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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 November 2025
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Better Health, Better Care, Better Lives - 10-Year Strategy, Deployment Plan
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Director of Strategy, Planning & Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Marie-Claire Griffiths, Head of Strategic Planning

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

ADRODDIAD SCAA
SBAR REPORT

1. Sefyllfa / Situation

Following the approval of the new organisational strategy Gwent 35: Better Health, Better Care, Better Lives it is essential the Health Board has plans in place that translate strategy into delivery. To (effectively) embed the required action within the organisational architecture the deployment and delivery plans sets out how to achieve this through the Integrated Medium-Term Plan and enabling plans and strategies.

A Board Development session was held in October to shape Strategy deployment and delivery set in the context of developing our next Integrated Medium-Term Plan and crucially our operating model.

The Board is asked to;

- Note and discuss the Strategy Deployment and Delivery plan, "Making it Happen"
- Note and discuss the supporting outcomes framework

2. Cefndir / Background

In July the new strategy for the Health Board was approved by the Board, Gwent 35: Better Health, Better Care, Better Lives. The strategy signals a step change – fundamentally rebalancing our focus towards healthy communities whilst setting out the intent to become powered by innovation and improvement in all that we do. It sets the ambition that by 2035 we want everyone to have the chance to live a long, healthy life and improved healthy life expectancy.

The Board needs to consider the steps required to deploy and deliver Gwent 35; Better Health, Better Care, Better Lives. The proposed Strategy Deployment and Delivery plan, Making it Happen is supported by an outcomes framework to ensure progress towards the implementation strategy is tracked.

3. Asesiad / Assessment

The diagram below outlines the key elements of the strategy approved by the Board in July 2025.

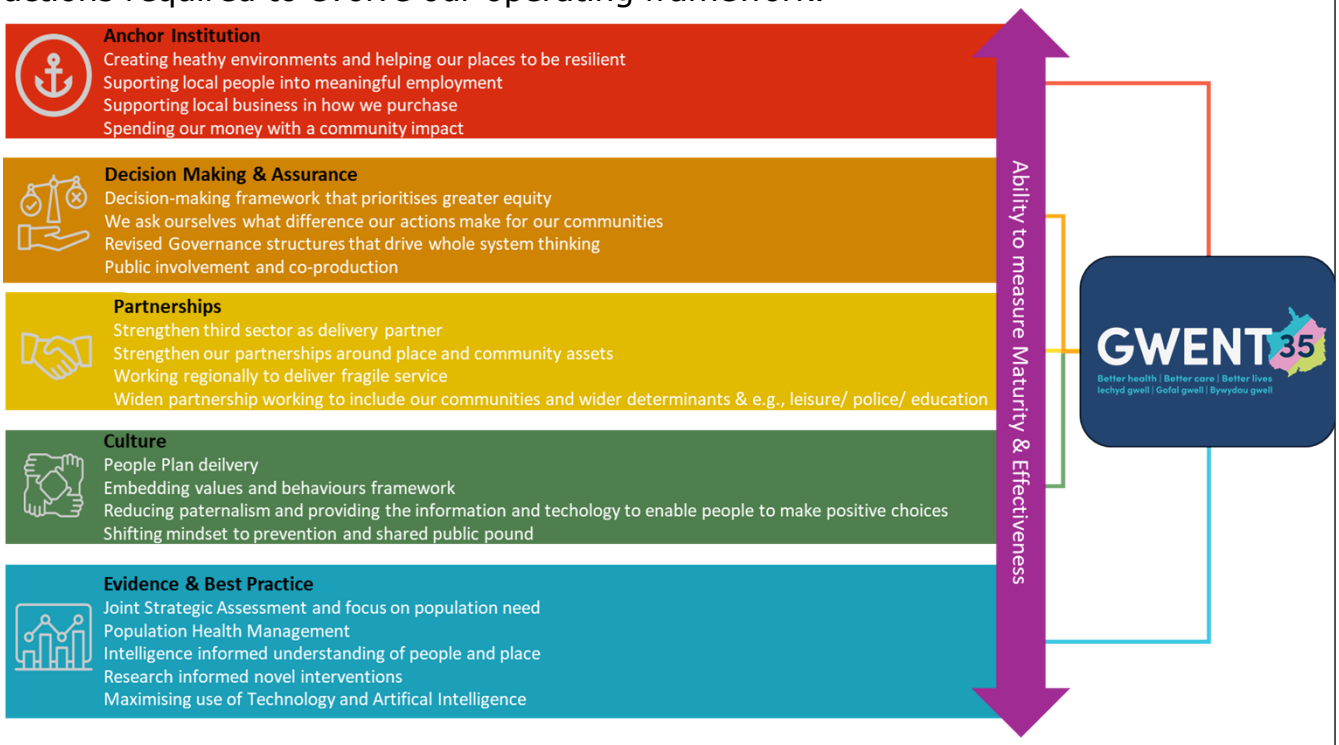
3.1. Strategy Deployment

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

In considering strategy deployment the key lines of enquiry need to be considered:

- How we ensure understanding of the Health Boards compact by our communities and what the Health Board can offer in to our communities
- How we embed the intent of strategy into our values and culture
- How we organise ourselves – meetings, committees
- How we prioritise
- How we make decisions (including investment and disinvestment)
- How we work with partnerships – with local authorities, third sector and with other health organisations.

The framework below is used in Appendix 1 "Making it Happen" to set out the key actions required to evolve our operating framework.

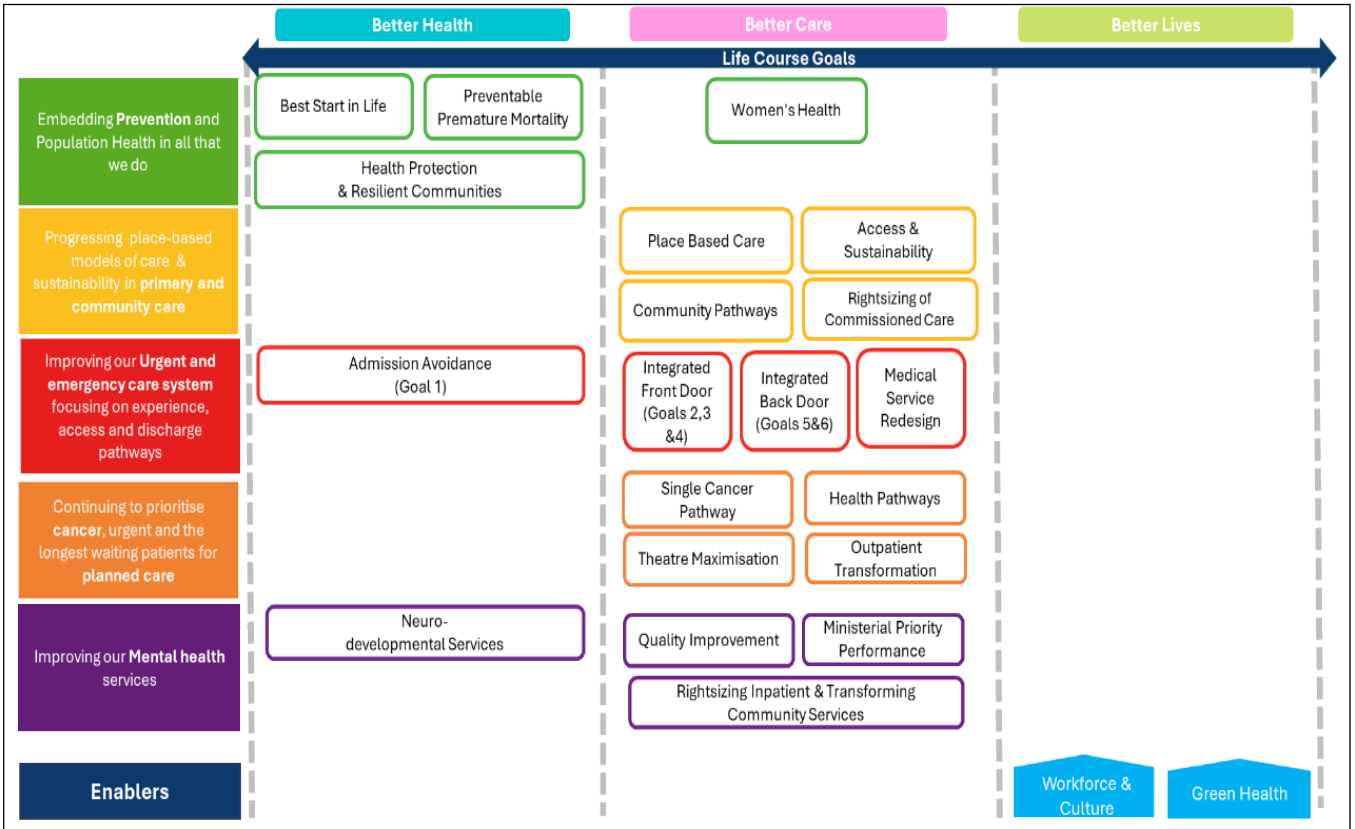


This reorientation is everyone's business, from Board through to front line staff and delivery against these actions will be tracked through a Making it Happen steering group. This will involve the Steering Group undertaken an assessment of maturity and how the Health Board ensures decisions are made on the basis of cost effectiveness.

3.2. Strategy Delivery

The IMTP, whilst being a three year plan, is refreshed and updated on an annual basis and is an essential part of setting out the priorities, commitments and outcomes to be delivered for services, system change and enabling (e.g. Digital) services. The IMTP is the key vehicle for strategy delivery as the planning processes are embedded throughout the organisation from Board to front line teams. By ensuring strategy delivery is rooted within the IMTP it builds into the business architecture of the organisation.

An assessment has been undertaken of the how the current (2025/26- 28) IMTP reflects the actions and commitments within the Strategy. The diagram below demonstrates how the deliverables within the current IMTP map across the three aims of better health, better care, better lives.



The challenge is to rebalance our priorities and focus in line with the strategy. "Making it Happen" sets out how future IMTPs will be commissioned to deliver the strategy from 2026 to 2028 keeping it as a live document through each cycle by assessing gaps in strategy delivery and developing the priorities accordingly. The diagram below illustrates the four priorities that sit under each strategic aim.

"Making it Happen" outlines the breakdown of each of the strategic aims confirming priorities with examples of the work programmes that sit underneath them, followed by the delivery expectation of each work programme.

There are two key elements that support strategy delivery: the outcomes framework and the strategic plans from the "Keys to Success" (People, Quality, Estates, Finance, Digital and Green Health). Making it Happen sets out the outcomes measurement and the timeline for each of the Keys to Success to fully implementing strategic plans with their delivery expectations.

Outcomes

The 10-year strategy centres on improving the health and equity of access across our population. Determining if the intended purpose is being met concentrates on reducing health inequalities and enhancing population health. The strategy sets the ambition to improve the opportunity to have a healthy life and how this will be delivered through better health, better care and better lives.

The outcomes to achieve this purpose focus on:

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

Specific measures for each key area of focus have been developed **(Appendix 2);** these measures are quantifiable and can be tracked over time. The measures draw from the known social determinants of good health and care, measuring the change in outcomes for our population that will be realised from the implementation of this strategy. They draw from a range of sources which have been established, validated and are used extensively by the Health Board, Public Health and Nationally. Importantly they can predominantly be broken down by Local Authority area so that the impact of delivery can be tracked across communities and enable localised decision making.

Baseline data for each measure has been established to understand the current position alongside realistic and achievable ambitions for each measure over the 10-year period. There are a small number of measures that are in development as part of the delivery plan for this Strategy and will be available by Q4.

Monitoring and evaluating progress will be carried out annually. Many of these measures are aligned to our existing plans and actions. This data will be used to assess the effectiveness of the interventions and allow adjustment as needed over the 10 years.

Better Health

Outcome	Measure	Life Course
There will be positive change in the factors that contribute to poor health	Proportion of adults (16+) who report drinking over 14 units of alcohol per week	Living Well
	Percentage of female/male children aged 11-16 who report smoking tobacco at least one a week	Growing Well
	Percentage of 18+ female/male population who are current smokers	Living Well
	11-16 year old females/males who were physically active every day (60 mins) in the past week	Growing Well
	Percentage who met physical activity guidelines in the previous week (150 mins)	Living Well
There will be more people who are a Healthy Weight	Healthy Weight :Adolescents Proportion of 11-16 year olds whose BMI is in healthy range	Growing Well

	Healthy Weight :Adults Proportion of 16+ with a BMI of 18.5-25	Living Well
There will be a reduction in preventable diseases	Proportion of Children who receive 4 in 1 preschool booster by age 4	Starting Well
	Bowel Screening uptake	Living Well
	Breast Screening uptake	Living Well
	Cervical Screening uptake	Living Well

Better Care

Outcome	Measure	Life Course
People with have more Healthy Days at Home	People with have more Healthy Days at Home	Aging Well
Our provided and commissioned services will meet the relevant quality and clinical standards	In development through QMG - definitions and standards	All
More people will be able to access health services in their local communities	Increase in people accessing Pharmacy Independent Prescribing where they would have visited their GP	Living Well
	Maintain the number of consultations undertaken by community pharmacy under Common Ailment Scheme	Living Well
	Maintain the number of patients accessing NHS Optometry Services	Living Well
	Maintain the number of patients accessing urgent emergency services - Dental	Living Well

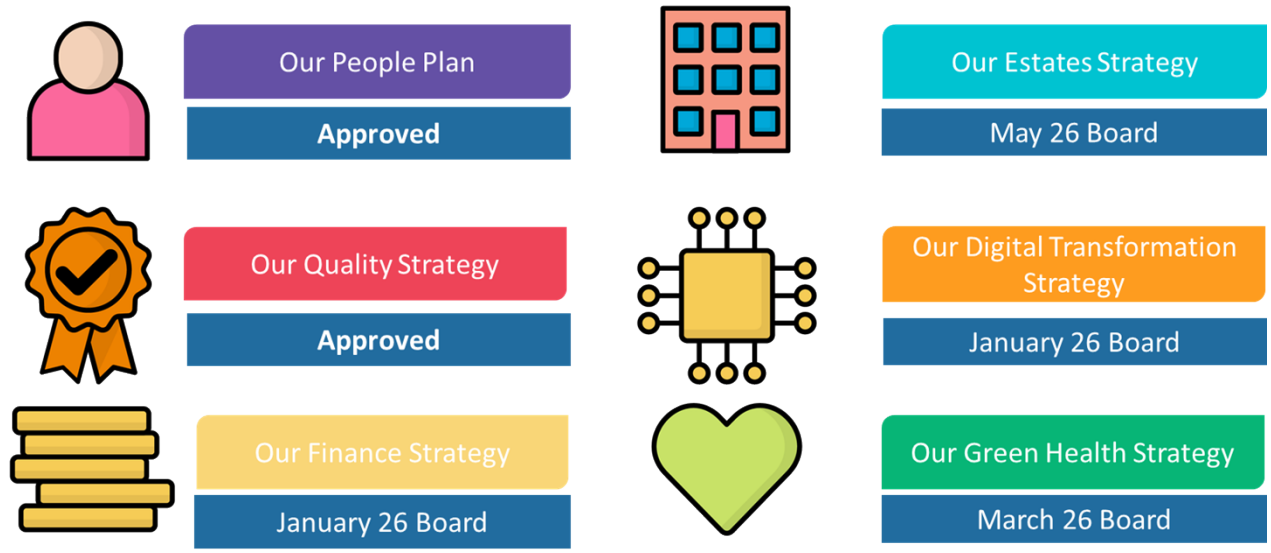
Better Lives

Outcome	Measure	Life Course
People will find it easier to connect with their communities, use local services, and feel respected	% of adults agreeing they belong to the area	Ageing Well

Our budget spent on services in the community will have increased across Gwent	Proportion of budget spent on out of hospital services	All
More people will engage with their local community to reduce loneliness and support good health	% of adults who are lonely	Ageing Well

Keys to Success

Gwent 35: Better Health, Better Care, Better Lives identifies six 'Keys to Success' which represent the foundations for system and service change. As part of strategy delivery, each of these will have plans that set out the relevant deliverables and milestones required to deliver the strategy. The timeline of when each of these will shared through our public boards is outlined below. In Making it Happen the delivery expectations against each of the actions included in the strategy for the keys to success.



Clinical Services plan

Whilst not a Key to Success, the development of a clinical services plan is a vital action to be delivered in the first two years of the strategy.

The diagram overleaf demonstrates the building blocks of the clinical services plan. Many of these are already being developed through regional and local clinical redesign programmes.

Considerable work was undertaken to develop clinical service models in preparation for the opening of the Grange University Hospital (GUH). Since the opening of GUH a clinical redesign programme with a focus on the Enhanced Local General Hospitals has been established. In addition, Mental Health Models of Care have been developed together with the development of Place Based Care.

Nationally and Regionally, fragile services are being addressed in partnership to deliver sustainable care collectively. The building blocks of a clinical services plan are in development.

The next stage will be to consolidate this work and, through further clinical engagement ensure the plans remain fit for the future in this fast moving landscape. There is a scheduled presentation with the Executive Team to test and shape this work. Following the outcomes of that presentation the Board will be involved through a development session.

3.3. Next Steps

Following discussion and feedback from the Board it proposed that a working group is established with relevant operational leads to drive forward Strategy Deployment.

Progress against strategy delivery will be embedded into the IMTP quarterly updates with a full report and review on an annual basis.

A Board development session on the development of a Clinical Services Plan will be held.

4. Argymhelliad / Recommendation

The Board is asked to;

- Note and discuss the Strategy Deployment and Delivery plan, Making it Happen

- Note and discuss the supporting outcomes framework

Appendices	
Appendix 1	Strategy Deployment and Delivery plan, Making it Happen
Appendix 2	Outcomes Framework

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	• Every Child has the best start in life • Getting it right for children and young adults • Adults in Gwent live healthily and age well • Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	• Experience Quality and Safety • Partnership First • Research, Innovation, Improvement, Value
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	• Work in partnership to reduce all hate crime • Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers • Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers • Improve patient experience by ensuring services are senstivie to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse • Improve the access, experience and outcomes of those who require mental health and learning disability services • Improve the experience of lesbian, gay, bisexual and trans (LGBTQ+) service users and staff

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	**Yes not yet available** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	1. Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs 2. Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies 3. Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves 4. 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 5. Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

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

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

Making it Happen

Gwent 35: Making it Happen

After listening to what is important to the people of Gwent, and learning from research, we developed three aims to ensure everyone in Gwent communities have the best healthcare, environment, and lifestyle to be healthy. We want everyone to have: better health, better care, and better lives.

The document outlines how as an organisation we will deliver and deploy the strategy with a focus on the first five years.

Principles & Approach

Following the approval of our Strategy we need to consider the steps we need to take to deliver and deploy Gwent 35; Better Health, Better Care, Better Lives.

Strategy Delivery : What we do

Our Strategy sets out a number of strategic actions we need to undertake this year and beyond. Our current IMTP sets out Strategy delivery for year 1. Key is how we commission the IMTP for next year to set out the future actions in a 3-year time frame.

Our IMTP will keep our strategy as a live document outlining the actions we are delivering over the next 1-3 years. It has the required governance and performance management already in place to embed strategy delivery throughout our organisation.

This document will describe what the IMTP says now aligned to the strategy and how we ask all teams in our organisation to respond to what they will deliver over the next three years to achieve Gwent 35: Better Health, Better Care, Better Lives.

There are two key elements that support strategy delivery. The outcomes framework and the strategic plans from the keys to success. In this document we outline the outcomes measurement and the timeline for each of the keys to success fully implementing strategic plans with their delivery expectations.

Strategy Deployment : How we do it

"a systematic approach for translating an organisation's strategic goals into actionable plans that guide tactical, operational and strategic decision making, priorities and resource allocation "

Its not just about **what** we do (our service changes and enabling activities) but about how we do things (our operating model).

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

In considering strategy deployment we need to consider the key lines of enquiry:

- How we embed our role and offer in our communities
- How we organise ourselves
- How we prioritise
- How we make decisions (including investment and disinvestment)
- How we work with and "show up" in partnerships – with local authorities, third sector and with other health organisations.

Throughout the development of the Strategy we had 10 design principles that guided our way. It is important that we continue to build on these as we focus on strategy deployment and delivery.

Design Principles

People at the heart of everything we do.
We will take time to learn about the whole person and design based on need. People, Patients, carers, families and staff.

Design with data.
We will let data and evidence drive decisions, learning from what has come before.

Prevention is best.
Start with prevention. Everyone to make the most of their capabilities and control their own lives.

Make use of what we have
Use just the resources available within our financial means to best effect so the NHS can have a long future.

Act with focus to improve outcomes.
Do what only the Health Board can do and create the conditions for success.

Do the hard work to make it simple.
Make it simple and easy to use even if complex behind the scenes.

Make things open, it makes things better.
Absolute transparency about challenges, opportunities and decisions. Regularly share learning and share our work.

Continuous Feedback.
We will test early and continue to refine. We said, we did, we need help with; not a singular process.

Be consistent not uniform.
Use the same models but apply them to the context promoting equity across Gwent.

This is just the start.
We are not done; this does not finish.

Organisational Planning Framework

Planning is the bedrock of NHS Wales. The diagram on the right-hand side outlines our organisational planning framework and the hierarchy of our organisational plans. Gwent 35 sits at the top as our long-term strategy. Its supported by;

- Six Keys to Success Strategic Plans
- 2 Overarching Delivery Plans – Clinical Services Plan & IMTP
- Supporting Partnership Delivery Plans
- Supporting Population Group Delivery Plans as required

We set out the Six Keys to Success Strategic Plans and the timeline for their development on page 39. We have set out how we will draw together the existing elements to articulate our clinical services plan and outline our approach to developing the IMTP on page 6. In addition, there is an assessment of how the current IMTP aligns with strategy delivery on pages 10 to 24. Furthermore, we outline how we will develop the next IMTP to reflect the three aims of Better Health, Better Care and Better Lives on pages 25 to 38.

In addition to the above delivery plans there are two supporting delivery plans to be aware of. These are Partnership Delivery Plans and Population Group Delivery Plans.

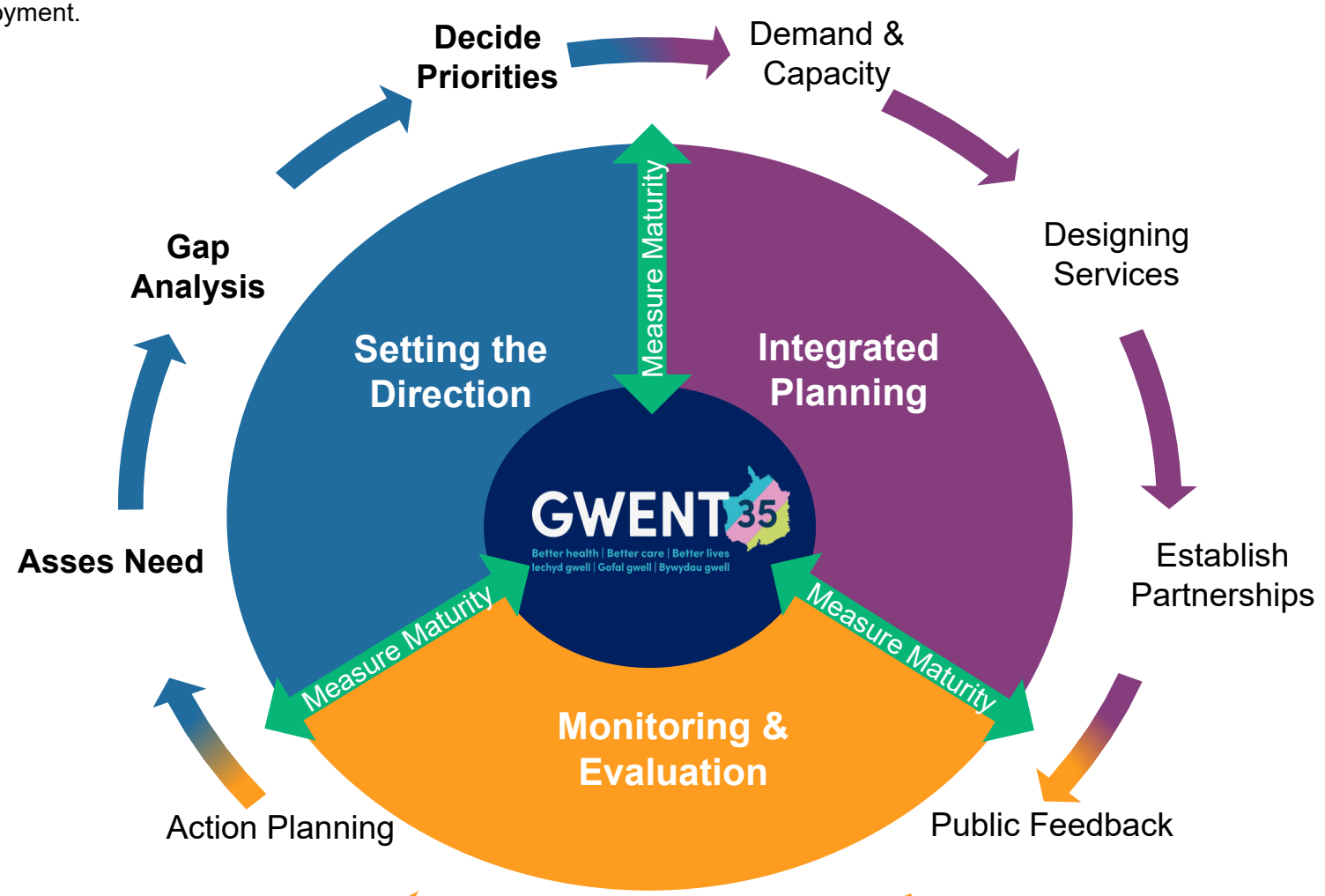
Partnership Delivery plans cover five main partnerships outlining the collective actions we will take to improve the health of our populations as a Region, Local Authority and Neighbourhood;

- Public Services Board
- Regional Partnership Board
- Integrated Service Partnership Boards
- Neighbourhood Care Networks
- Regional Joint Committee (with South East Wales health organisations)

Population Group Delivery plans reflect the local need and actions to improve the health of specific population groups, often translating national policy into local delivery. They can encompass a chronic condition such as Stroke or relate to a subset of the population such as Best Start in Life.

Organisational Planning Cycle

In addition to the organisational planning framework there is a planning cycle that articulates how to develop and monitor plan development. This is outlined in the diagram below with the areas of Board involvement in bold. We recognise as an organisation we have greater levels of maturity in some areas more than others. As a next step from this document, we propose we undertake a maturity assessment and identify areas we need to strengthen. This will be part of the strategy deployment.



Developing the Delivery Plans

Developing the IMTP

We develop our IMTP on an annual basis and its an essential part of setting the direction for the organisation. The IMTP planning processes are embedded throughout the organisation from Board to front line teams. By ensuring strategy delivery is rooted within the IMTP we are building it into the business architecture of the organisation. On page 10 we have set out how this years IMTP articulates delivery of the Strategy for 2025/26. On page 25 we set out our proposal of how we commission future IMTPs to deliver the strategy from 2026 to 2028 keeping it as a live document through each cycle by assessing gaps in strategy delivery and developing the priorities accordingly. Developing the IMTP is undertaken in five stages;

1. Board set priorities
2. Commission Organisational Response
3. Team develop plans
4. Aggregate whole system plan
5. Board Approval of Plan

This allows us to develop a plan where the Board sets the overarching priorities each individual team outlines its contribution to achieving the priorities.

Developing the Clinical Services Plan

The diagram on the right-hand side demonstrates the building blocks of our clinical services plan.

We have already undertaken considerable work to develop clinical service models in preparation for the opening of the Grange University Hospital (GUH). Since the opening of GUH we have been delivering a clinical redesign programme with focus on the Enhanced Local General Hospitals. In addition, we have been developing Mental Health Models of Care and progressing our ambition to deliver Place Based Care.

Since 2020 there has growing demand and acuity impacting our ability to deliver care in a timely way. Therefore, all our planned care specialities are developing sustainability plans to reduce the longest waits for our patients. We recognise that we have an ageing estate across our community hospitals to ensure best patient experience we are exploring the future community hospital model recognising their role in delivering place-based care coupled with the development of new Health and Wellbeing centres in the heart of our communities.

Nationally and Regionally, we are working in partnership to address our fragile services so we can collectively deliver sustainable care. We have the building blocks of a clinical services plan already. The next stage is to draw all of this work together and through clinical engagement ensure its fit for the future.

Strategy Deployment

To deploy our strategy we have identified five domains where we need to take targeted action and measure our maturity and effectiveness. These are outlined below;

Anchor Institution
Creating heathy environments and helping our places to be resilient
Suporting local people into meaningful employment
Supporting local business in how we purchase
Spending our money with a community impact

Decision Making & Assurance
Decision-making framework that prioritises greater equity
We ask ourselves what difference our actions make for our communities
Revised Governance structures that drive whole system thinking
Public involvement and co-production

Partnerships
Strengthen third sector as delivery partner
Strengthen our partnerships around place and community assets
Working regionally to deliver fragile service
Widen partnership working to include our communities and wider determinants & e.g., leisure/ police/ education

Culture
People Plan deilvery
Embedding values and behaviours framework
Reducing paternalism and providing the information and techology to enable people to make positive choices
Shifting mindset to prevention and shared public pound

Evidence & Best Practice
Joint Strategic Assessment and focus on population need
Population Health Management
Intelligence informed understanding of people and place
Research informed novel interventions
Maximising use of Technology and Artifical Intelligence
Working with partners to advance innovation

Ability to measure Maturity & Effectiveness

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Strategy Deployment

The necessary enabling steps for strategy deployment have been summarised in the below table;

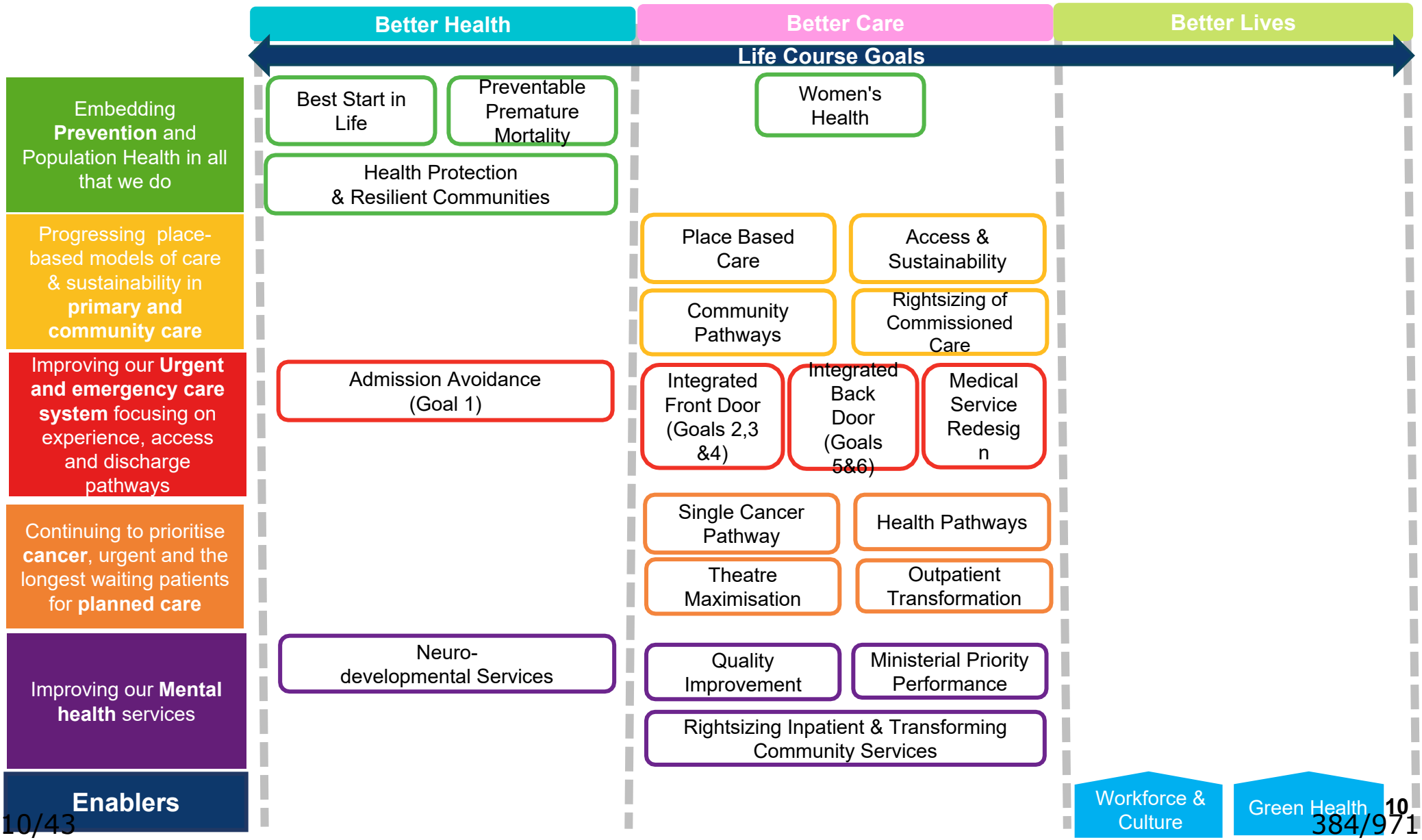
Focus Area	Action	Timescale
Anchor Institution	• Agree an organisational financial strategy that supports spending our money in and for communities of Gwent, including the shared public pound	Q1 2026
	• Strengthen inclusive recruitment, retention, and career development pathways that target our most deprived communities	Q2 2026
	• Establish the correct representation and relationships to be the voice of health when working with partners to develop local environments and infrastructures	Q4 2025
	• Establish development programmes and recruitment practices that ensure our senior leadership structures reflect the diverse nature of the communities we serve	Q1 2026
	• Use capital investments (e.g., Bevan Health and Wellbeing Centre) to regenerate communities and improve access	Q3 2026
Decision Making & Assurrance	• Work with the Board to develop a strategic decision-making framework that ensures as an organisation we are investing our resources and time into strategy delivery	Q1 2026
	• Work with the Board to assess our governance and committee structures to ensure they take the whole system approach to achieve our new ambition	Q4 2025
	• Establish a co-production framework that supports an organisational approach to embedding population voice into service design	Q1 2026
	• Embed community impact stories into our performance reporting	Q1 2026
	• Embed the use participatory budgeting to shape local health priorities	Q3 2026
Partnerships	• Establishment of the Regional Joint Committee for Southeast Wales to promote sustainable healthcare services across the regional footprint and a significant step toward integrated regional health governance	Q4 2025
	• Establish stronger partnership working arrangements sharing data and intent with Education, Police and Sports organisations	Q1 2026
	• Establish third sector commissioning processes	Q1 2026
	• Through RPB and ISPBs strengthen our partnership arrangements around place	Q1 2026

Strategy Deployment

Focus Area	Action	Timescale
Culture	• Model compassionate and inclusive leadership ensuring alignment with all people practices	Q4 2025
	• Build a diverse, representative workforce aligned with our Welsh Language, Anti-Racist, and LGBTQ+ commitments	Q4 2026
	• Provision of a range of wellbeing services that meet the complex and varied needs of people	Q2 2026
	• Embed employee voice, inclusion, and a Speaking Up Safely culture into our long-term organisational fabric	Q1 2026
	• Embed the principles needed to deliver our strategy into Senior Leadership development	Q1 2026
	• Equipping our people with the skills and confidence to make the most of new systems and technology in support of efficiency and sustainability	Q4 2026
	• Increase greater learning of the changes faced by our communities and the impact we have on their lives across our organisation	Q1 2026
Evidence & Best Practice	• Build on the launch of the Joint Strategic Assessment in Gwent to identify health inequalities and target interventions	Q3 2025
	• Develop frameworks to evaluate social value and anchor impact, learning from other NHS trusts like Leeds and East London	Q4 2025
	• Develop a Population Health Indicator Framework to monitor outcomes, inequalities, and service impact	Q3 2025
	• Establish a population health management system and the required partnerships through GP practices to achieve meaningful change	Q3 2026
	• Be a Research Active organisations that fosters research connections and relationships across Wales, establishing research opportunity as a normal part of patient's care pathway	Q3 2026
	• Establish new strategic partners to learn from industry and embed innovation	Q3 2026
	• Digital, Technology and A&I – develop agile strategies and frameworks that encourage innovation and maximise benefits for staff, patients and communities	Q1 2026

Year 1 Delivery Plan

We have undertaken an assessment of the how the current IMTP reflects the actions and commitments within our Strategy. The diagram below demonstrates how the milestones within the IMTP map across the three aims. The following pages take each of the strategy aims and articulate the performance measures and IMP milestones that deliver Gwent 35: Better Health, Better Care, Better Lives.



Strategy Action/ Commitment	IMTP 2025 Performance Expectations	National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Implement health protection through health screenings and vaccinations	% uptake of the COVID-19 vaccination for those eligible Spring Booster	75%	Yes	61%	-	75%	-	-
	% uptake of the COVID-19 vaccination for those eligible Autumn Booster	75%	Yes	49%*	-	-	-	75%
	% children up to date with vaccinations by age 5	95%	Yes	85.7%	86%	89%	92%	95%
	% of children receiving HPV vaccination 1 dose by the age of 15	90%	Yes	68%	75%	80%	85%	90%
	% uptake of the influenza vaccination amongst adults aged 65 years and over	75%	Yes	73%*	-	-	-	75%
Take action to support individuals to quit smoking	Percentage of adult smokers who make a quit attempt via smoking cessation services	5%	Yes	5.2%	5%	5%	5%	5%
	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40%	No	18%	20%	24%	28%	32%
Ensure every child has the best start in life	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	Yes	90%	90%	90%	90%	90%
	Maintain physical examination at 6 weeks rates (Healthy Child Wales)	-	-	90.9%	90%	90%	90%	90%
	Increase weight and measurement at 8 weeks rates (Healthy Child Wales)	-	-	65%	68%	72%	76%	80%
Take every opportunity to give people advice on a healthy lifestyle and proactive health information	Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	h	Yes	43.8%	44%	45%	46%	47%

Strategy	IMTP 2025-28			
Action (1-2 Years)	**System Change** **Exec Lead**	**Priority/Life Course**	**Milestones**	
Deliver health screenings and vaccinations in more places	Prevention and Population Health Executive Director of Public Health	Health Protection & Resilient Communities	Q1	Plan for the seasonal respiratory vaccinations campaign including roll out for 2- & 3-year-olds, care homes, pregnant women and older adults;
			Q2	Deliver seasonal respiratory vaccinations campaign;
			Q3	Monitor delivery of all vaccinations and targeted intervention in areas with low uptake;
			Q4	Deliver the change in childhood immunisations; Lead the implementation of vaccine equity strategy
			Year 2	Continue to respond to the National Immunisation Framework
Be the balanced view on health, providing information and guidance	Prevention and Population Health	Dying well as a part of life	Year 1	Publish Treatment Escalation public information leaflet to support the rollout of Future Care Planning
	Executive Director of Nursing / Planning	Getting It right for children & young people	Year 1	Increase provision for Children and Young People to make their own choices and manage their emotional health and wellbeing
Provide training and health information to people in our communities	Prevention and Population Health Executive Director of Public Health	Preventable Premature Mortality	Q1	Work in partnership with NCNs to identify eligible cohorts for Diabetes Prevention and establish Hypertension case finding service
			Q2	Following monitoring implement improvements in Diabetes Prevention and Hypertension case finding service including 12-week group-based behaviour change programme for people that require more intensive support
			Q3	Quarterly monitoring including evaluation of 12-week behaviour change programme and implement recommendations for improvement
			Q4	Commission an integrated model which amalgamates the Diabetes Prevention Programme and Hypertension Programme
			Year 2	Deliver integrated model for Diabetes and Hypertension

Strategy	IMTP 2025-28			
Action (1-2 Years)	**System Change** **Exec Lead**	**Priority/Life Course**	**Milestones**	
Work with leisure providers to help Gwent move more and feel better				
Reach out to partners to see what we can do together to keep people healthy	Primary and Community services Executive Director of Planning / Public Health	Adults in Gwent live healthily & age well	Year 1	Continue to collaborate with social care and third sector in response to the increase in anxiety levels across the county Support the Section 33 Frailty review with regional partners Provide evidence-based support for smokers wanting to quit smoking
Use our data to help people understand the signs they need to do more to stay well, especially young people	Prevention and Population Health Executive Director of Public Health	Best Start in Life	Q1	Define the scope of the early year's delivery plan; embedding the recommendations from the 0-4 years Joint Strategic Needs Assessment
			Q2	Undertake a series of workshops with partners to add granularity and shared commitment to the early year's delivery plan
			Q3	Produce the early years delivery plan including development of monitoring framework
			Q4	Framework delivery plan is approved by Gwent PSB and actions are implemented by partners
			Year 2	Continue delivery of early years delivery plan with partners
Improve data between all partners so we can work together to keep people healthy, active, and happy	Prevention and Population Health Executive Director of Public Health	Older adults are supported to live well & independently	Year 1	Create a process for gathering and sharing ABUHB and Gwent Police data on serious violence
	Primary and Community services Executive Director of Public Health	Adults in Gwent live healthily & age well	Year 1	Establish a population health management system across our NCNs with first area being piloted in 25/26

Strategy	IMTP 2025-28			
Action (1-2 Years)	**System Change** **Exec Lead**	**Priority/Life Course**	**Milestones**	
Create and spread widely a social prescribing framework so communities can access things locally to be healthy, active, and happy	Primary and Community services	Health Protection & Resilient Communities	Q1	Develop of a network of local neighbourhood hubs that connect residents with wellbeing assets, support, services, groups and activities
			Q2	Deliver community interventions within neighbourhoods equitably, at scale and with intensity proportionate to need
	Executive Director of Public Health		Q3	Accelerate action to embed community interventions that tackle the wider determinants of health recognising the local need and deprivation
			Q4	
			Year 2	

Strategy Action/ Commitment	IMTP 2025 Performance Expectations	National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Deliver sustainable, consistent, and equitable model for GP services. Expand care and support in communities	100% of GP practices achieving all National Access Standards for In hours GMS	100%	Yes	100%	-	-	-	100%
	Increase in people accessing PIPs where they would have visited their GP	h	Yes	22,919	4,820	9,583	17,131	24,065
	Maintain the number of consultations undertaken by community pharmacy under CAS	n	Yes	68,535	22,594	42,821	61,604	79,553
	Maintain the number of patients accessing NHS Optometry Services	n	Yes	246,133	58,471	121,913	184,023	246,133
	Maintain number of patients accessing urgent emergency services - Dental	n	Yes	43,153	9,093	20,333	31,743	43,153
Make accessing our services simple and reduce the time it takes to be seen by the right professional for your needs	Reduce the number of ambulance patient handovers over 1 hour	0	No	783	621	577	602	500
	Reduce the number of ambulance crew hours lost at GUH ED (per month)	-	-	3,158	2,750	2,500	2,750	2,500
	Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero	0	No	1,338	1,101	757	937	750
	Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU	95%	No	76%	75%	76.7%	78.4%	80%
	Reduction in time from arrival to ED triage - no waits over 60 minutes	-	-	392	300	250	250	200
	Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months	<60 mins	Yes	163 min	100 min	80 min	90 min	60 min

Strategy Action/ Commitment	IMTP 2025 Performance Expectations	National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Reduce waiting times for those waiting the longest	Continuous reduction in the number of people admitted as an emergency who remain in hospital over 21 days since admission	i	Yes	416	400	390	380	370
	Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard	♓	Yes	232	190	180	160	160
	Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard	-	-	9,487	7,290	7,219	7,184	6,437
	Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment	♓	Yes	16	20	17	14	12
	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	80%	No	67%	67%	68%	69%	70%
	Reduction in backlog of patients waiting over 62 days (SCP)	-	-	300	280	240	220	200
	Reduction in backlog of patients waiting over 104 days (SCP)	-	-	75	70	60	55	50
	Increase in rate of cancer diagnosis or discharges within 28 days	-	-	75%	75%	75%	75%	75%
	Numbers of patients waiting over 104 weeks (all stages)	0	No	464	966	1.917	2,680	3,291
	Number of patients waiting over 52 weeks for Outpatients	0	No	16,500	16,892	17,802	17,655	18,095
	Reduction in the number of patients waiting 100% past Outpatient follow-up target date	i	Yes	29,889	31,500	30,250	28,750	27,275

Strategy Action/ Commitment	IMTP 2025 Performance Expectations	National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Reduce waiting times for those waiting the longest	Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic	0	No	987	1,077	1,077	1,077	1,077
	No patient waiting more than 14 weeks for a therapeutic assessment	0	No	203	170	140	110	105
	Number of adults waiting more than 14 weeks for all audiology pathways	i	No	5,001	5,045	5,119	5,366	5,440
	Number of children waiting more than 6 weeks for all audiology pathways	i	No	805	1,654	2,501	2,783	3,630
	Maintain Adults Part 1a to national target (assessment completed within 28 days)	80%	Yes	90.3%	80%	80%	80%	80%
	Maintain Adults Part 1b to national target (interventions completed within 28 days)	80%	Yes	87.7%	80%	80%	80%	80%
	Maintain rate of psychological therapy received within 26 weeks	80%	No	45.4%	48%	60%	60%	60%
	Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)	80%	Yes	94%	80%	80%	80%	80%
	Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)	80%	Yes	84.8%	80%	80%	80%	80%
	Maintain CAMHS Part 2 national target compliance	90%	Yes	84.8%	90%	90%	90%	90%
	Improvement in Neurodevelopment waiting times compliance	80%	Yes	52.2%	70%	75%	80%	80%
	Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	80%	-	95%	80%	80%	80%	80%

Strategy Action/ Commitment	IMTP 2025 Performance Expectations	National Target	Meet Target?	Baseline	Q1	Q2	Q3	Q4
Organise our services to deliver best value and deliver care that is sustainable for the future	On 90% of days planned care inpatient/daycase/theatre recovery capacity should be protected from pressures and outliers	90%	Fully	97%	90%	90%	90%	90%
	Theatre Utilisation, late starts to less than 20%, early finishes to less than 10%, session utilisation to 85%	20/10/85%	Partially	44/47/89 %	40/43/ 85%	35/37/ 85%	30/31/ 85%	25/25/ 85%
	Deliver improvements in day surgery rates, achieving a BADS daycase rate	70% Apr 80% Jun	Partially	50%	45%	50%	55%	55%
	Increase in the rate of See On Symptom and Patient Initiated Follow-ups	h	Yes	10%	11%	12%	13%	13.5%
	Monitoring DNA/CNA for every Outpatient clinic. When DNA >5%, overbooking to be implemented & monitored and reduction of CNA	<5%	Partially	6%	5%	5%	5%	5%

Strategy	IMTP 2025-28			
Action (1-2 Years)	**System Change** **Exec Lead**	**Priority/Life Course**	**Milestones**	
Develop/start implementing our Clinical Services plan to organise our services to deliver best value	Urgent & Emergency Care System/ Cancer & Planned Care	Medical Service Redesign/ Theatre Maximisation	Q1	Finalise preparation of clinical service models for Nevill Hall Hospital (NHH) to inform the Strategic Outline Case to be submitted in May; Scoping current model, challenges and opportunities for Frailty & Care of the Elderly reconfiguration; Theatres Service Model developed to inform the planning of a Day Case Centre of Excellence as part of NHH Development Programme;
			Q2	Delivery of bed base reduction aligned to Clinical Futures model;
	Executive Director of Operations/Planning		Q3	Implementation of new service model at Royal Gwent Hospital (RGH) ahead of Winter; Progress Development of future service model for Frailty & Care of the Elderly reconfiguration
			Q4	Continued implementation of new service model at RGH and confirm clinical intake model at NHH; Finalise future service model for Frailty & Care of the Elderly reconfiguration
			Year 2	Embed Medical Model
Improve patient experience in Emergency department – increased staff and space	Urgent & emergency care system	Integrated Front Door (Goals 2,3 &4)	Q1	Further develop SDEC first model for Medicine at The Grange
			Q2	Completion of Emergency Department main wait extension phase 2
	Executive Director of Therapies		Q3	Develop an improved community falls response, linking to Gwent Telehealth
			Q4	Pilot of proposed Navigation Hub model
			Year 2	Roll out of Integrated Front Door Model

Strategy	IMTP 2025-28			
Action (1-2 Years)	**System Change** **Exec Lead**	**Priority/Life Course**	**Milestones**	
Deliver sustainable, consistent, and equitable model for GP services.	Primary and Community services	Access & Sustainability	Q1	Agree supplementary/enhanced service delivery for GP services and invest into General Dental Services through Newport East Development
			Q2	Ensure sustainable GP services and manage contractual changes in a timely manner; Undertake mid year reviews for General Dental Services
	Executive Director of Operations		Q3	Implementation of new and revised clinical pathways for Primary Care Optometry services
			Q4	Increase the number of pharmacies providing Pharmacist Independent Prescriber Service and services through Common Ailments Service
			Year 2	Maintain contractor sustainability
Expand care and support in communities	Primary and Community services	Place Based Care	Q1	Develop and agree outcomes framework and model specification for place-based care and integrated neighbourhood teams coupled with implementation in Blaenau Gwent as pathfinder working in partnership to create a whole system community model based on need
			Q2	Following findings of stocktake and gap analysis roll out targeted implementation of place-based care model specification across four other boroughs delivering through Integrated Service Partnership Boards
	Executive Director of Operations/ Public Health		Q3	Accelerate action through delegated governance and sustainable funding to support the delivery of place-based care models and integrated neighbourhood teams taking steps towards equity across Gwent
			Q4	Actions plans in place to expand integrated neighbourhood teams to be fully multi-professional making the necessary shift in resources and decision making from acute settings into our communities building community resilience
			Year 2	Accelerate and further expand integrated neighbourhood teams; Embed community pathways shifting care from an acute setting

Strategy	IMTP 2025-28			
Action (1-2 Years)	**System Change** **Exec Lead**	**Priority/Life Course**	**Milestones**	
People wishing to remain at home at the end of their life are supported to do so	Primary & Community Services /Urgent & Emergency Care System Executive Director of Nursing	Dying well as a part of life	Year 1	• Rollout of Primary Care Advanced Future Care Planning model • Develop Bereavement Pathway based on National Bereavement Standards • Embed principles of Care Aims and Balancing Rights and Responsibilities in End-of-Life Care Service Delivery • Extend Palliative Care Champions model
Reduce waiting times for those waiting the longest	Cancer & Planned Care Executive Director of Operations/Planning	Single Cancer Pathway/ Theatre Maximisation/ Mental Health	Q1	Sustain progress of Mental Health Part 1a and 1b for Adults and Children
			Q2	Newly tested HVLC lists and golden patient process embedded into business as usual service delivery; Deliver improvements in tumour site single cancer pathway with a focus on urology and gynaecology; Improve straight to test compliance; Improve measures for Psychological Services for Adults and start improvement project for Care Treatment Plans (CTP) for Children.
			Q3	Plans in place for increased Day Case activity aligned to BADS recommendations, for example default to day case where appropriate; Continue implementation plan for CTP improvement for Children.
			Q4	Make improvements in tumour site single cancer pathway with a focus on urology and gynaecology; Improve straight to test compliance; Sustain progress of Mental Health Part 1a and 1b for Adults and Children
			Year 2	Achieve 75% compliance with Single Cancer Pathway ; Continue to meet Ministerial Priority Performance for Mental Health
Our Keeping Well Service provides health and wellbeing advice to those waiting for our services	Cancer & Planned Care Executive Director of Planning	Theatre Maximisation	Q4	Keeping Well Service within the Health Board and seen as the Single Point of Contact for advice on Health and Wellbeing

Strategy	IMTP 2025-28			
Action (1-2 Years)	**System Change** **Exec Lead**	**Priority/Life Course**	**Milestones**	
Under 18s get the right support, at the right time, and easily transition into adult services				
Improve women's health focusing on their specific needs through our women's health plan	Prevention and Population Health Executive Director of Public Health	Women's Health	Q1	Establish baseline and understand the models and pathways being designed by Women's Health Network and Welsh Government
			Q2	Define scope and functions of Women's Health Hubs with teams across the Health Board and our partners
			Q3	Further develop service model to understand the financial and workforce implications whilst ensuring it fulfils the need of the local population
			Q4	Implement pathfinder Women's Health Hub by end of quarter
			Year 2	Evaluate pathfinder Women's Health Hub for further roll out

There are no performance expectations set within the IMTP 2025 that align to the Better Lives strategic aim.

Strategy	IMTP 2025-28			
Action (1-2 Years)	**System Change/Enabler** **Exec Lead**	**Priority/Life Course**	**Milestones**	
Be the voice of health when decisions made for our communities	Prevention and Population Health Executive Director of Public Health	Getting It right for children & young people	Year 1	• Implement policies around commercial determinants of health including-fast food planning applications
Closer working with schools – embedding health prevention in children's learning				
Increase chances for those with lived experience to support each other	Mental Health Services Executive Director of Planning/ Operations	Adults in Gwent live healthily & age well	Year 1	🤝Building on our co-production approach with people with lived experiences of our services to support a system to enable us to build the new alliance commissioning approach partners 🤝Incorporating people with lived experience into our workstreams to understand what matters and how we can best meet their needs • Extending Shared Lives across all boroughs for older people • Exploring Peer support in an Older Persons population
Continue to train/support people from our communities into care careers	Workforce and Culture Executive Director of Workforce	Sustainability	Q4	Continued roll out of the Integrated Schools Programme across all secondary schools in Gwent
With local partners develop volunteering opportunities supporting people into paid work	Workforce and Culture Executive Director of Workforce	Employer of Choice	Q3	Widening Access engagement/ check-ins with hosts to check progress with new process and update work experience policy and apprenticeship opportunities and access to training and education with Gwent Partners

Strategy	IMTP 2025-28			
Action (1-2 Years)	**System Change/Enabler** **Exec Lead**	**Priority/Life Course**	**Milestones**	
People have the tools needed for safe and caring relationships	Prevention and Population Health Executive Director of Public Health	Adults in Gwent live healthily & age well	Year 1	Establish evidence-based training for prevention of domestic abuse
Champion our green spaces and support more community green spaces				
Support community groups by opening up our buildings				
Further understand the needs of unpaid carers and support we can provide with partners				
Better coordination of public transport and work with charities who can transport people	Green Health Executive Director of Finance		Q2	Continue implementation of guidance set out in the Active Travel Action Plan for Wales

In this section we outline how ensure delivery of our Strategy through future IMTPs. This has been developed following the assessment of our current IMTP against our Strategy. The gaps identified are now contained within the delivery expectations of our priorities under the three strategic aims of Better Health, Better Care and Better Lives. The diagram below illustrates the four priorities that sit under each strategic aim. Over the next 13 pages we will breakdown each of the strategic aims confirming their priorities with examples of the work programmes that sit underneath them, followed by the delivery expectation of each work programme.

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

- **Health Protection**
- **Heath Improvement**
- **Prevention**
- **Early Years to Young Adulthood**

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

- **Place Based Care**
- **Access & Sustainability**
- **Improving Quality & Experience**
- **Embedding Value & Efficiency**

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

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

For each of the strategic aims we have set three outcomes we want to improve over the next 10 years. They focus on;

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

Specific measures for of the outcomes have been developed; these measures are quantifiable and trackable over time. The measures draw from the known social determinants of good health and care, measuring the change in outcomes for our population that will be realised from the implementation of this strategy. The measures for each of the outcomes are presented in this section.

For our ambition, By 2035 we want everyone across Gwent to have the same chance to live a long, healthy life and have an improved healthy living expectancy. We will measure this through seeing an improvement in the difference in years between the healthy life expectancy at birth of males and females living in the most and least deprived areas. We will expect to see a slight improvement in the least deprived areas with our most deprived areas reaching the healthy life expectancy of our least deprived areas. To close the gap in healthy life expectancy we will need to take actions through proportionate universalism ensuring an equitable offer for all with increased focus for our most deprived communities.

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

Outcomes

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

Priorities

Health Protection	Heath Improvement	Prevention	Early Years to Young Adulthood
• Screenings • Vaccinations • Infection & Disease Control • Emergency Planning	• Active & Sport Partnerships • Health Education & Training • Healthy Weight	• High Risk Populations • Preventable Premature Mortality • Reducing Cancer Inequalities • Population Health Management	• Perinatal Health • Maximising outcomes for Babies, Children & Young People • Whole Family Wellbeing

Impact Across the Life Course

Starting Well

Growing Well

Living Well

Ageing Well

Dying Well

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

Outcome	Measure	Life Course
There will be positive change in the factors that contribute to poor health	Proportion of adults (16+) who report drinking over 14 units of alcohol per week	Living Well
	Percentage of female/male children aged 11-16 who report smoking tobacco at least one a week	Growing Well
	Percentage of 18+ female/male population who are current smokers	Living Well
	11-16 year old females/males who were physically active every day (60 mins) in the past week	Growing Well
	Percentage who met physical activity guidelines in the previous week (150 mins)	Living Well
There will be more people who are a Healthy Weight	Healthy Weight :Adolescents Proportion of 11-16 year olds whose BMI is in healthy range	Growing Well
	Healthy Weight :Adults Proportion of 16+ with a BMI of 18.5-25	Living Well
There will be a reduction in preventable diseases	Proportion of Children who receive 4 in 1 preschool booster by age 4	Starting Well
	Bowel Screening uptake	Living Well
	Breast Screening uptake	Living Well
	Cervical Screening uptake	Living Well

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

Priority	Delivery Area	Delivery Expectations
Health Protection	Screenings	• Delivery of screening programmes in more community settings and targeting specific population groups who would benefit most • Working with others to advance technology and AI • Data informed screening communication through primary care data sets • Establishing outreach screening based on population need
	Vaccinations	• Expand delivery of vaccinations in more community settings and promotion to increase uptake rates for vaccinations for our clinically vulnerable groups • Working with partners target vaccination delivery to high contact population groups e.g. Bus Drivers • Lead the implementation of vaccine equity strategy • Continue to respond to the National Immunisation Framework
	Infection & Disease Control	• Support the elimination of Tuberculosis within Gwent • Support the elimination of Measles within Gwent • Elimination of Hepatitis B and C • Support the elimination of HIV improving quality of life and removing stigma • Reduce the transmission of STIs
	Emergency Planning	• Robust plans are in place to respond to a critical incident as and when needed • Ensure the health board and wider health protection system are prepared to respond to public health incidents
Health Improvement	Active & Sport Partnerships	• Embed active and sport partnerships into service delivery
	Health Education & Training	• Promotion of health, across the life-course, through provision of advice on healthy lifestyle • Provide evidence-based support for smokers wanting to quit smoking
	Healthy Weight	• Deliver the outcomes of the Healthy Weight debate
Prevention	High Risk Populations	• Support our High-Risk Adult Cohort in community settings • Establish MDT working for people who have greater complexity and are most at risk of deterioration

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

Priority	Delivery Area	Delivery Expectations
Prevention	**Population Health Management (PHM)**	• Supporting the rapidly evolving PHM landscape both locally and nationally • Support the roll out of a digital tool to enable population segmentation and risk stratification • Establish population health management processes across our NCNs
	Preventable Premature Mortality	• Reduce the risk of premature mortality from cardiovascular disease and cancer • Reduce harms from Tobacco smoking, passive smoking and nicotine addiction • Collaborative delivery of diabetes prevention and CVD risk factor management to ensure that programmes are delivered systematically and at scale
	Reducing Cancer Inequalities	• Improve low participation rates for cancer screening through communication programme • Establishing outreach screening based on population need • Delivery of interventions in more community settings and targeting specific population groups who would benefit most
Best Start in Life	**Perinatal Health**	• Support pregnant women to reduce the prevalence of gestational diabetes • Achieve accreditation in the Royal College of Psychiatrists Perinatal Quality Network standards for perinatal mental health.
	Maximising outcomes for Babies, Children & Young People	• Increase provision for Children and Young People to make their own choices and manage their emotional health and wellbeing • Working in partnership to support children with Speech & Language acquisition and to be School Ready • Prioritising surgical outcomes and performance for Babies, Children & Young People • Provide community nursing care to children and young people for minor illnesses to support admission avoidance and early discharge • Embed Children's Emergency Assessment Unit service change to improve emergency admission outcomes for Children • Delivery of MatNeo and Transitional Care
	Whole Family Wellbeing	• Delivery of early years delivery plan with partners • Working with partners to support healthy attachment & wider professional application of the Circle of Security • Working as national leaders in bringing together key frameworks, including NEST and Trauma-Informed Wales, to support a whole system approach • Collaborating with third sector partners to support referrals to autism assessment services and whole

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

Outcomes

People will have more Healthy Days at Home

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

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

Priorities

Place Based Care	Access & Sustainability	Improving Quality & Experience	Embedding Value & Efficiency
• Neighbourhood Hubs • Women's Health • Community Pathways	• GMS • 6 Goals for Urgent Care • Longest Waiters • Models of Care • Regional Planning	• Primary Care • Urgent Care • Planned Care & Cancer • Mental Health	• Theatre Maximisation • Health Pathways • Outpatient Transformation • Enhanced and Commissioned Care

Impact Across the Life Course

Starting Well

Growing Well

Living Well

Ageing Well

Dying Well

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

Outcome	Measure	Life Course
People with have more Healthy Days at Home	People with have more Healthy Days at Home	Aging Well
Our provided and commissioned services will meet the relevant quality and clinical standards	In development through QMG - definitions and standards	All
More people will be able to access health services in their local communities	Increase in people accessing Pharmacy Independent Prescribing where they would have visited their GP	Living Well
	Maintain the number of consultations undertaken by community pharmacy under Common Ailment Scheme	Living Well
	Maintain the number of patients accessing NHS Optometry Services	Living Well
	Maintain the number of patients accessing urgent emergency services - Dental	Living Well

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

Priority	Delivery Area	Delivery Expectations
Place Based Care	**Neighbourhood Hubs**	• Align NCNs and IWNs to further develop Place Based Care • Accelerate and further expand integrated neighbourhood teams • Embed new services within Place Based Care model that address preventative care across the life course • Creating the right system for professionals to easily connect those who would benefit from non-medical intervention into the appropriate community asset
	Women's Health	• Adopt a hub-and-spoke model for its Women's Health Hub • Further enhancement of the recently redesigned sexual health service and build on the menopause service and endometrial service through primary care engagement and training • Establish a women's unit that delivers more nurse led and one stop services in an ambulatory setting • Establish outreach events to raise awareness and provide support for those affected by endometriosis, pelvic health problems • Address any inequity in service provision with a particular focus on areas where there is recognised deprivation and reduced access to women's services
	Community Pathways	• Reducing preventable admissions and optimal hospital discharge through a Home First approach • Embed community pathways shifting care from an acute setting
Access & Sustainability	**General Medical Services**	• Ensure sustainable GP services and manage contractual changes in a timely manner
	Women's Health	• Further roll out of Women's health Hub across Gwent • Improve women's health focusing on their specific needs through our women's health plan
	Urgent Care System (6 Goals)	• Embed the Optimal Hospital Flow Framework & Optimal Ward Model • Roll out of Integrated Front Door Model and embed Medical Model • Implement a target operating model for a multi disciplinary navigation hub • Implement Frailty & Care of the Elderly reconfiguration • Embedded trusted assessor model across Gwent

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

Priority	Delivery Area	Delivery Expectations
Access & Sustainability	**Longest Waiters**	• Achieve 80% Compliance with Single Cancer Pathway • Establish Day Case Centre of Excellence • Sustain Part 1a and 1b performance for Adults and Children and Young People • Improve measures for Psychological Services for Adults
	Models of Care	• Phase 2 implementation of Models of Care within the Mental Health Strategy • Phase 3 implementation of Models of Care within the Mental Health Strategy • Embed single pathway for Mental Health Services access • Shift Mental Health care into the community
	Regional Planning	Contribute to the South East Regional Programmes for; • Llantrisant Health Park • Community Diagnostic Hub • Ophthalmology • Orthopaedics • Pathology • Stroke
Improving Quality & Experience	**Primary Care**	• Achieve and maintain access standards • Improve chronic condition management services to address any increased risk across the whole population • Plan for seasonal variation & provide rapid access, community services, to avoid unnecessary admissions
	Urgent Care	• Achieve and maintain no ambulance handovers over 45 mins • Improve Emergency Department wait to be seen by Clinician • Safe avoidance of unnecessary emergency admissions and early consideration of discharge arrangements • Ensure there is a clear pathway and communication process that supports transition to adults from children's and adolescent services

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

Priority	Delivery Area	Delivery Expectations
Improving Quality & Experience	**Planned Care & Cancer**	• Further develop and embed Prehabilitation • Nationally Optimised Pathways are embedded in local service delivery • Deliver transformation within the mortuary service to increase the safety and dignity of deceased patients • Adopt minimum communication standards for all our appointments • Ensure there is a clear pathway and communication process that supports transition to adults from children's and adolescent services
	Mental Health	• Embed single Neurodevelopmental pathway for Adults • Neurodevelopmental transformation for Children • Embed and sustain the commitments within the Quality Improvement plan • Ensure there is a clear pathway and communication process that supports transition to adults from children's and adolescent services
Embedding Value & Efficiency	**Theatre Maximisation**	• Continue to deliver initiatives to maximise Day Surgery • Improvement in performance against scheduling and utilisation KPI's • HVLC lists and golden patient process embedded
	Health Pathways	• Additional 50 localised pathways live on AneurinBevan local site per annum
	Outpatient Transformation	• Increased use of virtual clinics and identification of new pathways through scoping of opportunities in CIN and GIRFT recommendations • Ongoing monitoring of activity and opportunities for one-stop treatment pathways in the Outpatient Treatment Unit • Achieve 14.5% for SOS and PIFU • Reduction of Delayed Follow Ups Total Follow Ups
	Enhanced and Commissioned Care	• Rightsizing of Enhanced and Commissioned Care in community settings • Review of enhanced care on older adult wards to prevent deconditioning and ensure appropriate care • Improving outcomes for individuals who need longer term mental health support by developing a range of options within the Gwent area

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

Outcomes

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

Our budget spent on services in the community will have increased across Gwent

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

Priorities

Healthy Places	Resilient & Connected Communities	Safe Spaces	Quality of Life
• Commercial determinants of Health • Green Spaces • Education and School Partnerships	• Building Community Capacity • Social Prescribing • Carers • Transport	• Reducing Domestic Abuse • Healthy Relationships • Housing • Environmental Safeguarding	• Waiting Well • Recovery & Rehabilitation • End of Life Care

Impact Across the Life Course

Starting Well

Growing Well

Living Well

Ageing Well

Dying Well

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

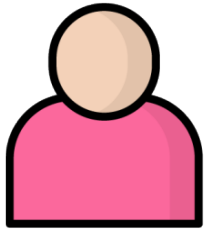
Outcome	Measure	Life Course
People will find it easier to connect with their communities, use local services, and feel respected	% of adults agreeing they belong to the area	Ageing Well
Our budget spent on services in the community will have increased across Gwent	Proportion of budget spent on out of hospital services	All
More people will engage with their local community to reduce loneliness and support good health	% of adults who are lonely	Ageing Well

Priority	Delivery Area	Delivery Expectations
Healthy Places	Commercial determinants of Health	• Implement policies around commercial determinants of health including-fast food planning applications
	Green Spaces	• Expand nature prescribing • Maximise the use of our green spaces to support wellbeing
	Working with Schools	• Embed education and school partnerships into service delivery • In reach to schools for mental health and wellbeing supporting school professionals
Resilient & Connected Communities	Social Prescribing	• Co-produce and deliver a 'social prescribing' model that connects people to activities, groups, and services in their community • Developing the tools to connect individuals into the community assets in their local area • Establishing a Social Prescribing Framework for Gwent • Supporting warm hubs and dementia hubs
	Carers	• Carers Support Spoke Model • Targeted short breaks for carers • Young Carers support
	Transport	• Designing services where people don't need to travel based on population need • Third sector commissioning of community transport/ car sharing
Safe Spaces	Healthy Relationships	• Create a process for gathering and sharing ABUHB and Gwent Police data on serious violence • Establish evidence-based training for prevention of domestic abuse
	Housing	• Our work in partnership to ensure appropriate housing for vulnerable groups and those who require transition housing • Warmer homes initiative • Develop locally based housing initiatives to improve outcomes for people with Mental Health and Learning Disabilities
	Environmental Safeguarding	• Improve the built environment to support good health

Priority	Delivery Area	Delivery Expectations
Quality of Life	**Waiting Well**	• Keeping Well Service within the Health Board and seen as the Single Point of Contact for advice on Health and Wellbeing
	Recovery & Rehabilitation	• Work in partnership with third sector to provide peer support opportunities for those with lived experience
	End of Life Care	• Establish Bereavement Collaboratives • Implement Bereavement Pathway based on National Bereavement Standards • Embed principles of Care Aims and Balancing Rights and Responsibilities in End-of-Life Care Service Delivery • Extend Palliative Care Champions model • Rollout of Primary Care Advanced Future Care Planning model

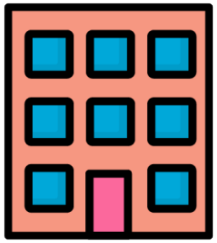
Keys to Success

In our Strategy we identified six keys to success and under each aim they had an action to achieve . Each of these will have plans that set out their commitments to deliver the strategy. The timeline of when each of these will shared through our public boards is outlined below. Over the next three pages we set out the delivery expectations against each of the actions included in the strategy for the keys to success.



Our People Plan

Approved

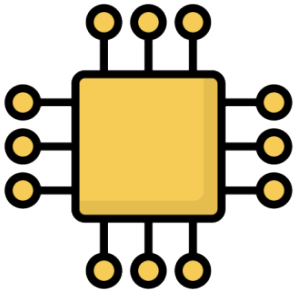


Our Estates Strategy

May 26 Board

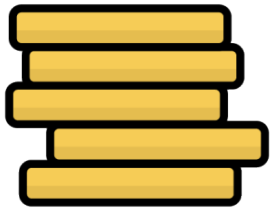
Our Quality Strategy

Approved



Our Digital Transformation Strategy

March 26 Board



Our Finance Strategy

January 26 Board

Our Green Health Strategy

March 26 Board

Keys to Success

Key to Success	Strategy Commitment	Delivery Expectations
Our People	**Be an employer that advocates fair work and opportunities to support the health and wellbeing of our staff**	• Embed Values & Behaviours framework • Embed our approach to Avoidable Employee Harm working with internal and external stakeholders • Roll out a Wellbeing and Empowerment Passport • Widening access to volunteer and career pathways so we are supporting the communities we serve into meaningful work
	Help our staff experience their work as meaningful and rewarding. Support them with awareness of cultural values	• Deliver training and support to raise awareness of cultural values • Promoting a 'Just Culture' that supports safety and psychological safety, encouraging staff to 'speak up safely' • Continued delivery of the SEP and All Wales Action Plans (WRES, LGBTQ+, Accessible Information, Disability)
	We will have shared values and ways of working with partners that connect our communities	• Continued roll out of the Integrated Schools Programme across all secondary schools in Gwent • Working towards developing shared values with partners across Gwent
Quality	**Develop and deliver a Quality Management System across all levels of our organisation**	• Integrate quality management systems to ensure continuous improvement and compliance with health standards • Implement robust quality management frameworks that align with national and international health standards • Regularly review and update policies and procedures to maintain high standards of care
	Improve patient experience and continue our commitment to Care Aims Principles to embed a person-centred approach	• Refreshed Patient Experience and Involvement Strategy • Staff learning and development programmes embed the principles of Care Aims and Balancing Rights and Responsibilities • People Participation Panels established for key areas with plan to extend
	Be an open, learning organisation that provides our people with the skills they need to continually improve	• Use data-driven approaches to inform quality improvement initiatives and enhance patient safety • Use of patient/staff stories to inform organisational learning • 1,000,000 minutes of Quality Improvement (QI) Coaching achieved by the end of 2028 • QI Faculty to support the development of organisational conditions for QI

Keys to Success

Key to Success	Strategy Commitment	Delivery Expectations
Finance	**Get the balance right so we can keep people well and invest in children and young people's futures**	• Measurement of financial impact of interventions that keep people well • Measurement of how we spend our money across the life course with an assessment of health economics
	Focus on value and efficiency across all services to achieve the best outcomes sustainably	• Refreshed three-year route map with targeted actions to deliver value and efficiency • Make better and more routine use of comparative data of all sorts, such as the VAULT, to inform service improvement
	Do our best to spend our money in Gwent and ensure it helps our communities	• Quantify current spend on primary and community services as a baseline, and agree a 5 year plan to shift more services from hospitals to community • Increase in primary and community investment from core capacity
Our Buildings	**Look outside our own buildings to deliver healthcare in a community setting**	• Deliver more services and interventions in community buildings that target those who needs our services most
	Ensure we have the right estates in place to deliver our Clinical Services plan to the best of our ability	• Refresh our Estates Strategy aligned to the development of our clinical services plan
	Our buildings that promote wellbeing, are open to communities to use and is shared with the public sector	• Open up our Health and Wellbeing Centres to community groups and third sector to use
Digital Innovation & Technology	**Use digital, innovation, and technology to provide tools to support a healthy thriving Gwent with connected communities**	• Enabling access to health information and supporting healthier lifestyles through data informed interventions • Enable individuals to manage their health and care through inclusive accessible digital tools
	Ensure our services have good digital infrastructure and people can be supported at home through technology	• Provide our staff with timely, accurate information and intelligent digital workflows to improve safety, quality, and coordination • Make digital systems easier to use and more effective in daily work for all staff • ensuring our systems are secure, scalable, and interoperable—capable of supporting the delivery of modern, responsive services across hospital, community, and home settings.
	Equip people in our communities with the access, skills, and confidence to engage with digital	• Reducing digital exclusion and supporting joined up care across health and social care systems

Keys to Success

Key to Success	Strategy Commitment	Delivery Expectations
Green Health	**Promote active travel and support good public transport to our services**	• Deliver our commitments in the Active Travel Action Plan for Wales • Assess the public transport to our services and work with partners and third sector to ensure accessibility
	Deliver Carbon Neutral targets through services that model green health and maximise our green spaces	• Embed the 'Green Theatre' initiative • Explore localised opportunities for low carbon transport infrastructure • Work towards implementing upgrades to ensure 60^ of generated heat at acute sites is low carbon by 2030 • Plans in place to eliminate fossil fuelled heating
	Communities across Gwent are able to connect through nature	• Expand our work with partners that supports nature prescribing across Gwent

Throughout this document we have outlined the steps we will take to deliver and deploy our Strategy.

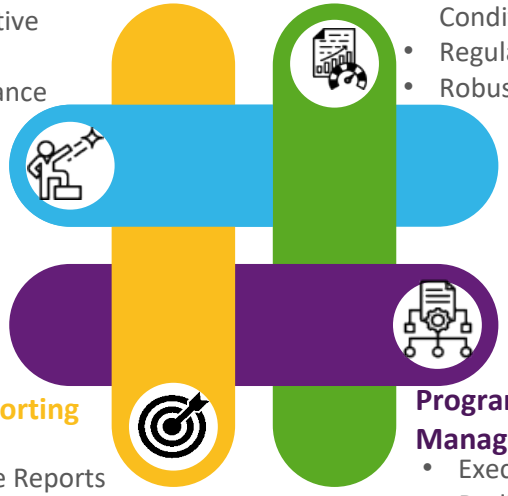
It is essential through Board oversight and organisational assurance mechanisms we hold ourselves to account and keep track of our progress against the delivery and deployment of our Strategy.

High performing organisations have clearly understood and effective Performance Management and Accountability Frameworks (PMF). Our internal PMF is the mechanism to enable, monitor and achieve delivery of the Health Board's strategic priorities, performance expectations and operational plans.

Our PMF coupled with our transformation programmes form a robust delivery framework for our organisation weaving together; Governance and Leadership, PMF, Programme Management Approach and Targeted Reporting. These key areas will be reviewed to ensure they reflect the necessary actions to deliver and deploy Gwent 35: Better Health, Better Care, Better Lives.

Governance and Leadership
- Accountability Structures
- Monthly Executive Oversight
- Monthly Assurance

Performance Management & Accountability Framework
- Accountability Conditions
- Regular Reviews
- Robust Reporting



Targeted Reporting
- Integrated Performance Reports
- Quality Outcomes Framework
- Deep Dives

Programme Management Approach
- Executive Ledership
- Dedicated PMO
- Standardised Processes, Governance & Reporting

In order to ensure we have assurance on strategy delivery and deployment we will undertake the following;

Strategy Delivery : What we do

- We will align our performance expectations to the three strategic aims and these will be reported to Board bi-monthly
- Our progress against actions within the IMTP will be reported to Board quarterly
- We will report against the Strategy Outcomes Framework annually
- We will review our transformation programmes and their key deliverables to ensure they align

Strategy Deployment : How we do it

- We will establish a Strategy Deployment Oversight Group with representation from across the organisation
- The Strategy Deployment Oversight Group will build on the work of this document to agree and own a detailed strategy deployment action plan
- We will undertake an Annual Review of Strategy Deployment to be shared with Board
- We have dedicated Board Development sessions on key areas of Strategy deployment to shape them further

By 2035 everyone has the same chance to live a long healthy life

Measures	Source	Area	Baseline	Latest data point	Ambition	Life Course Impact
Healthy Life Expectancy At Birth - Females	PHW Outcomes/Gwent Indicator Frameworks	Wales	59.6	2023		
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	57.9	2023	min 66 0 difference across areas	All
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	55.2	2023	min 66 0 difference across areas	All
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	58	2023	min 66 0 difference across areas	All
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	65.9	2023	min 66 0 difference across areas	All
	PHW Outcomes/Gwent Indicator Frameworks	Newport	56.7	2023	min 66 0 difference across areas	All
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	53.3	2023	min 66 0 difference across areas	All
Healthy Life Expectancy At Birth - Males	PHW Outcomes/Gwent Indicator Frameworks	Wales	60.3	2023		All
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	58.9	2023	min 66 0 difference across areas	All
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	56.7	2023	min 66 0 difference across areas	All
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	58.8	2023	min 66 0 difference across areas	All
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	65.9	2023	min 66 0 difference across areas	All
	PHW Outcomes/Gwent Indicator Frameworks	Newport	57.9	2023	min 66 0 difference across areas	All
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	54.9	2023	min 66 0 difference across areas	All
Deprivation Gap - Females The difference in years between the healthy life expectancy at birth of females living in the most and least deprived areas	PHW Outcomes/Gwent Indicator Frameworks	Wales	16.9	2023		All
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	20.5	2023	0	All
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	10.4	2023	0	All
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	16.9	2023	0	All
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	7.7	2023	0	All
	PHW Outcomes/Gwent Indicator Frameworks	Newport	25.5	2023	0	All
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	25.5	2023	0	All
Deprivation Gap - Males The difference in years between the healthy life expectancy at birth of females living in the most and least deprived areas	PHW Outcomes/Gwent Indicator Frameworks	Wales	13.3	2023		All
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	12.8	2023	0	All
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	11.7	2023	0	All
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	9.9	2023	0	All
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	3.1	2023	0	All
	PHW Outcomes/Gwent Indicator Frameworks	Newport	12.6	2023	0	All
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	11.3	2023	0	All

Notes:
No target for increase in Wales DHSC
Levelling up White Paper (Feb. 2022) target to close the gap and increase overall by 5 years

Better Health							
Measures	**Source**	**Area**	**Baseline**	**Latest data point**	**Ambition**	**Life Course Impact**	**Notes**
There will be positive change in the factors that contribute to poor health							
Proportion of adults (16+) who report drinking over 14 units of alcohol per week	StatsWales/Gwent Indicator Frameworks	Wales	16.4	2022/2023	14	Living Well	
	StatsWales/Gwent Indicator Frameworks	Gwent		2022/2023	14	Living Well	National recommendation
	StatsWales/Gwent Indicator Frameworks	Blaenau Gwent	14.3	2022/2023	14	Living Well	
	StatsWales/Gwent Indicator Frameworks	Caerphilly	17.5	2022/2023	14	Living Well	
	StatsWales/Gwent Indicator Frameworks	Monmouthshire	24.3	2022/2023	14	Living Well	
	StatsWales/Gwent Indicator Frameworks	Newport	12.4	2022/2023	14	Living Well	
	StatsWales/Gwent Indicator Frameworks	Torfaen	19.2	2022/2023	14	Living Well	
Percentage of female children aged 11-16 who report smoking tobacco at least one a week	PHW Outcomes/Gwent Indicator Frameworks	Wales	2.1	2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	2.2	2023	0 <5%	Growing Well	National Target
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent		2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	1.7	2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	2.7	2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Newport	2.2	2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	2.9	2023	0 <5%	Growing Well	
Percentage of male children aged 11-16 who report smoking tobacco at least one a week	PHW Outcomes/Gwent Indicator Frameworks	Wales	2.7	2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	2.7	2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent		2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	2.7	2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	3	2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Newport	2.8	2023	0 <5%	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	2.8	2023	0 <5%	Growing Well	
Percentage of 18+ female population who are curent smokers	ONS/Gwent Indicator Frameworks	Wales	11.1	2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Gwent		2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Blaenau Gwent	14.5	2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Caerphilly	12.5	2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Monmouthshire	7.8	2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Newport	11.9	2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Torfaen	16.6	2023	0 <5%	Living Well	

Percentage of 18+ male population who are curent smokers	ONS/Gwent Indicator Frameworks	Wales	14.2	2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Gwent		2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Blaenau Gwent	17.2	2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Caerphilly	14.8	2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Monmouthshire	6.4	2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Newport	15.6	2023	0 <5%	Living Well	
	ONS/Gwent Indicator Frameworks	Torfaen	16.1	2023	0 <5%	Living Well	
11-16 year old females who were physically active every day (60 mins) in the past week	PHW Outcomes/Gwent Indicator Frameworks	Wales	13.7	2023	14	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	12.5	2023	14	Growing Well	National ambition to increase, HB ambition to decrease the gap
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	10.6	2023	14	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	13	2023	14	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	14	2023	14	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Newport	12.9	2023	14	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	10.3	2023	14	Growing Well	
11-16 year old males who were physically active every day (60 mins) in the past week	PHW Outcomes/Gwent Indicator Frameworks	Wales	22.8	2023	Increase	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	21.1	2023	26	Growing Well	National ambition to increase, HB ambition to decrease the gap
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	16.3	2023	26	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	21.2	2023	26	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	25.9	2023	26	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Newport	20.8	2023	26	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	19.3	2023	26	Growing Well	
Percentage who met physical activity guidelines in the previous week (150 mins)	PHW Outcomes/Gwent Indicator Frameworks	Wales	55.4	2022/2023	Increase	Living Well	
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	49.9	2022/2023	58	Living Well	National ambition to increase, HB ambition to decrease the gap
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	45.4	2022/2023	58	Living Well	
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	51.1	2022/2023	58	Living Well	
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	57.2	2022/2023	58	Living Well	
	PHW Outcomes/Gwent Indicator Frameworks	Newport	48.6	2022/2023	58	Living Well	
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	40.6	2022/2023	58	Living Well	
Measures	**Source**	**Area**	**Baseline**	**Latest data point**			
There will be more people who are a Healthy Weight							
Healthy Weight :Adolecents Proportion of 11-16 year olds whose BMI is in healthy range	PHW Outcomes/Gwent Indicator Frameworks	Wales	65	2021	Increase	Growing Well	

	PHW Outcomes/Gwent Indicator Frameworks	Gwent	63.3	2021	67	Growing Well	National ambition to increase, HB ambition to decrease the gap
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	54.5	2021	67	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	62.4	2021	67	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	66.5	2021	67	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Newport	63.3	2021	67	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	65.6	2021	67	Growing Well	
Healthy Weight :Adults Proportion of 16+ with a BMI of 18.5-25	PHW Outcomes/Gwent Indicator Frameworks	Wales	36.3	2022/23	Increase	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	N/A	2022/23	45	Growing Well	National ambition to increase, HB ambition to decrease the gap
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	19.4	2022/23	45	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	27.9	2022/23	45	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	44.4	2022/23	45	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Newport	34.4	2022/23	45	Growing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	34.8	2022/23	45	Growing Well	
Measures	**Source**	**Area**	**Baseline**	**Latest data point**			
There will be a reduction in preventable diseases							
Proportion of Children who receive 4 in 1 preschool booster by age 4	PHW Outcomes/Gwent Indicator Frameworks	Wales	83.4	2023/2024	95	Starting Well	National target
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	83.6	2023/2024	95	Starting Well	
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	83	2023/2024	95	Starting Well	
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	85.7	2023/2024	95	Starting Well	
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	89.5	2023/2024	95	Starting Well	
	PHW Outcomes/Gwent Indicator Frameworks	Newport	78.8	2023/2024	95	Starting Well	
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	85.1	2023/2024	95	Starting Well	
Bowel Screening uptake	PHW Bowel Screening/Gwent Indicator Frameworks	Wales	67.2	2021/2022	Increase	Living Well	
	PHW Bowel Screening/Gwent Indicator Frameworks	Gwent	67.6	2021/2022	73	Living Well	National ambition to increase, HB ambition to decrease the gap
	PHW Bowel Screening/Gwent Indicator Frameworks	Blaenau Gwent	66.7	2021/2022	73	Living Well	
	PHW Bowel Screening/Gwent Indicator Frameworks	Caerphilly	68.5	2021/2022	73	Living Well	
	PHW Bowel Screening/Gwent Indicator Frameworks	Monmouthshire	72.5	2021/2022	73	Living Well	
	PHW Bowel Screening/Gwent Indicator Frameworks	Newport	64	2021/2022	73	Living Well	
	PHW Bowel Screening/Gwent Indicator Frameworks	Torfaen	66.3	2021/2022	73	Living Well	

Breast Screening uptake	PHW Outcomes/Gwent Indicator Frameworks	Wales	72.3	2021	80	Living Well	National target
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	72.5	2021	80	Living Well	
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	72.3	2021	80	Living Well	
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	72.7	2021	80	Living Well	
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	77.7	2021	80	Living Well	
	PHW Outcomes/Gwent Indicator Frameworks	Newport	68.2	2021	80	Living Well	
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	72.1	2021	80	Living Well	
Cervical Screeining uptake	Annual Population Survey/Gwent Indicator Frameworks	Wales	69.6	2021/2022	Increase	Living Well	
	Annual Population Survey/Gwent Indicator Frameworks	Gwent	70.8	2021/2022	76	Living Well	National ambition to increase, HB ambition to decrease the gap
	Annual Population Survey/Gwent Indicator Frameworks	Blaenau Gwent	68.9	2021/2022	76	Living Well	
	Annual Population Survey/Gwent Indicator Frameworks	Caerphilly	72.1	2021/2022	76	Living Well	
	Annual Population Survey/Gwent Indicator Frameworks	Monmouthshire	75.4	2021/2022	76	Living Well	
	Annual Population Survey/Gwent Indicator Frameworks	Newport	67.6	2021/2022	76	Living Well	
	Annual Population Survey/Gwent Indicator Frameworks	Torfaen	70.7	2021/2022	76	Living Well	

Better Care

Measures	Source	Area	Baseline	Latest data point	Ambition	Life Course Impact	Notes
People with have more Healthy Days at Home							
People with have more Healthy Days at Home	HDAH Dashboard	Wales				Ageing Well	
	HDAH Dashboard	Gwent				Ageing Well	
	HDAH Dashboard	Blaenau Gwent	359.34	2024		Ageing Well	
	HDAH Dashboard	Caerphilly	360.04			Ageing Well	
	HDAH Dashboard	Monmouthshire	359.77			Ageing Well	
	HDAH Dashboard	Newport	360.21			Ageing Well	
	HDAH Dashboard	Torfaen	359.91			Ageing Well	
Measures	**Source**	**Area**	**Baseline**	**Latest data point**	**Ambition**	**Life Course Impact**	**Notes**
Our provided and commissioned services will meet the relevant quality and clinical standards							
Our provided and commissioned services will meet the relevant quality and clinical standards	In development through QMG - definitions and standards					Ageing Well	
Measures	**Source**	**Area**	**Baseline**	**Latest data point**	**Ambition**	**Life Course Impact**	**Notes**
More people will be able to access health services in their local communities							
Placed based care measures (paper due for September Board						Living Well	
						Living Well	
		Blaenau Gwent				Living Well	
		Caerphilly				Living Well	
		Monmouthshire				Living Well	
		Newport				Living Well	
		Torfaen				Living Well	
100% of GP practices achieving all National Access Standards for In hours GMS	Primary Care	ABUHB	100%	Mar-25	100	Living Well	
Increase in people accessing PIPs where they would have visited their GP	Primary Care	ABUHB	22,919	Mar-25		Living Well	National ambition to increase
Maintain the number of consultations undertaken by community pharmacy under CAS	Primary Care	ABUHB	68,535	Mar-25	0% change	Living Well	National ambition to maintain
Maintain the number of patients accessing NHS Optometry Services	Primary Care	ABUHB	246,133	Mar-25	0% change	Living Well	National ambition to maintain
Number of patients accessing urgent emergency services - Dental	Primary Care	ABUHB	43,154	Mar-25		Living Well	National ambition to increase

Better Lives

Measures	Source	Area	Baseline	Latest data point	Ambition	Life Course Impact	Notes
People will find it easier to connect with their communities, use local services, and feel respected							
% of adults agreeing they belong to the area	Welsh Government National Survey for Wales/Gwent Indicator Frameworks					Ageing Well	
	Welsh Government National Survey for Wales/Gwent Indicator Frameworks					Ageing Well	
	Welsh Government National Survey for Wales/Gwent Indicator Frameworks	Blaenau Gwent	70.6	2021/2022	82	Ageing Well	
	Welsh Government National Survey for Wales/Gwent Indicator Frameworks	Caerphilly	78.1	2021/2022	82	Ageing Well	
	Welsh Government National Survey for Wales/Gwent Indicator Frameworks	Monmouthshire	81.2	2021/2022	82	Ageing Well	
	Welsh Government National Survey for Wales/Gwent Indicator Frameworks	Newport	73.8	2021/2022	82	Ageing Well	
	Welsh Government National Survey for Wales/Gwent Indicator Frameworks	Torfaen	78	2021/2022	82	Ageing Well	
Measures	**Source**	**Area**	**Baseline**	**Latest data point**	**Ambition**	**Life Course Impact**	**Notes**
Our budget spent on services in the community will have increased across Gwent							
Proportion of budget spent on out of hospital services	Out of Hospital Spend Analysis - Finance Health Board	Hospital	£ 823,655,807.00	2021/2022		All	
	Out of Hospital Spend Analysis - Finance Health Board	Out of Hospital	£ 687,425,822.00	2021/2022		All	
	Out of Hospital Spend Analysis - Finance Health Board	Overhead	£ 80,121,898.00	2021/2022		All	
	Out of Hospital Spend Analysis - Finance Health Board	Total (£)	£ 1,591,203,527.00	2021/2022		All	
Measures	**Source**	**Area**	**Baseline**	**Latest data point**	**Ambition**	**Life Course Impact**	**Notes**
More people will engage with their local community to reduce loneliness and support good health							
% of adults who are lonely	PHW Outcomes/Gwent Indicator Frameworks	Wales	12.7	2022/2023		Ageing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Gwent	11.6	2022/2023	8	Ageing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Blaenau Gwent	11	2022/2023	8	Ageing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Caerphilly	8.2	2022/2023	8	Ageing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Monmouthshire	17.9	2022/2023	8	Ageing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Newport	15.8	2022/2023	8	Ageing Well	
	PHW Outcomes/Gwent Indicator Frameworks	Torfaen	9	2022/2023	8	Ageing Well	

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 November 2025
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Llantrisant Health Park - Phase 2 OBC for Orthopaedics
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Hannah Evans, Director of Strategy, Planning and Partnerships

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In December 2022, CTMUHB submitted a successful business case to WG to purchase the former British Airways Avionics Engineering site at Llantrisant, with the purchase of the site completing in February 2023.

The vision for the Llantrisant Health Park (LHP) site is to establish a standalone site for high-volume, low-complexity surgical and diagnostic procedures to address capacity shortfalls, meet future demand challenges and support consolidation of services where this will add value to participating health boards. The Board supported the vision document for LHP at its March 2025 meeting.

LHP will also act an enabler for further regional service reconfiguration. The development of a dedicated facility for planned care, separated from emergency care, was a key commitment in the Welsh Government's recovery document, "Our Programme for transforming and modernising Planned Care and reducing waiting lists in Wales" (April 2022).

The project is being led by the LHP Project Team at CTM in partnership with ABUHB and CAVUHB. Health Boards in South East Wales have committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability.

The development of LHP will be undertaken via a phased approach which has been supported by WG. Phase 1 is the development of a Community Diagnostic Hub, which includes Radiology and Endoscopy, the OBC for phase 1 was noted at Board in September. Phase 2a will include a high volume, low complexity orthopaedic inpatient unit. The final future phases will be subject to a regional scoping exercise and may include a multi-modality day surgery unit.

This OBC specifically refers to Phase 2a of the scheme for an orthopaedic inpatient unit serving as a regional Arthroplasty facility.

Cefndir / Background

The Regional Orthopaedic Plan that informs this business case was noted at CAVUHB, ABUHB, CTMUHB Boards in September this year. It identified a clear need for additional lower limb arthroplasty capacity in South East Wales. Based on the demand and capacity analysis, the Arthroplasty facility will contribute to closing the demand and capacity gap, however the additional capacity alone will not fully meet the current demand, backlog and forecasted projections for lower limb arthroplasty.

It is noted that further work is needed to address the shortfalls, including efficiency assumptions and utilisation of existing capacity, all of which will be set out in the SE Wales Regional Lower Limb Arthroplasty Plan, due for completion April 2026 which will inform the LHP Full Business Case (FBC). Additionally, further regional work is required across other orthopaedic sub specialities to optimise delivery of orthopaedic services across the region.

Workforce planning will continue as a cornerstone of the next phase of the Orthopaedic planning work supporting all arthroplasty delivery sites. The LHP, as a regional service will bring development opportunities for our staff as we work is undertaken in collaboration together to deliver orthopaedic services. There will also be a key focus on establishing the additionality of staff to work within the South East Wales region as part of this development as an increased number of arthroplasty operations will impact on staffing requirements across the patient pathway including outpatients, radiology, pre-operative assessment care, rehab and follow-up.

Significant revenue will be required to fund the additional lower limb arthroplasty capacity. The revenue principles at this stage are.

- Where activity is shifting from existing services the money will follow the patient.
- Activity over and above core funded positions will require additional revenue funding,
- Planning will seek to secure financial benefits (i.e. procurement benefits) for reinvestment in the service.

The OBC includes;

- Demand and Capacity assumptions (as shared with Board in September 2025) that confirm the need for the LHP facility.
- Capital design.
- Emerging clinical model and operational model.

Engagement leads are working together to jointly produce an engagement plan for the Orthopaedic OBC and Community Diagnostic Hub FBC. The format will include the production of core content with clear messaging to increase the profile and understanding of LHP amongst public audiences. This will enable delivery of engagement actions locally in each Health Board which is also aligned to the vision across the region. The scope of work includes but is not limited to, key messages, content for web and social media, graphics, talking heads videos. This work will also include workforce engagement across the region.

Asesiad / Assessment

The draft OBC and capital cost addendum can be found in Appendix 1

Key issues and risks include:

1. **Revenue Funding:** There are significant risks associated with revenue funding availability for services. Based on potential revenue cost of operations projected usage by ABUHB may be £6.5m to maintain acceptable arthroplasty waiting times. This remains subject to a range of potential options and work is being undertaken to refine financial assumptions through to FBC.

   With uncertainty about the funding position in future years Boards are not in position to underwrite the scale of revenue investment required within the case. However, recognising the growth in demand for arthroplasty and wider orthopaedic the development of LHP is necessary to meet this challenge and will therefore require national support to enable the case to proceed

2. **Workforce Planning** – workforce shortages across a number of areas are highlighted. Further planning work is required include the detailed workforce model for the LHP. ABUHB is committed to maximising internal efficiencies and detailed workforce planning as regional plans develop.

3. **Operational Impact:** Local Health Board plans and LHP regional facility will support reduced waiting times and improved patient outcomes for ABUHB residents.

4. **Ongoing engagement** is required with regional partners and stakeholders including the public on the service redesign and the consequences for their care.

Argymhelliad / Recommendation

The Board is asked to:
• Approve the submission of the OBC to Welsh Government to proceed for consideration through to FBC • Note the potential revenue consequences and approach to seeking national support

Appendix 1


DRAFT%20LHP%20 OBC%20-%20Phase9


Capital%20Cost%20 addendum.docx

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Many of the regional work streams are informed by risk assessment and have been established to address and mitigate system risks
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 5.1 Timely Access 7.1 Workforce Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Produced on behalf of Cwm Taf Morgannwg UHB by

Archus
The healthcare infrastructure specialist

Outline Business Case for Llantrisant Health Park

(17) November 2025

Version 1.1 DRAFT

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SRO	Paul Mears, CEO Cwm Taf Morgannwg University Health Board
Programme Director	Rosie Cavill, Programme Director
Organisation	Cwm Taf Morgannwg University Health Board Cardiff and Vale University Health Board Aneurin Bevan University Health Board

Version control – record of edits

Version	Changes made	By	Date
0.1	Set up template and populate using relevant original OBC content	Bev Letherby	07/10/25
0.2	Updated Strategic Case	Glenys Mansfield	28/10/25
0.3	Strategic Case and commercial case updates	Rosie Cavill	28/10/25
0.4	Updated master version	Bev Letherby	29/10/25
0.4a	Formatted version	Kath Leeder	31/10/25
0.5	Updated Strategic Context, Commercial and Management cases	RC / KL	10/11/25
0.5a	Formatted version	Bev Letherby	11/11/25
1	Economic and Financial Cases added	Henry Mony de Kerloy	12/11/25
1.1	Updated with latest Capital Cost Profile	Henry Mony de Kerloy	16/11/25

Appendices

Appendix Ref	Appendix Name
Appendix 1	Strategic Overview Document
Appendix 2	Orthopaedic Regional Plan
Appendix 3	Arthroplasty Pathway
Appendix 4	LHP Operational and Clinical Model
Appendix 5	Benefits Register
Appendix 6	Risk Register
Appendix 7	Capital Cost Plan
Appendix 8	Revenue Costs Working Paper
Appendix 9	Comprehensive Investment Appraisal (CIA) Model
Appendix 10	Phase 2 Programme

Glossary

Term	Description
ABUHB/AB	Aneurin Bevan University Health Board
BAU	Business As Usual
BCR	Benefit Cost Ratio
BfW	Building for Wales
BIM	Building Information Modelling
BREEAM	Building Research Establishment Environmental Assessment Method
CDE	Common Data Environment
CIA	Comprehensive Investment Appraisal
CIA	Comprehensive Investment Appraisal
CSF	Critical success factor
CTMUHB/ CTM	Cwm Taf University Health Board
CAVUHB/ CAV	Cardiff and Vale University Health Board
DHSC	Department of Health and Social Care
FBC	Full Business Case
GiRFT	Get it Right First Time
HB	Health Board
JAG	Joint Advisory Group
MMC	Modern Methods of Construction

Term	Description
NEC	New Engineering Contract
NPC	Net Present Cost
NPSV	Net Present Social Value
NWSSP - SES	NHS Wales Shared Services Partnership - Specialist Estates Services
NZC	Net Zero Carbon
OBC	Outline Business Case
POWH	Princess of Wales Hospital
PM	Project Manager / Programme Manager / Project Management
PSC	Professional Services Contract
PWF	Preferred Way Forward
RGH	Royal Glamorgan Hospital
RPA	Risk Potential Assessment
SAB	SuDS Approval Body
SCP	Supply Chain Partner
SO	Spending Objective
SOC	Strategic Outline Case
SRO	Senior Responsible Officer
WG	Welsh Government

1 Executive summary

1.1 Structure and introduction

The purpose of this outline business case (OBC) is to outline key objectives, current plans for investment and seek approval for funding of **£1.67m** from Welsh Government to proceed to full business case (FBC) for Phase 2 of the Llantrisant Health Park (LHP) Programme.

The programme is being led by the LHP Project Team at Cwm Taf Morgannwg University Health Board (CTMUHB) in partnership with Aneurin Bevan University Health Board (ABUHB) and Cardiff and Vale University Health Boards (CAVUHB). Health Boards in South East Wales have committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability, as it does for this scheme.

The programme is being delivered across multiple phases to deliver improved regional access to diagnostics, endoscopy and orthopaedic surgery. Phase 1 of the programme covers provision of diagnostic and endoscopy services alongside provision of site wide supporting infrastructure and the OBC for that phase was approved in October 2025.

This OBC covers Phase 2 of the project being Orthopaedic Surgery and supporting ward accommodation. The structure of the OBC is outlined in the table below.

Case	Section	Purpose	Description
Strategic	2	Strategic Context	Provides an overview of current services and explains how the project is strategically placed to contribute to the delivery of organisational goals.
	3	Case for Change	Establishes the case for change by outlining the spending objectives, existing arrangements and business needs.
	4	Potential Scope and Services	Identifies the potential scope of the project in terms of the operational capabilities and service changes required to satisfy the identified business needs.
	5	Benefits and Risks	Identifies the benefits, risks, constraints and dependencies for the project.
Economic	6	Options Identification and Appraisal	Explores the preferred way forward by agreeing critical success factors (CSFs), determining the longlist of options, and undertaking a SWOT analysis to identify a shortlist of options.
	7	Economic Appraisal	Appraises the economic costs, benefits and risks for the short-listed options and concludes which option represents the best value for money.
Commercial	8	Procurement Route, Scope and Contractual Details	Outlines: • the procurement strategy and routes that have been agreed. • the scope of the procurement • the contractual arrangements of the potential deal to deliver the recommended solution for the project.
Finance	9	Financial Appraisal	Sets out the forecast financial implications of the preferred option.
Management	10	Management Arrangements	Sets out the arrangements put in place to manage the project to successful delivery.

1.1 Background and context

During autumn 2022, Cwm Taf Morgannwg University Health Board (CTMUHB) became aware of the intention of British Airways Avionics Engineering (BAAE) to sell their former engineering site in Llantrisant. The site was vacant, as BAAE had relocated their service provision to St Athan during early 2022 (but remained as tenants of the site).

The total site covers over 20 acres with a developed area comprising three separate buildings totalling over 10,300sqm. There is parking on site for around 300 cars. The site has the potential capacity and infrastructure for a wide range of clinical services, and in addition to the existing buildings, there is also an area of cleared ground that is available for further on-site development.

In December 2022 CTMUHB submitted a case to Welsh Government (WG) to support the purchase of the site, which was to be known as Llantrisant Health Park (LHP). This case set out the initial development aims and aspirations. Approval was given and £8m funding released to support the site purchase as a regional elective care facility. The purchase completed in February 2023.

The vision for LHP is to establish a standalone site for high-volume, low-complexity surgical and diagnostic procedures to address capacity shortfalls, meet future demand challenges and support consolidation of services where this will add value to participating health boards. LHP will also act an enabler for further regional service reconfiguration. The development of a dedicated facility for planned care, separated from emergency care, was a key commitment in the Welsh Government's recovery document, *"Our Programme for transforming and modernising Planned Care and reducing waiting lists in Wales"* (April 2022).

The need to introduce diagnostic and treatment capacity to the South East Wales region has never been greater. Since the COVID-19 pandemic, waiting lists have increased to their highest ever levels and Health Boards have struggled to address this within existing capacity and working practices. Set alongside this is the increasing aging population and acute medicine pressures which indicate that a significant change to current practice and how we use our existing infrastructure is essential if performance and access to treatment is to be improved.

LHP offers the region a unique opportunity to deliver new ring-fenced elective capacity, encompassing innovative developments and state of the art practice. The site will provide efficient and proven effective models of care to deliver increased diagnostic and treatment facilities across the region. These models are fully in line with the **Getting it Right First-Time** surgical hub models, recognised as best practice across the UK.

The proposal for Phase 1, subject to the earlier OBC, incorporates:

- **Imaging capacity** – incorporating MRI, CT and ultrasound as part of a Community Diagnostic Hub (CDH)
- **Endoscopy capacity** – elective and screening services to increase capacity across the region and address the projected six suite shortfall across the region by 2027/28 and to introduce a training academy to respond to workforce shortfalls.

This OBC, for phase 2, proposes a **High-volume, low-complexity orthopaedic inpatient unit** - providing capacity for up to six theatres to deliver arthroplasty (knees and hips) surgery for patients meeting the criteria for treatment without critical care support. An inpatient unit co-located with the theatres will accommodate patients requiring an overnight stay.

It is recognised that Health Boards have obligations in respect of public engagement and consultation when introducing significant service changes, and these will have some application when progressing a model of regionally based provision of elective services.

The principle of patients travelling further to access more timely care has been tested in a regional context with a recent engagement exercise for cataract surgery, when positive feedback was received from both public and Llais. Close contact with Llais will be maintained as the LHP plans progress, to ensure that the required arrangements are in place and that any concerns / issues arising are addressed and mitigated as appropriate.

This OBC seeks approval to progress to Full Business Case (FBC) for Phase 2 of the LHP Programme and to restate the case for a new regional Health Park across three health boards, CTMUHB, ABUHB and CAVUHB.

Welsh Government and the IIB are supportive of delivering this project, given the pressing need to improve regional acute services for the people of Southeast Wales.

Vision and spending objectives

The vision is for the Llantrisant Health Park to be an exemplar facility providing a standalone elective diagnostic and surgical facility for the South East Wales Region. Within this overarching vision, phase 2 is proposed to deliver a regional elective surgical hub (ESH) for primary arthroplasty surgery. The intention is to create a centre of excellence for planned (High Volume Low Complexity) HVLC primary arthroplasty surgery, delivering productivity and quality of care for patients that consistently meets best practice, and delivers optimum value.

The design of the LHP building will prioritise operational efficiency through ring-fenced theatre capacity, standardised care pathways, and lean scheduling practices. By removing the variability associated with mixed elective/emergency lists, the centre will achieve higher theatre utilisation rates and reduced cancellation rates. The use of day-case arthroplasty pathways, supported by enhanced recovery protocols and prehabilitation, will further improve throughput and reduce length of stay. Benchmarking against GIRFT metrics will be used to monitor performance and drive continuous improvement.

The LHP will be fit for the future. It is designed using evidence from a range of sources, including Getting it Right First Time (GIRFT) and the British Orthopaedic Association (BOA), the National Joint Registry (NJR), British Association of Day Surgery (BADS) and other professional bodies. There will be sufficient capacity to meet current and future demand resulting in timely access to services.

The spending objectives listed in the table below were agreed by members of the LHP Programme Board in September 2024.

Ref	Theme	Spending objective
SO1	Meet population needs	The delivery of an elective high volume low complexity model of care for the South East Wales Region on a phased basis. Phase 2 to focus on the delivery of elective orthopaedic arthroplasty,. Services to be operational by the end of the 2028/29 financial year. A Future phase 3 to consider further regional services such as pathology or day surgery.
SO2	Maximise capacity	To maximise clinical capacity on the LHP site. To ensure that the maximum amount of available space is directed towards direct service delivery with supporting services managed from the neighbouring RGH site.
SO3	Innovation and Standardisation	To facilitate and support the use of innovative design and delivery solutions in both clinical and non-clinical services. To implement standardised protocols and practices to promote efficient service delivery offering improved value for money, reported via comprehensive patient level costing, delivering a lower procedure cost than English tariff.
SO4	Enable training / development of future workforce	To enable increased training and development of secondary care staff including accommodating more medical trainees and medical students

Ref	Theme	Spending objective
SO5	LHP Models of Care and Workforce Models	To develop a new model of care and workforce models to support the delivery of the core services, the models will support efficient delivery of services
SO6	Sustainable estate	To deliver a sustainable infrastructure on the site maximising decarbonisation and net zero opportunities.

1.2 Case for change

Current service provision for the region is delivered for each of the health boards' populations within each health board's geographic footprint. Patients from each Health Board currently access services in other health boards as part of agreed patient flows for specific service pathways. Additional capacity is delivered through a range of means including internal additional capacity using NHS clinicians (commonly referred to as waiting list initiatives) and in-sourcing.

In considering the solution in the business case, considerable research has been undertaken by the LHP team alongside other clinical and non clinical colleagues. As well as considering evidence offered by GiRFT, they have undertaken learning with a number of established Elective Surgical Hub in England. This has made a contribution to the development of both pathways and processes as well as the building infrastructure and provided a compelling evidence base to support the development of a high volume low complexity primary arthroplasty unit at LHP.

There has been a regional focus on developing a solution to the challenges faced by orthopaedics across South East Wales which has culminated in the development of the Regional Orthopaedic Plan, Appendix 2 to this document. This plan is recognised as being in its first phase but has focused on the development of detailed regional demand and capacity modelling, undertaken with the support of WG colleagues, to prove the need for additional theatre capacity at LHP for the region.

The outcomes of the regional planning exercise clearly demonstrate that there is a shortfall in orthopaedic capacity in the region, with the greatest shortfall in lower limb, as shown in the table below.

Sub specs	South-east Wales		
	Recurrent demand IP24/25	Demand in 28/29·	
		1% growth	4% growth
FA	1,630	1,695	1,891
Paeds	358	372	415
Upper Limb	1,500	1,560	1,740
Hands	2,870	2,985	3.329
Lower Limb	4,895	5,091	5,678
Spine	1,476	1,535	1,712
Other	274	285	318
Total	**13,003**	**13,523**	**15,083**
Arthroplasty	*3,578*	*3,721*	*4,150*

The recurrent demand levels for lower limb surgery (which is predominantly arthroplasty related) is significantly larger than all other orthopaedic specialities in the region and this demand is set to grow in the next 3 years until 2028/29 when LHP is programmed to open.

The problems becomes even more apparent when factoring in capacity against these demand levels as shown below

Type	Current gap / surplus (2025/26)			Projected 2028/29 -position				
	New OP	Treatment	Tx w new OP conversion (40% assm)	Treatment / surplus gap if		Efficiency oppor-tunity	Recurrent net treatment gap / surplus (Mar 29) if	
				Demand @ 1% to 29	Demand @ 4% to 29		Demand @ 1%	Demand @ 4%
Foot / ankle	-422	-83	-252	-371	-728	98	-273	-630
Paeds	-211	-17	-101	-140	-255	16	-124	-239
Upper limb	487	81	81	-21	-326	125	104	-201
Hands	-394	-616	-774	-965	-1,538	209	-756	1,329
Lower limb	-2,278	-250	-1,161	-1,544	-2,691	1,148	-396	-1,543
Spine	1,074	-595	-595	-708	-1,047	44	-664	-1,003
Other	-198	-254	-333	-347	-390	0	-347	-390

From this table, against lower limb capacity shortfalls dominate both in 25/26 (shown in blue) and projected forward 2028/29, where, if the higher level of growth is realised, demand could exceed capacity by over 1,500 cases per annum for lower limb surgery.

The proposed solution our LHP is to build 6 theatres and 54 supporting beds that will form a regional primary arthroplasty hub. The Unit is planned to operate in line with GiRFT performance standards which would see delivery of 4 joints per day, at 5 days per week (although weekend working could become an option) over 48 weeks of the year. This would give additional capacity of 960 cases per theatre, a total of 5,760 cases per annum.

The LHP facility will be utilised to undertake both core and additional capacity for CTMUHB and additional capacity for the region. For CTMUHB there are significant efficiencies in co-locating with orthopaedic theatres in terms of improved performance, workforce efficiencies as well as benefits in plant and infrastructure. As a result the three theatres currently providing orthopaedic surgery at Princess of Wales Hospital (POWH) are proposed to transfer to LHP on opening, givinga further 3 theatres for additional regional activity.

Alongside the additional capacity created by LHP, the transfer of primary arthroplasty activity from the current 3 CTM theatres to LHP will enable the further development of sustainable orthopaedic services within the South East Wales Region. Since the roof works completed at Princess of Wales Hospital (POWH), CTM elective orthopaedic activity has transferred to POWH where it is being used as an early implementer site for the LHP pathway. The transfer of this activity to LHP will not only support the delivery of improved efficiencies within the service but will also offer up three theatres capacity to the overarching orthopaedic programme.

The focus on this OBC has been the development of additional capacity for the arthroplasty pathway through the creation of infrastructure to support HVLC primary arthroplasty surgery at LHP. However, the regional orthopaedic plan identifies additional orthopaedic specialities that are also under pressure. In looking at the numbers in table 5 above it is clear that further capacity is required to support treatment pathways for arthroplasty revisions, upper limb, hand and foot and ankle surgery.

From an overall systems viewpoint the capacity released at POWH has the ability to meet this, however it is recognised that a whole systems approach will need to be adopted as to how capacity should be managed and services provided across the region.

How the CTM capacity released through the transfer of arthroplasty to LHP can support further regional reconfiguration for other orthopaedic specialities will be explored in the second phase of the regional orthopaedic plan.

However, it is clear that this is a further beneficial opportunity from the LHP Hub and the centralisation of primary arthroplasty at LHP. The outputs and resources associated with the use of this capacity sit outside the scope of this OBC but will be part of the regional orthopaedics plan.

The benefits in location of the unit should see much improved reduced length of stay for lower limb arthroplasty and an improved patient experience. The proposal would be to offer capacity to regional partners and develop a collaborative model of regional lower limb arthroplasty service delivery.

1.3 Economic Case

Options identification

The purpose of the Options Analysis is to identify and appraise the options for the delivery of project and to recommend the option that is most likely to offer best value for money.

However, in this instance this section will not undertake a traditional options appraisal using the business case framework, which is an approach that has been agreed with colleagues in the Capital and Estates team in Welsh Government (WG).

The reasons for this centre on the fact that on purchase of the site a case for purchase was prepared and resulted in approval of capital funds to enable the same. The funding was made on the condition that CTM collaborated with other NHS organisations to develop the site as part of a regional approach to the delivery of services. Therefore, consideration of alternative site options is not relevant.

The services included at this business case stage are the same as those included in the original case for the purchase of the site, with some small changes to the numbers of the same, in line with demand and capacity modelling provided in Section 3 of this case. In addition, after purchase, regional partners were asked to nominate desired alternative or additional services to be included at LHP; no changes or additions to the scope of services were requested or proposed at this time.

As a result, this section will not consider alternative options for service change with the scope and scale having been proven in the sections above. In addition, following WG approvals, design work has already progressed beyond the traditional stage for an OBC, with WG approval to proceed to RIBA 3 given in December 2024. It should be noted that the current design leaves most of the site's *plateau area* un-developed which could support a further phase of expansion

Finally, a main contractor for completion of the design phase was appointed on 28 March 2025. This appointment was made after a lengthy tender process utilising the Crown Commercial Services Framework under 2 lots to encourage bidders from both pure modular and other off site construction backgrounds to develop the more beneficial construction solution for LHP.

The tender process demonstrated a modular form of MMC was preferred and WG approval to enter into the design contract was received on 14 March 2025. As a result, the build methodology has also been fully determined. Therefore, the economic appraisal in following sections will focus on the preferred option against a business-as-usual comparator only.

Economic appraisal

The results of the economic appraisal demonstrate that the preferred way forward offers value for public money. This option is an NHS-funded capital build for the Orthopaedic Surgical Hub at Llantrisant Health Park, delivering theatres and ward accommodation for high-volume, low-complexity arthroplasty procedures.

Requiring capital investment of £123.6m (including VAT) and ongoing revenue costs of £36.8m p.a. (excluding depreciation), based on estimated costs and benefits, it is anticipated that phase 2 of the LHP will deliver an incremental Net Present Social Value (NPSV) of £500.7m and a Benefit

Cost Ratio (BCR) of 1.54. This represents £1.54 of incremental benefit delivered for every £1.00 of incremental whole life cost, because of the quantifiable benefits that it has been possible to state in monetary values at this point in time, including:

- **High volume, low acuity model of care increasing throughput:** Delivery of the surgical hub will address current regional Arthroplasty capacity shortfalls and ensure future demand can be met. As well as reducing waiting times for patients, the delivery of high volume, low acuity model will enable the delivery of a standardised pathway, increasing throughput and making best use of resources.
- **Improved patient outcomes from earlier access to surgical intervention, reduced length of stay and less healthcare acquired infections:** Reduced length of stay is known to result in fewer complications and support speedier recovery times. This, combined with the reduced waiting times, lead directly to better patient outcomes, specifically improving quality of life for those requiring surgical interventions such as arthroplasties.

In addition to this, there are other quantifiable benefits which it has not yet been possible to state in monetary values given the information that is available at this time. These will be explored further at FBC-stage and, it is expected, will further strengthen the BCR. These include:

- **Productivity gains because of standardised pathways:** In addition to the reduced length of stay and increased throughput, the standardised pathway is likely to provide other opportunities to deliver productivity gains, such as delivering rota efficiencies and enabling more efficient procurement and reduced waste. Predictability of care also reduces the risk of cancellations and Did Not Attends (DNAs).
- **Impact of a more sustainable workforce:** The benefits identified in terms of improved recruitment and retention provide opportunities to reduce the impact of long-term vacancies reducing agency, locum and bank usage and, potentially, reducing recruitment time and costs.

LHP will also deliver various non-financial benefits which while they cannot be quantified in monetary terms are equally important to the delivery of local, regional and national policy. These include:

- **Improved patient experience:** As well as reduced waiting times and length of stay, patient experience is enhanced by the modern fit for purpose facilities and the ease of access the location of LHP offers, with its good road links and parking.
- **Increased staff satisfaction:** The improved training pathway and increased training opportunities, along with the modern fit for purpose facilities and a consolidated service model that enables more effective ways of working, contributes to staff satisfaction and creates an attractive place to work which will support recruitment and retention of highly trained health professionals.
- **Increased training opportunities:** The additional theatre capacity will provide significant opportunities to increase the number of training places available in the region.
- **Increased compliance:** Delivery of orthopaedic services in a hub will ensure alignment with GIRFT principles. Modern fit for purpose facilities that are compliant with WHBNs and HTNs, achieve BREEAM rating of Excellent.
- **Reduced health inequalities:** Reduction in waiting times and ease of access supports equality of access.
- **Community Benefits:** The contractor has agreed to implementing several community benefits, including hiring local, providing volunteering and donations to local organisations, investing in people learning and using Welsh and investing in the local supply chain.
- **Future proofing:** The site also provides a level of future proofing by providing expansion space that offers opportunities for other future developments.

- **Impact of a more sustainable estate:** The delivery of appropriately designed compliant facilities provides opportunities to contribute to CTM UHB's environmentally sustainable goals and national strategies around decarbonisation and optimising energy efficiency. The transformed model of care with its standardised pathway is likely to make it easier to implement and maintain sustainability programmes that CTM UHB has instituted in other areas, such as reducing waste and single use products.
- **Opportunities for future transformation:** The additional capacity offered by LHP provides opportunities to transform and reconfigure core local services and deliver things differently in the future. The successful delivery of a regional centre will also provide proof of concept as the basis for the development of any future regional pathways.

The results of the options appraisal are presented in the table below.

Table 1 - Results of options appraisal

Element	Option 0 - BAU	Option 1 - PWF
Initial capital investment (including VAT)	-	£123.6m
Incremental NPSV	-	£500.7m
Benefit Cost Ratio	-	1.54

It should be noted that this assessment is based on an initial assessment of benefits and further work is required to quantify these more fully. As outlined above, it is anticipated that this is likely to further strengthen the BCR and value for money case as the scheme progresses to FBC stage.

1.4 Commercial Case

To maintain momentum within the programme, the main contractor was appointed during RIBA 3 for continued development of the design and construction elements. This ensures the contractor is involved in the more detailed design incorporating the latest technology and identifying programme opportunities. The appointment was made via the Crown Commercial Services Framework which offered the opportunity to tender for both traditional and modern methods of construction. WG approved the appointment which was made in March 2025.

WG also approved early site wide demolitions in January 2025. These have been delivered by a contractor appointed under the Crown Commercial Framework. Works commenced on 14 April and completed on 6th October within the approved funding level despite a short programme delay.

For the main contract, WG have approved funding for the whole programme up to the end of RIBA 3. From July onwards the programme moved onto a phased basis and funding was split between the phases. After reconsideration of the scope of phase 2 this was instructed to recommence at the beginning of September with fees of £1.9M approved to fund this phase OBC. A further £1.669M fees will be required should the OBC be approved to enable completion of design and preparation of an FBC.

The Contractor tendered design fees will need to be uplifted to support Phase 2 design works. The tender fee assumed a single phase business case process and start on site with phased completions. The move to separate phases with differing design, business case and construction programmes has elongated the design phase. For the 2 main priority phases it has added ca 6 months to the programme. Whilst the uplift will be required for phase 2 it is covered in this case and shown below

Cost element	Original Tender £000	Phase 1 PCSC £000	Phase2 PCSC £000	Total PCSC Fees £000

RIBA 3	400	1,491	1,534	3,025
RIBA 4	3534	1,405	924	2,328
Total	**3,934**	**2,896**	**2,457**	**5,353**
				1,419
				36%

These increases are within procurement permitted levels and have been validated by CTM's Cost Advisors.

A further consequence of the move to separate phases has been the need to consider the construction (ECC) contract approach. Previously a single FBC would have approved the total contract sum for the entire construction period. On a phased basis approvals and funding will be staggered. As a result an options appraisal was undertaken that identified that separate ECC contracts would be entered into for the construction of each phase. This was considered the lowest risk option that delivered compliance with standing financial instructions and procurement regulations as well as reduced overall risk to cost and programme.

Site wide planning permission was granted on 29 September 2025, however this was based on original designs and layout, an amended planning application will need to be made for Phase 2 which will be undertaken between OBC and FBC stages.

1.5 Financial Case

The financial analysis demonstrates that delivery of the preferred way forward is affordable providing that Welsh Government capital funding can be secured, and agreement reached with commissioners about revenue funding requirements.

Capital affordability

The cost plan prepared by CTM's Cost Advisors, based on RIBA 2 design, estimates that delivery of LHP will result in capital investment requirements of £123.6m in total, including expenditure incurred to date. The funding requirement takes account of £1.933M funded to OBC approval:

- Fees to Complete RIBA 3 and 4 and FBC approval £1.669M

Construction - £120.0m.

It should be noted that this remains a forecast cost at this stage and the Board is requested to approve this OBC with this cost as a cost not to be exceeded. Due to the pace at which design has progressed a number of drawings and plans are being finalised which may impact on the final cost. The submitted OBC capital cost will not exceed the cost in this OBC.

Revenue affordability

Work undertaken by the programme team and finance leads indicates that the orthopaedic unit will incur recurring revenue costs of £39.9 million per annum, including:

- Pay costs of £15.0 million for approximately 220 WTE staff
- Non-pay costs of £24.8 million, covering theatre and ward consumables, building running costs, and depreciation of £3.16 million

These indicative costs are based on high level assumptions at this stage and will be firmed up at FBC stage once more detailed information, such as the workforce plan, is available.

£10.46m p.a. of funding has been identified which will partly cover these additional costs which include the following sources:

- £7.3m associated with the substitution of existing services at CTM including transfers of Ward, Theatres, Medical staff and non-pay costs
- Anticipated £3.16m of Welsh Government Central funding for depreciation

This leaves an affordability gap of £29.5 million across the region. Work is underway with partner Health Boards and Welsh Government to develop a sustainable solution that aligns with the regional service model and supports timely access to care. Engagement activity is being coordinated to ensure transparency and shared understanding, drawing on lessons from previous programmes and focusing on collaborative planning to address both financial and operational challenges.

1.6 Management Case

The overall LHP project has been and will continue to be managed to PRINCE2 project management standards with the LHP Project Team leading on delivery. The project governance and reporting structure is outlined in the management case, showing all key workstreams, task and finish groups, with boards and teams where approvals and decisions are made.

A project programme has been developed to control and track the progress and delivery of the project and resulting outcomes. The key milestones for the infrastructure programme are summarised below.

Milestone	Start	Completion
SOC submission and approval	Sept 2024	Sept 2024
OBC submission and approval	Oct 2025	Jan 2026
FBC submission and approval	May 2026	June 2026
Demolition works start	Apr 2025	Oct 2025
PCSA design works:		
RIBA 3 Design	Sept 2025	Dec 2025
RIBA 4 Design	Dec 2025	April 2026
RIBA 5 Design Construction	June 2026	July 2028
Surgical hub construction	June 2026	July 2028
Operational Commissioning	Aug 2028	Oct 2028
Handover of fully commissioned buildings	Nov 2028	Dec 2028

Within the PRINCE 2 governance arrangements the PMO is classed as part of the Assurance function.

Programme

- Review of upcoming programme activity and milestones with LHP Technical PM and Project Director to determine outputs required by workstreams.
- Create lookahead programme highlighting key programme deliverables over coming weeks/months for dissemination to workstreams.
- Track workstream output and performance toward achieving programme deliverables and feed progress into monthly reporting – PMO drumbeat.

Risk

- Review of risk with LHP Technical PM and Project Director to review and update risk register based on workstream risks.
- Track workstream risks and feed into project reporting – PMO drumbeat.

Key Performance Indicators (KPIs)

- Work with LHP Project Director to determine workstream KPIs.
- Track workstream KPIs and feed into project reporting – PMO drumbeat.

Reporting

- Work with PMO governance lead to integrate programme, risk and KPI updates into monthly drumbeat reporting.
- Provide updates to LHP Design Team Meeting and Programme Board.

1.7 Summary recommendation and requirements

The works funded so far have delivered interim mobile capacity on the site alongside the site wide building demolition works. All other work has been focused on the design of the total Health Park to end of RIBA Stage 3 and commencement of RIBA Stage 4 Design Works for Phase 1 CDH and supporting side wide infrastructure.

The recommended option is to. proceed to complete RIBA design stages 3 and 4 and develop an FBC for a regional orthopaedic hub .

Spend so far on this phase only is £1.9MM, all sunk costs have been included in the Phase 1 OBC and FBC. The LHP Programme is seeking urgent approval of this business case and the release of further funding of £1.67M for the RIBA 4 and 5 design stage of the Orthopaedic Surgical Hub to avoid delay to the programme.

Strategic Case

2 Strategic context

2.1 Introduction

This section of the business case outlines the strategic context for the proposals to develop the regional Llantrisant Health Park by explaining how the project is strategically placed to support delivery of services across the three Health Boards in the South East Wales Region, Aneurin Bevan (ABUHB), Cardiff and Vale (CAVUHB) and Cwm Taf Morgannwg (CTMUHB). This section will:

- Provide a summary of the Programme progress to date;
- Provide an overview of the organisations working in partnership to successfully deliver the project;
- Outline how the project will contribute to achieving our business strategies and aims;
- Describe how the project aligns with other relevant local and national strategies;
- Describe the geographical context and local health needs.

2.2 LHP programme context and background

The LHP site was acquired in February 2023 by CTMUHB for £7.8m capital funding provided by Welsh Government. The site is located directly adjacent to the Royal Glamorgan hospital and extends over 20 acres. At the time of purchase the site included two storeys separate buildings totalling over 10,300sqm. The layout of the site already supported car parking for over 299 and separate front and rear access roads to the buildings.

As well as the existing building footprints, there is a further developable area on the site for an additional building. The case for purchase described how the site was ideally suited to provide a high volume low complexity diagnostic and elective treatment centre with benefits for the whole South East Wales region. At the time of purchase the proposed scope of services to be provided at LHP were:

- A **Community Diagnostic Hub** comprising:
  - Diagnostic Imaging – CT, MRI and Ultrasound
  - Regional Endoscopy services
  - Plain Film X Ray
- A **Surgical Hub** comprising:
  - Up to six orthopaedic theatres for high volume low complexity works
  - Up to 54 beds to support the orthopaedic theatres
  - A self-contained day surgery unit containing six theatres

Immediately following the purchase of the site, a design team and internal programme team were appointed to commence site master-planning and design development. During this time, a successful early termination of the lease to the incumbent tenant was agreed giving CTMUHB full access to the site from October 2023. This access facilitated detailed and intrusive survey work to be undertaken which identified several limitations to the existing buildings impacting on their ability for use as healthcare premises.

At their request, a Strategic Overview Document was submitted to Welsh Government in September 2024 which gave a detailed overview of the programme and included a comprehensive option appraisal to identify the optimal way forward for the site infrastructure. The preferred option was the demolition of the existing buildings and replacement with modular buildings which would deliver the quickest and most value for money solution. This can be found in Appendix 1.

This approach was formally considered by Welsh Government alongside the completed RIBA 2 design works at the Infrastructure Investment Board in November 2024.

Following this meeting, approval was given to proceed to RIBA 3 design stage and in January 2025 approval was given to demolish the buildings on the site in a separate advance works package. Demolition works commenced on 14 April 2025 and works completed on 3rd October 2025. The works package was delivered within the funding envelope provided despite a small delay to the programme.

A condition of the approval to continue design work was that a business case was delivered at the completion of the RIBA Stage 3 of the development.

At this point, the programme was continuing under a single business case route but with phased completions, with the CDH completing ahead of the surgical hub. This position changed in July 2025, following a programme assurance review, with confirmation from WG that the programme should proceed under a phased approach with separate business cases for each of the proposed phases of development.

During the review, concerns were raised on the demand and capacity planning and ability to evidence the scope and scale of the proposed Hubs within the programme. This has been addressed for the services contained in the phase 1 OBC and to facilitate this for the orthopaedic activity, expertise from Welsh Government has been provided to develop the demand and capacity modelling with regional partners. However, the move to a phased approach prompted a further review on the scope of each phase. Whilst the CDH is a straightforward stand-alone phase, disaggregating the originally proposed surgical hub into phases was more complex.

Further to this, the orthopaedic demand and capacity has progressed at pace with regional engagement and support and highlights the criticality of increasing orthopaedic capacity. The activity and demand modelling for day surgery modalities has not developed at the same pace. In addition, a day case development would be CTM only. It is recognised that the overriding priority is the increase in diagnostic and orthopaedic capacity and therefore a decision was made to focus phase 2 on the orthopaedic hub only, with the number of theatres required being supported by the regional demand and capacity planning as well as a proposed transfer of CTM orthopaedic activity to LHP to support the realisation of further efficiencies.

The original (pre phasing) design had a surgical hub spread across 2 buildings, 1 containing theatres (day and orthopaedic) and the other containing inpatient facilities for the orthopaedic theatres. To create a standalone orthopaedic hub the RIBA 2 design has had to be revisited architecturally to create a single building with orthopaedic theatres and beds only. Day surgery may be in the scope of a later phase 3 development. However, the regional position has been to support phases 1 and 2 as the programme overriding priorities at this stage.

As a result of the redesign works at this OBC stage for Phase 2 drawings are at signed off RIBA 2 stage. The M&E strategy has required minimal changes but has had to be reviewed. There will be a short RIBA 3 phase before RIBA 4 design takes place following OBC approval.

The revised programme delivery structure is as set below:

- Phase 1: CDH comprising MRI, CT, non-obstetric ultrasound, plain film x-ray capability and endoscopy including a regional endoscopy training centre of excellence. This business case also includes the wider site infrastructure required to facilitate later developments. The OBC was approved in October 2025 with an FBC proposed to be submitted in early December 2025.
- Phase 2: surgical Hub comprising six orthopaedic theatres and supporting wards.
- Potential Phase 3: Scope to be subject to a regional review, could contain up to six-day surgery theatres.

This outline business case has been prepared to seek outline approval for the **Phase 2 – Regional Orthopaedic Arthroplasty Surgical Hub.**

The development of a Regional Elective Orthopaedic Primary Arthroscopy Centre in South East Wales represents a strategic response to the growing demand for minimally invasive orthopaedic procedures, particularly in the context of increasing musculoskeletal morbidity and constrained elective capacity across the region. This proposal aligns with the Welsh Government's *A Healthier Wales* strategy and the NHS Wales *Planned Care Recovery Plan*, which advocate for the transformation of elective services through regional collaboration, innovation, and sustainable models of care.

The LHP site delivers a unique opportunity to develop infrastructure that supports the design of a clinical pathway that incorporates best practice and challenges traditional ways of working. Significant research which looks at both UK and worldwide practice for delivering lower limb arthroplasty has been undertaken by the LHP clinical team and will be discussed in later sections of this case.

2.3 South East Wales regional overview

The South East Wales Region is establishing a Regional Joint Committee. The South-East Wales Regional Joint Committee (RJC) represents an evolution of and step change in the potential for existing partnership arrangements and is a strategic collaboration established by direction of the Cabinet Secretary for Health and Social Care. It more formally brings together Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board to oversee regional planning and service delivery for a catchment population exceeding 1.5 million, noting the service provision of these organisations reaches beyond this. The RJC seeks to transform regional collaboration by providing collective leadership for planning, commissioning, and delivering health services. It focuses on aligning clinical service development with population health needs, addressing service and financial challenges, and reducing unwarranted variation in outcomes and access.

The RJC will operate under four core partnership principles;

- A system-focused partnership aiming for agreed population outcomes
- A system enabler fostering collaboration
- A low-bureaucracy, high-trust environment
- A culture of constructive behaviours.

The RJC has been established to:

(a) Create a step change in the effectiveness of arrangements to collaborate across the regional footprint in the interests of our shared population, marking a change in the way we work collectively as health boards.

(b) Provide collective leadership for the regional planning, commissioning, and delivery of services for the population served by the three health boards, considering the service challenges, financial challenges and population health needs of all three organisations.

(c) Establish a regional approach to the development of clinical services planning, aligned to regional population health needs assessments, to develop and deliver sustainable services in terms of achieving quality and outcome measures, workforce and financial sustainability.

(d) Identifying priorities for the three health boards, where a regional approach will deliver benefit.

(e) Explore how the benefits of a regional health economy are harnessed to best serve the south-east Wales population of over 1.5million.

(f) Reduce unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level.

The RJC builds on the existing regional portfolio currently comprises several programmes: orthopaedics; diagnostics; ophthalmology; stroke; and cancer services. Health Boards in South East Wales have committed to active collaboration when adding value to clinical service delivery, access, and sustainability. Health Board planning teams (joined by clinical, operational, and other colleagues where beneficial) continue to meet on a regular basis to agree common approaches to strategic challenges, progress ongoing regional collaborative programmes, share experience / best practice and to consider future opportunities for closer working to mutual benefit.

2.3.1 Cwm Taf Morgannwg University Health Board

Established in 2009, Cwm Taf Morgannwg University Health Board (previously known as Cwm Taf University Health Board) provides primary, community, hospital and mental health services to the 450,000 people living in the County Boroughs of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf. The Health Board employs approximately 12,000 staff and has an annual budget of approximately £1.3 billion.

CTMUHB's long term strategy, CTM2030: Building Healthier Communities Together has four strategic goals: Improving Care; Creating Health; Sustaining our Future; and Inspiring People. Using population health focused information to drive decision making, the UHB aims to reduce health inequalities, deliver person-centred care and ensure high quality, safe services are sustainable in the future.

Regional working with partners actively supports the UHB's aims and vision, as working together to deliver the changes needed to ensure people living in CTM communities receive safe, good quality services and benefit from advances in treatment and care that will help them to live healthy longer lives.

CTMUHB is located between Wales' capital city Cardiff to the south, the coastal town of Porthcawl to the west, and the Brecon Beacons National Park to the north. Hospital sites include:

- Prince Charles Hospital
- Princess of Wales Hospital
- Royal Glamorgan Hospital
- Ysbyty Cwm Cynon
- Ysbyty Cwm Rhondda
- Ysbyty George Thomas
- Cefn Yr Afon
- Dewi Sant Health Park
- Glanrhyd Hospital
- Pontypridd Cottage Hospital
- Keir Hardy University Health Park
- Maestag Community Hospital
- Merthyr Renal Dialysis Unit
- Pinewood House.

The proposed Llantrisant Health Park is situated close to the Royal Glamorgan Hospital.

2.3.2 Cardiff and Vale University Health Board

CAVUHB is one of the largest NHS organisations in Europe, employing approximately 17,000 staff and spending around £1.4 bn every year on providing health and wellbeing services to a population of around 472,400 people living in Cardiff and the Vale of Glamorgan. The UHB also serves a wider population across South and Mid Wales for a range of specialities.

The UHB is structured and designed into eight Clinical Boards, which cover the four main service areas. The eight Clinical Boards were created in June 2013 and have focussed on providing strong leadership in clinical areas, resulting in the acceleration of operational decision-making, greatly enhancing the outcomes for patients in their care. The Boards are held to account via the Executive Directors, and a process of scrutiny is ensured through monthly performance boards and a robust authorisation process.

Hospital sites include

- University Hospital Wales
- University Hospital Llandough
- Noah's Ark Children's Hospital for Wales
- Barry Hospital
- St David's Hospital
- Hafan y Coed Mental Health Unit
- Cardiff Royal Infirmary
- University Dental Hospital.

CAVUHB's "Shaping Our Future Wellbeing" strategy outlines a long-term vision to improve population health, reduce inequalities, and deliver outstanding care by 2035. Building on the principles of prevention, person-centred care, and integrated services, the strategy sets four strategic objectives: Putting People First; Providing Outstanding Quality; Acting for the Future; and Delivering in the Right Places.

The Health Board aims to shift more services into community settings, enhance digital maturity, and develop modern, flexible facilities that support recovery and sustainability. It emphasises reducing health inequities, improving life expectancy, and ensuring care is accessible, timely, and safe. The strategy also prioritises workforce wellbeing, inclusivity, and the expansion of research and innovation in collaboration with academic and industry partners.

Collaborative regional working aligns directly with this vision, supporting the delivery of high-quality, efficient, and equitable care closer to home. Regional facilities enable the Health Board to help meet rising demand, reducing pressure on its acute hospitals, and contribute to the Health Board's goals of sustainability, digital transformation, and improved patient outcomes.

2.3.3 Aneurin Bevan University Health Board

ABUHB was established in October 2009 and serves the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys.

The UHB employs over 14,000 staff, two thirds of whom are involved in direct patient care and has an annual budget of approximately £1.7bn. There are more than 250 consultants in a total of over 1000 hospital and general practice doctors, 6,000 nurses, midwives, allied professionals and community workers. Hospital sites include acute sites:

- Grange University Hospital
- Royal Gwent Hospital
- Nevill Hall Hospital
- Ysbyty Ystrad Fawr

and a number of community hospitals and facilities, including:

- Rhymney Integrated Health and Social Care Centre
- County Hospital
- St Woolos Hospital
- Chepstow Community Hospital
- Monnow Vale Integrated Health and Social Care Centre.

2.4 National and regional strategies

2.4.1 Strategic fit with national priorities

The proposed LHP orthopaedic arthroplasty hub supports the strategic objectives of NHS Wales by:

- **Reducing waiting times** for elective arthroscopic procedures, thereby improving patient experience and outcomes.
- **Enhancing clinical productivity** through dedicated theatre capacity, streamlined pathways, and standardised protocols.
- **Supporting workforce sustainability** by enabling sub-specialist practice, training opportunities, and improved staff retention.
- **Improving system resilience** by decoupling elective care from emergency pressures and winter surges.

This initiative also complements the *Getting It Right First Time (GIRFT)* programme by embedding evidence-based practice and reducing variation in surgical technique, rehabilitation, and follow-up care.

2.4.2 Population health and value-based care

LHP will contribute to improved population health by addressing unmet need in orthopaedic care, particularly among working-age adults and older populations experiencing functional impairment due to joint pathology. By focusing on value-based outcomes—such as return to function, reduced pain, and patient-reported experience—LHP will support the shift towards prudent healthcare and optimise resource utilisation across the system

LHP will ideally be underpinned by a robust digital infrastructure, enabling real-time data capture, remote pre-operative assessment, and virtual follow-up pathways. Integration with the Welsh Clinical Portal and national PROMs datasets will support continuous improvement and benchmarking. LHP will also act as a testbed for innovation in surgical technique, anaesthesia, and rehabilitation, in partnership with academic and industry stakeholders.

2.4.3 South East Wales Regional Orthopaedic Plan

This sets out a collaborative plan for the South-East Wales (SEW) region to deliver high quality, sustainable orthopaedic services for the population. The plan has been developed through the regional Orthopaedic programme working closely with the LHP programme, national Orthopaedics leads and the NHS Wales Performance and Improvement Unit. It presents a comprehensive assessment for planned orthopaedic services over the next four years, emphasising the optimal use of existing resources and setting out both immediate and long-term strategies. The plan will continue to develop in line with the LHP programme timelines.

The SEW regional orthopaedic plan outlines the region's collective plans to delivering sustainable, high-quality orthopaedic services over the next four years. The plan in this initial phase, focuses on the acute phase of the Orthopaedic pathway and the demand and capacity modelling for the region.

A key component of the long-term vision is the development of a regional primary orthopaedic arthroplasty service at LHP. The plan aims to support the planning for this facility, specifically supporting the requirement for additional capacity to inform this OBC. The key elements / scope of the plan are as follows: -

- Examination and analysis of baseline health board positions of demand and capacity, covering case-mix, complexity, projected demand, waiting list growth and trends

- A focus on theatre and outpatient demand and capacity. Further work to be undertaken throughout the pathway including diagnostics, therapies, pre-operative and post-operative services
- Efficiency measures to optimise existing resource, including gaps, bottlenecks and unwarranted variation, and informed by bench marked examples of best practice
- Short term health board plans to address capacity gaps
- Longer term regional plans, incorporating LHP capacity and future clinical model
- Benefits and risks
- Planning assumptions, including workforce / finance / diagnostics / digital
- Programme governance and delivery including next steps and timescales
- Conclusions, and recommendations.

There are several areas of the plan which will further develop over the next six months to include areas such as detailed pathway, workforce and financial planning. It is anticipated that an updated version of the regional plan will be completed and submitted alongside the regional FBC for Phase 2. The latest version of this document can be found in Appendix 2.

2.5 Alignment with other local and national strategies

Optimisation Frameworks have been developed by the Strategic Programme for Planned Care, as a tool for all UHBs to be able to:

- review planned care specialities that are provided to patients
- identify areas of good practice
- identify areas for improvement across all Clinical Implementation Networks.

The framework is a result of collaboration between the Welsh NHS Executive, UHBs, and the **Getting It Right First Time (GiRFT)** guidance. They have been fully endorsed by Judith Paget, previous Director General of Health and Social Services and NHS Wales Chief Executive, as a comprehensive guide to help UHBs meet the challenges faced within the system.

The framework has been developed in two parts:

- A matrix designed to allow UHB's to score themselves based on maturity (0 – Nothing planned, 1 – Planned, 2 – Early progress, 3 – Results, 4 – Fully mature)
- A handbook that integrates advice, guidance, standard operating procedures, outpatient dashboard data, clinic guides and established pathways.

Both documents were developed by the NHS Executive with guidance from the Clinical Lead of each network and discussed with the wider network group for further feedback and input.

Results produced when using the matrix/handbook will subsequently provide actionable strategies, condition-specific interventions and evidence-based practices, to address the challenges identified. They will also help drive priorities and areas of focus UHBs need to target in future plans, whilst working closely with the Clinical Implementation Network.

Orthopaedics is one of the highest volume specialties and has one of the longest waiting lists. It is one of the first specialties to which GIRFT was applied to help drive efficiency, throughput and cost effectiveness. GIRFT first shone the light on areas for focus and improvement in Orthopaedics in March 2015.

GIRFT identified three key steps to improve quality and productivity for high volume, low complexity (HVLC) surgery, these are:

- separating elective and non-elective surgery
- increasing day case surgery rates
- improving the utilisation of asset such as operating theatres, x-ray equipment and other complex equipment, increasing theatre productivity and creating more efficient care pathways.

The NHS Elective Recovery Plan also includes surgical hubs as a key measure for focusing on high-volume routine surgery to enable a rapid increase in the number of patients can get seen more quickly, ensuring that emergency cases do not disrupt operations and cause cancellations or delays. Surgical hubs will reduce waiting lists; improve patient outcomes create a centre of excellence for clinical excellence and level up patient access and performance.

Despite an independent review by the GiRFT programme in 2014, key recommendations, particularly around increasing and safeguarding elective capacity have not been implemented to date, contributing to ongoing instability across the services in Southeast Wales. Pressures have been further exacerbated since this time by growing demands for urgent / unscheduled orthopaedic care and the impact of the COVID-19 pandemic.

The GIRFT report called for a shift from individual health board planning to a more integrated, regional model, based on common pathways and sharing of best practice. This now forms a key priority for Welsh Government, as reflected within the National Clinical Framework for NHS Wales. A letter from the Cabinet Secretary was received by Health Board Chairs in April 2025, indicating a wish to see accelerated progress in the planning and delivery of healthcare services on a regional level to maintain safety, quality, and sustainability.

2.5.1 National Blueprint for Orthopaedic Surgery Delivery in Wales

A further key informing document for the orthopaedic programme is the National Blueprint for Orthopaedic Surgical Delivery in Wales report that was developed as part of the National Clinical Strategy for Orthopaedic Surgery (NCSOS) in 2022. The report acknowledges that delays in elective orthopaedic care have been a persistent issue for decades, with temporary fixes like waiting list initiatives and private outsourcing masking deeper systemic problems. It concludes that if the current model of orthopaedic service delivery remains unchanged, the national elective orthopaedic backlog is projected to increase by up to 300% over the next five years.

Even with the implementation of mitigation strategies, such as efficiency improvements and service redesign, the backlog is still expected to grow by approximately 59%. This continued growth is attributed to critical systemic constraints, including:

- Inadequate estate infrastructure
- Insufficient ring-fenced elective beds
- Persistent workforce shortages.

These projections underscore the urgent need for a transformational shift in service configuration, capacity planning, and investment to prevent further deterioration in access and outcomes for orthopaedic patients across Wales.

2.5.2 Ministerial Advisory Group on NHS Wales Performance and Productivity

In addition, the report by the external Ministerial Advisory Group (MAG) on NHS Wales Performance and Productivity in April 2025 recommends that all health boards and trusts should take action to improve waiting list management. Prioritisation of available capacity for the longest-wait patients should become a pre-condition for receipt of additional funding from Welsh

Government for elective recovery. The report identified the following key factors driving long waiting times:

- Growth in outpatient referrals
- Uneven adoption of best practice in referral management
- Unwarranted variation in outpatient management
- Poor waiting list management
- Sub-optimal theatre and surgical productivity
- The absence of protected high volume elective surgical capacity
- Sub-optimal use of the independent sector
- Bottle necks, capacity and management issues in diagnostics
- Very high numbers waiting in a few providers.

The MAG report also identified that the individual preparation of IMTPs overlooks opportunities for shared service models even in underperforming areas. An example given is complex arthroplasty, where fragmented planning has contributed to inefficiencies, variability in access, and challenges in maintaining high-quality, sustainable care. A more integrated, regionally coordinated planning process has developed over the past 2-3 years and is essential to address these systemic issues and to ensure equitable, high performing orthopaedic services across Southeast Wales. The MAG report includes greater regional collaboration within its recommendations, and th**e regional orthopaedic** plan **and the LHP Programme are** intended to be a key first step towards addressing this need.

The review furthermore identified workforce productivity and leadership as critical levers for improving NHS Wales performance, as well as the need to align workforce planning with performance goals.

Within the broader strategic People context The National Workforce Implementation Plan for Wales (building on the Welsh Government 'A Healthier Wales: Our Workforce Strategy for Health and Social Care) sets the strategic direction for training, retention, new roles and regional workforce planning with stronger regional workforce levers. The LHP plans to will aim to work to these principles with agile, regional workforce models and better use of digital support to increase workforce capacity and productivity. It is noted that there remains workforce risks due to skills shortages in key areas which requires robust workforce planning

2.5.3 A Healthier Wales: Our Workforce Strategy for Health and Social Care (National Implementation Plan for Wales)

The workforce plan will be underpinned by A Healthier Wales: Our Workforce Strategy for Health and Social Care, which sets out a 10-year vision to create a motivated, engaged, and sustainable workforce, capable of meeting the evolving needs of the population.

The strategy emphasises seven core themes:

- An engaged, motivated and healthy workforce
- Attraction and recruitment
- Seamless workforce models
- Building a digitally ready workforce
- Excellent education and learning
- Leadership and succession
- Workforce supply and shape

The National Implementation Plan translates these ambitions into actionable steps, focusing on filling workforce gaps, improving recruitment and retention, and embedding digital innovation to support service transformation. By aligning with these principles, the initiative contributes directly to the delivery of a flexible and resilient workforce that can adapt to future challenges, including demographic change and increasing service demand.

The approach also reflects wider UK and Welsh Government priorities, including the Well-being of Future Generations (Wales) Act 2015 and the NHS Wales National Workforce Implementation Plan. These frameworks support long-term sustainability, integrated health and social care models, and investment in education and training to address chronic workforce shortages. The Parliamentary Review of Health and Social Care and subsequent A Healthier Wales plan reinforce the need for a seamless system designed around individuals, supported by a skilled workforce prepared for digital transformation and new models of care.

Within the broader strategic People context, The National Workforce Implementation Plan for Wales, sets the strategic direction for training, retention, new roles and regional workforce planning with stronger regional workforce levers. The LHP plans to will aim to work to these principles with agile, regional workforce models and better use of digital support to increase workforce capacity and productivity.

3 Case For Change

3.1 Introduction

This section of the business case establishes the case for change for the development of LHP by providing a clear understanding of:

- The spending objectives (what the proposals seek to achieve)
- Existing arrangements (what is currently happening)
- Business needs (what is required to close the gap between existing arrangements and what is required in the future).

3.2 Spending objectives

The main aim of the project is to deliver a Regional Health Park that is right-sized, to meet the current and future needs of the local population, supports the integration of primary, community and social care services, complies with regulatory standards and is suitable for the delivery of twenty first century healthcare.

The spending objectives listed in the table below were agreed by members at LHP Programme Board in September 2024.

Table 2 - Spending objectives

Ref	Theme	Spending objective	Benefit
SO1	Meet population needs	The delivery of an elective high volume low acuity model of care for the South East Wales Region on a phased basis. This second phase to focus on the delivery of elective orthopaedic arthroplasty, to be operational by the end of the 2028/29 financial year.	• Right-sized to meet current and future demand • Improves access to range of services • Centre of Excellence with efficient service delivery models and improved patient outcomes and increased throughput • Able to flex for the future
SO2	Maximise capacity	To maximise clinical capacity on the LHP site. To ensure that the maximum amount of available space is directed towards direct service delivery with supporting services managed from the neighbouring Royal Glamorgan site.	• Creates opportunities for centralisation of skillsets; centre of excellence • Enables greater collaboration regionally
SO3	Innovation and standardisation	To facilitate and support the use of innovative design and delivery solutions in both clinical and non-clinical services. To implement standardised protocols and practices to promote efficient service delivery offering improved value for money, reported via comprehensive patient level costing, over the English tariff.	• Standardisation of consumables, with financial savings • Standardisation of best practice/policies; efficiencies, increased throughput, reduction of wait lists

Ref	Theme	Spending objective	Benefit
SO4	Enable training / development of future workforce	To enable increased training and development of secondary care staff including accommodating more medical trainees and students.	• Accommodates placements for students (allowing role development and succession planning) • Improved workforce retention and recruitment
SO5	LHP Models of Care and Workforce Models	To develop a new model of care and workforce models to support the delivery of the core services, the models will support efficient delivery of services	• Environment / ways of working that support staff welfare and wellbeing • Improved skills and job satisfaction • Improved patient outcomes • Multi-disciplinary working
SO6	Sustainable estate	To deliver a sustainable infrastructure on the site maximising decarbonisation and net zero opportunities.	• Complies with relevant standards; NZC, BREEAM excellent and energy performance • Opportunities for future additional service provision for South East Wales. • Opportunities for further regional reconfiguration and enabling of service and or estate rationalisation.

3.3 Business need

The vision is to create a standalone site for high volume low complexity arthroplasty surgery that guarantees uninterrupted, effective, efficient services, which address both current capacity shortfalls and offers opportunity to meet future demand growth.

The need to significantly increase treatment capacity in Wales was set out in the Welsh Government Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales which was published in April 2022.

The plan set a clear direction for UHBs to recover the backlog of elective activity that has developed during the COVID-19 pandemic as well as responding to the increasing demand for surgical services due to demographic change and the challenge of health inequalities evident in many parts of Wales.

The plan has five main goals, which are underpinned by seven priorities to support and influence recovery planning and investment decisions as set out below.

Figure 1 - Welsh Government programme for Transforming and Modernising Planned Care Goals and Priorities

The seven priorities are:

1. **Transformation of outpatients**
2. **Prioritisation of diagnostic services**
3. **Focus on early diagnosis and treatment of suspected cancer patients**
4. **Implementing a fair and equitable approach to patient prioritisation to minimise health inequalities**
5. **Elimination of long waits at all stages of the pathway**
6. **Building sustainable planned care capacity across the care pathway**
7. **Provision of appropriate information and support to people**

The LHP programme aligns with planned care recovery programmes across with the region in the development of long-term additional capacity to support the delivery of efficient and effective solutions to support all three UHBs to eliminate long waits and reduce overall waits within the patient pathway, both in terms of access to orthopaedic services as well as in diagnostics.

The ability to create bespoke capacity, to maximise patient flow and increase efficiency and innovation in service delivery, offers additional benefits to the region from investment in the programme, including:

- standardisation of patient pathways and clinical practices which should increase efficiency and improve patient outcomes
- consolidation of services on LHP which will release space on existing sites and act as a key enabler for future regional reconfiguration and transformation
- an opportunity to standardise procurements thus achieving greater revenue savings on high volume items.

3.4 Clinical evidence and policies underpinning LHP, including Getting it Right First Time

The vision is for LHP to be an exemplar regional facility providing an elective orthopaedic primary arthroplasty hub (EAH),.

Surgical hubs are an important part of plans to increase surgical capacity and to offer hundreds of thousands more patients' quicker access to some of the most common procedures. Hubs focus mainly on providing 'high volume low complexity' (HVLC) surgery with particular emphasis on ophthalmology, general surgery, trauma and orthopaedics, gynaecology, ear nose and throat, and urology.

They bring together skills and expertise of staff under one roof – reducing waiting times for some of the most common procedures such as day surgeries and hip replacements. These operations can be performed quickly and effectively in one place.

3.4.1 What defines a HVLC hub?

- Exclusively perform elective surgery, avoiding emergency disruptions
- Operate with ring-fenced theatres, beds, and staff, ensuring continuity and infection control
- Has embedded – or is working towards – the principles of 6-day operating, 48 weeks per year, 2.5 session days and 85% theatre utilisation
- By separating elective care from emergency services, hubs reduce cancellations, improve patient flow, and support faster recovery.

3.4.2 Benefits of this approach

Improving quality and efficiency will mean patients have shorter waits for surgery, will be more likely to go home on the same day, and will be less likely to need additional treatment after surgery. As the hubs are separated from emergency services, surgical beds are kept free for patients waiting for planned operations, reducing the risk of short-notice cancellations due to other emergency admissions taking priority.

GiRFT identifies the **key benefits** as:

- More efficient use of theatre capacity and increased throughput
- Increased resilience against winter pressures
- Streamlined pathways and shorter length of stay
- Application of innovative, more sustainable workforce
- Reduced pressure on staff and improving morale, recruitment and retention.

The model being developed for LHP is consistent with the model recommended by GIRFT and the British Orthopaedic Association (BOA) and in Line with and Royal College of Surgeons (RSC) practices adopted widely across England.

The intention is to create a centre of excellence for planned HVLC elective primary arthroplasty surgery, delivering productivity and quality of care for patients that consistently meets best practice and delivers optimum value.

LHP will build on the learning from the South West London Elective Orthopaedic Centre (SWLEOC) , Exeter, Colchester and Oswestry elective orthopaedic centres (EOC) and Elective surgical hubs in Kidderminster and Emerson Green. The design has been focused on ensuring good flow in a timely manner to reduce wasted time and improve patient experience.

LHP will be fit for the future. It is designed using evidence from a range of sources from GIRFT and the BOA to the National Joint Registry, and other professional bodies. There will be sufficient capacity to meet current and future demand resulting in timely access to services for patients.

Following an assessment of various models, the chosen approach will support the region in meeting the collaboration's goals, addressing the capacity gap, and ensuring all facilities meet GIRFT standards and are accredited for HVLC surgery. The proposed clinical model includes a dedicated building, fully separate from any acute care facilities. The Arthroplasty unit will be completely ring-fenced to meet GIRFT and BOA requirements for an orthopaedic hub.

The potential benefits for patients include:

- Faster access (due to sufficient capacity)
- Equitable access
- Consistent and best practice care in a centre of excellence
- Better clinical outcomes
- Improved preoperative care
- Shorter length of inpatient stay
- Dedicated facilities and reduced likelihood of cancellation
- Dedicated, specialist post-operative care and service
- Increased investment due to potential savings from repatriation from out of sector.

3.4.3 Evidence supporting best practice

The GIRFT vision is for ‘cold’ elective surgical hubs, offering ring-fenced beds and ultra clean air theatres for orthopaedics, thus delivering evidence-based best practice in relation to protection against infection. Standardisation of care ensures the highest levels of productivity and value for money. This proposal is compatible with best practice recommendations from GIRFT, as shown, and is supported by the National Director of Clinical Improvement for the NHS and the Planned Care programme.

Since July 2023, GIRFT has been working with a group of 25 NHS trusts in England on a ‘Further Faster’ pilot, bringing together teams of highly engaged clinicians and operational colleagues with the challenge of collectively going further and faster to reduce 52-week waits. The specialties supported by this programme align with all those that are to be delivered within LHP. GIRFT have evidenced that HVLC in stand-alone, dedicated units deliver many benefits and transformation of day case pathways.

Data from the pilot shows that from October to mid-November 2023 the total 52-week backlog for all participating trusts reduced from 93.2% to 84.4% (by 9.8%), in comparison with a reduction among all other trusts from 105.5% to 103.9% (1.6%). This equates to a 19.5% difference in total backlog reductions between the pilot group and all other trusts since the Further Faster programme began. LHP will allow the adoption of the HVLC pathways for surgical hubs.

Table 3 - GIRFT best practice recommendations for elective orthopaedics

Theme	GIRFT comment	Meets best practice?
Ring-fenced beds	Best practice is rigidly to enforce ring-fencing of elective orthopaedics minimises infection.	✓
Hot and cold sites	By separating "hot" unplanned emergency work from their "cold" elective work, NHS organisations have seen reductions in average length of stay, reductions in cancellations of surgery and increased elective activity during winter pressures.	✓
Minimum volumes	Surgeons should perform 35 or more total hip replacements per year to avoid increased complication rates. LHP will support surgeons delivering high volume arthroplasty.	✓
Choice of implant	Surgeons should follow the evidence that choice of implant should be tailored to the patient need. Best practice is that 80% of patients over 70 should receive a cemented hip.	✓
Surgical site infection (SSI)	Variation in SSI rates were found when GIRFT started their visits. Ring-fencing, hot/cold sites and laminar flow are key factors in reducing infections.	✓
Rehabilitation services	Particularly relating to increased physiotherapy service for elective patients.	✓
Procurement	Variable implant costs and use of loan kits has been tackled through improved visibility and price negotiations.	✓

To support Wales in establishing an elective optimisation programme, Health Boards are required to focus on improving theatre efficiency and adopting HVLC and GIRFT pathways. It is vital that UHBs achieve 85% theatre utilisation, meet productivity measures, and maximise day case opportunities. Key objectives include reducing inpatient admissions, minimising cancellations, and ensuring patients are fit for surgery before scheduling. LHP is a driver to supporting these changes. The dedicated surgical Hubs in England have driven improvements and standardisation into the secondary care facilities. The case for change has been widely accepted and is in line with the drivers for change identified as:

- Growing demand and increasing waiting times
- Population health challenges, including large health inequalities
- Underperformance against key quality indicators, wide variations in quality and disruption to planned care caused by surges in unplanned car
- Insufficiently joined-up care across primary, community and acute services and care that is not sufficiently focused on the needs of the patient
- Unwarranted variations in theatre utilisation and downtime
- Staff recruitment and retention challenges.

As part of the strategic ambition, GIRFT Surgical Hub Accreditation will be sought for LHP shortly after opening. Securing this accreditation would not only affirm the quality and consistency of the elective care services but also develop LHP's reputation as a high-performing surgical hub within the national landscape.

Throughout the development and implementation phases of the LHP programme, the LHP team has have proactively engaged with the GIRFT Surgical Hub Accreditation team. This collaboration has informed the approach to service design, ensuring that the LHP infrastructure, workforce model, clinical pathways, and operating model are aligned with the standards required to achieve accreditation. This approach ensures maximum preparation for future assessment and recognition under the GIRFT framework.

Collaborative working regionally and nationally will continue to be vital as the team work towards delivery of the LHP alongside other priorities in our South East Wales Regional Portfolio.

All the progress on the primary arthroplasty pathway to date has been developed across the region with good clinical engagement. This has been informed by best practice and learning from other exemplar facilities, both positive and negative experiences.

One of the main actions from the Trauma and Orthopaedic Surgery Ministerial Summit December 2024 was that the Regional Orthopaedic Programmes reconfigure into Operational Delivery Networks/Groups (NW, SEW, SWW) working within the overarching WON, underpinned by the National Clinical Strategy for Orthopaedic Surgery. This aligns with the National Clinical Framework. The ODGs will establish processes to ensure implementation of regional working.

The establishment of surgical hubs delivering HVLC activity is not only endorsed by GiRFT, but it also forms and integral part of the orthopaedic strategic outline plan for Wales and the Orthopaedic Improvement Network (CIN). The Orthopaedic CIN is working towards ensuring adequate ring-fenced ward capacity for delivering elective arthroplasty surgery, as this is seen as essential to the delivery to reduce waiting times. Surgical hubs bring benefits to all day surgery specialties as well as orthopaedic arthroplasty.

British Orthopaedic Association (BOA) guidance: Delivering a Safe Elective Orthopaedic Environment

The British Orthopaedic Association (BOA) has published clear standards for providing a continuous, safe elective orthopaedic environment, particularly in the context of increasing demand and system pressures. These standards are designed to ensure consistent, high-quality care for patients undergoing planned orthopaedic procedures, including joint replacements.

Central to BOA guidance is the principle of ring-fencing both the physical and operational separation of elective orthopaedic services from emergency care. This includes dedicated beds, theatres, and staff exclusively for clean orthopaedic procedures. BOA also recommends:

- Defined facilities that exclusively accept appropriate orthopaedic patients
- Standard Operating Procedures (SOPs) for screening, decolonisation, and infection control
- Individual rooms for patients with infection risks
- Governance protocols to maintain the integrity of the ring-fenced environment, including escalation policies and executive oversight.

The proposed elective surgical hub at LHP has been designed in full alignment with BOA guidance. By embedding BOA principles into its design and operations, LHP will provide a resilient, high-quality environment for elective orthopaedic surgery.

Development of the LHP Clinical Model – external studies to inform best practice

The LHP Arthroplasty Unit has been developed through a comprehensive, evidence-based process that draws on best practice from across the United Kingdom and Internationally. The ambition has been to create a clinical and operational model that delivers high-quality, efficient, and patient-centred care, supported by infrastructure that enables and enhances patient experience and clinical excellence. To achieve this, the LHP team have undertaken a wide-ranging programme of research and engagement, including:

- Site visits to exemplar units such as South West London Elective Orthopaedic Centre (SWLEOC), University Hospital Dorset NHS Foundation Trust (UHD), One Welbeck, East Suffolk and Essex Elective Orthopaedic Centre (ESEOC), and South West Ambulatory Orthopaedic Centre (SWAOC), each offering valuable insights into different aspects of orthopaedic service delivery, innovation and best practice

- Participation in regional and national networks, including the South East Wales Regional Orthopaedic Programme, Orthopaedic and Anaesthetic Clinical Implementation Networks (CINs), and the National Planned Care Programme, which helped ensure alignment with local and national programmes
- Multidisciplinary workshops and workstreams, which enabled collaborative design of pathways, protocols, and infrastructure specifications for LHP
- Targeted consultations on key operational and clinical components, such as theatre and anaesthetic room design, staggered admissions and preoperative health screening questionnaires.

Each of these engagements has contributed to shaping a model that is both innovative and evidence based. For example, the visit to SWLEOC highlighted the benefits of staggered admissions and ring-fenced elective capacity, which has been incorporated into the LHP model. At UHD, the team explored their infrastructure, including barn theatres, ultimately deciding against this model in favour of a more traditional layout that better supports clinical workflows, patient privacy standards and resilience. One Welbeck highlighted the need for standardisation of room space and importance of smart use of space and materials.

These insights, along with many others, have directly influenced the design and delivery of the unit at LHP. The infrastructure has been purposefully developed to support the clinical model, ensuring optimal patient flow, efficient use of resources, and optimal outcomes

Table 4 - Engagement undertaken so far

Visits	Meetings	Workshops	Regional workstreams	Consultations
• Poole • SWLEOC • SWAOC • One Welbeck • ESEOC.	• SEW Regional Orthopaedic Board • Orthopaedic CIN • Anaesthetic CIN • National Planned Care Program.	• SEW Regional Orthopaedic programme workshops. • LHP Arthroplasty Pathway Development Workshop.	• Arthroplasty • Anaesthetic • Therapies.	• Staggered admission • Regional Health Screening questionnaire. • Arthroplasty development.

One Welbeck

In the initial phases of the LHP development, a team of senior clinicians, infrastructure, operational, digital and programme management representatives visited One Welbeck, one of the UK's largest and most advanced specialist outpatient healthcare centres. Located in central London, One Welbeck is an excellent example of modern, patient-centred approach to diagnostics, treatment, and day case surgery. The centre was built in an existing building, in-line with our initial plan to repurpose the existing British Airways buildings on the LHP site.

The facility is purpose built to deliver high quality, consultant led care across more than 14 specialties, including cardiology, gastroenterology, orthopaedics, ENT and dermatology.

Key features of One Welbeck that informed the development of model include:

- Co-location of outpatient and diagnostic facilities whereby patients can receive consultation, diagnostics, and results within the same day, streamlining the care journey and reducing delays
- Use of advanced digital infrastructure for imaging, diagnostics, and patient engagement, supporting both clinical and operational efficiency

- The environment is designed to be welcoming, with a strong emphasis on comfort, privacy and efficiency
- Outpatient spaces are standardised which supports efficiency, reducing variation, and enabling flexible use across specialties
- While the facility is highly efficient, the visit highlighted the operational challenges posed by insufficient clinical storage. This highlighted the importance of incorporating adequate, accessible storage solutions in our own infrastructure planning.

The visit provided valuable insights into how infrastructure, clinical design, and operational processes can be aligned to deliver efficient, high-quality care. The learning has directly influenced the LHP model, particularly in the areas of pathway integration, digital enablement, and infrastructure design.

University Hospitals Dorset NHS Foundation Trust

University Hospitals Dorset NHS Foundation Trust (UHD) was established in October 2020 following the merger of Poole Hospital, the Royal Bournemouth Hospital, and Christchurch Hospital. Located on the south coast of England, the Trust serves a diverse population of over 800,000 people across Bournemouth, Poole, Christchurch, east Dorset, Purbeck, and parts of the New Forest and South Wiltshire. With more than 9,000 staff, UHD provides a wide range of acute and specialist services, including cancer care, cardiology, trauma, and orthopaedics.

Poole Hospital, one of the Trust's three main sites, is a long established acute general hospital and the designated trauma unit for east Dorset, serving a population of approximately 500,000 people.

As part of UHD's strategic transformation programme, Poole Hospital is being developed into the region's major planned care hospital, focusing on elective procedures, and protected from emergency pressures. A key component of this transformation is the recent opening of a surgical hub, which includes five-storey extension housing eight new operating theatres. Among these is an open plan 'barn' theatre, designed to improve surgical efficiency, enhance teamwork, and reduce waiting times for elective orthopaedic procedures.

A team comprising clinicians, infrastructure programme leads, architects, and estates colleagues attended Poole Hospital to explore this new facility and gain insights into its design, functionality, and potential impact on elective care delivery.

The primary aim of the visit was to explore their implementation of barn theatres and understand the practical implications of operating in an open plan surgical environment. Key focus was on how the team maintained patient dignity despite the lack of physical barriers between operating spaces. Through thoughtful design and workflow management, they ensured privacy and comfort for patients throughout their surgical journey.

The LHP team gained valuable insight into how infection control risks were managed between patients in a shared space. The hosts demonstrated clear protocols and practices that mitigated cross-contamination. Similarly, radiation safety precautions specific to barn operating theatres were taken when X-ray imaging was used, ensuring both patient and staff safety.

Theatre etiquette was another area of learning, particularly around managing noise levels and the use of music. The team had established norms that balanced a positive working atmosphere with professionalism and respect for individual choice around the provision of music or not, with the default position being no music.

The barn theatre layout also offered significant benefits in terms of supervision and training. Trainees across all disciplines were more easily observed and supported, enhancing the learning environment. Working in an open-plan space also enabled teams to support one another more readily, improving communication and responsiveness.

However, the visit also highlighted several operational challenges. Servicing individual ventilation units was complex, and any maintenance work had the potential to disrupt multiple theatres. Accessing a specific theatre for maintenance during operating hours was particularly difficult, and the environmental impact was notable since all four ventilation units had to run continuously to maintain airflow, unlike traditional theatres which can be set back when not in use.

These insights were instrumental in informing the options appraisal for theatre architecture. While the LHP Programme ultimately chose to pursue a traditional theatre design, this decision making was significantly strengthened by the lived experience and practical knowledge shared by the Poole team.

Beyond the barn theatre insights, the visit highlighted the importance of adequate storage. Clear corridors free from clutter were essential for safety and efficiency, and this observation directly influenced the storage space allocation strategy across LHP.

South West Ambulatory Orthopaedic Centre (SWAOC)

SWAOC is a specialist elective surgical hub located at the NHS Nightingale Hospital Exeter, part of the Royal Devon University Healthcare NHS Foundation Trust. Originally established in 2020 as part of the national response to the COVID-19 pandemic, the Nightingale Exeter was one of several temporary hospitals designed to provide additional capacity for treating patients with coronavirus. Following its decommissioning as a COVID-19 facility, the site was repurposed into an elective care centre to help address the growing backlog of planned procedures across the South West. SWAOC officially opened in March 2022 and has since become a GIRFT-accredited surgical hub, recognised nationally for its innovative clinical pathways, excellent outcomes and patient satisfaction.

The centre features two operating theatres dedicated to day case and short stay orthopaedic procedures, including hip, knee, foot, ankle, and spinal surgery. It serves patients from across Devon, Cornwall, Somerset, and the wider South West region, supporting multiple NHS Trusts including Royal Devon, Torbay and South Devon, and Somerset Foundation Trusts.

The transformation of the Nightingale Exeter into SWAOC was a collaborative effort involving clinicians, infrastructure programme leads, architects, and estates teams. The redesign focused on delivering high-volume, efficient, elective orthopaedic care, with a strong emphasis on same day discharge and enhanced recovery protocols. The centre has achieved excellent outcomes, including same day discharge for almost all joint replacements, and has been instrumental in reducing waiting times for patients with musculoskeletal conditions.

Visits were arranged based on a personal recommendation from Professor Tim Briggs. Teams comprising of Health Board Executives, clinicians, operational managers infrastructure programme leads, architects, and estates colleagues attended the site to observe the facility and understand its operational model and design principles. The history of the site and its development, along with the key principles, made this directly comparable to the development of LHP.

Key elements of learning included:

- Centralising elective orthopaedic procedures for patients with lower clinical complexity in a dedicated hub to protect planned care from emergency pressures.
- Designing facilities around patient flow and surgical efficiency.
  - Admissions area where patients remain in their own clothes until 15 minutes before theatre.
  - Anaesthetic and prep rooms to improve theatre turnaround times.
  - Plain film X-ray room between recovery and the ward area.
  - Patient trolleys, suitable for an overnight stay, to reinforce the ambulatory model.
  - Colocation of therapies space to maximise the physiotherapy time spent with each patient.

    - Limited provision of television and radio and visiting to allow patients to concentrate on their recovery.
- Innovative staffing models.
    - Float anaesthetist
    - Nurse competencies
- Catering
    - Food available 24hrs a day.
    - Patients given a drink in recovery and encouraged to eat as soon as they return to the ward.
    - All members of staff take responsibility to offer and prepare food- this could be the nurse, physiotherapist, surgeon or anaesthetist.
- Standardised clinical pathways.
- Regional collaboration
    - Spread of improvement from SWAOC back to base hospitals.
- Patient experience
    - Willingness to travel to access high quality, timely care.
    - Acceptance of limited visiting, allowing patients to focus on recovery and discharge.
    - Patients prepared for same day discharge.
    - Competition and encouragement between patients to recover and go home.
    - Patients supported to be discharged home as soon as they are safe and ready to do so.
    - No cut-off time for discharge if is safe and supported.
- Home alone protocol to support patients, who may not have anybody else at home, to be discharged on the day of surgery.

The visits to SWAOC provided valuable insights that have directly shaped both the clinical model and physical infrastructure of the LHP elective orthopaedic hub. Central to their approach was the focus on HVLC patients in a dedicated surgical environment, effectively shielding planned care from emergency pressures. Much of this model has been adopted at LHP.

Facilities have been purposefully designed to support patient flow and surgical efficiency. For example, the LHP admissions area is close to theatre and allows patients to remain in their own clothes until shortly before surgery, promoting comfort, helping maintain body temperature and reducing anxiety. Anaesthetic and preparation rooms have been included to improve theatre turnaround times, and a plain film X-ray room has been positioned between recovery and the ward to streamline the postoperative check x-ray process. Patient trolleys suitable for overnight stays reinforce the ambulatory care model, and therapies spaces have been co-located to maximise the efficiency of the physiotherapy input. There is also a limited entertainment and visiting provision to help patients focus on recovery during a shortened length of stay.

Staffing models have been influenced by SWAOC's innovations, including the use of a float anaesthetist and enhanced nurse competencies to support flexible, efficient care. Catering has been designed to be available 24/7, with all staff empowered to offer and prepare food, encouraging a shared responsibility for patient wellbeing.

Standardised clinical pathways and regional collaboration are embedded in the LHP approach, ensuring consistency and enabling the spread of best practice. Patient experience remains central, with clear preparation for same-day discharge, flexible discharge times, and protocols such as "home alone" to support patients without immediate home support. These elements, drawn from SWAOC's successful model, have helped build a service at LHP that is both clinically robust and patient centred.

South West London Elective Orthopaedic Centre (SWLEOC)

Located on the Epsom General Hospital campus is one of the UK's most high-performing centres for planned orthopaedic surgery. Established in 2004 as part of a government initiative to reduce waiting times, SWLEOC operates as a standalone, ring-fenced surgical hub, in partnership with four NHS trusts: Epsom and St Helier, St George's, Croydon, and Kingston. SWLEOC is recognised as the largest joint replacement centre in the UK, and among the largest in Europe, performing over 6,300 procedures annually, including approximately 4,300 joint replacements. The centre comprises of 6 dedicated operating theatres and 72 inpatient beds. A multidisciplinary workforce including 43 consultant orthopaedic surgeons, nurses, physiotherapists, anaesthetists, and administrative staff.

The visiting clinical and operational team engaged with SWLEOC to understand the principles and practices that underpin its success, informing the development of a regional elective hub at LHP.

SWLEOC has a robust clinical and operational model focused on HVLC surgery supported by efficient scheduling and digital solutions. In contrast to many other stand-alone elective orthopaedic units, SWLEOC exclusion criteria is limited to patients requiring renal dialysis (a medical treatment that removes waste, toxins, and excess fluid from the blood when the kidneys are no longer able to do so effectively). The team is capable of managing patients with higher clinical needs, such as advanced airway management, cardiovascular support, or post-operative monitoring beyond standard ward care. To support this, the immediate post-operative ward is staffed by nurses with critical care experience, and 24/7 medical cover is provided by intensive care consultant doctors. On the surface, this approach may seem resource heavy, however, the team at SWLEOC have found that care delivered directly by senior doctors has reduced the time taken to make decisions and begin treatment which reduces recovery time and length of stay which ultimately reduces cost over a traditional staffing model.

SWLEOC's reputation for clinical excellence, patient outcomes, and operational efficiency has made it a national exemplar. In collaboration with the GIRFT programme, SWLEOC developed the Elective Hub Toolkit, a comprehensive online resource that distils two decades of learning into practical guidance for NHS teams. The toolkit covers every aspect of hub design and delivery, including patient pathways, staffing models, estate planning, IT systems, and governance structures. The key elements of the toolkit have been used to inform and guide the development if the clinical and operational model for LHP.

Essex and Suffolk Elective Orthopaedic Centre (ESEOC)

ESEOC is one of the UK's largest modular-built elective orthopaedic centres, spanning approximately 11,000 square metres. It serves patients across Suffolk and North East Essex, with capacity to treat around 10,000 patients per year. Completed in November 2024, it is one of the largest elective arthroplasty units in Europe. The centre includes 8 operating theatres with 72 inpatient beds. The unit has a focus on planned elective orthopaedic surgery, however, there some provision for planned trauma.

ESEOC serves a broadly similar regional population and geographical footprint to LHP, with both being designed to support elective care pathways for combined populations of multiple NHS organisations, making it directly comparable.

Key learning points include:

- The modular build enabled rapid deployment and scalability
- Clear strategic separation of elective and emergency care ("cold" vs "hot" sites) was essential to protect capacity
- Ringfencing elective beds with strong executive support helped maintain throughput
- Standardised pathways were embedded across all specialties (hip, knee, shoulder), with visual displays in public and staff areas to reinforce consistency

- Transparent use of data (e.g., dashboards on theatre utilisation and case throughput) supported performance improvement and accountability
- Governance structures included system wide MDTs and robust clinical oversight
- ESEOC achieved low length of stay (THR – 2.0 days; TKR – 1.9 days)
- Pre-assessment capacity was highlighted as critical, with a recommendation to operate at 115% of theatre capacity (GIRFT guidance)
- Challenges included delays in opening extended recovery areas and standardising processes across trusts
- A strong emphasis on building a unified team culture across clinical and operational staff
- High staff retention was supported by wellbeing initiatives and rest facilities
- The centre functioned as a high-volume training hub, addressing post-COVID training gaps
- All patients were treated without exclusion, with provision for enhanced care beds to support more complex cases
- The model promoted equity of access and reduced variation in care delivery.

The visit to ESEOC validated many of the principles already embedded within the LHP model. From this visit the team has established peer-to-peer links, enabling frontline teams to engage directly with ESEOC to learn from their experience. The concept of an enhanced care area, as demonstrated by ESEOC, has been instrumental in shaping infrastructure planning, allowing the accommodation of a broader cohort of patients safely and efficiently.

The LHP team were particularly interested in ESEOC's approach to displaying the clinical pathway throughout both clinical and public spaces. This has now been adopted as part of the LHP model implementation at Princess of Wales Hospital, making the pathway accessible to all clinical teams and encouraging patient engagement.

Together, these insights have strengthened confidence in the LHP model at the same time as validating many of the infrastructure decisions made to date. It clearly highlighted the benefits of a standardised approach to elective arthroplasty care, MDT engagement and regional collaboration. Patients within a directly comparable population have demonstrated a clear willingness to travel reasonable distances to access high quality elective care, particularly when the environment is purpose-built, efficient, and designed around their needs.

The following concepts for orthopaedics development are based on the learning from the research, visits and conversations with the GIRFT assessors, in collaboration with regional clinical colleagues:

- Arthroplasty moves to a day surgery model and pathway. There will be the facility for patients stay overnight by exception
- The design of the facility will challenge today's practice and people's traditional way of working. This will be achieved through the new unit and would be transformational for the region on changing how HVLC services are delivered
- Standardised approach and agreed principles for the unit to be followed by all.

Alongside this, there are several key supporting principles, embedded in the process around the surgical hub, to challenge performance and ensure efficiency and throughput is maximised. LHP will be different from existing models under these principles:

- Clinical pathways and supporting infrastructure will be designed to meet GIRFT Surgical Hub accreditation, including flexibility to support future innovation
- Supporting physical infrastructure is comfortable but will not encourage unnecessary overnight stays

- Planning for zero-day length of stay as default
- All aspects of clinical pathways will be standardised
- Productivity to meet or exceed GiRFT guidelines
- Ring-fenced unit and staff.
- Regular, job-planned, consultant sessions delivered at LHP
- Whole MDT team approach, competency frameworks to support staff working across traditional role boundaries
- Stand-alone unit- satellite site of the Royal Glamorgan for logistics only.

The delivery of these principles will be driven by focused clinical groups. These will be attended and led by clinical staff with a clinical project team in place to support. The architect and design team will be embedded within this clinical team and regional engagement will also be secured on an ongoing basis.

It is critical that throughout the design process the teams continue to engage with and learn from exemplar units from across the UK and further afield to support the development of forward thinking and innovative clinical pathways feeding into the physical infrastructure. The protocols developed alongside this will be clinically developed and support standardisation, innovation and patient safety with senior clinical MDT sign off throughout.

3.5 Growing demand for services and existing arrangements

Current service provision for the region is delivered for each of the health boards' populations within each health board's geographic footprint. Alongside this, patients from each health board currently access services delivered by other health boards as part of agreed patient flows for specific service pathways. Additional capacity is delivered through a range of means including internal additional capacity using NHS clinicians (commonly referred to as waiting list initiatives or backfill) and in-sourcing.

All regional partners are seeing shortfalls in capacity year on year with demand growth. The situation has been described as comprising "persistent orthopaedic backlogs projected to grow by up to 300% without intervention".

Considering these demand levels, the three health boards committed to developing a collaborative regional orthopaedic plan to deliver high quality and sustainable orthopaedic services for the region. The plan will develop sub speciality wide demand and capacity modelling and specifically consider the position in relation to regional primary arthroplasty services.

LHP is a key component of the long-term regional vision for orthopaedics. One of the aims of the plan is to support the planning for the LHP hub, specifically around supporting the requirement for additional capacity contained in later sections of the business case. The full text of the plan is included as Appendix 2 to this case. The first phase of the plan was presented to regional Boards in September 2025.

The plan recognises that lower limb primary arthroplasty is the most pressured orthopaedic sub speciality accounting for 50% of activity with annual demand exceeding available capacity. The following table sets out projected demand growth over the next few years. This is modelled on both 1% and 4% growth which reflects the range of growth observed in the region over the past 2-3 years.

Table 5 – Projected Orthopaedic demand growth (by UHB and region)

Sub specs	Aneurin Bevan			Cardiff and Vale		
	Recurrent demand IP24/25	Demand in 28/29·		Recurrent demand IP24/25	Demand in 28/29·	
		1% growth	4% growth		1% growth	4% growth
FA	1,057	1,099	1,226	368	383	427
Paeds		0	0	324	337	376
Upper Limb	700	728	812	321	334	372
Hands	1,150	1,196	1,334	1,172	1,219	1,360
Lower Limb	1,397	1,453	1,621	1,615	1,680	1,873
Spine	947	985	1,099	529	550	614
Other		0	0	0	0	0
Total	**5,251**	**5,461**	**6,091**	**4,329**	**4,502**	**5,022**
Arthroplasty	*922*	959	*1,070*	*1,244*	*1,293*	*1,443*

Sub specs	Cwm Taf Morganwwg			South-east Wales		
	Recurrent demand IP24/25	Demand in 28/29·		Recurrent demand IP24/25	Demand in 28/29·	
		1% growth	4% growth		1% growth	4% growth
FA	205	213	238	1,630	1,695	1,891
Paeds	34	35	39	358	372	415
Upper Limb	479	498	556	1,500	1,560	1,740
Hands	548	570	636	2,870	2,985	3.329
Lower Limb	1,883	1,958	2,184	4,895	5,091	5,678
Spine		0	0	1,476	1,535	1,712
Other	274	285	318	274	285	318
Total	**3,423**	**3,560**	**3,971**	**13,003**	**13,523**	**15,083**
Arthroplasty	*1,412*	*1,469*	*1,638*	*3,578*	*3,721*	*4,150*

Recurrent demand tor IP/DC without conversation from OP non-recurrent demand

The table illustrates that recurrent demand for orthopaedic treatments remains high, with lower limb arthroplasty driving demand. The conversion of new outpatients further increases the challenge. With additional outpatient activity being delivered in year, levels of treatment demand will also increase. Should growth be closer to the upper limit then treatment requirements will rise sharply in lower limb which risks RTT compliance and achievement of targets without structural capacity expansion.

3.6 Proposed patient pathways and clinical engagement

3.6.1 Inpatient Elective Orthopaedics at LHP

The South East Wales Regional Orthopaedic Programme had been leading on the development of the clinical model and clinical specification for the elective inpatient orthopaedic unit. More recently, this aspect is being taken forward by the LHP Programme with review and discussion via the regional group.

The current plans include the theatres will be on the first floor, with arthroplasty wards on the ground floor. They will be split into two wards; one will be recovery containing trolleys for patients to be discharged on the day of surgery or within 24 hours. Any patient needing to stay more than one night will be transferred to the single ensuite rooms on Ward 2.

The bed modelling assumes 20% patients to be discharged on the day of their surgery. For those not discharged on the day the 80% will be discharged after only one-night stay. It is proposed that the maximum stay will be three days. Through the preparatory work on the pathway, it is expected that the number of patients being discharged on *day zero* will improve by the opening of LHP. As a comparator the current CTM performance is just short of three-day ALOS. However recently the perfect month initiative was undertaken which put in place a range of support for post operative surgery such as co located physiotherapy, standard discharge drugs packages. This reduced the average length of stay to just 1.5 days giving confidence in this delivery model which is the same as that proposed for LHP based on learning from sites such as Exeter Nightingale Hospital.

This layout and design builds on much of the learning from both Exeter and SWELEOC (South West London elective orthopaedic Centre). CTMUHB have recently reorganised the delivery of arthroplasty to be primarily at Princess of Wales, where an arthroplasty hub on a single site has been developed as a pre cursor to the opening of LHP. The clinical model developed for LHP is being utilised at this arthroplasty hub. Three theatres will be ringfenced to provide this activity and this ringfenced activity has been incorporated into the LHP theatre modelling. The resource and activity will transfer directly into LHP on opening. There are elements of the LHP pathway that are related to the design and infrastructure and can't easily be achieved in existing buildings. The delivery of the clinical model is under regular review and amendments made if required. On the opening of LHP, the staff transferring will be very familiar with the LHP clinical model.

The bed base of 54 has been modelled on the expected length of stay and number of operating theatres. To ensure the facility does not have an excess of beds the exemplar sites visited have a very similar proportion of beds per theatre, this has supported the number for LHP.

3.7 Demand and capacity modelling for SEW

3.7.1 Demand and capacity background

As mentioned in earlier sections, to support decision making around clinical capacity and delivery of operational services the regional demand and capacity modelling of orthopaedics has been analysed to support planning for future services. Within this the planning, a focus on arthroplasty services has been prioritised to support the right sizing of LHP and ensure it can meet both current and future demand.

The work has been led by the Regional Orthopaedic Plan Project board working alongside Andrew Sallows from Welsh Government to produce the first phase of the regional orthopaedic plan for South East Wales. The outputs from the final plan will focus on the overall orthopaedics position in South East Wales, however to date the focus has been on the arthroplasty position, to support the development of the LHP business cases. The current version of the plan is included as Appendix 2 to this business case.

The current plan has been expressed as the first version only, with a further iteration to be developed in line with the FBC plan over the next six months. Further development on the detailed pathway, finance and workforce planning continues at pace. The second iteration of the plan will be developed for production to Boards in the Spring 2026 in line with the Phase 2 FBC.

For the purposes of this business case, arthroplasty will be the main focus and some of the key findings from the D&C assessment include:

- Lower limb arthroplasty is the most pressured subspecialty, accounting for ~50% of activity. Recurrent outpatient demand exceeds capacity by ~2,000 patients annually

- Significant gaps particularly in lower limb arthroplasty and other subspecialties, with projections showing demand growth of 1–4% annually through 2028/29
- Efficiency improvements alone are insufficient to close these gaps without additional capacity investment. Even with efficiency gains, the region cannot meet 26-week outpatient targets by March 2026 and projected treatment gaps could reach 5,334 cases by 2029.

There are several key assumptions within the regional orthopaedics plan, including recognition that existing services must demonstrate efficient and effective service delivery before the submission of a full business case for additional capacity. Benchmarking against national efficiency standards and metrics therefore forms a key element of the plan over the next four years.

Health Boards were asked to identify local opportunities to increase capacity and address remaining gaps in the interim period prior to the programmed LHP operational date in late autumn 2028. Each Health Board needed to identify their efficiency and productivity plans and ensure these are included in the modelling of future demand and capacity. Several options have been considered which include increasing core in house capacity, outsourcing and temporary additional session.

These plans are included in the later scenario planning and represent the scale of opportunity that could be delivered by each health board against current activity delivered to achieve optimum output. They reflect current practice and do not consider standardised utilisation of theatres i.e. 47 weeks a year across the region or an increase in clinical session allocation or additional clinicians for Orthopaedics. These plans are explored in detail for each organisation in Appendix 2.

3.7.2 Capacity scenarios modelled

The modelling looked at both outpatient and treatment demand and capacity. For the purposes of this case only the treatment position will be discussed, but the outpatient impact can be seen in the appendix. Outpatient capacity plans are to be determined locally by each Health Board and are outside the scope of this case.

Four capacity scenarios have been considered in the modelling (1) current core capacity, (2a) core plus local efficiency practices, (2b) core plus local efficiency and best practice standards, and (3) including the additional Welsh Government-commissioned activity. All scenarios considered the activity required to meet **recurrent demand** and additional data was collected to ensure the following maximum waiting time scenarios were considered: -

- Recurrent demand and backlog to 104 weeks
- Recurrent demand and backlog to 78 weeks
- Recurrent demand and backlog to 52 weeks.

Some of the key assumptions in modelling works are as set out below:

- Recurrent demand has been calculated using derived demand, which was agreed by all regional boards and is based on financial year to financial year (24/25 to 25/26: 1 April 24 to 31 March 26.
- Each Health board has calculated the split between Lower Limb and Arthroplasty. Arthroplasty refers to Primary Arthroplasty only; revisions appear in the Lower Limb NOT arthroplasty numbers.
- Conversion rates from New Outpatients to IPDC Treatments were modelled using local data and reflect the current position in each health board independently. Any conversions from activity within this year will not be observed in the demand on IP/DC Treatments in this Financial Year (realised in FY 26/27 and beyond).

- Welsh Government commissioned activity in FY2025/26 has been included in scenario 3 and has been apportioned by subspecialty based on local plans.
- Assumptions and data consistency reflect the best possible position at the current time.

3.7.3 The net capacity and demand position

The overarching orthopaedics demand and capacity position is as set out in the table below to give an overview of the total regional challenge facing orthopaedics.

Table 6 - Future demand / capacity gaps for orthopaedics across the South East Wales region

Type	Current gap / surplus (2025/26)			Projected 2028/29 -position				
	New OP	Treatment	Tx w new OP conversion (40% assm)	Treatment / surplus gap if		Efficiency oppor-tunity	Recurrent net treatment gap / surplus (Mar 29) if	
				Demand @ 1% to 29	Demand @ 4% to 29		Demand @ 1%	Demand @ 4%
Foot / ankle	-422	-83	-252	-371	-728	98	-273	-630
Paeds	-211	-17	-101	-140	-255	16	-124	-239
Upper limb	487	81	81	-21	-326	125	104	-201
Hands	-394	-616	-774	-965	-1,538	209	-756	1,329
Lower limb	-2,278	-250	-1,161	-1,544	-2,691	1,148	-396	-1,543
Spine	1,074	-595	-595	-708	-1,047	44	-664	-1,003
Other	-198	-254	-333	-347	-390	0	-347	-390

The left-hand (blue) side of the table above considers the current capacity gap position and applies a standard 40% conversion to treatment rate for the outpatient gap, to ensure the treatment position reflects the recurrent requirement, not just the current demand profile.

The right-hand (pink) side of the table factors in the projected demand growth (at both 1% and 4%) as well as subtracting the treatment efficiency opportunity identified by Health Boards as scenario B discussed above. The table assumes that all opportunities are delivered to provide a range in treatment gap, as at March 2029.

The table does not consider the additional backlog activity required to deliver improved waiting time targets. Therefore, this would just support the current waiting time position with an improvement in performance.

This table shows that all subspecialties are facing pressure with the most significant shortfall in treatment capacity within lower limb arthroplasty. This, alongside the GiRFT guidance, Orthopaedic CIN works and evidence from practice in England provides compelling evidence for LHP to create additional capacity in regional arthroplasty to bridge these gaps and provide an opportunity for further regional orthopaedic reconfiguration for other specialities.

The net position can be further broken down by region, the following table includes information for the orthopaedic lower limb speciality alone. This further illustrates the pressures that all organisations are or will be facing in treatment times by 2029.

Table 7 – Regional orthopaedic lower limb activity

Organisation	Gap / surplus (2025/26)			Treatment gap / surplus if		Efficiency opportunity	Recurrent net treatment gap / surplus (Mar 29) if	
	New OP	Treatment	Tx w new OP conversion (40% assm)	Demand @ 1% to 29	Demand @ 4% to 29		Demand @ 1%	Demand @ 4%
ABUHB	-1,032	128	-285	-414	-800	261	-153	-539
CAVUHB	-247	166	67	-52	-409	294	242	-115
CTMUHB	-1,000	-544	-944	-1,079	-1,482	593	-486	-889
SEW region	-2,278	-250	-1,161	-1,544	-2,691	1,148	-396	-1,543

In essence the recurrent arthroplasty gap assuming 100% of all efficiency opportunities are released sits between 396 and 1,543 cases per year. On a five-year trajectory, looking at the first five years of LHP operation demand could increase to the following range:

Table 8 – Orthopaedic lower limb forecast increase in activity (to 2034)

Organisation	Recurrent net treatment gap / surplus @ Mar 2029		Recurrent net treatment gap from 2030 for five years based on differing demand (%) growth									
			2030		2031		2032		2033		2034	
	@ 1% demand	@ 4% demand	@ 1%	@ 4%	@ 1%	@ 4%	@ 1%	@ 4%	@ 1%	@ 4%	@ 1%	@ 4%
ABUHB	-153	-539	-155	-561	-156	-583	-158	-606	-159	-631	-161	-656
CAVUHB	**242**	**-115**	244	-120	247	-124	249	-129	252	-135	254	-140
CTMUHB	-486	-889	-491	-925	-496	-962	-501	-1,000	-506	-1,040	-511	-1,082
SEW region	-396	**-1,543**	-400	-1,605	**-404**	-1,669	-408	-1,736	**-412**	-1,805	**-416**	**-1,877**

By 2034 it is possible that capacity shortfalls could exceed 1,800 cases. It is difficult to accurately reflect exact demand levels. Alongside this is the assumption that delivery of all efficiency and performance improvements will be achieved. If only 50% of these improvements are delivered this will add a further 500+ treatments to the existing gap per annum.

The proposal for LHP would be the building of six theatres to support regional primary arthroplasty cases. The plan is that three theatres would represent a transfer of activity of CTM arthroplasty into LHP. The balance of three theatres would be available capacity to meet regional demand.

LHP theatre productivity is based on GiRFT guidelines and utilisation, reflecting four joints per day over 5 days in a 48-week year. Initially the hub is proposed to operate five days per week giving the following additional capacity in terms of cases over a single, three and all six theatres.

Table 9 - LHP theatre capacity

No. theatres	Joints per day	Days per week	Week per year	Total capacity
1	4	5	48	**9,60**
3	12	5	48	**2,880**
6	24	5	48	**5,760**

Currently all the modelling is predicated on a five-days week. Should additional capacity be required it would be possible to consider weekend working, which could offer a further annual additional 384 cases per theatre (2,304 for all six theatres). However, length of stay improvements would need to be delivered to ensure that bed capacity could support additional weekend working. The streamlined and efficient workflow and standardisation of practice from LHP is expected to deliver performance efficiencies, and this could be an option in future years.

In considering how LHP will provide additional capacity to support the regional position in the future, the 4% growth position has been forecast forward in all modelling scenarios. In addition, only an 80% efficiency opportunity is recognised, reflecting the current pressures on performance faced by all organisations across the region. It is likely that with the standardisation and practices at LHP these efficiencies could be improved in the future.

The table below models the first five years of LHP opening, offering three theatres of additional capacity for the region based on current performance levels.

Table 10 - 5 Year demand and capacity modelling and impact of LHP capacity on net gap

Organisation	Recurrent net gap based on average demand growth at 4%				
	March 2029	March 2030	March 2031	March 2032	March 2033
ABUHB	-346	-355	-364	-373	-382
CAVUHB	64	65	67	68	70
CTMUHB	-688	-705	-722	-740	-759
SEW Region	**-970**	**-994**	**-1,019**	**-1,044**	**-1,070**
20% efficiency gap	-230	-230	-230	-230	-230
Forecast Capacity Gap	**-1,199**	**-1,223**	**-1,248**	**-1,274**	**-1,300**
LHP Capacity	2,880	2,880	2,880	2,880	2,880
Net Capacity Gain	**1,681**	**1,657**	**1,632**	**1,606**	**1,580**

As modelled above, the LHP capacity will provide the additional capacity to support the region to bridge the recurrent treatment gap for primary arthroplasty and offer additional capacity of over 1000 cases in the first five years. This additional capacity can be directed to address any residual waiting patients and offer an opportunity to begin to improve performance over and above the current baseline levels.

Should growth be less than the 4% modelled additional capacity could offer further performance improvements and likewise should all performance efficiencies be realised this could provide additional primary arthroplasty capacity to the region to improve the performance position further.

Alongside the additional capacity created by LHP, the transfer of primary arthroplasty activity from CTM theatres to LHP will enable the further development of sustainable orthopaedic services within the South East Wales Region. As mentioned in previous sections, since the roof works completed at POWH, CTM arthroplasty activity has transferred to POWH where it is being used as an early implementer site for the LHP pathway. The transfer of this activity to LHP will not only support the delivery of improved efficiencies within the service but will also offer up three theatres capacity to the overarching orthopaedic programme.

The focus on this OBC has been the development of additional capacity for the arthroplasty pathway through the creation of infrastructure to support HVLC primary arthroplasty surgery at LHP. However, the regional orthopaedic plan identifies additional orthopaedic specialities that are also under pressure. In looking at the numbers in table 5 above it is clear that further capacity is required to support treatment pathways for arthroplasty revisions, upper limb, hand and foot and ankle surgery.

From an overall systems viewpoint the capacity released at POWH has the ability to meet this, however it is recognised that a whole systems approach will need to be adopted as to how capacity should be managed and services provided across the region.

How the CTM capacity released through the transfer of arthroplasty to LHP can support further regional reconfiguration for other orthopaedic specialities will be explored in the second phase of the regional orthopaedic plan.

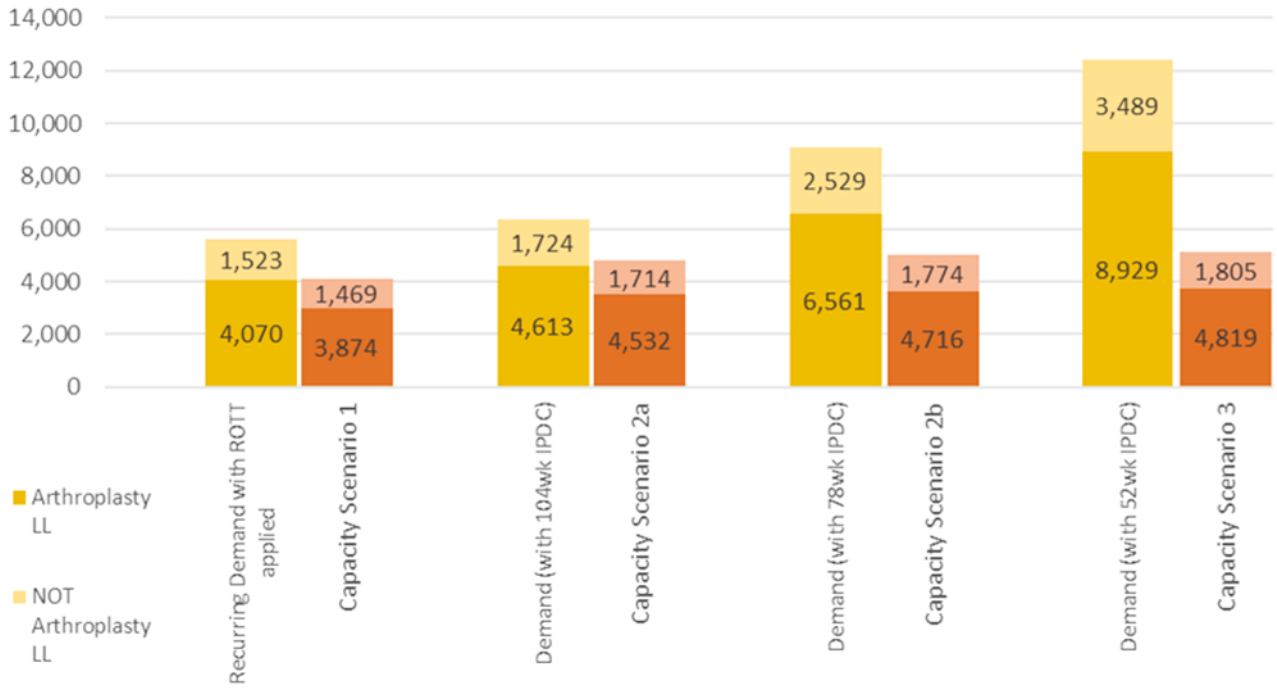
However, it is clear that this is a further beneficial opportunity from the LHP Hub and the centralisation of primary arthroplasty at LHP. The outputs and resources associated with the use of this capacity sit outside the scope of this OBC but will be part of the regional orthopaedics plan.

3.7.4 Lower limb / arthroplasty demand and capacity required to deliver performance improvements

The orthopaedic plan workings have considered the level of capacity required to deliver reduced backlog scenarios (52-week, 36-week, 26-week) which further increase the challenge.

The following charts illustrate the additional demand and capacity required to meet further reduced backlog scenarios. Arthroplasty activity is seen using the darker shading on the chart below

Figure 2 - SEW lower limb IPDC treatment, demand v capacity



Baseline treatment demand for lower limb arthroplasty 5,593 cases (1,523 non-arthroplasty and 4,070 arthroplasty). This shows that to improve performance to deliver 52 weeks would increase annual demand to 8,929 cases per annum. Assuming organisations can deliver all efficiency improvements within existing infrastructure this still gives a 4,110-case shortfall. LHP can support in addressing that shortfall, but more than 3 theatres would be required to fully meet unless weekend working is employed. Factoring in growth could see this increasing further.

LHP core capacity as outlined above will increase capacity further to meet enable the delivery of improvement performance. At 2029 demand levels LHP capacity could see backlog reductions to close to 78 weeks

Further capacity realised through increased efficiency gains at LHP and weekend working could further improve the backlog position by enabling more realisation of capacity for arthroplasty procedures.

3.7.5 Summary

The demand and capacity analysis clearly demonstrate shortfalls in capacity across the region. In order to address capacity challenges, it is essential that existing facilities are maximised before consideration of investment in additional assets.

The regional demand and capacity modelling identify capacity shortfalls across the region with lower limb primary arthroplasty demonstrating the most pressure and the highest contributor to the overall numbers. Once growth is factored in this gap intensifies despite plans to introduce local performance increases and improvements.

There is a net capacity gap that requires additional infrastructure to support the creation of a 6-theatre unit at LHP. This will provide a sustainable response to the pressures facing arthroplasty in the South East Wales Region, enabling the capacity gap to begin to be closed and deliver performance improvements and increased backlog reduction.

The demand and capacity modelling supports the proposal for a 6-theatre unit at LHP offering both an opportunity to create a unit which can fully deliver on efficiencies to offer improved performance and throughputs. The combination of transferred CTM capacity and wider regional additionality gives a chance for a fully established unit to deliver primary arthroplasty in line with accepted best practice and evidenced good practice in other units.

The infrastructure offers the opportunity of further increased capacity through extended days and working weekends to address further future growth.

Whilst LHP is designed to address regional primary arthroplasty activity only, the move of activity from CTM theatres can facilitate and support further orthopaedic speciality reconfiguration and offer increased capacity to enable improved delivery across the region. The resource implications of these further regional reconfigurations and moves are not covered in this OBC but will be addressed in the second phase of the orthopaedic plan.

4 Potential scope of services

This section of the business case identifies the potential scope of the project in terms of the key service requirements that should be considered in designing the future service model and developing options.

4.1 Key principles of the clinical model

(See Appendix 3 for Arthroplasty pathway and Appendix 4 for the LHP Operational and Clinical Model)

Patient pathways and length of stay

- Target day-case arthroplasty where clinically appropriate, with a maximum expected stay of three nights.
- Initial planning assumes a modest 20% day-case rate, with ongoing efforts to increase this in line with GIRFT standards.
- Clear inclusion criteria to guide patient selection, including plans for patient with a higher acuity through the provision enhanced care.
- Patient education embedded pre-operatively to set expectations, including digital “Joint School” programmes.
- Ring fenced elective capacity with dedicated theatres and beds

Staffing and workforce model

Staff operating at the top of their license, including side-skilling and blended roles (e.g., Band 4 staff supporting ward and recovery functions).

- Multi-professional team approach incorporating nursing, physiotherapy, and allied health professionals (AHPs) in clinical care.
- Consultants sharing care responsibilities to avoid extended on-site presence, with structured review of X-rays and post-operative follow-up by colleagues.
- Out of hours cover provision will require a medical model if enhanced care is provided.

Pre-operative and admission processes

- National standardisation of pre-assessment processes, including health questionnaires and virtual reviews.
- Staggered admission times to manage patient flow within the six admission rooms.
- Digital check-in supported by administrative staff for patient registration and discharge coordination.
- Consent clinics scheduled at least two weeks pre-operatively, ideally with digital consent solutions.

Theatre and recovery model

- Theatre scheduling in line with GIRFT case numbers, four joints per theatre per day, based on two hours per procedure. The theatres will operate Monday to Friday (Future capacity is available through extended days and weekend working)

- Assumption: three of the theatres will be CTM activity moved from Princess of Wales, and three theatres will be additional activity
- Six laminar-flow theatres with supporting infrastructure.
- Recovery staffing designed for efficiency: Stage 1 (post-anaesthesia monitoring) and Stage 2 (patients ready for ward transfer).
- Upskilled Band 4 staff in theatre to facilitate rapid turnover and first assistant roles.
- Senior anaesthetists providing list cover, utilising standardised protocols.
- Duty anaesthetist providing cross cover for breaks, relieving anaesthetists to review next patients, and supporting post-operative care.

Ward and post-operative care

- Two ward areas.
- Integrated plain film X-ray room adjacent to recovery for immediate post-operative imaging.
- Standardised discharge protocols including medications, Venous thromboembolism (VTE) prophylaxis, follow-up pathways, and 24-hour helpline support.
- Planned operating hours: Monday–Friday, 08:00–17:00, with scope to extend as required.
- Staff working across wards and admission areas and recovery, building in flexibility to meet operational requirements.
- Workflow optimised for throughput and minimal delays, ensuring separation from unplanned acute care.
- Enhanced competency framework to support early mobilisation outside of therapies working hours.

Future flexibility has been built in, having taken the lessons from other centres, where to fulfil capacity in the longer term, pathways for patients with a higher acuity have been incorporated into the facility. For LHP, the infrastructure of the 30 bedded ward has 8 beds that can manage those patients needing a higher level of care and can facilitate a post-operative care unit (POCU). Acceptance criteria will be enhanced to allow several the higher acuity patients to be treated at LHP in the future as required. The ward staff being skilled in all aspects of post-operative care and management will ensure there are the skills through a competency framework to deliver this

Standardisation and quality

- Alignment with GIRFT recommendations for case numbers per list, throughput, and enhanced recovery protocols.
- Standardised protocols for post-operative care, including early mobilisation and therapy-led discharge.
- Regional engagement ensures consistency of care pathways, patient education, and data collection (e.g., National Joint Registry compliance).
- Continuous learning from exemplar units incorporated into staffing models, patient flow, and operational efficiency.

As detailed in section 3.7, the arthroplasty unit at LHP will be utilised to undertake both core and additional capacity for CTMUHB and additional capacity for CAVUHB and ABUHB. This reconfiguration is not just about capacity however, but the opportunity to introduce greater standardisation and efficiency into clinical practices and develop a centre of excellence in Wales.

4.2 The Non Clinical and Clinical support models

4.2.1 Therapies support at LHP

Therapy services will play a pivotal role in supporting the regional arthroplasty surgical hub. The intention is to ensure those patients requiring occupational therapy input, receive this prior to admission to LHP. Early engagement enables timely provision of equipment, education on post-surgical expectations, and goal-setting that supports enhanced recovery pathways, reducing length of stay and minimising readmission risk.

This pre-admission discharge planning enables early action, optimisation, equipment provision and highlights the potential need for post-discharge social care input and multidisciplinary problem solving to minimise any potential barrier or delay in discharge. This ensures the patient is admitted to the right facility as not all patients will be suitable to have their treatment at. This service will aim to deliver a modernised approach to elective orthopaedic recovery and evidence-based care, with service provision being individualised based on patient need

Physiotherapy will be an integral component of the ward team within the orthopaedic surgical hub. The service will be delivered through a structured, patient-centred model. Post-operatively, physiotherapists will be embedded within the ward team to provide early mobilisation, functional assessments, and discharge planning, ensuring patients meet recovery milestones efficiently. Being integrated with surgical and nursing teams has proven benefits and supports enhanced recovery pathways, reduced length of stay, and minimises variation in outcomes, thereby contributing to improved patient experience and operational efficiency across the region.

The rostered hours for Physiotherapy will be aligned with the ward nursing team This enables a joint multidisciplinary handover in the morning and maximises the ability to discharge patients who are ready to go home, in the evening. Another benefit is that it promotes integrated, multi-professional team working. the hours staff members spend on tasks varies based on service need and non-clinical time which will be built within their role.

4.2.2 HSDU

To accommodate the proposed increase in surgical activity, a review of current HSDU infrastructure and capacity has been undertaken. The RGH site presents limitations due to spatial constraints, with no scope to install additional washers or sterilisers under the current configuration. Furthermore, the existing washer units are scheduled for replacement in March 2028. PCH will be non-operational until approximately Q1 2028 due to major capital works, placing additional pressure on RGH, which will be required to absorb PCH's workload during this period.

In contrast, the POW site is undergoing an AHU upgrade and will soon operate with seven washers and four steam sterilisers—significantly more than the three sterilisers currently available at both RGH and PCH. This enhanced capacity at POW presents a viable opportunity to support the increased demand, subject to appropriate transport logistics and the deployment of delegated drivers. Collaborative working with POW staff is already in place, as evidenced by the AHU relocation project at RGH, and has proven effective. From a service resilience perspective, preliminary work has commenced on an Operational Continuity Plan (OCP), making this expansion both timely and strategically aligned.

In terms of workforce requirements, to support 12 arthroplasty procedures per day across three theatres, the HSDU would require a minimum of three full-time equivalent (FTE) Technical Assistants to manage end-to-end processing, with an additional supervisory FTE to cover out-of-hours activity. A more detailed staffing model would be developed in line with theatre scheduling, including consideration of twilight shifts to support evening operating lists.

Outsourcing options have been explored with ABUHB to mitigate the overlap between PCH and POW, but they are unable to provide a thorough assessment of risks relating to equipment damage, turnaround times, traceability, decontamination standards, and accreditation implications,

as well as financial impact. At this point this has been excluded as the HSDU within CTMUHB with the planned improvements will have the capacity, subject to investment in workforce and surgical trays /instruments to provide the requirements for the additional three operating theatres These projections are based on the current service delivery model and remain flexible to accommodate any future changes in theatre planning.

4.2.3 Pharmacy

Pharmacy services at CTMUHB are undergoing a series of targeted developments to ensure readiness for the elective arthroplasty unit opening in late 2028. A hub and spoke model will be adopted for medication supply, with a DGH site (yet to be decided) acting as the central supply point for wards, theatre, and recovery areas. This is part of a wider transformation piece already underway for pharmacy services across CTMUHB, and as such, will be tried and tested prior to commissioning of LHP. LHP will, in essence, become an additional spoke site of the CTMUHB hub and spoke model.

The introduction of a new robotic dispensing system at RGH will streamline stock distribution to LHP, while automated dispensing cabinets (ADCs) linked to the pharmacy system will support automatic top-up ordering, reduce manual workload and improve stock availability. The procurement of the new robotic dispensing unit is well underway and will be installed and operational ahead of the commissioning of LHP.

To support efficient patient flow and safe medicines management, a Pharmacy Hub will be established at LHP for near patient dispensing of discharge medications. This will enable pre-dispensing of standardised discharge regimens using pre-packed medicines and controlled drugs, ensuring timely availability postoperatively. The implementation of electronic prescribing and medicines administration (ePMA) will allow for regular and discharge medications to be prescribed in advance of admission, facilitating early discharge planning and reducing delays. Again, the ePMA programme within CTMUHB is underway and will have matured by LHP go-live.

Clinical service enhancements will further support seamless care. Pharmacy technicians will conduct pre-operative reviews for patients with complex medication needs, such as compliance aids or care packages, reducing the risk of cancellations and or delayed discharges. Pharmacist prescribers will review patients in pre-operative assessment and pre-authorise medication regimens, including discharge prescriptions. A business case (CTMUHB) is also in development for a pharmacist-led anticoagulation bridging service for complex patients, ensuring continuity of care and reducing reliance on acute services.

4.3 Infrastructure design influenced by clinical model

The development of the clinical model for the new elective orthopaedic unit at LHP builds upon national best practice, including GIRFT standards, exemplar UK orthopaedic units, and Enhanced Recovery After Surgery (ERAS) protocols. The approach has focused on learning from leading units such as Essex and Suffolk Elective Orthopaedic Centre (ESEOC), Exeter South West Elective Orthopaedic Centre (SWEOC), One Welbeck, South West London Elective Orthopaedic Centre (SWLEOC), and others. Taking the best elements and adapting their proven models to the to meet the operational requirements of LHP and the regional population needs. The infrastructure has then been developed to deliver the clinical model ensuring compliance with National standards.

The infrastructure development for LHP has been purposefully designed to support the clinical model for HVLC elective orthopaedic surgery, ensuring alignment with GIRFT productivity benchmarks and delivering a safe, efficient, and patient-centred experience. A dedicated entrance for the surgical hub enables streamlined patient flow and ring-fenced nature of the service.

Upon arrival, patients use a digital self-check-in system, which reduces administrative delays and provides real-time updates to the admissions team, enhancing operational efficiency and patient experience.

Patient preparation rooms are located directly adjacent to six ultra-clean air theatres, each equipped with dedicated anaesthetic and prep rooms. This proximity supports continuous forward movement through the pathway, minimises inter-case times, and enables parallel processing of patients. The first stage recovery area has been innovatively designed to accommodate the initial wave of morning admissions, increasing capacity without expanding the estate footprint and improving turnaround times. A dedicated plain film X-ray suite positioned between recovery and the ward facilitates timely postoperative imaging, streamlining the pathway.

The ward infrastructure is designed for flexibility and infection control. Ward 1 includes 30 patient spaces split across male and female wings, with six individual rooms to support gender segregation in line with NHS England guidance and to accommodate patients requiring privacy or isolation. Ward 2 comprises 24 individual rooms, offering maximum protection in the event of a patient becoming infective. Both wards include dedicated physiotherapy spaces to maximise therapy input and support early mobilisation, a key enabler of same day discharge and a core component of the HVLC model.

Break-out and discharge areas encourage patients to mobilise and provide transitional space for those awaiting discharge, improving patient flow and creating capacity for incoming admissions. Interview rooms have been incorporated to ensure privacy for sensitive clinical conversations with patients and relatives, and double as staff training and development spaces when not in clinical use. Learning from site visits to exemplar centres, the team recognised the critical importance of adequate storage. Many high performing hubs reported challenges due to insufficient storage, resulting in equipment being stored in corridors, creating health, safety, fire, and infection control risks.

Anticipating future developments in orthopaedic practice, including the introduction of robotic surgery and other advanced technologies, LHP has incorporated HBN compliant storage capacity with an additional 20% buffer. This ensures that equipment can be safely and efficiently stored, supporting both current operations and future service expansion. In line with national guidance, separate left and right prosthesis stores have also been included to reduce the risk of error, improve inventory management, and support safe surgical practice.

Staff experience has been a central priority in the design of the unit at LHP, recognising that a well-supported workforce is essential to delivering high quality, efficient patient care. As part of a site wide strategy, infrastructure includes male, female, and individual changing rooms to offer staff choice, privacy, and dignity. This approach supports inclusivity and ensures that all staff feel comfortable and respected in their working environment, which is particularly important in a multidisciplinary and diverse workforce. To support infection control and operational efficiency, scrub suit dispensing machines have been installed. These machines ensure staff have access to the correct size garments, reduce waste, and improve stock control through automated inventory tracking. They also enhance hygiene by securely storing scrubs and preventing cross contamination.

Clog washers have also been included to support infection prevention. These specialist machines allow for the automated cleaning and thermal disinfection of surgical footwear, ensuring that clogs do not become a vector for hospital acquired infections. Autoclavable clogs processed through these washers meet the highest hygiene standards, reducing the risk of cross-contamination.

The unit features a dedicated staff entrance, which improves flow and security, allowing staff to access the facility efficiently without crossing patient pathways. This separation supports infection control and reinforces the ring-fenced nature of the elective hub. Staff rest areas have been designed with natural light, which has been shown to improve wellbeing.

To enable staff to focus fully on clinical work during operating sessions, meeting spaces have been intentionally excluded from the clinical zone. Instead, two-person work pods are available for completing mandatory training, confidential conversations, or supervision discussions. These pods offer quiet, private environments without disrupting clinical flow. Additional hot desking space is provided to support flexible working and documentation needs, and a dedicated office is available for the department manager to coordinate operations and support the team.

A surgeon's touchdown space is located between theatres, offering a quiet area for debriefing trainees or completing operation notes without needing to leave the immediate theatre area. This design choice improves efficiency, supports education, and ensures that clinical documentation is completed promptly and without distraction.

Overall, the staff support infrastructure has been designed to promote wellbeing, efficiency, and safety.

4.4 Digital Strategy

4.4.1 Digital by Design: A digital-first approach

Llantrisant Health Park will adopt a technology-enabled, Digital-First approach to the design, delivery, and operation of both clinical and non-clinical services and environment. This principle positions digital capability at the centre of service delivery, viewing technology as a core enabler of clinical excellence, operational efficiency, and patient experience, and a means to unlock the transformational potential of the Llantrisant Health Park development. The approach seeks to:

- **Optimise clinical safety** through consistent and repeatable hygiene standards, automated kit carts and smart rostering
- **Promote productivity and efficiency** by using analytical and smart systems and reducing manual and paper-based processes
- **Enhance patient experience** through improved access, digital communication channels, self-service tools, and data-driven scheduling
- **Enabling staff digitally**, in more appropriate working environments, with smarter tools to improve performance and outcomes
- **Support information flow** for patients and staff through interoperable systems and integrated data flows, improving data quality and integration to support decision-making and enabling remote access, flexible working, staff mobility, and multi-site collaboration
- **A smarter, safer healthcare environment managed to meet clinical needs and adapt to** service demands and occupant needs.

In practice, Digital First means that wherever a process can be effectively supported or automated by technology, it should be considered as the default method of delivery.
This includes areas such as diagnostic reporting, surgical planning and imaging review, clinical documentation, workforce coordination, patient engagement, remote monitoring and environmental management

The objective is to ensure that digital solutions enhance efficiency, accuracy, and care quality without introducing additional complexity or administrative burden.

4.4.2 Digital by Design: Building technology into the infrastructure

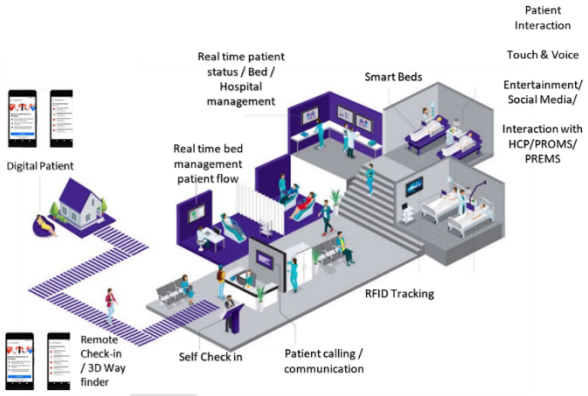
To operationalise a Digital First model, Llantrisant Health Park needs to be developed on Digital by Design principles thus ensuring that technology is embedded within the physical, technical, and operational fabric of the facility from the outset. This approach allows the building to function as an

interoperable, adaptive, and future-ready environment, capable of integrating emerging technologies throughout its lifecycle.

This must consider the three core aspects of digital enablement:

- Digital infrastructure
- Data flowing through the digital infrastructure
- Smart technologies utilising the infrastructure and data

"Adopting a 'digital first' and 'digital by design' philosophy in the design and delivery of new services, to promote mobile, flexible, patient and centred services & workforce models"



4.4.3 Digital by Design: Digital interplay with care delivery

Digital innovation, data-enabled decision-making, and new ways of accessing and delivering care are reshaping healthcare delivery. As systems move toward more proactive, coordinated, and patient-centred models, digital capability is a fundamental enabler of performance, experience, and sustainability.

At Llantrisant Health Park, digital is treated as a core design principle that underpins clinical operations, workforce models, patient pathways, and the built environment. It is important that the digital vision should be considered across three layers: Flow, Footprint and Fabric, which will ensure that information moves efficiently across pathways, that services are connected across organisations, and that smart-hospital capability is embedded into the estate from the outset.

These three layers form a coherent framework for how digital capability will operate:

Figure 3 - Digital framework

Flow	Examples					
Capabilities that support the flow of the information	Digital pathology	Enterprise wide EPR	Smart Beds	Clinical AI	Enterprise Digital Imaging	Voice recognition tools
	Smart Rostering	Smart Scheduling	Analytics system	Smart Triage	Automated dispensing cabinets	
Footprint	**Examples**					
Capabilities that connect the hospital to other care settings	Digital wayfinding	Digital front door	Integration gateways	Remote monitoring	Tele-medicine	Virtual assistant
Fabric	**Examples**					
Capabilities that are part of the hospital building	Digital twin	Asset and location tracking	IoT sensors	Facility security	Automated guided vehicles	

Llantrisant Health Park's digital architecture should bring together clinical systems, smart-hospital capabilities, and regional care connections, guided by underlying key principles:

Figure 4 - Digital architecture framework

Effective governance	Seamless Integration	Focus on Integrity	Fit for purpose
• Strong data stewardship and ownership aligned to NHS Wales policies • Compliance with Welsh digital and IG standards • Ethical and transparent use of data and digital tools	• Interoperable systems across LHP and wider CTM sites • Standardised platforms and maximised reuse of digital assets • Agile, scalable and connected infrastructure to support regional pathways	• Secure-by-design environment • Future-ready, resilient architecture • Scalable and compliant design	• Clinically-led design • Trackable operational efficiency • Intuitive, user-centred interfaces

Benefits for patients, staff and system

Stakeholders	Community Diagnostic Hub	Orthopaedic and Surgical Hub
For Patients	• Faster access to tests and results, reducing waiting times • One-stop experience multiple diagnostics in a single visit • Reduced need to travel to acute hospitals • Digitally supported navigation and check-in • Improved experience through modern, comfortable, and sustainable design	• Timely access to planned surgery, reducing waiting lists and delays • Protected elective capacity, minimising cancellations and last-minute changes • Enhanced pre-operative preparation and post-operative support through digital pathways • Modern day-case and enhanced recovery facilities enabling quicker recovery and discharge • Remote physiotherapy, wound monitoring, and follow-up reducing need for repeat travel
For Staff	• Co-location improves workflow efficiency and collaboration • Optimised scheduling, throughput, and utilisation of equipment • Frees acute capacity for emergency and inpatient care • Data-driven insight for demand forecasting and performance • Alignment with national diagnostic transformation and sustainability targets	• Streamlined theatre scheduling and reduced administrative burden • Dedicated elective setting supports predictable operating lists and fewer interruptions • Digital surgical planning, EPR access, and intra-operative tools improve safety and accuracy • Enhanced multidisciplinary collaboration and MDT space • Training environment for innovation in surgery, pre-hab and rehab pathways

For System	• Reduces pressure on acute diagnostic services • Improves system-wide flow by providing diagnostic capacity in the community • Supports early diagnosis and prevention models	• Protects emergency theatre capacity in acute hospitals • Increases elective surgery resilience and regional capacity • Reduces length of stay and avoids unnecessary admissions through day-case model • Enables regional elective recovery aligned to NHS Wales planned care priorities • Creates scalable elective hub model for future regional rollout

5 Benefits and Risks

5.1 Introduction

This section of the business case identifies the benefits, risks, constraints and dependencies in that have been considered when developing and assessing the options for the development of Llantrisant Health Park.

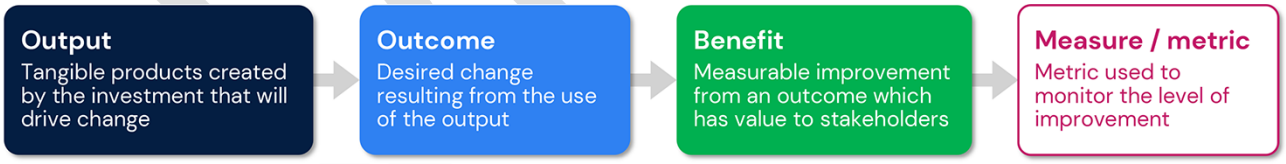
5.2 Benefits case

A systematic approach was undertaken to develop the benefits analysis as outlined in the diagram below.

Figure 5 - Benefit analysis process

A significant amount of work has been undertaken during the development of the programme to identify the benefits of LHP. This was consolidated within a series of workshops during April 2025 using the investment logic mapping approach outlined in the diagram below:

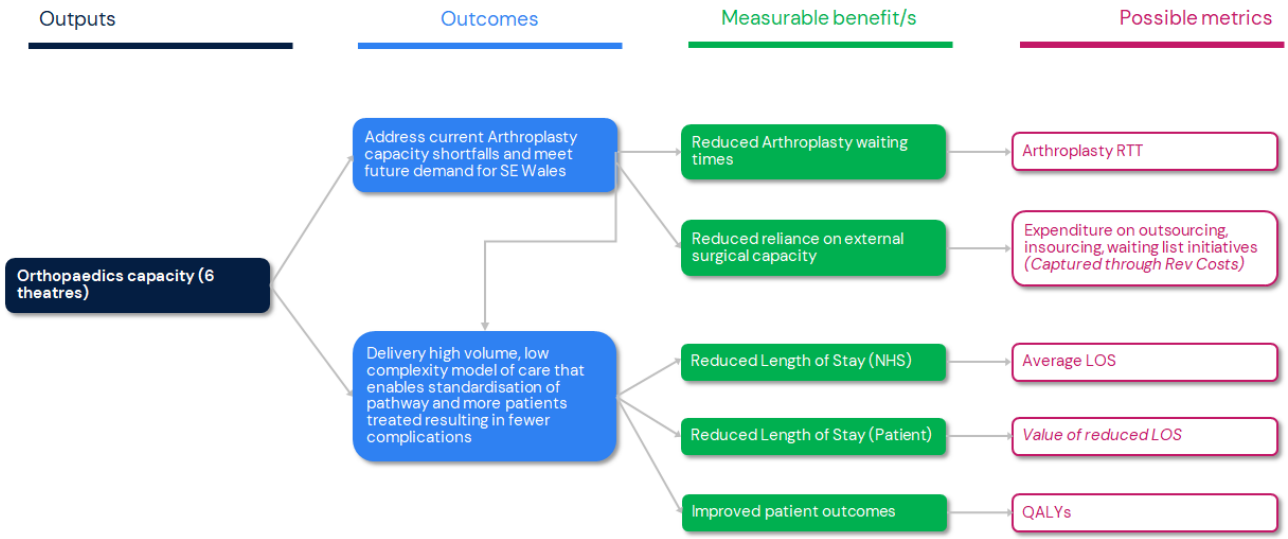
Figure 6 – Investment logic mapping approach



5.2.1 Creation of a Surgical Hub

Delivery of the surgical hub will allow LHP to provide additional surgical capacity to address current Arthroplasty capacity shortfalls and ensure future demand can be met. As well as reducing waiting times for patients, the delivery of high volume, low acuity model will enable the delivery of a standardised pathway. Earlier access to surgical interventions and reduced length of stay, which is known to reduce in fewer complications, will directly benefit patients, improving their quality of life. The additional capacity will also reduce reliance on expensive external Diagnostics capacity such as outsourcing, insourcing and waiting list initiatives.

*Figure 7 – Benefits mapping: creation of **Surgical Hub***

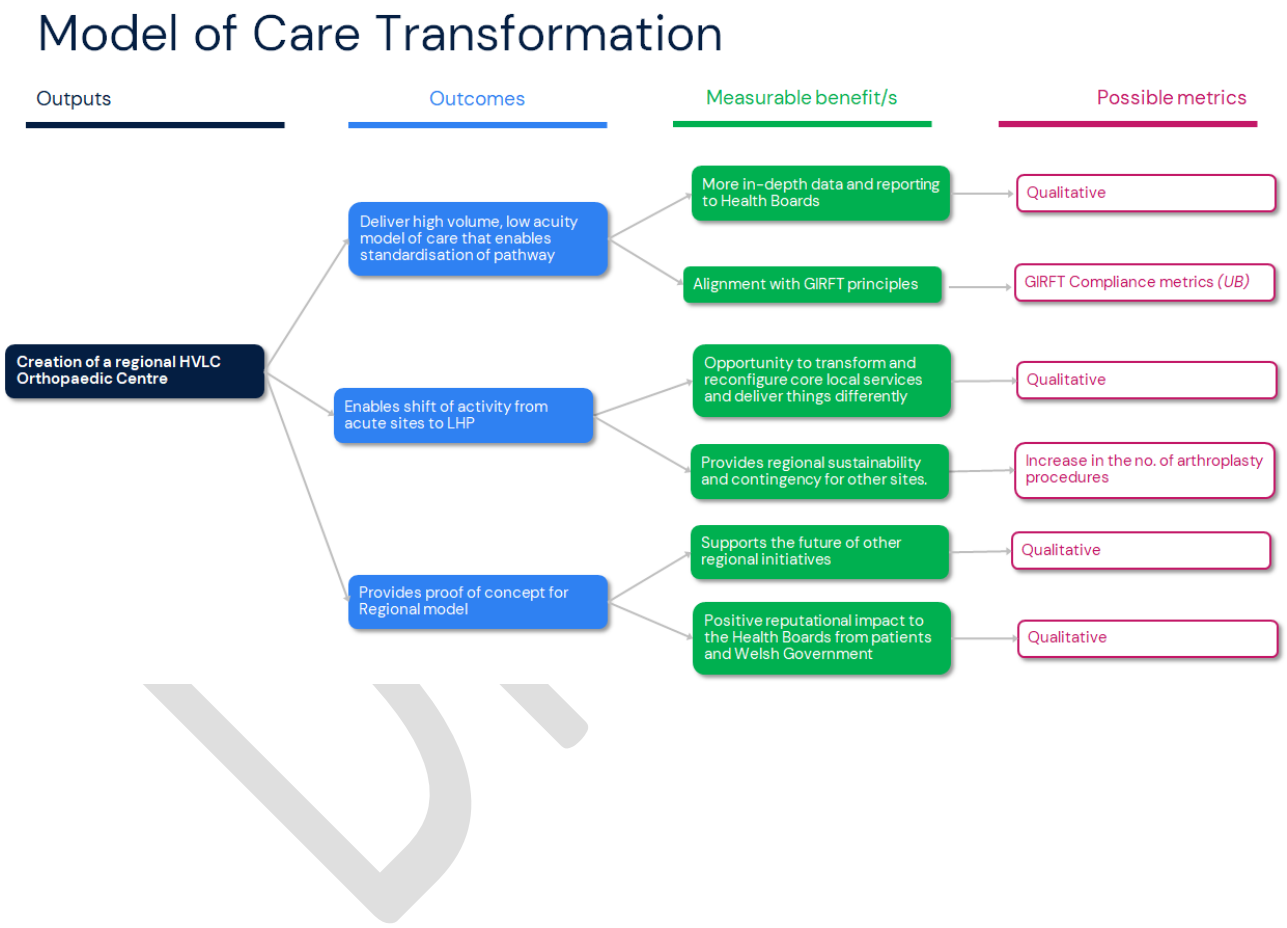


5.2.2 Model of care transformation

LHP will enable delivery of high volume, low acuity model of care that will enable the standardisation of patient pathways. This will result in better value for money due to increased throughput and better use of resources, reducing the average cost per procedure and providing opportunities for more efficient procurement. It will also ensure services align with GIRFT principles.

By providing capacity to shift activity from acute sites, the new surgical hub provides an opportunity to transform and reconfigure core local services and deliver things differently. For instance, the transfer of activity from CTM UHB to LHP provides opportunities to release space across the Estate in the future for other developments or to address risks around deteriorating facilities and reduce backlog maintenance. The successful delivery of a regional centre will also provide proof of concept as the basis for the development of any future regional pathways.

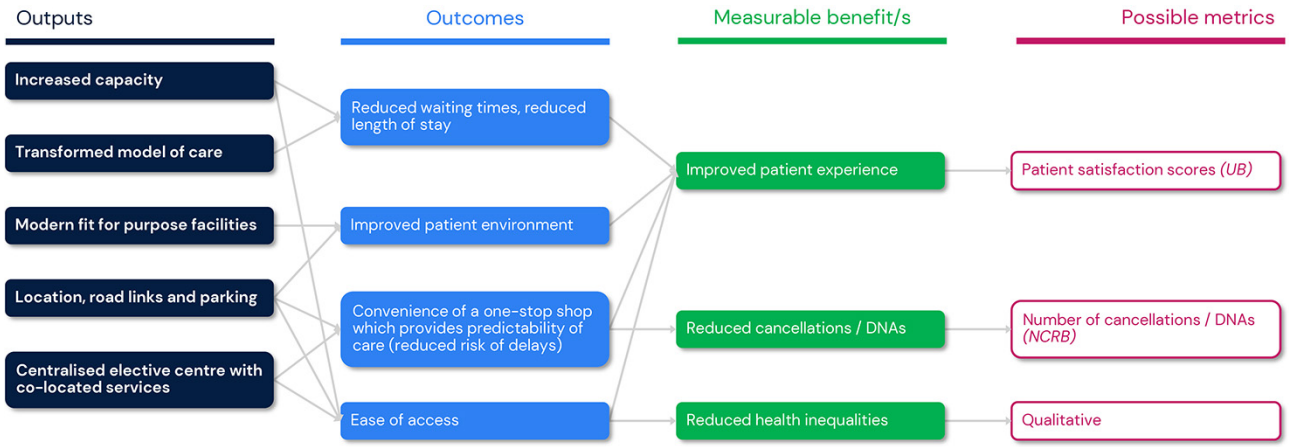
Figure 8 – Benefits mapping: model of care transformation



5.2.3 Improving patient experience

The outcomes presented above, such as reductions in waiting times and length of stay, will contribute to a significant improvement in patient experience. This is enhanced by the modern fit for purpose facilities and the ease of access the location of LHP offers, with its good road links and parking. Having a centralised elective centre with co-located services provides the convenience of a 'one-stop' shop clinic with greater predictability of care. This contributes to reducing the risk of cancellations and Did Not Attends (DNAs). In general, the improved access and reduced waiting times ensures a more equitable service is available within the region.

Figure 9 – Benefits mapping: ***patient experience***



5.2.4 Delivering a sustainable workforce

The workforce vision set out in the South East Wales Regional Orthopaedic Plan is to:

- Ensure safe and sustainable staffing to reduce vacancies and mitigate the need for premium rate temporary staffing.
- Redesign the workforce to support new models of care and cross-functional roles.
- Maximize the use of new roles and introduce competency-based training where appropriate.
- Improve the health and wellbeing of all staff, fostering a culture of inclusion, openness, and compassion.
- Focus clearly on retention and staff development.
- Implement flexible working models aligned with service delivery.
- Integrate and enable digital solutions to reduce administrative burden.
- Promote collaborative working across the region.

Nursing workforce will be employed by CTMUHB. The Medical workforce has been calculated in both sessions and hours for Consultant Anaesthetists and Consultant Surgeons.

A detailed options plan has been drafted to scope the therapy requirement for LHP, that will be a CTMUHB resourced service key principles include:

- Integral to the LHP ward team.
- A physiotherapy led solution.
- Extended hours to facilitate prompt discharge.
- Role utilisation particularly in the band 4.

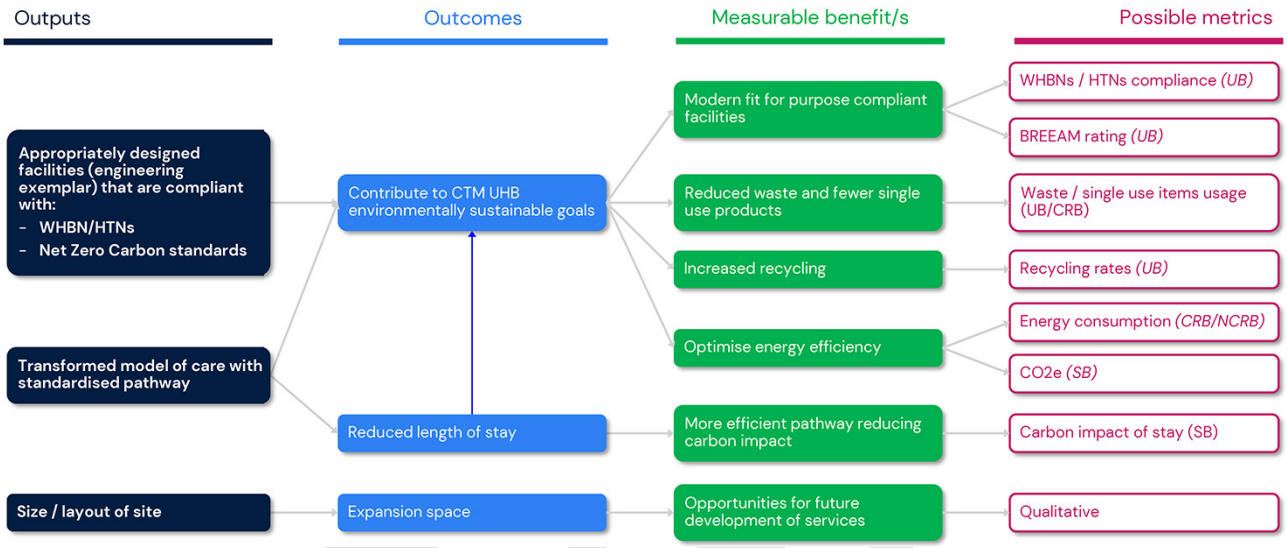
Additional service to support the operational delivery of LHP will be provided via a Hub and Spoke model (operational plans are in train through monthly workstream meetings) out of the Royal Glamorgan.

- Pharmacy
- Pathology
- HSDU
- Estates and Facilities.

5.2.5 Providing a sustainable estate

The delivery of appropriately designed compliant facilities provides opportunities to contribute to CTM UHB's environmentally sustainable goals and national strategies around decarbonisation, by ensuring they are compliant with WHBNs and HTNs, achieve BREEAM rating of Excellent and optimise energy efficiency. The transformed model of care with its standardised pathway is likely to make it easier to implement and maintain sustainability programmes that CTM UHB has instituted in other areas, such as reducing waste and single use products. The site also provides a level of future proofing by providing expansion space that offers opportunities for other future developments.

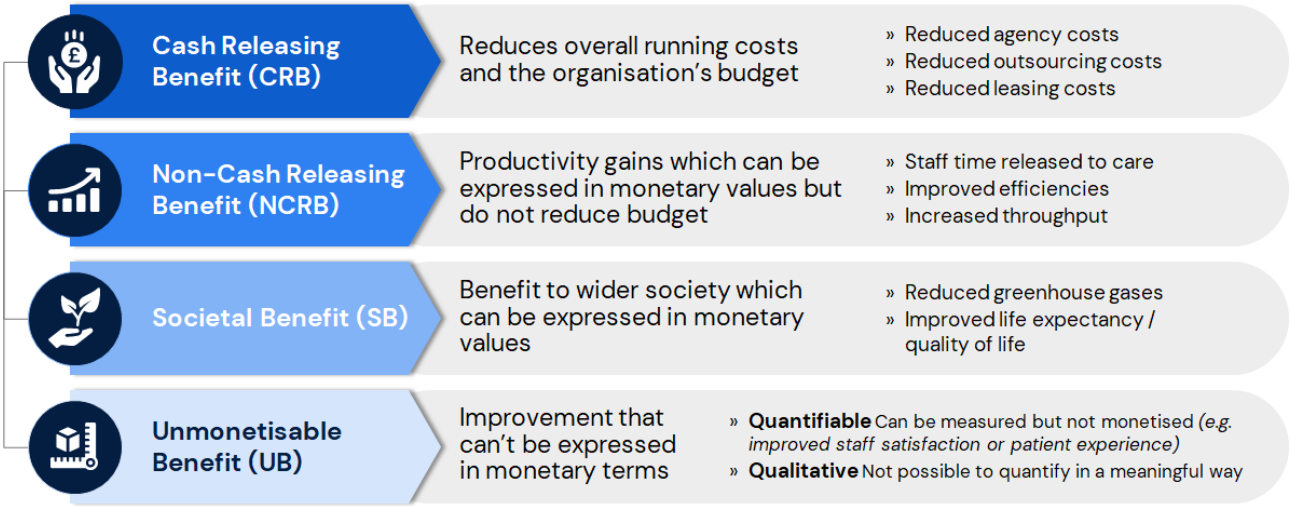
*Figure 10 – Benefits **mapping: sustainable estate***



5.3 Main benefits

The investment logic outlined in section 5.2 resulted in the identification of the main benefits for each of the categories outlined in the figure below.

Figure 11 – Benefits categories



The main benefits are summarised in the table below.

Table 11 - Main benefits

Theme	Benefit	Beneficiary	Type	Possible Metrics
Creation of surgical hub	Reduced waiting times across arthroplasty	Patients	Quantifiable	Waiting times
	Reduced length of stay/improved patient recovery time	Patients/ Health Board	Non-cash releasing/ Societal	Average length of stay
	Improved patient outcomes from reduced arthroplasty wait times	Patients	Societal	QALYs
	Reduced reliance on external surgical capacity	Health Board	Cash Releasing	Expenditure on outsourcing, insourcing, waiting list initiatives
Model of Care Transformation	Increased throughput and better use of resources	Health Board	Quantifiable	Average cost per procedure compared to benchmarks
	More efficient procurement	Organisational	Cash Releasing	Reduced non-pay costs/reduced procurement costs
	Improved performance and cost reporting	Health Board	Qualitative	N/A
	Greater alignment with GIRFT principles	Health Board	Quantifiable	GIRFT principles
	Provides opportunities for the future reconfiguration of services of CTM UHB	Health Boards	Qualitative	N/A
	Supports the future of other regional initiatives	Region	Qualitative	N/A
Improved Patient Experience	Improved patient experience	Patient	Quantifiable	Patient satisfaction scores
	Reduced cancellations and DNAs	Patients/Health Board	Non-cash releasing	Cancellations/ DNAs rate
	Reduced health inequalities	Patient/Society	Qualitative	N/A
Delivering a Sustainable Workforce	Improved training pathway and increased training opportunities	Staff / Health Boards	Quantifiable	Number of training places
	Increased staff satisfaction	Staff	Quantifiable	Staff survey scores
	Improved recruitment and retention	Health Board	Quantifiable	Vacancy rates Staff turnover
	Reduced reliance on temporary staffing	Health Board	Cash Releasing	Locum, Agency and Bank expenditure
	Workforce efficiencies	Health Board	Non-cash releasing	Rota efficiencies
	Opportunities to share best workforce practices across the region	Region	Qualitative	N/A
Providing a Sustainable Estate	Modern fit for purpose compliant facility	Health Board	Quantifiable	WHBN/HTMS BREEAM rating Enhanced facilities
	Reduced waste and single use products	Health Board/Society	Quantifiable	Waste and single use products usage
	Improved recycling	Health Board/Society	Quantifiable	Recycling rates
	Contribute to decarbonisation targets with energy efficiency	Health Board / Society	Societal	Energy consumption CO2e

Theme	Benefit	Beneficiary	Type	Possible Metrics
	Contribute to decarbonisation targets with more efficient pathway	Health Board / Society	Societal	CO2e reductions
	Provides opportunity for future expansion	Health Boards	Qualitative	NA

The quantification of these benefits is explored within section 7.6 of the Economic Case and realisation plans outlined in section 10.6 of the Management Case.

5.4 Main risks

Risk is the possibility of a negative event occurring that adversely impacts on the success of the delivery of the project and its benefits. Identifying, mitigating and managing the key risks is crucial to successful delivery, since the key risks are likely to be that the project will not deliver its intended outcomes and benefits within the anticipated timescales and spend.

The full quantified capital programme risk register can be found in Appendix 6 and informs the planning contingency. An operational / revenue risk register is also developed to cover those risks that do not have capital implications.

The currently identified top programme and infrastructure risks are as set out in the table below:

Table 12 - Top risks

Risk Description	Consequence	Likelihood	Risk
Approval of SAB resubmission required to support the building phasing	4	3	12
Regional healthcare stakeholder engagement	4	3	12
Unable to progress RDS/Clinical reviews at the pace required due to lack of clinician availability	4	3	12
Regional engagement to facilitate development of clinically led model	5	2	10
Welsh Government approval of OBC	5	2	10

5.5 Constraints

Constraints relate to the parameters that the project is working within and any restrictions or factors that might impact on the delivery of a project. These typically include limits on resources and compliance issues.

The project is subject to the following constraints:

- Facilities must be fit for purpose and have future flexibility/adaptability
- Implementation must not negatively impact continuation of current service provision
- Technical feasibility of the proposed solution
- Digital solution needs to be able to support patient record transfer from base HB to LHP
- The project must be delivered within agreed capital funding
- Workforce will need to be secured to deliver the additional capacity which will involve working with HEIW and education providers alongside development of recruitment strategies which will be more fully explored at FBC

- .Revenue funding will need to be secured to deliver the increased capacity

The project must support regional integration and collaboration and be supported by all three Health Boards.

5.6 Dependencies

Dependencies include things that must be in place to enable the project or project phases and typically include links to other projects and funding requirements that are likely to be managed elsewhere. The project is subject to the following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme:

- Availability of Welsh Government funding
- Approval from Welsh Government, IIB and other health boards
- Continued support for proposed service model
- Development of a full workforce model.
- Digital developments including changes to e-referral forms and information flows for reporting to ensure the proposed pathways for regional services are appropriately connected to health board systems. These interdependencies are identified and worked through by digital experts supporting the specification development and where changes are required to systems, these are highlighted to the Directors of Digital Services through the regional portfolio governance structure and support mechanisms.
- Workforce availability and planning - Recruitment and retention of skilled staff
- Transport and logistics - As this is a hub and spoke model reliant on RGH as the hub and the model will involve inter-site support (e.g., centralised decontamination pharmacy facilities, estates), robust transport logistics must be in place.
- Pathway coordination: Efficient patient movement through pre-op, intra-op, and post-op phases-ensuring standardisation of approach form all 3 health boards requiring system wider co ordination
- Clinical governance and accreditation - Cross-site working introduces complexity in maintaining consistent clinical governance, audit trails, and compliance with other regulatory standards.

Economic Case

6 Options identification and appraisal

The purpose of the Options Analysis is to identify and appraise the options for the delivery of project and to recommend the option that is most likely to offer best value for money.

However, in this instance this section will not undertake a traditional options appraisal using the business case framework, which is an approach that has been agreed with colleagues in the Capital and Estates team in Welsh Government (WG).

The reasons for this centre on the fact that on purchase of the site a case for purchase was prepared and resulted in approval of capital funds to enable the same. The funding was made on the condition that CTM collaborated with other NHS organisations to develop the site as part of a regional approach to the delivery of services. Therefore, consideration of alternative site options is not relevant.

The services included at this business case stage are the same as those included in the original case for the purchase of the site, with some small changes to the numbers of the same, in line with demand and capacity modelling provided in Section 3 of this case. In addition, after purchase, regional partners were asked to nominate desired alternative or additional services to be included at LHP; no changes or additions to the scope of services were requested or proposed at this time.

As a result, this section will not consider alternative options for service change with the scope and scale having been proven in the sections above. In addition, following WG approvals, design work has already progressed beyond the traditional stage for an OBC, with WG approval to proceed to RIBA 3 given in December 2024. It should be noted that the current design leaves most of the site's *plateau area* un-developed which could support a further phase of expansion.

During RIBA 2 it became apparent that there were some significant limitations to the existing site buildings. This prompted a detailed infrastructure options appraisal at that stage of the process which was fully documented in the strategic overview document submitted to WG in September 2024 and discussed at the IIB in November. The preferred option was to demolish the on-site buildings and build new facilities in line with *modern methods of construction* to deliver in the shortest programme possible.

The RIBA 2 design work was subject to scrutiny by Shared Services Specialist Estates and considered only the **preferred new build infrastructure option**. Scrutiny on the RIBA 2 phase closed on 18 December and approval to proceed to RIBA 3 was given on that date.

In addition to above funding, WG approval was granted to proceed with the demolition of the existing buildings on 31 January 2025, with planning licence approval granted on 2 April 2025. These works have commenced under a separate contract to the main design works and are programmed to complete by 21 August 2025. As a result, there is no scope to further consider infrastructure and build options.

Finally, a main contractor for completion of the design phase was appointed on 28 March 2025. This appointment was made after a lengthy tender process utilising the Crown Commercial Services Framework under 2 lots to encourage bidders from both pure modular and other off site construction backgrounds to develop the more beneficial construction solution for LHP.

The tender process demonstrated a modular form of MMC was preferred and WG approval to enter into the design contract was received on 14 March 2025. As a result, the build methodology has also been fully determined. Therefore, the economic appraisal in following sections will focus on the preferred option against a business-as-usual comparator only.

7 Economic Appraisal

7.1 Introduction

The purpose of the economic appraisal is to evaluate the costs, benefits and risks of the shortlisted options to identify the option that is most likely to offer best public value for money. In line with current Welsh Government Better Business Case and HM Treasury Green Book project business case guidance, this involves:

- Estimating the capital and revenue costs for each option.
- Undertaking an assessment of benefits and risks for each option, wherever possible quantifying these in monetary-equivalent values.
- Using the DHSC's Comprehensive Investment Appraisal (CIA) Model to prepare discounted cash flows and estimate the Net Present Social Value (NPSV) and Benefit Cost Ratio (BCR) for each option.
- Presenting the results, including sensitivity analysis, to determine the preferred option.

For the purposes of this case, only the preferred way forward is considered against the counterfactual Business as Usual position. As outlined in section 6 and as agreed as part of the Strategic Overview there are no other viable options available for consideration.

7.2 Summary of Phase 2 Preferred Way Forward

Element	Option 1 – PWF
Summary	Provide a high-volume, low-complexity orthopaedic inpatient unit, providing capacity for up to six theatres to deliver arthroplasty (knees and hips) surgery for patients meeting the criteria for treatment without critical care support. An inpatient unit adjacent to the theatres will accommodate patients requiring an overnight stay.
Initial Capital Cost	£123.6m
No. of Theatres	A total of 6 theatres: • 3-4 Theatres for CTMUHB • 0.5 Theatres for CAVUHB • 1.5 Theatres ABUHB
Activity provided	Capacity to provide 5,760 arthroplasty surgeries at LHP: • CTMUHB = 3,840 surgeries • CAVUHB = 960 surgeries • ABUHB = 960 surgeries

7.3 Capital costs

Capital costs for Phase 2 of the LHP have been estimated for the shortlisted options by the Health Board's Cost Advisors, prepared by the CTMUHB's Cost Advisors, Mott Macdonald using the following assumptions:

- Agreed Schedules of Accommodation and RIBA3b design. Agreed scope of Phase 2 to cover the build of the Orthopaedic Surgical Hub plus supporting ward accommodation

- Proposed that construction will begin in 2026-27 and proposed completion date as the end of September 2028, with 3 months commissioning before going live date of January 2029.
- Works costs calculated using benchmarked rates suitable for South Wales (including Healthcare Premises Cost Guide) @ BCIS TPI updated 11/11/2025.
- Allowances for fees, equipment costs, planning contingency have been applied as appropriate.
- No allowance for optimism bias has been applied given the degree of certainty at this stage in terms of maturity of design, knowledge of the site, and publicly declared political support for the development. It is therefore superseded by the Costed Risk Register figure.

The resulting capital costs estimates are summarised in the table below and a copy of the detailed capital cost forms is provided in Appendix 7.

Table 13 – Capital Costs

Element	Option 0 - BAU £'000	Option 1 – PWF £'000
Works Costs	-	70,924
Fees	-	8,357
Non-Works Costs	-	185
Equipment Costs	-	9,805
Quantified Risk Contingency	-	9,800
Subtotal	**-**	**99,071**
Inflation Adjustment		5,104
VAT	-	19,454
Total capital costs (as per capital cost forms)	**-**	**123,630**
Exclude sunk costs	-	0
Inflation adjustment to rebase to base year	-	-5,104
Exclude VAT	-	-19,454
Total capital costs (for Economic Case)	**-**	**99,071**

It should be noted that, in accordance with HM Treasury Green Book guidance, these costs have been adjusted for the purposes of the economic appraisal as follows:

- Exclude sunk costs.
- Exclude VAT.
- Are restated at base year prices.

7.4 Lifecycle capital costs

Ongoing investment requirements reflect the whole life costs of replacing, refurbishing or upgrading of assets over the lifetime of the appraisal period.

Building lifecycle costs across the appraisal period have been estimated for Option 1 based on a similar profile Phase 1's lifecycle costs. Please note that it will be investigated at FBC whether there are any synergies between the lifecycle costs in Phase 1 and Phase 2 and as such whether Phase 2's lifecycle costs could be reduced. As well as this, more detailed calculations will be provided as part of the FBC based on predicted schedule of major lifecycle repairs and replacement works over the estimated life of the new facilities, including the refurbishment of systems such as heating, replacement due to obsolescence or performance issues, provision for unscheduled renewal works, and redecoration.

It is also expected that equipment will be replaced every seven years in Option 1 (PWF) in line with the assumed useful life of the equipment. Please note that BAU equipment replacement costs have been estimated as 25% of Option 1's in line with the proportion of theatres in BAU that are being substituted in the PWF and similarly are replaced every seven years.

A breakdown of the current estimation of lifecycle costs across the whole appraisal period is provided in the table below:

Table 14 - Lifecycle costs

Lifecycle Costs, £'000	Option 0 - BAU £'000	Option 1 – PWF £'000
Building lifecycle Costs	0	126,263
Equipment replacement costs	19,610	78,442
Total lifecycle costs - Full appraisal period	**19,610**	**204,704**

7.5 Recurring revenue costs

The recurrent revenue costs as a result of the creation of the high-volume, low-complexity Orthopaedics Inpatient Unit in the preferred way forward has been estimated using the following assumptions:

- Pay costs associated with the 220.33 WTE required to operate the unit including medical, nursing, clinical, admin and ancillary staffing.
- Non-pay costs including supplies and services for Theatres, Ward and supporting areas.
- Building running costs

The BAU option includes costs for existing services which will be substituted within the PWF. This includes:

- Ward costs £2.5m
- Theatre costs £1.3m
- Medical staff costs £1.7m
- Non-pay costs £1.7m

The annual impact on each option is summarised in the table below, with a larger summary provided in Appendix 9– CIA Model and full workings provided in Appendix 8 – LHP OBC Phase 2 Revenue Model. It is assumed that costs will be incurred on a pro-rata basis from the start of January 2029, following planned completion of the facilities in September 2028 and a commissioning period from October – December 2028.

Table 15 – Annual revenue costs

Element	Option 0 – BAU £'000	Option 1 – PWF £'000
Pay Costs	5,598	15,035
Non Pay Costs	1,700	18,770
Building running costs	0	2,976
Total HVLC Orthopaedic Inpatient unit costs	**7,298**	**36,781**
Incremental impact on annual revenue costs	**0**	**29,483**

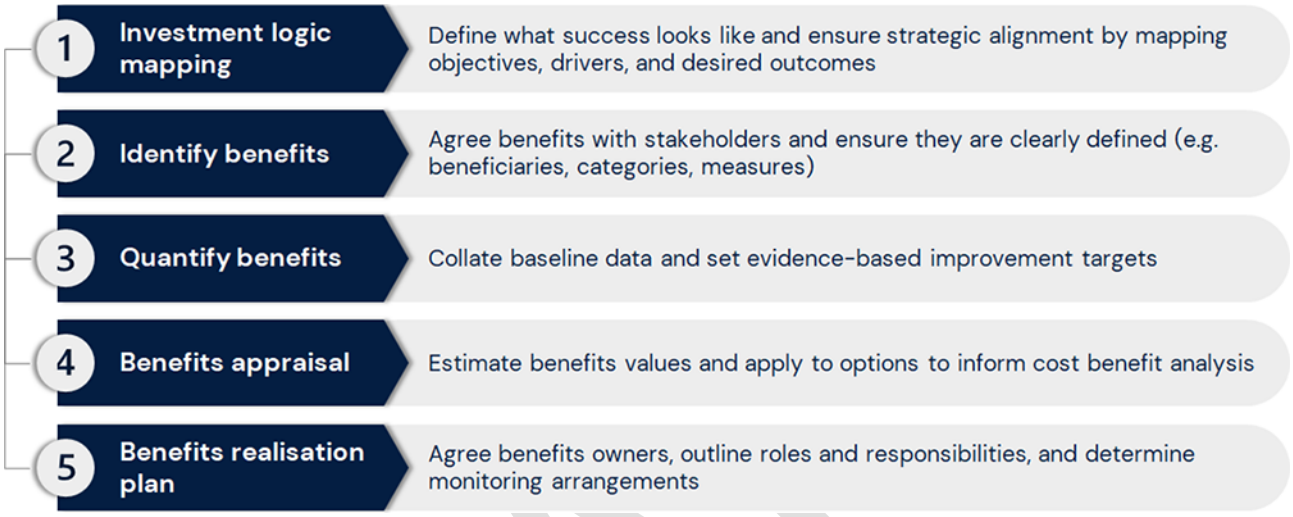
It should be noted that, in accordance with HM Treasury Green Book guidance, these costs exclude capital charges such as depreciation and therefore differ from the total figures in the Economic Case.

7.6 Benefits analysis

7.6.1 Benefits analysis approach

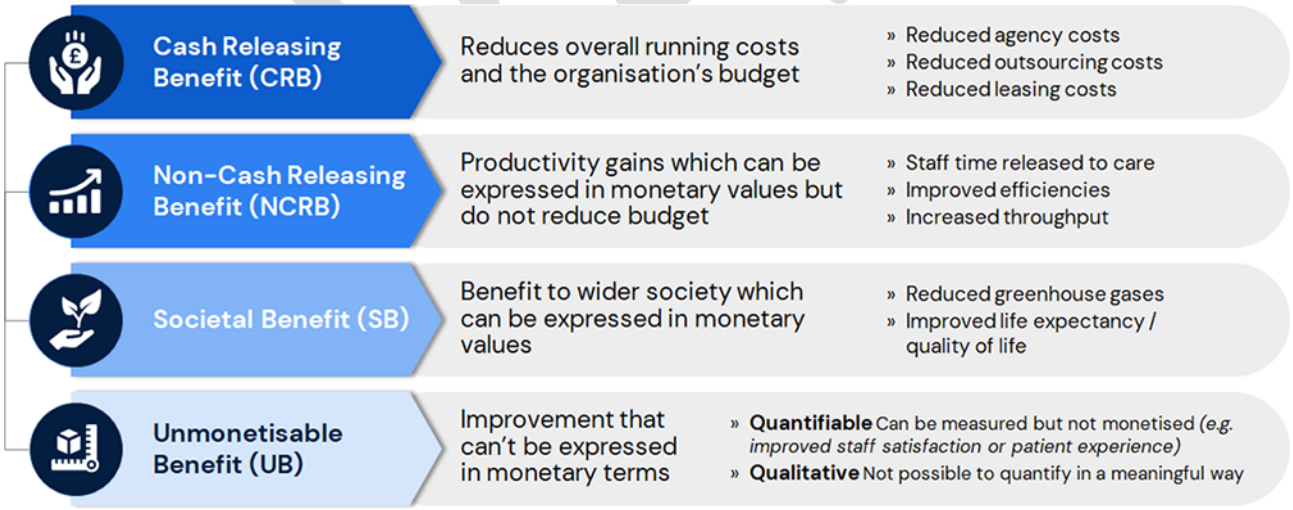
As outlined in sections 5.2-5.3 of the Strategic Case, a systematic approach has been undertaken to develop the benefits analysis, which involved establishing the benefits case and identifying measurable benefits, and metrics.

Figure 12 – Benefits approach



As part of the Economic Case, these benefits must be quantified to enable a robust value for money analysis to be undertaken, using the following categories.

Figure 13 – Benefits categories



An initial quantified benefits analysis has therefore been prepared based on the baseline and benchmarking data that is available at this stage. Every effort has been made to quantify the benefits for the OBC and, where possible, they have been stated in monetary equivalent values. Further work will continue into the FBC stage to validate assumptions, collate missing data and identify key baselines, as well as exploring benefits which have not yet been quantified.

7.6.2 Benefits assumptions

An overview of the main benefits that it is anticipated will be delivered as a result of the LHP, along with the key assumptions used to quantify them, is provided in the table overleaf. Detailed calculations are available in Appendix 5.

Table 16 - Overview of Phase 2 (Orthopaedic) LHP benefits

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Creation of surgical hub						
Reduced arthroplasty waiting times as a result of additional capacity provided by the surgical hub	Arthroplasty Referral to treatment times (RTT)	Average of 53 weeks (Based on average waiting times across the 3 UHBs from January 2024).	Preliminary target will be to achieve 36 weeks and then reduce to 26 weeks. (In line with NHS Wales Waiting time objectives that all patients whose care is too complex to be undertaken within 26 weeks or those who choose to wait longer receive their definitive treatment within maximum of 36 weeks)	Not monetisable	NHS Wales waiting time objectives taken from: Waiting times	UB1
Reduced length of stay: Delivery of a high volume, low acuity model of care allows standardisation of the pathway with more surgical procedures delivered as day cases	Average length of stay (ALOS) for arthroplasty	4.93 days (From September 2025 data for CTMUHB)	1.4 days (3.53 day improvement) (In line with perfect month ALOS that was achieved at CTMUHB)	£0.7m p.a. after confidence rating applied	The target average length of stay for Arthroplasty is based on the ALOS that was achieved at CTMUHB during a perfect month. It is expected that this would be achievable at LHP due to it providing elective high-volume, low complexity arthroplasty procedures in a Orthopaedic protected surgical unit. The methodology for calculating monetary value of this benefit is: • Apply 3.53 reduction in ALOS to 5,760 projected arthroplasty procedures p.a. equates to 20,321 fewer bed days p.a. • At a variable cost per bed day of £73, this equates to £1.5m p.a. (note only the variable cost per bed day has been applied instead of the full cost per bed day). • A 50% confidence rating has then been applied, noting that there is evidence from multiple sources suggesting this level of improvement is achievable. Further evidence to support this benefit includes: • The principles underlying the service to be provided at LHP have begun being implemented at the Princess of Wales Hospital, and this has seen ALOS for Arthroplasty reduce to 2.08 on a sustained	NCRB1

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
					basis. This shows that even at Princess of Wales Hospital which would likely have to deal with more complex procedures a low ALOS is achievable, as such it is expected that LHP would be able to achieve an even further improved ALOS. • The LOS at Essex and Suffolk Orthopaedic Elective Surgical Hub for total knee replacement was 1.9 days, suggesting 1.4 days is a reasonable target (especially after factoring in confidence rating). • At an Orthopaedic protected elective surgical unit (PESU), a single surgeon's hip replacements length of stay reduced by 38% compared to a pre-pandemic ward (4.8-day ALOS to 3.0 days). This is from a study[1] of 2022.	
Improved patient recovery time: Reduced length of stay allows patient to return home earlier and resume daily activities	Average length of stay (ALOS) for arthroplasty	N/A	Patients are discharged 3.53 days earlier on average (Based on achievement of ALOS outlined in outlined in NCRB1)	£0.8m p.a. after confidence rating applied	Methodology for calculating monetary value: Assume of the 20,321 reduction in bed days, 75% of these apply to patients in current employment Applying cost per day £109.25 per day (Source: Cost of an employed person sourced from Hidden costs of employee medical appointments and work (benenden.co.uk)) = £1.67m of societal benefit A 50% confidence rating has then been applied in line with NCRB1.	SB1

[1] 2022: Joseph, V, Boktor, J. GE, Roy, K. and Lewis, PM. (2022) '*Dedicated orthopaedic elective unit: our experience from a district general hospital*', Irish Journal of Medical Science (1971 -), https://doi.org/10.1007/s11845-022-03174-9

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Improved patient outcomes: Earlier surgical interventions and reduced length of stay, reducing complications and improving recovery, reduce pain leading to an overall improvement on patients' quality of life	QALYs (Based on reduced waiting times)	N/A	1,708 QALYs p.a. (Based on 11,556 patients undergoing arthroplasty surgery 17 weeks earlier on average achievement of preliminary RTT targets outlined in UB4)	£35.9m p.a. after confidence rating applied	Value of a quality adjusted life year for a person with Movement disorder (proxy for someone requiring Arthroplasty) is 0.548 as per WHO's QALY health state ratings[2] - Improvement in QALY from surgical procedure = 1-0.548 = 0.452 Assumed preliminary improvement in wait times is 17 weeks (or 0.33 of a year) – so they receive the improvement in QALYs earlier. Apply reduced wait times to improvement in QALY across the 11,556 patients currently waiting for Arthroplasty Apply QALY value of £70,000 as per HM Treasury Green Book (uplifted to base year prices) A prudent 25% confidence rating is applied, noting there are significant assumptions used in the calculation (e.g. the current run rate of average wait times would continue without LHP and that the patient seeing full improvement in QALY, where there may be other factors that influence this.)	SB2
Reduced reliance on external surgical capacity: Reduced outsourcing, insourcing and waiting list initiatives as a result of additional capacity provided by the surgical hub	Expenditure on surgical outsourcing, insourcing and waiting list initiatives	N/A	N/A	Included in BAU costs	Included in the transfer of costs associated with substitution of services at CTM UHB.	N/A
Model of care transformation						
Increased throughput and better use of resources: High volume, low acuity model with a standardised pathway will optimise throughput allowing for better use of resources	Average cost per Arthroplasty procedure compared to benchmarks	N/A	£6,907 per arthroplasty procedure (vs NHS England £7,910)	N/A Inherent within revenue model	NHS England arthroplasty tariff based on 2025-26 prices with a 5% MFF for the following codes: Very Major Hip Procedures for Non-Trauma with CC Score 2-3 Very Major Knee Procedures for Non-Trauma with CC Score 2-3	UB2
More efficient procurement: Increased standardisation of the pathway will provide opportunities for more	Consumables and supplies expenditure	To be confirmed at FBC	To be confirmed at FBC	To be confirmed at FBC	FBC Actions – establish the level of opportunities there are to standardise procurement. To give an indication however, it is estimated that there could be potentially a 10% improvement on	CRB1

[2] see: WHO Health Systems Performance Assessment, Debates, Methods and Empiricism, 2003, table 32.9 https://iris.who.int/handle/10665/42735

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
standardised products and consolidation of stores					purchase prices from buying in bulk and standardisation. Based on estimated non-pay costs for Phase 2 of the LHP, would equate to a £1.9m reduction in costs per year. This level of savings does seem reasonable based on other evidence such as the Suffolk and Northeast Essex wide implant rationalisation project (clinically led) for Foot and Ankle, Hip, Knee, Shoulder and Sports Medicine which saw savings on contracts of £2m - £4m year.	
Learnings and good practices identified from CRB1 can be passed on to other acute sites across the region, leading to better procurement practices throughout the region.	Qualitative	N/A	N/A	N/A	Not possible to quantify in a meaningful way	UB3
Improved performance and cost reporting: A dedicated surgical unit with standardised pathway will provide opportunities to increase transparency, reporting and understanding of performance and costing metrics	Qualitative	N/A	N/A	N/A	Not possible to quantify in a meaningful way	UB4
Greater alignment with GIRFT principles	GIRFT principles	N/A	Alignment with GIRFT principles	Not monetisable	N/A	UB5
Provides opportunities for the future reconfiguration of services of CTM UHB The move of existing surgical and diagnostics activity to LHP will release capacity at CTM UHB which provides opportunities to consolidate or reconfigure services with the potential for future rationalisation of the estate	Qualitative	N/A	N/A	N/A	Not possible to quantify in a meaningful way at this stage, please note that this just applies to CTMUHB, as CTMUHB is the only one that is transferring existing capacity.	UB6

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Supports the future of other regional initiatives Delivery of a successful regional model provides an evidence-base and acts as a potential exemplar, providing a catalyst for standardising other suitable pathways or centralising other suitable services in the future	Qualitative	N/A	N/A	Not monetisable	Not possible to quantify in a meaningful way at this stage	UB7
Providing regional sustainability and capacity to allow contingency at other sites.	Increase in the no. of Arthroplasty procedures provided	1,320	5,600	Not monetisable	As a result of the increased capacity at LHP it will provide regional sustainability and contingency at other acute sites.	UB8
Positive reputational impact to UHBs from patients and Welsh Government from positive outcomes of the initiative	Qualitative	N/A	N/A	Not Monetisable	It is assumed that the investment and service will be delivered in a productive and beneficial manner which will provide positive outcomes for patients, staff and the organisations. This will lead to a positive reputational impact from both patients and Welsh Government.	UB9
LHP will be a catalyst for change, improvement and employing best practice and collaboration across the region.	Qualitative	N/A	N/A	Not Monetisable	Not possible to quantify in a meaningful way at this stage	UB10
Reduced Healthcare Acquired Infections: Enhanced-recovery arthroplasty pathways with discharge on day 0–1 substantially reduce patients' exposure to hospital pathogens, minimise SSI and HAI rates, and lower cost of care.	Infection Incidence	2%	1%	£130k	Enhanced-recovery arthroplasty pathways with discharge on day 0–1 substantially reduce patients' exposure to hospital pathogens, minimise SSI and HAI rates, and lower cost of care. Adopting a short-stay model at Llantrisant Health Park is therefore expected decrease combined infection incidence from ~2% to ~1%. The methodology for calculating monetary value of this benefit is: • No. of procedures at LHP per year is 5,760 • A reduction from 2% to 1% of infection incidence applied to no. of procedures = 57.6 fewer infections	NCRB2

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
					• Assumed that each infection costs £3,000 in direct health care costs. • Monetisable value before confidence rating = £0.2m • Apply 75% confidence rating. At FBC stage a more robust value, including the value for the societal benefit of reduced HAI's will be investigated.	
Improving patient experience						
Improved patient experience as a result of reduced waiting times, ease of access, quality of care and reduced length of stay	Patient satisfaction scores	N/A (not possible to isolate existing patient scores from wider UHB)	95% (Based on current targets)	Not monetisable	N/A	UB11
Reduced cancellations and DNAs Centralised elective centre with co-location of equipment and clinical rooms making it a "one-stop" clinic provides predictability of care and reduces risk of delays and cancellations caused by winter pressures and other unplanned events.	Cancellations/ DNAs rate	To be confirmed at FBC	12.5% (In line with the PESU)	Potentially monetisable – to be explored at FBC	Orthopaedic protected elective surgical unit (PESU) cancellation rate: Only 12.5% of procedures were cancelled (24 out of 192). Compared to 52% in the Pre-pandemic ward. Based on a 2022 study[3]	UB12
Reduced health inequalities Reduction in waiting times and ease of access supports equality of access	Qualitative	N/A	N/A		Not possible to quantify in a meaningful way at this stage	UB13
Delivering a sustainable workforce						
Improved training pathway and increased training opportunities: The new Skills Academy in partnership with HEIW and additional theatres at LHP will provide capacity to	Number of training places	Orthopaedic Trainees: 6 Anaesthetic WTE Stage 1: 20	Potential Orthopaedic Trainees: 12 Potential Anaesthetic WTE Stage 1: 40	Not monetisable	**Delivery of these additional training places are dependent on:** • Additional funding over and above what is outlined in section 7.5 recurring revenue costs.	UB14

[3] Joseph, V, Boktor, JGE, Roy, K and Lewis, PM (2022) 'Dedicated orthopaedic elective unit: our experience from a district general hospital', Irish Journal of Medical Science (1971 -), https://doi.org/10.1007/s11845-022-03174-9

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
increase the number of training places		Anaesthetic WTE Stage 2: 13	Potential Anaesthetic WTE Stage 2: 26		• Close engagement with HEIW and the Welsh School of Anaesthesia to formalise these training pathways. Calculation based on: • Baseline no. of trainees at CTM are provided in an assumed 1.5 theatres. • LHP will provide 6 theatres, of which 3-4 are utilised by CTM, and the other theatres utilised to accommodate regional demand. The target is set on the additionality of the theatres that CTM utilises (assumed as 3 theatres), though this assumption will be revisited at FBC stage. This represents an 100% increase in capacity to provide training places, which has been applied to the baseline no. of trainees.	
Increased staff satisfaction since LHP will create a modern attractive place to work which provides increased training and career development opportunities as a Centre for Excellence and including the new Training Academy/Centre for training in partnership with HEIW. A more standardised pathway is likely to reduce stress.	Staff survey scores	To be confirmed at FBC	To be confirmed at FBC	Not monetisable	To be confirmed at FBC	UB15
Improved recruitment and retention since LHP will create a modern attractive place to work which provides increased training and career development opportunities as a Centre for Excellence and including the new Training Academy/Centre for training in partnership with HEIW	Vacancy Rates Staff Turnover	To be confirmed at FBC	To be confirmed at FBC	Not monetisable	To be confirmed at FBC	UB16
Reduced reliance on temporary staffing: Improved recruitment and retention will	Locum, agency and bank expenditure	To be confirmed at FBC	To be confirmed at FBC	To be confirmed at FBC	To be confirmed at FBC	CRB2

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
reduce usage of locum, bank and agency staff						
Reduced sickness absence	Sickness absence	To be confirmed at FBC	To be confirmed at FBC	To be confirmed at FBC	To be confirmed at FBC	CRB3
More efficient ways of working: Consolidated service model leading to optimised workforce planning and a team that can operate in a more agile way is expected to result in productivity improvements and rota efficiencies.	Rota efficiencies	Captured in Revenue Model	Captured in Revenue Model	Captured in Revenue Model	Captured as part of the Revenue Model workforce figure.	For noting
Opportunities to share best workforce practices across the region	Qualitative	N/A	N/A		Not possible to quantify in a meaningful way at this stage	UB17
Providing a sustainable estate						
Modern fit for purpose compliant facility that aligns with current guidance and provides more robust, resilient and sustainable facilities	WHBNs HTNs	N/A	Complies with relevant WHBNs and HTNs	Not monetisable	N/A	UB18
	BREEAM rating	N/A	BREEAM rated as excellent	Not monetisable	N/A	UB19
	Enhanced facilities	N/A	Enhanced facilities enhanced provisions (i.e. 2 oxygen tanks, N+N generator etc.)	Not monetisable	N/A	UB20
Community Benefits (Social Value provided by the contractor))	Number of local direct full time equivalent (FTE) employees hired or retained.	N/A	10 FTE	Not monetisable	Target as per Social Value information provided as part of the Tender documents by MTX. – Note this is the same as Phase 1's value.	UB21 (a)
	Number of weeks of apprenticeships provided to local staff.	N/A	250 weeks	Not monetisable	Target as per Social Value information provided as part of the Tender documents by MTX. – Note this is the same as Phase 1's value.	UB21 (b)

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
	Equipment or resources donated to local third sector and civil society organisations	N/A	£25,000 donated	Potentially monetisable	Target as per Social Value information provided as part of the Tender documents by MTX. – Note this is the same as Phase 1's value.	UB21 (c)
	Directly funded number of hours volunteering time provided to support local community projects.	N/A	250 Hours of volunteering time	Not monetisable	Target as per Social Value information provided as part of the Tender documents by MTX. – Note this is the same as Phase 1's value.	UB21 (d)
	Direct support and investment provided for people to learn and use Welsh (e.g. interactions and signage).	N/A	£25,000	Potentially monetisable	Target as per Social Value information provided as part of the Tender documents by MTX. – Note this is the same as Phase 1's value. Allocate £25,000 to support the Welsh language on a construction project by offering free Welsh lessons for workers, tailored to industry vocabulary (£12k). Introduce bilingual site signage, safety instructions, and manuals (£7k). Host community engagement events, such as guided tours and Welsh-themed workshops, in partnership with local schools or organizations (£5k). Celebrate Welsh culture onsite with events and competitions like St. David's Day (£1.5k). Leave a legacy with bilingual plaques or contributions to local Welsh programs (£1.5k). Partner with Mentrau Iaith or Learn Welsh Cymru for effective delivery and long-term impact, promoting Welsh language use onsite and beyond.	UB21 (e)
	Total amount (£) spent in the local supply chain.	N/A	£20,000,000 spent locally	Not Monetisable	Target as per Social Value information provided as part of the Tender documents by MTX. – Note this is the same as Phase 1's value. Potential social value generated by value spent locally = £20,000,000*1.76 (Local Multiplier) = £35,200,000. Note will not be included as a monetisable value in the CIA Model.	UB21 (f)

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Reduced waste and single use products: Contribute to CTM UHB environmentally sustainable goals by reducing waste and single use products	Qualitative	N/A	N/A	Not monetisable	Not possible to quantify in a meaningful way at this stage, but it is expected as a result of the standardisation of the site, more site wide reducing waste and single use product initiatives can be instituted and monitored.	UB22
Improved recycling: Contribute to CTM UHB environmentally sustainable goals by improved recycling and finding alternative ways of disposing of waste	Qualitative	N/A	N/A	Not monetisable	Not possible to quantify in a meaningful way at this stage, but it is expected as a result of the standardisation of the site, more site wide recycling initiatives can be instituted and monitored.	UB23
Contribute to decarbonisation targets with energy efficiency: Providing an energy efficient building which optimises energy consumption and associated CO2e	Qualitative	N/A	N/A	Not monetisable	The new building at LHP will be developed to comply with the net carbon zero strategy and principles. Gas will also not be used on site.	UB24
Contribute to decarbonisation targets with more efficient pathway: Reduced CO2e associated with reduced patient length of stay	Carbon impact of stay (Based on reduced length of stay)	N/A	Reduction of 770 tonnes of CO2e p.a. (Based on 20,321 fewer bed days p.a. based on ALOS reduction targets outlined in NCRB1)	£227k (average) after confidence rating applied	The average carbon impact of a stay on a low intensity ward is 37.9 kg CO2e i per bed day [Source: NHS England » Building on what we already do] Applying to 20,321 reduction in bed days = 770 tonnes p.a. At an average of £588.26 per tonne of CO2e [Source: DfT TAG Data book (Table A 3.4.1: Carbon Appraisal Values, £ per Tonne of CO2e] this equates to an average economic value of £453k p.a. A 50% confidence rating has then been applied in line with NCRB1.	SB3
Preservation of biodiversity and wetland area due to choice and design of site.	Qualitative	N/A	N/A	Not monetisable	As a result of the choice of site for the development and that is recycling a previously developed industrial site instead of a greenfield site, there is preservation of biodiversity in the region. The choice of design and ensuring it stays within the already developed portions of the site, the wetland area is preserved and protected from all development in line with Local Council's recommendations.	UB25
Enables and provides meaningful and adequate	Qualitative	N/A	N/A	Not monetisable	Not possible to quantify in a meaningful way at this stage	UB26

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
spaces for future phases of work that are planned						
Provides opportunity for future expansion: As a result of the choice of site and design, it allows for expansion to capacity in current services as well as development of future services	Qualitative	N/A	N/A	Not monetisable	Existing design allows for future increase in capacity (i.e. has design has factored in space for further equipment and rooms to accommodate providing additional capacity in the future)	UB27

7.6.3 Monetisable benefits analysis

While work continues to validate assumptions and explore benefits that it has not yet been possible to quantify, initial analysis has identified circa £37.6m of monetisable benefits p.a. as summarised in the table below.

Table 17 – Monetisable benefits values after confidence rating (when benefits are fully realised)

Element	Option 0 – BAU £'000	Option 1 – PWF £'000
Cash releasing benefits	0	0
Non-cash releasing benefits	0	872
Societal benefits	0	36,711
Total annual recurring benefits values	**0**	**37,583**

These figures can be considered risk-adjusted since, as outlined in the summary table above, relatively prudent confidence ratings have been applied to the majority of them to reflect the degree of uncertainty at this stage in the process. Further work will be undertaken at FBC to firm up these assumptions and reduce the level of uncertainty.

7.6.4 Unmonetisable benefits analysis

In addition to the monetisable benefits there are several benefits which it is not possible to monetise at this stage, either because they cannot be meaningful quantified or because they cannot be stated in monetary terms. A summary is provided in the table below.

Table 18 – Unmonetisable benefits analysis

Ref		Option 0 - BAU	Option 1 - PWF
UB1	Reduced arthroplasty waiting times	-	Patient waiting time for arthroplasty will preliminarily reduce to 36 weeks and then further to 26 weeks.
UB2	Increased throughput and better use of resources	-	Average cost per arthroplasty procedure is £6,907 compared to £7,910 NHS England Tarriff rate
UB3	Learnings and good practices identified in procurement can be passed on to other acute sites across the region, leading to better procurement practices throughout the region.		Qualitative
UB4	Improved performance and cost reporting	-	Qualitative
UB5	Greater alignment with GIRFT principles	-	Alignment with GIRFT principles
UB6	Provides opportunities for the future reconfiguration of services of CTM UHB	-	Qualitative
UB7	Supports the future of other regional initiatives	-	Qualitative
UB8	Providing regional sustainability and capacity to allow contingency at other sites.	-	5,600 arthroplasty procedures provided at LHP.
UB9	Positive reputational impact to UHBs from patients and Welsh Government from positive outcomes of the initiative	-	Qualitative

Ref		Option 0 - BAU	Option 1 - PWF
UB10	LHP will be a catalyst for change, improvement and employing best practice and collaboration across the region.	-	Qualitative
UB11	Improved patient experience	-	95% patient satisfaction
UB12	Reduced cancellations and DNAs		12.5% cancellation/DNA rate
UB13	Reduced health inequalities	-	Qualitative
UB14	Improved training pathway and increased training opportunities	-	Capacity to potentially provide training to 12 Potential Orthopaedic Trainees, 40 Potential Anaesthetic WTE Stage 1s and 26 Potential Anaesthetic WTE Stage 2s.
UB15	Increased staff satisfaction	-	To be confirmed at FBC
UB16	Improved recruitment and retention	-	To be confirmed at FBC
UB17	Opportunities to share best workforce practices across the region	-	Qualitative
UB18-20	Modern fit for purpose compliant facility	-	Complies with WHBN/HTMs BREEAM rated as excellent Enhanced facilities with enhanced provisions (i.e. 2 oxygen tanks, N+N generator etc.)
UB21	Community Benefits (Social Value provided by the contractor))	-	10 local direct full time equivalent (FTE) employees hired or retained. 250 weeks of apprenticeships provided to local staff. £25,000 worth of equipment or resources donated to local third sector and civil society organisations 250 Hours of volunteering time provided to support local community projects. £25,000 direct support and investment provided for people to learn and use Welsh (e.g. interactions and signage). £20,000,000 spent in the local supply chain.
UB22	Reduced waste and single use products	-	Qualitative
UB23	Improved recycling	-	Qualitative
UB24	Contribute to decarbonisation targets with energy efficiency	-	Qualitative
UB25	Preservation of biodiversity and wetland area due to choice and design of site.	-	Qualitative
UB26	Enables and provides meaningful and adequate spaces for future phases of work that are planned	-	Qualitative
UB27	Provides opportunity for future expansion: As a result of the choice of site and design, it allows for expansion to capacity in current services as well as development of future services	-	Qualitative

7.7 Risk analysis

The risks for each option have been assessed and, as far as possible, quantified and expressed in monetary equivalent terms, including:

- Quantified risk in relation to planning contingency included in capital cost forms
- Key project risks which have not been accounted for within capital costs.

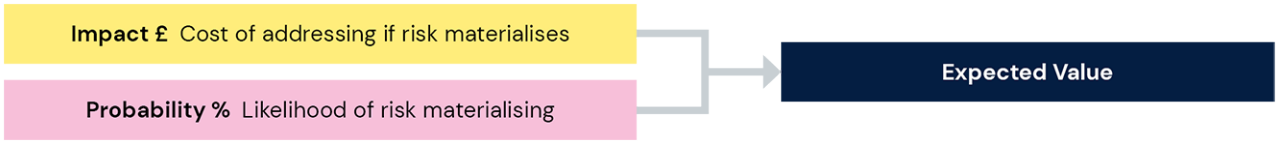
Key project risks have been identified which are not already accounted for within capital costs and these include the following:

- **Funding Risk - Unable to secure sufficient capital funding to deliver the project:** There is a risk that due to the significant amount of initial capital funding required to deliver the project it may take time to secure this funding which could lead to delays in the programme while alternative routes are explored.
- **Funding Risk - Unable to secure sufficient revenue funding to deliver the project:** There is a risk that due to the significant amount of ongoing revenue funding required to deliver the project it may take time to secure this funding which could lead to delays in the programme while alternative routes are explored.
- **Workforce Risks – Recruitment and Retention:** There is a risk that it would be difficult to recruit sufficient substantive staff, noting the increase staffing required, which could lead to a reliance on unplanned, expensive temporary and locum staff leading to increased staffing costs.

These risks have been quantified by calculating an 'expected value'. This provides a single value for the expected impact of all risks. It is calculated by multiplying the likelihood of the risk occurring (probability) by the cost of addressing the risk (impact) and summing the results for all risks and outcomes.

Please note these risks will be reviewed and refined at FBC stage to ensure they have been accurately captured.

Figure 14 - Risk quantification approach using single-point probability analysis



The assumptions included to assess the impact and probability of these risks are outlined in the table below.

Table 19 - Risk assumptions

Element	Option 0 - BAU	Preferred Option - Traditional capital build + ISP equip and deliver services via managed service contract
K1 – Funding Risk: Capital Funding		
Risk	**Unable to secure sufficient capital funding to deliver the project**	
Consequence	**Programme extended to allow time to explore alternative routes**	
Impact per year		Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m
Probability		5%
Timescales		Year 0
Total Risk Value £'000	**Does Not Apply**	**1,040**

Element	Option 0 - BAU	Preferred Option - Traditional capital build + ISP equip and deliver services via managed service contract
K2 – Funding Risk: Revenue Funding		
Risk	**Unable to secure sufficient revenue funding to deliver the project**	
Consequence	**Programme extended to allow time to explore alternative routes**	
Impact per year		Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m
Probability		10%
Timescales		Year 0
Total Risk Value £'000	**Does Not Apply**	**2,080**
K3 - Workforce Risk: Recruitment and Retention (long term)		
Risk	**Unable to recruit sufficient staff to enable delivery of the model in the long term**	
Consequence	**Reliance on unplanned outsourcing of services leading to increased costs**	
Impact per year		Pay costs re 10% higher than expected (£1.5m p.a.)
Probability		5%
Timescales		Years 4 – 63
Total Risk Value £'000	**Does Not Apply**	**4,511**

7.8 Economic appraisal

The Comprehensive Investment Appraisal (CIA) model has been populated with the assumptions outlined above to support the appraisal of overall value for money by producing a cost-benefit analysis of the shortlisted options.

The assumptions above have been incorporated into a discounted cash flow for each of the costs, benefits and risks are calculated over a 64-year appraisal period including Year 0 (base year) + ~ 3 years construction and commissioning + 60 years estimated useful life.

- Year 0 is 2025/26
- Costs and benefits use real base year prices – all costs are expressed at 2025/26 prices in line with the baseline costs.

The following costs are excluded from the economic appraisal:

- Exchequer ***transfer*** payments, such as VAT
- General inflation
- Sunk costs
- Non-cash items such as depreciation and impairments
- A discount rate of 3.5% is applied to years 1-30, 3.0% from year 31 onwards.

The economic summary is provided in the table below and a copy of the CIA model is provided in Appendix 9.

Table 20 - Economic summary

Element	Option 0 - BAU £'000	Option 1 - PWF £'000
Capital Expenditure (discounted)	-7,102	-166,999
Revenue Expenditure (discounted)	-195,276	-951,968
Operational Risks (discounted)	0	-4,848
Risk-adjusted Present Cost	**-202,377**	**-1,123,816**
Cash releasing benefits (discounted)	0	0
Non-cash releasing benefits (discounted)	0	19,929
Societal Benefits (discounted)	0	1,402,254
Total Benefits	**0**	**1,422,183**
Discounted Net Present Social Value (NPSV)	**-202,377**	**298,367**
Incremental costs - total	0	-921,439
Incremental benefits - total	0	1,422,183
Risk-adjusted Incremental Net Present Social Value (NPSV)	**0**	**500,744**
Benefit-cost ratio	**0.00**	**1.54**

The results of the economic modelling demonstrate that the preferred option will deliver an incremental Net Present Social Value (NPSV) of £500.7m when compared to the Business as Usual (BAU) position. This generates a Benefit Cost Ratio (BCR) of 1.54, which equates to £1.54 of incremental benefit delivered for every £1.00 of incremental whole life cost, which suggests LHP will deliver value for money.

It should be noted that this is based on an initial assessment of benefits and further work is required to quantify a number of the benefits as the scheme progresses to Full Business Case (FBC) stage. Where benefits have been quantified, values have been estimated based on current assumptions as outlined in section 7.6 of this case. Given further work is required at FBC to validate and refine these assumptions, a relatively low confidence rating has been attached to the majority of these to ensure a prudent approach is taken to claiming benefits until a more detailed analysis can be undertaken. It is therefore reasonable to assume that at FBC stage, the BCR is likely to increase and further strengthen the value for money case.

7.9 Sensitivity analysis

The results of the economic appraisal above have been subject to a sensitivity analysis to examine the impact of potential movements in capital and revenue costs.

The first part of this typically involves undertaking a switching values analysis to test the robustness of the ranking of options. This is applied to areas of material cash flows to identify the extent that costs and benefits of each of the alternative options must change in order for the Net Present Social Value (NPSV) to reflect that of the highest-ranking option (excluding BAU). Given that there are no alternative options to test in this case, this analysis is not required.

Instead, alternative scenarios have been calculated to consider how the value for money of the preferred option may be affected by future uncertainty as outlined in the table below.

Table 21 - Sensitivity analysis – scenarios

Scenario	Revised incremental costs	Revised incremental benefits	Revised NPSV	Revised BCR
Original Results	**-921,439**	**1,422,183**	**500,744**	**1.54**
1.Capital costs increase by 20%	-940,021	1,422,183	482,162	1.51
2. Revenue costs increase by 10%	-1,015,111	1,422,183	407,071	1.40
3a. Reduced length of stay benefits confidence rating reduced from 50% to 25%	-921,439	1,393,179	471,741	1.51
3b. Reduced length of stay benefits confidence rating increased from 50% to 75%	-921,439	1,451,186	529,747	1.57
4a. Improved patient outcomes because of shorter Arthroplasty waiting times and reduced LOS confidence rating increased from 25% to 12.5%	-921,439	755,071	-166,368	0.82
4b. Improved patient outcomes because of shorter Arthroplasty waiting times and reduced LOS confidence rating increased from 25% to 50%	-921,439	2,756,407	1,834,968	2.99

In summary:

- Scenario 1: Even if capital costs were to increase by 20% (c.£19.8m excluding VAT), this would have minimal impact on BCR, and the project would still deliver a positive NPSV.
- Scenario 2: A 10% increase in revenue costs (c. £4m p.a.) would result in a Net Present Social Cost, this would have minimal impact on BCR, and the project would still deliver a positive NPSV.
- Scenario 3: The monetised benefits directly associated with reduced length of stay (increased throughput, value of patient time saved) appear to have minimal impact on the value for money indicators. For instance, if the confidence rating was reduced from 50% to 25% this would only slightly reduce the BCR from 1.54 to 1.51. Similarly increasing it to 75% would only slightly improve the BCR from 1.54 to 1.57.
- Scenario 4: However, the value for money indicators do appear to be relatively sensitive to changes in assumptions about improved patient outcomes because of reduced waiting times and reduced length of stay for Arthroplasty patients. For instance, if the confidence rating was reduced from 25% to 12.5% this would almost halve the BCR from 1.54 to 0.82, while increasing it to 50% would almost double the BCR from 1.54 to 2.99. It should be noted that the baseline confidence rating of 25% is already relatively prudent to reflect the degree of uncertainty about the assumptions made within the calculation (for instance that the current run-rate of waiting times would continue without LHP but would be reduced by 17 weeks in line with targets as a result of LHP, and that, following recovery from surgery, each patient benefiting from this would see full improvement from 0.548 to 1 quality adjusted life year). It is assumed that any sensitivity in these assumptions are already accounted for within the prudent 25% confidence rating and, if these assumptions can be firmed up at FBC, the confidence rating would increase.

The results of the scenario analysis show that the BCR is relatively sensitive to some changes in assumptions, specifically patient outcomes associated with reducing surgical waiting times. However, it is believed that as the project progresses to FBC and assumptions can be firmed up, it will be possible to monetise further benefits and increase the confidence rating applied to those already quantified. This would likely increase the BCR overall.

7.10 Preferred option

The results of the economic appraisal demonstrate that the preferred way forward offers value for public money. This option is an NHS-funded capital build for the Orthopaedic Surgical Hub at Llantrisant Health Park, delivering theatres and ward accommodation for high-volume, low-complexity arthroplasty procedures.

Requiring capital investment of £123.6m (including VAT) and ongoing revenue costs of £36.8m p.a. (excluding depreciation), based on estimated costs and benefits, it is anticipated that phase 2 of the LHP will deliver an incremental Net Present Social Value (NPSV) of £500.7m and a Benefit Cost Ratio (BCR) of 1.54. This represents £1.54 of incremental benefit delivered for every £1.00 of incremental whole life cost, because of the quantifiable benefits that it has been possible to state in monetary values at this point in time, including:

- **High volume, low acuity model of care increasing throughput:** Delivery of the surgical hub will address current regional Arthroplasty capacity shortfalls and ensure future demand can be met. As well as reducing waiting times for patients, the delivery of high volume, low acuity model will enable the delivery of a standardised pathway, increasing throughput and making best use of resources.
- **Improved patient outcomes from earlier access to surgical intervention, reduced length of stay and less healthcare acquired infections:** Reduced length of stay is known to result in fewer complications and support speedier recovery times. This, combined with the reduced waiting times, lead directly to better patient outcomes, specifically improving quality of life for those requiring surgical interventions such as arthroplasties.

In addition to this, there are other quantifiable benefits which it has not yet been possible to state in monetary values given the information that is available at this time. These will be explored further at FBC-stage and, it is expected, will further strengthen the BCR. These include:

- **Productivity gains because of standardised pathways:** In addition to the reduced length of stay and increased throughput, the standardised pathway is likely to provide other opportunities to deliver productivity gains, such as delivering rota efficiencies and enabling more efficient procurement and reduced waste. Predictability of care also reduces the risk of cancellations and Did Not Attends (DNAs).
- **Impact of a more sustainable workforce:** The benefits identified in terms of improved recruitment and retention provide opportunities to reduce the impact of long-term vacancies reducing agency, locum and bank usage and, potentially, reducing recruitment time and costs.

LHP will also deliver various non-financial benefits which while they cannot be quantified in monetary terms are equally important to the delivery of local, regional and national policy. These include:

- **Improved patient experience:** As well as reduced waiting times and length of stay, patient experience is enhanced by the modern fit for purpose facilities and the ease of access the location of LHP offers, with its good road links and parking.
- **Increased staff satisfaction:** The improved training pathway and increased training opportunities, along with the modern fit for purpose facilities and a consolidated service model that enables more effective ways of working, contributes to staff satisfaction and creates an attractive place to work which will support recruitment and retention of highly trained health professionals.
- **Increased training opportunities:** The additional theatre capacity will provide significant opportunities to increase the number of training places available in the region.

- **Increased compliance:** Delivery of orthopaedic services in a hub will ensure alignment with GIRFT principles. Modern fit for purpose facilities that are compliant with WHBNs and HTNs, achieve BREEAM rating of Excellent.
- **Reduced health inequalities:** Reduction in waiting times and ease of access supports equality of access.
- **Community Benefits:** The contractor has agreed to implementing several community benefits, including hiring local, providing volunteering and donations to local organisations, investing in people learning and using Welsh and investing in the local supply chain.
- **Future proofing:** The site also provides a level of future proofing by providing expansion space that offers opportunities for other future developments.
- **Impact of a more sustainable estate:** The delivery of appropriately designed compliant facilities provides opportunities to contribute to CTM UHB's environmentally sustainable goals and national strategies around decarbonisation and optimising energy efficiency. The transformed model of care with its standardised pathway is likely to make it easier to implement and maintain sustainability programmes that CTM UHB has instituted in other areas, such as reducing waste and single use products.
- **Opportunities for future transformation:** The additional capacity offered by LHP provides opportunities to transform and reconfigure core local services and deliver things differently in the future. The successful delivery of a regional centre will also provide proof of concept as the basis for the development of any future regional pathways.

The results of the options appraisal are presented in the table below.

Table 22 - Results of options appraisal

Element	Option 0 - BAU	Option 1 - PWF
Initial capital investment (including VAT)	-	£123.6m
Incremental NPSV	-	£500.7m
Benefit Cost Ratio	-	1.54

It should be noted that this assessment is based on an initial assessment of benefits and further work is required to quantify these more fully. As outlined above, it is anticipated that this is likely to further strengthen the BCR and value for money case as the scheme progresses to FBC stage.

Commercial Case

8 Procurement strategy

8.1 Introduction

This section of the business case outlines the procurement strategy and proposed deal to deliver the preferred option develop a regional orthopaedic surgical hub, co-located with a regional diagnostics and endoscopy centre on the Llantrisant Health Park site, as discussed in the economic case.

The former British Airways Avionics Engineering (BAAE) site was acquired by CTMUHB in February 2023. The Llantrisant Health Park site will comprise a Community Diagnostics Hub, Orthopaedic Surgical Hub with associated ward accommodation, and other regional services, which may include Day Surgery. The Orthopaedic Surgical Hub will be delivered as the second phase of a multi-phase development.

The following section sets out the commercial arrangements for the capital LHP site.

To maintain momentum within the programme, a decision was made to proceed with demolitions under a separate contract. The main contractor was appointed in March 2025 during the original programme RIBA 3 stage to support continued development of the design and construction elements. This ensured that the contractor was involved in the more detailed design incorporating the latest technology and identifying programme opportunities. In addition, the contractor has been able to lead on the SAB and planning applications which are based on their design.

8.2 Demolition Contractor procurement

A detailed procurement tender was undertaken by CTMUHB procurement and NWSSP using the Crown Commercial Services Framework, Construction Works and Associated Services Lot 10 Demolition framework.

The procurement was prepared and completed by CTMUHB, the appointed design team and NWSSP procurement services. The procurement process was undertaken for a new contract, whereby an Expression of Interest was issued to 13 national demolition providers on 30 October 2024 and providers had until 31 October 2024 to respond. Following the deadline, only five providers responded to the Expression of Interest.

A Mini competition was undertaken, utilising *RM6088 Construction Works and Associated Services Framework lot 10 Demolition*, and was published via e-Tender Bravo portal, in which certain selection criteria was applied at the qualification, technical and commercial evaluation stages.

Tenders were published on 1 November with the deadline for submission on 25 November. At the end of the tender period, five submissions were received, however after review, two suppliers failed to meet the minimum criteria, leaving three for scoring. Detail of the scoring approach is included in the tender analysis submitted as part of the estates annex.

A preferred supplier was identified and appointed in January 2025 following WG approval of funding for demolition works to proceed.

The contract commenced and work began on site on 14 April 2025. This contract was originally programmed to conclude by 22 August 2025, however, there was a delay caused by contractor methodology in the earlier stages and plant failing in the latter phases. The contract completed with the contractor leaving site on the 3rd October. The delays were not at the cost of CTM therefore the demolition programme completed within the approved funding level.

8.2.1 Main Contractor procurement

The main contractor tender process completed in November 2024. The tender was issued via the Crown Commercial Services (CCS) framework. The Welsh NHS run Building for Wales (BfW) framework was not selected due to:

- Delays in the implementation of the new framework after the previous one ended in April 2024
- Delays associated with securing the funding information required to commence the tender
- Inclusion of high levels of modular development in the design, with no modular supplier on BfW this would not have provided value for money.

As a result, a framework was selected that enabled the Programme to test the appetite and ability of both modular and other modern methods of construction (MMC) contractors to respond and offer the most advantageous infrastructure solution to the programme. A two-stage design and build contract solution was selected with a fixed price for the professional services and a target cost model for the construction phase (similar to the contractual arrangements under BfW).

An expression of interest was issued in October 2024, and seven companies opted in to show an interest. The tender was published on 13 November 2024 and after two extensions, closed on 31 January 2025.

The process has been managed by Mott McDonald, acting as primary PM for tender and procurement exercise and at all stages support has been provided by NWSSP procurement services.

The tender period closed on 31 January 2025 with three responses received. There were some clarifications required from tendering parties, the detail of which is available if required. Legal advice was sought regarding the contractual terms and conditions.

By the end of the process, only one contractor confirmed full acceptance of the proposed terms and conditions for both design and build contracts. In addition, the same contractor offered the best overall score in the combined qualitative and quantitative analysis. This information can be found in the tender analysis report contained in the estates annex to the business case.

Following completion of the tender scoring, the outcome was presented to NWSSP-SES and a paper prepared for WG approval for CTMUHB to appoint MTX, the preferred contractor. This approval was granted by letter on 14 March and, following the mandatory 10-day standstill period, MTX were appointed as the successful contractor on 31 March 2025, under an NEC professional services contract, to deliver the design up to completion of RIBA 4 and development of target cost.

Tendering parties provided costs up to RIBA 4 completion, as per standard NEC professional services contract (PSC). This will enable generation of completed design, securing of planning and SAB approvals, with fully tendered build costs. As a design and build arrangement, and to proceed to construction, an ECC contract will be required to be entered into on FBC approval.

CTMUHB requested WG approval to enter into the full PSC contract, which would take the scheme up to RIBA 4, at a contractor design fee cost of £3.935m. This cost excludes VAT and the additional health board fees associated with both RIBA 3 and 4. Full costs are included in the finance section of this case.

It should be noted that the cost tendered by the contractor was based on a single business case process and start-on-site of a phased construction completion programme. The recent decision and instruction to split this work into phases, each with its own business case and development programme, has subsequently elongated the programme and increased the level of costs and fees incurred. A longer design period will mean further costs for all time-based consultants.

As mentioned in the strategic case, the split to a phase approach has increased the design fees over and above the original tendered sum. There are 3 reasons for this:

1. The redesign elements to ensure that Phase 1 can be fully stand alone and to change some of the supporting infrastructure to support a fully phased approach
2. The elongated programme as a result of the splitting of the programme into phases and confirmation of an OBC and FBC requirement for each separate phase, this has added circa 6 months to the PSC programme with Phase 2 FBC being completed by May 2026, previously October 2025 for the whole programme.
3. The decision made to reconfigure the former surgical hub area in the phased approach to focus phase 2 on the delivery of the regional orthopaedic hub and a future Phase 3 to be further scoped and possibly include day surgery.

The changes to the design on point 3 above have meant that there has had to be an architectural revisit of RIBA 2 which has been used as the basis for this OBC. RIBA 3 and 4 stages will take place during the FBC development works which explains the longer time between OBC and FBC for Phases 1 and 2 than for Phase 1.

As a result of the changes outlined above the amended PSC total fees for phases 1 and 2 are as set out in the table below

Table 23 - Comparison of phased PSC fees to original tendered fees

Cost element	Original Tender £000	Phase 1 PSC £000	Phase2 PSC £000	Revised Total PCSC Fees £000
RIBA 3	400	1,491	1,534	3,025
RIBA 4	3534	1,405	924	2,328
Total	***3,934***	***2,896***	***2,457***	***5,353***
Increase from Tendered Cost				1,419
% Uplift on Tendered Cost				36%

These costs only cover the MTX costs for each of the phases. The increase is within procurement and framework permitted allowances and has been fully scrutinised by the programme cost advisors, Mott MacDonald.

For this Phase 2 OBC, the above table sets out the main contractor fees from resumption of duties in September to FBC approval covering completion of RIBA stages 2, 3 and 4. The total costs are as set out in the table below and include internal HB and external consultant costs.

Table 24 – Total costs

Cost element	OBC £000	FBC £000	Total Phase 2 PSC £000
CTM Fees	228	340	568
MTX	1,534	924	**2,457**
External Consultant	125	227	352
Surveys & Planning	17	149	**166**
Risk	31	29	60
Total	***1,934***	***1,669***	***3,603***
Funded	-1,934	0	-1,934
Awaiting Funding	**0**	**-1,669**	**-1,669**

Total design stage fees amount to £3.6M with £1.9M fees to approval of OBC. The OBC fees have been approved that the balance of fees will be required on OBC approval to progress the programme to approval of FBC. These fees will be profiled over two financial years. If the OBC is approved in January 2026, a further £0.9M fees will be required to progress RIBA 4 design work to end March 2025. The balance of £0.77M will be required in the 2026/27 financial year.

8.3 Payment mechanism

As mentioned previously all tendering parties provided costs up to RIBA 4 completion, as per standard NEC professional services contract (PSC). This enables generation of completed design, securing of planning and SAB approvals, with fully tendered build costs. As a design and build arrangement and to proceed to construction, an ECC contract will be required to be entered into on FBC approval.

On contractor appointment CTMUHB requested WG approval to enter into the full PSC contract, which would have taken the original scheme up to RIBA 4, at a contractor design fee cost of £3.935m. As mentioned in the sections above this has now been uplifted to cover the additional phase associated with the phased approach and the changed focus for phase 2 of the development.

To date funding has been approved for the RIBA 2 and 3 design stage of £1.93M. This has enabled the revisit of RIBA Stage 2 for the amended design and work has commenced on RIBA 3 redesign and engineering elements.

8.4 Health Board contracting arrangements

As mentioned above, for the PSC design phase a single contract under NEC 4 has been entered into. The change to a phased construction approach will have an impact on the ECC contract for the construction phase. This will still be under NEC 4 Option C however will need to accommodate future option with differing approval and start on site timescales.

When a phased approach was confirmed, CTM conducted a detailed review of the contractual options for the programme considering the likely timeline in relation to the timing of WG approvals and funding release. Four potential contract structures were considered:

a) Enter into full contract award for Phase 1 CDH approved works cost with a provisional sum allowance for phase 2.

b) Enter into contract for phase 1 CDH with a later instructed compensation event for phase 2 (and possibly phase 3)

c) Separate ECC Contracts for each Phase

d) Contract for Phase 1 but include future phases using X22 Break Clause

The PM, CA and LHP technical team considered all 4 options and the risks and opportunities considered with each which are set out in the table below:

Table 25 – Opportunities and risks

Option	Opportunities	Risks
1	• Early inclusion of Phase 2 allows for some planning continuity and contractor engagement.	• Possible claim against £60m Prov sum not being proceeded with (6% loss of profit) • Provisional sums are not well-defined in NEC contracts, which may lead to ambiguity and

Option	Opportunities	Risks
	• May simplify procurement and contract administration by keeping both phases under one contract. • Continuity of workforce or shared resources across phases. • Reduces risk of contractor re negotiation	disputes (mitigated with comprehensive Z clauses) • Opportunity for MTX to increase Prelims, mitigated by negotiation reducing% back to original 6% • Lack of clarity on scope, pricing, and risk allocation for Phase 2 will reduce accuracy of Prov sum • Contractor may price risk conservatively, inflating the Phase 1 Target Cost. • Difficult to manage change control and performance incentives for Phase 2, mitigated through management of sectional completion • •HB approval of a contract which exceeds approved capital funding- SFI breach
2	• Allows flexibility to define Phase 2 scope and cost later, based on Phase 1 outcomes. • Keeps Phase 2 within the same contract, maintaining continuity and reducing procurement overhead. • Can be used to quickly mobilise Phase 2 if timing is critical. • Contractually protects client as no commitment to Phase 2	• Opportunity for MTX to increase Prelims, mitigated by negotiation reducing% back to original 6% • Compensation events are reactive, not ideal for large, planned works like Phase 2, mitigation would be managed as 2nd stage tender • Risk of contractor pricing Phase 2 with limited competitive tension or transparency, mitigation would be managed as 2nd stage tender • •Potential for misalignment with NEC principles of early warning and collaboration. • Framework and commercial acceptability of a compensation event ea 100% of awarded value • Due to above could not be used for Phase 3
3	• Clear commercial and legal separation between phases, reducing ambiguity. • Allows competitive tendering for Phase 2, potentially improving value for money. • Lessons learned from Phase 1 can inform Phase 2 scope, risk allocation, and pricing.	• Opportunity for MTX to increase Prelims • Loss of continuity in delivery team and supply chain. • Potential delays between phases due to contract negotiation • Risk of misalignment in programme, design standards, or stakeholder expectations • Possible duplication of resources between 2 contracts
4	• Clause X22 (Early Contractor Involvement) su[Pports collaborative planning and progressive cost definition. • Break clause provides flexibility to exit or re-scope Phase 2 if needed. • Aligns well with NEC principles of collaboration and transparency.	• X22 currently not included within ECC contract at tender stage • Requires robust governance and clarity on break clause triggers. • Contractor may invest effort in Phase 2 planning without guarantee of delivery. • Potential for sunk costs or disputes if Phase 2 is not progressed. • •May require careful drafting to ensure Phase 2 scope and pricing are appropriately managed. • Opportunity for MTX to increase Prelims, mitigated by negotiation reducing% back to original 6%

In reality Option 1 would be almost impossible to reconcile with CTMs standing financial instructions as it would require signing a contract with a value in excess of CTM approved capital sums. Whilst the provisional sum could be excluded from the contract in future it is included in the contract sum and could also give risk to a loss of profits claim from the contractor if they acted in reliance of the same and future phase were not approved. Further to this as any phase 3 is programmed behind phase 2 and does not yet have a fully confirmed scope. As a result any inclusion of a provisional sum for this phase would be highly forecast with a large number of caveats and risk allowances. The major risks of potential disputes and of HB financial noncompliance ruled this option out.

Similarly, the position in relation to Option 2 was considered too high risk for a similar reason in terms of the contract being for more than one phase therefore possibly also giving rise to a claim of loss of profit if the future phase(s) did not proceed. In addition, current procurement rules preclude contract sum increases over 50% of the original value awarded. Any sum would be well in excess of this and in excess of 100% therefore this was not recommended.

It was felt that despite specific protection in contractual clauses that option 4 would offer similar finance and procurement SFI risks around the contract values as well as use of largely untested contractual clauses. Drafting and agreement of the same could be timely and costly with specialist legal advisors.

In reality the differing approval timescales and associated funding release make separate contractual arrangements the lowest risk position for this programme. There is a risk of loss of administrative efficiency in terms of contract management as well as the risk that MTX may seek to vary contractual terms however this will need to be managed.

This was the preferred option proposed to MTX who agreed with the same as being the most logical way forward. Revised Phase 1 ECC contracts have been issued on the same contractual terms as the original single phase and to date no discussion re their variance has been received or included in their submitted construction costs.

As a result, it is proposed that each phase will require a separate ECC contract and this will be the proposed contracting solution for all approved phases.

8.5 Associated disposals

There are no known disposals associated with this development, which would generate income for the three UHBs.

8.6 Design and compliance with mandatory standards

8.6.1 NHS Net Zero compliance

In October 2020 the NHS published the ***Delivering a Net Zero National Health Service*** in response to the health emergency that climate change will bring. More intense storms and floods, more frequent heat waves and the spread of infectious diseases resulting from climate change threaten to undermine years of health gains.

Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

- For the emissions the NHS controls directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;

- For the emissions that can be influenced (the NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

NHS Net Zero Building Standard

The NHS Net Zero Building Standard, published in February 2023, provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future. 10% plus of the carbon emissions associated with operating the NHS estates are as a result of energy usage (operational carbon) alongside embodied carbon. The standard is a critical element in ensuring that the design and construction of new NHS buildings and the inevitable refurbishment / repurposing of the existing estate supports the “Delivering Net Zero” commitment to a zero-carbon estate by 2040.

The proposed LHP development design process will follow the guidance of the standard through RIBA stages 1-4.

The construction process for LHP will follow the guidance of the standard through RIBA stages 5-7. To facilitate this as required a Net Zero Carbon (NZC) Coordinator will be appointed who will be responsible for managing the process as well as being an advocate for Zero Carbon within the design team.

8.6.2 Modern Methods of Construction

NHS Wales and NHS Improvement with the Department of Health and Social Care, are working on progressing the approaches used to increase the use of Modern Methods of Construction (MMC) on all business cases requiring central NHS sign off. As part of this, an interim draft guidance has been developed for inclusion in the NHS Capital Business Case Fundamental Criteria Checklist.

Early consideration of the use of off-site manufacture, allows the process to be streamlined through the design and construction process, maximising the benefits this approach can bring. Agreement to an early BIM Execution Plan and sharing information in a project specific Common Data Environment (CDE) allows all parties to input in an integrated design, manufacturing, and assembly process.

LHP will be constructed using MMC and be entirely modular.

8.6.3 BREEAM

The Building Research Establishment Environmental Assessment Method (BREEAM) is the leading and most widely used environmental assessment method for buildings and communities. It sets the standard for best practice in sustainable design and has become the de facto measure used to describe a building's environmental performance.

As of 1 July 2008, all developments of new healthcare buildings in the UK seeking OBC approval must commit to acheiving an EXCELLENT rating (assessed against BREEAM New Construction) and all refurbishments (assessed against BREEAM Non-Domestic refurbishment and fit-out) to commit to a VERY GOOD rating. Any project with a capital value exceeding the £2m threshold must include a BREEAM assessment.

BREEAM provides clients, developers, designers and others with:

- Market recognition for low environmental impact buildings
- Assurance that best environmental practice is incorporated into a building development
- Inspiration to find innovative solutions that minimise the environmental impact
- A benchmark that is higher than regulation
- A tool to help reduce running costs, improve working and living environments
- A standard that demonstrates progress towards corporate and organisational environmental objectives.

BREEAM addresses wide ranging environmental and sustainability issues and enables developers and designers to prove the environmental credentials of their buildings to planners and clients and:

- Uses a straightforward scoring system that is transparent, easy to understand and supported by evidence-based research
- Has a positive influence on the design, construction and management of buildings
- Sets and maintains a robust technical standard with rigorous quality assurance and certification.

BREEAM is a compulsory requirement for projects of this scale in Wales, as such work towards accreditation has been ongoing since RIBA Stage 1. The Design Stage Tracker set out the target ambition for the project to achieve BREEAM 'Excellent'. Moving forward, workshops are to be set up for RIBA 3B stage, ensuring that design adaptions do not compromise the project trajectory.

Infection control

The proposed development will be designed and configured in compliance with WHBN and WHTM guidance to provide clean, well-designed environments within which clinical services and procedures can be carried out safely. Infection prevention and control measures will be designed into the new building through zoning, with appropriate clinical adjacencies to facilitate clean to dirty flows and the provision of good access for cleaning and maintenance to take place.

As planned for the design development at OBC stage, the clinical leads will be fully engaged to ensure the needs of users are understood and clearly articulated in the design brief. Health Board Infection Prevention and Control Teams will also be continually engaged by the Project Team and Design Team to inform the detailed designs.

Sustainability

Efficient building services design can have a positive impact on future climate scenarios by reducing energy consumption and greenhouse gas emissions associated with buildings.

Climate change is primarily driven by the release of greenhouse gases such as carbon dioxide, methane, and nitrous oxide into the atmosphere, and buildings account for a significant portion of these emissions.

When designing LHP, the aim will be to ensure that the building will operate as efficiently and sustainably as possible.

8.7 VAT recovery

A VAT Advisor has not yet been engaged for OBC stage, however the approach mirrors the advice given for the Phase 1 FBC and assumes full recovery on professional fees but no recovery on the building costs.

8.8 Interface

The LHP finance representative has confirmed there is no interface between any NHS LIFT, PFI, PF2 or other PPP and there are no joint venture agreements/contracts already in place and therefore there are practical or contractual issues in the light of HM Government changes to the use of PFI in its various forms.

8.9 Summary and conclusion

Following a robust tender process, MTX have been appointed as the preferred contractor offering the most commercially advantageous tender, following both qualitative and financial appraisal.

Welsh Government approval for fees to FBC of £1.67M with £0.7M in 25/26 and the balance to be funded in 2026/27.

Financial Case

9 Financial Case

9.1 Introduction

The purpose of the Financial Case is to outline the financial implications of the preferred option and assess affordability. As such it sets out the capital requirements and revenue consequences of the proposed scheme, along with underpinning assumptions. It outlines anticipated funding arrangements and the impact on the overall financial statements.

As outlined in the Economic Case, the preferred option is an NHS-funded capital build for the Orthopaedic Surgical Hub at Llantrisant Health Park, delivering theatres and ward accommodation for high-volume, low-complexity arthroplasty procedures.

9.2 Capital costs and funding

9.2.1 Capital costs

Delivery of the preferred option requires capital investment of £123.6m in total. This is based on capital requirements prepared by the Health Board's Cost Advisors, Mott Macdonald using the following assumptions:

- Agreed Schedules of Accommodation and RIBA 2 Order of Cost estimate.
- Due to the pace at which design has proceeded a number of drawings and design strategy information has not been available when formulating the costs. This information will become available prior to WG OBC submission. Therefore the costs included are as cost not to be exceeded. The figure in the submitted OBC may differ from those in this business case but will not exceed it.
- Proposed start on site September 2026 and proposed completion date of September 2028, with it officially opening at the start of January 2029, following a 3 month commissioning phase.
- Works costs calculated using benchmarked rates suitable for South Wales (including Healthcare Premises Cost Guide) @ BCIS TPI updated 06/11/2025.
- Allowances for fees, equipment costs, planning contingency have been applied as appropriate.
- No allowance for optimism bias has been applied at this stage. Given the early design maturity, significant unknowns remain around planning, structural, and sustainability requirements. Instead of applying a generic optimism bias, the estimate incorporates a quantified risk allowance (currently 12%, including contractor risk) to reflect these uncertainties. This approach will be reviewed and refined as design progresses.
- VAT advisor advice will be sought on VAT recovery options before FBC. Currently all fees are forecast to be VAT recoverable.

The resulting capital costs estimates are summarised in the table below and a copy of the detailed capital cost forms are provided in Appendix 7.

Table 26 – *Capital Costs*

	Net £'000	VAT £'000	Total £'000
Construction Costs	70,924	14,185	85,109
Project Fees	8,357	1,671	10,028
Non-Works	185	37	222
Equipment Costs	9,805	1,961	11,766
Planning Contingency	9,800	1,960	11,760

	Net £'000	VAT £'000	Total £'000
Inflation	5,104	1,020	6,125
Subtotal	104,175	20,835	125,010
Less: Recoverable VAT	0	-1,381	-1,724
Total capital costs	104,175	19,454	123,629

9.2.2 Funding requirements

Funding of £1.934M has been received to date. Further Funding of £121.7m is requested from Welsh Government which includes:

- RIBA 4 fees - £1.67m
- Construction - £120m

Table 27 – Capital cashflow and funding sources

	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	Total £'000
Costs					
Construction costs	0	16,884	42,210	11,831	70,924
Project fees	2,463	3,074	1,879	940	8,357
Non-works costs	78	57	30	20	185
Equipment costs	0	1,000	6,305	2,500	9,805
Planning contingency	87	3,468	4,163	2,082	9,800
Inflation	0	2,041	2,041	1,021	5,104
Subtotal	2,628	26,525	56,929	18,394	**104,175**
VAT	17	4,795	11,055	3,587	19,454
Total capital costs	2,645	31,320	67,684	21,980	123,629
Funding					
To OBC	1,934	0	0	0	1,934
Funding Received to Date	1,934				**1,934**
Funding Still Required	711	31,320	67,684	21,980	121,695
Total funding requirement	**2,645**	**31,320**	**67,684**	**21,980**	**123,629**

9.3 Revenue affordability

9.3.1 Recurring revenue costs

It is anticipated that the creation of the new Orthopaedic Surgical Hub will incur additional recurring full-year revenue costs of £39.9m per annum. This covers pay and non-pay costs associated with delivering procedures across theatres and supporting wards. This estimate is based on:

- Pay costs of £15m, covering 220.33WTE medical, nursing, allied health professionals, administrative and estates staff.
- Non-pay costs of £18.8m including supplies and services for Theatres, Ward and supporting areas.
- Building running costs of £3m related to rates, utilities, and maintenance

- Depreciation as outlined in section 9.4.

It is expected that activity and revenue costs will begin post completion and commissioning of Phase 2 of the build. Whilst the main contractor build programme will complete at the end of September 2028 it is expected that the handover, equipping and commissioning could take up to three additional months, which is expected to be at the end of December 2028, which means the first year will incur three months of activity and revenue costs.

A summary of costs is provided below with more detailed calculations provided in Appendix 8.

Table 28 – Summary of revenue costs

Revenue element	WTE	2028/29 (Assume 3 months) £'000	2029/30 – Onwards £'000
Pay Costs	220.33	3,759	15,035
Non Pay Costs		4,693	18,770
Building running costs		744	2,976
Depreciation		790	3,160
Total annual revenue costs		**9,985**	**39,941**

To reduce the overall revenue impact, several existing services will transfer into the new orthopaedic unit. These include ward and theatre activity, along with associated staff and non-pay costs. Together, these transfers are expected to offset approximately £7.3 million of the new unit's annual cost. Welsh Government support for depreciation adds a further £3.1 million, bringing total anticipated funding to £10.4 million. Despite these measures, a regional affordability gap of £29.5 million remains, which will need to be addressed collectively by partner Health Boards and Welsh Government.

9.3.2 Commissioner funding requirements

Revenue funding requirements for the orthopaedic surgical unit have been estimated based on projected activity levels and associated capacity needs. The hub will deliver 5,760 procedures annually, providing additional lower limb arthroplasty capacity to address the regional demand and capacity gap. Activity assumptions by Health Board are as follows:

- CTM UHB: 3,840 procedures
- Cardiff & Vale UHB: 960 procedures
- Aneurin Bevan UHB: 960 procedures

Indicative recurring revenue costs for the hub total £39.9 million per annum, covering pay costs for approximately 220 WTE staff, non-pay costs for theatre and ward consumables, building running costs, and depreciation of £3.1 million.

To reduce the overall revenue impact, several existing services will transfer into the new orthopaedic unit. These include ward and theatre activity, along with associated staff and non-pay costs. Together, these transfers are expected to offset approximately £7.3 million of the new unit's annual cost. Welsh Government support for depreciation adds a further £3.1 million, bringing total anticipated funding to £10.4 million. Despite these measures, a regional affordability gap of £29.5 million remains, which will need to be addressed collectively by partner Health Boards and Welsh Government.

Table 29 – Sources of funding

Revenue element	WTE	£'000
Pay Costs	220.33	15,035
Non-Pay Costs		18,770
Building running costs		2,976
Depreciation		3,160
Total annual revenue costs		**39,941**
Anticipated Funding:		
Transfers – Substitution of existing services		7,298
Welsh Government Central funding for Depreciation		3,160
Anticipated Funding		**10,458**
Regional Funding Requirement		**29,483**

9.3.3 Value for Money

Analysis has been undertaken to compare the commissioner funding requirements as a result of LHP compared to benchmarks, specifically NHS England tariff and outsourcing to a private provider. The results of this analysis, which are summarised in the table below (with more detailed calculations provided in Appendix 8), suggest that the Orthopaedic Hub offers relatively good value for money since:

- Compared to NHS England tariff: Estimated costs for the hub are lower than NHS England rates, with tariff-based costs projected to be around £45.6 million per annum, compared to the hub's estimated £39.8 million. This represents a difference of approximately 14.5% higher under tariff, equating to an additional £5.8 million per year if activity were funded at tariff levels.
- Compared to private outsourcing: Outsourcing the same activity to the independent sector would be significantly more expensive, with costs estimated at £52.1 million per annum which is around 31% higher than the hub model. This would result in an additional £12.3 million per year, creating a substantial financial impact for commissioners.

Table 30 - Funding model

Funding Model	Annual Cost £'000	Impact vs Hub £'000	Difference %
Orthopaedic Hub	39,941	0	0
NHS England Tariff	45,563	5,621	12%
Private Outsourcing	52,072	12,130	23%

9.4 Accounting treatment and capital charges

9.4.1 Accounting treatment

The resulting asset will be held on CTM's balance sheet and therefore be treated in line with the Health Board's policy in relation to depreciation and impairments.

9.4.2 Capital charges

Capital charges have therefore been estimated based on the following assumptions:

- Asset additions of £123.6m
- Impairment is applied when the resulting asset comes into use. Based on recent schemes in the region, it has been assumed to be 25%, although this will need to be confirmed with the District Valuer and CTMUHB's Auditors during the development of the FBC stage. Full impairment is assumed on fees, 25% on non-works costs, contingency and inflation.
- Depreciation charges are applied based on straight line depreciation using the following standard useful life:
  - **Buildings** – 60 years for buildings and 35 for engineering works (using a typical 65:35 split)
  - **Equipment** – seven years as a proxy for a mixture of short life ICT equipment (five years) and longer life equipment (10 years).

It is anticipated that this will result in:

- Circa £84.5m non-recurring AME impairment on completion of the new build which will be funded as AME funding via Welsh Government
- £3.16m annual depreciation, which will be funded by Welsh Government.

9.4.3 IFRS16 implications

There are no IFRS16 implications anticipated for the orthopaedic unit, as the facility will be delivered through capital investment rather than lease arrangements. All costs associated with construction an equipment are included within the capital expenditure and will be accounted for in line with standard depreciation and impairment policies. Any future contractual arrangements for services will be reviewed at FBC stage, but based on the current model, IFRS16 does not apply.

9.5 Overall affordability

The financial analysis demonstrates that delivery of the preferred way forward is affordable providing that Welsh Government capital funding can be secured, and agreement reached with commissioners about revenue funding requirements.

9.5.1 Capital affordability

The cost plan prepared by CTM's Cost Advisors, based on RIBA1 design, estimates that delivery of LHP will result in capital investment requirements of £123.6m in total, including expenditure incurred to date. Funding to date of £1.934M has been received leaving a balance of £121.695M to be funded. It is anticipated that the funding balance will be required from Welsh Government as follows:

- RIBA 4 fees - £1.669m
- Construction - £120.024m

9.5.2 Revenue affordability

Work undertaken by the programme team and finance leads indicates that the orthopaedic unit will incur recurring revenue costs of £39.9 million per annum, including:

- Pay costs of £15.0 million for approximately 220 WTE staff

- Non-pay costs of £24.8 million, covering theatre and ward consumables, building running costs, and depreciation of £3.16 million.

These indicative costs are based on high level assumptions at this stage and will be firmed up at FBC stage once more detailed information, such as the workforce plan, is available.

£10.4m p.a. of funding has been identified which will partly cover these additional costs which include the following sources:

- £7.3m associated with the substitution of existing services at CTM including transfers of Ward, Theatres, Medical staff and non-pay costs
- Anticipated £3.16m of Welsh Government Central funding for depreciation

This leaves an affordability gap of £29.5 million across the region. Work is underway with partner Health Boards and Welsh Government to develop a sustainable solution that aligns with the regional service model and supports timely access to care. Engagement activity is being coordinated to ensure transparency and shared understanding, drawing on lessons from previous programmes and focusing on collaborative planning to address both financial and operational challenges.

Management Case

10 Management arrangements

10.1 Introduction

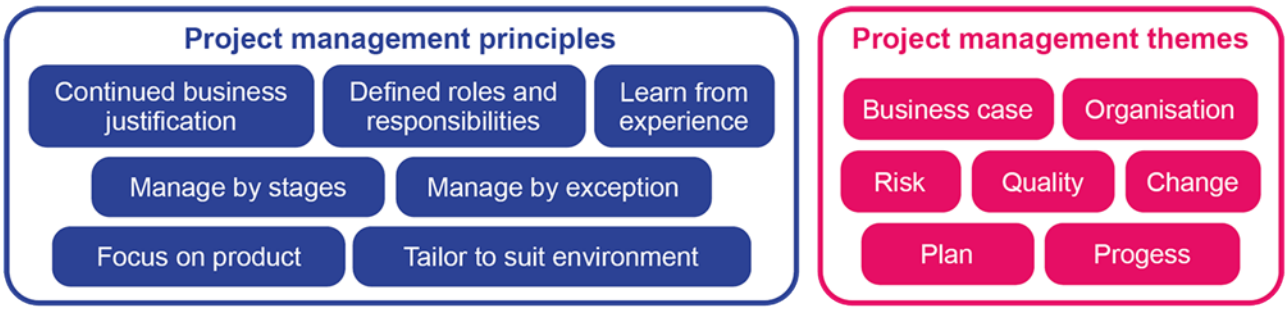
This section of the business case sets management arrangements that will successfully deliver Llantrisant Health Park Programme to time, cost and quality. The Management Case outlines the following arrangements:

- Project management arrangements
- Project assurance at different stages of the project
- Change management arrangements
- Benefits realisation and plans
- Risk management plans
- Contract management arrangements
- Post project evaluation plans
- Contingency plans.

10.2 Project management arrangements

The Project be delivered in line with PRINCE2 methodology. PRINCE2 is organised into seven principles and seven themes, which are deemed essential for any project to be deemed to be 'controlled'. This programme will apply these principles and themes throughout.

Figure 15 - Project management principles and themes



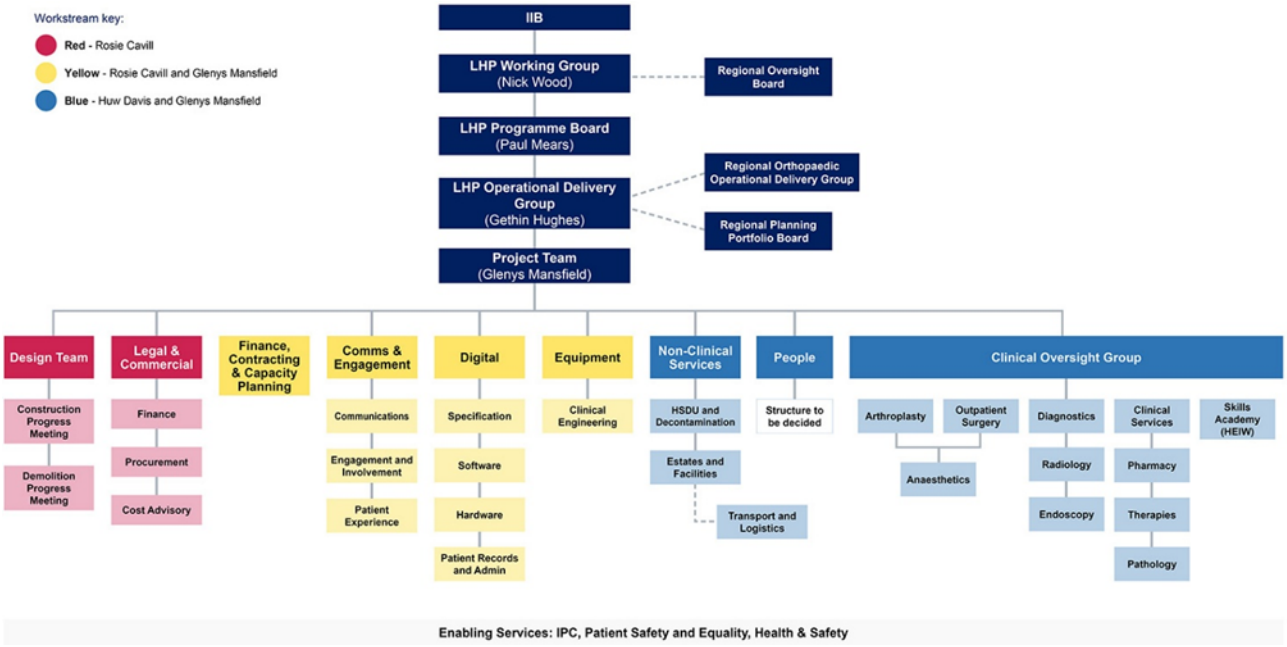
The key principles behind PRINCE2 are the identification of three main functional areas of the project governance structure, including governance, delivery and assurance functions.

10.2.1 Project reporting structure

The programme governance structure has been established to reflect the principles and themes of controlled project delivery. The workstreams will report into the Project Team and Steering Group, Steering Group then reports into Programme Board which then reports to the Regional Oversight Board and CTM UHB Governance.

The project governance arrangements are outlined below.

Figure 16 - Project governance arrangements



10.2.2 Governance pathway

There is a clear demarcation between those groups with a responsibility to produce outputs needed to deliver the project i.e. workstreams and delivery groups, and those forums with responsibility to scrutinise, challenge and approve the outputs ensuring that the programme is directed consistently across all subject matters i.e. governance committees.

The main governance routes for reporting include CTM UHB Main Board and the Regional Portfolio Oversight Board.

10.2.3 Programme Board

Chair: Paul Mears, Chief Executive Officer and SRO for the Project, CTM UHB

The Llantrisant Health Park Infrastructure Programme Board has responsibility for overseeing the management and delivery of all aspects of this programme including the design proposals and the associated business cases.

The duties of the Programme Board are as follows:

- Ensure the programme objectives and scope of all projects have been appropriately defined and that any material changes are formally approved and integrated
- Ensure a robust programme timetable has been produced and monitored and that each workstream lead is committed and remains committed to its delivery
- Oversee the delivery of all projects within the defined parameters of time, cost and to the required quality and specification
- Ensure the cost implications of the programme are fully set out within robust financial plans and that it remains within the health board's overall affordability envelope
- Ensure there is an effective system of cost control in place and receive regular reports on the current and planned expenditure relating to the delivery of the programme
- Ensure that the programme is sufficiently resourced to deliver within its agreed scope, time, cost, and quality parameters
- Ensure there is an effective risk management system in place and that regular reports on the risks and issues are effectively acted upon

- Ensure that all development proposals meet the highest possible standards of design in respect of clinical use, patient and staff environment and building quality
- Sign off key documents including the clinical services strategy, business case, prior to submission to the IIB/Welsh Government for approval, as well as other key programme documents as required.

10.2.4 Programme Management Office

The Programme Management Office (PMO) is responsible for the oversight of all workstream project management within the programme. The PMO maintains internal reports and PRINCE2 documents including risk registers, issues logs and an assumptions log for the redevelopment. The team provides assurance by maintaining a focus on governance and programme controls and through the regular review and mitigation of risks and issues.

The programme plan is regularly reviewed and revised by the PMO team to accurately reflect progress, identify potential delays and ensure lessons learned are applied to planning. The PMO support resource management within the programme and produce project artefacts and tools for workstreams.

The duties of the PMO are as follows:

- Establish and run an effective PMO to support the programme during the business case process
- Establish and implement a robust governance structure
- Collate and interrogate management reports, assessing the health of the programme delivery environment
- Assess the status of milestones and deliverables from each workstream
- Plan and schedule resources efficiently in order to meet objectives
- Streamline and automate processes and workflows, ensuring escalation routes to governance committees are robust and succinct
- Facilitate knowledge transfers between workstreams
- Support project management resource within workstreams, where appropriate
- Facilitate cross stream working and collaboration
- Develop progress and assurance reports for key groups and committees as required.

10.2.5 Specialist workstreams and task and finish group

Included in the structure above, are specialist task and finish groups to support the clinical and non-clinical aspects of the redevelopment. These groups are the key interface between the delivery functions and the ‘front line’ workforce who deliver clinical and operational (non-clinical) services. The groups provide feedback and knowledge on their departmental requirements to the programme technical delivery experts.

10.2.6 Design Team

A design team has been appointed to review the concept site assumptions made prior to the site acquisition and develop design proposals. The design team’s work will be informed by the regional workstreams’ clinical specification and proposed models of care.

The key deliverables from this work are:

- Review of the technical infrastructure report (completed)
- A high-level design (RIBA Stage 1) and master plan (completed)

- A concept design (RIBA Stage 2) for the agreed clinical pathways (completed)
- RIBA 3 design works developing on the agreed clinical pathways (underway)
- Undertaking of site surveys (completed)
- A specification of enabling works for the temporary diagnostics facility (completed)
- Preparation of a temporary planning application for the mobile diagnostics facility (completed)
- Appointment of modular partner (complete)
- Confirmation of planning strategy and development of planning applications as required during the timeframe.

Terms of reference for all key project groups i.e. Programme Board, Steering Group, Project Team or Design Team can be made available upon request.

10.2.7 Outline Project Roles and Responsibilities

Key Project delivery roles are described below:

Senior Responsible Officer (SRO)

The Chair/SRO role is held by **Paul Mears**, CEO of CTM UHB and responsibilities include:

- Keeping the Programme Board members informed of progress, escalating matters, as relevant
- Is responsible for providing leadership and the strategic activity of the Health Board, ensuring it is operating effectively and efficiently
- Being the ambassador within the local community and also at a regional and national level
- Ensuring that the programme aligns with the priorities of the wider Welsh Government plans
- Ensuring that the redevelopment programme fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money
- Sponsoring the project within CTM UHB and acts as the main point of contact with the Health Board and Executive Director
- Owning the vision for the project and the supporting business case
- Providing clear leadership and direction at an executive level throughout the programme
- Having full responsibility and accountability for the outcome of the project and realisation of the benefits
- Managing the interface with key senior stakeholders, keeping them engaged and informed
- Being the key link between the relationship between the programme, Regional Portfolio Oversight Board and Welsh Government;
- Maintaining the alignment of the project to the organisation's strategic direction
- Ensuring that the project remains affordable and will improve the quality of care to the target population
- Ensuring that the necessary resources are made available to deliver the scheme
- Chairing the Programme Board.

Infrastructure Programme Director

The Programme Director role is held by **Rosie Cavill**, LHP Programme Director and the main responsibilities include:

- Co-ordinating all workstreams to deliver the agreed objectives

- Monitoring progress, resolving issues, mitigating risks, and initiating corrective action as appropriate
- Providing an overall monitoring and assurance role across the project workstreams, ensuring that project risks and issues and any internal or external dependencies are defined, managed, and escalated where appropriate
- Ensuring appropriate risk, benefits and stakeholder management frameworks are in place for the project
- Acting as the day-to-day agent on behalf of the SRO for the infrastructure elements to ensure the successful delivery of the scheme
- Owning and reviewing the project plan, communicating the impact of any revisions in terms of milestones, timelines, and dependencies
- Ensuring the development of the business case and project documentation
- Ensuring that the initiatives and projects that support the infrastructure delivery of the Health Park are initiated on a consistent basis with governance arrangements that meet requirements
- Managing allocated outputs to the required quality within the agreed time and costs constraints
- Managing and providing assurance for the work of project team members
- Reporting regularly to all relevant individuals and groups using standard reporting processes and templates.

Clinical Operational Director

The Clinical Operations Director role is held by **Glenys Mansfield**, LHP Clinical Operations Director and the main responsibilities include:

- Clinical and operational pathway development to inform design and operational running of LHP
- Review of 1:200 and 1:50 designs
- Development of clinical governance structure
- Development of the workforce plan and delivery plan
- Development of the Digital infrastructure
- Establishing and managing task and finish groups
- Managing interdependencies of clinical model/pathways across workstreams
- Acting as the day-to-day agent on behalf of the SRO for the clinical pathway and operational elements to ensure the successful delivery of the scheme
- Ensuring that the initiatives and projects that support the delivery of the new hospital are initiated on a consistent basis with governance arrangements that meet requirements
- Ensuring appropriate risk, benefits and stakeholder management frameworks are in place for the project
- Reporting regularly to all relevant individuals and groups on clinical and operational pathway developments using standard reporting processes and templates.

Infrastructure Project Manager

The Infrastructure Project Manager role is held by **Alex Bowles**, Archus PM and the main responsibilities include:

- Ensure operational delivery of the project to time, quality, and budget
- Decision on matters for escalation and approval to Project Board and Health Board as required

- Management of risks and issues and escalation of appropriate matters for executive direction and/or approval
- Developing the format of the report, contents, and key requirements for consideration
- Planning and delivering stakeholder engagement and workshops
- Ensure the key milestones are agreed and communicated with all stakeholders.

Construction Partner

The role of Construction Partner Lead will be fulfilled by **MTX**. The role includes:

- Being point of contact for all infrastructure and estate related issues including arranging Isolations and issuing permits to work etc.
- Management of the construction programme
- Providing design/estates related input to OBC/FBC processes.

10.3 Special advisors – roles and responsibilities

Special Advisors have been used in a timely and cost-effective manner in accordance with the Treasury Guidance: Use of Special Advisors, to support the internal resources for this development. Special advisors and their roles on the project are shown below.

Business Case Support – Archus

- Manage the Business Case process including the facilitation of workshops, chasing of information etc.
- Stakeholder engagement
- Technical authoring of the OBC
- Support submission of OBC to WG
- Liaise with LHP Programme Lead on Business Case progress.

Technical Advisor (Architecture and Design) - Stride Treglown

- Providing design advice to the LHP Project Team on contractor lead design changes
- Liaise with appropriate stakeholders
- Preparing regular reports for the Project Manager.

Technical Advisor (Mechanical and Electrical Engineering) Stantec

- Providing technical advice and solutions to the Project/Design Team
- Liaise with appropriate stakeholders
- Assist with the design and construction teams where required
- Preparing regular reports for the Project Manager.

Cost Advisor – Mott MacDonald

- Full financial management and reporting of project costs together with payment recommendations for all expenditure incurred on the project
- Preparation of contract documents, procurement of contractors, payment of valuations and agreement of final accounts
- Budget estimating and cost modelling
- Cost planning
- Provision of cost advice
- Analysing and reporting on tenders received.

- Reporting and advising on all tendering and contractual arrangements
- Preparation of tender documents, including incorporation of client standard amendments and appropriate insurance provisions
- Preparing and issuing regular executive financial reports and cash flow summaries to the Project Manager.

Site Supervisor

This post will be appointed to after OBC approval, during the RIBA 4 design process.

10.4 PM and professional fees budget

The following table outlines the estimated project and professional fees budget for the project split by phase.

Table 31 – Professional fees for Phase 2

Company	Purpose	Total Fees	To OBC	To FBC	To RIBA 5 & Construction
Archus	Project Management	£1,530,000	£64,000	£132,000	£1,334,000
Archus	Business Case Support	£50,000	£18,450	£14,150	£17,400
Stride Treglown (ST)	TA Support	£25,000	£6,500	£8,500	£10,000
Mott Macdonald	Cost Advisor	£378,000	£29,125	£39,375	£309,500
TBA	NEC Supervisor	£520,000			£520,000
Stantec / ST	TA Support	£25,000	£6,500	£8,500	£10,000
NWSSP Audit	Capital Audit	£100,000		£25,000	£75,000
VAT and Legal Advice	Ernst & Young, NWSSP	£50,000			£50,000
CTMUHB	Client Fees	£1,800,000	£227,500	£340,362	£1,232,138
MTX	Construction (PSCP)	£3,878,798	£1,533,698	£923,514	£1,421,587
MTX	*Planning*	*Incl. in MTX fees*			
Stride Treglown (MTX)	*Design Planning*	*Incl. in MTX fees*			
MTX	*Building Services; M&E and Surveys*	*Incl. in MTX fees*			
TOTAL		**£8,356,798**	**£1,885,773**	**£1,491,401**	**£4,979,624**

10.5 Key milestones

A project programme has been developed to control and track the progress (attached at Appendix 10) and delivery of the project and resulting outcomes. Key milestones are summarised below.

Table 32 - Project timeline

Milestone	Start	Completion
SOC submission and approval	Sept 2024	Sept 2024
OBC submission and approval	Oct 2025	Jan 2026
FBC submission and approval	May 2026	June 2026
Demolition works start	Apr 2025	Oct 2025
PCSA design works:		
RIBA 3 Design	Sept 2025	Dec 2025

Milestone	Start	Completion
RIBA 4 Design	Dec 2025	April 2026
RIBA 5 Design Construction	June 2026	July 2028
Surgical hub construction	June 2026	July 2028
Operational Commissioning	Aug 2028	Oct 2028
Handover of fully commissioned buildings	Nov 2028	Dec 2028

10.6 Workforce Plans

10.6.1 Workforce Planning Overview

The purpose of the Llantrisant Health Park (LHP) workforce plan is to ensure the right workforce, in the right place, with the right skills, at the right time and cost to deliver improved regional access to diagnostics, endoscopy and orthopaedic surgery via regional collaboration (in accordance with Welsh Government and Ministerial Advisory Group (MAG) recommendations). This plan focuses specifically on the arthroplasty workforce as part of LHP Phase 2.

LHP, as a stand-alone facility, provides an exciting opportunity for workforce transformation. Through maximising skills and increasing workforce capacity the workforce plan will support the delivery of evidence-based, innovative practice, across multi-disciplinary teams, to reduce waiting lists and length of stay for high volume, low complexity, primary lower limb arthroplasty, across the South East Wales region.

The plan will deliver a workforce that is flexible, productive, efficient, cost effective and sustainable with multi-professional teams undertaking roles which are varied and transformational. It will be underpinned by digital and technological opportunities, to improve efficiency and capacity, delivering excellent patient outcomes, whilst also mitigating against some of the external workforce supply challenges. Collaborative working across the region aims to support improved training, cross boundary working, and workforce sustainability.

The plan will align to “A Healthier Wales: Our Workforce Strategy for Health and Social Care (National Implementation Plan for Wales)”, Welsh Language Standards, national programmes of work (e.g. Regional Orthopaedics, Regional Endoscopy, HEIW-led Theatres Workforce Transformation Project) and All Wales Strategic Workforce Plans (including Nursing, Pharmacy, Radiology, and Diagnostics).

The approach to delivering the workforce model and workforce plan will be underpinned by the People (& Culture) Plans across the three Health Boards, ensuring alignment and congruent with regional working and LHP. Essential to its delivery will be: Collaboration, Effective Leadership, Risk Management and Change Management.

Figure 17 - All Wales strategic workforce planning key requirements

Source: HEIW

To ensure standardisation and incorporation of best practice the plan will work in accordance with the National Blueprint for Orthopaedic Surgical Delivery in Wales, GIRFT recommendations and professional and national standards of clinical care.

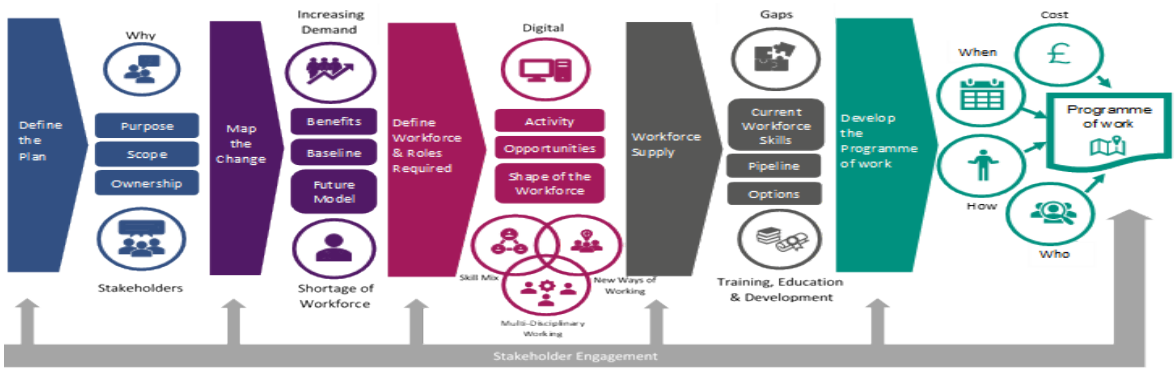
It is recognised that the transition to SEW regional collaboration at LHP is a critical step in the delivery of integrated, high-quality healthcare. The detail of this transformation depends heavily on the evolving design of the workforce model. Ensuring the right organisational design supported by organisational development to ensure effective leadership, cultural alignment, and clear communication across the system. The workforce plan for LHP will be dependent on the wider evolving work within the South East Wales regional Orthopaedics plan and the new Regional Joint Committee g (RJC), which will be essential enabling factors for its success.

Key next steps will be a continued focus on fostering collaboration, trust, and shared purpose among staff from the three Health Boards. Cultural readiness for change, combined with a tailored approach to organisational development (OD), will play a pivotal role in making this transition successful. The organisational development interventions outlined in the broader regional plan will be adapted and applied specifically to LHP to ensure seamless integration

10.6.2 Developing the Workforce Plan and Model

Our approach to workforce planning is underpinned by the All Wales Six Step Framework (and associated HEIW planning guidance & materials) and is aligned to and integrated across Service, Planning, Finance, and People:

Figure 18 - Fig – All Wales strategic workforce planning six step framework



Source: HEIW

LHP will be based on several key general workforce planning principles within the approach. These will need to be finalised, agreed and endorsed across the three Health Boards:

- Innovative service delivery models supported by transformational workforce approaches that embed flexibility, cross-skilling, and multidisciplinary team working.
- Strong and compassionate leadership, creating a shared vision and the right conditions for the workforce to thrive
- Teams brought together with shared values and a positive culture to support multi-disciplinary team working where equality, diversity, inclusion and wellbeing are at the heart of all we do
- Clear structures, roles, responsibilities and reporting lines
- A grounding in prudent health care principles with everyone working at the top of their competencies with the appropriate skill mix to reduce waste and variation for better patient outcomes
- Support for (if required and appropriate) cross boundary working, within agreed governance and training
- Improved patient experience across each stage of the pathway.
- A strong focus on designing infrastructure that supports workforce wellbeing and experience
- Digitally enabled transformation and solutions to deliver high quality elective care
- Consideration of national and professional standards of practice e.g. Nurse Staffing Act

The South East Wales regional orthopaedic plan will be used to support the development of the LHP workforce plan, with work already under way aiming to deliver sustainable, high-quality orthopaedic services, across the region, over the next four years. The plan in this initial phase, focuses on the acute phase of the Orthopaedic pathway and the Llantrisant Health Park (LHP). The plan will continue to develop in line with the LHP programme timelines.

Workforce planning has begun to identify skills shortages, especially in theatre staffing with critical medical roles, as a major constraint. The plan emphasises strategic workforce mapping, risk analyses, and the development of a regional workforce roadmap aligned with future clinical models to support recruitment, retention, and role standardisation. The SWOT analysis from the Regional Orthopaedic plan provides a baseline for workforce solutions to be developed on a regional basis to address the significant workforce risks that may not be easily be resolved due to local and national shortages.

The workforce plan will be an iterative process and will design, develop and aim to deliver a sustainable workforce, taking account of the strategic drivers, context and challenges set out in the workforce section of the Regional Orthopaedic Plan, Appendix 2 to this document. Timelines are being developed to ensure a more detailed workforce plan is in place in readiness for the full business case.

Defining the workforce and roles required

The workforce required has been mapped against the proposed service activities for LHP, with indicative modelling and numbers for the potential workforce required to support the service model. These numbers are based on current “knowns” and workforce models which either exist or have been agreed e.g. via the Orthopaedic CIN, along with learning from GIRFT accredited units. Within the current proposal, three CTMUHB orthopaedic theatres will move across to LHP and the associated funded WTE ward and theatre posts will also transfer (under an Organisational Change Programme), with three additional theatres to support additional activity from across the SEW region.

The workforce model will need to continue to evolve alongside and congruent to the clinical, operational, and digital elements of the programme. It will also need to align to the regional orthopaedic workforce plan to consider the impact on regional demand modelling and LHP

capacity requirements. Translating the activities at each stage of the clinical pathways into workforce skills, competencies, roles, and numbers to deliver the model effectively and efficiently. Key to this will be exploration of potential employment models for the medical workforce, as the regional orthopaedic plan SWOT analysis identified critical challenges (e.g. around job planning).

Exploration of roles

A key next step within the programme of work is further exploration of the potential for new, alternative and expanded roles within the workforce model using benchmarking to support a model that is sustainable. The workforce model, plan and resourcing plan will all draw upon learning high performing, elective orthopaedic treatment centres, across the United Kingdom and explore alternative ways of working beyond traditional approaches to service delivery. The pre-implementation period offers the opportunity to pilot new models of care and test concepts - capturing lessons learnt and measuring the effectiveness of changes. An example of this would be the new ways of working already being piloted within Princess of Wales hospital elective orthopaedic unit

Examples of this include:

- Use of alternative roles, e.g. Surgical First Assistants, Assistant Peri-Operative Practitioners
- Broadening the scope of roles, e.g. HCSW to include portering duties
- Increased therapies input, e.g. to enable discharge, through extension of shift patterns/cover, & “side skilling” nursing staff in therapies competencies such as mobilisation
- Enhancing skills to promote flexibility and the potential for “float” roles, e.g. a multiskilled nursing workforce to work across admissions, recovery and the wards
- Technology as an enabler and driver of innovation, efficiency and productivity e.g. automation, AI, virtual interactions

The workforce numbers and skills will continue to be developed and refined, taking into account any lesson learnt from Princess of Wales (POW) where we are implementing and learning from elements of the LHP clinical model.

10.6.3 Workforce Supply

Dependent on decisions taken within clinical and operating models, the workforce plan will need to consider an assessment of current roles, skills, and competencies, against requirements across the three Health Boards. This would include age profile, skill mix, turnover, vacancy rates and retirement projections. This assessment will further confirm anticipated current and future workforce gaps and risks. It is proposed there will be a dedicated core LHP workforce, with a “Hub & Spoke” model for support services. This emphasises the need for a regional workforce plan to be developed to understand the wider impacts on demand trajectories including LHP.

The work of the regional Orthopaedic planning group has identified several workforce challenges. These include recruiting and retaining medical teams, ongoing and increasingly critical shortage of skilled theatre staff (particularly among Operating Department Practitioners and anaesthetic support staff) which are placing significant and persistent pressure on surgical services across the system.

It also reported, that for the for the first time in a significant period, the supply of Registered Nurses in Wales is beginning to outpace demand, presenting an opportunity for health boards to address vacancies in scrub practitioner roles. This trajectory is expected to remain favourable over the next three to five years.

Retention is also a key challenge with as the time to replace, train and to reach full competency can be in excess of nine months for some roles creating considerable vulnerability in maintaining

safe and effective theatre staffing. These workforce shortages and retention issues are significantly constraining the ability to deliver elective orthopaedic procedures at the required scale.

The impact of the recent changes to the Resident Doctor contract in Wales are not yet known but any identified risks will also need to factor into the plan with actions to mitigate these risks.

To maximise the opportunities to staff the LHP and to support regional Orthopaedics the workforce model will need to be as attractive as possible, offering roles and an environment that individuals will want to work or rotate too.

Recruitment and resourcing

Further refinement of the workforce plan and the gap analysis within in will allow for the development of a robust recruitment and retention strategy as part of the FBC. This will include proposals for both Agenda for Change and Medical staff. There will be a focus on resourcing the facility to ensure the workforce and patient benefits are realised, but with a key commitment across all three Health Board's to work collaboratively on this agenda, noting the need to avoid destabiling the Southeast Wales workforce position.

Potential resourcing options and considerations are as follows:

- Recruitment – either via an internal recruitment team or via a partner organisation (e.g. a recruitment agency, an industry partner).
- Targeted recruitment campaigns e.g. for critical roles or linked to local residents and education institutions
- Insourcing either on a permanent basis or temporarily if resourcing was to be a limiting factor to the "go live" date
- Rotational posts to enable staff to move between LHP and other sites, gaining a breadth of experience and sharing learning to support both the individual and the organisation
- The use of regional Employment Models - including Service Level Agreements (SLA), honorary contracts, and Memorandum of Understanding (MOU) –options appraisal of best approach will be required which support existing variability in contracts and supports Regional Services
- Capitalise on opportunity from anticipated local oversupply within certain healthcare professions (e.g. nurses, paramedics, Physicians Associates)
- Education & training pipelines as a key supply route - such as student streamlining, and numbers in the training pipelines as a result of the Integrated Medium-Term Plans (IMTP) / education and training commissioning numbers
- Use of Health Boards internal education teams to ensure that any anticipated role/training needs are factored into training plans
- Temporary staffing: establish need to expand pools of available temporary staff to support the substantive workforce

The workforce plan will evolve from early implementation into the medium to longer term to move with the changing environment and allow for the development of new roles/skills e.g registered nursing associate (RNA) Band 4 role and for the impact of technology to be fully understood .

Education and training

The development of LHP offers workforce education and training opportunities across all staff groups. There is also a unique opportunity for Medical Training Opportunities, to significantly expand the surgical, orthopaedics and anaesthetics training and for wider benefits to the region, aligned to GIRFT principles.

Alignment with Health Education and Improvement Wales (HEIW) and the Deanery will be key to support rresident doctor training experience. In addition, links with NWSSP, as the Single Lead

Employer (SLE) around resident doctor placements to maximise opportunities to meet skills shortages and improve workforce supply.

10.6.4 Future organisational development plans

Once the workforce model is agreed, running alongside will be to focus on the design and implementation of a series of OD interventions aimed at unlocking the full potential of the LHP staff. These interventions will include:

Leadership development and alignment

Establishing strong, aligned leadership across the new organisation will be a priority. This will involve tailored leadership programmes that build shared practices, foster trust, and ensure the leadership team can drive the transformation effectively.

Communication and engagement strategies

Communication will be crucial at every stage of the journey. Working in close partnership with communication and engagement teams from the SEW region, we will implement a robust communication strategy that ensures staff are well-informed, actively engaged, and feel part of the transformation. This will include regular updates, feedback loops, and targeted engagement activities designed to bring staff along on the journey.

Culture and behavioural change

The LHP will only succeed if we can embed a shared vision and culture of collaboration across the three Health Boards. OD strategies will focus on developing the behaviours and relational conditions necessary for regional collaboration and will be designed to overcome the challenges inherent in merging diverse organisational cultures.

People potential at LHP

Recognising that the greatest asset in this transformation is the workforce itself, we will unlock the potential of LHP's people by aligning their development with the broader goals of integrated service delivery. Targeted interventions will aim to build capacity in areas such as systems thinking, change management, and inter-organisational collaboration.

By focusing on these areas, the Health Boards can ensure that the workforce is equipped to support the long-term success of Llantrisant Health Park, enabling it to achieve its vision of delivering equitable, sustainable, and high-quality healthcare to the communities it serves.

10.7 Stakeholder engagement

10.7.1 Engagement to date

Key staff stakeholders across all health boards have been involved in design so far. The original RIBA 3 design review meetings were held in April and May 2025 to confirm all key stakeholders were agreed with current designs. The redesign work has been shared with key stakeholders and further reviews will be held during the rework of RIBA 3 and development of RIBA 4 stages

An initial Arthroplasty workshop was successfully held in March 2025, to collaborate across the three health boards, confirming work to date, the vision for the health park and the importance of stakeholder input. The LHP programme also feeds into the Regional Orthopaedic Board on a monthly basis.

10.7.2 Future communications and engagement

The engagement and communication functions of the three southeast region health boards are working in partnership to develop and implement plans that reflect the requirements of the region and the localities.

The objective of this work is to

- inform and generate confidence among public and staff about the purpose, services, and benefits of Llantrisant Health Park.
- gather feedback, ideas, and concerns to shape the facility's development and service offering.
- build trust and foster a sense of ownership and partnership among stakeholders.
- identify potential engagement challenges and barriers to engagement early and collaboratively develop solutions.

In developing and delivering communications and engagement activities all Health Boards will:

- Foster and maintain stakeholder and public confidence in the LHP as a landmark development that will improve the provision of modern health care in south-east Wales
- Provide the public with a range of opportunities to inform the development of the LHP in ways that maximise access, clinical effectiveness and the experience of patients
- Take a collaborative approach, with NHS partners, to developing and disseminating messages and communications/engagement resources, that enable consistency, clarity and accuracy locally, across the region and nationally
- Use existing, trusted methods, platforms and forums to engage
- Respect and reflect local engagement needs, supporting differentiation of approaches based on local requirements whilst maintaining consistency and accuracy of messages
- Work alongside Llais to identify and deliver upon emerging opportunities to better engage and involve the public and patients throughout the lifetime of the programme
- Identify potential engagement challenges and barriers to engagement early and collaboratively develop solutions
- Promote opportunities to add social value within local communities
- Identify and celebrate programme milestones, alongside partners
- Involve local political partners and relevant third-sector organisations
- Provide assurance on the effectiveness of communications and engagement activities..

10.7.3 Working with Llais

The health boards are working with Llais at a regional and local level to enable it to influence and inform engagement plans. This includes working with Llais on LHP-specific briefing and planning sessions (next due on 14 November). To date Llais have made clear their expectations for regional engagement and that health boards should avoid duplication whilst learning from the outputs from previous engagement programmes.

10.7.4 Communication and engagement priorities

The engagement working group, comprising the three health boards (CTM, AB, CAV) are meeting weekly to develop and implement a shared programme of engagement across the region. The group's priorities include

- Creation and completion of assessment tool to:

- Enable structured and consistent interrogation of previous and live engagement activities across the SE Wales region, to identify shared learning about successful methods, collate learning, and provide a baseline a baseline of current public opinion on key issues relevant to the LHP programme
- Map the impact of LHP at health board level to enable prioritisation of engagement activities and resources
- Plot impact against Llais criteria for engagement/consultation
- Provide a single set of core data

- Interrogation of local stakeholder data to identify and prioritise audiences at a local and regional level. Development of a shared stakeholder map that enables engagement to be undertaken as efficiently as possible, with minimal duplication
- Through mapping, identify existing touchpoints/forums with patient, public, community and staff groups to maximise the efficiency and expediency of engagement
- Routine – min monthly – LHP/regional engagement meetings (next due 14 Nov) with Llais to enable input into plans and identify opportunities for Llais to amplify and enhance engagement.
- Creation of single channels for regional engagement to enable sharing and development of core programme content and learning
- Development of a single engagement and communication plan, using good practice from other engagement programmes, with a phased delivery plan for pace and relevance. To include a digital engagement plan to generate engagement through local web and social platforms.
- Development of an LHP patient panel to provide ongoing input into the programme on key elements affecting experience, including transport and travel, wayfinding, and patient information (concept being worked up with Llais)
- A regularly updated library of content, that provides all partners with the data, messages and tools to engage efficiently and effectively. CTM to provide resources centrally, in collaboration with partners, to enable localised delivery that meets local requirements and makes effective use of local platforms.

Producing core content to widen profile and understanding of LHP amongst public audiences and enable localised delivery of engagement actions. Inc. key messages, content for web and socials, graphics, talking heads videos

10.7.5 Timing and phasing

The engagement and communications plan in development will set out the appropriate phasing and timetable for activity, taking into account local issues and current programmes of work; particularly those involving public engagement (where appropriate we will aim to integrate engagement opportunities relevant to LHP into these programmes but not to the detriment of existing timetables).

We will also be cognisant of national issues – including the 2026 Senedd elections – that will impact upon the delivery of engagement, working within the guidance set out for the period of pre-election sensitivity.

10.8 Project assurance

The current governance structure allows for a clear separation between governance functions and those that deliver or approve outputs. The assurance functions will confirm that the processes and procedures followed by the delivery groups have been sufficient and in accordance with sound management principles. The assurance function will also act as the coordination point between the delivery and governance functions.

Within the PRINCE 2 governance arrangements the PMO is classed as part of the Assurance function.

10.8.1 Programme

- Review of upcoming programme activity and milestones with LHP Technical PM and Project Director to determine outputs required by workstreams
- Create lookahead programme highlighting key programme deliverables over coming weeks/months for dissemination to workstreams
- Track workstream output and performance toward achieving programme deliverables and feed progress into monthly reporting – PMO drumbeat.

10.8.2 Risk

- Review of risk with LHP Technical PM and Project Director to review and update risk register based on workstream risks
- Track workstream risks and feed into project reporting – PMO drumbeat.

10.8.3 Key Performance Indicators (KPIs)

- Work with LHP Project Director to determine workstream KPIs
- Track workstream KPIs and feed into project reporting – PMO drumbeat.

In addition to the above NWSSP Audit services are developing an audit plan with CTM to provide independent oversight of the capital programme. A notional fee budget has been included at OBC stage as the plan is developed, and this will be shared with NWSSP – SES once it is developed.

10.9 Change management

The Health Boards are aware that the project is a major change for staff working in the area and across all three Health Boards, therefore its success is predicated on staff supporting the project. To date, key staff have been involved in workshops regarding clinical flows and design and it is envisaged that they will continue to play an instrumental role as the project moves into its next phase. Prior to the new facilities opening, detailed planning work will be undertaken to understand any changes to ways of working, and staff will be supported by the project team to prepare for this. Transition plans will be developed in collaboration with all relevant stakeholders, to ensure the new facilities run smoothly and that staff are prepared for any changes to their working model as a result.

There will be no change to organisational structures following completion of the development. There is potential for positive cultural changes following completion to enable staff to work more effectively and efficiently in a new fit-for-purpose building. This can help contribute to higher levels of staff retention over the coming years to improve the working culture for both staff and patients.

Within each stage there will be a series of decision points where major documents produced by workstreams will be ratified within the governance arrangements. For example, clinical advice leaflets pre/post day surgery. All documents will be subject to a robust and consistent version control methodology. The following documents are core to the project at this stage:

- Strategy documents, including the Clinical Services Strategy, Workforce Plan, Programme etc.;
- Schedule of accommodation;
- Clinical models of care and patient flow diagrams;
- Clinical advice documents.

All changes will be subject to a formal change control process. Change is not design development. Change can only occur when strategic, operational policies or functional content quantities are altered from those included in the current approved documents. Change management associated with the infrastructure aspects of this project will be managed by the LHP Project Team through Programme Board and Regional Oversight Board.

10.10 Contingency plans

Should the current scheme fail to proceed, the only contingency plan would be to continue with business as usual for services regionally, working with wait list initiatives or temporary diagnostic solutions such as mobile MRI when required to meet additional demand.

10.11 Benefits realisation

A Benefits Realisation Plan will be developed by the Programme Board to put in place the necessary arrangements to ensure that the project delivers its anticipated benefits. This includes setting out the arrangements for planning, modelling and tracking the identified benefits as well as a framework that assigns responsibility for the realisation of the benefits throughout key phases of the project. The Benefits Realisation Plan will be owned by the Health Board's Infrastructure and Clinical and Operational Programme Directors.

The main benefits for the preferred option are outlined in the benefits register included in Appendix 5 while the actions required to realise the benefits will be confirmed at FBC stage and included as a full benefits realisation plan.

The spending objectives and aligned benefits used in the selection of the preferred option will be used to measure the project success.

This evaluation process will be run in parallel with the Post Project Evaluation Plan as noted below and will be developed as part of the detailed design stage. The Benefits Realisation Plan will be regularly reviewed and updated. This will ensure that – should any strategic change take place, such as a legislative change – the service and project will be flexed accordingly to ensure that the facility delivers a fit for purpose service from the point of operational commencement.

The benefits realisation approach outlined above is a key output to provide assurance on investment delivery and performance and will be shared with the Health Boards and Welsh Government to facilitate shared learning at FBC stage.

10.12 Risk management

The complexity of the LHP programme necessitates an appropriate risk management process is put in place to identify, assess and mitigate the likelihood of risks materialising throughout the programme duration.

Workstream risks are those which are considered by each workstream as a risk to successful delivery of business outcomes and targets. They vary from seemingly insignificant risks to risks which are potentially very damaging. Where risks are deemed to be significant (residual rating >12) and occur across a number of workstreams these are considered as programme risks and dealt with accordingly.

Risk management is therefore dealt with in a two-tier system approach:

- Workstream risk management is an iterative process undertaken by workstream leads, with a monthly reporting cycle up to the LHP Steering Group. All workstreams will be issued a risk register template to log their risks and issues

- Programme risk management is an iterative document that is reviewed monthly in the Programme Board and Steering Group meetings and updated to reflect any changes that may impact programme scope, cost, timeliness, quality, or designs.

Should any risks be identified through the programme that have an impact on the Health Board service delivery and / or strategic direction then it should be escalated via the SRO to the Assistant Director of Governance and Risk for inclusion and scrutiny on the Organisational Risk Register.

10.12.1 Consequence and likelihood definitions

The below tables include the initial definitions relating to the consequence and likelihood of a risk occurring. These definitions are used for both workstream-level risks that are maintained in the dashboard report *and* the programme levels risks that are reflected in the programme risk register.

Table 33 - Risk consequence definitions

Score	Descriptor	Actual or potential impact on the individual/service or organisation
1	Negligible	Minimal injury requiring no/minimal intervention or treatment. Potential for public concern Insignificant cost increase/ schedule slippage Minimal or no impact on the environment
2	Minor	Minor injury or illness, requiring minor intervention. Local media coverage – short-term reduction in public confidence <5% over project budget, schedule slippage Minor impact on the environment
3	Moderate	Moderate injury requiring professional intervention. Local media coverage – long-term reduction in public confidence 5 – 10% over project budget, schedule slippage Moderate impact on the environment
4	Major	Major injury leading to long-term incapacity/disability National media coverage with <3 days service well below reasonable public expectation 10-25% over project budget, schedule slippage, key objectives not met Major impact on the environment
5	Catastrophic	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Incident leading to > 25% over project budget, schedule slippage, key objectives note met Catastrophic impact on the environment

*Table 34 - Risk **likelihood** definitions*

Score	Descriptor	Likelihood of occurrence
1	Rare	This will probably never happen/recur
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so
3	Possible	Might happen or recur occasionally
4	Likely	Will probably happen/recur but it is not a persisting issue
5	Almost certain	Will undoubtedly happen/recur, possible frequently

10.12.2 Risk matrix

The risk matrix shown below is also consistent between both levels of risk management. The Health Board risk matrix is shown below.

Figure 19 - Risk scoring matrix (Likelihood x Consequence = Risk score)

Likelihood	Frequency	Consequence				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly unlikely: will probably never happen	not for years	1	2	3	4	5
2 Unlikely: not expected to happen / recur, but is possible	at least annually	2	4	6	8	10
3 Likely: might happen / recur occasionally	at least monthly	3	6	9	12	15
4 Highly likely: will probably happen / recur, but not a persistent issue	at least weekly	4	8	12	16	20
5 Almost certain: will undoubtedly happen / recur, possibly frequently	at least daily	5	10	15	20	25

Risks should be assessed and reviewed on a regular basis, as determined by their score:

1-6 Low	Low risks should be reviewed and progress on actions recorded and updated at least every 6 months
8-12 Moderate	Moderate risks should be reviewed and progress on actions recorded and updated at least quarterly
15-25 High	High risks should be reviewed and progress on actions recorded and updated at least every 2 months; if scored 20 or over the risk should be reviewed each month

The following management actions are taken for each category:

- **Red** – Reviewed at every Steering Group and Programme Board meeting with clear and determined action reviews in each pertinent workstream. Workstream leads are predominantly identified as the risk owner;
- **Amber** – Reviewed regularly and appropriate review dates are agreed at workstream groups/committees. The risk owner should be a senior member of the pertinent workstream; and
- **Yellow and Green** – Reviewed regularly to ensure the likelihood and/or consequence of the risk arising has not risen. Risk ownership can be assigned to anyone on the pertinent workstream.

10.13 Contract management

Robust contract management process will be put in place to oversee the construction contracts. The use of regular reviews and KPI monitoring will be critical to managing and overseeing performance throughout contract durations.

10.14 Post-project evaluation

Post-project evaluation (PPE) is a mandatory requirement for infrastructure projects that receive Welsh Government funding. The purpose of PPE is to improve project delivery through lessons learned during the project delivery phase and to appraise whether the project has delivered its anticipated outcomes and benefits.

The Health Board and its partners are committed to ensuring that a thorough and robust post-project evaluation is undertaken at key stages in the process to ensure that lessons are learnt.

The PPE also sets in place a framework within which the benefits realisation plan set out in section 10.11 can be tested to identify which benefits have been achieved and which have not.

The Health Board is exploring opportunities to work with a local university in carrying out the PPE. Detailed plans will be drawn up in partnership with the university. The evaluation will be carried out in line with NHS guidance, and will measure the project against the following factors:

- The extent to which the original objectives have been met
- Measurement against the Benefits Realisation Plan
- The cost of the project and the extent to which it can demonstrate value for money
- The Project outcome compared with the 'Do Nothing' or 'Do Minimum' scenarios
- The economic viability of the project in comparison with the 'Do Nothing option
- Risk allocation
- Timetable
- Functional Suitability – how the facility performs
- Functional Relationships – how well the various process flows (staff, patient, service) work
- User satisfaction
- Procurement route.

We envisage four key stages to the evaluation, outlined as follows:

Stage 1: Project procurement

The objective of the evaluation at this stage is to assess how well the project was managed from the time of OBC approval to commencement of the construction phase. It is planned that this evaluation will be undertaken within three months of construction commencement. The evaluation at this stage will examine:

- How effectively the project was managed
- The quality of the documentation prepared by the Health Board and its partners
- Communications and involvement during procurement
- The effectiveness of advisers used on the scheme
- The efficacy of NHS guidance in delivering the scheme.

Stage 2: Implementation

The objective of this stage is to assess how well the project was managed from the time the construction phase commences through to commencement of operational commissioning. It is considered that this should be undertaken three months following operational commissioning of the unit. The evaluation at this stage will examine: -

- How effectively the project was managed
- Communications and involvement during construction
- The effectiveness of the joint working arrangements established by the Contractor, the design team and the project team.

Stage 3: New operational model in place

The objective of this stage will be to assess how well the project was managed during the operational commissioning phase, through to operation in the new building. It is proposed that this stage will be undertaken up to 12 months after completion of operational commissioning of the scheme. The evaluation at this stage will examine:

- How effectively the project was managed
- Effectiveness of the new operational model
- Communications and involvement during commissioning, and into operations
- Overall success factors for the project in terms of cost and time
- Extent to which the new operational model meets users' needs – from the point of view of patients, carers and staff.

Stage 4: New operational model well-established

It is proposed that this evaluation is undertaken 18 months following completion of operational commissioning. The objective of this stage will assess how well and effectively the project was managed during the actual operation of the new Health and Wellbeing Centre. The evaluation at this stage will examine:

- Effectiveness of the new operational model
- Extent to which the new operational model meets users' needs – from the point of view of patients, carers and staff.

The evaluation process will be managed by the Project Manager via a bespoke team established to oversee the PPE. Evaluation reports will be made available to all relevant stakeholders, including Welsh Government.

Capital Cost Addendum to LHP OBC Phase 2 – Orthopaedic Surgical Hub

This cost addendum is being provided as an update to the LHP Phase 2 OBC Version 1 that has been circulated.

Due to a material omission in the original cost statement it has become necessary to provide an updated capital cost statement to support the OBC.

It should be noted that at this stage this remains a cost forecast, due to the pace at which the RIBA 2 design has occurred since restart in September, some key details have been received later than had been originally programmed and some elements of information are still outstanding and being developed by the design team. Therefore, there is still some further information to be received and verification to be carried out to confirm the cost level to be included in the OBC to be submitted to Welsh Government.

As a result this is proposed to be presented as a cost not to be exceeded for the purposes of Board approval in recognition that there may still be some smaller amendments to the total cost up until the beginning of December and the proposed OBC submittal date to WG. The final capital cost included in the WG submitted version will not exceed the sum in this document and the amended OBC.

Adjusted Capital Cost

The capital cost movement is as set out in the table below with a comparison between the original and revised position (Table 1). The following table (Table 2) sets out the revised capital cost and funding profile.

Table 1 Original and Revised OBC Capital Cost

Costs	Original OBC Cost £000	Revised OBC Cost £000	Movement £000
Construction Costs	63,042	70,924	7,882
Project Fees	9,275	8,357	-918
Non Works	185	185	0
Equipment Costs	9,805	9,805	0
Planning Contingency	9,661	9,800	139
Inflation	4,738	5,104	367
Subtotal	**96,705**	**104,175**	**7,470**
VAT	17,586	19,454	1,868
Total capital costs	**114,291**	**123,630**	**9,338**

Table 2 Revised Capital Cost and Funding Profile

	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	Total £'000
Costs					
Construction costs	0	16,884	42,210	11,831	70,924
Project fees	2,463	3,074	1,879	940	8,357
Non-works costs	78	57	30	20	185
Equipment costs	0	1,000	6,305	2,500	9,805
Planning contingency	87	3,468	4,163	2,082	9,800
Inflation	0	2,041	2,041	1,022	5,104
Subtotal	**2,628**	**26,525**	**56,629**	**18,394**	**104,176**
VAT	17	4,795	11,055	3,587	19,454
Total capital costs	**2,645**	**31,320**	**67,684**	**21,981**	**123,630**
Funding					
RIBA 2 & 3	1,934	0	0		1,934
Funding received to date	**1,934**	**0**	**0**	**0**	**1,934**
Funding still required	**711**	**31,320**	**67,684**	**21,981**	**121,696**
Total funding	**2,645**	**31,320**	**67,684**	**21,981**	**123,630**

Total capital costs are now forecast to be £123.6M, with £1.93M funded to date, this leaves a funding requirement of £121.7M from OBC approval.

The funding requirement to proceed to FBC approval stage remains unchanged at £1.669M, £0.71M is required in 25/26 with the balance required in 2026/27.

Revenue Impacts From the Change in Capital Cost

The only impacts on the revenue position from the changes to the capital cost are to both impairment and depreciation costs.

Annual recurrent depreciation has increased from £3.004M to £3.160M, as WG DEL funding will be applied for the cover the total depreciation cost this does not impact on the revenue funding position.

AME impairment on bringing the asset into use has increased to £84,5M and cover for this will be applied for in the year that the asset comes into use in 2028/29.

Therefore the revenue costs and value for money position remains unchanged.

Impact on the Economic Appraisal

The impact of the changed capital cost on the economic appraisal is minimal.

As a result the revised capital cost, the outcome of the economic appraisal has not materially changed. The preferred option requires capital investment of £123.6m (including VAT) and ongoing revenue costs of £36.8m p.a. (excluding depreciation), and based on estimated costs and benefits, it is anticipated that phase 2 of the LHP will deliver an incremental Net Present Social Value (NPSV) of £500.7m and a Benefit Cost Ratio (BCR) of 1.54. This represents £1.54 of incremental benefit delivered for every £1.00 of incremental whole life cost.

Conclusion and Next Steps

A revised OBC containing the capital not to exceed figure has been circulated. This OBC will be included in Board papers with the Board requested to approve as a not to exceed figure.

Any capital cost adjustments required following circulation of the Board papers will be verified and included in an updated cost in the OBC submitted to WG as long as they do not exceed the figure contained in the latest amended OBC.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 November 2025
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Women Health Programme Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Tracy Daszkiewicz, Executive Director for Public Health and Strategic Partnerships Clare Lipetz, Assistant Divisional Director for Family and Therapies, and ABUHB Clinical Lead for the Women's Health Programme
SWYDDOG ADRODD: **REPORTING OFFICER:**	• Sian Chard, Assistant General Manager, Family and Therapies Division • Chloe Trinder, Performance Manager, Families and Therapies Division • Shareen Ali, Head of Public Health, Gwent Public Health Team

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper provides a progress update on the women's health programme which was introduced in Spring 2025. The paper was considered by the Executive Team on the 13th November 2025 and the Board is now asked to receive, for information and assurance, the work progressed to date against the requirements set out by Welsh Government and provide any relevant feedback in relation to the next steps to develop a women's health pathfinder hub. Further information, including the service specification and operating model for the pathfinder hub, is planning to be shared with the Executive Committee for consideration in December 2025.

Cefndir / Background

Following the publication of the Welsh Government's *Quality Statement for Women's and Girls Health*[1] and *The Discovery Report-Foundations for a Women's Health Plan*[2] the Welsh Government launched *The NHS Wales Women's Health Plan: A 10-year plan for women's*

health in Wales[3] in December 2024. The plan is a ten-year vision that outlines an NHS Wales approach to improving health outcomes for women, with a focus on eight priority areas and a series of short, medium and long term actions. The plan outlines the key health inequalities experienced by women in Wales at a population level, and highlights some of the disparities in health that are emerging. It also highlights opportunities for closing the gender gap and improving health across our NHS services.

Following the publication of the plan Health Boards have been mandated to achieve the following by the end of March 2026:

- Establish at least one pathfinder women's health hub that should be sustained from April 2026 onwards.
- Have an agreed plan in place for the wider implementation of women's health hubs.
- Ensure women's health hubs are included in the 2026-27 IMTP.

To inform the service specification and operating model of the pathfinder hub three priority areas must be used. It is suggested they cover the three main stages of a woman's life course. These include:

- Contraception
- Menopause
- Menstrual health

Whilst the initial focus, in line with the three priorities outlined above and as required by Welsh Government, is on sex specific issues the long-term intention is that an approach to addressing issues beyond those that are related to gynaecological procedures and truly address inequalities for women is adopted.

2.1 Women in Gwent: The local picture

Differences in health outcomes

There are stark differences in life expectancy, mental well-being and access to healthcare services for the circa 303,000 women and girls (51% of the population) in Gwent. These disparities are compounded by factors such as poverty, education and access to meaningful employment. These translate into daily realities that affect their opportunity to live happy, healthy and fulfilled lives. Understanding the demographic, socioeconomic and health characteristics of women in Gwent is fundamental to ensuring the right services and interventions are in place to plan appropriately and proportionately for and respond to the needs of the women in Gwent.

It is well known that women have a longer life expectancy (number of years they live for) than men (ONS, 2024[4]). In Wales, women have a life expectancy of 82 years with men having a life expectancy of 78 years. Across Gwent, other than in Monmouthshire, the life expectancy for both men and women is lower than the Wales average. When considering the potential impact of deprivation and the drivers of differences in health outcomes, the highest proportion of the population living in the most deprived 20% is Blaenau Gwent (44.2% of residents) which has the lowest life expectancy for both men and women. In comparison 1.7% of residents in Monmouthshire live in the most deprived 20%. Despite women living longer than men they live a larger proportion of their life in poor health and there are significant variations in healthy life expectancy for women across Gwent; with a difference of over 10 years between Blaenau Gwent and Monmouthshire where women live for 55.2 years and 65.9 years respectively in good health (Figure 1). These variations are unjust and there is opportunity to narrow this gap. It must be noted that available data does not include those who identify as women (gender specific) and only captures those born as females at birth.

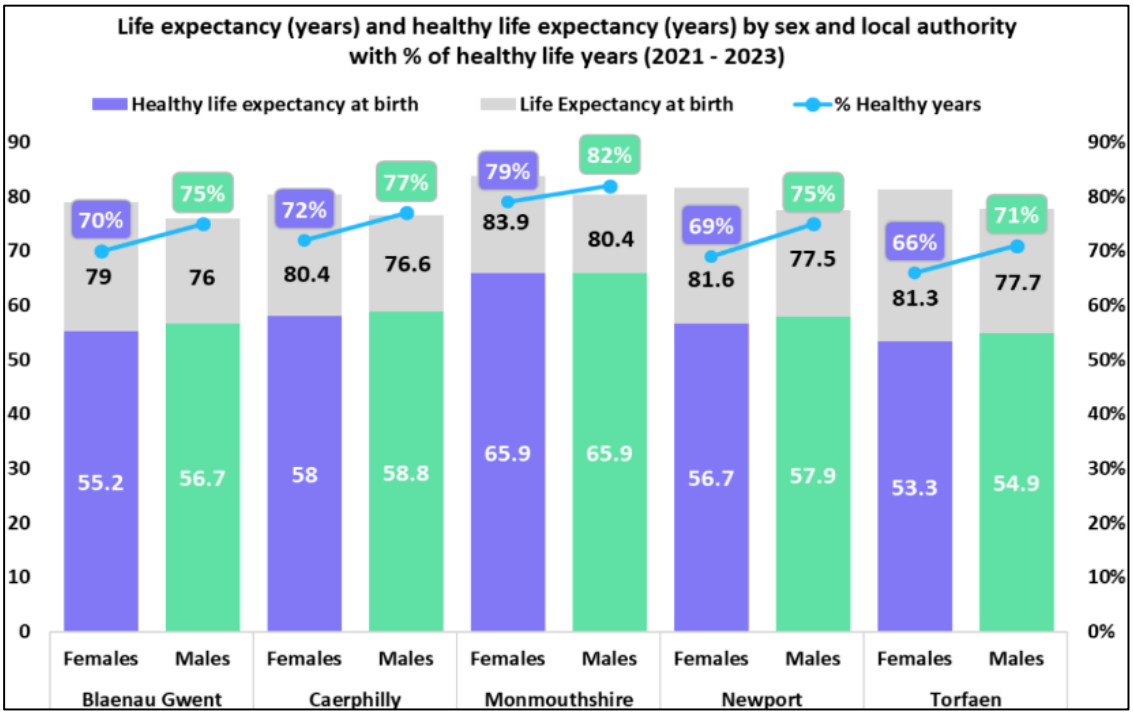


Figure 1: Life expectancy and healthy life expectancy by sex and local authority area (Gwent JSA[5])

As well as the notable differences in healthy life expectancy between males and females, as well as the stark differences between women living in different local authority areas across Gwent, figure 2 highlights the considerable differences in premature deaths from non-communicable diseases (NCDs) across Gwent. Apart from Monmouthshire all other areas have a higher rate than the Wales average. These differences highlight significant and persistent inequalities, with the most deprived areas experiencing the greatest burden of premature mortality.

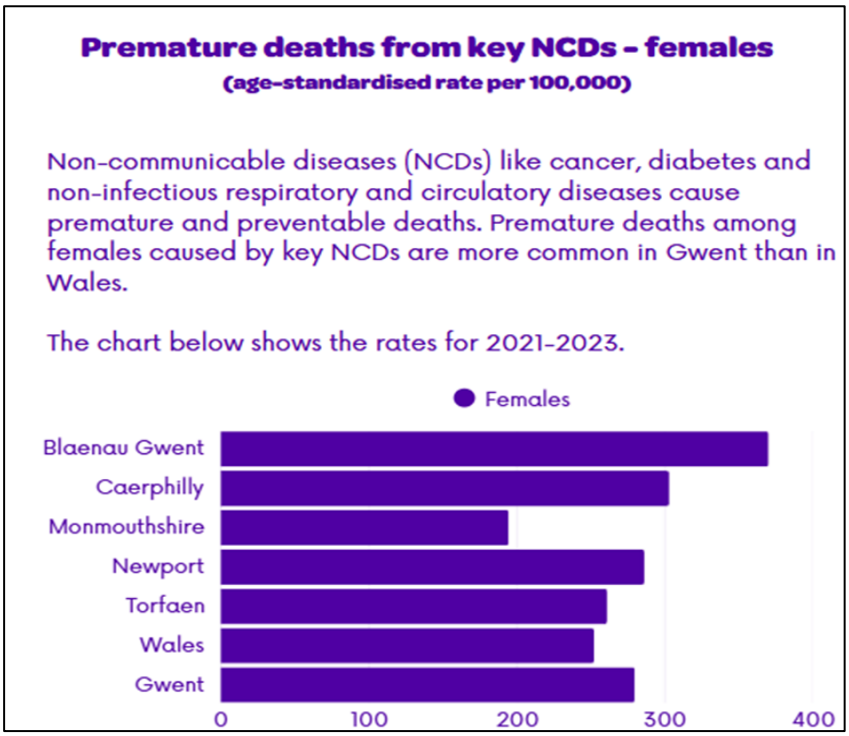


Figure 2: Premature deaths from key NCDs in females (Gwent JSA[5])

Cancers, type 2 diabetes and non-infectious respiratory and circulatory diseases are often preventable and as such there is a need for targeted interventions to address risk factors that contribute to these NCDs, improvements in access to services and reduce health and healthcare disparities across Gwent.

Access to women's services in Gwent

There is a wide range of services provided by ABUHB for women in Gwent. However, there are significant variations in access to these services as well as the inability to respond in a timely way to the demand for these services.

Figure 3 shows the sharp upward trend in outpatient waiting list numbers since 2020, broken down by service in figure 4. This reflects the significant increase in the demand for women's health (sex specific) gynaecology services.

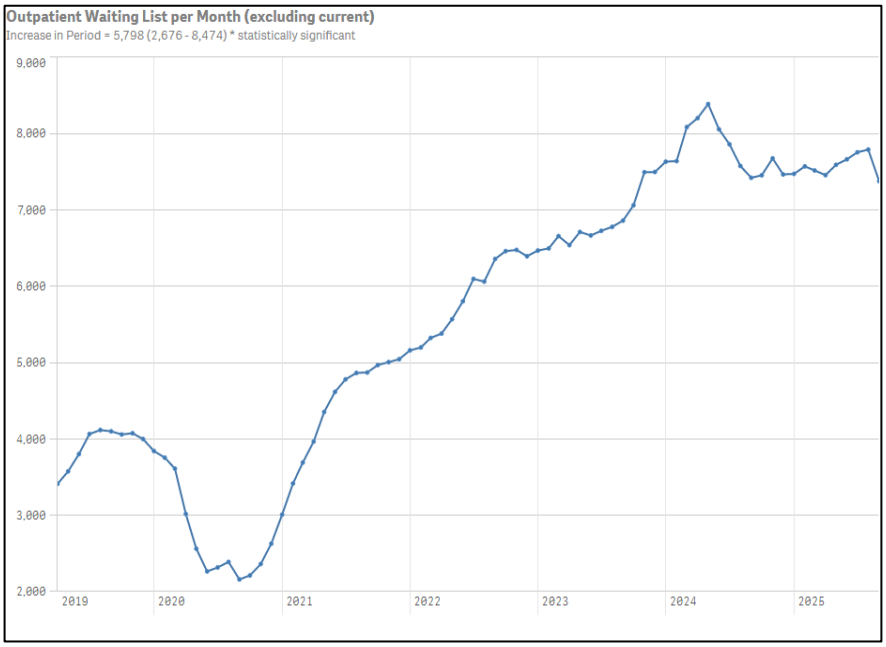


Figure 3: Outpatient waiting list numbers 2019-2025

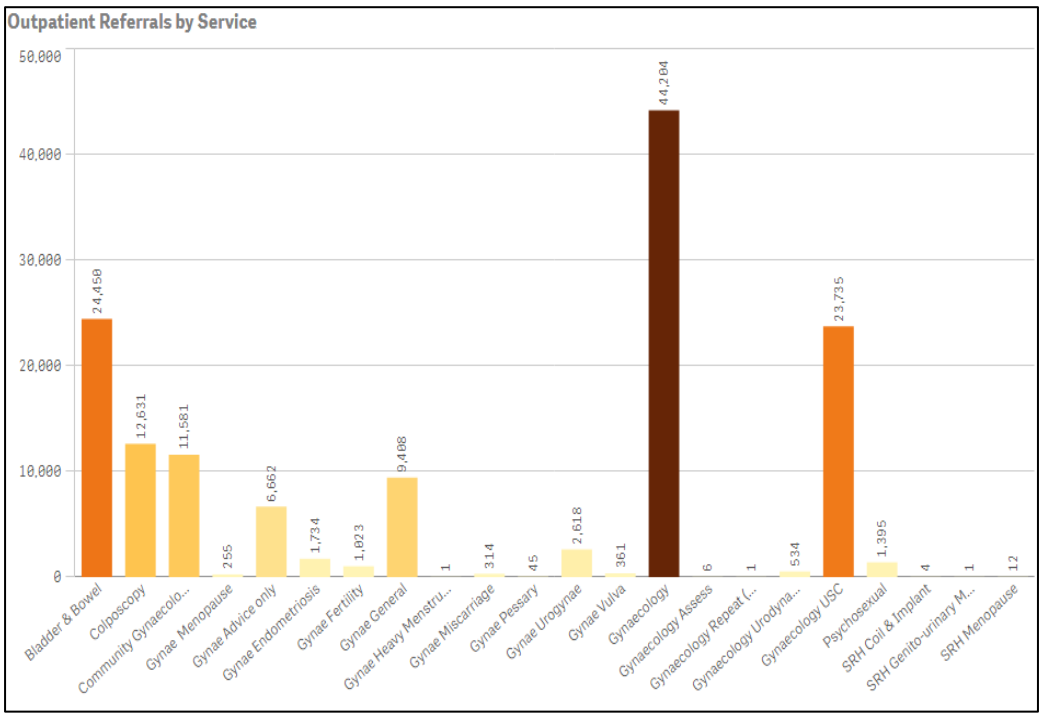


Figure 4: Outpatient referrals by service

Variations in access to women's services

As well as significant demands on women's health services that often result in significant delays in access, there are notable variations in access between women living in different areas across Gwent and noticeable changes across time. This section provides a summary of this variation for the current priority areas; contraception, menopause and menstruation.

Contraception

Combined hormonal contraceptive (CHC) prescribing rates within Primary Care have shown a downward trend over time, with the most deprived areas consistently prescribing less compared with least deprived areas (see figure 5). In contrast, emergency contraception prescribing rates have remained stable over time with the most deprived areas consistently being prescribed more than those within the least deprived areas (figure 6).

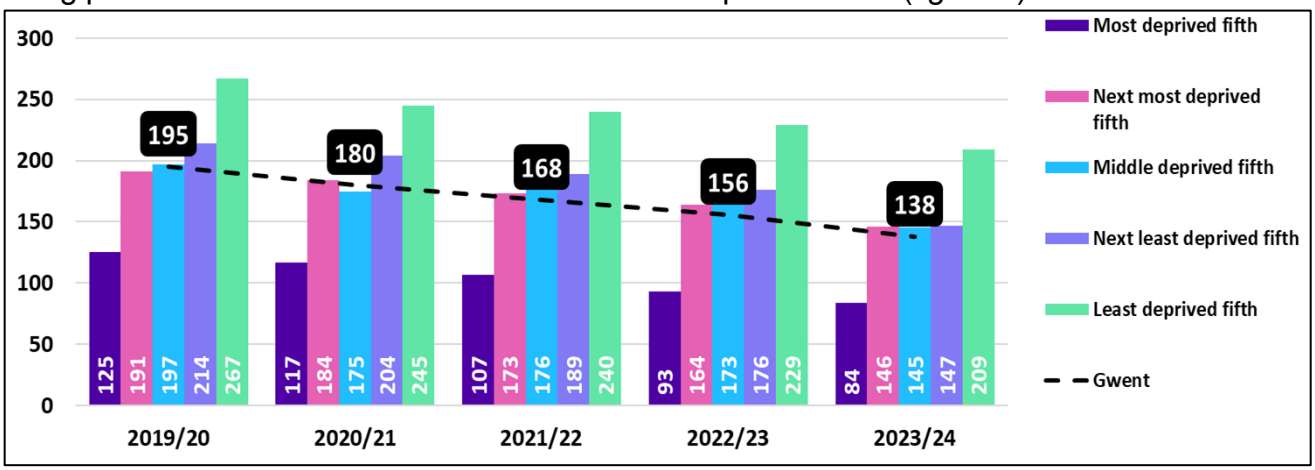


Figure 5: Primary Care combined hormonal contraception items prescribed per 1000 women aged 15-54, by deprivation quintile

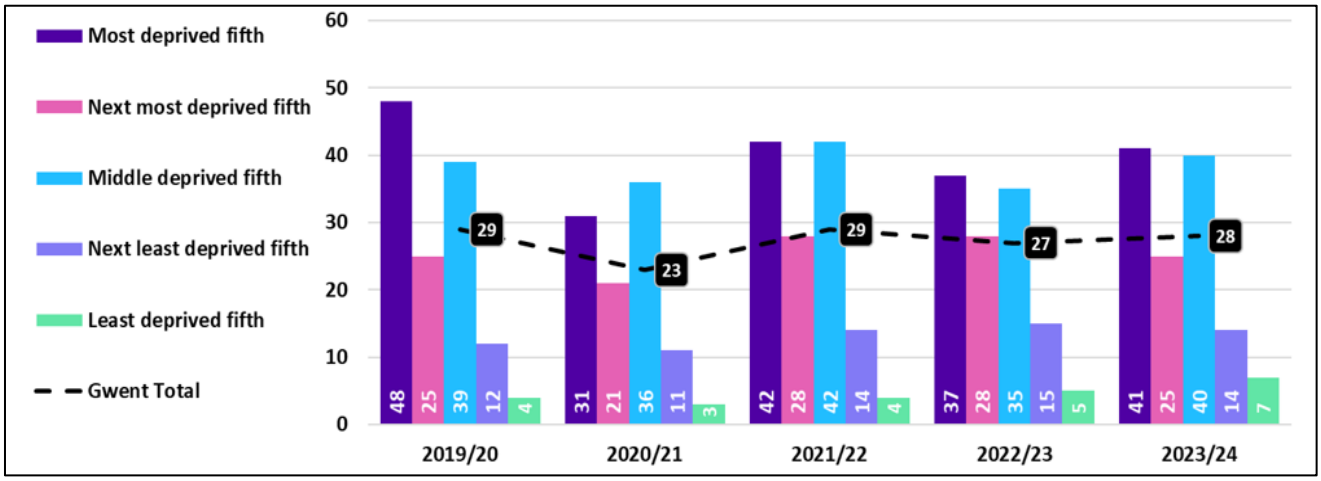


Figure 6: Emergency Hormonal Contraception: Consultations per 1000 women aged 15-55 in Gwent by deprivation quintile

Menopause

Since 2021 there have been increases in the rates of Hormonal Replacement Therapy (HRT) prescribing across all areas of Gwent. However there remains significant variation in these rates between local authority areas; with Newport having the lowest and Monmouthshire having the highest rate (figure 7).

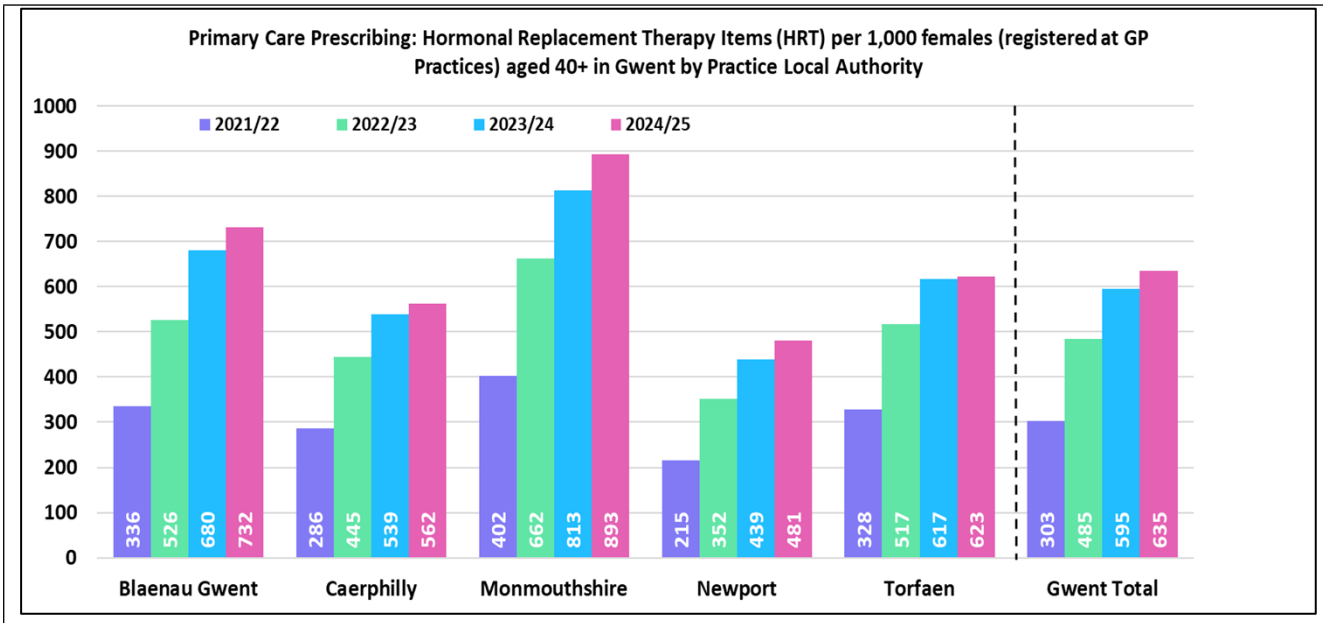


Figure 7: Primary Care HRT prescribing rates across Gwent

Menstruation

How women experience menstruation is varied. While many manage their periods without major disruption, a substantial proportion face challenges that affect their quality of life. One in three women experience heavy menstrual bleeding (HMB), which can lead to physical discomfort, emotional distress, and social withdrawal. Conditions such as endometriosis, polycystic ovary syndrome (PCOS), and premenstrual dysphoric disorder (PMDD) further complicate the menstrual health landscape, often going undiagnosed or untreated for years[1].

Economic inequality remains a key determinant of menstrual health. In areas of Gwent with higher deprivation, such as Blaenau Gwent, women and girls are more likely to experience period poverty. This includes limited access to affordable menstrual products, which can lead to the use of unsafe alternatives and increased risk of infection, and a less dignified experience (Period Proud Wales Action Plan, 2023[6]). As well as economic inequity, stigma and misinformation continue to impact menstrual experiences. In some communities, menstruation is still considered taboo, leading to feelings of shame. This cultural barrier can prevent individuals from seeking medical help or discussing symptoms openly.

Whilst improving access to contraception, menopause and menstruation services and interventions is important there is also a requirement to ensure that broader issues and drivers of inequity, and subsequent inequalities, are considered and incorporated into long term planning.

Asesiad / Assessment

Women's health hub requirements

The ambition for Women's Health Hubs in Wales is to bring together healthcare professionals and existing services to provide integrated women's health services in the community to meet the needs of women across the life course. Women's health hubs will aim to improve access to and experiences of care, improve health outcomes for women, and reduce health inequalities.

Welsh Government, enabled by the Women's Health Network, has provided an outline of what women's health hubs in Wales should be, with the three priority areas outlined above used as a focus for initial scoping:

- Based in the community

- Work at the interface between primary and secondary care and/or voluntary sector and beyond.
- Offer more than a single service (with provision of both gynaecological and contraception services) or demonstrate plans to.
- Have more than one organisation involved in design, commissioning and/or provision of care, beyond simply referring-in.
- The services should not replace GP services and should prioritise hard to reach populations
- To utilise Primary Care 'Cluster Networks', be staffed by multi-professional teams and involve patients, charities and third sector services.
- They should provide opportunities for education and training, utilise health pathways to streamline referrals, and be supported by specialists from within secondary care.
- Services provided through a hub should be provided in a choice of ways; face-to-face, virtual/remote with the provision of 'self-referral' where appropriate.
- Hubs should be supported by HB communication teams to ensure local populations are aware of their existence, what is provided and how they can book/be referred.

Health Boards are required to establish at least one women's health pathfinder hub by the end of March 2026 with the view to sustaining it beyond April 2026, with a supporting plan in place for the wider implementation of women's health hubs. It is important to note that there is currently no indication that additional funding will be made available from April 2026 onwards to support the sustainability of the initial pathfinder hub or enable the wider implementation of women's hubs.

Progress to date

A significant amount of work has taken place across the Health Board to progress the development of a pathfinder hub. This includes, but is not exhaustive of:

- Establishment of a Programme Board with task and finish groups to provide a specific focus to progress the three priority areas.
- Securing £300,000 of Welsh Government funding for 2025/26. This funding supports the ongoing ambition to implement and sustain a pathfinder hub by building appropriate capacity and learning in areas that includes, but is not exhaustive of:
    - Ongoing training and workforce development (e.g., Menopause BMC certificate, community pharmacy technician emergency contraception, ring pessary in primary care).
    - Capital investment into couches for Primary Care
    - Development of an extended in-house termination services and expansion of the vasectomy service to reduce waits
    - Upgrading booking and triage systems to increase capacity covering 24hrs (online out of hours).
    - Investment in public health intelligence expertise to lead the development of discovery report and needs assessment.
- Women's health hub workshop in October 2025 bringing together relevant stakeholders to support the development of the pathfinder hub.
- Women's health discovery report underway with an initial focus on the 2025/26 priority areas.
- Premenstrual Dysphoric Disorder (PMDD) needs assessment underway.
- Development of a pelvic health research funding bid, outcome TBC.
- Establishment of divisional interface groups, aiming to bring together Primary Care and Secondary Care clinicians to redesign pathways and develop new integrated models of care. This could include:
    - Consultant interface clinics;

    - GPs with Extended Roles (GPERs) working with consultant colleagues; and
    - Consultant input into virtual or in-person MDT meetings.
- Women's health hubs reflected in the Health Boards 2026/27 IMTP.

Proposed model for a women's pathfinder hub in Gwent

Based on the current understanding of the needs of women in Gwent, clinicians and patient feedback and the outputs of the stakeholder workshop a blueprint of how women's health hubs could be developed is reflected in appendix A. The proposed model intends to upstream services that traditionally sit within secondary care and move them into community settings. It is hoped that further planning on the range of services required at a locality level can be defined through appropriate existing mechanisms and aligned to existing programmes, e.g., ISPBs and Place Based Care.

Upskilling the workforce in primary care will enable enhanced support within communities to provide ring pessary's, coils and menopause support. The model suggests that fragile secondary care services should be centralised using ambulatory care units such as that In Nevill Hall Hospital, whilst exploring implementing more sustainable services within the community.

Work will continue with communities to gather ongoing systematic feedback to inform and develop the model.

<u>Underpinning principles</u>

- To build on and incorporate the Health Boards women's ambulatory unit and other exemplar services that the Families and Therapies Division has established over the last 5 years.
- To ensure alignment and incorporate any model with the Health Board's 10-year strategy: Better Health, Better Care, Better Lives, Place Based Care Programme, the violence against women, domestic abuse and sexual violence (VAWDASV) agenda, Best Start in Life and the priorities being led by the Maternal and Neonatal and Child Health Network. and emerging business case which is scheduled to be considered towards the end of this year.
- To continue to test new models of care and embed into the women's health hub and spoke model potentially with virtual access to services.
- To continue to enhance provision within Primary Care through training and education building on the work already taken forward
- Build on patient engagement and education through campaigns, co-production and intelligence drawn from PREMS/PROMS. To identify gaps, improve the patient experience and strengthen management out of hospital care.
- Capitalise on existing and explore new digital platforms for women's health that support signposting, education, and virtual co-ordination.

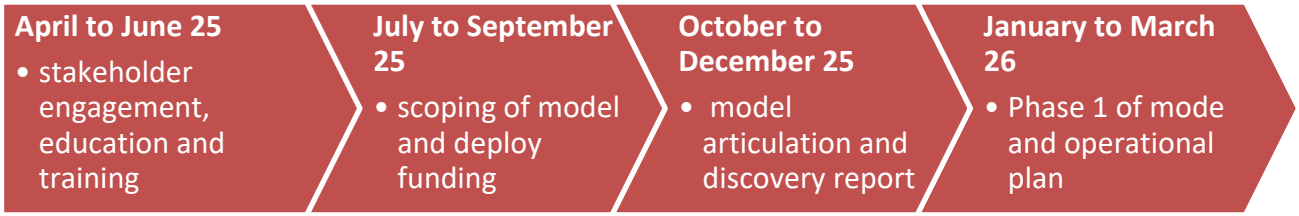
What will the women's hub model deliver

The women's health hub model aims to improve outcomes and experience for girls and women through education, increased service access, reduced health inequalities and providing integrated care close to home. Services will be holistic and take a life course approach so for example menopause services will offer education, clinical support along with lifestyle and psychological support. Once fully implemented, the model would hopefully deliver the planned outcomes outlined in appendix B.

The intention is that the proposed path finder hub service specification and operating model will address the three sex specific priority areas, as required by Welsh Government. However the long-term ambition is to use data and intelligence to identity need, improve health outcomes

and address the inequalities that exist for women/girl's long term. Whilst this will include e.g., addressing access to sex specific services it will also consider non-sex specific issues including violence against women, domestic abuse and sexual violence (VAWDASV), and chronic disease prevention, including increasing the prevention of gestational diabetes in line with the Priorities of the National Clinical Network for diabetes. This will be done by addressing clinical and behavioural risk factors as well as the fundamental building blocks for women's health that includes social, economic and environmental factors.

An overview of the timeline of activities for this year is outlined below:



Next Steps

To meet the ambition of developing and implementing a women's health pathfinder hub in Gwent the following next steps are planned:

- Complete the women's health discovery report and commence expansion into larger needs assessment to include non sex specific issues.
- Continue to implement projects and interventions supported by Welsh Government funding to inform development of pathfinder hub.
- Develop service specification and operating model for pathfinder hub and gain agreement from ABUHB executive team in December 2025.
- Ongoing strategic alignment of women's health hub with other health board and system priorities, e.g., Place Based Care. This to include the strengthening of relationships between secondary and primary care clinicians.
- Continue to strengthen links with community and engagement teams e.g., IWNs and ABUHB engagement team to engage with women and communities to inform ongoing development of pathfinder hub.

Risks to delivery

A number of risks and challenges to develop and implement an initial pathfinder hub and wider network of women's hubs have been identified:

- Lack of additional new money currently indicated to support the sustainability and scale up of women's hubs. Whilst the initial £300k pump prime funding for 2025/26 from Welsh Government intends to build capacity, learning and system efficiencies it is unknown if any efficiencies gained will be enough to enable reinvestment from within the Health Board at the scale required and within the current financial environment.
- Lack of insight in relation to 2026/27 national priorities for women's health.
- Challenging timescales to design and commence the implementation of the pathfinder hub alongside other national and Health Board priorities. Similar concerns have been expressed by other Health Boards and ABUHB have been liaising closely with WG around expectations.
- Significant consideration to the following is required to enable operational delivery of the hub(s):
    - workforce availability (including capacity and capability)
    - current system pressures
    - estates and facilities strategy
    - appropriate alignment with other priority areas of work

Argymhelliad / Recommendation

The Board are asked to:

- Consider the information presented and provide any relevant feedback or insight, in particular to proposed next steps, the proposed pathfinder hub for Gwent and the risks to delivery.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 1. Staying Healthy 4. Dignified Care 5. Timely Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	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)**

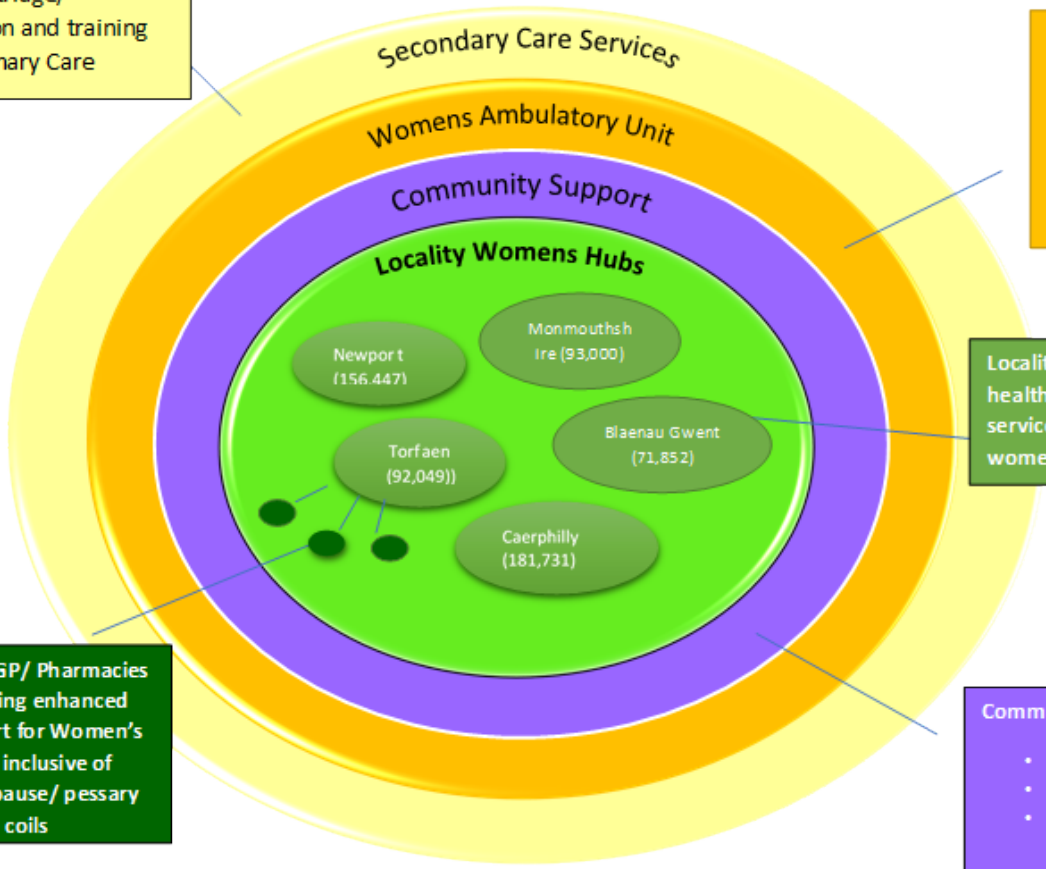
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice 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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

References

1: Quality statement for women and girls' health [HTML] | GOV.WALES
2: Women's Health in Wales - A Discovery Report - NHS Wales Performance and Improvement
3: The Women's Health Plan for Wales - NHS Wales Performance and Improvement
4: Life expectancies - Office for National Statistics
5: The Gwent Joint Strategic Assessment 2024/25 Edition - Aneurin Bevan University Health Board
6: Period Proud Wales Action Plan [HTML] | GOV.WALES

Appendix A: Blueprint of women's health hubs for Gwent

Secondary Care
Integrated Pathways/ referral triage/ education and training into Primary Care



Womens Health Unit

nurse and consultant led services/ USC Clinics/ Vulval clinics/biopsy/ polypectomies/ Urogynaecology clinics, , General benign gynaecology clinics, NLED pessary clinics

Digital support / women's website for signposting/ booking and scheduling/ virtual co-ordination

Locality Womens Hubs. Secure space in the largest HWBC/ sexual health hub for each locality. Provide a range of women related services ie.e pessary, nurse/ physio led gynaecology services. womens lifestyle support. Peripatetic GPwSI (subject to funding)

ISPB/ GP/ Pharmacies providing enhanced support for Women's health inclusive of menopause/ pessary fitting. coils

Community Support Including:

- Community support groups
- Integrated wellbeing network
- Community embedded health professionals like school nursing

Appendix B: Expected outcomes of the proposed model

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 November 2025
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Feedback on the Respiratory Reconfiguration and the General Medicine Model at GUH
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tracy Morgan, General Manager, Medicine Kate Fitzgerald, Head of Transformation and Delivery

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To provide the Board with an update on the implementation of the General Internal Medicine (GIM) model at Grange University Hospital (GUH), alongside the Respiratory Medicine reconfiguration introduced in November 2024. Key developments include:

- Realignment of medical staff from Nevill Hall Hospital (NHH) to GUH to strengthen the Respiratory team
- Establishment of clear clinical accountability for 16 GIM beds at GUH

Cefndir / Background

General Internal Medicine – Service Model Update

Since the opening of GUH in 2020, the site has operated a specialty-based bed model, with General Medical patients managed at enhanced Local General Hospitals (eLGHs). As a result, GUH has not delivered a General Medicine model for the past five years. This has impacted the ability of specialty patients to access appropriate beds, which potentially affects the timeliness of care for patients requiring general medical support—particularly among the elderly and frail population.

Following efforts to reduce the bed base in line with the Clinical Futures plan and given a partial reduction in surge beds at Nevill Hall Hospital (NHH) over the summer, an opportunity arose to address these challenges. A plan was developed through a series of planning and briefing sessions to support development and implementation.

Executive Committee – 12th September 2024
A paper was submitted seeking approval to implement a GIM model at GUH, aligned with the reconfiguration of the Respiratory Medicine service. Key elements included:

- Closure of medical inpatient beds on Ward 4/3 at NHH
- Phased introduction of a Respiratory in-reach model at NHH and YYF
- Establishment of clear clinical accountability for 16 GIM beds at GUH

Board Briefing – 9th October 2024
The Board received an update on the Inpatient Reconfiguration Programme, including the Respiratory service changes and the introduction of the GIM model at GUH.

Public Board – 26th November 2024
The Board received an update on the implementation of the GIM model which commenced during the week of 11th November 2024.

The **proposal** included:

- Reconfiguration of current medical beds and relocation of Respiratory High Care Unit to result in the General Internal Medicine capacity on the GUH site being provided across Wards **C4 and B4.**
- **Respiratory High Care Unit** on C4 to relocate to C2.
- **A3 beds** (currently utilised for outlying General Medical patients) allocated to Surgery.
- First floor General Medical patients continue to be managed by the **Acute Medical team**, as per previous model.
- Closure of a medical ward at which equated to **22 Respiratory and 6 Diabetes beds**, (Diabetes beds to be absorbed into existing footprint), a total reduction of 28 beds. This was enabled by absorbing the surge capacity on the wards at NHH into core numbers.
- Clear clinical accountability (Respiratory) for **16 General Medical** beds at GUH.

The **overall bed reduction**:

Overall Bed Reduction	
Medicine	
NHH	
22 Resp & 6 Diab, Diab beds to be absorbed into NHH footprint	-28
GUH	
A3 (gynae - used for medical outliers)	-8
C2 (machen)	6
Total	**-30**
Surgery	
GUH	
C2 (machen)	-6
A3 additional	8
Ambo CEPOD	2
Total	4
Bed Reduction	**-26**

Assessment

As outlined in the Public Board paper dated 26th November, a range of outcomes and benefits were anticipated as part of the proposed service change. This paper highlights expected improvements across key areas, including workforce, financial, patient experience and system-wide operational benefits.

Workforce Analysis
The following feedback and workforce benefits are noted from the **Respiratory Consultants**:

- Recent bed reconfiguration has significantly enhanced teamworking within the directorate—a development of considerable importance.
- Ward functions efficiently despite its size, supported by effective board rounds and strong leadership from a proactive ward manager.
- Concerns have been raised regarding insufficient non-clinical capacity at GUH to support virtual clinics and SPAs, resulting in consultants needing to travel off-site.
- Inpatient respiratory referrals at Nevill Hall Hospital remain manageable.
- Case mix on Ward C4 has shifted, particularly over the summer, with fewer respiratory admissions.
- Reduction in medical outliers managed by the Respiratory team has positively impacted workflow and staff morale across the GUH site.
- Despite changes in case mix, the average length of stay on C4 (including newly configured beds) has decreased since the reconfiguration.

The **Workforce support** provided to staff through the reconfiguration included:

- All staff affected by the proposed service change were supported in line with the all-Wales organisational change policy.
- Engagement was undertaken with Trade Union Partners.
- Staff preferences were honoured, with all individuals securing either their first or second choice.
- Staff were offered one-to-one meetings with senior management and workforce representatives to discuss concerns and options.
- Through mutual agreement, the Ward Manager and Deputy Ward Manager from Ward 4/3 transitioned into vacancies within the Acute Medical Unit at the NHH site.
- Divisional engagement sessions were held with representation from all staff groups, and an executive drop-in session at NHH led by the Chief Operating Officer and Executive Director of Nursing to provide further reassurance and an opportunity to address staff queries.
- Nursing staff were also supported to transfer to alternative hospital sites, enabling personal development and accommodating individual circumstances

Workforce Summary table

Role	Workforce Update	Additional Notes
Consultant	Increased by 1 WTE as planned for 2025/26 Phase 2 - recruitment of 1 WTE 2026/27	Recruitment currently in progress.

Physician Associate	Increased by 1 WTE due to substantiated post previously funded by Cardiology	Service model revised to provide 7-day clinical cover, mirroring consultant pattern
Nursing & HCSW	Workforce establishments increased	Ongoing recruitment; full recruitment affected by natural turnover

Consultant Office Space – Impact on Service Delivery

As part of the consultant contract, the Health Board is expected to provide suitable office space to support job planning requirements. Currently, no dedicated office space is available at GUH for consultants to undertake administrative duties and there is no consistent availability within the agile working area at GUH.

As a result, consultants are continuing to travel to RGH or NHH to complete this work. This arrangement is having a detrimental impact on capacity, particularly affecting the delivery of Direct Clinical Care (DCC) sessions as outlined in job plans.

A capital Project Proposal Document has been completed for reconfiguration of space in Grange House to support this. This is £12k. The estimated benefit of being able to create office space for this team on this site is equivalent of 6 DCC sessions, estimated at £17k per session, a total of £102k full year effect.

Finance Benefits
This table outlines the predicted net savings to be realised over a three-year period across the Health Board noting the reduction in savings for the Division of Medicine in 2026/27 due to the appointment of the second Consultant:

Division	**2024/25**	**2025/26**	**2026/27**
Medicine	-729,874	-1,617,527	-1,458,780
Surgery	-157,000	-471,000	-471,000
Estates & Facilities	-73,605	-220,815	-220,815
Total Net Savings	**-960,479**	**-2,309,342**	**-2,150,595**

The actual net savings achieved to date are outlined below:

Division	**2024/25**	**2025/26**	**2026/27**
Medicine	-472,000	-1,655,000	-1,496,000
Surgery	0	-471,000	-471,000
Estates & Facilities	-69,000	-221,000	-221,000
Total Net Savings	**-541,000**	**-2,347,000**	**-2,188,000**

The following points are noted:

- Savings were achieved within the Surgery Division during 2024/25 as a result of the change of Machen from elective surgery. The additional staffing has been absorbed into vacancies within the roster for C0
- Predicted savings within Medicine were not fully realised, primarily due to a delay in the anticipated reduction of nursing variable pay. This was expected to occur more rapidly during the transition period at NHH and GUH but did not materialise as planned.
- In addition, in Medicine, there was a short period of supernumerary and increased nursing working in NHH areas over and above the agreed establishment due to staff requesting to remain in NHH. The change in cohort of patients resulted in higher acuity patients on ward 4/4 compared to previously so the level of nursing enhanced care requirements via variable pay was higher, this has now settled.

Patient, Staff and System Benefits

The original proposal identified the following key benefits. Progress to date against each is outlined below:

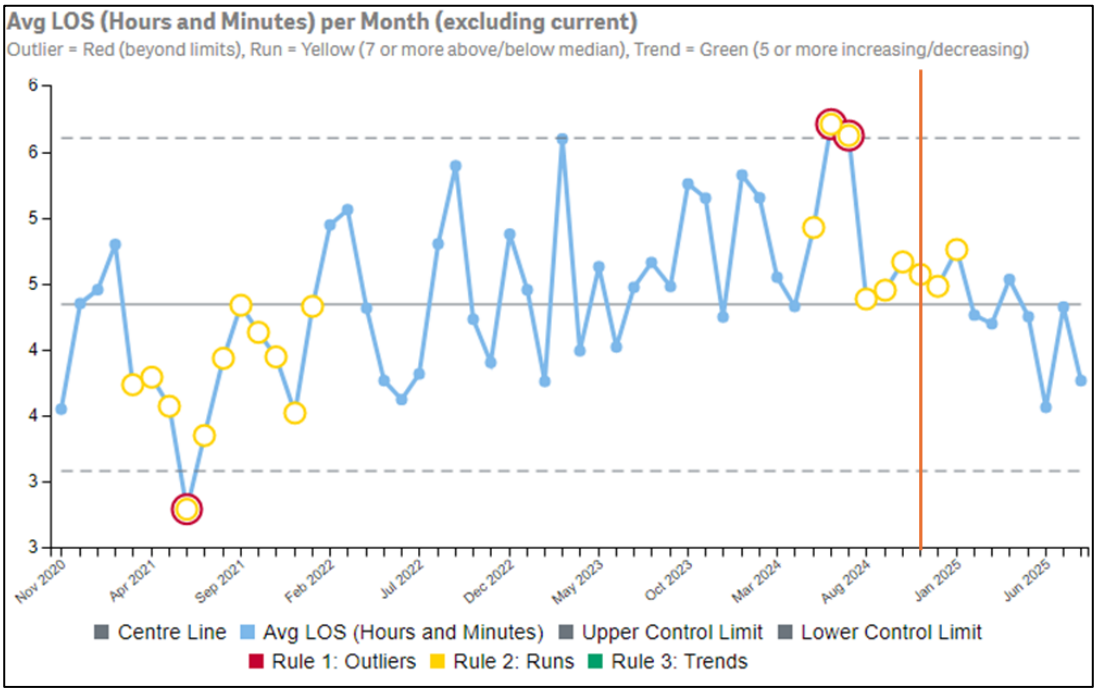
Benefit	Update October 2026
Clear clinical accountability for 16 GIM beds at GUH, improved patient experience and outcomes	**Achieved**, patient experience and outcomes highlighted through the data, reduced LOS at GUH
Respiratory medical staff aligned to speciality demand, caring for the right patients in the right place in the system	**Achieved –** Acute Respiratory patients requiring critical support are single sited at GUH with full support from the Respiratory team
Medical model of care at NHH aligned with demand, accommodating multi-morbid care of the elderly patients with complex discharge requirements, care delivered close to home	**Noting expected increase in LOS aligned to cohort of patients, elderly** and frail. The overall increase in LOS on ward 4/4 is minimal and in line with core COTE wards
Right sizing the bed base aligned to the Clinical Futures model, delivering safe, sustainable and efficient patient care	**Ongoing** - work continues to be supported through the Clinical Redesign Programme, with oversight from the Chief Operating Officer
Consistent Respiratory in reach model of care delivered across the eLGH sites, single site Respiratory inpatient bed base	**Ongoing** - recruitment continues, respiratory team have a clear referral process which is utilised and no concerns raised to date

Data Analysis

The data presented below highlights the positive outcomes observed following the service reconfiguration implemented in November 2024. Prior to the reconfiguration, data quality related to General Internal Medicine patients was inconsistent due to coding issues. However, following the change, a robust coding system has been implemented to support accurate data capture and enable reliable trend analysis.

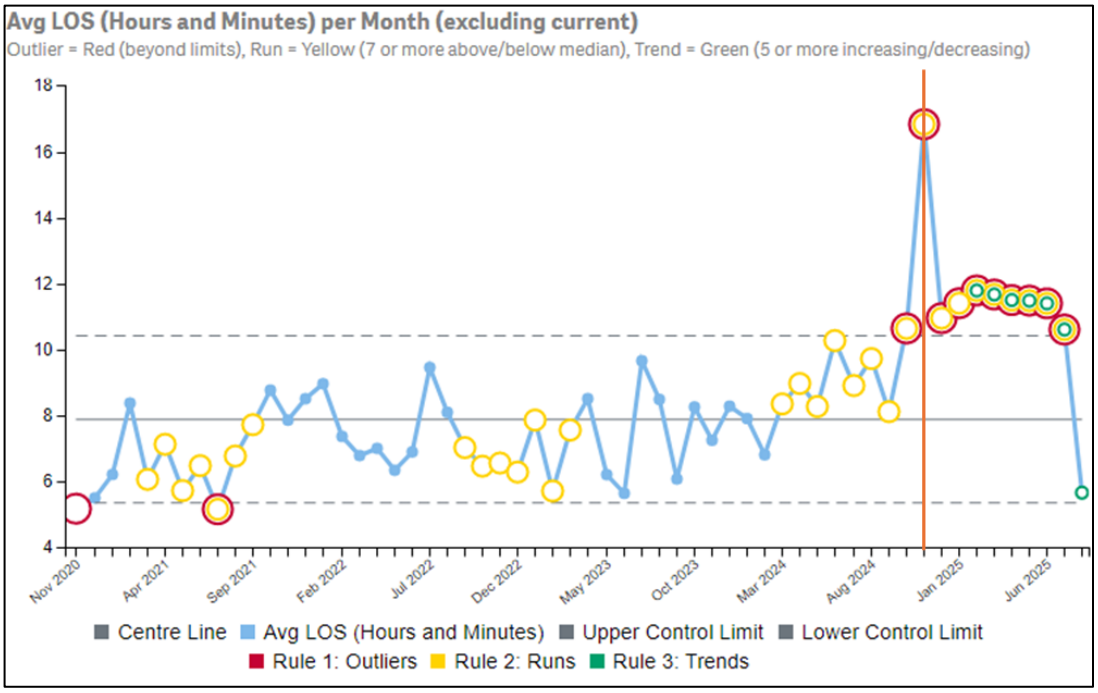
Following the reconfiguration the average LOS on C/4 has gradually decreased (**figure 1**), since April 2024. For most of the period, LOS was around 4-5 days but since May 2025 it has been around 3-4 days as highlighted on the graph below:

Figure 1 – Average LOS Ward C/4 GUH



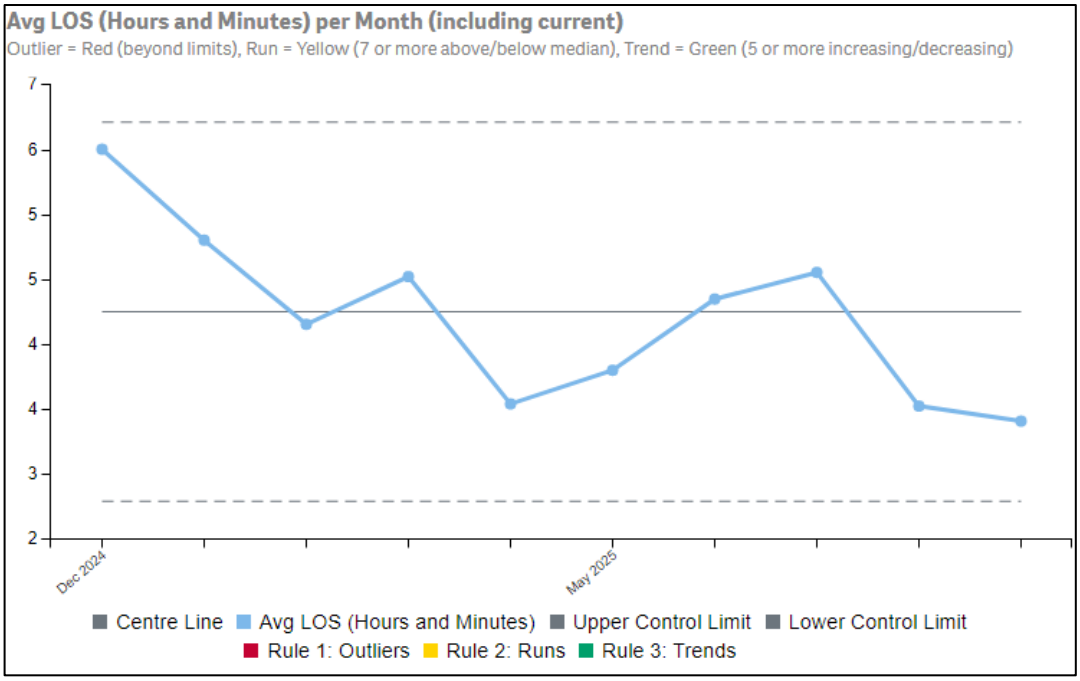
In terms of NHH average LOS on 4/4 (**figure 2**) between March 2024 and January 2025, the average LOS increased from 6-9 days to 10-12 days. This increase was anticipated due to the change in patient cohort, with the ward now functioning as a COTE ward. With the complexity and acuity associated with this cohort, a longer LOS is expected and is consistent with other COTE wards within the Health Board.

Figure 2 – Average LOS Ward 4/4 NHH



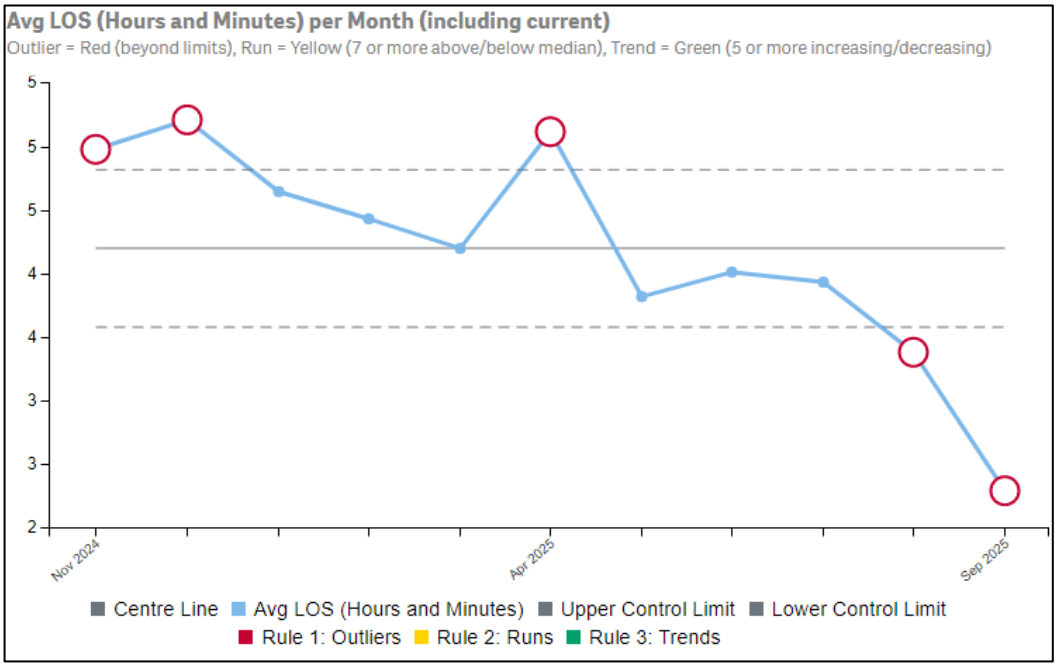
Since November 2024, there has been an anticipated increase in the number of General Medicine patients admitted to ward C/4, with a particularly sharp rise observed from March 2025 onwards. In recent weeks, the ward has consistently seen between 10 to 20 patient stays per week. Despite this increase in activity, the average LOS has shown a gradual improvement (**figure 3**), decreasing from approximately 5–6 days at the start of the year to around 4 days since April 2025:

Figure 3 – Average LOS Ward C/4 GUH General Medicine Patients



Since November 2024, there has been an overall reduction in the number of respiratory patients admitted to Ward C4 in line with demand, with weekly admissions decreasing from approximately 30 to 20. In parallel, the average length of stay (**figure 4**) has improved, reducing from around 5 days to between 3 and 4 days. These trends suggest positive progress in managing respiratory pathways, and improved patient flow across the system.

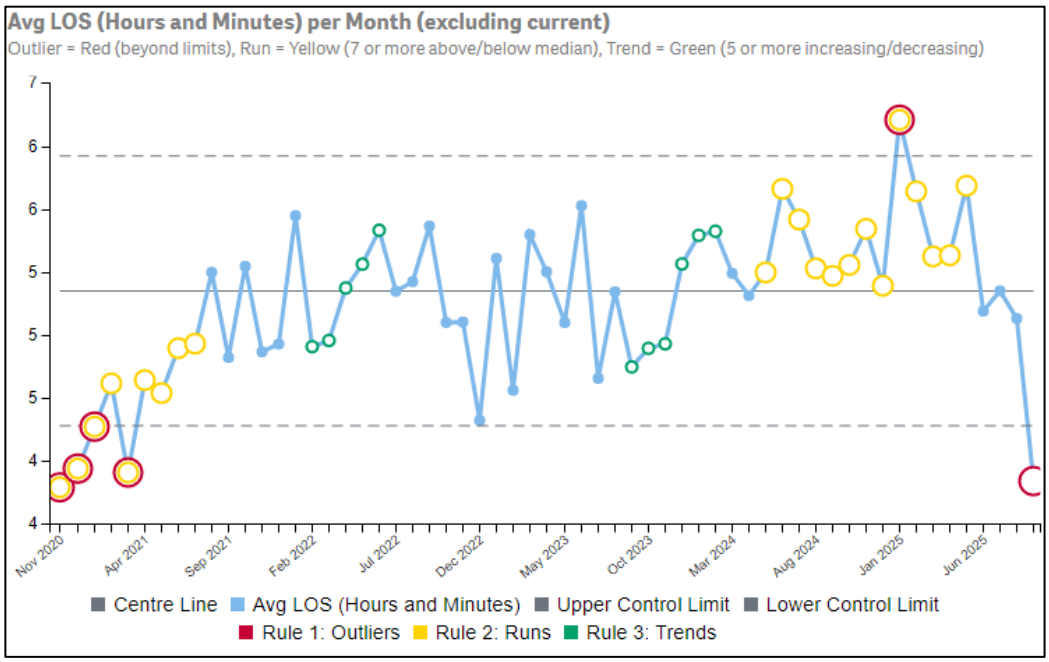
Figure 4 - Average LOS Ward C/4 GUH Respiratory Patients



An anticipated benefit of the reconfiguration was a reduction in LOS on specialty wards (**figure 5**), supported by the introduction of 16 dedicated General Medicine beds. This change has enabled clearer clinical accountability and reduced the need for General Medicine patients to be managed across multiple specialty areas. Consequently, specialty teams are afforded greater capacity to concentrate on their designated patient cohorts, resulting in a reduction in medical outliers. This, in turn, facilitates more efficient utilisation of inpatient beds and contributes to enhanced patient flow throughout the healthcare system.

The average LOS for Medical Specialties has remained relatively stable at around 5 days. In November 2024, LOS had levelled off at approximately 5–6 days, but following a peak in January, a gradual reduction has been observed. Over the past three months, the average LOS has returned to around 5 days, with September showing a further improvement to just under 5 days:

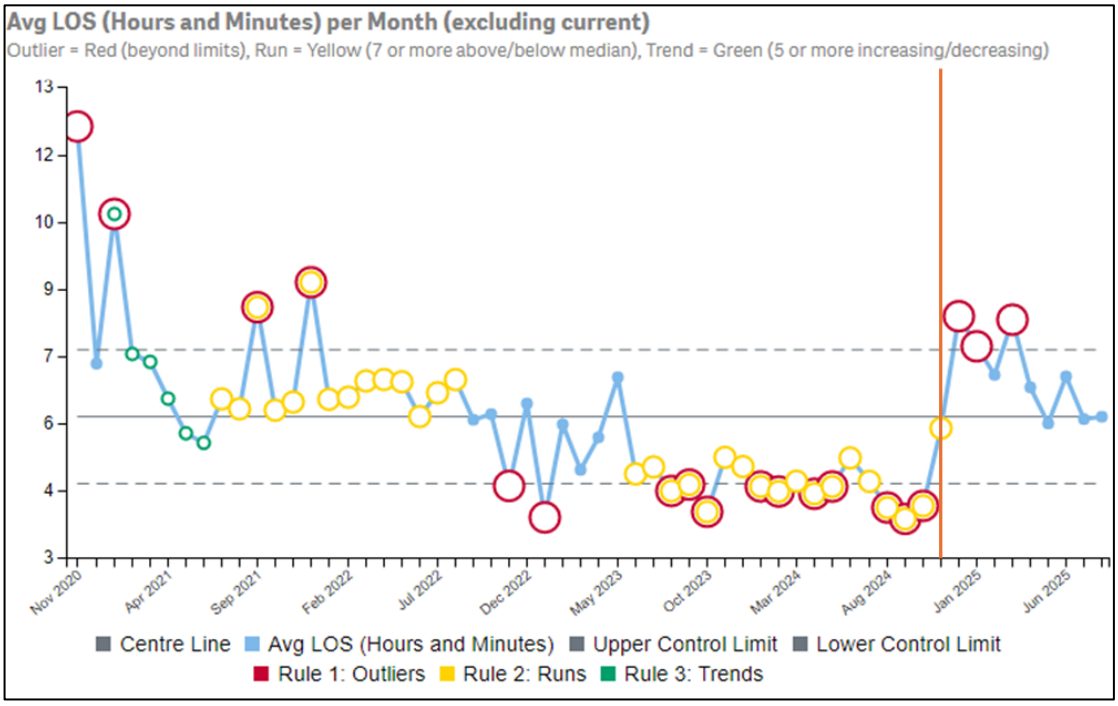
Figure 5 – Average LOS on Specialty Wards at GUH



Following the reconfiguration of high-care respiratory beds from Ward C4 to a dedicated unit within Ward C2, admissions to the critical care component of C2 have significantly reduced—from approximately 165–200 admissions per month to 80–120 admissions per month. The average cost per critical care bed day is £1500.

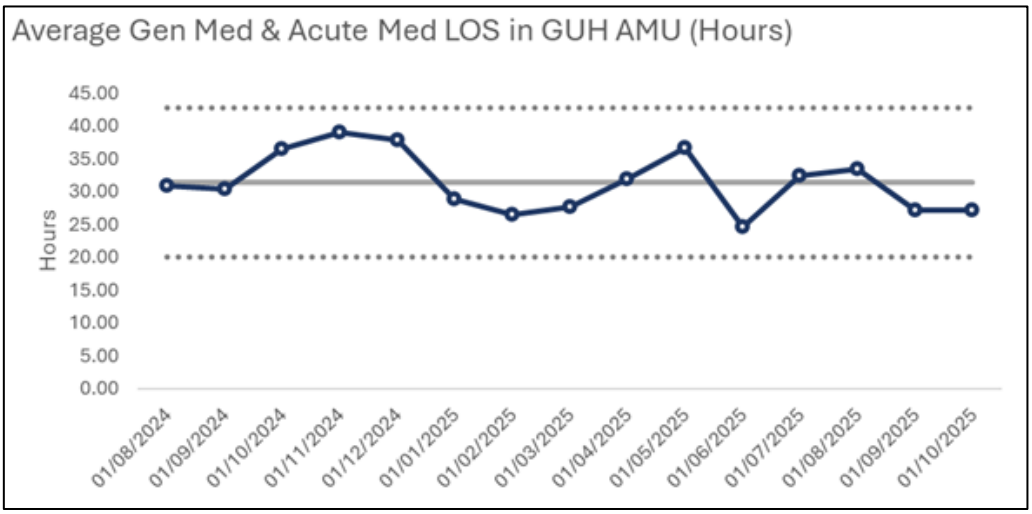
This change has contributed to a more targeted use of critical care resources. The LOS on the ward (**Figure 6**) has increased from around 4 days to 6–7 days, reflecting the higher acuity and complexity of patients now managed within the dedicated respiratory unit, the graph below highlights the ward stays:

Figure 6 – Average LOS Ward C2 GUH



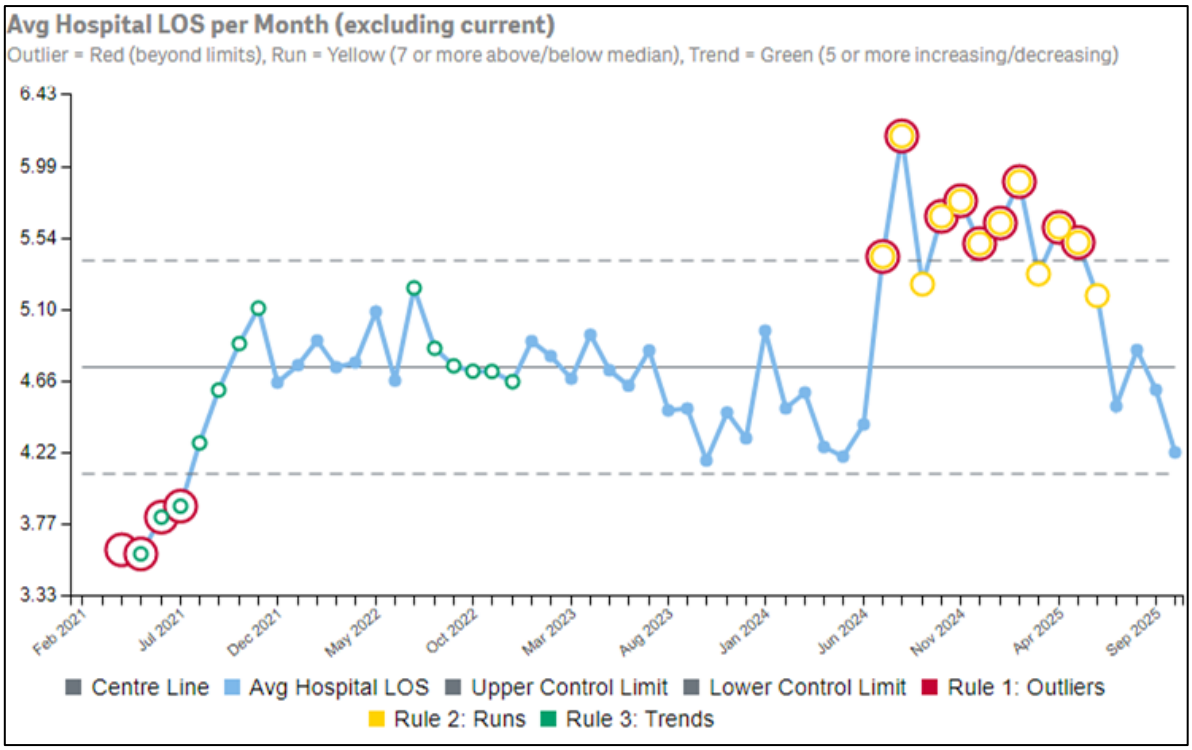
There has been a slight improvement in the LOS of general medicine and acute medicine patients within AMU at GUH, from around 34 hours since August 2024 to 31 hours in November 2024 (**figure 7**). While this was not an anticipated benefit of the reconfiguration, the most significant efficiencies have been realised once general medicine patients are transferred to a ward. This is evidenced by the reduction in LOS for these patients and the resulting improvement in patient flow.

Figure 7 – Average LOS General Medicine and Acute Med Patients in AMU at GUH



The recent reconfiguration at GUH appears to have had a modest initial impact on the overall LOS for patients admitted under the Divisions of Urgent Care and Medicine. While LOS remained relatively stable immediately following the change, a marked reduction has been observed from June/July 2025 onwards. This suggests that the benefits of the reconfiguration may have taken time to embed, potentially reflecting improved patient flow and greater operational efficiency across the site.

Figure 8 – Average Hospital LOS Patients Admitted (Urgent Care and Medicine)



Communication and Engagement
The following areas were progressed aligned to the reconfiguration:

- Divisional engagement session with the ward staff on wards 4/4 & 4/3 with representatives from all staff groups.
- Executive drop-in session with the Chief Operating Officer and Executive Director for Nursing to provide reassurance to the staff and respond to any concerns.
- Letters to stakeholders to inform them of the service change.
- Engagement with HEIW, TUPF and Llais.
- Wider staff communication via the intranet, focused communication with staff through team meetings, 1-1s and Divisional communication through the dedicated working group.

The Health Board will continue to monitor the anticipated benefits of the service change over time through established governance processes and regular operational oversight meetings. This ongoing evaluation will ensure that the expected improvements in workforce, financial sustainability, patient experience, and system-wide efficiency are realised and sustained, while also enabling responsive adjustments if required.

Argymhelliad / Recommendation

The Board are asked to:

- **Note** the realignment of medical staff from NHH to GUH to further support our Respiratory team and the clear clinical accountability for 16 GIM beds at GUH.
- **Note** the redeployment of nursing staff to support the change in bed configuration
- **Note** the positive feedback from staff and associated workforce benefits.

- **Note** the benefits illustrated through the data including reduced LOS for Respiratory and General Medicine patients and the improved LOS for Medical specialities.
- **Note** the targeted use of critical care resources.
- **Note** the improved model of care at NHH, aligned with demand for elderly patients.
- **Note** the benefits to be tracked and realised over time.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 4.1 Dignified Care 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	GUH Grange University Hospital NHH Nevill Hall Hospital GIM General Internal Medicine eLGH Enhanced Local General Hospital YYF Ysbyty Ystrad Fawr DCC Direct Critical Care WTE Whole Time Equivalent LOS Length of Stay RGH Royal Gwent Hospital COTE Care of the Elderly

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 November 2025
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Health, Safety & Fire Annual Report 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr, Executive Director of AHPs & Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Peter Carr, Executive Director of AHPs & Health Science

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to present to the Board the Health, Safety & Fire Annual Report for 2024/25.

The report identifies both the opportunities and challenges for the Health Board in ensuring and sustaining compliance with Health and Safety legislation, including specific compliance improvement action delivered in this period.

The Board is asked to receive the annual report and note the actions being taken to achieve compliance.

Cefndir / Background

The purpose of the annual report (Appendix A) is to provide the Health Board with a summary of principal activity and outcomes relating to the management of health and safety within Aneurin Bevan University Health Board during 2024/25. The report also highlights key priorities for the Health and Safety Committee and its subgroups for the financial year 2025/26.

The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health

Board. Additionally, the report provides information relating to key activities undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence and Aggression

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues to be the Executive Director of AHPs & Health Science.

Asesiad / Assessment

The progress against the Health, Safety & Fire Improvement Plan in 2023/24 has provided a focus resulting in a reduction in key risk areas of concern.

The following points highlight and support the increase in compliance and reduction in risk following implementation of the improvement plan:

- **RIDDOR Reporting Compliance:** increase from 67.7% (2023/24) to 69.8% (2024/25)
- **Health and Safety Statutory & Mandatory Training Compliance:** increase in 2024/25 compared with 2023/24. This includes Manual Handling and Violence Prevention & Reduction.
- **Health and Safety Monitoring:** a programme of health, safety and environment workplace inspections was completed for wards and departments in the Acute Hospitals, Community Hospitals and Mental Health & Learning Disabilities sites. These assessments yielded an average Health Board compliance score of 89.63%.
- **Health and Safety Risk Assessments:** an additional 226 employees trained in Health & Safety Risk Assessment.
- **Fire Risk Assessments:** 100% completed/reviewed against of the planned areas in 2024/25. This is an increase of 4% compared with 2023/24.
- **Fire Alarm Systems:** work has been completed on upgrading the fire alarm system at St Cadocs Hospital and a programme has commenced on replacing the fire alarm system at Royal Gwent Hospital. Fire alarm systems across the Health Board have been analysed and a planned replacement programme has been developed.
- **Fire Barriers (Compartmentation):** the condition of fire barriers has been analysed across Hospital sites which has identified improvements required at Nevill Hall Hospital and Royal Gwent Hospital. Funding has been secured to repair the fire resisting barriers on these sites.

In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of risk areas for focus for 2025/26.

The Strategic Health and Safety Action Plan identifies eight key risks areas for 2025/26. Delivering these priorities will strengthen the Health Board's health and safety culture.

Health and safety leadership
The lack of knowledge and understanding of health and safety responsibilities for Managers and Supervisors presents a significant risk to the Health Board.

Health and safety assistance
The resource allocated to the Corporate Health and Safety Department presents a risk to the Health Board to meet the requirements of health, safety and fire legislation.

Health and safety policies & procedures
Health and safety policy compliance is currently poor and presents a risk to the Health Board. Outdated policies and procedures may be unclear, contradictory, or inconsistent with other organisational documents. This can lead to confusion among employees, resulting in misunderstandings, errors, and conflicts.

Manual handling training
The level of compliance with manual handling training presents a concern to the Health Board and a lack of staff competence to undertake manual handling techniques safely increases the risk of injury to staff and patients.

Fire safety training
Compliance with requirements of fire safety training guidance (*HTM 05-03 part A: Operational provisions – Training*) presents a risk to the Health Board. The organisation is currently dependant of staff completing their training and gaining competence by attending eLearning training.

Violence in the Workplace
The level of violence to which Health Board staff are exposed is a significant risk and needs to be reviewed with prevention and reduction strategies implemented.

Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
Failure to comply with RIDDOR leaves the Health Board at risk of enforcement action from the relevant enforcing authority.

Health and safety monitoring
The lack of a formal and structured health and safety monitoring system presents a risk to the Health Board.

Health and safety risk assessments
The poor quality and standard of risk assessments increases the risk to the Health Board. The risk is based on the likelihood of accidents and incidents occurring resulting in harm and the increased chance of enforcement action.

Recognising the Health Board challenges in compliance, a health and safety strategic risk (SRR 010) was developed in 2023/24. The risk is monitored regularly and reported via the Audit, Risk and Assurance Committee. The risk level has been reduced following the implementation of plans to improve controls. However, the risk level remains outside of the target level and outside appetite threshold (minimal risk appetite level which should be managed to a Score of 8 or below). The risk areas of focus, listed above and set out in the annual report, will be the basis of the ongoing

compliance improvement plan for Health & Safety, with routine progress reported to the Executive Committee.

Argymhelliad / Recommendation

The Board is asked to:

- receive the annual report and note improvement in compliance during the reporting period, and the actions being taken to achieve ongoing compliance improvement.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	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:	Health, Safety & Fire Annual Report 2024/25
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Health and Safety Committee Executive Committee Patient Quality & Safety Outcomes Committee

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Choose an item.
• **Service Activity & Performance**	Choose an item.
• **Financial**	Choose an item.
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.

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

Health, Safety and Fire Annual Report 2024/25

Our Values and Behaviours

People First

Personal Responsibility

Passion for Improvement

Pride in What We Do

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1 EXECUTIVE SUMMARY

The purpose of the report is to provide the Health Board with a summary of principal activity and outcomes relating to the management of health and safety within Aneurin Bevan University Health Board during 2024/25. The report also highlights key priorities for the Health and Safety Committee and its subgroups for the financial year 2025/26.

The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health Board. Additionally, the report provides information relating to key activities undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence Prevention & Reduction

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues with the Executive Director of Allied Health Professions & Health Science.

The progress against the Health, Safety & Fire Improvement Plan in 2023/24 has provided a focus resulting in a reduction in key risk areas of concern.

The following points highlight and support the increase in compliance and reduction in risk following implementation of the improvement plan:

- **RIDDOR Reporting Compliance:** increase from 67.7% (2023/24) to 69.8% (2024/25)
- **Health and Safety Statutory & Mandatory Training Compliance:** increase in 2024/25 compared with 2023/24. This includes Manual Handling and Violence Prevention & Reduction.
- **Health and Safety Monitoring:** a programme of health, safety and environment workplace inspections was completed for wards and departments in the Acute Hospitals, Community Hospitals and Mental Health & Learning Disabilities sites. These assessments yielded an average Health Board compliance score of 89.63%.
- **Health and Safety Risk Assessments:** an additional 226 employees trained in Health & Safety Risk Assessment.
- **Fire Risk Assessments:** 100% completed/reviewed against of the planned areas in 2024/25. This is an increase of 4% compared with 2024/24.
- **Fire Alarm Systems:** capital investment was secured to enhance the fire alarm systems. Work programmes commenced on replacing the fire alarm systems at Royal Gwent Hospital and St Cadocs Hospital. Fire alarm systems across the Health Board have been analysed and a planned replacement programme has been developed.
- **Fire Barriers (Compartmentation):** condition of fire barriers analysed across Hospital sites, identifying improvements required at Nevill Hall Hospital and Royal Gwent Hospital.

In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of risk areas for focus for 2025/26.

1.1 Risk Areas for Focus in 2025/26

Health and safety leadership
The lack of knowledge and understanding of health and safety responsibilities for Managers and Supervisors presents a significant risk to the Health Board.

Health and safety assistance
The resource allocated to the Corporate Health and Safety Department presents a risk to the Health Board to meet the requirements of health, safety and fire legislation.

Health and safety policies & procedures
Health and safety policy compliance is currently poor and presents a risk to the Health Board. Outdated policies and procedures may be unclear, contradictory, or inconsistent with other organisational documents. This can lead to confusion among employees, resulting in misunderstandings, errors, and conflicts.

Manual handling training
The level of compliance with manual handling training presents a concern to the Health Board and a lack of staff competence to undertake manual handling techniques safely increases the risk of injury to staff and patients.

Fire safety training
Compliance with requirements of fire safety training guidance (HTM 05-03 part A: Operational provisions – Training) presents a risk to the Health Board. The organisation's Compliance data is currently based on staff completing eLearning training. The standard requires face to face training.

Violence in the Workplace
The level of violence that Health Board staff are exposed to is a risk and needs to be reviewed with prevention and reduction strategies implemented.

Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
Failure to comply with RIDDOR leaves the Health Board at risk of enforcement action from the relevant enforcing authority.

Health and safety monitoring
The lack of a formal and structured health and safety monitoring system presents a risk to the Health Board.

Health and safety risk assessments
The poor quality and standard of risk assessments increases the risk to the Health Board. The risk is based on the likelihood of accidents and incidents occurring resulting in harm and the increased chance of enforcement action.

2 INTRODUCTION

This report provides analysis of the level of health and safety performance throughout the Health Board for 2024/25.

The Health and Safety at Work (etc.) Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.

In particular, the Act requires an organisation to provide and maintain:

- A Health and Safety Policy;
- A system to manage and control risks in connection with the use, handling, storage and transport of articles and substances;
- A safe and secure working environment, including provision and maintenance of access to and egress from premises;
- Safe and suitable plant, work equipment and systems of work that are without risks;
- Information, instruction, training and supervision as necessary;
- Adequate welfare facilities;

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;
- Core Commissioning Requirements.

Health, Safety and Security is an identified quality pillar within the Health Board Quality Strategy. The 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

The Health Board operates a Health and Safety Management System, utilising the Health and Safety Executive (HSE) '*Managing for health and safety*' (HSG65) model.

The model is structured into the Plan, Do, Check, Act approach (see diagram 1).

Plan, Do, Check, Act helps achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

Diagram 1: PDCA Health and Safety Management Model

3 HEALTH, SAFETY AND FIRE GOVERNANCE STRUCTURE

3.1 Accountability

The Chief Executive Officer (CEO) is accountable for Health and Safety with responsibility for executive leadership delegated to the Executive Director of Allied Health Professions & Health Science.

3.2 Health and Safety Leadership

Effective health and safety performance is led by the senior responsible officers of the Health Board. Members of the Board have both collective and individual responsibility for health and safety. Directors and boards need to examine their own behaviours, both individually and collectively, against the guidance given and, where they see that they fall short of the standards it sets them, to change what they do to become more effective leaders in health and safety.

Why directors and board members need to act:

- Protecting the health and safety of employees or members of the public who may be affected by your activities is an essential part of risk management and must be led by the board.

- Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership.

- Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety.

Business leaders have responsibility for determining and implementing effective health and safety management and monitoring its success, so it's essential that they understand how to implement a risk management strategy.

To support Board Members and Executive Directors to deploy their health and safety responsibilities, training was planned and delivered in 2024/25.

Regulation 7 of The Management of Health and Safety at Work Regulations 1999 states that *"Every employer shall, subject to paragraphs (6) and (7), appoint one or more Competent Persons to assist him in undertaking the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions"*.

The legislation states that a person shall be regarded as 'competent' if they have sufficient training, experience, or knowledge and 'other qualities'.

The Corporate Health and Safety Department employs specialist safety professionals to advise and support the Health Board to deliver and maintain health and safety standards.

The department structure (as of end of March 2025) is illustrated in diagram 2.

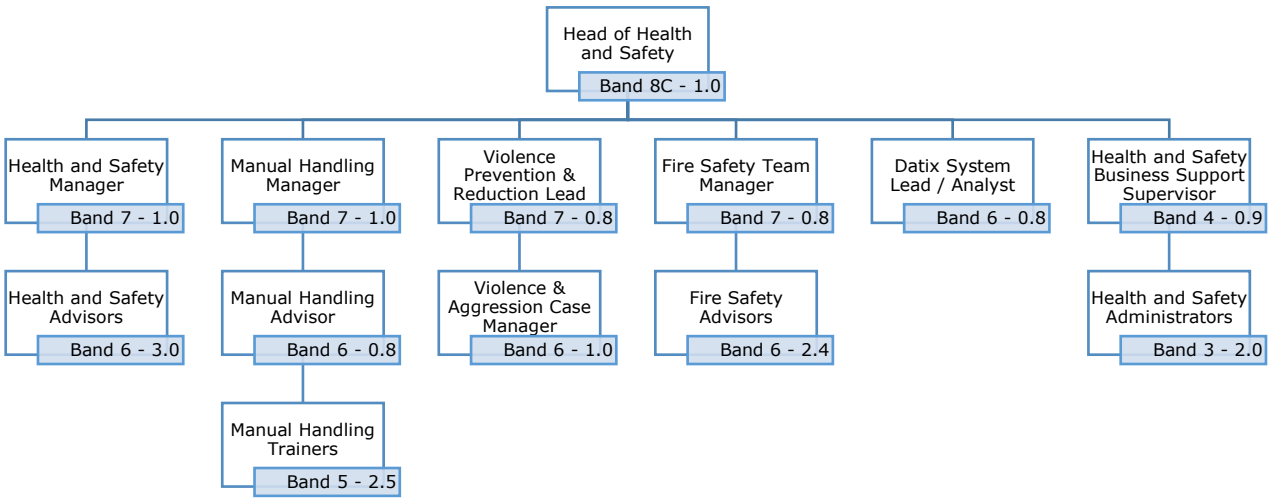


Diagram 2: Corporate Health and Safety Department Structure

Approval has been obtained in 2024/25 to recruit two new positions within the department; Deputy Head of Health, Safety & Fire (Band 8A) and Datix Systems Support Officer (Band 5). Plans are in place to recruit to these posts in 2025/26.

The Corporate Health and Safety Department is structured within specific functions i.e. health & safety, fire safety, manual handling and violence prevention & reduction.

The individuals within the functions are allocated areas of responsibility across the Health Board to support the development of effective relationships with key stakeholders. (See diagram 3)

Diagram 3: Map of Gwent Hospitals

During 2024/25 the Corporate Health and Safety Department has effectively integrated into the Health Board leadership structures and regularly engage via Divisional Quality and Patient Safety meetings and specific Health Board forums.

To ensure the Health Board can effectively meet its legal duties under Health and Safety legislation there is a need to consider the current resource available to the Corporate Health & Safety Department.

A review of the Corporate Health and Safety Department was completed in 2023/24. The review identified additional positions as key to enhancing the current establishment.

3.3 Health and Safety Reporting Arrangements

The Health and Safety Committee has been established to plan, manage and monitor Health Board compliance with statutory health and safety requirements and specific NHS duties.

The Executive Director of Allied Health Professions & Health Science is the Chair of the Health and Safety Committee, being the Director with delegated responsibility for health and safety within Aneurin Bevan University Health Board. The Health and Safety Committee is accountable to the Executive Committee and provides assurance to the Patient Quality and Safety Outcomes Committee.

The Health and Safety Committee receives reports from the subgroups and ratifies policies. The reporting arrangements are illustrated in diagram 4.

Diagram 4: Health and safety reporting arrangements

The Health and Safety Committee met three times in 2024/25. In June, September and December 2024.

The Committee Terms of Reference was agreed in September 2024 with agreed membership comprising of Executive Team members.

3.4 Health and Safety Committee Subgroups

Each subgroup is responsible for the production and updating of their own policies and terms of reference. These documents are submitted to the Health and Safety Committee for ratification.

During 2024/25 the subgroups did not meet. A plan of meeting dates for the subgroups will be implemented in 2025/26.

In addition to the corporate reporting arrangements, health and safety is a regular agenda item at the Divisional Quality and Patient Safety forums and Assurance meetings providing an opportunity to monitor health and safety performance.

3.5 Health and Safety Policies & Procedures

Health and safety policies and procedures have been developed within the Health Board to outline the organisations plans to achieve compliance with the relevant health and safety legislation and/or standards.

An objective for 2025/26 is to ensure all policies are reviewed and updated as appropriate.

Enforcement action taken by the Fire & Rescue Service against NHS Wales organisations relating to the control and management of ignition sources in healthcare has highlighted the requirement to develop a 'Search Policy'. This development is currently being led by the Corporate Health and Safety Department with engagement from key individuals across the Health Board.

A 'Vibration at Work Policy' is also in development to ensure the Health Board complies with the Control of Vibration at Work Regulations 2025. This policy is due to be finalise in 2025/26.

3.6 Audit and Assurance

There has been an Internal Audit on health and safety conducted during 2024/25. The outcome of the Internal Audit will be available in quarter 1 of 2025/26.

The Health and Safety Legislative Assurance Framework identifies the compliance with health and safety statutory instruments. The document is subject to an assessment by the Corporate Health and Safety Department in 2025/26.

4 HEALTH, SAFETY AND FIRE ENFORCEMENT ACTIVITY

During 2024/25, no prosecutions or enforcement actions have been issued by the Health and Safety Executive (HSE), however, South Wales Fire & Rescue Service (SWFRS) issued the Health Board with enforcement notices in February 2024 and April 2024 with respects to the fire safety arrangements at the staff accommodation buildings (Gerylyn and Bron Haul) at Nevill Hall Hospital.

The following matters highlight the non-compliance with the provisions of the Regulatory Reform (Fire Safety) Order 2005 for the buildings.

- Fire doors are being held open inappropriately
- Intumescent strip seals missing, damaged or defective
- The fire safety measures evaluated in the fire risk assessment have not been implemented
- The fire detection system is inadequate for the type and use of the premises
- The existing provision of manual firefighting equipment is inadequate
- Emergency routes and exits could not be used as quickly and as safely as possible
- The standard of fire separation is not adequate
- Fire resisting doors are not adequately maintained

A working group was formed to address the recommendations. Capital investment was secured to enhance the fire precautions in both building and the notices were complied with and subsequently lifted by South Wales Fire and Rescue Servicein December 2024.

Although the HSE didn't issue any enforcement against the Health Board, they did issue a notification of contravention in relation to a fatal patient fall. The HSE investigation of this incident is still ongoing.

During 2024/25 there have been HSE intervention costs of approximately £1,250.00. These costs relate specifically to HSE investigations into a patient fall incident. (The Health and Safety (Fees) Regulations 2012 places a duty on HSE to recover its costs for carrying out its regulatory functions, from those found to be in material breach of health and safety law.)

5 RISK MANAGEMENT AND RISK REPORTING

A health and safety strategic risk (SRR 010) was developed in 2023/24. The risk is monitored regularly at Health and Safety Committee meetings and reported via the Audit, Risk and Assurance Committee.

The risk level has been reduced following the implementation of plans to improve controls, however, the risk level is outside of target level and outside appetite threshold.

In addition to the health and safety strategic risk, directorate health and safety risks have been completed and are under regular review.

The completion of risks assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the risk assessment programme, the Corporate Health and Safety Department deliver risk assessment training, promoting best practice in the completion of a risk assessment and the principals of effective Risk Management within departments and in the wider organisation.

The Health and Safety Professionals within the Corporate Health and Safety Department continue to provide advice and guidance on the implementation of statutory risk assessments through the various subgroups. Specialist risk assessments being completed by the Health and Safety Professional upon request.

Most of the health and safety risks are reported via the risk module on the DatixWeb system. The Health Board also subscribe to CoSHH management software for the risk assessments relating to substances hazardous to health. All fire safety risk assessments are recorded via the NWSSP fire auditing and reporting system. New software for recording and monitoring fire risk assessments is now available and will be introduced in 2025/26.

The Health and Safety Committee receives reports on health and safety risks for consideration, action and assurance.

As part of the monitoring arrangements, the Corporate Health and Safety Department continually engage with Risk Leads to review the risks recorded as Extreme High and High with the view to provide further advice and support and ensure that appropriate mitigation is applied as a means to manage the risks at a level that is so far is reasonably practicable.

6 HEALTH, SAFETY AND FIRE TRAINING

Suitable and sufficient training is a requirement of The Health and Safety at Work Act 1974 and The Management of Health and Safety at Work Regulations 1999.

The Management of Health and Safety at Work Regulations state "every employer shall ensure that his employees are provided with adequate health and safety training".

The health and safety statutory and mandatory training compliance as of 31 March 2025 was as follows:

Training Course	2024/25 Compliance %	2023/24 Compliance %
Health and Safety	86.6%	86.7%
Fire Safety	82.3%	82.9%
Manual Handling	70.0%	55.3%
Violence Prevention & Reduction	86.1%	85.1%

During 2024/25 training compliance for health and safety, fire safety and violence prevention & reduction have been maintained compared with 2023/24.

With the exception of manual handling training, the delivery of the health and safety statutory and mandatory training programme in 2024/25 continues to be delivered by eLearning with access via the electronic staff record (ESR) self-service portal for ease to individuals. Line managers can view their team's compliance and are also notified when staff are nearing non-compliance. Positive changes are being progressed in relation to the requirements for manual handling training dependent on role. This will result in staff deemed low risk only required to conduct eLearning manual handling training every three years.

Manual handling training continues to prove a challenge for the Health Board with compliance levels well below the required standard of 85%. The manual handling training strategy has been reviewed in 2024/25 to ensure the Health Board has a sustainable programme of manual handling education, particularly for high-risk areas.

Manual Handling training within NHS Wales is delivered to the scope of the All-Wales Manual Handling Passport. This ensures a consistent and standard approach to training.

During 2024/25, the Manual Handling Team have continued to deliver manual handling training to Health Board staff.

The table below provides details of the manual handling training delivered and the attendance.

Manual Handling Course Title	No. of Sessions	No. of Attendees	No. of DNA's
People Handlers Foundation Training	74	718	163
People Handlers Update Training	48	259	76
Object Handlers Foundation Training	7	41	14
Object Handlers Update Training	0	0	0
People Handlers Trainers Foundation Training	3	12	6
People Handlers Trainers Update Training	9	50	16
Object Handlers Trainers Foundation Training	2	18	2
Object Handlers Trainers Update Training	3	16	2

Staff attendance on manual handling training and specifically those who do not attend remains a challenge.

Violence prevention and reduction training is aligned to the All-Wales NHS Violence & Aggression Passport Scheme. The passport scheme is broken down into four areas:

Module A – Induction and Awareness Training: Introduction to the basic concepts of violence and aggression prevention, including organisational policies and employee responsibilities.

Module B – Theory of Personal Safety and De-escalation: In-depth theoretical training on personal safety techniques and strategies for de-escalating potentially violent situations.

Module C – Breakaway Techniques: Practical training on breakaway techniques to safely disengage from physical confrontations.

Module D – Restrictive Physical Intervention: Training on the appropriate and safe use of restrictive physical interventions when necessary.

All Health Board staff are mandated to complete modules A & B, whist module C & D is based on risk assessment. Selected members of the Corporate Health and Safety Department have attended accredited training to enable them to teach module C and D.

Building on the work started in 2023/24, the Violence Prevention & Reduction Team continued delivering targeted training into the 2024/25. Specifically, three remaining training sessions were scheduled and delivered at Nevill Hall Hospital to complete the programme.

These sessions focused on the specific risks of violence and aggression posed by elderly patients in Care of the Elderly Wards. Recognising the difficulties faced by staff in these settings, bespoke training was developed to strengthen staff capability in managing such behaviours particularly where they intersect with dementia, mental health conditions, and environmental factors. Key areas covered included environmental safety and de-escalation techniques.

Feedback from attendees has been positive. Staff reported gaining a stronger understanding of the unique complexities involved in these scenarios and appreciated the practical nature of the techniques shared. Many noted increased confidence in managing challenging behaviours and a noticeable reduction in incidents requiring physical intervention.

6.1 Health and Safety Training for Executives and Senior Managers

In December 2024 and February 2025 seven members of the Executive Team, including the Chief Executive Officer attended the IOSH Safety for Executives and Directors. Plans are in place for the remaining members of the Executive Team to attend in 2025/26.

A Health and Safety for Managers Training package is currently being developed nationally. This work is being led by Cwm Taf Morgannwg University Health Board and will be agreed at the All-Wales Health and Safety Management Group.

Once the course is approved it will be implemented within the Health Board to provide Managers with an awareness of their role in health and safety management and implementation. The course will cover vital information such as the legal requirements, safety management systems, safety culture, risk assessment & hazard control and incident investigation.

6.2 Safety Guidance

Safety guidance have been implemented as a method to provide further information, instruction & training to Health Board employees in relation to health and safety matters.

The safety guidance provides safety reminders, brief refreshers and quick lessons on safety topics. The safety guidance is developed by the Corporate Health and Safety Department.

The use of safety guidance has provided greater opportunity to discuss recent incidents, near misses and everyday tasks.

6.3 Manual Handling Cascade Trainers Training

To support the delivery of the manual handling training strategy, cascade trainers are nominated in areas across the Health Board. The cascade trainers i.e. Transfer Specialists, Safer Handling Coaches etc. attend foundation training and are required to attend an update every two years to maintain their competency.

The register of cascade manual handling trainers was reviewed, cleansed and a programme of updates was delivered in 2024/25.

Trainer type	Number in organisation	Number currently out of date (over 2 years)
Transfer Specialist	234	53
Assistant Trainer	49	7
Safer Handling Coaches	224	93

6.4 Risk Assessment Training

The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the Health Board to maintain its legislative requirement and ensuring the provision of competent risk assessors, the Risk Assessor Training course has been revitalised for 2024/2025, 26 courses have been delivered and 226 Health Board Employees trained in Health & Safety Risk Assessment.

The aim of the course is to ensure all participants have an understanding on the concept of risk assessment, when a risk assessment is required within the workplace and how to conduct a suitable and sufficient risk assessment.

6.6 Fire Safety Training

The compliance data for fire safety training appears acceptable, however, these results are derived from compliance with eLearning modules alone. Staff with the responsibility to evacuate immobile patients require additional, practical evacuation training, delivered by Fire Safety Advisors. This requirement is highlighted in the fire safety guidance contained in Welsh Health Technical Memorandum (WHTM) 05:01.

This additional level of training is delivered to all Theatres, Critical Care and similar departments caring for high dependency patients. Efforts by the Fire Safety Team to expand face to face training to all inpatient wards in 2024/25 have been partially successful but problems securing release of staff persist.

A programme of fire evacuation training for staff on inpatient wards has been drawn up for 2025/26. However, delivery of the programme will be challenging at current Fire Safety Advisor resource levels.

6.7 Fire Warden Training

Fire wardens at Health Board premises perform a vital function in maintaining safe environments. Their role during fire emergencies is as a *critical friend* to department and ward managers who are responsible for initiating and managing evacuations.

Key functions of fire wardens include the continual monitoring and completion of monthly safety checks of their areas to identify fire safety concerns. They provide the valuable service of liaison with the Fire Safety Advisors to provide early warning and resolution of potential safety issues.

The Fire Safety Team continue to promote the role via the fire risk assessment process with the goal that every work area in the Health Board has at least one fire warden assigned.

An additional 73 fire wardens were identified and attended training in 2024/25.

Recruitment and retention of Fire Wardens is challenging. There are currently 349 wardens registered with 171 departments regularly submitting monthly fire safety checklist returns.

6.8 Fire Drills & Exercises

The Fire Safety Team conduct an annual programme of fire drills and exercises across the Health Board. The purpose of these is to confirm the fire evacuation strategies for the areas are robust.

In 2024/25, the Fire Safety Team carried out fire exercises in 12 departments across the Health Board. Exercises are conducted at high-risk departments, such as Theatres and Critical Care Units annually on multiple occasions to ensure staff compliance.

The annual programme of fire evacuation exercises continues to target 12 departments per year.

7 RIDDOR REPORTING

Under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013), certain workplace accidents, incidents, ill health and certain near miss events must be recorded. Depending on the severity and nature of the injury, and indeed the party affected, the Health Board has a legal duty to report this data to the Health and Safety Executive (HSE).

The reporting process to the HSE is undertaken by the Corporate Health and Safety Department.

During the period of April 2024 to March 2025 the Health Board reported a total of 73 incidents to the Health & Safety Executive which met the criteria of being reportable under RIDDOR. This is a 18.8% decrease on the number of incidents reported in 2023/24. (*See figure 1*)

30.2% of these incidents were reported outside of the legal reporting timeframes.

Non-compliance with RIDDOR duties can have consequences, both in terms of Health & Safety and legal ramifications for the Health Board.

To ensure the Health Board meets the legal requirements under RIDDOR the Corporate Health and Safety Department continues to deliver RIDDOR Awareness Training Sessions. This training is designed to provide all managers with a clear understanding of their duties under RIDDOR, ensuring that they can fulfil their responsibilities effectively. During 2024/25 44 staff attended the RIDDOR Awareness Training.

A RIDDOR Compliance Dashboard have been established within the Datix Cymru system to enable Divisions to proactively monitor their RIDDOR compliance and identify areas of good practice, but also areas of further improvement. Compliance with RIDDOR is a health and safety performance indicator which has been imbedded into the Divisional Assurance Reviews.

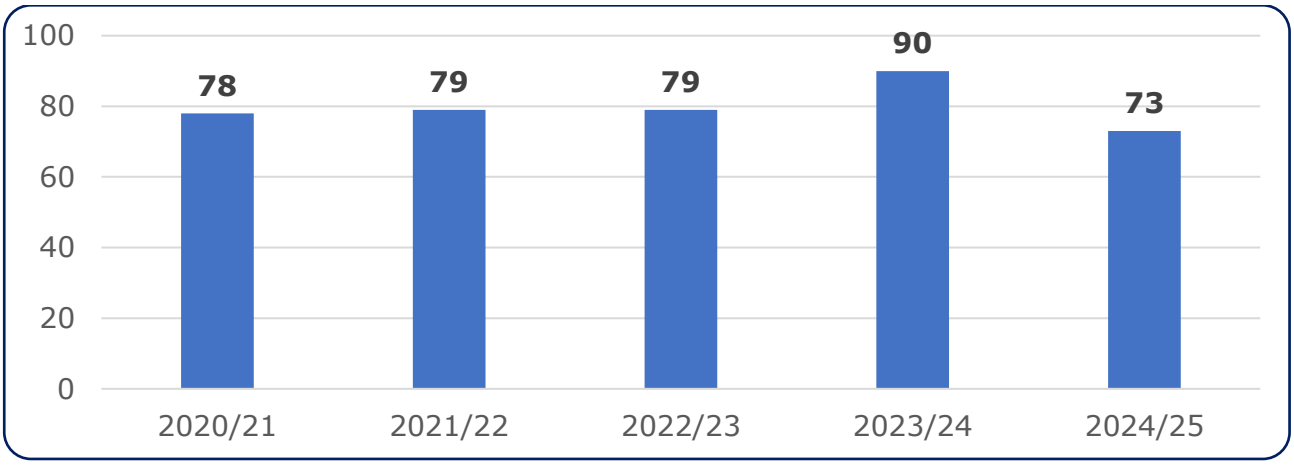


Figure 1: Total number of RIDDOR reportable incidents reported to the HSE for the past five financial years

In 2024/25 there has been three fatal incidents reported, all relating to patient falls. This is an increase from the one fatal incident reported in 2023/24. Over-seven-day incapacitation of a worker are the highest reported classification in 2024/25 with 48 incidents reported, a decrease of 9 incidents compared with 2023/24. The number of specified injuries has reduced from 26 incidents reported in 2023/24 to 11 in 2024/25. *(See figure 2)*

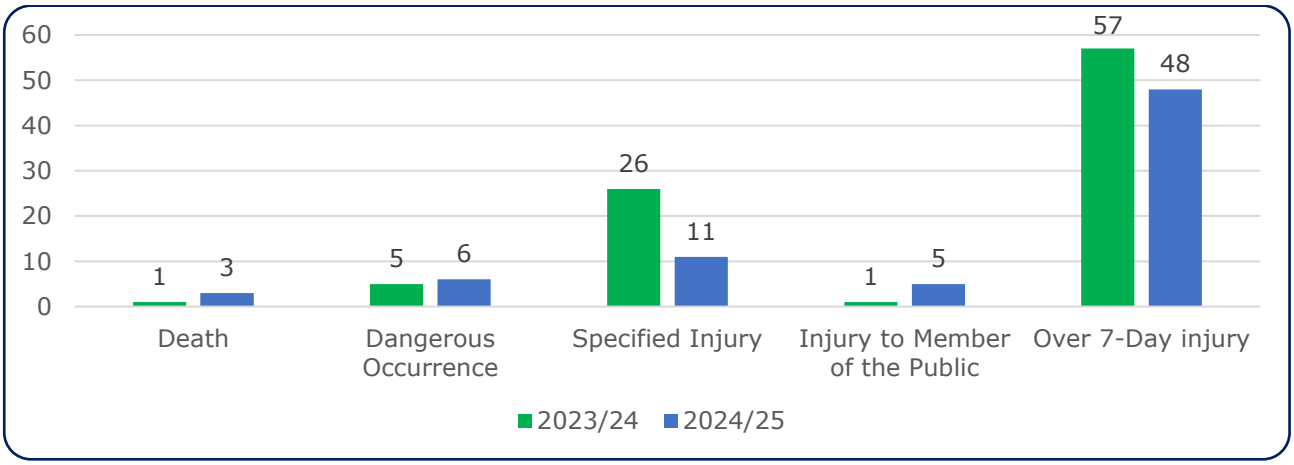


Figure 2: RIDDOR reportable incidents by classification reported to the HSE for 2024/25

Slips, trips and falls continue to be the highest type of RIDDOR reportable incident reported to the HSE, with 32 slips, trips and falls reported in 2024/25. However, this was a reduction on the 39 reported in the previous financial year (2023/24).
There was a significant reduction in the number of abuse to staff RIDDOR reportable incidents reported to the HSE in 2024/25 (12) compared with 2023/24 (23).

Manual handling RIDDOR reportable incidents have increased slightly in 2024/25, with 13 being reported to the HSE. This is compared with 12 incidents in 2023/24. *(See figure 3)*

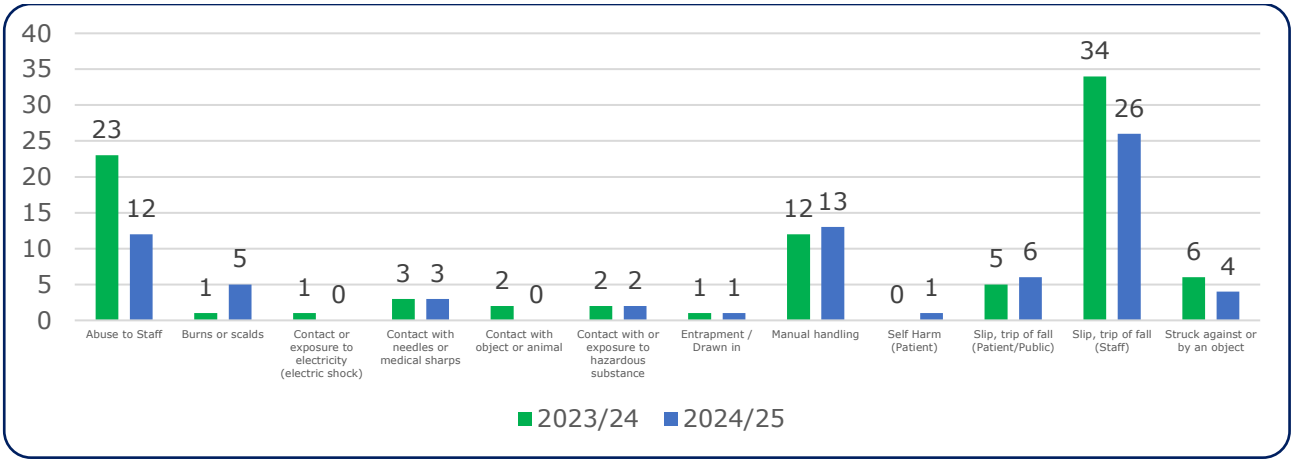


Figure 3: Type of RIDDOR Reportable incidents reported to the HSE for 2024/25

RIDDOR reporting compliance for 2024/25 was 69.8% a 2.1% improvement on the compliance reported in 2023/24 (67.7%).

8 LEARNING FROM EVENTS

The Corporate Health and Safety Department has implemented various communication methods to support learning from incidents across the Health Board.

As part of these methods, information is cascaded through Health and Safety performance reports, post investigation meeting de-briefs, amendment to relevant health and safety training packages and organisational alerts.

During 2024/25 health and safety information sheets have been issued which relate to the following:

- HSI-2024-004 - Seizure of Prohibited Articles
- HSI-2024-005 - Storage and Handling of Medical Gas Cylinders
- HSI-2024-006 - Management of Portable Electrical Appliances (Toasters)
- HSI-2024-007 - Safe Use of Temporary Portable Heating Appliances
- HSI-2025-001 - Suitability of chair castors used on flooring
- HSI-2025-002 - Management and storage of sharp objects

The Corporate Health & Safety Department has provided support to Legal Services in relation to Personal Injuries Claims by assisting in the investigation process, supplying necessary documentation, and facilitating the identification and communication of key learnings from events to prevent future occurrences.

During 2024/25, the Health Board received 9 personal injury cases involving slips, trips and falls, 6 cases of ill health (to include 4 covid cases), 5 violence and aggression cases, 4 cases involving sharps, 3 burns/scalds, 2 cases of individuals being struck against or by an object, 2 cases of entrapment (being injured in lift doors, doors falling on individuals), 1 data breach and 1 incident involving a manual handling task.

Over the last 12 months, there has been an increase in sharps cases and injuries involving burns/scalds.

Personal injury claims continue a year-on-year 16-year downward trend.

9 HEALTH AND SAFETY

9.1 Health and Safety Monitoring

The Corporate Health & Safety Department initiated a programme of workplace health, safety, and environment inspections spanning from October 2024 to March 2025.

These inspections align with the Workplace (Health, Safety and Welfare) Regulations 1992, which encompass fundamental health, safety, and welfare concerns applicable to the Health Board.

The inspection criteria have been developed based on the stipulations outlined in the Regulations, as well as consideration of other pertinent workplace hazards.

The inspection criteria included:

- Lighting
- Noise
- Prevention of Slips, Trips, & Falls (including falls from height and falling objects)
- Temperature & Ventilation
- Workstations, Seating, Furniture, and Fittings
- Welfare Facilities
- Cleanliness, Waste Management, & Sharp Safety
- Access and Egress
- Electrical Equipment
- Handling of Chemicals & Hazardous Substances
- Prevention of Violence & Aggression
- Alert Systems & Communications
- Provision of First Aid

A goal was established to complete health, safety, and environment workplace inspections for the wards and departments in the Acute Hospitals, Community Hospitals and Mental Health & Learning Disabilities sites by the end of March 2025. This objective has been successfully met, with a total of 64 inspections carried out.

These assessments yielded an average Health Board compliance score of 89.63%. The table (right) offers a detailed breakdown of the number of inspections completed per site and the corresponding site compliance score (average).

Site	Total Number of Inspections Scheduled	Total Number of Inspections Completed	Site Compliance (Average)
Chepstow Community Hospital	1	1	83.10%
County Hospital	5	5	84.30%
Grange University Hospital	9	9	96.10%
Maindiff Court Hospital	2	2	92.40%
Monnow Vale Hospital	1	1	89.70%
Nevill Hall Hospital	7	7	89.20%
Other Premises (Health Centres, Clinics)	8	8	91.40%
Royal Gwent Hospital	12	12	84.30%
St Cadocs Hospital	4	4	86.90%
St Woolos Hospital	2	2	91.50%
Ysbyty Aneurin Bevan	7	7	87.90%
Ysbyty Tri Chwm	1	1	89.80%
Ysbyty Ystrad Fawr	5	5	96.90%

The inspections revealed both areas of compliance and areas requiring attention to ensure a safe working environment. While an average Health Board compliance score of 89.63 indicates overall adherence to

regulations, specific areas of concern were identified of which further attention is required.

The main findings of the health, safety and environment workplace inspections are as follows:

Control of Substances Hazardous to Health (COSHH)

- Most areas lacked COSHH Inventories and Assessments.
- Workers lacked clarity on accessing COSHH Assessments and understanding precautionary measures for substance use.
- Cleaning substances, such as Actichlor solution, were frequently left unattended without proper storage and security measures.

Electrical Equipment Checks

- While user checks on electrical equipment were noted, there was insufficient evidence to confirm regular checks.

Tripping and Entrapment Hazards

- Cables supplying air mattresses and electric profiling beds were often positioned in ways that posed tripping and entrapment risks.

Unauthorised Access

- Various areas within ward environments were frequently left open, allowing unauthorised access.

Signage for Anti-Violence Measures

- Absence of signage regarding NHS Wales Anti-Violence Posters was noted.
- Seating for DSE Use
- In some clinical areas, ergonomic office chairs were utilised but often had castors unsuitable for the flooring type.

Use of medical gases

- In some clinical areas, Medical Gas Cylinders were not correctly stored.

Water safety

- In some premises, infrequently used outlets are not routinely flushed and flushing regime is not recorded. Ensure infrequently used outlets are routinely flushed and flushing regime is recorded.

First aid

- In some premises, there aren’t appointed first aiders. Conduct a First Aid Needs Assessment to identify specific requirements.

General Condition of Premises

- Flooring was generally in good condition with no significant defects or obstructions affecting safety.
- Lighting levels were found to be adequate for activities within the areas.
- Window restrictors limiting window opening were robust and tamper-proof.
- No workplace noise issues were identified, and employees did not raise concerns.
- No defects such as exposed wiring or damaged casing were identified.
- Workplace temperature was considered reasonable, and concerns regarding thermal comfort were limited.

Provision and Access to Welfare Facilities

- Welfare facilities such as break rooms and W/Cs were routinely available.
- Facilities for heating food/drinks and storing personal items were provided.

Employee Awareness and Reporting

- Employees demonstrated substantial awareness of how to raise health and safety concerns and report accidents, incidents, and near misses.

These findings highlight areas requiring attention to ensure compliance and maintain a safe working environment for all staff, patients and visitors.

The completion of these inspections resulted in the assignment of 594 actions which have been assigned to local ward/department managers and recorded on the Audit Management and Tracking (AMaT) platform.

Among these actions:

- 421 have been successfully marked as fully complete by the assigned responsible person (70.8%).
- 56 have been marked as partially complete by the assigned responsible person (9.5%).
- 117 actions are overdue and have not been completed within the assigned timeframe (19.7%)

Where actions in relation to non-compliance have been identified, these areas must be addressed in order to reduce the likelihood of accident and ill health and to close any gaps in compliance. The responsible person must ensure that sufficient progress notes are recorded within the assigned action point detailing the action(s) taken to address and remedy the identified non-compliance.

The Corporate Health & Safety Department continue to monitor the completion of these actions and provide updates on inspection findings and action completion during Divisional and Directorate Quality & Patient Safety meetings.

The conclusion of the health, safety, and environment workplace inspections emphasises the importance of ongoing monitoring of workplaces to uphold necessary standards and identify potential hazards. To facilitate this, the Corporate Health & Safety Department has devised local workplace inspection tools to assist areas in conducting regular monitoring. Divisions must ensure that appropriate systems are established to facilitate these inspections and promptly address any areas found to be non-compliant by implementing corrective measures.

The Health & Safety Work Plan for 2025/26 outlines key actions to ensure regular monitoring of workplaces across the Health Board. These include:

- Develop a health and safety management audit 3-year plan
  Year 1 (Inpatient Areas), Year 2 (Out Patient Areas), Year 3 (All Other Areas)
- Develop a workplace health and safety inspection proforma for inclusion in the ward accreditation programme in 2025/26
- Develop a manual handling management audit programme
- Conduct health and safety workplace inspections for community premises i.e. health centres and clinics

9.2 Health and Safety National Meetings

The All-Wales Health and Safety Management Steering Group represents Health & Safety professionals working in NHS Wales in all areas of health and safety management, providing a forum to network, share best practice and work collaboratively to develop improvements in health and safety.

The group represent all NHS organisations, recognising the importance of providing informative and stimulating meetings, workshops, and seminars for the continued professional development of all members.

The purpose of the All-Wales Health and Safety Management Steering Group is to:

- Discuss all areas of health and safety management to ensure compliance with the legislative and regulatory frameworks in place for managing health and safety effectively.
- Share lessons learned and best practice identified for effective health and safety management.
- Encourage strong leadership in health and safety and championing the importance of a common-sense approach to motivate focus on core aims distinguishing between real and trivial issues.
- Where appropriate, advise the Health Boards and Trusts on where and how, its health and safety management may be strengthened and developed further.

The aims of the group are to:

- Support members to develop the health and safety management arrangements within healthcare organisations.
- Provide a forum in which health and safety risk and issues can be debated, to ensure effective communication of ideas, sharing of experiences and areas of best practice.

Subgroups and workstreams have been established to review current health and safety practice is specific areas and develop minimum standards for implementation across NHS Wales.

During 2024/25 an All-Wales Health & Safety Workstream has been revitalised in relation to Health & Safety Incident Codes recorded within Datix Cymru. The purpose of this workstream is to standardise the Health & Safety Incident Codes for all NHS organisations in Wales in order to reduce barriers to incident reporting and to improve the quality of incident data which will further support in identifying learning from incident themes and trends.

9.3 Reinforced Autoclaved Aerated Concrete (RAAC)

The Corporate Health & Safety Department has conducted comprehensive Risk Assessments in areas of Nevill Hall Hospital (NHH) where Reinforced Autoclaved Aerated Concrete (RAAC) has been identified during structural surveys.

To ensure safety, Acrow props have been installed in these areas. The Risk Assessments focus specifically on evaluating the hazards and potential risks associated with the introduction of Acrow props into the working environment.

The assessment aims to mitigate any risks posed by the structural supports, ensuring that the hospital environment remains safe for both staff and patients. The Risk

Assessments have been recorded within the Datix Risk Module and local Department risk leads have been assigned to enable ongoing management of the risk.

As part of the governance arrangements in relation to the management of RAAC, the Corporate Health & Safety Department attend the RAAC Fortnightly Governance Group of which the group focus is on the actions that have been taken and the ongoing management of the challenges enabling wider discussions of service implications and also remediation plans.

9.4 Health and Safety Incident Reporting

The following data provides a detailed breakdown of the type of health and safety related incidents that have been reported in 2024/25. *This excludes violence and aggression and fire incidents as these are reported in the relevant sections of this report.*

Figure 4 indicates an increase of 8.5% in the number of reported incidents affecting staff and contractors compared with last two financial years.

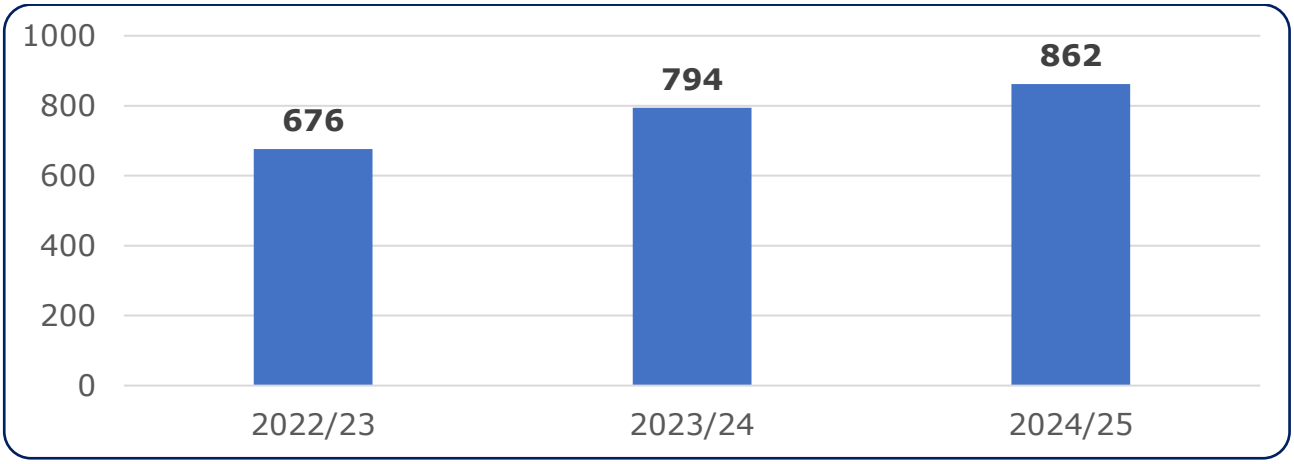


Figure 4: Number of reported incidents affecting staff and contractors for the past three financial years

Contact with needles or medical sharps is the most reported health and safety incident category affecting staff or contractors (215 incidents), this is an increase of 13.1% on the previous year. *(See figure 5)*

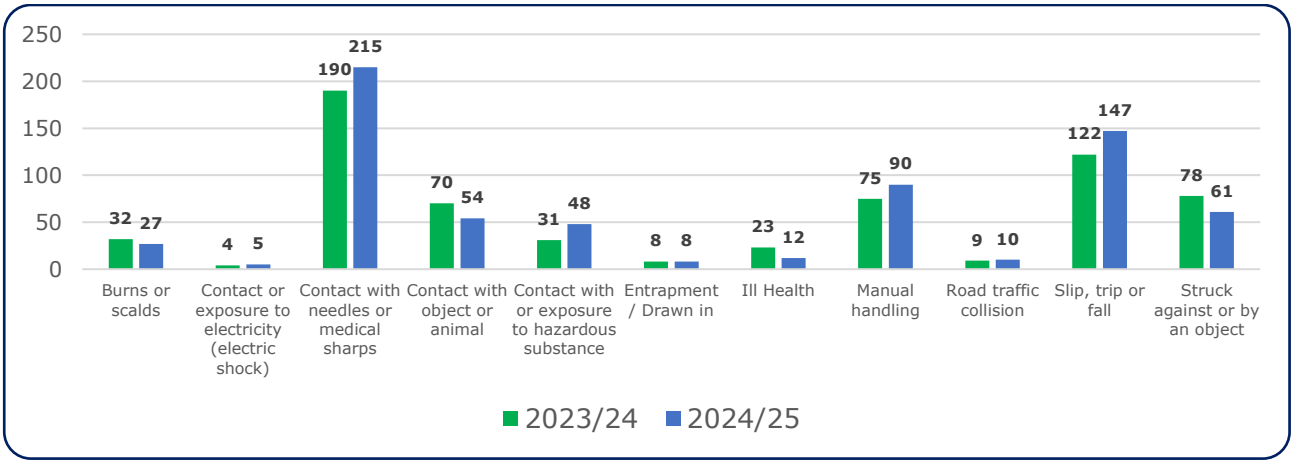


Figure 5: Type of incidents affecting staff and contractors for 2024/25

The number of contact with needles or medical sharps incidents reported in 2024/25 has increased by 13.1% from the previous financial year (215 reports). The incidents from contaminated / used sharps devices have increased by 21.1% in 2024/25. *(See figure 6)*

It is difficult to obtain data on the number of tasks or procedures carried out across the Health Board using needles or medical sharps. However, based on the incidents reported and the significant number of tasks and procedures the incident rate would be very low.

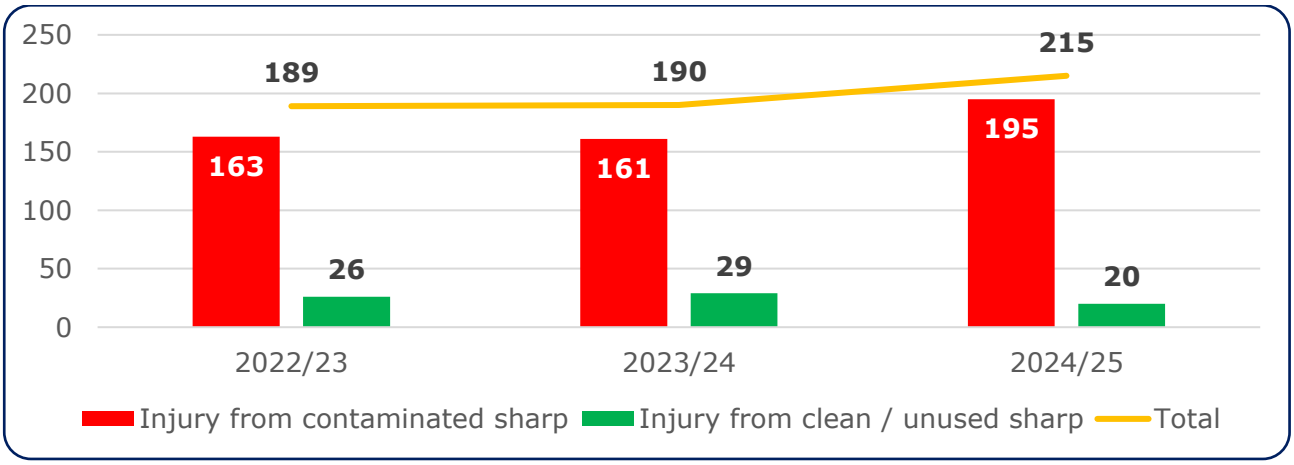


Figure 6: Total number of sharps incidents by type for 2024/25

To identify learning outcomes from sharps incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix Cymru system.

The revitalisation of the health and safety monitoring programme included an assessment of clinical area's adherence to best practices for the safe use of sharps. This assessment was designed to ensure that areas comply with the standards set out within the Health Boards Sharps Policy, and the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

As part of the inspection process, wards were specifically monitored for their procedures regarding sharps use and disposal of sharps. This includes the availability of safety engineered devices, the availability and correct use of sharps trays and sharps containers and adherence to protocols designed to reduce the likelihood of needlestick injuries and other sharps related incidents.

Throughout the inspections, instances of good practice were routinely identified. These practices provide assurances of compliance with best practice guidelines and legislative requirements. The findings of these inspections have also supported the development of training information such as Tool Box Safety Talk on the Safe Use of Sharps in order to further reinforce best practices.

The outcomes of the monitoring are reported to the Health and Safety Committee.

Slip, trip or falls is the second highest reported health and safety incident category affecting staff or contractors.

The number of slips, trips and falls incidents to staff, contractors or visitors reported in 2024/25 has increased by 15.4% from the previous financial year (142 reports). *(See figure 7)* These types of incidents continue to be the highest reported to the HSE in accordance with RIDDOR and those resulting in personal injury claims.

The highest categories of slips, trips or falls in 2024/25 were 'Fall on a slippery or wet surface' (56 incidents) and 'Trip or fall over an object or obstacle' (26). This is a significant increase reduction from the previous year's reporting.

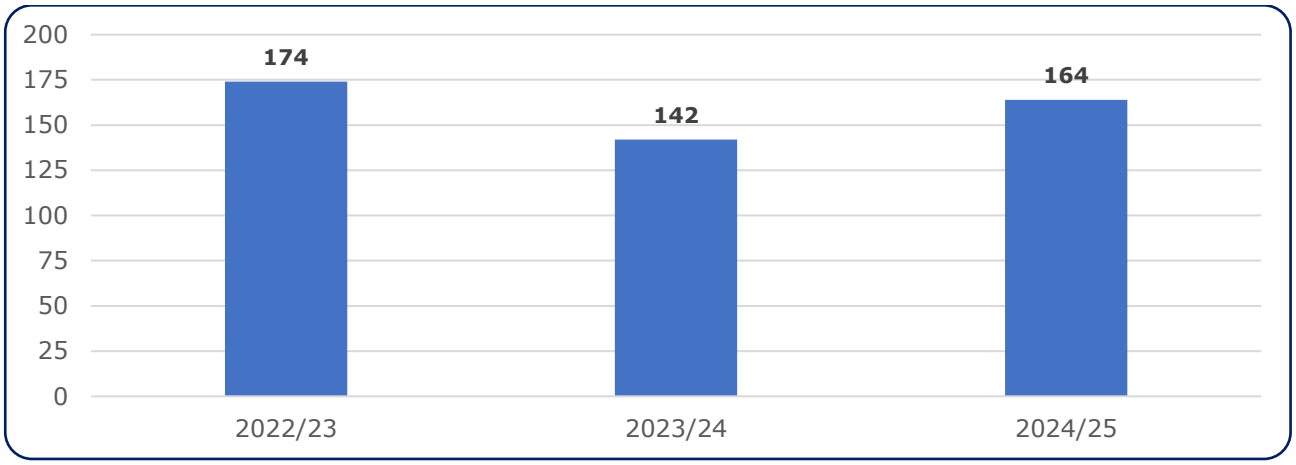


Figure 7: Number of reported slips, trips and falls incidents affecting staff, visitors and contractors for the past three financial years

9.5 Face Fit Testing

Where personal protective equipment and respiratory protective equipment is used, it must be able to provide adequate protection for individual wearers.

Face Fit testing ensures that the equipment selected is suitable for the wearer. Face fit testing is a mandatory requirement as prescribed by Health & Safety Executive Control of Substances Hazardous to Health Regulations Approved Code of Practice (ACoP) L5 and associated guidance documents that support the relevant statutory provisions.

The delivery of Face Fit Testing continues to remain a key tasking for the Corporate Health and Safety Department with weekly Face Fit Testing sessions being offered across the Health Board.

To enable the Health Board to maintain compliance with Face Fit Testing requirements a review of the Health Boards Face Fit Testing Strategy and Face Fit Testing resource allocation will been undertaken in 2025/26.

10 FIRE SAFETY

Fire safety is an umbrella term covering fire prevention and fire precautions. The principal requirements of fire safety legislation are:

- To reduce the probability and severity of a fire occurring within a building.
- To ensure that persons are kept safe or can safely evacuate a premises if a fire occurs.

Fire has the potential to cause widescale damage and disruption of NHS services that could have a serious consequence for service users. Therefore, in addition to life safety, property protection and business continuity are key aims of the Health Board fire safety policy.

The Regulatory Reform (Fire Safety) Order 2005 (FSO) is the main piece of legislation governing fire safety in buildings in England and Wales. The FSO applies the concept of the responsible person to ensure general fire precautions are in place to protect persons who work at, stay or visit premises in England and Wales.

The legislation imposes liability on managers proportionate with their levels of control. The principle responsible persons in the Health Board are the executive, directorate and departmental leaders.

The Executive Director of Allied Health Professions & Health Science is the Executive Director with delegated responsibility to ensure compliance with current fire safety legislation and responsibility for ensuring that fire safety issues are highlighted at Board level. In particular they will ensure, by delegation to The Fire Safety Manager that the fire safety policy is promulgated, and that Fire Risk Assessments are completed to record the general fire precautions required for all areas.

Individual divisional directors and divisional leadership groups as a collective are responsible for ensuring compliance with the Health Board Fire Safety Policy and that the general fire precautions are applied within their departments.

10.1 Provision of Officers with Specific Fire Safety Responsibilities

Health Boards are required to provide a structure of Fire Safety Management within their organisations aligned with WHTM 05:01.

The structure is based on delegated responsibility of fire safety functions to functional roles within the organisation. The nominated offers are accountable for fire safety functions assigned to them.

Fire Safety Protocol 031 Roles and Responsibilities for Implementation details the roles and delegated responsibilities for fire safety within the Health Board.
Key roles covered in the document (in addition to Executive Director with delegated responsibility and The Fire Safety Manager) are the Director of Estates and Facilities Division who bears key responsibilities for maintenance of systems and fire response, and Ward/Department managers who act as frontline fire safety managers.

Regardless of the roles designated, it should be understood that although accountability can be designated and shared, it cannot be legally transferred. All senior managers are legally accountable for adherence to the fire policy in any areas that are under their control or influence.

10.2 Fire Safety Risk Management

The Health Board are legally required to carry out and record fire risk assessments at all sites. The legislation requires that assessments are completed for all new buildings when staff first take occupancy and are reviewed on a regular basis.

Additional reviews are required if there are significant changes to staffing or working arrangements in departments and wards.

The Health Board fire safety team review fire risk assessments at a frequency based on risk as shown in the table below.

Type of Area to be Assessed	Frequency of Assessment
Buildings or parts of buildings that provide sleeping or inpatient accommodation	12 months
Other than above but areas provided for public access such as outpatient facilities	24 months
Other than above. Areas not provided for public access such as offices, plantrooms etc.	36 months

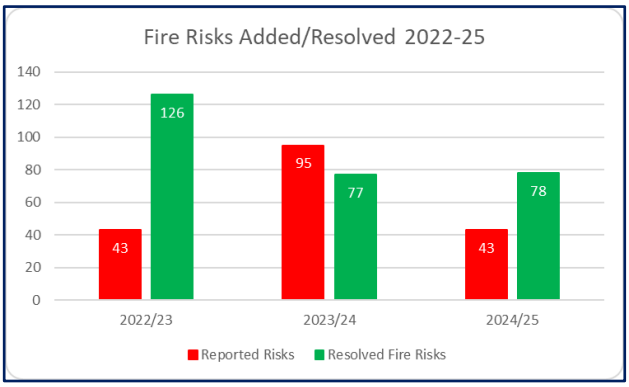
During the period April 2024 to March 2025 the Fire Safety Team completed 254 programmed fire safety risk assessment reviews. This represents 100% of the programmed assessments. The figures for major sites are displayed in the table below.

Hospital	Annual Assessments	Bi-annual Assessments	Tri-Annual Assessments
County Hospital	5	7	12
Grange University Hospital	26	1	16
Nevill Hall Hospital	20	9	22
Royal Gwent Hospital	32	6	12
St Cadocs Hospital	7	0	0
St Woolos Hospital	6	12	2
Ysbyty Aneurin Bevan	5	5	0
Ysbyty Ystrad Fawr	11	6	1

In addition to the above the Fire Safety Team completed fire risk assessments to:

- Support various moves of departments at the Royal Gwent, St Woolos and Nevill Hall Hospitals.
- Assess and record hazards associated with RAAC at Nevill Hall Hospital.
- Support the opening of 19 Hills Heath and Welling Centre and the new Satellite Radiology Unit at Nevill Hall Hospital.

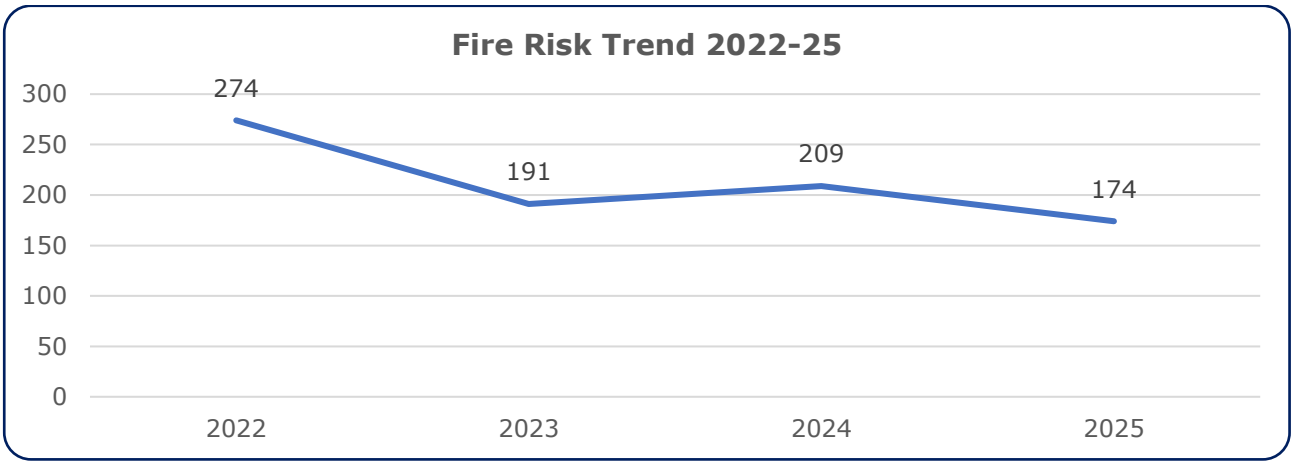
A register of the risks identified during the assessment process is handled by the Fire Safety Team and recorded on the DatixWeb system. The table (right) highlights the risks that have been added to the risk register following risk assessments and removed from the risk register after being rectified over the three-year period April 2022 to April 2025.



The decision taken by the Health Board to provide sprinkler protection at new hospitals has produced massive benefits for the management of fire safety and the safety of persons at the relevant premises. The hospitals are relatively risk free with no significant fire safety issues.

The major fire safety risks held on the system are legacy fire risks at older building stock including Royal Gwent and Nevill Hall Hospitals. These premises remain a priority for resolution and are likely to dominate the Fire Safety Discretionary Capital spend for the foreseeable future.

The risk trend for April 2022 to April 2025 is shown below.



10.3 Planning and Implementing Fire Safety Improvement Works

The duties of the Fire Safety Manager include planning and implementing a programme of improvement works to remove or mitigate fire risks carried by the organisation.

During 2024/25 improvements have been made in the following areas to ensure the Health Board meets minimum safety standards and fulfils its legal requirements.

Site	Area	Improvement
Nevill Hall Hospital	Third & Fourth Floors including inpatient wards	End of Life Replacement of Fire detection and sounders. The system in this area is now fully compliant.
Nevill Hall Hospital	Ward 4/1	Repairs to fire resisting barriers
Nevill Hall Hospital	Bron Haul & Gerylyn Staff Residencies	End of Life Replacement of Fire detection and Fire doors. These buildings are now fully compliant.
Royal Gwent Hospital	Ward D7 West, Blocks 3, 6 (Staff Residences) & 7, Level 2, Level 8 (Plantrooms)	Installation of new fire detectors connected to the new *Gent* panel system. The system in these areas is now fully compliant.
St Cadoc's Hospital	Whole Site	Replacement Fire Alarm System
Ebbw Vale Clinic	Whole Building	Replacement Fire Alarm System

In addition to the above there has been a continued incremental improvement across all building stock.

10.4 Key Fire Risks

The key residual fire risks carried by the Health Board are related to management of the aging infrastructure and degradation of fire protection at older acute hospitals, namely the Royal Gwent and Nevill Hall Hospitals.

The safety of large numbers of inpatients at these hospitals relies on the capability of the alarm systems to give early warning of fire and the capability of fire walls and fire doors to stop the spread of fire through the buildings.

Fire Alarm Systems: The fire alarm system at Nevill Hall Hospital has benefitted from a major replacement programme in 2024/25.

The detectors in all inpatient areas have been replaced and the system covering these areas is now full compliant with current standards. The fire control panel that monitors the staff residencies has also been replaced along with the detection in Bron Haul and Gerylyn. The detection in all other staff residencies is planned for replacement in 2025/26.

3 panels on site covering the works and estates offices, plantrooms and the undercroft are approaching their planned replacement date. It is important that these panels and the associated detection are replaced in the near future. On completion of this works the system will be fully compliant.

Although some progress has been made at the Royal Gwent Hospital, the situation is more severe. Improvements have been delivered to migrate some of the system over to a new replacement system. Eight of the blocks on site, including E Block and Block 6 Staff Residencies are now covered by the new system along with some areas in C&D Block.

However, the vast majority of C&D Blocks are still reliant a system which is obsolete and for which spare parts are no longer being manufactured. The system is functional but not reliable due to aging components that may be vulnerable to sudden failure.

Funding has been allocated to provide for the new system to be expanded into most of the inpatient wards by March 2027 but this will not be achievable without some disruption. It is estimated that a minimum of 40 weeks of single ward decants will be required to facilitate the works.

Attempts to carry out this work in a live ward environment were aborted in 2024/25 due to safety concerns.

Fire Walls and Fire Doors: The safety of inpatients at the Royal Gwent and Nevill Hall Hospitals relies on the ability of the structure of the buildings to withstand fire and stop fire spread between wards.

The Fire Safety Team have worked collaboratively with Facilities to introduce measures to ensure that fire barriers are effectively managed and protected. Work is now required to rectify existing breaches in the fire resisting partitions at both sites.

Surveys conducted at both hospitals has identified extensive works that is required to fix damage to the fire walls that protect the inpatient wards.

Funding has been secured to carry out remedial works at both sites. The feasibility of repairing the breaches on live wards is currently being considered, it is also possible to complete this works in tandem with the fire alarm replacement at The Royal Gwent Hospital if the decant wards are made available.

10.5 Emerging Risks

Capital investment is required to mitigate fire safety risks in the following areas.

- Replacement of end-of-life fire detectors at Ysbyty Aneurin Bevan.
- Replacement of the fire alarm system in the old hospital buildings at St Woolos Hospital (the system is not acceptable to modern standards, however clarity on the future use of the buildings is required before a commitment to spend circa £300k on a replacement system can be made).
- Enhanced Fixed electrical testing and of ageing electrical infrastructure on older sites.
- Risks associated with ageing ventilation infrastructure (Fire Dampers) for inpatient areas on older sites.

- The majority of fire doors at St Cadocs and St Woolos Hospital buildings are functional to older standards but are increasingly difficult to maintain. Replacement schemes are likely to be required within the next five years.

10.6 Planned Improvements

The following improvement schemes are planned to be completed in 2025/26.

- Partial replacement of the fire alarm system at Royal Gwent Hospital Site including fitting new detection and transition of levels 7, 6 & 5 of C & D Block to the new fire alarm system.
- End of Life replacement of detectors at Ysbyty Aneurin Bevan.
- Repairs to fire partitions on inpatient Wards at Nevill Hall Hospital.
- Replacement of 30-minute fire doors with 60-minute fire doors on inpatient wards at Nevill Hall Hospital.
- End of Life replacement of detectors at Ysbyty Ystrad Fawr.

10.7 Future Challenges and Priorities for the Fire Safety Team

The strategic goals for the Fire Safety Team are to improve fire strategies at older hospitals while replacing older, complex and costly alarm systems with modern systems incorporating graphics information displays that are easier to manage and economical to maintain.

A lack of available information on safety systems at these buildings continue to pose challenges in the production of detailed, site specific fire safety building strategies. Continued improvement will rely on acquisition of reliable documents such as:

- Fire Zone Plans
- Fire Alarm Cause and Effect Matrices
- As Fitted Fire Alarm System Device Drawings
- Fire Damper Plans

10.8 Fire Safety Advice and Support for Internal and External Partners

The Fire Safety Team provides advice and support to both internal and external partners across a variety of issues affecting fire safety.

Internal queries include advice and assessment of risk posed by shutting off areas to allow building work and application of building regulations for the repurposing of individual areas within a hospital.

External queries range from assessment of the suitability of fire safety building materials, design of cause and effect for fire alarm systems to active consultation with project managers on fire safety building regulations and fire strategies during the planning phase of new builds.

On completion of projects the Fire Safety Team provide training, risk assessment and updated fire safety strategies for new or repurposed areas and buildings.

The Fire Safety Team has been involved in the following projects currently being progressed or completed within the last financial year:

- Adoption of Chepstow Community Hospital from PFI
- Extension to Emergency Department (ED) at the Grange University Hospital

- Satellite Radiology Unit at Nevill Hall Hospital
- 19 Hills Health and Wellbeing Centre
- Upgrade to Pharmacy at Royal Gwent Hospital
- Decontamination Suite at Royal Gwent Hospital
- Crisis Hub at St Cadocs Hospital
- Replacement Roof Glen Usk Suite at St Cadocs Hospital
- The Bevan Health and Wellbeing Centre

10.9 Fire Safety National Groups

In addition to their duties for the Health Board the Fire Safety Team are actively engaged as members of The National Association of Healthcare Fire Officers (NAHFO). Fire advisors attend regular meetings of the Wales Branch of NAHFO where they receive updates on fire safety building regulations and legislation and discuss common issues and best practice with colleagues from the other health boards in Wales and Shared Services fire advisors.

The Fire Safety Team are also involved in the All-Wales Fire Safety Managers Group. The group is engaged in the development of a number of All Wales Fire Safety protocols, the Health Board currently chair the working group on Control of Ignition Sources and contribute to groups working on Fire Safety Training and Fire Safety Considerations for Bariatric Patients on Healthcare Premises.

10.10 Fire Safety Incident Reporting

The Health Board has suffered no serious fire incidents in the financial year 2024/25 . The most notable of the five minor incidents reported are:

- A spate of three repeated incidents of rough sleepers starting fires in the grounds of Pontllanfraith Health Centre between October 2024 and January 2025. As a consequence, fire safety advice was given around waste management and security at the site.

- Waste materials inside a dishwasher at Chepstow Community Hospital that came into contact with the heating element and caused smoke but without fire. Following which, fire safety advice was given regarding safe use of the appliance.

The number of unwanted fire signals (UwFS) reported in 2024/25 has seen an 8.5% reduction compared with 2023/24 (See figure 8).

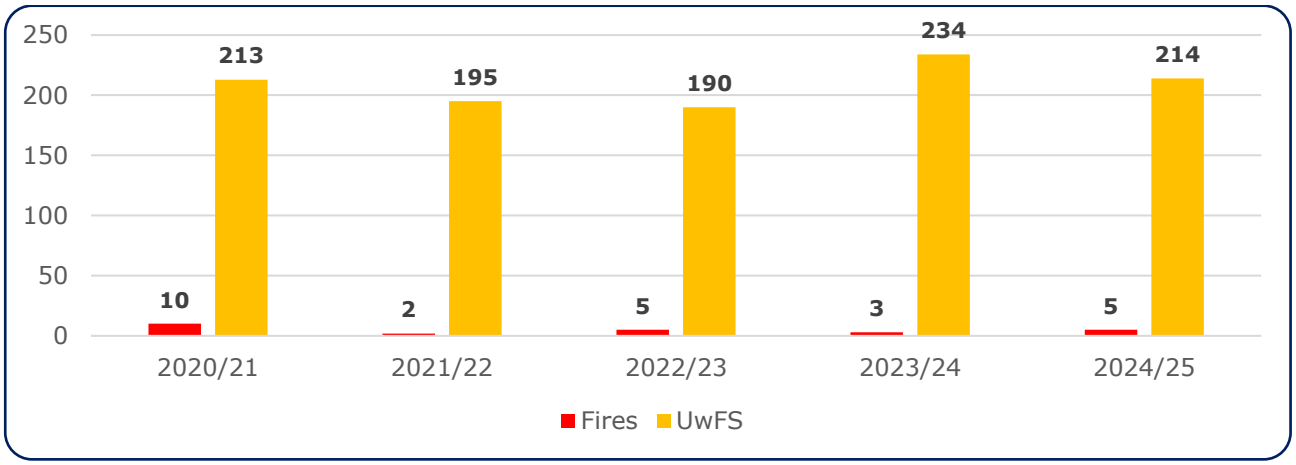


Figure 8: Number of reported fire safety incidents for the past five financial years

The overall trend in unwanted fire signals is flat and although improvements can be seen in the number of activations at County Hospital those at the Royal Gwent Hospital show a year-on-year increase.

Figure 9 provides a comparison on the number of unwanted fire signals by hospital by financial year.

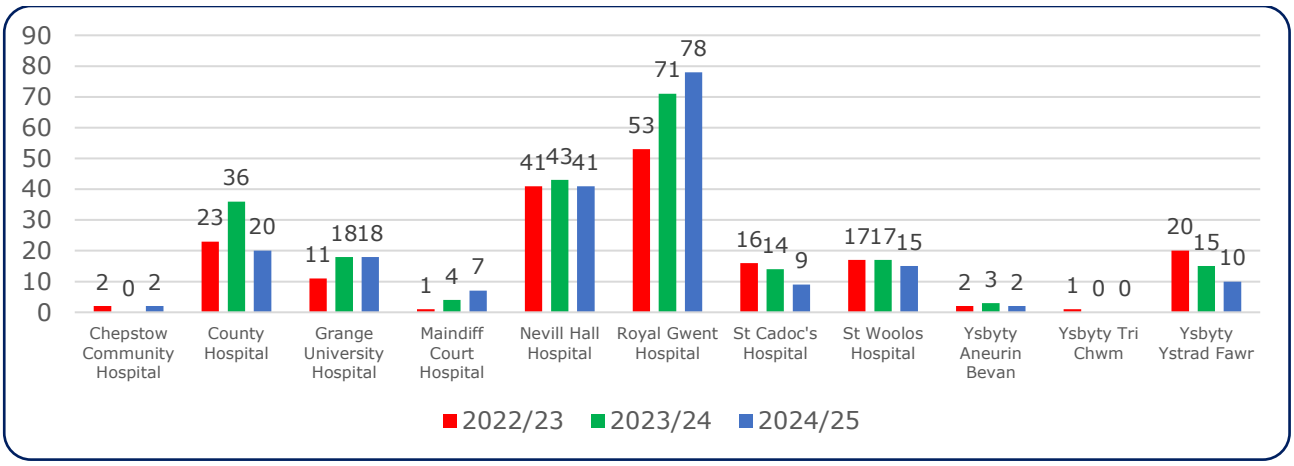


Figure 9: Number of reported unwanted fire signals by Hospital

A significant proportion of the false alarms at the Royal Gwent Hospital are directly attributable to malfunctions of the obsolete panels.

Performance grading of fire alarm systems for the generation of unwanted fire signals takes account of the size of the systems as well as the number of unwanted signals.

Using this metric, the trend is either stable or positive for all fire alarm systems at major sites (See figure 10). Notwithstanding, the continued objective of the team is to achieve an A grading for all systems.

Hospital	False alarms including UwFS	Actuation devices	2023/24 Grade	Current Grade
Chepstow Community Hospital	2	504	no incidents	A - performance should be maintained
County Hospital	20	1018	C	B - 10% reduction in UwFS
Grange University Hospital	18	2978	A	A - performance should be maintained
Llanfrechfa Grange	3	400	B	A - performance should be maintained
Maindiff Court Hospital	7	388	B	B - 10% reduction in UwFS
Monnow Vale Health & Social Care Facility	0	169	no incidents	A - performance should be maintained
Nevill Hall Hospital	41	2850	B	B - 10% reduction in UwFS
Royal Gwent Hospital	78	4560	B	B - 10% reduction in UwFS
St Cadoc's Hospital	9	1225	B	A - performance should be maintained
St Woolos Hospital	15	953	B	B - 10% reduction in UwFS
Ysbyty Aneurin Bevan	2	1150	A	A - performance should be maintained
Ysbyty Tri Chwm	0	130	no incidents	A - performance should be maintained
Ysbyty Ystrad Fawr	10	2267	A	A - performance should be maintained

Figure 10: Unwanted fire signals performance indicators by Hospital for 2024/25

The Fire Safety Team investigate all fires, unwanted fire signals and incidents that are related to fire or any report or incident that may affect fire response.

The purpose of the investigations is to provide data to facilitate a reduction in false alarms and a reduction in the number and severity of fire incidents.

11 MANUAL HANDLING & ERGONOMICS

The Manual Handling Team continue to provide mandatory training to support the education strategy, including providing expert advice as required i.e. selection of key equipment.

Based on current demands the Team's activity is primarily focused on training and improvements in compliance.

11.1 Manual Handling National Meetings

Manual Handling subject matter experts across NHS Wales meet on a quarterly basis to identify and support each NHS organisation with manual handling learning, best practice and action plan going forward.

11.2 Manual Handling Incident Reporting

The number of manual handling incidents reported in 2024/25 has increased by 20% compared with 2023/24 (See figure 11).

There has been a 51.2% increase in patient handling incidents compared with 2023/24.

To identify learning outcomes from manual handling incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix Cymru system.

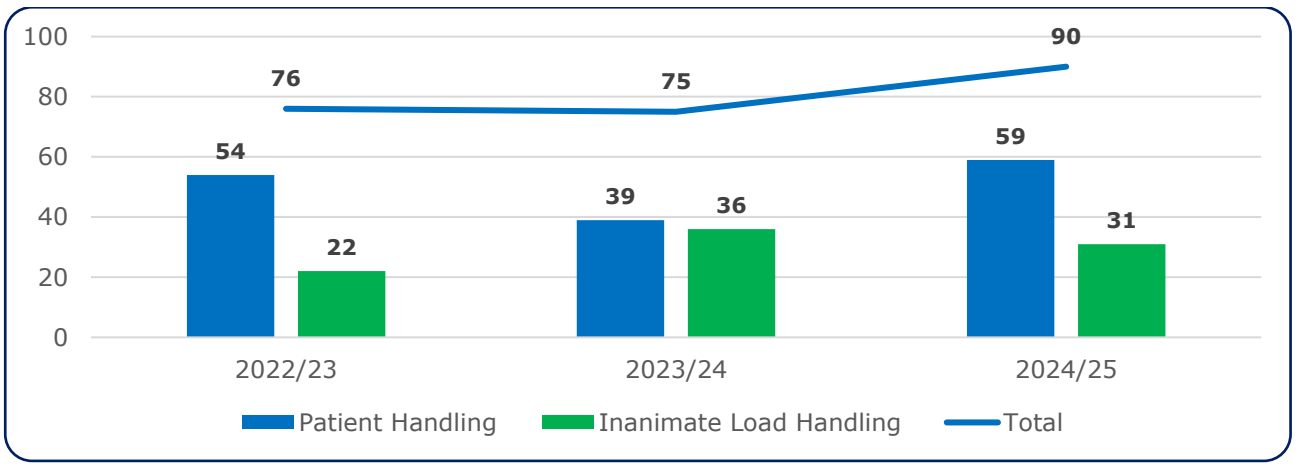


Figure 11: Number of reported manual handling incidents affecting staff for the past three financial years

11.3 Manual Handling Equipment

The Manual Handling Team lead on providing the necessary advice and support to the Health Board in the selection of manual handling equipment to aid in the delivery of care to patients.

All manual handling equipment and its accessories require the necessary testing, inspection or examination to ensure compliance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) or the Provision and Use of Work Equipment Regulations 1998 (PUWER).

The service and maintenance of the manual handling equipment is contracted to an external provider. The service contract supports the Health Board to meet its legal requirements and identifies the need for investment in new equipment.

'Insight' assessments undertaken by ARJO were completed in December 2024 across all Acute and Community Hospitals. The assessments assess the mobility levels of patients, the type, age and condition of patient handling equipment available and service and routine maintenance information.

The findings have provided the Health Board with the following information:

- Patient handling equipment assessments.
- Identification of aged/obsolete equipment with limited/no service support.
- The need for new equipment to meet patient functional levels and care processes.

There is a requirement to apply for capital investment in the obsolete equipment in 2025/26 and 2026/27.

11.4 Manual Handling Patient Handling Risk Assessments

The Manual Handling Team have contributed to the implementation of the patient handling Welsh Nursing Care Record (WNCR). The manual handling audit programme planned for 2025/26 will review the standard and quality of the patient handling assessments.

11.5 Display Screen Equipment (DSE)

Since the outbreak of Covid-19 more Health Board Staff are working in an agile manner across the Health Board at various sites and from private premises, whilst the increased flexibility of agile working can provide many benefits to both the individual and Health Board, the legal requirement for the Health Board to ensure the health, safety and welfare of its employees continues to apply in agile working situations.

To ensure that the risks associated with agile working are properly identified and managed, a series of guidance documents and policy amendments have been developed as a means to support individuals who are identified as agile workers. This includes amendments to the Health Boards Policy for Workstation Display Screen Equipment (DSE) and Display Screen Equipment Risk Assessment Form.

The Corporate Health and Safety Department in collaboration with the Occupational Health Department have conducted DSE risk assessments for the more complex cases.

12 VIOLENCE PREVENTION & REDUCTION

It is recognised that all NHS staff are among those most likely to face violence and abuse during the course of their employment. These incidents can involve patients, visitors or others acting aggressively towards staff or in a manner that makes staff feel threatened or vulnerable. The impacts of this can be profound on both the individual and the Health Board.

Through 'A healthier Wales' working with the Anti- Violence Collaborative (AVC), we are working towards an agreed approach to prevent violence and aggression towards NHS staff in Wales. We strive to create a culture where our staff feel safe and supported.

Following on from last year 2023/24, we have implemented the 'Obligatory Response to Violence in healthcare' The document sets out the responsibilities of healthcare organisations when dealing with incidents relating to violence or aggression in the NHS.

Its focus is on those incidents that need to be addressed by the criminal justice system that includes:

- Improving the reporting of violent incidents.
- Strengthen the investigation and prosecution process by improving the quality and timeliness of shared information.
- Improve victim and witness care and confidence.
- Raise the issues of violence and aggression against NHS staff as well as the action that will be taken by all parties.

Our team works closely with Gwent Police including monthly meetings to ensure that the objectives are met. The Health Board is committed to the delivery of a safe and secure environment for staff and patients, so that the highest possible standard of care can be delivered.

12.1 Violence & Aggression National Meetings

The Violence and Aggression Case Managers Group was established as a Sub-group of the NHS Wales Health and Safety Management Steering Group. The group plays a crucial role in ensuring the safety of both staff and patients by developing and implementing strategies for violence prevention and reduction. The Violence Prevention & Reduction Team continue to be involved in this group and contribute to the wider all Wales discussion on creating a safe and supported culture for our staff.
The purpose of the group is to:

- To provide a collaborative support to NHS V&A Case Managers.
- Ensuring that National Frameworks and Guidance associated with Violence and Aggression Management is successfully embedded and implemented across organisations. E.g. Obligatory Response to Violence and Aggression in Healthcare (ORV) and associated Welsh Health Circular.
- Establish Task and Finish Groups that will be responsible for the development of National Violence and Aggression Standard Operating Procedures/Guidance that can be adopted by NHS Wales E.g. Violence and Aggression Risk Management/ Assessment.
- The Group is also a forum for partner agencies from the CPS and the four Police Services in Wales, Health and Safety Executive to attend and participate, to foster good relationships and to ensure compliance with the aims of the ORV.
- Develop and agree Datix Cymru Violence and Aggression related codes. Review

coding and changes to the Datix Cymru system when necessary.

- Support and contribute to the review of the Violence and Aggression Training Passport and Information Scheme. Particularly in relation to risk assessment module.
- In support of the V&A Case Managers professional development, this Group will facilitate information and training opportunities for its members to participate, either as part of normal agenda or occasional separate events.
- To develop a minimum standard Job Description and Specification for a Violence and Aggression Case Manager.
- To inform the Anti-Violence Collaborative (AVC) of any relevant developments and concerns relating to the management of violence and aggression within NHS Wales organisations and seek support from the collaborative in influencing partner agencies in meeting the principles of the ORV.

12.2 Violence & Aggression Incident Reporting

Reported incidents of violence and aggression on staff have increased in 2024/2025 from the previous year by 6.9%. This increase could be explained by the work that has been implemented as part of the ORV as mentioned above to create a positive reporting culture.

Approximately 55% of violence and aggression incidents in 2024/2025 were reported from the Mental Health and Learning Disabilities Division. This is an increase of 2% from the previous year (2023/24).

Physical assaults on staff reported in 2024/25 has increased by 5.3% compared with 2023/24 (see Figure 12). The overall incident rates for 2024/2025 have remained consistent with previous years (2022/2023 and 2023/2024) at 1 in 20 staff experience physical assault.

There has been an 11% reduction in sexual assaults in 2024/25, compared with 2023/24.

To ensure quality data is available the Corporate Health and Safety Department validate all reported incidents of violence and aggression.

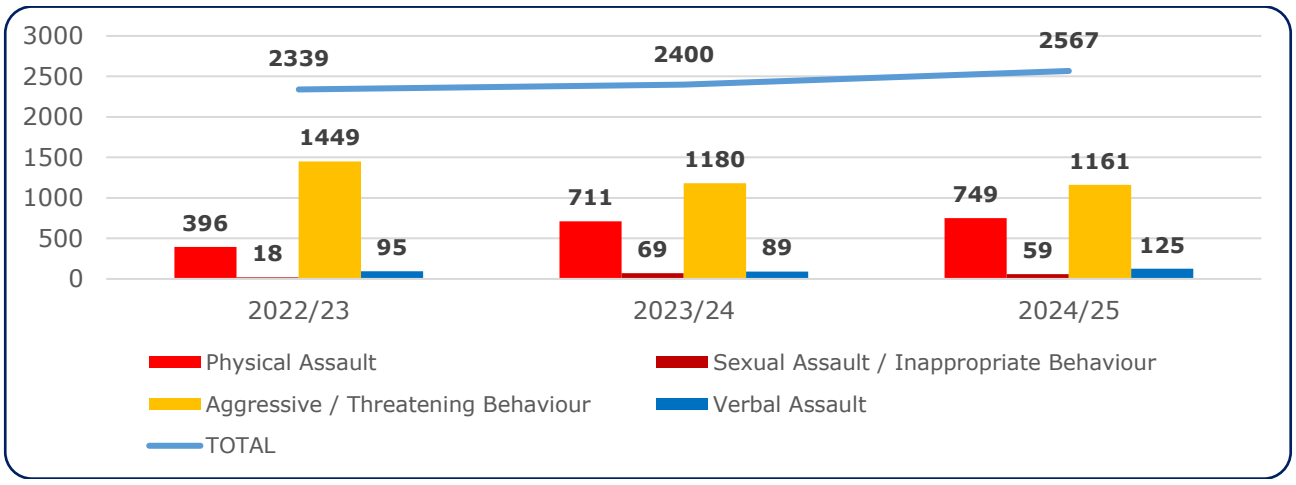


Figure 12: Number of reported violence and aggression incidents for the past three financial years

12.3 Support for NHS Staff Members

The Violence Prevention & Reduction (VPR) Team continue to support staff who have been subjected to incidence of workplace violence & aggression and where matters relating to personal safety are identified.

Where incidents are reported via Datix Cymru, a Violence Prevention & Reduction Advisor (VPR Advisor) is assigned to the incident and will provide advice in relation to the investigation of the incident including; supporting the Line Managers and signposting the person or people affected to relevant support services, internally and externally. A new collaborative approach to supporting victims of crime has been implemented and includes Wellbeing Services, Occupational Health and Connect Gwent to offer specialist and bespoke support to Health Board employees. In 2024/2025 6% of victims accepted a referral to Connect Gwent or CANOPI for additional support.

Between April 2024 and March 2025, the VPR Team has been actively involved in 1,120 incidents, demonstrating their critical role in supporting Health Board Employees who have been subjected to incidents of workplace violence and aggression. (See Figure 13)

Changes to the criteria for incident follow up has seen an increase in follow up in February and March 2025.

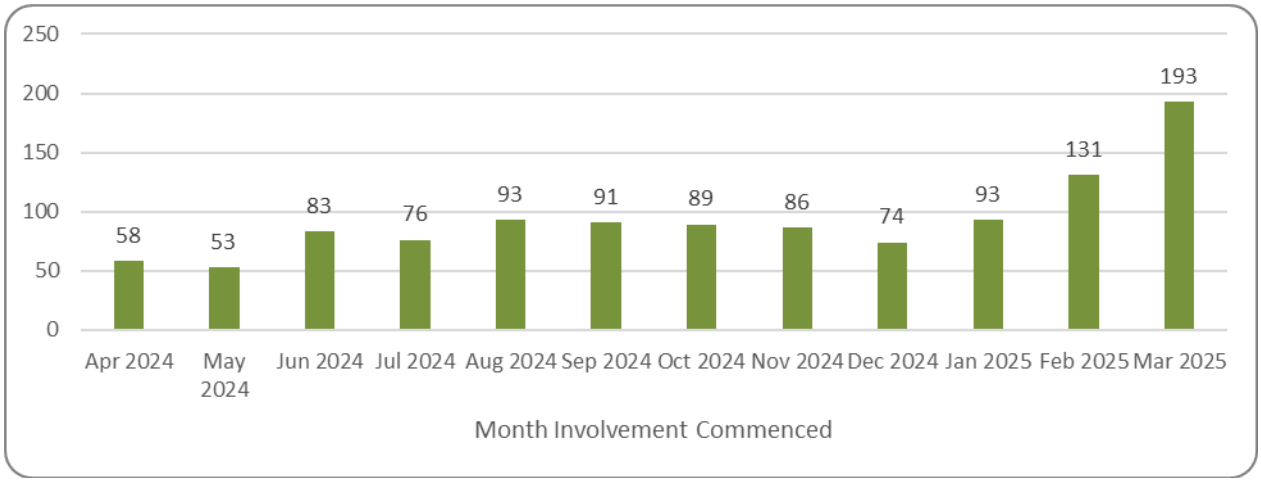


Figure 13: Number of violence and aggression incidents with VPR Advisor involvement

12.4 Engagement with Gwent Police

As mentioned above as part of the AVC and ORV objectives the Health Board has further improved its working relationship with Gwent Police, which has resulted in increased collaboration and wider partnership engagement.

This year in 2024/2025 the Health Board has implemented a Violence and Aggression Incident Review group which brings together key Health Board Employees and Gwent Police colleagues and is chaired by the Violence Prevention & Reduction Lead. The aim of the group is to implement a multi-agency approach to incidents of violence and aggression to reduce risks and attempt to achieve the safest outcome for the person, emergency services workers and members of the public.

12.5 Police Outcomes

Following a review of reported incidents, the Health Board engaged with the NWSSP Once for Wales Programme Team to progress enhancements to Datix Cymru to enable accurate recording of outcomes e.g. civil, criminal sanctions in relation to violence and aggression incidents.

This led to an increase in reporting of Health Board incidents to the Police as seen on Datix Cymru. In 2023/2024 only 1% of violence and aggression incidents against NHS staff were recorded on Datix Cymru as being reported to the Police. This has increased in 2024/2025 to 13% of incidents being reported to the Police.

However, this has only resulted in a total of 2% of violence and aggression incidents being investigated. From this total, 9% of those cases investigated led to an outcome such as a Community Resolution or a Conditional Caution given to the perpetrator. The VPR team will continue to work on creating a positive reporting culture and support investigations with Gwent Police to achieve outcomes that will reduce future risks.

12.6 All Wales Violence Prevention and Reduction Standards

During the period 2024/2025, significant progress has been made on an All-Wales basis to enhance the management and prevention of violence and aggression within NHS Wales.

The Health Board Violence Prevention & Reduction team has worked closely with the Anti-Violence Collaborative and other stakeholders across NHS Wales to create a Draft Version of the All-Wales Violence Prevention and Reduction Standards.

The review process entailed a detailed assessment of the existing standard, with particular attention to its relevance and applicability within the Welsh healthcare context. This has included evaluating current best practices, identifying potential areas for improvement, and ensuring that the standard aligns with the unique operational, cultural, and regulatory environment of NHS Wales. The Standards aim to be introduced and implemented across all NHS Health Boards in Wales in 2025/2026. This will be a key objective of the VPR Team for the next financial year and will feature in the Health Board Violence Prevention and Reduction Strategy.

The adoption of these standards is anticipated to bring several significant benefits to the Health Board, including:

Enhanced Safety for Staff and Patients: By implementing a robust and comprehensive framework for violence prevention and reduction, the updated standard will contribute to a safer working environment for staff and a more secure care environment for patients.

Consistency Across NHS Wales: A standardised approach will ensure that all NHS Wales organisations adhere to the same high standards, reducing variability in practices and enhancing the overall quality of violence prevention and management across NHS Wales.

Improved Reporting and Accountability: The new standard will establish clearer protocols for reporting incidents of violence and aggression, leading to better data collection, analysis, and accountability. This will enable NHS Wales to monitor trends, identify high-risk areas, and allocate resources more effectively.

Increased Staff Support and Training: The standard emphasises the importance of training and supporting staff in recognising, managing, and de-escalating violent situations. This will not only improve staff confidence and competence but also reduce the likelihood of incidents escalating to physical violence.

12.7 ABUHB Violence Prevention & Reduction Strategy

Preventing and reducing violence is a strategic enabler for improving the health and wellbeing of colleagues. Creating cultures where colleagues feel safe and supported can lead to higher retention, lower sickness absence rates, enhanced employee experience, and subsequent improvement to patient experience and outcomes.

In order to achieve change and ensure that we set out clear objectives the VPR Lead will develop and implement a specific Health Board Violence Prevention & Reduction Strategy for 2025/2026.

This Strategy will align our policies to recognise the needs and priorities of our Health Board. This piece of work will involve the VPR Team working collaborative with colleagues across the Health Board and key Stakeholders.

13 CONCLUSION

This report highlights the level of health, safety and fire focussed activity that has been undertaken during 2024/25 to improve the management of health, safety and fire in the Health Board.

The Health and Safety Committee continues to promote the health and safety programme.

The Corporate Health and Safety Department works to actively support the delivery of safe and compliant systems within the context of a health and safety culture. Failure to embed an interdependent and mature health and safety culture presents a risk to the Health Board.

The Health Board has seen a reduction in the number of incidents reported to the HSE in accordance with RIDDOR, however, there has been an increase in the number of incidents reported overall. This is potentially associated with the increase in awareness and a positive reporting culture. The Corporate Health and Safety Department will conduct thematic reviews in 2025/26 for needlestick & sharps injuries and manual handling injuries linked to patient handling.

The internal health and safety monitoring programmes are continuously improving as is the ongoing health and safety training programme.

There are challenges in relation to the current level of resource available within the Corporate Health and Safety Department to support the delivery of the legal requirements of health, safety and fire.

The implementation of the health, safety and fire improvement plan in 2023/24 and 2024/25 provided a focus for the Health Board on key risk areas.

A work plan will be developed for 2025/26 to address the risk areas for focus. Implementation of the actions, outlined in the work plan will support the Health Board to demonstrate continuous improvement and compliance with its legal responsibilities.

An Internal Audit is planned for quarter 4 of 2024/25 to assess the health and safety arrangements within the Health Board.