

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Women Health Programme Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Tracy Daszkiewicz, Executive Director for Public Health and Strategic Partnerships Clare Lipetz, Assistant Divisional Director for Family and Therapies, and ABUHB Clinical Lead for the Women's Health Programme
SWYDDOG ADRODD: REPORTING OFFICER:	<ul style="list-style-type: none"> • Sian Chard, Assistant General Manager, Family and Therapies Division • Chloe Trinder, Performance Manager, Families and Therapies Division • Shareen Ali, Head of Public Health, Gwent Public Health Team

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

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This paper provides a progress update on the women's health programme which was introduced in Spring 2025. The paper was considered by the Executive Team on the 13th November 2025 and the Board is now asked to receive, for information and assurance, the work progressed to date against the requirements set out by Welsh Government and provide any relevant feedback in relation to the next steps to develop a women's health pathfinder hub. Further information, including the service specification and operating model for the pathfinder hub, is planning to be shared with the Executive Committee for consideration in December 2025.

Cefndir / Background

Following the publication of the Welsh Government's *Quality Statement for Women's and Girls Health*¹ and *The Discovery Report-Foundations for a Women's Health Plan*² the Welsh Government launched *The NHS Wales Women's Health Plan: A 10-year plan for women's*

*health in Wales*³ in December 2024. The plan is a ten-year vision that outlines an NHS Wales approach to improving health outcomes for women, with a focus on eight priority areas and a series of short, medium and long term actions. The plan outlines the key health inequalities experienced by women in Wales at a population level, and highlights some of the disparities in health that are emerging. It also highlights opportunities for closing the gender gap and improving health across our NHS services.

Following the publication of the plan Health Boards have been mandated to achieve the following by the end of March 2026:

- Establish at least one pathfinder women's health hub that should be sustained from April 2026 onwards.
- Have an agreed plan in place for the wider implementation of women's health hubs.
- Ensure women's health hubs are included in the 2026-27 IMTP.

To inform the service specification and operating model of the pathfinder hub three priority areas must be used. It is suggested they cover the three main stages of a woman's life course. These include:

- Contraception
- Menopause
- Menstrual health

Whilst the initial focus, in line with the three priorities outlined above and as required by Welsh Government, is on sex specific issues the long-term intention is that an approach to addressing issues beyond those that are related to gynaecological procedures and truly address inequalities for women is adopted.

2.1 Women in Gwent: The local picture

Differences in health outcomes

There are stark differences in life expectancy, mental well-being and access to healthcare services for the circa 303,000 women and girls (51% of the population) in Gwent. These disparities are compounded by factors such as poverty, education and access to meaningful employment. These translate into daily realities that affect their opportunity to live happy, healthy and fulfilled lives. Understanding the demographic, socioeconomic and health characteristics of women in Gwent is fundamental to ensuring the right services and interventions are in place to plan appropriately and proportionately for and respond to the needs of the women in Gwent.

It is well known that women have a longer life expectancy (number of years they live for) than men (ONS, 2024⁴). In Wales, women have a life expectancy of 82 years with men having a life expectancy of 78 years. Across Gwent, other than in Monmouthshire, the life expectancy for both men and women is lower than the Wales average. When considering the potential impact of deprivation and the drivers of differences in health outcomes, the highest proportion of the population living in the most deprived 20% is Blaenau Gwent (44.2% of residents) which has the lowest life expectancy for both men and women. In comparison 1.7% of residents in Monmouthshire live in the most deprived 20%. Despite women living longer than men they live a larger proportion of their life in poor health and there are significant variations in healthy life expectancy for women across Gwent; with a difference of over 10 years between Blaenau Gwent and Monmouthshire where women live for 55.2 years and 65.9 years respectively in good health (Figure 1). These variations are unjust and there is opportunity to narrow this gap. It must be noted that available data does not include those who identify as women (gender specific) and only captures those born as females at birth.

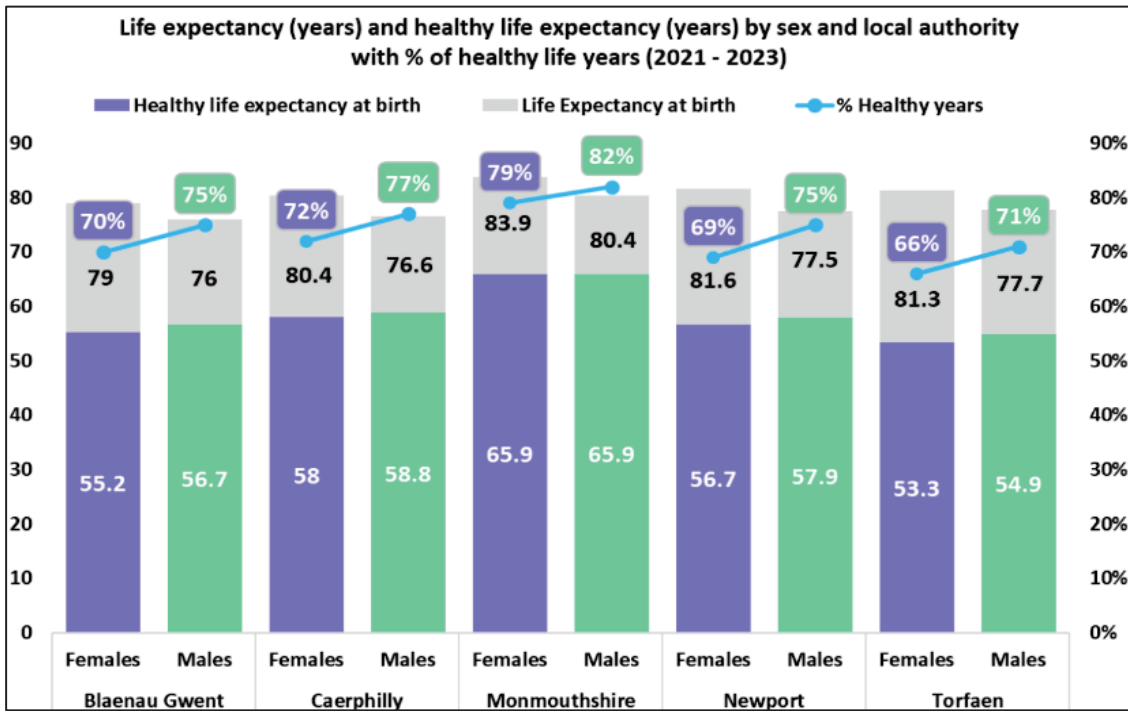


Figure 1: Life expectancy and healthy life expectancy by sex and local authority area (Gwent JSA⁵)

As well as the notable differences in healthy life expectancy between males and females, as well as the stark differences between women living in different local authority areas across Gwent, figure 2 highlights the considerable differences in premature deaths from non-communicable diseases (NCDs) across Gwent. Apart from Monmouthshire all other areas have a higher rate than the Wales average. These differences highlight significant and persistent inequalities, with the most deprived areas experiencing the greatest burden of premature mortality.

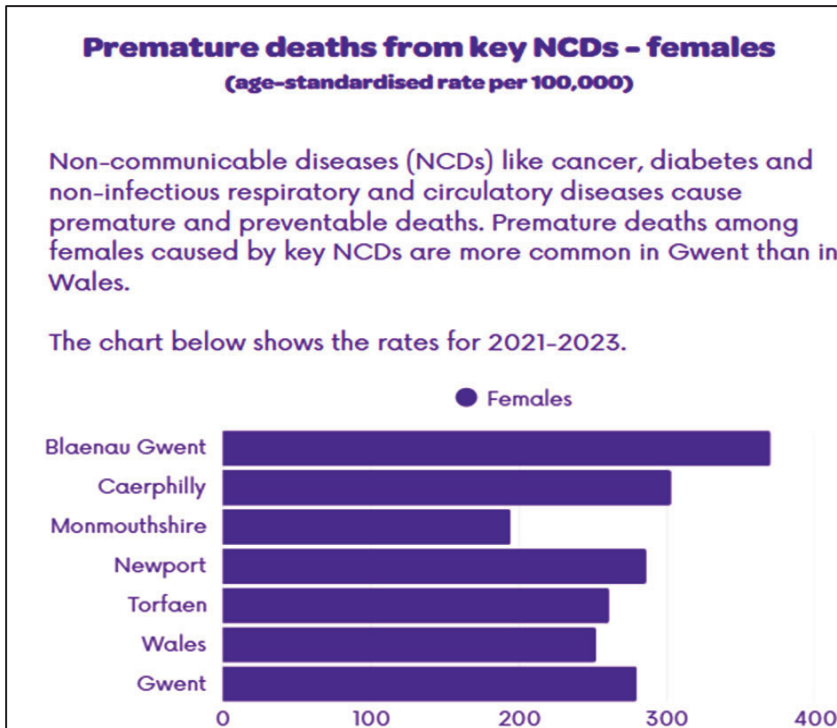


Figure 2: Premature deaths from key NCDs in females (Gwent JSA⁵)

Cancers, type 2 diabetes and non-infectious respiratory and circulatory diseases are often preventable and as such there is a need for targeted interventions to address risk factors that contribute to these NCDs, improvements in access to services and reduce health and healthcare disparities across Gwent.

Access to women’s services in Gwent

There is a wide range of services provided by ABUHB for women in Gwent. However, there are significant variations in access to these services as well as the inability to respond in a timely way to the demand for these services.

Figure 3 shows the sharp upward trend in outpatient waiting list numbers since 2020, broken down by service in figure 4. This reflects the significant increase in the demand for women’s health (sex specific) gynaecology services.

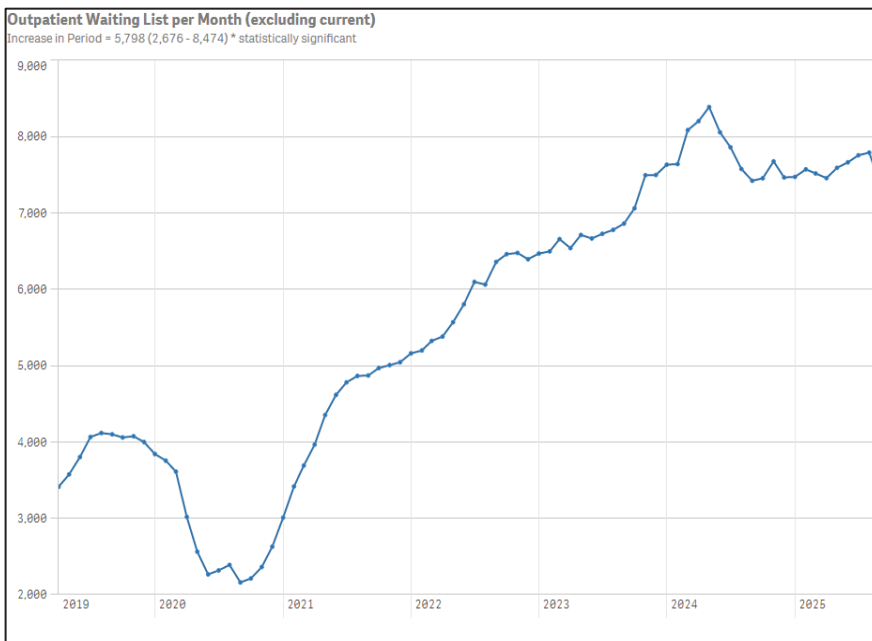


Figure 3: Outpatient waiting list numbers 2019-2025

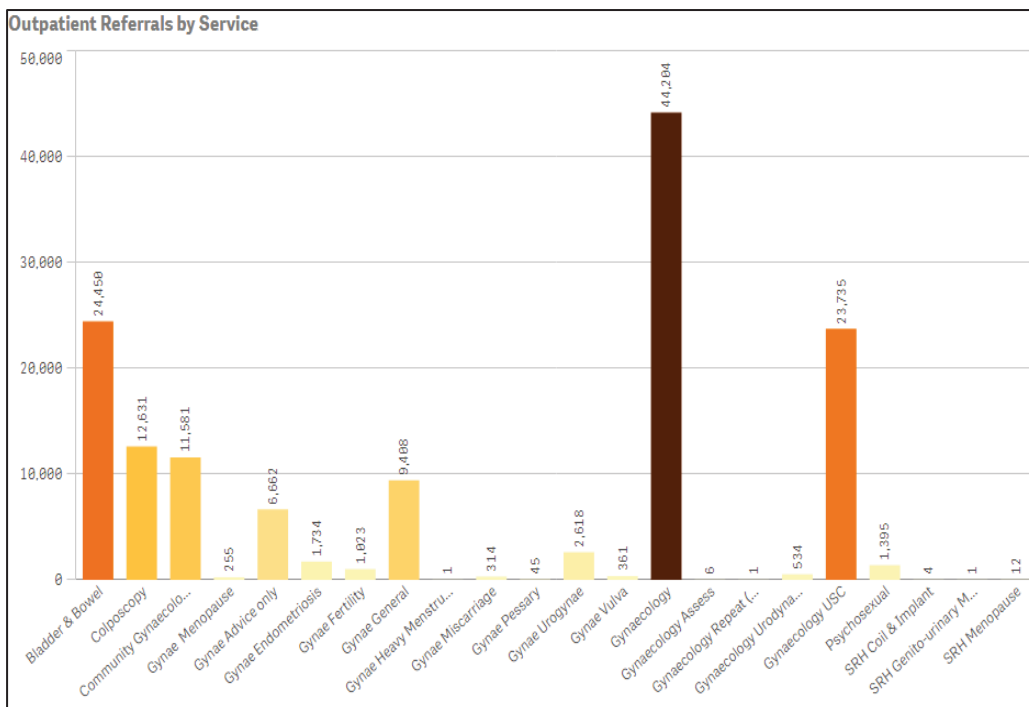


Figure 4: Outpatient referrals by service

Variations in access to women’s services

As well as significant demands on women’s health services that often result in significant delays in access, there are notable variations in access between women living in different areas across Gwent and noticeable changes across time. This section provides a summary of this variation for the current priority areas; contraception, menopause and menstruation.

Contraception

Combined hormonal contraceptive (CHC) prescribing rates within Primary Care have shown a downward trend over time, with the most deprived areas consistently prescribing less compared with least deprived areas (see figure 5). In contrast, emergency contraception prescribing rates have remained stable over time with the most deprived areas consistently being prescribed more than those within the least deprived areas (figure 6).

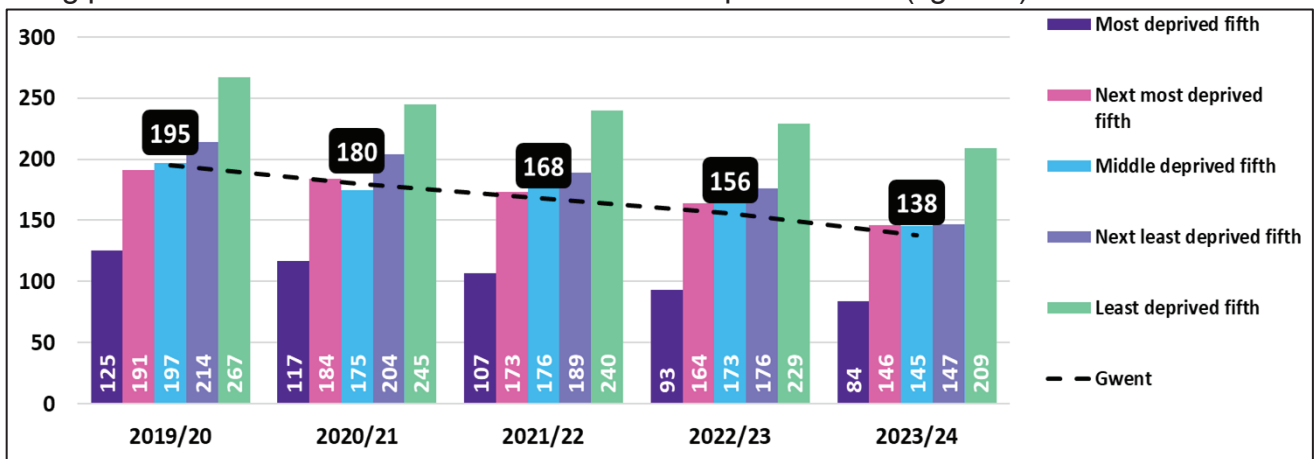


Figure 5: Primary Care combined hormonal contraception items prescribed per 1000 women aged 15-54, by deprivation quintile

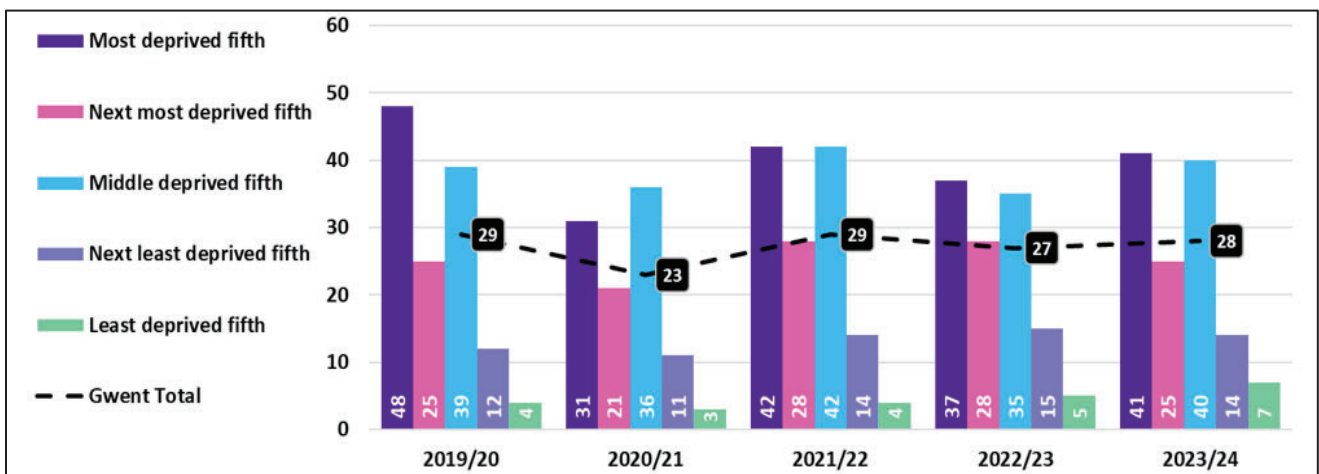


Figure 6: Emergency Hormonal Contraception: Consultations per 1000 women aged 15-55 in Gwent by deprivation quintile

Menopause

Since 2021 there have been increases in the rates of Hormonal Replacement Therapy (HRT) prescribing across all areas of Gwent. However there remains significant variation in these rates between local authority areas; with Newport having the lowest and Monmouthshire having the highest rate (figure 7).

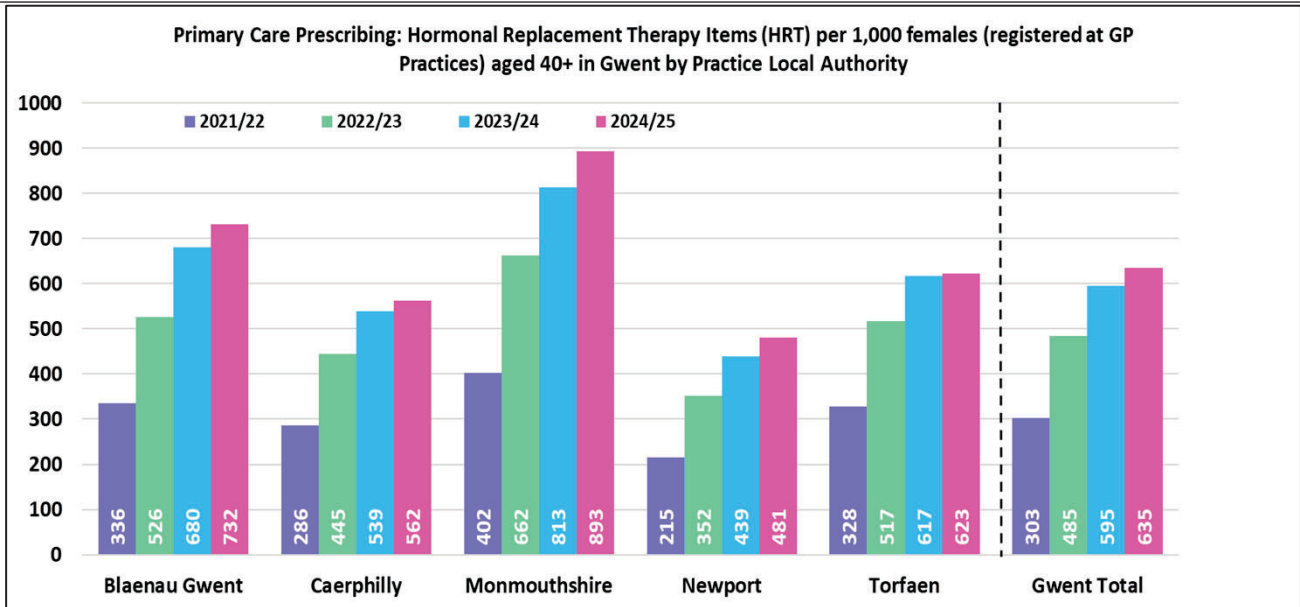


Figure 7: Primary Care HRT prescribing rates across Gwent

Menstruation

How women experience menstruation is varied. While many manage their periods without major disruption, a substantial proportion face challenges that affect their quality of life. One in three women experience heavy menstrual bleeding (HMB), which can lead to physical discomfort, emotional distress, and social withdrawal. Conditions such as endometriosis, polycystic ovary syndrome (PCOS), and premenstrual dysphoric disorder (PMDD) further complicate the menstrual health landscape, often going undiagnosed or untreated for years¹.

Economic inequality remains a key determinant of menstrual health. In areas of Gwent with higher deprivation, such as Blaenau Gwent, women and girls are more likely to experience period poverty. This includes limited access to affordable menstrual products, which can lead to the use of unsafe alternatives and increased risk of infection, and a less dignified experience (Period Proud Wales Action Plan, 2023⁶). As well as economic inequity, stigma and misinformation continue to impact menstrual experiences. In some communities, menstruation is still considered taboo, leading to feelings of shame. This cultural barrier can prevent individuals from seeking medical help or discussing symptoms openly.

Whilst improving access to contraception, menopause and menstruation services and interventions is important there is also a requirement to ensure that broader issues and drivers of inequity, and subsequent inequalities, are considered and incorporated into long term planning.

Asesiad / Assessment

Women’s health hub requirements

The ambition for Women’s Health Hubs in Wales is to bring together healthcare professionals and existing services to provide integrated women’s health services in the community to meet the needs of women across the life course. Women’s health hubs will aim to improve access to and experiences of care, improve health outcomes for women, and reduce health inequalities.

Welsh Government, enabled by the Women’s Health Network, has provided an outline of what women’s health hubs in Wales should be, with the three priority areas outlined above used as a focus for initial scoping:

- Based in the community

- Work at the interface between primary and secondary care and/or voluntary sector and beyond.
- Offer more than a single service (with provision of both gynaecological and contraception services) or demonstrate plans to.
- Have more than one organisation involved in design, commissioning and/or provision of care, beyond simply referring-in.
- The services should not replace GP services and should prioritise hard to reach populations
- To utilise Primary Care 'Cluster Networks', be staffed by multi-professional teams and involve patients, charities and third sector services.
- They should provide opportunities for education and training, utilise health pathways to streamline referrals, and be supported by specialists from within secondary care.
- Services provided through a hub should be provided in a choice of ways; face-to-face, virtual/remote with the provision of 'self-referral' where appropriate.
- Hubs should be supported by HB communication teams to ensure local populations are aware of their existence, what is provided and how they can book/be referred.

Health Boards are required to establish at least one women's health pathfinder hub by the end of March 2026 with the view to sustaining it beyond April 2026, with a supporting plan in place for the wider implementation of women's health hubs. It is important to note that there is currently no indication that additional funding will be made available from April 2026 onwards to support the sustainability of the initial pathfinder hub or enable the wider implementation of women's hubs.

Progress to date

A significant amount of work has taken place across the Health Board to progress the development of a pathfinder hub. This includes, but is not exhaustive of:

- Establishment of a Programme Board with task and finish groups to provide a specific focus to progress the three priority areas.
- Securing £300,000 of Welsh Government funding for 2025/26. This funding supports the ongoing ambition to implement and sustain a pathfinder hub by building appropriate capacity and learning in areas that includes, but is not exhaustive of:
 - Ongoing training and workforce development (e.g., Menopause BMC certificate, community pharmacy technician emergency contraception, ring pessary in primary care).
 - Capital investment into couches for Primary Care
 - Development of an extended in-house termination services and expansion of the vasectomy service to reduce waits
 - Upgrading booking and triage systems to increase capacity covering 24hrs (online out of hours).
 - Investment in public health intelligence expertise to lead the development of discovery report and needs assessment.
- Women's health hub workshop in October 2025 bringing together relevant stakeholders to support the development of the pathfinder hub.
- Women's health discovery report underway with an initial focus on the 2025/26 priority areas.
- Premenstrual Dysphoric Disorder (PMDD) needs assessment underway.
- Development of a pelvic health research funding bid, outcome TBC.
- Establishment of divisional interface groups, aiming to bring together Primary Care and Secondary Care clinicians to redesign pathways and develop new integrated models of care. This could include:
 - Consultant interface clinics;

- GPs with Extended Roles (GPERs) working with consultant colleagues; and
- Consultant input into virtual or in-person MDT meetings.
- Women's health hubs reflected in the Health Boards 2026/27 IMTP.

Proposed model for a women's pathfinder hub in Gwent

Based on the current understanding of the needs of women in Gwent, clinicians and patient feedback and the outputs of the stakeholder workshop a blueprint of how women's health hubs could be developed is reflected in appendix A. The proposed model intends to upstream services that traditionally sit within secondary care and move them into community settings. It is hoped that further planning on the range of services required at a locality level can be defined through appropriate existing mechanisms and aligned to existing programmes, e.g., ISPBs and Place Based Care.

Upskilling the workforce in primary care will enable enhanced support within communities to provide ring pessary's, coils and menopause support. The model suggests that fragile secondary care services should be centralised using ambulatory care units such as that In Nevill Hall Hospital, whilst exploring implementing more sustainable services within the community.

Work will continue with communities to gather ongoing systematic feedback to inform and develop the model.

Underpinning principles

- To build on and incorporate the Health Boards women's ambulatory unit and other exemplar services that the Families and Therapies Division has established over the last 5 years.
- To ensure alignment and incorporate any model with the Health Board's 10-year strategy: Better Health, Better Care, Better Lives, Place Based Care Programme, the violence against women, domestic abuse and sexual violence (VAWDASV) agenda, Best Start in Life and the priorities being led by the Maternal and Neonatal and Child Health Network. and emerging business case which is scheduled to be considered towards the end of this year.
- To continue to test new models of care and embed into the women's health hub and spoke model potentially with virtual access to services.
- To continue to enhance provision within Primary Care through training and education building on the work already taken forward
- Build on patient engagement and education through campaigns, co-production and intelligence drawn from PREMS/PROMS. To identify gaps, improve the patient experience and strengthen management out of hospital care.
- Capitalise on existing and explore new digital platforms for women's health that support signposting, education, and virtual co-ordination.

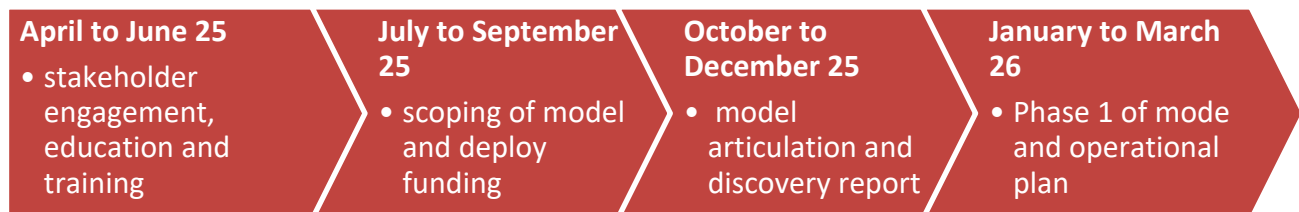
What will the women's hub model deliver

The women's health hub model aims to improve outcomes and experience for girls and women through education, increased service access, reduced health inequalities and providing integrated care close to home. Services will be holistic and take a life course approach so for example menopause services will offer education, clinical support along with lifestyle and psychological support. Once fully implemented, the model would hopefully deliver the planned outcomes outlined in appendix B.

The intention is that the proposed path finder hub service specification and operating model will address the three sex specific priority areas, as required by Welsh Government. However the long-term ambition is to use data and intelligence to identify need, improve health outcomes

and address the inequalities that exist for women/girl's long term. Whilst this will include e.g., addressing access to sex specific services it will also consider non-sex specific issues including violence against women, domestic abuse and sexual violence (VAWDASV), and chronic disease prevention, including increasing the prevention of gestational diabetes in line with the Priorities of the National Clinical Network for diabetes. This will be done by addressing clinical and behavioural risk factors as well as the fundamental building blocks for women's health that includes social, economic and environmental factors.

An overview of the timeline of activities for this year is outlined below:



Next Steps

To meet the ambition of developing and implementing a women's health pathfinder hub in Gwent the following next steps are planned:

- Complete the women's health discovery report and commence expansion into larger needs assessment to include non sex specific issues.
- Continue to implement projects and interventions supported by Welsh Government funding to inform development of pathfinder hub.
- Develop service specification and operating model for pathfinder hub and gain agreement from ABUHB executive team in December 2025.
- Ongoing strategic alignment of women's health hub with other health board and system priorities, e.g., Place Based Care. This to include the strengthening of relationships between secondary and primary care clinicians.
- Continue to strengthen links with community and engagement teams e.g., IWNs and ABUHB engagement team to engage with women and communities to inform ongoing development of pathfinder hub.

Risks to delivery

A number of risks and challenges to develop and implement an initial pathfinder hub and wider network of women's hubs have been identified:

- Lack of additional new money currently indicated to support the sustainability and scale up of women's hubs. Whilst the initial £300k pump prime funding for 2025/26 from Welsh Government intends to build capacity, learning and system efficiencies it is unknown if any efficiencies gained will be enough to enable reinvestment from within the Health Board at the scale required and within the current financial environment.
- Lack of insight in relation to 2026/27 national priorities for women's health.
- Challenging timescales to design and commence the implementation of the pathfinder hub alongside other national and Health Board priorities. Similar concerns have been expressed by other Health Boards and ABUHB have been liaising closely with WG around expectations.
- Significant consideration to the following is required to enable operational delivery of the hub(s):
 - workforce availability (including capacity and capability)
 - current system pressures
 - estates and facilities strategy
 - appropriate alignment with other priority areas of work

Argymhelliad / Recommendation

The Board are asked to:

- Consider the information presented and provide any relevant feedback or insight, in particular to proposed next steps, the proposed pathfinder hub for Gwent and the risks to delivery.

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

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 1. Staying Healthy 4. Dignified Care 5. Timely Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:

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

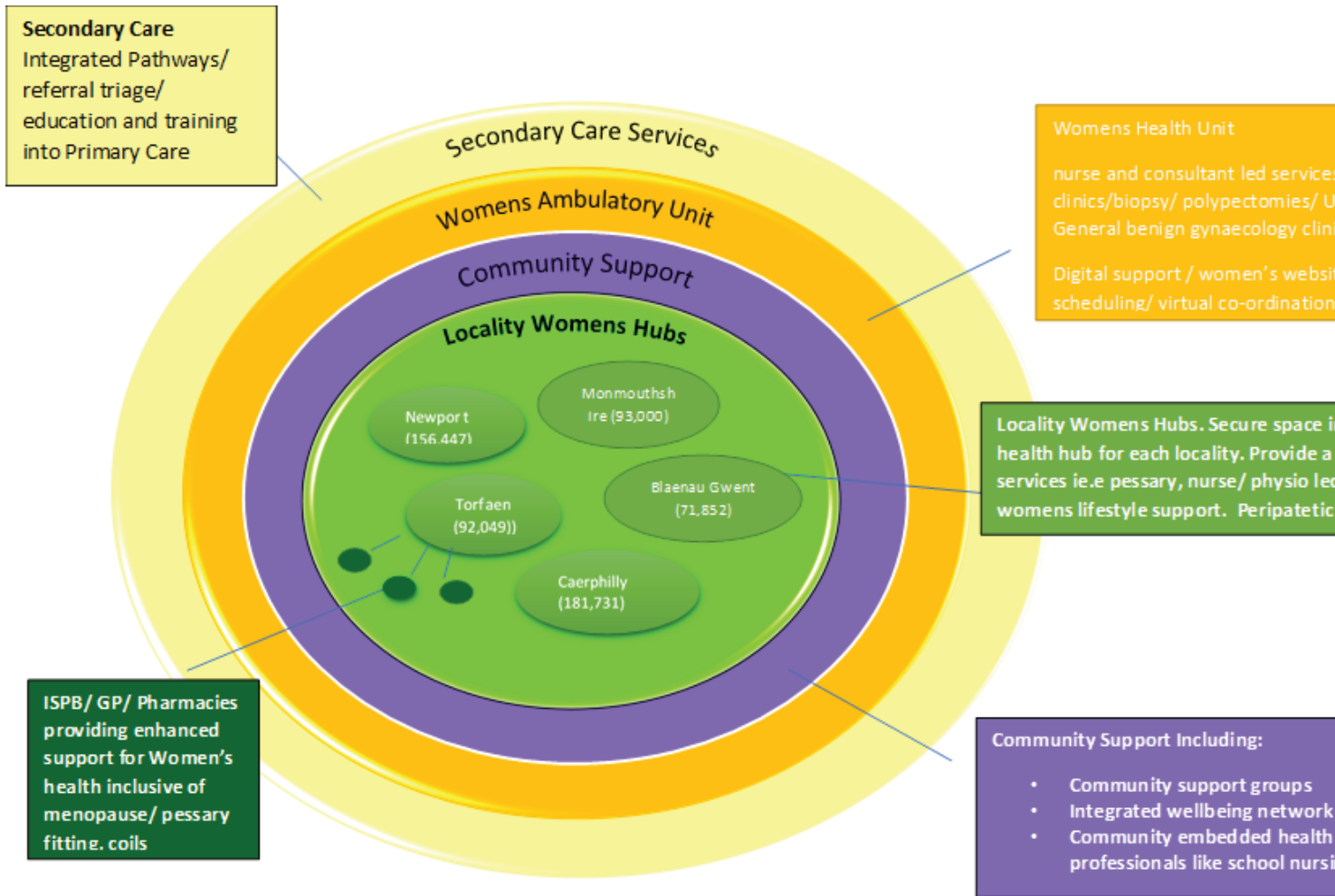
Effaith: (rhaid cwblhau) Impact: (must be completed)

	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

References

- 1: [Quality statement for women and girls' health \[HTML\] | GOV.WALES](#)
- 2: [Women's Health in Wales - A Discovery Report - NHS Wales Performance and Improvement](#)
- 3: [The Women's Health Plan for Wales - NHS Wales Performance and Improvement](#)
- 4: [Life expectancies - Office for National Statistics](#)
- 5: [The Gwent Joint Strategic Assessment 2024/25 Edition - Aneurin Bevan University Health Board](#)
- 6: [Period Proud Wales Action Plan \[HTML\] | GOV.WALES](#)

Appendix A: Blueprint of women's health hubs for Gwent



Appendix B: Expected outcomes of the proposed model

Improved **cervical cancer** screening uptake because of enhanced education and training

Connecting people to non-medical support by **capacity building in the community** reducing reliance on

Improved patient experience and outcomes for women accessing **abortion care** who currently travel outside

Holistic support for chronic conditions like endometrioses, PMDD, POI

Virtual **self-booking** giving timely access to ring pessary changes and self-referral for vasectomy

Holistic/ life course approach to **menopause** creating improved access and longer term health benefits

Improved support and access to **pre-conception** health advice and preparation for pregnancy

Enhanced **education** to improve access, screening, decision making. This includes period dignity/

Delivery of women's services and enhanced education to **vulnerable groups and those protected**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Feedback on the Respiratory Reconfiguration and the General Medicine Model at GUH
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Tracy Morgan, General Manager, Medicine Kate Fitzgerald, Head of Transformation and Delivery

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To provide the Board with an update on the implementation of the General Internal Medicine (GIM) model at Grange University Hospital (GUH), alongside the Respiratory Medicine reconfiguration introduced in November 2024. Key developments include:

- Realignment of medical staff from Nevill Hall Hospital (NHH) to GUH to strengthen the Respiratory team
- Establishment of clear clinical accountability for 16 GIM beds at GUH

Cefndir / Background

General Internal Medicine – Service Model Update

Since the opening of GUH in 2020, the site has operated a specialty-based bed model, with General Medical patients managed at enhanced Local General Hospitals (eLGHs). As a result, GUH has not delivered a General Medicine model for the past five years. This has impacted the ability of specialty patients to access appropriate beds, which potentially affects the timeliness of care for patients requiring general medical support—particularly among the elderly and frail population.

Following efforts to reduce the bed base in line with the Clinical Futures plan and given a partial reduction in surge beds at Nevill Hall Hospital (NHH) over the summer, an opportunity arose to address these challenges. A plan was developed through a series of planning and briefing sessions to support development and implementation.

Executive Committee – 12th September 2024

A paper was submitted seeking approval to implement a GIM model at GUH, aligned with the reconfiguration of the Respiratory Medicine service. Key elements included:

- Closure of medical inpatient beds on Ward 4/3 at NHH
- Phased introduction of a Respiratory in-reach model at NHH and YYF
- Establishment of clear clinical accountability for 16 GIM beds at GUH

Board Briefing – 9th October 2024

The Board received an update on the Inpatient Reconfiguration Programme, including the Respiratory service changes and the introduction of the GIM model at GUH.

Public Board – 26th November 2024

The Board received an update on the implementation of the GIM model which commenced during the week of 11th November 2024.

The **proposal** included:

- Reconfiguration of current medical beds and relocation of Respiratory High Care Unit to result in the General Internal Medicine capacity on the GUH site being provided across Wards **C4 and B4**.
- **Respiratory High Care Unit** on C4 to relocate to C2.
- **A3 beds** (currently utilised for outlying General Medical patients) allocated to Surgery.
- First floor General Medical patients continue to be managed by the **Acute Medical team**, as per previous model.
- Closure of a medical ward at which equated to **22 Respiratory and 6 Diabetes beds**, (Diabetes beds to be absorbed into existing footprint), a total reduction of 28 beds. This was enabled by absorbing the surge capacity on the wards at NHH into core numbers.
- Clear clinical accountability (Respiratory) for **16 General Medical** beds at GUH.

The **overall bed reduction**:

Overall Bed Reduction	
Medicine	
NHH	
22 Resp & 6 Diab, Diab beds to be absorbed into NHH footprint	-28
GUH	
A3 (gynae - used for medical outliers)	-8
C2 (machen)	6
Total	-30
Surgery	
GUH	
C2 (machen)	-6
A3 additional	8
Ambo CEPOD	2
Total	4
Bed Reduction	-26

Assessment

As outlined in the Public Board paper dated 26th November, a range of outcomes and benefits were anticipated as part of the proposed service change. This paper highlights expected improvements across key areas, including workforce, financial, patient experience and system-wide operational benefits.

Workforce Analysis

The following feedback and workforce benefits are noted from the **Respiratory Consultants**:

- Recent bed reconfiguration has significantly enhanced teamworking within the directorate—a development of considerable importance.
- Ward functions efficiently despite its size, supported by effective board rounds and strong leadership from a proactive ward manager.
- Concerns have been raised regarding insufficient non-clinical capacity at GUH to support virtual clinics and SPAs, resulting in consultants needing to travel off-site.
- Inpatient respiratory referrals at Nevill Hall Hospital remain manageable.
- Case mix on Ward C4 has shifted, particularly over the summer, with fewer respiratory admissions.
- Reduction in medical outliers managed by the Respiratory team has positively impacted workflow and staff morale across the GUH site.
- Despite changes in case mix, the average length of stay on C4 (including newly configured beds) has decreased since the reconfiguration.

The **Workforce support** provided to staff through the reconfiguration included:

- All staff affected by the proposed service change were supported in line with the all-Wales organisational change policy.
- Engagement was undertaken with Trade Union Partners.
- Staff preferences were honoured, with all individuals securing either their first or second choice.
- Staff were offered one-to-one meetings with senior management and workforce representatives to discuss concerns and options.
- Through mutual agreement, the Ward Manager and Deputy Ward Manager from Ward 4/3 transitioned into vacancies within the Acute Medical Unit at the NHH site.
- Divisional engagement sessions were held with representation from all staff groups, and an executive drop-in session at NHH led by the Chief Operating Officer and Executive Director of Nursing to provide further reassurance and an opportunity to address staff queries.
- Nursing staff were also supported to transfer to alternative hospital sites, enabling personal development and accommodating individual circumstances

Workforce Summary table

Role	Workforce Update	Additional Notes
Consultant	Increased by 1 WTE as planned for 2025/26 Phase 2 - recruitment of 1 WTE 2026/27	Recruitment currently in progress.

Physician Associate	Increased by 1 WTE due to substantiated post previously funded by Cardiology	Service model revised to provide 7-day clinical cover, mirroring consultant pattern
Nursing & HCSW	Workforce establishments increased	Ongoing recruitment; full recruitment affected by natural turnover

Consultant Office Space – Impact on Service Delivery

As part of the consultant contract, the Health Board is expected to provide suitable office space to support job planning requirements. Currently, no dedicated office space is available at GUH for consultants to undertake administrative duties and there is no consistent availability within the agile working area at GUH.

As a result, consultants are continuing to travel to RGH or NHH to complete this work. This arrangement is having a detrimental impact on capacity, particularly affecting the delivery of Direct Clinical Care (DCC) sessions as outlined in job plans.

A capital Project Proposal Document has been completed for reconfiguration of space in Grange House to support this. This is £12k. The estimated benefit of being able to create office space for this team on this site is equivalent of 6 DCC sessions, estimated at £17k per session, a total of £102k full year effect.

Finance Benefits

This table outlines the predicted net savings to be realised over a three-year period across the Health Board noting the reduction in savings for the Division of Medicine in 2026/27 due to the appointment of the second Consultant:

Division	2024/25	2025/26	2026/27
Medicine	-729,874	-1,617,527	-1,458,780
Surgery	-157,000	-471,000	-471,000
Estates & Facilities	-73,605	-220,815	-220,815
Total Net Savings	-960,479	-2,309,342	-2,150,595

The actual net savings achieved to date are outlined below:

Division	2024/25	2025/26	2026/27
Medicine	-472,000	-1,655,000	-1,496,000
Surgery	0	-471,000	-471,000
Estates & Facilities	-69,000	-221,000	-221,000
Total Net Savings	-541,000	-2,347,000	-2,188,000

The following points are noted:

- Savings were achieved within the Surgery Division during 2024/25 as a result of the change of Machen from elective surgery. The additional staffing has been absorbed into vacancies within the roster for CO
- Predicted savings within Medicine were not fully realised, primarily due to a delay in the anticipated reduction of nursing variable pay. This was expected to occur more rapidly during the transition period at NHH and GUH but did not materialise as planned.
- In addition, in Medicine, there was a short period of supernumerary and increased nursing working in NHH areas over and above the agreed establishment due to staff requesting to remain in NHH. The change in cohort of patients resulted in higher acuity patients on ward 4/4 compared to previously so the level of nursing enhanced care requirements via variable pay was higher, this has now settled.

Patient, Staff and System Benefits

The original proposal identified the following key benefits. Progress to date against each is outlined below:

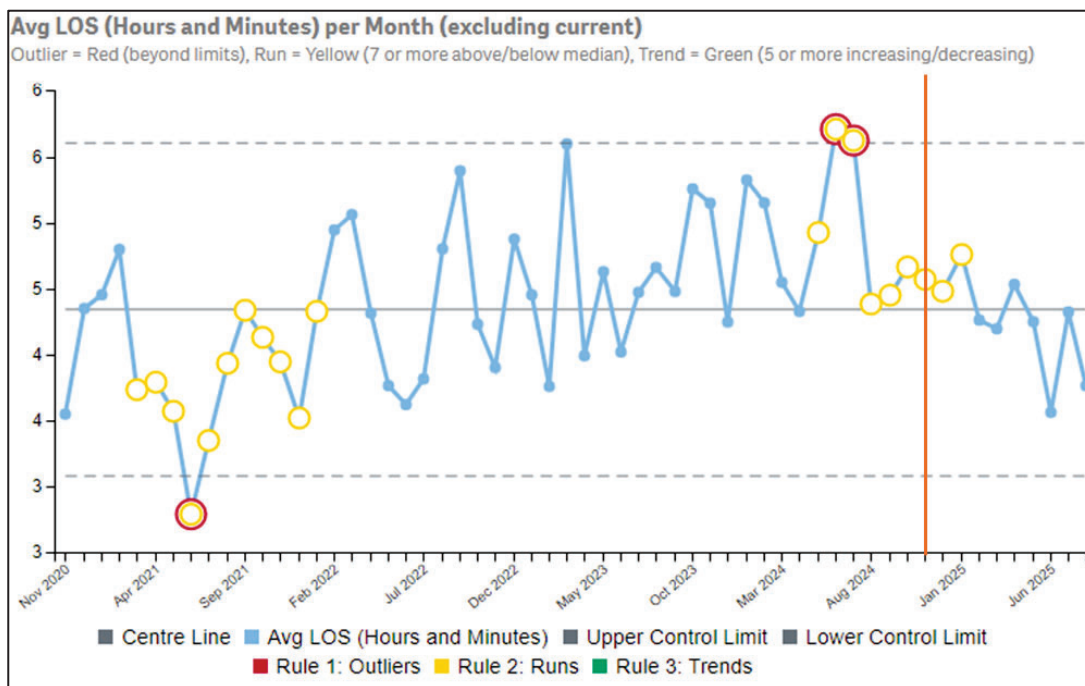
Benefit	Update October 2026
Clear clinical accountability for 16 GIM beds at GUH, improved patient experience and outcomes	Achieved , patient experience and outcomes highlighted through the data, reduced LOS at GUH
Respiratory medical staff aligned to speciality demand, caring for the right patients in the right place in the system	Achieved – Acute Respiratory patients requiring critical support are single sited at GUH with full support from the Respiratory team
Medical model of care at NHH aligned with demand, accommodating multi-morbid care of the elderly patients with complex discharge requirements, care delivered close to home	Noting expected increase in LOS aligned to cohort of patients, elderly and frail. The overall increase in LOS on ward 4/4 is minimal and in line with core COTE wards
Right sizing the bed base aligned to the Clinical Futures model, delivering safe, sustainable and efficient patient care	Ongoing - work continues to be supported through the Clinical Redesign Programme, with oversight from the Chief Operating Officer
Consistent Respiratory in reach model of care delivered across the eLGH sites, single site Respiratory inpatient bed base	Ongoing - recruitment continues, respiratory team have a clear referral process which is utilised and no concerns raised to date

Data Analysis

The data presented below highlights the positive outcomes observed following the service reconfiguration implemented in November 2024. Prior to the reconfiguration, data quality related to General Internal Medicine patients was inconsistent due to coding issues. However, following the change, a robust coding system has been implemented to support accurate data capture and enable reliable trend analysis.

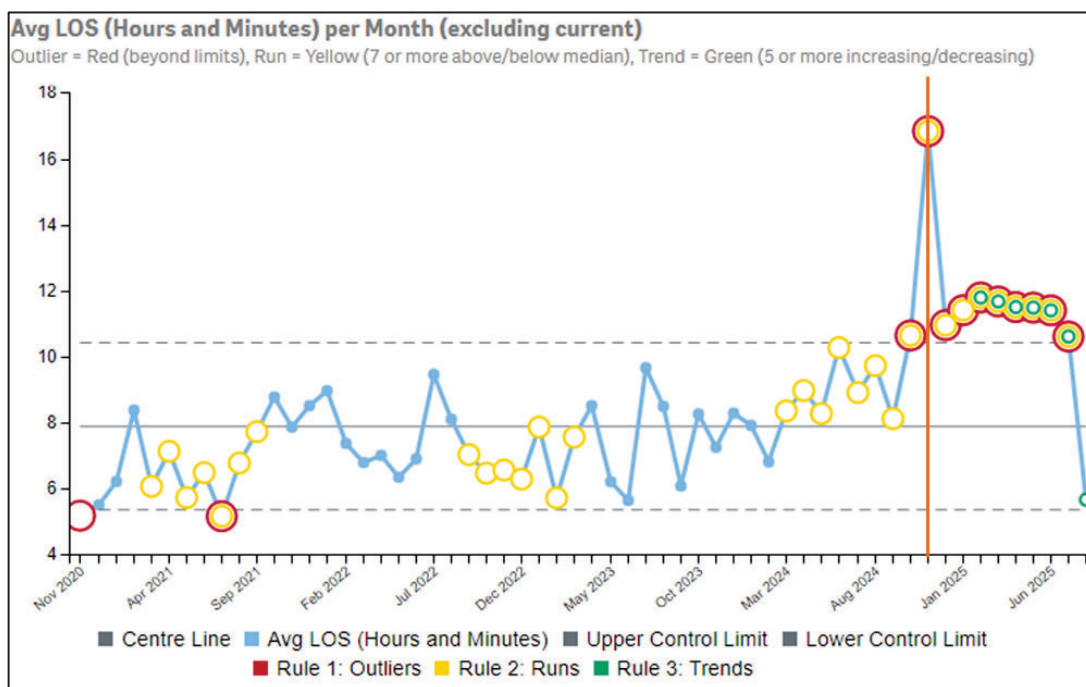
Following the reconfiguration the average LOS on C/4 has gradually decreased (**figure 1**), since April 2024. For most of the period, LOS was around 4-5 days but since May 2025 it has been around 3-4 days as highlighted on the graph below:

Figure 1 – Average LOS Ward C/4 GUH



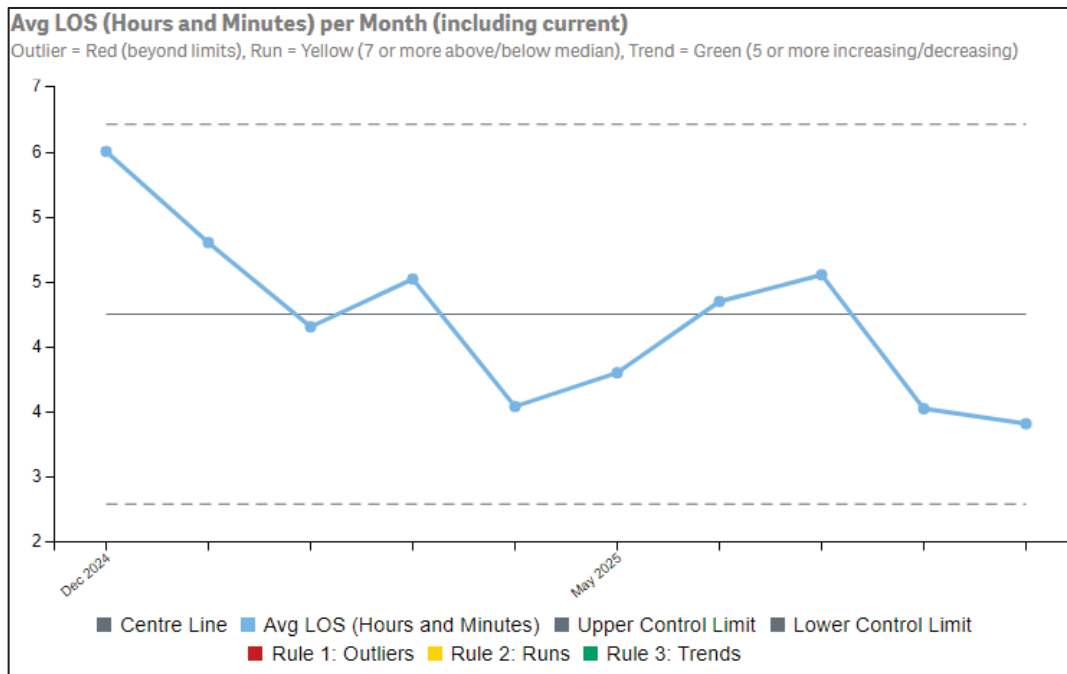
In terms of NHH average LOS on 4/4 (**figure 2**) between March 2024 and January 2025, the average LOS increased from 6-9 days to 10-12 days. This increase was anticipated due to the change in patient cohort, with the ward now functioning as a COTE ward. With the complexity and acuity associated with this cohort, a longer LOS is expected and is consistent with other COTE wards within the Health Board.

Figure 2 – Average LOS Ward 4/4 NHH



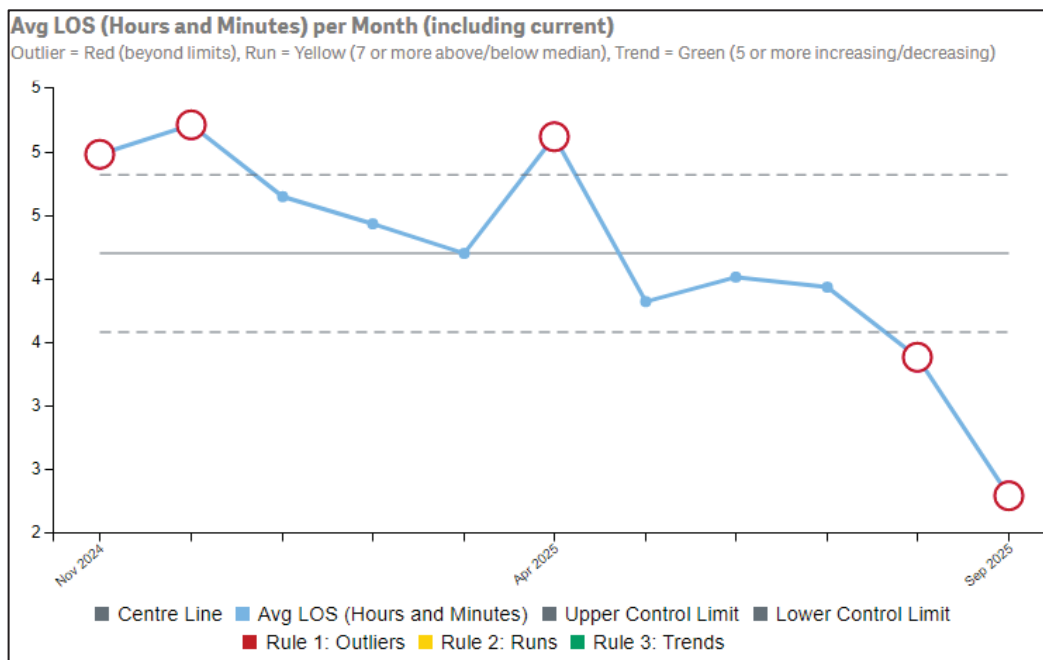
Since November 2024, there has been an anticipated increase in the number of General Medicine patients admitted to ward C/4, with a particularly sharp rise observed from March 2025 onwards. In recent weeks, the ward has consistently seen between 10 to 20 patient stays per week. Despite this increase in activity, the average LOS has shown a gradual improvement (**figure 3**), decreasing from approximately 5–6 days at the start of the year to around 4 days since April 2025:

Figure 3 – Average LOS Ward C/4 GUH General Medicine Patients



Since November 2024, there has been an overall reduction in the number of respiratory patients admitted to Ward C4 in line with demand, with weekly admissions decreasing from approximately 30 to 20. In parallel, the average length of stay (**figure 4**) has improved, reducing from around 5 days to between 3 and 4 days. These trends suggest positive progress in managing respiratory pathways, and improved patient flow across the system.

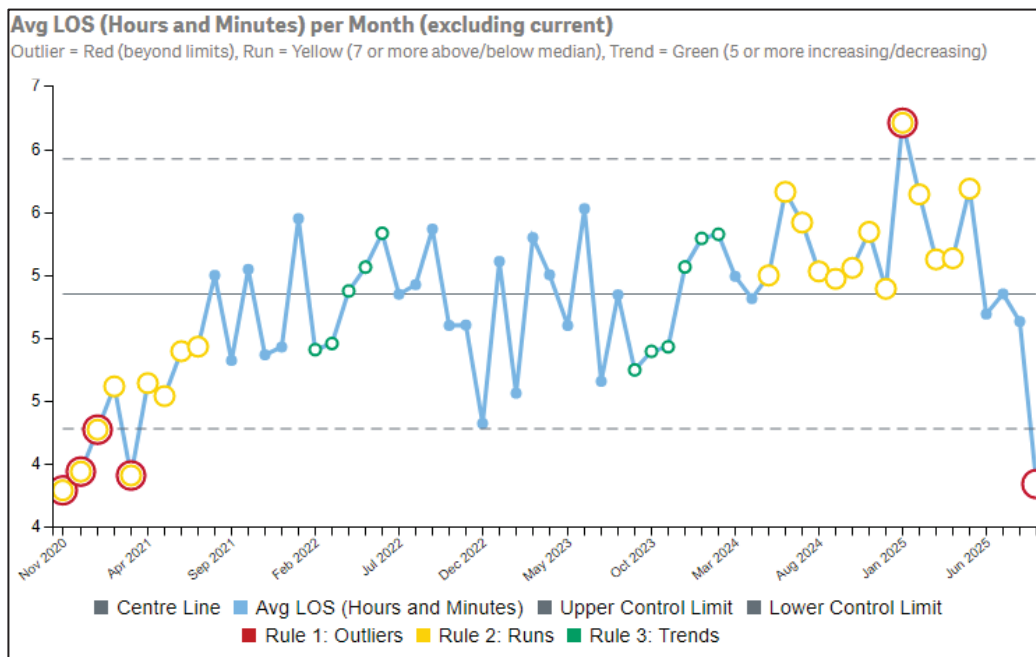
Figure 4 - Average LOS Ward C/4 GUH Respiratory Patients



An anticipated benefit of the reconfiguration was a reduction in LOS on specialty wards (**figure 5**), supported by the introduction of 16 dedicated General Medicine beds. This change has enabled clearer clinical accountability and reduced the need for General Medicine patients to be managed across multiple specialty areas. Consequently, specialty teams are afforded greater capacity to concentrate on their designated patient cohorts, resulting in a reduction in medical outliers. This, in turn, facilitates more efficient utilisation of inpatient beds and contributes to enhanced patient flow throughout the healthcare system.

The average LOS for Medical Specialties has remained relatively stable at around 5 days. In November 2024, LOS had levelled off at approximately 5–6 days, but following a peak in January, a gradual reduction has been observed. Over the past three months, the average LOS has returned to around 5 days, with September showing a further improvement to just under 5 days:

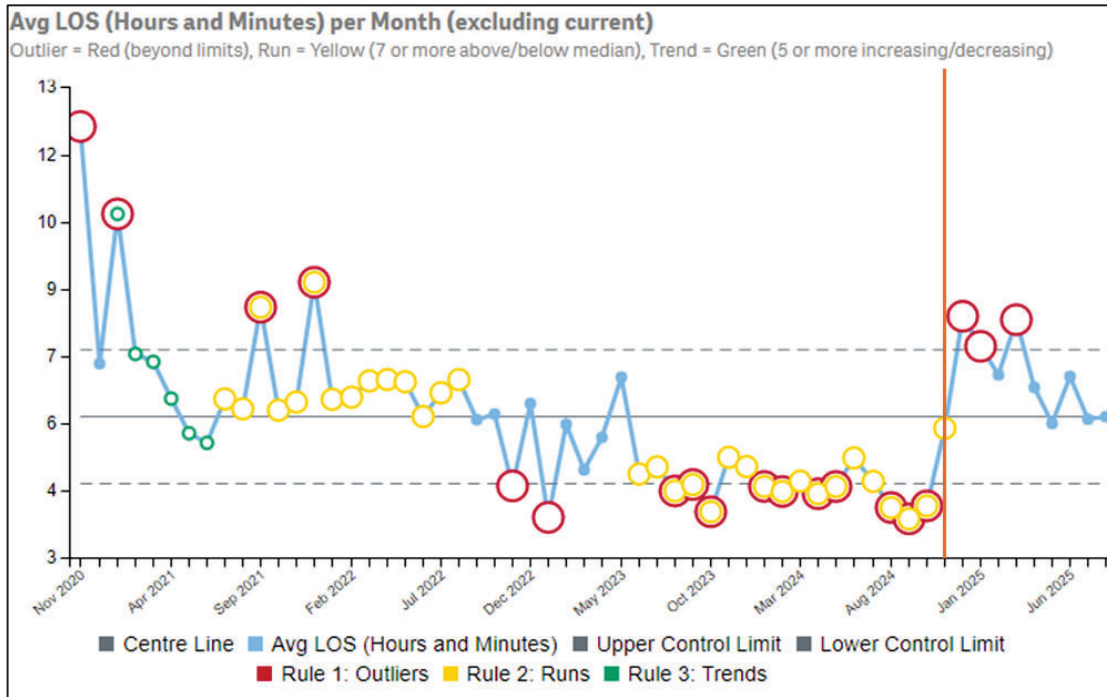
Figure 5 – Average LOS on Specialty Wards at GUH



Following the reconfiguration of high-care respiratory beds from Ward C4 to a dedicated unit within Ward C2, admissions to the critical care component of C2 have significantly reduced—from approximately 165–200 admissions per month to 80–120 admissions per month. The average cost per critical care bed day is £1500.

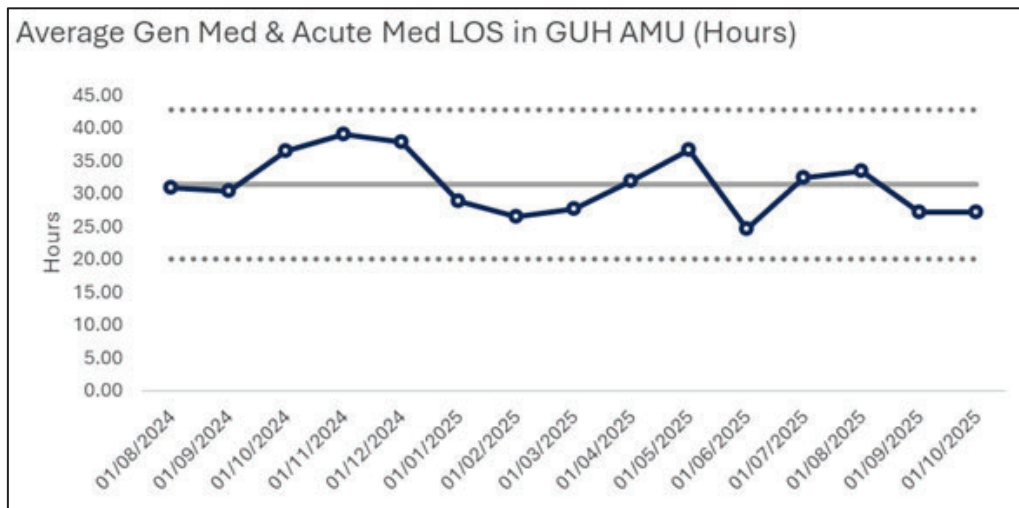
This change has contributed to a more targeted use of critical care resources. The LOS on the ward (**Figure 6**) has increased from around 4 days to 6–7 days, reflecting the higher acuity and complexity of patients now managed within the dedicated respiratory unit, the graph below highlights the ward stays:

Figure 6 – Average LOS Ward C2 GUH



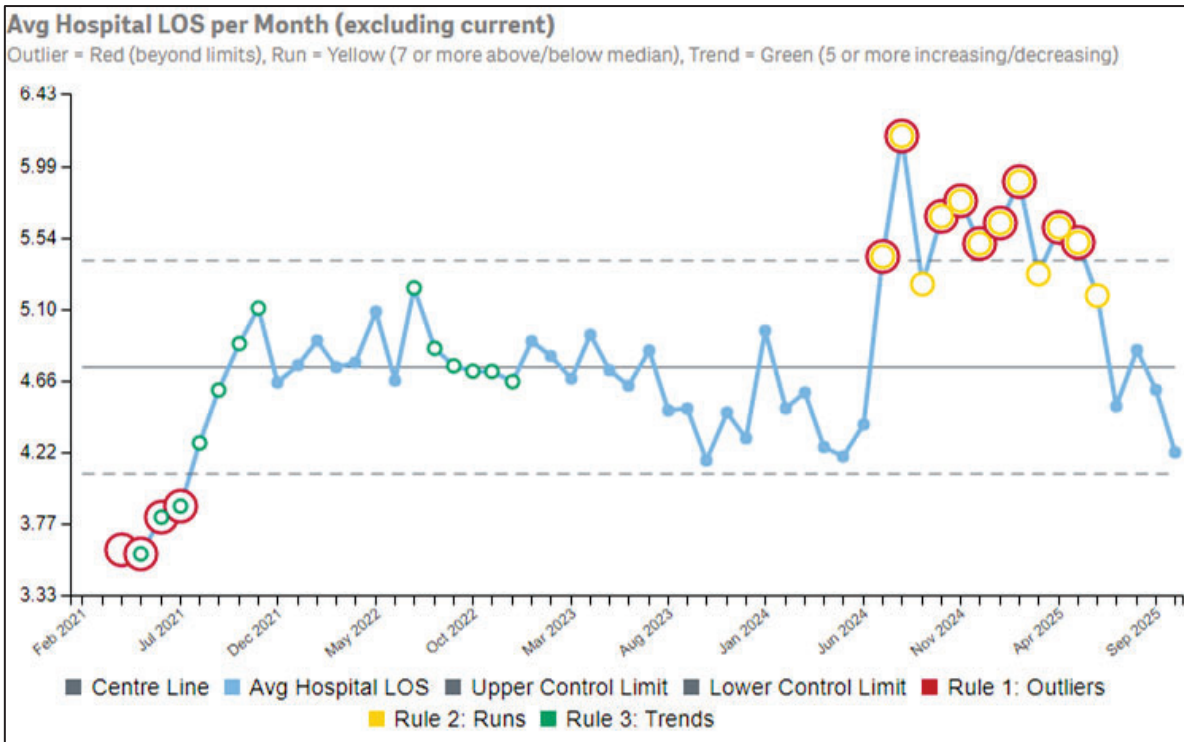
There has been a slight improvement in the LOS of general medicine and acute medicine patients within AMU at GUH, from around 34 hours since August 2024 to 31 hours in November 2024 (**figure 7**). While this was not an anticipated benefit of the reconfiguration, the most significant efficiencies have been realised once general medicine patients are transferred to a ward. This is evidenced by the reduction in LOS for these patients and the resulting improvement in patient flow.

Figure 7 – Average LOS General Medicine and Acute Med Patients in AMU at GUH



The recent reconfiguration at GUH appears to have had a modest initial impact on the overall LOS for patients admitted under the Divisions of Urgent Care and Medicine. While LOS remained relatively stable immediately following the change, a marked reduction has been observed from June/July 2025 onwards. This suggests that the benefits of the reconfiguration may have taken time to embed, potentially reflecting improved patient flow and greater operational efficiency across the site.

Figure 8 – Average Hospital LOS Patients Admitted (Urgent Care and Medicine)



Communication and Engagement

The following areas were progressed aligned to the reconfiguration:

- Divisional engagement session with the ward staff on wards 4/4 & 4/3 with representatives from all staff groups.
- Executive drop-in session with the Chief Operating Officer and Executive Director for Nursing to provide reassurance to the staff and respond to any concerns.
- Letters to stakeholders to inform them of the service change.
- Engagement with HEIW, TUPF and Llais.
- Wider staff communication via the intranet, focused communication with staff through team meetings, 1-1s and Divisional communication through the dedicated working group.

The Health Board will continue to monitor the anticipated benefits of the service change over time through established governance processes and regular operational oversight meetings. This ongoing evaluation will ensure that the expected improvements in workforce, financial sustainability, patient experience, and system-wide efficiency are realised and sustained, while also enabling responsive adjustments if required.

Argymhelliad / Recommendation

The Board are asked to:

- **Note** the realignment of medical staff from NHH to GUH to further support our Respiratory team and the clear clinical accountability for 16 GIM beds at GUH.
- **Note** the redeployment of nursing staff to support the change in bed configuration
- **Note** the positive feedback from staff and associated workforce benefits.

- **Note** the benefits illustrated through the data including reduced LOS for Respiratory and General Medicine patients and the improved LOS for Medical specialities.
- **Note** the targeted use of critical care resources.
- **Note** the improved model of care at NHH, aligned with demand for elderly patients.
- **Note** the benefits to be tracked and realised over time.

Amcanion: (rhaid cwblhau)	
Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 4.1 Dignified Care 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:	
Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	GUH Grange University Hospital NHH Nevill Hall Hospital GIM General Internal Medicine eLGH Enhanced Local General Hospital YYF Ysbyty Ystrad Fawr DCC Direct Critical Care WTE Whole Time Equivalent LOS Length of Stay RGH Royal Gwent Hospital COTE Care of the Elderly

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



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health, Safety & Fire Annual Report 2024/25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Peter Carr, Executive Director of AHPs & Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Peter Carr, Executive Director of AHPs & Health Science

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to present to the Board the Health, Safety & Fire Annual Report for 2024/25.

The report identifies both the opportunities and challenges for the Health Board in ensuring and sustaining compliance with Health and Safety legislation, including specific compliance improvement action delivered in this period.

The Board is asked to receive the annual report and note the actions being taken to achieve compliance.

Cefndir / Background

The purpose of the annual report (Appendix A) is to provide the Health Board with a summary of principal activity and outcomes relating to the management of health and safety within Aneurin Bevan University Health Board during 2024/25. The report also highlights key priorities for the Health and Safety Committee and its subgroups for the financial year 2025/26.

The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health

Board. Additionally, the report provides information relating to key activities undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence and Aggression

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues to be the Executive Director of AHPs & Health Science.

Asesiad / Assessment

The progress against the Health, Safety & Fire Improvement Plan in 2023/24 has provided a focus resulting in a reduction in key risk areas of concern.

The following points highlight and support the increase in compliance and reduction in risk following implementation of the improvement plan:

- **RIDDOR Reporting Compliance:** increase from 67.7% (2023/24) to 69.8% (2024/25)
- **Health and Safety Statutory & Mandatory Training Compliance:** increase in 2024/25 compared with 2023/24. This includes Manual Handling and Violence Prevention & Reduction.
- **Health and Safety Monitoring:** a programme of health, safety and environment workplace inspections was completed for wards and departments in the Acute Hospitals, Community Hospitals and Mental Health & Learning Disabilities sites. These assessments yielded an average Health Board compliance score of 89.63%.
- **Health and Safety Risk Assessments:** an additional 226 employees trained in Health & Safety Risk Assessment.
- **Fire Risk Assessments:** 100% completed/reviewed against of the planned areas in 2024/25. This is an increase of 4% compared with 2023/24.
- **Fire Alarm Systems:** work has been completed on upgrading the fire alarm system at St Cadocs Hospital and a programme has commenced on replacing the fire alarm system at Royal Gwent Hospital. Fire alarm systems across the Health Board have been analysed and a planned replacement programme has been developed.
- **Fire Barriers (Compartmentation):** the condition of fire barriers has been analysed across Hospital sites which has identified improvements required at Nevill Hall Hospital and Royal Gwent Hospital. Funding has been secured to repair the fire resisting barriers on these sites.

In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of risk areas for focus for 2025/26.

The Strategic Health and Safety Action Plan identifies eight key risks areas for 2025/26. Delivering these priorities will strengthen the Health Board's health and safety culture.

Health and safety leadership

The lack of knowledge and understanding of health and safety responsibilities for Managers and Supervisors presents a significant risk to the Health Board.

Health and safety assistance

The resource allocated to the Corporate Health and Safety Department presents a risk to the Health Board to meet the requirements of health, safety and fire legislation.

Health and safety policies & procedures

Health and safety policy compliance is currently poor and presents a risk to the Health Board. Outdated policies and procedures may be unclear, contradictory, or inconsistent with other organisational documents. This can lead to confusion among employees, resulting in misunderstandings, errors, and conflicts.

Manual handling training

The level of compliance with manual handling training presents a concern to the Health Board and a lack of staff competence to undertake manual handling techniques safely increases the risk of injury to staff and patients.

Fire safety training

Compliance with requirements of fire safety training guidance (*HTM 05-03 part A: Operational provisions – Training*) presents a risk to the Health Board. The organisation is currently dependant of staff completing their training and gaining competence by attending eLearning training.

Violence in the Workplace

The level of violence to which Health Board staff are exposed is a significant risk and needs to be reviewed with prevention and reduction strategies implemented.

Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013

Failure to comply with RIDDOR leaves the Health Board at risk of enforcement action from the relevant enforcing authority.

Health and safety monitoring

The lack of a formal and structured health and safety monitoring system presents a risk to the Health Board.

Health and safety risk assessments

The poor quality and standard of risk assessments increases the risk to the Health Board. The risk is based on the likelihood of accidents and incidents occurring resulting in harm and the increased chance of enforcement action.

Recognising the Health Board challenges in compliance, a health and safety strategic risk (SRR 010) was developed in 2023/24. The risk is monitored regularly and reported via the Audit, Risk and Assurance Committee. The risk level has been reduced following the implementation of plans to improve controls. However, the risk level remains outside of the target level and outside appetite threshold (minimal risk appetite level which should be managed to a Score of 8 or below). The risk areas of focus, listed above and set out in the annual report, will be the basis of the ongoing

compliance improvement plan for Health & Safety, with routine progress reported to the Executive Committee.

Argymhelliad / Recommendation

The Board is asked to:

- receive the annual report and note improvement in compliance during the reporting period, and the actions being taken to achieve ongoing compliance improvement.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	Health, Safety & Fire Annual Report 2024/25
Rhestr Termau: Glossary of Terms:	
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Health and Safety Committee Executive Committee Patient Quality & Safety Outcomes Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Choose an item.
• Service Activity & Performance	Choose an item.
• Financial	Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Health, Safety and Fire Annual Report 2024/25



Our Values and Behaviours

People First

Personal
Responsibility

Passion for
Improvement

Pride in What
We Do

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1 EXECUTIVE SUMMARY

The purpose of the report is to provide the Health Board with a summary of principal activity and outcomes relating to the management of health and safety within Aneurin Bevan University Health Board during 2024/25. The report also highlights key priorities for the Health and Safety Committee and its subgroups for the financial year 2025/26.

The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health Board. Additionally, the report provides information relating to key activities undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence Prevention & Reduction

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues with the Executive Director of Allied Health Professions & Health Science.

The progress against the Health, Safety & Fire Improvement Plan in 2023/24 has provided a focus resulting in a reduction in key risk areas of concern.

The following points highlight and support the increase in compliance and reduction in risk following implementation of the improvement plan:

- **RIDDOR Reporting Compliance:** increase from 67.7% (2023/24) to 69.8% (2024/25)
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- **Fire Risk Assessments:** 100% completed/reviewed against of the planned areas in 2024/25. This is an increase of 4% compared with 2024/24.
- **Fire Alarm Systems:** capital investment was secured to enhance the fire alarm systems. Work programmes commenced on replacing the fire alarm systems at Royal Gwent Hospital and St Cadocs Hospital. Fire alarm systems across the Health Board have been analysed and a planned replacement programme has been developed.
- **Fire Barriers (Compartmentation):** condition of fire barriers analysed across Hospital sites, identifying improvements required at Nevill Hall Hospital and Royal Gwent Hospital.

In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of risk areas for focus for 2025/26.

1.1 Risk Areas for Focus in 2025/26

Health and safety leadership

The lack of knowledge and understanding of health and safety responsibilities for Managers and Supervisors presents a significant risk to the Health Board.

Health and safety assistance

The resource allocated to the Corporate Health and Safety Department presents a risk to the Health Board to meet the requirements of health, safety and fire legislation.

Health and safety policies & procedures

Health and safety policy compliance is currently poor and presents a risk to the Health Board. Outdated policies and procedures may be unclear, contradictory, or inconsistent with other organisational documents. This can lead to confusion among employees, resulting in misunderstandings, errors, and conflicts.

Manual handling training

The level of compliance with manual handling training presents a concern to the Health Board and a lack of staff competence to undertake manual handling techniques safely increases the risk of injury to staff and patients.

Fire safety training

Compliance with requirements of fire safety training guidance (HTM 05-03 part A: Operational provisions – Training) presents a risk to the Health Board. The organisation's Compliance data is currently based on staff completing eLearning training. The standard requires face to face training.

Violence in the Workplace

The level of violence that Health Board staff are exposed to is a risk and needs to be reviewed with prevention and reduction strategies implemented.

Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013

Failure to comply with RIDDOR leaves the Health Board at risk of enforcement action from the relevant enforcing authority.

Health and safety monitoring

The lack of a formal and structured health and safety monitoring system presents a risk to the Health Board.

Health and safety risk assessments

The poor quality and standard of risk assessments increases the risk to the Health Board. The risk is based on the likelihood of accidents and incidents occurring resulting in harm and the increased chance of enforcement action.

2 INTRODUCTION

This report provides analysis of the level of health and safety performance throughout the Health Board for 2024/25.

The Health and Safety at Work (etc.) Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.

In particular, the Act requires an organisation to provide and maintain:

- A Health and Safety Policy;
- A system to manage and control risks in connection with the use, handling, storage and transport of articles and substances;
- A safe and secure working environment, including provision and maintenance of access to and egress from premises;
- Safe and suitable plant, work equipment and systems of work that are without risks;
- Information, instruction, training and supervision as necessary;
- Adequate welfare facilities;

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;
- Core Commissioning Requirements.

Health, Safety and Security is an identified quality pillar within the Health Board Quality Strategy. The 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

The Health Board operates a Health and Safety Management System, utilising the Health and Safety Executive (HSE) 'Managing for health and safety' (HSG65) model.

The model is structured into the Plan, Do, Check, Act approach (see diagram 1).

Plan, Do, Check, Act helps achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.



Diagram 1: PDCA Health and Safety Management Model

3 HEALTH, SAFETY AND FIRE GOVERNANCE STRUCTURE

3.1 Accountability

The Chief Executive Officer (CEO) is accountable for Health and Safety with responsibility for executive leadership delegated to the Executive Director of Allied Health Professions & Health Science.

3.2 Health and Safety Leadership

Effective health and safety performance is led by the senior responsible officers of the Health Board. Members of the Board have both collective and individual responsibility for health and safety. Directors and boards need to examine their own behaviours, both individually and collectively, against the guidance given and, where they see that they fall short of the standards it sets them, to change what they do to become more effective leaders in health and safety.

Why directors and board members need to act:

- Protecting the health and safety of employees or members of the public who may be affected by your activities is an essential part of risk management and must be led by the board.
- Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership.
- Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety.

Business leaders have responsibility for determining and implementing effective health and safety management and monitoring its success, so it's essential that they understand how to implement a risk management strategy.

To support Board Members and Executive Directors to deploy their health and safety responsibilities, training was planned and delivered in 2024/25.

Regulation 7 of The Management of Health and Safety at Work Regulations 1999 states that *"Every employer shall, subject to paragraphs (6) and (7), appoint one or more Competent Persons to assist him in undertaking the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions"*.

The legislation states that a person shall be regarded as 'competent' if they have sufficient training, experience, or knowledge and 'other qualities'.

The Corporate Health and Safety Department employs specialist safety professionals to advise and support the Health Board to deliver and maintain health and safety standards.

The department structure (as of end of March 2025) is illustrated in diagram 2.

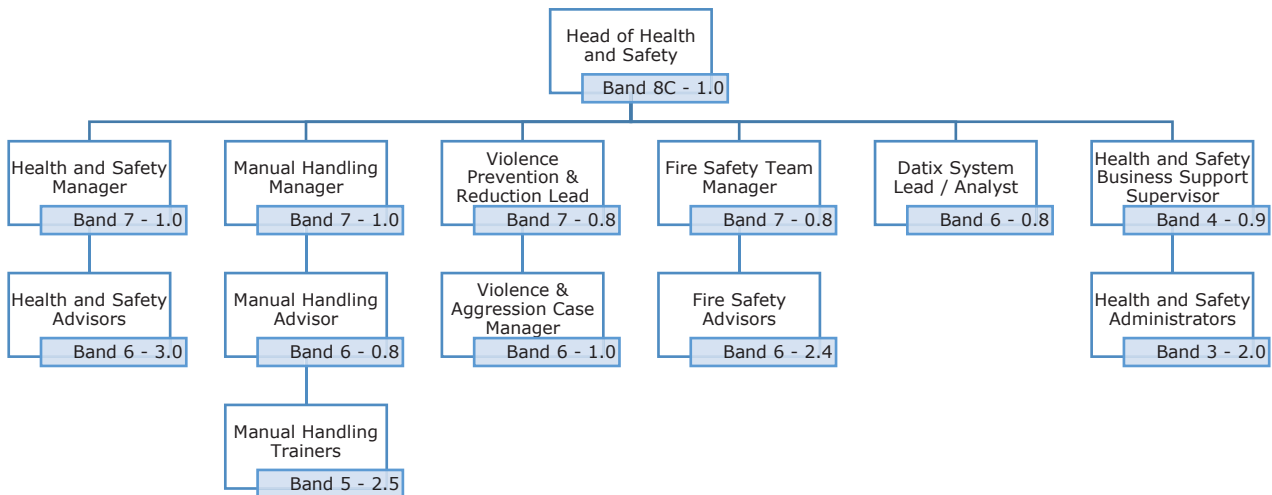


Diagram 2: Corporate Health and Safety Department Structure

Approval has been obtained in 2024/25 to recruit two new positions within the department; Deputy Head of Health, Safety & Fire (Band 8A) and Datix Systems Support Officer (Band 5). Plans are in place to recruit to these posts in 2025/26.

The Corporate Health and Safety Department is structured within specific functions i.e. health & safety, fire safety, manual handling and violence prevention & reduction.

The individuals within the functions are allocated areas of responsibility across the Health Board to support the development of effective relationships with key stakeholders. (See diagram 3)



Diagram 3: Map of Gwent Hospitals

During 2024/25 the Corporate Health and Safety Department has effectively integrated into the Health Board leadership structures and regularly engage via Divisional Quality and Patient Safety meetings and specific Health Board forums.

To ensure the Health Board can effectively meet its legal duties under Health and Safety legislation there is a need to consider the current resource available to the Corporate Health & Safety Department.

A review of the Corporate Health and Safety Department was completed in 2023/24. The review identified additional positions as key to enhancing the current establishment.

3.3 Health and Safety Reporting Arrangements

The Health and Safety Committee has been established to plan, manage and monitor Health Board compliance with statutory health and safety requirements and specific NHS duties.

The Executive Director of Allied Health Professions & Health Science is the Chair of the Health and Safety Committee, being the Director with delegated responsibility for health and safety within Aneurin Bevan University Health Board. The Health and Safety Committee is accountable to the Executive Committee and provides assurance to the Patient Quality and Safety Outcomes Committee.

The Health and Safety Committee receives reports from the subgroups and ratifies policies. The reporting arrangements are illustrated in diagram 4.



Diagram 4: Health and safety reporting arrangements

The Health and Safety Committee met three times in 2024/25. In June, September and December 2024.

The Committee Terms of Reference was agreed in September 2024 with agreed membership comprising of Executive Team members.

3.4 Health and Safety Committee Subgroups

Each subgroup is responsible for the production and updating of their own policies and terms of reference. These documents are submitted to the Health and Safety Committee for ratification.

During 2024/25 the subgroups did not meet. A plan of meeting dates for the subgroups will be implemented in 2025/26.

In addition to the corporate reporting arrangements, health and safety is a regular agenda item at the Divisional Quality and Patient Safety forums and Assurance meetings providing an opportunity to monitor health and safety performance.

3.5 Health and Safety Policies & Procedures

Health and safety policies and procedures have been developed within the Health Board to outline the organisations plans to achieve compliance with the relevant health and safety legislation and/or standards.

An objective for 2025/26 is to ensure all policies are reviewed and updated as appropriate.

Enforcement action taken by the Fire & Rescue Service against NHS Wales organisations relating to the control and management of ignition sources in healthcare has highlighted the requirement to develop a 'Search Policy'. This development is currently being led by the Corporate Health and Safety Department with engagement from key individuals across the Health Board.

A 'Vibration at Work Policy' is also in development to ensure the Health Board complies with the Control of Vibration at Work Regulations 2025. This policy is due to be finalise in 2025/26.

3.6 Audit and Assurance

There has been an Internal Audit on health and safety conducted during 2024/25. The outcome of the Internal Audit will be available in quarter 1 of 2025/26.

The Health and Safety Legislative Assurance Framework identifies the compliance with health and safety statutory instruments. The document is subject to an assessment by the Corporate Health and Safety Department in 2025/26.

4 HEALTH, SAFETY AND FIRE ENFORCEMENT ACTIVITY

During 2024/25, no prosecutions or enforcement actions have been issued by the Health and Safety Executive (HSE), however, South Wales Fire & Rescue Service (SWFRS) issued the Health Board with enforcement notices in February 2024 and April 2024 with respects to the fire safety arrangements at the staff accommodation buildings (Gerylyn and Bron Haul) at Nevill Hall Hospital.

The following matters highlight the non-compliance with the provisions of the Regulatory Reform (Fire Safety) Order 2005 for the buildings.

- Fire doors are being held open inappropriately
- Intumescent strip seals missing, damaged or defective
- The fire safety measures evaluated in the fire risk assessment have not been implemented
- The fire detection system is inadequate for the type and use of the premises
- The existing provision of manual firefighting equipment is inadequate
- Emergency routes and exits could not be used as quickly and as safely as possible
- The standard of fire separation is not adequate
- Fire resisting doors are not adequately maintained

A working group was formed to address the recommendations. Capital investment was secured to enhance the fire precautions in both building and the notices were complied with and subsequently lifted by South Wales Fire and Rescue Service in December 2024.

Although the HSE didn't issue any enforcement against the Health Board, they did issue a notification of contravention in relation to a fatal patient fall. The HSE investigation of this incident is still ongoing.

During 2024/25 there have been HSE intervention costs of approximately £1,250.00. These costs relate specifically to HSE investigations into a patient fall incident. (The Health and Safety (Fees) Regulations 2012 places a duty on HSE to recover its costs for carrying out its regulatory functions, from those found to be in material breach of health and safety law.)

5 RISK MANAGEMENT AND RISK REPORTING

A health and safety strategic risk (SRR 010) was developed in 2023/24. The risk is monitored regularly at Health and Safety Committee meetings and reported via the Audit, Risk and Assurance Committee.

The risk level has been reduced following the implementation of plans to improve controls, however, the risk level is outside of target level and outside appetite threshold.

In addition to the health and safety strategic risk, directorate health and safety risks have been completed and are under regular review.

The completion of risks assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the risk assessment programme, the Corporate Health and Safety Department deliver risk assessment training, promoting best practice in the completion of a risk assessment and the principals of effective Risk Management within departments and in the wider organisation.

The Health and Safety Professionals within the Corporate Health and Safety Department continue to provide advice and guidance on the implementation of statutory risk assessments through the various subgroups. Specialist risk assessments being completed by the Health and Safety Professional upon request.

Most of the health and safety risks are reported via the risk module on the DatixWeb system. The Health Board also subscribe to CoSHH management software for the risk assessments relating to substances hazardous to health. All fire safety risk assessments are recorded via the NWSSP fire auditing and reporting system. New software for recording and monitoring fire risk assessments is now available and will be introduced in 2025/26.

The Health and Safety Committee receives reports on health and safety risks for consideration, action and assurance.

As part of the monitoring arrangements, the Corporate Health and Safety Department continually engage with Risk Leads to review the risks recorded as Extreme High and High with the view to provide further advice and support and ensure that appropriate mitigation is applied as a means to manage the risks at a level that is so far is reasonably practicable.

6 HEALTH, SAFETY AND FIRE TRAINING

Suitable and sufficient training is a requirement of The Health and Safety at Work Act 1974 and The Management of Health and Safety at Work Regulations 1999.

The Management of Health and Safety at Work Regulations state “every employer shall ensure that his employees are provided with adequate health and safety training”.

The health and safety statutory and mandatory training compliance as of 31 March 2025 was as follows:

Training Course	2024/25 Compliance %	2023/24 Compliance %
Health and Safety	86.6%	86.7%
Fire Safety	82.3%	82.9%
Manual Handling	70.0%	55.3%
Violence Prevention & Reduction	86.1%	85.1%

During 2024/25 training compliance for health and safety, fire safety and violence prevention & reduction have been maintained compared with 2023/24.

With the exception of manual handling training, the delivery of the health and safety statutory and mandatory training programme in 2024/25 continues to be delivered by eLearning with access via the electronic staff record (ESR) self-service portal for ease to individuals. Line managers can view their team’s compliance and are also notified when staff are nearing non-compliance. Positive changes are being progressed in relation to the requirements for manual handling training dependent on role. This will result in staff deemed low risk only required to conduct eLearning manual handling training every three years.

Manual handling training continues to prove a challenge for the Health Board with compliance levels well below the required standard of 85%. The manual handling training strategy has been reviewed in 2024/25 to ensure the Health Board has a sustainable programme of manual handling education, particularly for high-risk areas.

Manual Handling training within NHS Wales is delivered to the scope of the All-Wales Manual Handling Passport. This ensures a consistent and standard approach to training.

During 2024/25, the Manual Handling Team have continued to deliver manual handling training to Health Board staff.

The table below provides details of the manual handling training delivered and the attendance.

Manual Handling Course Title	No. of Sessions	No. of Attendees	No. of DNA's
People Handlers Foundation Training	74	718	163
People Handlers Update Training	48	259	76
Object Handlers Foundation Training	7	41	14
Object Handlers Update Training	0	0	0
People Handlers Trainers Foundation Training	3	12	6
People Handlers Trainers Update Training	9	50	16
Object Handlers Trainers Foundation Training	2	18	2
Object Handlers Trainers Update Training	3	16	2

Staff attendance on manual handling training and specifically those who do not attend remains a challenge.

Violence prevention and reduction training is aligned to the All-Wales NHS Violence & Aggression Passport Scheme. The passport scheme is broken down into four areas:

Module A – Induction and Awareness Training: Introduction to the basic concepts of violence and aggression prevention, including organisational policies and employee responsibilities.

Module B – Theory of Personal Safety and De-escalation: In-depth theoretical training on personal safety techniques and strategies for de-escalating potentially violent situations.

Module C – Breakaway Techniques: Practical training on breakaway techniques to safely disengage from physical confrontations.

Module D – Restrictive Physical Intervention: Training on the appropriate and safe use of restrictive physical interventions when necessary.

All Health Board staff are mandated to complete modules A & B, whilst module C & D is based on risk assessment. Selected members of the Corporate Health and Safety Department have attended accredited training to enable them to teach module C and D.

Building on the work started in 2023/24, the Violence Prevention & Reduction Team continued delivering targeted training into the 2024/25. Specifically, three remaining training sessions were scheduled and delivered at Nevill Hall Hospital to complete the programme.

These sessions focused on the specific risks of violence and aggression posed by elderly patients in Care of the Elderly Wards. Recognising the difficulties faced by staff in these settings, bespoke training was developed to strengthen staff capability in managing such behaviours particularly where they intersect with dementia, mental health conditions, and environmental factors. Key areas covered included environmental safety and de-escalation techniques.

Feedback from attendees has been positive. Staff reported gaining a stronger understanding of the unique complexities involved in these scenarios and appreciated the practical nature of the techniques shared. Many noted increased confidence in managing challenging behaviours and a noticeable reduction in incidents requiring physical intervention.

6.1 Health and Safety Training for Executives and Senior Managers

In December 2024 and February 2025 seven members of the Executive Team, including the Chief Executive Officer attended the IOSH Safety for Executives and Directors. Plans are in place for the remaining members of the Executive Team to attend in 2025/26.

A Health and Safety for Managers Training package is currently being developed nationally. This work is being led by Cwm Taf Morgannwg University Health Board and will be agreed at the All-Wales Health and Safety Management Group.

Once the course is approved it will be implemented within the Health Board to provide Managers with an awareness of their role in health and safety management and implementation. The course will cover vital information such as the legal requirements, safety management systems, safety culture, risk assessment & hazard control and incident investigation.

6.2 Safety Guidance

Safety guidance have been implemented as a method to provide further information, instruction & training to Health Board employees in relation to health and safety matters.

The safety guidance provides safety reminders, brief refreshers and quick lessons on safety topics. The safety guidance is developed by the Corporate Health and Safety Department.

The use of safety guidance has provided greater opportunity to discuss recent incidents, near misses and everyday tasks.

6.3 Manual Handling Cascade Trainers Training

To support the delivery of the manual handling training strategy, cascade trainers are nominated in areas across the Health Board. The cascade trainers i.e. Transfer Specialists, Safer Handling Coaches etc. attend foundation training and are required to attend an update every two years to maintain their competency.

The register of cascade manual handling trainers was reviewed, cleansed and a programme of updates was delivered in 2024/25.

Trainer type	Number in organisation	Number currently out of date (over 2 years)
Transfer Specialist	234	53
Assistant Trainer	49	7
Safer Handling Coaches	224	93

6.4 Risk Assessment Training

The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the Health Board to maintain its legislative requirement and ensuring the provision of competent risk assessors, the Risk Assessor Training course has been revitalised for 2024/2025, 26 courses have been delivered and 226 Health Board Employees trained in Health & Safety Risk Assessment.

The aim of the course is to ensure all participants have an understanding on the concept of risk assessment, when a risk assessment is required within the workplace and how to conduct a suitable and sufficient risk assessment.

6.6 Fire Safety Training

The compliance data for fire safety training appears acceptable, however, these results are derived from compliance with eLearning modules alone. Staff with the responsibility to evacuate immobile patients require additional, practical evacuation training, delivered by Fire Safety Advisors. This requirement is highlighted in the fire safety guidance contained in Welsh Health Technical Memorandum (WHTM) 05:01.

This additional level of training is delivered to all Theatres, Critical Care and similar departments caring for high dependency patients. Efforts by the Fire Safety Team to expand face to face training to all inpatient wards in 2024/25 have been partially successful but problems securing release of staff persist.

A programme of fire evacuation training for staff on inpatient wards has been drawn up for 2025/26. However, delivery of the programme will be challenging at current Fire Safety Advisor resource levels.

6.7 Fire Warden Training

Fire wardens at Health Board premises perform a vital function in maintaining safe environments. Their role during fire emergencies is as a *critical friend* to department and ward managers who are responsible for initiating and managing evacuations.

Key functions of fire wardens include the continual monitoring and completion of monthly safety checks of their areas to identify fire safety concerns. They provide the valuable service of liaison with the Fire Safety Advisors to provide early warning and resolution of potential safety issues.

The Fire Safety Team continue to promote the role via the fire risk assessment process with the goal that every work area in the Health Board has at least one fire warden assigned.

An additional 73 fire wardens were identified and attended training in 2024/25.

Recruitment and retention of Fire Wardens is challenging. There are currently 349 wardens registered with 171 departments regularly submitting monthly fire safety checklist returns.

6.8 Fire Drills & Exercises

The Fire Safety Team conduct an annual programme of fire drills and exercises across the Health Board. The purpose of these is to confirm the fire evacuation strategies for the areas are robust.

In 2024/25, the Fire Safety Team carried out fire exercises in 12 departments across the Health Board. Exercises are conducted at high-risk departments, such as Theatres and Critical Care Units annually on multiple occasions to ensure staff compliance.

The annual programme of fire evacuation exercises continues to target 12 departments per year.

7 RIDDOR REPORTING

Under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013), certain workplace accidents, incidents, ill health and certain near miss events must be recorded. Depending on the severity and nature of the injury, and indeed the party affected, the Health Board has a legal duty to report this data to the Health and Safety Executive (HSE).

The reporting process to the HSE is undertaken by the Corporate Health and Safety Department.

During the period of April 2024 to March 2025 the Health Board reported a total of 73 incidents to the Health & Safety Executive which met the criteria of being reportable under RIDDOR. This is a 18.8% decrease on the number of incidents reported in 2023/24. (See figure 1)

30.2% of these incidents were reported outside of the legal reporting timeframes.

Non-compliance with RIDDOR duties can have consequences, both in terms of Health & Safety and legal ramifications for the Health Board.

To ensure the Health Board meets the legal requirements under RIDDOR the Corporate Health and Safety Department continues to deliver RIDDOR Awareness Training Sessions. This training is designed to provide all managers with a clear understanding of their duties under RIDDOR, ensuring that they can fulfil their responsibilities effectively. During 2024/25 44 staff attended the RIDDOR Awareness Training.

A RIDDOR Compliance Dashboard have been established within the Datix Cymru system to enable Divisions to proactively monitor their RIDDOR compliance and identify areas of good practice, but also areas of further improvement. Compliance with RIDDOR is a health and safety performance indicator which has been imbedded into the Divisional Assurance Reviews.

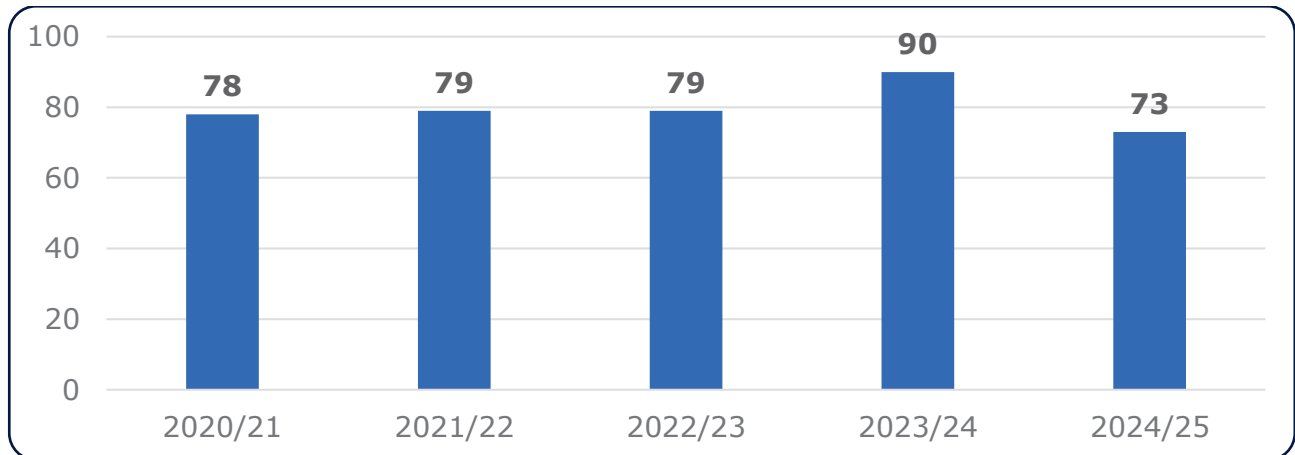


Figure 1: Total number of RIDDOR reportable incidents reported to the HSE for the past five financial years

In 2024/25 there has been three fatal incidents reported, all relating to patient falls. This is an increase from the one fatal incident reported in 2023/24. Over-seven-day incapacitation of a worker are the highest reported classification in 2024/25 with 48 incidents reported, a decrease of 9 incidents compared with 2023/24. The number of specified injuries has reduced from 26 incidents reported in 2023/24 to 11 in 2024/25. (See figure 2)

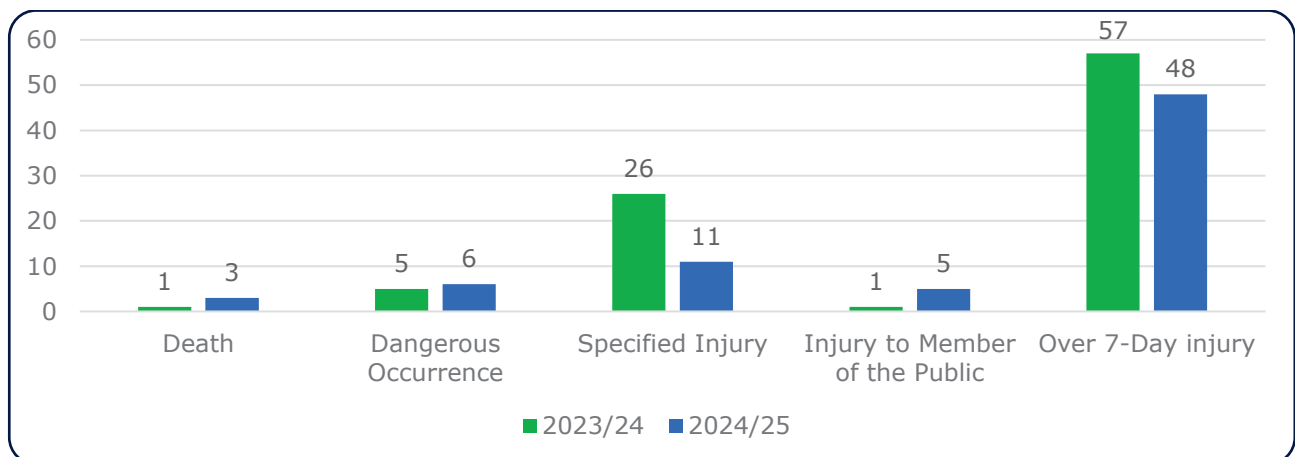


Figure 2: RIDDOR reportable incidents by classification reported to the HSE for 2024/25

Slips, trips and falls continue to be the highest type of RIDDOR reportable incident reported to the HSE, with 32 slips, trips and falls reported in 2024/25. However, this was a reduction on the 39 reported in the previous financial year (2023/24). There was a significant reduction in the number of abuse to staff RIDDOR reportable incidents reported to the HSE in 2024/25 (12) compared with 2023/24 (23).

Manual handling RIDDOR reportable incidents have increased slightly in 2024/25, with 13 being reported to the HSE. This is compared with 12 incidents in 2023/24. (See figure 3)

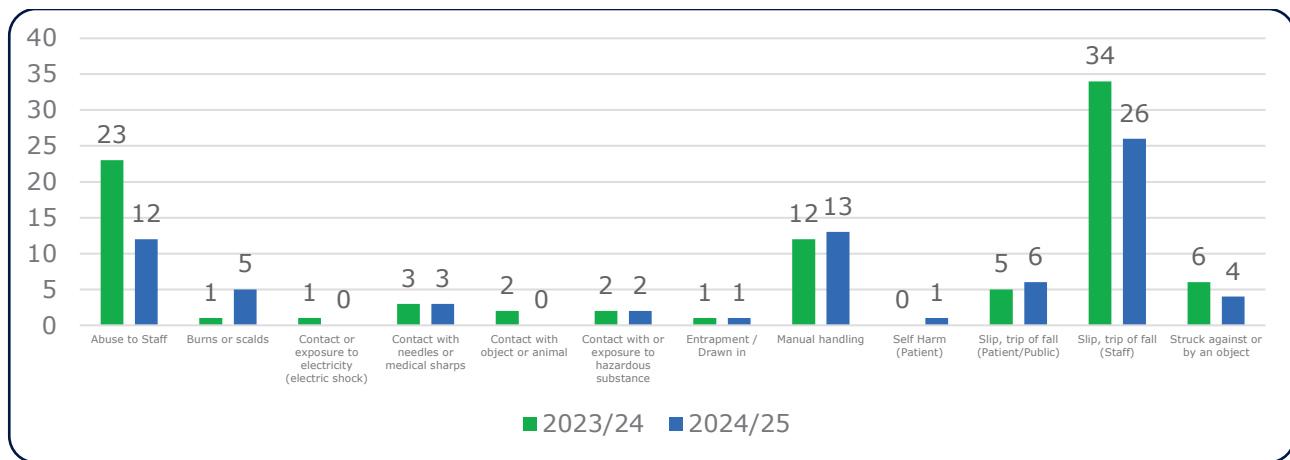


Figure 3: Type of RIDDOR Reportable incidents reported to the HSE for 2024/25

RIDDOR reporting compliance for 2024/25 was 69.8% a 2.1% improvement on the compliance reported in 2023/24 (67.7%).

8 LEARNING FROM EVENTS

The Corporate Health and Safety Department has implemented various communication methods to support learning from incidents across the Health Board.

As part of these methods, information is cascaded through Health and Safety performance reports, post investigation meeting de-briefs, amendment to relevant health and safety training packages and organisational alerts.

During 2024/25 health and safety information sheets have been issued which relate to the following:

- HSI-2024-004 - Seizure of Prohibited Articles
- HSI-2024-005 - Storage and Handling of Medical Gas Cylinders
- HSI-2024-006 - Management of Portable Electrical Appliances (Toasters)
- HSI-2024-007 - Safe Use of Temporary Portable Heating Appliances
- HSI-2025-001 - Suitability of chair castors used on flooring
- HSI-2025-002 - Management and storage of sharp objects

The Corporate Health & Safety Department has provided support to Legal Services in relation to Personal Injuries Claims by assisting in the investigation process, supplying necessary documentation, and facilitating the identification and communication of key learnings from events to prevent future occurrences.

During 2024/25, the Health Board received 9 personal injury cases involving slips, trips and falls, 6 cases of ill health (to include 4 covid cases), 5 violence and aggression cases, 4 cases involving sharps, 3 burns/scalds, 2 cases of individuals being struck against or by an object, 2 cases of entrapment (being injured in lift doors, doors falling on individuals), 1 data breach and 1 incident involving a manual handling task.

Over the last 12 months, there has been an increase in sharps cases and injuries involving burns/scalds.

Personal injury claims continue a year-on-year 16-year downward trend.

9 HEALTH AND SAFETY

9.1 Health and Safety Monitoring

The Corporate Health & Safety Department initiated a programme of workplace health, safety, and environment inspections spanning from October 2024 to March 2025.

These inspections align with the Workplace (Health, Safety and Welfare) Regulations 1992, which encompass fundamental health, safety, and welfare concerns applicable to the Health Board.

The inspection criteria have been developed based on the stipulations outlined in the Regulations, as well as consideration of other pertinent workplace hazards.

The inspection criteria included:

- Lighting
- Noise
- Prevention of Slips, Trips, & Falls (including falls from height and falling objects)
- Temperature & Ventilation
- Workstations, Seating, Furniture, and Fittings
- Welfare Facilities
- Cleanliness, Waste Management, & Sharp Safety
- Access and Egress
- Electrical Equipment
- Handling of Chemicals & Hazardous Substances
- Prevention of Violence & Aggression
- Alert Systems & Communications
- Provision of First Aid

A goal was established to complete health, safety, and environment workplace inspections for the wards and departments in the Acute Hospitals, Community Hospitals and Mental Health & Learning Disabilities sites by the end of March 2025. This objective has been successfully met, with a total of 64 inspections carried out.

These assessments yielded an average Health Board compliance score of 89.63%. The table (right) offers a detailed breakdown of the number of inspections completed per site and the corresponding site compliance score (average).

Site	Total Number of Inspections Scheduled	Total Number of Inspections Completed	Site Compliance (Average)
Chepstow Community Hospital	1	1	83.10%
County Hospital	5	5	84.30%
Grange University Hospital	9	9	96.10%
Maindiff Court Hospital	2	2	92.40%
Monnow Vale Hospital	1	1	89.70%
Nevill Hall Hospital	7	7	89.20%
Other Premises (Health Centres, Clinics)	8	8	91.40%
Royal Gwent Hospital	12	12	84.30%
St Cadocs Hospital	4	4	86.90%
St Woolos Hospital	2	2	91.50%
Ysbyty Aneurin Bevan	7	7	87.90%
Ysbyty Tri Chwm	1	1	89.80%
Ysbyty Ystrad Fawr	5	5	96.90%

The inspections revealed both areas of compliance and areas requiring attention to ensure a safe working environment. While an average Health Board compliance score of 89.63 indicates overall adherence to

regulations, specific areas of concern were identified of which further attention is required.

The main findings of the health, safety and environment workplace inspections are as follows:

Control of Substances Hazardous to Health (COSHH)

- Most areas lacked COSHH Inventories and Assessments.
- Workers lacked clarity on accessing COSHH Assessments and understanding precautionary measures for substance use.
- Cleaning substances, such as Actichlor solution, were frequently left unattended without proper storage and security measures.

Electrical Equipment Checks

- While user checks on electrical equipment were noted, there was insufficient evidence to confirm regular checks.

Tripping and Entrapment Hazards

- Cables supplying air mattresses and electric profiling beds were often positioned in ways that posed tripping and entrapment risks.

Unauthorised Access

- Various areas within ward environments were frequently left open, allowing unauthorised access.

Signage for Anti-Violence Measures

- Absence of signage regarding NHS Wales Anti-Violence Posters was noted.
- Seating for DSE Use
- In some clinical areas, ergonomic office chairs were utilised but often had castors unsuitable for the flooring type.

Use of medical gases

- In some clinical areas, Medical Gas Cylinders were not correctly stored.

Water safety

- In some premises, infrequently used outlets are not routinely flushed and flushing regime is not recorded. Ensure infrequently used outlets are routinely flushed and flushing regime is recorded.

First aid

- In some premises, there aren't appointed first aiders. Conduct a First Aid Needs Assessment to identify specific requirements.

General Condition of Premises

- Flooring was generally in good condition with no significant defects or obstructions affecting safety.
- Lighting levels were found to be adequate for activities within the areas.
- Window restrictors limiting window opening were robust and tamper-proof.
- No workplace noise issues were identified, and employees did not raise concerns.
- No defects such as exposed wiring or damaged casing were identified.
- Workplace temperature was considered reasonable, and concerns regarding thermal comfort were limited.

Provision and Access to Welfare Facilities

- Welfare facilities such as break rooms and W/Cs were routinely available.
- Facilities for heating food/drinks and storing personal items were provided.

Employee Awareness and Reporting

- Employees demonstrated substantial awareness of how to raise health and safety concerns and report accidents, incidents, and near misses.

These findings highlight areas requiring attention to ensure compliance and maintain a safe working environment for all staff, patients and visitors.

The completion of these inspections resulted in the assignment of 594 actions which have been assigned to local ward/department managers and recorded on the Audit Management and Tracking (AMaT) platform.

Among these actions:

- 421 have been successfully marked as fully complete by the assigned responsible person (70.8%).
- 56 have been marked as partially complete by the assigned responsible person (9.5%).
- 117 actions are overdue and have not been completed within the assigned timeframe (19.7%)

Where actions in relation to non-compliance have been identified, these areas must be addressed in order to reduce the likelihood of accident and ill health and to close any gaps in compliance. The responsible person must ensure that sufficient progress notes are recorded within the assigned action point detailing the action(s) taken to address and remedy the identified non-compliance.

The Corporate Health & Safety Department continue to monitor the completion of these actions and provide updates on inspection findings and action completion during Divisional and Directorate Quality & Patient Safety meetings.

The conclusion of the health, safety, and environment workplace inspections emphasises the importance of ongoing monitoring of workplaces to uphold necessary standards and identify potential hazards. To facilitate this, the Corporate Health & Safety Department has devised local workplace inspection tools to assist areas in conducting regular monitoring. Divisions must ensure that appropriate systems are established to facilitate these inspections and promptly address any areas found to be non-compliant by implementing corrective measures.

The Health & Safety Work Plan for 2025/26 outlines key actions to ensure regular monitoring of workplaces across the Health Board. These include:

- Develop a health and safety management audit 3-year plan
Year 1 (Inpatient Areas), Year 2 (Out Patient Areas), Year 3 (All Other Areas)
- Develop a workplace health and safety inspection proforma for inclusion in the ward accreditation programme in 2025/26
- Develop a manual handling management audit programme
- Conduct health and safety workplace inspections for community premises i.e. health centres and clinics

9.2 Health and Safety National Meetings

The All-Wales Health and Safety Management Steering Group represents Health & Safety professionals working in NHS Wales in all areas of health and safety management, providing a forum to network, share best practice and work collaboratively to develop improvements in health and safety.

The group represent all NHS organisations, recognising the importance of providing informative and stimulating meetings, workshops, and seminars for the continued professional development of all members.

The purpose of the All-Wales Health and Safety Management Steering Group is to:

- Discuss all areas of health and safety management to ensure compliance with the legislative and regulatory frameworks in place for managing health and safety effectively.
- Share lessons learned and best practice identified for effective health and safety management.
- Encourage strong leadership in health and safety and championing the importance of a common-sense approach to motivate focus on core aims distinguishing between real and trivial issues.
- Where appropriate, advise the Health Boards and Trusts on where and how, its health and safety management may be strengthened and developed further.

The aims of the group are to:

- Support members to develop the health and safety management arrangements within healthcare organisations.
- Provide a forum in which health and safety risk and issues can be debated, to ensure effective communication of ideas, sharing of experiences and areas of best practice.

Subgroups and workstreams have been established to review current health and safety practice in specific areas and develop minimum standards for implementation across NHS Wales.

During 2024/25 an All-Wales Health & Safety Workstream has been revitalised in relation to Health & Safety Incident Codes recorded within Datix Cymru. The purpose of this workstream is to standardise the Health & Safety Incident Codes for all NHS organisations in Wales in order to reduce barriers to incident reporting and to improve the quality of incident data which will further support in identifying learning from incident themes and trends.

9.3 Reinforced Autoclaved Aerated Concrete (RAAC)

The Corporate Health & Safety Department has conducted comprehensive Risk Assessments in areas of Nevill Hall Hospital (NHH) where Reinforced Autoclaved Aerated Concrete (RAAC) has been identified during structural surveys.

To ensure safety, Acrow props have been installed in these areas. The Risk Assessments focus specifically on evaluating the hazards and potential risks associated with the introduction of Acrow props into the working environment.

The assessment aims to mitigate any risks posed by the structural supports, ensuring that the hospital environment remains safe for both staff and patients. The Risk

Assessments have been recorded within the Datix Risk Module and local Department risk leads have been assigned to enable ongoing management of the risk.

As part of the governance arrangements in relation to the management of RAAC, the Corporate Health & Safety Department attend the RAAC Fortnightly Governance Group of which the group focus is on the actions that have been taken and the ongoing management of the challenges enabling wider discussions of service implications and also remediation plans.

9.4 Health and Safety Incident Reporting

The following data provides a detailed breakdown of the type of health and safety related incidents that have been reported in 2024/25. *This excludes violence and aggression and fire incidents as these are reported in the relevant sections of this report.*

Figure 4 indicates an increase of 8.5% in the number of reported incidents affecting staff and contractors compared with last two financial years.

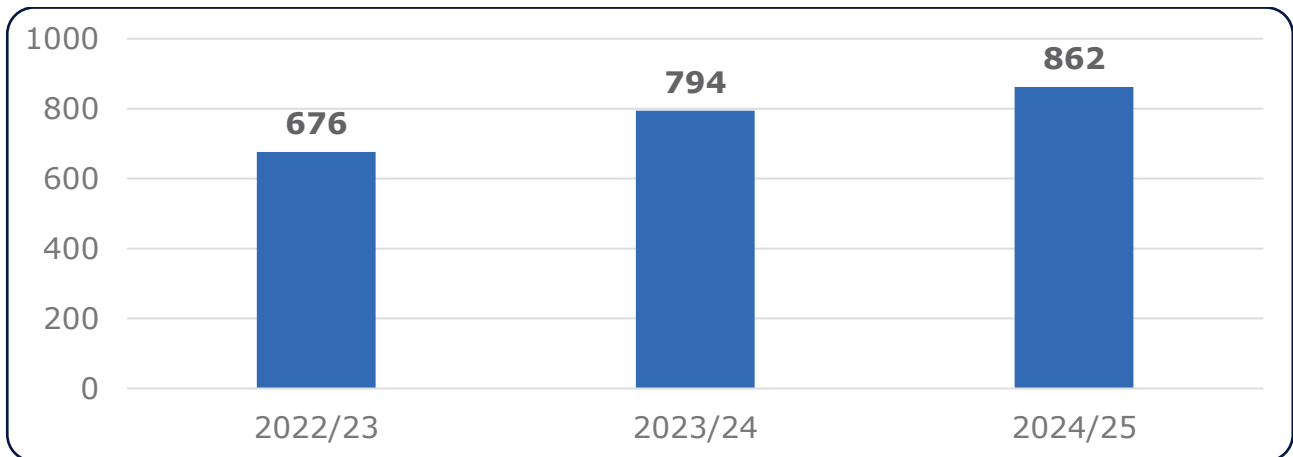


Figure 4: Number of reported incidents affecting staff and contractors for the past three financial years

Contact with needles or medical sharps is the most reported health and safety incident category affecting staff or contractors (215 incidents), this is an increase of 13.1% on the previous year. (See figure 5)

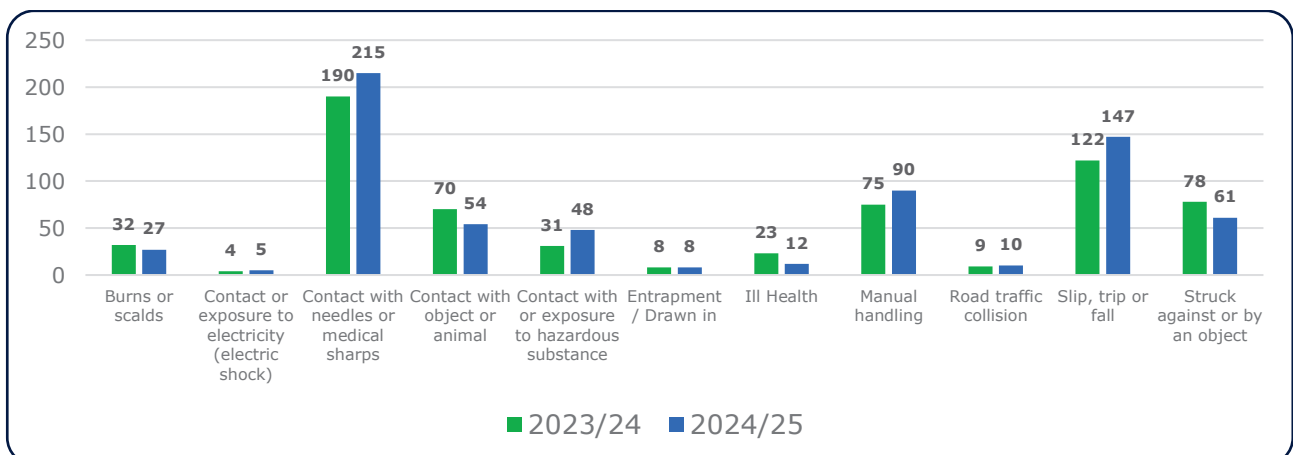


Figure 5: Type of incidents affecting staff and contractors for 2024/25

The number of contact with needles or medical sharps incidents reported in 2024/25 has increased by 13.1% from the previous financial year (215 reports). The incidents from contaminated / used sharps devices have increased by 21.1% in 2024/25. (See figure 6)

It is difficult to obtain data on the number of tasks or procedures carried out across the Health Board using needles or medical sharps. However, based on the incidents reported and the significant number of tasks and procedures the incident rate would be very low.

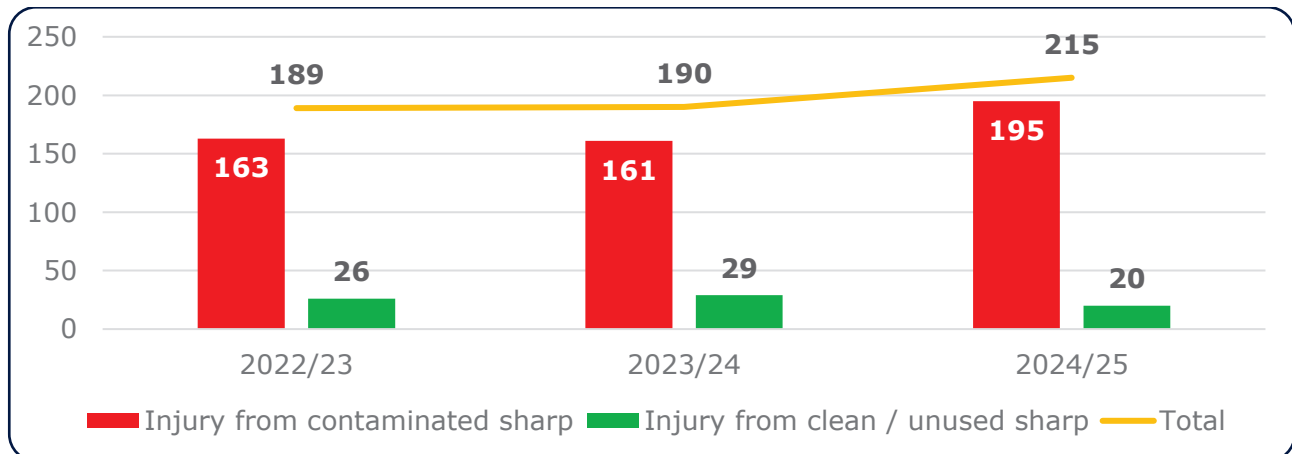


Figure 6: Total number of sharps incidents by type for 2024/25

To identify learning outcomes from sharps incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix Cymru system.

The revitalisation of the health and safety monitoring programme included an assessment of clinical area’s adherence to best practices for the safe use of sharps. This assessment was designed to ensure that areas comply with the standards set out within the Health Boards Sharps Policy, and the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

As part of the inspection process, wards were specifically monitored for their procedures regarding sharps use and disposal of sharps. This includes the availability of safety engineered devices, the availability and correct use of sharps trays and sharps containers and adherence to protocols designed to reduce the likelihood of needlestick injuries and other sharps related incidents.

Throughout the inspections, instances of good practice were routinely identified. These practices provide assurances of compliance with best practice guidelines and legislative requirements. The findings of these inspections have also supported the development of training information such as Tool Box Safety Talk on the Safe Use of Sharps in order to further reinforce best practices.

The outcomes of the monitoring are reported to the Health and Safety Committee.

Slip, trip or falls is the second highest reported health and safety incident category affecting staff or contractors.

The number of slips, trips and falls incidents to staff, contractors or visitors reported in 2024/25 has increased by 15.4% from the previous financial year (142 reports). (See figure 7) These types of incidents continue to be the highest reported to the HSE in accordance with RIDDOR and those resulting in personal injury claims.

The highest categories of slips, trips or falls in 2024/25 were 'Fall on a slippery or wet surface' (56 incidents) and 'Trip or fall over an object or obstacle' (26). This is a significant increase reduction from the previous year's reporting.

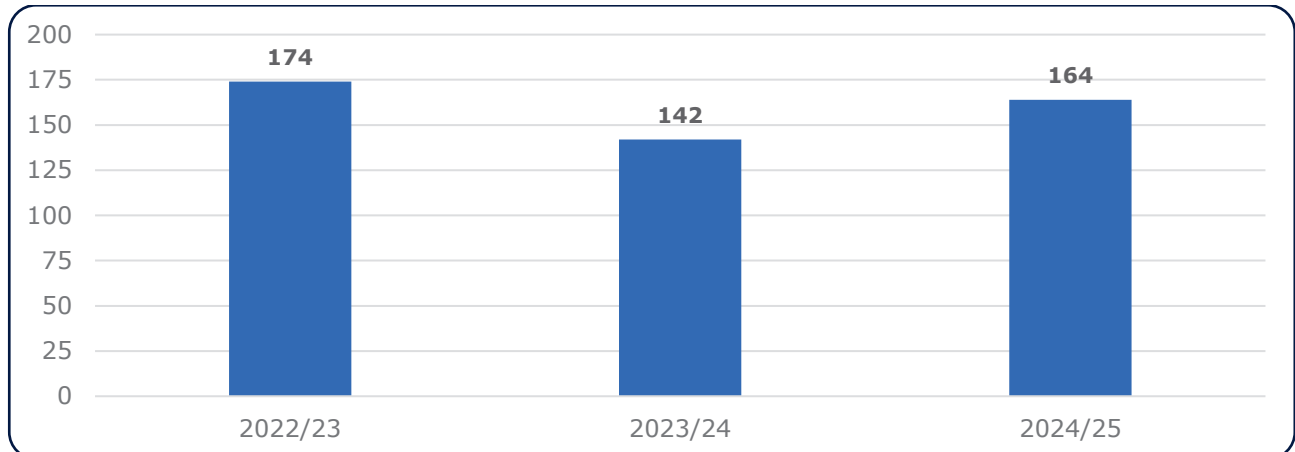


Figure 7: Number of reported slips, trips and falls incidents affecting staff, visitors and contractors for the past three financial years

9.5 Face Fit Testing

Where personal protective equipment and respiratory protective equipment is used, it must be able to provide adequate protection for individual wearers.

Face Fit testing ensures that the equipment selected is suitable for the wearer. Face fit testing is a mandatory requirement as prescribed by Health & Safety Executive Control of Substances Hazardous to Health Regulations Approved Code of Practice (ACoP) L5 and associated guidance documents that support the relevant statutory provisions.

The delivery of Face Fit Testing continues to remain a key tasking for the Corporate Health and Safety Department with weekly Face Fit Testing sessions being offered across the Health Board.

To enable the Health Board to maintain compliance with Face Fit Testing requirements a review of the Health Boards Face Fit Testing Strategy and Face Fit Testing resource allocation will be undertaken in 2025/26.

10 FIRE SAFETY

Fire safety is an umbrella term covering fire prevention and fire precautions. The principal requirements of fire safety legislation are:

- To reduce the probability and severity of a fire occurring within a building.
- To ensure that persons are kept safe or can safely evacuate a premises if a fire occurs.

Fire has the potential to cause widescale damage and disruption of NHS services that could have a serious consequence for service users. Therefore, in addition to life safety, property protection and business continuity are key aims of the Health Board fire safety policy.

The Regulatory Reform (Fire Safety) Order 2005 (FSO) is the main piece of legislation governing fire safety in buildings in England and Wales. The FSO applies the concept of the responsible person to ensure general fire precautions are in place to protect persons who work at, stay or visit premises in England and Wales.

The legislation imposes liability on managers proportionate with their levels of control. The principle responsible persons in the Health Board are the executive, directorate and departmental leaders.

The Executive Director of Allied Health Professions & Health Science is the Executive Director with delegated responsibility to ensure compliance with current fire safety legislation and responsibility for ensuring that fire safety issues are highlighted at Board level. In particular they will ensure, by delegation to The Fire Safety Manager that the fire safety policy is promulgated, and that Fire Risk Assessments are completed to record the general fire precautions required for all areas.

Individual divisional directors and divisional leadership groups as a collective are responsible for ensuring compliance with the Health Board Fire Safety Policy and that the general fire precautions are applied within their departments.

10.1 Provision of Officers with Specific Fire Safety Responsibilities

Health Boards are required to provide a structure of Fire Safety Management within their organisations aligned with WHTM 05:01.

The structure is based on delegated responsibility of fire safety functions to functional roles within the organisation. The nominated offers are accountable for fire safety functions assigned to them.

Fire Safety Protocol 031 Roles and Responsibilities for Implementation details the roles and delegated responsibilities for fire safety within the Health Board.

Key roles covered in the document (in addition to Executive Director with delegated responsibility and The Fire Safety Manager) are the Director of Estates and Facilities Division who bears key responsibilities for maintenance of systems and fire response, and Ward/Department managers who act as frontline fire safety managers.

Regardless of the roles designated, it should be understood that although accountability can be designated and shared, it cannot be legally transferred. All senior managers are legally accountable for adherence to the fire policy in any areas that are under their control or influence.

10.2 Fire Safety Risk Management

The Health Board are legally required to carry out and record fire risk assessments at all sites. The legislation requires that assessments are completed for all new buildings when staff first take occupancy and are reviewed on a regular basis.

Additional reviews are required if there are significant changes to staffing or working arrangements in departments and wards.

The Health Board fire safety team review fire risk assessments at a frequency based on risk as shown in the table below.

Type of Area to be Assessed	Frequency of Assessment
Buildings or parts of buildings that provide sleeping or inpatient accommodation	12 months
Other than above but areas provided for public access such as outpatient facilities	24 months
Other than above. Areas not provided for public access such as offices, plantrooms etc.	36 months

During the period April 2024 to March 2025 the Fire Safety Team completed 254 programmed fire safety risk assessment reviews. This represents 100% of the programmed assessments. The figures for major sites are displayed in the table below.

Hospital	Annual Assessments	Bi-annual Assessments	Tri-Annual Assessments
County Hospital	5	7	12
Grange University Hospital	26	1	16
Nevill Hall Hospital	20	9	22
Royal Gwent Hospital	32	6	12
St Cadocs Hospital	7	0	0
St Woolos Hospital	6	12	2
Ysbyty Aneurin Bevan	5	5	0
Ysbyty Ystrad Fawr	11	6	1

In addition to the above the Fire Safety Team completed fire risk assessments to:

- Support various moves of departments at the Royal Gwent, St Woolos and Nevill Hall Hospitals.
- Assess and record hazards associated with RAAC at Nevill Hall Hospital.
- Support the opening of 19 Hills Heath and Welling Centre and the new Satellite Radiology Unit at Nevill Hall Hospital.

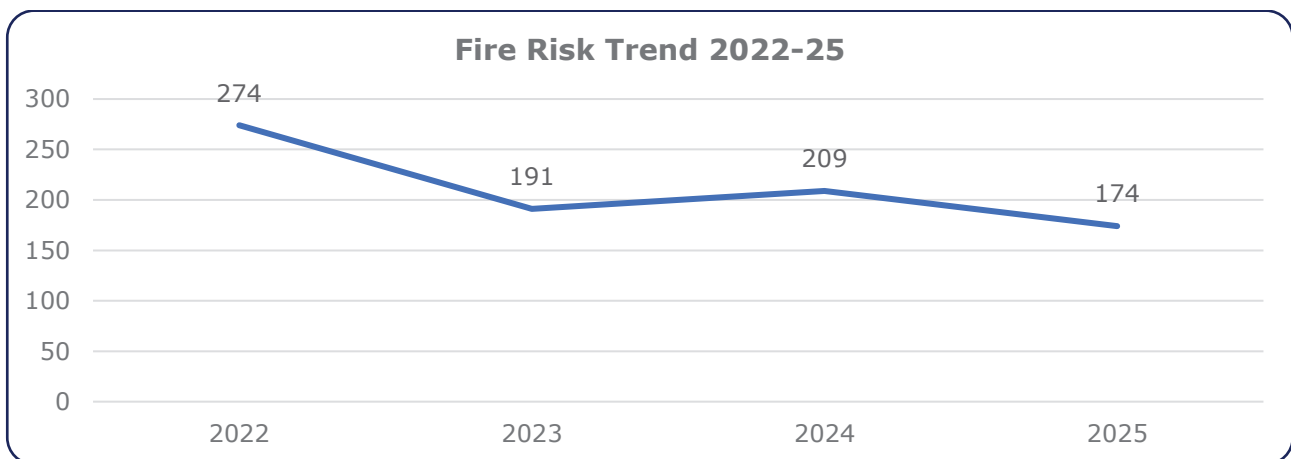
A register of the risks identified during the assessment process is handled by the Fire Safety Team and recorded on the DatixWeb system. The table (right) highlights the risks that have been added to the risk register following risk assessments and removed from the risk register after being rectified over the three-year period April 2022 to April 2025.



The decision taken by the Health Board to provide sprinkler protection at new hospitals has produced massive benefits for the management of fire safety and the safety of persons at the relevant premises. The hospitals are relatively risk free with no significant fire safety issues.

The major fire safety risks held on the system are legacy fire risks at older building stock including Royal Gwent and Nevill Hall Hospitals. These premises remain a priority for resolution and are likely to dominate the Fire Safety Discretionary Capital spend for the foreseeable future.

The risk trend for April 2022 to April 2025 is shown below.



10.3 Planning and Implementing Fire Safety Improvement Works

The duties of the Fire Safety Manager include planning and implementing a programme of improvement works to remove or mitigate fire risks carried by the organisation.

During 2024/25 improvements have been made in the following areas to ensure the Health Board meets minimum safety standards and fulfils its legal requirements.

Site	Area	Improvement
Nevill Hall Hospital	Third & Fourth Floors including inpatient wards	End of Life Replacement of Fire detection and sounders. The system in this area is now fully compliant.
Nevill Hall Hospital	Ward 4/1	Repairs to fire resisting barriers
Nevill Hall Hospital	Bron Haul & Gerylyn Staff Residencies	End of Life Replacement of Fire detection and Fire doors. These buildings are now fully compliant.
Royal Gwent Hospital	Ward D7 West, Blocks 3, 6 (Staff Residences) & 7, Level 2, Level 8 (Plantrooms)	Installation of new fire detectors connected to the new <i>Gent</i> panel system. The system in these areas is now fully compliant.
St Cadoc's Hospital	Whole Site	Replacement Fire Alarm System
Ebbw Vale Clinic	Whole Building	Replacement Fire Alarm System

In addition to the above there has been a continued incremental improvement across all building stock.

10.4 Key Fire Risks

The key residual fire risks carried by the Health Board are related to management of the aging infrastructure and degradation of fire protection at older acute hospitals, namely the Royal Gwent and Nevill Hall Hospitals.

The safety of large numbers of inpatients at these hospitals relies on the capability of the alarm systems to give early warning of fire and the capability of fire walls and fire doors to stop the spread of fire through the buildings.

Fire Alarm Systems: The fire alarm system at Nevill Hall Hospital has benefitted from a major replacement programme in 2024/25.

The detectors in all inpatient areas have been replaced and the system covering these areas is now full compliant with current standards. The fire control panel that monitors the staff residencies has also been replaced along with the detection in Bron Haul and Gerylyn. The detection in all other staff residencies is planned for replacement in 2025/26.

3 panels on site covering the works and estates offices, plantrooms and the undercroft are approaching their planned replacement date. It is important that these panels and the associated detection are replaced in the near future. On completion of this works the system will be fully compliant.

Although some progress has been made at the Royal Gwent Hospital, the situation is more severe. Improvements have been delivered to migrate some of the system over to a new replacement system. Eight of the blocks on site, including E Block and Block 6 Staff Residencies are now covered by the new system along with some areas in C&D Block.

However, the vast majority of C&D Blocks are still reliant a system which is obsolete and for which spare parts are no longer being manufactured. The system is functional but not reliable due to aging components that may be vulnerable to sudden failure.

Funding has been allocated to provide for the new system to be expanded into most of the inpatient wards by March 2027 but this will not be achievable without some disruption. It is estimated that a minimum of 40 weeks of single ward decants will be required to facilitate the works.

Attempts to carry out this work in a live ward environment were aborted in 2024/25 due to safety concerns.

Fire Walls and Fire Doors: The safety of inpatients at the Royal Gwent and Nevill Hall Hospitals relies on the ability of the structure of the buildings to withstand fire and stop fire spread between wards.

The Fire Safety Team have worked collaboratively with Facilities to introduce measures to ensure that fire barriers are effectively managed and protected. Work is now required to rectify existing breaches in the fire resisting partitions at both sites.

Surveys conducted at both hospitals has identified extensive works that is required to fix damage to the fire walls that protect the inpatient wards.

Funding has been secured to carry out remedial works at both sites. The feasibility of repairing the breaches on live wards is currently being considered, it is also possible to complete this works in tandem with the fire alarm replacement at The Royal Gwent Hospital if the decant wards are made available.

10.5 Emerging Risks

Capital investment is required to mitigate fire safety risks in the following areas.

- Replacement of end-of-life fire detectors at Ysbyty Aneurin Bevan.
- Replacement of the fire alarm system in the old hospital buildings at St Woolos Hospital (the system is not acceptable to modern standards, however clarity on the future use of the buildings is required before a commitment to spend circa £300k on a replacement system can be made).
- Enhanced Fixed electrical testing and of ageing electrical infrastructure on older sites.
- Risks associated with ageing ventilation infrastructure (Fire Dampers) for inpatient areas on older sites.

- The majority of fire doors at St Cadocs and St Woolos Hospital buildings are functional to older standards but are increasingly difficult to maintain. Replacement schemes are likely to be required within the next five years.

10.6 Planned Improvements

The following improvement schemes are planned to be completed in 2025/26.

- Partial replacement of the fire alarm system at Royal Gwent Hospital Site including fitting new detection and transition of levels 7, 6 & 5 of C & D Block to the new fire alarm system.
- End of Life replacement of detectors at Ysbyty Aneurin Bevan.
- Repairs to fire partitions on inpatient Wards at Nevill Hall Hospital.
- Replacement of 30-minute fire doors with 60-minute fire doors on inpatient wards at Nevill Hall Hospital.
- End of Life replacement of detectors at Ysbyty Ystrad Fawr.

10.7 Future Challenges and Priorities for the Fire Safety Team

The strategic goals for the Fire Safety Team are to improve fire strategies at older hospitals while replacing older, complex and costly alarm systems with modern systems incorporating graphics information displays that are easier to manage and economical to maintain.

A lack of available information on safety systems at these buildings continue to pose challenges in the production of detailed, site specific fire safety building strategies. Continued improvement will rely on acquisition of reliable documents such as:

- Fire Zone Plans
- Fire Alarm Cause and Effect Matrices
- As Fitted Fire Alarm System Device Drawings
- Fire Damper Plans

10.8 Fire Safety Advice and Support for Internal and External Partners

The Fire Safety Team provides advice and support to both internal and external partners across a variety of issues affecting fire safety.

Internal queries include advice and assessment of risk posed by shutting off areas to allow building work and application of building regulations for the repurposing of individual areas within a hospital.

External queries range from assessment of the suitability of fire safety building materials, design of cause and effect for fire alarm systems to active consultation with project managers on fire safety building regulations and fire strategies during the planning phase of new builds.

On completion of projects the Fire Safety Team provide training, risk assessment and updated fire safety strategies for new or repurposed areas and buildings.

The Fire Safety Team has been involved in the following projects currently being progressed or completed within the last financial year:

- Adoption of Chepstow Community Hospital from PFI
- Extension to Emergency Department (ED) at the Grange University Hospital

- Satellite Radiology Unit at Nevill Hall Hospital
- 19 Hills Health and Wellbeing Centre
- Upgrade to Pharmacy at Royal Gwent Hospital
- Decontamination Suite at Royal Gwent Hospital
- Crisis Hub at St Cadocs Hospital
- Replacement Roof Glen Usk Suite at St Cadocs Hospital
- The Bevan Health and Wellbeing Centre

10.9 Fire Safety National Groups

In addition to their duties for the Health Board the Fire Safety Team are actively engaged as members of The National Association of Healthcare Fire Officers (NAHFO). Fire advisors attend regular meetings of the Wales Branch of NAHFO where they receive updates on fire safety building regulations and legislation and discuss common issues and best practice with colleagues from the other health boards in Wales and Shared Services fire advisors.

The Fire Safety Team are also involved in the All-Wales Fire Safety Managers Group. The group is engaged in the development of a number of All Wales Fire Safety protocols, the Health Board currently chair the working group on Control of Ignition Sources and contribute to groups working on Fire Safety Training and Fire Safety Considerations for Bariatric Patients on Healthcare Premises.

10.10 Fire Safety Incident Reporting

The Health Board has suffered no serious fire incidents in the financial year 2024/25. The most notable of the five minor incidents reported are:

- A spate of three repeated incidents of rough sleepers starting fires in the grounds of Pontllanfraith Health Centre between October 2024 and January 2025. As a consequence, fire safety advice was given around waste management and security at the site.
- Waste materials inside a dishwasher at Chepstow Community Hospital that came into contact with the heating element and caused smoke but without fire. Following which, fire safety advice was given regarding safe use of the appliance.

The number of unwanted fire signals (UwFS) reported in 2024/25 has seen an 8.5% reduction compared with 2023/24 (See figure 8).

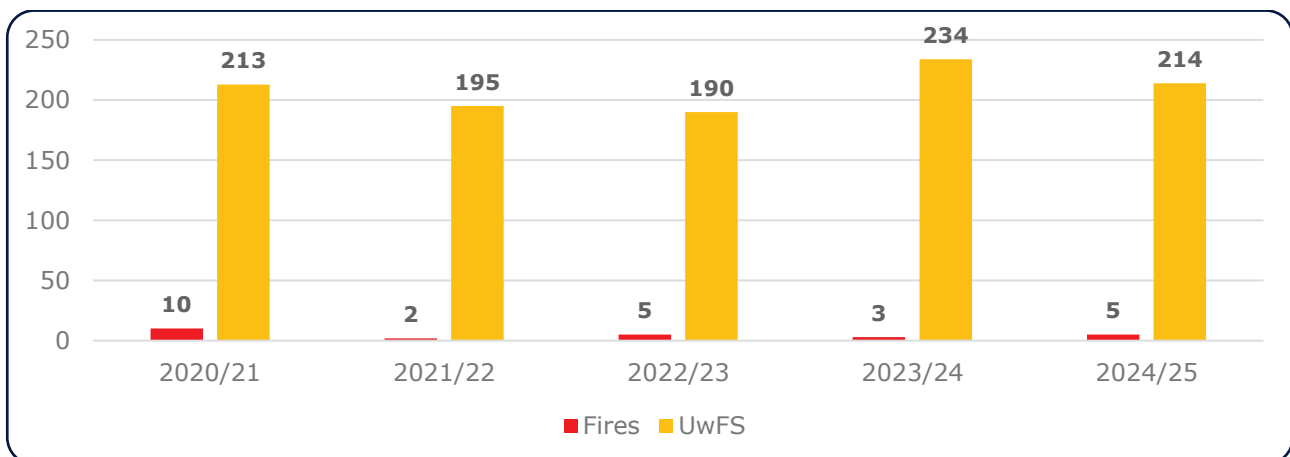


Figure 8: Number of reported fire safety incidents for the past five financial years

The overall trend in unwanted fire signals is flat and although improvements can be seen in the number of activations at County Hospital those at the Royal Gwent Hospital show a year-on-year increase.

Figure 9 provides a comparison on the number of unwanted fire signals by hospital by financial year.

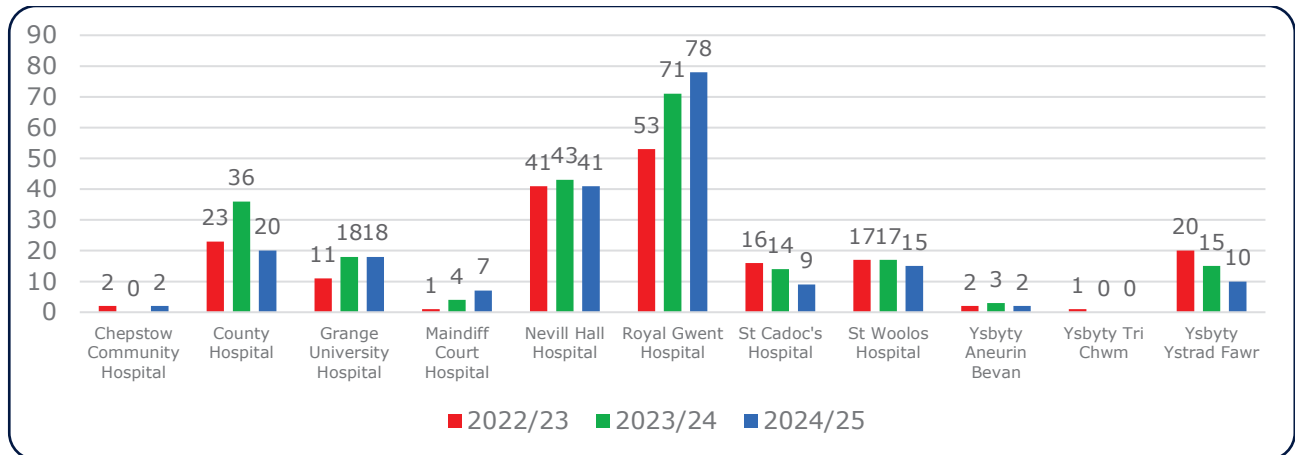


Figure 9: Number of reported unwanted fire signals by Hospital

A significant proportion of the false alarms at the Royal Gwent Hospital are directly attributable to malfunctions of the obsolete panels.

Performance grading of fire alarm systems for the generation of unwanted fire signals takes account of the size of the systems as well as the number of unwanted signals.

Using this metric, the trend is either stable or positive for all fire alarm systems at major sites (See figure 10). Notwithstanding, the continued objective of the team is to achieve an A grading for all systems.

Hospital	False alarms including UwFS	Actuation devices	2023/24 Grade	Current Grade
Chepstow Community Hospital	2	504	no incidents	A - performance should be maintained
County Hospital	20	1018	C	B - 10% reduction in UwFS
Grange University Hospital	18	2978	A	A - performance should be maintained
Llanfrehfa Grange	3	400	B	A - performance should be maintained
Maindiff Court Hospital	7	388	B	B - 10% reduction in UwFS
Monnow Vale Health & Social Care Facility	0	169	no incidents	A - performance should be maintained
Nevill Hall Hospital	41	2850	B	B - 10% reduction in UwFS
Royal Gwent Hospital	78	4560	B	B - 10% reduction in UwFS
St Cadoc's Hospital	9	1225	B	A - performance should be maintained
St Woolos Hospital	15	953	B	B - 10% reduction in UwFS
Ysbyty Aneurin Bevan	2	1150	A	A - performance should be maintained
Ysbyty Tri Chwm	0	130	no incidents	A - performance should be maintained
Ysbyty Ystrad Fawr	10	2267	A	A - performance should be maintained

Figure 10: Unwanted fire signals performance indicators by Hospital for 2024/25

The Fire Safety Team investigate all fires, unwanted fire signals and incidents that are related to fire or any report or incident that may affect fire response.

The purpose of the investigations is to provide data to facilitate a reduction in false alarms and a reduction in the number and severity of fire incidents.

11 MANUAL HANDLING & ERGONOMICS

The Manual Handling Team continue to provide mandatory training to support the education strategy, including providing expert advice as required i.e. selection of key equipment.

Based on current demands the Team's activity is primarily focused on training and improvements in compliance.

11.1 Manual Handling National Meetings

Manual Handling subject matter experts across NHS Wales meet on a quarterly basis to identify and support each NHS organisation with manual handling learning, best practice and action plan going forward.

11.2 Manual Handling Incident Reporting

The number of manual handling incidents reported in 2024/25 has increased by 20% compared with 2023/24 (See figure 11).

There has been a 51.2% increase in patient handling incidents compared with 2023/24.

To identify learning outcomes from manual handling incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix Cymru system.

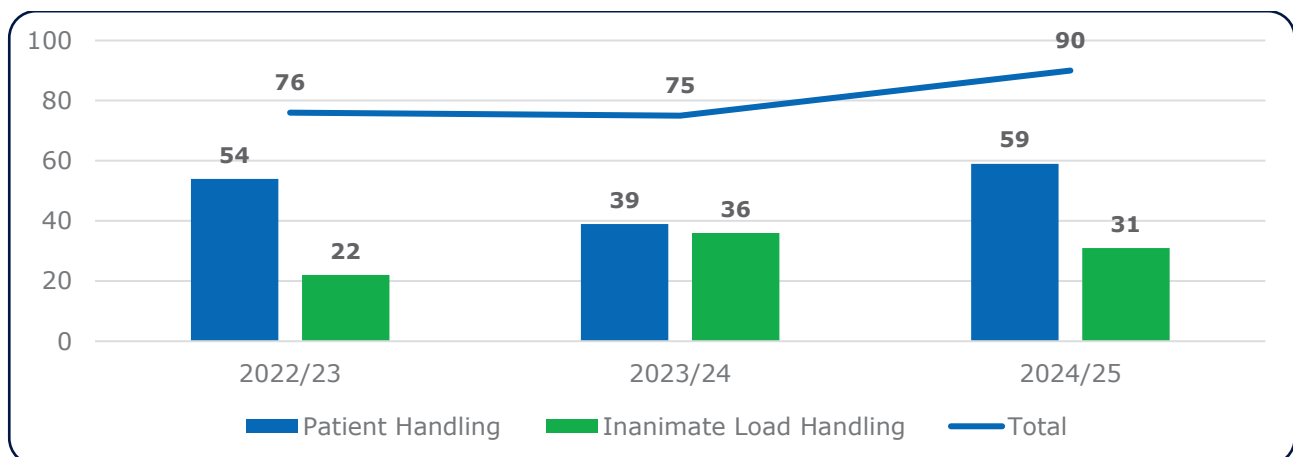


Figure 11: Number of reported manual handling incidents affecting staff for the past three financial years

11.3 Manual Handling Equipment

The Manual Handling Team lead on providing the necessary advice and support to the Health Board in the selection of manual handling equipment to aid in the delivery of care to patients.

All manual handling equipment and its accessories require the necessary testing, inspection or examination to ensure compliance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) or the Provision and Use of Work Equipment Regulations 1998 (PUWER).

The service and maintenance of the manual handling equipment is contracted to an external provider. The service contract supports the Health Board to meet its legal requirements and identifies the need for investment in new equipment.

'Insight' assessments undertaken by ARJO were completed in December 2024 across all Acute and Community Hospitals. The assessments assess the mobility levels of patients, the type, age and condition of patient handling equipment available and service and routine maintenance information.

The findings have provided the Health Board with the following information:

- Patient handling equipment assessments.
- Identification of aged/obsolete equipment with limited/no service support.
- The need for new equipment to meet patient functional levels and care processes.

There is a requirement to apply for capital investment in the obsolete equipment in 2025/26 and 2026/27.

11.4 Manual Handling Patient Handling Risk Assessments

The Manual Handling Team have contributed to the implementation of the patient handling Welsh Nursing Care Record (WNCR). The manual handling audit programme planned for 2025/26 will review the standard and quality of the patient handling assessments.

11.5 Display Screen Equipment (DSE)

Since the outbreak of Covid-19 more Health Board Staff are working in an agile manner across the Health Board at various sites and from private premises, whilst the increased flexibility of agile working can provide many benefits to both the individual and Health Board, the legal requirement for the Health Board to ensure the health, safety and welfare of its employees continues to apply in agile working situations.

To ensure that the risks associated with agile working are properly identified and managed, a series of guidance documents and policy amendments have been developed as a means to support individuals who are identified as agile workers. This includes amendments to the Health Boards Policy for Workstation Display Screen Equipment (DSE) and Display Screen Equipment Risk Assessment Form.

The Corporate Health and Safety Department in collaboration with the Occupational Health Department have conducted DSE risk assessments for the more complex cases.

12 VIOLENCE PREVENTION & REDUCTION

It is recognised that all NHS staff are among those most likely to face violence and abuse during the course of their employment. These incidents can involve patients, visitors or others acting aggressively towards staff or in a manner that makes staff feel threatened or vulnerable. The impacts of this can be profound on both the individual and the Health Board.

Through 'A healthier Wales' working with the Anti- Violence Collaborative (AVC), we are working towards an agreed approach to prevent violence and aggression towards NHS staff in Wales. We strive to create a culture where our staff feel safe and supported.

Following on from last year 2023/24, we have implemented the 'Obligatory Response to Violence in healthcare' The document sets out the responsibilities of healthcare organisations when dealing with incidents relating to violence or aggression in the NHS.

Its focus is on those incidents that need to be addressed by the criminal justice system that includes:

- Improving the reporting of violent incidents.
- Strengthen the investigation and prosecution process by improving the quality and timeliness of shared information.
- Improve victim and witness care and confidence.
- Raise the issues of violence and aggression against NHS staff as well as the action that will be taken by all parties.

Our team works closely with Gwent Police including monthly meetings to ensure that the objectives are met. The Health Board is committed to the delivery of a safe and secure environment for staff and patients, so that the highest possible standard of care can be delivered.

12.1 Violence & Aggression National Meetings

The Violence and Aggression Case Managers Group was established as a Sub-group of the NHS Wales Health and Safety Management Steering Group. The group plays a crucial role in ensuring the safety of both staff and patients by developing and implementing strategies for violence prevention and reduction. The Violence Prevention & Reduction Team continue to be involved in this group and contribute to the wider all Wales discussion on creating a safe and supported culture for our staff.

The purpose of the group is to:

- To provide a collaborative support to NHS V&A Case Managers.
- Ensuring that National Frameworks and Guidance associated with Violence and Aggression Management is successfully embedded and implemented across organisations. E.g. Obligatory Response to Violence and Aggression in Healthcare (ORV) and associated Welsh Health Circular.
- Establish Task and Finish Groups that will be responsible for the development of National Violence and Aggression Standard Operating Procedures/Guidance that can be adopted by NHS Wales E.g. Violence and Aggression Risk Management/ Assessment.
- The Group is also a forum for partner agencies from the CPS and the four Police Services in Wales, Health and Safety Executive to attend and participate, to foster good relationships and to ensure compliance with the aims of the ORV.
- Develop and agree Datix Cymru Violence and Aggression related codes. Review

- coding and changes to the Datix Cymru system when necessary.
- Support and contribute to the review of the Violence and Aggression Training Passport and Information Scheme. Particularly in relation to risk assessment module.
- In support of the V&A Case Managers professional development, this Group will facilitate information and training opportunities for its members to participate, either as part of normal agenda or occasional separate events.
- To develop a minimum standard Job Description and Specification for a Violence and Aggression Case Manager.
- To inform the Anti-Violence Collaborative (AVC) of any relevant developments and concerns relating to the management of violence and aggression within NHS Wales organisations and seek support from the collaborative in influencing partner agencies in meeting the principles of the ORV.

12.2 Violence & Aggression Incident Reporting

Reported incidents of violence and aggression on staff have increased in 2024/2025 from the previous year by 6.9%. This increase could be explained by the work that has been implemented as part of the ORV as mentioned above to create a positive reporting culture.

Approximately 55% of violence and aggression incidents in 2024/2025 were reported from the Mental Health and Learning Disabilities Division. This is an increase of 2% from the previous year (2023/24).

Physical assaults on staff reported in 2024/25 has increased by 5.3% compared with 2023/24 (see Figure 12). The overall incident rates for 2024/2025 have remained consistent with previous years (2022/2023 and 2023/2024) at 1 in 20 staff experience physical assault.

There has been an 11% reduction in sexual assaults in 2024/25, compared with 2023/24.

To ensure quality data is available the Corporate Health and Safety Department validate all reported incidents of violence and aggression.

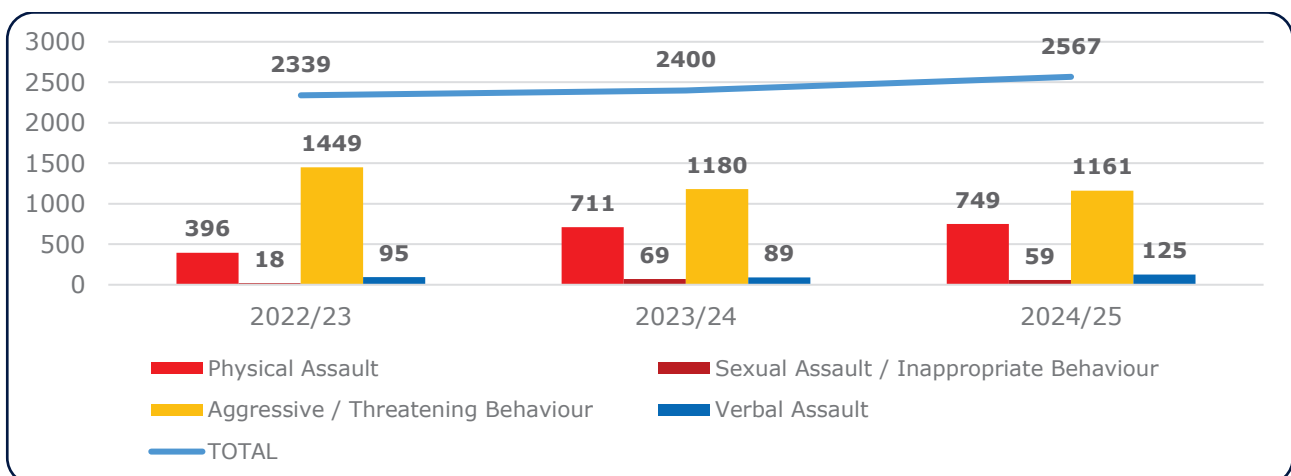


Figure 12: Number of reported violence and aggression incidents for the past three financial years

12.3 Support for NHS Staff Members

The Violence Prevention & Reduction (VPR) Team continue to support staff who have been subjected to incidence of workplace violence & aggression and where matters relating to personal safety are identified.

Where incidents are reported via Datix Cymru, a Violence Prevention & Reduction Advisor (VPR Advisor) is assigned to the incident and will provide advice in relation to the investigation of the incident including; supporting the Line Managers and signposting the person or people affected to relevant support services, internally and externally. A new collaborative approach to supporting victims of crime has been implemented and includes Wellbeing Services, Occupational Health and Connect Gwent to offer specialist and bespoke support to Health Board employees. In 2024/2025 6% of victims accepted a referral to Connect Gwent or CANOPI for additional support.

Between April 2024 and March 2025, the VPR Team has been actively involved in 1,120 incidents, demonstrating their critical role in supporting Health Board Employees who have been subjected to incidents of workplace violence and aggression. (See Figure 13)

Changes to the criteria for incident follow up has seen an increase in follow up in February and March 2025.

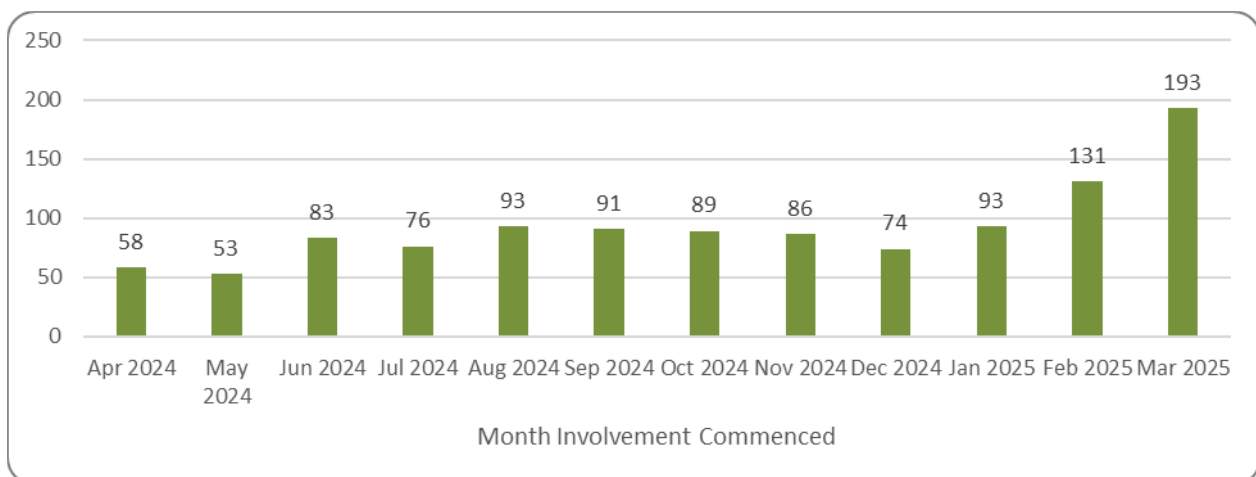


Figure 13: Number of violence and aggression incidents with VPR Advisor involvement

12.4 Engagement with Gwent Police

As mentioned above as part of the AVC and ORV objectives the Health Board has further improved its working relationship with Gwent Police, which has resulted in increased collaboration and wider partnership engagement.

This year in 2024/2025 the Health Board has implemented a Violence and Aggression Incident Review group which brings together key Health Board Employees and Gwent Police colleagues and is chaired by the Violence Prevention & Reduction Lead. The aim of the group is to implement a multi-agency approach to incidents of violence and aggression to reduce risks and attempt to achieve the safest outcome for the person, emergency services workers and members of the public.

12.5 Police Outcomes

Following a review of reported incidents, the Health Board engaged with the NWSSP Once for Wales Programme Team to progress enhancements to Datix Cymru to enable accurate recording of outcomes e.g. civil, criminal sanctions in relation to violence and aggression incidents.

This led to an increase in reporting of Health Board incidents to the Police as seen on Datix Cymru. In 2023/2024 only 1% of violence and aggression incidents against NHS staff were recorded on Datix Cymru as being reported to the Police. This has increased in 2024/2025 to 13% of incidents being reported to the Police.

However, this has only resulted in a total of 2% of violence and aggression incidents being investigated. From this total, 9% of those cases investigated led to an outcome such as a Community Resolution or a Conditional Caution given to the perpetrator. The VPR team will continue to work on creating a positive reporting culture and support investigations with Gwent Police to achieve outcomes that will reduce future risks.

12.6 All Wales Violence Prevention and Reduction Standards

During the period 2024/2025, significant progress has been made on an All-Wales basis to enhance the management and prevention of violence and aggression within NHS Wales.

The Health Board Violence Prevention & Reduction team has worked closely with the Anti-Violence Collaborative and other stakeholders across NHS Wales to create a Draft Version of the All-Wales Violence Prevention and Reduction Standards.

The review process entailed a detailed assessment of the existing standard, with particular attention to its relevance and applicability within the Welsh healthcare context. This has included evaluating current best practices, identifying potential areas for improvement, and ensuring that the standard aligns with the unique operational, cultural, and regulatory environment of NHS Wales. The Standards aim to be introduced and implemented across all NHS Health Boards in Wales in 2025/2026. This will be a key objective of the VPR Team for the next financial year and will feature in the Health Board Violence Prevention and Reduction Strategy.

The adoption of these standards is anticipated to bring several significant benefits to the Health Board, including:

Enhanced Safety for Staff and Patients: By implementing a robust and comprehensive framework for violence prevention and reduction, the updated standard will contribute to a safer working environment for staff and a more secure care environment for patients.

Consistency Across NHS Wales: A standardised approach will ensure that all NHS Wales organisations adhere to the same high standards, reducing variability in practices and enhancing the overall quality of violence prevention and management across NHS Wales.

Improved Reporting and Accountability: The new standard will establish clearer protocols for reporting incidents of violence and aggression, leading to better data collection, analysis, and accountability. This will enable NHS Wales to monitor trends, identify high-risk areas, and allocate resources more effectively.

Increased Staff Support and Training: The standard emphasises the importance of training and supporting staff in recognising, managing, and de-escalating violent situations. This will not only improve staff confidence and competence but also reduce the likelihood of incidents escalating to physical violence.

12.7 ABUHB Violence Prevention & Reduction Strategy

Preventing and reducing violence is a strategic enabler for improving the health and wellbeing of colleagues. Creating cultures where colleagues feel safe and supported can lead to higher retention, lower sickness absence rates, enhanced employee experience, and subsequent improvement to patient experience and outcomes.

In order to achieve change and ensure that we set out clear objectives the VPR Lead will develop and implement a specific Health Board Violence Prevention & Reduction Strategy for 2025/2026.

This Strategy will align our policies to recognise the needs and priorities of our Health Board. This piece of work will involve the VPR Team working collaborative with colleagues across the Health Board and key Stakeholders.

13 CONCLUSION

This report highlights the level of health, safety and fire focussed activity that has been undertaken during 2024/25 to improve the management of health, safety and fire in the Health Board.

The Health and Safety Committee continues to promote the health and safety programme.

The Corporate Health and Safety Department works to actively support the delivery of safe and compliant systems within the context of a health and safety culture. Failure to embed an interdependent and mature health and safety culture presents a risk to the Health Board.

The Health Board has seen a reduction in the number of incidents reported to the HSE in accordance with RIDDOR, however, there has been an increase in the number of incidents reported overall. This is potentially associated with the increase in awareness and a positive reporting culture. The Corporate Health and Safety Department will conduct thematic reviews in 2025/26 for needlestick & sharps injuries and manual handling injuries linked to patient handling.

The internal health and safety monitoring programmes are continuously improving as is the ongoing health and safety training programme.

There are challenges in relation to the current level of resource available within the Corporate Health and Safety Department to support the delivery of the legal requirements of health, safety and fire.

The implementation of the health, safety and fire improvement plan in 2023/24 and 2024/25 provided a focus for the Health Board on key risk areas.

A work plan will be developed for 2025/26 to address the risk areas for focus. Implementation of the actions, outlined in the work plan will support the Health Board to demonstrate continuous improvement and compliance with its legal responsibilities.

An Internal Audit is planned for quarter 4 of 2024/25 to assess the health and safety arrangements within the Health Board.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Integrated Performance Report: November Board
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships Sarah Simmonds, Director for Workforce and OD Jennifer Winslade, Director of Nursing Robert Holcombe, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Trish Chalk, Assistant for Director Planning and Performance Marie-Claire Griffiths, Head of Strategic Planning Paul Steynor, Head of System Planning and Performance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Board with an integrated overview of performance against the key Health Board and Ministerial Priorities through the first part of 2025/26, with performance figures including the most up-to-date, validated positions.

The Board is asked to:

- **Note** the progress against key performance metrics as of the latest, available positions and the improvement actions



Cefndir / Background

This report focusses on specific performance against the organisation's key priorities in line with the Health Board's 2025/26-28 IMTP, the National Performance Framework, and the Cabinet Secretary's priorities.

Asesiad / Assessment

This report is structured across sections as follows:

Performance Summary

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

This report covers the commitments in the 2025/26 IMTP, bringing together the wider reporting on system change priorities, value and sustainability and the enablers on a quarterly basis.

This Integrated Performance Report reflects the totality of performance committed to as part of the 2025/26 IMTP and includes updated metrics and trajectories.

A summary of the report is provided below:

Embedding Prevention and Population Health in All That We Do

The Health Board continues to make concerted efforts to embed prevention and population health across its services, with mixed progress against ministerial delivery expectations. COVID-19 vaccination uptake for the autumn booster stands at 35.24% at the end of October, and influenza vaccination rates among adults aged 65 and over stood at 59.1% at early November, both of which are currently exceeding the all-Wales average. The vaccination strategy highlights the need for intensified efforts to improve engagement. The Health Board has reviewed booking processes and is exploring innovative strategies, including text messaging and improved communication materials, as part of a PhD-led project aimed at enhancing uptake during winter campaigns.

Childhood vaccination rates have declined slightly to 85%, just below the Q1 trajectory of 86%, while HPV vaccination rates remain static at 66.4%, significantly under the 75% target. To address these gaps, the Health Board is developing a



Gwent Data Dashboard to identify underserved populations and tailor interventions accordingly. Eleven schools have been flagged for low HPV uptake, with targeted action plans now in place.

Smoking cessation services have seen 610 quit attempts in Q1, falling short of the target of 730. However, 136 of these attempts were carbon monoxide (CO) validated, surpassing the Q1 trajectory of 20%. The Health Board is implementing a comprehensive improvement programme, aligning behaviour change practitioners with local integrated neighbourhood teams. Executive approval has been granted for a smoke-free hospital strategy, which includes a new implementation group and a robust communications campaign. Additionally, the Gwent Nicotine Control Alliance has been established to combat underage and illicit tobacco use.

Performance in newborn hearing screening and six-week physical examinations remains strong, consistently exceeding national targets. The weight and measurement at eight weeks has shown remarkable improvement, reaching 84.8% in Q4 2024/25, up from just 16.8% in Q1 2022/23. This trajectory suggests the Health Board is well-positioned to meet its 80% target by Q4 2025/26.

Efforts in diabetes care have yielded incremental progress, with 43.8% of patients aged 12 and over receiving all eight NICE-recommended care processes in September, narrowly missing the Q2 trajectory of 45%. The Health Board's Value-Based Healthcare team is spearheading initiatives in diabetes prevention, including urinary ACR (albumin-to-creatinine ratio) screening and annual foot checks. Pilot programmes in Newport West and East are targeting individuals in the pre-diabetic range, with plans for further expansion

Progressing Place-Based Models of Care and Sustainability in Primary and Community Services

The Health Board has made notable strides in advancing place-based models of care, with several key services performing ahead of trajectory and contributing to the broader ambition of sustainable, community-focused healthcare delivery. The Pharmacist Independent Prescribing Service (PIPS) has seen a significant expansion, with consultations already surpassing 70% of the annual target by the end of Q2. The number of community pharmacies offering the service has grown from 49 in April 2025 to 61 in September, reflecting strong uptake and accessibility. Similarly, the Common Ailment Scheme (CAS) remains on track, with universal coverage across practices and high participation in key services such as sore throat testing, urinary tract infection management, and emergency contraception.

Optometry services have exceeded expectations, with over 10,000 more patients accessing care than planned. The publication of the Eye Health Needs Assessment and the development of an Integrated Eye Care Plan mark important milestones. Task and Finish groups have been established to support implementation, with activity commencing in Q2. Emergency dental services, while initially slow in April, have rebounded to near-average levels. Although still slightly below trajectory, performance has reached 92.4% of the planned activity by Q2, indicating a recovery trend.

Weekend community nursing activity remains a challenge. Despite incremental improvements, weekend activity levels continue to fall short of the ministerial



expectation to reach 80% of weekday capacity. Achieving this target will require a substantial shift in service delivery models to better support weekend care. It could be questioned whether or not that weekend demand exists to meet this ministerial measure. In contrast, Enhanced Community Care (ECC) services have performed well, with accepted referrals exceeding the Q2 trajectory. Services such as Rapid Response, the Ready to Go Ward at Royal Gwent Hospital, and Emergency Care at Home in Caerphilly are contributing to this success. Finally, GP referrals to Rapid Response services have remained stable. A winter pilot of the Navigation Hub/Single Point of Access was launched in late October to streamline GP access and improve referral access.

Improving Our Urgent and Emergency Care System: Experience, Access and Discharge Pathways

The Health Board has delivered a series of focused interventions aimed at improving urgent and emergency care (UEC) performance, with early signs of progress emerging despite persistent challenges. A major milestone was the implementation of the 45-minute ambulance handover protocol and the Our Next Patient (ONP) initiative at the Grange University Hospital (GUH) in September. These measures have reduced significantly handover delays, crew hours lost, and average handover times, achieving the lowest levels since GUH opened. This improvement is particularly noteworthy given the exceptionally high demand at the hospital's front door in September and October. The success of these initiatives reflects a system-wide effort to enhance patient flow and ensure timely access to care.

Despite these gains, patients waiting over 12-hours in emergency departments and minor injury units (EDMIUs) remain above (adverse to) target. However, GUH's performance in 2025/26 has been among the best since June 2021, with October achieving 85.8% compliance. Notably, the average time patients spend beyond the 12-hour threshold has halved from 15.2 hours in April to 8.7 hours in September, indicating improved throughput and discharge efficiency. Triage performance has also improved, with waits over 60 minutes continuing to decline. While median wait times to be seen by a clinician have remained relatively static, the ONP initiative has led to better performance on certain days. Nevertheless, overnight demand and capacity constraints continue to pose challenges, prompting the development of divisional action plans to address these issues. The Urgent Primary Care (UPC) service exceeded its Q2 trajectory by approximately 4,500 contacts and is on track to meet Q3 targets. The service is expected to absorb additional demand during the winter months, with planned activity increasing by 12,000 contacts in the second half of the year.

Stroke care presents a mixed picture. Direct admission to acute stroke wards within four hours remains low at 3.8% in Q1, largely due to operational pathways that route patients through the Acute Medical Unit before reaching stroke wards—an approach not recognised by SSNAP as meeting the target. Conversely, thrombectomy rates have improved significantly, reaching 12.9% in Q1, more than double the IMTP trajectory. Performance in stroke therapy assessments has been variable, with improvements in Occupational Therapy and Physical Therapy assessments during Q2, while Speech and Language Therapy assessments saw a decline.



Efforts to reduce Pathways of Care Delays (POCDs) have yielded positive results. The volume of delays was slightly below trajectory in October, and the overall trend remains downward. The total days associated with delays have stabilised at significantly lower levels than in 2024/25. A criteria-led discharge pilot and the rollout of the Optimal Hospital Flow Framework at GUH are supporting these improvements. Weekly scrutiny panels and length-of-stay meetings across acute and community sites are helping to identify and address bottlenecks. The subset of POCDs linked to assessments by nursing and allied health professionals (AHPs) saw a spike in September but improved in October. These delays are being actively reviewed and addressed through ONP-related actions. Additionally, the number of patients with lengths of stay exceeding 21 days continues to decline, aligning with the Health Board's long-term improvement trajectory.

Continuing to Prioritise Cancer, Urgent and the Longest Waiting Patients for Planned Care

The Health Board continues to face significant challenges in meeting Ministerial expectations for cancer and planned care pathways, though there are areas of progress and targeted improvement. Single Cancer Pathway (SCP) compliance has declined to 57.5% in September, the lowest in the past year. Despite seasonal pressures such as annual leave, the number of treatments delivered within 62 days remained stable between Q1 and Q2. Encouragingly, the median time from suspicion to treatment decision improved markedly, from 42 days in July to 27 days in September. This suggests that while overall compliance has dipped, operational efficiencies are being realised. A renewed focus on pathway management and ensuring treatment capacity within the 62-day window is expected to support recovery in the latter half of the year. The 62-day backlog remains above (adverse to) trajectory, with 380 patients waiting beyond this threshold in September, representing 10.9% of the total patient tracking list (PTL). Similarly, the 104-day backlog has reduced but remains higher than planned, though broadly aligned with IMTP expectations. In contrast, the 28-day decision-to-treat (DTT) rate remains strong, consistently exceeding trajectory and maintaining stability since early 2025. This reflects effective early-stage diagnostic and decision-making processes and is an important indicator for patients.

The number of patients waiting over 104-weeks from referral to treatment (RTT) has shown a positive deviation from trajectory in September, driven by internally funded initiatives in Orthopaedics, alongside the early impact of the national insourcing outpatient programme in ENT. The 52-week outpatient breach profile has also improved, with the national insourcing outpatient programme contributing to a significant reduction in September. This programme is being delivered in line with plans, achieving 99.3% of scheduled activity by early November. The Follow-Up Waiting List (FUWL) has stabilised, with 30,774 patients past the 100% target date in Q2, only a marginal increase from the previous year-end. The Outpatient Transformation Team is actively validating long-waiters and piloting retrospective transitions to See on Symptom (SOS) and Patient-Initiated Follow-Up (PIFU) pathways. Discharge rates onto these pathways has improved to 20.2% in 2025/26, up from 18.1% in 2024/25. Notable efforts include validation of post-operative patients in Trauma & Orthopaedics and the use of Consultant Connect to support PIFU in Neurology. Did Not Attend (DNA) rates have dropped to 5.5% in Q2, the



lowest since February 2025. Deep dives into high-rate specialties and the piloting of overbooking strategies are underway to further reduce missed appointments.

Diagnostic waiting times remain a concern, with the number of patients waiting over 8-weeks increasing over the summer due to capacity constraints, particularly in non-obstetric ultrasound. However, an action plan has been implemented, and early signs suggest improvement in October. The additional demand generated by the national insourcing outpatient programme is beginning to impact diagnostic services, prompting a report to Welsh Government on the programme's implications.

Audiology pathways have seen a rise in 14-week breaches for adults, narrowing the gap to IMTP forecast. Paediatric breaches are also increasing, though at a slower rate than forecast. Therapy services, particularly Physiotherapy, experienced a spike in breaches in July due to a surge in spinal and knee referrals from Trauma & Orthopaedics. However, the breach position improved over the following months, with Q2 performance (115 breaches) falling below the IMTP trajectory of 140.

Elective theatre protection continues to meet national standards, benefiting from the Health Board's unique system design. Theatre utilisation metrics, specifically late starts and early finishes, remain below trajectory. Late starts rose to 40.4% in Q2 against an IMTP trajectory of 35%, and early finishes held steady at 45.3% against an IMTP trajectory of 37%. The Theatres Utilisation Group is undertaking detailed sessional analysis to identify improvement opportunities. Initiatives such as autosend and golden patient scheduling have shown promise at Royal Gwent Hospital and are being rolled out to other sites. Session utilisation has improved incrementally, reaching 86.1% in Q2 and meeting the IMTP target. Day surgery rates, as measured by the British Association of Day Surgery (BADs), exceeded national ambitions, peaking at 82.9% in June. Although rates dipped slightly in July and August, they remain well above trajectory, with ongoing efforts to expand day surgery activity, particularly at Nevill Hall Hospital.

Improving Our Mental Health Services

The Health Board continues to demonstrate strong performance across most adult and child mental health access measures, with all but two indicators meeting or exceeding their respective IMTP trajectories. For Adult Mental Health Services, both Part 1a (assessment within 28 days) and Part 1b (intervention within 28 days) measures are performing well above the national standard of 80%, achieving 90.2% and 90.3% respectively in September. These results reflect the service's ability to effectively balance demand and capacity, ensuring timely access to care. Part 2 compliance, which measures the proportion of individuals with a valid Care and Treatment Plan (CTP), improved to 93.6% in September, exceeding the national target. Ongoing efforts are focused on improving dashboard usage and documentation accuracy, particularly in collaboration with Local Authorities. Data cleansing is underway to ensure the reliability of reporting, with expectations that CTP volumes will stabilise. Psychological Therapies, while showing improvement since the start of the year, remain below the Q2 trajectory of 60%, with September performance at 54%. A dedicated improvement session held in August identified key actions to enhance performance, including daily data validation, resetting waiting time clocks when reasonable offers are declined, and streamlining administrative processes. These initiatives aim to improve pathway flow and reduce long waits.



In Child and Adolescent Mental Health Services (CAMHS), Part 1a and 1b measures continue to perform strongly, with assessments and interventions both meeting or exceeding the 80% target. However, CAMHS Part 2 compliance fell to 74% in September, below the Q2 trajectory. This decline is attributed to persistent issues with documentation, including missing or incorrect entries. The Division is looking at next steps to ensure compliance with the national standards return. The Neurodevelopmental (ND) service within CAMHS is under considerable pressure due to rising demand and reduced capacity. September performance dropped to 60%, below the Q2 trajectory of 75%, with a growing number of children waiting over 26 weeks. A targeted action plan, supported by additional funding, is being implemented to address the legacy backlog and improve RTT compliance. Finally, Specialist CAMHS Choice Assessments continue to perform well, maintaining compliance well above the national standard of 80%, indicating consistent access to initial assessments for children and young people.

Workforce

The Health Board has seen a steady growth in staffing, with total WTE rising to 13,577 by September, surpassing IMTP targets. Increases were driven by Nursing, Medical, Allied Health Professionals, and Administration roles, including the TUPE transfer of GP practice staff. Turnover remains within target at 8.59%, with a strong stability rate of 91.17%. PADR compliance improved to 76.2%, and mandatory training held steady at 80%, though both remain below the 85% target.

Sickness absence rose slightly to 6.48%, with stress, musculoskeletal, and gastrointestinal issues being the top causes. A 12-month improvement plan is in development, supported by expanded wellbeing services. Variable pay usage continues to decline, with agency usage dropping to 106 WTE and medical locum usage also reducing. Strategic workforce planning is focused on reducing reliance on agency staff and improving recruitment timelines, which currently outperform the all-Wales target at 59.6 days.

Job planning compliance is improving, with consultant and SAS rates reaching 57.2% and 56.2% respectively. Measures to accelerate progress include linking job planning to divisional reviews and restricting pay-impacting changes for non-compliant staff.

Quality, Safety & Experience

The Health Board has seen a notable increase in patient engagement, with CIVICA survey responses doubling year-on-year and satisfaction scores rising to 87%. Key strengths include compassion and communication, though waiting times remain a concern. Initiatives such as bereavement cafés, neurodiversity resources, and improved accessibility for Deaf patients reflect a commitment to inclusive, person-centred care. PALS continues to support patients effectively, with communication issues being the most common concern.

On patient safety, incident reporting shows a high proportion of low-harm cases, with pressure ulcers, falls, and medication errors being key themes. Improvements



include enhanced validation, targeted education, and better equipment access. Mortality data governance is being strengthened through a new Learning from Death framework and improved clinical coding. Safeguarding activity remains robust, with increased awareness driving referrals and support calls. However, training compliance, particularly for Level 3 safeguarding, requires further investment to meet national mandates.

Overall, the Health Board is progressing well in embedding quality, safety, and experience across services, with clear actions in place to address areas of concern and ensure continuous improvement.

Finance

As of Month 6 in the 2025/26 financial year, the Health Board is reporting an adverse variance of £11.387 million, which is £0.5 million worse than the IMTP financial plan but £1 million better than the previous month’s forecast. The projected year-end deficit stands at £19.9 million, though this is subject to significant risk.

The forecast relies heavily on achieving £42.5 million in savings, alongside anticipated allocations from Welsh Government for wage awards, planned care, and other pressures. Key financial risks include increased costs from the Risk Pool (estimated at £7–8 million), unresolved Band 2–3 grievances, and operational pressures such as ambulance handover improvements and winter demand. The Health Board continues to monitor these risks closely and is implementing mitigation strategies to protect financial sustainability.

Argymhelliad / Recommendation

The Board is asked to:

- **Note** the performance report across the IMTP performance measures within the five system change themes, as well as the integrated updates, all as of the latest available positions.

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

<p>Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:</p>	<p>The report highlights key risks for delivery against the IMTP</p>
<p>Safon(au) Gofal ac Iechyd: Health and Care Standard(s):</p>	<p>Governance, Leadership and Accountability 1.1 Health Promotion, Protection and Improvement 2. Safe Care 2.1 Managing Risk and Promoting Health and Safety</p>



<p>Blaenoriaethau CTCI IMTP Priorities</p> <p>Link to IMTP</p>	<p>Choose an item.</p> <p>This is a report against the Integrated Medium-Term Plan and the key organisational priorities, informed by our detailed understanding of how our system operates.</p>
<p>Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP</p>	<p>Choose an item.</p>
<p>Amcanion cydraddoldeb strategol Strategic Equality Objectives</p> <p>Strategic Equality Objectives 2020-24</p>	<p>Improve the Wellbeing and engagement of our staff</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</p> <p>Choose an item.</p> <p>Choose an item.</p>

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
<p>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</p>	<p>Is EIA Required and included with this paper No does not meet requirements</p> <p>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk</p>



**Deddf Llesiant
Cenedlaethau'r Dyfodol – 5
ffordd o weithio
Well Being of Future
Generations Act – 5 ways
of working**

<https://futuregenerations.wales/about-us/future-generations-act/>

Choose an item.
Choose an item.



ABUHB BOARD

Integrated Performance

November 2025/20



Performance Summary

Section 1: Ministerial Delivery Expectations

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

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

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

Section 2: Our Performance & System Change Delivery

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

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

Quadruple Aim		Health Board's System Change Theme and Integrated Report
Aim 1	People in Wales have improved health and well-being with better prevention and self-management.	<ul style="list-style-type: none"> • Embedding Prevention and Population Health in all that we do
Aim 2	People in Wales have better quality and more accessible Health and Social Care Services, enabled by digital and supported by engagement.	<ul style="list-style-type: none"> • Progressing place based models of care and sustainability in Primary Care • Improving our Urgent and Emergency Care System focusing on Primary Care • Continuing to prioritise Cancer, Urgent and the longest waiting lists • Improving our Mental Health services
Aim 3	The Health and Social Care workforce in Wales is motivated and sustainable.	Workforce and Culture
Aim 4	Wales has a higher value Health and Social Care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	Quality, Safety and Experience Financial Performance

What went well?

- The implementation of the 45-minute handover protocol and Our Next Patient initiative at GUH has delivered record improvements in ambulance handover times and reduced lost hours, despite unprecedented demand, ensuring faster ambulance turnaround and better care for Gwent citizens.
- Mental Health performance for Parts 1a and 1b continue to deliver to national standards across both adults and CAMHS.
- The Healthy Child Wales metric for weight and measurement at 8 weeks has improved again, consolidating a huge improvement trend over the past 4 years.
- There has been a further reduction agency usage in last quarter 123.43WTE to 106WTE reported in July 25. Revised plan sets out quarterly reductions, target to reach 98WTE by March 2026.
- Consultant and SAS job planning are both showing a steady improvement trajectory towards achieving the target of 85%.

What w

- Single Cancer Pathway completed course of Q2, with September months.
- Whilst ambulance performance breaches and Waits to be S
- The CAMHS Neurodevelopmental pressure from rising demand performance falling to 60% waits over 26 weeks, prompt backlog and improve RTT co
- Compliance with nationally training for all registered he exceed 85% within the three constraints, prompting an S associated risks and recover

What actions are we taking to improve?

- As the Health Board moves into winter, there are significant areas of focus to ensure that improvements in system flow (particularly ambulance handovers) can be embedded and sustained. The pilot of the Single Point of Access/Navigation Hub will be critical to ensuring that patients are directed to the most appropriate services for their care needs, and that front door capacity is protected for those that need it most.
- PALS bedside sticker rollout is improving visibility and accessibility of support across the Health Board, with teams actively assisting patients in boarding spaces and collaborating with the deaf community to establish PALS as a recognised accessible contact point.
- The Health Board has strengthened falls prevention by introducing a revised review process for severe injury cases, publishing an updated Hospital Falls Policy, and implementing ward-level quality improvement projects.

What are

- The 2025/26 financial year month 04 is an adverse variance £0.5m worse compared to significant savings to be re £19.9m.
- The national insourcing ou strain on the 8 week diagnosis position for the longest wait difficult with no additional
- Winter pressures are already normal demand for Urgent indications that winter respiratory pressures on all parts of the Gwent.

Ministerial Delivery Expectations

Theme	Delivery Expectation	ABUHB commitment
Population Health & Prevention	Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	47% March 2026
	Achievement of vaccinations targets in the performance framework	Yes March 2026
Building Community Capacity	Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard	16% March 2026
	100% of GP practices achieving all National Access Standards for In hours GMS	100% March 2026
	Increase in number of people accessing PIPs for acute minor conditions and routine contraception services where the patient reports they would have otherwise visited their GP	24,000 March 2026
	Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25 and greater where possible	128,000 March 2026
	Increase in capacity of Enhanced Community Care to at least the required levels previously set for 2024/25 and greater where possible	5,200 March 2026
Women's Health	Establishment of one Women's Health Hub in each health board area by March 2026	Yes March 2026

Section 1 Ministerial Delivery Expectations

Ministerial Delivery Expectations

Theme	Delivery Expectation	ABUHB commitment
Timely Access to Care	Reduce the number of ambulance patient handovers over 1 hour –national target - zero	50 Mar
	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, <u>building towards the national target of zero</u>	75 Mar
	No patients waiting more than 104 weeks for referral to treatment.	3,2 Mar
	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion building toward a national target of 80% by 31 March 2026.	70 Mar
	No patients waiting more than 8 weeks for a specified diagnostic	1,0 Mar
Mental Health Access (Adult and CAMHS)	80% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral – Over 18s	80 Mar
	80% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS – Over 18s	80 Mar
	80% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral – Under 18s	80 Mar
	80% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS – Under 18s	80 Mar

Section 1 Ministerial Delivery Expectations

Progress Against our Integrated Medium-Term



Quality, Patient Safety & Experience

Workforce & Culture

Finance

Theme	Delivery Expectation
<p>Embedding Prevention and Population Health in all that we do</p>	% uptake of the COVID-19 vaccination for those eligible Spring Booster
	% uptake of the COVID-19 vaccination for those eligible Autumn Booster
	% uptake of the influenza vaccination amongst adults aged 65 years and over
	% children up to date with vaccinations by age 5
	% of children receiving HPV vaccination 1 dose by the age of 15
	Percentage of adult smokers who make a quit attempt via smoking cessation services
	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks
	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks
	Maintain physical examination at 6 weeks rates (Healthy Child Wales)

Theme	Delivery Expectation
Embedding Prevention and Population Health in all that we do	Increase weight and measurement at 8 weeks rates (Healthy Child Wales)
	Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes

Our Performance & System Change Delivery

Embedding Prevention and Population Health in all that we do

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

Ministerial Delivery

Performance: 56.45% (10/07/25, end of campaign)

Trajectory: 75%

National target: 75%

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

Measure: % uptake of the COVID-

Performance: 35.24% (as of 30/10/25)

Trajectory: 75% (Q4 25/26)

National target: 95%

Region	Performance (%)
Aneurin Bevan University Health Board	56.45
Blaenau Gwent	50.99
Caerphilly	54.55
Monmouthshire	66.96
Newport	53.64
Torfaen	54.36

Insight & Actions:

- COVID-19 spring booster: ABUHB performance was higher than the all Wales figure 53.18%, however this is short of the expectation. More broadly on seasonal, respiratory vaccination campaigns, a review of booking processes has been completed with several options being explored ahead of winter campaigns (e.g. use of text messaging services, improvement in uptake).

- COVID-19 autumn booster: Campaign commenced on 1st October, performance data includes vaccinations given and received up to the end of 30/10/2025. Current performance of 35.25% puts ABUHB marginally higher than the all Wales figure of 33.63%.

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

Ministerial Delivery

Performance: 59.1% (as of 04/11/25)

Trajectory: 75% (Q4 25/26)

National target: 75%

		65y and older		
		Immunised	Denominator	Uptake (%)
Aneurin Bevan UHB	Blaenau Gwent	8,930	15,385	58.0%
	Caerphilly	22,674	39,707	57.1%
	Monmouthshire	16,263	24,448	66.5%
	Newport	16,766	29,415	57.0%
	Torfaen	12,425	21,399	58.1%
	AB Total	77,058	130,354	59.1%

Insight & Actions:

- Influenza vaccination: ABUHB performance for residents aged 65 years and older 59.1% as of 4th November, higher than the all Wales figure of 55.9% and second only to BCU by 0.1%. The campaign remains ongoing and the vaccination programme continuing through Winter.

Our Performance & System Change Delivery

Embedding Prevention and Population Health in all that we do

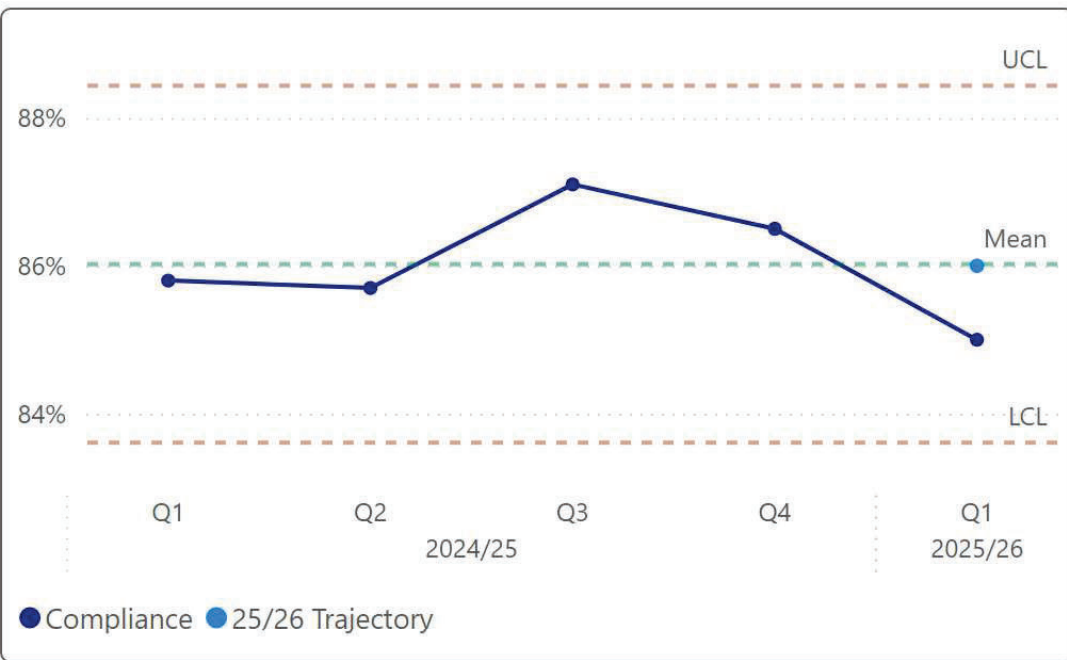
Measure: % children up to date with vaccinations by age 5

Performance: 85.0% (Q1)

Trajectory: 86.0% (Q1)

National target: 95.0%

Ministerial Delivery

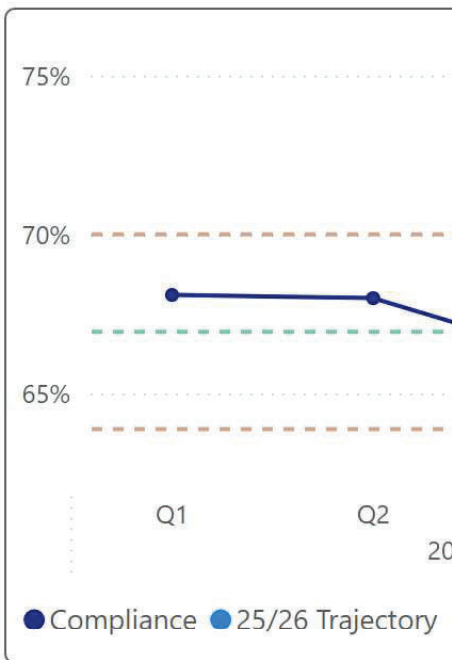


Measure: % of children receiving HPV

Performance: 66.4% (Q1)

Trajectory: 75.0% (Q1)

National target: 90.0%



Insight and Actions

- Childhood vaccinations: Q1 performance decreased slightly to 85%, marginally lower than trajectory (86%).
- HPV: Q1 performance increased slightly but remains broadly static at 66.4% and significantly below trajectory of 75%.
- As part of the Vaccine Equity Strategy, work is underway to develop a Gwent Data Dashboard focused on childhood immunisation. This will involve a detailed analysis to identify populations and programmes that require attention, enabling the co-design of targeted interventions with local teams. By presenting data at the highest possible level of granularity, the dashboard will support swift, responsive approaches across the region. For 2025/26, the key priorities are to improve vaccine uptake and reduce inequalities. Collaborative work is ongoing to improve uptake, while the Public Health team is investigating the reasons behind vaccination refusals. In line with a Welsh Government strategy, schools identified as areas of concern regarding HPV uptake. Action plans have been developed for each of these schools to address these concerns.

Our Performance & System Change Delivery

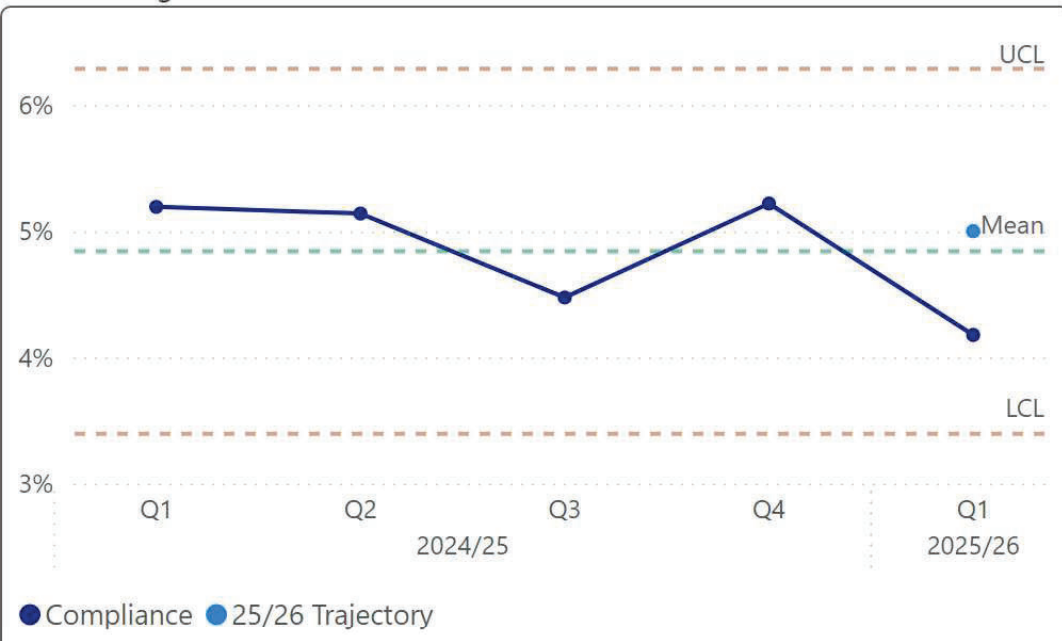
Embedding **Prevention** and Population Health in all that we do

Measure: Percentage of adult smokers who make a quit attempt via smoking cessation services

Performance: 4.2% (Q1)

Trajectory: 5.0% (Q1)

National target: 5.0%

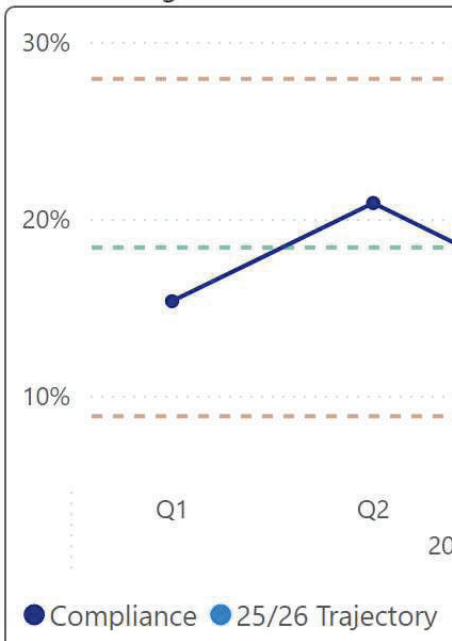


Measure: Percentage of adult smokers who are CO-validated

Performance: 22.3% (Q1)

Trajectory: 20.0% (Q1)

National target: 40.0%



Insight and Actions

- Smoking cessation performance across the two measures are based on annualised targets, however are presented here quarterly. There were 610 quit attempts in Q1 against a quartered target of 730. Of the 610 quit attempts, 136 were CO validated.
- As part of the public health commitment to delivering place-based care, behaviour change practitioners responsible for supporting individuals to achieve carbon monoxide-validated quits at four weeks rather than relying on a 12-week approval has been secured for the smoke-free hospital strategy, which includes re-establishing a clinically led implementation communications campaign. In addition, the Gwent Nicotine Control Alliance has been established to tackle underage and local messaging to reinforce this work.

Our Performance & System Change Delivery

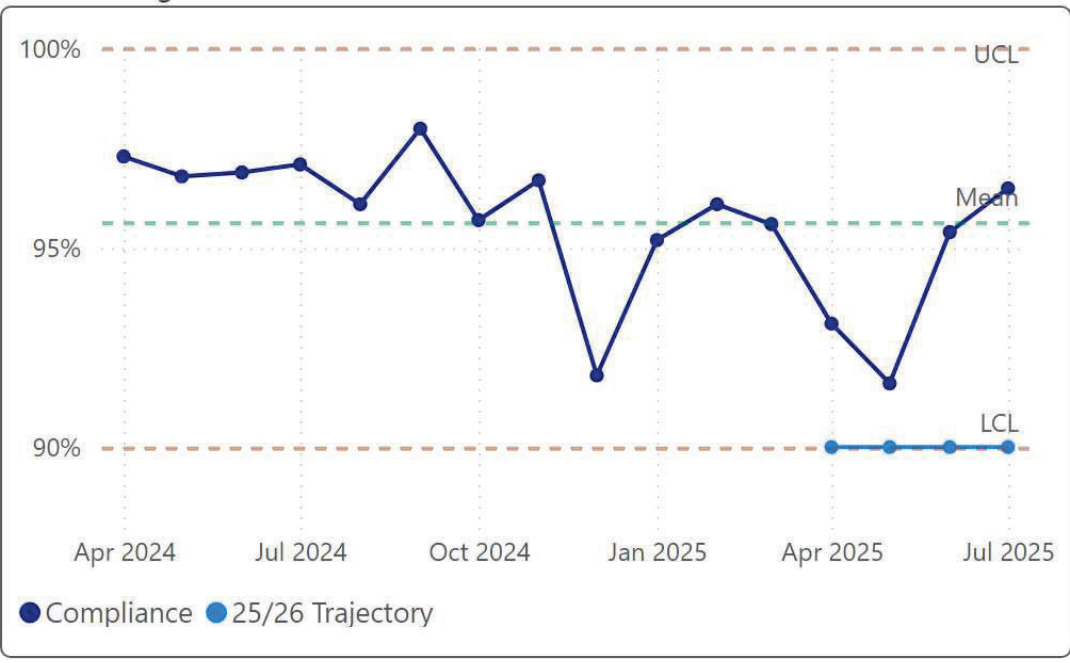
Embedding **Prevention** and Population Health in all that we do

Measure: Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks

Performance: 96.5% (July 2025)

Trajectory: 90.0% (Q2)

National target: 90.0%

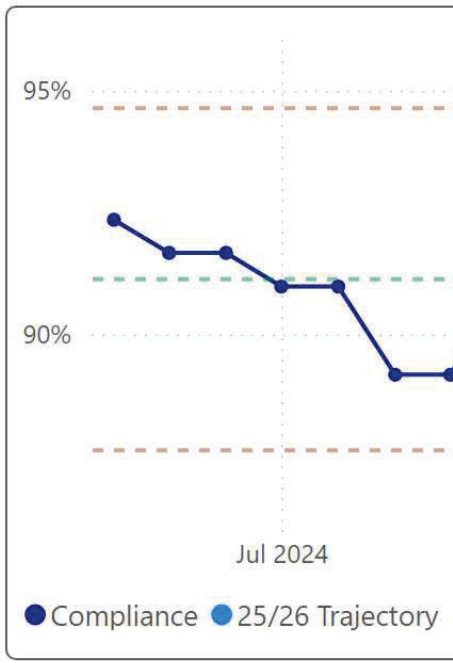


Measure: Maintain physical examination at 6 weeks

Performance: 92.6% (August 2025)

Trajectory: 90.0% (Q2)

National target: None



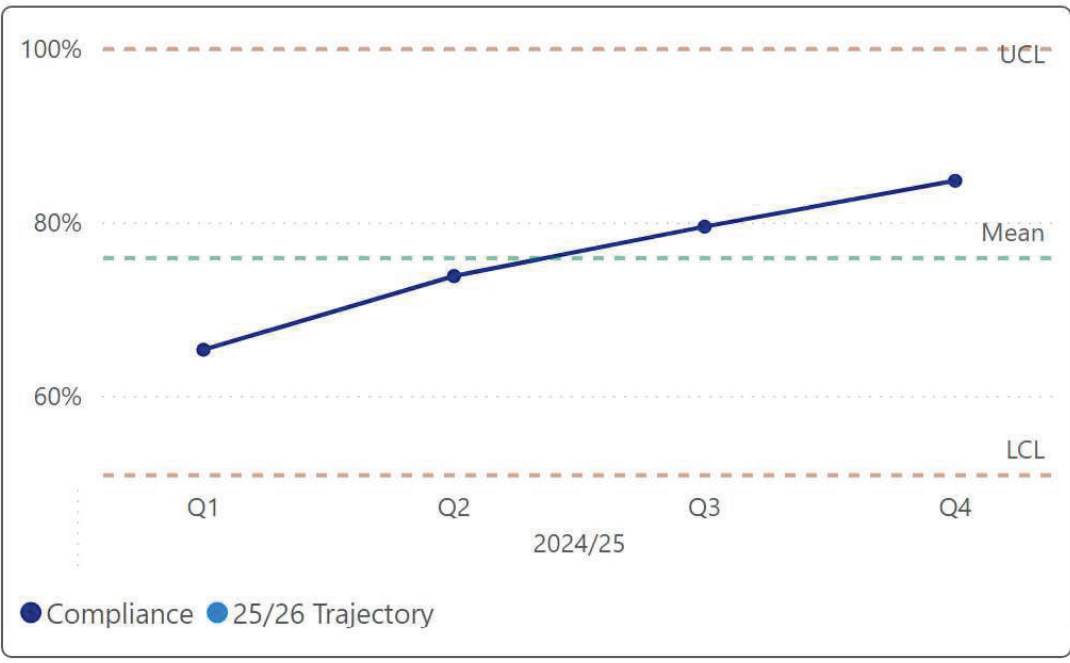
Insight and Actions

- Performance for both the new born hearing screening programme and the physical examination at 6 weeks remain above 25/26 to date.

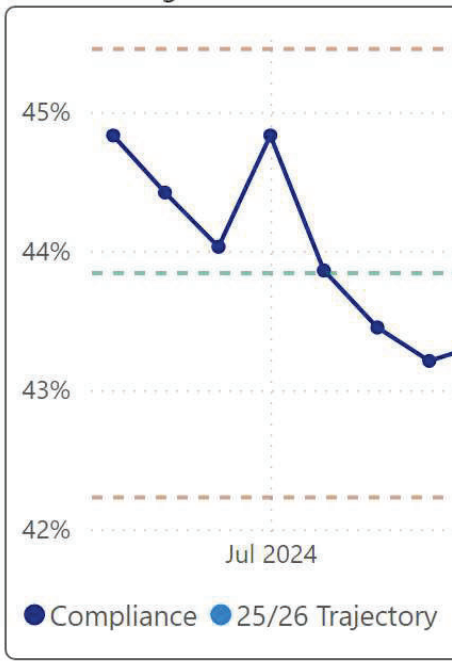
Our Performance & System Change Delivery

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

Measure: Increase weight and measurement at 8 weeks rates (Healthy Child Wales)
 Performance: 84.8% (Q4)
 Trajectory: 68.0% (Q1)
 National target: None



Measure: Increase in % of patients received all eight NICE recommendations
 Performance: 43.8% (September 2024)
 Trajectory: 45.0% (Q2)
 National target: None



Insight and Actions

- Weight and measurement at 8 weeks: Q4 24/25 data published in August, showing further improvement in performance over three years (16.8% in Q1 22/23), indicating capability to deliver against 25/26 IMTP trajectory of 80% by Q4. Q1 data expected to be published in September.
- 8 Diabetes processes: Performance remain within a relatively tight range (<2%) over the past 18 months, with September 2024 performance at 43.8% against a 25/26 trajectory of 45%. Value-Based Healthcare are leading initiatives focused on diabetes prevention, including urinary ACR screening in the first quarter, activity commenced in three surgeries in Newport West for individuals identified within the pre-diabetic range in the first quarter, with three additional surgeries in Newport East coming on stream.

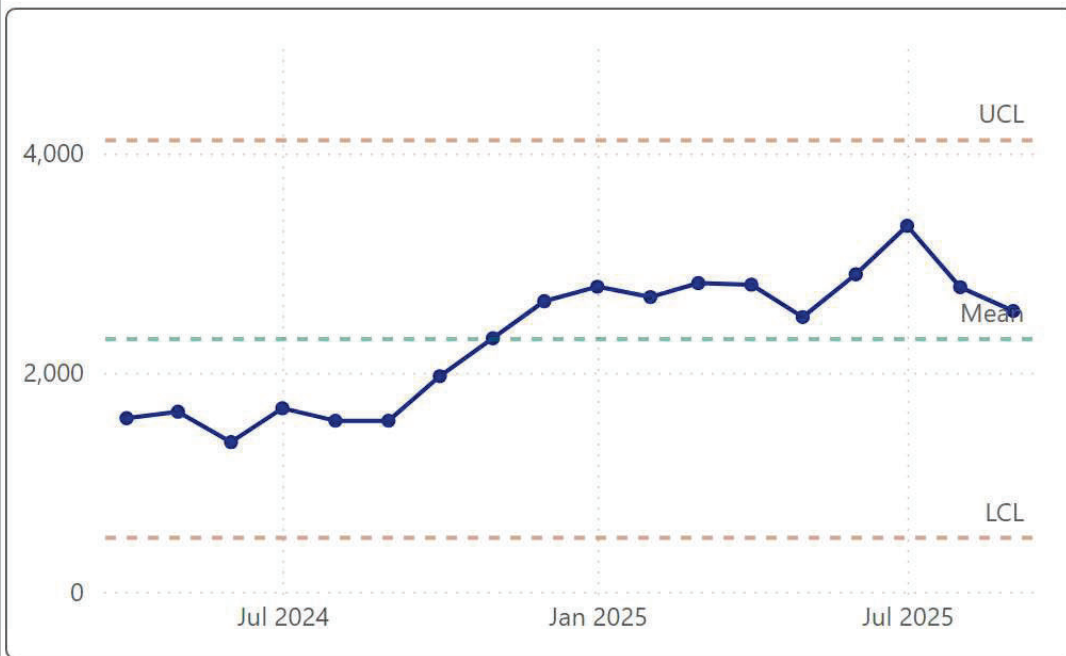
Theme	Delivery Expectation
<p>Progressing place based models of care and sustainability in primary and community services</p>	Increase in people accessing PIPs where they would have visited their GP
	Maintain the number of consultations undertaken by community pharmacy under CAS
	Maintain the number of patients accessing NHS Optometry Services
	Number of patients accessing urgent emergency services - Dental
	Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25
	Increase in capacity of Enhanced Community Care to at least the required levels previously set for 2024/25
	Maintain 95% of Palliative Care referrals assessed within 2 days
	Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s

Our Performance & System Change Delivery

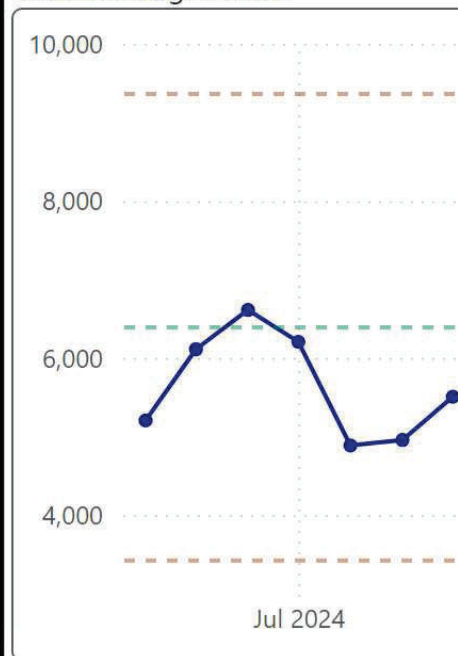
Progressing place based models of care and sustainability in **primary and community care**

Measure: Increase in people accessing PIPs where they would have visited their GP
 Performance: 16884 (September 2025)
 Trajectory: 9583 (Q2)
 National target: None

Ministerial Delivery



Measure: Maintain the number of claims under CAS
 Performance: 44431 (September 2025)
 Trajectory: 42821 (Q2)
 National target: None



Insight and Actions

- Pharmacist Independent Prescribing Service (PIPS): PIPs consultations are delivering significantly ahead of trajectory, having reached 16,884 in September 2025, compared to the Q2 trajectory of 9,583. The number of Community Pharmacies providing the PIPs service has increased to 61 (from 49 in April).
- Common Ailment Scheme (CAS): CAS claims remain on track against trajectory as of Q2. 100% of practices are delivering Throat Test and Treat; 86% offering CAS UTI service; 100% offering emergency contraception, and; 100% offering EC-Bridges.

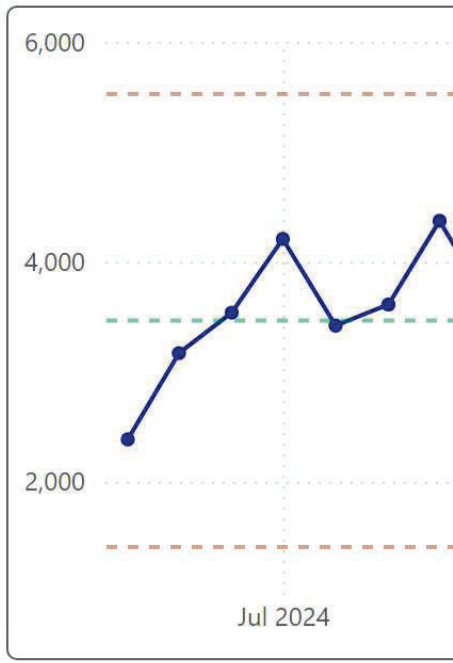
Our Performance & System Change Delivery

Progressing place based models of care and sustainability in **primary and com**

Measure: Maintain the number of patients accessing NHS Optometry Services
 Performance: 132429 (September 2025)
 Trajectory: 121913 (Q2)
 National target: None



Measure: Number of patients accessing NHS Emergency Dental Services
 Performance: 18798 (September 2025)
 Trajectory: 20333 (Q2)
 National target: None



Insight and Actions

-Optometry Services: Performance remains on track as of Q2, delivering ahead of trajectory with over 10,000 more patients than was planned. The Eye Health Needs Assessment has been published, and an Integrated Eye Care Plan has now been developed. New eye care groups are being established, with implementation beginning in Q2.

- Emergency Dental: Following the low start to the year in April, which is an observable trend in previous years, the number of patients using the service has been close to the mean value and, whilst still below trajectory, is 92.4% of the total number planned as of Q2.

Our Performance & System Change Delivery

Progressing place based models of care and sustainability in **primary and com**

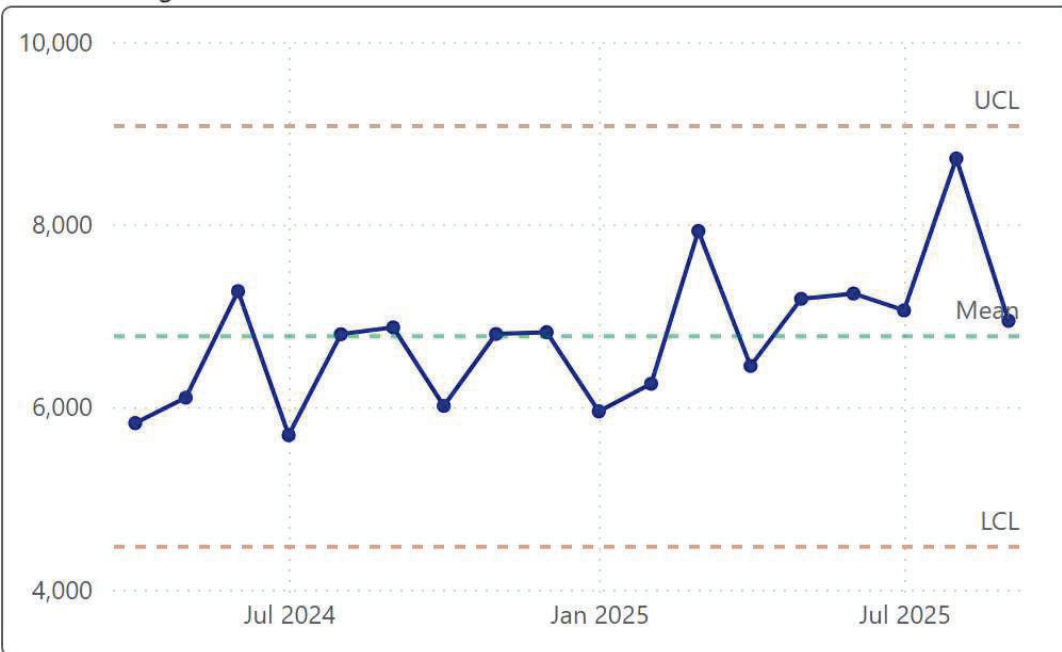
Measure: Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25

Performance: 43604 (September 2025)

Trajectory: 63497 (Q2)

National target: None

Ministerial Delivery

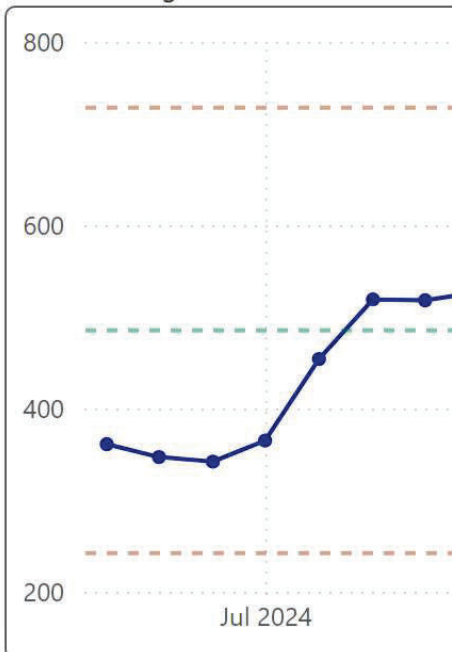


Measure: Increase in capacity of Enhanced Community Care (ECC) to at least the required levels previously set for 2024/25

Performance: 3201 (September 2025)

Trajectory: 2573 (Q2)

National target: None



Insight and Actions

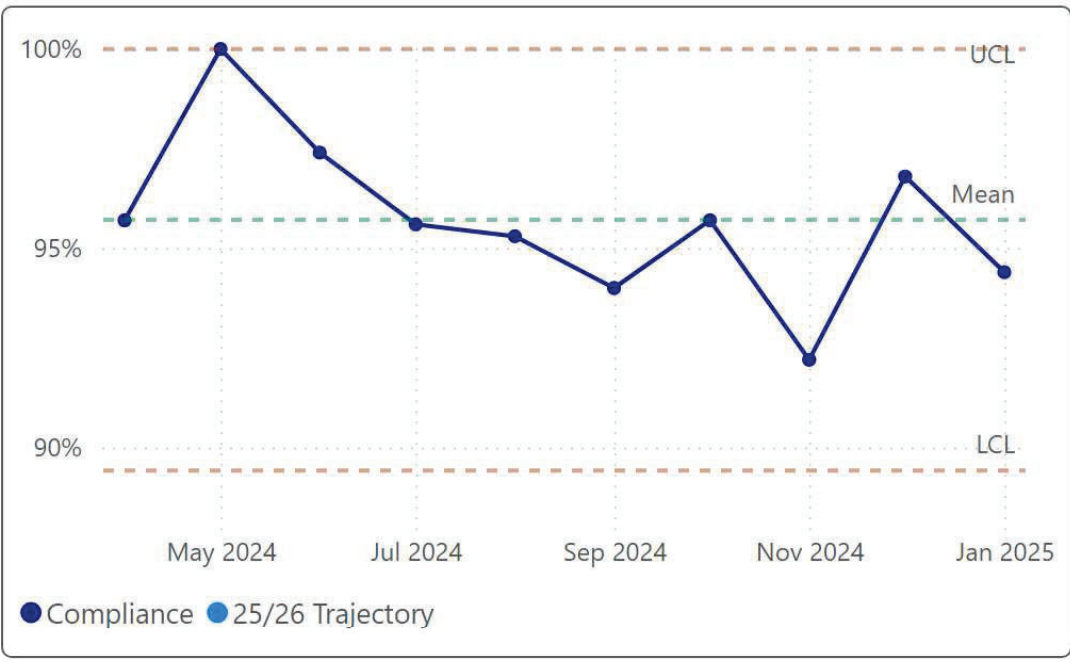
- Community Nursing: Current performance remains significantly behind the expected trajectory. Ministerial expectation of an average weekday level. Although weekend activity as a proportion of total activity is increasing, achieving the ministerial expectation would demand a significant shift in service delivery towards weekends.

- Enhanced Community Care (ECC): Accepted ECC referrals have remained relatively consistent over the past 12 months, Q2 performance (3,201 actual compared to 2,573 planned). The ABUHB services included within the national definition comprise Rapid Response across all sites, Rapid Response at Home, and Emergency Care at Home in Caerphilly.

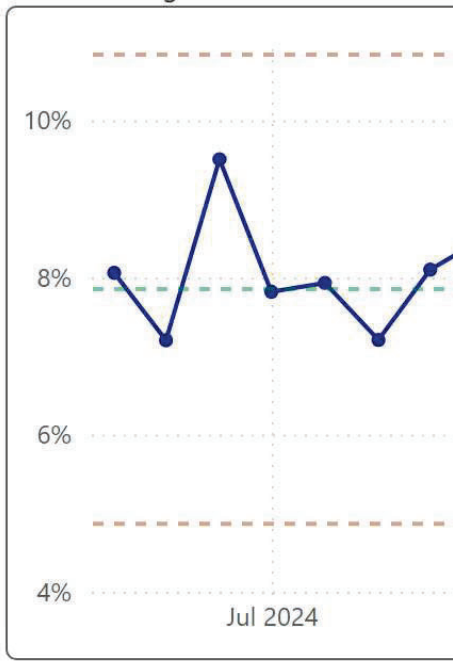
Our Performance & System Change Delivery

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

Measure: Maintain 95% of Palliative Care referrals assessed within 2 days
 Performance: 94.4% (January 2025)
 Trajectory: 95.0% (Q1)
 National target: 95.0%



Measure: Maintain proportion of GP referrals to Rapid Response services for over 65% of all medical assessments) for over 65% of all medical assessments)
 Performance: 7.5% (September 2024)
 Trajectory: 8.5% (Q2)
 National target: None



Insight and Actions

- Palliative Care: Following the implementation of the national system to complete Specialist Palliative Care forms in Weymouth, following the decommissioning of the previous system, the National team are currently working on reporting requirements to develop a national dataset for palliative care. In the interim, local options have been explored and a dataset recently identified, however there is a requirement for a quality assurance is underway to ensure accuracy of the data before this can be shared; the updated data will be available in early 2025.
- GP referrals to Rapid Reponse: Performance over the past 18 months has fluctuated but the overall proportion has remained static at 8%. There has been a noticeable increase in referrals to Rapid Response services from both front-door and back-door referrals. The Navigation Hub/Single Point of Access winter pilot commenced at the end of October, with the aim of making it easier to refer patients directly to Rapid Response services.

Theme	Delivery Expectation
<p>Improving our Urgent and emergency care system focusing on experience, access and discharge pathways</p>	Reduce the number of ambulance patient handovers over 1 hour
	Reduce the number of ambulance crew hours lost at GUH ED (per month)
	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
	Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU
	Reduction in time from arrival to ED triage - no waits over 60 minutes
	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.
	Maintain the number of Urgent Primary Care contacts (inc. virtual)
	% of patients directly admitted to an acute stroke ward <4hrs of clock start
	% of unique stroke patients given thrombectomy (all stroke types)

Theme	Delivery Expectation
<p>Improving our Urgent and emergency care system focusing on experience, access and discharge pathways</p>	% Assessed by OT within 24 hours
	% Assessed by PT within 24 hours
	% Assessed by SaLT within 72 hours
	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
	Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard
	Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment
	Continuous reduction in the number of people admitted as an emergency who remain in hospital over 21 days since admission

Our Performance & System Change Delivery

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

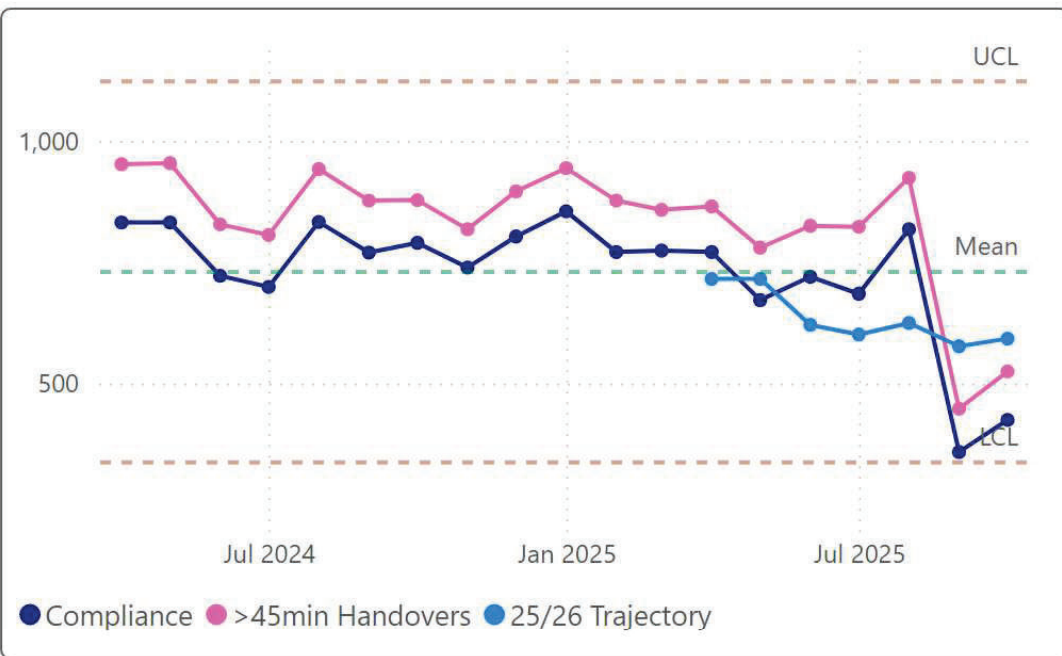
Measure: Reduce the number of ambulance patient handovers over 1 hour

Performance: 425 (October 2025)

Trajectory: 602 (Q3)

National target: 0

Ministerial Delivery

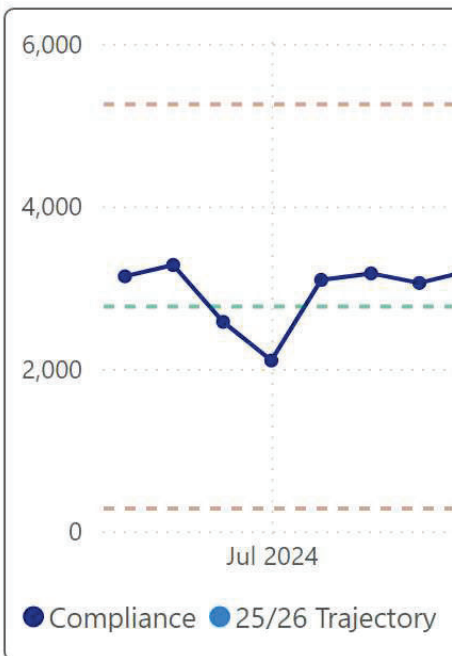


Measure: Reduce the number of ambulance patient handovers over 1 hour

Performance: 1103 (October 2025)

Trajectory: 2750 (Q3)

National target: None



Insight and Actions

- Ambulance handovers and lost hours: The 45-minute handover protocol and the Our Next Patient (ONP) initiative were marking a significant milestone in improving ambulance handover performance. This achievement reflects an extraordinary organisation, and the impact during September and October has been significant. Both the proportion and actual volume per hour have fallen to their lowest full-month levels since GUH opened. Similarly, crew hours lost and average handover time improvements have been delivered against a backdrop of exceptionally high demand at GUH ED, with September attendance and October ranking among the busiest months since GUH opened. Achieving such a step change under these circumstances system deserve recognition for their substantial efforts. This initiative was designed and delivered for the benefit of Gwent return to service quickly and reach those in urgent or emergency need, thereby protecting the most vulnerable patients

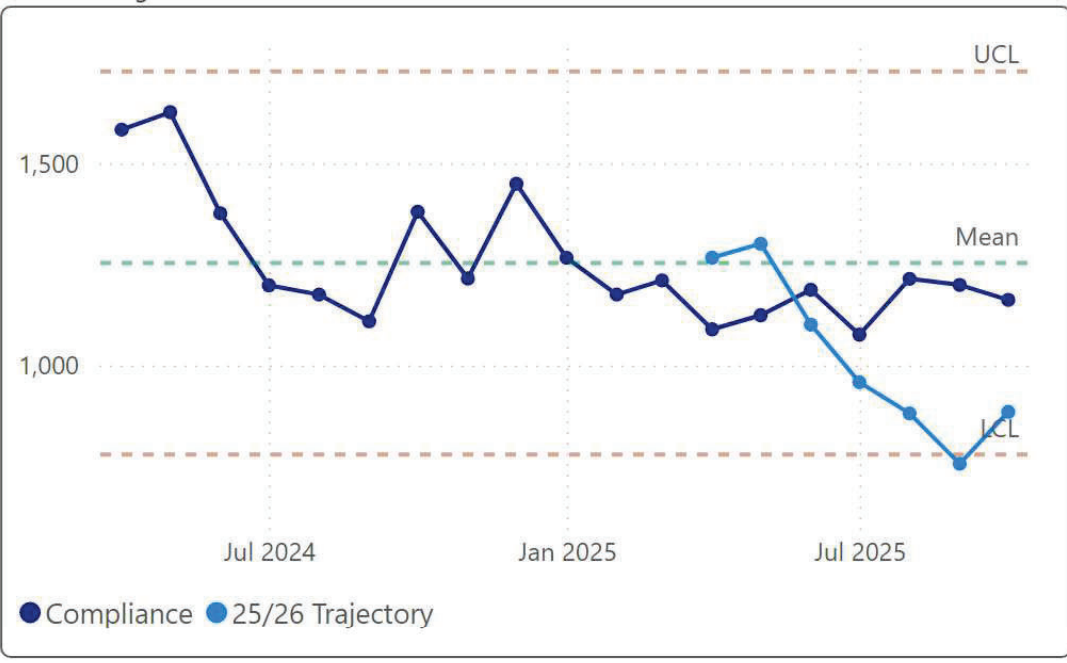
Section 2 Our Performance & System Change Delivery

Our Performance & System Change Delivery

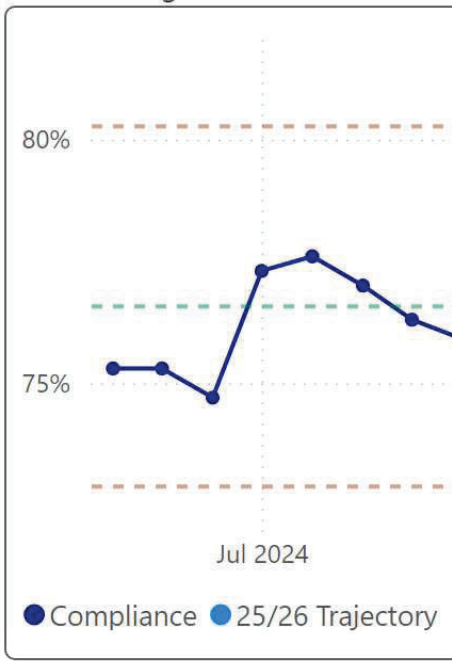
Improving our Urgent & emergency care system focusing on experience, access and

Measure: Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero
 Performance: 1162 (October 2025)
 Trajectory: 937 (Q3)
 National target: 0

Ministerial Delivery



Measure: Increase and maintain national target of <4 hours in ED/MIU
 Performance: 76.8% (October 2025)
 Trajectory: 78.4% (Q3)
 National target: 95.0%



Insight and Actions

- 12hr EDMIU and 4hr compliance: Patient spending more than 12hrs across our ED and MIUs remains higher than anticipated. In our overall profile there has been an improvement in 12hr compliance. At GUH ED performance through 25/26 has broadly been at a high level, in October reaching 85.8%, the second highest since July 2025 at 86.31%. The same is largely true when looking at 12hr compliance in our MIUs, with July performance of 93.8% (the highest since the opening of GUH) and October at 92.9%. Additionally, when undertaking system changes to reduce hours patients spend above and beyond 12hrs in the department, there has been a significant reduction through 25/26. The number of hours above the 12hrs was 15.2; this had reduced to 8.7hrs in September. 4hr EDMIU performance has been close to the mean, with a high of 79.1% in July, with Q2 performance meeting trajectory of 76.7%.

Our Performance & System Change Delivery

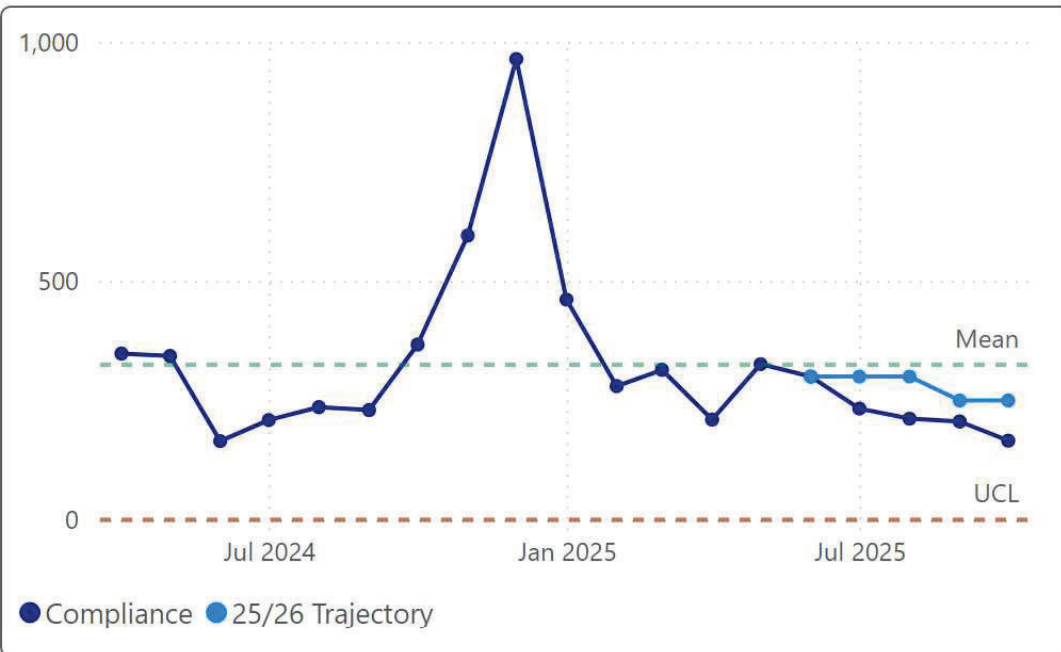
Improving our Urgent & emergency care system focusing on experience, access and

Measure: Reduction in time from arrival to ED triage - no waits over 60 minutes

Performance: 166 (October 2025)

Trajectory: 250 (Q3)

National target: None



Measure: Median time from arrival at clinical decision maker should not ex

Performance: 134 (October 2025)

Trajectory: 90 (Q3)

National target: 60



Insight and Actions

- Triage: Triage performance is ahead of trajectory, with waits over 60 minutes continuing to reduce through the course of 25/26.
- Wait to be seen (WTBS): Clinician median wait has remained broadly static through the course of 25/26 to date. There has been improvement since the launch of Our Next Patient, with median, daily performance regularly under 90 min. This however is balanced with overnight performance which can often deteriorate. There remains significant Divisional focus and an action plan in place to meet the demand and ensure that patients are seen in a timely fashion.

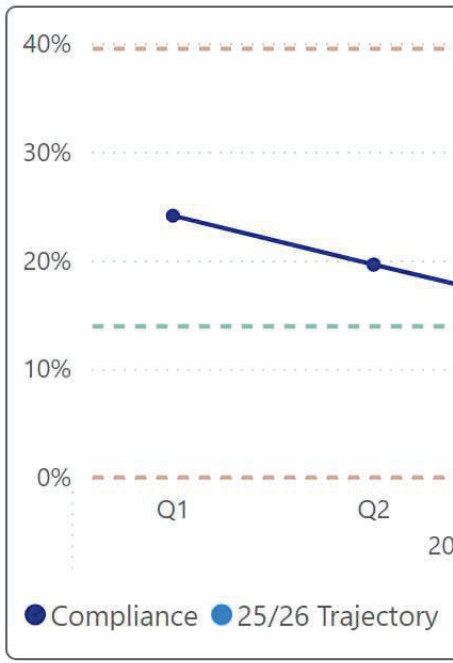
Our Performance & System Change Delivery

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

Measure: Maintain the number of Urgent Primary Care contacts (inc. virtual)
 Performance: 55895 (October 2025)
 Trajectory: 68488 (Q3)
 National target: None



Measure: % of patients directly admitted
 Performance: 3.8% (Q1)
 Trajectory: 20.0% (Q1)
 National target: 50.0%



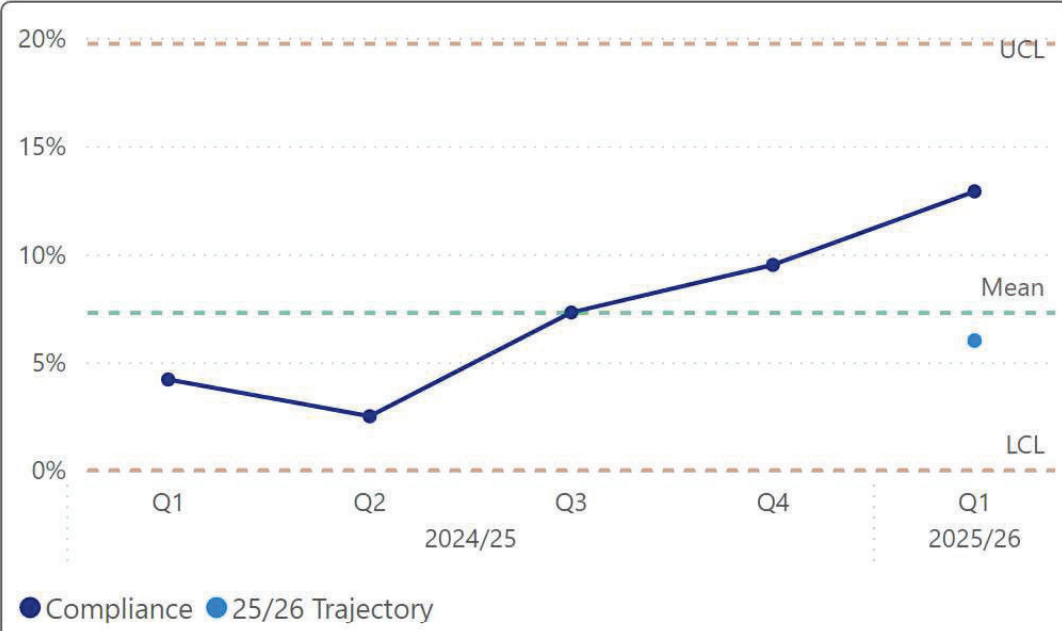
Insight and Actions

- Urgent Primary Care (UPC): UPC contacts exceeded the Q2 trajectory by ~4,500 and are on track to meet the Q3 target. The year to date are ~12,000 contacts more than in the first half, reflecting the additional activity the service is expected to pick up in the second half.
- Stroke 4hr target: Q1 25/26 SSNAP data released showing further decrease in performance in direct admission to acute stroke. Q1. If a patient goes to the Acute Medical Unit at GUH first before going onto the Stroke Ward within four hours, the SSNAP performance target due to not being a direct admission. Therefore this operational distinction will therefore limit the ability to meet the target.

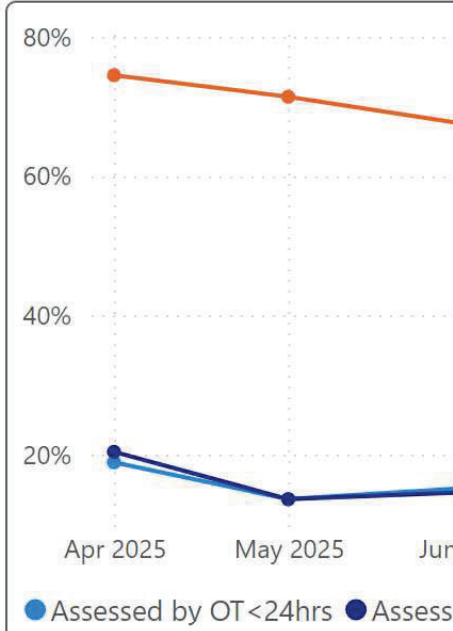
Our Performance & System Change Delivery

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

Measure: % of unique stroke patients given thrombectomy (all stroke types)
 Performance: 12.9% (Q1)
 Trajectory: 6.0% (Q1)
 National target: 10.0%



Measure: % Assessed by one of OT, PT and SaLT within 24hrs
 Assessed by OT <24hrs: 28.3% (Sep)
 Assessed by PT <24hrs: 27.9% (Sep)
 Assessed by SaLT <72hrs: 61% (Sep)



Insight and Actions

- Stroke thrombectomy: Again taken from the latest SSNAP data, thrombectomy rates improved in Q1 to 12.9% and well
- Stroke therapies: The IMTP measure is assessment by one of OT, PT and SaLT within 24hrs, however the national meas and PT within 24hrs and assessment by SaLT within 72hrs. To align with this way of reporting, all three measures are now performance sourced from the new national stroke dashboard. OT and PT performance improved through Q2, however s

Our Performance & System Change Delivery

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

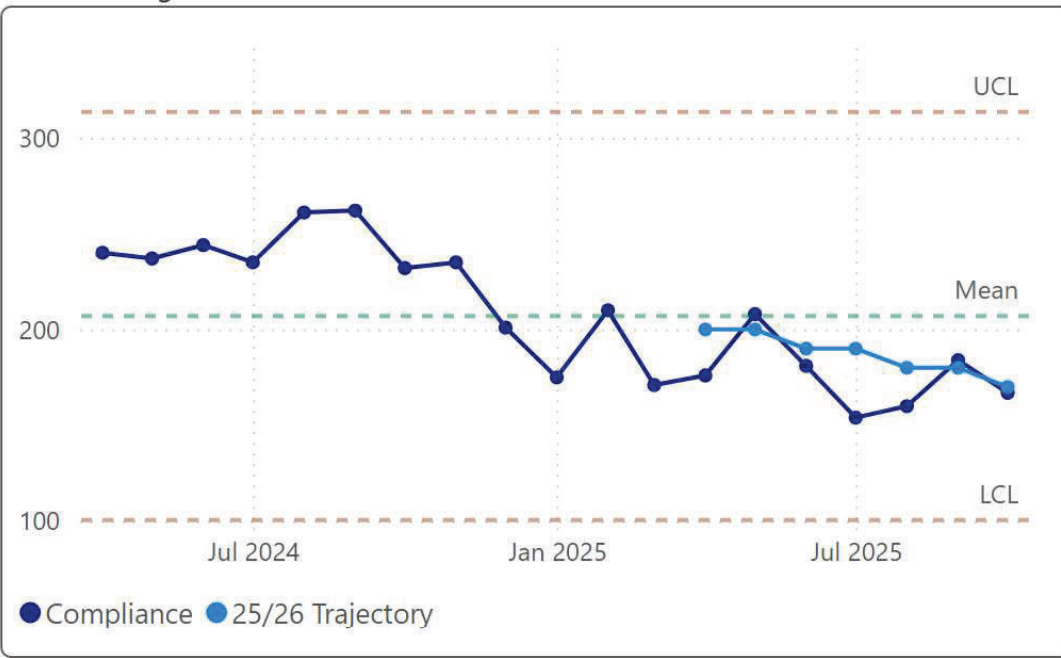
Measure: Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard

Performance: 167 (October 2025)

Trajectory: 160 (Q3)

National target: None

Ministerial Delivery

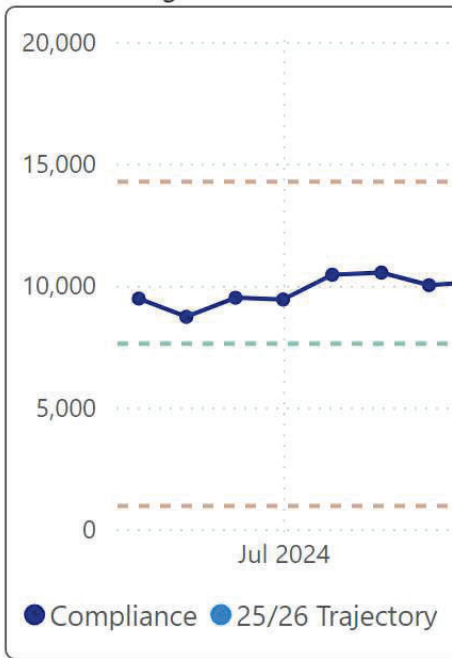


Measure: Deliver a 12-month reduction in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard

Performance: 5188 (October 2025)

Trajectory: 7184 (Q3)

National target: None



Insight and Actions

- Pathway of Care Delays (POCDs): POCDs by volume are marginally above trajectory as of October but the broader improvement in total days associated with delays has entered a period of relative stability and remains greatly reduced from the number of days associated with delays prior to the discharge pilot. The optimal hospital flow pilot is underway on three wards at GUH, supporting efforts to improve patient flow. The pilot is aligned with the 45-minute handover protocol. To address delays, a weekly scrutiny panel now reviews the top 20 longest discharges. A discharge policy ahead of winter to ensure timely discharge. Weekly length-of-stay meetings are being held across both GUH and St George's, with a focus on assessing the next steps from the POCD data to further support timely patient discharge.

Our Performance & System Change Delivery

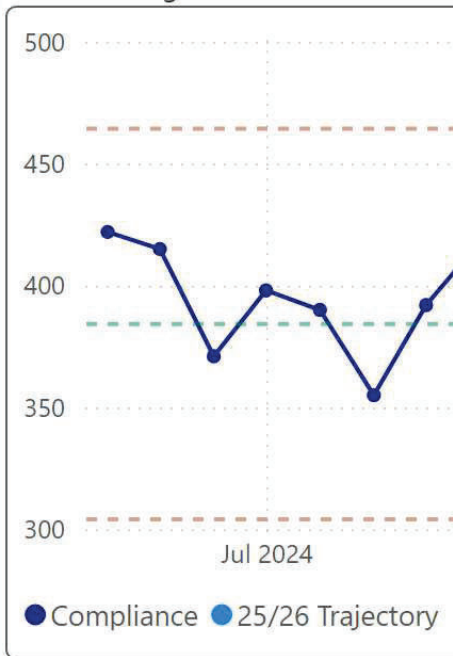
Improving our Urgent & emergency care system focusing on experience, access and

Measure: Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment
 Performance: 22 (October 2025)
 Trajectory: 14 (Q3)
 National target: None

Organisational Escalation



Measure: Continuous reduction in t who remain in hospital over 21 day
 Performance: 377 (September 2025)
 Trajectory: 390 (Q2)
 National target: None



Insight and Actions

- POCD subset: The POCD subset measure, which is a condition of UEC enhanced monitoring status, is above trajectory h September. This was driven by an increase in delays associated with awaiting assessment of AHPs (20) and nursing (16), respectively, and ongoing reviews of these delays have formed actions as part of the ONP initiative.

- 21 day Length of Stay: another measure as part of UEC enhanced monitoring status, performance is tracking below traj reduction trend over the past 18 months. This measure is another relevant to the ongoing work of the longest staying pa

Theme	Delivery Expectation
<p>Continuing to prioritise cancer, urgent and the longest waiting patients for planned care</p>	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion
	Reduction in backlog of patients waiting over 62 days (SCP)
	Reduction in backlog of patients waiting over 104 days (SCP)
	Increase in rate of cancer diagnosis or discharges within 28 days
	Numbers of patients waiting over 104 weeks (all stages)
	Number of patients waiting over 52 weeks for Outpatients
	Reduction in the number of patients waiting 100% past Outpatient follow-up target date
	Increase in the rate of See On Symptom and Patient Initiated Follow-ups
	Monitoring DNA/CNA for every Outpatient clinic. When DNA >5%, overbooking to be implemented & monitored and reduction of CNA

Ministerial Delivery Expectations

Theme	Delivery Expectation
<p>Continuing to prioritise cancer, urgent and the longest waiting patients for planned care</p>	Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic
	Number of adults waiting more than 14 weeks for all audiology pathways
	Number of children waiting more than 6 weeks for all audiology pathways
	No patient waiting more than 14 weeks for a therapeutic assessment
	On 90% of days planned care inpatient/daycase/theatre recovery capacity should be protected from pressures and outliers
	Theatre Utilisation late starts to less than 20%
	Theatre Utilisation early finishes to less than 10%
	Theatre Utilisation session utilisation to 85%
	Deliver improvements in day surgery rates, achieving a BADS daycase rate

Our Performance & System Change Delivery

Continuing to prioritise cancer, urgent and the longest waiting patients for p

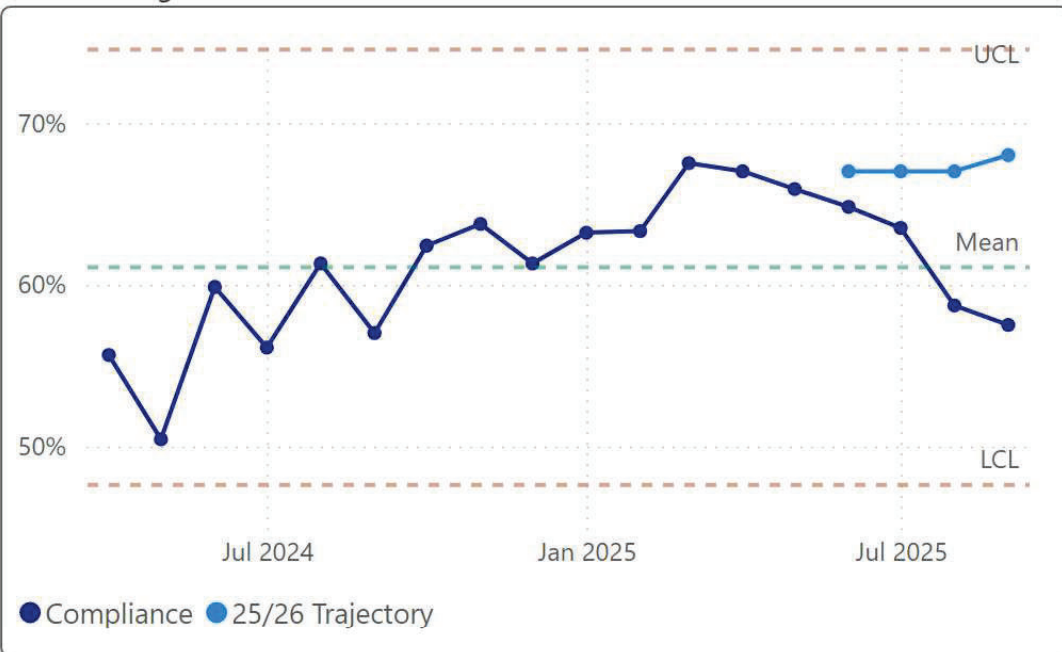
Measure: 12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion

Performance: 57.5% (September 2025)

Trajectory: 68.0% (Q2)

National target: 80.0%

Ministerial Delivery



Measure: Reduction in backlog of p

Performance: 380 (September 2025)

Trajectory: 240 (Q2)

National target: None



Insight and Actions

- SCP compliance: Performance has decreased through 25/26, with September performance at 57.5% which is the lowest since 2023. Challenges over the summer months with annual leave, the number of SCP treatments within 62 days in Q1 was 692 and in Q2 was 704. There was a small decrease in the volume of first outpatient appointments in August, but the median days to treatment was reduced over the quarter (42 day in July to 27 in September). A refocussing on forensic pathway management as well as ensuring that compliance improves again in the second part of the year.

- 62 day backlog: The target for the 62 day backlog is to be ~10% of the SCP Census, which has increased through 25/26. The backlog was reduced slightly through to September but a backlog of 380 represents 10.9% of the total PTL.

Our Performance & System Change Delivery

Continuing to prioritise cancer, urgent and the longest waiting patients for p

Measure: Reduction in backlog of patients waiting over 104 days (SCP)

Performance: 90 (September 2025)

Trajectory: 60 (Q2)

National target: None

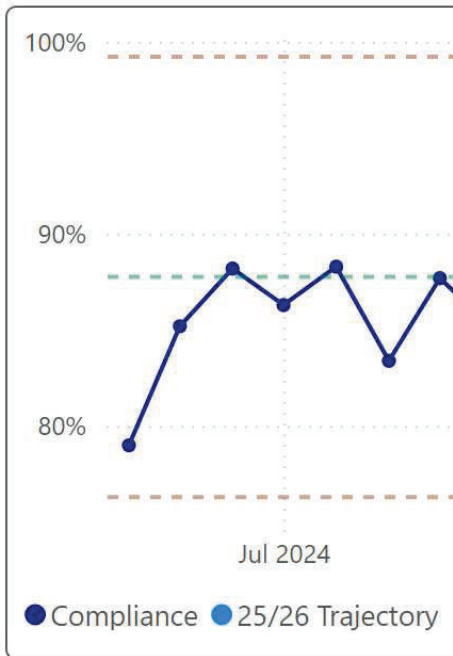


Measure: Increase in rate of cancer

Performance: 89.1% (September 2025)

Trajectory: 75.0% (Q2)

National target: None



Insight and Actions

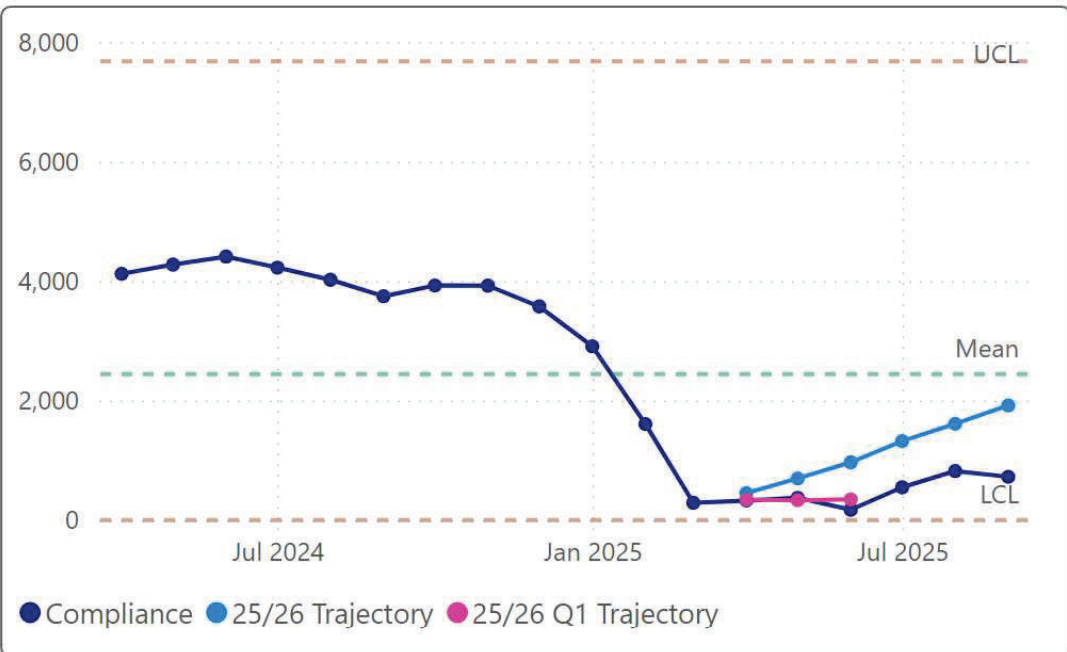
- 104 day backlog: This has reduced through Q2 and is broadly tracking against the IMTP trajectory albeit at a higher level in the context of the total PTL.
- 28 day decision to treat (DTT): Whilst rates decreased slightly through Q2, it was only a marginal deterioration and performance has been broadly stable since February 2025.

Our Performance & System Change Delivery

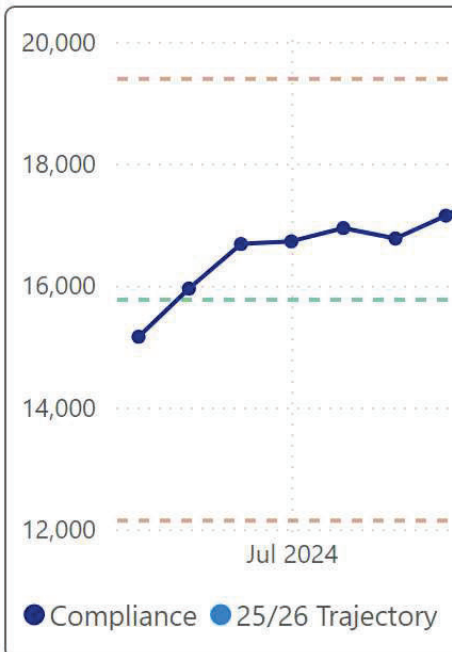
Continuing to prioritise cancer, urgent and the longest waiting patients for p

Measure: Numbers of patients waiting over 104 weeks (all stages)
 Performance: 723 (September 2025)
 Trajectory: 1917 (Q2)
 National target: 0

Ministerial Delivery



Measure: Number of patients waiting
 Performance: 13061 (September 2025)
 Trajectory: 17802 (Q2)
 National target: 0



Insight and Actions

- 104 weeks RTT: Following the Q1 funding, 104 week performance had been tracking against the IMTP trajectory with regard to volume. Positive deviation occurred in September, driven by internally funded WLIs and backfill in Orthopaedics as well as the programme in ENT. Current, internal forecast, on the basis recent funding for Q3 and factoring in implications of the 26 week profile of up to 600 with further review ongoing. Once there is a clarity on plans through to the end of the year, a Q3-Q4 trajectory forward.
- 52 week new Outpatient: The 26 week OP programme is now beginning to significantly impact on the 52 week breach profile in the September RTT submissions. The 26 week programme is volume based and there has been no request from WG to reprofile for the year, although clearly there should be significant, further reductions as the Health Board works towards the national target of 0 by the end of November, the Health Board was delivering in line with its plans for the 26 week programme (activity was 108.2% delivered)

Section 2 Our Performance & System Change Delivery

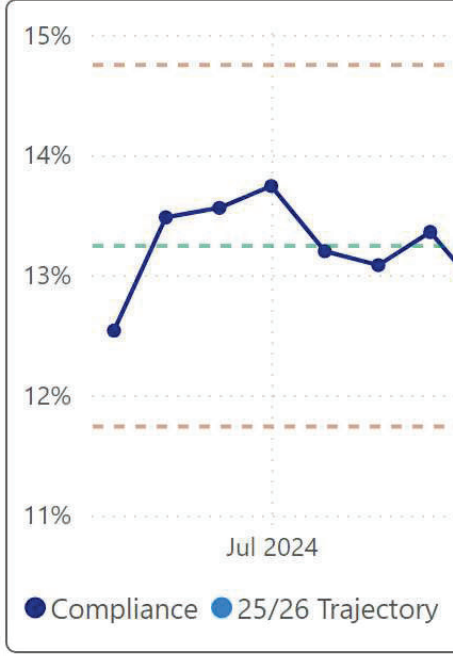
Our Performance & System Change Delivery

Continuing to prioritise cancer, urgent and the longest waiting patients for p

Measure: Reduction in the number of patients waiting 100% past Outpatient follow-up target date
 Performance: 30774 (September 2025)
 Trajectory: 30250 (Q2)
 National target: None



Measure: Increase in the rate of See
 Performance: 12.7% (September 20
 Trajectory: 12.0% (Q2)
 National target: None



Insight and Actions

- 100% past Follow Up Target Date: Follow-Up Waiting Lists (FUWL) have seen significant growth since 2020/21, however the 2025/26, with 30,774 patients past the 100% target as of Q2, 80 higher than the 2024/25 year end position. The Outpatient T waiters and supporting clerical validation, with a focus on those way in excess of 100% past target. A pilot is being developed patients to SOS/PIFU pathways, aligning with CIN protocols.
- SOS/PIFU: Implementation is tracked via outpatient appointment outcomes. Q2 started strongly at 14.5%, closing at 12.8%. date, from a 24/25 baseline of 18.1%. Significant work underway within the Division of Surgery in this area, including validation to identify patients who can be moved to SOS/PIFU retrospectively. The longest delayed follow up patients are reviewed on ro patients being discharged or added to SOS or PIFU list retrospectively where appropriate; pilot of Consultant Connect to supp measurement of activity and outcomes. Most CIN pathways are in place, with further work in ophthalmology under way.

Section 2 Our Performance & System Change Delivery

Our Performance & System Change Delivery

Continuing to prioritise cancer, urgent and the longest waiting patients for p

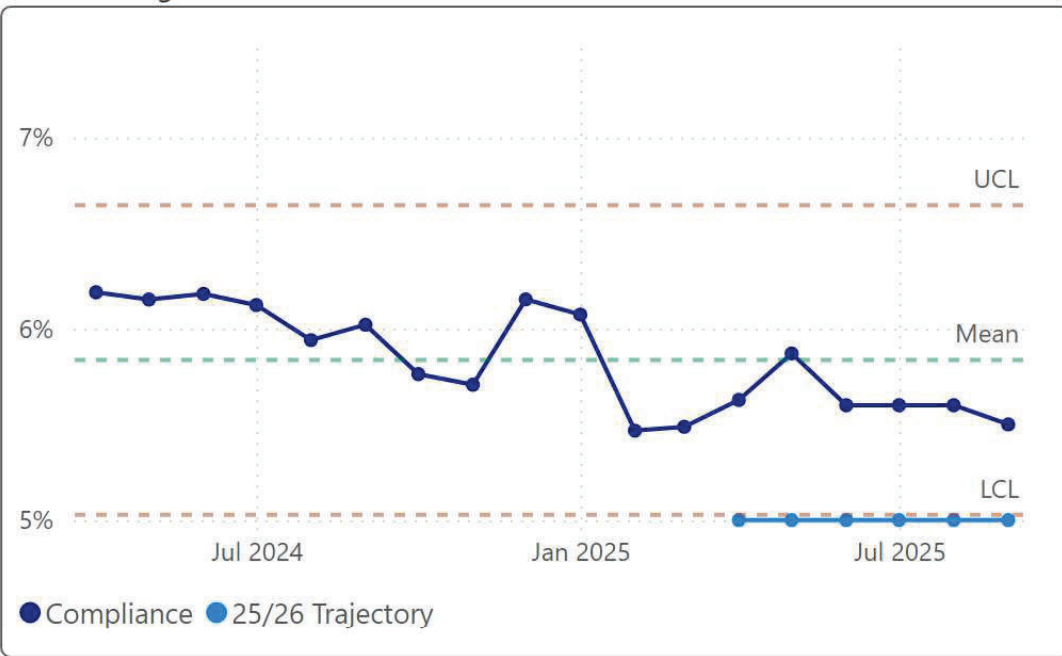
Measure: Monitoring DNA/CNA for every Outpatient clinic. When DNA >5%, overbooking to be implemented & monitored and reduction of CNA

Performance: 5.5% (September 2025)

Trajectory: 5.0% (Q2)

National target: 5.0%

Enabling Action



Measure: Reduction in the number specific diagnostic

Performance: 1808 (September 2025)

Trajectory: 1077 (Q2)

National target: 0



Insight and Actions

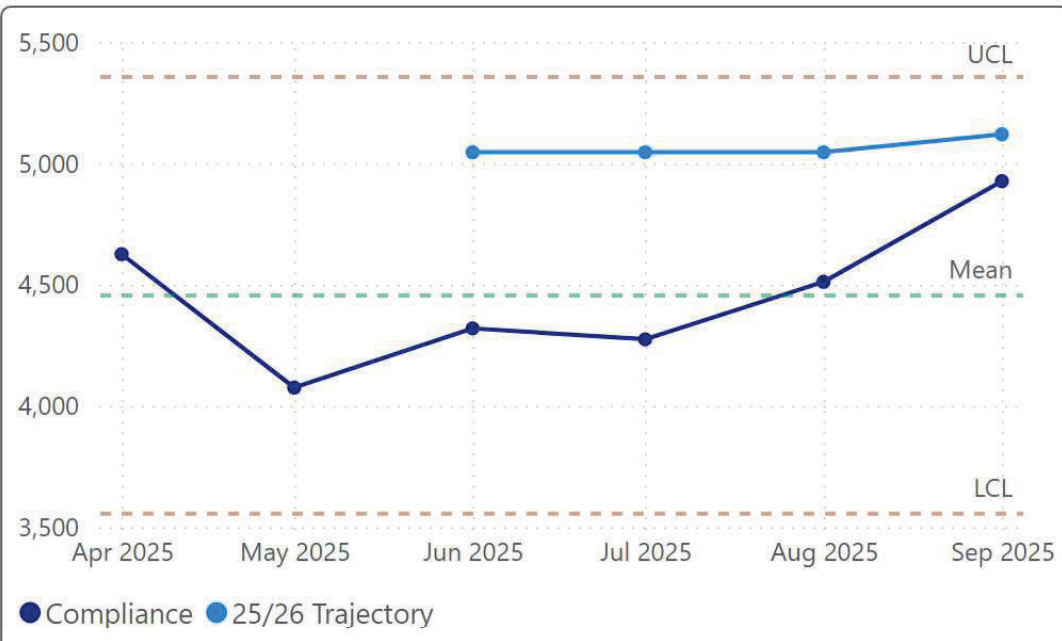
- DNA/CNA rates: DNA rates dropped to 5.5% in Q2 2025/26, the lowest since February 2025. As there remains variation across rate areas, and pilots are exploring overbooking and targeted validation of frequent non-attenders.

- Diagnostics: 8 week diagnostic breaches increased over the summer which was largely due to a lack of capacity to meet demand. Division developed an action plan and breach number have begun to decrease with further reductions expected in October period as a result of the 26 week OP programme are beginning to have a material impact, with the Health Board having to submit additionality that this programme is having.

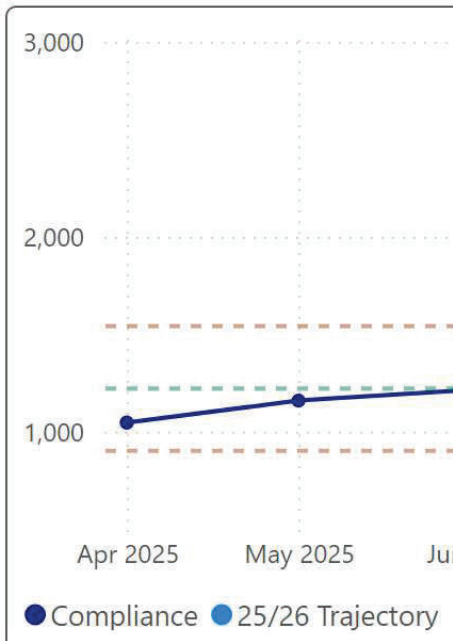
Our Performance & System Change Delivery

Continuing to prioritise cancer, urgent and the longest waiting patients for p

Measure: Number of adults waiting more than 14 weeks for all audiology pathways
 Performance: 4926 (September 2025)
 Trajectory: 5119 (Q2)
 National target: None



Measure: Number of children waiting more than 14 weeks for all audiology pathways
 Performance: 1318 (September 2025)
 Trajectory: 2501 (Q2)
 National target: None



Insight and Actions

- Audiology: Having been relatively stable through the first four months of 25/26, 14 week breaches for adult audiology pathways have increased, meaning that the gap to the IMTP has significantly reduced as of the Q2 position although it does remain below the forecast level. The number of children waiting is increasing although at a much slower rate than forecast in the IMTP trajectory.

Our Performance & System Change Delivery

Continuing to prioritise cancer, urgent and the longest waiting patients for p

Measure: No patient waiting more than 14 weeks for a therapeutic assessment

Performance: 115 (September 2025)

Trajectory: 140 (Q2)

National target: 0



Measure: On 90% of days planned

should be protected from pressures

Performance: 96.4% (September 2025)

Trajectory: 90.0% (Q2)

National target: 90.0%



Insight and Actions

- Therapies: July breaches saw a sharp increase to 204 patients, primarily driven by longer waits for Physiotherapy, which in turn led to a substantial increase in spinal and knee backlog referrals. These referrals were forwarded to the Physiotherapy waiting list following T&O. The breach position was reduced through the next two months and as of Q2 is now 115, below the IMTP trajectory of 140.
- Elective theatre protection: Performance has remained compliant with this measure for the past 18 months. As highlighted, this is a key advantage of the unique system in Gwent. The NHS P&I definition of this measure is based on the number of individual operations carried out on elective lists. However, the Health Board is currently awaiting a final, validated position on the national Enabling approach.

Our Performance & System Change Delivery

Continuing to prioritise cancer, urgent and the longest waiting patients for p

Measure: Theatre Utilisation late starts to less than 20%
 Performance: 40.4% (September 2025)
 Trajectory: 35.0% (Q2)
 National target: 20.0%

Enabling Action



Measure: Theatre Utilisation early finishes
 Performance: 45.3% (September 2025)
 Trajectory: 37.0% (Q2)
 National target: 10.0%



Insight and Actions

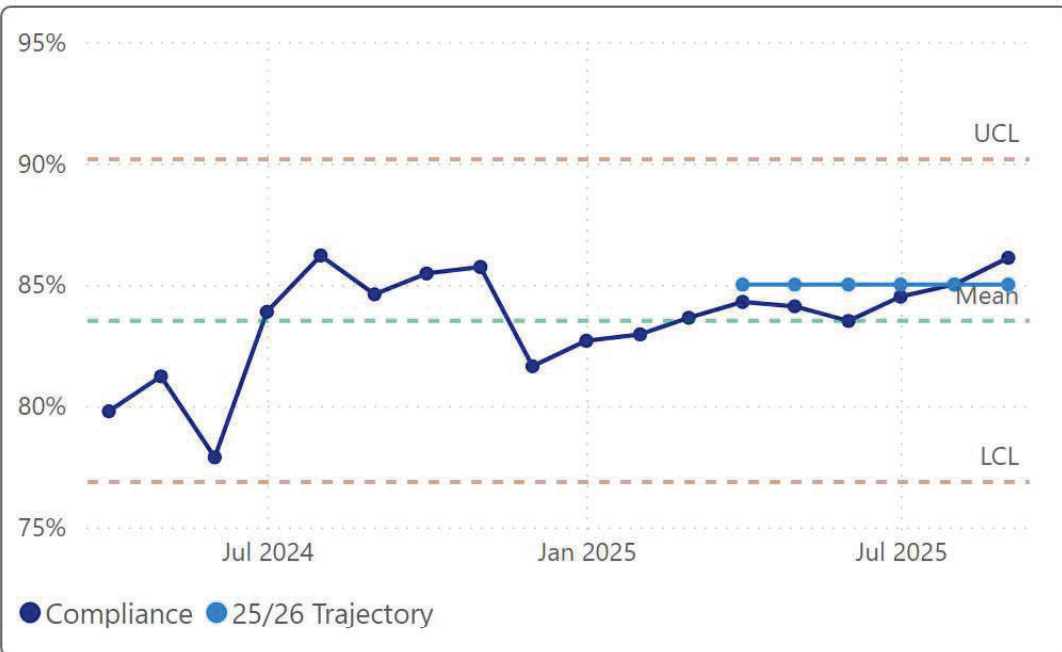
- Theatres late starts & early finishes: Late starts performance has deteriorated slightly through the first part of 25/26, w planned improvement as set out in the IMTP of 35%. Early finishes performance has been relatively static through 25/26, not met the IMTP trajectory of 37%. The Theatres Utilisation Group (TUG) will be focussed on closer analysis of the unde level, to identify improvements that can be made through the second half of the year. The autosend and golden patient results for improving late starts and theatre efficiency at RGH, with YYF and GUH now implementing; analysis will be un

Our Performance & System Change Delivery

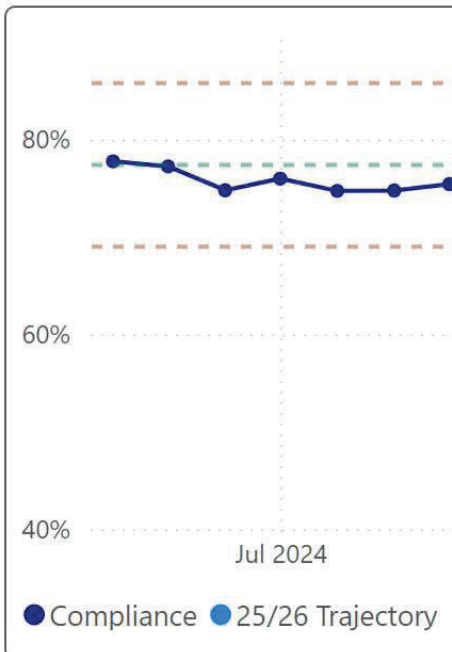
Continuing to prioritise cancer, urgent and the longest waiting patients for p

Measure: Theatre Utilisation session utilisation to 85%
 Performance: 86.1% (September 2025)
 Trajectory: 85.0% (Q2)
 National target: 85.0%

Enabling Action



Measure: Deliver improvements in
 Performance: 76.5% (August 2025)
 Trajectory: 50.0% (Q2)
 National target: 80.0%



Insight and Actions

- Session utilisation: Performance has been relatively close to the national standard of 85% over the course of the past 1 improvement through the first half of 25/26 with Q2 performance reaching 86.1% and meeting the IMTP trajectory.
- British Association of Day Surgery (BADs) rates: BADs rates exceeded the national ambition of 80%, reaching 82.9% in June. activity in NHH. Rates decreased slightly in Jul and Aug (78.7% and 76.5%), however a lag on the coding can sometimes mean

Improving our Mental health services: Performance Summary

Theme	Delivery Expectation
Improving our Mental health services	Maintain Adults Part 1a to national target (assessment completed within 28 days)
	Maintain Adults Part 1b to national target (interventions completed within 28 days)
	Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan)
	Maintain rate of psychological therapy received within 26 weeks
	Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)
	Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)
	Maintain CAMHS Part 2 national target compliance
	Improvement in Neurodevelopment waiting times compliance
	Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral

Our Performance & System Change Delivery

Improving our Mental health services

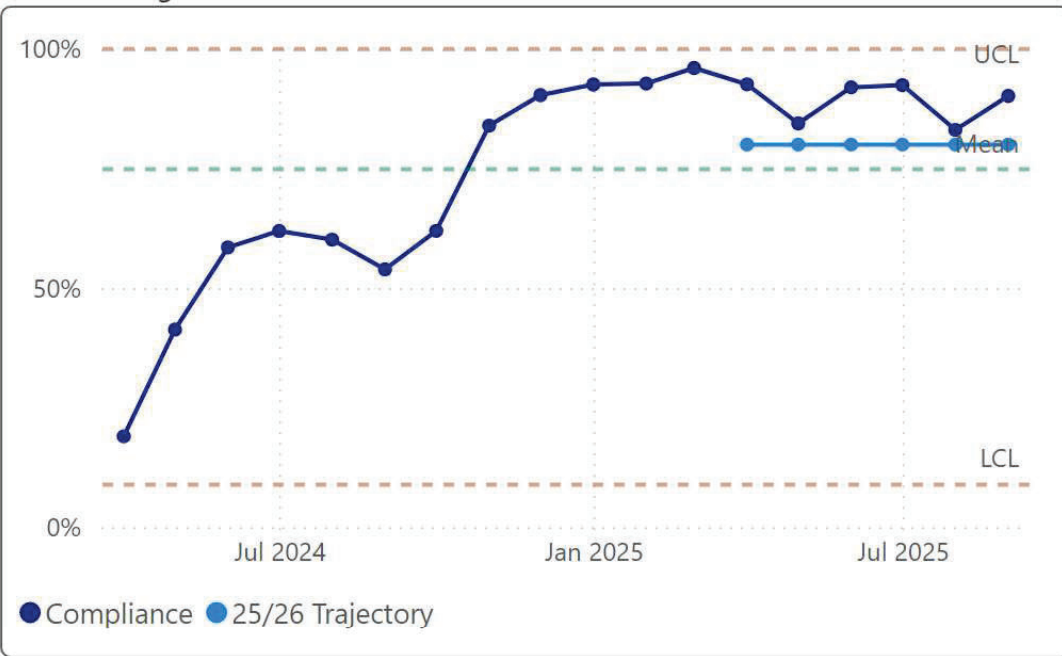
Measure: Maintain Adults Part 1a to national target (assessment completed within 28 days)

Performance: 90.2% (September 2025)

Trajectory: 80.0% (Q2)

National target: 80.0%

Ministerial Delivery

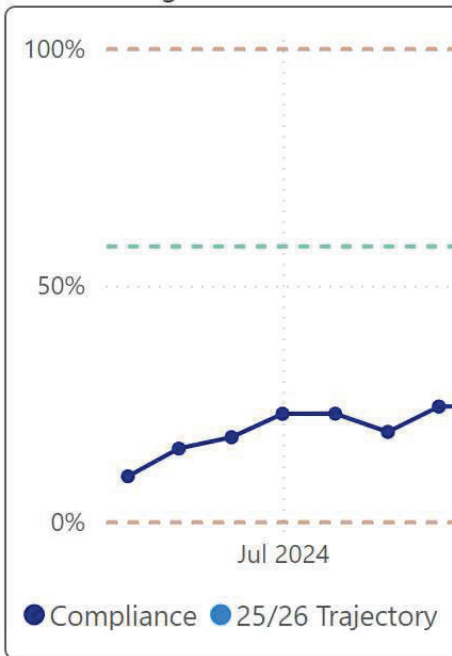


Measure: Maintain Adults Part 1b to national target (assessment completed within 28 days)

Performance: 90.3% (September 2025)

Trajectory: 80.0% (Q2)

National target: 80.0%



Insight and Actions

- Adults 1a & 1b: There are no issues with performance for these measures, with the service managing to balance both compliance with the national standard.

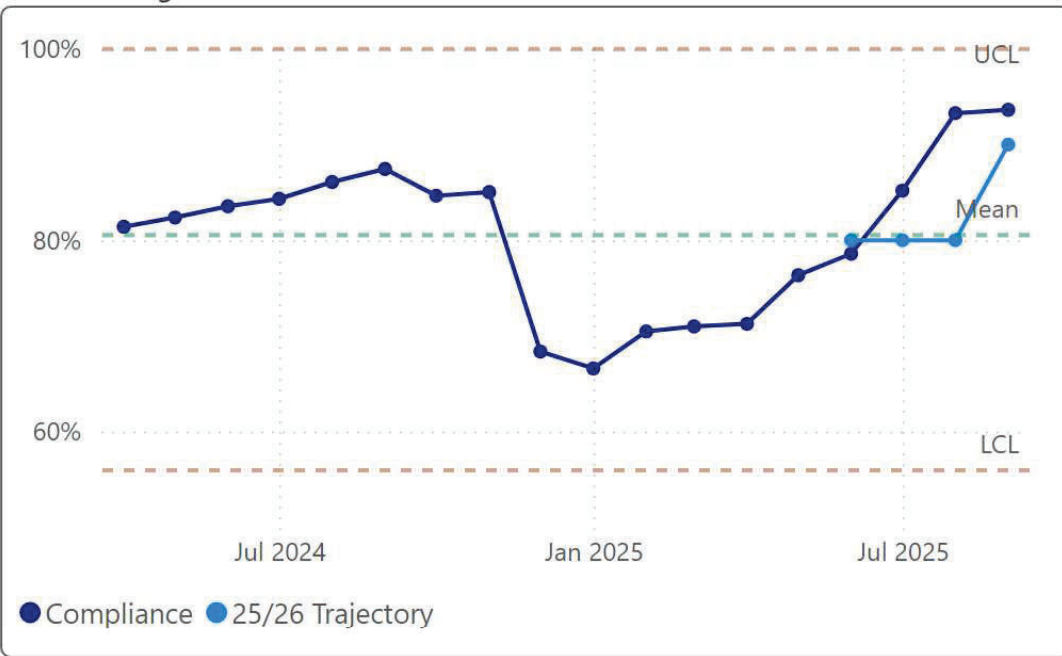
Improving our Mental health services

Measure: Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan)

Performance: 93.6% (September 2025)

Trajectory: 90.0% (Q2)

National target: 90.0%

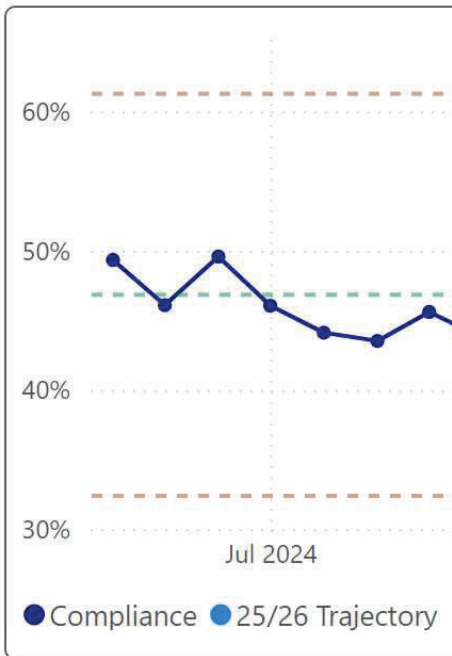


Measure: Maintain rate of psychological therapies

Performance: 54.0% (September 2025)

Trajectory: 60.0% (Q2)

National target: 80.0%



Insight and Actions

- Adults Part 2: Performance improved further in September, reaching 93.6% and achieving the national standard ahead of the trajectory. Work continues to address issues related to clinical use of the dashboard by staff, particularly around documentation. Engage staff to ensure care plan documentation is shared when they are responsible for completing it. Data cleansing remains in progress, however, the number of Care Plans (CTPs) and discharges from CTPs is expected to stabilise.

- Psychological Therapies: Whilst falling short of Q2 IMTP trajectory, performance has been stable over the past four months. A dedicated improvement session was held in August, focusing on key actions to drive progress. All dashboards are now in place and updated on a daily basis, although a significant number of incorrect pathways remain. Additional measures include resetting clocks where appropriate, implementing escalation processes for long waiters, and mapping administrative processes to identify opportunities for centralisation. We will finalise waiting list groupings and improve pathway flow and performance.

Our Performance & System Change Delivery

Improving our Mental health services

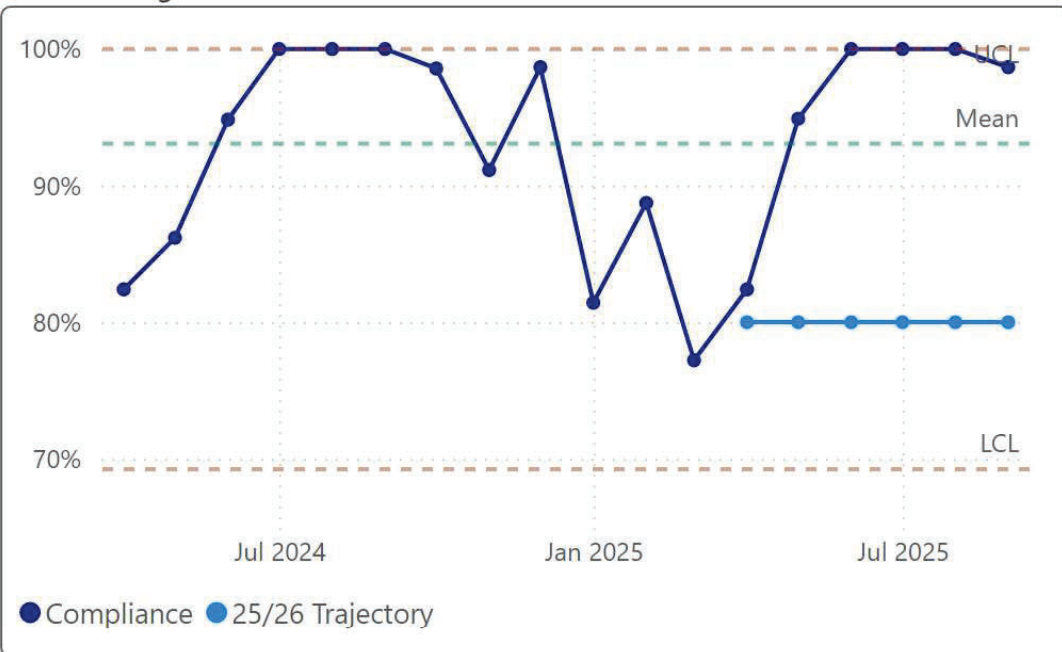
Measure: Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)

Performance: 98.7% (September 2025)

Trajectory: 80.0% (Q2)

National target: 80.0%

Ministerial Delivery

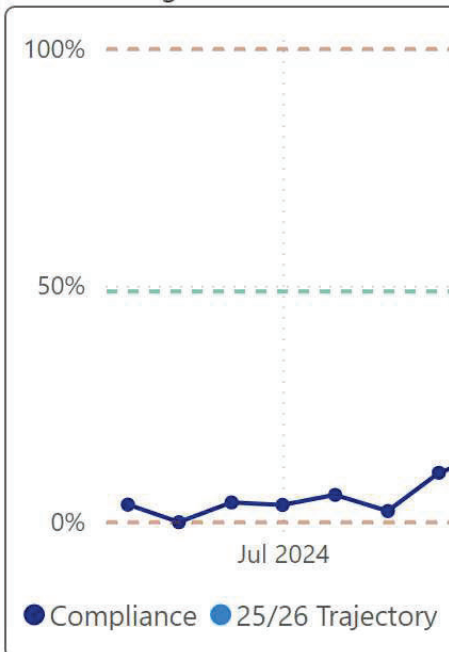


Measure: Maintain CAMHS Part 1b completed within 28 days)

Performance: 80.0% (September 2025)

Trajectory: 80.0% (Q2)

National target: 80.0%



Insight and Actions

- CAMHS 1a & 1b: Like with Adults there are no issues with performance for these measures, with the service managing ensure continued compliance with the national standard.

Our Performance & System Change Delivery

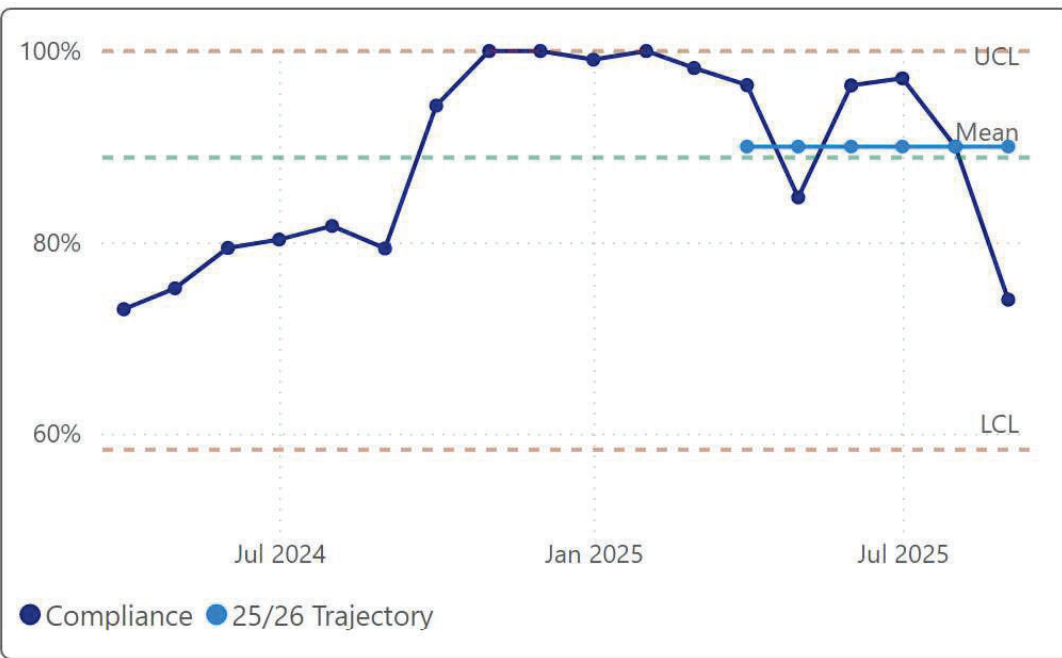
Improving our Mental health services

Measure: Maintain CAMHS Part 2 national target compliance

Performance: 74.0% (September 2025)

Trajectory: 90.0% (Q2)

National target: 90.0%

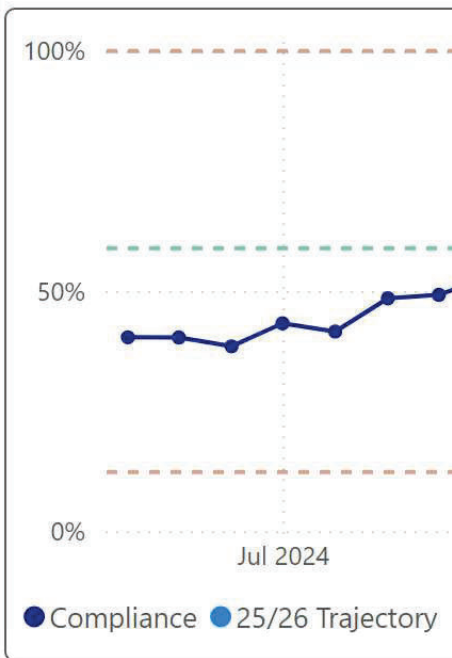


Measure: Improvement in Neurode

Performance: 60.0% (September 2025)

Trajectory: 75.0% (Q2)

National target: 80.0%

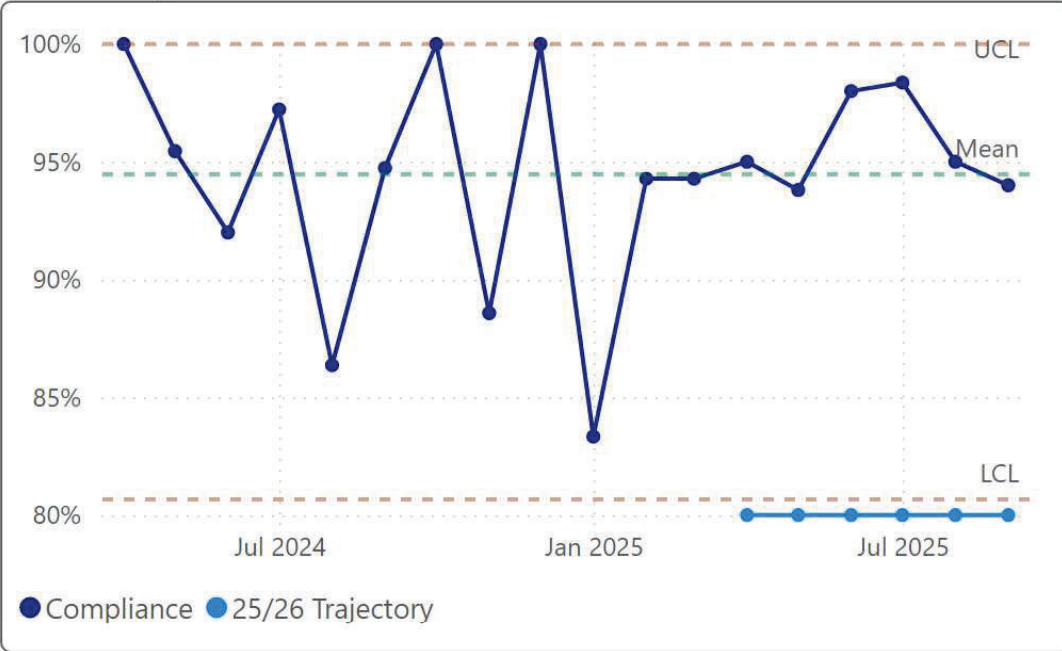


Insight and Actions

- CAMHS Part 2: Care and Treatment Plan (CTP) compliance in CAMHS decreased significantly in September to 74% to persistent non-compliance with CTP processes, such as clinicians not uploading plans, entering incorrect dates, and missing training and reminders. There will be dedicated focus within the Division to remediate performance, with one potential dedicated Clinical CTP Lead to enforce governance, ensure compliance, and act as a liaison for validation and process over
- ND assessment: CAMHS ND service faces significant strain due to rising demand and reduced capacity, impacting ability to manage care. Legacy backlog is driving RTT performance down, with September performance decreasing to 60% against a Q2 IMTP trajectory. A large number of children waiting over 26 weeks. An action plan associated with a small amount of additional funding has been developed for a pilot cohort, accelerating progress toward the RTT recovery goal.

Improving our Mental health services

Measure: Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral
Performance: 94.0% (September 2025)
Trajectory: 80.0% (Q2)
National target: 80.0%



Insight and Actions

- Specialist CAMHS Choice Assessments: No issue, performance continues to tracking well above national standard of 80

The Health Board's People Plan, 2022 -2025, 'Putting People First', outlines the Workforce and strategy in relation to workforce improvement, capability, and expertise with a clear focus on engagement of our people. A Workforce & OD Performance Dashboard has also been aligned of the People Plan objectives capturing the performance indicators of delivery of that plan and Workforce MDS (24/25):

Reporting Period end of September 25

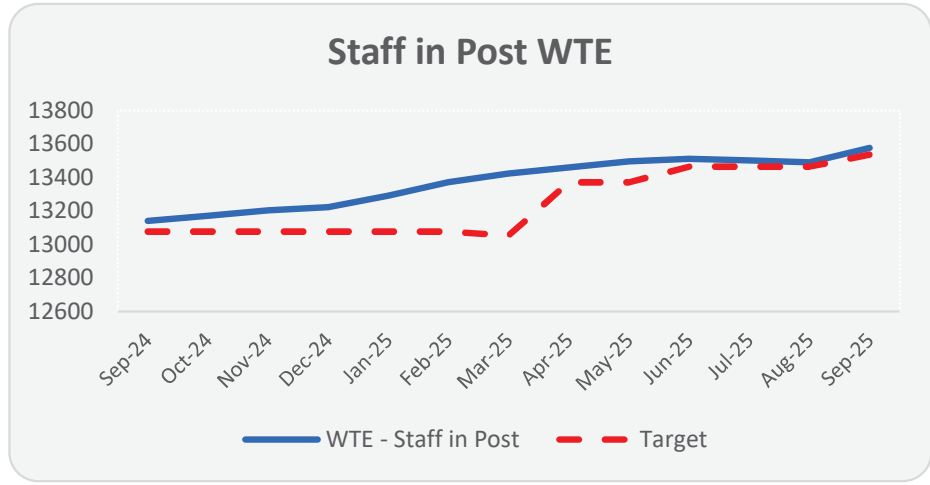
PUTTING PEOPLE FIRST

2022/25

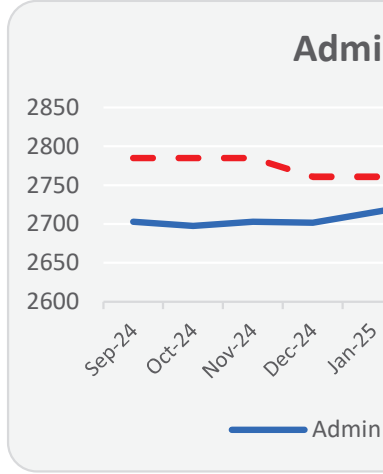
PEOPLE PLAN



Staff in Post



Administration Staff in Post



Performance Summary

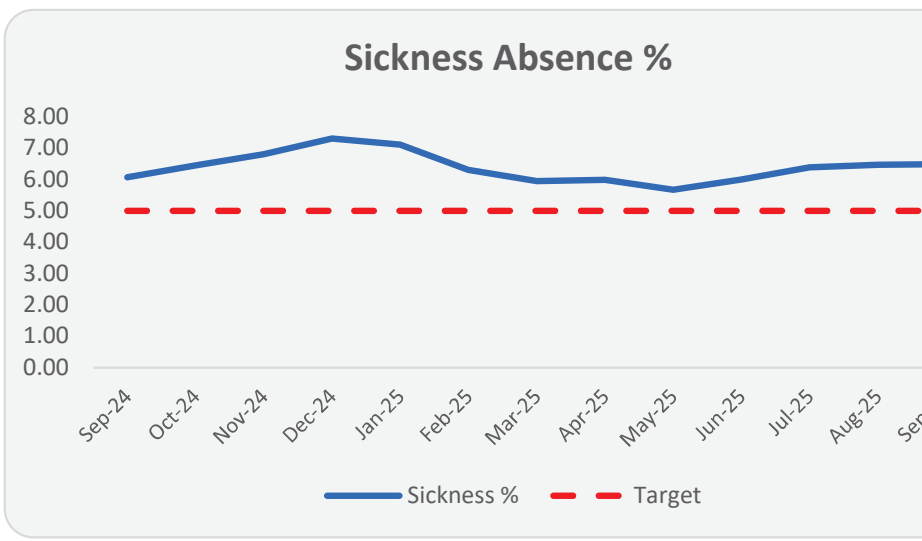
Staff in post is 13577 wte an increase of 75 wte since July 25. This is mostly attributed to:

- 39.7 wte increase in Nursing and Midwifery
- 15 wte Medical and Dental
- 12.1 wte Allied Health Professionals
- 8.7 wte in Administration and Clerical

Performance Summary

There has been an increase in administration staff due to the unplanned TUPE transfer into the organization in March 2025. Despite TUPE, the increase was not predicted. The increases have been supported by investment in new Digital and Technology.

Sickness Enabling Action



Performance Summary

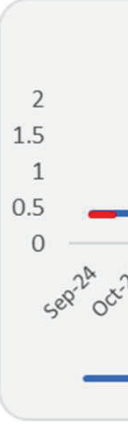
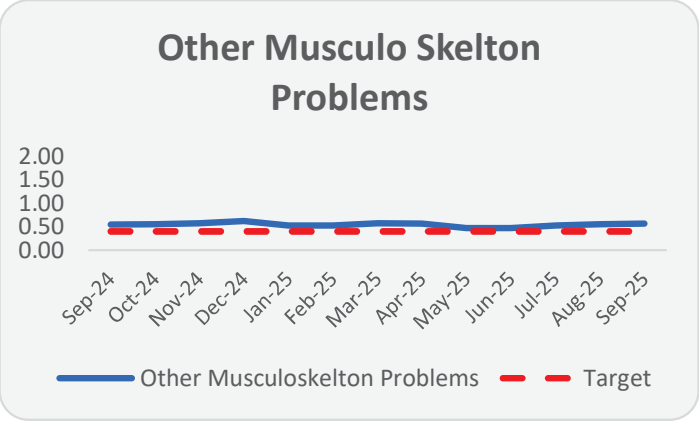
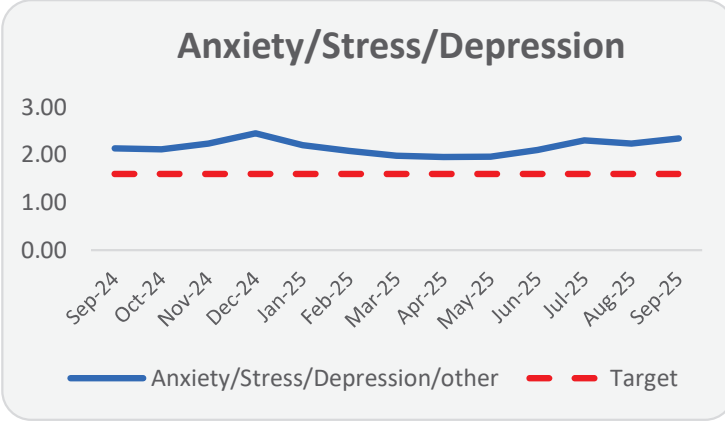
Sickness Absence has increased from the rate reported in July 25 was 6.38% (861 wte) to 6.48% (879 wte), some of which is still higher than the 6.06 wte sickness reported in the same reference period last year. Short term sickness has increased from 2.08 % to 2.22% and long term sickness (over 28 days) has remained the same at 4.22%. Target of 5% in Graph was set as part of the IMTP performance framework.

Key observations – highest sickness rates and changes in last quarter:

1. Additional Clinical services – 9.19%
2. Estates and Ancillary – 8.53% -reduction from 9.35%
3. Nursing and Midwifery 6.99% - an increase from 6.77%
4. Administration and Clerical 5.05% an increase from 4.32%

A 12-month project plan in development (in partnership with TUs), in conjunction with the actions of our People Plan (2024-2025) with the aim of supporting further reductions

Top Sickness Reasons Enabling Action



Performance Summary

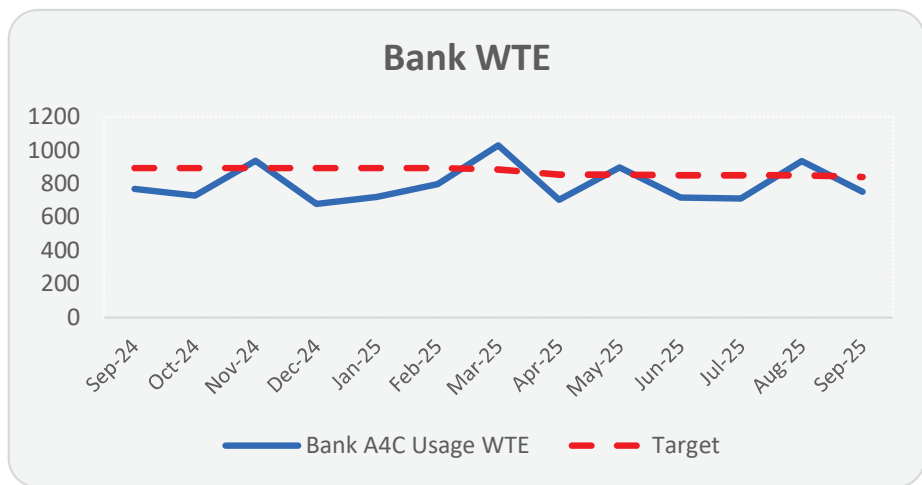
Anxiety/Stress/Depression remains the top reason for absence at 35.9% of overall sickness, contributing to 2.3% of all absence.

Musculoskeletal Problems 8.6% of overall sickness, an increase from 0.52% to 0.56 % of absence, above the target of 0.4%.

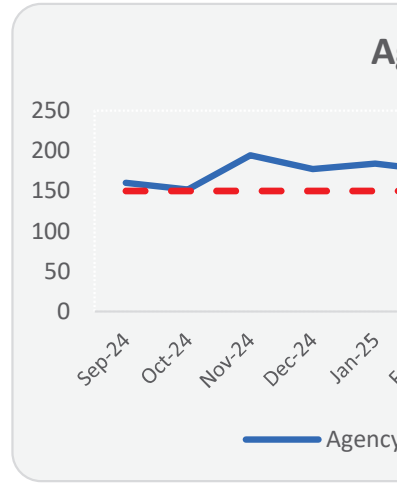
Gastrointestinal Problems 7.6% of overall absence. remained at 0.5%, above the target of 0.4%.

The Health and Wellbeing Service continues to increase the support options available for staff including psychological therapy tools. In addition, our “Wellbeing Matters” Programme provides advice and support to those suffering with physical conditions. We have also introduced an Employee Assistance Programme to support access to wellbeing support, which has reduced waiting times.

Variable Pay Bank Enabling Action



Variable Pay Agency Enabling Action



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

In July bank usage increased from 711.4 wte to 750.3 wte comparable with this reporting last year.

In September 25 the three highest users were HCSW 393.59 wte (52%), Nursing & Midwifery 246.14 wte (33%) and Facilities 76.66 wte (10%). Highest reason for usage is vacancies at 269.31 wte (36%)

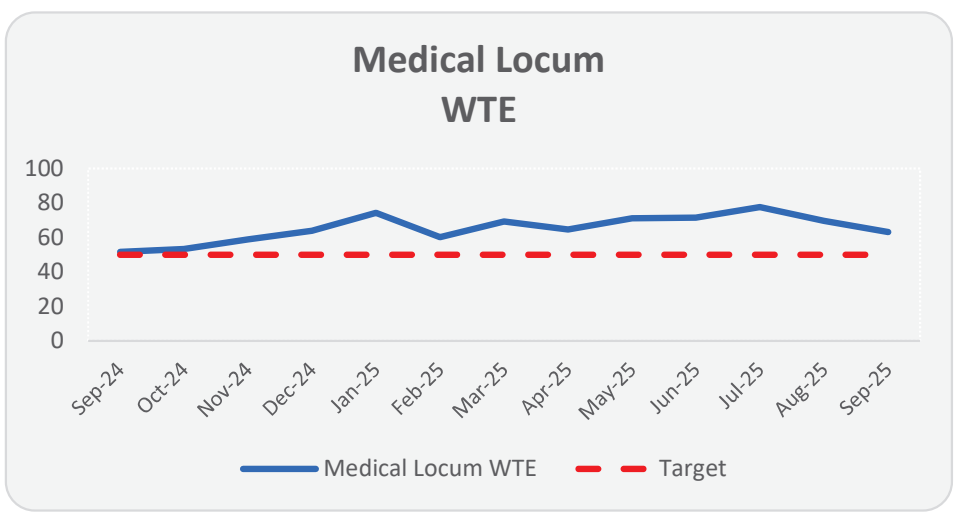
The target in graph was set as part of deliverables set out in IMTP performance framework.

Performance Summary
 There has been a further reduction in agency wte reported in July 25.

In September 11.61 wte (11%) was reported for Nursing and Midwifery. The top three reasons for usage were Vacancies 34.77 wte (33%), Sickiness 30.45 wte (26%) and Agency 11.61 wte (11%).

As part of our strategic workforce plan sets out a target to reduce agency wte to reach 98 WTE by March 2026. This includes zero agency contract, overseas recruitment and other measures.

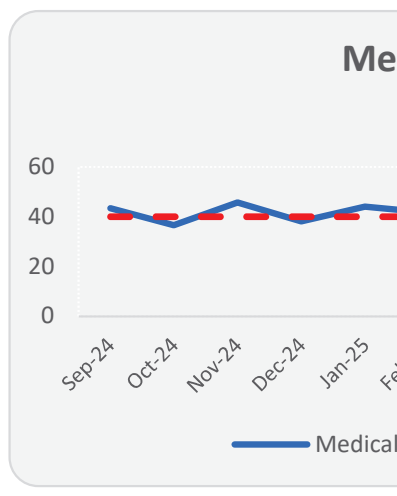
Variable Pay Medical Locum **Enabling Action**



Performance Summary

Current locum usage is 63.08 wte a reduction from 77.6 wte in the last quarter. There is ongoing work with the development of a Medical Workforce Strategy and the introduction of medical E-Systems to support this work. Target in graph was estimated as part of the IMTP performance framework and will be interchangeable with agency usage.

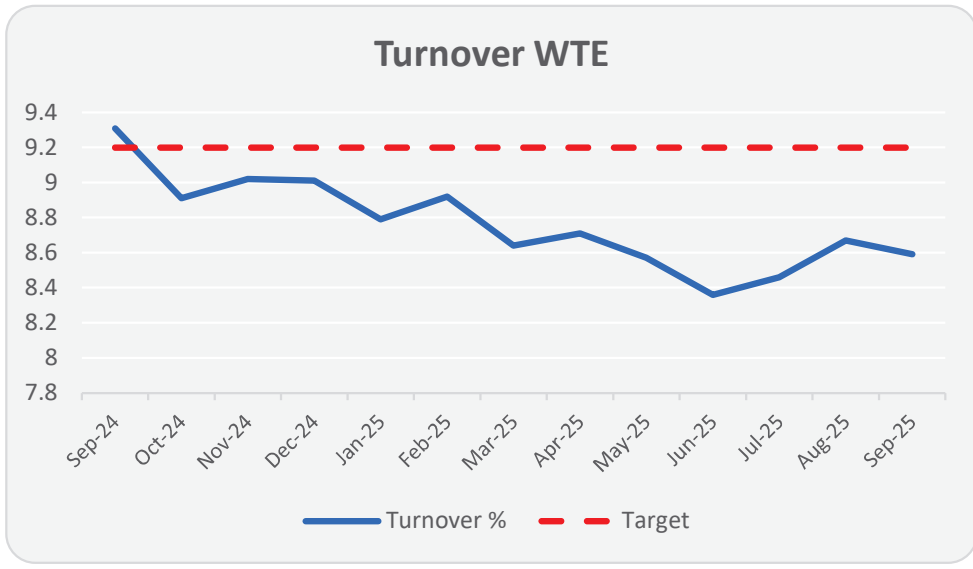
Variable Pay Medical Agency



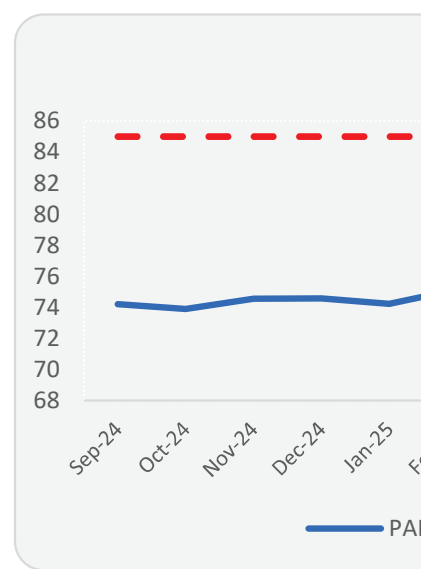
Performance Summary

Medical Agency has reduced from... The highest reason for usage is va... There is ongoing work with the de... the introduction of medical E-Syst... Target in graph was set as part of interchangeable with Locum usag

Turnover



PADR



Performance Summary

Current turnover rate is 8.59 % a slight increase from 8.46 %, reported in the last quarter. There has been an overall sustained reduction in turnover over the last 12 months and within target of 9.2%

Nursing and Midwifery have the lowest turnover rate of 5.85% whilst Estates & Ancillary have the highest turnover rate of 11.95%. The Stability Rate is 91.17%, the Health Board has retained 13,944 staff.

The target in graph was set as part of the IMTP performance framework.

Performance Summary

Current PADR compliance is 76.19%

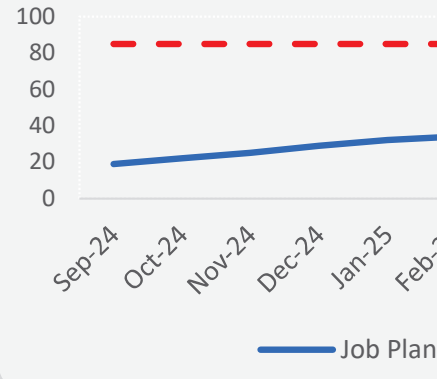
Work continues to achieve 85% A renewed tools and training for ma

Job Planning **Enabling Action**

Consultant Job Planning



SAS J



Performance Summary

Job Planning - In September 25 consultant job planning continued to improve to 57.2% from 53.5% , a steady month on month improvement from the 46% reported in the last quarter and is showing a steady improvement trajectory towards achieving the target of 85%.

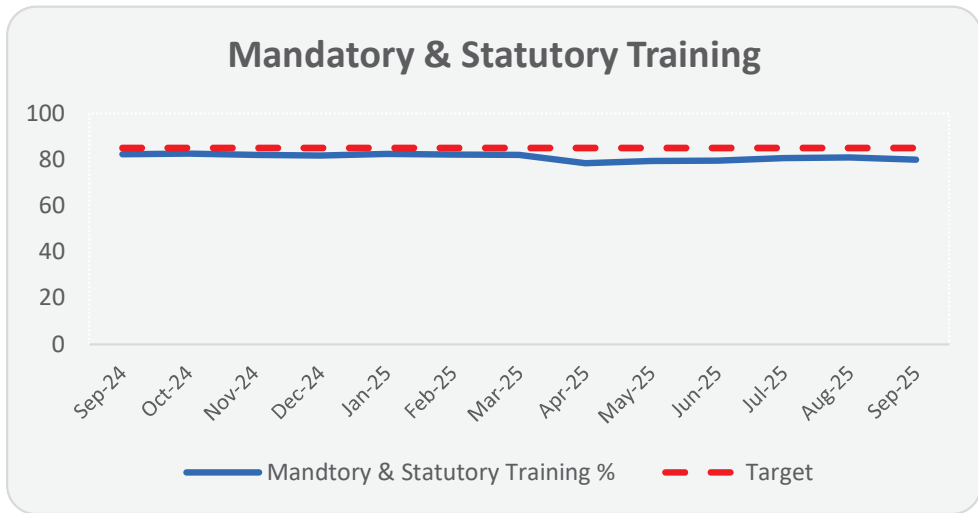
To support the targeted job planning compliance, key actions include integrating progress updates into Divisional Performance Reviews, conducting targeted deep dives, and withholding vacancy approvals until up-to-date consultant job plans are in place. Pay-impacting changes and study leave funding will also be restricted unless job plans are current or under appeal. Attendance at the Job Planning Consistency Group is now compulsory, and a formal reminder from the Medical Director and Chief Operating Officer will reinforce consultants’ contractual obligations.

Performance Summary

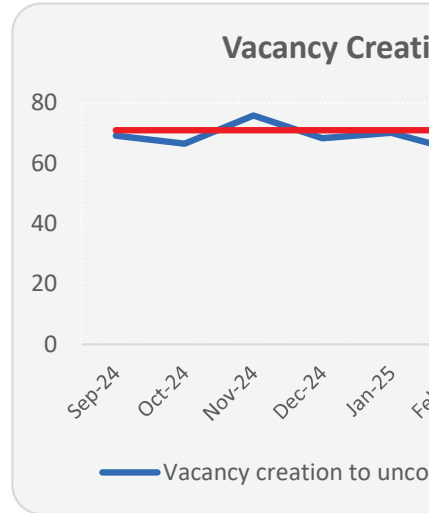
Job Planning - In September 25 SAS J job planning improved to 35% from 30% respectively, a steady month on month improvement from the 20% reported in the last quarter and is showing a steady improvement trajectory towards achieving the target of 85%.

To support the targeted job planning compliance, key actions include integrating progress updates into Divisional Performance Reviews, conducting targeted deep dives, and withholding vacancy approvals until up-to-date consultant job plans are in place. Pay-impacting changes and study leave funding will also be restricted unless job plans are current or under appeal. Attendance at the Job Planning Consistency Group is now compulsory, and a formal reminder from the Medical Director and Chief Operating Officer will reinforce consultants’ contractual obligations.

Mandatory Training



Time to Hire



Performance Summary

In September the mandatory and Statutory Training compliance rate was 80% which has remained consistent during the last quarter.

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

Performance Summary

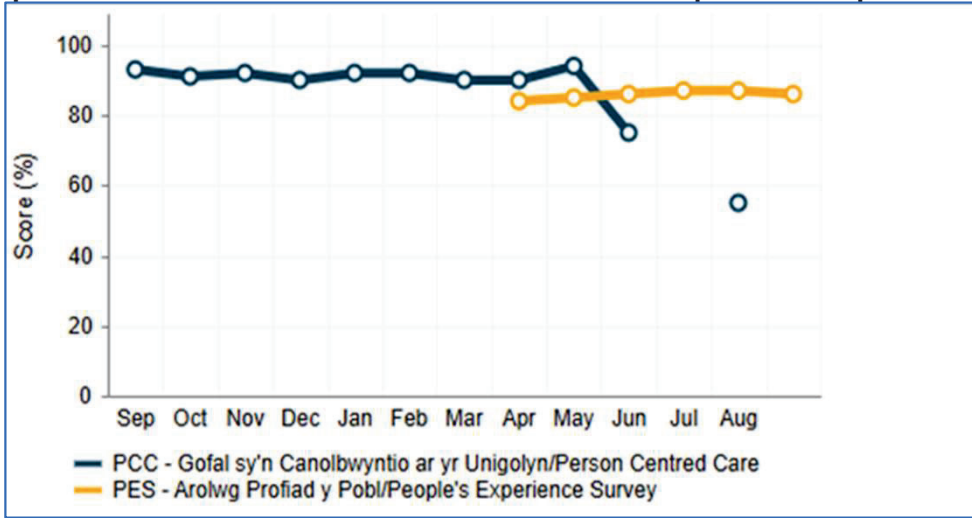
The All-Wales target for recruitment vacancy creation and successful appointments to the Health Board is exceeding performance.

More work is required to improve the time to appointment.

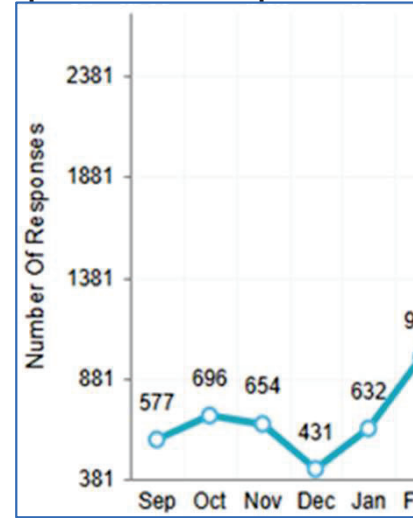


Pillar 1 Patient and staff feedback, concerns, complaints and compliments- Patient Experience

Graph 1- Overview of CIVICA satisfaction score from Sep 2024 to Sep 2025



Graph 2 - Overall response trend



Charts display CIVICA data (extracted 06/10/2025). Surveys already distributed via paper or text messages are expected to change over time. There has been a dramatic increase in responses to CIVICA Patient Experience Survey in Q2 2025, with 7478 responses for Q2. Currently, the highest month was July 2025, with 2596 feedback responses. The overall satisfaction score for Q2 (all surveys) is 87%, a slight improvement from 86% in Q1. The top three themes remain unchanged, with 'you waited' continues to receive the lowest scores each month, with a further decline noted in Sep 2025. Board to improve waiting times are ongoing with 'Your next patient' aiming to improve ambulance waiting times. List initiatives are underway in multiple directorates to bring down waiting list times.

Person-Centred Care (PCC) Survey – locally developed survey used within AB, designed to assess how well care that respected individual needs, dignity, and family involvement. Person-centred principles focus on partnership in care. Primarily used for local quality improvement and divisional reporting; limited since May 2025 following the introduction of the national People’s Experience Survey.

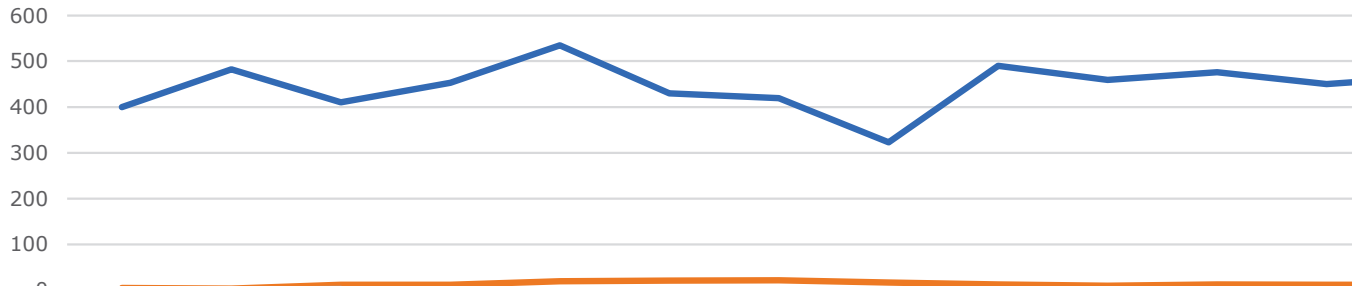
People’s Experience Survey (PES) - nationally standardised survey introduced across NHS Wales. Part of the Patient Experience Framework, captures patient experience consistently across all care settings. Data feeds into the Board and informs WG’s People’s Experience Strategy. Active since May 2025; designed for inclusivity and accessibility. Default survey, except for areas using national surveys (e.g. Maternity) or bespoke surveys (e.g. Bedside) questions.

Next steps: Health Visiting survey relaunched including 5 core questions. The core questions are two questions on 'what was good' and 'what was bad', and a question regarding overall experience. All surveys were launched in September via CIVICA SMS. With 166 responses for August and September. Working on the (Treatment) Survey later this year.

Section 2 Our Performance & System Change Delivery

Pillar 1 Patient and staff feedback, concerns, complaints and compliments- Patient Advice & Liaison

Graph 1– Breakdown of contacts received by PALS Total Contacts Received by PALS
Enquiries/Early Resolution/Escalated to PTR



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
	2024				2025							
Enquiries	400	482	410	453	535	430	419	323	490	459	476	450
Early Resolution	5	4	12	12	20	21	22	17	13	10	13	12
Escalated to PTR		1	3		1	1			1			

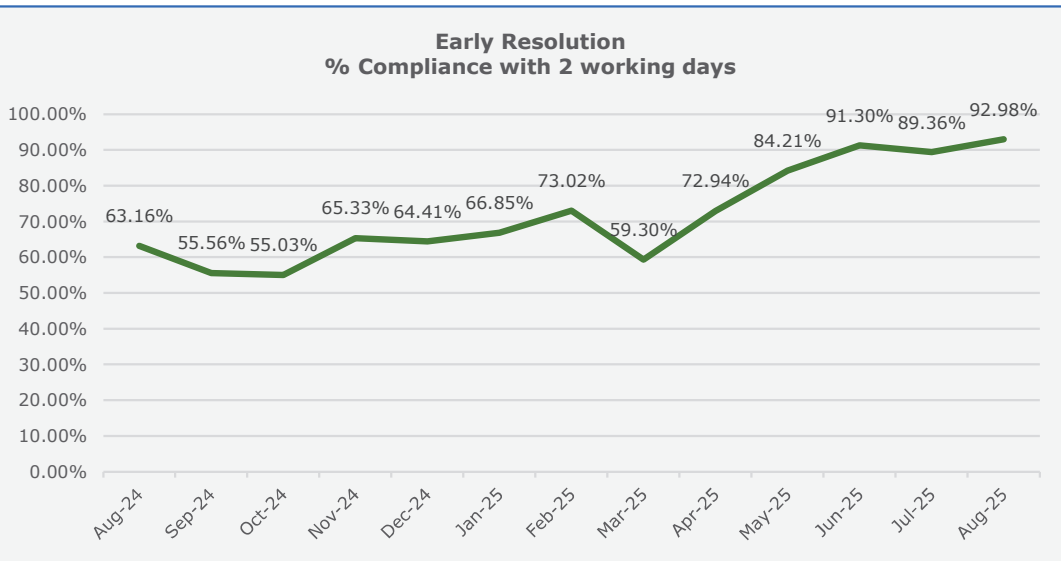
The total number of contacts being managed under PALS has remained consistent across the year. 'Communication Issues' make up 47% of all contacts.

Learning & Improvement

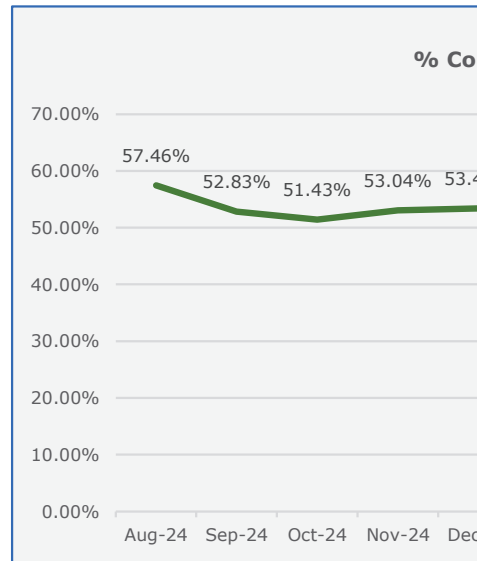
The rollout of PALS bedside stickers has commenced across the Health Board to enhance visibility and accessibility of support. PALS teams are actively supporting patients cared for in boarding spaces, ensuring their needs are met and concerns addressed. Work is underway to explore additional support from PALS service for the Community Assessment Lounge. Listening and concern meetings are being facilitated to strengthen patient engagement and resolve issues promptly. Pastoral support is provided to patients and families while formal complaints are being managed, ensuring compassionate communication throughout the process. Attendance at appointments to offer reassurance and advocacy where needed. Collaboration with the deaf community to establish PALS as a recognised point of contact for accessible support. Support for bereaved families, offering guidance and emotional care during difficult times. Involvement in People Participation Panels, collaboratives, and Big Conversations, ensuring patients shape service improvements. Assistance with digital patient stories, capturing real experiences to inform learning and drive change.

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

Graph 1- Early Resolution Performance



Graph 2 – Putting Things Right Performance



Graph 1 illustrates the compliance with the 2-day closure target for Early Resolution concerns. Compliance has been steadily increasing, reaching over 90% in recent months. Twice-weekly case reviews and dashboards have strengthened compliance with the Formal *Putting Things Right* process. It has remained relatively stable but consistent with standard. Achieving 75% compliance remains a key priority and core performance target for the year.

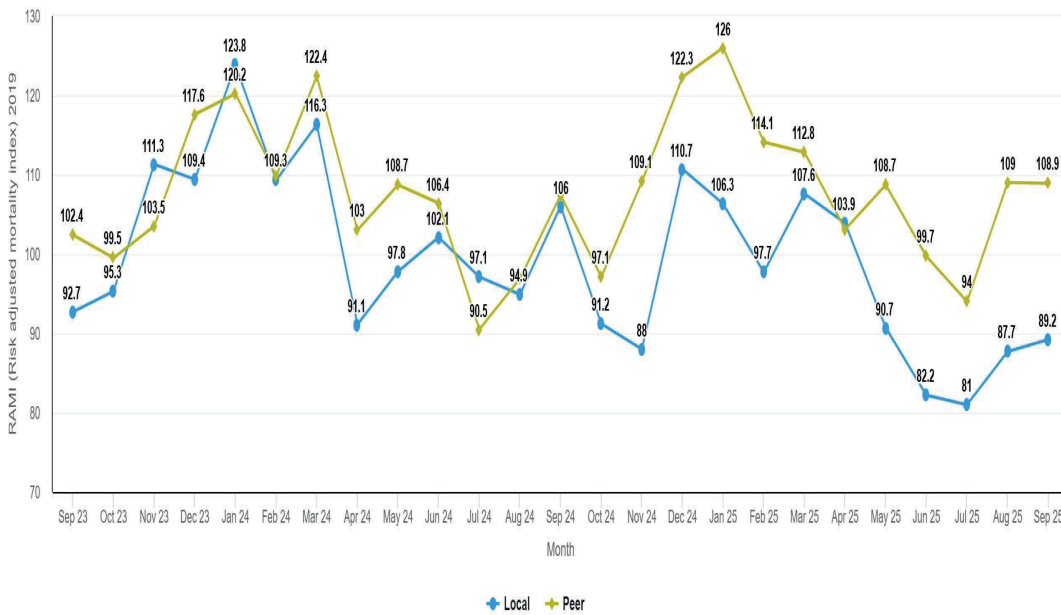
Key Themes and Learning - Consistently the most common theme across Early Resolution and *Putting Things Right* issues. This includes clarity of information, language barriers, and responsiveness. Targeted actions include standardised communication protocols. Complaints often relate to perceived delays, discharge planning, and scheduling, particularly in urgent care and outpatient services. Divisional engagement and case reviews have been used to address these concerns. Persistent issues include scheduling, particularly in urgent care and outpatient services. Improvement plans include better communication, enhanced empathy, and effective communication are recurring positive themes. Beyond duty of care, empathy, and effective communication are recurring positive themes. Empathy, and effective communication are recurring positive themes. Empathy, and effective communication are recurring positive themes. Empathy, and effective communication are recurring positive themes.

Improvements- Delivered four Investigating Officer Training sessions across the HB to colleagues. Training at several Divisional Senior Nurse Away Days, receiving highly positive feedback. Training achievements: 100% of attendees reported feeling better equipped to investigate complaints and PSOW. Reduction in interventions: from 37% (2024) to 28% (2025). 98% reduction in Ombudsman complaints process: from 41 (2023/24) to 1 (2024/25). Compliance with PSOW recommendation recommendations for 2024/25 completed. Positive impact noted by leadership teams, e.g., Caerphilly complaints management following training.

Pillar 2 – Patient Safety Including Incident Reporting - Mortality

Graph 1 - Risk Adjusted Mortality Index (RAMI)

RAMI (Risk adjusted mortality index) 2019



Graph 2 - Deaths per 1000 occupied

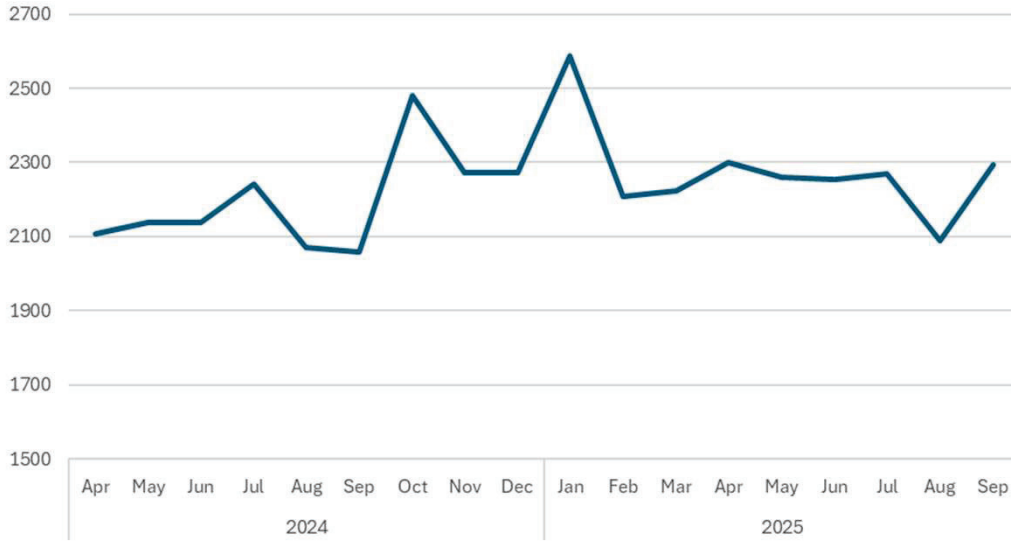


Graph 1 - The Health Board’s RAMI for Q2 is 86 similar to Q1, which was 92. RAMI adjusts for in-morbidities, enabling meaningful comparison between organisations. RAMI has been consistently date and is currently for year 2025 performing under the 100-benchmark suggesting that there are more than expected. In September 2025, the Health Board ranked second among the six members of the group. The accuracy of RAMI is highly dependent on the completeness and precision of clinical coding, as well as the systems used by the Health Board. There is a standard 6–8-week delay in clinical coding. This delay impacts the completion and accuracy in RAMI calculations.

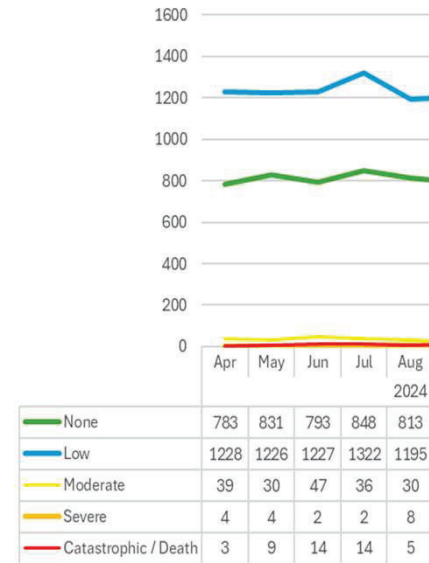
Graph 2 - Crude mortality measures the number of deaths in a population over a specific period. It compares current rates in a community, region, or country by comparing current deaths to the average over the previous period. The data includes all-cause mortality and as seen in the Aneurin Bevan Health Board, the above graph shows the actual number of deaths recorded within the Health Board in a hospital is consistently an average 15% lower deaths recorded than previous years. The graph also shows the seasonal fluctuations, most notably consistent yearly spikes in December and January.

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

Patient / Service User Incidents per Month



Number of Incidents by Harm



Incident Volume and Harm: Total Datix incidents in Q2 8,141, down from 8,436 in Q1. Compared to Q1 2024 is a 4.7% increase year on year. The distribution pattern remains consistent, with 'Patient/Service User' incidents being No Harm or Low Harm. Q2 2025/26: 98.5% no/low harm (manager interim assessment), up from Q1 2024/25 97.89% of incidents being graded as no/low harm.

Themes from Datix Incidents - Missing drug details in reports; corrective actions underway. Drug administration overdue cases. Mandatory fields for medication incidents; expanded taxonomy for patient factors. QMG reporting; antimicrobial prescribing linked to assurance processes. Audits planned for investigation. Dashboard solutions explored.

Learning & Improvement - H&S Team introduced monthly audits to flag incomplete or incorrect incident closure fields monthly to ensure lessons learned and recommendations are captured. 47% reduction in overdue incident closure plus a decrease in cases over 12 months. 74% of incidents closed within 30 working days, showing improvement. Encouraged to continue addressing historic records to maintain momentum. Strengthened patient safety reporting to Datix. Clinical directors encouraged to take ownership of prescribing-related incidents.

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

Top 5 most common themes of Datix Incidents (impacting patients/service users of all ages)				
	Pressure Damage, Moisture Damage	Accident, Injury	Behaviour (including violence and aggression)	Medication, IV Fluids
2024				
Sep	674	393	195	1
Oct	826	382	208	1
Nov	742	394	170	1
Dec	753	381	195	1
2025				
Jan	867	409	221	1
Feb	789	349	181	1
Mar	739	341	241	1
Apr	707	391	294	1
May	712	340	293	1
Jun	674	333	270	1
Jul	746	322	203	2
Aug	748	324	220	1
Sep	733	342	211	2
Grand Total	9710	4701	2902	2

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

'Pressure damage, moisture damage' incidents are the most common Datix incident, of which 55% relate to pressure ulcers present before or during their care. A dedicated slide on pressure ulcers explore the work being undertaken.

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

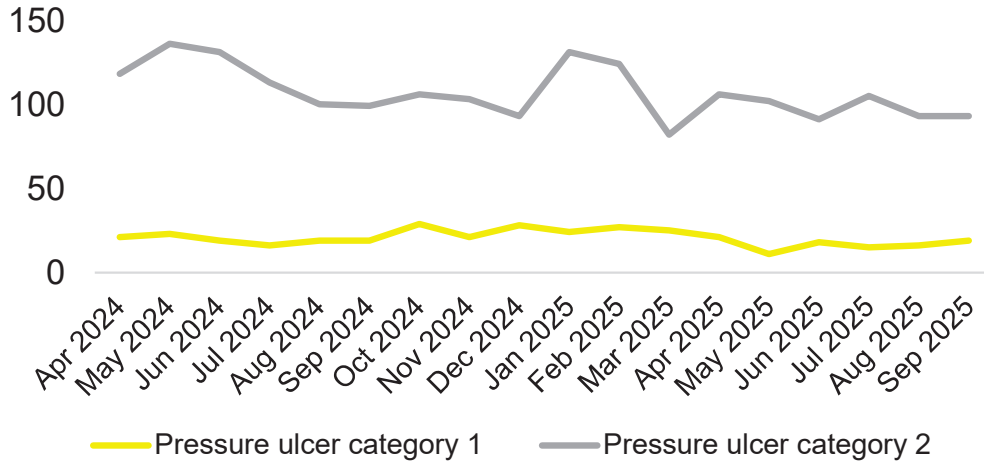
'Behaviour' incidents- 39% related to 'Self harm/injury', 24% relate to 'Restrictive practices' and 10% relate to 'absconding/missing patient'. Self harm and restrictive practices with improvement plans developed, this has been reflected in the improving picture seen within the incidents from January 2025 to September).

'Medication, IV Fluids' incidents- 47% relate to 'Administration errors' which would encompass delays, dose, strength, route of administration and 'Prescribing errors'. An increase in these incidents relate mainly to 'Administration errors' and 'Prescribing errors'. The Quality Management Committee multiple Divisional Highlight reports in September and the chair stated a need for a broader, corporate piece of work, involving the Medication rollout. Within Divisions multiple improvement projects are ongoing to address local concerns specific to medications or locations, such as the rollout of the new medication charting system.

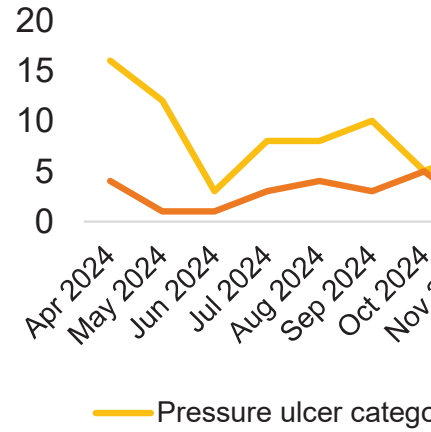
'Assessment, investigation, diagnosis' incidents- 61% are 'Diagnostic testing- Pathology', 24% are 'Clinical assessment/diagnosis' and 15% are 'Investigation'.

Pillar 2 – Patient Safety Including Incident Reporting – Pressure Ulcers

Healthcare Acquired Pressure Ulcers
Health Board Wide - Grade 1 & 2



Healthcare Acquired Pressure Ulcers
Health Board Wide - Grade 3 & 4

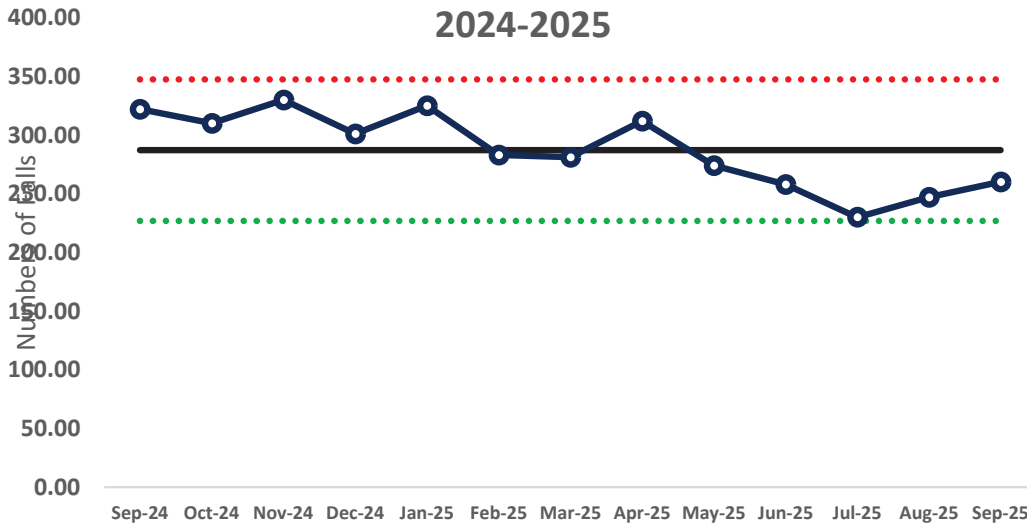


The majority of Pressure Ulcers recorded are category 2 (partial-thickness skin loss where the epidermis (deeper layer of skin), or both, are damaged). No statistically significant trends in the category 2 cases over the 12 months.

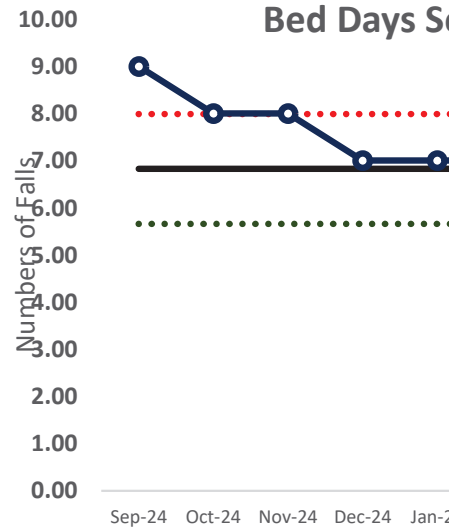
Issue	Action	Learning and Improvement
Quality of Datix Reporting – correct grading, duplication, adding a value (Avoidable or Unavoidable), Focus Reviews & closure	Through the Steering Group, work with divisions to develop achievable processes to improve the validation of incidents	Grading guides & resources reviewed with group. Policy reviewed with group. grade 1 and 2 cases
Access to air mattresses	Ensure staff are aware of how to access mattresses via Drive	Posters & booklets available. Plan to roll out to other sites.
Mattresses arriving in clean packaging – damaged or contaminated	Report incidents of damaged or contaminated mattresses to Drive immediately	Review process for mattresses. Process developed across sites.
Timely investigation & share learning	Establish regular scrutiny panels Complete investigations & Yorkshire contributory factors on Datix	Identify themes & actions. Share via QPS forums & HSB. Educational slides shared.
Validation for Grade 2 pressure ulcers	Senior Nurse review and sign off for all grade 2 pressure ulcers.	Information cascaded to all sites. All divisions aware of requirements.
High number of no value incidences within DATIX	Provide information for clinical teams on reporting, roles and responsibilities. Review current Health Board policy and All Wales reporting guidance	HB Policy and All Wales guidance reviewed. Flow chart on DATIX system developed.

Pillar 2 – Patient Safety Including Incident Reporting – Falls

Total Numbers of Inpatient Falls September 2024-2025

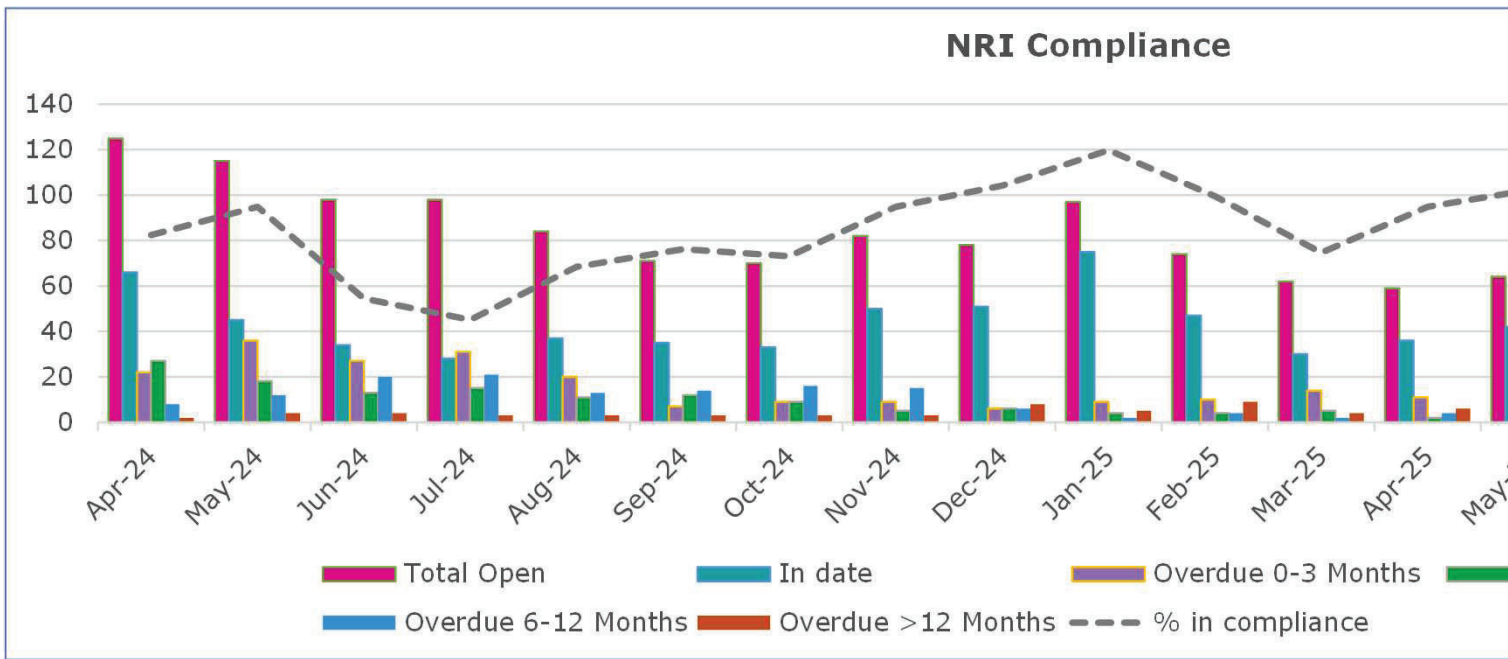


Average Number of Falls per 1000 Bed Days September 2024-2025



- The current mean average of falls incidents is 287, representing a decrease since the last report (295)
- Over the past five months, the average number of falls per 1000 bed days has shown a consistent decrease from 9.0 to 7.0, remaining below the current mean average, and below the UK benchmark (National Audit of Inpatient Falls)
- The improving rate coincides with a range of action being taken by the Health Board to reduce the number of falls, including the introduction of a revised process for reviewing those falls with severe injury which enables more to be reported, the publication of the Health Board’s revised Hospital Falls Policy supported with awareness raising activities, and a number of level of quality improvement projects targeting falls.
- During this period of improvement, there has been an enhanced level of monitoring of falls at ward level, supported by the current framework, thus increasing team awareness and ownership of the opportunities to reduce falls.

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



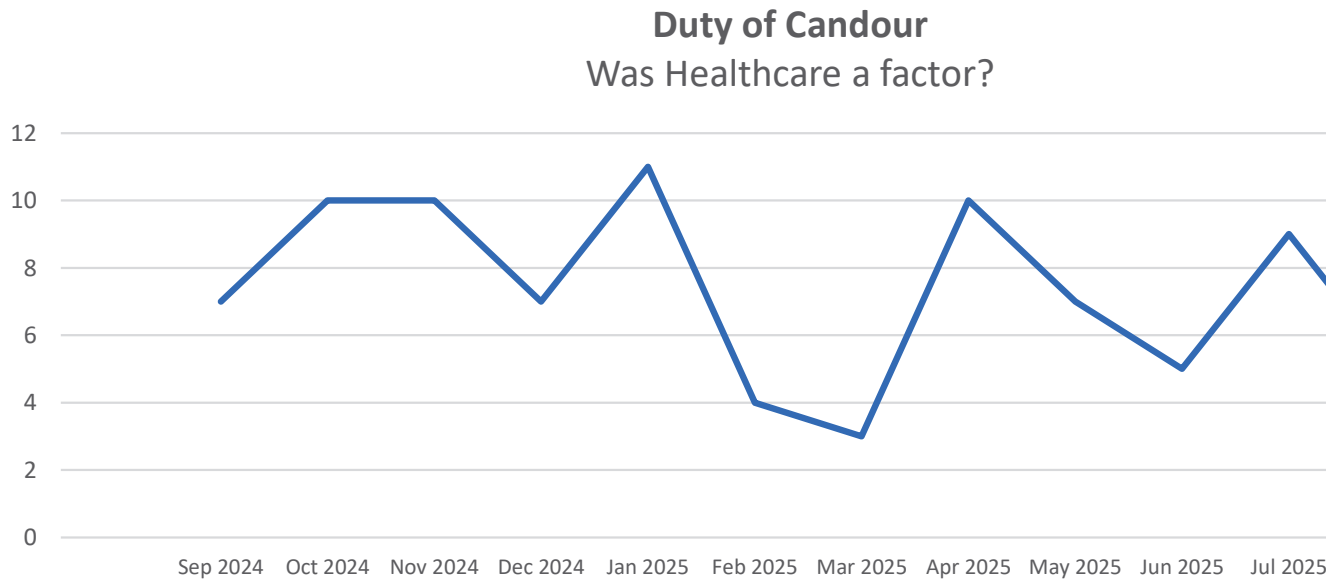
Q2 Slight increase in incidents; August spike followed by September decline. 98.51% of incidents medication safety issues, complaints and investigation training needs, safeguarding concerns in n Trend (as of September 2025): Four NRI cases open >12 months due to external complexities. C the last three months (up from 29%–49% same period last year)

Actions: Fortnightly focused action plan meetings with PSI team, QPS leads, and QI support. Col share best practice. Clear benchmarks for what 'good' looks like; compliance central to standards progress. Supporting Patients and Families: Development of Family Liaison Officer (FLO) role and Health Boards; SOP creation in progress. Proposal for training and resource materials under deve

Learning and Improvement - Feedback from families reinforces need for better communication role. Establishment of Falls Strategic Oversight Panel. Standardisation of mortality case reviews a across directorates. Bespoke training for complaints and incident investigations. Medication safety benchmarking and collaborative learning to define and embed best practice.

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

Graph 1 – Duty of Candour Events from Sep 2024 – Sep 2025



Duty of Candour information is extracted from RL Datix and represents an evolving picture; data number of Duty of Candour (DoC) events remains low. Common Categories of Incidents: *Treatment assessment / diagnosis, Slip, trip or fall and Pressure ulcer developing/worsening*. Slight reduction triggered DoC, mainly linked to mental health service user incidents, alleged criminal offences, and triggered DoC, with similar themes plus violent incidents and safeguarding concerns.

Actions: Embedded DoC into Datix Cymru reporting workflow. Introduced structured review process to trigger DoC where applicable. ESR Duty of Candour (DoC) training: Work in progress to implement for patient-facing staff.

Learning and Improvement: Mandatory training will strengthen understanding and statutory compliance. Feedback reinforces the need for timely, compassionate communication during DoC processes. Continued application and training effectiveness. Collaboration with other Health Boards to share best practice towards openness and honesty as core principles.

Pillar 3 Clinical Effectiveness – Ward Accreditation

Graph 1- Ward accreditation status over time



Quality Improvement Projects through ward accreditation

- Ward 4/2 : Quality & Dignified Care- improving continence care.
- Annwylfan Ward: Reducing Falls with a Focus on Footwear.
- Ward 3/3 : Timely care – timely risk assessments on admission with a checklist.
- OSU: Reducing length of Stay
- D3 East: Implementing a structure tool to improve communication with patients

Issue	Action	Learning and Improvement
Sharing learning	Linked accreditation pulse page to learning Hub and ABCi page.	Wider comms to staff
	Silver projects to be presented at listening / learning forum and other forums.	
Divisions easily reviewing accreditation data.	Live tracker created / managed by data analyst.	Will be launched in O Drop in teams session to show their data.

Pillar 4 - Health, Safety, Security and Compliance

Graph 1- RIDDOR % Compliance

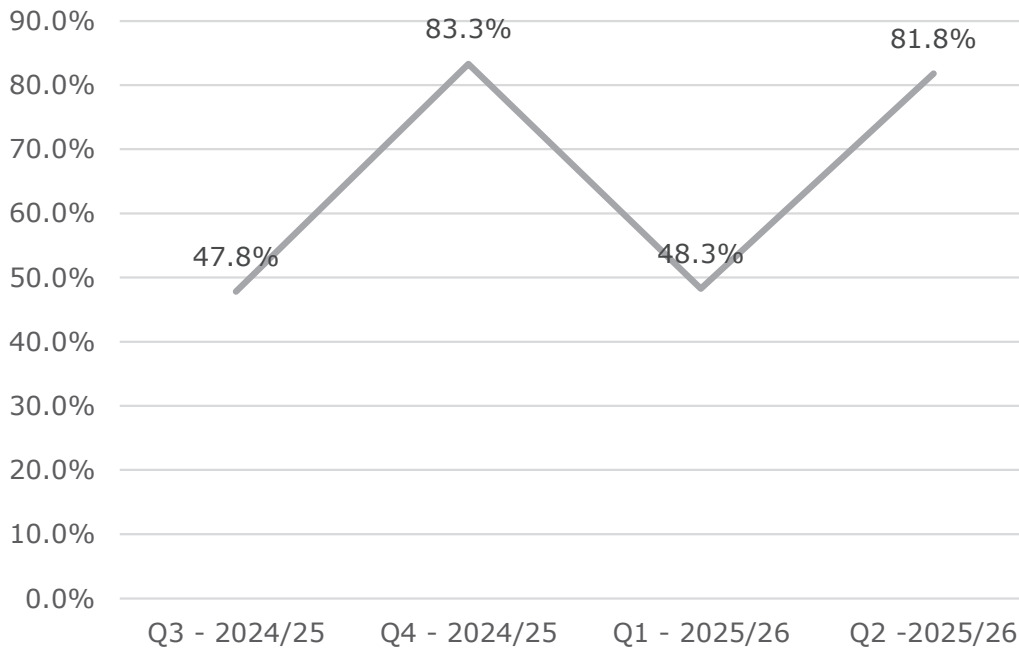


Table 1 - Health and Safety Training

Health and Safety Training Compliance
Health and Safety
Fire Safety
Manual Handling
Violence, Prevention & Reduction

Table 2 - Violence and Aggression

Staff Health and Safety Incident Report
Physical assault
Contact with needles or medical sharps
Slip, trip or fall
Verbal assault
Manual handling
Sexual assault and/or sexual inappropriate behaviour

Issue	Action	Learning and Improvement
Increased number of contact with needles or medical sharps reported in Quarter 2 (2025/26)	Thematic review to be conducted to identify themes and patterns Health and safety management audits to be carried out for all Inpatient areas in Q4 2025/26	Identification delivery of education
Achieving a high compliance rate of reporting incidents in accordance with RIDDOR with the legal timeframes	Implement RIDDOR Awareness eLearning Training and mandate the course for all managers via the Core Learning Committee	Sharing details Senior Management
Manual handling training compliance is significantly below the 85% target	Targeted approach for staff attending training courses	Competent workforce
Fire safety training compliance is below the 85% target	Implement fire safety training framework which is risk based	Competent workforce

Pillar Five - Infection Prevention & Control

Table 1 – Healthcare Associated Infections per 100,000 populations

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	41.87	1	23.78	59.96	21.44	7.37
Wales	44	2.02	25.21	68.7	24.9	4.85

Table 2 – Healthcare Associated Infections per 100,000 populations

	C. difficile	M. aureus BSI
Aneurin Bevan UHB	125	74
Wales	698	74

C difficile infection

Apr 2025 – Sept 2025 = 125 cases

50 = Healthcare associated

41 = Community acquired

11 = Indeterminate

19 = Relapse

4 = Other Health Board

Causes:

Period of increased incident Penallta ward and B3

Lapse with mattress checking

Shortage of mops in RGH

Actichlor strength not in line with new recommendations

Actions taken:

RCA undertaken on all HAI plus antimicrobial review for CAI

Ongoing reactive cleans

Ongoing promotion of fundamental infection prevention

Ongoing Quality improvement work

Support the all Wales C difficile collaborative 07.10.25

Developed a mattress ordering & replacement poster.

Purchased additional mattresses.

Order additional supply of mops. Using disposables to cover shortfall.

Pilot alternative chlorine releasing solution on A4.

Improvements:

Cubicle risk assessment supported at safe to start

Allocate bed space cleaning for normal discharge clean takes approximately 35 minutes

Geno sequencing confirmed different strains for B3 and Penallta

Cleaning of dirty utility rooms

Disposal of bodily fluids within ensuite

Extended antibiotic courses – not within HB guidelines

Staph Aureus BSI

Apr 2025 – Sept 2025 = 74 cases

30 = Healthcare associated

40 = Community acquired

1 = Indeterminate

0 = Relapse

3 = Other Health Board

Actions taken:

Ongoing monitoring of action plan v

all Wales steering group for proced

infection

Improvements:

Ongoing monitoring of action plan v

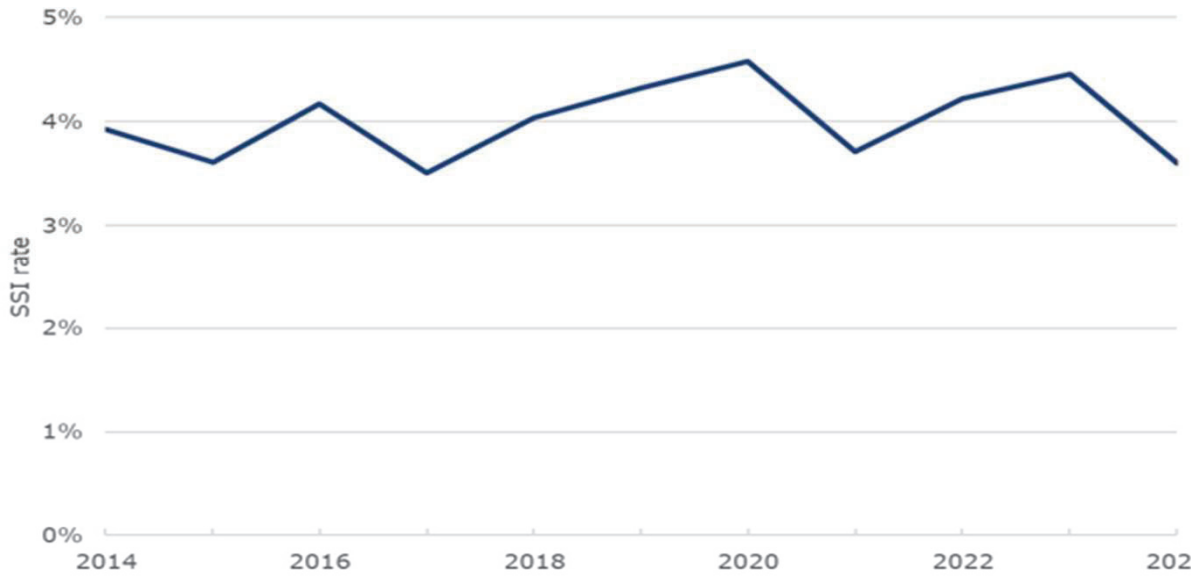
IPN representative on the all Wales

Link with CAP/HAP to respiratory in

Pillar Five - Infection Prevention & Control *Continued*

Graph 1 – Annual SSI Rates

Annual SSI Rates



Learning

A possible contributing factor is the change in surgical dressing; Leukomed was replaced after a contract to reduce costs. However, local teams have since raised concerns about the alternative.

Actions

- Promotion of ANTT across the Division
- Patient information has been updated, and new leaflets now outline both the risks and patients' infection risk
- Ladies are now being issued with a skin cleansing product
- The infection prevention team along with the Directorate has been supporting environmental cleaning team education.
- QI project ongoing

Pillar Five - Infection Prevention & Control *Continued*

Table 1 – Healthcare Associated Infections per 100,000 populations

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	41.87	1	23.78	59.96	21.44	7.37
Wales	44	2.02	25.21	68.7	24.9	4.85

Table 2 – Healthcare Associated Infections per 100,000 populations

	C. difficile	M. tuberculosis
Aneurin Bevan UHB	125	0
Wales	698	0

E coli BSI

Apr 2025 – Sept 2025 = 179
 45 = Healthcare associated
 126 = Community acquired
 3 = Indeterminate
 0 = Relapse
 5 = Other Health Board

Actions taken:

RCA for blood stream infection linked to CAUTI continues with ongoing promotion of HOUNDINI
 Multi drug resistance included in F1 training

Improvements:

Ongoing review of cleaning schedules and cross reference to national standards
 Commencing an alternative product for cleaning on A4 starting 08.09.25 awaiting staff evaluation.
 All Wales steering group for cleaning products .
 Next step option appraisal re disinfectant clean due to contact time and dilution required.

Pseudomonas BSI

Apr 2025 – Sept 2025 = 22
 8 = Healthcare associated
 10 = Community acquired
 1 = Indeterminate
 0 = Relapse
 3 = Other Health Board

Actions taken:

RCA for device related infections undertaken
 Drain disinfectant within critical care
 Ongoing promotion of urinary catheter care bundle

Improvements:

Consider earlier trial without catheter
 Ongoing review data analysis for completion

Klebsiella BSI

Apr 2025 – Sept 2025 = 64
 22 = Healthcare associated
 39 = Community acquired
 1 = Indeterminate
 0 = Relapse
 2 = Other Health Board

Actions taken:

Continue to promote ANTT
 Water sampling in augmented care areas

Pillar Five - Infection Prevention & Control

Table 1 – Weekly Respiratory Virus Overview –

Week 43 Monday 20 October 2025

Current Week		Past 3 weeks				
Week	2025w43	Trend*	Week	202542	202541	202540
Tests	217	↓	Tests	295	228	204
Total Flu	9	→	Total Flu	10	9	10
flu A	9	→	flu A	9	9	10
flu B	0	→	flu B	1	0	0
Total RSV	9	↑	RSV	1	3	0
Under 6	8	↑	Under 6	1	3	0
6 & over	1	→	6 & over	0	0	0
COVID-19	18	↓	COVID-19	34	53	49

* Current week compared to previous 3 weeks

Table 2: Summary of influenza p inpatients or residents

Week 43 Monday 20 October 2025

	Current season 2025 week 40 - 2025	
	Number	%
Tests	983	-
Total Flu	46	4.7
Total Flu A	45	97.8
Total Flu B	1	2.2

COVID-19

COVID-19 is now declining, but number of new detections and hospital inpatient cases remain slightly elevated. This trend is expected to continue over the next few weeks.

Influenza

Influenza numbers are currently very low but increasing (Table 2, Figure 3, 4). We continue to see week – on – week of influenza detected in ABUHB are community acquired detected in GPs or admission areas of hospital settings. The all-Wales trend for influenza is low numbers on an increasing trend. Surveillance indicators throughout Wales now show an increasing trend. We are still at baseline levels.

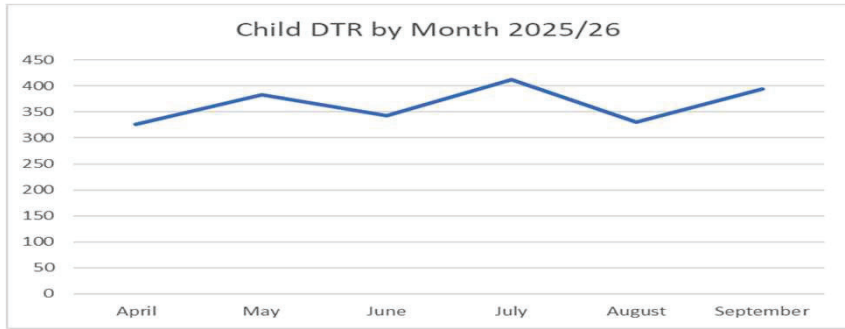
RSV

Last week we saw an increase in RSV to 9 new cases detected, 8 in children aged 5 and under and 1 in patients aged 6 and over. Across all-Wales surveillance indicators from children aged 5 and under suggest the RSV season has begun. Numbers are in line with All-Wales trends.

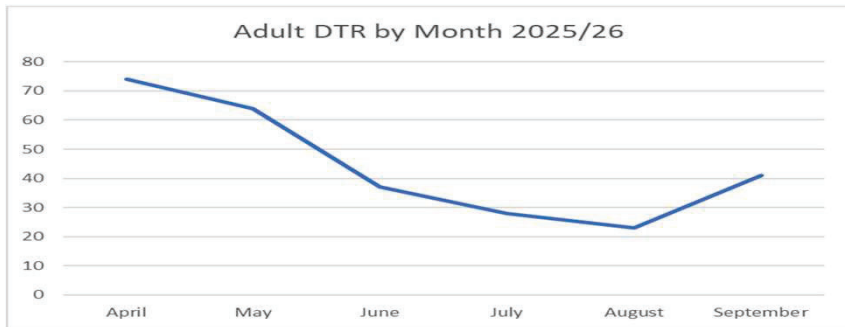
Current activity trends is in line with 2024-25 RSV seasonal trends – this was a slightly more severe season with a slight increase in activity. This does not mean the current season will be the same as last year.

Pillar Six - Safeguarding

Graph 1 – Child Duty to Report



Graph 2 – Adult Duty to Report



Graph 3 – Advice & Support Calls to Safeguarding Service

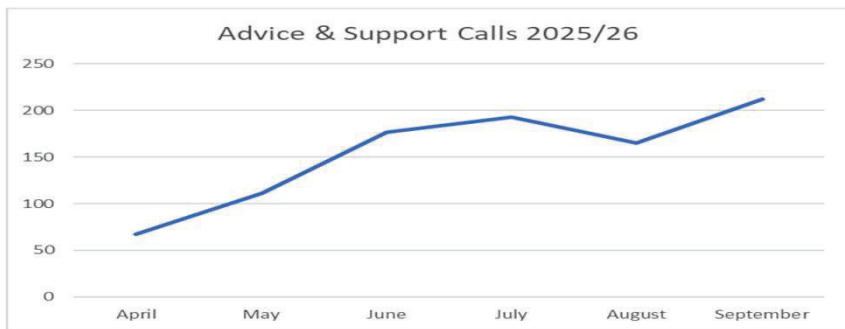


Table 1 - Child and Adult Safeguarding training

Training Module	Compliance %	T
Adult Safeguarding Level 1	82%	CH
Adult Safeguarding Level 2	85%	CH
Adult Safeguarding Level 3	24%	CH

Child Duty to Report:

Activity in relation to Child Safeguarding remains relatively stable, that our staff remain vigilant, raising concerns through appropriate channels in relation to physical abuse or neglect, within the family setting. Discussions with partners have highlighted that an increase in reporting has led to more timely reporting.

Adult Duty To Report

The volume of activity in relation to Adult Safeguarding concerns has decreased over quarter one, which can be partially attributed to a reduction in activity over quarter one, which was over reporting of incidents that were not from August there has been a gradual increase in activity, with the launch and subsequent uptake of Level 3 Safeguarding training.

Advice and Support Calls

The increase in calls for advice and support directly correlates to the increase in reporting, demonstrating that the workforce are more aware of potential risks and managing them.

Safeguarding Training:

Compliance at Level 1 and Level 2 sits below the required level, with Divisional leadership teams to address this at a local level. Whilst Level 3 Child Safeguarding Training is below the required level for 2025 and a clear plan is in place to achieve and maintain compliance. The Level 3 Adult Safeguarding Training was mandated in 2025 and is unlikely to achieve compliance of above 85% due to availability of staff. A report produced for the Health Board Executive Team to highlight the current situation and recovery. It should be noted that there is a national mandate for all registered health care staff. This mandate requires training to be face to face and be participatory. As such, this must be delivered in a face to face and be participatory.

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

Sep-25
Performance against key financial targets 2025/26

+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Year-end Forecast	Movement
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of its funding in each financial year. <i>This confirms the YTD and forecast variance.</i>	£'000	1,162	11,387	19,900	
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. <i>This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.</i>	£'000	2,231	11,885	0	
	£33,533	7%	35%		
Public Sector Payment Policy To pay a minimum of 95% of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	96.1%	97.1%	>95%	

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

The 2025/26 financial year to date shows an adverse variance of **£11.387m** against the IMTP MDS and £1m better than the budget profile for 2025/26.

Since month 5, the 2025/26 financial year shows a **deficit**, however, this carries over from the previous year.

This position relies on savings being made.

There remain risks associated with the anticipated allocations from the Welsh Government planned care funding, Welsh Government 2-3 grievance, 45 minutes and 45 minutes of services, in addition any new services. The achievement of the savings is dependent on the success of the savings strategy.

ABUHB Mid Year Review 2025/26 (m5)
Forecast Deficit Analysis - outside of MDS

Category	Amount
National Issues (£2.9m)	
Funding Ceased (£0.3m)	
Ministerial Priorities - Urgent & Emergencies (£1.3m)	
Ministerial Priorities - Cancer (£2.5m)	
Growth above plan (£5.3m)	
Unavoidable Investments / Risk mitigation (£1.2m)	
Total	

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Finance Performance Report – September 2025 (2025/26 Month 06)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rob Holcombe - Director of Finance, Procurement & VBHC
SWYDDOG ADRODD: REPORTING OFFICER:	Suzanne Jones – Assistant Director of Finance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

This report sets out the following:

- The financial performance at the end of September 2025 and the forecast position against the statutory revenue and capital resource limits,
- The savings position for 2025/26,
- The revenue reserve position on the 30th September 2025,
- The Health Board’s underlying financial position,
- The cash position, including the strategic cash support required,
- Public sector payment policy performance, and
- The Capital position.

A system link is included for the month 6 monitoring returns reported to Welsh Government.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report sets out the financial performance of Aneurin Bevan University Health Board, as at the 30th Sep 2025 (Month 06) for the financial year 2025/26.

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

Sep-25

Performance against key financial targets 2025/26

+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Year-end Forecast	Movement
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of its funding in each financial year. <i>This confirms the YTD and forecast variance.</i>	£'000	1,162	11,387	19,900	
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. <i>This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.</i>	£'000 £33,533	2,231 7%	11,885 35%	0	
Public Sector Payment Policy To pay a minimum of 95% of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	96.1%	97.1%	>95%	

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

Underlying Financial Position (Brought Forward ULP)	22/23	23/24	24/25	25/26 Forecast
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	£89.6m Deficit	£81.4m Deficit	£27.2m Deficit	£14m Deficit

At Month 06, the reported forecast revenue position continues to be reported as a £19.9m deficit. The reported capital position is break-even. There are risks to achieving the reported forecasts.

The year to date budget performance at month 6 is a deficit of £11.387m. This position is £1.0m better compared with the MMR month 6 profile for 2025/26. The year to date position is due to new in year pressures that include prescribing costs (April PAR) / drugs, CHC activity including Discharge to Assess case growth, winter wards remaining open, and variable pay relating to Mental Health and other operational pressures.

The forecast position remains a **£19.9m deficit**. The forecast deficit is reflective of full delivery of the IMTP savings plans (£42.5m) and in year cost pressures that are in addition to those within the IMTP. It is currently assessed as the best-case scenario. The Health Board will continue to seek ways to mitigate this position and any further additional costs. Risks remain within this forecast and the following notable financial issues are not factored into the above position, Welsh Risk Pool increased premium, winter plan implications and the potential impact of any band 2 to 3 HCSW national proposals.

Cefndir / Background

The Board approved 2025/26 IMTP financial plan was ambitious with a high delivery risk to achieve financial balance, requiring financial savings of £40m.

Through financial recovery actions the forecast achievement of savings and mitigating actions as at month 6 is £42.5m. However, the in year cost pressures driving the forecast deficit of £19.9m for which the Health Board does not currently have mitigating actions are listed in the table below:

ABUHB Mid Year Review 2025/26 (m5)		
Forecast Deficit Analysis - outside of IMTP plan		
Category	Issue	Value £m
National Issues (£2.9m)	National insurance > funding	2.20
	Theatres b2 to b3 grievance	0.30
	MS365	0.40
Funding Ceased (£0.3m)	Fracture liaison service	0.30
Ministerial Priorities - Urgent & Emergency Care (£4.5m)	winter beds 24/25	0.80
	Surge beds	2.00
	emergency department	0.20
	ITU capacity	1.50
Ministerial Priorities - Cancer (£2.5m)	Cancer	2.00
	Diagnostics growth	0.50
Growth above plan (£5.3m)	Drugs	2.00
	CHC	2.50
	Diabetes Pumps	0.80
Unavoidable Investments / Risk mitigations (£4.4m)	Mental health	3.90
	Thyroid loss of service	0.50
Total		19.90

As discussed at the Board meeting held on 10th September, all options currently available to the Health Board to minimise the impact of the emerging pressures were discussed and agreed, with risks. The Health Board will have limited ability to identify further mitigating actions without identification of further funding or cessation or reduction of services. This revised forecast and approach was approved by the Board at a briefing held on 10th July 2025.

The forecast position assumes that pay awards and any other pay related uplifts for 2025/26 will be fully funded by Welsh Government. In line with previous funding agreements, the Health Board has assumed the 2025/26 Real Living Wage step costs implemented on 1st April 2025 will be funded as part of the new year pay settlement. The Health Board has anticipated £31m funding for the 2025/26 wage award. This is based on staff in post at month 4 uplifted by 3.6% for A4C and 4%, plus £750 consolidated payment, where applicable, for Medical & Dental staff.

Asesiad / Assessment

- Revenue Performance

Year to date

A summary of the year to date financial performance is provided in the following table. The cost drivers causing the year to date overspend of £11.387m are related to those in the previous table. The year to date position and the forecast by delegated area is:

	Annual budget	YTD Reported Variance	Full-year Forecast Variance at M06	Full-year Forecast Variance at M05	Movement
	£000s	£000s	£000s	£000s	£000s
			C	X	
Operational Divisions:-					
Primary Care and Community	319,023	(405)	2,435	3,032	(597)
Prescribing	125,635	2,166	2,462	2,245	216
Community CHC & FNC	75,178	1,215	2,119	2,265	(146)
Mental Health & Learning Disabilities	152,897	3,854	7,176	7,170	6
Total Primary Care, Community and Mental Health	672,733	6,829	14,192	14,712	(520)
Surgery	156,316	6,777	9,314	8,875	438
Clinical Support Services	138,412	567	2,052	2,178	(126)
Medicine	179,303	3,165	5,302	3,846	1,457
Urgent Care	43,932	142	499	114	385
Family & Therapies	152,279	1,338	2,556	2,224	333
Estates and Facilities	98,064	(1,711)	(1,108)	(156)	(952)
Chief Operating Officer	9,857	(48)	(150)	(143)	(7)
Total Chief Operating Officer	778,164	10,230	18,465	16,938	1,527
Total Corporate Divisions	100,965	(2,007)	(5,024)	(5,250)	226
Total Specialist Services	199,144	499	1,431	985	446
Total External Contracts	134,068	(2,288)	(3,385)	(1,942)	(1,442)
Total Capital Charges	47,584	50	50	7	43
Total Delegated Position	1,932,658	13,313	25,730	25,450	280
Total Reserves	8,131	(1,659)	(5,830)	(5,550)	(279)
Total Income	(1,940,790)	(267)	0	0	0
Total Position	0	11,387	19,900	19,900	0
Total Reported Position	0	11,387	19,900	19,900	0

Summary of key operational points for Month 06

Key points to note for month 06 include:

The financial position at the 30th September 2025 shows a £11.387m deficit. The key issues in the month are described in this report.

- Expenditure within the Health Board for total pay was £76.2m. This is a decrease of £9.3m compared with August (£85.5m), due to the wage award back pay in the previous month.
- Non-pay expenditure (excluding capital adjustments) was £92.4m, a decrease of £4m compared with August. This is a result of higher than average spend in the previous month due to the pass through 2024/25 wage award funding via LTA's & Joint Commissioning Committee.
- CHC costs for Adult Community Care, Mental Health & Learning Disabilities and Children continue to present as a financial pressure due to inflationary price uplifts, volume increases, including Discharge to Assess placements, and an increase in high cost CHC packages of care. Within Mental Health & Learning Disabilities the high level of observations required are also a pressure.
- Prescribing spend has worsened compared with the Plan due to an increased average item price (to £7.86 from £7.41 plan) and the level of actual items prescribed in the April PAR. The forecast for growth has been reduced from 0.5% to 0.1%. This is offsetting the increase in average item price which has risen from £7.81 forecast in month 5 to £7.86 in month 6. This increase is mainly due to the in month average item price for July being 13.8p higher than forecast.
- On-going acute secondary care high cost drugs prices and growth in usage continue to be a pressure. The National V&SB Procurement and Medicines Management savings opportunities will be reviewed throughout the year and actions progressed to deliver any opportunities outside of the financial plan. Medicines management savings include an expectation to achieve £2.2m from the loss of exclusivity of Dapagliflozin. This is based on the price dropping to c.40% of the pre price reduction cost.
- Demand & flow pressures for beds across the whole system remain a significant cost driver. There has, however, been a favourable downward trend in delays since the end of last year falling by 29% since September 2024. However, there was a slight increase in numbers of in-patients fit for discharge at the WG data capture point (for pathways of care delays) in September (184 compared with 160 in August). This is reported as 51 Health delays, 43 Social care delays and 90 Joint delays. The top 5 reason categories in relation to delayed days are as follows:

Awaiting assessment	38%
Care Home related issues	13%
Home care related issues	8%
Step down issues	8%
Disagreements and disputes	7%

- The estimated cost for the year of continued blocked bed days for all reasons is c.£13.4m using a £200 cost per bed day (based on the number of in-patients for September). The demand and flow challenges drive surge bed capacity & increased demand in high-cost unfunded temporary staff.

Forecast Position

The plan financial forecast submitted following Board approval in March 2025 was a non-recurrent break-even position for 2025/26. The ABUHB IMTP financial plan was based on achieving IMTP savings (£40.4m) and through financial recovery actions the forecast achievement of savings and mitigating actions is now £42.5m.

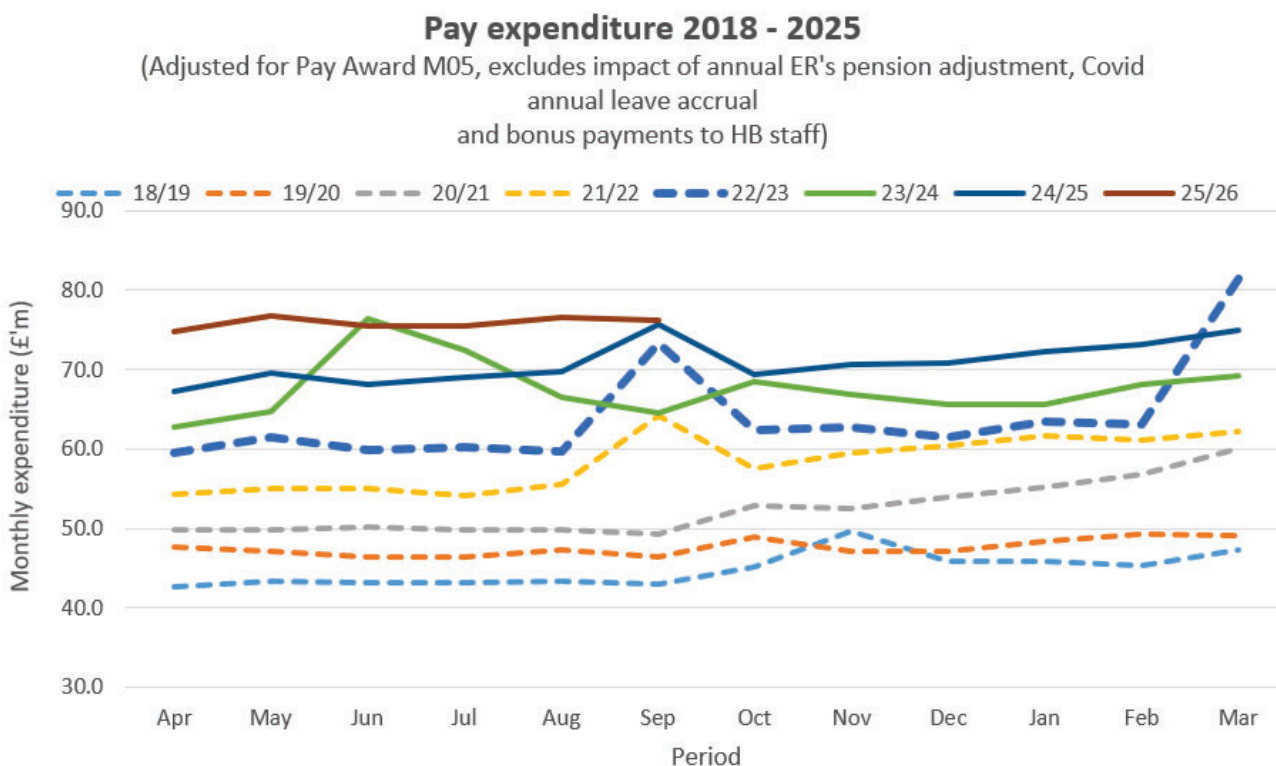
The Board took the decision to change from the planned financial position to a forecast £19.9m deficit due to the in-year pressures. The components of the forecast includes full delivery of the IMTP savings plan and new in year cost pressures that are in addition to those within the IMTP. This is currently assessed as the best-case scenario.

The Health Board will continue to seek ways to mitigate this position and any further additional costs, but risks remain in achieving this forecast.

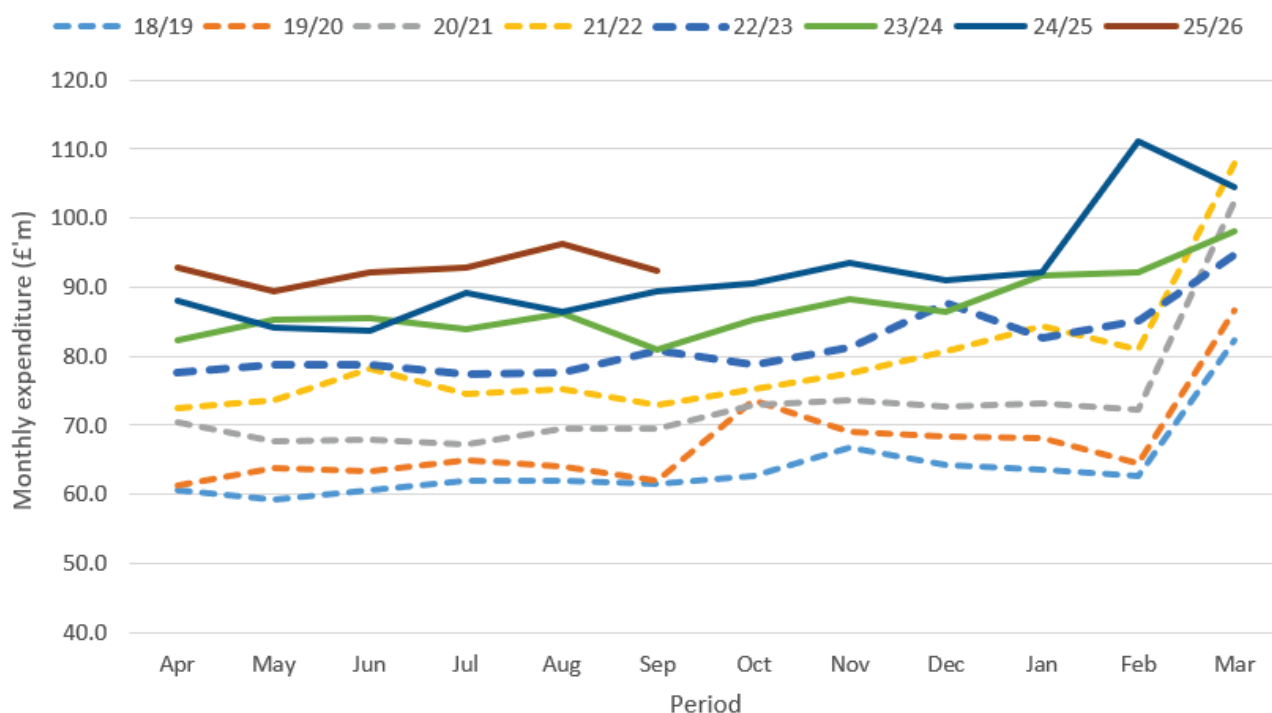
Additional risks outside the reported forecast include the Welsh Risk Pool increased premium, winter plan implications and the potential impact of any band 2 to 3 HCSW regrades (national proposal).

Expenditure run-rates

Pay and Non-Pay expenditure run-rates for the last seven financial years are shown below; assuming the current level of income, the expenditure run-rates need to reduce in order for the Health Board to meet its forecast position.



Non pay expenditure 2018 - 2025



Workforce

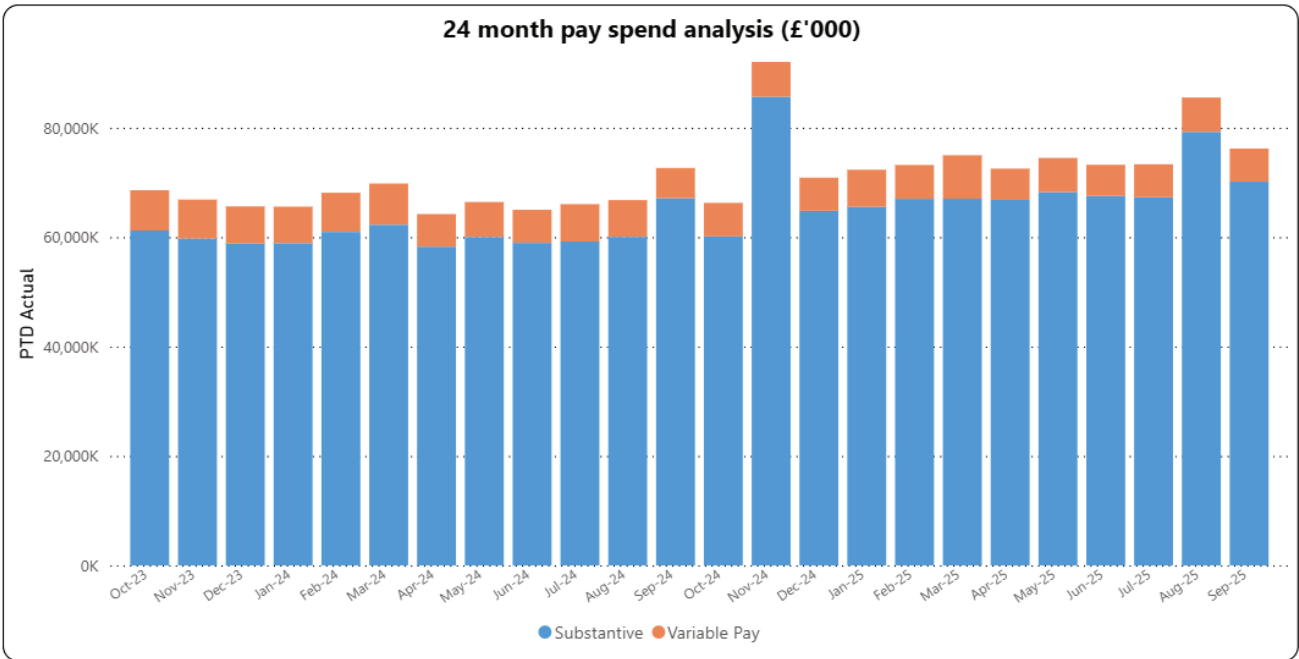
The Health Board spent £76.2m in September on workforce. The 25/26 A4C and Medical and Dental pay award was received in August, including arrears for M01-04.

Workforce Costs	Current month £m	Previous Month £m	Year to Date 25/26 £m
Total Pay	76.2	85.4	455.2
Substantive Pay	70.1	79.1	419.1
Variable Pay	6.1	6.3	36.1

Operational pressures including Enhanced Care, sickness and vacant posts continue to cause a pressure on the Health Board position. The focus remains on minimising variable pay with a range of operational actions and savings plans including service re-design and capacity reduction. Real terms total workforce cost reduction will be the key indicator.

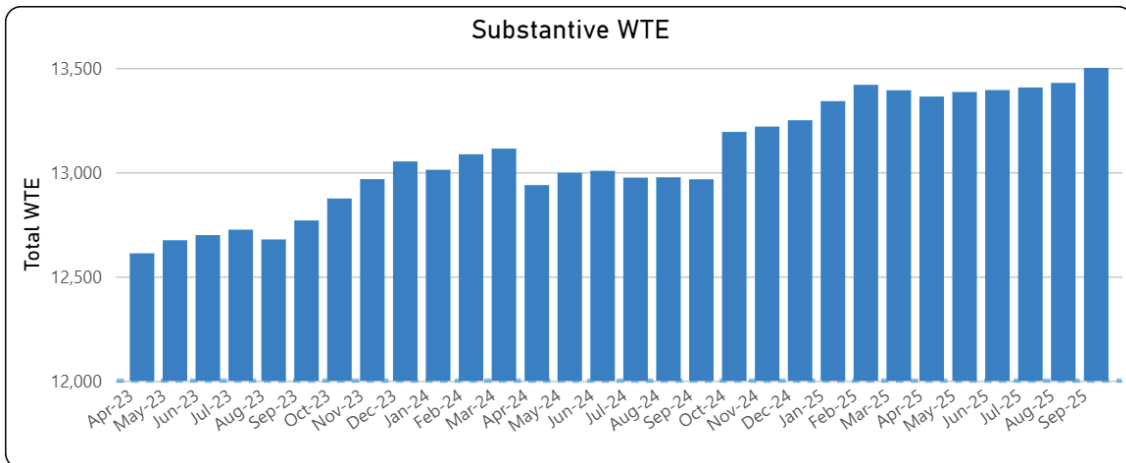
Workforce expenditure trends are shown below differentiating between substantive and variable pay¹:

¹ To enable useful comparisons and trends all references to 23/24 pay expenditure exclude the month 12 expenditure for additional employer pension contributions (6.3%/£32.1m).



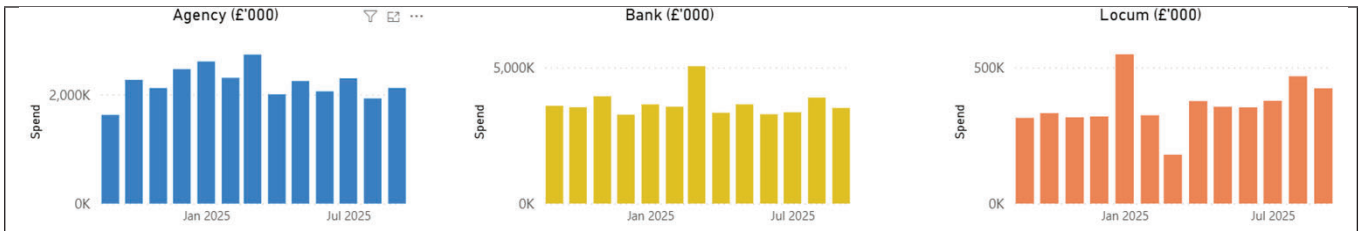
Substantive staff

Substantive pay was £70.1m in September, down £9m on the previous month (reflecting the Pay Award and M01-4 arrears processed last month). Substantive WTE's were 13,543 compared with 13,428 for August.



Variable pay

Variable pay (Agency, Bank and Locum) was £6.1m in September compared with £6.3m in August, a £0.2m decrease. The decrease in variable pay is reflective of the bank wage award paid in month 5.



Variable Pay Costs	Current month £m	Previous Month £m	Year to Date 25/26 £m
Agency - Nursing	0.7	0.6	3.9
Agency – Medical & Dental	0.9	0.9	5.8
Agency - HCSW	0.1	0.1	0.9
Agency – Estates & Other	0.4	0.3	1.9
Bank	3.5	3.9	21.0
Locums	0.4	0.5	2.3

Enhanced Care for September 2025 was £0.5m of expenditure using bank and agency registered nurses and health care support workers, for 20,677 hours worked.

Nursing vacancy cover for September 2025 variable pay relating to vacancies is c.£1.4m for 52,825 hours worked for bank and agency hours for shifts where ‘to cover vacancies’ is provided as the reason for use.

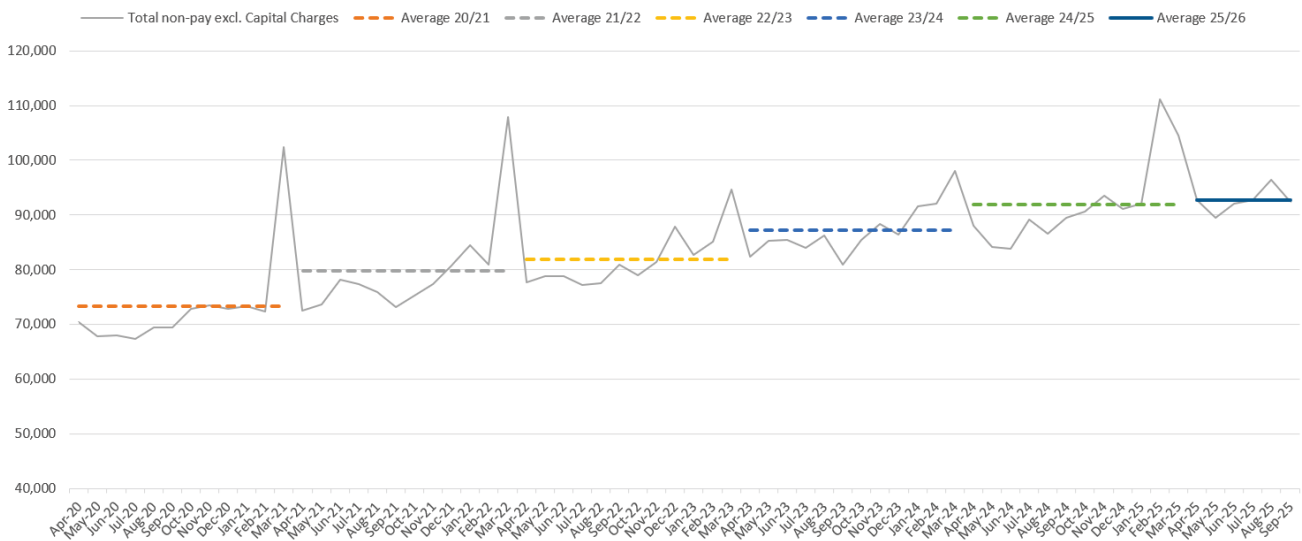
Nursing sickness cover for September 2025 variable pay relating to sickness is c.£1m (‘notional calculated’ expenditure) for 38,088 hours worked for bank and agency hours for shifts booked to cover sickness as input onto the e-roster system.

Non-Pay

Spend (excluding capital) was £92.4m in September, which was a decrease of £4m compared with August due to the pass through 2024/25 wage award funding via LTA’s & Joint Commissioning Committee.

The graph below presents non-pay expenditure since April 2020 (it should be noted that the peaks are year-end adjustments and Month 12 items):

Total non-pay excl. Capital Charges

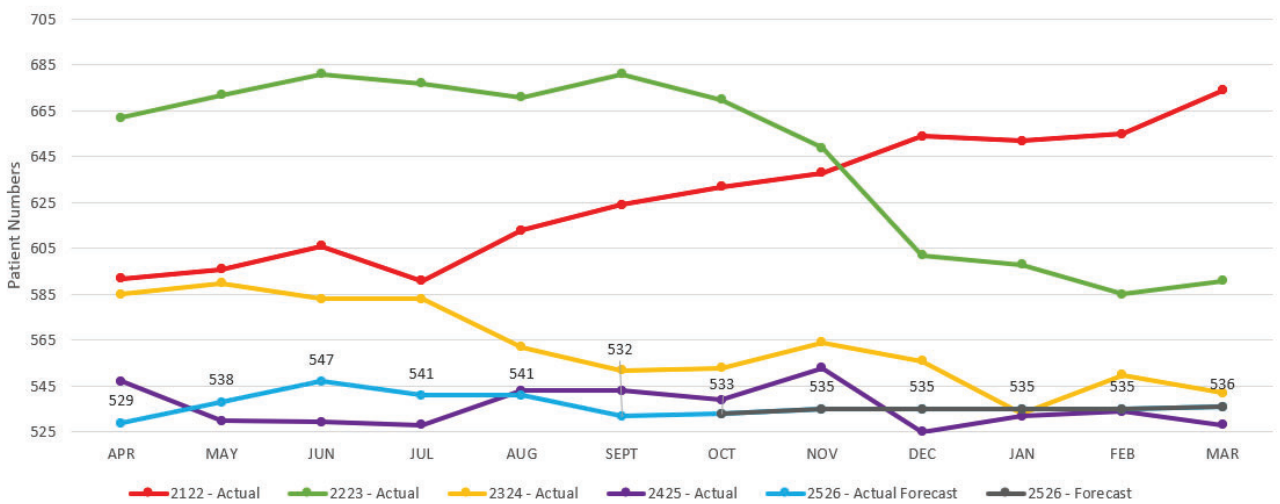


CHC

The Health Board spent £11.6m on CHC (all types) in September, which was a 0.5m decrease on last month. This is reflective of reduced inflationary pressures expected for 25/26 and some reductions in 1-2-1 supervision.

Adult Complex Care CHC activity over the last 5 financial years is summarised in the chart below: -

CHC ACTIVITY (incl DTA/ scth)



Childrens packages are more volatile and may present a risk in 2025/26 above plan assumptions. At month 6 there are 35 out of county packages of care, 5 of which are high values packages (cost more than £0.1m each). Childrens Community Nursing has 19 Internal open packages of care as at M6, 5 of which are classified as high value packages.

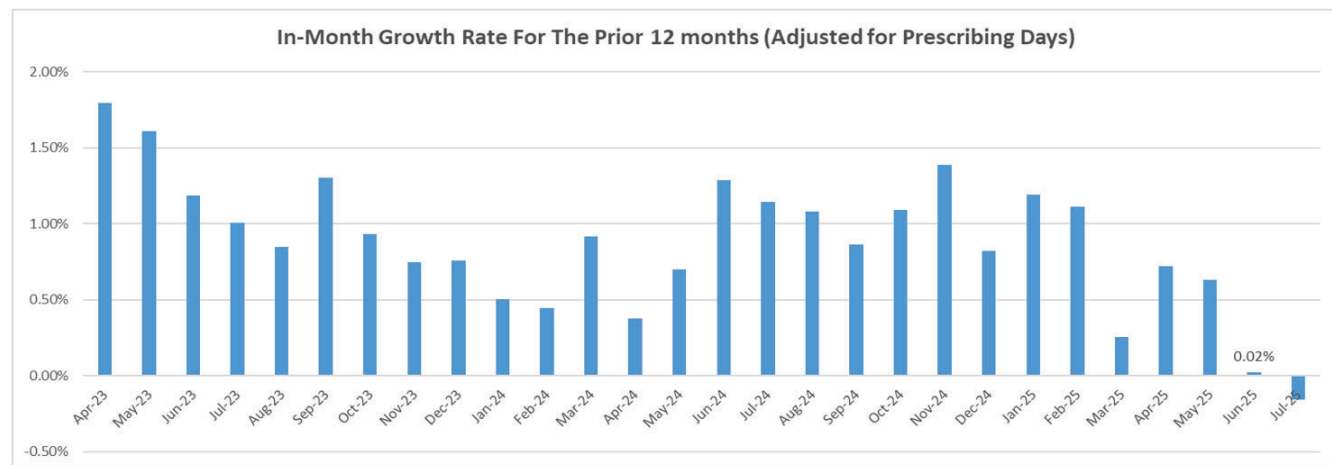
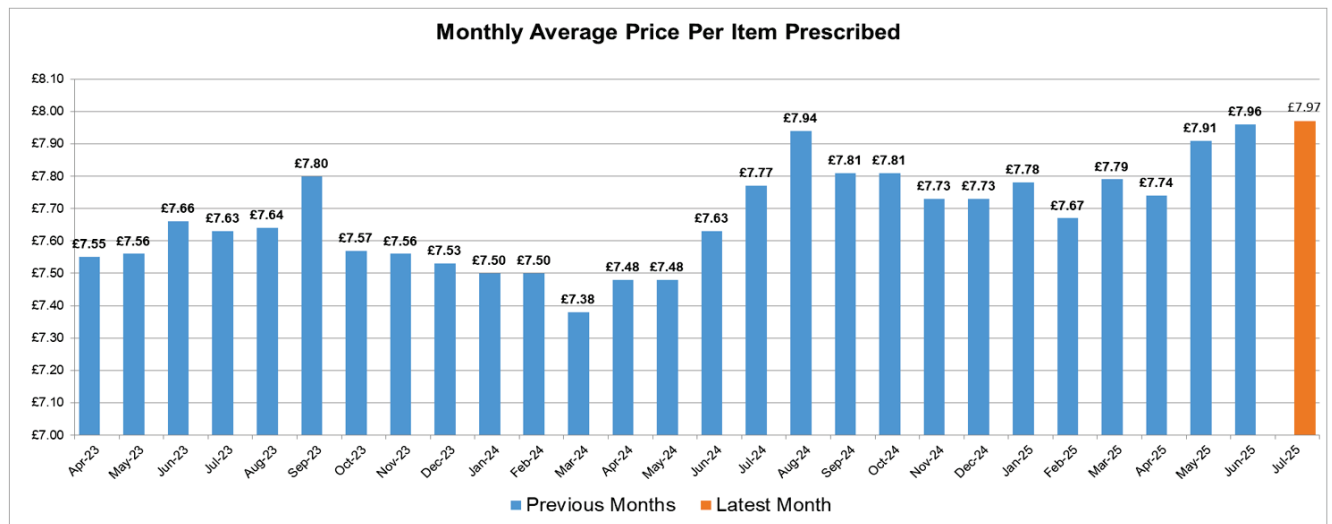
Mental Health CHC patient numbers had a net increase of one in month 6 taking MH packages of care to 277. There was no overall change in patient numbers for LD, packages remaining at 171, a total of 448 patients overall. 458 packages are forecast by the end of the year. MH packages are averaging £95k and LD £174k per annum.

Prescribing

Primary Care prescribing spend for September was £10.9m, in line with July and August expenditure.

Prescribing forecast spend has worsened compared with the Plan due to an increased average item price (to £7.86 from £7.41 plan) and the level of actual items prescribed in the April PAR. Based on the last four months data, at an ABUHB and all Wales level, there has been a reduction in item numbers prescribed, ABUHB reduced the forecast for growth from 0.5% to 0.1%. This offsets the forecast increase in average item price which has risen from £7.81 forecast in month 5 to £7.86 in month 6, this increase is mainly due to the in month average item price for July being 13.8p higher than forecast.

The graphs below show the monthly average price per item and item growth: -



For example the growth rate quoted in Aug24 will have been the growth in items for the 12 month period Sep23-Aug24 compared to Sep22-Aug23

Waiting Times Additional activity

The Health Board secured £1.5m from WG for additional waiting times activity to improve the 104 week waiting times position for patients. Good progress is being made to reduce waiting times; the table below provides a summary forecast of this position.

Specialty	Delivery Method	Funding £k	Plan Vol	Q1 Actual Vol	M04 Actual Vol	M05 Actual Vol	M06 Actual Vol	Q2 Actual Vol	M06 YTD Actual Vol	M06 YTD Variance Vol	M05 YTD Total Actual Cost £k	M05 YTD (Under) / Over spend £k
ENT	Insourced	300	440	464	-	-	-	-	464	24	224	- 76
	Outsourced	152	191	63	-	-	-	-	63	128	72	- 80
Non Cat Eyes	Insourced	28	50	50	-	-	-	-	50	-	12	- 16
Orthopaedics	WLI / Backfill	1,020	255	425	58	81	71	210	635	380	3,612	2,592
Total		1,500	936	1,002	58	81	71	210	1,212	276	3,920	2,420

Additional work has also been delivered through efficiency at an estimated marginal cost of £0.9m for the year.

Long Term Agreements (LTA's)

The Health Board has agreed and signed LTAs for all Welsh providers and commissioners with no disputes.

The Health Board has agreed LTAs with all English providers reflecting the CUF Uplift/National tariff changes. During a review of these agreements, it has been identified that several of the individual tariff lines have been inflated by up to 14.7% which is significantly more than the current WG funding, At this stage the health Board is assuming this will be managed internally but without funding or further mitigating actions this could generate an unfunded financial pressure to the Health Board of circa £0.7m.

At month 6 reporting, activity information to support LTA forecasts is based on month 5 data but initial indications suggest less than expected growth in NICE drug expenditure at CVUHB and Velindre. This forecast remains volatile with Velindre changing their forecast significantly in month 6 (improvement c£1m). We continue to meet with providers to manage and mitigate any further risks.

The Health Board is reflecting in it's deficit forecast the overspend that JCC is forecasting. However, discussions over managing and mitigating the significant risk to that position continue. In addition there is a contract performance risk if provider activity continues to increase. The Health Board also lost c£0.3m income linked with underperformance of Cardiology ICD's.

LTA contract performance risk is predominantly with Velindre and Cardiff. The Health Board is current forecast is in line with provider monitoring information. However there is risk of potential increases in activity by the provider through the year and increases in high cost drug recharges.

Revenue Reserves

Health Board reserves are held by the Board until such time as they agree their use or delegate this responsibility to the Chief Executive as Accountable Officer.

The reserves held at 30th September 2025 are £9.2m, including allocations to be delegated of £6.6m, specific commitment reserves of £1.2m, those supporting the financial position of £1m and a contingency investment reserve (eg. winter) of £0.4m.

The reserves include some elements of income assumed at risk associated with the submitted plan with £3.9m of anticipated funding for RTT activity, beyond current funded levels.

A summary of all Health Board reserves on 30th September can be found in the appendices.

Underlying Financial Position (ULP)

The Underlying (U/L) position brought forward into 2025/26 was a deficit of £27.2m with a forecast carry forward deficit into 2026/27 of £14m. This is per the plan submitted on the 31st March 2025.

The underlying deficit position was reviewed as part of the IMTP process for 2025/26 which can be summarised as below:

2025/26 Opening underlying position	24/25 Plan £m	25/26 movement £m	25/26 opening plan £m
Workforce & Variable Pay	2	3.9	5.9
CHC	2.6	1	3.6
Medicines management	4.8	5	9.8
JCC specialised services	5	2.8	7.8
Total	14.4	12.7	27.2

This resulted in a starting underlying position for 2025/26 of £27.2m

The elements and cost drivers making up the underlying deficit are under regular review to ensure actions to address the growth/pressure are being progressed and may be updated in conjunction with the review of the forecast.

Following the adjusted forecast to a deficit in year position the underlying forecast will also need to be updated. An exercise will be undertaken to establish the savings and mitigating actions that are recurrent. It is anticipated to show a worsening underlying financial position.

Savings delivery

The 2025/26 plan submitted by the Health Board to Welsh Government (March 2025), identified £40.4m as the required level of savings to support a breakeven forecast position for 2025/26. The savings schemes were shown as three categories:

- Identified savings schemes - £15.7m
- Identified Health Board level savings opportunities with work to be undertaken to attribute to specific schemes - £10.3m
- Pipeline opportunities not yet identified - £14.4m

Following financial recovery actions all savings and mitigating actions have been identified, albeit risk remains in their achievement.

As at month 6, the year to date saving target has been exceeded and the full year plan has also been exceeded with a full year forecast of £42.5m.

In line with WG expectation that there is a high degree of confidence in delivery of the savings at month 6, all savings schemes have been reported as green. There remains risk in the full achievement of some of the savings, and in the recurrent nature of some, but the Health Board expects to manage this as the financial year progresses.

The Health Board will continue to identify new schemes and to review performance on existing schemes to maximise the total achievement for the year and will continue to operate a Bi-weekly Value & Sustainability Board to identify and monitor savings delivery & new opportunities.

The table below presents the updated savings plan at a Divisional level (nb. The 'various' line were savings yet to be confirmed in the IMTP):

Savings YTD and forecast position (£'000)

Division	% of total Plan	Annual Plan	YTD Plan	YTD Achieved	YTD Variance	Forecast	Forecast variance to Plan	% Achieved
Clinical Support Services	3.6%	£1,438	£824	£1,413	£590	£3,609	£2,172	251.1%
Complex Care	1.9%	£781	£280	£219	-£61	£1,031	£251	132.1%
Contracting and Commissioning	0.0%	£0	£0	£2,425	£2,425	£3,659	£3,659	
Corporate	6.1%	£2,471	£1,047	£946	-£101	£10,079	£7,608	407.9%
Estates and Facilities	7.4%	£3,000	£1,502	£3,055	£1,553	£4,927	£1,927	164.2%
Families and Therapies	1.7%	£682	£301	£1,037	£736	£2,151	£1,469	315.5%
Medicine	5.6%	£2,250	£1,239	£2,054	£815	£4,448	£2,198	197.7%
Mental Health and Learning Disabilities	2.3%	£946	£207	£459	£252	£1,147	£201	121.3%
Prescribing	5.6%	£2,252	£766	£1,241	£476	£5,161	£2,909	229.2%
Primary Care and Community	4.0%	£1,614	£431	£1,242	£811	£2,316	£702	143.5%
Surgery	6.1%	£2,448	£1,116	£847	-£270	£3,001	£553	122.6%
Urgent Care	1.3%	£539	£217	£215	-£2	£970	£431	180.0%
Various	54.4%	£21,980	£0	£0	£0	£0	-£21,980	0.0%
Total	100.0%	£40,400	£7,929	£15,154	£7,225	£42,500	£2,100	105.2%

Savings summary (£'000)

Value & Sustainability category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to Plan	Full-year Annual Plan	Full-year Forecast savings	Full-year Variance to plan
CHC	10	£374	£475	£101	£2,563	£1,482	-£1,080
Medicines Management	37	£1,627	£2,581	£954	£4,520	£8,750	£4,230
Procurement & Non-pay	128	£3,384	£7,104	£3,720	£20,587	£19,783	-£804
Service redesign	3	£340	£845	£505	£1,980	£1,724	-£256
Workforce	76	£2,205	£4,149	£1,944	£10,750	£10,761	£10
Total	254	£7,929	£15,154	£7,225	£40,400	£42,500	£2,100

There are significant challenges to achieving the financial forecast for 2025/26.

Opportunities

The ABUHB Value & Sustainability Board and relevant Divisions / Departments are actively engaged in the identification of opportunities to deliver financial balance for ABUHB.

Following the update from DHCW in relation to the Microsoft VAT recovery claim, the related opportunity has been removed. However, an opportunity for further savings from the Diabetes drug Dapagliflozin of £0.482m exists if the price reduces to 10% of its original price.

At this stage the Health Board has not identified opportunities to mitigate all of the new in year cost pressures and must seek to identify recurrent opportunities for future years.

Potential further opportunities have been identified but are not at a point to include as savings:

Opportunities Pipeline September 25	No. Schemes	£000
Procurement & Non-Pay	9	(1,045)
Workforce	9	(2,460)
Medicines Management	6	(482)
CHC	2	(972)
	26	(4,959)

Risks

The risks have been updated to reflect additional in year pressures (above the £19.9m). Risks are reviewed regularly and updated based on the Health Board's assessment of the current level of risk to the financial position and its ability to manage those risks.

The most significant additional risks to the Health Board are:

Risks Excluded from Forecast £19.9m deficit		£m
WRP		7
band 2 to 3		6
Bank wage award not funded		1.5
RTT not funded - WJ's / internal solutions		3
RTT not funded - national insourcing		tbc
National OP insourcing s/fall		tbc
Winter		tbc
MH Variable Pay		2
ED45 mins (2 months extra nursing)		0.2
Pay settlements funding		tbc
Achievement of Full Savings plan		tbc
Operational Pressures in xs of forecast		tbc
Confirmation of anticipated funding (Wage awrds & Planned care)		tbc

These risks are outside the current forecast and if costs are incurred and mitigations or funding is not identified then it is highly likely that they will impact the year end forecast deficit.

Capital

The approved Capital Resource Limit (CRL) as at Month 6 totalled £33.388m. MMR Table I – Capital RLM is showing a forecast underspend against CRL of £0.274m that relates to an underspend against the 2nd MRI for Grange University Hospital Scheme. The underspend against this scheme will be reported to WG Capital colleagues in the October mid-year review submission. Once this CRL adjustment has been actioned the overall position will be brought back to breakeven.

AWCP Schemes

NHH Satellite Radiotherapy Centre – Main Scheme

The NHH Satellite Radiotherapy scheme building handover took place on the 6th May. After commissioning, the unit opened to patients on the 30th June 2025. The final account for the building works is now being agreed with the contractor. Associated smaller works and expenditure against the arts budget will continue throughout the remainder of the year.

GUH Emergency Department Extension

Works on the Grange University Hospital Emergency Department Extension Phase 1 are nearing completion. Discussions are underway with the contractor around Phase 2 delivery. The scheme is currently forecast to be £403k overspent which is being funded via the Discretionary Capital Programme (DCP). There is a risk of increased overspend if further claims submitted by the contractor in relation to prolongation of the programme and additional works are approved under the contract.

Head Lease for Chepstow Community Hospital

The order for this scheme has been raised, and works are expected to complete by the end of December.

Year End Funding October 2024 (GUH 2nd MRI)

The MRI machine was delivered at the end of June and is now operational. Works are complete and smaller associated equipment orders have been delivered. Whilst some final costs are anticipated, an underspend of £274k has been reported.

Centralised Decontamination Unit

The expected handover of the Centralised Decontamination Unit at RGH is delayed until February 2026. The commissioning period will then commence to allow the unit to open in April 2026. The reported underspend relates to the reimbursement to DCP for fees incurred in prior financial years (£0.139m).

RGH Blocks 1 & 2 Demolition and Car Park

A SAB application for this scheme is required to be re-submitted to Newport City Council; it is expected that a decision on this will take a further 6 weeks. A planning application will be submitted at the same time. Slippage against this allocation will be confirmed during the month and will be reported in the mid-year review at the end of October.

Backlog Maintenance 2024/25

The Backlog Maintenance slippage allocation totalling £2.017m relates to St Cadoc's duct works and lift door replacements at Royal Gwent and Nevill Hall Hospitals. Works are progressing on both schemes which are expected to complete by quarter 3 of 2025/26.

TEF National Programmes – Fire/ Infrastructure/ Decarbonisation/ Mental Health/ Infection Control/ Decontamination

Targeted Estates Funding (TEF) for 2025/26 has been revised to £8.388m as a slippage request of £1.150m has been approved by WG. The slippage relates to structural and roof works at St Cadoc's Hospital (£0.400m) and Window Replacements at the Royal Gwent Hospital (£0.750m). This funding has now been carried forward to 2026/27.

Additional slippage has been identified on other schemes within the programme, but the Health Board is currently managing this by bringing forward TEF expenditure approved for 2026/27 where this has been possible. An update will be sent to shared services to inform them of the changes being proposed.

EFAB Infrastructure

This allocation in relation to the original St Cadoc's Ducts work is now fully expended. The remaining works will continue under the backlog maintenance and TEF funding allocations.

CAMHS – Sanctuary Hub (HCF Funding)

The disabled access ramp is now installed and expenditure against this AWCP allocation is complete. The remainder of the ramp costs are funded from DCP.

YYF Unified Breast Unit

The final account is agreed, and the final VAT recovery claim has been submitted to HMRC in August. Some small works and equipment purchases are progressing.

Ty Gwent

Orders are raised for the outstanding works in relation to the external EV parking. The works are due to complete in the next few months.

Commercial Research Delivery Wales Equipment 2024/25

The slippage amount of £12k is now fully spent.

Digital Equipment 2024/25

The slippage amount of £53k is now fully spent.

Year End funding – February 2025

The slippage amount of £77k relates to the late delivery of bariatric beds. Final deliveries are awaited.

IRCF - Aber Valley Health and Wellbeing Centre and Aber Practice Development

The Outline Business Case (OBC) preparation is on-going. The flood mapping works have concluded, and the Health Board is actively meeting with the Local Authority to explore options within the Aber Park site. Costs are being agreed with the supply chain partner for Abervalley to complete the OBC (a forecast overspend of £230k has been included this month, however, final costs are still to be agreed). A notification of event submission will be made to the Regional Partnership Board (RPB) / WG for approval as soon as the requirements are confirmed.

IRCF - Monmouth Health and Wellbeing Centre and Dixton Surgery

Final environmental surveys have concluded for the Osbaston site. A decision has been made to investigate the feasibility of utilising Monnow Vale as a further site option for the development. Fees are being negotiated with the supply chain partner to undertake the workstream. Additional funding may be required to complete these works for which a notification of event will need to be submitted to the RPB/WG for approval.

Housing with Care Fund

Additional funding of £122k has been received in month. A VAT saving of £16k has been reported across these schemes. A request has been made to the RPB team to reallocate these funds to the DCP funded costs associated with the CAMHS Sanctuary Hub disabled access ramp.

DPIF - Medicines and Prescribing: Electronic Prescribing and Medicines Administration (ePMA)

There is likely to be slippage against this allocation which will be determined in October and reported in the October mid-year review.

DPIF - RISP

An allocation of £472k was approved into the CRL during July. The ABUHB RISP implementation go live date is now expected to be 8th May 2026. A small amount of slippage relating to the go live support costs in May 2026 will be determined and reported in the mid-year review.

Non-Radiology Ultrasound Replacement Funding

Procurement activities have commenced on the identified priority machines within the approved allocation of £576k. Procurement are currently awaiting specifications to be completed for many of the machines to progress. Once these have been received, and lead times are known for individual orders, the expenditure forecast will be updated.

Mental Health Quality & Safety Schemes

Works have commenced across the five identified projects within the £705k allocation.

Discretionary Capital Programme

The Health Board Discretionary Capital Programme (DCP) forecast for 2025/26 is £6.711m at Month 6 made up of:

- 2025/26 DCP Funding - £12.875m

- Less 30% TEF contribution - (£2.862m)
- Less 2024/25 AWCP scheme brokerage - (£3.235m)
- Plus Reimbursement of DCP Fees re: RGH Decon scheme - £0.139m
- Less 2025/26 AWCP scheme overspends - (£0.267m)
- Plus disposal proceeds 2025/26 - £0.061m

DCP expenditure to Month 6 totalled £2.366m. Several urgent schemes have been approved during July which include Additional Parking for GUH (£0.229m) and essential equipment replacements for Clinical Support Services. The unallocated contingency at the end of Month 6 is now £0.028m.

Cash

The cash balance at the 30th September is £4.500m, which is below the advisory figure set by Welsh Government of £6m.

The Health Board is currently forecasting an overspend of £19.9m in 2025/26, reflecting this overspend in the cash forecast means the Health Board will require strategic cash support towards the end of the year, if not reduced downwards toward break even.

The Health Board will be requesting strategic cash support of £19.9m, the Board is asked to approve this request and for an Accountable Officer letter to be submitted.

This increased strategic cash support from Welsh Government, based on the deficit forecast, will be required to enable the Health Board to continue to pay its suppliers in a timely manner.

Public Sector Payment Policy (PSPP)

The HB has achieved the target to pay 95% of the number of non-NHS creditors within 30 days of the delivery of goods/services in September and cumulatively.

Whilst the HB has achieved the target to pay 95% in September, on a cumulative basis we remain below the target. This is due to issues identified with the processing of Northumbria NHS Trust fleet solutions invoices. Whilst this issue is now resolved, the residual impact of previous months' dropping below the target means we are currently failing the 95% target on a year-to-date basis.

Category	Invoices	In Mth %	YTD %
NHS	Value	99.8	98.0
	Number	95.4	90.9
Non NHS	Value	97.4	96.8
	Number	96.1	97.1

Argymhelliad / Recommendation

The Board is asked to note for assurance:

- The financial performance at the end of September 2025 and forecast position against the statutory revenue and capital resource limits,
- The savings position for 2025/26,
- The revenue reserve position on the 30th September 2025,
- The Health Board's underlying financial position,
- The cash position,
- Public sector payment policy performance, and
- The capital position.

The Board is asked to approve:

- The request for £19.9m strategic cash support for 2025/26

Note: the appendices attached providing further detailed information.



Board%20Finance%
20Report%20Appen

September 2025 Monthly Monitoring Return:

[Key Documents - Aneurin Bevan University Health Board](#)

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a
Sgôr Cyfredol:
Datix Risk Register Reference
and Score:

Financial Sustainability

Safon(au) Gofal ac Iechyd:
Health and Care Standard(s):

7. Staff and Resources
Governance, Leadership & Accountability
All Health & Care Standards Apply
Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. All IMTP priorities
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	ABUHB efficiency compendium Value & Sustainability Board
Rhestr Termau: Glossary of Terms:	A&C – Administration & Clerical A&E – Accident & Emergency A4C - Agenda for Change AME – (WG) Annually Managed Expenditure AQF – Annual Quality Framework AWCP – All Wales Capital Programme AP – Accounts Payable AOF – Annual Operating Framework ATMP – Advanced Therapeutic Medicinal Products B/F – Brought Forward BH – Bank Holiday C&V – Cardiff and Vale CAMHS – Child & Adolescent Mental Health Services C/F – Carried Forward CHC – Continuing Health Care Commissioned Services – Services purchased external to ABUHB both within and outside Wales COTE – Care of the Elderly CRL – Capital Resource Limit Category M – category of drugs CEO – Chief Executive Officer CEAU – Children’s Emergency Assessment Unit CTM – Cwm Taf Morgannwg D&C – Demand & Capacity

DCP – Discretionary Capital Programme
 DHR – Digital Health Record
 DNA – Did Not Attend
 DOSA – Day of Surgery Admission
 D2A – Discharge to Assess
 DoLS - Deprivation of Liberty Safeguards
 DoF – Director(s) of Finance
 DTOC – Delayed Transfer of Care
 EASC – Emergency Ambulance Services Committee
 ED – Emergency Department
 EDCIMS – Emergency Department Clinical Information Management System
 eLGH – Enhanced Local general Hospital
 EFAB – Estates Funding Advisory Board
 ENT – Ear, Nose and Throat specialty
 EoY – End of Year
 ETTF – Enabling Through Technology Fund
 F&T – Family & Therapies (Division)
 FBC – Full Business Case
 FNC – Funded Nursing Care
 GDS – General Dental Services
 GMS – General Medical Services
 GP – General Practitioner
 GWICES – Gwent Wide Integrated Community Equipment Service
 GUH – Grange University Hospital
 GIRFT – Getting it Right First Time
 HCHS – Health Care & Hospital Services
 HCSW – Health Care Support Worker
 HIV – Human Immunodeficiency Virus
 HSDU – Hospital Sterilisation and Disinfection Unit
 H&WBC – Health and Well-Being Centre
 IMTP – Integrated Medium Term Plan
 INNU – Interventions not normally undertaken
 IPTR – Individual Patient Treatment Referral
 I&E – Income & Expenditure
 ICF – Integrated Care Fund
 LoS – Length of Stay
 LTA – Long Term Agreement
 LD – Learning Disabilities
 MH – Mental Health
 MSK - Musculoskeletal
 Med – Medicine (Division)
 MCA – Mental Capacity Act
 MDT – Multi-disciplinary Team
 MMR – Welsh Government Monthly Monitoring Return

NCA – Non-contractual agreements
 NCN – Neighbourhood Care Network
 NCSO – No Cheaper Stock Obtainable
 NI – National Insurance
 NICE – National Institute for Clinical Excellence
 NHH – Neville Hall Hospital
 NWSSP – NHS Wales Shared Services Partnership
 ODTG – Optometric Diagnostic and Treatment Centre
 OD – Organisation Development
 PAR – Prescribing Audit Report
 PCN – Primary Care Networks (Primary Care Division)
 PER – Prescribing Incentive Scheme
 PICU – Psychiatric Intensive Care Unit
 PrEP – Pre-exposure prophylaxis
 PSNC –Pharmaceutical Services Negotiating Committee
 PSPP – Public Sector Payment Policy
 PCR – Patient Charges Revenue
 PPE – Personal Protective Equipment
 PFI – Private Finance Initiative
 RGH – Royal Gwent Hospital
 RN – Registered Nursing
 RRL – Revenue Resource Limit
 RTT – Referral to Treatment
 RPB – Regional Partnership Board
 RIF – Regional Integration Fund
 SCCC – Specialist Critical Care Centre
 SCH – Scheduled Care Division
 SCP – Service Change Plan (reference IMTP)
 SLF – Straight Line Forecast
 SpR – Specialist Registrar
 STW – St.Woolos Hospital
 TCS – Transforming Cancer Services (Velindre programme)
 T&O – Trauma & Orthopaedics
 TAG – Technical Accounting Group
 UHB / HB – University Health Board / Health Board
 USC – Unscheduled Care (Division)
 UC – Urgent Care (Division)
 ULP – Underlying Financial Position
 VCCC – Velindre Cancer Care Centre
 VERS – Voluntary Early Release Scheme
 WET AMD – Wet age-related macular degeneration
 WG – Welsh Government

	<p>WHC – Welsh Health Circular</p> <p>WHSSC – Welsh Health Specialised Services Committee</p> <p>WLI – Waiting List Initiative</p> <p>WLIMS – Welsh Laboratory Information Management System</p> <p>WRP – Welsh Risk Pool</p> <p>YAB – Ysbyty Aneurin Bevan</p> <p>YTD – Year to date</p> <p>YYF – Ysbyty Ystrad Fawr</p>
<p>Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:</p>	<p>Executive Committee</p>

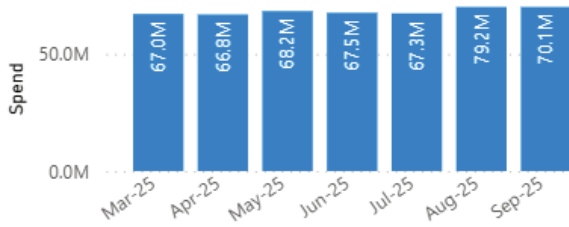
Effaith: (rhaid cwblhau) Impact: (must be completed)	
<p>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</p>	<p>Is EIA Required and included with this paper No does not meet requirements</p> <p>An EQIA is required whenever we are developing a policy, strategy, strategic implementation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

Aneurin Bevan University Health Board
Finance Report – September (Month 06) 2025
Appendices

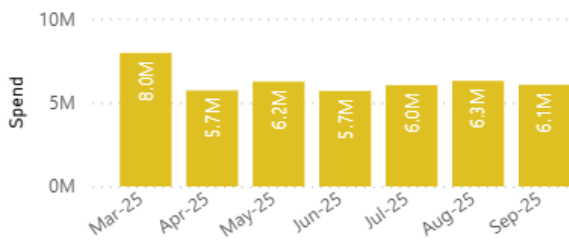
Section
Pay Summary 1
Pay Summary 2 Substantive Pay
Pay Summary 3 Variable Pay
Pay Summary 4 Bank & Agency Reasons RN's & HCSW's
Non-pay Summary
CHC Activity & Forecast
RTT & Waiting List Initiatives
Savings scheme RAG rating definitions
Divisional analysis
Reserves
Cash / Public Sector Payment Policy
External Contracts – LTA's
Joint Commissioning Committee (formerly WHSSC & EASC)
Balance sheet
Health Board Income – Other income
Capital Planning & Performance

Pay Summary (1) (excluding 6.7% Pension employer costs paid in March of each year)

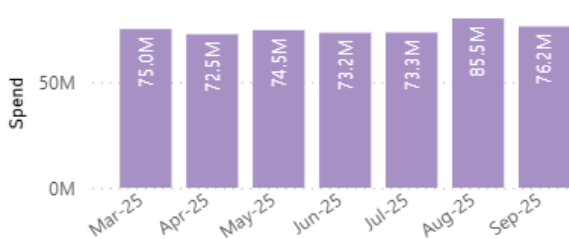
Substantive pay (£'M)



Variable pay (£'M)



Total Pay (£'M)



Substantive (£'000)

Pay category	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
ADD PROF SCIENTIFIC AND TECHNICAL	2,591	2,644	2,617	2,613	2,641	3,100
ADDITIONAL CLINICAL SERVICES	8,419	8,684	9,230	8,980	8,842	9,899
ADMINISTRATIVE & CLERICAL	10,114	10,722	10,526	10,760	10,818	12,600
ALLIED HEALTH PROFESSIONALS	4,348	4,501	4,567	4,507	4,519	5,420
ESTATES AND ANCILLIARY	3,253	3,387	3,681	3,516	3,499	3,790
HEALTHCARE SCIENTISTS	1,187	1,266	1,288	1,256	1,276	1,480
MEDICAL AND DENTAL	18,635	16,729	17,057	16,884	16,794	20,400
NURSING AND MIDWIFERY REGISTERED	18,460	18,869	19,265	19,014	18,901	22,510
STUDENTS	2	2	2	2	2	2
Total	67,008	66,804	68,232	67,533	67,291	79,230

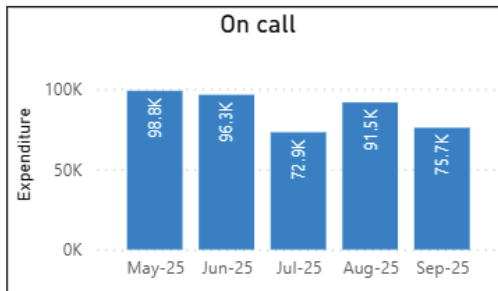
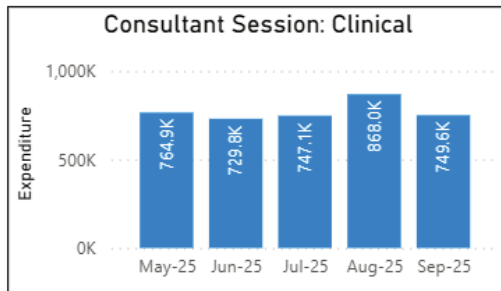
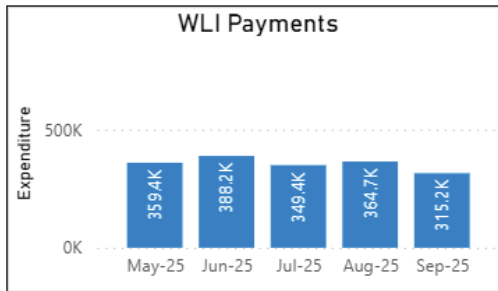
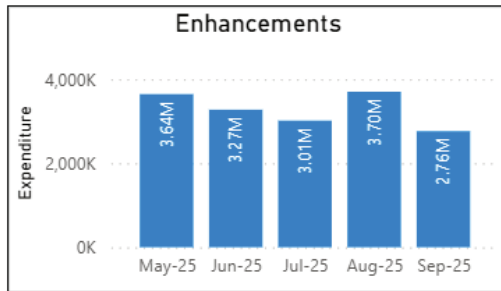
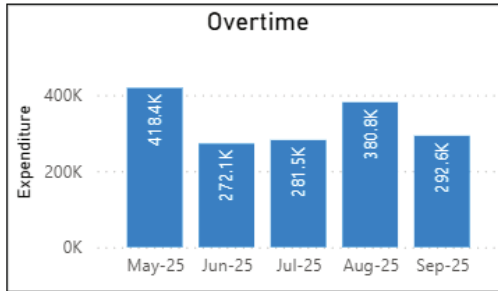
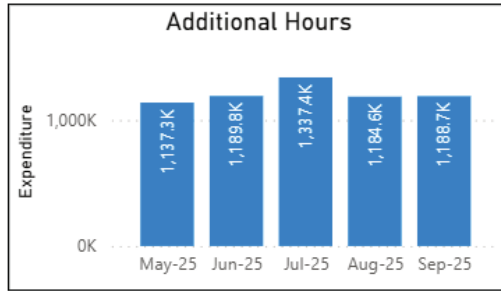
Variable pay (£'000)

Pay category	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Locum	180	376	356	353	377	468
Bank	5,044	3,336	3,643	3,279	3,354	3,891
Agency	2,735	2,005	2,249	2,060	2,300	1,930
Total	7,959	5,718	6,248	5,692	6,031	6,289

Total pay (£'000)

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Pay	74,968	72,521	74,480	73,225	73,322	85,520

Pay Summary (2): Substantive Pay: Additional pay element



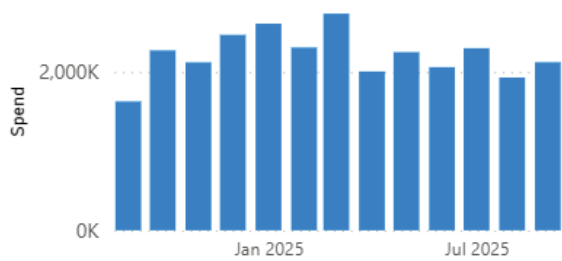
Division	Total a
Medicine	
Surgery	
Clinical Support Services	
Family and Therapies	
Urgent Care	
Primary Care and Community	
Estates and Facilities	
Mental Health and LD	
CHC and FNC	
Corporate	
Total	



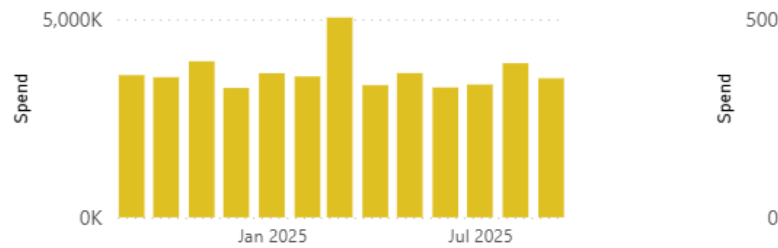
Pay Summary (3): Variable Pay (£'k)

Pay category	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Agency													
Admin & Clerical Agency	12	-6	-47	3	31	6	37	38	10	17	54	2	56
Allied Health Prof Agency	105	132	148	166	253	262	323	163	136	78	202	69	79
Estates & Ancilliary Agency	-446	78	36	34	67	-49	145	112	81	128	59	111	159
Medical Agency	792	876	962	859	868	900	1,038	858	1,156	945	991	883	903
Nurse HCA/HCSW Agency	39	58	43	120	131	92	202	115	172	189	197	95	84
Other Agency	63	76	51	79	50	92	98	91	68	135	96	137	144
Registered Nurse Agency	1,064	1,056	927	1,207	1,210	1,006	893	627	627	568	701	632	699
Total	1,627	2,271	2,121	2,468	2,609	2,308	2,735	2,005	2,249	2,060	2,300	1,930	2,122
Bank													
Admin & Clerical Bank	76	70	83	67	74	68	168	73	79	68	74	84	77
Estates & Ancilliary Bank	256	252	287	259	255	234	325	253	288	280	276	296	288
Nurse HCA/HCSW Bank	1,649	1,589	1,749	1,504	1,641	1,568	2,032	1,574	1,698	1,570	1,595	1,842	1,622
Other Bank	0	0	5	-2	-1	-2	233	27	37	25	34	35	38
Registered Nurse Bank	1,608	1,625	1,816	1,437	1,672	1,689	2,287	1,408	1,541	1,336	1,375	1,634	1,492
Total	3,590	3,537	3,939	3,265	3,641	3,557	5,044	3,336	3,643	3,279	3,354	3,891	3,511
Locum													
Medical Locum	315	332	317	320	548	324	180	376	356	353	377	468	423
Total	315	332	317	320	548	324	180	376	356	353	377	468	423
Total	5,532	6,140	6,377	6,053	6,798	6,189	7,959	5,718	6,248	5,692	6,031	6,289	6,051

Agency (£'000)

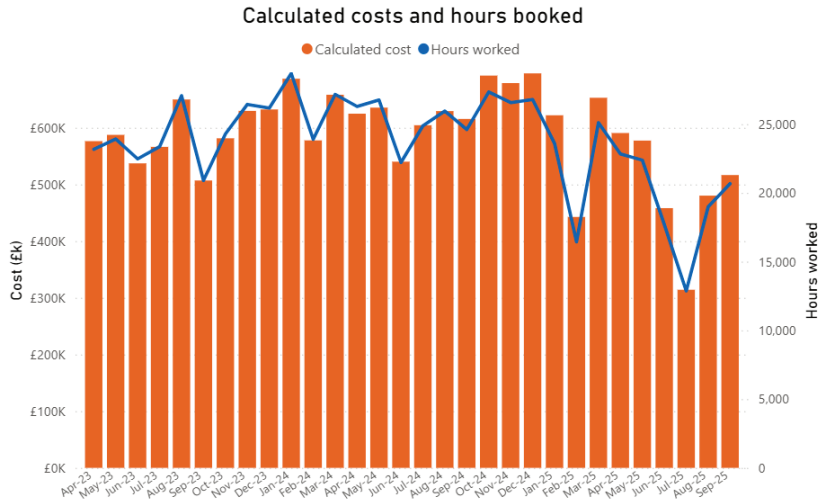


Bank (£'000)

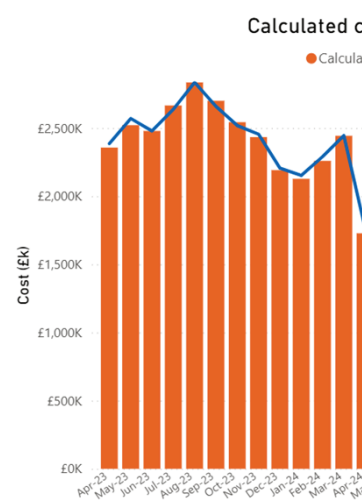


Pay Summary (4): Nurse Bank & Agency Reason for Booking (£'k)

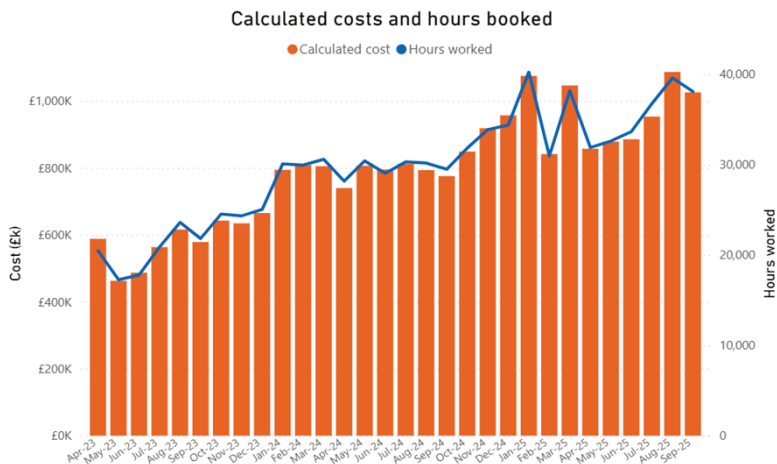
Enhanced Care



Established Vacancy Cover

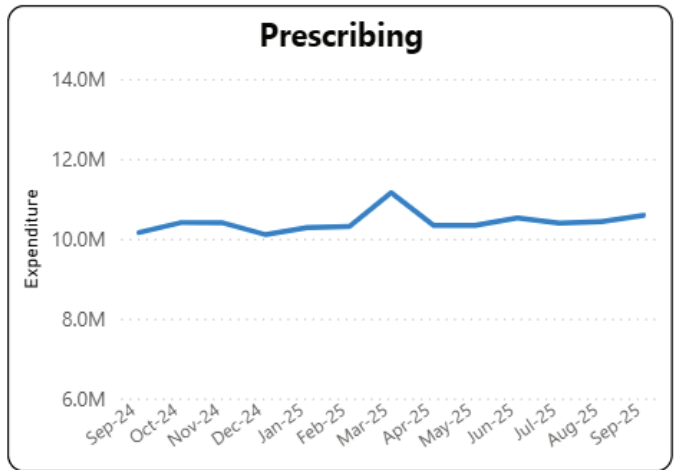
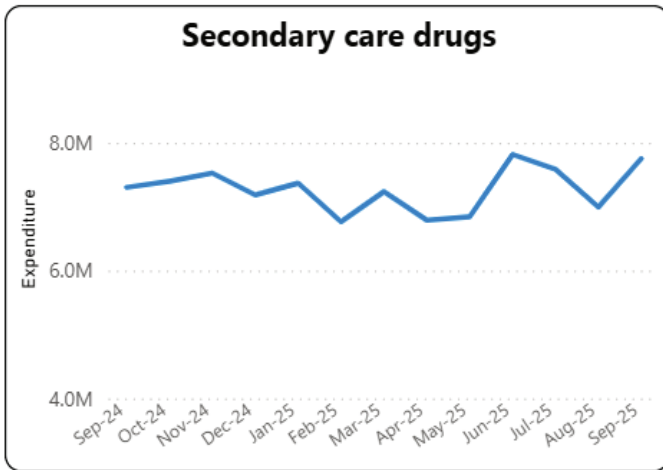
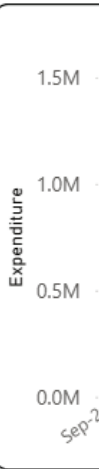
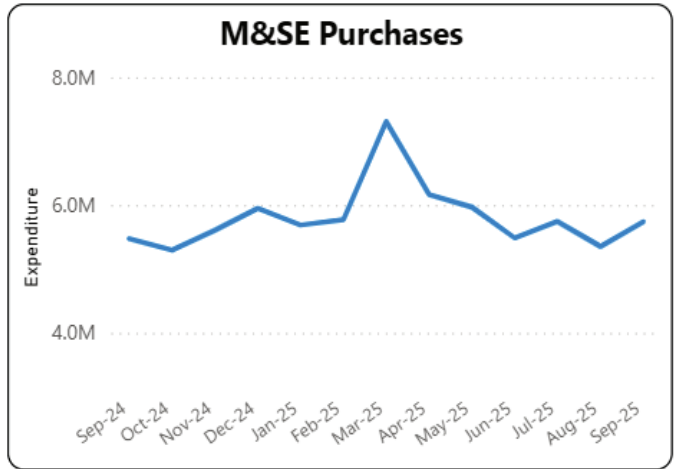
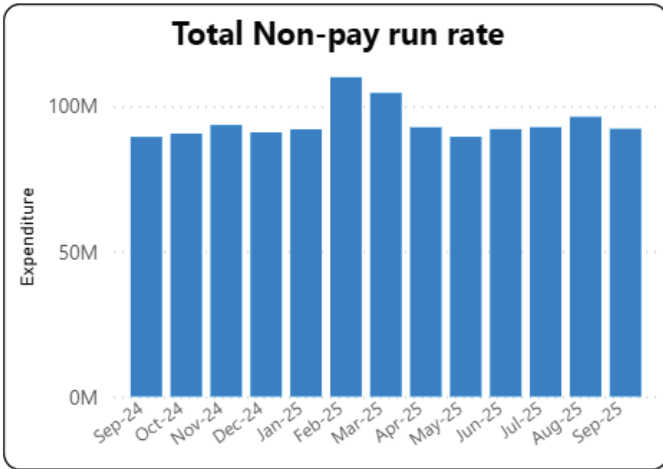


Sickness Cover



These graphs represent 'not' booking reasons for Bank and Healthcare Support Workers. The data is for the hours worked, per the month.

Non-Pay Summary:



CHC (Adult Community CHC): Activity And Spend - YTD & Forecast

Activity is forecast to increase by 65 cases when compared to the 2024/25 out-turn, spend is compared to the 24/25 out-turn.

Activity - Actual	Sep-25	Aug-25	Movement
D2A	29	30	-1
CAHT	47	48	-1
All Other EXT CHC	456	463	-7
Discharge schemes (RIF)	20	19	1
Total	552	560	-8

Activity - Forecast	Sep-25	24/25 Out-turn	Movement
D2A	29	18	11
CAHT	48	50	(3)
All Other EXT CHC	460	462	(2)
Discharge schemes (RIF)	25	27	(2)
Total	561	557	4

YTD & Forecast £'000	2025/26 forecast as at M06 £'000	2025/26 forecast as at M05 £'000	Movement
D2A	2,484	2,781	(297)
CAHT	10,392	10,207	185
All Other EXT CHC	46,014	45,920	94
Discharge schemes (RIF)	1,044	1,044	-
Total	59,934	59,952	(18)

Referral to Treatment (RTT):

- Elective Treatments for Sep '25 = 1,955 (Aug '25: 1,723. 2024/25 total: 25,658, 23/24 total: 23,240)

Planned Treatments (M06)					Actual Treatments (M06)			
Treatment	Core	Backfill	WLI	Total	Core	Backfill	WLI	Total
N107-Dermatology	272	0	15	287	275	9	0	284
N147-ENT	191	0	0	191	108	0	0	108
N105-General Surgery	300	9	0	309	239	17	0	256
N146-Oral Surgery	230	0	0	230	170	0	0	170
N148-Ophthalmology	440	0	0	440	301	0	0	301
N115-Trauma & Orthopaedics	553	24	20	597	516	55	22	593
N106-Urology	315	0	0	315	239	4	0	243
	2,301	33	35	2,369	1,848	85	22	1,955

- Outpatient activity for Sep '25 = 6,452 (Aug '25: 5,550. 2024/25 total: 74,787, 23/24 total: 72,237)

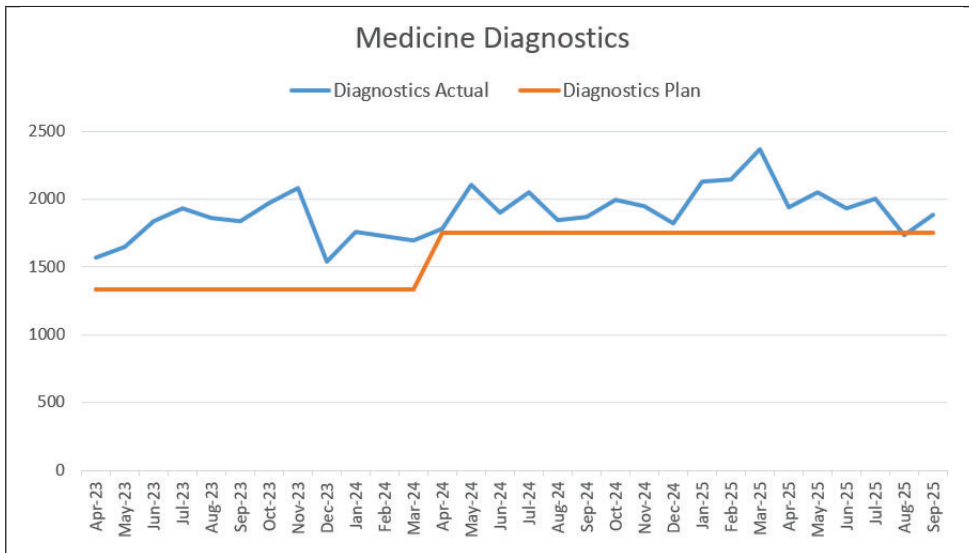
Planned Outpatients (M06)					Actual Outpatients (M06)				
Outpatient	Core	Backfill	WLI	Total	ACTUAL TYPE		WLI	Total	Outpatient
					Elective	Backfilled			
N107-Dermatology	1,443	0	0	1,443	1,393	0	0	1,393	N107-Derm
N147-ENT	733	0	0	733	607	0	0	607	N147-ENT
N105-General Surgery	2,027	165	29	2,221	1,510	125	43	1,678	N105-Gener
N146-Oral Surgery	268	0	0	268	370	32	0	402	N146-Oral
N148-Ophthalmology	778	0	31	809	701	0	0	701	N148-Opht
N108-Rheumatology	236	0	0	236	149	0	0	149	N108-Rheu
N115-Trauma & Orthopaedics	919	10	79	1,008	980	0	59	1,039	N115-Trau
N106-Urology	629	0	19	648	481	0	2	483	N106-Urol
Total	7,033	175	158	7,366	6,191	157	104	6,452	

Medicine Outpatients activity for Sep '25 was 2,125 - (Aug '25: 1,758. 2024/25: 23,000)

Sep-25			
	Assumed monthly activity	Actual activity	Variance
Gastroenterology	475	453	-22
Cardiology	430	355	-75
Respiratory (inc Sleep)	455	441	-14
Neurology	257	341	84
Endocrinology	186	217	31
Geriatric Medicine	313	318	5
Total	2116	2125	9

Sep-25	
YTD	YTD Plan
Gastroenterology	2850
Cardiology	2580
Respiratory (inc Sleep)	2730
Neurology	1542
Endocrinology	1116
Geriatric Medicine	1878
Total	12696

Medicine Diagnostics activity for Sep '25 was 1,882 (Aug '25: 1,737. 2024/25: 23,950)



YTD September 25	YTD Plan
Endoscopy	10494
Total	10494

RAG rating category definitions

Savings schemes are categorised as *Red*, *Amber* or *Green* according to the certainty of delivery. Definitions for each rating are as follows:

- **Green scheme:** Started delivering in the current month or prior month and is expected to continue delivering for the remaining period.
- **Amber scheme:** Agreed plan in place and expected to deliver starting in a future month. If delivery has started, therefore Amber due to the time factor risk.
- **Red scheme:** No plan in place and not expected to achieve.

The definitions are consistent with Welsh Government guidance and have been comm

Divisional analysis – Primary Care and Community

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
PCC-01	SLA's - Age Cymru & BHF	R	Month 1	Green	17	31
PCC-03	GMS - Improvement Grants	NR	Month 1	Green	49	100
PCC-05	30% Reduction of B&A vs 24/25 plan	R	Month 1	Green	24	150
PCC-06	6% Reduction of Non Pay across the area	R	Month 1	Green	10	23
PCC-07	Change the band 7 Discharge Liaison Nurse post [0.6wte £38K] to a band 4 administrative post [1.00wte £34k]	R	Month 1	Green	0	4
PCC-08	10% Reduction of OAMH	R	Month 1	Green	0	17
PCC-09	ONN Vehicle Lease Cars (minus 6k early release fee)	R	Month 1	Green	0	25
PCC-10	BG Locality Bank & Agency reduction	R	Month 1	Green	7	7
PCC-11	Reduction in DN teams from 8 to 7	R	Month 1	Green	5	10
PCC-12	Partial retirement savings non clinical staff	R	Month 1	Green	3	7
PCC-13	Stock review/control	R	Month 1	Green	0	5
PCC-14	Reduction/closure of boarding beds C5West and C5East	R	Month 1	Green	133	289
PCC-15	Closure of Victoria House	R	Month 1	Green	34	103
PCC-16	Service provision at Treveithin	R	Month 1	Green	35	69
PCC-17	Reconfiguration of senior nurse posts DN/CRT	R	Month 1	Green	17	33
PCC-18	Non pay opportunities	R	Month 1	Green	6	13
PCC-19	Medicines Management - SSP Opportunities identified by procurement	R	Month 1	Green	0	300
PCC-20	Remove Emergency Dental Service (QIA) - commissioned Monday to Friday via GDS providers (in addition to NUP provided by Contract	R	Month 1	Green	15	58
PCC-21	Non-clinical staff review across core UPC / HP / SPA	R	Month 1	Green	31	65
PCC-22	Enhancements on Specialist rates	R	Month 1	Green	15	36
PCC-23	Administered COVID-19 Vaccines	NR	In Year	Green	72	175
PCC-25	Procurement - A4 paper switch saving	R	In Year	Green	0	1
PCC-38	GMS Prior Year enhanced services accrual release	NR	In Year	Green	300	300
PCC-39	GDS prior year clawback benefit	NR	In Year	Green	108	108
PCC-40	Nursing non pay opportunities	NR	In Year	Green	9	21
PCC-41	GDS NR saving from contract variation	NR	In Year	Green	300	300
PCC-42	Respiratory - vacancies & maternity leave	NR	In Year	Green	2	16
PCC-43	Optometry contract Prior year accrual release	NR	In Year	Green	50	50
Annual Plan Target:				7,036	1,242	2,316
Distance from target (over)/under				4,720		

Divisional analysis – Prescribing

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD		Full year	
					Achieved £'000	Forecast £'000	Forecast £'000	Forecast £'000
PCC-02	Stoma Team Phase 2	NR	Month 1	Green	74		149	
PCC-04	Medicines Management	R	Month 1	Red	0		0	
PCC-04A	Dietitians	R	In Year	Green	16		52	
PCC-04B	Waste Reduction Scheme	R	In Year	Green	131		241	
PCC-04C	Pharmacy Led Savings	R	In Year	Green	52		130	
PCC-04D	Scriptswitch Acute	R	In Year	Green	105		227	
PCC-04E	Scriptswitch Repeat	R	In Year	Green	165		743	
PCC-04F	Liothyronine Formulation change	R	In Year	Green	1		1	
PCC-04G	DOAC (Edoxaban) switch to Apixaban / Rivaroxaban	R	In Year	Green	167		650	
PCC-04H	Bath & Shower Emollient Review	R	In Year	Green	3		5	
PCC-04I	Chloral Hydrate Prescribing Review	R	In Year	Green	25		55	
PCC-24	Only Order What You Need	NR	In Year	Green	396		594	
PCC-100	Dapagliflozin LOE	R	In Year	Amber	107		2,245	
PCC-101	Ticagrelor LOE	R	In Year	Amber	0		50	
PCC-102	Denosumab LOE	R	In Year	Amber	0		20	
Annual Plan Target:				2,826	1,241		5,161	
Distance from target (over)/under				(2,335)				

Divisional analysis – Complex Care

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD		Full year	
					Achieved £'000	Forecast £'000	Forecast £'000	Forecast £'000
CHC-01	Top 50 placement reviews	R	Month 1	Green	91		306	
CHC-02	Management and reduction of commissioned enhanced care one to one in care homes	R	Month 1	Green	0		108	
CHC-03	FNC Assessments	R	Month 1	Green	122		305	
CHC-04	Care at Home Team	R	Month 1	Green	0		32	
CHC-05	Rightsizing additional support	R	Month 1	Green	0		12	
CHC-06	Enhancements on Specialist rates	R	Month 1	Green	6		18	
CHC-07	Reduced growth chc	NR	In Year	Green	0		250	
Annual Plan Target:				1,676	219		1,031	
Distance from target (over)/under				645				

Divisional analysis – Mental Health and Learning Disabilities

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
MH-01	Mitchell Close	R	Month 1	Red	0	0
MH-02	Aripiprazole drug switch	R	Month 1	Green	0	5
MH-03	Reduction to variable pay	R	Month 1	Red	0	0
MH-04	CHC Dispute CB Hammersmith & Fulham	NR	Month 1	Red	0	0
MH-05	CHC Transition Cases (x2)	R	Month 1	Green	207	207
MH-06	MH Framework Uplifts	R	In Year	Green	172	344
MH-07	MH LD Adult / CAMHS Hospitals Framework Agreement	R	In Year	Green	25	50
MH-11	CHC DB Repat In house services	R	In Year	Green	54	262
MH-14	Cedar temp closure	NR	In Year	Amber	0	200
MH-15	Older Adult Psychology Posts	NR	In Year	Green	0	79
Annual Plan Target:				3,343	459	1,147
Distance from target (over)/under				2,196		

Divisional analysis – Surgery

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
SUR-01	Haematology drugs wastage reduction	R	Month 1	Red	0	0
SUR-02	Robot buy out of lease (GB)	R	Month 1	Green	143	286
SUR-03	Divisional - Pump Giving Sets (Procurement)	R	Month 1	Red	0	0
SUR-04	General Surgery - Workforce - Net savings as a result of appointing two substantive consultants.	R	Month 1	Green	0	18
SUR-05	General Surgery - Medication - Switching IV Co-trimoxazole and metronidazole to oral in GUH	R	Month 1	Red	0	0
SUR-06	General Surgery - Pinctuition seeds	R	Month 1	Green	31	65
SUR-07	Ear, Nose and Throat - Re-Usable Instruments	R	Month 1	Green	1	3
SUR-08	Ophthalmology - Workforce - Band 5 Orthoptist	R	Month 1	Green	10	10
SUR-09	Rheumatology - Workforce - Band 6 Rheumatology CNS	R	Month 1	Green	25	50
SUR-11	Trauma and Orthopaedics - Consolidation of maintenance contracts (Desoutter)	R	Month 1	Green	9	25

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
SUR-12	Trauma and Orthopaedics - Workforce - substantiate 1.2 WTE orthogeriatric ward doctor posts	R	Month 1	Green	0	26
SUR-13	Trauma and Orthopaedics - Workforce - Changes to on-call structures	R	Month 1	Red	0	0
SUR-14	Trauma and Orthopaedics - Workforce - 2 x consultant on-call cost replaced by 1x SAS on-call costs	R	Month 1	Green	2	3
SUR-15	Trauma and Orthopaedics - Bone Cleaning Device	R	Month 1	Green	33	69
SUR-16	Trauma and Orthopaedics - Workforce - substantiate 2.5 WTE JCF over establishment for RGH/OSU ward cover	R	Month 1	Amber	0	25
SUR-17	Urology - Cystoscopes - Disposable Cystoscopes	R	Month 1	Green	0	1
SUR-18	Urology - Medication - Switch to Dysport from BOTOX for N/Ps with Neuropathic Pain	R	Month 1	Green	0	0
SUR-19	Urology - Follow Up Patients - Spacing for follow Up Patients receiving BOTOX	R	Month 1	Green	0	2
SUR-20	Urology - Workforce - Associate Specialist Vacancy	R	Month 1	Green	24	24
SUR-21	Divisional Management - Medication - Sports Medicine review	R	Month 1	Red	0	0
SUR-22	Haematology - SLA - Bristol SLA	R	Month 1	Green	1	4
SUR-23	Haematology - Workforce - Admin team maternity leave	R	Month 1	Green	1	7
SUR-24	Haematology - Study - POLARIS-2; Study of Olverembatinib	R	Month 1	Red	0	0
SUR-25	Haematology - Workforce - Registrar to be recharged to another non surgical Directorate	R	Month 1	Green	7	15
SUR-26	Oral and Maxillofacial Services - Orthodontic Brackets - Reduce costs for Orthodontic brackets	R	Month 1	Green	2	4
SUR-27	Dermatology - IMF - ABUHB Pathology to delivery IMF (Indirect immunofluorescence)	R	Month 1	Red	0	0
SUR-28	Ear, Nose and Throat - Consumables - Review consumable usage for ENT treatment room	R	Month 1	Green	0	2
SUR-29	Trauma and Orthopaedics - Consumables - Review of generic theatre consumables charged to T&O	R	Month 1	Green	2	7
SUR-30	Ophthalmology - Workforce - 2X Consultant Posts	R	Month 1	Green	67	67
SUR-31	Ophthalmology - Workforce - Middle Grades starting which will remove agency usage from the service -	R	Month 1	Green	96	287
SUR-32	Ophthalmology - Medication - Conversion of 2mg Eyelea to 8mg to take advantage of lower price	R	Month 1	Red	0	0
SUR-33	Enhancements on Specialist rates	R	Month 1	Green	0	13
SUR-34	Medicines Management savings	R	Month 1	Green	376	942
SUR-35	Ophthalmology Visco Elastic Savings over the current financial year	R	In Year	Green	3	11
SUR-36	Drugs	NR	In Year	Green	0	400
SUR-43	All Wales standard and custom procedure packs	R	In Year	Green	0	300
SUR-44	5% Stryker hips and knees	R	In Year	Green	14	335
Annual Plan Target:				3,336	847	3,001
Distance from target (over)/under				335		

Divisional analysis – Clinical Support Services

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	
					Achieved £'000	Forecast £'000
CSS-01	Sysmex Maintenance Savings	R	Month 1	Green	81	178
CSS-02	Siemens KPI review	R	Month 1	Green	25	50
CSS-03	Sysmex MSC KPIs	R	Month 1	Green	3	5
CSS-04	Factor 8 Repatriation	R	Month 1	Green	3	6
CSS-05	WBS Commercial Products	R	Month 1	Green	3	6
CSS-06	Restructure of Management Positions	NR	Month 1	Green	4	13
CSS-08	Enhancements on Specialist Rates	R	Month 1	Green	157	392
CSS-10	Critical Care HCSW Variable Pay	R	Month 1	Green	20	20
CSS-11	Hepzyme Repatriation	NR	Month 1	Red	0	0
CSS-12	P3NP Repatriation	R	Month 1	Green	2	3
CSS-13	JCC funding for liver ablations	NR	Month 1	Green	41	122
CSS-14	IPFR income	NR	Month 1	Green	38	70
CSS-15	Ablation needles	R	Month 1	Green	3	5
CSS-16	Maintenance contracts for new DR equipment - NR	NR	Month 1	Green	14	30
CSS-17	Contrast bought in 24/25	NR	Month 1	Green	200	200
CSS-18	Blood Products from 24/25 Year End	NR	Month 1	Green	100	100
CSS-19	Additional Everlight reporting in 24/25	NR	Month 1	Green	46	46
CSS-20	Image Intensifier Maintenance	NR	Month 1	Green	7	16
CSS-21	Decommissioning of Fuji Equipment on current contracts	NR	Month 1	Green	11	22
CSS-22	C&V Ultrasound	NR	Month 1	Green	10	10
CSS-23	Cell Salvage income rebate	NR	Month 1	Green	24	47
CSS-24	Clariscan to Dotograf switch	R	Month 1	Green	6	15
CSS-25	Co-trimoxazole IV	R	In Year	Green	0	1
CSS-26	Lumicare	R	In Year	Green	12	25
CSS-27	Critical Care RN Variable Pay	R	In Year	Green	314	593
CSS-35	Radiology Maintenance contracts	NR	In Year	Green	78	78
CSS-36	Bis Monitoring - Supplier change	R	In Year	Green	7	29
CSS-37	Recycled Paper	R	In Year	Green	0	2
CSS-38	Medical Workforce - Intensity banding review	R	In Year	Green	5	11
CSS-39	Medical Workforce Variable Pay Spend	R	In Year	Green	21	33
CSS-40	Medicines Management - Green	R	In Year	Green	0	15
CSS-41	Medical Workforce Variable Pay Spend (Consultant)	R	In Year	Green	6	7
CSS-42	Medical Workforce Variable Pay Spend (Juniors/Middle Grades)	R	In Year	Green	46	63
CSS-43	Additional IPFR Income (Powys)	NR	In Year	Green	8	8
CSS-44	Outsourcing, linked to acute demand, Audit and deep dive. Reduce Foreca	NR	In Year	Green	27	117
CSS-45	Mycology Testing (PHW)	R	In Year	Green	3	11
CSS-46	Contract Funerals	R	In Year	Green	1	5
CSS-47	Serosep Contract	R	In Year	Green	0	16
CSS-48	Cessation of Weekend Enhancement Pay	R	In Year	Green	2	7

Clinical Support Services continued...

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
CSS-49	Utilisation of Blood Bikes	R	In Year	Green	2	6
CSS-50	Syphilis Repatriation	R	In Year	Green	3	10
CSS-51	Leica Bond III Contract	R	In Year	Green	8	30
CSS-52	Siemens MSC KPIs (Part 2)	NR	In Year	Green	0	50
CSS-53	Reduction in Carriage Charges	R	In Year	Green	0	1
CSS-54	Liver ablations	NR	In Year	Green	0	129
CSS-55	Reduction in Health Protection testing	NR	In Year	Green	25	101
CSS-56	New locum recruitment	R	In Year	Green	0	(14)
CSS-57	Savings on additional hours by recruiting locum consultant	R	In Year	Green	0	24
CSS-58	Reduction in Health Protection testing	NR	In Year	Amber	0	300
CSS-59	Risp reduced penalty	NR	In Year	Amber	0	312
CSS-60	Medical Illustration - Photo Materials	R	In Year	Green	0	11
CSS-61	Staff Slippage	NR	In Year	Green	10	29
CSS-62	RDC closure	R	In Year	Green	0	42
CSS-63	Additional Out of Area IR income Powys	NR	In Year	Green	14	34
CSS-64	Additional Out of Area IR income CTM	NR	In Year	Green	27	64
CSS-65	Contrast switch Omnipaque to Optiray	R	In Year	Green	0	6
CSS-66	BTW additional Income for increase in consultant sessions	R	In Year	Green	0	50
CSS-67	Dart Support	R	In Year	Green	0	2
CSS-68	Theatres Par Level Review - GUH	NR	In Year	Green	0	46
Annual Plan Target:				2,998	1,413	3,609
Distance from target (over)/under				(611)		

Divisional analysis – Medicine

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
MED-01	Biologic Switch of Ustekinumab	R	Month 1	Green	425	850
MED-02	Enhancements on Specialist rates	R	Month 1	Green	153	382
MED-03	National priorities - Teriparatide generic switch	R	Month 1	Green	2	3
MED-04	National priorities - Dimethyl fumarate - Generic switch	R	Month 1	Green	223	451
MED-05	National priorities - Omalizumab - transitional contract	R	Month 1	Green	0	50
MED-06	National priorities/Best value Biosimilars - Ustekinumab vials	R	Month 1	Green	286	403
MED-07	Neurology - Idebenone Homecare Supply	R	Month 1	Green	6	14
MED-08	Annual purchase of insulin pumps at preferential rate	NR	Month 1	Green	5	5
MED-09	Use of 24/25 purchased CPAP's for 25/26 activity	NR	Month 1	Green	64	247
MED-10	Use of 24/25 purchased colon capsules for 25/26 activity	NR	Month 1	Green	32	63
MED-11	Use of 24/25 purchased equip (leads etc) for 25/26 activity	NR	Month 1	Green	12	23
MED-12	Delay in prescribing Budesomide	NR	Month 1	Green	845	1,596
MED-13	COTE - Denosumab	R	In Year	Green	0	26
MED-14	Co-trimaxazole IV	R	In Year	Green	2	5
MED-21	National priorities/Best value Biosimilars - Rituximab biosimilar switch (Rixathon to Truxima)	R	In Year	Green	0	1
MED-22	Reduction in locum consultants replaced with substantive x3	R	In Year	Amber	0	14
MED-23	Reduction in RN agency	R	In Year	Amber	0	107
MED-24	Saving in sleep masks	R	In Year	Green	0	46
MED-25	Switch Acute 30 bedded ward to Community ward	R	In Year	Amber	0	128
MED-26	Haloperidol tablets to liquid switch	R	In Year	Green	0	35
Annual Plan Target:				3,877	2,054	4,448
Distance from target (over)/under				(571)		

Divisional analysis – Urgent Care

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
URG-01	Enhancements on Specialist rates	R	Month 1	Green	208	520
URG-02	Switch to a non-ported admin set with pump	R	Month 1	Green	2	2
URG-03	changing from the pre-made convenience FICB packs to individual items	R	In Year	Green	4	8
URG-10	Switch from dual giving set ports to single port	R	In Year	Green	2	6
URG-11	Close RGH & NHH Transfer Lounge	R	In Year	Amber	0	99
URG-12	Close RGH MIU Over night	R	In Year	Amber	0	83
URG-13	Delay Implementation of Medical Model in Flow Centre	NR	In Year	Amber	0	75
URG-14	Source E-Triage Funding	NR	In Year	Amber	0	178
Annual Plan Target:				942	215	970
Distance from target (over)/under				(28)		

Divisional analysis – Family & Therapies

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
F&T-01	Divisional drugs savings target	R	Month 1	Green	16	63
F&T-02	Health Visiting - Reduction in Rental Charges due to relocation to 19 Hills Health & Wellbeing Centre, Ringland East	R	Month 1	Green	6	11
F&T-03	Actim Prom and Partus	R	Month 1	Green	7	13
F&T-04	Non- renewal of Windmill Farm SLA with NPT LA for 25/26	R	Month 1	Green	150	300
F&T-05	Enhancements on Specialist rates	R	Month 1	Green	86	257
F&T-06	Cessation of Tafarn Newydd S28A SLA with Torfaen LA	R	Month 1	Green	15	31
F&T-07	Giving Sets for Infusion Pumps	R	Month 1	Green	1	2
F&T-08	Bulk purchase of Medtronic 780G Diabetic pumps and sensors	NR	Month 1	Green	5	5
F&T-09	LYRECO BUDGET WHITE A4 PAPER 80GSM - BOX OF 5 REAMS (5 X 500 SHEETS OF PAPER) Move to Recycle paper	R	In Year	Green	1	2
F&T-16	Financial recovery divisional scheme - pay R	R	In Year	Green	103	257
F&T-17	Financial recovery divisional scheme - pay NR	NR	In Year	Green	226	623
F&T-18	Financial recovery divisional scheme - Non-Pay R	R	In Year	Green	15	100
F&T-19	Financial recovery divisional scheme - Non-Pay NR	NR	In Year	Green	404	463
F&T-20	Financial recovery divisional scheme - Income	NR	In Year	Green	0	4
F&T-21	The All Wales Standard & Custom Procedure Packs (MED-OJEU-56015)	R	In Year	Green	0	20
Annual Plan Target:				3,252	1,037	2,151

Divisional analysis – Estates & Facilities

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
FAC-01	Chepstow Hospital Unitary Charge	R	Month 1	Green	251	500
FAC-02	ENERGY SAVINGS	R	Month 1	Green	851	1,850
FAC-03	Bed contract savings	R	Month 1	Green	131	250
FAC-04	Energy	R	Month 1	Green	125	250
FAC-11	Vacancies	NR	In Year	Green	240	360
FAC-12	Rates rebates	NR	In Year	Green	48	80
FAC-13	Kintra - Cost plus Credit	NR	In Year	Green	108	108
FAC-14	Vacancies	NR	In Year	Green	76	304
FAC-15	Accountancy gain - duplicate meter reading	NR	In Year	Green	1,225	1,225
Annual Plan Target:				2,185	3,055	4,927
Distance from target (over)/under				(2,742)		

Divisional analysis – Corporate

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
CORP-02	Reduction in non-pay spend	NR	Month 1	Green	25	50
CORP-06	Executive directorate stretch target saving	R	Month 1	Green	51	152
CORP-11	Executive directorate stretch target saving	R	Month 1	Green	75	242
CORP-90	Various Directors savings - vacancies	NR	In Year	Green	0	100
CORP-15	Executive directorate stretch target saving	R	Month 1	Green	21	29
CORP-92	Various Directors savings - vacancies	NR	In Year	Green	0	100
CORP-01	Reduction in workforce costs - on call allowance	NR	Month 1	Green	18	70
CORP-13	Executive directorate stretch target saving	R	Month 1	Green	175	700
CORP-93	Various Directors savings - vacancies	NR	In Year	Green	0	400
CORP-04	Scheme	NR	Month 1	Green	49	100
CORP-05	Opportunity	NR	Month 1	Green	49	100
CORP-91	Savings - Vacancies	NR	In Year	Green	0	200
CORP-08	Executive directorate stretch target saving	R	Month 1	Green	49	149
CORP-14	Executive directorate stretch target saving	R	Month 1	Green	60	97
CORP-95	Various Directors savings - vacancies	NR	In Year	Green	0	200

Corporate continued ...

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
CORP-03	Opportunity	R	Month 1	Green	151	151
CORP-07	Executive directorate stretch target saving	R	Month 1	Green	51	103
CORP-96	Various Directors savings - vacancies	NR	In Year	Green	0	200
CORP-16	Executive directorate stretch target saving	R	Month 1	Green	24	24
CORP-09	Executive directorate stretch target saving	R	Month 1	Green	51	102
CORP-10	Executive directorate stretch target saving	R	Month 1	Green	45	180
CORP-94	Various Directors savings - vacancies	NR	In Year	Green	0	100
CORP-12	Executive directorate stretch target saving	R	Month 1	Green	52	207
CORP-97	Various Directors savings - vacancies	NR	In Year	Green	0	200
CORP-84	Accountancy gain- release study leave accrual	NR	In Year	Green	0	3,204
CORP-85	Accountancy gain- dispute dilapidations	NR	In Year	Green	0	200
CORP-86	Accountancy gain- Dispute H&SE fine	NR	In Year	Green	0	400
CORP-88	Various Directors savings - non pay	NR	In Year	Amber	0	700
CORP-89	Various - rtt funding, reserve release, rif funding - presentation to be reviewed	NR	In Year	Amber	0	1,619
Annual Plan Target:				2,421	946	10,079
Distance from target (over)/under				(7,658)		

Divisional Analysis - Contracting & Commissioning

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
Con1	Accountancy benefit of NHS England end of year position	NR	In Year	Green	270	507
Con2	Forecast reduced activity- Cardiff LTA	R	In Year	Green	100	200
Con3	Forecast reduced activity- CTM LTA	R	In Year	Green	150	300
Con4	Forecast Additional Provider Income	R	In Year	Green	100	200
Con5	Accountancy benefit - service contracts	NR	In Year	Green	410	410
Con6	Accountancy benefit - service contracts	NR	In Year	Green	600	600
Con7	Forecast reduced activity- Velindre LTA	R	In Year	Green	475	950
Con8	Forecast Additional Provider Income	R	In Year	Green	75	150
Con9	Accountancy benefit of NHS England end of year position	NR	In Year	Green	46	46
Con10	Accountancy benefit of NHS England end of year position	NR	In Year	Green	102	102
Con11	Renegotiation of GH&C Contract Baseline	R	In Year	Green	97	194
Annual Plan Target:				2,463	2,425	3,659
Distance from target (over)/under				(1,196)		

Divisional Analysis - WHSCC

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
					0	0
					0	0
				Annual Plan Target:	3,296	
				Distance from target (over)/under	3,296	

Divisional Analysis - EASC

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
					0	0
					0	0
				Annual Plan Target:	936	
				Distance from target (over)/under	936	

Reserves

Reserves Delegation:

The reserves held at 30th September '25 is £9.2m. This consists of allocations to be delegated of £6.6m, specific commitment reserves of £1.2m, those supporting the financial position of £1m and a contingency investment reserve of £0.36m.

The reserves include some elements of risky income associated with the submitted plan with £3.9m of anticipated funding for RTT activity, beyond current-funded levels.

The HB reserves are in credit of £2.3m from divisions for 24/25 wage award funding, this will be pulled back from budgets in future months with income targets being set for those divisions being funded, instead, by HEIW and PHW.

Funding will continue to be reviewed with further anticipated allocations being retained within reserves pending delegation.

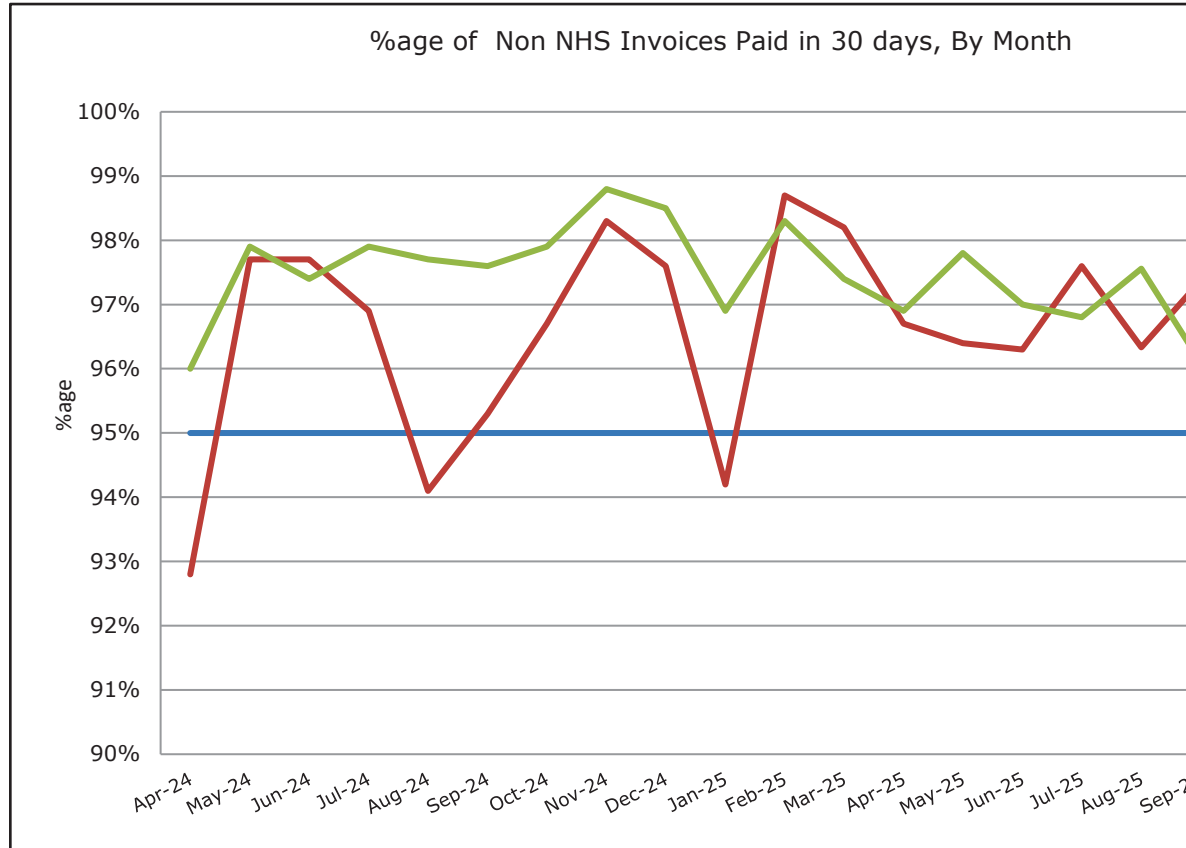
7769-ALLOCATIONS TO BE DELEGATED		
Confirmed or Anticipated	R / NR	Description
Anticipated	R	b/f balances re: pay related funding
		Balancing figure
Delegated	R	National Insurance increase (Ers) 25
Anticipated	NR	Overseas recruitment funding
Anticipated	NR	Planned Care Transformation Fund:
Delegated	R	Fracture liaison service - risky income allocation
Delegated	R	25/26 Physician Associates - risky income allocation
Anticipated	NR	Planned Care Transformation Fund: 3Ps)
Anticipated	NR	GP Gatekeeper
Anticipated	NR	Planned Care 2025-2026 - Phase 4
Anticipated / confirmed	R	2024/25 Wage Awards (including R
Anticipated	NR	Band 8 24/25 incremental impact 2025 funding rec'd from WG
Anticipated	R	R&D 2526 wage award
Confirmed	NR	25-26 Mental Health Sanctuary/Alte
Anticipated	NR	Planned care / rtt funding for activit
Anticipated	R	25/26 Pay Award - GP OOH Recove
		Confirmed Allocations to be appor
7788-COMMITMENTS TO BE DELEGATED		
Description		
Junior Doctors income: TGS		
Junior Doctors income: PGCME		
Recovery of E&F budget delegated for Portacabin - GUH T		
Total Commitments		
7501-SUPPORTING FINANCIAL POSITION		
Description		
IT Revenue to Capital April 25		
IT Revenue to Capital May 25		
IT Revenue to Capital June 25		
RTT Waiting times Q1 25-26 - anticipated delegation (Gen		
RTT Waiting times Q1 25-26 - anticipated delegation (Infra		
Recovery of E&F budget delegated for Portacabin - GUH T		
2526 Wage Award Roundings and KCOR		
Total Supporting Financial position		
7565-CONTINGENCY		
Description		
Investment Reserve		
Confirmed Allocations to be apportioned		

Cash Position

The cash balance at the 31st August is £4.5m, which is below the advisory figure set by Welsh

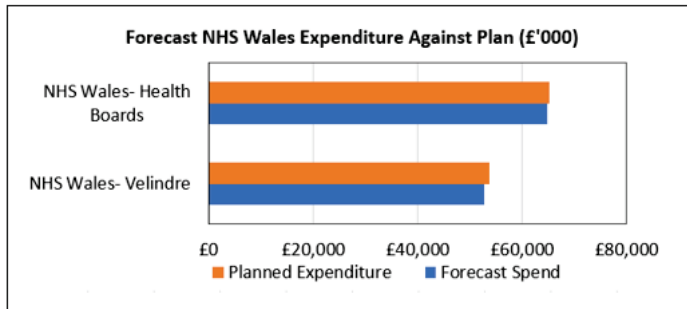
Public Sector Payment Policy (PSPP)

The HB has achieved the target to pay 95% of the number of both NHS and Non-NHS creditors w in September. Cumulatively, the HB has achieved the statutory 95% target for Non-NHS cred months' are having an impact on the cumulative NHS target.



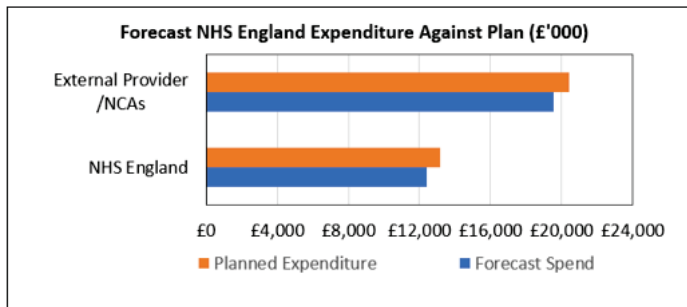
Contracting & Commissioning – LTA Spend & Income

At Month 6 the year-to-date financial performance for Contracting and Commissioning is £2.3m budget with a forecast year of £3.4m underspend. The key elements contributing to this position are:



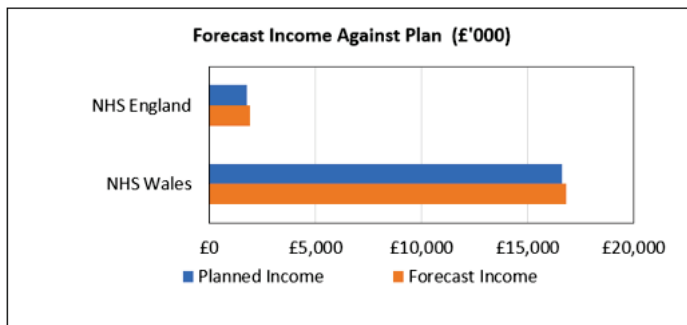
NHS Wales Expenditure

Expenditure in NHS Wales contracts is based on provider monitoring returns and is expected to be c£500k less than plan due to lower activity and recharged services at Cwm Taf and Cardiff and Vale and a further £950k less after receiving a revised lower forecast from Velindre Trust



NHS England Expenditure

Contract Expenditure with NHS England organisations is expected to be c£750k less than plan due to favourable settlements of 24/25 final balances following successful challenges by the commissioning team



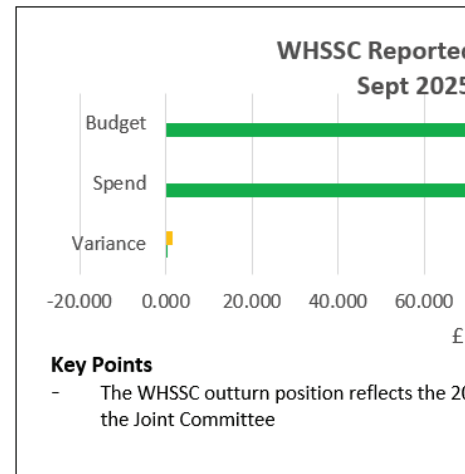
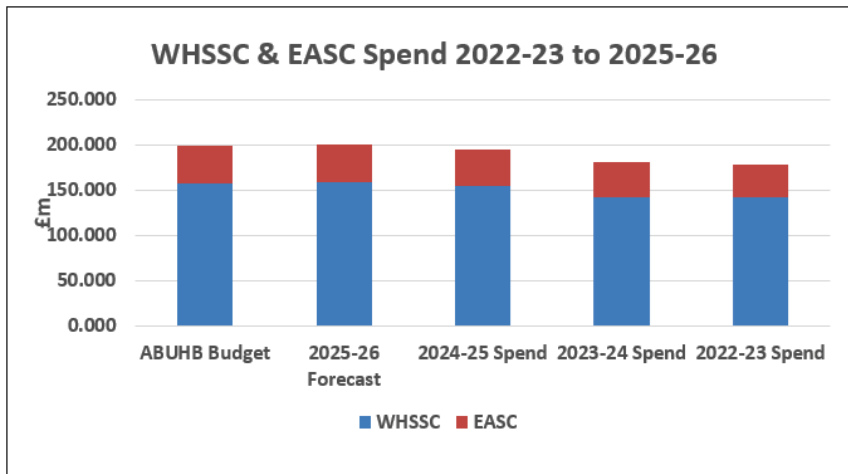
Provider Income

Provider income is forecast to be c£350k more than plan in 25/26 following higher activity levels in months 1-5 for Powys and other commissioners

- Key Issues 2025-26**
- All LTAs have been agreed and signed by ABUHB.
 - A recurrent annual settlement with Cwm Taf was agreed in a £1.5m recurrent settlement.
 - The expenditure being agreed with the provider monitoring returns.
 - An additional c£3.5m was allocated across the commissioning submission.
 - Additional budget was allocated for ophthalmology 2025/26 and Aneurin Bevan Health Board.

Joint Commissioning Committee (formerly WHSSC & EASC) Financial Position 2025-26

The Month 6 financial position for the JCC is a forecast overspend of £1.4m. The position reflects the 2024-25 current budget delegation for the Specialised Services (formerly WHSSC) and EASC e



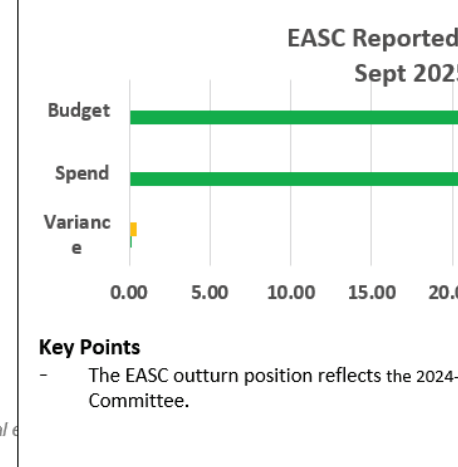
Key Issues 2025-26

Specialised Services

- Current forecast based on the agreed IMTP and forecast overperformance in respect of C&VUHB LTA Overperformance (£0.7m), Individual Patient Treatments (£1.6m) offset by slippage on developments (£1.2m)
- Key risk areas for 2025-26
 - Delivery of Savings Plans
 - Provider Overperformance
 - Slippage on Developments

EASC

- Current forecast based on the agreed IMTP
- Key risk areas for 2025-26
 - Unfunded Provider pressures
 - Confirmation of allocation assumptions



Balance Sheet

Balance sheet as at 30th September 2025			
	2025/26 Opening balance £000s	30th September 2025 £000s	Movement £000s
Fixed Assets	945,668	1,027,651	81,983
Other Non current assets	111,489	212,543	101,054
Current Assets			
Inventories	10,433	10,413	(20)
Trade and other receivables	167,220	85,261	(81,959)
Cash	4,823	4,500	(323)
Non-current assets 'Held for Sale'	0	0	0
Total Current Assets	182,476	100,174	(82,302)
Liabilities			
Trade and other payables	221,140	201,915	(19,225)
Provisions	207,724	229,527	21,803
	428,864	431,442	2,578
	810,769	908,926	98,157
Financed by:-			
General Fund	610,494	651,946	41,452
Revaluation Reserve	200,275	256,980	56,705
	810,769	908,926	98,157

Fixed Assets: The main movements since the end of 2025/25 relate to:

- An increase of £11.1m relating to capital programme purchases and capital purchases
- An increase of £93.7m as a result of upwards revaluations
- A decrease of £21.6m due to depreciation charged in year
- A net decrease of £1.4m in renewals and depreciation for

Other Non-Current Assets: This relates to a significant increase in intangible assets of £101.8m and a decrease in intangible assets of £0.7m since the end of 2024/25.

Inventories: The decrease in year relates to changes in stock held.

Current Assets, Trade & Other Receivables: The main movements are:

- A decrease in the value of debts outstanding on the Accounts Payable in August of £1.7m
- A net increase in the value of both NHS & Non-NHS accruals. Non-NHS accruals and £0.8m relates to a decrease in NHS Accruals
- A significant decrease in the value of Welsh Risk Pool claims
- A decrease in VAT and other debtors since the end of 24/25
- An increase in the value of prepayments held £6.9m

Cash: The cash balance held at the end of July is £4.5m.

Liabilities, Trade & other Payables:

The movement since the end of 2024/25 relates to a number of issues:

- A decrease in Capital accruals (£5.6m)
- A decrease in NHS Creditor accruals (£2.3m)
- A decrease in the level of invoices held for payment from trade payables (£8.9m)
- An increase in non NHS accruals (£8.9m)
- An increase in Tax & Superannuation (£2.0m)
- A decrease in other creditors (£15.2m)
- A decrease in the liability for lease payments (£1.2m)
- An decrease in payments on account (£0.5m)

Provisions:

- This is due to an overall increase in the provision for clinical negligence claims of £22.1m in the year, based on information provided by the Welsh Risk Pool of £22.1m and

General Fund: This represents the difference in the year to date cash draw down including capital.

Health Board Income WG Funding Allocations: £1.87bn

Confirmed Allocations as at September 2025 (M6 2025/26)

	£'000
HCHS	1,679,794
GMS	115,932
Pharmacy	36,808
Dental	36,722
Total Confirmed Allocations - September 2025	1,869,255

Plus Anticipated Allocation - September 2025	59,635
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Total Allocations - September 2025	1,928,890
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Other Income:

The HB receives income from a number of sources other than WG, based on the year-to-date income, this is forecast to be approximately £119m. (£125m for 24/25). The majority of this income is delegated to budget holders and therefore nets against their delegated budget positions. The main areas for income are: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Estimated funding (allocations & income) for the UHB totals £2bn (£2bn for 24/25).

WG Revenue Resou	
Funding Type	Description
GMS	GMS Refresh
GMS	Dispensing Drs and PADMS funding 24-
HCHS	Capital - DEL Depreciation - Baseline S
HCHS	Capital - DEL Depreciation - Strategic
HCHS	Capital - DEL Depreciation - Impairmen
HCHS	Capital - DEL Depreciation - IFRS 16 Lea
HCHS	Capital - AME Depreciation - IFRS 16 Le
HCHS	Capital - AME Depreciation - Donated
HCHS	Capital - AME Depreciation - Impairme
HCHS	Revenue Lease Payment Budget Redu
HCHS	Revenue Lease Payment Budget Redu
HCHS	Real Living Wage 24/25
HCHS	Clinical Excellence Awards (CDA's)
HCHS	AHW:Prevention & Early Years allocati
HCHS	Same Day Emergency Care (SDEC)
HCHS	Urgent Primary Care
HCHS	Learning Disabilities-Improving Lives
HCHS	New Medical Training Posts 2017-2022
HCHS	Welsh Risk Pool Risk Share agreement
HCHS	Neighbourhood District Nursing (incl.
HCHS	MCA and DoLs
HCHS	MCA - IMCA service
HCHS	International recruitment funding 24-
HCHS	Digital Priorities Investment Fund (DP
HCHS	RIF-Short breaks for Carers-confirmed
HCHS	Keeping Well (3Ps) funding 25-26 conf
HCHS	25/26 Neurodivergence (NDIP) fundin
HCHS	25/26 LIMs funding
HCHS	Pathfinder Womens Health Hub 25-26
HCHS	Real Living Wage (AB staff) 25-26
HCHS	Capital - DEL Depreciation - Accelerate
HCHS	Capital - AME Depreciation - Impairme
HCHS	Clinical Editors Funding 25-26
HCHS	National POPs Initiative Funding
HCHS	Planned Care Transformation Fund: Sp
HCHS	Planned Care Transformation Fund: Q3
HCHS	GP Gatekeeper
HCHS	Planned Care 2025-2026 - Phase 4 Diag
HCHS	National Planned Care Plan - Phase 3 A
HCHS	Planned Care Programme Out Patient
HCHS	Q2-4 Regional cataracts outsourcing
HCHS	Band 8 and above - increment impact t
HCHS	Planned care / rtt funding for activity g
HCHS	25/26 Full Year Pay Award (A4C + Medi
Total Anticipated: Per Ledger	

Capital Planning & Performance Month 06 2025/26

	2025/26				
	Original Plan £000	Revised Plan £000	Spend to M6 £000	Forecast Outturn £000	Variance £000
Source:					
Discretionary Capital:					
Approved Discretionary Capital Funding Allocation	12,875	12,875		12,875	0
Less Targeted Estates Fund Contribution	-3,762	-2,862		-2,862	0
Less AWCP Brokerage 2024-25	-3,353	-3,235		-3,235	0
NBV of Assets Disposed	0	61		61	0
Total Approved Discretionary Funding	5,760	6,839		6,839	0
All Wales Capital Programme Funding:					
AWCP Approved Funding	12,184	26,134		26,134	0
Total Approved and Anticipated AWCP Funding	12,184	26,134		26,134	0
IFRS16 Lease Funding:					
Approved IFRS16 Lease Funding	0	560		560	0
IFRS16 CRL reduction for Lease Asset Disposals	0	-84		-84	0
NBV of IFRS16 Leased Asset Disposals	0	84		84	0
Total Approved IFRS16 Lease funding	0	560		560	0
Total Capital Funding / Capital Resource Limit (CRL)	17,944	33,533		33,533	0
Applications:					
Discretionary Capital:					
Statutory Compliance Allocations	1,100	1,100	323	1,194	94
Other Commitments	1,050	1,050	450	1,050	0
Commitments b/f from 2024-25	544	1,146	243	1,073	-73
Divisional Priorities	2,370	3,401	1,308	3,322	-79
Corporate Priorities	0	45	42	44	0
Remaining DCP Contingency	696	97	0	28	-69
Total Discretionary Capital	5,760	6,839	2,366	6,711	-128
All Wales Capital Programme:					
NHH Satellite Radiotherapy Centre	1,991	1,250	869	1,250	0
GUH ED Extension	1,946	2,665	1,810	2,665	0
Head Lease for Chepstow Community Hospital	60	107	0	107	0
2nd MRI for Grange University Hospital	2,500	2,481	2,180	2,207	-274
Centralised Decontamination Unit RGH	3,925	3,999	1,639	3,860	-139
RGH – Block 1 and 2 Demolition and Car Park	269	271	2	271	0
Backlog Maintenance 2024-25	901	2,017	924	2,017	0
EFAB - Infrastructure 2024-25	0	224	224	224	0
YYF Breast Centralisation Unit	0	91	40	91	0
CAMHS Sanctuary Hub	0	104	104	104	0
Housing with Care Fund 2024-25	0	143	1	143	0
Ty Gwent	0	47	-20	47	0
Commercial Research Delivery Wales Equipment 2024-25	0	12	12	12	0
Diagnostic Equipment and Medical Devices Funding 2024-25	0	11	3	3	-8
Digital Equipment 2024-25	0	53	64	66	13
End of Year Funding 2024-25	0	77	73	77	0
IRCF - Abervalley H&WBC	592	550	65	780	230
IRCF - Dixton H&WBC	0	269	105	285	16
Targeted Estates Fund (TEF)	0	8,388	745	8,404	16
DPIF - Electronic Prescribing and Medicines Administration (ePMA)	0	1,622	52	1,622	0
Non-Radiology Ultrasound Replacement Funding	0	576	0	576	0
DPIF - RISP	0	472	0	472	0
Mental Health Quality & Safety Schemes	0	705	67	705	0
Total AWCP Capital	12,184	26,134	8,959	25,988	-146
Total IFRS16 Lease Expenditure	0	560	560	560	0
Total Programme Allocation and Expenditure	17,944	33,533	11,885	33,259	-274
Underspend against Overall Capital Resource Limit					-274
Slippage / Underspend on funding to return to WG re:					
2nd MRI for Grange University Hospital					274
Overall Break Even Position against CRL					0

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Public Services Ombudsman for Wales (PSOW) Annual Letter
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tracey Partridge-Wilson Deputy Director of Nursing Gemma Couch Head of Quality Patient Safety Rhiannon Price Senior Quality Patient Safety Manager

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

Er Sicrwydd/For Assurance

The purpose of the report is to respond to the Annual Letter from the Parliamentary Services Ombudsman Wales (PSOW). The Health Board is required by the PSOW to

- Present the Annual Letter to the Board and notify the PSOW of when these meetings will take place (26th November 2025).
- Consider the data in the Annual letter, alongside the Health Board's data, to understand more about organisational performance on complaints, including any patterns or trends and the organisation's compliance with recommendations made by the PSOW office.
- Provide the PSOW with a copy of the Health Board's Annual Report for 2024/25 on the Duty of Candour and Quality.
- Inform PSOW of the outcome of the Board's considerations and proposed actions on the above matters at the earliest opportunity

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board is responding to the Annual Letter from the PSOW to provide assurance and demonstrate that it will continue to deliver against the highlighted



actions and recommendations. The Ombudsman conveyed positive feedback on the Health Board's progress during the period.

Cefndir / Background

The management of concerns handling continues to receive organisational and Executive focus. In 2024/25, ABUHB received 3,190 complaints, of which 178 were escalated to the PSOW. Which equates to an average of 5.5% of the total complaints received.

Despite the stable number of complaints referred to the PSOW, there has been a reduction in the number of interventions received, dropping from 37% last year to 28%.

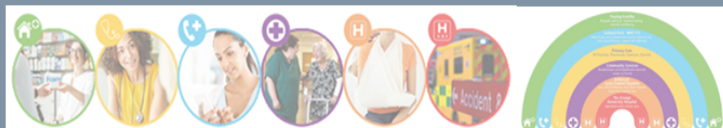
Compliance with completing PSOW recommendations within agreed timescales has decreased from 75% in 2023/24 to 66% in 2024/25. However, all recommendations for 2024/25 have now completed. The Health Board is committed to working collaboratively to reconcile all recommendations and actions to support improved compliance. This will be achieved through strengthening its local systems, closely monitoring deadlines, conducting regular audits, embedding lessons learnt to prevent delays and further improving complaint resolution processes.

Additionally, there has been a 98% reduction in the number of people complaining to the ombudsman about the complaints process, decreasing from 41 in 2023/24 to 1 in 2024/25.

Asesiad / Assessment

The Health Board has achieved significant progress in complaint management, reflected by a 98% decrease in referrals to the ombudsman regarding the complaints process from 41 in 2023/24 to 1 in 2024/25. This highlights the effectiveness of the ongoing initiatives aimed at improving the handling of complaints. The Health Board remains committed to further strengthening compliance with PSOW recommendations and optimising the complaints process.

- The Health Board's Investigating Officer (IO) training now includes a 'Train the Trainer' model to ensure PSOW complaints standards are delivered across the organisation.
- Divisional training sessions are scheduled throughout Autumn, with all PTR team members and new concerns team staff receiving dedicated training, supported by Once 4 Wales and key stakeholders.
- Training is monitored and refreshed periodically to address staff turnover and maintain robust complaint handling capability.
- This training supports the phased introduction of new PTR regulations planned for Spring 2026.
- Complaint handling remains a focus at both organisational and Executive levels.
- All complaints are now triaged with a person-centred focus, ensuring complainants are contacted to identify their key concerns and desired outcomes.



- Weekly meetings of the concerns team and strategy sessions for complex cases have improved communication, clarified roles, and reduced delays.
- Realignment of the PTR team has led to a consistent contact point and timelier updates, raising formal acknowledgements of concerns to over 90%.
- Communication Standards have been implemented to ensure consistency, clearly outlining proposals, actions, and timelines for keeping individuals informed.
- Regular collaborative meetings between Health Board and PSOW staff are scheduled to resume in September 2025, ensuring continued positive and open engagement with the PSOW office.

In accordance with statutory obligations to the PSOW, the Health Board has already implemented several measures. These actions leverage identified themes to drive organisational enhancement and continuous improvement.

Argymhelliad / Recommendation

- The Board is asked to note the contents of the Annual letter and the considerations of the Health Board data and the recommendations of the PSOW Annual Report
- Take assurance from the report

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.2 Communicating Effectively 3.3 Quality Improvement, Research and Innovation 6.3 Listening and Learning from Feedback 4.2 Patient Information
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives	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.



Strategic Equality Objectives 2020-24	Choose an item. Choose an item.
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Gwybodaeth Ychwanegol: Further Information:

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:	

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

	Is EIA Required and included with this paper
Asesiad Cydraddoldeb Equality Assessment (EIA) completed	<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 ABB.EDI@wales.nhs.uk</p>
Deddf Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	<p>Choose an item.</p> <p>Choose an item.</p>



Ann Lloyd CBE, Cadeirydd | Chair

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GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Our ref:

Direct line: 01633 435957

29 August 2025

Ms Michelle Morris
Public Services Ombudsman for Wales
1 Fford yr Hen Gae
Pencoed
CF35 5LJ

Sent by email: caseinfo@ombudsman.wales

Dear Ms Morris

Re: Annual letter 2024/25

Thank you for your letter dated and received by the Health Board on 14 August 2025.

In response, the following information is intended to provide assurance and to demonstrate the Health Board's delivery against the actions outlined.

1. Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.

The Annual Letter is intended to be presented to the Board on 24 September 2025.

2. Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.

Performance on complaints:

In the year 2024/25, Aneurin Bevan University Health Board (ABUHB) received 3,190 complaints. Of these, 178 were escalated to the Public Services Ombudsman for Wales (PSOW), which equates to 0.30 per 1,000 residents. We are pleased to report that there has been a significant reduction in the number of PSOW interventions received, with interventions decreasing by 30%, from 37% in 2023/24 to 28% in 2024/25. This positive trend reflects the ongoing efforts and commitment of the Health Board to improve complaint handling processes and address underlying issues proactively. Our continued focus on staff training, robust investigation procedures, and enhanced communication with service users has contributed to this marked improvement, demonstrating the effectiveness of the initiatives we have implemented.

Bwrdd Iechyd Prifysgol Aneurin Bevan
Pencadlys, Ysbyty Sant Cadog
Ffordd Y Lodj, Caerllion, Casnewydd NP18 3XQ

01633 436 700 f BwrddIechydPrifysgol X BIPANeurinBevan

Rydym yn croesawu gohebiaeth yn Gymraeg a byddwn yn ymateb yn Gymraeg heb oedi.
Bwrdd Iechyd Prifysgol Aneurin Bevan yw enw gweithredol Bwrdd Iechyd Lleol Prifysgol Aneurin Bevan.

Dyfodol Clinigol
Clinical Futures

Aneurin Bevan University Health Board
Headquarters, St Cadoc's Hospital
Lodge Road, Caerleon, Newport NP18 3XQ

01633 436 700 f AneurinBevanHealthBoard X AneurinBevanUHB

We welcome correspondence in Welsh and we will respond in Welsh without delay.
Aneurin Bevan University Health Board is the operational name of Aneurin Bevan University Local Health Board.

There has been a decline in compliance with completing PSOW recommendations within agreed timescales. For assurance, we confirm that all 2024/25 recommendations have been completed. We are committed to working collaboratively with your office to reconcile all recommendations and actions to support improved compliance. In addition, we are actively reviewing and strengthening our local systems and processes to address the underlying causes of any delays. This includes enhanced monitoring of recommendation deadlines, regular audits, and embedding lessons learned into our operational procedures. By taking these steps, we aim to ensure more timely completion of future recommendations and continued improvement in our overall approach to complaint resolution.

Additionally, there has been a 98% reduction in the number of people complaining to the ombudsman about the complaints process, decreasing from 41 in 2023/24 to 1 in 2024/25. This improvement is a testament to the ongoing efforts of our teams to enhance the complaints process, demonstrating the effectiveness of our systems and processes.

Learning and Improvement:

Learning from the PSOW investigations continues to be incorporated into the Patient Quality and Safety Learning and Improvement Forum bi-monthly, along with regular reporting at the Health Board's Quality Management Group and the Executive Committee.

The annual letter will be presented to the Quality Management Group and the Executive Committee on 4 September 2025. This will assist Executive Members in scrutinising the Health Board's performance and determining any further actions necessary based on the information provided.

Training and Compliance:

The Health Board's Investigating Officer (IO) training now incorporates the 'Train the Trainer', to ensure that the PSOW complaints standards are delivered organisationally. Dedicated Operational Divisional sessions have been scheduled across the Autumn period. Dedicated training has been provided to all Putting Things Right (PTR) team members, supported by key stakeholders such as the Once 4 Wales team and new members of the concerns team will also be provided with training to ensure that there is robust PTR capability within the system, which can be shared and cascaded. Training will be monitored and updated to offer periodic refresher training to account for staff turnover. The training will also form part of the staged approach to supporting staff with the introduction of the new PTR regulations, proposed in Spring 2026.

Complaint Handling Improvements:

The Health Board recognises the ongoing challenges in complaints handling and has introduced several measures to address them. All concerns now undergo an initial triage to ensure a person-centred approach, complainants are contacted following receipt of their concerns to identify the core questions for investigation and to understand what is most important to them to achieve a resolution to the concerns that they are raising. Weekly concerns team meetings enhance communication and support; strategy meetings are in place for complex cases in order to clarify roles and responsibilities to avoid delays. Realignment of members of the PTR team has ensured a consistent point of contact with more timely updates being provided to complainants, this has improved the formal acknowledgement of concerns to above 90%. The implemented Communication Standards continue to promote and underpin consistency in communication through outlining resolution proposals, actions, and timelines to keep

individuals informed throughout the process. Management of complaint handling continues to receive organisational and Executive focus.

Collaborative Meetings:

Regular meetings between Lowri Russell and Rhiannon Price will resume in September 2025, following the departure of PSOW Manager Matthew Harris. These meetings have previously been both informative and supportive, strengthening relationships. I would like to thank you for your kind acknowledgement of the openness and engagement with your office, and I am aware that this is reciprocated by Rhiannon Price and her team.

3. Provide my office with a copy of the Health Board's Annual Report for 2024/25 on the Duty of Candour and Quality.

A copy of the Health Boards Quality Annual Report for 2024/25 will be provided upon publication in September.

4. Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

The Board acknowledges the Annual Letter and will retain focused attention on Putting Things Right (PTR) and its processes. Progress will be monitored through the Quality Management Group with assurance provided to the Board sub-committee Patient Quality & Safety Oversight Committee, with any themes, learning or improvements discussed at the bi-monthly Patient Quality and Safety Learning and Improvement Forum.

The Health Board has reviewed and updated the Putting Things Right Concerns (Complaints) Policy to reflect recent legislative changes and necessary updates.

I hope that the information provided in relation to the actions being undertaken to strengthen complaint reporting and management provides robust assurance of the Health Board's commitment to improving the complaints process but also serves as an update on the Health Board's progress against the Complaints Standards work.

Please do not hesitate to contact me should you require any further information.

Yours sincerely



Ann Lloyd
Chair/Cadeirydd

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Nurse Staffing Levels (Wales) Act 2016: Annual Presentation of Nurse Staffing Levels 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Kelly Downes - Deputy Director of Nursing Laura Thomson – Nurse Staffing Act Lead

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

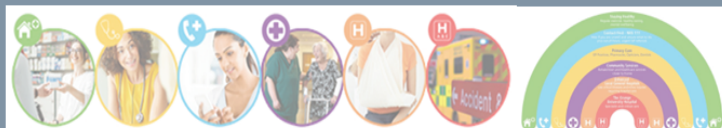
Er Sicrwydd/For Assurance

The Annual Presentation to Board (appendix 1) presents the outcomes of the Spring and Autumn 2025 recalculations conducted across all 25B wards, providing assurance regarding the Health Board's compliance with the Nurse Staffing Levels (Wales) Act 2016 (NSLWA).

Sefyllfa / Situation

In accordance with the NSLWA 2016, Health Boards and Trusts have a bi-annual duty to use the triangulated approach to calculate the nurse staffing levels in adult acute medical and surgical wards, and paediatric wards. There is also a requirement to report compliance in maintaining the nurse staffing levels as a means of providing assurance to the public, the Board and Welsh Government.

The All-Wales Nurse Staffing Group agreed a Once-for-Wales approach to provide consistency in reporting across all Health Boards. A clear governance process is required to inform the Board, or delegated committee, of any changes following the Bi-annual recalculations.



The Executive Team were apprised of the proposed changes to 25B Ward roster templates following the Spring 2025 recalculations. The changes were agreed to be supported with variable pay, pending further recalculation in the Autumn.

A summary of both Spring & Autumn 2025 calculations are presented below in the Assessment section.

Cefndir / Background

The NSLWA became law in 2016 and requires Health Boards to have regard for the provision of appropriate nurse staffing levels to ensure nurses have time to care for patients sensitively.

The designated person must calculate the nursing workforce appropriate to provide patient-centred care that meets all reasonable requirements in that situation.

In practice the nursing workforce means:

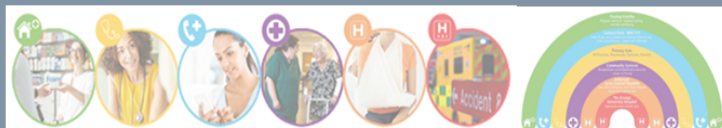
- the number of registered nurses (this being those with a live registration on sub parts 1 or 2 of the Nursing and Midwifery Council register) (Band 5 and Band 6)
- the number of rostered Assistant Practitioner (Band 4) (this will be superseded by the Registered Nursing Associate role once introduced in Wales).
- the number of Nursing Support Workers (Band 3).
- the number of Health Care Support Workers (Band 2).

The ward manager is not included in the planned roster and the required establishment needed to deploy the roster. Each ward will have a supernumerary ward manager.

In accordance with the Act, multi-professional roles are not included within the nurse staffing level calculation (the planned roster and the required establishment). However, consideration needs to be given to the presence and contribution that the multi-professional team and other healthcare professionals play in the delivery of patient care and the impact that not having these staff available will have on the duties that the ward nursing team will be required to undertake to ensure the provision of sensitive care.

Asesiad / Assessment

A robust, legislatively mandated triangulated methodology was applied to all Section 25B wards. This process involved multidisciplinary input from Divisional Nurses, Senior Nurses, Ward Managers, the Nurse Staffing Programme Lead, Health-Rostering, and Finance Teams. Professional judgement was central to decision-making, ensuring staffing levels were appropriate to each ward's needs.



The divisions followed well-established terms of reference to guide recalculation meetings. Discussions encompassed ward type, bed capacity, funded establishment, health-rostering efficiency, and safecare compliance. Acuity data from the preceding six months was reviewed alongside deployed staffing levels, including bank and agency usage and variable pay expenditure.

The successful rollout of Safecare to all 25B wards, has enabled ward staff to have access to monthly acuity data in the form of visualisers to help inform the recalculation meetings as opposed to a 1-month snapshot as in previous years.

Quality indicators from the same period were analysed, including hospital-acquired pressure ulcers, patient falls with harm, medication errors, infection rates, and complaints related to nursing care. Incident-related learning was shared, and ward managers were encouraged to highlight examples of good practice.

Progress in Ward Accreditation, PADR completion, mandatory training compliance, and staff sickness rates were also examined.

Following these reviews, collaborative professional judgement was applied to determine whether staffing levels are sufficient to deliver sensitive patient care. A standardised template for each Section 25B ward was then completed by the Divisional Nurse and submitted to the Executive Director and Deputy Director of Nursing during challenge and support meetings.

Spring 2025 Calculations (March-April 2025)

A total of 33 wards were reviewed during the Spring calculations; no changes were required to the wards in surgery, gynaecology and paediatrics. 5 of 19 medical wards proposed roster template changes, which the Executive Director of Nursing supported.

Medicine-proposed roster templates

The Division of Medicine identified 5 wards requiring amendments to roster templates to support the delivery of timely nursing care. The revised templates aim to enhance workforce stability, as current reliance on bank and agency staff has resulted in unfilled shifts. These changes are also expected to reduce variable pay costs, improve continuity of care, and promote equity across services.

Proposed changes to Establishments

Ward 4.4, Nevill Hall Hospital (30 Bedded Care of the Elderly Ward)



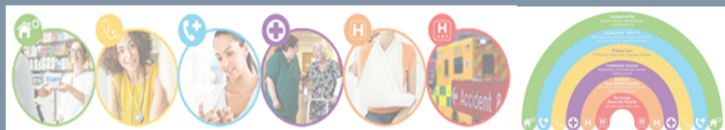
- **Change:** Increased Band 2 HCSW staffing to 4 per day, 7 days/week (2.8 WTE).
- **Rationale:** This ward was repurposed from a semi-acute respiratory ward to a Care of the Elderly (COTE) ward following the respiratory and general medicine reconfiguration in Autumn last year. The ward staff have found adjusting to a different patient profile challenging and have struggled to work within the previously agreed roster template, due to the consistent use of variable pay to support ward acuity—and to align staffing with other COTE wards on the Nevill Hall site.
- **Cost:** £103,499/year.
- **Roster Change:**
 - Previous: Day – 4 RN / 3 HCSW | Night – 2 RN / 4 HCSW
 - Proposed: Day – 4 RN / **4 HCSW** | Night – 2 RN / 4 HCSW

Bargoed Ward, Ysbyty Ystrad Fawr (27 Bedded Stroke Rehabilitation, capacity to board 2 patients)

- **Change:** Increased RN staffing to 4 per day, 7 days/week (2.84 WTE).
- **Rationale:** This ward functions as a Stroke Rehabilitation Unit with high levels of acuity and patient dependency. Following the centralisation of stroke services, patients are now being transferred from GUH earlier in their stroke pathway, resulting in a higher proportion of acutely unwell individuals. Many require PEG feeding, which significantly increases the time required for medication administration by a RN. To address this, an increase to 4 RN, 7 days per week (2.84 WTE) is required. This proposed change will bring Bargoed Ward in line with Oakdale Ward. The model also includes a review of Band 4 Assistant Practitioners, with a view to enabling them to work across both Bargoed and Oakdale Wards, ensuring equitable service delivery and consistent staffing levels across the two Stroke Rehabilitation Wards at YYF.
- **Cost:** £163,752/year.
- **Roster Change:**
 - Previous: Day – 3 RN / 6 HCSW | Night – 2 RN / 4 HCSW
 - Proposed: Day – **4 RN** / 6 HCSW | Night – 2 RN / 4 HCSW

Oakdale Ward YYF (28 bedded Stroke rehabilitation ward, no Surge Capacity)

- **Change:** Increased HCSW staffing to 5 per day, 7 days/week.



- **Rationale:** This ward operates as a Stroke Rehabilitation Unit with high acuity and patient dependency. Following the centralisation of stroke services, patients are now being transferred from GUH earlier in their stroke pathway, resulting in a higher proportion of acutely unwell individuals. Many require PEG feeding, which significantly extends the time required for medication administration by a RN. The current establishment includes 4 RNs during the day to support these prolonged medication rounds. However, due to the high dependency of patients, a professional judgment review, supported by variable pay data, concluded that the number of HCSW should be increased to 5 during the day, 7 days per week.
- **Cost:** £103,499/year.
- **Roster Change:**
 - Previous: Day – 4 RN / 4 HCSW | Night – 2 RN / 4 HCSW
 - proposed: Day – 4 RN / **5 HCSW** | Night – 2 RN / 4 HCSW

C6E Royal Gwent Hospital (30 bedded General Medical Ward, no Surge capacity)

- **Change:** Increased night HCSW staffing by 1 (7 days per week).
- **Rationale:** Patient dependency on this ward is high, and concerns have been raised regarding the Core Care Model, with the ward manager expressing a need for 4 RN during the day. However, this will be revisited following a full review of the Core Care Model and its alignment with the future Registered Nurse Associate role. It was noted that variable pay usage on this ward is consistently high, particularly due to additional HCSW shifts created at night to support patient dependency and enhanced care needs. To address this and ensure continuity of care, it was agreed to increase the establishment by 1 HCSW during the night, 7 days per week. This change is expected to help offset variable pay expenditure.
- **Cost:** £124,000/year.
- **Roster Change:**
 - Previous: Day – 3 RN / 5 HCSW | Night – 2 RN / 3 HCSW
 - Proposed: Day – 3 RN / 5 HCSW | Night – 2 RN / **4 HCSW**

C6W Royal Gwent Hospital (28 bedded Endocrinology ward with some General Medicine Beds)

- **Change:** **Cost-neutral** adjustment swapping RN night and HCSW day.
- **Rationale:** The Ward Manager highlighted that the current planned roster does not meet the operational needs of the ward. It was proposed that the ward would



function more effectively with an additional RN during the day shift to better manage workload. Additionally, an extra HCSW is consistently required at night to support patient acuity and enhanced care needs, contributing to increased variable pay. Following professional discussions, a cost-neutral adjustment to the roster was agreed. The revised roster will replace the RN on the night shift with an HCSW on the day shift. This change is expected to better align staffing with patient needs while maintaining cost neutrality.

Roster Change:

- Previous: Day – 3 RN / 5 HCSW | Night – 3 RN / 3 HCSW
- Proposed: Day – **4 RN / 4 HCSW** | Night – **2 RN / 4 HCSW**

Summary of amendments required to establishments post Spring 2025 recalculations

***Excluding Supernumerary Ward Manager**

Ward	Pre-Calculation			Post-Calculation			Additional Annual cost
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE	
4.4 NHH	17.32	19.58	36.99	17.32	22.36	39.68	£103,499
Bargoed ward YF	14.48	27.99	42.47	17.32	27.99	45.31	£163,752
Oakdale ward YF	17.32	22.4	39.72	17.32	25.19	42.51	£103,499
C6E RGH	14.48	22.42	36.9	14.48	25.2	39.68	£124,000
C6W RGH	17.32	22.42	39.74	17.32	22.42	39.74 cost neutral	0
Total Cost							£494,750

Roster efficiency

The E-rostering team have conducted roster efficiency analyses on the 4 wards requesting template increases, covering the period October 2024-March 2025.

There were high additional duties created for both grades in all areas. The working day unavailability has been used mainly when staff require supervision for instance when newly qualified staff or international nurses require supervision and cannot be included in the shift numbers.

Unavailability reasons



HCSW

- Sickness Absence:

Sickness levels were high across all areas, predominantly short-term.

Long-term sickness cases: Oakdale (3), Bargoed (6), NHH (7), C6W RGH (4)

- Study Leave:

Oakdale had an exceptionally high study leave recorded (1064.5 hours), with some individuals off for up to 3 weeks (attributed to international nurse induction and staff undertaking flexible route to registered nurse training).

- Bank Staff:

Bargoed: Low bank fill rate but high bank hours.

- Unfilled Hours:

High in all areas.

RN

- Sickness Absence:

High across all areas, mostly short-term.

Long-term sickness cases: Bargoed (2), 4/4 (1), C6W (3)

- Agency Use:

High in all areas, exceptionally high in Oakdale

The Divisional lead has given assurance that sickness is monitored and managed appropriately across the sites.

In addition to sickness, additional shifts have been created to reflect the acuity on the sites and the subsequent need to increase the number of staff on duty over and above the agreed template.

The study leave is high on Oakdale ward because there are several staff undertaking the flexible route to nursing and International Nurses requiring induction.

It must be noted that in areas such as YYF it is more difficult to fill the bank shifts, therefore increasing the pressures on the wards.

Spring Calculation Outcome

The paper was presented to the Executive Committee on 18 September 2025, where it was agreed that the Division of Medicine would implement the cost-neutral roster change for Ward C6W.

Regarding the proposed amendments for Ward 4.4 at Nevill Hall Hospital, Oakdale and Bargoed Wards at Ysbyty Ystrad Fawr, and Ward C6E at the Royal Gwent Hospital; to



ensure compliance with the Nurse Staffing Levels (Wales) Act, the Committee supported the continued use of variable pay to maintain staffing levels as outlined in the Spring recalculations.

A further multidisciplinary review involving workforce, finance, and nursing teams was agreed as part of the Autumn recalculation process, prior to confirming any permanent funding or roster adjustments.

Autumn 2025 Calculations (March-April 2025)

A total of **35 wards** were subject to staffing calculations Autumn 2025, comprising:

- **21 Acute Medical Wards**
- **13 Surgical Wards** (including 1 Gynaecological Ward)
- **1 Paediatric Ward** (50 beds)

The number of permanent medical 25B wards has increased by 1 following the reclassification of Penallta Ward at YF—a 28-bed COTE and palliative care ward—which now meets the criteria for a 25B designation. Additionally, a staffing calculation was carried out for Ward D7W at RGH (Winter Ward).

Outcome

The Surgical, Gynaecological, and Paediatric Nurse Staffing Templates remain the same, no changes to roster templates required.

Medical Wards

Medical wards retained Spring adjustments, (Ward 4.4 NHH, Bargoed & Oakdale wards YF, & C6E RGH) and are carried forward to the Autumn calculations

with the additional changes to:

- Ward C4 GUH, respiratory ward, increase RN Late shift 7 days/week
- Penallta ward YF, increase of 1 HCSW 7 nights/week
- Ward D7W, winter pressure ward – Calculation was undertaken to agree the template for temporary winter pressure ward.

Ward C4 GUH (45 bedded respiratory unit- spread over 3 areas, capacity to board a further 3 patients)

- **Change:** Increase RN late shift (7 days/week).
- **Rationale:** There is a need for a coordinator role to be in place for 12 hours a day due to the ward's extensive footprint and fast-paced environment. Patient turnover is high, with increasing acuity and elevated NEWS (National Early Warning Score) results. The intensity and pressure on the ward are sustained



throughout the day, making the coordinator role essential for ensuring smooth and effective ward operations. (This role has been utilised using variable pay following the reconfiguration of Respiratory and General medicine services. There is a clear need to receive permanent funding for this post).

- **Cost:** £75,053/year.
- **Roster Change:**
 - Previous: Early 9 RN / 7 HCSW, late 8 RN / 7 HCSW, Night 8 RN / 7 HCSW
 - Proposed: Early 9 RN / 7 HCSW, **late 9 RN** / 7 HCSW, Night 8 RN / 7 HCSW

Penallta Ward YYF (28 bedded COTE and Palliative Care ward), capacity to surge by 1

- **Change:** Increase HCSW by Night (7 days/week)
- **Rationale:** Penallta Ward has been reclassified as a 25B ward following a review of criteria. Now under the care of a General Medicine consultant, it admits Gen Med, COTE, and Palliative care patients. Although previously listed as 25A, it has consistently undergone biannual staffing calculations alongside other 25B wards at YYF due to its similar patient profile. Historically, professional discussions have supported the need for an additional HCSW at night, (currently, the additional HCSW is consistently utilised through variable pay). To ensure equity and reduce variable pay, the proposal is to increase night staffing from 3 to 4 HCSWs by night
- **Cost:** £124,000 /year
- **Roster Change:**
 - Previous: Day – 4 RN / 4 HCSW | Night – 2 RN / 3 HCSW
 - Proposed: Day – 4 RN / 4 HCSW | Night – 2 RN / **4 HCSW**

Ward D7W RGH (23 bedded Winter Pressure ward operational 3 months-January 2025 to end of March 2026).

A nurse staffing template was developed for the temporary winter pressure ward, based on comparable ward staffing model.

Nurse Staffing Template for Temporary Winter Pressure Ward

A nurse staffing template was developed specifically for the temporary winter pressure ward. This template was designed by referencing an established staffing model from comparable wards, ensuring that the approach aligns with best practice and meets the anticipated needs during the winter period.



To ensure safety and continuity, the ward will be overseen by a seconded Band 7 and Band 6, with support from redeployed substantive RNs and HCSWs from other areas, backfilled by temporary staff.

There is currently an advert on the Health Board pulse page encouraging substantive staff to register an interest to be redeployed to the winter ward. Additionally, the Nurse Bank will advertise 3-month temporary contracts to allow for consistency in filling the shifts.

Proposed Roster: Day: 3 RN / 3 HCSW | Night: 2 RN / 3 HCSW

This equates to WTE - B7 x1, Band 6 x1, B5 x 13.48, Band 2 x 13.98

Summary of amendments

The table below outlines the whole-time equivalent (WTE) figures before and after the Autumn calculations. Annual costings for each post have been provided by the Finance Partner for Medicine. These costings have increased compared to the Spring calculations due to this year's pay awards. Additionally, the Finance Business Accountant has revised the costing for the RN on Bargoed Ward, as the original Spring calculation was based on night shift rates rather than day shifts, resulting in an overestimation.

Summary of amendments required to establishments post Autumn 2025 Recalculations-including rollover of 4 wards from Spring calculations.

*Excluding Supernumerary Ward Manager

Ward	Pre-Calculation			Post-Calculation			Additional Annual cost	Variable Pay expenditure Oct 2024-September 2025
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE		
4.4 NHH	17.32	19.58	36.99	17.32	22.36	39.68	£104,338	£147, 621
Bargoed ward YYF	14.48	27.99	42.47	17.32	27.99	45.31	£139,100	£140, 057
Oakdale ward YYF	17.32	22.4	39.72	17.32	25.19	42.51	£104,338	£146, 220
Penallta ward YYF	17.32	19.56	36.88	17.32	22.36	39.68	£131,341	£253,701



C6E RGH	14.48	22.42	36.9	14.48	25.2	39.68	£131,341	£145, 026
C4 GUH	47.2	39.65	87.42	49.59	39.65	88.24	£75,053	£142, 573
Total Cost							£685,511	£975,198

Assurance Measures in Budget Oversight and Roster Monitoring

To provide assurance, divisional leads convene monthly meetings with business finance partners, senior nurses, and ward managers to review budget performance and address any areas of overspend. Key areas of focus include:

- Whole Time Equivalent (WTEs) versus vacancies
- Variable pay expenditure
- Monitoring of additional shifts against appropriate coding within the health-roster system

For enhanced assurance, the E-Roster team distributes monthly **SafeCare** reports to ward managers to support compliance with the twice-daily acuity census. Additionally, Divisional Leads have access to the workforce Divisional Nursing Hub dashboard, which allows them access to monthly reports on:

- Bank and agency usage
- Filled and unfilled shifts
- Roster efficiencies
- Sickness absence
- Pay scale Metrix
- Roster approval
- Supply and demand tracker
- Staff in post with age profile

The E-rostering team have conducted roster efficiency analyses on the 5 wards requesting template increases, covering the two months leading up to this report (August and September).

Overall, roster efficiencies are satisfactory, particularly in managing annual leave and other absences. However, sickness levels among HCSW are notably high, as is the allocation of study leave for Band 4 staff.

The Divisional Lead has confirmed that sickness is being effectively managed on the three wards requesting increased HCSW staffing. Sickness absence management processes and stages are discussed during weekly budget meetings.



The elevated study leave figures are attributed to Band 4 International Nurses currently undergoing induction and working towards NMC registration and band 4 nurses undertaking the flexible route to nurse registration.

Both ward C4 GUH and Bargoed ward YYF, are currently holding RN vacancies. The Divisional Lead has confirmed that these vacancies are being addressed through student streamlining on Ward C4 and the placement of International Nurses on Bargoed Ward. Once these posts are filled, RN vacancies will reduce to 0.22 WTE on Ward C4 and 0.21 WTE on Bargoed Ward.

The Divisional Lead is confident that all necessary steps are being taken to manage absences, improve roster efficiencies and reduce variable pay. Additionally, Senior Nurses are auditing enhanced care documentation to ensure compliance with policy. A clear escalation process is in place for requesting additional duties related to enhanced care needs.

It is important to note that the six wards requesting an increase to their staffing templates have consistently operated at the proposed levels over the past year through variable pay expenditure.

Executive Committee Discussion

The report was presented to the Executive Committee on 13 November 2025. The Executive Committee considered the options to meet the staffing requirements and supported the recommendation that the revised roster templates will be met through Variable pay with a request for further analysis of acuity to be undertaken.

Appendix 1: Annual Presentation of Nurse Staffing Levels

Appendix 2: Summary of Nurse Staffing levels

Argymhelliad / Recommendation

The Health Board has a duty to implement the statutory guidance and ensure compliance with the requirement of the Nurse Staffing Levels (Wales) Act.

The Board is asked to take assurance that: -

- The Health Board is meeting its statutory requirement to calculate the nurse staffing levels for all wards that fall under Section 25B of the NSLWA.



- The proposed changes to 6 planned rosters in the division of medicine outlined above and in Appendix 1 (Annual Presentation of Nurse Staffing levels) will be met through Variable Pay whilst a further review of acuity is undertaken

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 7. Staff and Resources 2. Safe Care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve 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.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	<ul style="list-style-type: none"> Nurse Staffing Levels (Wales) Act 2016 Health and Social Care (Quality and Engagement) (Wales) Act 2020.
Rhestr Termiau: Glossary of Terms:	
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	



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



Annual Presentation of Nurse Staffing Levels to the	
Health Board	ABUHB
Date of annual presentation of Nurse Staffing Levels to Board	25 November 2025
Period Covered	This report outlines the biannual Nurse Staffing Level Calculations for wards and details amendments to ward nursing establishments for 30 September 2025.
Number and identity of section 25B wards during the reporting period. <ul style="list-style-type: none"> • Adult acute <u>medical</u> inpatient wards • Adult acute <u>surgical</u> inpatient wards (inclusive of Women's Gynaecological inpatient wards) • <u>Paediatric</u> inpatient wards 	<p>The Board is required to consider and have due regard to its duties under the Staffing Levels (Wales) Act to ensure sufficient nursing staff are available to provide safe care wherever patients are receiving nursing services. The Board will continuously review and undertake comprehensive, systematic reviews of staffing levels.</p> <p>Under the Act, Health Boards and Trusts are also required to report on the outcomes for all wards that fall under Section 25B. These include paediatric wards.</p> <p>A total of 33 wards were classified as 25B wards during the Spring 2025 review following the Autumn review. This change is due to Penallta Ward being classified as a Care of the Elderly (COTE) and Palliative Care ward, meeting the criteria for 25B wards. Additionally, a staffing template was developed for the temporary ward at the Royal Gwent Hospital to support seasonal demand.</p>

	Total number of 25B wards				
		Spring 2025		Autumn 2025	
	Acute Medical:	19 Wards		21	
	Surgical:	12 Wards		12	
	Gynaecology:	1 Ward		1	
	Paediatrics:	1 Ward (50 beds)		1 Ward (50 beds)	
	Adult acute <u>medical</u> inpatient wards			Adult acute <u>surgical</u> inpatient wards	
	19 / 21			13	
Required establishment (WTE) calculated (November 2024 following respiratory reconfiguration)	RN	HCSW	RN	HCSW	
	359.22	459.49	233.5	250.53	

WTE of required establishment funded (November 2024 following respiratory reconfiguration)	359.22	459.49	233.5	250.43
Staffing requirements following Spring Cycle (May 2025)	Adult acute medical inpatient wards		Adult acute surgical inpatient wards	
Required establishment (WTE) calculated (May 2025)	RN	HCSW	RN	HCSW
	362.06	467.84	230.5	247.18
WTE of required establishment funded (May 2025)	359.22	459.49	230.5	247.18
Staffing requirements at end of reporting period (September 2025)	Adult acute medical inpatient wards		Adult acute surgical inpatient wards	
Required establishment (WTE) calculated (September 2025)	RN	HCSW	RN	HCSW
	380.8	481.44	230.5	247.18

WTE of required establishment funded (September 2025)	359.22	459.49	230.5	247.18
WTE Supernumerary band 7 sister/charge nurse at end of reporting period (funded but excluded from planned roster)	20		13	
Using the triangulated approach to calculate the Nurse staffing level on section 25B wards	<p>Evidence of Triangulated Approach</p> <p>A robust, legislatively mandated triangulated methodology was used. This process involved multidisciplinary input from Divisional Nurse Managers, the Nurse Staffing Programme Lead, e-rostering, and clinical judgement was central to decision-making, ensuring staffing levels met ward's needs.</p> <p>Key considerations included:</p> <ul style="list-style-type: none"> • Ward specialty, bed base, and current roster • Funded establishment and budget alignment • Health-Roster efficiency and Safecare compliance 			

	<ul style="list-style-type: none"> • Monthly patient acuity visualisers vs. deployed staffing • Variable pay data • Supplementary roles (e.g., ward clerks, discharge coordinators) • Care quality indicators (e.g., pressure ulcers, falls, medication errors) • Staff performance metrics (e.g., PADR compliance, training completion) • Ward accreditation and improvement initiatives <p>Following these reviews, ward-specific templates were completed and submitted to the Director of Nursing, Deputy Director of Nursing, and Nurse Staffing for review and assurance. Spring recalculations were submitted in June and October 2025.</p> <p>The Board has assurance that all Section 25B wards received a 24.8% uplift in establishments to account for leave and training. Ward Managers have a 24.8% uplift applied to their roles to ensure cover of the role in their absence. All staff receive a 24.8% uplift.</p>
<p>Finance and workforce implications</p>	<p>Spring Recalculations (March / April 2025)</p> <p>Surgery, Gynae & Paediatrics</p> <p>Following the in-depth recalculation meetings; the Divisions of Surgery, Gynaecology & Paediatrics deemed the planned rosters, and funded establishments were appropriate for the number of patients. No changes were required to previously agreed roster templates.</p>

Medicine

The Division of Medicine identified five wards requiring amendment to the delivery of timely nursing care. The revised templates aim to address the current reliance on bank and agency staff has resulted in unfilled posts. The revised templates are expected to reduce variable pay costs, improve continuity of care and patient services.

Proposed changes to establishments

Ward 4.4 Nevill Hall Hospital (30 bedded Care of the Elderly ward board 1 patient).

This ward was repurposed from a semi-acute respiratory ward to a general medicine ward following the respiratory and general medicine reconfiguration in 2022. Staff have found adjusting to a different patient profile challenging and the current roster is not aligned with the previously agreed roster template. Due to consistent use of agency staff and acuity—and to align staffing with other COTE wards on the Nevill Hall Hospital Band 2 Healthcare Support Worker (HCSW) provision should be increased to 3 per week (2.8 WTE). This adjustment, at an annual cost of £103,000, will reduce current variable pay expenditure and stabilise the workforce.

Previous roster: Day 4 RN / 3 HCSW - Night 2 RN / 4 HCSW

Proposed Roster: Day 4 RN / **4 HCSW** - Night 2 RN / 4 H

Presented to and approved by DMT in 6th May 2025

Total Cost: £103,499 per annum.

Bargoed Ward Ysbyty Ystrad Fawr (27 Bedded Stroke Rehabilitation Ward, currently board 2 patients).

This ward functions as a Stroke Rehabilitation Unit with high patient dependency. Following the centralisation of stroke services, patients from GUH earlier in their stroke pathway, resulting in a high number of individuals. Many require PEG feeding, which significantly increases medication administration by a Registered Nurse (RN).

To address this, the staffing template will be increased to four RNs to an uplift of 2.84 WTE at an annual cost of £163,752. This proposal is in line with Oakdale Ward. The model also includes a review of staff with a view to enabling them to work across both Bargoed and Oakdale service delivery and consistent staffing levels across the two Stroke Rehabilitation Units.

Previous roster: Day 3 RN / 6 HCSW - Night 2 RN / 4 H

Proposed Roster: Day **4 RN** / 6 HCSW - Night 2 RN / 4 H

Presented to and approved by DMT 6th May 2025

Total Cost: £ 163,752 per annum.

Oakdale Ward YYF (28 bedded Stroke rehabilitation ward, currently board 2 patients).

This ward operates as a Stroke Rehabilitation Unit with high dependency patients. Following the centralisation of stroke services, patients are now being admitted earlier in their stroke pathway, resulting in a higher proportion of acutely admitted patients requiring PEG feeding, which significantly extends the time required for care by Registered Nurse (RN).

The current establishment includes four RNs during the day to support patient care rounds. However, due to the high dependency of patients, a review of staffing supported by variable pay data—concluded that the number of Healthcare Support Workers (HCSWs) should be increased to five during the day, seven days a week. This annual cost of £103,499, will ensure both Stroke Rehabilitation staffing and service delivery.

Previous Roster: Day 4 RN / 4 HCSW - Night 2 RN / 4 HCSW

Proposed Roster: Day 4 RN / **5 HCSW** - Night 2 RN / 4 HCSW

Presented to and approved by DMT by 6th May 2025

Total Cost: £ 103,499 per annum

C6E Royal Gwent Hospital (30 bedded General Medical Ward)

Patient dependency on this ward is high, and concerns have been expressed under the Model, with the ward manager expressing a need for four Registered Nurses. However, this will be revisited following a full review of the Core C6E and the future Registered Nurse Associate role.

It was noted that variable pay usage on this ward is consistently high. Healthcare Support Worker (HCSW) shifts created at night to

enhanced care needs. To address this and ensure continuity of care at the establishment by one HCSW during the night, seven days a week, a total cost of £124,000, is expected to help offset variable pay expenditure.

Previous roster: Day 3 RN / 5 HCSW - Night 2 RN / 3 HCSW

Proposed Roster: Day 3 RN / 5 HCSW - Night 2 RN / **4 HCSW**

Presented to and approved by DMT 6th May 2025

Total cost £124,000 per annum

C6W Royal Gwent Hospital (28 bedded Endocrinology ward - 16 Beds).

The Ward Manager highlighted that the current planned roster does not meet the needs of the ward. It was proposed that the ward would function more effectively with 4 Registered Nurse (RN) during the day shift to better manage patient care. A Healthcare Support Worker (HCSW) is consistently required at night to manage enhanced care needs, contributing to increased variable pay.

Following professional discussions, a cost-neutral adjustment to the current roster will replace the RN on the night shift with an HCSW on the night shift to better align staffing with patient needs while maintaining cost neutrality.

Previous Roster: Day 3 RN / 5 HCSW - Night 3 RN / 3 HCSW

Proposed Roster: Day **4 RN / 4 HCSW** - Night **2 RN / 4 HCSW**

Presented to and approved by DMT 6th May 2025

Cost neutral

Summary of amendments required to establishments post

***Excluding Supernumerary Ward Manager**

Ward	Pre-Calculation			Post-Calculation		
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	T
4.4 NHH	17.32	19.58	36.99	17.32	22.36	
Bargoed ward YYF	14.48	27.99	42.47	17.32	27.99	
Oakdale ward YYF	17.32	22.4	39.72	17.32	25.19	
C6E RGH	14.48	22.42	36.9	14.48	25.2	
C6W RGH	17.32	22.42	39.74	17.32	22.42	
Total Cost						

Outcome

This paper was discussed at the Executive Committee on 18 September 2025, and it was agreed that the Division of Medicine would implement the cost-neutral roster changes.

Regarding the requests for 4/4 staffing at Nevill Hall Hospital, Oakdale Hospital, Ysbyty Ystrad Fawr, and C6E at the Royal Gwent Hospital, it was agreed to continue utilising variable pay to staff these wards as outlined in the Spring 2025 review in order to meet the requirements of the Act. A further review in the Autumn of the nursing teams was agreed as part of the Autumn calculation process to determine permanent funding arrangements or roster changes.

Autumn Recalculations 2025 (August / September 2025)

Surgery, Gynae Paediatric wards

During the Autumn cycle, 12 surgical wards, one gynaecology ward, and one paediatric unit were reviewed. The planned rosters for these areas were determined by the current roster templates did not require any changes.

Medicine

During the Autumn recalculations, 21 medical wards were reviewed for the upcoming Winter Pressures Ward. The proposed changes from the Spring review—Bargoed Ward (YYF), Oakdale Hospital (YYF), and C6E (RGH)—have been retained. These proposed changes, paid for through variable pay, remain in place.

In addition to the four template changes carried forward from the review concluded that there is a requirement to increase staffing to

Ward C4 GUH (45 bedded respiratory unit- spread over 3 beds).

Following the Respiratory and General Medicine reconfiguration, to include a wing on B4—bringing the total to 39 beds—and an additional 6 beds on C2 (total 45 beds). The staffing template and funded positions include a Registered Nurse (RN) coordinator role for 6 hours per day, 7 days a week.

Professional discussions highlighted several factors: the difficulty of managing a patient base across three areas, further compromised by increased activity and a new initiative, the fast-paced environment, increasing patient acuity, and a high (Warning Score) on many patients all contribute to increased ward complexity. To ensure safe and effective ward operation, the coordinator role should be a full-time day, 7 days a week permanently.

The Divisional Lead, in agreement with the Senior Nurse and Ward Manager, has identified the 12-hour coordinator role is essential. It should be noted that since the reconfiguration, this role has consistently been fulfilled through the current staffing, ensuring safety and operational efficiency.

To meet this requirement, an increase of 1.42 WTE RN is proposed.

Previous roster: Early 9 RN / 7 HCSW, late 8 RN / 7 HCSW

Proposed Roster: Early 9 RN / 7 HCSW, **late 9 RN** / 7 HCSW

Penallta Ward Ysbyty Ystrad Fawr (28 bedded, Gen Med capacity to surge by 1 bed).

Following a review of the 25B criteria, Penallta Ward has been classified as 25B. This ward is now overseen by a Gen Med consultant and accepts Gen Med, (COTE).

Despite previously being categorised as 25A, Penallta ward has been included in the 25B calculations along with the 25B wards in YYF due to its similar profile to the 25B wards being it was previously overseen by a CRT consultant.

Professional discussions have consistently highlighted the need to ensure that the costs for this to be reflected in the funded budget. This ward in line with the other wards consistently operates with 4 HCSW's by night, supported through a combination of variable pay and ensure equity of services across the YYF site, compared to other funded establishment by 1 HCSW at night, 7 days a week at a cost of £124,000 per annum.

Previous roster: Day 4 RN / 4 HCSW - Night 2 RN / 3 HCSW

Proposed Roster: Day 4 RN / 4 HCSW - Night 2 RN / 4 HCSW

Total cost £124,000 per annum

Ward D7W RGH (23 bedded Winter Pressure ward operational from March 2025- Acute COTE).

A calculation was undertaken to agree a Nurse Staffing Template for this ward on the Royal Gwent site. Despite not having data to review, the ward is currently operating with 4 HCSW's by night, supported through a combination of variable pay and ensure equity of services across the YYF site, compared to other funded establishment by 1 HCSW at night, 7 days a week at a cost of £124,000 per annum.

by the Divisional Leads in Medicine to determine the nurse staffing for a similar patient profile.

To ensure safety and stability, the ward will be overseen by a second in command. If possible the ward will be supported with the redeployment of subspecialty staff from medical and surgical wards who will be backfilled with temporary staff. We will advertise for 3-month contracts to help ensure continuity of temporary staff.

Proposed Roster: Day 3 RN / 3 HCSW - Night 2 RN / 3 HCSW

This equates to WTE - B7 x1, Band 6 x1, B5 x 13.48, Band 2 x 13.48

*Please note – the figures for the winter ward are not included in the current funded establishment table above – as the ward was not open during the winter period.

Summary of required amendments

The table below outlines the whole-time equivalent (WTE) figures and associated annual costings. Annual costings for each post have been provided by the Finance Business Accountant. These costings have increased compared to the Spring calculation. Additionally, the Finance Business Accountant has revised the costings on Bargoed Ward, as the original Spring calculation was based on 12 shifts, resulting in an overestimation.

Summary of amendments required to establishments post Spring 2019. Recalculations include -rollover of 4 wards from Spring 2018 proposals.

*Excluding Supernumerary Ward Manager						
Ward	Pre-Calculation			Post-Calculation		
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE
4.4 NHH	17.32	19.58	36.99	17.32	22.36	39.68
Bargoed ward YYF	14.48	27.99	42.47	17.32	27.99	45.31
Oakdale ward YYF	17.32	22.4	39.72	17.32	25.19	42.51
Penallta ward YYF	17.32	19.56	36.88	17.32	22.36	39.68
C6E RGH	14.48	22.42	36.9	14.48	25.2	39.68
C4 RGH	47.2	39.65	87.42	48.59	39.65	88.24

Total Cost	
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Assurance Measures in Budget Oversight and Roster Monitoring

To provide assurance, divisional leads convene monthly meetings with senior nurses, and ward managers to review budget performance and prevent overspend. Key areas of focus include:

- Whole Time Equivalent (WTEs) versus vacancies
- Variable pay expenditure
- Monitoring of additional shifts against appropriate coding w

For enhanced assurance, the E-Roster team distributes monthly reports to ward managers to support compliance with the twice-daily acuity census

Additionally, Divisional Leads have access to the workforce Divisional Roster which allows them access to monthly reports on:

- Bank and agency usage
- Filled and unfilled shifts
- Roster efficiencies
- Sickness absence
- Pay scale Metrix
- Roster approval
- Supply and demand tracker
- Staff in post with age profile

The E-rostering team have conducted roster efficiency analyses of increases, covering the two months leading up to this report (Aug

Band	Org. Units/Metrics	Vacancies	Additional Duties	Total Unavailability	Annual Leave %	Other L
HCSW	ME D 2/1 Oakdale YYF	Over Established by 1	34	41.32%	12.51%	
HCSW	ME D 4/4 COTE/Resp NHH	0.90wte vacancies	120	45.29%	8.83%	
HCSW	ME D C8E Respiratory RGH	2.5wte vacancies	34	44.41%	14.50%	
RN	ME D 2/2 Bargoed YYF	2.2wte vacancies	34	24.73%	11.22%	
RN	ME D C4 Respiratory GUH	2.8wte vacancies	8	23.94%	11.82%	

Overall, roster efficiencies are satisfactory, particularly in managing absences. However, sickness levels among Health Care Support V high, as is the allocation of study leave for Band 4 staff.

The Divisional Lead has confirmed that sickness is being effectively requesting increased HCSW staffing. Sickness absence management discussed during weekly budget meetings.

The elevated study leave figures are attributed to Band 4 International undergoing induction and working towards NMC registration and flexible route to nurse registration.

Both ward C4 GUH and Bargoed ward YYF, are currently holding Lead has confirmed that these vacancies are being addressed through Ward C4 and the placement of International Nurses on Bargoed V RN vacancies will reduce to 0.22 WTE on Ward C4 and 0.21 WTE

The Divisional Lead is confident that all necessary steps are being improve roster efficiencies and reduce variable pay. Additionally,

enhanced care documentation to ensure compliance with policy. A place for requesting additional duties related to enhanced care ne

It is important to note that the six wards requesting an increase t consistently operated at the proposed levels over the past year th Formal recruitment into these posts will help stabilise the workfor variable pay.

Options Appraisal

Option 1: Approve Permanent Changes and

It is recommended that permanent changes and associate wards to align budgets with the updated roster templates these posts will enhance workforce stability and ensure cons templates support equity in service delivery, continuity particularly critical as we approach the winter period.

Option 2: Continue Supporting Proposed Roster T

Continuing to support the proposed roster templates throug bed stability and support Health Board compliance with handover and continuous flow model. However, this approa a stable workforce. There is no guarantee that shifts—part be consistently filled, which may compromise timely care a

Conclusions and Recommendations

The Board is asked to:

- Acknowledge the Health Board is meeting its statutory re staffing levels for all wards that fall under Section 25B of th
- Note the proposed changes to 6 planned rosters in the div and in Appendix 1 (Annual Presentation of Nurse Staffing le
- Note the financial cost of increasing ward establishments advantages in terms of safe care delivery.
- Note the Executive Committee decision to opt for option 2 - the addition of further more detailed analysis of acuity to b

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Strategic Risk Report, November 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

Er Sicrwydd/For Assurance

The Strategic Risk Report provides the Board with an overview of the key strategic risks facing the Health Board, aligned to the priorities and objectives within the 2025–28 Integrated Medium-Term Plan (IMTP).

It seeks to provide assurance that these risks are being identified, monitored, and managed effectively, with proportionate actions in place to mitigate potential impacts on service delivery, financial sustainability, and patient safety.

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This report provides the Board with an assessment of the Health Board’s strategic risk profile as at November 2025.

The overall strategic risk position remains broadly stable, although the operating environment continues to present significant pressures. The Board is asked to note that six sub-risks currently sit outside the agreed risk appetite, each of which is subject to targeted management and enhanced oversight.

While challenges persist, particularly in relation to financial sustainability, workforce, and performance recovery, the Health Board continues to demonstrate a mature and proactive approach to managing risk through strengthened governance, robust assurance mechanisms, and sustained executive leadership focus.

Cefndir / Background

The Strategic Risk Register (SRR) is the principal mechanism through which the

Board gains assurance over the management of strategic risks. It currently includes nine principal risks and 21 associated sub-risks. Each risk has a designated Executive Director as lead, ensuring accountability for mitigation and oversight through relevant governance structures.

All strategic risks have been reviewed within the expected timeframe, and the overall control environment remains adequate. Where control gaps or assurance weaknesses have been identified, appropriate actions have been initiated to strengthen the relevant systems and processes.

Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

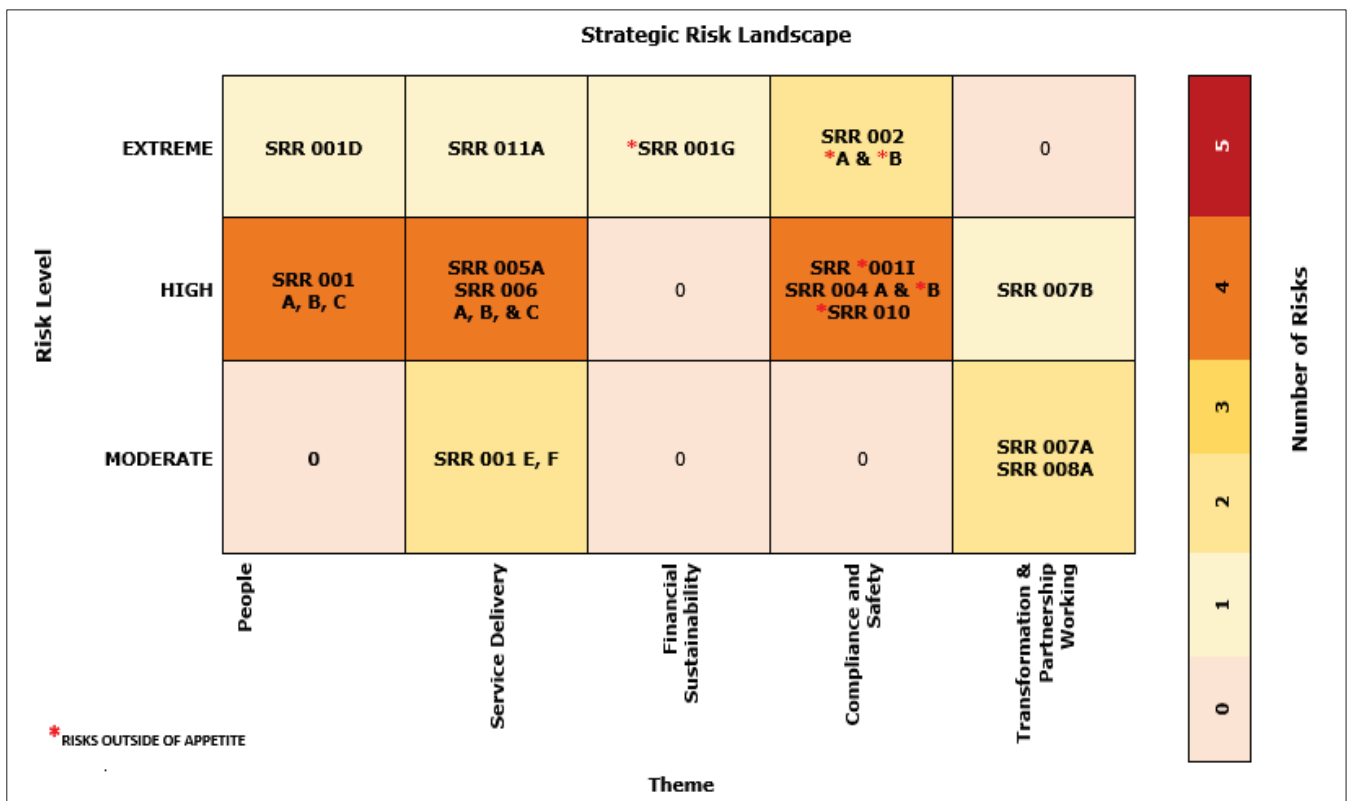
Asesiad / Assessment

Current Risk Profile

The Health Board’s strategic risk profile continues to reflect the scale and complexity of system-wide challenges. Most risks sit within the High category, particularly within Service Delivery and Compliance & Safety domains. These remain areas of sustained strategic focus and oversight.

Fewer risks are rated Extreme, but these represent the greatest potential threat to organisational resilience, patient safety, and delivery of IMTP objectives. These are subject to enhanced monitoring and reporting through the Executive Committee and relevant thematic committees.

The Heat Map, below, illustrates the current distribution of strategic risks and their relative severity.



*Represents the risk outside of appetite.

Risks outside of Appetite

The Table below sets out the six sub-risks that currently exceed the acceptable thresholds for their respective domains, all of which are under active management. Ongoing assessments are in place to monitor residual risk, ensuring that new threats and vulnerabilities are promptly identified and addressed.

Risk ID & Score Threshold	Sub Risk Description	Current Score	Management of the Risk
SRR 001G Score 12 and below	Due to the failure to deliver a sustainable financial position and longer-term financial plan.	20	The residual risk is being treated through strengthened financial controls, while opportunities are being taken to redesign services for long-term sustainability.
SRR 001I Score 8 and below	Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	12	The residual risk is being treated and opportunities taken to strengthen services and accountability structures.
SRR 002A Score 8 and below	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	15	The risk is being tolerated pending completion of remediation plans.
SRR 002B Score 8 and below	Due to significant levels of backlog maintenance and structural impairment.	12	The risk is being treated through proactive estate investment and maintenance planning.
SRR 004B Score 8 and below	Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident	12	The risk is being treated through the development, standardisation, and testing of business continuity and incident response plans.
SRR 010 Score 8 and below	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act.	12	The risk is being treated through strengthening governance and taking the opportunity to enhance staff safety culture.

Changes in Risk Exposure Requiring Board Attention

Since the last report to the Board in September, one material change in risk exposure has been recorded. Risk **SRR 001D**, relating to the potential impact of industrial action on service delivery, has increased in likelihood from a score of 3 (Possible) to 4 (Likely), resulting in a revised total risk score of 16.

This change reflects recent national developments, including the formal rejection of the 2025/26 pay offer by several trade unions and Unison's notice of intention to ballot members for industrial action. These developments have increased the likelihood of workforce disruption, which could in turn result in reduced service capacity, delays to patient care, and increased operational pressure. In addition, there are potential reputational and financial implications associated with managing contingency arrangements during periods of industrial action.

Although this risk remains within the Health Board's defined "open" risk appetite (a threshold of 17 or below), the situation warrants continued close oversight by the People and Culture Committee. However, the Board can take reasonable assurance that mitigation actions, including strengthened staff engagement, wellbeing support, and scenario-based contingency planning, are in place and monitored regularly.

Cross-Risk Dependencies and Collective Mitigation

The Health Board's 2025–28 IMTP is recognised as ambitious in scope, reflecting its commitment to deliver against a broad range of strategic objectives, ministerial priorities over the three-year period. The plan outlines an extensive programme of transformation and improvement across clinical services, workforce, and infrastructure, set against a persistently challenging operational and financial environment. Achieving financial balance continues to represent a significant delivery risk, with the IMTP requiring recurrent financial savings of around £40 million to support long-term sustainability.

The current strategic risk profile highlights clear interdependencies between financial sustainability, workforce capacity, and service delivery performance. These interconnected factors collectively influence the Health Board's ability to deliver its annual plans and, ultimately, the successful achievement of its IMTP objectives.

As at Month 06 (September) of the 2025/26 financial year, the Health Board is forecasting a year-end deficit of approximately £19.9 million, a variance from the previously planned break-even position. This deterioration reflects a combination of systemic pressures, including higher pay costs, growth in prescribing expenditure, increased Continuing Healthcare (CHC) activity, particularly within the Discharge to Assess pathway, ongoing operation of winter wards, and variable pay pressures within Mental Health and other service areas.

To ensure the Health Board remains ahead of principal risks materialising, a comprehensive programme of mitigation is being implemented to stabilise the financial position and strengthen organisational resilience. Enhanced scrutiny and reporting are being delivered through the Value and Sustainability Board, chaired by the Chief Executive Officer and supported by the Director of Finance and Procurement with targeted focus on efficiency delivery, cost control, and procurement optimisation.

In parallel, system-wide work continues to support the recovery of planned care, improve patient flow through strengthened collaboration with local authorities, and expand community-based care models. This integrated approach underpins both financial and operational sustainability and helps mitigate the wider portfolio of strategic risks across the Health Board.

To ensure these interconnected risks are anticipated and effectively mitigated, the Health Board recognises that strengthening organisational risk capability is essential. Effective delivery of the IMTP relies not only on operational action but on the continued development of a mature risk and assurance environment, one that provides earlier insight into the materialisation of principal risks, deeper understanding of cross-risk interconnectedness, and stronger governance over the effectiveness of mitigation.

The maturing healthcare risk system being developed across the organisation is therefore a critical enabler of our ability to manage strategic risks proactively, maintain focus on delivery outcomes, and intervene at pace where pressures escalate.

The following section sets out the progress being made in risk maturity and assurance development, and how this is underpinning resilience and supporting sustained improvement in strategic risk management.

Risk Maturity and Assurance Development

The Health Board continues to strengthen its organisational approach to risk, embedding a maturing governance and assurance environment that actively supports delivery of strategic priorities and mitigates the materialisation of principal risks.

Over the past year, notable progress has been made in enhancing risk capability and ownership across all levels of the organisation. Increased engagement with Executive Directors, senior leaders and operational teams has driven a more consistent and forward-looking approach to risk identification, assessment and escalation. As a result, risks are being recognised earlier, interdependencies are better understood, and mitigating actions are more clearly aligned with the successful delivery of the IMTP.

To support continuous improvement, a Corporate Governance Hub has been established as a central resource to coordinate risk, assurance, and governance activities. In parallel, work is progressing to implement a new electronic risk management system following the decommissioning of DatixWeb. This transition presents a major opportunity to enhance data quality, improve assurance mapping, and enable more dynamic, real-time oversight of delivery risks.

Independent audit insights have confirmed a positive trajectory toward a more mature risk culture. To embed this progress further, a Risk Maturity Matrix and a suite of risk performance indicators will be introduced over the next 3–6 months. These tools will provide increased visibility to the Board on whether or not controls remain effective and whether or not risk exposure is trending in line with required IMTP delivery outcomes.

Closing Position

As at November 2025, the Strategic Risk Register comprises nine high-level strategic risks and twenty-one sub-risks, of which six are operating outside their defined appetite levels. All risks continue to be monitored actively through the established governance framework, with particular focus on those presenting the greatest potential impact on service continuity, patient safety, or financial stability.

The Board can take reasonable assurance that strategic risks are being assessed, managed, and reviewed effectively and that the Health Board's risk management arrangements continue to mature in line with good governance expectations.

Argymhelliad / Recommendation

The Board is requested to:

- **CONSIDER** whether it has sufficient assurance that strategic risks are being appropriately managed and reviewed in line with the Health Board's governance framework;
- **ACCEPT** the change in risk score and exposure for sub-risk SRR 001D, but **NOTE** the efforts to minimise the impact to service delivery should the cause of the risk materialise;
- **NOTE** those risks that remain outside of the agreed appetite, recognising the ongoing work to strengthen controls and bring them within tolerance, and;
- **NOTE** the continued development of the Health Board's risk management and assurance framework as a key enabler of resilience, accountability, and sustainable service delivery.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau:	N/A

Glossary of Terms:	
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

Risk ID and Description			
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a) Due to an inability to recruit and retain staff across all disciplines and specialisms
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff
			c) Due to insufficient and ineffective leadership levels throughout the organisation
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and economic needs
	Director of Finance and Procurement		f) Due to unsustainable service models
	Director of Strategy, Planning and Partnerships.		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan
			h) Due to a failure to implement the required performance improvements in several areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures
			b) Due to significant levels of backlog maintenance
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident
			b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems
			b) Due to an adverse impact on service delivery in the implementation of new digital systems
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.
			b) Due to the impact of fragile services across the regional and supra regional geography
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience to enable patient involvement
SRR 010	Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.
SRR 011	Director of Finance and Procurement	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030).	a) The effect of a failure to meet this target is on the wider environment due to limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected

Key	Current Score	●
	Target Score	×
	Appetite Threshold	◊

RISK THEME	PEOPLE		
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE		
Strategic - SRR 001 A	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sus		
Threat <i>(As a result of)</i>	Due to an inability to recruit and retain staff across all disciplines and specialties.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> <ul style="list-style-type: none"> Adverse impacts on delivery of care to patients across acute and non-acute settings 	<u>Staff</u> <ul style="list-style-type: none"> Non-compliance with safe staffing principles and standards. Increased Workload 	<u>Organisational</u> <ul style="list-style-type: none"> Operational Disruption Quality of Services Reputational Damage Financial strain – use of staff
Lead Director	Director of Workforce & Organisational Development	<u>Risk Exposure</u>	Current Level
Monitoring Committee / Group	People & Culture Committee	Likelihood	3 (Possible)
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 October 2025	Risk rating	= 12 (High)
Next Review <i>(Quarterly based on risk score)</i>	01 January 2026		

Current Key Controls
<i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>
<ul style="list-style-type: none"> Monitoring Framework to support roll-out of the People Plan. Workforce Dashboard to track activity – recruitment, turnover, sickness absence. Supply and demand tracker (Nursing and HCSW). People Plan tracker to support delivery of actions within the People Plan 2022-25. Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. Management of attendance through All Wales Management Attendance at Work Policy. Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. Nurse Staffing Levels (Wales) Act 201625b/25c. Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. Workforce planning supported by Compendium of new roles to support innovative workforce models. Recruitment KPI's. IMTP (Integrated Medium-Term Plan) Educational Commissioning. Workforce Establishment controls national working group has been instigated. Value and Sustainability Board. Implementation of the Collective Agreement (Non-Pay Deal) 2022/24. Real Living Wage Employer. <p>Recruitment</p> <ul style="list-style-type: none"> Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. Annual programme of Apprentice recruitment. Overseas Nursing (All Wales Recruitment programme).

- Nursing Workforce Strategy 2023 – 2026
- Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022)
- Partnerships with employability schemes and FE/HE to widen access.
- Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board.
- Working with partners to improve visibility and attraction.
- DBS Policy in place with DBS risk assessment form.
- Introduced centralised HCSW talent pools from September 2023.
- Future Nurse Academy introduced in January 2024.

Retention

- Retention lead appointed with programme action plan in place for the next two years.
- Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR.
- Week of events planned to support retention agenda in 2025. This will include a mixed method of online webinars, videos and retention materials.
- Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts.
- Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return.
- Development of HCSW skills matrix and career framework has commenced.
- Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee.
- Career conversations and succession planning resources designed; Talent management succession planning workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked. Further workshops planned until the end of the year.
- All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline.
- Launch and support of the NHS Wales Staff Survey (October and November 2025).

Variable pay reduction

- Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board.

E- Systems

- Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all 'live' and rolled out within the Health Board.
- E-Rostering is planned to go live shortly following ESR interface testing and following increase in e-job planning compliance, provisionally scheduled for the end of July 2025.

Development of Alternative and New Roles

- Development of alternative and new roles.
- A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care.
- The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management.
- Mental Health Workforce plan development in line with new Models of Care.

Training

- The HEIW Education & Training Plan 2025/26 continues the investment in education and training in Wales that has been increasing over past years.
- The 2025/26 education training plan demonstrated increases in a number of medical training places in medical, surgical, diagnostics and mental health specialities. This is to support areas of high vacancies, population health predictions and Welsh Government Priorities. The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing (adult, health visiting, practice. Training numbers in Therapies and Health Care Science programmes will remain static at previous year's numbers.
- HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience.

- Ongoing investment in the Primary and Community Care Academy Network will be a key enabler to delivering innovation and transformation through the Strategic Workforce Plan for Primary Care and the Strategic Programme for Primary Care.
- Cadet Nursing programme in place – 16 candidates attended for the 2024 induction and work is ongoing to support all 16 to achieve accreditations. - 16 RCN cadets attending All Wales HCSW Clinical Skills Induction, currently 12 active.
- K102 bridging model now being offered to support HCSW pathways into registered nursing.
- Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx). Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024 with cohort 2 launching June 2025. Nursing and Midwifery Academy for senior level nurses and midwives, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff per year.
- Delivery of workforce planning training.

Vacancy Numbers and establishment control

- Quarterly reporting of vacancy numbers to WG as of 30 June 2025 was 442 WTE, a significant decrease of 220 WTE since March 2025.
- Development of ESR establishment control model commenced. Local delivery action plan has been agreed by the Executive Committee with expected 90% roll out completed by 31 October 2025.

Staff attendance

- Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work.
- “Hot spot” areas identified and plans in place to support.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insufficient)</i>
Level 1 Operational <i>(Implemented by the department)</i>		
<ul style="list-style-type: none"> • Workforce reports to the Nurse Strategic Workforce Group. • Monthly sickness monitoring reports. • Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. • Medical Staffing Co-ordinator review of medical rotas. • Cross site operational calls. 	<ul style="list-style-type: none"> • Occupational Health and Wellbeing dashboards report KPIs. • Recruitment KPIs • Medical & Dental and Student Streamlining fill rate reports 	
Level 2 Organisational <i>(Executed by risk management)</i>		
<ul style="list-style-type: none"> • Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. • Measurements of Wellbeing through the ABUHB 	<ul style="list-style-type: none"> • (Aneurin Bevan University Health Board) Staff Survey • Routine Reporting against nurse staffing levels. • Variable Pay Programme Board reporting to Value and Sustainability Board 	<ul style="list-style-type: none"> • Governance • risk management
Level 3 Independent <i>(Implemented by both audit and risk management)</i>		
<ul style="list-style-type: none"> • Internal Audit Reviews 2023 -24 • Long Term Sickness Absence Management (Q4) • Flexible Working (Q4) • External quarterly vacancy reporting to WG • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges. The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative. 	<ul style="list-style-type: none"> • External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • Workforce planning external audit action plan 2024 and Structured Assessment Response August 2025 • Resident Doctor Contract Reform 	<ul style="list-style-type: none"> • Latest information
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	PEOPLE		
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE		
Strategic - SRR 001 B	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sus		
Threat <i>(As a result of)</i>	Due to a deterioration in, and a failure to improve, the well-being of staff.		
Impact <i>(Consequences of the threat)</i>	<p>Patient</p> <ul style="list-style-type: none"> Adverse impacts on delivery of care to patients across acute and non-acute settings 	<p>Staff</p> <ul style="list-style-type: none"> High absence levels, with some sustained long periods Non-compliance with safe staffing principles and standards 	<p>Org</p> <ul style="list-style-type: none"> Reputational o board as an en Work-related Financial Impl
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level
Monitoring Committee / Group	People & Culture Committee	Likelihood	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 October 2025	Risk rating	= 12 (High)
Next Review <i>(Quarterly based on risk score)</i>	01 January 2025		

Current Key Controls

(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)

General

- Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard
- Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity
- Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority
- Strategic Equality Plan
- Rest and Facilities Charter – monitoring and compliance
- Staff related policies
- National Staff Survey and Health Board Employee Experience Survey
- External Employee Assistance Programme
- Speaking up Safely Action Plan
- Race/LGBT groups
- Wellbeing resources
- Staff diversity networks
- Regular Schwartz rounds arranged across the Health Board
- Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own
- Close links with the Arts in Health programme
- Chaplaincy service for staff
- Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate
- Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management.

- The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits
- The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB
- An externally commissioned SUS hotline
- An external Employee Assistance Programme (Vivup) has been commissioned for a further 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative

Occupational Health

- Additional occupational health resources secured to reduce waiting times
- Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes
- Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19
- Support equality and diversity of workforce
- A part time Disability Inclusion Officer has been seconded to the EDI Team and made permanent in December 2024
- Band 5 EDI Officer appointed and commenced in post at the end of March 2024
- Inclusive Leadership sessions embedded in the Leading People Programme
- Reverse Mentorship Programme launched February 2024

Other

- Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC
- Reducing fatigue poster developed

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	<i>(Insufficient)</i>
Level 1 Operational <i>(Implemented by the department)</i>	
<ul style="list-style-type: none"> • Dashboard reporting • Reporting to monitor the rollout of the People Plan 22-25 • Reporting to monitor of demand on wellbeing services 	<ul style="list-style-type: none"> • Understa
Level 2 Organisational <i>(Executed by risk management)</i>	
<ul style="list-style-type: none"> • People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and Facilities 	
Level 3 Independent <i>(Implemented by both assurance and risk management)</i>	
<ul style="list-style-type: none"> • National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers • Staff Welfare Charter • Sickness Absence Audit 2023/24 – Outcome: Reasonable Assurance 	<ul style="list-style-type: none"> • Latest loc
Assurance Rating <i>(Overall Assessment)</i>	
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.

RISK THEME	PEOPLE		
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE		
Strategic - SRR 001 C	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sus		
Threat (As a result of)	Due to insufficient and ineffective leadership levels throughout the organisation		
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Adverse impacts on delivery of care to patients across acute and non-acute settings; 	<p>Staff</p> <ul style="list-style-type: none"> Adverse impacts on staff recruitment and retention 	<p>Organis</p> <ul style="list-style-type: none"> Failure to deliver heal required improvement sustainability; Poor levels of account Reputational damage an employer;
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level
Monitoring Committee / Group	People & Culture Committee	Likelihood	3 (Possible)
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 October 2025	Risk rating	= 12 (High)
Next Review (Quarterly based on risk score)	01 January 2026		

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)
<ul style="list-style-type: none"> Talent and Succession Planning framework published Monitoring Framework to support roll out of the People Plan – Focus on Talent and Succession Planning. Monitoring Frameworks with HEIW Lead appointed July 2023 on secondment funded by HEIW to create organisational talent management framework to enable to organisation to be deliberate and consistently attract, identify and develop talent for critical roles across ABUHB. HEIW schemes 1 x HEIW funded graduate management trainee successfully appointed August 2025 following additional recruitment process. Develop Leadership Capabilities Leadership journey and programmes mapped, and 1 pager flyer designed and on intranet. Leadership development offer now available for entry level leaders and mangers, clinical directors, directorate managers (DMx), senior nurses and multi-disciplinary teams. Considering very senior leader programme. Learning masterclasses have been designed and developed for the organisation addressing ley themes such as giving feedback, developing team and having courageous conversations. Leading People Programme (started cohort 9 May 2025), CDx cohort 5 starting November 2025. 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire council; our graduate joined the health board in March 2023 and is supporting the decarbonisation agenda.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insuffi</i>
Level 1 Operational <i>(Implemented by the dep</i>		
<ul style="list-style-type: none"> • WOD Divisional reporting • Evaluation of internal leadership programmes and regular review of our internal offer 		
Level 2 Organisational <i>(Executed by ris</i>		
<ul style="list-style-type: none"> • Reporting to People and Culture Committee - progress against People Plan 22-25 / 2025 – 2028. 		
Level 3 Independent <i>(Implemented by both au</i>		
<ul style="list-style-type: none"> • Internal Audit Review • Talent and Succession Board 		
Assurance Rating <i>(Overall Assessment</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	PEOPLE		
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE		
Strategic - SRR 001 D	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sus		
Threat <i>(As a result of)</i>	Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level		
Impact <i>(Consequences of the threat)</i>	<p>Patient</p> <ul style="list-style-type: none"> Adverse impacts on delivery of care to patients across acute and non-acute settings 	<p>Staff</p> <ul style="list-style-type: none"> Non-compliance with safe staffing principles and standards 	<p>Org</p> <ul style="list-style-type: none"> Litigation & Fi Reputational board and los
Lead Director	Director of Workforce & Organisational Development	<u>Risk Exposure</u>	Current Level
Monitoring Committee / Group	People & Culture Committee	Likelihood	4 (Likely)
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 November 2025	Risk rating	= 16 (Extreme)
Next Review <i>(Monthly based on risk score)</i>	01 December 2025		

Current Key Controls
<i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>
<ul style="list-style-type: none"> All Wales Industrial Action Planning Group. Local Health Board planning arrangements. Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and CODE OF PRACTICE Industrial Action Ballots and Notice to Employers. Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. Effective derogation processes including Christmas Day cover definition. Local Negotiating Committee (LNC). Services Business continuity plans in place. Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. Command and control structure and leads established. Derogation test completed. Executive and Senior Manager leads established links with national planning cells. All Wales training sessions provide by legal and risk to support industrial action. Reducing impact on patients - Support for early supported discharge prior to industrial action. Picketing guidance supported and agreed. Workforce Peer Networks – WOD's and DEWOD's.

Sources of Assurance	(Insufficie
<i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	

Level 1 Operational <i>(Implemented by the dep</i>		
<ul style="list-style-type: none"> Local Staff re-deployments assessment Divisional engagement and service planning arrangements in place Local Negotiating Committee (LNC) Trade Union Partnership meetings Established processes and tools used for previous industrial action. 		
Level 2 Organisational <i>(Executed by ris</i>		
<ul style="list-style-type: none"> Reporting to Executive team Business Continuity groups Command and control structure in place to be implemented as required 		
Level 3 Independent <i>(Implemented by both au</i>		
<ul style="list-style-type: none"> All Wales IA group and Welsh Government planning group. Debriefing session planned to reflect and capture learning for any potential future action Resident Doctor Contract Reform Band 2/3 Implementation Framework – DRAFT, subject to Cabinet Secretary review/approval 		
Assurance Rating <i>(Overall Assessment</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	SERVICE DELIVERY		
LINK TO IMTP	SECTION 3: SYSTEM CHANGE		
Strategic/ Corporate Risk SRR 001 E	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sus		
Threat (As a result of)	Due to inadequate strategic plans which respond to population health and socio-economic needs.		
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Increased patient acuity levels Worsening of health inequalities Worsening of health outcomes 	<p>Staff</p>	<p>Organisa</p> <ul style="list-style-type: none"> Failure to train team management Failure to comply with Future Generations A Reputational damage confidence Increased demand
Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	Current Level
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	Likelihood	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 April 2025	Risk rating	= 8 (Moderate)
Next Review (Six monthly based on risk score)	01 October 2025		

<p>Current Key Controls</p> <p><i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i></p>
<ul style="list-style-type: none"> Health Board IMTP and associated KPIs Public Health Wales surveillance data QlikSense – performance dashboard Population Needs Assessment and Area Plan Marmot Region Programme

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insufficient)</i>
Level 1 Operational <i>(Implemented by the department)</i>		
<ul style="list-style-type: none"> • QlikSense – performance information • SFN – performance information 		
Level 2 Organisational <i>(Executed by risk management)</i>		
<ul style="list-style-type: none"> • IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee 		<ul style="list-style-type: none"> • Regional Planning reporting to Population Health, Planning and Partnerships Committee
Level 3 Independent <i>(Implemented by both audit and internal audit)</i>		
<p>Internal Audit Reviews 2023-24</p> <ul style="list-style-type: none"> • IMTP Planning (Q1) Outcome – Reasonable Assurance <p>Internal Audit Reviews 2024-25</p> <ul style="list-style-type: none"> • Internal Audit Partnership Arrangements – Limited Assurance 		
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.

RISK THEME	SERVICE DELIVERY		
LINK TO IMTP	SECTION 3: SYSTEM CHANGE		
Strategic Risk SRR 001 F	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sus		
Threat (As a result of)	Due to unsustainable Service Models		
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Increased demand Increased patient acuity levels Worsening of health inequalities Worsening of health outcomes 	<p>Staff</p> <p>N/A</p>	<p>Organisational</p> <ul style="list-style-type: none"> Failure to train team management Failure to comply with Future Generations Reputational damage confidence
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 April 2025	Risk rating	= 8 (Moderate)
Next Review (Six monthly based on risk score)	01 October 2025		

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)
<ul style="list-style-type: none"> The Health Board’s Integrated Medium-Term Plan (IMPT) and associated KPIs Strategic Programmes in place Public Health Wales surveillance data – Covid, flu and other communicable diseases. QlikSense – performance information. Population needs assessment and area plan development by the RPB. Southeast Wales Plan for fragile services.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insuffic</i>
Level 1 Operational <i>(Implemented by the dep</i>		
<ul style="list-style-type: none"> Public Health Wales surveillance data – COVID, flu and other communicable diseases. QlikSense – performance information 		
Level 2 Organisational <i>(Executed by ris</i>		
<ul style="list-style-type: none"> IMTP delivery and outcomes reporting to Board. RPB reporting to Board and Population Health, Planning and Partnerships Committee. Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. 	<ul style="list-style-type: none"> Regional Planning reporting to Population Health, Planning and Partnerships Committee. Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. 	
Level 3 Independent <i>(Implemented by both au</i>		
<p>Internal Audit Reviews 2023-24</p> <ul style="list-style-type: none"> IMTP planning Q1. Outcome – Reasonable Assurance. <p>Internal Audit Reviews 2024-25</p> <ul style="list-style-type: none"> IMTP – Service Plans (Q2) – Outcome - Reasonable Assurance Partnership Arrangements. Outcome – Limited Assurance 		<ul style="list-style-type: none"> Rec Ass
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	FINANCIAL SUSTAINABILITY		
LINK TO IMTP	SECTION 4: ENABLER - FINANCE		
Strategic - SRR 001 G	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sus		
Threat <i>(As a result of)</i>	Due to the failure to deliver a sustainable financial position and longer-term financial plan.		
Impact <i>(Consequences of the threat)</i>	<p style="text-align: center;"><u>Organisation</u></p> <ul style="list-style-type: none"> • Breach of statutory duty to breakeven over 3 years. • Instigation of NHS Wales Escalation & Intervention Arrangements. • Non-delivery of Health Board priorities, required improvements, and achieving longer-term sus • Prioritisation and possible disinvestment in service delivery. • Reputational damage and loss of public confidence. 		
Lead Director	Director of Finance and Procurement	<u>Risk Exposure</u>	Current Level
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	5 (Almost certain) x
Initial Date of Assessment	June 2023	Impact	4 (Major)
Last Reviewed	October 2025	Risk rating	= 20 (Extreme)
Next Review <i>(Monthly based on risk score)</i>	November 2025		

<p>Current Key Controls</p> <p><i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i></p>
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- IMTP 25/26-27/28
- IMTP Delivery Framework
- Sustainability Route Map revision
- Accountability Framework
- Performance Framework
- 3-year route map to sustainable recovery developed and approved by Board July 24.
- Scheme of Delegation
- Standing Financial Instructions (SFIs)
- Standing Orders (SOs)
- Final budget delegation
- Financial Control Procedure (FCP) Budgetary control
- Financial Budget Intelligence (FBI)
- Appropriately trained Finance Team (capacity & capability)
- Budget holder training & other business training tools
- Cost intervention procedures
- 25/26 savings plans & opportunities.
- Health Board financial escalation processes.
- Health Board Pre-Investment Panel (PIP) process.
- Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs.
- Executive groups and structures established to deliver statutory duties.
- Assessment of financial control environment within divisions and corporate teams.
- Financial Escalation Meetings
- Regular organisational Recovery plan meetings and briefings
- Value & Sustainability Board established.
- Revised accountability arrangements part of Executive governance.
- Budget holder financial recovery deep dive meetings,
- Enhanced forecasting and planning processes

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insuffi</i>
Level 1 Operational <i>(Implemented by the dep</i>		
<ul style="list-style-type: none"> • Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Day 5 comprehensive financial performance review – DoF led. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance 		None
Level 2 Organisational <i>(Executed by ris</i>		
<ul style="list-style-type: none"> • Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee 	<ul style="list-style-type: none"> • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position. 	None
Level 3 Independent <i>(Implemented by both au</i>		

Internal Audit

- Annual Report
- 2024/25 Financial Sustainability – **Reasonable Assurance** Sept 2025
- 2025/26 - Audit Reviews

External Audit Reports

- 2024 -25 – Annual Report
- 2025/26 - Audit Reviews

Welsh Government

- Financial assessment and review reports to Welsh Government – monthly
- Enhanced monitoring T.I. meetings with Welsh Government monthly
- IMTP plan to WG end of March 2025

• Recom

Assurance Rating (Overall Assessment)

Negative – Insufficient evidence that the controls

Reasonable - adequate evidence that the controls in place are working effectively.

RISK THEME	COMPLIANCE AND SAFETY		
LINK TO IMTP	SECTION 2: DRIVERS – PERFORMANCE EXPECTATIONS		
Strategic Risk SRR 001 I	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, sustain		
Threat (As a result of)	Due to a failure to implement the required performance improvements in some areas of the organisat Health Board's Performance Management Framework domains of Quality and Safety, Operational De		
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Unintended Patient Harm. Negative Public/Patient Experience. 	Staff <ul style="list-style-type: none"> Reduced Staff Morale leading to potential absence from work. 	Org <ul style="list-style-type: none"> Loss of patient confidence. Scrutiny from Adverse public Punitive Actio Financial impl
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level
Monitoring Committee	Finance and Performance Committee.	Likelihood	3 (Possible) x
Initial Date of Assessment	19 April 2024.	Impact	4 (Major)
Last Reviewed	01 July 2025	Risk rating	= 12 (High)
Next Review (Quarterly based on risk score)	01 October 2025		

Current Key Controls
<i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>
<ul style="list-style-type: none"> Performance Management and Assurance Framework Executive Accountability letters Divisional Directors Accountability letters Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off Reporting through to Finance and Performance Committee via Executives Specific areas of focus are discussed at Value and Sustainability Board System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. External scrutiny via Welsh Government and NHS Executive Capacity to run the performance framework and reporting requirements has been strengthened with the appointment of the Head of Systems Planning and Performance and analytical team who will fully be in place by January 2025 alongside the Business Partnering Support

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insuffi</i>
Level 1 Operational <i>(Implemented by the dep</i>		
<ul style="list-style-type: none"> DMTs in place for all Divisions Divisional oversight arrangements – monthly/fortnightly meetings Divisional plans in place and focussed agendas Cross Divisional meeting monthly – progress the wider system way of working. 	<ul style="list-style-type: none"> System Leadership Team for awareness and updates 	<ul style="list-style-type: none"> 12-mo
Level 2 Organisational <i>(Executed by ris</i>		
<ul style="list-style-type: none"> Established reporting to the Executive Committee Established reporting to the Finance and Performance and Patient, Quality and Safety Committee Established reporting to the Board Routine reporting through the IQPD process 		None
Level 3 Independent <i>(Implemented by both au</i>		
<ul style="list-style-type: none"> Internal Audit 2024/25 Plan Directorate Review - Mental Health and Learning Disabilities (Q2) Divisional Governance Arrangements (Q2) HIW Inspections Llais for feedback 		<ul style="list-style-type: none"> Interna Finding Arrang Finding Health
Assurance Rating <i>(Overall Assessment</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	COMPLIANCE AND SAFETY		
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES		
Strategic Risk SRR 002 A	There is a risk that there will be significant failure of the Health Boards Estates.		
Threat <i>(As a result of)</i>	Due to the presence of Reinforced Autoclaved Aeriaded Concrete (RAAC) within structures.		
Impact <i>(Consequences of the threat)</i>	<p style="text-align: center;">Patient</p> <ul style="list-style-type: none"> Harm or injury to patients Adverse impacts on delivery of care to patients across acute and non-acute settings 	<p style="text-align: center;">Staff</p> <ul style="list-style-type: none"> Harm or injury to staff 	<p style="text-align: center;">Org</p> <ul style="list-style-type: none"> Litigation & Fi Loss of estate
Lead Director	Chief Operating Officer	<u>Risk Exposure</u>	Current Level

Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	Likelihood	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	5 (Catastrophic)
Last Reviewed	01 November 2025	Risk rating	= 15 (Extreme)
Next Review (Monthly based on risk score)	01 December 2025		

<p>Current Key Controls</p> <p><i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i></p>
<ul style="list-style-type: none"> • Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (currently ongoing for June and July with report expected in August 2025) • Actions from previous reports including specific actions relating to ‘skylights’ in progress albeit some will require more substantial work -which is being scoped. • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance • Remediation work to areas of high-risk areas undertaken • Controlled access to roof areas which is being enhanced with proposals around cameras and designated walkways • Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. • Ongoing engagement with expert surveyor • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management • Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. Note: H&S assessments are around the location of props have been reviewed by H&S team and feedback provided to departments • Links with NHS England and other Health Boards in Wales for shared learning. • Regular dialogue with Welsh Government and Shared Services Estates. • Management Action Plan agreed following Internal Audit including the development of a Management Strategy and submitted to the ABUHB Health and Safety ‘Committee’ in March 2025

<p>Sources of Assurance</p> <p><i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i></p>	<p><i>(Insufficient evidence as to the</i></p>
Level 1 Operational <i>(Implemented by the dep</i>	
<ul style="list-style-type: none"> • Monthly checks in place for the props albeit fortnightly checks in new prop locations in OPD 2 department • Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) • Review of existing arrangements in place supported by external body 	<ul style="list-style-type: none"> • Ongoing management of
Level 2 Organisational <i>(Executed by ris</i>	

<ul style="list-style-type: none"> • Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor • risks and issues associated with any remedial measures implemented. • Outcome of H&S risk assessment in place and reviewed May 2025. H&S team will review (subject to risk score) every 3 months. • Formal reporting to the Board/Committees in place • Formal update to the PPHPC in July and SOC being developed, led by Planning team 	None
Level 3 Independent <i>(Implemented by both au</i>	
<ul style="list-style-type: none"> • Internal Audit 2024/25 Plan – report received as Reasonable Assurance (albeit Substantial Assurance on the process relating to surveys. Report submitted to Audit Committee November 2024. • Internal Audit also commented that the risk appetite needs to reflect the current position of monitoring and managing the RAAC pending SOC and FBC hence appetite of 15 should be considered by Board. 	<ul style="list-style-type: none"> • Recommendations identi Reports from the 2024/2
Assurance Rating <i>(Overall Assessment</i>	
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.

RISK THEME	COMPLIANCE AND SAFETY		
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES		
Strategic Risk SRR 002 B	There is a risk that there will be significant failure of the Health Boards Estates.		
Threat (As a result of)	Due to significant levels of backlog maintenance and structural impairment.		
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Harm or injury to patients. Adverse impacts on the delivery of care to patients across acute and non-acute settings. 	<p>Staff</p> <ul style="list-style-type: none"> Harm or injury to staff. 	<p>Org</p> <ul style="list-style-type: none"> Non-compl safety leg Litigation Loss of es
Lead Director	Chief Operating Officer	<u>Risk Exposure</u>	Current Level
Monitoring Committee / Group	Partnerships, Health Protection & Planning Committee	Likelihood	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 October 2025	Risk rating	= 12 (High)
Next Review (Quarterly based on risk score)	01 January 2026		

<p>Current Key Controls</p> <p><i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i></p>
<ul style="list-style-type: none"> Health Board Estates Rationalisation Strategy Health Board Estates Strategy Health Board policies and procedures related to the maintenance of Health Board estate. 6 Facet survey completed in 2019. Divisional Risk Register Multiple policies and SOPs published and communicated to staff. A robust internal training programme in place covering all aspects of estate management including food hygiene. Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) Asbestos reinspection programme (over the next 3 years) Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants A clear approach to compliance monitoring and escalation of AE reports has been implemented

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insufficient evidence)</i>
Level 1 Operational <i>(Implemented by the department)</i>		
<ul style="list-style-type: none"> Divisional reporting of Statutory and Mandatory training of staff Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. 		<ul style="list-style-type: none"> If the revised training levels are not met, this could result in reducing the effectiveness of the controls.
Level 2 Organisational <i>(Executed by risk management)</i>		
<ul style="list-style-type: none"> The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee 		None
Level 3 Independent <i>(Implemented by both internal and external audit)</i>		
<p>Internal Audit Reviews 2023- 24</p> <ul style="list-style-type: none"> Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and Finance and Performance Committee <p>Internal Audit Plan 2024-25</p> <ul style="list-style-type: none"> Estates Assurance – Energy Management (Q2) Outcome = Reasonable Assurance. Reported to the November ARA 	<ul style="list-style-type: none"> Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level 	<ul style="list-style-type: none"> Recommendations from Internal Audit Reports from 2023-24
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	COMPLIANCE AND SAFETY		
LINK TO IMTP	SECTION 3: SYSTEM CHANGE		
Strategic Risk SRR 004 A	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a		
Threat (As a result of)	Due to emergency planning arrangements at both the corporate and operational levels lacking the ne ensure an effective response.		
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Adverse impacts on delivery of care to patients across acute and non-acute settings Harm or injury to patients 	<p>Staff</p> <ul style="list-style-type: none"> Inability to respond to a major incident to meet needs of those affected Harm or injury to staff 	<p>Org</p> <ul style="list-style-type: none"> Health Board duties under t Act 2004 Litigation & Fi Reputational c public confide
Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	Current Level
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 October 2025	Risk rating	= 8 (Moderate)
Next Review (Six-monthly based on risk score)	01 May 2026		

Current Key Controls

(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)

- Local/Divisional action cards are in place in key areas
- Training undertaken service-specific relating to local response.
- Major incident exercise 'Euclid' undertaken 20 June 24. Approx. 100 participants and external observers, demonstrated that the Health Board was able to successfully respond to an incident. As a result of the exercise action cards refreshed and renewed with teams to incorporate learning
- Internal strategic on call training
- Executive Team attending 2-day strategic training.
- Loggist training is provided and accessed regularly
- New all Wales logbooks are in place for use
- Regular liaison with Gwent Local Resilience Forum (Strategic and tactical)
- Joint Planning and Training with LRF and across Wales.
- Ongoing Participation in exercises UK, Wales, LRF and HB.
- Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP)
- Continuing to work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner

<ul style="list-style-type: none"> • LRF Pandemic Solaris undertaken

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	<i>(Insuffi</i>
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Level 1 Operational <i>(Implemented by the dep</i>

<ul style="list-style-type: none"> • Departmental debrief following an incident to inform learning and enhance controls. • Training records • Plans and action cards in place and up to date • Debrief with key stakeholders following an incident to inform learning and enhance controls. 	<ul style="list-style-type: none"> • All inc
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Level 2 Organisational <i>(Executed by ris</i>

<ul style="list-style-type: none"> • Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness 	<ul style="list-style-type: none"> • EP
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Level 3 Independent <i>(Implemented by both au</i>

<p>Internal Audit Review(s)</p> <ul style="list-style-type: none"> • Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response - Reasonable Assurance • Outcome and feedback from national exercises 	<ul style="list-style-type: none"> • Ide • pre
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Assurance Rating <i>(Overall Assessment</i>
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Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.
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RISK THEME	COMPLIANCE AND SAFETY		
LINK TO IMTP	SECTION 3: SYSTEM CHANGE		
Strategic Risk SRR 004 B	There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to B		
Threat (As a result of)	<ul style="list-style-type: none"> Due to ineffective and insufficient arrangements across all service areas to respond to a Business Critical Incident 		
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Harm or injury to patients Adverse impacts on delivery of care to patients across acute and non-acute settings 	Staff <ul style="list-style-type: none"> Staff absence (injury, wellbeing) Harm or injury to staff 	Organisational <ul style="list-style-type: none"> Operational flow if services against the 5 key themes Loss of infrastructure; Financial implications due to Health Board breaches stat Civil Contingencies Act 200 Litigation & Financial Penal Reputational damage and l confidence
Lead Director	Director of Strategy, Planning and Partnerships	<u>Risk Exposure</u>	Current Level
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	3 (Likely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 October 2025	Risk rating	= 12 (High)
Next Review (Quarterly based on risk score)	01 January 2026		

Current Key Controls

(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)

- BC Policy
- BC Response Guidance
- BC Template & guidance (reviewed and updated April 2025)
- Divisional, Directorate & Service BC Plans across a number of key operational areas
- BC Exercise
- BC debrief learning.
- HB and LRF Plans.
- 3C (Command/Control, Communication) structure in place to respond to incidents.
- 1-2-1 training with Divisional BC leads and delivering BC workshops for services.
- EPRR Group Established.
- Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies.
- Awareness raising of the requirement for BC across the Health Board through various training programmes
- Infectious Diseases plan
- Joint plan with PH in response to infectious diseases and public health incidence response overall
- Internal strategic on call training
- Executive Team attending 2-day strategic training.
- Regular liaison with Gwent Local Resilience Forum (Strategic and tactical)
- Joint Planning and Training with LRF and across Wales.
- Ongoing Participation in exercises UK, Wales, LRF and HB.
- Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update

knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).

- Ability to warn & inform the organisation of critical BC incidents via the Health Board communications team.
- Health Board service BC supporting plan – to provide a generic response framework if they have no specific plans in place.
- A dedicated business continuity lead for IT applications and networks to reduce the highest key theme risk.
- The introduction of a business continuity Incident Response Group in the event that a BC incident that escalates to critical.
- Joint working with LRF partners – Exercise Solaris

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insuffi</i>
Level 1 Operational <i>(Implemented by the dep</i>		
<ul style="list-style-type: none"> • Plans and action cards in place and up to date. • Div/Service BC risk registers • Service BC training records • Departmental debrief following an incident to inform learning and enhance controls. • Debrief with key stakeholders following an incident to inform learning and enhance controls. 		<ul style="list-style-type: none"> • A in
Level 2 Organisational <i>(Executed by ris</i>		
<ul style="list-style-type: none"> • Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness • 		<ul style="list-style-type: none"> • EP
Level 3 Independent <i>(Implemented by both au</i>		
<p>Internal Audit Review(s) Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – Reasonable Assurance</p> <ul style="list-style-type: none"> • Outcome and feedback from national exercise 		<ul style="list-style-type: none"> • Identifi and ha
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	SERVICE DELIVERY		
LINK TO IMTP	SECTION 3: SYSTEM CHANGE		
Strategic Risk SRR 005 A	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services		
Threat (As a result of)	Due to inadequate arrangements to support system-wide patient flow		
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Avoidable deaths and significant harm. Delayed discharges from acute and non-acute settings resulting in deteriorating patients. Delays in releasing ambulances from hospital sites back into the community. 	<p>Staff</p> <ul style="list-style-type: none"> Increased workload Fatigue & burnout 	<p>Org</p> <ul style="list-style-type: none"> Litigation & F Reputational public confid
Lead Director	Chief Operating Officer	Risk Exposure	Current Level
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 September 2025	Risk rating	= 12 (High)
Next Review (Quarterly based on risk score)	01 December 2025		

<p>Current Key Controls</p> <p><i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i></p>
<ul style="list-style-type: none"> Escalation Policy. Performance and Accountability Framework Operational Framework Major incident Procedures Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. Enhanced monitoring in place for U&EC Range of performance measures/metrics in place Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. Planned care recovery meetings with the NHS execs. Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. WG – IQPD meetings to review areas of focus

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insufficient)</i>
Level 1 Operational <i>(Implemented by the dep</i>		
<ul style="list-style-type: none"> The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. Performance report against measures/metrics 	<ul style="list-style-type: none"> Evidence t across all a to KPI WG The impac improving 	
Level 2 Organisational <i>(Executed by ris</i>		
<ul style="list-style-type: none"> Divisional Assurance reviews. Performance against measures/metrics reported to the Executive Committee 	<ul style="list-style-type: none"> Effectivene 	
Level 3 Independent <i>(Implemented by both au</i>		
<p>Internal Audit Reviews</p> <ul style="list-style-type: none"> Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. External inspections/visits. - 	None	
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	SERVICE DELIVERY		
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY		
Strategic Risk SRR 006 A	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high		
Threat <i>(As a result of)</i>	Due to the full or partial failure of existing digital infrastructure and systems.		
Impact <i>(Consequences of the threat)</i>	<p>Patient</p> <ul style="list-style-type: none"> Unintended harm or Injury to Patients. 	<p>Staff</p> <ul style="list-style-type: none"> Unintended harm or injury to staff 	<p>Organisational</p> <ul style="list-style-type: none"> Data Breaches Litigation and Financial Reputational damage to confidence.
Lead Director	Director of Digital	Risk Exposure	Current Level
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 October 2025	Risk rating	= 12 (High)
Next Review <i>(Quarterly based on risk score)</i>	01 January 2025		

Current Key Controls
(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact)

- Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. This Action supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually.
- Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained.
- New Information Governance and Cyber Security governance and assurance processes reviewed and implemented.
- Governance group terms of reference agreed. Meetings started in November 2023.
- Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff
- Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will be included in the Monthly Cyber Report.
- Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against the patching plan captured within the monthly Cyber Report.
- Implement the recommendations from Templar report:
- Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation.
- Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the incident response plan.
- Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important version 1 is being managed through ICT Departmental risk management process. Risk impact reduced as recent loss of power at key data centre our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact.
- Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails.
- Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the monthly Cyber Report. will continue campaigns during 2023 to increase email security awareness among staff.
- Introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to improve staff skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises in 2023.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insufficient)</i>
Level 1 Operational <i>(Implemented by the department)</i>		
<ul style="list-style-type: none"> • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Single directorate risk registers now in place. 		<ul style="list-style-type: none"> • None
Level 2 Organisational <i>(Executed by risk management)</i>		
<ul style="list-style-type: none"> • Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan. • Annual Senior Information Risk Owner report. 		<ul style="list-style-type: none"> • None
Level 3 Independent <i>(Implemented by both internal and external)</i>		
<ul style="list-style-type: none"> • Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting on internal and backup systems. • Oversight from NHS Wales Cyber Resilience Unit. 	Internal Audit 2024/25	<ul style="list-style-type: none"> • None
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.

RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY			
Strategic Risk SRR 006 B	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality service delivery.			
Threat (As a result of)	Due to an adverse impact on service delivery in the implementation of new digital systems.			
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Unintended harm or Injury to Patients. Adverse impacts on delivery of care to patients across acute and non-acute settings. 	Staff <ul style="list-style-type: none"> Unintended harm or injury to staff 	Organisation <ul style="list-style-type: none"> Data Breaches Litigation and Financial Penalties Reputational damage and loss of public confidence. 	
Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	4 (Major) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 November 2025	Risk rating	= 16 (Extreme)	= 6 (Moderate)
Next Review (Monthly based on risk score)	01 December 2025			

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)
<ul style="list-style-type: none"> Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. Business change team in place to support services in improvement of clinical and administrative processes. Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. Projects support backfilling of clinical time where required. Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. Aggregated view of digital Lessons Learned available, and lessons are reviewed during project initiation for best chance of success. Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insufficie</i>
Level 1 Operational <i>(Implemented by the dep</i>		
<ul style="list-style-type: none"> ○ Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) ○ Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. ○ Risk management approach and escalation processes in place in line with the Health Board’s Risk Framework 		<ul style="list-style-type: none"> ● Escalation Digital an
Level 2 Organisational <i>(Executed by ris</i>		
<ul style="list-style-type: none"> ● Regular Reporting to the Finance & Performance Committee 		<ul style="list-style-type: none"> ● None
Level 3 Independent <i>(Implemented by both au</i>		
<p>Internal Audit 2023/24</p> <ul style="list-style-type: none"> ● Benefits Management review – Outcome Substantial Assurance ● Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance 	<p>Internal Audit 2024/25</p> <ul style="list-style-type: none"> ● Implementation of the Welsh Intensive Care System – future of programme to be decided 	<ul style="list-style-type: none"> ● Recomm
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	SERVICE DELIVERY		
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY		
Strategic Risk SRR 006 C	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high		
Threat (As a result of)	Due to failure to develop digital solutions that are sustainable and fit for the future.		
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Unintended harm or injury to patients. Adverse impacts on delivery of care to patients across acute and non-acute settings 	<p>Staff</p> <ul style="list-style-type: none"> Unintended harm or injury to staff. 	<p>Organisational</p> <ul style="list-style-type: none"> Data breaches Litigation & Financial Reputational damage confidence
Lead Director	Director of Digital	<u>Risk Exposure</u>	Current Level
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 September 2025	Risk rating	= 12 (High)
Next Review (Quarterly based on risk score)	01 December 2025		

Current Key Controls
<i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>
<ul style="list-style-type: none"> New Digital Service Request process in place which provides governance in several key areas: Automation of request process via 'Seren' the ICT Portal Information Governance – ensuring new services have appropriate controls to keep patient information safe. Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. Patient Safety – ensuring services do not introduce any patient safety risks. Records – ensuring new systems comply with the requirements of records management. Strong business analysis function in operation which ensures the “as-is” and “to-be” process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. Business change function which ensures implemented systems are effective and deliver the benefits required. Formal framework in place for the adoption of new digital services and best practice guidance followed. Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process New Digital Request processes include fortnightly senior leadership scrutiny of requests, New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards Annual operational plan completed and aligned with IMTP Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insufficient)</i>
Level 1 Operational <i>(Implemented by the department)</i>		
<ul style="list-style-type: none"> Quarterly reporting to DDAT Group 		<ul style="list-style-type: none"> If the ND The outco
Level 2 Organisational <i>(Executed by risk management)</i>		
<ul style="list-style-type: none"> Regular Reporting to the Finance & Performance Committee 		<ul style="list-style-type: none"> None
Level 3 Independent <i>(Implemented by both internal and external audit)</i>		
<p>Internal Audit 2023/24</p> <ul style="list-style-type: none"> LINC Programme– Outcome Reasonable assurance Network Infrastructure (VPN) - Outcome Reasonable assurance <p>Internal Audit 2024/25</p> <ul style="list-style-type: none"> Electronic document and records management solution - planned for Q4 		<ul style="list-style-type: none"> Recomm
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
LINK TO IMTP	SECTION 3: SYSTEM CHANGE			
Strategic Risk: SRR 007A	There is a risk that the Health Board will be unable to deliver truly integrated health and care services			
Threat <i>(As a result of)</i>	Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners, the Health Board footprint.			
Impact <i>(Consequences of the threat)</i>	<p>Patient</p> <ul style="list-style-type: none"> Unmet patient need resulting in harm 	<p>Staff</p> <p>N/A</p>	<p>Organisational</p> <ul style="list-style-type: none"> Ineffective use of combined resources leading to poor decision making Adverse impacts on delivery of services across acute and non-acute settings Failure to deliver health board strategic objectives, improvements and achieve financial sustainability Reputational damage and loss of trust 	
Lead Director	Director of Strategy, Planning, and Partnerships.	Risk Exposure	Current Level	
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	
Last Reviewed	01 April 2025	Risk rating	= 8 (Moderate)	
Next Review <i>(Six Months based on risk score)</i>	01 October 2025			

<p>Current Key Controls</p> <p><i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i></p>
<p>The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including:</p> <ul style="list-style-type: none"> The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insuffic</i>
Level 1 Operational <i>(Implemented by the dep</i>		
<ul style="list-style-type: none"> • PMO reporting to the Director of Strategy, Planning and Partnerships. • Regional Leadership Group Reporting 	<ul style="list-style-type: none"> • Systematic • Systematic • Governanc 	
Level 2 Organisational <i>(Executed by ris</i>		
<ul style="list-style-type: none"> • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. 	None	
Level 3 Independent <i>(Implemented by both au</i>		
Internal Audit Plan 2024/25 <ul style="list-style-type: none"> • RPB Governance Review (Q4) – Outcome = Limited Assurance. Reported to ARAC September 2024 • Partnership Arrangements Review (Q1) Deferred 	<ul style="list-style-type: none"> • Rec Gov 	
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING		
LINK TO IMTP	SECTION 3: SYSTEM CHANGE		
Strategic/ Corporate Risk SRR 007 B	There is a risk that the Health Board will be unable to deliver truly integrated health and care services		
Threat <i>(As a result of)</i>	Due to the impact of fragile services across the regional and supra regional geography		
Impact <i>(Consequences of the threat)</i>	<p style="text-align: center;"><u>Patient</u></p> <ul style="list-style-type: none"> Unmet patient need resulting in harm Adverse impacts on delivery of care to patients across acute and non-acute settings 	<p style="text-align: center;"><u>Staff</u></p> <p style="text-align: center;">N/A</p>	<p style="text-align: center;"><u>Organis</u></p> <ul style="list-style-type: none"> Failure to deliver health services required improvement in long term sustainability Reputational damage and loss of confidence Ineffective use of commissioning Delayed decision making
Lead Director	Director of Strategy Planning and Partnerships	<u>Risk Exposure</u>	Current Level
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	3 (Possible) x
Initial Date of Assessment	04 January 2024	Impact	3 (Moderate)
Last Reviewed	01 July 2025	Risk rating	= 9 (High)
Next Review <i>(Quarterly based on risk score)</i>	01 October 2025		

Current Key Controls <i>(What controls/ systems & processes do we already have in place in managing the risk and reducing the likelihood/ impact of the threat)</i>
<ul style="list-style-type: none"> A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. The south east Wales health boards agreed revised joint priorities and working arrangements for regional planning in 2024, following a review workshop attended by Chief Executives. Workstreams are underpinned by a Memorandum of Understanding between the participating health boards, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. In addition to these arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insufficient evidence)</i>
Level 1 Operational <i>(Implemented by the department)</i>		
<ul style="list-style-type: none"> • Service Divisions reporting to the Chief Operational Officer 		<ul style="list-style-type: none"> • Alignment
Level 2 Organisational <i>(Executed by risk management)</i>		
<ul style="list-style-type: none"> • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. • Regular touchpoint meetings of all key players to review progress and issues arising 		None
Level 3 Independent <i>(Implemented by both internal and external auditors)</i>		
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING		
LINK TO IMTP	SECTION 4: ENABLER - QUALITY		
Strategic Risk SRR 008	There is a risk that the Health Board fails to build positive relationships with patients, staff and the p		
Threat (As a result of)	Due to inadequate arrangements to listen and learn from patient experience and enable patient invo		
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> • Unmet patient needs resulting in patient harm. • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Negative experience of care • Distress and frustration. • Carer stress. 	<p>Staff</p> <p>Staff dissatisfaction Frustration Increased absence. Loss of confidence.</p>	<p>Organis</p> <ul style="list-style-type: none"> • Failure to deliver heal required improvement term sustainability • Reputational damage confidence
Lead Director	Director of Nursing	Risk Exposure	Current Level
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)
Last Reviewed	01 August 2025	Risk rating	= 8 (Moderate)
Next Review (Six monthly based on risk score)	01 February 2026		

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)
<ul style="list-style-type: none"> • Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys and National surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said..... we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX • Oversight of Medical Examiner reports to determine patient experience actions • Public Engagement- Big Conversation Bereavement held 20th March 2024 • People Participation Panel ED in Progress • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.

- Dementia Person centred Care team dedicated e mail address.
- Dementia Information and signposting through webpages.
- Patient feedback on the agenda for each of the dementia workstream meetings.
- Dementia - QR code for feedback at each training event and session.
- Dementia Thematic review from CIVICA team requested to inform actions and improvements in care.
- Dementia - Multi agency partnership workstreams measuring impact of service.
- Graces places set up in Newport, Caerphilly and Monmouthshire to support bereaved people

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gap <i>(Insufficient evidence as to the)</i>
Level 1 Operational <i>(Implemented by the dep</i>	
<ul style="list-style-type: none"> • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024 • Immediate feedback and escalation to clinical teams following PALS queries and concerns • Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly. • Bereavement survey built with CIVICA – Nov 2024 • CIVICA SMS launched 3rd March 2025 across ED and MIU'S 	<ul style="list-style-type: none"> • Currently there is limited SMS surveys. • No single point of contact patients/families/staff to meet Bereavement Stand • Survey of bereaved people left by patients/family. TH to be shared by each dep said, we did' / quality im
Level 2 Organisational <i>(Executed by ris</i>	
<ul style="list-style-type: none"> • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module 	None
Level 3 Independent <i>(Implemented by both au</i>	
<ul style="list-style-type: none"> • Bi-monthly LLais Reports • HIW inspections • Advocacy reports 	None
Assurance Rating <i>(Overall Assessment)</i>	
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.

RISK THEME	COMPLIANCE AND SAFETY		
LINK TO IMTP SECTION 4: ENABLER	QUALITY		
Strategic Risk: SRR 010	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors		
Threat (As a result of)	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place, the Health Board will not embed and monitor the Health Board's compliance with the Act's requirements		
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Unintended physical harm to patients Psychological trauma 	<p>Staff</p> <ul style="list-style-type: none"> Unintended physical harm to staff Psychological trauma Increased levels of staff sickness 	<p>Organisation</p> <ul style="list-style-type: none"> Punitive actions from the Health and Safety Executive (HSE) Loss of estates due to unsafe environments Financial implications Adverse publicity Reputational damage.
Lead Director	Director of Allied Health Professions and Health Science	<u>Risk Exposure</u>	Current Level
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) x
Initial Date of Assessment	01 December 2023	Impact	4 (Major)
Last Reviewed	01 September 2025	Risk rating	= 12 (High)
Next Review (Quarterly based on risk score)	01 December 2025		

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)
<ul style="list-style-type: none"> Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. Health and Safety Policies and Procedures Dedicated Health and Safety site on ABPULSE Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) Partial Programme of Health and Safety Monitoring (Active & Reactive) Corporate and Directorate Health and Safety Risk Register established. Board Training /development (Completed 24 April 2024) Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. Health and Safety Governance and reporting arrangements (Health and Safety Committee)

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		<i>(Insufficient evidence as to the)</i>
Level 1 Operational <i>(Implemented by the dep</i>		
Health and Safety compliance data extracted from ESR and Datix and reported Statutory reporting data reports and dashboards		<ul style="list-style-type: none"> Implementation of a health Health and Safety Committe ensure there is robust scrut Compliance on completion Consistent adherence and a
Level 2 Organisational <i>(Executed by ris</i>		
<ul style="list-style-type: none"> Established monitoring of H&S at the Executive Committee Corporate H&S Team report risk and assurance to the Health and Safety Group Health and Safety Annual Report Health and Safety Improvement Plan Established monitoring of H&S at the PQSO Committee 		<ul style="list-style-type: none"> Thematic Risk Register
Level 3 Independent <i>(Implemented by both au</i>		
Internal Audit 2024/25 Plan <ul style="list-style-type: none"> Health and Safety Internal Audit – Concluded Limited Assurance Performance reviews at All Wales Health and Safety Management Steering Group South Wales Fire & Rescue Service fire safety audit programme. <p>Health and Safety Executive reviews/inspections.</p>		<ul style="list-style-type: none"> Recommendations fro
Assurance Rating <i>(Overall Assessment)</i>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	

RISK THEME	SERVICE DELIVERY		
LINK TO IMTP	SECTION 4: ENABLER – GREEN HEALTH		
Strategic Risk SRR 011	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government. This is common to all Health Bodies across the country.		
Threat <i>(As a result of)</i>	Due to the limitations to change estate and structural operations and available funds to implement strategies, the Health Board is unable to scale to fully meet the target expected. (The effect of a failure to meet this target is on the wider environment)		
Impact <i>(Consequences of the threat)</i>	<p style="text-align: center;"><u>Organisation</u></p> <ul style="list-style-type: none"> • Failure to meet the target set on Welsh Health bodies for reducing carbon output • Non-delivery of health board priority in this regard, required improvements, and achieving long-term goals for the Health Board and nationally. • Reputational damage and loss of public confidence. • Opportunity cost of reduced energy costs 		
Lead Director	Director of Finance and Procurement	<u>Risk Exposure</u>	Current Level
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	5 (Almost Certain) x
Initial Date of Assessment	30 October 2024	Impact	3 (Moderate)
Last Reviewed	01 October 2025	Risk rating	= 15 (Extreme)
Next Review <i>(Monthly based on risk score)</i>	01 November 2025		

Current Key Controls
<i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>
<ul style="list-style-type: none"> • Quarterly review of projects and workstreams at the Decarbonisation Programme Board • The project structure has 5 key workstreams each with a Health Board Lead covering clinical, communications, resources, waste and facilities and estates • Regular reporting of financial data available • Significant work already with the ReFit programme and Investment Grade Proposal (IGP) which aims to secure funding for projects of £7.4m, to reduce carbon emissions by 995 tonnes Co2 with a 10-year payback on investment. • Refreshed Decarbonisation Action Plans for 2024-25. The DAPs are integrated with other sustainability plans and were approved at the Decarbonisation Project Board in July 24. • Annual net zero return submitted to Welsh Government • Regular reporting of success stories in this area communicated across the Health Board (e.g., “Gloves R off”) • Decarbonisation Action Plans reported annually Executive lead and publicised on the green health website • SUS Qi training • Met office training • Carbon literacy training HEIW • 4 modules on carbon reduction and net zero ESR • Spread & Scale academy training sessions

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department)</i>	
<ul style="list-style-type: none"> Regular meetings of the subgroups to discuss position, monitor and new ideas Bi-annual ISO14001 audit to be undertaken in October 2024. Estates operational meetings	<ul style="list-style-type: none"> Detailed level metrics and monitoring of equipment.
Level 2 Organisational <i>(Executed by risk management)</i>	
<ul style="list-style-type: none"> Six monthly updates to the Board Executive Committee (Clinical Futures Board) updates – Quarterly Six monthly updates to the Finance & Performance Committee Decarbonisation Programme Board – Quarterly reporting	<ul style="list-style-type: none"> None
Level 3 Independent <i>(Implemented by both assurance providers)</i>	
<p>Internal Audit Report in July 24.</p> <ul style="list-style-type: none"> Received “limited assurance” but not because of controls – the issues were largely around funding limitations. <p>External Audit Reports 2023 -24 Periodic reports from Audit Wales – considered by the Audit and Risk Assurance committee</p>	<ul style="list-style-type: none"> Funding for a comprehensive audit is not available.
Assurance Rating <i>(Overall Assessment)</i>	
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.



**CYFARFOD BWRDD IECHYD PRIFYSGOL
ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
MEETING**

MINUTES OF MEETING HELD

Date and Time	Wednesday 24th September 2025 at 09:30am	
Venue	Conference Centre, St Cadoc's Hospital and Microsoft Teams	
PRESENT	Ann Lloyd Paul Deneen Dafydd Vaughan Iwan Jones Neil Patrick Penny Jones Vivek Goel Akmal Hanuk Nicola Prygodzicz Tracy Daszkiewicz Jennifer Winslade Rob Holcombe Paul Solloway Hannah Evans Peter Carr Sarah Simmonds Leanne Watkins Andy Bagwell	Chair Independent Member (Community) Independent Member (Digital) Independent Member (Finance) Independent Member (Community) Independent Member (Community) Independent Member (Trade Union) Independent Member (Third Sector) Chief Executive Director of Public Health Director of Nursing Director of Finance & Procurement Director of Digital Director of Strategy, Planning and Partnerships Director of AHPs and Health Science Director of Workforce and OD Chief Operating Officer Interim Medical Director
IN ATTENDANCE	Rani Dash Karen Newman Thokozani Owino Paquita Sanges	Director of Corporate Governance Assistant Director of Communications and Engagement Aspiring Board Member Programme Lead Nurse, Early Gynaecology Assessment Unit (Patient Story)
APOLOGIES	Phil Robson Helen Sweetland	Vice Chair Independent Member (University)

PRELIMINARY MATTERS

**ABUHB
2409/01**

Welcome and Introductions

The Chair welcomed everyone to the meeting, in particular members of the public who had joined the meeting to observe.

It was noted that the meeting would be livestreamed and published on the Health Board's website following the meeting.

**ABUHB
2409/02**

Declarations of Interest for Noting

There were no declarations of interest raised.

**ABUHB
2409/03**

Consent Agenda

The Chair introduced the Consent Agenda and asked if there were any items to be brought forward for discussion. There were no requests made.

**ABUHB
2409/04**

Report from the Chair

Ann Lloyd (AL), Chair, provided her verbal report, with a focus on the following areas:

- The Chair explained that Chief Executives and Chairs had held meetings to discuss regional working, as directed by the Cabinet Secretary. The results of these discussions would be discussed as part of this meeting's. Velindre UNHST and Powys LHB had been invited to become associate members.
- The Chairs group had met three times to discuss new accountability arrangements with the Cabinet Secretary. ABUHB would be the first to be held to account publicly by the Cabinet Secretary in Cardiff. The Chair expressed disappointment that the agenda appeared to focus on operational performance rather than longer term strategic priorities.
- The Wales Maternity and Neonatal Assurance Assessment was due to start imminently, led by national experts. The Board would be updated at the local arrangements.
- Concerns were raised regarding the induction and training of Board members. HEIW had been commissioned to review and develop a controlled induction programme for both executive and non-executive directors.
- The Chair had attended a meeting to undertake Chair's Actions regarding outpatient performance and resource utilisation. Concerns about the lack of provision for paediatric patients in the insourcing contract were raised in a letter to Welsh Government. A response was yet to be received.
- Interviews had been held for an Independent Member (Local Authority) and a Deputy CEO position. The Chair noted the excellent calibre of candidates and stated that a final decision was awaited for the Independent Member. The Chair congratulated Jennifer Winslade, Director of Nursing, on her appointment to the Deputy CEO position for a 12 month period.
- She had taken part of the appointment panel for the Managing Director of NHS Wales Performance and Improvement role.

- The Princess Royal had visited Grange Hospital’s maternity unit. Positive feedback was received following the visit, including a letter from her lady-in-waiting. In the letter, the Princess Royal expressed her appreciation for the opportunity to visit the maternity unit, commended the impressive facilities, and praised the dedication and expertise of the staff. The Princess Royal noted that meeting the core maternity team and witnessing their commitment to delivering high-quality care was truly inspiring, and conveyed gratitude to all involved in organising and facilitating the visit.

The Board **NOTED** the Chair’s updates.

**ABUHB
2409/05**

Report from the CEO

Nicola Prygodzicz (NP), Chief Executive, provided her verbal report, with a focus on the following areas:

- The Health Board was approaching the half-year point for 2025/26, with a heavy focus on three priority areas namely National Planned Care Programme, National “Handover 45” Initiative and Financial Position and Savings.
- The National Planned Care Programme, led by Welsh Government, aimed to remove 200,000 people from waiting lists across Wales, with 30,000–40,000 patients affected locally. Significant work had been undertaken across the Health Board, particularly around the outpatient contract, with additional patients treated on weekends and evenings. The programme had been running for several weeks and was expected to progress at pace in the coming month, starting with ENT and expanding to other specialties.
- The National “Handover 45” Initiative, also led by Welsh Government, sought to ensure all patients in ambulances across Wales were handed over to emergency departments within 45 minutes. The Health Board had been working on this agenda, with the “Your Next Patient” programme commencing its third week. This programme aimed to embed sustainable change at the Grange University Hospital and across the wider system, supported by the executive team. Early improvements had been observed, with ongoing work required to sustain progress.
- There had been ongoing focus on financial pressures over the past four to five months. Intensive work had been undertaken with divisions to identify savings and deliver plans in line with targets. A new savings plan had been developed, but increased cost pressures had resulted in a forecast deficit, which would be further detailed in the Finance Report. Further work was required as the Health Board moved into the winter period.
- Strategic Planning for the next year had commenced, with efforts focused on aligning the Integrated Medium Term Plan (IMTP) with the Health Board’s strategy. Key priorities for the

coming year included prevention, digital transformation, and primary care. National focus remained on primary care plans and winter planning, with the Health Board actively involved in these areas.

- The importance of vaccinations for winter, noting that a downturn in uptake last year, had placed additional pressure on services. The Health Board had been working to promote vaccination rates and implement new initiatives to improve accessibility for staff and the public.
- The “When You Smoke, I Smoke” campaign had launched to raise the profile of smoking cessation.
- The successful opening of the “Big Conversation on Sepsis” all-day event, which brought together staff, the public, and individuals with lived experience of sepsis to discuss improvements. The event was described as powerful and emotional, with further developments anticipated.

The Board **NOTED** the Chief Executive’s updates.

**ABUHB
2409/05**

Patient Experience Presentation

The Board received a presentation focusing on early pregnancy and emergency gynaecology care. The presentation was delivered by Paquita Sanges (PS), Lead Nurse, Early Gynaecology Assessment Unit, and Rachel Robbins (RR), a patient who shared her personal story of pregnancy loss.

RR described the emotional and clinical challenges she faced, including the distress caused by waiting for confirmation of miscarriage and the lack of recognition for private scan results. Her experience had prompted the Health Board to review its service provision, resulting in several improvements. These included the introduction of a three-week follow-up call for women who had experienced miscarriage, enhanced staff training on communication and empathy, adjustments to staffing in the early pregnancy unit, and the development of a written information pack for patients.

The Board also noted the establishment of the Butterfly Room, a dedicated bed for patients experiencing miscarriage, and the creation of a counselling room for private support. Memory boxes and certificates of life were introduced to acknowledge pregnancy loss, and plans were underway to create a bereavement garden at the Grange Hospital. The Board discussed the importance of recognising the emotional impact of pregnancy loss and the need for flexibility in clinical guidelines, particularly regarding the acceptance of private scans.

Rachel’s story was commended for its bravery and for driving positive change within the Health Board and the Board thanked Rachel for her attendance at the meeting. The Board acknowledged the improvements

made and the ongoing commitment to compassionate care and noted that further research and evaluation would be undertaken to inform future service development.

The Board **RECEIVED** the presentation.

**ABUHB
2409/06**

People Plan 2025-2028

Sarah Simmonds (SS), Director of Workforce & OD, presented the People Plan for 2025–2028 to the Board.

SS explained that the new People Plan provided an opportunity to refresh the Health Board’s workforce and organisational development strategy. The plan had been created through reflection on previous achievements and extensive engagement with staff, trade union representatives, staff networks, and other groups. The themes of the plan remained consistent with previous core pillars, but the language and imagery had been updated to support the long-term strategy.

Feedback received during the development process indicated that priorities in the previous plan had been muddled. The new plan addressed this by introducing more thematic actions under each core pillar, which would be measured by specific outcomes. The plan had been designed as a five-year programme, aligning with the halfway point of the Health Board’s ten-year strategy, and would be reviewed annually.

An equality impact assessment had been undertaken, with no adverse impact reported. The aim was to launch the People Plan on 16th October 2025, alongside the refreshed values and behaviours framework.

The Board discussed the importance of promoting the staff survey, as staff feedback was crucial to measuring the success of the plan. SS acknowledged that return rates for the staff survey had been low in the past and outlined ongoing efforts to improve engagement, including providing incentives for staff participation.

The Board discussed the issue of staff survey fatigue, noting the large number of surveys distributed throughout the year and the resulting low response rates. Members emphasised the importance of targeted communication, incentives, and union involvement to improve engagement and ensure meaningful feedback.

Sickness absence rates were identified as a challenge for the Health Board, with Board members emphasising that even marginal improvements would provide a significant positive impact. The People Plan was commended for bringing sickness absence into central focus, and the Board supported ongoing efforts to develop measurable

actions and monitor progress through the People and Culture Committee.

The Board **APPROVED** the People Plan 2025–2028.

**ABUHB
2409/07**

Winter Plan 2025/26

Hannah Evans (HE), Director of Strategy, Planning and Partnerships, presented the Winter Plan for 2025/26 to the Board.

HE explained that the Health Board’s approach to winter planning had been iterative, building on lessons learned from previous years. The plan relied on national modelling from Public Health Wales to anticipate the timing and scale of infection surges. The latest modelling had not yet been received and was expected by the end of September. The Board noted that the plan would be further refined once this information became available.

HE highlighted several key areas of focus for the coming winter. Vaccination uptake remained a priority, as low rates in the previous year had contributed to increased pressure on services. The Health Board had already commenced its vaccination programme, with early indications of improved uptake compared with the previous year. Proactive management of high-risk patients in the community and the targeting of priority pathways, such as falls prevention, were also emphasised.

The plan included the development of granular surge bed capacity plans, recognising that additional beds would be required to manage increased demand. The Health Board had been working closely with partners, particularly within the Regional Partnership Board (RPB), to support patient discharge and maintain flow throughout the winter period. Investment had been made in discharge support schemes and seven-day working for social care.

Risks identified in the plan included uncertainty around funding, workforce capacity, and the timing of infection surges. HE noted that confirmation of any additional Welsh Government initiatives or funding had not yet been received. The Board acknowledged that operational and clinical teams would be working in parallel on the “Your Next Patient” initiative, which aimed to create headroom ahead of winter.

HE reported that governance arrangements had been strengthened, with weekly meetings to monitor vaccination uptake and progress against the plan. The Board discussed the importance of early action, robust modelling, and proactive engagement with partners. The need to address staff vaccination rates and ensure effective use of community assets was also highlighted.

The Board noted that contingency planning would be included in the final version of the Winter Plan, once national modelling and any funding information had been confirmed.

The Board **NOTED** the Winter Plan 2025/26 and endorsed the ongoing preparatory work.

**ABUHB
2409/08**

Regional Planning – Llantrisant Health Park OBC 1

Hannah Evans, Director of Strategy, Planning and Partnerships, presented the Outline Business Case (OBC) for Llantrisant Health Park (LHP) to the Board.

HE explained that the Board had approved the vision document for LHP in March, which set out the strategic opportunity and emerging thinking for the site. The OBC presented at this meeting was the first in a suite of business cases expected relating to the development of LHP. HE clarified that this OBC had been brought forward by Cwm Taf Morgannwg University Health Board (CTM) and was not for Aneurin Bevan University Health Board (ABUHB) to approve, but to note.

The focus of the OBC was development of the the community diagnostic hub element of LHP, which included radiology scans, endoscopies, and provision for an endoscopy training facility. HE noted that the radiology provision would support CTM only, while the endoscopy suites would serve CTM, Cardiff and Vale, and ABUHB. The inclusion of an endoscopy training facility, led by Health Education and Improvement Wales (HEIW), was highlighted as a regional benefit, addressing workforce challenges in endoscopy.

HE reported that a detailed assessment had been undertaken within ABUHB to determine future endoscopy requirements. The Health Board had recently opened a new endoscopy facility at the Royal Gwent Hospital, which was not yet fully optimised. The Board's assumption was that existing capacity would be maximised before commissioning any additional activity from LHP in 2028/29, when a capacity gap was anticipated due to growing demand in screening diagnostics and cancer pathways.

HE emphasised that any commissioning of endoscopy activity from LHP would be subject to value for money review and further work on costs and pricing, given the use of a managed service contract. The Board was advised that ongoing due diligence would be required as the business case progressed.

It was noted that the regional committee overseeing LHP was broader than the LHP project itself. The financial commitment and activity for ABUHB were minimal at this stage, reflecting the strategy to maximise

internal capacity before commissioning externally. The Board recognised the importance of maintaining oversight of workforce arrangements, particularly the development of the endoscopy training academy, to ensure a sustainable pipeline of skilled staff. Any agreement to invest in LHP would be subject to the required additional resources being made available.

The Board **NOTED** the Llantrisant Health Park OBC 1 and endorsed the regional approach, subject to ongoing due diligence and value for money tests.

**ABUHB
2409/09**

Regional Planning – Establishment of the South East Wales Regional Joint Committee

Rani Dash (RD), Director of Corporate Governance, presented the proposal for the establishment of the South East Wales Regional Joint Committee to the Board.

RD explained that the Committee had been established in response to a Cabinet Secretary direction issued in April. The Terms of Reference (ToRs) for the Committee had been developed collaboratively by Directors of Corporate Governance from Aneurin Bevan University Health Board (ABUHB), Cwm Taf Morgannwg University Health Board (CTM), and Cardiff & Vale University Health Board (C&V). The ToRs had been subject to extensive engagement and comment from Chairs, Chief Executives, and Directors of Planning across the region.

RD advised that the Joint Committee would provide a formal structure for regional cooperation and development, supporting the move towards integrated planning and delivery of services across South East Wales. The ToRs included a scheme of delegation and reservation of powers, outlining the scope of the Committee's authority and those matters reserved for individual Health Boards as statutory bodies. The priorities for the Joint Committee would be determined by the Boards, ensuring alignment with local and regional strategic objectives.

The Board noted that the establishment of the Joint Committee represented a significant step towards enhanced regional collaboration and governance. The Board noted the importance of clear delegation, robust terms of reference, and ongoing engagement with partner organisations.

The Board **APPROVED** the establishment of the South East Wales Regional Joint Committee and **ADOPTED** the Terms of Reference.

**ABUHB
2409/10**

Performance Management and Accountability Framework

Hannah Evans (HE), Director of Strategy, Planning and Partnerships, presented the updated Performance Management and Accountability Framework to the Board.

HE explained that the framework had been reviewed following two years of implementation, with feedback gathered from divisional teams, executive colleagues, and an internal audit report. The review aimed to strengthen the framework, clarify escalation processes, and incorporate best practice from similar frameworks elsewhere.

HE reported that the revised framework proposed an expansion of the domains considered for escalation, now including leadership and governance alongside finance, operational delivery, and quality. The triggers for escalation within each domain had been updated, and a broader suite of actions was available in response to escalation, including inviting teams to relevant committees to discuss improvement plans and progress.

HE noted that the framework continued to set out expectations for oversight and performance review through established meeting structures. The Finance and Performance Committee would maintain responsibility for tracking implementation and monitoring both internal and national escalation frameworks.

Neil Patrick (NP), Independent Member, raised concerns about the potential impact on committee agendas and time pressures should escalation with teams become a focus, but supported the approach if it delivered improved results. Rani Dash (RD), Director of Corporate Governance, suggested that additional space could be created for dedicated scrutiny, rather than detracting from core Committee business. Joining up with other committees where an integrated focus could be beneficial would also be considered.

HE confirmed that the framework would continue to evolve, with ongoing feedback and refinement as the organisation matured in its approach to performance management and accountability.

The Board **APPROVED** the updated Performance Management and Accountability Framework.

**ABUHB
2409/11**

General Medical Services – Aberbeeg Medical Centre Outcome of Vacant Practice Process

Leanne Watkins (LW), Chief Operating Officer, presented the outcome of the vacant practice process for Aberbeeg Medical Centre to the Board.

LW explained that Aberbeeg Medical Centre had previously operated as a managed practice. The Health Board had been approached by a number of local General Practitioners (GPs) expressing interest in taking on the contract for the practice. Following a thorough evaluation, the panel recommended the award of the contract to the interested local GPs.

The Board held a detailed discussion regarding the procurement process for, particularly the contract award for Aberbeeg Medical Centre. Members sought assurances on value for money, financial commitment, and the robustness of due diligence processes.

The Board noted that a number of local GPs had expressed interest in taking on the Aberbeeg Medical Centre contract. The panel had undertaken a comprehensive review of the applications, ensuring that the process was fair, transparent, and aligned with organisational procurement standards.

The Board emphasised the importance of safeguarding service continuity, maintaining workforce stability, and ensuring that the procurement process would not destabilise existing services. It was agreed that any commissioning of activity would be subject to further scrutiny, with safeguards to ensure that the procurement process would not compromise service quality or workforce arrangements.

The Board endorsed the recommendation to award the contract to the successful local GPs, subject to ongoing monitoring and assurance about the procurement process.

The Board **NOTED** the contract award for Aberbeeg Medical Centre.

**ABUHB
2409/12**

General Medical Services - North Celyn Practice – Branch Closure Request

Leanne Watkins (LW), Chief Operating Officer, presented the request for branch closure at North Celyn Practice to the Board.

LW explained that a formal request had been submitted to close the branch of North Celyn Practice. A consultation process had been undertaken, with 9.3% of patients responding to the consultation. The panel reviewed the feedback and recommended supporting the application to close the branch.

The Board **ENDORSED** the recommendation to support the application for closure of North Celyn Practice branch.

**ABUHB
2409/13**

Annual Quality Reporting 2024/25 - Annual Quality Report

Jennifer Winslade (JW), Director of Nursing, presented the Annual Quality Report for 2024/25 to the Board.

JW explained that the report set out achievements against the Health Board's quality pillars and outlined priorities for the year ahead. The Board noted that patient satisfaction rates had reached 87%, which was recognised as a significant achievement. JW reported that considerable work had been undertaken to establish patient participation panels, with a formal evaluation of the Patient Advice and Liaison Service (PALS) scheduled for the autumn. The Board was informed that the service continued to see a high number of patients using PALS and that the number of volunteers had increased.

From a patient safety perspective, JW highlighted the development of divisional dashboards and active participation in national clinical audit programmes. The Health Board had achieved success in the Head and Neck Q Lab programme and had improved rates of health and safety training. Ward accreditation had been extended, with plans to include teams beyond wards, such as the mortuary team.

Ann Lloyd (AL), Chair, raised the issue of the increased number of inquests. JW responded that the coroner had been supportive and that the increase was partly driven by the additionality of the Medical Examiner (ME) service. Andy Bagwell (AB), Interim Medical Director, confirmed that the ME service had contributed to the higher number of inquests.

The Board **APPROVED** and **NOTED** the Annual Quality Report for 2024/25.

**ABUHB
2409/14**

Annual Quality Reporting 2024/25 – Annual Putting Things Right Report

Jennifer Winslade (JW), Director of Nursing, presented the Annual Putting Things Right (PTR) Report for 2024/25 to the Board.

JW explained that the report set out the Health Board's achievements and ongoing work in relation to PTR regulations, which formed a key part of the organisation's quality management framework. JW reported that the Health Board had maintained high rates of early resolutions for complaints, which had contributed to improved processes and communication standards. The Board noted that significant efforts had been made to learn from complaints and drive service improvements.

JW highlighted that the Health Board had been working to improve the logging and management of compliments, recognising the value of positive feedback in supporting staff morale and organisational

learning. The report also noted that personal injury claims had continued a downward trend for the sixteenth consecutive year.

The Board discussed the importance of robust reporting mechanisms for overdue cases, recognising the need for enhanced scrutiny and accountability. It was agreed that the updated Performance Management and Accountability Framework would strengthen escalation processes and committee oversight, ensuring overdue cases are monitored and addressed in a timely manner. Changes had been made to the process applied to the most complex cases to improve performance.

JW advised that, in the coming year, the Health Board intended to combine the Annual Quality Report and the Annual PTR Report to provide a more integrated overview of quality and patient experience.

The Board **APPROVED** and **NOTED** the Annual Putting Things Right Report for 2024/25.

**ABUHB
2409/15**

2025/26 Performance Reporting - Integrated Performance Report Q1

Hannah Evans (HE), Director of Strategy, Planning and Partnerships, presented the Integrated Performance Report for Quarter 1 of 2025/26 to the Board.

Planned care performance was highlighted, with delivery against the 104-week target noted as a key achievement. HE reported that national outpatient activity had started to increase in several specialties, although the summer months had presented challenges for some specialities.

The Board was informed that the "Your Next Patient" initiative had already demonstrated positive impact, with ambulance hours lost to delays on the forecourt reduced from 170 hours the weekend before the initiative went live to only 20 hours the following week.

The Board discussed the effectiveness of initiatives such as "Your Next Patient" in improving ambulance handover times, and sought clarification on workforce challenges including recruitment, retention, and sickness absence rates. The Board was advised that the "Your Next Patient" initiative was already yielding measurable improvements in ambulance handover times, and that workforce challenges were being actively addressed through targeted interventions, continuous review, and transparent reporting.

The Board discussed the reliability and relevance of key performance metrics, the practicalities of meeting national targets, and the impact of workforce issues on service delivery and financial outcomes. The

importance of ongoing monitoring and transparent reporting to support continuous improvement was emphasised.

Sarah Simmonds (SS), Director of Workforce & OD, reported that the Health Board continued to face workforce challenges, particularly in relation to recruitment, retention, and sickness absence rates. SS confirmed that work was underway to clarify expectations for workforce performance and to address ongoing issues, including the implementation of targeted interventions to support staff wellbeing and reduce absence levels.

The Board **NOTED** the Integrated Performance Report for Q1 2025/26.

**ABUHB
2409/16**

2025/26 Performance Reporting - Financial Performance Report, Month 5

Robert Holcombe (RH), Director of Finance & Procurement, presented the Financial Performance Report for Month 5 to the Board.

RH explained that the year-to-date financial position for the Health Board remained positive in terms of capital and cash. However, the revenue forecast had shifted from a balanced position to a £19.9 million deficit, reflecting emerging risks and ongoing financial pressures. RH reported that informal sessions had been held with the Board to discuss the evolving financial situation and the actions required to support recovery.

The Board was informed that the Health Board had managed to increase savings and implement additional financial recovery actions. RH noted that the Band 2/3 national regrading proposal remained a national issue that needed resolution.

Reserves were currently being held at £1 million to support the forecast position, and the Board was advised that further requests from Welsh Government regarding the identification of financial balance were anticipated.

The Board acknowledged the challenges posed by inflation, pay awards, and rising operational costs. The importance of maintaining financial discipline while safeguarding service quality was emphasised. Every effort was being made to reduce the financial deficit.

The Board **NOTED** the Financial Performance Report for Month 5.

**ABUHB
2409/17**

Maternity and Neonatal Services – Annual Report

Jennifer Winslade (JW), Director of Nursing, presented the Annual Report on Maternity and Neonatal Services to the Board.

JW explained that the Health Board had supported approximately 6,000 maternity and neonatal appointments during the reporting period, with four birth settings available to service users.

JW highlighted several key achievements, including the implementation of a self-referral system for maternity services and the introduction of a digital maternity system which was the first of its kind in Wales. This digital system enabled women to access their own data and make informed choices about their care.

JW reported that birth numbers had remained relatively stable, with an increase in women choosing to have a caesarean.

The Board was informed that bereavement care and mortality reviews had continued to be a priority, and that a listening event had been commissioned in the neonatal unit, with plans to conduct a similar event in maternity services. The reviews had shown that a transitional care unit was needed.

The Board acknowledged the importance of continuous evaluation and engagement with service users to maintain high standards of care.

The Board **NOTED** the Annual Report on Maternity and Neonatal Services.

**ABUHB
2409/18**

Maternity and Neonatal Services – Assessment against SBUHB’s Review of Maternity and Neonatal Services

Jennifer Winslade (JW), Director of Nursing, presented the assessment against Swansea Bay University Health Board’s (SBUHB) review of maternity and neonatal services to the Board.

JW explained that the Health Board had completed a detailed analysis of its maternity and neonatal services in the light of the findings and recommendations from SBUHB’s review. The assessment process had involved a comprehensive review of current practices, outcomes, and service user feedback to ensure alignment with best practice and national standards.

JW reported that the Health Board had identified areas of strength, including the implementation of a digital maternity system, robust bereavement care, and ongoing engagement with service users through listening events. The assessment had also highlighted opportunities for further improvement, particularly in relation to

workforce development, patient choice, and the continued evaluation of service quality.

The Board discussed the importance of benchmarking local services against external reviews and welcomed the commitment to continuous improvement. The Board acknowledged the value of learning from the experiences of other Health Boards and the need to maintain high standards of care for mothers, babies, and families.

The Board **NOTED** the assessment against SBUHB's review of maternity and neonatal services and endorsed the ongoing work to address identified priorities.

**ABUHB
2409/19**

General Dental Services Reform Update

Leanne Watkins (LW), Chief Operating Officer, introduced the General Dental Services (GDS) Reform Update and invited Lloyd Hambridge (LH), Dental Programme Manager, Divisional Director – Community and Primary Care Services, to present to the Board.

LH delivered a detailed presentation on the progress and impact of the national dental contract reform programme. LH explained that the reform aimed to improve access to NHS dental services, enhance patient outcomes, and support the sustainability of dental practices across the region. The presentation outlined the key objectives of the reform, including a greater focus on prevention, patient-centred care, and the introduction of new performance monitoring and reporting standards.

LH reported that engagement with local dental practices had been ongoing, with the Health Board providing guidance and resources to support the transition to the new contract model. LH highlighted early feedback from dental practices, which had generally been positive, particularly regarding the increased emphasis on preventive care and improved patient pathways. However, LH also acknowledged ongoing challenges, including workforce recruitment and retention, and the need to ensure equitable access to dental services for all communities.

The Board discussed the importance of continued engagement with dental professionals and patients to monitor the impact of the reforms. Board members recognised the value of the data and insights provided in LH's presentation and commended both LH and the Primary Care team for their efforts in supporting practices and maintaining service continuity during the reform process.

The Board **NOTED** the General Dental Services Reform Update and thanked Lloyd Hambridge for his informative presentation.

Strategic Risk Report, September 2025

Nicola Prygodzicz (NP), Chief Executive, presented the Strategic Risk Report for September 2025 to the Board.

NP explained that the report maintained a focus on the Health Board’s key strategic risks, with particular attention given to those risks that remained outside the Board’s risk appetite. NP reported that the overall risk rating had increased for financial sustainability, reflecting the ongoing and emerging challenges faced by the organisation driven by cost pressures, savings delivery challenges, and the need for rigorous financial control.

NP highlighted other key risks, including health and safety, business continuity, and the delivery of major service transformation programmes. The Board was informed that progress had been made in strengthening governance and oversight in these areas, but that continued focus and mitigation efforts were essential.

The Board agreed that the report clearly reflected the current risk landscape and that the organisation was maintaining appropriate oversight and mitigation strategies. The Board acknowledged the importance of regular review and proactive management of strategic risks to ensure the ongoing resilience and effectiveness of the Health Board.

The Board **NOTED** the Strategic Risk Report for September 2025.

CONSENT AGENDA

The Board **APPROVED** the Draft Minutes of the Health Board Meeting, held on 16th July 2025

The Board **APPROVED** the Report on Sealed Documents and Chair’s Actions.

The Board **APPROVED** the Interim changes to NHS model Standing Financial Instructions

The Board **NOTED** the Board Action Log with Updates

The Board **NOTED** the Report from Llais, Gwent Region

The Board **NOTED** the Community Therapy MSK Transformation Update Report

The Board **NOTED** the Social Partnership Duty Report

The Board **NOTED** the Welsh Language Annual Report

The Board **NOTED** the Strategic Partnership Updates:
a. Regional Partnership Board

The Board **NOTED** the Executive Committee Chair’s report

The Board **NOTED** the Key Matters from Committees of the Board

	The Board NOTED the overview of Joint and Partnership Committee Activity a. NHS Wales Shared Services Partnership Committee
	OTHER MATERS
ABUHB 2409/22	Any Other Business There were no further items raised for discussion.
ABUHB 2409/23	Date of the Next Meeting: Wednesday 26 th November 2025

DRAFT

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Governance Matters: Report on Sealed Documents and Chair's Actions
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad **Purpose of the Report**

Ar Gyfer Penderfyniad/For Decision

This report is presented for compliance and assurance purposes to ensure the Health Board fulfils the requirements of its Standing Orders in respect of documents agreed under seal and situations where Chair's Action has been used for decisions.

ADRODDIAD SCAA **SBAR REPORT**

Sefyllfa / Situation

This paper presents for the Board a report on the use of Chair's Action and the Common Seal of the Health Board between 11th September and 12th November 2025.

The Board is asked to note that three (3) documents required the use of the Health Board's seal during the above period.

Chair's Action in Standing Orders requires approval by the Chair, Chief Executive and two Independent Members, with advice from the Board Secretary (the Director of Corporate Governance). All Chair's Actions require ratification by the Board at its next meeting.

During the period 11th September to 12th November 2025 two (2) Chairs Actions were agreed.

Cefndir / Background

1. Sealed Documents

The common seal of the Health Board is primarily used to seal legal documents such as transfers of land, lease agreements and other contracts. The seal may only be affixed to a document if the Board or Committee of the Board has

determined it should be sealed, or if the transaction has been approved by the Board, a Committee of the Board or under delegated authority.

Under the provisions of Standing Orders, the Chair or Vice Chair and the Chief Executive or Deputy Chief Executive must seal documents on behalf of the Health Board. Three documents were sealed between the 11th September and 12th November 2025, as outlined below.

Date	Title
09/09/2025	Monmouthshire/Torfaen Youth Offending Service Financial Agreement 2025-26
09/10/2025	Omnicele lease renewals at the Grange University Hospital and Nevill Hall Hospital between Aneurin Bevan University Health Board and Welsh Ambulance Services NHS Trust
22/10/2025	ReFit Investment Grade Proposal Decarbonisation Programme of Works

2. Chair's Action

Chair's Action is defined by the Health Board's Standing Orders as: Chair's action on urgent matters: There may be circumstances where decisions which would normally be taken by the Board need to be taken between scheduled meetings, and it is not practical to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

The Chair's Actions approved between 11th September and 12th November are summarised below:

Date	Title
25/09/2025	<p>Supply of 8 Multifiltrate Pros, ongoing consumables and maintenance - Fresenius Medical Care: Replacement of hemofiltration machines as current machines are of an outdated specification and increasingly prone to breakdowns resulting in significant service downtime.</p> <p>One off purchase of capital equipment plus 7 years consumable and maintenance agreement: Annual Value of contract: £142,800.00 – (Capital one off purchase year 1 only) £273,969.56 (Consumables and Maintenance)</p> <p>Total Value of Contract: £142,800.00 Capital Purchase cost £1,901,786.92 Consumables Maintenance and Capital Equipment Total: £2,044,586.92</p>

10/11/2025	<p>IHC and ISH Staining System: Leica Biosystems</p> <p>Contract to retain 2 current Bond III processing modules, along with 2 new units, and one of the existing units marked for replacement in the duration of the contract to enable the health board to minimise disruption to the lab.</p> <p>5 years plus up to 24 months extension option £2,470,008.28 ex VAT</p>
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3. Clinical Negligence Claims

In line with the Scheme of Delegation, all clinical negligence claims over £1m are agreed between the Chair, Chief Executive, and two Independent Members (following recommendation from 2 clinical executives) outside of formal Board meetings. During the period 11th September to 12th November 2025:

Number of Clinical Negligence Claims over £1m	Total value
4	<ul style="list-style-type: none"> • 2 cases approving authority to negotiate up to a combined total of £40,568,701. Noting that both cases would be subject to annual instalments over the claimants lifetime. • 2 cases where value has yet to be determined but likely to be over £1m

Asesiad / Assessment

In endorsing this report the Health Board will comply with its own Standing Orders.

Argymhelliad / Recommendation

The Board is asked to NOTE the documents that have been sealed and to RATIFY the action taken by the Chair on behalf of the Board.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Enabler
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable to this report

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	None
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

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

<https://futuregenerations.wales/about-us/future-generations-act/>

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Amendments to Standing Orders
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Health Board approved its current Standing Orders in July 2023. Following amendments issued by Welsh Government in January 2025, the current version was approved by the Board in March 2025.

On 2 April 2025, the Cabinet Secretary for Health and Social Care directed Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board to establish a Regional Joint Committee (RJC) to exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working.

As a result, revisions have been made to the Model Standing Orders for the Health Board.

Cefndir / Background

Standing Orders are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of Decisions reserved to the Board; a Scheme of Delegations to officers and others and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Local Health Board.

Asesiad / Assessment

South East Wales Regional Joint Committee

Following the establishment of the South East Wales Regional Joint Committee, the Health Board's Standing Orders have been updated to include:

- Section 6: Working in Partnership: Section updated to include the South East Wales Regional Joint Committee. **(Attachment One)**
- Schedule One: Scheme of Reservation and Delegation of Powers: Section updated to include schedule of matters relating to the South East Wales Regional Joint Committee. **(Attachment Two)**
- Schedule 6 added providing the South East Wales Regional Joint Committee Terms of Reference and Operating Arrangements. **(Attachment Three)**

As a result of the above amendments, corresponding changes have been made to the contents page.

Amendments to Joint Commissioning Committee Standing Orders

In January, the Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024 came into force.

These Regulations amended the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009, The National Health Service Trusts (Membership and Procedure) Regulations 1990 and The Health Education and Improvement Wales Regulations 2017.

One of the amendments related to the timescales for the publication of board and committee agendas and papers.

It has been agreed that the NHS Wales Joint Commissioning Committee (JCC) are to adopt same approach in committee proceedings (where appropriate) to ensure consistency across NHS boards.

The JCC is required to incorporate and adopt this latest review into their Standing Orders. The NHS Wales Joint Commissioning Standing Orders form part of Schedule 4 of the Local Health Board Model Standing Orders. The relevant changes are provided at **Attachment Four**.

Argymhelliad / Recommendation

The Board is asked to APPROVE the amendments to the Standing Orders.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Enabler
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable to this report

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	None
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Is EIA Required and included with this paper No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

**Deddf Llesiant
Cenedlaethau'r Dyfodol – 5
ffordd o weithio
Well Being of Future
Generations Act – 5 ways
of working**

<https://futuregenerations.wales/about-us/future-generations-act/>

Choose an item.

Choose an item.

Not applicable to this report

6.2 South East Wales (SEW)– Regional Joint Committee (RJC)

6.2.1 On 2 April 2025, the Cabinet Secretary for Health and Social Care directed Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board to establish a Regional Joint Committee (RJC) to exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working. This direction is given pursuant to the Welsh Ministers' power in section 12(3) of the National Health Service (Wales) Act 2006.

Refer to Schedule 6 for detailed Terms of Reference and Operating Arrangements for the SEW RJC

Schedule of Matters relating to the South East Wales Regional Joint Committee

1.1. SOUTH-EAST WALES REGIONAL JOINT COMMITTEE (RJC) - SCHEME OF DELEGATION AND

The tables below set out a Framework of Reservation and Delegations anticipated in respect of

Unless explicitly set out within the RJC's Terms of Reference and this Framework, every Health Board and Local Health Boards respectively. Where Health Boards have delegated functions to the RJC, each Health Board will be required to make decisions of the Joint Committee in accordance with the Schedule of Powers delegated to the RJC.

This Framework will be kept under active review and, where appropriate, will be revised to take account of any findings or other changes.

A. MATTERS RELATING TO THE RJC, RESERVED FOR HEALTH BOARDS		
REF.	AREA	MATTER
A1.	Operating Arrangements	Approve the Joint Committee's Terms of Reference (the Governance Framework for the RJC)
A2.	Strategy & Planning	Approve the annual priorities and programme of work as recommended by the RJC
A3.	Strategy & Planning	Approve a Regional Commissioning Strategy, if recommended for inclusion in Health Board Integrated Medium-Term Plans
A4.	Strategy & Planning	Approve the overarching financial commitment and to enable delivery of the priorities set for the RJC (A

A5.	Strategy & Planning	Approve Capital and Revenue Business Cases (priorities) within the framework of: <ul style="list-style-type: none"> • The agreed annual priorities and programme developments (A2) • The agreed Regional Commissioning Strategy • The overarching financial commitment and financial enable delivery of the priorities set for the RJC
A6.	Strategy & Planning	Approve the commencement of formal engagement on significant service change proposals
A7.	Strategy & Planning	Approve significant service change proposals for implementation

B. MATTERS RELATING TO THE RJC, <u>DELEGATED FROM HEALTH BOARDS</u> AND JOINT COMMITTEE		
REF.	AREA	MATTER
B1.	Operating Arrangements	Develop, vary, and amend the Joint Committee Operating Arrangements (the Governance Framework) for Health Board approval
B2.	Operating Arrangements	Develop and Approve the Terms of Reference for the following which are deemed necessary for the exercise of its functions: <ul style="list-style-type: none"> • Programme and Project Governance – Establish a framework for managing and controlling projects • Expert Panels – Established to review and make recommendations on specific subjects which require input from individuals with relevant knowledge and experience with the subject • Advisory Groups – Established to provide advice on specific subject matters which generally consists of a group of individuals with relevant knowledge and experience with the subject

		and/or external stakeholders to make recom issue.
B3.	Strategy & Planning	Develop and approve, prior to Health Board ap and programme of work for regional developm purpose and responsibilities
B4.	Strategy & Planning	Develop and approve, prior to Health Board ap Commissioning Strategy, for inclusion in Health Term Plans, where it is required
B5.	Strategy & Planning	Determine, for Health Board approval, the requ financial framework to enable delivery of the pr and A3)
B6.	Strategy & Planning	Approve Capital and Revenue Business Cases (required), within the framework of: <ul style="list-style-type: none"> • The agreed annual priorities and program developments (B3) • The agreed Regional Commissioning Str • The overarching financial commitment an required to enable delivery of the prioritie
B6.	Strategy & Planning	Develop significant service change proposals v developments, for Health Board approval
B7.	Strategy & Planning	Develop arrangements for the commencement consultation on service change proposals, for H
B8.	Performance & Assurance	Receive reports from Senior Responsible Offic performance in the delivery of the RJC's priorit and approve action required, including improve

B9.	Performance & Assurance	Receive assurance reports from the RJC's sub the delivery of those delegated programmes of
B10.	Performance & Assurance	Receive audit and review reports related to the to consideration through Health Boards)

C. MATTERS RELATING TO THE RJC, DELEGATED FROM THE JOINT COMMITTEES, GROUPS AND OTHERS

REF.	AREA	MATTER
		<i>To be determined upon establishment o</i>

**SOUTH-EAST WALES REGIONAL JOINT COMMITTEE (RJC)
TERMS OF REFERENCE & OPERATING ARRANGEMENTS**

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

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3 Introduction

1. On 2 April 2025, the Cabinet Secretary for Health and Social Care directed Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board to establish a Regional Joint Committee (RJC) to exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working. This direction is given pursuant to the Welsh Ministers' power in section 12(3) of the National Health Service (Wales) Act 2006.
2. For the purpose of these terms of reference, the three organisations comprising the RJC will be referred to as the health board.
3. To enhance collaboration in integrated care, representatives from Powys Teaching Health Board and Velindre NHS Trust will be Associate Members of the RJC.
4. Additionally, a Welsh Government Official is to receive a standing invitation to observe all meetings of the Committee. This will usually be a member of the Health, Social Care, and Early Years Executive Directors Team. This will provide the Cabinet Secretary with confidence that there is an appropriate level of oversight and assurance from the Welsh Government in place.
5. The RJC is expected to bring greater focus on:
 - regional planning and delivery of service models.
 - improved outcomes and a reduction in inequalities in access.
 - potential for service transformation, including new workforce models.
 - establishing new relationships and/or resetting existing relationships.
 - exploring regional solutions to advance sustainable service provision
 - providing coordinated support to the health boards.

4 Status

6. The RJC is to be established under the powers vested in Welsh Ministers under Section 12 of the National Health (Wales) Act 2006 which allows:
 - (1) Welsh Ministers to direct a Local Health Board to exercise in relation to its area:
 - (a) functions which were transferred to the National Assembly of Wales (now Welsh Government following the Government of Wales Act 2006) by the Health Authorities (Transfer of Functions, Staff, Property, Rights and Liabilities and Abolition) (Wales) Order 2003 (S.I. 2003/813 (W.98)),
 - (b) such other of their functions relating to the health service as are specified in the direction.
 - (2) The functions which may be specified in directions under subsection (1) include functions under enactments relating to mental health and care homes.
 - (3) The Welsh Ministers may give directions to a Local Health Board about its exercise of any functions.

5 Accountability, Responsibility and Authority

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7. The RJC is established by, and ultimately accountable to, the Boards of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB.
8. As a joint committee of the three Health Boards, the RJC is not a separate legal entity from each of the LHBs.
9. The RJC shall report to each Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf.
10. Ultimately, the three Health Boards remain accountable for planning, securing and delivering health services to their respective populations.
11. Each Health Board has delegated authority to the RJC for the exercise of certain functions, as set out within these Terms of Reference.
12. These RJC Terms of Reference form a schedule of each Health Board's own Standing Orders and have effect as if incorporated within them.
13. Where Health Boards have delegated functions to the RJC, each Health Board shall be bound by the decisions of the Joint Committee in accordance with the Schedule of Powers delegated to the RJC (**Appendix A**).

6 Purpose of the RJC

14. 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) Identify 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.

Be cognisant of the wider environment of health services in Wales, including the needs of those who use health services in the south-east Wales region but are from populations which are outside of the responsibility of the three health boards.

7 Objectives of the RJC

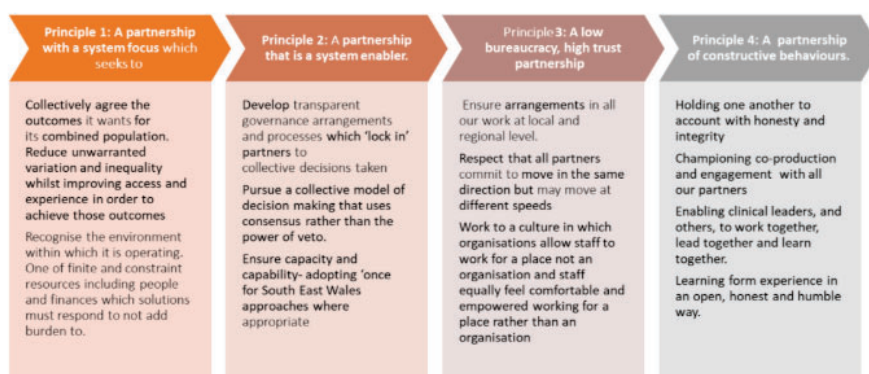
15. In-line with delegated levels of authority and accountability (**Appendix A**), the RJC will specifically:

- a) Develop a regional programme of work, aligned to individual Health Board plans, to ensure the benefits of a regional health economy for a population of over 1.5million are realised.
- b) Review baseline activity, based on individual Health Board clinical services plans, focusing on cost efficiencies, quality, and service fragility.
- c) Develop and oversee an approach to prioritisation of capital programmes which underpin the regional health economy approach.
- d) Consider and prioritise the regional projects included within the regional programme of work, approving Business Cases and identifying and agreeing to any further projects to be included in the regional programme.
- e) Seek assurance that projects deliver against their outcomes and timescales, and deliver against the quality measures and programme benefits, as identified in their PIDs and or Business Cases.
- f) Provide a vehicle to progress work programmes within the remit of the RJC without unnecessary recourse elsewhere to ensure pace.
- g) Seek assurance that integrated impact assessments are undertaken of all planned service change programmes and embedded in the ways of working of the RJC.
- h) Develop, implement and evaluate the required governance framework to deliver the regional programme of work, underpinning the RJC.
- i) Consider any audit and review related activity relevant to the work of the RJC to inform learning and improvement.

8 Partnership Principles

16. As a strategic partnership of the three Health Boards in the region, the RJC will adopt and embed the following four partnership principles into its business and operating arrangements. The RJC will be:

- a) A partnership with a system focus which seeks to collectively agree the outcomes it wants for its combined population.
- b) A partnership that is a system enabler.
- c) A low bureaucracy, high trust partnership.
- d) A partnership of constructive behaviors.



9 Chairing Arrangements

17. The Chair of the RJC will be drawn from one of the Chairs of the three health boards and this position will rotate amongst the three chairs on an annual basis at the meeting of the RJC in April of each year. The RJC will be established in October 2025 and the first appointed Chair will serve until March 2027.

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18. The other two health board Chairs will jointly become vice chairs of the RJC and will agree who deputises and presides at a meeting in the absence of the Chair.

10 Membership

19. The RJC shall have the following members drawn from the three health boards, as follows:

- Chairs of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3)
- Vice Chairs, or 1 nominated Independent Member, of each of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3)
- Chief Executives of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3)
- 1 nominated Executive Director from each of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3)

20. With the permission of the Chair of the RJC, the members of the RJC set out above may nominate a substitute, equivalent Board Member (as defined above) to attend a meeting that they are unable to attend. The substitute may speak and vote on their behalf. The decision of the Chair regarding the authorisation of nominated substitutes is final.

11 Associate Membership

21. The RJC shall have the following associate members, attending meetings on an ex-officio basis, without voting rights:

- a) A nominated Board Member of Powys Teaching Health Board (1)
- b) A nominated Board Member of Velindre NHS Trust (1)

22. With the permission of the Chair of the RJC, the associate members of the RJC set out above may nominate a substitute to attend a meeting that they are unable to attend. The substitute may speak on their behalf. The decision of the Chair regarding the authorisation of nominated substitutes is final.

12 In Attendance

23. At the discretion of the Chair of the RJC, the RJC may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This may include, but is not limited to:

- a) Employees of the three Health Boards as appropriate.
- b) The Senior Responsible Officers of RJC programmes.
- c) Representatives from the Health and Care system, including NHS Bodies and Local Authorities.
- d) Representatives from the Voluntary, Community and Social Enterprise sector.
- e) Representatives of Llais.

24. The RJC will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the RJC (whether directly or through the activities of bodies such as Llais) and to demonstrate openness and transparency in the conduct of business.

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25. A Welsh Government Official will receive a standing invitation to observe all meetings of the RJC.

13 Accountable Officers

26. Chief Executives of Health Boards are designated Accountable Officers, in-line with Managing Welsh Public Money, and hold several personal responsibilities. Accountable Officers have a personal responsibility for: propriety and regularity of the public finances delegated to them; affordability and sustainability; value for money; management of opportunity and risk; learning from feedback; and accounting accurately.

27. The Chief Executive, as the Accountable Officer (Accounting Officer), of each respective Health Board is included within the membership of the RJC to ensure any decisions delegated from Boards to the RJC do not undermine the personal responsibilities Accountable Officers hold.

28. Accountable Officers will need to be cognisant of their responsibilities, as set out within Managing Welsh Public Money (MWPM) and their respective Accountable Officer Memorandums, ensuring principles are applied to decision making, including:

- a) MWPM 3.8.5 – “There are sensitivities about the role of the Accounting Officer in a public body which is governed by an independent board, e.g. a charity or a company. The Accounting Officer, who will normally be a member of the board, must take care that his or her personal responsibilities do not conflict with his or her duties as a board member. In particular, the Accounting Officer should vote against any proposal which appears to cause such a conflict; it is not sufficient to abstain.”
- b) MWPM 3.8.6 – “Moreover, if the chair or board of such a public body is minded to instruct its Accounting Officer to carry out a course inconsistent with the standards in box 3.1, then the Accounting Officer should make his or her reservations clear, preferably in writing....”

14 Working with Llais (Citizen Body for Health and Social Care)

29. In exercising its responsibilities, the RJC shall ensure arrangements are in place to engage and co-operate with representatives of Llais as appropriate.

30. Part 4 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (the 2020 Act) places a range of duties on Local Health Boards and Trusts in relation to the engagement and involvement of Llais in their operations, which are extended to the activities of the RJC.

31. The RJC will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning, developing, considering proposals for service change, in-line with delegated levels of authority.

15 Delegated Functions and Powers

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- 32.** When exercising any Delegated Functions, the RJC will ensure that it acts in accordance with, and that its decisions are informed by, the relevant policies and procedures which have been developed by the three health boards to support those functions and to inform the commissioning, provision and delivery of any relevant services.
- 33.** Within the framework approved by each Health Board and set out within these RJC Terms of Reference, and subject to any directions that may be given by the Welsh Ministers; the RJC may make arrangements for certain functions to be carried out on its behalf, so that regional planning and delivery may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the RJC must set out clearly the terms and conditions upon which any delegation is made.
- 34.** The RJC's determination of those matters that it will retain, and those that will be delegated to others shall be set out in **Appendix A**:
- a) Schedule of matters reserved for the RJC; and a
 - b) Scheme of delegation to joint sub-Committees and others;
- all of which must be formally adopted by the RJC and approved by Health Boards as a schedule to their own Standing Orders.

16 Sub-Committees, Groups and Panels

- 35.** The RJC may and, where approved by the LHB Boards jointly, or directed by Welsh Ministers, must appoint joint sub-Committees of the RJC either to undertake specific functions on the RJC's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).
- 36.** This may also extend to:
- a) Programme and Project Governance – Established to provide a framework for managing and controlling programmes and projects.
 - b) Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field.
 - c) Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue.
- 37.** The RJC shall determine a governance structure that meets its own advisory and assurance needs and in doing so the needs of the three Health Boards. These would be set out within agreed Terms of Reference and Operating Arrangements, agreed by the RJC.

17 Meetings

Scheduling meetings

38. The RJC will ordinarily meet quarterly, and, as a minimum, shall meet on three occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

39. The three Health Boards may ask the RJC to convene further meetings to discuss issues on which they want RJC advice, subject to the agreement of the Chair.

Quoracy

40. In order for a meeting to be quorate there must be at least six members in attendance, which shall include:

a) An Independent Member (Chair or Vice Chair) and an Executive member (CEO or other executive) from each of the three health boards.

41. If any member of the RJC has been disqualified from participating in an item on the agenda, because of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Nominated deputies who have been authorised by the Chair shall count towards quorum.

42. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Voting

43. The RJC will ordinarily reach conclusions by consensus. If this is not possible, the Chair may call a vote. Only members of the RJC Committee (or nominated substitute as set out in section 20) may vote; each Member is allowed one vote. The result of the vote will be recorded in minutes

44. Where there is no consensus and the likelihood of no consensus at a subsequent meeting, the Chair of the RJC will refer the decision to each Board of the three respective Health Boards for further consideration. If the same decision is not made by each of the three Health Boards, the dispute process (**Appendix B**) will be enacted.

45. Should a decision be referred to the three respective Health Boards as set out in section 44, the outcome of all three decisions will be reported to the next meeting of the RJC and recorded in minutes.

Papers and notice

46. A minimum of seven clear days' notice of all meetings is required, which shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

47. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers

shall be permitted in exceptional circumstances at the discretion of the Chair.

Virtual attendance

48. It is for the Chair to decide whether the RJC will meet virtually. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such a meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Recordings of meetings

49. Except with the permission of the Chair, no person admitted to a meeting of the RJC shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Minutes

50. The minutes of meetings will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the RJC together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting.

Governance support

51. Governance Advice and Secretariat support for the RJC will be provided by the organisation from which the Chair is elected and will therefore rotate between the three Health Boards on an annual basis.

Interpretation

52. Where there is doubt as to the applicability or interpretation of the RJC's terms of reference and operating arrangements, the Chair of the RJC, with advice from the nominated Governance Advisor, shall have the final say, provided that the decision does not conflict with rights, liabilities or duties as prescribed by law.

Confidential information

53. Where confidential information is presented to the RJC all attendees will ensure that they treat that information appropriately considering any confidentiality requirements and information governance principles.

Openness and Transparency

54. As far as is practicably possible and appropriate, the RJC will meet in public to promote openness and transparency. A public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on each Health Boards website, where the papers supporting the public part of the agenda will be available.
55. There will be occasions when some of the RJC's business is more appropriately considered in private session; this is to ensure that any business considered is not prejudicial to public interest, commercial sensitivities and data protection.
56. The final decision on whether business should be discussed in private or public session shall be made by the RJC Chair, having taken advice from the nominated Governance Advisor.

18 Conflicts of Interest

57. Conflicts of interest will be managed in accordance with relevant policies and procedures and shall be consistent with the three health boards' respective statutory duties and applicable national guidance.
58. Where individual RJC members identify an interest in relation to any aspect of RJC business set out in the meeting agenda, that member must declare an interest at the start of the meeting. RJC members should seek advice from the Chair before the start of the meeting if they are in any doubt as to whether they should declare an interest at the meeting.
59. All declarations of interest made at a meeting must be recorded in the Joint Committees minutes.
60. It is the responsibility of the Chair, on behalf of the RJC, to determine the action to be taken in response to a declaration of interest declared. Where the Joint Committee Chair declares a personal interest, any decision on the action to be taken shall be made the Vice-Chair designated for that meeting.

19 Disputes

61. Where a dispute arises between the three health boards, which is connected to the operation of the RJC and its work, this shall be resolved in accordance with the dispute resolution procedure at **Appendix B**.

20 Behaviours and Conduct

- 62.** Members will be expected to behave and conduct business in accordance with:
- a) The policies, procedures and governance documents that apply to their respective Health Board.
 - b) Any collectively developed procedures or codes.
 - c) The Values and Standards of Behaviour Framework of NHS Wales.
 - d) The Nolan Principles
 - e) Agreed partnership principles.
- 63.** Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.
- 64.** Within the constraints of these Terms of Reference, RJC Members will act in the best interests of the population of the south-east Wales region, rather than representing the individual interests of an individual health board.

21 Reporting Arrangements

- 65.** A copy of the meeting minutes of each meeting of the RJC, along with a summary report, shall be shared with the three Health Boards for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval.

22 Review

- 66.** The RJC will review its effectiveness at least annually on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. The outcome of this will be included within the standing report to the three Health Boards set out in 65.
- 67.** These terms of reference, including membership and chairing arrangements, will be reviewed at least annually and more frequently if required.
- 68.** Any proposed amendments to these terms of reference will be submitted to the three Health Boards for approval.

23 APPENDIX A - SOUTH-EAST WALES REGIONAL JOINT COMMITTEE (RJC) - SCHEME OF DELEGATION AND RESERVATION OF POWERS

The tables below set out a Framework of Reservation and Delegations anticipated in respect of RJC business.

Unless explicitly set out within the RJC's Terms of Reference and this Framework, everything is retained by the three Health Boards respectively. Where Health Boards have delegated functions to the RJC, each Health Board shall be bound by the decisions of the Joint Committee in accordance with the Schedule of Powers delegated to the RJC

This Framework will be kept under active review and, where appropriate, will be revised to take account of developments, review findings or other changes.

D. MATTERS RELATING TO THE RJC, RESERVED FOR HEALTH BOARDS		
REF.	AREA	MATTER
A1.	<i>Operating Arrangements</i>	<i>Approve the Joint Committee's Terms of Reference and Operating Arrangements (the Governance Framework for the RJC)</i>
A2.	<i>Strategy & Planning</i>	<i>Approve the annual priorities and programme of work for regional developments, as recommended by the RJC</i>
A3.	<i>Strategy & Planning</i>	<i>Approve a Regional Commissioning Strategy, if recommended by the RJC, for inclusion in Health Board Integrated Medium-Term Plans</i>
A4.	<i>Strategy & Planning</i>	<i>Approve the overarching financial commitment and financial framework required to enable delivery of the priorities set for the RJC (A2 and A3)</i>
A5.	<i>Strategy & Planning</i>	<i>Approve Capital and Revenue Business Cases (prior to WG approval if required), within the framework of:</i> <ul style="list-style-type: none"> • <i>The agreed annual priorities and programme of work for regional developments (A2)</i> • <i>The agreed Regional Commissioning Strategy (A3)</i> • <i>The overarching financial commitment and financial framework required to enable delivery of the priorities set for the RJC (A4)</i>
A6.	<i>Strategy & Planning</i>	<i>Approve the commencement of formal engagement and consultation on significant service change proposals</i>
A7.	<i>Strategy & Planning</i>	<i>Approve significant service change proposals for implementation</i>

E. MATTERS RELATING TO THE RJC, DELEGATED FROM HEALTH BOARDS AND RESERVED FOR THE JOINT COMMITTEE		
REF.	AREA	MATTER
B1.	<i>Operating Arrangements</i>	<i>Develop, vary, and amend the Joint Committee's Terms of Reference and Operating Arrangements (the Governance Framework for the RJC) for Health</i>

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		<i>Board approval</i>
<i>B2.</i>	<i>Operating Arrangements</i>	<p><i>Develop and Approve the Terms of Reference and Operating Arrangements for the following which are deemed necessary to support the RJC in the exercise of its functions:</i></p> <ul style="list-style-type: none"> <i>• Programme and Project Governance – Established to provide a framework for managing and controlling programmes and projects.</i> <i>• Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field.</i> <i>• Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue.</i>
<i>B3.</i>	<i>Strategy & Planning</i>	<i>Develop and approve, prior to Health Board approval, the annual priorities and programme of work for regional developments, in line with the RJC's purpose and responsibilities</i>
<i>B4.</i>	<i>Strategy & Planning</i>	<i>Develop and approve, prior to Health Board approval, a Regional Commissioning Strategy, for inclusion in Health Board Integrated Medium-Term Plans, where it is required</i>
<i>B5.</i>	<i>Strategy & Planning</i>	<i>Determine, for Health Board approval, the required financial commitment and financial framework to enable delivery of the priorities set for the RJC (A2 and A3)</i>
<i>B6.</i>	<i>Strategy & Planning</i>	<p><i>Approve Capital and Revenue Business Cases (prior to WG approval if required), within the framework of:</i></p> <ul style="list-style-type: none"> <i>• The agreed annual priorities and programme of work for regional developments (B3)</i> <i>• The agreed Regional Commissioning Strategy (B4)</i> <i>• The overarching financial commitment and financial framework required to enable delivery of the priorities set for the RJC (B5)</i>
<i>B6.</i>	<i>Strategy & Planning</i>	<i>Develop significant service change proposals which relate to regional developments, for Health Board approval</i>
<i>B7.</i>	<i>Strategy & Planning</i>	<i>Develop arrangements for the commencement of formal engagement and consultation on service change proposals, for Health Board approval</i>
<i>B8.</i>	<i>Performance & Assurance</i>	<i>Receive reports from Senior Responsible Officers on progress and performance in the delivery of the RJC's priorities and programme of work, and approve action required, including improvement plans where required</i>

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B9.	Performance & Assurance	Receive assurance reports from the RJC's sub-Committees and groups on the delivery of those delegated programmes of work
B10.	Performance & Assurance	Receive audit and review reports related to the work of the RJC (in addition to consideration through Health Boards)

F. MATTERS RELATING TO THE RJC, DELEGATED FROM THE JOINT COMMITTEE TO SUB-COMMITTEES, GROUPS AND OTHERS		
<i>REF.</i>	<i>AREA</i>	<i>MATTER</i>
		<i>To be determined upon establishment of the RJC</i>

24 APPENDIX B - SOUTH-EAST WALES REGIONAL JOINT COMMITTEE (RJC) - PROCESS FOR DISPUTES AND ARBITRATION

1. In accordance with the Terms of Reference for the RJC, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board (the Health Boards) will seek to work cooperatively with each other as constituent members of the RJC and with the RJC as a whole. Where there is an impasse which cannot be resolved by means of conciliation between appropriate individuals, then as a last resort the following process should be followed.
2. In the event of any dispute between Health Boards relating to RJC business, all parties involved in the dispute must try to reach an agreement. This will involve meeting to discuss and trying to resolve the issues. All reasonable efforts must be made before escalating any disputed issues.
3. If a dispute cannot be resolved in accordance with the provisions of paragraph 2, the respective Health Board Chief Executive should have a further meeting with the two other Chief Executives of the RJC to determine if the matter can be resolved in-line with the partnership principles agreed within the RJC's Terms of Reference.
4. If a dispute cannot be resolved in accordance with the provisions of paragraph 3, the respective Health Board Chair should have a further meeting with the two other Health Board Chairs to determine if the matter can be resolved in-line with the partnership principles agreed within the RJC's Terms of Reference. The Health Board Chairs may wish to engage their respective wider Boards on this matter.
5. If a dispute still cannot be resolved in accordance with the provisions of paragraph 5, it shall be referred to the Welsh Government Director General for Health and Social Services and ultimately onwards to the Cabinet Secretary for Health and Social Services for resolution.

Attachment Four

Amendments to the Standing Orders of the NHS Wales Joint Commissioning Committee

Section 7 – Committee Meetings: Notifying the public and others

Amend the highlighted text within the following paragraph, from:

7.12 Except for meetings called in accordance with SOs, at least 10 calendar days before each meeting of the Joint Committee, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh) as follows:

- Each LHBs website shall link to the JCC website, where the papers supporting the public part of the agenda will be available; as well as
- Through other methods of communication as set out in the Joint Committee's communication strategy.

When providing notification of the forthcoming meeting, each LHB shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g., as Braille, large print, etc.

To:

7.12 Except for meetings called in accordance with SOs, at least 10 calendar days before each meeting of the Joint Committee, a public notice of the time and place of the meeting shall be displayed bilingually (in English and Welsh):

- On the JCC's website;
- Each LHBs website shall link to the JCC website; as well as

-Through other methods of communication as set out in the JCC's communication strategy.

When providing notification of the forthcoming meeting, the committee shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g., as Braille, large print, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Committee.



Outstanding	In Progress	Not Due	Completed
-------------	-------------	---------	-----------

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date
26 November 2024	ABUHB 2611/15	Management of General Medicine Patients at the Grange University Hospital A Six-month review of the respiratory Medicine reconfiguration to be presented to the Board.	Action: Chief Operating Officer	May/Jul 2025

All actions in this log are currently active and are either part of the Board's forward work program or require immediate attention, such as an update on the action or confirmation that the item scheduled to be ready.

Once the Board is assured that an action is complete, it will be removed. This will be agreed at the next meeting.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Regional Partnership Board Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans – Executive Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Amy Dolben – Assistant Director of Partnership & Integration Rebecca Stanton – Regional Children & Families Transformation Lead

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

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

1. Sefyllfa / Situation

The Social Services and Wellbeing Act 2014 sets out the requirement for Local Authorities and Local Health Boards to establish Regional Partnership Boards (RPB), to manage and develop services to secure strategic planning and partnership working. RPBs need to work with wider partners such as the third sector and providers to ensure care and support services are in place to meet the needs of their respective populations.

This report provides an update on the activities of the Gwent RPB.

2. Cefndir / Background

This report is provided to the Board for information only to ensure consistent messaging and updates between the RPB and the Health Board.

3. Aseiad / Assessment

3.1. Welsh Government updates

3.1.1. Integrated Community Care System

In December 2024, Welsh Government issued a position statement for the Regional Integration Fund (RIF), the Housing with Care Fund (HCF) and the



Integration and Rebalancing Care Fund (IRCF) and proposed Integrated Community Care System (ICCS). Welsh Government's vision for an ICCS is to build a healthier Wales through: integrating health and social care systems; and building capacity for people to receive the care and support they need at or closer to home.

Proposals around the ICCS have progressed at pace in 2025. Welsh Government has created an ICCS 'blueprint' and has developed a new governance framework for RPBs around the ICCS – this new governance framework will become operational in September 2025. The first National Leadership Group and Gwent-focussed Enhancing Community Capacity meetings regarding this model have taken place and will continue for the remainder of this financial year. The Blueprint is included in Appendix 1.

3.2. Gwent RPB Updates

The RPB has recently appointed Steve Tiley as its new Vice Chair. He brings extensive experience in the Third Sector and currently serves as Chief Executive of GAVO.

The RPB Annual Report has now been published and is available to the public on the Gwent RPB [website](#).

3.3. Revenue Portfolio

3.3.1. Neurodivergence Improvement Programme

On 23 June 2025, Welsh Government issued an award letter for the 2025/26 Neurodivergence Improvement Programme (NDIP).

The funding award outlined in the letter was lower than the previous allocation (i.e. £352,961 compared with £945,726 in 2024/25) with a proscribed focus on maintaining under 52-week waiting times for children's diagnostic assessments only. Previously funding had applied across the adults and children's portfolios. As a result of the reduced level of funding and the proscribed area of focus, the NDIP cannot be used to support adult provision, nor third sector support for children or adults.

The RPB has now assigned the full amount to the Health Board's Children's ND service, and further non-recurrent investment from RIF has been allocated to support the ongoing pathway transformation.

A letter regarding the concerns of a reduced NDIP allocation has been produced and issued by the RPB directly to Welsh Government. The RPB is awaiting a response. A copy of the letter can be found in Appendix 2: NDIP letter.

3.4 Impact Assessments

The impact assessment process for this financial year commenced in September 2025 – this process will inform funding decisions for 2026/27, which is the final year of the Regional Integration Fund (RIF). The impact assessment process for this financial year is notably different than in previous years, with a focus on: (i) strategic alignment with key RPB priorities; and (ii) impact achieved for the



population of Gwent. By contrast the previous process focussed on quality of reporting.

The team has been working closely with projects across the partnership to ensure that Senior Responsible Officers (SROs) of the RIF projects are fully informed of the requirements and subsequent process.

The following table outlines the timeline for the remainder of this year’s impact assessment process which will apply to all funded RPB projects.

December 2025	Review of all impact assessments at extraordinary Strategic Partnership meetings to validate assessments and make recommendations for funding in 2026/27.
January / February 2026	Review of SP recommendations at Regional Leadership Group (RLG) / RPB to make final decisions on funding for 2026/27. Issue financial award letters at earliest opportunity.
February / March 2026	Collate project impact assessments and undertake impact assessment at programme-level to inform post-RIF plans.

3.5 Capital Portfolio

3.5.1 Annual Portfolio Funding

The following table outlines the funding streams available to support capital developments in 2025/26.

Funding Stream	Funding Allocation
IRCF	£70 million across Wales, on a first-come-first served basis
HCF	£11.609 million for Gwent (Objective 3 Minors: £1.161m, Objective 3 DFG: £0.581m)

At Month 5, £6.111m of schemes have been approved, with £4.300m forecast for in-year delivery. The programme remains under-programmed by £6.317m, resulting in a projected under-utilisation of £8.128m. Despite a strong pipeline, overall utilisation is projected at 59%.

The RPB continues to consider ways to proactively address the current challenges in utilising the full allocation, including expediting approval processes via virtual approvals.

3.5.2 Strategic Capital Plan

The RPB is required to submit a Strategic Capital Plan (SCP) to Welsh Government on an annual basis. The work is underway, and the team is currently focusing on the following areas:

- Mapping and gapping to assess current accommodation provision across priority groups such as beds for older people and children and identify future needs. This gap analysis will highlight unmet needs and guide future delivery, potentially through visual tools like mapping.
- Data alignment



- Thematic workshops: following the recent success of the Dementia workshop, further sessions are being developed for other population groups to stimulate new pipeline ideas and test regional need.

4. Argymhelliad / Recommendation

The Board is asked to note the updates included in this report.

Appendices

Appendix 1: ICCS Blueprint



20250605 - DoSS -
Integrated Care meeti

Appendix 2:NDIP letter



RPB letter NDIP
2025_.doc

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):

Blaenoriaethau CTCI
IMTP Priorities

[Link to IMTP](#)

Galluogwyr allweddol o fewn y
CTCI
Key Enablers within the IMTP

Amcanion cydraddoldeb
strategol
Strategic Equality Objectives

[Strategic Equality Objectives
2020-24](#)

All Health & Care Standards Apply
Choose an item.
Choose an item.
Choose an item.

Every Child has the best start in life
Getting it right for children and young adults
Adults in Gwent live healthily and age well
Older adults are supported to live well and
independently
Dying Well as part of life

Partnership First

Work in partnership with carers to continue
awareness raising, provide information and
improve practical support for carers
Improve the access, experience and outcomes of
those who require Mental Health and Learning
Disability Services
Choose an item.
Choose an item.



Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	<p>HCF Housing with Care Fund IRCF Integration and Rebalancing Care Fund RPB Regional Partnership Board RIF Regional Integration Fund RLG Regional Leadership Group</p>
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau)

Impact: (must be completed)

	Is EIA Required and included with this paper
<p>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</p>	<p>No does not meet requirements</p> <p>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk</p>
<p>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</p> <p>https://futuregenerations.wales/about-us/future-generations-act/</p>	<p>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</p> <p>Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives</p> <p>Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their 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> <p>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</p>



Trefniadau newydd ar gyfer 2025/26

**Model llywodraethu ddrafft y System
Gofal Cymunedol Integredig (ICCS)**

New arrangements for 2025/26

**Draft Integrated Community Care
System (ICCS) governance model**

Lly
Wo

Esblygiad tuag at System C Gymru Evolution towards a

RIF

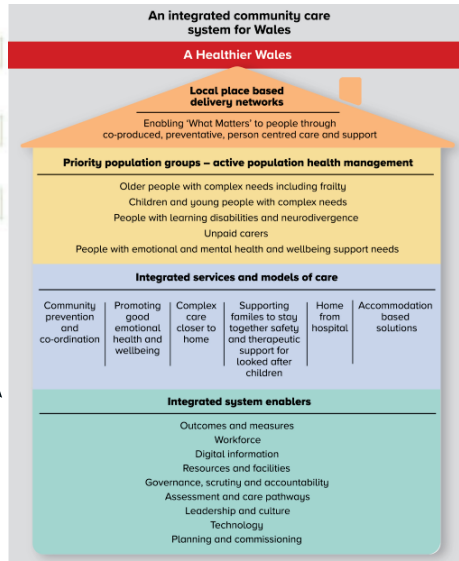
Fig. 1 – National models of care for the RIF



2022



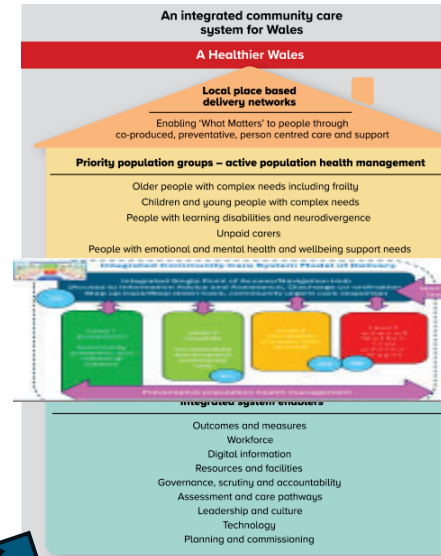
ICCS Blueprint v1



2023



ICCS Blueprint v2
Alignment with 6 Goals
and SPPC Programmes



2024

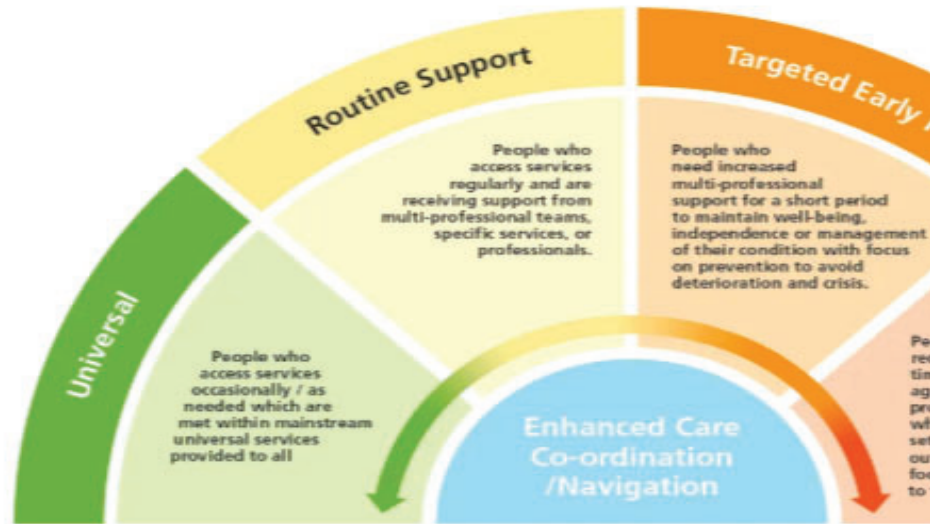


Integrated Community Health and Care for Wales

Local place-based planning & delivery

Enabling 'What Matters' to people through co-produced, preventative, person centred care and support

Preventative Population Health Management



Integrated System Enablers

Housing and Accommodation with Care	Outcomes and Measures	Workforce	Resources and Facilities
Governance, Scrutiny and Accountability	Assessment and Care Pathways	Leadership and Culture	Technology

 Add a comment



Your ref/Eich cyf:
Our ref/Ein cyf: Cllr DD/NH
Date/Dyddiad: 16th September 2025

Please contact/Cysyllter â: Cllr David Daniels
Direct line/Llinell ffôn: 01495 761691

Email/Ebost: GwentRegionalPartnershipBoard@torfaen.gov.uk

Dear Sarah Murphy, MS,

The Gwent Regional Partnership Board is writing to express our concern regarding the sustainability of the National Neurodivergence Improvement Programme (NDIP), in light of the recent reduction in funding for 2025/2026.

We welcome the Welsh Government's continued commitment to neurodivergence services, particularly the recent announcement of £13.7 million in additional funding to extend NDIP until March 2027. The programme has been instrumental in driving forward integrated, needs-led approaches to support neurodivergent individuals and families across Wales. Locally, it has enabled us to pilot innovative models, improve workforce capability, and reduce waiting times for children's neurodevelopmental assessments.

Through our transformation efforts, we have made significant improvements to our children's neurodevelopmental pathway, enhancing access, streamlining processes, and embedding more holistic, family-centred support. These changes have had a profound impact on children and families navigating neurodivergence, and we are proud of the progress made.

However, we are increasingly aware of the growing need for equivalent investment and transformation in adult neurodivergence services. Many adults are coming forward with "neuro-curiosity," often prompted by supporting their children through diagnosis and care. These individuals deserve timely, compassionate, and informed pathways to explore their own neurodivergent identities and access appropriate support.

The financial pressures currently facing the partnership pose a significant risk to the continued delivery and scaling of these improvements. As we navigate the constraints of targeted intervention, we are concerned that the progress made through NDIP may be compromised without additional support or flexibility in how funding is allocated and protected at the local level.

We respectfully request that the Welsh Government consider:

- Safeguarding NDIP-related funding streams within the RPB
- Provide clarity on how the NDIP funding will be distributed and monitored locally past March 2026.
- Ensure parity of investment and strategic focus between children's and adult neurodivergence pathways.

THIS DOCUMENT IS AVAILABLE IN LARGER PRINT AND BRAILLE UPON REQUEST

We welcome correspondence in Welsh and English.
Correspondence received in Welsh will be answered in Welsh and will not lead to delay.
Rydym yn croesawu gohebiaeth yn Gymraeg a Saesneg.
Cewch ateb Cymraeg i bob gohebiaeth yn Gymraeg ac ni fydd yn arwain at oedi.

Civic Centre, Pontypool, Torfaen, NP4 6YB Tel 01495 762200 Fax 01495 766904
Y Ganolfan Ddinesig, Pont-y-pŵl, Torfaen, NP4 6YB Ffôn 01495 762200 Ffacs 01495 766904
www.torfaen.gov.uk

We remain committed to the principles and ambitions of NDIP and are eager to work collaboratively to ensure its success is not undermined by broader financial challenges. We would welcome the opportunity to discuss this further and explore potential solutions that maintain momentum and equity in service delivery.

Thank you for your continued leadership and support.

Yours sincerely

Cllr David Daniels
Chair, Gwent Regional Partnership Board

THIS DOCUMENT IS AVAILABLE IN LARGER PRINT AND BRAILLE UPON REQUEST

We welcome correspondence in Welsh and English.
Correspondence received in Welsh will be answered in Welsh and will not lead to delay.

*Rydym yn croesawu gohebiaeth yn Gymraeg a Saesneg.
Cewch ateb Cymraeg i bob gohebiaeth yn Gymraeg ac ni fydd yn arwain at oedi.*

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Aneurin Bevan University Health Board Key Issues Report

Board Date:	26 th November 2026		
Period of:	04 September to 01 November 2025	Report of:	The Executive Committee

The Executive Committee meets on a weekly basis and focusses on the breadth of the organisation's business. These formal meetings are supplemented by:

- Informal Executive Team Sessions, which are used to focus on strategic developments, information sharing and Executive Team engagement.
- A weekly formal meeting which enables the Executive Team to oversee implementation of the Board's strategic priorities, take decisions and resolve issues which may be impacting delivery.
- A monthly Executive Committee Performance Meeting, which enables the Executive Team to monitor the Health Board's integrated performance to enable a focus on quality, workforce, activity and financial performance.
- Regular Executive Team development sessions focussing on the effectiveness of the Executive Team and its way of working.

Much of the business of the Executive Committee informs onward reporting to the Board's assurance committees, providing assurance to the Board on the effective management of the organisation and achievement of the Board's strategic objectives. The Executive Committee's business also informs much of the Board's formal meeting agendas, given the Executive Team's responsibility for strategy development and its implementation.

The Workplan of the Executive Committee is based on five key areas to ensure appropriate focus, oversight of the organisation's business, and enable the Chief Executive Officer and Executive Team members to discharge their responsibilities effectively:

- Quality, Safety and Culture
- Delivery, Performance and Efficiencies
- Strategic Planning and Service Development
- Strategic Partnership Arrangements
- Transformational programmes.

During the period 04 September 2025 – 01 November 2025 the following matters were some of the issues considered by the Executive Committee.

<p>1</p>	<p>Quality, Safety and Culture</p>	<p>Quality Reports: The Committee received the Annual Quality Report and Putting Things Right (PTR) statutory report which focused on challenges, priorities, and improvement work. The reports contained positive feedback from the Public Services Ombudsman, and it was agreed to combine the Annual Quality and PTR reports in next year’s report.</p> <p>Safety Briefings: At each weekly meeting, the Executive Committee receives a Safety Briefing which includes a summary of recent Patient Safety Incidents, Complaints, Never Events, and Injurious Falls. The Committee also continues to maintain a focus on the performance of the urgent and emergency care system, including ambulance handover delays and red release requests to ensure that the level of risk in the community is balanced across the entire system. A weekly overview of hospital deaths and hospital boarding is also reported weekly as part of the safety briefing. Within this reporting period, notable improvements in falls rates, pressure ulcers, and fire safety compliance were all evidenced, and violence prevention training and support for staff had been highlighted as areas of improvement moving forward.</p> <p>Culture & Staff Wellbeing: The Committee received the Staff survey results which showed an improved satisfaction with teamwork and management, but highlighted workload pressures and work-life balance concerns. The results emphasised the need for further anti-racist training and EDI initiatives, with ongoing investigations and engagement with police on safeguarding matters.</p> <p>Neonatal & Maternity Services: The Committee received regular updates on Neonatal & Maternity services with ongoing improvement plans, risk assessments, and listening exercises. The areas for improvement are acknowledged, with assurance received that care quality is not being impacted.</p>
<p>2</p>	<p>Delivery, Performance and Efficiencies</p>	<p>Performance Management: The Committee received the updated Performance Management and Accountability Framework, with new escalation domains and triggers included. The Committee agreed that Divisions in enhanced escalation may be invited to relevant committees, in order for more support to be offered to them. The Committee</p>

		<p>welcome the updated Framework to include a focus on leadership and governance.</p> <p>Operational Efficiency: During this reporting period, the Committee has seen improvements in ambulance handover times and a reduction in crew hours lost. In addition, the Committee noted successful onboarding of new nurses for winter planning.</p> <p>Benchmarking & Audit: The Health Board has participated in the NHS Benchmarking Network work, with management action plans for improvement put in place. The Committee received the recent financial sustainability internal audit which provided the Committee with substantial assurance on savings processes.</p> <p>Efficiency Opportunities: The Committee was informed of national efforts to rationalise hip and knee prosthesis suppliers, aiming for significant savings. Furthermore, the Committee heard how the Llantrisant Health Park Outline Business Case and the future Endoscopy Plan were all opportunities for future efficiency savings across the Health Board.</p>
3	Strategic Planning and Service Development	<p>Winter Planning: The Committee agreed to proceed with the opening of two additional wards to support winter pressures, emphasising the need for operational clarity and robust workforce planning. While dedicated financial provision for winter pressures was not included in the current plan, the Committee recognised that savings achieved through workforce streamlining could be utilised as a financial buffer to support these measures. In addition to this, the Committee agreed that the Emergency Department extension would also support the creation of additional capacity.</p> <p>IMTP (Integrated Medium-Term Plan) 2026-29 The Committee held a detailed session on the development of the Integrated Planning Framework setting out divisional messaging, financial balance requirements, performance targets, and strategic priorities for the upcoming IMTP.</p> <p>Key performance areas were identified including the single cancer pathway, Referral to Treatment (RTT), mental health access, and efficiency targets.</p>

		<p>The Committee recognised and agreed that all Divisions needed to submit plans which achieve financial balance, prioritise patient safety, balanced budgets and progress against the 12 performance improvement targets set by Welsh Government.</p> <p>Regional Planning: During this reporting period, the Committee maintained a focus on regional planning development, including the development of regional business cases, prior to due consideration by respective boards.</p> <p>Dental Services Reform: The Committee received an update on the Welsh Government Consultation on NHS General Dental Services contract reform and heard there had been concerns about access and workforce implications. The Committee was assured that Operational planning was well underway to prepare for potential service gaps.</p>
4	Strategic Partnership Arrangements	<p>Partnership Reports: The Committee received the Regional Partnership Board (RPB) and Public Services Board (PSB) updates, including priorities, ways of working, and membership changes.</p> <p>During this reporting period, the Health Board has emphasised learning from best practice and other areas with emphasis on collaborative approaches such as those underway in the Greater Manchester area which the Chief Executive had visited recently.</p>
5	Transformational programmes (IMTP/Clinical Futures)	<p>Community Therapy MSK Transformation: The Committee heard how this development is now business as usual, with expansion into Minor Injury Units and improved access. In addition, the Committee heard that recruitment had been successful, with no negative impact on other services. Furthermore, the Committee heard about the ongoing engagement with GPs to refer into community pathway.</p> <p>Planned Care Priority Programme: The Committee received an update in respect of the Planned Care Priority Programme and was informed about progress across health pathways, outpatient transformation, theatre maximisation, diagnostics, and GP interface.</p>

The Committee was informed that current funding for the Keeping Well service was due to end, and that an audit of outcomes was currently underway to inform next steps.

Digital Transformation:

Welsh Community Care Information System (WCCIS)

The Committee received the draft business case for replacing the Welsh Community Care Information System (WCCIS) system, focusing on operational efficiency, staff experience, and data quality.

The Committee was informed that the business case included a seven-year financial plan—two years for implementation and five for service delivery—and identified a funding gap of approximately £4.75 million, mainly due to increased system and device costs. Some capital funding had been secured, but future revenue funding from Welsh Government remained uncertain. The business case was supported for further development, with additional work requested to refine costings, benefit realisation, and risk articulation.

Infrastructure Upgrades The Committee received and approved a presentation outlining the planned network infrastructure upgrades at Royal Gwent Hospital.

The need for these remedial works was emphasised, as they were essential to address clinical risks associated with outdated network components. The Committee was assured that all affected wards had received individual communications outlining the planned impact, and that business continuity arrangements had been put in place. These included support from the digital, emergency planning, and desktop services teams. In addition to this, the Committee heard that on-site accommodation had been secured for staff, which removed the need for travel and associated expenses.

Digital Dictation

The Committee held a discussion on the ongoing G2 system outages, outlining the troubleshooting efforts, identified root causes, and the impact on clinical services.

The Committee heard how the performance issues had been traced to a routine database upgrade that was incompatible

with the current version of G2. The Committee was informed that downgrading the database had resolved the issue, highlighting key lessons around system compatibility and cybersecurity processes.

The Committee agreed to a temporary business continuity solution, subject to clear protocols and guidance and further agreed to accelerate the procurement of the long-term replacement of the G2 system.

End of Life Care Programme: The Committee received a presentation detailing the current status, strategic plans for 2025/26, and key risks associated with the End-of-Life Care Programme.

Significant progress was acknowledged across the four main workstreams:

- **Future Care Planning:** Successful delivery of the Big Conversation engagement event, introduction of new digital tools such as Padlet and updated TEP resources, and positive outcomes from care home pilot projects.
- **Education and Training:** Ongoing roll-out of SAGE & THYME communication training and development of the Care Decisions Guidance (CDG) e-learning module.
- **End-of-Life and Bereavement Care:** Embedding of the GRACE model, launch of bereavement cafés, and 92 referrals recorded since August 2024.
- **Outcome Measures:** Transition of Specialist Palliative Care teams to WCP and EMIS systems, establishment of a dedicated working group to address data gaps, and alignment with national dashboards.

The Committee also noted the priorities of the programme for 2025/26, which include:

- Expanding engagement in Future Care Planning and further developing digital tools.
- Delivering a structured, cross-disciplinary training programme.
- Growing the bereavement support network and improving accessibility.
- Defining meaningful metrics and enhancing data visibility.

Anticipated benefits of the programme were highlighted as follows:

- **For Patients & Families:** Greater dignity, increased ability to die in their preferred place, and improved bereavement support.
- **For Staff:** Enhanced confidence and morale, with a reduced emotional burden.
- **For the System:** Fewer avoidable hospital admissions, improved data quality, and stronger planning

Transformation Programmes

The Committee received a report outlining the current suite of established transformation programmes across the Health Board, each designed to drive system-wide change. These programmes are strategically aligned with national priorities and have been shaped by input from programme leads and executive discussions. Each programme details its key workstreams, anticipated benefits, leadership structures, and associated risks.

The programmes are:

Planned Care Programme

- Focus: Health Pathways, Outpatient Transformation, Theatres Maximisation.
- Targets: 85% theatre utilisation, 156 localised pathways, reduced delayed follow-ups and DNAs (Did Not Attend).
- Risks: Workforce capacity and funding continuity

Transforming Cancer Services

- Focus: Full pathway transformation—prevention, early detection, timely diagnosis, improved and standardised care.
- Targets: Reduce cancer inequalities, achieve 80% HPV vaccination.
- Risks: Funding for digital tools and staffing.

Six Goals for Urgent and Emergency Care

- Focus 1: Urgent Care Close to Home—avoid unnecessary admissions for older/frail people.
- Focus 2, 3 & 4: Signposting, alternatives to hospital admission, rapid response (Single Point of Access, Community Falls Programme).
- Focus 5 & 6: Discharge improvement—optimal hospital flow, home-first approach.
- Target: Improve outcomes for the most at-risk 0.5% of the population.
- Risks: Staffing, funding, digital integration, system-wide capacity, and inter-agency collaboration.

Place Based Care and Population Health

- Focus: Community resilience, reduced inequalities, integrated care.
- Deliverables: Costed implementation plans, workforce and financial strategies.
- Risks: Programme infrastructure and governance delay

Mental Health and Learning Disabilities Transformation

- Focus: Redesign of inpatient/community services, Single Point of Access, crisis response.
- Deliverables: Integrated pathways, crisis protocols, accommodation options.
- Risks: Workstream interdependencies and funding gaps

Clinical Redesign Programme

- Focus: Reconfigured models for older people and acute care.
- Deliverables: Workforce and finance plan, bed plan.

		<ul style="list-style-type: none"> • Risks: Interdependencies, stakeholder engagement, scale of change <p>Decarbonisation</p> <ul style="list-style-type: none"> • Focus: Achieve Net Zero by 2030 through energy efficiency and sustainable practices. • Targets: 16% carbon reduction by end of 2025, 10% reduction in clinical waste and IV paracetamol use. • Risks: Pace of change, funding, and legislative requirements <p>The Committee noted that each programme is underpinned by clear aims, measurable targets, and identified risks. The Committee emphasised that successful delivery relies on strong leadership, sufficient funding, workforce capacity, and effective collaboration across services and agencies.</p> <p>The importance of robust monitoring and regular reporting was highlighted, with progress updates to be provided quarterly. These updates will be shared with the Executive, Planning, and, where relevant, the Finance & Performance Committee, ensuring transparency and accountability. The transformation agenda remains closely aligned with national priorities and is focused on supporting the long-term well-being of the population.</p>
6	Other Formal Business	<p>As standing agenda items, the Executive Committee receives:</p> <ul style="list-style-type: none"> • Quality and Safety Performance Report • Workforce Performance Dashboard • Strategic Risk Report • Financial Performance Report • Activity & Performance Report, including Ministerial Priorities <p>In this reporting period, the Executive Committee has also considered regular updates on staff achievements, awards, and campaigns (e.g., NHS Full of Pride, Lead 6 Dementia Programme, and Nurse of the Year shortlist).</p> <p>In addition, the Committee also provided a number of formal approvals in the way of submission of reports to Board, including Quality, Performance, People Plan, Welsh</p>

		<p>Language Annual Report, and financial procedures. Furthermore, the Committee approved a number of Business Cases including digital upgrades, car parking expansion, and service changes (e.g., Dermatology photo referrals, cessation of Rapid Diagnostic Clinic).</p> <p>The Committee regularly reviews the Strategic and corporate risk registers, with thematic registers for quality and workforce. Quarterly reviews of these registers have been scheduled, and risk mitigation plans developed.</p>
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DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Key Matters from Committees of the Board
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Naomi Murtagh, Board Business Manager

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

In line with the Health Board's Standing Orders, a number of Board Committees and Advisory Groups have been established. This report provides, for assurance, an overview of the business undertaken by these committees during the reporting period, and highlights key matters for Board consideration, where required.

Cefndir / Background

The Health Board's Standing Orders, approved in line with Welsh Assembly Government guidance, require that a number of Board Committees and advisory groups be established. The following Committees and advisory groups have been established:

- Audit, Risk and Assurance Committee
- Charitable Funds Committee
- Patient Quality, Safety and Outcomes Committee
- Mental Health and Learning Disabilities Committee
- People and Culture Committee
- Remuneration and Terms of Service Committee
- Partnerships, Population Health and Planning Committee
- Finance and Performance Committee

Assurance Reporting

The following Committee assurance reports for the period are included at Appendix 1:

- Finance and Performance Committee – 29th September 2025
- Charitable Funds Committee – 30th September 2025
- Patient, Quality, Safety and Outcomes Committee – 1st October 2025
- Partnerships Population Health and Planning Committee – 7th October 2025
- People & Culture Committee – 15th October 2025
- Audit, Risk and Assurance Committee – 21st October 2025

Asesiad / Assessment

In receiving this report, the Board is contributing to the good governance practice of the organisation in ensuring that Committee business is reported to the Board and any key matters escalated, where appropriate.

Argymhelliad / Recommendation

The Board is asked to NOTE for assurance this report, and the updates provided from Health Board Committees.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. There is no direct link to the Plan associated with this report, however the work of individual committees contributes to the overall implementation and monitoring of the IMTP.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Included within the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Committee Chairs

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

Aneurin Bevan University Health Board Key Issues Report

Board Date:		26 November 2025	
Date of Committee		29 September 2025	Report of: Finance and Performance Committee
Quoracy met:		Yes	
1	Agenda and papers	abuhb.nhs.wales/files/key-documents/finance-and-performance-committee/fpc-20250929-final-boardbook-pdf/	
2a	Matters referred to the attention of the Board	<p>The Committee considered several key issues:</p> <ul style="list-style-type: none"> • Outpatient Transformation Programme: The Outpatient Transformation Programme had integrated Welsh Government, internal, and benchmarking initiatives to improve outpatient performance. The GP interface work in 11 specialties was highlighted for its dual role in referral management and learning, with ENT as an early adopter. • Non-pay meetings: Monthly non-pay meetings with all divisions was emphasised as crucial for sharing ideas and best practices, supporting divisions with challenges, and ensuring awareness of national initiatives. This approach surfaced and progressed further savings opportunities and facilitated the sharing of best practices across divisions. • National digital programmes: Updates on 52 active digital projects were provided, with progress and key risks summarised. The Committee were advised that new governance structures had been established to address risks and improve project delivery. • Subject access requests: Subject access requests remained at 100% compliance, and clinical coding performance was improving year-on-year. However, there were 213 information governance incidents, mainly involving information sent to incorrect recipients and documentation issues which were being used to inform learning. 	

		<ul style="list-style-type: none"> • Urgent Care: Urgent Care remained in escalation internally for operational delivery and quality/safety. Improvements had been seen through initiatives such as Next Patient and Task force 45, but are not sustained, and divisions had not yet been de-escalated for finance.
2b	Assurance	<ul style="list-style-type: none"> • Escalation arrangements: Detailed reports on national and internal escalation arrangements were provided, with assurance from the Director of Strategy, Planning and Partnerships. The new performance management framework, supported by Welsh Government, was discussed, and the Committee noted its emphasis on sustaining improvements and ongoing opportunities for review. • Performance: An overview of performance against 2025/26 IMTP Key Performance Metrics was received, including updated data and benchmarking against Ministerial Priorities. Improvements in smoking cessation, child health checks, diabetes care, and community pharmacy services were evidenced with recent data. • Finance Reports: Monthly finance reports and monitoring returns were received, including updated Value and Sustainability Board savings dashboards. Evidence of increased firm savings (from £20.5m to £21.5m) and progress in efficiency opportunities was presented. The Committee expressed confidence in the ongoing work to address financial risks and deliver savings, supported by thematic reviews and monthly non-pay meetings. • National Data Standards Board: The establishment of the National Data Standards Board is leading to the formalisation of data definitions and consistency, supporting external benchmarking and reporting.

2c	Review of Risks	<ul style="list-style-type: none"> • Financial position: Aneurin Bevan’s financial position had deteriorated by £20 million, significantly impacting the overall NHS Wales deficit forecast. • Welsh Risk Pool: A new risk regarding the Welsh Risk Pool had emerged, with contributions potentially increasing to £14–16 million. The Welsh Government advised that they could not cover any increase in this national pressure. • Digital: Changes in the risk profile for digital infrastructure were highlighted, with further discussion scheduled at future Committee meetings. • Cybersecurity: Cybersecurity remained a significant focus and targeted training was being provided following phishing exercises. • Staff absence: The relationship between staff absence and financial risk was questioned, with a need for clarification in future risk papers.
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Aneurin Bevan University Health Board Key Issues Report			
Board Date:		Wednesday 26 th November 2025	
Date of Committee		Tuesday 30 th September 2025	Report of: Charitable Funds Committee
Quoracy met:		Yes	
1	Agenda and papers	Agenda and Papers	
2a	Matters referred to the attention of the Board	<ul style="list-style-type: none"> • Financial Reporting Improvements: The Committee welcomed a new, clearer format for the financial performance report, providing a more balanced view of income, expenditure, and fund composition. This approach was commended for aiding strategic direction and will be shared with the Executive Committee for wider learning. 	

		<ul style="list-style-type: none"> • Small Grants and Bids: Five small grant scheme applications were approved, totalling £25,809. The Committee noted the robust assessment criteria developed for grant applications, which stimulated constructive debate and ensured transparent decision-making. • Large Bid Deferred: A significant bid (“Speaking Up Safely”, £204,000 over three years) was supported in principle, but a decision was deferred pending further breakdown of costs and funding options. The Committee emphasised the importance of affordability and impact assessment before commitment. • Options for Growing the Charity: The Committee discussed benchmarking against other NHS charities and considered options for increasing charitable income, including a staff lottery and enhanced marketing. The preferred approach is incremental, “soft” promotion, leveraging existing touchpoints (e.g., bereavement services, patient awards) rather than aggressive fundraising. • Magazine Proposal: The Committee supported in principle the development of a charity magazine (funded by external advertising, at no cost to the Health Board), subject to further due diligence and legal review. • Fund Utilisation: The Committee continues to monitor slow-moving funds and is working with fund holders to ensure legacy and restricted funds are used in line with donor intent and for maximum patient and staff benefit. Protocols are being developed to ensure timely use of funds, with escalation where plans are not forthcoming.
2b	Assurance	<ul style="list-style-type: none"> • Financial Controls: The Committee received and scrutinised the financial performance report for the first quarter, noting that income and expenditure are both down compared with the previous year, largely due to timing of grant receipts. Investments remain stable, with no significant risks identified. • External Audit: The Committee received the draft accounts and annual report for 2024/25, noting a net decrease in funds due to increased expenditure and reduced income. Audit Wales

		<p>plan and timetable were received, with assurance that the audit is on track for completion within statutory deadlines.</p> <ul style="list-style-type: none"> • Legislative Compliance: The Committee noted ongoing compliance with changes to charity accounting standards and confirmed that recommended actions are either complete or in progress. • Grant Assessment: The Committee was assured by the use of a structured, criteria-based approach to grant approvals, and by the transparency of decision-making. • Fund Monitoring: The Committee reviewed the status of funds with balances over £25,000, noting positive progress in reducing unspent balances and agreeing further actions for funds with limited movement.
2c	Review of Risks	<ul style="list-style-type: none"> • Investment Risk: The Committee noted the transfer of CCLA investments to Jupiter and is undertaking due diligence to ensure ongoing suitability. No immediate concerns were identified. • Income Generation: The Committee recognised the ongoing challenge of declining income and is exploring new, sustainable fundraising options, mindful of reputational and operational risks. • Fund Utilisation: The risk of legacy and restricted funds remaining unspent is being actively managed through regular review, engagement with fund holders, and development of protocols for escalation and reallocation where appropriate. • Large Bid Affordability: The Committee identified a risk in committing to multi-year, high-value bids without clear funding streams. Decisions are being deferred until full information is available. • Audit and Reporting: The Committee is assured that external audit processes are robust and on schedule, reducing the risk of late or qualified accounts.

Date of Committee	Wednesday 1 st October 2025	Report of:	Patient, Quality, Safety and Outcomes
Quoracy met:	Yes		
1	Agenda and papers	Agenda and Papers	
2a	Matters referred to the attention of the Board	<ul style="list-style-type: none"> • Quality Management System & Framework: The Committee received an update on the implementation of the new Quality Management System Framework, including the transition to a revised set of six pillars for reporting from Q2 onwards. The Health Board was recognised as being ahead in this area, but there was a national piece of work ongoing so there may be structured support from NHS Wales and the Health Foundation. • Learning from Patient Experience: A listening event on sepsis and early warning systems was held, highlighting the importance of lived experience in shaping improvement work. Learning from complaints and incidents, particularly around nutrition and hydration, had been shared through the Learning Improvement Forum, resulting in tangible changes to practice. • Ward Accreditation Scheme: The Ward and Team Accreditation Scheme continued to be a significant morale booster and driver of quality improvement, with possible evidence of reduced patient safety incidents in accredited areas (to be evaluated). The scheme was inclusive of all staff groups and was fostering healthy competition across wards. • Positive External Feedback: The Committee noted some positive feedback from recent Health and Safety Executive (HSE) and Healthcare Inspectorate Wales (HIW) visits, particularly in Mental Health and Learning Disability services. Immediate actions from inspections had been completed, and further written reports were awaited. • Patient Safety and Outcomes: The Committee was informed of improvements in patient safety metrics, including the lowest mortality rate (RAMI) in four years, reduced serious incidents, and a downward trend in avoidable harm. • Primary Care and Contract Reform: Ongoing contract reform in primary care, 	

		<p>dentistry, and ophthalmology, with a focus on needs-based care and prevention. The implementation of a centralised dental access portal was improving data on demand and capacity, though challenges remained with waiting times and access.</p> <ul style="list-style-type: none"> • Health and Safety Culture: There had been a significant improvement in health and safety governance, training compliance, and reporting culture. Ongoing development of the Health and Safety Strategy and embedding a culture where health and safety was everyone’s responsibility continues. • Violence and Aggression: The Committee discussed the increase in reported incidents of violence and aggression towards staff, a Violence Prevention and Reduction Strategy was in development. • Contract Monitoring: Primary care contracts for General Medical Services (GMS) were monitored monthly, with formal quarterly reviews and an annual contract assurance framework. Enhanced monitoring was in place where challenges were identified. Patient voice for a variety of services was incorporated through regular engagement with Llais and Patient Reported Outcome Measures (PROMs)/Patient reported Experience Measures (PREMs).
2b	Assurance	<ul style="list-style-type: none"> • Quality Improvement Evidence: The Committee received evidence of sustained improvement in patient safety outcomes, including reduced mortality, falls, and pressure ulcers. The implementation of divisional dashboards and regular engagement with divisions provided robust assurance on quality and safety performance. • Safeguarding: The annual safeguarding report provided assurance that statutory responsibilities were being met, with strengthened governance, increased reporting, and targeted workforce development. Level 3 safeguarding training remained a challenge, but a risk-based approach was being taken to prioritise high-risk areas. • Putting Things Right: The Committee was assured by the significant reduction in long-standing complaints, improved early resolution rates, and positive feedback from the Public Services Ombudsman about the quality of investigations. Ongoing work to improve the

		timeliness of investigations. Learning from complaints was driving quality improvement.
2c	Review of Risks	<ul style="list-style-type: none"> • Health and Safety Risks: While progress has been made, the Health Board’s health and safety risk level remained above appetite. Manual handling, fire safety in older buildings, and timely RIDDOR reporting were ongoing risks, with targeted action plans and capital investment in place. • Violence and Aggression: The increase in incidents of violence and aggression towards staff was a significant risk. The Committee noted the development of a Violence Prevention and Reduction Strategy and the need for continued focus on staff support and security. • Safeguarding Training: Achieving compliance with Level 3 safeguarding training was a risk due to capacity constraints. A risk-based approach was being taken, with prioritisation of high-risk areas and ongoing monitoring. • Contractual Limitations in Primary Care: The limitations of current primary care contracts could restrict the Health Board’s ability to enforce quality standards and data sharing. This was recognised as a national issue, and there was ongoing engagement with Welsh Government and national bodies to try and address these barriers. • Data and Digital Integration: The need for improved data integration and digital dashboards was highlighted as essential for ongoing quality assurance and risk management.

Aneurin Bevan University Health Board Key Issues Report			
Board Date:		Wednesday 26 th November 2025	
Date of Committee		Tuesday 7 th October 2025	Report of: Partnerships Population Health and Planning Committee
Quoracy met:		Yes	
1	Agenda and papers	Agenda and Papers	
2a	Matters referred to the attention of the Board	<ul style="list-style-type: none"> • St Woolos Hospital: The Committee noted the positive direction of travel in the rationalisation of St Woolos Hospital, with staff engagement and welfare being 	

		<p>prioritised during the transition to improved facilities.</p> <ul style="list-style-type: none"> • Engagement on the future of Nevill Hall Hospital was extensive, with feedback focusing on service retention, transport, and the need for clear communication. • Regional planning: The Committee noted ongoing regional planning activities, including the establishment of the Regional Joint Committee and developments in regional orthopaedics and ophthalmology. • Priority programmes: The Committee received an update on the seven priority programmes aligned with the Integrated Medium Term Plan (IMTP), including developments in planned care, cancer services, urgent and emergency care, and mental health transformation. Notably, the opening of the radiotherapy unit and a successful skin cancer awareness campaign were highlighted as positive developments. The Committee welcomed the proposal for more detailed deep dives on priority programmes and recognised the challenges of managing complex, cross-cutting initiatives. • Strategic Planning approach: The Committee acknowledged the need for flexibility in planning, particularly in the context of national uncertainty and potential changes in government policy.
<p>2b</p>	<p>Assurance</p>	<ul style="list-style-type: none"> • Integrated Medium Term Plan (IMTP): The Committee received assurance that the planning process for the next Integrated Medium Term Plan (IMTP) cycle was underway, with a mature approach to demand and capacity planning and lessons learned from previous cycles being incorporated. The Committee received assurance that the priority programmes were progressing in line with the Health Board’s strategic objectives, with clear governance structures, milestones, and risk management processes in place. • Estates Strategy: Updates on the Estates Strategy and the rationalisation of St Woolos Hospital provided

		<p>assurance that capital investment was being prioritised based on risk, clinical need, and opportunity, with robust engagement of stakeholders. The Estates Strategy was being refreshed to reflect changing priorities, with a focus on rationalising existing estate, supporting agile working, and prioritising investment based on risk and clinical need. The Committee noted significant progress on high-priority projects, including the use of existing buildings and targeted capital investment.</p> <ul style="list-style-type: none"> • Engagement: The Committee noted ongoing engagement with Welsh Government and regional partners, particularly in relation to capital investment priorities and regional planning activities
2c	Review of Risks	<p>Risks:</p> <ul style="list-style-type: none"> • Corporate Risk Register: The Committee noted that ongoing work with the Corporate Risk Register continues, with higher-level operational risks now being tracked more visibly. • Programme Risks: Uncertainty regarding national funding for the Health Pathways programme and the need for robust risk management across all priority programmes. • Estates Risks: The deteriorating condition of the older estate at St Woolos Hospital, with significant backlog maintenance and the need for capital investment. • Winter Preparedness: Concerns regarding the absence of dedicated winter funding and the impact on service delivery. • Regional Risks: Ongoing revenue challenges and reduced funding for neurodevelopmental services.

Aneurin Bevan University Health Board Key Issues Report	
Board Date:	Wednesday 26 th November 2025

Date of Committee		Wednesday 15 th October 2025	Report of:	People & Culture Committee
Quoracy met:		Yes		
1	Agenda and papers	Agenda and Papers		
2a	Matters referred to the attention of the Board	<ul style="list-style-type: none"> • NHS Wales Staff Survey: The Committee noted a significant improvement in staff survey engagement, with a return rate of 8.3% by the end of week 2. The approach included drop-in centres, outreach to wards, and incentives such as meal vouchers. Early qualitative feedback highlighted positive staff experiences, including engagement from long-serving staff who had not previously participated. The survey closing date would be 1st December 2025, with results expected in February 2026. • People Plan and Workforce Development: The Committee discussed implementation, success measures, and the need for annual review aligned with staff survey results. Key themes included health and wellbeing, workforce development, and equality, diversity, and inclusion. The Committee highlighted the importance of supporting network groups, professional associations, and ongoing engagement with staff. • Suspensions and Employee Relations: The Committee discussed the challenge of prolonged staff suspensions due to ongoing police investigations, and the need for legal advice and national guidance to resolve these cases more efficiently. • Workforce Changes and Recruitment: The Committee noted continued progress in reducing time to hire, now consistently around 60 days, down from over 100 days, and improvements in job planning compliance and occupational health KPIs. 		
2b	Assurance	<ul style="list-style-type: none"> • Sickness Absence Management: Sickness absence rates remained above pre-COVID levels, currently just under 6.5%. Stress, anxiety, and depression were the leading causes of absence, with a notable increase of 40% of cases. The Committee was assured by the comprehensive data analysis, benchmarking, and action planning in place to address sickness absence. The Committee noted a recent audit of attendance management provided a “reasonable assurance” outcome. The Committee noted the 		

launch of a Respect and Resolution programme in November.

- **DBS Checks:** The Committee received assurance of significant progress in reconciling staff DBS records, with nearly 50% of previously non-compliant records now resolved. The process improvements and ongoing audit were noted as key to maintaining safeguarding standards. The Committee also noted that the Recruitment Modernisation Group had made a DBS blocking check for new starters, providing an additional safety net.
- **Audit Reporting:** A recent audit on attendance management provided reasonable assurance, while the previously limited assurance for the "Speaking Up Safely" process had prompted improvements and a re-audit was now underway.
- **Workforce Performance:** The Committee reviewed the monthly Workforce Performance Dashboard and noted improvements in job planning compliance and recruitment, with time to hire now below target. Increased manager referrals to Occupational Health were seen as a positive sign of active sickness absence management. The Committee was assured by the robust monitoring and reporting processes in place, with the dashboard serving as a key tool for ongoing organisational performance review.
- **Speciality Doctors and Clinical Fellows:** The Committee reviewed progress on the framework for Speciality Doctors, Associate Specialists, Specialist Doctors (SAS), and Locally Employed Doctors (LEDs), noting their increasing importance to the workforce. The Committee was assured that the framework provided clear governance, robust assessment, and structured support for SAS and LED doctors, and would continue to monitor further developments as the programme evolves.
- **Workforce Organisational Changes:** The Committee reviewed significant workforce changes over the past five years, including major service expansions and the opening of the Grange University Hospital. Notable progress was made in reducing vacancies across key staff groups. The Committee highlighted the need for ongoing workforce planning and flexible entry routes in response to changing service demands and a decline in young entrants. The Committee noted all new roles and business cases over £50K were

		subject to a robust approval process to ensure alignment with organisational priorities.
2c	Review of Risks	<ul style="list-style-type: none"> • Workforce Risks: The Committee noted heightened concerns around industrial action due to pay disputes, persistent high sickness absence, recruitment and retention challenges, and the impact of prolonged suspensions; the new corporate risk register aimed to enhance visibility of emerging risks and align with strategic objectives, with a consolidated report due to the Board in January.

Aneurin Bevan University Health Board Key Issues Report

Board Date:		26 November 2025	
Date of Committee		21 October 2025	Report of: Audit, Risk and Assurance Committee
Quoracy met:		Yes	
1	Agenda and papers	abuhb.nhs.wales/files/key-documents/audit-risk-and-assurance-committee/arac-20251021-final-boardbook-pdf/	
2a	Matters referred to the attention of the Board	<ul style="list-style-type: none"> • Clinical Audit: The Committee reiterated concerns about the absence of a comprehensive local clinical audit plan. Assurance cannot be provided until a plan is approved and monitored. • Discharge Planning: Significant delay in closing audit recommendations. A robust update is expected at the next meeting, including alignment of actions with original recommendations. • Job Planning: Progress noted in some areas (e.g., Mental Health and General Practice achieving high compliance), but barriers and operational challenges remain unclear. • Eye Care Services (Audit Wales): <ul style="list-style-type: none"> ○ Regional Visionary Eye Care approach shows positive intent but slow implementation and narrow focus on cataracts. ○ Local planning fragmented; long-term direction unclear. 	

		<ul style="list-style-type: none"> ○ Governance and risk oversight require strengthening. ○ Harm reviews exist but reporting and learning at Committee level need improvement. ○ Workforce shortages (up to 30% reduction in ophthalmologists post-COVID) improving but remain a risk. ○ Board requested updates on delivery against the original business case and value for money. <ul style="list-style-type: none"> • Financial Pressures: Emerging cost pressure (~£1m) due to increased clinical negligence/personal injury claims under £25k and penalties for late “lessons learned” reporting. This will be reflected in Month 06 financial reporting. • Safeguarding: Internal Audit highlighted low compliance with Level 3 safeguarding training for senior staff. Alternative delivery methods (virtual sessions, protected time) are being explored.
2b	Assurance	<ul style="list-style-type: none"> • Financial Governance: All Standing Financial Instructions and Financial Control Procedures are current. Banking arrangements remain efficient and compliant with Government Banking Service requirements. • Internal Audit Plan - Progress against the plan is strong, supported by improved engagement. • Safeguarding audit provided reasonable assurance; controls found robust, with recommendations to improve Level 3 training compliance and SOP updates. • Final Accounts Memorandum presented with five recommendations (Declarations of Interest, working papers, IT controls). Management responses and timelines deemed appropriate. • Declarations of Interest: Assurance provided on implementation of revised policy and progress in embedding processes, supported by an implementation plan. • National Fraud Initiative: Mandatory data matching exercise underway; 7,591 matches identified locally, with investigations progressing. Governance review planned using NFI self-assessment checklist • Risk Management Maturity continues to mature, supported by governance improvements and targeted training.

2c	Review of Risks	<ul style="list-style-type: none">• Corporate Risk Register established with 31 high-level operational risks that could impact strategic objectives.• Financial risk: Increased negligence claims and penalties for late reporting.• Workforce risk: Eye Care Services and safeguarding training compliance.• Operational risk: Delays in implementing audit recommendations (e.g., discharge planning)
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DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Joint Commissioning Committee (JCC) Update Report – September 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Rani Dash, Director of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the NHS Wales Joint Commissioning Committee (JCC) as a Joint Committee of the Board.

Cefndir / Background

The JCC is a Joint Committee of all Health Boards in NHS Wales. Membership of the JCC consists of the Chief Executive Officer of each Local Health Board; an Independent Chair (the Chair); and not more than five Non-Officer Members (NOMs). The Chair and NOMs (to be known as Lay Members) are appointed by the Welsh Ministers. The JCC's membership also includes an Associate Member, who shall have no voting rights, who will be the Chief Commissioner of the Joint Commissioning Committee Team (JCCT). The Chief Commissioner is employed by CTMUHB as the Host Body and this individual holds the Accountable Officer status, as delegated by Welsh Government, for certain elements of their role, namely the propriety and regularity for public finances as delegated to them through the JCC from Local Health Boards.

Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of services as identified below for residents within their area.

- specialised services for: · cancer and blood disorders

- cardiac conditions
- mental health and vulnerable groups · neurosciences, and · women and children.
- services where there is agreement between the Local Health Boards that they should be arranged on a regional or national basis
- emergency medical services
- non-emergency patient transport services
- emergency medical retrieval and transfer services
- NHS 111 services
- sexual assault referral centres, and
- other services as directed by the Welsh Ministers.

Asesiad / Assessment

The Joint Committee last met on 16th September 2025. The papers for these meetings are available at [Meeting Dates and Papers - NHS Wales Joint Commissioning Committee](#).

The Committee's Assurance Report from this meeting is attached at **Appendix A**.

The Committee is due to next meet on 25th November 2025, papers for which can also be accessed at the link above. The assurance report from this meeting will be presented to the Board once made available.

Argymhelliad / Recommendation

The Board is asked to RECEIVE this report by way of an update on NHS Wales Joint Commissioning Committee (JCC) Committee activity.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.
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Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Choose an item.

Glossary of Terms

- EASC – Emergency Ambulance Service Committee
- WAST – Welsh Ambulance Service Trust+

- SDEC- Same Day Emergency Care
- ICAP – Integrated Commissioning Action Plan
- ROSC – Return of spontaneous circulation
- CHARU- Cymru High Acuity Response Units
- NEPTS- Non-Emergency Patient Transport Service
- EMRTS Cymru – Emergency Medical Retrieval and Transfer Service
- CASC – Chief Ambulance Services Commissioner
- BCUHB – Betsi Cadwalader University Health Board
- CTMUHB – Cwm Taf Morgannwg University Health Board
- C&VUHB – Cardiff and Vale University Health Board
- HDUHB – Hywel Dda University Health Board
- SBUHB – Swansea Bay University Health Board
- DHCW – Digital Health and Care Wales
- SEDC – Same Day Emergency Care
- SPC – Statistical Process Control

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee

Dyddiad y Cyfarfod / Date of Meeting	16/09/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Matthew Edwards, Acting Assistant Committee Secretary, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Huw George, Chief Commissioner, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Huw George, Chief Commissioner, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Health Boards	November 2025	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer Members of the Joint Committee with a summary of the key issues considered by the NHS Wales Joint Commissioning Committee (JC) at its public meeting on 16 September 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the JC is set out in Paragraphs 2.18 and 2.20 of the NWJCC [Standing Orders \(SOs\)](#).

3. HIGHLIGHT REPORT

(Links to reports highlighted [September 2025 - NHS Wales Joint Commissioning Committee](#)).

Status	Update
Alert / Escalate	<p>During the meeting, Members:</p> <ul style="list-style-type: none"> • Plastic Surgery Commissioning Project – Members: <ul style="list-style-type: none"> ○ Noted the work undertaken to date on the first phase of the plastic surgery commissioning project to realign commissioning responsibilities for plastic surgery between NWJCC and HBs ○ Discussed the 3 options set out in the paper, namely Option 1 to transfer non-specialised plastics to Health Board commissioning, Option 2 to transfer all plastics to HB commissioning, and Option 3 to retain current arrangements ○ Noted the view and advice of the Collaborative Commissioning Leadership Group (CCLG) and differing advice of NWJCC officers ○ Support the continuity of current commissioning arrangements with a view to realign commissioning responsibility back to HBs through the IMTP, working collaboratively with HBs to identify improved pathway commissioning and to seek assurance from the provider HB that they are addressing the coding issues. • Welsh Kidney Network (WKN) Governance Report – <ul style="list-style-type: none"> ○ Members noted: <ul style="list-style-type: none"> • The independent review undertaken on the governance and reporting arrangements of the WKN • Engagement with the current Independent Chair of the WKN and the agreed actions to be taken in response to the review • Conversations regarding future chairing arrangements for the WKN. ○ Members resolved to: <ul style="list-style-type: none"> • Note the findings and recommendations within the Independent Review Report • Note the management response to the report and actions within to strengthen the governance and reporting arrangements for the WKN in the new NWJCC operating model.
Advise	<ul style="list-style-type: none"> • The Chair's Report noted the recent JC Strategy Session held on 19 August 2025 with a focus on the NWJCC Financial Plan, Cardiac Review (a NWJCC Strategic Priority) and NHS 111 Wales and the NHS Wales Chairs Peer Group meeting held on 26 August 2025.

Status	Update
	<ul style="list-style-type: none"> • The Chief Commissioner's Report included an update on: <ul style="list-style-type: none"> ○ The progress made in relation to implementing the new organisational structure for the NWJCC (with a 32% vacancy rate [August 2025] with key appointments having been made to leadership roles, these would be commencing by 1 October 2025 ○ NWJCC Foundation Plan 2025-26 – correspondence received from Welsh Government confirming the plan had been assessed as satisfactory and a set of accountability conditions has been agreed to support the Plan’s implementation ○ CCLG – meeting held on 26 August 2025 with a focus on plastic surgery, cardiac, cystic fibrosis, specialised immunology and immunoglobulin therapy and the NWJCC IMTP (2026-29) ○ Programmes of Work – an update on a number of national programmes and the need to redirect NWJCC capacity to work on these. The programmes included National Commissioning Arrangements for Third Sector Organisations, Sexual Assault Referral Centres (SARC). • Reports from each of the Commissioning Directors: <ul style="list-style-type: none"> ○ Director of Commissioning for Ambulance Services and 111 Members noted: <ul style="list-style-type: none"> • The Phase 2 of the New Ambulance Response Model in Wales, due for implementation by 31 December 2025 • The multi-faceted review process to ensure a comprehensive evaluation in relation to the Manchester Arena Inquiry • Challenges for the Non-Emergency Patient Transport Service and the cancellation of patient journeys to prioritise the use of resources • The establishment of the 111 Re-Roster Project Board to ensure effective roster practices and to improve access • The update on the Judicial Review in relation to the Emergency Medical Retrieval and Transfer Service • Discussions with NHS Performance and Improvement regarding the future options for hosting the neonatal clinical lead roles. ○ Director of Commissioning for Specialised Services Members noted: <ul style="list-style-type: none"> • The request for Cardiff and Vale University Health Board (CVUHB) to submit a revised business case by the end of

Status	Update
	<p>September 2025 for the expansion of Thrombectomy Service in South Wales</p> <ul style="list-style-type: none"> • Following a formal provider designation process, correspondence sent to Betsi Cadwaladr University Health Board advising that the NWJCC intended to commission the Health Board as a designated Stereotactic Ablative Body Radiotherapy (SABR) provider for the population of North Wales • The Joint Accreditation Committee of the European BMT Society (JACIE) accreditation inspection was taking place week commencing 15 September 2025 • The Project Initiation Document (PID) for Cardiac Review Phase 2, to be delivered in collaboration with CVUHB, Swansea Bay University Health Board, and the Regional Specialised Services Provider Planning Partnership. The Review would be progressed, noting discussions at the JC's Strategy Session in August 2025 around the need for meaningful stakeholder engagement and wider consultation and ensuring robust and inclusive decision-making. <ul style="list-style-type: none"> ○ <u>Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups</u> Members noted: <ul style="list-style-type: none"> • The update provided on the Care Home Framework Agreement, the key risks and matters for escalation and discussions on the potential to extend the existing Framework as a contingency measure • The work being undertaken by SBUHB in relation to the Caswell Clinic and the review by the NWJCC team of the service delivered there to consider the best approach to commission a service which offers good quality and safety alongside value for money • The update provided against the separate agenda item on the work being undertaken by the NWJCC with Cwm Taf Morgannwg University Health Board and Public Health Wales colleagues in relation to Traumatic Stress Wales. • <u>Development of NWJCC IMTP 2026-29</u> – Members noted: <ul style="list-style-type: none"> ○ The update provided on the development of the IMTP to date and discussions at the CCLG meeting in August 2025 to ensure support for the approach and draft Commissioning Principles ○ The IMTP would define the NWJCC's role in supporting Health Boards on delivery for Better Health and Care ○ The IMTP as a Corporate Plan with agreed Commissioning Principles

Status	Update
	<ul style="list-style-type: none"> The timelines as presented including a discussion on high level risks at October's CCLG and a draft IMTP being presented at the JC meeting in January 2026.
Assure	<ul style="list-style-type: none"> Governance & Risk Management: <ul style="list-style-type: none"> The Risk Register at 31 July 2025 was received and approved The Corporate Governance Report including updates on the internal audit programme, new NWJCC Committee Secretary and the Independent Governance Review – Welsh Kidney Network was noted.
Inform	<ul style="list-style-type: none"> The Committee received the Month 5 Finance Report and the Operational Performance Report The Committee received the following assurance reports: <ul style="list-style-type: none"> Quality, Safety and Outcomes Sub-Committee Planning, Performance and Finance Sub-Committee.
Appendices	None.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality	Effective
	Efficient; Equitable; Person-centred; Timely; Safe

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

5. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.



DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Shared Services Partnership Committee (NWSSP) Update Report – September 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Rani Dash, Director of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the NHS Wales Shared Services Partnership Committee as a Joint Committee of the Board.

Cefndir / Background

NHS Wales Shared Services Partnership Committee (NWSSP) was established in November 2010 and became operational in April 2011 and through its work delivers economies of scale; efficiencies and consistency of quality and process for the business and professional services that are directly managed and delivered by local NHS bodies.

The membership is comprised of representatives from each NHS organisation that use the services and from Welsh Government in an observer capacity. The NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General / CEO NHS Wales and Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by an Independent Member, Professor Tracy Myhill OBE.

Asesiad / Assessment

The Joint Committee last met on 30th September 2025 and the papers for meetings are available at [Committee Schedule and Papers - NHS Wales Shared Services Partnership](#) . The Committee Chair's Assurance Report from this meeting is attached at **Appendix A**.

The Committee is next due to meet on 14th November 2025. The assurance report from this meeting will be reported to the Board once made available.

Argymhelliad / Recommendation

The Board is asked to RECEIVE this update report on NHS Wales Shared Services Partnership Committee activity.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. N/A
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A

Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A
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Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Choose an item.



**ASSURANCE REPORT
NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE**

Reporting Committee	Shared Services Partnership Committee
Chaired by	Professor Tracy Myhill OBE, NWSSP Chair
Lead Executive	Neil Frow OBE, Managing Director, NWSSP
Author and contact details	Roxann Davies, Corporate Services Manager and James Quance, Assistant Director of Corporate Services
Date of meeting	30 September 2025
Summary of key matters including achievements and progress considered by the Committee and any related decisions made	
<p>Chair’s Report - The Chair updated the Committee on activities since the last meeting, which included:</p> <ul style="list-style-type: none"> • chairing two meetings of the Welsh Risk Pool Committee in July and September 2025, with both sessions involving substantive discussions on the financial implications of claims. These deliberations continue to inform the broader risk and assurance landscape across NHS Wales; • conducting NF’s appraisal in August 2025, in collaboration with Welsh Government; and • participating in the September 2025 Chairs’ Peer Group Meeting, noting key changes in membership and a substantive discussion was held regarding the staff survey, with particular concern raised over the low response rate. TM welcomed the proactive engagement from Chairs and encouraged reflection on future strategies to enhance staff participation and voice. <p>The Committee NOTED the Chair’s Report.</p>	
<p>Managing Director Update - The Managing Director presented his report, which included the following updates:</p> <ul style="list-style-type: none"> • Welsh Risk Pool (WRP) – A summary of key items from the WRP Committee was provided. At the September meeting a productive discussion was held on risk sharing and financial implications. Positive work is continuing in maternity, obstetrics and consent, with a focus on learning lessons across Wales. • Finance - The financial position was reported with a continued surplus at month 5, although financial risks remain as set out in the finance report. Discussions with Welsh Government regarding Personal Protective Equipment are ongoing. A decision will be required with partners and Welsh Government on the use of any year-end surplus. • Pharmacy Developments - Progress has been made on the Radiopharmacy Service, with panel construction expected to begin shortly and it is anticipated there will be significant physical progress made on-site during October 2025. • The Outline Business Case for the South East Hub has been approved by Welsh Government, and NWSSP has received the approval and funding letter to release the fees for the next stage in terms of the Full Business Case (FBC). In recognising 	

that timescales are tight, with the impact of the upcoming Senedd election, Welsh Government will confirm the final submission deadline for the FBC and organisations must work back from this date, to avoid delays. Discussions are being held in respect of the matters requested to be resolved prior to FBC submission, particularly around clinical trials. Discussions with Cardiff and Vale University Health Board and Velindre University NHS Trust are progressing regarding the model.

- Discussions have been positive in terms of taking forward the North Wales TrAMS programme and a more detailed meeting with the Betsi Cadwaladr University Health Board Chief Executive and the team will be arranged in due course. As regards the South West Hub, unfortunately the preferred site was recently purchased by a third party and therefore the teams are actively exploring alternative site options in West Wales.
- **All-Wales Vaccination Programme** - The programme has delivered approximately 800,000 doses, with nearly 1 million received. The programme is entering the final phase, focusing on redistribution to sites that were initially unable to accept full allocations due to storage limitations and responding to additional requests from sites requiring further supply. A small reserve of purchased vaccines remains available to meet any further demand. In addition, the 400,000 COVID vaccines are arriving at the Imperial Park 5 Newport site, with distribution to commence shortly. NF expressed his personal gratitude towards colleagues for their outstanding efforts in delivering this programme.
- **Senior Appointments** - Colin Powell, Director of Pharmacy Technical Services, will retire at the end of October 2025. Laura-Jayne Keating, the current Deputy Director, will be acting up in an interim role for six months, with a permanent appointment to follow.
- **Laundry Service** - Operations have seen capital investment and operational adjustments, which are expected to yield further savings.
- **Primary Care Workforce Intelligence System (PCWIS)** - The new PCWIS system has successfully launched across all four contractor groups. TM welcomed this development, noting its importance in addressing long-standing workforce risks.
- **Medical Examiner Service** - Winter surge planning has commenced and is informed by lessons learned, arising from last year. A number of sessions with colleagues and Welsh Government have been held as part of this workstream. A Schedule 5 Notice has been received from the Coroner in North Wales regarding a death, and correspondence is ongoing with both the Coroner and the UK Medical Examiner's Office as part of the response.
- **Accommodation** - NWSSP have been working in partnership with the Welsh Ambulance Service NHS Trust (WAST) in terms of consolidating the footprint and rationalising the estate. WAST will move into the top floor of the West Wales Regional Hub at Matrix House, in Swansea. Additionally, as part of the process, WAST will take up occupation of our Samlet Road site.
- **Personal Protective Equipment (PPE)** - Discussions continue regarding the Service Level Agreement (SLA) for PPE requirements. A finalised SLA will be brought to a future Committee for openness and transparency, to ensure the Committee has oversight of the arrangements.
- **Recognition** - The Committee noted that NWSSP was named runner-up in the Wales Team of the Year award at the HFMA Conference. The Committee congratulated the team for the achievement and acknowledged the excellent work of the Oracle teams in cloud development.

The Committee **NOTED** and **DISCUSSED** the Managing Director's Report.

Items for Approval

Transforming Access to Medicines Service (TrAMS) Programme and Service Management Board Terms of Reference (ToR) - The Committee received and approved the revised ToR for the TrAMS Programme and Service Management Board, subject to minor amendments. The revisions reflect feedback from the July meeting and align with the implementation of the new Radiopharmacy Service. The Committee welcomed progress and acknowledged the programme's complexity. Members requested consideration be given as to broader representation beyond Pharmacy, clearer distinction between decision-makers and contributors, and mechanisms to assess governance effectiveness. The final ToR are to be circulated once updated. A six-month review will be undertaken to evaluate effectiveness and inform further refinement.

The Committee **APPROVED** the TrAMS Programme and Service Management Board ToR, subject to the matters outlined above.

Assignment of Lease for Samlet Road to Welsh Ambulance Services NHS Trust (WAST) - The Committee received the proposal to assign the lease for the Samlet Road premises from NWSSP (formally named as Velindre University NHS Trust, on the lease) to WAST. The proposal offers mutual benefit, including a financial saving for NWSSP. The assignment will proceed to the Velindre University NHS Trust Board in November 2025 for final approval and execution.

The Committee **APPROVED** the Assignment of the Lease for Samlet Road to WAST.

Wales Energy Group (WEG) and Wales Energy Operational Group (WEOG) Annual Review of Terms of Reference (ToR) - The Committee received the updated ToR in line with the requirement to review these annually, with minor updates noted. Members raised a strategic challenge regarding the proportionality of current governance arrangements, given the stabilisation of the energy market and it was agreed to review the frequency and structure of meetings, noting that while volatility persists, recent updates from Crown Commercial Services suggest a new form of stability. This will be considered at the next WEG meeting in November 2025.

The Committee **APPROVED** the WEG and WEOG Terms of Reference.

Low Vision Aid Supply and Recycling Service Commitment of Expenditure - The Committee received proposed operational and financial arrangements for the Low Vision Aid Supply and Recycling Service, delivered through NWSSP's Primary Care Services Division. The service operates under an all-Wales contractual framework, endorsed by Welsh Government and procured through standard processes.

The Committee **APPROVED** the proposed arrangements outlined for the Low Vision Aid Supply and Recycling Service Commitment of Expenditure.

Defence Engagement Fellowships – NHS Wales and Defence Medical Services - The Committee received a proposal outlining a new collaboration between NHS Wales and the Defence Medical Services to facilitate Defence Engagement Fellowships. The initiative builds on NWSSP's role as a GMC Sponsorship Organisation and aims to support the placement of foreign military medical professionals into NHS Wales training environments. The proposal centres on a primary, non-legally binding Memorandum of Understanding (MOU) between NWSSP and Defence Medical Services, enabling Defence Medical Services to approach NHS Wales organisations with fellowship opportunities. Participating Health Boards would then enter into secondary MOUs with the relevant foreign military, detailing

employment, funding, and operational arrangements. NWSSP's role is facilitative, providing technical and HR support, with clinical and employment responsibilities remaining with individual Health Boards. The Committee was supportive of the initiative, recognising its strategic value and alignment with international recruitment and workforce development goals.

The Committee **APPROVED** the proposal outlining a new collaboration between NHS Wales and the Defence Medical Services to facilitate Defence Engagement Fellowships.

Items for Noting and Discussion

Personal Protective Equipment (PPE) Preparedness Update - The Committee received a report on PPE Preparedness, outlining the current position regarding PPE stockpiling arrangements. An internal project team is in place to oversee this work and Welsh Government has indicated potential changes to the required stock profile, particularly in relation to hygiene products. Final confirmation is awaited. It is intended that the proposed Service Level Agreement for PPE stockpiling will be brought to the Committee in November 2025. NWSSP will seek to rotate PPE stock through business-as-usual supply chains to minimise the risk of write-downs or write-offs and ensure value for money.

The Committee **NOTED** the PPE Preparedness Update.

Draft Committee Development Day Agenda - The Committee received and noted a verbal update on the agenda for the Development Day on 10 October 2025 at Public Health Wales, Cardiff. The session will focus on strategic planning and cross-organisational engagement, including review of the NWSSP Strategy Map, Ministerial Advisory Group recommendations, and updates on TrAMS and ESR replacement. A placeholder is included for the NWSSP Governance and Accountability Review, subject to report availability. Members confirmed support for the event, recognising its value in shaping NWSSP's future direction and delivery priorities.

The Committee **NOTED** the update provided in relation to the Committee Development Day Agenda.

Finance, Performance, People, Programme and Governance Updates

Finance Report – The Committee noted the financial position as at month 5, confirming a year-to-date surplus of £2.597m, driven by vacancy levels and strategic re-investment. Pay award confirmation is pending, with an estimated cost impact of £3.927m. Capital spend stands at £1.135m against an £8.701m Capital Expenditure Limit, with discretionary funding now fully committed, whilst Public Sector Payment Policy performance remains strong.

People and Organisational Development Report – The Committee received the latest workforce update to 31 August 2025, which highlighted improving sickness absence trends, strong time-to-hire performance, and positive feedback from Welsh Government on equality standards. Key developments include the launch of the Speaking of Safety platform, staff survey communications and external recognition for NWSSP programmes.

Performance Information Report – The Committee received the report detailing the Key Performance Indicators (KPIs) from May to August 2025. The report confirmed that all KPIs were met in August, with continued delivery against stretch targets and NWSSP having generated £53 million in professional influence benefits for the year to date as at

31 August 2025. A review of performance targets is underway as part of IMTP development. There were no areas of concern to be brought to the Committee's attention.

Outcome Measures Report – The Committee received the report focused on outcomes aligned to NWSSP's strategic objectives across services, people and value. NWSSP continues to demonstrate progress in evidencing impact and the overarching report detailed high levels of customer satisfaction, strong employee engagement, and positive impact across procurement, decarbonisation and foundational economy.

Integrated Medium-Term Plan (IMTP) Quarter 1 of 2025-26 Update Report –The Committee received the latest update in respect of progress made against NWSSP's IMTP. The overarching report confirmed that 85% of objectives are on track, with targeted actions in place for off-track items. Key areas of focus included the Medicines Unit, Speaking Up Safely, International Recruitment, the National Ophthalmic Contract for Wales and the Electronic Prescribing Service. There remains work ongoing to strengthen data quality in procurement, progress in equality and diversity, staff well-being, and continued development of digital and recruitment initiatives. NWSSP received a satisfactory rating from Welsh Government for its IMTP submission, with positive recognition from the Cabinet Secretary.

Transformation Management Office (TMO) Update Report – The Committee received an update on the work of the TMO. The overarching report summarised the breadth of transformation activity across NWSSP and national programmes, indicating a stable position with 18 projects, 2 programmes and 5 initiatives currently being tracked. Of which, 2 are red, 7 are amber and 16 are green-rated projects. Overall, the portfolio demonstrates consistent delivery momentum across a diverse range of transformation and service improvement programmes, with 92% of projects rated green or amber and several nearing completion.

NWSSP Corporate Risk Register – The Committee received the latest Risk Register update, which was reported as stable and continues to be scrutinised regularly at each Senior Leadership Group meeting. The latest position identifies 17 risks for action, comprising four red, twelve amber and one yellow-rated risk. In addition, four risks are recorded for monitoring, including one amber and three yellow. The overarching report also outlines four emerging risks currently under consideration.

The Committee **DISCUSSED** and **NOTED** the above Reports.

Options for the Appointment of the Shared Services Partnership Committee Chair

The Vice Chair chaired this item due to the interest declared by the Chair. The Committee reached consensus to **APPROVE** the offer of a 12-month extension to the current Chair's term.

Papers for Information

The following items were provided for information only and the Committee **NOTED** receipt of the reports:

- Integrated Medium-Term Plan 2025-28 Accountability Conditions
- SSPC Forward Plan 2025-26
- Finance Monitoring Returns (Months 4 and 5)
- Personal Protective Equipment (PPE) Reports (August and September 2025)
- NWSSP Audit Committee Assurance Reports (May and July 2025)
- Wales Infected Blood Support Scheme Annual Report 2024-25

Part B - Private	
The Committee received one item for NOTING and DICSUSSION , in the Welsh Risk Pool Expenditure Update. In addition, the Committee received the Draft Welsh Energy Group Minutes of the meeting held on 21 August 2025 and the Welsh Risk Pool and Legal and Risk Services Annual Review 2024-25, for information.	
Any Other Business (AOB)	
No matters were raised under Any Other Business.	
Matters requiring Board/Committee level consideration and/or approval	
The Board is asked to NOTE the work of the Shared Services Partnership Committee.	
Matters referred to other Committees	
No further matters were referred to other Committees.	
Date of next meeting	Friday 14 November 2025, 10.00am to 12.00pm