

Aneurin Bevan University Health Board Public Board

Wed 24 September 2025, 09:30 - 13:00

Conference Centre, St Cadoc's Hospital

Agenda

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

0 min

 PB20250924_Board Consent Agenda.pdf (3 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence for Noting

Oral *Chair*

1.3. Declarations of Interest for Noting

Oral *Chair*

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

0 min

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

Oral *Chair*

09:30 - 09:30 3. KEY UPDATES

0 min

3.1. Update from the Chair

Oral *Chair*

3.2. Update from the Chief Executive

Oral *Chief Executive*

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

0 min

4.1. Patient Experience Story

Presentation *Director of Nursing*

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

0 min

5.1. People Plan 2025-2028

Attachment *Director of Workforce & OD*

- 📄 PB 20250924 Agenda Item 5.1 People Plan 2025-2028.pdf (6 pages)
- 📄 PB 20250924 Agenda Item 5.1 People Plan 2025-2028 Appendix A.pdf (24 pages)
- 📄 PB 20250924 Agenda Item 5.1 People Plan 2025-2028 Appendix B.pdf (19 pages)

5.2. Winter Plan 2025/26

Attachment *Director of Strategy, Planning and Partnerships*

- 📄 PB 20250924 Agenda Item 5.2 Winter Plan 2025-26.pdf (11 pages)
- 📄 PB 20250924 Agenda Item 5.2 Winter Plan 2025-26 Appendix 1a.pdf (4 pages)
- 📄 PB 20250924 Agenda Item 5.2 Winter Plan 2025-26 Appendix 1b.pdf (19 pages)
- 📄 PB 20250924 Agenda Item 5.2 Winter Plan 2025-26 Appendix 2.pdf (2 pages)
- 📄 PB 20250924 Agenda Item 5.2 Winter Plan 2025-26 Appendix 3a.pdf (1 pages)
- 📄 PB 20250924 Agenda Item 5.2 Winter Plan 2025-26 Appendix 3b.pdf (7 pages)
- 📄 PB 20250924 Agenda Item 5.2 Winter Plan 2025-26 Appendix 3c.pdf (1 pages)
- 📄 PB 20250924 Agenda Item 5.2 Winter Plan 2025-26 Appendix 3d.pdf (3 pages)

5.3. Regional Planning

Attachment *Director of Strategy, Planning and Partnerships*

a) Llantrisant Health Park OBC 1

b) Establishment of the South-East Wales Regional Joint Committee

- 📄 PB 20250924 Agenda Item 5.3a Llantrisant Health Park OBC 1.pdf (5 pages)
- 📄 PB 20250924 Agenda Item 5.3a Llantrisant Health Park OBC 1 Appendix A.pdf (135 pages)
- 📄 PB 20250924 Agenda Item 5.3b Establishment of the South-East Wales Regional Joint Committee.pdf (7 pages)
- 📄 PB 20250924 Agenda Item 5.3b Establishment of the South-East Wales Regional Joint Committee Appendix A.pdf (14 pages)

5.4. Performance Management and Accountability Framework

Attachment *Director of Strategy, Planning and Partnerships*

- 📄 PB 20250924 Agenda Item 5.4 Performance Management and Accountability Framework.pdf (7 pages)
- 📄 PB 20250924 Agenda Item 5.4 Performance Management and Accountability Framework Appendix A.pdf (18 pages)
- 📄 PB 20250924 Agenda Item 5.4 Performance Management and Accountability Framework Appendix B.pdf (18 pages)

5.5. General Medical Services

Attachment *Chief Operating Officer*

a) Aberbeeg Medical Centre Outcome of Vacant Practice Process

b) North Celynen Practice – Branch Closure Request

- 📄 PB 20250924 Agenda Item 5.5a General Medical Services.pdf (5 pages)
- 📄 PB 20250924 Agenda Item 5.5b General Medical Services.pdf (7 pages)
- 📄 PB 20250924 Agenda Item 5.5b General Medical Services Appendix A.pdf (16 pages)

09:30 - 09:30 6. ITEMS FOR DISCUSSION

0 min

6.1. Annual Quality Reporting 2024/25:

Attachment *Director of Nursing*

a) Annual Quality Report

b) Annual Putting Things Right Report

- 📄 PB 20250924 Agenda Item 6.1a Annual Quality Report.pdf (6 pages)
- 📄 PB 20250924 Agenda Item 6.1a Annual Quality Report Appendix A.docx.pdf (56 pages)
- 📄 PB 20250924 Agenda Item 6.1b Annual Putting Things Right Report.pdf (6 pages)
- 📄 PB 20250924 Agenda Item 6.1b Annual Putting Things Right Report Appendix A.pdf (36 pages)

6.2. 2025/26 Performance Reporting

Attachment *Executive Leads*

a) Integrated Performance Report, Q1

b) Financial Performance Report, Month 04

 PB 20250924 Agenda Item 6.2a Integrated Performance Report, Q1.pdf (8 pages)

 PB 20250924 Agenda Item 6.2a Integrated Performance Report, Q1 Appendix 1.pdf (12 pages)

 PB 20250924 Agenda Item 6.2a Integrated Performance Report, Q1 Appendix A.pdf (60 pages)

 PB 20250924 Agenda Item 6.2b Financial Performance Report, Month 05.pdf (23 pages)

 PB 20250924 Agenda Item 6.2b Financial Performance Report, Month 05 Appendix A.pdf (28 pages)

6.3. Maternity and Neonatal Services

Attachment *Director of Nursing*

a) Annual Report

b) Assessment against SBUHB's review of Maternity and Neonatal Services

 PB 20250924 Agenda Item 6.3a Maternity and Neonatal Services Annual Report.pdf (4 pages)

 PB 20250924 Agenda Item 6.3a Maternity and Neonatal Services Annual Report Appendix A.pdf (19 pages)

 PB 20250924 Agenda Item 6.3b Assessment against SBUHB's review of Maternity and Neonatal Services.pdf (19 pages)

6.4. General Dental Services Reform Update

Presentation *Chief Operating Officer*

 PB 20250924 Agenda Item 6.4 General Dental Services Reform Update.pdf (16 pages)

6.5. Strategic Risk Report, September 2025

Attachment *Chief Executive*

 PB 20250924 Agenda Item 6.5 Strategic Risk Report, September 2025.pdf (7 pages)

 PB 20250924 Agenda Item 6.5 Strategic Risk Report, September 2025 Appendix A.pdf (45 pages)

09:30 - 09:30

0 min

7. CONSENT AGENDA

7.1. FOR APPROVAL

7.1.1. Draft Minutes of the Health Board Meeting, held on 16th July 2025

Attachment *Chair*

 PB 20250924 Agenda Item 7.1.1 Draft Minutes of Public Meeting Held on 16 July 2025.pdf (15 pages)

7.1.2. Report on Sealed Documents and Chair's Actions

Attachment *Chair*

 PB 20250924 Agenda Item 7.1.2 Report on Sealed Documents and Chairs Actions.pdf (5 pages)

7.1.3. Interim changes to NHS model Standing Financial Instructions

Attachment *Director of Corporate Governance*

 PB 20250924 Agenda Item 7.1.3 Interim changes to NHS model Standing Financial Instructions.pdf (3 pages)

7.2. FOR NOTING

7.2.1. Board Action Log with Updates

Attachment *Chair*

 PB 20250924 Agenda Item 7.2.1 Board Action Log.pdf (1 pages)

7.2.2. Report from Llais, Gwent Region

Attachment *Regional Director, Llais*

 PB 20250924 Agenda Item 7.2.2 Report from Llais, Gwent Region.pdf (13 pages)

7.2.3. Community Therapy MSK Transformation Update Report

Attachment *Director of Therapies and AHPs*

 PB 20250924 Agenda Item 7.2.3 Community Therapy MSK Transformation Update Report.pdf (16 pages)

7.2.4. Social Partnership Duty Report

Attachment *Director of Workforce & OD*

 PB 20250924 Agenda Item 7.2.4 Social Partnership Duty Report.pdf (10 pages)

7.2.5. Welsh Language Annual Report

Attachment *Director of Workforce & OD*

 PB 20250924 Agenda Item 7.2.5 Welsh Language Annual Report.pdf (5 pages)

 PB 20250924 Agenda Item 7.2.5 Welsh Language Annual Report Appendix A.pdf (27 pages)

7.2.6. Strategic Partnership Updates

Attachment *Director of Strategy, Planning and Partnerships*

a) Regional Partnership Board

 PB 20250924 Agenda Item 7.2.6a Strategic Partnership Updates.pdf (6 pages)

 PB 20250924 Agenda Item 7.2.6a Strategic Partnership Updates Appendix A.pdf (3 pages)

7.2.7. Executive Committee Chair's report

Attachment *Chief Executive*

 PB 20250924 Agenda Item 7.2.7 Executive Committee Chair's report.pdf (9 pages)

7.2.8. Key Matters from Committees of the Board

Attachment *Committee Chairs*

 PB 20250924 Agenda Item 7.2.8 Key Matters from Committees of the Board.pdf (10 pages)

7.2.9. An overview of Joint and Partnership Committee Activity

Attachment *Chief Executive*

a) NHS Wales Shared Services Partnership Committee

 PB 20250924 Agenda Item 7.2.9b NHS Wales Shared Services Partnership Committee.pdf (3 pages)

 PB 20250924 Agenda Item 7.2.9b NHS Wales Shared Services Partnership Committee Appendix A.pdf (8 pages)

09:30 - 09:30

0 min

8. OTHER MATTERS

8.1. Any Other Business

8.2. Date of the Next Meetings

26th November 2025

09:30 - 09:30

0 min

9. PRIVATE/IN COMMITTEE SESSION

Motion to Exclude Members of the Public and the Press

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

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

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

AGENDA

Date and Time		Wednesday 24 th September 2025 at 9.30 am	
Venue		Conference Centre, Headquarters, St Cadoc's Hospital	
Item	Title	Format	Presenter
1	PRELIMINARY MATTERS		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence for Noting	Oral	Chair
1.3	Declarations of Interest for Noting	Oral	Chair
2	CONSENT AGENDA BUSINESS		
2.1	The Chair will ask if there are any items from the Consent Agenda (Item 7) that Board Members wish to bring forward to the Main agenda for discussion		Chair
3	KEY UPDATES		
3.1	Update from the Chair	Oral	Chair
3.2	Update from the Chief Executive	Oral	Chief Executive
4	PATIENT EXPERIENCE AND PUBLIC ENGAGEMENT		
4.1	Patient Experience Story	Presentation	Director of Nursing
5	ITEMS FOR DECISION		
5.1	People Plan 2025-2028	Attachment	Director of Workforce & OD
5.2	Winter Plan 2025/26	Attachment	Director of Strategy, Planning and Partnerships
5.3	Regional Planning: a) Llantrisant Health Park OBC 1 b) Establishment of the South-East Wales Regional Joint Committee	Attachment	Director of Strategy, Planning and Partnerships
5.4	Performance Management and Accountability Framework	Attachment	Director of Strategy, Planning and Partnerships
5.5	General Medical Services a) Aberbeeg Medical Centre Outcome of Vacant Practice Process	Attachment	Chief Operating Officer

	b) North Celynen Practice – Branch Closure Request		
6	ITEMS FOR DISCUSSION		
6.1	Annual Quality Reporting 2024/25: a. Annual Quality Report b. Annual Putting Things Right Report	Attachment	Director of Nursing
6.2	2025/26 Performance Reporting: a. Integrated Performance Report, Q1 b. Financial Performance Report, Month 05	Attachment	Executive Leads
6.3	Maternity and Neonatal Services: a. Annual Report b. Assessment against SBUHB's review of Maternity and Neonatal Services	Attachment	Director of Nursing
6.4	General Dental Services Reform Update	Presentation	Chief Operating Officer
6.5	Strategic Risk Report, September 2025	Attachment	Chief Executive
7	CONSENT AGENDA		
7.1	FOR APPROVAL		
7.1.1	Draft Minutes of the Health Board Meeting, held on 16 th July 2025	Attachment	Chair
7.1.2	Report on Sealed Documents and Chair's Actions	Attachment	Chair
7.1.3	Interim changes to NHS model Standing Financial Instructions	Attachment	Director of Corporate Governance
7.2	FOR NOTING		
7.2.1	Board Action Log with Updates	Attachment	Chair
7.2.2	Report from Llais, Gwent Region	Attachment	Regional Director, Llais
7.2.3	Community Therapy MSK Transformation Update Report	Attachment	Director of Therapies and AHPs
7.2.4	Social Partnership Duty Report	Attachment	Director of Workforce & OD
7.2.5	Welsh Language Annual Report	Attachment	Director of Workforce & OD
7.2.6	Strategic Partnership Updates: a) Regional Partnership Board	Attachment	Director of Strategy, Planning and Partnerships
7.2.7	Executive Committee Chair's report	Attachment	Chief Executive

7.2.8	Key Matters from Committees of the Board	Attachment	Committee Chairs
7.2.9	An overview of Joint and Partnership Committee Activity a. NHS Wales Shared Services Partnership Committee	Attachment	Chief Executive
8	OTHER MATTERS		
8.1	Any Other Business		
8.2	Date of the Next Meetings: <ul style="list-style-type: none"> • 26th November 2025 		
9.	PRIVATE/IN COMMITTEE SESSION		
	<p>Motion to Exclude Members of the Public and the Press</p> <p>There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting:</p> <p>“Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.”</p> <p><i>Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960</i></p>		



CYFARFOD BWRDD I ECHYD PRIF YSGOLN
ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	People Plan 2025-2030
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sarah Simmonds - Executive Director of Workforce & OD
SWYDDOG ADRODD: REPORTING OFFICER:	Katelyn Falvey – Assistant Director of Workforce & OD

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

Ar Gyfer Penderfyniad/For Decision

To gain approval from Board for the refreshed workforce and organisational development strategy, our People Plan 2025-2030.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The People Plan 2025–2030 has been developed as a core enabler of the Health Board’s Long Term Strategy and Integrated Medium-Term Plan (IMTP). This is the second development of our People Plan, with the first plan published in 2022 to cover the period to 2025. The progress we made during this time has provided strong foundations for us to build on, whilst recognising that the challenges and opportunities for our people and communities may have shifted since the first plan.

The plan sets out our workforce and organisational development strategy over the next five years, the timeline providing a crucial mid-point review of our 10-year Long Term Strategy and a timely opportunity to review progress mid-way through this journey.

The plan has been developed with consideration of our current and predicted future context, challenges and opportunities. Importantly it has been developed through listening to the feedback from our people and stakeholders.

Cefndir / Background

The first iteration of the Health Board People Plan (2022–2025) set clear ambitions around staff wellbeing, recruitment and retention, and workforce transformation. Over the past three years, significant progress has been made, including:

- Significant reduction in staff turnover and medical/nursing vacancies.
- Reduced reliance on variable pay and avoided costs of c. £34m.
- Launch of the “Speaking Up Safely” framework.
- Expansion of leadership development and the creation of bespoke development for middle managers.
- Expansion and additional opportunities to access training and employment, including increased work experience and volunteering schemes.
- Implementation of new workforce systems and workforce data reporting to support front line services.
- Development of Staff Recognition and Talent Management & Succession Planning Frameworks
- Embedding agile working opportunities.
- Development of a new Values and Behaviours Framework.
- Progress on equality, diversity, and inclusion through the Strategic Equality Plan.

Despite positive progress in a range of areas, workforce pressures remain significant. An ageing population, rising demand and complexity of care, skills shortages across several staff groups, and changing generational expectations about the world of work, mean our refreshed People Plan must prepare us for a new future.

The People Plan has been developed to respond to these challenges and opportunities, building on achievements to date, and ensuring alignment to both national policy and local priorities.

Asesiad / Assessment

Our People Plan (2025-2030) has been shaped by a wide range of national, organisational, and workforce priorities. It reflects the ambitions of our new Long Term strategy and IMTP, whilst aligning with themes emerging from service changes and workforce transformation programmes.

National context has also informed our approach, including the *NHS Wales Workforce Implementation Plan* and profession-specific workforce strategies (e.g. Nursing, Primary Care, Mental Health, Pharmacy, Diagnostics, Genomics). Wider policy drivers such as *A Healthier Wales*, the *Wellbeing of Future Generations Act*, and Equality, Diversity & Inclusion standards (including the Strategic Equality Plan, Welsh Language standards, and Workforce Race Equality Standards) underpin our commitments.

We have also been guided by workforce performance data, such as sickness absence, staff survey results (which indicate priorities around reducing workplace bullying, improving staff engagement, and promoting healthier working environments) and Ministerial workforce priorities.

In addition, the plan has been shaped through comprehensive and inclusive engagement, ensuring it reflects the insights, needs, and priorities of our people and stakeholders. By drawing on staff feedback, Trade Union input, professional networks, and organisational intelligence, the plan is evidence-based, forward-looking, and responsive to both national and local priorities.

Our engagement approach has included:

- Health Board-wide communications via 'news stories' utilising internal digital platforms to keep staff informed and involved.
- Surveys, feedback forms, webinars, and workshops to capture a wide range of perspectives and ideas.
- Divisional outreach through forums, local roadshows, and direct engagement with teams.
- Consultation with EDI networks, professional groups, and Senior Leadership Teams to ensure diverse voices shape decision-making.

This approach ensures our People Plan is not only informed by evidence but also driven by the lived experiences and expertise of those it serves, creating a framework that supports meaningful workforce development and organisational transformation.

The emerging themes identified through our engagement approach have directly informed the development of the new People Plan which is shaped around three strategic pillars; *Better Health & Wellbeing*, *Better Future Workforce*, and *Better Working Lives*. This aligns directly with our Long Term Strategy of *Better Health, Better Care and Better Lives*.

Feedback from staff and stakeholders provided clear and consistent messages about workforce priorities, which have been translated into the key actions and commitments set out in the final Plan. Emerging themes were:

- **Staff Wellbeing and Support:** Wellbeing was identified as a fundamental priority. Staff called for better access to support, earlier intervention in workplace issues, and a culture built on compassionate and restorative people practices. These insights have informed the plan's focus on enhanced wellbeing provision, strengthened accountability, and improved pathways for informal resolution and sickness absence management.
- **Equity, Inclusion and Organisational Culture:** Feedback emphasised the need for inclusion to be fully embedded rather than delivered as isolated initiatives. The expectation that our values of kindness, integrity and respect are consistently demonstrated has underpinned the plan's commitment to making equity, diversity and inclusion a golden thread throughout all activity.
- **Workplace Environment and Digital Enablement:** Staff highlighted the importance of safe, functional environments and reliable digital systems to enable them to work effectively. Their call for flexibility, agility and innovative workforce models has shaped the plan's actions on workforce design, and ambition to align with the developing Digital Workforce Strategy.
- **Career Development and Future Skills:** Opportunities for skills development, career progression and leadership growth were consistently raised. This feedback has influenced the plan's emphasis on succession

planning, leadership development, and preparing a multi-generational workforce for future challenges.

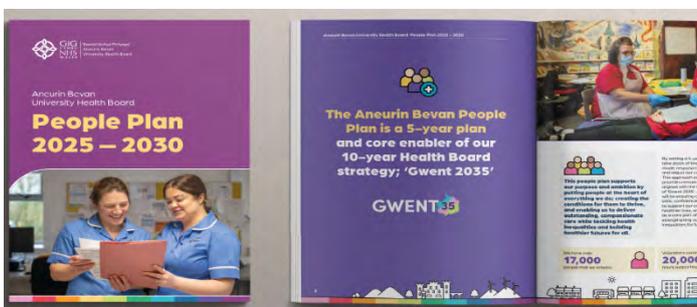
- People Processes and Workforce Systems: Recruitment, induction and job planning processes were identified as areas requiring improvement. Staff welcomed data-led, digitally enabled decision-making but stressed that systems must remain people-centred. These views have directly shaped the plan's priorities to enhance recruitment processes, strengthen workforce systems, and improve people's experience of HR processes.
- Leadership and Management: Staff expressed a strong need for leaders who are well-prepared, supported, and equipped to lead effectively. This has driven the plan's commitment to more targeted leadership development and organisational development interventions to strengthen management confidence and capability.

Together, these themes form the foundation of our People Plan, ensuring that its priorities are firmly rooted in staff voice, aligned with organisational values, and responsive to the workforce challenges ahead.

Delivery of the People Plan will be supported through a detailed Delivery Plan, which will sit beneath the overarching strategy. This Delivery Plan will set out the specific actions, baseline information and data and annual milestones, and measures of success required to translate the Plan's priorities into practice. It will incorporate:

- Commitments within the IMTP, ensuring alignment with organisational planning and resource allocation.
- Ministerial priorities and national expectations, providing assurance that our workforce priorities are fully aligned with Welsh Government requirements.
- Local deliverables and performance measures, capturing the priorities identified through staff and stakeholder engagement and ensuring accountability for progress.

Progress will be monitored through existing governance mechanisms, with regular reporting to the Executive Committee and People and Culture Committee to ensure transparency and oversight. This approach provides a clear line of sight from national and local priorities through to delivery on the ground, ensuring that the People Plan leads to tangible outcomes for staff, patients, and the wider system.



Subject to approval of the People Plan, the format will be amended to reflect that of our Long Term Strategy and Values and Behaviours Framework as shown. In addition, a concise and accessible 'easy read' version will be produced and published in both digital and non-digital formats to ensure broad accessibility for all staff.

Argymhelliad / Recommendation

The Board is asked to:

1. Note the engagement undertaken and the themes that have shaped the Plan.
2. Approve the People Plan 2025–2030

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business are a key element of the Health Board's assurance framework.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7. Staff and Resources 7.1 Workforce Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item.
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	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:	
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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.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

PEOPLE PLAN

2025 - 2030

DRAFT

CONTENTS

TO FOLLOW

INTRODUCTION

The Aneurin Bevan People Plan is a 5-year plan and core enabler of our 10-year Health Board strategy; 'Gwent 2035'. It supports our purpose and ambition by putting people at the heart of everything we do; creating the conditions for them to thrive, and enabling us to deliver outstanding, compassionate care while tackling health inequalities and building healthier futures for all.

By setting a 5-year timeframe, we can take stock of the progress already made, respond to emerging challenges, and adjust our course where needed. This approach ensures our workforce priorities remain dynamic, relevant, and aligned with the long-term ambitions of 'Gwent 2035'. A key part of this will be ensuring our people have the skills, confidence, and opportunities to support our communities in living healthier lives, embedding prevention as a core part of how we work and strengthening our role in reducing inequalities for future generations.

A MESSAGE FROM THE CHIEF EXECUTIVE



I'm proud to introduce our People Plan 2025 - 2030, which builds on the strong foundations of our previous plan and sets a clear direction for how we will support, grow, and invest in our people in the years ahead.

Our people are at the heart of everything we do. This updated plan aligns with our Integrated Medium-Term Plan and is guided by our Organisational Long-Term Strategy, which reflects both national priorities and regional ambitions for the future of public services in Wales. Underpinned by key strategies including 'A Healthier Wales: The Long-Term Plan for Health and Social Care', it will ensure that our actions contribute meaningfully to social, economic, environmental, and cultural wellbeing. As a designated Marmot Region, we

are focused on tackling health inequalities by promoting fair employment and improving outcomes for our communities.

Shaped by the voices and experiences of our people, the plan focuses on three strategic pillars: Better Health & Wellbeing, Better Working Lives, and Better Future Workforce. These reflect both our values and our commitment to investing in the wellbeing, diversity, and future readiness of our workforce. We remain proud of our compassionate and inclusive culture and will continue to foster a working environment built on kindness, integrity and respect.

This plan offers a clear vision of our shared priorities and inspires continued collective effort to make this vision a reality. Thank you for your ongoing dedication and commitment to improving lives across Gwent.

Nicola Prygodzicz

Chief Executive Officer, ABUHB

FOREWORD FROM THE EXECUTIVE DIRECTOR OF WORKFORCE & ORGANISATIONAL DEVELOPMENT

I want to thank all colleagues who shared their feedback, insights, and ideas during the engagement phase. Your voices have helped shape this plan and ensure it reflects what truly matters to our people.



Over recent years, we've seen the unwavering dedication and professionalism of our people, both in times of crisis and in the everyday delivery of safe, person-centred care. It is our people who make the greatest difference across our Health Board.

Our first People Plan laid a strong foundation. It guided us through a period of significant change, including the consequences of the COVID-19 pandemic. The resilience and adaptability shown by our people during this time has been, and continues to be, extraordinary.

Now, as we look ahead with our second phase of the People Plan, we continue to be ambitious in our aspirations. Rooted in three strategic pillars, this plan builds on our progress and sharpens our focus on what matters most: creating a positive and supportive working environment where people feel valued, engaged, and able to grow.

The plan sets out our continued commitment to improving the employee experience, developing leadership, and enabling transformation for the 17,000 people that we employ. It also recognises the contribution of our volunteers who give over 20,000 hours of their time to supporting our services.

Our Plan is a clear roadmap to help us strengthen our workforce, now and for the future and will support. Together, we will continue to shape a thriving, future ready workforce.

Sarah Simmonds

Executive Director for Workforce & OD, ABUHB

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CONTINUING TO BUILD ON ACHIEVEMENTS

This is the second development of our People Plan, with the first plan published in 2022-2025. The progress we made during this time provided the great foundations for us to build on, whilst recognising that the challenges and opportunities for our people and communities may have shifted since the first plan. There are also many aspects of work that remain as important now as they were in 2022, which we will continue to progress further through this plan.

We are proud that by working together, with our people, partners and wider stakeholders we committed to, and achieved the following:

Improved Staff Health and Wellbeing	Employer of Choice	Workforce Sustainability
<ul style="list-style-type: none"> • Coproduced a new Values and Behaviours Framework • Implemented a Speaking up Safely Framework • Improved PADR compliance from 58% to 75% • Introduced 9 new staff Networks to support our people with protected characteristics • Developed an Award-winning Avoidable Employee Harm Programme for best practice in employee relations processes • Celebrated 10 years of Swartz Rounds • Developed our Well-being Service to offer a host of supportive initiatives and introduced an Employee Assistance Package • Embedded Compassionate Leadership approach across our system with refreshed and new leadership programmes delivered to 850 people • Introduced a Health and Wellbeing Passport to support reasonable adjustments at work. • Celebrating and recognising staff and volunteers 	<ul style="list-style-type: none"> • Turnover reduced from 11% to 8% which means less people are leaving the Health Board now • Recruited 90 apprentices in a range of disciplines. • Improvements in our recruitment processes resulting in a reduction in 'Time to Hire' from >150 days to <60 days • Development of a new Nursing, Midwifery & SSCPN Workforce Strategy and associated Learning Academy • Our integrated schools programme reaches >1000 pupils per year – our potential future workforce • Our Volunteer to Career programme supported 20 volunteers into employment • Developed a dedicated approach to Employee Recognition • Introduced a Reverse Mentorship Scheme • Created a network for administrative staff to share experiences and support development opportunities. 	<ul style="list-style-type: none"> • Savings on variable pay - £34 million • Reduced vacancies: Nursing by 300 wte with potential for 0 rostered vacancies by the end of 2025, Medical & Dental by 43 wte and HCSW by 150 wte. • Successful Medical and Nursing international recruitment programmes. • Use of 'Talent Pools', creating a ready supply of employees to fill vacancies more quickly. • Developed 'digital workforce information hubs' that make workforce data more accessible • Implemented E-Systems to support Medical Workforce • Opened 'Ty Gwent' - our first bespoke Agile Working site • Strengthened career pathways such as RCN Wales Healthcare Connect Programme • Introduced and trained managers on our Talent & Succession Planning Framework.

YOUR FEEDBACK

We believe the health, wellbeing, and success of our communities begins with our people. Our vision is to create a healthy, supported, skilled, and engaged workforce; one that is empowered to make a difference, proud to work here, and enabled to deliver outstanding care every day.

To bring this vision to life, we have worked with our people to shape a strategy that reflects their experiences, priorities, and aspirations. Through open conversations, forums, roadshows, surveys, and local outreach, you have told us what is working well, where change is needed, and the actions that would make the biggest difference to your working lives.

You shared that **wellbeing matters**; not only in times of challenge, but every day. You want better access to wellbeing support, earlier help to resolve workplace issues, and a culture where compassionate and restorative people practices are the norm. You called for clearer accountability, informal pathways to address concerns, and targeted support to help manage sickness absence.

You told us that how we work matters just as much as what we do. You want your **voice to be heard** and acted upon, for inclusion to be lived and not left to stand-alone initiatives, and for our values of kindness, integrity, and respect to be woven into everyday practice.

You also spoke about the importance of the **environments** in which you work; safe, functional spaces and modern, reliable digital systems that enable you to do your job well. Flexibility, agility, and innovative workforce models were high on your list, alongside opportunities to grow your skills and progress your career here.

Finally, you told us our **people processes** must work better for you; from faster, clearer recruitment to more supportive induction and job planning. You value data-led, digitally enabled decision-making, but you want it to remain firmly centred on people; and you want leaders who are prepared, supported, and equipped to help you succeed now and in the future.

Everything you told us has shaped this People Plan. It sets out three clear pillars of action for the next five years, each designed to create the conditions for you to thrive.

We have used your insight to shape three pillars that will guide our work over the next five years. Each pillar reflects what you've told us matters most, and each one connects directly to our Long-Term Strategy aims of **Better Health, Better Care, and Better Lives**.

These pillars form the structure of our People Plan. They are our commitment to you: to act on what you've told us, to create the conditions for you to succeed, and to build a workplace where you are proud to be and able to do your best work; every day.

VISION: EMPOWERING OUR PEOPLE TO THRIVE - SO WE CAN CARE BETTER FOR OUR COMMUNITIES

Better Health & Wellbeing

We will create the conditions for every colleague to thrive by embedding wellbeing, inclusion, and psychological safety into our culture. Our focus will be on strengthening the staff wellbeing offer, developing innovative and sustainable Occupational Health solutions, and embedding compassionate and restorative people practices to prevent harm. We will support attendance through proactive, supportive mechanisms, address the factors that influence employee experience, and ensure that every voice can be heard safely. Together, these actions will build a healthier, more engaged, and resilient workforce.

Better Future Workforce

We will work with our partners to create a future-ready workforce that meets the evolving needs of our communities. This will be achieved through strategic, data-led workforce planning, enhanced access to NHS careers, and clear career pathways underpinned by strong progression frameworks and talent development. We will create innovative, flexible roles, transform our ways of working, and grow digital literacy and capability across our teams. By embracing innovation and adaptability, we will build a workforce that is agile, skilled, and prepared for the challenges and opportunities ahead.

Better Working Lives

We will be an organisation where people feel valued, supported, and proud to belong. We will build a diverse and representative workforce by delivering on our Welsh Language, Anti-Racist, and LGBTQ+ commitments, and by widening access through targeted, inclusive recruitment and retention approaches. Our values will shape a positive working culture, supported by modern, flexible, and inclusive work environments. We will strengthen the employee journey through talent mapping, career development, and succession planning, while ensuring recognition of staff and volunteers remains central to engaging our people.

GWENT 2035



BETTER HEALTH AND WELLBEING

A thriving workforce is the foundation of outstanding care. We will create the conditions for every colleague to perform at their best by embedding wellbeing, inclusion, and safety to 'speak up' into everyday working life. Our approach will be proactive, preventative, and focused on resilience, valuing care for our people as much as care for our patients.

We will:

- Embed wellbeing, inclusion, and 'speaking up safely' as part of our long-term culture.
- Strengthen support systems, including sustainable Occupational Health services and restorative people practices.
- Proactively address the factors that enable staff to thrive and reduce sickness absence.

KEY INITIATIVES

Enabling Staff Voice, Inclusion, and Speaking Up Safely

A culture where people feel safe to speak up is essential for trust, innovation, and continuous improvement. We will embed inclusive practices and ensure that all voices are heard and acted upon.

We will:

- Embed employee voice, inclusion, and a Speaking Up Safely culture into our long-term organisational fabric.
- Actively listen and respond to feedback to build trust and transparency.
- Create a culture where everyone feels safe, supported, and confident to speak up and be heard.

Strengthen our Wellbeing Offer

We will expand and diversify wellbeing services, so they are inclusive, accessible, and relevant to all. This means making resources easy to find, proactively preventing issues, and ensuring they meet the needs of every role and circumstance.

We will:

- Offer a wide range of tailored wellbeing services, that meet a range of needs ensuring these are visible and easy to access.
- Promote early support to prevent problems before they arise.
- Integrate wellbeing resources into the everyday work environment.

Sustainable Occupational Health Service

A responsive and future-proof Occupational Health service is essential for maintaining employee health and capability. We will focus on prevention, accessibility, and early intervention to keep our people thriving.

We will:

- Enhance our occupational health service to ensure colleagues can access timely advice, assessments, and interventions.
- Focus on maintaining capability and preventing long-term absence.
- Explore a regional occupational health service, underpinned by digital technology.

Supporting Attendance and Reducing Sickness Absence

Employee attendance is essential for delivering high-quality care, and supporting people to remain in work benefits individuals and teams. We will take a supportive, proactive approach to attendance management.

We will:

- Provide proactive, supportive mechanisms to help people stay in work.
- Address the root causes of sickness absence.
- Recognise and support those returning from absence.

Compassionate and Restorative People Practices

How we handle issues shapes trust and organisational culture. By embedding compassionate and restorative approaches, we will reduce harm and build stronger, fairer relationships.

We will:

- Approach people processes in a fair, supportive way that avoids unnecessary harm for all parties.
- Share best practice, develop and coach managers to address issues early and constructively.
- Promote fairness, respect, and care in all decisions through the application of our policies and people practices.

Optimising Employee Experience

The way our people feel at work directly impacts performance, wellbeing, and retention. We will take a proactive approach to shaping a positive employee experience so that everyone has the best possible chance to thrive.

We will:

- Identify and address factors that influence employee experience.
- Create an environment where everyone will feel valued and supported.
- Measure progress and act on feedback to drive improvement.

Success Measures:

- Provision of a range of wellbeing services that meet the complex and varied needs of people and improve waiting times.
- Reduced sickness absence rates.
- Consistent improvement in Occupational Health key performance indicators.
- Improved scores in staff survey wellbeing and safety culture questions and an increase in the number of people who are confident to speak up safely.
- Reduction in formal grievance and dispute cases.
- Evidence of shared learning to improve employee experience.

The impact of our actions will be evaluated by success measures that will be monitored through regular reporting through our governance arrangements with an annual delivery report to Executive and People and Culture Committees.

BETTER FUTURE WORKFORCE

A better future depends on a workforce that is ready for the challenges and opportunities ahead. We will work with our partners to plan strategically, develop talent, and embrace innovation. By building digital skills, creating flexible roles, and opening routes into NHS careers, we will ensure we have the right people, in the right roles, with the right skills for years to come.

We will:

- Use strategic, data-led planning to shape the future workforce.
- Increase workforce planning capability across the Health Board.
- Expand entry access to NHS careers and strengthen career pathways including volunteering opportunities.
- Drive innovation through flexible roles, transformed ways of working, and growing digital capability.

KEY INITIATIVES

Strategic, Data-Led Workforce Planning

Good planning depends on good data. We will use insight to understand workforce needs, address gaps, and prepare for the future in partnership with others.

We will:

- Collaborate with system partners within and across the regions to plan services, share knowledge, use resources wisely, with a priority focus on workforce planning in support of Place Based Care models.
- Continuously horizon scan population and workforce demographics to inform the delivery of our IMTP and Long-Term strategy.
- Support access to training and development to increase workforce planning capabilities.

Growing Digital Literacy and Capability

A digitally confident workforce is essential for modern healthcare delivery. In line with our Health Board Digital Transformation Strategy, we will secure the foundations for digital transformation by equipping our people with the skills and confidence to make the most of new systems and technology in support of efficiency and sustainability.

We will:

- Align the People Plan with the emerging Digital Workforce Plan
- Optimise the use of digital technology that is already available to us
- Build confidence and capability in digital healthcare delivery.

Enhancing Access to NHS Careers for our Future Workforce

We will open doors for people from all backgrounds to enter and progress in NHS careers, ensuring our people reflect the communities we serve.

We will:

- Increase entry routes into the NHS through apprenticeships or training roles and supported employment.
- Work with schools, colleges, and communities to promote the various NHS careers.
- Work with national partners and education providers to support clear and accessible pathways into health roles.

Creating Innovative, Flexible Roles

Healthcare needs are changing, and so must our roles. We will design adaptable positions that make best use of skills, technology, and new models of care.

We will:

- Prioritise requirements for organisational design and developing high functioning teams to work within new models of service delivery.
- Redesign roles to better meet patient needs and service demands

with a continued focus on enhanced practice recognising the complex needs of our population now and in the future.

- Embrace technology and new models of care.
- Encourage multi-skilled, adaptable teams.

Success measures:

- Increased number of volunteering, apprenticeships, training roles and widened access routes.
- Clear progression frameworks implemented in all key professions.
- Increased number of people trained in workforce planning.
- Workforce plans are aligned with the long-term strategy and IMTP and regularly reviewed.
- Staff survey improvements on digital capability and tools.

BETTER WORKING LIVES

A great employer is one where people feel valued, supported, and proud to belong. We will create an environment where diversity is celebrated, inclusion is lived, and every colleague has the opportunity to grow. We will invest in modern, flexible working arrangements, career development, and recognition so that our people feel motivated, engaged, and able to reach their potential.

We will:

- Build a diverse, representative workforce aligned with our Welsh Language, Anti-Racist, and LGBTQ+ commitments.
- Strengthen inclusive recruitment, retention, and internal and external career development pathways through our Talent and Succession Planning Framework.
- Create positive, flexible, and supportive working environments where our values shape the culture.
- Strengthen how we recognise and celebrate our people.

KEY INITIATIVES

Building a Diverse and Representative Workforce

Our workforce should reflect the communities we serve. We will take targeted action to increase diversity, ensure equity, and create an inclusive environment where all colleagues can succeed.

We will:

- Deliver Welsh Language, Anti-Racist, and LGBTQ+ action plans.
- Identify and proactively overcome barriers to recruitment and career progression.
- Monitor and improve diversity at all levels whilst ensuring staff training reflects empathy and understanding of neurodiversity as an area of growing focus.

Embedding Values and Positive Working Culture

Our values shape how we work and how we treat each other. We will make them a lived reality in behaviour, decision-making, and leadership at every level.

We will:

- Create a cross-organisational steering group to integrate and test the Values and Behaviours framework.
- Model compassionate and inclusive leadership ensuring alignment with all people practices.
- Recognise and address behaviours that fall short of expectations.

Targeted and Inclusive Recruitment and Retention

We need to attract people with the right skills, values, and potential; and retain them. We will use data and insight to target recruitment efforts and strengthen retention strategies.

We will:

- Strengthen approaches to attract and keep the right people.
- Widen access to opportunities for underrepresented groups.
- Showcase our organisation as an employer of choice.

Enhancing the Staff Journey and Career Development

Our people should have clear opportunities to grow, supported by structured, open and inclusive development and progression routes. We will create a career journey that inspires and retains talent and supports local population to access employment and training.

We will:

- Create internal pipelines of future talent through structured progression frameworks.
- Offer high-quality learning and development opportunities from aspiring to experienced levels.
- Provide targeted professional development opportunities.

Accessible, Flexible, and Supportive Work Environments

An environment that offers agile working practices supports collaboration, productivity, and wellbeing. We will optimise opportunities to design spaces, tools, and technology that make work easier, healthier, and more engaging.

We will:

- Work alongside planned changes to estates and services through the implementation of our agile working framework.
- Promote wellbeing through modern, accessible, and supportive workplaces.
- Design working environments that inspire teamwork, inclusion, and pride whilst supporting the decarbonisation agenda.

Recognising and Valuing Our People

Recognition drives engagement and pride. We will ensure that celebrating success is a regular and meaningful part of working life.

We will:

- Promote regular recognition at all levels, celebrating colleagues' achievements and contributions.
- Link recognition initiatives to our organisational values with a calendar of celebration themes.
- Create and implement tools to support teams and managers to regularly celebrate achievements and say thank you.

Success measures:

- Improved diversity and representation across all staff groups and leadership roles.
- Sustained reduction in vacancies and turnover with corresponding improvements in variable pay.
- Higher employee engagement and inclusion scores in the staff survey.
- Increased internal mobility and career progression rates.
- Increase in the number of staff participating in development programmes.
- Employee recognition programme participation and satisfaction levels.
- Created a mechanism to monitor implementation of our values and behaviours framework and other workforce data, by triangulating with quality and patient safety indicators.

DELIVERING OUR PEOPLE PLAN TOGETHER

Delivering our People Plan relies on a shared commitment from us all, working together we can create the culture, environment, and opportunities that enable all of us to thrive and deliver outstanding care for our communities.

LIVING OUR VALUES: THE HEART OF OUR PLAN

At Aneurin Bevan University Health Board, how we work is just as important as what we do. Our recently updated values - **Kindness, Integrity, and Respect** - which have been co-created with our people, are the golden threads running through everything in this strategy. They are not just words on a page; they are the standard we hold ourselves to, the guide for how we treat each other, and the compass for the decisions we make.

These values underpin every aspect of the People Plan. They influence decision-making, guide behaviour, and set the standard for the culture we want to nurture; one that is compassionate, inclusive, and focused on the wellbeing of all.



[Link to Values and Behaviours Framework to be added](#)

In supporting the implementation of the Plan we promise to prioritise:

- Prioritise your health and wellbeing and continue to develop and promote services that support your personal and professional resilience to thrive in work.
- Listen to your voice through open and honest engagement and respond meaningfully.
- Provide fair access to development, progression, and recognition opportunities.
- Create inclusive, respectful workplaces where diversity is celebrated and every colleague feels they belong.
- Equip leaders and managers to lead with compassion, clarity, and accountability.
- Be transparent about our progress and communicate to you our achievements and our challenges.

We ask you to:

- Engage with us honestly: share your views, participate in surveys, and speak up when needed.
- Treat colleagues and patients with dignity, respect, and kindness, in line with our values.
- Be open to learning; embrace opportunities for development, growth, and collaboration.
- Support a culture of inclusion, safety, and shared learning.

- Take shared responsibility for wellbeing: yours, your team's, and the wider organisations.
- Be an ambassador for the Health Board values in how you present yourself professional at work and to provide a first-class service to our population.
- Commit to your role and responsibilities in delivering the best possible care by living our values in everything you do.

The Health Board will deliver the People Plan with an ongoing commitment to working in partnership with staff side colleagues. We have a strong track record on partnership working and recognise the intrinsic value of, and collaborative intent between, the Health Board and the Trades Unions and other professional bodies. Our approach engenders ongoing partnership and engagement processes which are open, collaborative, and timely. The Health Board is committed to hearing the voices of staff and working in partnerships with Trade Unions as well as actively engaging with our diverse workforce. The strategies to implement the People Plan will create opportunities to connect with colleagues informally and formally through our established Trades Union Partnership Forum and Local Negotiating Committee.

Our Workforce and Organisational Development (OD) team will take a lead in supporting the implementation of the People Plan. We recognise that to support this implementation a range of "best-in-class" policies, guidelines, systems and learning offers that will need to be in place to make sure our people have the tools they need to perform at their best. The Workforce and OD team will prioritise the review and development of the support mechanisms that need to be in place to ensure a solid platform for the success of this Plan.

A range of tools, data and access to development opportunities can be found via the Workforce and OD sharepoint page. [Add link here](#)

WHAT SUCCESS WILL LOOK LIKE

Success for this strategy is not just about meeting targets, it's about creating a place where our people genuinely feel they can thrive.

Over the next five years, we will know we are making a difference when:

- **Our people feel valued and supported.** The NHS Wales Annual Staff Survey will become the central way to hear the voices of staff and the results show high levels of engagement, trust, and belonging; with more people saying they would recommend us as a place to work and receive care.
- **Wellbeing is protected and prioritised.** Sickness absence rates are reduced, staff feel able to ask for help early, and support services are accessible, responsive, and trusted.

- **Our culture reflects our values in action.** Speaking up safely is the norm, inclusion is woven into everyday practice, and diversity in our workforce better reflects the communities we serve. Partnership working remains firmly embedded as a core enabler of engaging with staff voices.
- **Careers and development are thriving.** Turnover remains low and/or reduces in some areas as more people progress within the organisation. Volunteering, apprenticeships and supported employment pathways are well used and thriving, and talent pipelines are strong for critical roles.
- **We are 'future ready'.** Workforce plans are strategic and data-led, modern ways of working are embedded, and our digital tools and environments help, not hinder, great work.
- **Our communities feel the impact.** Improved employee experience translates into better patient care, stronger community relationships, and progress towards our 2035 ambition for longer, healthier lives for all.
- This vision of success is about more than numbers. It's about the lived experience of our people every day; because when our people thrive, our communities do too.

As well as measuring our improvements through workforce data we will continue to gather feedback from staff via staff survey and personal experiences will be a central focus for evaluating the impact of the People Plan. Staff Stories provide impactful information on employee experience and how this will shape how we implement people focused initiatives.

Health and Wellbeing Passport:

When I first heard about the Health and Well-being Passport, I was unsure. I wasn't convinced that putting my needs down on paper would really change anything. In the end I decided to give it a go, and it is one of the best decisions I've made.

The passport gave me a way to explain how my neurodiversity affects me at work clearly, honestly, and without fear of judgment. I was able to write down what helps me focus, what can overwhelm me, and what small changes could make a big difference. Things like needing written instructions instead of verbal ones or having a quiet space to work when things get too noisy.

But what surprised me the most was how it helped my colleagues understand me better. Instead of awkward conversations or misunderstandings, we had open, supportive discussions. My manager took the time to read my passport and asked how they could help. That meant a lot to me.

With small but meaningful adjustments in place, I didn't just manage in work, I flourished. I felt seen, respected, and supported. I could finally bring my whole self to work without fear and that has made me more confident, more productive, and more connected to my team.

The Health and Well-being Passport didn't just help me stay in work it helped me thrive. It turned what used to feel like barriers into bridges. And for the first time in a long time, I feel like I truly belong.

Supported Career Development:

I joined the Health Board in September 2024 when I joined the RCN Connect Programme working at the Grange on the Surgical Assessment Unit. I completed the course in March 2025 with a view to enrolling on a full-time Nursing course in September 2025. When my 6-month fixed term contract came to an end, I was given a permanent contract which was really helpful to me as I am getting married in August and we have just bought our first house.

When I heard there was an opportunity to study flexibly, I was really interested in this as it allowed me to earn a salary while learning and so I jumped at the chance! I have now been accepted onto a flexi-nursing course with USW which I am starting in September and I'm really looking forward to starting on my journey to becoming a Registered Nurse. I can't thank the whole team at Aneurin Bevan enough from my Line Manager to the Recruitment Team to the Nurse Education Team – I couldn't have done it without their support.

Agile Working at Ty Gwent:

I was initially concerned with the move to Ty Gwent and an open plan office environment, as my team had previously had its own dedicated office and we didn't want this to change. We were engaged with the design of our working space and there was engagement throughout the process and during the moves.

The team has settled down now in Ty Gwent in our dedicated space. We have found that having the team working in one single location has been better for linking in with our everyday work. The premises are great, central location, clean and tidy, they aren't cramped as our initial thoughts. We had concerns of sharing spaces but everyone at Ty Gwent respects the facilities. What has worked well for my team is being able to continue to work in an agile way. The meeting rooms and breakaway space have been welcomed as places to go and work or have conversations with other staff when needed.

THE CHALLENGES AHEAD – LONG TERM PROFILING

Whilst our achievements have provided solutions and benefits to our workforce and communities, our long-term profiling tells us that population and demographic changes mean our plans need to be agile to change, to ensure our people are still able to provide the best health and care to our communities and future generations, relevant to their needs.

Over the next 5 years, the population of Gwent is due to increase by 15,897 (2.6%), with the highest proportion of growth in older adults age 65+ (+13,923) as people are living longer with

more complex co-morbidities, widening inequalities and increased health and social care needs.

At the same time, our workforce profile will age as we have seen a steady reduction in birth rates; by 2030 there will be 6,049 less children under 16 in Gwent (-5.6%). This means the number of young adults choosing to work in a healthcare role will reduce, whilst demand for healthcare will increase.

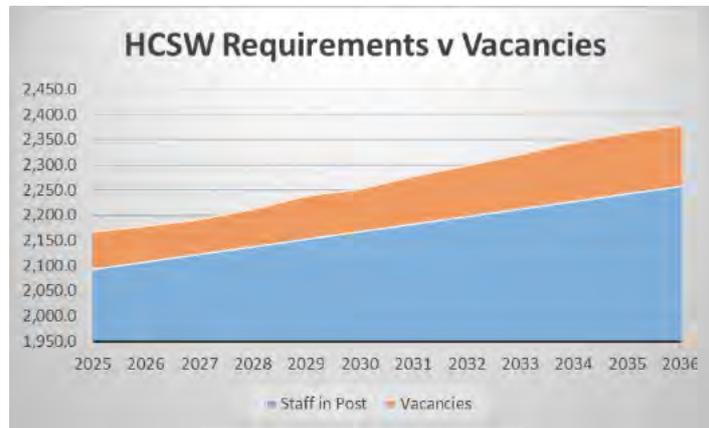
Therefore, our People Plan 2025-2030 is crucial in recognising these challenges and changing demographics to design our models of care. We know we will have to work differently, compete with career opportunities outside of healthcare and support the changing needs of our people and communities.



Looking ahead, we know that the shape of our workforce will need to change to meet the demands of the next decade. The following workforce projections help us to consider what our teams may look like over the coming years, highlighting where growth, new roles, and different skills may be needed. These insights guide how we recruit, develop, and retain our people to ensure we have the right workforce in place to deliver safe, high-quality, and sustainable care for our communities.

The 10-year workforce forecast is based on current turnover, age profiles, and growth trends. It does not yet factor in future changes such as population growth, new workforce models, or emerging education and training pipelines beyond 2029. It also does not account for wider enabling actions, including advances in Artificial Intelligence, robotics, genomics, or evolving population health needs; which will be essential to supporting an ageing population and rising demand for services.

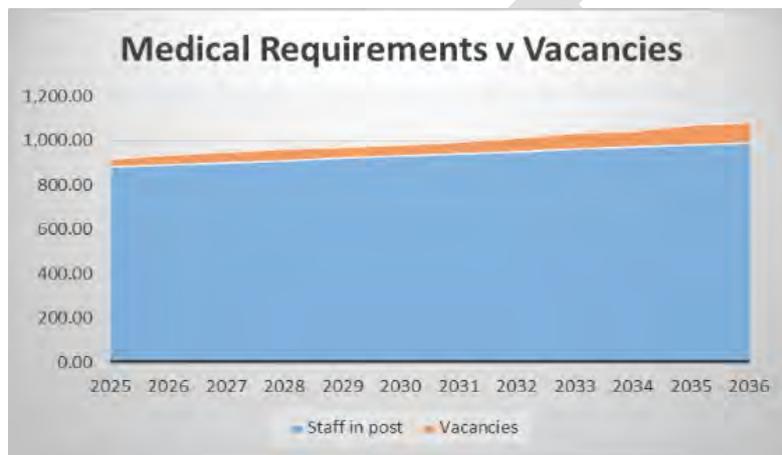
Healthcare Support Workers (HCSW): The HCSW workforce is projected to grow steadily over the next decade, reflecting both increasing demand for direct patient care and the vital role support staff play in new models of care. While our data indicates that vacancies may increase due to the ageing nature of the workforce, we have a strong track record of filling these roles and will continue to strengthen the pipeline through targeted recruitment, development, and retention initiatives, ensuring a sustainable workforce for the future.



Registered Nurses: The graph illustrates our projected nursing workforce over the coming years based on previous growth trends. Thanks to targeted workforce planning and strategic recruitment initiatives, we have successfully strengthened our registered nurse pipelines, placing us in a position of relative stability. This projection assumes that current efforts and approaches continue at the same pace; however, we recognise that this “status quo” scenario may not reflect future realities. Increasing healthcare demands, driven by our changing population demographics, will place additional pressure on our services. To meet these future needs, it is essential that we continue to invest in, develop, and expand our nursing workforce, ensuring that we can maintain safe, high-quality care for the populations we serve.



Doctors: The graph illustrates our projected medical workforce over the next ten years. The number of staff in post is expected to grow, as demand for doctors is projected to rise based on previous growth trends, creating a widening gap between supply and demand. This projection takes into account previous trends, an ageing workforce, and the increasing number of Certificate of Completion of Training (CCT) holders up to 2029. Although sustained investment in training places and the development of CCTs has strengthened our workforce pipeline, these measures alone will not be sufficient to meet future needs. To address this growing shortfall and ensure safe, high-quality care, ongoing investment in recruitment, retention, and workforce development and widening contribution from multi-disciplinary workforce to support delivering of patient care will be essential.



We will review our long-term projections on an annual basis in line with wider changes and service models outlined in future IMTPs to continue to understand the impact on requirements for:

- Education and Training commissioning and training scheme changes.
- Working with Higher Education and HEIW to provide positive training experiences to secure trainees returning as our future workforce.
- Reviewing our skill mix and workforce profiles.
- Impact of international recruitment pipelines increasing or declining
- Consider developing and increasing enhanced practice roles in existing and new areas
- Newly developed national roles (e.g. Registered Nurse Associate) and new national job profiles and impact on skill mix
- Supporting career pathways and in particular impact on retaining our existing staff
- Impact on how we attract in the future with the impact of wider competition from other sectors, digital and technological advances and new ways of working

Our projections will support us evaluating the plan and inform our IMTP workforce plans over this period.

GOVERNANCE AND REPORTING

Strong governance is about learning, adapting, and making things happen, not just a tick box exercise.

These arrangements are key to making sure our People Plan works. They help us turn our goals into action, track progress, and stay accountable to our staff for the commitments we've made.

Everyone has a part to play. From Board leaders to team members, delivering this Plan is a shared responsibility.

By having clear reporting, accountability, and shared ownership at all levels, we'll make sure the People Plan isn't just words, but drives real, measurable improvements.



The governance framework will be supported by:

- Regular review of corporate and strategic risk registers.
- Staff Engagement.
- Established cross organisational working groups addressing core issues such as sickness absence, flexible working, speaking up safely, retention, PADR and HCSW education which operate in partnership with Trades Union colleagues and professional and operational leaders to work collaboratively to deliver outcomes.
- Internal and External audit and review processes.
- Scrutiny of regular reporting data and key performance indicators and outcome/success measures. This will include core measures reported via the Integrated Quality Report provided to Board.

This will support the plan being a living framework with annual milestone reviews providing the ability to adjust for social, political, economic and technological changes as well as changing requirements of our service demand and population need. Detailed reports showing changes to baseline data over time on specific measures outlined linked to our plan will be provided to Executive and People and Culture Committees of progress and impact by each pillar with an annual outcome measure report.

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APPENDIX IMPLEMENTING OUR PEOPLE PLAN

Our five-year implementation plan focuses on delivering sustainable impact by sequencing initiatives in a way that builds strong foundations before moving into deeper cultural embedding and, finally, system-wide innovation. Annual operational plans will be developed to support the achievement of the *People Plan*.

- Embedding and Expanding: Builds on the foundations of the previous People Plan through deep cultural embedding, development of career pathways, targeted inclusion work, and enhanced staff recognition.
- Innovating and Partnering: Improving on the platform built in the first two years to drive innovation, pilot new role models, forge system-level partnerships, and maximise the impact of data-driven workforce improvements.
- Sustaining and Maturing: Extends the most successful initiatives across the whole organisation, embedding them into business-as-usual. Focus shifts to continuous improvement, workforce mobility and future skills and partnerships remain fit for the future.

This phased approach ensures that our efforts are focused, achievable, and adaptable; avoiding the risk of doing too much at once, while creating the conditions for sustained success.

STRATEGIC COMMITMENT	INITIATIVE	2026	2027	2028	2029	2030
BETTER HEALTH AND WELLBEING	Enable Staff Voice, Inclusion & Speaking Up Safely	Implementation	Embedding	Embedding	BAU (Business as Usual)	
	Strengthen our Wellbeing Offer	Implementation	Embedding	Embedding	BAU (Business as Usual)	
	Sustainable Occupational Health Service	Design	Implementation	Embedding	BAU (Business as Usual)	
	Compassionate and Restorative People Practices	Design	Implementation	Embedding	Embedding	BAU (Business as Usual)
	Supporting Attendance and Reducing Sickness Absence	Implementation	Implementation	Embedding	Embedding	BAU (Business as Usual)
	Optimising Employee Experience	Embedding	Implementation	Embedding	Embedding	BAU (Business as Usual)
BETTER WORKING LIVES	Building a Diverse and Representative Workforce	Implementation	Embedding	Embedding	Embedding	BAU (Business as Usual)
	Targeted and Inclusive Recruitment and Retention	Design	Implementation	Embedding	Embedding	BAU (Business as Usual)
	Embedding Values and Positive Working Culture	Implementation	Embedding	Embedding	Embedding	BAU (Business as Usual)
	Enhancing the Staff Journey and Career Development	Design	Implementation	Embedding	Embedding	BAU (Business as Usual)
	Modern, Flexible, and Supportive Work Environments	Design	Implementation	Embedding	Embedding	BAU (Business as Usual)
	Recognising and Valuing Our People	Embedding	Implementation	Embedding	BAU (Business as Usual)	
BETTER FUTURE WORKFORCE	Strategic, Data-Led Workforce Planning	Implementation	Embedding	Embedding	Embedding	BAU (Business as Usual)
	Enhancing Access to NHS Careers	Design	Implementation	Embedding	Embedding	BAU (Business as Usual)
	Strengthening Career and Volunteering Pathways for Future Workforce		Implementation	Embedding	Embedding	BAU (Business as Usual)
	Creating Innovative, Flexible Roles	Design	Design	Implementation	Embedding	BAU (Business as Usual)
	Growing Digital Literacy and Capability	Design	Implementation	Embedding	Embedding	BAU (Business as Usual)



Integrated Impact Assessment		 GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board
Ref no:		
Name of the policy, service, scheme or project: People Plan 2025 - 2030	Service Area Workforce and OD	
Our Values are....		
Mae ein Gwerthoedd yn.....		
<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>People First</p> </div> <div style="text-align: center;"> <p>Personal Responsibility</p>  </div> <div style="text-align: center;"> <p>Passion for Improvement</p>  </div> <div style="text-align: center;"> <p>Pride in what we do.</p>  </div> <div style="text-align: center;">  <p>Pobl yn Gyntaf</p> </div> <div style="text-align: center;"> <p>Cyfrifoldeb Personol</p>  </div> <div style="text-align: center;"> <p>Brwdfrydedd dros Wella</p>  </div> <div style="text-align: center;"> <p>Balchder yn yr hyn a wnawn</p>  </div> </div>		
Preparation		
<p>The purpose and aims of the policy, procedure, strategy or decision required</p> <p>Please include;</p> <ul style="list-style-type: none"> • the overall objective or purpose • the stated aims (including who the intended beneficiaries are) • a broad description of how this will be achieved • the measure of success will be • the time frame for achieving this • a brief description of how the purpose aims of the policy are relevant to equality and intended beneficiaries. 	<p>The People Plan 2025–2030 is a 5-year workforce strategy that underpins the Health Board’s long-term vision, <i>Gwent 2035</i>.</p> <ul style="list-style-type: none"> • Overall Objective / Purpose: To place people at the heart of everything we do, creating conditions for staff to thrive and enabling the delivery of outstanding, compassionate care while tackling health inequalities and building healthier futures for all • Aims (and intended beneficiaries): <ul style="list-style-type: none"> ◦ To improve staff health and wellbeing. ◦ To create a positive, inclusive working environment where diversity is valued. ◦ To ensure a future-ready workforce through recruitment, retention, and development. ◦ Beneficiaries include all Health Board staff, prospective employees, patients, carers, and the wider Gwent community. • How this will be achieved: Through three strategic pillars: 	

	<p>0. Better Health & Wellbeing – embedding wellbeing, inclusion, and psychological safety.</p> <p>1. Better Working Lives – building a diverse and representative workforce with inclusive recruitment and supportive environments.</p> <p>2. Better Future Workforce – strategic workforce planning, career pathways, apprenticeships, and digital literacy.</p> <ul style="list-style-type: none"> • Measures of success: Improved staff survey results, reduced sickness absence, greater diversity, reduced vacancies and turnover, improved access to NHS careers, and enhanced digital capability • Timeframe: Five years (2025–2030), aligned with annual reviews and milestones. • Relevance to equality: The strategy explicitly commits to anti-racist practice, Welsh Language Standards, LGBTQ+ inclusion, carer support, and widening access for underrepresented group
<p>Who is the Executive Sponsor?</p>	<p>Director of Workforce & Organisational Development</p>
<p>We have a legal duty to engage with people with protected characteristics under the Equality Act 2010 identified as being relevant to the policy.</p> <ul style="list-style-type: none"> • What steps will you take to engage and consult with stakeholders, (internally and externally)? • How will people with protected characteristics be involved in developing the policy, procedure, strategy and or decision from the start? • Outline how proposals have/will be communicated? • What are the arrangements for engagement as the policy/procedure/strategy or decision is being implemented? 	<ul style="list-style-type: none"> • Internal stakeholders: Staff engagement through surveys, forums, networks, workshops, and direct feedback (e.g. staff stories included in the Plan). • External stakeholders: Engagement with partners including trade unions, schools/colleges, national workforce bodies, and community representatives. • Protected characteristics involvement: Networks representing protected groups (LGBTQ+, Disability, Carers, Ethnic Minority staff) were consulted. • Communication: Roadshows, surveys, intranet updates, and formal governance reporting.

	<ul style="list-style-type: none"> • Implementation engagement: Ongoing through annual review cycles, partnership forums, and staff-side collaboration • _____
<p>Does the policy assist services or staff in meeting their most basic needs such as;</p> <ul style="list-style-type: none"> • Improved Health • Fair recruitment etc. 	<ul style="list-style-type: none"> • Yes – It promotes improved health, fair and inclusive recruitment, flexible working, career progression, recognition, and a safe, supportive environment.
<p>Who and how many (if known) may be affected by the policy?</p>	<ul style="list-style-type: none"> • Directly: approx. 16,000 staff across Aneurin Bevan University Health Board. • Indirectly: Patients, carers, and local communities who benefit from improved care delivered by a well-supported workforce.
<p>In review of the Well-being of Future Generations Act Which Well-being Goals does this contribute to and how?</p> <p>Please select from drop down box, if multiple, please list.</p> <p>If none, how will it be adapted to contribute to one?</p>	<p>A More Equal Wales</p> <ul style="list-style-type: none"> • A More Equal Wales – by tackling workforce inequality and promoting fair employment. • A Healthier Wales – by improving staff wellbeing and embedding prevention. • A Wales of Cohesive Communities – by building a workforce representative of the communities served. • A Wales of Vibrant Culture and Thriving Welsh Language – through Welsh language commitments and bilingual services.
<p>Evidenced used/considered</p> <p>Your decisions must be based on robust evidence. What evidence base have you used in support?</p> <p>Evidence includes views and issues raised during engagement; service user or citizen journeys, case studies, or experiences; and qualitative and experience based research, not just quantitative data and statistics.</p>	<ul style="list-style-type: none"> • Staff survey results and engagement feedback (forums, roadshows, surveys, networks). • Workforce data including demographics, turnover, vacancy rates, sickness absence. • Equality and inclusion data, including representation by protected characteristic. • External research and best practice e.g. Marmot Region principles, NHS workforce strategies.

Please list the source of this evidence;

- Identify and include numbers of staff, broken down by protected characteristics and other relevant information
- What research or other data is available locally or nationally that could inform the assessment of impact on different equality groups? Is there any information available (locally/nationally) about how similar policies/procedures/strategies or decisions have impacted on different equality groups (including any positive impact)?

Do you consider the evidence to be strong, satisfactory or and are there any gaps in the evidence?

- National/local evidence on recruitment, retention, and equality gaps.
- Strong evidence, but ongoing monitoring will address gaps in representation data and long-term projections

Our Values are....



Mae ein Gwerthoedd yn.....



Does the policy/area of work align with our values?
Please explain why.

Yes. The People Plan is explicitly underpinned by the updated Health Board values – Kindness, Integrity, and Respect

Does this policy/area of work impact on the Armed Forces Covenant?
The new Duty requires the NHS to consciously consider the Armed Forces Community when developing policy and making decisions in the

The Plan recognises the unique needs of protected groups. It supports fair access to employment and career progression and therefore aligns with the principles of the Covenant. The People Plan is underpinned by a strategic Programme of work specifically around Armed Forces.

<p>specified policy areas, taking the three principles set out below into consideration.</p> <ol style="list-style-type: none"> 1. Recognizing the unique obligations of, and sacrifices made by, the Armed Forces. 2. That it is desirable to remove disadvantages arising for service people from membership, or former membership, of the Armed Forces. 3. That special provision for Service People may be justified by the effect on such people of membership, or former membership, of the Armed Forces. 	<ol style="list-style-type: none"> 1. Recognising the unique obligations and sacrifices <ul style="list-style-type: none"> • Values and culture emphasise respect for service and sacrifice. • Wellbeing support recognises impact of deployment and service-related health needs. 2. Removing disadvantages from service membership <ul style="list-style-type: none"> • Recruitment considers transferable military skills. • Flexible working supports reservists. • Equal access to training, career progression, and wellbeing services. 3. Justifying special provision where needed <ul style="list-style-type: none"> • Tailored recruitment pathways for veterans. • Occupational health support for service-related conditions. • Partnerships with Armed Forces networks to provide targeted support
<p>The Health Board published its Strategic Equality Objectives in 2020 for the period 2020-24. Does this policy/ area of work meet the objectives?</p>	
<p>Objective 1: Work in partnership to reduce all hate crime.</p>	<p>NA</p>
<p>Objective 2: Work in partnership to reduce the incidence of domestic abuse, ‘honour’ based violence and elder abuse</p>	<p>NA</p>
<p>Objective 3: Work in partnership with carers to continue awareness raising, provide information, and improve practical support for carers.</p>	<p>NA</p>
<p>Objective 4: Improve the wellbeing and engagement of our staff.</p>	<p>The People Plan focuses on 3 key pillars, with one being Improved Staff Health and Wellbeing, with key strategic objectives to continually improve staff wellbeing and engagement.</p>

Objective 5: 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.	Improve patient experience by ensuring services are sensitive to needs – Indirectly supported through a stronger workforce
Objective 6: Improve the access, experience and outcomes of those who require Mental Health and Learning Disability services.	The People Plan focuses on improved employee experience and Wellbeing which in turn will improve patient experience across the Health Board
Objective 7: Improve the experience of lesbian, gay, bisexual and Trans (LGBTQ+) service users and staff.	Our Strategic Equality Plan (SEP) underpines our People Plan and through that work a collaborative LGBTQ+Action Plan is currently in development.
Objective 8: Gender and Pay – Develop a fuller understanding of the reasons for any differences in pay and take the necessary action to address this.	Our Strategic Equality Plan (SEP) underpines our People Plan and through that action plan, Gender Pay and Race Pay Gaps is reviewed ongoing with actions to address these gaps.
Who is involved in undertaking the EQIA	The Senior Workforce and OD Team

This section of the form is completed by the policy/ work area lead prior to attending the EQIA group meeting. If you need support in completing this section please email ABB.EDI@wales.nhs.uk

Equality Duties, Sustainable Development Principles

Does the policy/procedure, strategy, e-learning, guidance etc meet <ul style="list-style-type: none"> Public Sector & specific duties -Equality Act 2010 Welsh Language Standards (2011) Sustainable Development Principles? 	Protected Characteristics									Additional		WBFG Principles				
	Race	Sex/Gender	Disability	Sexual orientation	Religion and Belief	Age	Gender reassignment	Pregnancy and Maternity	Marriage/ civil Partnerships	Welsh Language	Carers	Long Term	Collaboration	Involvement	Prevention	Integration
To eliminate discrimination and harassment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-					
Promote equality of opportunity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					
Promote good relations and positive attitudes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					
Encourage participation in public life	-	-	-	-	-	-	-	-	-	-	-					
In relation to disability only, should the policy/service/project or scheme take account of difference, even if involves treating some individuals more favorably?	✓															

Key	
✓	Yes
x	No
-	Neutral

Human Rights Based Approach – Issues of Dignity & Respect

The Human Rights Act contains 15 rights, all of which NHS organisations have a duty. The 7 rights that are relevant to healthcare are listed below.			
Consider is the policy/service/project or scheme relevant to:	Yes	No	N/A
Article 2: The Right to Life	yes		
Article 3: the right not to be tortured or treated in a inhumane or degrading way	yes		
Article 5: The right to liberty			X
Article 6: the right to a fair trial	yes		
Article 8: the right to respect for private and family life	yes		
Article 9: Freedom of thought, conscience and religion	yes		
Article 14: prohibition of discrimination	yes		

Measuring the Impact

Reason for your decision (including evidence used). Include details of how it might impact on people from this group and how opportunities to advance equality and good relations have been maximised.	
Protected Characteristics & Other Areas	Impact – operational & financial

<ul style="list-style-type: none"> • Race • Sex • Disability • Sexual orientation • Religion belief & non belief • Age • Gender Identity • Pregnancy & maternity • Marriage & civil partnership • Carers 	<ul style="list-style-type: none"> • Race: Positive impact through anti-racist action plan and targeted recruitment. • Sex/Gender: Promotes equal opportunities and career progression. • Disability: Inclusive recruitment, reasonable adjustments, wellbeing passport. • Sexual orientation / Gender identity: Explicit commitments to LGBTQ+ inclusion. • Religion/Belief: Respectful, inclusive policies. • Age: Apprenticeships and early career routes; flexible working for older staff. • Pregnancy & Maternity: Supportive leave and flexible policies. • Carers: Ongoing awareness raising and support frameworks
<p>Welsh Measures</p>	<p>Please show how the proposal addresses the core objectives of the Welsh Language Measure 2011.</p>
<p>Ensure an environment that enables patients to choose to live and receive services through the medium of Welsh</p>	<ul style="list-style-type: none"> • The Plan supports bilingual service provision and opportunities to work, learn, and develop in Welsh. • It treats Welsh no less favourably than English. • Positive impact through implementation of Welsh Language action plan
<p>Encourage staff to use Welsh in the workplace and to have opportunities to learn and improve their Welsh</p>	<p>The people plan is underpinned by the Welsh Language Action Plan</p>
<p>Encourage new staff and students to take up Welsh language learning opportunities and to appreciate the socio-economic and cultural context of Wales</p>	<p>The people plan is underpinned by the Welsh Language Action Plan</p>
<p>Act as a catalyst for cultural awareness, understanding, activity and integration</p>	<p>The people plan is underpinned by the Welsh Language Action Plan</p>
<p>NOTE: As you complete this tool you will be asked for evidence to support your views. When you formulate a new policy, or review or revise an existing policy, you must consider what effects, if any (whether positive or adverse), the policy decision would have on (a) opportunities for persons to use the Welsh language, and (b) treating the Welsh language no less favourably than the English language. The tool should allow you to identify whether any changes resulting from the implementation of the recommendation will have a positive or negative effect on the Welsh language. Data sources include for example:</p> <ul style="list-style-type: none"> • <i>Welsh Language Standards requirements for the department / service</i> • <i>Welsh Language skills data for staff</i> 	

- *Welsh Language skills data for service users*
- *Welsh medium recruitment*
- *Welsh medium training provision*
- *Welsh medium administrative provision*

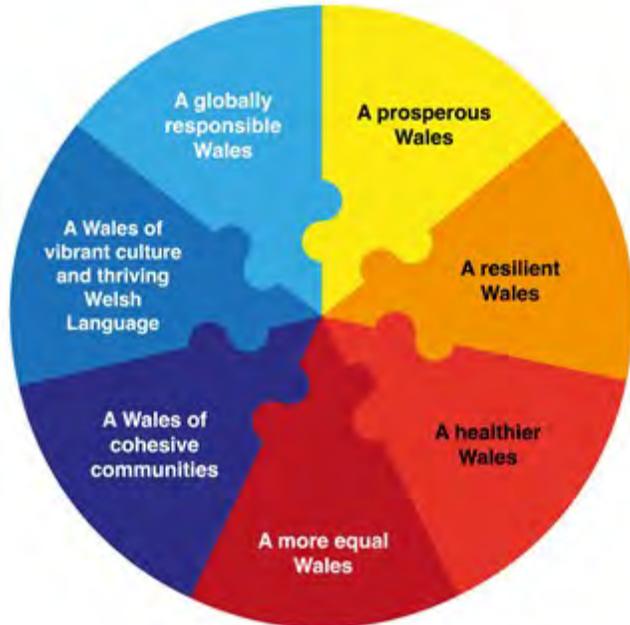
Welsh Language Impact Assessment <i>In this section you need to consider the impact, the evidence and any action you are taking for improvement. This is to ensure that the opportunities for people who choose to live their lives and access services through the medium of Welsh are not inferior to what is afforded to those choosing to do so in English, in accordance with the requirement of the Welsh Language Measure 2011.</i>				Describe why it will have a positive/negative or negligible impact on the Welsh language.	What evidence do you have to support this view?	What action(s) can you take to mitigate any negative impacts or better contribute to positive impacts?
Will the proposal be delivered bilingually (Welsh & English)? e.g. <i>Will the proposal increase or decrease the opportunities for people to receive information or access information in Welsh?</i>	Yes	No	No impact/ Negligible	. The people plan is underpinned by the Welsh Language Action Plan		
	x					
Will the proposal have an effect on opportunities for persons to use the Welsh language? e.g. <i>Will the proposal alter the linguistic nature of the department?</i> <i>What opportunities does the proposal provide to develop Welsh language skills within the department?</i>	Yes	No	No impact/ Negligible	The people plan is underpinned by the Welsh Language Action Plan		
	x					
Will the proposal increase or reduce the department/division's ability to deliver services	Increase	Reduce	No impact/ Negligible	The people plan is underpinned by the Welsh Language Action Plan		

<p>through the medium of Welsh? e.g.</p> <p><i>Will the proposal ensure that people can access services in their preferred language, Welsh or English?</i></p> <p><i>Will the proposal increase or reduce the opportunity for persons to use the Welsh language within the workplace?</i></p> <p><i>Will the proposal impact on the number of Welsh speaking staff within the service?</i></p> <p><i>Will the proposal increase or reduce the opportunity for staff to improve their Welsh language skills or access training via the medium of Welsh?</i></p>	x					
<p>Will the proposal treat the Welsh language no less favourably than the English language? e.g.</p> <p><i>How will the proposal ensure that Welsh speakers receive services to the same standard as those who access the same services through the medium of English?</i></p>	Yes	No	No impact/ Negligible	The people plan is underpinned by the Welsh Language Action Plan		
	x					

Wellbeing Goals

How does the policy/procedure, strategy, e-learning, guidance etc. embed, prioritise the Well-being Goals and Sustainability Development Principle of the Well-being of Future Generations (Wales) Act 2015?

Please describe and provide evidence below of how the 5 ways of working have been met, inclusive of the 7 well-being goals, to maximise the social, economic, environmental and cultural wellbeing of people and communities in Wales.



- Long-term: 5-year strategy aligned to 10-year Health Board vision.
- Prevention: Focus on staff wellbeing, attendance, and proactive support.
- Integration: Links directly to organisational strategy and NHS Wales priorities.
- Collaboration: Developed with staff, trade unions, and partners.
- Involvement: Shaped by extensive engagement

Sustainable Development Principles



Balancing short term with long term needs

- Five-year plan with annual reviews aligned to 10-year *Gwent 2035* strategy.
- Immediate workforce improvements (wellbeing, recruitment) balanced with future workforce planning and digital capability.

Cydweithio



Collaboration

Working together to deliver aims and objectives.

- Developed with staff, trade unions, and partners.
- Ongoing collaboration across health, education, and community sectors.

Cynnwys



Involvement

Involving those with an interest and seeking their views

- Staff surveys, forums, networks, and roadshows shaped priorities.
- Continued engagement through partnership forums and governance structures

Atal



Prevention

Putting resources into preventing problems occurring or getting worse

- Focus on staff wellbeing and occupational health to prevent sickness absence.
- Early intervention through restorative practices to avoid harm and dispute



Considering impact on all wellbeing goals together and on other bodies

- Directly supports “A More Equal Wales” and “A Healthier Wales.”
- Workforce diversity, inclusion, and fair employment contribute to social, economic, and cultural wellbeing.
- Aligns with NHS Wales, regional partners, and wider public service goal

Socio -economic Impact

Impact – Operational & Financial

The Socio-economic Duty came into force in Wales on 31 March 2021. It improves decision making and helps those who are socio-economically disadvantaged.

The Socio-economic Duty gives us an opportunity to do things differently in Wales. It puts tackling inequality at the heart of decision-making, and will build on the good work public bodies are already doing.

If this policy/decision etc is a Strategic Decision, it will also need to go through a specific Socio-economic Assessment

Additional Assessment NOT needed

- The Plan contributes to reducing inequalities by widening access to NHS careers, targeting deprived communities, and improving employment outcomes.
- Supports local foundational economy through apprenticeships and inclusive recruitment.

How does the policy/procedure, strategy, e-learning, guidance etc. ensure transparent and effective measures to address the inequality of outcome that result from socio-economic disadvantage?

Examples of inequality of outcome might include for example, education attainment, employment and earning potential, health and mental health access to services and goods, opportunity to participate in public life, housing.

- Widening Access to NHS Careers: Expands apprenticeships, training roles, and supported employment to create pathways into work for people from disadvantaged backgrounds.
- Targeted Recruitment: Focuses on underrepresented groups and communities with higher unemployment or barriers to entry, helping address inequality in employment and earning potential.
- Career Development & Progression: Provides clear progression frameworks and learning opportunities,

	<p>enabling staff from all backgrounds to move into higher-paid roles.</p> <ul style="list-style-type: none"> • Health and Wellbeing Support: Strengthens occupational health, wellbeing services, and preventative support to reduce inequalities in physical and mental health outcomes. • Flexible and Supportive Work Environments: Embeds agile working practices and reasonable adjustments, enabling participation in the workforce for those with caring responsibilities, long-term health conditions, or financial pressures. • Recognition and Inclusion: Actively builds a culture of fairness and respect, reducing barriers to participation and ensuring all staff feel valued regardless of socio-economic background. • Community Engagement: Works with schools, colleges, and local communities to raise awareness of NHS career opportunities, addressing gaps in educational attainment and aspiration. • Foundational Economy Contribution: Supports local employment and reduces inequality by investing in jobs that reflect and serve the local population. • <input type="checkbox"/> Digital Literacy Development: Improves access to digital training and skills across the workforce, preventing digital exclusion and improving career and income prospects
<p>Positive Action</p>	<p>Impact – Operational & Financial</p>
<p>If the policy, procedure, strategy and or decision is intended to increase equality of opportunity through positive action, does it appear to be lawful?</p> <p>Positive action is defined as voluntary actions employers can take to address any imbalance of opportunity or disadvantage that an individual with a protected characteristic could face.</p>	<p>Lawful positive action measures include targeted recruitment and support for underrepresented groups, in line with Equality Act 2010.</p>

Outcome report

Action Required		Potential Outcomes	Time-scale	Lead Officer	Resource implications
1	Implement People Plan actions in line with annual milestone		quarterly	SMT	
2	Strengthen data collection on workforce protected characteristics		On-going	EDI Team	
3	Monitor impacts on equality groups through staff survey and networks		On-going	EDI Team	
4	Embed Welsh Language action plan across all workforce policies		On-going	Welsh Language Lead	

Equality Impact Assessment: Recommendations
Please list below any recommendations for action that you plan to take as a result of this impact assessment



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Risk Assessment based on above recommendations – if policy is approved in original format refer to grading in Annex 1

Recommendation	Likelihood	Impact	Risk Grading
1			

Reputation and compromise position	Monitoring Arrangements
Training and dissemination of policy	

Is the policy etc. lawful?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Review date
Does the EQIA group support the policy be adopted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Signed on behalf of Trust Equal Impact Assessment Group		Signed Lead Officer	
Date:		Date:	

Impact, Consequence score (severity levels) and examples				
1	2	3	4	5
Negligible	Minor	Moderate	Major	Catastrophic

Statutory duty	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation	Single breach in statutory duty	Multiple breaches in statutory duty	Multiple breaches in statutory duty
	Potential for public concern	Formal complaint	Challenging external recommendations	Legal action certain between £100,000 and £1million	Legal action certain amounting to over £1million
	Informal complaint	Local media coverage – short term reduction in public confidence	Local media interest	Multiple complaints expected	National media interest
	Risk of claim remote	Failure to meet internal standards	Claims between £10,000 and £100,000	National media interest	Zero compliance with legislation
		Claims less than £10,000	Formal complaint expected		Impacts on large percentage of the population
	Elements of public expectations not being met	Impacts on small number of the population		Gross failure to meet national standards	

Annex 1

LIKELIHOOD DESCRIPTION	
5 Almost Certain	Likely to occur, on many occasions
4 Likely	Will probably occur, but is not a persistent issue
3 Possible	May occur occasionally
2 Unlikely	Not expected it to happen, but may do
1 Rare	Can't believe that this will ever happen

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Winter Briefing Paper 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Executive Director Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Chris Dawson-Morris, Deputy Director Strategy, Planning and Partnerships

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 sets out how the Health Board, with partners, will respond to the challenges which will be faced by the health and care system over the winter months. Building system resilience is part of the core focus of the Health Board and activity in core programmes, such as the Six Goals for Urgent and Emergency Care, as well as work through the Regional Partnership Board, all support meeting the additional challenges of the period. Therefore, this plan should not be considered in isolation of the wider work programme of the organisation set out in the IMTP. Partnership, whole system working, and transparency will be essential in planning and meeting the tasks that lie ahead.

Cefndir / Background

The health and social care system continues to operate under sustained and significant pressure and continues to balance responding to urgent and emergency

care demand with improving access for patients by reducing backlogs for outpatients and treatments. Respiratory illness will again pose a threat this year with anticipated waves of COVID-19, influenza and Respiratory Syncytial Virus (RSV) likely to peak in December and January.

National scenario modelling is expected to be published towards the end of September 2025. Early indication from the southern hemisphere suggests a challenging Winter in Europe as the rate of respiratory infection observed surpassed levels seen in 2023 and 2024. In 2024/25 peaks in infection and subsequent hospital admissions were seen in the first two weeks of January. Following publication of scenario modelling for the coming winter, the health board will model the additional bed capacity requirements but based on recent experience, this is likely to require an additional 2 wards of bed capacity or equivalent mitigation. Consideration will be given to the potential impact of closed beds due to infection prevention control measures. Full modelling will take place once the national scenario is received from Public Health Wales, due at the end of September.

Against the backdrop of increasing demand, driven by an aging population and staffing challenges, services across the region will be required to meet the health and well-being needs of both staff and the population in evermore complex and pressured circumstances.

Within this context, this plan sets out the outline actions that will provide focus, enabling flow and considering best utilisation of capacity. In addition, it sets out work in partnership between health and social care through the Regional Partnership Board, to support the system and deliver preventative activity.

Importantly, this plan builds upon local urgent and emergency care plans, delivered through the Health Board's Six Goals for Urgent Care programme, which focuses upon enhancing capacity within the community and providing alternatives to admission. Recognising the financial situation of the organisation this plan highlights the risks and opportunities in delivering winter actions to the financial plan.

The region has been asked to provide assurance to Welsh Government and NHS Performance and Improvement via the attached proformas:

- Planning together for Winter Guidance Toolkit – Submission 12th September 2025
- Local Winter Resilience Planning Assurance – Submission 31st October 2025

Regions have been asked through the national directives to ensure that the following key areas of focus are included within submissions:

- Building community capacity to support care closer to home
- Maximise available acute and community hospital capacity
- Optimal hospital patient flow and a home first approach

The content of the regional submission is subject to ratification through RPB governance during September 2025.

Asesiad / Assessment

Key Learnings from 2024/2025

Post winter 24/25, a lessons learnt reflection with operational and corporate teams was conducted. The key lessons highlighted from the group were as follows;

- Separate business as usual activity from specific winter period activity. Plans contained a mix of action from different programmes as well as new interventions and therefore confused governance and reporting.
- Focus on preventative care planning targeting populations at risk. There was benefit from the proactive care planning which took place, however it was too late in the period, these plans need to be in place before November.
- Simplify the governance. Too many groups were involved in attempting to oversee winter actions therefore there was overlapping and duplications of governance.
- Focus on increasing capacity in the Respiratory and falls pathways for the period. Scale up RACU and falls planning with specific plans for November to March
- Expand work on increasing weekend working in the period (CRT and DN) to support system flow on a 7-day basis
- Hospital to Home demonstrated good outcomes, plan to scale in the period
- Enhance communications with families in relation to supporting discharge and review choice policy
- Focus on single point of access/navigation to support system flow

Partnership Actions Winter 2025/26

Actions summarised below represent whole-system actions in partnership with local authorities developed through the winter planning self-assessment process. Primary and Community care alongside hospital system actions and social care. Increasing capacity in primary and community care in the winter period will enable individuals to maintain support within their community and prevent deterioration to a higher level of care.

The full self assessment against the Planning Together for Winter framework is attached at Annex 1.

Strategic Area	Action	Anticipated Impact
Vaccination Uptake	Plans to increase staff uptake through 'walking the wards' initiative and peer vaccinator incentives Targeted campaign for influenza, RSV and COVID-19 with vaccination offered at	75% uptake ambition for school aged children and pregnant women 75% uptake ambition for adults over 65

	<p>antenatal clinics and capacity within flying start/nursery settings</p> <p>Promotion of newly established Cwmbran vaccination centre that offers 6 days per week walk-in access for a wide range of vaccinations for all age groups including; Covid-19 Boosters, Flu Vaccines, HPV and many others</p>	
Proactive management of 0.5% most at risk of urgent care needs	<p>Robust MDT processes in 3 Local Authorities established to review most at risk individuals</p> <p>An updated version of Directed Supplementary Service (additional provision over the GMS contract) anticipated this winter</p> <p>Virtual MDTs to target patients with chronic respiratory conditions</p>	<p>Maintain delivery of MDTs in Gwent.</p> <p>Increase the number of MDTs subject to DSS issuance.</p>
Community Falls Response	<p>Successful initial care home education and training initiative, a bid submitted to Six Goals fund to increase the number of care home participation</p> <p>Additional funding secured via RIF to Improve capacity of the enhanced community falls response service in Gwent. Working with WAST to maximize impact of the level 2 response.</p> <p>Programme established to improve navigation and hospital response timeliness for non-injurious falls patients</p>	<p>Reaching a potential of up to 20 homes with additional falls prevention and mitigation training through winter</p> <p>A reduction of Level 1 and Level 2 falls conveyances to acute hospitals by 10%</p>

<p>Navigation Hub / SPOA</p>	<p>Single point of access for health care professionals in place for some time with call handlers navigating Urgent primary, secondary and community referrals. Work on-going to simplify existing structures to improve outcomes.</p> <p>Plans to implement an MDT clinical review step in the process for identified cohorts ie Falls, care homes, over-65s</p> <p>Advanced Paramedic Practitioner in-place within the Nav hub at VPH and they will form part of the MDT</p>	<p>A reduction of care home conveyances to acute hospitals by 10%</p> <p>Increase in utilization of alternative pathways for care home residents and falls presentations</p>
<p>45 Minute handover</p>	<p>45 minute handover workshop held on 29th August to initiate winter handover improvement plan</p> <p>Implementation of 'continuous flow model' effective from September</p> <p>Develop and implement clear, written protocols for flexible use of assessment and transfer lounge spaces, especially overnight and during escalation.</p> <p>Develop existing processes to maximize transfer lounge utilization at The Grange</p> <p>GIRFT follow-up review in September</p>	<p>Eliminate ambulance handover waits over 45 minutes across acute sites</p> <p>Significantly reduce the number of patients waiting longer than 24 hours within the Emergency Department</p> <p>Increase transfer lounge utilization to at least 125 weekly based on performance high point</p>
<p>Same Day Emergency Care</p>	<p>Combined SDEC patient throughput has increased substantially in 2025 with 'SDEC first' principles embedded at The Grange</p>	<p>Increase the number of patients assessed-out from SDEC services</p>

	Respiratory Ambulatory Care Unit (RACU) continues to provide a specialist SDEC service for respiratory conditions, working to explore additionality this winter	Increase utilization of same day alternative pathways
Bed Capacity	<p>Planning for 2 additional wards to support winter resilience</p> <p>1x Medical and 1x Community noting the financial and staffing constraints associated with this</p>	<p>Capacity to support demand at peak predicted timeframes</p> <p>Up to 40 beds to come on line subject to modelling</p>
Redesigned Home First Model	<p>Plans to re-shape the RIF funded home first model with effect this winter</p> <p>Newport social care staffing consolidation to provide economy of scale, streamline operations and improve efficiency.</p> <p>Ensuring home first/social care representation at daily board rounds.</p>	<p>Increase referrals made to home first – baseline 46 weekly.</p> <p>Increase front door discharge rates – baseline 60%</p>
Optimal Hospital Flow Framework	<p>Rolling-out Framework initially on 5 wards in the Royal Gwent Hospital. Commenced in August for impact over winter.</p> <p>Implemented morning board rounds and afternoon huddles plus adoption of D2RA model</p> <p>A focus on pre-midday discharge planning in collaboration with LA colleagues</p>	<p>Increase the proportion of pre-midday discharges – baseline 15%</p> <p>Reduce the number of pathway of care delays – baseline 201 reported in December 2024</p> <p>Increase transfer lounge utilization to at least 125 weekly based on performance high point</p>
Pathway of Care Delays	<p>Continued focus on top 20 longest-staying patients via weekly scrutiny panel</p> <p>Strengthen social care capacity to reduce discharge delays via increased assessment,</p>	<p>Reduce the number of pathway of care delays – baseline 201 reported in December 2024</p> <p>Increase the proportion of pre-midday</p>

	<p>domiciliary care and reablement capacity</p> <p>Additional assessment posts in Monmouthshire and Blaenau Gwent supported by agency cover, additional IAA posts in Caerphilly.</p> <p>A fast tracked (2-week) assessment and brokerage process in Blaenau Gwent</p> <p>Redesigned Home first model via Newport</p>	<p>discharges – baseline 15%</p>
<p>Discharge to Assess Enhanced Care (1-1 Care Homes)</p>	<p>Application into Gwent RIF Supporting the enhanced care element for a period of up to 6 weeks, based on clinical need. This initiative proved successful last winter</p>	<p>Additional in-house emergency / bridging domiciliary care to minimise ABUHB reablement waiting list – approximately 360 hours</p>

ED Extension

There is a live capital development scheme which will increase the footprint of the ED in the Grange Hospital. Phase 1 of this project is due to complete in mid October and will offer opportunities to improve flow, experience and congestion in the ED through Winter period. Further detailed operational planning will take place to inform the detail.

Operational Framework

The Health Board's Operational Framework will be a key mechanism in the management of demand peaks and service escalations, it is designed to enhance patient care quality and safety by addressing systemic challenges in patient flow and ambulance handover times. The framework aims to ensure timely patient handovers from ambulances to hospital services, particularly during periods of high demand and seasonal peaks by clearly setting out the expectations of all parts of the system.

The framework outlines necessary steps to ensure patient safety, minimise risks, and normalise operations post-escalation. It details the roles and responsibilities of staff across four key areas: Pre-Hospital, Acute Front End, Transport, and On-Call.

- Pre-Hospital: Focuses on optimising patient flow in community settings.
- Acute Front End: Aims to improve efficiency in emergency departments, medical assessment units, and surgical assessment units, emphasising timely patient reviews and discharges.

- Transport: Discusses services provided by the Welsh Ambulance Services NHS Trust, including emergency medical services, inter-site transfers, and non-emergency patient transport.
- Effective Discharge Planning: Involves clear communication with patients and families, timely preparation of medicines, and coordination with nursing and residential homes.
- Planned Care Capacity: Identifying times where escalated action is required and decisions may have to be made in relation to the balance of risk between urgent and planned services. To support this, the above Operational Framework escalation plans set out processes for decision making should this be needed.

The framework also includes detailed escalation processes for managing increased demand and operational pressures, ensuring patient safety and system efficiency.

Governance

A key lesson from 2024/25 was the need to simplify governance for winter. Therefore, in 2025/26 the Health Board operational oversight will take place via the Cross Divisional Forum with the Integrated Discharge Board providing the primary interface with social care partners. An operational group overseeing the planning of the additional winter capacity will be established with appropriate operational and corporate team representation.

Financial Position

ABUHB is currently facing significant financial pressures. There are no additional resources in the financial plan as rest at month 5 identified for the winter period although any opportunities to offset additional costs via additional opportunities such as variable pay reductions will be explored. Costs incurred in 2024/25 were partially met via income from Welsh Government and use of partnership funding on a non-recurrent basis, however there were significant additional costs for a number of schemes described above as well as the financial impact of the declared critical incident. It is not determined at this stage as to whether there will be Welsh Government or any other funding made available for 2025/26.

It should also be noted that there are some further operational and financial pressures specific to 2025/26 which may impact potential capacity and surging options. These include additional elective capacity to meet WG targets (e.g. 26 week outpatients and 8 week diagnostics) and estates moves for essential maintenance or closures (e.g. RAAC and St. Woolos buildings).

There may be a need to consider and approve options for the 'surging' and additional surge capacity for specific services alongside other actions to meet the increased demand and acuity of services over the winter period. It is necessary to ensure that any additional actions with a financial consequence are approved at Executive level given the financial position of the organisation in 2025/26.

Summary

This winter, our services will face many complex challenges underpinned by significant uncertainty.

Through undertaking the actions set out in this plan the organisation will endeavour to meet the challenges of the winter. The organisation will target the areas of greatest challenge and provide the best opportunity to ensure people access care and support in the right place, first time, whilst optimising effective flow through our system.

The extent to which the demand materialises will be proactively tracked via the governance mechanisms set out.

Argymhelliad / Recommendation

The Board is asked to:

- Note the context with which the Health System is operating, the winter forecasts and potential impact upon the system as well as actions planned to mitigate.

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	Experience Quality and Safety
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:	ED Emergency Department GP General Practitioner UPC Urgent Primary Care IMTP Integrated Medium Term Plan GUH Grange University Hospital CRT Community Resource Team RGH Royal Gwent Hospital YYF Ysbyty Ystrad Fawr NHH Nevill Hall Hospital STW St Woolos Hospital ICU Intensive Care unit SDEC Same Day Emergency Care DVT Deep Vein Thrombosis IPC Infection, Prevention and Control
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	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

Grŵp Iechyd a Gwasanaethau Cymdeithasol
Dirprwy Brif Weithredwr, GIG Cymru

Health and Social Services Group
Deputy Chief Executive, NHS Wales



Llywodraeth Cymru
Welsh Government

**Chief Executives of Local Health Boards and NHS Trusts
Directors of Social Services, Local Authorities
Chairs / Leads, Regional Partnership Boards**

Our Ref: NW/A58841268

14 July 2025

Dear Colleagues,

Planning Together for Winter 2025/26 – Expectations and key actions

As we approach the autumn period, the Welsh Government is setting out clear expectations for the development and delivery of robust winter plans across health and social care organisations and their partners.

The late autumn and winter period will bring predictable seasonal pressures, compounded by ongoing system challenges, and it is essential that we act early and collaboratively to mitigate risks to patient safety and service resilience. This should build on the positive progress made by health and social care partners through the 50-day integrated health and social care challenge in 2024/2025.

1. Key areas of focus

The Cabinet Secretary hosted a national Winter Summit meeting on 31 March 2025 at which key actions were proposed towards enabling more resilient services over Winter 2025/2026 following a difficult period last year. In addition, Welsh Government Officials hosted an event in May with key system leaders and stakeholder to reflect on the learning and work achieved through the 50-Day Integrated Care Winter Challenge and Care Action Committee, to ensure our planning for this winter took account of valuable feedback that has helped shaped the way forward.

Key actions have been distilled into three key areas of focus and regional winter plans must include clear actions and contingencies against the following:

1. **Building community capacity to support care closer to home** through:
 - Prevention
 - Proactive / early intervention
 - Urgent response; and
 - 'Step Up' enhanced community care and multi professional wrap around care
2. **Maximise available acute and community hospital capacity** - ensuring there is sufficient Emergency Department and hospital capacity during peaks in demand to reduce risk of harm for people requiring emergency care
3. **Optimal hospital patient flow and a home first approach** - Strengthen discharge planning and patient flow to reduce delays and promote supported recovery at home

A 'Planning Together for Winter' guidance toolkit, featuring the key actions for delivery and good practice guidance, in addition to a self-assessment template are enclosed to support your integrated regional planning.

2. Timely submission of regional integrated self-assessments against Welsh Government guidance

We expect you to work collaboratively and regionally to review the enclosed guidance toolkit and use the self-assessment template to assure yourselves that your regional integrated planning for Winter 2025/2026 aligns to the Welsh Government's expectations.

Utilising Regional Partnership Board's as the coordination mechanism, please submit a completed self-assessment template and assurance that the review has been undertaken in partnership between health boards, NHS Trusts, local authorities, primary care, social care partners, and third sector organisations where appropriate, by **12 September 2025**. Please send returns to UrgentAndEmergencyCare.GovernmentBusiness@gov.wales. Instructions on completing the template are included within the template itself.

To complement your self-assessment template, we will also issue additional correspondence and guidance in July to support development of robust operational resilience plans for the period *22 December – 13 January 2026*.

Regional Partnership Boards also manage, and can help coordinate other discretionary resources/grants, that are available alongside core budgets to support our ambitions of building community capacity to deliver better outcomes for people and improve system performance – annex 1. Partners need to be planning and working together strategically to ensure alignment of investment and secure the greatest impact and value for money when developing operational resilience plans.

3. Data and monitoring

Organisations must ensure real-time data sharing and reporting mechanisms are in place to support system oversight and rapid response. This includes daily situation reporting and escalation protocols.

Performance against key outcomes / KPIs will be monitored through existing performance management routes at a national level to help reduce the burden on partners. This will be supported by the Integrated Community Care System (ICCS) meeting arrangements,

overseen by the Cabinet Secretary (3 times a year) and officials (bi-monthly), which will be established from September 2025.

4. National enabling activity

A range of enabling action is under development by national partners including the development of vaccination campaigns, a training programme for operational managers, communications campaigns and evidence-based modelling.

5. Learning from previous winters

All plans should incorporate insights gained from the 2024/25 winter period, including feedback provided by staff, patients, and system partners. Enclosed is a summary closure report on the '50-day challenge' 2024/2025, which we recommend reviewing and utilising during the development of regional plans.

We recognise the significant effort required to prepare for winter and thank you for your continued collaboration, leadership and commitment.

If you have any questions or require further guidance, please contact UrgentAndEmergencyCare.GovernmentBusiness@gov.wales

Yours sincerely,



Nick Wood
Deputy Chief Executive
NHS Wales



Albert Heaney CBE
Chief Social Care Officer for Wales
Welsh Government



Alex Slade
Director of Primary Care, Mental Health and Early Years
Welsh Government

Cc:
Judith Paget, Director General HSCEY / Chief Executive NHS Wales
Chief Executives, Local Authorities
LHB Directors of Public Health
Medical Directors LHBs/NHS Trusts
Heads of Adult Social Services
WLGA
Directors of Nursing LHBs/NHS Trusts
Directors of Planning
Chief Operating Officers LHBs/NHS Trusts
Directors of Primary and Community Care
Sue Tranka, Chief Nursing Officer, Welsh Government
Isabel Oliver, Chief Medical Officer, Welsh Government

Annex 1: Regional grants and funding streams 2025/26

Funding	Total All Wales Amount 2025/26	Status
Allied Health Professional	£4,950,000	Recurring
Dementia Action Plan and Memory Assessment Services	£12,700,000	Recurring
Further Faster	£11,950,000	Recurring
Integrated Rebalancing Care Funding: Revenue to support capital planning	£3,150,000	Ends March 2027
Pathways of Care Delay transformation grant	£30,000,000	Recurring
Regional Integration Fund: Core including Dementia Action Plan (above)	£146,800,000	Ends March 2027
Short Breaks for Unpaid Carers	£1,287,000	Ends March 2026
Urgent Goals	£18,800,000	Recurring



Llywodraeth Cymru
Welsh Government

Cynllunio Gyda'n Gilydd ar gyfer y Gaeaf

**Pecyn Cymorth i Ategu Dull Iechyd
a Gofal Cymdeithasol Integredig**

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1. Cyflwyniad

Fel y nodir yn “Cymru Iachach”, mae iechyd a gofal cymdeithasol integredig yn hanfodol ar gyfer darparu cymorth effeithiol, cydgysylltiedig, sy’n canolbwyntio ar unigolion ac sy’n mynd i’r afael ag anghenion amrywiol unigolion, teuluoedd a chymunedau. Gan fod poblogaethau’n heneiddio a chan fod anghenion gofal yn mynd yn fwyfwy cymhleth, mae cydweithredu di-dor ar draws gwasanaethau iechyd a rhwng gwasanaethau iechyd a gofal cymdeithasol yn bwysicach nag erioed o’r blaen. Mae’r cydweithredu hwn yn arbennig o bwysig yn ystod misoedd heriol y gaeaf.

Bwriad y Pecyn Cymorth hwn yw helpu gweithwyr proffesiynol, darparwyr gwasanaethau a chomisiynwyr i greu a chynnal modelau gofal integredig ar gyfer y gaeaf. Mae’n cynnig ymarfer seiliedig ar dystiolaeth, fframweithiau polisi ac offer ymarferol ar gyfer pontio bylchau mewn gwasanaethau a gwella canlyniadau i bobl sydd angen gofal. Drwy ei roi ar waith mewn modd cyson, bydd modd cryfhau’r system iechyd a gofal cymdeithasol yn ystod pwysau’r gaeaf heb effeithio’n fawr ar wasanaethau brys ac argyfwng.

Diben y Pecyn Cymorth

- Darparu dull strwythuredig o gynllunio a darparu gofal integredig a llywio asesiadau rhanbarthol yn barod ar gyfer y gaeaf.
- Cynnig astudiaethau achos, templedi a chanllawiau ymarferol a fydd yn cynorthwyo i roi pethau ar waith.
- Hyrwyddo nodau, iaith a gwerthoedd cyffredin ledled sectorau iechyd a gofal cymdeithasol.

Ar gyfer pwy mae’r Pecyn Cymorth hwn?

Caiff y pecyn cymorth hwn ei anelu at y grwpiau canlynol:

- Ymarferwyr iechyd a gofal cymdeithasol
- Rheolwyr gwasanaethau ac arweinwyr timau
- Comisiynwyr a chynllunwyr strategol

Sut i ddefnyddio’r Pecyn Cymorth

Trefnir y pecyn cymorth ar ffurf tri ‘Nod ar gyfer y Gaeaf’, sef:

1. Meithrin capasiti cymunedol i ategu gofal yn nes at y cartref
2. Gwneud y mwyaf o gapasiti ysbytai aciwt ac ysbytai cymunedol
3. Optimeiddio llyf cleifion mewn ysbytai a rhoi dull ‘gartref yn gyntaf’ ar waith

Mae'r pecyn cymorth yn cynnwys:

- Disgwyliadau allweddol ac arferion gorau'n ymwneud â'r tri Nod ar gyfer y Gaeaf
- Offer ymarferol a rhestrau gwirio
- Dolenni'n arwain at ragor o adnoddau a chanllawiau polisi
- Fframwaith mesur canlyniadau;
- Manylion am drefniadau llywodraethiant ac adrodd

2. Nodau ar gyfer y Gaeaf

Nod 1 ar gyfer y Gaeaf: **Meithrin capasiti cymunedol i ategu 'gofal yn nes at y cartref'**

Cyflwyniad

Mae pobl ag anghenion cymhleth yn wynebu risg uwch o fod angen gofal brys yn ystod y gaeaf. Mae'r Datganiad o Fwriad ynglŷn â 'Meithrin Gallu drwy Ofal Cymunedol: Ymhellach, Yn Gyflymach' yn nodi bod ein system gyfredol yn rhy ymatebol a'i bod yn colli cyfleoedd i atal a darparu gofal rhagweithiol. Mae hyn yn arwain at niwed y mae modd ei osgoi ar gyfer pobl ag eiddilwch neu anghenion cymhleth ac mae'n cynyddu'r pwysau ar wasanaethau brys ac argyfwng.

Mae'r [Datganiad Ansawdd Integredig ar gyfer Pobl Hŷn sy'n Byw gydag Eiddilwch](#) yn nodi'r nodweddion ansawdd sy'n perthyn i system sy'n cydweddu ag eiddilwch. Gellir crynhoi'r nodweddion hyn ar draws gofal integredig ar bedair lefel, sef:

- **Atal** ar gyfer y boblogaeth sy'n ffit ac yn iach a'r rhai y pennir eu bod yn wynebu 'risg isel' o fod angen cymorth iechyd a gofal.
- **Gofal Rhagweithiol / Ymyrraeth Gynnar** ar gyfer grwpiau sy'n wynebu 'risg gynyddol' neu 'risg uwch'.
- **Ymateb Brys** i Anghenion sy'n Dwysáu / Cyfnodau Argyfwng.
- **Gofal Cymunedol Uwch 'Cam i Fyny' neu 'ofal cofleidiol' Amlbroffesiynol** (gan gynnwys ailalluogi) am gyfnod byr i ategu adferiad ac i adsefydlu ar ôl anaf a salwch.

Mae'r nod *Meithrin Gallu Cymunedol* ar gyfer y Gaeaf (2025/26) yn ceisio safoni arferion drwy bwysleisio dulliau o reoli iechyd y boblogaeth drwy gyfrwng dull iechyd a gofal cymdeithasol integredig ar draws y pedair lefel hyn.

Atal

Cam Gweithredu 1: Cynyddu niferoedd y rhai sy'n manteisio ar frechlynnau i'w diogelu rhag anhwylderau anadlol y gaeaf

Er mwyn cyflawni'r nod hwn, mae'r ymyriadau gofynnol yn cynnwys:

- Ymgysylltu a chyfathrebu clir, sy'n canolbwyntio ar unigolion
- Canolbwyntio ar degwch a thargedu grwpiau anoddach eu cyrraedd, gan gynnwys rhai mewn ardaloedd economaidd ddifreintiedig, a grwpiau imiwnoataliedig
- Cynyddu nifer y staff sy'n cael eu brechu (gan gynnwys staff cartrefi gofal);
- Gwneud i bob cyswllt gyfrif er mwyn cynyddu nifer y bobl a gaiff eu brechu

Dolen:	Fframwaith imiwneiddio cenedlaethol Cymru LLYW.CYMRU
Cyswllt defnyddiol	Llywodraeth Cymru Joanne.larner@llyw.cymru gareth.ashman01@llyw.cymru

Gofal rhagweithiol

Cam Gweithredu 2: Dylai byrddau iechyd annog timau gofal clinigol sylfaenol a chymunedol sy'n rheoli clefydau anadlol cronig ac aciwt i ddefnyddio, pan fo'n briodol, y canllawiau rheoli cytunedig ar gyfer clefyd rhwystrol cronig yr ysgyfaint (COPD), asthma, bronciolitis RSV, a niwmonia a gafwyd yn y gymuned.

Dolenni:	Llwybrau a chanllawiau – Perfformiad a Gwella GIG Cymru
Cysylltiadau defnyddiol:	NationalRespiratory.Network@wales.nhs.uk

Cam Gweithredu 3: Dylai gwasanaethau iechyd a gofal cymdeithasol weithio gyda'i gilydd drwy gyfrwng y 60 Clwstwr i nodi'r 0.5% uchaf o'r boblogaeth y mae risg uchel y bydd ganddynt anghenion gofal brys. Dylent gynllunio gofal ar gyfer y dyfodol er mwyn helpu unigolion i aros yn iach neu i gael gofal angenrheidiol, gan gynnwys yn eu cartref neu mewn cartref gofal.

Mae pedair egwyddor yn sail i ofal rhagweithiol, sef:

- Nodi'r 0.5% uchaf o boblogaeth y clwstwr sy'n wynebu'r risg uchaf o fod angen gofal brys.
- Cynnal asesiad amlbroffesiynol.

- Sefydlu a gweithredu cynllun gofal ar gyfer y dyfodol.
- Sicrhau parhad gofal.

Mae Meddygaeth Deulu mewn sefyllfa ddelfrydol i ddarparu gofal rhagweithiol i boblogaethau cofrestredig. Mae'r *Contract Unedig ar gyfer Gwasanaethau Meddygol Cyffredinol* yn nodi y dylai'r gwaith o reoli cyflyrau cronig ddilyn llwybrau neu ganllawiau clinigol y cytunwyd arnynt yn genedlaethol. Mae gweithredu Llwybrau Iechyd Cymunedol drwy Gymru yn meithrin dull cyson o ymdrin â gofal cleifion. Gan ddechrau ym mis Ebrill 2025, mae'n ofynnol i bractisau meddygon teulu fynd ati'n rhagweithiol i bennu unigolion ag eiddilwch cymedrol neu ddifrifol, fel y gellir ymdrin yn well â'u hanghenion.

Er mwyn ategu mwy ar y gwaith o bennu a chydgyssylltu gofal drwy gyfrwng Clystyrau ar gyfer y boblogaeth hon, gall Byrddau Iechyd gomisiynu Gwasanaeth Ychwanegol gan y Gwasanaethau Meddygol Cyffredinol. Cynhaliwyd y Gwasanaeth Ychwanegol dan Gyfarwyddyd ar gyfer Eiddilwch ac Amlforbidrwydd Cymhleth rhwng Rhagfyr 2024 a Mawrth 2025; ac yn ôl adborth gan fyrddau iechyd a meddygon teulu, cafodd effaith gadarnhaol ar weithgareddau atal. Bydd manyleb arall, fwy diweddar, ar gyfer Gwasanaethau Ychwanegol dan Gyfarwyddyd yn cael ei chyhoeddi cyn bo hir.

Mae gwasanaethau lleol, gan gynnwys Meddygaeth Deulu a thimau cymunedol, yn meddu ar ddata helaeth yn ymwneud ag unigolion sy'n wynebu risg uwch o fod angen gofal brys. Fodd bynnag, nid yw'r seilwaith data/seilwaith digidol a geir yng Nghymru ar hyn o bryd yn ategu dulliau systematig o segmentu a phennu lefelau ar gyfer y boblogaeth. Wrth inni ddatblygu, caffael a gweithredu'r gallu digidol hwn mewn perthynas â rheoli iechyd y cyhoedd, cydnabyddir y bydd y gwaith o bennu lefelau a chanfod y 0.5% o garfannau yr ystyrir eu bod yn wynebu 'risg uchel o fod angen gofal brys' yn dibynnu ar ddulliau a bennir yn rhanbarthol.

Er mwyn sicrhau dull cyson, cynigir diffiniad cenedlaethol, lefel uchel o'r garfan 'risg uchel', fel a ganlyn:

Oedolion ag anghenion cymhleth (amforbidrwydd ac eiddilwch), fel arfer dros 75 oed (ond nid o angenrheidrwydd), y mae eu cyflyrau'n amrywio, lle mae angen rhoi gwaith monitro rhagweithiol ar waith a mynd ati'n gynnar i ganfod anghenion sy'n dwysáu neu argyfyngau.

Drwy roi'r dull hwn ar waith, byddai modd cynnwys unigolion y mae risg uchel y byddant yn cwmpo ac sydd, efallai, yn byw mewn cartref gofal neu sy'n cael gofal hirdymor mynych yn eu cartref.

Dolen: [Fframwaith Gofal Rhagweithiol](#)

**Cysylltiadau
defnyddiol:**

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Perfformiad a Gwella GIG Cymru
Sue.morgan22@wales.nhs.uk
zoe.wallace@wales.nhs.uk

Penaethiaid Gofal Cymdeithasol Oedolion Cymru Gyfan:
j.bennett@valeofglamorgan@gov.uk
catrin.perry@conwy.gov.uk

Cam Gweithredu 4: Rhoi Gwybodaeth, Cyngor a Chymorth (IAA) a hwylusir drwy dechnoleg ar waith ar lefel y gymdogaeth.

Mae gwasanaethau amlbroffesiynol ac amlasiantaethol integredig yn esgor ar ddull gofal rhagweithiol, a hefyd maent yn hwyluso'r arfer o ganfod dirywiad yn gynnar ac maent yn ymdrin ag anghenion sy'n ymgyflwyno, yn enwedig pan fo angen ymateb ar frys i anghenion sy'n dwysáu.

Dolen: [Gwybodaeth, Cyngor a Chymorth Integredig ar gyfer Oedolion ag Anghenion Cymhleth](#)

**Cyswllt
defnyddiol:** Llywodraeth Cymru
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catrin.perry@conwy.gov.uk

Dolen: [Fframwaith Gofal Cymunedol Integredig a Hwylusir drwy Dechnoleg](#)
I'w gyhoeddi fis Tachwedd 2025

**Cyswllt
defnyddiol:** Llywodraeth Cymru
Rhian.matthews001@llyw.cymru
Shelley.davies052@llyw.cymru

Cam Gweithredu 5: Mae byrddau iechyd yn darparu gwasanaethau nyrsio cymunedol cadarn i gynorthwyo'r tîm amlbroffesiynol o gwmpas yr unigolyn dros gyfnod o 7 diwrnod. Dylai capasiti'r penwythnos fod tua 80% o'r hyn ydyw yn ystod yr wythnos. Dylai'r hunanasesu a'r cynllunio dilynol ystyried a chynghori trywyddau gwella yn erbyn y disgwyliad targed

Er mwyn gallu darparu gwasanaethau iechyd cymunedol effeithiol yn ystod y gaeaf, mae'n hanfodol cynnig gwasanaethau nyrsio cymunedol cynhwysfawr 7 diwrnod yr wythnos i gynorthwyo'r tîm amlbroffesiynol. Disgwylir i bob rhanbarth a bwrdd iechyd gynllunio a gweithio tuag at ddarparu gwasanaethau nyrsio yn y gymdogaeth drwy gyfrwng eu Gwasanaeth Nyrsys Ardal. Dylai'r gwasanaeth allu diwallu anghenion cymdogaethau 7 diwrnod yr wythnos, a dylai'r gwasanaeth gael ei ategu gan fynediad at ofal nyrsio diwedd oes/lliniarol arbenigol.

Dolen:	Manyleb Genedlaethol Nyrsio Cymunedol
Arfer da:	Drwy ddefnyddio system amserlennu CIVICA, gellir adolygu lefel y gohiriadau a wneir gan y Gwasanaeth Nyrsys Ardal fesul tîm, fel arwydd o allu cyffredinol y tîm i ddiwallu anghenion y gymdogaeth ac fel arwydd o dîm / gwasanaeth a allai wynebu problemau gwaeth y gaeaf hwn.
Cyswllt defnyddiol:	Llywodraeth Cymru paul.labourne@llyw.cymru Perfformiad a Gwella GIG Cymru chiquita.cusens@wales.nhs.uk

Gofal Brys / Ymateb Brys

Cam Gweithredu 6: Dylai Byrddau Iechyd Hyrwyddo Gwasanaethau Fferyllfeydd Cymunedol

Mae'r Gwasanaeth Anhwylderau Cyffredin, sydd ar gael yn 99% o fferyllfeydd Cymru, yn cynnig cyngor a thriniaeth am ddim ar gyfer 28 o gyflyrau. Rhoddwyd y gwasanaeth Profi a Thrin Dolur Gwddf ar waith ym mis Mehefin a bydd y gwasanaeth ar gyfer Heintiau'r Llwybr Wrinol ar gael o 1 Hydref.

Ar hyn o bryd, mae'r gwasanaeth Fferyllwyr-ragnodwyr Annibynnol ar gael mewn traean a mwy o fferyllfeydd Cymru. Mae'r gwasanaeth hwn yn cynnig mynediad at ragnodi amrywiaeth o gyflyrau, gan gynnwys heintiau'r glust, y trwyn a'r gwddf.

Dolenni:	GIG 111 Cymru - Gwasanaethau Lleol: Fferyllfeydd Y Gwasanaeth Anhwylderau Cyffredin Y Gwasanaeth Anhwylderau Cyffredin - Gwasanaeth Cyngori ar Feddyginiaethau Cymru
Cysylltiadau defnyddiol:	Llywodraeth Cymru Natalie.Proctor@llyw.cymru Emma.Hinks@llyw.cymru Gemma.McCamley@llyw.cymru

Cam Gweithredu 7: Oddi mewn i fodel gofal Gwybodaeth, Cyngor a Chymorth (IAA) Integredig, cyflawni 'Fframwaith ar gyfer Ymateb i Gwympiadau yn y Gymuned' y rhaglen chwe nod ar gyfer gofal brys a gofal mewn argyfwng.

Dolenni:	Fframwaith Cenedlaethol Cymru ar gyfer Ymateb i Gwympiadau yn y Gymuned
Cysylltiadau defnyddiol:	Llywodraeth Cymru rhian.matthews001@llyw.cymru jemma.morgan@llyw.cymru Perfformiad a Gwella GIG Cymru ABB.SixGoalsUEC@wales.nhs.uk

Cam Gweithredu 8: Cyflawni 'Fframwaith Un Pwynt Mynediad' y rhaglen chwe nod ar gyfer gofal brys a gofal mewn argyfwng.

Dolenni:	Y Fframwaith Un Pwynt Mynediad Cenedlaethol
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Cysylltiadau defnyddiol: Perfformiad a Gwella GIG Cymru
ABB.SixGoalsUEC@wales.nhs.uk

Cam Gweithredu 9: Dylai Byrddau Iechyd ac Awdurdodau Lleol gydweithredu er mwyn cynyddu atgyfeiriadau at Ofal Cymunedol Uwch a Gofal Cofleidiol Amlbroffesiynol (Ailalluogi)

Cysylltiadau defnyddiol: Llywodraeth Cymru
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denise.moultrie@llyw.cymru
mark.bradley@llyw.cymru

Perfformiad a Gwella GIG Cymru
kerrie.phipps@wales.nhs.uk

Nod 2 ar gyfer y Gaeaf: Gwneud y mwyaf o gapasiti ysbytai aciwt ac ysbytai cymunedol

Cyflwyniad

Rhaid i fyrddau iechyd weithio gyda phartneriaid i sicrhau y bydd gan ysbytai aciwt/ysbytai cymunedol ac adrannau argyfwng ddigon o gapasiti yn ystod cyfnodau pan ragwelir y bydd galw mawr am eu gwasanaethau, er mwyn lleihau'r perygl y daw niwed i ran pobl sydd angen gofal argyfwng.

Cam Gweithredu 10: Rhaid i Fyrddau Iechyd werthuso cynlluniau cyflawni adrannau argyfwng yn unol â'r meini prawf a nodir yn y datganiad ansawdd ar gyfer gofal mewn adrannau argyfwng, argymhellion GIRFT (Cael Hi'n lawn y Tro Cyntaf) a chanllawiau trosglwyddo cleifion o ambiwlansys.

Dolenni: [Datganiad ansawdd ar gyfer gofal mewn adrannau achosion brys](#)
[Canllawiau ar drosglwyddo cleifion o ambiwlansys 2024](#)

Cysylltiadau defnyddiol: Perfformiad a Gwella GIG Cymru
ABB.SixGoalsUEC@wales.nhs.uk

Cam Gweithredu 11: Datblygu cynlluniau cydnerthedd gweithredol rhanbarthol ar gyfer y cyfnod rhwng 22 Rhagfyr 2025 ac 13 Ionawr 2026

Dolenni: [Canllawiau a thempled i'w cyhoeddi gan Lywodraeth Cymru / Perfformiad a Gwella GIG Cymru \(Gorffennaf 2025\)](#)

Cysylltiadau defnyddiol: [Llywodraeth Cymru](#)
GofalBrysAcArgyfwng.BusnesYLlywodraeth@llyw.cymru

Cam Gweithredu 12: Parhau i fwrw ymlaen â gweithredu gwasanaethau gofal argyfwng yr un diwrnod, cyflawni'r chwe nod ar gyfer gofal brys a gofal mewn argyfwng – 'Fframwaith Cymru ar gyfer Gwasanaeth Eiddilwch Acíwt wrth y Drws Ffrynt ar gyfer Ysbytai Acíwt'

Dolenni: [Adroddiad y Fframwaith ar gyfer Gwasanaeth Eiddilwch Acíwt wrth y Drws Ffrynt, gofal brys ar yr un diwrnod, ac adroddiad rhaglen SDEC:](#)

[Fframwaith Cenedlaethol Cymru ar gyfer Gwasanaeth Eiddilwch Acíwt wrth y Drws Ffrynt](#)

Cysylltiadau defnyddiol: [Perfformiad a Gwella GIG Cymru](#)
ABB.SixGoalsUEC@wales.nhs.uk

Cam Gweithredu 13: Rhaid i Fyrddau lechyd ddilyn canllawiau ar Atal a Rheoli Heintiau er mwyn lleihau trosglwyddo Heintiau Anadlol Acíwt

Rhaid ystyried y canlynol:

- Defnyddio dulliau asesu/brysbennu a phrofion er mwyn gallu adnabod yn gynnar y cleifion hynny sy'n dioddef o heintiau anadlol aciwt.
- Defnyddio llwybrau cleifion i garfannu neu ynysu cleifion yn unol â chanlyniadau profion.
- Ystyried gwisgo masgiau'n gyffredinol yn unol â chyngor a data Atal a Rheoli Heintiau Iechyd Cyhoeddus Cymru ar gyfraddau / achosion o heintiau anadlol aciwt.
- Y modd y gadewir i'r cyhoedd ymweld ag ysbytai yn ystod cyfnodau pan fo llawer o heintiau anadlol aciwt, a / neu yn ystod brigiadau o achosion.

Dolenni:	Iechyd Cyhoeddus Cymru, Mesurau Atal a Rheoli Heintiau ar gyfer Heintiau Anadlol Acíwt mewn Lleoliadau Iechyd a Gofal Cymdeithasol – Cymru
Cysylltiadau defnyddiol:	Llywodraeth Cymru Rebecca.Jewell001@llyw.cymru Rebecca.Phillips@llyw.cymru

Cam Gweithredu 14: Heintiau sy'n Gysylltiedig â Gofal Iechyd: Rhaid i Fyrddau Iechyd ac Ymddiriedolaethau'r GIG gyflawni yn erbyn y nodau gwella a nodir yn y rhifyn o Gylchlythyr Iechyd Cymru a gyhoeddwyd ym mis Medi 2024

Mae Heintiau sy'n Gysylltiedig â Gofal Iechyd yn parhau i fod yn fater hollbwysig o ran iechyd cleifion, ac mae'n hanfodol canolbwyntio ar leihau eu mynychder. Bydd rhagor o ganllawiau'n cael eu cyhoeddi'n ddiweddarach eleni.

Dolenni:	Heintiau sy'n gysylltiedig â gofal iechyd a nodau ymwrthedd gwrthficrobaidd 2024 i 2025 (WHC/2024/038) LLYW.CYMRU
Cysylltiadau defnyddiol:	Llywodraeth Cymru AnsawddANyrsio@llyw.cymru

Nod 3 ar gyfer y Gaeaf: Optimeiddio llif cleifion mewn ysbytai a rhoi dull 'gartref yn gyntaf' ar waith

Cyflwyniad

Drwy ymestyn yr her 50 diwrnod, ynghyd â gwella llif cleifion mewn ysbytai a rhoi dull 'Gartref yn Gyntaf' ar waith, gellir esgor ar fanteision i'r boblogaeth a'r system gyfan. Er

mwyn cyflawni hyn, rhaid i systemau iechyd a gofal cymdeithasol weithio ar y cyd, felly mae ymdrech gydgysylltiedig ar draws amryfal ffrydiau gwaith yn angenrheidiol.

Cam Gweithredu 15: Ymwreiddio'r chwe nod ar gyfer gofal brys a gofal mewn argyfwng yn y Fframwaith Optimeiddio Llif Ysbytai

Dolenni:	Y Fframwaith Optimeiddio Llif Ysbytai Optimeiddio gwasanaethau fferyllol wrth ryddhau cleifion o'r ysbyty i wella llif cleifion
Cysylltiadau defnyddiol:	Perfformiad a Gwella GIG Cymru ABB.SixGoalsUEC@wales.nhs.uk
Dolenni:	Canllaw Rhyddhau o'r Ysbyty: Ionawr 2025
Cysylltiadau defnyddiol:	Llywodraeth Cymru christopher.pickett@llyw.cymru

Cam gweithredu 16: Gweithredu dull cymesur o ddefnyddio gweithio 7 diwrnod ar draws gwasanaethau iechyd a gofal cymdeithasol i hwyluso rhyddhau cleifion ar y penwythnos ac atal derbyniadau.

Er mwyn sicrhau bod prosesau rhyddhau effeithlon ar gael dros y penwythnos, mae'n ofynnol cael strategaeth fanwl a chydgyssylltiedig. Dylai uwch-benderfynwyr fod wrth law i gynnig goruchwyliaeth a chymorth di-oed ar gyfer rhyddhau cleifion, gan hwyluso penderfyniadau cyflym a phendant. Yn achos unigolion sy'n bodloni'r meini prawf perthnasol, dylid rhoi "gweithdrefnau rhyddhau a gaiff eu harwain gan feini prawf" ar waith.

Dylai gwasanaethau fferyllol fod ar gael mewn ysbytai bob diwrnod, gan ddarparu mynediad amserol at feddyginiaethau. Yn yr un modd, rhaid i weithwyr proffesiynol perthynol i iechyd fod ar gael ar gyfer cleifion sydd angen asesiadau adsefydlu neu asesiadau symudedd.

Rhaid sicrhau bod cyfarpar hanfodol ar gael fel y gellir rhyddhau cleifion yn ddiogel, a hefyd dylid sicrhau bod trafndiaeth ddigonol ar gael i gleifion sy'n dychwelyd adref neu i gleifion sy'n cael eu trosglwyddo. Dylai hybiau rhyddhau aros ar agor ar benwythnosau i gydgysylltu'r ymdrechion hyn yn effeithlon.

Yn ogystal, dylai Aseswyr Dibynadwy a gweithlu Gofal Cymdeithasol fod ar gael i gynnal asesiadau amserol ac i ategu cynlluniau gofal. Dylai gwasanaethau cymorth cymunedol fod wrth law i ddarparu parhad gofal, a rhaid i gartrefi gofal fod yn barod i dderbyn preswylwyr dros y penwythnos.

Ymhellach, mae'n hanfodol sicrhau bod modd comisiynu a gweithredu gwasanaethau gofal cartref a gwasanaethau ailalluogi yn ystod penwythnosau, gan sicrhau bod cleifion yn cael y cymorth angenrheidiol heb unrhyw oedi diangen.

Rhaid i'r mentrau hyn gael eu hategu gan ddulliau arwain a chydgylltu effeithiol drwy gydol yr wythnos. Mae'n hanfodol sicrhau y bydd gwasanaethau rhyddhau a roddir ar waith saith diwrnod yr wythnos yn cryfhau, yn hytrach nag yn lleihau, y pwyslais ar ryddhau cleifion yn effeithlon yn ystod dyddiau'r wythnos.

Cysylltiadau
defnyddiol:

Perfformiad a Gwella GIG Cymru
ABB.SixGoalsUEC@wales.nhs.uk

Cam Gweithredu 17: Defnyddio Adnoddau Ategu Penderfyniadau (DST) / Gofal Iechyd Parhaus (CHC) yn y Gymuned

Mae Awdurdodau Lleol a Byrddau Iechyd yn gyfrifol am y canlynol:

- Comisiynu 'bloc' o welyau neu welyau 'a brynir yn ôl y galw' mewn perthynas â gwelyau 'cam i lawr' mewn cartrefi gofal. Dylid defnyddio'r gwelyau hyn pan na fo'n briodol rhyddhau'r unigolyn i'w gartref.
- Pan fo'n ymarferol, cynorthwyo unigolion i gael eu rhyddhau i'w cartrefi gyda chymorth priodol, tra'n aros am asesiad.
- Sicrhau bod gweithwyr proffesiynol cymunedol ar gael, sicrhau eu bod yn meddu ar sgiliau priodol a sicrhau eu bod wedi cael hyfforddiant i gynnal asesiad DST/CHC drwy ddatblygu tîm integredig a chydweithredol.
- Dylid cytuno ar gyllid ar gyfer gwasanaethau cartref/lleoliadau 'cam i lawr' cyn y broses asesu, gan hollti cydgyllidebau neu gyllidebau cyfun 50/50.

Mae'n hollbwysig sicrhau bod pob unigolyn yn cael ei asesu'n ddi-oed.

Egwyddorion:

- Dylid seilio penderfyniadau ar sail resymegol glir a thryloyw.
- Mae'n hanfodol cynnal uniondeb proffesiynol.
- Dylid cynnwys a hysbysu unigolion a'u cynrychiolwyr yn llwyr drwy gydol y broses asesu, yn eu dewis iaith neu fformat.
- Dylid osgoi unrhyw oedi – dylid ystyried opsiynau'n ymwneud â chydgyllido a chyllidebau cyfun fel y gellir cael ymatebion mwy ystwyth ac effeithlon i ddewisiadau ac anghenion unigol.

- Dylid rhoi dull integredig ar waith er mwyn meithrin ymddiriedaeth rhwng sefydliadau partner.
- Dylid sicrhau bod llwybrau priodol ar waith, megis llwybrau rhyddhau i asesu a llwybrau carlam.

Dolenni:	Fframwaith cenedlaethol ar gyfer Gofal Iechyd Parhaus y GIG LLYW.CYMRU
Cysylltiadau defnyddiol:	Llywodraeth Cymru Jemma.morgan017@wales.gov john.spence@llyw.cymru sianparry.jones@llyw.cymru

Cam Gweithredu 18: Gweithredu dull integredig ar gyfer Llywio Systemau

Dylai'r dull hwn gynnwys y canlynol:

- Cydgysylltu gyda gwasanaethau IAA Awdurdodau Lleol.
- Man canoledig sy'n rhoi pwyslais ar osgoi cludo a derbyn cleifion, gan ddarparu dewisiadau amgen amserol a diogel yn lle mynychu adrannau argyfwng a chan sicrhau bod cymorth a threfniadau cydgysylltiedig ar waith saith diwrnod yr wythnos i ategu'r arfer o ryddhau cleifion.

Egwyddorion:

- Rhoi gwybodaeth, cyngor a chymorth amserol i aelodau'r boblogaeth leol ynglŷn â'u hanghenion iechyd a gofal cymdeithasol, a'u cyfeirio at adnoddau sy'n mynd i'r afael â'r anghenion hynny.
- Cynnal asesiadau amlbroffesiynol o anghenion a goruchwylio cynlluniau gofal dilynol er mwyn diwallu anghenion cyfannol a chymhleth y boblogaeth a wasanaethir.
- Sicrhau bod carfannau risg uchel yn cael eu canfod a bod cofnod cyffredin cymesur ar gael i'r holl weithwyr proffesiynol sy'n gysylltiedig â gofal yr unigolyn.
- Derbyn atgyfeiriadau gan weithwyr iechyd a gofal cymdeithasol ar gyfer asesu ac ystyried anghenion sy'n dwysáu (gan gynnwys rhyddhau o'r ysbyty, cartrefi gofal ac Ymddiriedolaeth Gwasanaethau Ambiwylans Cymru) fel y gellir lleihau'r risg y bydd argyfwng yn digwydd a darparu dewis amgen diogel yn lle mynd i'r ysbyty (e.e. Gofal Cymunedol Uwch a/neu ailalluogi), pan fo'n ddiogel ac yn briodol gwneud hynny.

- Derbyn atgyfeiriadau gan weithwyr ‘999’ / ‘111’ a gweithwyr gofal iechyd proffesiynol eraill.
- Darparu mynediad uniongyrchol at lwybrau sy’n hwyluso asesiadau diagnostig, megis atgyfeiriadau uniongyrchol at ofal argyfwng yr un diwrnod.
- Rhoi dull sy’n canolbwyntio ar unigolion a dull sy’n seiliedig ar werth ar waith, gan ganolbwyntio ar yr hyn sy’n bwysig i’r unigolyn a chan ddefnyddio’r ymyriad lleiaf ymwthiol sy’n bodloni dymuniadau’r unigolyn. Er mwyn gwneud hyn, mae angen gofal parhaus a chyson gan feddygon teulu lleol a’u cydweithwyr amlbroffesiynol. Pan fo modd, os yw’r unigolyn yn hysbys i wasanaethau cymunedol, dylid sicrhau mai’r gweithiwr proffesiynol sy’n adnabod yr unigolyn orau a fydd yn cynnal yr asesiad.
- Mynd ati’n effeithiol i reoli’r galw ar y system iechyd a gofal a’i gwasanaethau.
- Optimeiddio’r modd y defnyddir cyfalaf y gweithlu drwy ddefnyddio un man ar gyfer asesu a darparu gofal, gan leihau amrywio a dyblygu ar draws disgyblaethau proffesiynol, gwasanaethau a thimau ag amcanion tebyg.
- Gwella cyfalaf y gweithlu drwy gydweddu â Chanolfannau Monitro Larymau Argyfwng a Hwylusir drwy Dechnoleg. Mae canolfannau o’r fath yn cynorthwyo i reoli unigolion agored i niwed mewn modd rhagweithiol ac maent yn cynnig arwyddion cynnar bod unigolion yn dirywio, fel y gellir ymateb mewn modd amserol a lleihau’r risg y bydd argyfwng yn digwydd.
- Wrth ategu’r arfer o ryddhau cleifion o’r ysbyty, cynnig un man cyswllt ar gyfer darparwyr gofal cyn rhyddhau’r claf ac am 72 awr ar ôl ei ryddhau.

Dolenni: [Y Fframwaith Un Pwynt Mynediad Cenedlaethol](#)

Cysylltiadau defnyddiol: [Perfformiad a Gwella GIG Cymru](#)
ABB.SixGoalsUEC@wales.nhs.uk

Dolenni: [Safonau ac Egwyddorion ar gyfer Gwybodaeth, Cyngor a Chymorth Integredig](#)

[Fframwaith Gofal Cymunedol Integredig a Hwylusir drwy Dechnoleg](#)
I’w gyhoeddi fis Tachwedd 2025

Cysylltiadau defnyddiol: [Llywodraeth Cymru](#)
Rhian.matthews001@llyw.cymru
Shelley.davies052@llyw.cymru

Cam Gweithredu 19: Cyflawni'r model Aseswyr Dibynadwy

- Rhoi'r model 'Gartref yn Gyntaf' ar waith – rhyddhau i asesu.
- Dylai'r model Aseswyr Dibynadwy hwyluso asesiad cytbwys o'r claf, gan ei ryddhau i wasanaethau ailalluogi byrdymor, gwasanaethau 'cam i lawr' neu wasanaethau pontio a chan hyrwyddo ei adferiad hyd nes y bydd asesiad llawn wedi'i gynnal ar gyfer unigolion ag anghenion gofal a chymorth parhaus.
- Sicrhau bod ymatebion gan wasanaethau penodedig a gomisiynir ar gael fel y gellir cynorthwyo i ryddhau cleifion drwy gydol y flwyddyn.
- Dylai sectorau lechyd a Gofal Cymdeithasol ymrwmo i adolygu pob gwasanaeth 'cam i lawr' neu bob gwasanaeth a gomisiynir o fewn 14 diwrnod, gan roi amser i'r unigolyn adfer.

Enghreifftiau o fodelau Aseswyr Dibynadwy

- Defnyddio timau/staff datrys problemau yn yr Adran Argyfwng a fydd yn gallu cyrraedd wardiau, gan ddefnyddio asesiadau cymesur i hwyluso gofal 'cam i lawr' mewn cartrefi gofal neu wasanaeth ailalluogi a gomisiynir neu wasanaethau pontio cymunedol.
- Sefydlu hybiau rhyddhau proffesiynol/amlsefydliadol, lle bydd staff hyfforddedig yn gweithredu fel Aseswyr Dibynadwy i gynnal asesiadau cymesur a threfnu gofal 'cam i lawr' mewn cartrefi gofal neu wasanaeth ailalluogi a gomisiynir neu wasanaethau pontio cymunedol.
- Galluogi ffisiotherapyddion neu therapyddion galwedigaethol mewn ysbytai i ddefnyddio asesiadau cymesur i hwyluso gofal 'cam i lawr' mewn cartrefi gofal neu i gomisiynu gwasanaeth ailalluogi neu wasanaethau pontio cymunedol.
- Defnyddio Aseswyr Dibynadwy i gynorthwyo pobl a fydd yn dychwelyd i gartrefi gofal a/neu bobl a fydd yn dychwelyd at wasanaethau gofal cartref, er mwyn hwyluso'r arfer o ryddhau cleifion.
- Grymuso Aseswyr Dibynadwy i ragnodi cyfarpar angenrheidiol.
- Rhoi protocolau ar waith ar gyfer cynnal Asesiadau Dibynadwy mewn perthynas â lleoliadau ailalluogi/adfer 'cam i lawr' mewn cartrefi gofal.
- Hwyluso gwasanaethau cymunedol i gyrraedd a dylanwadu (timau Nyrsys Cyswllt Rhyddhau cymunedol), gan ddefnyddio asesiadau cymesur i gomisiynu cynlluniau rhyddhau priodol.
- Yn achos cleifion cymhleth, neu pan fo'r ddeddfwriaeth yn nodi bod angen cynnal asesiad cynhwysfawr, dylid sicrhau bod gweithwyr proffesiynol â sgiliau

priodol yn cychwyn y broses asesu'n brydlon, ac na fyddant yn oedi hyd nes y bydd y claf yn ffit yn glinigol.

- Sicrhau y sefydlir trefniadau 'cam i lawr' addas a gomisiynir ar y cyd, fel y gellir cynnal asesiadau cynhwysfawr y tu allan i'r ysbyty pa bryd bynnag y bo hynny'n ymarferol.

Dolenni: [Nod 6 - Perfformiad a Gwella GIG Cymru](#)

Cysylltiadau defnyddiol: [Perfformiad a Gwella GIG Cymru](#)
ABB.SixGoalsUEC@wales.nhs.uk

Cam Gweithredu 20: “Gartref yn Gyntaf” fydd y safon ar gyfer unigolion sy'n ffit yn glinigol – bydd y gwaith o gynllunio ar gyfer rhyddhau cleifion yn dechrau ar ôl iddynt gael eu derbyn i'r ysbyty. Bydd cydweithredu rhwng Iechyd a Gofal Cymdeithasol yn gwella effeithlonrwydd y dull hwn.

Ymwreiddio Llwybrau Rhyddhau i Adfer yna Asesu mewn ymarfer:

- Yn achos yr holl gleifion a gaiff eu derbyn i wardiau oedolion cyffredinol, rhaid neilltuo llwybr 'Rhyddhau i Adfer yna Asesu' (D2RA) ar eu cyfer o fewn diwrnod o'u derbyn i'r ysbyty, ar ôl cynnal sgwrs “yr hyn sy'n bwysig i mi” gyda'r claf / perthnasau / gofalwyr, a rhaid mynd ati i gynllunio ar gyfer rhyddhau'r cleifion hyn.
- Rhaid adolygu llwybrau D2RA yn ddyddiol a rhaid gweithredu ac ymgysylltu'n unol â hynny i ategu cynlluniau rhyddhau.
- Rhaid sicrhau mai 'Gartref yn Gyntaf' fydd yr opsiwn diofyn:
 - Dylid defnyddio asesiad rhyddhau cymesur pan fo modd.
 - Dylid comisiynu gwasanaethau adsefydlu a phontio a all ymateb.
 - Yn achos pobl ag anghenion gofal a chymorth parhaus, dylid cynnal asesiad llawn yn y cartref ar ôl iddynt gael peth amser i adfer.
- Bydd llunio cynllun rhyddhau wrth dderbyn cleifion i'r ysbyty yn esgor ar y canlynol:
 - Llwybr 0 – rhyddhau cleifion yr un diwrnod, gan wneud trefniadau gyda darparwyr gwasanaethau ar gyfer cleifion a fydd yn dychwelyd at y gwasanaethau a oedd ganddynt cyn iddynt gael eu derbyn i'r ysbyty.
 - Llwybrau 1, 2 a 3 – rhaid rhyddhau cleifion o fewn 48 awr ar ôl iddynt gyrraedd cyflwr 'ffit yn glinigol'.

Dolenni: [Gartref yn gyntaf: eich rhyddhau o'r ysbyty | LLYW.CYMRU](#)

**Cysylltiadau
defnyddiol:**

Llywodraeth Cymru
christopher.pickett@llyw.cymru

Perfformiad a Gwella GIG Cymru
ABB.SixGoalsUEC@wales.nhs.uk

Rhaid sicrhau bod cyd-drefniadau ar waith rhwng lechyd a Gofal Cymdeithasol i ategu cynlluniau rhyddhau.

3. Y Fframwaith Canlyniadau a Gwella

Mae'n ofynnol i sefydliadau gael prosesau amser real ar gyfer rhannu data ac adrodd er mwyn ategu goruchwyliaeth ac ymateb amserol. Mae hyn yn cynnwys adroddiadau dyddiol ar y sefyllfa a phrotocolau uwchgyfeirio.

Bydd perfformiad sy'n gysylltiedig â chanlyniadau allweddol a Dangosyddion Perfformiad Allweddol yn cael ei olrhain drwy gyfrwng systemau perfformiad cenedlaethol sy'n bodoli eisoes, er mwyn lleihau'r gofynion ychwanegol ar bartneriaid.

Bydd strwythurau cyfarfod Systemau Gofal Cymunedol Integredig, o dan oruchwyliaeth Ysgrifennydd y Cabinet (deirgwaith y flwyddyn) a swyddogion (ddwywaith y mis), yn cael eu rhoi ar waith o fis Medi 2025 ymlaen.

Yn 'Cynllunio gyda'n gilydd ar gyfer y gaeaf: templed hunanasesu integredig rhanbarthol', ceir cyfres o ganlyniadau a dangosyddion sy'n cyd-fynd â pholisïau a rhaglenni cenedlaethol cyfredol megis y Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng, y Rhaglen Strategol Gofal Sylfaenol, y Gronfa Integreiddio Rhanbarthol, 'Ymhellach, Yn Gyflymach' a Gweithwyr Proffesiynol Perthynol i lechyd. Mae'r datganiadau Canlyniadau wedi'u diweddarau ar gyfer System Gofal Cymunedol Integredig Cymru ac maent yn berthnasol i'r cynllun hwn ar gyfer y gaeaf.

Grŵp Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Gweithrediadau, GIG Cymru

Health and Social Services Group
Director of Operations, NHS Wales



Llywodraeth Cymru
Welsh Government

Chief Operating Officers
Directors of Planning
Local Health Boards

Regional Partnership Boards, Leads

Our Ref: JG/A59361032

22 August 2025

Dear Colleagues,

Planning for Winter Period 2025

I am writing regarding operational delivery arrangements for the forthcoming winter period from 1 December 2025 to 31 January 2026. This is an extended period from the **'Planning Together for Winter'** guidance toolkit – Action 11 based on a review of the demand and activity data of the UEC pathway.

The historical increase in clinical and operational pressures during the winter season, requires a specific operational focus based on historical and forecasted modelling of spikes of demand which impact on the systems cadence to respond. I request the attached template is completed to provide assurance of your organisations and systems actions to meet the statutory requirement of the Duty of Quality.

I ask that you continue to build on the whole system approach you have taken for previous winters and ensure our health and care system can maintain service provision to respond to the increased demands during this period. The strong relationship building and collaborative working should set a strong foundation for this work.

You will already have begun the process of reviewing the national **'Planning Together for Winter'** guidance toolkit and considering how key actions can be accelerated in preparation for the Winter period. We have requested you submit a self-assessment by 12 September 2025 following regional and whole system planning discussions.

I should be grateful if your teams would complete and return to the UEC mailbox UrgentAndEmergencyCare.GovernmentBusiness@gov.wales by no later than close on **31 October 2025**.

Thank you for your attention to this matter. I look forward to your response.



Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Jeremy.Griffith@wales.nhs.uk
Gwefan • website: www.wales.gov.uk

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'J Griffith', with a horizontal line underneath.

Jeremy Griffith

Director of Operations
NHS Wales

Cc: **Nick Wood**, Deputy Chief Executive, NHS Wales
Samia Edmonds MBE, Director of Strategic Planning

Planning together for Winter - Regional Self Assessment Template

1. Purpose of the Template

This self-assessment is designed to help regions to coordinate and integrate plans to support a more resilient health and social care system over winter 2025/2026. It is intended to help you to:

- Review your preparedness for winter pressures
- Provide expected improvement trajectories against targets (where indicated)
- Identify any gaps or risks to delivery
- Provide assurance to partners and the Welsh Government

NB Learning from the 2024/25 50 Day Integrated Care Winter Challenge shows that a health and social care integrated, partnership approach to planning and service delivery benefits a whole-system response to shared pressures, increases opportunities to collaborate and build positive relationships. We would therefore encourage a partnership approach to this self assessment and subsequent planning that allows joint consideration of the expected actions. Such an approach supports improved experiences of people accessing services and the staff delivering care and support.

2. Who should complete it

The template should be completed by a **senior officer(s)** with sufficient knowledge and oversight of the region's health and social care / integrated plan to deliver the actions set out in Welsh Government guidance for Winter 2025/2026

Input from relevant health and social care teams (e.g. clinical, operational, estates, finance) is encouraged

3. How to Complete It

- For each action provide a RAG rating
- Provide **brief supporting comments** or evidence on implementation status
- Provide brief comments or evidence on risks, gaps and controls in place
- If an area is not yet complete, outline the **planned actions and timeline**.

4. Key Areas Covered

The template will ask about regional plans to deliver actions set out in Welsh Government correspondence / guidance. These actions are framed by three winter goals:

1. Building Community Capacity to support care closer to home
2. Maximising available acute and community hospital capacity
3. Optimising hospital patient and delivering a 'home first' approach

5. Submission

Please return the completed template by 29 August 2025 to UrgentAndEmergencyCare.GovernmentBusiness@gov.wales

If you need support, review the 'planning together for winter' toolkit and contact the relevant team via the useful contacts list

Tips for Completion

Be honest and realistic—this is about improvement, not judgement.

Use bullet points for clarity.

Keep responses concise (1–2 sentences per comment box is fine).

Planning Together for Winter 2025/2026: Regional Self-Assessment Template

This template is provided as part of the Planning Together for Winter 2025/2026 Toolkit to support regions to self-assessing their readiness against the expectations outlined. Please complete the self-assessment template and return it to *(insert email address)* by *(date)* 2025.

Winter Strategic Goal	Key Actions	Deadline for delivery	RAG Rating	Implementation Status	Risks	Gaps	Controls In Place
1. Building community capacity to support care closer to home	Proactive management of 0.5% most at risk of urgent care (including falls / care home residents) through implementation of Proactive Care principles by Regional Partnership Boards, Pan Cluster Planning Groups and integrated health and social care community	01-Dec-25	Amber	<p>Three boroughs have robust MDT processes in place, the fourth borough is rolling out their MDT response and the final is agreeing how this should be developed. The work will continue to be developed in all five boroughs with clear articulation of what is being delivered and how it is measured. High level data will be shared monthly.</p> <p>Virtual MDTs to target patients with chronic respiratory conditions during the winter period as per WG correspondence (NW/A59190761). Registers to be generated by practices or utilise HRAC analysis for patients with COPD to identify eligible cohorts in each locality.</p> <p>The DSS communication has not yet been received from WG and will be shared across practices when it is</p> <p>Options for focus on patients with</p>	<p>There is a risk of reluctance to engage from independent contractors without adequate support and resources</p> <p>Challenges in demonstrating the link between MDT and DSS and the impact on GP, community and ED services</p>	<p>GP's as independent contractors do not have to produce data for sharing with the HB. The development of a Shared Dataset continues to have a high profile at WG</p> <p>National Winter modelling not yet issued</p> <p>DSS not issued nationally as yet</p>	Baseline data will continue to be collated
	Health boards provide robust community nursing services to support the multiprofessional team around the person across a 7 day period - Weekend capacity should be at circa 80% of that of weekday. Self Assessment and subsequent planning should consider and advise improvement trajectories against target expectation	01-Dec-25	Amber	<p>This forms part of the Community Nursing Model/Older Person's pathway work and will continue to be monitored monthly.</p> <p>Teams leaders meeting with DHoN regularly to review progress against the target and ensure that team members are fully briefed</p> <p>Plan for 5 locality winter planning sessions, with each locality expected to determine their delivery plan during escalation. Aligned to existing plans to extend community services through extended hours or interdisciplinary working between teams to manage system pressures.</p> <p>A defined BCM plan is developed for the implementation of 'Combined Community Teams', with defined triggers for escalation leading to a co-</p>	<p>Some service users prefer to be treated on certain days</p> <p>Increased staff cost by allocating additional people to weekend shifts</p> <p>Partnership working</p>	<p>7 days resilience in some areas, use of bank to be utilized where needed</p>	Monthly monitoring of data from Civica tool

<p>Health Boards and Local Authorities to collaborate to continue to increase referrals to Enhanced Community Care and Multi Professional Wrap Around Care (including Reablement). Self Assessment and subsequent planning should consider and advise improvement trajectories.</p>	<p>01-Dec-25</p>	<p>Red</p>	<p>Sessions are planned with GP's to provide additional updates regarding ECC services. There will be a continued focus to ensure that community practitioners & GPs are aware of the alternative provision to conveyance.</p> <p>Application into Gwent RIF to support 10 locum consultant sessions to support the initial phase of the expansion into North Gwent</p> <p>Regular meetings have taken place to gather relevant information for the CDoS and a focus will be retained</p> <p>Workstream is currently managed via Goal one and is led by the divisional nurse. The development of the Rapid Entry model will continue across</p>	<p>Access to alternative provision can be problematic and difficult, requiring more than one phone call</p> <p>Risk that services do not all engage Information must be updated to ensure reliability and engagement Currently the provision of CDoS is challenging due resource limitations</p> <p>Risk that there will be insufficient staff to provide both an inreach and community response model</p>	<p>7 days resiliance in some areas, use of bank to be utilized where needed</p>	<p>Data is monitored weekly and monthly and reported to SLT</p>
<p>Implement Single Point of Access to Urgent Care (LHBs) as a component of enhanced regional system navigation</p>	<p>Oct-25</p>	<p>Green</p>	<p>Single point of access for health care professionals in place for some time with call handlers navigating Urgent primary, secondary and community referrals.</p> <p>Work on-going to simplify existing structures to improve outcomes. Plans to implement an MDT clinical review step in the process for identified cohorts ie Falls, care homes, over-65s</p> <p>Bid submitted to SPOA Six Goals fund to support the clinical resourcing of the MDT (GP, OT, Frailty specialist) on</p>	<p>Clinical capacity to support the SPOA in particular frailty clinicians given the spread across the system in Gwent</p>	<p>Senior Clinical Decision maker across the primary and acute pathway</p>	<p>MDT clinical Capacity to be added prior to winter</p>
<p>Implement community breathlessness hubs (*three pilot sites only)</p>	<p>31-Oct-25</p>	<p>Amber</p>	<p>Breathlessness hub to consist of re-organisation of spirometry hub capacity.</p> <p>Led in conjunction with Secondary Care Implementation depends on completion of development of model by AZ to enable pilot to commence within timeframe.</p>	<p>There is a risk of endorsement by LMC to implement the model due to lack of engagement with independent contractors</p> <p>Risk of service inequity delivering 1 pilot within ABUHB may result in service users being unable to access hub</p>	<p>Will require community EMIS to implement a referral which can support self population of patient information</p>	<p>A number of focus groups have been established by the National Respiratory Network which will shape the national pathway,</p>
<p>Health boards to commission Supplementary Services from General Medical Services to support identification of 0.5% population at greatest risk of urgent care needs</p>	<p>01-Dec-25</p>	<p>Red</p>	<p>Health Board has assessed previous DSS uptake and are linked in with Welsh Government, with awareness that national negotiations are ongoing with GPC Wales Implementation depends on a defined specification & funding source</p>	<p>No identified resource No DSS received as yet</p>	<p>No identified resource No DSS received as yet</p>	<p>On-going MDT approach in Gwent as per row 7</p>

Health Boards to promote community pharmacy services (Sore Throat Test and Treat / UTI services)	01-Oct-25	Green	<p>Services are Business as usual and will be mandatory from Oct 25.</p> <p>Communications Colleague engaged in promoting Community Pharmacy Services. Comms plan will be in place and uptake will be monitored. Draft comms plan developed and ready for signoff. w/c 18/08 - plan signed off. w/c 15/09 supporting material developed (posters / videos/ FAQs/ translation/ practice manager presentation) w/c 15/09 publish staff intranet article/ develop social media w/c 23/09 stakeholders contacted inc</p>	Communication plan does not reach target groups. Community Pharmacy Contractors unable to meet additional demand affecting patients confidence in HB messaging. No minimum delivery requirements in service specification so provision may not match demand.	Two pharmacies not currently providing CCPS so not an universal offer (these are by exception and due to performance related sanction)	Clear communication plan. Ongoing contract management and service specifications.
Increasing uptake among staff groups through LHB review of winter 25/26; vaccination champions; peer vaccinators; MECC; and routine monitoring	31-Dec-25	Green	<p>Plan in place to improve staff influenza vaccination uptake through closer monitoring and 'walking the wards' in high-risk clinical areas or sites with low uptake, staff and peer vaccinator incentives and additional routes to vaccination beyond peer vaccinators and occupational health clinics (e.g. GPs, Community Pharmacy, Cwmbran Vaccination Centre). Flu Champion training established and on-going.</p>	Lack of clinical leadership and managerial commitment to advocate for the influenza vaccination campaign and/or released peer vaccinators from operational duties. Complacency, lack of motivation or vaccine hesitancy amongst staff.	Gaps and discrepancies in the reporting data throughout the season.	A specific staff flu vaccination oversight group is being set up to monitor delivery of the programme and escalate any risk during the season.
To increase uptake of vaccines to protect against winter respiratory illnesses, consider targeting populations in areas of socio-economic deprivation	01-Oct-25	Green	<p>Plan in place to improve influenza, RSV and COVID-19 uptake in specific cohorts - pregnant women, 2&3 year olds, housebound, care homes, HMP Usk/Prescoed and people with respiratory disease.</p> <p>Targeted campaign for influenza, RSV and COVID-19 with vaccination offered at antenatal clinics and capacity within flying start/nursery settings</p> <p>Promotion of newly established Cwmbran vaccination centre that offers 6 days per week walk-in access for a wide range of vaccinations for all</p>	Complacency, lack of motivation or vaccine hesitancy among pregnant women, parents of 2 & 3 year olds and people with respiratory disease. Timing of the initial wave of influenza and peak immunity from vaccination.	Dedicated vaccination offer available in hospital antenatal clinics and for antenatal appointments in general practice. Capacity to deliver Fluenz clinics from Flying Start childcare and Nursery settings across the Gwent region. Parental consent for school age children.	The Vaccination Operation Group will provide operational oversight of Winter seasonal vaccination programme and address any risk to delivery, escalating any residual risks to SIG or Exec Committee where further mitigation is required.

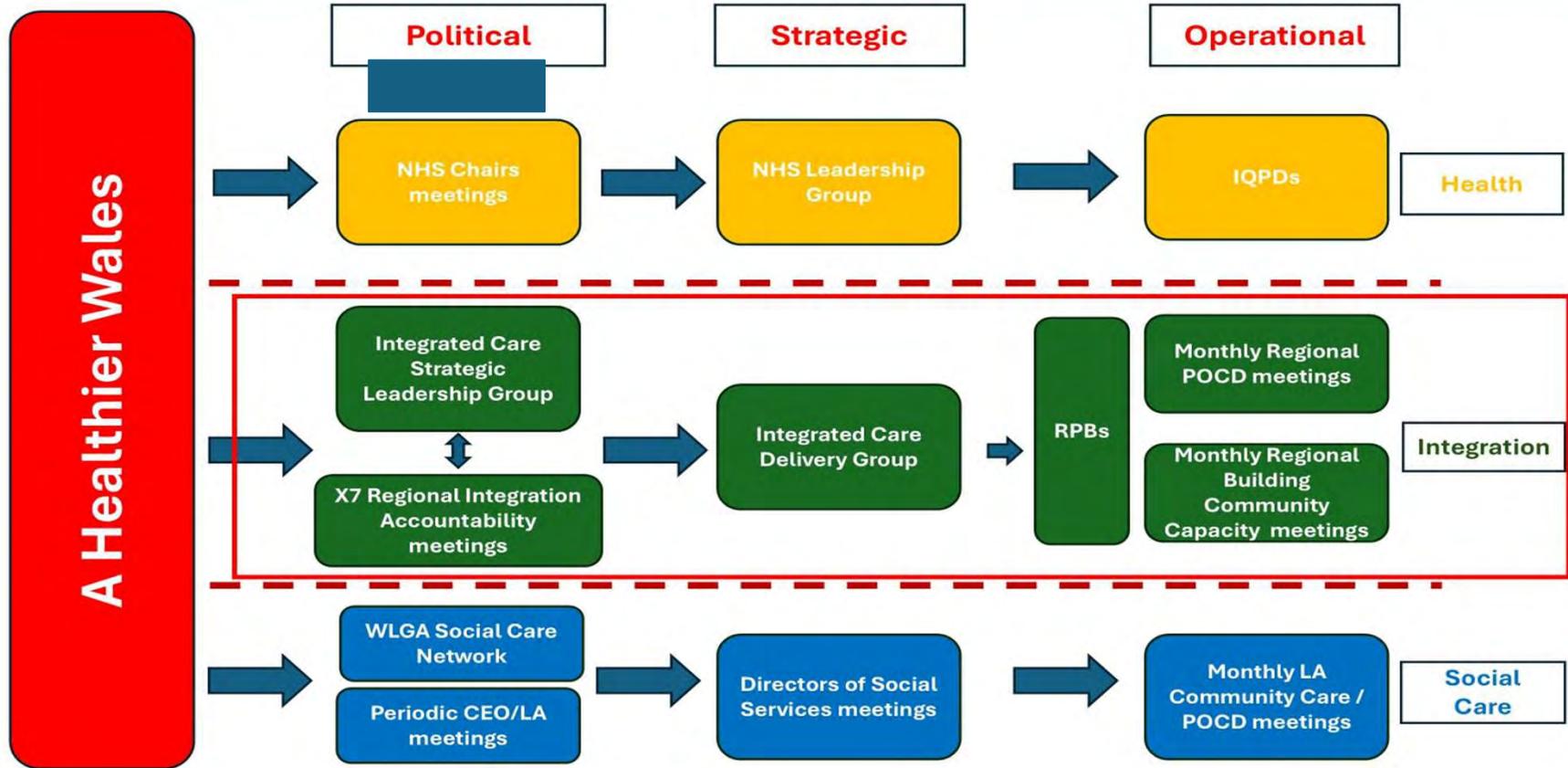
	Health boards to ensure clinical teams in primary and community settings dealing with chronic and acute respiratory disease are encouraged to apply, where appropriate, the nationally agreed management guidelines for COPD, asthma, RSV Bronchiolitis, and Community Acquired Pneumonia.	01-Dec-25	Red	<p>Increase the use of 'just in time' medication boxes</p> <p>Household warmth / Healthy Homes</p> <p>Increase access to Smoking Cessation Programme</p> <p>Self management options, including Expert Patient Groups, pulmonary rehabilitation and national exercise referral schemes</p> <p>Resources and capacity are in the process of being defined and discussion planned at NCN Clinical Leads in August 2025 to agree an equitable local response</p>	There is a risk of reluctance to engage from independent contractors without adequate support and resources	GP's as independent contractors do not have to produce data for sharing with the HB. The development of a Shared Dataset continues to have a high profile at WG	Business as usual / Escalation plans in place
	Within an integrated IAA model of care, implement the six goals programme community-based falls response framework	Nov-25	Green	<p>Successful initial care home education and training initiative, a bid submitted to Six Goals fund to increase the number of care home participation</p> <p>Additional funding secured via RIF to Improve capacity of the enhanced community falls response service in Gwent. Working with WAST to maximize impact of the level 2 response.</p> <p>Plan to add an AHP within the SPOA to support this area</p> <p>Programme established to improve</p>	<p>Clinical capacity to support the enhanced falls response</p> <p>Ability to secure AHP resourcing for vehicles or within the SPOA</p>	Potential resourcing gaps in backfill as clinical input required to support falls programme	Established L1 and L2 community falls response in place. Continue locume/agency AHP support to L2 response if required
	Implement 'neighbourhood level' timely, accessible, coordinated and TEC enabled Information, Advice and Assistance (IAA)	01-Dec-25	Green	<p>We have local and well established IAA service that responds to requests for support from vulnerable adults, their carers and associated professionals. This offer also includes opportunities for Technology enabled care (TEC), including digital devices, remote monitoring, community alarm provision, watch apps, falls detectors</p>	<p>Impact of paying for care / charging systems for technology based care and support solutions which may result in the citizen refusing to accept intervention.</p> <p>Continuing development of IT based solutions that are constantly being updated and revised.</p>	Ability to utilise AI and tech solutions as part of an integrated model of support that could include anticipatory interventions such as wellbeing calls, falls response schemes and community activities.	Use of wider research and information provided by LA technology experts / wider tech networks etc
2. Maximise available acute hospital capacity	Implement an Acute Front Door Frailty Service at all acute hospitals (building on implementation of SDEC services)	Ongoing development	Green	<p>Building on the existing processes developed at GUH where a combination of acute frailty response, home first and community therapies team exist co-located. An inreach model is being developed at all eLGH sites, community therapies team available 5 days per week at RGH and NHH, 7 days at GUH</p> <p>Combined SDEC patient throughput has increased substantially in 2025</p>	Insufficient staffing in times of escalation	Training for hospital staff to undertake CFS, CGA etc	Informal weekly review, formally monthly review of progress and metrics

Enable surge bed capacity	01-Dec-25	Amber	Planning for 2 additional wards to support winter resilience: 1x Medical 1x Community	staffing risk, financial risk	identified funding stream	Business as usual / Escalation Plan in place / Boarding protocols
Deliver a pilot 'Urgent Care Centre' service at up to three sites across Wales (co-located and standalone) (*pilot sites only)	01-Dec-25	Red	Not being progressed locally - not a pilot site	N/A	N/A	N/A
Health boards must follow Infection Prevention and Control guidance to reduce Acute Respiratory Infections transmission and other winter virus i.e norovirus	Throughout	Green	Specific targets for Community Hospital sites: In line with WG reduction plan. Robust protocols in place for winter. Silver command group will be utilized	Increase in Hospital Acquired Infections, mask wearing preparedness, ward closure possibilities access to point of care testing	national winter modelling not yet issued	Leadership walkabout, IPC audits monitored via AMAAT. ARC rollout, incidences of HAI. Infection Prevention anti microcobiol Strategic Group. Mask fit testing
Healthcare Associated Infections (HCAI): Health boards and NHS Trusts must deliver against the improvement goals set out in the Welsh Health Circular issued in September 2024	Throughout	Green	Specific targets for Community Hospital sites: In line with WG reduction plan. Robust protocols in place for winter. Silver command group will be utilized	Increase in Hospital Acquired Infections, mask wearing preparedness, ward closure possibilities	national winter modelling not yet issued	Leadership walkabout, IPC audits monitored via AMAAT. ARC rollout, incidences of HAI. Infection Prevention anti microcobiol Strategic Group.
Review of emergency department delivery plans informed by GIRFT recommendations, ambulance patient handover guidance (WHC) and the quality statement for care in ED	Nov-25	Amber	for October 6th at the Grange 45 minute handover workshop to be held on 29th August to initiate winter handover improvement plan Develop and implement clear, written	Winter demand profile, System navigation, eLGH discharge profile	improvements seen however, gap remains in consistency in acheiving handover targets , national winter modelling not yet issued	Business as usual / Escalation Plan in place
Develop regional operational resilience plans for the period 22 December 2025 – 13 January 2026 (*separate guidance to be issued by WG July 2025)	15-Oct-25	Amber	HB escalation plans in place requires regional working through RPB Winter plans to be ratified through governance channels in September 2025	HB escalation plans in place	HB escalation plans in place , national winter modelling not yet issued	Business as usual / Escalation Plan in place
Development and delivery of a plan capable of effectively managing periods of increased demand in paediatric care across acute services on an all-Wales basis (*health boards to connect to nationally led NHS PI work)	01-Dec-25	Green	footprint complete Additional equipment requirement and orders completed Escalation Plan updated	Paediatric winter demand profile, outbreaks and national communications , 111 demand and capacity	national winter modelling not yet issued	Business as usual / Escalation Plan in place

3. Optimal hospital patient flow and a home first approach	Applying a proportionate approach to 7-day health and social care working to enable discharge of people during the weekend and prevent admission.	01-Dec-25	Amber	Utilise additional weekend working in DNs to free up Rapid Response Nurses from core tasks, to increase focus on Rapid Nursing to facilitate discharge. Nursing/medical model working groups to pick this up Regular meetings with local teams have been	Impact on pay costs associated with increased weekend working		Review by partnership leadership to bring focus to locality operational and professional teams
	Undertaking Decision Support Tools (DST)/CHC process in the community	01-Dec-25	Green	Utilize Established Practice . MDT facilitators identify if there are triggers for CHC and discharged under Discharge to Asses . DST 's only take place at the request	Funding streams		Business as usual / escalation protocols
	Implementing an integrated method for System Navigation - SPOA	01-Dec-25	Green	see row 10	see row 10	see row 10	see row 10
	Consistent delivery of the six goals programme 'optimal hospital flow framework'	01-Dec-25	Amber	wards in the Royal Gwent Hospital. Commenced in August for impact over winter. Implemented morning board rounds and afternoon huddles plus adoption of D2RA model A focus on pre-midday discharge planning in collaboration with LA colleagues Plans to re-shape the RIF funded home first model with effect this	Scale of change, moving from single-site to multiple, cultural elements to change implementation , champion post funding	Currently working to initiate within RGH, plan to roll-out across sites	Six goals and Integrated Discharge Board oversight of actions and trajectories
	Consistent delivery of the Trusted Assessor model	01-Dec-25	Amber	have explored and developed the principles of the trusted assessor model, as and where appropriate. This has been developed in line with the National Trusted assessor guidance to ensure that when applicable, appropriate assessments	Staff capacity to undertake additional assessments Most posts / staff are RIF grant funded and will potentially cease in March 27		Governance oversight via the Regional Partnership Board Adult Service Group (GASP)

	Embed D2RA Pathways into practice (optimising the Home First approach)	01-Dec-25	Green	<p>Continued focus on top 20 longest-staying patients via weekly scrutiny panel</p> <p>Strengthen social care capacity to reduce discharge delays via increased assessment, domiciliary care and reablement capacity</p> <p>Additional assessment posts in Monmouthshire and Blaenau Gwent supported by agency cover, additional IAA posts in Caerphilly and Monmouthshire.</p> <p>A fast tracked (2-week) assessment</p>	Subject to RIF / resilience funding, CWS2 system training and compliance, Scale of change, moving from single-site to multiple, cultural elements to change implementation , champion post funding	CWS2 digital reporting tool rolled-out across sites. D2RA training continues to initiate within RGH, plan to roll-out across sites	Six goals and Integrated Discharge Board oversight of actions and trajectories
	Hospital to Home / Enhanced Care	01-Dec-25	Amber	<p>Application into Gwent RIF Supporting the enhanced care element for a period of up to 6 weeks, based on clinical need. This initiative proved successful last winter</p> <p>Application into Gwent RIF to support provision of additional individual placements in order to drive an overall increase in discharges for Winter.</p>	Subject to RIF / resilience funding	Winter Gap this year compared with last winter if not successful in achieving the funding	Business as usual / escalation protocols

Proposed Governance for Winter Planning and Building Community Capacity / Place Based Commissioning Going Forward



The Outcome we Want

The approach this year aims to facilitate further progress on mitigating system pressures through joint working across our partners and which recognises the benefits of an integrated community care system that manages 'high risk of urgent care' population needs proactively and providing urgent response to escalated needs (including supporting early discharge from hospital). Most importantly, as well as contributing to managing demand on health and social care, a preventative and proactive approach will reduce avoidable harm and improve outcomes for this population group.

System Outcome Indicators (remain as per 24 / 25 CAC Monitoring):

- Number of people receiving domiciliary care / residential care (per 100k)
- Number of people waiting for domiciliary care / residential care (per 100k)
- Number of emergency admissions for adults > 75 years
- Proportion of emergency admissions with LOS > 21 days

System Process (Improvement) Measures (remain as per 24 / 25 CAC Monitoring):

Proactive and Urgent Care in Community

- Number of people seen by District Nursing
- Number of visits undertaken by District Nursing
- District Nursing Weekend day Capacity as a % of Weekday day Capacity
- Number of people receiving reablement
- Number of people waiting for reablement
- Number of referrals to Enhanced Community Care (from community and from hospital)
- Number of discharges from Enhanced Community Care
- % of people receiving ECC who remained at home

Optimal Hospital Flow

- % increase of daily (7/7) acute discharge rates
- Reduce days delayed by 20% by March 2026
- Reduce total delays by 15% by March 2026

In addition the following will also be monitored in 25 / 26 :

Urgent Care

- Reduction in conveyance and admission of people who fall - Reduce level 1 and 2 fallers conveyed by ambulance to ED by 10% by December 2025, and 25% by March 2026 (on March 2025 baseline). **(expectation of LHBs re 6 Goals Prog.)**
- Reduce admissions of level 1 and 2 fallers by 10% by December 2025, and 25% by March 2026 (on March 2025 baseline) **(expectation of LHBs re 6 Goals Prog.)**
- Reduction in conveyance and admission of people with breathing problems
- Increase in the number of referrals / acceptance rates for alternative acute services for example SDEC **(expectation of LHBs re 6 Goals Prog.)**

Emergency Care

- Ambulance patient handovers in 15 mins (%) and 45 minutes **(expectation of LHBs re 6 Goals Prog.)**
- % improved Ambulance response times
- Time to assessment in ED
- Average ED admission rate (%)
- 4-hour ED performance %

- 4-hour ED performance %
- Patients in ED for >12 hours
- Lost hours per ambulance arrival
- Median time to register a death

Prevention

- Increase vaccination rates among key population groups
- Reduced 'flu incidence
- Fewer admissions who are symptomatic of flu
- Reduction in HCAIs
- Number of hospital beds closed to new admissions due to IP&C issues
- All eligible community pharmacies to be offering Sore Throat Test and Treat (STTT) service and Urinary Tract Infection (UTI) Service prior to winter 2025-26
- More Choose Pharmacy consultations undertaken freeing up GP appointments

Additional Considerations For Regional Partners

H&SC System-level Outcomes

- Whole system approach providing seamless cross-organisations care, treatment and support for segmented and stratified populations in their home now and into the future
- A joined-up model that ensures continuity and coordination of care across services.
- Assessment, care and support is person centred and proportionate to the needs of the individuals and the system; this should be accessible (7/7) with 24/7 care provision delivered by the appropriate professional and their teams at the right time and in the individual's preferred setting. Emphasis on prevention and early identification of escalating needs to avoid crisis enabling early intervention in the community where safe and appropriate to do so and hence preventing avoidable harm (loss of independence, conveyance and admission to hospital, safeguarding).
- Enable higher quality care and value through reducing variation, waste and harm.
- System efficiency and equity are prioritised.

Organisational-level workforce outcomes

- The multi-professional workforce has the necessary skills, knowledge and ability to work collaboratively.
- Staff are equipped and supported to deliver integrated care.
- Reduced duplication of visits and information collection between professionals.
- Streamlined processes improve efficiency and reduce burden on individuals and staff.

Individual-level outcomes

- People live well and remain in their own home.
- Whether in the community, supported living, or care settings, people are enabled to stay where they feel most at home Experience good wellbeing. Access to proactive, timely, and holistic services that support physical, mental, and emotional health. Live safely and stay connected.
- Integrated services promote safety, inclusion, and meaningful social connections. Maintain healthy lifestyles. Empowerment through education and community programmes to support healthy choices. Live independently with support. Tailored services maximise independence and dignity within homes and communities.

Additional Measures for consideration

Prevention and Proactive Care

- Number of all contacts (new and existing service users) to local authorities
- Number of people offered IAA Number of people eligible for a care and support plan
- number of people with needs met by other means, number of people with no eligible needs
- % of people benefitting from IAA proportionate assessment
- % of people who went on to integrated assessment, following IAA proportionate assessment.

- Number and % of integrated (social work) assessments that resulted in long term care requirement / new and / or increase
- % of stratified cohort that have been offered Future Care Planning
- % stratified cohort that have had medication reviews / Falls assessment
- Step up and Step Down and therapy led programmes

Urgent and Emergency Care

increase in the number of appropriate or 'approved' dispatches for target patient cohorts and minimise patients passed to the ambulance service. reduction in the number of inappropriate conveyances to ED for target patient cohorts.

increase access to a 2-hour holistic and personalised urgent care response taking a shared approach across services.

Increase in the number of appropriate referrals and in acceptance rates to wider community, ECC services, mental health (including 111 Press 2) and /or social care services.

Increase in the number of referrals /acceptance rates for alternative acute services for example SDEC (**expectation of LHBS - six goals programme plan**) Step up and Step Down and therapy led programmes

Optimal Hospital Flow

- Deconditioning
- Effectiveness of D2RA

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Regional Planning: Llantrisant Health Park – Outline Business Case
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	David Hanks, Head of Service Planning

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The attached outline business case (OBC) has been developed by Cwm Taf Morgannwg University Health Board in collaboration with regional health board partners in respect of the first phase of the development of Llantrisant Health Park.

Cefndir / Background

In December 2022, Cwm Taf Morgannwg University Health Board (CTMUHB) submitted a successful business case to Welsh Government to purchase the former British Airways Avionics Engineering site at Llantrisant, with the purchase of the site completing in February 2023.

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



“Our Programme for transforming and modernising Planned Care and reducing waiting lists in Wales” (April 2022), and the development of the site has been prioritised in subsequent communication from the Cabinet Secretary and the Chief Executive of NHS Wales. The vision for Llantrisant Health Pard was approved by the Board in its March 2025 meeting.

The project is being led by the LHP Project Team at CTMUHB in partnership with regional partners - Health Boards in south east Wales have committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability. By agreement, the development of LHP will be undertaken via a phased approach:

- Phase 1 is the development of a community diagnostic hub, comprising imaging and endoscopy
- Phase 2a will include a high volume, low complexity orthopaedic inpatient unit
- The final phase 2b will include a multi-modality day surgery unit

This outline business case refers specifically to Phase 1.

Asesiad / Assessment

The purpose of the Phase 1 LHP outline business case (OBC) is to outline key objectives, current plans for investment and to seek approval for funding from Welsh Government to proceed to full business case for the community diagnostic hub (CDH) element of the project. This OBC supports the improvement of regional access to regional community diagnostic services including radiology (CTMUHB only) and endoscopy (regional).

The attached OBC sets out the strategic, economic, commercial, financial and management case for the development.

The CDH proposal incorporates:

- Imaging capacity – incorporating MRI, CT and non-obstetric ultrasound to serve the CTM population
- Endoscopy capacity – elective and screening services to increase capacity across the south east region
- Training capacity - working with Health Education and Improvement Wales, the scheme offers a diagnostic training academy space which links into existing endoscopy suites and provides a base for the endoscopy training academy as well as resources and facilities to support the wider diagnostic training facilities.

The OBC also includes the development of the wider site infrastructure requirements. This will mitigate the operational impact on the CDH during later phases of construction (Phases 2a and 2b). The OBC seeks £2.17m of fees from Welsh Government to continue from OBC to FBC. The draft capital costs in the case of the preferred option are £109.1m. The draft revenue consequences of the case are £7.5m recurring, notionally 0.7m of this would be an ABUHB commissioner share of additional endoscopy activity from 2028/9.

Noting staffing challenges across the region the proposed delivery model for diagnostics for the first seven years of LHP operation is to appoint an Independent



Service Provider to deliver services within the site with activity commissioned from Health Boards.

The Phase 1 LHP OBC is being presented to the CTMUHB Board for approval. As this is a regional partnership development, the OBC is also being presented to the Boards of Aneurin Bevan University Health Board (ABUHB) and Cardiff & Vale University Health Board (CAVUHB) on the 24th and 25th of September. The CDH contract will be held by CTMUHB and the other two health boards will commission activity from this contract and will not be contract holders. It remains important however that they support the development. Therefore the Board is being asked to;

- Note the OBC as a CTM case with regional elements
- Endorse the commitment to commissioner share for Endoscopy phased from 27/28
- Note the Endoscopy Plan within the case for expansion of services in RGH, pending additional revenue

Endoscopy Commitment

Informed by detailed demand and capacity plans, ABUHB has committed to the commissioning of endoscopy activity at LHP to the equivalent of five sessions or half an endoscopy theatre by 2028/29.

The OBC contains the full extent of regional plans for the expansion of endoscopy services. This includes further development of services through maximisation of the Royal Gwent Hospital (RGH) ahead of the commissioning of activity from LHP. The case acknowledges that service expansion across the region will require additional of revenue, this case relates to capital cost therefore does not specifically request this funding at this stage however it does acknowledge the interdependency.

The Chief Executive wrote to CTM as the lead for the endoscopy programme in April 25 with a number of points for clarification as part of the regional plan for endoscopy. A response to this letter was received in August 25 and is attached in Appendix 2. It was agreed via the Regional Oversight Board that the additional clarity would feature in the LHP OBC for Phase 1.

No commitment has been made at this stage for ABUHB to commission any imaging activity, although this option remains for future consideration if required.

Project risks are set out in section 4.3 of the attached OBC. The key risk currently recorded is the non-approval of the OBC by Welsh Government. To mitigate this risk, a thorough approach is being taken to the development of the OBC, supported by robust governance arrangements.

The Board is not being asked to formally approve the commissioning of activity from LHP, this would come once the project moves to the delivery phase, subject to approval, but to endorse the principle of commissioning from the site based on demand and capacity requirements.



Argymhelliad / Recommendation

The Board is asked to:

- Note the OBC as a CTM case with regional elements
- Endorse the commitment to commissioner share for Endoscopy phased from 27/28
- Note the Endoscopy Plan within the case for expansion of services in RGH, pending additional revenue

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

<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>Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives</p> <p>Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs</p>





GIG
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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Produced on behalf of Cwm Taf Morgannwg UHB by

Archus
The healthcare infrastructure specialist

Outline Business Case for Llantrisant Health Park Community Diagnostic Hub

September 2025

Version 0.7 DRAFT



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Summary sheet

Llantrisant Health Centre OUTLINE BUSINESS CASE (OBC) – HIGH VALUE (OVER £2 MILLION VALUE OF PROCUREMENT)	
SRO	Paul Mears, CEO Cwm Taf Morgannwg University Health Board
Programme Director	Rosie Cavill, Programme Director
Organisation	Cwm Taf Morgannwg University Health Board Cardiff and Vale University Health Board Aneurin Bevan University Health Board

Version control – record of edits

Version	Changes made	By	Date
0.1	Set up template first draft	EH (Ellie Harvey)	25/06/25
0.2	Update with text from Diagnostics Nov 24 business case	BL (Bev Letherby)	30/07/25
0.3	Updated with text from Regional Endoscopy Plan	BL	05/08/25
0.4	Updated with text from Rosie Cavill	RC (Rosie Cavill)	06/08/25
0.4.1	Updated commercial case text and GM comments	BL	14/08/25
0.5	Updated with strategic and commercial case from Elle Beadle	BL	18/08/25
0.6	Updated with Economic Appraisal and Financial Case	HMDK (Henry Mony de Kerloy)	02/09/25
0.7	Reformatted with updated Strategic Case	RC / Archus	03/09/25
0.7b	Final draft for circulation with HB's	RC/Archus	04/09/25
0.7c	Draft with adjusted Exec Summary	RC	05/09/25
0.7d	Draft incorporating CDM comments – issued to WG	CDM/RC	08/09/25
0.7e	Updated with appendices	RC	11/09/25

Appendices

Appendix Ref	Appendix Name
Appendix 1	Strategic Overview Case
Appendix 2	Demand & Capacity Findings
Appendix 3	National Endoscopy Programme Identification of Potential Areas for Regional Centres
Appendix 4	NHS Wales Clinical Skills and Simulation Academy Proposal
Appendix 5	Capital Quantified Risk Register
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Appendix 8	Capital Cost Plan
Appendix 9	Revenue Costs Working Paper
Appendix 10	Comprehensive Investment Appraisal (CIA) Model
Appendix 11	Phase 1 Infrastructure Programme

Glossary

ABUHB	Aneurin Bevan University Health Board	ISP	Independent Service Provider
BAU	Business As Usual	MMC	Modern Methods of Construction
BCR	Benefit Cost Ratio	NEC	New Engineering Contract
BfW	Building for Wales	NPC	Net Present Cost
BIM	Building Information Modelling	NPSV	Net Present Social Value
BREEAM	Building Research Establishment Environmental Assessment Method	NWSSP – SES	NHS Wales Shared Services Partnership - Specialist Estates Services
CDE	Common Data Environment	NZC	Net Zero Carbon
CDH	Community Diagnostic Hub	BJC	Business Justification Case
CIA	Comprehensive Investment Appraisal	OBC	Outline Business Case
CIA	Comprehensive Investment Appraisal	PM	Project Manager / Programme Manager / Project Management
CSF	Critical success factor	PSC	Professional Services Contract
CTMUHB	Cwm Taf University Health Board	PWF	Preferred Way Forward
C&VUHB	Cardiff and Vale University Health Board	RPA	Risk Potential Assessment
DHSC	Department of Health and Social Care	SAB	SuDS Approval Body
FBC	Full Business Case	SCP	Supply Chain Partner
GiRFT	Get it Right First Time	SO	Spending Objective
HB	Health Board	SOC	Strategic Outline Case
IIB	Infrastructure Investment Board (Welsh Government strategic committee)	SRO	Senior Responsible Officer
		WG	Welsh Government

1 Executive summary

1.1 Structure and introduction

The purpose of this outline business case (OBC) is to outline key objectives, current plans for investment and seek approval for funding of **£2.177M** from Welsh Government to proceed from OBC approval to full business case (FBC) approval for the Phase 1 of the Llantrisant Health Park (LHP) Programme which comprises the Community Diagnostic Hub (CDH) and site wide infrastructure works to prepare for later phases.

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

This OBC supports the first priority, to improve access to regional Community Diagnostic services including Radiology and Endoscopy. Business cases for later phases of this development including Orthopaedic Surgery with supporting ward accommodation and Day Surgery will be prepared as later phases in the programme.

The structure of the OBC is outlined in the table below.

Case	Section / Purpose	Description
Strategic	2 Strategic Context	Provides an overview of current services and explains how the project is strategically placed to contribute to the delivery of organisational goals.
	3 Case for Change	Establishes the case for change by outlining the spending objectives, existing arrangements and business needs.
	4 Potential Scope and Services	Identifies the potential scope of the project in terms of the operational capabilities and service changes required to satisfy the identified business needs.
	5 Benefits and Risks	Identifies the benefits, risks, constraints and dependencies for the project.
Economic	6 Options Identification and Appraisal	Explores the preferred way forward by agreeing critical success factors (CSFs), determining the longlist of options, and undertaking a SWOT analysis to identify a shortlist of options.
	7 Economic Appraisal	Appraises the economic costs, benefits and risks for the short-listed options and concludes which option represents the best value for money.
Commercial	8 Procurement Route, Scope and Contractual Details	Outlines: <ul style="list-style-type: none"> • the procurement strategy and routes that have been agreed. • the scope of the procurement • the contractual arrangements of the potential deal to deliver the recommended solution for the project.
Finance	9 Financial Appraisal	Sets out the forecast financial implications of the preferred option.
Management	10 Management Arrangements	Sets out the arrangements put in place to manage the project to successful delivery.

1.2 Background and context

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

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

In December 2022 CTMUHB submitted a case to Welsh Government (WG) to request funding for the purchase of the site, which was to be known as Llantrisant Health Park (LHP). This case set out the initial development aims and aspirations and was approved by CTMUHB Bard. WG approved the purchase and released £8M funding for the purchase of the site on the condition that the development was for a regional health facility for the South East Wales Region. The purchase completed in February 2023.

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

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

LHP offers the region a unique opportunity to deliver new ring-fenced elective capacity, encompassing innovative developments and state of the art practice. The site will provide efficient and proven effective models of care to deliver increased diagnostic and treatment facilities across the region.

The CDH proposal incorporates:

- **Imaging capacity** – incorporating MRI, CT and ultrasound as part of a Community Diagnostic Hub (CDH). The unit will also have the capability to deliver plain film X ray
- **Endoscopy capacity** – elective and screening services to increase capacity across the region and address the projected six suite shortfall across the region by 2027/28 and to introduce a training academy to respond to workforce shortfalls.
- **Training capacity** - working with HEIW, the scheme offers a diagnostic training academy space which links into existing endoscopy suites and provides a base for the endoscopy training academy as well as resources and facilities to support the wider diagnostic training facilities.

This OBC seeks approval to progress to Full Business Case (FBC) for phase 1 of the LHP Programme. To develop a CDH and undertake site infrastructure works to mitigate impact on the operational CDH during later phases of construction,

As well as phase 1, the LHP Programme consists of the following phases which will be subject to separate business cases:

- **Phase 2 - High-volume, low-complexity orthopaedic inpatient unit** - providing capacity for up to six theatres to deliver arthroplasty (knees and hips) surgery for patients meeting the criteria for treatment without critical care support. An inpatient unit adjacent to the theatres will accommodate patients requiring an overnight stay.
- **Phase 3 - Multi-modality day surgery unit** – principally focused on addressing the significant shortfall in dedicated day surgery capacity across CTMUHB, it will be a dedicated and fully efficient centre of excellence that reduces wait times.

Whilst capital funding will be applied for all phases to design and build the units, the plan for the CDH is that the service will be provided by an independent service provider (ISP) under a managed service contract for an initial 7 year term, which can be extended for up to 3 years on a year by year basis. The ISP will equip and staff the unit. The procurement for the ISP is currently ongoing with a preferred supplier proposed to be selected by the end of September and an appointed confirmed by the end of October.

CTMUHB is the lead party in the procurement and will be the contracting party for the managed service contract with the ISP. The OBC is based on the fact that there is agreement that both C&VUHB and ABUHB will contract for endoscopy services only from the CDH in line with the outputs from the regional planning exercise recently undertaken. The imaging provision initially will be contracted for CTMUHB for their patients only. ABUHB has stated that it may look to commission imaging services from LHP in the future.

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

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

1.3 Vision and spending objectives

The vision of the LHP programme is to create a standalone site for high volume low complexity surgery and diagnostics that guarantees uninterrupted, effective, efficient services, which address both current capacity shortfalls and offers opportunity to meet future demand growth. Phase 1 will deliver the diagnostic element of the programme and enable the future phases on the site.

The spending objectives listed in the table below were agreed by members of the LHP Programme Board in September 2024 as overriding programme objectives which have been adapted to apply directly to this phase 1.

Ref	Theme	Spending objective	Benefit
SO1	Meet population needs	The delivery of an elective high volume low acuity model of care for the South East Wales Region on a phased basis. The first phase to focus on diagnostics and endoscopy. A second and third phase to focus on orthopaedics and day surgery respectively. Phase 1 services to be operational during the 2027/28 financial year. Future phases to consider further regional services such as pathology.	<ul style="list-style-type: none"> • Right-sized to meet current and future demand • Improves access to range of services • Centre of Excellence with efficient service delivery models and improved patient outcomes and increased throughput • Able to flex for the future
SO2	Maximise capacity	To maximise clinical capacity on the LHP site. To ensure that the maximum amount of available space is directed towards direct service delivery with supporting services managed from the neighbouring Royal Glamorgan site.	<ul style="list-style-type: none"> • Creates opportunities for centralisation of skillsets; centre of excellence • Enables greater collaboration regionally • Creates opportunity for one stop diagnostics, improved use of resources and appointments
SO3	Innovation and standardisation	To facilitate and support the use of innovative design and delivery solutions in both clinical and non-clinical services. To implement standardised protocols and practices to promote efficient service delivery offering improved value for money and addressing the modifiable drivers of increased cost against English Tariff, excluding those aspects driven by Welsh Policy.	<ul style="list-style-type: none"> • Standardisation of consumables, with financial savings • Standardisation of best practice/policies; efficiencies, increased throughput, reduction of wait lists
SO4	Enable training / development of future workforce	To enable increased training and development of secondary care staff including accommodating more medical trainees and students.	<ul style="list-style-type: none"> • Accommodates placements for students (allowing role development and succession planning) • Improved workforce retention and recruitment
SO5	LHP Models of Care and Workforce Models	During phase 1 to ensure that the managed service provider delivers compliant and innovative models of care and workforce models, following the initial terms to develop innovative and new models of care to bring the CDH back into NHS management and control. . In Phases 2 and 3 to develop a new model of care and workforce models to support the delivery of the core services, the models will support efficient delivery of services	<ul style="list-style-type: none"> • Environment / ways of working that support staff welfare and wellbeing • Improved skills and job satisfaction • Improved patient outcomes • Multi-disciplinary working

Ref	Theme	Spending objective	Benefit
SO6	Sustainable estate	To deliver a sustainable infrastructure on the site maximising decarbonisation and net zero opportunities.	<ul style="list-style-type: none"> Complies with relevant standards; NZC, BREEAM excellent and energy performance Opportunities for future additional service provision for South East Wales. Opportunities for further regional reconfiguration and enabling of service and or estate rationalisation.

1.4 Case for change

NHS diagnostic services remain under significant pressure despite concerted endeavours of health boards to increase capacity and improve access to reduce waiting times.

The *Diagnostics Recovery and Transformation Strategy for Wales 2022-2025* sets out the plan to improve, transform and redesign diagnostic pathways in Wales. This national strategy seeks to deliver on the following aims:

- Improving outcomes and reducing pressure on secondary care.
- Addressing unmet care need that has been exacerbated by COVID-19.
- Enabling people to live longer, healthier lives at home.
- Identifying treatments earlier in disease which enables intervention and care management more rapidly.
- Creating a sustainable and intelligent integrated health system which reduces inequality.
- Making Wales a great place to live and work.

The South East Wales Regional Diagnostics plan for Community Diagnostic Hubs aligns with this strategy and its aims through the intention to seek both a rapid expansion of diagnostic service access and the delivery of new models of care with a focus on providing centres of excellence which will attract and retain the required workforce. Alongside this the Hub will align with GiRFT and JAG principles in promoting best practice.

Radiology

Radiology forms part of the 26 week **referral to treatment time** target (RTT) and 62 day single cancer pathway target, from suspicion to first definitive treatment. It is also anticipated that with increased capacity and significantly reduced waiting times there will be further opportunity to gain efficiencies across the health system by developing clinical pathways that incorporate diagnostics at an earlier stage, aiming to reduce pressures on services and improve the patient experience.

Radiology demand and capacity modelling has focused on the CTMUHB position only. The current waiting times are as set out below:

Date	Non Cardiac CT		Non-Cardiac MRI		Non Obstetric USS		Total	
	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks
Jan-24	1,716	966	1,765	1,166	2,685	3,427	6,166	5,559
Jun-25	2,154	994	1,964	33	3,483	1771	7,601	2,798

The number of patients waiting within CTMUHB has increased in the last 15 months. This is despite the use of non recurrent funding to provide interim and additional temporary capacity such as the siting of a mobile MR and CT on the LHP site. This has significantly reduced the over 8 week waits but has not reduced the total number of patients waiting.

When considering the actual imaging capacity within CTMUHB to projected demand there is a clear ongoing shortfall in capacity and without additional intervention waiting times will continue to increase. As part of the regional imaging planning processes, all organisations have been looking at whether they can maximise utilisation of existing assets by extending working days and hours.

Modality	Potential capacity	Forecast	2026/27	2027/28	2028/29	2029/30	2030/31
MRI	30,087	Demand	27,729	29,947	32,343	34,931	37,725
		Variance ¹	2,358	140	-2,256	-4,844	-7,638
CT	100,512	Demand	90,013	94,514	99,239	116,250	126,596
		Variance	10,499	5,998	1,273	-15,736	-26,084
Ultrasound	80,484	Demand	45,519	47,794	50,184	52,693	55,328
		Variance	34,965	32,690	30,300	27,791	25,156

By maximising capacity in the short term CTMUHB can continue to meet demand in all modalities until the end of 2027/28. From 28/29 shortfalls in MRI and CT start to become apparent. LHP is due to open in late summer 2027/28 so will be in place to meet the shortfalls within CTM. However this does not account for CTMs ability to be able to recruit suitable workforce or the level of resource required to secure this level of service. Whilst MRI and CT capacity can be increased to mitigate demand growth additional capacity will still be required from LHP.

On the face of it, CTMUHB has potential capacity to meet ultrasound demand over the next five years and beyond, however NOUS services are under extreme pressure on all sites within CTMUHB and are recognised as being a service under pressure nationally in Wales. Much is due to the high workforce input into this modality which leads to strains on the existing resource and sees higher levels of sickness and rest breaks generally required by sonographers.

The deliverability of the potential capacity levels for NOUS are not realisable due to two important drivers due to the high demand for obstetric scanning coming from the changes in the care pathways and the ergonomic challenges of the patient group which is resulting in increased sickness and RSI issues within the workforce and driving down productivity.

- Firstly, changes to antenatal care pathways are driving an increase in obstetric scanning and this must be prioritised over elective scanning, due to the shorter timescales.
- Secondly, due to the volume of obstetric scanning and ergonomic challenges of our patient group, we are seeing increased sickness driven by RSI issues which is further limiting the actual capacity.

The provision of a standalone service, provided by a workforce distinct to our obstetric services is critical to deliver NOUS waiting times and provide ringfenced service whilst existing capacity can be focused on achieving obstetric scanning demand. It is clear that alongside increases to existing asset hours of operation the services at LHP will be critical to deliver a sustainable diagnostic performance.

¹ Surplus / **shortfall**

Endoscopy

Despite significant work undertaken by the three health boards in the South East Wales region, the performance profile currently indicates a significant proportion of patients waiting more than the target waiting time of accessing diagnostic endoscopy within eight weeks. In August 2024 there were nearly 8,000 patients waiting more than eight weeks for a diagnostic endoscopy, although this position has improved because of additional non-recurrent funding.

The demand and capacity model developed by the National Endoscopy Programme for Wales (NEP), has identified a recurrent shortfall in capacity. This demand is driven by increasing symptomatic demand coupled with the phased extension of the age range for Bowel Screening. The outcomes of this modelling work confirmed a six-room shortfall in the South Wales region by 2027/28 and recommended the introduction of a JAG compliant standalone regional endoscopy unit.

Regional planning teams have developed integrated plans to address the resultant capacity shortfall of six rooms. Local plans and capacity increases will meet some of the demand leaving a four-room operational shortfall to be met by LHP from 2027/28. In addition, there is a desire to create at least one training room which would equate to a requirement of five rooms at LHP. The current design incorporates six endoscopy rooms and associated supporting space. This provides a sustainable and resilient approach to the development; it enables the absorption of future growth or changes in screening requirements by Public Health Wales as well as offering training opportunities and resilience in case of down time in any room.

This OBC focuses on the delivery and resources associated with the LHP site only. Any further resources required to support local plans will be developed further through the regional planning process.

1.5 Economic Case

1.5.1 Clinical service delivery options

In determining the case to support regional CDHs in South East Wales, the Regional Diagnostic Board led an exercise to consider how HB could deliver improved performance in diagnostics. The criteria agreed for the option appraisal were:

- Strategic viability (does it fit with the local and regional plans?)
- Does this option meet the service demand requirements?
- Will this deliver sustainable diagnostic services?
- Clinical viability (can the option deliver the procedures included in the service specification?)
- Operational viability (can this be operational within project timeframes?)
- Workforce viability: does this option:
 - ◆ Support sustainable workforce?
 - ◆ Deliver on national strategy?
 - ◆ Facilitate training?
 - ◆ Have implications for existing workforce?
- Estates viability (would this option facilitate the appropriate spaces, e.g. clinic rooms and outpatients space?)
- Financial viability (are the revenue and capital costs reasonable?)
- Geographic suitability / accessibility.

In the first instance regional HBs developed an options longlist for improvement of access to regional diagnostic services against the evaluation criteria.

During 2023, this long list was reviewed collaboratively through the clinical and operational leads group against an agreed set of criteria and subsequently tested by each health board prior to consideration by project and programme boards.

The options considered by the regional Project Board are set out below.

Option 1	Do nothing - Health boards would continue to provide services as per current arrangements.
Option 1a	Different approach to the use of existing services in each health board, and work toward collaboration through shared processes. Health board expansion of internal capacity and/or other forms of regional working.
Option 2	Independent Community Diagnostic Hubs (CDH) – each health board operating their own CDH with no cross-border treatments.
Option 3	Regional Community Diagnostic Hubs – a minimum of one per health board, delivering cross-border diagnostic treatment.
Option 4	A single Regional Radiology Diagnostic centre , located on one site, serving all three health boards.
Option 5	Combined approach - Regional Diagnostic Centre/community diagnostic hubs.
Option 6	Community Diagnostic Hub with Mobile Units – as option 3 but with mobile units attached to reach outlying communities through community diagnostic clinics.

Assessment by the clinical and operational leads resulted in a short-list of model options for consideration by the Project Board. The shortlist included three options:

- **1a** – different approach to the use of existing services
- **3** – Community diagnostic hubs (CDH) with a minimum of one per health board area, and
- **6** – Community diagnostic hubs with the option of mobile units.

The Project Board considered these options formally on 23 January 2024 and confirmed the acceptability of both **Option 3** and **Option 6** with the preferred option of development of a community diagnostic hub model for the region, which may incorporate mobile units, as required.

1.5.2 Site and infrastructure delivery options

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

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

This is due to the fact the purchase of the LHP site was approved and funded by WG in December 2022 on the condition the funding was used to develop the site as part of a regional approach to the delivery of services. Therefore, consideration of alternative site options is not relevant.

The services included at this business case stage are the same as those included in the original case for the purchase of the site, with some small changes to the numbers of the same, in line with demand and capacity modelling provided in Section 3 of this case.

As a result, this section will not consider alternative options for service change with the scope and scale having been proven in the sections above. In addition, following WG approvals, design work has already progressed beyond the traditional stage for an OBC, with WG approval to proceed to RIBA 3 given in December 2024.

The RIBA 2 design work was subject to scrutiny by Shared Services Specialist Estates and considered only the **preferred new build infrastructure option**. Scrutiny on the RIBA 2 phase closed on 18 December and approval to proceed to RIBA 3 was given on that date. In addition funding has been provided for the demolition of the buildings on the site which is due to complete in September 2025. As a result, there is no scope to further consider infrastructure and build options.

Finally, a main contractor for completion of the design phase was appointed on 28 March 2025. The tender process demonstrated a modular form of MMC was preferred and WG approval to enter into the design contract was received on 14 March 2025. As a result, the build methodology has also been fully determined. Therefore, the economic appraisal in following sections will focus on the delivery options for the CDH only in terms of the scope of the agreement with the third party provider.

1.5.3 Summary of Phase 1 service delivery options

Whilst the decision has been made to appoint an independent service provider to deliver the model in the CDH, there are options about the extent to which this can be delivered by the partner. As a result, this has been the focus of a more detailed option appraisal with the key options being:

Components	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Building	ISP Design and Build (Costs captured through revenue costs)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)
General Building Equipment	ISP Design and Build (Costs captured through revenue costs)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)
Specific Service Delivery Equipment – First 10 Years after completion of LHP	ISP provide and maintain (Costs captured through revenue costs)	ISP provide and maintain (Costs captured through revenue costs)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)
Specific Service Delivery Equipment – After 10 years	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)
Service Delivery (Staffing) – First 10 Years after completion of LHP	ISP Staffing	ISP Staffing	ISP Staffing	NHS Staffing
Service Delivery (Staffing) – After 10 Years	NHS Staffing	NHS Staffing	NHS Staffing	NHS Staffing
Lifecycle Costs – First 10 Years after completion of LHP	N/A	Building Lifecycle Costs	Building Lifecycle Costs	Building Lifecycle Costs

Components	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Lifecycle Costs – After 10 years	NHS (WG Capital Funding) buys building buy back at net book value after 10 years. Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs

1.5.4 Economic Appraisal

An economic appraisal was prepared, in line with HM Treasury Green Book guidance, to evaluate the whole life costs, benefits and risks of the shortlisted options in order to identify the option that is most likely to offer best public value for money.

The results of the economic appraisal demonstrate that the preferred way forward offers value for public money.

Option 2 (preferred option), which utilises a traditional capital for the build of phase 1 of the LHP (the Community Diagnostics Hub portion), with an ISP providing the service provision equipment and delivering the service via a managed service contract for up to 10 years before the service becomes inhouse and run by the Health Boards, (7 years initial contract with up to 3 1 year extensions on the same), will require capital investment of £109.1m and ongoing revenue costs of £7.5m (excluding depreciation) for the initial 10 year period of the managed services contract, reducing to £5.4m after the end of the contract. Based on estimated costs and benefits, it is anticipated that this option will deliver an incremental Net Present Social Value (NPSV) of £38.9m and a Benefit Cost Ratio (BCR) of 1.13. It should be noted that this relates to the capital and revenue element of CDH only, to realise regional plans for diagnostic, additional revenue investment is also required on other UHB sites.

This represents £1.13 of incremental benefit delivered for every £1.00 of incremental whole life cost, because of the quantifiable benefits that it has been possible to state in monetary values at this point in time, including:

- **Improved patient outcomes from earlier diagnosis:** Delivery of the CDC will address CTMUHB Diagnostic Imaging and regional Endoscopy capacity shortfalls and ensure future demand can be met. This will have a direct impact on waiting times for patients and support the cancer pathway by enabling earlier diagnosis, more targeted interventions and improved monitoring. This will lead directly to delivering better patient outcomes, specifically contributing to improved cancer survival rates.
- **Improved patient outcomes from earlier diagnosis (non-cancer related):** Delivery of a significant increase in additional Endoscopy capacity should lead to earlier and increased diagnosis for patients with health issues other than cancer such as hypertension, which will lead to better patient outcomes and help contribute to reduced mortality related to those health issues.

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

- **Release of elective diagnostic capacity at Acute sites, which can be used for urgent and emergency care patients/pathways:** The capacity provided at LHP for more elective diagnostic tests will free up Acute sites to use their diagnostic capacity for non-elective scans/tests, which reduce delays for urgent and emergency patients.
- **Improved predictability and confidence in booking scans and tests:** The centralised elective centre with co-located services provides a ‘one-stop’ shop clinic with greater predictability of care which in turn means that scans and tests can be booked with more confidence leading to improved utilisation of the service.
- **Impact of a more sustainable estate:** The delivery of appropriately designed and compliant facilities provides opportunities to contribute to CTMUHB’s environmentally sustainable goals and national strategies around decarbonisation and optimising energy efficiency. The transformed model of care with its standardised pathway is likely to make it easier to implement and maintain sustainability programmes that CTMUHB has instituted in other areas, such as reducing waste and single use products.

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

- **Additional Imaging and Endoscopy capacity leading to reduced waiting times:** The additional capacity at LHP will allow the Health Boards to meet the NHS Wales target that no patient is waiting more than 8 weeks for imaging or endoscopy tests.
- **Help to meet ‘Straight to Test Guidance’:** The additional capacity provided at LHP will assist with meeting ‘Straight to Test Guidance’, allowing an increase in the number of direct referrals from GPs to radiology. It will also allow for improved regional sustainability and provide contingency for other sites across the region.
- **Increased number of and improved clinical pathways:** Due to LHP being a centralised elective centre and a “one-stop” clinic, it will lend itself to developing and delivering more and improved clinical pathways. These pathways and improved ways of working could be used as an exemplar and then also be rolled out across the region.
- **Reduced health inequalities:** Reduction in waiting times and ease of access supports equality of access.
- **Community Benefits:** The contractor has agreed to implementing several community benefits, including hiring local, providing volunteering and donations to local organisations, investing in people learning and using Welsh and investing in the local supply chain.
- **Improved patient experience:** As well as reduced waiting times patient experience is enhanced by the modern fit for purpose facilities and the ease of access the location of LHP offers, with its good road links and parking. Having a centralised elective centre with co-located services provides the convenience of a **one-stop shop** clinic with greater predictability of care.
- **Increased staff satisfaction:** The improved training pathway and increased training opportunities, along with the modern fit for purpose facilities and a consolidated service model that enables more effective ways of working, contributes to staff satisfaction and creates an attractive place to work which will support recruitment and retention of highly trained health professionals in the long term.
- **Develop a skilled endoscopy workforce:** Delivery of the Skills Academy in partnership with HEIW will provide significant opportunities to increase the number of training places available in the region and help to build a skilled and sustainable endoscopy workforce.
- **Increased compliance:** The dedicated CDC will ensure that the Health Boards have capacity across the region to ensure alignment with GiRFT principles and continue to achieve JAG accreditation. Modern fit for purpose facilities that are compliant with WHBNs and HTNs, achieve BREEAM rating of Excellent.

- **Future proofing:** The site also provides a level of future proofing by providing expansion space that offers opportunities for other future developments.
- **Opportunities for future transformation:** The additional capacity offered by LHP provides opportunities to transform and reconfigure core local services and deliver things differently in the future. Further to this the robust and in-depth data/reporting the service at LHP will provide to the Health Boards will greatly inform future decisions. The successful delivery of a regional centre will also provide proof of concept as the basis for the development of any future regional pathways and will have a positive reputational effect.

The results of the options appraisal (excluding BAU) are presented in the table below.

Element	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Initial capital investment	£0m	£109.1m	£119.7m	£119.7m
Incremental NPSV	-£10.8m	£39.9m	£24.9m	£16.5m
Benefit Cost Ratio	0.97	1.13	1.08	1.05
Key benefits	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option
Key risks	<ul style="list-style-type: none"> • Unable to secure a service provider who would be willing to provide the service • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales • Significant risks around handover of the building at the end of the managed service contract period, including higher than expected handover costs and that the building would not fully meet the Health Boards requirements. 	<ul style="list-style-type: none"> • Significant initial capital outlay • Unable to secure revenue funding 	<ul style="list-style-type: none"> • Significant initial capital outlay • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales 	<ul style="list-style-type: none"> • Significant initial capital outlay • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales • Unable to recruit sufficient staff to enable delivery of the model in the short term

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

1.6 Commercial Case

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

In addition, the contractor will be critical for SAB and planning applications to ensure that the approved design does not require further planning amendments, which could delay the programme.

WG also approved early site wide demolitions in January 2025. These have been delivered by a contractor appointed under the Crown Commercial Framework. Works commenced on 14 April and are due to complete by 20 September 2025.

WG have approved funding for the whole programme up to the end of RIBA 3 and have recently approved a further £2.828M to support the completion of a phased RIBA 1 OBC and to commence RIBA 4 works (which will include the redesign necessary for Phase 1 to be fully standalone. This funding will cover works up to OBC approval, but further funding of £2.177M will be required to complete RIBA 4 on OBC approval.

Should a decision be made not to complete RIBA 4 following the outcome of this business case then there is a risk of a contractor claim against the Health Board under the PSC contract.

The phased approach will increase design stage fees over and above those in the original tender however this will be covered more in the Phase 2 OBC. Tendered fees will cover Phase 1.

1.6.1 Independent Service Provider (ISP) procurement

CTMUHB, acting on behalf of the three Health Boards in South East Wales is currently undertaking a procurement exercise to appoint a prime contractor to act as a design partner and contributor to the pathway redesign currently being scoped out for diagnostic services to provide one imaging CDH with the option to flex to one further CDH over the course of the contract. In addition, the CDH will also have at the same location, an ISP staffed Endoscopy Suite comprising of up to four rooms co-located with an NHS staffed two room Endoscopy Training Academy. The endoscopy suite requirements will be designed and fitted out to meet JAG accreditation standards.

There will be a co-located training academy which will include an endoscopy theatre. It is expected that the fitting out of the academy training rooms, and delivery of activity will be facilitated by NHS organisations through collaborative work with Health Education and Improvement Wales.

The Regional Radiology Project Board and the Regional Diagnostics Programme Board endorsed the use of competitive dialogue to test the market potential to support the development of a regional diagnostic centre and associated community diagnostic hubs, one of which will be on the LHP site. The competitive dialogue procedure is flexible and allows the Procurement Evaluation team to discuss proposed solutions with bidders to understand advantages and disadvantages.

The recommended option is to develop a regional endoscopy centre through a traditional NHS capital build proposal and to seek the equipment and delivery of the centre activity through contract with a commercial partner.

To drive this strategy, further competitive dialogue will need to be completed to understand financial implications and other non-financial risks. The current procurement programme leads to the appointment of the ISP by the end of October 2025.

1.7 Financial Case

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

1.7.1 Capital affordability

The cost plan prepared by CTMUHB's Cost Advisors, based on RIBA 3a design, estimates that delivery of LHP will result in capital investment requirements of £110.0m in total, including expenditure incurred to date. It is anticipated that this will be funded by Welsh Government as follows:

Funding of £18.1m had been received to date from WG for:

- Site purchase - £8.0m
- RIBA 2 fees - £3.1m
- RIBA 3 fees - £3.5m
- Demolition - £0.7m
- RIBA 4 fees - £2.8m.

This includes funding of £2.828m which has been approved in August 2025 to support the Phase 1 OBC redesign and the commencement of RIBA 4 works to support the FBC being completed for November boards.

Further funding of £2.771M is sought from this OBC to enable the Health Board to deliver an FBC and continue progress through RIBA 4 and 5 stages to be ready to commence with on-site works on FBC approval.

This forms part of the total additional funding of £91.9m which will be required to deliver the Phase 1 CDH and supporting site wide infrastructure works following approval of the FBC.

1.7.2 Revenue affordability

Work undertaken to date by the programme team and finance leads estimates that provision of services at LHP will incur recurring revenue costs of £9.3m for contracted out services for MRI, CT, NOUS, and Endoscopy.

It is expected that the contract value will be reduced through the agreement of a tariff discount in return for the ISP's use of land and buildings. This has been estimated for the purposes of the OBC at £1.9m per year.

These indicative costs are based on high level assumptions at this stage and will be firmed up at FBC stage once more detailed information is available and the preferred ISP partner has been identified following the final stage of the tender.

This therefore results in a recurring revenue funding requirement of £7.5m. This has been allocated across the three Health Boards, based on projected activity assumptions which have been identified at this time, which equates to the following:

- CTMUHB £6.0m p.a. (£4.8m after the proposed tariff discount)
- C&VUHB £2.7m p.a. (£2.2m after the proposed tariff discount)
- ABUHB £0.7m p.a. (£0.5m after the proposed tariff discount).

These requirements reflect each Health Boards current position to commission the following services from LHP. ABUHB half an endoscopy room, Cardiff and Vale UHB 1.7 endoscopy rooms and CTMUHB will commission endoscopy and imaging services comprising CT, MRI and ultrasound.

For both ABUHB and C&VUHB their commissioning intentions for endoscopy reflect the outcomes from the regional endoscopy planning exercise that has been undertaken. Part of the planning identified several measures to meet un-met demand in endoscopy services and it should be noted

that the revenue contributions contained in this case only reflect the costs of services provided at LHP. Health Boards will incur further revenue costs in delivering additional diagnostic activity and these will be covered in separate business cases.

It should be noted that these cost and activity levels remain subject to change during the procurement and contracting process and should activity levels being commissioned change as will costs.

1.8 Management Case

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

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

Milestone	Start	Completion
Confirm Scope and Develop OBC	14/07/2025	31/08/2025
Draft OBC Submitted to WG	05/09/2025	05/09/2025
HB OBC Approval	08/09/2025	15/10/2025
WG OBC Review and Approval	04/09/2025	16/10/2025
Planning Application	11/07/2025	15/10/2025
RIBA 4 and FBC Prep	28/07/2025	20/11/2025
HB FBC Approval and WG Submission	27/11/2025	27/11/2025
Scrutiny and WG FBC Approval	28/11/2025	23/01/2026
Contractor Mobilisation	23/01/2026	26/02/2026
Construction	01/03/2026	30/06/2027
Supplier Fit out of CDH	01/07/2027	31/08/2027
Commissioning	01/09/2027	31/10/2027

The milestones for the ISP procurement are shown in the following table, it is assumed that on appointment the provider will join the Infrastructure design team and work alongside the main contractor in the finalisation of the programme. It is possible this could lead to further programme efficiencies in the fitout and commissioning phases which will be clarified as the programme progresses.

Milestone	Start	Completion
ISP Tender Issue	18/08/2025	18/08/2025
ISP Tender Period	18/08/2025	19/09/2025
ISP Tender Evaluation	22/09/2025	03/10/2025
HB ISP Approval	06/10/2025	06/10/2025

WG ISP Procurement Approval	06/10/2025	16/10/2025
Intent to Award and Standstill Period	17/10/2025	31/10/2025
ISP Provider Appointment	31/10/2025	31/10/2025

Within the PRINCE2 governance, the PMO is classed as part of the Assurance function.

Programme

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

Risk

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

Key Performance Indicators (KPIs)

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

Reporting

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

1.9 Summary recommendation and requirements

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

The recommended option is to proceed to construct the CDH and carry out the site wide infrastructure. The construction to be led by MTX as main contractor and the buildings to be of modular construction. The service will be procured by an Independent Service Provider (ISP) who will deliver the imaging and endoscopy services as well as equip the unit.

Capital Spend to date is £18.1m. This represents total costs to date and includes the site purchase and site wide RIBA 1, 2 and 3 works.

The LHP Programme is seeking urgent approval of this business case and the release of funding of £2.771m for completion of the RIBA 4 and 5 design stage of the CDH to avoid delay to the programme. This funding forms part of the total funding ask within this OBC of £91.9m to deliver the total Phase 1 OBC works.

Strategic Case

2 Strategic context

2.1 Introduction

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

The section will:

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

2.2 LHP programme context and background

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

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

- **A Community Diagnostic Hub** comprising:
 - ◆ Diagnostic Imaging – CT, MRI and Ultrasound
 - ◆ Regional Endoscopy services
 - ◆ Plain Film X Ray
- **A Surgical Hub** comprising
 - ◆ Up to 6 orthopaedic theatres for high volume low complexity works
 - ◆ Up to 64 beds to support the orthopaedic theatres
 - ◆ A self-contained day surgery unit containing up to 6 theatres.

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

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

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

Following this meeting, approval was given to proceed to RIBA 3 design stage and in January 2025 approval was given to demolish the buildings on the site in a separate advance works package. Demolition works commenced on 14 April and are due to complete by mid-September.

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

At this point, it was still assumed that the development would proceed under a single business case route but with phased completions with the CDH completing ahead of the surgical hub. , Alongside the capital design works there is an ongoing procurement exercise to identify a preferred partner to deliver the managed service contract for the CDH at LHP. This position changed in July with confirmation from WG that they would prefer to receive individual business cases for the separate phases of development. The revised delivery structure is as set below,

- Phase 1: CDH comprising MRI, CT, non-obstetric ultrasound, plain film x-ray capability and endoscopy including a regional endoscopy training centre of excellence. This business case also includes the wider site infrastructure required to facilitate later developments.
- Phase 2: surgical Hub comprising six orthopaedic theatres and supporting wards.
- Phase 3: six-day surgery theatres with supported space with full scope to be determined.

This outline business case has been prepared to seek outline approval for the **Phase 1 – CDH and wider infrastructure enabling works**.

The aims of the diagnostic regional solution outlined in this business case are:

- to enact a collaborative regional approach to recovery and delivery of sustainable radiology services
- to provide shared regional capacity for radiology
- to support the implementation of the new pathways that will enhance services
- to demonstrate optimal utilisation of our assets and resources across the region
- to address current waiting list backlogs and create sustainable capacity
- to reduce clinical risk on an equitable basis across the region
- to provide services that are accessible to the population of the region in line with the findings of Professor Sir Mike Richards' Independent Review of Diagnostic Services for NHS England².

Health Boards in South East Wales have committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability. Health Board planning teams (joined by clinical, operational, and other colleagues where beneficial) continue to meet on a regular basis to agree common approaches to strategic challenges, progress ongoing regional collaborative programmes, share experience / best practice and to consider future opportunities for closer working to mutual benefit.

Collaborative planning has involved each UHB leading a formal programme, with ABUHB overseeing ophthalmology and cancer, C&VUHB overseeing orthopaedics and stroke and CTMUHB overseeing diagnostics (consisting of endoscopy, pathology, and community diagnostic hubs).

² Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England

2.3 Individual organisation overview

The LHP programme is being led by the LHP Project Team at CTMUHB in partnership with ABUHB and C&VUHB as part of the South East Wales regional network.

An overview of the main organisations who will collaborate to implement the changes and oversee services delivered from the new facilities is provided below.

2.3.1 Cwm Taf Morgannwg University Health Board

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

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

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

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

2.3.2 Cardiff and Vale University Health Board

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

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

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

2.3.3 Aneurin Bevan University Health Board

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

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

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

and a number of community hospitals and facilities, including:

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

2.4 Regional overview

The Regional Portfolio is made up of three main programmes: Orthopaedics, Diagnostics and Ophthalmology. The three UHBs in South East Wales work together regionally adopting the following regional working principles:

- To reduce unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level.
- To improve resilience.
- To make effective use of capacity and capability in whichever organisation it sits.
- To create critical mass for effective high quality care delivery when and where it makes sense to do so accepting that may not reside in every organisation.
- Take all opportunities to use the evidence base and best practice to improve quality, efficiency, productivity and use of finite resources.
- To enable clinical leaders, and others, to work together, lead together and learn together.
- Distributed leadership approach collaboration with benign intent, honesty, transparency and integrity in order to build trusting and effective relationships.
- To agree approaches to engagement and communications together.
- To avoid leaving anyone behind and learn from the past and progress in an open, honest and humble way.

The Regional Diagnostics Programme was initiated with the intended aim of developing and implementing both short and medium to long-term service changes which will provide more timely access to diagnostics in a sustainable way. The three health boards are committed to regional working, where clinically appropriate, through the Regional Portfolio Board.

The Regional Diagnostics Programme comprises three projects: radiology, endoscopy and pathology.

The Regional Endoscopy project was initiated with the aim of achieving the following:-

- A single regional service model philosophy across a range of sites, with appropriate differentiation of procedures undertaken at each facility where indicated – as determined by D&C data and providing capacity to support bowel screening activity if / as appropriate
- A single service team philosophy, with common roles, responsibilities, standard operating procedures, skill mix and staff rewards (banding etc.), together with a philosophy of learning and sharing of best practice at all levels of the service.
- Professional Joint Accreditation Group (JAG) accreditation across all facilities (actual or equivalent)
- Movement towards management of a shared waiting list and addressing the longest waiters on a regional basis
- Collaborative approach to training arrangements, working with HEIW via an academy model
- IM&T systems to enable the sharing of data, including e-referral, reporting and onward referral and appropriate interface with FIT testing results.
- Enhanced shared understanding of demand and capacity data, with common approaches and definitions.

The regional endoscopy planning has been informed by the following guidance and policy documents.

- Our programme for transforming and modernising planned care and reducing waiting lists in Wales, Welsh Government (2022)
- Diagnostics Recovery and Transformation Strategy for Wales (2022-2025)
- Independent Review of Diagnostics Services (Professor Sir Mike Richards) (2020)

Regional partners have worked together to develop overarching regional plans for endoscopy and imaging identify the demand and capacity plans and regional solutions to address. The following sections discuss the outcomes of this work.

2.5 NHS Wales business strategy and aims

This OBC illustrates how LHP will support a key priority to improve access to Diagnostic and Endoscopy services, and provides the infrastructure required for provision of these much-needed regional services.

The proposals are aligned with the national strategic context, supporting a broad range of national strategies and policies, including:

- The NHS Wales Planning Framework 2023-2026
- National Clinical Framework: A Learning Health and Care System (2021)
- The Parliamentary Review of Health and Social Care in Wales. Final Report. (January 2018)
- A Healthier Wales: Our Plan for Health and Social Care (June 2018)
- The Wellbeing of Future Generations (Wales) Act 2015
- Prudent Healthcare: Securing Health and Wellbeing for Future Generations
- Informed Health and Care: A Digital Health and Care Strategy for Wales (2015)
- NHS Wales Decarbonisation Strategic Delivery Plan 2021-2030.

The Diagnostics Recovery and Transformation Strategy for Wales 2022-2025 sets out the plan to improve, transform and redesign diagnostic pathways in Wales. Diagnostic services are a fundamental aspect of modern healthcare delivery. Clinical pathways cannot function properly without sufficient capacity to turnaround diagnostic tests, procedures and reports in a timely manner.

Large backlogs of diagnostic procedures hold the NHS back from making improvements in referral to treatment times, impair screening pathway effectiveness, result in poor patient experience, and have the potential to result in harms and poorer outcomes.

The Diagnostics Strategy outlines the need to:



This national strategy seeks to deliver on the following aims:

- Improving outcomes and reducing pressure on secondary care
- Addressing unmet care need that has been exacerbated by COVID-19
- Enabling people to live longer, healthier lives at home
- Identifying treatments earlier in disease which enables intervention and care management more rapidly
- Creating a sustainable and intelligent integrated health system which reduces inequality
- Making Wales a great place to live and work.

The South East Wales Regional Diagnostics plan for Community Diagnostic Hubs aligns with this strategy and its aims through the intention to seek both a rapid expansion of diagnostic service access and the delivery of new models of care with a focus on providing centres of excellence which will attract and retain the required workforce.

Further support for new models of delivery was set out in Professor Sir Mike Richards' **Independent Review of Diagnostics Services** (October 2020); it highlighted the need for investment in equipment, facilities and workforce, and proposed a model of community diagnostic hubs established away from acute hospital sites.

The review sets out a vision for diagnostic hubs to provide a consistent approach to support health checks for people in deprived areas and potentially detect health issues that can be treated to prevent the conditions worsening. This model also aligns with national strategy through providing services away from acute sites, thereby improving access and reducing pressure on acute sites.

The Richards' report made a total of 24 recommendations, and the key elements are summarised in seven points here.

- **Diagnostic equipment and facilities should be expanded and upgraded as soon as possible.** High-quality data on imaging facilities already existed on which estimates of numbers of machines could be made. For other diagnostic modalities (e.g. endoscopy and physiological sciences) where national data are not available, baseline surveys should be undertaken.
- **The diagnostic workforce should be expanded substantially across all modalities**, with new roles being developed and training academies being established.

- **New service delivery models with new pathways to diagnosis should be established.** These should separate emergency/acute and elective diagnostics, wherever possible, to improve efficiency and reduce delays for patients. Community Diagnostic Hubs (CDH) should be rapidly established.
- **Improving connectivity and digitisation** should be prioritised across all aspects of diagnostics.
- **Innovative approaches to diagnostics should be evaluated** as quickly as possible and then implemented across the NHS. These are likely to include the use of artificial intelligence (AI) to assist human reporting in imaging, pathology and endoscopy. The use of new diagnostic technologies that can be used in patients' homes should be expanded, building on learning from home testing for COVID-19.
- Clinical and managerial leadership should be put in place for all diagnostic disciplines at national, regional and local/system/network levels.
- **Standardised data should be collected across all diagnostic modalities** to drive operational performance, support business planning and to inform service improvement.

The Richards' Report noted that **the key aims of Community Diagnostic Hubs are to:**

improve population health outcomes	improve productivity and efficiency	deliver a better, more personalised diagnostic experience for patients
increase diagnostic capacity	contribute to reducing health inequalities	promote primary/community and secondary integration

This model of Community Diagnostic Hub (CDH) provision has broad support from professional bodies such as the British Medical Association (BMA) Wales who advocated for increased access to diagnostics, in their letter to Welsh Government in May 2021.

It is also anticipated that CDHs will contribute to improve staff satisfaction, making every contact count, research and innovation and net zero carbon emissions. They should also act as anchor institutions for the populations they serve.

2.5.1 Getting it Right First Time (GiRFT)

The GiRFT Report considers the challenges of a post-COVID 19 Radiology service across the UK, with demand having increased between 2013 and 2019 by 22% with an expectation that this growth will continue.

The report captures a detailed account of the challenges faced by Radiology services and makes a number of recommendations to:



The report identifies a positive vision for change, of making radiology more patient-centric. That includes faster access to imaging, but also seeking to make services more convenient and accessible, and improving the physical environment of radiology departments.

This business case and the long term plans of the South East Wales region acknowledge and align with the points raised in the report and recommendations outlined.

The focus of the region's work is on both delivery of sustainable services through a range of means and seeking to better manage demand through alternative pathways.

2.5.2 Strategy for Developing a Regional Workforce Model for Wales

During 2021/22 Health Education and Improvement Wales (HEIW) supported the Imaging Workforce and Education Group (IWEG) and the National Imaging Programme to develop the *Building the NHS Wales Imaging Workforce Model – Strategy for Developing a Radiology Workforce for Wales*.

The Strategy sets out several recommendations to support and facilitate the development of a strong, resilient, and sustainable Radiology workforce for the future. These recommendations require both a national and local approach to implementation to ensure that the benefits are realised for both patients and staff. This includes developing plans for the recruitment of staff at a local level and identifying scope for workforce transformation opportunities.

3 Case For Change

3.1 Introduction

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

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

3.2 Spending objectives for the LHP Programme

The main aim of the overarching LHP programme is to deliver high-volume low-complexity care away from crowded DGH sites; which will provide both additional capacity to meet ongoing increasing demand and free up existing resources to better meet emergency and unplanned care pressures. In turn, this should reduce patient wait times and facilitate earlier discharges on DGH sites across the region.

For Phase 1, the aim of this project is to deliver a Community Diagnostic Hub that is right-sized to meet the current and future needs of the local population, relieves pressures on existing DGH sites, supports the integration of primary, community and social care services, complies with regulatory standards and is suitable for the delivery of twenty first century healthcare.

The spending objectives listed in the table below were agreed by members at LHP Programme Board in September 2024 for the programme as applicable to all phases including phase 1 – CDH and Supporting Infrastructure.

Table 1 - Spending objectives

Ref	Theme	Spending objective	Benefit
SO1	Meet population needs	The delivery of an elective high volume low acuity model of care for the South East Wales Region on a phased basis. The first phase to focus on diagnostics and endoscopy. A second and third phase to focus on orthopaedics and day surgery respectively. Phase 1 services to be operational during the 2027/28 financial year. Future phases to consider further regional services such as pathology.	<ul style="list-style-type: none"> • Right-sized to meet current and future demand • Improves access to range of services • Centre of Excellence with efficient service delivery models and improved patient outcomes and increased throughput • Able to flex for the future
SO2	Maximise capacity	To maximise clinical capacity on the LHP site. To ensure that the maximum amount of available space is directed towards direct service delivery with supporting services managed from the neighbouring Royal Glamorgan site.	<ul style="list-style-type: none"> • Creates opportunities for centralisation of skillsets; centre of excellence • Enables greater collaboration regionally • Creates opportunity for one stop diagnostics, improved use of resources and appointments

Ref	Theme	Spending objective	Benefit
SO3	Innovation and standardisation	To facilitate and support the use of innovative design and delivery solutions in both clinical and non-clinical services. To implement standardised protocols and practices to promote efficient service delivery offering improved value for money and addressing the modifiable drivers of increased cost against English Tariff, excluding those aspects driven by Welsh Policy.	<ul style="list-style-type: none"> • Standardisation of consumables, with financial savings • Standardisation of best practice/policies; efficiencies, increased throughput, reduction of wait lists
SO4	Enable training / development of future workforce	To enable increased training and development of secondary care staff including accommodating more medical trainees and students.	<ul style="list-style-type: none"> • Accommodates placements for students (allowing role development and succession planning) • Improved workforce retention and recruitment
SO5	LHP Models of Care and Workforce Models	During phase 1 to ensure that the managed service provider delivers compliant and innovative models of care and workforce models, following the initial terms to develop innovative and new models of care to bring the CDH back into NHS management and control. . In Phases 2 and 3 to develop a new model of care and workforce models to support the delivery of the core services, the models will support efficient delivery of services	<ul style="list-style-type: none"> • Environment / ways of working that support staff welfare and wellbeing • Improved skills and job satisfaction • Improved patient outcomes • Multi-disciplinary working
SO6	Sustainable estate	To deliver a sustainable infrastructure on the site maximising decarbonisation and net zero opportunities.	<ul style="list-style-type: none"> • Complies with relevant standards; NZC, BREEAM excellent and energy performance • Opportunities for future additional service provision for South East Wales. • Opportunities for further regional reconfiguration and enabling of service and or estate rationalisation.

3.3 Existing arrangements

3.3.1 Radiology

Radiology is an important diagnostic test for a wide range of clinical conditions and is a key stage in many cancer and non-cancer pathways. Within Wales, the Welsh Government target for diagnostic tests (including radiology), is a maximum waiting time of eight weeks. Waiting times for radiology also form part of the 26-week referral to treatment time target (RTT) and 62 day single cancer pathway target, from suspicion to first definitive treatment. Many inpatients also require radiology as a diagnostic test, with waiting times, therefore, impacting patient outcomes and experience including length of stay and overall hospital efficiency.

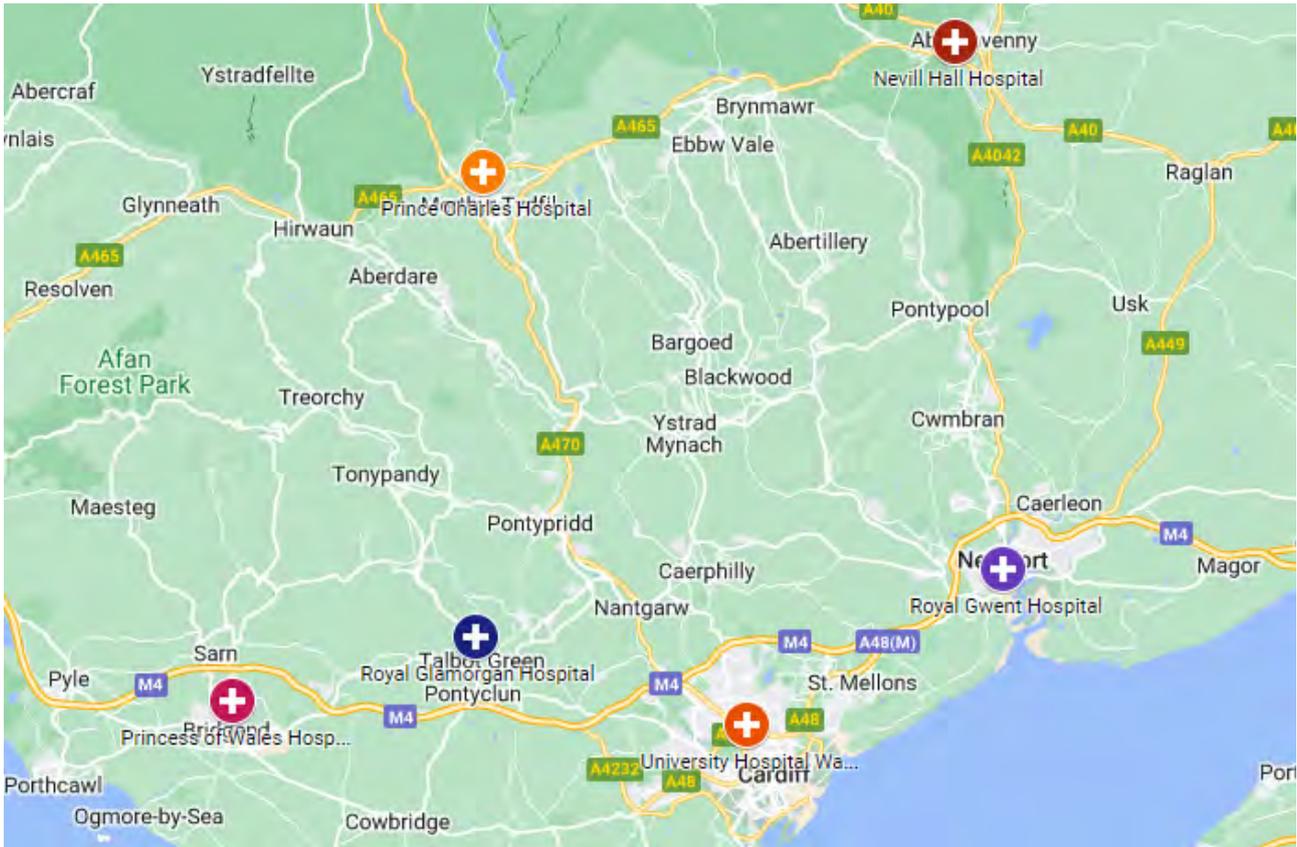
Current service provision for the region is delivered for each of the health boards' populations within each health board's geographic footprint. Patients from each health board currently access diagnostics in other health boards as part of agreed patient flows for specific service pathways but not commonly purely for diagnostics tests.

Additional capacity is delivered through a range of means including internal additional capacity using NHS clinicians (commonly referred to as waiting list initiatives) and in-sourcing.

Location of existing Imaging services

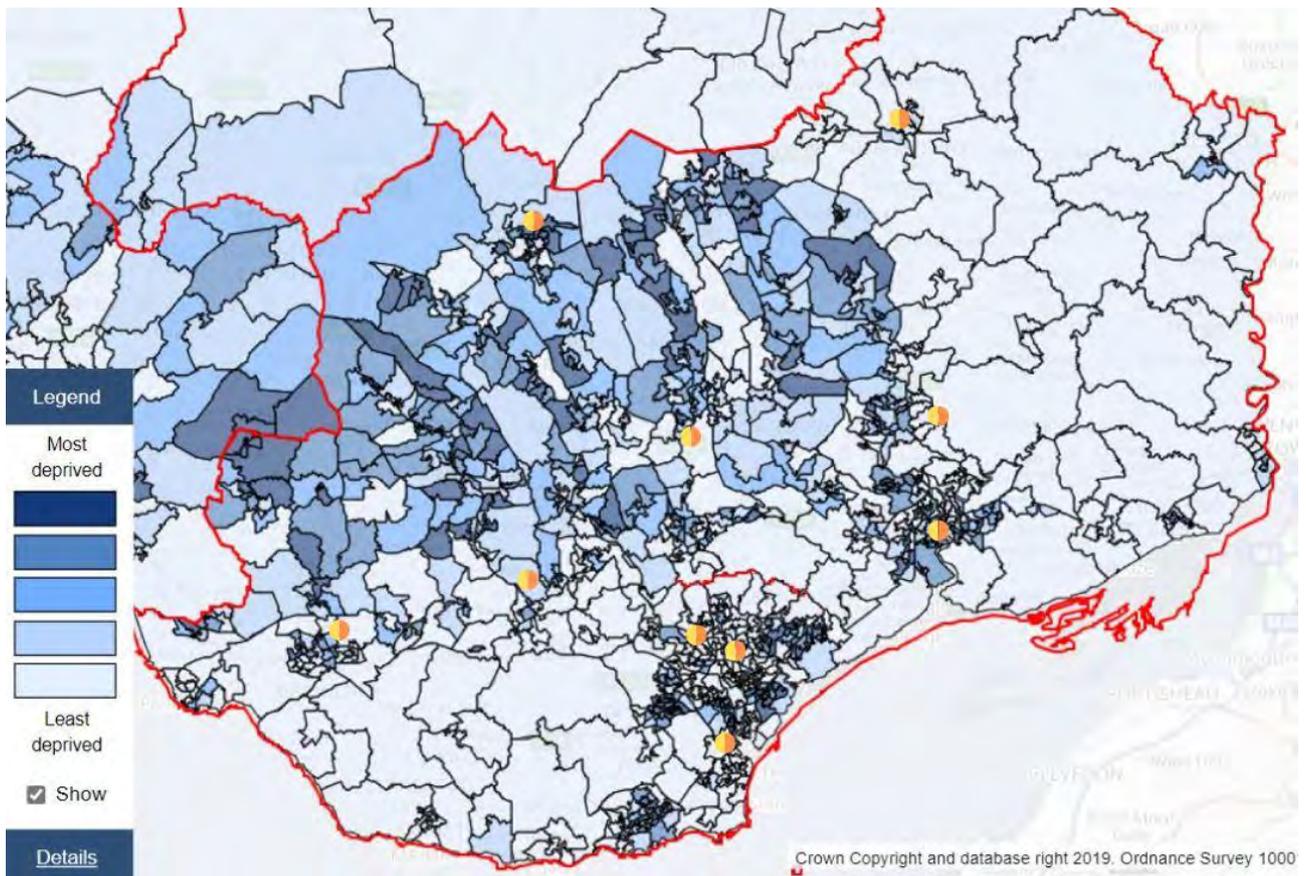
The South East Wales region comprises a large geographic area with varying ease of access for residents in discrete areas within the region due to road network and public transport options.

Figure 1 - District general hospital sites and the associated travel infrastructure



Given the agreed aim of ensuring access to residents living in areas of deprivation, the existing diagnostic infrastructure has been mapped against the Welsh Index of Multiple Deprivation (WIMD). The map below shows the location of CT and MRI facilities across the region.

Figure 2 - Location of CT and MRI facilities across the region (yellow and orange)



There is work underway being led by the regional imaging group to review service provision and create updated demand, and capacity modelling across the region. This will be used to develop a regional plan for imaging to address waiting times across the region. This is due to be completed shortly, however underpinning assumptions around demand and capacity have been used in completing this business case.

At this moment, only CTMUHB has confirmed an intention to commission imaging services from LHP. Cardiff and Vale and Aneurin Bevan University Health Boards have confirmed that they do not intend to commission services from LHP in the short term. Aneurin Bevan has indicated that it may consider doing so in the future, but there is no confirmed timeline for this. As this business case is focused on LHP only CTMUHB demand and capacity modelling will be included for the remainder of the case as they are the only confirmed contracting party.

The latest current imaging provision for CTMUHB is set out in the table below

Table 2 - Current delivery CTMUHB Imaging provision by site

Site	Modality	Days per week	Hours		Annual Capacity (Visits)
			From	To	
RGH	MRI 1	7	07.30	20.00	7,497
	MRI 2	5	07.30	20.00	5,187
	CT 1	7	08.00	20.00	16,752
	CT 2		09.00	17.00	7,350
	NOUS 4.5 rooms	5	09.00	17.00	14,994

Site	Modality	Days per week	Hours		Annual Capacity (Visits)
			From	To	
POW	MRI	5	07.30	20.30	5,434
	CT 1	7	08.00	20.00	16,752
	CT 2	7	09.00	17.00	7,350
	NOUS 4 rooms	5	09.00	17.00	13,314
PCH	MRI	7	07.00	19.30	1,476
	CT 1	7	08.00	20.00	16,752
	CT 2	5	09.00	17.00	7,350
	NOUS 4 rooms	5	09.00	17.00	13,314

In summary the total activity per modality based on patient visits is as set out below. These capacity figures have been derived by CTMUHB based on an average length of visit, days and hours of opening and includes accounting for planned downtime. The detail behind these calculations is included as appendix 2

Table 3 - CTMUHB summary Imaging capacity by modality

Modality	RGH	POWH	PCH	Total
MRI	12,684	5,434	7,476	25,594
CT	24,102	24,102	24,102	72,306
NOUS	14,994	13,314	13,314	41,622

3.3.2 Endoscopy

Endoscopy procedures are currently carried out from a range of sites across the three health boards. The table below sets out the permanent capacity arrangements in place across the region:

Table 4 - Endoscopy facilities, operating hours, days, sessions

Facility	No. rooms	Operating hours	Days / sessions	Procedures per year (ave.)
Aneurin Bevan UHB				
Grange University Hospital (weekends - inpatient / emergency on call only)	1	0800-1800	9 sessions gastro 1 session respiratory 5 days inpatients 7 days emergencies	1,956
Nevill Hall Hospital	2	0800-1800	5 days per week	5,392 (364 of which WG additional funds)
Royal Gwent Hospital	2	0800-1800	5 days per week	12,718 (902 WG)
	2		7 days per week	
Ysbyty Ystrad Fawr	2	0800-1800	5 days per week	5,845 (259 WG)

Facility	No. rooms	Operating hours	Days / sessions	Procedures per year (ave.)
Cwm Taf Morgannwg UHB				
Royal Glamorgan Hospital		0900-1700	5 days per week	7,435
Prince Charles Hospital		0900-1700	5 days per week	5,257
Princess of Wales Hospital		0830-1630	5 days per week	2,276
Cardiff and Vale UHB				
University Hospital Llandough (UHL)**	6	0900-1600	5 days per week 2 sessions	12,638
University Hospital Wales (UHW)	2	0900-1600	5 days per week 2 sessions	4,536

* Although C&VUHB have eight rooms there is only a nursing capacity to run seven rooms and endoscopists to run six rooms. Currently 7 rooms are run with the support of an initiative with Medinet.

** Utilisation at UHL was relatively low during this period. Room 6 only became operational in Q4, and Room 5 faced ongoing staffing constraints which limited its use throughout the year.

Detailed demand and capacity modelling has been undertaken by the National Endoscopy Programme for Wales (NEP), which has identified a recurrent shortfall in capacity. This demand is driven by increasing symptomatic demand coupled with the phased extension of the age range for Bowel Screening. This modelling concluded that there would be a six rooms shortfall in the South East Wales region by 2027/28 and has also recommended the establishment of regional endoscopy centres across Wales to support meeting a national shortfall in capacity against demand. This plan is included as Appendix 3 to this document and identifies an area outside of Cardiff for the facility in South East Wales. LHP would be an idea location for the same.

The regional diagnostic group have led on the development of the regional endoscopy plan based on work undertaken by NEP. The outcomes of this work are set out in the sections below but will focus on the whole region as both C&VUHB and ABUHB have included LHP additional capacity in their plans.

Whilst there are differences in the activity being undertaken across HB and sites, the group have confirmed that it is not possible to increase activity across all sites. This is due to workforce and estate constraints and there are recognised benefits to economies of scale of having larger consolidated units. This has supported the argument for the endoscopy service at LHP being regional provision.

3.4 Business need

The vision is to create a standalone site for diagnostics that guarantees uninterrupted, effective and efficient services that address both current capacity shortfalls and offers opportunity to meet future demand growth. The vision is to provide patient centred care away from an acute hospital setting which also supports emergency care pathways by preserving capacity for unplanned and urgent procedures on DGH sites.

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

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

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

Figure 3 - Welsh Government programme for transforming and modernising planned care goals and priorities



The seven priorities are:

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

The LHP programme aligns with planned care recovery programmes across with the region in the development of long-term additional capacity to support the delivery of efficient and effective solutions to support all three Health Boards to eliminate long waits and reduce overall waits within the patient pathway in terms of access to diagnostic services. This is in addition to each Health Board fully utilising existing assets as it is recognised that both are needed to ensure efficient diagnostic care for the region.

The ability to create bespoke capacity to maximise patient flow and increase efficiency and innovation in service delivery offers additional benefits to the region from investment in the programme. These include standardisation of patient pathways and clinical practices which should increase efficiency and improve patient outcomes, consolidation of services on LHP will release space on existing sites and act as a key enabler for future regional reconfiguration and transformation and the opportunity to standardise procurements thus achieving greater revenue savings on high volume items.

3.5 Increasing demand for services

All Health Boards in the region are operating waiting lists for endoscopy and for CTMUHB there are waiting lists for all imaging modalities. The following sections set out the CTMUHB demand and capacity for imaging and the regional demand and capacity for endoscopy services.

3.5.1 Radiology

The regional imaging group initially reviewed service provision, demand, and capacity to support the 2023 regional procurement to appoint an independent service provider (ISP), the procurement of which remains ongoing and will be discussed in later sections. This work is being updated following Judith Paget's letter, of 27 January 2025, which requested an integrated regional imaging plan to developed by the three Health Boards.

The refreshed demand and capacity information for the regional plan remains under development and will be presented to regional boards and WG under separate cover. The modelling for CTMUHB included in this OBC has taken the outputs from the work completed to date and ensured a consistent approach to data application and assumptions.

In the first instance an overview of current waiting times for patients within CTMUHB is as set out below and compared to the 2024 figures included in the submitted strategic overview document.

Table 4 - Current waiting times (CTM)

Date	Non Cardiac CT		Non-Cardiac MRI		Non Obstetric USS		Total	
	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks
Jan-24	1,716	966	1,765	1,166	2,685	3,427	6,166	5,559
Jun-25	2,154	994	1,964	33	3,483	1771	7,601	2,798

Table 6 illustrates that there has been an overall increase in the number of patients waiting for scans across all disciplines with CT also seeing an increase in patients waiting over 8 weeks despite the presence of mobile imaging on the LHP site during 2024. Non recurrent additional capacity alongside some improvements in productivity have seen a fall in the over 8 week waits for MRI and ultrasound but these are now starting to increase again and are expected to continue to do so.

These waits can be explained when the latest demand and capacity data is considered. The location and operating hours of the current equipment with CTMUHB has already been detailed in Table 2 above, and has informed the capacity element of the demand and capacity modelling set out below (Table 6). Demand is based on information from CTMUHB with uplifts being based on outputs from modelling undertaken by Cardiff and Vale UHB and shared with the regional programme. The baseline 2025/26 Activity has been used as year one data as set out below:

Table 5 - Demand and capacity forecast / gap analysis

Modality	Actual capacity	Demand 25/26	Gap 25/26
MRI	25,594	25,675	-81
CT	72,306	82,657	-10,351
NOUS	41,622	43,351	-1,729

This clearly illustrates a shortfall in capacity in 2025/26 requiring non recurrent measures to be introduced and resourced at a premium cost to meet the level of demand based on an 8-week target. No improvements on this time can be offered and non-recurrent measures at a premium will be required to being performance in line with targets.

When demand growth is considered then the position clearly worsens with the table below setting out the position for the next 5 years. The demand increases are 8% for MRI, 8.9% for CT and 5% for ultrasound. This has been projected forward over a 5 year plan period with 2025/26 demand data contained in Table 5 above being used as the baseline year 0.

Table 6 - Imaging demand and capacity analysis

Modality	Current capacity	Forecast	2026/27	2027/28	2028/29	2029/30	2030/31
MRI	25,594	Demand	27,729	29,947	32,343	34,931	37,725
		Variance ³	-2,135	-4,353	-6,749	-9,337	-12,131
CT	72,306	Demand	90,013	98,025	106,749	116,250	126,596
		Variance	-17,707	-25,719	-34,443	-43,944	-54,490
Ultrasound	41,622	Demand	45,519	47,794	50,184	52,693	55,328
		Variance	-3,897	-6,172	-8,562	-11,071	-13,706

There are several assumptions within the figures provided, namely that one CT on each DGH site is used as “hot capacity” and, whilst they are operated over 24 hours, the capacity outside the normal operating hours of 08.00 and 20.00 has been excluded, as this is demand-led and not operating at the same levels of efficiency.

There is a clear and significant gap in CT provision based on current capacity, which equates to in excess of one CT operating over 12 hours by 2026/27. Both MRI and NOUS are also showing year on year capacity shortfalls under the current model.

When considering the shortfall in actual capacity against demand, consideration has been given to whether utilisation of current assets has been maximised. There are some not insignificant issues with increasing capacity for imaging and there are existing pressures on workforce for both scanning and reporting. To deliver increased capacity it will be essential to secure workforce from the private sector to support the same. Despite this an exercise looking at the potential capacity increases that could be introduced has been developed.

³ Surplus / **shortfall**

Table 7 - CTMUHB current v potential delivery capacity

Site	Modality	Current delivery model			Potential delivery model			Capacity increase
		Days/wk	Hours/day	Capacity ⁴	Days/wk	Hours/day	Capacity	
RGH	MRI 1	7	12	7,497	7	12	7,497	0
	MRI 2	5	12	5,187	7	12	7,371	2,184
	CT 1	7	12	16,752	7	12	16,752	0
	CT 2	5	7.5	7,350	7	12	16,752	9,402
	NOUS 4.5 rooms	5	7.17	14,994	6	7.5	34,764	19,770
POW	MRI	5	12.5	5,434	7	12.5	7,722	2,288
	CT 1	7	12	16,752	7	12	16,752	0
	CT 2	5	7.5	7,350	7	12	16,752	9,402
	NOUS rooms	5	7.17	13,314	6	7.5	22,860	9,546
PCH	MRI	7	12	7,476	7	12	7,497	21
	CT 1	7	12	16,752	7	12	16,752	0
	CT 2	5	7.5	7,350	7	12	16,752	9,402
	NOUS rooms	5	7.17	13,314	6	7.5	22,860	9,546

Some of the key changes in capacity concern the move of the second MRI at RGH to a 7 day 12 hour working option with staffing required to be sourced to support the same. For CT all second machines on sites have been increased to seven- day and 12-hour working for elective patients. With NOUS the increased capacity modelling assumes that a further two rooms at RGH can be resourced and operated alongside the 4.5 rooms already in operation. In addition, it is assumed that 50% of the rooms on each site will operate a seven-day working model. For NOUS, hours of operation have not been increased due to the high level of manual intervention required in this modality

There are obviously a considerable number of risks around assuming the availability of this capacity, most notably around workforce availability and cost but also all consumable and supporting costs associated with this capacity increase. However, when the capacity increase is modelled against the demand levels mentioned above it can be seen that shortfalls in imaging capacity can be met in the immediate term.

Table 8 – Potential Demand v capacity based on Increased use of Existing Assets

Modality	Potential capacity	Forecast	2026/27	2027/28	2028/29	2029/30	2030/31
MRI	30,087	Demand	27,729	29,947	32,343	34,931	37,725
		Variance ⁵	2,358	140	-2,256	-4,844	-7,638
CT	100,512	Demand	90,013	94,514	99,239	116,250	126,596
		Variance	10,499	5,998	1,273	-15,736	-26,084
Ultrasound	80,484	Demand	45,519	47,794	50,184	52,693	55,328
		Variance	34,965	32,690	30,300	27,791	25,156

⁴ Number of annual visits

⁵ Surplus / shortfall

By maximising capacity in the short term CTMUHB can continue to meet demand in all modalities until the end of 2027/28. From 28/29 shortfalls in MRI and CT start to become apparent. LHP is due to open in late summer 2027/28 so will be in place to meet the shortfalls within CTM.

On the face of it, CTMUHB has potential capacity to meet ultrasound demand over the next five years and beyond, however NOUS services are under extreme pressure on all sites within CTMUHB and are recognised as being a service under pressure nationally in Wales. Much is due to the high workforce input into this modality which leads to strains on the existing resource and sees higher levels of sickness and rest breaks generally required by sonographers.

The potential capacity relates to a desktop increase in operational hours and rooms reflecting the actual physical capacity, but for NOUS this is not realisable due to two important drivers:

- Firstly, changes to antenatal care pathways are driving an increase in obstetric scanning and this must be prioritised over elective scanning, due to the shorter timescales.
- Secondly, due to the volume of obstetric scanning and ergonomic challenges of our patient group, we are seeing increased sickness driven by RSI issues which is further limiting the actual capacity.

This makes the provision of a standalone service, provided by a workforce distinct to our obstetric services critical to deliver waiting times and provide ringfenced service whilst existing capacity can be focused on achieving obstetric scanning demand.

In addition, covering sudden and unplanned absences is almost impossible with a high level of very short term list cancellations taking place. Unlike CT and MRI where services can still run albeit at a possible lower throughput, a loss of staff in NOUS can lose a list for at least a day whilst cover is attempted to be found. In reality, this makes achieving the level of performance to meet the potential capacity numbers in ultrasound almost impossible.

To deliver these levels of capacity in house bestows a high level of financial and service risk on CTMUHB with no capacity to cover sickness. In addition, it is likely that any additional capacity realised will have to be diverted to support obstetric scanning. The delivery of services at a premium (agency or private sector rate) can be prohibitive and extremely difficult to secure regularly which explains why these levels of capacity have not been achieved.

The reality is that to meet growing demand levels, an increase in existing capacity on standalone ringfenced site will be required in NOUS to provide a sustainable future focussed service.

It should also be noted that the above tables consider growth in demand associated with population growth and changes, however additional demand associated with the straight to test cancer pathway has not been factored into this model, neither has the opportunity to create a shorter than eight-week pathway to imaging and diagnostic service. There are also expected to be increased pressures from programmes such as lung health screening which will put further as yet unmodelled pressure on imaging services.

Within CTMUHB there are a further number of emerging pressures that have not been factored into the demand figures above but will service to further increase pressures on imaging services over the next 12-24 months. These include:

- Plans to repatriate the Cauda Equina Pathway OOHs back from C&VUHB.
- There are plans in SBUHB to repatriate all CTMUHB activity in Cardiac MR and CT back to CTMUHB from Neath Port Talbot Hospital. The POW MRI will not cope with demand of MR Cardiac as only one session a month can be accommodated. An additional scanner will be needed to support this activity or activity transferred to LHP to enable additional session to take place at POWH.

- There are also plans for SBUHB to transfer all CTMUHB Maxillofacial services back and this will further increase demand on US and CT. Cone Beam CT will be a new service in PCH however the US demand will need to be met from somewhere.
- MCAT – physio service at NPT will be repatriated in near future resulting increased MSK requests for MR, US and X-Ray.

Radiology forms a critical part of the 26-week referral to treatment time target (RTT) and 62-day single cancer pathway target, from suspicion to first definitive treatment. As a result it is also anticipated that with increased capacity and significantly reduced waiting times increased radiology capacity will be required to deliver efficiencies across the health system by developing clinical pathways that incorporate diagnostics at an earlier stage, aiming to reduce pressures on services and improve the patient experience. A fundamental principle of this work is equity of access across the region, to ensure that these benefits are realised evenly to all patients and communities. Increased radiology capacity plays a key role in supporting accelerated pathways to treatment.

Additional permanent capacity can support Radiology services across South East Wales to consistently deliver within the required timeframes to provide a good patient experience, support inpatient flows, expedite cancer and referral to treatment pathways and increase compliance with component waiting times targets. To create permanent capacity will provide a better value for money solution than short term temporary investments.

3.5.2 Endoscopy

Despite significant work undertaken by the three health boards in the South East Wales region, the performance profile currently indicates a significant proportion of patients waiting more than the target waiting time of accessing diagnostic endoscopy within eight weeks.

In August 2024 there were nearly 8,000 patients waiting more than 8 weeks for a diagnostic endoscopy, although this position improved during 2024/25 because of additional non-recurrent funding.

Table 9 - Endoscopy position at August 2024

Health Board	Colonoscopy		Gastroscopy		Sigmoidoscopy		Total	
	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks	<8 weeks	>8 weeks
AB	758	1,000	763	282	408	328	1,929	1,610
C&V	476	1,788	412	2,864	178	1,246	1,066	5,898
CTM	677	113	454	106	245	34	1,376	253
Total	1,911	2,901	1,629	3,252	831	1,608	4,371	7,761

The regular demand and capacity assessments facilitated for NHS Wales organisations by the National Endoscopy Programme (part of the NHS Wales Executive) have evidenced sustained growth in demand. This growth is evident for both symptomatic cases and for screening activity, due to the expansion of the Bowel Screening Wales programme to incorporate people aged between 51 and 55 years.

The impact of the growth in screening demand is set out by health board below and equates to a requirement for an extra 10 screening lists (one theatre) per week by 2027-2028.

Table 10 - Endoscopy screening demand increase

Procedure type	Year -1 Oct 23-Sep 24	Year 0 Oct 24-Sep 25	Year 1 Oct 25-Sep 26	Year 2 Oct 26-Sep 27	Year 3 Oct 27-Sep 28
Cwm Taf Morgannwg UHB					
Index procedures	828	1,112	1,112	1,112	1,112
Repeat procedures	196	264	264	264	264
Surveillance procedures	78	67	72	132	178
Total Procedures	1,102	1,443	1,448	1,508	1,554
*Lists per week	7	9	9	9	10
Cardiff and Vale UHB					
Index procedures	819	1,100	1,100	1,100	1,100
Repeat procedures	194	261	261	261	261
Surveillance procedures	60	72	88	131	176
Total Procedures	1,073	1,433	1,449	1,492	1,537
*Lists per week	7	9	9	9	10
Aneurin Bevan UHB					
Index procedures	1,116	1,499	1,499	1,499	1,499
Repeat procedures	264	355	355	355	355
Surveillance procedures	89	115	136	179	240
Total Procedures	1,470	1,969	1,990	2,033	2,094
*Lists per week	9	12	12	13	13

The National Endoscopy Programme (NEP) has facilitated several national demand and capacity assessments, with the autumn 2023 assessment of data identifying a total capacity gap (symptomatic and screening demand) across the south east Wales region (based on existing capacity) of approximately six rooms by 2027/28.

The NEP modelling is based on theatres operating on 10 sessions per week at 10 points per list. Further details of the demand and capacity exercise are included in Annex 1. A summary of the total demand increase for the south east Wales region is shown in the table below (based on points).

Table 11 - SE Wales total Endoscopy demand

Procedure type	2024-25	2025-26	2026-27	2027-28
Symptomatic (inc surveillance)	82,911	86,662	90,616	94,783
Screening	16,498	19,906	20,313	21,084
Total	99,409	106,568	110,929	115,867

3.6 Proposed service provision at LHP

To support decision making around clinical capacity and delivery of operational services, the regional demand and capacity modelling for the key services, covered in the previous section, has been analysed to support the right sizing of LHP to ensure it can meet both current and future demand. This will be covered in turn for each of the services.

3.6.1 Radiology

There is a drive within Wales to improve our cancer performance, this will be heavily reliant on diagnostics, in particular Radiology. Current pathways often rely on patients being referred into secondary care where they are reviewed, with relevant imaging then being requested. To expedite the diagnosis, the ability to send patients straight to test is required, as identified in the optimal Single Cancer Pathways produced by NHS Wales.

The current scanners on our acute hospital sites are busy with the acute and unpredictable inpatient demand. This will always limit the ability to completely maximise service provision in line with potential capacity modelling and be able to offer prompt access to the complex imaging required by these patients. The CDH will revolutionise the way we diagnose patients. We can follow the relevant Single Cancer Pathways, allowing our Primary Care colleagues direct access to the necessary imaging. In addition, by utilising Health Pathways, non-cancer referrals can be fast tracked to the CDH.

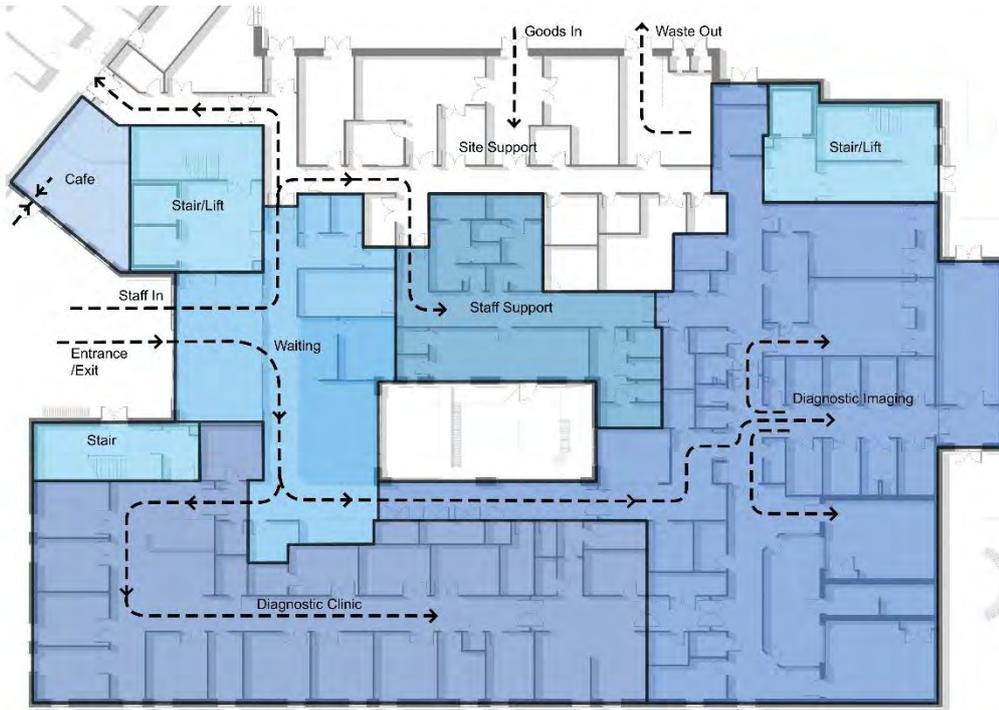
As a result of this, the direction for the infrastructure development has been to create the space to support the future growing demand and unknown increased screening and testing requirements. The proposed capacity will also be available to support regional partners should they determine that they cannot meet demand within their existing resources in the coming years.

The building has been designed to accommodate up to two MRI, two CT, three ultrasound and has the infrastructure in place to provide plain film x-ray. A suite of clinical and procedure rooms is included to support the provision of one stop clinics exploiting the adjacencies of the full range of diagnostic testing that will exist at LHP. These clinic spaces can focus on areas such as urology and lower GI which are two of CTMUHB's most challenged pathways for cancer performance. This gives the building a clear, cost effective and future focused approach to service delivery and ensures it can respond swiftly and effectively to changes or increases in commissioning arrangements, demand, screening requirements or be able to provide planned services away from emergency sites if required in the future.

This phased approach will enable rapid but stepped increases in diagnostic capacity, in line with the Diagnostics Recovery and Transformation Strategy alongside workforce planning and development to increase the NHS workforce, which will pave the way to potential future extension in operating hours of hospital-based diagnostic services, if required in future.

Currently, the proposed imaging provision at LHP will only be contracted by and provided for CTMUHB. The image below shows the current design for Diagnostics.

Figure 4 - Current Diagnostics layout plan



The CDH service provision is being procured from a third party provider, and the procurement remains ongoing at the time of writing this business case. The proposal is for an initial seven-year managed service contract with the provider supplying equipment and staffing to run and operate the imaging and endoscopy elements of the unit. The option appraisal to support this decision is set out in the economic case.

Recognising the need to step up services over time, the initial procurement documentation requests the provider to bid for the following contracted activity levels:

Table 12 - Diagnostic contracted activity

Year	MRI scans	CT scans	Non-obstetric U/S scan
Year 1 onwards	8,000	12,000	6,000

As this will be elective diagnostics and more HVLC work then it will be possible to undertake 8,000 scans on one MRI per year and the 12,000 CT scans would only require one CT. Therefore, it is expected that the initial contract with the provider would require one MR, one CT and two ultrasound rooms to be fitted out by them. The infrastructure offers an opportunity to step up capacity in a shortened timeframe should demand increase further or regional partners determine a need to commission radiology activity.

It is recognised that the discussion around the regional planning for imaging remains ongoing with the regional planning work due to complete shortly and present findings to their Boards. This will provide an overview of how all three organisations propose to meet their demand and capacity shortfalls within the WG confirmed position that capital funding will be directed towards LHP and not to other capital cases for the services within LHP.

The current pathway work with the service indicates that there are considerable benefits to the creation of a future proofed service by including two MRI and two CT alongside rooms for 3 NOUS in the design and infrastructure solution.

The business case proposes that the second MRI and CT rooms are included as shells within the building so that, as required, they can be equipped and utilised at a future date without disrupting flow and maximising design efficiencies. In addition, up to three ultrasound rooms will be included within the design alongside several procedure and clinical rooms. This will provide future flexibility to the CDH to expand and flex the services offered, including more multi-disciplinary one stop clinics utilising the existing imaging equipment alongside treatment spaces. This ensures the creation of a flexible, future focussed facility where one stop clinics utilising the on-site imaging technology can be delivered..

The proposed imaging design solution offers a regional solution if required in terms of the space and facilities built in. To attempt to create these spaces later will incur a premium cost, cause major disruption to the functioning unit and will compromise patient flow and efficiencies. To have a design which can incorporate demand growth and offer resilience and flexibility in its future usage is a unique opportunity within this programme. Capacity can also be managed to support Public Health screening requirements such as the lung screening programme or further other regional screening or diagnostic interventions. The capacity can also support major downtime across the region as required potentially reducing the need for expensive mobile hires for elective diagnostic procedures.

3.6.2 Endoscopy

The National Endoscopy programme (NEP) has facilitated several national demand and capacity assessments, using the Autumn 2023 data, identifying an expected gap across the South East Wales region of 6.3 rooms by 2027/28.

The following table summarises how the health board plans above impact on the original NEP capacity gap projection, together with the net recurrent requirement for a regional facility.

Table 13 - Endoscopy forecast capacity gap by 2027/28

	Rooms	Plan
NEP projected room gap 2027/8	6	
Net health board capacity requirements after individual plans		
ABUHB	0.5	Following 7/7 operating at Royal Gwent Hospital
C&VUHB	1.7	UHL operational model
CTMUHB	2	
Remaining gap to be addressed at regional facility	4.2	Four commissioned core rooms, supplemented by some academy activity and efficiency gains

The information supporting this has been shared in the section above and has also been presented to regional Boards to underpin the endoscopy model proposed for LHP. In addressing the shortfall in capacity, Health Boards have individual plans to mitigate the impact, and these plans are set out below as included in the overarching planning document produced in March 2025.

3.7 Regional Plans to bridge the gap between Capacity and Demand

The project undertook an option appraisal to identify options to meet the collective capacity gap. Key assumptions were that health boards would firstly work to fully utilise existing internal capacity, and then collaborate to address remaining capacity gaps, noting that workforce was a key constraint. On this basis, the appraisal identified a preferred option of the development of a regional endoscopy centre with a co-located regional training academy. The regional training academy is described further in section 3.7.4.

The subsequent site option appraisal identified Llantrisant Health Park (LHP) as the only suitable site within the south-east Wales region for a development of this nature and size.

Individual UHB plans (covering the interim period prior to the opening of a regional facility) are set out below. It should be noted that these plans will be pivotal in managing endoscopy demand in the South East Wales region alongside the infrastructure at LHP. The revenue funding to support these measures will need to be determined alongside the revenue requirements to fund LHP.

3.7.1 Aneurin Bevan University Health Board

ABUHB has reviewed its projected demand and capacity position, based on NEP assumptions of 5% core demand growth per annum and the published future commissioning intentions of Bowel Screening Wales. It is intended to move to full utilisation of the Royal Gwent Hospital endoscopy facility from April 2026, with all four theatres extended to seven days working from that date. Based on a 49-week per year operation (inclusive of backfill), this would deliver an additional 392 lists and enable the health board to maintain all relevant diagnostic targets until 2027/28, this will require additional revenue to deliver.

If the additional activity is delivered from April 2026, the resulting capacity gap in 2027-2028 is minimal, equating to approximately one list per week. From 2028-2029 the recurrent gap amounts to approximately five half-day sessions per week, or half a theatre. It is intended that this activity would be delivered through LHP (made up of screening and surveillance procedures), thereby enabling continued maintenance of all relevant diagnostic targets.

3.7.2 Cardiff and Vale University Health Board

C&VUHB has extended its capacity in University Hospital Llandough with two new theatres in 2024. The plan for the health board incorporates maximising the use of these theatres, noting workforce constraints have been a limiting factor.

The health board has undertaken a demand and capacity assessment and has identified a minimum requirement for 17 sessions or 1.7 theatres to be sourced from LHP from 2027/28. This activity will be a mix of both screening and surveillance procedures covering colonoscopy, flexi - sigmoidoscopy and gastroscopy (surveillance only).

3.7.3 Cwm Taf Morgannwg University Health Board

CTMUHB extended its internal capacity in 2024 with the opening of an additional endoscopy theatre at Prince Charles Hospital. During 2025, the Health Board experienced reduced capacity from the impact of the critical incident at Princess of Wales Hospital, however at the time of writing, works have been completed, and capacity has returned to previous levels. During the remainder of 2025-26 the Health Board will work towards the implementation of phase two of the internal endoscopy plan, which incorporates:

- Expansion to the substantive staffing of the third unit at Prince Charles Hospital

- Development of the trans-nasal endoscopy service. This will review the requirements for gastroscopy
- Implementation of manometry services.

Notwithstanding these developments, the Health Board will have a residual capacity gap equivalent to two theatres of activity from 2027/28 onwards.

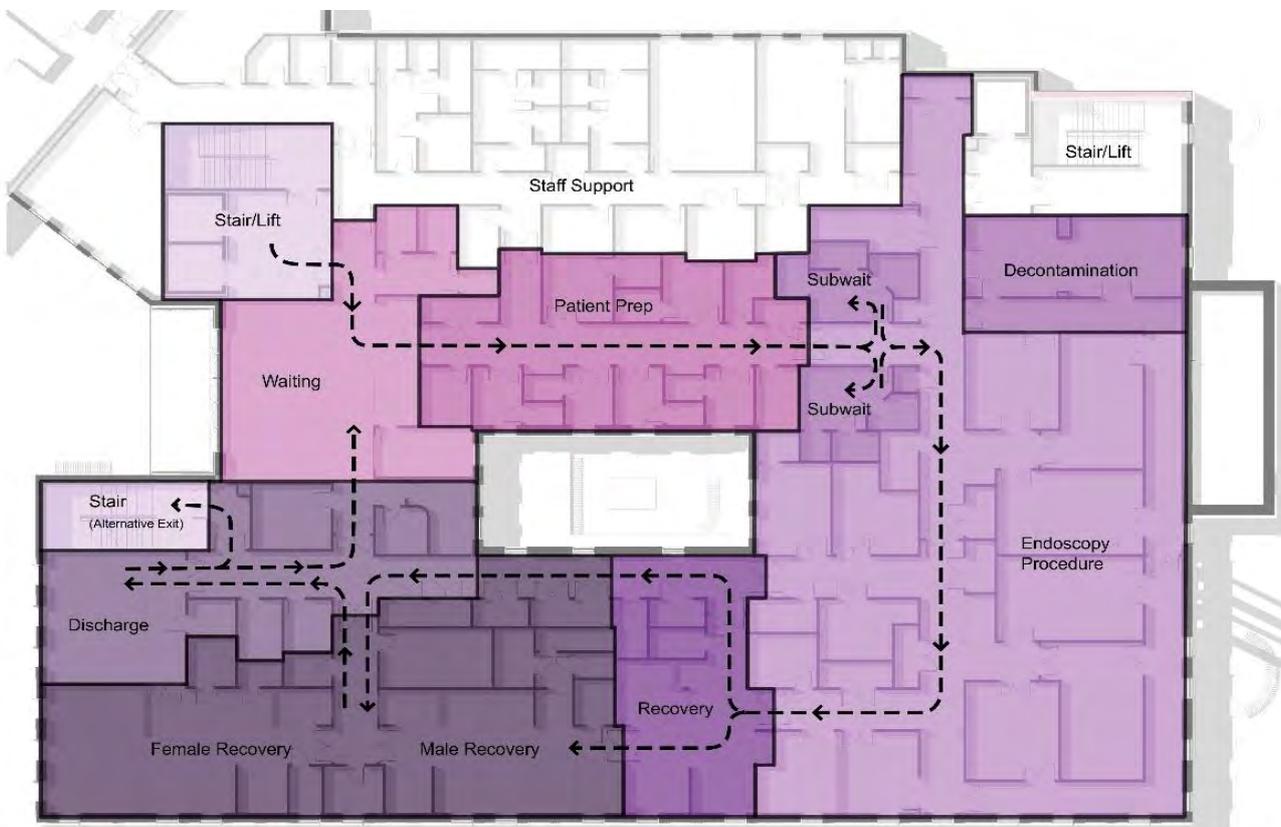
The anticipated requirement for CTMUHB remains as per the case mix established for the regional service specification in 2024 (40% gastroscopy, 40% sigmoidoscopy and 20% colonoscopy).

As part of the regional endoscopy planning, and as detailed above, it was identified that, should all local plans to optimise existing infrastructure be realised, there will be a need for just over four rooms to be commissioned in 2027/28.

The regional modelling confirms a need for four operational endoscopy rooms by 2027/28 based on the most recent demand modelling and regional Health Board agreed plans. In addition, there is a desire to create at least one training room, which would equate to a requirement of just over five rooms at LHP. The current design incorporates six endoscopy rooms and associated supporting space. This provides a sustainable and resilient approach to the development and enables the absorption of future growth or changes in screening requirements by Public Health Wales, as well as offering training opportunities and resilience in case of down time in any room.

The image below shows the current proposed layout for the Endoscopy unit, these designs have been discussed with the Welsh JAG lead, who has confirmed that they conform to current JAG requirements. It should also be noted that the physical aspects of CTM's endoscopy Unit at Royal Glamorgan Hospital make it practically impossible to achieve JAG compliance and therefore the LHP facility will increase the levels of endoscopy undertaken in a compliant estate.

Figure 5 - Proposed Endoscopy layout plan



3.7.4 Regional Endoscopy Training Academy

Endoscopy is a complex and evolving specialty requiring specialist education and training for all staff. Tailored training improves recruitment, retention, competency, and patient care. The JAG Endoscopy Training System (JETS) provides a structured framework for workforce training, progressing staff from foundation to leadership levels, with mandatory training requirements for JAG accreditation.

Endoscopy Training Academies have been established in the UK to enhance multi-professional learning, innovation, and workforce development. They have the potential to provide greater health system value than traditional education models as they:

- Enable training and supervision capacity to be expanded quickly and much more cost effectively
- Enable innovation in training through rapid at-scale adoption of technology enhanced learning and new multi-disciplinary learning models
- Accelerate independent working and service delivery productivity of trainees
- Enable more geographical equity in the distribution of training and hence the health professional workforce.

Through the Endoscopy Training Academy, training is provided to the whole endoscopy workforce, including nurses and support staff, in a multi-disciplinary environment. A south-east Wales Endoscopy Training Academy, co-located with the regional endoscopy suite, is proposed to support sustainable workforce training.

The development of a regional endoscopy training academy is a priority for Health Education and Improvement Wales (HEIW), as set out in its 2024-2027 intermediate medium-term plan. HEIW has developed a formal proposal for the training element of the academy, but this does not include consideration of the required physical infrastructure. The current working assumption for the LHP programme therefore includes the provision of a minimum of one theatre for the development of the academy. HEIW have committed to regular meetings with the regional endoscopy planning team to develop plans in alignment and will provide confirmation of the recurrent cost model for the academy for inclusion in the LHP full business case which will be prepared for health boards' consideration by November 2025 at the latest.

The requirements from health boards to facilitate a regional academy are to be confirmed. C&VUHB recently undertook a fixed term funded trial of an accelerated training programme, and the learning from this is informing the planning for the academy.

Following meetings with the design team and workstream meetings, the Endoscopy element of the Skills Academy includes; two theatres dedicated to providing training lists both for morning and afternoon sessions five days per week (Mon-Fri). The top floor is planned to be utilised as a multi-professional training space for simulation training (use of ex-vivo models) and a lecture theatre or seminar room for training courses (including live AV links to theatres thus meeting requirements and supporting endoscopy and surgical training.

One of the aims of the academy is the ability to train adequate endoscopy staff to allow the region to fill vacancies to provide safe and high-quality care and reduce reliance on outsourcing and in sourcing. This will also support the transition of the managed service contract staffing back to NHS staffing in LHP by the end of the contract. The current plans will support an environment appropriate to the delivery of all the course types required to develop the endoscopy workforce within the national requirements and standards for training set out by the JAG, as well as ensuring practice considerations.

In terms of the allocation of staff in the two theatres, the proposal is that:

- The Endoscopy Academy would provide ‘the Trainer’ (this will be a Centrally Contracted Endoscopist whose sessional time is paid for by HEIW), in addition HEIW will also fund and coordinate the process by which trainees are allocated to attend training lists and ensure backfill arrangements are in place in the event a Trainer is suddenly unavailable. The Trainers (endoscopists) will be responsible for following up any histology and ensuring that additional tests e.g. imaging is reported.
- The LHP ‘host UHB’ will be responsible for providing the Nursing Staff to staff the two theatres and will provide all the available endoscopic equipment, accessories and IT systems required to perform a high-quality endoscopy and report the findings onto an integrated reporting systems (so that results are available on WCP). The theatres will be equipped with both Scope Guides and AV (SMOTS) systems to ensure an appropriate training environment.
- For the third-floor training space HEIW will provide any endoscopic equipment that is solely required for model training and will provide the administrative and technical staff to support all endoscopy courses. These staff will require appropriate accommodation in the training space, but it is understood that they will need to share the accommodation / facilities with staff supporting other speciality courses and training.

An Endoscopy training facility within the academy has the potential to provide (aside from basic endoscopy training) immersion training, train-the-trainer courses, colonoscopy upskilling, non-technical skills, national assistant practitioner training, simulation and upper GI best practice training. Additional training opportunities within a skills academy include:

- Perioperative workforce; accelerated anaesthetic practitioner programmes, assistant perioperative practitioner programmes, foundations of perioperative practice and surgical first assistants.
- Additional activities; OSCE preparation, pre-induction support for health and social care staff, national bronchoscopy and EBUS training, clinical skills for pharmacists, biomedical scientist registration portfolio, cultural humility resources, high volume cataract surgery resources and research institute which is attractive to current and potentially new staff.

3.7.5 Accelerated training for Endoscopy

Through investing in accelerated training infrastructure, the Endoscopy Academy will be able to plan, implement and target accelerated training to enable the trainee workforce to be available earlier to support service delivery. As JAG Certification is the UK standard for independent practice as an Endoscopist, if this has been achieved before completion of Specialist Training, the Endoscopist can actively contribute to service delivery. This affords Health Boards the option to address rising demand and capacity challenges by utilizing this workforce resource early in the training cycle through allocation to suitable lists and procedures.

The recommended approach would deliver 70 hours of intensive, hands-on training over a two-week period under 1:1 trainer supervision. This method compresses the traditional learning curve by up to 45%, enabling trainees to reach competency faster.

Modelling has demonstrated significant gains from accelerated training in terms of an increased number of certified upper GI endoscopists (within one year) and colonoscopists (over two years). A similar approach can be adopted for nurses, where acceleration can reduce the time taken to achieve independent practice for new nurse endoscopists from 9-12 to 5-6 months.

A pilot of accelerated endoscopy training commenced in University Hospital Llandough (CV) in January 2025 for a period of three months and anticipates within this short period in delivering endoscopies, bringing endoscopists through to achieve JAG upper GI Endoscopy Certification.

Projected additional endoscopy procedures delivered per year post accreditation, based on modelling

- Registrars: 256 OGD procedures or 128 colonoscopies (based on 1 list/week for 32 weeks per year adjusted for on calls and leave).
- Clinical Endoscopists: 1,408 OGD procedures or 704 colonoscopies (4 lists/week for 44 weeks per year).

Estimated workforce output

- Year 1: 7–11 JAG Certified UGI endoscopists.
- Year 2: 10–22 JAG Certified colonoscopists.

If 50% of these certified trainees were allocated regular service delivery lists, it would result in:

- **2,000 additional** UGI endoscopies annually.
- **1,280 additional** colonoscopies annually.

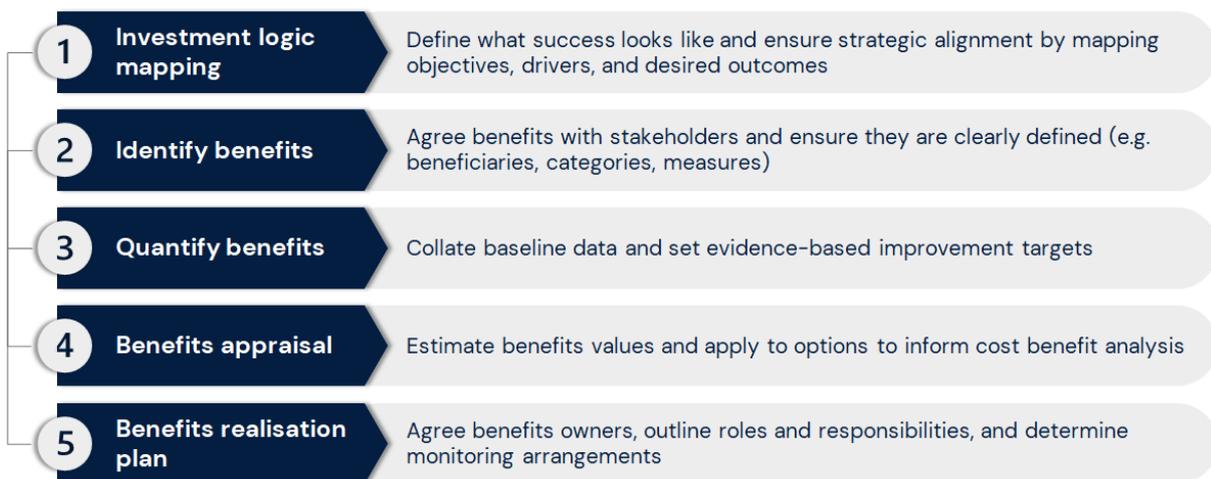
4 Benefits and Risks

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

4.1 Benefits case

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

Figure 6 - Benefit analysis process



A significant amount of work has been undertaken during the development of the programme to identify the benefits of LHP.

This was consolidated within a series of workshops during April 2025 using the investment logic mapping approach outlined in the diagram below, following the restructure of the programme the benefits were reviewed to only include those directly related to Phase 1 :

Figure 7 - Investment logic mapping approach

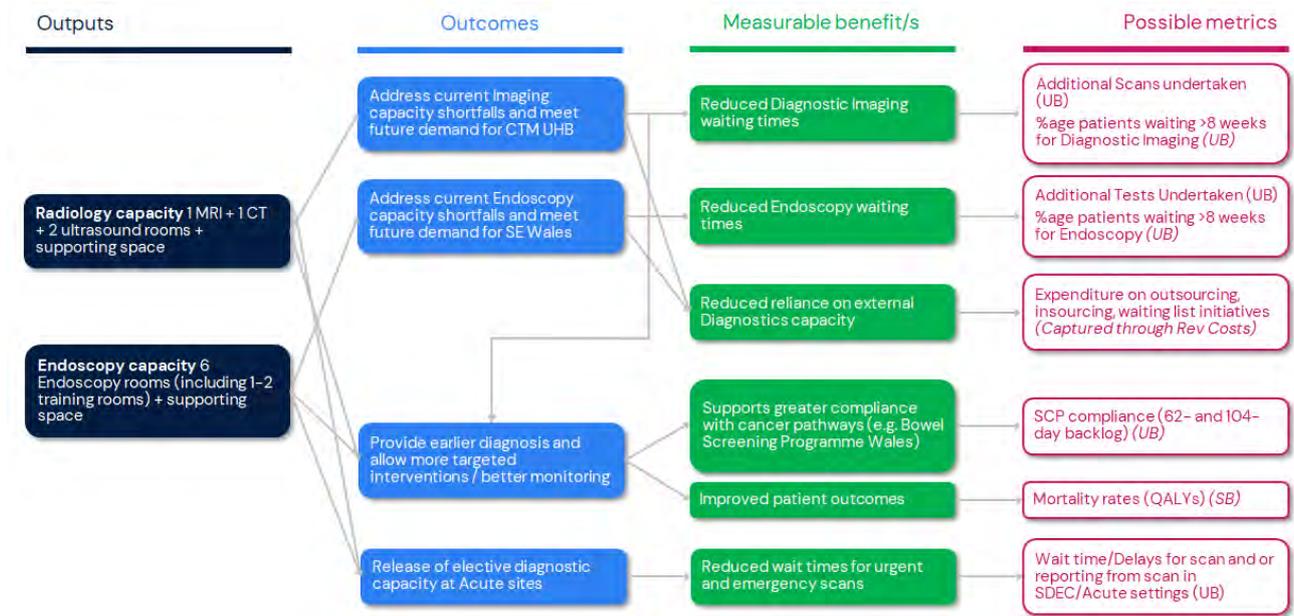


4.1.1 Creation of Diagnostics Centre

Delivery of the CDC will allow LHP to provide additional Diagnostic Imaging and Endoscopy capacity in the region to address current capacity shortfalls and ensure future demand can be met. As well as reducing waiting times for patients, this will support the cancer pathway by enabling earlier diagnosis, more targeted interventions and improved monitoring.

This will lead directly to delivering better patient outcomes, specifically improved cancer survival rates. In addition, the additional capacity will reduce reliance on expensive external Diagnostics capacity such as outsourcing, insourcing and waiting list initiatives.

Figure 8 - Benefits mapping: creation of **Diagnostics Centre**

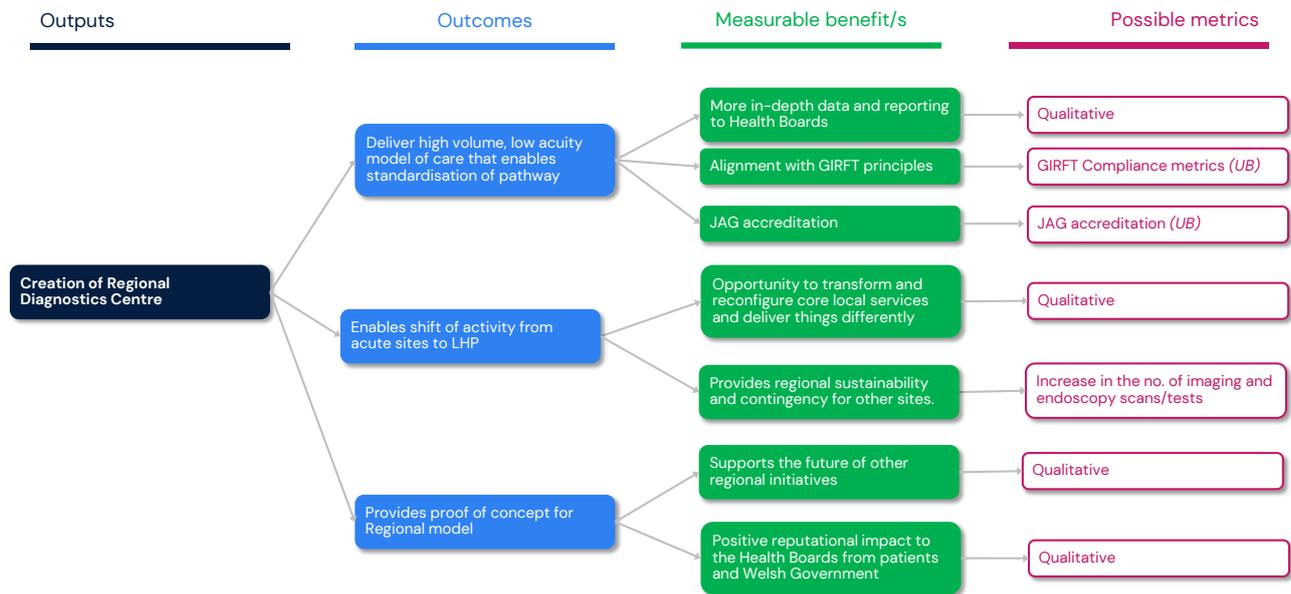


4.1.2 Model of care transformation

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

By providing capacity to shift activity from acute sites, the new CDC provides an opportunity to transform and reconfigure core local services and deliver things differently. For instance, the transfer of activity from CTMUHB to LHP provides opportunities to release space across the Estate in the future for other developments or to address risks around deteriorating facilities and reduce backlog maintenance. It is anticipated that these benefits may not accrue to regional partners for whom LHP will represent additional capacity only. The successful delivery of a regional centre will also provide proof of concept as the basis for the development of any future regional pathways.

Figure 9 - Benefits mapping: **model of care transformation**



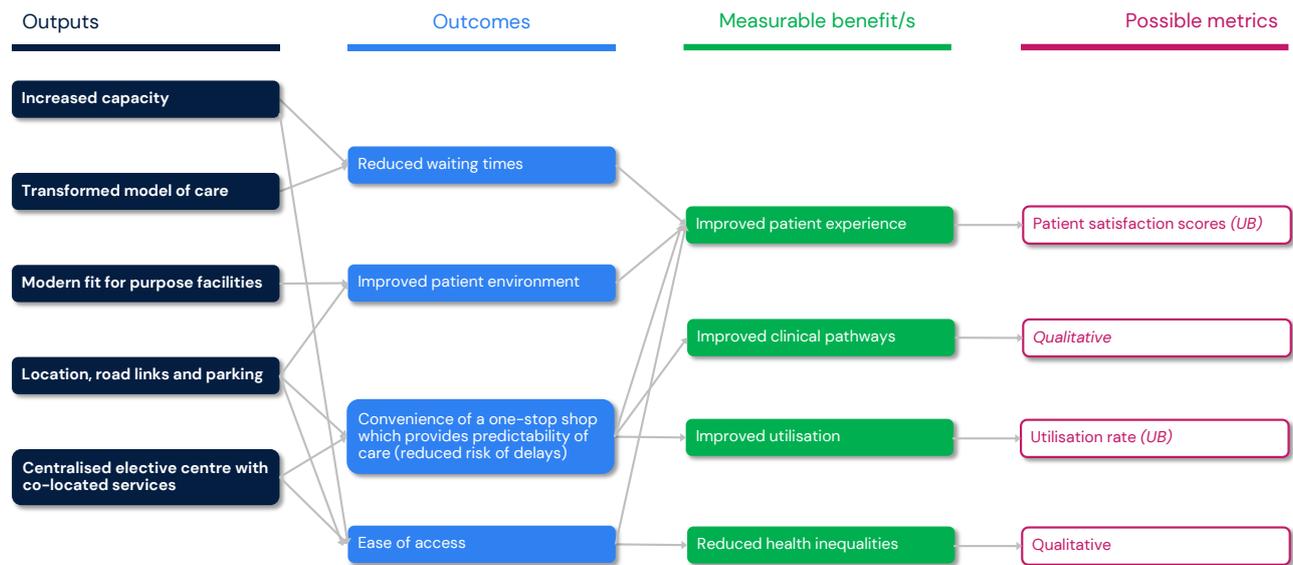
4.1.3 Improving patient experience

The outcomes presented above, such as reductions in waiting times, will contribute to a significant improvement in patient experience.

This is enhanced by the modern fit for purpose facilities and the ease of access the location of LHP offers, with its good road links and parking. Having a centralised elective centre with co-located services provides the convenience of a 'one-stop' shop clinic with greater predictability of care.

This contributes to more confidence in booking patients and tests which should lead to improved utilisation. In general, the improved access and reduced waiting times ensures a more equitable service is available within the region.

Figure 10 - Benefits mapping: patient experience

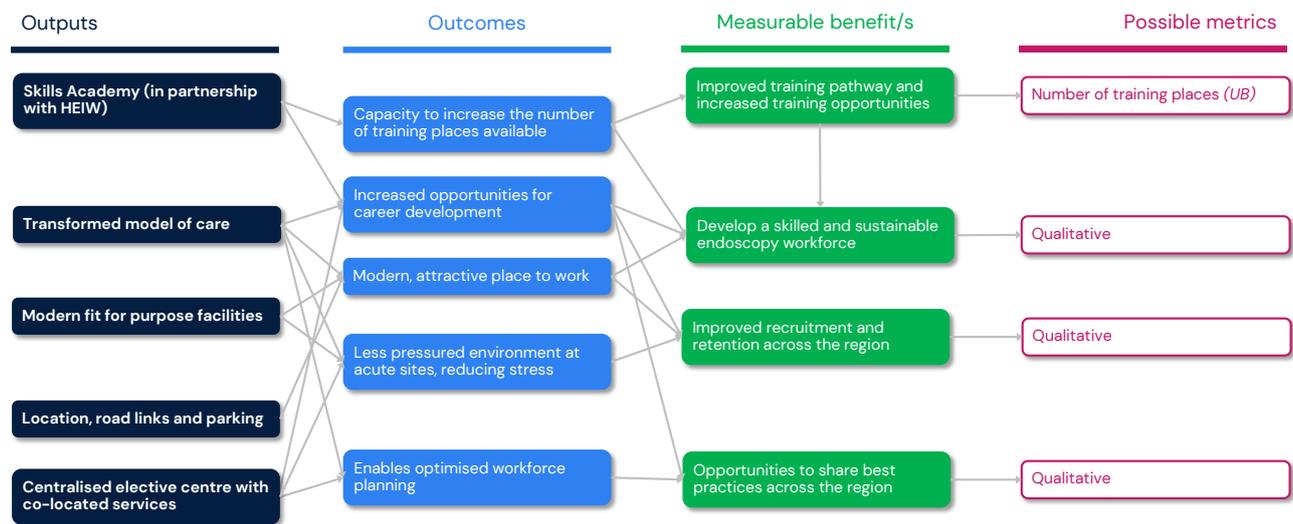


4.1.4 Delivering a sustainable workforce

Delivery of the Endoscopy Academy in partnership with HEIW will provide significant opportunities to increase the number of training places available in the region.

The improved training pathway and increased training opportunities, along with the modern fit for purpose facilities and a consolidated service model that enables can reduce pressures on acute sites contributes to staff satisfaction across the region. It also creates an attractive place to work in the future which will support recruitment and retention of highly trained health professionals.

Figure 11 - Benefits mapping: **sustainable workforce**



For the CDH, the initial plan is that the workforce will largely be provided via the managed service contract with the appointed provider. Therefore, there will be direct benefits for them in terms of recruitment and retention however these benefits are expected to flow to regional partners when the service is brought back in house at the end of the contract. It is clear therefore, that the majority of the workforce benefits will be indirect for the contractual phase.

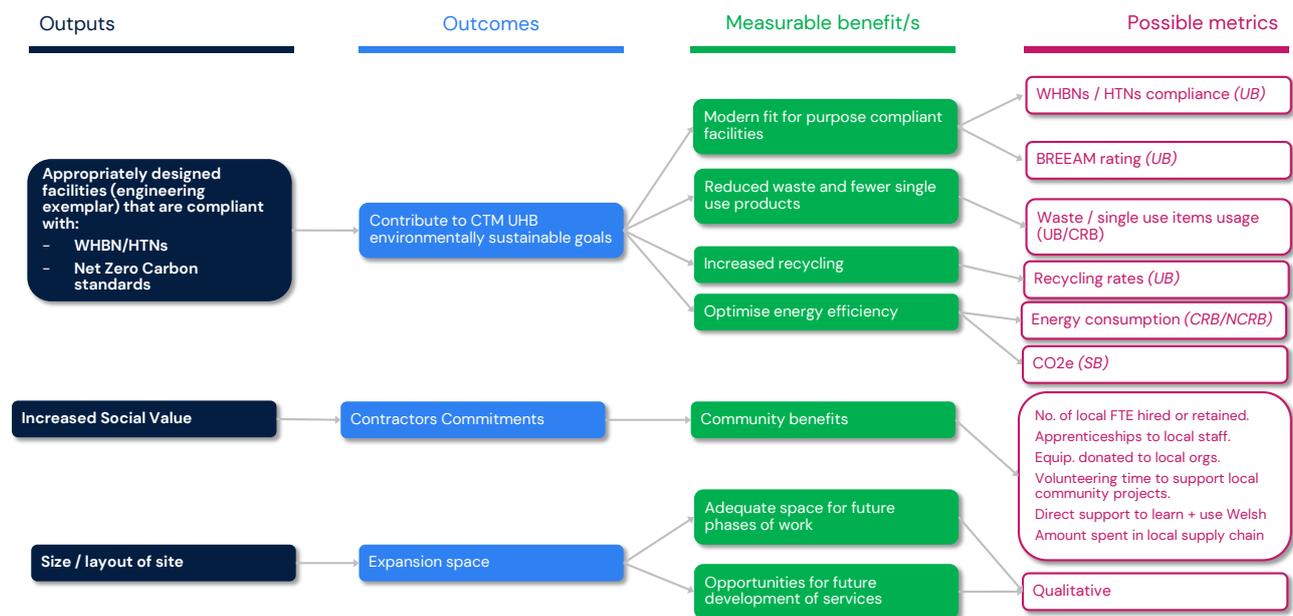
4.1.5 Providing a sustainable estate

The delivery of appropriately designed compliant facilities provides opportunities to contribute to CTMUHB’s environmentally sustainable goals and national strategies around decarbonisation, by ensuring they are compliant with WHBNs and HTNs, achieve BREEAM rating of Excellent and optimise energy efficiency.

The transformed model of care with its standardised pathway is likely to make it easier to implement and maintain sustainability programmes that CTMUHB has instituted in other areas, such as reducing waste and single use products.

The site also provides a level of future proofing by providing expansion space that offers opportunities for other future developments.

Figure 12 - Benefits mapping: **sustainable estate**



4.2 Main benefits

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

Figure 13 - Benefits categories



The main benefits are summarised in the table below.

Table 14 - Main benefits

Theme	Benefit	Beneficiary	Type	Possible Metrics
Creation of diagnostics centre	Increased Imaging and Endoscopy Capacity	Patients / Health Boards	Quantifiable	Additional scans / test undertaken
	Reduced waiting times across Endoscopy and Imaging	Patients	Quantifiable	Number of patients waiting over 8 weeks
	Release of elective diagnostic capacity at Acute sites, which can be used for urgent and emergency care patients/pathways.	Patients	Quantifiable	No. of scans undertaken in SDEC Wait time / delays for scan and or reporting from scan in SDEC/Acute settings
	Supports greater compliance with cancer pathways leading to better patient outcomes	Patients	Societal	SCP compliance (62- and 104-day backlogs) Improved mortality rates (QALYs)
	Improved patient outcomes (non-cancer related):	Patients	Societal	No of Additional Endoscopy tests undertaken (leading to improved mortality rates (QALYs))
	Reduced reliance on external Diagnostics capacity	Health Boards	Captured via revenue costs	Expenditure on outsourcing, insourcing, waiting list initiatives
	Assist with meeting 'Straight to Test' guidance.	Health Boards	Quantifiable	No. of direct referrals from GPs to Radiology
Model of Care Transformation	Greater alignment with GIRFT principles and achievement of JAG compliance	Health Boards	Quantifiable	GIRFT principles JAG accreditation
	Provide more robust and in-depth data and reporting to Health Boards	Health Boards	Qualitative	N/A

Theme	Benefit	Beneficiary	Type	Possible Metrics
	Providing regional sustainability and capacity to allow contingency at other sites.	Health Boards	Quantifiable	Increase in the no. of imaging and endoscopy scans/tests
	Provides opportunities for the future reconfiguration of services at the Health Boards	Health Boards	Qualitative	N/A
	Supports the future of other regional initiatives	Region	Qualitative	N/A
	Positive reputational impact to the Health Boards from patients and Welsh Government from positive outcomes of the initiative	Health Boards	Qualitative	N/A
Improved Patient Experience	Improved patient experience	Patient	Quantifiable	Patient satisfaction scores
	Improved utilisation	Patients / Health Boards	Quantifiable	Utilisation rate
	Increased number of and improved clinical pathways developed and delivered at LHP	Patients / Health Boards	Qualitative	N/A
	Reduced health inequalities	Patient / society	Qualitative	N/A
Delivering a Sustainable Workforce	Develop a skilled and sustainable endoscopy workforce	Staff / Health Boards	Qualitative	N/A
	Improved recruitment and retention across the region	Health Board	Qualitative	N/A
	Opportunities to share best workforce practices across the region	Region	Qualitative	N/A
Providing a Sustainable Estate	Modern fit for purpose compliant facility	Health Board	Quantifiable	WHBN/HTMS BREEAM rating Enhanced facilities
	Community Benefits	Region	Quantifiable	No. local direct full time equivalent (FTE) employees hired or retained. No. of weeks of apprenticeships provided to local staff. Equipment or resources donated to local third sector and civil society organisations Directly funded no. hours volunteering time provided to support local community projects. Direct support and investment provided for people to learn and use Welsh (e.g. interactions and signage). Total amount (£) spent in the local supply chain.
	Reduced waste and single use products	Health Board/Society	Quantifiable	Waste and single use products usage

Theme	Benefit	Beneficiary	Type	Possible Metrics
	Improved recycling	Health Board/Society	Quantifiable	Recycling rates
	Contribute to decarbonisation targets (Net Carbon Zero) with energy efficiency	Health Board / Society	Societal	Energy consumption CO2e
	Contribute to decarbonisation targets with more efficient pathway	Health Board / Society	Societal	CO2e reductions
	Preservation of biodiversity and wetland area due to choice and design of site.	Society	Qualitative	N/A
	Enables and provides meaningful and adequate spaces for future phases of work that are planned	Health Boards	Qualitative	NA
	Provides opportunity for future expansion	Health Boards	Qualitative	NA

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

4.3 Main risks

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

The full quantified capital programme risk register can be found in Appendix 5 and informs the planning contingency. An operational / revenue risk register is also developed to cover those risks that do not have capital implications.

Availability of resources to fund the required regional service developments has been highlighted as a risk to deliverability. The diagnostics programme was working on the basis that the funding would be derived from health board budgets, and additional recurrent funding allocated for regional services and performance improvement is intended to support the developments. However, it has been identified that the resource required for revenue funding exceeds funds currently available to health boards and the recommended course of action is to seek funding support for these new service developments from Welsh Government.

Delivery of value for money is a core underpinning principle and requirement. This is being supported by both the development of a robust service specification and assessment of all options, including commercial, for the delivery of community diagnostic hubs.

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

Table 15 - Top risks (current assessment) C x L = R

Description	Consequence	Likelihood	Rating
Regional engagement to facilitate development of clinically led model	5	4	20
Delayed Welsh Govt approval of OBC	5	4	20
Car parking provision available within site confines results in delayed Planning permission	4	4	16
Approval of SAB resubmission required to support the building phasing	4	4	16
FFE provision exceeds the high-level allowances within the cost plan	4	4	16
Medical equipment provision exceeds the high-level allowances within the cost plan	4	4	16
Last minute issues delay completion of building and handover	5	3	15
Contractor insolvency	5	3	15

4.4 Constraints

Constraints relate to the parameters that the project is working within and any restrictions or factors that might impact on its delivery. These typically include limits on resources and compliance issues. The project is subject to the following constraints:

- facilities must be fit for purpose and have future flexibility/adaptability
- implementation must not negatively impact continuation of current service provision
- the proposed solution must be technically feasible
- it must be delivered within agreed capital and revenue funding.

The project must support regional integration and collaboration and be supported by all 3 Health Boards.

4.5 Dependencies

Dependencies include things that must be in place to enable the project or project phases and typically include links to other projects and funding requirements that are likely to be managed elsewhere.

The project is subject to the following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme:

- Availability of Welsh Government funding for both capital and revenue
- Approval from Welsh Government, IIB and other health boards
- Continued support for proposed service model and successful procurement process leading to the appointment of the managed service provider for diagnostics.
- Access to pathology, particularly for endoscopy services. There is a recognised regional capacity gap for pathology. The Regional Diagnostics Programme includes a pathology project whose current main focus is the development of cellular pathology.
- A national business case for digital cellular pathology is a key enabler for regional cellular pathology development and the maintenance of cellular pathology services, as training moves away from the use of microscopes to processing digital samples. The national business case is

awaited, and the regional programme has links to the National Diagnostics Programme to ensure that the digital cellular pathology business case is considered. This will have revenue cost implications for health boards.

- Digital developments including changes to e-referral forms and information flows for reporting to ensure the proposed pathways for regional services are appropriately connected to health board systems. These interdependencies are identified and worked through by digital experts supporting the specification development and where changes are required to systems, these are highlighted to the Directors of Digital Services through the regional portfolio governance structure and support mechanisms.

Economic Case

5 Options identification and appraisal

5.1 Potential scope of services

This section of the business case identifies the scope of the project in terms of the key service requirements that should be considered in designing the future service model and developing options. The case for purchase of the site identified the following services as being integral to the creation of the Phase 1 elective diagnostic hub:

- Diagnostic Imaging Capacity – MRI, CT, Ultrasound and potential X Ray
- Provision of a regional Endoscopy Academy for training
- Endoscopy

These services constitute the core services required for delivery of a diagnostic hub on the LHP site. In terms of deliverability, currently the Health Board, is involved in a procurement exercise to appoint a partner for the delivery of the community diagnostic hub (CDH).

The proposal is that the partner will provide diagnostic services comprising both imaging and endoscopy in the CDH. The ongoing procurement will appoint a partner to provide the services on the LHP site with an option to create facilities on future sites. The CTMUHB CDH is the only one proposed to include regional endoscopy services as well as accommodating an endoscopy academy.

The current design combines capacity to meet the forecast level of demand when the centre opens but with an opportunity to further expand to meet further growth or changes in health screening requirements. The ability to easily absorb and accommodate demand increases gives LHP a unique position of being future ready at the day of opening and the ability to respond quickly and directly to ongoing service pressures.

5.2 CDH - Clinical service delivery options

In November 2022, prior to the full implementation of the Regional Diagnostics Programme a clinical summit was held with representatives of the clinical body from each of the region's health boards. At this point there was agreement on the aims and objectives of the regional working, which were subsequently built into the Project Initiation Document and approved by the Project and Programme Board.

To achieve the stated aims of the business case, the options are required to ensure that:

- Delivery is more accessible to residents living in areas of socio-economic deprivation and able to deliver to more than one health board population in the region.
- Developments deliver an increase in capacity.
- Developments will be founded on seeking sustainable solutions to demand backlogs.

To align with other programmes within the South East Wales Regional Portfolio, the criteria for assessment used for the regional ophthalmology programme for the cataracts interim solution were reviewed and expanded for use to assess the options for radiology service developments. The criteria agreed for the option appraisal were:

- Strategic viability (does it fit with the local and regional plans?)
- Does this option meet the service demand requirements?
- Will this deliver sustainable diagnostic services?

- Clinical viability (can the option deliver the procedures included in the service specification?)
- Operational viability (can this be operational within project timeframes?)
- Workforce viability: does this option:
 - ♦ Support sustainable workforce? ♦ Deliver on national strategy?
 - ♦ Facilitate training? ♦ Have implications for existing workforce?
- Estates viability (would this option facilitate the appropriate spaces, e.g. clinic rooms and outpatients space?)
- Financial viability (are the revenue and capital costs reasonable?)
- Geographic suitability / accessibility.

Stage 1 of the consideration of options for regional collaboration was to develop and test a range of potential models. The long list of model options for appraisal was developed in spring 2023 to inform the Project Initiation Document and were reviewed by the Programme Board in a Position Statement to the April 2023 Board. The outcome of this initial appraisal was that community diagnostic hubs and changes to existing practices in collaboration were to be considered further. There was recognition of the potential benefits of the CDH model based on the literature, as set out in the Strategic Case.

During 2023, this long list has been reviewed collaboratively through the clinical and operational leads group against an agreed set of criteria and subsequently tested by each health board prior to consideration by project and programme boards.

Further consideration of appropriate service models have been undertaken by ABUHB as part of the assessments which led to the development of a business justification case for a community diagnostic hub, managed wholly in-house within the NHS (and enabled by the establishment of a second MRI scanner at the Grange University Hospital), which is intended to be located within an existing community services setting. The business justification case sits alongside the regional business case for a managed service contract, with the intention that a community diagnostic hub initiated in the ABUHB area would be geographically accessible to C&VUHB and CTMUHB residents as per the agreed programme aims and principles.

The options considered by the regional Project Board are set out below.

Option 1	Do nothing - Health boards would continue to provide services as per current arrangements.
Option 1a	Different approach to the use of existing services in each health board, and work toward collaboration through shared processes. Health board expansion of internal capacity and/or other forms of regional working.
Option 2	Independent Community Diagnostic Hubs (CDH) – each health board operating their own CDH with no cross-border treatments.
Option 3	Regional Community Diagnostic Hubs – a minimum of one per health board, delivering cross-border diagnostic treatment.
Option 4	A single Regional Radiology Diagnostic centre , located on one site, serving all three health boards.
Option 5	Combined approach - Regional Diagnostic Centre/community diagnostic hubs.
Option 6	Community Diagnostic Hub with Mobile Units – as option 3 but with mobile units attached to reach outlying communities through community diagnostic clinics.

Assessment by the clinical and operational leads resulted in a short-list of model options for consideration by the Project Board. The shortlist included three options:

- **1a** – different approach to the use of existing services
- **3** – Community diagnostic hubs (CDH) with a minimum of one per health board area, and
- **6** – Community diagnostic hubs with the option of mobile units.

The Project Board considered these options formally on 23 January 2024 and confirmed the acceptability of both **Option 3** and **Option 6** with the preferred option of development of a community diagnostic hub model for the region, which may incorporate mobile units, as required.

Potential options for the CDH delivery model include the following, which have been tested on the basis of timely delivery, financial delivery and through the site identification and appraisal:

- Repurposing existing estate in the community, staffed by NHS workforce.
- Repurposing existing estate in community, staffed by commercial provider.
- New build (capital), staffed by NHS workforce.
- New build (capital), staffed by commercial provider.
- Partnership with commercial provider (estate and workforce solution).

5.3 Site and infrastructure delivery options

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

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

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

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

As a result, this section will not consider alternative options for service change with the scope and scale having been proven in the sections above. In addition, following WG approvals, design work has already progressed beyond the traditional stage for an OBC, with WG approval to proceed to RIBA 3 given in December 2024. RIBA 3 has completed for Phase 1 and to maintain programme, RIBA 4 works have also commenced.

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

In addition to above funding, WG approval was granted to proceed with the demolition of the existing buildings on 31 January 2025, with planning licence approval granted on 2 April 2025.

These works have commenced under a separate contract to the main design works and are programmed to complete by 16 September 2025. As a result, there is no scope to further consider infrastructure and build options.

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

The tender process demonstrated a modular form of MMC was preferred and WG approval to enter into the design contract was received on 14 March 2025. As a result, the build methodology has also been fully determined. Therefore, the economic appraisal in following sections will focus on the delivery options for the CDH only in terms of the scope of the agreement with the third party provider.

6 Economic Appraisal

6.1 Introduction

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

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

As per Section 5 above, for the purposes of this case, the scope of the **do something** options is all the same (outlined in 5.3), with only how the service is delivered differing. As agreed, as part of the Strategic Overview, there are no other scope options viable for consideration.

6.2 Summary of Phase 1 service delivery options

Whilst the decision has been made to appoint an independent service provider to deliver the model in the CDH, there are options about the extent to which this can be delivered by the partner. As a result, this has been the focus of a more detailed option appraisal with the key options being:

Table 16 - Phase 1 service delivery options summary

Components	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Building	ISP Design and Build (Costs captured through revenue costs)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)
General Building Equipment	ISP Design and Build (Costs captured through revenue costs)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)	NHS Design and Build (WG Capital Funding)
Specific Service Delivery Equipment – First 10 Years after completion of LHP	ISP provide and maintain (Costs captured through revenue costs)	ISP provide and maintain (Costs captured through revenue costs)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)
Specific Service Delivery Equipment – After 10 years	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)	NHS Provide and Maintain (WG Capital Funding)
Service Delivery (Staffing) – First 10 Years after completion of LHP	ISP Staffing	ISP Staffing	ISP Staffing	NHS Staffing

Components	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Service Delivery (Staffing) – After 10 Years	NHS Staffing	NHS Staffing	NHS Staffing	NHS Staffing
Lifecycle Costs – First 10 Years after completion of LHP	N/A	Building Lifecycle Costs	Building Lifecycle Costs	Building Lifecycle Costs
Lifecycle Costs – After 10 years	NHS (WG Capital Funding) buys building buy back at net book value after 10 years. Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs	Building Lifecycle and equipment replacement Costs

6.3 Capital costs

Capital costs for construction of phase 1 of the LHP have been estimated and prepared for the Preferred Way Forward (Option 2) by the Health Board’s Cost Advisors, Mott Macdonald using the following assumptions:

- Agreed Schedules of Accommodation and RIBA 3b design. Agreed scope of Phase 1 to cover the build of the CDH plus additional site wide infrastructure to facilitate later phases
- Proposed start on site 26 February 2026 and proposed construction completion date of July 2027 (though final commissioning continues until the end of October 2027).
- Works costs calculated using benchmarked rates suitable for South Wales (including Healthcare Premises Cost Guide) @ BCIS TPI updated 20/08/2025
- Allowances for fees, equipment costs, planning contingency have been applied as appropriate.
- No allowance for optimism bias has been applied given the degree of certainty at this stage in terms of maturity of design, knowledge of the site, and publicly declared political support for the development. It is therefore superseded by the Costed Risk Register figure.

The capital costs for Options 3 and 4 are the same as Option 2, except for an adjustment made to the equipment costs, to account for these options providing specific service delivery equipment. This has a flow on effect to the Quantified Risk Contingency and VAT. The value of the equipment has been estimated by the Health Board, with a full breakdown of the equipment and costs provided in appendix 10 (CIA Model).

The resulting capital costs estimates are summarised in the table below and a copy of the detailed capital cost form for Option 2 is provided in Appendix 8.

Table 17 - Initial capital costs

Element, £'000	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Works Costs	-	-	58,058	58,058	58,058
Fees	-	-	14,463	14,463	14,463
Non-Works Costs	-	-	10,362	10,362	10,362
Equipment Costs	-	-	2,628	11,483	11,483
Quantified Risk Contingency	-	-	10,583	11,680	11,680
Subtotal	-	-	96,094	106,046	106,046
VAT	-	-	13,895	15,666	15,666
Total capital costs (as per capital cost forms)	-	-	109,989	121,712	121,712
Exclude sunk costs	-	-	-15,123	-15,123	-15,123
Exclude Inflation adjustment to rebase to base year	-	-	-2,553	-2,553	-2,553
Exclude VAT	-	-	-13,895	-15,666	-15,666
Total capital costs (for Economic Case)	-	-	78,417	88,369	88,369

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

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

6.4 Lifecycle capital costs

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

Building lifecycle costs across the appraisal period have been estimated for Options 1-4 using lifecycle figures provided by the Health Board's Cost Advisors, Mott Macdonald. It is also expected that both general and specific service delivery equipment will be replaced every 10 years in every "do something" option. Further refinement of lifecycle costs will be provided at FBC stage.

Further to this it is assumed in Option 1, at the end of the managed service contract the Health Boards would have to buy back the building from the provider at the assumed net book value.

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

Table 18 - Lifecycle Costs

Lifecycle Costs, £'000	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Building Buy Back Costs	-	61,457	-	-	-
Building lifecycle Costs	-	106,361	112,821	112,821	112,821
Equipment replacement costs	-	57,413	57,413	57,413	57,413
Total lifecycle costs - Full appraisal period	-	225,232	170,234	170,234	170,234

6.5 Recurring revenue costs

6.5.1 Assumptions

Recurring revenue costs for the period of the managed service contract (10 years) for each option has been estimated using the following assumptions:

Option 1 - Fully outsourced managed service contract

- No pay costs
- No non-pay costs
- Healthcare Services costs calculated by: 2025-26 Tariff price of scan/test with a 5% market forces factor applied multiplied by amount of activity of relevant scan/test.
- Assumed additional rental costs for the endoscopy Skills Academy space which is estimated at a daily rental cost of £6,000 based on indications from providers.

Option 2 - Traditional capital build + ISP equip and deliver services via managed service contract

- No pay costs
- No non-pay costs
- Healthcare Services costs calculated by:
 - ◆ 2025-26 Tariff price of scan/test with a 5% market forces factor applied multiplied by amount of activity of relevant scan/test.
 - ◆ Applying a 20% tariff discount due to the Health Boards providing the LHP land and building.

Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract

- Pay costs for site-based staffing (i.e. receptionists etc.)
- Non-pay costs for imaging, endoscopy and site-based elements, including supplies, utilities, equipment maintenance etc.
- Healthcare Services costs calculated by: Assumed cost of managed services contracted staffing.

Option 4 - Traditional capital build and equip + NHS staffing and service provision

- Pay costs for cost of using NHS staff to provide the imaging and endoscopy.
- Non-pay costs for imaging, endoscopy and site based elements, including supplies, utilities, equipment maintenance etc.
- No Healthcare Services costs

6.5.2 Recurring revenue costs summary

The annual impact on each option for the period of the managed service contract (10 years) is summarised in the table overleaf. It is assumed that costs will be incurred from the start of 2027-28 for each option. More detailed calculations are provided in Appendix 9 and 10.

Table 19 - Annual revenue costs during managed service contract period (first 10 years post implementation)

Element, £'000	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Pay Costs	-	-	-	324	2,788
Non-Pay Costs	-	-	-	3,313	2,587
Healthcare Services (cost of managed service contract)	-	9,341	7,473	3,780	-
Rental Payment for Endoscopy Skills Academy	-	2,190	-	-	-
Total annual revenue costs	-	11,531	7,473	7,417	5,376
<i>Incremental Impact on Annual Revenue Costs</i>	-	11,531	7,473	7,417	5,376

After the end of the managed services contract, it is assumed that the service will come in house and all options will have Option 4's recurring revenue costs.

A breakdown of the annual revenue costs after the managed service contract period is outlined in the table below:

Table 20 - Annual revenue costs post managed service contract period

Element, £'000	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Pay Costs	-	2,788	2,788	2,788	2,788
Non-Pay Costs	-	2,587	2,587	2,587	2,587
Total annual revenue costs	-	5,376	5,376	5,376	5,376
<i>Incremental Impact on Annual Revenue Costs</i>	-	5,376	5,376	5,376	5,376

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

6.6 Transitional costs after the end of managed service contract period

It is expected that after the end of the managed service contract period for Option 1, due to it being a complete handover, there would be 6 months of dual running costs while the inhouse service ramps up, this would equate to c.£4.7m in 2037/38.

It is not expected that there would be any significant transitional costs in any of the other options.

6.7 Benefits analysis

6.7.1 Approach

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

Figure 14 - Benefits analysis approach



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

Figure 15 - Benefits categories



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

6.7.2 Benefits assumptions

An overview of the main benefits that it is anticipated will be delivered as a result of the LHP, along with the key assumptions used to quantify them, is provided in the table overleaf. Detailed calculations are available in Appendix 6.

Table 21 - Overview of LHP benefits

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Creation of diagnostics centre						
Increased Imaging capacity	Additional scans undertaken	N/A	TBC (26,000 scans provided at LHP by the managed service)	Not monetisable	To be confirmed exact extent but it is assumed a portion of the imaging capacity will be a transfer of current capacity, but the vast majority will be additional capacity. This helps with freeing up space in acute settings for emergency care patients and pathways. (Likely an additional benefit) – Could look at same day emergency care no. of scans (delays over a week for scans and reporting) Helps to focus on emergency work.	UB1 (a)
Increased Endoscopy capacity	Additional tests undertaken	N/A	11,330 additional endoscopy tests at LHP	Not monetisable	The increased endoscopy capacity will be additional to current levels.	UB1 (b)
Reduced Imaging waiting times as a result of additional capacity provided by the diagnostics centre.	% of patients waiting over 8 weeks for Imaging	47% (CTMUHB % as of January 2024. Source: Strategic Overview Case 2025)	0% (In line with NHS Wales target wait times)	Not monetisable	Comparators <ul style="list-style-type: none"> NHS England’s planning guidance for 2024/25 requests that the percentage of patients waiting 6 weeks or more should be at most 5%. NHS Wales target is that the maximum wait for access to specified diagnostic tests is 8 weeks. 	UB2 (a)
Reduced Endoscopy waiting times as a result of additional capacity provided by the diagnostics centre.	% of patients waiting over 8 weeks for Endoscopy	64% (Average for 3 UHBs in August 2024. Source: Regional Endoscopy Plan 2025)	0% (In line with NHS Wales target wait times)	Not monetisable	The target improvements will be incorporated into the managed service contract as KPI’s meaning there will be a high degree of certainty that the improvement will be reached.	UB2 (b)
Release of elective diagnostic capacity at Acute sites, which can be used for urgent and emergency care patients/pathways. This would lead to reduced waiting times for urgent scans and subsequent reports.	No. of scans undertaken in SDEC Wait time/Delays for scan and or reporting from scan in SDEC/Acute settings	To be confirmed at FBC	To be confirmed at FBC	Not Monetisable	The additional capacity provided at LHP will free up capacity at acute sites for urgent and emergency patients requiring scans/tests. This will lead to more prompt turnaround of scans and subsequent reporting. Measures included as potential ways to measure this benefit, but quantification will be completed at FBC stage.	UB3

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Supports greater compliance with cancer pathways: By providing earlier diagnosis which will allow more targeted interventions and better monitoring.	Single suspected cancer pathway (SCP) compliance: 62-day backlog %age of patients starting treatment within 62 days	58% Equates to 444 patients waiting longer than 62 days (Source: CTMUHB)	80% Equates to c.211 patients waiting longer than 62 days (In line with national target)	Contributes to SB1	National target of at least 80% of people starting first definitive treatment for cancer within 62-days as per NHS Wales planning framework 2025 to 2028, Annex 1: key delivery expectations (NHS Wales planning framework 2025 to 2028 GOV.WALES) The target improvements will be incorporated into the managed service contract as KPI's meaning there will be a high degree of certainty that the improvement will be reached.	UB4
	SCP compliance: 104-day backlog	130 patients waiting longer than 104 days (Based on a 2024-25 average Source: CTMUHB.)	39 patients waiting longer than 104 days (In line with CTMUHB Target for March 2026)	Contributes to SB1	104-day backlog targets in line with CTMUHB Target. The target improvements will be incorporated into the managed service contract as KPI's meaning there will be a high degree of certainty that the improvement will be reached.	UB5
Improved patient outcomes: Earlier diagnosis of cancers leading to more targeted interventions and better monitoring will contribute to improved mortality rates	Single suspected cancer pathway (SCP) compliance: 62-day backlog %age of patients starting treatment within 62 days	58% Equates to 444 patients waiting longer than 62 days (Source: CTMUHB)	80% Equates to 211 patients waiting longer than 62 days (This equates to an assumed 16 QALYs p.a. based on 24 patients benefit from earlier cancer diagnosis as result of achievement of SCP compliance 62-day backlog targets)	£3.4m p.a. after confidence rating applied	Based on figures provided by Cancer Research UK in written evidence to the UK parliament on 4 common types of cancer, the average 10-year survival rate when diagnosed at the earliest stage is 78% compared to 10% at the latest stage. Percentage of suspected cancer referrals to cancer diagnosis was 10% based on data from NHS England Cancer Waiting Times Feb 2024-25 It is therefore assumed for the c.233 patients who receive an earlier diagnostic test (due to - achievement of SCP compliance 62-day backlog targets outlined in UB1), 24 will receive a cancer diagnosis. As a result of the earlier diagnosis, those 24 patients will have increased their 10-year survival rate by 68%. Apply 1 QALY for 10 years to the increased survival rate per patient. QALY value of £70,000 as per HM Treasury Green Book (uplifted to base year prices)	SB1

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
					A prudent 25% confidence rating is then applied noting the significant increase in 10-year survival rate that has been applied, and that it assumes that by achieving the 62-day backlog target, those patients will receive the diagnosis at the earliest stage compared to the latest stage.	
Improved patient outcomes: Earlier diagnosis of other clinical issues (non-cancer related) leading to more targeted interventions and better monitoring will contribute to improved quality of life for patients.	No of additional Endoscopy tests undertaken	N/A	11,330 additional endoscopy tests at LHP	£5.2m after confidence rating applied	<p>Increased number of endoscopy tests will lead to an increase in the number of people with hypertension being diagnosed. This diagnosis will cause the patient to get treatment and management of Hypertension. This will in turn lead to a potential reduction in all-cause mortality by 13% of those diagnosed with hypertension.</p> <p>The following assumptions have been used to calculate a monetary value:</p> <ul style="list-style-type: none"> • Only focused on the increased number of endoscopy tests (11,330) as these are all additional. • Prevalence of Hypertension in CTM's catchment area is 16.9% (See: https://www.gov.wales/general-practice-disease-registers-interactive-dashboard). • Assume that the additional tests diagnose patients with hypertension in line with prevalence and that 50% of those patients otherwise did not know they had it/was not controlled <ul style="list-style-type: none"> • It is noted that this is a large assumption, but this is factored into a low confidence rating (outlined below). • No. of additional patients diagnosed with hypertension per year = 957 • This leads to those patients undertaking treatment and controlling it, which reduces the risk of all-cause mortality by 13% (see: https://www.england.nhs.uk/blog/under-control-why-getting-to-grips-with-blood-pressure-is-a-win-win-intervention-for-healthcare-systems/) • Potential reduction in mortality per year is 124. 	SB2

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
					<ul style="list-style-type: none"> Assume this results in 1 QALY for 10 additional years per reduction in mortality. QALY value of £70,000 as per HM Treasury Green Book (uplifted to base year prices) A prudent 5% confidence rating is then applied noting there are significant assumptions within the calculation including that a significant no. of patients that are tested are not already aware they have hypertension and that as a result of knowing there will be a significant reduction in mortality that does not take into account other factors.	
Release of capacity at acute sites to undertake Bowel cancer screenings.	No. of Bowel Cancer Screenings undertaken at acute sites	To be confirmed at FBC	To be confirmed at FBC	To be confirmed at FBC (potentially monetisable)	To be confirmed at FBC	SB3
Reduced reliance on external Diagnostics capacity: Reduced outsourcing, insourcing and waiting list initiatives as a result of additional capacity provided by CDC	Expenditure on Diagnostics outsourcing, insourcing and waiting list initiatives	N/A	N/A	Included in BAU costs	Included in the transfer of costs associated with substitution of services at CTMUHB. It should be noted that the LHP and the managed service contract has been built/developed so that additional capacity can be accommodated. This would mean that if there was an increase in the capacity required it could be managed without having to rely on relatively more expensive and shorter term outsourcing, insourcing and waiting list initiatives. Note FBC Actions include verify whether the other UHBs can reduce costs / all 3 UHBs can reduce the risk of these costs as a result of LHP.	N/A
Assist with meeting 'Straight to Test' guidance.	No. of direct referrals from GPs to Radiology	TBC	TBC	TBC	LHP will increase the ability to have direct referrals from GP to radiology will help meet the Straight to Test guidance. This will also improve waiting list cleanliness because it will help to ensure that the lists only have the necessary patients who require the service on them.	UB6

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Model of care transformation						
Greater alignment with GIRFT principles	GIRFT principles	To be confirmed at FBC	To be confirmed at FBC	Not monetisable	N/A – Will help all of the other sites to align with GIRFT principles.	UB7
Achievement of JAG accreditation	JAG accreditation	To be confirmed at FBC	Achieve JAG accreditation (minimum contract requirement)	Not monetisable	N/A – Will help all of the other sites to reach JAG accreditation.	UB8
Provide more robust and in-depth data and reporting to Health Boards: the managed service can provide more robust and in-depth data to the Health Boards which can be used to better inform decisions.	Qualitative	N/A	N/A	Not Monetisable	Not possible to quantify in a meaningful way at this stage	UB9
Providing regional sustainability and capacity to allow contingency at other sites.	Increase in the no. of imaging and endoscopy scans/tests	N/A	26,000 imaging scans provided at LHP by the managed service and 11,330 additional endoscopy tests at LHP	Not monetisable	As a result of the increased capacity at LHP it will provide regional sustainability and contingency at other acute sites.	UB10
Provides opportunities for future reconfiguration of services at the 3 UHBs: The move of diagnostic activity to LHP will release regional capacity, providing the UHBs opportunities to consolidate or reconfigure services for future rationalisation	Qualitative	N/A	N/A	Not Monetisable	Not possible to quantify in a meaningful way at this stage	UB11
Supports other regional initiatives: Delivery of a successful regional model provides an evidence-base and acts as a potential exemplar, providing a catalyst for standardising other suitable pathways or centralising other suitable services	Qualitative	N/A	N/A	Not Monetisable	Not possible to quantify in a meaningful way at this stage	UB12

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Positive reputational impact to UHBs from patients and Welsh Government from positive outcomes of the initiative	Qualitative	N/A	N/A	Not Monetisable	It is assumed that the investment and service will be delivered in a productive and beneficial manner which will provide positive outcomes for patients, staff and the organisations. This will lead to a positive reputational impact from both patients and Welsh Government.	UB13
Improving patient experience						
Improved patient experience as a result of reduced waiting times, ease of access and quality of care.	Patient satisfaction scores	N/A (not possible to isolate existing patient scores from wider UHB)	95% (Based on current targets)	Not monetisable	N/A	UB14
Ability to achieve better utilisation as result of confidence in level of booking: Centralised elective centre with co-location of equipment and clinical rooms making it a “one-stop” clinic provides predictability of care and planning.	Utilisation rate	To be confirmed at FBC	To be confirmed at FBC	Potentially monetisable – to be explored at FBC	Due to LHP being a centralised elective centre, there would be more confidence in how many elective scans will be utilised and hence how many should be booked, leading to better utilisation. This would be a benefit to both the Health Boards and patients and would assist with reducing waiting times and throughput.	UB15
Increased number of and improved clinical pathways developed and delivered at LHP	Qualitative	N/A	N/A		Due to LHP being a centralised elective centre and a “one-stop” clinic, it will lend itself to developing and delivering more and improved clinical pathways. These pathways and improved ways of working could be used as an exemplar and then also be rolled out across the region.	UB16
Reduced health inequalities Reduction in waiting times and ease of access supports equality of access	Qualitative	N/A	N/A		Not possible to quantify in a meaningful way at this stage	UB17

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Delivering a sustainable workforce						
Develop a skilled and sustainable endoscopy workforce: The new Skills Academy in partnership with HEIW at LHP will train and develop a skilled endoscopy workforce that can provide high quality endoscopy service.	Qualitative	N/A	N/A	Not monetisable	<p>The skills academy in partnership with HEIW will provide training opportunities to help develop a highly skilled and sustainable endoscopy workforce, so that at the end of the managed services contract LHP can be staffed adequately and provide high quality endoscopy services.</p> <p>The skills academy in partnership with HEIW will provide improved access to consistent, high-quality training programmes to ensure uniform competencies among endoscopy practitioners. Due to the network of regional training centres provided by HEIW, best practices can also be shared across the region. It will also encourage collaboration among healthcare professionals to enhance team-based care in endoscopy services</p> <p>It should be noted that currently there are endoscopy workforce challenges including risk that a significant portion of the workforce may retire in the short to medium term, meaning that development of staff to replace them is of a high priority.</p> <p>Although it is assumed that should there be the opportunity for the transfer of some staff into opportunities at LHP after the end of the managed service contract this would be incidental. The main goal and benefit would be in partnership with HEIW to develop an endoscopy workforce during the period of the managed services contract that would be able to manage the service at the end.</p>	UB18
Improved recruitment and retention across the region due to the improved training and development provided at LHP as well as from reduced pressure on acute sites as a result of increased capacity at LHP.	Qualitative	N/A	N/A	Not monetisable	<p>It is expected that as a result of the improved opportunities for training and development at LHP that would be available for endoscopy workforce across the region, this will lead to improved recruitment and retention across the region (from opening).</p> <p>It is also expected staff at Acute sites will have reduced pressure on them from the increased capacity at LHP, which will lead to staff being able to provide timelier service to patients at those acute</p>	UB19

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
					sites, which in turn should lead to less complaints/concerns and a better place to work, contributing to improved recruitment and retention. It is also expected that after the end of the managed service contract, there will be significant and desirable new opportunities for colleagues to continue providing the service at LHP.	
Opportunities to share best workforce practices across the region	Qualitative	N/A	N/A	Not monetisable	Learnings around more efficient ways of workings can be taken from the managed diagnostics service. This will lead to optimised workforce planning and a team that can operate in a more agile way is expected to result in productivity improvements and rota efficiencies	UB20
Providing a sustainable estate						
Modern fit for purpose compliant facility that aligns with current guidance and provides more robust, resilient and sustainable facilities	WHBNs HTNs	N/A	Complies with relevant WHBNs and HTNs	Not monetisable	N/A	UB21
	BREEAM rating	N/A	BREEAM rated as excellent	Not monetisable	N/A	UB22
	Enhanced facilities	N/A	Enhanced facilities enhanced provisions (i.e. 2 oxygen tanks, N+N generator etc.)	Not monetisable	N/A	UB23
Community Benefits (Social Value provided by the contractor))	Number of local direct full time equivalent (FTE) employees hired or retained.	N/A	10 FTE	Not monetisable	Target as per Social Value information provided as part of the Tender documents by MTX.	UB24 (a)
	Number of weeks of apprenticeships provided to local staff.	N/A	250 weeks	Not monetisable	Target as per Social Value information provided as part of the Tender documents by MTX.	UB24 (b)
	Equipment or resources donated to local third sector and civil society organisations	N/A	£25,000 donated	Potentially monetisable	Target as per Social Value information provided as part of the Tender documents by MTX.	UB24 (c)

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
	Directly funded number of hours volunteering time provided to support local community projects.	N/A	250 Hours of volunteering time	Not monetisable	Target as per Social Value information provided as part of the Tender documents by MTX.	UB24 (d)
	Direct support and investment provided for people to learn and use Welsh (e.g. interactions and signage).	N/A	£25,000	Potentially monetisable	Target as per Social Value information provided as part of the Tender documents by MTX. Allocate £25,000 to support the Welsh language on a construction project by offering free Welsh lessons for workers, tailored to industry vocabulary (£12k). Introduce bilingual site signage, safety instructions, and manuals (£7k). Host community engagement events, such as guided tours and Welsh-themed workshops, in partnership with local schools or organizations (£5k). Celebrate Welsh culture onsite with events and competitions like St. David's Day (£1.5k). Leave a legacy with bilingual plaques or contributions to local Welsh programs (£1.5k). Partner with Mentrau Iaith or Learn Welsh Cymru for effective delivery and long-term impact, promoting Welsh language use onsite and beyond.	UB24 (e)
	Total amount (£) spent in the local supply chain.	N/A	£20,000,000 spent locally	Not Monetisable	Target as per Social Value information provided as part of the Tender documents by MTX. Potential social value generated by value spent locally = £20,000,000*1.76 (Local Multiplier) = £35,200,000. Note will not be included as a monetisable value in the CIA Model.	UB24 (f)
Reduced waste and single use products: Contribute to CTMUHB environmentally sustainable goals by reducing waste and single use products	Waste and single use products usage	TBC at FBC	TBC at FBC	TBC at FBC	TBC at FBC (however examples include the Gloves off initiative)	UB25

Benefit	Measure	Baseline	Target Improvement	Value	Assumptions	Ref
Improved recycling: Contribute to CTMUHB environmentally sustainable goals by improved recycling and finding alternative ways of disposing of waste	Recycling rates	TBC at FBC	TBC at FBC	TBC at FBC	TBC at FBC	UB26
Contribute to decarbonisation targets (Net Carbon Zero) with energy efficiency: Providing an energy efficient building which optimises energy consumption and associated CO2e	Energy consumption CO2e	No baseline available as new facility	TBC at FBC	TBC at FBC	TBC at FBC	UB27
Preservation of biodiversity and wetland area due to choice and design of site.					As a result of the choice of site for the development and that is recycling a previously developed industrial site instead of a greenfield site, there is preservation of biodiversity in the region. The choice of design and ensuring it stays within the already developed portions of the site, the wetland area is preserved and protected from all development in line with Local Council's recommendations.	
Enables and provides meaningful and adequate spaces for future phases of work that are planned	Qualitative	N/A	N/A	Not monetisable	Not possible to quantify in a meaningful way at this stage	UB28
Provides opportunity for future expansion: As a result of the choice of site and design, it allows for expansion to capacity in current services as well as development of future services	Qualitative	N/A	N/A	Not monetisable	Not possible to quantify in a meaningful way at this stage Existing design allows for future increase in capacity (i.e. has design has factored in space for further equipment and rooms to accommodate providing additional capacity in the future)	UB29

6.7.3 Monetisable benefits analysis

While work continues to validate assumptions and explore benefits that it has not yet been possible to quantify, initial analysis has identified circa £8.6m of monetisable benefits per year, as summarised in the table below.

Table 22 - Monetisable benefits values after confidence rating (when benefits are fully realised)

Element	Option 0 – BAU £'000	All “Do Something” Options £'000
Cash releasing benefits	0	0
Non-cash releasing benefits	0	0
Societal benefits	0	8,619
Total annual recurring benefits values	0	8,619

These figures can be considered risk-adjusted since, as outlined in Table 22 above, relatively prudent confidence ratings have been applied to them to reflect the degree of uncertainty at this stage in the process. Further work will be undertaken at FBC to firm up these assumptions and reduce the level of uncertainty.

6.7.4 Unmonetisable benefits analysis

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

Table 23 - Unmonetisable benefits analysis

Ref	Description	Option 0 - BAU	All “Do Something” Options
UB1 (a)	Increased Imaging capacity	-	TBC (26,000 scans provided at LHP by the managed service)
UB1 (b)	Increased Endoscopy capacity	-	11,330 additional endoscopy tests at LHP
UB2 (a)	Reduced Imaging waiting times	-	Percentage patient wait times for imaging of greater than 8 weeks will reduce from 47% to 0% for CTMUHB
UB2 (b)	Reduced Endoscopy waiting times	-	Percentage of patient wait times for endoscopy of greater than 8 weeks will reduce from 64% to 0% across the 3 Health Boards
UB3	Release of elective diagnostic capacity at Acute sites, which can be used for urgent and emergency care patients/pathways.	-	To be confirmed at FBC
UB4/5	Supports greater compliance with cancer pathways	-	SCP Compliance = 75% 62-day backlog = 279 patients 104-day backlog = 39 patients
UB6	Assist with meeting ‘Straight to Test’ guidance.	-	To be confirmed at FBC
UB7/8	Greater alignment with GIRFT principles and achievement of JAG compliance	-	Achieve JAG accreditation (minimum contract requirement)
UB9	Provide more robust and in-depth data and reporting to Health Boards	-	Qualitative
UB10	Providing regional sustainability and capacity to allow contingency at other sites.	-	26,000 imaging scans provided at LHP by the managed service and 11,330 additional endoscopy tests at LHP

Ref	Description	Option 0 - BAU	All "Do Something" Options
UB11	Provides opportunities for the future reconfiguration of services at the three Health Boards	-	Qualitative
UB12	Supports the future of other regional initiatives	-	Qualitative
UB13	Positive reputational impact to the Health Boards from patients and Welsh Government from positive outcomes of the initiative	-	Qualitative
UB14	Improved patient experience	-	95% patient satisfaction
UB15	Ability to achieve better utilisation as result of confidence in level of booking	-	To be confirmed at FBC
UB16	Increased number of and improved clinical pathways developed and delivered at LHP	-	Qualitative
UB17	Reduced health inequalities	-	Qualitative
UB18	Develop a skilled and sustainable endoscopy workforce	-	Qualitative
UB19	Improved recruitment and retention across the region due to the improved training and development provided at LHP as well as from reduced pressure on acute sites as a result of increased capacity at LHP.	-	To be confirmed at FBC
UB20	Opportunities to share best workforce practices across the region	-	Qualitative
UB21-23	Modern fit for purpose compliant facility	-	Complies with WHBN/HTMs BREEAM rated as excellent Enhanced facilities with enhanced provisions (i.e. 2 oxygen tanks, N+N generator etc.)
UB24	Community Benefits (Social Value provided by the contractor))	-	10 local direct full time equivalent (FTE) employees hired or retained. 250 weeks of apprenticeships provided to local staff. £25,000 worth of equipment or resources donated to local third sector and civil society organisations 250 Hours of volunteering time provided to support local community projects. £25,000 direct support and investment provided for people to learn and use Welsh (e.g. interactions and signage). £20,000,000 spent in the local supply chain.
UB25	Reduced waste and single use products	-	To be confirmed at FBC
UB26	Improved recycling	-	To be confirmed at FBC
UB27	Contribute to decarbonisation targets (Net Carbon Zero) with energy efficiency	-	To be confirmed at FBC
UB28	Preservation of biodiversity and wetland area due to choice and design of site.	-	Qualitative

Ref	Description	Option 0 - BAU	All “Do Something” Options
UB29	Enables and provides meaningful and adequate spaces for future phases of work that are planned	-	Qualitative
UB30	Provides opportunity for future expansion: As a result of the choice of site and design, it allows for expansion to capacity in current services as well as development of future services	-	Qualitative

6.8 Risk analysis

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

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

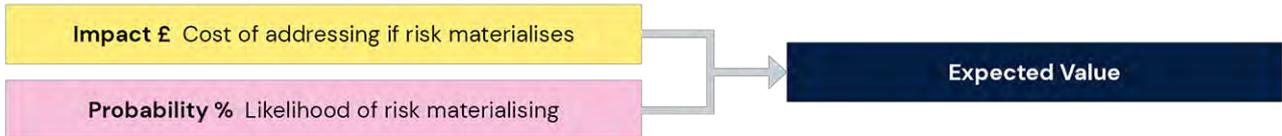
Key project risks have been identified which are not already accounted for within capital costs and these include the following:

- **Funding Risk - Unable to secure sufficient capital funding to deliver the project:** There is a risk that due to the significant amount of initial capital funding required to deliver the project it may take time to secure this funding which could lead to delays in the programme while alternative routes are explored.
- **Funding Risk - Unable to secure sufficient revenue funding to deliver the project:** There is a risk that due to the significant amount of ongoing revenue funding required to deliver the project it may take time to secure this funding which could lead to delays in the programme while alternative routes are explored.
- **Implementation Risk – Increased procurement timescales lead to delays:** There is a risk that the procurement timescales are longer than expected leading to delays in implementation of the project and resulting in the programme having to be extended.
- **Outsourcing Risk – Unable to secure a partner to provide the service:** There is a risk that due to the ISP having to provide the new LHP and to a much lesser extent provide the service that it would be difficult to find a provider that is willing to partner on the project. This could lead to delays in the programme while alternative routes are explored.
- **Workforce Risks – Recruitment and Retention (short term):** There is a risk that in the option where the service would be provided by NHS staff, that it would be difficult to recruit sufficient substantive staff in the short term, which could lead to a reliance on unplanned, expensive temporary and locum staff leading to increased staffing costs.
- **Workforce Risks – Recruitment and Retention (long term):** There is a risk that after the end of the ISP contract period that it would be difficult to recruit sufficient substantive staff, which could lead to a reliance on unplanned, expensive temporary and locum staff leading to increased staffing costs. It should be noted that this risk is significantly mitigated in the options where an ISP provides the service in the short term as that will have given the Health Boards an opportunity to train staff and share learnings ready for the service to be provided by NHS staff.
- **Outsourcing Risk – Increased Handover Costs:** There is a risk that after the end of the ISP contract period, for the fully outsourced option, when the Health Boards purchase the building back from the ISP, the cost of this has been understated, leading to an increased handover payment.

- Outsourcing Risk – The building that would be provided by the ISP doesn't meet the health Boards' requirements:** There is a risk that the ISP owned building that is handed over to the Health Boards after the end of the ISP contract period does not fully meet the Health Boards requirements due to the Health Boards having less control at design stage. This could lead to increased lifecycle costs for the building.

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

Figure 16 - Risk quantification approach using single-point probability analysis



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

Table 24 - Risk assumptions

Element	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
K1 – Funding Risk: Capital Funding					
Risk	Unable to secure sufficient capital funding to deliver the project				
Consequence	Programme extended to allow time to explore alternative routes				
Impact per year			Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m
Probability			5%	10%	10%
Timescales			Year 0	Year 0	Year 0
Total Risk Value £'000	Does Not Apply	Does Not Apply	1,040	2,080	2,080
K2 – Funding Risk: Revenue Funding					
Risk	Unable to secure sufficient revenue funding to deliver the project				
Consequence	Programme extended to allow time to explore alternative routes				
Impact per year		Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension at a run rate of £400k per week, which equals £20.8m
Probability		30%	10%	10%	10%
Timescales		Year 0	Year 0	Year 0	Year 0
Total Risk Value £'000	Does Not Apply	6,240	2,080	2,080	2,080
K3 – Implementation Risk: Delays from increased procurement timescales					
Risk	Implementation is delayed due to increased procurement timescales				
Consequence	Programme extended				
Impact per year		Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m		Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m
Probability		75%		15%	15%
Timescales		Year 0		Year 0	Year 0
Total Risk Value £'000	Does Not Apply	15,600	Does not Apply	3,120	3,120

Element	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
K4 – Outsourcing Risk: Unable to Secure Partner					
Risk	Unable to secure partner to provide the service				
Consequence	Programme extended to allow time to explore alternative routes				
Impact per year		Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m	Assume a 12-month extension to the programme at a run rate of £400k per week, which equals £20.8m	
Probability		75%	2.5%	5%	
Timescales		Year 0	Year 0	Year 0	
Total Risk Value £'000	Does Not Apply	15,600	520	1,040	Does Not Apply
K5 – Workforce Risk: Recruitment and Retention (short term)					
Risk	Unable to recruit sufficient staff to enable delivery of the model in the short term				
Consequence	Reliance on unplanned outsourcing of services leading to increased costs				
Impact per year					Assume unplanned outsourcing is equal to cost of outsourcing the service in Option 1 (£4m p.a.)
Probability					75%
Timescales					Years 2 - 11
Total Risk Value £'000	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply	29,740
K6 - Workforce Risk: Recruitment and Retention (long term)					
Risk	Unable to recruit sufficient staff to enable delivery of the model in the long term				
Consequence	Reliance on unplanned outsourcing of services leading to increased costs				
Impact per year		Assume unplanned outsourcing is equal to cost of outsourcing the service in Option 1 (£4m p.a.)	Assume unplanned outsourcing is equal to cost of outsourcing the service in Option 1 (£4m p.a.)	Assume unplanned outsourcing is equal to cost of outsourcing the service in Option 1 (£4m p.a.)	Assume unplanned outsourcing is equal to cost of outsourcing the service in Option 1 (£4m p.a.)
Probability		2.5%	2.5%	2.5%	5%
Timescales		Years 12 - 62	Years 12 - 62	Years 12 - 62	Years 12 - 62
Total Risk Value £'000	Does Not Apply	5,056	5,056	5,056	10,112

Element	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
K7 - Outsourcing Risk: Increased Handover Costs					
Risk	For the fully outsourced option, risk that costs for the handover of ISP owned building at end of the contract is understated				
Consequence	Increased handover payment at end of contract				
Impact per year		25% increase on current assumed Handover Cost			
Probability		25%			
Timescales		Year 12			
Total Risk Value £'000	Does Not Apply	15,364	Does Not Apply	Does Not Apply	Does Not Apply
K8 – Outsourcing Risk: Building Provided by ISP Doesn't Meet HB Requirements					
Risk	For the fully outsourced option, risk that handover of ISP owned building at end of the contract does not fully meet HB requirements due to less control at design stage				
Consequence	Increased lifecycle costs				
Impact per year		Lifecycle Costs are doubled			
Probability		10%			
Timescales		Years 12 - 62			
Total Risk Value £'000	Does Not Apply	9,870	Does Not Apply	Does Not Apply	Does Not Apply

6.9 Economic appraisal

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

The assumptions above have been incorporated into a discounted cash flow for each of the costs, benefits and risks are calculated over a 63-year appraisal period including Year 0 (base year) + 19 months construction/commissioning + 60 years estimated useful life.

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

The following costs are excluded from the economic appraisal:

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

The economic summary is provided in the table below and a copy of the CIA model is provided in Appendix 10.

Table 25 - Economic summary

Element	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Capital expenditure including contingency (discounted)	0	-98,417	-137,538	-146,828	-146,828
Revenue expenditure (discounted)	0	-180,472	-145,534	-145,498	-129,422
Operational Risks	0	-59,101	-5,291	-9,971	-34,480
Risk-adjusted Present Cost	0	-337,989	-288,363	-302,298	-310,729
Cash releasing benefits (discounted)	0	0	0	0	0
Non-cash releasing benefits (discounted)	0	0	0	0	0
Societal Benefits (discounted)	0	327,217	327,217	327,217	327,217
Total Benefits	0	327,217	327,217	327,217	327,217
Discounted Net Present Social Value (NPSV)	0	-10,772	38,855	24,920	16,488
Incremental costs - total	0	-337,989	-288,363	-302,298	-310,729
Incremental benefits - total	0	327,217	327,217	327,217	327,217

Element	Option 0 - BAU	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Risk-adjusted Incremental Net Present Social Value (NPSV)	0	-10,772	38,855	24,920	16,488
Benefit-cost ratio	0.00	0.97	1.13	1.08	1.05

Option 2, which entails a traditional capital build of Phase 1 of the LHP (the Community Diagnostics Hub portion), with an ISP providing the service provision equipment and delivering the service via a managed service contract for the first 10 years before the service becomes inhouse and run by the Health Boards, provides the best value for money of the options. This option would deliver an incremental Net Present Social Value (NPSV) of £38.9m when compared to the Business as Usual (BAU) position and a Benefit Cost Ratio (BCR) of 1.13. This means that £1.13 of incremental benefit is delivered for every £1.00 of incremental whole life cost, which suggests LHP will deliver value for money.

Option 2 offers the best value for money primarily due to it bringing the least operational risk when compared to the other options, while also providing all the same quantifiable benefits as the other options. This option also provides all the outlined non-monetisable benefits, including the ability to develop a robust, skilled and sustainable endoscopy workforce.

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

Option 3, which involves a Traditional Capital Build for LHP Phase 1 with the specific service provision equipment being supplied by Welsh Government/Health Boards, while the diagnostics service is provided by an ISP through a managed service contract for the initial period, has the next best value for money of the options. It has a slightly lower BCR (1.08) and NPSV (£24.9m) largely because it provides the same benefits as Option 2 but has a higher initial capital outlay from the Health Boards having to provide the specific service provision equipment and having slightly higher level of risk attributed to it.

Option 4, which entails a Traditional Capital Build for LHP Phase 1 and the whole diagnostics service being provided by the Health Boards, offers the next best value for money, with a BCR of 1.05 and an NPSV of £16.5m. There are significant risks around this option including that there would be difficulty recruiting sufficient NHS diagnostics staff to deliver the service in the first 10 years, which could lead to a poorer service being provided, expensive temporary and locum staff having to be used, or poorer service occurring across the region, as staff in those areas are re-located to LHP. It should be noted that a key benefit of using a managed service contract for the initial period is to develop a diagnostic workforce capable of providing the service during that period, which would not be available in this option.

Option 1, which entails both the construction of Phase 1 of LHP and the diagnostics service being fully outsourced to an ISP, delivers the lowest BCR (0.97) and would result in a Net Present Cost of £10.8m. This is because there are significantly higher revenue impacts in this option; it is still expected that the Health Boards would have to purchase the LHP back from the ISP at the end of the managed service contract at, at least the Net Book Value and that there are significant risks attached to this option including finding an ISP that would be willing to design and construct the LHP which would lead to significant delays to the programme.

6.10 Sensitivity analysis

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

The first part of this involves undertaking a switching values analysis to test the robustness of the ranking of options. This is applied to areas of material cash flows to identify the extent that costs and benefits of each of the alternative options must change for the BCR to reflect that of the highest-ranking option (excluding BAU). This analysis is outlined in the table below:

Table 26 - Sensitivity switching analysis (BCR)

	Option 1 - Fully outsourced managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Increase in benefits to equal preferred option	17.2%	4.8%	7.8%
Decrease in capital costs to equal preferred option	-50.4%	-9.5%	-15.2%
Decrease in revenue costs to equal preferred option	-27.5%	-9.6%	-17.3%
Decrease in quantitative risks to equal preferred option	-84.0%	-139.8%	-64.9%
Decrease in total costs to equal preferred option	-14.7%	-4.6%	-7.2%

This demonstrates that in order to change the ranking of the options:

- Option 3 would need to improve its current benefits by 4.8% (£15.8m) or otherwise reduce capital costs by 9.5% or revenue costs by 9.6% (£13.9m) to rank equal to Option 2.
- Option 4 would need to improve its current benefits by 7.8% (£25.4m) or otherwise reduce capital costs by 15.1%, revenue costs by 17.3% or quantified risk by 64.9% (£22.4m) to rank equal to Option 2.
- Option 1 would need to improve its current benefits by 17.2% (£56.3m) or otherwise reduce capital costs by 50.4%, revenue costs by 27.5% or quantified risk by 84.0% (£49.6m) to rank equal to Option 2.

This suggests that Options 3's rankings are relatively sensitive to benefit or cost assumptions, however noting that this option and the preferred option have the same benefits and relatively similar cost assumptions it is likely that any change in benefits and costs would be similar in both Option 3 and the preferred option. As such it is unlikely that this option could overtake Option 2 as the preferred option.

This suggests that Options 1 and 4's rankings are not particularly sensitive to benefit or cost assumptions and so it is unlikely that these options would overtake Option 2 as the preferred option.

Additionally, to the switching analysis, alternative scenarios have been calculated to consider how the value for money of the options may be affected by future uncertainty as outlined in the table below.

Table 27 - Sensitivity analysis scenarios

Scenario	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 1 - Fully outsourced managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Original Results (BCR)	1.13	0.97	1.08	1.05
1. Initial Capital costs increase by 20%	1.08	0.97	1.03	1.00
2. Revenue costs in Options 2 and 3 are 10% higher due to the tariff discount for land and building in options 2 and 3 not being as large as estimated	1.08	0.92	1.03	1.01
3. Building Buy Back value in Option 1 is 20% lower than expected	1.13	0.99	1.08	1.05
4a. Improved patient outcomes (cancer related) as a result of shorter diagnostics waiting times confidence rating decreased from 25% to 12.5%	0.92	0.78	0.87	0.85
4b Improved patient outcomes (cancer related) as a result of shorter diagnostics waiting times confidence rating increased from 25% to 50%	1.57	1.34	1.50	1.46
5a. Improved patient outcomes (non-cancer related) as a result of shorter diagnostics waiting times confidence rating decreased from 25% to 12.5%	0.80	0.68	0.76	0.74
5b Improved patient outcomes (non-cancer related) as a result of shorter diagnostics waiting times confidence rating increased from 25% to 50%	1.81	1.55	1.73	1.68
6. Costed Risks are overstated by 20%	1.14	1.00	1.09	1.08

In summary:

- **Scenario 1:** Even if initial capital costs were to increase by 20% (c.£14m excluding VAT), this would have minimal impact on the BCR of all options, and the preferred option would still deliver a positive NPSV.
- **Scenario 2:** A 10% increase in revenue costs in Options 2 and 3 (c. £538-747k p.a. increase in the preferred option) would have minimal impact on the BCR of Options 2 and 3, and the preferred option would still deliver a positive NPSV.
- **Scenario 3:** if the Building Buy Back value in Option 1 is 20% lower than expected Option 1's BCR would increase however it would not overtake Option 2 as the preferred option.
- **Scenario 4:** The benefit associated with improved patient outcomes as a result of reduced Diagnostics waiting times for patients with a suspected cancer appears to have a significant impact on the value for money indicators for all options. For instance, if the confidence rating was reduced from 25% to 12.5% this would reduce the BCR for the preferred option from 1.13 to 0.92, while increasing it to 50% would improve the BCR to 1.57. While this suggests value for money is relatively sensitive to changes in the confidence rating applied to this benefit, it should be noted that there is still some work to be done at FBC stage to quantify more of the benefits, as well as firming up the level of certainty in those already quantified, which would likely mitigate this.
- **Scenario 5:** The benefit associated with improved patient outcomes as a result of reduced Diagnostics waiting times for patients with non-cancer related health issues also appear to have a significant impact on the value for money indicators for all options. For instance, if the confidence rating was reduced from 25% to 12.5% this would reduce the BCR for the preferred option from 1.13 to 0.80, while increasing it to 50% would improve the BCR to 1.81. While this suggests value for money is relatively sensitive to changes in the confidence rating applied to this benefit, it should be noted that there is still some work to be done at FBC stage to quantify more of the benefits, as well as firming up the level of certainty in those already quantified, which would likely mitigate this.
- **Scenario 6:** if the costed risks in each of the options was overstated by 20%, this would have minimal impact on each of the options BCRs and it would have no effect on the rankings.

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

6.11 Preferred option

The results of the economic appraisal demonstrate that the preferred way forward offers value for public money.

Option 2, which utilises a traditional capital for the build of phase 1 of the LHP (the Community Diagnostics Hub portion), with an ISP providing the service provision equipment and delivering the service via a managed service contract for the first 10 years before the service becomes inhouse and run by the Health Boards, will require capital investment of £109.1m and ongoing revenue costs of £7.5m (excluding depreciation) for the initial 10 year period of the managed services contract, reducing to £5.4m after the end of the contract. Based on estimated costs and benefits, it is anticipated that this option will deliver an incremental Net Present Social Value (NPSV) of £38.9m and a Benefit Cost Ratio (BCR) of 1.13.

This represents £1.13 of incremental benefit delivered for every £1.00 of incremental whole life cost, because of the quantifiable benefits that it has been possible to state in monetary values at this point in time, including:

- **Improved patient outcomes from earlier diagnosis:** Delivery of the CDC will address CTMUHB Diagnostic Imaging and regional Endoscopy capacity shortfalls and ensure future demand can be met. This will have a direct impact on waiting times for patients and support the cancer pathway by enabling earlier diagnosis, more targeted interventions and improved monitoring. This will lead directly to delivering better patient outcomes, specifically contributing to improved cancer survival rates.
- **Improved patient outcomes from earlier diagnosis (non-cancer related):** Delivery of a significant increase in additional Endoscopy capacity should lead to earlier and increased diagnosis for patients with health issues other than cancer such as hypertension, which will lead to better patient outcomes and help contribute to reduced mortality related to those health issues.

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

- **Release of elective diagnostic capacity at Acute sites, which can be used for urgent and emergency care patients/pathways:** The capacity provided at LHP for more elective diagnostic tests will free up Acute sites to use their diagnostic capacity for non-elective scans/tests, which reduce delays for urgent and emergency patients.
- **Improved predictability and confidence in booking scans and tests:** The centralised elective centre with co-located services provides a 'one-stop' shop clinic with greater predictability of care which in turn means that scans and tests can be booked with more confidence leading to improved utilisation of the service.
- **Impact of a more sustainable estate:** The delivery of appropriately designed and compliant facilities provides opportunities to contribute to CTMUHB's environmentally sustainable goals and national strategies around decarbonisation and optimising energy efficiency. The transformed model of care with its standardised pathway is likely to make it easier to implement and maintain sustainability programmes that CTMUHB has instituted in other areas, such as reducing waste and single use products.

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

- **Additional Imaging and Endoscopy capacity leading to reduced waiting times:** The additional capacity at LHP will allow the Health Boards to meet the NHS Wales target that no patient is waiting more than 8 weeks for imaging or endoscopy tests.
- **Help to meet 'Straight to Test Guidance':** The additional capacity provided at LHP will assist with meeting 'Straight to Test Guidance', allowing an increase in the number of direct referrals from GPs to radiology. It will also allow for improved regional sustainability and provide contingency for other sites across the region.
- **Increased number of and improved clinical pathways:** Due to LHP being a centralised elective centre and a "one-stop" clinic, it will lend itself to developing and delivering more and improved clinical pathways. These pathways and improved ways of working could be used as an exemplar and then also be rolled out across the region.
- **Reduced health inequalities:** Reduction in waiting times and ease of access supports equality of access.

- **Community Benefits:** The contractor has agreed to implementing several community benefits, including hiring local, providing volunteering and donations to local organisations, investing in people learning and using Welsh and investing in the local supply chain.
- **Improved patient experience:** As well as reduced waiting times patient experience is enhanced by the modern fit for purpose facilities and the ease of access the location of LHP offers, with its good road links and parking. Having a centralised elective centre with co-located services provides the convenience of a **one-stop shop** clinic with greater predictability of care.
- **Increased staff satisfaction:** The improved training pathway and increased training opportunities, along with the modern fit for purpose facilities and a consolidated service model that enables more effective ways of working, contributes to staff satisfaction and creates an attractive place to work which will support recruitment and retention of highly trained health professionals in the long term.
- **Develop a skilled endoscopy workforce:** Delivery of the Skills Academy in partnership with HEIW will provide significant opportunities to increase the number of training places available in the region and help to build a skilled and sustainable endoscopy workforce.
- **Increased compliance:** The dedicated CDC will ensure that the Health Boards have capacity across the region to ensure alignment with GiRFT principles and continue to achieve JAG accreditation. Modern fit for purpose facilities that are compliant with WHBNs and HTNs, achieve BREEAM rating of Excellent.
- **Future proofing:** The site also provides a level of future proofing by providing expansion space that offers opportunities for other future developments.
- **Opportunities for future transformation:** The additional capacity offered by LHP provides opportunities to transform and reconfigure core local services and deliver things differently in the future. Further to this the robust and in-depth data/reporting the service at LHP will provide to the Health Boards will greatly inform future decisions. The successful delivery of a regional centre will also provide proof of concept as the basis for the development of any future regional pathways and will have a positive reputational effect.

The results of the options appraisal (excluding BAU) are presented in the table below.

Table 28 - Results of options appraisal

Element	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
Initial capital investment	£0m	£109.1m	£119.7m	£119.7m
Incremental NPSV	-£10.8m	£39.9m	£24.9m	£16.5m
Benefit Cost Ratio	0.97	1.13	1.08	1.05
Key benefits	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option	As per benefits outlined above for the Preferred Option
Key risks	<ul style="list-style-type: none"> • Unable to secure a service provider who would be willing to provide the service • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales 	<ul style="list-style-type: none"> • Significant initial capital outlay • Unable to secure revenue funding 	<ul style="list-style-type: none"> • Significant initial capital outlay • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales 	<ul style="list-style-type: none"> • Significant initial capital outlay • Unable to secure revenue funding • Implementation is delayed due to increased procurement timescales • Unable to recruit sufficient staff to enable

Element	Option 1 - Fully outsourced managed service contract	Option 2 (PWF) - Traditional capital build + ISP equip and deliver services via managed service contract	Option 3 - Traditional capital build and equip + ISP deliver services via managed service contract	Option 4 - Traditional capital build and equip + NHS staffing and service provision
	<ul style="list-style-type: none"> Significant risks around handover of the building at the end of the managed service contract period, including higher than expected handover costs and that the building would not fully meet the Health Boards requirements. 			delivery of the model in the short term

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

Commercial Case

7 Procurement strategy

7.1 Introduction

This section of the business case outlines the procurement strategy and proposed deal to deliver the preferred option to develop a community diagnostic hub for CTMUHB, co-located with a regional endoscopy centre on the Llantrisant Health Park site, as discussed in the economic case. The preferred delivery model would be to undertake the build and fit out of the site using NHS capital funds and deliver the services through a contract with a commercial service partner who would also equip the facility.

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

The following section sets out the commercial arrangements for the capital LHP site, including procurement and delivery of the design and build and fit out, with the procurement strategy for the independent delivery partner shown in section 7.3.

7.2 Procurement of the Capital Build and Fit Out

Work on the design of the CDH commenced shortly after the site purchase in the autumn 2023 and progressed via the appointed design team lead by Strides Treglowan Architects. The design team progressed through the RIBA design stages from masterplanning to completion of RIBA 2 in December 2024 culminating in the approval to commence demolition works and RIBA 3 design works in December 2024.

Alongside the completion of the RIBA 2 works, work had commenced on the appointed of separate contractors for the demolitions and the main build programmes and each will be set out as below:

7.2.1 Demolition Contractor procurement

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

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

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

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

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

The contract has commenced and works began on site on 14 April 2025. This contract was originally programmed to conclude by 22 August 2025, however, there has been a delay of around three weeks, and the works are now expected to complete by 20 September, when the contractor will leave site.

7.2.2 Main Contractor procurement

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

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

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

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

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

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

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

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

Once FBC approval is received, CTMUHB will enter into an ECC contract with MTX to deliver the phased construction solution. This is expected to be structured to support sectional completion in line with the LHP phased construction programme.

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

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

It should be noted that the cost tendered by the contractor was based on a single business case process and start-on-site of a phased construction completion programme. The recent decision and instruction to split this work into phases, each with its own business case and development programme, has subsequently elongated the programme and increased the level of costs and fees incurred. A longer design period will mean further costs for all time-based consultants. Additional design works will also be required to ensure that Phase 1 can be fully operational as a standalone building for a longer period. In addition, the ability to create linked buildings whilst maintaining the operational status of the CDH has also had to be considered and resulted in some redesign of the area that will immediately adjoin Phase 2.

One of the key areas of impact has been around the mechanical and electrical engineering and medical gases works, where short term solutions had been proposed to support a phased opening whilst construction of other phases, including the permanent engineering infrastructure, was completed. With the risk of a longer period of opening without this infrastructure in place, the timing and location of much of the supporting infrastructure has had to be reconsidered and alternative areas included. This has also brought much of this forward in the programme and means it is included in Phase 1.

Work with the construction partner has confirmed the level of fees to support the Phase 1 contract however the design fees for Phases 2 and 3 are under review and being developed at the time of writing this business case. This information will be included in the phase 1 FBC and the Phase 2 OBC.

In December funding was approved for the RIBA 3 design stage of £3.5m which included stages 3A and 3B, 3B undertaken by MTX. RIBA 3A was completed by the end of March 2025, with RIBA 3B completed by the main contractor by 30 June 2025.

As per the tender return, the total MTX fees only for the design stage are £3.935m based on a fixed price submission. The total Phase 1 fees have now been agreed and sit within this sum. Phase 2 fees are currently being agreed, and it is likely that these will exceed this original tendered sum and will require an uplift.

Table 29 - Breakdown of original tendered fees

Cost element	RIBA 3 £000	RIBA 4 £000	Total £000
Design fees	377	2,632	3,009
Management services	-	495	495
Surveys	-	207	207
Overhead and profit @ 6%	23	200	223
Total	400	3,535	3,935

As mentioned above this covered the total programme costs. Whilst the RIBA 3 costs have not changed, from those committed above, the sums for phase 1 RIBA 4 have changed.

Phase 1 RIBA 4 costs are £2.573m, however this represents main contractor design fees only. The total RIBA 4 cost up to approval of the FBC and contractor start on site are as set out in Table 30 *Table 31* below, to date £2.828m funding has been received from WG, approved on 12 August. Therefore, the balance sought to complete RIBA 4 and proceed to works on site will be £2.177m

Table 30 - Requested fees to complete RIBA 4 up to start on site

Fee description	Forecast cost £000
Health Board Fees	1,507
MTX Fees	2,573
Non works costs	341
Planning Fees	430
Sub total	4,851
VAT (less recoverable)	154
Total cost	5,005
Funding Received to OBC	-2,828
Balance of funding required	2,177

Should a decision be made not to complete RIBA 4 following the outcome of this business case then there is a risk of a contractor claim against the Health Board under the PSC contract. Whilst any payment is likely to be negotiated, it is probable that a sum amounting to any actual costs rightfully incurred and incurred will be paid, alongside a claim for loss of profit on all phases and likely to be around two months of committed / contracted cost.

As a worst-case scenario, this could amount to a liability of approximately, £1.3m however it is likely to be significantly lower after negotiation.

7.3 Independent Service Provider (ISP) procurement

CTMUHB, acting on behalf of the three Health Boards in South East Wales is currently undertaking a procurement exercise to appoint a prime contractor to act as a design partner and contributor to the pathway redesign currently being scoped out for diagnostic services to provide one imaging CDH with the option to flex to one further CDH over the course of the contract. In addition, the CDH will also have at the same location, an ISP staffed Endoscopy Suite comprising of up to four rooms co-located with an NHS staffed two room Endoscopy Training Academy. The endoscopy suite requirements will be designed and fitted out to meet JAG accreditation standards.

There will be a co-located training academy which will include an endoscopy theatre. It is expected that the fitting out of the academy training rooms, and delivery of activity will be facilitated by NHS organisations through collaborative work with Health Education and Improvement Wales.

The Regional Radiology Project Board and the Regional Diagnostics Programme Board endorsed the use of competitive dialogue to test the market potential to support the development of a regional diagnostic centre and associated community diagnostic hubs, one of which will be on the LHP site. The competitive dialogue procedure is flexible and allows the Procurement Evaluation team to discuss proposed solutions with bidders to understand advantages and disadvantages.

The recommended option is to develop a regional endoscopy centre through a traditional NHS capital build proposal and to seek the equipment and delivery of the centre activity through contract with a commercial partner.

To drive this strategy, further competitive dialogue will need to be completed to understand financial implications and other non-financial risks. The current procurement programme leads to the appointment of the ISP by the end of October 2025.

The successful provider will provide a range of new clinical and non-clinical equipment items, including furniture as required for the commissioned services. Equipment must be new and installed at the start of the contract. The overall requirement would be expected to provide economies of scale linked to staff resources, training and cross cover; logistics associated with consumables, equipment, maintenance, corporate and management overheads.

The proposed contract between CTMUHB and the ISP is for an initial period of seven years from the operational commencement date with an option to extend for up to an additional three years (in 12 month tranches).

As stated above, MTX, the main contractor, has been appointed to undertake the modular construction of the whole site and the CDH shell for the ISP to equip, commission and operate.

7.4 Health Board contracting arrangements

CTMUHB will enter into the ISP contract with the successful bidder. The proposed contract mechanism with the ISP partner will be a cost per case arrangement with a base minimum level of expected activity creating a floor financial value for each modality of service. Any activity over and above this floor will be charged on an agreed marginal cost per case using agreed activity currencies.

Initial volumes indicate a potential for surplus capacity at the site that the commercial service provider could utilise for private patient access, all non NHS activity undertaken at the site will attract an enhanced rate for the health boards' contract with the supplier for the NHS activity.

During the next few months arrangements with regional partners will be confirmed so that upon entering into contract with the ISP there is a confirmed and signed agreement in place with all regional partners for contracting and recompense. This will be further detailed at FBC stage.

7.5 Workforce Plan for CDH Delivery via ISP/MS e plans

7.5.1 Background

There is a well-documented shortage in the diagnostic workforce across Wales, particularly in radiology and endoscopy. This has created a significant barrier to timely diagnostics and service delivery, impacting patient outcomes and system flow across south Wales.

To address this, the Community Diagnostic Hub (CDH) model will be delivered in the medium term through an Independent Sector Provider (ISP) under a Managed Service Contract (MSC). The ISP will operate independently with its own commercial and operational model but must align with NHS Employers standards and the strategic workforce objectives of Cwm Taf Morgannwg UHB (CTM) and the wider South East Wales region.

The MSC is expected to be a seven-year contract, with the option of three one-year extensions (7+1+1+1), subject to performance and strategic review. This provides a stable platform for service delivery while allowing flexibility for future transition planning addressing the workforce pipelines shortages that will be essential to transition back in house.

Whilst the new ISP provider must define its own commercial structure to have its own identity and flexibility to function, through this it must also provide robust assurance to all stakeholders. They must provide a safe and effective workforce that delivers a safe and high-quality service to the users of the facility.

7.5.2 Assurance

To ensure the ISP delivers a safe, effective, and sustainable workforce model, a robust assurance framework will be embedded in the tender and contract documentation.

Workforce KPIs

The contract will include a suite of workforce-related Key Performance Indicators (KPIs), such as:

- Staffing levels and skill mix appropriate to meet service demand demonstrating efficiency
- Compliance with professional registration and revalidation
- Completion of Statutory and Mandatory Training (StatMan Framework)
- Sickness absence, turnover, and retention rates
- Use of agency or temporary staff, ratio to substantive
- Evidence of qualifications, DBS checks, and safe recruitment practices
- Percentage of workforce recruited from within South East Wales, the wider UK, and internationally.

Recruitment standards

All recruitment must align with NHS Employers governance and standards. The ISP will be required to demonstrate adherence to safe recruitment practices, including verification of qualifications, right to work checks, enhanced DBS clearance, and reference checks.

These requirements will be explicitly stated in the tender and contract documentation aligned to the parameters of the framework compliance.

Workforce impact mitigation

While the ISP cannot be contractually prevented from recruiting CTMUHB staff, the contract will include mechanisms to monitor and limit the impact on the existing South East Wales workforce. KPIs will track recruitment sources and workforce movement to ensure the ISP does not destabilise local services. The ISP will be expected to work collaboratively with CTMUHB and regional partners to support workforce sustainability.

Partnership and governance

CTMUHB will ensure senior workforce representation on the tender evaluation panel. Workforce and clinical experts will review the provider's submitted workforce plan to ensure appropriate skill mix and competencies, suitability for CDH service delivery, and alignment with patient safety and training standards.

Providers will be expected to demonstrate experience of collaborative working with NHS facilities in England or similar settings, with a proven record of partnership and workforce stability.

There will be monitoring of the service delivery and workforce through regular contract meetings with the ISP

7.5.3 Transition back in-house

The long-term ambition is to transition diagnostic service delivery back into CTM, ensuring integration, sustainability, and alignment with NHS values.

Transition planning

The timing of the transition will be defined collaboratively with the appointed provider during the tender and contract agreement stage, recognising the dialogue-based nature of the contract. CTMUHB will begin scoping the transition plan during the contract period, depending on service maturity and workforce readiness. The addition of the Skills academy will support the development of an increased work force to provide a greater number of staff trained with skills to work within an endoscopy environment. This will form a key component of the plan to bring the CDH endoscopy service back into the NHS

The transition plan will include:

- A training and development programme to support internal workforce growth
- Exploration of dual running costs to support over-recruitment and phased handover
- Scope and develop a transition plan that will comply with the legal regulation (TUPE) to move workforce from the ISP to CTMUHB contract of employment
- Engagement with HEIW (for endoscopy) and the Radiology Academy to support workforce development and succession planning.

Workforce Development

CTMUHB will explore opportunities to develop new roles and increase skill mix, including:

- Clinical support workers
- Assistant practitioners
- Advanced radiographers.

These roles will be developed in partnership with the ISP, drawing on their experience and models used elsewhere throughout Wales and England. The transition plan will also include a skills gap analysis and a future workforce model to ensure readiness for in-house delivery model with a clear plan around the transition timeline.

Education and training

CTMUHB and regional partners will work to provide better access to education and training, supporting:

- Upskilling of existing staff
- Development of new career pathways
- Attraction and retention of local talent.

The ISP will be expected to contribute to this agenda by sharing best practice, supporting placements, and participating in joint workforce planning.

Monitoring and evaluation

Regular review points will be built into the MSC to assess readiness for transition. Workforce impact assessments will inform decision-making. Ongoing stakeholder engagement will ensure transparency and shared ownership of the transition process.

7.5.4 TUPE arrangements and/or transfer of staff

It is not anticipated that TUPE will apply to any existing NHS staff in the establishment of the service agreement as there will be no change to existing capacity at the Health Board.

Following the end of the Contract term there may be TUPE implications for staff employed by the Commercial Service Provider in the continuation of the services either by NHS providers or by any subsequent Commercial Service Provider Partner.

It is anticipated that there will be no TUPE arrangements required in relation to the wider site development as staff would not be required to transfer out of their existing organisation. This will be reviewed at FBC.

7.5.5 Adapted-risk service model

Detailed workforce implications will continue to be developed as part of revenue assessments. This service model is anticipated to lead to some workforce efficiencies as there will be improved integration within teams and support systems.

7.6 Associated disposals

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

7.7 Design and compliance with mandatory standards

7.7.1 NHS Net Zero compliance

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

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

- For the emissions the NHS controls directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions that can be influenced (the NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

NHS Net Zero Building Standard

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

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

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

7.7.2 Modern Methods of Construction

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

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

LHP will be constructed using MMC and be entirely modular.

7.7.3 BREEAM

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

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

BREEAM provides clients, developers, designers and others with:

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

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

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

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

7.7.4 Infection control

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

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

7.7.5 Sustainability

Efficient building services design can have a positive impact on future climate scenarios by reducing energy consumption and greenhouse gas emissions associated with buildings. Climate change is primarily driven by the release of greenhouse gases such as carbon dioxide, methane, and nitrous oxide into the atmosphere, and buildings account for a significant portion of these emissions.

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

See Appendix 7; RIBA 3a report for further information on the design details.

7.8 VAT recovery

A VAT Advisor has not yet been engaged for OBC stage, but the Cost Forms allow for VAT recovery on fees and a nominal amount (5%) on the main build. Once into FBC Stage, engagement with the VAT Advisor will be sought.

7.9 Interface

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

7.10 Summary and conclusion

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

Welsh Government approval for the balance of RIBA 4 cost of £2.177m which will fund the programme to complete RIBA 4 stage and through FBC approval and start on site is being sought as part of this business case.

Financial Case

8 Financial appraisal

8.1 Introduction

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

As outlined in the Economic Case the preferred option involves an NHS funded capital build while an independent sector provider (ISP) provides and manages the necessary equipment and delivers MRI, CT, non-obstetric ultrasound (NOUS), and Endoscopy services.

8.2 Capital costs and funding

8.2.1 Capital costs

Delivery of the preferred option requires capital investment of £109.1m in total, including expenditure incurred to date. This is based on capital requirements prepared by the Health Board's Cost Advisors, Mott Macdonald using the following assumptions:

- Agreed Schedules of Accommodation and RIBA 3b design. Agreed scope of Phase 1 to cover the build of the CDH plus additional site wide infrastructure to facilitate later phases
- Proposed start on site 26 February 2026 and proposed works completion date end of July 2027. At completion the site will be handed over to the ISP for equipping and commissioning which is estimated to last 3-4 months
- Works costs calculated using benchmarked rates suitable for South Wales (including Healthcare Premises Cost Guide) @ BCIS TPI updated 20/08/2025.
- Allowances for fees, equipment costs, planning contingency have been applied as appropriate.
- No allowance for optimism bias has been applied given the degree of certainty at this stage in terms of maturity of design, knowledge of the site, and publicly declared political support for the development. It is therefore superseded by the Costed Risk Register figure.
- VAT advisor advice will be sought on VAT recovery options before FBC. Currently all fees are forecast to be VAT recoverable.

The resulting capital costs estimates are summarised in the table below and a copy of the detailed capital cost forms are provided in Appendix 8.

Table 31 - Capital costs

Element	Net £'000	VAT £'000	Total £'000
Works costs	58,058	11,611	69,669
Fees	14,463	2,892	17,355
Non-works costs	10,362	2,072	12,435
Equipment costs	2,628	526	3,145
Quantified risk contingency	10,583	2,116	12,699
Subtotal	96,094	19,218	115,312
Less: recoverable VAT	-	-5,323	-5,323
Total capital costs	96,094	13,895	109,989

The capital cost schedule includes costs for the provision of the CDH alongside a range of site wide infrastructure works to support the later phases of development. This is the most efficient way to deliver these services as it avoids having to dig up areas more than once. It also offers efficiencies in only requiring machinery and certain skills for a concentrated period of time in one phase therefore further reducing the risk of duplication in a phased approach.

The scope of sitewide works is detailed in the estates annex to this business case and has been shared with NWSSP-SES for their consideration. The inclusion of this element of the infrastructure does therefore mean that the capital costs appear above benchmarking if just measured across the 9,500m² building footprint for Phase 1.

8.2.2 Funding requirements

Funding of £18.1m had been received to date from WG for:

- Site purchase - £8.0m
- RIBA 2 fees - £3.1m
- RIBA 3 fees - £3.5m
- Demolition - £0.7m
- RIBA 4 fees - £2.8m.

This includes funding of £2.828m which has been approved in August 2025 to support the phase 1 OBC redesign and the commencement of RIBA 4 works to support the FBC being completed for November Boards. Further funding of £91.9m is therefore requested from Welsh Government.

Table 32 - Capital cashflow and funding sources

	2022/23 £'000	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	Total £'000
Costs							
Construction costs	0	0	0	1,803	42,054	14,200	58,058
Project fees	0	791	3,498	5,544	3,759	871	14,463
Non-works costs	7,990	268	962	825	310	8	10,362
Equipment costs	0	0	0	0	0	2,628	2,628
Planning contingency	0	0	0	1,746	5,891	2,945	10,583
Subtotal	7,990	1,059	4,460	9,918	52,013	20,652	96,094
VAT	0	0	192	874	9,651	3,178	13,895
Total capital costs	7,990	1,059	4,652	10,794	61,664	23,830	109,989
Funding							
Site purchase	7,990	10	0	0	0	0	8,000
RIBA 2	0	1,049	2,042	0	0	0	3,091
RIBA 3	0	0	2,013	1,486	0	0	3,499
Demolition	0	0	109	591	0	0	700
RIBA 4	0	0	0	2,828	0	0	2,828
Funding received to date	7,990	1,059	4,164	4,905	0	0	18,118
Construction	0	0	0	5,889	61,664	23,830	91,871
Funding still required	0	0	0	5,889	61,664	23,830	91,871
Total funding	7,990	1,059	4,164	10,794	61,664	23,830	109,989

As mentioned in section 7.2.2 in table 32, this OBC is requesting fees to take the programme from OBC approval to FBC approval and start on site, currently forecast to be late February 2026. The fee requested is contained in table 32 and excludes any works costs. This is why the funding balance differs slightly from that in Table 33 above. On FBC approval it is anticipated that the remaining 2025/26 funding of £3.712M will be required within the 25/26 CRL to avoid programme delay.

8.3 Revenue affordability

8.3.1 Recurring revenue costs

It is anticipated that the creation of the new diagnostics centre will incur additional recurring full year revenue costs of £9.3m p.a. related to the managed service contract with the ISP for the provision of equipment and delivery of services related to MRI, CT, NOUS, and Endoscopy. This is based on:

- Activity based on individual HB requirements included in the ISP procurement specification.
- ISP cost estimate currently based on 2025/26 NHSE CDC tariff.
- Case mix assumptions are based on 2024/25 CTMUHB activity.
- ISP procurement specification assumes seven-year contract with the option to extend for a further three years.
- Excludes depreciation and any IFRS16 implications (which are considered in section 9.4).

It is expected that the contract value will be reduced through the agreement of a tariff discount in return for the ISP's use of land and buildings. This has been estimated for the purposes of the OBC at £1.9m p.a.

It is also expected that activity and revenue costs will begin post completion and ISP commissioning of Phase 1 of the build. Whilst the main contractor build programme will complete at the end of June it is expected that the handover, equipping and commissioning could take up to four months, which is expected to be at the end of October 2027, which means the first year will incur five months of activity and revenue costs.

A summary of costs is provided below with more detailed calculations provided in Appendix 9 and 10.

Table 33 - Summary of revenue costs

Revenue element	2027/28 (assume opening - end of October 2027)	2028/29	2029/30 until end of ISP contract period
Activity	No. of tests	No. of tests	No. of tests
MRI	3,333	8,000	8,000
CT	5,000	12,000	12,000
NOUS	2,500	6,000	6,000
Gastroscopy	1,413	3,390	3,390
Colonoscopy	2,568	6,491	6,947
Sigmoidoscopy	250	763	992
Revenue costs	£'000	£'000	£'000
MRI	544	1,307	1,307
CT	518	1,242	1,242
NOUS	155	373	373
Gastroscopy	713	1,711	1,711
Colonoscopy	1,584	4,003	4,284
Sigmoidoscopy	107	326	423
Total ISP contract	3,621	8,961	9,341
Less: tariff discount for land	-724	-1,792	-1,868
Total ISP costs after discount	2,897	7,169	7,473

8.3.2 Commissioner funding requirements

Commissioner revenue funding requirements have been estimated for each of the three Health Boards based on projected activity assumptions at this stage, as outlined in the table below.

Table 34 - Activity assumptions

UHB	Revenue element	2027/28 ⁶	2028/29	2029/30 ⁷
CTM	Activity	No. of tests	No. of tests	No. of tests
	MRI	3,333	8,000	8,000
	CT	5,000	12,000	12,000
	NOUS	2,500	6,000	6,000
	Gastroscopy	850	2,040	2,040
	Colonoscopy	1,360	3,264	3,264
	Costs	£'000	£'000	£'000
	Allocation of ISP contract costs	2,486	5,965	5,965
	Less: allocation of tariff discount for land	-497	-1,193	-1,193
	Allocation of revenue costs	1,989	4,772	4,772
C&V	Activity	No. of tests	No. of tests	No. of tests
	Gastroscopy	563	1,350	1,350
	Colonoscopy	1,208	2,900	2,900
	Sigmoidoscopy	250	600	600
	Costs	£'000	£'000	£'000
	Allocation of ISP contract costs	1,135	2,726	2,726
	Less: allocation of tariff discount for land	-227	-545	-545
Allocation of revenue costs	908	2,181	2,181	
AB	Activity	No. of tests	No. of tests	No. of tests
	Colonoscopy	0	327	784
	Sigmoidoscopy	0	163	392
	Costs	£'000	£'000	£'000
	Allocation of ISP contract costs	0	271	651
	Less: allocation of tariff discount for land	0	-54	-130
Allocation of revenue costs	0	217	521	

These assumptions will be firmed up at FBC stage once more detailed information is available and funding requirements adjusted accordingly. This results in a full year funding requirement of £9.3m p.a. (£7.5m per year after the proposed tariff discount) associated with the ISP contract, to be allocated as follows:

- CTMUHB £6.0m p.a. (£4.8m after the proposed tariff discount)
- C&VUHB £2.7m p.a. (£2.2m after the proposed tariff discount)
- ABUHB £0.7m p.a. (£0.5m after the proposed tariff discount)

⁶ assumed opening - end of July 2027

⁷ until end of ISP contract period

8.4 Accounting treatment and capital charges

8.4.1 Accounting treatment

The resulting asset will be held on CTMUHB's balance sheet and therefore be treated in line with the Health Board's policy in relation to depreciation and impairments.

8.4.2 Capital charges

Capital charges have therefore been estimated based on the following assumptions:

- Asset additions of £110.0m
- Impairment is applied when the resulting asset comes into use. Based on recent schemes in the region, specifically the Grange as a new build development at ABUHB, it is anticipated that this will be in the region of 20%, although this will need to be explored with the District Valuer and CTMUHB's Auditors during the development of the FBC stage. Full impairment is assumed on fees and non-works costs
- Depreciation charges are applied based on straight line depreciation using the following standard useful life:
 - ♦ **Buildings** – 60 years for buildings and 30 for engineering works (using a typical 65:35 split)
 - ♦ **Equipment** – seven years as a proxy for a mixture of short life ICT equipment (five years) and longer life equipment (10 years). This will be explored further at FBC stage when a costed equipment list is available.

It is anticipated that this will result in:

- Circa £48.0m non-recurring AME impairment on completion of the new build which will be funded as AME funding via Welsh Government
- £2.29m annual depreciation, which will be funded by Welsh Government.

8.4.3 IFRS16 implications

There will be IFRS16 implications associated with the external contract with the independent sector provider for Diagnostic Imaging and Endoscopy services. These will be calculated at FBC stage once more detail is available about equipment requirements and contractual arrangements. An estimate of these costs has been being provided via the WG required non cash returns.

8.5 Overall affordability

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

8.5.1 Capital affordability

The cost plan prepared by CTMUHB's Cost Advisors, based on RIBA3a design, estimates that delivery of LHP will result in capital investment requirements of £110.0m in total, including expenditure incurred to date. It is anticipated that this will be funded as follows:

- £18.1m has been received, to date from WG, for:
 - ♦ Site purchase - £8.0m
 - ♦ RIBA 3 fees - £3.5m
 - ♦ RIBA 4 fees - £2.8m
 - ♦ RIBA 2 fees - £3.1m
 - ♦ Demolition - £0.7m

This includes funding of £2.828m which has been approved in August 2025 to support the phase 1 OBC redesign and the commencement of RIBA 4 works to support the FBC being completed for November Boards.

Further funding of £91.9m is therefore requested from Welsh Government for construction works.

8.5.2 Revenue affordability

Work undertaken to date by the programme team and finance leads, estimates that provision of services at LHP will incur recurring revenue costs of £9.3m for contracted out services for MRI, CT, NOUS, and Endoscopy.

It is expected that the contract value will be reduced through the agreement of a tariff discount in return for the ISP's use of land and buildings. This has been estimated for the purposes of the OBC at £1.9m per year.

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

This therefore results in a full year recurring revenue funding requirement of £7.5m. This has been allocated across the three Health Boards, based on projected activity assumptions which have been identified at this point in time, which equates to the following:

- CTMUHB £6.0m per year (£4.8m after the proposed tariff discount)
- C&VUHB £2.7m per year (£2.2m after the proposed tariff discount)
- ABUHB £0.7m per year (£0.5m after the proposed tariff discount)

It should be noted that should less activity be required funding requirements adjusted accordingly.

Management Case

9 Management arrangements

9.1 Introduction

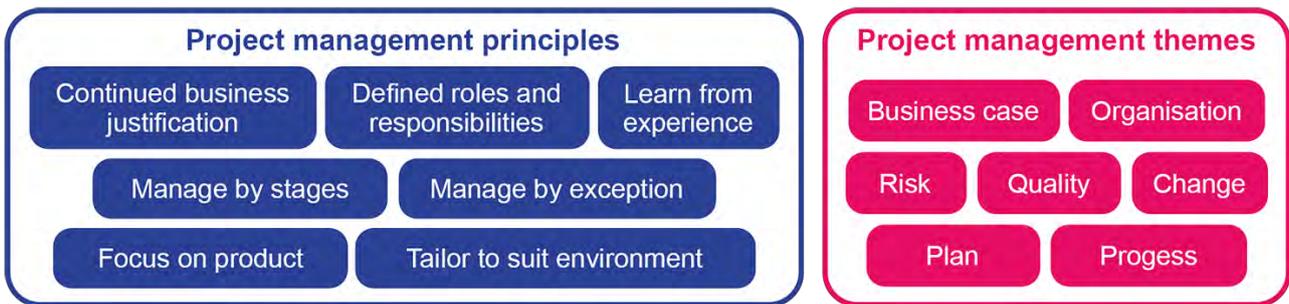
This section of the business case sets management arrangements that will successfully deliver Llantrisant Health Park Programme to time, cost and quality. The Management Case outlines the following arrangements:

- Project management arrangements
- Project assurance at different stages of the project
- Change management arrangements
- Benefits realisation and plans
- Risk management plans
- Contract management arrangements
- Post project evaluation plans
- Contingency plans.

9.2 Project management arrangements

The project will be delivered in line with PRINCE2 methodology. PRINCE2 is organised into seven principles and seven themes, which are deemed essential for any project to be deemed to be 'controlled'. This programme will apply these principles and themes throughout.

Figure 17 - Project management principles and themes



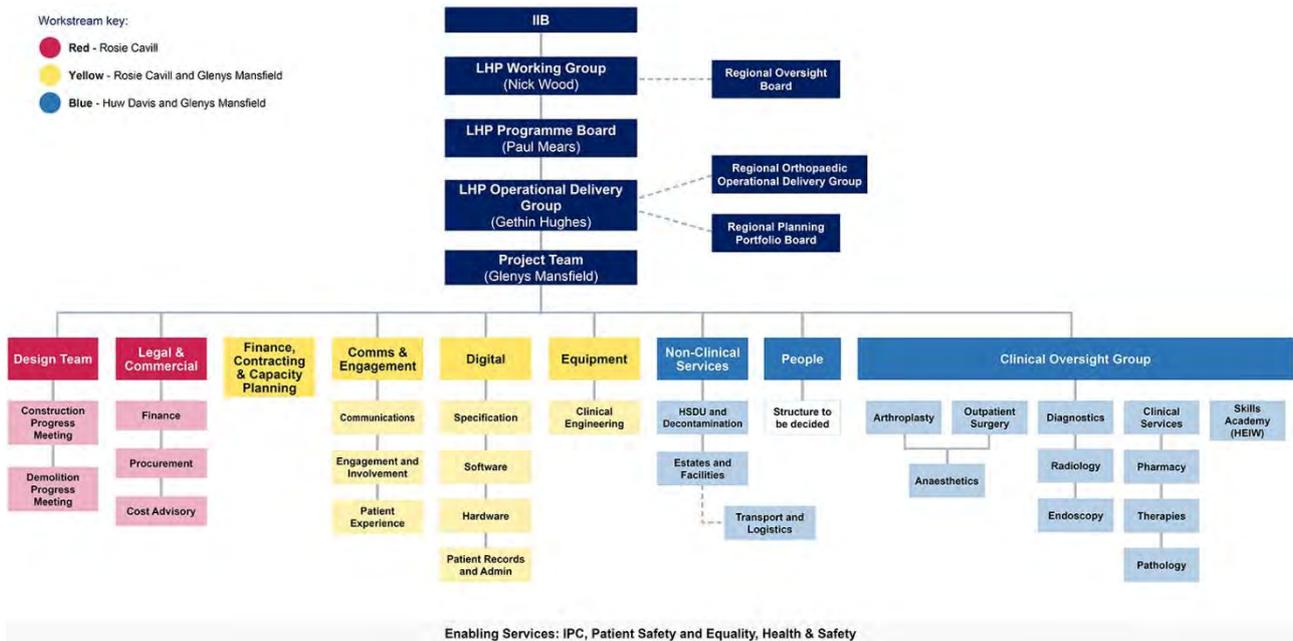
The key principles of PRINCE2 are the identification of three main functional areas of the project governance structure, including governance, delivery and assurance functions.

9.2.1 Project reporting structure

The programme governance structure has been established to reflect the principles and themes of controlled project delivery. The workstreams will report into the Project Team and Steering Group, Steering Group then reports into Programme Board which then reports to the Regional Oversight Board and CTMUHB Governance.

The project governance arrangements are outlined below.

Figure 18 - Project governance arrangements



9.2.2 Governance pathway

There is a clear demarcation between those groups with a responsibility to produce outputs needed to deliver the project i.e. workstreams and delivery groups, and those forums with responsibility to scrutinise, challenge and approve the outputs ensuring that the programme is directed consistently across all subject matters i.e. governance committees.

The main governance routes for reporting include CTMUHB Main Board and the Regional Portfolio Oversight Board.

9.2.3 Programme Board

Chair: Paul Mears, Chief Executive Officer and SRO for the Project, CTMUHB

The Llantrisant Health Park Infrastructure Programme Board has responsibility for overseeing the management and delivery of all aspects of this programme including the design proposals and the associated business cases.

The duties of the Programme Board are as follows:

- Ensure the programme objectives and scope of all projects have been appropriately defined and that any material changes are formally approved and integrated
- Ensure a robust programme timetable has been produced and monitored and that each workstream lead is committed and remains committed to its delivery
- Oversee the delivery of all projects within the defined parameters of time, cost and to the required quality and specification
- Ensure the cost implications of the programme are fully set out within robust financial plans and that it remains within the health board's overall affordability envelope
- Ensure there is an effective system of cost control in place and receive regular reports on the current and planned expenditure relating to the delivery of the programme
- Ensure that the programme is sufficiently resourced to deliver within its agreed scope, time, cost, and quality parameters
- Ensure there is an effective risk management system in place and that regular reports on the risks and issues are effectively acted upon

- Ensure that all development proposals meet the highest possible standards of design in respect of clinical use, patient and staff environment and building quality
- Sign off key documents including the clinical services strategy, business case, prior to submission to the IIB/Welsh Government for approval, as well as other key programme documents as required.

9.2.4 Programme Management Office

The Programme Management Office (PMO) is responsible for the oversight of all workstream project management within the programme. The PMO maintains internal reports and PRINCE2 documents including risk registers, issues logs and an assumptions log for the redevelopment. The team provides assurance by maintaining a focus on governance and programme controls and through the regular review and mitigation of risks and issues.

The programme plan is regularly reviewed and revised by the PMO team to accurately reflect progress, identify potential delays and ensure lessons learned are applied to planning. The PMO support resource management within the programme and produce project artefacts and tools for workstreams.

The duties of the PMO are as follows:

- Establish and run an effective PMO to support the programme during the business case process
- Establish and implement a robust governance structure
- Collate and interrogate management reports, assessing the health of the programme delivery environment
- Assess the status of milestones and deliverables from each workstream
- Plan and schedule resources efficiently in order to meet objectives
- Streamline and automate processes and workflows, ensuring escalation routes to governance committees are robust and succinct
- Facilitate knowledge transfers between workstreams
- Support project management resource within workstreams, where appropriate
- Facilitate cross stream working and collaboration
- Develop progress and assurance reports for key groups and committees as required.

9.2.5 Specialist workstreams and task and finish group

Included in the structure above (Figure 18) are specialist task and finish groups to support the clinical and non-clinical aspects of the redevelopment. These groups are the key interface between the delivery functions and the 'front line' workforce who deliver clinical and operational (non-clinical) services. The groups provide feedback and knowledge on their departmental requirements to the programme technical delivery experts.

9.2.6 Design Team

A design team has been appointed to review the concept site assumptions made prior to the site acquisition and develop design proposals. The design team's work will be informed by the regional workstreams' clinical specification and proposed models of care.

The key deliverables from this work are:

- Review of the technical infrastructure report (completed)
- A high-level design (RIBA Stage 1) and master plan (completed)
- A concept design (RIBA Stage 2) for the agreed clinical pathways (completed)
- RIBA 3 design works developing on the agreed clinical pathways (underway)
- Undertaking of site surveys (completed)
- A specification of enabling works for the temporary diagnostics facility (completed)
- Preparation of a temporary planning application for the mobile diagnostics facility (completed)
- Appointment of modular partner (completed)
- Confirmation of planning strategy and development of planning applications as required during the timeframe.

Terms of reference for all key project groups i.e. Programme Board, Steering Group, Project Team or Design Team can be made available upon request.

9.2.7 Outline project roles and responsibilities

Key Project delivery roles are described below:

Senior Responsible Officer (SRO)

The Chair/SRO role is held by **Paul Mears**, CEO of CTMUHB - responsibilities include:

- Keeping the Programme Board members informed of progress, escalating matters, as relevant
- Is responsible for providing leadership and the strategic activity of the Health Board, ensuring it is operating effectively and efficiently
- Being the ambassador within the local community and also at a regional and national level
- Ensuring that the programme aligns with the priorities of the wider Welsh Government plans
- Ensuring that the redevelopment programme fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money
- Sponsoring the project within CTMUHB and acts as the main point of contact with the Health Board and Executive Director
- Owning the vision for the project and the supporting business case
- Providing clear leadership and direction at an executive level throughout the programme
- Having full responsibility and accountability for the outcome of the project and realisation of the benefits
- Managing the interface with key senior stakeholders, keeping them engaged and informed
- Being the key link between the relationship between the programme, Regional Portfolio Oversight Board and Welsh Government;
- Maintaining the alignment of the project to the organisation's strategic direction
- Ensuring that the project remains affordable and will improve the quality of care to the target population
- Ensuring that the necessary resources are made available to deliver the scheme
- Chairing the Programme Board.

Infrastructure Programme Director

The Programme Director role is held by **Rosie Cavill**, LHP Programme Director - the main responsibilities include:

- Co-ordinating all workstreams to deliver the agreed objectives
- Monitoring progress, resolving issues, mitigating risks, and initiating corrective action as appropriate
- Providing an overall monitoring and assurance role across the project workstreams, ensuring that project risks and issues and any internal or external dependencies are defined, managed, and escalated where appropriate
- Ensuring appropriate risk, benefits and stakeholder management frameworks are in place for the project
- Acting as the day-to-day agent on behalf of the SRO for the infrastructure elements to ensure the successful delivery of the scheme
- Owning and reviewing the project plan, communicating the impact of any revisions in terms of milestones, timelines, and dependencies
- Ensuring the development of the business case and project documentation
- Ensuring that the initiatives and projects that support the infrastructure delivery of the Health Park are initiated on a consistent basis with governance arrangements that meet requirements
- Managing allocated outputs to the required quality within the agreed time and costs constraints
- Managing and providing assurance for the work of project team members
- Reporting regularly to all relevant individuals and groups using standard reporting processes and templates.

Clinical Operational Director

The Clinical Operations Director role is held by **Glenys Mansfield**, LHP Clinical Operations Director - the main responsibilities include:

- Clinical and operational pathway development to inform design and operational running of LHP
- Review of 1:200 and 1:50 designs
- Development of clinical governance structure
- Development of the workforce plan and delivery plan
- Development of the Digital infrastructure
- Establishing and managing task and finish groups
- Managing interdependencies of clinical model/pathways across workstreams
- Acting as the day-to-day agent on behalf of the SRO for the clinical pathway and operational elements to ensure the successful delivery of the scheme
- Ensuring that the initiatives and projects that support the delivery of the new hospital are initiated on a consistent basis with governance arrangements that meet requirements
- Ensuring appropriate risk, benefits and stakeholder management frameworks are in place for the project
- Reporting regularly to all relevant individuals and groups on clinical and operational pathway developments using standard reporting processes and templates.

Infrastructure Project Manager

The Infrastructure Project Manager role is held by **Alex Bowles**, Archus PM - the main responsibilities include:

- Ensure operational delivery of the project to time, quality, and budget
- Decision on matters for escalation and approval to Project Board and Health Board as required
- Management of risks and issues and escalation of appropriate matters for executive direction and/or approval
- Developing the format of the report, contents, and key requirements for consideration
- Planning and delivering stakeholder engagement and workshops
- Ensure the key milestones are agreed and communicated with all stakeholders.

Construction Partner

The role of Construction Partner Lead will be fulfilled by **MTX**. The role includes:

- Being point of contact for all infrastructure and estate related issues including arranging Isolations and issuing permits to work etc.
- Management of the construction programme
- Providing design/estates related input to OBC/FBC processes.

9.3 Special advisors – roles and responsibilities

Special Advisors have been used in a timely and cost-effective manner in accordance with the Treasury Guidance: Use of Special Advisors, to support the internal resources for this development. Special advisors and their roles on the project are shown below.

Business Case Support – Archus

- Manage the Business Case process including the facilitation of workshops, chasing of information etc.
- Stakeholder engagement
- Technical authoring of the OBC
- Support submission of OBC to WG
- Liaise with LHP Programme Lead on Business Case progress.

Technical Advisor (Architecture and Design) - Stride Treglown

- Providing design advice to the LHP Project Team on contractor lead design changes
- Liaise with appropriate stakeholders
- Preparing regular reports for the Project Manager.

Technical Advisor (Mechanical and Electrical Engineering) Stantec

- Providing technical advice and solutions to the Project/Design Team
- Liaise with appropriate stakeholders
- Assist with the design and construction teams where required
- Preparing regular reports for the Project Manager.

Cost Advisor – Mott MacDonald

- Full financial management and reporting of project costs together with payment recommendations for all expenditure incurred on the project
- Preparation of contract documents, procurement of contractors, payment of valuations and agreement of final accounts
- Budget estimating and cost modelling
- Cost planning
- Provision of cost advice
- Analysing and reporting on tenders received.
- Reporting and advising on all tendering and contractual arrangements
- Preparation of tender documents, including incorporation of client standard amendments and appropriate insurance provisions
- Preparing and issuing regular executive financial reports and cash flow summaries to the Project Manager.

Site Supervisor

To be appointed during RIBA 4

9.4 PM and professional fees budget

The following table outlines the estimated project and professional fees budget for the OBC.

Table 35 - Fees and non-work costs

Company	Purpose	Total fees spent incl. 20% VAT
Archus	Project Management	£1,069,127
Archus	Business Case Support	£20,250
Stride Treglown (ST)	Design Planning to RIBA 3a	£1,026,114
Mott Macdonald	Cost Advisor	£423,480
TBA	NEC Supervisor	£310,000
Stantec / ST	TA Support	£180,000
CTMUHB	Client Fees	£4,158,299
MTX	Construction (PSCP)	£8,555,529
<i>MTX</i>	<i>Planning</i>	<i>Incl. in MTX fees</i>
<i>MTX</i>	<i>Building Services; M&E and Surveys</i>	<i>Incl. in MTX fees</i>
<i>Stride Treglown (MTX)</i>	<i>Design Planning</i>	<i>Incl. in MTX fees</i>
Total		£15,742,799

9.5 Key milestones

A construction project programme has been developed to control and track the progress (attached at Appendix 11 and included in the estates annex) and delivery of the project and resulting outcomes. Key milestones for Phase 1 are summarised below.

Table 36 - Phase 1 project timeline

Milestone	Start	Completion
Confirm Scope and Develop OBC	14/07/2025	31/08/2025
Draft OBC Submitted to WG	05/09/2025	05/09/2025
HB OBC Approval	08/09/2025	15/10/2025
WG OBC Review and Approval	04/09/2025	16/10/2025
Planning Application	11/07/2025	15/10/2025
RIBA 4 and FBC Prep	28/07/2025	20/11/2025
HB FBC Approval and WG Submission	27/11/2025	27/11/2025
Scrutiny and WG FBC Approval	28/11/2025	23/01/2026
Contractor Mobilisation	23/01/2026	26/02/2026
Construction	01/03/2026	30/06/2027
Supplier Fit out of CDH	01/07/2027	31/08/2027
Commissioning	01/09/2027	31/10/2027

Indicative Milestones dates are also provided for the procurement of the ISP which should see them brought on line just at the completion of RIBA stage 4. It has been assumed that the ISP procurement is approved at IIB on 16th October alongside the Phase 1 OBC. In addition, whilst the date of the provider appointment is given it is anticipated that there will be a number of contractual negotiations during the construction phase. The ISP will become part of the design team moving forward so that programmes around equipping and commissioning can be fully aligned. It is anticipated that this may shorten the fit out and commissioning programme allowances however this cannot be confirmed at this stage.

Table 37 - ISP provider appointment timeline

Milestone	Start	Completion
ISP Tender Issue	18/08/2025	18/08/2025
ISP Tender Period	18/08/2025	19/09/2025
ISP Tender Evaluation	22/09/2025	03/10/2025
HB ISP Approval	06/10/2025	06/10/2025
WG ISP Procurement Approval	06/10/2025	16/10/2025
Intent to Award and Standstill Period	17/10/2025	31/10/2025
ISP Provider Appointment	31/10/2025	31/10/2025

9.6 Stakeholder engagement

9.6.1 Engagement to date

Key staff stakeholders across all health boards have been involved in design so far. RIBA 3 design review meetings were held in April and May 2025 to confirm all key stakeholders were agreed with current designs. In addition, the LHP Clinical team have worked closely with clinical users to ensure compliance with clinical standards and also with members of JAG compliance teams to ensure compliance.

9.6.2 Future communications and engagement

A communications and engagement group will be put in place to manage the engagement, consultation and communication processes for the regional Diagnostic Programme. This group will consist of communications and engagement leads for each health board, service leads and other colleagues to be co-opted as required.

The communications and engagement plan will be supported by the following key steps:

- Facilitating and supporting stakeholder identification, mapping and analysis
- Engagement with patients, clinicians, staff and the public to discuss and explore issues, refine and evaluate proposals, and decide which questions to consult on. This includes the proposed pre- engagement activity to assess the public's views on the development of diagnostic services (endoscopy and radiology) delivered outside of an acute hospital setting on both a local and regional level, and to identify their needs and any barriers they face in accessing services.
- Focused formal consultation on fully evaluated proposals will last a minimum of six weeks
- Communication of agreed changes to key stakeholders, organisation-wide staff groups, and the public – it should be noted that this activity does not replace management communications with specific teams.

In developing and delivering our communications and engagement activities we will:

- Maintain stakeholder and public confidence in the LHP as a landmark development that will improve the provision of modern health care in south-east Wales
- Provide the public with a range of opportunities to inform the development of the LHP in ways that maximise access, clinical effectiveness and the experience of patients
- Take a collaborative approach, with NHS partners, to developing and disseminating messages and communications/engagement resources, that enable consistency, clarity and accuracy across the region and nationally
- Identify and promote opportunities to add social value within local communities
- Identify and celebrate programme milestones, alongside partners
- Involve local political partners and relevant third-sector organisations
- Provide assurance to the programme board and national bodies on the effectiveness of communications and engagement activities and seek to continually improve.

9.6.3 Involving and engaging the public

It is important that those communities who will benefit from the LHP, are provided with meaningful opportunities to inform the ways in which they will experience, and access healthcare and support provided from the facility.

Working in partnership with Llais, and through collaboration across NHS partner organisations, we are developing approaches and resources that enable people to be engaged and involved in a range of ways, recognising and respecting barriers and protected characteristics, and adhering to best practice and law including the Llais Service Change Protocol as appropriate.

We will take a continual involvement approach that seeks to embed the patient voice into the structure of the programme and the development of the facility. This may include the formation of a citizens' panel which would include representation from different communities across the region.

9.7 Project assurance

The current governance structure allows for a clear separation between governance functions and those that deliver or approve outputs. The assurance functions will confirm that the processes and procedures followed by the delivery groups have been sufficient and in accordance with sound management principles. The assurance function will also act as the coordination point between the delivery and governance functions. Within the PRINCE 2 governance arrangements the PMO is classed as part of the Assurance function.

Programme

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

Risk

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

Key Performance Indicators (KPIs)

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

9.8 Change management

The Health Boards are aware that the project will cause major change for staff working in the area and across all three Health Boards, and therefore its success is predicated on staff supporting the project. To date, key staff have been involved in workshops regarding clinical flows and design, and it is envisaged that they will continue to play an instrumental role as the project moves into its next phase. Prior to the new facilities opening, detailed planning will be undertaken to understand any changes to ways of working, and staff will be supported by the project team to prepare for this. Transition plans will be developed, in collaboration with relevant stakeholders, to ensure the new facilities run smoothly and that staff are prepared for any resulting changes to their working models

There will be no change to organisational structures following completion of the development. There is potential for positive cultural changes following completion to enable staff to work more effectively and efficiently in a new fit-for-purpose building. This can help contribute to higher levels of staff retention over the coming years to improve the working culture for both staff and patients.

Within each stage there will be a series of decision points where major documents produced by workstreams will be ratified within the governance arrangements. For example, clinical advice leaflets pre/post day surgery. All documents will be subject to a robust and consistent version control methodology.

All changes will be subject to a formal change control process. Change is not design development. Change can only occur when strategic, operational policies or functional content quantities are altered from those included in the current approved documents. Change management associated with the infrastructure aspects of this project will be managed by the LHP Project Team through Programme Board and Regional Oversight Board.

9.9 Contingency plans

Should the current scheme fail to proceed, the only contingency plan would be to continue with business as usual for services regionally, working with wait list initiatives or temporary diagnostic solutions such as mobile MRI when required to meet additional demand.

9.10 Benefits realisation

A Benefits Realisation Plan will be developed by the Programme Board to put in place the necessary arrangements to ensure that the project delivers its anticipated benefits. This includes setting out the arrangements for planning, modelling and tracking the identified benefits as well as a framework that assigns responsibility for the realisation of the benefits throughout key phases of the project. The Benefits Realisation Plan will be owned jointly by the Health Board's Infrastructure and Clinical and Operational Programme Directors.

The main benefits for the preferred option are outlined in the benefits register included in Appendix 6 while the actions required to realise the benefits will be confirmed at FBC stage.

The spending objectives and aligned benefits used in the selection of the preferred option will be used to measure the project success.

This evaluation process will be run in parallel with the Post Project Evaluation Plan as noted below and will be developed as part of the detailed design stage. The Benefits Realisation Plan will be regularly reviewed and updated. This will ensure that – should any strategic change take place, such as a legislative change – the service and project will be flexed accordingly to ensure that the facility delivers a fit for purpose service from the point of operational commencement.

The benefits realisation approach outlined above is a key output to provide assurance on investment delivery and performance and will be shared with the Health Boards and Welsh Government to facilitate shared learning at FBC stage.

9.11 Risk management

The complexity of the LHP programme necessitates an appropriate risk management process is put in place to identify, assess and mitigate the likelihood of risks materialising throughout the programme duration.

Workstream risks are those which are considered by each workstream as a risk to successful delivery of business outcomes and targets. They vary from seemingly insignificant risks to risks which are potentially very damaging. Where risks are deemed to be significant (residual rating >12) and occur across several workstreams these are considered as programme risks and dealt with accordingly.

Risk management is therefore dealt with in a two-tier system approach:

- Workstream risk management is an iterative process undertaken by workstream leads, with a monthly reporting cycle up to the LHP Steering Group. All workstreams will be issued a risk register template to log their risks and issues
- Programme risk management is an iterative document that is reviewed monthly in the Programme Board and Steering Group meetings and updated to reflect any changes that may impact programme scope, cost, timeliness, quality, or designs.

Should any risks be identified through the programme that have an impact on the Health Board service delivery and / or strategic direction then it should be escalated via the SRO to the Assistant Director of Governance and Risk for inclusion and scrutiny on the Organisational Risk Register.

9.11.1 Consequence and likelihood definitions

The below tables include the initial definitions relating to the consequence and likelihood of a risk occurring. These definitions are used for both workstream-level risks that are maintained in the dashboard report *and* the programme levels risks that are reflected in the programme risk register.

Table 38 - Risk consequence definitions

Score	Descriptor	Actual or potential impact on the individual/service or organisation
1	Negligible	<ul style="list-style-type: none"> • Minimal injury requiring no/minimal intervention or treatment. • Potential for public concern • Insignificant cost increase/ schedule slippage • Minimal or no impact on the environment
2	Minor	<ul style="list-style-type: none"> • Minor injury or illness, requiring minor intervention. • Local media coverage – short-term reduction in public confidence • <5% over project budget, schedule slippage • Minor impact on the environment
3	Moderate	<ul style="list-style-type: none"> • Moderate injury requiring professional intervention. • Local media coverage – long-term reduction in public confidence • 5 – 10% over project budget, schedule slippage • Moderate impact on the environment
4	Major	<ul style="list-style-type: none"> • Major injury leading to long-term incapacity/disability • National media coverage with <3 days service well below reasonable public expectation • 10-25% over project budget, schedule slippage, key objectives not met • Major impact on the environment
5	Catastrophic	<ul style="list-style-type: none"> • National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) • Incident leading to > 25% over project budget, schedule slippage, key objectives not met • Catastrophic impact on the environment

Table 39 - Risk likelihood definitions

Score	Descriptor	Likelihood of occurrence
1	Rare	This will probably never happen/recur
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so
3	Possible	Might happen or recur occasionally
4	Likely	Will probably happen/recur but it is not a persisting issue
5	Almost certain	Will undoubtedly happen/recur, possible frequently

9.11.2 Risk matrix

The risk matrix shown below is also consistent between both levels of risk management. The Health Board risk matrix is shown below.

Figure 19 - Risk scoring matrix (Likelihood x Consequence = Risk score)

Likelihood	Frequency	Consequence				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly unlikely: will probably never happen	not for years	1	2	3	4	5
2 Unlikely: not expected to happen / recur, but is possible	at least annually	2	4	6	8	10
3 Likely: might happen / recur occasionally	at least monthly	3	6	9	12	15
4 Highly likely: will probably happen / recur, but not a persistent issue	at least weekly	4	8	12	16	20
5 Almost certain: will undoubtedly happen / recur, possibly frequently	at least daily	5	10	15	20	25

Risks should be assessed and reviewed on a regular basis, as determined by their score:

1-6 Low	Low risks should be reviewed and progress on actions recorded and updated at least every 6 months
8-12 Moderate	Moderate risks should be reviewed and progress on actions recorded and updated at least quarterly
15-25 High	High risks should be reviewed and progress on actions recorded and updated at least every 2 months; if scored 20 or over the risk should be reviewed each month

The following management actions are taken for each category:

- **Red** – Reviewed at every Steering Group and Programme Board meeting with clear and determined action reviews in each pertinent workstream. Workstream leads are predominantly identified as the risk owner;
- **Amber** – Reviewed regularly and appropriate review dates are agreed at workstream groups/committees. The risk owner should be a senior member of the pertinent workstream; and
- **Yellow and Green** – Reviewed regularly to ensure the likelihood and/or consequence of the risk arising has not risen. Risk ownership can be assigned to anyone on the pertinent workstream.

9.12 Contract management

Robust contract management process will be put in place to oversee both the construction contracts and the managed service contracts with the ISP. The use of regular reviews and KPI monitoring will be critical to managing and overseeing performance throughout contract durations.

9.13 Post-project evaluation

Post-project evaluation (PPE) is a mandatory requirement for infrastructure projects that receive Welsh Government funding. The purpose of PPE is to improve project delivery through lessons learned during the project delivery phase and to appraise whether the project has delivered its anticipated outcomes and benefits.

The Health Board and its partners are committed to ensuring that a thorough and robust post-project evaluation is undertaken at key stages in the process to ensure that lessons are learnt. The PPE also sets in place a framework within which the benefits realisation plan set out in section 10.11 can be tested to identify which benefits have been achieved and which have not.

The Health Board is exploring opportunities to work with a local university in carrying out the PPE. Detailed plans will be drawn up in partnership with the university. The evaluation will be carried out in line with NHS guidance, and will measure the project against the following factors:

- The extent to which the original objectives have been met
- Measurement against the Benefits Realisation Plan
- Risk allocation
- Timetable
- The economic viability of the project in comparison with the 'Do Nothing option
- Functional Suitability – how the facility performs
- Functional Relationships – how well the various process flows (staff, patient, service) work.
- The cost of the project and the extent to which it can demonstrate value for money
- The Project outcome compared with the 'Do Nothing' or 'Do Minimum' scenarios
- User satisfaction
- Procurement route

We envisage four key stages to the evaluation, outlined as follows:

Stage 1: Project procurement

The objective of the evaluation at this stage is to assess how well the project was managed from the time of OBC approval to commencement of the construction phase. It is planned that this evaluation will be undertaken within three months of construction commencement. The evaluation at this stage will examine:

- How effectively the project was managed
- The quality of the documentation prepared by the Health Board and its partners
- Communications and involvement during procurement
- The effectiveness of advisers used on the scheme
- The efficacy of NHS guidance in delivering the scheme.

Stage 2: Implementation

The objective of this stage is to assess how well the project was managed from the time the construction phase commences through to commencement of operational commissioning.

It is considered that this should be undertaken three months following operational commissioning of the unit. The evaluation at this stage will examine:

- How effectively the project was managed
- Communications and involvement during construction
- The effectiveness of the joint working arrangements established by the Contractor, the design team and the project team.

Stage 3: New operational model in place

The objective of this stage will be to assess how well the project was managed during the operational commissioning phase, through to operation in the new building. It is proposed that this stage will be undertaken up to 12 months after completion of operational commissioning of the scheme. The evaluation at this stage will examine:

- How effectively the project was managed
- Effectiveness of the new operational model
- Communications and involvement during commissioning, and into operations
- Overall success factors for the project in terms of cost and time
- Extent to which the new operational model meets users' needs – from the point of view of patients, carers and staff.

Stage 4: New operational model well-established

It is proposed that this evaluation is undertaken 18 months following completion of operational commissioning. The objective of this stage will assess how well and effectively the project was managed during the actual operation of the new Health and Wellbeing Centre. The evaluation at this stage will examine:

- Effectiveness of the new operational model
- Extent to which the new operational model meets users' needs – from the point of view of patients, carers and staff.

The evaluation process will be managed by the Project Manager via a bespoke team established to oversee the PPE. Evaluation reports will be made available to all relevant stakeholders, including Welsh Government.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Establishment of the South-East Wales Regional Joint Committee
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Rani Dash, Director of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

Background and current situation:

Partnership and collaborative working has been progressing across South East Wales Health Boards and Velindre NHST since September 2022 in the guise of a South East Wales regional planning portfolio. Good progress has been made during this time.

The South-East Wales Regional Joint Committee (RJC) represents an evolution of and step change in the potential for these existing arrangements and is a strategic collaboration established by direction of the Cabinet Secretary for Health and Social Care. It more formally brings together Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board to oversee regional planning and service delivery for a catchment population exceeding 1.5 million, noting the service provision of these organisations reaches beyond this.

The RJC aims to enhance collaboration, reduce inequalities, and promote sustainable healthcare services across the regional footprint and represents a significant step toward integrated regional health governance through collaborative leadership and shared accountability among the constituent health boards and associate members.

The attached Terms of Reference provides a comprehensive framework for its operation and governance, ensuring that regional health needs are met effectively and efficiently.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Status and Authority

The RJC is formed under the powers of the Welsh Ministers pursuant to the National Health Service (Wales) Act 2006. It is not a separate legal entity but a joint committee accountable to the Boards of the three constituent health boards. Each board delegates certain functions to the RJC, which is bound by these decisions under the schedule of delegated powers. The health boards retain ultimate responsibility for the planning and delivery of health services to their populations but may choose to be bound by a majority view at the joint committee.

The RJC's Terms of Reference includes a schedule of reserved and delegated powers which clarifies the division of responsibilities between the health boards and the RJC, ensuring clear governance and accountability.

Chief Executives of the health boards serve as Accountable Officers with personal responsibilities for financial propriety, sustainability, value for money, risk management, and accurate accounting. Their membership in the RJC ensures decisions respect these duties, avoiding conflicts between personal responsibilities and board roles.

Purpose and Objectives

The RJC seeks to transform regional collaboration by providing collective leadership for planning, commissioning, and delivering health services. It focuses on aligning clinical service development with population health needs, addressing service and financial challenges, and reducing unwarranted variation in outcomes and access. Specific objectives include developing a regional work programme, reviewing baseline activities for

efficiency and quality, prioritizing capital projects, approving business cases, and ensuring integrated impact assessments for service change.

Chairing and Membership

Upon establishment, the RJC will appoint a Chair from the Health Board Chair representatives and rotate annually thereafter between the three health board Chairs. Membership of the RJC includes representatives from each health board, including Chairs, Vice Chairs, Chief Executives, and nominated Executive Directors. Associate membership is extended to representatives from Powys Teaching Health Board and Velindre University NHS Trust, who attend meetings without voting rights. The committee may invite additional attendees to assist its work, including representatives from the wider health and care system and community sectors.

Values, Behaviours and Principles

The RJC will operate under four core partnership principles:

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

RJC members will be expected to adhere to their respective health board policies, NHS Wales values, Nolan Principles, and agreed partnership principles. They must consider equality, diversity, and inclusion in decision-making and prioritize regional population interests over individual health board interests.

The RJC will promote openness and transparency by holding public meetings where possible, while safeguarding confidential information as necessary. Conflicts of interest will be managed per health board policies, with declarations required at meetings and appropriate actions determined by the RJC Chair or Vice-Chair.

Disputes between health boards related to RJC operations will follow a structured resolution process beginning with discussions among involved parties, escalating to chief executives, then chairs, and ultimately to the Welsh Government Director General and Cabinet Secretary if unresolved. This process emphasizes cooperative resolution in line with the agreed partnership principles.

Meetings and Decision-Making

The RJC will typically meet quarterly, with a minimum of three meetings per year. A quorum requires at least six members, including an Independent Member and an Executive member from each health board.

Decisions will be reached by consensus or, in exceptional circumstances, by vote among RJC members or referral to respective health boards. Meeting notices and papers are distributed in advance, and meetings are conducted with transparency, including public sessions when appropriate.

Governance support to the RJC will rotate annually among the health boards based on the chairing arrangement in place.

Review and Reporting

The effectiveness of the RJC will be reviewed annually, with reports submitted to the health boards. The Terms of Reference will also be reviewed regularly to ensure they remain relevant and effective with an initial review planned to take place six months after establishment.

RJC meeting minutes and summary reports will be shared with the health boards for assurance and transparency.

Creating the wider conditions for success

There is an abundance of evidence however which suggests structural change by itself is not a likely route to successful or sustainable regional service delivery / improvement.

Establishing successful partnerships between organisations requires shared objectives and demands the engagement of 'hearts and minds' across all levels of the system.

Emotional and cultural alignment will be essential to build trust, foster collaboration, and ensure that joint working is sustained through periods of change and challenge. Trust and psychological safety will also be foundational to an effective partnership. When individuals and teams believe in each other's intentions and feel safe to express concerns or ideas, they are more likely to engage openly and constructively. This environment will also support shared problem-solving and reduce the risk of siloed thinking or defensive behaviors.

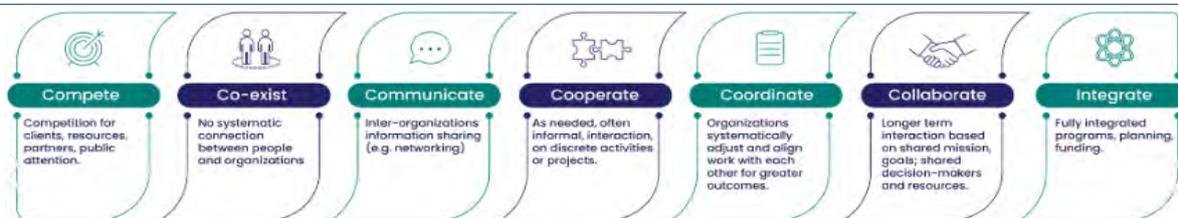
Creating these wider conditions will require a number of actions / considerations to be progressed in the early phase of the RJC -

- a) Development of a value proposition and shared sense of purpose that goes beyond that laid out by the Minister.

Aligning purpose alongside further developing and embedding values (described above) across the RJC and constituent partners will help to create a unified direction. While partners will have different operational pressures ensuring that all partners are committed to a common vision for patient care and system improvement will translate into stronger ownership of shared goals and greater resilience in the face of operational or financial pressures.

- b) Assessment of the spectrum of collaboration.

The extent to which any partnership collaborates can vary considerably (as shown in the spectrum of collaboration below). Ensuring a collective acknowledgement on both where the current partnership is and where the RJC does, and does not, strive to get to will be vital in building trust and transparency. It will guard against any particular partner being unfairly labelled 'difficult' merely because their expectations of the partnership differs from others but has not been fully understood from the outset.



The Tamarack Institute. (June, 2017). *The collaboration spectrum – tool* [Illustration]. The Tamarack Institute. <https://www.tamarackcommunity.ca/library/collaboration-spectrum-tool>



Figure adapted by The Center for Implementation

c) Exploration and agreement of the partnerships 'sweet spot' in terms of responsibility at scale v's at-site.

The more 'at scale' the partnership operates the more diluted the benefits of strong local/organisational leadership. The stronger the local/organisational leadership the less likely the partnership will achieve benefits at scale.

The choice of 'at scale' or 'at site' need not be a binary one but a transparent conversation between partners as to where the collective 'sweet spot' is for the RJC will enable progress at a pace that all partners are comfortable with.

Trust and a willingness to work in collaboration can often be eroded through frustration at the perceived pace of progress, or lack of. Learning and reflections on regional working over the past three years has shown that too often partners have focused, too heavily, on specific regional models of care that need deploying compared to other foundational elements that also need time and attention. These would ultimately support delivering those service models at greater pace. Further consideration thus needs to be given to;

d) Wider enablers of effective collaboration.

A focus on achieving collective consensus at an RJC level on the approach towards a number of key enablers will provide the foundations for collective service delivery at scale.

These enablers will include how clinical leadership is embraced, how digital (including data sharing) solutions are best exploited across organisational boundaries and also how regional approaches to workforce are best developed.

e) 'Alignment versus assimilation'

An equal focus on building trust through considering an early emphasis on aligning and stream-lining pathways, standardising clinical policies, joint management / clinical leadership models as opposed to moving directly to regional delivery of service (assimilation of services) will also help build confidence within the RJC.

In creating the wider conditions for success and to ensure the RJC meets from a position of strength points a – e above should be considered through the development of a regional Organisational Development (OD) programme that is wrapped around the emerging RJC and its partners.

Recommendation:

Respective Boards are asked to:

- Approve the establishment of the South-East Wales Regional Joint Committee (RJC) and its associated terms of reference and operating arrangements as attached;

- Note the RJC will appoint a Chair from its membership followed by a rotating period of appointment. Governance support will be provided by the Health Board of the Chair appointed as RJC Chair;
- Determine membership from each respective health board to join the RJC, in-line with the membership requirements;
- Note the wider determinants for the RJC's long term sustainable success and;
- Approve the development of a regional OD programme for the RJC and its partners.

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

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.

SOUTH-EAST WALES REGIONAL JOINT COMMITTEE (RJC)

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

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 boards.
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.

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.

Accountability, Responsibility and Authority

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**).

Purpose of the RJC

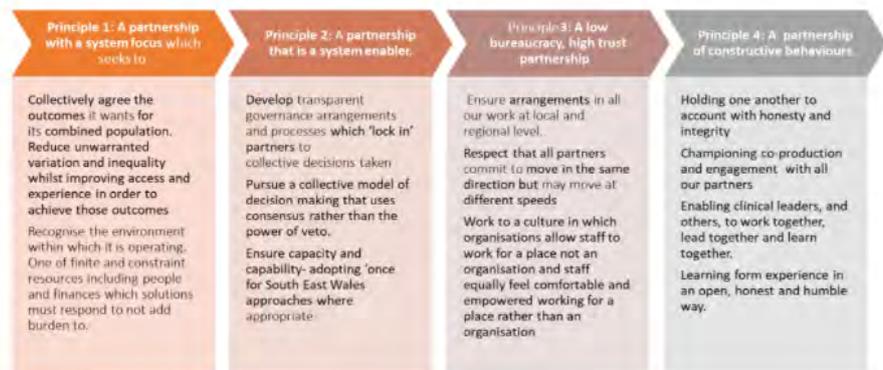
14. The RJC has been established to:
 - (a) Create a step change in the effectiveness of arrangements to collaborate across the regional footprint in the interests of our shared population, marking a change in the way we work collectively as health boards.
 - (b) Provide collective leadership for the 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.
 - (g) 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.

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.

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.



<p>Chairing Arrangements</p>	<p>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.</p> <p>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.</p>
<p>Membership</p>	<p>19. The RJC shall have the following members drawn from the three health boards, as follows:</p> <ul style="list-style-type: none"> • 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) <p>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.</p>
<p>Associate Membership</p>	<p>21. The RJC shall have the following associate members, attending meetings on an ex-officio basis, without voting rights:</p> <ol style="list-style-type: none"> a) A nominated Board Member of Powys Teaching Health Board (1) b) A nominated Board Member of Velindre NHS Trust (1) <p>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.</p>

<p>In Attendance</p>	<p>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:</p> <ul style="list-style-type: none"> 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. <p>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.</p> <p>25. A Welsh Government Official will receive a standing invitation to observe all meetings of the RJC.</p>
<p>Accountable Officers</p>	<p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> 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....”

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.

Delegated Functions and Powers

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.

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.

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.

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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.

	<p>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.</p> <p>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.</p>
<p>Conflicts of interest</p>	<p>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.</p> <p>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.</p> <p>59. All declarations of interest made at a meeting must be recorded in the Joint Committees minutes.</p> <p>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.</p>
<p>Disputes</p>	<p>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.</p>
<p>Behaviours and Conduct</p>	<p>62. Members will be expected to behave and conduct business in accordance with:</p> <ul style="list-style-type: none"> 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. <p>63. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.</p> <p>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.</p>

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.
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.

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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.

A. MATTERS RELATING TO THE RJC, RESERVED FOR HEALTH BOARDS		
REF.	AREA	MATTER
A1.	Operating Arrangements	Approve the Joint Committee's Terms of Reference and Operating Arrangements (the Governance Framework for the RJC)
A2.	Strategy & Planning	Approve the annual priorities and programme of work for regional developments, as recommended by the RJC
A3.	Strategy & Planning	Approve a Regional Commissioning Strategy, if recommended by the RJC, for inclusion in Health Board Integrated Medium-Term Plans
A4.	Strategy & Planning	Approve the overarching financial commitment and financial framework required to enable delivery of the priorities set for the RJC (A2 and A3)
A5.	Strategy & Planning	Approve Capital and Revenue Business Cases (prior to WG approval if required), within the framework of: <ul style="list-style-type: none"> • The agreed annual priorities and programme of work for regional developments (A2) • The agreed Regional Commissioning Strategy (A3) • The overarching financial commitment and financial framework required to enable delivery of the priorities set for the RJC (A4)
A6.	Strategy & Planning	Approve the commencement of formal engagement and consultation on significant service change proposals
A7.	Strategy & Planning	Approve significant service change proposals for implementation

B. MATTERS RELATING TO THE RJC, DELEGATED FROM HEALTH BOARDS AND RESERVED FOR THE JOINT COMMITTEE		
REF.	AREA	MATTER
B1.	Operating Arrangements	Develop, vary, and amend the Joint Committee's Terms of Reference and Operating Arrangements (the Governance Framework for the RJC) for Health Board approval
B2.	Operating Arrangements	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:

		<ul style="list-style-type: none"> • Programme and Project Governance – Established to provide a framework for managing and controlling programmes and projects. • 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. • 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.
B3.	Strategy & Planning	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
B4.	Strategy & Planning	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
B5.	Strategy & Planning	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)
B6.	Strategy & Planning	Approve Capital and Revenue Business Cases (prior to WG approval if required), within the framework of: <ul style="list-style-type: none"> • The agreed annual priorities and programme of work for regional developments (B3) • The agreed Regional Commissioning Strategy (B4) • The overarching financial commitment and financial framework required to enable delivery of the priorities set for the RJC (B5)
B6.	Strategy & Planning	Develop significant service change proposals which relate to regional developments, for Health Board approval
B7.	Strategy & Planning	Develop arrangements for the commencement of formal engagement and consultation on service change proposals, for Health Board approval
B8.	Performance & Assurance	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
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)

C. MATTERS RELATING TO THE RJC, DELEGATED FROM THE JOINT COMMITTEE TO SUB-COMMITTEES, GROUPS AND OTHERS		
REF.	AREA	MATTER
		<i>To be determined upon establishment of the RJC</i>

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.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Review of the Performance Management and Accountability Framework
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Trish Chalk, Assistant Director of Planning and Performance,

**Pwrpas yr Adroddiad
Purpose of the Report**

Ar Gyfer Penderfyniad/For Decision

The purpose of this report is to seek Board approval for the updates to the Performance Management and Accountability Framework (PMF) following a thorough review.

Specifically, the Board is asked to:

- Note the work and outcomes of the review.
- Note the recommendations from the review and for updating the Framework.
- Approve the updated Framework

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

In September 2023, the PMF was approved by the Board following recognition that the Health Board required a systematic approach and clarity around the performance and accountability requirements, which needed strengthening, incorporating current good practice internally and reflecting best practice.

The PMF supports the Health Board's strategic goals by tracking and improving performance to achieve better outcomes for patients and staff. The PMF sets out the arrangements for the oversight of operational Divisions and Corporate teams

how they are assessed, and the consequences of poor performance via the escalation section.

The design principles for the current Framework are integrated bringing together quality and safety, operational delivery, and finance.

In line with the national Planning and Performance Frameworks, the Integrated Medium-Term Plan 2025-2028, and national priorities, it is important to revisit and refresh the PMF to ensure relevance, effectiveness, and engagement.

A review commenced in December 2024 to evaluate the implementation actions, gather feedback and wider opinion about the effectiveness of the current Framework in achieving its aims to monitor and improve organisational performance.

[Cefndir / Background](#)

The comprehensive review of the Performance Management and Accountability Framework (2023) was commissioned to ensure alignment with national and ABUHB priorities recognising during the period the organisation had commissioned a review of its 10-year strategy and the changes in escalation status. The review evaluated the framework's effectiveness in promoting accountability since implementation, improving performance, and supporting safe, effective service delivery. It was recognised the PMF would require review and iteration, as supporting components were developed and learning through application.

The 2023 PMF was developed with engagement from the Board, Executive team, and the Cross Divisional leadership group. When launched, the Framework set out the benefits anticipated to having a PMF, these included:

Oversight and integration of approaches to addressing performance, strengthening "grip" on key issues, and learning from existing approaches,

- Providing a linkage from PADRs through to strategic objectives,
- Provide a mechanism to objectively assess risk and areas across organisation that need support and focus,
- Bring an appreciation of issues affecting delivery of operations closer to corporate teams and identifying any opportunities to support,
- Clarity and appreciation of the contribution of corporate teams to delivering statutory, strategic, and operational priorities,
- Improving alignment of performance across the organisation, including the new Quality Outcomes Framework.

The review has sought to understand if these benefits are being realised by the Organisation through having the Framework in place, and address areas that could further improve accountability and delivery. The review has looked at the following areas:

- Review the understanding of the purpose and principles
- Learn from the experiences of implementation and feedback since 2023, and if the Framework is still fit for purpose

- Understand individual and collective understanding, and if the Framework reflects the status of the organisation and understanding of accountability at all levels.
- Oversight arrangements – to understand the alignment between individual, team, and organisational goals and do the arrangements ensure timely follow up and intervention
- Escalation – understand if the 3x3 model is fit for purpose and the triggers are understood, along with if the support has been clear and effective
- If the Framework promotes a culture of ongoing feedback and continuous improvement
- Understand if it is appropriate to align to the national levels of escalation and domains

It is worth noting that since the review was implemented the national escalation framework has been updated: NHS Oversight, Assurance, Escalation and Intervention Framework. The Health Board, like all NHS organisations is assigned an escalation status which is currently Level 3 (known as Enhanced monitoring) for finance, strategy and planning and performance and outcomes related to urgent and emergency care pathways at The Grange University hospital emergency department. The organisation was de-escalated from Level 4 (Targeted Intervention) for finance, strategy and planning in July 2025.

Assessment

Key changes and improvements implemented since the PMF was introduced include (but are not limited to):

- Development of Integrated Performance Report tracking directly to delivery of IMTP commitments (covering operational performance, workforce quality and finance)
- Established use of accountability letters for all Directors
- that cover the broader spectrum of deliverables over and above budget delivery and include individual objectives,
- Accountability letters alongside the same model for all Divisions have been developed and issued
- Introduction of Executive Team focused sessions on performance oversight
- Strengthening of the planning cycles to ensure there is better clarity on delivery expectations alongside clear milestones and clarity on delivery mechanisms – this will further strengthen the accountability letters for future years
- Corporate teams undergoing Reviews
- Deployment of the financial governance checklist
- New Quality assurance framework
- Strengthen capacity and capability in the performance function

The refresh of the PMF is intended to build on the progress outlined above and to assess understanding, alignment, escalation appropriateness, and culture of continuous improvement through a two-part review involving desktop evidence analysis and direct feedback via surveys, internal audit, and facilitated sessions.

The full review and report can be found in Appendix 1

A summary of the review can be found below:

- Framework purpose and benefits: The PMF was designed to integrate performance oversight, link individual objectives to strategic goals, assess organisational risks objectively, and enhance alignment across the ABUHB including the Quality Outcomes Framework, Standard Financial Instructions and Accountability Conditions. The review aimed to assess these intended benefits and identify improvement areas.
- National escalation context: The Welsh Government's Oversight and Escalation Framework define escalation levels and domains, with ABUHB experiencing changes in escalation status in 2024 and 2025, for finance, planning, and urgent and emergency care. These changes influenced the PMF's escalation processes and application throughout the organisation. It was also noted that outside of national processes the Health Board addressed operational risk through application of the PMF for mental health services.
- Feedback and engagement: Facilitated sessions and surveys revealed strong support for the PMF's purpose but highlighted challenges such as unclear escalation triggers, administrative burden, and mixed perceptions of accountability effectiveness. Independent member involvement and clearer guidance were recommended to be strengthened in the refreshed PMF..
- Audit insights: An internal audit found reasonable assurance in framework adequacy but identified areas needing improvement, including clearer escalation consequences, resource demands, delayed reviews, and lack of deep dive analyses. Plans to address these were outlined in the management actions.
- Implementation of the Framework findings: It was found that the actions were carried out as intended, for example accountability letters issued to executives and divisions and review meetings, though timing and clarity issues were noted. The planning cycle was refreshed with clearer delivery expectations and governance. Assurance reviews and escalation meetings have been conducted regularly, supporting performance oversight.
- Emerging themes: The review confirmed the PMF's value but emphasised needs for improved clarity on escalation, streamlined processes, timely accountability communication, enhanced support mechanisms, and inclusion of leadership and governance domains within escalation criteria.

Recommendations

The following recommendations for revisions are made based on the review:

Recommendation 1 - Board and Independent Member involvement in implementing the Framework

The involvement of independent members in the escalation process would further strengthen support for improvement and actions and is aligned to the national intention for greater transparency in escalation processes from September 2025. Practically this means that teams in escalation may be invited to attend relevant Committees to update on improvement plans. Including the relevant Executive Director in this will be critical.

Recommendation 2 - Alignment with organisational direction and strategy

The process for agreeing and communicating accountability conditions aligned with the IMTP should remain with a review of the time taken to produce and circulate to Divisions. A clear timeline should be agreed and included in the accountability conditions for Divisions supporting this process.

Recommendation 3 - Triggers and escalation

The triggers for escalation should be revised with new domains added for leadership and corporate governance. De-escalation criteria should be clearer and communicated at the time of escalation with a clear timeframe for review. The domains should remain locally defined and not aligned to Welsh Government framework because they are well understood. The level of escalation should be proportional and within the scope of delegation of the Division.

Recommendation 4 - Enhanced feedback mechanisms balanced with resource availability

The assurance meetings should be streamlined, with an annual in depth review every 12 months for all Divisions and a 6-month review for Operational Divisions. Quarterly reviews should be removed Operational Divisions should have monthly assurance reviews with a streamlined agenda.

Recommendation 5 - Quality metrics

The measures for quality and reporting should be reviewed and streamlined for all assurance meetings aligned with the new QOF, Integrated Performance Report and Quality Management Group structure

Recommendation 6 - Format

The content PMF should be revised and streamlined to provide clearer information and expectations, local arrangements should be aligned with the PMF, this was noted as already in place in Primary Care.

Recommendation 7 - Deep Dives and Recovery meetings

The use of deep dives and/or budget recovery meetings should be established and implemented to support understanding risks and corrective actions.

The updated PMF incorporating the recommendations can be found in Appendix 2

Summary of the updates 2023/2025

Change	Summary of Update
Document	New format with triggers, escalation and de-escalation criteria updated
Domains	Corporate Governance and Leadership added
Reporting	Updated to provide clarity on which Committees receive information and when
Accountability	Accountable domain leads added
Governance and Reporting	Updated organigram to show reporting against escalation process triggers and the actions for Enhanced Monitoring and Deep Dive/Special budget meetings
Assurance meetings	Defined set of metrics against each domain
6/12 monthly reviews	Assurance meetings updated with the removal of quarterly meetings. All Divisions Operational/Corporate to have a 12 monthly review, and Operational Divisions to also have a 6 monthly review.

Escalation Triggers updated and defined	Enhanced Monitoring is triggered if a minimum of 3 months of delivery is below standard/target which is unlikely to recover in year. Special Measures is triggered if there is no assurance the standards/ targets can be met within the year, or there is a lack of progress /engagement against the actions set
Triggers and Actions	Against each domain, there is a defined set of metrics
Actions	Updated actions that take place as a result of escalation with the inclusion of Independent Members in recovery and deep dive meetings as appropriate
Support	A section added to signpost to the relevant teams for support of information

Argymhelliad / Recommendation

The Board is asked to:

- Note the work and outcomes of the review.
- Note the recommendations from the review and for updating the Framework.
- Approve the updated Framework for submission to Board
-

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	007
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply All Health & Care Standards Apply Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
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 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 Improve the access, experience and outcomes of those who require mental health and learning disability services

	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)	
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	Yes, outlined within the paper
• Service Activity & Performance	Yes, outlined within the paper
• Financial	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements
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/	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 Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

Review of the ABUHB Performance and Accountability Framework (2023)

Introduction

Performance management and clear accountability is an integral component of supporting and assuring our organisational performance, and the delivery of safe and effective services.

The Performance Management and Accountability Framework (PMF) is in place to enable teams and individuals to align their objectives with overall ABUHB goals and delivery plans, embedding a culture of continuous improvement across our organisation.

In line with the national Planning and Performance Frameworks, the Integrated Medium-Term Plan 2025-2028, and national priorities, it is important to revisit and refresh the PMF to ensure relevance, effectiveness, and engagement.

In September 2023, the PMF was approved following recognition that the Health Board required an approach and clarity around the performance and accountability requirements, which needed strengthening, incorporating current good practice internally and reflecting best practice.

A review commenced in December 2024 to evaluate the implementation actions, gather feedback and wider opinion about the effectiveness of the current Framework in achieving its aims to monitor and improve organisational performance.

This report sets out the response to the comprehensive review and provides the recommendations along with a draft refreshed PMF based on the learning during this period. This report offers insights from this work, best practices, and recommendations to promote a culture of continuous improvement and accountability.

The Rationale for Refreshing the Performance Management Framework

The PMF was developed with engagement from the Board, Executive Team, and the Cross Divisional Leadership Group. When launched, the Framework set out the benefits anticipated to having a PMF, these included:

- Oversight and integration of approaches to addressing performance, strengthening “grip” on key issues, and learning from existing approaches,
- Providing a linkage from PADRs through to strategic objectives,
- Provide a mechanism to objectively assess risk and areas across organisation that need support and focus,
- Bring an appreciation of issues affecting delivery of operations closer to corporate teams and identifying any opportunities to support,
- Clarity and appreciation of the contribution of corporate teams to delivering statutory, strategic, and operational priorities,

- Improving alignment of performance across the organisation, including the new Quality Outcomes Framework.

The review has sought to understand if these benefits are being realised by the Organisation by having the Framework in place, and address areas that could further improve accountability and delivery.

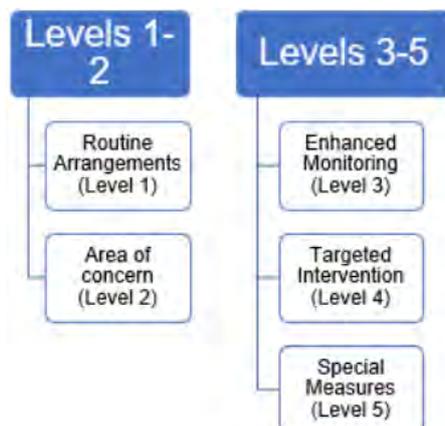
National Context

The Welsh Government Oversight and Escalation Framework – NHS Wales Organisations (Jan 2024 – updated July 25) [[NHS Oversight, Assurance, Escalation and Intervention Framework](#)] sets out the process by which escalation levels are considered, triggered, and responded to. The escalation levels are considered by tripartite meetings twice yearly between Welsh Government officials, Audit Wales, and Healthcare inspectorate Wales (HIW).

The 6 national escalation domains are defined as:



There are 5 national escalation levels as per below:



In February 2024, the Health Board's escalation levels were increased from Enhanced Monitoring (level 3) to Targeted intervention (level 4) for planning and finance and from routine arrangements (level 1) to Enhanced monitoring (level 3) for performance and outcomes related to urgent and emergency care at The Grange University Hospital.

In July 2025 following assessment and consideration of progress against the de-escalation criteria, it was confirmed a change to the escalation status. Finance, strategy and planning were de-escalated from level 4 (targeted intervention) to level 3 (enhanced monitoring). The escalation levels are now as follows:

- Level 3 (enhanced monitoring) - Finance, Strategy, and Planning.
- Level 3 (enhanced monitoring) - Performance and Outcomes related to Urgent and Emergency Care Pathways at the Grange University Hospital Emergency Department.

Key Objectives of the Refresh and Approach

The refreshed performance management framework aims to:

- Review the understanding of the purpose and principles.
- Learn from the experiences of implementation and feedback since 2023, and if the Framework is still fit for purpose.
- Understand individual and collective understanding, does the Framework reflect the status of the organisation and understanding of accountability at all levels.
- Oversight arrangements – to understand the alignment between individual, team, and organisational goals and if the arrangements ensure timely follow up and intervention.
- Escalation – understand if the 3x3 model is fit for purpose and the triggers are understood, along with, if the support has been clear and effective.
- If the Framework promotes a culture of ongoing feedback and continuous improvement.
- Understand if it is appropriate to align to the national levels of escalation and domains.

To achieve the objectives for reviewing the PMF, the review was carried out in two parts:

1. Desk top review of evidence: evaluating if the agreed actions were implemented and the anticipated benefits have been realised.
This included:
 - a. Effectiveness of the accountability letters for Executive Directors and Divisions.
 - b. The planning cycle and delivery expectations alongside clear milestones and clarity on delivery mechanisms.
 - c. A review of the structured Quarterly Outcomes Report strengthened reporting and performance reviews.

- d. Review of escalation status at the 6-month Assurance Review.
2. Collection of direct feedback via:
- a. A survey,
 - b. Directly through feedback,
 - c. External audit,
 - d. Facilitated group sessions

The table below sets out the methods used to review against each of the anticipated benefits:

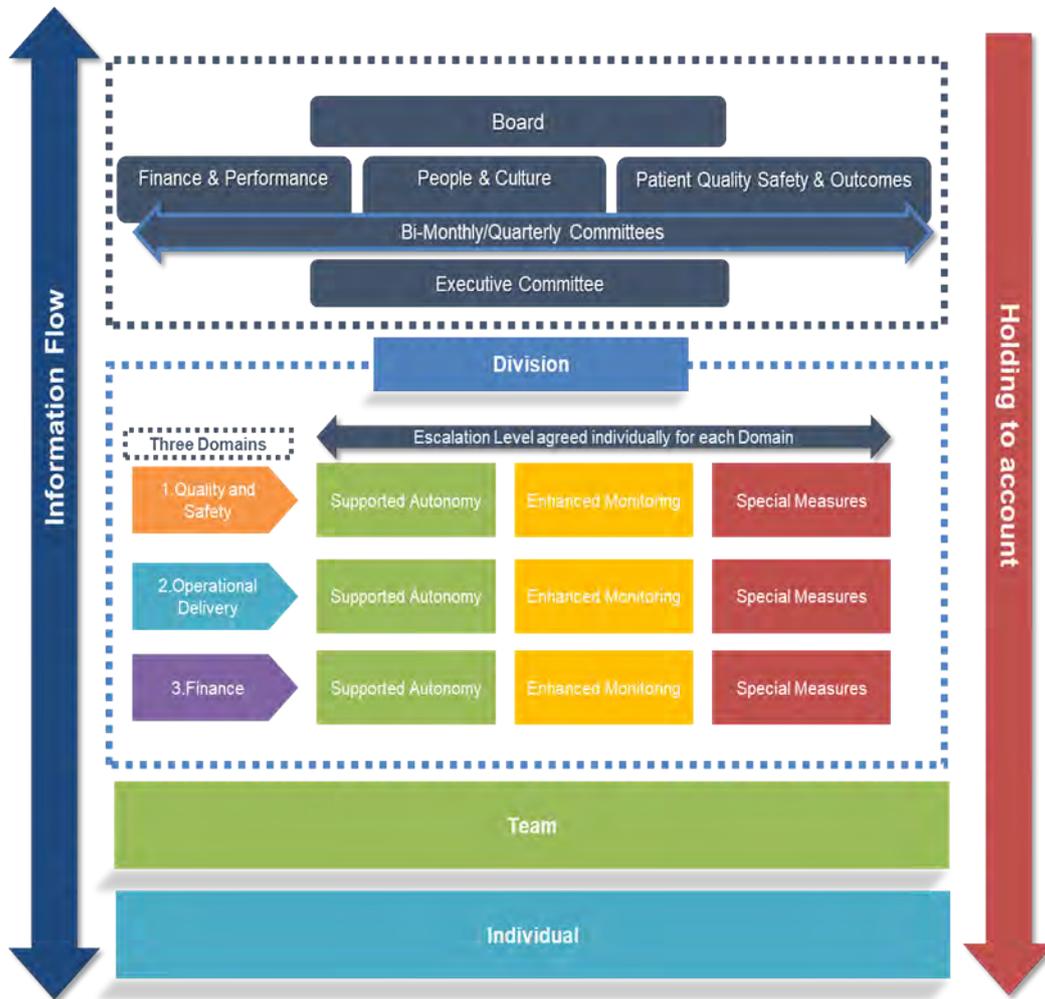
Benefits	How this was assessed
Oversight and integration of approaches to addressing performance, strengthening “grip” on key issues, and learning from existing approaches.	Outcomes and progress from Assurance Reviews and escalation meetings, Accountability letters, Feedback.
Providing a linkage from PADR’s through to strategic objectives.	Feedback.
Provide a mechanism to objectively assess risk and areas across organisation that need support and focus.	Outcomes and progress from assurance reviews and escalation meeting, Accountability letters, Quarterly reports.
Bring an appreciation of issues affecting delivery of operations closer to corporate teams and identifying any opportunities to support.	Outcomes and progress from Assurance Reviews and escalation meetings, Accountability letters, Feedback.
Clarity and appreciation of the contribution of Corporate Teams to delivering statutory, strategic and operational priorities.	Outcomes and progress from assurance reviews and escalation meetings, Accountability letters, Feedback.
Improving alignment of performance across the organisation, including the new Quality Outcomes Framework.	Outcomes and progress from assurance reviews and escalation meetings, Accountability letters, Quarterly reports, Feedback.

Context and Assessment of the Current Framework

The PMF supports the Health Board's strategic goals by tracking and improving performance to achieve better outcomes for patients and staff. It clearly outlines which metrics are monitored, how they are assessed, and the consequences of poor performance.

The design principles for the current Framework are integrated bringing together quality and safety, operational delivery, workforce, finance, public health, and planning.

How information and accountability is implemented is set out below using a 3 x 3 model for escalation and assessment against 3 domains, Quality and Safety, Operational Delivery and Finance.



The PMF allows for consideration of escalation levels to occur at any time in line with triggers in the same section. However, as a minimum, a formal review of status has occurred every 6 months.

The end of year reviews are completed from mid-June and the Executive Committee consider current escalation levels informed by:

- Outcomes of 12-month reviews,
- In year delivery and management of risks,
- In year delivery of financial plan.

A Division in escalation must meet certain criteria to be de-escalated which is evaluated at the 6 months/12-month review points.

Results of the review

Part 1- Desk top review

PMF Implementation actions - evidence of adoption and implementation

1. Accountability letters for Executive and Divisional Directors

The 25/26 planning cycle is the third year of issuing accountability letter to Executive Directors and Divisions that cover more than just delegated budgets. These accountability letters include:

- Individual objectives for the planning cycle.
- The key relevant IMTP targets and performance ambitions. The measures are aligned to the IMTP measures and include the escalation and ministerial priorities.
- The workforce expectations and targets for the workforce directorate in line with IMTP expectations.
- The budget delegation and delivery expectations including the contribution to the savings requirement for the planning cycle.
- The contribution to wider system change required to support sustainability across the Health Board.
- To capture the full expectations from the IMTP, delivery requirements are also included as an appendix. These commitments are submitted as part of the minimum data set, as part of the issued national planning framework to capture the planned activity and triangulate to workforce, finance, and activity. This action also linked to escalation criteria set out in the Planning Maturity Matrix.

The letters are prepared by the Planning Department and agreed for issue by the respective Executive Director. The same format used for the executive accountability, is used for the Divisional accountability and supported by the Planning Team and issued by the Chief Operating Officer's Office.

In 2024 the timing for the Divisional accountability letters were issued at the same time as the 12-month reviews in August, with the Executive letters circulated in June. This did result in a heavy administration burden for both Corporate and

Divisional teams. It was noted through feedback that initially the understanding of accountability/performance ambitions/ delivery commitments was confusing.

The letters were issued later than intended due to operational pressures and leave, and require considerable time required to bring together and check, balancing demanding operational pressures at the time. For 2025, there has been similar pressures experienced, and they will be circulated again in August.

2. The planning cycle to be more explicit about delivery expectations alongside clear milestones and clarity on delivery mechanisms

A review of the 23/24 and 24/25 planning cycle was undertaken with Executives and Divisions. This resulted in a refreshed approach to the Annual Planning process which included:

- A new governance structure.
- Bringing together all elements into an integrated framework.
- Agreed top priorities supported by commitments and parameters. These have been aligned to the commitments set out in the 3-year road map through the integrated framework and ensured:
 - Greater understanding of staff in post and variable pay usage.
 - Greater understanding of core activity and efficiency opportunities.
 - Develop divisional plans to achieve financial sustainability.

The mechanism for ensuring assurance against Annual Plan/IMTP and accountability letters has been through monthly, 6 monthly Executive led reviews and yearly assurance review meetings taking place.

The format of the reviews has changed over the period with a standard agenda and data pack. Reviews during the most recent cycle were reduced to an hour to support operational delivery over the winter period. These meetings have been supported by a standard agenda and a set slide deck to ensure consistency. The administration of the meetings and capturing of the actions is supported by the Planning Team and the wider Business Partnering Team, this has maintained alignment with the accountability set out in the Annual Plan/IMTP.

Whilst escalation can happen at any point, the Executive Committee have reviewed the escalation levels formally every 6 months line with:

- Outcome of 6 and 12-month reviews,
- Operational delivery,
- Consideration of any prevailing quality concerns (HIW etc),
- Financial position,
- Any national escalation of services.

It was noted that in line with expectations:

- Escalation levels were accordingly discussed and amended.
- Formal reports to Finance and Performance Committee were made in a timely manner.
- In addition, the Divisions of Mental Health and Urgent Care have both been subject to higher levels of escalation for the domains of Quality and Operational Performance. Mental Health was in Special Measures at the time of launching the PMF (Sept 23) and in August 24 was de-escalated to Enhanced Monitoring.
- Additional leadership resource was deployed to support Division de-escalation and the Improvement Plan, overseen via a Director of Nursing fortnightly meeting.
- The Urgent Care Division was escalated to internal enhanced monitoring in January 2024. Shortly after in February 2024 the ED service in the Grange was escalated by Welsh Government.
- Progress against national escalation metrics has been overseen via COO led weekly Safety Flow meeting with monthly reporting to Welsh Government
- All Divisions have at some point since the PMF been in escalation for finance in line with triggers.
- In response to this escalation a number of cycles of special budgetary meetings have taken place

3. Reporting

In year review of the structured Quarterly Report strengthened reporting and performance reviews.

The existing Quarterly Report has undergone ongoing iteration and improvement. A new quarterly integrated reporting format has been agreed for the Board to include an interim set of quality metrics. This is linked to a monthly briefing for Executives which has been aligned to other national reporting asks such as JET, IOPD, Escalation and TI meetings. This report will be further developed in line with the revised Quality Outcomes Framework when available.

4. Other areas of progress and focus

- Executive Director accountabilities and portfolio leads have undergone review, led by the Director of Corporate Governance.
- The Board has approved a Quality Assurance Framework, including the establishment of the Quality Management Group.
- In line with national escalation, cascading of budget holder training and governance checklists

Part 2 Engagement and Feedback

Facilitated Sessions

A number of facilitated sessions were held including:

- Executive Team
- Clinical and Divisional teams (Cross Divisional meeting)
- The planned session with the Independent Members had to be cancelled due to unforeseen reasons and an opportunity to feedback virtually was provided.

Executive Time Out Session

An Executive time out Session was held covering all aspects of implementing the Framework. The following recommendations were made as a result of the session:

- Quality measures to be reviewed for assurance and escalation.
- Extra escalation domain to be added for leadership and corporate governance.
- Triggers for escalation and de-escalation to be reviewed and updated.
- Clarity on roles and responsibilities at all levels to be reviewed.
- Quarterly reviews to be removed – Operational Divisional Assurance to be continued monthly with an escalation review in 6th month with Executives.

Cross Divisional Time Out Session and Time at Divisional Management Meetings

A further timeout session was held at cross divisional and individual team management meetings which resulted in the following recommendations:

- A need for consistency, clarity, and support what is required for implementation, and the understanding the importance to addressing barriers to accountability.
- Support provided by Business Partners in Finance, Planning, and Workforce, highlighting the challenges of limited capacity and the need for better integration and support for Divisions.
- A need for clear criteria for escalation and de-escalation in the escalation framework, as well as sufficient support for divisions in understanding and managing the process.
- The Quality and Patient Safety metrics are not clearly defined, the levels need to be defined clearly in terms of trigger points, the current definitions make it difficult to have a consistent approach.
- Schemes approved that are not funded, Divisions should not fall into accountability with financial elements of the PMF and further flexibility is needed in this area and proportional to delivery areas.
- Many areas of reporting can support information flow for accountability but are parallel processes to Divisional accountability process e.g. Quality and the Health and Safety agenda should look to be streamlined.

- Operational Divisions feedback it is helpful to have a structured approach; however performance is often concentrated on particular areas, and it is difficult to maintain approach across the board due to firefighting/ministerial priorities.
- Underperformance in some areas is related to shift of resources to other areas.
- Improving ownership and transparency of performance is essential and while offered in framework as “additional local measures”, this could be incorporated into the accountability letters so a formal approach in the Division’s response.

Independent members – Virtual Feedback

- The principles and purpose of the PMF were understood and need to remain.
- Whilst not explicitly drawn-out further clarity is required in respect of the flow of all performance and outcomes information for escalation and expectations.
- There should be the opportunity for Independent Members to observe and provide scrutiny and support sessions for those Divisions in escalation.
- A response to escalation should be for teams to be invited to committees, with relevant Director to update on improvement plan progress.

Internal Audit

An internal audit (Appendix 1) of Aneurin Bevan University Health Board’s Performance and Accountability Framework (PMF) reporting in May 2025 (June Audit Committee) and provided “reasonable assurance” on the framework’s adequacy and implementation, while identifying areas for improvement and full execution. The following recommendations were provided:

- Framework review overdue: The PMF was formally approved in September 2023 but was overdue for its annual review at the time of audit; a full review is underway to update and align the framework with current practices.
- Escalation implications need clarity: The framework includes escalation arrangements but lacks explicit detail on the consequences across Quality & Safety, Operational Delivery, and Finance domains.
- Resource burden significant: The current performance review processes demand substantial senior staff time and administrative effort, with some Executives delegating attendance.
- Timing of reviews requires adjustment: End-of-year and six-monthly reviews are conducted later than scheduled, impacting timely target setting and reporting; efforts are planned to ensure earlier completion and prompt issuance of accountability letters.
- Corporate Team reviews not conducted: Despite being part of the framework, Corporate Team Assurance Meetings have not taken place in 2024/25; decisions will be made to either reinstate or remove this requirement.
- Deep dive reviews absent: No deep dive reviews have been performed since framework implementation; a schedule for 2025/26 deep dives has been established to better understand risks and corrective actions.

- Delayed committee reporting: Reports to the Finance and Performance Committee on six-monthly and end-of-year reviews are received four to five months late, hindering effective management decisions; improving timeliness

Survey and Direct Feedback

A Survey was circulated via MS forms and email to Operational Divisional Management, Clinical Leaders, Corporate Leadership and Business Partners.

The response rate was 11% of which the majority of respondents (68%) were from Corporate Teams. The smallest response rate was from Operational Divisions, however there were a number of face-to-face facilitated sessions held with operational teams through Cross Divisional, Senior Leadership Group and Divisional Management Team meetings about the review. The survey was split into five themes with a mix of open and closed questions:

1. Understanding and clarity
2. Accountability - Personal and conditions,
3. Escalation,
4. Assurance Review meetings
5. Performance information:

A summary of the responses are as follows:

SECTION	RESPONSE MEASURES	FEEDBACK
1. Understanding and clarity	92% of respondents felt they understood the purpose of the PMF.	<i>18-page document is too long, Diagrammatic representation is too complicated, more accessibility and simplicity is requested through simplifying and consolidating documentation</i>
2. Accountability – personal and conditions	69% felt having a PMF supports understanding of personal accountability, and the conditions attached. 65 % stated accountability conditions were included in their PADR's.	<i>The framework is overly document-heavy and embedded in a culture of excessive paperwork. It is not always clear what is meant by accountability, this could be clearer i.e. what happens if the requirements are not met Clarifying levels of accountability will help with linking performance to patient impact. Where there are cross divisional responsibilities and interdependencies</i>



		<p><i>the accountability is open to interpretation.</i></p> <p><i>Through the accountability conditions it would be better if this could be clearer from the outset.</i></p> <p><i>We are still prioritising everything, can we capture clear priorities to truly focus on as there are multiple exec boards making decisions that impact on delivery /spend/development.</i></p>
3. Escalation	<p>There was a mixed response regarding escalation highlighting concerns about consistency and equity with responses weighted rated slightly towards not understanding the process or reasons for escalation or the triggers.</p>	<p><i>Escalation is not always perceived as supportive.</i></p> <p><i>There is lack of guidance on how to improve or change or how to de-escalate.</i></p>
4. Assurance Review meetings	<p>The feedback about the value of Assurance Meetings and Accountability Letters was mixed this suggests mixed perceptions of their effectiveness in clarifying accountability.</p> <p>55% felt the meetings were effective however comments for improvement requested faster production of the outcomes and circulation of the actions which are tracked and followed up.</p>	
5. Performance Information:	<p>The comments about the availability of performance information linked to the accountability conditions, highlighted a number of areas for improvement.</p>	<p><i>More competent system management and clearer support mechanisms.</i></p> <p><i>Please can Planning provide support in accessing and interpreting data.</i></p> <p><i>I think equity of approach across the whole organisation is critical for people to engage with this. I think some of our systems and processes cut across performance management which either dilutes and or confuses accountability.</i></p>

Emerging Themes

Through the comprehensive review internally and externally it is recognised the 2023 PMF would require review and iteration, as supporting components were developed and learning through application.

The review of actions has shown that the arrangements required to implement the PMF have mostly been met in line with the expectations which included:

- Accountability letters for Executive Directors.
- Accountability letters for all Divisions, alongside the same model.
- The planning cycle and governance review was more explicit about delivery expectations alongside clear milestones and clarity on delivery mechanisms.
- An in-year review of the structured Quarterly Outcomes Report strengthened reporting and performance reviews.
- Review of Escalation Status at the 6-month Assurance Review and at 12 months has been carried out and implemented in a timely manner.

The following themes were noted for consideration:

Understanding

- The importance having a PMF is understood, recognised and supported.
- The priorities and principles are understood and remain current.
- Lack of understanding of the triggers for escalation and escalation.
- Proportionality of triggers at all levels along with de-escalation was not clear.

Process

- There is risk to cultural acceptance and understanding if there is not clarity of expectations.
- Bureaucracy over improvement is a concern through the implementation.
- Timeliness of the accountability letters potentially hampers understanding of accountability.
- Lack of assurance processes in place for Corporate Departments.

Support

- Lack of the use of deep dives to understand issues and put in place corrective actions.
- A review of the length of Assurance Meetings.
- Assessment of the workload against the timeline of certain Executives to implement and agree the accountability conditions, notably the COO.
- The appropriate escalation response needs to be reviews and how this is supported by independent members.

Assessment of implementation against the expected benefits:

Benefits	Assessment
Oversight and integration of approaches to addressing performance, strengthening “grip” on key issues, and learning from existing approaches.	Through having a Framework in place, there was evidence of issues being highlighted and addressed, and this learning fed into future Assurance Meetings and actions.
Providing a linkage from PADR's through to strategic objectives.	There was evidence of accountability conditions included in PADR's, the extent thou could not be determined to truly assess impact.
Provide a mechanism to objectively assess risk and areas across organisation that need support and focus.	The PMF has provided an evidence base to assess status and performance, the understanding of escalation and risk could be robustly evidenced.
Bring an appreciation of issues affecting delivery of operations closer to corporate teams and identifying any opportunities to support,.	Through the Assurance Meetings, accountability conditions and reviews issues are being highlighted, however the volume of information and time to issue the responses meant sometimes this was confusing.
Clarity and appreciation of the contribution of corporate teams to delivering statutory, strategic and operational priorities.	This benefit could not be clearly evidenced as being in place however the changes to the planning process governance and external audit would imply this has been implemented.
Improving alignment of performance across the organisation, including the new Quality Outcomes Framework.	The review of the planning processes, Assurance Meetings and reviews have shown consistency of approach and understanding. The QOF however has been in development for the period of this review and therefore could not be evidenced.

Recommendations

The following recommendations for revisions are made based on the review:

Recommendation 1 - Board and Independent Member involvement in implementing the Framework

The involvement of independent members in the escalation process would further strengthen support for improvement and actions and is aligned to the national intention for greater transparency in escalation processes from September 2025. Practically this means that teams in escalation may be invited to attend relevant Committees to update on improvement plans. Including the relevant Executive Director in this will be critical.

Recommendation 2 - Alignment with organisational direction and strategy

The process for agreeing and communicating accountability conditions aligned with the IMTP should remain with a review of the time taken to produce and circulate to Divisions. A clear timeline should be agreed and included in the accountability conditions for Divisions supporting this process.

Recommendation 3 - Triggers and escalation

The triggers for escalation should be revised with new domains added for leadership and corporate governance. De-escalation criteria should be clearer and communicated at the time of escalation with a clear timeframe for review. The domains should remain locally defined and not aligned to Welsh Government framework because they are well understood. The level of escalation should be proportional and within the scope of delegation of the Division.

Recommendation 4 - Enhanced feedback mechanisms balanced with resource availability

The assurance meetings should be streamlined, with an annual in depth review every 12 months for all Divisions and a 6-month review for Operational Divisions. Quarterly reviews should be removed Operational Divisions should have monthly assurance reviews with a streamlined agenda.

Recommendation 5 - Quality metrics

The measures for quality and reporting should be reviewed and streamlined for all assurance meetings aligned with the new QOF, Integrated Performance Report and Quality Management Group structure

Recommendation 6 - Format

The content PMF should be revised and streamlined to provide clearer information and expectations, local arrangements should be aligned with the PMF, this was noted as already in place in Primary Care.

Recommendation 7 - Deep Dives and Recovery meetings

The use of deep dives and/or budget recovery meetings should be established and implemented to support understanding risks and corrective actions.

Conclusion

In summary, the review found there was widespread understanding of the PMF and its need with extensive application.

There were improvements noted as required for timeliness, clarity of escalation and support requirements. The recommendations as a result of the review, collectively support a more coherent approach to assurance, strengthening the understanding of the triggers and actions.

By aligning review mechanisms with operational needs, redesigning the documentation, refining quality metrics, and implementing deep dives clarity about accountability, and responsiveness can be provided.

Appendix 1 - Internal Audit Report: Performance and Accountability Framework



ABUHB-2425-05
Performance Framev



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



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

Performance Management & Accountability Framework 2025

Document Control:

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For Use By:	Internal use for Health Board

Version History:

Version	Date	Author	Reason and changes
V0.1	12 June 2023	Hannah Evans	First draft for initial testing (COO, DCOO, DoF, Director of Corporate Governance)
V.0.2	July 23	Hannah Evans	Second draft following initial comments – shared to inform Executive Development session
V.0.3	5 Sept 2023	Hannah Evans	Version shared with Executive Committee for 14 Sept meeting
V.1	18 Sept 2023	Hannah Evans	FINAL VERSION (1) for Board
V.1.1	3 rd September 2025	Trish Chalk	Refresh following review – Executive team 11 Sept
V.2		Trish Chalk	Final DRAFT of Version of refresh

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1	Introduction
2	Aims and Principles
3	The Performance & Accountability Domains
4	Roles and Responsibilities 4.1 Board and Committees 4.2 Executive Committee 4.3 Division /Directorate 4.4 Mid Year and End of Year Reviews
5	Governance and Reporting
6	Escalation Processes 6.1 Escalation Processes 6.2 Triggers and Actions 6.3 Meetings: Reviews, Recovery and Deep Dives
7	Timelines and actions
8	Support and Resource
	Appendix 1 Summary table of metrics, triggers, actions and support by domain



1. Introduction

Our Approach

The Performance Management and Accountability Framework (PMF) sets out our approach to performance management and improvement. Its purpose is to support teams and services to be clear on and then meet delivery expectations and improve outcomes for patients and staff.

The PMF sets expectations at all levels and outlines performance monitoring and management processes along with what support is available to drive improvement and focus on what is important for our staff and patients.

This framework applies to our whole organisation. Aligned with our values, kindness, integrity and respect recognising everyone has a role to play in identifying opportunities for improvement, and in enacting them to improve outcomes and health for patients, staff and our population.

The PMF aligns with existing corporate governance documents such as the Standing Financial Instructions and the Scheme of Delegations.

Performance and Accountability across 5 domains:

1

Quality & Safety

2

Leadership

3

Corporate Governance

4

Finance

5

**Operational Performance
& Delivery**

2. Aims and principles

The PMF is designed to support a culture of continuous improvement for the benefit of patients, communities and staff and is intended to provide:

- **Clarity** on the performance management and accountability arrangements, and roles and responsibilities at all levels within our organisation.
- The metrics and trajectories by which performance is assessed against and **aligned** to the NHS Wales Performance Framework and Planning Framework.
- Provides alignment and **integration** between quality, performance, planning, workforce, risk management and finance to identify areas of improvement.
- Provide an **opportunity** to listen and learn through our assurance processes to enact change to improve our services and patient experience.

The key principles underpinning approach:

Transparent and Mutually Agreed

- Expectations and accountabilities clearly set out
- Performance targets and measures clear in escalation and de-escalation
- Positive performance recognised and support to understand expectations
- Accountability and performance arrangements aligned to PADR's

Integrated and Comprehensive

- Accountability and performance arrangements will be integrated covering Quality and Safety, Workforce, Performance and Finance data sets
- Performance delivery will be aligned with national IMTP accountability conditions, escalation status (where relevant) and benchmarking.

Improvement Focused

- Accountability and performance arrangements will support the development of a culture of continuous performance improvement
- Services identified as falling short on delivery will be supported through the escalation framework via a suite of possible responses

Proportionality and Balance

- Accountability and performance arrangements will ensure that interventions and actions are proportionate
- Balance the burden of reporting and providing assurance to delivery the best outcomes for patients and staff

Empowerment and Delegation

- Foster a culture of accountability, through staff empowerment
- The structure will nurture collaboration and transparency to solve problems to optimise delivery.
- Greater support will be offered to make improvements through the agreed escalation process.

3. The Performance and Accountability Domains

The Performance and Accountability domains, though distinct in their focus, are interdependent to encompass the structures, processes, ownership and behaviours to improve performance and accountability from individual to organisation. Robust performance and accountability leads to outcomes that are demonstrable and sustainable with a commitment to continuous improvement.

Performance and Accountability will focus across 5 domains:

1

Quality & Safety

Focuses on quality assurance which measured through a range of quality and safety metrics aligned with the Quality Outcomes Framework e.g. patient safety incidents, complaints, medical examiner issues, Duty of Candour, deteriorating patients, infections and patient satisfaction

2

Leadership

Assesses the effectiveness of leadership in place to ensure the organisation is well led at all levels. Evaluates against a number of key metrics as well as staff and employer experience.

3

Corporate Governance

Assesses the effectiveness of quality governance, risk management, audit and inspection compliance, and decision-making processes. Escalation levels are determined by consideration across audits, risk management, meeting effectiveness and the timeliness of policy updates

4

Finance

Focuses on financial performance, including in year and forecast overspend, budget management, savings plans and the financial governance and processes. Escalation levels are determined by the extent of overspend, the robustness of financial plans, and the effectiveness of savings initiatives

5

Operational Delivery

Evaluates performance against key targets and agreed improvement trajectories. Escalation levels are determined by the extent of underperformance and the effectiveness of recovery plans.

4.1 Boards and Committees

The role of the Board is to:

- Set the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the health boards performance across all areas

The role of the Committees are to:

- Provide the challenge and scrutiny on elements of performance within this remit, for example financial performance delivery sits with the remit of the Finance and Performance Committee

Performance reporting is undertaken for all domains through the Assurance or Committee meetings and against the Health Board's integrated medium plan. These performance reports provide Welsh Government, Board, Quarterly Committees and Executive Team assurance on our organisational performance.

Reporting Mechanisms		
	Board	Committees:
		<ul style="list-style-type: none"> • Finance & Performance, • People & Culture • Patient Experience, Quality and Safety Committee • Audit
Report	Integrated Performance Report Financial report	<ul style="list-style-type: none"> • PMF update • Quality Outcomes Framework (QOF) • Performance Report • Finance Report • Workforce Report • Deep dives as required
Purpose	Monitors progress against strategic objectives' performance objectives, risks and outcomes	<ul style="list-style-type: none"> • Tracks delivery against agreed plans (IMTP or recovery) • Monitors the application of the PMF • Quality and Safety Outcomes • Areas in escalation
Frequency	Every Board	<ul style="list-style-type: none"> • QOF - Quarterly • PMF - 6 monthly • Monthly for areas in escalation

4.2 Executive Committee

Role of the Executive Committee

The Executive Committee, led by the Chief Executive, offers a platform for the Executive Team to deliberate on strategic or operational issues before, when appropriate, referring them to the Board or its Committees.

A focused performance session is held on a monthly basis with detailed discussion on performance across all of domains. Deep Dives and issues by exception or for services or teams in escalation at received on a more frequent basis as required. Members of the Executive Committee review performance reports and address any unresolved issues at the local level.

The Executive Committee evaluates Divisional performance reports to determine whether any performance deviations are minor or significant according to the Health Board's escalation procedures outlined above.

The Executive Director for Planning, Partnerships and Performance is the Executive Director with responsibility for establishing and managing the performance framework.

Each Executive Team member is responsible for delivering their performance targets within their respective Divisions /Directorates.

The Executive leads for each of the 5 domains :

Domain Leads

Quality & Safety:

Director of Nursing, Quality and Patient Experience

Leadership:

Director of Workforce and Organisational Development

Corporate Governance:

Director of Corporate Governance

Finance:

Director of Finance

Operational Delivery:

Chief Operating Officer



4.3 Division/Directorate

Role of the Division/Directorate

This PMF requires Divisions and teams to implement their own local performance reporting and management systems.

The expectation of this PMF is that they meet regularly with service leads, monitoring performance, implement good governance and working with staff to unblock issues and drive forward improvements.

Each Division/Directorate is expected to:

- Set clear goals and objectives aligned with Health Board strategic objectives .
- Identify the metrics how they will do this.
- Identify and mitigate risks affecting delivery
- Regularly meet to check progress and address issues together.
- Collaborate across to resolve issues and areas for improvement.
- Through Divisional Assurance mechanisms assess progress.

Divisional Assurance for Operational Divisions occurs monthly and should cover metrics in the 5 domains, twice a year there is a Chief Executive lead review, and escalation status is reviewed following these reviews.

Should separate, more detailed finance (or other) discussions be required, these will be agreed through the assurance review process using the escalation options.

There is an expectation that the reviews will build on the historical reporting to look ahead on a rolling quarterly basis and define the actions to ensure performance is delivered and where relevant recovered from any position of variance.

	Operational Monthly Assurance
Report	Divisional Assurance Slide deck – covers all domains of this PMF. Report out of each Assurance Review with themes and actions shared with Executive team
Purpose	Monitors progress performance objectives, risks and outcomes against the 5 domains and aligned to the accountability conditions
Frequency	Monthly

4.4 Mid Year and End of Year Reviews

Role of the Mid Year and End of Year Review

This PMF applies to the whole organisation

Mid year and End of Year Reviews for Operational Divisions will be chaired by the CEO with all Executives in attendance.

Reviews will focus on delivery against the 5 domains will be supported by agreed action notes and a formal letter from the Chair of the meeting.

Each of the Corporate Divisions will have an End of Year Review to cover off the areas of their portfolio as agreed in the scheme of delegation and delivery against key metrics in the 5 domains.

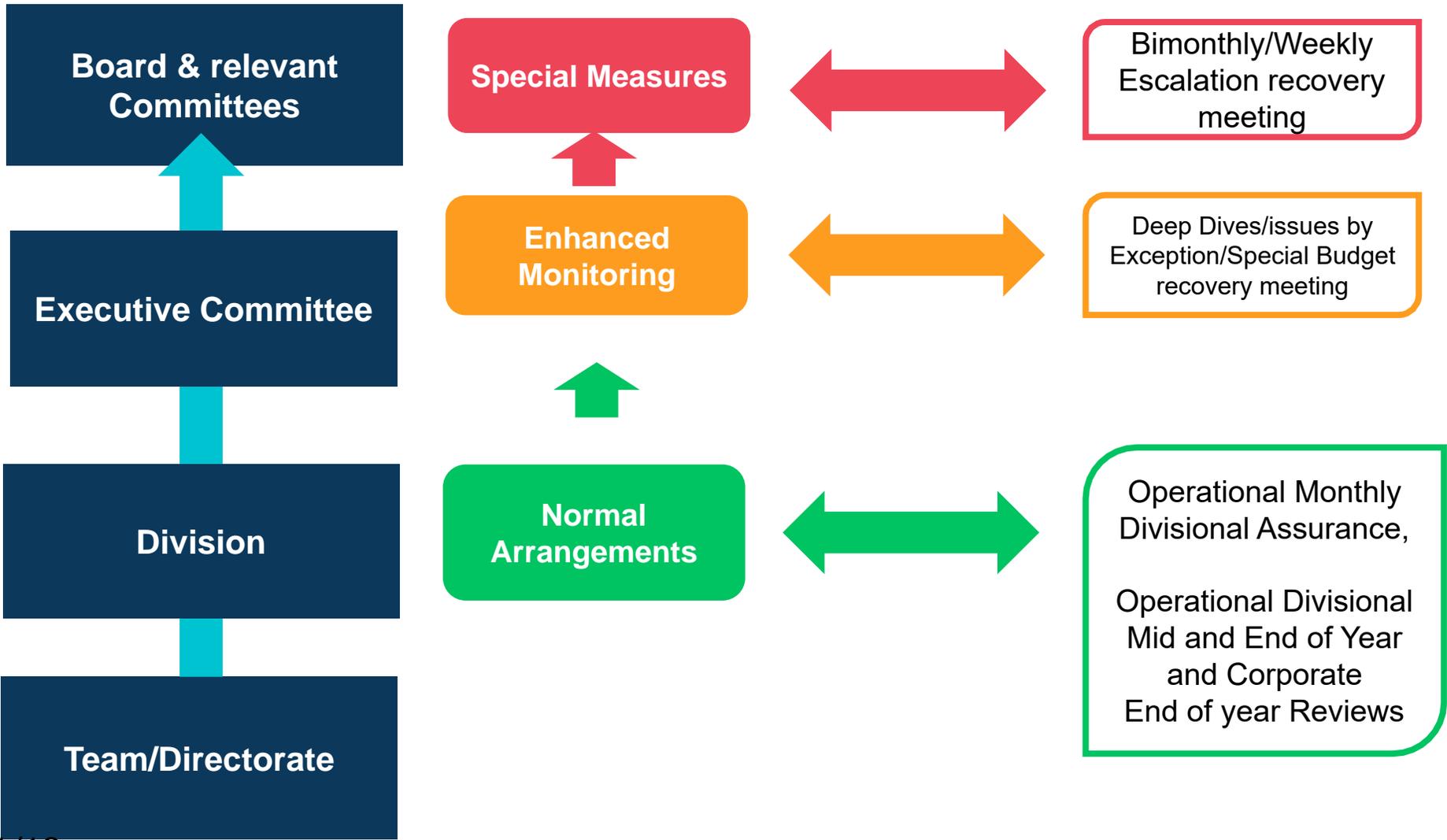
Corporate reviews will focus on key objective delivery and financial, workforce and other areas of performance and will be supported by agreed action notes and a formal letter from the Chair of the meeting.

	Mid Year and End of Year Review
Report	Standard side deck covering key achievements, risks and forecasts against the 5 domains
Purpose	Monitors progress against strategic objectives, performance expectations, risks and outcomes against the 5 domains and aligned to the accountability conditions
Frequency	6 monthly for operational divisions Annual for corporate teams



5. Governance and Reporting

The following diagram shows how the Framework assurance mechanisms feed into the escalation arrangements and management structures. The principal mechanism for assessing performance and agreeing actions to improve performance will be assurance and review meetings. The arrangements for these meetings are set out in the following slides below for both operational Divisions and Corporate Directorates, along with the escalation mechanisms



6.1 Escalation Processes

The PMF is predicated on the principle that, wherever possible, issues should be resolved at individual, team, Division or Corporate Directorate level and that Divisions and Corporate Directorates should work collaboratively and be mutually supportive in line with our values. Escalation should be very much the exception and that, where it is necessary, proportionate and appropriate support and intervention takes place at the earliest opportunity to ensure performance remains on track to achieve our objectives. The lead Director for each domain will provide a view on the escalation levels which will be ratified at the Executive meeting against the following criteria:

	Quality & Safety	Leadership	Corporate Governance	Finance	Operational Delivery
Triggers	<p>Limited or no assurance that the Division can meet prescribed targets/standards N^o within a 3-month rolling period</p> <p>N^o of actions not completed within the stated action plan</p> <ol style="list-style-type: none"> 1. PTR volume / compliance 2. NRI volume / compliance 3. Increase in number of patient incidents resulting in harm 4. N^o of reg 28s / inquests 5. Progress of actions from Reg 28's 	<p>Limited or no assurance that the Division can meet prescribed targets/standards for the following areas:</p> <ul style="list-style-type: none"> • Employee relations cases • PADR Completion • Mandatory training • Overdue pay progressions • Rosters & job plans (includes agency use) • Staff Survey Feedback 	<p>Limited or no assurance that the Division can meet prescribed targets/standards</p> <p>Continued failure to respond /maintain in more than 1 key deliverable/area:</p> <ul style="list-style-type: none"> • Risk management • Audits/ inspections responses • WHCs/ Ministerial Directives • Governance arrangements • Policies in/out of date • Freedom of information and MS/MP responses 	<p>Limited or no assurance that the Division can meet prescribed targets/standards within the year</p> <ul style="list-style-type: none"> • Where divisional level budget is forecast to overspend by more than £1m through monthly financial reporting • Where corporate level budget is forecast to overspend through monthly financial reporting 	<p>Limited or no assurance that the Division can meet prescribed targets/standards against the accountability conditions within the year</p> <ul style="list-style-type: none"> • Out of seasonal range performance for more than a minimum of 3 months • Off track performance against forecast for more than a minimum of 3 months

Normal Arrangements

Reasonable assurance that the Division can meet agreed targets, standards and expectation in a given domain within the

Enhanced Monitoring

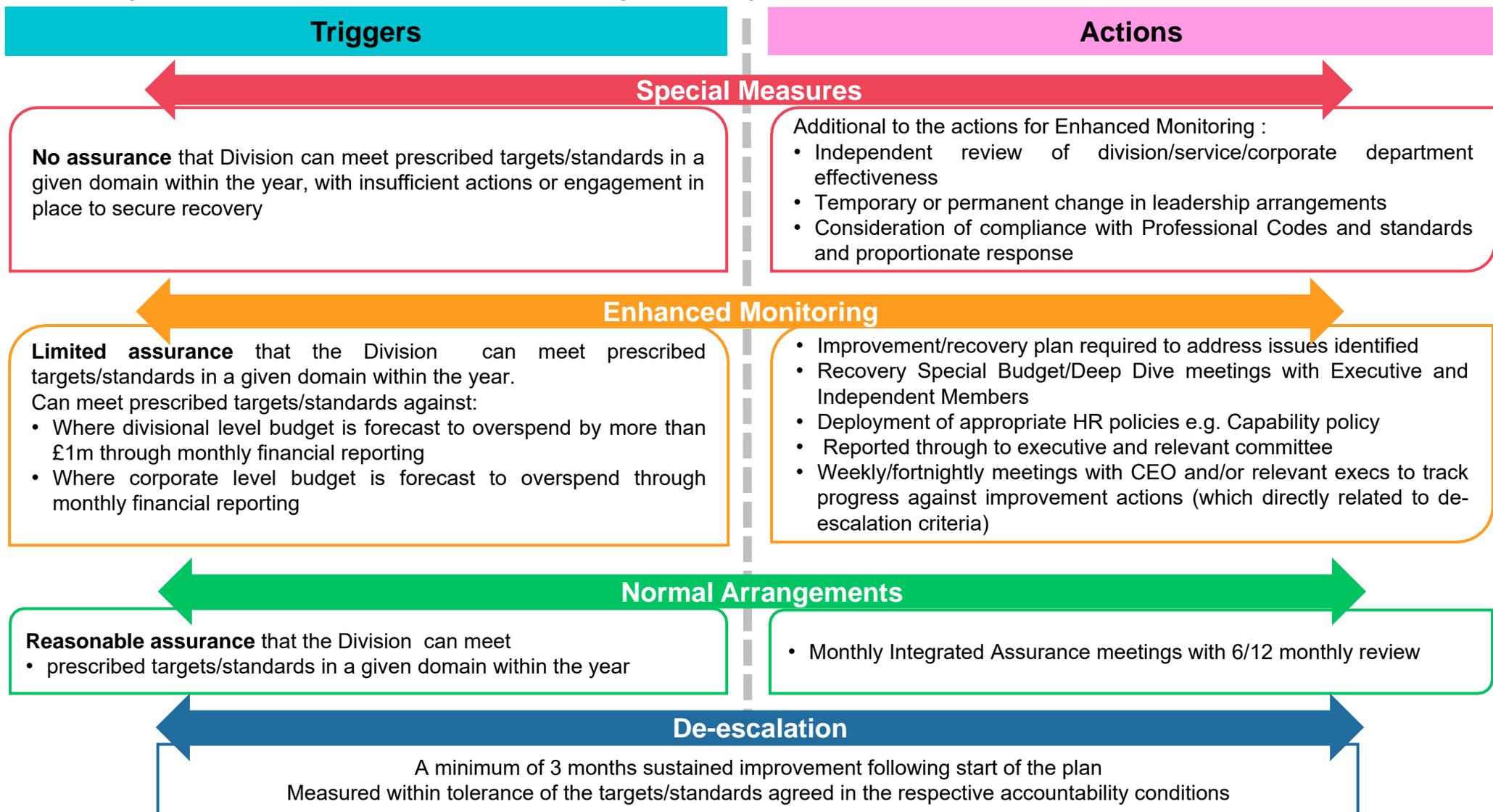
Minimum 3 months of delivery below required standards/targets and limited assurance these can be met within the year

Special Measures

No assurance that the required targets/standards can be met within the year, with insufficient actions or engagement in place to secure recovery

6.2. Escalation Processes – Triggers and Actions

The PMF allows for consideration of escalation levels to occur at any time in line with triggers. However, as a minimum, a formal review of status has occurred every 6 months. Every 6 months, the Executive will review the progress of each function against the key metrics and through the 6 months assurance meeting and end of year review, the actions set out below are proportional to the level along with the criteria for de-escalation set and agreed through the actions.



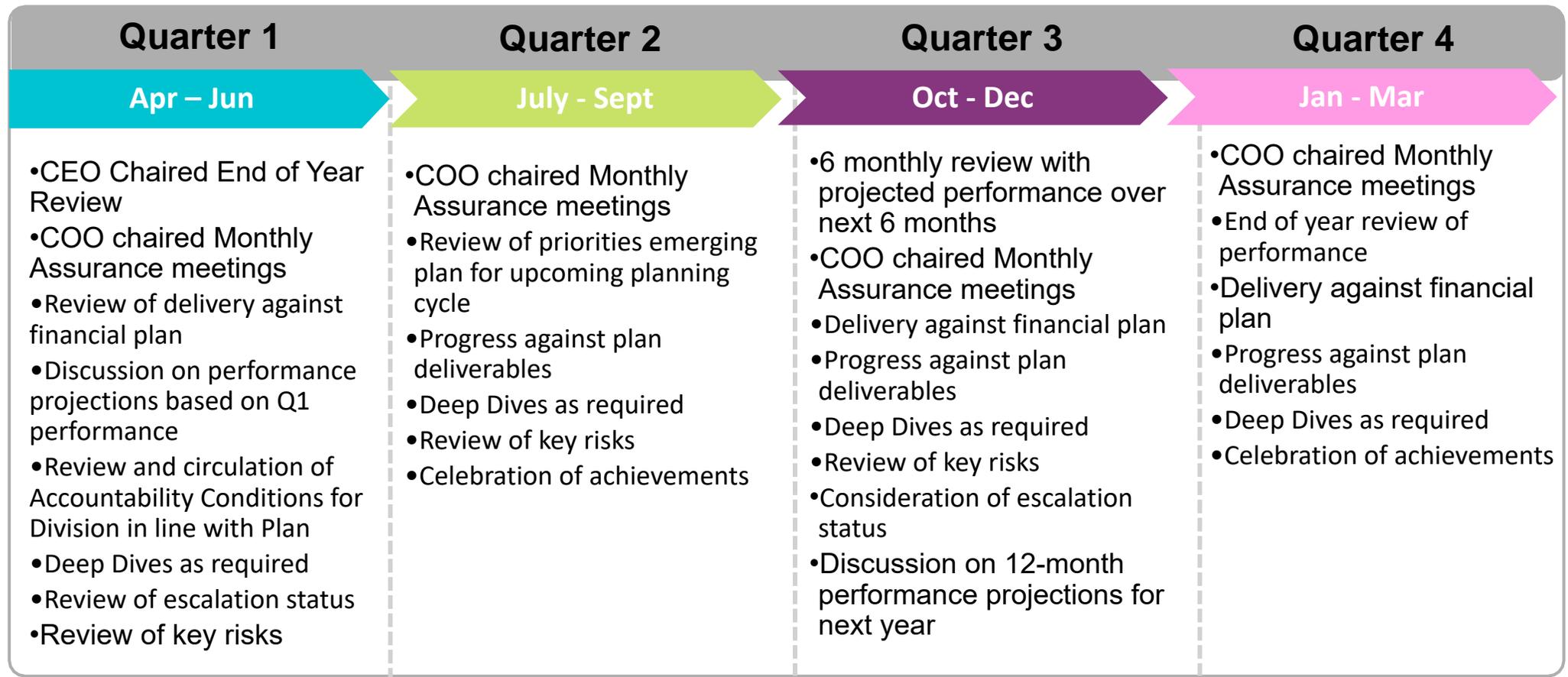
6.3. Meetings: Reviews, Recovery and Deep Dives

The table below sets out the minimum metrics, attendance and frequency for meetings at each level of escalation

	Normal Arrangements		Escalation		
	Monthly Assurance and 6-month review	End of Year Review	Recovery	Deep Dive/Special Budget	
Metrics	<ol style="list-style-type: none"> Performance - Accountability Conditions Variable Pay and Agency spend Cost Pressures Savings progress Employee relations cases Sickness Turnover PADR Completion Mandatory training Overdue pay progressions 	<ol style="list-style-type: none"> Staff Survey completion Rosters & job plans (includes agency use) Risk management Audits/ inspections responses WHCs/ Ministerial Directives Freedom of information and MS/MP responses PTR volume / compliance NRI volume / compliance Patient incidents resulting in harm Number of reg 28s / inquests Progress of actions from Reg 28's 	<p>Operational Divisions</p> <ul style="list-style-type: none"> Reflections to year end IMTP Priorities Domain performance Successes plus Annual Review monthly assurance metrics Risks and Issues <p>Corporate Divisions</p> <ul style="list-style-type: none"> Reflections to year end IMTP Priorities Domain performance where appropriate Risks and Issues 	<p>Metrics for monitoring and de-escalation determined at kick off meeting relevant to domain</p>	<p>Metrics for monitoring and de-escalation determined at kick off meeting relevant to domain</p>
Attendance	<ul style="list-style-type: none"> COO Triumvirate Business Partners Month 6 - All Execs in attendance 	<ul style="list-style-type: none"> Annual Review All Execs, Chaired by CEO Triumvirate Business Partners 	<ul style="list-style-type: none"> If a Division is escalated in any of the 5 key domains, the domain's director or nominated deputy are required to hold recovery meetings Triumvirate Business Partners Independent Members 	<ul style="list-style-type: none"> If a Division is escalated in any of the 5 key domains, the domain's director or nominated deputy are required to hold recovery meetings Triumvirate Business Partners Independent Members 	
Frequency	<ul style="list-style-type: none"> Monthly 	<ul style="list-style-type: none"> Annual 	<ul style="list-style-type: none"> Bimonthly/Weekly Escalation recovery meeting 	<ul style="list-style-type: none"> As determined by escalation 	

7. Timeline and Actions through the year

It is the responsibility of each Division and Corporate Directorate to implement their own local performance reporting and management systems and frequency. The expectation of this PMF is that the following ,meetings and actions occur over the course of the year as part of deploying the Framework:



8. Support Available

Key resources available to support

It is recognised insight and support is a key enabler for accountability and improvement. There are a number of teams, dashboards and reports that can support the application of the Framework and continuous improvement across all domains.

The following resources are available to support the implementation of the PMF:

- Integrated Performance report
- Quarterly Quality Outcomes Framework report
- Weekly Putting Things Right dashboard
- Monthly Divisional Monthly Assurance reports
- Management Information Financial Packs - monthly
- Value and Sustainability Dashboard and reports
- Workforce Dashboard

Teams

- Planning, Finance and Workforce Business Partner Teams
- Performance, Analytics and Modelling Team
- Information Team
- Value-Based Health Care Team
- Primary Care Information Team
- Public Health Analytics Team
- Quality Improvement Team

External Support and resources

Depending on improvements required, external support and/or resources may be secured to support teams. Terms of reference, scope and duration of support will be clearly defined at the outset of the support period.



Appendix 1 - Summary table of metrics, triggers, actions and support

	Quality and Safety	Leadership	Corporate Governance	Finance	Operational Delivery
Accountability Conditions					
Metrics	<ol style="list-style-type: none"> PTR volume / compliance NRI volume / compliance Increase in number of patient incidents resulting in harm Number of reg 28s / inquests Progress of actions from Reg 28's 	<ol style="list-style-type: none"> Employee relations cases Sickness Turnover PADR Completion Mandatory training Overdue pay progressions Rosters & job plans (includes agency use) Staff Survey Completion 	<ol style="list-style-type: none"> Risk management Audits/ inspections responses WHCs/ Ministerial Directives Governance arrangements Policies in/out of date Freedom of information and MS/MP responses 	<ol style="list-style-type: none"> Variable Pay and Agency spend Sickness rates Activity increases/decreases Service efficiency Drug costs Savings progress 	<ol style="list-style-type: none"> Out of seasonal range performance for more than a minimum of 3 months Off track performance against forecast for more than a minimum of 3 months
Triggers	<ul style="list-style-type: none"> Limited or no assurance that the Division can meet prescribed targets/standards Number within minimum a 3-month rolling period Number of actions not completed within the stated action plan 	<p>Limited or no assurance that the Division can meet prescribed targets/standards for the following areas:</p> <ul style="list-style-type: none"> Employee relations cases PADR Completion Mandatory training Overdue pay progressions Rosters & job plans (includes agency use) Staff Survey Feedback 	<ul style="list-style-type: none"> Limited or no assurance that the Division can meet prescribed targets/standards Continued failure to respond /maintain in more than 1 key deliverable/area 	<p>Limited or no assurance that the Division can meet prescribed targets/standards within the year</p> <ul style="list-style-type: none"> Where divisional level budget is forecast to overspend by more than £1m through monthly financial reporting Where corporate level budget is forecast to overspend through monthly financial reporting 	<p>Limited or no assurance that the Division can meet prescribed targets/standards against the accountability conditions</p>

Appendix 1 - Summary table of metrics, triggers, actions and support

	Quality and Safety	Leadership	Corporate Governance	Finance	Operational Delivery
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Accountability Conditions

Accountability Conditions	Quality and Safety	Leadership	Corporate Governance	Finance	Operational Delivery
<p>Actions and Support</p> <ul style="list-style-type: none"> Improvement plan development – clear milestones and measures of improvement Targeted internal support Independent review of division/service/corporate department effectiveness Temporary or permanent change in leadership arrangements Consideration of compliance with Professional codes and standards and proportionate response Deployment of appropriate HR policies e.g. Capability policy Weekly/fortnightly meetings with CEO and/or relevant execs to track progress against improvement actions (which directly related to de-escalation criteria), with members of QMG Invite to relevant committee, supported by Executive Director. To outline improvement plan 	<ul style="list-style-type: none"> Improvement plan development – clear milestones and measures of improvement Targeted OD support Additional training and resource Deployment of appropriate HR policies e.g. Capability policy Deep Dives into subject areas Independent review of division/service/corporate department effectiveness Invite to relevant committee, supported by Executive Director. To outline improvement plan 	<ul style="list-style-type: none"> Improvement plan development – clear milestones and measures of improvement Targeted internal support Time bound action plan against each indicator Additional training and resource Deployment of appropriate HR policies e.g. Capability policy Deep Dives into subject areas Invite to relevant committee, supported by Executive Director. To outline improvement plan 	<ul style="list-style-type: none"> Agreed action plan established monitored through financial reporting arrangements Internal support as required (QI/VBHC/planning – issue dependent) CEO to call a special ‘Budget Review Meeting’ of all Executive Directors and Invite to relevant committee, supported by Executive Director. To outline improvement plan 	<ul style="list-style-type: none"> Improvement plan development – clear milestones and measures of improvement Internal support as required (Finance QI/VBHC/planning – issue dependent) Time bound action plan against each indicator Additional training and resource Deployment of appropriate HR policies e.g. Capability policy Internal Governance support Deep Dives into subject areas Invite to relevant committee, supported by Executive Director. To outline improvement plan 	

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 <p>GIG CYMRU NHS WALES</p> <p>Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board</p>	<p>CYFARFOD BWRDD I ECHYD PRI FYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING</p>
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DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	General Medical Services (GMS) – Aberbeeg Medical Practice – Outcome of Vacant Practice Process.
CYFARWYDDWR ARWEINIOL: LEAD:	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Lloyd Hambridge, Divisional Director for Primary Care, Community Services, Complex and Long Term Care

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

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to inform the Board of the outcome of the interview panel following a robust procurement exercise in respect of Aberbeeg Medical Practice, Blaenau Gwent East.

Cefndir / Background

The Health Board is responsible for providing General Medical Services (GMS) to residents throughout Aneurin Bevan University Health Board and commissions services from independent contractors through The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023.

There are currently 68 General Practices, 5 of which are Health Board managed:

- Aberbeeg Medical Practice; From 1 March 2025
- Brynmawr Medical Practice; From 1 March 2025
- Blaenavon Medical Practice; From 1 March 2025
- Tredegar Health Centre; From 1 April 2025
- Bryntirion Surgery (including Markham Branch Surgery); From 1 April 2025

Practices are responsible for providing care to patients between 08:00 and 18:30 Monday to Friday. Outside of these “core hours”, access to medical care is provided by the Health Board’s Out of Hours Service, operating between 18:30 and 08:00 each weekday evening and throughout weekends and Bank Holidays.



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It was agreed in February 2025 by the Executive Committee and subsequently endorsed by Board, to instigate the Vacant Practice Policy and undertake a procurement process for Aberbeeg Medical Practice due to the Health Board being approached by a number of local GPs, both existing contractors and those keen to establish a partnership, expressing an interest in acquiring the GMS contract for Aberbeeg Medical Practice, should this be an option.

The procurement process, undertaken in accordance with the Health Services (Provider Selection Regime) (Wales) Regulations 2025, commenced on 6 June 2025.

Asesiad / Assessment

The Health Board commenced a procurement process in accordance with the Health Services (Provider Selection Regime) (Wales) Regulations 2025. The Invitation to Tender (ITT) and associated documents was published with a deadline for applications of 18 July 2025.

Two submissions were received, with one bid successful at the evaluation stage and invited to interview on 31 July 2025.

The evaluation and interview panels consisted of Health Board officials, Gwent Local Medical Committee, Local Authority, NWSSP Procurement and a local Councillor covering Llanhilleth ward.

A Llais representative was invited to participate but was unable to attend. This did not impact quoracy. The Primary Care Contracting Team will liaise with Llais, in confidence, regarding the evaluation stage.

The evaluation panel considered each bid in turn against the evaluation criteria covering quality, value, collaboration and service sustainability, improving access and reducing health inequalities and social responsibility and carbon footprint.

One submission was discounted as did not meet the threshold in the evaluation criteria and one submission progressed to interview stage - Dr Shore-Nye & Partners, who also hold the GMS contract for Cwm Calon Surgery.

Interview Format

Bidders were required to deliver a 10-minute presentation on 'How they propose to deliver the Aberbeeg Medical Practice GMS Contract in accordance with [The National Health Service \(General Medical Services Contracts\) \(Wales\) Regulations 2023](#) and in line with the Specification of Requirements issued by the Health Board.' Bidders were advised that their presentation should include the following (but is not limited to):

- Workforce
- Quality
- Provision of Services
- Business Continuity and Sustainability
- Financial

A series of questions from the interview panel followed the presentation.

The interview panel was held on the 31 July 2025. Dr Shore-Nye, Dr Powell and the Practice Manger, Angela Jarrett were in attendance.

The interview panel comprised of;

- Lloyd Hambridge, Divisional Director
- Dr Liam Taylor, Deputy Medical Director



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- Rachel Prangley, Head of Primary Care
- Kay Morris, Finance Business Partner
- Michelle Llewellyn, Senior Primary Care Manager
- Dr Natasha Collins, LMC Chair
- Councillor Lee Parsons

- Andrew Woods, Primary Care Contracts Manager (Observer)
- Hannah Shotton, Procurement Lead (Facilitator)

The partnership delivered an assured presentation, and responses to panel questions, covering the 5 domains, offering a clear commitment to the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) obligations and the integration of the two practice teams to ensure continuity of care and the delivery and expansion of high-quality services to the patients currently registered with Aberbeeg Medical Practice.

Also highlighted, was the commitment to maintaining the delivery of services from Aberbeeg Medical Practice premise. The intention to merge both contracts within the first 12 months, whilst retaining the same level of service in both practices, was also outlined.

The partners described a clear workforce plan, with additional resource during the transition period being provided by the partners and existing salaried GPs along with locum engagement whilst they actively recruit.

As a neighbouring practice, with GPs who have previously worked in Aberbeeg, they are familiar with the needs of the registered population.

The intention to nominate a Clinical Governance lead was positively acknowledged by the panel as was the commitment to expand the delivery of supplementary services aligned to the Health Board's NCN priorities, along with the ambition to expand their commitment as an existing training practice.

The partners provided a high-level overview of their financial model and additional support required from the Health Board and both the panel and the partners acknowledged that further detail was required on both parts to accurately determine the level of mobilisation and transition support required over a defined period.

Overall, the panel were satisfied that the partnership provided sufficient assurance that they would be able to deliver the full GMS Contract for Aberbeeg Medical Practice.

Outcome

Based on the outcome of the interview, the panel were unanimous in recommending that the full General Medical Services Contract for Aberbeeg Medical Practice be awarded to Dr Shore-Nye and Partners of Cwm Calon Surgery. This would result in the current services continuing to be delivered from Aberbeeg Medical Practice and all staff subject to TUPE.

The recommendation was approved by the Executive Committee on 7 August 2025.

Following the conclusion of the standstill period in accordance with the PSR requirements, further discussions will be had with the incoming partnership regarding transition arrangements, including commencement date, support requirements and monitoring arrangements. It is anticipated that the contract will be in place by the 1 December 2025, if not sooner.

Next steps

- Confirm transition arrangements



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- Formally write to all stakeholders regarding the outcome
- Formally write to patients regarding ongoing arrangements

Argymhelliad / Recommendation

The Board is requested to note the content of this report and the successful awarding of the General Medical Services contract for Aberbeeg Medical Practice to an existing independent contractor within the Health Board area.

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):	5. Timely Care 5.1 Timely Access 3.1 Safe and Clinically Effective Care 6. Individual 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	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail dystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	N/A



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Parties / Committees consulted prior to University Health Board:	
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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	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. N/A



DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	General Medical Services North Celynen Practice: Branch Closure Request
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Rachel Prangle, Head of Primary Care Lloyd Hambridge, Divisional Director of Primary Care, Community Services and Complex and Long-Term Care

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

Ar Gyfer Penderfyniad/For Decision

This purpose of this report is to inform the Board of the recommendation of the Branch Practice Review Panel held on 7 August 2025, regarding the Branch Closure request received from North Celynen Practice in the Caerphilly East locality, in respect of the branch site at Ashfield Road, Newbridge.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

On 20 March 2025, the Health Board received a request from North Celynen Practice, Caerphilly East, to close their branch site at Ashfield Road, Newbridge.

All branch surgery requests are subject to consideration in accordance with the Health Board's Branch Surgery Closure Policy (Annex A).

The decision on the closure of a branch surgery is the statutory duty of the Health Board as each GP is contracted to the Health Board for the provision of General Medical Services. Whilst there is limited guidance in this regard, paragraph 4.56 of the Primary Care Contract Quality Standards states:

"A branch surgery can be closed subject to agreement between the PCO and



providing practice. In the event there is no agreement the practice can give notice that it wishes to close a branch surgery. There will be a given period in which the PCO can issue a counter-notice, to allow for any required consultation, requiring the surgery to remain open until the issue is resolved. Normal appeal procedures will apply, or where both the practice and the PCO agree that the surgery should remain open, then the PCO is required to continue supporting it with the necessary funding.”

The Primary Care Organisation (PCO) in the Welsh context is the Health Board.

Cefndir / Background

North Celynen Practice is a 5 GP Partner and 1 ANP Partner practice with a registered list size of 9,338 (NWSSP July 2025). The Practice also has two salaried GPs. The practice currently provides 49/51 GP equivalent sessions on alternate weeks across both sites. This represents 2.3-4.3 sessions above the local benchmark of 1 GP equivalent session per 200 registered patients.

The practice currently provides General Medical Services (GMS) across two sites as below:

- Main site – North Celynen Practice, Crown St, Crumlin, Caerphilly East
- Branch site – Ashfield Road, Newbridge, Caerphilly East

The Newbridge branch premise is a two - storey purpose-built building. The building is owned by previous partners of Newbridge Medical Centre and is leased to the current partners of the practice. The lease is due to expire in December 2025.

Newbridge branch surgery is open 8:00am – 1:00pm every day apart from Thursdays when it is closed and is 0.7 miles away from the main site in Crumlin. There is a direct bus service from Newbridge to Crumlin.

Upon receipt of the application, the Primary Care Contracting team met with the partners to discuss the details of their application and reasons for the proposed closure.

The practice feels that by consolidating resources in the main site in Crumlin this would support the continued delivery of the full range of services to their registered population, any existing services currently offered from the Newbridge branch surgery would be relocated to the Crumlin site, with no reduction in service. All staff that currently work in the Newbridge branch would also re-locate to Crumlin.

Currently, a clinician undertakes one session, four mornings a week at the Newbridge branch.



The practice does not envisage any negative impact to patient care should their application be supported and, in their experience, patients accept an offer of being seen by a clinician at the main site.

In accordance with the Branch Surgery Closure Policy, the Primary Care Contracting Team in conjunction with Llais, agreed an 8-week stakeholder engagement period which ran from 9 June 2025 until 1 August 2025. All registered patients, aged 16 and over, were sent a questionnaire offering them the opportunity to consider, and provide their views, on how the proposed changes may affect them. During the engagement period, two drop-in sessions were held at the branch practice, with both practice and Health Board colleagues in attendance to respond to any patient queries. Interested parties were also afforded the opportunity to make any representations regarding the proposal during the engagement period with letters issued to all relevant stakeholders.

Asesiad / Assessment

The Branch Practice Review Panel convened on 7 August 2025 to consider the practice business case and the results of patient and stakeholder engagement.

Panel members:

- Lloyd Hambridge (Chair), Divisional Director of Primary Care, Community Services and Complex and Long Terms Care
- Dr Alun Walters, Primary Care Clinical Director
- Rachel Prangle, Head of Primary Care
- Andrew Lloyd, Division Accountant
- Jodie Collins, Deputy Head of Primary Care
- Michelle Llewellyn, Senior Primary Care Manager
- Dr Natasha Collins, LMC Representative
- Isolde Shore-Nye, NCN Representative
- Etienne North, Llais Cymru
- Eira Turner – Head of Service, Caerphilly NCN

The panel considered a range of information collated by the Primary Care Contracting Team. The information considered is detailed below.

North Celyn Practice Business Case:

- The reasoning for the request for closure; Lease agreement ending December 2025.
- The financial saving to the practice is in the region of £45,000 annually.
- The branch is not utilised to a level where renewing the lease would be beneficial. One clinical session is provided four days a week



- No reduction in service provision would occur as a result of the closure of the branch and all services and clinical sessions would relocate to the main site in Crumlin.

Claire Bowen (Practice Manager) also attended the panel to present the practice business case on behalf of the GP partners, outlining that when the Crumlin practice and Newbridge Surgery merged in 2014 it was agreed that they would retain the Newbridge premises as a branch site and honour the terms of the lease until it expired. The panel were given the opportunity to ask Ms Bowen any questions relating to the closure application. Ms Bowen outlined that in response to concerns raised around the potential disruption to parking within Crown Street, the practice had purchased permanent signs for outside the building requesting patients not to park on the street. Unfortunately, there are not any parking restrictions on Crown Street, therefore the practice is not able to enforce this, but they continue to advise patients of the public parking facilities at the end of the street. Ms Bowen also advised that the savings made by not renewing the lease could be used to improve patient services.

Patient & Stakeholder Engagement:

- Patient engagement at the drop-in sessions was low with a total of seven patients attending across the two dates.
- The response rate for the patient questionnaire was 9.3% and 95% of respondents indicated they already attend the main site in Crumlin.
- 56% of respondents had no concerns should the application be supported
- 36% of respondents were concerned that service provision would be reduced and that it would be harder to get an appointment if the branch should close.
- Representation was made through Councillor Woodland that residents of Crown Street, where the main site is located, voiced concerns that if the application is supported the parking situation, which is currently difficult, would be exacerbated with an increase in traffic to the main site.

Equality Impact Assessment (EqIA)

- An EqIA was undertaken and identified that elderly and disabled patients may be disadvantaged more than others due to potential frailty and mobility issues, should they need to rely on public transport to attend the main site.

The panel acknowledged the potential negative impact for a small number of patients who would be required to travel to Crumlin to attend the main site, however felt this would be minimal due to public transport links.

The panel also recognised the concerns in respect of the parking situation however, as the majority of registered patients already attend the main site, the panel felt there would be minimal disruption. It was also noted that there are Health Board and Local Authority staff working within the premises at Crumlin and the Locality



Head of Service agreed they would liaise with them to ensure staff utilise the designated staff parking or public car park.

The panel unanimously supported the application to close the Ashfield Road site in Newbridge, subject to the required 3 months' notice and therefore effective 1 December 2025.

It was noted that concerns around service provision and parking issues should be addressed in patient letters, should the decision be ratified by the Executive Committee. The proposed change has attracted some local media interest and, should the application be supported, proactive communication will be developed in conjunction with the Health Board's Communication and Engagement team.

Next steps (with approximate time frames), subject to ratification by Executive Committee;

- 21/08/25 - Executive Committee consideration
- 22/08/25 - Practice informed of outcome
- W/C 25/08/2025 - IP communication to be issued (MS/MP's, Local Councillors, NCN leads)
- W/C 01/09/2025 – Patient communication to be issued providing the required 3 months' notice
- 01/12/2025 Branch Surgery closure effective

Argymhelliad / Recommendation

The Board is asked to consider the content of this report and endorse the recommendation of the Branch Practice Review Panel to support the application to close Newbridge branch surgery, effective 1 December 2025.

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):	1. Staying Healthy 2. Safe Care 3. Effective Care 5. Timely Care



Blaenoriaethau CTCI IMTP Priorities <u>Link to IMTP</u>	Adults in Gwent live healthily and age well
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 <u>Strategic Equality Objectives 2020-24</u>	Choose an item. 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/>

Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs
Choose an item.





Aneurin Bevan University Health Board

General Medical Services Branch Surgery Closure Policy

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document

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8	Annex 3	15
9	Revised Sustainability Framework Risk Matrix (including guidance notes)	16

1.0 Definition of a Branch Surgery

A subsidiary practice utilising the resources and staff of the parent practice. Usually attended only at specified, limited hours, with the opportunity for a patient to go to the parent practice in an emergency.

2.0 Background

This document sets out a draft process for the management of branch surgery closure applications.

A branch surgery can be closed subject to agreement between the Health Board and the providing practice. Whilst there is limited guidance in this regard, the Primary Care Contract Quality Standards relating to "branch / split – site surgeries" (paragraphs 4.53 – 4.59) outlines a process under paragraph 4.56;

"A branch surgery can be closed subject to agreement between the PCO and providing practice. In the event there is no agreement the practice can give notice that it wishes to close its branch surgery. There will be a given period in which the PCO can issue a counter-notice, to allow for any required consultation, requiring the surgery to remain open until the issue is resolved. Normal appeal procedures will apply, or where both the practice and PCO agree that the surgery should remain open, then the PCO is required to continue supporting it with the necessary funding."

The PCO in this instance will be the Health Board.

The Health Board is required to put arrangements in place to consider branch surgery applications. This document describes a process and links to formal NHS appeals mechanism.

All arrangements for considering branch surgery closure applications will be managed by the Primary Care and Community Division.

The Health Board is aware that Llais, as a statutory organisation, could consider a Branch Surgery Closure to be a significant loss of service to the patients accessing services in this venue. The views of Llais will be presented to the Board independently as part of the decision-making process.

3.0 Process for considering Branch Surgery Closure applications

The rationale for developing this process is to ensure that all interested parties work collaboratively to ensure that the delivery of patient care is paramount in all considerations.

All arrangements for considering branch surgery closure applications will be managed by the Primary Care and Community Division

3.1 A Branch Practice Review Panel will be established by the Primary Care and Community Division. This group will be responsible for the decision process, the end result of which will be a recommendation to proceed with the appropriate option for the branch practice.

Proposed membership of the Branch Practice review Panel is:

- ABUHB Divisional Director Primary Care & Community Services/ General Manager
- ABUHB Deputy Medical Director (General Practice) / Primary Care Clinical Director
- ABUHB Head of Primary Care / Deputy Head of Primary Care
- Senior Primary Care Manager
- Neighbourhood Care Network Lead / Head of Service
- Local Medical Committee (LMC) representative (voting rights)
- Llais Gwent Region representative (non-voting)
- Other Primary Care colleagues involved in the process
- Additional representatives may be invited as per local agreement and decision.

4.0 Notification and Management of request to close Branch Surgery

The practice formally writes to the Health Board with their request to close a branch surgery, detailing:

- Reasons for the proposed closure request including an up-to-date sustainability report, i.e., Sustainability Assessment Framework risk matrix (the income streams information is not required for the purposes of this process)
- Detail on any estate issues
- Opening times and surgery times of the branch and main surgeries
- Current access rates
- The list size of the practice
- Number of patients accessing the surgery services in the last three years, broken down by month
- Number of patients that have accessed services at the branch site alone in the last three years, broken down by month. Where the Practice is unable to identify patients who use the

Branch Surgery, then all patients registered with the practice will need to be consulted with

- Services that are currently being provided from the branch surgery
- Impact the closure will have on patients and services at the main site
- Proposals for how the information will be communicated to patients if the closure application is approved
- Details of the timing of the closure if approved, i.e. a phased closure.
- Details of any engagement already undertaken with key stakeholders including NCNs and neighbouring practices
- Impact on patients including consideration to vulnerable groups.

The Primary Care Contracting Team will:

1. Acknowledge the request for closure in writing within 5 working days of receipt and inform Llais and the Local Medical Committee that this has been received, asking for their views on the application.

The Primary Care Contracting Team, in conjunction with the Practice will also identify the following:

- Premises infrastructure concerns, i.e. costs to meet DDA compliance, statutory regulations compliance
 - Any other purpose for which the branch surgery is used
 - Details of the nearest GP practices and pharmacies. This should be presented on a map
 - Any proposed changes to services at the main practice
 - Details of public transport links from the branch site to the main practice site
 - Conduct and review the outcomes of an Equality Impact Assessment
 - Practice patient distribution map plus boundary maps of neighbouring practices.
2. Escalate the notification internally and establish the timeline for decision making, Branch Surgery Closure process and implementation of the outcome.
 3. Issue confidential communication notice to WG, LMC and Llais.
 4. Inform in confidence, MS/MPs and local councillors, issue patient letters and questionnaires, advising of consultation process.

-
5. The Primary Care Contracting Team will co-ordinate and agree the consultation process with Llais, identifying key stakeholders which may include:
- NCN Leads
 - Local Medical Committee
 - Llais
 - Community Pharmacists in the area
 - Other appropriate Llais Regions, if impacted by the proposal (outside the Health Board area)
 - Other practices in the area which may be impacted upon from the closure
 - Local politicians
 - Patient Participation Group representation

A patient consultation process will take place, in conjunction with engagement with Local Politicians, using an approved questionnaire and other relevant forms, which will also be available in Welsh. All patients accessing the Branch Surgery will be consulted with. If the practice is unable to identify those patients, then the total practice population will be subject to the patient consultation.

Local drop-in sessions for patient consultation may be considered by the Primary Care Contracting Team, in collaboration with the practice and appropriate support from the Health Board Communication & Engagement team, and advertised within the practice, details will also be included on the patient letters.

Consultation should last a minimum of four weeks (extended if this coincides with holiday periods) or Llais deems a longer period necessary. This will be agreed with Llais.

The Health Board and practices may choose to progress further patient consultation in addition to the questionnaire, for example attendance at patient forum and/or community group.

The Primary Care Contracting Team will progress an Equality Impact Assessment.

The Health Board will inform neighbouring Local Health Boards, of the request, that may be affected by the closure.

Once the consultation is completed the Primary Care Contracting Team will collate and review the responses to the questionnaire. A further review will be conducted on the additional information provided by the practice and Primary Care Contracting Team.

6. Arrange a Branch Practice Review Panel meeting. A Panel will be convened to consider the application from the Practice, the outcome of the patient consultation, views of Llais and Local

Medical Committee, and the Equality Impact Assessment, to make a decision. The Primary Care Contracting Team will prepare the information packs and issue these seven days before the panel meeting will take place. The Practice will be offered the opportunity to present their case in the form of a 15-minute presentation during the course of the meeting so that the panel are briefed and able to ask questions.

7. The Branch Practice Review Panel will consider the request from the Practice, the outcome of the patient consultation, views of Llais, Local Medical Committee and other interested parties and determine a recommendation to either support the application in full, partially support or reject the application.
8. Representatives from Llais and Gwent Local Medical Committee (voting rights) will be in attendance to observe the process, Llais will not have voting rights.
9. If there is a change to service there will be a requirement that following the approval of the recommendation by the Executive Team, this decision is then considered by the Llais Executive Committee. The timeframe for this will be discussed and agreed accordingly.
10. The decision of the Board or Committee will be notified to all listed stakeholders which will include the practice and interested parties and patients. Where the closure application is approved, a clear communication plan will be agreed to ensure all registered patients are informed of the closure and how they will access services from the Practice.

Practices should ensure a minimum of 3 months' notice following the Board approval to close, unless agreed otherwise with the Health Board.

Where the closure application is approved it is the responsibility of the practice to meet all associated costs with closing the surgery including redundancy and practice information costs.

Where an Improvement Grant has been provided to upgrade the premises which are being closed, the Health Board will assess whether this warrants a recovery, advise practice of same and implement a recovery plan.

Where the closure application is not supported by the Board or Committee, the Primary Care Contracting Team will discuss with the Practice the sustainability implications of this decision.

-
11. Further correspondence to be issued to all stakeholders following the Branch Practice Review Panel including the outcome of the patient consultation.

Each Branch Practice Review will need to be considered on its individual merits and the local context:

- Health Board Strategic Plan: this will be based on proactive planning from the cluster and sustainability framework
- Local population health needs including distance from other services, demography, local provider assets and other commissioned contractor services.

5.0 Appeals

Any appeal against the decision of the Board in relation to Branch Surgery Closure applications will be resolved through the contractual appeals process "Contract Dispute Resolution – Part 10 of Schedule 3 to the National Health Service (General Medical Services Contracts) (Wales) Regulations 2023("The Regulations").

The decision of the appeal will be made in consultation with the Llais and the Executive Board.

The decision of the Board or Committee will be notified to all listed stakeholders which will include the practice and interested parties and patients.

Objection from Llais

Llais has a right to undertake an independent consultation, should they not consider the Health Board's consultation to be a robust process.

If Llais objects to the Health Board's decision they have a right of appeal to the Cabinet Secretary for Health and Social Care (as per the Welsh Government Guidance for Engagement and consultation on changes to Health Services).

Quoracy

Branch Practice Review Panel will be quorate when the following are in attendance:

- 1 Clinical Representative
- 1 Head/Deputy Head of Primary Care/Senior Primary Care Manager
- 1 Divisional Director/General Manager
- 1 Independent Representative LMC/Llais

Annex1

PROCESS FOR CONSIDERATION OF BRANCH SURGERY CLOSURE APPLICATION

The practice formally writes to the Health Board with their request to close a branch surgery and provides additional information on access, opening times, impact on patients etc.

The Primary Care Contracting Team will:

- Acknowledge the application within 5 working days.
- Progress further information in conjunction with the practice.
- Inform the Local Medical Committee, Llais and neighbouring Local Health Boards (if required).
- The Health Board will establish a Branch Practice Review Group.

The Primary Care Contracting Team will co-ordinate the engagement process. Key stakeholders to include; Patients, Local Medical Committee, Llais, Local Community Groups, Local politicians and Patient Participation Group representation.

The Primary Care Contracting Team will implement the engagement process to include Patient Questionnaire and other forms of engagement as required - Minimum of 4 weeks.

The Primary Care Contracting Team will conduct a Equality Impact Assessment to support the process.

The Primary Care Contracting Team will collate and review the responses to the questionnaire.

- The Branch Practice Review Panel will convene to review the application and information provided from patient consultations, Sustainability framework risk matrix, Equality Impact Assessment, LMC and Llais views.
- The panel will decide whether or not to support the closure application and make a recommendation for consideration by the Board. The practice will be offered the opportunity to present their case in the form of a 15 minute presentation at the beginning of the Review Panel.
- Each member of the panel will receive an information pack 7 days before the date of the panel.

Recommendation from the Branch Surgery Review Panel, with the views of the LMC and Llais will be presented to the Board, who will make the final decision.

The decision of the Board will be notified to the Practice, Patients, Llais, Local Medical Committee and neighbouring practices within 1 week.

Appeal Process if required.

Practice Submission

Practice Name;
Completed by;

Annex 2

- 1 Reasons for the proposed closure, including an update on the practice's sustainability status plus any issues relating to your primary care estate. Please enclose a current sustainability assessment framework risk assessment matrix .

- 2 What are the current opening times of your main surgery and your branch surgery?

- 3 Practice current list size.

4 Number of patients accessing the main surgery services over the last three years, broken down by month.

Services	Year 1	Year 2	Year 3

5 Number of patients that have accessed services at the branch site alone in the last three years, broken down by month (if unable to identify these specific patients then all patients will need to be consulted with).

Services	Year 1	Year 2	Year 3

6 Detail on services currently being provided from the branch surgery including a timetable of clinics/services. Please also any other purpose for which the branch surgery is used.

7 What impact will the closure have on patients including vulnerable groups and how it will affect services at the main site?

8 Detail on how this proposal will be communicated to patients if application to close is approved by the Health Board.

9 Detail of any engagement already undertaken with cluster networks and neighbouring practices.

10 Detail of the timing of the closure i.e. will this be a phased closure?

11 Any other relevant information.

Annex 3

Time Frames

Detail of workflow	Days	
Acknowledgement of formal request received from practice including further information if required.	5 days	Within 5 working days
Consultation with stakeholders	8 weeks	By Week 9
PCC Team to collate and review responses and complete EIA	5 days	By Week 15
Panel meeting - documents issued prior to panel	5 days	By Week 16
Panel meeting	1 day	By Week 17
Inform stakeholders/IP's of recommendation		By Week 17/18
Paper to be prepared for Executive Board	1 day (following Thursday after panel)	By Week 18
Paper to be presented to Executive Board	1 day	By Week 17/18
Practice and all IPs notified of decision	1 day (within 5 days of Exec decision)	By Week 17/18/19
Patients notified	1 day	By Week 17/18/19

Revised Sustainability Framework Risk Matrix (including guidance notes)

The framework involves applying a Red/Amber/Green (RAG) weighted score against the risk matrix criteria. The following weighting has been applied:

- High/Red -10
- Medium/Amber – 5
- Low/Green - 1

The outcome of the risk assessment matrix score has been set as follows:

- High risk of unsustainability > or = 80
- Medium risk of unsustainability >55 -79
- Low risk of unsustainability <55

Practice:

Area	Indicator	Ranking	Ranking	
Demographics: STAGE 1	Open/closed list	Open	Low	
		Application submitted (formal/informal)	Medium	
		Closed	High	
	Welsh index of multiple deprivation (WIMD % of patients living in the two most deprived fifths)	< 10%	Low	
		10 -20%	Medium	
		>20%	High	
	Practice population age spread %	<30% over 65	Low	
		30% - 50% over 65	Medium	
		>50% over 65	High	
Premises: STAGE 1	Number of sites/branch surgeries (to include both open and temporarily closed branch surgeries)	1 site	Low	
		>1 site	Medium	
		>3 sites	High	
	Condition of premises; (practices with more than 1 site will be ranked against a judgement of the total estate condition)	adequate/new or approved funding	Low	
		Poor, but working towards improving	Medium	
		Poor quality	High	
	Capacity of premises	Adequate for current needs only	Low	
		Inadequate to accommodate current service needs	High	

Workforce – General Practitioner: STAGE 1	Partnership/singlehanded	Partnership	Low	
		Singlehanded	High	
	Patients 000's per WTE GP (WTE assumed as 8 sessions)	<2000 patients	Low	
		>2000 patients	Medium	
		>2500	High	
	Age profile (individual GP ages will be used to give an overall rank for age profile. To include all substantive GPs including principles and salaried posts.)	<50 years	Low	
		50-55 years	Medium	
		>55 years	High	
	Current vacancies Linked to % of WTE	<10%	Low	
		10 – 20%	Medium	
		>20%	High	
	Length of vacancies	< 6 months	Low	
6 months		Medium		
>6 months		High		
Reliance on locums (sessions per average week)	<3 sessions	Low		
	3-5 sessions	Medium		
	>5 sessions	High		
Workforce General: STAGE 1	Patient 000's per WTE senior clinician (GP, Advanced Practitioner, Pharmacist etc.)	<2000	Low	
		>2000	Medium	
		>2500	High	
	No of unfilled clinical sessions per week	0	Low	
<3		Medium		
>3		High		
Income Streams: STAGE 1	Income loss arising after MPIG redistribution (as a % of GSE)	<10%	Low	
		10%-15%	Medium	
		>15%	High	
Access to Services: STAGE 1	Opening hours (per site) - recent changes (Relating to a reduction in hours only)	No	Low	
		Yes	High	
	Total			

High Risk	>70
Medium Risk	50-70
Low Risk	<50



CYFARFOD BWRDD I ECHYD PRI FYSGOLN
ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Annual Quality Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andy Bagwell, Acting Executive Medical Director Jennifer Winslade, Executive Director of Nursing Peter Carr, Executive Director of Therapies & Health Science Tracey Daszkiewicz, Executive Director of Public Health
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson – Deputy Director Nursing

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board's Annual Quality Report for 2024/25 presents a comprehensive account of the Health Board's commitment to delivering safe, effective, and compassionate care. This report is not only a statutory requirement under the Duty of Quality and Duty of Candour, but also a reflection of the Health Board's values and culture. It captures the collective efforts of staff across all services to improve outcomes, enhance patient experience, and embed quality into every aspect of care. The report is structured around the Health Board's Pillars of Quality and the STEEEP domains—Safe, Timely, Effective, Efficient, Equitable, and Person-centred—and provides assurance that quality is being actively managed and continuously improved.

Aneurin Bevan University Health Board presents its Annual Quality Report for 2024/25, aligned with the reporting requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This legislation places quality, transparency, and engagement at the heart of healthcare through the Duty of Quality, Duty of Candour, and the Citizen's Voice body, Llais.

The report narrates our quality journey over the past year, reflecting on previous objectives and setting new priorities to improve patient and staff safety, outcomes, and experiences. A strong focus was placed on developing our quality management system to support this work. As we move into 2025/26, we carry forward these achievements with a renewed commitment to continuous quality improvement.

The Health and Care Quality Standards continue to provide a clear framework for planning, delivering, and monitoring healthcare services, and the outcomes and indicators reported here align with the Health Board's strategic goals—covering clinical outcomes, patient safety, and experience. This Annual Quality Report offers a comprehensive account of our commitment to delivering safe, effective, and compassionate care.

Cefndir / Background

Over the past year, the Health Board has made significant strides in strengthening its quality infrastructure. The implementation of the Quality Strategy and the Patient Experience and Involvement Strategy has provided a clear framework for improvement, while the development of the Quality Management Group and Framework has enhanced governance and oversight. The Ward Accreditation Programme has expanded to cover more clinical areas, and the launch of the Quality Improvement Capability Strategy for 2025–2028 has embedded a culture of continuous improvement across the organisation. These developments have been supported by robust data systems, inclusive engagement mechanisms, and a commitment to learning from lived experience, incidents, and feedback.

Asesiad / Assessment

The Annual Quality Report provides information on our progress to deliver the Duty of Quality and review our reporting and assurance framework. The Health Board adopted a reporting structure which mapped progress on quality and patient safety as mapped against the Pillars of quality:

- Patient and staff experience and stories
- Incident reporting – falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments

- Health, safety and security
- Infection Control and Prevention
- Safeguarding

The report demonstrates measurable progress across all domains of quality.

In terms of safety, there has been a reduction in inpatient falls and pressure ulcers, improved infection prevention and control, and the establishment of a Sepsis Working Group. Safeguarding referrals have increased, and staff training compliance has improved, reflecting a proactive approach to keeping people safe.

Timeliness has been enhanced through early resolution of complaints, rapid response to infection outbreaks, and strengthened escalation protocols.

Effectiveness has been evidenced by participation in national clinical audits, the implementation of the Learning from Deaths Framework, and the use of PDSA cycles and real-time dashboards to drive improvement.

Efficiency has been improved through centralised complaints handling, better antibiotic stewardship in GP surgeries, and streamlined resolution of Public Services Ombudsman for Wales cases.

Equity has been promoted through inclusive bereavement support, engagement with diverse communities, and the use of accessible feedback platforms.

Person-centred care remains a cornerstone, with high satisfaction rates, active patient panels, and real-time feedback mechanisms shaping service delivery.

The Health Board has also demonstrated strong leadership and workforce development, with the QI Coach Programme and the Human Factors Programme improving safety culture in high-risk areas. Digital tools such as CIVICA and AMaT have supported data-driven decision-making, while collaborative learning events and patient stories have helped embed a culture of openness and improvement.

Looking ahead to 2025/26, the Health Board should continue to embed the Quality Management System and Pillars of Quality into everyday practice. This includes rolling out the new Quality Improvement Strategy, expanding coaching and training programmes, and strengthening data systems for real-time assurance. Engagement with patients, families, and communities should be deepened, with a focus on inclusive service design and feedback mechanisms. Strategic oversight should be maintained through governance forums such as the Clinical Advisory Forum and the Quality Management Group, ensuring that quality remains the golden thread running through all aspects of care.

By sustaining momentum, investing in staff capability, and fostering a culture of learning and collaboration, the Health Board will be well positioned to deliver on its

statutory duties and continue improving outcomes and experiences for the communities it serves.

Argymhelliad / Recommendation

The Board is requested to note the progress of work over the past 12 months as reflected in the annual quality report and to take assurance from this 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. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
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 Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

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

Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	
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Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives



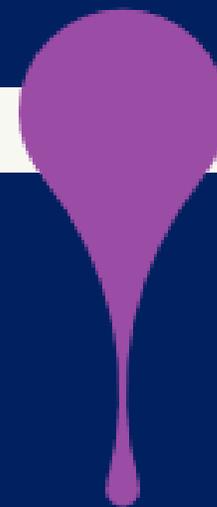
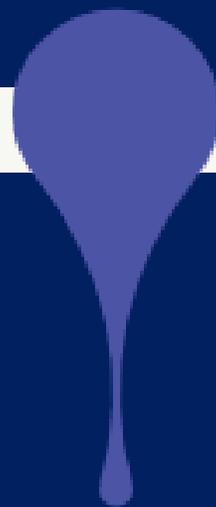
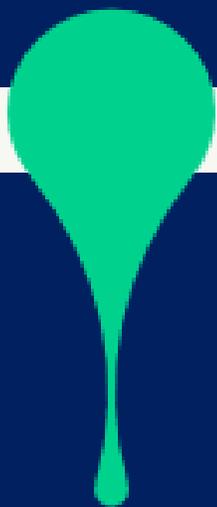
GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Quality Annual Report

2024/25



Chief Executive's Introduction to the Annual Quality Report

I am pleased to present our organisation's Annual Quality Report, which reflects our ongoing commitment to the highest standards of health care, as enshrined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This report is both a record of our achievements and a transparent assessment of areas where we must continue to improve, as we strive to consistently meet exceptional standards of care for those we serve across Gwent.

The success of our quality improvement journey is underpinned by the dedication and expertise of our workforce. Over the past year, our teams have worked tirelessly against unprecedented challenges. The ongoing impact of the COVID-19 pandemic, alongside increased demand and workforce pressures, has continued to test the resilience of services and individuals alike. Despite these difficulties, I am proud to report that our staff have continued to uphold the core values of NHS Wales – putting people at the heart of everything we do.

As we look to the future, our priorities remain clear. We will continue to focus on:

- Enhancing patient and service user experience through person-centred care and genuine co-production
- Strengthening data-driven quality improvement and sharing best practice across services
- Addressing health inequalities and improving accessibility for all groups
- Investing in workforce wellbeing, development, and leadership
- Embedding a culture of openness, candour, and accountability at all levels of the organisation.

In partnership with our communities, staff, and stakeholders, we will continue our journey toward excellence – never losing sight of our duty to deliver safe, compassionate, and effective health care.

I would like to extend my deepest gratitude to all our staff, volunteers, partners, and the individuals and families who put their trust in us. Your commitment, courage, and resilience inspire everything we do. Together, we are shaping a health and social care system that is truly worthy of the people of Gwent.

Thank you.

Nicola Prygodcicz



Executive Summary: A Message from the Clinical Executives

We are proud to present the 2024/25 Annual Quality Report on behalf of Aneurin Bevan University Health Board.

This report is more than a statutory requirement, it is a heartfelt reflection of the care, compassion, and commitment shown by our staff every single day. It tells the story of a Health Board that is learning, listening, and improving together. A Health Board where quality is not just a word, it is a shared value, a lived experience and the golden thread that runs through everything we do.

We would like to begin by sincerely thanking our teams across all services. Their dedication, resilience, and humanity have been extraordinary. Whether at the bedside, behind the scenes, or in leadership roles, they have kept the patient at the centre of every decision. Our staff have spoken up, shared learning and supported one another through challenges and change. This report is a tribute to their efforts.

Over the past year, we have strengthened how we report on quality, not just to meet our duties under the Duty of Quality and Duty of Candour, but to make assurance meaningful. Through our Pillars of Quality programme, we have created a structure that allows us to report with clarity, consistency, and compassion. We have worked hard to ensure that this report is not only comprehensive, but also accessible, so that everyone, from frontline staff to patients and families, can see what quality means in practice and how it connects to their own experiences.

Aligned with the STEEP domains: Safe, Timely, Effective, Efficient, Equitable and Person-centred, this report highlights the progress we've made, the lessons we've learned, and the areas where we must continue to grow. It reflects a culture where improvement is not a project, it is a way of being.

As we move ahead to 2025/26, we remain committed to nurturing a culture of openness, inclusion, and continuous learning. To ensure we will keep building a system that is caring, more responsive and more collaborative for everyone.



Jennifer Winslade
Executive Director of Nursing



Dr James Calvert
Executive Medical
Director



Peter Carr
Executive Director of
Therapies and Health
Science



Tracy Daszkiewicz
Executive Director of Public
Health and Strategic
Partnerships

Introduction

As a Health Board within NHS Wales, it is our moral and legal duty to demonstrate how we are delivering high quality and safe care. This Annual Quality Report serves as a vital assurance tool—in demonstrating our openness and transparency in our quality reporting through this report, an easy-to-understand story of our progress, challenges, and commitment to quality, keeping people safe, learning and improving.

It enables us to show how we are meeting the expectations set out in:

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

These structures place quality and safety at the heart of everything we do. The 2020 Act strengthens this focus by introducing a Duty of Quality and a Duty of Candour, and by establishing Llais, the independent Citizen Voice body.

The Annual Quality Report is not just a statutory requirement, it is a vital opportunity to reflect on our progress, share our achievements and be transparent about the challenges we face. It helps build trust with the public demonstrate accountability and continuously improve the care we

Key Achievements

The Health Board has made considerable progress in delivering both Strategies, guided by a strong focus on insight, involvement, and improvement. This supports our wider ambition: to deliver high-quality, safe, and compassionate care every day.

Insight

We have deepened our understanding of keeping people safe by drawing intelligence from a range of sources, including incident reports, medical examiner reviews, and patient feedback. This comprehensive, system-wide approach enables more informed decision-making and the development of targeted interventions to improve care.

The use of data analytics has further enhanced our ability to monitor performance and drive improvement. In particular, the development and refinement of our Quality Outcomes Framework (QOF) allows us to systematically measure, report, and raise standards of care across all services.

Improvement

We have launched several quality improvement programmes, including our participation in the Safe Care Collaborative a National quality programme which focuses on key safety priorities. These programmes provide structured support for teams to test, implement, and embed changes that lead to lasting improvements in care.

Alongside this, we are investing in staff development through targeted training, direct coaching, and support for frontline improvement initiatives, ensuring our workforce has the skills and confidence to lead important areas of change.

By fostering a whole-system approach to quality, we are strengthening collaboration across departments and services. This integrated way of working ensures that improvement efforts are not only effective, but also

Involvement

The introduction of the CIVICA Citizen Feedback System has significantly increased the volume and richness of feedback from both patients and staff. These insights are actively shaping service delivery and informing ongoing improvements.

Our commitment to person-centred care is evident in how people are included in planning and decision-making processes, which involve patients, families, carers, and system partners. This has contributed to an overall satisfaction score of 88% within Civica, exceeding the benchmark of 85%.

We continue to promote a culture of openness and helping people to feel safe to speak up and encouraging staff to report incidents and raise concerns without fear of blame. This supports continuous learning and shared accountability across the organisation.

A Whole System Commitment to Quality and Safety

Together, these efforts reflect our wider commitment to become a true team that learns and improves, where every member of staff is empowered to contribute to the delivery of safe, effective, and person-centred care.

The work we are doing through insight, involvement, and improvement is helping us to better understand our systems of care, build collective capability through an 'all teach, all learn' approach, and foster a culture of curiosity and innovation.

Our improvement efforts are continuously shaped by the voices of patients, families, carers, staff, and communities. We are committed to learning from mistakes and to creating an environment where people feel safe, supported, and encouraged to speak up.

Quality is not just a principle, it is embedded in our systems, behaviours, and outcomes. Above all, we believe that important and sustainable change happens with our patients and communities—not just for them but their involvement is central to our vision. Together, we are building a safer, more responsive, and more compassionate health system.

Quality Strategy

This three-year strategy sets out a clear and ambitious blueprint for delivering safe, effective, and person-centred care.



It places quality and safety at the heart of everything we do, recognising that risks and challenges evolve over time. The strategy commits us to:

- A culture that values quality and ensuring we improve.
- A flexible and responsive approach to emerging safety and quality issues.
- Clearly defined improvement plans to address themes from feedback and supporting structures to drive measurable progress.

By embedding quality into our planning delivery, and evaluation processes, we are actively fulfilling our statutory Duty of Quality.

Together, these strategies provide clear evidence of how the Health Board is delivering on its statutory responsibilities under both the Duty of Quality and the Duty of Candour. They establish a robust and integrated structure for assurance, demonstrating how we improve with clear accountability through ensuring that the care delivered is as good as it can be, that people are kept safe, and how people feel about care remains central to everything we do.

Both articulate our goals to enhance outcomes and experiences, whilst ensuring that everything we do has a culture of engagement. They reflect our commitment to listening to feedback, learning from it, and using that

Patient Experience and Involvement Strategy

Developed in direct response to feedback from patients, families, carers and staff, this strategy ensures that lived experience shapes the way we design and deliver services. It reflects our belief that:

- Learning from experience must be central to our improvement efforts.
- Staff are passionate about improving the experience of those who use our services.
- Engagement must ensure that, everyone is included and that this is an ongoing process.



Milestones Achieved to Date

The Health Board has made considerable progress in embedding principles and processes for quality and embedding these in everything we do, in order to make sure we do a good job and are honest, with a whole-system approach that is grounded in evidence, shaped by lived experience, and driven by a culture of openness, learning, and collaboration.



- Successfully implemented the Quality and Engagement (Wales) Act
- Developed a comprehensive Reporting Framework and Quality Outcomes Framework (QOF) aligned to the Health Board's Six Pillars of Quality and the Health and Care Quality Standards.
- Reviewed and strengthened Quality, Safety and Patient Experience (QPS) structures within divisions and directorates, formalising lines of responsibility, accountability, escalation, and assurance.
- Restructured the QPS function under the Executive Director of Nursing, including redefining the Deputy Head of QPS role to focus on data and performance analysis, ensuring alignment with the Quality Strategy, Patient Experience and Involvement Strategy, and Quality Improvement approach.
- Implemented an escalation process to support divisional teams in managing Public Services Ombudsman for Wales (PSOW) cases and other critical issues, ensuring timely resolution and accountability.
- Established regular meetings with Divisional Triumvirates to facilitate communication, set work plans, and address divisional priorities.
- Designed a Quality Improvement Approach and a commissioning model that places quality at the centre of service planning and delivery.

Embedding a System to Check and Improve Care

- Refined the Quality Outcomes Framework (QOF) to systematically measure, monitor, and enhance healthcare quality, supporting benchmarking and evidence-based practice.
- ensuring robust systems to monitor and drive the QPSE agenda.
- Dashboards are being developed to enable real-time monitoring of escalated cases and action plans.

To further strengthen governance and assurance across the Health Board, a dedicated Quality Management Group has been established in 2025/26. This group provides strategic oversight of quality performance, escalation, and improvement across all domains of care. It serves as a central forum for reviewing real-time data, monitoring trends, and ensuring that divisional and corporate priorities are aligned with the Health Board's statutory Duty of Quality.

The Quality Management Group is underpinned by a robust Quality Management Framework, which defines the Health Board's approach to quality planning, control, improvement, and assurance. This framework supports the delivery of safe, effective, person-centred, timely, efficient, and equitable care by:

- Embedding performance monitoring and escalation processes.
- Aligning reporting structures with strategic priorities.
- Supporting evidence-based decision-making through dashboards and data triangulation.
- Ensuring consistent compliance with Health and Care Quality Standards.
- Promoting a culture of accountability and continuous improvement.

Together, the Group and Framework will enhance transparency, responsiveness and assurance, ensuring that quality is not only measured but actively managed across all services.

Patient Experience, Engagement and Support

- Rolled out the 'Big Conversation' Engagement Strategy across all boroughs, enabling important community, staff and patient involvement in end-of-life care planning.
- Introduced single points of access for key services including PALS, Dementia, GRACE (end-of-life and bereavement), and enhanced the deployment of Volunteers and Companions.
- Implemented the Immediate Support Pathway for sudden and unexpected deaths in children and young people up to age 25, ensuring timely and compassionate support for families.
- Delivered the National Bereavement Pathway for Wales and implemented the Health Board's Bereavement Model by August 2024, standardising care and support for those who are bereaved.

Learning, Insight and Improvement

- Launched a 'Listening and Learning Framework' and established a Learning and Improvement Forum, learning from and sharing themes and trends, putting rapid learning cycles into everything we do and improving care and services.
- Improved early resolution of complaints and strengthened learning and communication around Health and Safety.
- Developed a Learning from Death Framework and a Mortality Report, triangulating data from the Medical Examiner Service to inform learning and assurance.
- Increased the number of safeguarding referrals and improved training uptake, enhancing protection for vulnerable individuals.
- Embedded organisational learning through monthly Learning from Events Reports (LFERs) and drop-in sessions to support interpretation and action.
- Supported the launch of new psychological support programmes, improvements in patient waiting areas, falls assessment tools, and enhanced pain management following HIW inspections.

Clinical Effectiveness and Assurance

- Developed and implemented an Annual Clinical Audit Plan, an Annual Audit Activity Report, and launched a web-based Audit Management and Tracking System to improve oversight and accountability.
- Established a Clinical Advisory Forum to provide strategic oversight and drive quality improvement across clinical services.
- Strengthened evidence-based Infection Prevention practices and introduced process improvements in Infection Prevention and Control, including targeted action plans in response to escalated issues such as C. difficile outbreaks, norovirus, and Covid-19, coordinated through a Silver Command Group.

Clinical Effectiveness will become one of the Pillars of Quality for 2025/26, as part of our review and refinement. These milestones reflect a Health Board that is not only meeting its statutory duties—but actively delivering visible, patient focused and measurable improvements in care with what matters to people at the centre. They demonstrate a culture of learning

Ongoing work for 2024/25 was outlined in our ambitions for our Year Two Quality Strategy.

Workplans were developed for:

1

Infection
Prevention
&
Control

2

Refining
the
Reporting
Structure

Workstream Priorities and Achievements



4

Sepsis

3

Human
Factors
Programme

Infection Prevention and Control

The Health Board has taken a proactive and system-wide approach to infection prevention and control this year. A strategic leadership group and organisational action plan were established to address rising healthcare-associated infections, particularly C. difficile and Staph aureus. Outbreaks were managed swiftly with enhanced cleaning, rapid isolation, and targeted staff education. Quality improvement projects focused on hand hygiene, environmental cleanliness, and compliance with care bundles. Monitoring and assurance were strengthened through dashboards, regular check-ups, and leadership surveys. Despite a rise in some infection rates, the Health Board responded with updated policies, investment in cleaning resources, and piloting new decontamination technologies. Learning from root cause analyses was widely shared, and careful use of antibiotics remains a continuous focus. These actions have reinforced IPC as a cornerstone of keeping people safe and high-quality care.

As part of the Infection Prevention and Control (IPC) pillar of our Quality Strategy, the Health Board is strengthening its focus on careful use of antibiotics and the safe use of antibiotics. Routine reporting of infection rates continues, and a dedicated workstream has been established to improve prescribing practices and to reduce healthcare-associated infections (HCAIs).



Enhanced Cleaning Programme

A robust cleaning strategy has been implemented to reduce HCAIs. This approach balances keeping people safe with operational pressures such as bed availability and ward reconfiguration, using a more targeted and risk-



Patient Flow and Infection Prevention

Daily participation in Patient Flow Meetings ensures infection prevention is embedded in patient placement decisions, supporting safe and timely care.



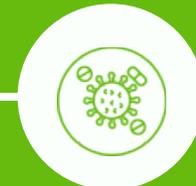
Reporting and Root Cause Analysis

Datix is used to report and analyse HCAIs, with virtual root cause analysis meetings reinstated to identify themes, share learning, and drive improvement.



Supporting Divisions

IPC teams continue to work closely with clinical divisions to promote best practice and provide expert guidance on infection



Antimicrobial Prescribing, Stewardship and Resistance

In collaboration with clinical teams, the Health Board is reinforcing the Start Smart - Then Focus principles, ensuring antibiotics are prescribed appropriately,

This workstream reflects our commitment to the Duty of Quality, ensuring that infection prevention and careful use of antibiotics are embedded across all services, supported by data, education, and improvement.

Refining the Reporting Structure

During 2024-2025, the Health Board has made progress in refining its reporting structure to provide greater assurance, transparency, and responsiveness in quality and keeping people safe. The Quality Outcomes Framework (QOF) was systematically reviewed and enhanced to highlight trends, enabling more timely and actionable insights. The development of the system to check and improve care framework and the establishment of a dedicated Quality Management Group in the last 12 months has ensured that reporting is not only standardised but also aligned with strategic priorities and the Duty of Quality.

Regular meetings with Divisional Triumvirates, the implementation of dashboards for real-time monitoring, and ensuring escalation processes for safeguarding, incidents, and regulatory concerns are part of everyday practice have further strengthened quality assurance. These developments mean that the Board and operational leaders now have access to robust, information from a number of sources with stories and peoples experience, supporting evidence-based decision-making and how we improve across all domains of quality.

To ensure the Health and Care Quality Standards are consistently met, we have:

1

Refined and strengthened the Health Board Clinical Audit Plan to ensure that all priority areas are systematically reviewed and that check-up activity is aligned with national standards and local priorities.

2

Produced regular, comprehensive annual reports that track compliance, highlight areas of good practice, and identify themes and therefore opportunities for improvement, enabling targeted action and transparent Board-level assurance.

3

Enhanced corporate support and streamlined decision-making, ensuring that Divisions have access to expert guidance and that escalation routes for quality and safety issues are clear and effective.

4

Embedded robust assurance mechanisms by consistently monitoring performance against quality and safety standards, using real-time dashboards, information from different places, and regular review meetings.

5

Leveraged existing tools, staff expertise, and digital technology to drive improvement, support learning, and enable timely, data-driven decision-making.

6

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Human Factors Programme

Over the past year, the Health Board has made huge strides in putting human factors principles into clinical practice and quality improvement. The Human Factors Programme has focused on the building of capability and safety culture, particularly in high-risk areas such as theatres. Theatres have benefited from the introduction of Human Factors simulation sessions, safety culture surveys, and the roll-out of the updated WHO checklist and the "Pause for the Gauze" initiative, all designed to reduce serious mistakes that should not happen in a theatre environment and improve team communication.

The Quality Improvement Coach Programme has also incorporated human factors training, with 31 coaches trained to date and a target of one million minutes of QI coaching over four years. Human factors principles are now routinely included in QI projects, safety briefings, and incident reviews, supporting a just culture and ensuring that staff feel safe to speak up. These efforts have contributed to a sustained period without serious mistakes that should not happen in theatres with improved staff engagement, and a demonstrable shift towards proactive risk identification and system-based learning across the organisation.

In 2025, the programme expanded beyond Theatres to include Cardiology and Obstetrics & Gynaecology, with

Key Components:

- Regular introductory and advanced training sessions delivered by the Human Factors Lead, tailored to clinical context and team needs.
- Embedding Human Factors principles into everyday practice to foster psychologically safe, open, and high-performing environments, ensures department integration.
- Undertaking cultural transformation by empowering staff at all levels to speak up, challenge unsafe practice, and contribute to continuous learning and improvement.

This workstream is a critical enabler of the Health Board's commitment to the Duty of Quality, driving safer care through behavioural insight, systems thinking, and team-based learning.

Sepsis

As part of our ongoing commitment to keeping people safe and the Duty of Quality, the Health Board is actively implementing the updated NICE Sepsis Guideline (NG51). This work addresses systemic challenges in recognising and managing deteriorating patients, with a strong focus on early identification, timely intervention, and effective escalation of care.

Over the past year, we have prioritised:

- Early recognition of sepsis through the planned rollout of updated Early Warning Scores for adults, paediatrics, maternity and neonates. across all divisions. This has been planned for implementation throughout 2025/26.
- A comprehensive approach encompassing digital tools, education, implementation, escalation pathways, and check-up.
- A standardised education package has been developed and will be delivered throughout 2025.

A dedicated Sepsis Working Group has been established. There has been a scoping exercise to review current practice and align with updated NICE and Academy of Medical Royal Colleges guidance. In November 2024, the Health Board launched an internal sepsis awareness campaign, with a public-facing campaign planned for April 2025. This will include a new website, staff Pulse page, and awareness materials to support wider engagement.

We are also applying quality improvement methods, such as PDSA cycles, to test and implement the UK Sepsis Trust tool within acute settings. Compliance and effectiveness are being continuously reviewed through a developing check and assurance structure.

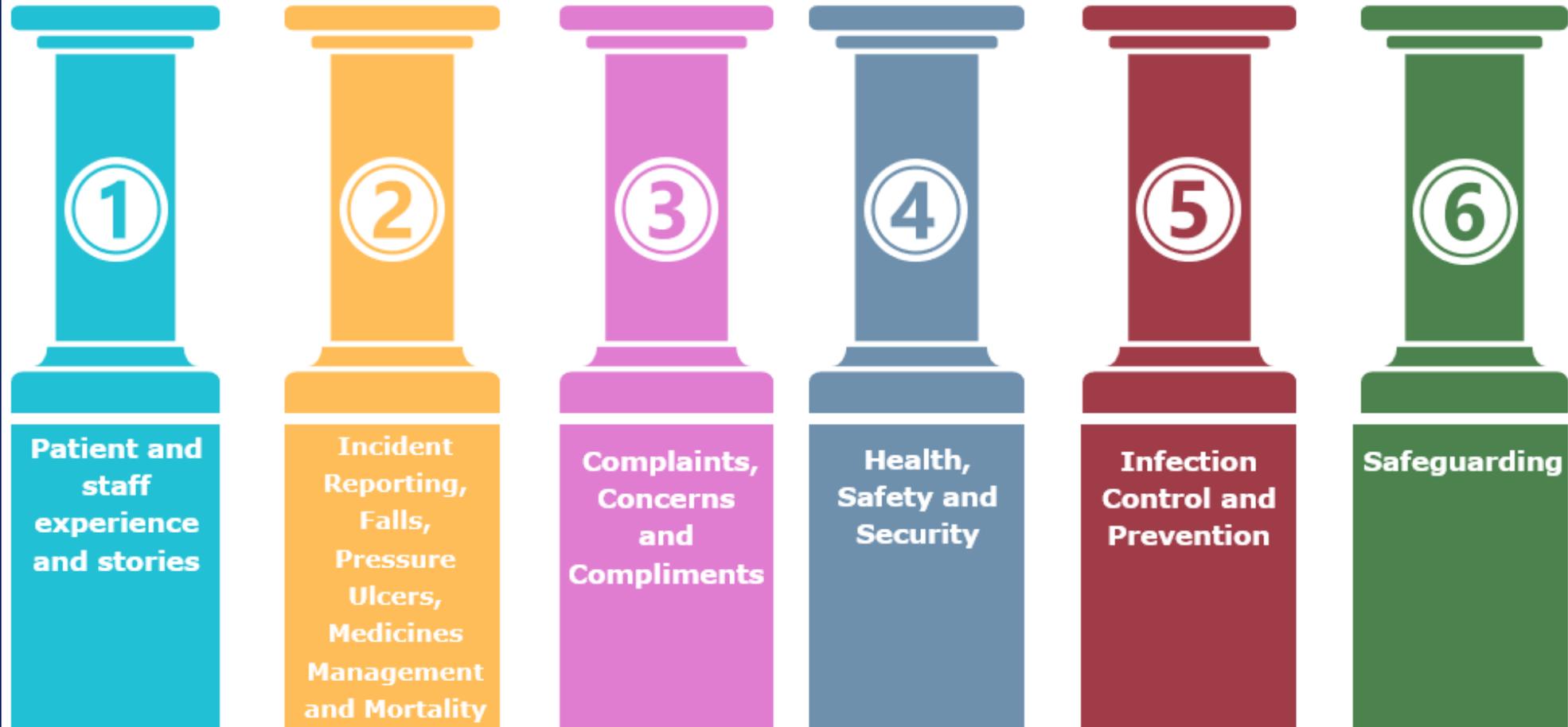
The Health Board continues to contribute to national sepsis forums and the development of eLearning resources, ensuring alignment with national standards and shared learning.

The sepsis workstream is structured around the following:

- Initial Treatment - Timely prescribing and administration of antibiotics
- Source Identification - Prompt identification of infection source
- Early Monitoring - Rapid clinical assessment and review
- Escalation of Care - Strengthened protocols including Call for Concern and Martha's Rule
- Information and Support - Accessible sepsis information for patients and families
- Training and Education - Building staff confidence and capability
- Audit and Assurance - Monitoring compliance and driving improvement

Our collaboration with the UK Sepsis Trust continues to embed best practice and strengthen our contribution to national efforts to improve sepsis recognition, response, and outcomes.

6 Pillars of Quality



Pillar One: Patient and Staff Experience and Stories

Key Achievements and Successes

Embedding Patient Experience and Involvement

Feedback Platform

The roll-out of the CIVICA electronic feedback system, has enabled real-time collection of opinions and thoughts from patients. Over 8,900 answers were received in 2024/25. with an overall satisfaction rate of 89% and 91% for Person Centred Care (PCC) questionnaires.

Positive Emotional Trends

86-91% of answers reflected positive emotions, with compassion, emotional/physical support and friendliness consistently the top positive themes.

Patient Participation Panels

Ongoing involvement through patient panels, Patient Advice and Liaison Service (PALS), loss of a loved one (bereavement) services, and volunteer programmes has strengthened care that focuses on the person and provided direct input into service improvement. Funding has also been secured for a dedicated Patient and Family Involvement Lead to take forward a community of Practice.

Award Recognition

The Patient Experience and Involvement Team and Maternity Services achieved the silver distinction award as part of the Diverse Cymru Black, Asian and Minority Ethnic Cultural Competence Certification Scheme. The Fracture Liaison Service won the MediWales Innovation Award.

Volunteer and Peer Support

Volunteering Service

Volunteers have played a key role in supporting patient experience, especially for those whose first language is not English, and in collecting opinions and thoughts. Over 20,000 volunteer hours were provided.

Cancer Cafés and Support Groups

Initiatives such as cancer cafés and help for feelings (psychological) support groups have been launched in response to patient feedback, enhancing help with improving the support for people receiving care and people who help others.

Pillar One: Patient and Staff Experience and Stories

Results

Quantitative

CIVICA Survey Responses: 8,985 total answers (2024/25), with 7,472 PCC questionnaire answers and 918 Emergency Department questionnaire answers. 595 other surveys received (e.g. endoscopy, children)

Compliments and Positive Feedback: Compliments logged via CIVICA and Datix increased, with "beyond duty of care," communication, and listening as frequent themes

Patient Advice and Liaison Service (PALS) Activity: PALS managed an average of 476 enquiries per month, with communication issues and access to services as the most common themes



Qualitative

Patient Stories: Patient stories and case studies (e.g. Patient Advice and Liaison Service interventions, cancer patient panels, end of life care) have been used to drive service improvements and inform training.

Learning Forums: Regular Learning and Improvement Forums have facilitated cross-divisional sharing of best practice and learning from incidents.

Cultural Competence Initiatives: The Diverse Cymru accreditation process has led to tangible changes in staff training, Recruitment, and patient engagement practices.



Challenges

Sustaining High Engagement and Data Quality

While response rates are high, some locations still have limited feedback, and there are ongoing efforts to increase involvement in underrepresented areas. This improved coverage and reduces survey fatigue.

A recent CIVICA system upgrade led to queries about the accuracy of "waiting" as a negative theme, highlighting the need for ongoing data validation.

Addressing Negative Themes

"Waiting," "food & beverages," and "facilities" remain the top negative themes in patient feedback, indicating persistent issues with timeliness and the care environment. Bespoke reports are sent to the Facilities team and other areas each month capturing comments and themes.

The theme of communication issues is broad, including language barriers and continues to be the most common theme raised through PALS enquiries and early resolution complaints. Because this feedback is received in real time, it allows for quicker identification of concerns where possible. The Health Board is now working to explore defining the specific issues related to communication by expanding the categorisation options. This will support more meaningful data integration and help clarify what is meant by "communication" in different contexts.

Equity and Inclusion

While progress has been made on culture competence, there is a need to further embed cultural competence and address health inequalities, particularly for minority ethnic groups and those with additional needs.

Priorities for 2025/26

Establish People Participation Panels

- To bring together those with different backgrounds (protected characteristics) and seldom-heard voices, including condition-specific groups, to ensure their experiences shape services and improvements.

Establish a Community of Practice

- To provide a safe space for patients, carers and staff to share opinions and thoughts and speak up, strengthening trust and driving meaningful service improvement.



Expand CIVICA and All-Wales Surveys

- Continue to increase coverage and response rates, including the launch of the All-Wales People's Experience Survey and targeted questionnaires for maternity and looked-after children.

Enhance Real-Time Feedback

- Further develop real-time opinions and thought mechanisms and ensure a rapid response to emerging themes.

Pillar One: Patient and Staff Experience and Stories

Bereavement Summary

The Health Board has made significant progress in developing a compassionate, inclusive and responsive loss of a loved one (Bereavement) support system. The approach is based on a principle of working together involving both staff and bereaved people and is underpinned by robust opinions and thought mechanisms and a commitment to improvement. Priorities for the coming year include; further involvement with diverse communities, enhancing staff support, developing and delivering staff training and ensuring that 'loss of a loved one' services are easy to use and meet the needs of all who experience loss.

Collaborative Approach and Engagement

- In September 2024, the Bereavement Collaborative event brought together 94 people (staff and bereaved members of the public), with 42 attending in person. Priorities included pregnancy loss, child loss, and loss from traumatic experiences. Over the last 12 months, 400 people have been involved in the collaboratives.
- 12 bereavement subgroups have been identified, some led by bereaved people themselves, ensuring lived experience is at the heart of improvement work.
- A dedicated event for workers (Staff Bereavement Collaborative) was arranged for December 2024 to coincide with National Grief Awareness Week, focusing on psychological support, workforce and staff needs.

Survey and Feedback

- A new Bereavement Survey questionnaire was tested and amended, now built into the CIVICA platform and including a National Core Question. The questionnaire is easy to use in audio and British Sign Language (BSL) formats, supporting changes to help people and inclusivity.
- The questionnaire captured a range of experiences, including place of death (home, hospital, care home, hospice, pregnancy, elsewhere,) relationship to the deceased, and satisfaction with 'loss of a loved one' support (ratings from "very poor" to "very good"). It also asked whether the death was expected or unexpected, and if support needs were met.

Key Priorities and Actions

- There is a focused plan for Engagement with People with Protected Characteristics to engage bereaved people with different backgrounds and needs through face-to-face and webinar events.
- Engagement events have been agreed for staff, people living with dementia, people with sensory loss, people whose first language is not English, and those affected by baby loss.
- The questionnaire on Reasonable Adjustments and involvement activities are designed to be easy to use, with adjustments for audio and BSL users.

Learning and Improvement

- There has been collaboration when prioritising pregnancy loss, child loss, sensory loss, and traumatic loss, recognising the unique needs of these groups.
- Staff Support: Recognising support for staff is needed when dealing with the loss of colleagues and loved ones and developing resources and events to address this.
- End of Life Care Senior Nurse and Patient and Family Support Officer roles commenced in October 2024 to strengthen bereavement support and end-of-life care.

Snapshot of Survey Findings

(baseline findings prior to implementing the loss of a loved one model)

- Place of Death: Most common were at home and in hospital, but also included care homes, hospices, during pregnancy, etc.
- Relationship to Deceased: Responses included parents, spouses/partners, children, siblings, and extended family.
- Satisfaction: Responses ranged from "very poor" to "very good," with a spread across all categories, highlighting variability in experiences.
- Most respondents indicated their support needs were not fully met.
- Expected vs Unexpected Death: Both expected and unexpected deaths were represented, with a slight majority being expected.

Pillar Two: Patient Safety/Incidents

Key Achievements and Successes

Number of Incidents Reported

It has been encouraging to see a high number of incidents being reported on Datix Cymru, with a clearly defined process for those that go onto Patient Safety Incidents (PSIs) investigations. The Health Board maintained a strong learning culture, with regular thematic reviews and divisional dashboards. Staff reported **26,661 incidents** using the Datix Cymru system. This shows people are speaking up to help make care safer.

Serious Incidents Investigated

Out of all the reports, 528 were serious and looked at more closely to ensure that we learn and improve.

Being Honest When Things Go Wrong

84 cases triggered the Duty of Candour, which means we told patients and families when something went wrong and shared what we learned. Duty of Candour triggers have a robust divisional monitoring and an improvement programme.

Fewer Late Reports

The number of overdue serious incidents (called NRIs) dropped from 71% to 51%, which means we are getting better at closing them on time.

Never Events

Two very serious mistakes happened. They were fully investigated and downgraded from never events and lessons were shared to stop them from happening again. No Never Events happened between January and March 2025.

Learning Together

Staff joined monthly learning sessions and drop-ins to talk about what happened, themes, what went well, and what could be better.

Early Warnings

142 Early Warning Notifications (EWNs) were sent to the Welsh Government. These helped us act quickly on issues like violence, safeguarding, and patients going missing.

Pillar Two: Patient Safety/Incidents

Results

What Was Reported:

Total Incidents	Serious Incidents (PSIs)	Duty of Candour Cases	National Reportable Incidents (NRIs)	Early Warning Notifications (EWNs)
26,661	528	84	948	142

Never Events

2 serious mistakes were investigated and shared, and declassified as never events

Closing Cases

Serious cases are being closed faster, but some still take time, between 76 and 299 days, depending on how serious they are.

Learning and Sharing

Monthly reports and sessions help staff learn from real events. Improvements were made in areas like blood clot prevention, baby monitoring, and follow-up care regular learning forums, thematic reviews, and monthly divisional reporting.

Challenges

- Some serious cases still take too long to finish, especially when they are complicated and involve multiple agencies.
- Some incidents are hard cases to investigate as involve many teams or outside groups, which makes them harder to sort out.
- It's important to get the details right and write down what happened clearly and correctly, especially for things like pressure sores and falls.
- There are high numbers of incidents and not always enough people to investigate them quickly.
- It can be hard to keep staff focused on reporting and learning when they're busy with other work.

Pillar Two: Patient Safety/Incidents

Priorities for 2025/26



Keep using the Duty of Candour to be open and honest with patients and families and learn from what happened.



Make sure all reports are written clearly and correctly, with good training and checks.



Make sure safety teams feel supported and have enough people and time to do their work well.



Keep working to close serious incidents more quickly and improve how we investigate them.



Focus on preventing Never Events and sharing lessons, to help further occurrence when they do happen.



Keep using Early Warning Notifications to act fast and learn from serious issues.



Themes and Learning

01

Learning from Events held as monthly learning sessions and reports help teams understand what happened and how to improve and how themes can be identified to support others.

02

The Duty of Candour process encourages being open and honest and helps staff spot when healthcare caused harm, so we can be honest and learn from it.

03

Families are now more involved in investigations, and their questions are included in reports.

04

For complicated incidents, teams meet early and work together to make sure everything is done properly. Early contact with internal and external stakeholders and strategy meetings for complex cases have improved the coordination and quality of investigations.

05

Reviews have already helped improve care in areas like blood clots, baby monitoring and follow-up appointments.

Pillar Two: Falls

Key Achievements and Successes

- The number of inpatient falls showed a downward trend in the final quarter, with March 2025 recording the lowest monthly figure (281) since April 2024.
- Most falls resulted in no or low harm (96.5%), with severe/catastrophic harm being rare.
- Falls with severe or greater harm, Q1 and Q2, a total of one PER quarter, and zero for Q3 and Q4.
- Regular falls panels and executive huddles reviewed all falls with fractures, supporting learning and prevention.

Results

- 3,625 inpatient falls were reported in 2024/25, with detailed severity analysis and monthly reporting. For 2023/24 this was 3,480 inpatient falls reported annually.
- Falls prevention strategies included daily huddles, targeted audits, and sharing of learning through QPS forums.
- Trauma service reviews and ring-fencing beds to reduce A&E delays.

Challenges

- Variation between divisions in falls rates and harm severity.
- Some falls closed without full senior nurse validation or focused review.
- Delays in transfer to orthopaedic wards and in surgery for hip fractures.

Pillar Two: Falls

Priorities for 2025/26

1

Further analysis of themes and trends with a focus on high-risk areas.

3

Embed the newly established methodology to review all falls with fractures and falls with associated head injuries by means of a concise review as aligned to recommendations of the National Audit of inpatients Falls.

5

Ensure all incidents receive Senior Nurse validation and that a focused review is completed for all incidents of falls.



Embed and monitor the requirements of the updated 'Falls Policy for Hospital Adult Inpatients'.

2

Increase the implementation of evidenced bases practice and methodologies to reduce the incidents of falls e.g. Swarms.

4

Expand daily huddles and use of digital tools for early identification and prevention.

6

Themes and Learning

01

Most falls resulted in no or low harm (96.5%). Severe or catastrophic harm related to 1 fall in Q1, 1 Fall in Q2 and no falls in Q3, and there were no severe/catastrophic falls in the final quarter (number of falls with severe or greater harm per Quarter were Q1=1, Q2=1 and Q3 and Q4 were zero).

02

Falls with fractures are reviewed weekly at Executive huddles, and all data is available at ward level for review and discussion. This enables rapid identification of trends, learning and targeted interventions.

03

Some falls were closed without full Senior Nurse validation or focused review, highlighting the need for improved documentation and validation processes. Inconsistencies in completion of the Multifactorial Risk Assessment (MFRA) in terms of quality of information to support current patient status.

04

The National Hip Fracture Database audit highlighted the importance of prompt orthogeriatric assessment, timely surgery, and early mobilisation. These are being reinforced through regular governance meetings and action planning.

05

Delays in transfer to orthopaedic wards and in surgery for hip fractures were identified as areas for improvement. Trauma service reviews and ring-fencing beds are being used to address these issues.

Pillar Two: Pressure Ulcers (PU)

Key Achievements and Successes

- There was a notable reduction in pressure ulcers in March 2025, reflecting the impact of early identification, daily huddles, and improved documentation.
- Most divisions reported fewer hospital-acquired pressure incidences, and grades 1, 2, and 3 pressure damage over time.
- A professional forum group was established to enhance assurance and validation of Datix reporting.

Results

- This year, 8,963 pressure ulcers were recorded, with breakdown by category and avoidability reported. For 2023.24, 8429 were reported. These are high level figures and do not relate to harm. This is a 6% increase.
- There has been a steady volume of pressure ulcers with Grade 2 being reported and a slight increase in Grade 3 ulcers in December and February.
- Monthly audits, daily huddles, and a professional forum group for validation and learning.
- Implementation of symbols on PSAG boards and use of the PANDO app for wound imaging.
- PDSA cycles are being used to test and refine improvements.

Challenges

- Ensuring accurate grading, documentation, and validation of pressure ulcers.
- Some cases closed without full senior nurse validation or focused review.
- Variation in performance between divisions.

Pillar Two: Pressure Ulcers

Priorities for 2025/26

1

Continue to promote early identification and response strategies.

3



Strengthen validation processes and ensure all cases are reviewed by senior nurses.

2

Share successful practices.

Themes and Learning

01

A professional forum group is being established to enhance assurance and validation of Datix reporting. This will include monthly meetings to review dashboards and validate incidents.

02

Early identification and response strategies, such as daily huddles and the use of symbols on PSAG boards, have contributed to the reduction in pressure ulcers.

03

Improved documentation, staff training in tissue viability, and the use of the PANDO app for wound imaging are supporting better prevention and management.

04

Scrutiny and oversight panels and focused reviews, with Senior Nurse sign-off have been key to PU management

05

Most divisions reported fewer hospital-acquired pressure incidences demonstrating learning from data.

06

Scrutiny panels and focussed reviews with Senior Nurse sign off have been key to PU management.

Pillar Three: Complaints, Concerns and Compliments

Key Achievements and Successes

Sustained High Performance in Early Resolution

Early Resolution of concerns was maintained at an average of 67-71% throughout the year, with some divisions consistently above 80%.

Fewer Late Complaints

Focused efforts, such as weekly meetings and daily huddles, led to a reduction in the number of overdue and long-standing complaints.

One Place to Handle Complaints

Complaints are managed centrally ensuring staff respond to calls efficiently and the process is more streamlined. This approach enhances consistency, eliminates duplication, and provides more robust oversight.

Learning from Complaints

Teams worked together to find better ways to fix problems and make things easier by encouraging open communication and sharing ideas.

More Thank You Messages

Staff received more compliments from patients during the reporting period. October saw the largest surge in compliments as teams are proactively recording the compliments received.

Better use of PALS

The PALS team implemented a new system to record compliments, helping everyone see the good work being done.

Pillar Three: Complaints, Concerns and Compliments

Priorities for 2025/26

1

Training staff to produce better information and write down complaints clearly and correctly. Give staff training and keep patients informed during the complaints process.

3

Keep writing down compliments to celebrate good work and use the system to show what's going well.

5

Make communication better with clearer messages and language support.

Continue to focus on improved timeliness and closure rates, reducing overdue complaints and increasing compliance with 30-day closure targets, especially for PTR-managed concerns.

2

Use reviews and action plans to share learning and help all teams learn from complaints.

4

Build better dashboards and tools to help manage complaints in real time.

6

Pillar Three: Complaints, Concerns and Compliments

Learning and Improvement

1

Holding monthly learning sessions has enabled teams to discuss themes and how to address issues.

2

Every team includes members dedicated to addressing issues promptly.

3

Teams employ intelligent methods to identify the root causes of problems and implement improvements.

4

Reports now include questions from patients and families to make sure their voices are heard and illustrate we are listening.

5

A dashboard assists in identifying issues and improving staff training on the system's use.

6

A strategy meeting helped the Medicine team decrease complaints by 13%

7

The legal and complaints teams have shown their commitment to collaborating on complaints by meeting monthly to resolve issues promptly.

8

Making sure that every team member is present to take calls and properly trained to address complaints effectively.

Pillar Three: Patient Advice & Liaison Service (PALS)

Key Achievements and Successes

Helping People

PALS helped with about 476 questions every month. They gave advice and support to patients and families who needed help or had concerns.

Fixing Problems Early

PALS helped solve about 18 complaints each month before they became bigger issues. Most were about treatment, but they also helped with communication, appointments, leaving hospital, and patient care.

Recording Good Feedback

Since January 2025, PALS started using a new system called CIVICA to write down compliments. This helps everyone see what's going well.

Supporting Patients and Families

PALS helped patients and families in many ways—like helping them talk to hospital staff, supporting people with autism or communication needs, and helping with discharge plans.

Results

- About 476 contacts are received each month, mostly about communication and getting services. 18 complaints solved early each month, mostly about treatment.
- Over 500 compliments were written down. People said staff went “above and beyond,” listened well, and were kind.
- PALS helped create real-life stories in tough situations, like supporting people with serious illnesses, setting up video calls for lonely patients, and helping those with communication or memory problems.
- Learning and Feedback has been pivotal as the PALS team shared what they learned in monthly reports so the whole organisation could improve.

Challenges

- There is a high volume of work as PALS had many questions and complex problems to deal with, which made it hard to keep up.
- New rules and systems meant staff needed training to make sure everything was written down properly and to help keep good records.
- At times there are not enough staff, when staff were off duty, some calls went to voicemail, and fewer questions were recorded.
- Some problems were challenging cases and involved many teams, which made them harder to fix quickly.

Pillar Three: Patient Advice & Liaison Service (PALS)

Priorities for 2025/26

1

Make sure there are enough staff to answer questions quickly, even when someone is off duty.

3

Help more patients and families, especially those who find it hard to ask for help, so our outward reach increases.

5

Keep using CIVICA to record compliments and make sure all PALS work is written down clearly.

2

Train PALS staff to keep solving problems swiftly and share good ideas/practice with other teams.

4

Learn from Good and Bad Feedback, by using both compliments and complaints to learn and improve across the organisation.

Learning and Improvement

01

PALS share real life cases and stories (without names) in reports and meetings to show what went well and what could be better to enhance learning.

02

PALS feedback to hospital teams what they have heard from patients so services can improve.

03

The new CIVICA system and changes to complaint rules helped PALS improve processes in how they record and follow up on cases.

04

PALS staff get regular training on how to talk with people, solve problems, and manage information.

Pillar Three: Legal Services / Public Service Ombudsman for Wales/ Regulation 28

Key Achievements and Successes

Better Oversight and Clear Rules

Reports were shared regularly with the Board to demonstrate the legal and risk workload. New rules were put into place for big cases (over £1 million) and inquests to help things run smoothly and fairly.

Managing Inquests Well

349 new inquests came in this year. 291 were completed —67 had staff speak in person, and 224 were undertaken with written answers. This saved time and helped staff.

Fewer Serious Reports from the Coroner

Only 3 reports were sent by the Coroner to help prevent future deaths. That's fewer than last year, showing we're learning and improving.

Clearing Old Cases

A special project helped close old redress cases faster, reducing risks and delays.

Improved Legal Team Structure

The legal team changed how they work. Now they focus on different areas of work i.e claims or inquests, which helps them respond faster and be more expert in their work.

Results

- 349 new inquests came in; 291 were finished (67 in person, 224 in writing), 3 serious reports from the Coroner were received, 34 redress cases were looked at; 14 were settled, saving about £30,000 each compared to bigger legal claims, 123 new clinical negligence cases were received; 419 were still open at the end of the year and 37 new personal injury cases came in; 82 were still open at the end of the year.
- Reports were shared every few months. New rules were made for significant cases and inquests, The Board and leaders were kept updated.
- In 2024/25, the Health Board received 3,190 complaints. Of these, 178 were escalated to PSOW, which is equivalent to 0.30 per 1,000 residents. The number of interventions decreased by 30%, from 37% in 2023/24 to 28% in 2024/25, reflecting a reduction in the number of full investigations conducted. 6 reports were issued, with 3.3% of referred cases to the Health Board upheld in 2024/25, compared to 25 cases upheld in 2023/24.
- Lessons from Ombudsman cases were shared through posters and updates, contributing to improvements in areas such as discharge advice and patient information.

Challenges

- Some cases take a long time, especially when they involve outside groups or large sums of money
- There are lots of cases, which makes it hard for the team to finish them quickly.
- It's sometimes hard to keep all the paperwork and details correct and on time.
- Legal cases and inquests can be stressful. Staff need support to manage the emotional and work pressure.

Pillar Three: Legal Services / Ombudsman / Regulation

20

Priorities for 2025/26

1

Make sure lessons from legal cases and Ombudsman reports are shared and lead to real improvements.

3

Give staff training, feedback, and emotional support when they're involved in legal cases.

5

Keep working to close inquests and legal cases more quickly.

2

Improve how we track and report legal and risk work.

4

Keep improving rules, reports, and Board updates to make sure everything is well managed.

Learning and Improvement

01

Every serious report is reviewed. Action plans are made and shared to help everyone learn. For example, advice after leaving hospital was improved to include tips on drinking water, leg exercises, and more. Important lessons are shared using posters and bulletins so staff know what happened and how to improve.

02

03

The legal team now works in smaller groups focused on different topics. This helps them respond faster and learn more.

04

Legal and risk lessons are included in monthly reports and reviewed in meetings.

Pillar Four: Health, Safety and Security

Key Achievements and Successes

Most staff completed important safety training:

A new training for manual handling started in April 2025. The goal is to reach 85% in high-risk areas by December.

No new warnings or actions were needed from the Fire Service. Some changes were requested to help fire alarms work better.

Reporting of serious incidents, there were 12 were reported to the Health and Safety group in the last part of the year. Most (83.3%) were reported on time, which is an improvement.

The team helped with 1,120 incidents where staff faced violence or aggression at work. This shows how important Health and Safety is in keeping people safe.

Results

- Training and Safety Checks are:
Health & Safety training: 86.5%
Fire Safety: 82.3%
Violence & Aggression: 86%
Manual Handling: 70%
- Of the serious incidents were reported in the last part of the year. Most were reported on time. Two cases about patient falls are still being reviewed.
- Health and safety updates were shared often with the Board and top managers.

Challenges

- More staff need to complete Manual Handling Training, the new programme will help.
- The Health Board is waiting for advice from the Fire Service about alarm changes in old buildings. Work is still going on to make older buildings safer.
- Some problems, like burns or serious falls, take longer to understand and fix as they are complicated incidents. Outside experts are helping.

Pillar Four: Health, Safety and Security

Priorities for 2025/26



Learning and Improvement

- 01 RIDDOR awareness sessions are being developed to enhance understanding of reporting requirements and responsibilities under the Regulations.
- 02 Ensure regular checks and review for safety training compliance. Dashboards are being made to help teams understand their progress.
- 03 All serious incidents are reviewed to learn from them. Complicated cases are shared with experts like the Health and Safety group and the Fire Service.
- 04 A review of the training framework is being undertaken to evaluate both the competency requirements and the methods of delivery. This review will adopt a risk-based approach, ensuring that training remains relevant and proportionate to individual job profiles.
- 05 Health and Safety Management Audits are being integrated into the Audit Tracking and Management System (AMaT) to support the development of a performance dashboard.

Pillar Five: Infection Prevention and Control (inc. Antimicrobial

Key Achievements and Successes

The team worked hard to stop infections like C. difficile, norovirus, COVID-19, and others. They instigated cleaning more often, checked wards regularly, and acted quickly when problems appeared.

Special projects helped wards improve infection control. These included work on C. difficile and oral hygiene. Infection control was also added to leadership training.

The team met their goals for using fewer antibiotics in GP surgeries. In hospitals, they worked on improving how antibiotics are prescribed using digital systems. They also taught staff and checked how antibiotics were used.

When infections spread, the team held quick meetings, instigated cleaning, grouped patients safely, and managed visiting to stop further spread.

Results

Infection Numbers - 275 cases of C. difficile (20% more than last year), 189 Staph Aureus infections (47% more), 376 E. coli infections (8% more), 115 Klebsiella infections (15% less), 42 Pseudomonas infections (68% more)

Ward Closures - 21 closed for C. difficile, 30 for norovirus, 25 for COVID-19, 3 for flu - over the 12 months.

Checks and Training - Regular infection checks and staff training, Webinars on topics like C. difficile and winter viruses, Surveys to check how well staff understand infection control

Antibiotic Use - GP surgeries met their goal for using fewer antibiotics but didn't reach the target for using the safest types, Hospitals created dashboards and held meetings to track antibiotic use. GP surgeries received

Challenges

- Some infections increased, partly due to shared spaces, poor airflow, and busy wards.
- GP surgeries didn't meet the target for using the safest antibiotics. Hospitals had staff shortages and delays in using new digital systems.
- There were delays in getting clean mops and replacing old ones which created cleaning delays .
- Some infection and antibiotic records weren't complete, making it harder to track and learn.
- It was hard to keep staff focused on infection control with so many other things going on.

Pillar Five: Infection Prevention and Control (inc. Antimicrobial

Priorities for 2025/26

1

Reach the goal for using safer antibiotics in GP surgeries, use digital systems in hospitals to track and improve antibiotic use, providing GP surgeries with more that need support

3

Plan for Resources, by making sure there are enough cleaning supplies and staff to keep up with infection control.

5

01

Special projects helped wards take charge of infection control. These were supported by regular checks and leadership involvement. Quick meetings were held during outbreaks. Lessons learned were shared to help prevent future problems.

02

03

Infection checks and staff training helped teams learn and improve. Results were shared to keep everyone informed.

04

Staff were trained regularly on infection control, how to use antibiotics safely, and how to manage data.

Focus on reducing infection rates like C. difficile, Staph Aureus, E. coli, and Pseudomonas with better cleaning and fast action.

2

Make sure infection and antibiotic records are complete and accurate. Use dashboards to help wards see and improve their results.

4

Keep teaching staff about infection control and include it in leadership training.

Pillar Six: Safeguarding

Key Achievements and Successes

There were more reports made to help keep adults and children safe. Adult reports went up by 31%, and children's reports went up by 14%.

Strong Safeguarding Groups were formed, the team worked with leaders to set up regular meetings about keeping people safe. Smaller groups were also created to focus on adults, children, and staff concerns.

Most staff completed their safeguarding training. If any areas fell behind, plans were made to help them catch up.

Timely referral ensured staff could engage early with patients, families and their representatives to develop safety plans. The statutory safeguarding processes enabled us to work closely with multiple services within our own organisation, as well as with statutory partners and third sector organisations, to ensure the correct support is in place from the correct

Results

Reports Made: 506 reports to help adults, 4,290 reports to help children

Training:

- Level 1 Adult Safeguarding: 81% completed
- Level 1 Children's Safeguarding: 82% completed
- Level 2 Adult Safeguarding: 82% completed
- Level 2 Children's Safeguarding: 83% completed
- Level 3 training is now required and will be tracked from early next year

Managing Cases: A new digital system has commenced to help track safeguarding concerns and actions. Cases open longer than three months were reviewed to make sure they were dealt with quickly

Challenges

- The number of safeguarding concerns has gone up and there are more complex issues resulting in increased demand on the safeguarding team.
- Some teams didn't reach the 85% training goal, extra help and support has been provided.
- The new Datix system to track safety concerns is being rolled out, which has presented challenges.
- There are different arrangements in different areas within the five local authorities, which has made things confusing at times, work is underway with partners to make the systems clearer.
- Some cases have taken an extended time to complete, especially when external partners were involved. This has at times affected staff wellbeing and made workloads more challenging.

Pillar Six - Safeguarding

Priorities for 2025/26

1

Finalise the configuration of the Datix digital system to effectively monitor and report safety issues.

3

Continue collaborating with partners to regularly review cases that remain open for long durations, enabling prompt learning and timely action.

5

Reach Training Goals by ensuring 85% of staff complete their safety training, especially those in leadership roles.

2

Work with local authorities and Police to ensure that procedures and policies are consistently applied.

4

Provide staff with consistent feedback and ensure they feel supported while handling challenging safeguarding cases to promote their wellbeing.

Learning and Improvement

01

Regularly examining cases that remain open for extended periods allows teams to gain insights and expedite closure. This practice has become a routine and has received positive feedback from both staff and partners.

02

Collaborate with Local Authorities and the Safeguarding Board to clarify procedures and guidance, minimising confusion about what needs to be reported.

03

A new Safeguarding Datix Module is currently being developed for release, awaiting the completion of the All-Wales multi-agency referral form.

04

Awareness raising around the importance of initiating early communication with patients, their families, and representatives to collaboratively create safety plans at an early stage.

Ward Accreditation: Annual Review

The Ward Accreditation Programme developed in 2024-25. More areas have achieved accreditation and staff are motivated to improve and achieve accreditation, and quality improvement is now part of everyday work. In 2025-26, the focus will be on finishing the rollout, improving data and audits, and keeping staff supported and engaged.

Key Achievements and Successes

The Ward Accreditation Programme now covers 78 areas, including adult wards, mental health, learning disabilities, and children's wards.

Programme Growth is evident - Phase 1 is finished. Phase 2 (including theatres and critical care) has started, and Phase 3 (maternity and district nursing) will begin in

Independent Checks are carried out - 14 reviews were completed. 8 wards earned bronze awards, and 2 were ready for Silver.

Staff morale was improved and staff were more aware and involved thanks to updates, online tools, and news posts.

Quality improvement (QI) is now part of daily work, not just a special project.

Results

- Monthly checks are now normal, which look at patient care, staff feedback, and team improvements. "One Patient One Day" audits help show how care is improving. New folders help teams plan and track their progress. A data expert started in May 2025 to help with reporting. Staff can use Padlet (an online tool) to find audit information and resources.
- Feedback forms help teams share what they need. Senior nurses help keep audits on track. Guides and tools are being updated to help staff understand the process.

Challenges

- Staff said some audits were repeated too often, which slowed down awards.
- Data issues can be a hindrance, with challenges in pulling useful information from the audit system. A data analyst is starting in post in May 2025.
- Some wards didn't meet the 6-hour goal for risk assessments or had delays due to staff shortages.
- Keeping Up Momentum and maintaining audits was a concern. Staff have needed clear guidance and regular support.

Ward Accreditation

What Should We Be Focussing on in 2025-26



Use the new data analyst to improve reports and spot trends. Make Padlet easier to use and share good ideas.



Keep Staff Involved by sharing stories and celebrate wins. Build a team of experts to help others improve.



Start Phase 3 - Begin accreditation for health visitors, district nurses, maternity, and specialist teams.



Improve Audits and Support by cutting down on repeated audits. Help teams complete their folders and keep audit quality high. Update guides so everyone understands what's needed.



Learning and Improvement

01

Staff feedback helped reduce repeated audits and improve folder formats, listening to staff is important.

02

Reviews showed the need for clearer time targets. Teams are now comparing with other health boards to improve.

03

Supporting areas which are struggling. Wards that didn't achieve Bronze are receiving extra help. Lessons from reviews are shared with senior nurses.

04

Making QI Part of Everyday Work as the programme is helping teams to improve every day, not just during special projects.

05

Better Access to Information includes using a Padlet and other tools are making it easier for staff to find what they need and stay on track.

Nutrition and Hydration Progress Overview

In response to concerns raised through complaints, Regulation 28 notices, and audit findings, the Nutrition and Hydration Task & Finish Group was established under the Aneurin Bevan University Health Board (ABUHB) Nutrition and Hydration Strategic Group. The group initially focused on two priority workstreams—Nutrition Escalation and Fluid Balance Monitoring, which were later amalgamated to streamline efforts and enhance shared learning.

Nutrition Escalation

Key drivers included inconsistent escalation of nutritional needs and gaps in staff awareness and timely action for patients with complex requirements, such as those with learning disabilities, swallowing difficulties, or requiring tube feeding. In response, the group developed a 7-minute briefing and an Action Card to support staff in identifying and escalating nutritional concerns. The WAASP tool was promoted for risk screening within 24 hours of admission or extended ED stays. Clear guidance was provided for patients unable to participate in assessments, those with swallowing difficulties (including SLT referral pathways), and those with cultural, religious, or therapeutic dietary needs. Protocols were also established for tube feeding and missed meals.

Assurance measures included dissemination of materials across divisions, audit and feedback mechanisms, and ongoing development of training and escalation procedures.

Fluid Balance Monitoring

This workstream was driven by Regulation 28 concerns regarding poor documentation and associated patient harm. Audits revealed that over half of staff had not received training on completing fluid balance charts. To address this, a 7-minute briefing and Action Card were developed to standardise practice. Roles and responsibilities were clarified across the multidisciplinary team, and criteria were defined for when fluid balance charts are required (e.g. sepsis, AKI, IV fluids, enteral/parenteral nutrition). Detailed guidance was provided on accurate input/output recording, recognising signs of dehydration, and understanding measurement standards and receptacle volumes.

Assurance measures included pilot audits showing improved practices, such as midday calculations and alternate-day weighing. PDSA cycles were used to refine the approach, and SOPs and guidelines are currently under review by the Clinical Policy Group.

Forward Planning

Future plans include continued audit and improvement cycles for both workstreams, the development of a Nutrition and Hydration intranet resource hub, an annual action plan, and expansion of the Clinical Sub-Group's membership.

Embedding a Culture of Listening, Learning and Improvement

The Health Board's commitment to becoming a true team that learns and improves is clearly demonstrated through the implementation of our Listening and Learning Framework. This provides a structured and consistent approach to capturing, analysing, and acting on learning from incidents, feedback, and lived experience. It ensures that learning is not only identified but also embedded into practice—supporting safer, more effective, and more compassionate care.

A key enabler of this work is our web-based learning repository, which allows us to track how learning is identified, triangulated, shared, and implemented across the organisation. This supports a culture of appreciative enquiry and improvement, while also enhancing the experience of our workforce.

We are committed to becoming a team that learns and improves—one that improves keeping people safe, people's experience of care responding to insights and feedback in order to continuously improve. Our plans and priorities are continuously adapted to ensure we are doing the right things, in the right way, at the right time.

Collaborative Learning, Education and Improvement

The Health Board has taken a strategic and system-wide approach to learning and education as core enablers of quality, safety, and patient experience. Key achievements include:

- Identifying key quality issues and keeping people safe priorities through using multiple sources of intelligence, shaped by the voices of service users, to inform a responsive learning plan.
- Strengthening partnerships between corporate and educational teams to support the development of health professionals around core quality and safety themes.
- Facilitating cross-disciplinary education that aligns with organisational priorities and promotes shared understanding across teams and services.
- Ensuring learning and education are embedded in key quality and keeping people safe groups across the organisation, supporting alignment between clinical and corporate priorities.
- Supporting divisions and directorates to develop annual improvement plans based on insights from complaints, incidents, surveys, and reviews—ensuring a standardised, consistent and evidence-informed approach.
- Building capacity within teams to co-produce digital patient stories that support important listening, reflection, and learning.
- Standardising training, education, and competency records to reduce unwarranted variation and strengthen assurance.
- Establishing Collaborative Learning Events, multi-agency, public, and staff collaboratives, including learning events attended by patients, families, and carers to ensure a collective and inclusive approach to improvement.

This integrated approach reflects the Health Board's commitment to learning and improvement where education, insight, and collaboration drive improvement in care quality and patient and staff experience.

Delivering Assurance Through the Quality Management System (QMS)

The Health Board is committed to delivering safe, high-quality, and equitable care through the development and implementation of a comprehensive QMS.

This system will define the Assurance Framework that underpins our approach to quality planning, control, improvement, and assurance—ensuring that care is consistently safe, effective, patient-centred, timely, efficient, and equitable.

The QMS will support the Health Board in embedding a culture of improvement and accountability, with a clear focus on the following objectives:

- Implementing proactive plans to minimise risk, reduce avoidable harm and keep people safe.
- Ensuring clinical care is evidence-based and grounded and consistently delivers optimal outcomes.
- Fostering a culture for Person-Centred Care that prioritises the needs, preferences, and experiences of patients and their families.
- Optimising the use of available resources to deliver high-quality care in a sustainable and cost-effective manner.
- Addressing disparities in healthcare access, equity and outcomes to ensure all patients receive the same high standard of care.
- Measuring and understanding the quality and safety implications of timely access to care.
- Setting clear performance metrics and monitoring systems for each pillar of quality to ensure comprehensive oversight and improvement.
- Evaluating changes to service access and delivery to ensure they enhance safety, effectiveness, and experience—while preventing health inequalities and promoting improvement.

By aligning these objectives with the principles of Quality Planning, Quality Control, and Quality Improvement, the QMS will provide a structured and transparent approach to delivering assurance. It will enable the Health Board to demonstrate how quality is being embedded at every level of the organisation, supporting our statutory duties under the Duty of Quality and ensuring that patients receive the highest standard of care, every time.

Clinical Advisory Forum

To strengthen clinical oversight and embed assurance into our quality governance arrangements, the Health Board established a dedicated Clinical Advisory Forum during 2024-25. This strategic group was created to provide expert guidance, challenge, and support across all clinical services, ensuring that decisions about care are informed by evidence, lived experience, and best practice.

The Forum brings together senior clinical leaders and subject matter experts to review performance, share learning, and drive improvement aligned with our Quality Strategy and the statutory Duty of Quality.

As part of its strategic oversight function, the Clinical Advisory Forum has taken on a pivotal role in reviewing and assuring Quality Impact Assessments (QIAs) across the Health Board. This ensures that any proposed changes to services, pathways, or models of care are rigorously evaluated for their potential impact on patient safety, clinical effectiveness, and experience.

The Forum provides a structured, multi-disciplinary space where QIAs are scrutinised through a clinical lens, balancing innovation and transformation with the statutory Duty of Quality. By embedding QIA review into its core business, the Forum supports evidence-based decision-making, promotes consistency in quality assurance, and ensures that risks are identified, mitigated, and transparently addressed before implementation. This approach strengthens governance and reinforces the Health Board's commitment to delivering safe, effective, and equitable care.

Quality Improvement

Over the past year, Aneurin Bevan UHB has made significant strides in embedding a culture of quality improvement (QI) across the organisation. The development and launch of the new Quality Improvement Framework approach for 2025–2028 has been a cornerstone achievement, setting a clear vision for QI as a core organisational value and daily practice. This strategy was shaped through broad engagement, including staff at all levels, QI leaders, and external experts, and is aligned with the Health Board's Quality Management System.

A key feature of the QI culture is the empowerment of staff to lead and participate in improvement activities. The ABUHB QI Knowledge and Skills Programme is building internal capacity for QI and is contributing to a network of QI Coaches and Practitioners who support colleagues, facilitate change, and drive improvement from the ground up. The expansion of the Ward/Team Accreditation Programme to include QI is reinforcing local accountability and continuous improvement at the frontline.

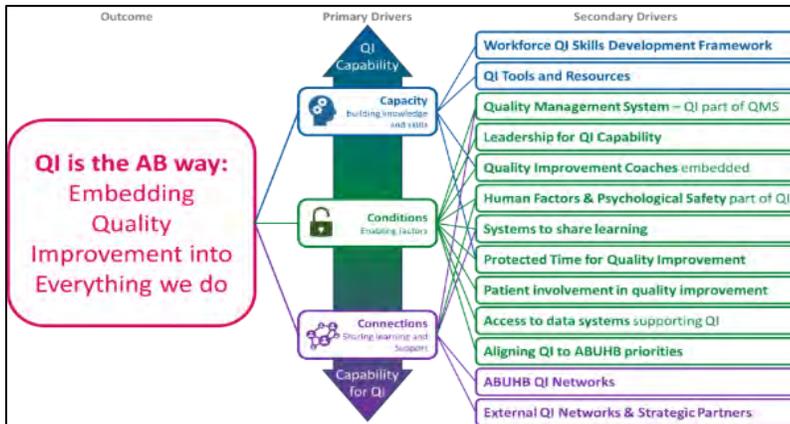
The Health Board's approach to QI is characterised by openness, collaboration, and a willingness to learn from both success and challenge. Staff are encouraged to undertake improvement locally, celebrate achievements and share best practice. As a result, QI is increasingly seen not as a separate initiative, but as an integral part of everyone's role. The culture is one where improvement is continuous, learning is valued, and staff at all levels are empowered to make a difference for patients, families, and colleagues. This cultural shift is laying the foundation for even greater achievements in the coming year, as the Health Board continues to implement its QI Capability Strategy and build on the successes of 2024/25.

Quality Improvement

Key Achievements and Successes

Number of Incidents Reported

The Health Board developed and launched a new Quality Improvement (QI) approach for 2025–2028, with broad engagement from staff, QI leaders, and external experts. The strategy sets out a vision for embedding QI into every aspect of organisational practice as part of a wider Quality Management System. It aims to develop the Health Board as a learning organisation where clinical & non-clinical staff share ownership over the services they provide, have the agency to improve them, and an environment that enables them to do so. It will do this by building QI capacity, creating enabling conditions, and fostering connections for shared learning and improvement. This has helped to create a more open, proactive, and collaborative culture for QI, where improvement is seen as everyone’s responsibility and is part of daily work. The Driver Diagram below outlines key areas of work to achieve this



QI Coach Programme

Spread and Scale of QI Coaching capacity is key to enabling teams to improve quality locally. The QI Coach Programme was launched in 2024. The ultimate aim is to “unleash a million minutes of QI Coaching over the next four years,” with 17,355 minutes delivered so far. This is about embedding improvement capability and empowered staff at all levels to lead and support change.

Continuous Improvement Culture

Through the implementation of the QI Capability Strategy the Health Board embedding a culture of continuous improvement. Regularly engaging with health board teams, sharing learning, using QI principles and tools, staff are being encouraged to celebrate success and address ongoing challenges. .

QI Programmes

NHS Wales - Safe Care Collaborative ended in May 2024:

- Increase from 40 to 490 days between cardiac arrests on Ward C0 - 17 cardiac arrests avoided with potential savings of over £290k
- Positive outcomes also achieved by the Monmouth Integrated Team and the OT Early Intervention Memory Service

Theatre Safety Programme - reduction in Never Events

- Increase from 90 to 518 days between Never Events in theatres - 5 Never Events avoided up to March 2025 with a potential saving of over £330k

Q Lab - Head and Neck Cancer

- Duration between initial suspicion of cancer to decision to treat halved to 31 days, with 7 potential deaths avoided. Compliance with suspected cancer pathway doubled to over 61%. Estimated health benefit value between £2-3 million annually

Quality Improvement

Outputs

Quality Improvement Knowledge and Skills Framework: This has been developed to 'dose' appropriate knowledge and skills training around QI principles and methodology targeted at staff at different levels. Training is delivered through the following programmes:

- **QI Coach Programme** - 31 coaches trained by the end of 2024. Programme is set up to train 75 QI Coaches across 3 cohorts per year to create 300 QI Coaches integrated into services by the end of 2028.
- **PocEd QI virtual training** - 349 staff undertook virtual QI method/tools training (a 32% increase, with 102 trained in 2024)
- **PocEd Measurement virtual training** - 67 staff completed measurement training focused on run charts and SPC. This has improved the organisation's ability to use data for improvement and to measure the impact of changes.

QI Networks/Partnerships

- Positive links with external QI Bodies such as the national Quality Safety and Improvement, Q Community, Q Lab, Q Lab Cymru, NHS Elect.

QI Resources:

- QI Padlets including Problems to Solutions tool

Challenges

Sustaining Momentum: Keeping up the pace of QI work and ensuring protected time for QI coaches and staff, especially as the programme scales up.

Corporate and divisional leadership - structures to support quality improvement as part of a wider Quality Management System

Priorities for 2025/26



Clinical Effectiveness: Ensuring Quality and Patient Safety

Delivering consistently safe, effective, and evidence-based care is central to the Health Board's vision and our statutory Duty of Quality. Over the past 12 months, we have strengthened our focus on how well care works to support improved outcomes and keeping people safe across all services.

National Clinical Audit Programme

The Health Board actively participates in the National Clinical Audit Programme, using its findings to benchmark the quality of care and identify areas for improvement. Our Annual Clinical Audit Plan outlines the timeline of national check-up publications and ensures alignment with local priorities. Insights from these check-ups are reviewed by the Clinical Standards and Effectiveness Group and reported to the Patient Quality, Safety, and Outcomes Committee, ensuring robust oversight and accountability. These

Learning from Deaths Framework

We have strengthened our approach to deaths review through the implementation of a comprehensive Learning from Deaths Framework, supported by a detailed report capturing key deaths metrics and insights. This work is triangulated with data from the Medical Examiner Service, which now reviews all deaths within the Health Board. Emerging themes are shared through newsletters and briefings, ensuring learning is disseminated and embedded into practice.

By putting continuous improvement into our governance, audit, and learning systems, we are ensuring that quality and keeping people safe remain at the heart of everything we do—delivering the highest standards of care to the communities we serve.

Clinical effectiveness will be embedded as a core component of the Health Board's Quality Pillars for 2025/26, enhancing our ability to monitor, measure, and report on the delivery of safe, evidence-based care with greater consistency and transparency.

Structured Audit Participation

We have implemented a standardised approach to clinical audit through the development of a Clinical Audit Strategy, Annual Clinical Audit Plan, and Annual Audit Report. This ensures purposeful participation in both national and local audits. Local actions and recommendations are captured and tracked through our Audit Management and Tracking (AMaT) system, enabling teams to refine practice, raise standards, and improve patient outcomes.

Continuous Improvement and Collaboration

Our commitment to how continuous improvement is supported through collaboration with other NHS Wales Boards, Trusts, and the NHS Wales Executive via the Safer Care Partnership. This national initiative supports local teams in delivering safe, reliable, and high-quality care, and ensures that improvement is informed by shared learning and best practice.

Conclusion

The 2024/25 Annual Quality Report reflects Aneurin Bevan University Health Board's unwavering commitment to delivering care that is safe, timely, effective, efficient, equitable, and person-centred, aligned with the STEEP domains of quality. These principles are not just aspirational; they are embedded in our systems, behaviours, and outcomes, guiding every aspect of our work.

Our Pillars of Quality programme has provided a robust framework for assurance, enabling us to monitor performance, escalate concerns, and celebrate achievements across all domains of care. It ensures that our statutory Duty of Quality and Duty of Candour are actively upheld, and that quality remains the golden thread running through everything we do.

We would like to extend our heartfelt thanks to all our staff and teams across the Health Board. Their dedication, compassion, and relentless focus on putting the patient at the centre of everything we do is the foundation of our success. It is through their hard work and commitment to learning and improvement that we continue to deliver safe, effective, and compassionate care.

As we look ahead to 2025/26, we remain focused on listening, learning, and improving-together. With our Quality Management System and Pillars of Quality guiding the way, we are building a health system that is safer, more responsive, and more inclusive for all.

Appendices

To strengthen our assurance and demonstrate meaningful progress under the Duty of Quality, the following table outlines key achievements from 2024-25 mapped against the STEEEP domains of quality – Safe, Timely, Effective, Efficient, Equitable, and Person-centred and the core quality enablers that underpin our improvement efforts. These examples reflect how the Health Board has embedded quality into its systems, behaviours, and outcomes, supported by robust governance, data-driven decision-making, and inclusive engagement. Together, they provide clear evidence of how we are delivering safe, effective, and compassionate care, while continuously learning and improving across all services.

STEEEP Domains Summary

The Health Board's Quality Management System (QMS) aligns with the **STEEEP** domains, ensuring care is:

- **Safe:** Through incident reporting, infection control, safeguarding, and sepsis management.
- **Timely:** Via improved patient flow, early identification of issues, and rapid response mechanisms.
- **Effective:** Through evidence-based practice, clinical audits, and structured learning from deaths.
- **Efficient:** By optimising resources, refining reporting structures, and reducing delays in investigations.

Domains of Quality (STEEEP): Achievements with Assurance Focus

Domain	2024-25 Achievements	Assurance Mechanisms
Safe	<ul style="list-style-type: none"> Reduction in inpatient falls and pressure ulcers Sepsis Working Group and updated NICE guideline implementation Infection control response to outbreaks (C. difficile, norovirus, COVID-19) 	<ul style="list-style-type: none"> Executive huddles and scrutiny panels for falls and pressure ulcers Real-time dashboards and Datix reporting Root cause analysis and thematic reviews
Timely	<ul style="list-style-type: none"> Early resolution of complaints via PALS Rapid response to infection outbreaks Escalation processes for safeguarding and regulatory concerns 	<ul style="list-style-type: none"> Monthly divisional reviews and escalation protocols Dashboards for incident tracking and patient flow
Effective	<ul style="list-style-type: none"> Participation in National Clinical Audit Programme Launch of AMaT audit system PDSA cycles as part of Quality Improvement 	<ul style="list-style-type: none"> Annual Audit Plan and Clinical Advisory Forum Mortality Report triangulated with Medical Examiner data
Efficient	<ul style="list-style-type: none"> Centralised complaints handling Improved antibiotic stewardship in GP surgeries Escalation and resolution of PSOW cases 	<ul style="list-style-type: none"> Quality Outcomes Framework (QOF) and reporting structure refinement CIVICA system for feedback and compliments
Equitable	<ul style="list-style-type: none"> Engagement with diverse communities in bereavement support CIVICA feedback in BSL and audio formats Diverse Cymru accreditation 	<ul style="list-style-type: none"> Protected characteristic panels and inclusive survey design Community of Practice and targeted webinars
Person-centred	<ul style="list-style-type: none"> 89% satisfaction rate from CIVICA feedback Patient panels and volunteer programmes Bereavement collaborative and support roles 	<ul style="list-style-type: none"> Patient Experience and Involvement Strategy Real-time feedback and monthly learning forums

Quality Enablers Summary

The report identifies several **quality enablers** that support the Duty of Quality and STEEEEP domains:

Leadership: Strategic oversight and governance through divisional structures and executive engagement.

Information: Dashboards, CIVICA feedback platform, AMaT audit system, and real-time monitoring tools.

Learning, Improvement and Research: Listening and Learning Framework, Learning from Events Reports, and collaborative forums.

Workforce: Training programmes, QI coaching (aiming for one million minutes over four years), and human factors integration.

Culture: Patient panels, bereavement collaboratives, and multi-agency learning events.

Whole Systems Approach: Quality Outcomes Framework (QOF), Clinical Audit Plan, and structured reporting.

Quality Enablers: Achievements with Assurance Focus

Enabler	2024-25 Achievements	Assurance Mechanisms
Leadership	<ul style="list-style-type: none"> • Strategic oversight via Divisional Triumvirates • Executive huddles for falls and infection control 	<ul style="list-style-type: none"> • Governance structures and escalation pathways • Quality Management Group planned for 2025/26
Information	<ul style="list-style-type: none"> • CIVICA feedback platform • Real-time dashboards for QOF and infection rates • AMaT audit tracking system 	<ul style="list-style-type: none"> • System to check and improve care Framework • Data triangulation and reporting tools
Learning, Improvement and Research	<ul style="list-style-type: none"> • Listening and Learning Framework • Monthly Learning from Events Reports (LFERs) • Drop-in sessions for staff reflection 	<ul style="list-style-type: none"> • Learning and Improvement Forum • Embedded learning from incidents and deaths
Workforce	<ul style="list-style-type: none"> • Human Factors Programme and simulation training • QI Coach Programme (1 million minutes target) • Training in sepsis, safeguarding, and infection control 	<ul style="list-style-type: none"> • Standardised education and competency records • Strategic representation in quality groups
Culture	<ul style="list-style-type: none"> • Bereavement collaboratives and subgroup leadership by bereaved individuals • Multi-agency learning events • Patient and Family Support Officer roles 	<ul style="list-style-type: none"> • Inclusive engagement strategies and feedback loops • Community involvement in service design
Whole System Approach	<ul style="list-style-type: none"> • Quality Outcomes Framework (QOF) • Structured audit plans and reporting • Escalation and accountability frameworks 	<ul style="list-style-type: none"> • Clinical Audit Strategy and AMaT system • Monthly governance meetings and performance monitoring



**CYFARFOD BWRDD I ECHYD PRIF YSGOLN
ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
MEETING**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	PTR Annual Report 2024-2025
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 QPS, Learning and Improvement

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

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Putting Things Right (PTR) Annual Report has been prepared in accordance with the PTR Regulations. The annual report demonstrates our ongoing commitment to the population of the Health Board, which covers Blaenau Gwent, Torfaen, Monmouthshire, Caerphilly, and Newport. This equates to around 600,000 children, young people and adults. It will provide an overview of the 2024/2025 position in terms of how Aneurin Bevan University Health Board (ABUHB) has managed concerns, Redress cases, Claims, Patient Safety Incidents, Duty of Candour and Public Services Ombudsman for Wales (PSOW) cases during this reporting period. It will provide information on progress, performance as well as an overview of emerging themes and trends, including lessons learnt and emphasises the Health Board's dedication to openness, honesty, and patient-centred care and the subsequent vision for 2025/2026.

Cefndir / Background

The Report focuses on and describes the successes and challenges related to 'Putting Things Right' during the reporting period. It encompasses, Complaints, Compliments, Redress, Patient Safety Incidents, and PSOW cases and Duty of Candour all of which are underpinned by the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

The Health Board values feedback and concerns from service users and families, recognising their vital role in improving services and patient safety. The introduction of the Health and Social Care Quality and Engagement (Wales) Act and NHS Duty of Candour on 1 April 2023 further strengthens our organisational responsibility to communicate openly, learn from concerns, and integrate these principles into everyday practice.

The report also details the organisational structure and governance of the Putting Things Right/Quality Patient Safety (QPS)/Putting Things Right (PTR) teams, which have been aligned with the Nursing Directorate since February 2024

Assessment

The period 2024/25 has brought both opportunities and challenges.

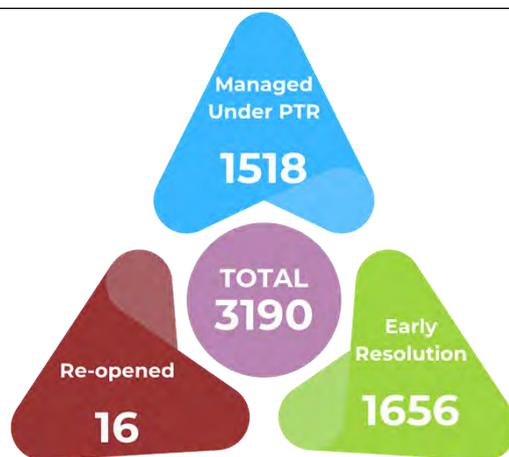
At the heart of the "Putting Things Right" (PTR) and Duty of Candour arrangements is the requirement to be open and honest when dealing with concerns. Most importantly to play a significant role in improving patient safety; endorse a person-centred approach to concerns management and reinforce a culture of organisational learning and quality. This is underpinned by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) 2011.

The Health Board is committed to making it easy for people to raise concerns, feel that they are being listened to, and that their concerns are being taken seriously.

The Organisational Change Process, which integrated the Divisional and Nursing Directorate resources for Quality and Patient Safety, was completed in February 2024, with the Quality Improvement team from ABCi joining in May 2024. This new model is now in place, ensuring that Quality Patient Safety (QPS), Putting Things Right (PTR) and Quality Improvement (QI) services are coordinated and aligned to deliver the vision set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020, 'A Healthier Wales' (Welsh Government, 2018), and the more recent 'NHS Quality & Safety Framework', Duty of Quality and Duty of Candour. The effectiveness of this organisational change will be subject to evaluation to ensure it achieves the intended outcomes.

As a Health Board we aim to echo the NHS core values by putting Quality and Patient Safety first by always providing high value evidence-based care for our communities and delivering that via a Person-Centred approach.

The Health Board position for the delivery of the PTR regulations in 2024/25 is as follows: -



Patient Experience: Complimentary to the PTR process the Patient Experience and Involvement team have supported clinical teams in meeting with patients or patients' relatives who would like to share their experiences following either incidents and or complaints.

Dedicated members of the Patient Experience and Involvement team meet with the person who has agreed to talk about their experiences to support listening and learning. The person agrees to the format of their 'story' and consents to their story being used either internally, externally or both. The person is not interviewed, rather, they speak from the heart about an episode of care that has had the most significant impact on them, either positive or negative. The person is shown the film once it has been edited for their approval. The whole process gives them an opportunity to talk about what has happened and to put structure to it in the format of a 'patient story', which can then be shared for learning and quality improvement.

Some patients or carers who have shared their experiences are also invited to participate in involvement events such as the Bereavement Collaborative, People Participation Panels and the Dementia In-Patient Working Group. The involvement of patients and carers is increasing through listening and ongoing collaboration.

Formal complaints: During the reporting period, the Health Board has taken receipt of 1518 concerns which have been managed under the Putting Things Right regulations, meaning that a formal investigation has been undertaken, the findings of which have been collated into a letter of response which is reviewed and signed by the CEO.

Early Resolution: In addition to concerns Managed Under the Putting Things Right guidelines, the Health Board can attempt to address concerns within 48 hours, and these are considered as Early Resolution. This aims to bring concerns that are appropriate to a swift resolution for people without needing to await a formal investigation and response.

Patient Safety Incidents and Never Events: During the reporting period 161 patient safety incidents met national reporting criteria, reflecting a decrease from 187 in the previous year. Never Events, which are serious and preventable incidents, continued to decline, with only two reported this period—one historic case and one wrong-site surgery. This downward trend demonstrates the effectiveness of ongoing safety measures and quality improvement.

Redress Panel: Of the Redress Panels convened by the Health Board, 40 cases were prepared, heard and deliberated upon. Redress panels assess and determine concerns where potential failings and resulting patient harm have occurred. This is a high-level panel with quorate membership.

Inquests: Over the last 3 years, the Health Board has seen a year-on-year growth in the number of new Inquest matters with 299 inquests concluded in year

PSOW Cases: The Public Service's Ombudsman for Wales (PSOW) referred 178 cases to the Health Board for consideration during the reporting period. These encompass matters which are enquiries only, full investigations, anonymous queries and in some cases where a full investigation is undertaken by the PSOW service. The PSOW has been complimentary in meetings of the improvements that the Health Board have made.

The 2024/25 reporting year has been both challenging and rewarding for the Corporate Putting Things Right (PTR) Team. The Health Board has continued to evolve its approach to complaint management, building on earlier improvements and introducing new initiatives to enhance patient experience and service quality.

Significant progress has been made in centralising processes, embedding a culture of early engagement, and strengthening the infrastructure for timely, person-centred resolution. Despite operational pressures, the team has focused on improving communication, compliance, and learning from experience to drive system-wide improvement. The Health Board's commitment to quality, safety, and listening to patient voices remains at the heart of everything we do.

The Health Board will build on its achievements in 2024/2025, maintaining a commitment to continuous learning and improvement. This process will incorporate feedback from service users as well as insights gained through internal evaluations to identify opportunities for quality improvement. The PTR Annual Report sets out the key priorities for 25/26.

Argymhelliad / Recommendation

The Board is asked to: -

- APPROVE the Putting Things Right Annual Report 2024/2025.
- NOTE the three key priorities for the PTR Annual Work Programme.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg
Corfforaethol a Sgôr Cyfredol:
Corporate Risk Register
Reference and Score:

CRR002

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care 6.3 Listening and Learning from Feedback 3.2 Communicating Effectively
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Not Applicable
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	Choose an item. Choose an item. Choose an item. Choose an item.

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

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.

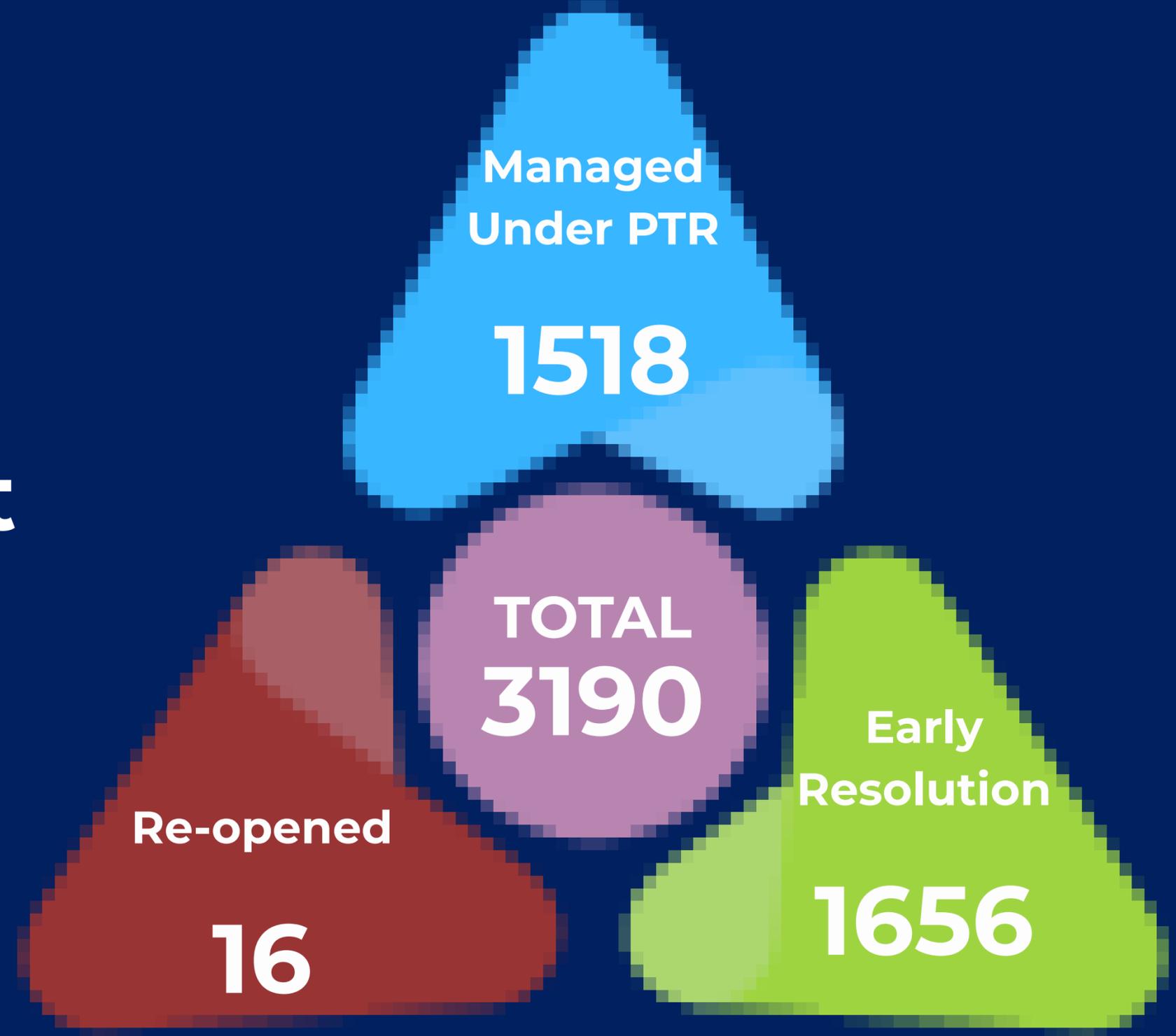
	<p>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk</p>
<p>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</p> <p>https://futuregenerations.wales/about-us/future-generations-act/</p>	<p>Choose an item. Choose an item.</p>



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Putting Things Right ANNUAL REPORT 2024-2025



Introduction

This Annual Putting Things Right Report covers April 2024 to March 2025, reflecting Aneurin Bevan University Health Board's commitment to over 600,000 residents across Blaenau Gwent, Torfaen, Monmouthshire, Caerphilly, and Newport.

At the core of PTR and Duty of Candour arrangements is a commitment to openness, honesty, and person-centred concern management, supporting patient safety and organisational learning. This approach is guided by the NHS (Concerns, Complaints and Redress Arrangements) (Wales) 2011.

The Health Board values feedback and concerns from service users and families, recognising their vital role in improving services and patient safety. The introduction of the Health and Social Care Quality and Engagement (Wales) Act and NHS Duty of Candour on 1 April 2023 further strengthens our organisational responsibility to communicate openly, learn from concerns, and integrate these principles into everyday practice.

If you require a printed version of the Annual Report or in alternative formats/languages, please contact us using the details below:

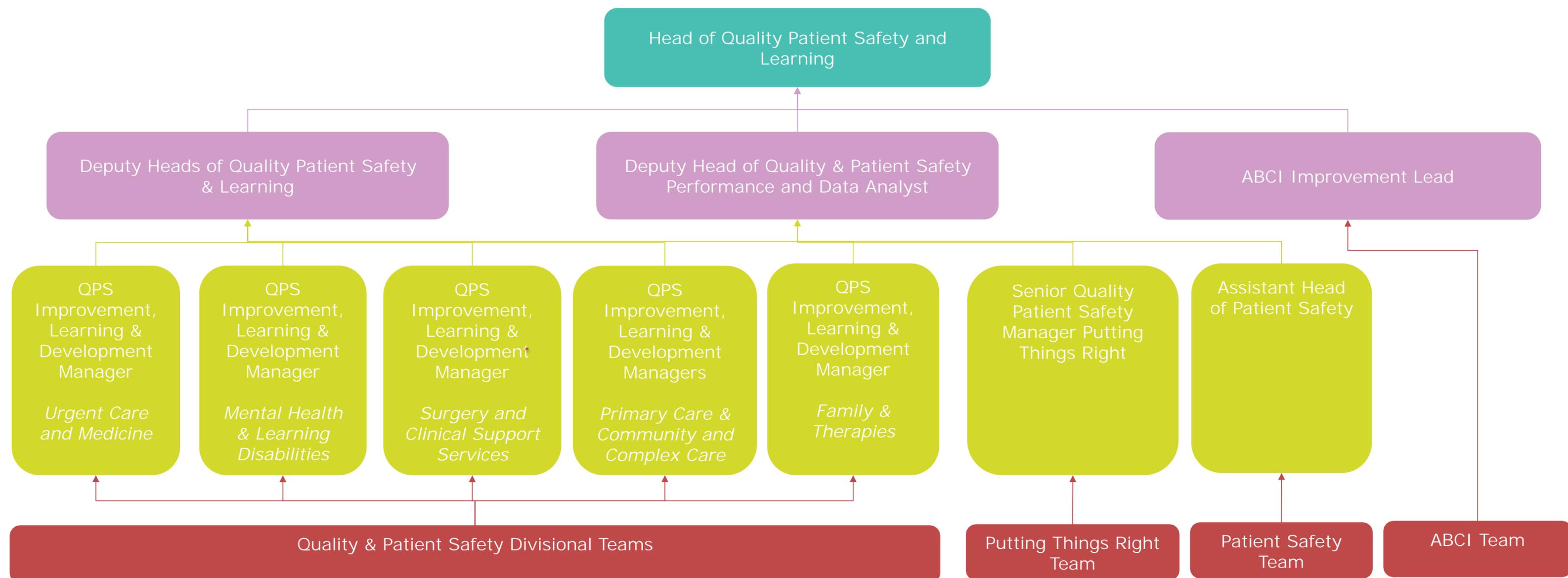
Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
NP18 3XQ

Staffing and Governance

There is a structure underpinning PTR, with executive leadership delegated to the Executive Director of Nursing (EDoN). Since the end of February 2024, the central Divisional Quality Patient Safety (QPS)/PTR teams have been aligned to the Nursing Directorate. Assurance is provided by reporting to the Quality Management Group, Patient Quality and Safety Learning and Improvement Forum, which in turn reports to the Executive Committee and the Patient Quality and Safety Outcomes Committee.

This committee sets out the Health Board's strategy and objectives to encourage continuous improvement, as well as compliance with national and local policies. It is further tasked with responsibility to develop and implement systems for quality monitoring that are robust, auditable and effective, as well as raising the awareness of the PTR and QPS agenda.

The current Putting Things Right/QPS Team structure is illustrated below:



Summary of Achievements

In last years annual report, we set our priorities for 2023-204. How did we do?

Priority 1

PTR Regulations and Health Board Concerns Management

- Ensured readiness for revised Putting Things Right regulations through collaboration with external partners and internal teams.
- Streamlined quality assurance processes for earlier resolution and a more person-centred approach.
- Improved documentation, response, and investigation of concerns, with enhanced engagement and accessibility for service users.
- Introduced Communication Standards and established a dedicated acknowledgment team to deliver consistent and timely updates to individuals raising concerns.

Priority 2

Improving Quality Patient Safety Experience, Learning and Improving

- Established central QPS/PTR/QI teams to improve operations and drive patient safety and quality initiatives.
- Delivered targeted training (including Once for Wales sessions), workshops, learning events, and newsletters to enhance staff expertise.
- Enhanced support for Patient Safety Incidents (PSI) through specialised training, a dedicated toolkit, and updated templates to meet Duty of Candour requirements.
- Launched the Quality Improvement Coach programme in Autumn 2024 to foster improvement skills within the organisation.
- Introduced a new Listening and Learning Framework and set up robust forums, including a central repository and the Patient Quality and Safety Learning and Improvement Forum for shared learning and continuous improvement.

Priority 3

Strengthened collaboration with key external partners, ensuring community voices shaped our work and fostering ongoing improvement in service delivery.

- Collaborated closely with the Medical Examiner's Office to implement Death Certification Reform, enhancing transparency, improving accuracy in the certification process and ensuring timely communication for bereaved families.
- Implemented the GRACE bereavement model across services, providing compassionate and consistent support for bereaved families, with comprehensive staff training to maintain high standards of care.
- Developed an inclusive End of Life Care model through wide consultation with people, staff, and partners, ensuring the model reflected collective experiences and needs.
- Hosted the "Big Conversation" event to raise awareness and encourage participation in Future Care Planning, gathering valuable community feedback.
- Leveraged the CIVICA system to capture timely patient feedback and enable divisional teams to act quickly on insights for continuous service improvement.

Arrangements for the Management of Concerns

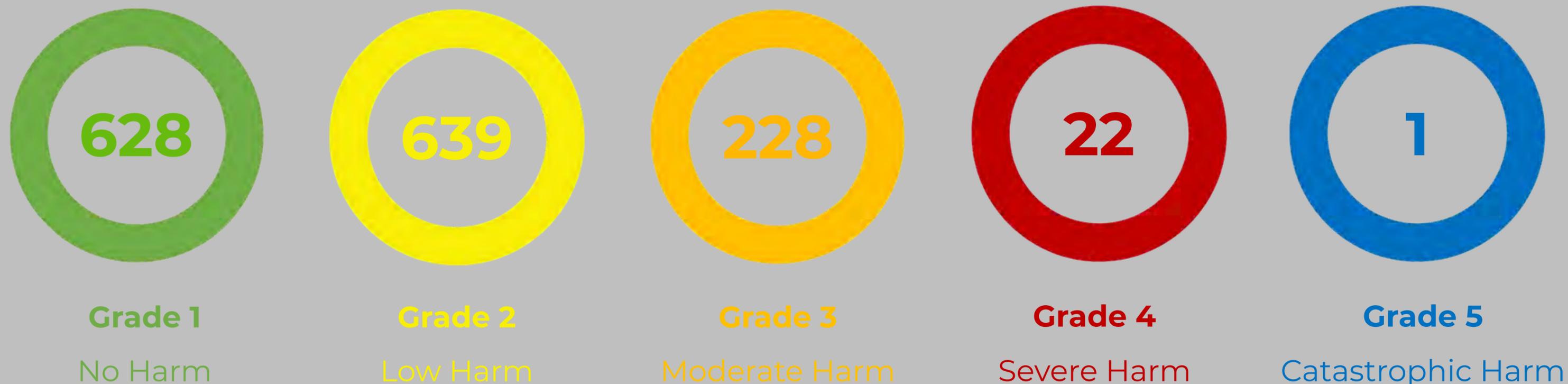
To support the effective management of complaints and patient safety incidents the Health Board has implemented the Putting Things Right Policy for the Management of concerns (complaints) policy along with the Patient Safety Incident Reporting & Management Policy. These should be read in conjunction with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting Things Right Guidance (2013).

Complaints are submitted through various channels, including direct submissions from patients, families, staff, partner organisations, and feedback systems such as CIVICA. The primary method for contacting the Health Board is email, which represents 57.1% of complaints received; 25.7% are submitted by phone.

Feedback reporting channels include:



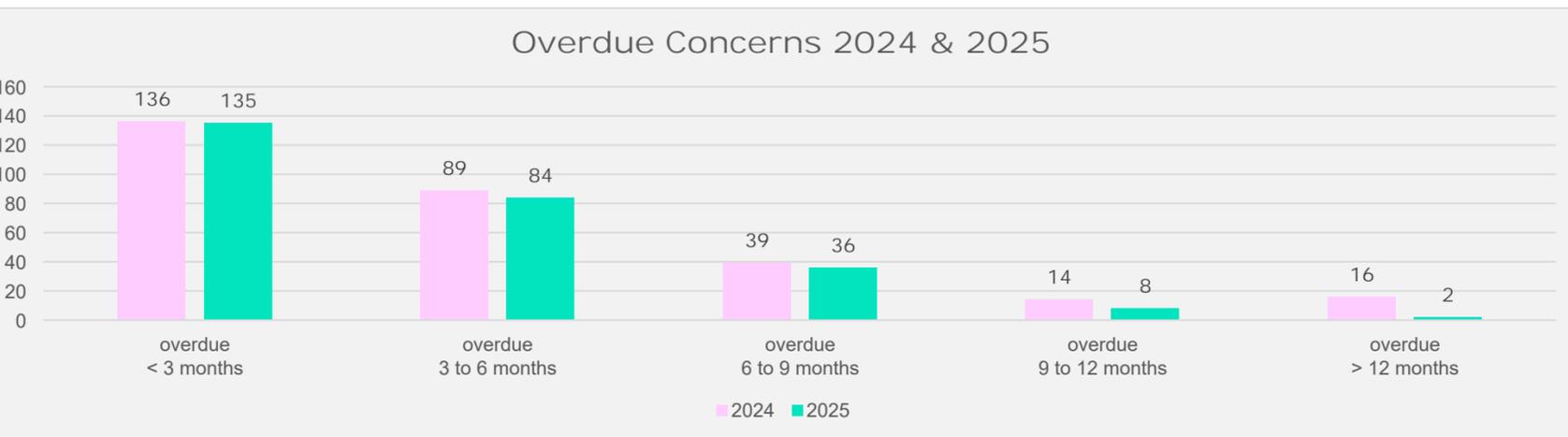
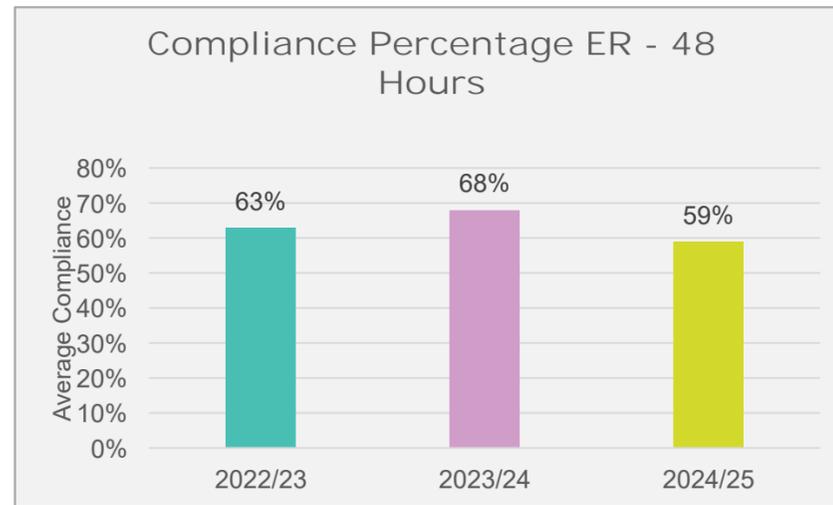
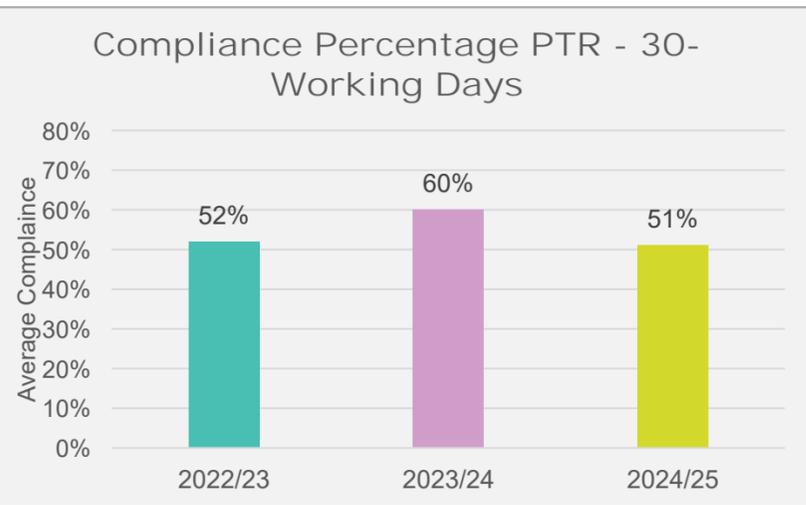
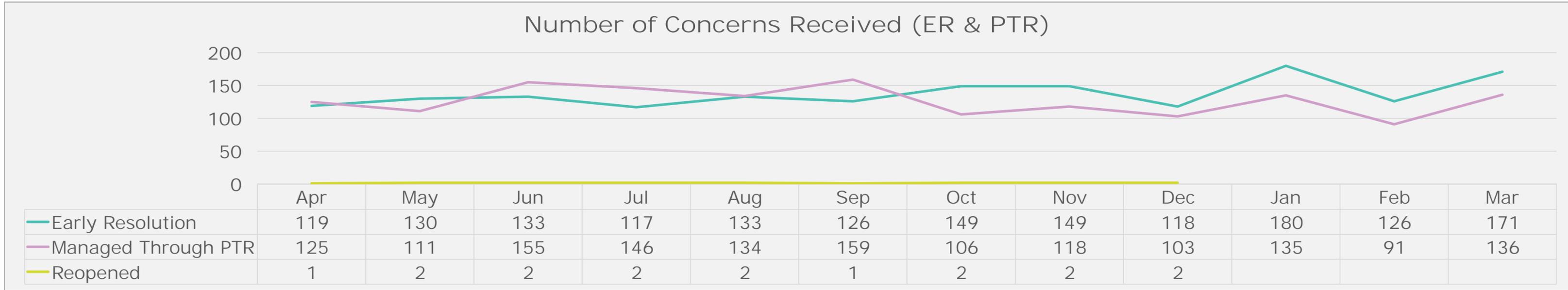
Grading of Managed under PTR Complaints upon Receipt 2024/25



All complaints are graded and triaged upon receipt, from 1 (No Harm) to 5 (catastrophic Harm) in accordance with the All-Wales Grading Framework. This will determine the level of investigation required in dealing with concerns raised. All complaints undergo an assessment of harm to determine the grading and whether there is a possibility that the Health Board may have breached its duty of care, to ensure that the appropriate level of investigation is commissioned. This structured approach facilitates timely investigation, resolution, and learning from each case, helping to drive ongoing improvements in service quality and patient safety.

A large proportion of concerns 83.5% were categorised as Grade 1 and 2 (low or having caused no harm (upon receipt, with Grade 3's (moderate) representing 15%, and with Grades 4 and 5 (severe and catastrophic) accounting for 1.5% of the total received. The grading of complaints is dynamic and should be kept under review throughout the investigation.

Overall Health Board Compliance



Compliance with the Welsh Government 30-working day target averaged 51% across the reporting period.

Extensive collaborative work, involving the Deputy Director of Nursing, the Head of Quality Patient Safety, Deputy Heads of Quality Patient Safety, and the dedicated PTR and divisional teams, has taken place alongside the Once for Wales data team and Divisional leadership teams to prioritise and finalise concerns investigations.

The PTR & QPS teams have made progress in managing and resolving aged concerns more efficiently, resulting in an 87.5% decrease in the number of cases open longer than 365 days.

Trends in Compliance Data - ER/PTR

In 2024/25, the Health Board received 1,518 formal complaints and addressed 1,656 concerns through early resolution. This suggests that recent enhancements to complaint management processes have had a positive impact, with more issues being resolved via Early Resolution approaches in a person-centred way, thereby reducing the need for formal investigations.

The Health Board aspires to resolve 75% of concerns as Early Resolution, as well as attaining a 75% compliance with Managed through PTR.

The main themes relate to: Clinical treatment/assessment; Appointments and Communication issues across 2024/25. The Health Board has been undertaking significant work across these areas which aims to support and improve patient experience.

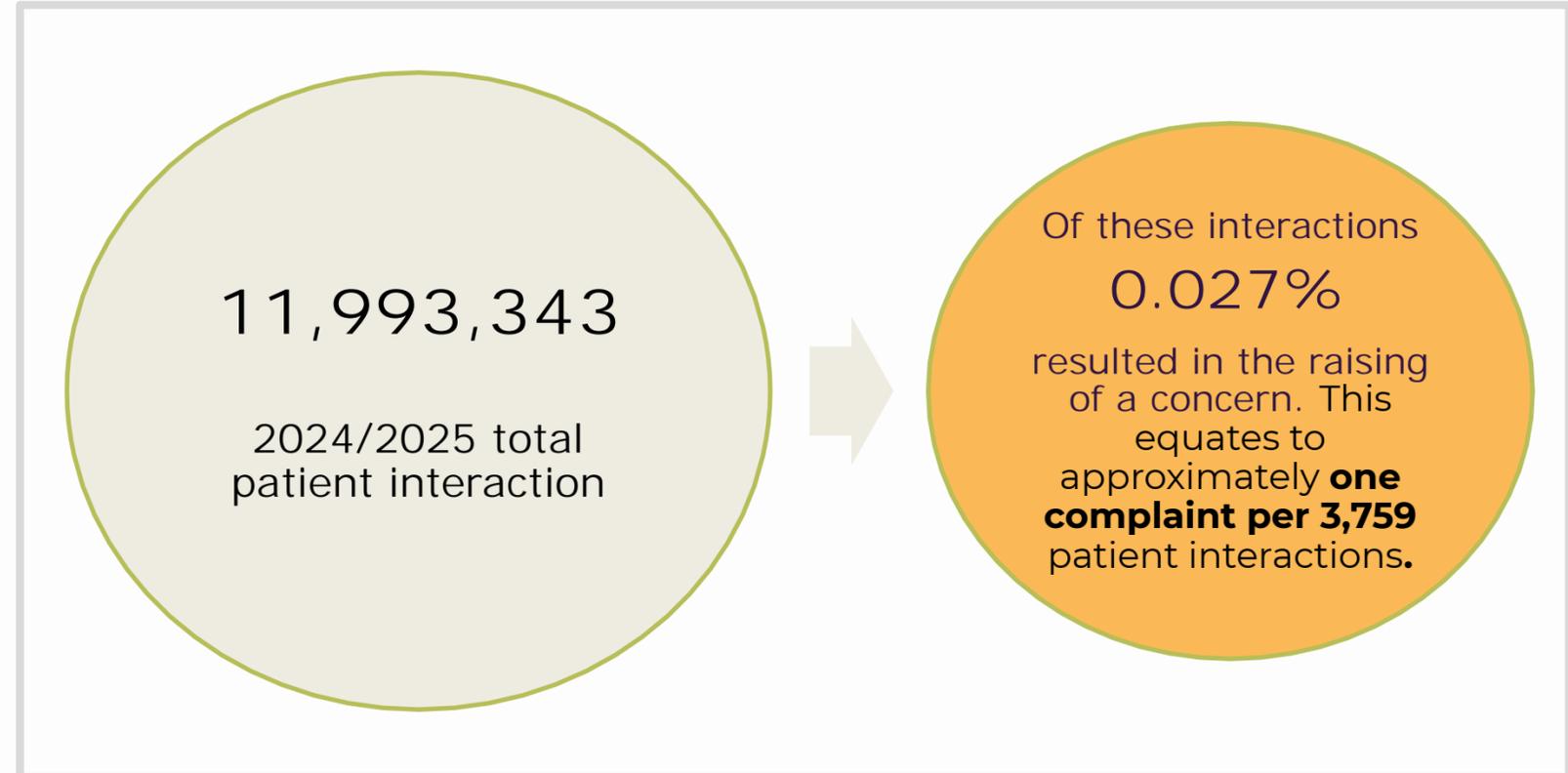
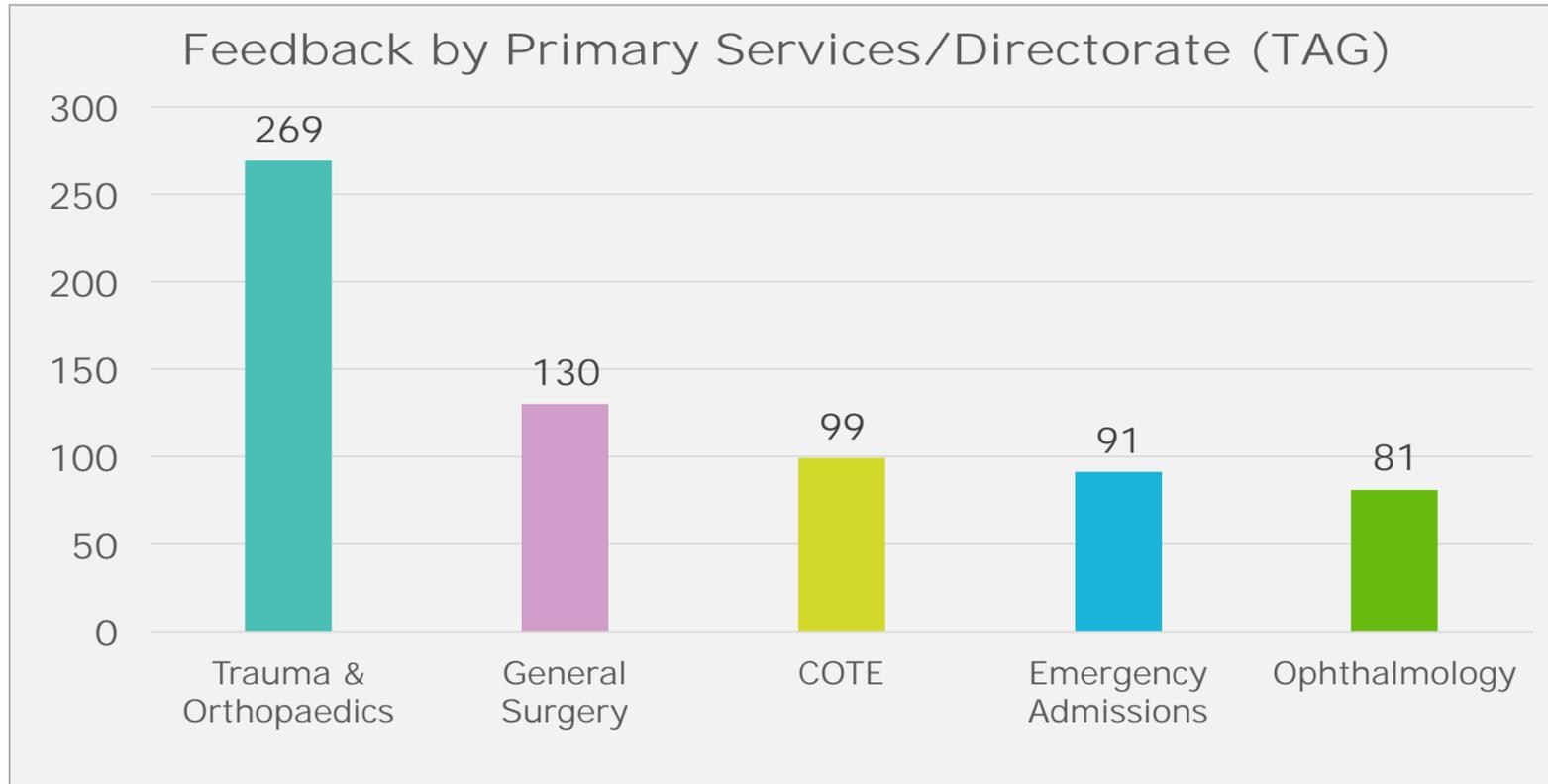
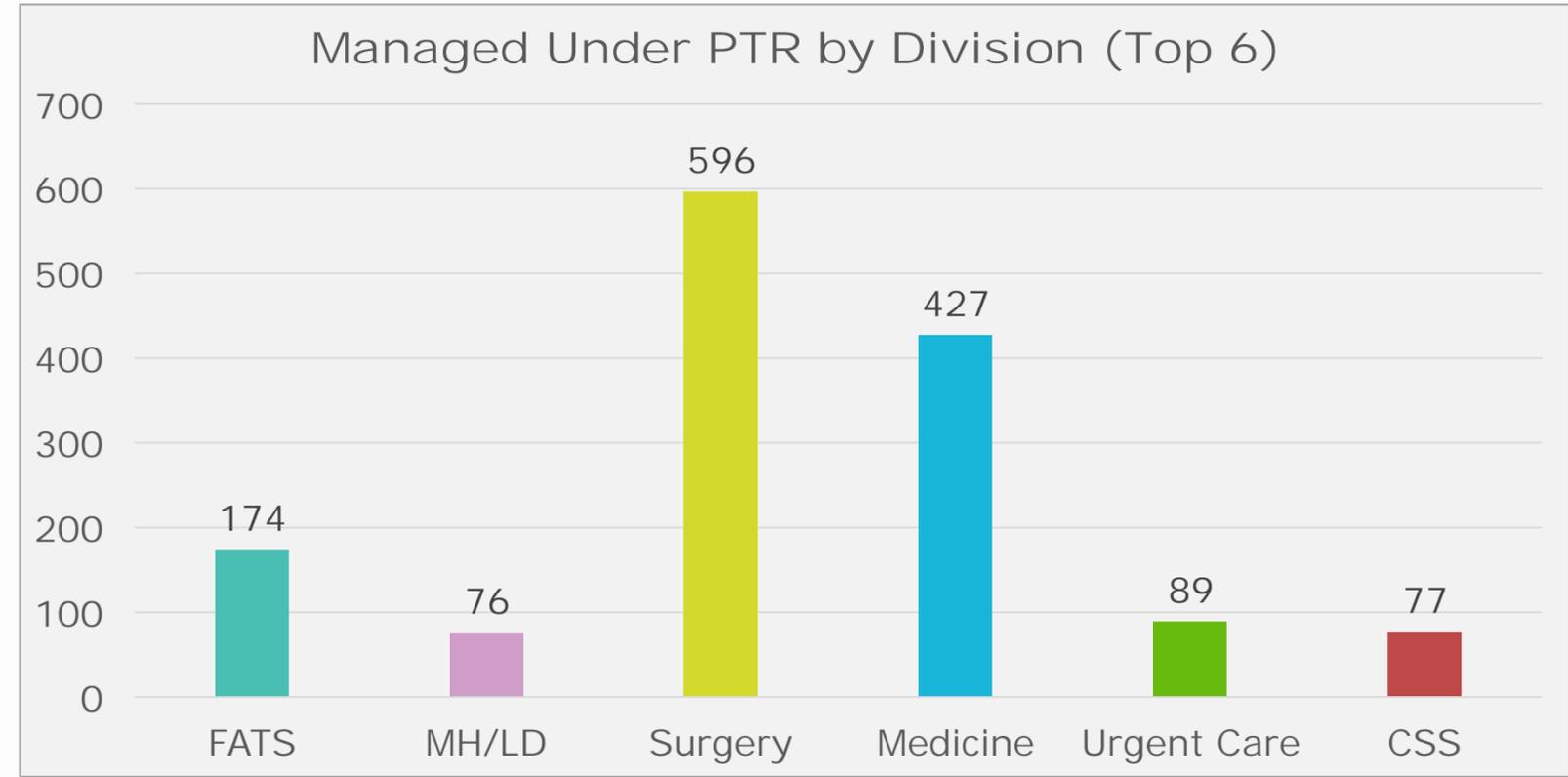
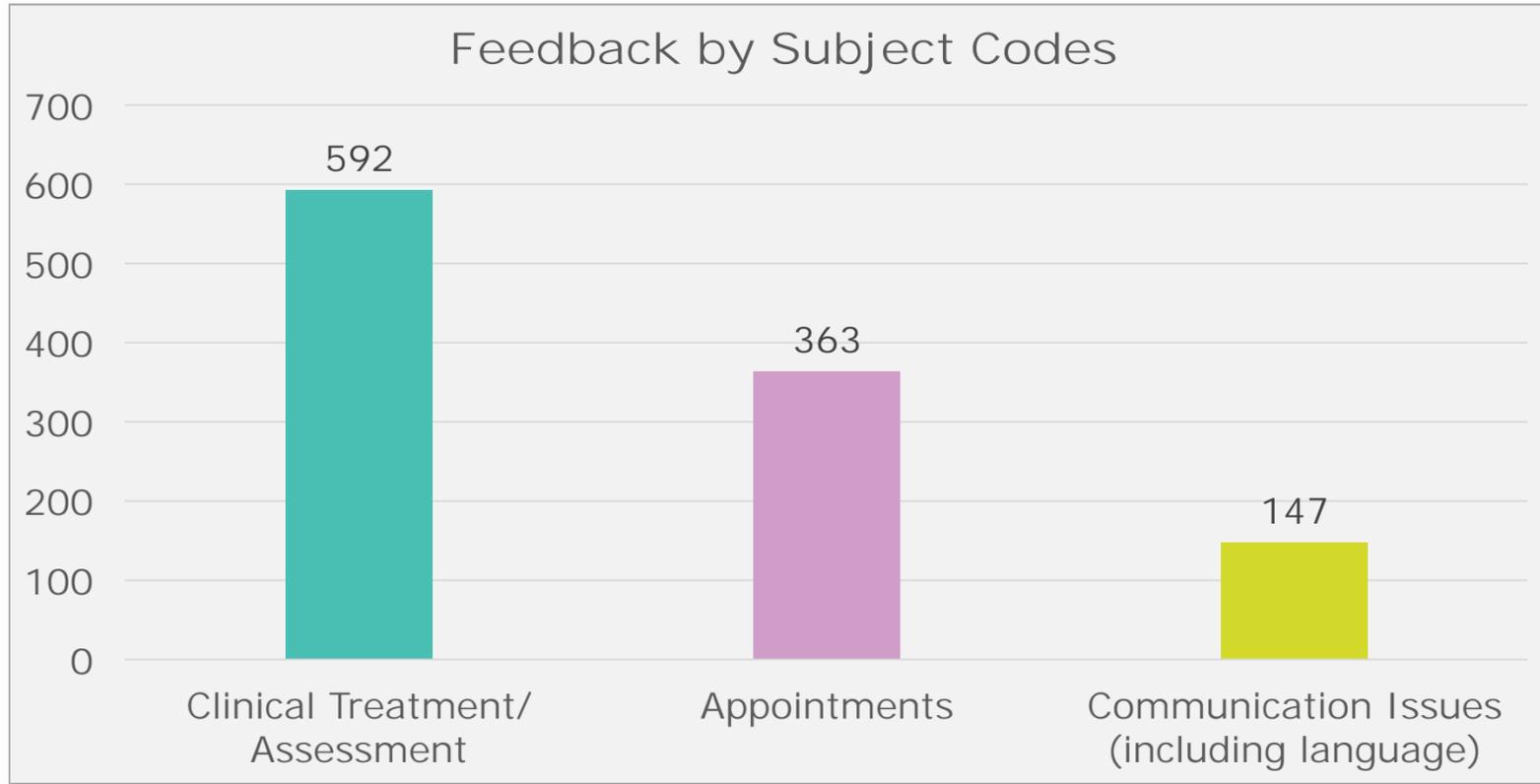
The Health Board achieved significant progress in 2024/25 across key priorities, notably reducing long referral to treatment waits and making advances in cancer and diagnostics performance. Targeted funding enabled substantial decreases in patients waiting over 104 weeks for treatment, especially in ENT, Ophthalmology, and Trauma & Orthopaedics, with some specialties reporting zero patients above this threshold. Waits exceeding 156 weeks were eliminated, and nearly 3,000 fewer patients waited over 52 weeks for outpatient appointments.

Collaborative work with the Welsh Ambulance Services Trust improved system flow and while system reconfiguration and service redesigns, such as the extension of Community Resource Teams and the establishment of an Acute Frailty Response Team, enhanced care for older people. The Same Day Emergency Care model expanded its reach, serving increasing numbers at Grange University Hospital and Ysbyty Ystrad Fawr. Efforts to facilitate early discharge, including the 50-day challenge and the Hospital 2 Home initiative, further improved patient transitions and partnership working with local authorities.

The Health Board also focused on communication improvements, adopting a more person-centred approach to managing concerns and complaints. These initiatives, recognised positively by the Public Services Ombudsman for Wales and Llais, have led to earlier engagement and more effective resolutions for patients and families.

The Health Board reports and monitors concerns received by all divisions. This allows identification and active engagement in collaboration with services that are receiving concerns to understand areas of good practice or where targeted improvement and action may be required. This supports the Health Board in its aim to be a proactive learning organisation.

Concerns Data



Learning From Concerns

Over the past year, the Health Board has continued to evolve its approach to complaint management, building on earlier improvements and introducing new initiatives to enhance patient experience and service quality. The key learning points are as follows:

The Health Board has prioritised transparency and open communication, valuing all feedback as opportunities for learning and improvement.

Communication Standards have been developed to standardise interactions with patients and families, focusing on timeliness, clarity, and empathy.

The centralisation of the QPS and Complaints Team has matured improving consistency, collaboration, and knowledge-sharing across divisions, allowing for better integration of learning from complaints and incident reviews.

There has been significant progress in reducing complaints breaching the 30-day response target, due to targeted action plans and real-time monitoring.

A formalised acknowledgement process, launched in mid-2024, reinforces prompt, personalised initial contact with complainants, leading to earlier engagement and more tailored resolutions.

Regular meetings with external bodies (PSOW and Llais) and direct engagement with patients support a culture of openness, leading to deeper insights into community concerns and stronger accountability.

Weekly cross-team meetings, with expanded participation facilitate rapid sharing of learning and escalation of challenges across departments.

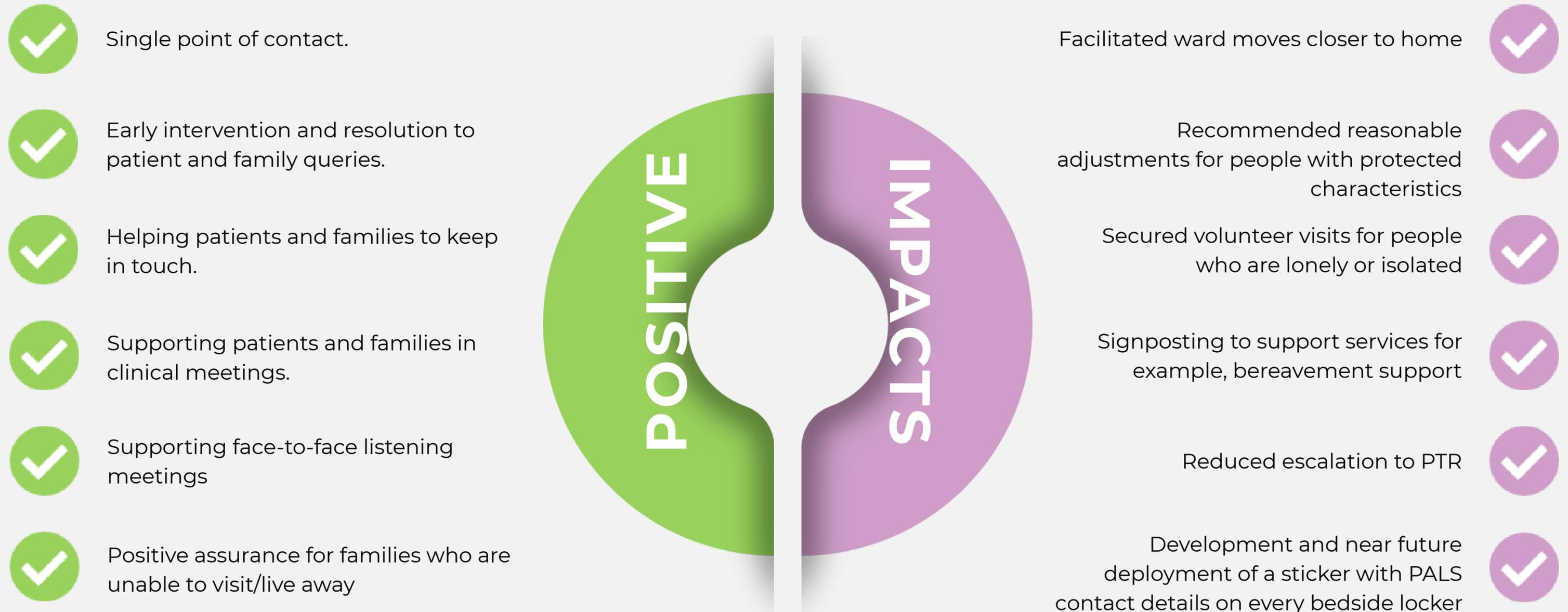
Patient stories and learning events are widely shared across the organisation, ensuring real-life experiences inform continuous improvement and foster a culture of empathy.

Learning From Concerns: PALS Performance/Impact

5940 calls were received over the 12-month period to the PALS Team.

The total number of complaints escalated to the Putting Things Right (PTR) over the past 12 months = 20 (0.34%).

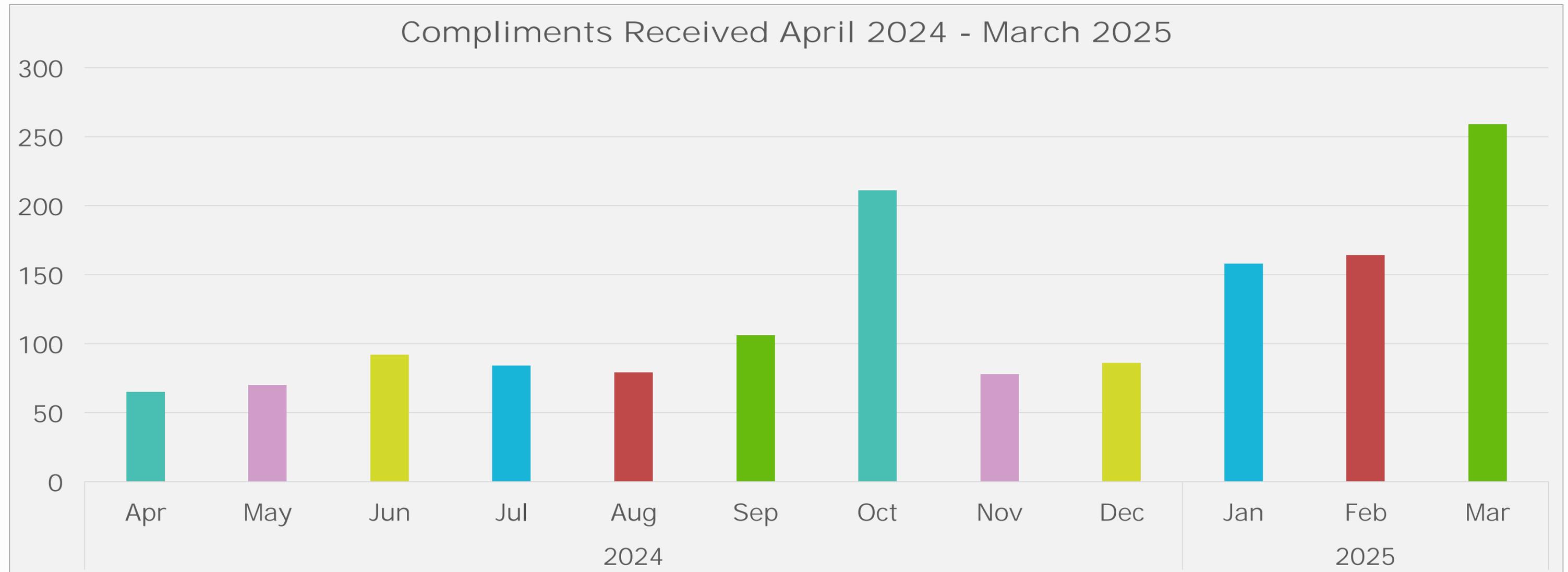
The positive impacts PALS has had on patient experience is significant and includes:



Compliments

The Health Board receives compliments through various channels, such as letters, emails, telephone calls, cards, conversations, and social media. Compliments provide valuable feedback, highlight positive practices, support staff morale, and help measure patient satisfaction and drive improvement. Complainants often include a compliment within a complaint; areas are encouraged to share these with staff.

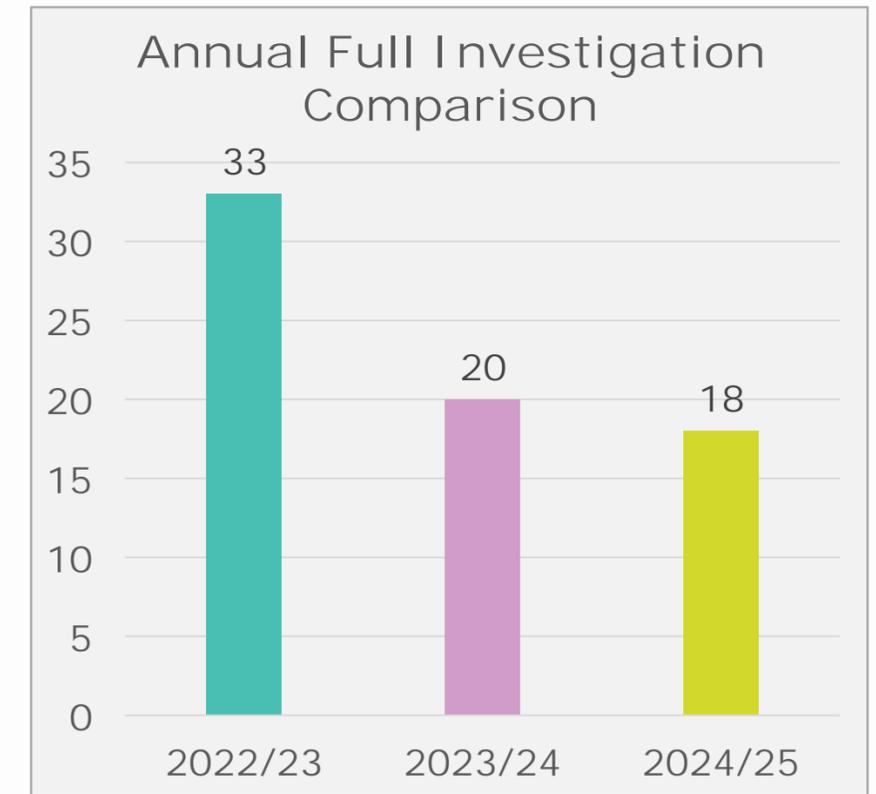
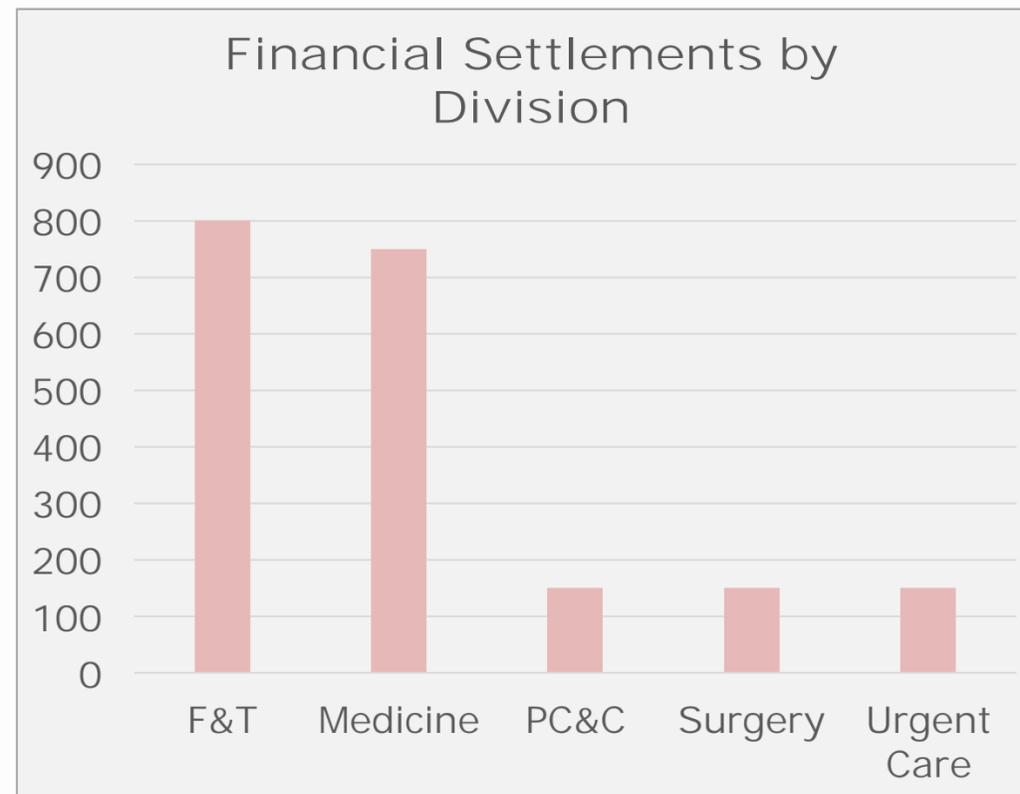
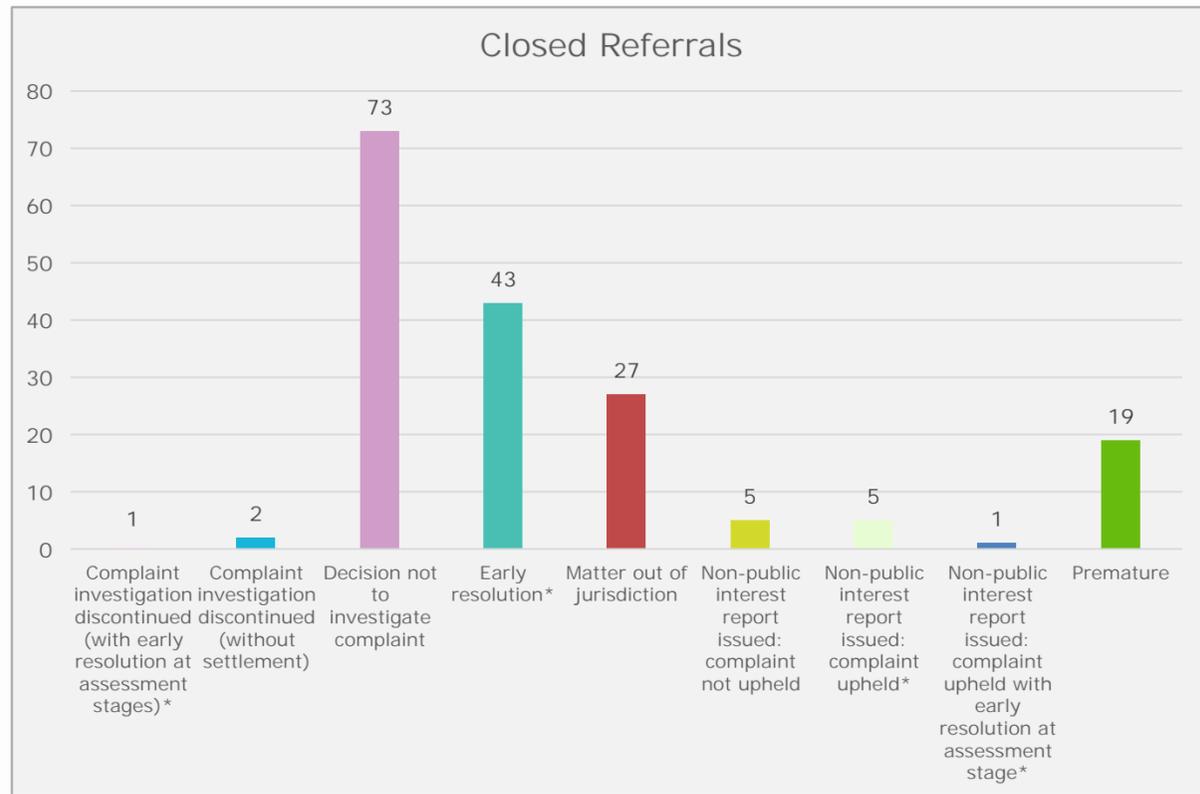
1452 compliments were captured on the RL Datix system during 2024/25 which is a 219% increase on the compliments recorded in the reporting period 2023/24. Further work is ongoing to have a more systematic approach to capturing compliments.



Public Services Ombudsman for Wales (PSOW)

In 2024/25, the Health Board held quarterly meetings with the PSOW Improvement Officer and Head of Complaints Standards, along with relevant managers, to address concerns and complaints. If a complainant is not satisfied with the Health Board's response, they may refer their case to the Public Ombudsman for Wales (PSOW), who provides independent and impartial support for issues involving public services and NHS organisations.

The PSOW ensures impartial delivery of public services, has the authority to uphold concerns, and can make recommendations for improvement. Despite efforts to resolve complaints, some cases may still be referred to the PSOW. The Health Board values collaboration with the PSOW to achieve positive outcomes for complainants and maintains agreed processes to meet deadlines whenever possible.



In 2024/25, the PSOW received 178 new referrals and closed 176 cases – including some carried over from the previous year. Of these, 1 complaint investigation was discontinued with early resolution at assessment stage*; 2 complaint investigations were discontinued without settlement; PSOW decided not to investigate 73 complaints; The Health Board settled 43 matters through Early resolution* and 27 matters were considered out of jurisdiction. There were 6 instances where non-public interest reports were issued, meaning 3.3% of the cases referred to the Health Board being upheld in 2024/25 compared to 25 cases being upheld in 2023/24.

The number of PSOW interventions decreased by 30%, from 37% in 2023/24 to 28% in 2024/25, reflecting a reduction in the number of full investigations conducted.

There has been a reduction in financial compensation awarded for the year 2024/25, representing a positive reflection of settlements ordered. In 2023/24 it equated to £3000.00, which was approximately 33.3% more than 2024/25 which was £2000.00. The Ombudsman has conveyed highly positive feedback regarding the Health Board's achievements over the past year.

* Denotes intervention

Feedback from the Ombudsman including Learning and Actions Implemented

Of the six cases upheld by the PSOW, the main themes identified throughout the period relate to complaint handling. Specifically, the Health Board either did not adhere to PTR guidance appropriately or delayed sharing the findings of the investigation.

1

ACCOUNTABILITY AND GOVERNANCE

Systems and processes have been introduced to improve accountability and focus roles and responsibilities across the wider PTR team. This will ensure appropriate levels of escalation and monitoring oversight regarding concerns management.

2

CLINICAL DOCUMENTATION AND COMMUNICATION

Emphasis on documenting clear clinical rationale and management plans when deviating from BNF guidance. This has been cascaded to all relevant staff and included in trainee inductions.

3

COMMUNITY NURSING AND DOCUMENTATION MANAGEMENT

Community nursing teams are currently evaluating and enhancing documentation procedures in anticipation of transitioning to electronic records, with the goal of achieving greater integration through the All-Wales community nursing initiatives.

4

FLUID MANAGEMENT AND HYDRATION

Fluid management and hydration have been recurring themes in cases where PSOW has intervened. An Educating and Recommendations After Significant Events (ERASE) poster has been shared to highlight the Ombudsman's findings and ensure learning is shared.

5

LEARNING FROM ACCIDENTS AND INCIDENTS

The ABUHB Physiotherapy service has emphasised the importance of assessing patients who display unexpected mobility changes or lack of progress, and to request X-rays if necessary, considering joints above and below the site of pain.

6

CLEAR DISCHARGE GUIDANCE

Obstetrics, Gynaecology, and related services have implemented discharge information sheets advising on worsening symptoms, contact details, and fluid intake to prevent dehydration.

Legal Services: Claims

ABUHB Legal Services oversee the management of clinical negligence claims, personal injury claims, concerns progressed under the PTR Redress Scheme, and Coroner inquests.

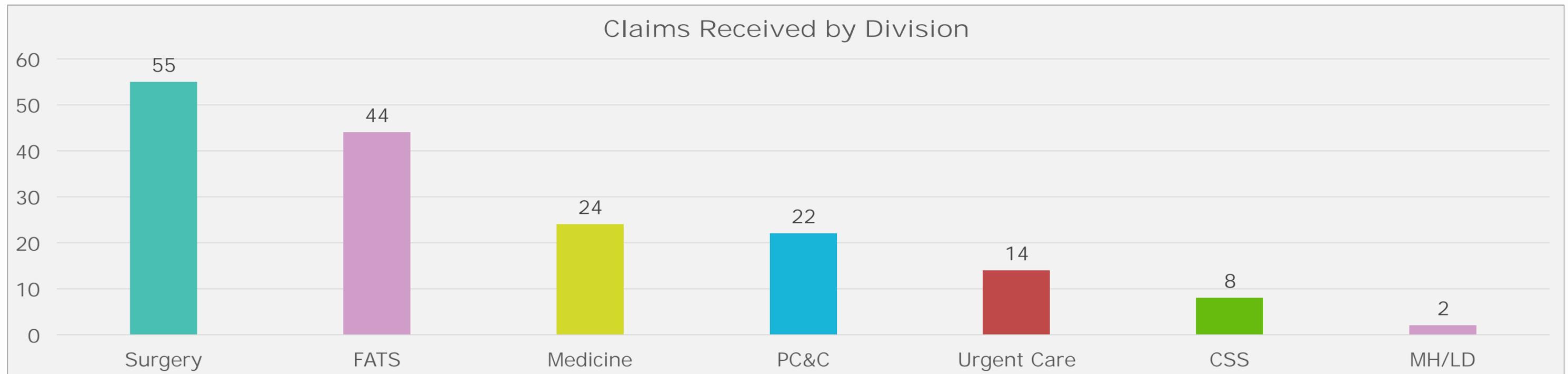
Quarterly Reports with data, analysis and learning are formally reported to Board by way of assurance and governance (2024-2025).

Clinical Negligence and Personal Injury are indemnified activities under the Welsh Risk Pool all-Wales indemnity scheme.

As at 31 March 2025 the Health Board had a combined 505 live claims under management.

Clinical negligence live claim numbers have increased to 422 with the preceding year at 368.

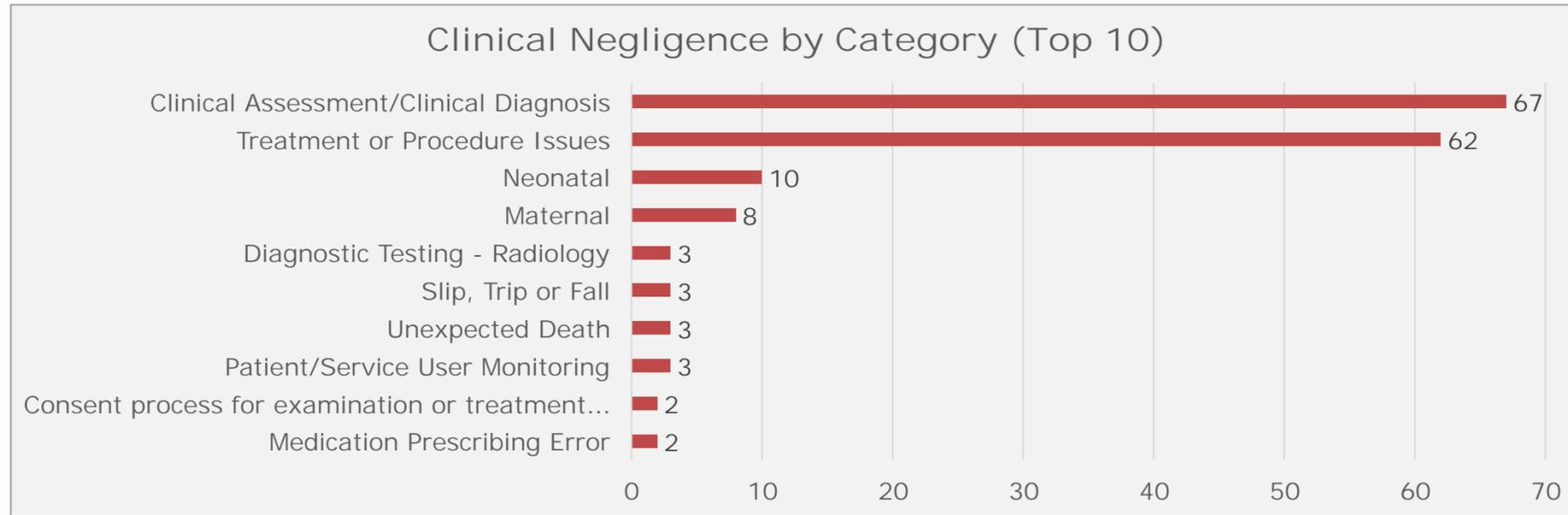
Personal injury claims continue a year-on-year 16-year downward trend with 83 live claims.



Clinical Negligence

The Health Board aims to provide its patients with the best level of healthcare and treatment possible. Most people do not experience any difficulties, but occasionally things can go wrong, and this may result in adverse outcomes for patients. This may then lead to people seeking out independent legal advice in relation to the care they received from the organisation.

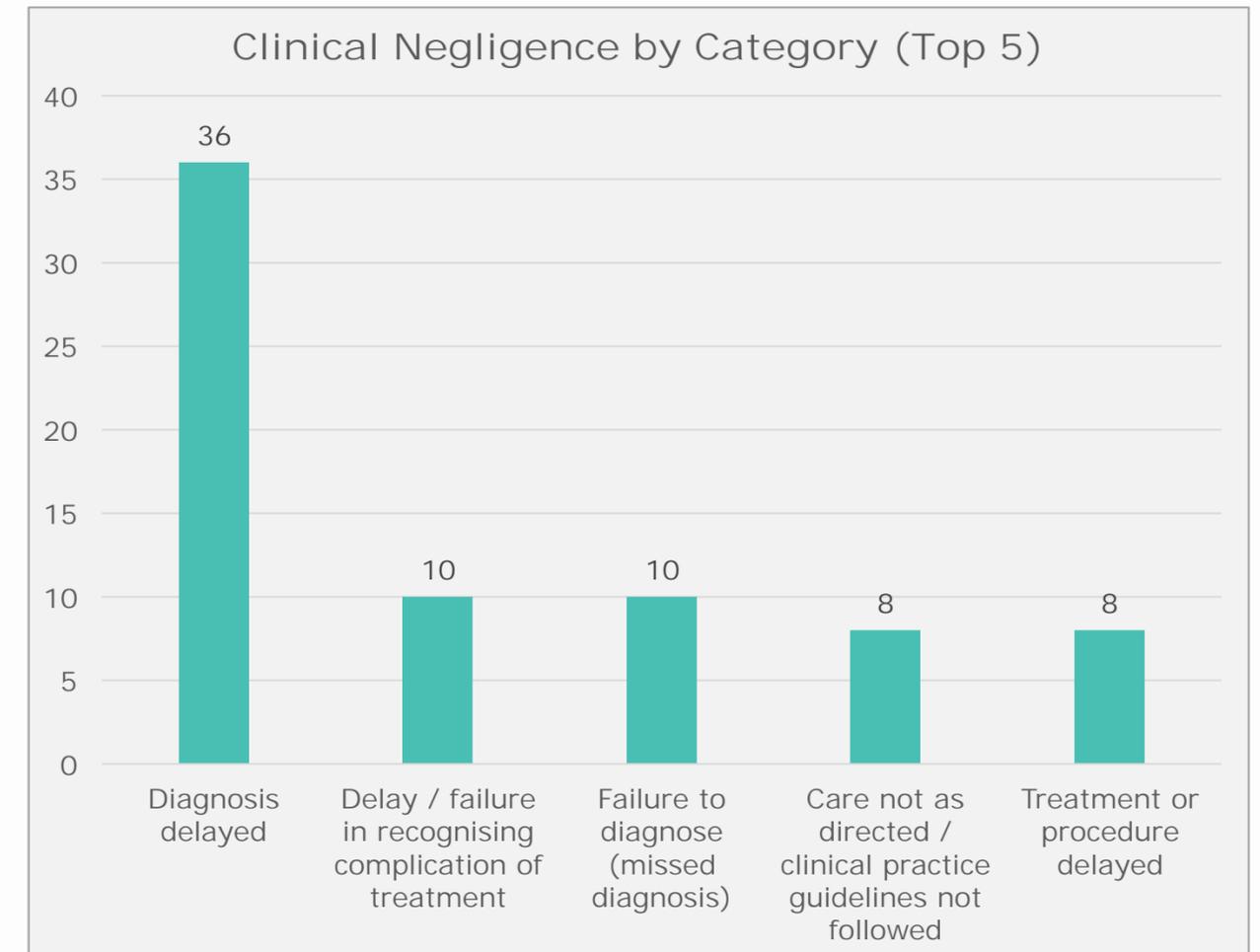
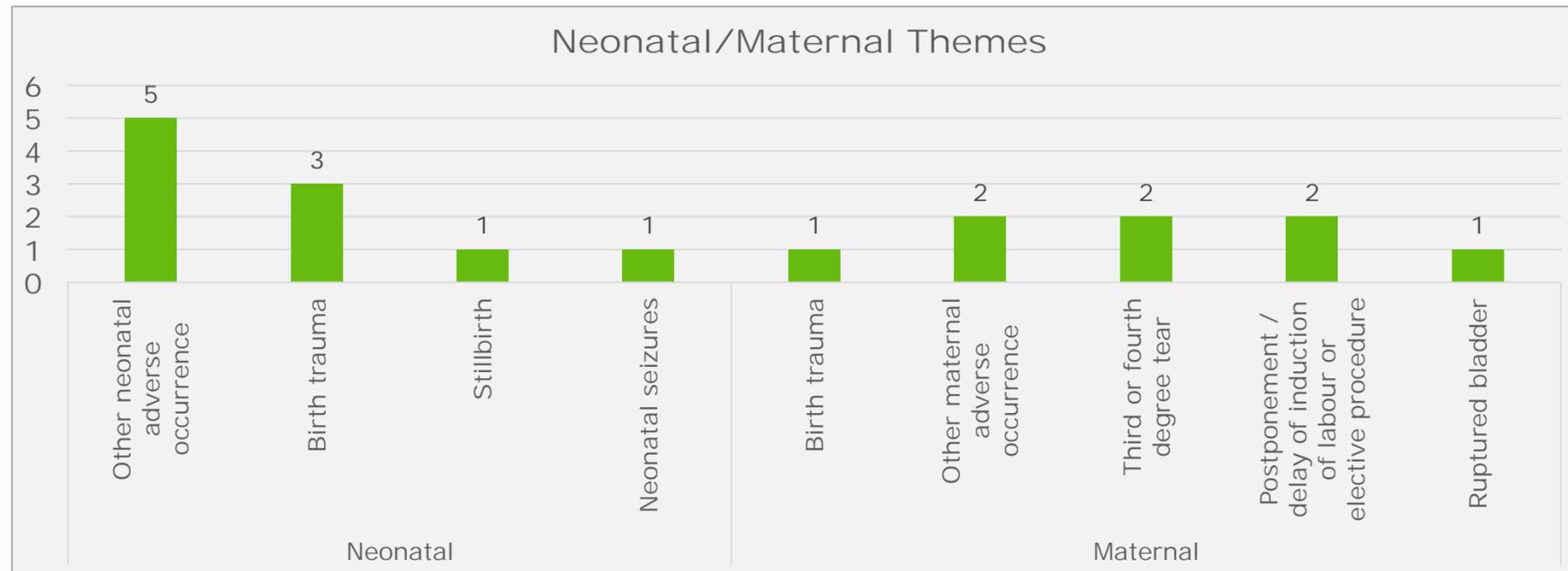
169 new clinical negligence claims were received during 2024-2025.



Claims are spread across Divisions and Directorates. Numbers are higher as expected in higher risk areas, including surgery, trauma & orthopaedics, urgent care, midwifery and obstetrics.

There continues to be a mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with key themes:

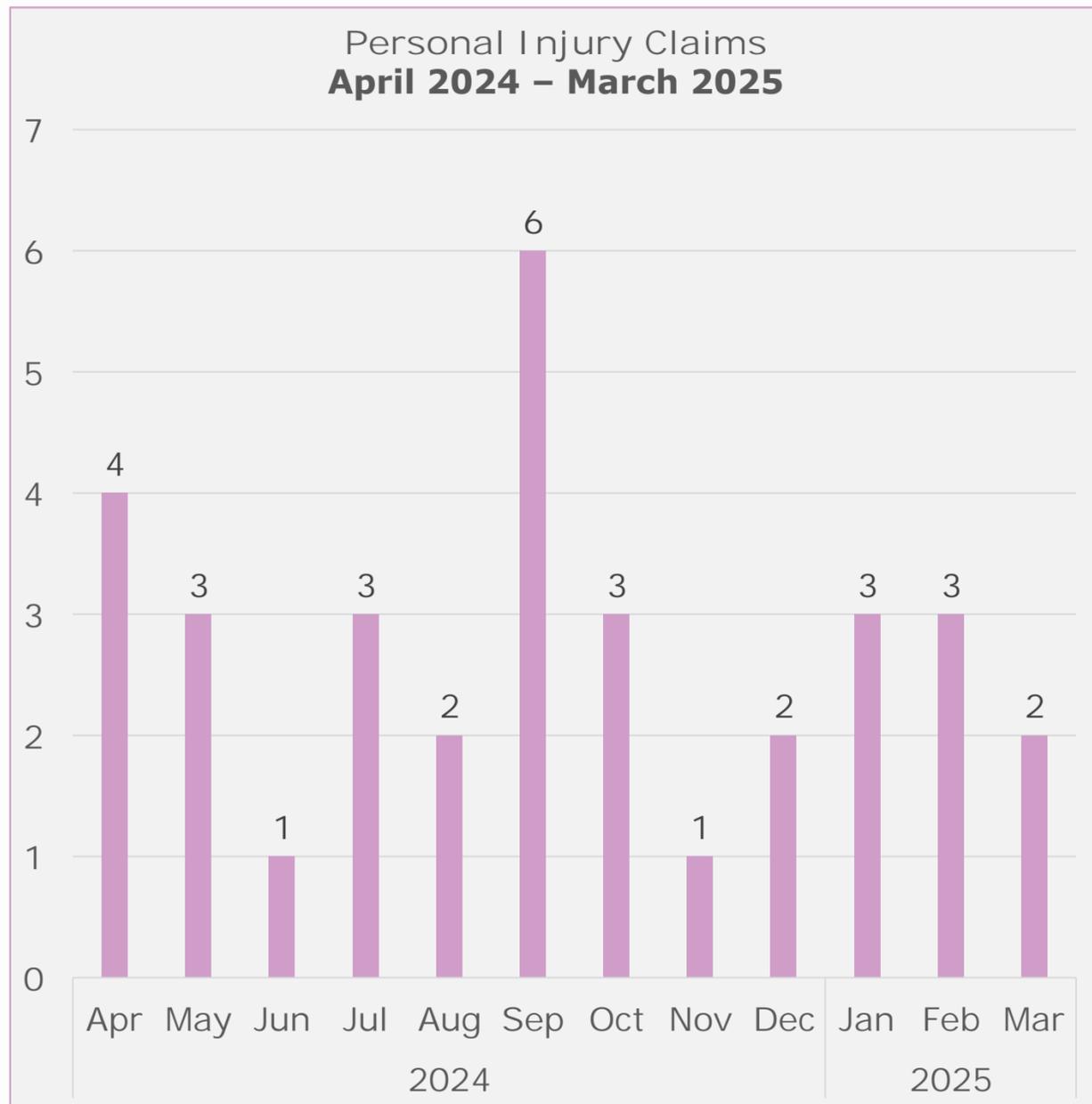
Further context on the Neonatal and Maternal categories:



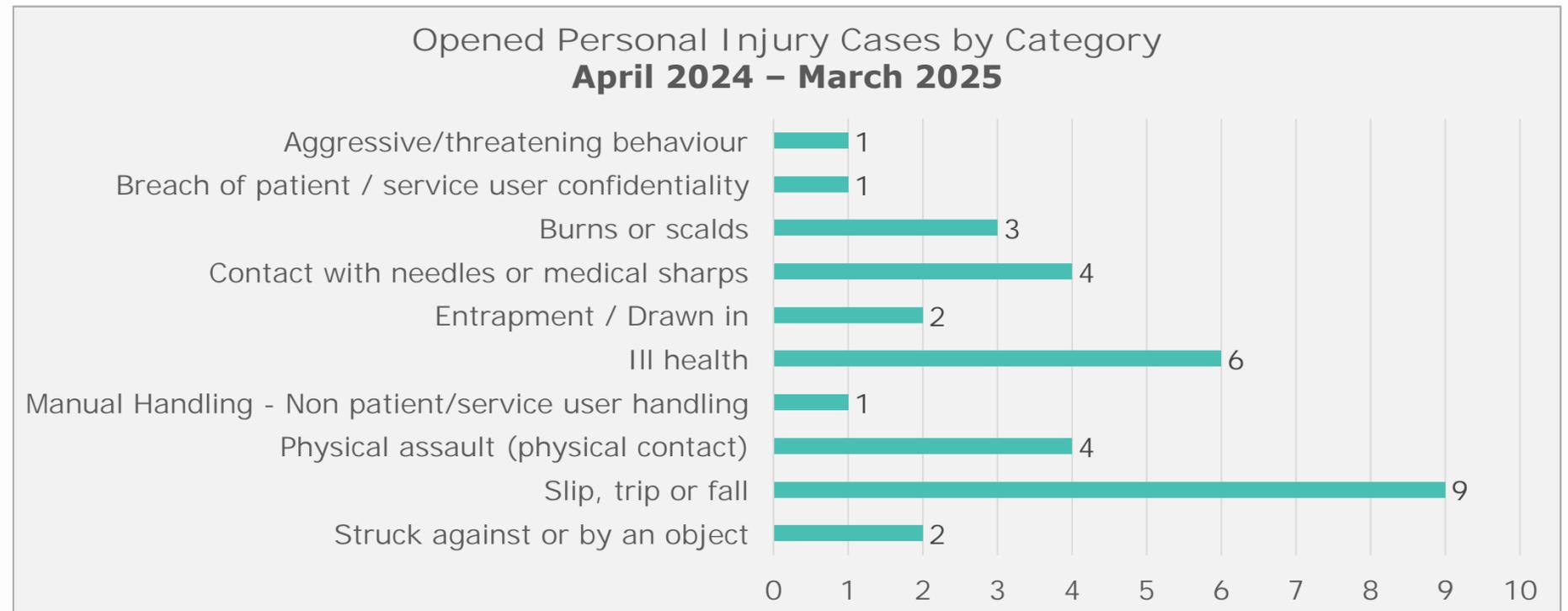
Personal Injury

Personal injury claims are a mixture of employer liability claims (injury sustained by employees within the course of their employment with the Health Board) and public liability claims (injury sustained by members of the public whilst on Health Board owned or managed premises).

From 1 April 2024 – 31 March 2025 the Health Board received 33 new personal injury claims. By way of comparison, over the same period in 2023-24, the Health Board received 38 new claims – this is a 13% decrease in new claims.



Personal injury claims have declined steadily over 16 years, with current live cases down to 83 from over 160. Of the 33 new claims this year, 85% were from employees. This sustained reduction reflects strong preventative efforts across the Health Board, with Legal Services managing all active cases.



Over the last 12 months, we have seen an increase in sharps cases and injuries involving burns/scalds. Please see exemplar learning in response to this.

Learning From Claims: Key Lessons and Improvements Implemented



Staff are reminded to promptly report hazards and defects, such as unsafe infrastructure, to ensure timely repairs and prevent repeat incidents. Clear guidance has been issued to all community premises on their responsibilities.



New guidelines and mandatory training for managers and supervisors have been introduced to strengthen local risk assessment skills, particularly in high-risk environments like showers and cleaning areas, preventing slips and workplace accidents.



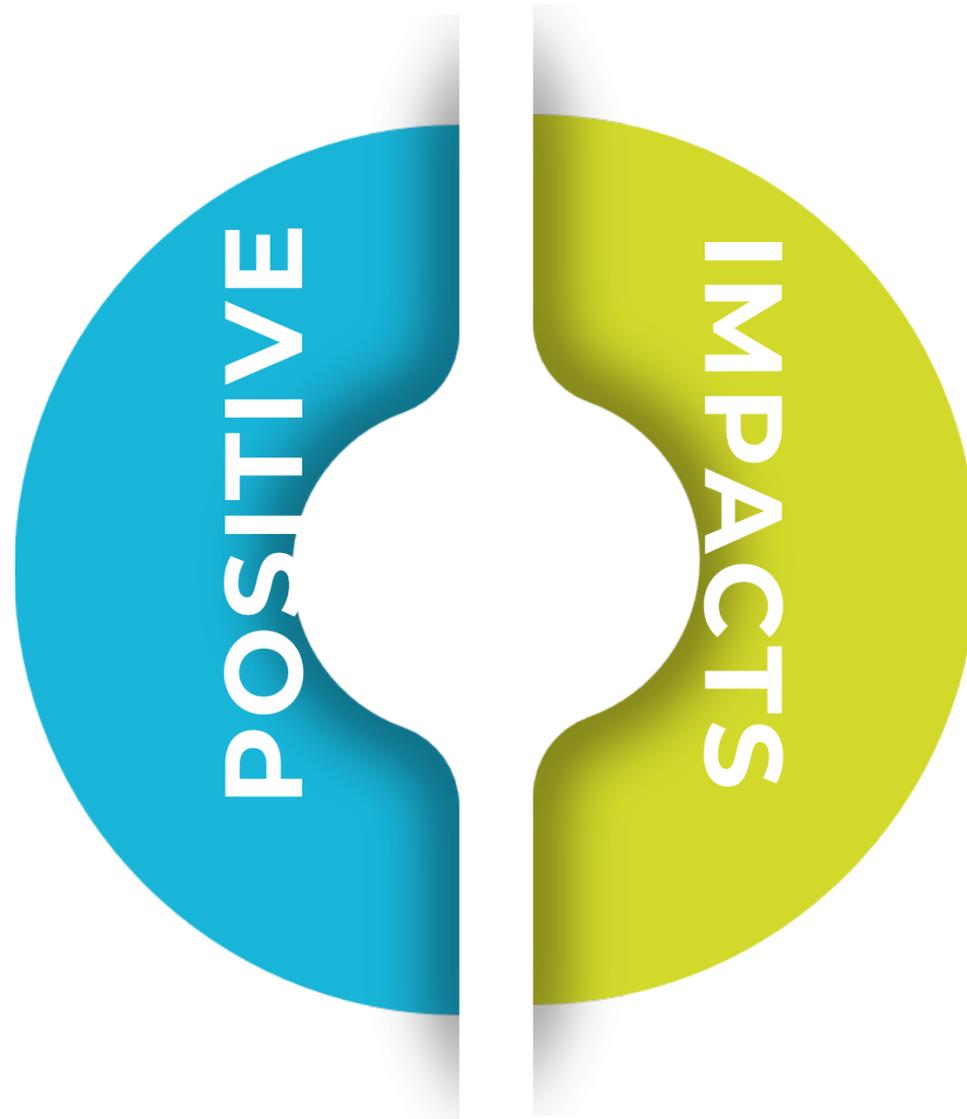
Reviews led to adjustments in equipment placements, such as relocating or deactivating hand dryers and switching to hand towels, to reduce slip hazards in bathrooms.



Regular inspections, clear marking, and removal of faulty clinical waste bins are now policy. Contracts with external contractors are being updated to ensure robust procedures for checking and repairing critical equipment.



Enhanced risk assessments, safety alerts, and staff reminders around sharps disposal and equipment checks have been implemented. There is now increased collaboration between Health and Safety and Estates/Facilities to reduce injuries from sharps and burns.



Governance and Assurance: All learning from claims is captured in Learning from Events Reports, scrutinised by the Welsh Risk Pool and Learning Advisory Panel, ensuring actions are robust, improvements are made, and learning is shared Health Board-wide.

Clinical Practice Improvements:



Neonatology: Guidelines, training, and induction processes have been strengthened to improve management of neonatal hypoglycaemia. All staff have easy access to policies and participate in regular training.



Surgery and Orthopaedics: Dedicated teaching sessions and audit meetings are used to address previous diagnostic oversights and share learning on fracture assessment.



Emergency and Paediatrics: Clear rules now require all children with repeat visits to be reviewed by a senior doctor, improving early identification of serious conditions.



Primary Care: GPs are encouraged to use standard assessment tools, such as the NICE 7-point checklist, to improve cancer detection and referral practices. Learning is shared across teams.



Maternity: Updated guidelines, training, and patient information materials now support better post-natal bladder care, with learning shared widely among midwives.



Radiology and Emergency Department: Cross-divisional sharing of learning stresses the importance of correct imaging procedures and documentation, with training updated accordingly.

Redress

Redress is a range of actions that can be taken to resolve a concern.

- An apology and explanation of what happened;
- and/or an offer of treatment/rehabilitation to help relieve the problem;
- and/or financial compensation. In these cases there has to be consideration of Breach of duty and Causation.

The Health Board manage a redress portfolio in accordance with the PTR regulations. This involves assessing concerns/investigations where a breach of duty of care has been identified causing moderate harm or above. Redress cases are currently capped at £25,000.

There are significant benefits to the redress scheme. Often the alternative route available to patients/families is the option of pursuing a clinical negligence claim.

Redress allows the Health Board to make an early admission of liability. This early dialogue is often appreciated by patients/families who find it beneficial during distressing times.

Data for 2024-25 is consistent with the previous year, with a similar number of cases of qualifying liability determined both years, The data demonstrates higher referrals to redress from the emergency department and obstetrics, this is unsurprising given these are “high risk areas” from a claims/litigation perspective. In addition, these are departments which proactively refer matters under the redress scheme..

The majority of cases concerned issues of delayed diagnosis and failure to diagnose. The previous year, the category of “clinical treatment including delayed diagnosis” was the highest category. As such, there appears to be little change in the trend on themes. Pressure ulcer cases have reduced in numbers in comparison with the previous year.

Whilst again the largest class of cases, there continues to be a very mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with no evident area of concern or outlier identified.



Learning From Redress

Every case presented to the Redress Panel is the subject of consideration of any immediate actions or follow up actions to prevent future patient harm or improvement in services, including the assurance of personal learning and reflections where appropriate.

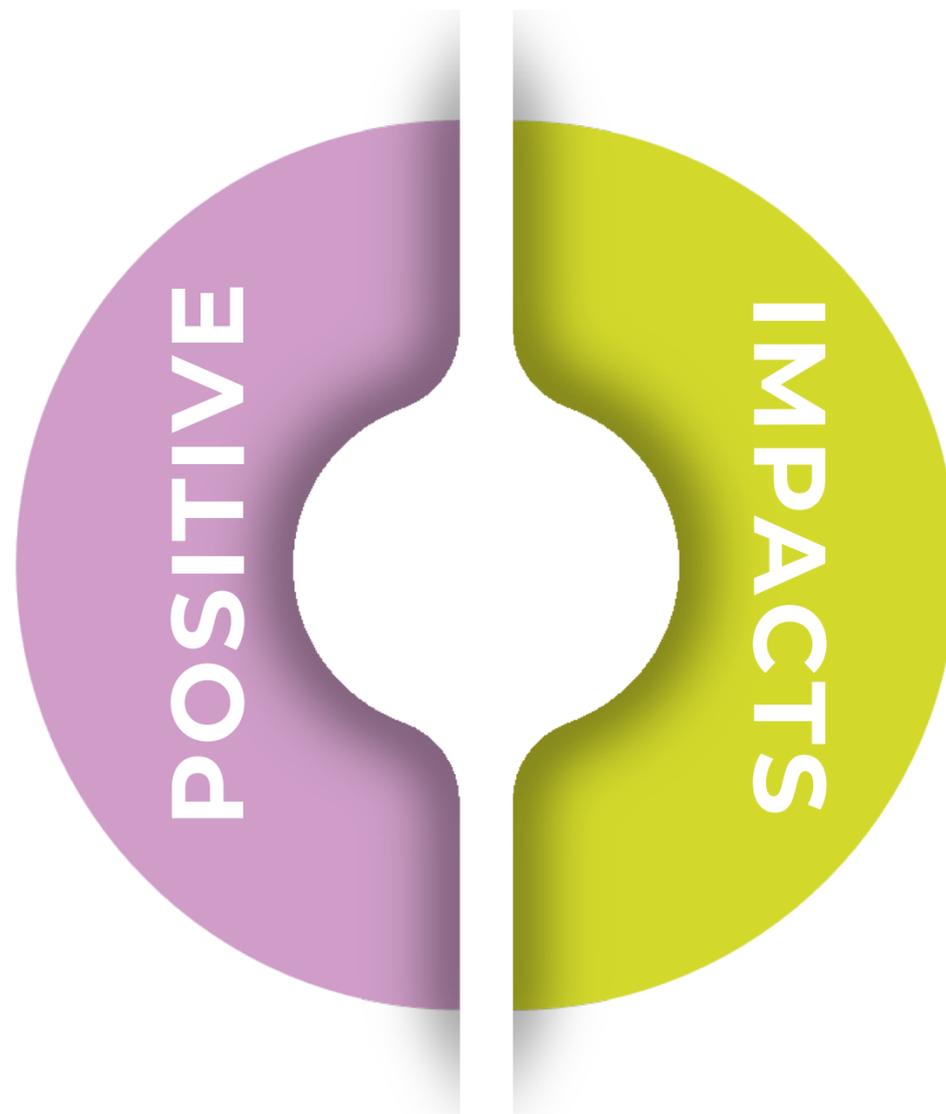
A Divisional Learning from Events Report (LFER) is produced for each case, setting out the key 'issues' identified from the investigation and the resulting 'actions' by way of learning/improvement/assurance of all actions taken and to be taken to prevent future harm. Where a qualifying liability is identified every LFER will then undergo several stages of vigorous scrutiny and assessment by the Welsh Risk Pool, including clinical and peer review via a 'Learning Advisory Panel' (LAP) to provide robust assurance and approval of the Health Board's actions taken, improvements and learning.



Improvements in stroke care have been implemented following a case involving delayed thrombolysis, including increased specialist nurse staffing and enhanced training for ward nurses in stroke management and administration of thrombolysis.



Maternity practices have been updated to reduce the risk of retained swabs, with induction programmes and induction packs now reinforcing swab counting procedures during births.



Mandatory 'Gap training' for all staff is being closely monitored, with compliance and audit evidence provided to ensure continued improvement in clinical practice.



Guidance on the induction of labour for patients with gestational diabetes is under review and clarification, prompted by a redress case, to ensure clear and safe planning for timing of birth.



Inquests

Inquest Data 2024/25 Financial Year

Inquests opened in year:	349
Total Open live inquests (31/3/25):	241

Concluded Inquests

Inquests in Writing 231	<ul style="list-style-type: none"> Inquests where the Coroner feels assured by the witness statements and reports Without the need for Health Board staff to attend Savings on clinical time and resource 77% of concluded inquests
Inquests in Person 68	<ul style="list-style-type: none"> High profile/complex cases High numbers of staff attending Over several days in length 23% of concluded cases

Increasing volume

Q1-3 (April-Dec 2024/25):	226 new Inquests (= 25 pm)
Q4 (Jan-March 2025):	123 new Inquests (= 41 pm)
% increase per month in Q4:	Monthly increase of 64 %

Over the last 3 years, the Health Board has seen a year-on-year growth in the number of new Inquest matters.

Regulation 28 Prevention of Future Death Reports

Inquests concluded in year:	299
Regulation 28 Reports issued:	3
Reports issued to Inquests heard as %:	1%
Decrease for 2024-25:	5 reports for 2023-24
Themes / Trends:	There were no connecting themes or trends

Standard Operating Pathway (SOP) – Inquest Management

This year the Legal Team have developed a SOP with regards to the management of Health Board Inquest files.

The intention is to drive improvement in consistency and timeliness of management of the Health Board's Coronial matters

Inquests

The Health Board has strengthened its approach to inquest management, developing clear procedures and prioritising consistency and timeliness. Emphasis has been placed on learning from inquests, with the sharing of reports, action plans, and lesson learning statements to improve practice and promote organisational learning. Enhanced collaboration with the Coroner's Office—including meetings, staff sessions, and relationship building—has further supported this work and contributed to a reduction in Prevention of Future Deaths reports. Feedback and debrief sessions post-inquest have been positively received, reinforcing a culture of openness, improvement, and support for staff and families.

Health Board staff are supported throughout their inquest journey at every stage, from initial notification, to statement, to preparing for and attendance at inquest, and post inquest de-briefs, working with Divisional peer support colleagues.

Positive feedback received from staff this year has included -

Staff Feedback

Thank you for all your help, it made the experience much easier than I had worried it would be.

Your guidance on the inquest procedure, help to secure relevant statement bundles, and your presence on the day itself was invaluable. It really made a difference to have such thorough support throughout the process.

You have been completely accessible throughout this whole process, offering expert advice, support and reassurance, and I for one am very grateful for that.

I was really nervous going in but thank you for all your support and advice it made it much easier.

Can I just thank you once again for all your help in the preparation of my statements - all your help has been very much appreciated.

I really appreciated your support, and the support of legal services for the duration of the process. A big thank you from me, and please do extend this to the wider team.

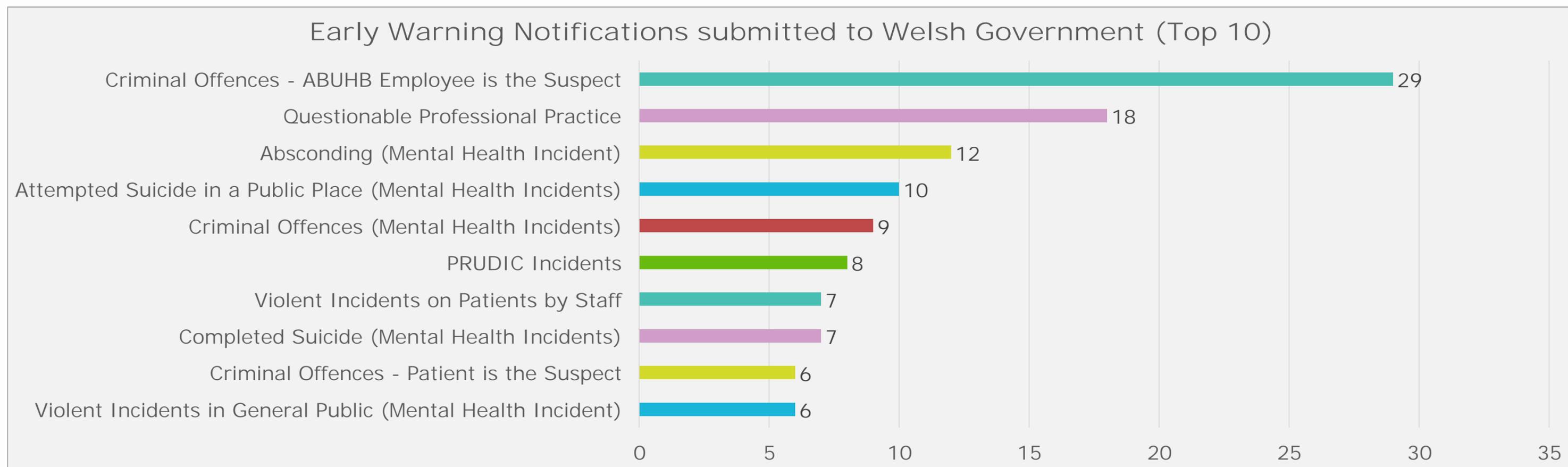
Early Warning Notifications (EWN's)

An Early Warning Notification (EWN) is a formal communication mechanism used to rapidly alert Welsh Government to issues that may or may not involve patient safety incidents but could impact:

- Service provision
- Organisational reputation
- Media coverage
- Political sensitivity
- Public interest (e.g., Regulation 28 inquests or PSOW reports)
- Positive developments worth highlighting

They are distinct from Nationally Reportable Incidents (NRIs), though both processes must be followed if an incident qualifies for both.

During the reporting period, 142 Early Warning Notifications were processed, compared to 127 in the previous year. The top 10 themes were:



Patient Safety Incidents

From 1 April 2024 to 31 March 2025, a total of **25944** patient safety incidents were reported via RL DATIX across all ABUHB sites, representing a 3.95% increase from 2023-24. Following investigation, 25,617 (98.74%) incidents were categorised as resulting in no or low harm. During the reporting period 161 patient safety incidents met national reporting criteria, reflecting a decrease from 187 in the previous year. Never Events, which are serious and preventable incidents, continued to decline, with only two reported this period—one historic case and one wrong-site surgery. This downward trend demonstrates the effectiveness of ongoing safety measures and quality improvement. This increase is representative of the Health Boards safety culture, and staff willingness to report to enhance organisational learning.

Top Three Patient Safety Incident Themes

Theme 1

Unexpected admissions to Neonatal Intensive Care Unit (NICU) (37 weeks+ gestation)

There were 136 incidents, up from 121 in 2023-24. Out of these incidents, 1 resulted in the submission of an NRI, the remainder have been investigated and closed with the harm assessments post-investigation low or no harm.

Theme 2

Health Care Associated Infections (HCAI)

All HCAs are reported on RL Datix as NRIs. In total, 71 NRI notifications were sent for HCAs, compared to 68 NRIs submitted in 2023/24. A full Root Cause Analysis (RCAs) is conducted for each outbreak. IPaC operates an ongoing infection prevention programme.

Theme 3

Inpatient fall with fracture

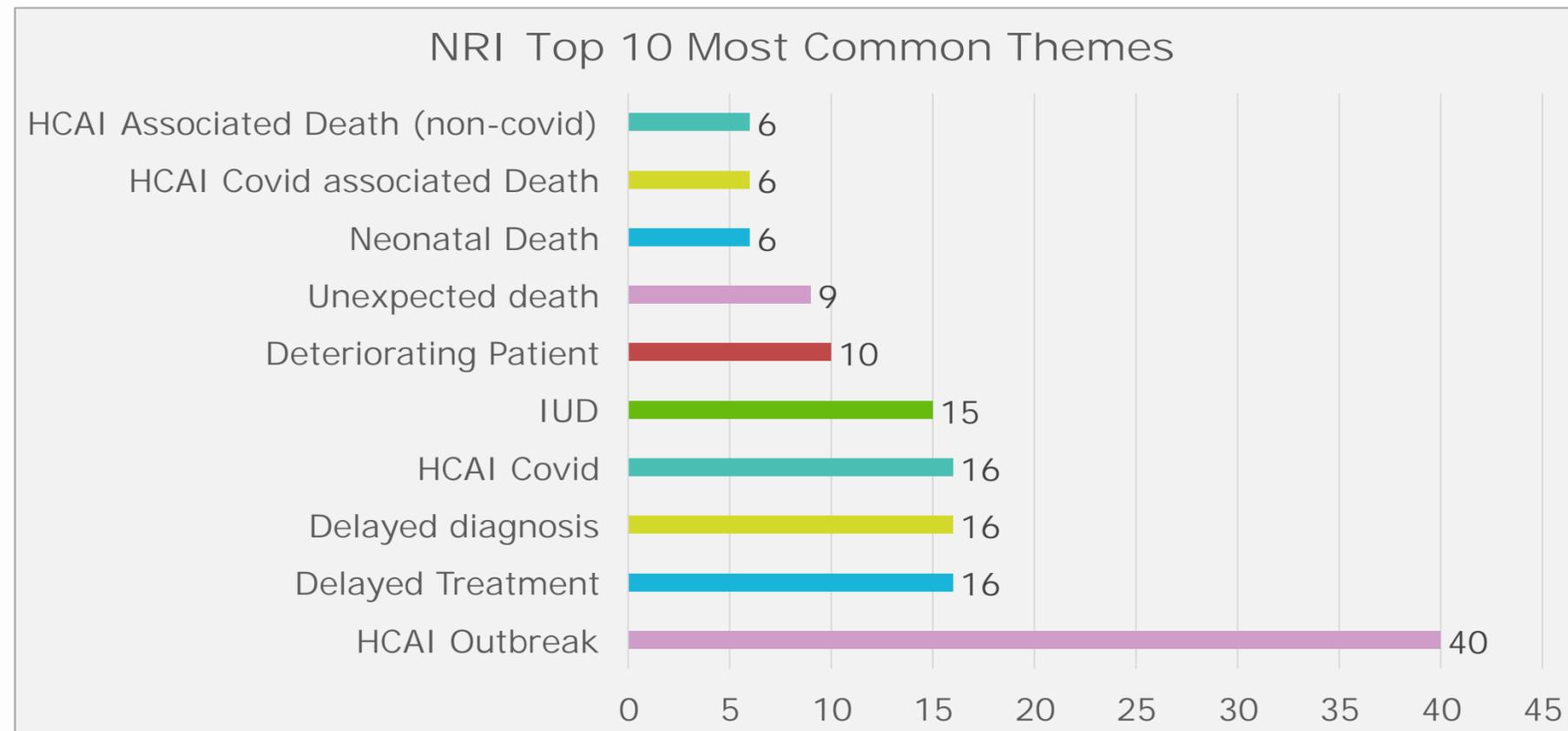
There were 101 falls with fractures reported on RL Datix for 2024-25, a 12% reduction from the 115 incidents in 2023-24. Since 2021, inpatient falls with fractures have been retrospectively reported as NRI's to represent Healthcare Acquired Harm. In this category, 1 NRI was recorded. Ongoing activities related to falls, bone health, and risk assessments continue led by the Falls and Bone Health Strategic Group.

Patient Safety Incidents (PSI) resulting in Moderate harm and above including Never Events in the reporting period undergo scrutiny by the Clinical Executives on a weekly basis to determine level of investigation required.

Nationally Reportable Incidents

A Nationally Reportable Incident (NRI) is a patient safety incident that has caused or contributed to the unexpected or avoidable death or severe harm of one or more patients, staff, or members of the public during NHS-funded healthcare. Patient Safety Incidents that meet the reporting criteria of the National Reporting Framework are reported to the NHS Executive as NRI's.

From 1 April 2024 to 31 March 2025, 161 incidents were identified as meeting the reporting criteria of the National Reporting Framework. This demonstrates a decrease in reported incidents in comparison, to the reporting period of 1 April 2023 - 31 March 2024 187 PSIs were reported which could be reflective of the criteria for Duty of Candour (moderate and above).



Never Events

Never Events are one of the categories of Patient Safety Incidents that are always nationally reportable, even where no harm has occurred. These are defined as:

“Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers”.

Reduction in Never Events

During the reporting period, two Never Events were captured. These included: -

- 1) A historic case from 2010 relating to a retained guidewire after a vascular procedure
- 1) Wrong site surgery (wrong site dermatology biopsy).

The Health Board has observed a consistent decline in Never Events, decreasing from 10 in 2021-22 to 7 in 2022-23, and further down to 5 in 2023-24.

Duty of Candour

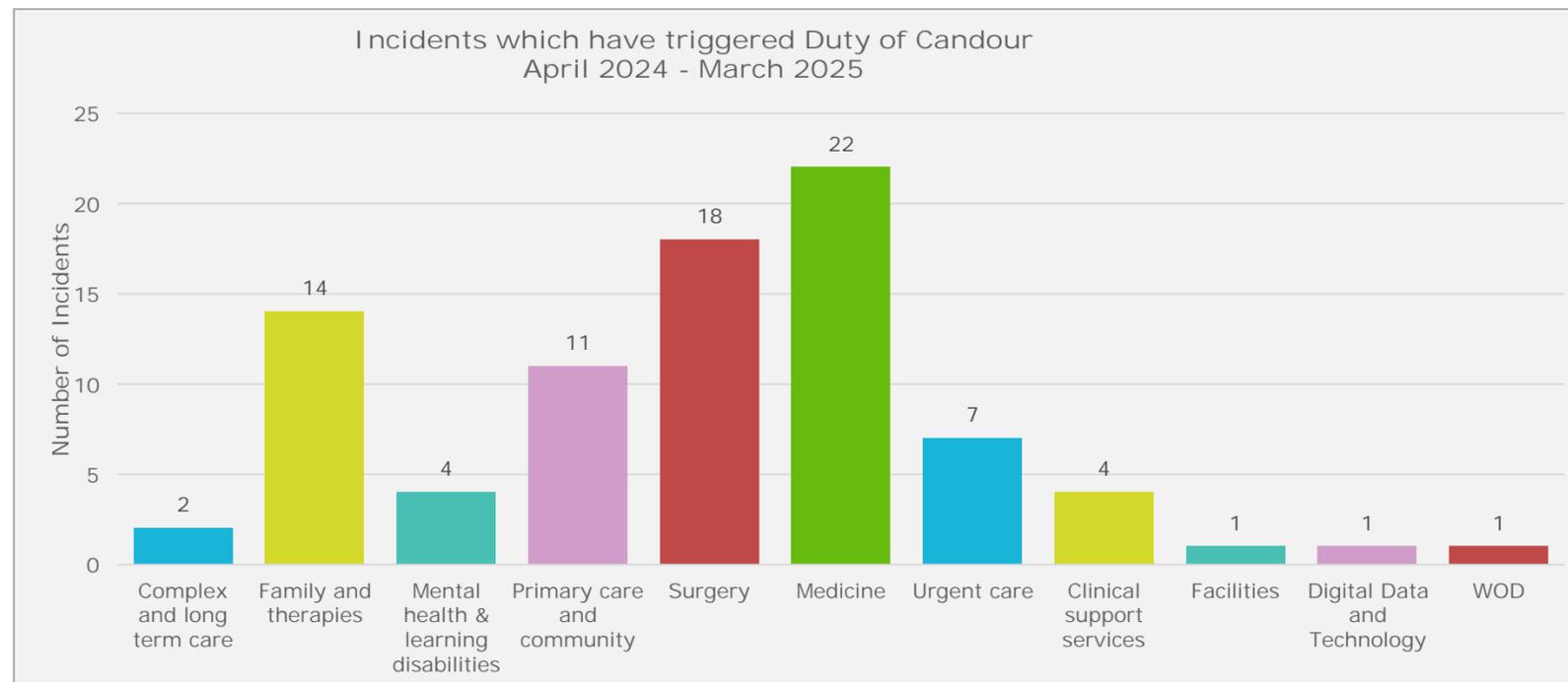
The Duty of Candour came into effect on 1 April 2023 with statutory provisions set through the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

The organisational duty on all NHS bodies requires incident reporting, management and investigation into the circumstances of a notifiable adverse patient safety event to be undertaken in an open and timely manner, including any actions to be taken under the Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011.

The Duty of Candour is triggered when a review of an adverse patient safety event identifies that the service user experienced, or could experience, unexpected or unintended harm that is more than minimal (moderate, severe, death), whilst in receipt of NHS funded care and where the provision of health care was or could have been a factor in that harm occurring.

In preparation for this transition the Health Board reviewed its management of incidents, systems and processes to align to the requirements of the Duty of Candour to minimise disruption to service user experience.

Following the DoC triggered by management review of incidents, there were 85 incidents that were found to be healthcare related harm.



Over the past year there has become a better understanding amongst staff of the definitions of the Duty of Candour and the difference between actual harm and healthcare associated harm as defined by the Law. The focus of the organisation going forward must be to improve compliance with the requirements of fulfilling notification and outcome correspondence following the investigation.

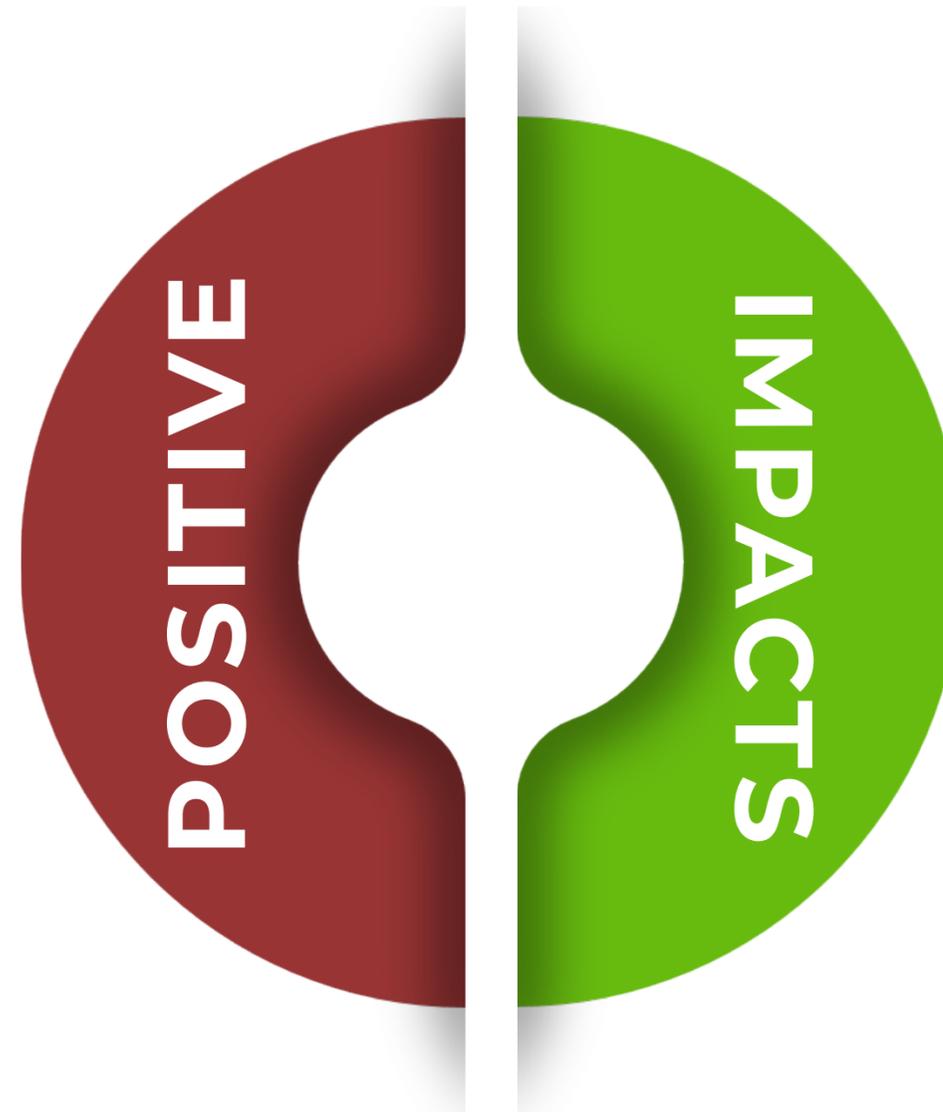
Next Steps for 2025/26

- Relaunch Duty of Candour (DoC) training on ESR for staff who have not undertaken this. DoC training to become mandatory to all patient facing staff with the Health Board.
- The Assistant Head of Quality Patient Safety will oversee organisational efforts to improve compliance with, and understanding of, statutory requirements.
- Encourage Divisional use of DoC dashboards to provide visual cues of requirements.
- Implement changes and improvements based on lessons learned.
- Foster a culture of continuous learning and improvement.
- To produce quarterly data for divisional review at the QPS, Learning and Improving meetings.
- Learning and Improvement to be discussed at Patient Quality and Safety Learning and Improvement Forum.

Patient Safety: Learning and Improvement Initiatives

The organisation has embedded a multi-layered approach to capturing and applying learning, including:

- ✓ Divisional accountability for implementing actions and sharing learning through reports and presentations
- ✓ Integration of incident, complaint, audit, and patient feedback data
- ✓ Quality Outcomes Framework to monitor progress and drive decision-making
- ✓ Support for a positive, learning-focused safety culture aligned with national standards
- ✓ Acute Medical Unit (AMU): Staffing adjustments and improved handover processes were implemented following incidents related to patient deterioration and escalation, enhancing capacity management and medical follow-up.



✓ Nutrition & Hydration: Investigations identified the need for board-wide protocols and multidisciplinary coordination, especially for vulnerable patients. An Executive-led task and finish group was established to improve nutritional assessment, monitoring, and referral processes.

✓ Bell's Palsy: Delayed diagnoses led to a health board ALERT and a standardized referral pathway to ENT, in line with NICE guidance, to raise awareness across primary care and emergency settings.

✓ Avoidable In-patient Falls: There has been a reduction in avoidable, injurious falls classified as Serious Incidents, reflecting ongoing safety improvements.

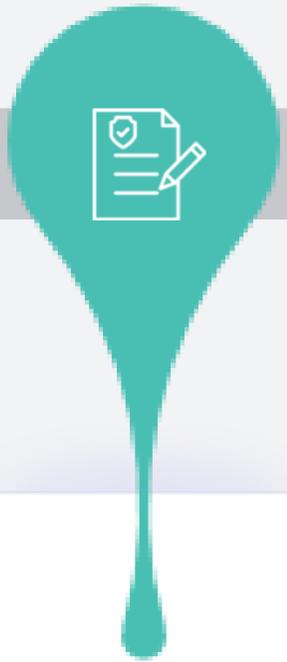
✓ Nosocomial Measles Outbreak: Lessons learned prompted new measures, including a Pre-Triage Screening Questionnaire to better identify and isolate potential cases.

These initiatives demonstrate a commitment to learning, continuous improvement, and enhanced patient safety across the organisation.

Patient Safety Team

The corporate Patient Safety Incident (PSI) Team oversee the investigation and management of Patient Safety Incidents where patient harm is moderate, severe or catastrophic.

Key Achievements for 2024-2025 include:



ABUHB Patient Safety Incident Reporting & Management Policy further updated and refreshed to map to current best practice, patient and family feedback.



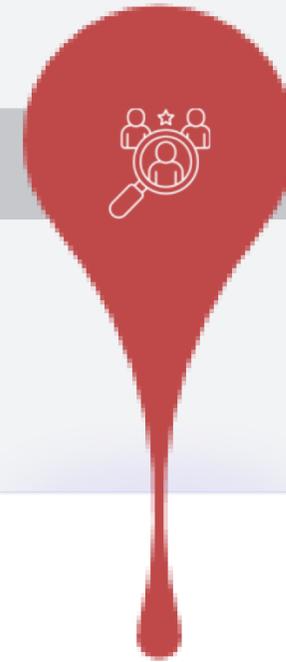
Embedding of revised PSI Reporting template incorporating current best practice in Human Factors methodologies.



Patient safety incidents information leaflet updated to align to Duty of Candour.



Reduced NHS Executive historical case closures and improved NRI closure compliance.



Recruitment to vacancies within the team.

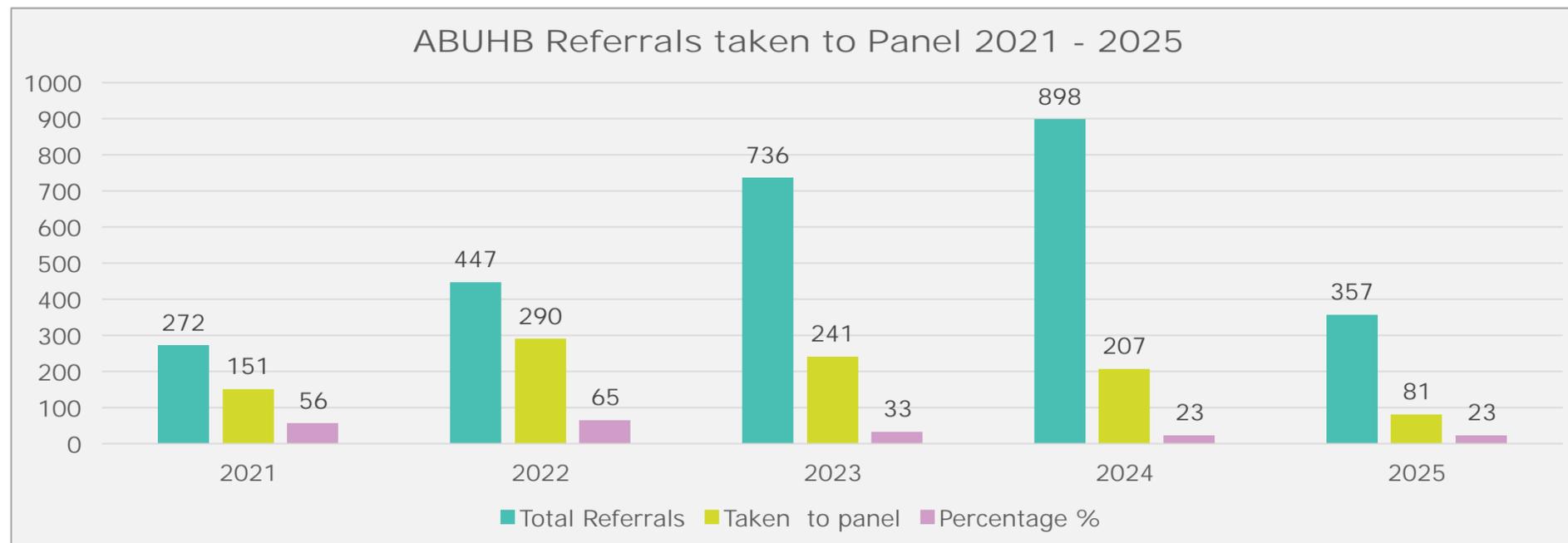


Providing individual support for Investigating Officers

Medical Examiner Service and Mortality Review Screening Panel

The Medical Examiner Service (MES) in Wales, hosted by NHS Wales Shared Services Partnership (NWSSP), provides independent scrutiny of deaths not referred to the coroner. Experienced Medical Examiners (MEs) ensure the accuracy of death certification, identify concerns for further review, and take into account the views of the bereaved families. To maintain impartiality, MEs are employed by NWSSP and avoid reviewing deaths from their own work areas. The service offers external oversight and refers concerns back to Health Boards. MES was introduced in January 2021 and achieved full coverage across hospital, primary care and community settings by the end of 2024. MES findings are shared with care providers to support system-wide learning. This included identifying patterns in causes of death and enabling Health Boards to reflect on and respond to concerns. It provides families with a transparent way to raise issues, aligning with the goals of Putting Things Right. Referrals MEs that require a case review are assigned to a member of the Health Board’s Mortality Review (MR) Screening Panel. This is a multidisciplinary group with cross divisional representation that meets weekly. An assigned panel member reviews and presents the case to the group, which then determines whether further investigation is warranted. Recommended actions are clarified and communicated to the relevant team or clinician for completion. To reinform learning, a biannual newsletter is produced that shares key themes and insights from MES referrals and reviews. All ME-referred deaths undergo a structured three-level review process:

Level 1:	Initial review to determine if further investigation is needed.
Level 2:	Cases requiring escalation are reviewed by the multidisciplinary Mortality Review Screening Panel, which meets weekly to assign actions.
Level 3:	Actions may include clinical reviews at Mortality and Morbidity (M&M) meetings, investigations under the Putting Things Right (PTR) process, or specialist panel reviews (e.g. Falls Review Panel).



Over a 12-month period, a total of 843 ME referrals were received in 23/24, this constituted 30% of the total deaths at ABUHB during that period. 715 cases between 2024/25, representing approximately 37% of all ABUHB deaths during that time.

The Health Board produced a twice-yearly report on Learning from Deaths, which includes a Framework on mortality rates, MES data, trends, learning and improvement. The Mortality Screening Panel publishes a twice-yearly newsletter, sharing learning and raising awareness, highlighting themes and insights from MES referrals

Learning Overview and Trends:

No Further Action: These referrals have decreased, likely due to improved referral quality and increased local sharing by the Health Board's Mortality s MR Screening Panel. Many involve concerns already under review via other processes (e.g. Datix).

Infection Prevention & Control Referrals: Declined in line with reduced nosocomial COVID-19 cases.

Serious Incident (SI) Referrals: Continued to fall, possibly due to earlier proactive management of incidents.

HMC Referrals: Increased compared to previous periods—trend to monitor.

Closed on Datix: Closure rates have improved significantly, though further progress is still needed.

Thematic Analysis of MES Referrals:

Acute Setting

Delays: The most frequent theme, covering perceived delays in treatment, ambulance handover, diagnostics, and access to urgent care beds.

DNACPR: Concerns about incomplete documentation, particularly missing senior clinician signatures in Part 6. Frequency is gradually decreasing.

Communication: Ongoing issues in interactions between clinicians, services, patients, and families.

COVID-19: Referrals related to hospital- or community-acquired cases have declined.

Pressure Damage: Referrals have reduced from 5% to 3%.

Primary Care and Community Setting

Concerns from bereaved families regarding GP care.

Issues related to care delivery in residential and nursing homes.

Delays in the Medical Certificate of Cause of Death (MCCD) process.

I honestly can't fault them at all, they gave 100%. She said (The staff) were very attentive, very respectful and mindful.

The care (her husband) received was excellent on both wards that he was on during his last admission. She said the nursing team were brilliant and she couldn't thank them enough.

She said the care (her mother) received was excellent and she could have not wished for better care.

She said the actual nurses were amazing, they looked after the family as well as (her husband)/ She said 'they were absolutely lovely'.

'At every point (the staff) were all amazing. Communication was excellent - we knew everything they were doing and why. They really looked after my and my mum too. I really can't thank them enough.'

In the hospital (the staff) were second to none, absolutely brilliant. The ward staff were brilliant, and the ward manager was superb.

Future Goals:

Aims for the remainder of 2025 include: -

- 1. Maintain the biannual newsletter** to support shared learning by highlighting key themes and insights from MES referrals.
- 2. Share positive feedback** from MES referral letters, which often include valuable comments from bereaved families about the care received—this qualitative data will continue to be collected and shared.
- 3. Improve referral closure rates** on the Mortality Module in Datix to enhance data quality and support organisational learning.
- 4. Develop a Health Board-wide approach:** Collaborate with the Care After Death Team and the Patient Engagement and Involvement Team to ensure that the voices of bereaved families, along with feedback from the MES, inform and shape our learning and improvement efforts.

Sepsis

Following a serious incident and the resulting action plan, the Health Board has prioritised sepsis as a key focus within one of the workstreams of the Quality Strategy. This commitment has been further strengthened by the drive to standardise electronic Early Warning Scores, supporting timely recognition and response to deteriorating patients.

Sepsis is a syndrome defined as life-threatening organ dysfunction due to a dysregulated host response to infection (NICE, 2024). The UK Sepsis Trust estimates that in the UK, sepsis affects 245,000 per year, results in 48,000 deaths per year and 5 deaths per hour.

Over the past 12 months, the Medical Director's Quality and Patient Safety team have been collaboratively developing a two-year sepsis strategy. The primary aim is to enhance patient safety and improve outcomes by addressing systemic challenges in the identification and management of sepsis. This includes ensuring compliance with the latest National Institute Care Excellence (NICE) NR51 guidance and adopting best practice from the Academy of Medical Royal Colleges (AoMMRC) guidance.

Strategic Goals include:

Improve sepsis recognition and management

Enhance the timely identification, treatment and management of sepsis across ABUHB

Strengthening initial treatment

Review current resources and update sepsis related policies and clinical materials

Implement and enhance sepsis tools

Roll out Early Warning Scores (EWS) across all divisions to support clinical decision-making

Standardise staff education and training

Promote consistency and raise awareness to improve the effectiveness of sepsis response and management

Audit and Assurance Framework

Develop a robust audit strategy to monitor compliance and provide assurance on sepsis management

Quality Improvement Support

Provide a mechanism for direct support to Divisions using QI methodology to deliver sustainable high-quality care

Service User Engagement

Gather feedback from patients and the public to identify missed opportunities and areas for improvement

National Collaboration

Continue working with UK Sepsis Trust and NHS Wales Health Boards to maintain up-to-date guidance and explore innovative practices

Progress Report

National Drivers for Deteriorating Patient: The Welsh Health Circular (WHC) 2024/035 mandates the standardised use of Early Warning Scores (EWS) to identify and manage acute deterioration. The Health Board is actively working to meet the implementation deadline of 30th September 2025. This initiative is supported by the Safer Care Partnership, led by NHS Executive and Improvement Cymru, is focusing on this initiative, including the rollout of Martha's rule (Call for Concern).

Local Implementation: The Health Board's Deteriorating Patient Working Group has formed dedicated task groups to implement NEWS2, focusing on digital enablement, education, escalation protocols, and audit. Planning for Paediatric EWS is underway, with a target launch in September 2025. For Maternity and Neonatal EWS, workshops and follow-up meetings have established groups with digital templates scheduled for release.

These efforts aim to improve sepsis awareness, treatment, and outcomes across the Health Board.

Quality Improvement and Learning



Human Factors Training for All Staff:

We have introduced comprehensive Human Factors Training focusing on communication, decision-making, and teamwork. By embedding this programme into induction and ongoing education, staff across the Health Board are now better equipped to communicate clearly, make sound decisions, and collaborate effectively—even in high-pressure situations.



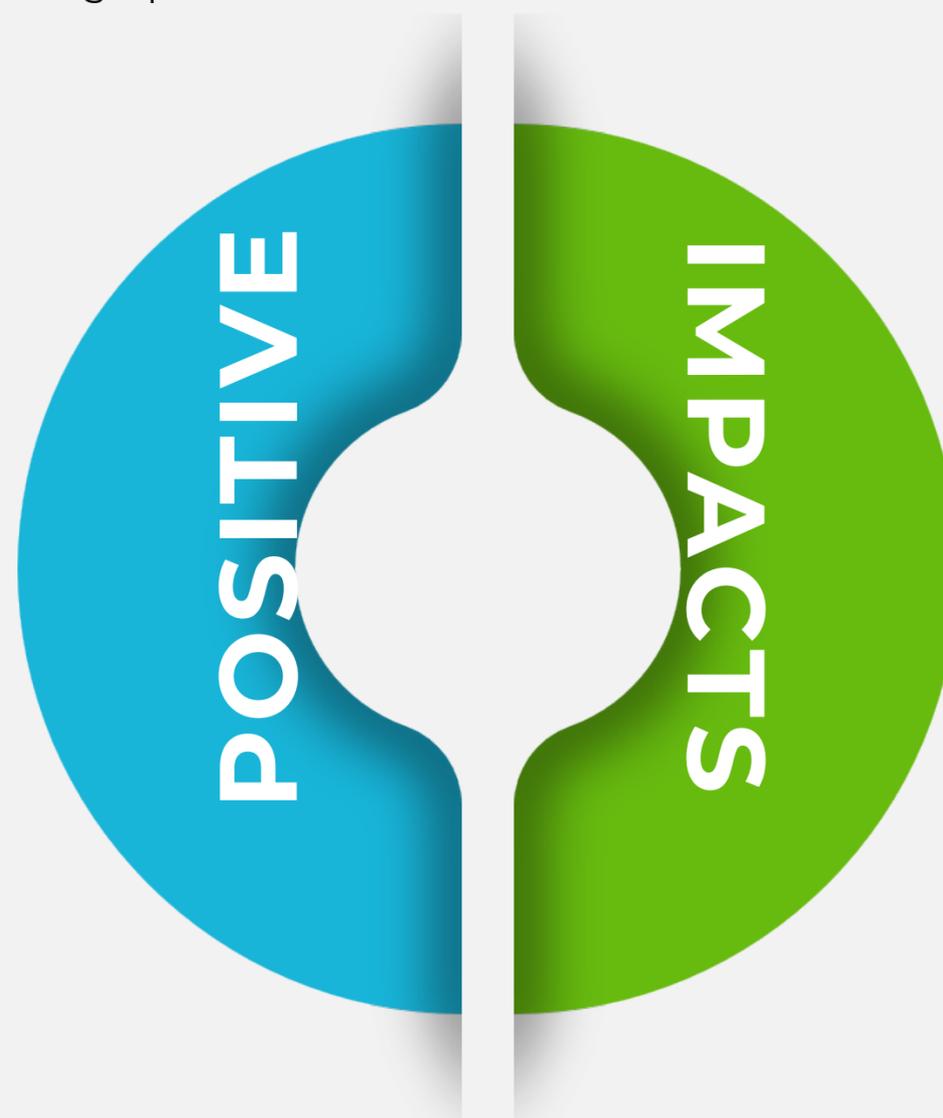
Empowering Teams through Quality Improvement Coaching:

We have expanded the role of QI (Quality Improvement) coaches, who are now working alongside clinical teams to systematically address patient safety incidents and complaints. By introducing structured improvement methods and supporting staff to use their own expertise, we have fostered a culture where solutions come from within our teams, not just from top-down directives.



Embedding Learning into Everyday Practice:

Our commitment to continuous learning means that staff are encouraged to reflect on complaints and safety events, identify root causes, and implement changes to prevent recurrence. Through the development of QI Coaches and our “million minutes of QI coaching” initiative, we have increased our organisation’s capacity for quality improvement, ensuring safer and higher-quality care for all.



Building a Culture of Openness and Early Engagement:

By integrating best practices and learning from incidents into staff education, we have reduced the likelihood of issues escalating to formal complaints. This proactive approach supports a culture of openness, learning, and continuous improvement, leading to faster, more empathetic resolutions for our patients and their families.



Enhancing Patient Experience and Outcomes:

By strengthening communication and teamwork, our initiatives have created a safer, more responsive environment for those we care for. This not only improves outcomes but also aligns with our broader strategy of early engagement and person-centred resolution.

Collectively, these improvements demonstrate our ongoing commitment to learning, collaboration, and delivering the highest quality of care across the Health Board.