Board

In line with the agreed regional ophthalmology strategy, the cataracts "North Hub" will be based in Nevill Hall Hospital. This location is well placed to care for patients from the Heads of the Valleys area that includes north Aneurin Bevan and north Cwm Taf Morgannwg University Health Boards.

The North Hub will deliver surgery from the theatre in Llanwenarth Suite in Nevill Hall Hospital, with outpatient clinics delivered in the same location incorporating best practice from the Exeter model

An interim cataracts case for investment secured £7m for the region on a recurrent basis in addition to non-recurrent monies being made available.

Future expansion of regional cataracts (over and above the £7m) would be subject to a regional business case being supported

1.8.9.18 Capacity Plans

Based on the assumptions above the following surgery capacity is planned:

- 7 sessions per week
- 7 patients on a list
- 42 weeks per year
- 95% efficiency
- 1955 surgeries per year

1.8.9.19 Monthly Capacity Plans

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Surgery	163	163	163	163	163	163	163	163	163	163	163	162	1955
OP	150	150	150	150	150	150	150	150	149	149	149	149	1796

Table 15: Ophthalmology Monthly Capacity Plans

Health Board Ophthalmology provision: currently 98% of the 25 specified procedures are currently undertaken as day cases at the Royal Gwent Hospital (RGH) and Nevill Hall Hospital. 11% of these day case procedures take place at NHH. The bespoke day case setting could increase the day case rate by 1% for these specified procedures, resulting in an annual increase from 5,691 to 5,763 cases. Through increasing capacity at NHH, this could increase the throughput at this site from 10% to 99%. Through enabling additional cases suitable for Procedure Room, there is an opportunity to move 450 of these day case procedures into a procedure room as part of a co-located outpatient treatment unit.

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1.8.9.20 Women's Health Hub

The requirement for a Women's Health Hub is set out in Welsh Government policy guidance. The Women's Health Hub for the health board will be based at NHH. The current Gynaecology provision is 86% of the 14 specified procedures are currently undertaken as day cases at the Royal Gwent Hospital (RGH), Nevill Hall Hospital (NHH) and Ysbyty Ystrad Fawr, 60% of these day case procedures take place at NHH.

The proposed future model is to increase in Day Case Rate through a bespoke day case setting which will increase the day case rate by 5% for these specified procedures, resulting in an annual increase from 2,829 to 2,976 cases. If situated at NHH, this could increase the throughput at this site from 60% to 90%, there is an opportunity to move 1,476 of these day case procedures into a procedure room as part of a co-located outpatient treatment unit.

Interdependencies

IT system for PACCT

Discharge by 23:59 with extended recovery

One stop shop – outpatient, pre-assessment and treatment all in one day

Day surgery as specialty for anaesthetics

Anesthetic criteria to be reviewed.

Regional Ophthalmology Programme

Admin accommodation

1.8.9.21 Diagnostics

Encompassing diagnostics, pharmacy, and essential enablers of timely, safe, and effective clinical care.

1.8.9.22 Current Activity

Radiological services are driven by specialties on clinical need; method of investigation or modality utilised to ensure optimum image quality. The service model needs to meet the clinical and Radiological standards in appropriate settings, offer patient choice of location, and ensure patient and staff safety.

The opening of The Grange University Hospital (GUH) in 2020 provided the opportunity to deliver high acuity inpatient critical care, with the eLGHs providing urgent care, inpatients, routine outpatients, diagnostic and treatment services, and care closer to home.

1.8.9.23 CT Activity

CT Scanning	RGH	NHH	YYF	GUH
2023/24 Activity	21,688	15,499	11,713	36,287
2022/23 Activity	19,523	12,867	9,774	32,847
Variance	+11%	+20%	+19.9%	+10.5%

Table 16: CT Activity

1.8.9.24 MRI Activity

MRI Scanning	RGH	NHH	YYF	GUH
2023/24 Activity	9228	9201	9023	8947
2022/23 Activity	8413	8492	8447	7465
Variance	+9.7%	+8.3%	+6.8%	+19.9%

Table 17: MRI Activity

1.8.9.25 Plain Film Activity

PF Scanning	RGH	NHH	YYF	GUH
2023/24 Activity	62688	32155	42010	52194
2022/23 Activity	58336	31151	39261	53391
Variance	+7.5%	+3.2%	+7%	-2.2%

Table 18: Plain Film Activity

1.8.9.26 Ultrasound Activity

US Scanning	RGH	NHH	YYF	GUH
2023/24 Activity	26168	9794	5078	5246
2022/23 Activity	23722	8307	3750	4840
Variance	+10.3%	+17.9%	+35.4%	+8.4%

Table 19: Ultrasound Activity

1.8.9.27 Vascular Ultrasound

Activity for 23/24 totalled 7123, with 29% taking place at NHH.

1.8.9.28 Future Assumptions

The Radiology model is proposed to increase capacity by 1 MRI scanner at NHH as highlighted in the table below to meet the current demand now and in the future.

1.8.9.29 CT Assumptions

- In 2023/24 the CT Scanning activity totalled 85,187 examinations.
- The annual growth for CT scanning is currently around 10%.
- Activity totals are based on the number of examinations performed.
- CT will continue to be delivered from existing hospital sites, and hours of operation and supporting workforce will remain the same at NHH.

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1.8.9.30 MRI Assumptions

- In 2023/24 the MR Scanning activity totalled 37,683 examinations.
- The annual growth for MR scanning is currently around 6%.
- Activity totals are based on the number of examinations performed.
- MRI will continue to be delivered from existing hospital sites, and hours of operation and supporting workforce will remain the same at NHH.

1.8.9.31 Plain Film Assumptions

- In 2023/24 the total Plain Film activity at the Health Board was 244,484 examinations. 13% of this (32,155 examinations) was undertaken at NHH.
- The annual growth for Plain Film Imaging is currently around 2%.
- Activity totals are all based on number of examinations performed.
- Plain Film will continue to be delivered from existing hospital sites, and hours of operation and supporting workforce will remain the same at NHH.

1.8.9.32 Ultrasound Service Assumptions

- In 2023/24 the US scanning activity totalled 24,703 examinations. 39% of this (9,794 examinations) was undertaken at NHH.
- The annual growth for US Scanning is currently 8%.
- Activity totals are all based on number of examinations performed
- Ultrasound will continue to be delivered from existing hospital sites, and hours of operation and supporting workforce will remain the same at NHH.
- A&E referrals for Ultrasound will be performed at The Grange University Hospital.
- A&E, MAU and SAU referrals have a VIP service which are accommodated at NHH.

1.8.9.33 Vascular Ultrasound Assumptions

The service at NHH will maintain current levels operating from Monday to Friday, 07:45 – 15:45 each week, and staffed by 0.8 WTE.

1.8.9.34 Capacity split by site and Modality

Modality	GUH	RGH	NHH	YYF	Total Provision (all sites)
X-ray rooms	x4 24/7 service	x5 24/7 service	x3 24/7 service	x3 24/7 service	15
CT scanners	x2 1 in operation 24/7 1 in operation Mon-Fri 09:00 – 17:00	x2 1 in operation 07:30 – 20:00 7 days per week 1 in operation Mon-Fri 09:00 – 17:00 20:00-07:30 No on call, however CT head service in operation	x1 In operation Mon-Fri 07:30 – 20:00 20:00-07:30 No on call, however CT head service in operation	x1** In operation Mon-Fri 07:30 – 20:00 20:00-07:30 No on call, however CT head service in operation	6

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MRI scanners	x2 In operation 07:30 – 20:00 7 days per week 20:00 – 07:30 MR urgent lumbar spine cover for CES	x1 In operation 07:30 – 20:00 7 days per week	x2 In operation 7:30 – 20:00 7 days per week	x1 In operation 07:30 – 20:00 7 days per week	4
US Scanners	x3 In operation Mon-Fri 09:00 – 17:00	x8 In operation Mon-Fri 09:00 – 17:00	4 In operation Mon-Fri 09:00 – 17:00	3 In operation Mon-Fri 09:00 – 17:00	18
Nuclear Medicine	x0	x1 gamma camera In operation Mon-Fri 09:00 – 17:00	x1 gamma camera In operation Mon-Fri 09:00 – 17:00	x0	
Interventional radiology rooms	x2 In operation Mon-Fri 09:00 – 17:00 17:00 – 09:00 on-call service (regional cover)	x1 In operation Mon-Fri 09:00 – 17:00 (incl. vasc)	x0	x0	3
Cardiology screening rooms	x2 In operation Mon-Fri 09:00 – 17:00	x0	x0	x0	2
General screening rooms	x1 In operation Mon-Fri 09:00 – 17:00	x1 In operation Mon-Fri 09:00 – 17:00	x0	x0	2
Consultant Cover	09:00 – 17:00 Monday to Friday Saturday and Sunday. Out of hours/On call available at all times for evenings and weekends				

Table 20: Radiology Capacity Split by Site

1.8.9.35 Endoscopy

An endoscopy service will be maintained in NHH. The service will be routine elective; however, it will include some inpatient slots to prevent inpatients from requiring unnecessary transfer to GUH. There will be no emergency endoscopy service at NHH.

1.8.9.36 Current Activity

The total number of procedures completed in NHH has been increasing since 2021 with a return to full activity and utilization of the capacity available.

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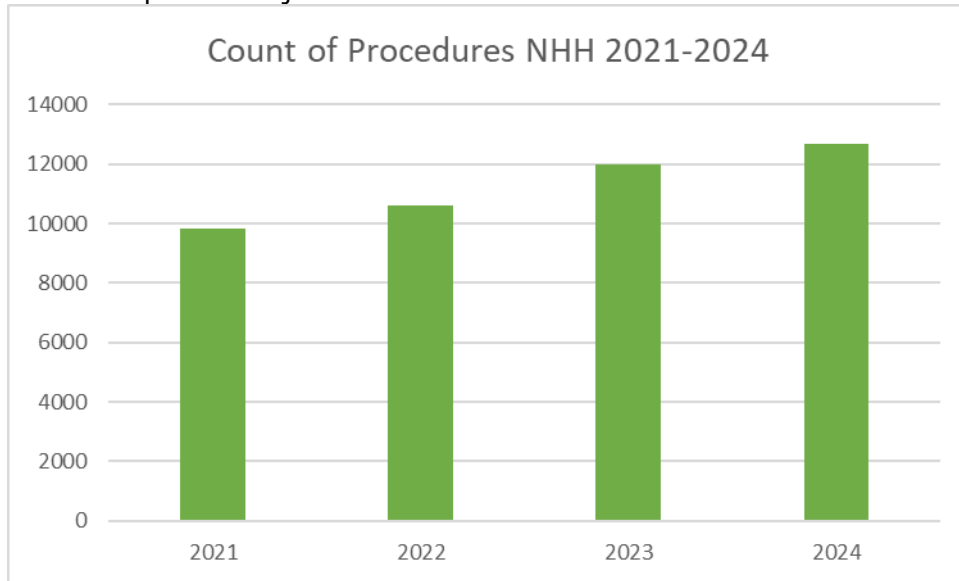
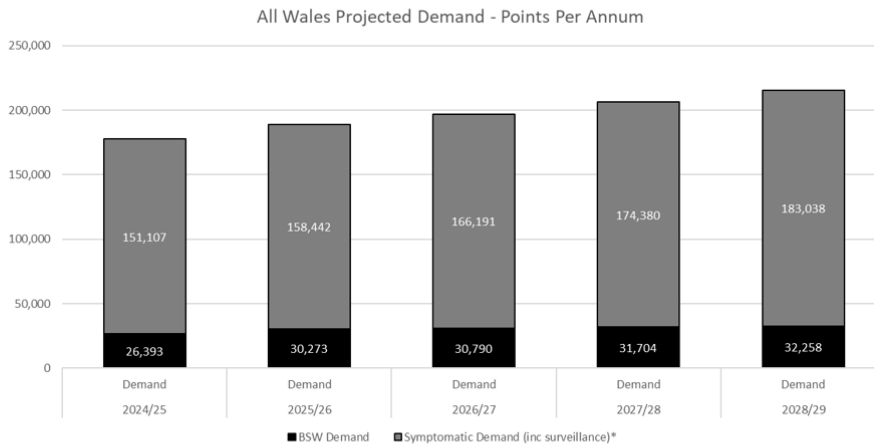


Figure 11: Radiology Procedures NHH 2021-2024

1.8.9.37 Future Activity

The current service offer at NHH includes two theatres at NHH; this will be maintained through the development. However, it should be noted there are forthcoming increased demand within Endoscopy, as evidenced below, there is a requirement to future-proof the NHH site. This is to ensure future demand is considered and appropriately factored into the planning. The current planning assumption is that this will be provided through regional solutions such as Llantrisant Health Park, subject to approval of capital and revenue requirements.

Demand Profile – All Wales



Overall demand increase 4.9% per annum (4.9% symptomatic and 5.1% screening)
Refer to benchmarking document for a breakdown by HB



Figure 12: Endoscopy Demand Profile – All Wales

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Aneurin Bevan Health Board - Endoscopy					
Total Anticipated Symptomatic Demand in Points					Average Expected Annual increase
2024/25	2025/26	2026/27	2027/28	2028/29	
31910	33506	35181	36940	38787	5.00%

Table 21: Endoscopy Total Anticipated Symptomatic Demand in Points

1.8.9.38 Urgent and Emergency Care – Assessment and Inpatient

Centered around an Integrated Front Door model
Encompassing inpatient wards and the medical take.

1.8.9.39 Current Activity

The bed base at NHH is will be maintained at current levels in line with the Clinical Futures Bed base. Historical data is reflective of both changes to site configuration and seasonality with expected peaks during winter period, for example. Average midnight occupancy for 24/25 to date has been 226. This is against a current, core bed base of 206 which does not include surge and boarding.

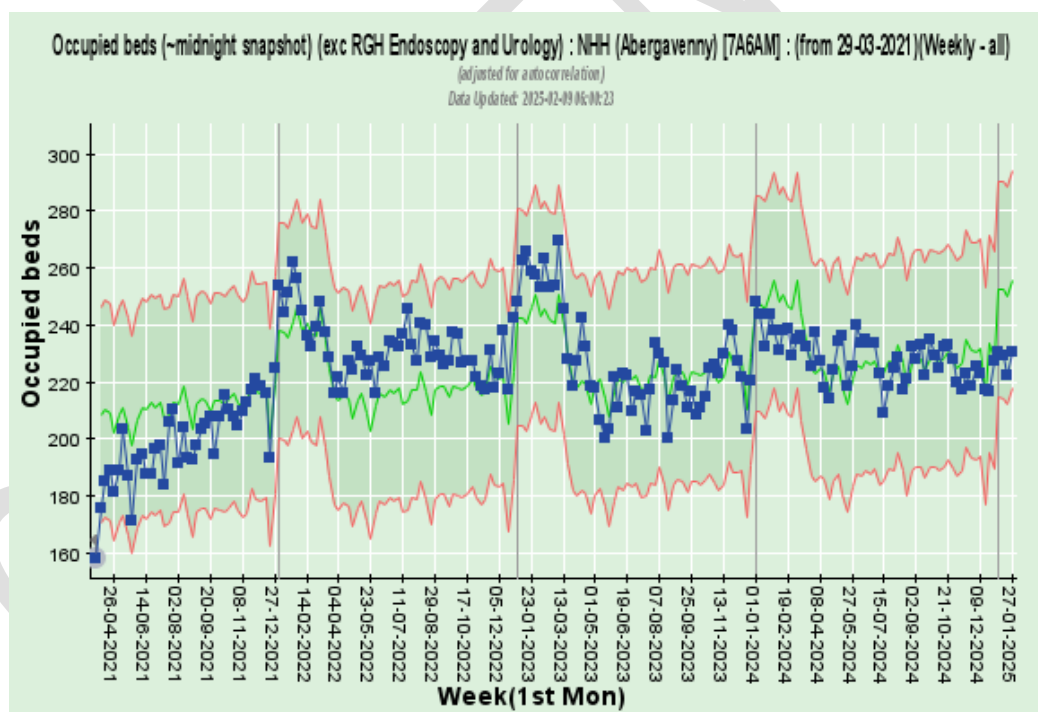


Figure 13: Weekly Midnight Bed Occupancy at NHH (Excluding RGH Endoscopy and Urology), 2021–2025

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Ward Name	Division	Speciality / Function	2024/25 bed base (core)	2025/26 bed plan
3.1 (Glan Ebbw)	Medicine	COTE / Diabetes	31	31
3.2 (Usk)	Medicine	COTE / Green Nurse Led	32	32
3.3 (Duffryn)	Medicine	COTE	32	32
3.4	Medicine	COTE	32	32
4.3 (Gwent)	Medicine	AMU	24	24
4.4 (Llanellen)	Medicine	COTE / Endocrine	32	32
4.2 (Crickhowell)	Surgery	T&O	25	25
TOTALS			208	208

Figure 14:NHH Bed base by specialty / function

1.8.9.40 Front Door Model

MIU demand is subject to seasonality, but there has been some increase over time in total presentations per year since 22/23 (~5%). Admit rate decreased through to 22/23 where, whilst subject to small fluctuations, has averaged 2.6% since.

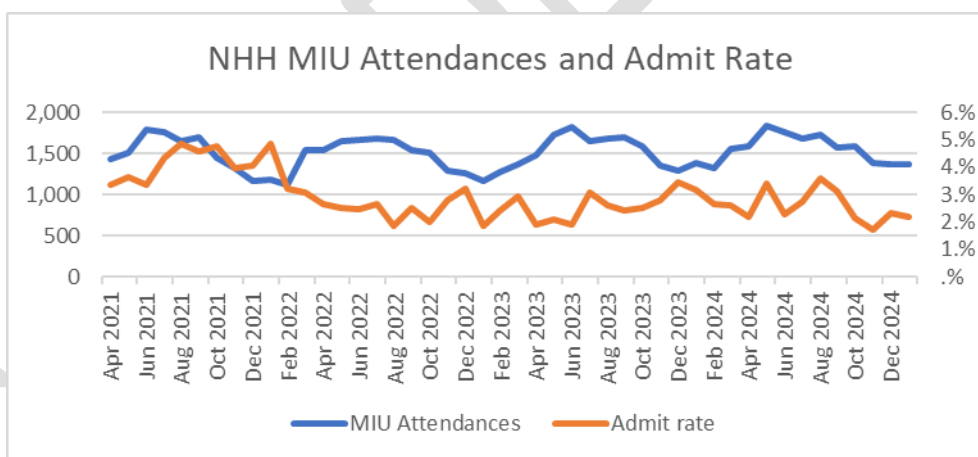


Figure 15:NHH MIU Attendances and Admit Rate

1.8.9.41 Cancer Care

Oncology services (SRU) including diagnostics, treatment, and follow-up care for the site particularly the expansion of SACT.

Cancer SACT activity has significantly increased post COVID, in addition to the steady growth in demand that was forecast prior to the pandemic. At the point the North Gwent Business Plan was written, the figures of 2020/21 illustrate the reduction in

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presentations and referrals as people stayed at home and did not access primary care services in the same way. As restrictions lifted this has resulted in a marked rise in suspected cancer referrals, with a steady cancer conversion rate maintained.

1.8.9.42 Current Activity

Aneurin Bevan UHB Outreach (Outpatients, Ambulatory Care, Solid tumour SACT) the Windsor Suite (Nevill Hall) providing 7 chairs (plus 1 non-treatment chair) Tuesday and Thursday. Pre-Covid, oncologists ran clinics at the RGH, SWH, NHH and outreach offered Windsor Suite (10 chairs/1day week), plus St David's Hospice (2 chairs and Chemo bus)

1.8.9.43 Future Assumptions

Modeling for the North Gwent Cancer Plan forecasted Haematology SACT activity is expected to grow by approximately 45 procedures per month by Autumn 2025, resulting in an 18% increase for the service. The capacity required to meet demand now and to 2030 was to deliver of Outreach SACT was a minimum of 11 chairs. Combining SACT Outreach, Ambulatory and Outpatient activity, the Health Board will be required from 2024 to deliver to 67% of our patients, which equates to the below projected amounts:

ABUHB Outreach Activity - total	2024	2031/32
SACT Total (2024 projected data)	8419	11886
Ambulatory Total (*with 2% increase from 22/23 figures)	672*	921
Outpatient Total (*with 2% increase from 22/23 figures)	14982*	19365
TOTALS	24,073	32,172

Table 22: Outreach Activity

This means that weekly activity levels will be at 463 procedures per week in 2024 (nearly 93 per day). This activity has been identified to be delivered initially in North Gwent by regional modelling. This total will rise to 619 by 2031/32, an increase of 34%.

1.8.9.44 Family and Therapies

Ensuring alignment with multidisciplinary care pathways and patient-centred delivery.

There are no proposed changes to the inpatient therapies model, other than optimisation of existing estate to access fir for purpose rehabilitation closer to the wards, Inpatient therapies are predominantly supported through physio, typically sees ~1,100 patients per month. Dietetics ~210 per month. Speech and Language Therapy activity has decreased following Stroke reconfiguration; however, activity has increased through 24/25 YTD. OT activity only commenced from 24/25. CNRS and Podiatry & Orthotics are both low volumes.

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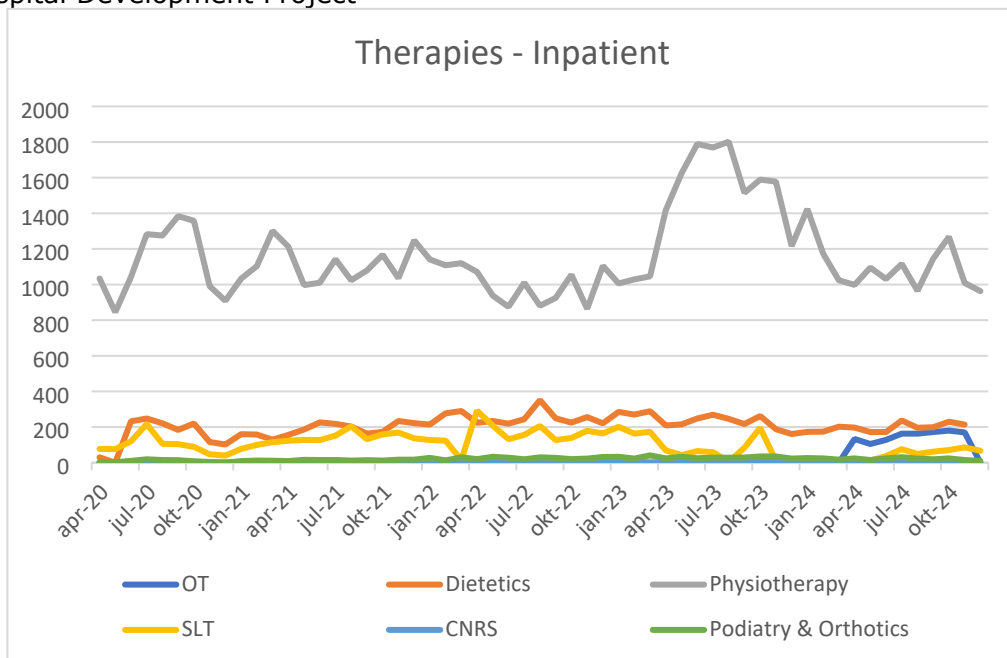


Figure 16: Therapies Inpatient Activity by specialty

1.8.9.45 Mental Health

Supporting system-wide transformation and estate optimisation.

At the present time there are no proposed changes to the capacity required, other than optimisation of existing estate to relocate to NHH. Mental Health are reviewing all of their models of care in 2025 and 2026.

The Maindiff Court site comprises 4 main buildings with 15 beds. Ty Skirrid, Hiraeth, Rholben Villa, and four interlinked blocks - Admin, Ty Bryn, and Tregaron

Capacity provision will be required for 190 staff are currently based on the Maindiff Court site (ESR Report June 2025)

1.9 New Development at the NHH Site

The redevelopment of Nevill Hall Hospital represents an opportunity to transform the estate in line with the Health Board's long-term strategic ambitions. As a designated enhanced Local General Hospital (eLGH), the site is central to delivering safe, modern, and sustainable care within the Clinical Futures model. The proposed new development will address critical infrastructure issues, improve functionality and flow, and support the delivery of integrated services within a high-performing, decarbonised estate. This section outlines how the redevelopment aligns with the Health Board's Estates Strategy, addressing both current challenges and future aspirations.

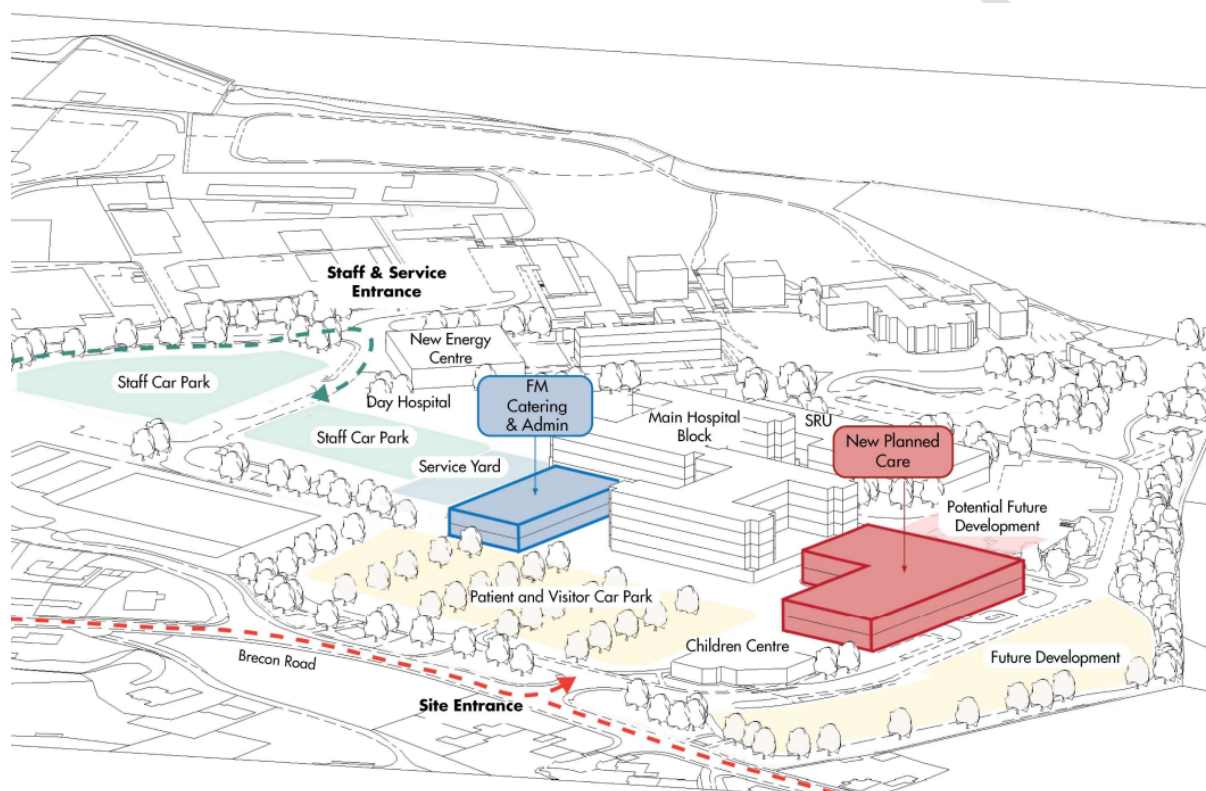


Figure 17: Diagram of proposed development for Option 5

1.9.1.1 Estates Strategy Overview (2018–2028)

ABUHB has developed a comprehensive Estates Strategy covering the period 2018 to 2028. This strategy aligns closely with the Health Board's Clinical Futures Strategy and sets out a vision for delivering a future-focused, fit-for-purpose estate that supports modern models of care.

Key Strategic Aims:

- A commitment to aligning the estate with patient need and service demand.
- Delivery of a sustainable, efficient, and supportive environment for healthcare delivery.
- Focus on transforming the estate to support integrated, flexible, and modern ways of working.

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Current Estate Context:

- The estate includes acute hospitals, community hospitals, mental health hospitals, and primary/community care premises.
- The strategy highlights significant backlog maintenance issues, with a total backlog of £54.6 million. This does not include the RAAC removal / remediation costs.
- Underutilisation is a known challenge, with approximately 10% of space underused and 3% identified as empty.
- Energy consumption and carbon emissions are key concerns, with 45% of the estate consuming more energy than Welsh Government targets.

Future State Vision:

- The strategy outlines a desired future state for the estate:
- A modern, sustainable, and flexible estate that facilitates effective service delivery and partnership working.
- Improved utilisation of space, reduction in backlog maintenance, and enhanced environmental performance.
- Development of integrated health, care, and wellbeing hubs in key locations to support regional models of care.

Strategic Objectives – Focus on Nevill Hall Hospital:

Reconfiguration and Rationalisation of Acute Hospitals: Nevill Hall Hospital has been developed as an enhanced Local General Hospital.

Review Mental Health Hospital Services: Including the future role of Maindiff Court Hospital and the implications for Nevill Hall.

Address Backlog Maintenance: With a focus on high and significant risk categories; review and invest in maintenance regimes.

Energy Strategy Implementation: Finalise and deliver a new energy strategy to reduce emissions and meet energy performance targets.

This strategy was developed prior to the detailed Reinforced Autoclaved Aerated Concrete (RAAC) assessment works, which have since introduced new considerations for site redevelopment and investment priorities.

The redevelopment of Nevill Hall Hospital represents a key opportunity to deliver the priorities set out in the Health Board's Estates Strategy. As a designated enhanced Local General Hospital, the scheme will enable the reconfiguration and rationalisation of acute services, address high-risk backlog maintenance, and significantly improve energy performance across the estate. It provides a platform to modernise infrastructure, reduce underutilised and inefficient space, and create flexible, future-ready environments that support integrated models of care.

Crucially, the development also contributes to the Health Board's long-term vision for a sustainable and resilient estate. It aligns with the Clinical Futures strategy, supports strategic site optimisation, and helps fulfil the Health Board's

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duties under the Well-being of Future Generations (Wales) Act, delivering positive outcomes for health, equality, and environmental responsibility.

Our estate is a **core enabler** of service & clinical transformation.
The Health Board's extant **Estates Strategy** (2018–2028), which underpins all capital investment decisions, including the redevelopment of Nevill Hall Hospital.

Strategic Priorities

- Align estate with **clinical need** and future **service demand**
- Tackle **backlog maintenance - £54.6 million**
- Improve **space utilisation** and reduce underused/empty areas
- Deliver on **decarbonisation goals** and energy efficiency
- Support **integrated and flexible working environments**

Why It Matters for NHH

- NHH is a key action within the extant strategy (Strategic priority 1) and long-term prioritisation exercise approved at Board (number 2)
- Directly supports estate **rationalisation** and **reconfiguration**
- Addresses RAAC and high-risk estate issues
- Creates **future-ready spaces**
- Advances the Health Board's long-term vision for a **resilient, optimised estate**
- Agreed as a priority by WG

Figure 18: Strategic Estates Priorities and Alignment with the project

1.9.1.2 Maindiff Court Opportunity – Estate Optimisation

The redevelopment of Nevill Hall Hospital provides a strategic opportunity to rationalise Health Board estate by reviewing services currently delivered from Maindiff Court Hospital and consolidating them onto a single, modernised site. Maindiff Court, located nearby in Abergavenny, currently accommodates a broad range of Mental Health and Learning Disabilities (MHL) services, including outpatient clinics, community teams, rehabilitation wards, and specialist provision such as substance misuse, eating disorders, and veterans' services. The site also houses several Family and Therapies services and associated Facilities functions.

While Maindiff Court has played an important role in the delivery of care, the site is operationally constrained, offers limited scope for future expansion or modernisation, and incurs ongoing maintenance costs due to its ageing infrastructure. The configuration of services across two separate sites also creates operational inefficiencies, duplication of support functions, and limits opportunities for integrated working.

Bringing appropriate services from Maindiff Court onto the Nevill Hall site as part of the redevelopment would:

- Support estate rationalisation by removing inefficient and underutilised buildings from the Health Board's estate portfolio.
- Enable the creation of modern, flexible accommodation that supports integrated MHL models aligned with community and acute care.

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- Improve staff and service user experience through co-location with broader clinical services, improved accessibility, and a fit-for-purpose environment.
- Align with the Health Board's commitment to delivering care closer to home and in settings that promote recovery and inclusion.
- Reduce long-term revenue and capital liabilities associated with maintaining a suboptimal estate.

The inclusion of Maindiff Court within the scope of the Nevill Hall redevelopment supports both the emerging clinical strategy, while also building on the principles established under the previous Clinical Futures strategy and Estates strategies by ensuring care is delivered from the right place, in a manner that is operationally, clinically, and financially sustainable. While a range of patient services are provided at Maindiff Court, a significant proportion of the site is currently occupied by non-patient-facing administrative functions, including office accommodation, meeting spaces, and support services. These functions could be more appropriately relocated to alternative premises, allowing the site to be released or repurposed. The existing estate does not make optimal use of clinical space, and rationalising these activities through the Nevill Hall redevelopment would support more efficient space utilisation, reduce overheads, and improve the alignment of estate use with service delivery priorities.

Maindiff Court

- 1 Rholben Villa
- 2 Hiraeth
- 3 Ty Siriol
- 4 Tregaron
- 5 Ty Bryn
- 6 Admin



Figure 19: Maindiff Court Hospital Site Configuration

1.9.1.3 Managing the impact of RAAC Risk Factors

Working alongside professional advisors management of RAAC is assessed and managed by area of impact as shown below -

Area of Impact	Rationale
Patient, Visitor and Staff Safety	Mitigating RAAC is essential to maintain a safe environment for patients, staff and visitors. Continued reliance on RAAC-affected buildings increases the risk of structural failures, which could lead to evacuation or even shutdown of critical service areas, severely impacting care delivery and patient safety.
Operational Continuity	Current monitoring provides only temporary assurance. A long-term solution is needed to ensure more reliable, uninterrupted service delivery, reducing the risk of downtime or partial closures. The failure of RAAC panels may impact on the distribution of infrastructure services critical for life-safety in specific areas.
Compliance and Risk Management	National guidance strongly advises organisations to remove or reinforce RAAC in public buildings. Failing to address RAAC could expose the Health Board to compliance risks and liabilities, should any incidents occur due to neglected structural vulnerabilities.
Financial Sustainability	Ongoing monitoring and repair of RAAC structures incur costs that could otherwise be directed toward patient care and clinical investments.

Mott MacDonald conducted a yearly review of the 'high critical' and 'high' risk RAAC panels at The aim was to reassess the condition of the RAAC panels, evaluate associated risks, and establish an ongoing management strategy. Key findings from the latest survey are summarised below.

Category	Details
Roof Panels	7,353 RAAC roof panels identified, many classified as high risk due to inadequate bearing widths (50-70mm instead of 75mm)
Wall Panels	463 RAAC wall panels noted, primarily non-load bearing, some require further investigation
High Critical Panels	113 panels with significant defects, require immediate propping or secondary support
Bearing Issues	All remaining panels are classified as high risk due to inadequate / poor panel supports. This aligns to the recommendations made within the Institution of Structural Engineers RAAC Panel guidance.
Water Damage	Common around building perimeter and internal downpipes, causing spalling and corrosion
Cracking and Spalling	Significant shear cracks and spalling observed, particularly around supports and service penetrations

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Adverse Loading	Additional loads from plant equipment and services increased the risk
Primary Frame	Investigations into the primary precast frame have found signs of structural distress; cracking and voids. Further investigation has been scheduled, and remedial works will be required.

Table 23: RAAC Issues Across NHH Site

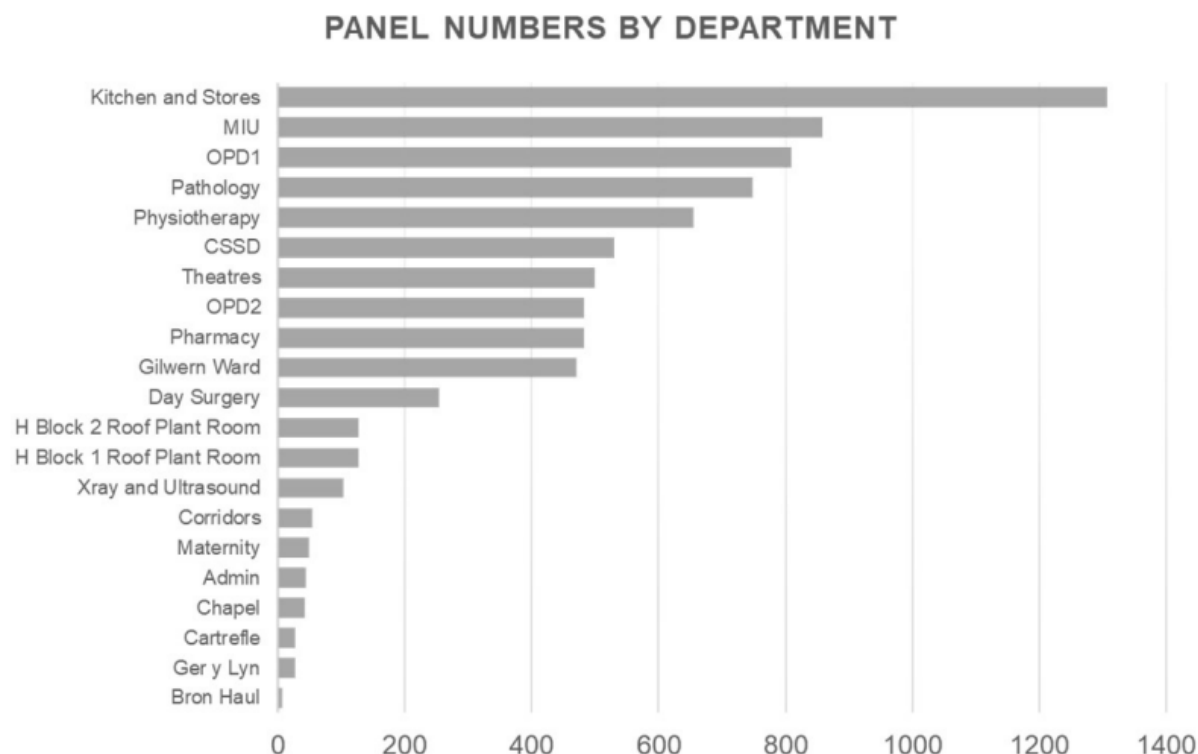


Figure 20: RAAC Panels by Department

The presence of RAAC reinforces the urgency of delivering a long-term, strategic solution for the Nevill Hall site. While not the sole driver of redevelopment, it significantly strengthens the case for capital investment by highlighting the unsuitability of the existing infrastructure to support modern models of care. Addressing RAAC within a broader strategic redevelopment ensures the Health Board avoids piecemeal investment and delivers a coherent, long-term solution aligned with clinical and estate priorities. This integrated approach maximises the value of capital funding, supports future service resilience, and ensures that safety improvements are delivered alongside wider estate and service modernisation.

1.9.1.3 Backlog Maintenance

Both Nevill Hall Hospital and Maidiff Court Hospital sites face significant backlog maintenance pressures, driven by the age, condition, and outdated functionality of key buildings. This presents operational, financial, and safety risks, and is a core driver for the proposed redevelopment.

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Nevill Hall Hospital, a long-established acute site, includes ageing infrastructure that no longer meets modern healthcare standards. Challenges include:

- Clinical blocks and plant rooms with limited adaptability for future models of care.
- High-cost, reactive maintenance of outdated mechanical and electrical systems.
- Poor energy performance and non-compliance with decarbonisation targets.

Capital investment will address these issues by:

- Replacing non-compliant infrastructure with purpose-built, future-proof facilities.
- Rationalising the site footprint
- Avoiding further investment in buildings with limited long-term value.

Maindiff Court Hospital includes a mix of inpatient, outpatient, and administrative functions, much of which is in estate with limited future utility. Key concerns include:

- High maintenance costs for non-clinical buildings in poor condition.
- Inefficient infrastructure, including single glazing, inadequate insulation, and limited accessibility.
- Fire safety and ventilation system deficiencies.

Redevelopment of Nevill Hall enables the rationalisation and relocation of appropriate functions from Maindiff Court, thereby:

- Reducing maintenance liabilities.
- Supporting potential disposal or repurposing of surplus estate.
- Aligning with the Health Board's estate strategy to deliver care from modern, sustainable environments.

1.9.1.4 Sustainability and Decarbonisation Strategy

ABUHB is committed to achieving net zero carbon emissions by 2030, in line with Welsh Government policy and the NHS Wales Decarbonisation Strategic Delivery Plan. This commitment is set out in the Health Board's Decarbonisation Framework, which defines the strategic objectives, key drivers, and workstreams required to deliver a more sustainable and resilient estate.

This approach underpins wider organisational goals to embed sustainability principles across all capital investment, operational delivery, and estate modernisation programmes, including the redevelopment of Nevill Hall Hospital.

1.9.1.5 Strategic Drivers for Decarbonisation

The Health Board's sustainability approach is informed by the following drivers:

Environmental and Social Responsibility: Following the Welsh Government's declaration of a climate emergency in 2019, the Health Board recognises the direct link between environmental impact and public health. The organisation

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aims to lead by example in reducing emissions from buildings, fleet, and service delivery.

Financial Pressures: Rising energy costs and volatility in global energy markets highlight the need for improved forecasting, cost management, and long-term investment in energy efficiency and carbon reduction measures.

Regulatory Compliance: Key legislation such as the Climate Change Act and Environment (Wales) Act 2015 establishes statutory carbon reduction targets. The Health Board aligns its decarbonisation objectives with NHS Wales delivery plans, including annual reporting against national milestones.

Reputation and Public Accountability: ABUHB reports its carbon footprint annually to Welsh Government and is committed to demonstrating leadership through collaboration, transparency, and continual improvement.

The Health Board's strategy focuses on five thematic areas:

Buildings – Improving the energy performance of existing assets and embedding sustainability in all new developments.

- Transport – Transitioning the Estates and Facilities fleet to electric vehicles and supporting sustainable travel alternatives.
- Procurement – Ensuring procurement practices reflect environmental standards and drive decarbonisation within the supply chain.
- Estate and Land Use – Optimising land for climate-resilient use, biodiversity, and efficient infrastructure.
- Smarter Healthcare – Supporting agile working, digital transformation, and low-carbon service delivery models.

1.9.1.6 Existing Plant Infrastructure

The plant infrastructure at Nevill Hall Hospital is currently managed under a Private Finance Initiative (PFI) agreement, which remains in place until 2026. The redevelopment provides a timely opportunity to modernise and decarbonise the site infrastructure as part of a broader transformation.

The redevelopment of Nevill Hall Hospital presents an opportunity for ABUHB to accelerate its decarbonisation ambitions by delivering a modern, energy-efficient facility aligned with the NHS Wales target of net zero carbon by 2030. Replacing ageing infrastructure with high-performance, sustainable buildings will reduce reliance on fossil fuels, lower energy consumption, and improve the carbon footprint of the site. The project enables the integration of low-carbon technologies, optimisation of building systems, and rationalisation of estate use, all of which contribute to long-term environmental, financial, and operational sustainability.

1.9.1.7 Feasibility Study Development Options

To support the development of this Strategic Outline Case, ABUHB has commissioned a detailed feasibility study to explore viable redevelopment options for the Nevill Hall Hospital site ([Appendix 1](#)). This work was undertaken

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to assess how the estate could be optimised to support the revised clinical model and strategic ambitions outlined in the Estates Strategy and Clinical Futures Programme. The feasibility study has been essential in identifying practical estate configurations, assessing spatial requirements, and informing the proposed Schedule of Accommodation. The following section sets out the development options considered, and the rationale for the preferred spatial strategy moving forward.

The following development and estates options were developed in alignment with the scope options:

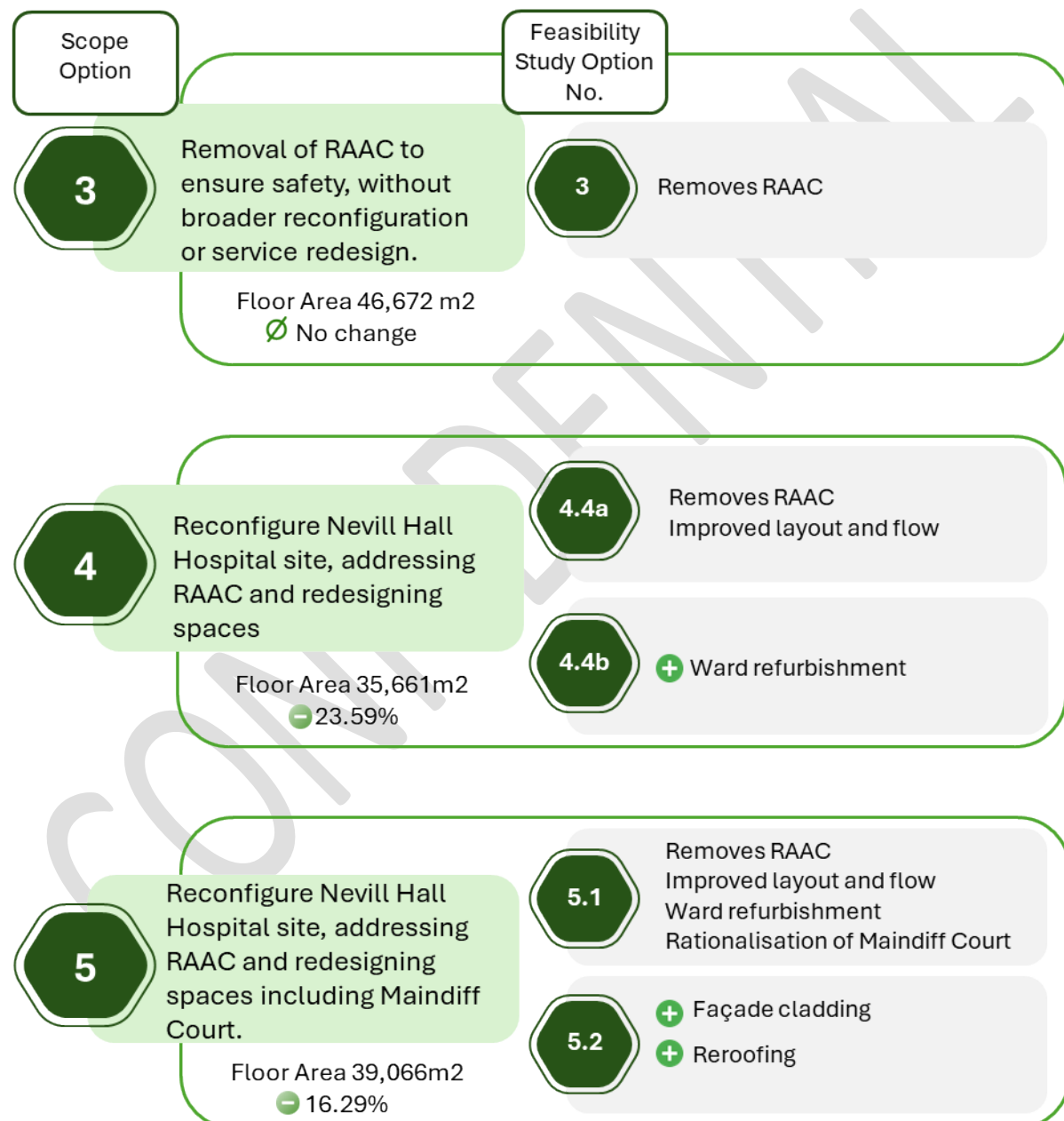


Table 24: Development / Estates Options aligned with Scope

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1.9.1.8 Schedule of Accommodation and Spatial Strategy

As part of the feasibility work, a detailed Schedule of Accommodation (SoA) has been developed to test and refine the spatial response required to deliver the proposed service model at Nevill Hall Hospital. The SoA consolidates and rationalises accommodation currently provided at both Nevill Hall Hospital and Maidiff Court, ensuring a more efficient and clinically aligned estate footprint.

Key benefits of the preferred SoA include:

- **Dedicated and Streamlined Theatre Flows**
Dedicated day surgery, ophthalmology, and endoscopy facilities are supported by shared clinical and non-clinical support areas, creating operational efficiencies. This supports the ambition to establish Nevill Hall Hospital (NHH) as a regional ophthalmology hub.
- **Single-Occupancy Recovery Rooms**
For endoscopy Stage 2 recovery and pre-operative preparation areas will comprise 100% single rooms, zoned by specialty. This layout supports privacy, separation of patient flows (e.g. gowned/ungowned), and aligns with requirements for JAG accreditation in endoscopy.
- **Optimised Ward Configuration**
Wards are planned as 24 or 32-bed units to support efficient nursing models. Accommodation will include a mix of 2-bed and 4-bed bays, with 2 single isolation rooms per ward. Further work is ongoing to assess the achievable percentage of single rooms within the retained estate.
- **Optimised Outpatient Spaces**
Outpatients will be delivered through standardised consultation/examination rooms and flexible procedure rooms, enabling maximum use across specialities. Specialist accommodation will be provided in clustered zones alongside generic spaces. The model also assumes a growing proportion of remote consultations.
- **Centralised Administration**
Administrative functions will be centralised outside of clinical departments to free up clinical space. Within departments, decentralised touchdown areas/workstations will be provided to support clinical roles and workflows.

This spatial approach enables delivery of the clinical model within a future-proof, flexible, and efficient estate configuration that responds to service priorities, workforce models, and strategic drivers for sustainability, patient dignity, and digital transformation.

The graph below indicates the changes in various departments as existing and proposed. In overall, the comparison of the existing GDA (Gross Departmental Allowance) and the preferred way forward indicates a circa 40% reduction in the proposed GSA (Gross Spatial Allowance) when compared to the existing.

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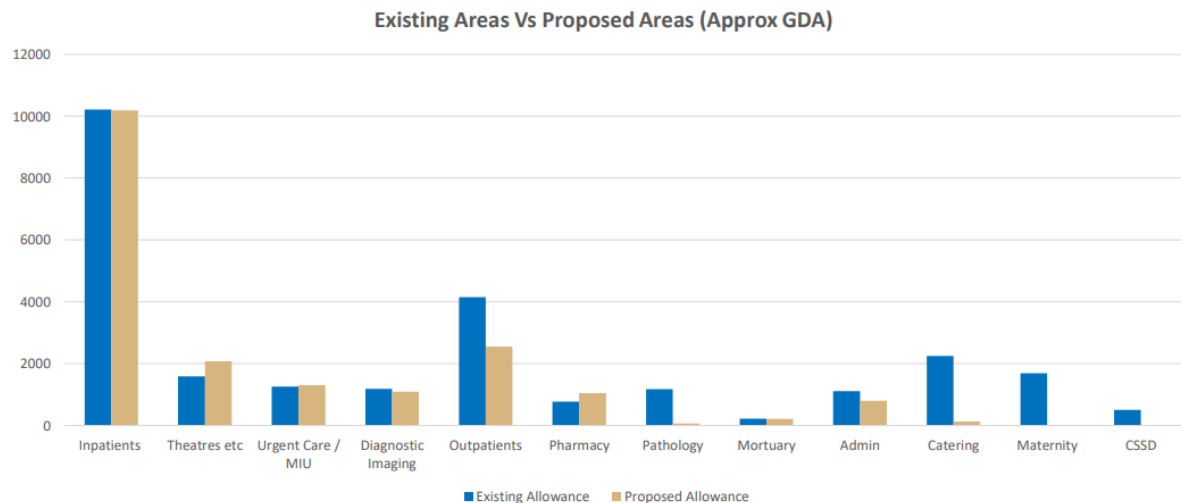


Figure 21: Existing areas versus proposed areas (Approx GDA)

- **Inpatient areas** remain broadly similar to existing provision, with layouts updated to align with current compliance and design standards.
- **Theatre areas** have increased in size to support the delivery of compliant and modern surgical environments.
- **Urgent care, imaging, mortuary, and pharmacy** areas remain broadly consistent with existing departmental footprints.
- **Outpatient accommodation** is significantly reduced, reflecting the planned shift in activity towards virtual consultations and more efficient in-person care models.
- **Pharmacy and catering services** are notably reduced in line with modernised operational models and improved supply chain integration.
- **Maternity services and CSSD** have been either removed or significantly reduced, consistent with the revised clinical model and site function.

• **Reconfigured Parking and Access Strategy**

The redevelopment of the site includes the re-provision of parking and access to support the proposed new layout. As the New Planned Care building will occupy the current patient and visitor car park, a new car park will be developed near the A40 site entrance, including accessible bays and drop-off zones adjacent to the new hospital entrance. Staff parking will be relocated to the rear of the site with access via Union Road West. This redesign separates staff and patient traffic flows, improves overall circulation, and maintains appropriate parking capacity to support the reconfigured estate.

The schedule of accommodation and spatial strategy represents a strategic rationalisation of space across the site, focusing on modern, efficient, and fit-for-purpose environments. This approach enables a significant reduction in the overall spatial footprint, while supporting improved patient flows, operational efficiencies, and alignment with future service delivery.

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Optimisation of the site will enable the consolidation of services currently delivered across Nevill Hall and Maindiff Court, supporting a more streamlined and clinically effective service model. The reduced footprint reflects a move towards modern, flexible healthcare spaces that are better aligned with contemporary clinical practice, digital delivery, and agile working. It also supports the Health Board's decarbonisation goals by replacing inefficient and high-maintenance infrastructure with energy-efficient, right-sized facilities, contributing to backlog maintenance reduction and long-term estate sustainability. This project is a key enabler of ABUHB's aim to deliver a fit-for-purpose, value-driven healthcare estate that meets the needs of current and future populations.

1.9.1.9 Retained Estate at NHH

As shown in **Error! Reference source not found.** all single-storey areas shown in red in the diagram below contain RAAC. It's proposed that these are to be removed as part of the redevelopment.



Figure 22: NHH Site Map

It is proposed that the main building 'H' tower blocks (dark green) will be retained, located to the centre of the site. In addition, the newly completed Satellite Radiotherapy Unit (SRU), and the Children's Centre will be retained. None of these buildings are impacted by RAAC. The Conference Centre to the south of the site and Nevill Hall Lodge located to the north of the site are part of the historic estate and are also to be retained.

Strategic Outline Case: Nevill Hall Hospital Development Project



Figure 23: Picture of Nevill Hall H Block / Towers

The redevelopment of Nevill Hall Hospital will enable the Health Board to deliver services from a modern, efficient estate that is better aligned with clinical priorities and future demand. By consolidating services, reducing underutilised space, and addressing critical infrastructure risks, the scheme introduces a more functional, flexible, and sustainable infrastructure for care delivery. It supports integrated service models, improves patient and staff environments, and ensures the estate is fit for purpose in the long term. This investment creates the necessary conditions for delivering safe, high-quality care within a more resilient and cost-effective estate.

1.9.1.10 Digital

The Nevill Hall Hospital (NHH) Development Project aligns with the Health Board's forthcoming Digital Transformation Strategy, recognising digital as a core enabler of high-quality, sustainable care. As part of the project's essential requirements, digital infrastructure and capability must be embedded from the outset to support modern clinical delivery, agile working, and improved patient and staff experience. This development provides a unique opportunity to modernise digital infrastructure and integrate advanced technologies across clinical and non-clinical services. Key areas of alignment include:

Digital-First Care Models: Enabling paper-free outpatient and inpatient services, aligned with national ambitions for digitised patient records, remote monitoring, and virtual consultations.

Clinical Decision Support & Integration: Investment in digital tools that enhance clinical decision-making and integrate seamlessly with existing platforms, supporting more efficient workflows and reducing duplication.

Agile Working: Provision of digitally enabled agile hubs to support flexible working across teams, with secure access to systems and collaborative platforms regardless of location.

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End-User Technology: Deployment of communication devices, workstations, mobile hardware, and access to public and staff Wi-Fi across the site.

Innovation-Ready Facilities: Futureproofed estate capable of accommodating advanced technologies such as AI-supported diagnostics, robotic-assisted surgery, and smart building systems.

Digital will be a critical driver in delivering many of the project's expected benefits, including improved flow, reduced duplication, enhanced patient safety, and optimised resource utilisation. The digital specification for the NHH redevelopment will be co-designed with the Health Board's digital team and aligned with national programmes and local transformation priorities.

1.9.1.11 Decant and Business Continuity Considerations

Decanting during construction is recognised as a critical risk to the delivery of the project. The Strategic Outline Case has identified and captured two key risks: *Decant Space Availability* and *Business Continuity During Implementation* (detailed in [Main Risks](#)). These reflect the potential challenges in maintaining essential services on an active acute hospital site and the availability of suitable decant space to enable phased delivery.

While detailed mitigation measures and logistics planning will be developed as part of the Outline Business Case (OBC) and Full Business Case (FBC). These include:

- A phased construction approach to minimise operational disruption,
- Use of temporary or modular accommodation,
- Exploration of available space within the existing estate to support decanting,
- Early engagement with clinical and operational leads to maintain service continuity, and
- A communication strategy to ensure staff and patient awareness of any temporary changes during the implementation phase.

A high-level decant strategy will be refined as the options are developed in more detail through the next stages of the business case process.

1.9.2 Sustainable Workforce and Financial Model

Delivering a modern, flexible, and future-proof healthcare facility at Nevill Hall Hospital requires a workforce and financial model that is both sustainable and responsive to evolving service demands. The NHH Development Project is designed to support these aims by enabling new ways of working, reducing reliance on temporary staffing, and creating a high-quality working environment that enhances staff wellbeing and retention. This section outlines how the proposed development aligns with the Health Board’s workforce strategy and financial objectives, ensuring long-term service resilience and value for money.

1.9.2.1 Workforce

As of December 2024, we employ 13,238 WTE (15,395 individuals), making us the largest employer in Gwent. We have made notable progress in reducing vacancies among registered nurses and medical and dental staff over the past two years. However, challenges remain in recruiting to certain medical specialties. We also continue to experience long-term vacancies in Therapies, Pharmacy, and non-clinical roles such as mechanical and craftsperson positions. Our ongoing priority is to recruit, develop, and retain directly employed staff. A substantive workforce is essential for building and sustaining effective teams, which in turn enhances the patient experience.

The redevelopment of Nevill Hall Hospital directly supports the ambitions of the Health Board’s People Plan 2022–2025: Putting People First, by creating a modern environment that enables new ways of working and enhances the staff experience. We are currently developing our People Plan for 2025/26 to 2028/29. The table below summarises the key alignment points:

People Plan Priority	NHH Redevelopment Alignment
Staff Health & Wellbeing	Creation of a purpose-built facility with improved break areas, wellbeing rooms, natural light, and dedicated quiet spaces. Close location to where over 64% staff work and live, supporting decarbonisation and time to travel to work and work life balance. Current workforce absence is 6.92 % for Nevill Hall which is higher than the Health Board average of 6.3%. Maindiff Court sickness absence is 9.88%.
Workforce Sustainability	More modern facilities will offer better working conditions, more modern technology, and potentially more appealing features, which can improve job satisfaction and attract new recruits. Delivery of a flexible workforce model through agile working spaces, consolidated teams, and co-location of services to reduce duplication and improve collaboration.
Becoming an Employer of Choice	Modern workspaces, access to education and training zones, improved facilities for mentoring and professional development. Supports attraction and retention through agile working principles, new estates and engagement

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Inclusive & Digitally Ready Workforce	Dedicated digital infrastructure for agile working, virtual consultations, and hybrid delivery. Supports remote access and flexibility across the workforce.
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Table 25: People Plan Project Alignment

These improvements will create a safer, more attractive working environment that supports sustainable staffing models, improves staff morale, and enables delivery of high-quality patient care. By aligning capital investment with workforce priorities, the Health Board will be better positioned to attract and retain a skilled workforce, reduce reliance on agency staffing, and deliver services in a more efficient and patient-centred way.

1.9.2.2 Nevill Hall Hospital

Approximately 1456 staff are based at Nevil Hall from a contractual perspective which is 10% of the Health Board workforce. 75 % of these staff are female and 61% of the staff based here work less than full time. 40% of the workforce are over the age of 50 years. This includes staff who may outreach to other sites but doesn't include staff that may be based at other sites and may work part of their time at Nevil Hall. The number of staff based at the site reduce following the opening of the Grange University Hospital where several staff transferred with their services.

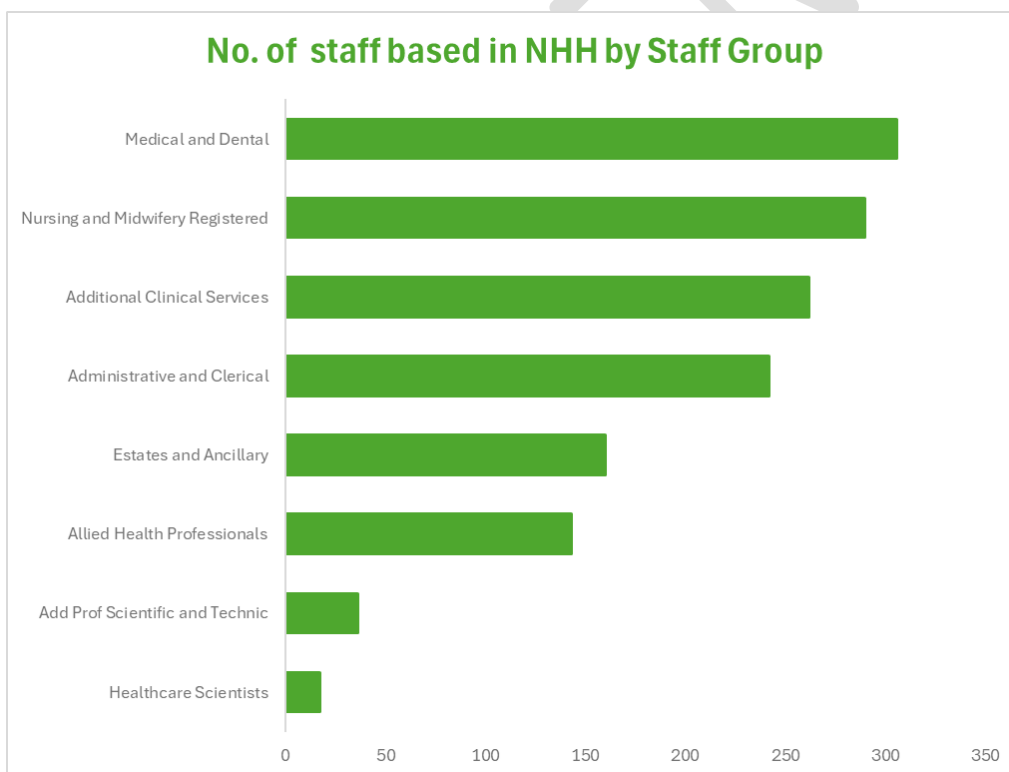
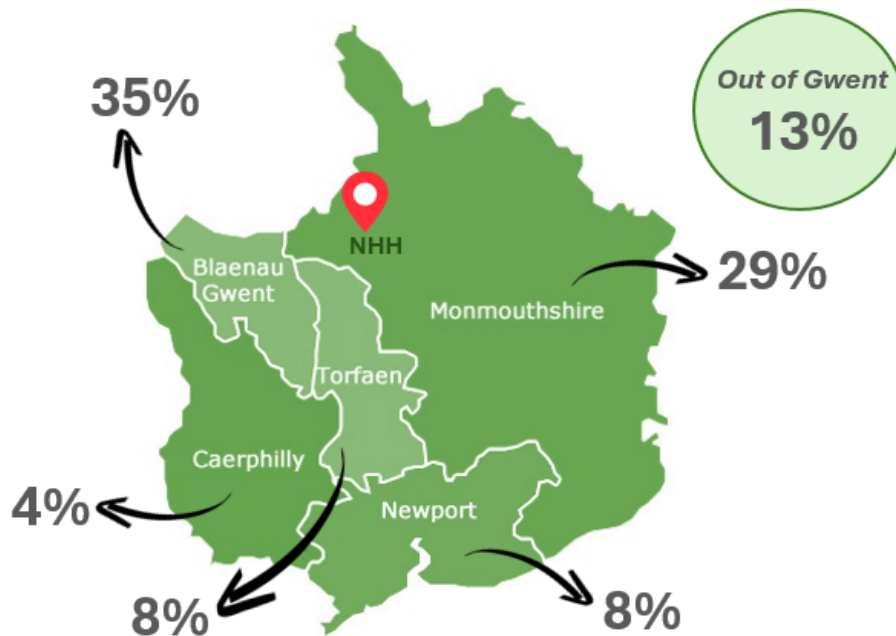


Figure 24: No. of Staff Based at Nevil Hall Hospital by Staf Group

64% of staff who are based at Nevill Hall Hospital live in either Monmouthshire or Blaenau Gwent.



Based on audit of 95 staff members whose home addresses are known.
Figure 25: Map of Gwent illustrating NHH staff home county

An audit of the staff based at Nevill Hall Hospital demonstrates a strong local employment base, with 64% of staff residing in either Monmouthshire or Blaenau Gwent. This reflects the hospital's important role as an anchor institution, supporting the local economy and providing employment opportunities within its surrounding communities.

1.9.2.3 Maindiff Court Hospital

According to the Electronic Staff Record (ESR), 186 staff are based at Maindiff Court Hospital. Of these, 54% live in Monmouthshire or Blaenau Gwent, further emphasising the importance of maintaining accessible employment opportunities within the locality.

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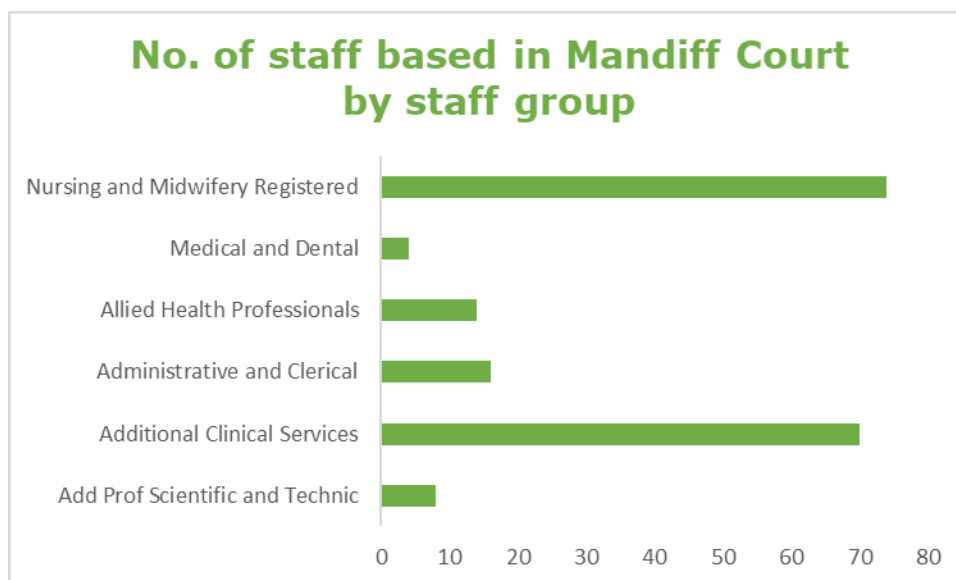


Figure 26: No. of Staff based at Maindiff Court by Staff Group

1.9.2.4 Workforce Planning for Nevill Hall Hospital

Workforce assumptions within the Strategic Outline Case are currently based on high-level planning assumptions and efficiency drivers, with recognition that further detailed service modelling and workforce planning will be required.

- As delivering of models and sites change, staff will transfer alongside the services relocating to different sites (e.g. day surgery).
- No changes are anticipated for the site delivery of some services (e.g. Pharmacy).
- Efficiencies delivered through co- location of sites, single site, reduce single access points, reduce bed base in line with Clinical Futures assumptions, digital solutions to streamline administration tasks, multidisciplinary approach, improved hospital configuration that supports flow, communication and configuration of teams.

1.9.2.5 Workforce Planning Approach

Our approach will include the following components and will support delivery of workforce solutions and potential efficiencies. This work will be developed in more detail at the next stage of the business case process:

Strategic Alignment

Align workforce plans with clinical strategy, service models, and national priorities.

Demand Modelling

Use activity-based modelling to estimate workforce requirements based on projected patient volumes, case mix, service configuration, and clinical pathways.

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Supply Analysis

Assess current workforce availability, future pipeline, and identify gaps.

Workforce Design

Define future workforce structures, roles, skill mix, and digital capabilities.

Scenario Planning

Model workforce options and assess their impact on cost, quality, and deliverability.

Financial Modelling

Calculate workforce costs and ensure alignment with the business case.

Implementation Planning

Plan recruitment, training, and change management activities.

Governance & Risk Management

Establish oversight mechanisms, identify risks, and define mitigation strategies.

1.9.2.6 Enabling Innovation and Inclusion

We will adopt a multidisciplinary workforce planning approach that supports flexibility and digital enabled workforce. This includes:

- Recognising the valuable contribution of volunteers
- Reviewing skill mix
- Developing and introducing advanced and extended roles
- Embedding person-centred care
- Supporting hybrid and innovative roles
- Aligning training needs with education commissioning

1.9.2.7 Equality, diversity, and inclusive leadership

will be embedded throughout the development of the workforce plan. These principles will enhance employee experience and support the changes required in service delivery, underpinned by robust organisational change processes.

1.9.2.8 Sustainability and Data-Driven Workforce Planning

Our approach will maximise the use of data and technological advancements to:

- Reduce reliance on bank and agency staff
- Build a sustainable, long-term workforce model
- A hospital that prioritises and supports wellbeing of staff
- Create a workplace that staff are proud to be part of and where Nevill Hall is an attractive place to work and train.

1.9.2.9 Administrative Hub Functionality

As part of the redevelopment, the Health Board intends to establish a dedicated administrative hub within the Nevill Hall Hospital site. This hub will consolidate non-clinical functions currently dispersed across the site and wider estate,

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creating a centralised, flexible workspace designed to support agile working. The aim is to release clinical and patient-facing spaces for frontline activity by relocating office-based teams into a purpose-built environment that promotes collaboration, digital working, and efficient use of space. The hub will support a range of corporate and service teams who require onsite presence but do not need to be located in clinical zones, enabling a clearer separation of clinical and administrative environments across the hospital. It will also form part of the Health Board's wider network of agile sites, offering a shared, bookable workspace for staff working across the North Gwent area and contributing to a more flexible, sustainable, and connected estate model.

1.9.2.10 Agile Working

The Health Board has adopted a clear vision and set of principles for agile working, which align closely with the workforce objectives of the NHH Development Project. This approach recognises that work is an activity, not a location, and supports the creation of flexible, digitally enabled environments that bring together people, IT, and estate.

Agile Working Principles

Opening up Opportunities...

- ✓ *To enable staff to work in a location that is best for them, their services and our patients.*
- ✓ *To better support staff health and wellbeing.*
- ✓ *To optimise the effective use of our time.*
- ✓ *To maximise the use of available technology.*
- ✓ *To promote space/desk sharing by reducing the current 1:1 desk ratio.*
- ✓ *To ensure our future estate and digital strategy should seek to align with agile/hybrid working.*
- ✓ *To provide a network of agile hubs with breakout space and storage space.*

Figure 27: Agile Working Principles

By embedding agile working principles into the design and operation of Nevill Hall Hospital, the development will:

- Enable flexibility for staff to work in the most appropriate location for their role, improving service delivery and staff wellbeing.
- Support new models of care by integrating clinical and administrative functions, reducing unnecessary travel, and promoting collaboration across teams.
- Optimise use of space and technology, supporting shared workspaces and reducing the need for fixed desks through smarter working practices.
- Promote staff wellbeing, with modern, well-designed environments that balance clinical need with quiet, collaborative, and restorative areas.
- Reduce estate costs and improve efficiency by aligning space utilisation with service demands and the Health Board's digital strategy.

The NHH Development Project directly contributes to these principles by designing spaces that support hybrid and agile working models, ensuring infrastructure and technology enable seamless connectivity and collaboration.

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This will maximise the benefits of a flexible workforce model and reinforce the hospital's position as a resilient and attractive place to work.

The adoption of agile and hybrid working delivers a range of benefits to both the workforce and the organisation. These include a reduced carbon footprint through lower travel and estate usage, improved staff wellbeing and work-life balance, and better use of the existing estate by releasing space for clinical activities. It supports the creation of inclusive, collaborative workspaces and local hubs, increases the proportion of staff able to work from a variety of locations, and promotes innovation, creativity, and trust. Staff feedback to agile working to date has been overwhelmingly positive, with noted improvements in autonomy, engagement, and team dynamics.

1.9.3 Financial Sustainability and Affordability

The project is being developed with a clear focus on long-term financial sustainability and alignment with the Health Board's financial recovery objectives. While capital funding will be sought from the All-Wales Capital Programme, the preferred way forward has been scoped to minimise additional revenue pressures and ensure affordability within the context of the Health Board's Integrated Medium-Term Plan (IMTP).

The proposed service model and estate strategy aim to:

- Optimise existing resources through the rationalisation of the Nevill Hall and Maiddiff Court sites
- Reduce high-cost backlog maintenance and address RAAC risks through comprehensive redevelopment
- Improve operational efficiency by consolidating services, enhancing clinical adjacencies, and enabling digitally supported models of care
- Increase day case and outpatient capacity through redesigned pathways, maximising throughput without proportionate cost growth.

Initial modelling indicates a revenue consequence range of **£5.5m–£10.1m** across the shortlisted options, with the preferred way forward reflecting potential efficiency benefits and space rationalisation. These costs are indicative and will be subject to detailed review at Outline Business Case stage, including consideration of operational commissioning, staffing models, utilities, digital infrastructure, and wider whole-system impacts.

Further detail on the assumptions, cost estimates, and revenue implications is provided within the [Financial Case](#)

1.10 Main Benefits

The proposed redevelopment of Nevill Hall Hospital is expected to generate a wide range of benefits spanning patient care, workforce and staff wellbeing, estate improvements, and financial sustainability. These benefits reflect the project's alignment with the Health Board's clinical strategy and strategic priorities, including system integration, care closer to home, and decarbonisation.

In line with HM Treasury's Green Book guidance and reflecting the Strategic Outline Case (SOC) stage of development, we have focused on the 20% of benefits that are likely to generate 80% of the project's overall value. This enables early clarity on the outcomes that will drive the greatest impact and inform decision-making as the project progresses.

To support the realisation and tracking of these outcomes, a comprehensive Benefits Strategy has been developed ([Appendix 2](#)). This strategy provides the overarching framework for identifying, measuring, and monitoring benefits throughout the project lifecycle. The following table sets out the anticipated high-level benefits that will be tracked and measured over the lifecycle of the project. These benefits are underpinned by the enabling capabilities outlined in the Business Needs section and mapped in detail in the Benefits Map ([Appendix 3](#)). The Benefits Realisation Plan will be used to monitor and evaluate their delivery over time, with owners identified to support accountability

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Benefit ID	Title	Description	Category	Measurement Method	Baseline	Target
NHH001	Reduced Waiting Times	Reduction in waiting times for elective and unscheduled appointments	Patient Care	% treated within 62 days (cancer) 4hr A&E waits Outpatients -Reduce proportion of patients waiting over 26wks Diagnostics -proportion of patients waiting over 8 weeks	Cancer - 67.5% GUH ED 4hr - 54.2% 26wk OP - 43.6% 36wk OP - 30.8% 8wk DX - 7.4%	Cancer - GUH ED 4hr - 26wk OP - 36wk OP - 8wk DX - TBD at OBC stage
NHH003	Improved Patient Flow	Improved efficiency in clinical service including LOS, bed use	Patient Care	LOS, bed occupancy, theatre utilisation	AvLoS - 23.64 days Theatre utilisation (capped) - 80.1% Bed occupancy - 202 BADS compliance - 77% (all sites / 24/25)	TBD at OBC stage
NHH004	Improved Staff Wellbeing	Healthier working environment to support staff recruitment and retention	Workforce & Staff Wellbeing	Turnover, sickness rates,	Sickness rates within the Health Board – 8%	Sickness rates within the Health Board – 6%

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NHH005	Improved Estate Utilisation	Better use of space and reduced backlog maintenance	Configuration of Infrastructure	Utilisation data, estate condition survey	Backlog maintenance £54.6m at NHH Based on 6 Facet survey Condition B(C)	New build spaces A Refurbished Areas B
NHH006	Financial Sustainability and Resource Optimisation	Optimised Resource Utilisation and Estates Cost Efficiency	Financial Efficiency	Running costs/m ² , backlog costs, agency usage	~£68/m ² (based on 2024/25 utility + rates spend) Backlog maintenance £54.6m at NHH Increased throughput per revenue unit (activity/£)	may rise due to better utilisation – TBD at OBC stage Significantly reduced backlog maintenance – tbd Throughput per Revenue Unit (Activity/£ - TBD)
NHH007	Reduced Carbon Emissions	Lower estate carbon footprint via efficient infrastructure	Configuration of Infrastructure	kWh/m ² , BREEAM compliance	Electricity: 27kWh/sqm Gas: 375kWh/sqm	Net Zero Carbon
NHH009	RAAC Removal	Eliminating structural risks through RAAC removal	Configuration of Infrastructure	RAAC removal confirmation, safety certification	Significant presence of RAAC throughout building	Zero presence of RAAC

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NHH010	Day Case and Treatment Centre	Establishing day treatment capacity for HVLC activity	Patient Care	% day case delivery, BADS compliance, throughput	Day case - 99.2% BADS - 77% (all sites 24/25) Elective inpatient admissions - 19 Theatre utilisation (capped) - 80.1% HVLC sessions -2 session per month (General Surgery)	Day case - BADS - Elective inpatient admissions - Theatre utilisation (capped) - HVLC sessions – 1/3 of General Surgery sessions TBD at OBC stage
NHH011	JAG (Joint Advisory Group) Accredited Endoscopy Unit	High quality unit to support diagnostics and accreditation	Patient Care	JAG status	Not currently JAG accredited	JAG accreditation
NHH014	Regeneration Catering Model	Modern food delivery model with reduced waste	Configuration of Infrastructure	Cost per meal, food waste volume	Chef rota fill rate (%) Number of reported food safety incidents (e.g. allergy-related Datix reports)	Chef rota fill rate (%) 24.3% Average Q1 2025

Note: Baseline metrics and target benefits are indicative at this Strategic Outline Case (SOC) stage and will be further refined and validated as part of the Outline Business Case (OBC), informed by detailed modelling, stakeholder engagement, and updated cost and activity data.

1.11 Main Risks

The Project involves a complex set of requirements, dependencies, and resource needs, which introduce various risks to achieving the project’s spending objectives. Effective risk management is essential to ensure the project stays within budget, meets timeline expectations, and delivers the intended benefits. A comprehensive risk register will be maintained and updated at each project phase. This risk register will include cause-event-effect analysis and assign scores for likelihood and consequence to prioritise risk responses. Regular risk assessments will ensure high-priority risks are promptly addressed and that mitigation strategies remain aligned with project goals, timelines, and resource allocation.

The following key risks have been identified:

Risk Title	Description	Effect	Score	Mitigation Strategy
RAAC Structural Safety Prior to Redevelopment	RAAC planks may deteriorate faster than expected or develop defects that compromise safety before major works begin.	May necessitate emergency decant or mitigation works, causing disruption, increased costs, and reputational risk.	15	Continue close monitoring through existing RAAC active monitoring project group and working with structural engineers.
Change in RAAC Guidance	Guidance on the assessment, treatment, or removal of Reinforced Autoclaved Aerated Concrete (RAAC) may evolve during the project lifecycle.	Could necessitate redesign, scope adjustment, or additional works outside of current cost or time estimates.	15	Maintain active monitoring of national guidance, engage early with technical advisors
Capacity Constraints in Service Design Engagement	Operational and clinical teams are at capacity with existing duties, limiting engagement in the service design process.	Could lead to a suboptimal service model that doesn’t fully meet clinical and operational needs.	20	Support from Planning Team to develop model and specifications; monitoring and adjusting engagement levels as needed.
Interdependencies with Other Workstreams	Dependencies on other projects/workstreams may hinder progress	Delays and suboptimal outcomes for the service redesign.	20	Programme manager to coordinate information across workstreams and ensure alignment with the eLGH programme

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<p>Regional Planning Interdependency – Llantrisant Health Park</p>	<p>planning assumptions are based in part on regional service changes, including proposals for an expansion of services at Llantrisant Health Park. If these are not approved or delayed, additional demand may fall to NHH, exceeding the capacity currently planned.</p>	<p>Potential for under-provision of capacity and infrastructure at NHH, leading to service pressures, compromised patient flow, and the need for adaptation post-build.</p>	<p>20</p>	<p>Ongoing engagement with regional planning forums to track the status of Llantrisant proposals Clear articulation of planning assumptions within the SOC and associated capacity modelling Escalation through the Health Board and regional collaboration structures if assumptions change</p>
<p>Low Staff Morale at NHH</p>	<p>Decline in staff morale due to redesign and perceived loss of site identity.</p>	<p>Could lead to staff turnover, negatively impacting staffing levels and service delivery.</p>	<p>20</p>	<p>Promote positive developments (e.g., Satellite Radiotherapy Unit), and implement a detailed communication action plan.</p>
<p>Balancing RAAC Mitigation with future planning</p>	<p>The need to address RAAC remediation urgently may conflict with project funding timelines, potentially leading to investment in areas that may undergo redevelopment, resulting in abortive costs.</p>	<p>Delays in funding could result in redundant spending on RAAC mitigation in areas identified for future redevelopment, leading to inefficient use of resources.</p>	<p>20</p>	<p>Develop a phased, prioritised plan for RAAC remediation focused on areas critical for immediate safety. Coordinate closely with Welsh Government to secure timely support, minimising the risk of abortive costs. Align RAAC mitigation with the broader redevelopment timeline to ensure efficient resource allocation.</p>
<p>Public Opinion on the New Clinical Model</p>	<p>Risk of negative public perception of the new clinical service model</p>	<p>Potential damage to Health Board’s reputation, loss of public trust, and possible judicial review.</p>	<p>16</p>	<p>A comprehensive communication and engagement plan; Liaise with Llais; Compliance with public engagement / consultation requirements; Key</p>

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				messaging to address public concerns
Business Continuity During implementation	Maintaining essential services on an active acute site while construction is underway poses operational challenges.	Potential disruptions to service delivery, impacting patient care and staff workflow.	16	Develop a phased construction plan to minimise disruption, establish temporary facilities if needed, and coordinate closely with clinical teams to maintain service continuity. Implement robust communication channels to inform staff and patients of any temporary changes.
Decant Space Availability	Lack of appropriate decant space during refurbishment may delay construction or impact service delivery.	Project delays or interruption to services.	16	Identify and plan decant strategy early; consider modular/temporary builds or off-site alternatives.
Change Fatigue and Resistance	Continuous or concurrent service changes (e.g., from Clinical Futures, GUH transitions, etc.) may lead to change fatigue among staff.	Reduced engagement, implementation delays, lower quality input to design.	16	appoint change champions within services.
Supply Chain / Market Volatility	Inflation, material shortages, or contractor availability issues may increase costs or delay delivery.	Capital overspend or timeline slippage.	12	Early market engagement; built-in cost contingency;
Delays in Approvals / Business Case Sign-off	Prolonged review or feedback cycles with Welsh Government or internal governance may delay mobilisation.	Increased costs, loss of programme momentum, impact on RAAC risk mitigation.	16	Early engagement with approvers; pre-submission reviews; clear alignment to IMTP and national priorities.
Assumptions based on current Anaesthetic criteria may constrain volume of activity	If the existing anaesthetic and pre-assessment criteria at Nevill Hall remain unchanged, the site may be unable to deliver the full range and volume of	- Reduced theatre utilisation and productivity Inability to realise high-volume, low-complexity	16	Review and define clinical governance pathways and escalation options Explore workforce models that may allow expansion of case mix

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	<p>procedures needed to maximise theatre capacity and throughput. This risk is heightened by the site's standalone nature and lack of co-located acute services, which constrain the complexity of cases that can be managed safely.</p>	<p>(HVLC) ambitions Potential need to redirect patients to alternative sites, impacting flow and waiting list management</p>		
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Table 26: Risks

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1.12 Constraints

The Project faces several constraints that impact its planning, resourcing, and implementation. These constraints stem from the practical challenges of redeveloping an active acute healthcare site while balancing immediate safety needs, resource limitations, and the complexities of future-proofing the hospital’s services. The constraints identified reflect both the internal and external factors that may influence the project’s scope, timeline, and funding requirements.

The following table summarises the main constraints that have been placed on the project:

Constraint	Description
Availability of Resources to Support Change	Limited availability of both capital and revenue resources may impact the ability to fund all aspects of the project within desired timelines.
Capacity of Teams to Engage in the Project	Operational and clinical teams have limited capacity to engage fully in the project due to ongoing responsibilities, potentially slowing down decision-making and progress.
Alternative Estate Provision in the Area	Limited alternative estate options in the area may restrict the ability to relocate services or staff temporarily during construction or redevelopment phases.
Ability to Recruit and Retain Staff	Challenges in recruiting and retaining skilled staff may affect the project’s progress, particularly in critical roles essential to implementation and ongoing operations.
Interdependencies with Other Workstreams	The project is dependent on the progress and alignment of other workstreams, which may impact timelines and coordination efforts.
Resource to Develop Clinical Service Plan	Limited resources available to develop the Clinical Service Plan at the required pace may delay project and planning stages.
Anaesthetic and Clinical Criteria Limitations	Nevill Hall operates within defined anaesthetic and pre-assessment criteria that are aligned to ensure patient safety. As a standalone site without co-located acute services, these criteria typically support the treatment of lower-risk patients, which places limitations on the range and complexity of procedures that can be undertaken on site. Expanding this scope would require changes to infrastructure, workforce model, and clinical governance. It may limit the patients that can safely be operated on at the site.

Table 27: Constraints

1.13 Dependencies

The success of the Project relies on several key dependencies that lie outside the project's direct scope and control. These external factors and partnerships are essential to achieving project objectives, maintaining timelines, and ensuring that the redesigned hospital can operate effectively. Understanding and managing these dependencies is critical for proactive planning, as any changes or delays in these areas could impact the project's progress and success. The following list summarises the primary external dependencies upon which the project is reliant:

Dependency	Description
Funding Approval and Allocation	The project's success depends on timely funding. Delays or changes in funding availability could impact the project timeline and scope.
Collaboration with Local Health Providers and Authorities	Effective collaboration with other local health providers and authorities is essential, particularly regarding patient pathways
Interdependencies with Broader Clinical Futures Programme and emergent clinical strategy	The project must maintain alignment with both the legacy Clinical Futures Programme and the newly launched clinical strategy. Any changes in regional or national service planning, models of care, or strategic priorities may affect the scope, configuration, or phasing of the redevelopment. Ongoing coordination with system-wide programmes is essential to ensure consistency of clinical models and avoid misalignment with future service delivery goals.
Supply Chain Stability and Availability	The project depends on the availability of construction materials, medical equipment, and technology. External supply chain factors, such as market volatility or supplier constraints, may affect costs, timelines, and material availability.
Regulatory Compliance	The project must secure ongoing regulatory approvals and align with healthcare regulations and standards. Changes in regulatory requirements from health authorities may necessitate modifications to design or implementation, impacting costs and timelines.
Engagement with Community and Public Health Stakeholders	Public perception and community support are essential for the project's success. The project's outcomes rely on effective communication and engagement with stakeholders to ensure local buy-in and avoid negative impacts on public trust.

Table 28: Dependencies

2. ECONOMIC CASE

The Economic Case sets out how the Project Team has selected the short list of options to be taken forward to the next stage of planning, the Outline Business Case. This was undertaken in line with the requirements of the Five Case Model and encompassed the recommended five “categories of choice” and a sixth choice relating to “Estate Solution”. The six categories included:

- **Service Scope**
- **Service Solution**
- **Service Delivery**
- **Implementation**
- **Funding**
- **Estate / Development Solution**

2.1 Critical success factors (CSFs)

The following Critical Success Factors (CSFs) have been established to guide the evaluation and decision-making process for the project. These CSFs ensure that each option is assessed consistently against key priorities, including alignment with strategic objectives, long-term value, operational feasibility, and stakeholder support. The CSFs are designed to capture essential elements for project success, helping to identify options that are both realistic and beneficial for the Health Board’s objectives.

Critical Success Factor	Description
CSF1: Strategic Fit and Business Needs	Consistent with national and regional strategies Consistent with clinical strategy Meets national standards and guidance Addresses the Health Board’s priority needs, meeting current and anticipated healthcare demands.
CSF2: Value for Money	Provides long-term cost benefits, maximising resource efficiency and reducing waste and supports decarbonisation Demonstrates effective use of public funds by achieving the best balance of costs and benefits. Minimises potential future maintenance and operational costs.
CSF3: Supply-Side Capacity and Capability	Leverages internal and external resources effectively to deliver project outcomes. Ensures that required skills, expertise, and materials are available within the supply chain. Supports workforce stability, improving staff recruitment and retention.
CSF4: Affordability	Fits within available funding envelopes and demonstrates a sustainable financial model. Balances upfront capital costs with future operating costs, ensuring budget compliance over time. Avoids unnecessary financial risks to the Health Board.

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Critical Success Factor	Description
CSF5: Achievability	Realistic in terms of the project timeline and the potential to obtain necessary approvals and planning consents. Minimises disruption to existing services, ensuring business continuity. Supported by stakeholders, ensuring a feasible pathway to completion.

Table 29: Critical Success Factors

2.2 Long List Development and Appraisal

To address the structural risks, estate inefficiencies, and service model challenges at Nevill Hall Hospital, a broad range of potential options was developed. These were assessed using a structured options appraisal process aligned with the Five Case Model and Treasury Green Book guidance to ensure full consideration of possible approaches.

2.2.1 Options Framework and Evaluation Method

The long list was developed using a structured options framework focusing on key dimensions. Each of these dimensions represents a distinct area of decision-making. The options within each dimension were not interdependent but instead considered individually to explore a broad configuration of possibilities:

Service Scope defines the extent of change, from maintaining existing services to full reconfiguration.

Service Solution addresses how services will be delivered, for example through modernisation or risk mitigation.

Service Delivery considers who provides the service and the delivery model.

Implementation looks at the timing and phasing of delivery.

Funding assesses affordability and potential funding sources.

Estate solution that delivers service scope

Each dimension includes a range of sub-options (e.g. 1.1, 1.2, 1.3 for Service Scope, 2.1, 2.2, 2.3 for Service Solution), which are combined to form potential delivery options. The shortlisting process identifies the most strategically aligned combination of sub-options, which are then carried forward for detailed appraisal. The preferred way forward represents the combination that delivers the best balance of benefit, deliverability, and value for money.

2.2.2 Appraisal Against Investment Objectives and Critical Success Factors

Each option was assessed against the project's agreed Investment Objectives (IOs) and Critical Success Factors (CSFs) using structured appraisal tools, including a SWOT analysis. The purpose was to determine the extent to which each option aligned with the strategic intent and deliverability of the programme.

Options were scored as follows:

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- ✓ – Fully aligned with CSFs and IOs
- ? – Partially aligned or with delivery uncertainty
- x – Did not satisfy CSFs and Ios

This appraisal enabled the identification of those options most likely to deliver the required benefits, mitigate key risks, and support a sustainable future model. Options with low alignment or significant feasibility concerns were discounted at this stage.

2.2.3 Option 0 – Do Nothing (Baseline)

As part of the initial long-list development, a “Do Nothing” option was considered to establish a baseline for comparison. This would involve no further investment in the site, with continued use of the existing facilities and no remedial action taken to address structural or service delivery challenges. However, this option was discounted at an early stage on the basis that: The presence of Reinforced Autoclaved Aerated Concrete (RAAC) necessitates active remediation or removal to comply with statutory obligations and ensure patient and staff safety.

Continuing without intervention would expose the Health Board to significant clinical, operational, and financial risks, including emergency repairs, unplanned service disruption, and potential regulatory non-compliance.

The option fails to meet the investment objectives, particularly those relating to estate safety, decarbonisation, service efficiency, and workforce sustainability. As such, Option 0 was not included in the formal options appraisal, as it does not represent a viable course of action. However, it has been retained as a baseline for comparative purposes in assessing the relative value and impact of the viable options.

2.3 Summary of the Long List Using the Options Framework

A full SWOT of the long-listed options, appraisal scores, and rationale is provided in [Appendix 4](#).

Project	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
<p>1. Service Scope</p> <p><i>Defines the breadth and boundaries of what the project or service will cover, including the target population, geographical area, and key service components.</i></p>	<p>1.1 Maintain existing facilities without new investment – remediation of RAAC only</p>	<p>1.2 Close NHH</p>	<p>1.3 Removal of RAAC to ensure safety, without broader reconfiguration or service redesign</p>	<p>1.4 Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces</p>	<p>1.5 Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces including Maindiff Court</p>	<p>1.6 Full Reconfiguration of North Gwent Services (Includes removal of RAAC in NHH)</p>
	Carried Forward	Discounted	Carried Forward	Carried Forward	Carried Forward	Discounted
<p>2. Service Solution</p> <p><i>Identifies the preferred approach or method for delivering the defined scope, including technologies,</i></p>	<p>2.1 Maintain existing services without new investment. Only essential statutory maintenance is performed to meet minimum compliance and safety</p>	<p>2.2 Cease operations at Nevill Hall Hospital and relocate services to alternative existing sites within the region</p>	<p>2.3 Address RAAC-related risks by focusing on removal only, ensuring buildings remain safe but without significant service redesign or modernisation.</p>	<p>2.4 Modernise and redesign existing services at Nevill Hall Hospital, addressing RAAC and creating flexible, efficient, and sustainable clinical spaces</p>	<p>2.5 Extend the reconfiguration of NHH to include the rationalisation of Maindiff Court, integrating and optimising service delivery across both sites and</p>	<p>2.6 Comprehensive redesign and delivery of healthcare services across North Gwent, encompassing NHH, Maindiff Court, Ysbyty Tri Cwm and Ysbyty</p>

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<i>facilities, and operational models.</i>	standards. remediation of RAAC only			and decommissioning non-essential buildings where required.	decommissioning non-essential buildings where required.	Aneurin Bevan to ensure system-wide improvement.
	Carried Forward	Discounted	Carried Forward	Carried Forward	Carried Forward	Discounted
3. Service Delivery <i>Focuses on how the solution will be operationalised, including who will deliver it, roles, responsibilities</i>	3.1 Internal teams continue existing operations	3.2 Internal teams, no external support.	3.3 Internal teams with contracted support for RAAC removal	3.4 Internal teams with contracted specialists for major phases of redevelopment.	3.5 Combination of internal expertise and contracted services	3.6 Fully outsourced or partnership with external contractor.
	Carried Forward	Discounted	Carried Forward	Carried Forward	Carried Forward	Carried Forward
4. Implementation <i>Covers the process of putting the solution into action, including timelines, resources, phasing, and change management.</i>	4.1 continue existing operations	4.2 Phased removal, addressing critical areas first	4.3 Targeted Incremental redevelopment over time, focusing on essential clinical spaces.	4.4 multi-phase plan over several years, balancing immediate RAAC removal with broader site upgrades	4.5 multi-phase, with integration of Maindiff Court services into the new NHH configuration.	4.6 Single, continuous phase ("big bang" approach) modernising the entire site at once. Temporary service relocations are required to maintain operations
	Carried Forward	Carried Forward	Carried Forward	Carried Forward	Carried Forward	Discounted

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5. Funding <i>Explores capital funding sources to deliver the project</i>	5.1 Discretionary Capital	5.2 All Wales Capital	5.3 Mix of Discretionary Capital and All Wales Capital	5.4 Mix of private and Welsh Government funding	5.5 Private Finance	
	Discounted	Carried Forward	Discounted	Carried Forward	Discounted	
6. Estate / Development Options	6.1 RAAC Remediation	6.2 Close NHH	6.3 RAAC Removal <i>(aligns with feasibility option 3)</i>	6.4 New Build reconfiguring NHH Site <i>(aligns with feasibility option 4.4a / 4.4b)</i>	6.5 New Build reconfiguring NHH Site including Maindiff Court <i>(aligns with feasibility option 5.1 / 5.2)</i>	
	Carried Forward	Discounted	Carried Forward	Carried Forward	Carried Forward	

Table 30: Summary of the long list of options

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2.3.1 Summary of Scope Options

Below is a summary of the long-listed scope options, including their descriptions, advantages, disadvantages, and a conclusion regarding how well each option meets the investment objectives and CSFs.

Scope Options	Description	Advantages	Disadvantages	Conclusion	Carried Forward / Discounted
1.1	Maintain existing facilities without new investment – RAAC remediation only	<ul style="list-style-type: none"> - Minimal disruption to services. - Retains existing service locations. 	<ul style="list-style-type: none"> - RAAC risks remains, posing long-term safety issues. - Increased maintenance costs and potential emergency repairs. - Does not address service inefficiencies or future demand. - Fails to meet NHS Wales decarbonisation targets. - Non-compliance with modern healthcare standards. 	Offers minimal improvement; insufficient to support future service needs.	Carried Forward (Do Minimum)
1.2	Close NHH	<ul style="list-style-type: none"> - Removes RAAC risks by decommissioning the site. - Potential financial savings from estate rationalisation. - Opportunity to redirect resource and investment into other healthcare facilities. 	<ul style="list-style-type: none"> - Major loss of acute and local healthcare provision in North Gwent. - Increased demand on other hospitals, leading to capacity issues. - Negative impact on patient access, particularly for rural communities. 	Not aligned with strategic or population health needs	Discounted

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			- Political and public opposition likely		
1.3	Removal of RAAC to ensure safety, without broader reconfiguration or service redesign	<ul style="list-style-type: none"> - Addresses immediate RAAC risks and ensures building safety. - Lower capital investment compared to full redevelopment. - Minimal service disruption. 	<ul style="list-style-type: none"> - Does not improve clinical space efficiency or estate functionality. - Potential for abortive costs if future reconfiguration is needed. - Does not future-proof services or address changing healthcare demands. - May require further works in the near future, leading to higher costs over time. 	Offers short-term mitigation but lacks long-term value	Carried Forward
1.4	Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces	<ul style="list-style-type: none"> - Removes RAAC risks and ensures long-term estate safety. - Optimises existing space for improved patient flow and clinical efficiency. - Supports modern service models and workforce needs. - Aligns with clinical strategy and decarbonisation agenda. - Retains acute and local healthcare provision in North Gwent. 	<ul style="list-style-type: none"> - Requires significant capital investment. - Service disruption during construction. - Planning and approvals process may be complex and time-consuming. - Phased redevelopment may be required to ensure business continuity. 	Strong alignment with strategic, clinical, and estate objectives	Carried Forward

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1.5	Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces including Maindiff Court	<ul style="list-style-type: none"> - Removes RAAC - Enables better integration of services across NHH and Maindiff Court. - Optimises clinical and administrative spaces to support workforce needs. - Creates opportunities for improved efficiency and service co-location. - Aligns with regional service delivery goals and decarbonisation targets. - Opportunity to rationalise estate 	<ul style="list-style-type: none"> - Higher cost and complexity compared to option 1.4. - Requires relocation of services from Maindiff Court. - Potentially longer project timeline due to additional estate considerations. 	Offers the greatest strategic, clinical, and estate strategy alignment and operational benefit	Carried Forward
1.6	Full Reconfiguration of North Gwent Services (Includes removal of RAAC in NHH)	<ul style="list-style-type: none"> - Most strategic and future-proof solution for North Gwent healthcare. - Enables complete redesign of service delivery to align with regional needs. - Removes RAAC risks and maximises estate efficiency. - Supports long-term sustainability, adaptability, and workforce planning. - Creates opportunities 	<ul style="list-style-type: none"> - Likely significant cost and most complex implementation. - Significant service reorganisation and potential workforce impact. - Requires extensive stakeholder engagement and approvals. - Longest timeframe for completion, potentially leading to interim estate issues. - Affordability may be challenging 	Ambitious long-term solution but not deliverable within current scope. Focus should remain on RAAC removal in this phase, with potential for wider transformation in future phases.	Discounted

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		for regional collaboration and integration.			
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Table 31: Summary of Scope Options

Based on the appraisal of shortlisted scope options, Option 1.5, Reconfiguration of Nevill Hall Hospital including Maindiff Court, is identified as the Preferred Way Forward. This option delivers the greatest strategic fit, addresses critical estate and safety risks, and enables a future-proof clinical model that supports the Health Board's long-term objective

2.3.2 Summary of Funding Options

Funding Option	Description	Advantages	Disadvantages	Conclusion	Carried Forward / Discounted
5.1	Discretionary Capital	<ul style="list-style-type: none"> – Fully controlled by the Health Board – No external approval required 	<ul style="list-style-type: none"> – Insufficient to meet project scale 	Not viable for a scheme of this size	Discounted
5.2	All Wales Capital Programme (AWCP)	<ul style="list-style-type: none"> – Aligns with national infrastructure priorities – Appropriate for strategic transformation 	<ul style="list-style-type: none"> – Requires approval through competitive WG process 	Best fit for strategic alignment and scale.	Carried Forward
5.3	Mixed Discretionary and AWCP Funding	<ul style="list-style-type: none"> – Reduces AWCP burden slightly – Shows Health Board commitment 	<ul style="list-style-type: none"> – Still beyond the scale of discretionary capital – Impact to availability for other schemes across the Health Board 	May compromise Health Board's ability to manage capital risks and deliver smaller scale projects	Discounted
5.4	Mixed Private and WG Funding	<ul style="list-style-type: none"> – Potentially reduces upfront capital ask from WG – Spreads capital costs over time. 	<ul style="list-style-type: none"> – Introduces governance, risk, and commercial complexity 	Precedent exists within NHS Wales (e.g., Velindre Cancer Centre Mutual Investment Model (MIM)). May offer	Carried Forward

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		- Offers long-term maintenance guarantees.		flexibility if AWCP is constrained	
5.5	Private Finance	- Could enable earlier access to funding	- Significant long-term revenue implications - Limited precedent in current NHS Wales context	Viable only if aligned with wider funding strategy and affordability	Discounted

Table 32: Summary of Funding Options

The preferred funding route is Option 5.2 – Full capital funding via the All-Wales Capital Programme (AWCP). This reflects the strategic nature, complexity, and scale of the proposed redevelopment, which aligns closely with national investment priorities, including the clinical strategy.

The scheme requires a coordinated and comprehensive investment to address multiple priorities, including RAAC mitigation, service model transformation, decarbonisation, and estate rationalisation. These requirements extend beyond the scope and scale of the Health Board’s discretionary capital allocation and are best supported through a dedicated Welsh Government capital investment.

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2.3.3 Summary of Estate / Development Options

Below is a summary of the long-listed estate and development options for the Nevill Hall Hospital (NHH) site. Each option is assessed in terms of its description, advantages, disadvantages, and a conclusion regarding how well it supports the investment objectives and critical success factors (CSFs).

Within the SOC Option framework (Options 1–6), several of the estate/development options incorporate [sub-options](#) developed through the feasibility study and cost advisor analysis.

Estate / Development Option	Description	Advantages	Disadvantages	Conclusion	Carried Forward / Discounted
6.1	RAAC Remediation	<ul style="list-style-type: none">- Targeted remediation of RAAC-affected areas at NHH	<ul style="list-style-type: none">- Service disruption during works.- RAAC remains present, posing long-term risk- Limited scope to modernise estate or address service model needs. Does not fully support decarbonisation or optimise clinical adjacencies.	Provides short-term risk mitigation but fails to achieve long-term objectives or transformational change.	Carried Forward
6.2	Close NHH	<ul style="list-style-type: none">- Removes RAAC risks by decommissioning the site.- Potential financial savings from estate rationalisation.- Opportunity to redirect	<ul style="list-style-type: none">- Major loss of acute and local healthcare provision in North Gwent.- Increased demand on other hospitals, leading to capacity issues.- Negative impact on	Not aligned with strategic or population health needs	Discounted

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		resource and investment into other healthcare facilities.	patient access, particularly for rural communities. - Political and public opposition likely		
6.3	RAAC Removal <i>(aligns with feasibility Option 3)</i>	- Full removal of RAAC-affected structures and replacement with compliant infrastructure. - Eliminates structural safety risks. - Improves compliance and estate condition. - May allow selective modernisation.	- Disruptive to service delivery. - Significant capital investment required - Retains some legacy inefficiencies in the site layout.	Addresses safety but falls short of delivering a comprehensive service model or estate transformation and alignment with strategic objectives	Carried Forward
6.4	New Build Reconfiguring NHH Site <i>(aligns with feasibility Options 4.4a / 4.4b)</i>	- Full removal of RAAC-affected structures and replacement with compliant infrastructure. - Eliminates structural safety risks. - Replaces outdated infrastructure with modern, fit-for-purpose facilities.	Higher capital cost. - Requires decant or phased construction approach. - Increased complexity of workforce and service transitions.	Strong alignment with strategic goals; enables transformation and long-term sustainability and rationalise of estate.	Carried Forward
6.5	New Build Reconfiguring NHH Site including Maindiff	- All benefits of Option 6.4. - Improves the quality and functionality of retained areas.	- Higher capital cost due to additional refurbishment works.	Enhances the base option (6.4) by improving the quality of retained estate, supporting long-	Carried Forward

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	<i>(aligns with feasibility Option 5.1 / 5.2)</i>	<ul style="list-style-type: none"> - Enhances staff working environment and digital infrastructure. - Supports decarbonisation and space efficiency. 	<ul style="list-style-type: none"> - May introduce complexity in construction phasing. 	term use and improved estate condition	
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Table 33: Summary of Estate / Development Options

Based on the appraisal of shortlisted estate options, Option 6.5 (*feasibility Option 5.1*), New Build Reconfiguration of the Nevill Hall Hospital site including Maindiff Court is identified as the Preferred Way Forward. This option delivers the strongest strategic fit, fully addresses the RAAC and estate condition risks, and enables a modern, sustainable clinical model aligned with the Health Board's long-term objectives.

2.3.3.1 Estate Options – Mapping to Feasibility Study Sub-Options

The following sub-options were developed through the feasibility study and cost advisor analysis are referenced in the Financial Case Option

Estate / Development Option	Feasibility / Cost Advisor Option	Description
6.3 RAAC Removal	3	Full removal of RAAC-affected structures without broader site redesign or service change.
6.4 New Build Reconfiguring NHH Site	4.4a	Reconfigure NHH Site, RAAC removal and redesign spaces excluding wards refurbishment
	4.4b	Reconfigure NHH Site, RAAC removal and redesign spaces including wards refurbishment
6.5 New Build Reconfiguring NHH Site including Maindiff	5.1	Reconfigure NHH Site, RAAC removal and redesign spaces, ward refurbishments and including Maindiff Court

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	5.2	Reconfigure NHH Site, RAAC removal and redesign spaces, ward reconfiguration and refurbishments, façade cladding, reroofing and including Maindiff Court
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2.4 Shortlisted Options

The 'preferred' and 'possible' options identified above have been carried forward into the shortlist for further appraisal and evaluation, allowing for a comprehensive assessment of each viable solution. Options deemed impracticable or misaligned with the Critical Success Factors (CSFs) and investment objectives were excluded at this stage to maintain focus on feasible approaches that best meet strategic and operational needs.

The shortlisted options provide a range of interventions, from maintaining the status quo to pursuing a full redevelopment. Each option has been evaluated in terms of its service scope, estate solution, service delivery approach, implementation strategy, and funding model. This structure ensures that all aspects of feasibility, sustainability, and value for money are considered in detail.

Based on this analysis, the recommended shortlist for further appraisal includes the following options:

Service Scope	Service Options	Service Delivery	Implementation	Funding	Development / Estate Option
<i>Defines the option and approach.</i>	<i>Defines the approach to service provision, addressing the types and extent of service enhancements or adjustments.</i>	<i>Specifies how the services will be delivered (e.g., in-house, outsourced, public-private partnership).</i>	<i>Describes the timeline and method for carrying out the project (e.g., phased, big bang, pilot).</i>	<i>Identifies the sources and structure of the funding required to deliver the preferred option.</i>	<i>Refers to the physical estate or infrastructure solution, detailing the nature of facility improvements, replacements, or new builds.</i>
1.1 Maintain existing facilities without new investment.	2.1 Maintain existing services without new investment. Only essential statutory maintenance is performed to meet minimum compliance and safety standards. RAAC mitigation only.	3.1 Internal teams continue existing operations	4.1 Continue existing operations	5.2 All Wales Capital	6.1 - RAAC Remediation

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<p>1.3 Removal of RAAC to ensure safety, without broader reconfiguration or service redesign</p>	<p>2.3 Address RAAC-related risks by focusing on removal only, ensuring buildings remain safe but without significant service redesign or modernisation.</p>	<p>3.3 Internal teams with contracted support for RAAC removal</p>	<p>4.2 Phased removal, addressing critical areas first</p>		<p>6.3 RAAC Removal (Aligns with feasibility option 3)</p>
<p>1.4 Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces</p>	<p>2.4 Modernise and redesign existing services at Nevill Hall Hospital, addressing RAAC and creating flexible, efficient, and sustainable clinical spaces and decommissioning non-essential buildings where required</p>	<p>3.4 Internal teams with contracted specialists for major phases of redevelopment.</p>	<p>4.3 Targeted Incremental redevelopment over time, focusing on essential clinical spaces.</p>		<p>6.4 New build Development (Aligns with feasibility option 4a/4b)</p>
<p>1.5 Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces including Maindiff Court</p>	<p>2.5 Extend the reconfiguration of NHH to include the rationalisation of Maindiff Court, integrating and optimising service delivery across both sites and decommissioning non-essential buildings where required.</p>	<p>3.5 Combination of internal expertise and contracted services</p>	<p>4.4 multi-phase plan over several years, balancing immediate RAAC removal with broader site upgrades</p>		<p>6.5 New build Development including Maindiff Court (Aligns with feasibility option 5.1/5.2)</p>

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		3.6 Fully outsourced or partnership with external contractor.	4.5 multi-phase, with integration of Maindiff Court services into the new NHH configuration.		

Table 34: Shortlist of Options

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2.5 Preferred Way Forward

2.5.1 Summary Table of Preferred Way Forward Options

Options	Business as usual	Do Minimum	Preferred Way Forward	Less Ambitious Preferred Way Forward
Scope Options	0 – No Change	1.1 - RAAC Remediation Only	1.5 - Reconfigure NHH incl. Maindiff Court	1.4 - Reconfigure NHH Only
Service Options		2.1 - Maintain Existing Services	2.5 - Reconfigured Services incl. Maindiff Integration	2.4 - Modernised Services at NHH Only
Service Delivery		3.4 - Internal teams with contracted support for RAAC	3.5 - Mixed Delivery (Internal & Contracted)	
Implementation		4.1 - Continue Existing Operations	4.3 - Multi-Phase incl. Broader Upgrades	4.4 - Targeted Incremental Redevelopment
Funding			5.2 - All-Wales Capital	
Development / Estate Options		6.1 - RAAC Remediation	6.5 New Build Reconfiguring NHH Site including Maindiff Court and Refurbishment of 'H Blocks' (<i>feasibility Options 5.1</i>)	6.4 - New Build and refiguration (<i>feasibility Options 4.4b</i>)

Table 35: Summary of Preferred Way Forward

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2.5.2 Scope Option 0 – “Do Nothing”

Option 0 has been retained as a baseline for comparison purposes but excluded from the formal appraisal, as it does not represent a viable course of action. It provides a benchmark against which the value for money of all viable options can be assessed, in line with HM Treasury Green Book guidance.

2.5.3 Scope Option 1.1 – “Do Minimum”

Option 1.1 involves RAAC remediation only and was included to assess the minimum compliant investment that still allows continued safe use of the estate.

2.5.4 Preferred Way Forward: Scope Option 1.5

Based on this assessment, Scope Option 1.5 –Reconfiguration of Nevill Hall Hospital Site including Maindiff Court – is identified as the Preferred Way Forward. This option provides the strongest alignment with the investment objectives, critical success factors, and clinical and estate strategies.

This option:

- ✓ Fully addresses RAAC risks.
- ✓ Enables consolidation of clinical and administrative functions to improve efficiency and flow.
- ✓ Supports a future-proof model of care aligned to the clinical strategy.
- ✓ Maximises use of the Health Board's existing land and infrastructure
- ✓ Enables rationalisation of Maindiff Court
- ✓ is considered most likely to optimise public value

2.5.5 Preferred Way Forward: Estate Option 6.5 (*feasibility Option 5.1*)

Based on this assessment, Estate Option 6.5, New Build Reconfiguration of the Nevill Hall Hospital site including Maindiff Court, is identified as the Preferred Way Forward. This option offers the strongest alignment with the investment objectives, critical success factors, and the Health Board’s long-term estates and clinical strategies.

This option:

- ✓ Fully addresses the risks associated with RAAC through removal and redevelopment.
- ✓ Consolidates clinical and administrative functions, improving adjacencies, flow, and operational efficiency.
- ✓ Supports a modern, sustainable model of care aligned with the clinical strategy.
- ✓ Maximises use of existing Health Board land and infrastructure.
- ✓ Enables the rationalisation of Maindiff Court, contributing to wider estate optimisation
- ✓ Is considered the most likely option to deliver long-term value for money and support future service resilience.

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This option:

- ✓ Fully addresses the risks associated with RAAC through removal and redevelopment.

Though, acknowledging the current financial climate within the NHS in Wales, the Health Board is proposing the less ambitious Preferred Way Forward for phase 1 and Estate option 6.4 to redevelop the Nevill Hall Hospital (NHH) site to address the significant risk posed by the presence of RACC.

2.5.6 Indicative Economic Appraisal

An indicative economic appraisal is a key requirement of the business case process to support option selection. At this Strategic Outline Case (SOC) stage, a high-level assessment has been undertaken to inform the identification of a preferred way forward, drawing on indicative capital costs and anticipated benefits.

A full economic appraisal, including quantified Net Present Social Value (NPSV) analysis and sensitivity testing, will be completed at Outline Business Case (OBC) stage. This will assess the economic viability of the shortlisted options in greater detail, in line with HM Treasury Green Book guidance.

2.5.7 Conclusion

The Economic Case has demonstrated a robust and transparent approach to option development and appraisal, ensuring alignment with HM Treasury Green Book guidance and the Five Case Model. Through the structured evaluation of service, delivery, implementation, funding, and estate options, the Health Board has identified a Preferred Way Forward that delivers the greatest strategic fit, addresses critical infrastructure and safety risks, and enables a modern, sustainable model of care. The combination of Scope Option 1.5 and Estate Option 6.5 presents the most balanced solution in terms of benefits, deliverability, and long-term value for money. However, acknowledging the current financial climate within the NHS in Wales, the Health Board is proposing the less ambitious Preferred Way Forward for phase 1 and Estate option 6.4 (feasibility option 4.4b) to redevelop the Nevill Hall Hospital (NHH) site to address the significant risk posed by the presence of RACC. This option will now be taken forward for further development and detailed analysis at the Outline Business Case stage.

3. COMMERCIAL CASE

The Commercial Case sets out the initial considerations around how the Health Board intends to procure the required services and infrastructure to deliver the proposed scheme.

At this early stage, a full procurement strategy has not yet been developed. However, the Health Board anticipates adopting a procurement route that ensures value for money, encourages market competition, and is aligned with Welsh Government capital guidance and procurement policy.

Subject to approval of this Strategic Outline Case, it is anticipated that:

- A Supply Chain Partner will be appointed via the NHS Building for Wales Framework to lead the development of the design and construction proposals.
- Key external advisors including a Project Manager, Cost Advisor, and Design Team will be appointed through compliant procurement frameworks to support the development of the Outline and Full Business Cases.
- The use of frameworks will support expediency, compliance, and access to pre-qualified, experienced suppliers, reducing procurement risk and timeline pressures.
- Early market engagement may be undertaken to test capacity and interest, particularly considering current market volatility and inflationary pressures in the construction sector.

The Health Board has prior experience successfully delivering capital schemes using framework-based procurement routes, and lessons learned from previous projects will inform the development of the full commercial strategy at the Outline Business Case stage.

In line with Welsh Government expectations, the delivery strategy will consider: The use of Modern Methods of Construction (MMC) to accelerate delivery, improve build quality, and support decarbonisation
Opportunities to embed Net Zero Carbon design principles and ensure the construction process contributes to sustainability targets
The integration of digital infrastructure and Smart Hospital principles to future-proof the development and enable technology-enabled care.

These elements will be explored in more detail as part of the development of the Outline and Full Business Cases.

3.1 Funding Model

At this stage, it is anticipated that the proposed scheme will be funded via the All-Wales Capital Programme (AWCP), subject to Welsh Government approval through the standard business case process. The Health Board will develop the scheme in line with Welsh Government capital investment guidance, ensuring affordability, value for money, and alignment with strategic priorities.

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The Strategic Outline Case forms the first stage in securing capital funding, with further detail to be provided within the Outline and Full Business Cases, including full capital and revenue affordability assessments.

The Health Board is committed to ensuring that its commercial approach is robust, compliant, and aligned with both local priorities and national expectations. The full commercial strategy, including procurement route, contracting arrangements, risk allocation, and market engagement plans, will be developed in detail as part of the Outline Business Case.

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4. FINANCIAL CASE

This section sets out an initial financial impact of the investment proposal from a capital and revenue perspective and provides an early assessment of overall affordability.

While full cost certainty will be developed at Outline and Full Business Case stages, this Strategic Outline Case provides an early view of the financial requirements and affordability considerations. Detailed modelling of revenue impacts and any potential savings will be developed at OBC stage.

4.1 Organisational Financial Context

Aneurin Bevan University Health Board (ABUHB), like all NHS organisations in Wales, is operating within a highly challenging financial environment. The Health Board continues to experience sustained operational and financial pressures linked to increasing service demand, inflationary cost growth and workforce challenges. The UHB continues to be impacted by operational pressures combined with the local and national focus to reduce elective and diagnostic waiting lists. These pressures result in a financial environment which provides minimal scope to invest/re-align in services from a long-term perspective.

In line with national direction, ABUHB is focused on delivering recurrent savings and improving cost efficiency while protecting the quality and safety of patient care. The Health Board is working to address a significant underlying financial deficit, which is subject to regular review and scrutiny by the Welsh Government through the Integrated Medium-Term Plan (IMTP) process and monthly financial monitoring returns.

Despite these pressures, the Health Board remains committed to progressing strategic investments that support long-term sustainability, value for money, and health system transformation. Capital investment proposals, including this Strategic Outline Case, are being developed with a strong focus on affordability, financial risk management, and alignment with clinical and estate priorities across the organisation and region.

The delivery of this scheme will be contingent upon external capital funding and will be sequenced to ensure compatibility with the organisation's wider financial recovery trajectory.

- The proposed service model and estate strategy are focused on optimising existing resources, reducing backlog maintenance, and improving operational efficiency, ensuring long-term affordability.
- The scheme has been scoped with a clear intent to remain within the financial envelope available to the Health Board, avoiding additional pressure on revenue or capital budgets.
- By enabling more efficient use of space, consolidating services, and supporting digitally enabled care, the redevelopment aims to deliver greater value for money.
- The financial principles underpinning this proposal reflect the Health Board's commitment to sustainable investment, cost containment, and system-wide benefit realisation.

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These financial considerations are fully aligned with the wider priorities outlined in the organisation's Integrated Medium-Term Plan (IMTP) and are explored in further detail within this chapter

4.2 Overall options

The current long list of options for the primary redevelopment are listed below (as per the Economic Case scope options 1.1 – 1.6). It should be noted that the full scope and sub-options can be described in greater detail at subsequent stages: -

Option 1 (baseline) – Do minimum and maintain existing facilities without new investment

Option 2 – Close NHH (discounted)

Option 3 – RAAC removal without broader redevelopment

Option 4 – Reconfigure NHH (Address RAAC & Redesign Spaces)

Option 5 – Reconfigure NHH & Maindiff Court

Option 6 – Full Reconfiguration of North Gwent Services (includes removal of RAAC in NHH) (not considered for SOC given Programme reconfiguration required)

For clarity Options 1, 3, 4 and 5 are considered as part of the shorter list to consider revenue consequences. Other assumptions noted are as follows:-

- Scope - The main buildings on the NHH are considered within scope alongside Maindiff Court as necessary. NHH Residences, the conference centre and a number of other buildings e.g. Medical Education are regarded as out of scope for all options.
- Activity assumption - In options 1 and 3 activity demand growth is assumed to require additional expenditure however it is unconfirmed as to how the capacity will be delivered. For options 4 and 5 it is assumed that activity demand growth will be mitigated through efficiency gains, the increased capacity obtained through additional theatres and the greater capacity enabled through the revised service models relating to this project.
- In future stages of the business case, the overall UHB capacity requirements would be fully established in greater detail. This analysis will ensure that the potential impact on the NHH site is considered and confirmed alongside other sites. There will potentially be an opportunity to reduce the cost base on other sites however this will need further analysis and review at the OBC stage.
- Bed capacity is defined as c.208 beds which includes 24 Assessment beds/trolleys. This level of capacity is in line with current capacity and therefore no cost/saving is assumed for specific changes.
- Workforce baseline establishments have been sought from relevant services and are not shown in this section. A baseline using staff in post as at April 2025 is shown in the workforce section. The relevant impacts are calculated

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where necessary but will be analysed in greater detail at future stages of the business case.

- No inflationary impact/wage awards are assumed in this analysis.

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4.3 Capital costs

	Option 0 - Do Nothing	Option 1 - Do Minimum	Option 3 - RAAC removal, no redevelopment	Option 4.4a - Reconfigure NHH Site, RAAC removal and redesign spaces excl. Ward refurbishments	Option 4.4b - Reconfigure NHH Site, RAAC removal and redesign spaces incl. Ward refurbishments	Option 5.1 - Reconfigure NHH Site, RAAC removal and redesign spaces including MCH	Option 5.2 - Reconfigure NHH Site, RAAC removal and redesign spaces including MCH
	£000	£000	£000	£000	£000	£000	£000
Works Cost	58,258	81,351	87,819	150,867	218,812	241,917	294,318
Fees	0	0	16,203	27,760	40,261	44,513	54,154
Non Works Costs	0	0	5,275	6,979	8,847	9,987	11,428
Equipment Costs	0	0	5,675	11,537	17,811	20,097	21,130
Planning Contingency (15%)	0	0	17,246	29,571	42,860	47,477	57,155
VAT	0	4,619	26,443	45,343	65,718	72,798	87,637
VAT Recovery	0	0	-6,203	-6,787	-12,610	-13,460	-15,802
Project Cost	58,258	85,970	152,457	265,269	381,701	423,329	510,020
Optimism Bias (Inc VAT)	0	0	48,201	63,906	92,624	102,602	123,516
Overall Cost Estimate	58,258	85,970	200,658	329,175	474,324	525,930	633,536
Funding Split:							
AWCP Capital Funding	58,258	85,970	197,361	329,175	474,324	525,930	633,536
IFRS16 Capital Funding	0	0	3,296	0	0	0	0
Overall Cost Estimate	58,258	85,970	200,658	329,175	474,324	525,930	633,536

The table below indicates the initial analysis of capital costs for the options considered.

Figure 28: Table of Capital Costs by Scope Option

It should be noted that the costs included for option 0 – do nothing relate to the backlog maintenance costs (with inflationary assumptions included).

There are sub-options considered (4.4b and option 5) from a capital perspective that include refurbishment of ward areas within the main 'H-block' building.

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Accommodation for services moved from Maindiff Court has been included in options 5.1 and 5.2 however no disposal proceeds have been included at present. Updated cladding on NHH buildings has been included in option 5 which present a significant cost.

The table includes an element of lease costs for temporary buildings in option 3 (c.£2.7m). From an affordability perspective, the financial ledger transactions relating to IFRS 16 will ultimately impact revenue assuming WG will recover funding accordingly.

4.3.1 Estate/Development Sub-Options Mapping

Several of the scope options include estate/development sub-options, developed through the feasibility study and cost advisor analysis. These are shown in the table below to ensure alignment between the SOC appraisal, feasibility outputs, and capital cost estimates.

Scope Option	Feasibility / Cost Advisor Option	Description
3	3	Full removal of RAAC-affected structures
4	4.4a	Reconfigure NHH Site, RAAC removal and redesign spaces excluding wards refurbishment
	4.4b	Reconfigure NHH Site, RAAC removal and redesign spaces including wards refurbishment
5	5.1	Reconfigure NHH Site, RAAC removal and redesign spaces, ward refurbishments and including Maindiff Court
	5.2	Reconfigure NHH Site, RAAC removal and redesign spaces, ward reconfiguration and refurbishments, façade cladding, reroofing and including Maindiff Court

4.4 Optimism Bias

In accordance with HM Treasury Green Book guidance, an optimism bias adjustment has been applied to capital cost estimates to account for potential underestimation of costs at this early stage of business case development. This adjustment is intended to reflect the inherent uncertainty and risk associated with capital schemes at Strategic Outline Case (SOC) stage, particularly where there is limited design development and a higher degree of assumption in scope, timelines, and market conditions.

The cost advisor has included an appropriate optimism bias allowance within the capital cost estimates to provide a more realistic view of potential outturn costs. This is consistent with benchmark percentages recommended for healthcare

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infrastructure schemes and ensures that economic appraisal reflects a prudent and robust estimate of investment need.

Optimism bias will be reviewed and refined as the project progresses through Outline and Full Business Case stages, and as risk is progressively mitigated through detailed design, procurement strategy, and market testing.

4.5 Revenue consequences

The revenue costs for the each of the options are set out below. Each analysis includes an assessment of the internal costs, required to support each option. Costs are based on relevant workforce and service plans where possible. The revenue baselines and consequences are listed as direct and indirect support costs. They do not include overheads and externally commissioned costs for this case. This may be reviewed for future submissions given potential impact to for example Velindre oncology. Patient flow changes across Health Boards are assumed to be negligible for this element of the case.

For the purposes of this analysis, no costs are included for other North Gwent services nor areas such as theatres within other eLGHs. The baseline costs included relate to the 2024/25 financial year and include direct costs allocated or within NHH alongside apportioned indirect support costs (e.g. therapies, clinical support costs). There remains some difficulty apportioning some staffing costs and this element will need further review.

The table below shows an initial analysis of baseline costs linked to Nevill Hall Hospital (NHH) and Maindiff Court (MCH).

Area / Division	Total Baseline (Direct / Indirect) £000s
Operational Divisions:-	
Primary Care and Community	2,456
Mental Health & Learning Disabilities	5,419
Surgery	20,134
Clinical Support Services	8,207
Medicine	31,253
Urgent Care	2,590
Family & Therapies	8,406
Estates and Facilities	11,541
Total - Operational Divisions	90,006
Corporate areas	2,545
Total baseline (Direct / Indirect exc. Overheads)	92,551

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The net revenue consequences of each option have been considered as an initial estimate and the summary table is shown below:

Option	Narrative	Year 1 £000s	Year 2 £000s	Year 3 £000s	Year 4 £000s	Year 5 (recurrent) £000s
	Baseline cost	92,551	92,551	92,551	92,551	92,551
Option 1 - Do nothing/minimum	Additional expenditure Operational commissioning Savings	2,124 3,006 0	2,324 - 0	2,524 - 0	2,924 - 0	3,124 - 0
Option 1 - Do nothing/minimum	Net cost	5,130	2,324	2,524	2,924	3,124
Option 3 - RAAC only	Additional expenditure Operational commissioning Savings	2,626 3,009 0	2,726 - 0	2,826 - 0	3,026 - 0	3,126 - 0
Option 3 - RAAC only	Net cost	5,635	2,726	2,826	3,026	3,126
Option 4 - NHH services only	Additional expenditure Operational commissioning Savings	2,844 2,504 0	2,844 - (743)	2,844 - (743)	2,844 - (743)	2,844 - (743)
Option 4 - NHH services only	Net cost	5,348	2,101	2,101	2,101	2,101
Option 5 - NHH and MCH service reconfiguration	Additional expenditure Operational commissioning Savings	2,844 2,504 (231)	2,844 - (745)	2,844 - (745)	2,844 - (745)	2,844 - (745)
Option 5 - NHH and MCH service reconfiguration	Net cost	5,117	2,099	2,099	2,099	2,099

The estimated revenue consequences are based on the following broad assumptions:

- The 'do nothing/minimum' option 1 is considered in the context of costs to undertake additional activity (1,187 procedures) potentially using external providers but is unconfirmed, alongside costs to cover service provision from unusable estate. This option is included as a baseline and can be considered further if required.
- Consideration of option 3 would require additional costs to undertake the extra activity (1,187 procedures) for day case procedures which would be more efficiently processed using a day-case and treatment centre. Day-case unit costs (23/24) excluding overheads have been used to estimate the costs alongside additional theatre capacity as per other options but can be reviewed and refined for future iterations.
- Consideration of options 4 and 5 currently assume expenditure requirements for additional theatre capacity for the day-case centre. The assumption is that the 6 NHH theatres (including Ophthalmology) will be operational for 10 hours per day for 5.5 days (currently 9 hours per day over 5 days) with an additional 4 treatment rooms based on the same model as the unit in RGH (estimated total cost c.£1.8m). There is an expectation that additional activity will also be enabled by efficiencies and increased through-put of activity.
- It is assumed that for option 5 that the ward beds and step-down beds/flats in Maindiff Court move across to NHH with no revenue impact. The model of care and specific requirements will be reviewed in further iterations.
- The outpatient elective model has no additional costs at present with increased demand being managed through efficiencies. This assessment

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will be refined for the OBC and FBC as the detailed model and staffing requirements are reviewed.

- The Family and Therapies model only includes costs for option 3 in order to undertake additional physiotherapy which is currently reduced given the impact of RAAC. The community-based rehabilitation therapies model will be developed and any further expenditure will be identified in the OBC.
- The Urgent care model will have minimal additional expenditure other than potentially some support/reception staffing for the revised MIU/main entrance.
- An estimated cost of c.£0.1m has been included for clinical support services / diagnostics (excluding those for operational commissioning). It is assumed that the majority of additional demand can be met through the new facilities, but it is likely that there will be additional radiology and other diagnostics costs. This assumption will be tested and analysed for the OBC.
- There are no revenue costs assumed for a potential 2nd MRI scanner and PET scanner, this would be considered as a separate business case but should be regarded as a key risk given the costs involved.
- Options 1 and 3 include additional estates and facilities costs linked to maintenance and/or other costs to maintain the NHH estate and movement of staffing accordingly. This will be reviewed in greater detail at the OBC stage against capital estimates for backlog maintenance.
- All options are assuming a change in catering model from traditional to 'cook-freeze'. Further modelling will be undertaken depending on whether there is sufficient space to use the hybrid model within many other ABUHB sites. Any saving assumed is offset by additional provisions which will need to be considered further depending on exact layout and operation. There may also be an impact of staff catering income which will require further review.
- Cancer service provision outside of the Satellite Radiotherapy Unit (SRU) for SACT and related costs (e.g. pharmacy and facilities) are unconfirmed assumed to be linked to Long Term Agreements with other NHS bodies.
- The inpatient model for Care of the Elderly, Community and the necessary interfaces are being developed. For the purposes of this analysis, this is assumed to be cost neutral.
- Energy and rates savings have been included for NHH and Maindiff Court as appropriate using estimate £/m² for the 2024/25 financial year. This assumes the current floor area for NHH will reduce and Maindiff Court will close accordingly. No assessment of energy consumption (usage within specific areas) has been considered at present.
- Digital revenue costs have been estimated based on the capital estimate provided.
- Operational commissioning expenditure is likely to be extensive for all options in year 1 given the number of changes required and potential for double-running on services. The estimated costs have been analysed based on previous plans for YYF and GUH appreciating the actual impact on GUH was considerably different given the nature of opening. These costs will be refined once further detail with regards to the steps and processes as necessary.

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- The PFI contract for the Energy Performance Centre is due to cease in December 2026. Further consideration of the impact and likely replacement of equipment will be undertaken at the OBC stage.
- To summarise, the cost differential between options 1 and 3 compared to options 4 and 5 relates to reduced day case and outpatient costs. In addition, estates and facilities costs are lower coupled with assumed utilities savings resulting in an overall lower net revenue costs.

4.6 Affordability and other related factors for consideration

- The additional revenue expenditure identified would need to be included in future UHB IMTP documents with off-setting savings plans being required to ensure overall financial balance for the organisation. Revenue affordability remains a key principle and the OBC will review the options to provide a balanced approach between affordability and longer-term sustainability.
- The initial financial analysis provided indicates the level of investment and potential savings for each of the four options considered. Further analysis for the OBC will be undertaken to indicate the increased level of activity in NHH and the improved patient outcomes through day case procedures, improved outpatient facilities and consistent clinical models.
- There are several areas on the NHH site which are effectively outside the scope of this analysis such as the residences, creche and conference centre. Further consideration of capital expenditure which could be enable long-term revenue benefit could be considered separately.
- With regards to overall population improvement and the Well-being of Future Generations Act; some of the expenditure described for therapies, cancer and outpatient facilities could be classed as preventative expenditure with the overall outcome benefits seen on a longer-term basis.

4.7 Summary

The Financial Case sets out the financial impact of the investment proposal from a capital and revenue perspective and assesses overall affordability. The initial indicative recurrent revenue cost of the short-listed options range from **c.£3.1m to c.£2.1m**. It should be noted however that the range of service models underpinning this analysis needs considerable refinement alongside the impact of operational commissioning. These service model reviews will undoubtedly change the cost impact accordingly.

The preferred option (Option 5) assumes a significant efficiency benefit by enabling a greater through-put of both day case procedures and outpatient attendances. As a result, the cost differential shown excludes a significant level of non-cash releasing benefits.

At future stages of this case, the whole system effect would need to be considered and analysed. As a result, the confirmation of the net financial impact of this overall business case would need to be determined and agreed. Any net increases in revenue costs would be **unaffordable** in the current financial context of the Health Board.

5. MANAGEMENT CASE

5.1 Programme Management Arrangements

This development is an integral part of the Health Boards Integrated Medium Term Plan and Clinical Redesign Programme.

5.2 Project Management Arrangements

The project is being managed in accordance with the requirements of the Building for Wales Framework, the NHS capital investment manual and PRINCE 2 methodology.

5.3 Reporting Structure

The NHH Development Project Board has been established to oversee the project. The Board will be chaired by the Executive Director of Strategy, Planning and Partnerships and will report to the Executive Committee. The Board has clear Terms of Reference which will be reviewed on an annual basis.

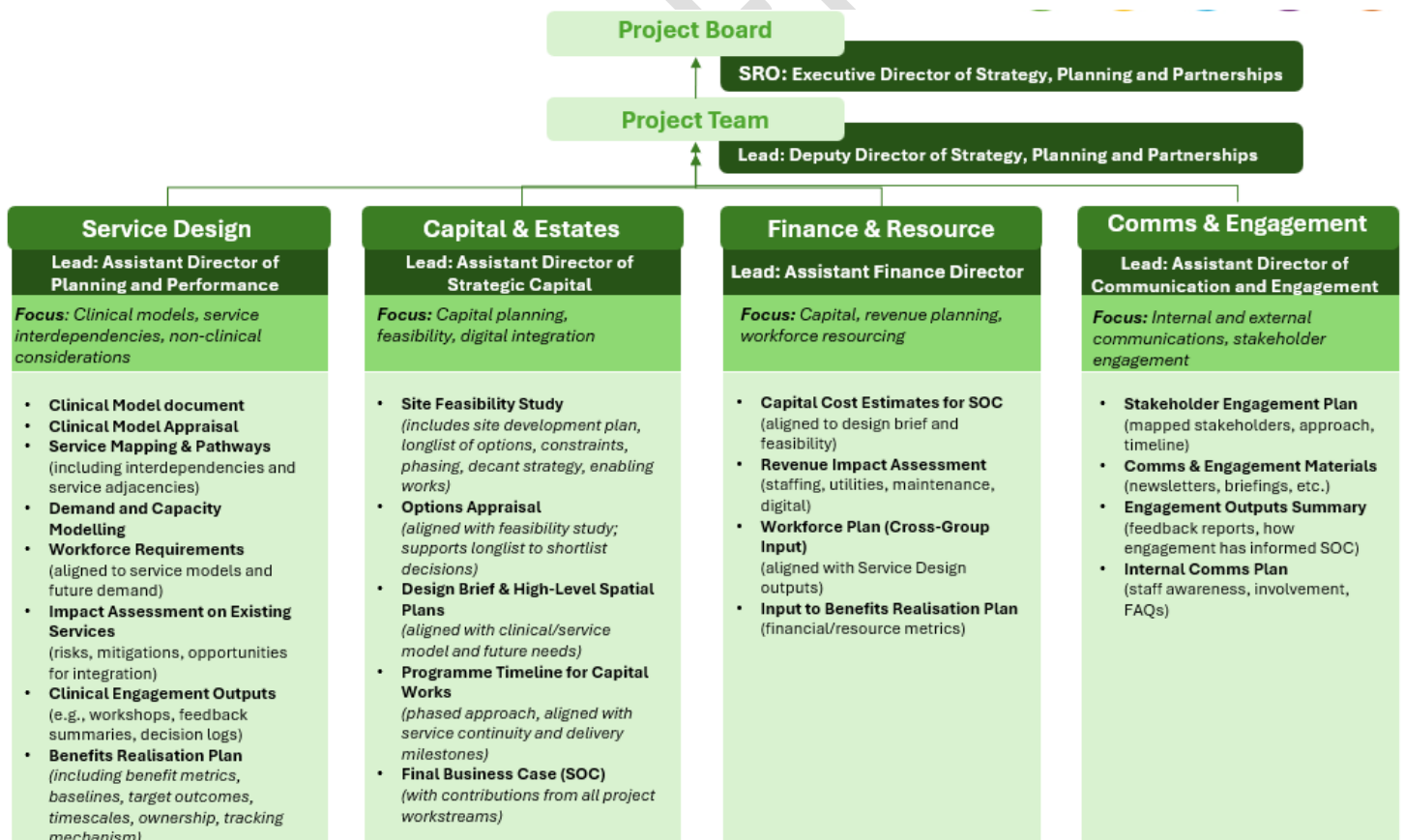


Figure 29: Diagram of Project Structure

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A number of working groups have been established to develop key products required to support the delivery of the project. These include external advisors in order to ensure that the Project Director receives appropriate advice and support.

5.4 Project Roles and Responsibilities

Key Project Roles and Responsibilities are outlined below:

Senior Responsible Owner – Executive Director of Strategy, Planning and Partnerships

The Senior Responsible Owner (SRO) is responsible for ensuring that the Programme’s objectives are delivered on time and within the desired cost and quality constraints.

Project Director – Assistant Director of Strategic Capital and Estates

The Project Director is accountable to the Senior Responsible Officer and is responsible for ensuring that the Project remains focused on achieving its objectives and that the project benefits will be realised.

Project Lead – Deputy Director Executive Director of Strategy, Planning and Partnerships

The Project Lead provides operational leadership for the delivery of the Project. This role is responsible for coordinating workstreams, ensuring alignment with the service model and strategic planning objectives, and acting as a key liaison between clinical, planning, and capital colleagues. The Project Lead supports the realisation of benefits and the delivery of service transformation outcomes.

5.5 Outline Project Plan

Subject to approval of the Strategic Outline Case (SOC), the key implementation milestones for the project are expected to follow the indicative timescales below. These are dependent on the timing of approvals from Welsh Government and may be subject to change.

Activity	Start	Finish
SOC submission and approval	Nov 2025	March 2026
Appointment of SCP/PM/ TCA	May 2026	May 2026
OBC commencement and completion	June 2026	June 2027
OBC submission and approval	July 2027	Sept 2027
FBC commencement and completion	Nov 2027	April 2028
FBC submission and approval	Sept 2028	Dec 2032

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Construction start and completion		
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Table 36: Outline Project Plan

An indicative delivery programme for the Preferred Way Forward (Option 5.0) has been developed by the professional advisors (Mott MacDonald). The programme spans 2026–2036 and includes phased design, construction, and decanting activity to maintain operational continuity. Subject to funding certainty, there is potential to accelerate delivery through overlapping design and construction phases, reducing the programme to 2032/33. A full programme is provided in [Appendix 1](#).

5.6 Risk Management

An overarching risk management process has been established which constitutes the following phases: identification; classification; assessment and action. A project dashboard, including risk register will be maintained and project risks will be reviewed monthly by the Project Board.

5.7 Benefits Realisation Monitoring

A benefits realisation plan will be developed which contains details of the specific benefits, how they will be delivered, who is responsible for delivery and the appropriate measures.

The Director of Strategy, Planning and Partnerships will report performance to the Executive Team on a quarterly basis

5.8 Change Control Process

A formal change control process is in place to manage any proposed changes to scope, cost, programme or quality. All change requests must be submitted via the standard Change Control Form and formally sent to the Project Manager for initial review. The Project Manager will assess the implications of the change, consult with relevant workstream leads as necessary, and escalate to the Project Board and Project Director for approval, ensuring transparency and appropriate governance throughout the project lifecycle. A log of requests and decisions will be maintained.

5.9 Stakeholder Engagement and Management

A stakeholder engagement and communication strategy has been developed and is detailed in the Strategic Case. The Project Team will maintain active engagement with clinical teams, staff groups, Llais, patients, and wider public stakeholders throughout design and delivery.

5.9.1 Engagement Strategy

A dedicated Communications and Engagement Plan ([Appendix 5](#)) has been developed to support the Nevill Hall Hospital Development Project, recognising the importance of engaging with stakeholders at all levels to inform, shape and

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respond to proposed service changes. Working closely with Llais (the citizen voice body for health and social care in Wales), the plan has been set within a context of reviewing the configuration of services at all of the health board's key enhanced local general hospitals (eLGH), to ensure that the overall health system is balanced and provides the most efficient and effective support to the specialist and critical care centre at the Grange University Hospital. The plan then sets out the strategic rationale for commencing this process at Nevill Hall Hospital. An initial eight-week engagement will commence in June in respect of the overall principles of service configuration, to be supported by further bespoke initiatives for areas of more significant service change.

The plan aligns with the Health Board's statutory duty to engage, the guidance set out by Llais and the values underpinning the Clinical Futures programme. It outlines a structured two-phase approach to engagement that will inform and involve the public, staff, and key partners in decisions affecting the future configuration of services delivered from Nevill Hall Hospital and the wider eLGH network.

5.9.1.1 Objectives

The overarching objectives of the engagement plan are to:

- Explain the rationale for the redevelopment and its alignment with Clinical Futures.
- Raise awareness of the challenges within current service arrangements.
- Provide clarity on the proposed future direction for NHH as part of the eLGH network.
- Capture feedback, concerns and suggestions from stakeholders, ensuring these are transparently considered and inform the decision-making process.

5.9.1.2 Principles

Engagement activities will be guided by the following principles:

- **Inclusive and transparent:** Ensuring all affected groups, including underserved populations, have opportunities to participate
- **Accessible and bilingual:** Communication materials and sessions will comply with Welsh language standards and accessibility best practice
- **Iterative and responsive:** Feedback will be actively used to shape ongoing design and planning, with themes analysed and published
- **Proportionate and phased:** Initial engagement will seek views on broad principles, with follow-up targeted engagement for more significant service change proposals.

5.9.1.3 Delivery

The approach will be coordinated through a programme of targeted and public-facing activity, including:

- Public meetings (both in-person and online),
- Staff briefings and consultation,

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- Stakeholder-specific engagement sessions (e.g. with Local Authorities, Powys HB, community organisations),
- Patient surveys and scenario-based discussions to explore impact,
- Ongoing digital communications, including a dedicated web presence and social media updates.

5.9.1.4 Future Planning and Risk Management

A stakeholder map ([Appendix 6](#)) has been developed as part of this Strategic Outline Case to support targeted and proportionate engagement aligned to levels of interest and influence. This has informed the structure and focus of both Phase 1 and Phase 2 engagement activity. While this early mapping has guided the approach to date, a more detailed risk mitigation strategy, including the management of potential opposition and risk of legal challenge or judicial review, will be developed at Outline Business Case (OBC) stage. This will ensure alignment with the Corporate Risk Register, which captures the risk of judicial review in relation to major capital projects and will support the Health Board to demonstrate delivery of its statutory duties and transparent decision-making throughout the programme.

5.9.1.5 Engagement Activity

Phase	Description	Timeframe	Key Activities
Phase 1: Initial Engagement	Engagement on overarching principles for NHH and eLGHs	23 June – 15 August 2025	Public sessions, surveys, stakeholder communications, website and social media activity
Feedback Collation and Reporting	Analyse input from Phase 1 to inform next steps	August – September 2025	Engagement summary report, presentation to Llais and Board
Phase 2: Targeted Engagement	Further engagement on specific service proposals (e.g. stroke rehab)	October – December 2025	Bespoke service-specific engagement as required
Final Planning and Decision-Making	Incorporate feedback into final service model proposals	January 2026	Finalisation of larger-scale changes and presentation to Board

Table 37: Engagement Activity

This engagement activity will be supported by an evaluation framework and culminate in a comprehensive report for Llais and the Board, ensuring transparency and public accountability.

5.10 Workforce Implications and Organisational Change

The proposed relocation of services and staff from Maindiff Court to Nevill Hall Hospital may require a variation in employment contract. The NHS Wales Organisational Change Policy will be applied to manage any variation in employment contract. This will be supported by a robust engagement process

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with staff and through existing partnership working arrangements. A detailed workforce plan will be developed to assess the impacts on staff and organisational change and consultation requirements.

5.11 Post Project Evaluation

A post project evaluation will be undertaken once the NHH development has been established for a sufficient period to allow an appropriate evaluation to be undertaken (likely to be 12 months post project). This will aim to establish whether the expected benefits have been delivered, and any lessons learnt

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6. Appendices

6.1 Appendix 1 – Feasibility Study



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-RP-S-0100 Feasibilit

6.2 Appendix 2 - Benefits Strategy



202504 NHH
Development Benefi

6.3 Appendix 3 – Benefits Map



20250430 NHH
Development Benefi

6.4 Appendix 4 – Options Appraisal



202511 NHH
Development Optio

6.5 Appendix 5 – Communication and Engagement Plan



NHH Briefing



NHH FAQs



NHH survey

document (updated (updated 17.06.25) f questions (updated

6.6 Appendix 6 – Stakeholder Map



eLGH Development
Stakeholder Analysis:

6.7 Appendix 7 – Glossary of Terms

Abbreviation	Full Term
ABUHB	Aneurin Bevan University Health Board
ADHD	Attention Deficit Hyperactivity Disorder
AMU	Acute Medical Unit
AWCP	All-Wales Capital Programme
BADS	British Association of Day Surgery
BREEAM	Building Research Establishment Environmental Assessment Method
CADT	Care After Death Team
CAMHS	Child and Adolescent Mental Health Services
CCNS	Community Children's Nursing Service
CDC	Community Diagnostic Centres
CLDT	Community Learning Disabilities Team
CMHT	Community Mental Health Team
CNRS	Clinical Nurse Specialist
COTE	Care of the Elderly
CSF	Critical Success Factors
CT	Computed Tomography
DNA	Did Not Attend

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DC	Day Case
DSU	Day Surgery Unit
ECT	Electroconvulsive Therapy
EFU	Elderly Frailty Unit
eLGH	Enhanced Local General Hospital
ENT	Ear, Nose and Throat
ETR	Electronic Test Request
FBC	Full Business Case
FM	Facilities Management
GAU	Gynaecology Ambulatory Unit
GAVO	Gwent Association of Voluntary Organisations
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMS	General Medical Services
GOPD	General Outpatient Department
GP	General Practitioner
GPhC	General Pharmaceutical Council
GUH	Grange University Hospital
GWICES	Gwent Wide Integrated Community Equipment Service
H&S	Health and Safety
HB	Health Board
HVLC	High Volume Low Complexity
IMTP	Integrated Medium-Term Plan
ITU	Intensive Therapy Unit
JAG	Joint Advisory Group
LHP	Llantrisant Health Park
Llais	The Citizen Voice Body for Health and Social Care in Wales
MHRA	Medicines and Healthcare products Regulatory Agency
MMC	Modern Methods of Construction

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MCH	Maindiff Court Hospital
MS	Multiple Sclerosis
MRI	Magnetic Resonance Imaging
NHH	Nevill Hall Hospital
OBC	Outline Business Case
PCMHSS	Primary Care Mental Health Support Service
PHN	Public Health Nursing
POCT	Point of Care Testing
RAAC	Reinforced Autoclaved Aerated Concrete
SACT	Systemic Anti-Cancer Therapy
SOC	Strategic Outline Case
SRO	Senior Responsible Owner
SRU	Satellite Radiotherapy Unit
UHB	University Health Board
WDA	Wholesale Distributor Authorisation
WG	Welsh Government

Table 38: Glossary of Terms