

# Aneurin Bevan University Health Board Public Board

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

Conference Centre, St Cadoc's Hospital

## Agenda

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### 09:30 - 09:30 1. PRELIMINARY MATTERS

0 min

 PB20251126\_Board Consent Agenda.pdf (3 pages)

#### 1.1. Welcome and Introductions

*Oral*      *Chair*

#### 1.2. Apologies for Absence for Noting

*Oral*      *Chair*

#### 1.3. Declarations of Interest for Noting

*Oral*      *Chair*

### 09:30 - 09:30 2. CONSENT AGENDA BUSINESS

0 min

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

*Oral*      *Chair*

### 09:30 - 09:30 3. KEY UPDATES

0 min

#### 3.1. Update from the Chair

*Oral*      *Chair*

#### 3.2. Update from the Chief Executive

*Oral*      *Chief Executive*

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

0 min

#### 4.1. Diabetes Management:

*Presentation*      *Director of Public Health*

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



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

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

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




## 5.1. Nevill Hall Hospital Strategic Outline Case

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

-  PB 20251126 Agenda Item 5.1 Nevill Hall Hospital Strategic Outline Case.pdf (8 pages)
-  PB 20251126 Agenda Item 5.1 Nevill Hall Hospital Strategic Outline Case Appendix 1.pdf (152 pages)

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




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

-  PB 20251126 Agenda Item 5.2 Better Health Better Care Better Lives -10-Year Strategy, Deployment Plan.pdf (11 pages)
-  PB 20251126 Agenda Item 5.2 Better Health, Better Care, Better Lives -10-Year Strategy, Deployment Plan Appendix 1.pdf (43 pages)
-  PB 20251126 Agenda Item 5.2 Better Health, Better Care, Better Lives -10-Year Strategy, Deployment Plan Appendix 2.pdf (7 pages)

## 5.3. Regional Planning:

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

a) Orthopaedics OBC

-  PB 20251126 Agenda Item 5.3 Regional Planning Orthopaedics OBC.pdf (5 pages)
-  PB 20251126 Agenda Item 5.3 Regional Planning Orthopaedics OBC Appendix 1.pdf (133 pages)
-  PB 20251126 Agenda Item 5.3 Regional Planning Orthopaedics OBC Appendix 2.pdf (3 pages)

09:30 - 09:30

0 min

## 6. ITEMS FOR DISCUSSION


### 6.1. Women's Health Update Report

*Attachment*                      *Director of Public Health*

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



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

*Attachment*                      *Chief Operating Officer*

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

### 6.3. Health, Safety & Fire Annual Report





*Attachment*                      *Director of Allied Health Professions & Health Science*

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

### 6.4. 2025/26 Performance Reporting:



*Attachment*                      *Executive Leads*

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

-  PB 20251126 Agenda Item 6.4a Integrated Performance Report.pdf (10 pages)
-  PB 20251126 Agenda Item 6.4a Integrated Performance Report Appendix A.pdf (74 pages)
-  PB 20251126 Agenda Item 6.4b Financial Performance Report, Month 06.pdf (26 pages)
-  PB 20251126 Agenda Item 6.4b Financial Performance Report, Month 06 Appendix A.pdf (29 pages)



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

*Attachment*                      *Director of Nursing*

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



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

*Attachment*                      *Director of Nursing*

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

## **6.7. Strategic Risk Report, November 2025**

*Attachment*                      *Chief Executive*

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

**09:30 - 09:30**

## **7. CONSENT AGENDA**

0 min

### **7.1. FOR APPROVAL**

#### **7.1.1. Draft Minutes of the Health Board Meeting, held on 24th September 2025**

*Attachment*                      *Chair*

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

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

*Attachment*                      *Chair*

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

#### **7.1.3. NHS Standing Orders and Standing Financial Instructions Updates**

*Attachment*                      *Director of Corporate Governance*

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

### **7.2. FOR NOTING**

#### **7.2.1. Board Action Log with Updates**




*Attachment*                      *Chair*

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

#### **7.2.2. Strategic Partnership Updates:**

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

a) Regional Partnership Board

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

#### **7.2.3. Executive Committee Chair's report**

*Attachment*                      *Chief Executive*

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

#### **7.2.4. Key Matters from Committees of the Board**

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

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


Attachment Chief Executive


a) NHS Wales Joint Commissioning Committee

b) NHS Wales Shared Services Partnership Committee

 PB20251126\_Agenda\_Item\_7.2.5 a\_Joint Commissioning Committee.pdf (4 pages)

 PB20251126\_Agenda\_Item\_7.2.5 a JC Highlight Report - 16 Sept 2025.pdf (6 pages)

 PB20251126\_Agenda Item 7.2.5 b NHS Wales Shared Services Partnership Committee.pdf (3 pages)

 PB20251126\_Agenda\_Item\_7.2.5 b SSPC Assurance Report 30 September 2025.pdf (6 pages)

## **09:30 - 09:30 8. OTHER MATTERS**

0 min

### **8.1. Any Other Business**

### **8.2. Date of the Next Meeting**

28th January 2025

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

0 min

### **Motion to Exclude Members of the Public and the Press**

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

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

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

**AGENDA**

<b>Date and Time</b>		<b>Wednesday 26<sup>th</sup> November 2025 at 9.30 am</b>	
<b>Venue</b>		<b>Conference Centre, Headquarters, St Cadoc's Hospital</b>	
<b>Item</b>	<b>Title</b>	<b>Format</b>	<b>Presenter</b>
<b>1</b>	<b>PRELIMINARY MATTERS</b>		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence for Noting	Oral	Chair
1.3	Declarations of Interest for Noting	Oral	Chair
<b>2</b>	<b>CONSENT AGENDA BUSINESS</b>		
2.1	The Chair will ask if there are any items from the Consent Agenda (Item 7) that Board Members wish to bring forward to the Main agenda for discussion		Chair
<b>3</b>	<b>KEY UPDATES</b>		
3.1	Update from the Chair	Oral	Chair
3.2	Update from the Chief Executive	Oral	Chief Executive
<b>4</b>	<b>PATIENT EXPERIENCE AND PUBLIC ENGAGEMENT</b>		
4.1	Diabetes Management: a. Patient Experience Story b. Diabetes Services Annual Report	Presentation	Director of Public Health
4.2	Report from Llais, Gwent Region	Attachment	Regional Director, Llais
<b>5</b>	<b>ITEMS FOR DECISION</b>		
5.1	Nevill Hall Hospital Strategic Outline Case	Attachment	Director of Strategy, Planning and Partnerships
5.2	Better Health, Better Care, Better Lives - 10-Year Strategy, Deployment Plan	Attachment	Director of Strategy, Planning and Partnerships
5.3	Regional Planning: a) Orthopaedics OBC	Attachment	Director of Strategy, Planning and Partnerships
<b>6</b>	<b>ITEMS FOR DISCUSSION</b>		
6.1	Women's Health Update Report	Attachment	Director of Public Health

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

- 28<sup>th</sup> January 2025

**9. PRIVATE/IN COMMITTEE SESSION**

**Motion to Exclude Members of the Public and the Press**

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

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

**Pwrpas yr Adroddiad**  
**Purpose of the Report**

Ar Gyfer Trafodaeth/For Discussion

**ADRODDIAD SCAA**  
**SBAR REPORT**

Sefyllfa / Situation

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

**Public Health and Economic Drivers**

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

**Health inequality and prevention**

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

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

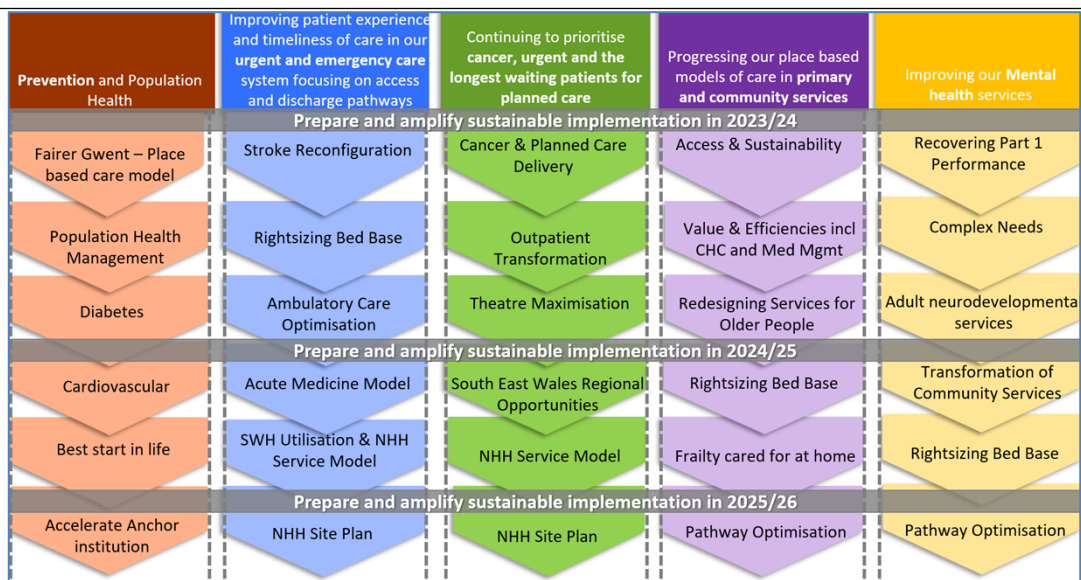
The 2024 DPH Annual Report [We are Gwent Annual Director of Public Health Report 2024h](#) set out the scale and impact of preventable premature mortality, and a need to accelerate progress in the prevention and treatment of Diabetes. Diabetes is also a strategic priority in the ABUHB 10 year strategic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

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

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

### **Cefndir / Background**

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



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

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

### Priority 1

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

### Priority 2

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

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

## Asesiad / Assessment

### Progress against the two priorities:

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

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

## Overview of diabetes services in the ABUHB

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

## Conclusion

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

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

### **Strategic Priorities 2025 - 2030**

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

### **Argymhelliad / Recommendation**

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

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

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

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

**Amcanion: (rhaid cwblhau)**

**Objectives: (must be completed)**

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

**Gwybodaeth Ychwanegol:**

**Further Information:**

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

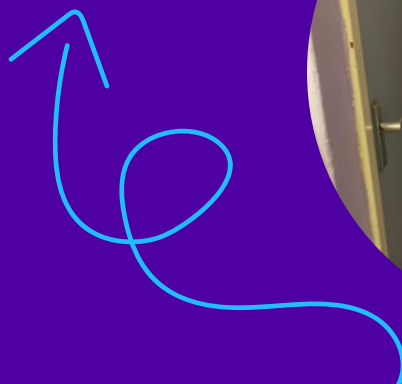
<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
	<b>Is EIA Required and included with this paper</b>
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<b>No does not meet requirements</b>  An EQIA is required whenever we are developing a policy, strategy,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

Aneurin Bevan University Health Board

# Diabetes

# Annual Report

2024-25



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



## What is Diabetes?

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

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

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

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

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



### Lynette's Story

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

### Donna's Story

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



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## **Background**

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

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



retinopathy (leading to vision loss), nerve damage, and diabetic foot (leading to ulcers or amputation). Short-term complications include low blood sugar (hypoglycaemia), high blood sugar (hyperglycaemia) and diabetic ketoacidosis (DKA). Managing diabetes and its complications in Wales accounts for 10% of the annual NHS Wales budget and costs approximately £500m per year, [Tackling diabetes together is key to people living longer, healthier lives in Wales - Public Health Wales](#) with much of this linked to avoidable complications and emergency admissions. Early diagnosis, the eight care processes, diabetes eye screening and effective self-management support lead to better outcomes and reduced demand on services. Regular monitoring will help reduce mortality, emergency admissions amputations and diabetic retinopathy [Diabetes is Serious Report Digital\\_0.pdf](#).

## National Priority

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

## Public Health and Economic Drivers

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

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

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

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

## Health inequality and prevention

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

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

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

## Prevalence

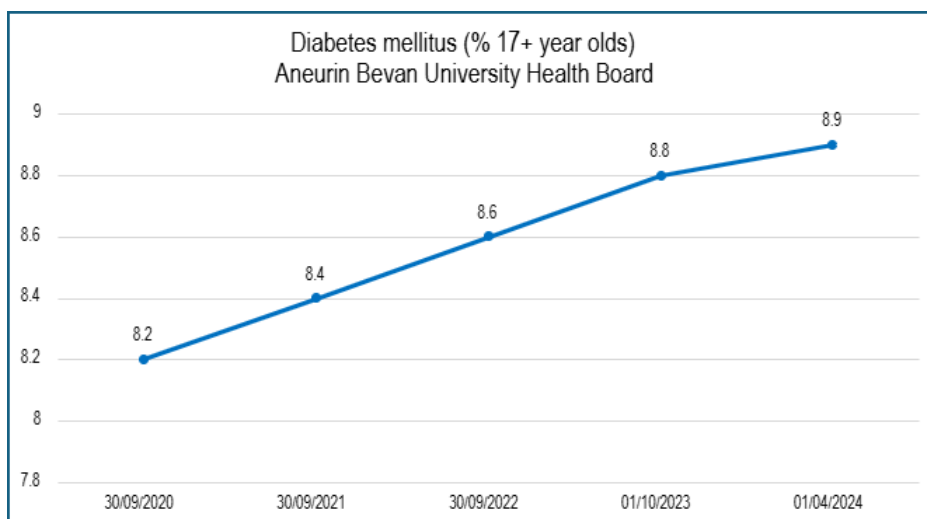
Gwent prevalence is in line with the Wales national average with prevalence at just over **8%** of the adult population living with diabetes and estimates suggest the prevalence in Gwent of diabetes may rise to 10% of the population by 2035 in line with national predictions. Whilst Type 1 diabetes affects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

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

## Risk Factors

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

**Chart 1 – Diabetes percentage 17+ years 2020-2024**

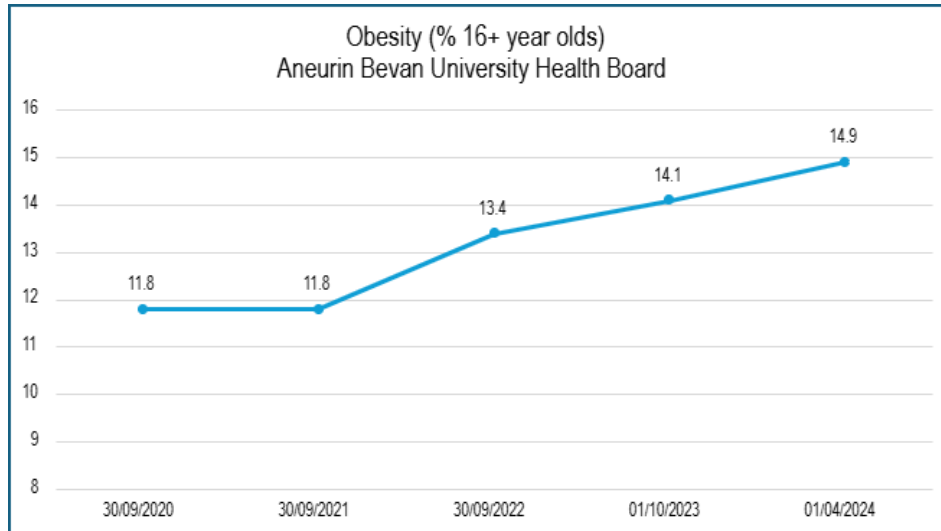


Source: [Disease registers by local health board, cluster and GP practice](#)

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



**Chart 2 – Obesity percentage 16+ years 2020 - 2024**



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

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

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

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

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

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

## Vision

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

## Strategic Priorities 2024-25

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

### Priority 1

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

### Priority 2

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

## Progress So Far

### Priority 1

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

### Priority 2

#### Hybrid Closed Loop System for Adults

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



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

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

### Hybrid Closed Loop System for children and young people

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

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



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

## Aneurin Bevan University Health Board Diabetes Services

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

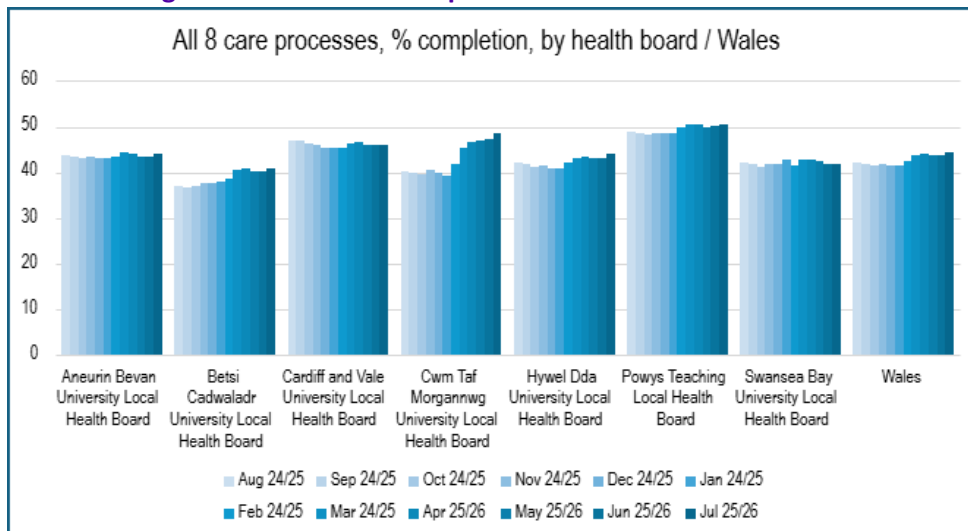
## Managing and Monitoring Diabetes in Primary Care

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



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

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



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

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

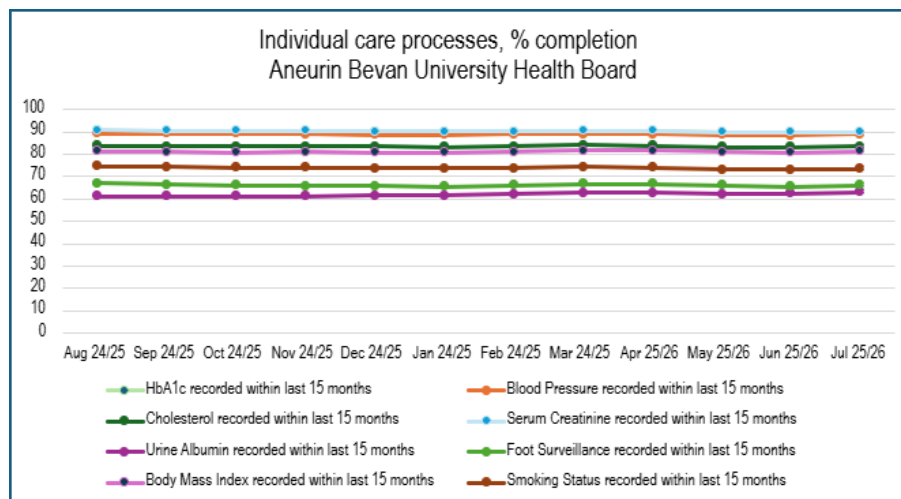


Chart 4 shows the percentage of T1 and T2 ABUHB patients with a recorded completion within the past 15 months of each individual care process. As with the combined data, the trend has remained mostly flat, with variations of less than one percentage point over the year on six of the eight metrics.

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

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



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

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

## Managing and Monitoring Diabetes in Secondary Care

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

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

### Type 2 Diabetes Remission Service

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

## Value-Based Healthcare Projects

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

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

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

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



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

## Self-management

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

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

## Structured Education Programmes

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

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

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

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

## Preventing Diabetes

### All Wales Diabetes Prevention Programme

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

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



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

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

### **Managing Lifestyle Risk Factors**

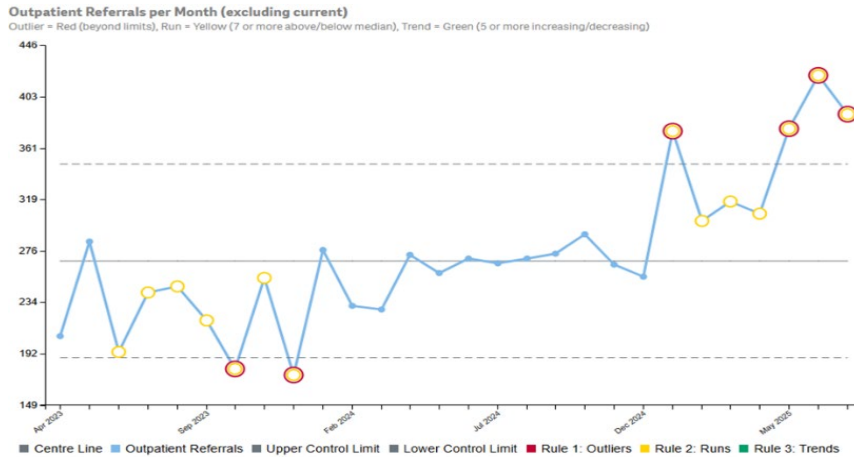
The Health Board provides a range of services to reduce the lifestyle risk factors attributable to diabetes. These services offer behavioural change support to adopt and maintain healthy life style choices. These services include:

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

### **Diabetes and Endocrinology Capacity and Demand**

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

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

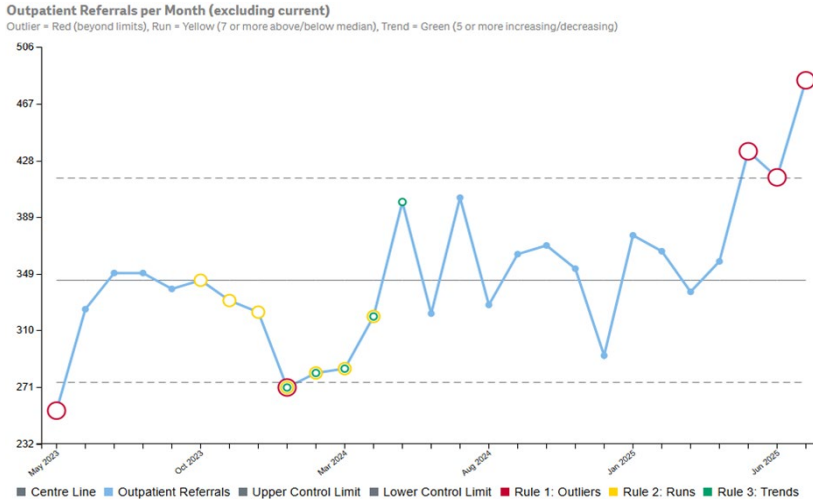


**Outpatient referrals per month:**  
 Apr 23 position: 206  
 Jul 25 position: 389

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

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

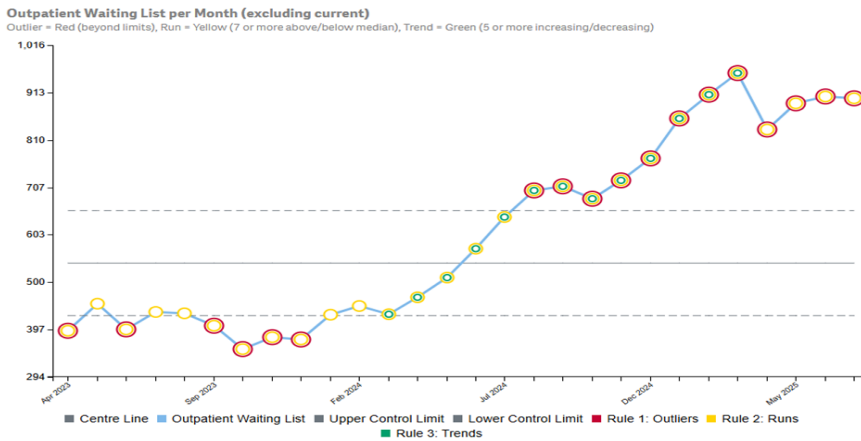
**Chart 6 - Endocrinology Outpatient Referrals per month (May 23 – Jul 25)**



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

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

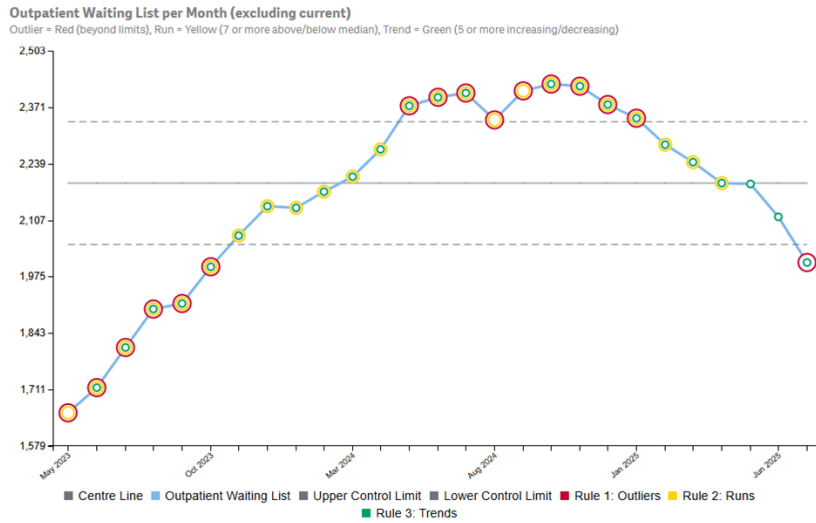
**Chart 7 - Diabetic Medicine New Outpatient Waiting List (Apr 23 – Jul 25)**



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

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

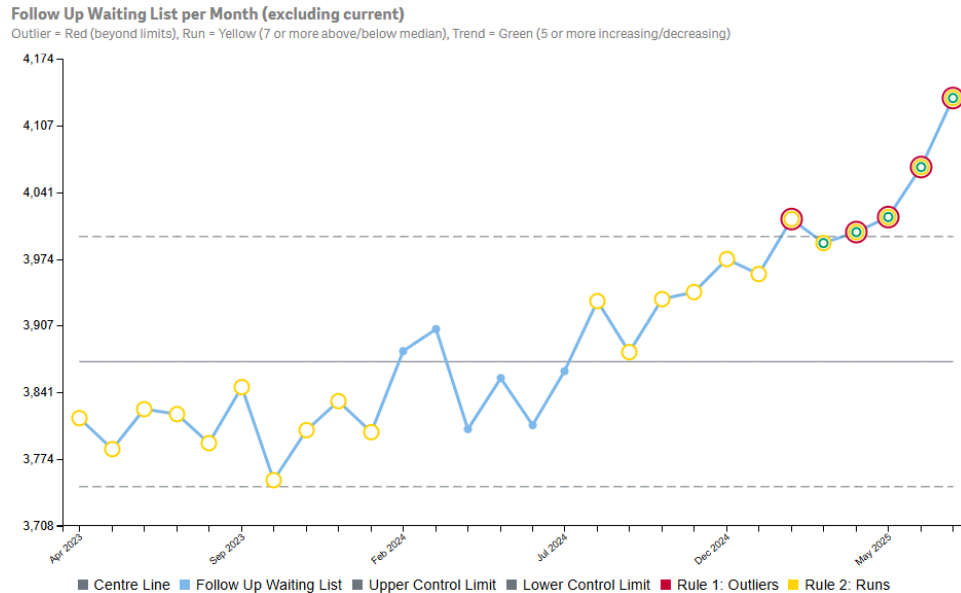
**Chart 8 - Endocrinology New Outpatient Waiting List (May 23 – Jul 25)**



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

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

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



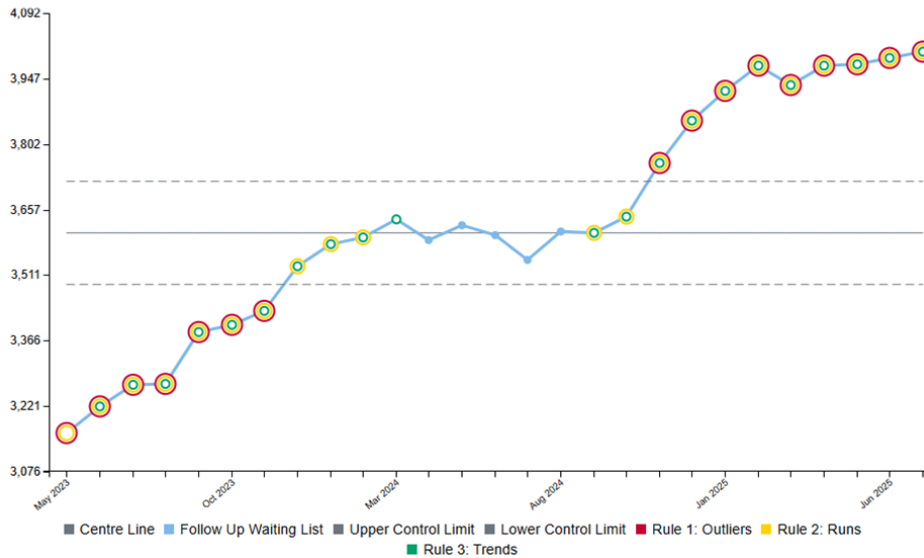
**Outpatient referrals per month:**  
Apr 23 position: 3,815  
Jul 25 position: 4,135

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

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

Follow Up Waiting List per Month (excluding current)

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



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

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

## Strategic Priorities 2025 - 2030

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

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

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

## Risks

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

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

## Conclusion

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

## Recommendations

### Service Development, Strategy and Programme Development

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

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

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

### Funding and Sustainability

Understand total funding gap across diabetes pathways.

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

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

### Workforce Planning

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

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

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

Prevention and Inequalities

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

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

### Structured Education and Digital Innovation

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

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

### Monitoring, Data and Outcomes

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

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

### Appendix 1 – Diabetes across the intervention and life course



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

## Appendix 2 – Diabetes Annual Plan 2024/25



2425 Diabetes Annual Plan Pack.ppt

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

**Protect your kidneys**  
**Return your sample**

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

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

In severe cases **kidney failure can be life-threatening.**

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



Damaged kidney      Healthy kidney

**Act Early, Test Yearly.**

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

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

**Living with Diabetes?**

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

2 in 5 people miss this simple check.



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

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

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

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



**Act Early, Test Yearly.**

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

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







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

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






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

## Appendix 5 – Register of risks for diabetes.

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



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



Aneurin Bevan University Health Board

# Diabetes Annual Report

2024-25

## Diolch | Thank You

For further information on this  
report please contact:  
[Scott.Wilson-Evans@wales.nhs.uk](mailto:Scott.Wilson-Evans@wales.nhs.uk).



<b>DYDDIAD Y CYFARFOD:</b> <b>DATE OF MEETING:</b>	26 November 2025
<b>CYFARFOD O:</b> <b>MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD:</b> <b>TITLE OF REPORT:</b>	Nevill Hall Hospital Strategic Outline Case
<b>CYFARWYDDWR</b> <b>ARWEINIOL:</b> <b>LEAD DIRECTOR:</b>	Hannah Evans - Director of Strategy, Planning & Partnerships
<b>SWYDDOG ADRODD:</b> <b>REPORTING OFFICER:</b>	Hannah Capel – Assistant Director, Strategic Capital

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

**Ar Gyfer Penderfyniad/For Decision**

The purpose of this paper is to:

- Gain approval to submit the Strategic Outline Case (SOC) to Welsh Government for an estimated investment of **£474.4m** for Nevill Hall Hospital. The investment will remove the significant presence of Reinforced Autoclaved Aeriated Concrete (RAAC), whilst rationalising the current footprint in order to deliver fit for purpose modern estate in line with the Health Board’s strategic direction.
- Set out the initial revenue implications of the development, noting the further work required as part of OBC development to test the assessment and seek opportunities to reduce further.
- Set out the feedback from the engagement exercise to support SOC development.

**ADRODDIAD SCAA**  
**SBAR REPORT**

**Sefyllfa / Situation**

The Strategic Outline Case (SOC) sets out the rationale and case for change for investment at the Nevill Hall hospital site to create a modern, safe, and sustainable facility aligned with the Health Board’s clinical model. Whilst investment into Nevill Hall has featured as part of the Health Board’s extant Estates strategy, the significant presence of Reinforced Autoclaved Aeriated Concrete (RAAC) has



increased the priority for investment into this estate. Whilst primarily required to manage the risks associated with RAAC, investment into the site and estate will provide an opportunity to refine the capacity and services following the opening of the Grange Hospital recognising NHH key role in providing a core set of services.

The clinical models have been reviewed and considered from a whole system perspective, which has resulted in a requirement for a reduction in the overall footprint at Nevill Hall Hospital through the delivery of services to reflect population needs and increased efficiency. This supports the rationalisation of estate, considers opportunities which may arise in relation to working with AB's neighbouring Health Boards. Critical to this consideration is the presence on the NHH site of the new Velindre @ Nevill Hall Radiotherapy Centre Unit which is of strategic importance to the region and demands a level of clinical and nonclinical service presence in NHH.

## **Cefndir / Background**

Under the Health Board's current clinical model and extant Estates Strategy, Nevill Hall is recognised as key site in the hospital system network both as a provider of services for the local catchment but also as a key part of health the network in terms of capacity and flow. Whilst work on reviewing and developing the clinical services plan for the Health Board , NHH is considered a fixed point in the hospital network due to:

- Its role in supporting the wider urgent and emergency care system in terms of local MIU and UPC services.
- Supporting the step-down model from the Grange University Hospital,
- In line with national policy, supporting care closer to home for low risk elective services such as outpatients, diagnostics and day surgery,
- Provision of care to families, children and women via the Children's centre, gynaecology ambulatory care and the emerging AB Women's Health Hub
- Its strategic location for the region as identified through travel times analysis for the satellite radiotherapy centre and recently as a north hub for south east Wales for cataracts for the region
- In addition, NHH site has a key role in the provision of staff residence, multi disciplinary education and management and administrative bases.

In February 2023 an alert was received from Welsh Government in relation to Reinforced Autoclaved Aeriated Concrete (RAAC), requesting that all Health Boards undertake a desktop review to determine whether or not there was any RAAC present within the Health Board's estate. This exercise identified Nevill Hall Hospital as the only site within the Health Board with RAAC present. Working alongside professional advisors Mott MacDonald detailed surveys and assessments have been undertaken. This has identified that RAAC panels are located across circa 19,010 m2 of roof space within the NHH estate with a total number of panels of approximately 7,816. This is a significant number in comparison with other RAAC installations across the UK and Nevill Hall is considered a "whole RAAC hospital" for this reason. Whilst the risks associated with RAAC are being proactively managed and mitigated in the short to medium term, the only way to



eliminate fully the risk is to remove RAAC or decommission those spaces affected. This risk cannot be removed unless the RAAC panels are removed.

The Health Board is working with its professional advisors to continue to manage and monitor the presence of RAAC in line with latest IStructE guidance and are inspecting and propping areas where identified. However this is not a sustainable solution in the long term.

### **Asesiad / Assessment**

The SOC sets out the case for change for investment into NHH based on the presence of RAAC and the emerging direction on service models, estates options and potential phasing.

Based on this work, the SOC proposes a “preferred way forward” as a reconfiguration of the NHH site that:

- Will provide new-build and right sized accommodation, providing capacity (only as required) for the services that currently sit in RAAC areas
- Allows for the refurbishment of the retained “H” Blocks (ward blocks where there is no RAAC),
- In a reduced footprint compared with current estate,
- Will provide more effective use of clinical space and agile working space in North Gwent.
- Provides for, as a potential future phase, the potential for integration of the services currently on Maindiff Court onto NHH site, thus reducing the overall size of the AB estate.

Acknowledging the challenges of availability and affordability of capital, the proposal requires funding for Phase 1 of capital investment of an estimated £474.4 million to redevelop the Nevill Hall Hospital (NHH) site and ultimately address the significant risk posed by the presence of RAAC. This figure represents the total anticipated investment required to deliver the scheme based on current cost modelling and assumptions. Support for the SOC will enable further option refinement, full affordability modelling, and continued engagement with stakeholders to confirm the preferred option at Outline Business Case (OBC) stage.

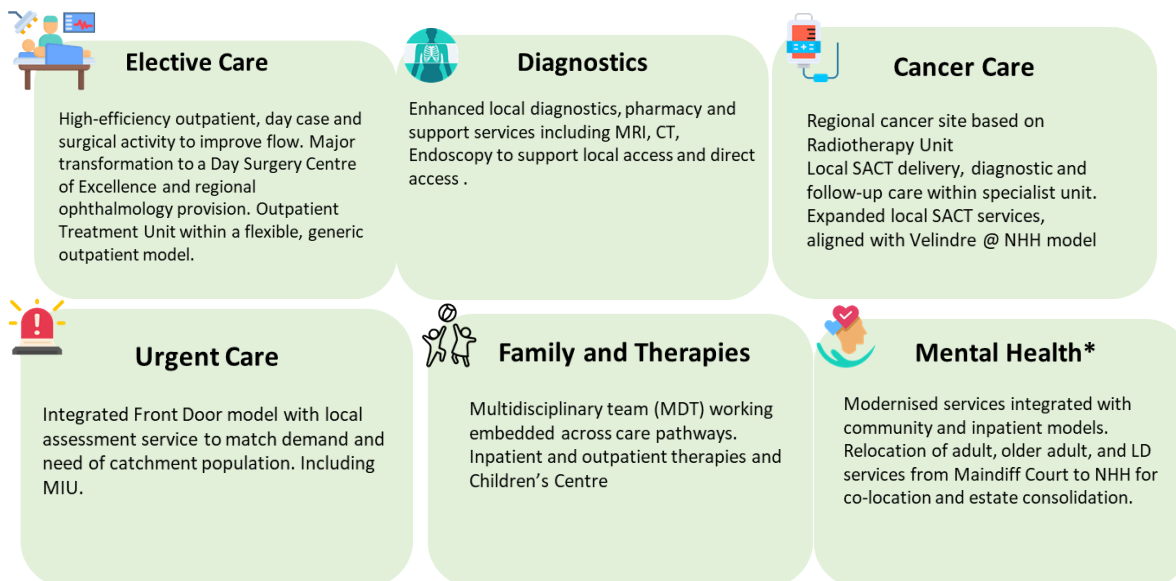
As outlined above, further benefits could be realised via future phases of investment that see the option of Maindiff court services being brought on to the NHH site. However the priority remains the removal of the RAAC risk.

The SOC is set out against the 5 case model with key messages from each case set out below:

The strategic case sets out the case for change in line with the above. It sets out the policy context and the assessment of risk associated with RAAC.

In terms of the emerging clinical model the infographic below gives an overview of services and capacity that is being assumed at this SOC stage, recognising greater levels of planning is required in the next stage of the business case process - the Outline Business Case (OBC).

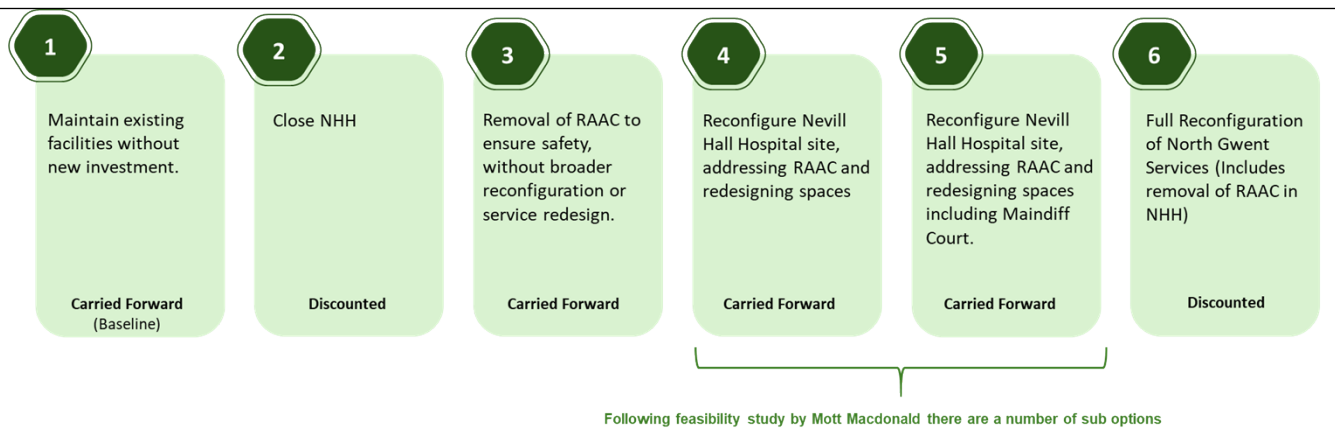




The **Economic Case** demonstrates that the Health Board has applied a rigorous and transparent approach to identifying a value-for-money solution that meets strategic and clinical objectives. A comprehensive long list of options was developed across six categories: service scope, service solution, service delivery, implementation, funding, and estate solution; and appraised against agreed Investment Objectives and Critical Success Factors.

<b>IO1: Quality</b>	To provide a model of care for the NHH site that is sustainable, removes RAAC, and is flexible to respond to future needs and workforce changes.
<b>IO2: Sustainability</b>	Develop a model of care for the NHH site that supports improved efficiency in service delivery and optimising resource use
<b>IO3: Efficiency</b>	Deliver an operationally efficient model of care at the NHH site that reduces unnecessary complexity and streamlines care processes and enables decarbonisation
<b>IO4: Economy</b>	Maximise the use of available resources at the NHH site, ensuring services align with Clinical Futures and provide cost-effective healthcare
<b>IO5: Effectiveness</b>	Provide a model of care for the NHH site that delivers patient care in line with best practice, meeting the needs of patients, carers, and staff.

From this process 4 key options were taken forward for detailed consideration as set out in the SOC.



The options appraisal will be revisited and thoroughly tested against a greater level of granular service model detail as part of the OBC economic case development in order to determine a preferred option.

From a **Commercial case** perspective, the Health Board will seek to appoint a Supply Chain Partner through the appropriate procurement frameworks, along with the necessary external advisors to support project delivery. In line with the national process, this step typically happens following Welsh Government support for SOC. This approach will ensure access to experienced suppliers, reduce procurement risk, and support timely delivery. Opportunities to embed Modern Methods of Construction (MMC), Net Zero Carbon principles, and digital infrastructure will be explored further to align with Welsh Government policy and sustainability goals.

If approved, the scheme is expected to be funded through the All-Wales Capital Programme (AWCP), and the Health Board will ensure that the commercial strategy supports value for money, compliance, and deliverability throughout the next stages of business case development.

The **Financial Case** sets out the indicative capital and revenue implications of the redevelopment proposals for Nevill Hall Hospital and provides an early view of affordability. A detailed feasibility study has been completed, which provides an initial assessment of the likely capital requirements and estate solutions. This SOC presents indicative costs based on that feasibility work. While detailed modelling will be undertaken at Outline Business Case (OBC) stage, the SOC presents an initial financial assessment to inform decision-making. The initial indicative recurrent revenue cost of the short-listed options range from c.£3.1m to c.£2.1m, with the preferred way forward delivering the lowest net cost through:

- Increased throughput in day case and outpatient activity.
- Rationalisation of estate, including the Phase 2 relocation of services from Maindiff Court
- Operational and clinical efficiencies from revised service models.

### Engagement on Case for change for NHH

In line with best practice and guidance, ongoing engagement with staff and communities as part of service change is a key obligation for health organisations. As part of SOC development, a two phased comprehensive engagement approach



was developed ensuring inclusive participation to shape the future of NHH and the wider hospital system. This approach was agreed with Llais. Phase 1 was an eight-week period between June and August focussing on the case for change for NHH (setting out the reasons why arrangements in NHH cannot remain as currently configured), principles underpinning the plans, and emerging thinking on service models. Phase 2 has recently commenced and focusses on specific and concrete proposals, e.g. the long-term model for stroke rehabilitation.

In terms of Phase 1 engagement, engagement activity can be summarised below:

- A total of 437 responses were received from the on-line survey
- The web page covering the engagement information received a total of 3354 views over the eight weeks, representing 3167 unique users. The top three sources of traffic were Facebook (1464), AB Pulse (557), ABUHB Website (284).
- In person attendance at the nine public events was variable, with the greatest interest unsurprisingly at events within the Nevill Hall Hospital catchment area. A total of 91 people attended the public engagement events.
- During the eight-week period, a total of 32 community engagement sessions took place and conversations held with 406 people
- Eleven posts were shared on Facebook which had a total reach of just over 300,000. A total of 436 comments were received and there were 305 shares
- Three updates were shared on the Health Board's WhatsApp channel which has 427 followers.
- Three bespoke responses from wider stakeholders e.g. via e-mail and phone were received
- 
- Bespoke session with Monmouthshire Council

Key findings and themes from the process were as follows:

- Understanding of case for change and RAAC situation
- Support for the principles proposed
- Desire to return more services to NHH, for example some of those that moved to the Grange,
- Desire for more information regarding services available and how to access them,
- Desire for straightforward contacts e.g. outpatient appointments to be available closer to home
- Importance of public and other transport links between hospitals



Many of the themes identified from the engagement exercise can be addressed as part of current plans and are not reliant on development at NHH.

The Health Board and project is committed to ongoing engagement with staff and stakeholders and as part of the OBC process more detailed engagement will be undertaken on the confirmed service models.

**Argymhelliad / Recommendation**

The Strategic Outline Case for NHH sets out the case for change and the need to response to the RAAC risks. As would be expected we have taken the opportunity to consider service models and further opportunities offered by the NHH site as part of the SOC development, noting that it is a site of regional strategic importance.

The Board is asked to:

- Support the Strategic Case for Change as set out in the SOC
- Approve submission of the Strategic Outline Case to Welsh Government to support the redevelopment of the Nevill Hall site in order to remove the risk which is posed by the presence of RAAC with an estimated potential capital cost of £474.4m
- Note the current assessment of potential revenue consequences of the development, acknowledging that there is further work to test and reduce
- Note the emerging thinking on service models, noting further work to fully test and refine
- Note the outcome of the engagement as part of SOC and the commitment to continue to engagement with staff, communities and stakeholders through the next phases of development
- Support the development of the Outline Business Case following Welsh Government approval of the SOC

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

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination 3.1 Safe and Clinically Effective Care 3. Effective Care
Blaenoriaethau CTCI IMTP Priorities  <a href="#">Link to IMTP</a>	Choose an item.



Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives <a href="#">Strategic Equality Objectives 2020-24</a>	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
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:	

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
	<b>Is EIA Required and included with this paper</b>
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a>
<b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b>  <a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a>	Choose an item. Choose an item.



## STRATEGIC OUTLINE CASE

**Project Name:** Nevill Hall Hospital Development Project

<b>Authors:</b>	<p>Leigh-Anne Challenger Senior Programme Manager</p> <p>Hannah Capel Assistant Director of Strategic Capital</p> <p>Trish Chalk Assistant Director of Planning and Performance</p>
<b>Owner:</b>	<p>Hannah Evans Executive Director of Strategy, Planning and Partnerships</p>
<b>Document Number:</b>	<p>Version 0.12</p>

**i. Document Control**

**Version History**

<b>Amended By</b>	<b>Version</b>	<b>Status</b>	<b>Date</b>	<b>Summary of Changes</b>
Leigh-Anne Challenger	0.1	Draft	23/10/24	Rough draft
Leigh-Anne Challenger	0.2	Draft	21/1/25	Working draft
Leigh-Anne Challenger	0.3	Draft	14/5/25	Working draft
Project Team	0.4	Draft	16/5/25	Project Team incorporated updates into live working document
Leigh-Anne Challenger	0.5	Draft	20/6/25	Updated for review by SRO, Project Lead, and Project Director ahead of PIP and Executive Committee submission
Leigh-Anne Challenger	0.6	Draft	23/6/25	Updated following comments from SRO
Leigh-Anne Challenger	0.7	Draft	24/6/25	Updated following comments from PIP and Project Board
Leigh-Anne Challenger	0.8	Draft	2/7/25	Editable version held following submission to EC
Leigh-Anne Challenger	0.9	Draft	13/8/25	Financial Case updated and updated capital costs
Leigh-Anne Challenger	0.10	Draft	24/9/25	Nomenclature changed from day centre of excellence to Day Case and Treatment Centre
Trish Chalk	0.10	Draft	3/11/25	Updates to Clinical Model section
Hannah Capel	0.10	Draft	3/11/25	Updates to Executive summary
Leigh-Anne Challenger	0.10	Draft	4/11/25	Updated Table of Contents, tables and figures; Outline plan updated
Leigh-Anne Challenger	0.11	Draft	11/11/25	Additional narrative in Strategic Context
Hannah Capel	0.12	Draft	19/11/25	Changes to some narrative for November Board version

### Approvals

This document has been approved by:

Name	Date	Version

### Distribution

This document has been distributed to:

Name	Date	Version
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NHH Development Project Team	22/5/25	0.4
Project Lead, SRO, Project Director, Service Design Lead	20/6/25	0.5
NHH Development Project Board	23/6/25	0.5
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Executive Committee	2/7/25	0.7
SRO, Project Director	4/11/25	0.10
SRO, Project Director	11/11/25	0.11

## ii. Executive Summary

The Strategic Outline Case (SOC) sets out the rationale and case for change for investment at the Nevill Hall hospital site to create a modern, safe, and sustainable facility aligned with the Health Board's clinical model. Whilst investment into Nevill Hall has featured as part of the Health Board's extant Estates strategy, the significant presence of Reinforced Autoclaved Aeriated Concrete (RAAC) has urgently increased the priority for investment into this estate. Whilst primarily required to manage the risks associated with RAAC, investment into the site and estate will provide an opportunity to rightsize the capacity and services post the Grange Hospital opening recognising NHH key role in providing a core set of capability and capacity.

The clinical models have been reviewed and considered for NHH from a whole system perspective, which has resulted in a requirement for a reduction in the overall footprint at Nevill, by right-sizing of services to reflect population needs and increased efficiency. This supports the rationalisation of estate, considers opportunities from working not only on a regional basis, but also any opportunities which may arise in relation to working with AB's neighbouring Health Boards. Critical to this consideration is the presence on the NHH site of the new Velindre @ Radiotherapy Centre Unit which is of strategic importance to the region and immediately demands a level of clinical and non clinical service presence in NHH

## **Strategic Outline Case:**

Nevill Hall Hospital Development Project

This SOC proposes a “preferred way forward” as a reconfiguration of the NHH site that:

- Will provide new-build and right sized accommodation, providing capacity (only as required) for the services that currently sit in RAAC areas
- Refurbishment of the retained “H” Blocks (ward blocks where this is no RAAC),
- All in a reduced footprint compared to current estate,
- More effective use of clinical space and agile working space in North Gwent.
- And, as a potential future phase the integration of the services currently on Maindiff Court onto NHH site, thus reducing overall AB estate.

Acknowledging the challenges of availability and affordability of capital, the proposal is for funding for Phase 1 of capital investment of an estimated £474.4 million to redevelop the Nevill Hall Hospital (NHH) site and ultimately address the significant risk posed by the presence of RAAC. This figure represents the total anticipated investment required to deliver the scheme, including optimism bias, based on current cost modelling and assumptions. Support for the SOC will allow further option refinement, full affordability modelling, and continued engagement with stakeholders to confirm the preferred option at Outline Business Case (OBC) stage.

### **Strategic Case**

The strategic case sets out the policy context and the assessment of risk associated with RAAC. Under the Health Board’s current clinical model and extant Estates Strategy, Nevill Hall is recognised as key site in the hospital system network both as a provider of services for the local catchment but also as a key part of the network in terms of capacity and flow. Whilst work on reviewing and developing the clinical services plan for the Health Board, NHH is considered a fixed point in the hospital network due to:

- Its role in supporting the wider urgent and emergency care system in terms of local MIU and UPC services through to supporting the step-down model from the Grange University Hospital,
- In line with national policy, supporting care closer to home for low risk elective services such as outpatients, diagnostics and day surgery,
- Provision of care to families, children and women via the Children’s centre, gynae ambulatory care and the emerging AB Women’s Health Hub
- Its strategic location for the region as identified through travel times analysis for the satellite radiotherapy centre and recently as a north hub for south east Wales for cataracts for the region
- In addition, NHH site has a key role in the provision of staff residence, multi disciplinary education and management and administrative bases.

This SOC outlines the strategic case for change and rationale for investment at NHH, driven by these key factors:

**Structural Risk and Estate Condition:** The presence of Reinforced Autoclaved Aerated Concrete (RAAC) presents a significant risk and

## **Strategic Outline Case:**

### Nevill Hall Hospital Development Project

challenge with the existing concrete structural frame and a high-risk maintenance backlog pose ongoing safety and operational risks.

**Alignment with clinical strategy:** As a designated enhanced Local General Hospital (eLGH), NHH is vital to the delivery of general and routine care closer to home, supporting whole-system flow from the Grange University Hospital and across the network of hospitals and underpinned by strong and effective “place based” care models in the communities of north Gwent.

**Modernisation of the Service Model:** The current layout and service model requires reconfiguration to improve efficiency, better integrate services, and meet population health needs, particularly through the consolidation of activity across NHH and Maindiff Court.

**Decarbonisation and Estate Rationalisation:** Replacing outdated infrastructure will help meet NHS Wales decarbonisation targets and ensure long-term sustainability of the estate.

**Workforce Sustainability:** The redevelopment will support modern workforce models, promote agile working, and improve staff wellbeing and recruitment.

These drivers have informed the agreed investment objectives, which provide a robust framework for appraising the preferred way forward.

## **Economic Case**

The Economic Case demonstrates that the Health Board has applied a rigorous and transparent approach to identifying a value-for-money solution that meets strategic and clinical objectives. A comprehensive long list of options was developed across six categories: service scope, service solution, service delivery, implementation, funding, and estate solution; and appraised against agreed Investment Objectives and Critical Success Factors.

Based on this work, the SOC proposes a “preferred way forward” as a reconfiguration of the NHH site that:

- Will provide new-build and right sized accommodation, providing capacity (only as required) for the services that currently sit in RAAC areas
- Refurbishment of the retained “H” Blocks (ward blocks where this is no RAAC),

- All in a reduced footprint compared to current estate,

- More effective use of clinical space and agile working space in North Gwent.

- And, as a potential future phase the integration of the services currently on Maindiff Court onto NHH site, thus reducing overall AB estate.

Acknowledging the challenges of availability and affordability of capital, the proposal is for funding for Phase 1 of capital investment of an estimated £474.4 million to redevelop the Nevill Hall Hospital (NHH) site and ultimately address the significant risk posed by the presence of RACC. This figure represents the total anticipated investment required to deliver the scheme, including optimism bias,

## **Strategic Outline Case:**

Nevill Hall Hospital Development Project

based on current cost modelling and assumptions. Support for the SOC will be able to further refine options, full affordability modelling, and continued engagement with stakeholders to confirm the preferred option at Outline Business Case (OBC) stage.

## **Commercial Case**

The Commercial Case outlines the intended procurement approach. Subject to approval of this SOC, the Health Board will seek to appoint a Supply Chain Partner via the appropriate procurement frameworks, along with the necessary external advisors to support project delivery. This approach will ensure access to experienced suppliers, reduce procurement risk, and support timely delivery. Opportunities to embed Modern Methods of Construction (MMC), Net Zero Carbon principles, and digital infrastructure will be explored further to align with Welsh Government policy and sustainability goals.

If approved, the scheme is expected to be funded through the All-Wales Capital Programme (AWCP), and the Health Board will ensure that the commercial strategy supports value for money, compliance, and deliverability throughout the next stages of business case development.

## **Financial Case**

The Financial Case sets out the indicative capital and revenue implications of the redevelopment proposals for Nevill Hall Hospital and provides an early view of affordability. A detailed feasibility study has been completed, which provides an initial assessment of the likely capital requirements and estate solution. This Strategic Outline Case presents indicative costs based on that feasibility work. While detailed modelling will be undertaken at Outline Business Case (OBC) stage, this Strategic Outline Case presents an initial financial assessment to inform decision-making.

The Health Board is operating within a challenging financial environment, with limited flexibility for revenue growth. However, strategic investment remains a priority where it supports long-term sustainability, improves service efficiency, and reduces risk.

Four short-listed scope options (Options 1, 3, 4, and 5) have been assessed for both capital and revenue impact. Initial capital cost estimates include allowances for optimism bias in line with HM Treasury guidance. The initial indicative recurrent revenue cost of the short-listed options range from **c.£3.1m to c.£2.1m**, with the preferred way forward (Option 5) delivering the lowest net cost through:

- Increased throughput in day case and outpatient activity.
- Rationalisation of estate, including the relocation of services from Maindiff Court.
- Operational and clinical efficiencies from revised service models.

Revenue assumptions will be further refined at OBC stage, including operational commissioning, digital costs, energy savings, and service transitions. The

**Strategic Outline Case:**

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affordability of any uplift will be considered alongside the Health Board's Integrated Medium-Term Plan (IMTP), with a clear focus on cost containment and long-term value for money.

The Financial Case demonstrates that, with appropriate external capital funding and a robust service model, the preferred option can support sustainable healthcare delivery while optimising public investment.

**Management Case**

The project will be delivered in accordance with national frameworks and PRINCE2 methodology. A dedicated NHH Development Project Board, chaired by the Director of Strategy, Planning and Partnerships, has been established and reports to the Executive Committee. The governance structure sets out clear roles and responsibilities, with the Senior Responsible Owner (SRO) and Project Director accountable for delivery.

An outline project plan has been developed, subject to SOC approval. A formal risk management framework is in place, and a benefits realisation plan will be implemented to track delivery of key outcomes. A post-project evaluation will be undertaken within 12 months of completion to assess impact and capture learning for future investment.

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### iii. Structure of Document

This SOC has been prepared using the agreed standards and format for Business Cases, as set out in:

- HM Treasury Guide to Developing the Project Business Case 2018
- NHS Wales Infrastructure Planning Guidance (2015)
- HM Treasury, the Green Book: Appraisal and Evaluation in Central Government: Treasury Guidance (2003).
- Public Sector Business Cases using the Five Case Model: A Toolkit Guidance and Templates (2007)

The approved format is the 5 Case Model, which comprises of the following key components:

- **The Strategic Case** which sets out the Strategic Context and the Case for Change, together with the supporting investment objectives for the Scheme.
- **The Economic Case** which demonstrates that ABUHB has selected a Value for Money approach whilst recognising the limited options available to meet the current need of the service.
- **The Commercial Case** which outlines the potential procurement strategy.
- **The Financial Case** which addresses the capital and revenue implications and the issue of affordability.
- **The Management Case** which demonstrates that the scheme is achievable and can be successfully delivered in accordance with accepted best practice.

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## **1. STRATEGIC CASE**

### **1.1 Strategic Context**

#### **1.1.1 Organisational Overview**

Aneurin Bevan University Health Board was established in October 2009 and achieved 'University' status in December 2013. The Health Board's principal role is to ensure the effective planning and delivery of our local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for our citizens, and in a manner that promotes human rights. To fulfil this role, we are required to work with our partners and stakeholders in the best interests of the population we serve.

As a Health Board, the organisation serves the population of Gwent which reflects the five local authority areas: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The demographics of Gwent are varied and include rural countryside areas, urban centres and the most easterly of the South Wales valleys.

The Population Needs Assessment for the region can be found here: [Gwent Joint Strategic Assessment - Aneurin Bevan University Health Board](#)

We employ 13,238 WTE (15,395 people; December 2024) and are the largest employer in Gwent. The workforce is ageing, as is the demographic profile of our population and the health inequalities of our population are also found within our workforce and 80% of our staff live within our communities. Therefore, it is essential that staff health and wellbeing is a key priority and a feature of our preventative plans.

The Health Board has an annual budget from the Welsh Government of just over £1.7 billion per year from which the organisation plans and delivers services for the population of Gwent. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being (Wales) Act 2014 and the Well Being of Future Generations (Wales) Act 2015.

Services - The Health Board provides a comprehensive range of acute hospital based, Community based, Mental Health and Primary Care services via a large and complex estate consisting of the following:

- 4 Acute Hospitals – Grange University Hospital, Royal Gwent, Nevill Hall, Ysbyty Ystrad Fawr
- 5 Community Hospitals - County, Ysbyty Aneurin Bevan, St Woolos, Chepstow and Monnow Vale
- 4 Mental Health Hospitals - St Cadoc's, Llanfrechfa, Maindiff Court, Ysbyty Tri Chwm

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8 Locality based Mental Health Units and 1 Residential Unit on LGH site, 4 unoccupied units across Gwent.

30 Locality based Community clinics

The University Health Board contracts with independent practitioners in respect of primary care services which are delivered by General Practitioners, Opticians, Pharmacists and Dentists. Outside of normal practice hours the University Health Board has responsibility for and provides an Out of Hours Primary Care Service. There are 281 WTE General Practitioners and Salaried GPs providing general medical services from 72 General Practices. Supporting these are 194.8 WTE practice nurses, 156.8 health care support workers 689.7 WTE administrative staff, including practice managers, receptionists, secretaries and IT officers. Around 375 General Dental Practitioners provide general dental services from 79 practices. There are 131 Community Pharmacies and 69 Optometry premises across the University Health Board.

A wide and growing range of community-based services are increasingly being delivered in patient's homes, through community hospitals, health centres and clinics. There are several smaller community hospitals, integrated health and social care centres, and health centres providing important clinical services to our residents closer to home.

The Health Board also provides comprehensive Mental Health and Learning Disabilities services in both hospital and community settings to the population of Gwent and South Powys

## **1.2 Business Strategy and Aims**

### **1.2.1 National Policy /Service Context**

'**A Healthier Wales**' sets out a long term, future vision of a whole system approach to health and social care which is focussed on health and wellbeing and on preventing illness. The ambition is for the continued development of a seamless, integrated system of health and social care, predicated on a place-based approach to service delivery, to improve service sustainability, quality and safety and to improve population wellbeing.

**The Social Services and Wellbeing (Wales) Act and Wellbeing of Future Generations (Wales) Act 2015** provide an enabling legislative framework which requires the Health Board and partners to work collaboratively in an integrated way across the whole system, involving the public in developing long term solutions to prevent avoidable illness and provide sustainable services in the future.

**The Wellbeing of Future Generations (Wales) Act** established 7 National goals and places a Well-being duty on Welsh Public Bodies. The legislation requires the Health Board to carry out Sustainable Development by acting in accordance with the Sustainable Development Principle through applying five ways of working to its decision making, namely:

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- Long term thinking (where consideration should be given to the balance between current demands and longer-term impacts over a 25-year period).
- An Integrated approach (how wellbeing objectives impact upon each other and in turn on the objectives of other public bodies and then how decisions impact on supporting the 7 national well-being Goals).
- Preventative Action (deploying resources now to prevent problems occurring or getting worse).
- Collaboration (acting collaboratively with other bodies or with other parts of the Health Board to assist in the achievements of the objectives of all).
- Involvement (involving the people and communities whose well-being is being considered and engaging them and others in finding sustainable solutions).

By applying these ways of working the Health Board will bring about the organisational culture change needed to deliver on the ambition of 'A Healthier Wales'.

#### **1.2.2 Regional Context**

There is an ongoing requirement for co-ordinated service planning and delivery at a regional level to ensure the provision of safe, sustainable, and high-quality care across Southeast Wales. The Health Board continues to play an active role in strengthening regional planning in collaboration with neighbouring Health Boards and NHS Trusts. This includes:

Collaboration with Velindre NHS Trust and Powys, CTM and Cardiff & Vale LHBS on the development of a Satellite Radiotherapy Unit at Nevill Hall Hospital, which will enhance accessibility to cancer treatment for the populations of South East Wales and support broader system resilience.

Development of the Regional Ophthalmology Service a hub and spoke model with some regional cataract services based at Nevill Hall Hospital. This model, utilising shared theatre and outpatient capacity, forms part of a wider regional eye care pathway. It responds to increasing demand for high-volume, low-complexity procedures and is being developed in line with regional strategic priorities. Further expansion of this service is anticipated but is subject to a business case for sustainable cataract services.

Ongoing engagement in the Llantrisant Health Park (LHP) development, led by Cwm Taf Morgannwg University Health Board. As a proposed regional centre for planned care, LHP's evolving role has direct interdependencies with Nevill Hall Hospital's service configuration. The services to be provided in LHP are being modelled on the assumption of additionality to existing capacity, including that in NHH. Continued regional dialogue will be essential to ensure alignment, minimise duplication, and maximise system-wide efficiency.

## **Strategic Outline Case:**

### **Nevill Hall Hospital Development Project**

At this stage, whilst the Strategic Outline Case focuses primarily on the strategic need and case for change within Aneurin Bevan University Health Board, active consideration has been given to how it can align services with neighbouring Health Boards specifically in relation to regional working opportunities. This review will continue as we move forward through the Outline and Full Business Case stages and onto the operationalisation of the hospital.

### **1.2.3 Strategic Regional Fit**

The Nevill Hall Hospital Development Project has been designed to complement, not duplicate, regional service developments. It has been shaped through regional dialogue and is aligned with existing and emerging models across South East Wales. The case recognises the importance of avoiding fragmentation and duplication and ensures that the services proposed for Nevill Hall are targeted, appropriate to local need, and coordinated with neighbouring health systems. This strategic fit underpins the role of Nevill Hall as a key component of a balanced, regionally integrated healthcare system.

### **1.2.4 Local Policy Context**

The Health Board's Integrated Medium-Term Plan for the next three years 2025-2028 is a statement of the Health Board's ambition to improve the health and wellbeing of the population through services delivered closer to home. The plan sets out the change we will deliver against five themes:

1. Embedding prevention and population health in all that we do
2. Progressing place-based models of care and sustainability in primary and community services
3. Improving our urgent & emergency care system focusing on experience, access and discharge pathways
4. Continuing to prioritise cancer, urgent and the longest waiting patients for planned care
5. Improving our mental health services

Our plan sets out how we will purposefully advance our prevention priorities including, population health management and place-based care starting in deprived communities. This will be demonstrated through our continued partnership working across Gwent.

Our plan for next year will focus on:

- ✓ Further step towards financial sustainability through three-year route map
- ✓ Drive quality of care and improving health outcomes
- ✓ Delivery of improved performance in line with ministerial priorities and enabling actions
- ✓ Targeted actions to support organisation de-escalation in Urgent and emergency Care

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- ✓ Purposefully advancing our prevention priorities including, population health management and place-based care starting in deprived communities
- ✓ Supporting our staff and resilience of our workforce models

Our plan responds to several UK wide, National, Regional and Local drivers that form the strategic context we are delivering within. In addition, it's important we reflect the national legislation and framework that guides our focus over the next three years to deliver sustainable services, Value-Based interventions, improvement of care and outcomes that matter for our population. Throughout the plan we have evidenced our commitment to the duties of quality and candour including implementation of quality statements which have informed our delivery plan development.

The development of our new strategy **Gwent 2035** champions population health and puts the Wellbeing of Future Generations at the heart of everything we do to improve the health of our population through partnerships.

The Gwent Joint Strategic Assessment provided the evidence base and case for change highlighting the health inequity experienced by our population. Therefore, it was timely that the Health Board considered a new long-term strategy which articulates its joint commitments with the population of Gwent through to 2035. The development of a new strategy has provided a unique opportunity to look to the future with communities to determine what matters to them; and how we can work in partnership to improve wellbeing through place-based care.

The development of the strategy from 2025 to 2035 has ensured a comprehensive evidence base that has included an extensive horizon scanning library, engagement with staff, partners and population and significant data analysis from a range of sources including the Gwent Joint Strategic Assessment. Through thousands of rich and meaningful conversations, we have developed a better understanding of what is important for our population to feel healthy and have used themes from this public engagement to shape a new strategic framework of the organisation.

The Health Board has developed the strategy due to be considered by the Board in July entitled Gwent 2035: Better Health, Better Care, Better Lives'. The strategy sets out our purpose to Improve the health of our population achieving equity for all and our ambition that by 2035 everyone has the same chance to live a long healthy life

Under the Wellbeing of Future Generations Act (2015) we have a statutory responsibility to set and publish wellbeing objectives, and these are proposed to be our new strategic aims as set out below:

Our Aims	
<b>Better Health</b>	Together we will support people to be healthy, active and happy.
<b>Better Care</b>	Together we will deliver what matters to people, supporting our staff to thrive and achieving quality, kind and sustainable care.

## Strategic Outline Case:

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**Better  
Lives**

Together we will create strong, safe, and connected communities.

These aims will enable us to improve the health of our population achieving equity for all working across the whole system. This can only be achieved by acting as an anchor institution and influencing all the factors that make people live healthy lives.

### **1.2.5 Clinical Futures Service model and The Grange University Hospital**

The Clinical Futures programme set out a whole-system model of care built on the principle of providing safe, high-quality services in the most appropriate setting, delivering specialist and critical care in a specialist critical care centre, while supporting access to general and routine care as close to home as possible.

A major milestone in delivering this vision was the opening of the Grange University Hospital (GUH) in November 2020. As a purpose-built centre for specialist and emergency care, GUH consolidated complex and high-acuity services into a single site, allowing other acute hospitals, including Nevill Hall Hospital, to focus on the delivery of enhanced Local General Hospital (eLGH) functions. These include elective surgery, diagnostics, outpatient care, medical support, therapies, and rehabilitation.

The implementation of Clinical Futures and the opening of GUH have delivered measurable improvements in system flow, access to specialist care, and the ability to manage high-risk patients in dedicated environments. This is set out in the Hospital System Report presented to the Board in November 2024. There have been significant achievements since the reconfiguration in 2020 against the original objectives of the Clinical Futures FBC:

- ✓ Improved outcomes for the most seriously unwell
- ✓ Improved quality and safety
- ✓ Greater staffing sustainability in core services such as critical care and maternity
- ✓ Separation of planned and emergency activity
- ✓ Improved staffing and recruitment for essential specialties
- ✓ Greater resilience in services
- ✓ Ability to innovate within the system model

The Full Business case for the GUH was based on a set of demand assumptions using 2015 as a baseline. Annual demand since 2015 had been above predicted levels with significant pressures across the health and social care system. New modelling had been undertaken as part of the refreshed planning post FBC approval. The impact of the pandemic further compromised the modelling assumptions which have seen unpredictable patterns of demand as we have moved through the different phases of the pandemic.

There continues to be annual increases in the demand across most services including primary care and community services, urgent and emergency care,

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planned care, cancer services, Mental Health Services, women and children services and therapy services and diagnostics. The challenges that this presents is significant at a time when the organisation is trying to address the backlog of waiting lists, increasing acuity and public expectations. As well as increased demand the Office for National Statistics forecasting that by 2035 there will be 18% less 18-year-olds entering the workforce.

Most people who work for the Health Board also live in the Gwent area, so with forecasts of fewer 18-year-olds starting work by 2035 there will be fewer younger people starting their career in healthcare. Now, just 15% of our staff are aged between 21 and 30, while 36% are over the age of 50. Therefore, the organisation cannot continue to staff its services in the way it does now.

There are several areas to consider:

**Workforce and service fragility:** Whilst the opening of the GUH has strengthened workforce resilience in several critical services, it has stretched resources over additional sites. The full delivery of the proposed model set out in the FBC has not been achieved and there remains a higher number of beds open in the health boards system, stretching workforce in several areas. The demographic changes mean it is unlikely to be able to provide sustainability in the current model of care.

**Estate mismatch:** Many facilities, including those at Nevill Hall Hospital, were not originally designed for the revised model of care set out in the clinical futures FBC. This has resulted in inefficiencies, poor patient flow, and limitations on service modernisation. The GUH has delivered significant improvement in Infection Prevention Control (as set out in the [Hospital System Report](#)) via the building design which have not been achieved on other eLGH sites.

**System interdependencies:** The success of GUH relies on eLGH sites operating effectively as part of the whole system. Delays or limitations in day surgery, diagnostics, outpatient pathways and patient discharge at sites like Nevill Hall have a direct impact on overall system performance. In essence the eLGH sites support the operational function of the GUH and wider system.

**Need for proactive investment:** The initial success of GUH highlighted the importance of delivering estate improvements and clinical model alignment in tandem. Retrofitting changes after operational go-live can limit the effectiveness of transformation.

**Stakeholder engagement:** The proactive identification of stakeholders was key to the successful delivery of GUH, this included public engagement and engagement with Llais. Recent service change at NHH reinforces the proactive and early engagement of stakeholders as a core part of the project plan.

The Nevill Hall Development Project represents a critical opportunity to consolidate these learning points and ensure the next phase of the Health Board's transformation programme delivers a fully integrated, future-proofed

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### **Nevill Hall Hospital Development Project**

model of care based on population need. The project will address the estate and service limitations currently faced at Nevill Hall, enable sustainable efficient workforce and service models aligned to need to support the long-term success of the Gwent region.

### **1.3 Case for Change**

The redevelopment of Nevill Hall Hospital is essential to ensure safe, sustainable, and high-quality healthcare for the North Gwent population. The case for change is now primarily driven by the significant structural risk due to the presence of Reinforced Autoclaved Aerated Concrete (RAAC), a growing backlog of maintenance, and outdated infrastructure that no longer meets modern standards of care. At the same time, services must adapt to meet the changing needs of patients, deliver care closer to home, and support the wider clinical model development. This project provides a unique opportunity to rationalise and modernise the estate, align with regional service plans, and create an environment that supports future workforce models, improved patient outcomes, and long-term value for money.

The Health Board is now just over five years into the implementation of a significant change to the clinical model, following the opening of the Grange University Hospital in November 2020. The enhanced Local General Hospital (eLGH) sites are a key component of the ABUHB model supporting the operational function of the Grange University Hospital and the wider system. NHH is a key site that provides opportunities to further support the GUH and provide patient care close to home for the population of north Gwent while also providing regional specialist service such as ophthalmology and radiotherapy.

The NHH Development Project forms part of the Clinical Redesign Programme. The Clinical Redesign Programme is one of the Health Board's key priority transformation programmes, established to take forward clinical reconfiguration opportunities and service redesign aligned to the Health Board's Clinical Futures Strategy, with the overall aim of reducing health inequality and improving population health. The consolidation of the Stroke rehabilitation service and the Respiratory services provide examples of recent clinical redesign at NHH which aimed to deliver improved patient care and sustainable service delivery.

The purpose of the Nevill Hall Development Project is to establish an open process for identifying and confirming the preferred future model of care for Nevill Hall Hospital (NHH). This model aims to deliver quality, patient-centred care, ensure workforce stability, and optimise services to enhance patient outcomes and experiences, creating a future-proof model of care. The objectives are:

- Address the presence of Reinforced Autoclaved Aerated Concrete (RAAC) within the existing estate through the delivery of a long-term, sustainable infrastructure solution that mitigates structural risk and avoids ongoing monitoring and reactive maintenance
- Right size our key services to match capacity with anticipated demand

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- Rationalise the Health Board Estate
- Ensure that as many services as possible are provided close to home, whilst also recognising that where more complex acute care is required, this is provided according to best practice and the highest clinical standards
- Ensure service delivery is aligned with patient need for the north of Gwent
- Ensure all services are efficient and sustainable (this will help us to improve patient experience and reduce length of stay)
- Optimise the flow of patients through the system
- Match workforce resource to demand

#### **1.3.1 Reinforced Autoclaved Aerated Concrete (RAAC)**

Reinforced Autoclaved Aerated Concrete (RAAC) is a lightweight, precast concrete material used in construction between the 1950s and 1990s. It consists of steel reinforcement, high-temperature steam curing, and aerated concrete with air bubbles formed through a chemical reaction, additionally -

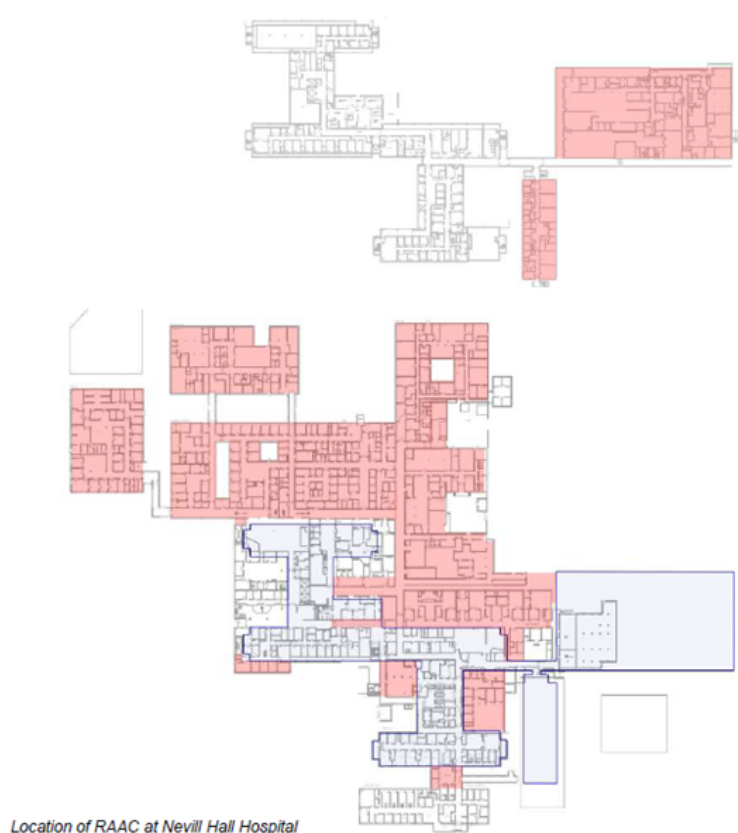
- It was widely used in the UK the 1950s to the 1990s, particularly in flat roofs, floors, and wall panels in public buildings, including hospitals, schools, and offices.
- Unlike traditional concrete, RAAC is more porous and weaker.
- Over time, it can degrade, especially when exposed to moisture.
- RAAC has a design life of around 30 years

RAAC panels are less dense and have lower compressive strength compared to traditional concrete. They are commonly used in roof structures, but also in floors and walls. However, RAAC has significant structural issues, including poor end-bearing, susceptibility to water damage, and potential for sudden failure, leading to concerns about its longevity and safety in buildings. RAAC panels are located across circa 19,010 m<sup>2</sup> of roof space within the NHH estate. The total number of panels is approximately 7,816. This excludes areas that have been demolished as of the date of the most recent inspection. This is a significant number in comparison to other RAAC installations across the UK. Nevill Hall is considered a whole RAAC hospital for this reason. The presence of RAAC can compromise the safety of healthcare buildings. This risk cannot be removed unless the RAAC panels are removed.

The installation consists of mainly flat roof panels, although some pitched roof panels exist above the theatre plant room space. There are a few instances of wall panels across the site, which are non-load bearing. There is a RAAC management strategy in place which has been developed alongside the Health Boards professional advisors and is adapted in line with the latest guidance as it is updated.

The following diagram indicates the extent of the presence of RAAC in NHH, which is highlighted in pink -

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### 1.3.2 Contribution to Whole-System Resilience

The redevelopment of Nevill Hall Hospital plays a pivotal role in enhancing the resilience of the Health Board's elective, routine, and diagnostic activity. By maximising day surgery and outpatient capacity at NHH, the scheme alleviates pressure on elective services currently at the Royal Gwent Hospital (RGH) and aligns with the Health Boards IMTP as a key enabler to meeting the GIRFT (Getting It Right First Time) recommendations, protecting elective capacity and flexible theatre and treatment room capacity. This, in turn, strengthens system-wide resilience by preserving emergency capacity at the Grange University Hospital (GUH), which is dedicated to acute and complex care. RGH currently hosts a Surgical High Care Unit (SHCU) enabling it to treat higher-acuity elective patients who would otherwise require intervention at GUH. By enabling lower-acuity elective activity to be delivered at NHH, the Health Board can safeguard RGH capacity for those higher-acuity cases. This redistribution of activity improves patient flow, reduces elective backlogs, and supports a more sustainable, whole-system model of care.

NHH is a key site supporting patient flow across the system, following an acute period of care, patients may be required to step down to an eLGH from the GUH to receive further care or while awaiting the next step in their patient pathway. This is the model of care implemented following the opening of GUH in November 2020, the eLGH sites including NHH support whole system following ensuring the patient receives the right care in the right place first time. The bed base at NHH supports care close to home and improved patient flow ensuring

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patients receive discharge planning support from local team supporting timely patient discharge and reduced length of stay.

**1.3.3 Summary of Key Drivers**

To guide investment decisions, six key strategic drivers have been identified (Figure 1). These reflect the core challenges and opportunities underpinning the case for change and will shape both the preferred solution and assessment of options.

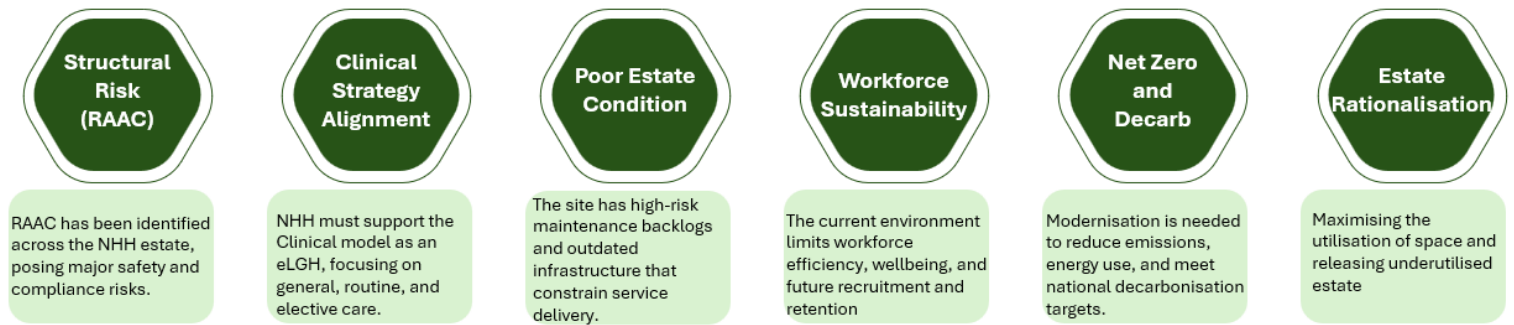


Figure 1: Summary of Key Drivers

The key drivers outlined above set the context for this investment, capturing the strategic, clinical, and operational challenges the scheme must address. These drivers have directly informed the development of investment objectives, which will be used to evaluate options and guide the design of a sustainable, future-focused solution for Nevill Hall Hospital.

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**1.3.4 Investment Objectives**

The following Investment Objectives have been established to provide a clear framework for evaluating and selecting options for the project. These objectives focus on delivering measurable outcomes that align with the Health Board's strategic priorities, ensuring each option contributes to the project's overarching goals. The Investment Objectives serve as benchmarks for assessing the potential impact, effectiveness, and sustainability of each option, helping to identify solutions that will drive long-term benefits, meet patient and service needs, and support organisational growth and resilience. The agreed Investment Objectives for this project are as follows:

	<b>Investment Objective</b>	<b>Investment Theme</b>	<b>Specific</b>	<b>Measurable</b>	<b>Achievable</b>	<b>Relevant</b>	<b>Timebound</b>
1	To provide a sustainable and high quality eLGH model of care on the NHH site	Economy	Allocate resources effectively at NHH to enhance service delivery and comply with strategic objectives, focusing on reducing costs and avoiding waste.	Track and report costs and resource utilisation	Conduct regular resource audits to identify areas for reallocation or efficiency improvements.	Ensures alignment with strategic goals and supports financial sustainability	Achieve targeted resource efficiency by 1 year following opening.
2	Provide a model of care for the NHH site that delivers patient care in line with best practice, meeting the needs of patients, carers, and staff.	Effectiveness	Implement a care model at NHH that adheres to national best-practice standards, ensuring all specialties deliver high-quality, consistent care.	Compliance with best-practice guidelines across specialties and maintain patient satisfaction scores	Engage multidisciplinary teams in developing model of care	Aligns with the Health Board's goal to improve health outcomes and enhance patient experience through reliable, evidence-based care.	Complete model implementation within 6 months of opening.

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3	To provide a safe and fit for purpose estate and environment that removes the risks associated with RAAC and aligns with the decarbonisation agenda and the principles of the Well-being of Future Generations (Wales) Act.	Quality	Develop a care model at NHH that supports adaptability for evolving clinical practices, patient demographics, and workforce structures, while removing all RAAC to ensure long-term safety.	Completion of RAAC removal and the development of a care model evidenced by approval of final plans by stakeholders	Aligns with the Health Board's Clinical Futures strategy, ensuring NHH remains fit-for-purpose in a changing healthcare environment and adheres to safety standards.	Aligns with the Health Board's Clinical Futures strategy, ensuring NHH remains fit-for-purpose in a changing healthcare environment.	Complete RAAC removal and decarbonisation upgrades by completion of build.
4	Deliver a model of care for the NHH site that supports improved efficiency in service delivery and optimising resource use.	Sustainability	Implement care pathways at NHH that shift focus from high-cost inpatient services to efficient outpatient and community-based care.	Achieve target efficiency metrics in care delivery	Utilise evidence-based practices incorporating technology and alternative care settings.	Supports the Health Board's goal for sustainable service models, enhancing patient outcomes and reducing operational costs.	Target efficiency improvements to be fully operational by 1 year following opening.
5	To deliver models of care and infrastructure that supports sustainable workforce models	Efficiency	Redesign care processes at NHH to minimise redundancy and reduce wait times, using integrated systems and streamlined workflows.	Monitor KPIs efficiency metrics in care delivery	Collaborate with clinical teams to introduce process improvements, technology, and training for streamlined care	Essential for maintaining high-quality care standards while optimising operational efficiency.	Complete efficiency improvements and achieve targeted reductions by 1 year following opening.

Table 1: Investment Objectives

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Together, these investment objectives provide a clear and measurable framework to guide the development and appraisal of options. They ensure that any proposed solution not only addresses the structural and clinical challenges currently facing the site, but also supports the delivery of high-quality, sustainable services aligned with the clinical strategy. The objectives will be used to evaluate the economic case and determine which option offers the best value for money while delivering the intended outcomes for patients, staff, and the wider health system.

### 1.3.5 Existing Arrangements

# Nevill Hall Hospital



Figure 3: NHH Site Map

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### 1.3.6 Site Location and Description

Nevill Hall Hospital is in Abergavenny, Monmouthshire. The hospital serves as a key site within the Health Board's acute portfolio and currently accommodates a range of clinical services. The aerial image above illustrates the scale and complexity of the Nevill Hall Hospital (NHH) site, which comprises a mix of patient-facing clinical facilities and non-clinical areas distributed across multiple buildings. While the main hospital block remains the central hub for acute care delivery, the wider estate includes numerous peripheral structures that support a variety of operational functions. The dispersed layout, combined with varying building age and condition, contributes to ongoing challenges in space utilisation, wayfinding, and service integration.

The site was originally home to Nevill Hall, a Grade II listed country house that was repurposed as a hospital in the 1920s. In response to increasing service demand, a new hospital facility was constructed on the grounds in the late 1960s, with the main building officially opening in 1970. The hospital comprises a four-storey tower block positioned above a single-storey podium level. The primary structure is formed using a concrete frame, with in-situ cast waffle and ribbed concrete slabs for the tower and a precast concrete frame for the podium. The podium features infill panels formed from Reinforced Autoclaved Aerated Concrete (RAAC), creating a flat roof construction.

Over time, additional buildings have been developed on the site to accommodate service expansion, including the Abergavenny and Gilwern Ward, Day Hospital, Clinical School, Children's Centre, and the Llanwenarth Suite. Construction of a new Satellite Radiotherapy Unit (SRU) has recently been completed, with full operation commencing in summer 2025.

Despite its strategic importance, the hospital site faces several operational challenges:

**Presence of Reinforced Autoclaved Aerated Concrete (RAAC):**

presents known structural risks and requires active monitoring. Its presence is a key driver for long-term site redevelopment and risk mitigation. The precast concrete frame of the podium buildings has been found to have structural issues, which require further investigation, and may require further remediation.

**Underutilisation of the Site:** Since the opening of the Grange University Hospital (GUH), several services have relocated, resulting in large parts of the estate being underutilised. The current configuration no longer reflects the service delivery needs of a post-GUH model and does not make best use of available space.

**Inefficient Layout:** The estate has not been designed to maximise clinical efficiency. Key adjacencies between services are suboptimal, limiting the ability to streamline patient pathways and optimise staff productivity.

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**Estate Condition:** The overall condition of the hospital infrastructure is poor, contributing to high levels of backlog maintenance. Backlog is currently estimated at £54.6 million (excluding RAAC remediation costs).

The redevelopment of Nevill Hall Hospital provides an opportunity to address these issues through a comprehensive reconfiguration and investment in modern, sustainable infrastructure.

### **1.4 Service Overview**

The plan for Nevill Hall hospital, as part of the Clinical Futures Strategy was delivery of the majority of hospital services focusing on general and routine care (elective, sub-acute, rehab, palliative, therapies, outpatients, investigations)

- Emergency care available 24/7 – with link to the Grange University Hospital
- Proposed Cancer Centre & Satellite Radiotherapy Unit
- Surgical Day Centre
- Care of the Elderly COTE – Elderly Frail Unit (EFU)
- Enhanced services available including MRI, CT, medical assessments from 8:00-20:00
- Reconfiguration of the site to keep it updated including proposed refurbished single 'front door'
- A dedicated, purpose designed Children's Outpatient Department providing dedicated waiting areas and play area; Clinic rooms and counselling facilities; Family room; and children's centre for children with disabilities
- Consultant and midwife antenatal and postnatal care
- Midwifery led birthing unit for women who are likely to have normal deliveries, with single en-suite delivery and aftercare rooms and water birth facilities

The current clinical model at NHH includes:

**Minor Injuries Unit (MIU):** Offers urgent care for minor injuries and illnesses (Open from 7.00am to 1.00am, seven days per week)

**Main Outpatients Department:** Provides a wide range of specialist outpatient clinics for consultations, follow-up care, and minor treatments.

**Day Surgery Unit:** Performs surgical procedures, enabling patients to undergo surgery and return home on the same day.

**Diabetes Centre:** Focuses on the management and treatment of diabetes, offering comprehensive care including patient education, monitoring, and support.

**Children's Centre:** Delivering specialised services to address the health needs of children.

**Diagnostic Services:** including radiology and pathology services, for accurate and timely diagnosis of medical conditions.

**Gynaecology Ambulatory Care:** Provides specialised outpatient care for gynaecological conditions, emphasizing non-emergency and ambulatory services.

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**Haematology Day Unit:** Delivers day treatments for blood disorders, such as chemotherapy and transfusions, for patients requiring ongoing haematological care.

**Medical Inpatient Wards:** Offers inpatient care for patients with a variety of medical conditions, ensuring continuous monitoring and treatment.

**Orthogeriatric Step Down Ward:** Provides specialised care for elderly patients recovering from orthopaedic surgery or injuries, facilitating their transition from acute care to home or other care settings.

**Day Hospital:** Offers specialised services including rheumatology clinics and other specialist outpatient services.

**Pharmacy:** Delivers comprehensive pharmaceutical care, including medication dispensing, management, and advice.

**Research and Delivery:** Facilitates the delivery of clinical research and trials, supporting innovation and evidence-based improvements in patient care.

**Endoscopy services:** diagnostic and therapeutic endoscopic procedures for a range of gastrointestinal conditions.

**Urgent Primary Care:** Provides urgent primary care services and GP out-of-hours care for patients needing immediate attention.

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**1.4.1 Summary of Services across North Gwent**

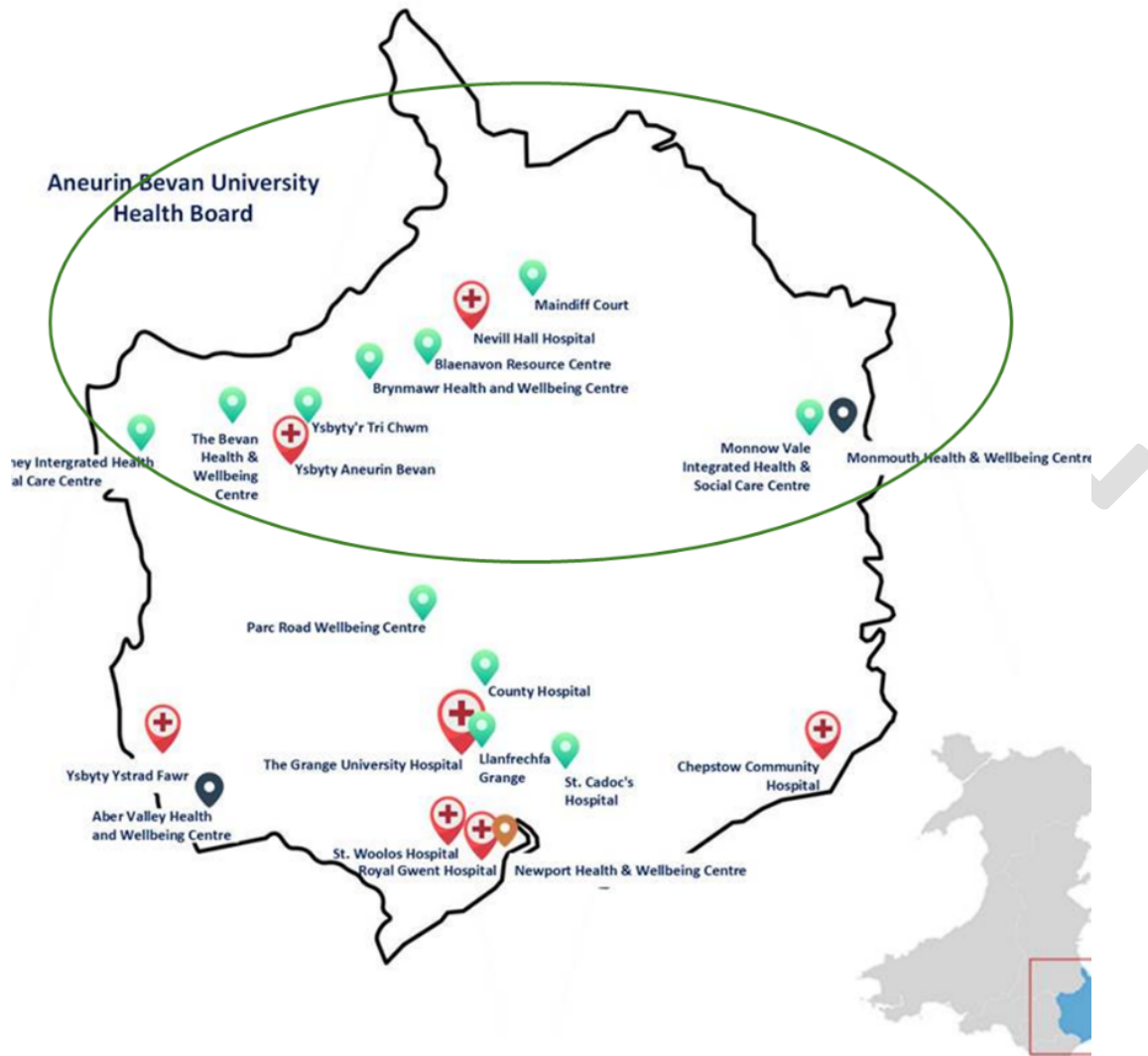


Figure 4: Maps of ABUHB Sites

The role of Nevill Hall Hospital is central to the delivery of the North Gwent service model, which is made up of a network of interconnected community hospitals, health and wellbeing centres, and specialist mental health facilities. Table 2 below provides a summary of the key services delivered across North Gwent:

Site	Services
Nevill Hall Hospital, Abergavenny	<ul style="list-style-type: none"> <li>• Day surgery</li> <li>• Outpatients</li> <li>• Gynaecology ambulatory care</li> <li>• Haematology Unit</li> <li>• Diabetes Centre</li> <li>• Minor Injuries Unit</li> <li>• Medical Inpatient Ward</li> <li>• Orthogeriatric Step down</li> <li>• Day Hospital</li> <li>• Pharmacy</li> <li>• Diagnostics</li> <li>• Children’s centre</li> <li>• Maternity ANC</li> <li>• Health Visiting</li> <li>• School Nursing</li> </ul>

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Maindiff Court, Abergavenny	<ul style="list-style-type: none"> <li>• MH&amp;LD Outpatients and ECT</li> <li>• Adult Community Mental Health Team</li> <li>• Older Adult Mental Health</li> <li>• Primary Care Mental Health</li> <li>• Adult Mental Health Rehabilitation ward</li> <li>• Mental Health Residential Units</li> </ul>	<ul style="list-style-type: none"> <li>• Learning Disabilities Service</li> <li>• Substance Drug and Alcohol Service</li> <li>• Veterans Service</li> <li>• Eating Disorder Service</li> <li>• Health Visiting</li> <li>• School Nursing</li> </ul>
Ysbyty Aneurin Bevan, Ebbw Vale	<ul style="list-style-type: none"> <li>• Adult Acute Mental Health Ward</li> <li>• Adult Community Mental Health Team</li> <li>• Minor Injuries Unit</li> <li>• Radiology Department</li> <li>• Outpatient Department</li> </ul>	<ul style="list-style-type: none"> <li>• Maternity Birthing Pool</li> <li>• Physiotherapy Department</li> <li>• Podiatry</li> <li>• Diagnostic Imaging</li> <li>• Family &amp; therapies</li> <li>• Children's department</li> </ul>
Ysbyty Tri Cwm, Ebbw Vale	<ul style="list-style-type: none"> <li>• Mental Health Inpatient ward (Dementia Assessment Unit)</li> <li>• Older Adult Community Mental Health Team</li> <li>• Older Adult Memory Assessment Service</li> </ul>	<ul style="list-style-type: none"> <li>• MH&amp;LD ADHD Service</li> <li>• Primary Care Mental Health Support Service</li> <li>• Older Adult Mapping</li> <li>• Education and Carers Service</li> </ul>
Brynmawr Health & Wellbeing Centre	<ul style="list-style-type: none"> <li>• GMS Services</li> <li>• Pharmacy</li> <li>• Dental</li> <li>• Memory Assessment Clinic</li> </ul>	<ul style="list-style-type: none"> <li>• AAA</li> <li>• District Nurses</li> <li>• Psychology</li> <li>• Diabetic eye screening</li> <li>• Family and Therapy clinics</li> </ul>
The Bevan Health and Wellbeing Centre, Tredegar	<ul style="list-style-type: none"> <li>• GMS Services</li> <li>• Pharmacy</li> <li>• GDS</li> <li>• Health Visitors</li> <li>• District Nurses</li> <li>• Midwifery</li> <li>• Lymphoedema</li> <li>• Diabetic Eye Screening</li> <li>• Gwent Specialist Substance Misuse Service</li> <li>• CAMHS</li> <li>• Adult Mental Health Psychology Service</li> <li>• Podiatry</li> <li>• Audiology</li> </ul>	<ul style="list-style-type: none"> <li>• Perinatal Mental Health</li> <li>• Children's Weight Management Clinic</li> <li>• Community S&amp;LT</li> <li>• Lac / School Nursing Team</li> <li>• Eating Disorder Service</li> <li>• All Wales Diabetes Prevention Programme</li> <li>• Child and Family Psychology</li> <li>• Smoking Cessation</li> <li>• Veterans Service</li> <li>• Occupational Therapy: Blaenau Gwent Community Mental Health Team</li> <li>• Flying Start Breast Feeding Support Group</li> <li>• Expert Patient Programme – GAVO (Gwent Association of Voluntary Organisation)</li> <li>• Family Therapy</li> </ul>

Table 2: Summary of North Gwent Services

## **Strategic Outline Case:**

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### **1.5 Business Needs – Current and Future**

The Nevill Hall Hospital (NHH) development project seeks to address service gaps and operational challenges, ensuring that NHH is fit for purpose to meet the current and future needs of the local population. Since the opening of Grange University Hospital, the Health Board has faced several key challenges, which highlight the need for service improvements at NHH:

- Many of our services are under severe pressure and not always set up in such a way as to ensure efficiency and effectiveness
- The Health Board is under significant financial pressure, affecting our ability to invest in priority service areas
- Additional beds were added to the system during COVID-19, exceeding the capacity initially planned under the Clinical Futures strategy. This increased bed count is unsustainable due to staffing and financial limitations, highlighting the need for a more efficient model of care.

These issues, coupled with the presence of RAAC and a backlog of high-risk maintenance, reinforce the urgent need for a more effective, sustainable model of care at NHH. To ensure effective system operation and sustainability, the enhanced Local General Hospital (eLGH) sites, including NHH, must be designed with a fit-for-purpose and sustainable workforce model. This model should be capable of delivering high-quality, accessible care that meets the evolving needs of the local community.

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### 1.6 Potential Scope and Service Requirements

The scope of the Nevill Hall Hospital redevelopment has been shaped through extensive clinical engagement, feasibility testing, and alignment with key strategic drivers. To support decision-making and future design development, requirements have been grouped into three categories: Core (Essential), Desirable, and Optional, based on their contribution to safety, compliance, service sustainability, and long-term transformation goals (Table 3: Scope Options).

While the current business case is focused on addressing critical estate and service needs, most notably the removal of RAAC and delivery of a sustainable eLGH model, there are broader opportunities for the Nevill Hall site that could be explored as part of a longer-term Development Control Plan. These include the potential for integrated primary care provision, such as a co-located GP surgery, and the development of staff accommodation in partnership with housing providers to support workforce sustainability. While these opportunities are not within the immediate scope of this investment, they remain important strategic considerations that can be developed further once the core infrastructure and service model are secured.

Requirement Level	Definition	Description
<b>Core / Essential</b>	<i>These are non-negotiable elements that must be included in the project to meet fundamental goals, such as safety, compliance, and the immediate healthcare needs of the community. Core requirements directly impact the hospital's ability to operate effectively and sustainably.</i>	<ul style="list-style-type: none"><li>• Removal of Reinforced Autoclaved Aerated Concrete (RAAC), and repair of the precast frame, to address structural risk and ensure ongoing compliance.</li><li>• Refresh of clinical model to deliver a fit-for-purpose eLGH model, including inpatient wards, day surgery, diagnostics, outpatient care, rehabilitation, family and therapies and appropriate supporting clinical and non-clinical functions to support.</li><li>• Establishment of a sustainable workforce and finance model, supported by an environment that enables agile, multidisciplinary working.</li><li>• Incorporation of decarbonisation measures, improved patient flow, and modern estate design aligned with NHS Wales standards.</li><li>• Integration of digital infrastructure and capability to support agile working, digital-first care models</li></ul>
<b>Desirable</b>	<i>These elements add significant value to the project but are not strictly</i>	<ul style="list-style-type: none"><li>• Refurbishment of ward block (H Blocks)</li><li>• Rationalise Maindiff Court as part of an efficient use of resources within the Health Board's estate.</li></ul>

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	<p><i>required to meet the minimum operational standards. Desirable requirements aim to enhance service delivery, patient experience, and operational efficiency. They support long-term goals.</i></p>	<ul style="list-style-type: none"> <li>• Provide an administrative hub for staff to maximise clinical spaces and meet the demand for non-clinical spaces within the hospital</li> </ul>
<p><b>Optional</b></p>	<p><i>These are additional features that provide added benefits but do not impact the project's core functionality or primary objectives. Optional requirements may be included if resources permit and can enhance the overall patient experience and community support.</i></p>	<ul style="list-style-type: none"> <li>• Consider Ysbyty Tri Chwm (YTC), which has a mental health ward, as an option to support broader care needs by relocating the mental health ward to NHH and repurposing YTC for community use.</li> </ul>
<p><b>Future Opportunities</b></p>	<p><i>These are potential future developments or service enhancements that are not currently included within the scope of this business case but align with long-term strategic goals. They may be considered in future phases or aligned programmes, subject to funding availability,</i></p>	<ul style="list-style-type: none"> <li>• Development of a primary care hub or co-located GP surgery to support integrated out-of-hospital care models.</li> <li>• Staff accommodation delivered in partnership with local housing associations</li> <li>• Opportunities to further consolidate community services</li> <li>• Maggie's Centre</li> </ul> <p><b>While outside the immediate scope of this business case, these future opportunities are strategically important and may be considered as part of a future Development Control Plan.</b></p>

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	<i>partnership development, or wider system planning.</i>	
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Table 3: Scope Options

**1.6.1 Scope Options to Address the Case for Change**

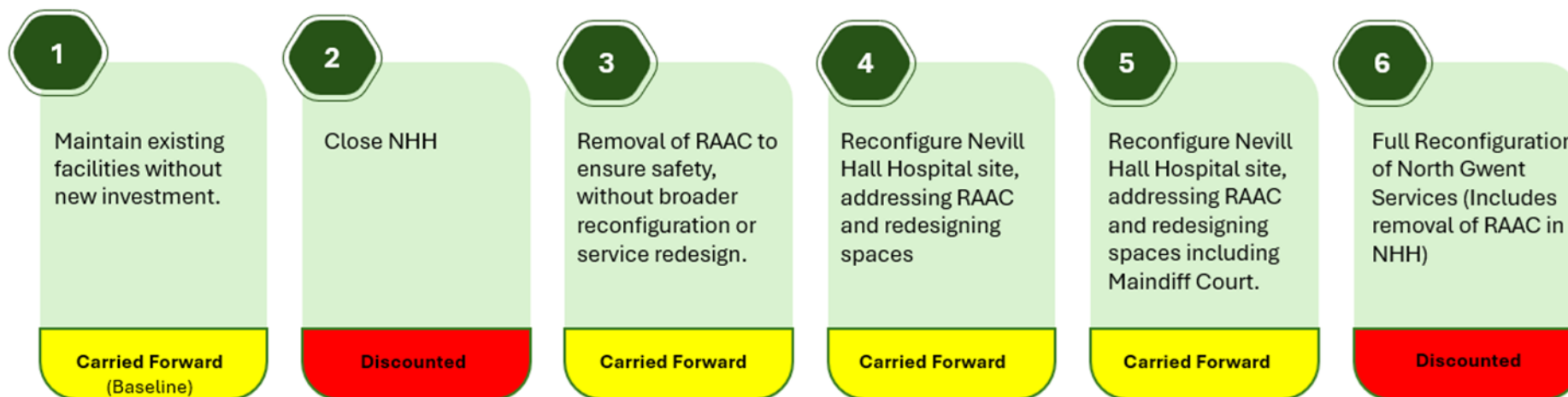


Figure 5: Diagram of Scope Options

In response to the challenges outlined, including ageing infrastructure, the presence of Reinforced Autoclaved Aerated Concrete (RAAC), suboptimal clinical adjacencies, and the need for a modernised service model 6 scope options were identified (Figure 5).

- Option 1:** Maintain existing facilities without new investment – RACC mitigation only
- Option 2:** Close NHH – Discounted due to unacceptable impact on access, acute resilience, and local service provision.
- Option 3:** Remove RAAC only – Carried forward due to the urgent need to mitigate structural risk, although it does not address wider service or estate inefficiencies.
- Option 4:** Reconfigure NHH site (RAAC removal + redesign) – Carried forward as a feasible option delivering improved safety, service flow, and modern infrastructure.

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**Option 5:** Reconfigure NHH including Maindiff Court – Carried forward as it supports rationalisation of the estate and integrated service delivery.

**Option 6:** Full reconfiguration of North Gwent services – Discounted at this stage due to the scale and complexity of the option, the significant funding and time required to develop a business case, and the urgent need to address RAAC risks at Nevill Hall Hospital. While outside the immediate scope of this business case, these future opportunities are strategically important and may be considered as part of a future Development Control Plan.

The [Economic Case](#) provides a detailed appraisal of the long list of options.

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## 1.7 Enabling Capabilities

To address the challenges outlined in the Business Needs section, and in alignment with the project scope options, the NHH Development Project aims to enable a set of core capabilities aligned with the Health Board’s strategic priorities. These reflect the new ways of working required to deliver safe, sustainable, and high-quality care, and form the foundation for the project’s expected benefits.

Enabling capabilities are the key systems, functions, and ways of working that must be in place to support delivery of the project’s objectives. Table 4 outlines the enabling capabilities required to support delivery of the project’s objectives. These capabilities are aligned with the Health Board’s strategic priorities and underpin the transformation needed to deliver safe, sustainable, and high-quality care.

Capability	Description
Refreshed Clinical Model	Standardised operating procedures, improved patient pathways, generic outpatient and treatment spaces, and purpose-built facilities to support integrated, multidisciplinary care. Includes the rightsizing of services aligned to population need, ensuring services are designed based on evidence and demand, improving access and outcomes for the north Gwent population.
New Development at the NHH Site	Delivery of a modern estate with improved layout, low-carbon infrastructure, enhanced patient access (e.g. drop-off zones, signage), and more efficient use of space.
Sustainable Workforce and Financial Model	Workforce model that supports agile/hybrid working, improves staff wellbeing and retention, and reduces reliance on temporary staffing, underpinned by cost-effective resource use.

Table 4: Enabling Capabilities

## 1.8 Refreshed Clinical Model

The new clinical service model will be developed embedding the following principles (Figure 6):



Figure 6: Design Principles

### 1.8.1 Clinical Model

The Nevill Hall Development Project is centred on delivering high-quality, sustainable care through a modernised, integrated clinical model. Aligned with the Clinical Futures strategy and wider system needs, the proposal positions NHH as an enhanced Local General Hospital (eLGH), supporting general and routine care closer to home. It enables best practice through:

The future model is designed around:

- **Integrated, system-wide pathways** supporting early intervention and whole-system flow.
- **Diagnostics and Treatment Services** to improve access and reduce delays.
- **Local Assessment Services** that minimise unnecessary admissions.
- **Non-clinical enablers** (digital, workforce, estates) that underpin safe, agile care.
- Delivery of **children's services** through the existing Children's Centre

### 1.8.2 Proposed Clinical Model – Summary Overview

Table 5 provides a summary overview of the proposed clinical model, highlighting the key focus areas and planned transformations across both clinical and non-clinical service model.

Model	Model Focus and Key Transformation
Elective Care	High-efficiency outpatient, day case and surgical activity to improve flow. <b>Day Surgery and treatment centre</b> , with increased <b>HVLC</b> throughput and regional ophthalmology provision. <b>Outpatient Treatment Unit</b> within a flexible, generic outpatient model.
Diagnostics	Enhanced <b>local diagnostics</b> , pharmacy and support services to enable effective treatment.
Urgent & Emergency Care	<b>Integrated Front Door model</b> with local assessment and medical inpatient services. New assessment model and <b>inpatient bed base</b> , aligned to system demand.
Cancer Care	Local <b>SACT delivery</b> , diagnostic and follow-up care within specialist unit. Expanded local SACT services, aligned with <b>Velindre @ NHH</b> model
Family & Therapies	<b>Multidisciplinary team (MDT)</b> working embedded across care pathways. Inpatient and outpatient therapies and Children’s Centre
Mental Health	<b>Modernised services</b> integrated with community and inpatient models. Relocation of adult, older adult, and LD services from Maindiff Court to NHH for co-location and estate consolidation.
Non-Clinical Services	Safe, sustainable support services and infrastructure enabling effective clinical care. Adoption of <b>agile working</b> model and <b>admin hub</b> . Catering transitions to regeneration model. Infrastructure upgrades support digital, estates, and FM functions.

Table 5: Summary of Clinical Model

The clinical model has been approached from a whole-system perspective and the interdependencies across the Health Board’s acute and community sites. The modelling undertaken has recognised the Health Board Strategies, e.g. Place Based Care ensuring the optimal location of activity across the estate to improve patient flow, maximise the use of existing assets, and align activity to the appropriate level of acuity. This ensures that services are delivered in the most efficient and effective setting, supporting system-wide sustainability and improved patient outcomes. Future stages of the business case will continue to test and refine this approach in collaboration with regional partners to ensure alignment with broader service models and population health need

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**Strategic Fit**

- **Aligned with National Policy Direction:** including, GIRFT, and sustainability agendas: the model supports national priorities including *Getting It Right First Time (GIRFT)*
- **Supports Whole-System Flow and Resilience:** NHH, as an enhanced Local General Hospital (eLGH), plays a critical role in supporting flow from the Grange University Hospital (GUH) and maintaining capacity across the wider health system, enabling right care, right place, first time.
- **Enables Workforce Sustainability:** Modernised clinical environments, integrated team models, and agile working infrastructure help retain and attract staff, improve efficiency, and support new ways of working.

A summary of the proposed changes to the model of care at Nevill Hall Hospital (NHH) as part of the NHH Development Project, categorised by service type and transformation approach.

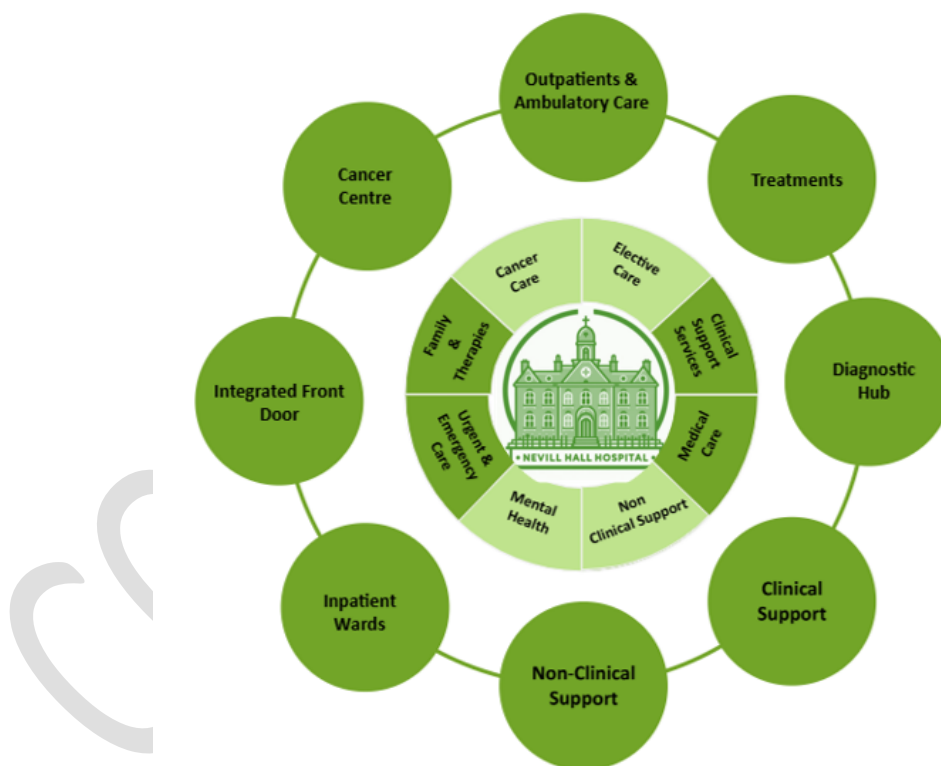


Figure 7: Clinical Model Diagram

The tables below outline the service model across the following key models:

- **Elective Care**
- **Diagnostics**
- **Urgent Care – Assessment and Inpatient**
- **Family and Therapies**
- **Mental Health**

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- **Cancer**
- **Non-Clinical Services**

The following definitions provide clarity on key terms used throughout the table:

**Proposed Change Levels**

**No Change** – The service remains in its current form with no modifications.

**Minor Change** – Small-scale adjustments to improve efficiency or patient experience, with minimal impact on service delivery.

**Moderate Change** – More substantial changes, such as service reconfiguration, pathway redesign, or relocation within the existing hospital footprint.

**Major Change** – Significant transformation, such as merging services, expanding capacity, or restructuring clinical functions. While new estate may be built to improve pathways and patient flow, this does not necessarily indicate a major change to clinical pathways. A major change would involve fundamental transformations in the way a service is delivered, impacting clinical pathways, workforce structures, or patient access.

**New Service** – A service that is being introduced to enhance patient care and address emerging healthcare needs.

**Relocation** - The service will be moved within NHH or to another site within the Health Board to improve access, optimise space, or align with strategic priorities.

**Decommissioned** – Services that will no longer be provided

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### 1.8.3 Elective Care Model

Table 6 provides a detailed summary of proposed changes across elective care services, including day surgery, outpatients, and associated specialist functions.

<b>Elective</b>			
<b>Area</b>	<b>Service</b>	<b>Level of proposed Change</b>	<b>Summary of proposed change</b>
Day Surgery and treatment centre	Theatres All surgical specialties	Major Change	<p>The day surgery model will undergo major change, with a shift towards a bespoke day case model based on best practice (Getting it Right First Time – GIRFT accreditation).</p> <p>Dedicated theatre space for elective No. Theatres 4 – up to 2 Laminar Flow, 4 treatment rooms Plus (Regional) Ophthalmology – 2 Theatres, based on Exeter.</p> <p>There will be a dedicated Ophthalmology unit based on the Exeter model</p> <p>Opportunity to increase in throughput of day cases increasing BADS (British Association of Day Surgery) overall delivery from 65% to 70%.</p> <p>Introduction of a bespoke day case model, focus on HVLC (High Volume Low Complexity) procedures, requires new pathways, workflows,</p>

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			<p>and infrastructure adjustments in line with GIRFT recommendations</p> <p>DSU with extended hours to accommodate some intermediate procedures who require longer than a standard day surgery admission but do not require an overnight stay</p>
Anaesthetics	Anaesthetics	Major change	<p>The anaesthetic model will evolve in line with changes to the day case service.</p> <p>Staffing and resource allocation will be adjusted to meet the demands of the updated day case pathway.</p>
Regional Ophthalmology	Regional Ophthalmology	Major change	<p>The regional ophthalmology service is an existing service</p> <p>Regional ophthalmology will be utilising Llanwenarth Suite as a dedicated theatre from end of March 25; core ophthalmology will also utilise this space for 3 core sessions per week. There is an assumption that this will not change.</p> <p>It is expected that regional work will need to expand to meet increasing demand and is therefore considered a major change. The preferred model is to incorporate back-to-back theatres, which would allow for greater efficiency in surgical throughput. This would be subject to a business case for the regional for sustainable cataracts service.</p>

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<p>Outpatients</p>	<p>General Surgery Dermatology Max Fax Eyes Orthopaedics ENT (Ears, Nose and Throat) Audiology Community Dentistry Gynaecology General Medicine Gastro Respiratory Sleep COTE (Care of the Elderly) Cardiology Neurology Stroke Rheumatology (GOPD) MS (Multiple Sclerosis) Infusions Anaesthetics ITU Nephrology Neurophysiology Endocrinology Speech and Language Therapy Plastic surgery Medical Genetics Bladder and Bowel Psychology Tissue Viability Nurse Paediatric</p>	<p>Minor Change &amp; new service</p>	<p>Outpatient services will transition to a flexible, generic space model, with consultation and examination rooms designed to support multiple specialties, maximising occupancy, utilisation, and future-proofing the estate. Specialty-specific rooms will be provided only where necessary. To support this model, a standardised room booking and scheduling platform will be required.</p> <p>Virtual Appointments – Dedicated spaces for clinicians near clinical rooms to support virtual consultations while ensuring clinical spaces remain prioritised for face-to-face care. Optimisation frameworks being implemented to facilitate in space for ‘mega clinics’</p> <p>A new outpatient treatment service will be introduced at Nevill Hall Hospital, replicating the existing model currently operational at Royal Gwent Hospital. The specific procedures to be delivered are to be confirmed.</p> <p>Maindiff Court outpatient activity provided in bespoke space appropriate for the needs of these patients.</p>
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	Outpatients Treatment Unit		
Ophthalmology OPD	Ophthalmology	No Change & Potential New Service	The service currently delivers diagnostics, laser, outpatients and orthoptics. While core Ophthalmology OPD services will remain unchanged, there is potential for a service reconfiguration and expansion into a full diagnostic hub, contingent on estate availability. This would involve pathway redesign, space reallocation, and service integration
Cardiology Centre	Cardiology	Minor Change	Service currently provide Cardiac rehabilitation and cardiology centre on level 1.
Rheumatology Day Unit	Rheumatology	No change	Rheumatology Day Unit incorporated in the Outpatient Unit to remain as there is no suitable site on any other HB site.
Diabetes Centre	Diabetes	No change	Diabetic Day centre currently on level 1
Respiratory	Respiratory	No change	Respiratory services, including the sleep service and bronchoscopies currently in Llanwenarth Suite Respiratory specialist nurses, physiologists, and chest clinic area. These services would have dedicated specialist space where needed and incorporated in the Outpatient Unit where appropriate
Inpatient Ward - Surgical	Orthogeriatric	No Change	Orthogeriatric ward model will remain unchanged (25 beds)
	Clinical Photography	No change	No fundamental changes to the clinical photography model are planned. The service will need to be positioned near the Outpatients Department to support operational efficiency and patient accessibility.

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Research & Delivery	Research and Delivery	No change	A dedicated research office allows for storage of active trials, clinical workspace and designated lab is required.
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*Table 6: Elective Model*

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**1.8.4 Diagnostic Model**

Table 7 provides a detailed summary of the proposed changes across diagnostic services, including endoscopy, radiology, pathology, and pharmacy.

<b>Diagnostics</b>			
<b>Area</b>	<b>Service</b>	<b>Level of proposed Change</b>	<b>Summary of proposed change</b>
Endoscopy	Endoscopy	Minor	<p>The service will be for routine elective cases as per current model however will include some inpatient slots to prevent inpatients from requiring unnecessary transfer to GUH.</p> <p>There will be no emergency endoscopy service at NHH in line with current provision.</p> <p>There is a need for further expansion to meet ongoing service demands, screening changes and achieve cancer RTT targets. Additionality will be driven through efficiencies, expansion at RGH to 7 days (subject to funding) and access to LHP (subject to funding)</p> <p>The service proposes it requires a 2-theatre unit at NHH, similar to the development, as a standalone unit.</p>
Radiology	Radiology MR CT Plain / US Dental Imaging	Minor plus new service	<p>Radiology services at NHH currently include X-ray, CT, MRI, Mammo, Ultrasound, Vascular Ultrasound, and Nuclear Medicine. These services are proposed to remain on site, with the space to add a second MRI</p>

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	<p>Nuclear Medicine Vascular Ultrasound Option for PET and 2nd MRI</p>		<p>scanner to enhance diagnostic capacity and meet growing demand. The model is in alignment with regional planning for Community Diagnostic Centres (CDCs) via an in-house management model</p>
<p>Pathology</p>	<p>Pathology Haematology Blood Transfusion Biochemistry Phlebotomy POCT Andrology CADT / Body store ETR</p>		<p>Blood Bank: On-site service, Mon–Fri, 9–5, with 24/7 emergency blood collection. Includes product storage, batch cupboard, emergency fridge, and staff desk area. Point of Care Testing (POCT): Maintained for rapid testing where laboratory services are unavailable. Includes staff desk space, cold and room temp storage, and connection to Blood Bank.</p> <p>Body Store: 5 spaces with vehicular access, wash facilities, and admin area. No family viewing: reduced capacity will need to be offset elsewhere.</p> <p>Andrology: To be relocated offsite to another Health Board location, co-located with required facilities.</p> <p>Stores: Supplies for primary and secondary care to be managed at IP5 site by Shared Services.</p> <p>Administration:</p>

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			All admin and office functions to move offsite, including hot desks, supervisor and manager bases, and consultant rooms.
Pharmacy	Pharmacy	No change	<p>The pharmacy service will continue operating as it currently does, with no planned changes to its core functions.</p> <p>The existing pharmacy robot at NHH requires replacement; it currently provides an income stream, and there is a special licence linked to the service.</p> <p>NHH holds a Wholesale Distributor Authorisation (WDA) with MHRA, allowing it to supply medications to external entities such as PTHB (Stocklines), WAST, and St David's Hospice.</p> <p>NHH is also registered with the General Pharmaceutical Council (GPhC) to dispense named patient lines to PTHB.</p>

Table 7: Diagnostic Model

**1.8.5 Urgent Care Model**

Table 8 summarises the proposed changes for urgent care and inpatient services at Nevill Hall Hospital, including current planning assumptions and areas where further work is required.

<b>Urgent Care – Assessment and Inpatient</b>			
<b>Area</b>	<b>Service</b>	<b>Level of proposed Change</b>	<b>Summary of proposed change</b>
Integrated Front Door	Intake Model UPC (Urgent Primary Care) MIU (Minor Injuries Unit) Assessment Unit Operation Hub – admin and consultant space available in dept. Discharge lounge	tbc	<p>There will need to be an assessment facility and service at NHH in the future to respond to population needs and support the wider urgent and emergency care system.</p> <p>The service will need to be sustainable from a demand and workforce perspective</p> <p>Further work in ongoing to fully design, test and agree the model. This will emerge as part of the 2025/26 HB plan.</p> <p>Planning assumptions at this stage is that MIU and UPC will be on NHH site.</p>
Inpatient Ward	COTE / Gen Med	tbc	<p>There will be a requirement for inpatient beds to support the wider hospital network and to respond to the front door assessment model.</p> <p>Assumption for SOC is for Bed base to return to Clinical Futures agreed numbers (157 medical beds plus 24 spaces on AMU)</p>

Table 8: Urgent Care Model

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			Exact designation of beds will be determined as part of OBC planning
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**1.8.6 Family and Therapies Model**

Table 9 provides a summary of proposed changes across family and therapy services, outlining the anticipated scale of change and key service dependencies.

<b>Family and Therapies</b>			
<b>Area</b>	<b>Service</b>	<b>Level of proposed Change</b>	<b>Summary of proposed change</b>
Therapy & Rehabilitation Inpatient Model	Physiotherapy Occupational Therapy Speech and Language Dietetics	tbc	<p>Inpatient models will influence therapy service delivery, workforce planning, and space requirements, therapy space will be incorporated into refurbishment of inpatient ward areas.</p> <p>Physiotherapy (Inpatient) Currently lacks dedicated ward-based rehab space; relies on main physiotherapy department. Future model requires improved proximity to wards, safe stair access for assessments, and enhanced rehab facilities.</p> <p>Occupational Therapy (Inpatient) needs to remain onsite to support hospital discharge. Requires dedicated facilities for assessments/interventions aligned with future ward configuration.</p> <p>Speech &amp; Language Therapy (Inpatient) delivered via in-reach model; future provision</p>

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			<p>depends on which specialties (e.g., Care of the Elderly, Cancer Centre) remain on site.</p> <p>Dietetics (Inpatient) services depend on the type of inpatient care retained at NHH (e.g., elderly care, trauma). Future staffing and location plan dependent on clarity regarding inpatient specialties.</p>
<p>Children Centre</p>	<p>Maternity &amp; Community Midwifery                  Health Visiting, School Nursing, Looked After Children Services                  Children with Disabilities (Therapies, Community Paediatrics, Psychology)                  Child &amp; Family Psychology                  Paediatric Outpatients (General &amp; Sub-specialty)                  CAMHS (Primary, Secondary, Neurodevelopmental services)                  Dietetics &amp; Speech &amp; Language Therapy (Paediatrics)                  Podiatry &amp; Orthotics (Paediatric services)</p>	<p>Major Change</p>	<p>Services currently delivered for children with complex and additional learning needs will be enhanced through modern, up-to-date facilities, with clear links to interdependent services including maternity, paediatrics, and CAMHS.</p> <p>The centre will bring together maternity services, specialist services for children with additional and complex needs, and adolescent services (including transition) under one roof – ensuring a consistent and coordinated patient journey from birth through to the age of 25.</p> <p>Further discussion is needed to define the specific clinical models for each of the services currently supporting children with complex and additional learning needs.</p> <p>This integrated model cannot be delivered within the footprint of the existing Children’s Centre</p>

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<p>Outpatient Centre</p>	<p>Physiotherapy (Inpatient &amp; Outpatient – MSK, Neuro, Respiratory, Pelvic Health) Occupational Therapy (Inpatient and Long-Term Conditions) Speech &amp; Language Therapy (Adult services) Dietetics &amp; Weight Management (Adult services) Podiatry &amp; Orthotics (including workshop space) Symptom Management Service (Adferiad/Chronic Fatigue, Fibromyalgia, Persistent Pain)</p>	<p>Major Change</p>	<p>Outpatient model to be revisited in line with the emerging rehab strategy and community partnership model</p> <p>Inpatient model aims would be to co-locate as many rehabilitation services as possible on site, with better access to wards and improved storage facilities.</p> <p>Co-location of therapy teams will support efficient multidisciplinary working and improved patient flow.</p> <p>The Physiotherapy Outpatient services model is to be reviewed in line with community delivery delivered from NHH Physiotherapy Outpatient department includes MSK, Respiratory, Neurology &amp; Pelvic Health. Staff are also based in the department that supports Cardiac Rehab provision which is provided at a different location on the site. The department also houses GWICES peripheral store for inpatient and outpatient equipment.</p> <p>The GWICES peripheral store for inpatient and outpatient equipment, currently located in the physiotherapy department, must also be accommodated within the new centre. Suitable hotdesking through the administration hub and group rooms are needed for flexible working and outreach service delivery. Currently, group delivery is limited due to</p>
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			space constraints, particularly because of RAAC and asbestos risks.
Women's Health Centre within Day Case and Outpatient Centre	Gynaecology Ambulatory Care Unit Sexual & Reproductive Health Services Bladder & Bowel Services	Major Change	Expanded clinical space for cancer diagnostics and treatment. Increased theatre use and extended hours for day case procedures. Hub-and-spoke model maintained (NHH as hub; Caldicot as spoke). Flexibility for multi-use procedure rooms Maintain and build on the work being undertaken at the Gynaecology Ambulatory Unit (GAU) – Since opening in 2020, the number of women's health procedures and services delivered at the GAU has continued to increase. We need to ensure expansion of the service is possible at Nevill Hall, ensuring that Sexual & Reproductive Health and Bladder & Bowel services also continue to be delivered on site (Bladder & Bowel to remain separate from Women's Health Unit).
Community Services	Health Visiting Community Midwifery	Major Change	There are a range of services including Health Visiting and Community Midwifery that are in and around the Abergavenny area including at GP premises. There have been increased instances of our services needing to vacate such venues at short notice. Delivering services at a dedicated centre at Nevill would provide a certain future to our services who rely on clinic venues to deliver a significant proportion of their models. In addition, data shows that attendance for Health Visiting

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			appointments is higher at hospital sites than at community venues.
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Table 9: Family and Therapies Model

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**1.8.7 Mental Health Model**

Table 10 outlines the proposed changes across Mental Health services, summarising the key relocations planned as part of the Nevill Hall Hospital redevelopment.

<b>Mental Health</b>			
<b>Area</b>	<b>Service</b>	<b>Level of proposed Change</b>	<b>Summary of proposed change</b>
Older Adult	ECT (Electroconvulsive Therapy) Older Adult Monmouthshire CMHT (Community Mental Health Team)	Relocation	Relocation from Maindiff Court
Adult Mental Health	Eating Disorders Service Veteran Service North Monmouthshire Adult CMHT ABSDAS (Aneurin Bevan Specialist Drug and Alcohol Service) PCMHSS (Primary Care Mental Health) Ty Skirrid – Forensic Rehab Ward (16 beds)	Relocation	Relocation to Nevill Hall from Maindiff Court
Learning Disabilities	Monmouthshire CLDT (inc. Local Authority) Community Learning Disabilities Team	Relocation	Relocation to Nevill Hall from Maindiff Court

Table 10: Mental Health Model

**1.8.7.1 Cancer Model**

Table 11 summarises the proposed developments across cancer services, highlighting those that will remain stable and those that require regional planning or expansion.

<b>Cancer</b>			
<b>Area</b>	<b>Service</b>	<b>Level of proposed Change</b>	<b>Summary of proposed change</b>
Haematology Unit	Haematology Unit	No change	Based on ward 2/4 model Development of ways of working in line with developments of Velindre @ model (radiotherapy and SACT)
Satellite Radiotherapy Unit	Velindre @ Nevill Hall Radiotherapy Unit	No Change	Service to develop in line with SRU FBC – noting future phases for additional tumour sites likely subject to future planning across region
Outpatients	Systemic Anti-Cancer Therapy (SACT)	Major Change	In line with clinical model in the new Velindre Cancer Centre business case, the strategic direction of travel is for more SACT service to occur closer to home (and less in Velindre)  Currently 3-day service from Windsor suite (7 chairs).  Future planning with Velindre required to scope opportunities and requirements in NHH (and other AB sites)
Supporting patients with cancer			MDT meeting and hot desk space ABUHB / VCC Research hub Welfare and Benefits, inc. outreach from

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			ABUHB and Outreach Cancer Services Maggie's Centre is a future opportunity
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Table 11: Cancer Model

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**1.8.8 Non-Clinical Services Model**

Table 12 summarises the proposed changes and continuities across non-clinical services, including support functions, estates and administration

<b>Non-Clinical Services</b>			
<b>Area</b>	<b>Service</b>	<b>Level of proposed Change</b>	<b>Summary of proposed change</b>
Informatics	Medical Records	No change	Active scanning and destruction processes ongoing, but space needs remain high in the short to medium term. Future estates planning must consider appropriate, compliant, and secure storage environments for physical records and office accommodation for staff
Facilities Management (FM)	Catering Restaurant	Major Change	<p><u>Catering</u> Current patient catering model (Cook-Serve): Meals are freshly prepared, cooked in a central kitchen, and then distributed directly to patients for immediate consumption. New Model (Regen): Meals are pre-prepared, chilled or frozen, and then regenerated (reheated) at central kitchen before serving.</p> <p><u>Restaurant</u> Staff, patient and visitor restaurant / canteen with a hybrid approach with regen and traditional cook.</p>

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Facilities Management (FM)	Endoscopic Decontamination	No change	The fundamental service model will remain unchanged, but the decontamination unit is likely to be relocated within the hospital footprint to align with future operational and spatial planning. Maintaining proximity to the endoscopy unit is a key requirement to minimise transit time and enhance departmental communication. Surgical decontamination from Day Surgery Unit to be transferred to HSDU GUH as per current model
Facilities Management	Portering Cleaning Waste General Office Site Security Stores	No change	The facilities management model will remain unchanged, with portering, cleaning, waste, and general office services continuing as core functions.
Administration Accommodation	Quality and Patient Safety Overseas visitors Health and Safety Informatics Medical staffing Older adult psych liaison Palliative Care Infection control Primary care Mental Health Primary Care Volunteers	Relocation	As part of the Health Board's adoption of an agile working model, several non-clinical functions currently occupying office space within the hospital are proposed to be relocated. This aligns with the broader strategy of optimising clinical and patient-facing areas while supporting flexible and efficient working practices. The vision is for there to be a centralised staff admin hub where most admin activities will take place.

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	<p>Medical Secretaries                  Inpatient scheduling                  Outpatient booking                  Radiology booking                  Cancer Service - AOS                  Medicine Management Team (site lead, medical staffing, and senior nurses)                  nurse specialists and medical secretaries across multiple specialties                  Occupational Therapy                  Family and Therapies Management Team                  Eating Disorders Service                  Veterans Service                  North Mon Adult CMHT                  ABSDAS                  Learning Disabilities - Mon CLDT                  PCMHSS                  Health Visitors                  School Nursing                  CCNS                  PHN                  Consultants</p>		<p>Teams from Maindiff Court that do not require clinical space to be relocated to the administration centre.</p>
Medical Education	Medical Education	No change	Existing facilities and functions remaining unchanged
Works and Estates	Works and Estates	No change	Works and Estates service will remain unchanged, but it will require a defined footprint on-site to continue supporting the hospital's operational and maintenance needs effectively and adequate space for fleet car to support community sites.
Residential	Staff residence	No change	Residential accommodation is to be considered as part of future opportunities and a development plan for the site. It

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			remains unchanged within the scope of this case.
Chaplaincy	Chapel	No change	Service expected to continue with a chapel remaining on site to offer space for prayer and / or quiet reflection spiritual and pastoral care for patients, staff, and visitors
Creche	Crèche (non-HB service)	No change	The crèche is currently provided by a third-sector organisation occupying Health Board accommodation.

*Table 12: Non-clinical Service Model*

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## Strategic Outline Case:

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### 1.8.9 Demand and Capacity

The SOC focuses on the investment associated with delivering more effective care and estate at NHH. A large majority of services currently provided at NHH will remain on the site. The changes afforded by the development will facilitate a modern estate that will enable co-location of services and increased efficiency with the ability to respond to changes in the population and future technological developments.

It is important to stress at this stage are based on high level estimates derived from demand and capacity modelling of service requirements and the scale of change proposed. These will be further refined at the OBC stage.

The NHH Development Project forms part of the Clinical Redesign Programme, one of the Health Board's key priority transformation programmes. The objectives of the programme are to:

- Right-size key services
- Ensure as many services as possible are delivered closer to home
- Ensure services are efficient and sustainable
- Optimise flow
- Match workforce resource to demand

This Programme includes several changes and interdependencies which affect multiple pathways and sites across the Health Board not just NHH, the work is ongoing and includes:

- Medical and Inpatient model
- Therapies: Rehabilitation Strategy and model
- Mental Health: Future Models of Care
- Theatres: Daycase and treatment centre and regional delivery model
- Women's Health Plan

Many services will remain at NHH; however, a more in-depth exercise has been undertaken to determine the future anticipated demand and capacity requirements for elective procedures, in line with the existing Planned Care Programme, Theatre Maximisation Programme, and Regional Programmes including Endoscopy and Ophthalmology.

There is further work planned as part of the Planned Care Programme and Theatre Maximisation Programme aligned with benchmarking opportunities identified to increase efficiencies and utilisation based on the current models and anticipated from the reconfiguration. This will include new ways of working such as extended working, digital integration to improve pathways or new models of care.

The service requirements are outlined below in terms of the following patient pathways:

- **Elective Care**
- **Diagnostics**
- **Urgent Care – assessment and inpatient**
- **Cancer Care**
- **Family and Therapies**
- **Mental Health**

## **Strategic Outline Case:**

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### **1.8.9.1 Summary of Planning Intentions and Assumptions**

### **1.8.9.2 Elective Care**

- Theatre provision reflecting national policy and planning requirements for improved daycase throughput and high-volume low complexity activity and recommendation from the 2025 Ministerial Advisory Group
- Provision of outpatients offering opportunity for one stop shop models, mega clinics, tele health and virtual and outpatient treatments.

### **1.8.9.3 Diagnostics**

- The provision of services reflecting the current throughput, with the space to add a planned 2nd MRI to support the regional diagnostics programme, and the opportunity to future proof for PET is also provided.
- The development of Llantrisant Health Park will complement the development at NHH with maintenance of Endoscopy at current levels providing access to services in North Gwent.

### **1.8.9.4 Urgent Care and Emergency Care**

- Providing an integrated front door model based on current activity, with added provision for a Frailty SDEC. (Frailty SDEC is indicative and may be subject to change as the pathway is refined.)
- Inpatient model and take based on the Clinical Futures bed base and current site provision.

### **1.8.9.5 Cancer Care**

- A Southeast Wales hub for cancer services responding to population needs, addressing equity of provision and improving outcomes. Colocation of services and delivery of Outreach SACT to meet demand for 2030.

### **1.8.9.6 Family and Therapies**

- The Children's Centre future scope is based on current service models and activity levels and is to remain on site.
- The Women's Health Hub to be located on site with ambulatory care and centralization of services.
- Therapies inpatients services remain based on current activity levels and outpatients will be incorporated within the Outpatients Department.

### **1.8.9.7 Mental Health**

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- Maidiff Court & Mental Health OPD Cluster services located at Maidiff Court in scope for this project with capacity requirements to be based on current activity levels.

**1.8.9.8 Non-Clinical Support**

- The non-essential admin from OPD will be carried out in the central Admin block, however, this will need to be reviewed/confirmed by workforce. This facility is to include agile working and to accommodate staff from Maidiff Court

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**1.8.9.9 Elective Care**

Focused on planned procedures, outpatient treatment, and day surgery, designed to optimise efficiency and flow., including Outpatients, Theatres, Endoscopy

**1.8.9.10 Outpatients**

**1.8.9.11 Current Activity**

Outpatient activity has increased since the beginning of 21/22 (~8,000 appts per month) through to peaks of over 12,000 since 23/24 (Figure 8). This increase in growth in appointments delivered has stabilised since the end of 23/24 and has been used for forward assumptions.

The trend of face-to-face appointments is analogous to that of overall demand, with virtual appointments relatively now relatively static in the post, peak pandemic era.

Year-on-year outpatient activity by specialty is summarised in Table 13, demonstrating both high-volume areas and emerging service demand.

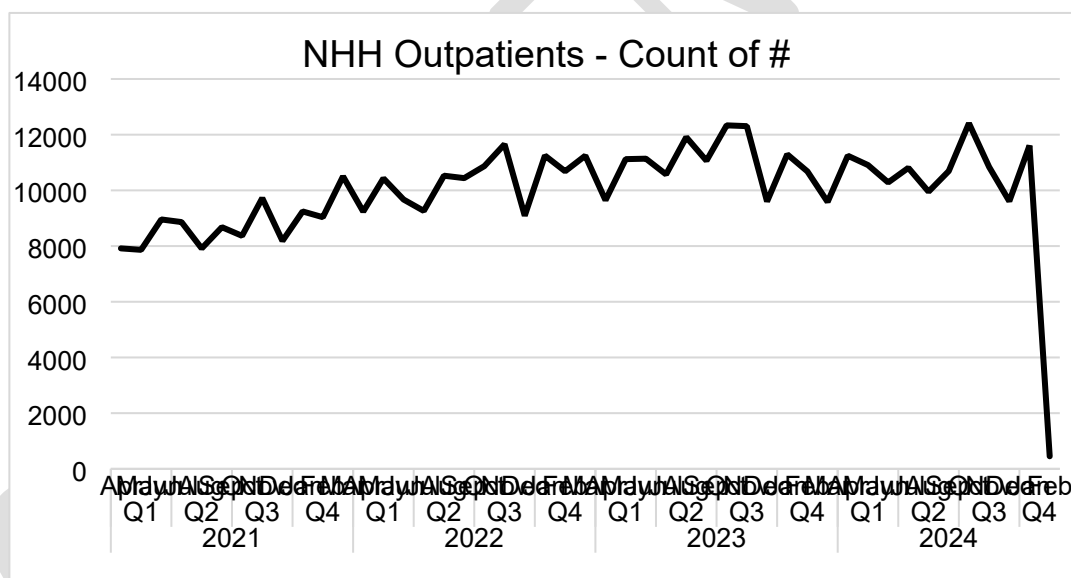


Figure 8: NHH Outpatients – Monthly Appointment Count by Quarter (Apr 2021–Feb 2025)

Specialty	2021	2022	2023	2024
Anaesthetics	3546	4857	153	162
Cardiac Rehab	0	0	1125	2315
Cardiology	9232	12113	13685	8582
Care Of the Elderly	1874	1767	1806	1688
Clinical Haematology	11172	12201	14246	11942
Clinical Microbiology	860	935	789	611
Critical Care Medicine	0	0	0	60
Dermatology	2172	3565	3909	3300
Diabetes & Endocrinology	2750	3058	51	0

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<b>Diabetic Medicine</b>	0	0	1711	1435
<b>Diagnostic Imaging</b>	0	201	165	632
<b>Dietetics</b>	62	379	490	364
<b>Ear Nose &amp; Throat</b>	2789	3240	3210	3302
<b>Endocrinology</b>	0	0	1223	1435
<b>Fostering and Adoption</b>	0	0	12	137
<b>Gastroenterology</b>	1959	1433	1711	1482
<b>General Surgery</b>	9881	8757	9005	3361
<b>Gynaecology</b>	8838	8958	10015	8784
<b>Infectious Diseases</b>	159	192	259	209
<b>Maternal Weight Management</b>	0	11	63	0
<b>Maxillo-Facial</b>	1626	1503	1359	1148
<b>Medical Virology</b>	2300	650	0	0
<b>Midwife Led Care</b>	1666	1744	2942	3191
<b>Nephrology</b>	1314	1349	1769	1725
<b>Neurology</b>	527	560	654	554
<b>Neurophysiology</b>	0	0	0	268
<b>Nursing Activity</b>	4	4	11	0
<b>Obstetrics</b>	1300	1212	1100	2209
<b>Obstetrics Ante Natal</b>	3127	2584	1692	144
<b>Occupational Therapy</b>	198	464	654	551
<b>Ophthalmology</b>	4497	4913	5180	3879
<b>Optometry</b>	0	0	0	99
<b>Orthodontics</b>	713	719	769	648
<b>Orthoptic - Medical Eyes</b>	1304	1514	1718	960
<b>Orthotics</b>	108	73	1002	825
<b>Pain Management</b>	0	1	0	0
<b>Palliative Care</b>	68	46	26	11
<b>Physiotherapy</b>	7064	9075	10338	9134
<b>Podiatry</b>	0	0	0	723
<b>Respiratory</b>	4723	5386	5453	4501
<b>Respiratory Physiology</b>	2743	3099	3649	3841
<b>Rheumatology</b>	4426	4823	5429	5119
<b>Sleep Medicine Service</b>	0	0	0	44
<b>Speech &amp; Language Therapy</b>	364	903	610	684
<b>Stroke</b>	102	326	288	206
<b>Transient Ischaemic Attack</b>	0	22	234	158
<b>Trauma &amp; Orthopaedic</b>	4089	14915	16757	13870
<b>Urology</b>	0	0	0	137
<b>Vascular Surgery</b>	57	657	125	152
<b>Total</b>	97614	118209	125387	104582

Table 13: Outpatient activity by specialty, by year

**1.8.9.12 Future assumptions**

The planning assumptions are based current activity levels and growth in face to face assumed at 10% accommodated through some shift in appropriate activity and assumed uplift in digital/tele consultation and consolidation of patients' consultations,

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diagnostic testing (e.g., imaging, blood tests), and minor procedures in a single visit through one stop clinics and 90% utilisation.

#### 1.8.9.13 Regional Ophthalmology

The regional ophthalmology service outpatients subject to an approved Business Case will be provided in a single unit linked to the Theatres, based on the Exeter model located in Llanwenarth Suite.

To provide enough patients for the 1955 surgeries, 1796 outpatient slots are required as follows:

- 7.5 patients per session (8 in the morning and 7 in the afternoon)
- 6 sessions per week
- 42 weeks per year
- 95% efficiency

#### Interdependencies

- Outpatient booking system.
- One stop shop – outpatient, pre-assessment and treatment all in one day
- Flow between outpatient/ambulatory/day case unit.
- Consolidation of Outpatients into one area
- Regional Ophthalmology sustainable business case
- Admin accommodation

#### 1.8.9.14 Theatres - Day Case and Treatment Centre

#### 1.8.9.15 Current Activity

Day case activity at NHH has stabilised through 22/23 and 23/24 (~3,800), however there has been a slight increase in 24/25 YTD with 3,780 by the end of M10. The specialty split is utilized between General Surgery, Gynaecology and T&O. In 24/25 YTD there has been a significant increase in activity for Ophthalmology which is expected to be maintained and grow in line with regional services (Figure 8).

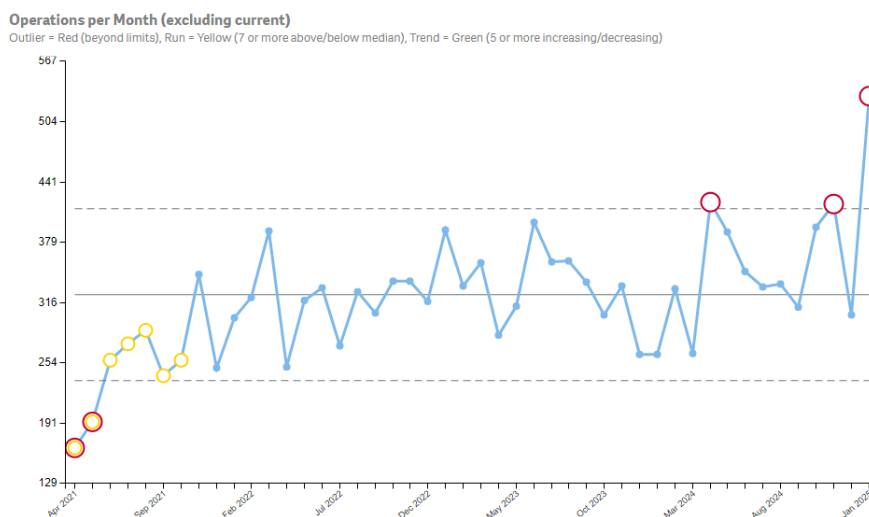


Figure 9: Monthly Day Case Activity at NHH

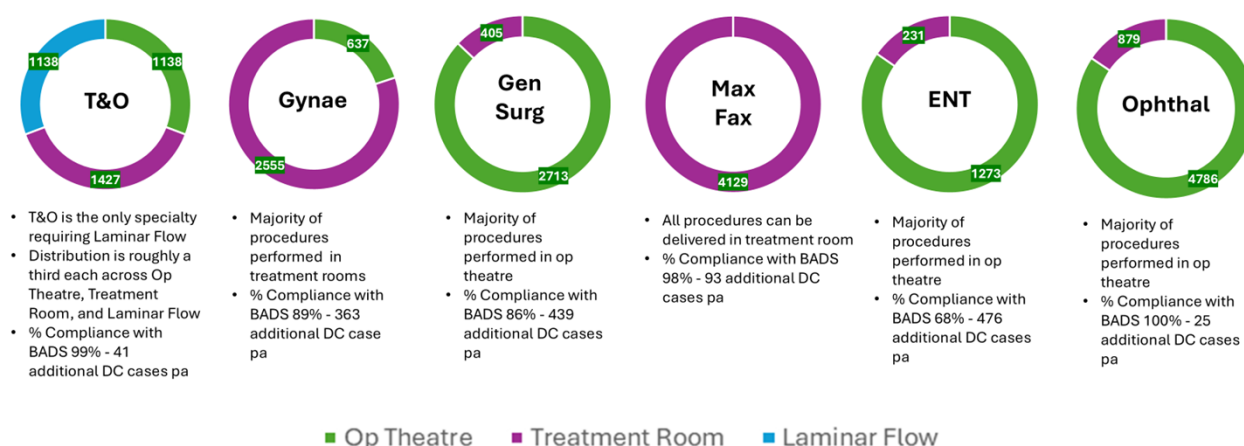
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**1.8.9.16 Future Assumptions**

As part of the options development, a series of options for theatre provision/configuration was assessed reflecting the ambition of the health board to increase high volume low complexity and increase activity up to ~ 15,000 procedures per annum. Demographic growth estimated at a 10% increase.

The capacity requirement assumptions were based on, a conservative utilisation rate of 75%, acknowledging that current utilisation levels will be improved and ~ 11,000 procedures at 60 minutes each and in line with GIRFT recommendations. This translates to ~6 theatres, 5.5 days/week, 10 hours/day, at 75% utilisation

**Day Case Procedures Distribution and BADS Compliance**

If BADS recommendations were fully achieved, a total of **1,437 procedures per year** could be converted to day case across all specialities.



Data is based on procedures identified as suitable for day case by specialty. A clinical review informed space suitability (Op Theatre, Treatment Room, Laminar Flow). Some clinical exceptions may still require alternative spaces despite this modelling. Some clinical exceptions and practical limitations (e.g. equipment and travel) may still prevent full compliance despite this modelling.

Figure 10: Day Case Procedures Distribution by speciality

Table 14: Day Case Procedure Activity, BADS Compliance by Specialty and Location

Specialty	Number of procedures done as DC	Potential number of procedures as DC if BADS recommendation followed	% Compliance with BADS	Count of Procedure Type in Op theatre	Count of Procedures in Op Theatre	Count of Procedure Type in Trx Room	Count of Procedures in Trx Room	Count of Procedure Type in Laminar flow	Count of Procedures in Laminar Flow
<b>T&amp;O</b>	2777	2818	99%	4	1138	7	1427	4	1138
<b>Gynae</b>	2829	3192	89%	9	637	5	2555	0	0
<b>Gen Surg</b>	2679	3118	86%	10	2713	2	405	0	0
<b>Max Fax</b>	4036	4129	98%	0	0	26	4129	0	0
<b>ENT</b>	1028	1504	68%	14	1273	3	231	0	0

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<b>Ophth</b>	5661	5686	100%	9	4786	3	879	0	0
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#### 1.8.9.17 Ophthalmology: Regional and Health Board

In line with the agreed regional ophthalmology strategy, the cataracts "North Hub" will be based in Nevill Hall Hospital. This location is well placed to care for patients from the Heads of the Valleys area that includes north Aneurin Bevan and north Cwm Taf Morgannwg University Health Boards.

The North Hub will deliver surgery from the theatre in Llanwenarth Suite in Nevill Hall Hospital, with outpatient clinics delivered in the same location incorporating best practice from the Exeter model

An interim cataracts case for investment secured £7m for the region on a recurrent basis in addition to non-recurrent monies being made available.

Future expansion of regional cataracts (over and above the £7m) would be subject to a regional business case being supported

#### 1.8.9.18 Capacity Plans

Based on the assumptions above the following surgery capacity is planned:

- 7 sessions per week
- 7 patients on a list
- 42 weeks per year
- 95% efficiency
- 1955 surgeries per year

#### 1.8.9.19 Monthly Capacity Plans

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Surgery	163	163	163	163	163	163	163	163	163	163	163	162	1955
OP	150	150	150	150	150	150	150	150	149	149	149	149	1796

Table 15: Ophthalmology Monthly Capacity Plans

Health Board Ophthalmology provision: currently 98% of the 25 specified procedures are currently undertaken as day cases at the Royal Gwent Hospital (RGH) and Nevill Hall Hospital. 11% of these day case procedures take place at NHH. The bespoke day case setting could increase the day case rate by 1% for these specified procedures, resulting in an annual increase from 5,691 to 5,763 cases. Through increasing capacity at NHH, this could increase the throughput at this site from 10% to 99%. Through enabling additional cases suitable for Procedure Room, there is an opportunity to move 450 of these day case procedures into a procedure room as part of a co-located outpatient treatment unit.

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### 1.8.9.20 Women's Health Hub

The requirement for a Women's Health Hub is set out in Welsh Government policy guidance. The Women's Health Hub for the health board will be based at NHH. The current Gynaecology provision is 86% of the 14 specified procedures are currently undertaken as day cases at the Royal Gwent Hospital (RGH), Nevill Hall Hospital (NHH) and Ysbyty Ystrad Fawr, 60% of these day case procedures take place at NHH.

The proposed future model is to increase in Day Case Rate through a bespoke day case setting which will increase the day case rate by 5% for these specified procedures, resulting in an annual increase from 2,829 to 2,976 cases. If situated at NHH, this could increase the throughput at this site from 60% to 90%, there is an opportunity to move 1,476 of these day case procedures into a procedure room as part of a co-located outpatient treatment unit.

#### Interdependencies

IT system for PACCT

Discharge by 23:59 with extended recovery

One stop shop – outpatient, pre-assessment and treatment all in one day

Day surgery as specialty for anesthetics

Anesthetic criteria to be reviewed.

Regional Ophthalmology Programme

Admin accommodation

### 1.8.9.21 Diagnostics

Encompassing diagnostics, pharmacy, and essential enablers of timely, safe, and effective clinical care.

### 1.8.9.22 Current Activity

Radiological services are driven by specialties on clinical need; method of investigation or modality utilised to ensure optimum image quality. The service model needs to meet the clinical and Radiological standards in appropriate settings, offer patient choice of location, and ensure patient and staff safety.

The opening of The Grange University Hospital (GUH) in 2020 provided the opportunity to deliver high acuity inpatient critical care, with the eLGHs providing urgent care, inpatients, routine outpatients, diagnostic and treatment services, and care closer to home.

### 1.8.9.23 CT Activity

CT Scanning	RGH	NHH	YYF	GUH
2023/24 Activity	21,688	15,499	11,713	36,287
2022/23 Activity	19,523	12,867	9,774	32,847
Variance	<b>+11%</b>	<b>+20%</b>	<b>+19.9%</b>	<b>+10.5%</b>

Table 16: CT Activity

### 1.8.9.24 MRI Activity

MRI Scanning	RGH	NHH	YYF	GUH
2023/24 Activity	9228	9201	9023	8947
2022/23 Activity	8413	8492	8447	7465
Variance	<b>+9.7%</b>	<b>+8.3%</b>	<b>+6.8%</b>	<b>+19.9%</b>

Table 17: MRI Activity

### 1.8.9.25 Plain Film Activity

PF Scanning	RGH	NHH	YYF	GUH
2023/24 Activity	62688	32155	42010	52194
2022/23 Activity	58336	31151	39261	53391
Variance	<b>+7.5%</b>	<b>+3.2%</b>	<b>+7%</b>	<b>-2.2%</b>

Table 18: Plain Film Activity

### 1.8.9.26 Ultrasound Activity

US Scanning	RGH	NHH	YYF	GUH
2023/24 Activity	26168	9794	5078	5246
2022/23 Activity	23722	8307	3750	4840
Variance	<b>+10.3%</b>	<b>+17.9%</b>	<b>+35.4%</b>	<b>+8.4%</b>

Table 19: Ultrasound Activity

### 1.8.9.27 Vascular Ultrasound

Activity for 23/24 totalled 7123, with 29% taking place at NHH.

### 1.8.9.28 Future Assumptions

The Radiology model is proposed to increase capacity by 1 MRI scanner at NHH as highlighted in the table below to meet the current demand now and in the future.

### 1.8.9.29 CT Assumptions

- In 2023/24 the CT Scanning activity totalled 85,187 examinations.
- The annual growth for CT scanning is currently around 10%.
- Activity totals are based on the number of examinations performed.
- CT will continue to be delivered from existing hospital sites, and hours of operation and supporting workforce will remain the same at NHH.

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### 1.8.9.30 MRI Assumptions

- In 2023/24 the MR Scanning activity totalled 37,683 examinations.
- The annual growth for MR scanning is currently around 6%.
- Activity totals are based on the number of examinations performed.
- MRI will continue to be delivered from existing hospital sites, and hours of operation and supporting workforce will remain the same at NHH.

### 1.8.9.31 Plain Film Assumptions

- In 2023/24 the total Plain Film activity at the Health Board was 244,484 examinations. 13% of this (32,155 examinations) was undertaken at NHH.
- The annual growth for Plain Film Imaging is currently around 2%.
- Activity totals are all based on number of examinations performed.
- Plain Film will continue to be delivered from existing hospital sites, and hours of operation and supporting workforce will remain the same at NHH.

### 1.8.9.32 Ultrasound Service Assumptions

- In 2023/24 the US scanning activity totalled 24,703 examinations. 39% of this (9,794 examinations) was undertaken at NHH.
- The annual growth for US Scanning is currently 8%.
- Activity totals are all based on number of examinations performed
- Ultrasound will continue to be delivered from existing hospital sites, and hours of operation and supporting workforce will remain the same at NHH.
- A&E referrals for Ultrasound will be performed at The Grange University Hospital.
- A&E, MAU and SAU referrals have a VIP service which are accommodated at NHH.

### 1.8.9.33 Vascular Ultrasound Assumptions

The service at NHH will maintain current levels operating from Monday to Friday, 07:45 – 15:45 each week, and staffed by 0.8 WTE.

### 1.8.9.34 Capacity split by site and Modality

Modality	GUH	RGH	NHH	YYF	Total Provision (all sites)
<b>X-ray rooms</b>	<b>x4</b> 24/7 service	<b>x5</b> 24/7 service	<b>x3</b> 24/7 service	<b>x3</b> 24/7 service	<b>15</b>
<b>CT scanners</b>	<b>x2</b> 1 in operation 24/7 1 in operation Mon-Fri 09:00 – 17:00	<b>x2</b> 1 in operation 07:30 – 20:00 7 days per week 1 in operation Mon-Fri 09:00 – 17:00 <b>20:00-07:30</b> No on call, however CT head service in operation	<b>x1</b> In operation Mon-Fri 07:30 – 20:00 <b>20:00-07:30</b> No on call, however CT head service in operation	<b>x1**</b> In operation Mon-Fri 07:30 – 20:00 <b>20:00-07:30</b> No on call, however CT head service in operation	<b>6</b>

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<b>MRI scanners</b>	<b>x2</b> In operation 07:30 – 20:00 7 days per week  <b>20:00 – 07:30</b> MR urgent lumbar spine cover for CES	<b>x1</b> In operation 07:30 – 20:00 7 days per week	<b>x2</b> In operation 7:30 – 20:00 7 days per week	<b>x1</b> In operation 07:30 – 20:00 7 days per week	<b>4</b>
<b>US Scanners</b>	<b>x3</b> In operation Mon-Fri 09:00 – 17:00	<b>x8</b> In operation Mon-Fri 09:00 – 17:00	<b>4</b> In operation Mon-Fri 09:00 – 17:00	<b>3</b> In operation Mon-Fri 09:00 – 17:00	<b>18</b>
<b>Nuclear Medicine</b>	<b>x0</b>	<b>x1 gamma camera</b> In operation Mon-Fri 09:00 – 17:00	<b>x1 gamma camera</b> In operation Mon-Fri 09:00 – 17:00	<b>x0</b>	
<b>Interventional radiology rooms</b>	<b>x2</b> In operation Mon-Fri 09:00 – 17:00  <b>17:00 – 09:00</b> on-call service (regional cover)	<b>x1</b> In operation Mon-Fri 09:00 – 17:00 (incl. vasc)	<b>x0</b>	<b>x0</b>	<b>3</b>
<b>Cardiology screening rooms</b>	<b>x2</b> In operation Mon-Fri 09:00 – 17:00	<b>x0</b>	<b>x0</b>	<b>x0</b>	<b>2</b>
<b>General screening rooms</b>	<b>x1</b> In operation Mon-Fri 09:00 – 17:00	<b>x1</b> In operation Mon-Fri 09:00 – 17:00	<b>x0</b>	<b>x0</b>	<b>2</b>
<b>Consultant Cover</b>	<b>09:00 – 17:00</b> Monday to Friday Saturday and Sunday. Out of hours/On call available at all times for evenings and weekends				

Table 20: Radiology Capacity Split by Site

#### 1.8.9.35 Endoscopy

An endoscopy service will be maintained in NHH. The service will be routine elective; however, it will include some inpatient slots to prevent inpatients from requiring unnecessary transfer to GUH. There will be no emergency endoscopy service at NHH.

#### 1.8.9.36 Current Activity

The total number of procedures completed in NHH has been increasing since 2021 with a return to full activity and utilization of the capacity available.

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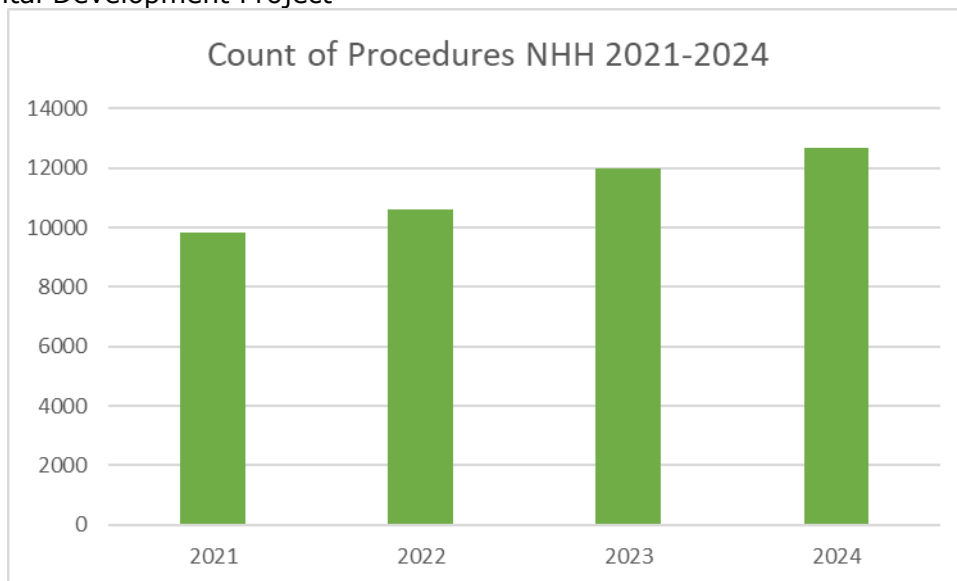
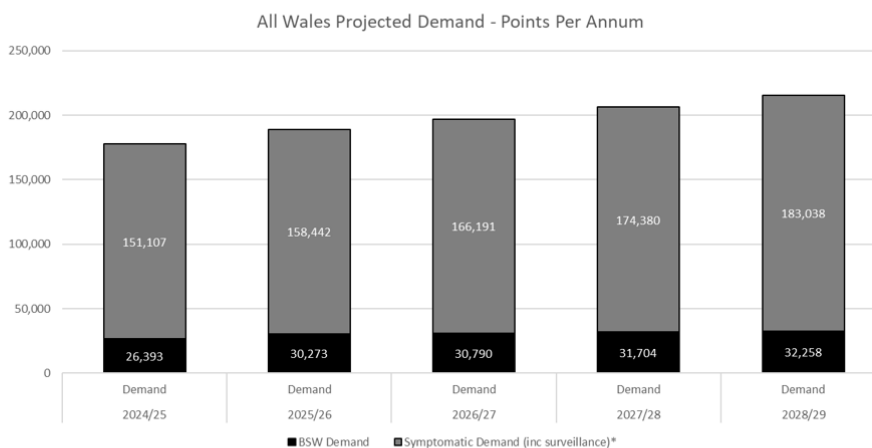


Figure 11: Radiology Procedures NHH 2021-2024

**1.8.9.37 Future Activity**

The current service offer at NHH includes two theatres at NHH; this will be maintained through the development. However, it should be noted there are forthcoming increased demand within Endoscopy, as evidenced below, there is a requirement to future-proof the NHH site. This is to ensure future demand is considered and appropriately factored into the planning. The current planning assumption is that this will be provided through regional solutions such as Llantrisant Health Park, subject to approval of capital and revenue requirements.

**Demand Profile – All Wales**



Overall demand increase 4.9% per annum (4.9% symptomatic and 5.1% screening)  
Refer to benchmarking document for a breakdown by HB



Figure 12: Endoscopy Demand Profile – All Wales

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Aneurin Bevan Health Board - Endoscopy					
Total Anticipated Symptomatic Demand in Points					Average Expected Annual increase
2024/25	2025/26	2026/27	2027/28	2028/29	
31910	33506	35181	36940	38787	5.00%

Table 21: Endoscopy Total Anticipated Symptomatic Demand in Points

**1.8.9.38 Urgent and Emergency Care – Assessment and Inpatient**

Centered around an Integrated Front Door model  
Encompassing inpatient wards and the medical take.

**1.8.9.39 Current Activity**

The bed base at NHH is will be maintained at current levels in line with the Clinical Futures Bed base. Historical data is reflective of both changes to site configuration and seasonality with expected peaks during winter period, for example. Average midnight occupancy for 24/25 to date has been 226. This is against a current, core bed base of 206 which does not include surge and boarding.

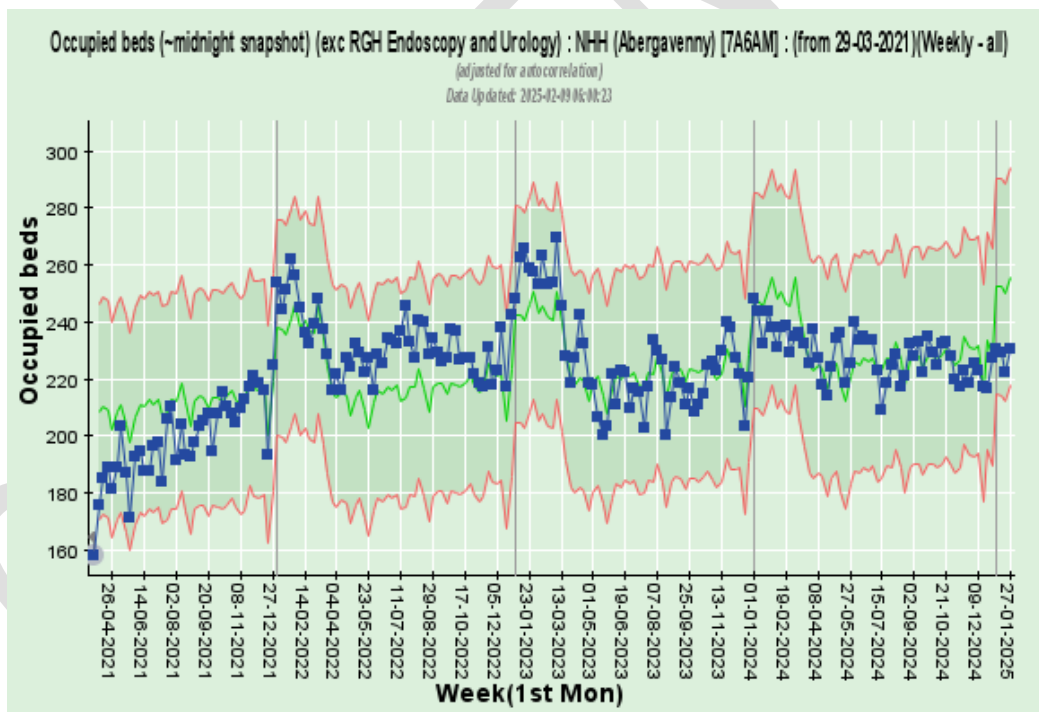


Figure 13: Weekly Midnight Bed Occupancy at NHH (Excluding RGH Endoscopy and Urology), 2021–2025

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Ward Name	Division	Speciality / Function	2024/25 bed base (core)	2025/26 bed plan
3.1 (Glan Ebbw)	Medicine	COTE / Diabetes	31	31
3.2 (Usk)	Medicine	COTE / Green Nurse Led	32	32
3.3 (Duffryn)	Medicine	COTE	32	32
3.4	Medicine	COTE	32	32
4.3 (Gwent)	Medicine	AMU	24	24
4.4 (Llanellen)	Medicine	COTE / Endocrine	32	32
4.2 (Crickhowell)	Surgery	T&O	25	25
<b>TOTALS</b>			<b>208</b>	<b>208</b>

Figure 14:NHH Bed base by speciality / function

**1.8.9.40 Front Door Model**

MIU demand is subject to seasonality, but there has been some increase over time in total presentations per year since 22/23 (~5%). Admit rate decreased through to 22/23 where, whilst subject to small fluctuations, has averaged 2.6% since.

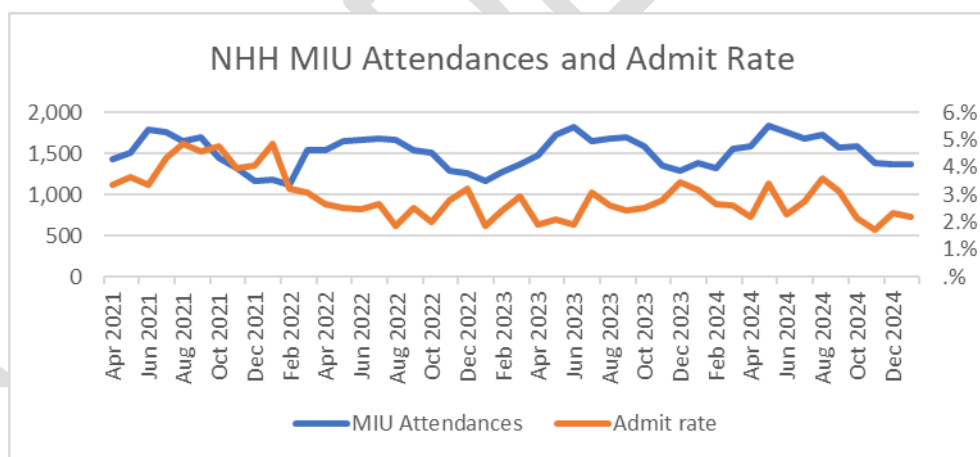


Figure 15:NHH MIU Attendances and Admit Rate

**1.8.9.41 Cancer Care**

Oncology services (SRU) including diagnostics, treatment, and follow-up care for the site particularly the expansion of SACT.

Cancer SACT activity has significantly increased post COVID, in addition to the steady growth in demand that was forecast prior to the pandemic. At the point the North Gwent Business Plan was written, the figures of 2020/21 illustrate the reduction in

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presentations and referrals as people stayed at home and did not access primary care services in the same way. As restrictions lifted this has resulted in a marked rise in suspected cancer referrals, with a steady cancer conversion rate maintained.

#### 1.8.9.42 Current Activity

Aneurin Bevan UHB Outreach (Outpatients, Ambulatory Care, Solid tumour SACT) the Windsor Suite (Nevill Hall) providing 7 chairs (plus 1 non-treatment chair) Tuesday and Thursday. Pre-Covid, oncologists ran clinics at the RGH, SWH, NHH and outreach offered Windsor Suite (10 chairs/1day week), plus St David's Hospice (2 chairs and Chemo bus)

#### 1.8.9.43 Future Assumptions

Modeling for the North Gwent Cancer Plan forecasted Haematology SACT activity is expected to grow by approximately 45 procedures per month by Autumn 2025, resulting in an 18% increase for the service. The capacity required to meet demand now and to 2030 was to deliver of Outreach SACT was a minimum of 11 chairs. Combining SACT Outreach, Ambulatory and Outpatient activity, the Health Board will be required from 2024 to deliver to 67% of our patients, which equates to the below projected amounts:

<b>ABUHB Outreach Activity - total</b>	<b>2024</b>	<b>2031/32</b>
SACT Total (2024 projected data)	8419	11886
Ambulatory Total (*with 2% increase from 22/23 figures)	672*	921
Outpatient Total (*with 2% increase from 22/23 figures)	14982*	19365
<b>TOTALS</b>	<b>24,073</b>	<b>32,172</b>

Table 22: Outreach Activity

This means that weekly activity levels will be at 463 procedures per week in 2024 (nearly 93 per day). This activity has been identified to be delivered initially in North Gwent by regional modelling. This total will rise to 619 by 2031/32, an increase of 34%.

#### 1.8.9.44 Family and Therapies

Ensuring alignment with multidisciplinary care pathways and patient-centred delivery.

There are no proposed changes to the inpatient therapies model, other than optimisation of existing estate to access fir for purpose rehabilitation closer to the wards, Inpatient therapies are predominantly supported through physio, typically sees ~1,100 patients per month. Dietetics ~210 per month. Speech and Language Therapy activity has decreased following Stroke reconfiguration; however, activity has increased through 24/25 YTD. OT activity only commenced from 24/25. CNRS and Podiatry & Orthotics are both low volumes.

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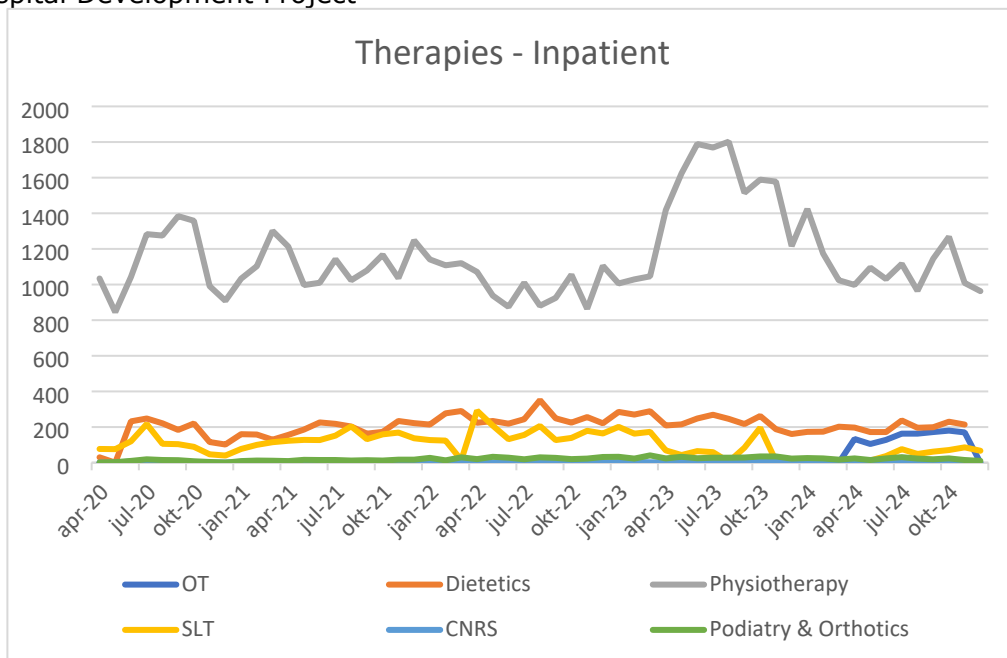


Figure 16: Therapies Inpatient Activity by specialty

**1.8.9.45 Mental Health**

Supporting system-wide transformation and estate optimisation.

At the present time there are no proposed changes to the capacity required, other than optimisation of existing estate to relocate to NHH. Mental Health are reviewing all of their models of care in 2025 and 2026.

The Maindiff Court site comprises 4 main buildings with 15 beds. Ty Skirrid, Hiraeth, Rholben Villa, and four interlinked blocks - Admin, Ty Bryn, and Tregaron

Capacity provision will be required for 190 staff are currently based on the Maindiff Court site (ESR Report June 2025)

## 1.9 New Development at the NHH Site

The redevelopment of Nevill Hall Hospital represents an opportunity to transform the estate in line with the Health Board's long-term strategic ambitions. As a designated enhanced Local General Hospital (eLGH), the site is central to delivering safe, modern, and sustainable care within the Clinical Futures model. The proposed new development will address critical infrastructure issues, improve functionality and flow, and support the delivery of integrated services within a high-performing, decarbonised estate. This section outlines how the redevelopment aligns with the Health Board's Estates Strategy, addressing both current challenges and future aspirations.

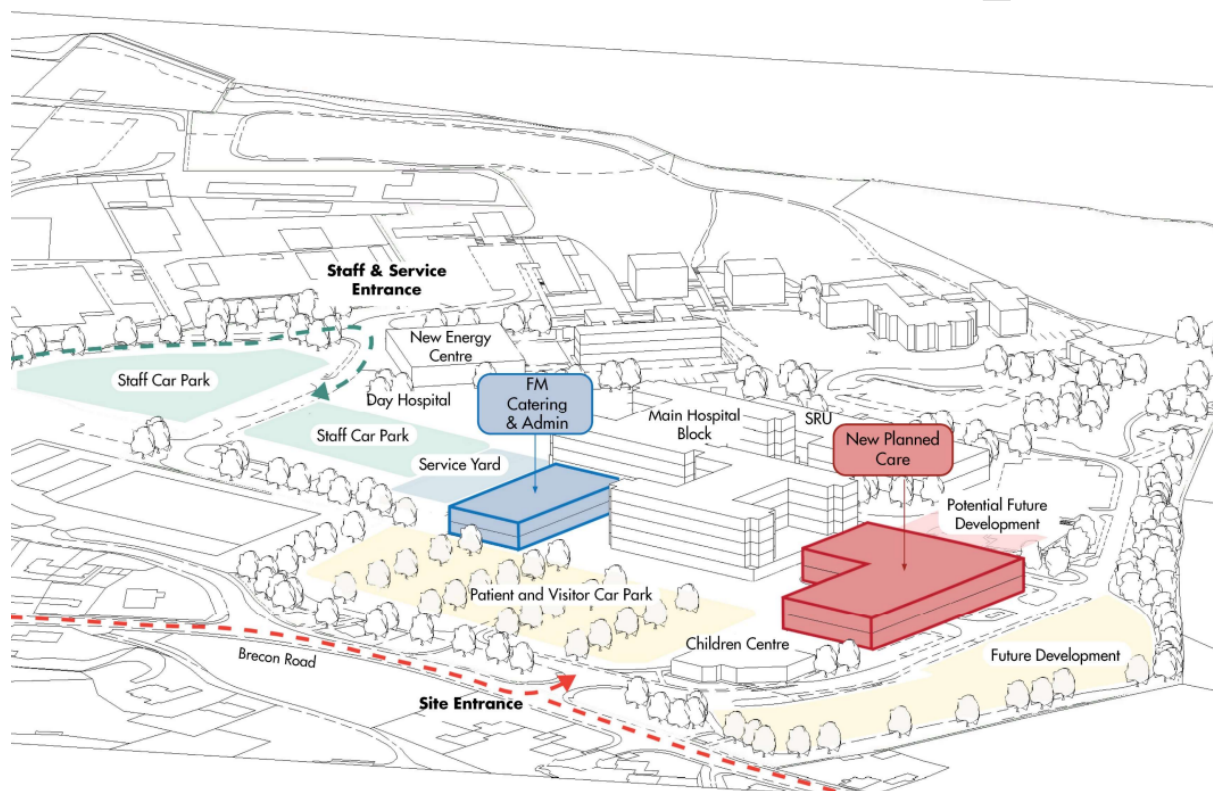


Figure 17: Diagram of proposed development for Option 5

### 1.9.1.1 Estates Strategy Overview (2018–2028)

ABUHB has developed a comprehensive Estates Strategy covering the period 2018 to 2028. This strategy aligns closely with the Health Board's Clinical Futures Strategy and sets out a vision for delivering a future-focused, fit-for-purpose estate that supports modern models of care.

Key Strategic Aims:

- A commitment to aligning the estate with patient need and service demand.
- Delivery of a sustainable, efficient, and supportive environment for healthcare delivery.
- Focus on transforming the estate to support integrated, flexible, and modern ways of working.

## Strategic Outline Case:

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### Current Estate Context:

- The estate includes acute hospitals, community hospitals, mental health hospitals, and primary/community care premises.
- The strategy highlights significant backlog maintenance issues, with a total backlog of £54.6 million. This does not include the RAAC removal / remediation costs.
- Underutilisation is a known challenge, with approximately 10% of space underused and 3% identified as empty.
- Energy consumption and carbon emissions are key concerns, with 45% of the estate consuming more energy than Welsh Government targets.

### Future State Vision:

- The strategy outlines a desired future state for the estate:
- A modern, sustainable, and flexible estate that facilitates effective service delivery and partnership working.
- Improved utilisation of space, reduction in backlog maintenance, and enhanced environmental performance.
- Development of integrated health, care, and wellbeing hubs in key locations to support regional models of care.

### Strategic Objectives – Focus on Nevill Hall Hospital:

**Reconfiguration and Rationalisation of Acute Hospitals:** Nevill Hall Hospital has been developed as an enhanced Local General Hospital.

**Review Mental Health Hospital Services:** Including the future role of Maindiff Court Hospital and the implications for Nevill Hall.

**Address Backlog Maintenance:** With a focus on high and significant risk categories; review and invest in maintenance regimes.

**Energy Strategy Implementation:** Finalise and deliver a new energy strategy to reduce emissions and meet energy performance targets.

This strategy was developed prior to the detailed Reinforced Autoclaved Aerated Concrete (RAAC) assessment works, which have since introduced new considerations for site redevelopment and investment priorities.

The redevelopment of Nevill Hall Hospital represents a key opportunity to deliver the priorities set out in the Health Board's Estates Strategy. As a designated enhanced Local General Hospital, the scheme will enable the reconfiguration and rationalisation of acute services, address high-risk backlog maintenance, and significantly improve energy performance across the estate. It provides a platform to modernise infrastructure, reduce underutilised and inefficient space, and create flexible, future-ready environments that support integrated models of care.

Crucially, the development also contributes to the Health Board's long-term vision for a sustainable and resilient estate. It aligns with the Clinical Futures strategy, supports strategic site optimisation, and helps fulfil the Health Board's

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duties under the Well-being of Future Generations (Wales) Act, delivering positive outcomes for health, equality, and environmental responsibility.

Our estate is a **core enabler** of service & clinical transformation.  
The Health Board's extant **Estates Strategy** (2018–2028), which underpins all capital investment decisions, including the redevelopment of Nevill Hall Hospital.

### Strategic Priorities

- Align estate with **clinical need** and future **service demand**
- Tackle **backlog maintenance - £54.6 million**
- Improve **space utilisation** and reduce underused/empty areas
- Deliver on **decarbonisation goals** and energy efficiency
- Support **integrated and flexible working environments**

### Why It Matters for NHH

- NHH is a key action within the extant strategy (Strategic priority 1) and long-term prioritisation exercise approved at Board (number 2)
- Directly supports estate **rationalisation and reconfiguration**
- Addresses RAAC and high-risk estate issues
- Creates **future-ready spaces**
- Advances the Health Board's long-term vision for a **resilient, optimised estate**
- Agreed as a priority by WG

Figure 18: Strategic Estates Priorities and Alignment with the project

### 1.9.1.2 Maindiff Court Opportunity – Estate Optimisation

The redevelopment of Nevill Hall Hospital provides a strategic opportunity to rationalise Health Board estate by reviewing services currently delivered from Maindiff Court Hospital and consolidating them onto a single, modernised site. Maindiff Court, located nearby in Abergavenny, currently accommodates a broad range of Mental Health and Learning Disabilities (MHL) services, including outpatient clinics, community teams, rehabilitation wards, and specialist provision such as substance misuse, eating disorders, and veterans' services. The site also houses several Family and Therapies services and associated Facilities functions.

While Maindiff Court has played an important role in the delivery of care, the site is operationally constrained, offers limited scope for future expansion or modernisation, and incurs ongoing maintenance costs due to its ageing infrastructure. The configuration of services across two separate sites also creates operational inefficiencies, duplication of support functions, and limits opportunities for integrated working.

Bringing appropriate services from Maindiff Court onto the Nevill Hall site as part of the redevelopment would:

- Support estate rationalisation by removing inefficient and underutilised buildings from the Health Board's estate portfolio.
- Enable the creation of modern, flexible accommodation that supports integrated MHL models aligned with community and acute care.

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- Improve staff and service user experience through co-location with broader clinical services, improved accessibility, and a fit-for-purpose environment.
- Align with the Health Board's commitment to delivering care closer to home and in settings that promote recovery and inclusion.
- Reduce long-term revenue and capital liabilities associated with maintaining a suboptimal estate.

The inclusion of Maindiff Court within the scope of the Nevill Hall redevelopment supports both the emerging clinical strategy, while also building on the principles established under the previous Clinical Futures strategy and Estates strategies by ensuring care is delivered from the right place, in a manner that is operationally, clinically, and financially sustainable. While a range of patient services are provided at Maindiff Court, a significant proportion of the site is currently occupied by non-patient-facing administrative functions, including office accommodation, meeting spaces, and support services. These functions could be more appropriately relocated to alternative premises, allowing the site to be released or repurposed. The existing estate does not make optimal use of clinical space, and rationalising these activities through the Nevill Hall redevelopment would support more efficient space utilisation, reduce overheads, and improve the alignment of estate use with service delivery priorities.

## Maindiff Court

- 1 Rholben Villa
- 2 Hiraeth
- 3 Ty Siriol
- 4 Tregaron
- 5 Ty Bryn
- 6 Admin



Figure 19: Maindiff Court Hospital Site Configuration

### 1.9.1.3 Managing the impact of RAAC Risk Factors

Working alongside professional advisors management of RAAC is assessed and managed by area of impact as shown below -

Area of Impact	Rationale
<b>Patient, Visitor and Staff Safety</b>	Mitigating RAAC is essential to maintain a safe environment for patients, staff and visitors. Continued reliance on RAAC-affected buildings increases the risk of structural failures, which could lead to evacuation or even shutdown of critical service areas, severely impacting care delivery and patient safety.
<b>Operational Continuity</b>	Current monitoring provides only temporary assurance. A long-term solution is needed to ensure more reliable, uninterrupted service delivery, reducing the risk of downtime or partial closures. The failure of RAAC panels may impact on the distribution of infrastructure services critical for life-safety in specific areas.
<b>Compliance and Risk Management</b>	National guidance strongly advises organisations to remove or reinforce RAAC in public buildings. Failing to address RAAC could expose the Health Board to compliance risks and liabilities, should any incidents occur due to neglected structural vulnerabilities.
<b>Financial Sustainability</b>	Ongoing monitoring and repair of RAAC structures incur costs that could otherwise be directed toward patient care and clinical investments.

Mott MacDonald conducted a yearly review of the 'high critical' and 'high' risk RAAC panels at The aim was to reassess the condition of the RAAC panels, evaluate associated risks, and establish an ongoing management strategy. Key findings from the latest survey are summarised below.

Category	Details
Roof Panels	7,353 RAAC roof panels identified, many classified as high risk due to inadequate bearing widths (50-70mm instead of 75mm)
Wall Panels	463 RAAC wall panels noted, primarily non-load bearing, some require further investigation
High Critical Panels	113 panels with significant defects, require immediate propping or secondary support
Bearing Issues	All remaining panels are classified as high risk due to inadequate / poor panel supports. This aligns to the recommendations made within the Institution of Structural Engineers RAAC Panel guidance.
Water Damage	Common around building perimeter and internal downpipes, causing spalling and corrosion
Cracking and Spalling	Significant shear cracks and spalling observed, particularly around supports and service penetrations

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Adverse Loading	Additional loads from plant equipment and services increased the risk
Primary Frame	Investigations into the primary precast frame have found signs of structural distress; cracking and voids. Further investigation has been scheduled, and remedial works will be required.

Table 23: RAAC Issues Across NHH Site

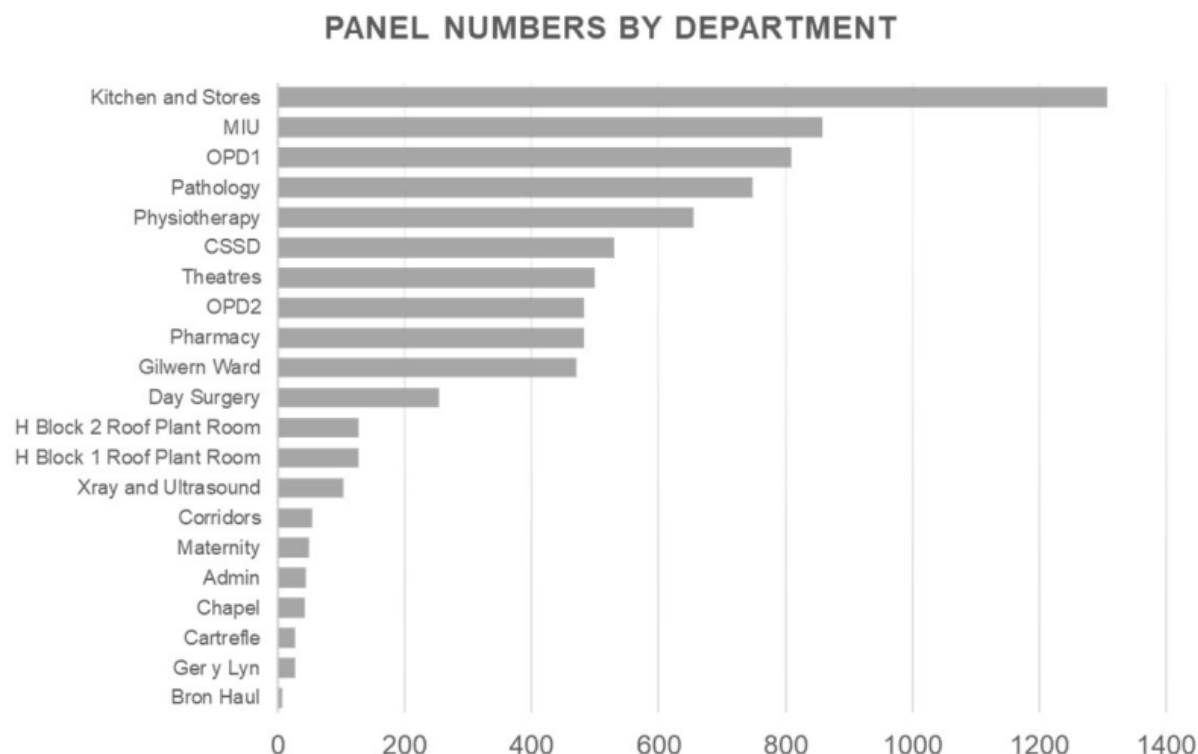


Figure 20: RAAC Panels by Department

The presence of RAAC reinforces the urgency of delivering a long-term, strategic solution for the Nevill Hall site. While not the sole driver of redevelopment, it significantly strengthens the case for capital investment by highlighting the unsuitability of the existing infrastructure to support modern models of care. Addressing RAAC within a broader strategic redevelopment ensures the Health Board avoids piecemeal investment and delivers a coherent, long-term solution aligned with clinical and estate priorities. This integrated approach maximises the value of capital funding, supports future service resilience, and ensures that safety improvements are delivered alongside wider estate and service modernisation.

**1.9.1.3 Backlog Maintenance**

Both Nevill Hall Hospital and Maidiff Court Hospital sites face significant backlog maintenance pressures, driven by the age, condition, and outdated functionality of key buildings. This presents operational, financial, and safety risks, and is a core driver for the proposed redevelopment.

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Nevill Hall Hospital, a long-established acute site, includes ageing infrastructure that no longer meets modern healthcare standards. Challenges include:

- Clinical blocks and plant rooms with limited adaptability for future models of care.
- High-cost, reactive maintenance of outdated mechanical and electrical systems.
- Poor energy performance and non-compliance with decarbonisation targets.

Capital investment will address these issues by:

- Replacing non-compliant infrastructure with purpose-built, future-proof facilities.
- Rationalising the site footprint
- Avoiding further investment in buildings with limited long-term value.

Maindiff Court Hospital includes a mix of inpatient, outpatient, and administrative functions, much of which is in estate with limited future utility. Key concerns include:

- High maintenance costs for non-clinical buildings in poor condition.
- Inefficient infrastructure, including single glazing, inadequate insulation, and limited accessibility.
- Fire safety and ventilation system deficiencies.

Redevelopment of Nevill Hall enables the rationalisation and relocation of appropriate functions from Maindiff Court, thereby:

- Reducing maintenance liabilities.
- Supporting potential disposal or repurposing of surplus estate.
- Aligning with the Health Board's estate strategy to deliver care from modern, sustainable environments.

#### **1.9.1.4 Sustainability and Decarbonisation Strategy**

ABUHB is committed to achieving net zero carbon emissions by 2030, in line with Welsh Government policy and the NHS Wales Decarbonisation Strategic Delivery Plan. This commitment is set out in the Health Board's Decarbonisation Framework, which defines the strategic objectives, key drivers, and workstreams required to deliver a more sustainable and resilient estate.

This approach underpins wider organisational goals to embed sustainability principles across all capital investment, operational delivery, and estate modernisation programmes, including the redevelopment of Nevill Hall Hospital.

#### **1.9.1.5 Strategic Drivers for Decarbonisation**

The Health Board's sustainability approach is informed by the following drivers:

**Environmental and Social Responsibility:** Following the Welsh Government's declaration of a climate emergency in 2019, the Health Board recognises the direct link between environmental impact and public health. The organisation

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aims to lead by example in reducing emissions from buildings, fleet, and service delivery.

**Financial Pressures:** Rising energy costs and volatility in global energy markets highlight the need for improved forecasting, cost management, and long-term investment in energy efficiency and carbon reduction measures.

**Regulatory Compliance:** Key legislation such as the Climate Change Act and Environment (Wales) Act 2015 establishes statutory carbon reduction targets. The Health Board aligns its decarbonisation objectives with NHS Wales delivery plans, including annual reporting against national milestones.

**Reputation and Public Accountability:** ABUHB reports its carbon footprint annually to Welsh Government and is committed to demonstrating leadership through collaboration, transparency, and continual improvement.

The Health Board's strategy focuses on five thematic areas:

Buildings – Improving the energy performance of existing assets and embedding sustainability in all new developments.

- Transport – Transitioning the Estates and Facilities fleet to electric vehicles and supporting sustainable travel alternatives.
- Procurement – Ensuring procurement practices reflect environmental standards and drive decarbonisation within the supply chain.
- Estate and Land Use – Optimising land for climate-resilient use, biodiversity, and efficient infrastructure.
- Smarter Healthcare – Supporting agile working, digital transformation, and low-carbon service delivery models.

### **1.9.1.6 Existing Plant Infrastructure**

The plant infrastructure at Nevill Hall Hospital is currently managed under a Private Finance Initiative (PFI) agreement, which remains in place until 2026. The redevelopment provides a timely opportunity to modernise and decarbonise the site infrastructure as part of a broader transformation.

The redevelopment of Nevill Hall Hospital presents an opportunity for ABUHB to accelerate its decarbonisation ambitions by delivering a modern, energy-efficient facility aligned with the NHS Wales target of net zero carbon by 2030. Replacing ageing infrastructure with high-performance, sustainable buildings will reduce reliance on fossil fuels, lower energy consumption, and improve the carbon footprint of the site. The project enables the integration of low-carbon technologies, optimisation of building systems, and rationalisation of estate use, all of which contribute to long-term environmental, financial, and operational sustainability.

### **1.9.1.7 Feasibility Study Development Options**

To support the development of this Strategic Outline Case, ABUHB has commissioned a detailed feasibility study to explore viable redevelopment options for the Nevill Hall Hospital site ([Appendix 1](#)). This work was undertaken

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to assess how the estate could be optimised to support the revised clinical model and strategic ambitions outlined in the Estates Strategy and Clinical Futures Programme. The feasibility study has been essential in identifying practical estate configurations, assessing spatial requirements, and informing the proposed Schedule of Accommodation. The following section sets out the development options considered, and the rationale for the preferred spatial strategy moving forward.

The following development and estates options were developed in alignment with the scope options:

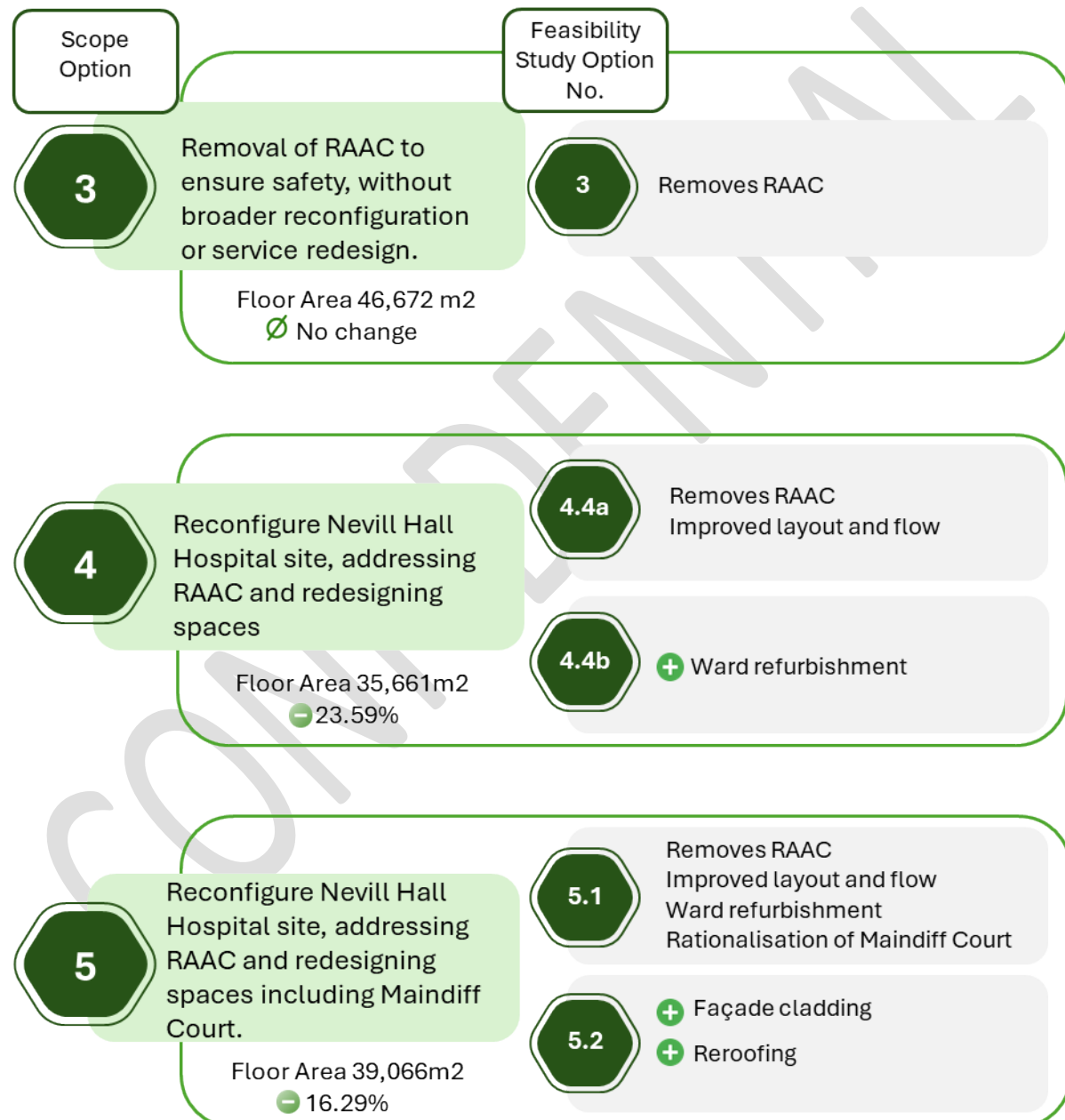


Table 24: Development / Estates Options aligned with Scope

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### **1.9.1.8 Schedule of Accommodation and Spatial Strategy**

As part of the feasibility work, a detailed Schedule of Accommodation (SoA) has been developed to test and refine the spatial response required to deliver the proposed service model at Nevill Hall Hospital. The SoA consolidates and rationalises accommodation currently provided at both Nevill Hall Hospital and Maidiff Court, ensuring a more efficient and clinically aligned estate footprint.

Key benefits of the preferred SoA include:

- **Dedicated and Streamlined Theatre Flows**  
Dedicated day surgery, ophthalmology, and endoscopy facilities are supported by shared clinical and non-clinical support areas, creating operational efficiencies. This supports the ambition to establish Nevill Hall Hospital (NHH) as a regional ophthalmology hub.
- **Single-Occupancy Recovery Rooms**  
For endoscopy Stage 2 recovery and pre-operative preparation areas will comprise 100% single rooms, zoned by specialty. This layout supports privacy, separation of patient flows (e.g. gowned/ungowned), and aligns with requirements for JAG accreditation in endoscopy.
- **Optimised Ward Configuration**  
Wards are planned as 24 or 32-bed units to support efficient nursing models. Accommodation will include a mix of 2-bed and 4-bed bays, with 2 single isolation rooms per ward. Further work is ongoing to assess the achievable percentage of single rooms within the retained estate.
- **Optimised Outpatient Spaces**  
Outpatients will be delivered through standardised consultation/examination rooms and flexible procedure rooms, enabling maximum use across specialities. Specialist accommodation will be provided in clustered zones alongside generic spaces. The model also assumes a growing proportion of remote consultations.
- **Centralised Administration**  
Administrative functions will be centralised outside of clinical departments to free up clinical space. Within departments, decentralised touchdown areas/workstations will be provided to support clinical roles and workflows.

This spatial approach enables delivery of the clinical model within a future-proof, flexible, and efficient estate configuration that responds to service priorities, workforce models, and strategic drivers for sustainability, patient dignity, and digital transformation.

The graph below indicates the changes in various departments as existing and proposed. In overall, the comparison of the existing GDA (Gross Departmental Allowance) and the preferred way forward indicates a circa 40% reduction in the proposed GSA (Gross Spatial Allowance) when compared to the existing.

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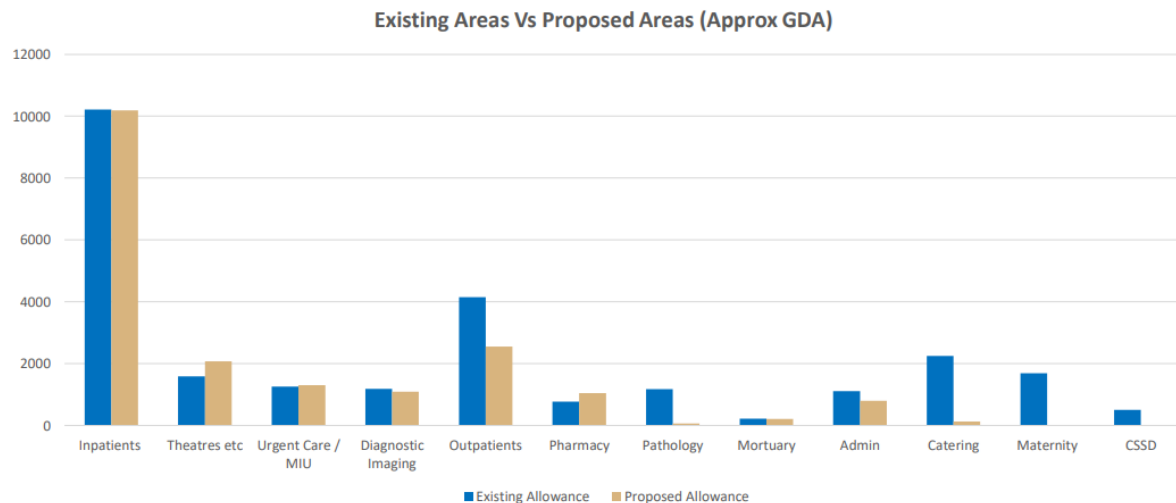


Figure 21: Existing areas versus proposed areas (Approx GDA)

- **Inpatient areas** remain broadly similar to existing provision, with layouts updated to align with current compliance and design standards.
- **Theatre areas** have increased in size to support the delivery of compliant and modern surgical environments.
- **Urgent care, imaging, mortuary, and pharmacy** areas remain broadly consistent with existing departmental footprints.
- **Outpatient accommodation** is significantly reduced, reflecting the planned shift in activity towards virtual consultations and more efficient in-person care models.
- **Pharmacy and catering services** are notably reduced in line with modernised operational models and improved supply chain integration.
- **Maternity services and CSSD** have been either removed or significantly reduced, consistent with the revised clinical model and site function.

• **Reconfigured Parking and Access Strategy**

The redevelopment of the site includes the re-provision of parking and access to support the proposed new layout. As the New Planned Care building will occupy the current patient and visitor car park, a new car park will be developed near the A40 site entrance, including accessible bays and drop-off zones adjacent to the new hospital entrance. Staff parking will be relocated to the rear of the site with access via Union Road West. This redesign separates staff and patient traffic flows, improves overall circulation, and maintains appropriate parking capacity to support the reconfigured estate.

The schedule of accommodation and spatial strategy represents a strategic rationalisation of space across the site, focusing on modern, efficient, and fit-for-purpose environments. This approach enables a significant reduction in the overall spatial footprint, while supporting improved patient flows, operational efficiencies, and alignment with future service delivery.

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Optimisation of the site will enable the consolidation of services currently delivered across Nevill Hall and Maindiff Court, supporting a more streamlined and clinically effective service model. The reduced footprint reflects a move towards modern, flexible healthcare spaces that are better aligned with contemporary clinical practice, digital delivery, and agile working. It also supports the Health Board's decarbonisation goals by replacing inefficient and high-maintenance infrastructure with energy-efficient, right-sized facilities, contributing to backlog maintenance reduction and long-term estate sustainability. This project is a key enabler of ABUHB's aim to deliver a fit-for-purpose, value-driven healthcare estate that meets the needs of current and future populations.

### 1.9.1.9 Retained Estate at NHH

As shown in **Error! Reference source not found.** all single-storey areas shown in red in the diagram below contain RAAC. It's proposed that these are to be removed as part of the redevelopment.



Figure 22: NHH Site Map

It is proposed that the main building 'H' tower blocks (dark green) will be retained, located to the centre of the site. In addition, the newly completed Satellite Radiotherapy Unit (SRU), and the Children's Centre will be retained. None of these buildings are impacted by RAAC. The Conference Centre to the south of the site and Nevill Hall Lodge located to the north of the site are part of the historic estate and are also to be retained.

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Figure 23: Picture of Nevill Hall H Block / Towers

The redevelopment of Nevill Hall Hospital will enable the Health Board to deliver services from a modern, efficient estate that is better aligned with clinical priorities and future demand. By consolidating services, reducing underutilised space, and addressing critical infrastructure risks, the scheme introduces a more functional, flexible, and sustainable infrastructure for care delivery. It supports integrated service models, improves patient and staff environments, and ensures the estate is fit for purpose in the long term. This investment creates the necessary conditions for delivering safe, high-quality care within a more resilient and cost-effective estate.

#### **1.9.1.10 Digital**

The Nevill Hall Hospital (NHH) Development Project aligns with the Health Board's forthcoming Digital Transformation Strategy, recognising digital as a core enabler of high-quality, sustainable care. As part of the project's essential requirements, digital infrastructure and capability must be embedded from the outset to support modern clinical delivery, agile working, and improved patient and staff experience. This development provides a unique opportunity to modernise digital infrastructure and integrate advanced technologies across clinical and non-clinical services. Key areas of alignment include:

**Digital-First Care Models:** Enabling paper-free outpatient and inpatient services, aligned with national ambitions for digitised patient records, remote monitoring, and virtual consultations.

**Clinical Decision Support & Integration:** Investment in digital tools that enhance clinical decision-making and integrate seamlessly with existing platforms, supporting more efficient workflows and reducing duplication.

**Agile Working:** Provision of digitally enabled agile hubs to support flexible working across teams, with secure access to systems and collaborative platforms regardless of location.

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**End-User Technology:** Deployment of communication devices, workstations, mobile hardware, and access to public and staff Wi-Fi across the site.

**Innovation-Ready Facilities:** Futureproofed estate capable of accommodating advanced technologies such as AI-supported diagnostics, robotic-assisted surgery, and smart building systems.

Digital will be a critical driver in delivering many of the project's expected benefits, including improved flow, reduced duplication, enhanced patient safety, and optimised resource utilisation. The digital specification for the NHH redevelopment will be co-designed with the Health Board's digital team and aligned with national programmes and local transformation priorities.

### **1.9.1.11 Decant and Business Continuity Considerations**

Decanting during construction is recognised as a critical risk to the delivery of the project. The Strategic Outline Case has identified and captured two key risks: *Decant Space Availability* and *Business Continuity During Implementation* (detailed in [Main Risks](#)). These reflect the potential challenges in maintaining essential services on an active acute hospital site and the availability of suitable decant space to enable phased delivery.

While detailed mitigation measures and logistics planning will be developed as part of the Outline Business Case (OBC) and Full Business Case (FBC). These include:

- A phased construction approach to minimise operational disruption,
- Use of temporary or modular accommodation,
- Exploration of available space within the existing estate to support decanting,
- Early engagement with clinical and operational leads to maintain service continuity, and
- A communication strategy to ensure staff and patient awareness of any temporary changes during the implementation phase.

A high-level decant strategy will be refined as the options are developed in more detail through the next stages of the business case process.

### 1.9.2 Sustainable Workforce and Financial Model

Delivering a modern, flexible, and future-proof healthcare facility at Nevill Hall Hospital requires a workforce and financial model that is both sustainable and responsive to evolving service demands. The NHH Development Project is designed to support these aims by enabling new ways of working, reducing reliance on temporary staffing, and creating a high-quality working environment that enhances staff wellbeing and retention. This section outlines how the proposed development aligns with the Health Board’s workforce strategy and financial objectives, ensuring long-term service resilience and value for money.

#### 1.9.2.1 Workforce

As of December 2024, we employ 13,238 WTE (15,395 individuals), making us the largest employer in Gwent. We have made notable progress in reducing vacancies among registered nurses and medical and dental staff over the past two years. However, challenges remain in recruiting to certain medical specialties. We also continue to experience long-term vacancies in Therapies, Pharmacy, and non-clinical roles such as mechanical and craftsperson positions. Our ongoing priority is to recruit, develop, and retain directly employed staff. A substantive workforce is essential for building and sustaining effective teams, which in turn enhances the patient experience.

The redevelopment of Nevill Hall Hospital directly supports the ambitions of the Health Board’s People Plan 2022–2025: Putting People First, by creating a modern environment that enables new ways of working and enhances the staff experience. We are currently developing our People Plan for 2025/26 to 2028/29. The table below summarises the key alignment points:

<b>People Plan Priority</b>	<b>NHH Redevelopment Alignment</b>
Staff Health & Wellbeing	Creation of a purpose-built facility with improved break areas, wellbeing rooms, natural light, and dedicated quiet spaces. Close location to where over 64% staff work and live, supporting decarbonisation and time to travel to work and work life balance. Current workforce absence is 6.92 % for Nevill Hall which is higher than the Health Board average of 6.3%. Maindiff Court sickness absence is 9.88%.
Workforce Sustainability	More modern facilities will offer better working conditions, more modern technology, and potentially more appealing features, which can improve job satisfaction and attract new recruits. Delivery of a flexible workforce model through agile working spaces, consolidated teams, and co-location of services to reduce duplication and improve collaboration.
Becoming an Employer of Choice	Modern workspaces, access to education and training zones, improved facilities for mentoring and professional development. Supports attraction and retention through agile working principles, new estates and engagement

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Inclusive & Digitally Ready Workforce	Dedicated digital infrastructure for agile working, virtual consultations, and hybrid delivery. Supports remote access and flexibility across the workforce.
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Table 25: People Plan Project Alignment

These improvements will create a safer, more attractive working environment that supports sustainable staffing models, improves staff morale, and enables delivery of high-quality patient care. By aligning capital investment with workforce priorities, the Health Board will be better positioned to attract and retain a skilled workforce, reduce reliance on agency staffing, and deliver services in a more efficient and patient-centred way.

**1.9.2.2 Nevill Hall Hospital**

Approximately 1456 staff are based at Nevil Hall from a contractual perspective which is 10% of the Health Board workforce. 75 % of these staff are female and 61% of the staff based here work less than full time. 40% of the workforce are over the age of 50 years. This includes staff who may outreach to other sites but doesn't include staff that may be based at other sites and may work part of their time at Nevil Hall. The number of staff based at the site reduce following the opening of the Grange University Hospital where several staff transferred with their services.

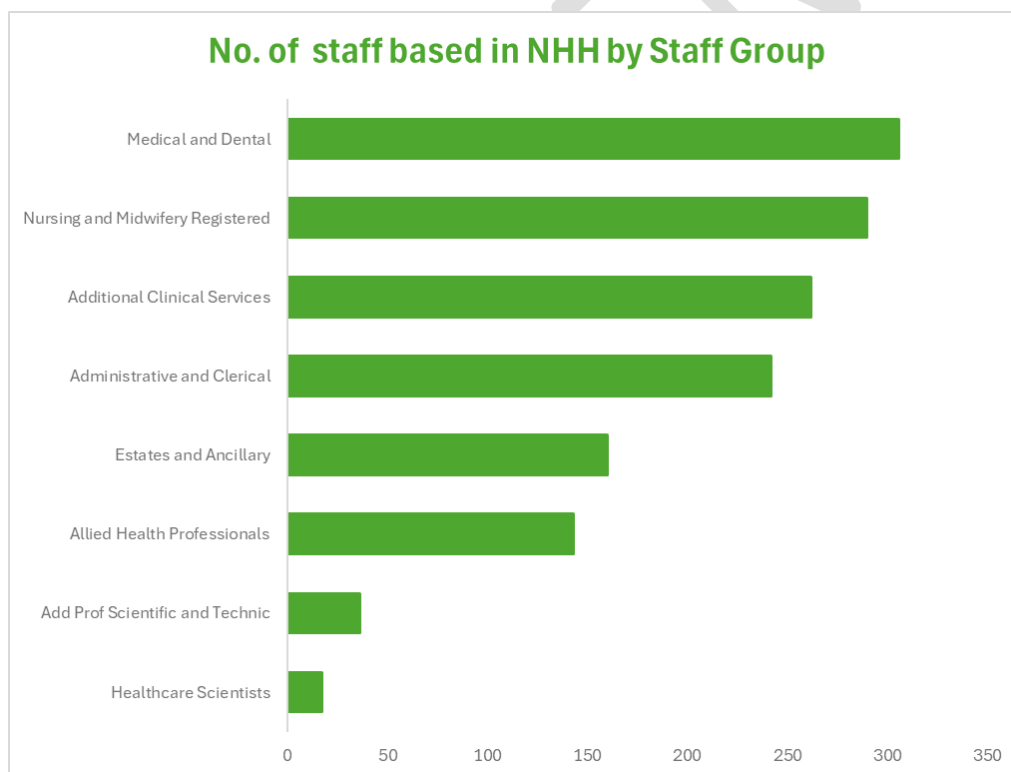
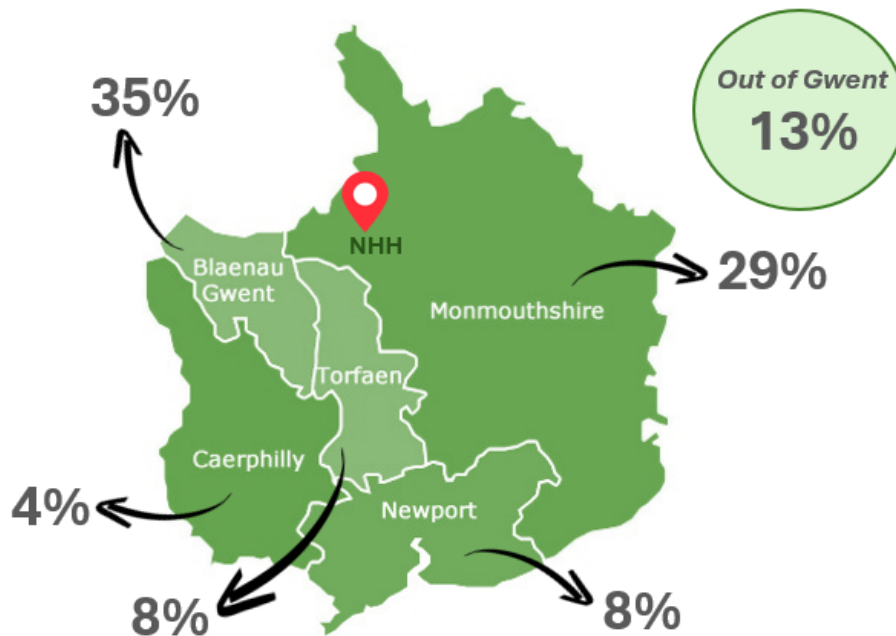


Figure 24: No. of Staff Based at Nevil Hall Hospital by Staf Group

**64%** of staff who are based at Nevill Hall Hospital live in either Monmouthshire or Blaenau Gwent.



*Based on audit of 95 staff members whose home addresses are known.*  
Figure 25: Map of Gwent illustrating NHH staff home county

An audit of the staff based at Nevill Hall Hospital demonstrates a strong local employment base, with 64% of staff residing in either Monmouthshire or Blaenau Gwent. This reflects the hospital's important role as an anchor institution, supporting the local economy and providing employment opportunities within its surrounding communities.

### **1.9.2.3 Maindiff Court Hospital**

According to the Electronic Staff Record (ESR), 186 staff are based at Maindiff Court Hospital. Of these, 54% live in Monmouthshire or Blaenau Gwent, further emphasising the importance of maintaining accessible employment opportunities within the locality.

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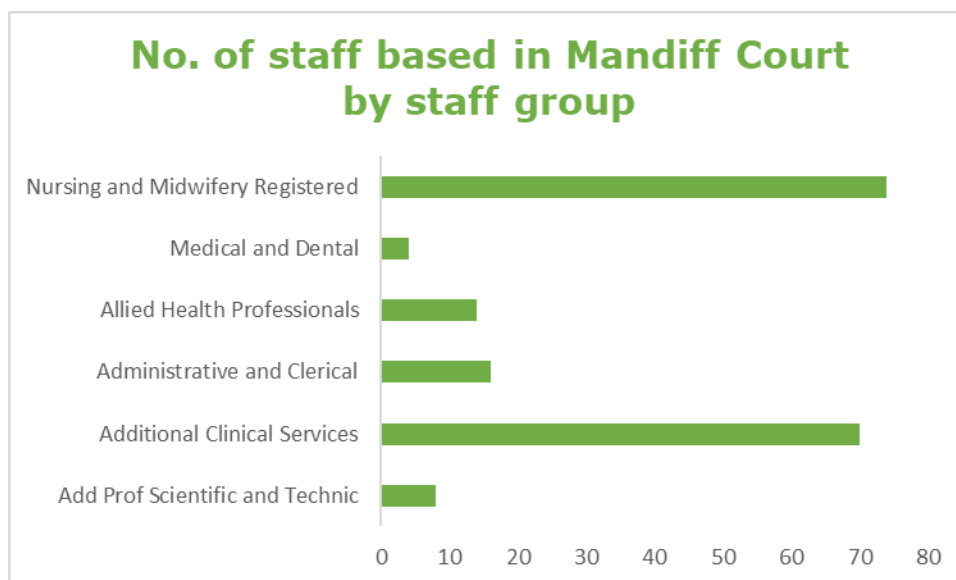


Figure 26: No. of Staff based at Maindiff Court by Staff Group

#### 1.9.2.4 Workforce Planning for Nevill Hall Hospital

Workforce assumptions within the Strategic Outline Case are currently based on high-level planning assumptions and efficiency drivers, with recognition that further detailed service modelling and workforce planning will be required.

- As delivering of models and sites change, staff will transfer alongside the services relocating to different sites (e.g. day surgery).
- No changes are anticipated for the site delivery of some services (e.g. Pharmacy).
- Efficiencies delivered through co- location of sites, single site, reduce single access points, reduce bed base in line with Clinical Futures assumptions, digital solutions to streamline administration tasks, multidisciplinary approach, improved hospital configuration that supports flow, communication and configuration of teams.

#### 1.9.2.5 Workforce Planning Approach

Our approach will include the following components and will support delivery of workforce solutions and potential efficiencies. This work will be developed in more detail at the next stage of the business case process:

##### **Strategic Alignment**

Align workforce plans with clinical strategy, service models, and national priorities.

##### **Demand Modelling**

Use activity-based modelling to estimate workforce requirements based on projected patient volumes, case mix, service configuration, and clinical pathways.

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**Supply Analysis**

Assess current workforce availability, future pipeline, and identify gaps.

**Workforce Design**

Define future workforce structures, roles, skill mix, and digital capabilities.

**Scenario Planning**

Model workforce options and assess their impact on cost, quality, and deliverability.

**Financial Modelling**

Calculate workforce costs and ensure alignment with the business case.

**Implementation Planning**

Plan recruitment, training, and change management activities.

**Governance & Risk Management**

Establish oversight mechanisms, identify risks, and define mitigation strategies.

**1.9.2.6 Enabling Innovation and Inclusion**

We will adopt a multidisciplinary workforce planning approach that supports flexibility and digital enabled workforce. This includes:

- Recognising the valuable contribution of volunteers
- Reviewing skill mix
- Developing and introducing advanced and extended roles
- Embedding person-centred care
- Supporting hybrid and innovative roles
- Aligning training needs with education commissioning

**1.9.2.7 Equality, diversity, and inclusive leadership**

will be embedded throughout the development of the workforce plan. These principles will enhance employee experience and support the changes required in service delivery, underpinned by robust organisational change processes.

**1.9.2.8 Sustainability and Data-Driven Workforce Planning**

Our approach will maximise the use of data and technological advancements to:

- Reduce reliance on bank and agency staff
- Build a sustainable, long-term workforce model
- A hospital that prioritises and supports wellbeing of staff
- Create a workplace that staff are proud to be part of and where Nevill Hall is an attractive place to work and train.

**1.9.2.9 Administrative Hub Functionality**

As part of the redevelopment, the Health Board intends to establish a dedicated administrative hub within the Nevill Hall Hospital site. This hub will consolidate non-clinical functions currently dispersed across the site and wider estate,

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creating a centralised, flexible workspace designed to support agile working. The aim is to release clinical and patient-facing spaces for frontline activity by relocating office-based teams into a purpose-built environment that promotes collaboration, digital working, and efficient use of space. The hub will support a range of corporate and service teams who require onsite presence but do not need to be located in clinical zones, enabling a clearer separation of clinical and administrative environments across the hospital. It will also form part of the Health Board's wider network of agile sites, offering a shared, bookable workspace for staff working across the North Gwent area and contributing to a more flexible, sustainable, and connected estate model.

#### 1.9.2.10 Agile Working

The Health Board has adopted a clear vision and set of principles for agile working, which align closely with the workforce objectives of the NHH Development Project. This approach recognises that work is an activity, not a location, and supports the creation of flexible, digitally enabled environments that bring together people, IT, and estate.

##### Agile Working Principles

###### Opening up Opportunities...

- ✓ *To enable staff to work in a location that is best for them, their services and our patients.*
- ✓ *To better support staff health and wellbeing.*
- ✓ *To optimise the effective use of our time.*
- ✓ *To maximise the use of available technology.*
- ✓ *To promote space/desk sharing by reducing the current 1:1 desk ratio.*
- ✓ *To ensure our future estate and digital strategy should seek to align with agile/hybrid working.*
- ✓ *To provide a network of agile hubs with breakout space and storage space.*

Figure 27: Agile Working Principles

By embedding agile working principles into the design and operation of Nevill Hall Hospital, the development will:

- Enable flexibility for staff to work in the most appropriate location for their role, improving service delivery and staff wellbeing.
- Support new models of care by integrating clinical and administrative functions, reducing unnecessary travel, and promoting collaboration across teams.
- Optimise use of space and technology, supporting shared workspaces and reducing the need for fixed desks through smarter working practices.
- Promote staff wellbeing, with modern, well-designed environments that balance clinical need with quiet, collaborative, and restorative areas.
- Reduce estate costs and improve efficiency by aligning space utilisation with service demands and the Health Board's digital strategy.

The NHH Development Project directly contributes to these principles by designing spaces that support hybrid and agile working models, ensuring infrastructure and technology enable seamless connectivity and collaboration.

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This will maximise the benefits of a flexible workforce model and reinforce the hospital's position as a resilient and attractive place to work.

The adoption of agile and hybrid working delivers a range of benefits to both the workforce and the organisation. These include a reduced carbon footprint through lower travel and estate usage, improved staff wellbeing and work-life balance, and better use of the existing estate by releasing space for clinical activities. It supports the creation of inclusive, collaborative workspaces and local hubs, increases the proportion of staff able to work from a variety of locations, and promotes innovation, creativity, and trust. Staff feedback to agile working to date has been overwhelmingly positive, with noted improvements in autonomy, engagement, and team dynamics.

### **1.9.3 Financial Sustainability and Affordability**

The project is being developed with a clear focus on long-term financial sustainability and alignment with the Health Board's financial recovery objectives. While capital funding will be sought from the All-Wales Capital Programme, the preferred way forward has been scoped to minimise additional revenue pressures and ensure affordability within the context of the Health Board's Integrated Medium-Term Plan (IMTP).

The proposed service model and estate strategy aim to:

- Optimise existing resources through the rationalisation of the Nevill Hall and Maiddiff Court sites
- Reduce high-cost backlog maintenance and address RAAC risks through comprehensive redevelopment
- Improve operational efficiency by consolidating services, enhancing clinical adjacencies, and enabling digitally supported models of care
- Increase day case and outpatient capacity through redesigned pathways, maximising throughput without proportionate cost growth.

Initial modelling indicates a revenue consequence range of **£5.5m–£10.1m** across the shortlisted options, with the preferred way forward reflecting potential efficiency benefits and space rationalisation. These costs are indicative and will be subject to detailed review at Outline Business Case stage, including consideration of operational commissioning, staffing models, utilities, digital infrastructure, and wider whole-system impacts.

Further detail on the assumptions, cost estimates, and revenue implications is provided within the [Financial Case](#)

### **1.10 Main Benefits**

The proposed redevelopment of Nevill Hall Hospital is expected to generate a wide range of benefits spanning patient care, workforce and staff wellbeing, estate improvements, and financial sustainability. These benefits reflect the project's alignment with the Health Board's clinical strategy and strategic priorities, including system integration, care closer to home, and decarbonisation.

In line with HM Treasury's Green Book guidance and reflecting the Strategic Outline Case (SOC) stage of development, we have focused on the 20% of benefits that are likely to generate 80% of the project's overall value. This enables early clarity on the outcomes that will drive the greatest impact and inform decision-making as the project progresses.

To support the realisation and tracking of these outcomes, a comprehensive Benefits Strategy has been developed ([Appendix 2](#)). This strategy provides the overarching framework for identifying, measuring, and monitoring benefits throughout the project lifecycle. The following table sets out the anticipated high-level benefits that will be tracked and measured over the lifecycle of the project. These benefits are underpinned by the enabling capabilities outlined in the Business Needs section and mapped in detail in the Benefits Map ([Appendix 3](#)). The Benefits Realisation Plan will be used to monitor and evaluate their delivery over time, with owners identified to support accountability

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Benefit ID	Title	Description	Category	Measurement Method	Baseline	Target
NHH001	Reduced Waiting Times	Reduction in waiting times for elective and unscheduled appointments	Patient Care	% treated within 62 days (cancer) 4hr A&E waits  Outpatients -Reduce proportion of patients waiting over 26wks  Diagnostics -proportion of patients waiting over 8 weeks	Cancer - 67.5%  GUH ED 4hr - 54.2%  26wk OP - 43.6%  36wk OP - 30.8%  8wk DX - 7.4%	Cancer -  GUH ED 4hr -  26wk OP -  36wk OP -  8wk DX -  TBD at OBC stage
NHH003	Improved Patient Flow	Improved efficiency in clinical service including LOS, bed use	Patient Care	LOS, bed occupancy, theatre utilisation	AvLoS - 23.64 days  Theatre utilisation (capped) - 80.1%  Bed occupancy - 202  BADS compliance - 77% (all sites / 24/25)	TBD at OBC stage
NHH004	Improved Staff Wellbeing	Healthier working environment to support staff recruitment and retention	Workforce & Staff Wellbeing	Turnover, sickness rates,	Sickness rates within the Health Board – 8%	Sickness rates within the Health Board – 6%

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NHH005	Improved Estate Utilisation	Better use of space and reduced backlog maintenance	Configuration of Infrastructure	Utilisation data, estate condition survey	Backlog maintenance £54.6m at NHH Based on 6 Facet survey Condition B(C)	New build spaces A Refurbished Areas B
NHH006	Financial Sustainability and Resource Optimisation	Optimised Resource Utilisation and Estates Cost Efficiency	Financial Efficiency	Running costs/m <sup>2</sup> , backlog costs, agency usage	~£68/m <sup>2</sup> (based on 2024/25 utility + rates spend) Backlog maintenance £54.6m at NHH Increased throughput per revenue unit (activity/£)	may rise due to better utilisation – TBD at OBC stage Significantly reduced backlog maintenance – tbd Throughput per Revenue Unit (Activity/£ - TBD)
NHH007	Reduced Carbon Emissions	Lower estate carbon footprint via efficient infrastructure	Configuration of Infrastructure	kWh/m <sup>2</sup> , BREEAM compliance	Electricity: 27kWh/sqm Gas: 375kWh/sqm	Net Zero Carbon
NHH009	RAAC Removal	Eliminating structural risks through RAAC removal	Configuration of Infrastructure	RAAC removal confirmation, safety certification	Significant presence of RAAC throughout building	Zero presence of RAAC

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NHH010	Day Case and Treatment Centre	Establishing day treatment capacity for HVLC activity	Patient Care	% day case delivery, BADS compliance, throughput	Day case - 99.2% BADS - 77% (all sites 24/25) Elective inpatient admissions - 19 Theatre utilisation (capped) - 80.1% HVLC sessions - 2 session per month (General Surgery)	Day case - BADS - Elective inpatient admissions - Theatre utilisation (capped) - HVLC sessions – 1/3 of General Surgery sessions TBD at OBC stage
NHH011	JAG (Joint Advisory Group) Accredited Endoscopy Unit	High quality unit to support diagnostics and accreditation	Patient Care	JAG status	Not currently JAG accredited	JAG accreditation
NHH014	Regeneration Catering Model	Modern food delivery model with reduced waste	Configuration of Infrastructure	Cost per meal, food waste volume	Chef rota fill rate (%) Number of reported food safety incidents (e.g. allergy-related Datix reports)	Chef rota fill rate (%) 24.3% Average Q1 2025

**Note:** Baseline metrics and target benefits are indicative at this Strategic Outline Case (SOC) stage and will be further refined and validated as part of the Outline Business Case (OBC), informed by detailed modelling, stakeholder engagement, and updated cost and activity data.

### 1.11 Main Risks

The Project involves a complex set of requirements, dependencies, and resource needs, which introduce various risks to achieving the project’s spending objectives. Effective risk management is essential to ensure the project stays within budget, meets timeline expectations, and delivers the intended benefits. A comprehensive risk register will be maintained and updated at each project phase. This risk register will include cause-event-effect analysis and assign scores for likelihood and consequence to prioritise risk responses. Regular risk assessments will ensure high-priority risks are promptly addressed and that mitigation strategies remain aligned with project goals, timelines, and resource allocation.

The following key risks have been identified:

<b>Risk Title</b>	<b>Description</b>	<b>Effect</b>	<b>Score</b>	<b>Mitigation Strategy</b>
RAAC Structural Safety Prior to Redevelopment	RAAC planks may deteriorate faster than expected or develop defects that compromise safety before major works begin.	May necessitate emergency decant or mitigation works, causing disruption, increased costs, and reputational risk.	15	Continue close monitoring through existing RAAC active monitoring project group and working with structural engineers.
Change in RAAC Guidance	Guidance on the assessment, treatment, or removal of Reinforced Autoclaved Aerated Concrete (RAAC) may evolve during the project lifecycle.	Could necessitate redesign, scope adjustment, or additional works outside of current cost or time estimates.	15	Maintain active monitoring of national guidance, engage early with technical advisors
Capacity Constraints in Service Design Engagement	Operational and clinical teams are at capacity with existing duties, limiting engagement in the service design process.	Could lead to a suboptimal service model that doesn’t fully meet clinical and operational needs.	20	Support from Planning Team to develop model and specifications; monitoring and adjusting engagement levels as needed.
Interdependencies with Other Workstreams	Dependencies on other projects/workstreams may hinder progress	Delays and suboptimal outcomes for the service redesign.	20	Programme manager to coordinate information across workstreams and ensure alignment with the eLGH programme

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Regional Planning Interdependency – Llantrisant Health Park	planning assumptions are based in part on regional service changes, including proposals for an expansion of services at Llantrisant Health Park. If these are not approved or delayed, additional demand may fall to NHH, exceeding the capacity currently planned.	Potential for under-provision of capacity and infrastructure at NHH, leading to service pressures, compromised patient flow, and the need for adaptation post-build.	20	Ongoing engagement with regional planning forums to track the status of Llantrisant proposals Clear articulation of planning assumptions within the SOC and associated capacity modelling Escalation through the Health Board and regional collaboration structures if assumptions change
Low Staff Morale at NHH	Decline in staff morale due to redesign and perceived loss of site identity.	Could lead to staff turnover, negatively impacting staffing levels and service delivery.	20	Promote positive developments (e.g., Satellite Radiotherapy Unit), and implement a detailed communication action plan.
Balancing RAAC Mitigation with future planning	The need to address RAAC remediation urgently may conflict with project funding timelines, potentially leading to investment in areas that may undergo redevelopment, resulting in abortive costs.	Delays in funding could result in redundant spending on RAAC mitigation in areas identified for future redevelopment, leading to inefficient use of resources.	20	Develop a phased, prioritised plan for RAAC remediation focused on areas critical for immediate safety. Coordinate closely with Welsh Government to secure timely support, minimising the risk of abortive costs. Align RAAC mitigation with the broader redevelopment timeline to ensure efficient resource allocation.
Public Opinion on the New Clinical Model	Risk of negative public perception of the new clinical service model	Potential damage to Health Board’s reputation, loss of public trust, and possible judicial review.	16	A comprehensive communication and engagement plan; Liaise with Llais; Compliance with public engagement / consultation requirements; Key

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				messaging to address public concerns
Business Continuity During implementation	Maintaining essential services on an active acute site while construction is underway poses operational challenges.	Potential disruptions to service delivery, impacting patient care and staff workflow.	16	Develop a phased construction plan to minimise disruption, establish temporary facilities if needed, and coordinate closely with clinical teams to maintain service continuity. Implement robust communication channels to inform staff and patients of any temporary changes.
Decant Space Availability	Lack of appropriate decant space during refurbishment may delay construction or impact service delivery.	Project delays or interruption to services.	16	Identify and plan decant strategy early; consider modular/temporary builds or off-site alternatives.
Change Fatigue and Resistance	Continuous or concurrent service changes (e.g., from Clinical Futures, GUH transitions, etc.) may lead to change fatigue among staff.	Reduced engagement, implementation delays, lower quality input to design.	16	appoint change champions within services.
Supply Chain / Market Volatility	Inflation, material shortages, or contractor availability issues may increase costs or delay delivery.	Capital overspend or timeline slippage.	12	Early market engagement; built-in cost contingency;
Delays in Approvals / Business Case Sign-off	Prolonged review or feedback cycles with Welsh Government or internal governance may delay mobilisation.	Increased costs, loss of programme momentum, impact on RAAC risk mitigation.	16	Early engagement with approvers; pre-submission reviews; clear alignment to IMTP and national priorities.
Assumptions based on current Anaesthetic criteria may constrain volume of activity	If the existing anaesthetic and pre-assessment criteria at Nevill Hall remain unchanged, the site may be unable to deliver the full range and volume of	- Reduced theatre utilisation and productivity Inability to realise high-volume, low-complexity	16	Review and define clinical governance pathways and escalation options Explore workforce models that may allow expansion of case mix

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	<p>procedures needed to maximise theatre capacity and throughput. This risk is heightened by the site's standalone nature and lack of co-located acute services, which constrain the complexity of cases that can be managed safely.</p>	<p>(HVLC) ambitions Potential need to redirect patients to alternative sites, impacting flow and waiting list management</p>		
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Table 26: Risks

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### 1.12 Constraints

The Project faces several constraints that impact its planning, resourcing, and implementation. These constraints stem from the practical challenges of redeveloping an active acute healthcare site while balancing immediate safety needs, resource limitations, and the complexities of future-proofing the hospital's services. The constraints identified reflect both the internal and external factors that may influence the project's scope, timeline, and funding requirements.

The following table summarises the main constraints that have been placed on the project:

<b>Constraint</b>	<b>Description</b>
Availability of Resources to Support Change	Limited availability of both capital and revenue resources may impact the ability to fund all aspects of the project within desired timelines.
Capacity of Teams to Engage in the Project	Operational and clinical teams have limited capacity to engage fully in the project due to ongoing responsibilities, potentially slowing down decision-making and progress.
Alternative Estate Provision in the Area	Limited alternative estate options in the area may restrict the ability to relocate services or staff temporarily during construction or redevelopment phases.
Ability to Recruit and Retain Staff	Challenges in recruiting and retaining skilled staff may affect the project's progress, particularly in critical roles essential to implementation and ongoing operations.
Interdependencies with Other Workstreams	The project is dependent on the progress and alignment of other workstreams, which may impact timelines and coordination efforts.
Resource to Develop Clinical Service Plan	Limited resources available to develop the Clinical Service Plan at the required pace may delay project and planning stages.
Anaesthetic and Clinical Criteria Limitations	Nevill Hall operates within defined anaesthetic and pre-assessment criteria that are aligned to ensure patient safety. As a standalone site without co-located acute services, these criteria typically support the treatment of lower-risk patients, which places limitations on the range and complexity of procedures that can be undertaken on site. Expanding this scope would require changes to infrastructure, workforce model, and clinical governance. It may limit the patients that can safely be operated on at the site.

*Table 27: Constraints*

### 1.13 Dependencies

The success of the Project relies on several key dependencies that lie outside the project's direct scope and control. These external factors and partnerships are essential to achieving project objectives, maintaining timelines, and ensuring that the redesigned hospital can operate effectively. Understanding and managing these dependencies is critical for proactive planning, as any changes or delays in these areas could impact the project's progress and success. The following list summarises the primary external dependencies upon which the project is reliant:

Dependency	Description
Funding Approval and Allocation	The project's success depends on timely funding. Delays or changes in funding availability could impact the project timeline and scope.
Collaboration with Local Health Providers and Authorities	Effective collaboration with other local health providers and authorities is essential, particularly regarding patient pathways
Interdependencies with Broader Clinical Futures Programme and emergent clinical strategy	The project must maintain alignment with both the legacy Clinical Futures Programme and the newly launched clinical strategy. Any changes in regional or national service planning, models of care, or strategic priorities may affect the scope, configuration, or phasing of the redevelopment. Ongoing coordination with system-wide programmes is essential to ensure consistency of clinical models and avoid misalignment with future service delivery goals.
Supply Chain Stability and Availability	The project depends on the availability of construction materials, medical equipment, and technology. External supply chain factors, such as market volatility or supplier constraints, may affect costs, timelines, and material availability.
Regulatory Compliance	The project must secure ongoing regulatory approvals and align with healthcare regulations and standards. Changes in regulatory requirements from health authorities may necessitate modifications to design or implementation, impacting costs and timelines.
Engagement with Community and Public Health Stakeholders	Public perception and community support are essential for the project's success. The project's outcomes rely on effective communication and engagement with stakeholders to ensure local buy-in and avoid negative impacts on public trust.

Table 28: Dependencies

## 2. ECONOMIC CASE

The Economic Case sets out how the Project Team has selected the short list of options to be taken forward to the next stage of planning, the Outline Business Case. This was undertaken in line with the requirements of the Five Case Model and encompassed the recommended five “categories of choice” and a sixth choice relating to “Estate Solution”. The six categories included:

- **Service Scope**
- **Service Solution**
- **Service Delivery**
- **Implementation**
- **Funding**
- **Estate / Development Solution**

### 2.1 Critical success factors (CSFs)

The following Critical Success Factors (CSFs) have been established to guide the evaluation and decision-making process for the project. These CSFs ensure that each option is assessed consistently against key priorities, including alignment with strategic objectives, long-term value, operational feasibility, and stakeholder support. The CSFs are designed to capture essential elements for project success, helping to identify options that are both realistic and beneficial for the Health Board’s objectives.

Critical Success Factor	Description
CSF1: Strategic Fit and Business Needs	Consistent with national and regional strategies Consistent with clinical strategy Meets national standards and guidance Addresses the Health Board’s priority needs, meeting current and anticipated healthcare demands.
CSF2: Value for Money	Provides long-term cost benefits, maximising resource efficiency and reducing waste and supports decarbonisation Demonstrates effective use of public funds by achieving the best balance of costs and benefits. Minimises potential future maintenance and operational costs.
CSF3: Supply-Side Capacity and Capability	Leverages internal and external resources effectively to deliver project outcomes. Ensures that required skills, expertise, and materials are available within the supply chain. Supports workforce stability, improving staff recruitment and retention.
CSF4: Affordability	Fits within available funding envelopes and demonstrates a sustainable financial model. Balances upfront capital costs with future operating costs, ensuring budget compliance over time. Avoids unnecessary financial risks to the Health Board.

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Critical Success Factor	Description
CSF5: Achievability	Realistic in terms of the project timeline and the potential to obtain necessary approvals and planning consents. Minimises disruption to existing services, ensuring business continuity. Supported by stakeholders, ensuring a feasible pathway to completion.

Table 29: Critical Success Factors

## 2.2 Long List Development and Appraisal

To address the structural risks, estate inefficiencies, and service model challenges at Nevill Hall Hospital, a broad range of potential options was developed. These were assessed using a structured options appraisal process aligned with the Five Case Model and Treasury Green Book guidance to ensure full consideration of possible approaches.

### 2.2.1 Options Framework and Evaluation Method

The long list was developed using a structured options framework focusing on key dimensions. Each of these dimensions represents a distinct area of decision-making. The options within each dimension were not interdependent but instead considered individually to explore a broad configuration of possibilities:

**Service Scope** defines the extent of change, from maintaining existing services to full reconfiguration.

**Service Solution** addresses how services will be delivered, for example through modernisation or risk mitigation.

**Service Delivery** considers who provides the service and the delivery model.

**Implementation** looks at the timing and phasing of delivery.

**Funding** assesses affordability and potential funding sources.

**Estate solution** that delivers service scope

Each dimension includes a range of sub-options (e.g. 1.1, 1.2, 1.3 for Service Scope, 2.1, 2.2, 2.3 for Service Solution), which are combined to form potential delivery options. The shortlisting process identifies the most strategically aligned combination of sub-options, which are then carried forward for detailed appraisal. The preferred way forward represents the combination that delivers the best balance of benefit, deliverability, and value for money.

### 2.2.2 Appraisal Against Investment Objectives and Critical Success Factors

Each option was assessed against the project’s agreed Investment Objectives (IOs) and Critical Success Factors (CSFs) using structured appraisal tools, including a SWOT analysis. The purpose was to determine the extent to which each option aligned with the strategic intent and deliverability of the programme.

Options were scored as follows:

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- ✓ – Fully aligned with CSFs and IOs
- ? – Partially aligned or with delivery uncertainty
- x – Did not satisfy CSFs and Ios

This appraisal enabled the identification of those options most likely to deliver the required benefits, mitigate key risks, and support a sustainable future model. Options with low alignment or significant feasibility concerns were discounted at this stage.

#### **2.2.3 Option 0 – Do Nothing (Baseline)**

As part of the initial long-list development, a “Do Nothing” option was considered to establish a baseline for comparison. This would involve no further investment in the site, with continued use of the existing facilities and no remedial action taken to address structural or service delivery challenges. However, this option was discounted at an early stage on the basis that: The presence of Reinforced Autoclaved Aerated Concrete (RAAC) necessitates active remediation or removal to comply with statutory obligations and ensure patient and staff safety.

Continuing without intervention would expose the Health Board to significant clinical, operational, and financial risks, including emergency repairs, unplanned service disruption, and potential regulatory non-compliance.

The option fails to meet the investment objectives, particularly those relating to estate safety, decarbonisation, service efficiency, and workforce sustainability. As such, Option 0 was not included in the formal options appraisal, as it does not represent a viable course of action. However, it has been retained as a baseline for comparative purposes in assessing the relative value and impact of the viable options.

### 2.3 Summary of the Long List Using the Options Framework

A full SWOT of the long-listed options, appraisal scores, and rationale is provided in [Appendix 4](#).

Project	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
<p>1. Service Scope</p> <p><i>Defines the breadth and boundaries of what the project or service will cover, including the target population, geographical area, and key service components.</i></p>	1.1 Maintain existing facilities without new investment – remediation of RAAC only	1.2 Close NHH	1.3 Removal of RAAC to ensure safety, without broader reconfiguration or service redesign	1.4 Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces	1.5 Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces including Maindiff Court	1.6 Full Reconfiguration of North Gwent Services (Includes removal of RAAC in NHH)
	<b>Carried Forward</b>	<b>Discounted</b>	<b>Carried Forward</b>	<b>Carried Forward</b>	<b>Carried Forward</b>	<b>Discounted</b>
<p>2. Service Solution</p> <p><i>Identifies the preferred approach or method for delivering the defined scope, including technologies,</i></p>	2.1 Maintain existing services without new investment. Only essential statutory maintenance is performed to meet minimum compliance and safety	2.2 Cease operations at Nevill Hall Hospital and relocate services to alternative existing sites within the region	2.3 Address RAAC-related risks by focusing on removal only, ensuring buildings remain safe but without significant service redesign or modernisation.	2.4 Modernise and redesign existing services at Nevill Hall Hospital, addressing RAAC and creating flexible, efficient, and sustainable clinical spaces	2.5 Extend the reconfiguration of NHH to include the rationalisation of Maindiff Court, integrating and optimising service delivery across both sites and	2.6 Comprehensive redesign and delivery of healthcare services across North Gwent, encompassing NHH, Maindiff Court, Ysbyty Tri Cwm and Ysbyty

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<i>facilities, and operational models.</i>	standards. remediation of RAAC only			and decommissioning non-essential buildings where required.	decommissioning non-essential buildings where required.	Aneurin Bevan to ensure system-wide improvement.
	Carried Forward	Discounted	Carried Forward	Carried Forward	Carried Forward	Discounted
3. Service Delivery  <i>Focuses on how the solution will be operationalised, including who will deliver it, roles, responsibilities</i>	3.1 Internal teams continue existing operations	3.2 Internal teams, no external support.	3.3 Internal teams with contracted support for RAAC removal	3.4 Internal teams with contracted specialists for major phases of redevelopment.	3.5 Combination of internal expertise and contracted services	3.6 Fully outsourced or partnership with external contractor.
	Carried Forward	Discounted	Carried Forward	Carried Forward	Carried Forward	Carried Forward
4. Implementation  <i>Covers the process of putting the solution into action, including timelines, resources, phasing, and change management.</i>	4.1 continue existing operations	4.2 Phased removal, addressing critical areas first	4.3 Targeted Incremental redevelopment over time, focusing on essential clinical spaces.	4.4 multi-phase plan over several years, balancing immediate RAAC removal with broader site upgrades	4.5 multi-phase, with integration of Maindiff Court services into the new NHH configuration.	4.6 Single, continuous phase ("big bang" approach) modernising the entire site at once. Temporary service relocations are required to maintain operations
	Carried Forward	Carried Forward	Carried Forward	Carried Forward	Carried Forward	Discounted

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5. Funding <i>Explores capital funding sources to deliver the project</i>	5.1 Discretionary Capital	5.2 All Wales Capital	5.3 Mix of Discretionary Capital and All Wales Capital	5.4 Mix of private and Welsh Government funding	5.5 Private Finance	
	Discounted	Carried Forward	Discounted	Carried Forward	Discounted	
6. Estate / Development Options	6.1 RAAC Remediation	6.2 Close NHH	6.3 RAAC Removal  <i>(aligns with feasibility option 3)</i>	6.4 New Build reconfiguring NHH Site  <i>(aligns with feasibility option 4.4a / 4.4b)</i>	6.5 New Build reconfiguring NHH Site including Maindiff Court  <i>(aligns with feasibility option 5.1 / 5.2)</i>	
	Carried Forward	Discounted	Carried Forward	Carried Forward	Carried Forward	

Table 30: Summary of the long list of options

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### 2.3.1 Summary of Scope Options

Below is a summary of the long-listed scope options, including their descriptions, advantages, disadvantages, and a conclusion regarding how well each option meets the investment objectives and CSFs.

Scope Options	Description	Advantages	Disadvantages	Conclusion	Carried Forward / Discounted
1.1	Maintain existing facilities without new investment – RAAC remediation only	<ul style="list-style-type: none"> <li>- Minimal disruption to services.</li> <li>- Retains existing service locations.</li> </ul>	<ul style="list-style-type: none"> <li>- RAAC risks remains, posing long-term safety issues.</li> <li>- Increased maintenance costs and potential emergency repairs.</li> <li>- Does not address service inefficiencies or future demand.</li> <li>- Fails to meet NHS Wales decarbonisation targets.</li> <li>- Non-compliance with modern healthcare standards.</li> </ul>	Offers minimal improvement; insufficient to support future service needs.	Carried Forward (Do Minimum)
1.2	Close NHH	<ul style="list-style-type: none"> <li>- Removes RAAC risks by decommissioning the site.</li> <li>- Potential financial savings from estate rationalisation.</li> <li>- Opportunity to redirect resource and investment into other healthcare facilities.</li> </ul>	<ul style="list-style-type: none"> <li>- Major loss of acute and local healthcare provision in North Gwent.</li> <li>- Increased demand on other hospitals, leading to capacity issues.</li> <li>- Negative impact on patient access, particularly for rural communities.</li> </ul>	Not aligned with strategic or population health needs	Discounted

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			- Political and public opposition likely		
1.3	Removal of RAAC to ensure safety, without broader reconfiguration or service redesign	<ul style="list-style-type: none"> <li>- Addresses immediate RAAC risks and ensures building safety.</li> <li>- Lower capital investment compared to full redevelopment.</li> <li>- Minimal service disruption.</li> </ul>	<ul style="list-style-type: none"> <li>- Does not improve clinical space efficiency or estate functionality.</li> <li>- Potential for abortive costs if future reconfiguration is needed.</li> <li>- Does not future-proof services or address changing healthcare demands.</li> <li>- May require further works in the near future, leading to higher costs over time.</li> </ul>	Offers short-term mitigation but lacks long-term value	Carried Forward
1.4	Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces	<ul style="list-style-type: none"> <li>- Removes RAAC risks and ensures long-term estate safety.</li> <li>- Optimises existing space for improved patient flow and clinical efficiency.</li> <li>- Supports modern service models and workforce needs.</li> <li>- Aligns with clinical strategy and decarbonisation agenda.</li> <li>- Retains acute and local healthcare provision in North Gwent.</li> </ul>	<ul style="list-style-type: none"> <li>- Requires significant capital investment.</li> <li>- Service disruption during construction.</li> <li>- Planning and approvals process may be complex and time-consuming.</li> <li>- Phased redevelopment may be required to ensure business continuity.</li> </ul>	Strong alignment with strategic, clinical, and estate objectives	Carried Forward

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1.5	Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces including Maindiff Court	<ul style="list-style-type: none"> <li>- Removes RAAC</li> <li>- Enables better integration of services across NHH and Maindiff Court.</li> <li>- Optimises clinical and administrative spaces to support workforce needs.</li> <li>- Creates opportunities for improved efficiency and service co-location.</li> <li>- Aligns with regional service delivery goals and decarbonisation targets.</li> <li>- Opportunity to rationalise estate</li> </ul>	<ul style="list-style-type: none"> <li>- Higher cost and complexity compared to option 1.4.</li> <li>- Requires relocation of services from Maindiff Court.</li> <li>- Potentially longer project timeline due to additional estate considerations.</li> </ul>	Offers the greatest strategic, clinical, and estate strategy alignment and operational benefit	Carried Forward
1.6	Full Reconfiguration of North Gwent Services (Includes removal of RAAC in NHH)	<ul style="list-style-type: none"> <li>- Most strategic and future-proof solution for North Gwent healthcare.</li> <li>- Enables complete redesign of service delivery to align with regional needs.</li> <li>- Removes RAAC risks and maximises estate efficiency.</li> <li>- Supports long-term sustainability, adaptability, and workforce planning.</li> <li>- Creates opportunities</li> </ul>	<ul style="list-style-type: none"> <li>- Likely significant cost and most complex implementation.</li> <li>- Significant service reorganisation and potential workforce impact.</li> <li>- Requires extensive stakeholder engagement and approvals.</li> <li>- Longest timeframe for completion, potentially leading to interim estate issues.</li> <li>- Affordability may be challenging</li> </ul>	Ambitious long-term solution but not deliverable within current scope. Focus should remain on RAAC removal in this phase, with potential for wider transformation in future phases.	Discounted

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		for regional collaboration and integration.			
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Table 31: Summary of Scope Options

Based on the appraisal of shortlisted scope options, Option 1.5, Reconfiguration of Nevill Hall Hospital including Maindiff Court, is identified as the Preferred Way Forward. This option delivers the greatest strategic fit, addresses critical estate and safety risks, and enables a future-proof clinical model that supports the Health Board’s long-term objective

**2.3.2 Summary of Funding Options**

Funding Option	Description	Advantages	Disadvantages	Conclusion	Carried Forward / Discounted
5.1	Discretionary Capital	<ul style="list-style-type: none"> <li>– Fully controlled by the Health Board</li> <li>– No external approval required</li> </ul>	<ul style="list-style-type: none"> <li>– Insufficient to meet project scale</li> </ul>	Not viable for a scheme of this size	Discounted
5.2	All Wales Capital Programme (AWCP)	<ul style="list-style-type: none"> <li>– Aligns with national infrastructure priorities</li> <li>– Appropriate for strategic transformation</li> </ul>	<ul style="list-style-type: none"> <li>– Requires approval through competitive WG process</li> </ul>	Best fit for strategic alignment and scale.	Carried Forward
5.3	Mixed Discretionary and AWCP Funding	<ul style="list-style-type: none"> <li>– Reduces AWCP burden slightly</li> <li>– Shows Health Board commitment</li> </ul>	<ul style="list-style-type: none"> <li>– Still beyond the scale of discretionary capital</li> <li>- Impact to availability for other schemes across the Health Board</li> </ul>	May compromise Health Board’s ability to manage capital risks and deliver smaller scale projects	Discounted
5.4	Mixed Private and WG Funding	<ul style="list-style-type: none"> <li>– Potentially reduces upfront capital ask from WG</li> <li>- Spreads capital costs over time.</li> </ul>	<ul style="list-style-type: none"> <li>– Introduces governance, risk, and commercial complexity</li> </ul>	Precedent exists within NHS Wales (e.g., Velindre Cancer Centre Mutual Investment Model (MIM)). May offer	Carried Forward

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		- Offers long-term maintenance guarantees.		flexibility if AWCP is constrained	
5.5	Private Finance	- Could enable earlier access to funding	- Significant long-term revenue implications - Limited precedent in current NHS Wales context	Viable only if aligned with wider funding strategy and affordability	Discounted

Table 32: Summary of Funding Options

The preferred funding route is Option 5.2 – Full capital funding via the All-Wales Capital Programme (AWCP). This reflects the strategic nature, complexity, and scale of the proposed redevelopment, which aligns closely with national investment priorities, including the clinical strategy.

The scheme requires a coordinated and comprehensive investment to address multiple priorities, including RAAC mitigation, service model transformation, decarbonisation, and estate rationalisation. These requirements extend beyond the scope and scale of the Health Board’s discretionary capital allocation and are best supported through a dedicated Welsh Government capital investment.

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### 2.3.3 Summary of Estate / Development Options

Below is a summary of the long-listed estate and development options for the Nevill Hall Hospital (NHH) site. Each option is assessed in terms of its description, advantages, disadvantages, and a conclusion regarding how well it supports the investment objectives and critical success factors (CSFs).

Within the SOC Option framework (Options 1–6), several of the estate/development options incorporate [sub-options](#) developed through the feasibility study and cost advisor analysis.

<b>Estate / Development Option</b>	<b>Description</b>	<b>Advantages</b>	<b>Disadvantages</b>	<b>Conclusion</b>	<b>Carried Forward / Discounted</b>
6.1	RAAC Remediation	<ul style="list-style-type: none"><li>- Targeted remediation of RAAC-affected areas at NHH</li></ul>	<ul style="list-style-type: none"><li>- Service disruption during works.</li><li>- RAAC remains present, posing long-term risk</li><li>- Limited scope to modernise estate or address service model needs.</li></ul> Does not fully support decarbonisation or optimise clinical adjacencies.	Provides short-term risk mitigation but fails to achieve long-term objectives or transformational change.	Carried Forward
6.2	Close NHH	<ul style="list-style-type: none"><li>- Removes RAAC risks by decommissioning the site.</li><li>- Potential financial savings from estate rationalisation.</li><li>- Opportunity to redirect</li></ul>	<ul style="list-style-type: none"><li>- Major loss of acute and local healthcare provision in North Gwent.</li><li>- Increased demand on other hospitals, leading to capacity issues.</li><li>- Negative impact on</li></ul>	Not aligned with strategic or population health needs	Discounted

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		resource and investment into other healthcare facilities.	patient access, particularly for rural communities. - Political and public opposition likely		
6.3	RAAC Removal <i>(aligns with feasibility Option 3)</i>	- Full removal of RAAC-affected structures and replacement with compliant infrastructure. - Eliminates structural safety risks. -Improves compliance and estate condition. - May allow selective modernisation.	- Disruptive to service delivery. - Significant capital investment required - Retains some legacy inefficiencies in the site layout.	Addresses safety but falls short of delivering a comprehensive service model or estate transformation and alignment with strategic objectives	Carried Forward
6.4	New Build Reconfiguring NHH Site <i>(aligns with feasibility Options 4.4a / 4.4b)</i>	- Full removal of RAAC-affected structures and replacement with compliant infrastructure. - Eliminates structural safety risks. - Replaces outdated infrastructure with modern, fit-for-purpose facilities.	Higher capital cost. - Requires decant or phased construction approach. - Increased complexity of workforce and service transitions.	Strong alignment with strategic goals; enables transformation and long-term sustainability and rationalise of estate.	Carried Forward
6.5	New Build Reconfiguring NHH Site including Maindiff	- All benefits of Option 6.4. - Improves the quality and functionality of retained areas.	- Higher capital cost due to additional refurbishment works.	Enhances the base option (6.4) by improving the quality of retained estate, supporting long-	Carried Forward

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	<i>(aligns with feasibility Option 5.1 / 5.2)</i>	<ul style="list-style-type: none"> <li>- Enhances staff working environment and digital infrastructure.</li> <li>- Supports decarbonisation and space efficiency.</li> </ul>	<ul style="list-style-type: none"> <li>- May introduce complexity in construction phasing.</li> </ul>	term use and improved estate condition	
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Table 33: Summary of Estate / Development Options

Based on the appraisal of shortlisted estate options, Option 6.5 (*feasibility Option 5.1*), New Build Reconfiguration of the Nevill Hall Hospital site including Maindiff Court is identified as the Preferred Way Forward. This option delivers the strongest strategic fit, fully addresses the RAAC and estate condition risks, and enables a modern, sustainable clinical model aligned with the Health Board’s long-term objectives.

**2.3.3.1 Estate Options – Mapping to Feasibility Study Sub-Options**

*The following sub-options were developed through the feasibility study and cost advisor analysis are referenced in the Financial Case Option*

<b>Estate / Development Option</b>	<b>Feasibility / Cost Advisor Option</b>	<b>Description</b>
6.3 RAAC Removal	3	Full removal of RAAC-affected structures without broader site redesign or service change.
6.4 New Build Reconfiguring NHH Site	4.4a	Reconfigure NHH Site, RAAC removal and redesign spaces excluding wards refurbishment
	4.4b	Reconfigure NHH Site, RAAC removal and redesign spaces including wards refurbishment
6.5 New Build Reconfiguring NHH Site including Maindiff	5.1	Reconfigure NHH Site, RAAC removal and redesign spaces, ward refurbishments and including Maindiff Court

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	5.2	Reconfigure NHH Site, RAAC removal and redesign spaces, ward reconfiguration and refurbishments, façade cladding, reroofing and including Maindiff Court
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### 2.4 Shortlisted Options

The 'preferred' and 'possible' options identified above have been carried forward into the shortlist for further appraisal and evaluation, allowing for a comprehensive assessment of each viable solution. Options deemed impracticable or misaligned with the Critical Success Factors (CSFs) and investment objectives were excluded at this stage to maintain focus on feasible approaches that best meet strategic and operational needs.

The shortlisted options provide a range of interventions, from maintaining the status quo to pursuing a full redevelopment. Each option has been evaluated in terms of its service scope, estate solution, service delivery approach, implementation strategy, and funding model. This structure ensures that all aspects of feasibility, sustainability, and value for money are considered in detail.

Based on this analysis, the recommended shortlist for further appraisal includes the following options:

<b>Service Scope</b>	<b>Service Options</b>	<b>Service Delivery</b>	<b>Implementation</b>	<b>Funding</b>	<b>Development / Estate Option</b>
<i>Defines the option and approach.</i>	<i>Defines the approach to service provision, addressing the types and extent of service enhancements or adjustments.</i>	<i>Specifies how the services will be delivered (e.g., in-house, outsourced, public-private partnership).</i>	<i>Describes the timeline and method for carrying out the project (e.g., phased, big bang, pilot).</i>	<i>Identifies the sources and structure of the funding required to deliver the preferred option.</i>	<i>Refers to the physical estate or infrastructure solution, detailing the nature of facility improvements, replacements, or new builds.</i>
1.1 Maintain existing facilities without new investment.	2.1 Maintain existing services without new investment. Only essential statutory maintenance is performed to meet minimum compliance and safety standards. RAAC mitigation only.	3.1 Internal teams continue existing operations	4.1 Continue existing operations	5.2 All Wales Capital	6.1 - RAAC Remediation

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<p>1.3 Removal of RAAC to ensure safety, without broader reconfiguration or service redesign</p>	<p>2.3 Address RAAC-related risks by focusing on removal only, ensuring buildings remain safe but without significant service redesign or modernisation.</p>	<p>3.3 Internal teams with contracted support for RAAC removal</p>	<p>4.2 Phased removal, addressing critical areas first</p>		<p>6.3 RAAC Removal (Aligns with feasibility option 3)</p>
<p>1.4 Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces</p>	<p>2.4 Modernise and redesign existing services at Nevill Hall Hospital, addressing RAAC and creating flexible, efficient, and sustainable clinical spaces and decommissioning non-essential buildings where required</p>	<p>3.4 Internal teams with contracted specialists for major phases of redevelopment.</p>	<p>4.3 Targeted Incremental redevelopment over time, focusing on essential clinical spaces.</p>		<p>6.4 New build Development (Aligns with feasibility option 4a/4b)</p>
<p>1.5 Reconfigure Nevill Hall Hospital site, addressing RAAC and redesigning spaces including Maindiff Court</p>	<p>2.5 Extend the reconfiguration of NHH to include the rationalisation of Maindiff Court, integrating and optimising service delivery across both sites and decommissioning non-essential buildings where required.</p>	<p>3.5 Combination of internal expertise and contracted services</p>	<p>4.4 multi-phase plan over several years, balancing immediate RAAC removal with broader site upgrades</p>		<p>6.5 New build Development including Maindiff Court (Aligns with feasibility option 5.1/5.2)</p>

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		3.6 Fully outsourced or partnership with external contractor.	4.5 multi-phase, with integration of Maindiff Court services into the new NHH configuration.		

Table 34: Shortlist of Options

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## 2.5 Preferred Way Forward

### 2.5.1 Summary Table of Preferred Way Forward Options

Options	Business as usual	Do Minimum	Preferred Way Forward	Less Ambitious Preferred Way Forward
<b>Scope Options</b>	0 – No Change	1.1 - RAAC Remediation Only	1.5 - Reconfigure NHH incl. Maindiff Court	1.4 - Reconfigure NHH Only
<b>Service Options</b>		2.1 - Maintain Existing Services	2.5 - Reconfigured Services incl. Maindiff Integration	2.4 - Modernised Services at NHH Only
<b>Service Delivery</b>		3.4 - Internal teams with contracted support for RAAC	3.5 - Mixed Delivery (Internal & Contracted)	
<b>Implementation</b>		4.1 - Continue Existing Operations	4.3 - Multi-Phase incl. Broader Upgrades	4.4 - Targeted Incremental Redevelopment
<b>Funding</b>			5.2 - All-Wales Capital	
<b>Development / Estate Options</b>		6.1 - RAAC Remediation	6.5 New Build Reconfiguring NHH Site including Maindiff Court and Refurbishment of 'H Blocks' ( <i>feasibility Options 5.1</i> )	6.4 - New Build and refiguration ( <i>feasibility Options 4.4b</i> )

Table 35: Summary of Preferred Way Forward

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### **2.5.2 Scope Option 0 – “Do Nothing”**

Option 0 has been retained as a baseline for comparison purposes but excluded from the formal appraisal, as it does not represent a viable course of action. It provides a benchmark against which the value for money of all viable options can be assessed, in line with HM Treasury Green Book guidance.

### **2.5.3 Scope Option 1.1 – “Do Minimum”**

Option 1.1 involves RAAC remediation only and was included to assess the minimum compliant investment that still allows continued safe use of the estate.

### **2.5.4 Preferred Way Forward: Scope Option 1.5**

Based on this assessment, Scope Option 1.5 –Reconfiguration of Nevill Hall Hospital Site including Maindiff Court – is identified as the Preferred Way Forward. This option provides the strongest alignment with the investment objectives, critical success factors, and clinical and estate strategies.

This option:

- ✓ Fully addresses RAAC risks.
- ✓ Enables consolidation of clinical and administrative functions to improve efficiency and flow.
- ✓ Supports a future-proof model of care aligned to the clinical strategy.
- ✓ Maximises use of the Health Board's existing land and infrastructure
- ✓ Enables rationalisation of Maindiff Court
- ✓ is considered most likely to optimise public value

### **2.5.5 Preferred Way Forward: Estate Option 6.5 (*feasibility Option 5.1*)**

Based on this assessment, Estate Option 6.5, New Build Reconfiguration of the Nevill Hall Hospital site including Maindiff Court, is identified as the Preferred Way Forward. This option offers the strongest alignment with the investment objectives, critical success factors, and the Health Board’s long-term estates and clinical strategies.

This option:

- ✓ Fully addresses the risks associated with RAAC through removal and redevelopment.
- ✓ Consolidates clinical and administrative functions, improving adjacencies, flow, and operational efficiency.
- ✓ Supports a modern, sustainable model of care aligned with the clinical strategy.
- ✓ Maximises use of existing Health Board land and infrastructure.
- ✓ Enables the rationalisation of Maindiff Court, contributing to wider estate optimisation
- ✓ Is considered the most likely option to deliver long-term value for money and support future service resilience.

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This option:

- ✓ Fully addresses the risks associated with RAAC through removal and redevelopment.

Though, acknowledging the current financial climate within the NHS in Wales, the Health Board is proposing the less ambitious Preferred Way Forward for phase 1 and Estate option 6.4 to redevelop the Nevill Hall Hospital (NHH) site to address the significant risk posed by the presence of RACC.

### **2.5.6 Indicative Economic Appraisal**

An indicative economic appraisal is a key requirement of the business case process to support option selection. At this Strategic Outline Case (SOC) stage, a high-level assessment has been undertaken to inform the identification of a preferred way forward, drawing on indicative capital costs and anticipated benefits.

A full economic appraisal, including quantified Net Present Social Value (NPSV) analysis and sensitivity testing, will be completed at Outline Business Case (OBC) stage. This will assess the economic viability of the shortlisted options in greater detail, in line with HM Treasury Green Book guidance.

### **2.5.7 Conclusion**

The Economic Case has demonstrated a robust and transparent approach to option development and appraisal, ensuring alignment with HM Treasury Green Book guidance and the Five Case Model. Through the structured evaluation of service, delivery, implementation, funding, and estate options, the Health Board has identified a Preferred Way Forward that delivers the greatest strategic fit, addresses critical infrastructure and safety risks, and enables a modern, sustainable model of care. The combination of Scope Option 1.5 and Estate Option 6.5 presents the most balanced solution in terms of benefits, deliverability, and long-term value for money. However, acknowledging the current financial climate within the NHS in Wales, the Health Board is proposing the less ambitious Preferred Way Forward for phase 1 and Estate option 6.4 (feasibility option 4.4b) to redevelop the Nevill Hall Hospital (NHH) site to address the significant risk posed by the presence of RACC. This option will now be taken forward for further development and detailed analysis at the Outline Business Case stage.

### **3. COMMERCIAL CASE**

The Commercial Case sets out the initial considerations around how the Health Board intends to procure the required services and infrastructure to deliver the proposed scheme.

At this early stage, a full procurement strategy has not yet been developed. However, the Health Board anticipates adopting a procurement route that ensures value for money, encourages market competition, and is aligned with Welsh Government capital guidance and procurement policy.

Subject to approval of this Strategic Outline Case, it is anticipated that:

- A Supply Chain Partner will be appointed via the NHS Building for Wales Framework to lead the development of the design and construction proposals.
- Key external advisors including a Project Manager, Cost Advisor, and Design Team will be appointed through compliant procurement frameworks to support the development of the Outline and Full Business Cases.
- The use of frameworks will support expediency, compliance, and access to pre-qualified, experienced suppliers, reducing procurement risk and timeline pressures.
- Early market engagement may be undertaken to test capacity and interest, particularly considering current market volatility and inflationary pressures in the construction sector.

The Health Board has prior experience successfully delivering capital schemes using framework-based procurement routes, and lessons learned from previous projects will inform the development of the full commercial strategy at the Outline Business Case stage.

In line with Welsh Government expectations, the delivery strategy will consider:  
The use of Modern Methods of Construction (MMC) to accelerate delivery, improve build quality, and support decarbonisation  
Opportunities to embed Net Zero Carbon design principles and ensure the construction process contributes to sustainability targets  
The integration of digital infrastructure and Smart Hospital principles to future-proof the development and enable technology-enabled care.

These elements will be explored in more detail as part of the development of the Outline and Full Business Cases.

#### **3.1 Funding Model**

At this stage, it is anticipated that the proposed scheme will be funded via the All-Wales Capital Programme (AWCP), subject to Welsh Government approval through the standard business case process. The Health Board will develop the scheme in line with Welsh Government capital investment guidance, ensuring affordability, value for money, and alignment with strategic priorities.

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The Strategic Outline Case forms the first stage in securing capital funding, with further detail to be provided within the Outline and Full Business Cases, including full capital and revenue affordability assessments.

The Health Board is committed to ensuring that its commercial approach is robust, compliant, and aligned with both local priorities and national expectations. The full commercial strategy, including procurement route, contracting arrangements, risk allocation, and market engagement plans, will be developed in detail as part of the Outline Business Case.

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## **4. FINANCIAL CASE**

This section sets out an initial financial impact of the investment proposal from a capital and revenue perspective and provides an early assessment of overall affordability.

While full cost certainty will be developed at Outline and Full Business Case stages, this Strategic Outline Case provides an early view of the financial requirements and affordability considerations. Detailed modelling of revenue impacts and any potential savings will be developed at OBC stage.

### **4.1 Organisational Financial Context**

Aneurin Bevan University Health Board (ABUHB), like all NHS organisations in Wales, is operating within a highly challenging financial environment. The Health Board continues to experience sustained operational and financial pressures linked to increasing service demand, inflationary cost growth and workforce challenges. The UHB continues to be impacted by operational pressures combined with the local and national focus to reduce elective and diagnostic waiting lists. These pressures result in a financial environment which provides minimal scope to invest/re-align in services from a long-term perspective.

In line with national direction, ABUHB is focused on delivering recurrent savings and improving cost efficiency while protecting the quality and safety of patient care. The Health Board is working to address a significant underlying financial deficit, which is subject to regular review and scrutiny by the Welsh Government through the Integrated Medium-Term Plan (IMTP) process and monthly financial monitoring returns.

Despite these pressures, the Health Board remains committed to progressing strategic investments that support long-term sustainability, value for money, and health system transformation. Capital investment proposals, including this Strategic Outline Case, are being developed with a strong focus on affordability, financial risk management, and alignment with clinical and estate priorities across the organisation and region.

The delivery of this scheme will be contingent upon external capital funding and will be sequenced to ensure compatibility with the organisation's wider financial recovery trajectory.

- The proposed service model and estate strategy are focused on optimising existing resources, reducing backlog maintenance, and improving operational efficiency, ensuring long-term affordability.
- The scheme has been scoped with a clear intent to remain within the financial envelope available to the Health Board, avoiding additional pressure on revenue or capital budgets.
- By enabling more efficient use of space, consolidating services, and supporting digitally enabled care, the redevelopment aims to deliver greater value for money.
- The financial principles underpinning this proposal reflect the Health Board's commitment to sustainable investment, cost containment, and system-wide benefit realisation.

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These financial considerations are fully aligned with the wider priorities outlined in the organisation's Integrated Medium-Term Plan (IMTP) and are explored in further detail within this chapter

## **4.2 Overall options**

The current long list of options for the primary redevelopment are listed below (as per the Economic Case scope options 1.1 – 1.6). It should be noted that the full scope and sub-options can be described in greater detail at subsequent stages: -

**Option 1 (baseline)** – Do minimum and maintain existing facilities without new investment

**Option 2** – Close NHH (discounted)

**Option 3** – RAAC removal without broader redevelopment

**Option 4** – Reconfigure NHH (Address RAAC & Redesign Spaces)

**Option 5** – Reconfigure NHH & Maindiff Court

**Option 6** – Full Reconfiguration of North Gwent Services (includes removal of RAAC in NHH) (not considered for SOC given Programme reconfiguration required)

For clarity Options 1, 3, 4 and 5 are considered as part of the shorter list to consider revenue consequences. Other assumptions noted are as follows:-

- Scope - The main buildings on the NHH are considered within scope alongside Maindiff Court as necessary. NHH Residences, the conference centre and a number of other buildings e.g. Medical Education are regarded as out of scope for all options.
- Activity assumption - In options 1 and 3 activity demand growth is assumed to require additional expenditure however it is unconfirmed as to how the capacity will be delivered. For options 4 and 5 it is assumed that activity demand growth will be mitigated through efficiency gains, the increased capacity obtained through additional theatres and the greater capacity enabled through the revised service models relating to this project.
- In future stages of the business case, the overall UHB capacity requirements would be fully established in greater detail. This analysis will ensure that the potential impact on the NHH site is considered and confirmed alongside other sites. There will potentially be an opportunity to reduce the cost base on other sites however this will need further analysis and review at the OBC stage.
- Bed capacity is defined as c.208 beds which includes 24 Assessment beds/trolleys. This level of capacity is in line with current capacity and therefore no cost/saving is assumed for specific changes.
- Workforce baseline establishments have been sought from relevant services and are not shown in this section. A baseline using staff in post as at April 2025 is shown in the workforce section. The relevant impacts are calculated

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where necessary but will be analysed in greater detail at future stages of the business case.

- No inflationary impact/wage awards are assumed in this analysis.

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### 4.3 Capital costs

	Option 0 - Do Nothing	Option 1 - Do Minimum	Option 3 - RAAC removal, no redevelopment	Option 4.4a - Reconfigure NHH Site, RAAC removal and redesign spaces excl. Ward refurbishments	Option 4.4b - Reconfigure NHH Site, RAAC removal and redesign spaces incl. Ward refurbishments	Option 5.1 - Reconfigure NHH Site, RAAC removal and redesign spaces including MCH	Option 5.2 - Reconfigure NHH Site, RAAC removal and redesign spaces including MCH
	£000	£000	£000	£000	£000	£000	£000
Works Cost	58,258	81,351	87,819	150,867	218,812	241,917	294,318
Fees	0	0	16,203	27,760	40,261	44,513	54,154
Non Works Costs	0	0	5,275	6,979	8,847	9,987	11,428
Equipment Costs	0	0	5,675	11,537	17,811	20,097	21,130
Planning Contingency (15%)	0	0	17,246	29,571	42,860	47,477	57,155
VAT	0	4,619	26,443	45,343	65,718	72,798	87,637
VAT Recovery	0	0	-6,203	-6,787	-12,610	-13,460	-15,802
<b>Project Cost</b>	<b>58,258</b>	<b>85,970</b>	<b>152,457</b>	<b>265,269</b>	<b>381,701</b>	<b>423,329</b>	<b>510,020</b>
Optimism Bias (Inc VAT)	0	0	48,201	63,906	92,624	102,602	123,516
<b>Overall Cost Estimate</b>	<b>58,258</b>	<b>85,970</b>	<b>200,658</b>	<b>329,175</b>	<b>474,324</b>	<b>525,930</b>	<b>633,536</b>
<b>Funding Split:</b>							
AWCP Capital Funding	58,258	85,970	197,361	329,175	474,324	525,930	633,536
IFRS16 Capital Funding	0	0	3,296	0	0	0	0
<b>Overall Cost Estimate</b>	<b>58,258</b>	<b>85,970</b>	<b>200,658</b>	<b>329,175</b>	<b>474,324</b>	<b>525,930</b>	<b>633,536</b>

The table below indicates the initial analysis of capital costs for the options considered.

Figure 28: Table of Capital Costs by Scope Option

It should be noted that the costs included for option 0 – do nothing relate to the backlog maintenance costs (with inflationary assumptions included).

There are sub-options considered (4.4b and option 5) from a capital perspective that include refurbishment of ward areas within the main 'H-block' building.

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Accommodation for services moved from Maindiff Court has been included in options 5.1 and 5.2 however no disposal proceeds have been included at present. Updated cladding on NHH buildings has been included in option 5 which present a significant cost.

The table includes an element of lease costs for temporary buildings in option 3 (c.£2.7m). From an affordability perspective, the financial ledger transactions relating to IFRS 16 will ultimately impact revenue assuming WG will recover funding accordingly.

**4.3.1 Estate/Development Sub-Options Mapping**

Several of the scope options include estate/development sub-options, developed through the feasibility study and cost advisor analysis. These are shown in the table below to ensure alignment between the SOC appraisal, feasibility outputs, and capital cost estimates.

Scope Option	Feasibility / Cost Advisor Option	Description
3	3	Full removal of RAAC-affected structures
4	4.4a	Reconfigure NHH Site, RAAC removal and redesign spaces excluding wards refurbishment
	4.4b	Reconfigure NHH Site, RAAC removal and redesign spaces including wards refurbishment
5	5.1	Reconfigure NHH Site, RAAC removal and redesign spaces, ward refurbishments and including Maindiff Court
	5.2	Reconfigure NHH Site, RAAC removal and redesign spaces, ward reconfiguration and refurbishments, façade cladding, reroofing and including Maindiff Court

**4.4 Optimism Bias**

In accordance with HM Treasury Green Book guidance, an optimism bias adjustment has been applied to capital cost estimates to account for potential underestimation of costs at this early stage of business case development. This adjustment is intended to reflect the inherent uncertainty and risk associated with capital schemes at Strategic Outline Case (SOC) stage, particularly where there is limited design development and a higher degree of assumption in scope, timelines, and market conditions.

The cost advisor has included an appropriate optimism bias allowance within the capital cost estimates to provide a more realistic view of potential outturn costs. This is consistent with benchmark percentages recommended for healthcare

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infrastructure schemes and ensures that economic appraisal reflects a prudent and robust estimate of investment need.

Optimism bias will be reviewed and refined as the project progresses through Outline and Full Business Case stages, and as risk is progressively mitigated through detailed design, procurement strategy, and market testing.

### 4.5 Revenue consequences

The revenue costs for the each of the options are set out below. Each analysis includes an assessment of the internal costs, required to support each option. Costs are based on relevant workforce and service plans where possible. The revenue baselines and consequences are listed as direct and indirect support costs. They do not include overheads and externally commissioned costs for this case. This may be reviewed for future submissions given potential impact to for example Velindre oncology. Patient flow changes across Health Boards are assumed to be negligible for this element of the case.

For the purposes of this analysis, no costs are included for other North Gwent services nor areas such as theatres within other eLGHs. The baseline costs included relate to the 2024/25 financial year and include direct costs allocated or within NHH alongside apportioned indirect support costs (e.g. therapies, clinical support costs). There remains some difficulty apportioning some staffing costs and this element will need further review.

The table below shows an initial analysis of baseline costs linked to Nevill Hall Hospital (NHH) and Maindiff Court (MCH).

Area / Division	Total Baseline (Direct / Indirect) £000s
<b>Operational Divisions:-</b>	
Primary Care and Community	2,456
Mental Health & Learning Disabilities	5,419
Surgery	20,134
Clinical Support Services	8,207
Medicine	31,253
Urgent Care	2,590
Family & Therapies	8,406
Estates and Facilities	11,541
<b>Total - Operational Divisions</b>	<b>90,006</b>
<b>Corporate areas</b>	<b>2,545</b>
<b>Total baseline (Direct / Indirect exc. Overheads)</b>	<b>92,551</b>

**Strategic Outline Case:**  
Nevill Hall Hospital Development Project

The net revenue consequences of each option have been considered as an initial estimate and the summary table is shown below:

Option	Narrative	Year 1 £000s	Year 2 £000s	Year 3 £000s	Year 4 £000s	Year 5 (recurrent) £000s
	Baseline cost	92,551	92,551	92,551	92,551	92,551
Option 1 - Do nothing/minimum	Additional expenditure Operational commissioning Savings	2,124 3,006 0	2,324 - 0	2,524 - 0	2,924 - 0	3,124 - 0
<b>Option 1 - Do nothing/minimum</b>	<b>Net cost</b>	<b>5,130</b>	<b>2,324</b>	<b>2,524</b>	<b>2,924</b>	<b>3,124</b>
Option 3 - RAAC only	Additional expenditure Operational commissioning Savings	2,626 3,009 0	2,726 - 0	2,826 - 0	3,026 - 0	3,126 - 0
<b>Option 3 - RAAC only</b>	<b>Net cost</b>	<b>5,635</b>	<b>2,726</b>	<b>2,826</b>	<b>3,026</b>	<b>3,126</b>
Option 4 - NHH services only	Additional expenditure Operational commissioning Savings	2,844 2,504 0	2,844 - (743)	2,844 - (743)	2,844 - (743)	2,844 - (743)
<b>Option 4 - NHH services only</b>	<b>Net cost</b>	<b>5,348</b>	<b>2,101</b>	<b>2,101</b>	<b>2,101</b>	<b>2,101</b>
Option 5 - NHH and MCH service reconfiguration	Additional expenditure Operational commissioning Savings	2,844 2,504 (231)	2,844 - (745)	2,844 - (745)	2,844 - (745)	2,844 - (745)
<b>Option 5 - NHH and MCH service reconfiguration</b>	<b>Net cost</b>	<b>5,117</b>	<b>2,099</b>	<b>2,099</b>	<b>2,099</b>	<b>2,099</b>

The estimated revenue consequences are based on the following broad assumptions:

- The 'do nothing/minimum' option 1 is considered in the context of costs to undertake additional activity (1,187 procedures) potentially using external providers but is unconfirmed, alongside costs to cover service provision from unusable estate. This option is included as a baseline and can be considered further if required.
- Consideration of option 3 would require additional costs to undertake the extra activity (1,187 procedures) for day case procedures which would be more efficiently processed using a day-case and treatment centre. Day-case unit costs (23/24) excluding overheads have been used to estimate the costs alongside additional theatre capacity as per other options but can be reviewed and refined for future iterations.
- Consideration of options 4 and 5 currently assume expenditure requirements for additional theatre capacity for the day-case centre. The assumption is that the 6 NHH theatres (including Ophthalmology) will be operational for 10 hours per day for 5.5 days (currently 9 hours per day over 5 days) with an additional 4 treatment rooms based on the same model as the unit in RGH (estimated total cost c.£1.8m). There is an expectation that additional activity will also be enabled by efficiencies and increased through-put of activity.
- It is assumed that for option 5 that the ward beds and step-down beds/flats in Maindiff Court move across to NHH with no revenue impact. The model of care and specific requirements will be reviewed in further iterations.
- The outpatient elective model has no additional costs at present with increased demand being managed through efficiencies. This assessment

## Strategic Outline Case:

### Nevill Hall Hospital Development Project

will be refined for the OBC and FBC as the detailed model and staffing requirements are reviewed.

- The Family and Therapies model only includes costs for option 3 in order to undertake additional physiotherapy which is currently reduced given the impact of RAAC. The community-based rehabilitation therapies model will be developed and any further expenditure will be identified in the OBC.
- The Urgent care model will have minimal additional expenditure other than potentially some support/reception staffing for the revised MIU/main entrance.
- An estimated cost of c.£0.1m has been included for clinical support services / diagnostics (excluding those for operational commissioning). It is assumed that the majority of additional demand can be met through the new facilities, but it is likely that there will be additional radiology and other diagnostics costs. This assumption will be tested and analysed for the OBC.
- There are no revenue costs assumed for a potential 2<sup>nd</sup> MRI scanner and PET scanner, this would be considered as a separate business case but should be regarded as a key risk given the costs involved.
- Options 1 and 3 include additional estates and facilities costs linked to maintenance and/or other costs to maintain the NHH estate and movement of staffing accordingly. This will be reviewed in greater detail at the OBC stage against capital estimates for backlog maintenance.
- All options are assuming a change in catering model from traditional to 'cook-freeze'. Further modelling will be undertaken depending on whether there is sufficient space to use the hybrid model within many other ABUHB sites. Any saving assumed is offset by additional provisions which will need to be considered further depending on exact layout and operation. There may also be an impact of staff catering income which will require further review.
- Cancer service provision outside of the Satellite Radiotherapy Unit (SRU) for SACT and related costs (e.g. pharmacy and facilities) are unconfirmed assumed to be linked to Long Term Agreements with other NHS bodies.
- The inpatient model for Care of the Elderly, Community and the necessary interfaces are being developed. For the purposes of this analysis, this is assumed to be cost neutral.
- Energy and rates savings have been included for NHH and Maindiff Court as appropriate using estimate £/m<sup>2</sup> for the 2024/25 financial year. This assumes the current floor area for NHH will reduce and Maindiff Court will close accordingly. No assessment of energy consumption (usage within specific areas) has been considered at present.
- Digital revenue costs have been estimated based on the capital estimate provided.
- Operational commissioning expenditure is likely to be extensive for all options in year 1 given the number of changes required and potential for double-running on services. The estimated costs have been analysed based on previous plans for YYF and GUH appreciating the actual impact on GUH was considerably different given the nature of opening. These costs will be refined once further detail with regards to the steps and processes as necessary.

## Strategic Outline Case:

### Nevill Hall Hospital Development Project

- The PFI contract for the Energy Performance Centre is due to cease in December 2026. Further consideration of the impact and likely replacement of equipment will be undertaken at the OBC stage.
- To summarise, the cost differential between options 1 and 3 compared to options 4 and 5 relates to reduced day case and outpatient costs. In addition, estates and facilities costs are lower coupled with assumed utilities savings resulting in an overall lower net revenue costs.

#### 4.6 Affordability and other related factors for consideration

- The additional revenue expenditure identified would need to be included in future UHB IMTP documents with off-setting savings plans being required to ensure overall financial balance for the organisation. Revenue affordability remains a key principle and the OBC will review the options to provide a balanced approach between affordability and longer-term sustainability.
- The initial financial analysis provided indicates the level of investment and potential savings for each of the four options considered. Further analysis for the OBC will be undertaken to indicate the increased level of activity in NHH and the improved patient outcomes through day case procedures, improved outpatient facilities and consistent clinical models.
- There are several areas on the NHH site which are effectively outside the scope of this analysis such as the residences, creche and conference centre. Further consideration of capital expenditure which could be enable long-term revenue benefit could be considered separately.
- With regards to overall population improvement and the Well-being of Future Generations Act; some of the expenditure described for therapies, cancer and outpatient facilities could be classed as preventative expenditure with the overall outcome benefits seen on a longer-term basis.

#### 4.7 Summary

The Financial Case sets out the financial impact of the investment proposal from a capital and revenue perspective and assesses overall affordability. The initial indicative recurrent revenue cost of the short-listed options range from **c.£3.1m to c.£2.1m**. It should be noted however that the range of service models underpinning this analysis needs considerable refinement alongside the impact of operational commissioning. These service model reviews will undoubtedly change the cost impact accordingly.

The preferred option (Option 5) assumes a significant efficiency benefit by enabling a greater through-put of both day case procedures and outpatient attendances. As a result, the cost differential shown excludes a significant level of non-cash releasing benefits.

At future stages of this case, the whole system effect would need to be considered and analysed. As a result, the confirmation of the net financial impact of this overall business case would need to be determined and agreed. Any net increases in revenue costs would be **unaffordable** in the current financial context of the Health Board.

## 5. MANAGEMENT CASE

### 5.1 Programme Management Arrangements

This development is an integral part of the Health Boards Integrated Medium Term Plan and Clinical Redesign Programme.

### 5.2 Project Management Arrangements

The project is being managed in accordance with the requirements of the Building for Wales Framework, the NHS capital investment manual and PRINCE 2 methodology.

### 5.3 Reporting Structure

The NHH Development Project Board has been established to oversee the project. The Board will be chaired by the Executive Director of Strategy, Planning and Partnerships and will report to the Executive Committee. The Board has clear Terms of Reference which will be reviewed on an annual basis.



Figure 29: Diagram of Project Structure

## **Strategic Outline Case:**

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A number of working groups have been established to develop key products required to support the delivery of the project. These include external advisors in order to ensure that the Project Director receives appropriate advice and support.

### **5.4 Project Roles and Responsibilities**

Key Project Roles and Responsibilities are outlined below:

**Senior Responsible Owner** – Executive Director of Strategy, Planning and Partnerships

The Senior Responsible Owner (SRO) is responsible for ensuring that the Programme's objectives are delivered on time and within the desired cost and quality constraints.

**Project Director** – Assistant Director of Strategic Capital and Estates

The Project Director is accountable to the Senior Responsible Officer and is responsible for ensuring that the Project remains focused on achieving its objectives and that the project benefits will be realised.

**Project Lead** – Deputy Director Executive Director of Strategy, Planning and Partnerships

The Project Lead provides operational leadership for the delivery of the Project. This role is responsible for coordinating workstreams, ensuring alignment with the service model and strategic planning objectives, and acting as a key liaison between clinical, planning, and capital colleagues. The Project Lead supports the realisation of benefits and the delivery of service transformation outcomes.

### **5.5 Outline Project Plan**

Subject to approval of the Strategic Outline Case (SOC), the key implementation milestones for the project are expected to follow the indicative timescales below. These are dependent on the timing of approvals from Welsh Government and may be subject to change.

<b>Activity</b>	<b>Start</b>	<b>Finish</b>
SOC submission and approval	Nov 2025	March 2026
Appointment of SCP/PM/ TCA	May 2026	May 2026
OBC commencement and completion	June 2026	June 2027
OBC submission and approval	July 2027	Sept 2027
FBC commencement and completion	Nov 2027	April 2028
FBC submission and approval	Sept 2028	Dec 2032

## Strategic Outline Case:

Nevill Hall Hospital Development Project

Construction start and completion		
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Table 36: Outline Project Plan

An indicative delivery programme for the Preferred Way Forward (Option 5.0) has been developed by the professional advisors (Mott MacDonald). The programme spans 2026–2036 and includes phased design, construction, and decanting activity to maintain operational continuity. Subject to funding certainty, there is potential to accelerate delivery through overlapping design and construction phases, reducing the programme to 2032/33. A full programme is provided in [Appendix 1](#).

### 5.6 Risk Management

An overarching risk management process has been established which constitutes the following phases: identification; classification; assessment and action. A project dashboard, including risk register will be maintained and project risks will be reviewed monthly by the Project Board.

### 5.7 Benefits Realisation Monitoring

A benefits realisation plan will be developed which contains details of the specific benefits, how they will be delivered, who is responsible for delivery and the appropriate measures.

The Director of Strategy, Planning and Partnerships will report performance to the Executive Team on a quarterly basis

### 5.8 Change Control Process

A formal change control process is in place to manage any proposed changes to scope, cost, programme or quality. All change requests must be submitted via the standard Change Control Form and formally sent to the Project Manager for initial review. The Project Manager will assess the implications of the change, consult with relevant workstream leads as necessary, and escalate to the Project Board and Project Director for approval, ensuring transparency and appropriate governance throughout the project lifecycle. A log of requests and decisions will be maintained.

### 5.9 Stakeholder Engagement and Management

A stakeholder engagement and communication strategy has been developed and is detailed in the Strategic Case. The Project Team will maintain active engagement with clinical teams, staff groups, Llais, patients, and wider public stakeholders throughout design and delivery.

#### 5.9.1 Engagement Strategy

A dedicated Communications and Engagement Plan ([Appendix 5](#)) has been developed to support the Nevill Hall Hospital Development Project, recognising the importance of engaging with stakeholders at all levels to inform, shape and

## **Strategic Outline Case:**

### Nevill Hall Hospital Development Project

respond to proposed service changes. Working closely with Llais (the citizen voice body for health and social care in Wales), the plan has been set within a context of reviewing the configuration of services at all of the health board's key enhanced local general hospitals (eLGH), to ensure that the overall health system is balanced and provides the most efficient and effective support to the specialist and critical care centre at the Grange University Hospital. The plan then sets out the strategic rationale for commencing this process at Nevill Hall Hospital. An initial eight-week engagement will commence in June in respect of the overall principles of service configuration, to be supported by further bespoke initiatives for areas of more significant service change.

The plan aligns with the Health Board's statutory duty to engage, the guidance set out by Llais and the values underpinning the Clinical Futures programme. It outlines a structured two-phase approach to engagement that will inform and involve the public, staff, and key partners in decisions affecting the future configuration of services delivered from Nevill Hall Hospital and the wider eLGH network.

#### **5.9.1.1 Objectives**

The overarching objectives of the engagement plan are to:

- Explain the rationale for the redevelopment and its alignment with Clinical Futures.
- Raise awareness of the challenges within current service arrangements.
- Provide clarity on the proposed future direction for NHH as part of the eLGH network.
- Capture feedback, concerns and suggestions from stakeholders, ensuring these are transparently considered and inform the decision-making process.

#### **5.9.1.2 Principles**

Engagement activities will be guided by the following principles:

- **Inclusive and transparent:** Ensuring all affected groups, including underserved populations, have opportunities to participate
- **Accessible and bilingual:** Communication materials and sessions will comply with Welsh language standards and accessibility best practice
- **Iterative and responsive:** Feedback will be actively used to shape ongoing design and planning, with themes analysed and published
- **Proportionate and phased:** Initial engagement will seek views on broad principles, with follow-up targeted engagement for more significant service change proposals.

#### **5.9.1.3 Delivery**

The approach will be coordinated through a programme of targeted and public-facing activity, including:

- Public meetings (both in-person and online),
- Staff briefings and consultation,

## Strategic Outline Case:

### Nevill Hall Hospital Development Project

- Stakeholder-specific engagement sessions (e.g. with Local Authorities, Powys HB, community organisations),
- Patient surveys and scenario-based discussions to explore impact,
- Ongoing digital communications, including a dedicated web presence and social media updates.

#### 5.9.1.4 Future Planning and Risk Management

A stakeholder map ([Appendix 6](#)) has been developed as part of this Strategic Outline Case to support targeted and proportionate engagement aligned to levels of interest and influence. This has informed the structure and focus of both Phase 1 and Phase 2 engagement activity. While this early mapping has guided the approach to date, a more detailed risk mitigation strategy, including the management of potential opposition and risk of legal challenge or judicial review, will be developed at Outline Business Case (OBC) stage. This will ensure alignment with the Corporate Risk Register, which captures the risk of judicial review in relation to major capital projects and will support the Health Board to demonstrate delivery of its statutory duties and transparent decision-making throughout the programme.

#### 5.9.1.5 Engagement Activity

Phase	Description	Timeframe	Key Activities
Phase 1: Initial Engagement	Engagement on overarching principles for NHH and eLGHs	23 June – 15 August 2025	Public sessions, surveys, stakeholder communications, website and social media activity
Feedback Collation and Reporting	Analyse input from Phase 1 to inform next steps	August – September 2025	Engagement summary report, presentation to Llais and Board
Phase 2: Targeted Engagement	Further engagement on specific service proposals (e.g. stroke rehab)	October – December 2025	Bespoke service-specific engagement as required
Final Planning and Decision-Making	Incorporate feedback into final service model proposals	January 2026	Finalisation of larger-scale changes and presentation to Board

Table 37: Engagement Activity

This engagement activity will be supported by an evaluation framework and culminate in a comprehensive report for Llais and the Board, ensuring transparency and public accountability.

## 5.10 Workforce Implications and Organisational Change

The proposed relocation of services and staff from Maindiff Court to Nevill Hall Hospital may require a variation in employment contract. The NHS Wales Organisational Change Policy will be applied to manage any variation in employment contract. This will be supported by a robust engagement process

**Strategic Outline Case:**

Nevill Hall Hospital Development Project

with staff and through existing partnership working arrangements. A detailed workforce plan will be developed to assess the impacts on staff and organisational change and consultation requirements.

**5.11 Post Project Evaluation**

A post project evaluation will be undertaken once the NHH development has been established for a sufficient period to allow an appropriate evaluation to be undertaken (likely to be 12 months post project). This will aim to establish whether the expected benefits have been delivered, and any lessons learnt

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## 6. Appendices

### 6.1 Appendix 1 – Feasibility Study



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### 6.2 Appendix 2 - Benefits Strategy



202504 NHH  
Development Benefi

### 6.3 Appendix 3 – Benefits Map



20250430 NHH  
Development Benefi

### 6.4 Appendix 4 – Options Appraisal



202511 NHH  
Development Optio

### 6.5 Appendix 5 – Communication and Engagement Plan



NHH Briefing



NHH FAQs



NHH survey

document (updated (updated 17.06.25) f questions (updated

## 6.6 Appendix 6 – Stakeholder Map



eLGH Development  
Stakeholder Analysis:

## 6.7 Appendix 7 – Glossary of Terms

Abbreviation	Full Term
ABUHB	Aneurin Bevan University Health Board
ADHD	Attention Deficit Hyperactivity Disorder
AMU	Acute Medical Unit
AWCP	All-Wales Capital Programme
BADS	British Association of Day Surgery
BREEAM	Building Research Establishment Environmental Assessment Method
CADT	Care After Death Team
CAMHS	Child and Adolescent Mental Health Services
CCNS	Community Children's Nursing Service
CDC	Community Diagnostic Centres
CLDT	Community Learning Disabilities Team
CMHT	Community Mental Health Team
CNRS	Clinical Nurse Specialist
COTE	Care of the Elderly
CSF	Critical Success Factors
CT	Computed Tomography
DNA	Did Not Attend

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DC	Day Case
DSU	Day Surgery Unit
ECT	Electroconvulsive Therapy
EFU	Elderly Frailty Unit
eLGH	Enhanced Local General Hospital
ENT	Ear, Nose and Throat
ETR	Electronic Test Request
FBC	Full Business Case
FM	Facilities Management
GAU	Gynaecology Ambulatory Unit
GAVO	Gwent Association of Voluntary Organisations
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMS	General Medical Services
GOPD	General Outpatient Department
GP	General Practitioner
GPhC	General Pharmaceutical Council
GUH	Grange University Hospital
GWICES	Gwent Wide Integrated Community Equipment Service
H&S	Health and Safety
HB	Health Board
HVLC	High Volume Low Complexity
IMTP	Integrated Medium-Term Plan
ITU	Intensive Therapy Unit
JAG	Joint Advisory Group
LHP	Llantrisant Health Park
Llais	The Citizen Voice Body for Health and Social Care in Wales
MHRA	Medicines and Healthcare products Regulatory Agency
MMC	Modern Methods of Construction

**Strategic Outline Case:**

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MCH	Maindiff Court Hospital
MS	Multiple Sclerosis
MRI	Magnetic Resonance Imaging
NHH	Nevill Hall Hospital
OBC	Outline Business Case
PCMHSS	Primary Care Mental Health Support Service
PHN	Public Health Nursing
POCT	Point of Care Testing
RAAC	Reinforced Autoclaved Aerated Concrete
SACT	Systemic Anti-Cancer Therapy
SOC	Strategic Outline Case
SRO	Senior Responsible Owner
SRU	Satellite Radiotherapy Unit
UHB	University Health Board
WDA	Wholesale Distributor Authorisation
WG	Welsh Government

*Table 38: Glossary of Terms*

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

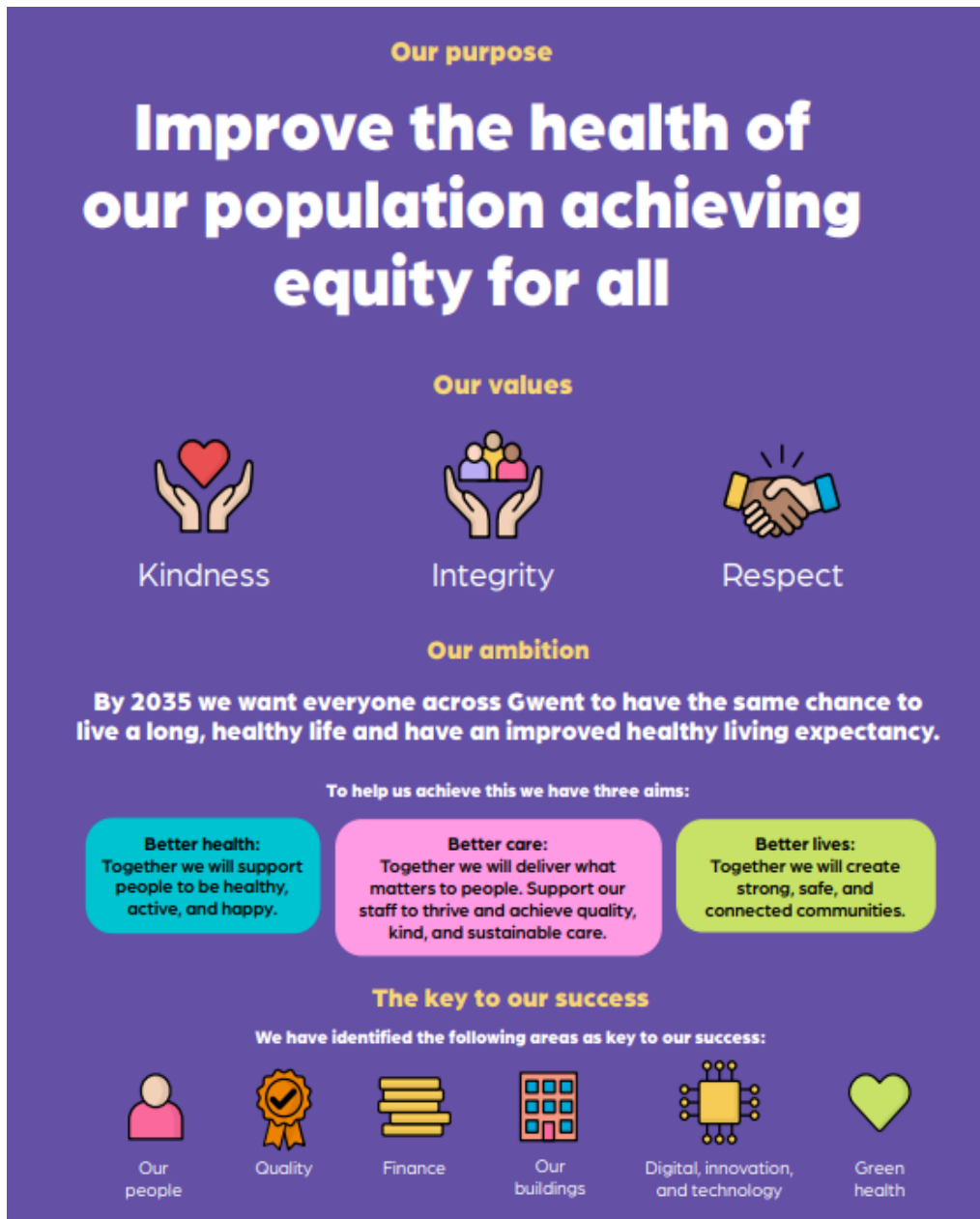
**2. Cefndir / Background**

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.

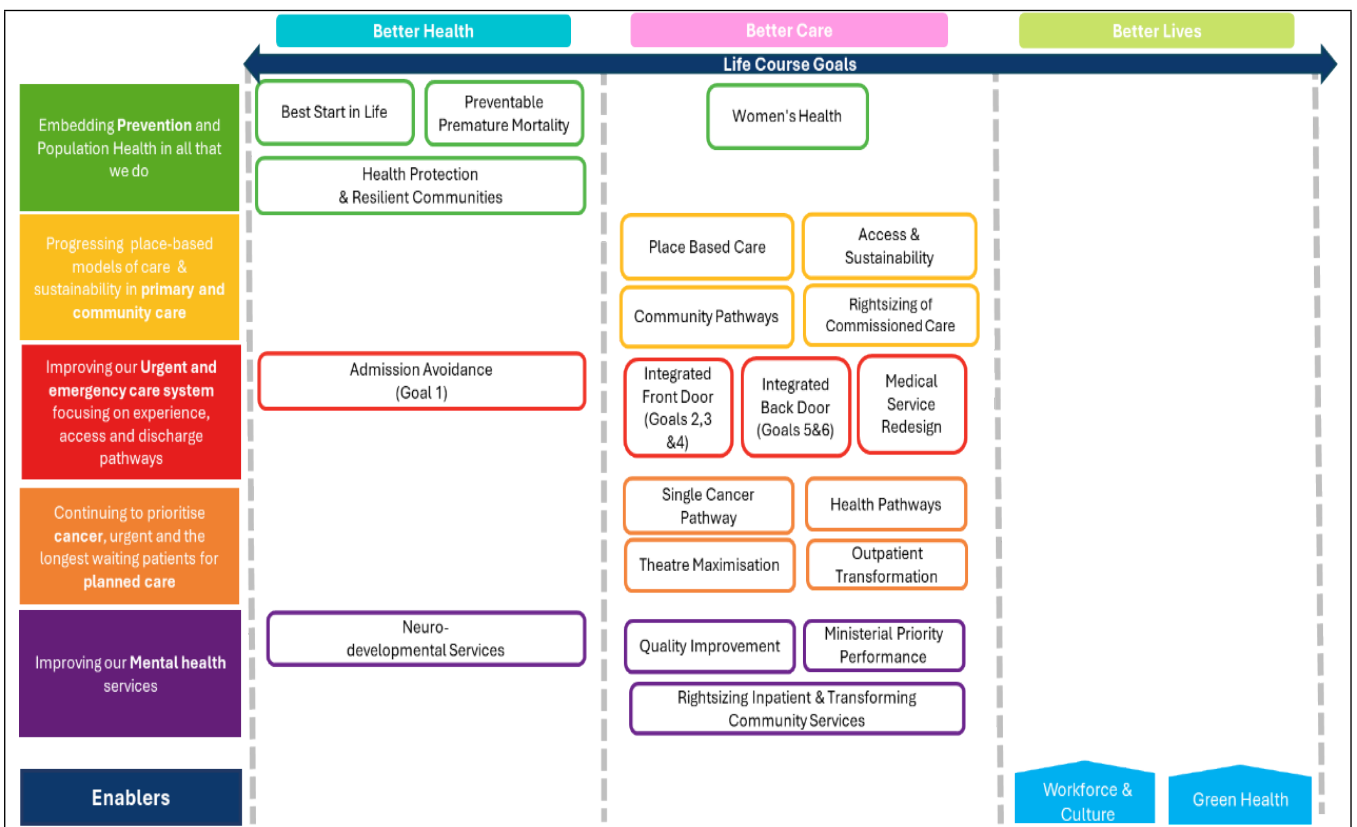


This reorientation is everyone’s business, from Board through to front line staff and delivery against these actions will be tracked through a Making it Happen steering group. This will involve the Steering Group undertaken an assessment of maturity and how the Health Board ensures decisions are made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



**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**

“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

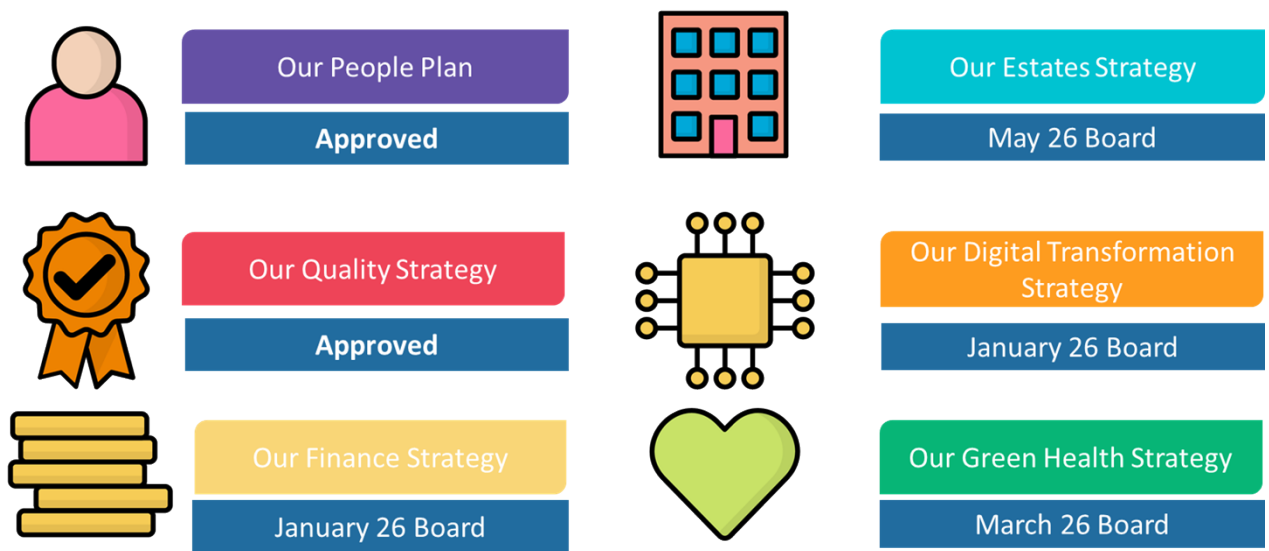
### Better Lives

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 be 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

<b>Appendices</b>	
<b>Appendix 1</b>	Strategy Deployment and Delivery plan, Making it Happen
<b>Appendix 2</b>	Outcomes Framework

<b>Amcanion: (rhaid cwblhau) Objectives: (must be completed)</b>	
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  <a href="#">Link to IMTP</a>	<ul style="list-style-type: none"> <li>• Every Child has the best start in life</li> <li>• Getting it right for children and young adults</li> <li>• Adults in Gwent live healthily and age well</li> <li>• Older adults are supported to live well and independently</li> </ul>
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	<ul style="list-style-type: none"> <li>• Experience Quality and Safety</li> <li>• Partnership First</li> <li>• Research, Innovation, Improvement, Value</li> </ul>
Amcanion cydraddoldeb strategol Strategic Equality Objectives  <a href="#">Strategic Equality Objectives 2020-24</a>	<ul style="list-style-type: none"> <li>• Work in partnership to reduce all hate crime</li> <li>• Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers</li> <li>• Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers</li> <li>• Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse</li> <li>• Improve the access, experience and outcomes of those who require mental health and learning disability services</li> <li>• Improve the experience of lesbian, gay, bisexual and trans (LGBTQ+) service users and staff</li> </ul>

**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:	

<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
	<b>Is EIA Required and included with this paper</b>
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<b>Yes not yet available</b>  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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a>
<b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b>  <a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a>	<ol style="list-style-type: none"> <li>1. Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs</li> <li>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</li> <li>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</li> <li>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</li> <li>5. Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives</li> </ol>



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board



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.

Contents	Page No
Principles & Approach	3
Organisational Planning Framework	4
Organisational Planning Cycle	5
Developing the Delivery Plans	6
Strategy Deployment	7
Year 1 Delivery	10
Year 2-5 Delivery & Outcomes	25
Keys to Success	39
Oversight & Assurance	43


Our purpose

# Improve the health of our population achieving equity for all


Our values



Kindness



Integrity



Respect

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.**

To help us achieve this we have three aims:


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

**Better care:**  
Together we will deliver what matters to people. Support our staff to thrive and achieve quality, kind, and sustainable care.


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

**The key to our success**


We have identified the following areas as key to our success:




Our people




Quality




Finance



Our buildings



Digital, innovation, and technology



Green health



# 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 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.

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.

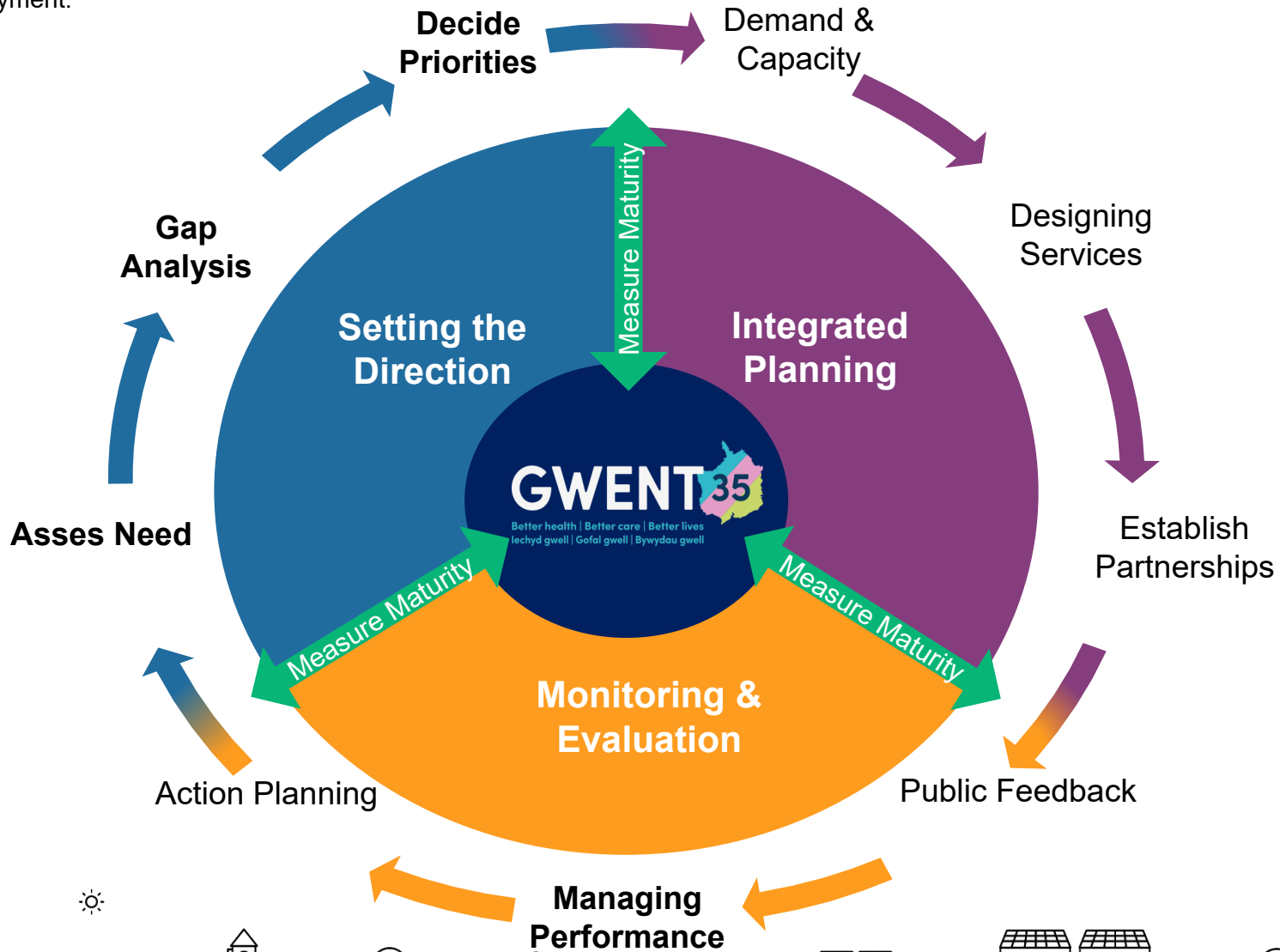
Partnership Delivery plans cover five main partnerships outlining the collective actions we will take to improve the health of our populations as a Region, Local Authority and Neighbourhood;

- 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.



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 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. ☀️



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
- Supporting 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 delivery
- 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 Artificial Intelligence
- Working with partners to advance innovation

Ability to measure Maturity & Effectiveness

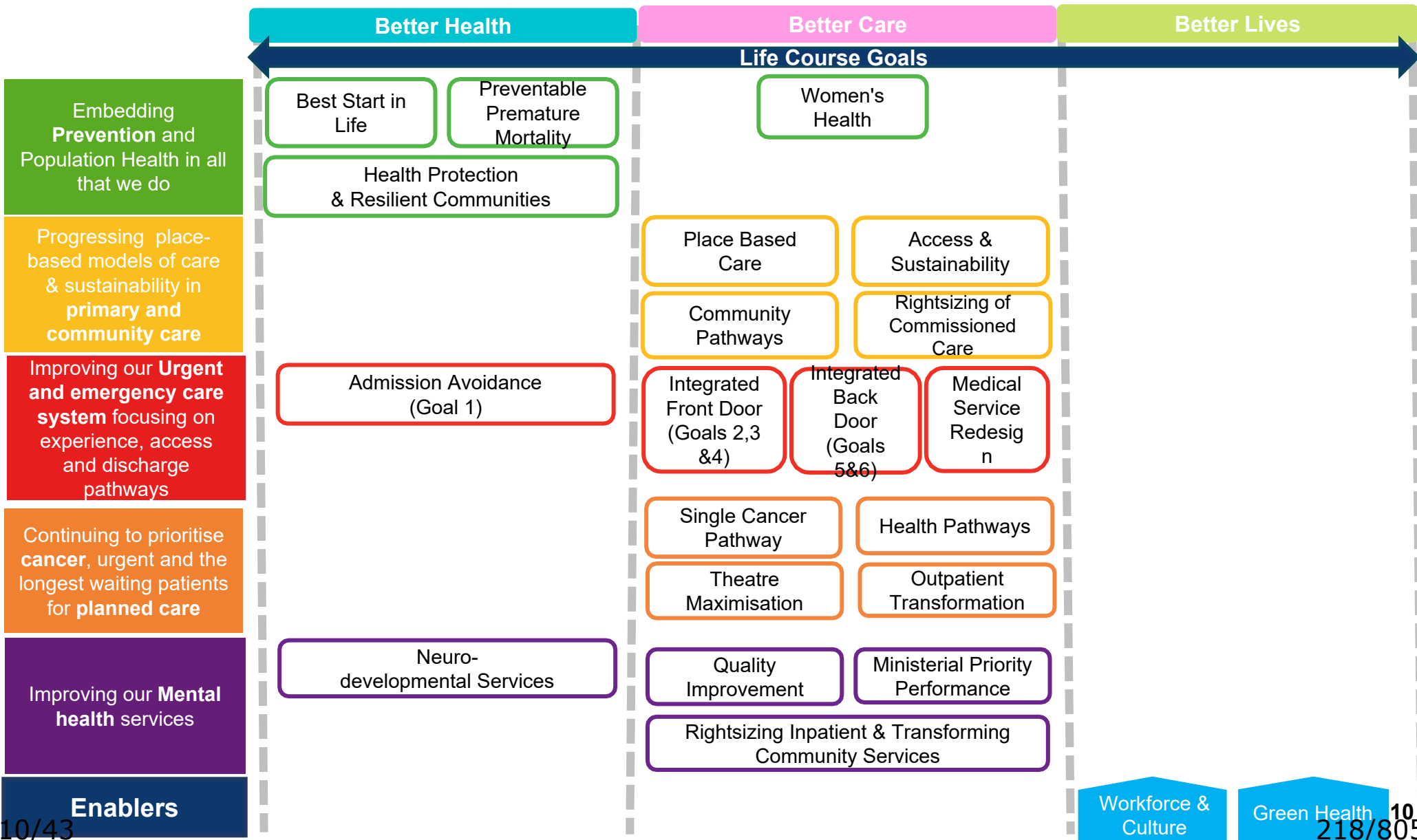


The necessary enabling steps for strategy deployment have been summarised in the below table;


Focus Area	Action	Timescale
<b>Anchor Institution</b>	<ul style="list-style-type: none"> <li>• Agree an organisational financial strategy that supports spending our money in and for communities of Gwent, including the shared public pound</li> </ul>	Q1 2026
	<ul style="list-style-type: none"> <li>• Strengthen inclusive recruitment, retention, and career development pathways that target our most deprived communities</li> </ul>	Q2 2026
	<ul style="list-style-type: none"> <li>• Establish the correct representation and relationships to be the voice of health when working with partners to develop local environments and infrastructures</li> </ul>	Q4 2025
	<ul style="list-style-type: none"> <li>• Establish development programmes and recruitment practices that ensure our senior leadership structures reflect the diverse nature of the communities we serve</li> </ul>	Q1 2026
	<ul style="list-style-type: none"> <li>• Use capital investments (e.g., Bevan Health and Wellbeing Centre) to regenerate communities and improve access</li> </ul>	Q3 2026
<b>Decision Making &amp; Assurance</b>	<ul style="list-style-type: none"> <li>• 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</li> </ul>	Q1 2026
	<ul style="list-style-type: none"> <li>• Work with the Board to assess our governance and committee structures to ensure they take the whole system approach to achieve our new ambition</li> </ul>	Q4 2025
	<ul style="list-style-type: none"> <li>• Establish a co-production framework that supports an organisational approach to embedding population voice into service design</li> </ul>	Q1 2026
	<ul style="list-style-type: none"> <li>• Embed community impact stories into our performance reporting</li> </ul>	Q1 2026
	<ul style="list-style-type: none"> <li>• Embed the use participatory budgeting to shape local health priorities</li> </ul>	Q3 2026
<b>Partnerships</b>	<ul style="list-style-type: none"> <li>• 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</li> </ul>	Q4 2025
	<ul style="list-style-type: none"> <li>• Establish stronger partnership working arrangements sharing data and intent with Education, Police and Sports organisations</li> </ul>	Q1 2026
	<ul style="list-style-type: none"> <li>• Establish third sector commissioning processes</li> </ul>	Q1 2026
	<ul style="list-style-type: none"> <li>• Through RPB and ISPBs strengthen our partnership arrangements around place</li> </ul>	Q1 2026

Focus Area	Action	Timescale
<b>Culture</b>	<ul style="list-style-type: none"> <li>Model compassionate and inclusive leadership ensuring alignment with all people practices</li> </ul>	Q4 2025
	<ul style="list-style-type: none"> <li>Build a diverse, representative workforce aligned with our Welsh Language, Anti-Racist, and LGBTQ+ commitments</li> </ul>	Q4 2026
	<ul style="list-style-type: none"> <li>Provision of a range of wellbeing services that meet the complex and varied needs of people</li> </ul>	Q2 2026
	<ul style="list-style-type: none"> <li>Embed employee voice, inclusion, and a Speaking Up Safely culture into our long-term organisational fabric</li> </ul>	Q1 2026
	<ul style="list-style-type: none"> <li>Embed the principles needed to deliver our strategy into Senior Leadership development</li> </ul>	Q1 2026
	<ul style="list-style-type: none"> <li>Equipping our people with the skills and confidence to make the most of new systems and technology in support of efficiency and sustainability</li> </ul>	Q4 2026
	<ul style="list-style-type: none"> <li>Increase greater learning of the changes faced by our communities and the impact we have on their lives across our organisation</li> </ul>	Q1 2026
<b>Evidence &amp; Best Practice</b>	<ul style="list-style-type: none"> <li>Build on the launch of the Joint Strategic Assessment in Gwent to identify health inequalities and target interventions</li> </ul>	Q3 2025
	<ul style="list-style-type: none"> <li>Develop frameworks to evaluate social value and anchor impact, learning from other NHS trusts like Leeds and East London</li> </ul>	Q4 2025
	<ul style="list-style-type: none"> <li>Develop a Population Health Indicator Framework to monitor outcomes, inequalities, and service impact</li> </ul>	Q3 2025
	<ul style="list-style-type: none"> <li>Establish a population health management system and the required partnerships through GP practices to achieve meaningful change</li> </ul>	Q3 2026
	<ul style="list-style-type: none"> <li>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</li> </ul>	Q3 2026
	<ul style="list-style-type: none"> <li>Establish new strategic partners to learn from industry and embed innovation</li> </ul>	Q3 2026
	<ul style="list-style-type: none"> <li>Digital, Technology and A&amp;I – develop agile strategies and frameworks that encourage innovation and maximise benefits for staff, patients and communities</li> </ul>	Q1 2026

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	Priority/Life Course	Milestones		
	Exec Lead				
Deliver health screenings and vaccinations in more places	Prevention and Population 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	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	Priority/Life Course	Milestones	
	Exec Lead			
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	Adults in Gwent live healthily & age well	Year 1	<ul style="list-style-type: none"> <li> Continue to collaborate with social care and third sector in response to the increase in anxiety levels across the county</li> <li> Support the Section 33 Frailty review with regional partners</li> <li> Provide evidence-based support for smokers wanting to quit smoking</li> </ul>
	Executive Director of Planning / Public Health			
Use our data to help people understand the signs they need to do more to stay well, especially young people	Prevention and Population 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
	Executive Director of Public Health		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	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
	Executive Director of Public Health			
	Primary and Community services	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
	Executive Director of Public Health			

Strategy	IMTP 2025-28				
Action (1-2 Years)	System Change	Priority/Life Course	Milestones		
	Exec Lead				
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	Priority/Life Course	Milestones	
	Exec Lead			
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;
			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
	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	
	Executive Director of Operations/Planning			
	Executive Director of Therapies			


Strategy	IMTP 2025-28			
Action (1-2 Years)	System Change	Priority/Life Course	Milestones	
	Exec Lead			
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
			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
	Executive Director of Operations/ Public Health		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	Priority/Life Course	Milestones	
	Exec Lead			
People wishing to remain at home at the end of their life are supported to do so	Primary & Community Services /Urgent & Emergency Care System	Dying well as a part of life	Year 1	<ul style="list-style-type: none"> <li>• Rollout of Primary Care Advanced Future Care Planning model</li> <li>• Develop Bereavement Pathway based on National Bereavement Standards</li> <li>• Embed principles of Care Aims and Balancing Rights and Responsibilities in End-of-Life Care Service Delivery</li> <li>• Extend Palliative Care Champions model</li> </ul>
	Executive Director of Nursing			
Reduce waiting times for those waiting the longest	Cancer & Planned Care	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 21/43 services	Cancer & Planned Care	Theatre Maximisation	Q4	Keeping Well Service within the Health Board and seen as the Single Point of Contact for advice on Health and Wellbeing
	Executive Director of Planning			

Strategy	IMTP 2025-28			
Action (1-2 Years)	System Change	Priority/Life Course	Milestones	
	Exec Lead			
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	Women's Health	Q1	Establish baseline and understand the models and pathways being designed by Women's Health Network and Welsh Government
	Executive Director of Public Health		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	Priority/Life Course	Milestones	
	Exec Lead			
Be the voice of health when decisions made for our communities	Prevention and Population Health	Getting It right for children & young people	Year 1	<ul style="list-style-type: none"> <li>Implement policies around commercial determinants of health including-fast food planning applications</li> </ul>
	Executive Director of Public Health			
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	Adults in Gwent live healthily & age well	Year 1	<ul style="list-style-type: none"> <li> 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</li> <li> Incorporating people with lived experience into our workstreams to understand what matters and how we can best meet their needs</li> <li>Extending Shared Lives across all boroughs for older people</li> <li>Exploring Peer support in an Older Persons population</li> </ul>
	Executive Director of Planning/ Operations			
Continue to train/support people from our communities into care careers	Workforce and Culture	Sustainability	Q4	Continued roll out of the Integrated Schools Programme across all secondary schools in Gwent
	Executive Director of Workforce			
With local partners develop volunteering opportunities supporting people in paid work	Workforce and Culture	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
	Executive Director of Workforce			

Strategy	IMTP 2025-28			
Action (1-2 Years)	System Change/Enabler	Priority/Life Course	Milestones	
	Exec Lead			
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.

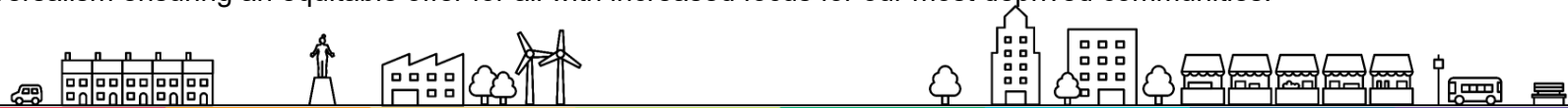


For each of the strategic aims we have set three outcomes we want to improve over the next 10 years. They focus on;

- 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

- Screenings
- Vaccinations
- Infection & Disease Control
- Emergency Planning

### Health Improvement

- Active & Sport Partnerships
- Health Education & Training
- Healthy Weight

### Prevention

- High Risk Populations
- Preventable Premature Mortality
- Reducing Cancer Inequalities
- Population Health Management

### Early Years to Young Adulthood

- 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

Priority	Delivery Area	Delivery Expectations
Health Protection	<b>Screenings</b>	<ul style="list-style-type: none"> <li>• Delivery of screening programmes in more community settings and targeting specific population groups who would benefit most</li> <li>• Working with others to advance technology and AI</li> <li>• Data informed screening communication through primary care data sets</li> <li>• Establishing outreach screening based on population need</li> </ul>
	<b>Vaccinations</b>	<ul style="list-style-type: none"> <li>• Expand delivery of vaccinations in more community settings and promotion to increase uptake rates for vaccinations for our clinically vulnerable groups</li> <li>• Working with partners target vaccination delivery to high contact population groups e.g. Bus Drivers</li> <li>• Lead the implementation of vaccine equity strategy</li> <li>• Continue to respond to the National Immunisation Framework</li> </ul>
	<b>Infection &amp; Disease Control</b>	<ul style="list-style-type: none"> <li>• Support the elimination of Tuberculosis within Gwent</li> <li>• Support the elimination of Measles within Gwent</li> <li>• Elimination of Hepatitis B and C</li> <li>• Support the elimination of HIV improving quality of life and removing stigma</li> <li>• Reduce the transmission of STIs</li> </ul>
	<b>Emergency Planning</b>	<ul style="list-style-type: none"> <li>• Robust plans are in place to respond to a critical incident as and when needed</li> <li>• Ensure the health board and wider health protection system are prepared to respond to public health incidents</li> </ul>
Health Improvement	<b>Active &amp; Sport Partnerships</b>	<ul style="list-style-type: none"> <li>• Embed active and sport partnerships into service delivery</li> </ul>
	<b>Health Education &amp; Training</b>	<ul style="list-style-type: none"> <li>• Promotion of health, across the life-course, through provision of advice on healthy lifestyle</li> <li>• Provide evidence-based support for smokers wanting to quit smoking</li> </ul>
	<b>Healthy Weight</b>	<ul style="list-style-type: none"> <li>• Deliver the outcomes of the Healthy Weight debate</li> </ul>
Prevention	<b>High Risk Populations</b>	<ul style="list-style-type: none"> <li>• Support our High-Risk Adult Cohort in community settings</li> <li>• Establish MDT working for people who have greater complexity and are most at risk of deterioration</li> </ul>

Priority	Delivery Area	Delivery Expectations
<b>Prevention</b>	<b>Population Health Management (PHM)</b>	<ul style="list-style-type: none"> <li>Supporting the rapidly evolving PHM landscape both locally and nationally</li> <li>Support the roll out of a digital tool to enable population segmentation and risk stratification</li> <li>Establish population health management processes across our NCNs</li> </ul>
	<b>Preventable Premature Mortality</b>	<ul style="list-style-type: none"> <li>Reduce the risk of premature mortality from cardiovascular disease and cancer</li> <li>Reduce harms from Tobacco smoking, passive smoking and nicotine addiction</li> <li>Collaborative delivery of diabetes prevention and CVD risk factor management to ensure that programmes are delivered systematically and at scale</li> </ul>
	<b>Reducing Cancer Inequalities</b>	<ul style="list-style-type: none"> <li>Improve low participation rates for cancer screening through communication programme</li> <li>Establishing outreach screening based on population need</li> <li>Delivery of interventions in more community settings and targeting specific population groups who would benefit most</li> </ul>
<b>Best Start in Life</b>	<b>Perinatal Health</b>	<ul style="list-style-type: none"> <li>Support pregnant women to reduce the prevalence of gestational diabetes</li> <li>Achieve accreditation in the Royal College of Psychiatrists Perinatal Quality Network standards for perinatal mental health.</li> </ul>
	<b>Maximising outcomes for Babies, Children &amp; Young People</b>	<ul style="list-style-type: none"> <li>Increase provision for Children and Young People to make their own choices and manage their emotional health and wellbeing</li> <li>Working in partnership to support children with Speech &amp; Language acquisition and to be School Ready</li> <li>Prioritising surgical outcomes and performance for Babies, Children &amp; Young People</li> <li>Provide community nursing care to children and young people for minor illnesses to support admission avoidance and early discharge</li> <li>Embed Children's Emergency Assessment Unit service change to improve emergency admission outcomes for Children</li> <li>Delivery of MatNeo and Transitional Care</li> </ul>
	<b>Whole Family Wellbeing</b>	<ul style="list-style-type: none"> <li>Delivery of early years delivery plan with partners</li> <li>Working with partners to support healthy attachment &amp; wider professional application of the Circle of Security</li> <li>Working as national leaders in bringing together key frameworks, including NEST and Trauma-Informed Wales, to support a whole system approach</li> <li>Collaborating with third sector partners to support referrals to autism assessment services and whole</li> </ul>

**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

Priority	Delivery Area	Delivery Expectations
Place Based Care	Neighbourhood Hubs	<ul style="list-style-type: none"> <li>Align NCNs and IWNs to further develop Place Based Care</li> <li>Accelerate and further expand integrated neighbourhood teams</li> <li>Embed new services within Place Based Care model that address preventative care across the life course</li> <li>Creating the right system for professionals to easily connect those who would benefit from non-medical intervention into the appropriate community asset</li> </ul>
	Women's Health	<ul style="list-style-type: none"> <li>Adopt a hub-and-spoke model for its Women's Health Hub</li> <li>Further enhancement of the recently redesigned sexual health service and build on the menopause service and endometrial service through primary care engagement and training</li> <li>Establish a women's unit that delivers more nurse led and one stop services in an ambulatory setting</li> <li>Establish outreach events to raise awareness and provide support for those affected by endometriosis, pelvic health problems</li> <li>Address any inequity in service provision with a particular focus on areas where there is recognised deprivation and reduced access to women's services</li> </ul>
	Community Pathways	<ul style="list-style-type: none"> <li>Reducing preventable admissions and optimal hospital discharge through a Home First approach</li> <li>Embed community pathways shifting care from an acute setting</li> </ul>
Access & Sustainability	General Medical Services	<ul style="list-style-type: none"> <li>Ensure sustainable GP services and manage contractual changes in a timely manner</li> </ul>
	Women's Health	<ul style="list-style-type: none"> <li>Further roll out of Women's health Hub across Gwent</li> <li>Improve women's health focusing on their specific needs through our women's health plan</li> </ul>
	Urgent Care System (6 Goals)	<ul style="list-style-type: none"> <li>Embed the Optimal Hospital Flow Framework &amp; Optimal Ward Model</li> <li>Roll out of Integrated Front Door Model and embed Medical Model</li> <li>Implement a target operating model for a multi disciplinary navigation hub</li> <li>Implement Frailty &amp; Care of the Elderly reconfiguration</li> <li>Embedded trusted assessor model across Gwent</li> </ul>

Priority	Delivery Area	Delivery Expectations
<b>Access &amp; Sustainability</b>	<b>Longest Waiters</b>	<ul style="list-style-type: none"> <li>• Achieve 80% Compliance with Single Cancer Pathway</li> <li>• Establish Day Case Centre of Excellence</li> <li>• Sustain Part 1a and 1b performance for Adults and Children and Young People</li> <li>• Improve measures for Psychological Services for Adults</li> </ul>
	<b>Models of Care</b>	<ul style="list-style-type: none"> <li>• Phase 2 implementation of Models of Care within the Mental Health Strategy</li> <li>• Phase 3 implementation of Models of Care within the Mental Health Strategy</li> <li>• Embed single pathway for Mental Health Services access</li> <li>• Shift Mental Health care into the community</li> </ul>
	<b>Regional Planning</b>	Contribute to the South East Regional Programmes for; <ul style="list-style-type: none"> <li>• Llantrisant Health Park</li> <li>• Community Diagnostic Hub</li> <li>• Ophthalmology</li> <li>• Orthopaedics</li> <li>• Pathology</li> <li>• Stroke</li> </ul>
<b>Improving Quality &amp; Experience</b>	<b>Primary Care</b>	<ul style="list-style-type: none"> <li>• Achieve and maintain access standards</li> <li>• Improve chronic condition management services to address any increased risk across the whole population</li> <li>• Plan for seasonal variation &amp; provide rapid access, community services, to avoid unnecessary admissions</li> </ul>
	<b>Urgent Care</b>	<ul style="list-style-type: none"> <li>• Achieve and maintain no ambulance handovers over 45 mins</li> <li>• Improve Emergency Department wait to be seen by Clinician</li> <li>• Safe avoidance of unnecessary emergency admissions and early consideration of discharge arrangements</li> <li>• Ensure there is a clear pathway and communication process that supports transition to adults from children's and adolescent services</li> </ul>

Priority	Delivery Area	Delivery Expectations
Improving Quality & Experience	<b>Planned Care &amp; Cancer</b>	<ul style="list-style-type: none"> <li>• Further develop and embed Prehabilitation</li> <li>• Nationally Optimised Pathways are embedded in local service delivery</li> <li>• Deliver transformation within the mortuary service to increase the safety and dignity of deceased patients</li> <li>• Adopt minimum communication standards for all our appointments</li> <li>• Ensure there is a clear pathway and communication process that supports transition to adults from children's and adolescent services</li> </ul>
	<b>Mental Health</b>	<ul style="list-style-type: none"> <li>• Embed single Neurodevelopmental pathway for Adults</li> <li>• Neurodevelopmental transformation for Children</li> <li>• Embed and sustain the commitments within the Quality Improvement plan</li> <li>• Ensure there is a clear pathway and communication process that supports transition to adults from children's and adolescent services</li> </ul>
Embedding Value & Efficiency	<b>Theatre Maximisation</b>	<ul style="list-style-type: none"> <li>• Continue to deliver initiatives to maximise Day Surgery</li> <li>• Improvement in performance against scheduling and utilisation KPI's</li> <li>• HVLC lists and golden patient process embedded</li> </ul>
	<b>Health Pathways</b>	<ul style="list-style-type: none"> <li>• Additional 50 localised pathways live on AneurinBevan local site per annum</li> </ul>
	<b>Outpatient Transformation</b>	<ul style="list-style-type: none"> <li>• Increased use of virtual clinics and identification of new pathways through scoping of opportunities in CIN and GIRFT recommendations</li> <li>• Ongoing monitoring of activity and opportunities for one-stop treatment pathways in the Outpatient Treatment Unit</li> <li>• Achieve 14.5% for SOS and PIFU</li> <li>• Reduction of Delayed Follow Ups Total Follow Ups</li> </ul>
	<b>Enhanced and Commissioned Care</b>	<ul style="list-style-type: none"> <li>• Rightsizing of Enhanced and Commissioned Care in community settings</li> <li>• Review of enhanced care on older adult wards to prevent deconditioning and ensure appropriate care</li> <li>• Improving outcomes for individuals who need longer term mental health support by developing a range of options within the Gwent area</li> </ul>

**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**

- Commercial determinants of Health
- Green Spaces
- Education and School Partnerships

**Resilient & Connected Communities**

- Building Community Capacity
- Social Prescribing
- Carers
- Transport

**Safe Spaces**

- Reducing Domestic Abuse
- Healthy Relationships
- Housing
- Environmental Safeguarding

**Quality of Life**

- Waiting Well
- Recovery & Rehabilitation
- End of Life Care

**Impact Across the Life Course**



Starting Well



Growing Well



Living Well



Ageing Well



Dying Well

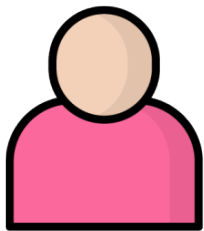
# Better Lives: Together we will create strong, safe, and connected communities.

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	<ul style="list-style-type: none"> <li>Implement policies around commercial determinants of health including-fast food planning applications</li> </ul>
	Green Spaces	<ul style="list-style-type: none"> <li>Expand nature prescribing</li> <li>Maximise the use of our green spaces to support wellbeing</li> </ul>
	Working with Schools	<ul style="list-style-type: none"> <li>Embed education and school partnerships into service delivery</li> <li>In reach to schools for mental health and wellbeing supporting school professionals</li> </ul>
Resilient & Connected Communities	Social Prescribing	<ul style="list-style-type: none"> <li>Co-produce and deliver a ‘social prescribing’ model that connects people to activities, groups, and services in their community</li> <li>Developing the tools to connect individuals into the community assets in their local area</li> <li>Establishing a Social Prescribing Framework for Gwent</li> <li>Supporting warm hubs and dementia hubs</li> </ul>
	Carers	<ul style="list-style-type: none"> <li>Carers Support Spoke Model</li> <li>Targeted short breaks for carers</li> <li>Young Carers support</li> </ul>
	Transport	<ul style="list-style-type: none"> <li>Designing services where people don’t need to travel based on population need</li> <li>Third sector commissioning of community transport/ car sharing</li> </ul>
Safe Spaces	Healthy Relationships	<ul style="list-style-type: none"> <li>Create a process for gathering and sharing ABUHB and Gwent Police data on serious violence</li> <li>Establish evidence-based training for prevention of domestic abuse</li> </ul>
	Housing	<ul style="list-style-type: none"> <li>Our work in partnership to ensure appropriate housing for vulnerable groups and those who require transition housing</li> <li>Warmer homes initiative</li> <li>Develop locally based housing initiatives to improve outcomes for people with Mental Health and Learning Disabilities</li> </ul>
	Environmental Safeguarding	<ul style="list-style-type: none"> <li>Improve the built environment to support good health</li> </ul>

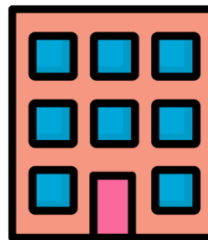
Priority	Delivery Area	Delivery Expectations
Quality of Life	Waiting Well	<ul style="list-style-type: none"> <li>• Keeping Well Service within the Health Board and seen as the Single Point of Contact for advice on Health and Wellbeing</li> </ul>
	Recovery & Rehabilitation	<ul style="list-style-type: none"> <li>• Work in partnership with third sector to provide peer support opportunities for those with lived experience</li> </ul>
	End of Life Care	<ul style="list-style-type: none"> <li>• Establish Bereavement Collaboratives</li> <li>• Implement Bereavement Pathway based on National Bereavement Standards</li> <li>• Embed principles of Care Aims and Balancing Rights and Responsibilities in End-of-Life Care Service Delivery</li> <li>• Extend Palliative Care Champions model</li> <li>• Rollout of Primary Care Advanced Future Care Planning model</li> </ul>

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 be 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



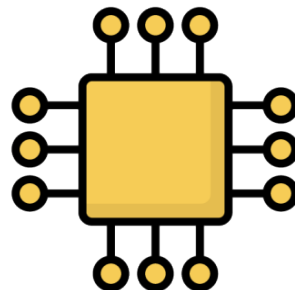
Our Estates Strategy

May 26 Board



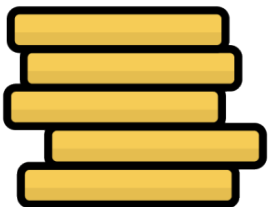
Our Quality Strategy

Approved



Our Digital Transformation Strategy

March 26 Board



Our Finance Strategy

January 26 Board



Our Green Health Strategy

March 26 Board



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	<ul style="list-style-type: none"> <li>Embed Values &amp; Behaviours framework</li> <li>Embed our approach to Avoidable Employee Harm working with internal and external stakeholders</li> <li>Roll out a Wellbeing and Empowerment Passport</li> <li>Widening access to volunteer and career pathways so we are supporting the communities we serve into meaningful work</li> </ul>
	Help our staff experience their work as meaningful and rewarding. Support them with awareness of cultural values	<ul style="list-style-type: none"> <li>Deliver training and support to raise awareness of cultural values</li> <li>Promoting a 'Just Culture' that supports safety and psychological safety, encouraging staff to 'speak up safely'</li> <li>Continued delivery of the SEP and All Wales Action Plans (WRES, LGBTQ+, Accessible Information, Disability)</li> </ul>
	We will have shared values and ways of working with partners that connect our communities	<ul style="list-style-type: none"> <li>Continued roll out of the Integrated Schools Programme across all secondary schools in Gwent</li> <li>Working towards developing shared values with partners across Gwent</li> </ul>
Quality	Develop and deliver a Quality Management System across all levels of our organisation	<ul style="list-style-type: none"> <li>Integrate quality management systems to ensure continuous improvement and compliance with health standards</li> <li>Implement robust quality management frameworks that align with national and international health standards</li> <li>Regularly review and update policies and procedures to maintain high standards of care</li> </ul>
	Improve patient experience and continue our commitment to Care Aims Principles to embed a person-centred approach	<ul style="list-style-type: none"> <li>Refreshed Patient Experience and Involvement Strategy</li> <li>Staff learning and development programmes embed the principles of Care Aims and Balancing Rights and Responsibilities</li> <li>People Participation Panels established for key areas with plan to extend</li> </ul>
	Be an open, learning organisation that provides our people with the skills they need to continually improve	<ul style="list-style-type: none"> <li>Use data-driven approaches to inform quality improvement initiatives and enhance patient safety</li> <li>Use of patient/staff stories to inform organisational learning</li> <li>1,000,000 minutes of Quality Improvement (QI) Coaching achieved by the end of 2028</li> <li>QI Faculty to support the development of organisational conditions for QI</li> </ul>

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	<ul style="list-style-type: none"> <li>Measurement of financial impact of interventions that keep people well</li> <li>Measurement of how we spend our money across the life course with an assessment of health economics</li> </ul>
	Focus on value and efficiency across all services to achieve the best outcomes sustainably	<ul style="list-style-type: none"> <li>Refreshed three-year route map with targeted actions to deliver value and efficiency</li> <li>Make better and more routine use of comparative data of all sorts, such as the VAULT, to inform service improvement</li> </ul>
	Do our best to spend our money in Gwent and ensure it helps our communities	<ul style="list-style-type: none"> <li>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</li> <li>Increase in primary and community investment from core capacity</li> </ul>
Our Buildings	Look outside our own buildings to deliver healthcare in a community setting	<ul style="list-style-type: none"> <li>Deliver more services and interventions in community buildings that target those who needs our services most</li> </ul>
	Ensure we have the right estates in place to deliver our Clinical Services plan to the best of our ability	<ul style="list-style-type: none"> <li>Refresh our Estates Strategy aligned to the development of our clinical services plan</li> </ul>
	Our buildings that promote wellbeing, are open to communities to use and is shared with the public sector	<ul style="list-style-type: none"> <li>Open up our Health and Wellbeing Centres to community groups and third sector to use</li> </ul>
Digital Innovation & Technology	Use digital, innovation, and technology to provide tools to support a healthy thriving Gwent with connected communities	<ul style="list-style-type: none"> <li>Enabling access to health information and supporting healthier lifestyles through data informed interventions</li> <li>Enable individuals to manage their health and care through inclusive accessible digital tools</li> </ul>
	Ensure our services have good digital infrastructure and people can be supported at home through technology	<ul style="list-style-type: none"> <li>Provide our staff with timely, accurate information and intelligent digital workflows to improve safety, quality, and coordination</li> <li>Make digital systems easier to use and more effective in daily work for all staff</li> <li>ensuring our systems are secure, scalable, and interoperable—capable of supporting the delivery of modern, responsive services across hospital, community, and home settings.</li> </ul>
	Equip people in our communities with the access, skills, and confidence to engage with digital services	<ul style="list-style-type: none"> <li>Reducing digital exclusion and supporting joined up care across health and social care systems</li> </ul>

Key to Success	Strategy Commitment	Delivery Expectations
Green Health	Promote active travel and support good public transport to our services	<ul style="list-style-type: none"> <li>• Deliver our commitments in the Active Travel Action Plan for Wales</li> <li>• Assess the public transport to our services and work with partners and third sector to ensure accessibility</li> </ul>
	Deliver Carbon Neutral targets through services that model green health and maximise our green spaces	<ul style="list-style-type: none"> <li>• Embed the 'Green Theatre' initiative</li> <li>• Explore localised opportunities for low carbon transport infrastructure</li> <li>• Work towards implementing upgrades to ensure 60% of generated heat at acute sites is low carbon by 2030</li> <li>• Plans in place to eliminate fossil fuelled heating</li> </ul>
	Communities across Gwent are able to connect through nature	<ul style="list-style-type: none"> <li>• Expand our work with partners that supports nature prescribing across Gwent</li> </ul>



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.



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
<b>There will be positive change in the factors that contribute to poor health</b>							
<b>Proportion of adults (16+) who report drinking over 14 units of alcohol per week</b>	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	
	<b>Percentage of female children aged 11-16 who report smoking tobacco at least one a week</b>	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	
<b>Percentage of male children aged 11-16 who report smoking tobacco at least one a week</b>		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	
	<b>Percentage of 18+ female population who are curret smokers</b>	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	

<b>Percentage of 18+ male population who are current smokers</b>	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	
<b>11-16 year old females who were physically active every day (60 mins) in the past week</b>	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	
<b>11-16 year old males who were physically active every day (60 mins) in the past week</b>	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	
<b>Percentage who met physical activity guidelines in the previous week (150 mins)</b>	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	
<b>Measures</b>	<b>Source</b>	<b>Area</b>	<b>Baseline</b>	<b>Latest data point</b>			
<b>There will be more people who are a Healthy Weight</b>							
<b>Healthy Weight : Adolescents Proportion of 11-16 year olds whose BMI is in healthy range</b>	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	
<b>Healthy Weight :Adults Proportion of 16+ with a BMI of 18.5-25</b>	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	
<b>Measures</b>	<b>Source</b>	<b>Area</b>	<b>Baseline</b>	<b>Latest data point</b>			
<b>There will be a reduction in preventable diseases</b>							
<b>Proportion of Children who receive 4 in 1 preschool booster by age 4</b>	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	
<b>Bowel Screening uptake</b>	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	

<b>Breast Screening uptake</b>	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	
<b>Cervical Screening uptake</b>	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	
<b>People with have more Healthy Days at Home</b>								
<b>People with have more Healthy Days at Home</b>	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	
<b>Our provided and commissioned services will meet the relevant quality and clinical standards</b>								
<b>Our provided and commissioned services will meet the relevant quality and clinical standards</b>	In development through QMG - definitions and standards					Ageing Well		
Measures	Source	Area	Baseline	Latest data point	Ambition	Life Course Impact	Notes	
<b>More people will be able to access health services in their local communities</b>								
<b>Placed based care measures (paper due for September Board)</b>						Living Well		
						Living Well		
			Blaenau Gwent				Living Well	
			Caerphilly				Living Well	
			Monmouthshire				Living Well	
			Newport				Living Well	
			Torfaen				Living Well	
<b>100% of GP practices achieving all National Access Standards for In hours GMS</b>	Primary Care	ABUHB	100%	Mar-25	100	Living Well		
<b>Increase in people accessing PIPs where they would have visited their GP</b>	Primary Care	ABUHB	22,919	Mar-25		Living Well	National ambition to increase	
<b>Maintain the number of consultations undertaken by community pharmacy under CAS</b>	Primary Care	ABUHB	68,535	Mar-25	0% change	Living Well	National ambition to maintain	
<b>Maintain the number of patients accessing NHS Optometry Services</b>	Primary Care	ABUHB	246,133	Mar-25	0% change	Living Well	National ambition to maintain	
<b>Number of patients accessing urgent emergency services - Dental</b>	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
<b>People will find it easier to connect with their communities, use local services, and feel respected</b>							
<b>% of adults agreeing they belong to the area</b>	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
<b>Our budget spent on services in the community will have increased across Gwent</b>							
<b>Proportion of budget spent on out of hospital services</b>	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
<b>More people will engage with their local community to reduce loneliness and support good health</b>							
<b>% of adults who are lonely</b>	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	

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	26 November 2025
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Llantrisant Health Park - Phase 2 OBC for Orthopaedics
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Hannah Evans, Director of Strategy, Planning and Partnerships
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	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 Capital%20Cost%20 OBC%20-%20Phase%20 addendum.docx

<b>Amcanion: (rhaid cwblhau)</b> <b>Objectives: (must be completed)</b>	
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  <a href="#">Link to IMTP</a>	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  <a href="#">Strategic Equality Objectives 2020-24</a>	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

<b>Gwybodaeth Ychwanegol:</b> <b>Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	



Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	
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**Effaith: (rhaid cwblhau)**  
**Impact: (must be completed)**

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





GIG  
CYMRU  
NHS  
WALES

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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## Summary sheet

<b>Llantrisant Health Centre</b> OUTLINE BUSINESS CASE (OBC) – HIGH VALUE (OVER £2 MILLION VALUE OF PROCUREMENT)	
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

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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

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## 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: <ul style="list-style-type: none"> <li>the procurement strategy and routes that have been agreed.</li> <li>the scope of the procurement</li> <li>the contractual arrangements of the potential deal to deliver the recommended solution for the project.</li> </ul>
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 as 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
<b>Total</b>	<b>13,003</b>	<b>13,523</b>	<b>15,083</b>
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 opportunity	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, giving a 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 6<sup>th</sup> 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
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RIBA 3	400	1,491	1,534	3,025
RIBA 4	3534	1,405	924	2,328
<b>Total</b>	<b>3,934</b>	<b>2,896</b>	<b>2,457</b>	<b>5,353</b>
				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

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## 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 3<sup>rd</sup> 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
- Maesteg 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 the **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.

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## 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.	<ul style="list-style-type: none"> <li>• Right-sized to meet current and future demand</li> <li>• Improves access to range of services</li> <li>• Centre of Excellence with efficient service delivery models and improved patient outcomes and increased throughput</li> <li>• Able to flex for the future</li> </ul>
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.	<ul style="list-style-type: none"> <li>• Creates opportunities for centralisation of skillsets; centre of excellence</li> <li>• Enables greater collaboration regionally</li> </ul>
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.	<ul style="list-style-type: none"> <li>• Standardisation of consumables, with financial savings</li> <li>• Standardisation of best practice/policies; efficiencies, increased throughput, reduction of wait lists</li> </ul>

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.	<ul style="list-style-type: none"> <li>Accommodates placements for students (allowing role development and succession planning)</li> <li>Improved workforce retention and recruitment</li> </ul>
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	<ul style="list-style-type: none"> <li>Environment / ways of working that support staff welfare and wellbeing</li> <li>Improved skills and job satisfaction</li> <li>Improved patient outcomes</li> <li>Multi-disciplinary working</li> </ul>
SO6	Sustainable estate	To deliver a sustainable infrastructure on the site maximising decarbonisation and net zero opportunities.	<ul style="list-style-type: none"> <li>Complies with relevant standards; NZC, BREEAM excellent and energy performance</li> <li>Opportunities for future additional service provision for South East Wales.</li> <li>Opportunities for further regional reconfiguration and enabling of service and or estate rationalisation.</li> </ul>

### 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 care
- 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 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 an 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
<ul style="list-style-type: none"> <li>• Poole</li> <li>• SWLEOC</li> <li>• SWAOC</li> <li>• One Welbeck</li> <li>• ESEOC.</li> </ul>	<ul style="list-style-type: none"> <li>• SEW Regional Orthopaedic Board</li> <li>• Orthopaedic CIN</li> <li>• Anaesthetic CIN</li> <li>• National Planned Care Program.</li> </ul>	<ul style="list-style-type: none"> <li>• SEW Regional Orthopaedic programme workshops.</li> <li>• LHP Arthroplasty Pathway Development Workshop.</li> </ul>	<ul style="list-style-type: none"> <li>• Arthroplasty</li> <li>• Anaesthetic</li> <li>• Therapies.</li> </ul>	<ul style="list-style-type: none"> <li>• Staggered admission</li> <li>• Regional Health Screening questionnaire.</li> <li>• Arthroplasty development.</li> </ul>

## 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 of 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 is 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
<b>Total</b>	<b>5,251</b>	<b>5,461</b>	<b>6,091</b>	<b>4,329</b>	<b>4,502</b>	<b>5,022</b>
Arthroplasty	922	959	1,070	1,244	1,293	1,443

Sub specs	Cwm Taf Morganwgwg			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
<b>Total</b>	<b>3,423</b>	<b>3,560</b>	<b>3,971</b>	<b>13,003</b>	<b>13,523</b>	<b>15,083</b>
Arthroplasty	1,412	1,469	1,638	3,578	3,721	4,150

*Recurrent demand for 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 opportunity	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	<b>242</b>	<b>-115</b>	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	<b>-1,543</b>	-400	-1,605	<b>-404</b>	-1,669	-408	-1,736	<b>-412</b>	-1,805	<b>-416</b>	<b>-1,877</b>

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	<b>9,60</b>
3	12	5	48	<b>2,880</b>
6	24	5	48	<b>5,760</b>

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
<b>SEW Region</b>	<b>-970</b>	<b>-994</b>	<b>-1,019</b>	<b>-1,044</b>	<b>-1,070</b>
20% efficiency gap	-230	-230	-230	-230	-230
<b>Forecast Capacity Gap</b>	<b>-1,199</b>	<b>-1,223</b>	<b>-1,248</b>	<b>-1,274</b>	<b>-1,300</b>
LHP Capacity	2,880	2,880	2,880	2,880	2,880
<b>Net Capacity Gain</b>	<b>1,681</b>	<b>1,657</b>	<b>1,632</b>	<b>1,606</b>	<b>1,580</b>

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.

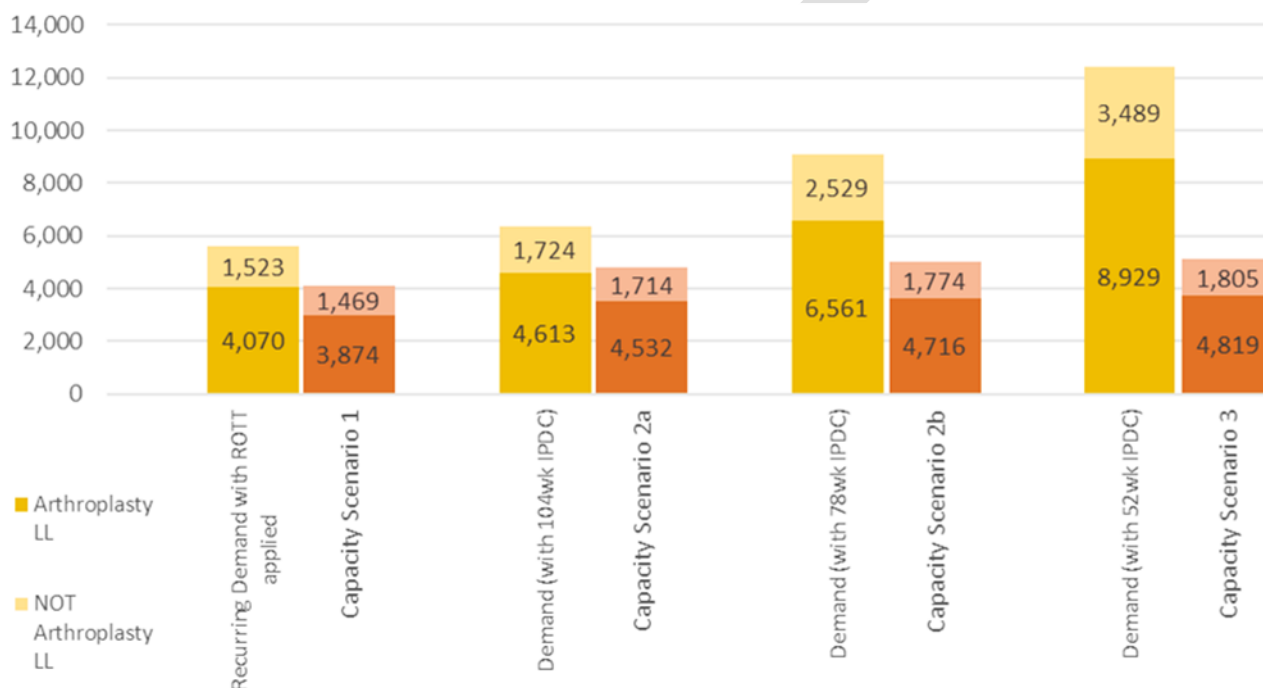
However, it is clear that this is a further beneficial opportunity from the LHP Hub and the centralisation of primary arthroplasty at LHP. The outputs and resources associated with the use of this capacity sit outside the scope of this OBC but will be part of the regional orthopaedics plan.

### 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.

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## 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

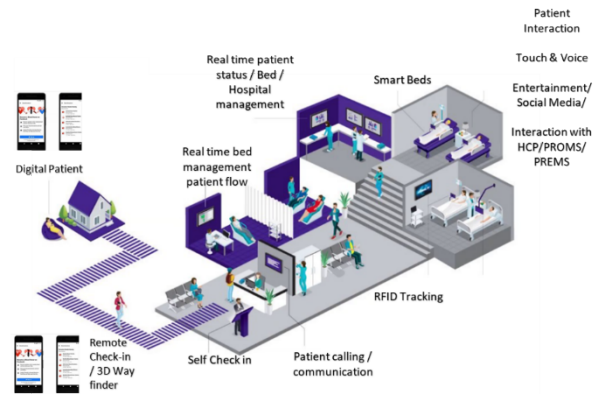
To operationalise a Digital First model, Llantrisant Health Park needs to be developed on Digital by Design principles thus ensuring that technology is embedded within the physical, technical, and operational fabric of the facility from the outset. This approach allows the building to function as an

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
<ul style="list-style-type: none"> <li>Strong data stewardship and ownership aligned to NHS Wales policies</li> <li>Compliance with Welsh digital and IG standards</li> <li>Ethical and transparent use of data and digital tools</li> </ul>	<ul style="list-style-type: none"> <li>Interoperable systems across LHP and wider CTM sites</li> <li>Standardised platforms and maximised reuse of digital assets</li> <li>Agile, scalable and connected infrastructure to support regional pathways</li> </ul>	<ul style="list-style-type: none"> <li>Secure-by-design environment</li> <li>Future-ready, resilient architecture</li> <li>Scalable and compliant design</li> </ul>	<ul style="list-style-type: none"> <li>Clinically-led design</li> <li>Trackable operational efficiency</li> <li>Intuitive, user-centred interfaces</li> </ul>

### Benefits for patients, staff and system

Stakeholders	Community Diagnostic Hub	Orthopaedic and Surgical Hub
<b>For Patients</b>	<ul style="list-style-type: none"> <li>Faster access to tests and results, reducing waiting times</li> <li>One-stop experience multiple diagnostics in a single visit</li> <li>Reduced need to travel to acute hospitals</li> <li>Digitally supported navigation and check-in</li> <li>Improved experience through modern, comfortable, and sustainable design</li> </ul>	<ul style="list-style-type: none"> <li>Timely access to planned surgery, reducing waiting lists and delays</li> <li>Protected elective capacity, minimising cancellations and last-minute changes</li> <li>Enhanced pre-operative preparation and post-operative support through digital pathways</li> <li>Modern day-case and enhanced recovery facilities enabling quicker recovery and discharge</li> <li>Remote physiotherapy, wound monitoring, and follow-up reducing need for repeat travel</li> </ul>
<b>For Staff</b>	<ul style="list-style-type: none"> <li>Co-location improves workflow efficiency and collaboration</li> <li>Optimised scheduling, throughput, and utilisation of equipment</li> <li>Frees acute capacity for emergency and inpatient care</li> <li>Data-driven insight for demand forecasting and performance</li> <li>Alignment with national diagnostic transformation and sustainability targets</li> </ul>	<ul style="list-style-type: none"> <li>Streamlined theatre scheduling and reduced administrative burden</li> <li>Dedicated elective setting supports predictable operating lists and fewer interruptions</li> <li>Digital surgical planning, EPR access, and intra-operative tools improve safety and accuracy</li> <li>Enhanced multidisciplinary collaboration and MDT space</li> <li>Training environment for innovation in surgery, pre-hab and rehab pathways</li> </ul>

**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

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# 5 Benefits and Risks

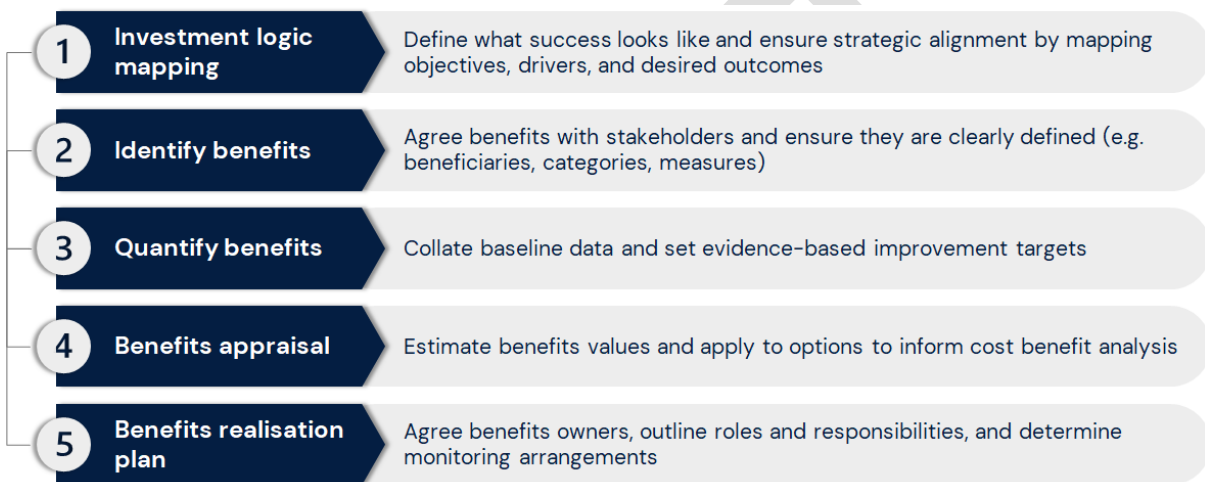
## 5.1 Introduction

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

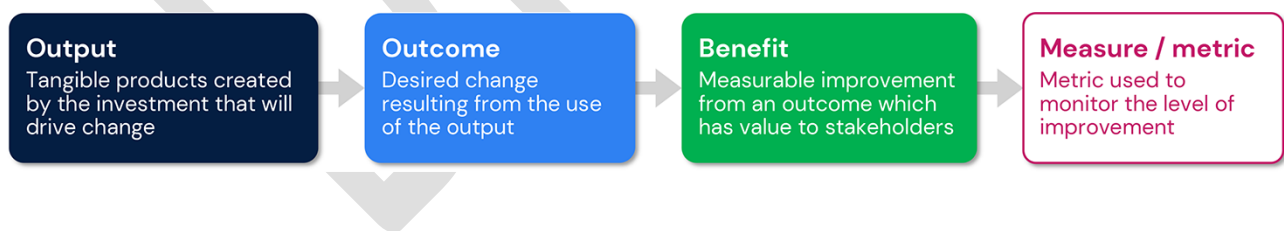
A systematic approach was undertaken to develop the benefits analysis as outlined in the diagram below.

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:

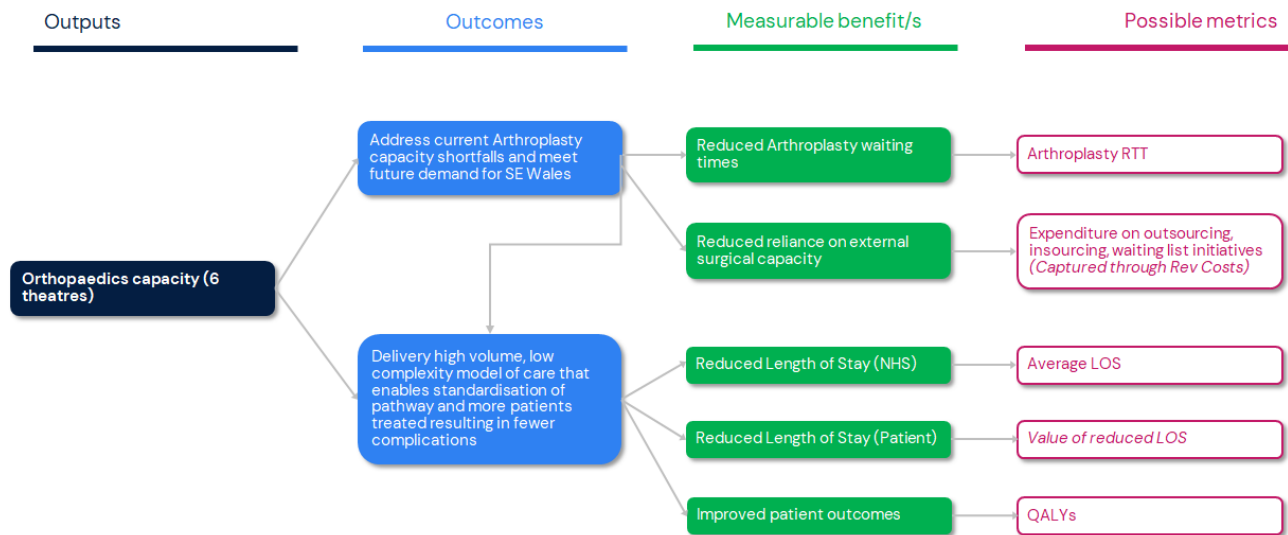
Figure 6 – Investment logic mapping approach



## 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**

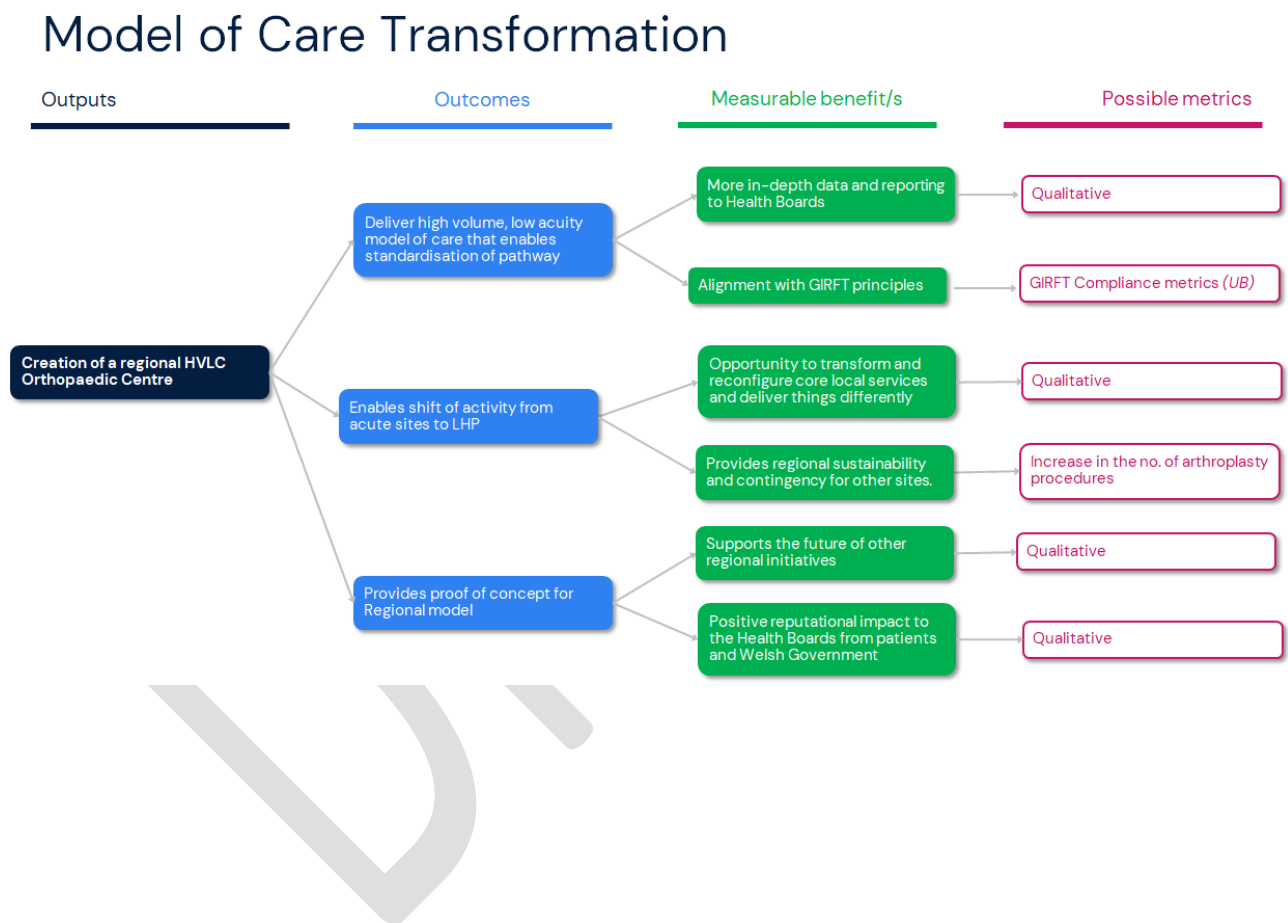


## 5.2.2 Model of care transformation

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.

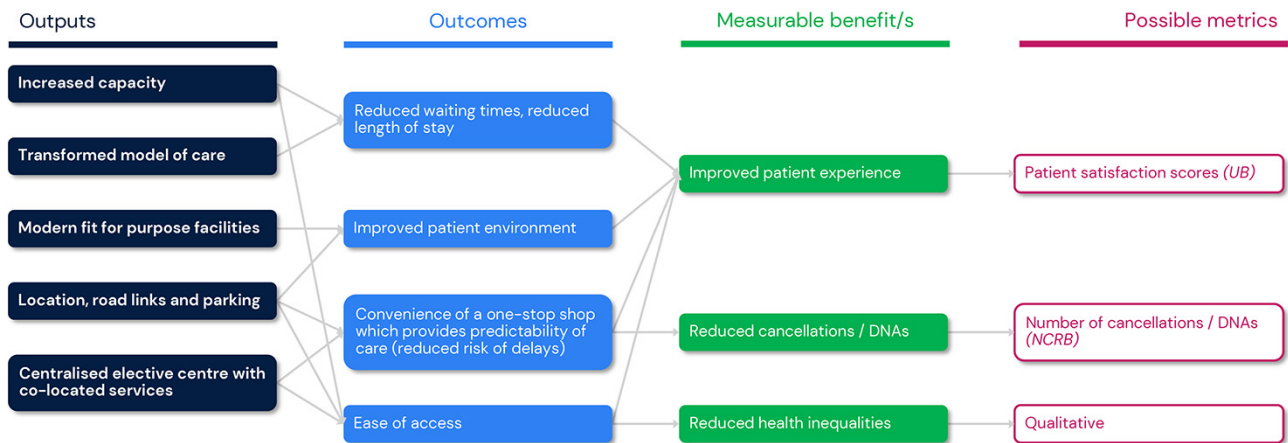
Figure 8 – Benefits mapping: model of care transformation



### 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**



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## 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.

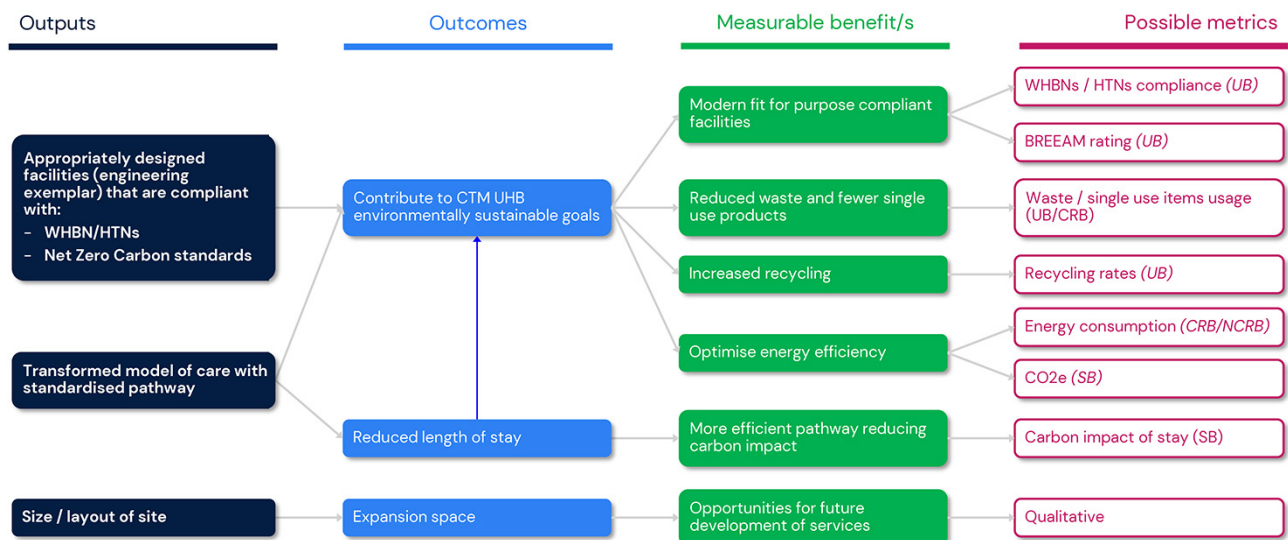
Additional service to support the operational delivery of LHP will be provided via a Hub and Spoke model (operational plans are in train through monthly workstream meetings) out of the Royal Glamorgan.

- 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

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## 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: <ul style="list-style-type: none"> <li>• 3-4 Theatres for CTMUHB</li> <li>• 0.5 Theatres for CAVUHB</li> <li>• 1.5 Theatres ABUHB</li> </ul>
Activity provided	Capacity to provide 5,760 arthroplasty surgeries at LHP: <ul style="list-style-type: none"> <li>• CTMUHB = 3,840 surgeries</li> <li>• CAVUHB = 960 surgeries</li> <li>• ABUHB = 960 surgeries</li> </ul>

## 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
<b>Subtotal</b>	-	<b>99,071</b>
Inflation Adjustment		5,104
VAT	-	19,454
<b>Total capital costs (as per capital cost forms)</b>	-	<b>123,630</b>
Exclude sunk costs	-	0
Inflation adjustment to rebase to base year	-	-5,104
Exclude VAT	-	-19,454
<b>Total capital costs (for Economic Case)</b>	-	<b>99,071</b>

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
<b>Total lifecycle costs - Full appraisal period</b>	<b>19,610</b>	<b>204,704</b>

## 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
<b>Total HVLC Orthopaedic Inpatient unit costs</b>	<b>7,298</b>	<b>36,781</b>
<b>Incremental impact on annual revenue costs</b>	<b>0</b>	<b>29,483</b>

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

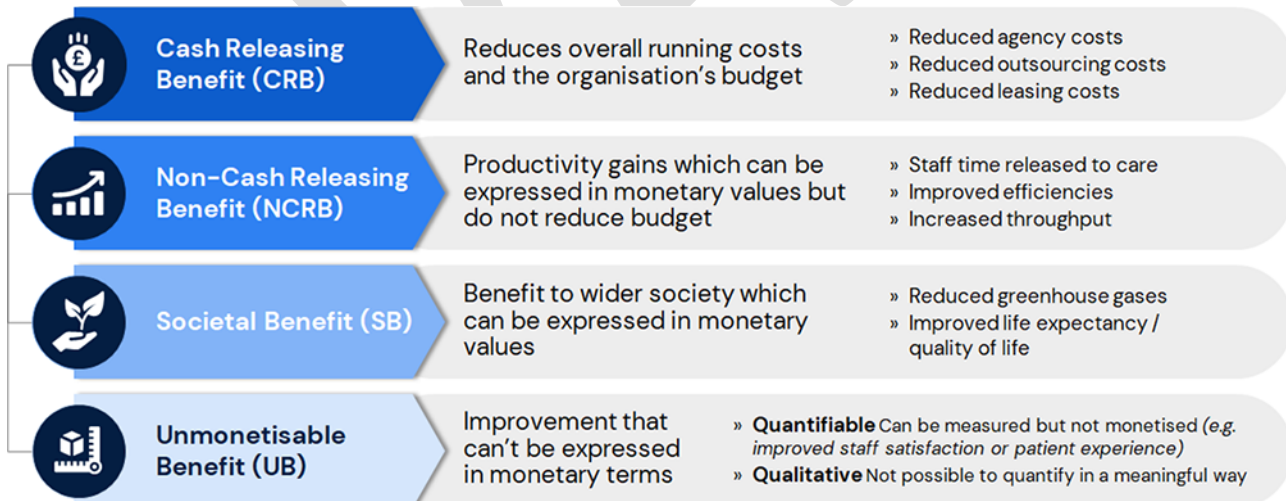
As outlined in sections 5.2-5.3 of the Strategic Case, a systematic approach has been undertaken to develop the benefits analysis, which involved establishing the benefits case and identifying measurable benefits, and metrics.

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.

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

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
<b>Creation of surgical hub</b>						
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: <a href="#">Waiting times</a>	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	<p>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.</p> <p>The methodology for calculating monetary value of this benefit is:</p> <ul style="list-style-type: none"> <li>Apply 3.53 reduction in ALOS to 5,760 projected arthroplasty procedures p.a. equates to 20,321 fewer bed days p.a.</li> <li>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).</li> <li>A 50% confidence rating has then been applied, noting that there is evidence from multiple sources suggesting this level of improvement is achievable.</li> </ul> <p>Further evidence to support this benefit includes:</p> <ul style="list-style-type: none"> <li>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</li> </ul>	NCRB1

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
					<p>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.</p> <ul style="list-style-type: none"> <li>• 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).</li> <li>• 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<sup>1</sup> of 2022.</li> </ul>	
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	<p>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 <a href="https://www.benenden.co.uk">Hidden costs of employee medical appointments and work (benenden.co.uk)</a>) = £1.67m of societal benefit A 50% confidence rating has then been applied in line with NCRB1.</p>	SB1

<sup>1</sup> 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 <sup>2</sup> - 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
<b>Model of care transformation</b>						
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

<sup>2</sup> 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	<p>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.</p> <p>Adopting a short-stay model at Llantrisant Health Park is therefore expected decrease combined infection incidence from ~2% to ~1%.</p> <p>The methodology for calculating monetary value of this benefit is:</p> <ul style="list-style-type: none"> <li>No. of procedures at LHP per year is 5,760</li> <li>A reduction from 2% to 1% of infection incidence applied to no. of procedures = 57.6 fewer infections</li> </ul>	NCRB2

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
					<ul style="list-style-type: none"> <li>Assumed that each infection costs £3,000 in direct health care costs.</li> <li>Monetisable value before confidence rating = £0.2m</li> <li>Apply 75% confidence rating.</li> </ul> <p>At FBC stage a more robust value, including the value for the societal benefit of reduced HAI's will be investigated.</p>	
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 <sup>3</sup>	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	<b>Delivery of these additional training places are dependent on:</b> <ul style="list-style-type: none"> <li>Additional funding over and above what is outlined in section 7.5 recurring revenue costs.</li> </ul>	UB14

<sup>3</sup> 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		<ul style="list-style-type: none"> <li>Close engagement with HEIW and the Welsh School of Anaesthesia to formalise these training pathways.</li> </ul> <p>Calculation based on:</p> <ul style="list-style-type: none"> <li>Baseline no. of trainees at CTM are provided in an assumed 1.5 theatres.</li> <li>LHP will provide 6 theatres, of which 3-4 are utilised by CTM, and the other theatres utilised to accommodate regional demand.</li> </ul> <p>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.</p> <p>This represents an 100% increase in capacity to provide training places, which has been applied to the baseline no. of trainees.</p>	
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: <a href="#">NHS England » Building on what we already do</a> ] 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
<b>Total annual recurring benefits values</b>	<b>0</b>	<b>37,583</b>

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 meaningfully 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.

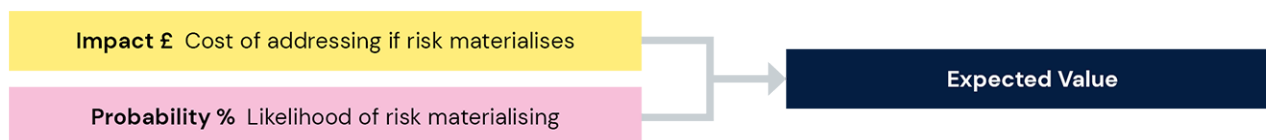
Key project risks have been identified which are not already accounted for within capital costs and these include the following:

- **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
<b>K1 – Funding Risk: Capital Funding</b>		
<b>Risk</b>	<b>Unable to secure sufficient capital funding to deliver the project</b>	
<b>Consequence</b>	<b>Programme extended to allow time to explore alternative routes</b>	
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
<b>Total Risk Value £'000</b>	<b>Does Not Apply</b>	<b>1,040</b>

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

## 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
<b>Risk-adjusted Present Cost</b>	<b>-202,377</b>	<b>-1,123,816</b>
Cash releasing benefits (discounted)	0	0
Non-cash releasing benefits (discounted)	0	19,929
Societal Benefits (discounted)	0	1,402,254
<b>Total Benefits</b>	<b>0</b>	<b>1,422,183</b>
<b>Discounted Net Present Social Value (NPSV)</b>	<b>-202,377</b>	<b>298,367</b>
Incremental costs - total	0	-921,439
Incremental benefits - total	0	1,422,183
<b>Risk-adjusted Incremental Net Present Social Value (NPSV)</b>	<b>0</b>	<b>500,744</b>
<b>Benefit-cost ratio</b>	<b>0.00</b>	<b>1.54</b>

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
<b>Original Results</b>	<b>-921,439</b>	<b>1,422,183</b>	<b>500,744</b>	<b>1.54</b>
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

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## 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 3<sup>rd</sup> 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
<b>Total</b>	<b>3,934</b>	<b>2,896</b>	<b>2,457</b>	<b>5,353</b>
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	<b>2,457</b>
External Consultant	125	227	352
Surveys & Planning	17	149	<b>166</b>
Risk	31	29	60
<b>Total</b>	<b>1,934</b>	<b>1,669</b>	<b>3,603</b>
Funded	-1,934	0	-1,934
<b>Awaiting Funding</b>	<b>0</b>	<b>-1,669</b>	<b>-1,669</b>

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	<ul style="list-style-type: none"> <li>• Early inclusion of Phase 2 allows for some planning continuity and contractor engagement.</li> </ul>	<ul style="list-style-type: none"> <li>• Possible claim against £60m Prov sum not being proceeded with (6% loss of profit)</li> <li>• Provisional sums are not well-defined in NEC contracts, which may lead to ambiguity and</li> </ul>

Option	Opportunities	Risks
	<ul style="list-style-type: none"> <li>• May simplify procurement and contract administration by keeping both phases under one contract.</li> <li>• Continuity of workforce or shared resources across phases.</li> <li>• Reduces risk of contractor re negotiation</li> </ul>	<ul style="list-style-type: none"> <li>• disputes (mitigated with comprehensive Z clauses)</li> <li>• Opportunity for MTX to increase Prelims, mitigated by negotiation reducing% back to original 6%</li> <li>• Lack of clarity on scope, pricing, and risk allocation for Phase 2 will reduce accuracy of Prov sum</li> <li>• Contractor may price risk conservatively, inflating the Phase 1 Target Cost.</li> <li>• Difficult to manage change control and performance incentives for Phase 2, mitigated through management of sectional completion</li> <li>• •HB approval of a contract which exceeds approved capital funding- SFI breach</li> </ul>
2	<ul style="list-style-type: none"> <li>• Allows flexibility to define Phase 2 scope and cost later, based on Phase 1 outcomes.</li> <li>• Keeps Phase 2 within the same contract, maintaining continuity and reducing procurement overhead.</li> <li>• Can be used to quickly mobilise Phase 2 if timing is critical.</li> <li>• Contractually protects client as no commitment to Phase 2</li> </ul>	<ul style="list-style-type: none"> <li>• Opportunity for MTX to increase Prelims, mitigated by negotiation reducing% back to original 6%</li> <li>• Compensation events are reactive, not ideal for large, planned works like Phase 2, mitigation would be managed as 2nd stage tender</li> <li>• Risk of contractor pricing Phase 2 with limited competitive tension or transparency, mitigation would be managed as 2nd stage tender</li> <li>• •Potential for misalignment with NEC principles of early warning and collaboration.</li> <li>• Framework and commercial acceptability of a compensation event ea 100% of awarded value</li> <li>• Due to above could not be used for Phase 3</li> </ul>
3	<ul style="list-style-type: none"> <li>• Clear commercial and legal separation between phases, reducing ambiguity.</li> <li>• Allows competitive tendering for Phase 2, potentially improving value for money.</li> <li>• Lessons learned from Phase 1 can inform Phase 2 scope, risk allocation, and pricing.</li> </ul>	<ul style="list-style-type: none"> <li>• Opportunity for MTX to increase Prelims</li> <li>• Loss of continuity in delivery team and supply chain.</li> <li>• Potential delays between phases due to contract negotiation</li> <li>• Risk of misalignment in programme, design standards, or stakeholder expectations</li> <li>• Possible duplication of resources between 2 contracts</li> </ul>
4	<ul style="list-style-type: none"> <li>• Clause X22 (Early Contractor Involvement) supports collaborative planning and progressive cost definition.</li> <li>• Break clause provides flexibility to exit or re-scope Phase 2 if needed.</li> <li>• Aligns well with NEC principles of collaboration and transparency.</li> </ul>	<ul style="list-style-type: none"> <li>• X22 currently not included within ECC contract at tender stage</li> <li>• Requires robust governance and clarity on break clause triggers.</li> <li>• Contractor may invest effort in Phase 2 planning without guarantee of delivery.</li> <li>• Potential for sunk costs or disputes if Phase 2 is not progressed.</li> <li>• •May require careful drafting to ensure Phase 2 scope and pricing are appropriately managed.</li> <li>• Opportunity for MTX to increase Prelims, mitigated by negotiation reducing% back to original 6%</li> </ul>

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 achieving 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 adaptations 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

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# 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
<b>Total capital costs</b>	<b>104,175</b>	<b>19,454</b>	<b>123,629</b>

## 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
<b>Costs</b>					
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	<b>104,175</b>
<b>VAT</b>	17	4,795	11,055	3,587	19,454
<b>Total capital costs</b>	<b>2,645</b>	<b>31,320</b>	<b>67,684</b>	<b>21,980</b>	<b>123,629</b>
<b>Funding</b>					
To OBC	1,934	0	0	0	1,934
Funding Received to Date	1,934				<b>1,934</b>
Funding Still Required	711	31,320	67,684	21,980	121,695
<b>Total funding requirement</b>	<b>2,645</b>	<b>31,320</b>	<b>67,684</b>	<b>21,980</b>	<b>123,629</b>

## 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
<b>Total annual revenue costs</b>		<b>9,985</b>	<b>39,941</b>

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
<b>Total annual revenue costs</b>		<b>39,941</b>
<b>Anticipated Funding:</b>		
Transfers – Substitution of existing services		7,298
Welsh Government Central funding for Depreciation		3,160
<b>Anticipated Funding</b>		<b>10,458</b>
<b>Regional Funding Requirement</b>		<b>29,483</b>

### 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 and 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

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# 10 Management arrangements

## 10.1 Introduction

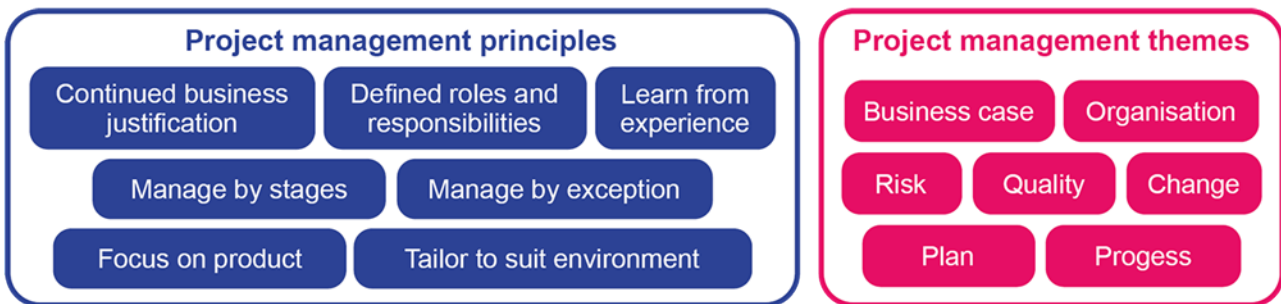
This section of the business case sets management arrangements that will successfully deliver Llantrisant Health Park Programme to time, cost and quality. The Management Case outlines the following arrangements:

- 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



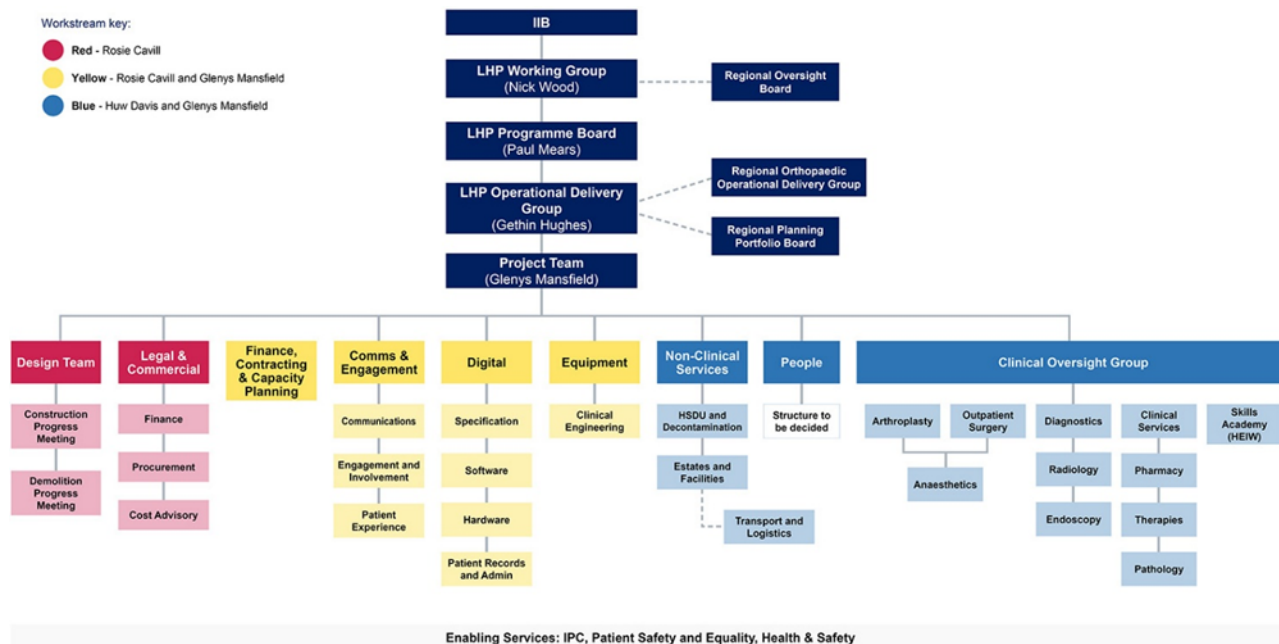
The key principles behind PRINCE2 are the identification of three main functional areas of the project governance structure, including governance, delivery and assurance functions.

### 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			
<b>TOTAL</b>		<b>£8,356,798</b>	<b>£1,885,773</b>	<b>£1,491,401</b>	<b>£4,979,624</b>

## 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.

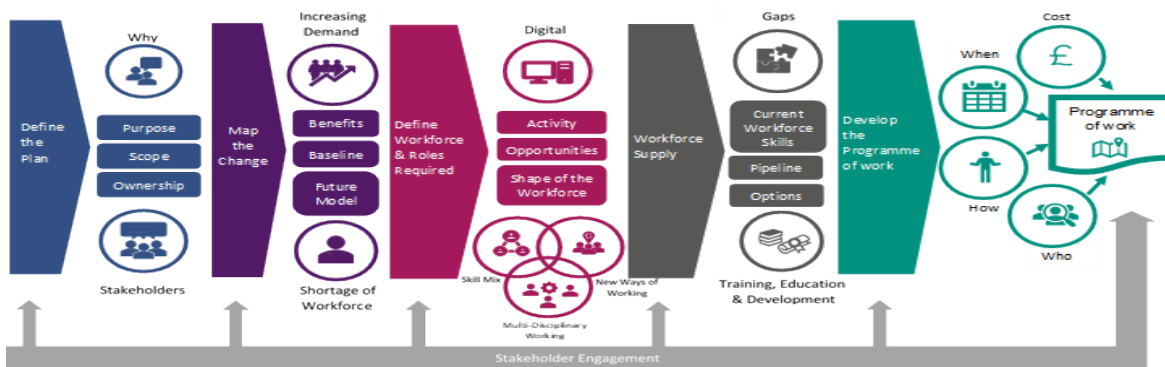
It is recognised that the transition to SEW regional collaboration at LHP is a critical step in the delivery of integrated, high-quality healthcare. The detail of this transformation depends heavily on the evolving design of the workforce model. Ensuring the right organisational design supported by organisational 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 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 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 destabilising 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 resident 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.;
- Clinical models of care and patient flow diagrams;
- Schedule of accommodation;
- 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 not 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:

<b>1-6 Low</b>	Low risks should be reviewed and progress on actions recorded and updated at least every 6 months
<b>8-12 Moderate</b>	Moderate risks should be reviewed and progress on actions recorded and updated at least quarterly
<b>15-25 High</b>	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*

<b>Costs</b>	<b>Original OBC Cost £000</b>	<b>Revised OBC Cost £000</b>	<b>Movement £000</b>
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
<b>Subtotal</b>	<b>96,705</b>	<b>104,175</b>	<b>7,470</b>
<b>VAT</b>	<b>17,586</b>	<b>19,454</b>	<b>1,868</b>
<b>Total capital costs</b>	<b>114,291</b>	<b>123,630</b>	<b>9,338</b>

*Table 2 Revised Capital Cost and Funding Profile*

	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	Total £'000
<b>Costs</b>					
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
<b>Subtotal</b>	<b>2,628</b>	<b>26,525</b>	<b>56,629</b>	<b>18,394</b>	<b>104,176</b>
<b>VAT</b>	<b>17</b>	<b>4,795</b>	<b>11,055</b>	<b>3,587</b>	<b>19,454</b>
<b>Total capital costs</b>	<b>2,645</b>	<b>31,320</b>	<b>67,684</b>	<b>21,981</b>	<b>123,630</b>
<b>Funding</b>					
RIBA 2 & 3	1,934	0	0		1,934
<b>Funding received to date</b>	<b>1,934</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,934</b>
<b>Funding still required</b>	<b>711</b>	<b>31,320</b>	<b>67,684</b>	<b>21,981</b>	<b>121,696</b>
<b>Total funding</b>	<b>2,645</b>	<b>31,320</b>	<b>67,684</b>	<b>21,981</b>	<b>123,630</b>

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.