Aneurin Bevan University Health Board Public Board

Monday 28 September 2026, 09:00 - 13:00

Conference Centre, St Cadoc's Hospital

Agenda

09:00 - 09:00
0 min

1. PRELIMINARY MATTERS

PB 202600928_Board Consent Agenda.pdf (4 pages)

1.1. Welcome and Introductions

Chair

1.2. Apologies for Absence for Noting

Chair

1.3. Declarations of Interest for Noting

Chair

09:00 - 09:00
0 min

2. CONSENT AGENDA BUSINESS

2.1. The Chair will ask if there are any items from the Consent Agenda (Item 6) that Board Members wish to bring forward to the Main agenda for discussion

Chair

09:00 - 09:00
0 min

3. CHAIR & CEO UPDATES

3.1. Update from the Chair

Chair

3.2. Update from the Chief Executive

Chief Executive

09:00 - 09:00
0 min

4. PERFORMANCE & DELIVERY

4.1. Cancer Services

Chief Operating Officer

a. Priority Programme Review

b. End of Strategy

PB 20260928 Agenda Item 4.1a Cancer Services.pdf (7 pages)
PB 20260928 Agenda Item 4.1a Cancer Services Appenidx A.pdf (29 pages)
PB 20260928 Agenda Item 4.1b Cancer Services.pdf (23 pages)

4.2. Priority Programme Review: Place Based Care

Director of Public Health

PB 20260928 Agenda Item 4.2 Priority Programme Review - Place Based Care.pdf (7 pages)
PB 20260928 Agenda Item 4.2 Priority Programme Review - Place Based Care Appendix A.pdf (21 pages)
PB 20260928 Agenda Item 4.2 Priority Programme Review - Place Based Care Appendix B.pdf.pdf (4 pages)
PB 20260928 Agenda Item 4.2 Priority Programme Review - Place Based Care Appendix C.pdf (1 pages)

4.3. 2026/27 Performance Reporting

Executive Leads

a. Integrated Performance Report

b. Financial Performance Report, Month 05

PB 20260928 Agenda Item 4.3a Integrated Performance Report.pdf (10 pages)
PB 20260928 Agenda Item 4.3a Integrated Performance Report Appendix A.pptx.pdf (82 pages)
PB 20260928 Agenda Item 4.3a Integrated Performance Report Appendix B.pdf (16 pages)
PB 20260928 Agenda Item 4.3b Financial Performance Report, Month 05.pdf (17 pages)
PB 20260928 Agenda Item 4.3b Financial Performance Report, Month 05 Appendix A.pdf (55 pages)

4.4. Winter Plan

Director of Strategy, Planning and Partnerships

- Evaluation 2025/26
- 2026/27 Winter Plan

PB 20260928 Agenda Item 4.4 Winter Plan.pdf (6 pages)
PB 20260928 Agenda Item 4.4 Winter Plan Appendix A Winter Plan Evaluation 2025-26.pdf (9 pages)
PB 20260928 Agenda Item 4.4 Winter Plan Appendix B 2026-27.pdf (13 pages)
PB 20260928 Agenda Item 4.4 Winter Plan Appendix B 2026-27 Winter Plan Annex A.log.pdf (15 pages)
PB 20260928 Agenda Item 4.4 Winter Plan Appendix B 2026-27 Winter Plan Annex B.pdf (6 pages)
PB 20260928 Agenda Item 4.4 Winter Plan Appendix B 2026-27 Winter Plan Annex C.pdf (3 pages)

4.5. Maternity & Neonatal Services Annual Report

Director of Nursing

PB 20260928 Agenda Item 4.5 Maternity & Neonatal Services Annual Report.pdf (10 pages)
PB 20260928 Agenda Item 4.5 Maternity & Neonatal Services Annual Report Appendix A.pdf (21 pages)

4.6. Quality Annual Report

Director of Nursing

PB 20260928 Agenda Item 4.6 Quality Annual Report.pdf (8 pages)
PB 20260928 Agenda Item 4.6 Quality Annual Report Appendix A.pdf (50 pages)

4.7. Health, Safety & Fire Annual Report

Director of Allied Health Professions & Health Science

PB 20260928 Agenda Item 4.7 Health, Safety & Fire Annual Report.pdf (6 pages)
PB 20260928 Agenda Item 4.7 Health, Safety & Fire Annual Report Appendix A.pdf (38 pages)

09:00 - 09:00
0 min

5. ASSURANCE MATTERS

5.1. Welsh Language

Director of Workforce & OD

- Staff Story
- Annual Report

PB 20260928 Agenda Item 5.1 Welsh Language Annual Report.pdf (6 pages)
PB 20260928 Agenda Item 5.1 Welsh Language Annual Report Appendix A.pdf (33 pages)
PB 20260928 Agenda Item 5.1 Welsh Language Annual Report Appendix B.pdf (30 pages)

5.2. Key Matters from Committees of the Board

Committee Chairs

PB 20260928 Agenda Item 5.2 Key Matters from Committees of the Board.pdf (23 pages)

5.3. Risk Management and Assurance Framework

Chief Executive

PB 20260928 Agenda Item 5.3 Risk Management and Assurance Framework.pdf (4 pages)
PB 20260928 Agenda Item 5.3 Risk Management and Assurance Framework Appendix A.pdf (18 pages)
PB 20260928 Agenda Item 5.3 Risk Management and Assurance Framework Appendix B.pdf (14 pages)
PB 20260928 Agenda Item 5.3 Risk Management and Assurance Framework Appendix C.pdf (25 pages)

5.4. Strategic Risk Report, September 2026

Chief Executive

PB 20260928 Agenda Item 5.4 Strategic Risk Report September 2026.pdf (8 pages)
PB 20260928 Agenda Item 5.4 Strategic Risk Report September 2026 Appendix A.pdf (3 pages)
PB 20260928 Agenda Item 5.4 Strategic Risk Report September 2026 Appendix B.pdf (2 pages)

5.5. Report from Llais, Gwent Region

Regional Director, Llais

PB 20260928 Agenda Item 5.5 Report from Llais, Gwent Region.pdf (13 pages)

09:00 - 09:00
0 min

6. CONSENT AGENDA

6.1. FOR APPROVAL

6.1.1. Discretionary Capital Approval Update

Director of Strategy, Planning & Partnerships

PB 20260928 Agenda Item 6.1.1 Discretionary Capital Approval Update.pdf (5 pages)

6.1.2. Draft Minutes of the Health Board Meeting, held on:

Chair

29th July 2026

PB 20260928 Agenda Item 6.1.2 Draft Minutes of the Public Board Meeting held on 29 July 2026.pdf (20 pages)

6.1.3. Report on Sealed Documents and Chair's Actions

Chair

PB 20260928 Agenda Item 6.1.3 Governance Matters.pdf (6 pages)

6.2. FOR NOTING

6.2.1. Board Action Log with Updates

Chair

PB 20260928 Agenda Item 6.2.1 Board Action Log.pdf (1 pages)

6.2.2. Emergency Preparedness, Resilience and Response Annual Report

Director of Strategy, Planning and Partnerships

PB 20260928 Agenda Item 6.2.2 Emergency Preparedness, Resilience and Response Annual Report.pdf (4 pages)
PB 20260928 Agenda Item 6.2.2 Emergency Preparedness, Resilience and Response Annual Report Appendix A.pdf (16 pages)

6.2.3. Pharmaceutical Needs Assessment

Director of Public Health

PB 20260928 Agenda Item 6.2.3 Pharmaceutical Needs Assessment.pdf (6 pages)
PB 20260928 Agenda Item 6.2.3 Pharmaceutical Needs Assessment Appendix A.pdf (27 pages)
PB 20260928 Agenda Item 6.2.3 Pharmaceutical Needs Assessment Appendix B.pdf (274 pages)

6.2.4. Executive Committee Chair's report

Chief Executive

PB 20260928 Agenda Item 6.2.4 Executive Committee Chair's report.pdf (9 pages)

6.2.5. Strategic Partnership Updates:

Director of Strategy, Planning and Partnerships

a) Regional Partnership Board

b) Public Services Board

PB 20260928 Agenda Item 6.2.5a Regional Partnership Board.pdf (6 pages)
PB 20260928 Agenda Item 6.2.5a Regional Partnership Board Appendix A.pdf (57 pages)
PB 20260928 Agenda Item 6.2.5b Public Services Board.pdf (5 pages)

6.2.6. An overview of Joint and Partnership Committee Activity

Chief Executive

a. NHS Wales Joint Commissioning Committee

b. NHS Wales Shared Services Partnership Committee

PB 20260928 Agenda Item 6.2.6a Joint Commissioning Committee.pdf (4 pages)
PB 20260928 Agenda Item 6.2.6a Joint Commissioning Committee Appendix A.pdf (5 pages)
PB 20260928 Agenda Item 6.2.6b NHS Wales Shared Services Partnership Committee.pdf (3 pages)
PB 20260928 Agenda Item 6.2.6b NHS Wales Shared Services Partnership Committee Appendix A.pdf (5 pages)

6.2.7. Summary of Board Business held In-Committee

Director of Corporate Governance

PB 20260928 Agenda Item 6.2.7 Summary of Board Business held In Committee July 2026.pdf (4 pages)

09:00 - 09:00
0 min

7. OTHER MATTERS

7.1. Any Other Business

7.2. Date of the Next Meetings:

- 18th November 2026

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

AGENDA	
Date and Time	Monday 28th September 2026 at 09:00
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 6) that Board Members wish to bring forward to the Main agenda for discussion		Chair
3	CHAIR & CEO UPDATES		
3.1	Update from the Chair	Oral	Chair
3.2	Update from the Chief Executive	Oral	Chief Executive
4	PERFORMANCE & DELIVERY		
4.1	Cancer Services: a) Priority Programme Review b) End of Strategy	Attachment	Chief Operating Officer
4.2	Priority Programme Review: Place Based Care	Attachment	Director of Public Health
4.3	2026/27 Performance Reporting: a. Integrated Performance Report b. Financial Performance Report, Month 05	Attachment	Executive Leads

4.4	Winter Plan: • Evaluation 2025/26 • 2026/27 Winter Plan	Attachment	Director of Strategy, Planning and Partnerships
4.5	Maternity & Neonatal Services Annual Report	Attachment	Director of Nursing
4.6	Quality Annual Report	Attachment	Director of Nursing
4.7	Health, Safety & Fire Annual Report	Attachment	Director of Allied Health Professions & Health Science
5	ASSURANCE MATTERS		
5.1	Welsh Language: • Staff Story • Annual Report	Attachment	Director of Workforce & OD
5.2	Key Matters from Committees of the Board	Attachment	Committee Chairs
5.3	Risk Management and Assurance Framework	Attachment	Chief Executive
5.4	Strategic Risk Report, September 2026	Attachment	Chief Executive
5.5	Report from Llais, Gwent Region	Attachment	Regional Director, Llais
	CONSENT AGENDA		
6.1	FOR APPROVAL		
6.1.1	Discretionary Capital Approval Update	Attached	Director of Strategy, Planning & Partnerships
6.1.2	Draft Minutes of the Health Board Meeting, held on: • 29th July 2026	Attachment	Chair
6.1.3	Report on Sealed Documents and Chair's Actions	Attachment	Chair
6.2	FOR NOTING		
6.2.1	Board Action Log with Updates	Attachment	Chair

6.2.2	Emergency Preparedness, Resilience and Response Annual Report	Attachment	Director of Strategy, Planning and Partnerships
6.2.3	Pharmaceutical Needs Assessment	Attachment	Director of Public Health
6.2.4	Executive Committee Chair's report	Attachment	Chief Executive
6.2.5	Strategic Partnership Updates: a) Regional Partnership Board b) Public Services Board	Attachment	Director of Strategy, Planning and Partnerships & Director of Public Health
6.2.6	An overview of Joint and Partnership Committee Activity: a. NHS Wales Joint Commissioning Committee b. NHS Wales Shared Services Partnership Committee	Attachment	Chief Executive
6.2.7	Summary of Board Business held In-Committee	Attachment	Director of Corporate Governance
7	OTHER MATTERS		
7.1	Any Other Business		
7.2	Date of the Next Meetings: • 18th November 2026		
8	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*		

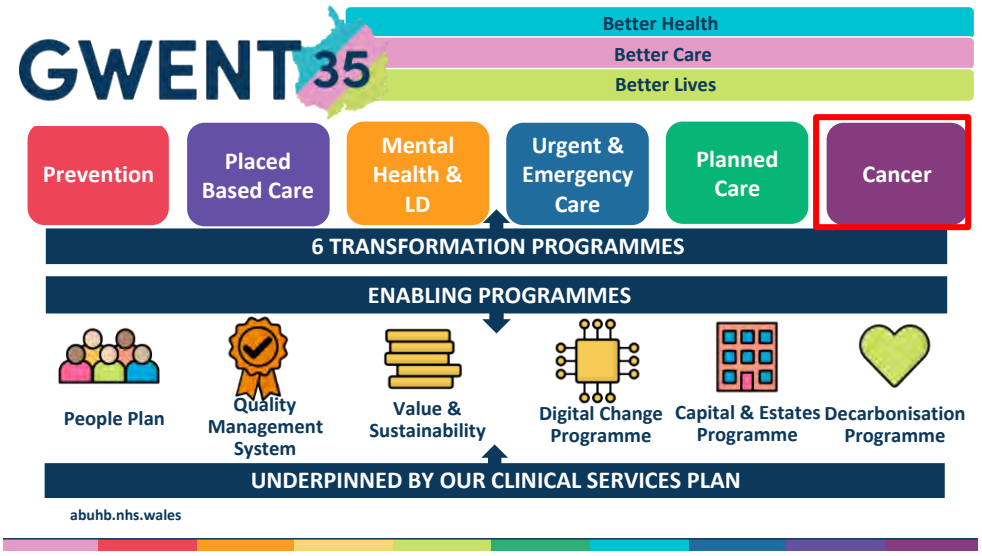
	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 September 2026
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Cancer Programme Deep Dive & Strategy Evaluation
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins Chief Operating Office
SWYDDOG ADRODD: REPORTING OFFICER:	Clare Small Senior Programme Manager, Transformation & Delivery Dr Ian Williamson Assistant Medical Director, Cancer Service Margaret Parrott Cancer Services manager Anne May Strategic Lead Cancer Nurse Simon Roberts Head of Transformation & Delivery

Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)
Er Gwybodaeth/For Information

Sefyllfa / Situation

The Cancer Programme is a key component of the Health Board's transformation portfolio and brings together national policy, the Quality Statement for Cancer, Ministerial performance expectations and commitments within the 2026/27 Annual Plan. There were also six pillars of the Cancer strategy: Prevention; Early Detection; Timely Diagnosis; Improved and Standardised Care; Living Well With and After Cancer; and Improving Cancer Knowledge through Research and Education



Cancer demand has increased significantly. Suspected cancer referrals rose from 29,896 in 2019/20 to 40,347 in 2025/26, an increase of 35%, while first treatments increased from 3,704 to 4,635, an increase of 25%. The Health Board now receives approximately 40,000 suspected cancer referrals and records around 4,600 cancer diagnoses each year.

Current performance presents a mixed picture:

- 62-day Single Cancer Pathway compliance is 63.7% (August 2026), against the national target of 75%
- 28-day diagnostic performance is 76%, against the Health Board's benchmark of 75%
- The backlog currently comprises 308 patients waiting over 62 days and 89 waiting over 104 days, with both positions reducing following increases during 2025.

Performance against the 62-day standard remained below target between April 2025 and August 2026, ranging from 58% to 66%. Although performance has generally remained above the All-Wales average, variation persists between tumour sites because of differences in diagnostic complexity, specialist testing, surgical capacity and reliance on regional services.

An evaluation of the Gwent Cancer Strategy 2020-2025 highlights a number of transformational developments that have improved cancer services across Gwent. The report concludes that the foundations established through the 2020–2025 strategy provide a strong platform for the development of the Gwent Cancer Plan 2035, which will build on these achievements and provide a renewed focus on prevention, innovation, workforce development and sustainable service transformation

A copy of the full deep dive paper is included in Appendix 1.

A copy of the Cancer Strategy evaluation (2020-2025) is included in Appendix 2.

Cefndir / Background

Cancer remains one of the Health Board's highest strategic priorities because of rising referrals and diagnoses, persistent inequalities, national performance expectations and the need to improve survival, patient experience and quality of care. The overall aim is to prevent cancer where possible, detect disease earlier, optimise complex pathways and ensure that patients are appropriately supported throughout diagnosis, treatment and recover.

The overall assessment is that the Cancer Programme has maintained delivery and achieved significant service improvements despite sustained growth in referrals and treatment demand. Governance, programme oversight, digital intelligence and organisational ownership have strengthened, and tangible improvements have been delivered in prevention, early detection, specialist treatment, acute oncology, personalised care, research and patient experience.

The programme has continued delivery against the 2020–2025 Cancer Strategy while preparing the Gwent Cancer Plan 2035. Progress has been made across all six pillars, supported by strengthened governance, programme management, organisational ownership and performance intelligence.

Asesiad / Assessment

The Cancer Programme has continued to deliver significant improvements across prevention, early detection, diagnosis, treatment, personalised care and research despite unprecedented growth in demand. Key achievements include strengthened prevention and screening initiatives, expansion of specialist cancer services closer to home, implementation of innovative diagnostic and treatment models, enhanced cancer intelligence and performance reporting, and significant improvements in patient experience and personalised care. Major developments such as the Velindre @ Nevill Hall Satellite Radiotherapy Unit, expansion of Acute Oncology Services, one-stop diagnostic pathways and increased access to psychological support and survivorship services have strengthened service capacity, quality and access for patients across Gwent.

Whilst substantial progress has been made, significant challenges remain. Rising referral demand, workforce pressures, diagnostic and treatment capacity constraints, inequalities in outcomes and continued underperformance against the 62-day Single Cancer Pathway target require sustained focus and service

transformation. The development of the Gwent Cancer Plan 2035 provides an opportunity to build on the strong foundations established through the current strategy, with a renewed focus on prevention, earlier diagnosis, pathway redesign, workforce sustainability, digital innovation and reducing inequalities to improve long-term cancer outcomes for the population of Gwent.

The Gwent Cancer Plan 2035 provides the strategic mechanism for addressing these challenges. The Executive Board approved its development in April 2026, and engagement has subsequently taken place with staff, patients, the public and stakeholders. The first draft is scheduled for consideration by the Cancer Board in January 2027, with finalisation anticipated in early 2027.

The Plan will retain the six strategic pillars and incorporate cross-cutting “Golden Threads”, including inequalities, workforce, digital enablement and patient experience. Major deliverables will include:

- A fully costed three-year Cancer Improvement Plan.
- Alignment of tumour pathways with National Optimal Pathways.
- Directorate-level transformation plans.
- A benefits realisation framework.
- Strengthened governance and accountability.
- Clear outcomes and performance measures across all workstreams.
- Prioritised investment in workforce, digital capability, diagnostics, endoscopy, pathology and treatment infrastructure

Argymhelliad / Recommendation

The Board is asked to:

- Note the contents of the attached Cancer Programme Deep Dive report.
- Note the contents of the attached Cancer Strategy Evaluation (2020-2025) .

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1.1 Health Promotion, Protection and Improvement 3.2 Communicating Effectively 5.1 Timely Access 7.1 Workforce

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. FInance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

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

ABUHB	Aneurin Bevan University Health Board
AOS	Acute Oncology Service
CIN	Clinical Implementation Network
ED	Emergency Department
FIT	Faecal Immunochemical Test
GP	General Practitioner
HER2	Human Epidermal Growth Factor Receptor 2
H	Help Me Quit
HNA	Holistic Needs Assessment
HPV	Human Papillomavirus
IHC	Immunohistochemistry
IT	Information Technology
LHB	Local Health Board
MDT	Multidisciplinary Team
MSCC	Metastatic Spinal Cord Compression
MUO	Malignancy of Unknown Origin
NHS	National Health Service
nVCC	New Velindre Cancer Centre

	ONS: Office for National Statistics PDSA: Plan, Do, Study, Act PREMs: Patient-Reported Experience Measures PROMs: Patient-Reported Outcome Measures Q1: Quarter 1 RAG: Red, Amber, Green SACT: Systemic Anti-Cancer Therapy SCP: Single Cancer Pathway SDEC: Same Day Emergency Care UHB: University Health Board VCC: Velindre Cancer Centre WG: Welsh Government
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

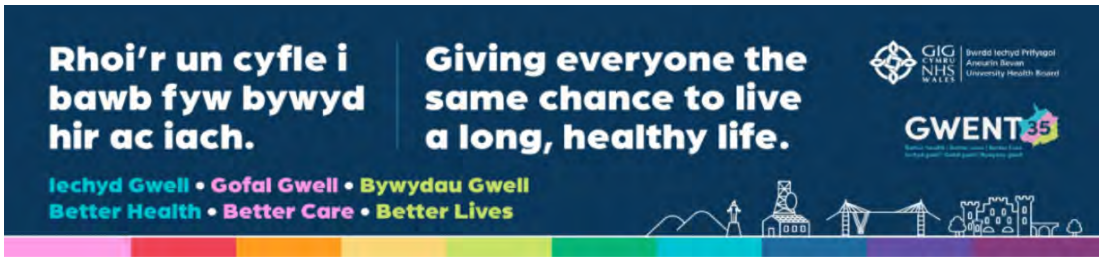
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term 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

Appendix 1 - deep dive paper

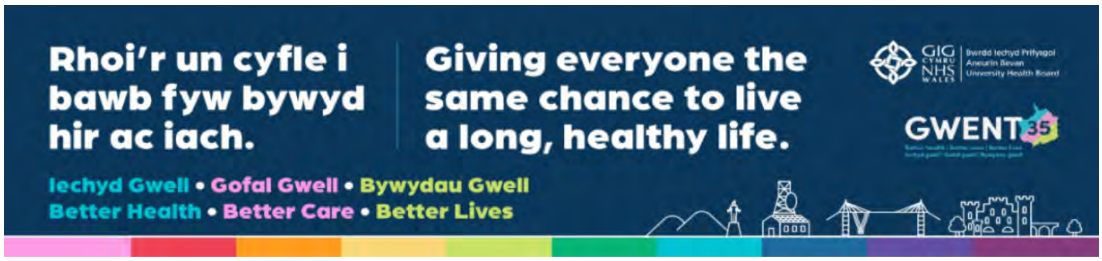
Cancer Programme Deep Dive September

Appendix 2 - Cancer Strategy evaluation (2020-2025)

Strategy Evaluation 2020- 2025 Final V1.p

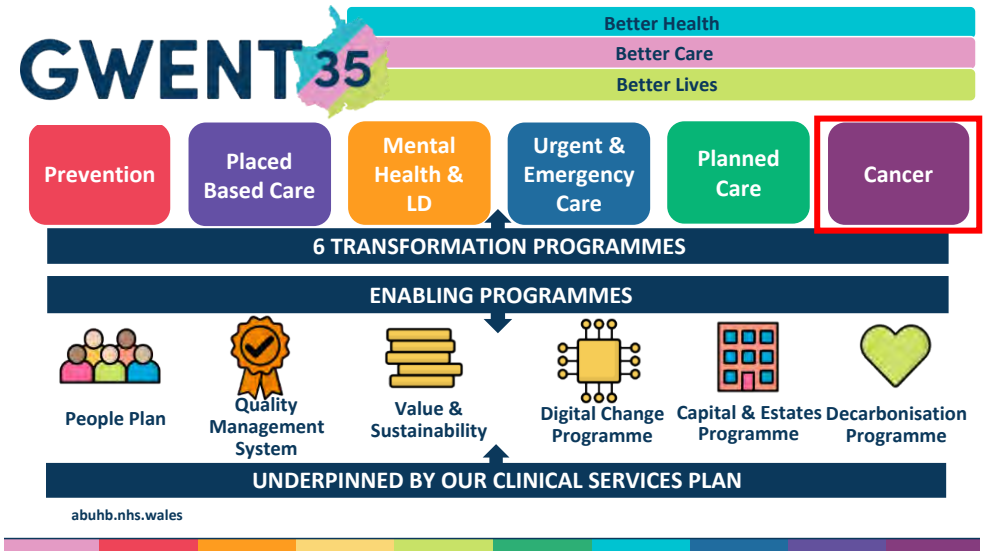


Cancer Programme Deep Dive September 2026



1. INTRODUCTION

The Cancer Programme is one of the key Transformation Programmes within the Health Board's strategic change portfolio as outlined below. The programme is chaired by the Chief Operating Officer, Leanne Watkins.



The Cancer Services Programme brings together national planned care policy, standards and guidance alongside local priorities and commitments as per the 2026/27 Annual plan. National expectations for cancer are set out via the following methods:

- Ministerial Performance standards (62 day pathway)
- The Quality Statement for Cancer

This report outlines the scope of the Cancer Programme and provides an update on delivery to date against the Aneurin Bevan University Health Board Cancer Strategy, key objectives for the next period and key risks within the Programme.

The programme consists of six workstreams as outlined below and each include several projects within:

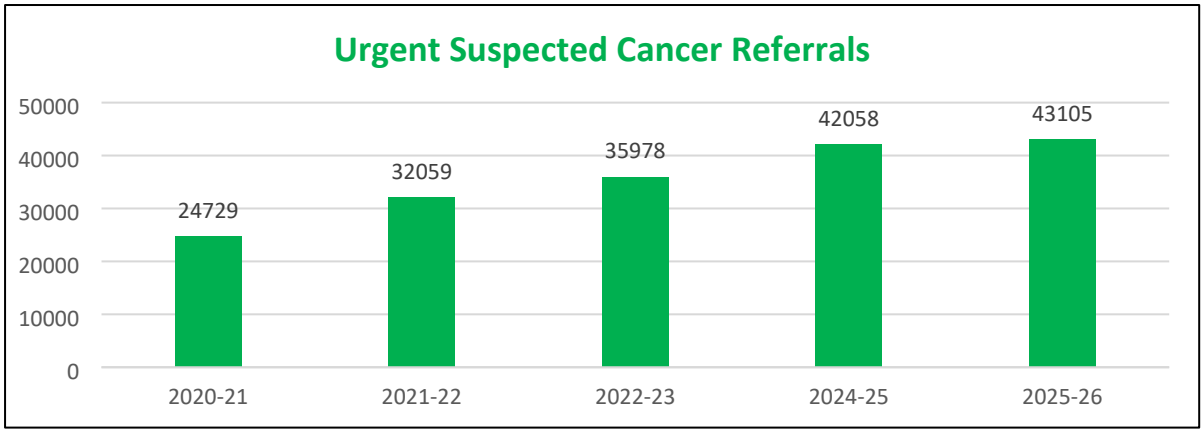
1. Prevention
2. Early Detection
3. Timely Diagnosis
4. Improved & Standardised Care
5. Living Well With and After Cancer
6. Improving our Cancer Knowledge (Research & Education)

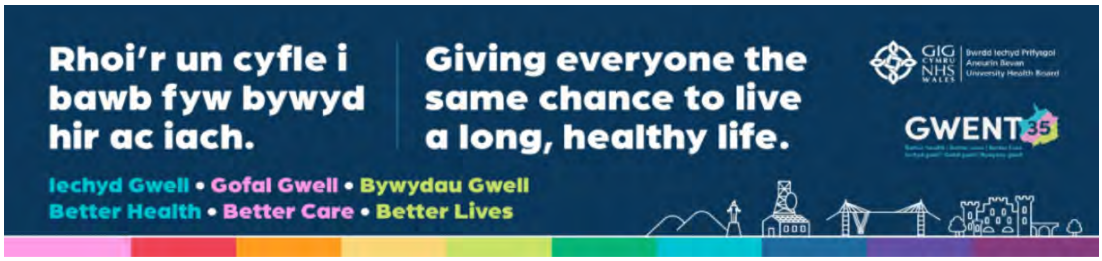
2. CONTEXT

Cancer is the most common cause of death and premature death, accounting for around one quarter of all deaths in Wales. Partly due to increased life expectancy and the resulting ageing of the population, around 1-in-2 people will be diagnosed with a cancer during their lifetime. Therefore, it is vital that cancer is effectively prevented where possible, that cases of cancer are detected at earlier stages, and that complex treatment pathways are optimised to provide rapid access to treatment; while throughout people are properly supported and co-produce their care. Ultimately, the aim is to reduce the incidence of cancer and to improve cancer survival and mortality rates.

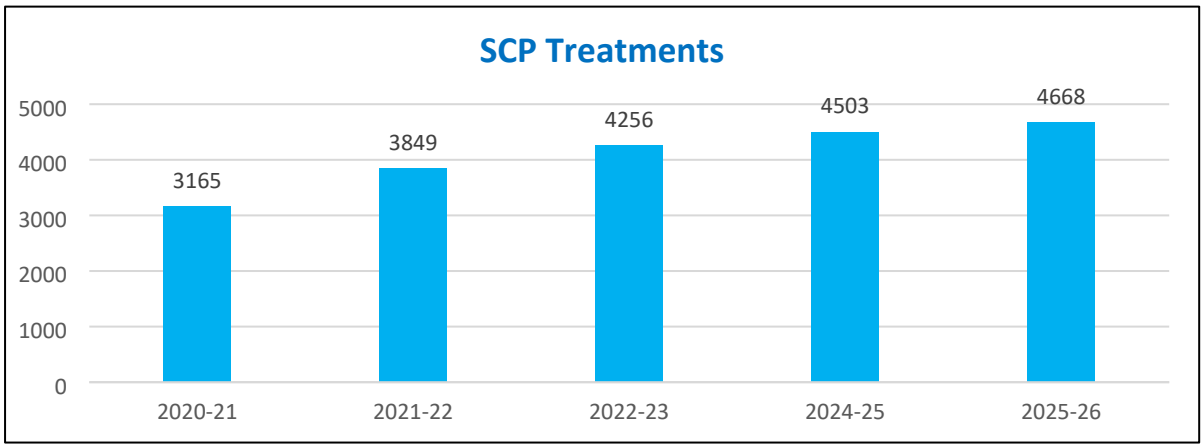
Each year the Health Board receivers around 40000 referrals leading to around 4600 diagnosis each year, which follows the Single Cancer Pathway, an NHS Wales standard designed to streamline and measure cancer waiting times.

There has been a significant increase in the number of patients referred with a suspicion of cancer across most of our tumour sites with 29,896 referrals in 2019/2020, increasing by 35% to in 40,347 in 2025/26.





We have diagnosed and treated more patients with cancer than in previous years. In 2019/20 3704 first treatments, increasing by 25% to 4635 first treatments in 2025/2026.



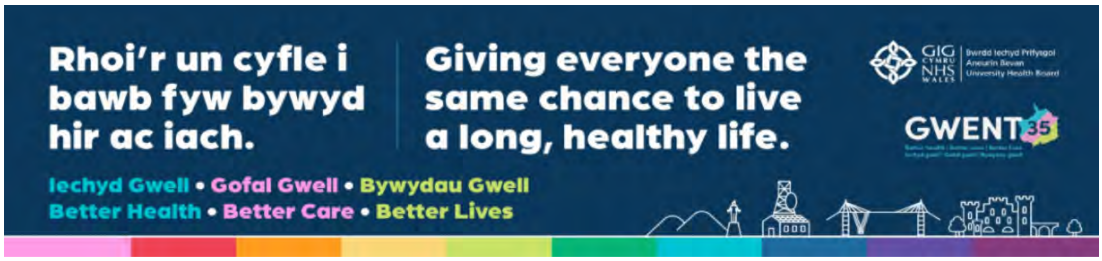
Cancer is one of the Health Board's highest strategic priorities due to:

- Continued growth in referral demand.
- Increasing cancer diagnoses.
- Persistent inequalities in outcomes.
- National performance expectations for SCP compliance.
- The need to improve survival, patient experience and quality of care.

Cancer Performance Overview

The performance measures detailed below are derived from the NHS Planning Framework, which includes both Ministerial Delivery Expectations and Enabling Actions, and the NHS Performance Framework

Metric	Q1 Position
62-day SCP Compliance	Current performance of 63.7% against national target of 75% (August 2026)



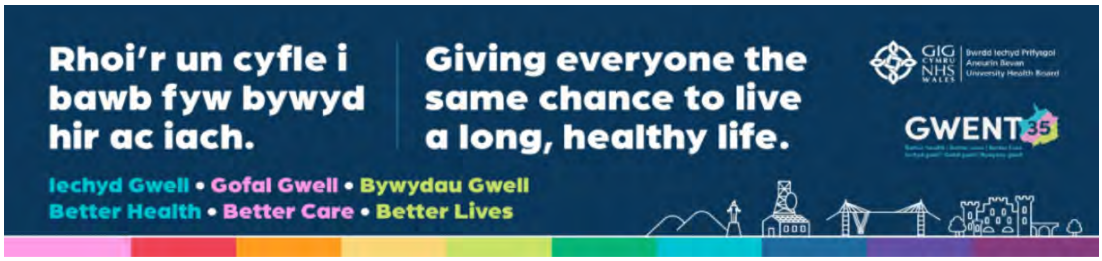
Metric	Q1 Position
28-day Diagnostic Performance	Current performance of 76% against the Health Boards benchmark of 75%
>62 Day Backlog	Currently 308 patients and decreasing following an increase through 2025
>104 Day Backlog	Currently 89 patients and decreasing following an increase through 2025

Key points to note:

- Significant progress has been made in strengthening cancer governance, programme management and organisational ownership of cancer performance.
- Performance against the Single Cancer Pathway (SCP) remains below the national target, although improvements have been achieved in several tumour pathways and diagnostic stages.
- Demand for suspected cancer referrals remains substantially higher than pre-pandemic levels, creating ongoing pressure across diagnostics, pathology and treatment services.
- Delivery has continued across the six pillars of the Cancer Strategy, with particular progress in prevention, early diagnosis, pathway redesign, digital innovation and reducing inequalities.

Key Programme Achievements in 25/26

The Cancer Services programme for 2025-2026 continues to work towards the 2020-2025 strategy aims across the pillars, whilst developing the Gwent Cancer Plan 2035.

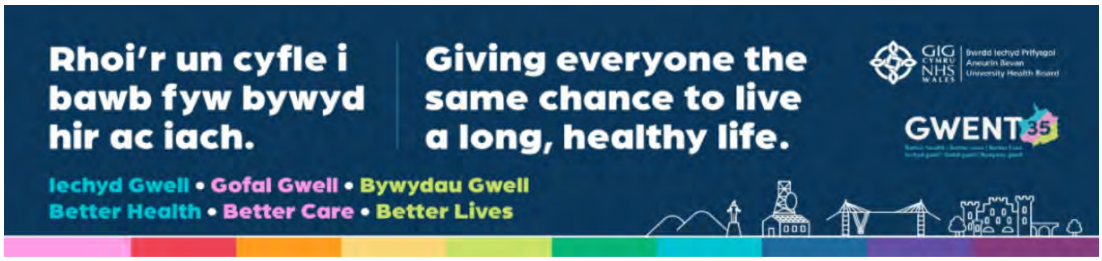


- Implementation of task and finish groups that support the development of prevention and early detection actions for our prevention and screening programmes Human Papillomavirus (HPV) Vaccine Uptake, Cervical screening, Bowel Screening and Skin Cancer Prevention.
- Developing an HPV E-Consent form for roll out in school year 2026/2027
- Cancer Services representation on the Aneurin Bevan University Health Board Nicotine Alliance and Smoke Free Site groups
- As of May 2026, over 400 local hair and beauty professionals, tutors and students have been training on spotting the early signs of skin cancer and sun safety
- Development of an IT system that allowed visualisation and reporting of data
- A major milestone was the development and opening in June 2025 of the Velindre @ Nevill Hall Satellite Radiotherapy Unit
- In February 2026 PREMs for cancer patients were implemented and now has 6 months of data to support development.
- ABUHB Cancer Conference and MSCC Education Day
- Workshops to engage staff in the developing of the Gwent Cancer Plan 2035

3. WORKSTREAM UPDATES

This following section is set out by workstream and provides an update of key areas of progress including progress against key metrics. It also sets out priorities for 26/27.

The following table reflects the current assessment of progress on the programme workstreams.



Pillar	RAG	High level reflection
1. Prevention		• Increased awareness and screening participation across Gwent • Further focus required on behaviour change and reducing health inequalities
2. Early Detection		• FIT testing and pathway improvements have supported earlier diagnosis • Continued focus needed on primary care engagement, earlier presentation and reducing inequalities
3.Timely Diagnosis		• Diagnostic services demonstrated resilience despite unprecedented demand pressures • Service redesign remains essential to improve performance and sustainability
4. Improved and standardised care		• Treatment quality and pathway performance improved, supported by stronger MDT working • Variation between tumour sites remains and requires continued standardisation and pathway optimisation
5. Living well with and after Cancer		• Personalised care and survivorship support have expanded significantly • Greater consistency is required in access to psychological support and holistic care services
6. Improving Cancer Knowledge – Research & Education		• Education, engagement and research opportunities have increased across the Health Board • Further work is required to increase research participation and strengthen primary care engagement

Additional areas of focus		
Intelligence, Innovation & Improvement		• Improved data, intelligence and performance reporting have strengthened oversight and transparency • Focus should now shift towards using insights to drive service transformation and innovation
Workforce, Leadership & Culture		• Workforce growth and leadership development have supported service delivery during a period of rising demand • Long-term workforce planning and service redesign are required to address ongoing capacity challenges

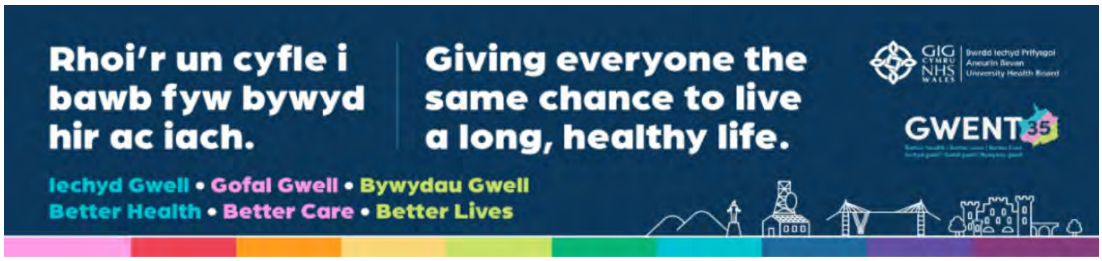
1. Prevention

Objectives

- Reduce prevalence of tobacco smoking in adults to 15%
- Develop smoking cessation services within the Health Board
- Offer HPV vaccination of all teenage boys and girls and targeted interventions
- Develop initiatives to reduce cancer risk in our hard-to-reach populations.

Key Achievements

Strong partnerships have been established with Public Health, Communications and Engagement, and wider system partners to support a coordinated approach to cancer prevention, early detection and tackling inequalities. This has led to the creation of the Reducing Cancer Inequalities Board, Prevention Working Group and a series of focused task and finish groups covering HPV vaccination, cervical screening, bowel



screening and skin cancer prevention. Together, these groups have strengthened collaboration, supported targeted interventions and improved organisational focus on preventing cancer and diagnosing it earlier.

Working closely with Communications and Engagement colleagues, the programme has delivered a range of public awareness campaigns to promote trusted cancer prevention and screening messages. The Cervical Screening campaign alone generated over 900,000 impressions across digital platforms, extending the reach of prevention and early detection messaging across Gwent. In parallel, the development of a Population Needs Assessment and associated digital intelligence tool has enhanced understanding of cancer risk factors, mortality, screening uptake and inequalities, enabling more targeted interventions for communities at greatest risk

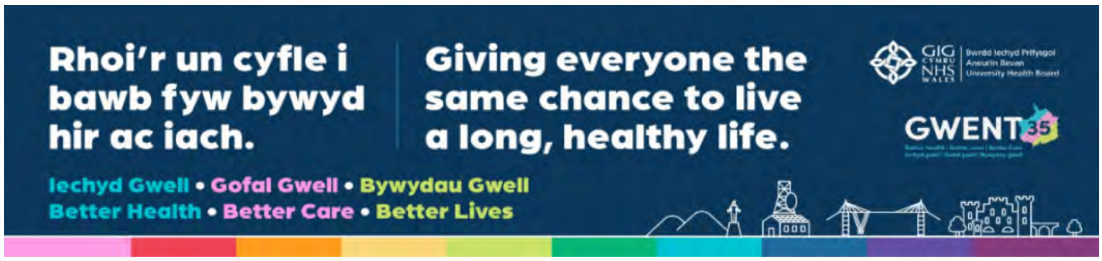
HPV working group

Improving HPV vaccination uptake has been a key focus area, recognising the ongoing impact of post-pandemic reductions in vaccine uptake (as outlined below) and persistent socio-economic inequalities. In 2025, a multi-agency HPV Working Group was established, bringing together Cancer Services, School Nursing, Public Health and Communications colleagues to develop and deliver targeted improvement actions.

Uptake of HPV vaccine in children reaching 15 years of age between 01/09/25 and 31/08/26 (School Year 10) and resident on 31/12/25

Public Health Wales Cover Report 157	% of resident children	% of resident girls	% of resident boys
Blaenau Gwent LA	69.5%	73.3%	66.4%
Caerphilly LA	73.0%	77.3%	68.6%
Monmouthshire LA	74.0%	74.6%	73.4%
Newport LA	65.4%	66.6.%	64.2%
Torfaen LA	73.7%	78.1%	69.5%
Health board total	**70.6%**	**73.3%**	**67.9%**

Early interventions have demonstrated positive results. A telephone consent pilot delivered through the Integrated School Nursing Team increased vaccination uptake by 6%, while development of an electronic consent process is underway to support wider implementation from 2027.



Additional measures have included embedding HPV awareness within sexual health education, enhancing staff confidence in vaccination consent processes, and introducing targeted support pathways for young people facing barriers to immunisation. This work has received national recognition and is informing wider adoption across Wales.

The programme will continue to build on these foundations through the Gwent Cancer Plan 2035, maintaining a strong focus on prevention, screening uptake, reducing inequalities and engaging communities through partnerships such as the Nicotine Alliance, Healthy Weight Assembly and local outreach events

Reducing Smoking Prevalence

Help Me Quit (HMQ) is the national NHS stop smoking service for Wales, launched in 2017 as part of a wider Welsh Government strategy to reduce smoking-related illness and health inequalities. It brought together existing local NHS stop smoking services under one national brand, making support easier to access across Wales.

Between 2019 and 2024 the prevalence of tobacco smoking in adults has fallen from 16.1% to 11.7% (ONS-Smoking Habits Dataset). Some local authorities within Gwent have seen an even greater reduction. Blaenau Gwent has seen its smoking prevalence fall from 19.6% to 11.4%. Cancer Services are represented in the Aneurin Bevan University Health Board Nicotine Alliance and Smoke Free Site groups. We will ensure we are recognising changes in trends in Caerphilly and Torfaen that see small increases and work with colleagues in the group to target and education appropriately.

% of Population currently smoking by Local Authority						
Year	2019	2020	2021	2022	2023	2024
Caerphilly	17.1	16.0	14.7	12.6	12.8	13.8
Blaenau Gwent	19.6	16.9	18.3	15.5	14.9	11.4
Torfaen	18.8	14.2	15.5	17.5	15.4	14.5
Monmouth shire	9.7	7.6	9.2	7.6	6.7	6.9
Newport	15.9	18.1	14.5	13.8	12.9	10.6

The impact of reduced smoking prevalence on cancer incidence will become increasingly evident over time. Early indications are encouraging, with lung cancer incidence beginning to show a modest reduction.
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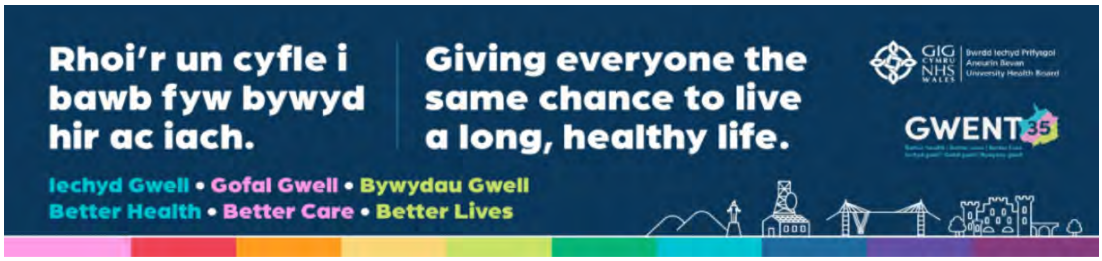
Key Priorities for 2026/27:

- Supporting the Nicotine Alliance and subsequent groups to understand Smoking prevalence and variable reduction in rates in certain boroughs
- Understanding the impact of vaping and other nicotine products
- Understand of the deprivation-related inequalities in prevention and across the pathway and developing methods of working with our communities to reduce this.
- Reduce the variable HPV Vaccine uptake across Gwent, and decrease the deprivation gap in vaccine uptake.

2. Early Detection

Objectives

- Optimise uptake of breast and cervical cancer screening to 85%



- Increase uptake of colorectal cancer screening within the specified age range.
- Prepare to implement new cancer screening programmes which may include targeted lung cancer screen programme.
- Abolish inequities linked to deprivation across our communities

Key Achievements

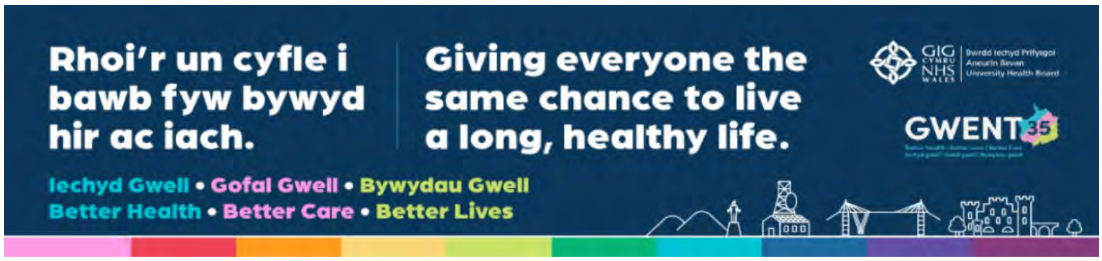
Skin Cancer

The Skin Cancer Prevention Working Group has developed an innovative partnership with the Hair and Beauty sector to support earlier identification of skin cancer and promote sun safety awareness. As of May 2026, over 400 hair and beauty professionals, tutors and students have received training, significantly extending the reach of prevention and early detection messaging into local communities. This work has been recognised through both the Aneurin Bevan University Health Board Population Health and Wellbeing Award (2025) and the Moondance Award for Excellence in Cancer Leadership and Delivery (2026).

Building on this success, the programme is extending its approach to other higher-risk groups, including agricultural and outdoor workers, to further increase awareness of skin cancer prevention, encourage earlier presentation and help reduce health inequalities across Gwent.

Screening

The Bowel and Cervical Screening Groups have supported a coordinated programme of public awareness and engagement activities to increase understanding of cancer prevention, screening participation, and the early signs and symptoms of cancer. Working in partnership with the Reducing Cancer Inequalities Board, efforts have increasingly focused on understanding variation in outcomes and screening uptake across communities, enabling the development of more targeted interventions to address inequalities and improve early detection



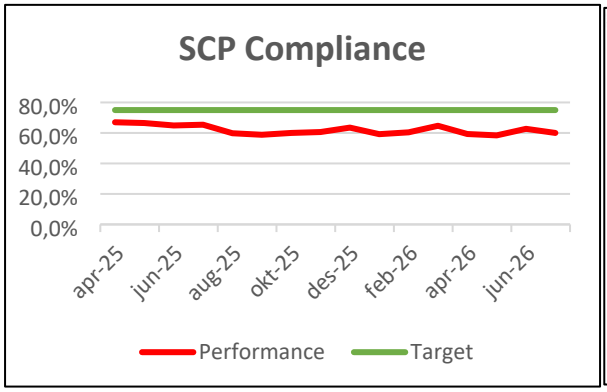
Key Priorities for 2026/27:

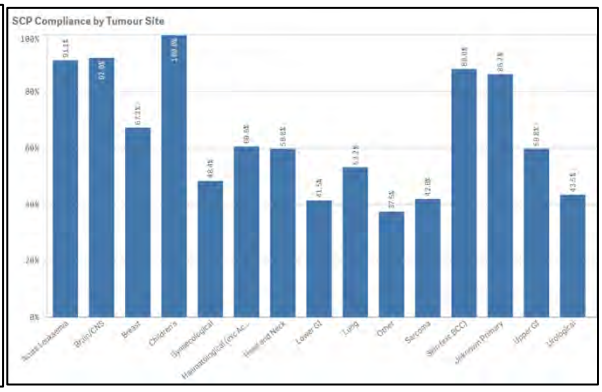
- Variable screening uptake across Gwent, impacting on inequalities
- Increasing referrals into our pathways
- Increasing numbers of FIT positives who attend a follow up colonoscopy
- Continuing work to promote a sun safe population, and developing measures of understanding the impact of cancer related health promotion work.
- Improve access to timely data, and outcome measures of screening rates within the geographical area to supported targeted intervention

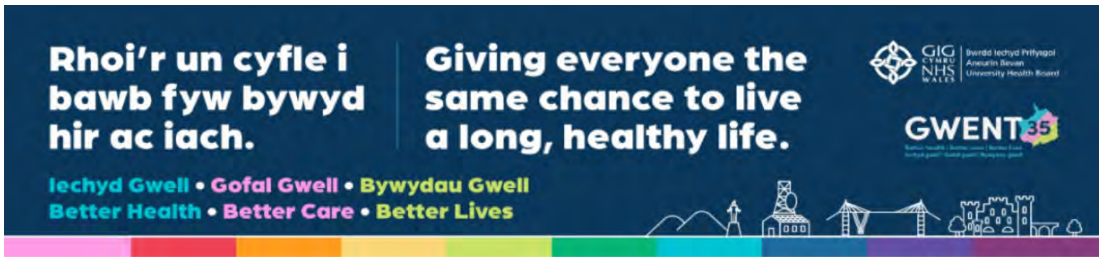
3. Timely Diagnosis / Performance

Single Cancer Pathway

Single Cancer Pathway (SCP) performance has remained below the Welsh Government target of 75% throughout the reporting period (April 2025 to August 2026), with compliance ranging between 58% and 66%. Performance was strongest at the start of the period, achieving 66% in April 2025, before declining during the summer and autumn months and reaching a low of 58% in September and October 2025. During this period, the Health Board was also required to deliver significant planned care recovery activity in response to Welsh Government funding aimed at reducing the longest waiting patients. While this work was essential, the additional demand on diagnostic and treatment capacity is likely to have contributed to pressures across cancer pathways







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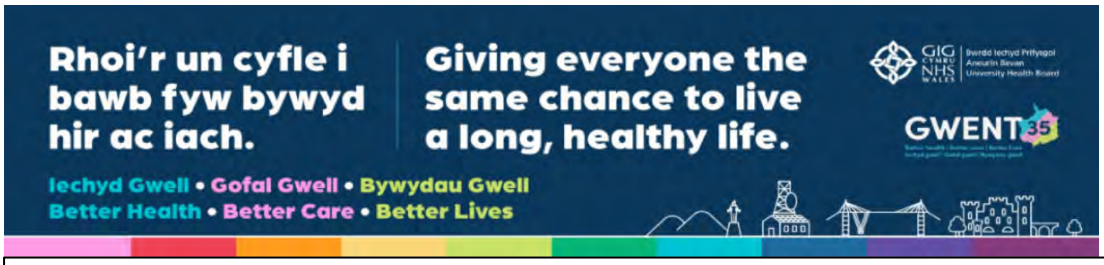
Performance during 2025/26 remained challenging but demonstrated resilience, recovering to 65% in March 2026 before stabilising between 58% and 62% during the first quarter of 2026/27. Compliance was recorded at 58% in April 2026, 60% in May 2026, 62% in June 2026, 60% for July 2026 and 63% in August 2026.

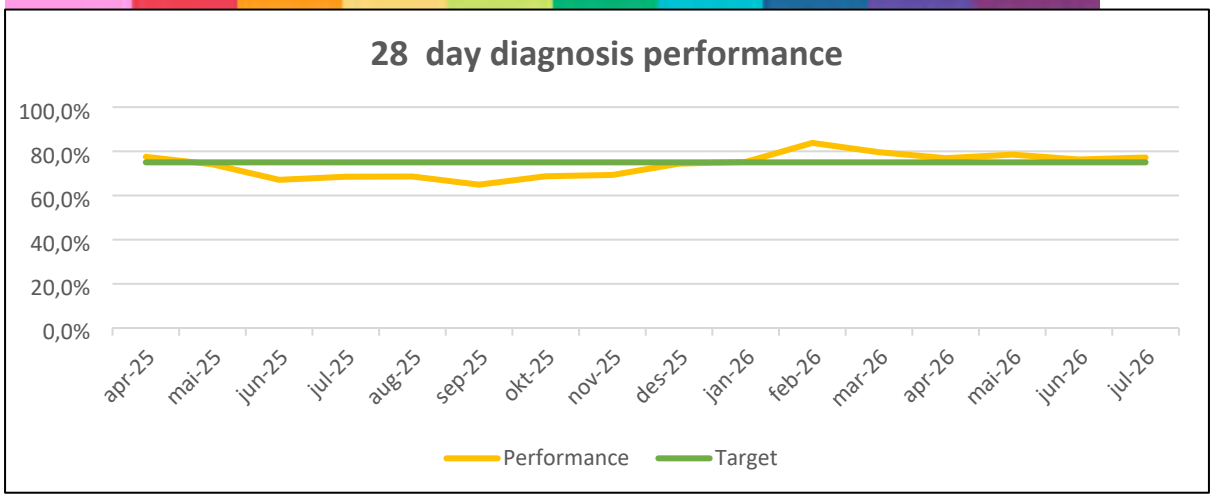
Despite continued challenges in achieving the 75% target, the Health Board has consistently performed above the All-Wales average throughout the reporting period. Performance also varies across tumour sites, reflecting differences in diagnostic complexity, treatment pathways, capacity constraints and reliance on regional and specialist services. Continued pathway redesign, diagnostic improvement and targeted recovery actions remain key priorities in improving compliance with the Single Cancer Pathway

28 Day Diagnosis

The 28-Day Diagnosis Measure is designed to reduce the time patients spend waiting for a definitive diagnosis and minimise the uncertainty associated with a suspected cancer referral. Timely diagnosis is a key determinant of patient experience and supports earlier access to treatment for those diagnosed with cancer. Whilst Wales does not currently performance manage this measure, the Health Board benchmarks performance against the NHS England standard of diagnosing 75% of patients within 28 days of referral.

Performance across 2025/26 and 2026/27 year-to-date averaged 73.5% (median 74.8%) , demonstrating that the majority of patients receive a diagnosis within the expected timeframe. However, performance varies across tumour sites, reflecting differences in pathway complexity, diagnostic requirements and service demand, as outlined below.

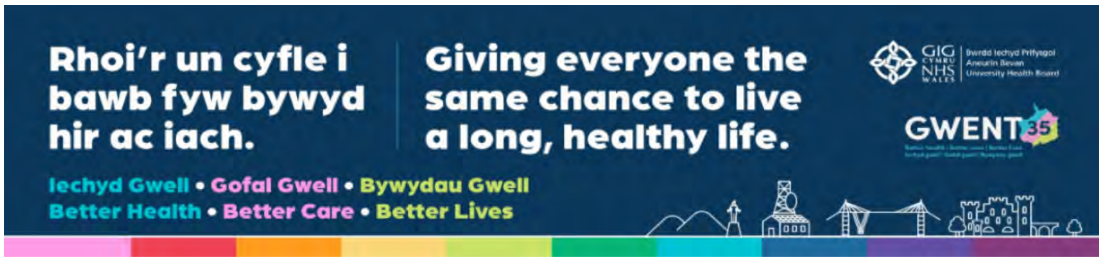




Tumour Site Performance

Performance across tumour sites varies, reflecting differences in pathway complexity, diagnostic requirements, treatment models and capacity constraints. Whilst several pathways demonstrate strong performance against the 28-day diagnostic and 31-day treatment standards, achieving compliance with the overall 62-day Single Cancer Pathway (SCP) target remains challenging. Common contributory factors include diagnostic complexity, specialist testing requirements, surgical capacity constraints and dependencies on regional treatment services. The table below provides a summary of performance across the major tumour sites together with the key factors influencing pathway delivery

Tumour Site	SCP Compliance %	14-Day First Contact %	28-Day Diagnosis %	31-Day Treatment %	Supporting Narrative
Breast	67.3	32.6	94.5	80.6	• One-stop model combines specialist review and diagnostics, reducing patient visits. • Previous delays in external HER2 testing impacted SCP performance. • Introduction of in-house HER2 testing has reduced turnaround times to <7 days and is expected to improve future performance.
Colorectal	41.0	79.0	73.7	86.5	Improvement in SCP performance since June 2026, averaging 46%. • Improved attendance for colonoscopy following service improvement initiatives. • Ongoing challenges in securing timely surgical capacity. • Increased use of robotic surgery provides clinical benefits but can reduce overall theatre throughput.
Gynae-Oncology	48.4	75.0	71.6	83.0	• SCP performance has improved since April 2026, averaging 56%. • Further work required to improve diagnostic and pathway performance to meet trajectory
Haematology	60.6	78.1	87.2	97.4	• Patients frequently enter the pathway through other tumour sites due to non-specific symptoms. • Diagnostic delays are often associated with cross-specialty investigations and referrals. • Once under haematology care, diagnosis and treatment progress rapidly.
Head & Neck	59.8	81.6	81.1	90.1	• Performance recovery achieved during May-July 2026, meeting trajectory. • Ongoing actions in place to maintain improved compliance and pathway performance.
Lung	53.4	93.3	91.3	93.2	• SCP performance impacted by specialist molecular and IHC testing undertaken externally. • Regional treatment model requires access to services at Cardiff & Vale UHB and Velindre Cancer Centre. • Treatment capacity and specialist testing timelines can extend overall pathway duration despite rapid diagnosis



Key Priorities for 2026/27:

- Continue to reduce patient-initiated delays within cancer pathways through a targeted programme of improvement focused on reducing non-attendance and appointment cancellations. This includes behavioural insight approaches, enhanced patient communications, psychology-led interventions, and improvements to patient contact processes to support timely access to appointments.
- Develop the case for a centralised Cancer Command Centre to provide enhanced oversight and proactive management of time-critical cancer pathways. This would support real-time performance monitoring, earlier identification of delays and bottlenecks, and coordinated action to improve pathway timeliness and Single Cancer Pathway performance

4. Improved and Standardised Care

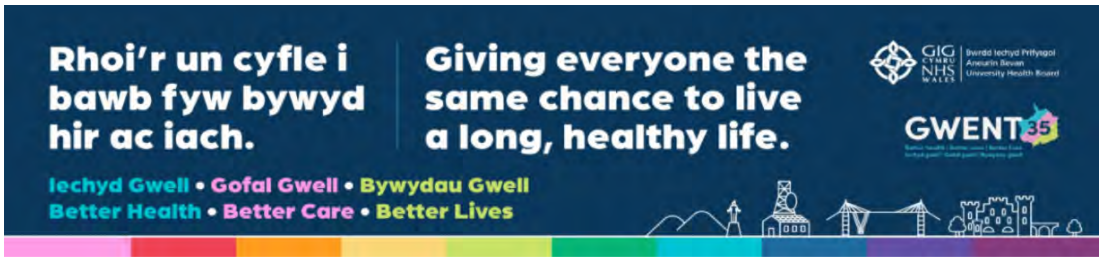
Objectives

- Enhance Access to Specialist Cancer Care Closer to Home
- Strengthen Regional Collaboration and Service Integration
- Expand Capacity and Improve System Resilience
- Improve Clinical Outcomes Through Innovation and Advanced Technology

Key Achievements

Specialist Cancer Care Closer to Home

A major milestone was the opening of the Velindre @ Nevill Hall Satellite Radiotherapy Unit in 2025, delivered in partnership with Velindre University NHS Trust. The facility provides advanced radiotherapy services closer to home, reducing travel burden for patients while increasing regional radiotherapy capacity by approximately 20%. This represents a significant step forward in improving access to specialist cancer treatment and strengthening system resilience across South East Wales.



In parallel, outpatient Systemic Anti-Cancer Therapy (SACT) capacity at Nevill Hall Hospital has continued to expand through the outreach model developed in partnership with Velindre Cancer Centre. This approach supports delivery of care closer to home and will play an increasingly important role in preparation for the opening of the new Velindre Cancer Centre, with around 40% of SACT activity expected to be delivered through outreach services. Continued collaboration with Velindre Cancer Centre will be critical to supporting sustainable regional cancer services and improving patient access to treatment

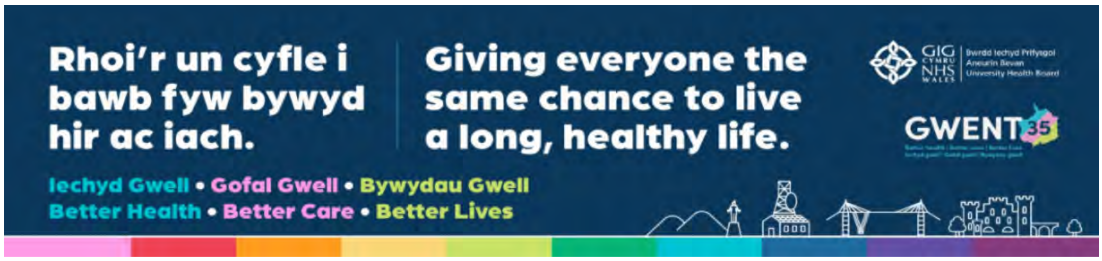
To support Prehabilitation , a digital Health Optimisation tool was implemented. The questionnaire is sent at point of suspicion and offers universal assessment and signposting to healthy lifestyle behaviors, with over 40,000 forms issued and a 56% completion rate. Since April 2025, this has been offered to all GP clusters. (Appendix 3)

The Health Board's Acute Oncology Service (AOS) has played a key role in the development and implementation of a regional South East Wales business case designed to strengthen acute oncology capacity and support greater regional collaboration. This investment enabled the expansion of the local workforce and the establishment of a sustainable nurse-led, multi-site AOS model, significantly enhancing the service's ability to provide timely specialist reviews, with an increasing proportion of patients assessed within 24 hours.

In parallel, collaboration with Velindre Cancer Centre has continued to strengthen specialist oncology support available to patients across Aneurin Bevan University Health Board. This now includes daily input through a virtual multidisciplinary team (MDT) model and dedicated on-site specialist sessions. These arrangements will be further enhanced in 2026, with dedicated Health Board sessions increasing from one to two per week, improving access to specialist expertise, supporting workforce resilience, and strengthening integrated cancer care across the region

The AOS team have strengthened integration with Hospital acute teams, inpatient wards and cancer pathways, ensuring rapid specialist oncology input:

- Faster access to specialist oncology expertise (often within 24 hours)
- Reduced waiting times in urgent care (up to 8 hours saved via SDEC)
- Improved experience with timelier, coordinated care
- Reduced unnecessary admissions and shorter length of stay



- Improved patient flow from ED and acute medicine
- Stronger multidisciplinary collaboration across acute and cancer teams
- Increased capability of generalist staff through education and support
- More resilient, standardised acute cancer service model

Innovation and Advanced Technology

A state-of-the-art surgical robot has been introduced at Royal Gwent Hospital. Used initially in urology the robotic arms are equipped with specialised instruments and a high-definition camera, which provides magnified 3D views of the surgical area to enhance the accuracy of delicate surgical procedures. As a result, the minimal trauma to surrounding tissues allows faster recovery times, and improved outcomes for patients.

The colorectal robotic surgery outcome study has shown the initial early improvements, as outlined below.

What went well?

Analysis is based on **47** cases. An additional **33** cases were undertaken as part of training.

Benefit	Baseline (as outlined in Business Case)	Target Future State (as outlined in Business Case)	Actual
It will provide a reduction in length of stay for colorectal cancer patients	6.8 days LOS (Rectal Resection)	0.8-1 day LOS reduction	TBC
	5 day LOS (Colon Resection)		
It will reduce the rate of surgical complications	13.1% complication rate (Rectal Resection)	8% complication rate (Rectal Resection)	6% ↓
	16.1% complication rate (Colon Resection)	3% complication rate (Colon Resection)	15% ↓
It will reduce the number of conversions to open surgery	15% conversion rate (Rectal Resection)	1.3% conversion rate (Rectal Resection)	0% ↓
It will reduce the rate of readmissions or reoperations for colorectal cancer patients	11.6% Readmission rate (Rectal Resection)	8% Readmission rate (Rectal Resection)	6% ↓
	4.9% Readmission rate (Colon Resection)	1% Readmission rate (Colon Resection)	6% ↑

Based on the outcomes, 2 complications, 5 conversions to open surgery and 2 readmissions/ reoperations have been avoided. This has resulted in a total efficiency saving of **£42,531.** A breakdown is provided below:

- 5 conversions = £11,105
- 2 complications = £26,626
- 2 readmissions/ reoperations = £4,800

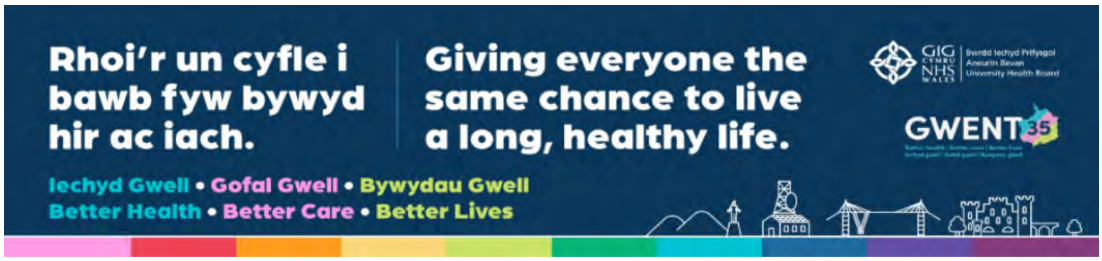
Notes:

- This review is based on a small sample size (47 cases) and may therefore not fully reflect overall outcomes. The benefits of the change are not expected to be realised immediately, and further data will be required to understand the full impact over time.

Next Steps:

- Findings will be developed into a **full written paper** and shared with **all group members** once complete alongside full financial reconciliation with business case

Use of the robot has expanded, and the Royal Gwent Hospital became the first in the country to carry out colorectal surgery using the advanced Da Vinci surgical robot.



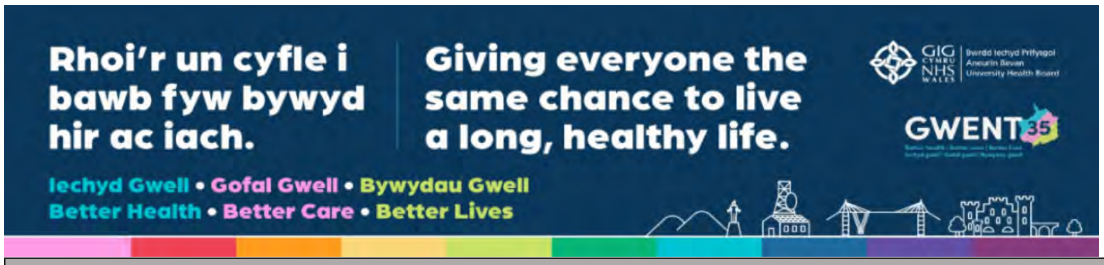
The introduction of cryoablation for kidney cancers offered significant patient-centred benefits, particularly as a minimally invasive alternative to traditional surgery. By utilizing extreme cold to target and destroy tumour cells, this procedure preserves surrounding healthy kidney tissue, thereby maintaining renal function and reducing the risk of long-term complications such as dialysis. Cryoablation are all day cases and allow us to treat larger and more central lesions and outcomes reduce morbidity and mortality. We now join the regional small masses MDT and bring in more regional referrals so there is more equitable care offered across South Wales for the treatment

Service Transformation & Integration

The opening of the Breast Unit at Ysbyty Ystrad Fawr in February 2024 represented a significant advancement in breast cancer services across Gwent. The introduction of a one-stop assessment model enables patients to receive a comprehensive diagnostic assessment during a single visit, including clinical examination, imaging and biopsy where required. This streamlined approach supports faster diagnosis, reduces delays in treatment pathways and improves the overall patient experience. In 2024/25, the service supported over 4,500 breast cancer referrals across the Health Board

Key Priorities for 2026/27:

- Developing regional collaboration, with our partners and stake holders.
- Supporting stringer relationships with VCC as they prepare for the opening of nVCC in 2027.
- Working towards consistent pathway management
- Developing the AOS MUO Pathway in the LHB.



5. Living Well With and After Cancer

Objectives

- Improve access to written advice and support for cancer patients
- Provide all patients diagnosed with cancer with a written care plan
- Improve access to psychological support services
- Routinely collect Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) to optimise patient experience and value-based cancer care.

Key Achievements

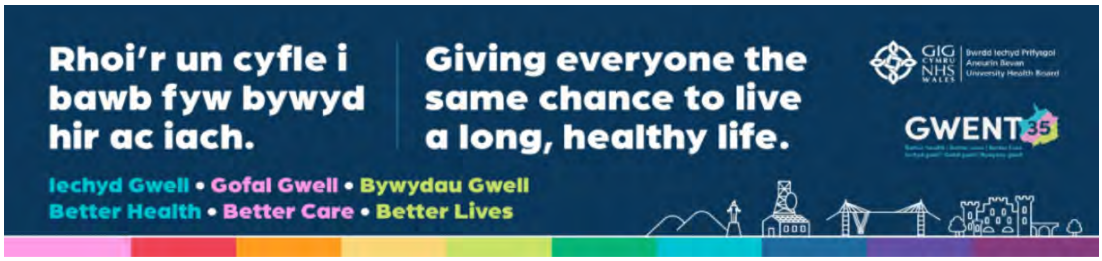
Workforce Development

Investment in the cancer workforce has strengthened the Health Board's ability to deliver personalised care and improve patient experience. This has included the expansion of Cancer Nurse Specialist and Cancer Support Worker roles, alongside the recruitment of a range of nursing and support staff to support delivery of the Cancer Strategy. While some additional support roles were delivered on a time-limited basis, these developments have enhanced service capacity and patient support across the cancer pathway.

Personalised Care and Support

A comprehensive review of supportive care interventions led to the introduction of a stratified model of care, ensuring patients can access support appropriate to their individual needs through universal, targeted and specialist interventions. Central to this approach has been the replacement of the low-uptake digital Holistic Needs Assessment with personalised "What Matters to You" conversations and personalised care plans, supporting a more patient-centred approach to care.

Significant progress has also been made in improving access to supportive services and information. Psychology services have expanded substantially, with referrals increasing from 260 in 2022 to 408 in 2025. Education programmes have supported both patients and staff in areas such as fatigue management and managing uncertainty, while the launch of the Cancer Services website has improved access to trusted information and resources. In addition, Cancer Cafés have been



established across all five boroughs, providing valuable peer support opportunities, and a Patient Engagement Panel has been embedded to ensure patient voices inform service development. Implementation of Patient Reported Outcome Measures (PROMs) remains dependent on the development of a national programme.

Patient Experience

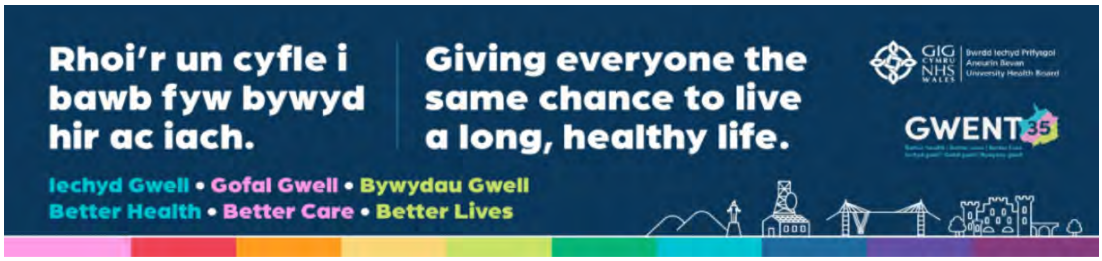
The introduction of the Civica platform has enabled routine collection of Patient Reported Experience Measures (PREMs), providing valuable insight into patient experience and supporting continuous quality improvement. Since implementation in February 2026, 980 surveys have been issued, generating 291 responses (30% response rate).

Patient feedback has been overwhelmingly positive, with:

- 94% of respondents rating their cancer care as good or very good.
- 85% reporting they were informed about their diagnosis in a sensitive manner.
- 93% stating they felt well supported by their healthcare team following diagnosis.

Key Priorities for 2026/27:

- Development of the patient panel to improve diversity and representation across the Health Boards demographic and continue utilising the patient voice in our developments across the programme workstreams.
- Continue to develop the cancer services website and improve its reach as a resource for our communities.



6. Improving our Cancer Knowledge

Objectives

- Increase patient participation and access to cancer research opportunities.
- Strengthen research capability by focusing on areas of clinical excellence and strategic importance
- Embed research, innovation and evidence-based practice within routine cancer care
- Develop and support the cancer workforce through education, training and professional development opportunities
- Foster collaboration and engagement across the Health Board and wider cancer system to inform future service development and strategic planning

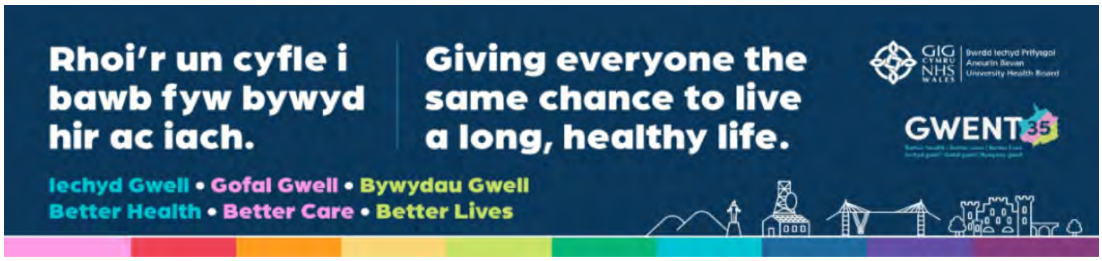
Key Achievements

Workforce Development and Professional Education

Investment from the Moondance Foundation and Keith James Grants has enabled staff to access national and international educational and development opportunities, including the World Cancer Congress, Cancer of Unknown Primary Conference, and the World Congress of Prehabilitation and Perioperative Medicine. These opportunities have directly supported service development, innovation and the adoption of best practice across a range of cancer programmes. The quality of work being delivered locally has also been recognised through national awards for Excellence in Nursing and Clinical Delivery.

Research and Innovation

Despite fluctuations in research recruitment over time, significant progress has been made in expanding access to research opportunities for patients. The research portfolio has broadened across multiple tumour groups, providing a more sustainable and diverse range of studies for patients to participate in.



A more focused approach to research delivery has also been established, aligning activity with areas of organisational strength, including haematology, biomarkers and early diagnosis. This has strengthened the Health Board's ability to attract and deliver research studies while supporting wider service development and innovation.

Encouragingly, awareness of research across clinical teams has continued to grow, with research increasingly being incorporated within care pathways. Whilst further work is required to ensure consistency across all services, research is becoming a more visible component of routine cancer care.

Education, Collaboration and Knowledge Sharing

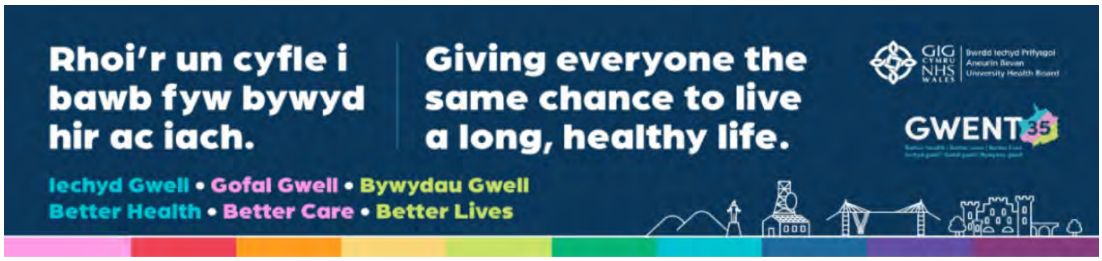
The Health Board has continued to invest in education and knowledge sharing across the cancer workforce. In October 2025, the Acute Oncology Service, in partnership with Velindre Cancer Centre and Macmillan Cancer Support, delivered a regional Metastatic Spinal Cord Compression (MSCC) Education Day, attracting over 70 attendees from across Wales and beyond. This event strengthened awareness, collaboration and professional development across cancer services.

Annual ABUHB Cancer Conferences have been held which have further supported learning, innovation and collaboration across the Health Board. The 2025 conference attracted over 100 attendees and provided an important opportunity to engage staff in the development of the Gwent Cancer Plan 2035.

Education, workforce development and research will remain central to the Gwent Cancer Plan 2035, with continued emphasis on building capability, supporting innovation and developing a skilled, sustainable workforce able to meet future cancer service needs

Key Priorities for 2026/27:

- Explore methods of increasing recruitment to research studies.
- Improving population access and participation
- Development of the future Cancer Strategy informed by staff and stakeholder engagement.



4. GWENT CANCER PLAN 2035

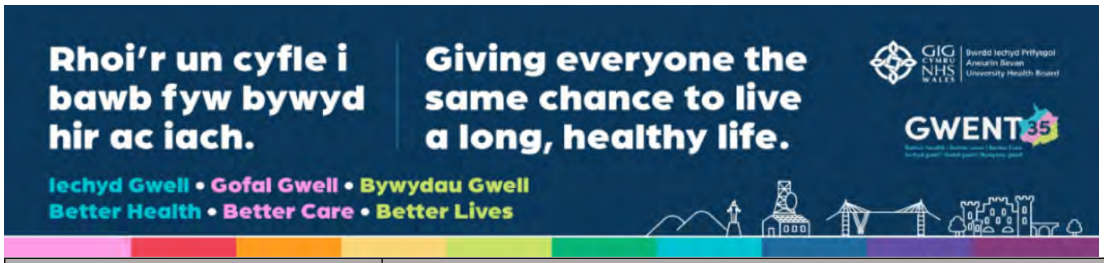
A key outcome of the 2025 Cancer Conference was the initiation of engagement activities to inform the development of the Gwent Cancer Plan 2035. Staff workshops confirmed the continued relevance of the six strategic pillars from the 2020-2025 Cancer Strategy, while identifying a series of cross-cutting "Golden Threads" to ensure areas such as inequalities, workforce, digital enablement and patient experience are embedded throughout future delivery plans

In April 2026, the Executive Board approved the development of the Gwent Cancer Plan 2035 as a supporting plan to the Gwent Strategy 2035. A comprehensive programme of engagement with staff, patients, the public and key stakeholders has since been undertaken, including a series of workshops held during June and July 2026. The first draft of the Plan is scheduled for consideration by the Cancer Board in January 2027, with finalisation anticipated in early 2027

Major Deliverables

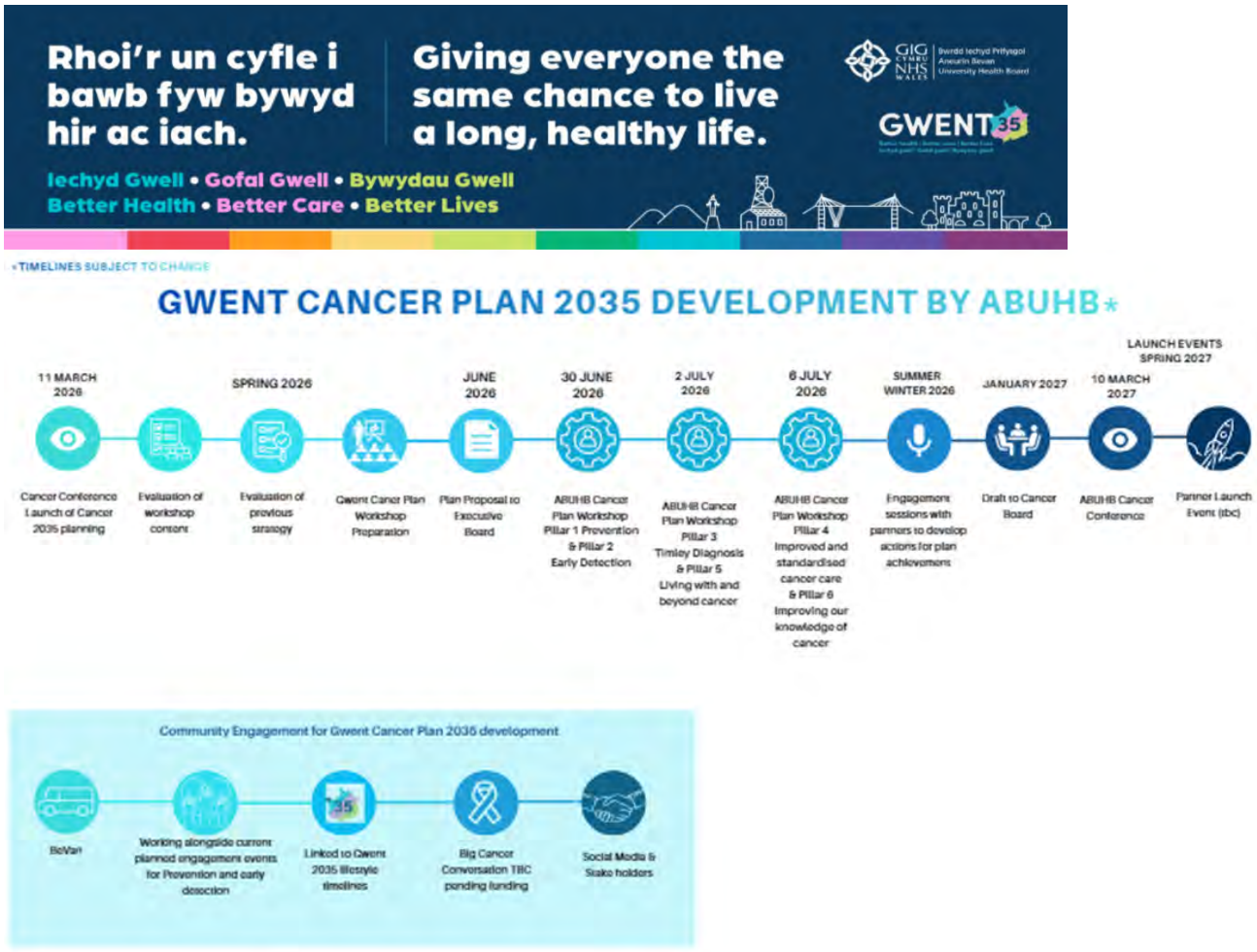
- 6 Workstreams with golden threads for inclusivity of key areas across the pillars
- Development of a fully costed three-year Cancer Improvement Plan.
- Alignment of all tumour pathways to National Optimal Pathways.
- Directorate-level transformation plans.
- Benefits realisation framework.
- Enhanced programme governance and accountability.
- Development of clear outcomes and targets to support reporting against all of the workstreams.

The key elements of the Gwent Cancer are set out below:



Key Element	Priorities
Governance	Delivery structure through: • Cancer Board • Executive Team • Directorate Performance Reviews • Tumour Site Improvement Groups
Workforce	Key priorities include: • Workforce planning aligned to future demand. • Consultant and specialist workforce sustainability. • Addressing diagnostic workforce gaps. • Succession planning
Digital	• Working with the Digital, Data and Technology team to develop our infrastructure • Improved pathway tracking. • Enhanced performance dashboards that support all pillars in the cancer pathway. • Data-driven pathway management
Capacity & Infrastructure	• Diagnostics • Endoscopy • Pathology • Treatment delivery areas

The planned timeline for development of the Cancer plans is as follows:



5. RISKS AND MITIGATIONS

There are risks associated within each workstream that are managed locally. These follow a number of themes:

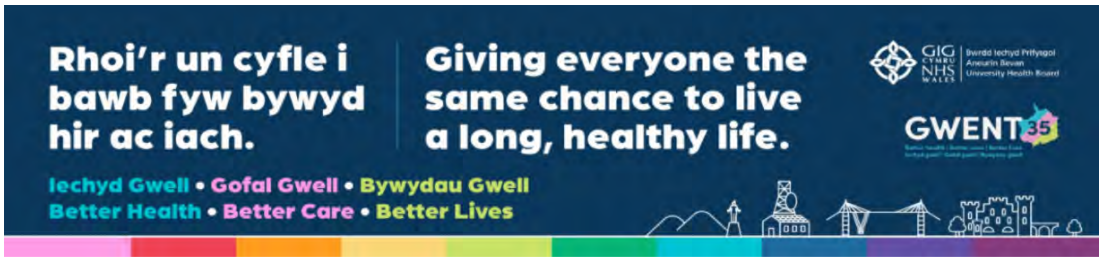
Risk	Mitigation
Risk in achieving SCP target	Delivery of tumour-specific recovery and improvement plans, strengthened performance oversight through the Cancer Board, and implementation of pathway redesign initiatives to improve throughput and reduce delays
Diagnostic capacity constraints	Targeted recovery and service redesign programmes across diagnostics, including radiology, pathology, endoscopy and tumour-specific pathways such as Metastatic Cancer of Unknown Origin (MUO). Continued investment in pathway optimisation and demand management
Workforce shortages	Workforce planning aligned to future demand, targeted recruitment, development of specialist roles, succession

	planning, and regional collaboration to improve workforce resilience and service sustainability
Financial sustainability	Development of a fully costed Cancer Improvement Plan as part of the Gwent Cancer Plan 2035, supported by benefits realisation, prioritisation processes and alignment with strategic investment opportunities
Health inequalities	Delivery of targeted prevention, screening and early diagnosis interventions informed by population health intelligence, with a focus on underserved populations and reducing inequities in access, experience and outcomes
Screening uptake Variability	Targeted public awareness campaigns, community engagement, and locality-based interventions designed to improve screening participation, particularly within populations experiencing lower uptake and poorer outcomes

6.CONCLUSION

The Cancer Programme remains a key component of the Health Board's transformation portfolio, supporting delivery of national cancer standards, the Quality Statement for Cancer and local priorities. Cancer demand continues to rise significantly, with suspected cancer referrals increasing by 35% since 2019/20 and first cancer treatments increasing by 25% over the same period. Despite these pressures, the programme has delivered substantial progress across prevention, early detection, diagnosis, treatment, personalised care and research, while also strengthening governance, performance management and organisational oversight of cancer services. Current performance demonstrates achievement against the 28-day diagnostic target, whilst continued improvement is required to meet the national 62-day Single Cancer Pathway standard.

Key achievements include the opening of the Velindre @ Nevill Hall Satellite Radiotherapy Unit, expansion of Acute Oncology Services, development of innovative diagnostic and digital solutions, implementation of cancer PREMs, strengthened prevention and screening initiatives, and increased access to clinical research opportunities. Whilst significant progress has been made across all six strategic workstreams, challenges remain in relation to diagnostic capacity, workforce



sustainability, inequalities, screening uptake and pathway performance. The programme is now focused on developing the Gwent Cancer Plan 2035, which will provide a long-term framework for transformation, including workforce planning, digital enablement, pathway redesign, infrastructure development and a fully costed cancer improvement plan to ensure sustainable, high-quality cancer services for the population of Gwent

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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Cancer Strategy Evaluation

2020-2025

Foreword

Welcome to the Cancer Strategy Evaluation for Cancer Services at Aneurin Bevan University Health Board. It summarises the work and progress achieved in the delivery of the cancer strategy 2020-2025 and our continued commitment to delivering quality cancer care for our population.

The Aneurin Bevan University Health Board (ABUHB) Cancer Strategy 2020–2025 set out a system-wide vision to improve cancer outcomes for our population through disease prevention, earlier diagnosis, timely access to treatment, high-quality care, and improved survivorship. A Cancer Board was developed in June 2020 to oversee the delivery of this strategy and over the last 5 years there has been credible progress across all domains, despite a rising demand and the operational impact of theCOVID-19 pandemic.

Over the timeframe of the strategy, there has been a significant increase in the number of patients referred with a suspicion of cancer across most of our tumour sites, and we have diagnosed and treated more patients with cancer than in previous years. We have adapted many of our local cancer pathways in line with the published national optimal pathways, with the introduction of straight-to-test wherever possible. Much of this information is routinely captured and reported in the recently extended cohort of national cancer audits.

Timely diagnosis and treatment of cancer remains a priority, and the progress we have made in improving our cancer pathways is largely due to the hard work of the tumour site teams across the organisation. These teams have, with support from core Cancer Services, effectively eliminated the backlog of patients awaiting cancer treatment. However, although there has been real progress in improving the efficiency and reliability of our cancer pathways, with the introduction of better coordination mechanisms, digital tracking, and strengthened multidisciplinary teams, these improvements have fallen short in the consistent delivery of compliance with the national cancer waiting time performance target of 75%.

Throughout the timeframe of the strategy, ABUHB has continued to investment in the cancer workforce, with further development of specialist nursing roles, advanced clinical practitioners, and diagnostic capacity through targeted recruitment and training initiatives. Workforce redesign has supported service resilience, particularly in radiology, pathology, and oncology, while fostering a culture of continuous improvement and multidisciplinary collaboration.

Collaboration with our patients and partners has been a particular area of focus in 2024 and we are pleased that our Cancer Patient Panel has grown in strength and become increasingly embedded into the development of our work. As we look ahead to the coming year, we acknowledge significant challenges remain, but the enthusiasm for improvement that our clinicians, patients, and managers demonstrate is very encouraging.

The strategy also fostered strong regional and national partnerships. A major milestone was the development and opening in 2025 of the Velindre @Nevill Hall Satellite Radiotherapy Unit, delivered in partnership with Velindre University NHS Trust. This facility provides state-of-the-art radiotherapy closer to home, incorporates advanced treatment and planning capability, and increases regional radiotherapy capacity by around 20%.The unit represents a transformational step in improving access, reducing travel burden for patients, and strengthening system capacity.

In summary, the ABUHB Cancer Strategy 2020–2025 has delivered meaningful change in the delivery of a comprehensive and increasingly patient-centred transformation of cancer services across Gwent, with measurable improvements in early diagnosis, treatment efficiency, patient-centred care, workforce capability, and system integration. While challenges remain, particularly in demand pressures and timeliness of treatment and health inequalities, the foundations established during this period have provided ABUHB a strong platform on which to deliver further improvements in cancer outcomes in the years ahead.

We would like to thank everybody who has worked in collaboration with us on the delivery of our strategy over the last 5 years, in the ambition to improve cancer outcomes for our patients, and we look forward to continuing this journey with you.

Ian Williamson
Assistant Medical Director for Cancer Services

Margaret Parrott
Cancer Services Manager

Anne May
Strategic Lead Cancer Nurse

Verity Butcher
Macmillan Optimal Cancer Pathway Manager

Anne Johnson
Consultant Clinical Psychologist

Mary Craig
GP Cancer Lead

Sian Lewis
Macmillan Lead AHP for Cancer Services

Clare Small
Senior Programme Manager

Guiding our work

Our cancer strategy

The work we do and the services we deliver are built upon the vision described within our five-year Cancer Strategy. This strategy helped to guide and focus our efforts to transform and improve cancer services across Aneurin Bevan University Health Board.

We published our Cancer Strategy, *Delivering a Vision 2020-2025*, in 2019. It consists of six core themes that address how we can reduce cancer risks, optimise treatments, improve patient outcomes, and minimise health inequalities for our population and those we serve.

Each of the six themes contains targets that we have worked towards meeting by 2025. Throughout this report we discuss each of these themes in turn and present the work that has been done in each area. We highlight our successes and outline where we still need to make progress.

Our six core themes

Reducing the risk of cancer
Research shows that up to 40% of diagnosed in Gwent each year could be avoided.

Early detection
If cancer is detected early, treatment is more likely to be curative and more people survive.

Timely diagnosis
Investigations to confirm or rule out a suspected cancer are a vital first step in preventing delays to treatment.

Improved cancer care for everyone
Ensuring that patients get the right standard of care that meets their individual needs will help to enhance experience and outcomes.

Living well with and beyond cancer
Each patient should have the appropriate support to cope with the impacts of cancer during and after treatment.

Improving our knowledge of cancer
Improving cancer education for our population and clinicians is fundamental in meeting our aims. Increasing the number of participants in cancer research studies will advance future treatments and care.

Strategic objectives

Prevention

"Research suggests that more than 40% of cancers have preventable risk factors"

Cancer Research UK report that around 4 in 10 UK cancer cases could be prevented through healthy lifestyle changes.

The Public Health team work with partners, including our cancer teams, to improve health through programmes that aim to:

- reduce smoking rates
- increase physical activity
- tackle obesity, and
- reduce alcohol dependency.

Cancer Strategy Aims

Our aims during this period have been to:

- reduce prevalence of tobacco smoking in adults to 15%
- develop smoking cessation services within the Health Board
- offer HPV vaccination of all teenage boys and girls and targeted interventions

The purpose of these initiatives is to reduce cancer risk in our hard-to-reach populations.

Reflections

The HPV vaccine has been offered to girls school year 8 since 2008. In September 2019 the HPV vaccine was officially extended to boys. During the Covid pandemic the school based delivery of the vaccine was paused, alongside school closures in March 2020. Following the pandemic, catch up sessions were offered to anyone who missed the vaccine up to the age of 25.

However, our HPV vaccine rates have not recovered, likely due to a combination of vaccine fatigue and confidence, and misconceptions of the reasons for vaccine, and Gwent's socio-economical inequalities.

Since 2024 we have established links with our communications team to bring together regular and informative social media campaigns to support the delivery of trusted cancer prevention & early detection information to our communities.

Members of the Cancer Services team have been actively engaged with the Public Health Team and are included in the membership of Gwent wide prevention groups such as the Nicotine Alliance and Healthy Weight Assembly.

In 2024-2025, the following task and finish groups have been established with Key ABUHB staff to support both prevention and early detection messaging:

- Skin Cancer Prevention and Screening Uptake Group
- Bowel Cancer Prevention & Screening uptake Group
- Cervical Cancer Prevention and Screening Uptake Group
- HPV Vaccination Uptake Group

Delivery Highlights

Early detection

If cancer is detected early, treatment is more likely to be curative and more people survive.

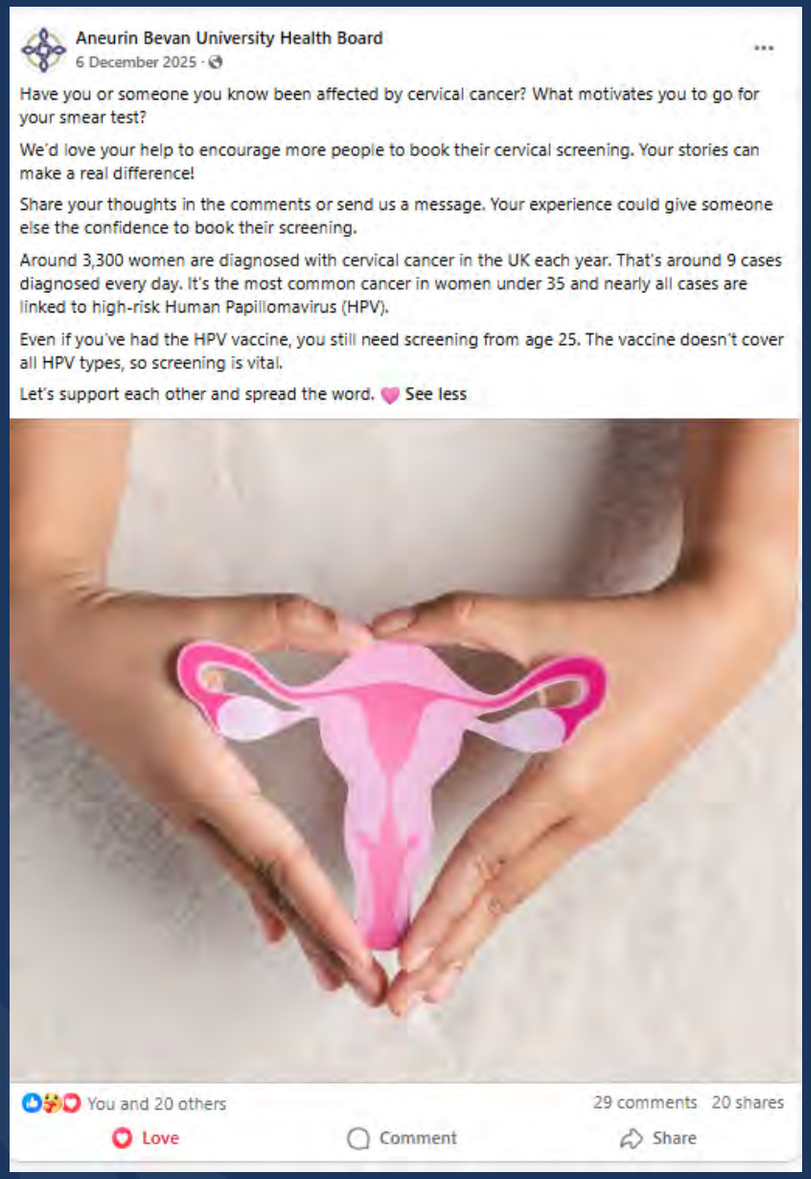
HPV Vaccination

If cancer is detected early, treatment is more likely to be curative and more people survive.

Preventative Communication Strategy

Communication leads established for priority cancer campaigns and messaging

Strategic Communication Delivery Highlights

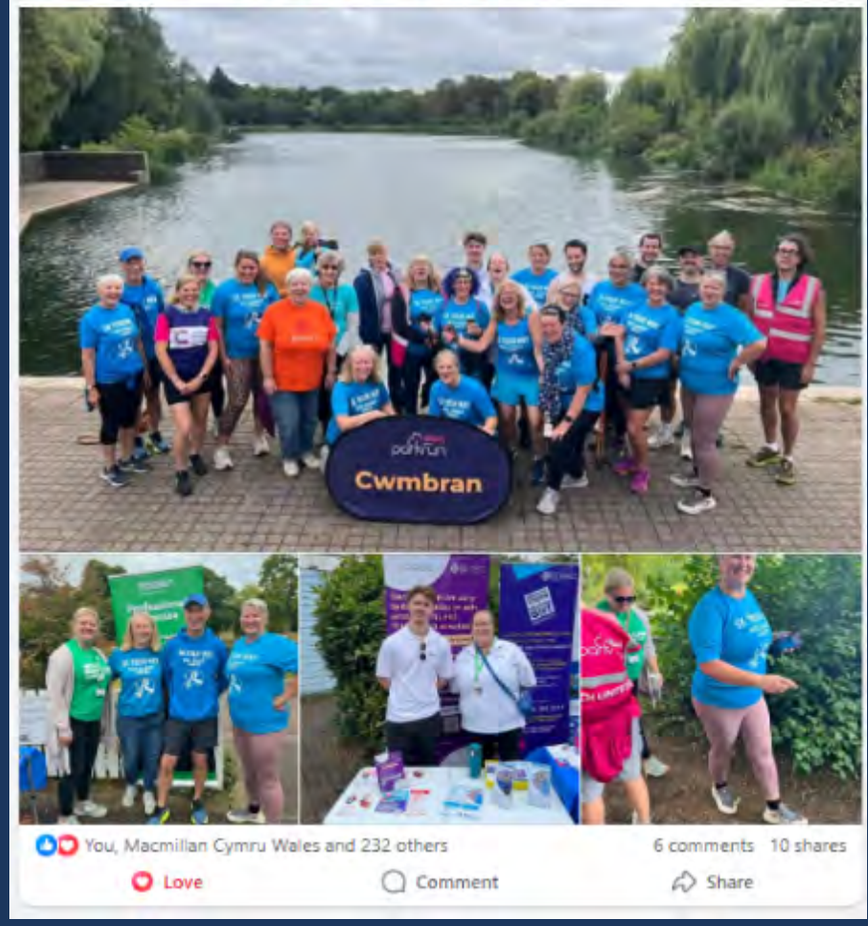


During Cervical Cancer Prevention Week 2025, a targeted communications campaign promoted cervical screening and prevention messages across stakeholder, staff, media, and community channels.

The campaign achieved a social media reach of 547,000, generated high engagement (2,312 likes and 549 shares), and drove traffic to newly developed cervical cancer webpages. A further outcome was the recruitment of six patient advocates whose lived experiences will help shape future awareness campaigns and patient engagement activities.

Launched during Breast Cancer Awareness Month, the campaign focused on risk reduction, symptom awareness, and support through treatment and recovery.

It reached over 316,000 people and generated more than 1,000 engagements, with patient stories and service insights proving particularly effective.



In August 2025, we partnered with Cwmbran parkrun to deliver a cancer awareness event promoting screening, healthy lifestyles, and support for people affected by cancer.

The initiative achieved strong community engagement, generating over 800 reactions, 130 shares, and 60 comments across social media platforms.

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Reducing Smoking Prevalence

In the strategy two prevention goals were described to reduce smoking prevalence:
•Reduce prevalence of tobacco smoking in adults living in Gwent to 15%
•Development of smoking cessation services within the Health Board

Between 2019 and 2024 the prevalence of tobacco smoking in adults has fallen from 16.1% to 11.7% (ONS-Smoking Habits Dataset). Some local authorities within Gwent have seen an even greater reduction. Blaenau Gwent has seen its smoking prevalence fall from 19.6% to 11.4%.
The impact of this reduction on the incidence of related cancers such as lung cancer will grow over time. So far lung cancer incidence has seen a small rate reduction.

Smoking cessation services

Help Me Quit (HMQ) is the national NHS stop smoking service for Wales, launched in 2017 as part of a wider Welsh Government strategy to reduce smoking-related illness and health inequalities. It brought together existing local NHS stop smoking services under one national brand, making support easier to access across Wales.

face behavioural support and offered telephone support instead. The service has since resumed its face-to-face clinics in each local authority area of Gwent, and provision of cessation support through level 3 community pharmacies has continued, with 96 pharmacies offering the service.

In addition to the Gwent wide provision of Help Me Quit support, a Smoke free hospital policy was introduced in 2021 and a revised Smoke-Free hospital action plan and implementation group were set up in 2025. The related policies and actions aim to create a healthier and safer environment for patients, staff, and visitors across all hospital sites in Gwent.

% of Population currently smoking by Local Authority						
Year	2019	2020	2021	2022	2023	2024
Caerphilly	17.1	16.0	14.7	12.6	12.8	13.8
Blaenau Gwent	19.6	16.9	18.3	15.5	14.9	11.4
Torfaen	18.8	14.2	15.5	17.5	15.4	14.5
Monmouth shire	9.7	7.6	9.2	7.6	6.7	6.9
Newport	15.9	18.1	14.5	13.8	12.9	10.6

Interventions for Har d-to-reach groups

The face-to-face clinics of the HMQ service are in areas of higher smoking prevalence, which are correlated with areas of higher deprivation. The service has also worked with probation services, mental health services and drug and alcohol services, to offer cessation support for groups of the population who are underserved. Work to strengthen the offer for hard-to-reach groups will continue as part of the service's embedding of place-based care.

Watch Lisa's story here

"Your family want memories with you, not memories of you- Quit smoking today".

Strategic objectives

Reducing the risks of cancer

HPV Vaccination

The strategy described one prevention goal in relation to the HPV vaccination:
Increasing the HPV Vaccination to teenage boys and girls.

Between 2018 and 2025 the HPV vaccination programme experienced substantial growth and development. From September 2019, boys in Year 8 (aged 12–13) in Wales began receiving the HPV vaccine routinely through the school immunisation programme alongside girls. The rollout aimed to improve overall population protection and to offer direct protection to HPV which can also cause cancers affecting men, including throat, anal and penile cancers. In 2022 the newer Gardasil 9 vaccine replaced the earlier Gardasil 4 vaccine. Gardasil 9 protects against nine HPV types and offers broader protection against HPV-related cancers and genital warts.

Another significant change occurred in September 2023 following the publication of evidence of the effectiveness of a single-dose vaccine was comparable to two doses. This reduced the burden on services whilst maintaining high levels of protection for young people.

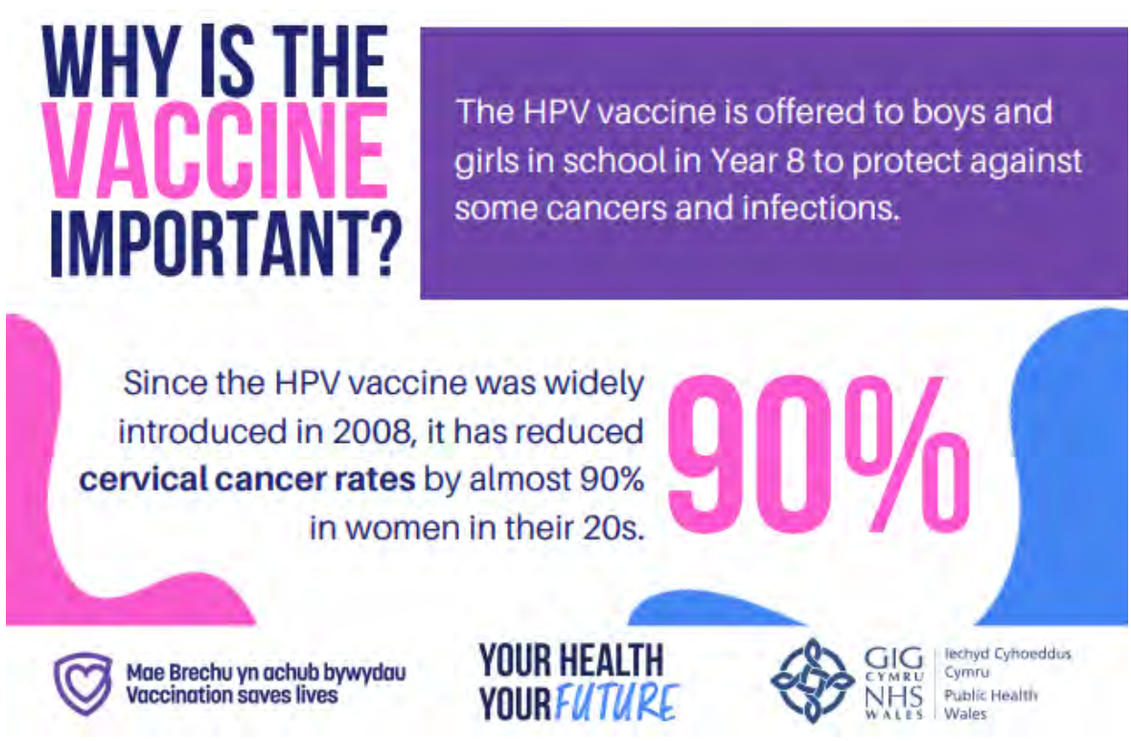
Today, the HPV vaccination programme routinely offers one dose of Gardasil 9 to boys and girls aged 12–13, with catch-up vaccination available up to age 25 for eligible groups. Immunosuppressed individuals and some higher-risk groups still receive additional doses.

HPV working group

In 2025 the HPV working group commenced, bringing together staff members from Cancer Services, School Nursing, the Public Health team and Communications & Engagement to plan a strategy to improve HPV vaccination rates across Gwent.
A significant initiative was piloted in ABUHB by the integrated school nursing tam. This involved catch up calls to obtain consent over the phone from those who had not responded to the consent letter. The telephone consent catch-up saw a 6% increase in those who received their HPV vaccination. In addition, ABUHB started to explore e-consent, to mirror the process already used for flu vaccinations in school. E-consent for HPV vaccination is under construction for full roll out in 2027.

Furthermore, Specialist Community Public Health School Nurses have integrated HPV vaccination messaging into sexual health education sessions, which has proven effective in engaging young people who previously missed their vaccination. Training improved nurses' confidence in assessing self-consent to vaccinations, with the work being recognised at the Welsh Immunisation Conference and being adopted by Public Health Wales for All Wales rollout. A referral pathway was introduced for health and education partners to support young people with barriers to immunisations, with assessment directing to catch-up clinics or domiciliary visits. Expanded access was provided through community clinics for Electively Home Educated children and those educated other than at school; with targeted, proportionate interventions to improve uptake and equity in low-uptake schools.

Work will continue to decrease the inequity gap, in both gender, and deprived areas.



Uptake of HPV vaccine in children reaching 15 years of age between 01/09/25 and 31/08/26 (School Year 10) and resident on 31/12/25

Public Health Wales Cover Report 157	% of resident children	% of resident girls	% of resident boys
Blaenau Gwent LA	69.5%	73.3%	66.4%
Caerphilly LA	73.0%	77.3%	68.6%
Monmouthshire LA	74.0%	74.6%	73.4%
Newport LA	65.4%	66.6.%	64.2%
Torfaen LA	73.7%	78.1%	69.5%
Health board total	**70.6%**	**73.3%**	**67.9%**

To get your child vaccinated you can either:

- ***Walk into the Cwmbran Vaccination centre Vaccination Pop-up Clinics - ABUHB***
- ***Book into a community catch-up clinic Community Immunisation Clinics***
- ***Call our SPOA to talk to a nurse who specialises in vaccinations on 01633 431 685***

Next Steps

- Breast Cancer Prevention and screening uptake working group to be established.
- Continue working with Public Health Wales On prevention and screening developments.
- In 2026 we celebrated HPV awareness day at Coleg Gwent sites to support vaccine and cervical screening awareness as part of future work to eliminate cervical cancer in Wales. Working on preventative messaging and events will continue.
- Link with the Gwent 2035 strategy to support improvements on prevention and behavioural messaging for children and young people.
- Strengthen and expand collaboration with parkrun and 5K Your Way across the Health Board to increase community engagement and support cancer awareness, with a commitment to delivering two dedicated awareness events annually.

Strategic objectives

Early Detection

Finding cancer early means it's easier to treat and there are improved outcomes for patients. Cancer screening remains one of the most effective methods of identifying cancer at an early stage, but we still face challenges in ensuring that people engage with these programmes in our most deprived communities. Increasing awareness and encouraging uptake has therefore remained a priority this year

We continue to work with primary care to improve awareness of our processes for referral onto the suspected cancer pathway.

Cancer Strategy aims

- Optimise uptake of breast and cervical cancer screening to 85%
- Increase uptake of colorectal cancer screening within the specified age range.
- Prepare to implement new cancer screening programmes which may include targeted lung cancer screen programme.
- Abolish inequities linked to deprivation across our communities

In 2020, as a result of the Covid-19 pandemic, all cancer screening programmes were suspended, which severely impacted our efforts to improve early detection of cancer.

Breast Cancer Screening uptake has returned to pre-pandemic levels, but uptake of Cervical Cancer Screening has never fully recovered.

Bowel Screening

Diagnostic colonoscopies within four weeks of bowel screening assessment have risen from 11.8 to 31% during 2024 but remained below the BSW target of 90%. Our 2025 compliance data is not yet available from Public Health Wales.

The Bowel Cancer Prevention and Screening Working group was established in December 2025, and has focused on targeted communication leading to Bowel Screening Awareness Month in April 2026. Work is continuing to explore methods of uptake of at home FIT test and has also highlighted a gap in encouraging those with positive result to attend their follow up appointments.

Delivery Highlights:

Established links with the Hair & Beauty Industry

As of May 2026 over 400 local hair and beauty professionals, tutors and students have been training on spotting the early signs of skin cancer and sun safety.

Screening working groups

If cancer is detected early, treatment is more likely to be curative and more people survive.

- Skin Cancer Prevention and Screening Uptake Group
- Bowel Cancer Prevention & Screening uptake Group
- Cervical Cancer Prevention and Screening Uptake Group
- HPV Vaccination Uptake Group

Abolish Inequities linked to deprivation across our communities

Communication leads established for priority cancer campaigns and messaging

Increase uptake of colorectal cancer screening within the specified age range

During the strategy, the bowel screening age in Wales officially lowered to 50 in October 2024. This marked the final step in a four-year phased rollout that began by dropping the age from 60 to 58 in 2021, and gradually expanding it to younger age groups every year until it reached 50.

"What a fantastic initiative. So pleased that your amazing team gave your time to deliver this session."

"I am writing to extend my sincere gratitude for the invitation to the Skin Cancer Awareness event. It is an honour for us to participate in this significant initiative, which addresses such a critical public health issue."

Next Steps

- Breast Cancer Prevention and screening uptake working group to be established.
- Continue to support work to reduce inequality linked to deprivation across our communities, and in line with PHW screening equity strategy which is due to be published
- Lung screening 2028- Prepare to work with Public Health Wales to implement new cancer screening programmes which may include targeted lung cancer screening programme – this optimising its delivery and is scheduled to be implemented in Wales in 2028.

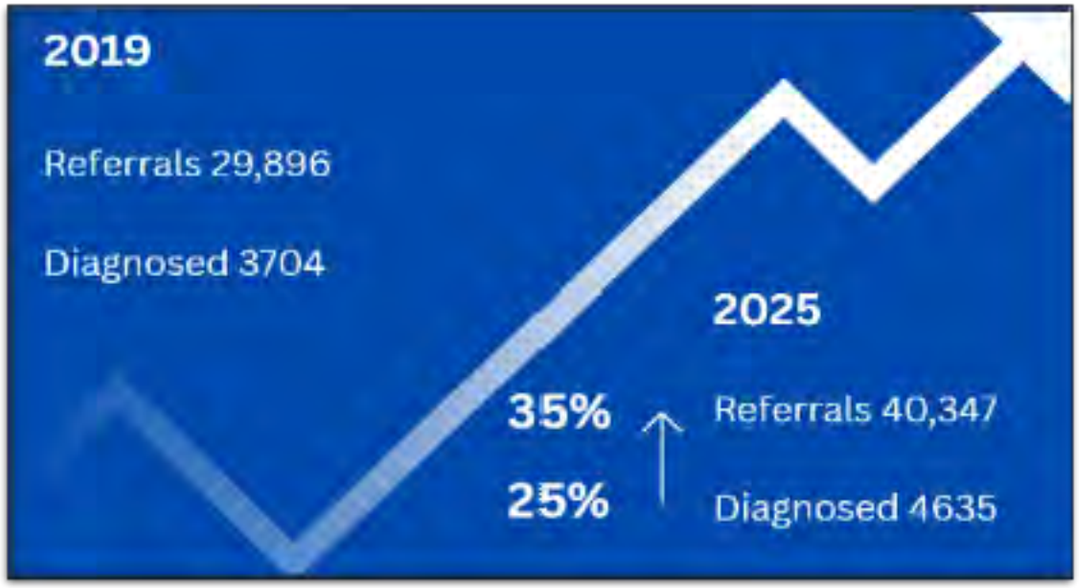
Strategic objectives

Timely Diagnosis

Cancer Strategy Aims

Our aims within this pillar for 2020 -2025 were:

- Adoption of the Single Cancer Pathway with incremental improvements in performance against the waiting time target.
- Ensure sufficient capacity within diagnostics to consistently deliver optimal cancer pathways
- Rapid adoption of new therapies and access to genomic testing



Reflections

Between 2020 and 2025, cancer diagnosis and treatment waiting times in the UK struggled to meet official NHS targets, with Wales consistently missing its 75% target for the Suspected Cancer Pathway (SCP) and England frequently falling short of its 85% standard for 62-day treatment (CRUK). In Aneurin Bevan University Health Board, since the launch of our strategy, we've seen referrals into our cancer pathways increase by 35%, and those diagnosed with cancer have increased by 25%.

These increases are primarily attributed to an ageing population, and an increase in early-detection screening programmes (Bowel Screening age has reduced to age 50). The SCP was successfully adopted in June 2019 and with this, a lower threshold for GPs to investigate symptoms.

Timely Diagnosis

Impact of Covid-19 pandemic

During the first wave of the Covid-19 pandemic, like the rest of the UK we saw a significant drop in the number of patients referred with suspected cancer. Following the pandemic, in 2022 there was a sustained increase in cancer referrals across many of our tumour sites, before these plateaued in 2025. Overall, the proportion of our patients that received their cancer treatment within 62 days has remained below the ministerial target of 75%. Whist there was an incremental improvement in compliance during 2024, this has not been sustained.

Straight to Test

The health board has been successful in the implementation of straight to test cancer investigations across several tumour sites, as recommended within the relevant National Optimal pathways. This has improved our diagnosis rate within 28 days of suspicion and for most patients, provides timely reassurance that their symptoms are not due to cancer.

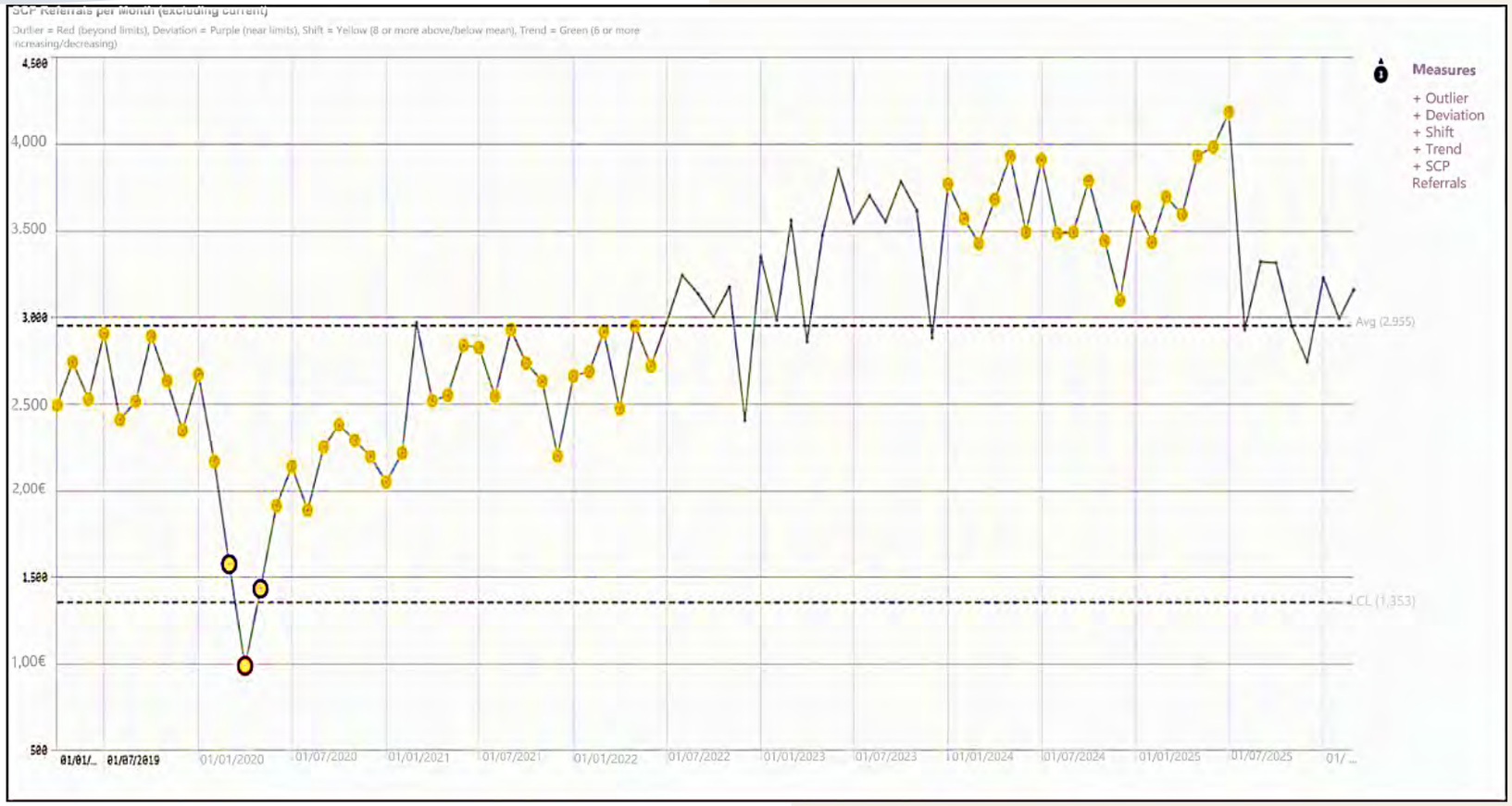
- We were early adopters of incorporating FIT10 within the colorectal pathway, to help stratify the urgency for colonoscopy.
- The opening of the unified breast unit @ YYF facilitated the introduction of the one-stop triple assessment clinic for patients referred with suspected breast cancer

Tumour site	Straight-to-test investigation
Bladder	CT scan / 1-Stop Haematuria clinic
Prostate	MRI scan
Endometrial	1-Stop Post Menopausal Bleeding clinic
Breast	1-Stop triple assessment clinic
Colorectal	Telephone Assessment and colonoscopy / CT as indicated Same day CT if suspicion of cancer at Endoscopy & MRI same day/within 48hrs

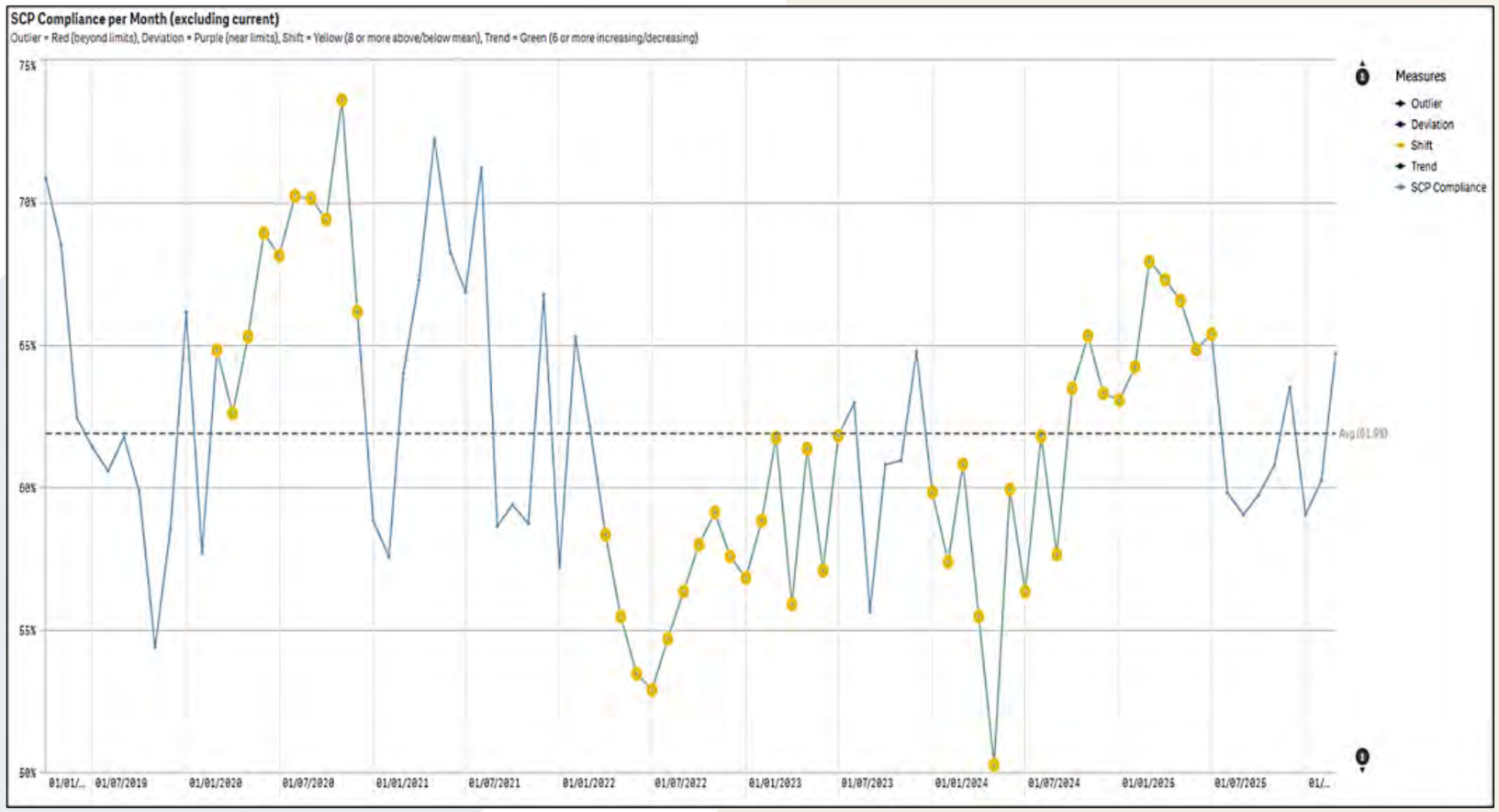
Preparing for optimal treatment

Throughout the duration of the strategy, we have been successful in the early adoption of innovative investigations relating to cancer diagnosis. These include new additional diagnostic and staging investigations that are required before optimal treatment plans can be recommended. A good example here is the early adoption of a blood test for tumour genomics (liquid biopsy) that has been successfully embedded within the lung cancer pathway.
Cancer treatment plans have also become more complex over the last 5 years, with patients increasingly requiring multi-modality treatments such as peri-operative systemic therapies, the coordination of which can take longer than more conventional cancer pathways.

SCP Referrals per Month



SCP Compliance per Month



Strategic objectives

Improved cancer care for everyone

When a person has a suspected cancer, we must ensure not only that they get the right standard of care, but that care meets their individual needs.

We have nine cancer multidisciplinary teams who manage and individualise cancer care. They tailor treatment to each patient, taking into account best evidence and recommendations as well as genetic, biochemical, and other factors. Where oncology care is required, our teams work with Velindre Cancer Centre. Our teams are also supported by our Acute Oncology Service, who provide personalised care for cancer patients who require emergency interventions.

Cancer Strategy Aims

Our aims for 2019-2025 are:

- Integration of Prehabilitation for all patients within the Single Cancer Pathway
- Ensure sufficient surgical capacity to meet the needs of the population
- Redesign of Systemic Anti Cancer Therapy Services within our Cancer Network
- Review and development of Acute Oncology Service to meet needs of our patients
- Support Velindre Cancer Centre to develop Satellite Radiotherapy Unit at NHH

Prehabilitation

Patients have told us that they do not always feel prepared for their cancer treatment, and are not aware of what they can do to help themselves prepare.

Evidence shows that a multimodal prehabilitation service offers significant advantages. These include reducing postoperative complications, shortening hospital LOS, and lowering readmission rates. The goal is to improve patients' readiness for treatment and recovery, resulting in better functional outcomes, enhanced quality of life, and improved long-term survival.

To date we have not implemented a multi modal risk stratified prehabilitation service.

However, in 2025, work commenced on the development of a business case aimed at supporting patients undergoing surgery for colorectal and complex urological cancers. The business case is scheduled for submission in summer 2026, with potential implementation from 2027, subject to approval. Specific patients access tertiary prehabilitation services for thoracic, upper gastrointestinal (GI), and gynaecological cancers.

To help address the current absence of a dedicated prehabilitation service, first-line information has been co-produced with patient representatives.

This collaborative approach has increased awareness of getting ready for cancer treatment and provided patients with accessible information and support to optimise their health and wellbeing before and during treatment. Work has included:

Webpage:

A dedicated *Getting Ready for Cancer Treatment*' webpage has been developed, bringing together key prehabilitation information and support in a single accessible resource.

Written resources:

Health Board representatives led on the development of national prehabilitation patient information resources, supporting the delivery of consistent and evidence-based information across Wales.

Training:

We have delivered training to endoscopy nurses, pre-assessment nurses, physician assistants (anaesthetics), cancer support workers, clinical nurse specialists and Allied Health Professionals (AHPs) in order to better support patients in preparing for treatment.

Customised *What Matters To You* conversation:

The *What Matters To You* telephone conversation has been modified to include the core elements for getting ready for cancer treatment. This telephone assessment is delivered in 7 of our 9 tumour sites.

Multi-agency partnerships:

We have worked to raise awareness of charities that patients can refer themselves to, including a 45 minute prehabilitation workshop run by Maggie's Cancer Care and The World Cancer Research Fund Nutrition Helpline.

Strategic objectives

Improved individualised care

Acute Oncology Service (AOS)

During the 2019-2025 strategy the Acute Oncology Service (AOS) at the Health Board were involved in the strategic development and implementation of a regional Southeast Wales business case to expand capacity and support regional working. This included additional workforce at the Health Board and saw the recruitment of staff to further develop a now established a nurse-led, multi-site AOS model delivering more reviews within 24 hours.

Specialist Oncology support from Velindre Cancer Centre is now offered daily from a virtual MDT and dedicated Health Board session once a week increasing to twice a week in 2026.
The AOS team have strengthened integration with ED,
inpatient care and cancer pathways, ensuring rapid specialist oncology input:

- Faster access to specialist oncology expertise (often within 24 hours)
- Reduced waiting times in urgent care (up to 8 hours saved via SDEC)
- Improved experience with more timely, coordinated care
- Reduced unnecessary admissions and shorter length of stay
- Improved patient flow from ED and acute medicine
- Stronger multidisciplinary collaboration across acute and cancer teams
- Increased capability of generalist staff through education and support
- More resilient, standardised acute cancer service model

In October 2025, in collaboration with Velindre Cancer Centre and Macmillan Cancer Support, the Health Boards AOS Team held a Metastatic Spinal Cord Compression (MSCC) education day to celebrate AOS awareness week and to raise awareness on the care of patients with metastatic spinal cord compression. Over 70 colleagues attended including neighbouring Health Boards and nationally across UK.

Further Improvements:

- The local MUO (malignancy of unknown origin) diagnostic pathway, is outstanding, leaving significant risk for patients presenting without a known primary. Business case to be developed.

- The second phase of the business case refers to integrating Allied Health professionals within the AOS team, to enhance holistic care. Aiming to improve patient outcomes, reduce length of stay and prevent readmission. This phase requires further scoping.

Radiotherapy Unit at Nevill Hall

This new £38 million regional facility is a collaborative between Aneurin Bevan University Health Board, Velindre Cancer Centre, and South East Wales health boards. It opened in June 2024 and has brought radiotherapy treatment to the Nevill Hall site in Abergavenny.

What is the aim of the unit?

The unit has been developed to:

- Provide high quality, safe and resilient services across South East Wales
- Increase radiotherapy capacity by 20%
- Reduce patient treatments times
- Introduce new treatments and technology for patient treatments over time
- Directly support the improvement of cancer outcomes across the region

Who is it for?

The unit is seeing breast and prostate cancer patients who meet clinical criteria. Patients from across south east Wales who are referred for radiotherapy treatment will be assigned to either Velindre Cancer Centre in Whitchurch or the Velindre Radiotherapy Unit at Nevill Hall.

What will the unit offer?

Service and resources provided by the Satellite radiotherapy will include:

- **Two Advanced Linac Machines -** These state-of-the-art machines will provide precise and effective radiotherapy treatments.
- **Radiotherapy Planning** - Tailored treatment plans to meet your specific needs.
- **On-Treatment Review** - Regular check-ins to monitor your progress and adjust treatments as necessary.
- **On-Treatment Education** - Information and support to help you understand your treatment and manage side effects.
- **CT Simulator** - Advanced imaging to ensure accurate treatment delivery.

Strategic objectives

Living well with and beyond cancer

Living with and beyond cancer is a UK wide initiative launched in 2010, to improve services and support for people diagnosed with cancer.

It was recognised that improving diagnosis and treatment alone did not enable people living with cancer to have health and quality of life outcomes.

Cancer Strategy Aims

- Improve access to written advice and support for cancer patients
- Provide all patients diagnosed with cancer with a written care plan
- Improve access to psychological support services
- Routinely collect Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) to optimise patient experience and value-based cancer care.

Approach

Over the past five years, there has been a system-wide redesign of support for people affected by cancer, extending across the five boroughs of Gwent.

further development of the programme, drawing attention to the importance of addressing emotional wellbeing alongside physical care. We gained a £300,000 grant from NHS Charities to enhance this work alongside existing ABUHB teams. A wide range of stakeholders were involved, with a strong emphasis on listening to people living with cancer and identifying where gaps in support existed.

We reviewed how interventions were offered and stratified our model into universal, targeted and specialist.:

We delivered through a 6-concept model,

- Improved resources for patients
- Roll out of health optimisation self assessment and information tool
- Improved access to psychological support
- Launched patient workshops for emotional wellbeing
- Launched Cancer Services website for patients and the public
- Replaced low-uptake digital HNA with “What matters to you” conversations and personalised care plans.
- Educated staff and patients (e.g. fatigue management, managing uncertainty)
- Established Cancer cafés in all five boroughs
- Embedded a patient engagement panel to inform our design
- Implemented a PREM tool to assess how we are doing.

“There was very little warning of how hard it would be, psychologically, once the medical treatment was complete.”

“When everything dies down, that is the time when the enormity of the situation sinks in. However, you find you are suddenly left on your own at this point with no support.”

Delivery Highlights

Launch of our ABUHB Cancer Services Website [Cancer Services - Aneurin Bevan University Health Board]

Launched in 2025 to empowering our patients to use trusted information to be informed and active with their health outcomes.

Digital Health Optimisation Self Assessment Tool (dHOSAT)

The dHOSAT was implemented 2023. The interactive tool is offered to all patients referred to secondary care on an Urgent Suspected Cancer pathway via a text message link. Includes 7 health questions with automatic referral to smoking and alcohol services when identified.

Established a Patient Panel

Meeting since 2023 to help shape our pathway s and interventions.

Education to patients

Monthly online workshops have been established to assist patients on adjusting to their diagnosis, to deal with uncertainty and difficult and fatigue management, so that they can focus on what matters to them most.

Established Cancer Cafes across the boroughs:

Caerphilly Library
Sedbury Space, Chepstow
Rivermead Centre, Rogerstone
19 Hills, Newport
Moose Hall, New Tredegar
Salvation Army, Pontypool
Maggies, Abergavenny

.***"These cafes really are a great resource for those of us trying to move on. It is really does help such a lot to speak to other people & realise we are all dealing with the same things"***

Collaborated with Maggie's Cancer Support to launch a monthly outreach service in Abergavenny in 2025

Providing local support for our patients in Gwent

MAGGIE'S
Everyone's home of cancer care

What our patients say:

In February 2026, a post cancer treatment survey was launched using CIVCA. It shows that patient support has improved across all nine tumour sites with 94% of patients reporting that the conversation to discuss concerns was useful , compared to 49 % of patients in the 2021 Welsh CPES.

70% patients report that they received support to reduce the impact of cancer in 2026 compared with 37% in 2021

90% of patients in 2026 report they have a high satisfaction with their cancer care.

Further achievements:

Referrals to psychology have increased by 56% (260 in 2022 to 406**)**

Welfare benefit advisers supported 747 patients in 2025 compared to 319 in 2020

Prostate patients have access to digital follow-up with nurse led preparation workshop.

Shortlisted for National Patient Experience Network Award in 2024

The dHOSAT has sent 40,000 text invitations achieving a response rate of 56%.
12% smoke, 49% want to give up
84% don't exercise to recommended level, 74% want to make a change and increase
66% eat less than 5 pieces fruit and veg a day, 49% want to make a change to increase

Coalfield regeneration trust in combination with Macmillan 2025, support cancer patients in their communities in some of our most deprived areas across Gwent

Coalfields Regeneration Trust
BUILDING PROSPERITY & OPPORTUNITY

Worked collaboratively with parkrun and 5K Your Way, to establish four local 5K Your Way groups, increasing access to peer support and physical activity opportunities for people living well with and beyond cancer

Next Steps

- Work to further develop our website.
- Develop our links with the End of Life Care Board and workstreams.
- Grow our Specialist Cancer Psychology Team to ensure that all patients receive the 1-1 and targeted support required
- Improve support programmes post treatment, including rehabilitation
- Improve education and support for carers, family members and friends.
- Skin Cancer continue to receive a high number of referrals and would benefit from a cancer support worker.

Strategic objectives

Improving our Knowledge of Cancer Education and Research

Cancer Strategy Aims

- Improve/ cancer education for our population and clinicians
- Increase the number of participants in cancer research studies to 10%
- Horizon scanning and rapid adoption of new technologies

Education Highlights

ABUHB annual Cancer Services Conferences

Successfully held a Cancer Conference in 2024 (70 attendees), and 2025 (110 attendees). Key highlights included our patient panel and spotlight talks.

Cancer Connect

Established a bi-monthly Cancer Nursing and AHP Forum across Gwent, connecting professionals involved in cancer care delivery. Led jointly by the Lead Cancer Nurse and Macmillan AHP Cancer Lead, the forum facilitates communication, collaboration, shared learning, and service updates across the cancer workforce.

Patient Centred Care in Cancer Innovation Event 2022

Forty nurses and Allied Health Professionals gathered in-person at the Christchurch Centre, Malpas. With guest speakers Bethan Hawkes, Dr Ricky Fraser and Jackie Pottle.

Advanced Communication course

Using funding from Macmillan grant and Keith James we have delivered three externally facilitated courses for thirty CNS, support workers and AHPs.

Psychology

Five workshops for CNS and AHPs to enhance abilities in psychological skills and delivery.

Moondance & Keith James Grants

Moondance & the Keith James Grants have been utilised to provide staff with educational and development opportunities at the World Cancer Congress directly supporting the work on HPV vaccine update, Cancer of Unknown Primary Conference.
Working group attended World Prehabilitation Congress in Canada and observe prehab services in the UK.

Improving our Knowledge of Cancer Education and Research

Research

Cancer research within Aneurin Bevan UHB has undergone significant development during the strategy period, following recovery from the COVID-19 pandemic and changes to research delivery models nationally. Research has progressed from a relatively small component of overall research activity to a more established and strategic function within cancer services.

Whilst recruitment growth has not been consistent year on year due to study complexity and portfolio availability, cancer research has increased from approximately 3% of overall Health Board research activity in 2022/23 to over 30% by 2025/26. Importantly, the portfolio has expanded across multiple tumour groups and specialty areas, increasing opportunities for patients to participate in research closer to home.

There has also been greater integration of research into clinical services, improved engagement with multidisciplinary teams, and increased awareness of research opportunities amongst both staff and patients.

Highlights

- Significant increase in cancer research activity and patient access opportunities across the Health Board.
- Development of a more strategic and sustainable portfolio aligned to local clinical strengths, including haematology, biomarkers, screening, and early detection.
- Improved recruitment performance and reputation as a reliable research delivery site, with continued achievement of recruitment to time and target.
- Increased visibility of research through engagement activity and the introduction of initiatives such as Research Champions.
- Growing multidisciplinary involvement in research delivery, supporting the aim of embedding research within routine cancer care.
- Strengthened collaboration with academic, regional, and national partners to support study delivery and future development.
- Contribution to horizon scanning and adoption of innovation through delivery of commercial and non-commercial research studies, providing early access to emerging treatments, diagnostics, and technologies.

Next Steps

- Further embed research within cancer pathways, MDTs, and routine clinical practice.
- Continue development of Research Champions and workforce capability to increase awareness of and participation in research.
- Build on areas of recognised strength whilst expanding opportunities across additional tumour groups and pathways.
- Strengthen collaboration across organisational boundaries to improve access to research and streamline study delivery.
- Improve data capture and reporting to better understand patient participation and impact.
- Align future research activity with national cancer strategy priorities, innovation opportunities, and emerging technologies.

Looking forward

In April 2026, the Executive Board have agreed to the development of a Cancer Plan to sit alongside the Gwent Strategy 2035. This work is progressing and includes activities to engage staff, patients, public and stake holders in its development. Following a series of workshops and engagement opportunities in June and July 2026, it is anticipated that this work will be completed early 2027, with the first draft of the Gwent Cancer Plan 2035 to be delivered to Cancer Board in January 2027. The Cancer Services team are exploring potential funding opportunities to hold a Big Cancer conversation in the early stages of the Gwent Cancer Plan 2035 to engage our stake holders, including education, local councils, charities, Velindre Cancer Centre and the Southeast Wales Health Boards to engage their support in the delivery of the Gwent Cancer Plan 2035.

*TIMELINES SUBJECT TO CHANGE

GWENT CANCER PLAN 2035 DEVELOPMENT BY ABUHB*

11 MARCH 2026
Cancer Conference Launch of Cancer 2035 planning

Evaluation of workshop content

SPRING 2026
Evaluation of previous strategy

Gwent Caner Plan Workshop Preparation

JUNE 2026
Plan Proposal to Executive Board

30 JUNE 2026
ABUHB Cancer Plan Workshop **Pillar 1 Prevention & Pillar 2 Early Detection**

2 JULY 2026
ABUHB Cancer Plan Workshop **Pillar 3 Timley Diagnosis & Pillar 5 Living with and beyond cancer**

6 JULY 2026
ABUHB Cancer Plan Workshop **Pillar 4 Improved and standardised cancer care & Pillar 6 Improving our knowledge of cancer**

SUMMER - WINTER 2026
Engagement sessions with partners to develop actions for plan achievement

JANUARY 2027
Draft to Cancer Board

10 MARCH 2027
ABUHB Cancer Conference

LAUNCH EVENTS SPRING 2027
Partner Launch Event (tbc)

Community Engagement for Gwent Cancer Plan 2035 development

BeVan

Working alongside current planned engagement events for Prevention and early detection

Linked to Gwent 2035 lifestyle timelines

Big Cancer Conversation TBC pending funding

Social Media & Stake holders

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 September 2026
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Place Based Care Programme across Gwent
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Tracy Daszkiewicz – Executive Director of Public Health and Strategic Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lloyd Hambridge – Divisional Director, Primary Care & Community Service and Complex Care Will Beer- Consultant in Public Health and Assistant Divisional Director, Primary Care & Community Service and Complex Care

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The Placed Based Care (PBC) Deep Dive paper provides an overview of the Place Based Care programme, outlining the strategic framework, alignment with Gwent 35 and national priorities, and progress made to date across neighbourhood intelligence, Integrated Neighbourhood Teams, multidisciplinary pathways and community infrastructure. It summarises the phased approach to implementation, the operating model, governance arrangements and enabling workstreams, and highlights emerging delivery risk, particularly workforce sustainability and variation in local readiness. The paper sets out the actions required to move from design into consistent neighbourhood-level delivery and the areas where continued Board oversight is needed to embed PBC as the default model across Gwent.

The Board is asked to:

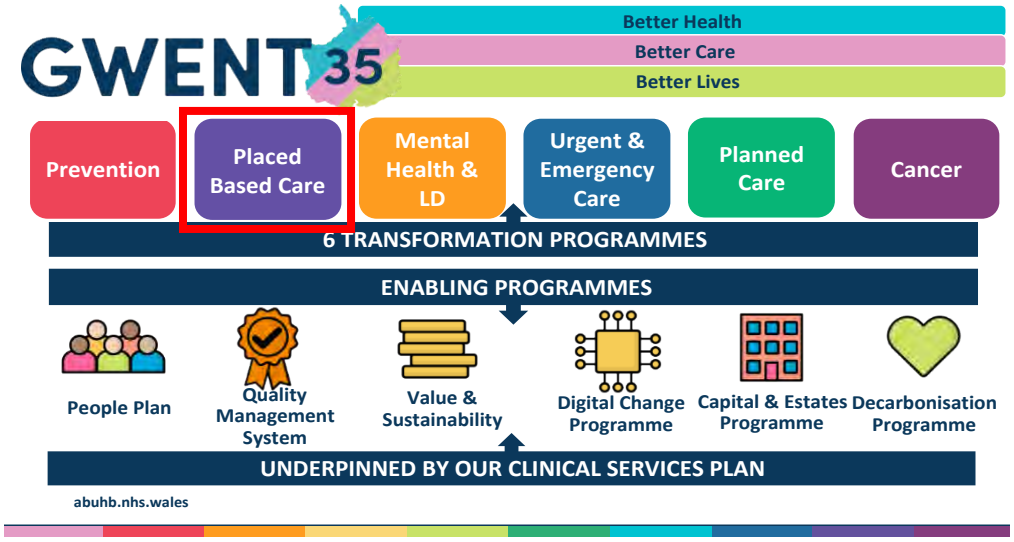
- **NOTE** the context, policy alignment and framing for the Health Board's strategic Programme for Place Based Care and its pivotal role in driving Gwent 35 strategy forward
- **NOTE** the progress made to date
- **NOTE** the key next steps and further work

Cefndir / Background

Place Based Care is the Health Board's core model for improving population health, reducing inequalities and delivering coordinated support close to home. The Health Board's Annual Plan 2026/27 positions PBC as the main vehicle for delivery of the strategy Gwent 2035 and national priorities including Community by Design. In this vein it will form a key component of a new Clinical Services Plan.

As agreed,as part of the Annual Plan Delivery Framework in the May Board, the Place Based Care Programme is one of the six Priority Programmes as set out below:

Figure 1: Health Board Priority Programmes



The Executive Committee endorsed the strategic approach in May 2026, confirming alignment with A Healthier Wales and Integrated Community Care Systems (ICCS), and agreeing leadership and governance arrangements through the PBC Programme Board and the Partnership, Population Health and Planning Committee.

Key achievements during 2025/26 include:

- Establishment of programme governance and appointment of programme management capacity.
- Engagement of Integrated Service Partnership Boards (ISPBs) as accountable delivery vehicles.
- Completion of an external evaluation showing broad support for the approach.
- Development of place profiles and community asset mapping.

- Introduction of Integrated Neighbourhood Teams (INTs).
- Progress in community-based delivery models including frailty MDTs, Women's Health, Breathlessness Pathways, Pharmacy expansion and Single Point of Access arrangements.

The programme is structured around three phases:

1. Discovery - establishing governance, ownership and baseline understanding.
2. Design - developing operating models, place intelligence and tests of change.
3. Delivery - implementation through ISPB-level delivery plans and workforce/resource changes

Asesiad / Assessment

The attached report covers:

- **Strategic Alignment** - Alignment with national policy context and local strategy
- **Plan Commitments** - How the PBC programme is rooted in the commitments as set out in the Annual Plan
- **Governance and Accountability** - an overview of arrangements including key interface with Regional Partnership Board and Integrated Service Partnership Boards (ISPBs)
- **Progress Against Phases** - a focus on some key areas of progress including agreement of operating model, progress towards profiling all 26 places and an overview of the Integrated Network Teams that will be central to delivery
- **Delivery Assurance** - how the programme receives and seeks assurance on progress
- **Next steps** – a summary of key next steps including development of detailed costed plan.

The report explores key areas of progress which include:

Strategic alingment	Clearer Governance arrangement	Robust Programme arrangments	Maturing intelligence of places	Developing Operating Model
•Clear alignment with Gwent 35, Better Health, Better Care and Better Lives. •Consistent with national direction through Community by Design and ICCS	•Programme Board in place. Clear reporting and assurance arrangements. ISPBs identified as key delivery structures.	•Governance, programme management and leadership arrangements established. •Learning informed by NAPC and extensive stakeholder engagement	•Development of 26 place profiles provides a strong foundation for evidence-based prioritisation and tackling inequalities. •Combining population health intelligence, community assets and local service data	•Three-tier model established: ○Community wellbeing. ○Community navigation. •Integrated neighbourhood delivery

Place Based Care represents an exciting opportunity to drive purposeful change across Gwent for communities. However, there are a number of risks and challenges identified:

Delivery confidence remains conditional The National Association of Primary Care (NAPC) evaluation found strong consensus around the vision but concerns regarding grip, ownership, delivery capability and pace of implementation. It highlighted the need to move rapidly from ambition to execution.

Workforce sustainability risk Many key preventative and community-based roles remain dependent on time-limited funding ending in 2027, requiring a sustainable workforce plan and clear funding.

Variation across localities There is inconsistent access to key neighbourhood roles such as MDT coordinators, health coaches, psychological health practitioners and IWN support across boroughs.

Need for resource shift A key risk remains the ability to genuinely move resources upstream into prevention and community-based services.

The Board is asked to:

- **NOTE** the context, policy alignment and framing for the Health Board's strategic Programme for Place Based Care and its pivotal role in driving Gwent 35 strategy forward
- **NOTE** the progress made to date
- **NOTE** the key next steps and further work

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	SSR001e SSR007
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 1.1 Health Promotion, Protection and Improvement 1. Staying Healthy Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. All
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. All
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 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:	PBC – Place Based Care MDT - Multi-Disciplinary Team PHP - Psychological Health Practitioners MSK - Musculoskeletal IWN – Integrated Wellbeing Network ABUHB – Aneurin Bevan University Health Board RPB – Regional Partnership Board ISPB – Integrated Services Partnership Board ICCS – Integrated Community Care System CbD – Community by Design
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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

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

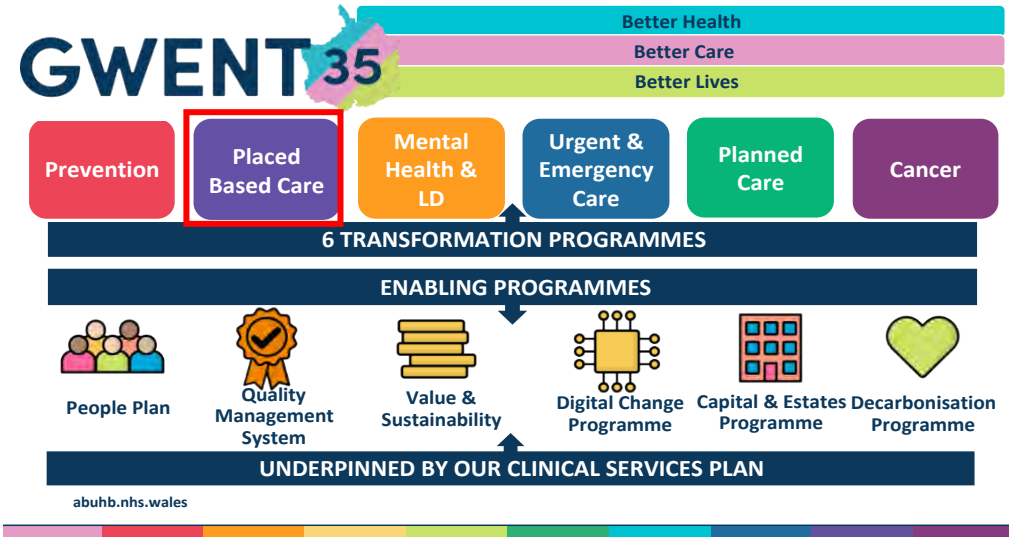
Place Based Care Programme Deep Dive

1. Introduction

Place Based Care (PBC) aims to improve health and wellbeing, reduce preventable harm and narrow inequalities by strengthening the conditions that enable people and communities to live well. It represents a deliberate shift from reacting to illness towards creating health in neighbourhoods, recognising that most determinants of health sit outside formal services and that effective support must build on people's strengths, networks and local assets. By organising delivery around place, PBC enables earlier intervention, more coordinated community support and a clearer focus on what matters to people.

This approach is central to rebalancing the system. Across Gwent, rising complexity, widening inequity and increasing demand linked to long-term conditions and frailty cannot be addressed through traditional service-led models alone. PBC provides a coherent framework for aligning multidisciplinary teams, intelligence and resources around neighbourhoods, ensuring support is proportionate to need and targeted where it will have greatest impact. It strengthens prevention, improves access to coordinated care close to home and supports fair opportunities for a healthy, independent life.

PBC is a core enabler of the Health Board's strategic aims for Better Health, Better Care, Better Lives, translating the ambition of Gwent 35 into practical delivery at place level. By focusing on the places and populations where need is greatest, and by integrating action across health, social care and the third sector, PBC supports improved outcomes, stronger community resilience and the long-term sustainability of health and care services across Gwent.



2. Background

As a whole-system model for improving population health and wellbeing, the success of PBC is that it is organised around people and communities rather than services or institutions. It brings together health, social care, local government, the third sector and communities to act on the wider determinants of health, prevent ill-health, reduce

inequalities and provide coordinated, person-centred support as close to home as possible. In this vein the Integrated Service Partnerships Boards (ISPBs) that exist at borough (or combined in the case of Blaenau Gwent and Torfaen) level are critical to delivery of PBC at local level.

The table below supports the consistent communication of PBC.

*Table 1: Definition of what Place Based Care is and common **misconceptions***

What Place Based Care IS	What Place Based Care IS NOT
A strategic framework and programme, not a single service or project, providing an overarching approach to prevention, community wellbeing, integrated delivery and population health management across neighbourhood, place and system levels.	A new standalone service or organisational restructure. It does not replace statutory responsibilities or create a parallel programme.
Starts with prevention and the wider determinants of health, recognising the influence of housing, income, education, environment, social connection and lived experience, and deliberately shifts focus and resources upstream.	Limited to admission avoidance or discharge support. While flow and reduced hospital reliance are important, PBC has a broader long-term purpose.
Community centred and coproduced, working with residents and communities to identify priorities, build on local assets and design solutions that reflect what matters locally.	A top down or professionally driven model that excludes community voice or lived experience.
Aligns and integrates existing programmes and delivery models, including Integrated Community Care System (ICCS), Community by Design (CbD), Integrated Neighbourhood Teams (INTs), Neighbourhood Care Networks (NCNs), and local authority and third sector approaches.	A rebadging of existing services. Services retain their own accountability and PBC simply provides the framework to better connect and target them locally.
Provides a consistent operating model across Gwent, with flexibility to respond to local need, rurality and deprivation through neighbourhood level delivery and place-based governance.	A one size fits all model applied uniformly regardless of local context.
Connects public health and service delivery, embedding population health intelligence, prevention and early intervention alongside primary, community and social care.	Solely a workforce expansion bid. While investment is needed, PBC is fundamentally about changing how the system works together.
Enabled through clear governance and accountability, via the PBC Programme Board and Integrated Strategic Partnership Boards, providing a single line of sight from neighbourhood delivery to system outcomes.	A time limited transformation initiative. PBC is intended to become the default way of working across Gwent.
Focused on improving healthy life expectancy, reducing inequalities and strengthening community resilience over the long term.	A short-term improvement project focused only on immediate performance metrics.

3. Strategic alignment

Place Based Care as described by the Health Board is fully aligned with the Welsh national policy as set out in Community by Design and Integrated Community Care System and in Gwent will be the language and mechanism through which these agendas are driven forward.

The Executive Committee endorsed the strategic approach to PBC in May 2026, confirming alignment with A Healthier Wales and Welsh Government's policy direction. This included agreement on leadership and governance arrangements, with the PBC Programme Board providing system-wide oversight and strategic coordination, and

Board assurance routed through the Partnership, Population Health and Planning Committee.

The programme is well positioned to continue building the evidence base for PBC. Through evaluation, population health intelligence and outcomes measurement, it will demonstrate the value of community-based models, inform future resource decisions and support the longer-term shift towards prevention, wellbeing and neighbourhood-based delivery across Gwent.

4. Plan Commitments

The Place Based Care Programme for 2026/27 builds on the achievements of 2025/26 as set out below:

✓ Established robust Programme governance & strategic oversight including appointment of Programme Manager to drive delivery.

✓ Learning session with the National Association of Primary Care.

✓ Held a series of joint leadership meetings with Torfaen and Blaenau Gwent Local Authority to set the ambitions and commitment.

✓ Evaluation Report completed showing conditional support & cautious optimism among stakeholders.

✓ Engagement of Integrated Service Partnership Boards (ISPBs) as accountable vehicles for delivery.

✓ Identified critical risks including governance complexity, uneven ownership, & capacity gaps.

✓ Early examples of progress in community infrastructure through Integrated Neighbourhood Teams & Multidisciplinary Teams.

✓ Strong system alignment around prevention, partnership, & place-based care principles.

The Annual Plan 2026/27 is framed around the aims of Gwent 35 (Better Health, Better Care, Better Lives) and deliverables, milestones and actions associated with PBC predominantly feature under the Better Health and Better Care sections. At a high level the key focus in the 26/27 plan can be summarised as follows:

All PBC commitments are drawn together in a summary and is included as Annex A. This "programme on a page" sets out the key milestones alongside the key metrics, baselines and performance expectations. The majority of these commitments are tracked through the PBC Programme Board, noting that pure primary care commitments sit more naturally with the Primary and Community Care Division. The scope of this paper is focused on the wider PBC areas rather than pure primary care eg GMS, Community Pharmacy, GDS, WGOS. Primary care will feature as separate updates to Committee and Boards with alignment with PBC drawn out as required

The Programme is framed around 10 key principles and objectives:

Place-Based Care Core Objective	Key Indicators – What Success Looks Like
1. Reduce Health Inequality	Improved healthy life expectancy in the most disadvantaged communities; a demonstrable narrowing of health outcome gaps between the least and most deprived areas.
2. Enable Coproduction & Citizen Voice	Empowered communities actively guiding services and policies, with citizens reporting meaningful involvement in decision-making. The health and care system "works with communities rather than on them," evidenced by community representation in governance and feedback loops driving continuous improvements.
3. Build Resilient & Connected Communities	Stronger, more connected communities, with greater social support, volunteering, civic activity, and local community leadership. This is reflected in increased community participation, enhanced social cohesion, and community-led health initiatives, all contributing to improved wellbeing.

4. Focus on Prevention & Early Intervention	People will access community support to build the foundations for better health. This will be evidenced by people living healthier lives for longer. Where care and support are needed this will be provided at an early stage for people at "rising risk" supporting identification and management of chronic conditions at earlier stages and reduce emergency presentations over time.
5. Establish Integrated Neighbourhood Teams (INTs)	Integrated local teams provide seamless, coordinated support close to home. Success is seen in more care delivered in community settings and improved continuity of care for complex cases.
6. Provide Care Closer to Home	Patients receive earlier access to community diagnostics and specialist treatment through integrated and accessible local services. This will be evidenced by a reduction in hospital admissions for preventable conditions. Reduced demand on acute and hospital services over time, due to increased capacity and capability in community-based care.
7. Streamline Access to Specialist Support	People and professional will have easier access to specialist expertise in the community experience in accessing care. This will be evidenced by more prudent referrals, shorter waiting times and higher satisfaction. Care pathways become more seamless and coordinated across primary, community, and specialist services reducing duplication and delays in treatment.
8. Strengthen Community Resources to Prevent Admissions & Support Discharge	Continue to right size community resources and intermediate care service in response to local need and ensure the right support is available at the right time to keep people well at home. This will be evidenced by fewer avoidable hospital admissions and shorter hospital stays, particularly for frail patients and those with chronic conditions. Success is demonstrated by declines in emergency admissions and timely, supported discharges, as community services manage more care in the home setting.

9. Support Leadership, Governance & Capacity for PBC	Effective multi-tier governance and sustainable resources for PBC. Measured by the functioning of the PBC Programme Board and ISPBs, cross-sector engagement at all levels, and dedicated programme capacity (e.g. senior programme manager in post). Over time, this yields accountable leadership for community health outcomes and persistent alignment of resources toward prevention and community care.
10. Promote Continuous Feedback, Transparency & Learning	A system that continuously learns and adapts, reflected in regular evaluations showing improvements in population health and equity metrics. An outcomes and measurement framework tracks progress in wellbeing, preventable harm, and inequalities, ensuring that the programme stays focused on health improvement and equity.

The approach set out has been shaped by the following engagement and expertise:

- Board development sessions
- Executive Team Timeouts, one facilitated by the National Association of Primary Care
- Integrated Service Partnership Boards (ISPB) workshops
- Third sector (GAVO/TVA) engagement
- Regional Partnership Board (RPB) development workshop

These objectives are being taken forward in a phased approach as set out in section 5. Place Based Care is already being progressed purposefully across Gwent with key achievements summarised below:

Headline Progress to date	Key Achievements and Impact
Community Asset Mapping & Place Profiles	Development of 26 place profiles combining population need, services and community assets to support evidence-based planning and targeting of inequalities.
Integrated Wellbeing Networks (IWN's)	Strengthened alignment of IWNs towards PBC to support the connection of community networks connecting people to local assets and support, strengthening community resilience and improving access to preventative services.
Neighbourhood Care Networks (NCNs)	Orientated well established NCNs into PBC to provide clinical leadership and coordination across primary and community care, supporting more consistent neighbourhood-level service delivery.
Integrated Neighbourhood Teams (INTs)	Commenced introduction of INTs which will be core structures are now being implemented, enabling more proactive, coordinated and locally responsive care. See figure 6.
Frailty & Complex Care Multi-disciplinary Teams (MDT's)	Supported the delivery of multidisciplinary team (MDT) care for frail and complex adults across Gwent, supporting people to remain safely at home, maintain independence, and avoid unnecessary hospital admissions through proactive, coordinated care.
Older People's Pathway	Supported the delivery of an older people's pathway focused on early intervention, prevention and proactive support for the 0.5% population with the most complex needs, enabling people to remain independent at home and reducing avoidable hospital admissions.
Breathlessness Pathway	Development of early intervention and personalised support improving outcomes for people with chronic respiratory conditions and reducing escalation to urgent care.
Women's Health Hub	Supported improving access to women's health services through digital access, direct booking pathways, and expanded community-based provision, ensuring timely support closer to home and reducing reliance on hospital services.
Community Pharmacy & Optometry Expansion	Supported an increase in access to care closer to home through expanded common ailment, contraception, emergency medicine and enhanced optometry services.
Single Point of Access & Community Clinical Desk	Supported the SPoA to deliver a place-based care approach by providing a coordinated gateway to health, social care and community services, ensuring timely access to the right support, promoting independence, and reducing avoidable hospital admissions.

Governance & Leadership	Strengthened governance arrangements across regional and local partnerships, improving accountability, decision-making and oversight of delivery. Community by Design principles embedded within existing Place Based Care governance, reducing duplication and strengthening delivery through established local structures.

5. Governance and Accountability

A Place Based Care Programme Board has been established under the leadership of the Executive Director for Public Health and provides strategic oversight, strengthens accountability and aligns delivery of Place Based Care, Community by Design and the Integrated Community Care System across Gwent, supporting the shift towards prevention, care closer to home and integrated neighbourhood-based care.

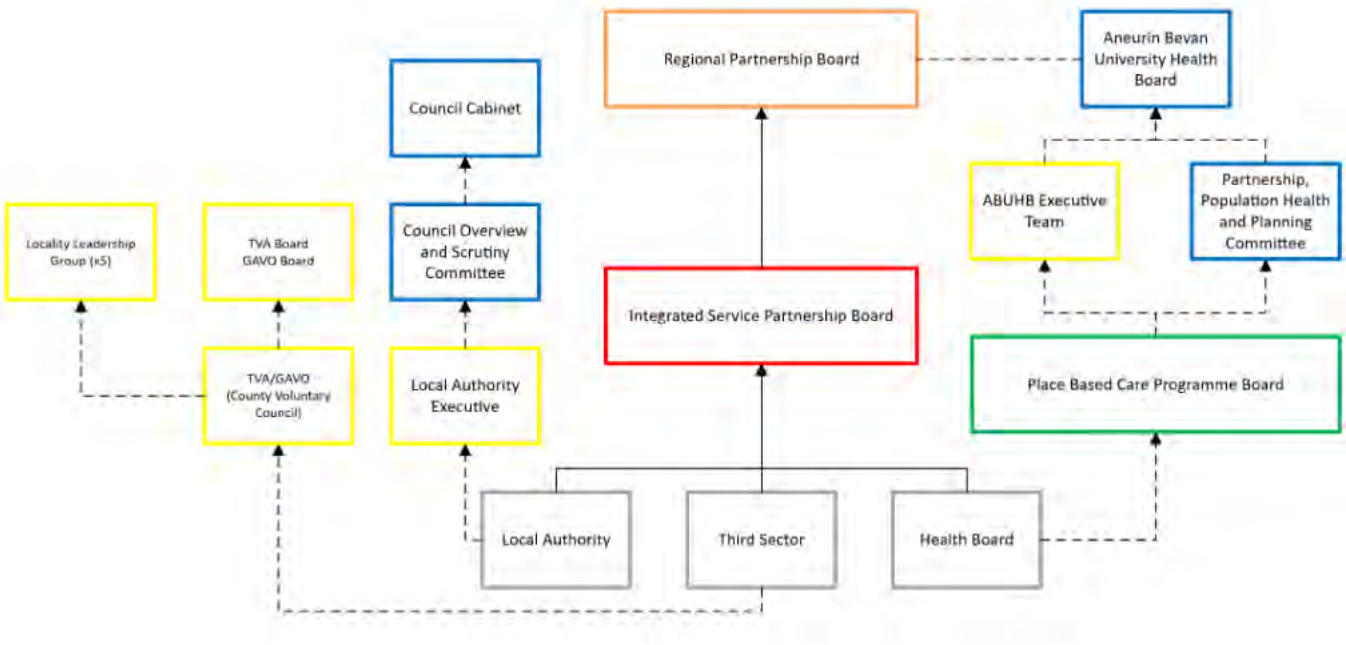


Figure 1 - Place Based Care Programme Governance Framework

The programme is established across three key phases, aspects of which will run concurrently rather than sequentially. The table below describes the key focus and expected deliverables at each stage, providing a clear roadmap from establishing governance and programme foundations through to local implementation and delivery. This phased approach is designed to ensure a consistent strategic framework, informed by place-based intelligence and supported by robust planning, workforce alignment and performance monitoring

Phase	Focus	Key deliverables
DISCOVERY: Timeframe – immediate Purpose - Establish vision & grip	Confirm governance, ownership and programme capacity; agree the common model design brief; complete	➢ Named SROs and leads ➢ Terms of reference ➢ Integrated plan

	baseline stocktake across ISPBs.	➢ Consistent baseline template ➢ Confirmed decisions and risks.
DESIGN: Timeframe – Near term Purpose - Design and test models	Complete the model, use place intelligence to test it against local circumstances and identify quick wins through better alignment of existing roles and pathways.	➢ Draft operating model ➢ Initial place profile ➢ Local gap and overlap analysis Agreed tests of change ➢ Benefits measures.
DELIVERY: mobilise	Translate the model into costed ISPB plans and begin implementation through frontline teams and skilled change agents.	➢ Five delivery plans @ ISPB level ➢ Workforce transition actions ➢ Resource-shift proposals ➢ Routine dashboard and exception reporting

Underpinning these phases are a number of enabling workstreams. These workstreams will be commissioned to undertake key pieces of work as the phases progress.

Enabling Workstreams	Lead
Communication & Engagement	Head of Strategic Communications - Public Health
Data, Digital & Technology	Director of Digital
Estates & Facilities	Director Estates and Facilities
Finance	Assistant Director of Finance
Intelligence & Evaluation	Head of Public Health / Head of Business and Performance
Workforce & Organisational Development	Deputy Director of Workforce

For the Board, it has a critical role in creating the conditions necessary for successful implementation of PBC. Beyond the programme team's responsibilities, the Board can strengthen delivery by:

- Providing strategic leadership by consistently reinforcing PBC as the primary organising framework for improving population health, reducing inequalities, and delivering integrated care across Gwent.
- Driving whole-system alignment by ensuring that organisational priorities, programmes, partnerships, and resources are aligned to a shared vision for PBC.
- Enabling delivery through governance and investment by supporting sustainable workforce models, appropriate financial arrangements, and effective governance structures that underpin long-term transformation.
- Championing prevention and collaboration by promoting community-centred, preventative approaches and fostering a culture of partnership across health, local government, third sector organisations, and communities.
- Providing visible oversight and assurance through established governance and scrutiny mechanisms, ensuring progress is monitored, risks are managed, and delivery remains focused on achieving population health outcomes

The following section focuses on some of the key deliverables above.

6. PROGRESS AGAINST PHASES

6.1 Operating model

The delivery of PBC offers a shift from current operating arrangements. As part of the Design Phase set out above, the PBC Programme has developed a three-tier operating model for Gwent, with a universal core offer and proportionate local variation based on population need, existing assets and each ISPB's starting point. The sets out key components of the PBC operating model:

Table 2: Operating model

Tier	Core offer	Primary delivery arrangements	Practical focus
1. Community wellbeing	Community groups, volunteering, peer support, leisure, housing support, financial inclusion and community assets.	IWNs, local authorities, third sector and community anchor organisations.	Strengthen protective factors, resilience, social connection and early support.
2. Community navigation	A coordinated navigation function connecting residents to health, care, wellbeing and community support. Different roles may remain, but the public should experience a coherent route to support.	Community Navigators, Health Coaches, Community Connectors and Social Prescribers, aligned through local arrangements.	Reduce duplication, improve access and help people reach the right support earlier.
3. Integrated neighbourhood delivery	Proactive, multidisciplinary support for population groups with complex or escalating needs.	INTs aligned with primary care, community services, social care, mental health, public health and the third sector.	Frailty, long-term conditions, inclusion health, prevention of deterioration and coordinated care closer to home.

6.2 Understanding Communities and Place

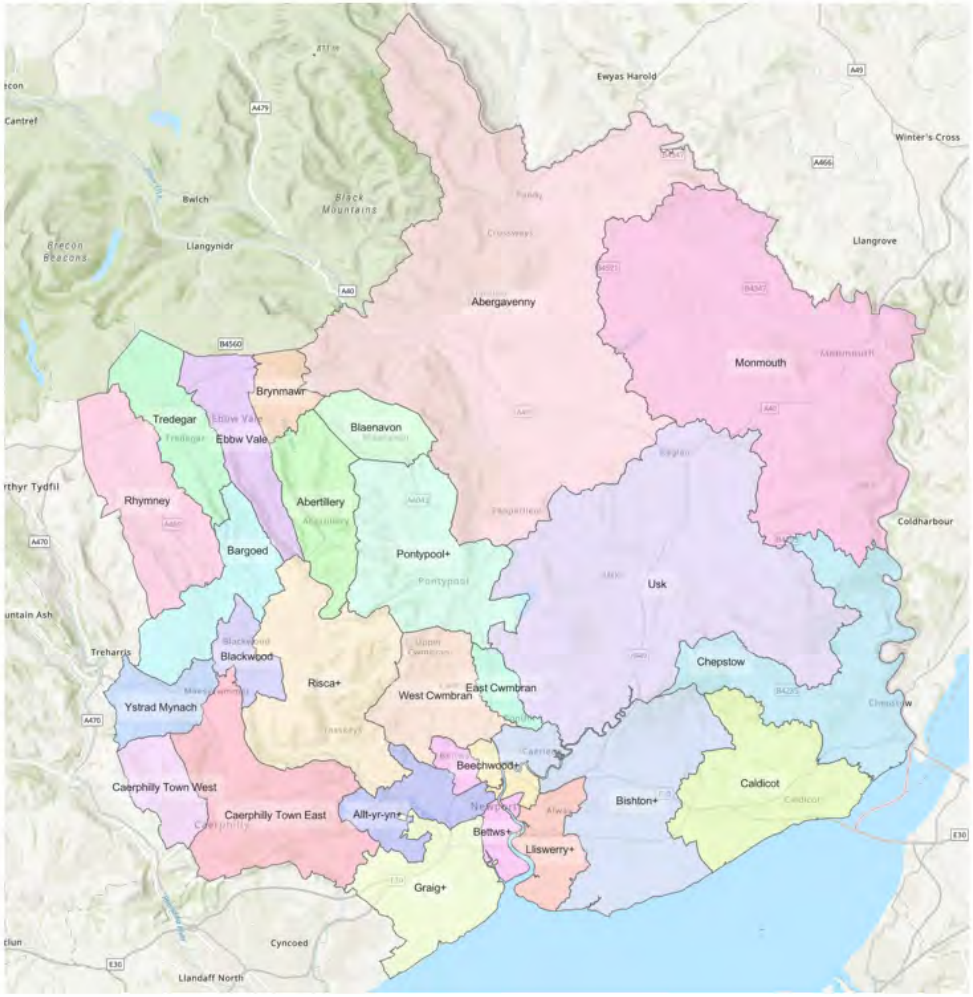
A key deliverable under the Design phase is the development of a suite of comprehensive profiles for each of the 26 agreed places across Gwent (Figure 2). Identified through the ISPBs, these profiles provide a consistent, evidence-based picture of local population need and context, combining data on demographics, health and wellbeing, housing, education, skills and economic factors. They also capture community strengths and social networks, reflecting an asset-based approach that highlights what supports wellbeing as well as areas of need. Mapping of local facilities, services and community anchors offers a full view of each place's infrastructure, supported by IWNs to ensure lived experience informs priorities and delivery.

Together with indicators such as Healthy Days at Home, the place profiles provide a robust foundation for proportionate, evidence-led decision-making, enabling partners to target resources effectively, reduce inequalities and build on the strengths already present within Gwent's communities.

Figure 2: Place Based Care agreed places and proposed boundaries

Place Based Care agreed places and boundaries

ISPB	NCN	Places
Blaenau Gwent	Blaenau Gwent	• Ebbw Vale • Tredegar • Brynmawr • Abertillery
Torfaen	Torfaen	• Blaenavon • Pontypool & Abersychan • East Cwmbran (Ponthir & Llanfrechfa CC and Croesyceiliog & Llanyrafon CC) • West Cwmbran (Henllys CC & Cwmbran CC)
Caerphilly	Caerphilly North Caerphilly East Caerphilly South	• Rhymney • Bargoed • Newbridge/Risca • Pontllanfraith • Ystrad Mynach • Caerphilly Town East • Caerphilly Town West
Monmouthshire	Monmouthshire North Monmouthshire South	• Abergavenny • Monmouth • Usk • Caldicot • Chepstow
Newport	Newport East Newport West	• Allt-yr-yn/Rogerstone North/Rogerstone West/Rogerstone East • Bettws/Stow Hill/Victoria/Pillgwenlly • Graig/Gaer/Tredegar Park and Marshfield • Beechwood/St Julians/Shaftesbury/Malpas • Lliswerry/Ringland/Alway • Bishton and Langstone/Caerleon/Llanwern



Bargoed, in Caerphilly, was the first area profile developed to show how population data, service profiles, community assets and wellbeing resources can be combined to create a rounded understanding of a place. It is a community rich in heritage, with strong anchors such as schools, voluntary groups, faith organisations, sports clubs, green spaces and active community hubs, alongside a resilient high-street identity. The profile emphasises local strengths, illustrating how heritage, assets and social infrastructure shape community resilience and support more preventative, community-centred delivery. This approach is now being applied across all 26 places, with additional resource required to develop and sustain place profiles at scale.

Figure 3: Bargoed, Caerphilly (example profile)

In addition to the asset mapping (summarised above) population health data is summarised at borough (figure 4) and where available, place level (figure 5). This is critical to support local identification of need.

Figure 4: Example of Population Health Data

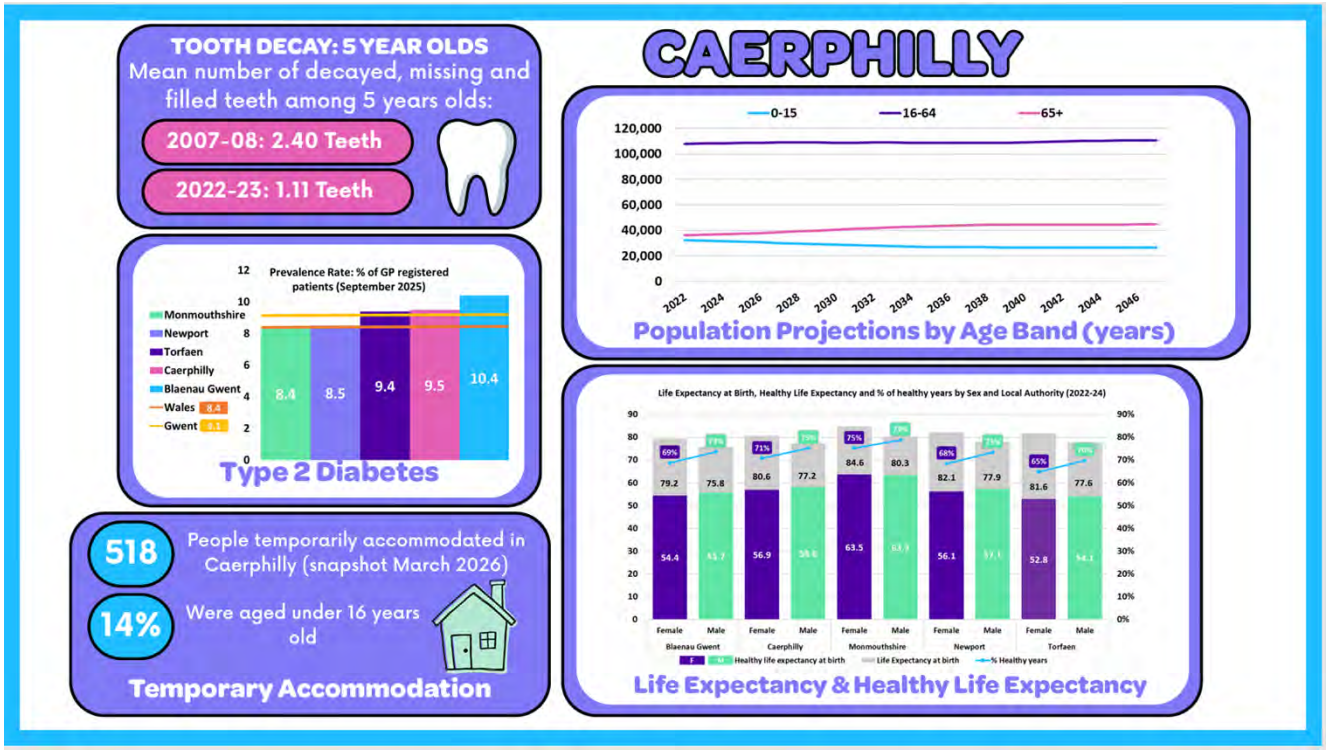
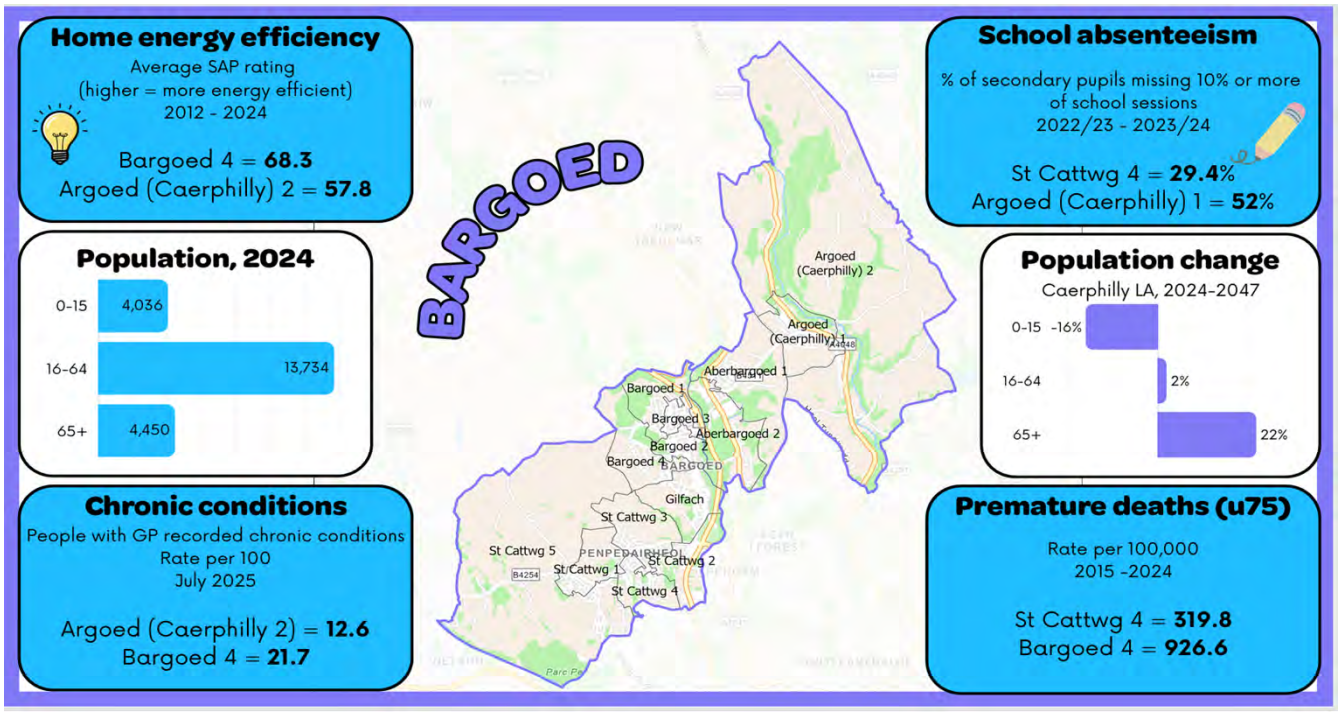


Figure 5: Example of Population Health Data



Strengthening the intelligence base for Place Based Care in Bargoed gives neighbourhood teams a clearer understanding of the factors shaping local health and wellbeing. By analysing patterns in health outcomes, wider determinants and population change, the system can identify where need is greatest and intervene earlier with support that reflects the realities of people's lives. This enables more timely help, better continuity for those with complex needs and more effective planning for future demand as the population evolves. Overall, this intelligence helps reduce inequalities, improve long-term outcomes and build a more resilient and connected Bargoed.

Based on this insight, the Integrated Neighbourhood Teams will take forward a proactive, neighbourhood-level model of support. They will identify people with rising risk and emerging frailty, strengthen continuity for those with long-term conditions, and improve access and navigation across community services. Working closely with partners, the INTs will address wider determinants such as housing, financial insecurity and educational engagement to ensure residents receive coordinated, practical support that meets local need. By focusing on prevention, early intervention and joined-up working, the INTs will reduce avoidable crises, improve outcomes and strengthen community resilience across Bargoed.

The completing of these profiles at all 26 places is underway and will support the ISPBs in developing a full understanding of need, gaps and opportunity.

6.3 Developing Integrated Neighbourhood Teams (INT)

As part of the emerging operating model, INTs, supported by IWNs are a key delivery component of PBC. The intent is for each place to be supported by a core team of generalist professionals who work collaboratively to identify needs, coordinate care and provide timely support. Integral to the model is the ability to connect individuals with neighbourhood networks, community assets and wider sources of support, recognising that health and wellbeing are influenced by a range of social factors. Dedicated roles, such as Social Prescribers, Wellbeing Connectors and Health Coaches, help individuals access these resources and build resilience. Underpinned by a strengths-based approach, Integrated Neighbourhood Teams aim to empower people to lead happy independent and fulfilling lives, while improving health outcomes and reducing reliance on acute services. It brings together previously siloed teams into a single, coordinated approach, fostering a shared sense of ownership and accountability for local population health outcomes.

The development of INTs and IWNs provides the operational foundation for delivering Place Based Care across Gwent. To support consistent implementation, a regional delivery framework has been established to translate strategic intent into measurable action.

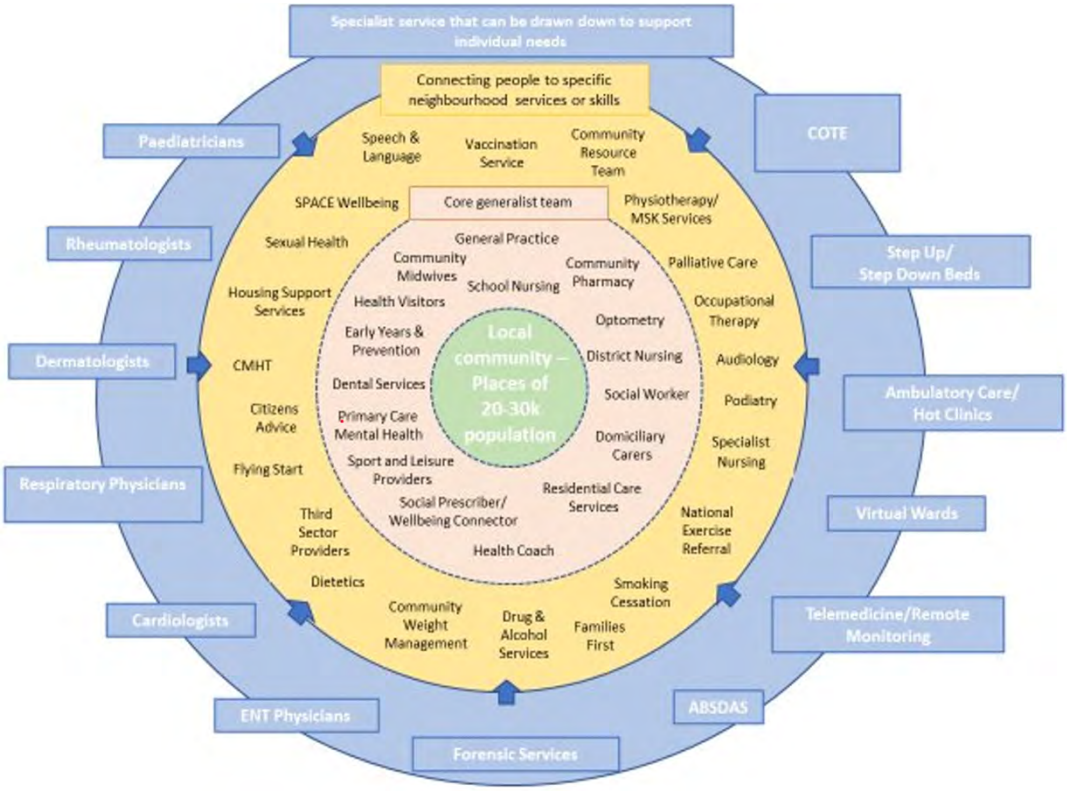


Figure 6: Integrated Neighbourhood Teams (INT's)

Delivering this model requires a sustainable, community-focused workforce capable of supporting prevention, early intervention, and coordinating neighbourhood-based care. Key roles include MDT Coordinators, Health Coaches, PHP's, First Contact MSK Practitioners, and IWN staff, all of whom play a critical role in shifting the system from reactive care towards proactive, preventative support.

Many of these roles are currently funded through time-limited investment streams that are due to end in 2027. To support the long-term sustainability of PBC, a comprehensive workforce review will be undertaken in order to inform the development of a sustainable and equitable workforce plan, ensuring that workforce capacity, capability, and investment are aligned to future service needs and population outcomes across Gwent.

In terms of establishment of INTs, they are being introduced in phases, aligning teams around natural neighbourhood footprints and building on existing multidisciplinary working. Early implementation focuses on establishing core membership, shared operating practices and neighbourhood-level coordination. Initial INTs are forming in areas with established collaboration, with learning informing wider rollout. Service

Improvement Managers are being funded to provide day-to-day coordination and improvement support to drive consistent, effective INT delivery across neighbourhoods.

7. Delivery assurance

Whilst still undergoing development, assurance is provided to the PBC Programme Board via a single exception-based dashboard covering delivery milestones, named accountability, finance and affordability, workforce and funding risks, dependencies, decisions required, outcome and benefit measures, and variation across the five ISPB areas. This provides a clear line of sight from neighbourhood action to system outcomes and enables the Board to distinguish progress in engagement and design from demonstrable implementation.

At a Health Board level, as set out above, the Annual plan set out performance expectations against a number of key metrics against the theme of Place Based Care. Many of these metrics are driven by national and ministerial expectations and are activity or process measures. Delivery against these metrics and actions is summarised in the Integrated Performance Report (IPR) presented to each board under the PBC section. The PBC Programme continues to develop a more effective suite of indicators which will focus more on outcomes and be available at place level. Delivery against the Annual Plan key performance metrics is included in the IPR but can be summarised as follows:

- Strong growth in community-based care, with Community Pharmacy (PIPS, CAS) and NHS Optometry all exceeding planned activity levels.
- Common Ailment Scheme significantly outperforming trajectory, reflecting increased uptake and public awareness.
- Community Pharmacy services continuing to expand, helping divert demand from GP and hospital services.
- Optometry services delivering above plan, demonstrating effective use of primary care alternatives.
- Continued progress in delivering care closer to home, reducing reliance on traditional acute settings.
- Performance remains mixed across community and urgent care pathways.
- Emergency dental activity remains below trajectory following implementation of the new NHS Wales dental contract.
- Community nursing capacity is improving, but remains below Ministerial expectations.

- Rapid Response referrals and palliative care assessments are slightly below planned levels.
- GP referrals into Rapid Response remain below trajectory, indicating further opportunities to strengthen access routes.

Additional assurance - Formative Evaluation

In March 2026, the Health Board commissioned the National Association of Primary Care (NAPC) to undertake a formative evaluation of the PBC Programme. The formative evaluation concluded that the system in Gwent is strongly aligned around the need for change with widespread consensus. The evaluation team found that PBC is consistently viewed as the most credible mechanism for delivering the shift towards prevention, partnership and place. However, confidence in the programme was described as "conditional" with some uncertainty about grip, ownership and delivery power. It was felt that the programme needed to move decisively from ambition to execution with simultaneous top-down and bottom-up action. It was suggested that this would require a permissive culture, simplification of governance, shift in resources and protection for the PBC programme during periods of operational pressure. They also highlighted the importance of redesigning care around real communities, neighbourhoods and the frontline operational reality. These findings were presented to the Programme Board, providing early insights into the programme's development and impact, and informing future implementation and evaluation arrangements.

Development of the 26 place profiles will continue, combining population intelligence, service mapping and community insight to support evidence-based decision-making and targeted action to reduce inequalities.

This intelligence will inform the accelerated development of INTs, supported by a common operating framework that defines core functions, workforce requirements and governance arrangements whilst allowing flexibility to reflect local circumstances. Together with IWNs, INTs will deliver more coordinated, preventative and person-centred support.

This marks the transition from strategic development to implementation. With a shared delivery framework and robust place intelligence, the programme is well positioned to deliver the ambitions set out in Gwent 2035, Community by Design and the Integrated Community Care System.

The PBC Programme has identified a number of key risks:

- Workforce sustainability: The absence of a sustainable workforce model may hinder the ability to maintain and scale key preventative and community-based functions, particularly where roles remain dependent on time-limited funding arrangements.
- Variation in provision: Inequitable access to Multi-Disciplinary Team (MDT) Coordinators, Health Coaches, Psychological Health Practitioners (PHP), First Contact Musculoskeletal (MSK) Practitioners and IWN staff across boroughs may result in inconsistent delivery, unequal outcomes and widening variation in access to support.
- Insufficient investment in prevention: Failure to shift resources upstream towards prevention, early intervention and community wellbeing may constrain the system's ability to reduce demand, improve population health and realise the intended benefits of PBC.
- Programme misalignment: Lack of alignment with wider transformation and service improvement programmes may create duplication, fragmentation and competing priorities, reducing the overall coherence and impact of delivery.
- Limited strategic planning for community infrastructure: Without coordinated workstreams to map Health and Wellbeing Hub provision, identify gaps and align future capital and estate planning, there is a risk that physical infrastructure will not adequately support the development of community-based, preventative models of care.

The Programme Board and ISPBs will be responsible for identifying and managing these risks throughout each phase of implementation.

8. Next Steps

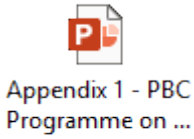
In terms of next steps, the programme is rebalancing focus from Discovery and Design phases to Design and Delivery. Key next steps include:

- Regional launch — Bring partners and communities together to build awareness, share progress and reinforce collective leadership.
- Place profiles — Finalise 26 profiles to guide evidence-based decisions, target inequalities and strengthen community wellbeing.
- INT rollout — Establish a common operating framework, core functions, workforce needs and governance for INTs across all localities.
- Neighbourhood delivery — Use intelligence and community insight to develop INTs/IWNs that deliver coordinated, preventative, person-centred care.

- Shift to implementation — Continue moving from planning into active delivery, with partners already applying the PBC model in practice and progressing the ambitions of Gwent 2035, CbD and the ICCS.
- Based on above – developed costed implementation plan to enable delivery of PBC. To be tested with Executive Committee in October.

9. ANNEXES

Annex A Place Based Care – Programme on a Page (Annual Plan March 2026) and Highlight report



Annex B – Implementation Plan

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

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

Programme on a Page

Programme on a Page 2026/27

Programme Title	Place Based Care Programme						
Programme Aims & Objective	Build resilient and connected communities, reduce health inequalities, reduce preventable morbidity and mortality, provide care and support closer to home and streamline access to specialist care by bringing together members of the community, organisations, services and teams who are responsible for the health and well-being of the population/community within a place.						
Executive Lead	Tracy Daszkiewicz	**SPM**	Kate Williams	**SRO**	Lloyd Hambridge	**Workforce**	TBC
Finance	Chris Commins						

Workstreams & Priorities	Key Deliverables	Intended Benefits *(include KPIs, Finance and Performance data)*	Interdependencies & Risks
• Intelligence & Evaluation • Communication & Engagement • Estates & Facilities • Digital, Data & Technology • Financial Strategy • Workforce Development	Establish Place-Based Care (PBC) and Population Health Management (PHM) operating model – Agreed and implemented across ISPBs and neighbourhoods, including linked health, social care and wider determinants datasets. Core-funded neighbourhood workforce models – Decisions and implementation for IWN Leads, CIOs, Health Coaches, MDT Coordinators, PHPs and Diabetes Prevention Programme. Single, accessible digital and community asset directory – A Gwent-wide platform providing clear routes to wellbeing support, social prescribing and community assets, co-maintained with Third Sector partners. Strengthened community infrastructure and engagement model – IWN collaboratives embedded, community anchor organisations identified and supported, and residents actively shaping local priorities. Development of new models of care for earlier access and prevention – Including Inclusion Health and peer support models, women's health at place level, and initial pathways (e.g. breathlessness).	Reduced health inequalities and preventable demand – Targeted interventions in areas of greatest deprivation using PHM intelligence and local data. Care delivered closer to home – Improved access to prevention, assessment and support through neighbourhood MDTs, social prescribing and community services. Improved system flow and reduced pressure on acute services – Alignment with UEC Improvement and Stabilisation Plan, supporting earlier escalation prevention and timely discharge. More efficient and sustainable use of resources – Reduced duplication through consistent models, clearer workforce roles and shared digital infrastructure. Stronger investment case for place-based prevention and early intervention – Clear articulation of foundational, enabling and legacy roles supporting long-term population health outcomes.	Workforce funding and sustainability decisions – Risk of delivery gaps if core funding decisions are delayed or inconsistent across 26/27 and 27/28. Data availability, linkage and digital capability – Dependency on timely access to high-quality linked datasets and functional digital platforms. System alignment and governance clarity – Risk of duplication or slowed delivery without clearly embedded governance across RPB, ISPBs and the PBC Programme Board. Third Sector and community capacity – Reliant on the capacity and resilience of community anchor organisations, particularly in deprived areas. Implementation pressure and variable local implementation – Risk of uneven delivery across Gwent if engagement, communication and support for places and neighbourhoods is inconsistent.

Programme on a Page 2026/27

Programme Title	Place Based Care Programme							
Programme Aims & Objective	Build resilient and connected communities, reduce health inequalities, reduce preventable morbidity and mortality, provide care and support closer to home and streamline access to specialist care by bringing together members of the community, organisations, services and teams who are responsible for the health and well-being of the population/community within a place.							
Executive Lead	Tracy Daszkiewicz	**SPM**	Kate Williams	**SRO**	Lloyd Hambridge	**Workforce**	TBC	**Finance**	Chris Commins

Key Milestones

Q1/Q2

- Request to permanently core fund IWN Lead and CIO roles across Gwent.
- Seek agreement to core fund Health Coaches, MDT Coordinators, PHP's and the Diabetes Prevention Programme in 26/27
- Align PBC with UEC Improvement and Stabilisation Plan 2026 / 27 – oversight of delivery and milestones via UEC Programme Board – 5 Pillars, Our Next Patient, Discharge
- Review Governance Structure RPB, ISPB and Place Based Care Programme Board and Partnerships
- Establish a PHM operating model across the partnership.
- Work on ensuring linked datasets are available
- Use existing linked datasets within the data warehouse to identify cohorts at risk
- Blaenau Gwent/Torfaen ISPB to present PBC model to AB Execs
- Undertake a review to assess whether the First Contact MSK model is being delivered equitably across Gwent
- Deliver an Exec Time Out session to confirm strategic direction, priorities and enablers

Q3/Q4

- Build or enhance a digital platform providing: Easy access to wellbeing and community information; Clear routes to request support or link worker contact
- Agree approach to a single, accessible directory of community assets, co-maintained with Third Sector partners
- Confirm IWN Leads as local coordinators of community support systems in each place/neighbourhood
- Maintain and strengthen IWN collaboratives
- Formalise IWN Leads as the operational link between ISPB priorities and neighbourhood delivery
- ISPBs identify existing and potential community anchor organisations, prioritising growth in deprived communities
- Use Public Health data and local intelligence to identify: Variations in community capacity between places; Areas with the greatest inequality or disadvantage
- Use IWN Leads and CVCs to: Support meaningful community engagement and participation; Enable residents and community groups to shape local priorities
- Scope Inclusion Health and peer support models, focusing on lived experience, MH and addictions
- Develop outline business case for paid peer roles (e.g. community link workers) – led by Public Health
- Begin development of new models of care for earlier access to assessment, diagnostics and diagnosis e.g. breathlessness pathway
- Seek decision to core fund Health Coaches, MDT Coordinators, PHP's and the Diabetes Prevention Programme in 27/28
- Establish a consistent and equitable MDT Coordinator model across Gwent
- Agree and embed a consistent social prescribing model across all places
- Embed the Women's Health Plan at place level, ensuring equitable access and improved outcomes
- Launch or implement the single Gwent-wide directory of community assets
- Ensure alignment with social prescribing and IWN delivery
- Embed updated governance arrangements across ISPBs, Place-Based Care and partnership structures
- Confirm accountability for IWN delivery, digital platforms and community engagement
- Finalise Inclusion Health peer support business case for decision-making
- Prepare transition plans for sustained delivery into 2027/28

Place Based Care and Population Health Programme

Exec Lead: Tracy Daszkiewicz

SRO: Lloyd Hambridge

Reporting Period: Q1 2026/2027

Programme Objective

Build resilient and connected communities, reduce health inequalities, reduce preventable morbidity and mortality, provide care and support closer to home and streamline access to specialist care by bringing together members of the community, organisations, services and teams who are responsible for the health and well-being of the population/community within a place.

What Went Well this Period

- SBAR and implementation plan presented to the PBC Programme Board (17th April) and approved by Executive Committee (7th May) on Advancing Place Based Care across Gwent.
- Development of a deliverable programme plan with workstream leads following Executive Committee approval of the overarching implementation plan.
- Ongoing engagement with Blaenau Gwent / Torfaen, Caerphilly, Newport and Monmouthshire ISPBs to progress development of Place Based Care operating models in each borough.

Key Milestones and Deliverables for the Next Period

- Facilitate a Place Based Care Implementation Workshop with Programme Board members to progress implementation across the agreed places, in line with the Executive-approved implementation plan. An agreed action plan will be developed from the workshop to support delivery and accountability.
- Develop a communications and engagement plan to support Place Based Care implementation, including public-facing messaging, agreed language and key communications materials to raise awareness and understanding amongst stakeholders and communities.
- Produce an interactive Place Based Care map, showcasing the agreed places and supporting improved visibility of local assets, services and community resources.
- Develop a place-based intelligence framework, including a core set of indicators aligned to defined statistical geographies (electoral wards mapped to MSOAs), enabling the creation of comprehensive place profiles through the integration of demographic, health and administrative data to support planning, targeting and evaluation.
- Continue community asset mapping and capacity-building activities across each place, working with Integrated Services Partnership Boards (ISPBs) to strengthen community anchors and support the development of local hub networks.

Key Risks

- Financial pressures across NHS Wales - Ongoing and escalating financial pressures may limit the ability to invest in, sustain and scale place-based care, with short-term acute and statutory priorities reducing capacity for preventative and community-based transformation.
- Stakeholder engagement and system alignment - Variable engagement, differing organisational priorities and unclear roles across partners may lead to fragmentation, duplication or delays in implementing place-based care.
- Resource and workforce constraints - Workforce shortages, skills gaps and limited system capacity may constrain delivery, particularly at neighbourhood level, and reduce staff ability to engage in transformation activity.
- Public perception and confidence - Place-based care may be perceived as a reduction or withdrawal of services, with poor communication risking loss of public trust, engagement and support.
- Population growth, ageing and multi-morbidity - Increasing demand driven by population growth, ageing and rising complexity may outpace the system's ability to respond, even with place-based models in place.

Workstream RAG Ratings

- Workforce Development
- Financial Strategy
- Digital Data & Technology
- Estates & Facilities
- Communication & Engagement
- Intelligence & Evaluation

Intended Benefits *(include KPIs, Financial and Performance)*

Reduced Health Inequalities
- Services designed around local population need, targeting deprivation, protected characteristics and unmet need within neighbourhoods.
- Improved equity of access to prevention, early intervention and community support.

Reduced Preventable Morbidity and Mortality
- Earlier identification and management of long-term conditions and frailty.
- Strengthened prevention and population health management approaches.

Care and Support Delivered Closer to Home
- Shift from acute/hospital-centric models to integrated community-based provision.
- Improved continuity of care across primary, community, local authority and third sector services.

Improved System Integration and Collaboration
- Stronger alignment between NHS, local authorities, primary care clusters, voluntary sector and community assets through ISPBs.
- Reduced duplication and fragmentation of services.

Improved Access to Specialist Care
- More streamlined referral pathways with clearer escalation and step-up/step-down models.
- Specialist input targeted to those with the greatest need.

More Resilient and Connected Communities
- Empowered communities actively involved in co-production

High level objective	Immediate priorities	2026/2027				2027/2028			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Reduce Health Inequalities **Place Based Care will target the root causes of poor health by focusing on prevention, early intervention, and community led solutions.**	Shift the focus towards prevention and earlier intervention starting with a systematic approach for connecting people to community support, particularly socially vulnerable groups experiencing health inequalities.								
	Establish Population Health Management as the cornerstone of a data-driven approach that improvement population health by identifying at risk cohorts, enables proactive and preventative care and reducing health inequalities by optimising resource allocation.								
Coproduction and Citizen Voice **Communities shape priorities, design solutions, and evaluate impact.**	Embed a place-based wellbeing collaborative that bring together partners and communities to strengthen local skills, resources, and relationships that enable local residents to thrive.								
	Create the conditions for good health in communities through the development of well-being collaboratives made up of communities and professionals to co-produce solutions to improve that community's health and well-being.								
Build Resilient and Connected Communities **Communities are partners, not recipients – with wellbeing networks, assets, and local leadership strengthened.**	Strengthen community wellbeing by aligning capacity, resources, and roles across ISPB partner organisations—public sector, voluntary sector, and community groups—to build on existing assets and respond to local needs.								
	Strengthen the Health Inclusion Service so it can effectively meet the needs of socially vulnerable groups (e.g. people experiencing homelessness, people with substance misuse problems, asylum seekers and refugees)								
Focus on Prevention and Early Intervention **Prevention becomes a shared responsibility across INTs, NCNs, Public Health, and community partners.**	Introduce a Health Coach team who can provide low intensity, high volume brief intervention for people with or at risk of cardiovascular disease and diabetes and proactively engage with vulnerable populations to access preventative programmes.								
	Embed Behaviour Change Practitioners in NCNs to deliver targeted, evidence based support that helps people adopt healthier behaviours and improve long term outcomes, with tailored interventions for those who face the greatest barriers to good health.								
	Establish an integrated and systematic CVD Risk Factor Management Service and Diabetes Prevention Programme based on the ABCD+ approach recommended by PHW and the Wales Cardiovascular Disease Network.								
Integrated Neighbourhood Teams (INTs) **INTs are the engine of Place Based Care – multidisciplinary, multiagency, and locality led.**	Create activated INTs as the core delivery unit for Place Based Care with a collective ethos based on the Balancing Rights and Responsibilities principles. (Blaenau Gwent & Torfaen initially)								
	Establish MDT working in each INT to coordinate holistic, person-centred, proactive care particularly for the "rising risk" cohort. **(Blaenau Gwent & Torfaen initially)**								
Streamline Access to Specialist Support **Make it easier for people and professionals to navigate the system.**	Continue to develop the Single Point of Access (including the Community Clinical Desk) in order to streamline and simplify access to intermediate and ambulatory care, providing a safe and appropriate alternatives to hospital admission.								
	Create new models of care that enable earlier access to assessment, diagnostics and diagnosis, initially through development of the breathlessness and women's health services.								
	Expand the capacity and range of service provided through Community Pharmacy and Optometry services.								
Provide Care Closer to Home **Shift activity from hospital to community settings through integrated, proactive, and accessible local services.**	Mainstream the Psychological Health Practitioner Service to improve access to psychosocial assessment primary care to demedicalise common mental health problems and ensure prudent referrals into mental health support service and released GP capacity for more complex patients.								
	Establish First Contact MSK Practitioner provision to enhance the existing Move Better Gwent model, in line with the All-Wales MSK Strategic Network service specification for an integrated MSK service.								
Strengthen Community Resources to Prevent Avoidable Admissions & Optimise Discharge **Ensure the right support is available at the right time to keep people well at home.**	Continue to rightsize community resources and intermediate care service in response to local need.								
	Fully implement the Directed Supplementary Service (DSS) for Multi morbidity and Frailty, enabling proactive identification and personalised management of the 0.5% highest risk cohort								
Promote Continuous Feedback, Transparency & Learning **A learning system that adapts, tests, and improves.**	Enhance the community diabetes model, improving uptake of essential care processes, strengthening early intervention pathways, and ensuring that all population groups, including those experiencing exclusion and inequality, can access high quality, person centred care.								
Support Leadership, Governance & Capacity for Place Based Working **Clear accountability, empowered local decision making, and strong system leadership.**	Ensure senior leadership commitment to ISPBs with delegated authority for Place Based Care in each locality.								
	Continue to build professional leadership for Place Based Care through the Public Health Team, NCNs and professional collaboratives.								
	Continue to embed the governance structures for the planning and delivery of Place Based Care across the Gwent region.								

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 September 2026
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Integrated Performance Report: September 2026 Board
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Director of Strategy, Planning and Partnerships Sarah Simmonds, Director for Workforce and OD Jennifer Winslade, Director of Nursing Robert Holcombe, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Trish Chalk, Assistant for Director Planning and Performance Paul Steynor, Head of System Planning and Performance Caroline Norris, Senior Performance Management Analyst

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation The purpose of this report is to provide the Board with an integrated overview of performance against the key Health Board and Ministerial Priorities as outlined in the Annual Plan 2026/27, with performance figures including the most up-to-date, validated positions. An appendix is also included detailing the progress against the Annual Plan Milestones as of Q1 26/27. The Board is asked to:

- Note the progress against key performance metrics as of the latest, available validated information,
- Note the insight and actions identified in context of performance achievement, and;
- Note the progress against the Annual Plan Milestones as of Q1 (included as an Appendix)

Cefndir / Background

The report focuses on performance against the organisation's key priorities in line with the Heath Board's 2026/27 Annual Plan. The Integrated Performance Report is structured across the following sections:

Section 1:	• Performance Summary & Ministerial Delivery Expectations
Section 2:	• Performance by Theme o Population Health and Prevention o Place Based Care o Timely Access to Care – Urgent & Emergency Care o Timely Access to Care – Cancer, Planned Care & Diagnostics o Mental Health Access
	• Workforce
	• Quality & Patient Safety
	• Finance
Appendix	Enabling Actions Q1 Update

Asesiad / Assessment

Population Health and Prevention

Theme	On track	Off track within tolerance	Off track	Not yet reporting in year
Population Health and Prevention	2/14	3/14	0/14	9/14

Q1 2026/27 vaccination performance has not yet been published and therefore there are no new updates from the previous report.
For Q4 25/26 childhood vaccination coverage improved to 86.2%. In Q4 25/26, HPV vaccination uptake reached 70.7% in the same period, continuing the trend of improvement over the past five quarters. Significant work is underway to improve vaccination uptake across Gwent, including delivery of Vaccination Brief Advice training, a targeted MMRV improvement pilot across Newport and Torfaen GP Practices, and outreach initiatives with Gypsy and Traveller communities to reduce inequalities and improve access. Healthy Child Wales measures remain strong, with physical

examinations at six weeks consistently exceeding the 90% target and achieving 99.6% performance, while weight and measurement checks at eight weeks also remain well above target at 92%. Smoking cessation performance remains more challenging, with quit attempts marginally below trajectory and CO-validated quits significantly below target, although service redesign, community-based support and targeted communications are contributing to improving outcomes and a substantial increase in validated quits compared with the previous year.

Diabetes related measures show encouraging progress overall, with performance for all eight NICE diabetes care processes improving steadily and reaching 48.1%, slightly above the Q2 trajectory. Foot surveillance and urine albumin recording has also improved compared with historical performance but remain below planned trajectories, prompting continued improvement work through the Foot Care Project, gestational diabetes initiatives and pathway reviews. The Urine ACR project has now concluded successfully, with more than half of participating practices achieving significant improvements in compliance. Meanwhile, engagement with the Melo wellbeing website has remained relatively stable, with performance becoming more consistent than in previous years, although visits have fallen slightly below trajectory during June and July despite plans to expand content and promotional activity.

Place Based Care

Theme	On track	Off track within tolerance	Off track
Place Based Care	3/9	5/9	1/9

Place Based Care Services continue to demonstrate positive performance across a number of primary and community care measures. Pharmacist Independent Prescribing Service (PIPS) consultations and Common Ailment Scheme (CAS) activity both show sustained improvement, supported by service expansion and increased public awareness, with CAS significantly exceeding its Q1 trajectory. NHS Optometry Services also performed strongly, comfortably exceeding planned levels of activity. These achievements highlight the continued shift towards care delivered closer to home and the successful utilisation of community based services to manage demand that might otherwise present to general practice or hospital settings.

Performance is more mixed across Community and Urgent Care pathways. Emergency dental activity remains significantly below trajectory following implementation of the new NHS Wales dental contract, which has redirected urgent appointments into general dental practices. Community nursing capacity is improving but remains behind the level required to meet Ministerial expectations, while Palliative Care assessments, Rapid Response referrals and GP referrals into Rapid Response are all slightly below planned trajectories. Urgent Primary Care activity remains stable but is also marginally behind target. Improvement efforts are focused on reducing barriers to Rapid Response access through the Urgent and Emergency Care transformation programme, strengthening integrated Community services, and continuing to expand alternative care models that

support people to remain independent and receive care in Community settings, wherever possible.

Timely Access to Care: Urgent and Emergency Care

Theme	On track	Off track within tolerance	Off track
Timely Access to Care: Urgent & Emergency Care	8/18	4/18	6/18

Urgent and Emergency Care performance improved significantly during August, particularly in relation to ambulance handovers and ambulance lost hours. Following a combination of operational interventions, enhanced executive oversight, discharge initiatives and implementation of the Rapid Release Protocol on the 12th August, the number of ambulance handovers exceeding 45 minutes reduced to the lowest levels recorded since the opening of The Grange University Hospital. Performance met both the Annual Plan trajectory and the Targeted Intervention de-escalation threshold, while ambulance crew hours lost also fell to record low levels. These improvements were supported by the six-week UEC Sprint programme, which delivered a range of pathway improvements including enhanced escalation processes, discharge planning, AMU reconfiguration, Hospital to Home developments and strengthened operational oversight.

Despite these improvements, wider front-door performance remains challenging. Twelve-hour Emergency Department waits continue to exceed trajectory, although there were some signs of improvement following the introduction of the Rapid Release Protocol. Performance against triage standards and median wait-to-be-seen times also remains below plan, with clinician waits continuing to exceed target levels despite recent improvements. Four-hour ED performance has trended downwards and remains slgihtly below both trajectory and historical performance levels. The Health Board recognises that improving patient flow across the entire Urgent and Emergency Care pathway is critical to addressing these pressures, with discharge processes, bed availability and system wide flow continuing to be key constraints. The Multi Agency Discharge Event (MADE) highlighted barriers including diagnostic delays, rehabilitation capacity constraints, workforce pressures and variation in discharge processes.

Performance in Pathway of Care Delays (POCDs) and Stroke Services presents a mixed picture. POCDs by volume reduced substantially in August, reaching the lowest level in the available dataset and is marginally above the Annual Plan trajectory and targeted intervention de-escalation criteria, POCDs by days delayed remain behind trajectory. Within Stroke Services, direct admission to a Stroke ward within four hours and Therapy assessments show improved performance and exceed trajectories, demonstrating sustained improvement. However, stroke scanning within 20 minutes and thrombectomy rates remain significantly below target, prompting ongoing pathway reviews, service improvement initiatives and discussions regarding commissioning arrangements. Work is also underway to optimise rehabilitation pathways, strengthen Early Supported Discharge models and improve patient flow through dedicated Stroke Services

Timely Access to Care: Cancer, Planned Care & Diagnostics

Theme	On track	Off track within tolerance	Off track
Timely Access to Care: Cancer, Planned Care & Diagnostics	9/19	5/19	5/19

Cancer performance remains mixed, with strong progress in diagnostic performance and backlog reduction, but continued challenges in treatment timeliness. The 28-day diagnostic standard achieved 77.6% in July, exceeding both trajectory and the national target, while the 62-day and 104-day cancer backlogs continued to reduce and both performed better than planned. However, Single Cancer Pathway (SCP) compliance fell to 60.2%, well below the July trajectory of 73.4%, driven by a higher than planned number of patients who waited longer than 62 days for treatment, despite overall, planned treatment volumes being delivered. Recovery work is particularly focused on Lower GI, Upper GI and Urology pathways, which account for most of the cancer backlog, alongside detailed tumour-specific improvement plans and continued emphasis on earlier diagnostics.

Planned Care recovery continues to deliver strong results, particularly for the longest waits. Following the significant achievement of reducing 104-week RTT waits to just 23 patients at the end of 2025/26, the lowest level since April 2020, the Health Board submitted regional recovery plans with the elimination of 104-week waits identified as a core objective. Additional non-recurrent funding has already supported extra surgical activity across a number of specialties, contributing to continued improvement, with patients waiting more than 104 weeks for treatment reducing to 385 in August. Further funding is expected to be confirmed during September, and revised trajectories are being developed to reflect additionally funded delivery plans. Performance against 52-week and 26-week outpatient waits also remains ahead of plan following the benefits realised through the national outpatient insourcing programme. Diagnostics breach numbers have increased through 2026/27, with the August position marginally above the planned trajectory. Updated trajectories are being developed alongside the Welsh Government recovery programme to reflect revised assumptions and additional funded activity. The implementation of the Radiology Information System Programme (RISP) has increased the level of month end validation required to ensure accurate performance reporting.

Demand pressures across Planned Care continue to increase, with referral rates remaining above trajectory and the RTT waiting list growing to 112,914 patients by August. The Health Board is responding through an intelligence led referral optimisation programme using Health Pathways, Interface GPs, Advice & Guidance Services and enhanced analytics to reduce unwarranted variation and improve referral quality. Delayed follow-up waiting lists also remain a significant challenge, with targeted work underway to validate waiting lists, expand See on Symptom (SOS) pathways and focus on the most delayed patients. Workforce and demand pressures continue to affect Audiology and Therapies Services, particularly Physiotherapy, contributing to rising waiting times. Theatre productivity remains a key focus, with late starts increasing and

utilisation remaining slightly below the 85% national standard. In response, the new Theatres Optimisation Programme has been established to improve theatre efficiency, reduce cancellations, improve utilisation and increase day-case activity to maximise available capacity and support continued Planned Care recovery.

Mental Health Access

Theme	On track	Off track within tolerance	Off track
Mental Health Access	6/10	3/10	1/10

Performance across core Adult Mental Health Services and CAMHS access standards remains strong. Adult Part 1a and Part 1b performance continues to exceed the national target, with the service successfully balancing demand and capacity throughout 2025/26 and into 2026/27. CAMHS performance is similarly positive, with both Part 1a and Part 1b measures maintaining compliance above national standards. Specialist CAMHS Choice Assessments continue to perform well above the 80% target, while performance against Out of Area Placements remains on track, with zero bed days recorded in 2026/27 to date, avoiding both the patient impact and financial cost associated with placements outside the Health Board area.

The main areas of challenge relate to Adult Part 2, Psychological Therapies and CAMHS Neurodevelopmental Services. Adult Part 2 compliance has fallen slightly below trajectory in recent months, and a focused programme of improvement work is underway to restore performance. Psychological Therapies has shown improvement in two of the last three months but remains below the annual trajectory, with a modelling project being undertaken with Cardiff University to identify the service changes and workforce requirements needed to achieve future access standards. Neurodevelopmental Services continue to face recovery pressures following a sustained focus on eliminating the longest waits. In response, significant NDIP funding has been secured for 2026/27 to protect existing capacity, recruit additional staff, fund extra clinical hours and introduce AI supported waiting list management tools to improve RTT performance and service sustainability.

Workforce & Culture

Workforce numbers remain stable and several indicators showing positive progress. Staff in post stood at 13,682 WTE in July, slightly above planned trajectories in some staff groups, while turnover remains relatively stable at 9.1% with a workforce stability rate of 91.7%. Recruitment performance continues to be strong, with time-to-hire averaging 58.4 days, outperforming the All-Wales target of 71 days. Variable pay controls are also showing benefits, with reductions in both bank and agency usage during the quarter, while medical agency use has continued a sustained downward trend supported by increasing adoption of direct engagement arrangements.

The key workforce challenges remain sickness absence, compliance and productivity measures. Sickness increased to 7.15%, driven largely by long-term absence and particularly high rates among Nursing and Midwifery, Additional Clinical Services and

Estates staff. Anxiety, stress and depression remain the leading cause of absence, followed by musculoskeletal conditions. Job planning compliance for both Consultants and SAS Doctors remain below target despite ongoing improvement work, while mandatory training compliance has fallen slightly below the Health Board's ambition. In response, the Health Board is implementing a comprehensive sickness reduction programme in partnership with Trade Unions, strengthening establishment controls, introducing enhanced workforce management systems, undertaking targeted job planning reviews with Divisions, and continuing implementation of the People Plan to improve workforce wellbeing, productivity and organisational resilience.

Quality, Safety & Experience

Patient experience remains positive overall, supported by the continued rollout of the CIVICA feedback platform across the Health Board. Patient feedback is now being captured across a broad range of Inpatient and Outpatient Services, providing valuable insight into patient experience and enabling local learning and improvement. Whilst overall satisfaction remains high, there is variation in response rates and engagement across Services, and further work is underway to improve accessibility, demographic representation and the consistent use of feedback to drive quality improvement.

Quality and patient safety systems continue to focus on learning, assurance and reducing harm. Ongoing monitoring of incidents, complaints, mortality, infection prevention and control, and patient safety concerns is supporting organisational learning and service improvement. Work continues to strengthen the quality governance framework, improve thematic reporting and ensure that intelligence from multiple sources is used to identify emerging risks and target improvement activity. Infection prevention remains a key area of operational focus, supporting the Health Board's wider quality and safety objectives.

Safeguarding performance remains strong, with good compliance achieved across Levels 1 and 2 safeguarding training and continued progress against longer-term Level 3 training ambitions. Increasing staff competence is supporting earlier identification and management of safeguarding concerns, reflected in rising demand for advice and support services. However, significant growth in child safeguarding activity, particularly strategy meetings, continues to place pressure on the service and has been recognised as a corporate risk. Continued workforce development, training and service improvement activity are therefore focused on strengthening safeguarding capacity and maintaining safe, timely responses to vulnerable children and adults.

Finance

The Health Board continues to face significant financial challenge in 2026/27, reporting a year-to-date adverse variance of £30.238m at Month 5 and a forecast year-end deficit of £41.6m. While the in-year position includes a profiled £9.5m Welsh Risk Pool cost pressure, underlying performance remains broadly in line with the expected MMR profile. Delivery of the financial plan is dependent upon the achievement of planned savings and mitigation actions, with a number of material risks remaining, including workforce cost pressures associated with resident doctor rotas, uncertainty around

receipt of national funding streams (including DPIF, pay awards and terms and conditions funding), inflationary and utility cost increases, Joint Commissioning Committee cost developments, operational pressures linked to performance delivery, and the requirement to identify further mitigating actions to offset unplanned cost pressures.

Appendix – Q1 Planned Milestones Update

Overall, Q1 milestone delivery is positive, with the majority of milestones reported as Complete/On Schedule across Population Health, Place Based Care, UEC, Planned Care, Mental Health and Women's Health. Key progress includes implementation of vaccination initiatives, smoking cessation improvements, community nursing developments, front-door flow initiatives, cancer pathway recovery work, CAMHS performance, Women's Health expansion and Maternity Service improvements.

Areas requiring attention are generally reported as "off track within tolerance" rather than significantly off track. The main themes are delays in prevention and risk stratification programmes, Primary Care data integration, neighbourhood team development, Audiology recovery, Memory Assessment Services, theatre productivity, outpatient utilisation and across key Planned Care transformation programmes. A small number of milestones are significantly off track, including the 1001-Days programme, Corporate Parenting monitoring framework, T&O Perfect Month work and Outpatient space utilisation. Key enablers of future delivery include additional Planned Care funding, recovery programmes, digital developments, service redesign and workforce investment, while several workstreams remain dependent on funding decisions, national system developments, regional programme progress and resource availability.

Argymhelliad / Recommendation

The Board is asked to:

- Note the progress against key performance metrics as of the latest, available validated information,
- Note the insight and actions identified in context of performance achievement, and;
- Note the progress against the Planned Milestones as of Q1 (included as an Appendix)

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 Link to IMTP	Every Child has the best start in life Getting it right for children and young adults Adults in Gwent live healthily and age well Older adults are supported to live well and independently Dying Well as part of 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 the Wellbeing and engagement of our staff 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:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

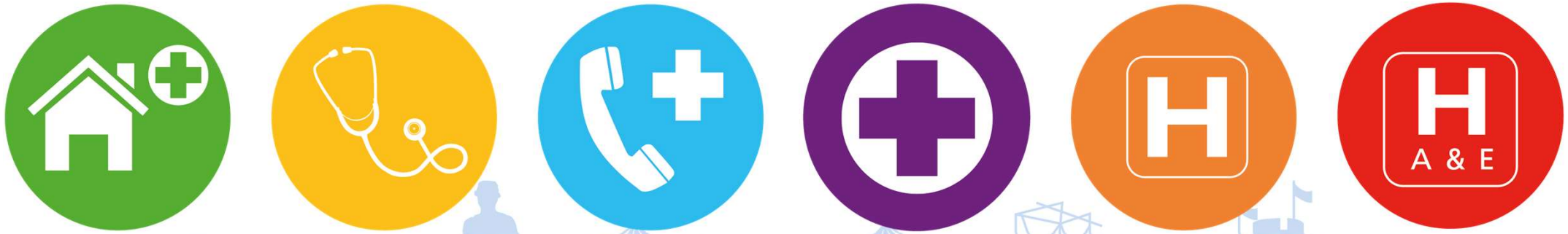
Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal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

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

ABUHB BOARD

Integrated Performance Report

September 2026 Board



The Cabinet Secretary for Health and Social Services has outlined delivery expectations across 6 themes;

- Population Health and Prevention
- Community By Design
- Women's Health
- Timely Access to Care
- Mental Health Access
- Quality and Safety

A summary of the latest performance against these measures is included for quick reference.

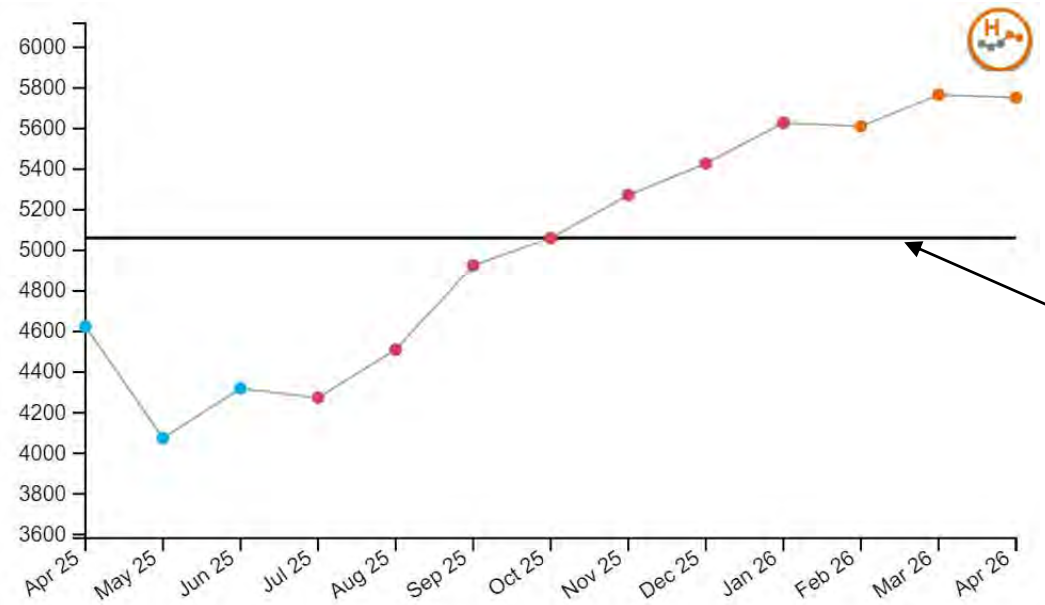
This section provides detail of Health Board performance across the core performance measures included within the 26/27 Annual Plan, as well as progress against Annual Plan milestones (updated quarterly). These have been grouped to align with the Welsh Government themes as follows:

- Population Health and Prevention
- Place Based Care
- Timely Access to Care – Urgent & Emergency Care
- Timely Access to Care – Cancer, Planned Care & Diagnostics
- Mental Health Access

Each measure also has a flag to show which strategic aim it relates to (Better Health/Better Care/Better Lives), as per the 26/27 Annual Plan.

Key

- Deteriorating trend
- Negative shift from median
- Positive shift from median
- Improving trend



A Run Chart is recommended when there are **fewer than 15 data points** to plot on a time series.

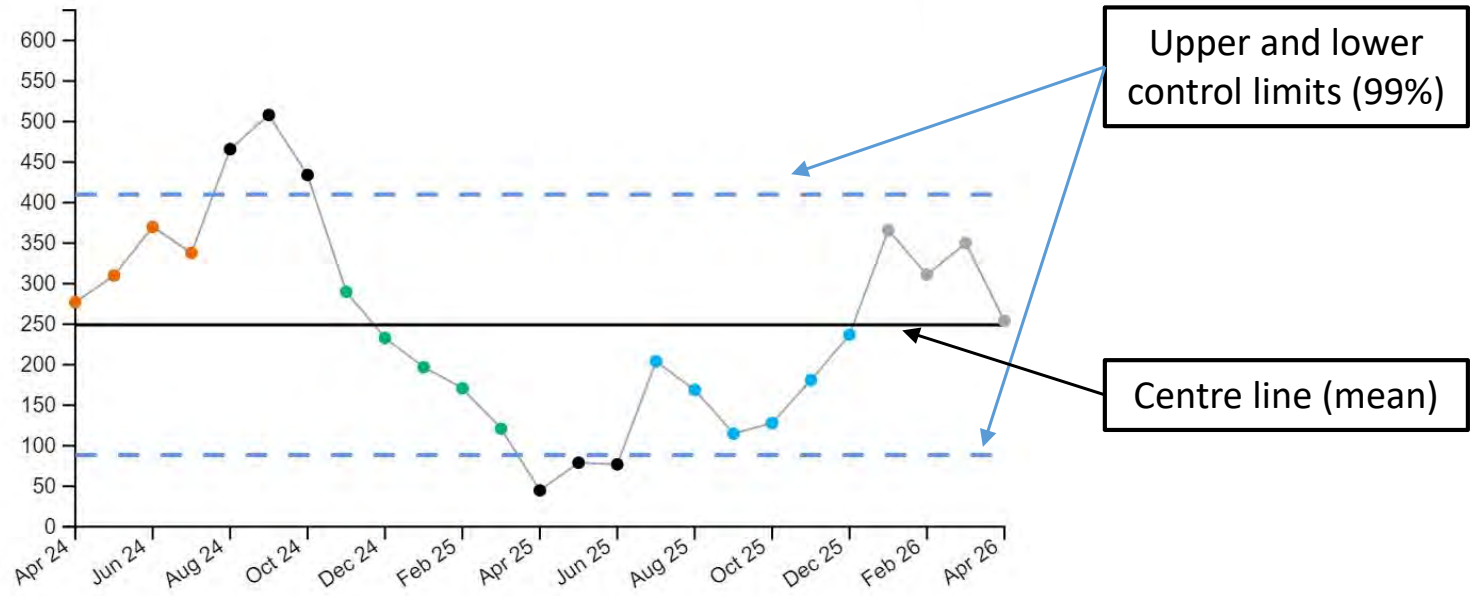
Centre reference line: the average line, represented by the median.

Six consecutive points above or below the median line (shift from median): a run of six or more values above or below the average (median) line represents a trend that should not result from natural variation in the system. The nature of the shift (positive/negative) is dependent on the direction of improvement for each individual measure.

Five consecutive points increasing or decreasing (trend): a run of five or more values showing continuous increase or decrease is a sign that something unusual is happening in the system. The nature of the trend (improving/deteriorating) is dependent on the direction of improvement for each individual measure.

Key

- Astronomical point
- Deteriorating trend
- Negative shift from mean
- Positive shift from mean
- Improving trend



A minimum of **15 data points** is recommended for a Statistical Process Control (SPC) Chart.

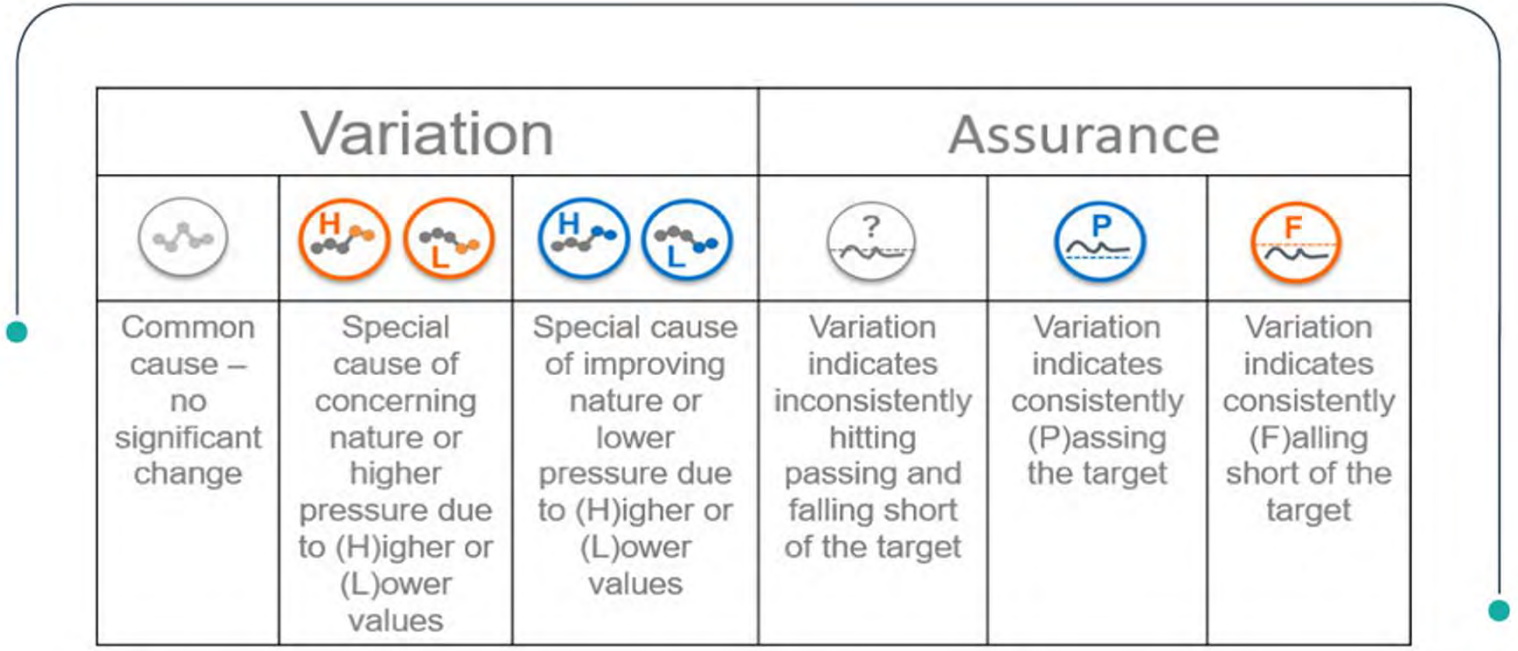
Centre reference line: the average line, represented by the mean.

Upper and lower reference lines: the process limits, also known as control limits, set to 99%.

Astronomical point: a single point outside the control limits. Whenever a data point falls outside a process limit (upper or lower) something unexpected has happened because we know that 99% of data should fall within the process limits.

Seven consecutive points above or below the mean line (shift from mean): a run of seven or more values above or below the average (mean) line represents a trend that should not result from natural variation in the system. The nature of the shift (positive/negative) is dependent on the direction of improvement for each individual measure.

Six consecutive points increasing or decreasing (trend): a run of six or more values showing continuous increase or decrease is a sign that something unusual is happening in the system. The nature of the trend (improving/deteriorating) is dependent on the direction of improvement for each individual measure.



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and grey indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A grey icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

NB: Assurance icons will be available from June 2026; a minimum of two data points in 2026/27 is required to plot trajectory lines.

Section 1.2: Performance Summary

What went well?

- August delivered the lowest number of 45 minute ambulance handover breaches since the opening of The Grange University Hospital, meeting both the Annual Plan trajectory and the Targeted Intervention de-escalation threshold following implementation of the Rapid Release Protocol and focused operational improvements.
- Six-week physical examination rates consistently exceeded the national target, reaching 99.6%.
- Within Stroke, the 4-hour admit to Ward and Therapist assessment measures all significantly exceeded trajectory.
- The Health Board has maintained zero Out of Area Placement bed days during 2026/27 to date, avoiding both patient disruption and associated costs.
- Both bank and agency usage reduced during the quarter, while medical agency usage continued its sustained downward trend, supported by increased direct engagement arrangements.

What were the challenges?

- Despite improvements in ambulance handovers, 12-hour performance, triage breaches and clinician wait-to-be-seen times remain above trajectory.
- Single Cancer Pathway (SCP) compliance remains below trajectory as of July. Whilst planned treatment volumes were achieved, the number of treatment breaches was higher than expected, resulting in underperformance.
- Within Emergency Dental, Q1 activity reached only 3,210 contacts compared to a trajectory of 9,043, reflecting the impact of the new NHS Wales dental contract and changes in urgent dental care delivery.
- Theatre productivity remains challenged in some areas, with late starts having trended in the wrong direction over the past few reportable months.
- Overall sickness absence increased to 7.15%, exceeding the IMTP target of 6.25%, with long-term sickness accounting for around 70% of all absence.

What actions are we taking to improve?

- Vaccination Brief Advice training, a MMRV improvement pilot across GP Practices, and focused outreach work to Gypsy and Traveller Communities are being implemented to improve uptake and reduce inequalities.
- The Older People's workstream and the development on the Navigation Hub/Single Point of Access will reduce barriers for GPs and improve referrals into Rapid Response services.
- The Multi Agency Discharge Event (MADE) has identified barriers to discharge and is supporting work to improve discharge processes, Estimated Dates of Discharge (EDD) management and pathway consistency across sites.
- Detailed tumour-specific recovery plans, particularly within colorectal services, are targeting diagnostic bottlenecks and treatment pathway delays to improve SCP compliance.
- Continued integration of patient feedback, complaints, incidents and safeguarding intelligence is supporting a more mature approach to quality governance, risk identification and service improvement.

What are our risks to delivery?

- Continued lower vaccination rates, particularly among hard-to-reach communities, risk widening health inequalities and preventing achievement of national immunisation targets.
- Referral rates continue to increase and the RTT waiting list is growing, creating additional pressure across Outpatient, Diagnostic and Treatment pathways.
- Growing demand for Community Services without equivalent capacity growth could impact delivery against Place Based Care trajectories.
- Sustaining recent ambulance handover improvements will require continued operational focus on whole system flow, which will become more challenged a Winter approaches.
- Failure to improve consultant and SAS job planning compliance could affect workforce productivity, service planning and delivery of operational performance objectives.

Section 1.3: Ministerial Delivery Expectations

WG Theme	Delivery Expectation	ABUHB commitment	Meet National Standard?	In month performance against trajectory	Variance	Assurance
Population Health & Prevention	Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes.	50% Mar-27	No	48.1% Jul-26 (Q2 Trajectory: 48%)	H	
	Reduce inequity in the uptake in the most and least deprived areas in preventing ill-health especially in relation to vaccination, screening and diabetes prevention and care.	Yes Mar-27	Yes	First reported Q2		
	Increase the proportion of children in Wales who are a healthy weight by halting the rise, and contributing to a year-on-year decrease in the levels of overweight and of obesity as measured and reported through the National Child Measurement Programme, focusing on those most disadvantaged.	Yes Mar-27	Yes	Expected Q2 2028/29		
	At least 90% of individuals identified via the Audit Plus Frailty Tool (or its replacement) to receive proactive care in line with their agreed care plans.	90% Mar-27	Yes	Reported Q4		
Community By Design	Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25 and greater where possible.	118,223 Mar-26	Yes	30,524 Jul-26 (Q2 Trajectory: 59,112)	H	
	Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard.	120 Mar-27	Yes	152 Aug-26 (Aug Trajectory: 140)		?
	Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard.	3,840 Mar-27	Yes	5,160 Aug-26 (Aug Trajectory: 4,200)		?
Women's Health	Improving the quality of our maternity services by reducing perinatal mortality rates.	5.067 Mar-27	Yes	Reported Q4		
	Further expansion of the Women's Health Hub model in each health board area by March 2027 (aligned to the Women's Health Plan).	Yes Mar-27	Yes	Reported Q4		

Section 1.3: Ministerial Delivery Expectations

Theme	Delivery Expectation	ABUHB commitment	Meet National Standard	In month performance against trajectory	Variance	Assurance
Timely Access to Care	Ensure no ambulance patient handover waits over 45 minutes [All location types, GUH & eLGHs].	91 Mar-27	No	352 Aug-26 (Aug Trajectory: 505)	L	F
	Ensure no ambulance patient handover waits over 45 minutes [GUH ED only].	80 Mar-27	Yes	290 Aug-26 (Aug Trajectory: 413)	L	F
	Reduce the number of patients who spend 12-hours or more in all Major and Minor Emergency Care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero .	799 Mar-27	No	1,312 Aug-26 (Aug Trajectory: 941)		F
	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion.	75% Mar-27	No	60.2% Jul-26 (Jul Trajectory: 73.4%)		F
	Reduction in backlog of patients waiting over 62-days (SCP).	170 Mar-27	No	274 Jul-26 (Jul Trajectory: 335)		?
	Reduction in backlog of patients waiting over 104-days (SCP).	50 Mar-27	No	86 Jul-26 (Jul Trajectory: 100)		?
	Numbers of patients waiting over 104-weeks RTT (all stages).	2,291 Mar-27	No	375 Aug-26 (Aug Trajectory: 998)		P
	Reduction in the number of patients waiting more than 8- weeks for a specific diagnostic.	0 Mar-27	Yes	2,997 Aug-26 (Jul Trajectory: 2,715)	H	?

Section 1.3: Ministerial Delivery Expectations

Theme	Delivery Expectation	ABUHB commitment	Meet National Standard	In month performance against trajectory	Variance	Assurance
Mental Health Access	Implement and evaluate Open Access Mental Health Support by March 2027.	Yes Mar-27	Yes	Reported Q4		
	Improve safety in Secondary Care Mental Health services (measured through agreed Mental Health safety matrix and PROM ReQuol) by March 2027.	Yes Mar-27	Yes	Reported Q4		
	Improve Physical Health of People with long term MH problems by carrying out mortality reviews and implementing improvement plans from the learning by March 2027.	Yes Mar-27	Yes	Reported Q4		
Quality and Safety	Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.	Programme of work to predict % Mar-27	Yes	1.35% Jun-26 (Q1 Trajectory: 1.39%)		
	Days of safe care delivered since the last never event, monitored using SPC T-Chart.	Yes Mar-27	Yes	To be implemented		
	Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027.	40% Mar-27	Yes	93.9% Jun-26 (Q1 Trajectory: 35%)		
	The clinical coding service must ensure that at least 95% of Inpatient and Day-Case episodes are fully coded within one reporting month of discharge, in line with Welsh Government delivery measures. In addition, 90% of all identified coding errors must be corrected within 35-days of identification, ensuring timely and accurate data quality improvements across all Health Boards. There must be a focus on quality of coding with an emphasis on specificity, and comorbidity capture demonstrated by an increase in depth index by 10% year-on-year.	95% Mar-27	Yes	90.1% May-26 (May Trajectory: 91%)		

Progress Against our Annual Plan

Drivers

- Joint Strategic Assessment
- Gwent 35
- Quality
- Performance Expectations
- Financial Sustainability
- Risks

Strategic Aims

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

- Health Protection
- Health Improvement
- Prevention
- Babies Children & Young People

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

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

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

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

Enablers

- Quality
- Workforce & Culture
- Digital, Data & Technology
- Estates
- Finance
- Green Health
- Value, Innovation & Research

Section 2.1: Population Health and Prevention Performance Summary

Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance
Population Health and Prevention	% children up to date with vaccinations by age 5.	95% Mar-26	86.2% Q4 25/26 (Q4 Trajectory: 95%)	
	% of children receiving HPV vaccination 1 dose by the age of 15.	90% Mar-26	70.7% Q4 25/26 (Q4 Trajectory: 90%)	H
	Maintain physical examination at 6 weeks rates (Healthy Child Wales).	90% Mar-27	99.6% Apr-26 (Apr-26 Trajectory: 90.0%)	H
	Increase weight and measurement at 8 weeks rates (Healthy Child Wales).	80% Mar-26	92% Q4 25/26 (Q4 Trajectory: 80%)	H
	Percentage of adult smokers who make a quit attempt via Smoking Cessation Services.	5% Mar-26	4.6% Q4 25/26 (Q4 Trajectory: 5%)	
	Percentage of adult smokers who made a quit attempt via Smoking Cessation Services who are CO-validated as quit at 4 weeks.	32% Mar-26	22.2% Q4 25/26 (Q4 Trajectory: 32%)	
	Uptake of eligible patients who attend cardiovascular disease risk factor management programme (CVDRFMP).	3,125 Mar-27	**First reported Q2 26/27**	
	% of people who attended cardiovascular disease risk factor management programme (CVDRFMP) diagnosed.	312 Mar-27	**First reported Q2 26/27**	

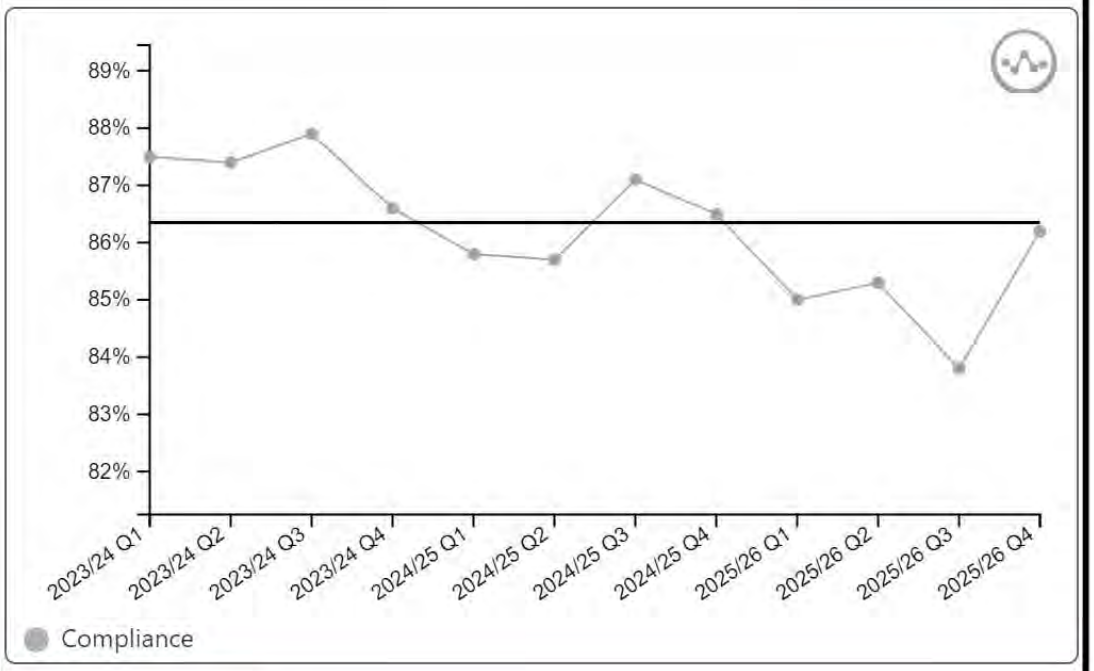
Section 2.1: Population Health and Prevention Performance Summary

Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance
Population Health and Prevention	No. starting 12-week intervention with Level Two Adult Weight Management Service.	1,500 Mar-27	First reported Q1 26/27	
	No. with end weight recorded who accessed 8+ sessions who lost >5% weight.	450 Mar-27	First reported Q2 26/27	
	Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes.	50% Mar-27	48.1% Jul-26 (Q2 Trajectory: 48.0%)	H
	Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months.	80% Mar-27	66.2% Jul-26 (Q2 Trajectory: 73.5%)	
	Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months.	80% Mar-27	71.9% Jul-26 (Q2 Trajectory: 74.0%)	H
	Number of visits to the Melo Website.	48,000 Mar-27	15,896 Jul-26 (Q2 Trajectory: 24,000)	

Population Health and Prevention

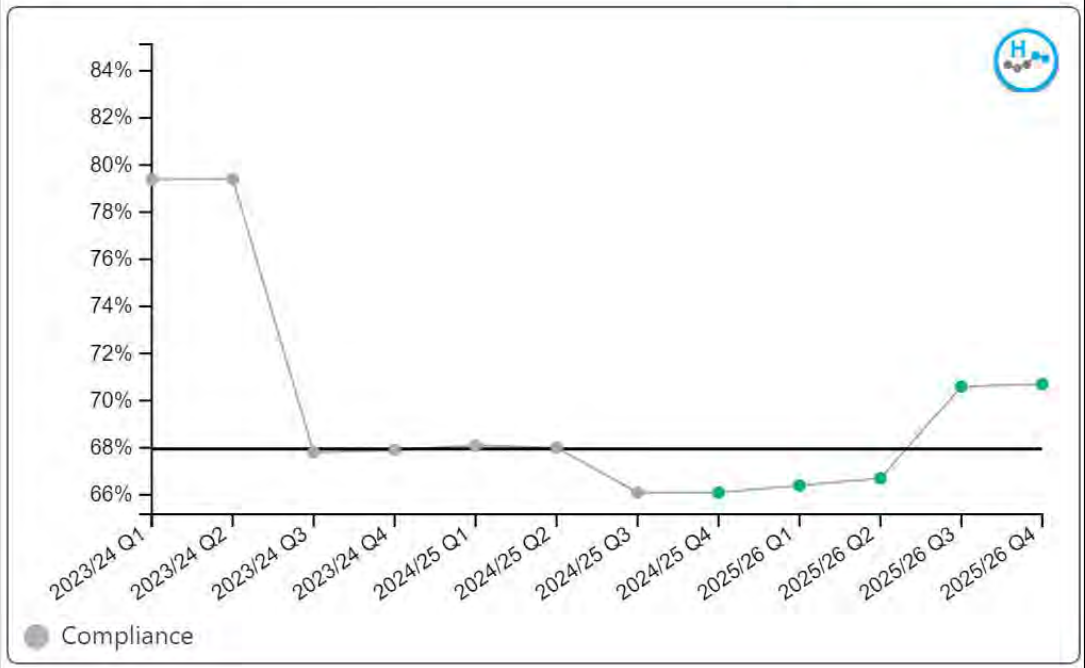
Measure: % children up to date with vaccinations by age 5
Performance: 86.2% (Q4 25/26)
Trajectory: 95.0% (Q4 25/26)
National target: 95.0%

Better Health



Measure: % of children receiving HPV vaccination 1 dose by the age of 15
Performance: 70.7% (Q4 25/26)
Trajectory: 90.0% (Q4 25/26)
National target: 90.0%

Better Health



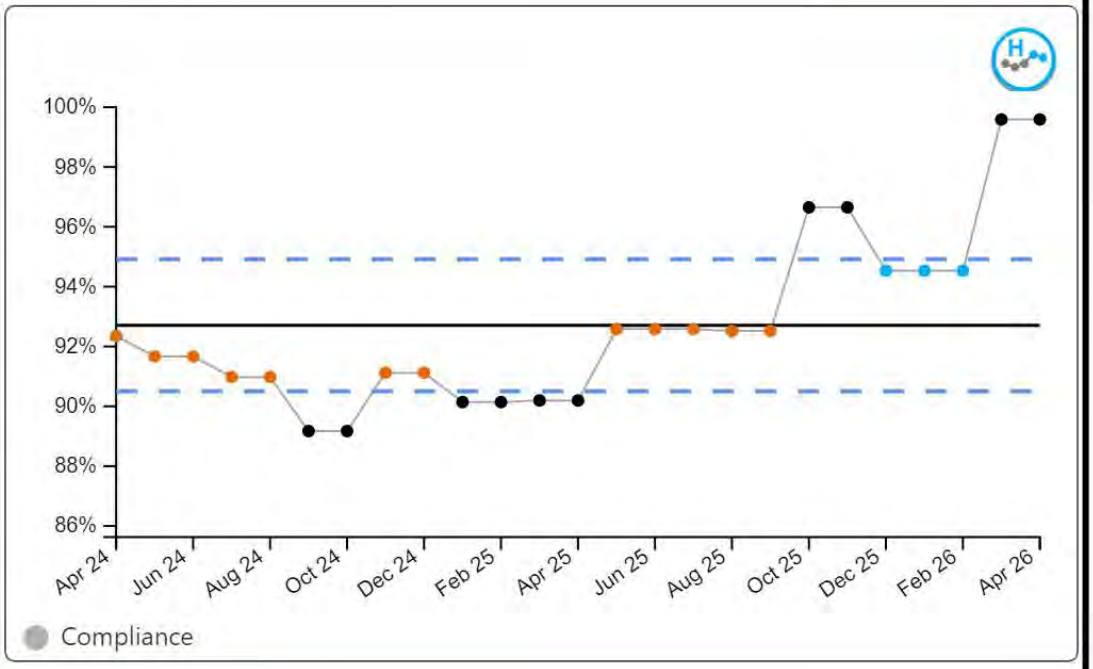
Insights and Actions

- Childhood vaccinations: Q4 performance increased to 86.2%, but overall performance across 25/26 is below trajectory (95%) and below the three-year average (86.3%).
- HPV: Q4 performance has maintained the above average improvement from Q3, with compliance at 70.7%. This continues an improvement trend for the last 5 quarters.
- Vaccination improvement work continues to progress across Gwent. Vaccination Brief Advice (VBA) training has been launched, with seven sessions delivered to date and a further nine planned, reflecting strong demand. The programme aims to improve healthcare professionals' confidence in addressing vaccine hesitancy and has also attracted interest from Betsi Cadwaladr University Health Board. The MMRV improvement pilot is commencing across six GP Practices in Newport and Torfaen to identify barriers to uptake, review vaccination processes, and develop sustainable approaches to improve coverage, reduce inequalities, and support equitable access. Targeted outreach through the Nye BeVAN has been developed to improve access for Gypsy and Traveller communities, with positive early engagement and seven children vaccinated across the first three outreach sessions. Key learning highlights the value of sustained community engagement, relationship-building, and flexible delivery models to support uptake among underserved groups.

Population Health and Prevention

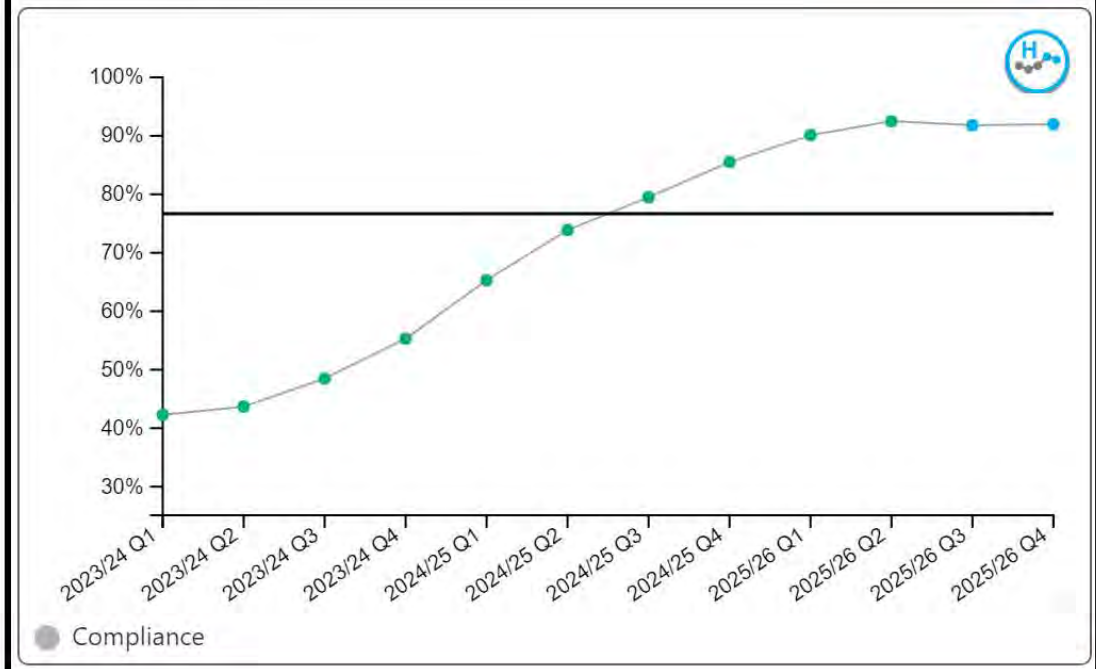
Measure: Maintain physical examination at 6 weeks rates (Healthy Child Wales)
Performance: 99.6% (April 2026)
Trajectory: 90.0% (April 2026)
National target: None

Better Health



Measure: Increase weight and measurement at 8 weeks rates (Healthy Child Wales)
Performance: 92.0% (Q4 25/26)
Trajectory: 80.0% (Q4 25/26)
National target: None

Better Health



Insights and Actions

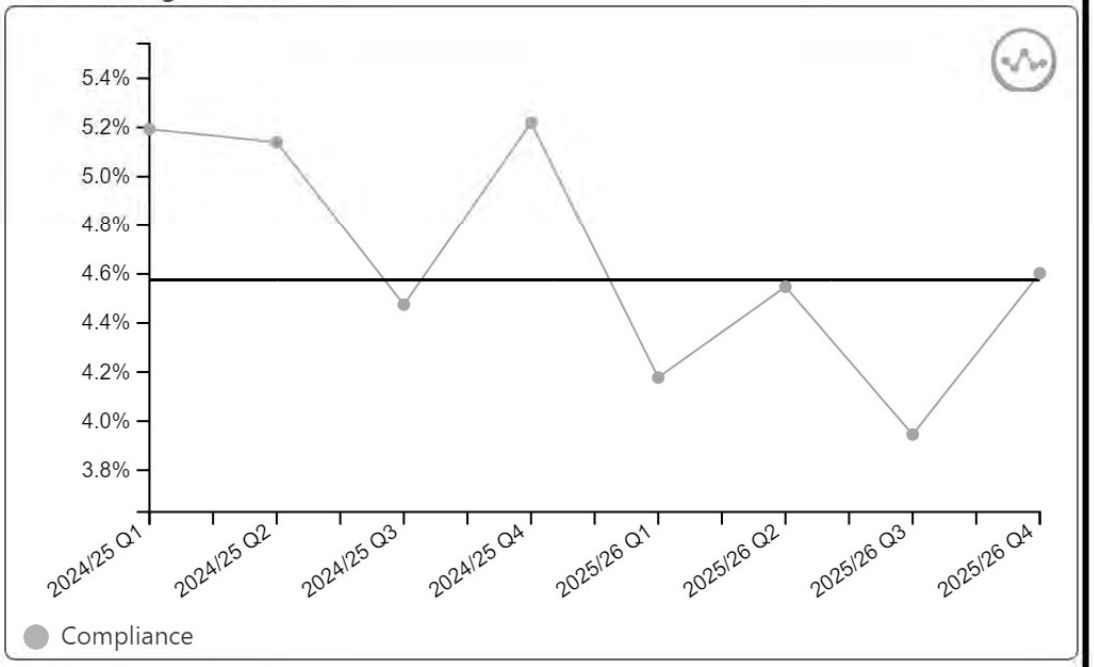
- Performance for physical examinations at 6-weeks continues to improve and has consistently achieved the national target (90%) through the course of 25/26. The past 2 months have shown exceptionally high performance at 99.6%, above the expected range of 90.5%-94.9%. The lower control limit is currently higher than the April trajectory (90.5% compared to 90%), demonstrating that the target will be consistently achieved.

- Weight and measurement at 8-weeks: Q3 performance dropped slightly to 91.8%, which indicates the end of a consistent improvement trend from Q1 23/24, with performance now showing no significant change from the previous quarter. The trajectory has been comfortably met every quarter through 25/26.

Population Health and Prevention

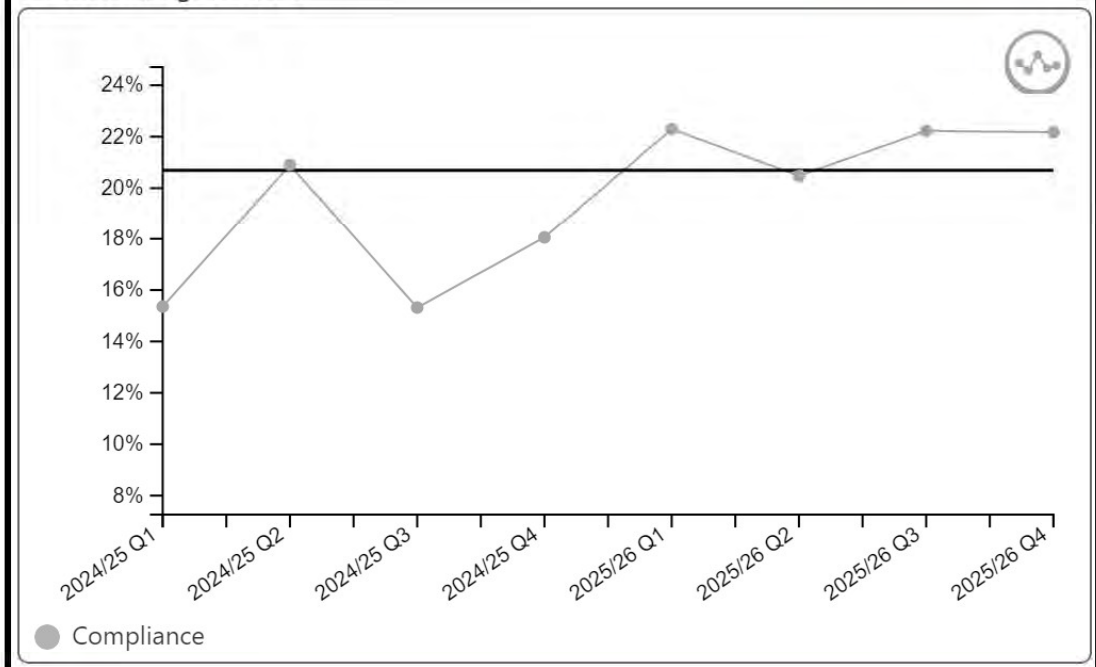
Measure: Percentage of adult smokers who make a quit attempt via smoking cessation services
Performance: 4.6% (Q4 25/26)
Trajectory: 5.0% (Q4 25/26)
National target: 7.5%

Better Health



Measure: Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks
Performance: 22.2% (Q4 25/26)
Trajectory: 32.0% (Q4 25/26)
National target: 40.0%

Better Health



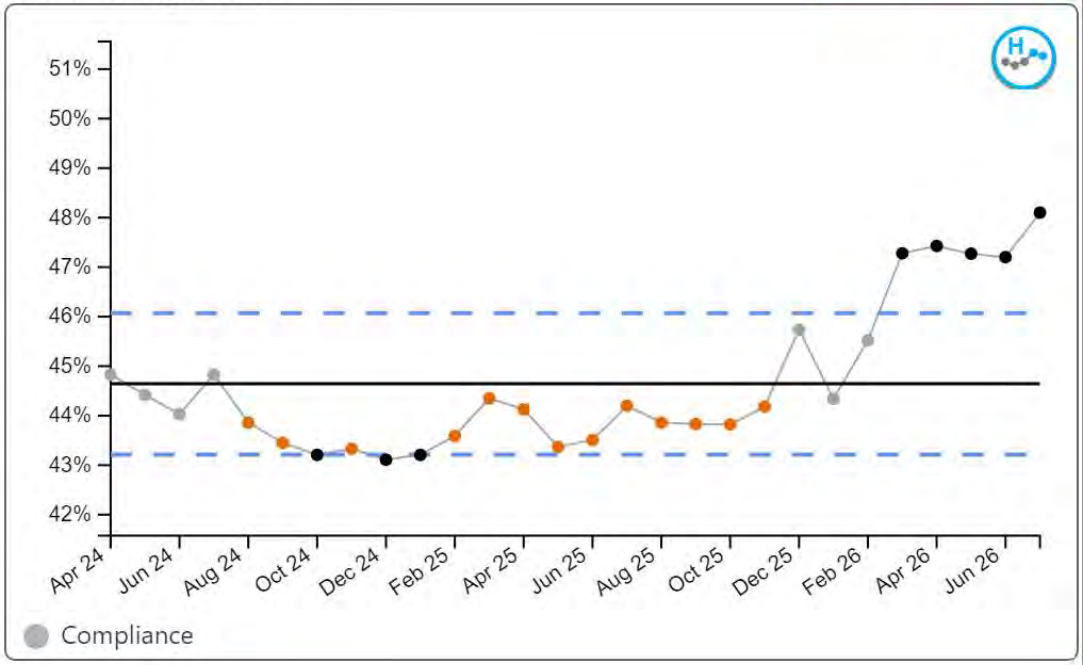
Insights and Actions

- Smoking Cessation performance across the two measures is based on annualised targets, however, are presented here quarterly to give assurance on progress. Q4 quit attempt performance increased to 4.6%, which represents the two-year average and is marginally short of the 25/26 trajectory of 5%. CO validated quits have been maintained at 22.2% in Q4, with the year end position finishing 10% below the trajectory of 32%.
- Behaviour Change Practitioners within the Health Board's Smoking Cessation Service are continuing to embed within their localities and strengthen relationships with Partners and Communities. A comprehensive improvement programme is underway to optimise service delivery through the review and redesign of processes, with a greater focus on supporting individuals and groups to achieve CO-validated quits at four weeks, rather than relying solely on self-reported outcomes. This is being supported through increased Community-based clinic capacity and by enabling practitioners to become fully embedded within their respective localities and place-based teams. Work is also continuing to ensure that capacity is deployed proportionately to support vulnerable populations at greatest risk of tobacco-related harm. A communications plan has been developed for promoting Help Me Quit with community groups and stakeholders as well as continuous monitoring to ensure maximal attendance at clinics. As a result of these improvements, the service recorded a 69% increase in CO-validated quits in March 2026 compared with March 2025, subject to final validation and data submission.

Population Health and Prevention

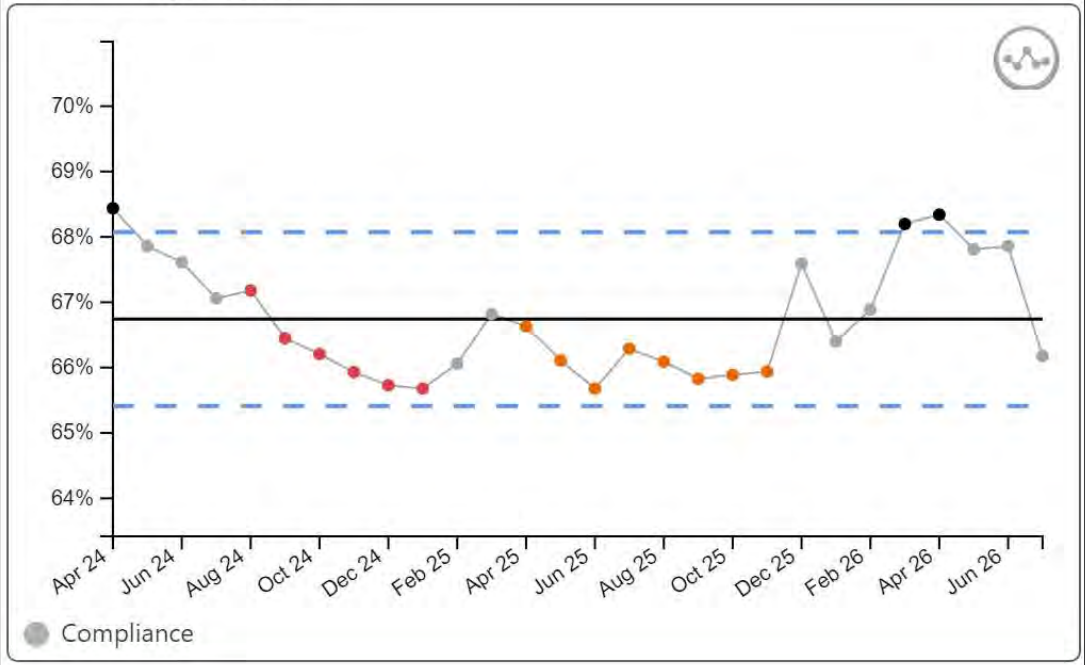
Measure: Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes
Performance: 48.1% (July 2026)
Trajectory: 48.0% (Q2 26/27)
National target: 80.0%

Ministerial Delivery
Better Health



Measure: Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months
Performance: 66.2% (July 2026)
Trajectory: 73.5% (Q2 26/27)
National target: 80.0%

Better Health



Insights and Actions

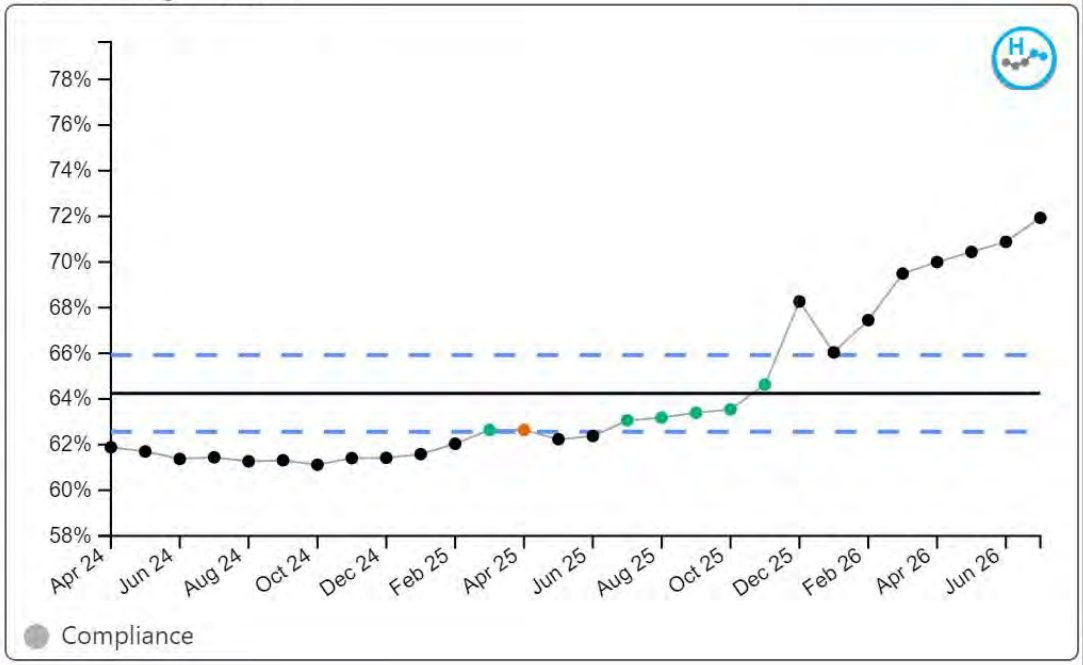
- 8 Diabetes processes: Performance is improving, with the past five-months showing out of normal range high values (47%+), compared to the expected performance range of 43%-46%. July performance of 48.1% has just exceeded the Q2 IMTP trajectory of 48%.

- Diabetes foot surveillance: Performance shows a similar improvement trend to the 8 Diabetes processes, with exceptionally high performance in March and April (68%+), reducing to in May and June. July performance has dropped below the mean to 66.2% and is currently behind the Q2 IMPT trajectory of 73.5%. The Foot Care project has distributed education materials across Secondary Care and all 68 ABUHB practices, with baseline data established. Follow-up analysis and pathway improvement work will continue in Q2. Additionally, the Gestational Diabetes project has established two workstreams focused on pre-conception care and postnatal follow-up. Early data shows only 43% compliance with follow-up testing within three months of delivery, with improvement work planned through Q2 and Q3. For Transition to Adult Services, pathway mapping and scoping have been completed. Demand and capacity pressures remain a challenge, and Q2–Q3 activity will focus on identifying improvement opportunities within existing resources.

Population Health and Prevention

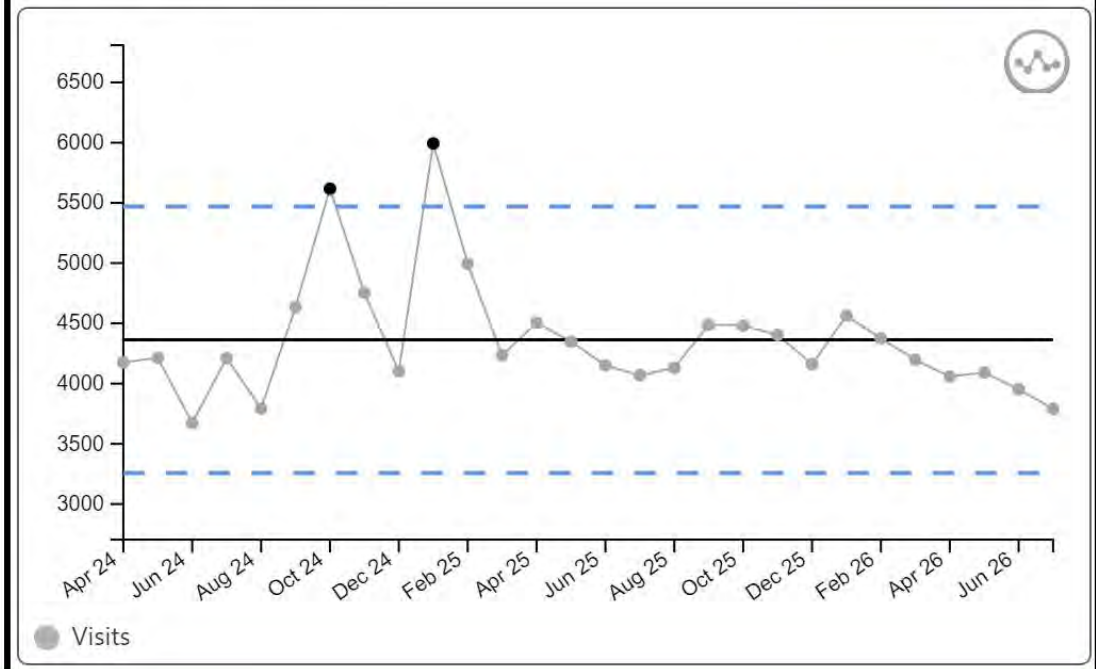
Measure: Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months
Performance: 71.9% (July 2026)
Trajectory: 74.0% (Q2 26/27)
National target: 80.0%

Better Health



Measure: Number of visits to the Melo Website
Performance: 15,896 (July 2026)
Trajectory: 24,000 (Q2 26/27)
National target: None

Better Lives



Insights and Actions

- Diabetes uACR: Performance has shown an improving trend since February 25, with improved performance of 66%-72% achieved in the past 8 months, compared to the expected range of 62.6%-65.9%. July performance of 71.9% is currently behind the Q2 IMTP trajectory of 74%. The Urine ACR project has now closed, with over half of participating practices achieving a >5% improvement in compliance at six months.

- Melo visits: Melo is the Health Board's website containing information, advice and self-help resources to help people look after their Mental Health and wellbeing. Three new topics are being introduced in 2026 (Smoking and Mental Wellbeing, Hoarding, Neurodivergence) and free promotional materials are being made available to engage service users across ABUHB. The number of visits to the website is currently showing no significant change month-to-month, however performance has become more consistent around the mean (4,401) in 25/26 compared to 24/25, now ranging from ~4,000-4,500 visits per month. June and July have shown slightly lower monthly visits (<4,000) with the July position at 15,896 visits for the year to date.

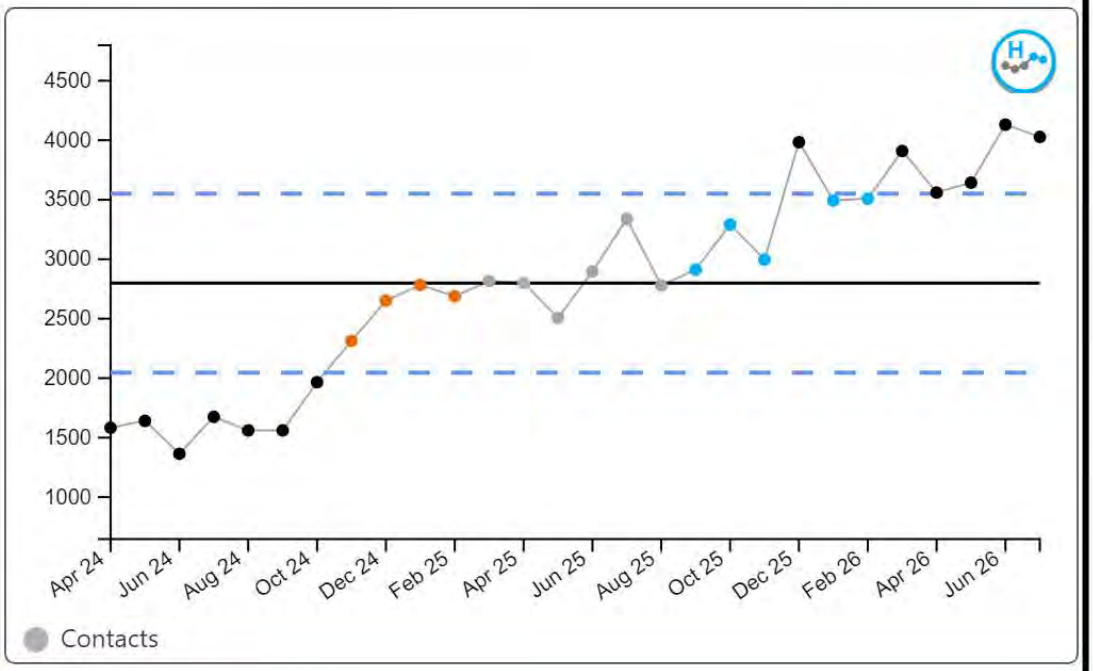
Section 2.1: Place Based Care Performance Summary

Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance
Place Based Care	Increase in people accessing PIPs where they would have visited their GP.	45,620 Mar-27	15,363 Jul-26 (Q2 Trajectory: 22,810)	H
	Maintain the number of consultations undertaken by Community Pharmacy under CAS.	99,871 Mar-27	39,411 Jul-26 (Q2 Trajectory: 49,936)	H
	Maintain the number of patients accessing NHS Optometry Services.	265,118 Mar-27	92,742 Jul-26 (Q2 Trajectory: 132,559)	
	Number of patients accessing urgent emergency services - Dental.	36,173 Mar-27	3,210 Jun-26 (Q1 Trajectory: 9,043)	
	Increase in capacity at the weekend of Community Nursing and Specialist Palliative Care Nursing to at least the required levels previously set for 2024/25.	118,223 Mar-27	30,524 Jul-26 (Q2 Trajectory: 59,112)	H
	Maintain 95% of Palliative Care referrals assessed within 2 days.	95% Mar-27	88.4% Jun-26 (Q1 Trajectory: 92%)	
	Increase in number of accepted referrals to Rapid Response services.	5,068 Mar-27	1,525 Jul-26 (Q2 Trajectory: 2,534)	
	Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s.	8.5% Mar-27	7.6% Jul-26 (Q2 Trajectory: 8.5%)	
	Maintain the number of Urgent Primary Care contacts (inc. virtual).	101,746 Mar-27	25,054 Jun-26 (Q1 Trajectory: 25,437)	

Place Based Care

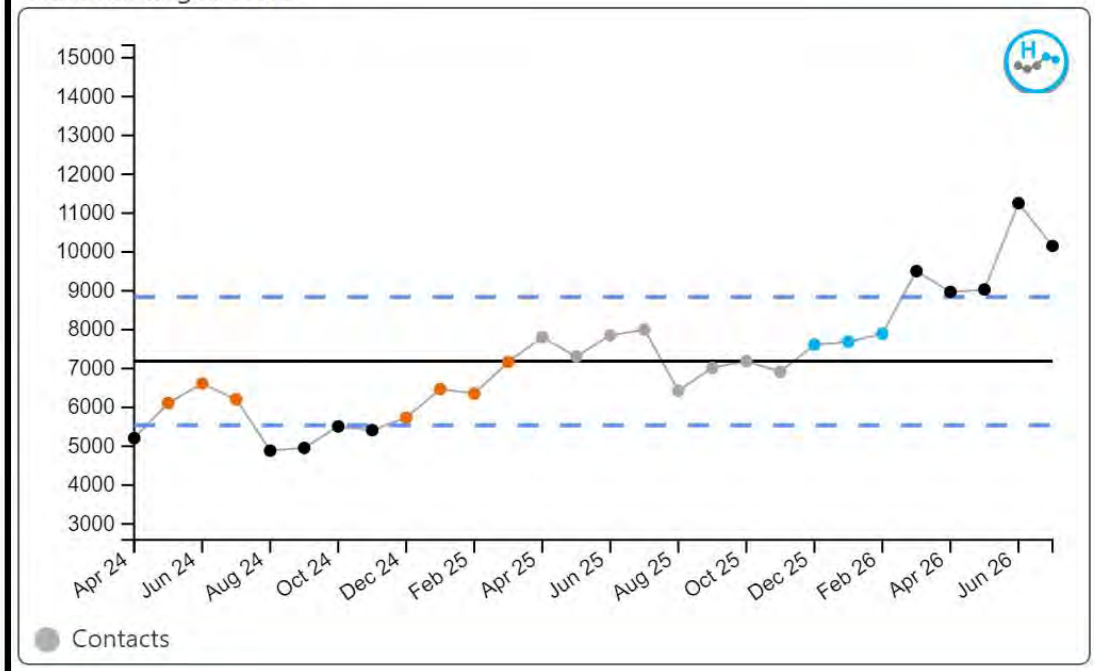
Measure: Increase in people accessing PIPs where they would have visited their GP
Performance: 15,363 (July 2026)
Trajectory: 22,810 (Q2 26/27)
National target: None

Better Care



Measure: Maintain the number of consultations undertaken by community pharmacy under CAS
Performance: 39,411 (July 2026)
Trajectory: 49,936 (Q2 26/27)
National target: None

Better Care



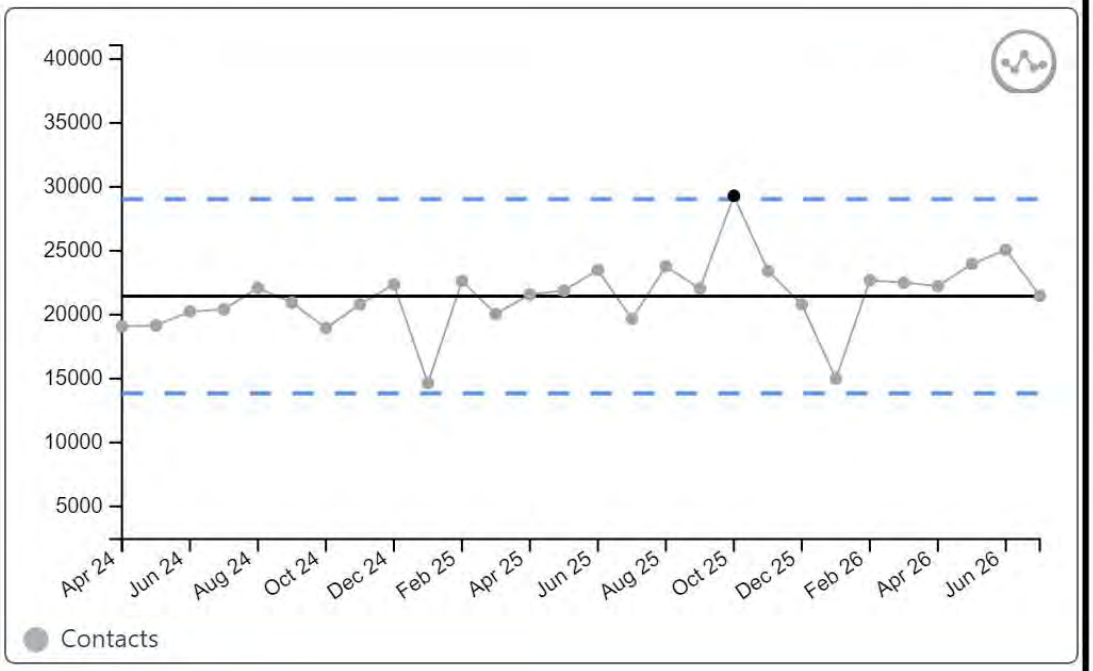
Insights and Actions

- Pharmacist Independent Prescribing Service (PIPS): PIPs consultations continue the improving trend, seen for the past 11 months and consistent improved performance (>3,551) for the past 5 months. Q1 performance finished just behind the Q1 IMTP trajectory with 11,336 contacts compared to 11,405 contacts. July performance to date is 15,363 contacts.
- Common Ailment Scheme (CAS): CAS claims show an improving trend, with consistent above-mean performance for the past 7 months. March performance to date has been excellent, with the number of claims exceeding the expected range of 5,540-8,840. Q1 performance exceeded the Q1 IMTP trajectory by over 4,000 contacts, with 29,256 contacts total compared to the trajectory of 24,968. July performance to date is 39,411 contacts.
- PIPS and CAS contacts continue to increase following an extension to the clinical conditions feasibly managed by the service and a successful public awareness campaign. It is anticipated that activity will continue to grow but at a lower rate in the coming years as we approach the ceiling for CAS in particular.

Place Based Care

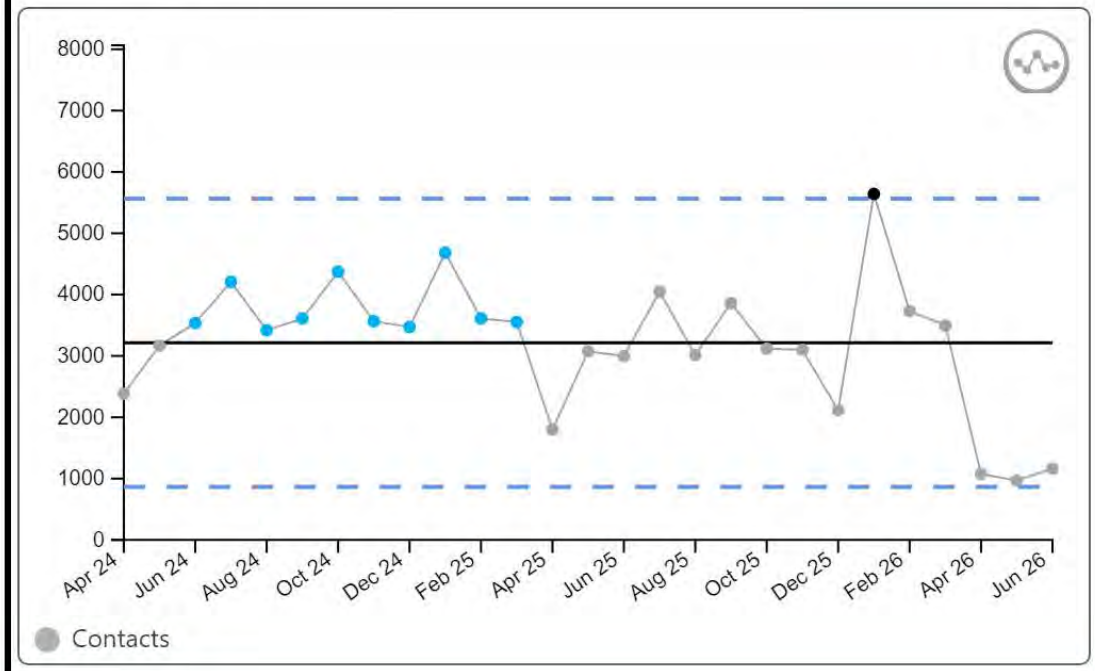
Measure: Maintain the number of patients accessing NHS Optometry Services
Performance: 92,742 (July 2026)
Trajectory: 132,559 (Q2 26/27)
National target: None

Better Care



Measure: Number of patients accessing urgent emergency services - Dental
Performance: 3,210 (June 2026)
Trajectory: 9,043 (Q1 26/27)
National target: None

Better Care



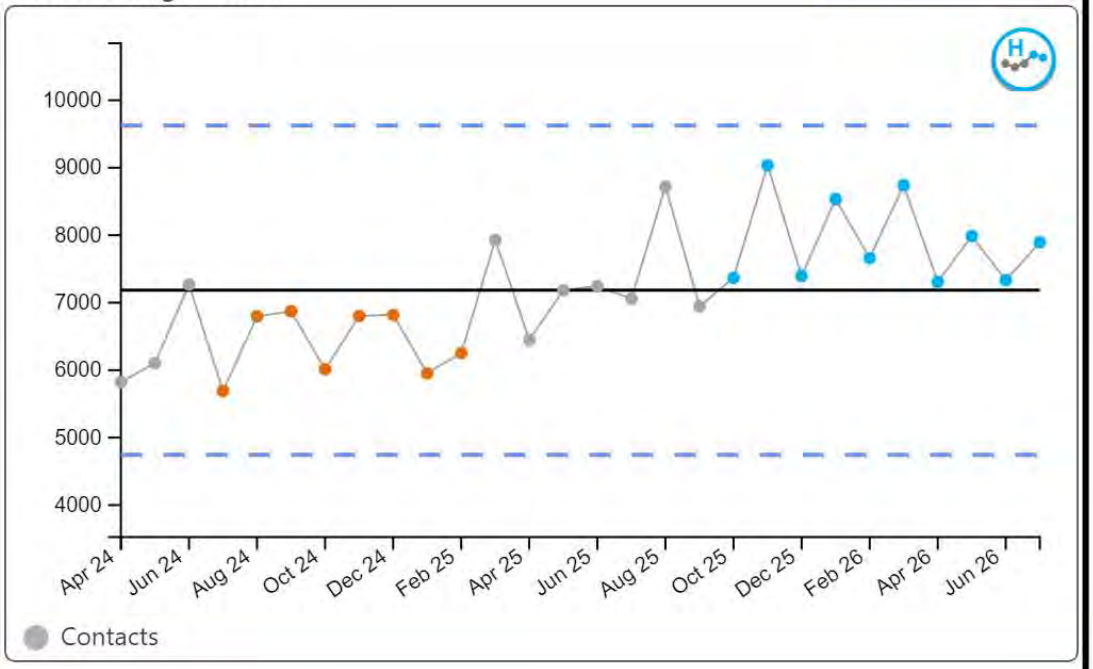
Insights and Actions

- Optometry Services: Performance for 26/27 has been above the mean of 21,436 patients per month to date. The total patients accessing NHS optometry services for Q1 was 71,270, comfortably exceeding the Q1 IMTP trajectory of 66,820 contacts. July performance to date is 92,743 contacts.
- Emergency Dental: Performance has dropped very close to the lower control limits for Q1 26/27, with around a 1,000 contacts a month compared to the average of over 3,000 in 2024/25 and 2025/26. This is due to implementation of the new NHS Wales dental contract, with all practices now required to see a proportion of urgent appointments. There are currently approx. 240 appointments a week available through practices compared to 60 through EDS, which has resulted in the significant reduction in performance. Subsequently, the Q1 IMTP trajectory of 9,043 has not been met, with 3,210 contacts in total for Q1.

Place Based Care

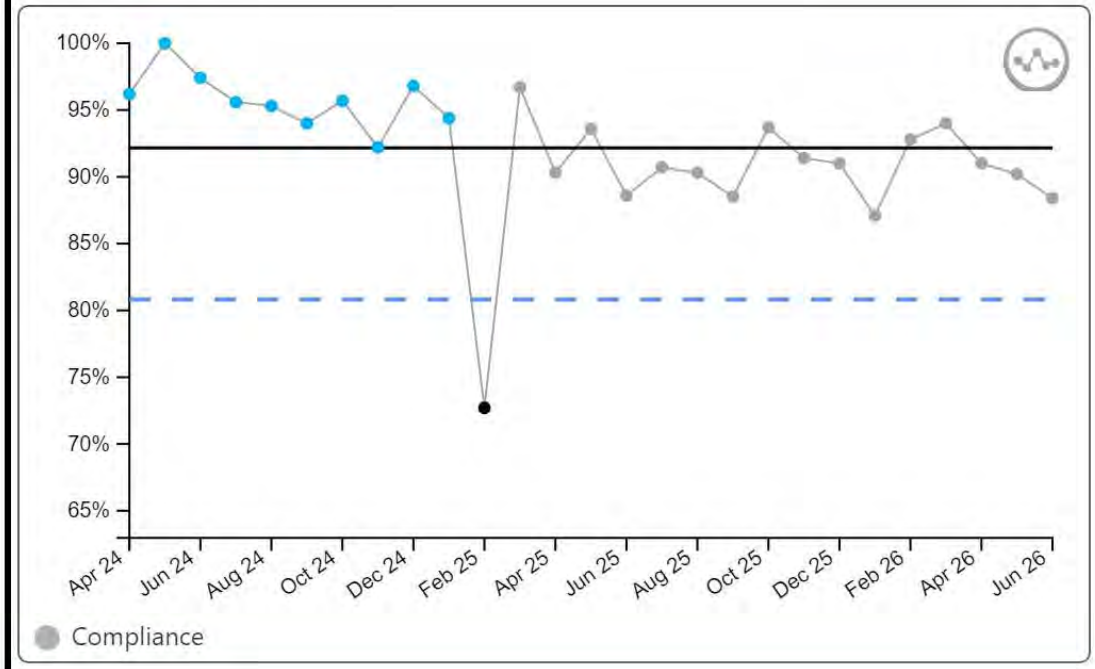
Measure: Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25
Performance: 30,524 (July 2026)
Trajectory: 59,112 (Q2 26/27)
National target: None

Ministerial Delivery
Better Lives



Measure: Maintain 95% of Palliative Care referrals assessed within 2 days
Performance: 88.4% (June 2026)
Trajectory: 92.0% (Q1 26/27)
National target: None

Better Lives



Insights and Actions

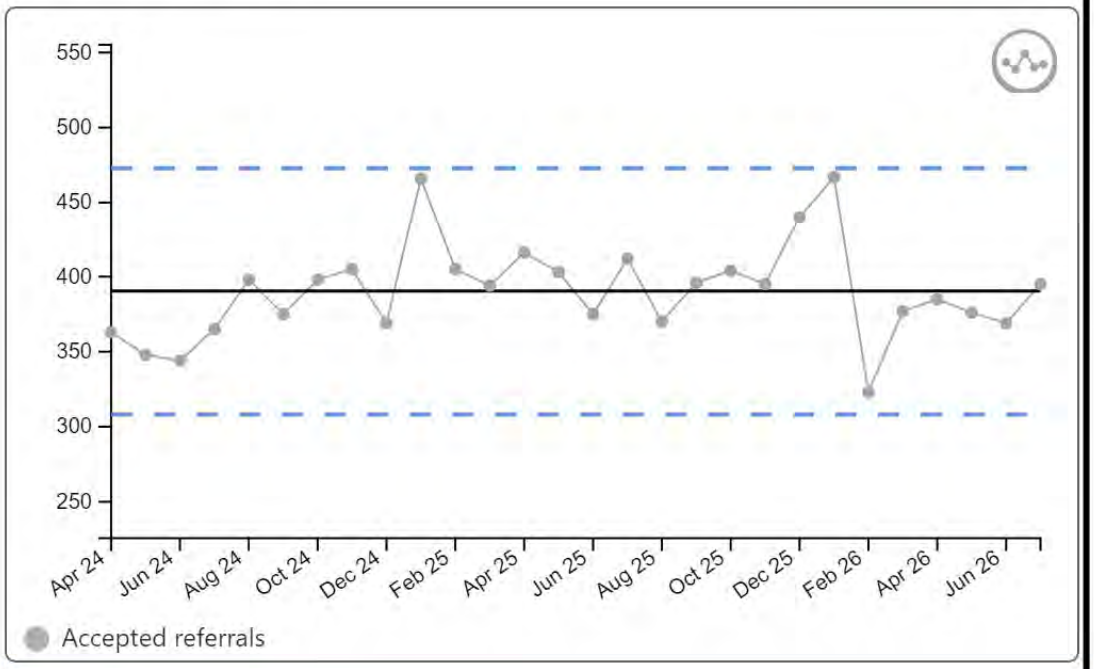
- Community Nursing: Performance is currently showing an improving trend, with above-mean capacity for the past 10 months. Q1 performance finished behind the expected trajectory, with only 77% of the IMTP trajectory delivered. Ministerial expectations set out that weekend activity reaches 80% of an average weekday level. Although weekend activity as a proportion of total activity is increasing and overall contacts are trending upwards as shown in the graph, achieving the ministerial measure from a volume perspective would demand a significant shift in service delivery towards weekends. July performance to date is 30,524 contacts.

- Palliative Care: Performance is currently showing no significant monthly change, and is just below the mean of 92%. The June position is 88.4% and just behind the Q1 IMTP trajectory of 92%.

Place Based Care

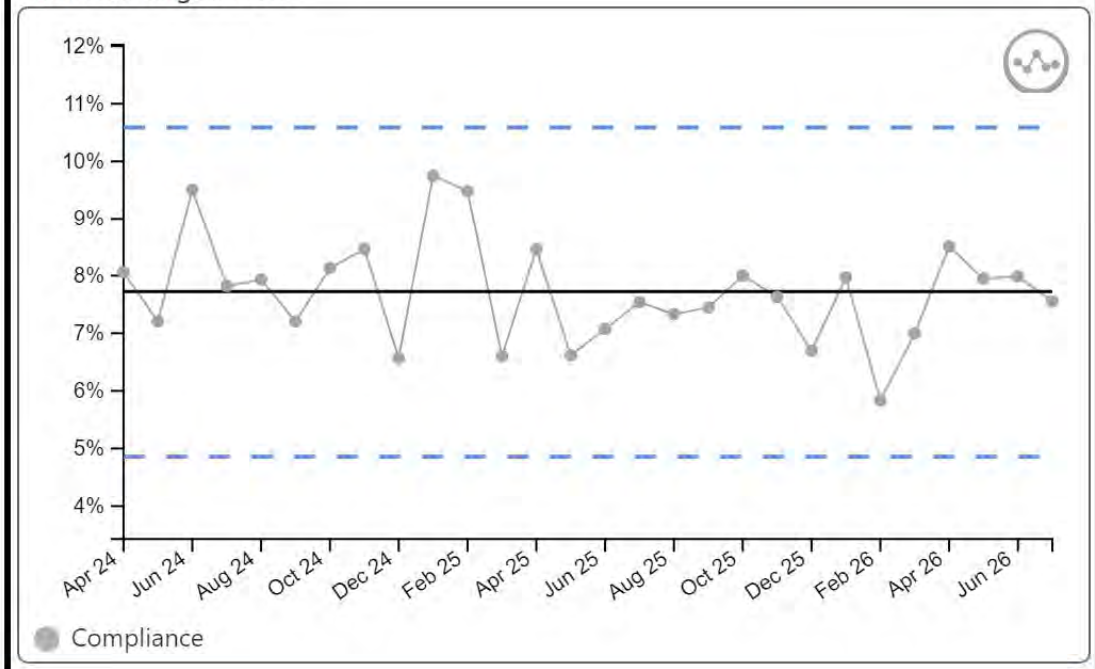
Measure: Increase in number of accepted referrals to Rapid Response services
Performance: 1,525 (July 2026)
Trajectory: 2,534 (Q2 26/27)
National target: None

Better Care



Measure: Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s
Performance: 7.6% (July 2026)
Trajectory: 8.5% (Q2 26/27)
National target: None

Better Care



Insights and Actions

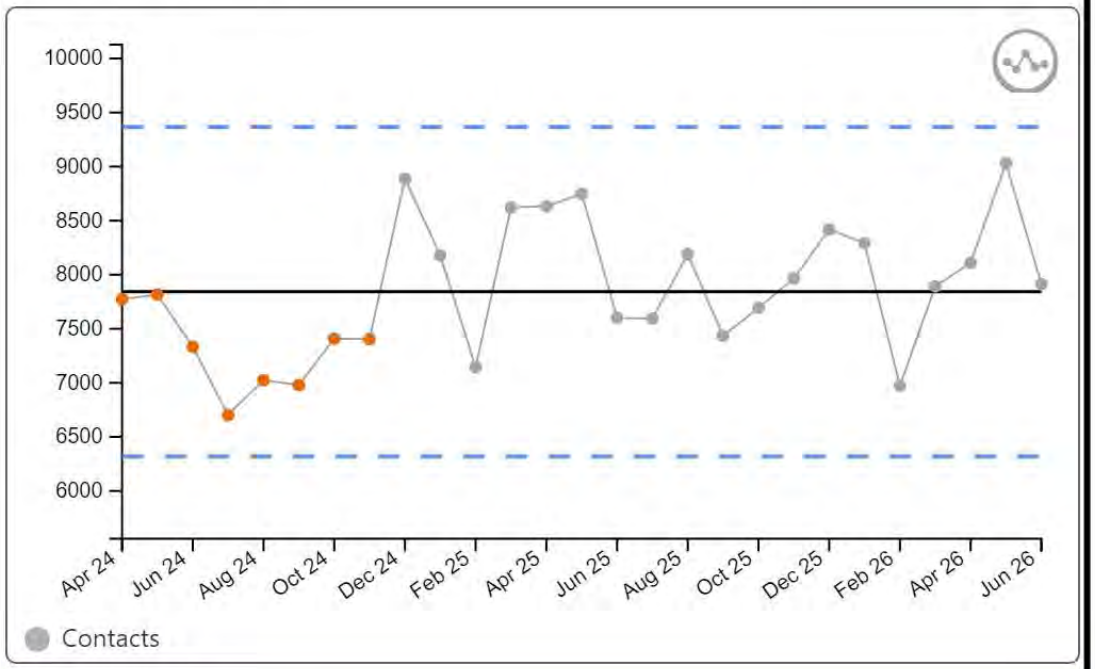
- Accepted referrals to Rapid Response: The number of accepted referrals currently shows no significant monthly change, with wide process limits indicating that performance is expected to vary between 310-470 accepted referrals per month. 26/27 performance to date has been more consistent at around 380 accepted referrals per month. Performance for Q1 was a total of 1,110 accepted referrals, around 150 less than the IMTP trajectory of 1,267. July performance to date is 1,525 referrals.

- GP referrals to Rapid Response for 65+: The proportion of GP referrals made to Rapid Response for over 65s also shows no significant monthly change. Again, there are wide process limits, indicating that the proportion referred is expected to vary between 5%-11%. April performance met the Q1 IMTP trajectory of 8.5%, but performance has been just under this in May (7.9%) and June (8%). July performance has continued this downward trend at 7.6%. As part of the UEC transformation programme (older people workstream), one of the outcomes of the Navigation Hub/Single Point of Access will be to reduce barriers for GPs to access Rapid Response Services.

Place Based Care

Measure: Maintain the number of Urgent Primary Care contacts (inc. virtual)
Performance: 25,054 (June 2026)
Trajectory: 25,437 (Q1 26/27)
National target: None

Better Care



Insights and Actions

- Urgent Primary Care (UPC): UPC contacts currently show no significant change month-on-month and exhibit a wide expected range of 6,300-9,400 contacts per month. Q1 performance finished on 25,054 contacts, around 400 contacts below the IMTP trajectory of 25,437.

Section 2.1: Timely Access to Care – Urgent & Emergency Care Performance Summary

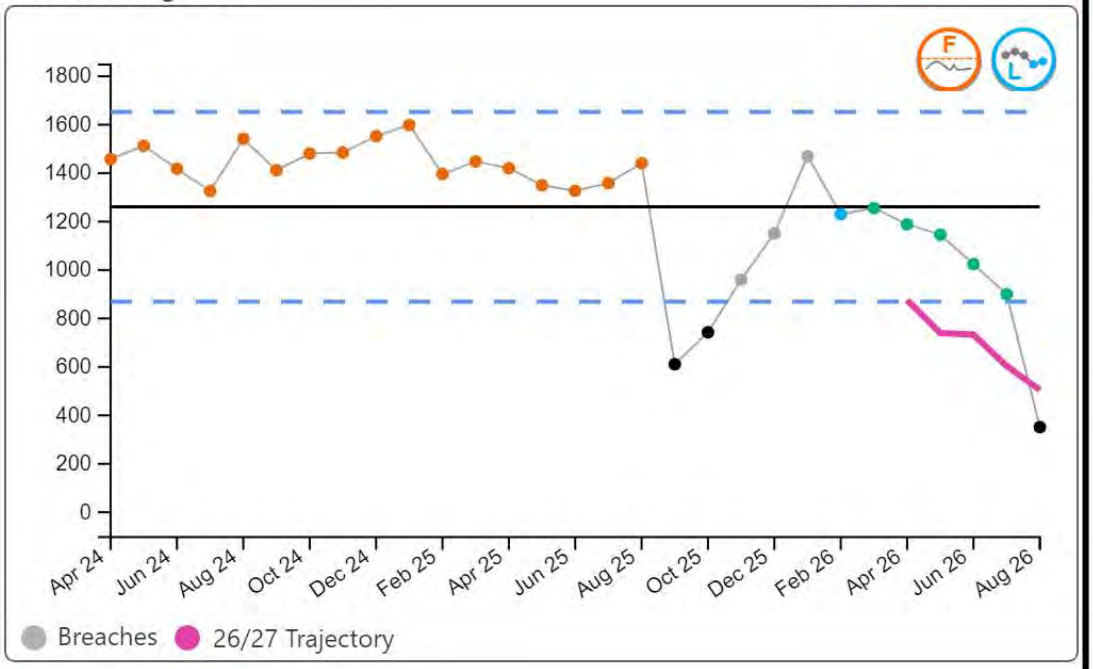
Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Urgent and Emergency Care	Ensure no ambulance patient handover waits over 45 minutes [All location types, GUH & eLGHs]	91 Mar-27	352 Aug-26 (Aug-26 Trajectory: 505)	L	F
	Ensure no ambulance patient handover waits over 45 minutes [GUH ED only]	80 Mar-27	290 Aug-26 (Aug-26 Trajectory: 413)	L	F
	Reduce the number of ambulance crew hours lost [All location types, GUH & eLGHs]	960 Mar-27	539 Aug-26 (Aug-26 Trajectory: 1,733)	L	?
	Reduce the number of ambulance crew hours lost [GUH ED only]	768 Mar-27	480 Aug-26 (Aug-26 Trajectory: 1,386)	L	?
	Reduce the number of patients who spend 12-hours or more in all Major and Minor Emergency Care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero	799 Mar-27	1,312 Aug-26 (Aug-26 Trajectory: 941)		F
	% of patients who spend less than 12 hours in all Major and Minor Emergency Care (i.e. A&E) facilities from arrival until admission, transfer or discharge	95% Mar-27	91.9% Aug-26 (Aug-26 Trajectory: 94%)		F
	Reduction in time from arrival to ED triage - no waits over 60 minutes	200 Mar-27	546 Aug-26 (Aug-26 Trajectory: 300)		?
	Median time from arrival at an Emergency Department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months.	60 Mar-27	151 Aug-26 (Aug-26 Trajectory: 100)		F
	Increase and maintain national target of the percentage of patients waiting <4-hours in ED/MIU	77% Mar-27	71.8% Aug-26 (Aug-26 Trajectory: 75%)	L	?

Section 2.1: Timely Access to Care – Urgent & Emergency Care Performance Summary

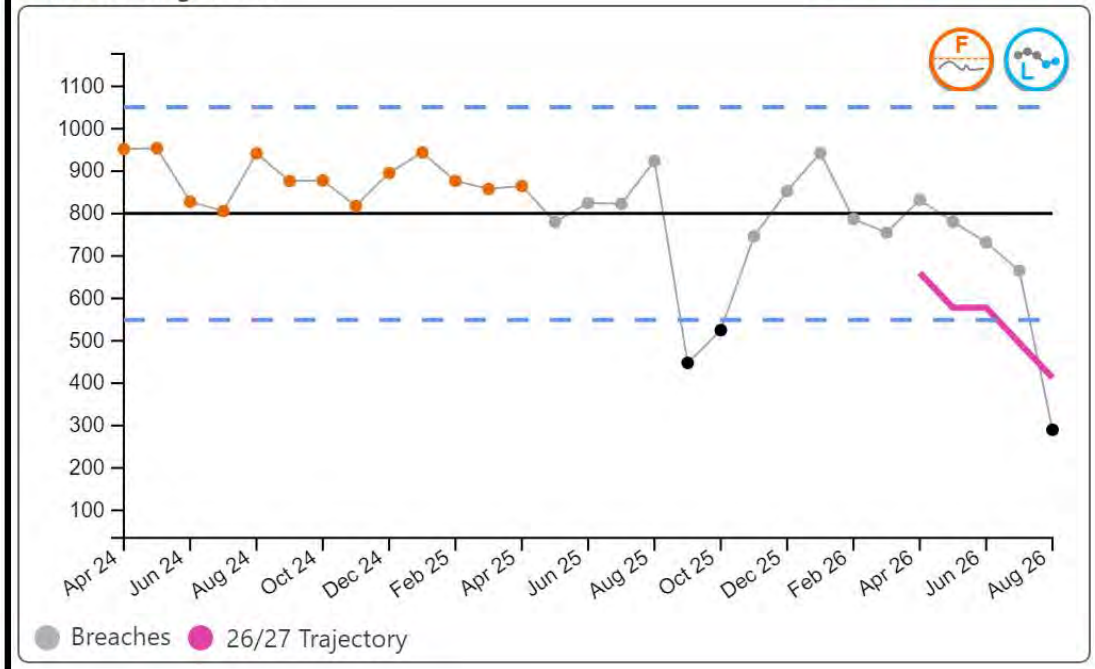
Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Urgent and Emergency Care	Improve the percentage of pre noon Provider Spell discharges	17.1% Mar-27	16% Aug-26 (Aug-26 Trajectory: 16.5%)		
	Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard	120 Mar-27	152 Aug-26 (Aug-26 Trajectory: 140)		
	Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard	3,840 Mar-27	5,160 Aug-26 (Aug-26 Trajectory: 4,200)		
	Percentage of suspected stroke patients scanned within 20 minutes of clock start	35% Mar-27	15.3% Jul-26 (Jul-26 Trajectory: 26%)		
	% of patients directly admitted to an Acute Stroke Ward <4-hrs of clock start	23% Mar-27	35.7% Jul-26 (Jul-26 Trajectory: 20%)	H	
	% of unique Stroke patients given Thrombectomy (all stroke types)	6% Mar-27	1.7% Jul-26 (Jul-26 Trajectory: 5%)		
	% Assessed by OT within 24hrs	32.5% Mar-27	47.5% Jul-26 (Jul-26 Trajectory: 28%)	H	
	% Assessed by PT within 24hrs	30% Mar-27	49.2% Jul-26 (Jul-26 Trajectory: 25%)	H	
	% Assessed by SaLT within 72hrs	72% Mar-27	89.7% Jul-26 (Jul-26 Trajectory: 68%)		

Urgent & Emergency Care System

Measure: Ensure no ambulance patient handover waits over 45 minutes [All location types, GUH & eLGHs]
Performance: 352 (August 2026)
Trajectory: 505 (August 2026)
National target: 0



Measure: Ensure no ambulance patient handover waits over 45 minutes [GUH ED only]
Performance: 290 (August 2026)
Trajectory: 413 (August 2026)
National target: 943



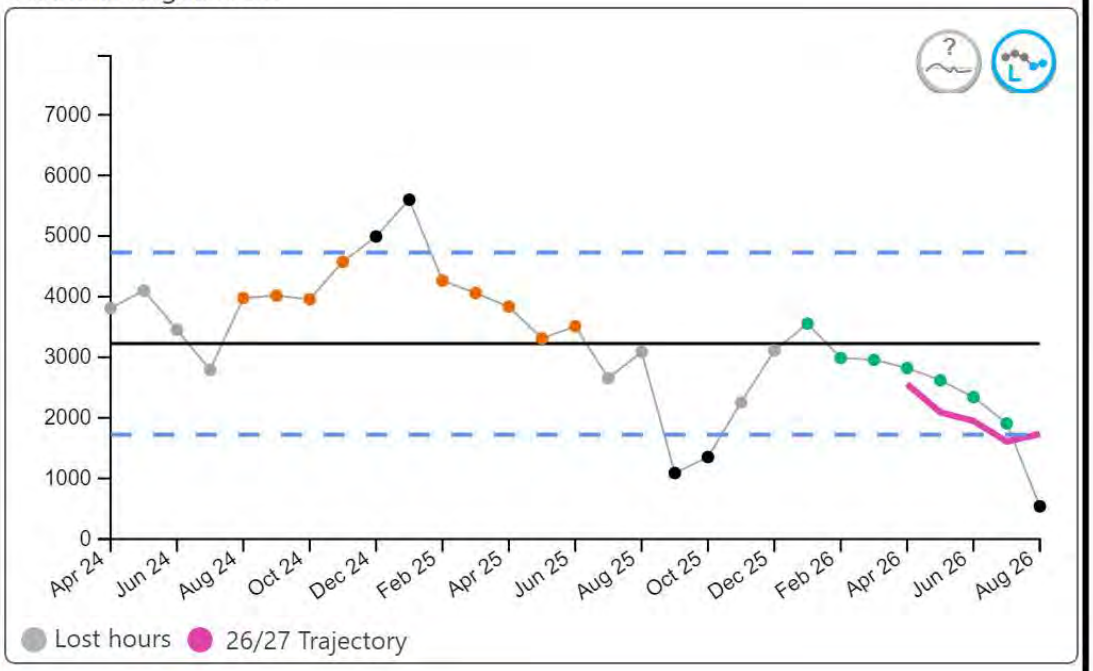
Insights and Actions

- Ambulance handovers over 45 minutes: August saw significant improvement achieved against the Handover 45 (H45) standard. Under both the new Targeted Intervention (TI) definition (ambulances over 45 minutes at GUH & eLGHs across all location types, previously ambulances over 1 hour at GUH ED only) and 45 minute breaches at GUH ED reduced to their lowest ever levels since the opening of the Grange. Under the new TI measure, both the annual plan performance trajectory (505) and the TI de-escalation threshold (651) have been met, however the latter does need to be maintained for three months to full satisfy the criteria. Since the Rapid Release Protocol was enacted from the 12th August, 45 minute handover compliance at GUH ED has been 93.6% with several days achieving 100% compliance. 45 minute handover compliance improvement is also evident at locations beyond GUH ED, with August performance of: GUH AMU: 89.3%; GUH SAU: 98.4%, and; eLGH AMUs: 95.8%.

Urgent & Emergency Care System

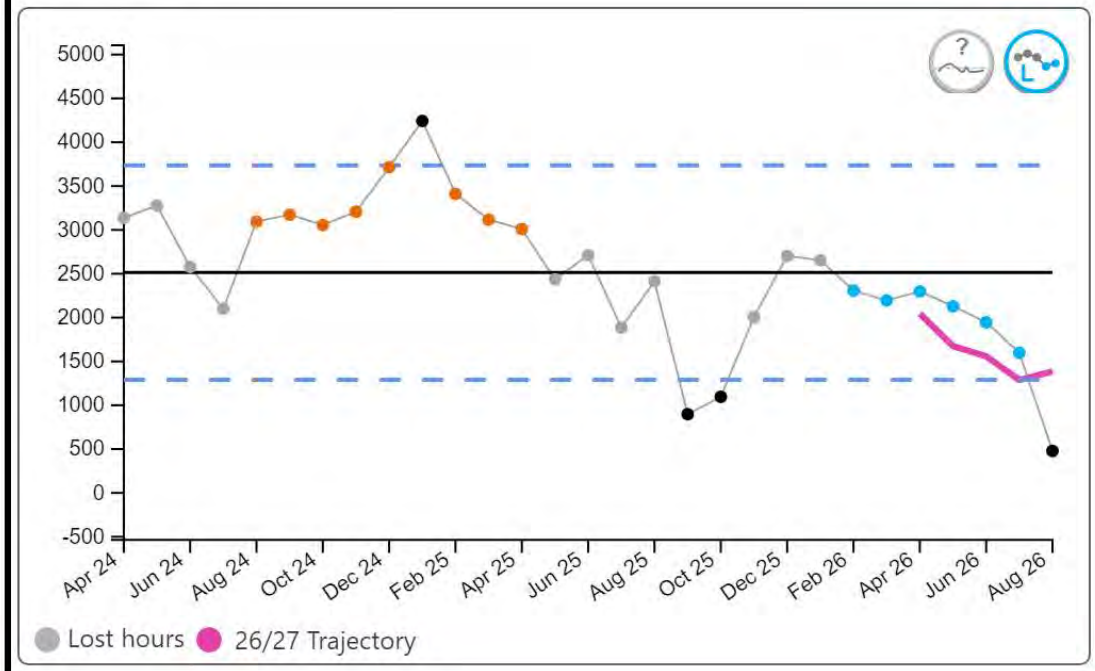
Measure: Reduce the number of ambulance crew hours lost [All location types, GUH & eLGHs]
Performance: 539 (August 2026)
Trajectory: 1,733 (August 2026)
National target: None

Better Care



Measure: Reduce the number of ambulance crew hours lost [GUH ED only]
Performance: 480 (August 2026)
Trajectory: 1,386 (August 2026)
National target: None

Better Care



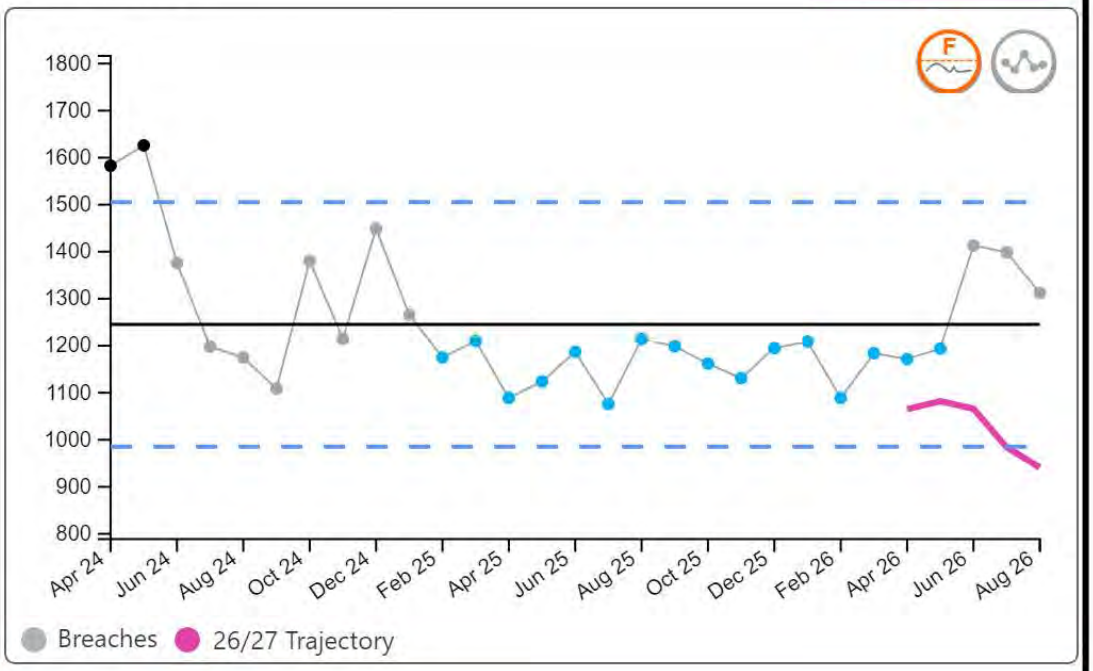
Insights and Actions

- Ambulance lost hours: Correspondingly, crew hours lost across both measures also saw reductions to record lows in August. At GUH ED, In the first part of August (from 1st to 11th Aug) lost hours was 346. From the 12th onwards crew hours lost totalled just 134. August average handover time was 34 minutes, with the isolated period since Rapid Release Protocol (from 12th to month end) Aug averaging 19 minutes. Under the wider measure (GUH & eLGHs), average handover reduced to 27 minutes for the month with the period from the 12th to month end being 17 minutes. 59 crew hours were lost outside of GUH ED in August, with just 23 from the 12th to month end. The six-week UEC sprint which ran through the summer was central to delivering a series of improvements across the entirety of the UEC pathway which has enabled improved handover performance, including strengthened escalation arrangements, standardised patient flow processes, enhanced discharge planning, improved operational oversight, AMU reconfiguration, Hospital to Home enhancements and the rollout of the "What Five Questions" approach.

Urgent & Emergency Care System

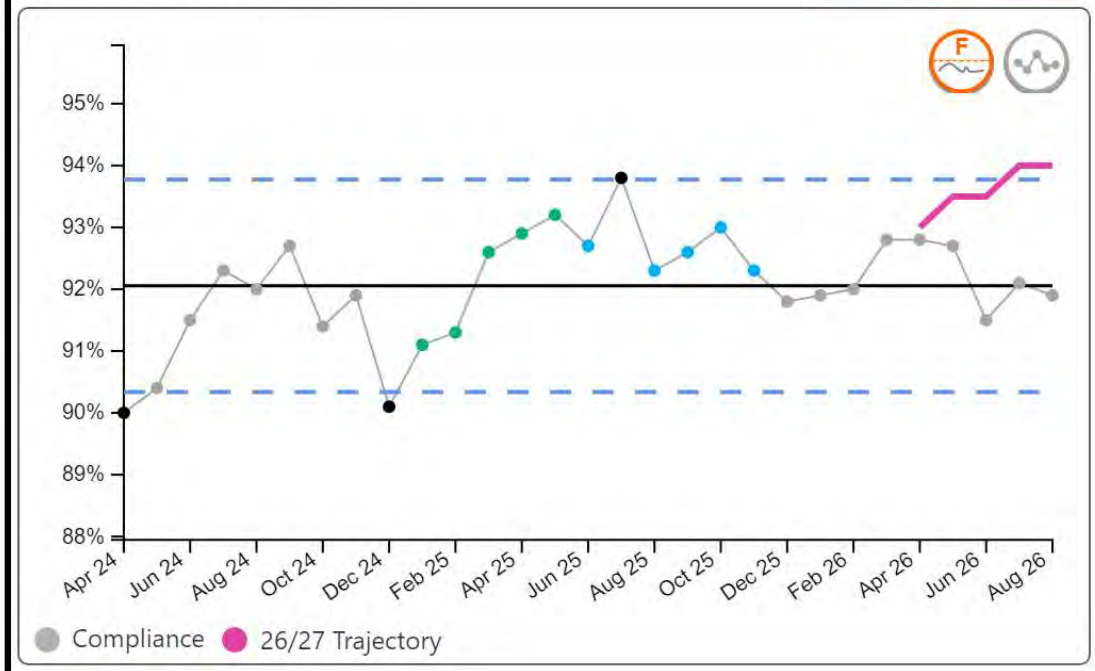
Measure: Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero
Performance: 1,312 (August 2026)
Trajectory: 941 (August 2026)
National target: 0

Ministerial Delivery
Better Care



Measure: % of patients who spend less than 12 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge
Performance: 91.9% (August 2026)
Trajectory: 94.0% (August 2026)
National target: 93.0%

Targeted Intervention
Better Care



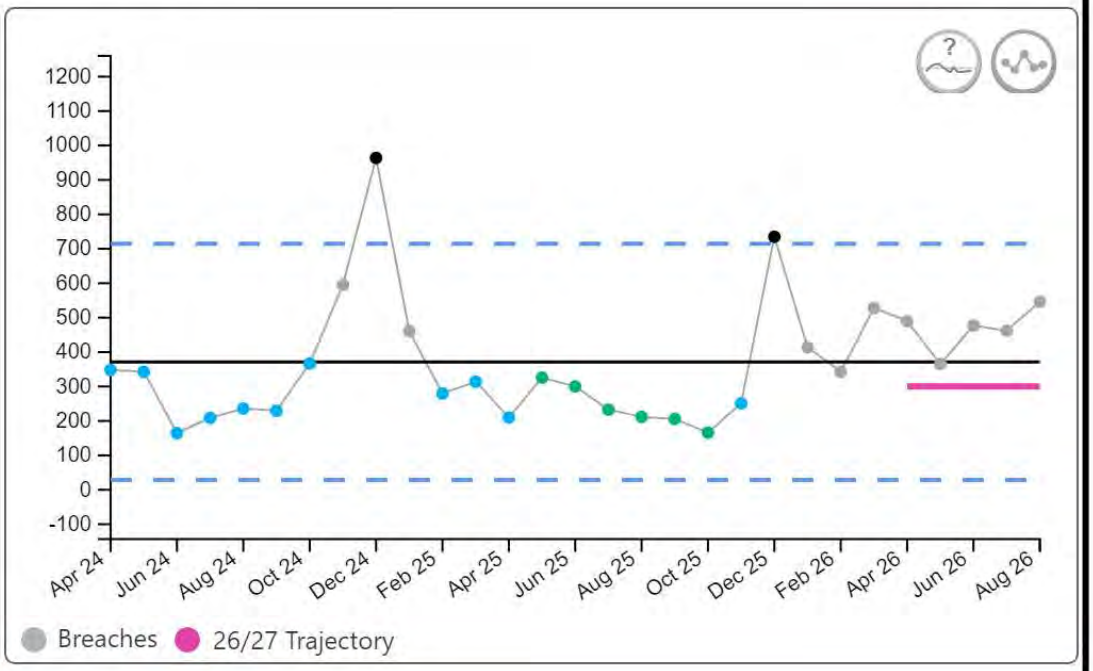
Insights and Actions

- 12hr EDMIU: 12-hour performance has been more challenged over the past three months, both by total breach volume and as a percentage of all attendances (e.g. compliance, shown on the right), with neither meeting the respective Annual Plan trajectories as of the August position. There was marginal improvement in performance when comparing August performance pre and post 12th August (introduction of the Rapid Release Protocol), with daily average breaches reducing by ~10, however more data points and adjacent flow indicators will need to be analysed before any confident assessment can be made on correlation with ambulance handover performance. Improved flow through the entirety of the UEC pathway remains central to delivering improved patient experiences and outcomes, as well as meeting the four measures within the targeted intervention criteria (ambulance handovers, 12hr performance, clinician waits to be seen, and pathway of care delays). The Multi Agency Discharge Event (MADE) brought together Health, Social Care and System Partners to review discharge processes and identify barriers preventing timely discharge. The event highlighted a number of common themes across sites, including delays in diagnostics and specialist reviews, limited therapy and rehabilitation capacity, variation in discharge pathways, workforce pressures, inconsistent management of Estimated Dates of Discharge (EDD), and increasing levels of patient complexity.

Urgent & Emergency Care System

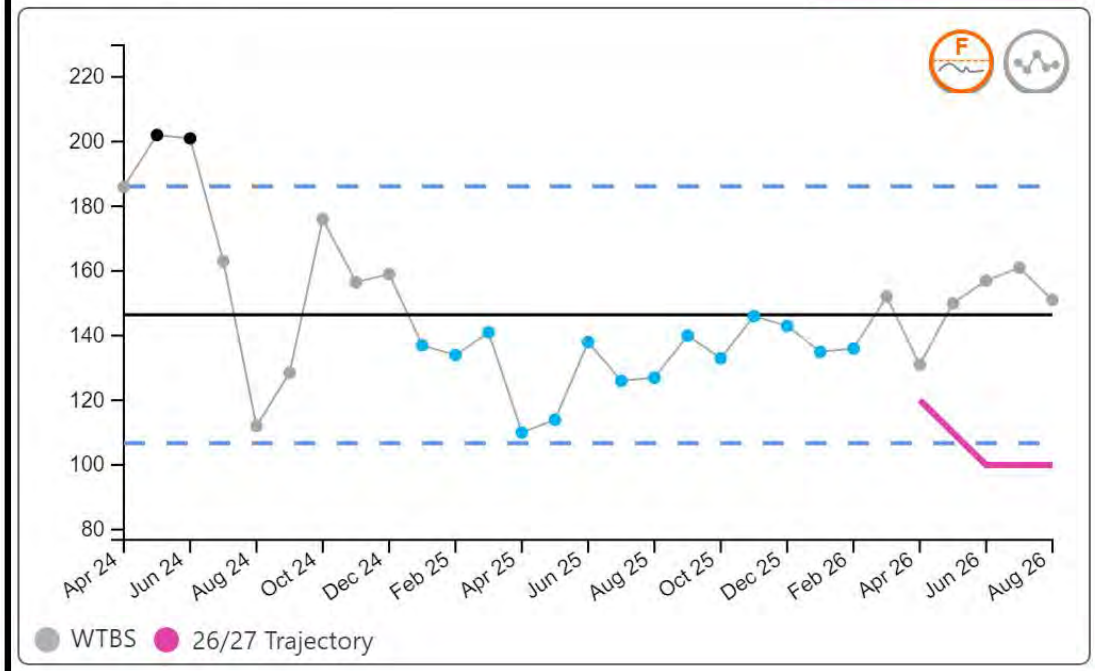
Measure: Reduction in time from arrival to ED triage - no waits over 60 minutes
Performance: 546 (August 2026)
Trajectory: 300 (August 2026)
National target: None

Better Care



Measure: Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months.
Performance: 151 (August 2026)
Trajectory: 100 (August 2026)
National target: 60

Targeted Intervention
Better Care



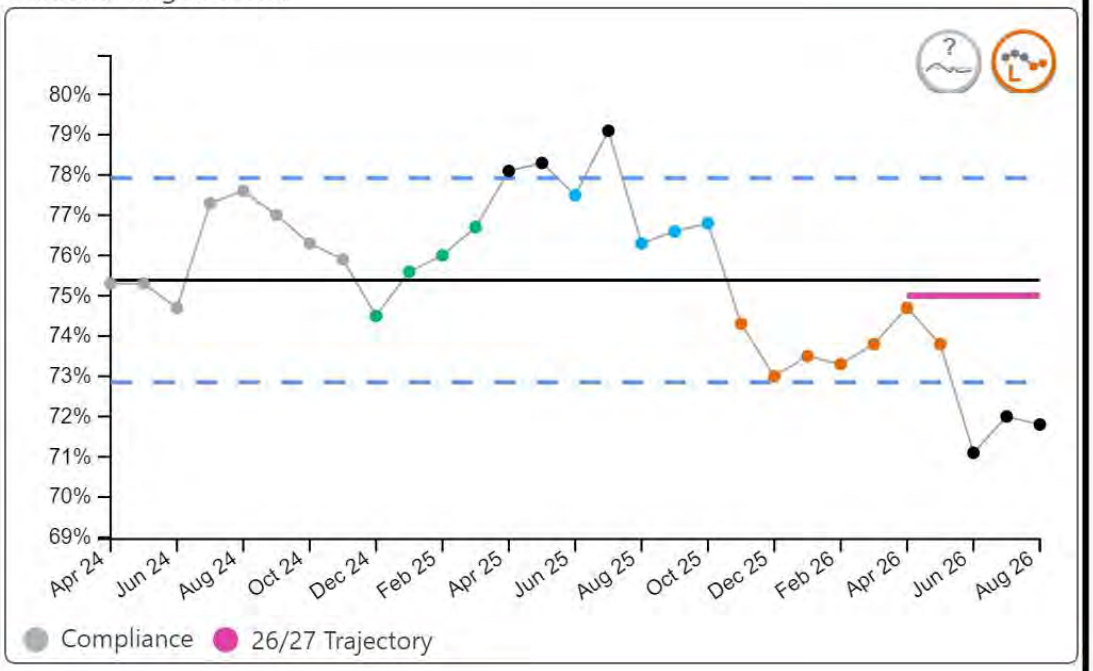
Insights and Actions

- Triage: Following the Winter peak in January, 60-minute triage breaches have remained elevated when compared to the same period in 2025. The August, daily, breach profile is analogous to that of the previous months this calendar year, whereby outlier days have a high volume of breaches. There is no significant variance in performance between the two pre and post 12th Aug periods.
- Wait to be seen (WTBS): Clinician Median Wait/WTBS has been on an a slight, overall upwards trajectory since Apr-25 and remains in excess of the Annual Plan improvement trajectory. In August there has been a small reduction median wait to be seen at GUH ED. There was a 24 minute improvement when comparing the pre and post 12th August periods. The rate of attendances seen within 60-minutes is improved again at 24.3% (May 21.3%, Jun 22.7%, Jul 23.4%), and the cohort of patients who wait more than 6 hours improved slightly by reducing to 19.9% (from 20.4% in July).

Urgent & Emergency Care System

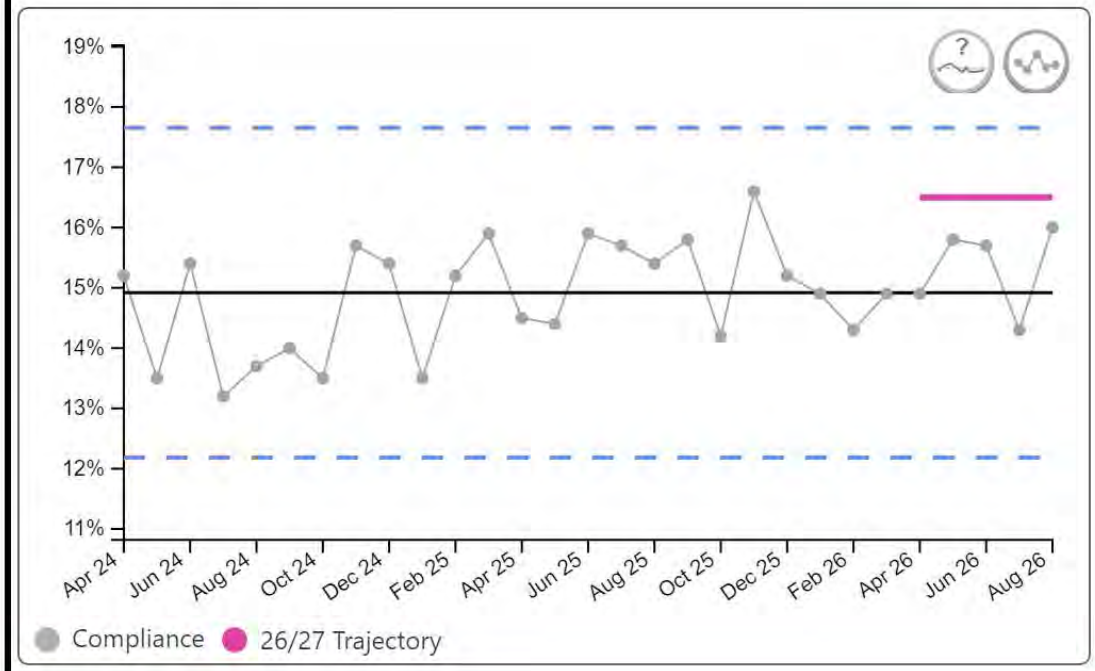
Measure: Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU
Performance: 71.8% (August 2026)
Trajectory: 75.0% (August 2026)
National target: 95.0%

Better Care



Measure: Improve the percentage of pre noon Provider Spell discharges
Performance: 16.0% (August 2026)
Trajectory: 16.5% (August 2026)
National target: 33.0%

Better Care



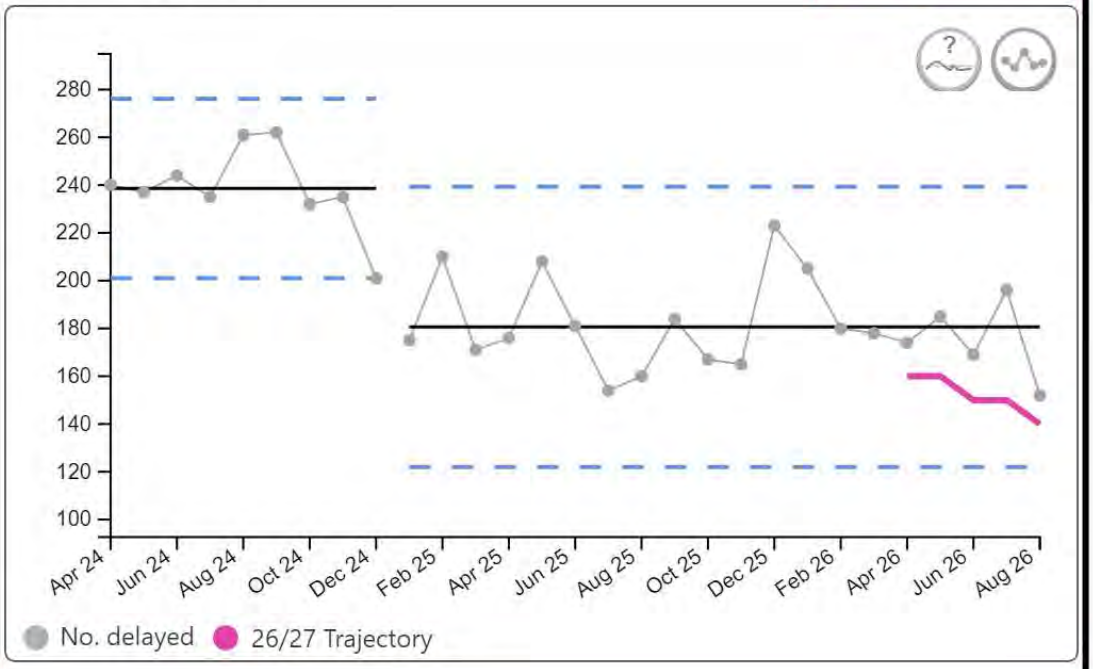
Insights and Actions

- 4hr EDMIU: 4-hour performance has been below the mean since October 25, driven by performance at the GUH. In the past three reportable months, performance has decreased further to levels outside of the lower process control limit and materially below the Annual Plan trajectory. GUH ED performance has decreased to below 45%%, with decreases in compliance also observed at the eLGH MIUs. As per the actions already described around embedding the continuous flow model through the entirety of the UEC pathway, delivery of these is central to improving the performance of this front door metric.
- Pre noon discharge performance: Pre noon discharge performance was one of the key metrics monitored by NHS P&I during the Winter Sprint periods and continues to form part of the daily operational returns submitted by the Health Board. It is recognised that earlier discharges enable better flow through the hospitals, and therefore the Health Board included this measure in the 26/27 Annual Plan for the first time. As backdoor flow remains a critical part of the overarching UEC transformation plan, the work underway through embedding the Optimal Hospital Flow Framework (OHFF) seeks to improve the rate of pre noon Provider Spell (e.g. patients going to their usual place of residence/leaving the system rather than transfers). August performance increased to 16% (0.5% lower than current trajectory), driven by improvements at GUH and NHH.

Urgent & Emergency Care System

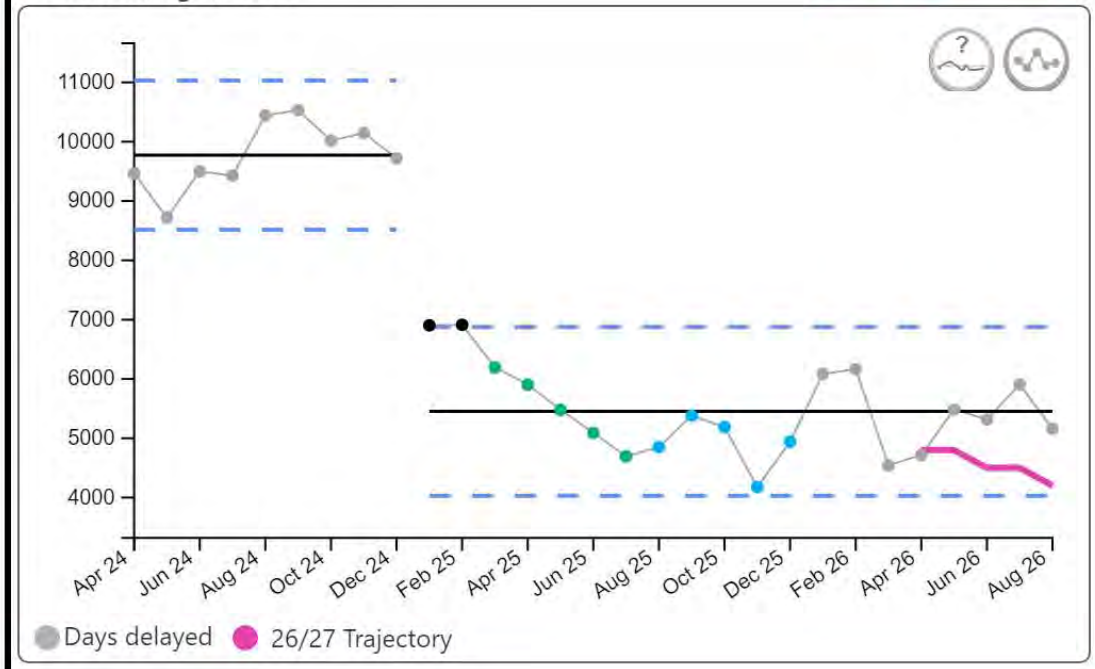
Measure: Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard
Performance: 152 (August 2026)
Trajectory: 140 (August 2026)
National target: None

Ministerial Delivery
Targeted Intervention
Better Care



Measure: Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard
Performance: 5,160 (August 2026)
Trajectory: 4,200 (August 2026)
National target: None

Ministerial Delivery
Better Care



Insights and Actions

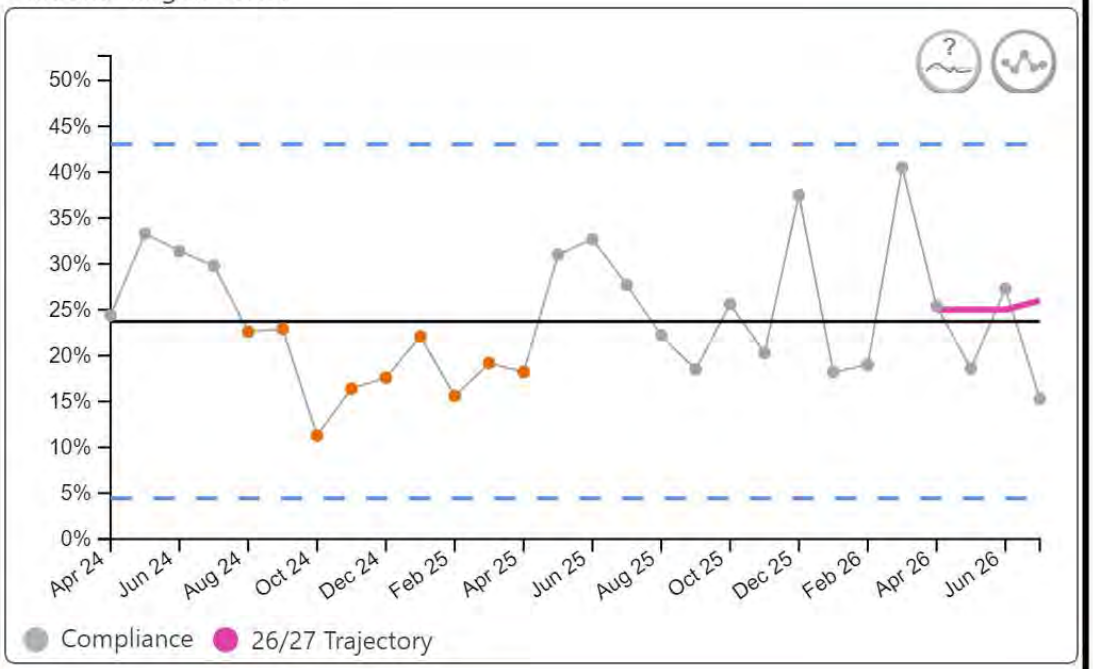
- Pathway of Care Delays (POCDs): The number of POCDs has been maintained around the mean of 178 from February 26, sustaining improvement from the 2025/26 high in December. The August position is a substantial reduction on July (-44, -22.4%) and the lowest position in the held dataset. This improvement has been primarily driven by a reduction in Joint and Social assessment delays. POCDs by days delayed has shown more variability but has demonstrated close to mean (5,455) performance for the past four months. The August position has reduced back down below the mean to 5,160 days, which is a reduction on the July position (-12.6%) but a slight increase on last year (+6.4%). Average days delayed increased consistently from March 26 (27 days) to June26 (31 days), following the relative stability in POCDs and increase in days delayed. The substantial reduction in POCDs in August has been proportionally greater than the reduction in days delayed, increasing the average days delayed to 34 in August. Despite a substantial reduction in POCDs in August, POCDs by volume and days delayed remain behind the IMTP trajectories. Significant focus remains on reviewing the longest staying patients, as well as new processes in place across Divisions to improve the accuracy of Estimated Discharge Dates (EDDs) and the recording of reasons that are preventing patients moving to the next step of the discharge planning process.

NB: The POCD and Days delayed charts have been split from Jan-25, reflecting the sustained improvement born out of partnership working in the 50-day challenge.

Urgent & Emergency Care System

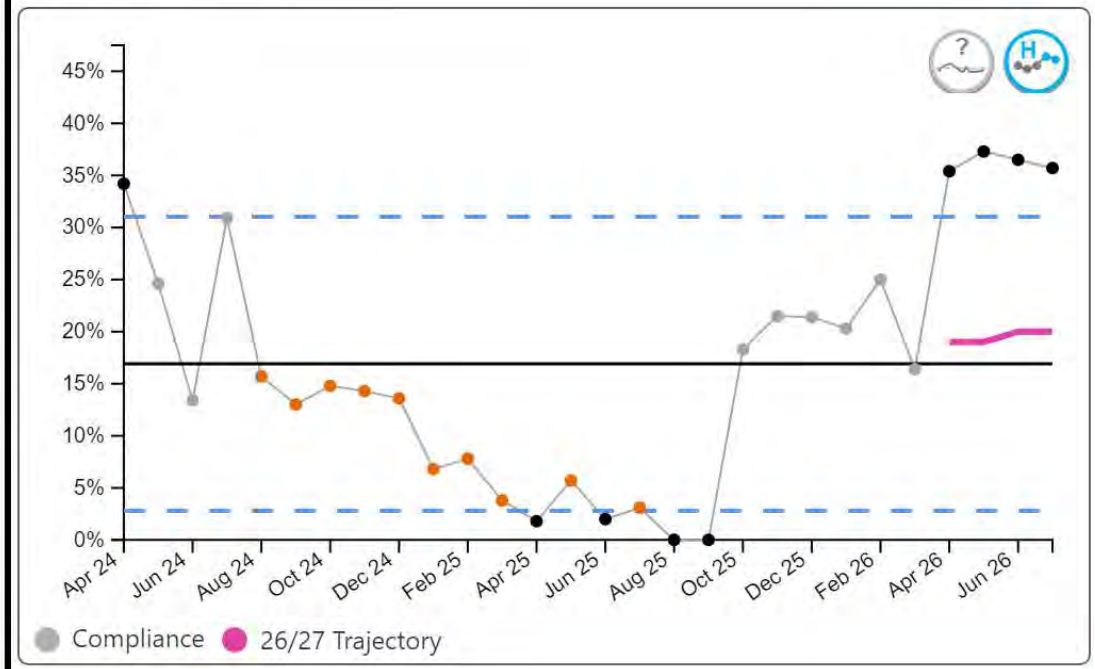
Measure: Percentage of suspected stroke patients scanned within 20 minutes of clock start
Performance: 15.3% (July 2026)
Trajectory: 26.0% (July 2026)
National target: 40.0%

Better Care



Measure: % of patients directly admitted to an acute stroke ward <4hrs of clock start
Performance: 35.7% (July 2026)
Trajectory: 20.0% (July 2026)
National target: 50.0%

Better Care



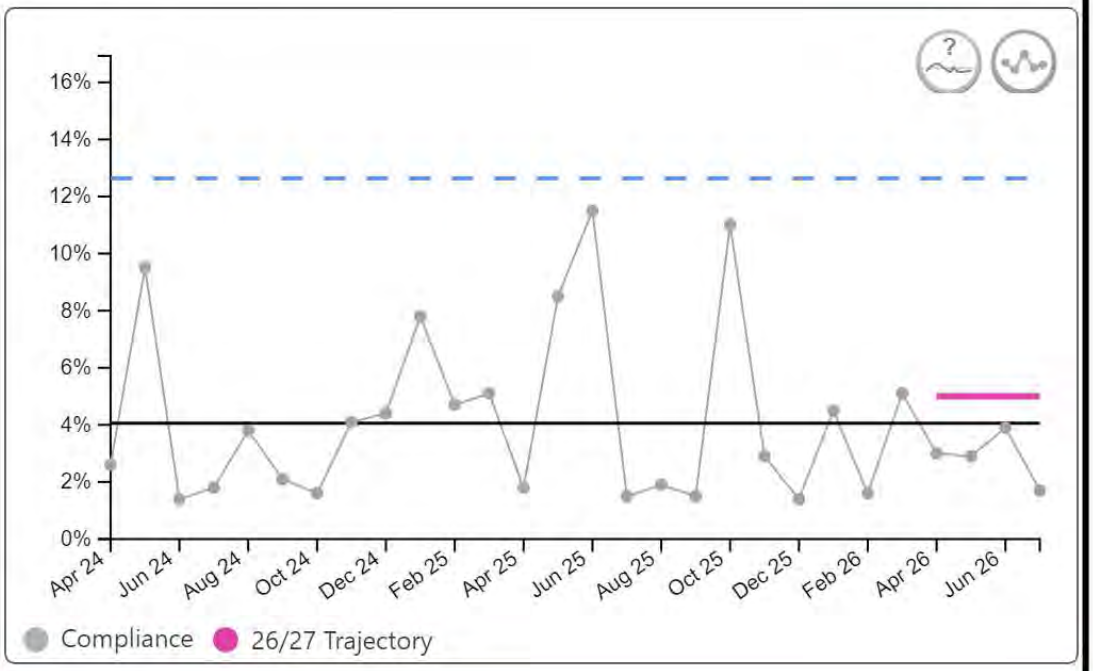
Insights and Actions

- Stroke time to scan: The percentage of patients scanned within 20 minutes of clock start has been included within the 26/27 NHS Wales Performance Framework and has been adopted by the Health Board as a core performance measure within the Annual Plan for 26/27. Year to date performance has fluctuated, with July performance decreasing to 15.3%. A review of the CT scanning pathway and adoption of perfusion scanning is underway.
- Stroke 4-hour target: Year to date 4-hour performance has been much improved and consistent, in excess of 35% and materially above trajectory. A pathway improvement workshop was held in July, identifying several opportunities to enhance performance, including reducing portering delays across the patient pathway, establishing clearer exit routes for stroke mimic patients to improve flow, and reviewing rehabilitation capacity and the availability of B4 beds to support timely transfers and reduce delays.

Urgent & Emergency Care System

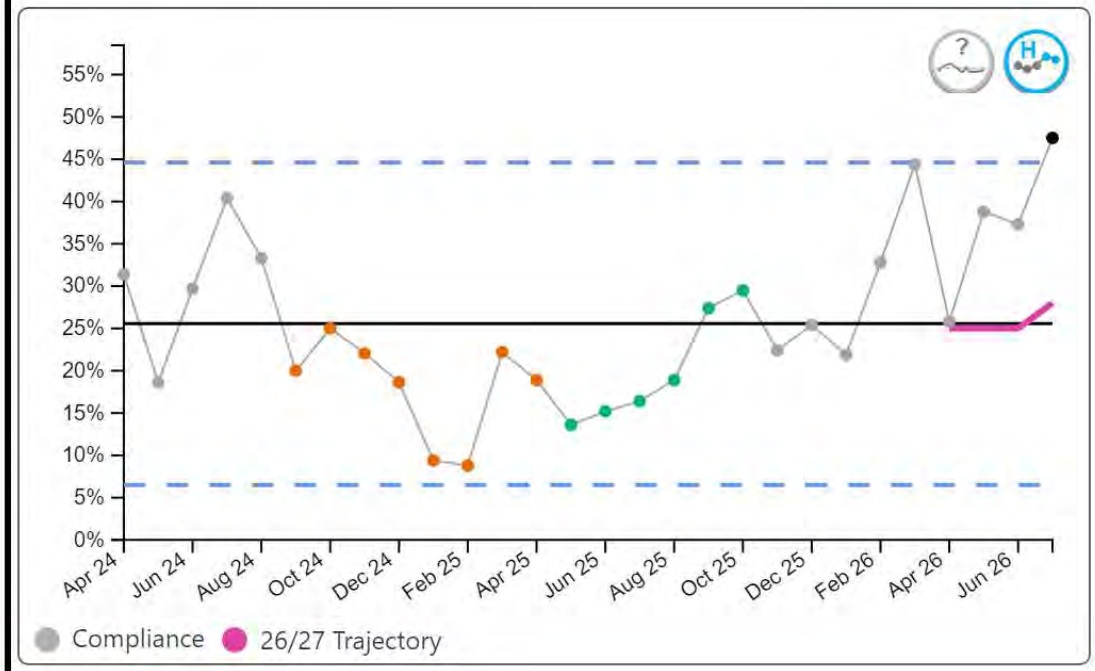
Measure: % of unique stroke patients given thrombectomy (all stroke types)
Performance: 1.7% (July 2026)
Trajectory: 5.0% (July 2026)
National target: 10.0%

Better Care



Measure: % Assessed by OT within 24hrs
Performance: 47.5% (July 2026)
Trajectory: 28.0% (July 2026)
National target: None

Better Care



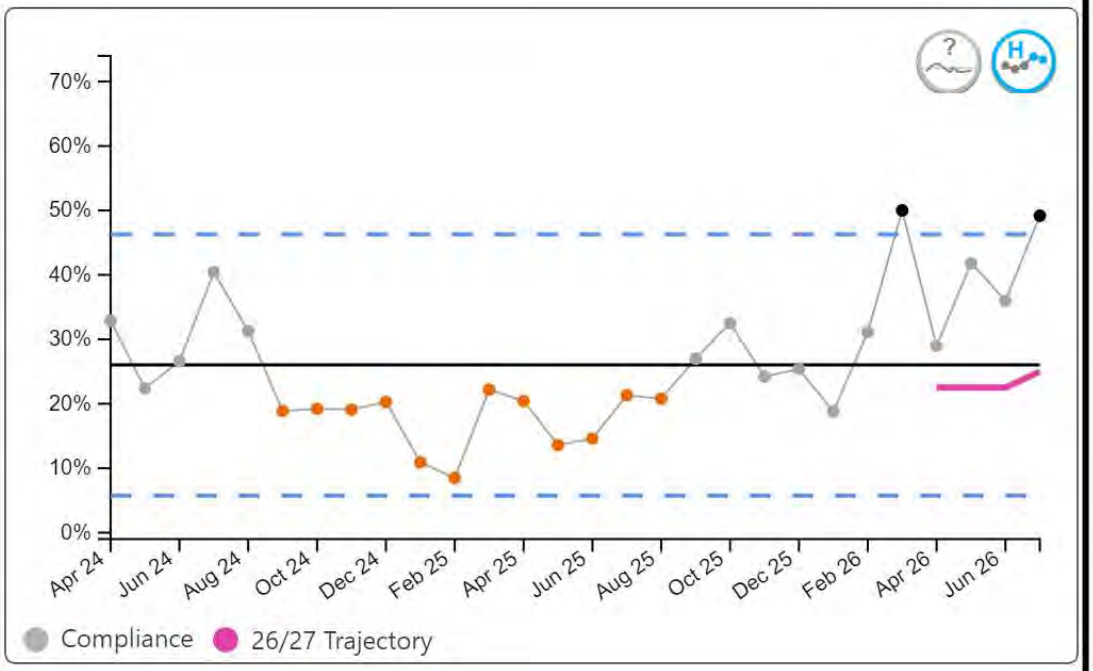
Insights and Actions

- Stroke thrombectomy: Thrombectomy rates were improved slightly through the first quarter of the 26/27, however there remains no overall variation in performance and July decreased to 1.7%. Thrombectomy commissioning and data capture has been discussed between ABUHB and NHS P&I. NHS P&I are liaising with the JCC around commissioning approach and particularly hours of service provided from Southmead (NBT), an extension to which could assist in improving rates further. The internal Stroke improvement plan linked to improving thrombolysis rates is underway and will have linked benefit to thrombectomy where applicable, with shared learning from other Health Boards who have introduced and significantly improved thrombolysis rates.

Urgent & Emergency Care System

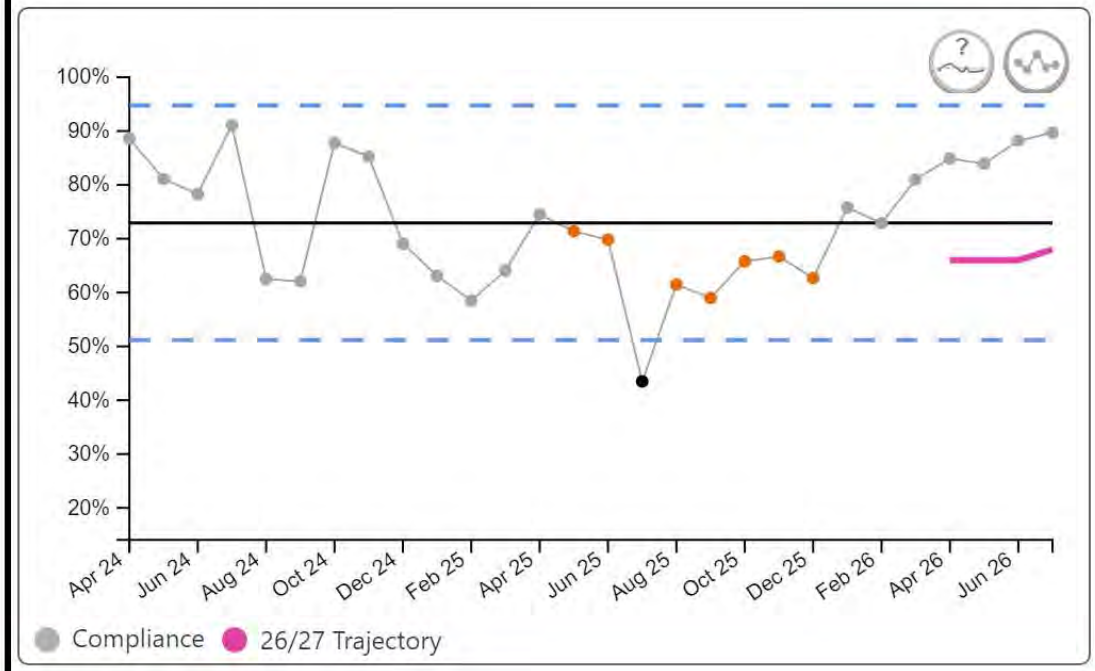
Measure: % Assessed by PT within 24hrs
Performance: 49.2% (July 2026)
Trajectory: 25.0% (July 2026)
National target: None

Better Care



Measure: % Assessed by SaLT within 72hrs
Performance: 89.7% (July 2026)
Trajectory: 68.0% (July 2026)
National target: None

Better Care



Insights and Actions

- Stroke therapies: Occupational (previous page) and Physiotherapy assessment within 24-hours continue to demonstrate an overall improvement trajectory, with each recording their latest performance in excess of the upper control limit. Speech & Language within 72-hours also continues to deliver elevated levels of compliance. Work is underway with clinical teams to optimise Early Supported Discharge (ESD) pathways, including the development of direct discharge models from GUH and via YYF, alongside exploration of a dedicated Therapist model within GUH. Further opportunities include optimising length of stay within the dedicated Inpatient Rehabilitation Unit at YYF and reducing reliance on boarding within rehabilitation beds to improve patient flow and maximise rehabilitation capacity.

Section 2.1: Timely Access to Care – Cancer, Planned Care & Diagnostics Performance Summary

Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Cancer, Planned Care & Diagnostics	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	75% Mar-27	60.2% Jul-26 (Jul-26 Trajectory: 73.4%)		F
	% of urgent suspected cancer patients diagnosed within 28-days from point of suspicion	75% Mar-27	77.6% Jul-26 (Jun-26 Trajectory: 72.5%)	H	?
	Reduction in backlog of patients waiting over 62-days (SCP)	170 Mar-27	274 Jul-26 (Jul-26 Trajectory: 335)		?
	Reduction in backlog of patients waiting over 104-days (SCP)	50 Mar-27	86 Jul-26 (Jul-26 Trajectory: 100)		?
	Numbers of patients waiting over 104-weeks (all stages)	2,291 Mar-27	375 Aug-26 (Aug-26 Trajectory: 998)		P
	Reduction in the number of patients waiting more than 8-weeks for a specific diagnostic	0 Mar-27	2,997 Aug-26 (Aug-26 Trajectory: 2,715)	H	?
	Number of patients waiting over 52-weeks for Outpatients	3,012 Mar-27	1,463 Aug-26 (Aug-26 Trajectory: 2,794)	H	P
	Number of patients waiting over 26-weeks for Outpatients	18,306 Mar-27	14,078 Aug-26 (Aug-26 Trajectory: 14,544)	H	P
	Reduction in referral rate per 100,000 population by December 2026 - utilising Health Pathways optimally	6,600 Mar-27	6,046 Aug-26 (Aug-26 Trajectory: 6,700)		?

Section 2.1: Timely Access to Care – Cancer, Planned Care & Diagnostics Performance Summary

Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Cancer, Planned Care & Diagnostics	Monitoring of DNA rates Outpatient clinics	5% Mar-27	5.7% Aug-26 (Aug-26 Trajectory: 5%)		F
	Reduction in the number of patients waiting 100% past Outpatient follow-up target date	23,606 Mar-27	33,898 Aug-26 (Aug-26 Trajectory: 28,078)	H	F
	Increase in the rate of See On Symptom and Patient Initiated Follow-ups	15% Mar-27	12.6% Aug-26 (Aug-26 Trajectory: 13.8%)	L	?
	Number of adults waiting more than 14-weeks for all Audiology pathways	7,385 Mar-27	5,949 Aug-26 (Aug-26 Trajectory: 6,432)	H	P
	Number of children waiting more than 6-weeks for all Audiology pathways	1,762 Mar-27	1,363 Aug-26 (Aug-26 Trajectory: 1,428)	H	?
	No patient waiting more than 14-weeks for a Therapeutic assessment	830 Mar-27	857 Aug-26 (Aug-26 Trajectory: 540)	H	P

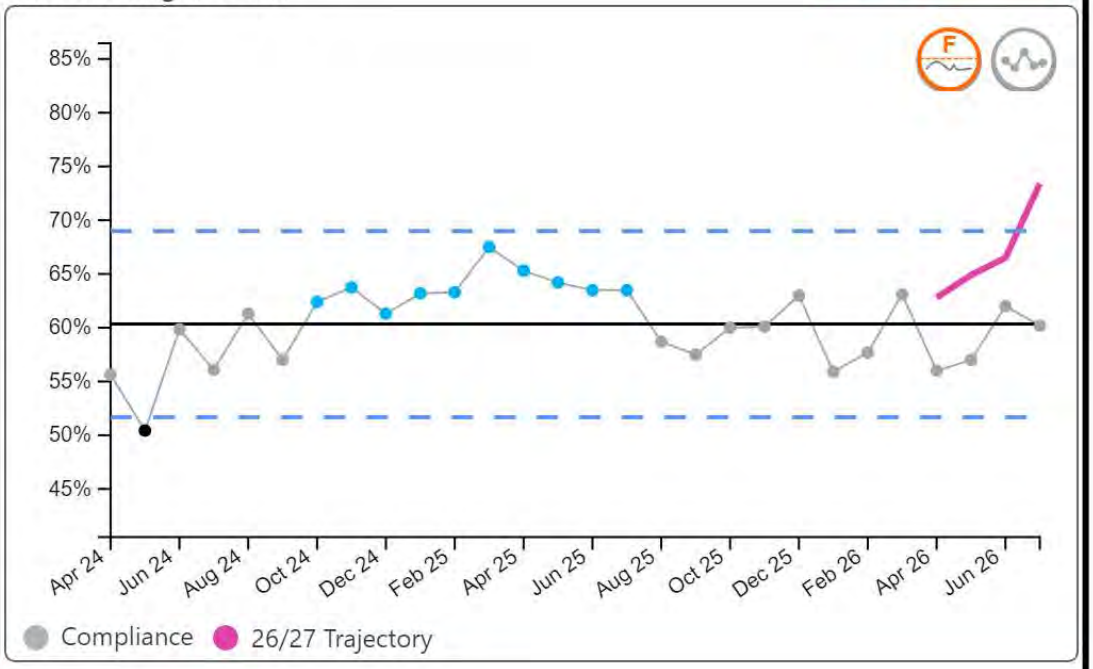
Section 2.1: Timely Access to Care – Cancer, Planned Care & Diagnostics Performance Summary

Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Cancer, Planned Care & Diagnostics	Theatre Utilisation: late starts to less than 20%	25% Mar-27	44.9% Aug-26 (Aug-26 Trajectory: 35%)		F
	Theatre Utilisation: early finishes to less than 10%	15% Mar-27	24.6% Aug-26 (Aug-26 Trajectory: 22.5%)		?
	Theatre Utilisation: session utilisation to 85%	85% Mar-27	82% Aug-26 (Aug-26 Trajectory: 85%)		?
	Deliver improvements in day surgery rates, measured through BADS day case rates	80% Mar-27	77.2% Apr-26 (Apr-26 Trajectory: 78%)		

Cancer

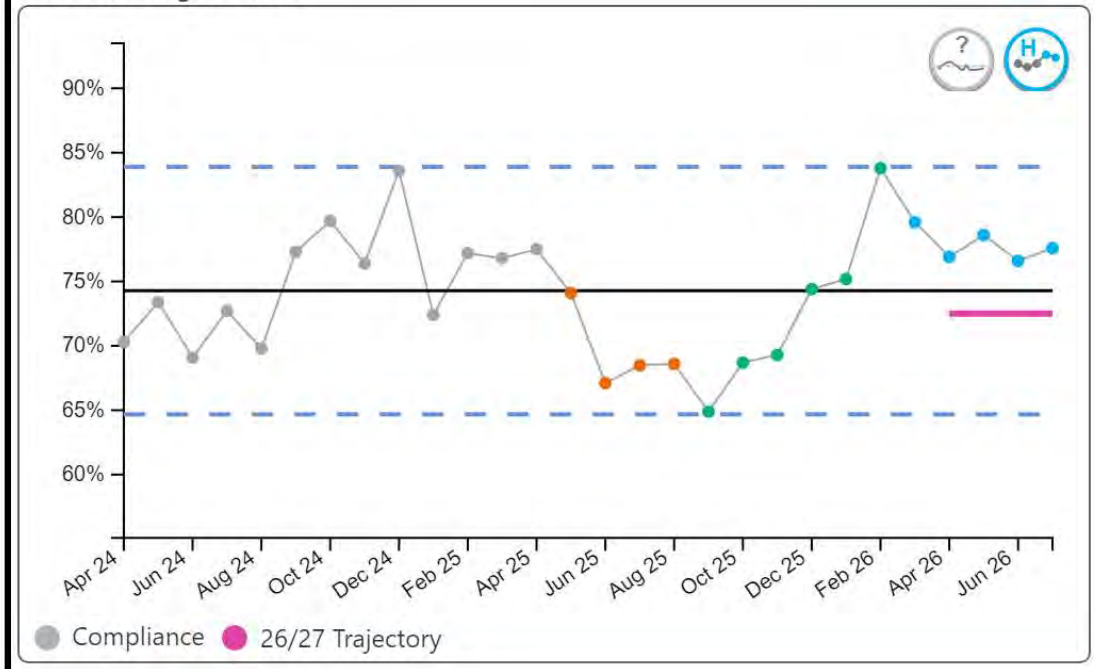
Measure: 12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion
Performance: 60.2% (July 2026)
Trajectory: 73.4% (July 2026)
National target: 75.0%

Ministerial Delivery
Better Care



Measure: % of urgent suspected cancer patients diagnosed within 28 days from point of suspicion
Performance: 77.6% (July 2026)
Trajectory: 72.5% (July 2026)
National target: 75.0%

Better Care



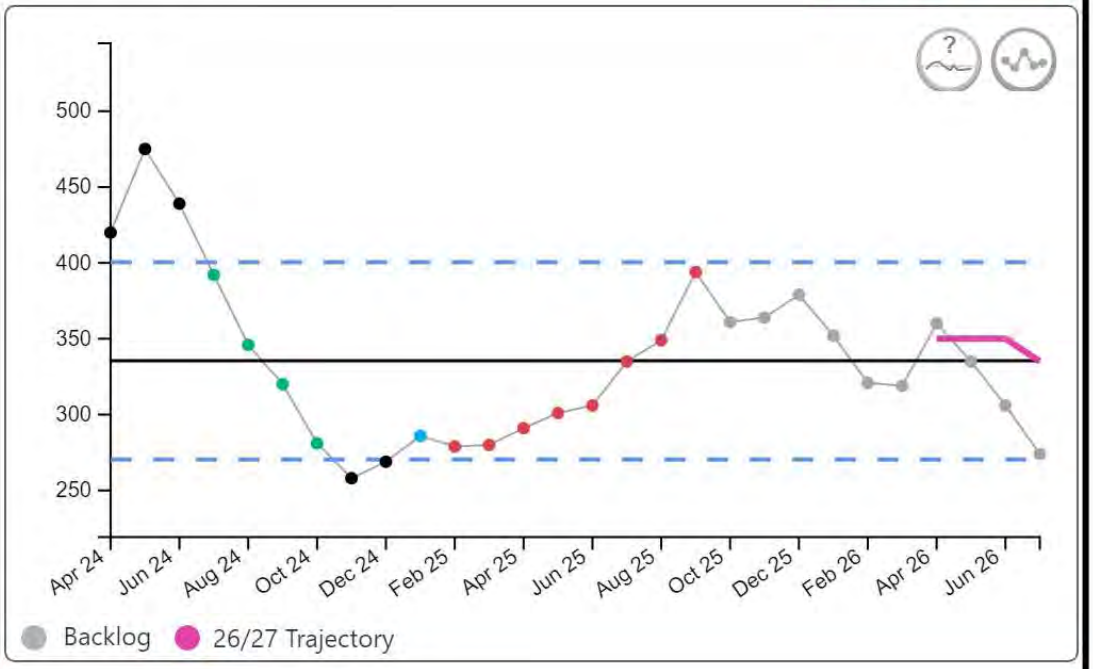
Insights and Actions

- SCP compliance: Performance dropped slightly in July, with compliance at 60.2%. The IMTP plan for July was 387 treatments, of which 103 would be breaches and 284 SCP achieved. Total treatments were as planned, but the volume of breaches was above plan (+51) leading to compliance not meeting the July IMTP trajectory of 73.4%. The majority of tumour sites showed below trajectory compliance for July, with only Head & Neck and Skin performing above trajectory and Gynaecological just meeting trajectory. Of note, LGI has maintained its improvement in compliance from 16% in May up to 49% in June, with 41% in July. In colorectal services, a detailed action plan has been developed to support improvements in patient pathways and SCP compliance, supported by the establishment of a recovery action planning group to focus on key areas for improvement. A priority is addressing significant challenges at the first diagnostic stage of the pathway. Regionally some work on urology tumour site is being commissioned due to challenges across all Health boards
- 28 day diagnosis compliance: Performance has shown a period of improvement from the second half of 2025/26 and compliance remains above the mean (74.3%) into 2026/27. July performance is 77.6%, achieving the IMTP trajectory of 72.5% and surpassing the national target of 75%.

Cancer

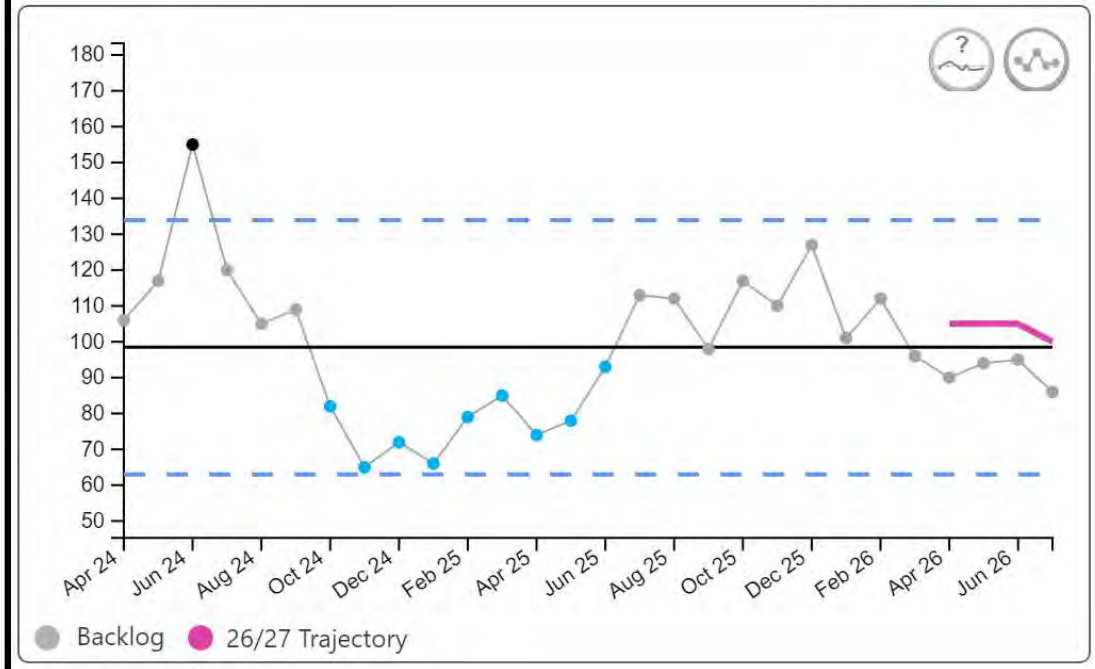
Measure: Reduction in backlog of patients waiting over 62 days (SCP)
Performance: 274 (July 2026)
Trajectory: 335 (July 2026)
National target: None

Ministerial Delivery
Better Care



Measure: Reduction in backlog of patients waiting over 104 days (SCP)
Performance: 86 (July 2026)
Trajectory: 100 (July 2026)
National target: None

Ministerial Delivery
Better Care



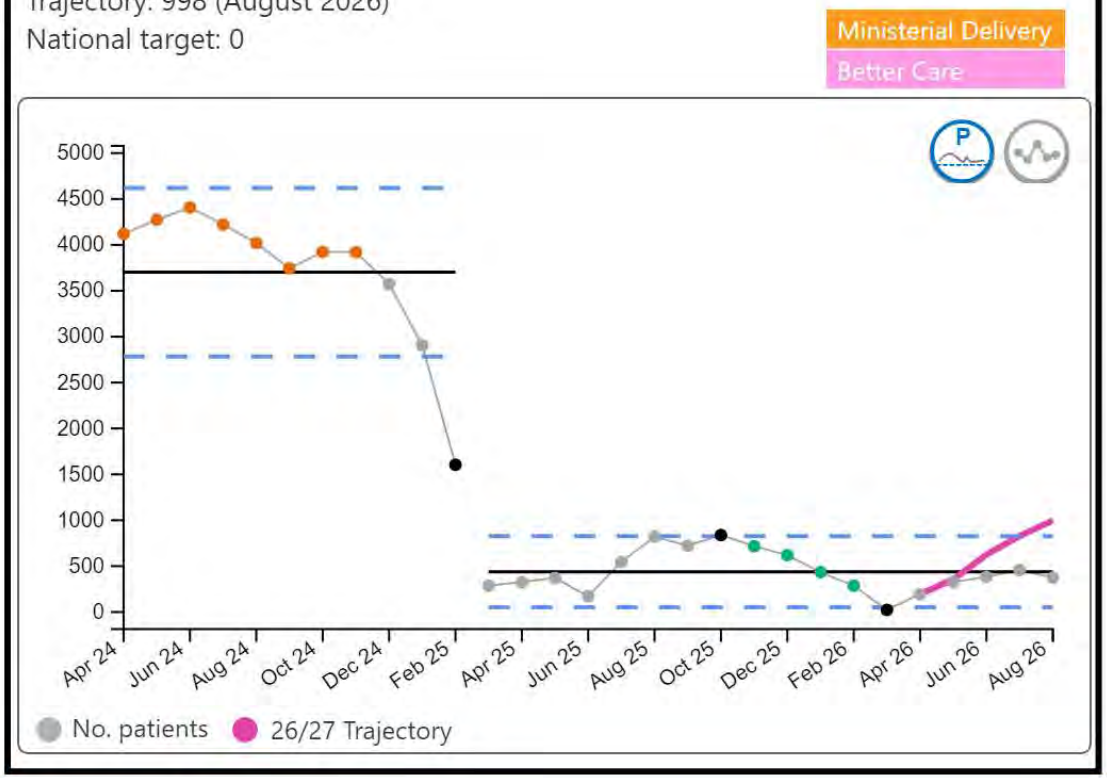
Insights and Actions

- 62-day backlog: The 62-day backlog showed a prolonged period of deterioration from February 25 until September25, increasing by around 100 patients. This has been steadily reducing since, reaching a 9-month low in March 26. July performance has continued a 3-month reduction with performance at 274, surpassing the IMTP trajectory of 335. The commitment for the 62-day backlog is to be 10% of the SCP Census, aspiring to 5% of the SCP Census. The SCP Census has mirrored the 62 day backlog trend, increasing through 25/26 reaching a high of ~3,900 in July, followed by a sustained reduction, maintained at around 2,800 since May. The July backlog of 274 represents 9.7% of the total PTL. There remains a continued focus to reduce the backlog in the three tumour sites the make up over 66% of the entire 62 day backlog (Lower GI, Upper GI and Urology).

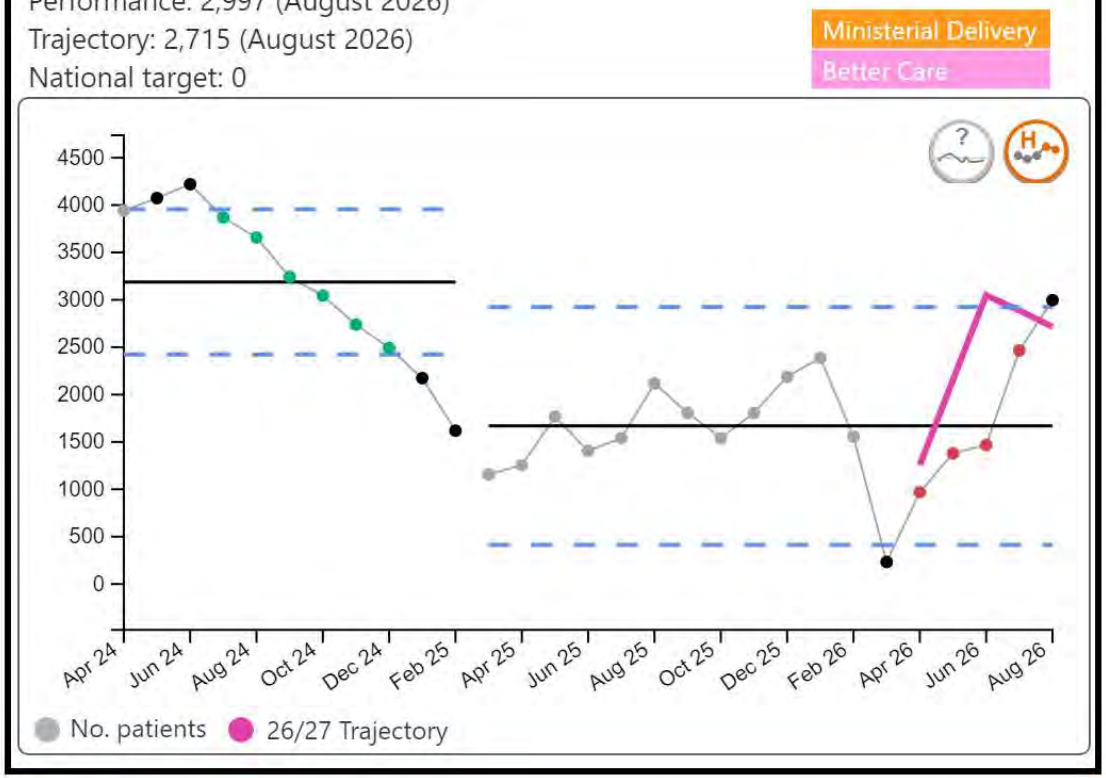
- 104-day backlog: The 104-day backlog has been largely stable around the mean (98) for the past year, even in the context of an SCP Census that has been subject to fluctuation. The last 5-months have seen performance drop back below the mean, with 86 patients in July surpassing the IMTP trajectory of 100. The commitment for the 104-day backlog is to be no more than 3% of the SCP Census, which has been met in July with 3% of the SCP Census waiting over 104 days.

Planned Care & Diagnostics

Measure: Numbers of patients waiting over 104 weeks (all stages)
Performance: 375 (August 2026)
Trajectory: 998 (August 2026)
National target: 0



Measure: Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic
Performance: 2,997 (August 2026)
Trajectory: 2,715 (August 2026)
National target: 0



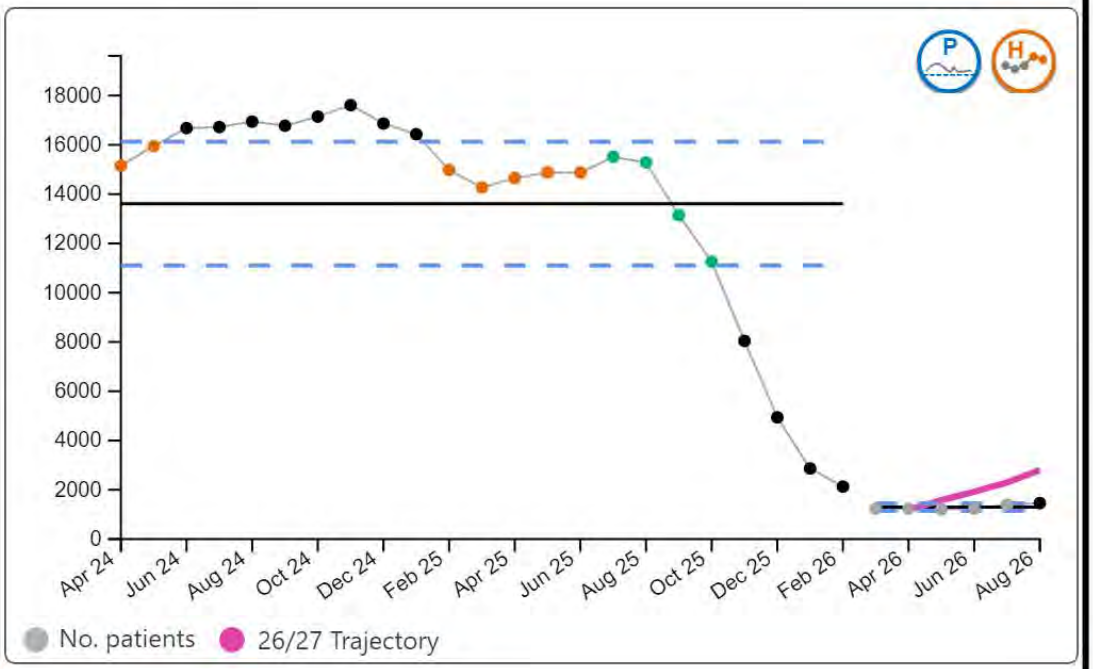
Insights and Actions

- 104 weeks RTT: Following the significant achievement in reducing planned care waits over 104 weeks to 23 at the end of the 25/26, the lowest number since April 2020, the Health Board responded to a national request by submitting (in collaboration with the SE Wales Regional Health Boards) Planned Care Recovery plans within which the elimination of 104wk waits was one component. As of the end of the August there has been a level of non-recurrently funded, additional to core activity delivered across several surgical specialities, which is reflected in the validated July & August positions. The Health Board is currently finalising its delivery plan following the recent funding announcement, which will include an end of year to reflect the additional activity that any new monies can facilitate.
- Diagnostics: Following the receipt of additional funding in the latter part of 25/26, March saw the Health Board deliver an extraordinary reduction in 8 weeks breaches, reducing from 1,557 in February to a year end position of 233. As of August, the number of patients waiting over 8 week is marginally above trajectory but within tolerance. Like with 104wk waits, diagnostic recovery was included in the plan submitted to WG and trajectories by modality are currently in the process of being updated to reflect not only updated assumptions from the original Annual Plan trajectory, but also to reflect any additionally funded delivery. RISP implementation has made in month reporting for Radiology more challenging, with significant month end validation required to ensure accuracy of reporting.

Planned Care & Diagnostics

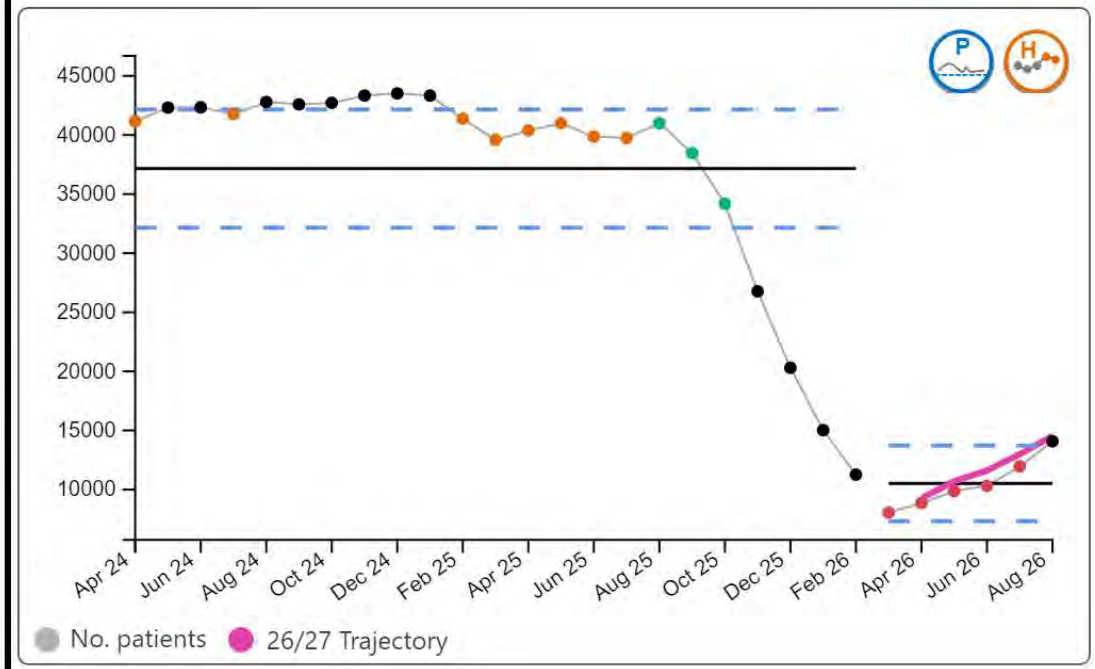
Measure: Number of patients waiting over 52 weeks for Outpatients
Performance: 1,463 (August 2026)
Trajectory: 2,794 (August 2026)
National target: 0

Better Care



Measure: Number of patients waiting over 26 weeks for Outpatients
Performance: 14,078 (August 2026)
Trajectory: 14,544 (August 2026)
National target: 0

Better Care

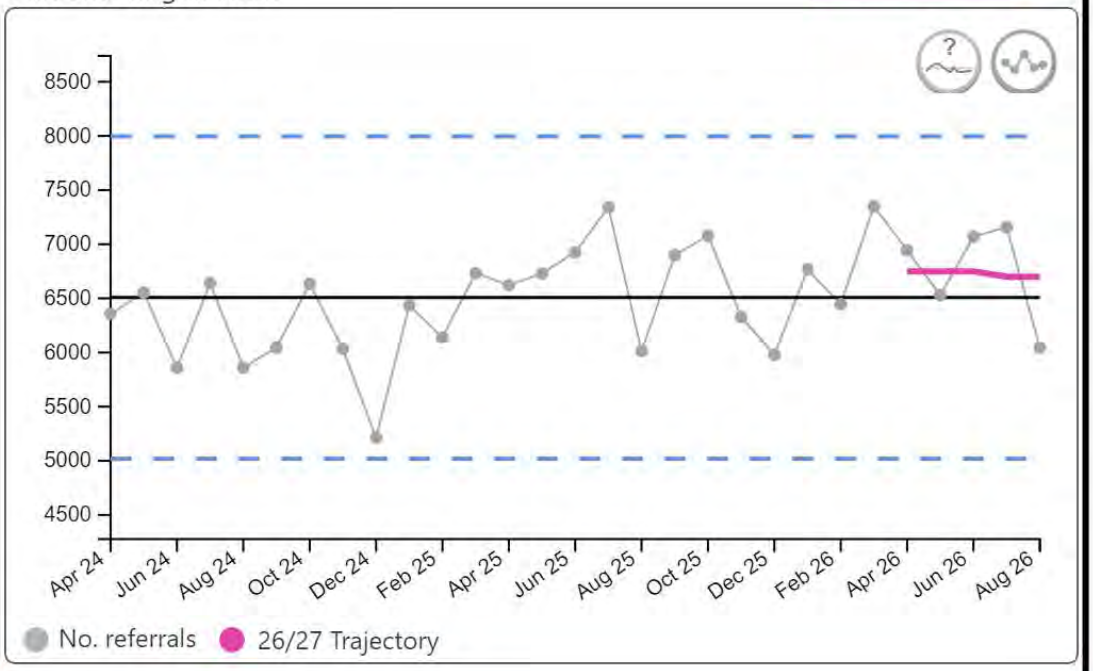


Insights and Actions

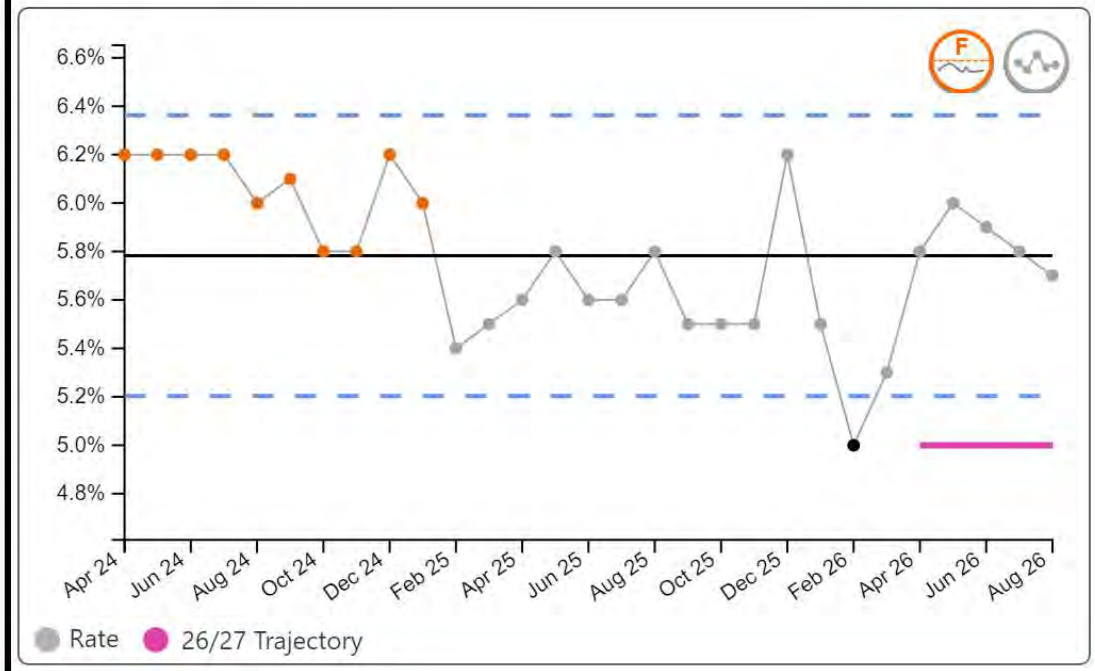
- 26 & 52 week new Outpatient: The charts for patients waiting over 52 and 26 weeks for a new outpatient appointment show the impact that the national outpatient insourcing programme, which delivered 33,202 additional appoints against a plan of 33,612, had on these two measures. This is clearly positive and has meant that the entire RTT waiting list decreased from 128,270 to 101,373 over the course of 25/26. However, there have been additional pressures created on specific services at diagnostic, therapies and follow up stages. The 52-week Outpatient breach position has held relatively stable through the first part of the year, with ongoing analysis on cohort reductions and ROTT rates underway to understand the variance. The 26-week Outpatient breach position is broadly rising in line with the expected trajectory as of August.

Planned Care & Diagnostics

Measure: Reduction in referral rate per 100,000 population by December 2026 - utilising Health Pathways optimally
Performance: 6,046 (August 2026)
Trajectory: 6,700 (August 2026)
National target: None



Measure: Monitoring of DNA rates Outpatient clinics
Performance: 5.7% (August 2026)
Trajectory: 5.0% (August 2026)
National target: 5.0%



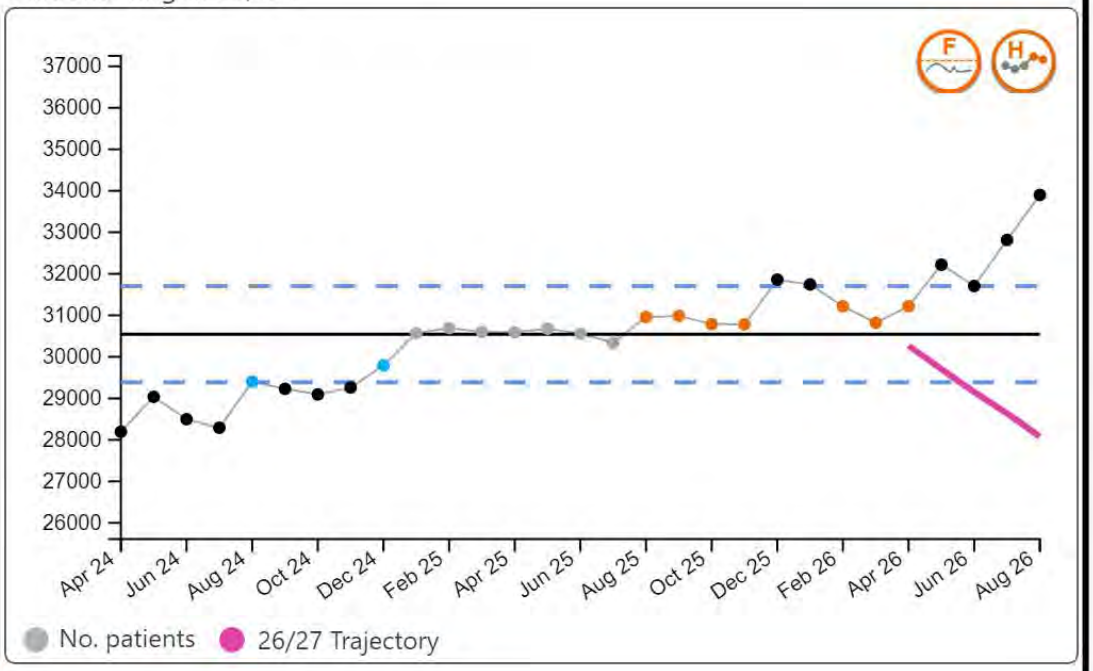
Insights and Actions

- Referral rates: A new Enabling Action for 26/27 is a reduction in Primary Care Planned Care referral rates. This rate has been on a sustained, upwards trajectory since 21/22. Whilst there was a significant decrease in August to below trajectory, this is a pattern seen in the same month in the preceding two years. The total RTT waiting list has increased to 112,914 in August (+~11,500 from the end of 25/26 low), representing a higher rate of growth through the first four months of the year than that seen in previous years. There are several actions which seek to aid in demand management, including Health Pathways, Interface GPs and E-Advice. Work is underway to develop an intelligence-led referral optimisation programme, using linked Primary and Secondary Care data to identify unwarranted variation in referral patterns and support more effective clinical decision-making. The project will combine enhanced analytics, implementation of national requirements, greater use of Health Pathways and Advice & Guidance services, and targeted education and engagement to improve referral quality, reduce variation, and ensure patients access the most appropriate care pathway.
- DNA/CNA rates: Rates have reduced over the past three months following in the increases from March. The monthly DNA report and Hospital Initiated Cancellation directorate report recommenced in August. Diab and Endo directorate are working with DDAT on use of AI predictor model to allow identification of patients most likely to DNA and support an intervention e.g. nurse or admin phone call (currently used in Endoscopy).

Planned Care & Diagnostics

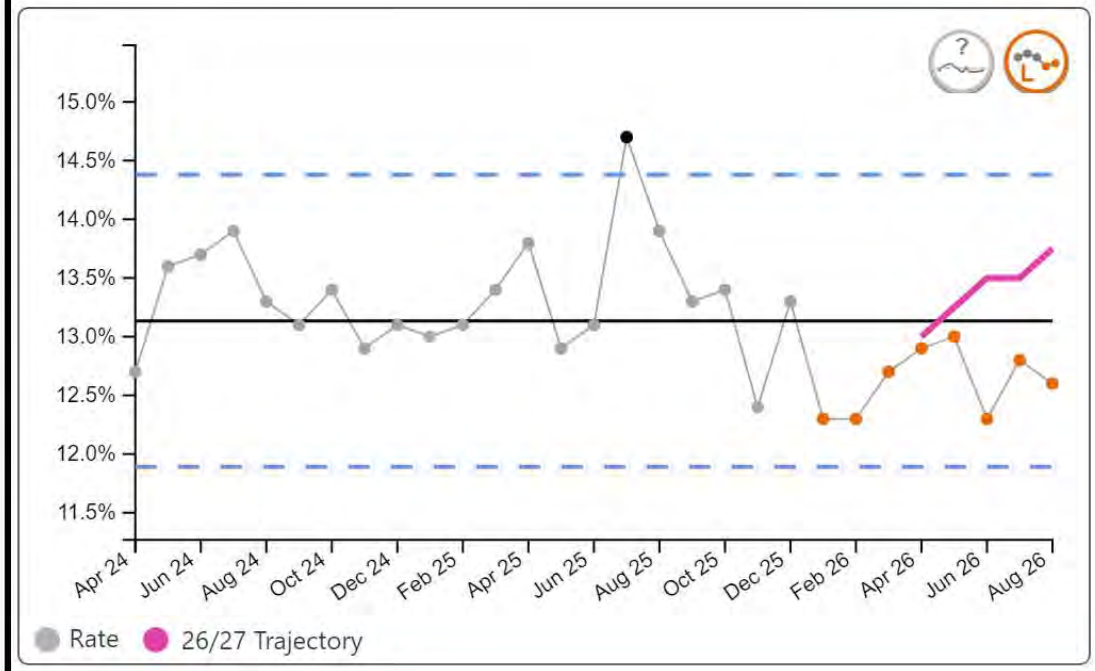
Measure: Reduction in the number of patients waiting 100% past Outpatient follow-up target date
Performance: 33,898 (August 2026)
Trajectory: 28,078 (August 2026)
National target: 23,694

Better Care



Measure: Increase in the rate of See On Symptom and Patient Initiated Follow-ups
Performance: 12.6% (August 2026)
Trajectory: 13.8% (August 2026)
National target: None

Better Care



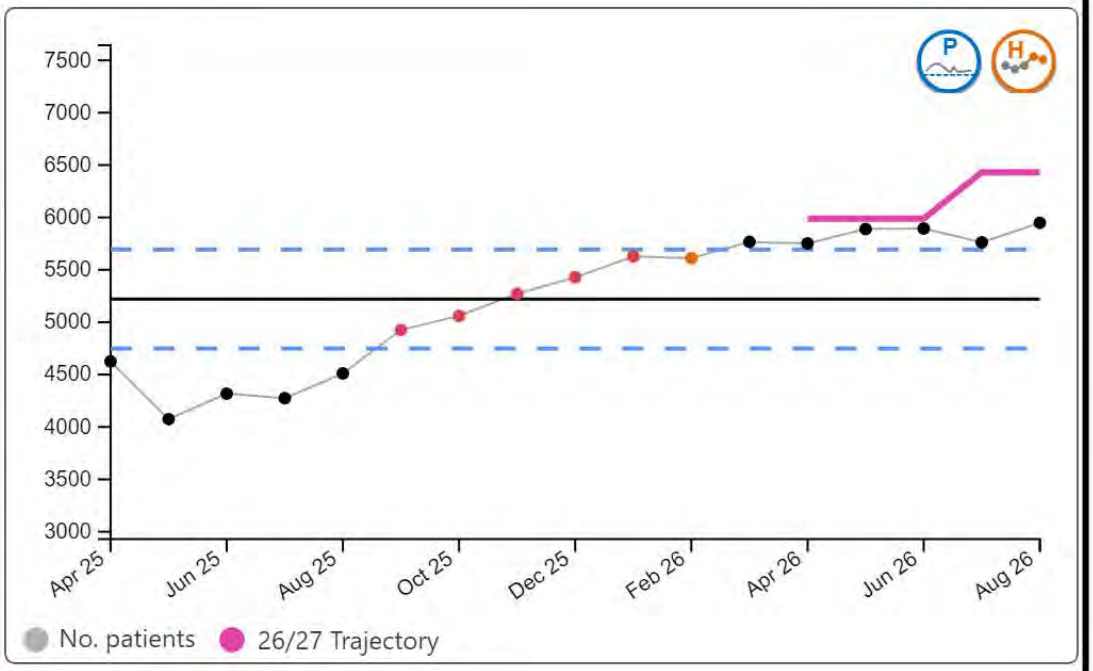
Insights and Actions

- The delayed follow up waiting list remains high, although the Health Board has committed to delivering against the national expectation of reducing the size of this list by 25%. Ongoing monitoring and validation of the most delayed patients continues, with weekly targeting of extreme long waiters (currently 2,106 patients waiting over 1,000% of their target wait). An audit of one week's Trauma & Orthopaedics (T&O) follow-up additions was undertaken to identify key themes. The Ophthalmology Directorate is undertaking application of the SOS pathway for the longest-waiting patients on the follow-up list. It should be noted that this activity does not impact reported SOS/PIFU rates, as patients are added to WPAS through the "Patients Seen Outside of Regular Clinic" process, which is excluded from these measures. However, the total number of patients on SOS/PIFU pathways has increased from 552 at the end of May to 994 in August. A validation, text messaging and removal letter process is currently being established to support waiting list validation activity. As part of this work, patient contact details are being reviewed and confirmed to ensure records are accurate and up to date.

Planned Care & Diagnostics

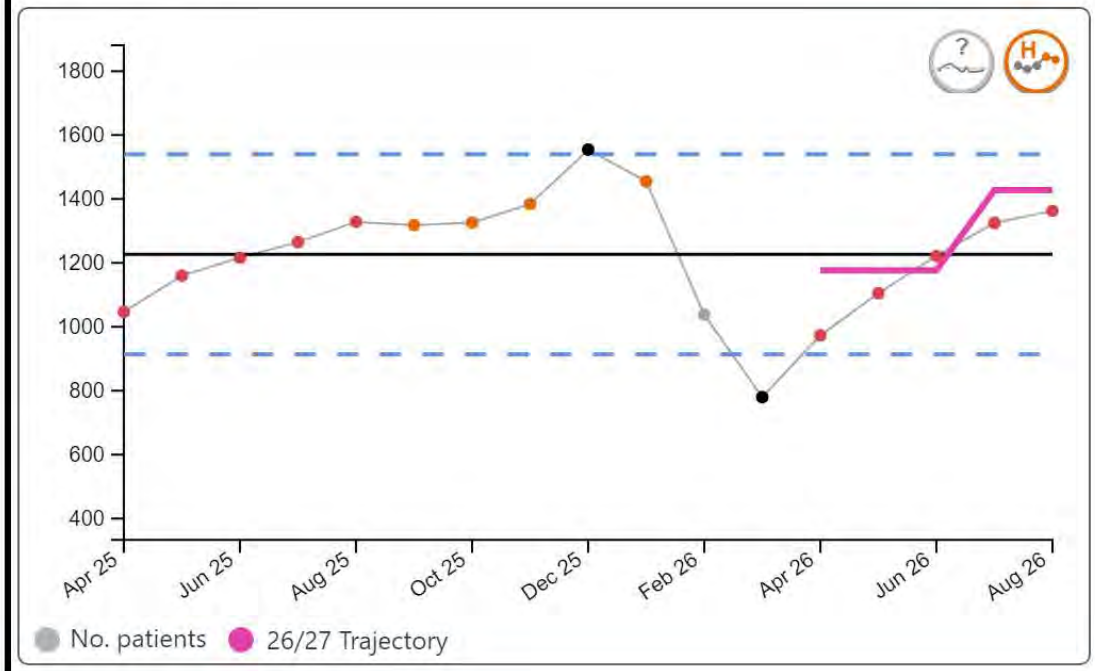
Measure: Number of adults waiting more than 14 weeks for all audiology pathways
Performance: 5,949 (August 2026)
Trajectory: 6,432 (August 2026)
National target: 0

Better Care



Measure: Number of children waiting more than 6 weeks for all audiology pathways
Performance: 1,363 (August 2026)
Trajectory: 1,428 (August 2026)
National target: 0

Better Care



Insights and Actions

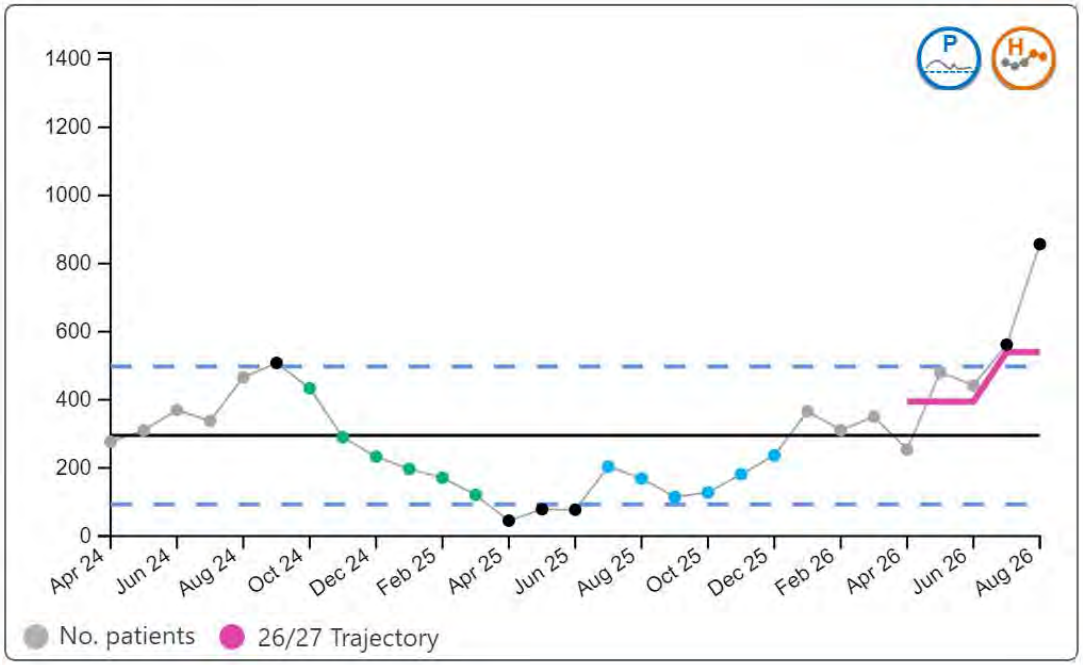
- Audiology: Adult pathway breaches were rising in line with forecast, however there was a slight reduction in July. The national OP insourcing programme has placed additional demand placed on the Service as a result of the activity undertaken within ENT, which has front loaded the rate of demand to the Adult Hearing New (AHN) and diagnostic pathways. Audiology has also faced workforce challenges, including long-term sickness absence of a Band 4 Associate Audiologist, redesign of a Band 6 Adult post to a split Adult/Paediatric role, and a Band 4 maternity leave. For Paediatric pathways, additional, end of year funding enabled a significant reduction in waiting list breaches. The cessation of this has seen breaches climb again through the first four months of the year, in line with forecast. Additional funding to reduce waits across both Adult and Paediatric pathways has been included in the Planned Care Recovery Plan.

A recently published external audit reported that the Audiology service at ABUHB met the overall national audit target (85%) and achieved required performance in 8 out of 9 standards, with strong practice noted in areas such as aural rehabilitation, collaboration, and links with Specialist Services. However, it reported some shortcomings on access standards, with key issues including long waiting times, challenges managing referrals, limited repair capacity in outreach settings, and insufficient access to ear care. Overall, it reported that, while the service performs well, addressing access, capacity, and outcome measurement is critical to improving quality and sustainability.

Planned Care & Diagnostics

Measure: No patient waiting more than 14 weeks for a therapeutic assessment
Performance: 857 (August 2026)
Trajectory: 540 (August 2026)
National target: 0

Better Care



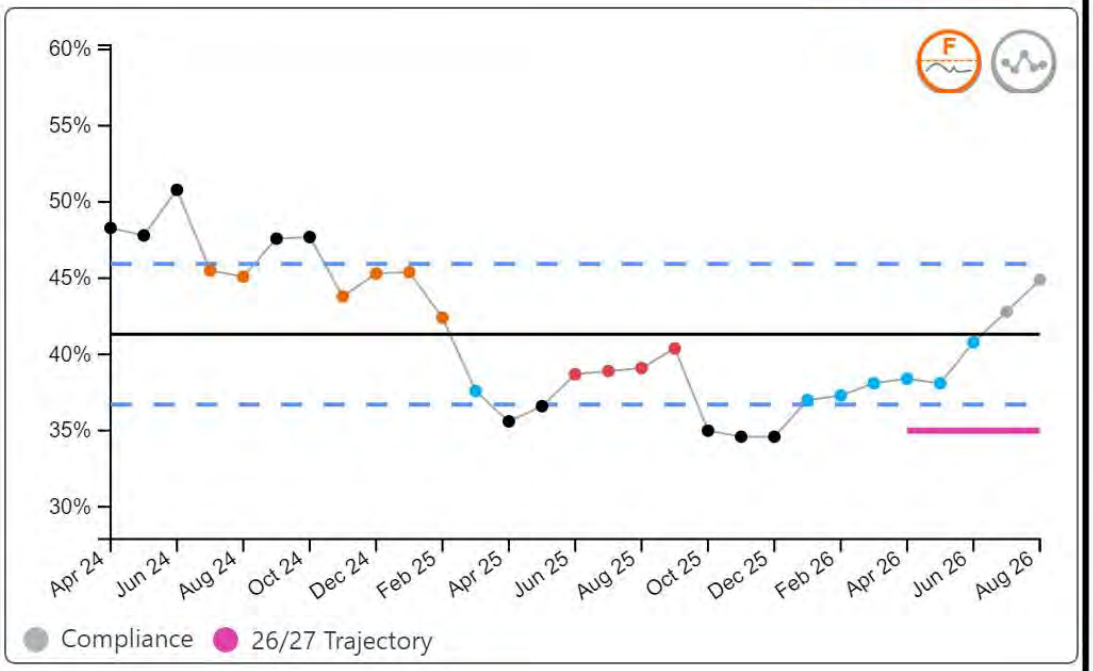
Insights and Actions

- Therapies: Therapies 14-week breaches increased in Jul, in line with trajectory however August saw another, sharper increase. Physiotherapy is the therapy experiencing the most demand related pressure, with 735 breaches (+388 from June). The number of patients breaching waiting time standards continues to increase because of sustained growth in referral demand, particularly since January. The Service is also managing the impact of staff sickness and vacancies, which is contributing to the current position. To accommodate T&O patients approaching the 104-week RTT threshold (with a Physiotherapy RTT wait of 0 weeks), MSK capacity continues to be reduced by 12 new patient (NP) appointments per month. While this supports the T&O recovery trajectory, it is creating additional pressure on MSK waiting lists. Whilst the number of 104-week waiters has reduced, there remains a potential risk of six breaches in August and an unknown position for September. Consequently, the protected clinic capacity will remain in place and be reviewed at the end of August. Within Dietetics (85 breaches in August), Paediatric Dietetics Restrictive Eating Groups remains the highest breach area following integration of CAMHS/ARFID referrals. Discussions with CAMHS continue regarding sustainable demand, resourcing and referral criteria. Increased Paediatric Home Enteral Feeding demand limits capacity available for Outpatient clinics.

Planned Care & Diagnostics

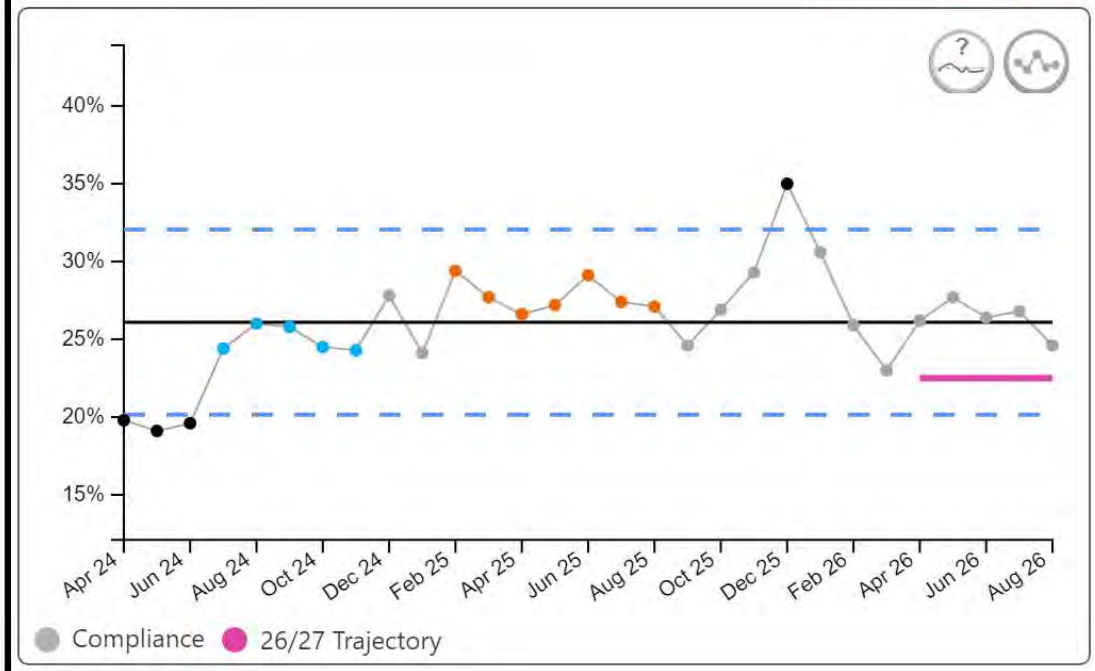
Measure: Theatre Utilisation: late starts to less than 20%
Performance: 44.9% (August 2026)
Trajectory: 35.0% (August 2026)
National target: 20.0%

Enabling Action
Better Care



Measure: Theatre Utilisation: early finishes to less than 10%
Performance: 24.6% (August 2026)
Trajectory: 22.5% (August 2026)
National target: 10.0%

Enabling Action
Better Care



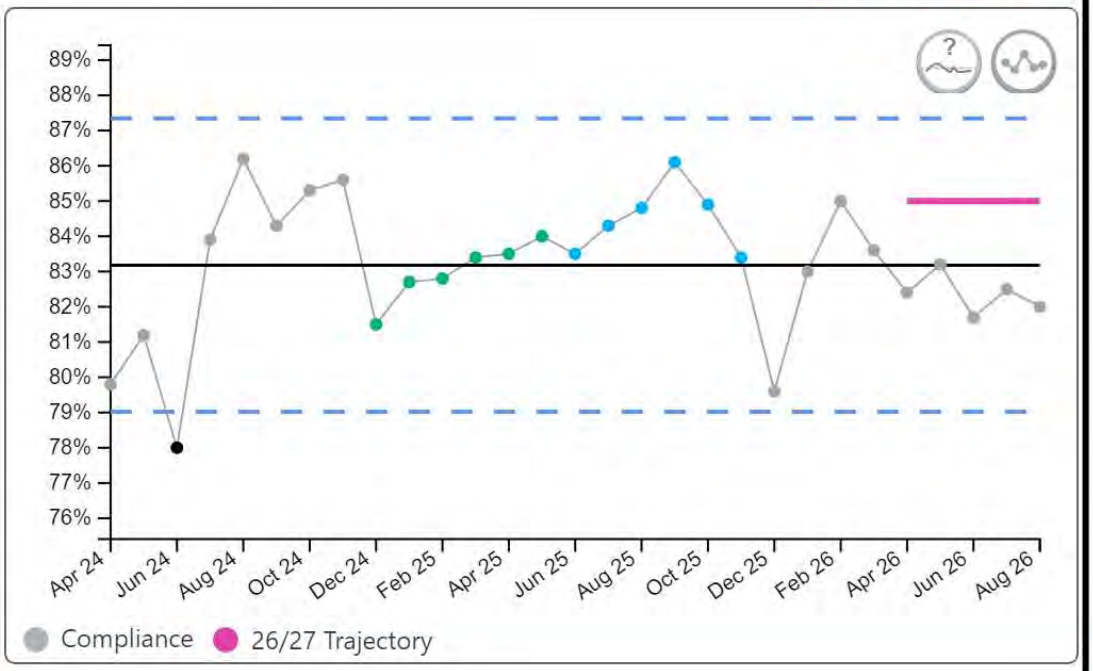
Insights and Actions

- Late starts have increased over the past 3 months following a period of relatively stable performance, and early finishes have remained in line with average performance through 26/27 to date.
- The Theatres Optimisation Programme (TOP) was refreshed in May, reinforcing Theatre Services as a key Health Board priority. The programme adopts a whole-system approach to improve theatre productivity and performance through workstreams focused on workforce, theatre efficiency, right procedure/right place, and surgical hub accreditation. A key objective is the development of a simplified, consistent set of KPIs and performance measures to support decision-making and track improvement. In October, the Theatres Utilisation Group (TUG) will be reformed to drive operational improvements, initially focusing on short-notice cancellations, late starts, procedures per list, early finishes, utilisation and BADS day-case rates, with additional productivity metrics currently under development.

Planned Care & Diagnostics

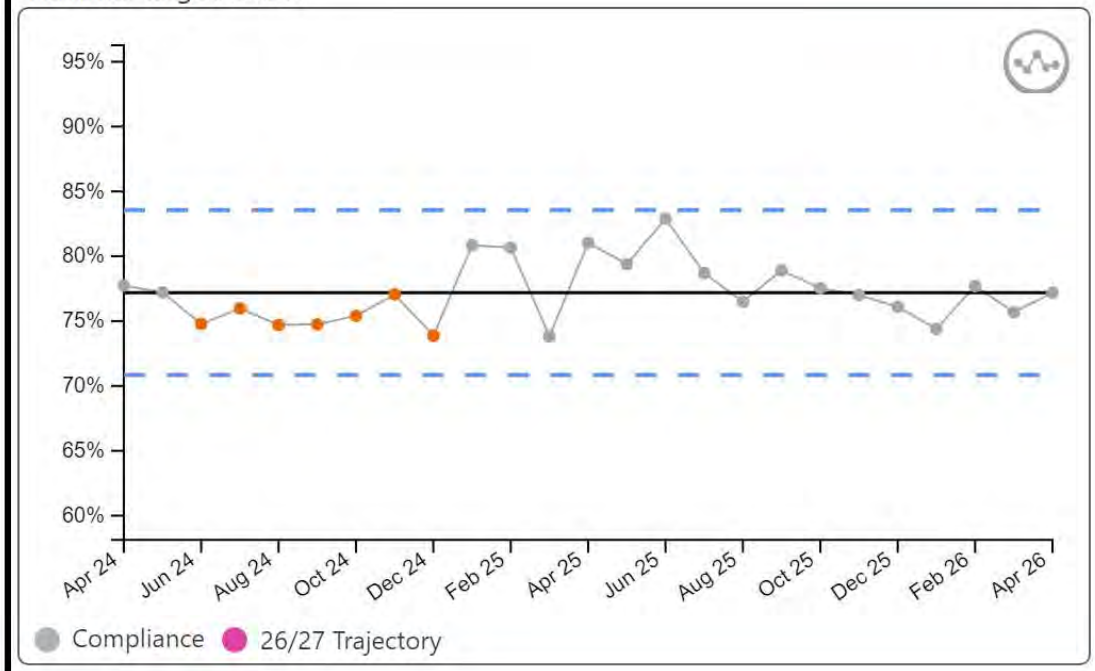
Measure: Theatre Utilisation: session utilisation to 85%
Performance: 82.0% (August 2026)
Trajectory: 85.0% (August 2026)
National target: 85.0%

Enabling Action
Better Care



Measure: Deliver improvements in day surgery rates, measured through BADS day case rates
Performance: 77.2% (April 2026)
Trajectory: 78.0% (April 2026)
National target: 80.0%

Better Care



Insights and Actions

- Session utilisation: Performance has been relatively close to the national standard of 85% since July 2024. Effective utilisation will be a key focus of the Theatres Optimisation Programme Group, as well as the reformed Theatres Utilisation Group. A decrease in June performance was anticipated, due to disruption from the heatwave and declaration of critical incident, with year to date performance marginally below the national expectation of 85%.

- British Association of Day Surgery (BADS) rates: BADS rates continue to track closely to the national standard of 80%. Through the annual planning process for 26/27, the treatment demand and capacity plans indicate that Day Case treatments are set to increase by 7.7% (set it the context of an overall treatment increase of 2.7%). In the Plan the Health Board has committed to attaining the 80% standard by the end of the year. Validated day case rates are subject to lag, however April performance is largely in line with the Q1 trajectory.

Section 2.1: Mental Health Access Performance Summary

Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Mental Health Access	Maintain Adults Part 1a to national target (assessment completed within 28-days)	80% Mar-27	88.4% Jul-26 (Jul-26 Trajectory: 80%)	H	?
	Maintain Adults Part 1b to national target (interventions completed within 28-days)	80% Mar-27	96.7% Jul-26 (Jul-26 Trajectory: 80%)		P
	Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan)	90% Mar-27	83.5% Jul-26 (Jul-26 Trajectory: 90%)		?
	Maintain rate of psychological therapy received within 26-weeks	62% Mar-27	52.5% Jul-26 (Jul-26 Trajectory: 56%)		F
	Implement actions to deliver a material reduction in the number of out-of-area placements in 2026/27, and associated costs.	0 Mar-27	0 Jul-26 (Q2 Trajectory: 0)	L	
	Maintain 80% compliance of SCAMHS Choice Assessments within 28-days from referral	80% Mar-27	93.9% Jul-26 (Jul-26 Trajectory: 80%)		P
	Maintain CAMHS Part 1a national target compliance (assessment completed within 28-days)	80% Mar-27	96.9% Jul-26 (Jul-26 Trajectory: 80%)		P
	Maintain CAMHS Part 1b national target compliance (intervention completed within 28-days)	80% Mar-27	84.1% Jul-26 (Jul-26 Trajectory: 80%)		?
	Maintain CAMHS Part 2 national target compliance	90% Mar-27	88.8% Jul-26 (Jul-26 Trajectory: 90%)		?

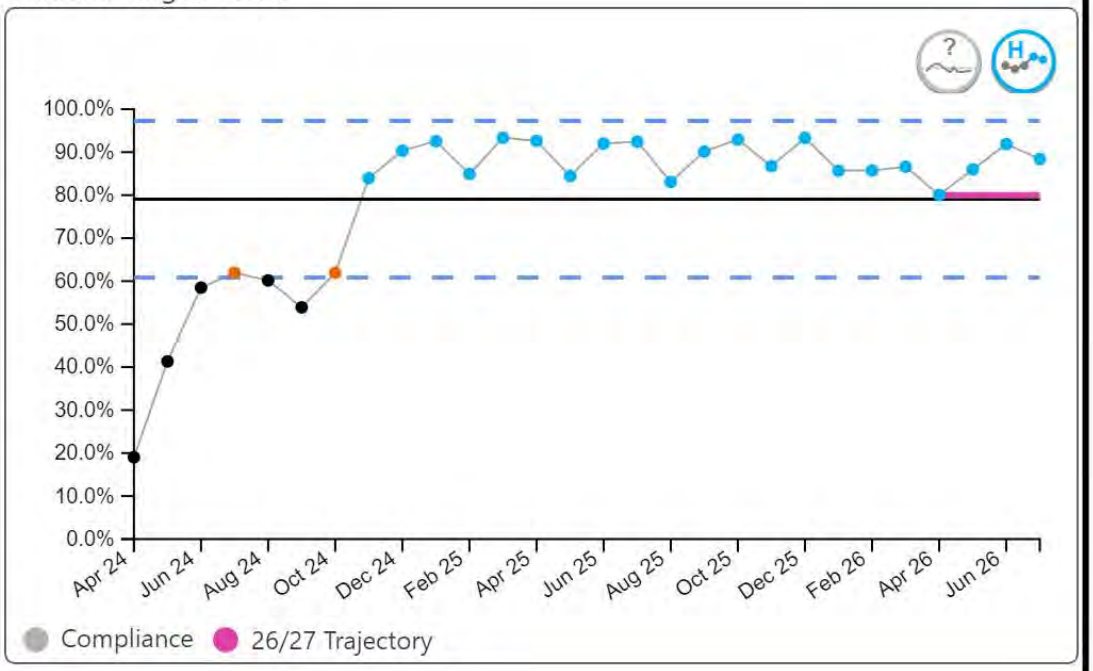
Section 2.1: Mental Health Access Performance Summary

Theme	Delivery Expectation	ABUHB commitment	In month performance against trajectory	Variance	Assurance
Mental Health Access	Improvement in Neurodevelopment waiting times compliance	**80%** Mar-27	**52.2%** Jul-26 (Jul-26 Trajectory: 60%)	L	?

Mental Health

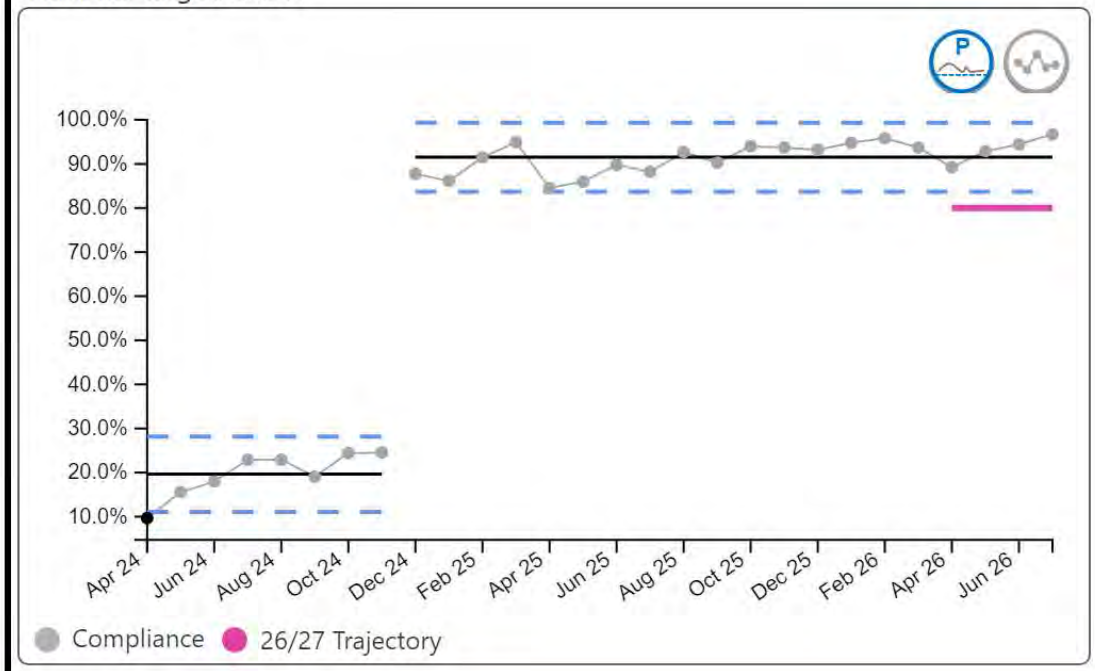
Measure: Maintain Adults Part 1a to national target (assessment completed within 28 days)
Performance: 88.4% (July 2026)
Trajectory: 80.0% (July 2026)
National target: 80.0%

Better Care



Measure: Maintain Adults Part 1b to national target (interventions completed within 28 days)
Performance: 96.7% (July 2026)
Trajectory: 80.0% (July 2026)
National target: 80.0%

Better Care



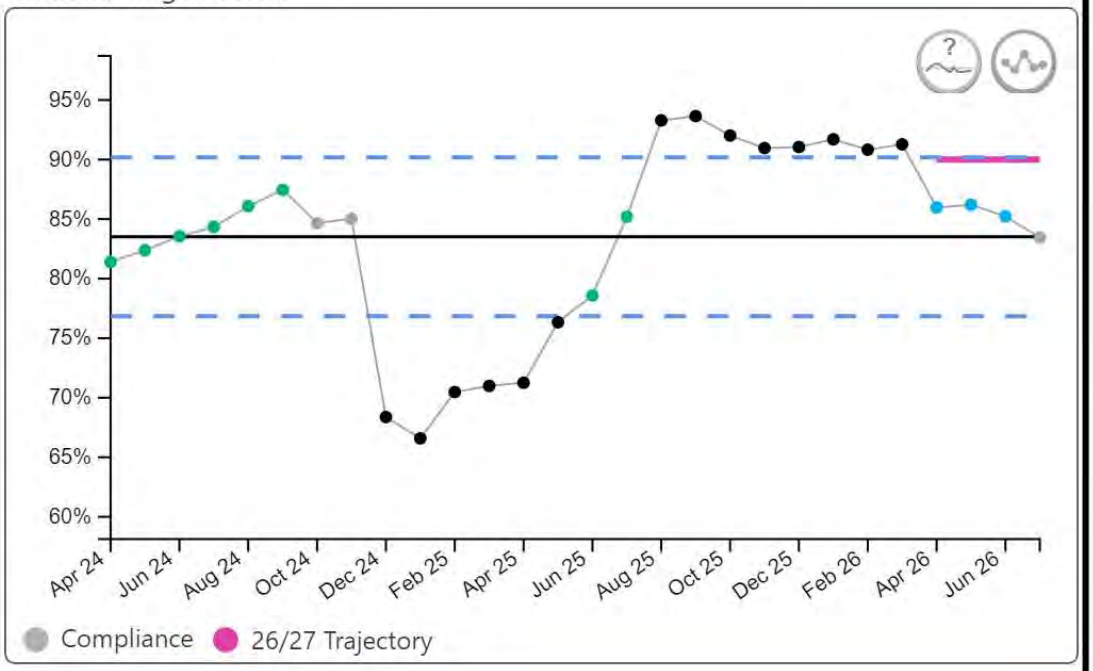
Insights and Actions

- Adults 1a & 1b: Delivery remains strong against these measures, with the Service balancing both demand and capacity to ensure continued compliance with the national standard through the entirety of 2025/26 and into 2026/27. The SPC chart for Part 1b has had a process break inserted from December 2024 to reflect the change in performance since this time, following the extensive data cleansing work and service improvements that were delivered.

Mental Health

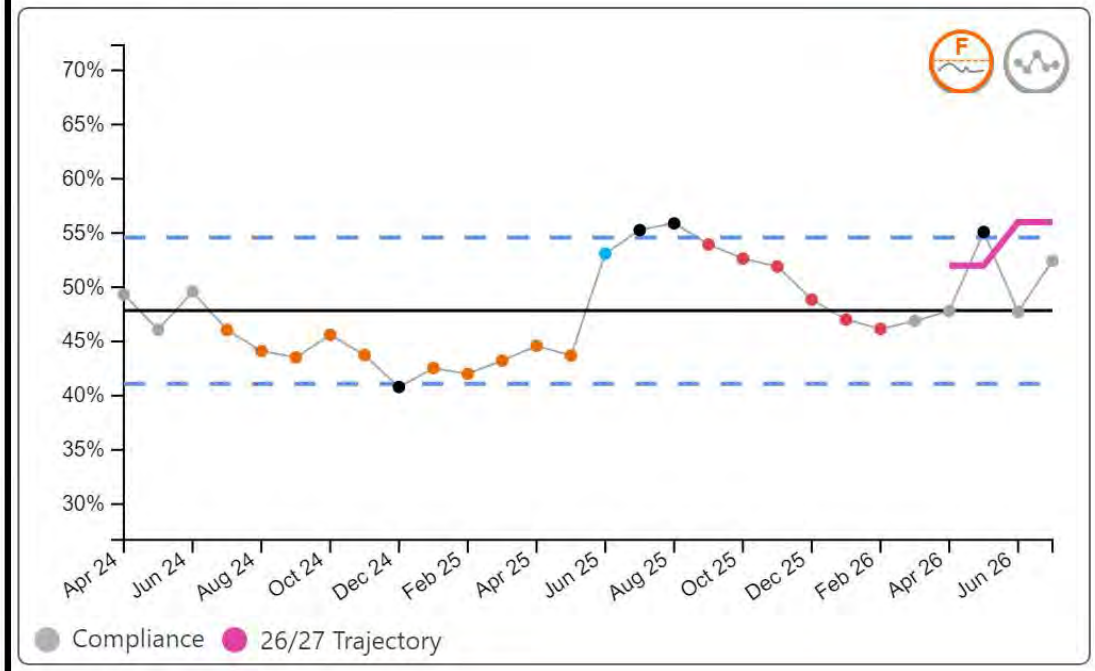
Measure: Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan)
Performance: 83.5% (July 2026)
Trajectory: 90.0% (July 2026)
National target: 90.0%

Better Care



Measure: Maintain rate of psychological therapy received within 26 weeks
Performance: 52.5% (July 2026)
Trajectory: 56.0% (July 2026)
National target: 80.0%

Better Care



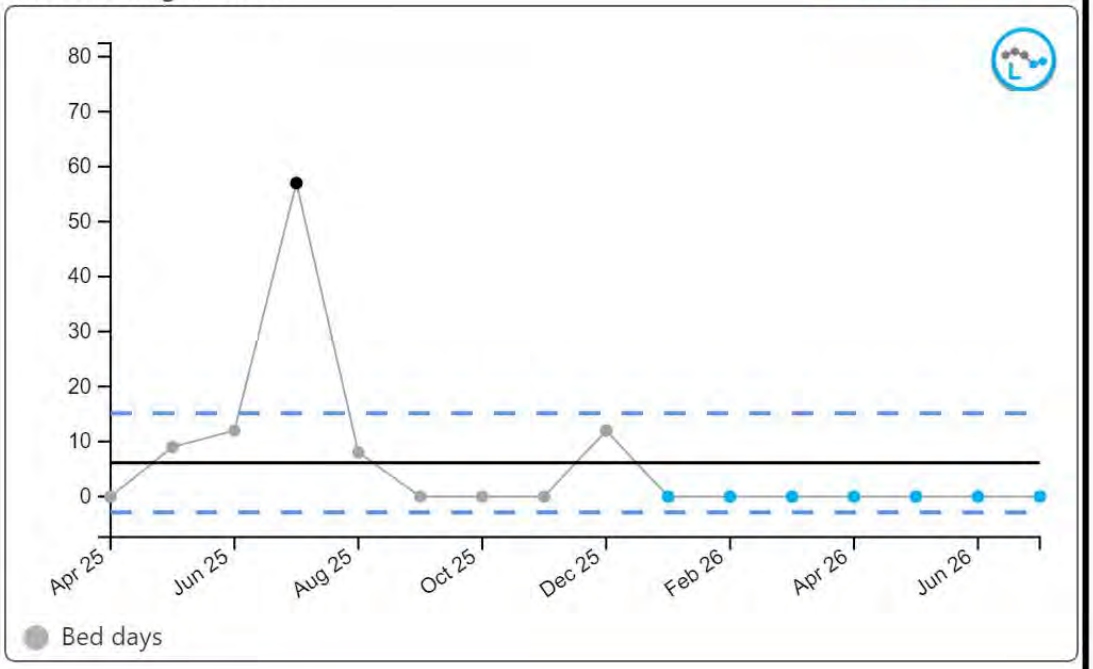
Insights and Actions

- Adults Part 2: Part 2 performance has decreased slightly below trajectory for the past three months with the Division commencing a targeted piece of work over Q2 to ensure compliance returns, however performance has remained in line or above with the average since Apr-24. Data cleansing remains in progress, however the volume of new Care and Treatment Plans (CTPs) and discharges from CTPs is expected to stabilise.
- Psychological Therapies: The Divisional recovery plan, which aims to improve performance to 62% by the end of the year, has shown improvement in two of the past three months however it remains slightly under the Annual Plan trajectory. ABUHB, in conjunction with Cardiff University, are hosting a Masters student to work with the Service over the summer of a project for an MSc dissertation. This project will develop a simulation model of adult psychological therapy pathways across the seven CMHTs in Gwent to understand the factors driving long waits and assess the impact of alternative service designs on patient flow and access to treatment. The model will test options such as different triage and treatment arrangements, changes to care coordination, workforce reconfiguration, and the effects of non-engagement and drop-out rates, to identify the staffing and service model required to achieve the Welsh Government target of 80% of patients starting treatment within 26 weeks. This project is scheduled for completion at the end of Q2.

Mental Health

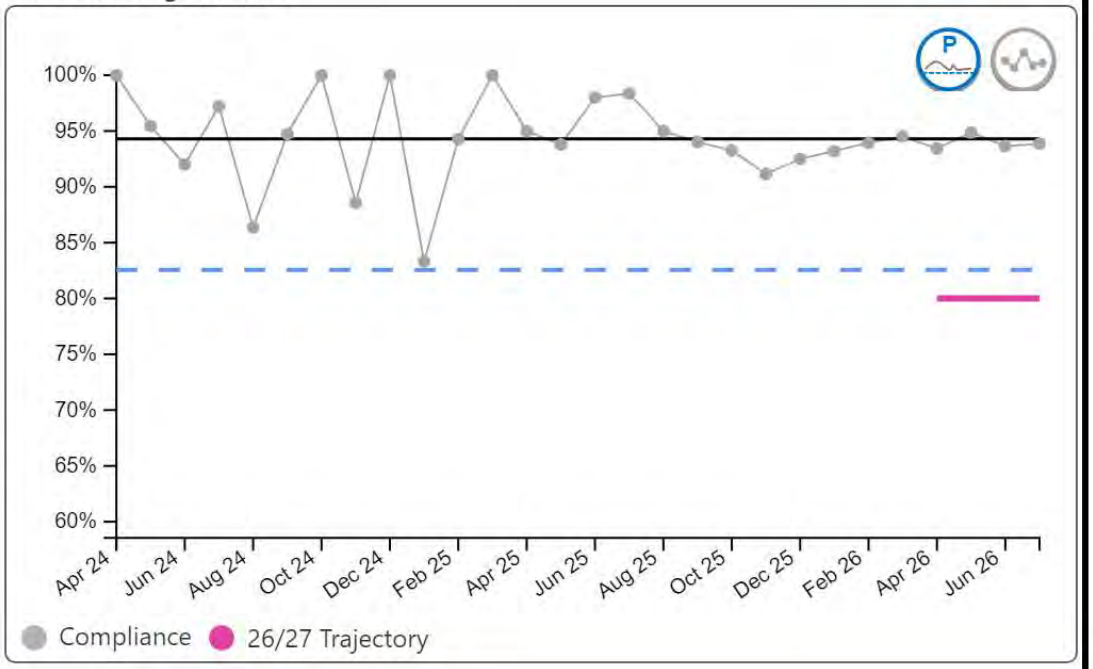
Measure: Implement actions to deliver a material reduction in the number of out of area placements in 2026/27, and associated costs.
Performance: 0 (July 2026)
Trajectory: 0 (Q2 26/27)
National target: None

Enabling Action
Better Care



Measure: Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral
Performance: 93.9% (July 2026)
Trajectory: 80.0% (July 2026)
National target: 80.0%

Better Care



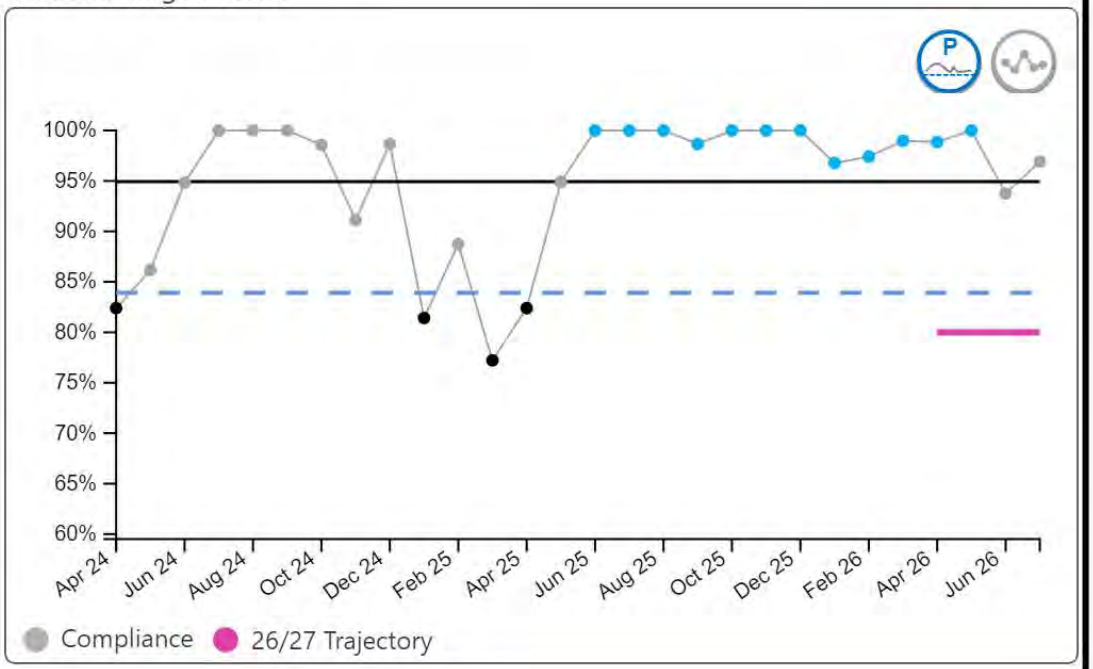
Insights and Actions

- Out of Area Placements (OAPs): A new Enabling Action for 26/27 and included in the Annual Plan as a core performance measure, the national directive is to reduce placements and the costs associated with them. OAPs can have a significant negative impact on mental health patients by separating them from their families, support networks, and local services, which are often critical to recovery. They can also lead to poorer patient experience, disruption to continuity of care, and increased lengths of stay, while creating additional financial pressures. The national reporting format was formalised after the submission of the plan, and the measurement is by bed days rather than the number of individual placements. Placement categories in scope of the reporting are: Adult & Adult PICU, and Older Adult and Older Adult PICU. In 25/26 the Health Board commissioned 98 bed days of OAPs with just four individual months of the year incurring them, at a total cost of £86,450. The 26/27 ambition in the plan is to deliver to zero bed days and thus cost, and as of July this remains on track.
- Specialist CAMHS Choice Assessments: No issues, performance continues to track well above national standard of 80%.

Mental Health

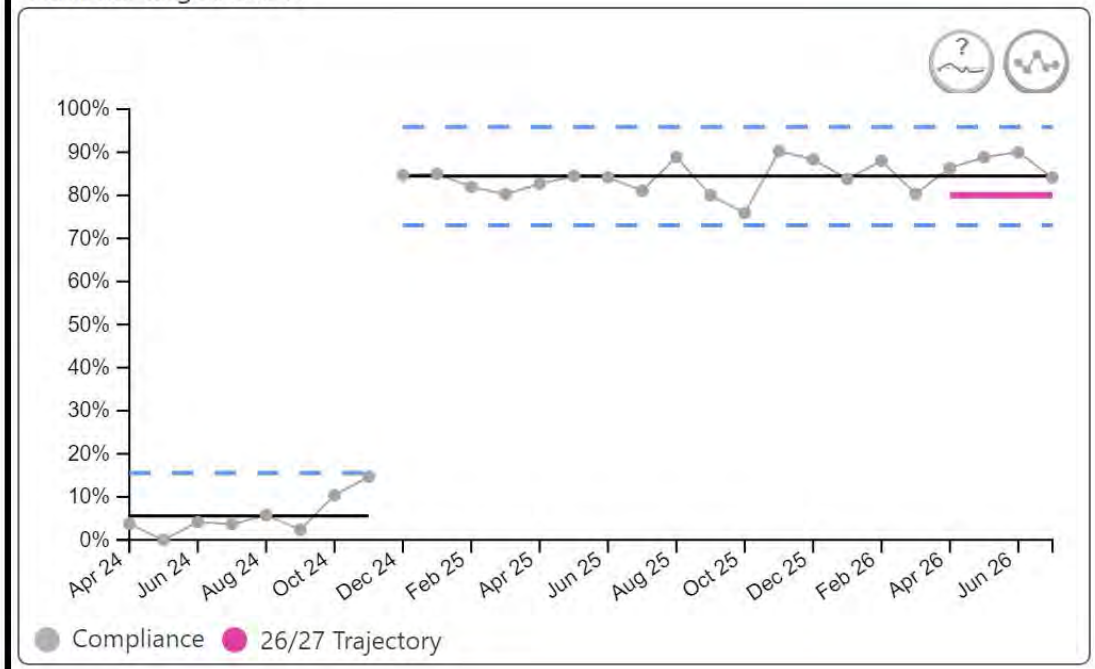
Measure: Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)
Performance: 96.9% (July 2026)
Trajectory: 80.0% (July 2026)
National target: 80.0%

Better Care



Measure: Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)
Performance: 84.1% (July 2026)
Trajectory: 80.0% (July 2026)
National target: 80.0%

Better Care



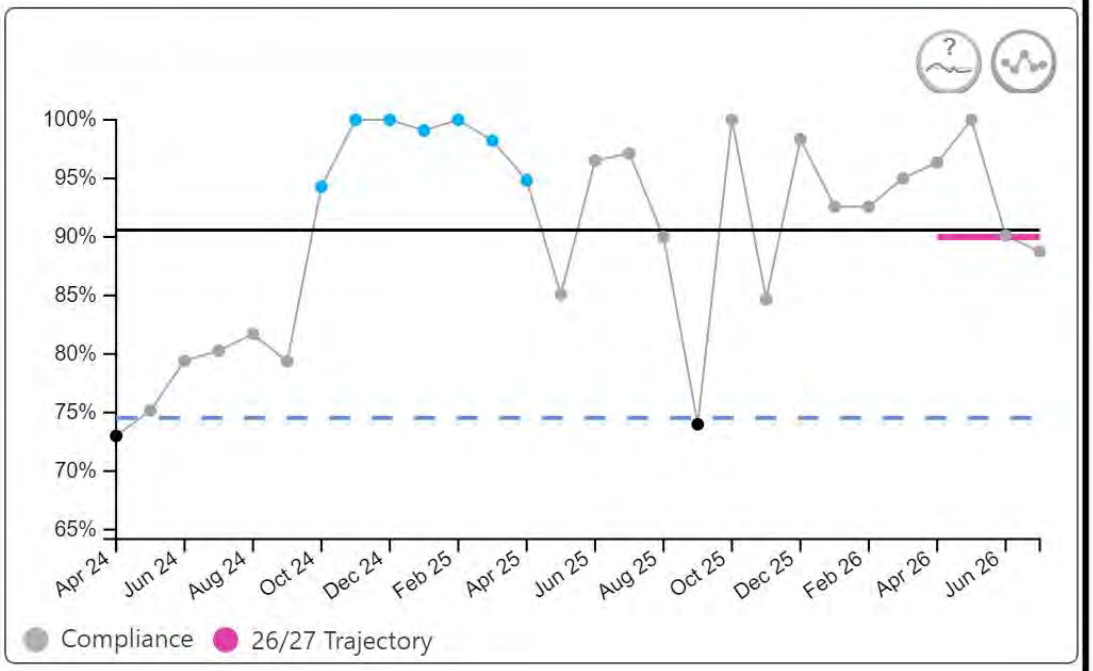
Insights and Actions

- CAMHS 1a & 1b: Like with Adults, strong delivery has been maintained for these measures, with the service balancing both demand and capacity to ensure continued compliance with the national standard, with 1a having met the national standard for the entirety of 2025/26 and continued in to 2026/27. The SPC chart for Part 1b has had a process break inserted from December 2024 to reflect the change in performance since this time, following the extensive data cleansing work and service improvements that were delivered.

Mental Health

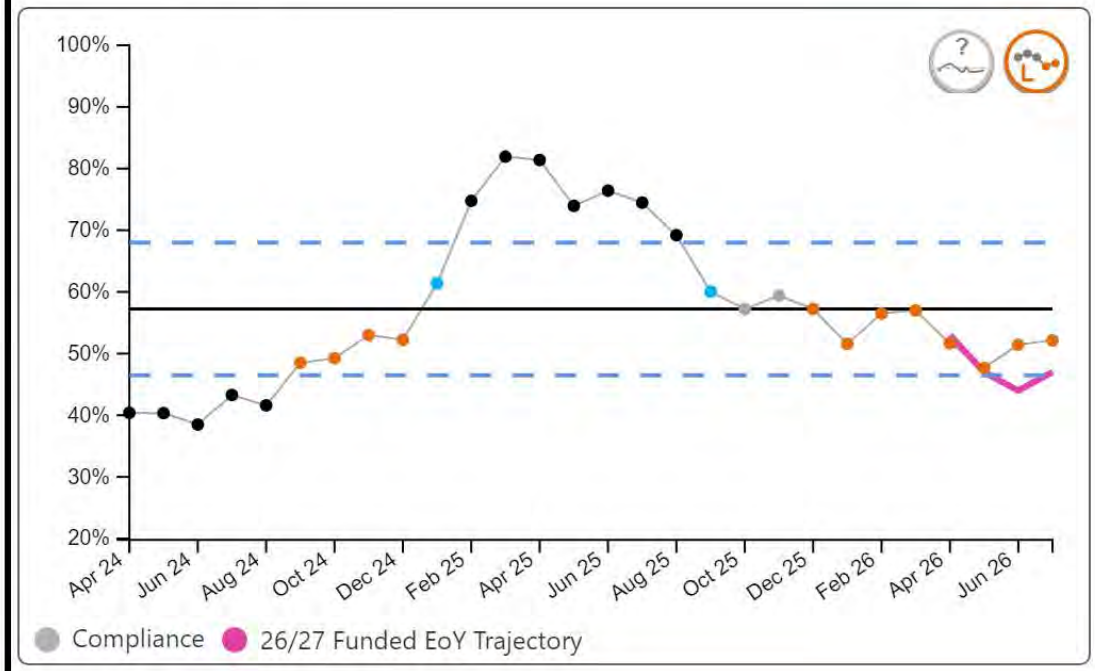
Measure: Maintain CAMHS Part 2 national target compliance
Performance: 88.8% (July 2026)
Trajectory: 90.0% (July 2026)
National target: 90.0%

Better Care



Measure: Improvement in Neurodevelopment waiting times compliance
Performance: 52.2% (July 2026)
Trajectory: 60.0% (July 2026)
National target: 80.0%

Better Care



Insights and Actions

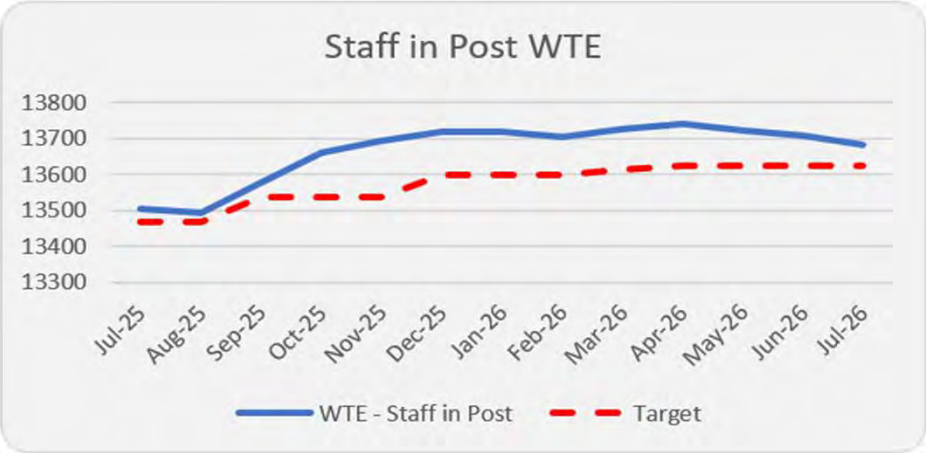
- CAMHS Part 2: Whilst there has been a decrease in the past two reportable months, performance remains close to trajectory and the national standard.
- CAMHS ND: Following a period of extensive challenge within the Service, whereby it has prioritised keeping the longest waits under 52-weeks at the cost of the <26-week compliance measure, NDIP funding of £568,536 has been secured for 2026/27 to support CAMHS Neurodevelopmental (ND) Referral to Treatment Time (RTT) recovery and service sustainability. This includes £281,706 to address existing staffing funding shortfalls, ensuring current service capacity can be maintained, and £187,512 to establish additional workforce capacity, including 3.1 WTE Band 6 Practitioners, 2.0 WTE Band 4 Support Workers and 1.0 WTE Band 4 Administrative Assistant. A further £95,318 has been allocated to fund additional staff hours, increasing clinical delivery and supporting RTT recovery. This allocation also includes £4,000 for the CHRONOS AI pilot, which will support service efficiencies, improve waiting list management, and strengthen RTT performance monitoring and reporting. Collectively, this investment will help stabilise the service, expand capacity, and accelerate progress towards achieving RTT recovery targets.

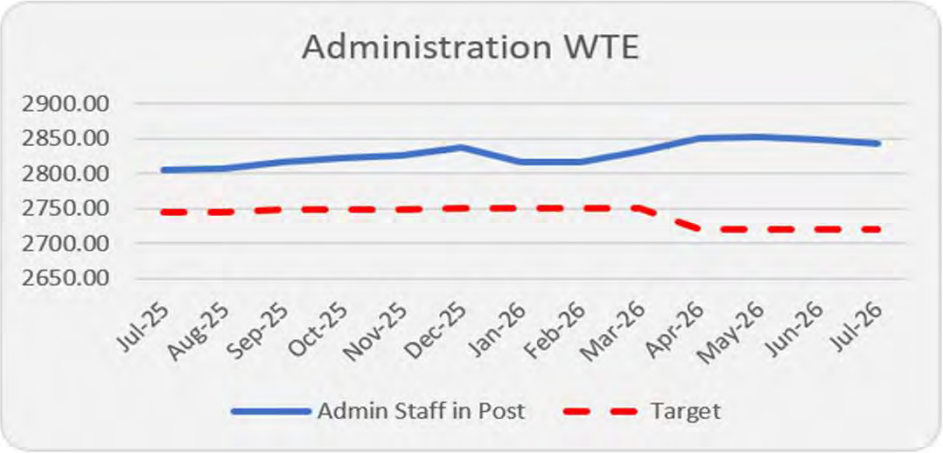
The Health Board's People Plan, 2025 -2030 supports our purpose and ambition by putting people at the heart of everything we do; creating the conditions for them to thrive, and enabling us to deliver outstanding, compassionate care while tackling health inequalities and building healthier futures for all.

A key part of our revised plan 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 generation.

Reporting Period end of July 2026

Staff in Post





Performance Summary

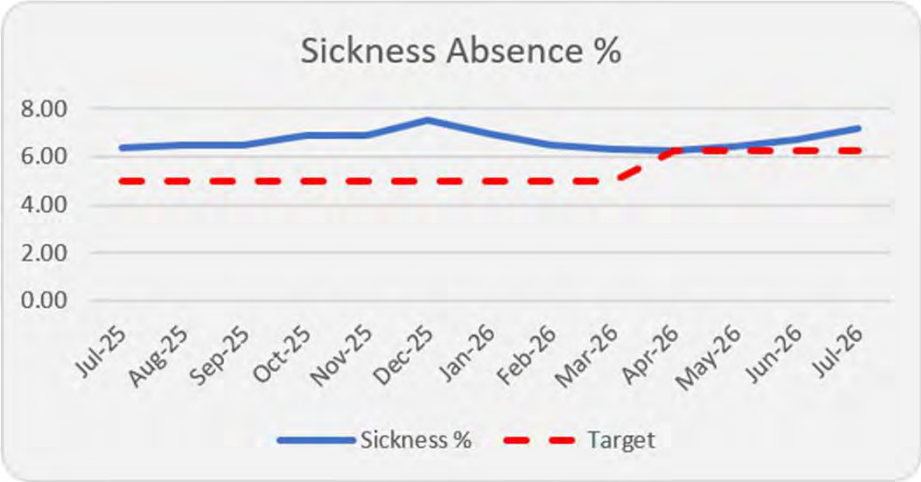
Staff in post as of end of July 2026 totalled 13681.74 a reduction from 13724 wte reported in May against an identified staffing establishment of 13,970 wte with relatively decreasing trend. The staff in post remains slightly higher than the forecast trajectory in administration and clerical staff due transfer of managed Practices and data cleansing of staff coding included in the original workforce trajectories. The Establishment Control Project has now been completed for non medical staff and will become a more prominent feature, providing greater assurance regarding workforce establishment and financial data and trajectory monitoring.

Changes by staff groups since 1st April 2026:

- Medical and Dental staffing decreased by 20 wte, driven by 12 wte voluntary resignations (mainly clinical fellow posts), a small number of retirements and 5.5 wte from the end of fixed term contracts. Following a peak in medical staffing levels in April, the highest point in the previous 12 months, this reduction is likely to reflect a return towards previous staffing levels;
- Nursing and Midwifery a decrease of 21.75 wte, change to reflect over recruitment at the start of the year and vacancies being held for student streamlining;
- Administration and Clerical decrease of 8 wte.
- Other workforce staff groups remained consistent

The targets in graph reflect the IMTP for 26/28 as it stands to date and updated to reflect the resubmission of the plan to Welsh Government.

Sickness Enabling Action



Performance Summary

Sickness rates had remained stable at the start of the first quarter. However, In July 26, sickness absence was 7.15% (978 wte), compared to 6.38 % absence rate reported in the same period last year. While the reasons for this increase are likely to be multifactorial, it coincided with a period of extreme hot weather and the summer school holiday period, data suggests that this may have influenced attendance levels. National guidance recognises that high temperatures can adversely affect staff health and wellbeing, increasing the risk of heat-related illness.

70% of sickness is long term which has increased in the last 3 months from 4.47% to 4.96%. Short term sickness has decreased has remained at 2.19% The target of 6.25% was set as part of the IMTP performance framework 2026/2027.

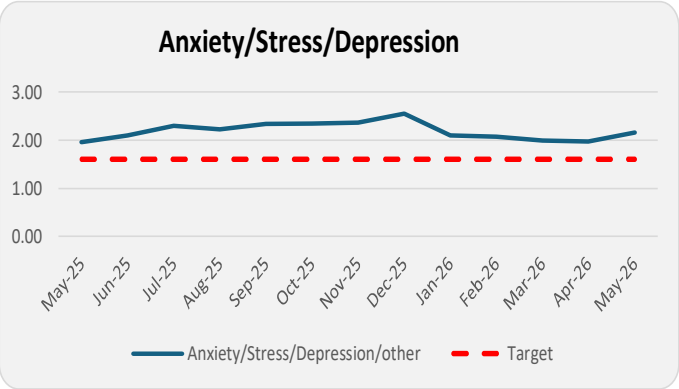
Key observations – 3 highest staff groups rate changes since April 26:

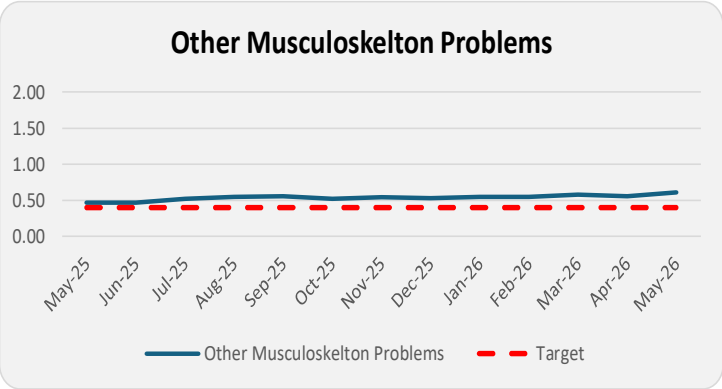
1. Additional Clinical Services (HCSWs) – 10.21% an increase from 8.97% ;
2. Estates and Ancillary – 9.97% an increase from 9.22% ;.
3. Nursing and Midwifery – 7.61% an increase from 6.43% at the start of the first quarter

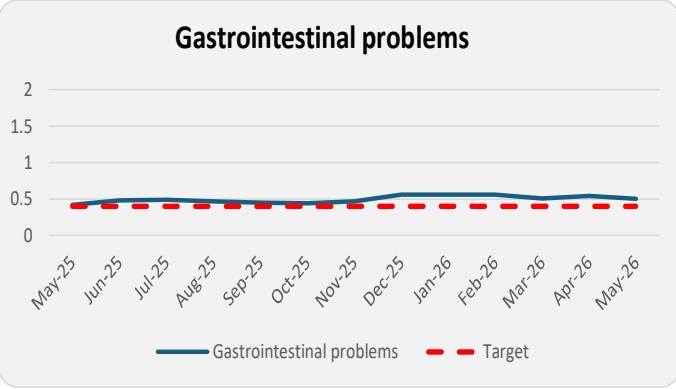
The target in graph was set as part of the IMTP performance framework for 2026/27.

Sickness Absence is a key priority for the Health Board with a project plan in development (in partnership with TUs), in conjunction with the actions of our People Plan (2025-2030) to focus on main reasons for absence with the aim of supporting a sustainable reduction in absence.

Top Sickness Reasons Enabling Action







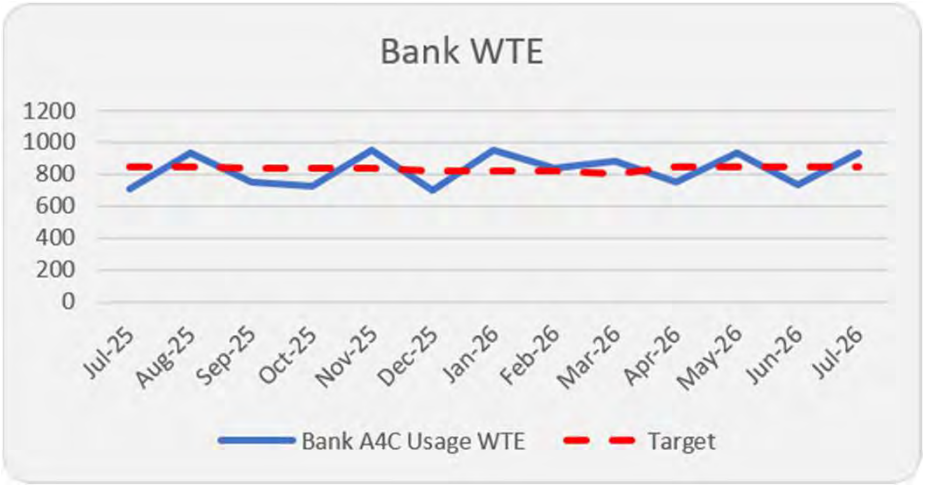
Performance Summary

Anxiety/Stress/Depression remains the top reason for absence have been increasing steadily from 1.97% to 2.52% which is above the target of 1.6%.
Musculoskeletal Problems the 2nd highest reason remained have increase slightly from 0.56 to 0.75% above the target of 0.4%.
Gastrointestinal problems has replaced Coughs and Colds in past quarter as the 3rd highest reason**.** with marginal increase in rate from 0.54% to 0.59% and above the target of 0.4%.

The Health and Wellbeing Service continues to increase the support options available for staff including psychological therapy, counselling and self-help guidance tools. In addition, our "Wellbeing Matters" Programme provides advice and support to those suffering with physical conditions (e.g. back problems). The Health Board have also introduced an Employee Assistance Programme to support access to wellbeing support, which has reduced waiting times for our internal staff wellbeing service. The target in each graph was set as part of the IMTP 2026/27.

The Sickness Absence Programme, developed in partnership with Trade Union colleagues, comprised four key workstreams aimed at reducing sickness absence across the organisation. These focused on data and analytics, training and development, research and best practice, and a dedicated workstream addressing stress, anxiety and depression**.**

Variable Pay Bank Enabling Action



Performance Summary

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

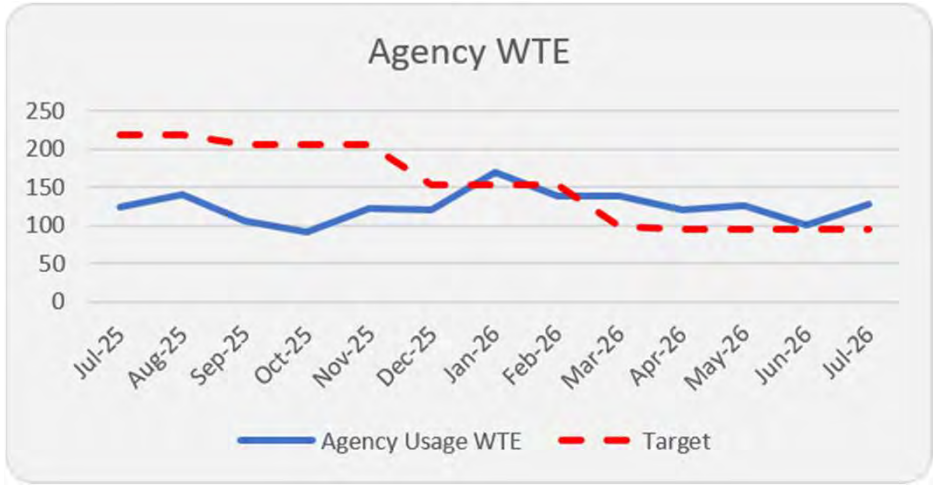
In July, bank usage was 792.18 wte compared with 849 wte recorded at the start of the first quarter representing decreasing usage. Bank usage is 84.67 wte above target.

At the end of July 26 the three highest users were HCSW, 389 wte, a decrease from 511.16 wte recorded in May (49%), Nursing & Midwifery, 272.9 wte, a decrease from 290.44 wte (34%) and Facilities, 95.3 wte, a decrease from 100.50 wte (12%).

The highest reason for usage is Vacancies 253.06.wte (32%).

The target in graph was set as part of the IMTP 2026/27 performance targets.

Variable Pay Agency Enabling Action



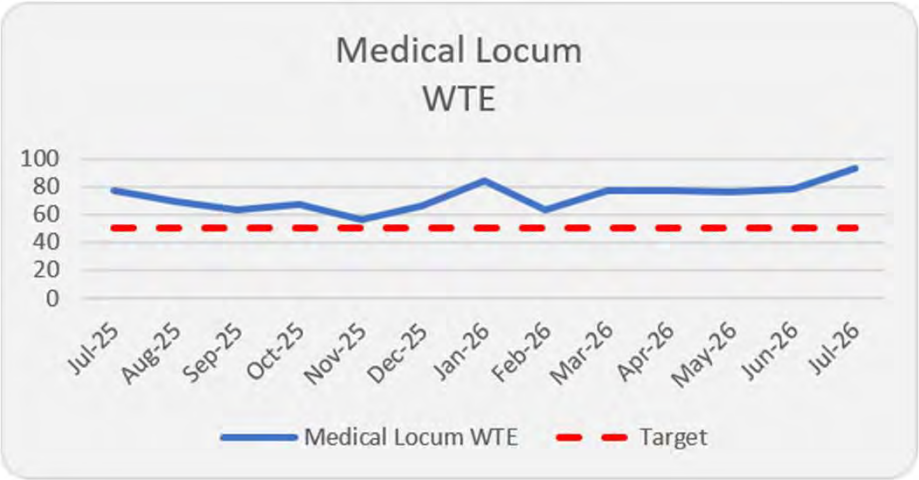
Performance Summary

Agency usage has decreased again in the last quarter to 127.35 wte from 138.87 wte.

In July 26 14.88 wte (13%) were used for HCSW and 100.90 wte (87%) for Nursing and Midwifery. The top three reasons for Agency usage are Sickness 34.11 wte (29%), and Vacancies 24.83wte (22%), Enhanced Care 20.3 wte (18%)

The target in graph was set as part of the IMTP 2026/27 performance targets. This approach aligns with our broader goals of zero agency contract for specific staff groups and MDS enabling actions.

Variable Pay Medical Locum Enabling Action



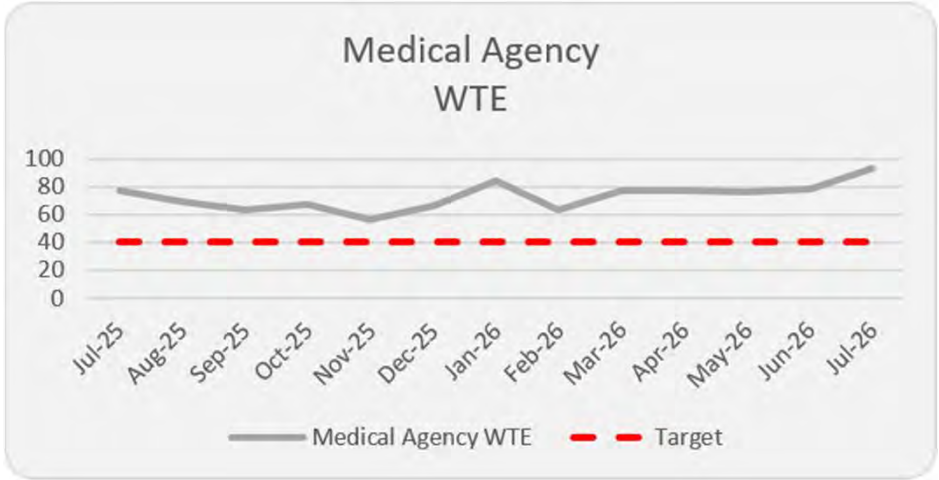
Performance Summary

Locum usage has increased from 76.63 wte to 93.18 wte over this period.
Vacancies continue to be the primary driver of combined locum and agency usage, accounting for 71.49 WTE (57%). However, the increase in temporary staffing cannot be attributed solely to vacancies, as the workforce stability index remains relatively high. This suggests that workforce productivity pressures and increased service demand are also contributing factors.

There is ongoing work with the development of a Medical Workforce Strategy and the introduction of medical e-Systems to support reducing reliance on variable pay.

Target in graph was estimated as part of the IMTP performance framework for 2026/27.

Variable Pay Medical Agency Enabling Action



Performance Summary

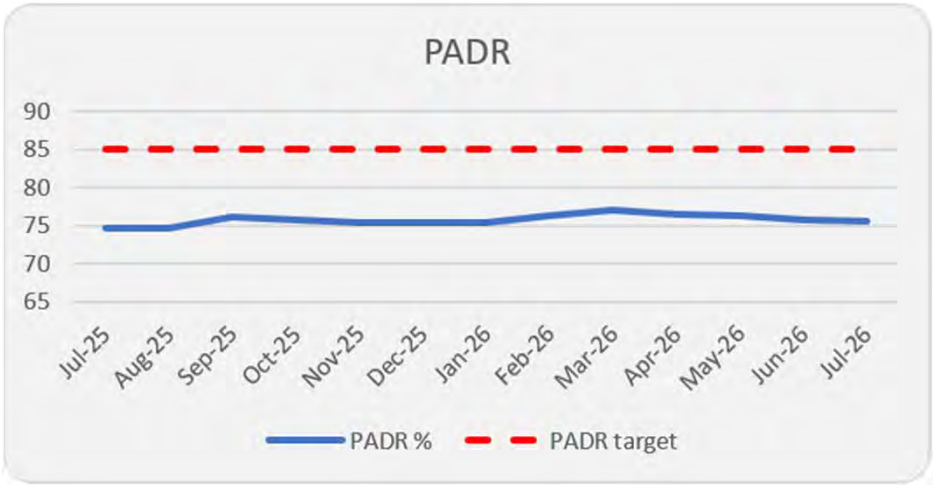
Medical Agency had a sustained a continuous reduction from October 2025 from 40 wte to 32.02 wte in July.
There has been positive progress with direct engagement (DE) with a baseline of 32% in Nov 25 which has increased to 81% in July 26.

There is ongoing work with the development of a Medical Workforce Strategy and the introduction of medical E-Systems to support this work.

Target in graph was set as part of the IMTP performance for 2026/27.

Turnover

PADR



Performance Summary

Turnover rate has remained relatively stable at 9.1% from the start of the 1st and increase from the 8.46% recorded this time last year.
Nursing & Midwifery have the lowest turnover rate of 6.98% whilst Estates & Ancillary have the highest turnover rate of 12.72%. The Stability Rate is 91.67%, the Health Board has retained 14,424 staff.

The target in graph was set as part of the IMTP for 2026/27.

Performance Summary

PADR compliance has remained stable at 76%.

A further review of PADR compliance demonstrates a positive position, with 84.58% of staff having received a PADR review within the last 15 months.

Work continue towards achieving 85% All Wales target through divisional reporting, renewed tools and training for managers.

Job Planning Enabling Action

Performance Summary

Job Planning - Job planning compliance for the consultant workforce has reduced to 49.8% from the 55.1.4% reported at the start of the first quarter. A key factor is job plans falling out of the 12 month compliance period and ongoing complexities being worked through with Directorates.

An All-Wales agreement has been reached to report job planning compliance over a 15-month period, subject to agreed conditions. Following updates to the reporting system, the Health Board's reported position will change from 31 August to reflect this revised approach.

To support the targeted job planning compliance, key actions include integrating progress updates into Divisional Performance Reviews, conducting targeted deep dives, and withholding vacancy approvals until up-to-date consultant job plans are in place. Pay-impacting changes and study leave funding will also be restricted unless job plans are current or under appeal.

Deep dives with divisional management have been undertaken to review compliance levels, action plans and support required.

The target in graph was set as part of the IMTP performance framework for 2026/27.

Performance Summary

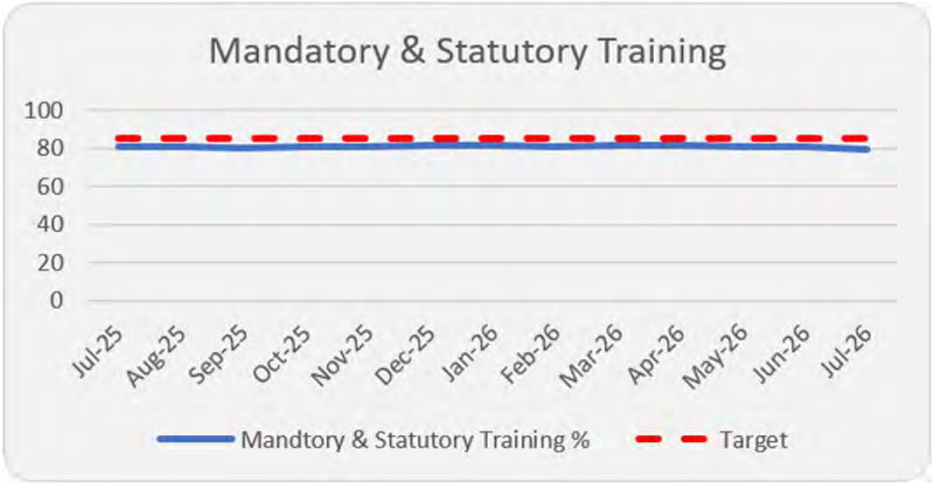
Job Planning – Job planning compliance is current 49.1 which has decreased slightly in the past 2 months but still an overall improvement since the start of the first quarter at 47.5%. The same actions are being undertaken to improve SAS Job Planning as Consultants.

An All-Wales agreement has been reached to report job planning compliance over a 15-month period, subject to agreed conditions. Following updates to the reporting system, the Health Board's reported position will change from 31 August to reflect this revised approach.

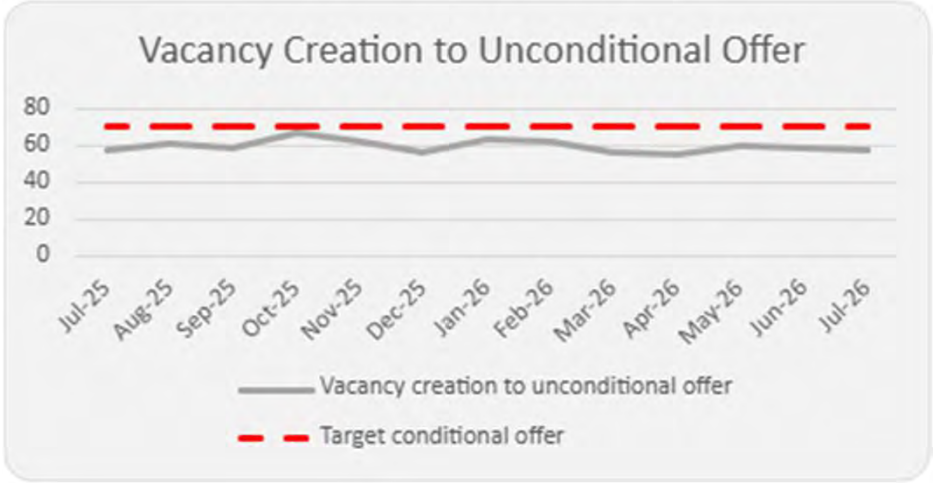
The Medical Workforce E-System Team remains actively engaged with Directorates to support sustained improvements in compliance for consultant and SAS and to ensure that completed job plans are reviewed and updated as necessary prior to their expiry, maintaining continuity going forward.

The target in graph was set as part of the IMTP performance framework 2026/27.

Mandatory Training



Time to Hire



Performance Summary

Mandatory & Statutory Training has remained had remained stable at level at circa 81% and has reduced in the past month to 79.88% which is 4% off the target. There are 3 Divisions/Corporate Services that have reached/higher than the target of 85%.

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

A national review of Statutory and Mandatory training has commenced, facilitated by HEIW.

Performance Summary

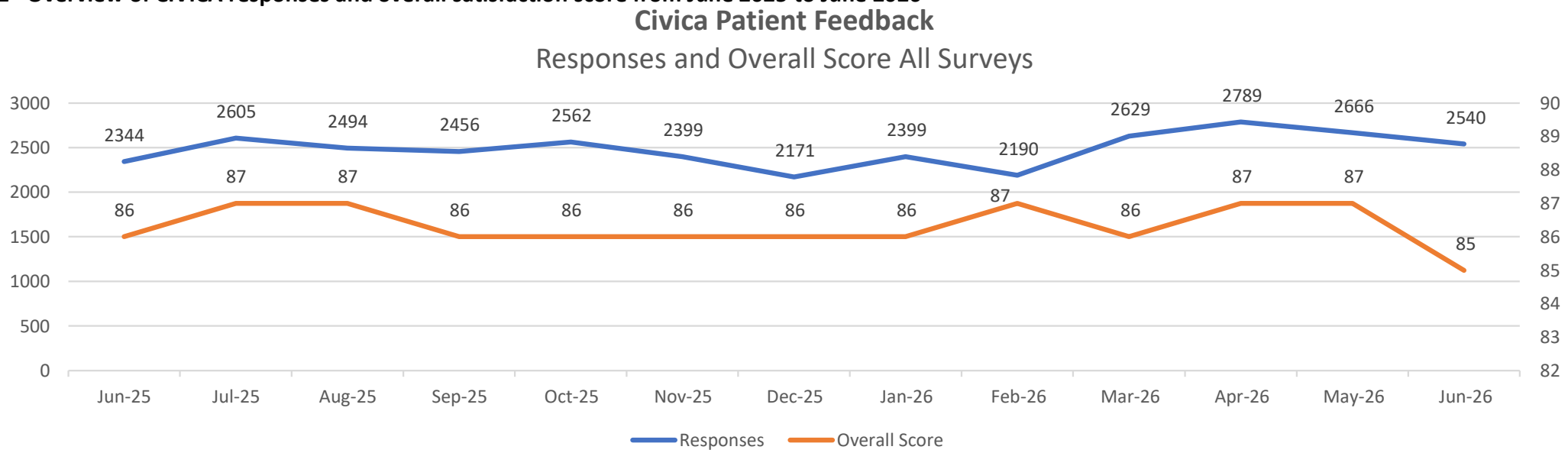
The All-Wales target for recruitment Time to Hire (the time interval between vacancy creation and successful candidate ready for start date) is 71 days and the Health Board continues to improve and exceed the target at 58.4 days.

This target will continue to be stretched further to reduce the time to hire and optimise recruitment start dates.


6 Pillars of Quality
1
Patient and Staff Feedback, Complaints, Concerns & Compliments
2
Patient Safety
3
Clinical Effectiveness
4
Health, Safety, Security and Compliance
5
Infection Prevention and Control
6
Safeguarding

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

Graph 1– Overview of CIVICA responses and overall satisfaction score from June 2025 to June 2026



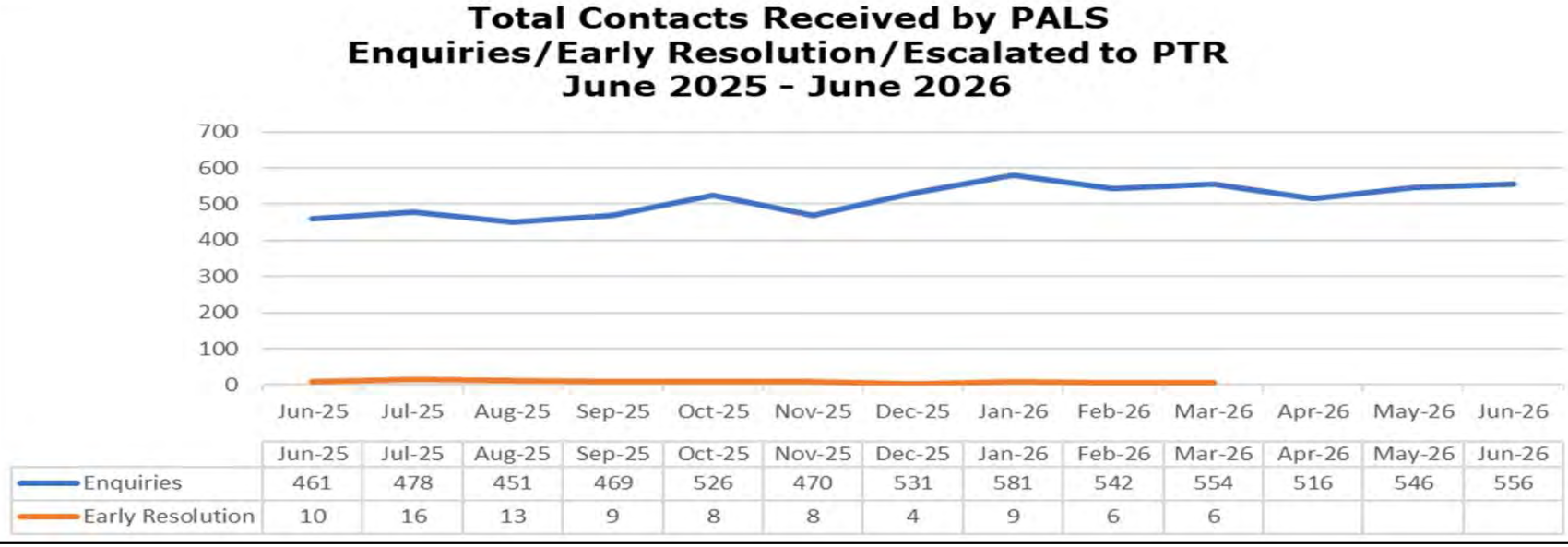
Listening & Learning - What we are Hearing

Patient feedback received through the CIVICA platform continues to provide valuable insight into the experiences of patients, families and carers across the Health Board. As of June 2026, CIVICA was live in 636 service areas, with approximately 61% of those areas having received patient feedback. Overall satisfaction scores remain positive; however, June 2026 recorded the lowest overall satisfaction score since May 2025 at 85%. Analysis also highlights variation in response rates and engagement between Services, with some areas demonstrating strong use of patient feedback whilst others have limited participation. Opportunities remain to improve demographic data completeness, engagement with under-represented groups and the consistent capture and reporting of learning arising from patient feedback.

Listening & Learning - What we are Doing

Work continues to expand and strengthen the use of CIVICA across the Health Board, supporting a more consistent approach to capturing and responding to patient experience. During Quarter 1, rollout was extended across Inpatient wards and most Outpatient services, with 20 surveys available, including 11 national All Wales surveys. Accessibility improvements are being progressed through the introduction of additional languages, British Sign Language (BSL) and Easy Read formats. Regular sharing of intelligence with the Welsh Language Unit and Equality, Diversity and Inclusion teams is supporting improved understanding of the experiences of different patient groups. Training and support also continue, with over 650 staff trained in the use of CIVICA since implementation, alongside ongoing work to strengthen feedback collection, thematic reporting and organisational learning through the "You Said, We Did" approach.

Pillar 1 Patient and staff feedback, concerns, complaints and compliments- Patient Advice & Liaison Service (PALS) (June 25-June 26)



	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Enquiries	461	478	451	469	526	470	531	581	542	554	516	546	556
Early Resolution	10	16	13	9	8	8	4	9	6	6			

Themes	Count
Communication Issues (including Language)	3139
Access (to Services)	1408
Appointments	570
Patient Care	476
Clinical Assessment / Treatment	262
Discharge issue	149
Complaints handling	88
Record Keeping	83
Post death issues	81
Test and Investigation Result	61

What is the data telling us

PALS experienced sustained demand throughout Quarter 1, with enquiries increasing from 516 in April to 556 in June 2026. Communication issues remained the predominant reason for contact, alongside access to services, appointments and patient care concerns. Activity continued to be concentrated within Urgent Care, Medicine and Surgery, with Inpatient services generating the majority of contacts.

Learning and Improvements

Analysis continues to demonstrate that improvements in communication, appointment management and access to services would reduce avoidable demand on PALS and improve patient experience. During the quarter, PALS embedded the Listening to People (LtP) approach, enabling ongoing pastoral support to be recorded within a single Datix record, while strengthening thematic reporting and organisational insight into emerging patient experience issues.

Successes

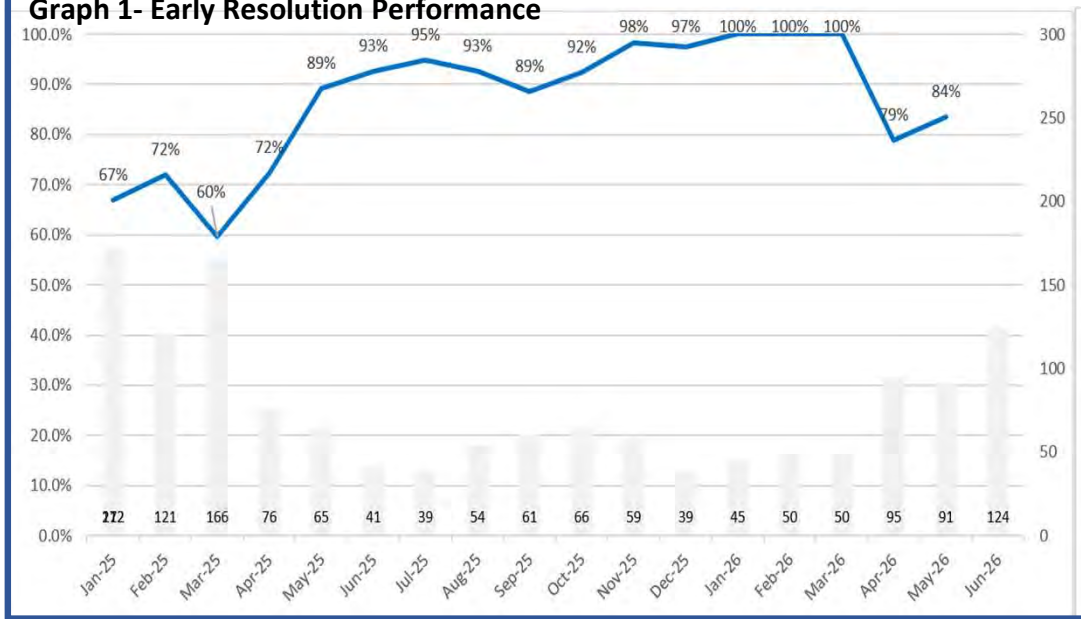
Despite increasing demand, PALS continued to provide effective advocacy, reassurance and early intervention for patients and families, helping to resolve concerns before escalation. Enhanced reporting has improved understanding of demand hotspots and recurring themes, while patient feedback and case studies highlight the positive impact of proactive support, communication and liaison with clinical teams.

Challenges

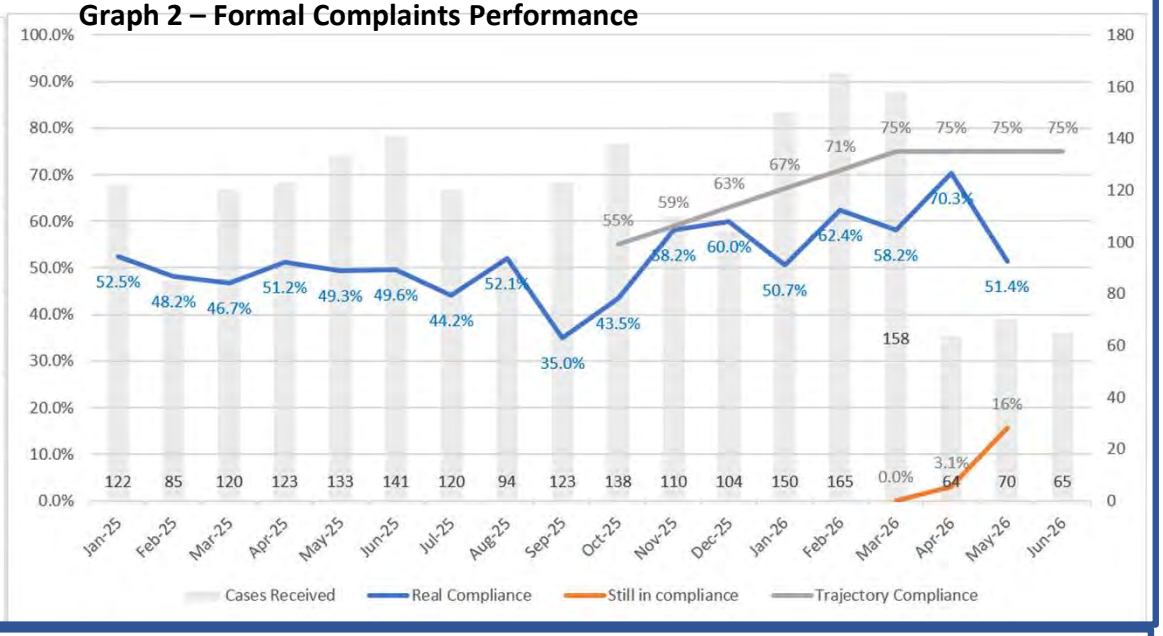
Demand remains significantly above historical levels and continues to place pressure on a relatively small team delivering a seven-day service. Response times have extended, averaging 48 to 72 hours, reducing capacity for outreach, visibility and proactive support. Communication and access-related enquiries continue to account for the majority of contacts, indicating ongoing system pressures within frontline services.

Pillar 1 Patient and staff feedback, concerns, complaints and compliments- Putting Things Right / Listening to People

Graph 1- Early Resolution Performance



Graph 2 – Formal Complaints Performance



Graph 1 Early Resolution activity has sustained above the 75% target following the Listening to People Regulations being introduced in April 2026, this is despite a ~100% increase in volume of complaints being managed through this process. **Graph 2** shows formal complaints activity, compliance, cases remaining within statutory timescales, and the improvement trajectory. Compliance should be considered in the context of revised statutory timeframes (30, 60, 90, 120, 6 months). A proportion of cases remain appropriately within compliance, with 3.1% of April and 16% of May cases still progressing within expected timeframes rather than representing delay.

Key Themes and Learning –

In Q1 2026/27, complaints continued to be predominantly related to clinical treatment and assessment, which accounted for 317 complaints (53.9%) and represented the highest volume and proportion reported during the period. Communication issues remained the second most common theme, comprising 90 complaints (15.3%). Whilst appointments, attitude and behaviour, and access to services continued to feature within the top five complaint categories, all have reduced in volume compared to Q1 2025/26. Notably, complaints relating to access to services reduced from 55 to 20, and attitude and behaviour complaints reduced from 56 to 36 over the same period. Overall, the complaint profile demonstrates an increasing concentration of concerns relating to clinical treatment and assessment, whilst other complaint themes have remained stable or shown a downward trend.

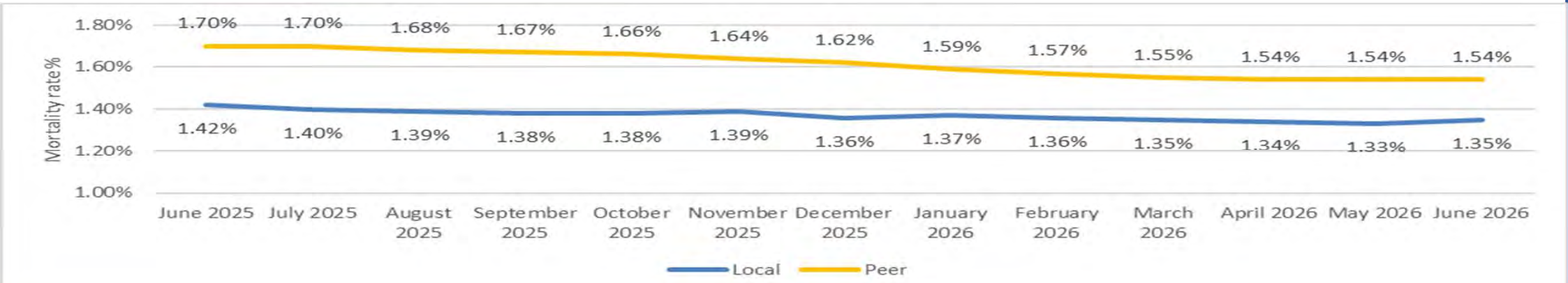
Improvements-

Daily senior oversight of complaint triage was introduced to support consistent application of the All-Wales triage framework and prioritisation of Early Resolution, contributing to a substantial reduction in formal complaints requiring investigation, with reports noting a reduction of approximately 50% in formal cases. Targeted action to address historical backlog cases also resulted in a reduction in overdue complaints (32% reduction in Q1), including a decrease in cases exceeding 6 months old (54% reduction in Q1), whilst strengthening compliance monitoring and reporting arrangements. Further improvements included the implementation of new Early Resolution documentation, updated Datix dashboards, revised PSOW monitoring processes, dedicated complaint mailboxes to improve resilience and continuity, and enhanced divisional engagement to support timely and proportionate resolution of concerns.

Pillar 2 – Patient Safety Including Incident Reporting - Mortality

Graph 1 - Risk Adjusted Mortality Index (RAMI)

Graph 2- Rolling Mortality Rate

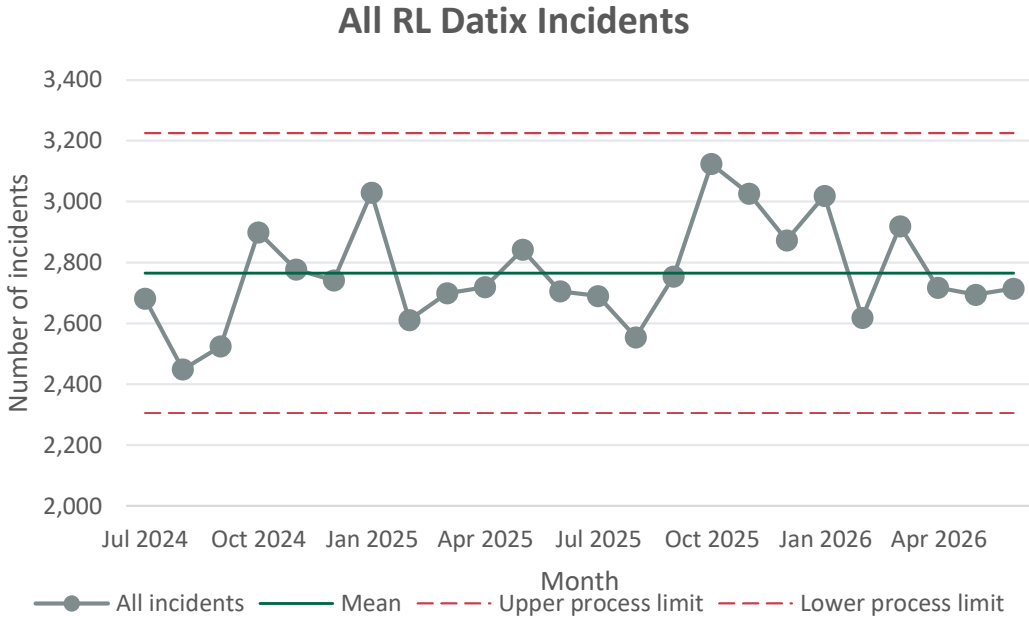


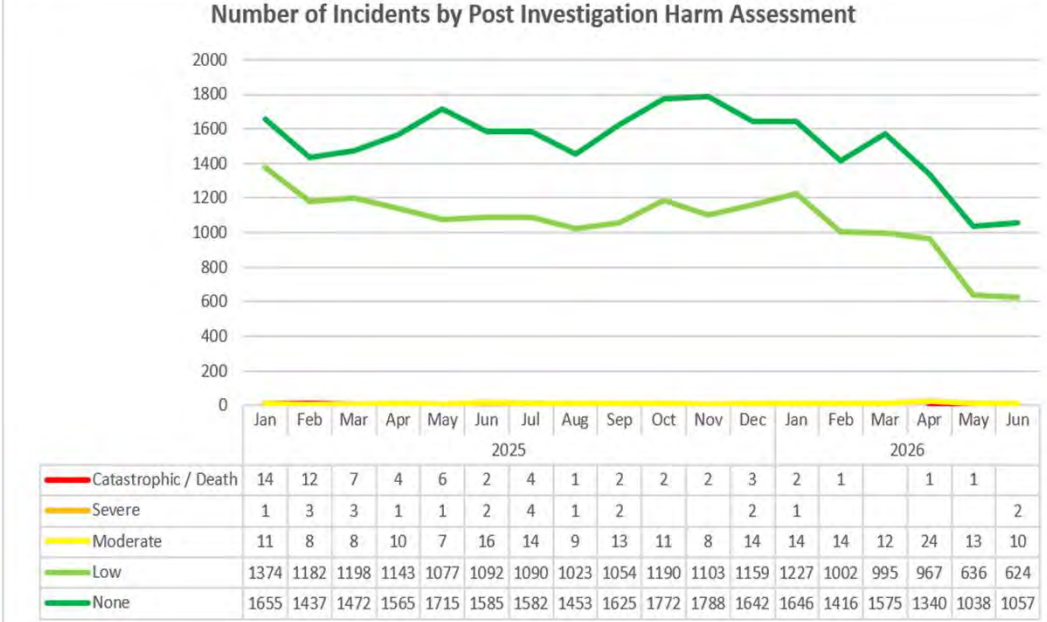
Graph 1 – The Health Board's Risk-Adjusted Mortality Index (RAMI) for Q1 (April and May) is currently 88.61, ranking 3rd within the All-Wales peer group. (Please note: 8-week delay on RAMI figures for reporting). The recent rebasing of RAMI from the 2019 model to a 2023 baseline reflects CHKS's standard approach to recalibrating the index using more contemporary national hospital activity data. This ensures the benchmark remains centred around the national norm of 100 and aligned with current clinical practice.

Graph 2 – Ministerial priorities have included reporting the rolling mortality rate. Mortality rates have remained stable over the past year, with actual rates at or below 1.43 for the last 12 months. Performance has remained in line with the peer group, with the Health Board consistently achieving a comparatively lower mortality rate.

Learning and Improvement – Mortality governance arrangements continue to support learning and improvement through mortality reviews, the Mortality Review Screening Panel, Learning from Deaths processes and routine dissemination of shared learning across the HB. Key themes during the reporting period included communication, family engagement, timely recognition and escalation of deterioration, and effective multidisciplinary decision-making. Actions arising from reviews are monitored through established governance processes to support safer and more equitable care.

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

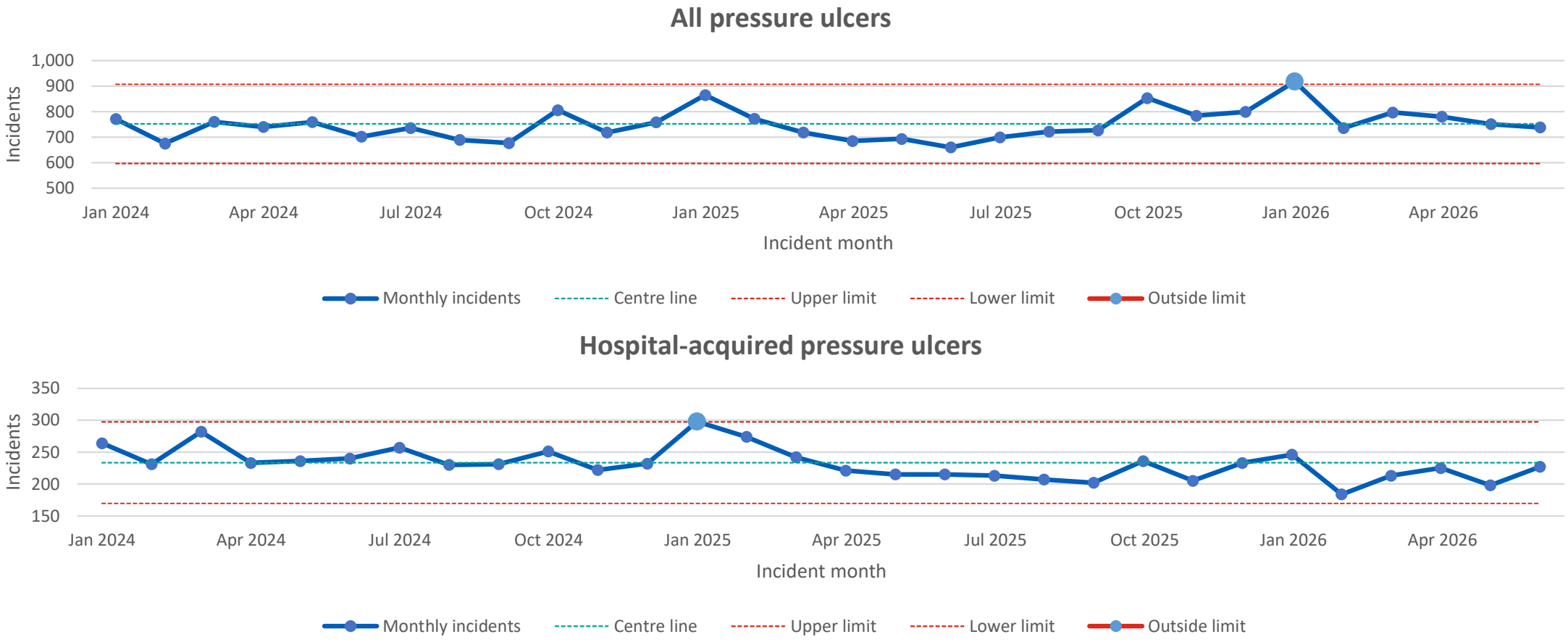




	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	2025												2026					
Catastrophic / Death	14	12	7	4	6	2	4	1	2	2	2	3	2	1		1	1	
Severe	1	3	3	1	1	2	4	1	2			2	1					2
Moderate	11	8	8	10	7	16	14	9	13	11	8	14	14	14	12	24	13	10
Low	1374	1182	1198	1143	1077	1092	1090	1023	1054	1190	1103	1159	1227	1002	995	967	636	624
None	1655	1437	1472	1565	1715	1585	1582	1453	1625	1772	1788	1642	1646	1416	1575	1340	1038	1057

Incident Volume and Harm:
8,226 incidents were reported during April to June 2026 compared with 8,556 incidents during January to March 2026, representing a reduction of 330 incidents (3.9%). The incident profile remained unchanged across both quarters, with Pressure Damage, Moisture Damage incidents continuing to account for the largest proportion of reports, followed by Behaviour (including violence and aggression) and Accident, Injury incidents. Medication, IV Fluids incidents and Assessment, Investigation, Diagnosis incidents also remained among the most commonly reported categories, indicating a consistent pattern of reporting across the organisation.
Post-investigation harm assessments continued to indicate that the majority of incidents resulted in no or low harm. During April to June 2026, 2,227 incidents were assessed as low harm, 47 as moderate harm, two as severe harm and two as catastrophic/death, compared with 3,224 low harm, 40 moderate harm, one severe harm and three catastrophic/death incidents during January to March 2026. The number of incidents remaining open beyond 30 working days continues to be an area of targeted improvement to ensure learning for incidents can be rapidly embedded within services.
Learning & Improvement –
Learning and improvement activity focused on translating incident themes into practical action, particularly in relation to medication safety, documentation quality, communication accessibility, incident investigation timeliness and implementation of the Call for Concern model. Positive feedback from Welsh Government recognised the Health Board's high standard of National Reportable Incident submissions and performance against reporting timescales. QMG additionally received assurance that divisions were strengthening local quality and patient safety processes, improving incident closure trajectories and embedding more structured approaches to learning, escalation and quality improvement..

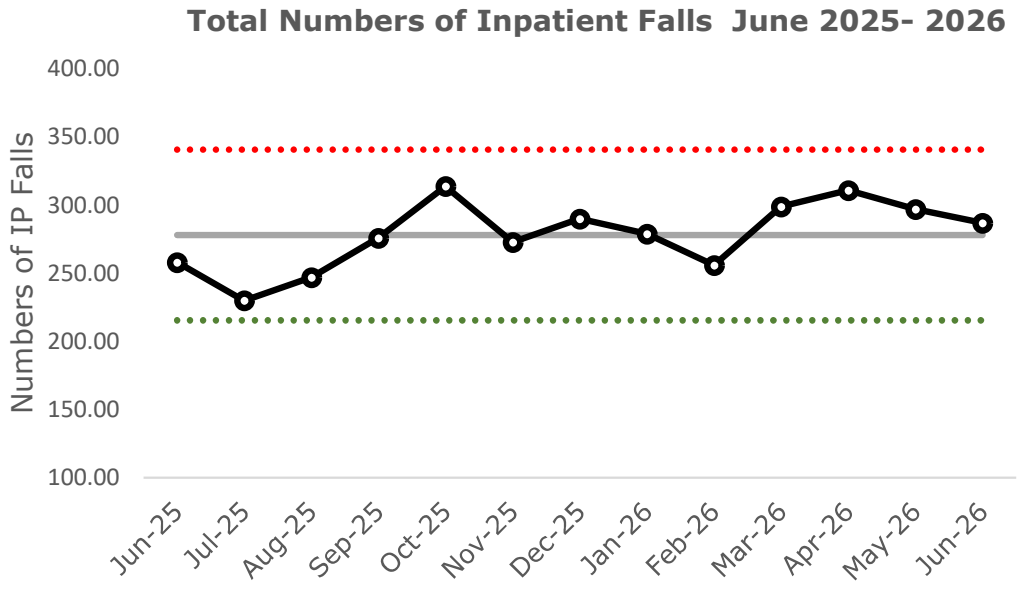
Pillar 2 – Patient Safety Including Incident Reporting – Pressure Ulcers

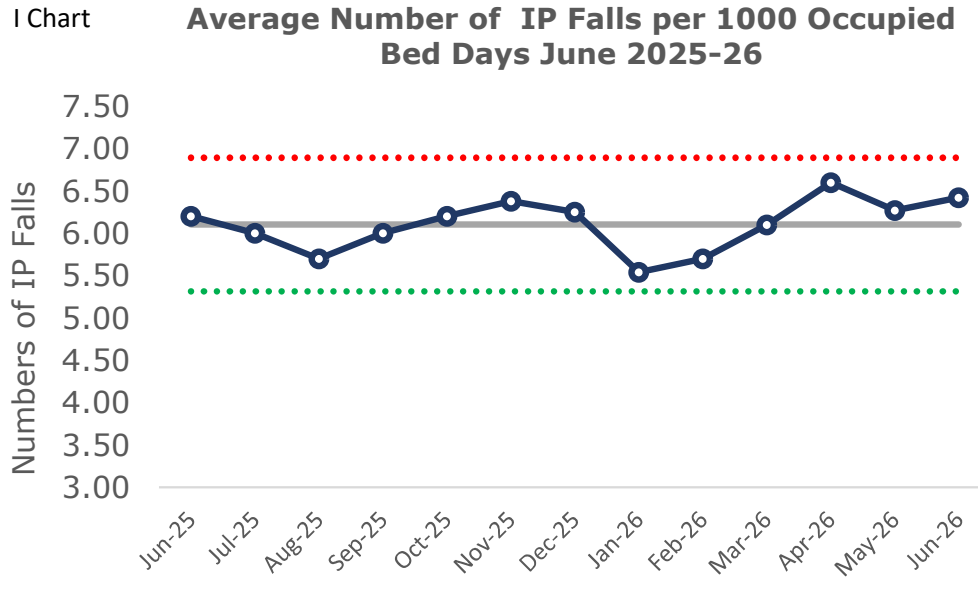


During Q1 2026/27 (April to June 2026) pressure ulcer incidents remained stable overall and within expected statistical control limits, with no evidence of special cause variation. Total reported incidents demonstrated a gradual reduction across the quarter, falling from 780 in April to 751 in May and 738 in June (2,269 incidents overall). Hospital-acquired pressure ulcers remained relatively consistent at 225, 198 and 227 respectively, suggesting no sustained deterioration in performance. Category 2 pressure ulcers (partial-thickness skin loss where the epidermis (outer layer of skin) or dermis (deeper layer of skin), or both, are damaged) continued to account for the largest proportion of incidents, although numbers reduced compared to April before partially increasing in June.

The most notable variation was an increase in unstageable pressure ulcers, which rose steadily from 13 in April to 26 in June, alongside a small increase in device-related pressure ulcers during June. Suspected deep tissue injuries showed improvement, reducing from 36 in April to 28 in May and remaining stable thereafter. Category 3 ulcers remained low throughout the quarter and no Category 4 pressure ulcers were recorded. Overall, the quarter reflects a stable pressure ulcer profile with a modest downward trend in total incidents; however, the increase in unstageable ulcers and device-related harm in June warrants further review to identify any emerging themes or learning opportunities.

Pillar 2 – Patient Safety Including Incident Reporting – Falls

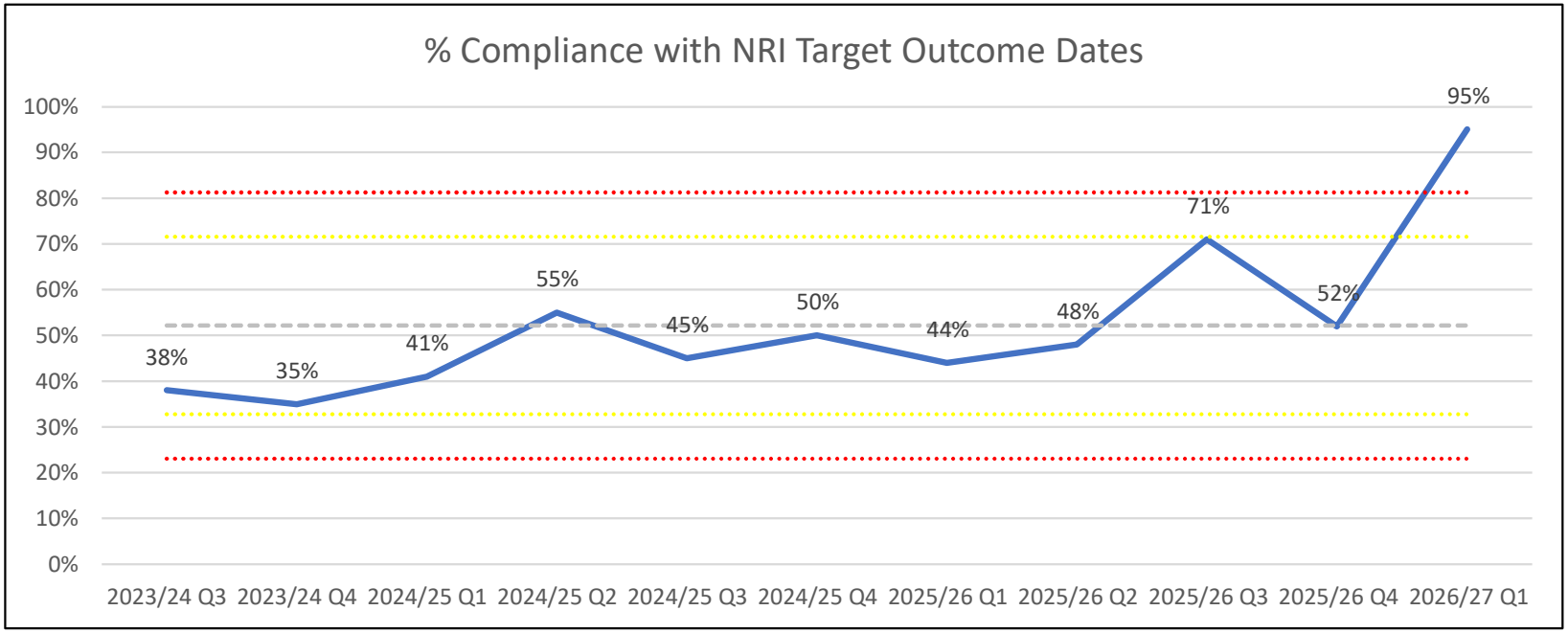




During Q1 2026/27, reported inpatient falls across ABUHB normal month-to-month variation within a stable system, with no statistical evidence of a significant change in performance, with no significant special cause variation identified. April represented the highest point of the quarter, with falls increasing to 311, before reducing to 297 in May and 287 in June. Falls per 1,000 occupied bed days also fluctuated, increasing to 6.60 in April, reducing to 6.27 in May and rising marginally to 6.42 in June, with May and June remaining below the national average of 6.6. The overall position is therefore one of stable but variable performance, with early evidence of an in-quarter reduction in reported falls following the April peak, but not yet a statistically significant improvement trajectory. Harm data should be interpreted with caution, as a proportion of May and June incidents were still awaiting confirmed manager-attributed harm grading at the time of reporting.

Actions during the quarter have focused on strengthening oversight, learning and prevention. Falls data continues to be monitored through RLDatix and Qlik, with ward-level extracts supporting weekly review and monthly Quality Outcomes Framework reporting. Falls resulting in fracture or falls-related head injury are escalated through the weekly Executive huddle and reviewed through the Falls Strategic Oversight Panel, using concise review methodology to identify themes, trends, learning and any associated Duty of Candour or RIDDOR considerations. Wider improvement work is being progressed through the Falls and Bone Health Strategic Group, including Fracture Liaison Services, implementation of the National Community-Based Falls Response Framework for Wales, consideration of the WAST Falls Desk, and the Medicine Division Falls Champions initiative. Current learning highlights the need to maintain ward-level visibility, strengthen thematic review, improve consistency of data quality and address fragmented digital systems, while continuing to translate review findings into practical learning and sustained improvement

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



Overdue NRIs

	End of Q3 2025/26	End of Q4 2025/26	End of Q1 2026/27
Over 12 months	4	2	0
Between 6-12 months	2	3	1
Between 3-6 months	3	3	3
Between 0-3 months	9	8	3
Total	**18**	**16**	**7**

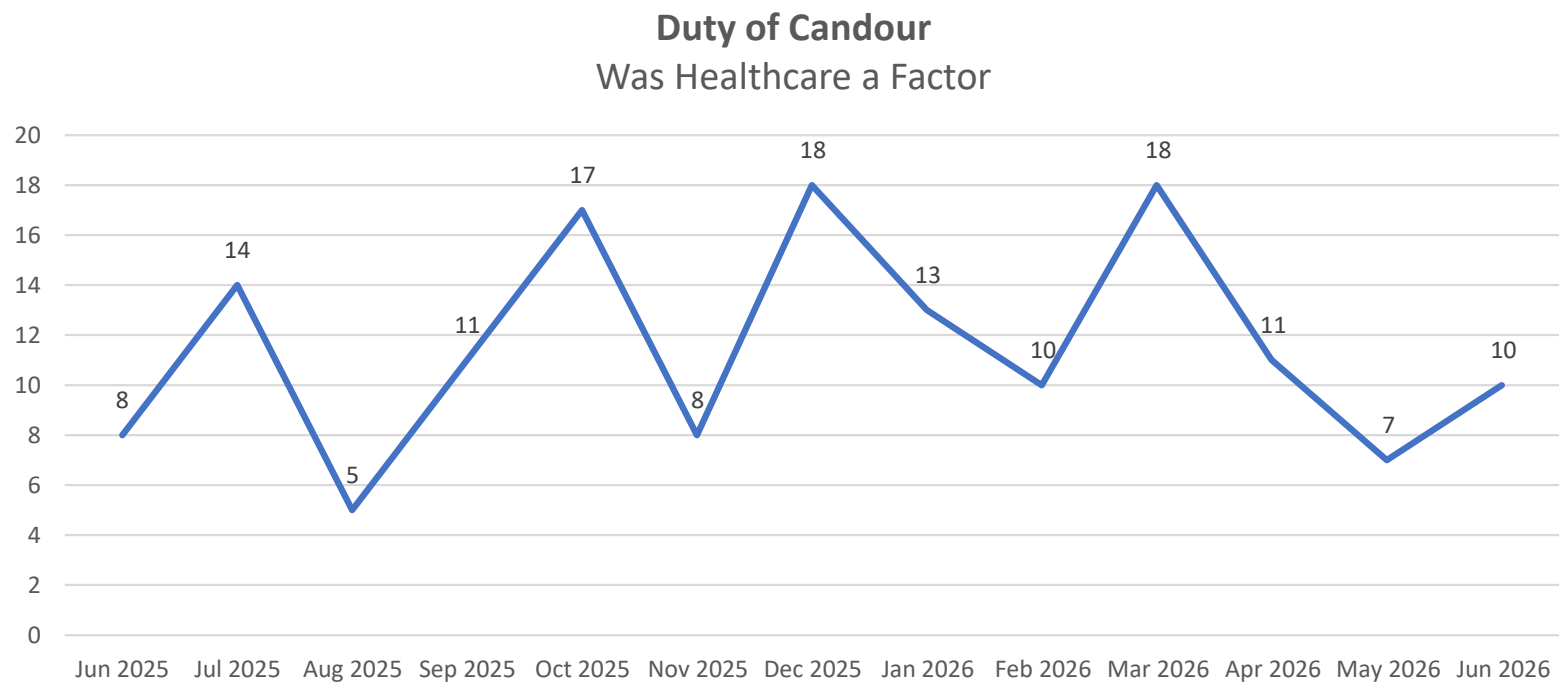
The Patient Safety Incident Team has made significant progress in strengthening the management of Nationally Reportable Incidents (NRIs), with sustained improvements in both compliance and oversight. Overdue NRIs have reduced substantially, down to just 7 at the end of Q1 2025/26 compared to a high of 70 in July 2024. Compliance reached 95% in Q1 2026/27 a record high for the organisation.

Corporate oversight of all NRI cases was introduced in Q1 to improve oversight and early escalation of cases. This has contributed to the improved compliance observed with 58 of 61 NRIs due for closure being completed on or before the NHS P&I deadline. This is reinforced by compliments received by NHS P&I in relation to the improved quality of closure forms and compliance.

Work also commenced to improve data quality, reporting arrangements and governance through the development of dashboards, standard operating procedures and strengthened quality assurance processes prior to closure. Alongside this, development of Family Liaison Officer capability commenced, with national training identified and plans progressing to strengthen support for patients and families affected by serious incidents.

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

Graph 1 – Duty of Candour Events



The number of Duty of Candour events continues to vary month to month, reflecting the point at which management reviews confirm whether Duty of Candour thresholds are met. This remains an evolving position, with data accurate as of 13 August 2026 and subject to change as reviews are completed.

What is the data telling us
In Q1 2026/27 there were 21 DoC events, compared to 41 in Q4 2025/26 and 26 during Q1 2025/26.
The DoC themes for Q1 were clinical assessment/diagnosis (29%) medication prescribing and treatment / procedure issue (11% each) and Administration errors and patient injury (7% each).

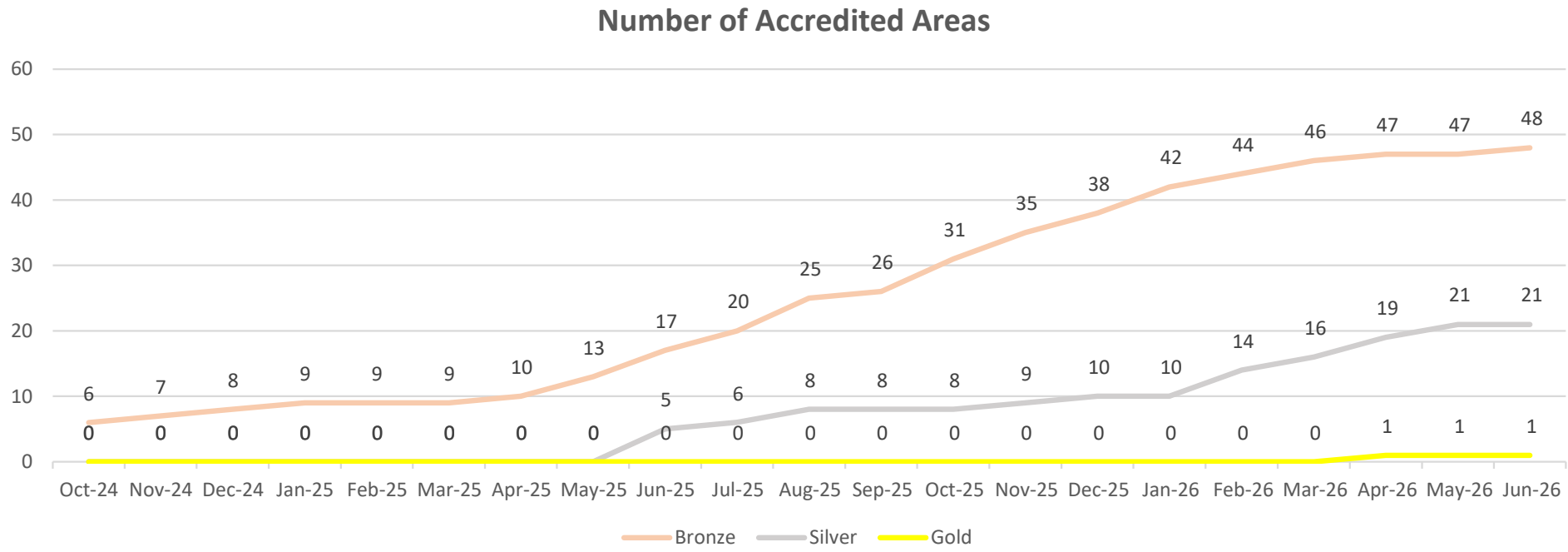
Learning and Improvement

Significant progress was made in strengthening Duty of Candour arrangements. Corporate oversight was enhanced through the introduction of the daily 10@10 review process, ensuring earlier consideration of Duty of Candour, redress and reportability requirements.

Development of a DoC Divisional Dashboard is undergoing validation alongside validation of DoC compliance through Qlik.

Pillar 3 Clinical Effectiveness – Ward Accreditation

Graph 1- Ward accreditation status over time



The accreditation programme has now progressed beyond traditional Inpatient wards and is expanding across multiple clinical settings. Phase 3 implementation commenced during Q1, with accreditation frameworks developed or in development for District Nursing, Health Visiting, School Nursing, Community Mental Health Teams and Child and Adolescent Mental Health Services (CAMHS). This represents a significant expansion of the programme and supports the ambition of achieving full organisational coverage.

The accreditation programme demonstrates sustained engagement across clinical services and increasing organisational maturity. The primary focus during Q1 was not simply increasing award numbers, but establishing the systems, governance and assurance arrangements needed to ensure accreditation delivers measurable improvements in quality, safety and patient experience. This included development of an accreditation assurance framework, creation of an accreditation panel, work towards integrated digital dashboards using WNCR and Careflow data, and the introduction of divisional compliance heat maps and thematic audit tracking.

Pillar 4 - Health, Safety, Security and Compliance

Graph 1- RIDDOR % Compliance

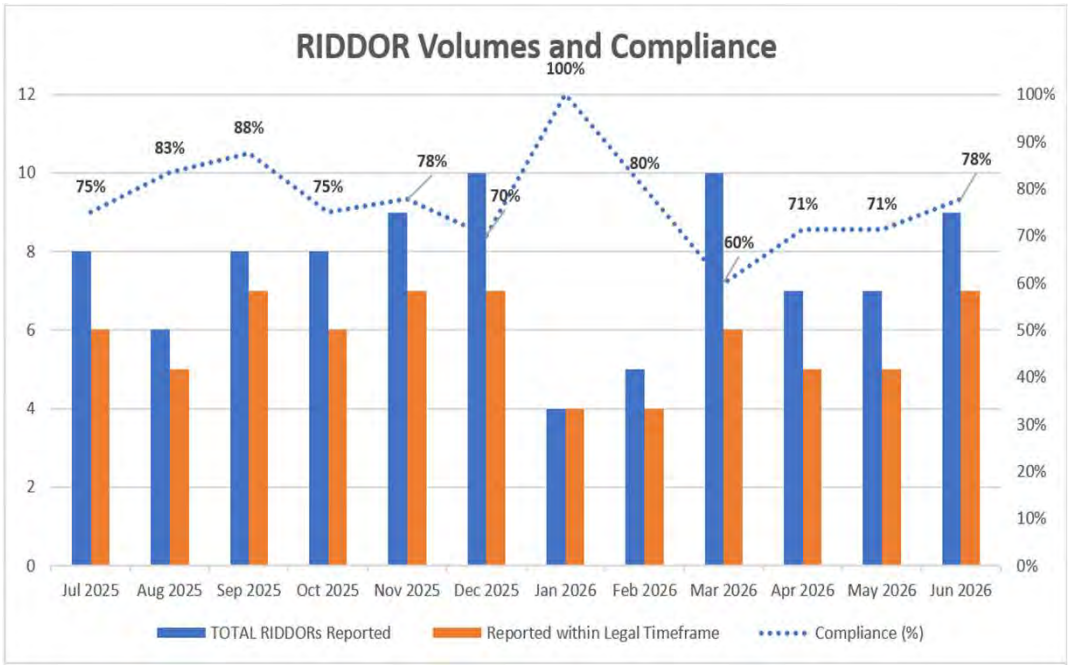


Table 1 - Health and Safety Training Compliance

Statutory & Mandatory Training Compliance	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026
Health and Safety	87.0%	87.2%	87.5%	87.1%	87.1%	87.0%
Fire Safety	82.2%	82.4%	83.5%	84.3%	84.3%	84.3%
Manual Handling	65.4%	64.8%	64.5%	64.3%	64.3%	63.3%
Violence Prevention & Reduction	85.2%	85.3%	85.5%	85.2%	85.2%	85.1%

Table 2 – Top 4 staff incident categories

Staff Health and Safety Incident Reporting	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026
Physical assault	91	88	83	107	121	95	45
Contact with needle or medical sharps	24	23	10	21	16	23	22
Verbal assault	14	11	20	16	21	18	11
Slip, trip or fall	7	28	16	8	14	9	13

Issue	Action		Learning and Improvement
Violence towards staff	Violence Prevention & Reduction Strategic Plan approved by Board	Under-reporting and normalisation of abuse	The VPR Strategic Plan sets out objectives to improve reporting and culture
Needlestick & sharps	Reduction in number of injuries in Q4 2025/26	Poor practice relating to safe disposal of sharps identified as a contributory factor to injuries	QI project to reduce needlestick and sharps injuries to commence in Q3 26/27 in conjunction with H&S, IPaC and Occupational Health
Winter slips, trips and falls	Winter falls thematic review conducted by Corporate Health & Safety	Slips, trips and falls in Q4 25/26 significantly above the quarterly average and data for the same period in Q4 24/25	Areas for improvement identified within the thematic review to be shared with Facilities Division
RIDDOR reporting compliance with the legal timeframes	RIDDOR SOP revised	Timely reporting and investigation of incidents to determine an outcome on RIDDOR	RIDDOR Awareness eLearning Training to be implemented in Q3 26/27. Submission to Core Learning Committee in September 2026 to mandate this training for managers
Manual Handling Training	Manual handling training programme developed for 2026/27	Backlog of staff requiring the 2-day People Handling Foundation Training	Focus on supporting Cascade Trainers (Transfer Specialists) to ensure update training is delivered locally

Pillar Five - Infection Prevention & Control (June 2026)

ABUHB Q1 data compared to All Wales average data for total counts and rates per 100,000 population.

All Wales – Current FY count of specimens

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	50	6	42	96	29	7
Wales	338	21	213	539	172	38

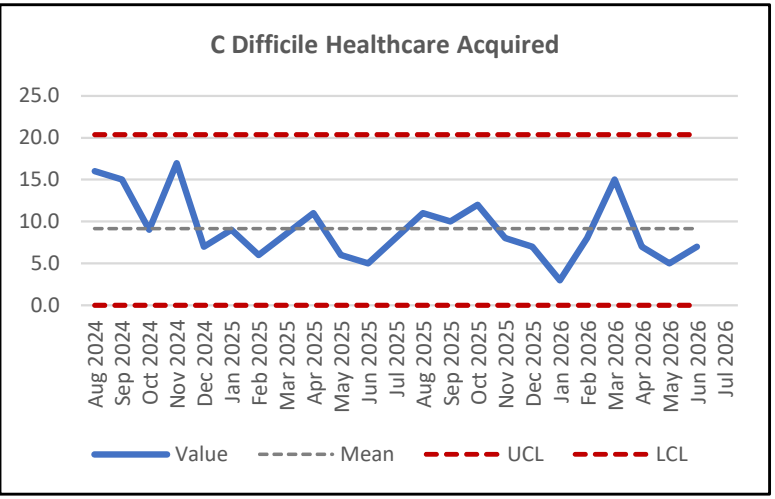
All Wales – Current FY rate per 100,000 population

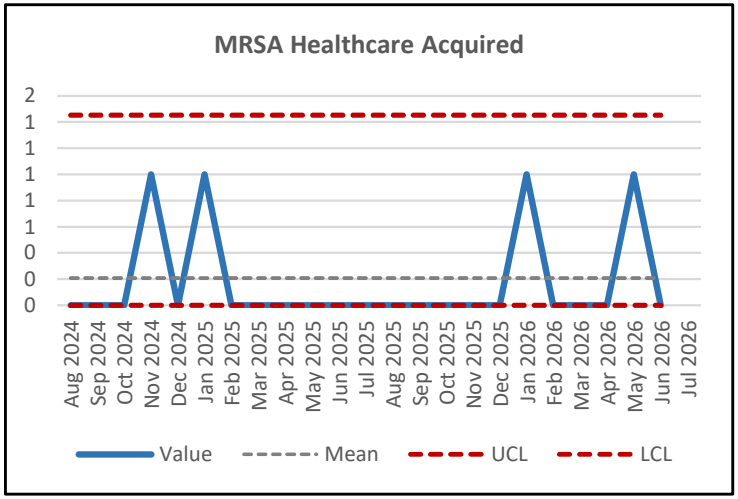
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	33.33	4	28	64	19.33	4.67
Wales	42.54	2.64	26.81	67.84	21.65	4.78

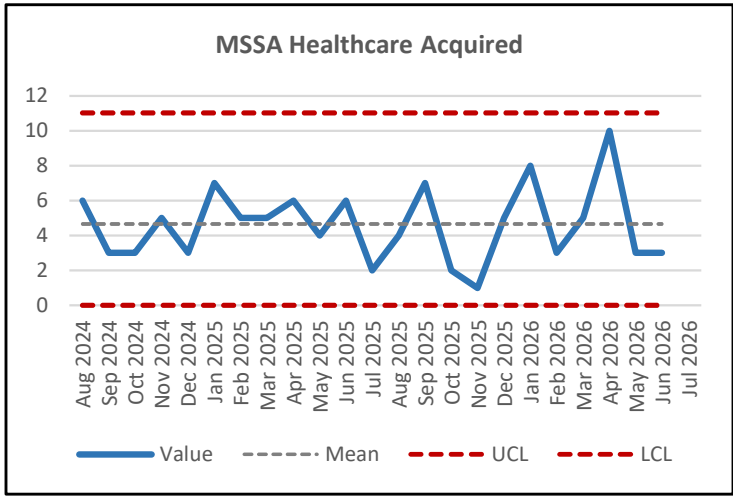
Pillar Five - Infection Prevention & Control

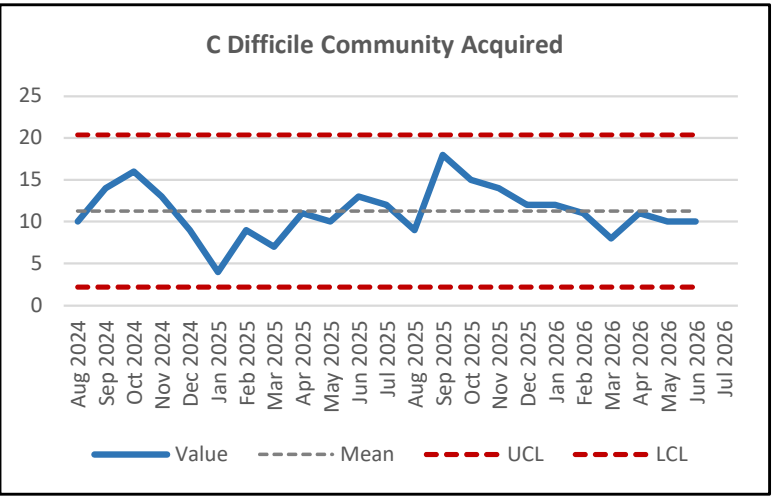
Themes & Trends	Successes	Challenges	Learning & Improvement
C difficile 50 cases reported for April –June 2026. This is 8 less than the equivalent period 2025/26. This is a HB rate of 33.33 per 100,000 population	Enhanced proactive cleaning started within NHH and GUH wards 1 ward environmental upgrade at Royal Gwent Hospital Ongoing QI project Submit a poster for C difficile learning event 09/06/25	Timely isolation at community ward within RGH due to enhanced care Ongoing vacancies and sickness within facilities team Capacity to allow for full ward decant cleans 2 wards clusters identified with geno sequencing.	Checking of mattress and decontamination of near patient equipment HPV cleaned in response to PII IPC advice.
Staph Aureus blood stream infections (MRSA/MSSA) 48 cases (MRSA and MSSA) reported for April – June 2026. This is 9 more than the equivalent period 2025/26. This is a HB rate of 32.00 per 100,000 population	Erase developed for the cleaning of patient skin prior to venepuncture Engagement from 2 medical wards to start QI for line care currently in the process of scoping staff knowledge ANTT paper developed with a recommendation to re-establish ANTT working group. Divisional data included in May dashboard	1 CAI MRSA linked to community acquired wound infection Recall of skin prep products for cannulation associated with heat impact ESR job profiles not linked to ANTT competency requirement making reporting re ANTT compliance difficult. Decontamination of ultrasound probes	Cleaning of skin prior to venepuncture not robust across the HB Divisions supporting the ANTT working group to review training compliance and observational audits re practice Assurance gained care packs are promoted within all TVS training, and the importance of wound hygiene etc. TVN team reviewing patient information leaflet to support best practice SOP developed with key areas outside of radiology

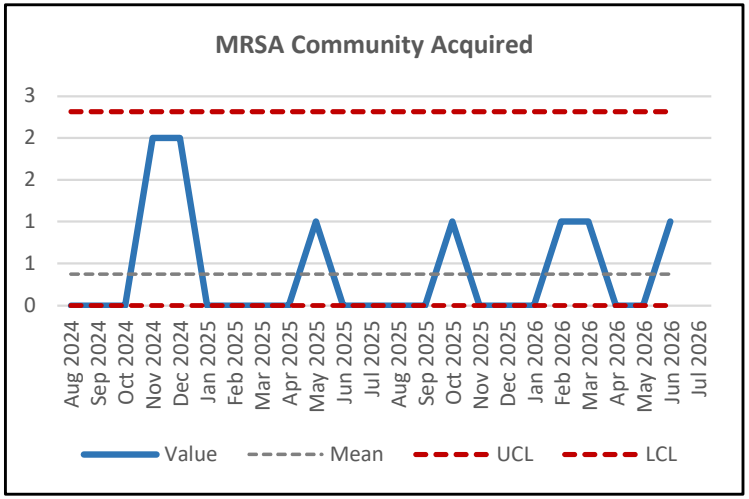
Pillar Five - Infection Prevention & Control

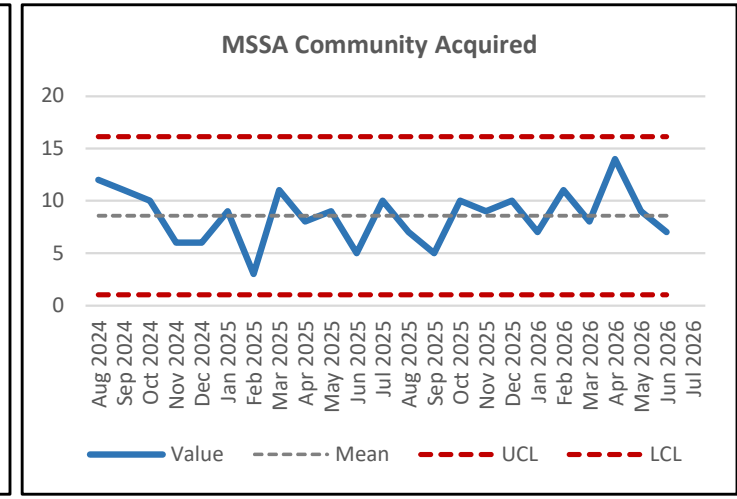








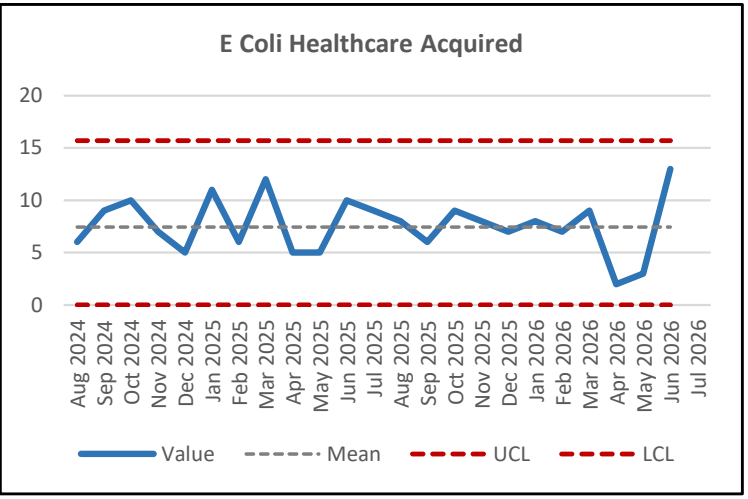


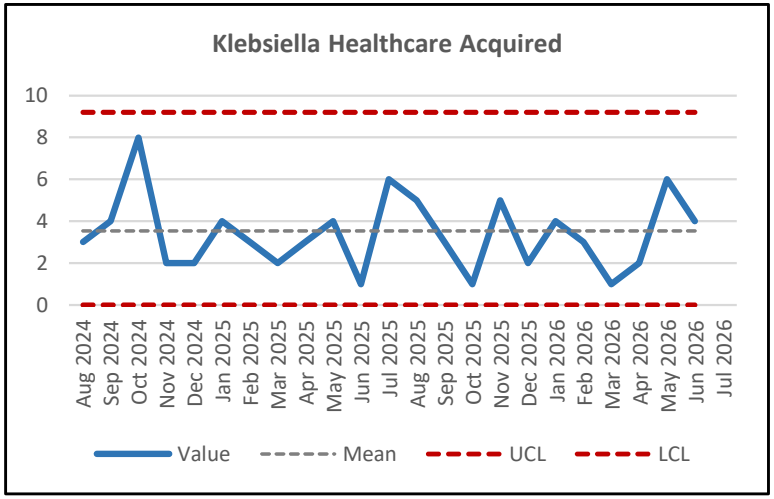


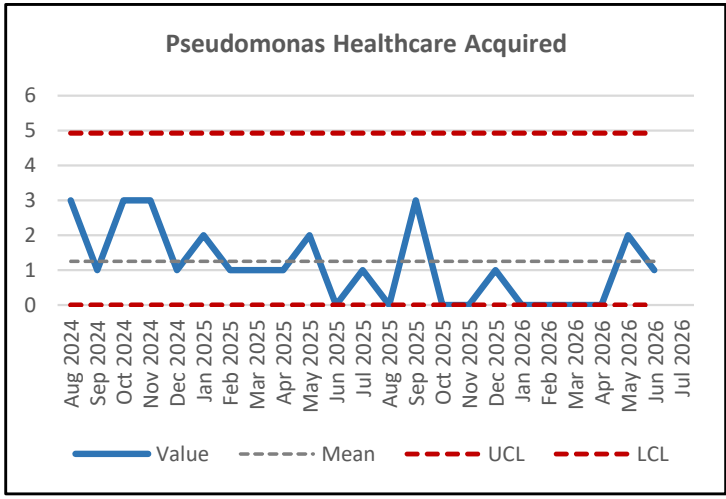
Pillar Five - Infection Prevention & Control

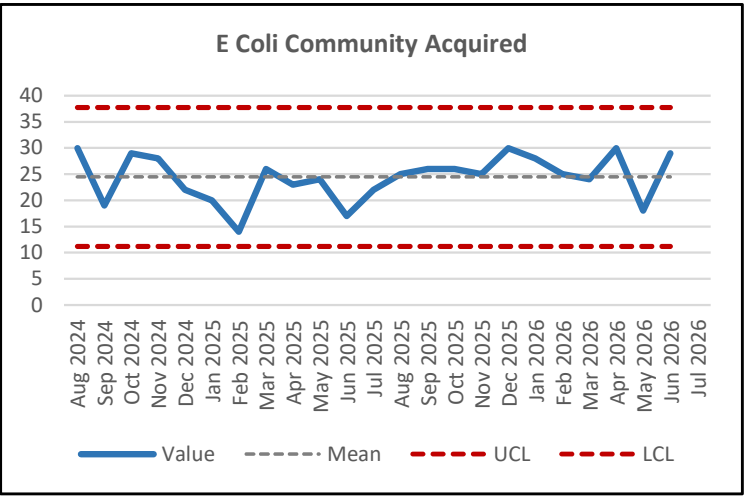
Themes & Trends	Successes	Challenges	Learning & Improvement
Gram Negative blood stream infections 96 cases of **E coli BSI** reported for April –June 2026. This is 12 more than the equivalent period 2025/26. This is a HB rate of 64 per 100,000 population	Paper developed for E coli largest source urinary tract infection Currently lowest rate in Wales for E coli No clusters identified through robust monitoring	Welsh Nursing Care Record does not include the HOUNIDI care bundle Extreme Hot weather - increases risk of acute kidney injury - UTI is the largest burden of infection	Reminder of the importance of selecting correct urine sample pot to support timely treatment plan
29 cases of **Klebsiella BSI** reported for April –June 2026. This is 4 more than the equivalent period 2025/26. This is a HB rate of 19.33 per 100,000 population	No clusters identified through robust monitoring	Extreme Hot weather - potential impact on PPE compliance and procedure packs	Promotion of Wales Urinary Tract Infection Key 9 standards for management and prevention of UTI Link with care home re personal hygiene campaign
7 cases of **pseudomonas BSI** reported for April -June 2026. This is 4 less than the equivalent period 2025/26. This is a HB rate of 4.67 per 100,000 population	No clusters identified through robust monitoring	Wound infection is the largest source of infection	Promotion of patient hydration especially during warmer weather climate

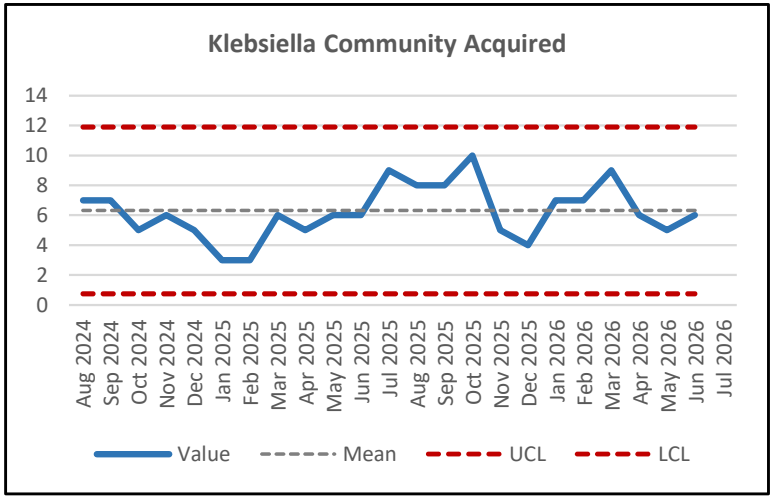
Pillar Five - Infection Prevention & Control

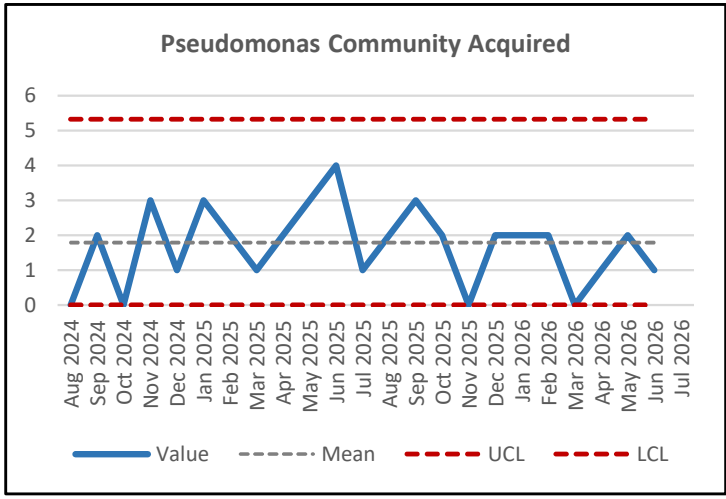






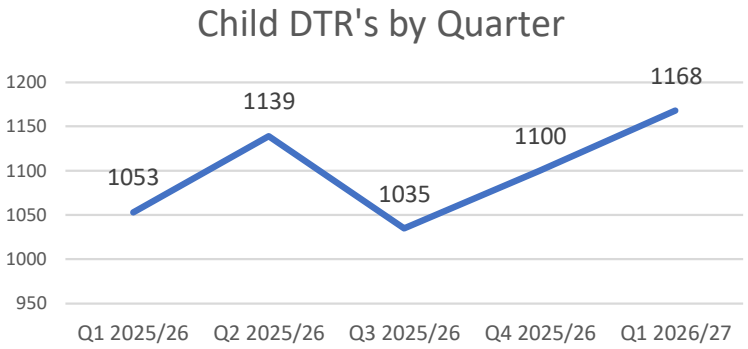




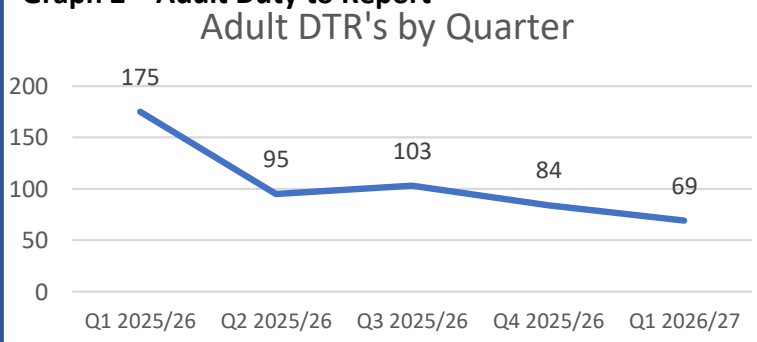


Safeguarding

Graph 1 – Child Duty to Report



Graph 2 – Adult Duty to Report



Graph 3 – Advice & Support Calls to Safeguarding Service

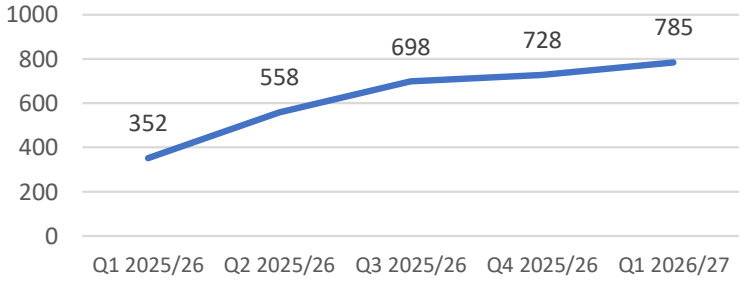
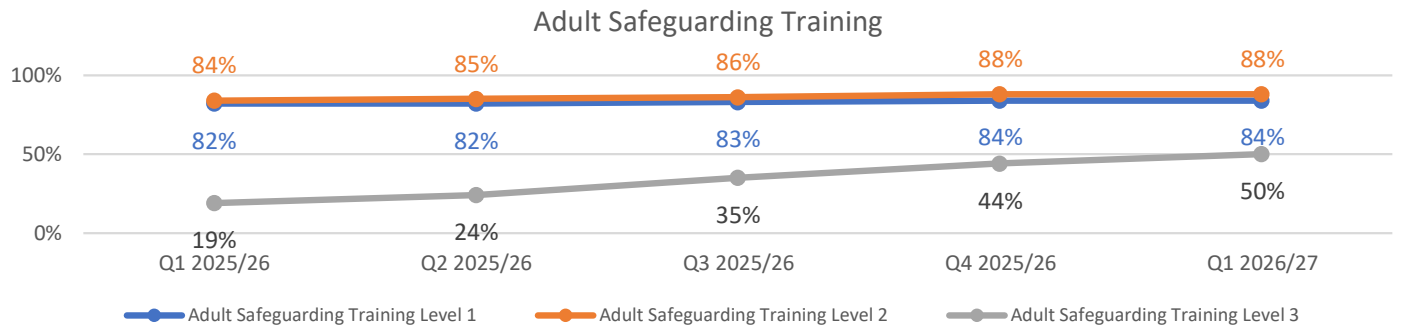
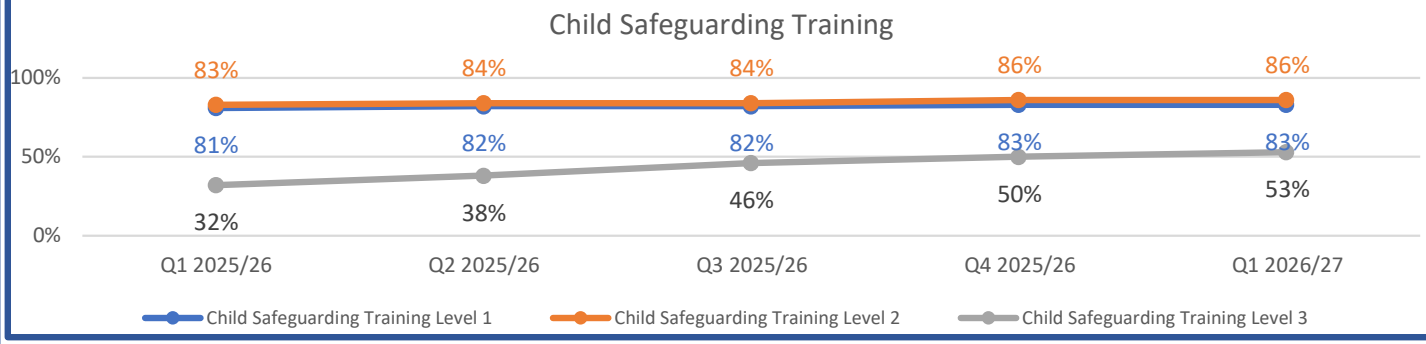


Table 1 - Child and Adult Safeguarding training compliance (levels 1, 2 & 3)





Child Duty to Report:
Child safeguarding Duty to Report activity continues to. Staff awareness and escalation of safeguarding concerns are supported through ongoing training, however the service is experiencing a significant increase in child strategy meetings and is currently unable to meet demand. This has created a recognised patient safety and reputational risk, with strategy meeting attendance highlighted on the Corporate Risk Register.

Adult Duty To Report
Adult safeguarding Duty to Report activity is monitored across local authority areas, categories and divisions. Increased compliance with Level 3 safeguarding training has resulted in more advice and support requests and fewer cases requiring formal escalation through a Duty to Report, suggesting earlier identification and management of safeguarding concerns. However, limitations within RLDatix currently restrict detailed analysis of Duty to Report activity by division and local authority.

Safeguarding Training:
Safeguarding training compliance remains strong for Levels 1 and 2, with adult training at 84% and 87% respectively and child training at 83% and 86%. Level 3 compliance is improving and remains on trajectory to achieve the long-term target by April 2028. The training programme is increasing staff competence in identifying, escalating and managing safeguarding concerns, contributing to more timely interventions to protect patients from harm.

The 2026/27 financial performance is measured by comparing actual expenditure with the budgets as delegated and approved by the Board and CEO. The Health Board has statutory financial duties and other financial targets which must be met. The table below summarises these and the Health Board's performance against them.

The 2026/27 financial year to date budget performance as at month 05 is an adverse variance of **£30.238m**. The Welsh Risk Pool cost pressure has been profiled into the year to date position (£9.5m), but for this, this position is in line with the expected MMR profile for month 05. The deficit movement each month reduces later in the year due to the profile of savings achievement expected. In Month 05 the forecast position is **a reported forecast of £41.6m deficit**.

Aug-26
Performance against key financial targets 2026/27
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Year-end Forecast	Movement
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	5,384	30,238	41,630	⇔
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.*	£'000	£2.726	£11.119	0	⇔
	£32.842	8%	34%		
Public Sector Payment Policy To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	96.8%	97.3%	>95%	●
Savings The 2026/27 IMTP submitted identified **£44.9m** of savings which included, division identified schemes of **£13.2m**, QIA and workforce savings of **£14.7m**, and pipeline savings of **£17m.**	£'000	2,799	11,001	44,937	↑

Target	Unit	Cash Guideline	Actual	Variance	Rating
Cash The Health Board must not end any month with an overdrawn cash balance. Welsh Government also sets an advisory maximum month-end cash balance of £6m, which should not be exceeded.	£'000	6,000	2,905	3,095	●

Risks

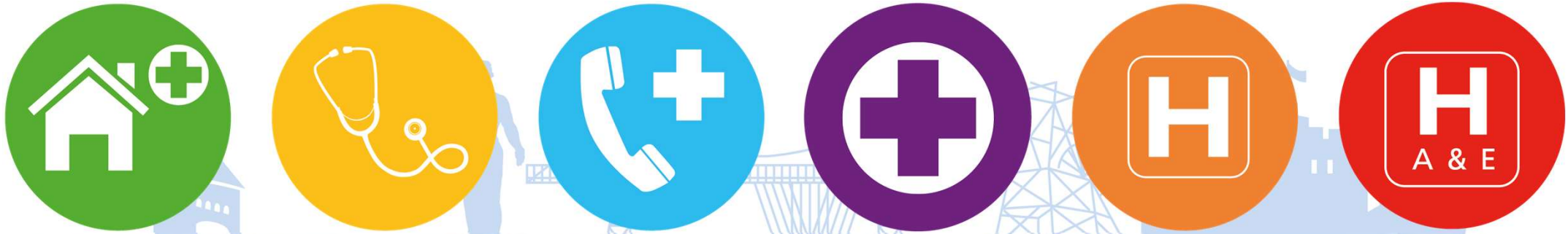
- Resident Doctors risk impact of potential cost of additional doctors to comply with medical rotas over and above funding currently anticipated.
- Full receipt of DPIF funding for LIMS and RISP – this funding was assumed at risk
- Full receipt of wage award pay and terms & conditions funding
- JCC developments >1.11% uplift, expected to be managed through JCC savings plans
- Inflation & Change in Utilities pricing – as advised by NWSSP
- Full mitigating actions / increased savings to offset net unmitigated increase in cost pressures not aligned with planned assumptions (£3.1m).
- Opportunities reducing the net mitigating actions required not realised (£3.5m)
- Increase in business travel expense reimbursement rates
- Operational pressures to achieve targets and manage demand

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

ABUHB BOARD

IPR Appendix 1: Q1 26/27 Progress Against Planned Milestones

September 2026 Board



Population Health and Prevention

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Health Protection	Cancer prevention focus on screening within low uptake areas reducing inequity & addressing inequalities	Off track within tolerance	Task and finish groups remain in place with key ABUHB staff to support both prevention and early detection messaging in: Skin Cancer Prevention and Screening Uptake Group, Bowel Cancer Prevention & Screening Uptake Group, Cervical Cancer Prevention and Screening Uptake Group and HPV Vaccination Uptake Group. There was one specific action undertaken in Q1 to improve targeted communication during the Bowel Screening Awareness Month in April 2026
	Implementation of Blaenau Gwent Vaccination Centre	Complete/On schedule	Vaccination centre provision continues through the Torfaen Vaccination Centre, which has been operating six days a week since 24 April 2025. The Centre delivers planned and opportunistic vaccinations to eligible populations, alongside clinical advice and support relating to all vaccination programmes.
	Commence delivery of Brief Advice Awareness sessions	Complete/On schedule	Partner and stakeholder engagement has been supported through a dedicated webinar. Additionally, Vaccination Brief Advice training has been developed and is being rolled out across relevant staff groups, including health visitors and behaviour change practitioners.
	Develop partnerships with GDAS to deliver Hepatitis B&C elimination plan	Complete/On schedule	Partnership arrangements with GDAS remain in place to support delivery of the Hepatitis B & C Elimination Plan. A local elimination group has been established to meet regularly to review progress and oversee implementation of the agreed action plan.
	Develop HIV action plan with Fast Track Partners	Complete/On schedule	A local HIV implementation plan has been developed with Fast Track partners. This incorporates all actions from the Wales HIV Action Plan, together with progress against national actions and local responses to the Welsh Government HIV audit completed in July 2025.
	Digital eC-Card & increase condom access	Complete/On schedule	Progress continues on the development of the eC-Card scheme, with implementation planned for September 2026. Condom access has been strengthened through the expansion of eC-Card across youth services and ongoing engagement to widen availability across Gwent.
	Development of robust training & exercise plan from learning from Pegasus	Complete/On schedule	Learning from Pegasus is being incorporated into a revised Health Protection Response/Pandemic Plan, including a structured training and exercise programme. A Health Protection exercise is planned for Autumn 2026, subject to operational capacity.

Population Health and Prevention

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Health Improvement	Implement early years Make Every Contact Count (MECC) hub/spoke model	Complete/On schedule	Implementation of the Early Years MECC hub and spoke model is underway, with 34 staff trained in Q1 and evidence of learning being embedded into routine practice. Work is continuing to support wider engagement and sustainability of the model.
	Following successful pilot Bite-Sized Mental Health Sessions at 9 Rugby Clubs further roll out	Complete/On schedule	Further rollout of Bite-Sized Mental Health Sessions across rugby clubs in Gwent is progressing, supporting increased awareness of Mental Health and wellbeing. Engagement with clubs continues to promote uptake.
	Commission Level 2 weight management from local providers, fitness & wellbeing tools	Complete/On schedule	Scoping and stakeholder discussions are continuing to support the development of a Level 2 weight management offer, including consideration of training requirements and delivery models. Work is underway to progress the next phase of implementation with Partner providers.
	Implementation of plan to increase treated smokers & % CO validated quits	Complete/On schedule	Progress continues against the smoking cessation implementation plan, with HMQ services now established across all hospital sites and community settings. Targeted work with priority groups and regular performance monitoring are supporting increases in treated smokers and CO-validated quits.
Prevention	Develop evidence based patient identification method for 0.5% population at greatest risk of admission & those rapid risers i.e. proactive frailty	Off track within tolerance	Populations at Risk group has been re-established with risk stratification being a key focus of the work programme.
	Continue to implement CVD risk-factor model embedding learning from 25/26 & combining with diabetes prevention	Complete/On schedule	Progress continues with implementation of the CVD risk-factor model, with 44 of 68 practices currently signed up to deliver LSS. Targeted engagement with remaining practices is underway to support the integration of diabetes prevention approaches.
	Cancer prevention group focusing on symptom awareness within under served population groups	Complete/On schedule	Cancer Prevention working groups established across specialties. The Skin Cancer Prevention working group has established links with the Hair & Beauty Industry, as of May 2026, over 400 local hair and beauty professionals, tutors and students have been training on spotting the early signs of skin cancer and sun safety. The team involved in this initiative have won the Moondance Award for Excellence in Cancer Leadership and Delivery in 2026.
	Import Primary Care data into Public Health Data Warehouse & agree initial cohorts	Off track within tolerance	Import of Primary Care data into the Public Health Data Warehouse has been delayed pending resolution of contractual arrangements for the Optum data feed. The issue has been escalated and work continues with DHCW to enable data access and progression of cohort identification.

Population Health and Prevention

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Babies, Children & Young People	Develop 1st 1001-Days project plan that aligns to 1001 Critical Days Foundation Grant	Significantly off track	The opportunity to develop a 1001-Days project plan aligned to the 1001 Critical Days Foundation Grant was explored; however, following a decision by Barnardo's not to progress the funding application, this workstream will not be taken forward.
	Review Child Measurement process & identify service improvements	Complete/On schedule	Programme of work has commenced on child weight management. Mapping work via Public Health reporting to NHS Wales Performance and Improvement. Task & Finish group to be established linking with Dietetics and Public Health to address Level 2 Gaps in Child Weight Management.
	Implement training on amplifying the voice of the baby across social care	Complete/On schedule	Work is progressing to support implementation of training on amplifying the voice of the baby across Social Care. Engagement with Social Care Partners is ongoing to support training rollout and embed the approach within practice.
	Develop monitoring framework to identify actions to progress against parenting charter	Significantly off track	Development of the monitoring framework remains dependent on completion of the refreshed Corporate Parenting Charter. Engagement with ABUHB professionals and care experienced children and young people is ongoing to support Charter development and enable progression of this workstream.
Place based care	Develop & agree frailty patient identification	Off track within tolerance	The Populations at Risk group has been re-established with this programme being a key focus. The PHM programme will deliver work to one practice this year and will support risk stratification and as the OPP work continues to develop the YYF pilot includes assessment based on risk stratification which will provide an excellent opportunity for evaluation. Two specific protocols to support people who have sustained a long period of time on floor and who have a head injury in a Care Home are in the process of being signed off. Both pathways will ensure patient receive the right level of care in their preferred setting and reduce inappropriate conveyances.
	Pilot Breathlessness hubs to improve early intervention in care for patients with chronic respiratory symptom	Complete/On schedule	Pilot pathway live across Blaenau Gwent 9/7/26. PROMS/PREMS pathways created - interim manual data pull whilst await national translation for PROMS. Interim arrangements via WCG/CWS/WPAS whilst awaiting EMIS

Population Health and Prevention

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Safe Spaces	Promote Men's Ally Network & provide understanding of Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) impact	Off track within tolerance	Promotion of the Men's Ally Network continues through targeted staff engagement and communications activity. Alternative approaches are being developed to increase participation and strengthen awareness of the impact of VAWDASV across the workforce.
	Review Public Health & Severn Wye evaluation & implement findings into Gwent Warmer Homes project	Complete/On schedule	Implementation of findings from the Public Health and Severn Wye evaluation is progressing through the development of the Gwent Warm & Well Programme. This multi-agency initiative is currently in the pre-implementation phase and will provide coordinated support, including heating-on-prescription, across Gwent during winters 26/27 and 27/28.

Place Based Care

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Access & Sustainability	From 1st April management & ensure ongoing GMS provision of GP Practices without independent contractor status	Complete/On schedule	From 1 April 2025, management arrangements were implemented to ensure the continued provision of GMS Services for GP Practices operating without independent contractor status.
	Implement initial variation for Dental Practices of the new dental contract reform	Complete/On schedule	Preparatory work for implementation of the new Dental Contract Reform has been completed, with transition communications issued to all eligible NHS GDS practices. A standard all Wales contract variation notice is being progressed to support formal implementation during 2026/27.
	Full implementation of all Welsh Government Optometry Services pathway 4 elements	Off track within tolerance	Progress has been made with implementation of WGOS 4, including the establishment of Primary Care-to-Primary Care pathways. Full implementation remains contingent on rollout of the ERS and EPS systems to support glaucoma monitoring transfer from Secondary to Primary Care.
Embedding Value & Efficiency	Delivery of Direct Payments aligned to legislation from April 2026	Complete/On schedule	Implementation of Direct Payments in line with the legislative requirements from April 2026 is progressing well. Finalisation of the All Wales policies and procedures is subject to completion of the legal review process, after which formal implementation documentation will be issued.
	Roll out Care Cubed Digital platform	Complete/On schedule	Rollout of the Care Cubed digital platform is progressing, with early indications demonstrating cost savings and opportunities for further efficiencies. Provider engagement has commenced to support the validation and assessment of care costs, with ongoing work to better understand the full benefits and longer-term impacts of the platform.
Improving Quality & Experience	Undertake review of NCN supplementary services to understand the gap in provision	Complete/On schedule	Review and mapping of NCN supplementary services continues, with initial priority areas identified and agreed. Early findings will be used to understand gaps in provision and inform future service development.

Place Based Care

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Quality of Life	Review Third Sector commissioned work to understand how they can best support reduction in loneliness & isolation	Complete/On schedule	A workshop was facilitated with the Gwent Voluntary Provider Forum to explore how support across Gwent can reach people earlier, more consistently and at a greater scale. Strengths and challenges were identified and practical priorities were identified for the next 6-12 months, including clearer routes into support, smarter funding decisions, stronger commissioning for collaboration and better support for smaller community groups. A previous workshop also explored how Third Sector organisations define and apply management fees within project delivery to build a shared understanding to inform future recommendations to the Gwent RPB. An independent Value of the Third Sector report has been commissioned and shared with the Gwent Regional Leadership Group and Regional Partnership Board. The report highlights the contribution of the Third Sector across Gwent, identifying that: - 6,996 Third Sector organisations operate across Gwent, supporting communities through a wide range of activities. This figure is under-stated as this is extracted only from the records on the Third Sector Support Wales database. - Whilst only 24% of organisations deliver commissioned services on behalf of statutory bodies, the majority contribute to the Regional Partnership Board priorities, with 91% supporting Living Well, 85% Staying Well and 71% Starting Well. - The report estimates that the Third Sector secures substantial funding from non-statutory sources and benefits from a significant contribution from volunteers, demonstrating the wider investment and community capacity that complements public funding. - The report identifies opportunities to strengthen partnership working through more sustainable funding, proportionate reporting, greater collaboration and improved recognition of the third sector's contribution to system-wide outcomes.
	Operationalising new workstreams (Workforce, Clinical Delivery, Digital & Data, Children Young people & Families & Bereavement & Carer support) aligned to New National Service specification & competency framework	Off track within tolerance	Workstreams 2, 4 and 5 operationalised with work underway to establish leadership and support arrangements for workstream 1 and 3. Mapping against service specification and competency framework has began.

Place Based Care

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Place based care	Strengthen weekend working across Community nursing maintaining 57% average	Complete/On schedule	Ongoing progress is being made across teams, with performance reaching 57.3% in the final month of Quarter 1. Work continues to focus on supporting teams to achieve sustained improvement against the target.
	Define local integrated neighbourhood team roles & responsibilities aligned with Place-Based Care principles	Off track within tolerance	Work to define local integrated neighbourhood team roles & responsibilities is being progressed through the Place Based Care Programme Board in collaboration with ISPCs. Current activity is focused on developing consistent principles, including clarity on professional roles, leadership arrangements, accountability and collaborative working.
	Define multi-disciplinary team best practice and scale up across ISPBs	Off track within tolerance	The Place Based Care Programme Board is working alongside ISPBs to identify, capture and define best practice to multi-disciplinary team (MDT) working. This includes reviewing existing models with a focus on establishing a scalable approach that can be embedded across all ISPBs.
Resilient & Connected Communities	Find a new voluntary sector delivery partner for patient transport	Complete/On schedule	The opportunity to increase the scale of the WAST provision has been explored, and a new Provider has been appointed (1-2-1 Medics) via the WAST Framework for Q1 2026/27 to deliver C6 stretcher transport (the patient must have a medical need to travel on a stretcher) and support patients into their homes. This will allow assessment of service effectiveness and inform procurement for Q2–Q4 2026/27.
	Map existing community assets and implement social prescribing pathway to align with Place Based Care model	Off track within tolerance	Community asset mapping is progressing to plan and continues to build an understanding of local community resources. Social prescribing activity is being progressed through the Integrated Wellbeing Networks.
	Enhance recruitment of wellbeing friends network	Complete/On schedule	The Wellbeing Friends network continues to expand through targeted recruitment and engagement activities. Established referral pathways are supporting growth, including opportunities for individuals completing Wellbeing Coaching support in Blaenau Gwent to transition into Wellbeing Friend roles.

Timely Access to Care: Urgent and Emergency Care

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Access & Sustainability	Enhance integrated front-door by streamlining access & Community Assessment Lounge (CAL) evaluation to inform future model	Complete/On schedule	Since 20 April 2026, a dedicated Consultant has been working within the Community Assessment Lounge (CAL) as a test of change to evaluate the impact of enhanced medical leadership. A report detailing the findings was circulated and demonstrated increased CAL utilisation, earlier patient transfers from the front door, and improved patient flow with a Consultant present. Following a review of CAL a decision has been made to relocate the CAL function to the Transfer Lounge. The Front Door Response Hub teams (CAATT, Home First and RFR) will continue to work collaboratively to support patient assessment, discharge planning and patient flow at the front door within the new model.
	Simplify access developing an options appraisal for sustainable clinical model for Single Point of Access (SPOA)	Complete/On schedule	An options appraisal has been completed and presented at UEC Board. Re-introduced though funding issues remain unresolved.
	Continue to embed Optimal Hospital Flow Framework & criteria led discharge across all sites monitoring progress & benefits	Complete/On schedule	Continue to embed the OHFF, oversight through monthly Integrated Discharge Board, progressing digital solution to monitor criteria led discharge.
	Identify areas to pilot the Trusted Assessor (TA) model through engagement with stakeholders	Complete/On schedule	Agree to pilot with Caerphilly and Monmouthshire, monitor the impact.
	Define the optimal service model for Acute Medicine & undertake service modelling	Complete/On schedule	Service modelling has been undertaken, and there is ongoing work to define the future model, supported by the Executive Medical Director.

Timely Access to Care: Urgent and Emergency Care

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Access & Sustainability	Deliver Stroke Improvement Board agreed action plan aligned with revised National Stroke Quality Statement	Complete/On schedule	The action plan associated with the previous Stroke Improvement Board has now evolved to a refreshed Stroke Improvement Workstream as part of the Urgent & Emergency Care Programme. Efforts have been maintained to improve access times, with stroke QIMs evidencing continuous improvement in performance against targets for stroke patients to access Physiotherapy, Occupational Health and S&LT. A workshop has been held to support pathway mapping, and identification of opportunities and challenges to inform an updated stroke improvement work programme.
	Incorporate feedback into the Older Persons model to ensure alignment with strategic priorities	Complete/On schedule	Older Person Pathway and Acute Medical Model - oversight through UEC Programme Board to ensure alignment with strategic priorities
Improving Quality & Experience	Review interim ED clinical model and identify if there are any digital opportunities to support delivery	Off track within tolerance	Procurement of phase 2 ED extension - review of clinical model now focused on Wait to be Seen
Quality of Life	Develop a community directory outlining pre-hospital & discharge services	Complete/On schedule	Options appraisal has been prepared awaiting decision regarding next steps noting the resource and finance implication

Timely Access to Care: Cancer and Planned Care

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Access & Sustainability	Commence pilot of service improvements in Endoscopy including Cytosponge, Colon Capsule, Trans Nasal Endoscopy & Speedboat	Complete/On schedule	Transnasal Endoscopy - This intervention remains in the development phase. Work is currently underway to define and refine the patient cohort most suitable for TNE, prior to wider implementation and evaluation. Colon Capsule - The Colon Capsule service is currently being piloted, with 35 procedures undertaken since January 2026. No complications have been reported to date. The current patient cohort comprises individuals who would otherwise have undergone repeat colonoscopy. As the pilot remains at an early stage, a greater volume of cases will be required before a comprehensive review can be undertaken to assess clinical outcomes, service impact, and potential benefits. Cytosponge - The Cytosponge pilot is now well established, with 214 procedures completed since December 2025 and no reported complications. The current cohort primarily includes patients who would otherwise have been referred for gastroscopy. It is recognised that a proportion of patients may subsequently require an OGD; however, the scale of this requirement is not yet known. This will be examined in detail as part of the 12-month pilot evaluation in December 2026. A dedicated tracking system is in place, ensuring that the data required to support robust evaluation and reporting is readily available. Speedboat - The initial pilot phase is nearing completion, with 35 cases undertaken to date. The average length of stay has been 0.4 days, compared with an average of 7 days for the conventional alternative intervention, demonstrating a significant reduction in Inpatient bed utilisation. 4 complications have been recorded during the pilot period. The next step will be the development of a business case to support continuation of the pilot for a further 40 cases. This is expected to be presented to PIP during Q2.
	Commence implementation of Audiology sustainability action plan to improve waiting times for Babies, Children & Adults	Off track within tolerance	Progress on the Audiology Sustainability Action Plan is focused on securing funding to support backlog reduction. A funding bid has been submitted through the Planned Care process, with delivery plans developed to clear the PAN and AHN backlogs by year end.

Timely Access to Care: Cancer and Planned Care

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Access & Sustainability	Lower GI Cancer recovery plan driving reduction in time to scope	Complete/On schedule	A collaborative group has been established between Cancer Services and Endoscopy to manage patients waiting for colonoscopy, with a view to reducing down to 14 days or less. At the most recent audit, this was down to 8 days. Weekly meetings between Cancer Services and Endoscopy have been stepped down through the summer whilst strong compliance is maintained, however if this starts to slip then the meetings will be reinstated immediately. Compliance is monitored informally on a weekly basis, and formally on a fortnightly basis through the Cancer Assurance Meeting.
	Establish Upper GI & Breast Cancer recovery groups	Off track within tolerance	The Upper GI pathway has been incorporated into the Cancer Recovery meetings to give focus on the actions required to improve the position. A Breast recovery group has not yet been established, it's likely this will be established following the summer period when staffing is back to optimal levels. NHS Performance and Improvement have undertaken a visit to Cancer Services, currently awaiting the output of that visit, it is anticipated this output will be the catalyst for future areas of focus.

Timely Access to Care: Cancer and Planned Care

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Access & Sustainability	Primary Arthroplasty model & pathway developed with workforce & finance model Regional diagnostics management group established Development of a Business Case for Regional Cellular Pathology Unit	Off track within tolerance	Primary Arthroplasty model and pathway developed across the region with demand & capacity, workforce and finance to enable submission of Regional Orthopaedic Plan and Llantrisant Health Park phase 2 to Boards in July 2026. Regional Diagnostics Groups have been established as 3 separate programme boards (Radiology, Endoscopy & Pathology) with ABUHB representatives. Case for change for a regional Cellular Pathology Unit is still being developed by Regional programme, and a project group established to support the development of a Capital SOC.
Improving Quality & Experience	Undertake gap analysis of GIRFT recommendations & develop action plan	Off track within tolerance	A gap analysis against GIRFT and CIN recommendations has been completed, with key priorities discussed at the Planned Care Board in June 2026. Work is now underway with NHS Performance and Improvement colleagues to review CIN outcomes and develop an updated action plan aligned to both CIN priorities and Health Board objectives.
	Develop plans to improve Psychology support for Cancer patients	Off track within tolerance	Business case to support the development of the Psychology Team to strengthen the workforce and provide resilience and support for up to 25% more patients is in development.
Embedding Value & Efficiency	Capture detailed learning from T&O Perfect Month & national benchmarking to achieve EA standard	Significantly off track	A working group has been established and planning is underway for the delivery of a 'Perfect Month' during the current financial year. Progress has been impacted by ward refurbishment programmes, and discussions are ongoing with Nursing, Estates and Facilities colleagues to identify the most appropriate timeframe to maximise bed capacity and support delivery of the planned activity levels.

Timely Access to Care: Cancer and Planned Care

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Embedding Value & Efficiency	Drive improvements in late starts/early finishes & theatres	Off track within tolerance	A Theatres Optimisation Programme Group has been established to oversee delivery of the programme. Following endorsement by the Executive Team in April 2026, work is progressing across key workstreams, including reducing late starts and early finishes to improve productivity, with associated KPIs currently being developed.
	Implement additional 8 new pathways	Complete/On schedule	A total of 10 pathways were implemented during Quarter 1, supporting standardisation of patient pathways. Monitoring of implementation and benefits will continue as part of ongoing programme delivery.
	Develop approach to monitor consistency & GP feedback loops post triage	Complete/On schedule	Feedback from the GP Interface has been reviewed and formally captured. Findings have informed Health Pathways priorities and implementation plans for 2026/27, ensuring learning from stakeholder feedback is incorporated into future development and delivery.
	Review outpatient space utilisation through audits of room use/start & finish time	Significantly off track	Work to implement revised clinic start and finish times has been temporarily paused due to workforce pressures, with recommencement planned for Quarter 4. Development of the clinic application continues, with requirements, functionality and implementation timescales currently being refined.
	SOS/PIFU retrospective application roll out	Off track within tolerance	Work is underway to identify priority specialties for retrospective implementation, with options currently being assessed based on service need and feasibility. Once agreed, recommendations will be considered through the Planned Care Programme to determine the most appropriate areas for rollout.
	Implement Validation Strategy	Off track within tolerance	A validation strategy has been developed for the first six months of the financial year, with the remaining elements drafted and subject to further review, including financial support requirements. Innovative approaches are being tested to maximise the impact and efficiency of validation activity, including an algorithm-based prioritisation model that identifies patients requiring validation based on clinical and operational priority, regardless of pathway type.
Quality of Life	Set up a further Cancer Café, run by volunteers in 19 Hills Wellbeing Centre	Complete/On schedule	The Cancer Cafe has been running monthly, but is still in its infancy. To improve visibility local social media pushes and support from a CNS/HCSW have been implemented.

Mental Health Access

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Access & Sustainability	Agree strategic estate direction for inpatient & community based Mental Health service model	Complete/On schedule	Site opportunities for rationalisation and service reconfiguration identified - options appraisal for Older Adult Mental Health undertaken.
	Start to embed Open Access principles by expanding self-referral pathways	Complete/On schedule	Progress has been made in embedding Open Access principles across Mental Health Services through a number of demonstrator projects supported by Performance Improvement Wales. Self-referral and needs-led access are now being tested through Psychological Health Practitioners in GP Surgeries and a nine-month walk-in pilot at the 19 Hills Wellbeing Centre. A Peer Supported Open Dialogue (POD) project is also in development, with training and engagement activity underway ahead of implementation. In South Caerphilly, work is focused with GPs on reducing waiting times to first contact and establishing direct-access pathways. An evaluation and reflection phase is planned for September to review outcomes, including changes in same-day contacts, impact on waiting lists, staff awareness of Open Access practices, and opportunities for wider implementation.
	Commence action plan delivery to meet national target for Memory Assessment Service	Off track within tolerance	May performance was 42% and there was been improvement since April. The performance is dependent on system changes within the service and full implementation is expected in the Autumn of 2026. From this time performance is expected to improve significantly to meet targets by the end of March 2027. Performance for June was 41%.
	Maintain Part 2 Care & Treatment Plan Adults national target of 90%	Off track within tolerance	May performance was 89% which is just under the compliance target of 90%. June's performance was 86% and the Division is taking actions to improve the performance in Quarter 2.
	Maintain CAMHS Part 1a & Part 1b national target of 80% compliance	Complete/On schedule	Both Part 1a and Part 1b have sustained the strong performance achieved in 2025/26, continuing to exceed the 80% compliance target. In June 2026, compliance reached 97.0% for Part 1a and 87.3% for Part 1b.
	Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	Complete/On schedule	Strong performance has been maintained for SCAMHS Choice Assessments throughout Quarter 1, with compliance consistently exceeding the 80% target. June 2026 performance was 93.65%.
Improving Quality & Experience	Complete Older Adults ward accreditation to at least bronze level	Complete/On schedule	All Older Adult wards have achieved accreditation to at least Bronze level. The Division is continuing the roll-out of ward accreditation across all areas.
	Carry out mortality reviews and ensure mechanisms for capturing learning in place	Complete/On schedule	Twice per year Sudden and Unexpected Death reports are provided to the Corporate Centre and reviewed through the Divisional Quality, Patient Safety Process. The Division is reviewing their processes to enhance learning from any sudden or unexpected processes.

Women's Health

Priority	Q1 Planned	Q1 Progress	Q1 Comments
Babies, Children & Young People	Embed evidence-based care across maternity pathway with early optimisation public health messaging	Complete/On schedule	Work is continuing to embed evidence-based care and early optimisation messaging across the Maternity pathway, supported by ongoing MECC training, with over 85% of Maternity staff completing training in 2025/26. Collaboration underway with Public Health to support Best Start in Life programme delivery.
	Establish a single point of access for Maternity triage for all women	Complete/On schedule	A single point of access for Maternity triage for all women was implemented in April 2026 and is now fully operational.
Place based care	Rollout of Women's Health Pathfinder Hub through digital platform & service expansion of Gynae Ambulatory Care Unit & Sexual Health Services	Complete/On schedule	Proposed model identified and agreed by the Executive Team and Board. Clinical Lead for Women's Health appointed and Business Case being developed. Single point of Access established in Sexual Health, this allows direct booking arrangements for Women's Services. On-going work of the digital platform for Women's Health and dedicated website is in place. Scope of services increasing in the Gynae Ambulatory Unit and across the Community. Second phase of Women's Health funding awaiting approval July 2026, to provide infrastructure for further development, Primary Care investments and expansion of specialist GP for Women's Health, development of clinical leadership, and expansion of nurse led endometriosis and pelvic health.
Improving Quality & Experience	MatNeo A3 progressed to develop transitional care space & additional postnatal beds	Complete/On schedule	A business case has been developed, and work is progressing with Estates and Facilities to determine space requirements and identify the costs associated with delivery.
	Workforce review of Sonography Services & ongoing audit of small gestational age babies with shared learning	Complete/On schedule	Two additional Midwife Sonographers completed training and commenced in post during Quarter 1, increasing service capacity. The Small for Gestational Age (SGA) guideline is now embedded within routine clinical practice.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 September 2026
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Finance Performance Report – August 2026 (2026/27 Month 5)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rob Holcombe – Executive Director of Finance, Procurement & VBHC
SWYDDOG ADRODD: REPORTING OFFICER:	Suzanne Jones – Assistant Director of Finance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

This report sets out for the Aneurin Bevan University Health Board:

- The financial performance at the end of August 2026, for statutory targets (Revenue & Capital) and other financial performance targets.
- An assessment of:
  - the year to date spend,
  - the forecast financial position,
  - savings,
  - reserves, and
  - risks and opportunities.

A system link is included for the monthly monitoring return reported to Welsh Government.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report sets out the financial performance as at the 31st August 2026 (Month 5) for the 2026/27 financial year.

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

Aug-26
Performance against key financial targets 2026/27
+Adverse / () Favourable

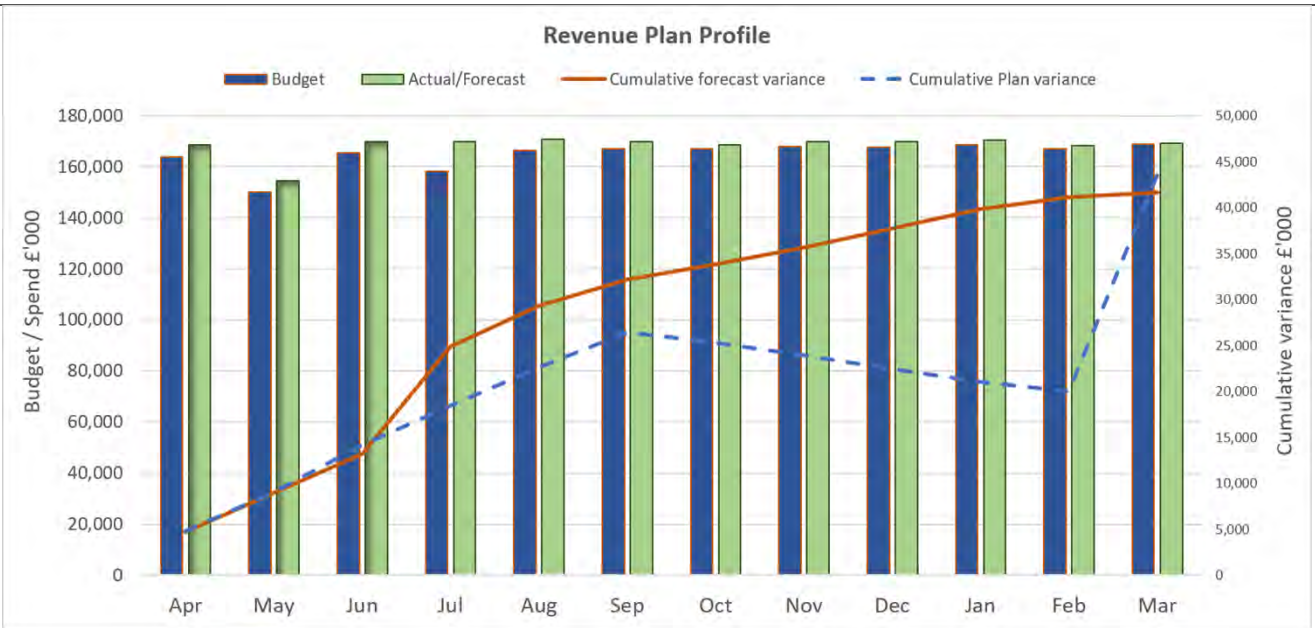
Target	Unit	Current Month	Year to Date	Year-end Forecast	Movement
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	5,384	30,238	**41,630**	
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.*	£'000	£2.726	£11.119	**0**	
	£32.842	8%	34%		
Public Sector Payment Policy To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	96.8%	97.3%	**>95%**	
Savings The 2026/27 IMTP submitted identified **£44.9m** of savings which included, division identified schemes of **£13.2m**, QIA and workforce savings of **£14.7m**, and pipeline savings of **£17m.**	£'000	2,799	11,001	**44,937**	

Target	Unit	Cash Guideline	Actual	Variance	Rating
Cash The Health Board must not end any month with an overdrawn cash balance. Welsh Government also sets an advisory maximum month-end cash balance of £6m, which should not be exceeded.	£'000	6,000	2,905	**3,095**	

The Health Board is forecasting a year end revenue deficit of £41.6m. The forecast deficit includes full delivery of the £45m savings plan (see Savings section below).

As this is not a balanced financial forecast position it constitutes a breach of the statutory financial duty to break-even.

An annual profile of revenue performance for the Health Board is presented below:



The chart above shows the profile of budget with spend. A significant proportion of savings are forecast to be achieved in the latter half of the year, however spending is expected to remain above budget levels resulting in a forecast overspend. The cumulative forecast variance is showing a net adverse position compared to plan from July due to the reprofiling (bringing forward) of the Welsh Risk pool (WRP) cost pressure for the year, as requested by Welsh Government. Excluding the WRP profile adjustment, performance is in line with plan for the year to date.

To achieve the Annual Plan financial forecast the Health Board needs to reduce the actual monthly expenditure, mitigate new in year cost pressures and deliver the full level of savings.

Cefndir / Background

At its March 2026 meeting, the Board approved an Annual Plan for 2026/27 (a forecast revenue deficit requires an annual plan not an IMTP). The plan forecast a deficit of £43.7m in 2026/27 and assumed elements of specific additional funding related to national digital initiatives and wage awards, and an ambitious target level of savings delivery of £45m (not all of which were identified).

This table summarises the 2026/27 Annual Revenue Plan:

ABUHB 2026/27	Forecast £m
Starting deficit	18.32
Underlying adjustments	19.87
OPENING UNDERLYING DEFICIT 26/27	**38.19**
Savings (Green/Amber)	(21.14)
Savings QIA to deliver	(6.80)
Further Savings to find (2+%)	(17.00)
TOTAL SAVINGS	**(44.94)**
FUNDING UPLIFT (&DPIF)	**(24.74)**
Demand & Inflation	37.56
National Pressures	4.43
Local Quality Priorities	1.15
Performance Delivery	4.05
Winter/ONP	3.00
TOTAL COSTS	**50.19**
FORECAST DEFICIT (BEFORE WRP)	**18.70**
Welsh Risk Pool (WRP)	25.00
Forecast DEFICIT 26/27 @ Plan & M1	**43.70**

The forecast has subsequently been revised to a £41.6m deficit position to reflect the removal of the WRP risk (£2.1m) as directed by Welsh Government.

Financial sustainability is a statutory requirement, and governance mechanisms have been strengthened to drive delivery of an improved financial forecast through the Finance & Performance Committee, Value and Sustainability Board and associated workstreams.

Asesiad / Assessment

Revenue Performance

The table below presents the Health Board's performance by delegated budget area:

Summary Reported position - August 2026 (M05)	Full Year Budget £000s	YTD Reported Variance - M05 £000s	Prior month reported variance £000s	Movement from prior month £000s	Full-year Forecast at M05 £000s	Full-year Forecast at M04 £000s	Movement £000s
Operational Divisions:-							
Primary Care and Community	340,740	1,774	1,683	91	439	1,193	(754)
Prescribing	125,553	1,190	743	447	2,901	2,901	(0)
Community CHC & FNC	75,697	2,431	2,218	213	3,814	4,699	(885)
Mental Health & Learning Disabilities	156,827	3,317	2,843	474	9,059	9,461	(402)
Surgery	163,658	4,436	3,878	558	10,438	9,537	901
Clinical Support Services	143,075	1,461	1,081	380	3,474	3,473	1
Medicine	184,944	4,537	4,018	519	8,436	7,568	868
Urgent Care	44,154	886	784	103	1,720	1,720	0
Family & Therapies	157,715	1,090	910	181	2,980	3,140	(161)
Estates and Facilities	100,457	(494)	(353)	(141)	(456)	(356)	(100)
Chief Operating Officer	8,752	419	281	137	(1,034)	489	(1,523)
Total Operational Divisions	**1,501,573**	**21,048**	**18,086**	**2,962**	**41,770**	**43,825**	**(2,055)**
Corporate Divisions	79,852	10,013	7,516	2,497	21,660	22,826	(1,166)
Specialist Services	207,892	375	299	75	899	899	(0)
External Contracts	123,172	(674)	(539)	(135)	(2,917)	(2,467)	(450)
Capital Charges	45,694	(39)	(33)	(6)	0	0	0
Total Delegated Position	**1,958,183**	**30,722**	**25,329**	**5,393**	**61,412**	**65,083**	**(3,671)**
Total Reserves	20,009	(484)	(475)	(9)	(19,782)	(23,453)	3,671
Total Allocations	(1,962,212)	0	0	0	0	0	0
Other Corporate Income	(15,979)	0	0	0	0	0	0
Total Reported Position	**0**	**30,238**	**24,854**	**5,384**	**41,630**	**41,630**	**(0)**

Year-to-date Performance

Year-to-date (YTD) expenditure is £30.238m over budget, representing a favourable variance of £0.259m against the forecast YTD position for Month 5, as reported in Month 4.

Income

	YTD £m	Full Year £m
WG Anticipated Income	-10.040	12.746
WG Confirmed Income	805.743	1,949.466
Trading Income	54.532	129.598
Total Funding	**850.235**	**2,091.810**

The Health Board has reflected anticipated Welsh Government funding where agreement has been indicated. Net anticipated allocations currently total £12.746m. Material items include £27.7m for Agenda for Change pay awards, £7.7m for Medical and Dental Pay Awards, Planned Care Recovery Funding £3.8m, Resident Doctor Contract Reform £0.8m, offset by a £29.5m reduction in funding in relation to the Welsh Risk Pool (reflected in YTD), and a net £5.6m of capital charge reductions.

The negative year to date figure is in relation to the profile of the WRP contribution.

Pay

	Month 5 £m	Month 4 £m	YTD Average £m	25/26 Average £m	Month 5 WTE	Month 4 WTE	YTD Average WTE	25/26 Average WTE
Substantive Pay	74.10	74.87	74.27	70.80	13,687	13,720	13,725	13,542
Variable Pay	6.05	5.84	5.79	5.70	1,211	1,168	1,158	1,124
Total Pay	**80.15**	**80.71**	**80.06**	**76.50**	**14,898**	**14,888**	**14,884**	**14,666**

Total pay expenditure for the Health Board in Month 5 was £80.15m, a decrease of £0.6m compared with the previous month. The reduction is the result of the one-off impact of arrears payments made in Month 4 to staff assimilated from Band 2 to Band 3, which included backdated payments to April 2026. These arrears did not recur in Month 5, therefore overall pay expenditure reduced accordingly.

The increased expenditure compared to the 2025/26 average is primarily attributable to the A4C pay award (3.3%–5.9%), and the Medical and Dental pay award applied during 2026/27. The full-year impact of these awards is estimated at £35m, with £2.9m recognised each month. The Health Board anticipates receiving full funding to cover the 2026/27 pay award, however, confirmation has not yet been received. Additional substantive posts are driving the balance of increased costs.

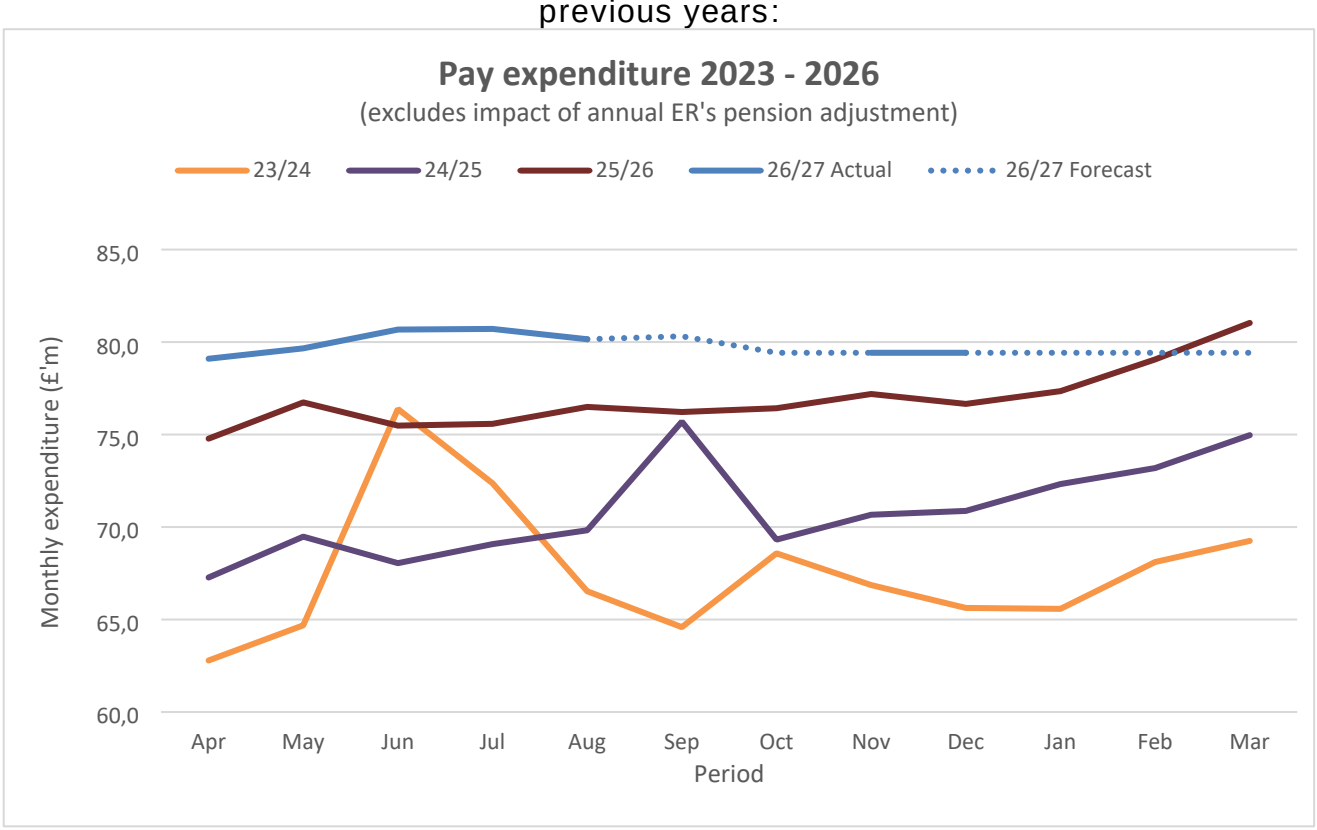
Variable Pay:

	Month 5 £m	YTD Average £m
Locum	0.46	0.50
Bank	4.04	3.69
Agency	1.56	1.60
Total Variable Pay	**6.05**	**5.79**

Variable pay for the month totalled £6.0m. Bank expenditure was £4.0m, representing an increase of £0.4m compared with Month 4. The majority of Bank spend was for Nursing, with spend of £1.9m for HCA and £1.7m for Registered Nurses. Agency spend decreased by £0.1m in the month to £1.6m, with Registered

Nursing accounting for the largest proportion of total Agency spend (£0.6m). Medical locum expenditure was £0.5m, consistent with prior months.

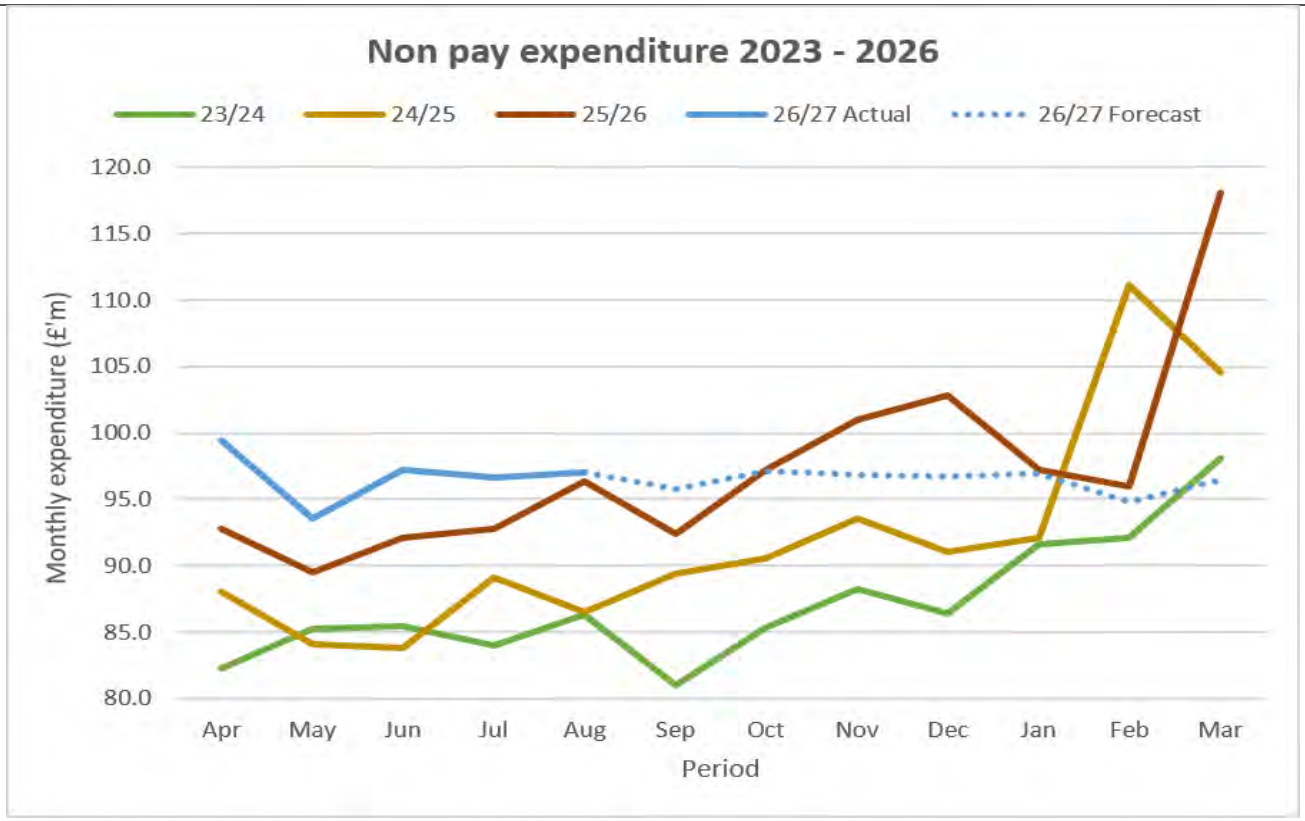
The table below shows the pay run rates expected in 2026/27 and actuals for 3 previous years:



Pay expenditure is expected to remain broadly consistent over the first six months of the year, with a reduction anticipated in months 7–12 as savings plans are achieved.

Non-Pay

The table below shows the non pay run rates expected in 2026/27 and actuals for 3 previous years:



note the increases in March is related to year end accounting / adjustments

Non-Pay spend for Month 5 was £97.1m, which is consistent with the average for the first 4 months of the year.

- Continuing Healthcare (CHC) - (CHC) Expenditure was £10.7m in Month 5, £0.5m lower than the year-to-date monthly average, this is primarily due to a reduction of 8 patients.

- Secondary Care Drugs - Secondary Care drug expenditure in Month 5 was £5.5m, a decrease of £1.0m compared to Month 4. The reduction is primarily driven by Neurology costs returning to expected levels following elevated expenditure on Fampridine prescribing for MS patients in Month 4, alongside lower expenditure within Surgical Specialties after a particularly high-cost month previously.

- Primary care prescribing – Total spend £10.7m. Year-to-date average unit cost £8.18 to August compared to £8.08 to July, with volume growth reduced to 0% from 1.24%.

- Long Term Agreement (LTA) – During August, £20.9m was spent on LTA's, £0.9m above the average for the year due to a Vertex allocation during August.

- General Medical Services (GMS) - expenditure was £10.4m in Month 5, an increase of £0.2m from Month 4, reflecting a return to expected expenditure levels following increased enhanced services costs in July.

- Pathway of Care Delays (POCD) – these delays are driving significant unnecessary costs estimated at £5.4m for the year to date, with 152 patients

fit for discharge in July due to; 'Health care' (42), 'Social care' (24), and 'Joint' (86) delays.

Forecast Position

The forecast deficit for Month 5 remains at £41.6m, and is inclusive of full delivery of the savings plan totalling £44.9m. This is in line with the Annual Plan (IMTP) forecast submitted to Welsh Government. In addition, achievement of the forecast position assumes mitigating actions are identified to offset in-year additional cost pressures.

At month 5, additional cost pressures outside of the submitted plan total £6.6m (c£2.8m in the YTD position) partially mitigated by £3.5m of opportunities for spend reductions or funding. The remaining net cost pressure of £3.1m will need to be mitigated in order to achieve the current deficit forecast position of £41.6m. These pressures pose a further risk if no action is taken to stop / reduce the spend in future months.

Costs outside plan to be mitigated - M5	Additional Costs in additional mitigating actions at m5 £m
Spend Category	**£m**
Acuity / Nursing Workforce	1.6
Resident Dr's	1.4
Digital funding assumed in plan	0.8
Urgent care clinical model	0.7
Urgent Care paediatric nursing	0.6
Critical Care pressures	0.3
Medical staffing	0.6
Secondary care drugs & consumables	0.5
Cost Pressures	**6.6**
Potential Mitigating Actions	**£k**
WRP (delayed settlements)	(1.6)
Assume Connecting care funding (not confirmed)	(0.5)
Successful UEC bids supporting ONP initiatives	(0.4)
Additional Workforce savings	(1.0)
Potential Mitigating Actions	**(3.5)**
Mitigating Actions to be found	**3.1**

As a matter of urgency the Health Board requires additional mitigating actions or savings to maintain the current forecast deficit.

There remain risks to this position as stated in the Plan plus emerging in year risks, as outlined in the Risks section.

Savings

MMR category	Number of Schemes	Annual Plan £'m
CHC and Funded Nursing Care	30	7,074
Commissioned Services	4	636
Medicines Management	64	9,377
Non-Pay	158	14,247
Pay	281	13,602
Total	**537**	**44,937**

The 2026/27 plan submitted by the Health Board to Welsh Government (March 2026), identified £45m savings and opportunities to support the forecast position for 2026/27.

Savings achieved year-to-date total £11.0m, approximately £4.8m ahead of plan.

During the month Divisions strengthened confidence in the delivery of £5.6m of savings plans shifting amber savings to green.

Reserves

The Health Board has reserves of £20.0m including some areas of anticipated income. All items are committed in line with the Annual Plan or existing recognised costs. A proposal for delegating these has been agreed by the Board on 29th July 2026, this enables the CEO to distribute in line with the Annual Plan.

A small number of reserves are being held for specific areas of expenditure. These will be delegated following internal governance processes but are committed as part of the annual plan spend. However, the availability of these reserves for priorities could be impacted by the need to mitigate new in year cost pressures.

A further breakdown of reserves can be found in the appendix.

Risks

Risks are reviewed monthly and updated based on the Health Board's assessment of the current level of risk to the financial position and its ability to manage those risks.

The most significant risks to the Health Board are:

- Resident Doctors (£1.3m) – impact of the contract reform change to pay and conditions. This comprises £0.6m relating to the additional cost of the new terms and conditions (above that of the £0.8m costs and expected funding currently anticipated), including study leave, and £0.7m relating to the requirement for additional medical staffing to maintain safe and compliant rotas under the revised contractual arrangements (above the £1.4m costs already included in the forecast).

- Joint Commissioning Committee (JCC) savings plan achievement (£1.600m) – the Health Board recognised the plan uplift as 1.11% for the JCC, with priority developments mitigated through savings delivery.
- Full receipt of Digital Priorities Investment Fund (DPIF) funding (£0.6m) – this funding is assumed at risk; bids have been submitted to WG.
- Change in Utilities pricing (£0.8m) – reflecting international implications on energy price certainty.
- Increase in Mileage rate reimbursement (£0.3m) – the potential impact of the mileage rate increase from 45p to 55p.
- Full mitigating actions / increased savings to offset net unmitigated increase in cost pressures not aligned with planned assumptions (£3.1m).
- Opportunities reducing the net mitigating actions required not realised (£3.5m)
- Winter cost pressures above plan (£1.0m)
- Full achievement of savings plans and identification and delivery of opportunities.
- Full receipt of all wage award and terms & conditions funding.
- Additional priority investments agreed above plan.

Opportunities

Opportunities are reviewed monthly as part of financial reporting. The ABUHB Value & Sustainability Board and divisions and departments are actively engaged in the identification of opportunities to reduce the forecast deficit and to improve the financial position of the Board.

The most significant opportunities, outside of the assumed mitigating actions already required, for the Health Board include:

- Potential for national funding
- Further savings beyond current plan
- Favourable movements on financial plan estimates.

Capital

	Plan £m	YTD Spend £m	Forecast Outturn £m	Forecast Variance £m
Total Discretionary Capital	9.9	1.5	9.7	-0.2
Total AW Capital Programme	22.9	9.7	23.1	0.2
Total Programme Allocation and Expenditure	32.8	11.1	32.8	0.0

The approved Capital Resource Limit (CRL) for 2026/27 is £32.842m and, at Month 5, the Health Board is forecasting a break-even position. The Nevill Hall Hospital Satellite Radiotherapy Unit is operational, with final accounts progressing, while the Royal Gwent Hospital Centralised Decontamination Unit has been completed and commissioned, with final costs under review.

The Targeted Estates Funding (TEF) programme and REFIT Decarbonisation programme continue to report strong expenditure performance and are expected to deliver planned benefits, with ongoing monitoring to maximise utilisation of available funding. Strategic developments, including the Abervalley and Monmouth Health and Well-being Centre Outline Business Cases, continue to progress, while the Royal Gwent Hospital Gamma Camera replacement scheme remains in procurement and is currently forecasting additional cost pressures. Additional Digital and Estates Backlog funding of £1.807m has also been secured during the year.

The Health Board's Discretionary Capital Programme remains balanced, with an unallocated contingency of £2.5m available at Month 5 following reduced forecast expenditure across a number of schemes and the receipt of additional funding. However, emerging pressures relating to critical digital infrastructure, equipment replacement and estate requirements have necessitated a review of capital priorities. A number of discretionary schemes have been paused pending reprioritisation and consideration by the Executive Team.

Argymhelliad / Recommendation

The Board is asked to note for assurance:

- The financial performance at the end of August 2026, for statutory targets (Revenue & Capital) and other financial performance targets.

- An assessment of:
    - the year to date spend,
    - the forecast financial position,
    - savings,
    - reserves,
    - risks and opportunities, and
    - capital

Note: the appendices attached providing further detailed information.

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August 2026 Monthly Monitoring Return:
Key Documents - Aneurin Bevan University Health Board

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Financial Sustainability
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7. Staff and Resources Governance, Leadership & Accountability All Health & Care Standards Apply Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. All IMTP priorities
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	ABUHB efficiency compendium Value & Sustainability Board
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Team Finance & Performance Committee
Rhestr Termau: Glossary of Terms:	A&C – Administration & Clerical A&E – Accident & Emergency A4C - Agenda for Change AME – (WG) Annually Managed Expenditure AQF – Annual Quality Framework AWCP – All Wales Capital Programme AP – Accounts Payable AOF – Annual Operating Framework ATMP – Advanced Therapeutic Medicinal Products B/F – Brought Forward BH – Bank Holiday C&V – Cardiff and Vale CAMHS – Child & Adolescent Mental Health Services C/F – Carried Forward CHC – Continuing Health Care Commissioned Services – Services purchased external to ABUHB both within and outside Wales COTE – Care of the Elderly CRL – Capital Resource Limit Category M – category of drugs CEO – Chief Executive Officer CEAU – Children's Emergency Assessment Unit CTM – Cwm Taf Morgannwg D&C – Demand & Capacity DCP – Discretionary Capital Programme DHR – Digital Health Record DNA – Did Not Attend DOSA – Day of Surgery Admission D2A – Discharge to Assess DoLS - Deprivation of Liberty Safeguards DoF – Director(s) of Finance DTOC – Delayed Transfer of Care EASC – Emergency Ambulance Services Committee ED – Emergency Department EDCIMS – Emergency Department Clinical Information Management System

	eLGH – Enhanced Local general Hospital EFAB – Estates Funding Advisory Board ENT – Ear, Nose and Throat specialty EoY – End of Year ETTF – Enabling Through Technology Fund F&T – Family & Therapies (Division) FBC – Full Business Case FNC – Funded Nursing Care GDS – General Dental Services GMS – General Medical Services GP – General Practitioner GWICES – Gwent Wide Integrated Community Equipment Service GUH – Grange University Hospital GIRFT – Getting it Right First Time HCHS – Health Care & Hospital Services HCSW – Health Care Support Worker HIV – Human Immunodeficiency Virus HSDU – Hospital Sterilisation and Disinfection Unit H&WBC – Health and Well-Being Centre IMTP – Integrated Medium Term Plan INNU – Interventions not normally undertaken IPTR – Individual Patient Treatment Referral I&E – Income & Expenditure ICF – Integrated Care Fund LoS – Length of Stay LTA – Long Term Agreement LD – Learning Disabilities MH – Mental Health MSK - Musculoskeletal Med – Medicine (Division) MCA – Mental Capacity Act MDT – Multi-disciplinary Team MMR – Welsh Government Monthly Monitoring Return NCA – Non-contractual agreements NCN – Neighbourhood Care Network NCSO – No Cheaper Stock Obtainable NI – National Insurance NICE – National Institute for Clinical Excellence NHH – Neville Hall Hospital NWSSP – NHS Wales Shared Services Partnership ODTC – Optometric Diagnostic and Treatment Centre OD – Organisation Development PAR – Prescribing Audit Report

	PCN – Primary Care Networks (Primary Care Division) PER – Prescribing Incentive Scheme PICU – Psychiatric Intensive Care Unit PrEP – Pre-exposure prophylaxis PSNC –Pharmaceutical Services Negotiating Committee PSPP – Public Sector Payment Policy PCR – Patient Charges Revenue PPE – Personal Protective Equipment PFI – Private Finance Initiative RGH – Royal Gwent Hospital RN – Registered Nursing RRL – Revenue Resource Limit RTT – Referral to Treatment RPB – Regional Partnership Board RIF – Regional Integration Fund SCCC – Specialist Critical Care Centre SCH – Scheduled Care Division SCP – Service Change Plan (reference IMTP) SLF – Straight Line Forecast SpR – Specialist Registrar STW – St.Woolos Hospital TCS – Transforming Cancer Services (Velindre programme) TEF – Targeted Estates Funding T&O – Trauma & Orthopaedics TAG – Technical Accounting Group UHB / HB – University Health Board / Health Board USC – Unscheduled Care (Division) UC – Urgent Care (Division) ULP – Underlying Financial Position VCCC – Velindre Cancer Care Centre VERS – Voluntary Early Release Scheme WET AMD – Wet age-related macular degeneration WG – Welsh Government WHC – Welsh Health Circular WHSSC – Welsh Health Specialised Services Committee WLI – Waiting List Initiative WLIMS – Welsh Laboratory Information Management System WRP – Welsh Risk Pool YAB – Ysbyty Aneurin Bevan YTD – Year to date YYF – Ysbyty Ystrad Fawr

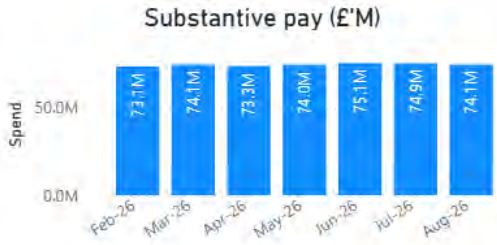
Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or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

Aneurin Bevan University Health Board

Finance Report – August (Month 05) 2026/27

Appendices

Pay Summary (1) (excluding 9.4% Pension employer costs paid in March of each year):



Substantive (£'000)

Pay category	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Change	%	Avg 25/26
ADD PROF SCIENTIFIC AND TECHNICAL	2,788	2,765	2,870	2,842	2,850	2,867	2,871	3	0.1%	2,758
ADDITIONAL CLINICAL SERVICES	9,563	11,101	9,645	9,720	9,134	10,074	9,454	-620	-6.2%	9,275
ADMINISTRATIVE & CLERICAL	11,476	11,439	11,730	12,035	11,929	11,988	11,909	-79	-0.7%	11,236
ALLIED HEALTH PROFESSIONALS	4,982	5,074	5,067	5,046	5,068	5,061	4,981	-80	-1.6%	4,821
ESTATES AND ANCILLIARY	3,923	3,732	3,793	3,850	3,923	3,797	3,853	56	1.5%	3,600
HEALTHCARE SCIENTISTS	1,334	1,367	1,370	1,383	1,403	1,378	1,393	15	1.1%	1,333
MEDICAL AND DENTAL	17,768	18,405	17,810	17,853	19,463	18,826	18,842	16	0.1%	17,784
NURSING AND MIDWIFERY REGISTERED	21,219	20,246	21,003	21,237	21,345	20,874	20,791	-83	-0.4%	20,026
STUDENTS	2	2	2	2	2	6	5	0	-6.3%	2
Total	**73,054**	**74,131**	**73,289**	**73,968**	**75,116**	**74,871**	**74,099**	**-772**	**-1.0%**	**70,836**

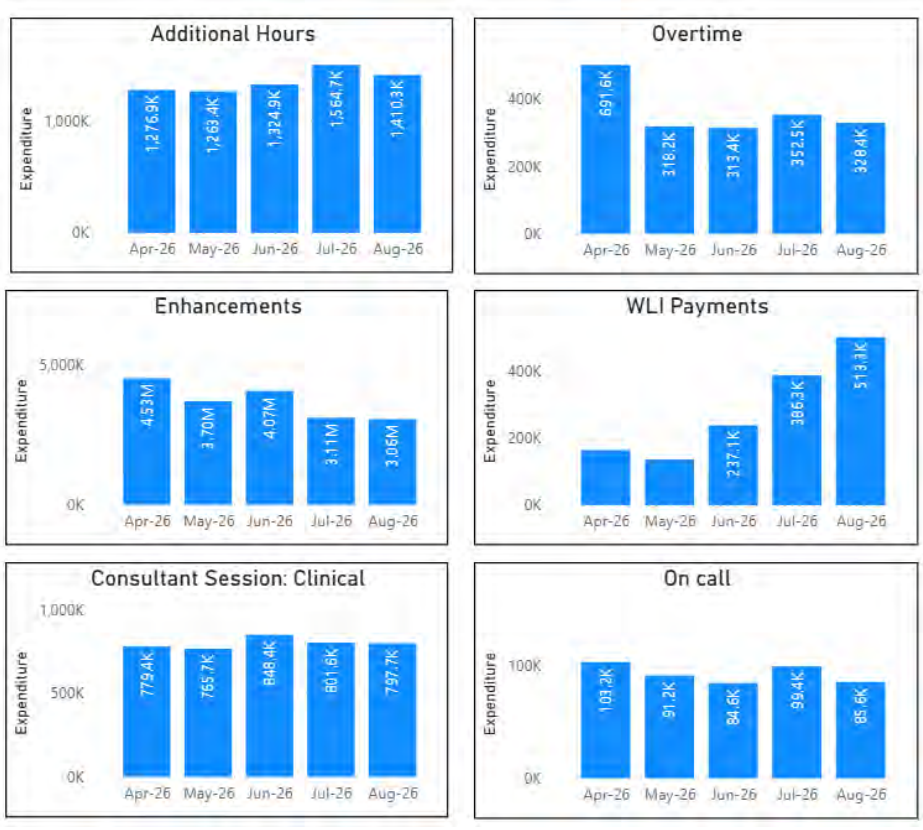
Variable pay (£'000)

Pay category	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Change	%	Avg 25/26
Agency	1,881	2,147	1,805	1,343	1,605	1,678	1,558	-120	-7.1%	2,074
Bank	3,615	4,167	3,500	3,839	3,410	3,664	4,040	377	10.3%	3,580
Locum	511	591	504	510	545	498	456	-42	-8.5%	428
Total	**6,007**	**6,905**	**5,809**	**5,693**	**5,560**	**5,840**	**6,054**	**215**	**3.7%**	**6,081**

Total pay (£'000)

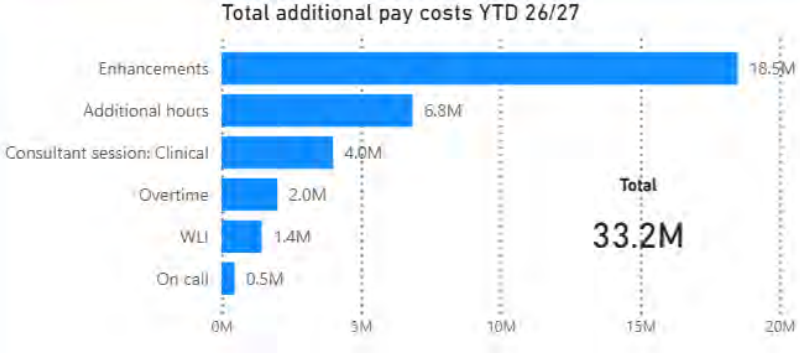
	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Change	%	Avg 25/26
Pay	**79,061**	**81,036**	**79,099**	**79,660**	**80,676**	**80,711**	**80,153**	**-557**	**-0.7%**	**76,917**

Pay Summary (2): Substantive Pay: Additional pay element



Total additional pay by Division (£'000)

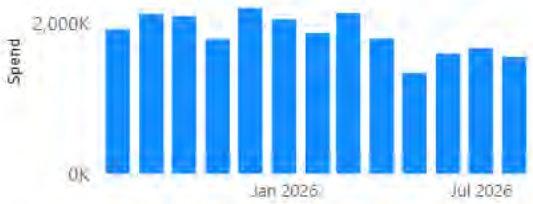
Division	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Total
Medicine	1,724	1,435	1,677	1,617	1,586	**8,038**
Surgery	1,079	884	974	1,042	1,112	**5,091**
Clinical Support Services	930	776	869	848	869	**4,293**
Primary Care and Community	836	698	762	603	525	**3,424**
Family and Therapies	772	657	718	598	623	**3,369**
Urgent Care	663	597	579	555	464	**2,859**
Estates and Facilities	698	553	608	468	479	**2,805**
Mental Health and LD	563	473	491	400	366	**2,294**
CHC and FNC	172	132	137	107	110	**658**
Corporate	106	72	64	80	65	**387**
Total	**7,544**	**6,278**	**6,880**	**6,318**	**6,198**	**33,218**



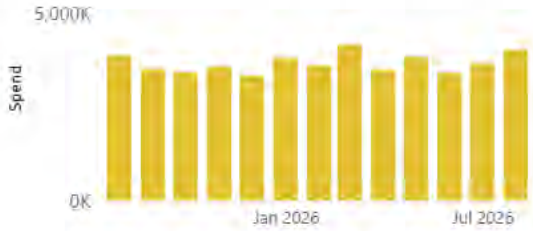
Pay Summary (3): Variable Pay (£'k)

Pay category	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Change	%	Avg 25/26
Agency																
Admin & Clerical Agency	2	61	20	26	29	54	77	47	-31	4	-3	4	-27	-31	-784.1%	36
Allied Health Prof Agency	69	79	68	59	104	148	160	230	139	145	110	177	143	-33	-18.9%	125
Estates & Ancilliary Agency	111	159	161	103	137	75	103	104	113	108	82	87	102	14	16.6%	111
Medical Agency	883	903	1,015	736	972	725	609	735	750	392	716	674	540	-134	-19.9%	877
Nurse HCA/HCSW Agency	95	84	98	40	126	96	97	129	126	93	98	76	98	22	29.1%	120
Other Agency	137	150	97	181	113	90	138	112	46	78	102	62	98	36	58.7%	117
Registered Nurse Agency	632	695	646	652	734	875	697	788	662	524	499	598	604	5	0.9%	687
Total	**1,930**	**2,131**	**2,105**	**1,797**	**2,214**	**2,064**	**1,881**	**2,147**	**1,805**	**1,343**	**1,605**	**1,678**	**1,558**	**-120**	**-7.1%**	**2,074**
Bank																
Admin & Clerical Bank	84	74	88	101	80	92	72	84	51	68	67	63	65	3	4.0%	81
Estates & Ancilliary Bank	296	288	266	274	287	290	286	350	302	344	339	338	408	70	20.7%	286
Nurse HCA/HCSW Bank	1,842	1,622	1,611	1,693	1,590	1,708	1,646	1,922	1,766	1,947	1,647	1,694	1,856	161	9.5%	1,673
Other Bank	35	38	32	27	36	33	51	94	21	22	31	45	42	-3	-6.8%	39
Registered Nurse Bank	1,634	1,492	1,429	1,485	1,352	1,686	1,560	1,718	1,359	1,457	1,325	1,524	1,669	146	9.6%	1,501
Total	**3,891**	**3,515**	**3,427**	**3,580**	**3,345**	**3,809**	**3,615**	**4,167**	**3,500**	**3,839**	**3,410**	**3,664**	**4,040**	**377**	**10.3%**	**3,580**
Locum																
Medical Locum	468	423	443	408	391	436	511	591	504	510	545	498	456	-42	-8.5%	428
Total	**468**	**423**	**443**	**408**	**391**	**436**	**511**	**591**	**504**	**510**	**545**	**498**	**456**	**-42**	**-8.5%**	**428**
Total	**6,289**	**6,069**	**5,975**	**5,786**	**5,950**	**6,309**	**6,007**	**6,905**	**5,809**	**5,693**	**5,560**	**5,840**	**6,054**	**215**	**3.7%**	**6,081**

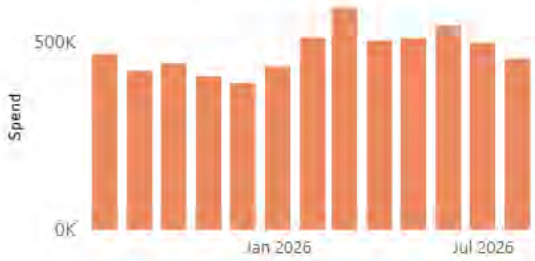
Agency (£'000)



Bank (£'000)

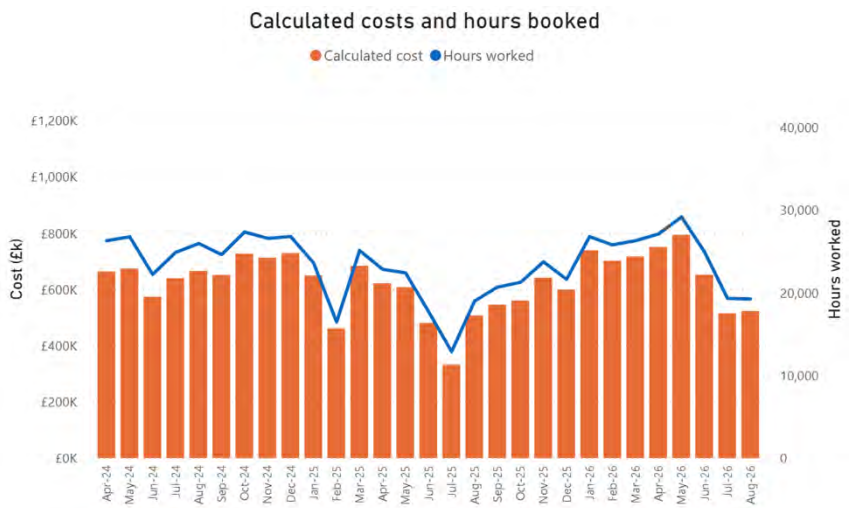


Locum (£'000)

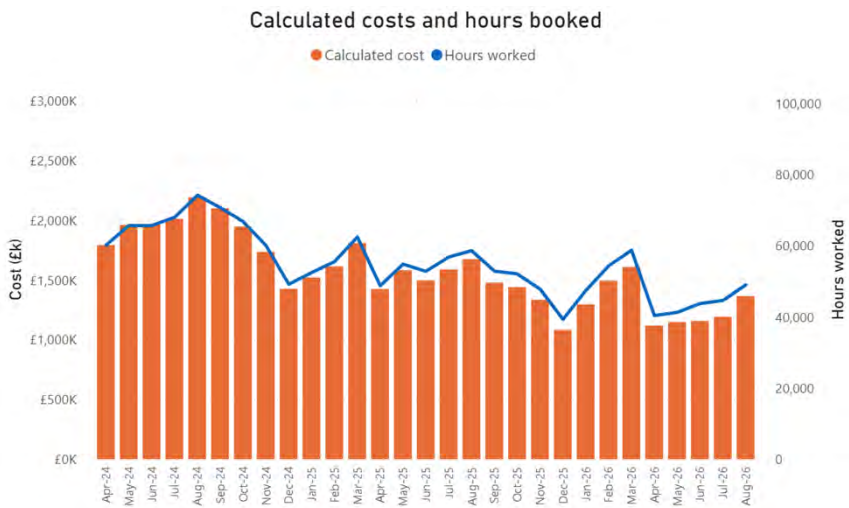


Pay Summary (4): Nurse Bank & Agency Reason for Booking (£'k)

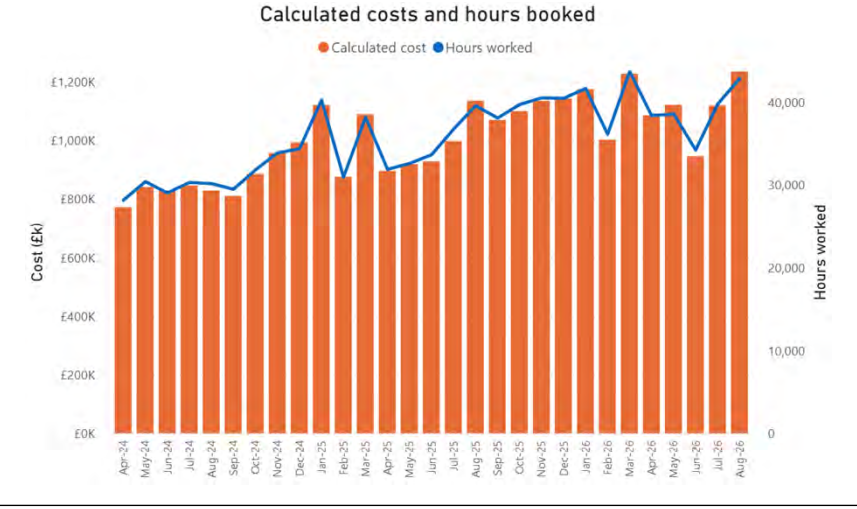
Enhanced Care



Established Vacancy Cover

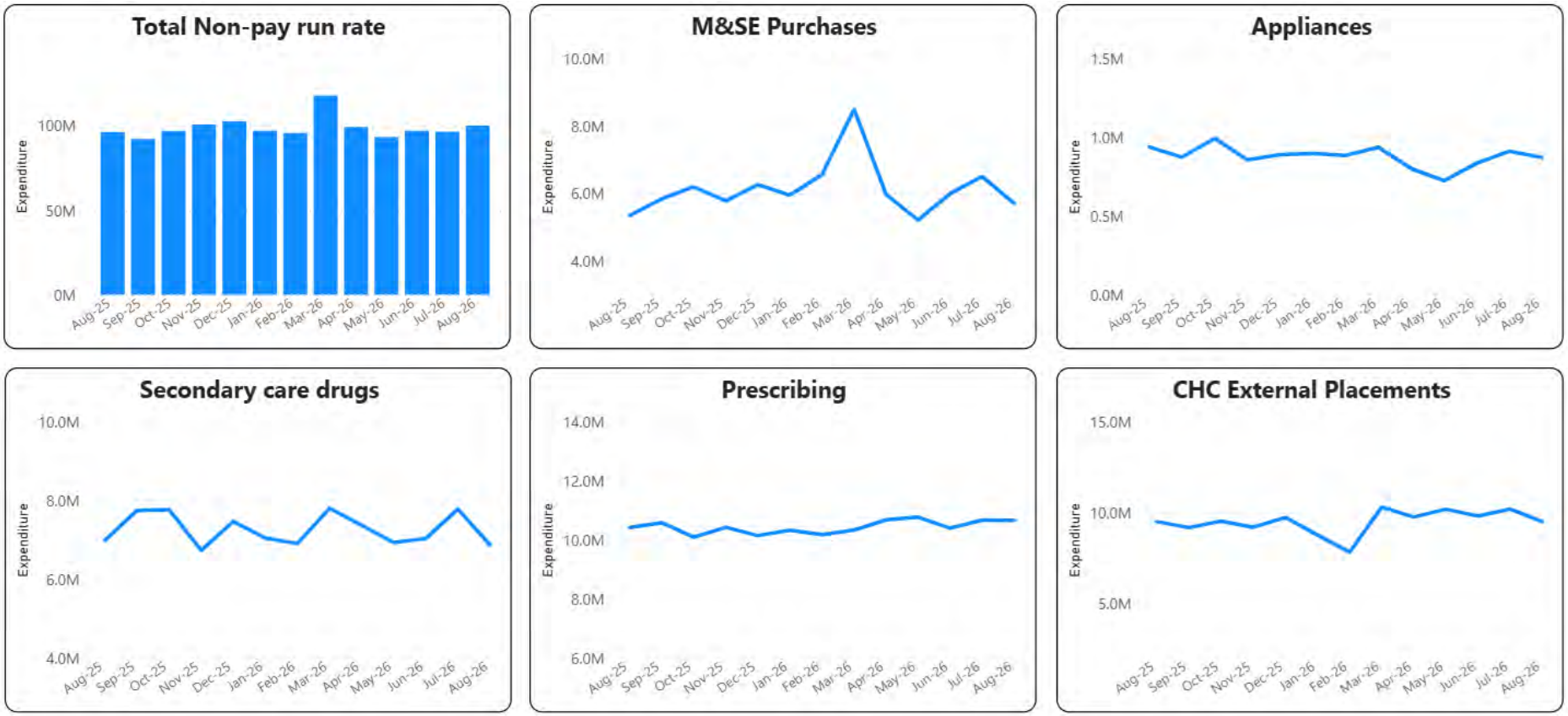


Sickness Cover

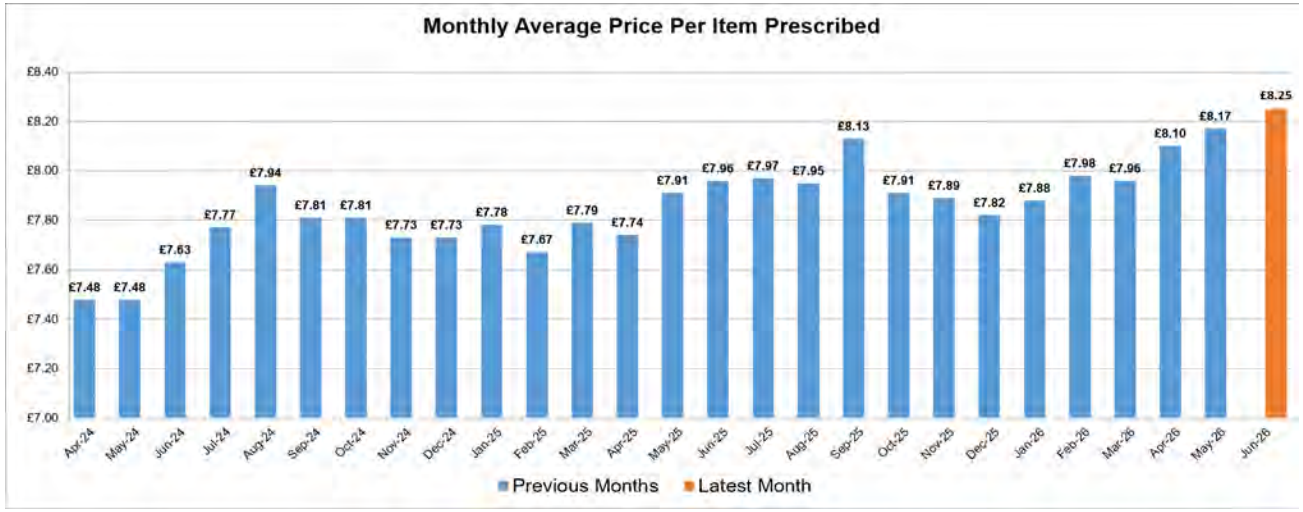


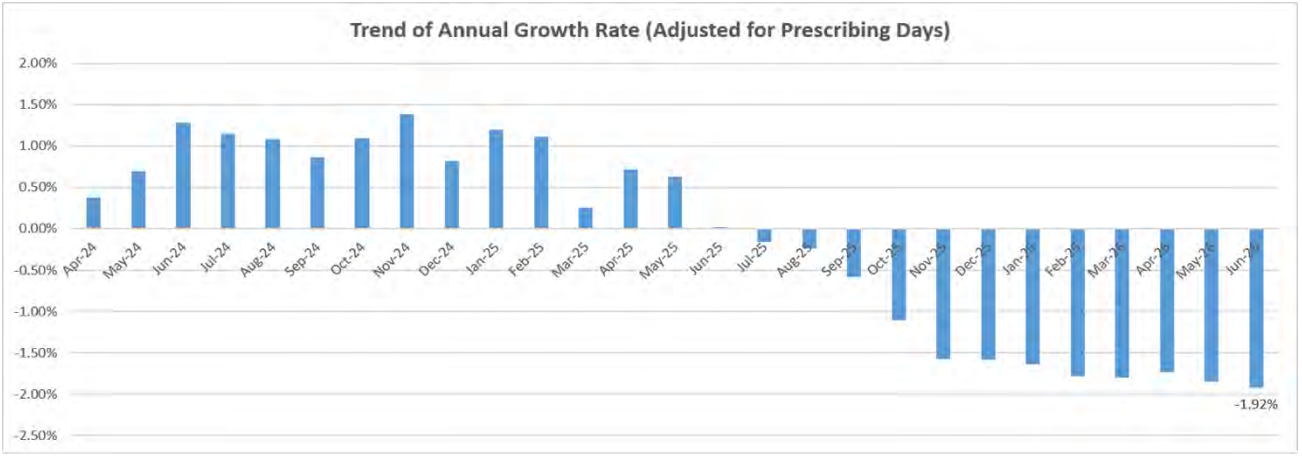
These graphs represent 'notional calculated cost' of these booking reasons for Bank and Agency - Registered Nurses and Healthcare Support Workers. This means assigning an average cost for the hours worked, per the reasons reported in e-roster.

Non-Pay Summary: -



Prescribing Trends: 2026/27



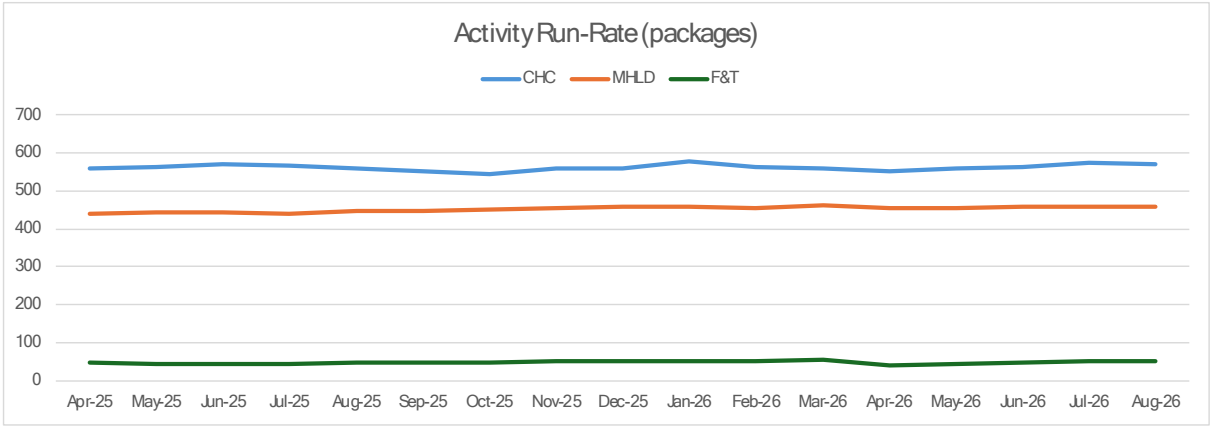


These graphs show:

- The average item price per month trend since April 24
- the 12-month annual growth rate each month since April 2024
- £10.9m was spent in month 5 on prescribing
- Average Unit Cost in June ’26 PAR is £8.25 (year-to-date average £8.18)
- Forecast volume growth is estimated at 0%, a decrease from month 4.
- At month 5 the prescribing full year forecast is an overspend of £2.9m, this is £1.3m lower than plan.
- The year-to-date variance of £1.2m.

CHC (Adult Community CHC): Activity and Spend - YTD & Forecast

Service / Package Type	ACTIVITY - PACKAGES (NUMBERS)			EXPENDITURE				
	Last Month (Jul-26)	Current Month (Aug-26)	Movement	Last Month (Jul-26) £'000s	Current Month (Aug-26) £'000s	Movement £'000s	YTD (26/27) £'000s	Full-Year Forecast (Current Month) £'000s
CHC:								
D2A	22	25	3	237	160	(77)	1,157	2,889
CAHT	43	45	2	1,042	1,081	38	5,339	12,756
Adult CHC	464	456	(8)	3,909	3,738	(171)	19,572	44,573
Discharge Schemes (RIF)	46	46	0	95	109	15	431	1,062
CHC Total:	**575**	**572**	**(3)**	**5,284**	**5,089**	**(195)**	**26,499**	**61,280**
MH&LD CHC:								
Mental Health Packages	288	287	(1)	2,424	2,356	(67)	11,941	28,519
Learning Disabilities Packages	169	171	2	3,070	2,822	(248)	14,393	34,453
MHLD Total:	**457**	**458**	**1**	**5,494**	**5,178**	**(316)**	**26,335**	**62,972**
F&T Children's CHC:								
Out of County Placements	35	31	(4)	181	148	(33)	879	2,153
Internal Placements	15	19	4	111	152	41	603	1,631
F&T Children Total:	**50**	**50**	**0**	**292**	**300**	**8**	**1,482**	**3,784**
TOTAL	**1,082**	**1,080**	**(2)**	**11,069**	**10,567**	**(502)**	**54,315**	**128,037**



Referral to Treatment (RTT)

Additional Funding was agreed with WG for additional activity in August relating to specific areas of wait.

- Elective Treatments for Aug 2026 = 1,726 (Jul: 2,174. 2025/26 total: 22,699, 24/25 total: 25,658, 23/24 total: 24,688)

Treatments	M05	Actual Treatments M05					Actual Treatments M05 104 Week Activity Split			YTD	Actual Treatments YTD					Actual Treatments YTD 104 Week Activity Split		
	Planned Core	Core	Backfill	WLI	Total	*variance*	Backfilled	WLI	TOTAL	Planned Core	Core	Backfill	WLI	Total	*Variance*	Backfilled	WLI	TOTAL
N107-Dermatology	340	178	0	0	**178**	*(162)*			**0**	1,539	973	0	0	**973**	*(566)*			**0**
N147-ENT	159	123	0	0	**123**	*(36)*	8		**8**	673	598	38	0	**636**	*(37)*	14		**14**
N105-General Surgery	331	296	7	0	**303**	*(28)*	37	26	**63**	1,697	1,508	21	0	**1,529**	*(168)*	37	41	**78**
N146-Oral Surgery	208	183	0	0	**183**	*(25)*			**0**	949	1,022	0	0	**1,022**	*73*			**0**
N148-Ophthalmology	246	248	0	0	**248**	*2*			**0**	1,153	1,471	0	0	**1,471**	*318*			**0**
N108-Rheumatology	0	0	0	0	**0**	*0*			**0**	0	0	0	0	**0**	*0*			**0**
N115-Trauma & Orthopaedics	624	481	0	0	**481**	*(143)*	103	67	**170**	2,933	2,617	0	0	**2,617**	*(316)*	160	110	**270**
N106-Urology	344	210	0	0	**210**	*(134)*			**0**	1,563	1,116	0	0	**1,116**	*(447)*	1		**1**
Total	**2,252**	**1,719**	**7**	**0**	**1,726**	***(526)***	**148**	**93**	**241**	**10,507**	**9,305**	**59**	**0**	**9,364**	***(1,143)***	**212**	**151**	**363**

- Outpatient activity for Aug 2026 = 5,382 (Jul: 5,012. 2025/26 total: 68,434, 24/25 total: 74,787, 23/24 total: 71,165)

Outpatients	M05	Actual Outpatients M05					YTD	Actual Outpatients YTD				
	Planned Core	Core	Backfill	WLI	Total	*Variance*	Planned Core	Core	Backfill	WLI	Total	*Variance*
N107-Dermatology	942	1,173	0	0	**1,173**	*231*	4,290	6,022	55	0	**6,077**	*1,787*
N147-ENT	578	479	0	0	**479**	*(99)*	2,556	2,710	0	0	**2,710**	*154*
N105-General Surgery	1,929	1,564	145	23	**1,732**	*(197)*	9,118	9,159	308	281	**9,748**	*630*
N146-Oral Surgery	296	320	0	0	**320**	*24*	1,387	1,742	66	0	**1,808**	*421*
N148-Ophthalmology	938	572	0	0	**572**	*(366)*	4,063	3,138	0	0	**3,138**	*(925)*
N108-Rheumatology	192	139	0	0	**139**	*(53)*	880	747	0	0	**747**	*(133)*
N115-Trauma & Orthopaedics	925	470	0	0	**470**	*(455)*	3,966	2,623	0	0	**2,623**	*(1,343)*
N106-Urology	552	495	0	2	**497**	*(55)*	2,554	2,645	0	34	**2,679**	*125*
Total	**6,352**	**5,212**	**145**	**25**	**5,382**	***(970)***	**28,814**	**28,786**	**429**	**315**	**29,530**	***716***

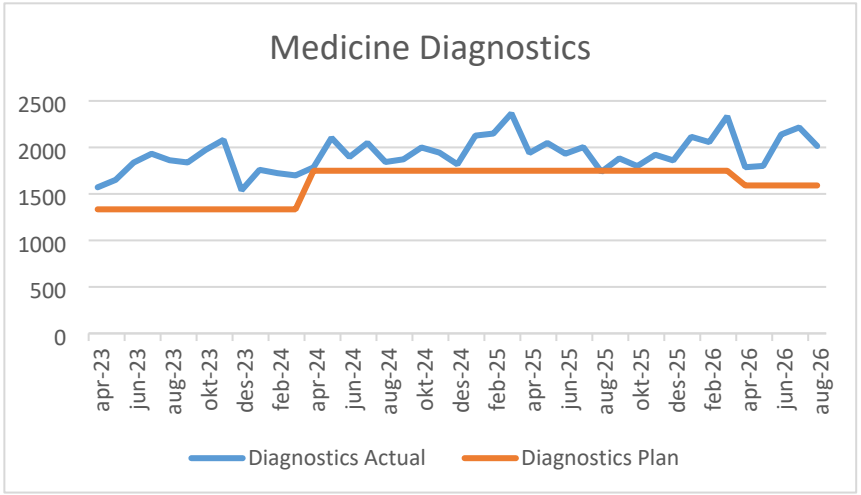
Source Data: Surgery Divisional Management (Trauma activity has been removed from the elective treatments in prior month data for comparison)

Medicine Outpatients activity for Aug ’26 was 1,535 - (Jul ’26: 1,848. 2025/26: 24,754. 2024/25: 23,053)

Aug-26	In-Month		
	Assumed monthly activity	Actual activity	Variance
Gastroenterology	379	289	-90
Cardiology	464	316	-148
Respiratory (inc Sleep)	625	366	-259
Neurology	381	310	-71
Endocrinology	201	108	-93
Geriatric Medicine	201	146	-55
Total	**2251**	**1535**	**-716**

Aug-26	YTD			
	Assumed monthly activity	Actual activity	Variance	Variance
Gastroenterology	1895	1461	-434	-23%
Cardiology	2320	1739	-581	-25%
Respiratory (inc Sleep)	3125	2435	-690	-22%
Neurology	1905	1693	-212	-11%
Endocrinology	1005	862	-143	-14%
Geriatric Medicine	1005	831	-174	-17%
Total	**11255**	**9021**	**-2234**	**-20%**

Medicine Diagnostics activity for Aug ’26 was 2,015 (Jul ’26: 2,215. 2025/26: 23,628. 2024/25: 23,952)



Aug-26	In-Month		
	Assumed monthly activity	Actual activity	Variance
Endoscopy	1591	2015	424
Total	**1591**	**2015**	**424**

Aug-26	YTD			
	Assumed monthly activity	Actual activity	Variance	Variance
Endoscopy	7955	9957	2002	25%
Total	**7955**	**9957**	**2002**	**25%**

POCDs:

Demand and flow pressures across the system continue to drive significant costs. In August, the number of in-patients fit for discharge at the Welsh Government data capture point was 152 (Jul: 196). Of these, 42 were Health delays, 24 Social Care delays, and 86 Joint delays. The categories of reasons for delayed days are as follows:

		Delay Owner		
Reason	Total Number of Patients	Health	Social	Joint
Assessment Issues	54	31	6	17
Care Home placement arrangements	35	4	0	31
Disagreements /Legislation	19	0	1	18
Home care related issues	12	1	9	2
Step down to recover and assess	6	0	0	6
Home adaptation/equipment issues	5	3	0	2
Housing related issues	14	0	5	9
Funding Issues	4	0	3	1
Transfer related issues	3	3	0	0
	152	42	24	86
		28%	16%	57%
		% of Total		

The estimated cost for the year attributed to continued blocked bed days for all reasons is c.£12.8m using a £200 cost per bed day (based on the average number of patients YTD). The demand and flow challenges drive surge bed capacity & increased demand in high-cost unfunded temporary staff.

New In year Cost Pressures: By Division:

At month 5 remaining mitigating actions are required of £3.1m to achieve the current deficit forecast position of £41.6m. This relates to additional cost pressures outside of the submitted plan, a large proportion of which are in the year-to-date position (£2.8m). These cost pressures pose a further risk if no action is taken to stop / reduce the spend in future months. The total cost pressure at month 5 is £6.6m, of which £3.5m of potential actions have been identified leaving a net requirement of £3.1m to be found.

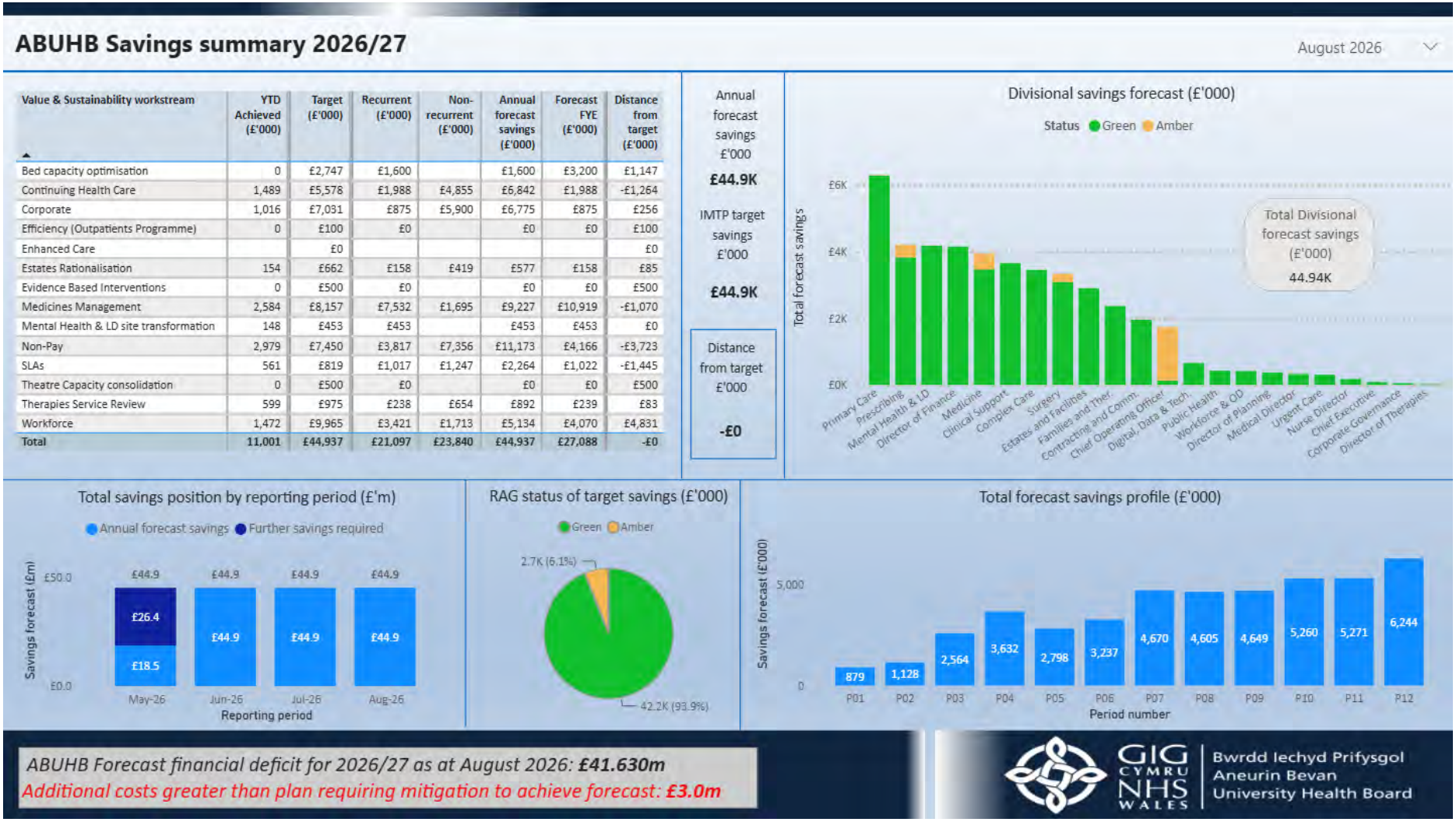
	Additional costs in additional mitigating actions at M5
CSS	812
DDAT	825
Medicine	1,274
PCCS	543
Surgery	1,847
Urgent Care	1,279
New Mitigating Actions Needed	**6,580**
WRP (delayed settlements)	-1,600
Assume Connecting care funding (not confirmed)	-500
Successful UEC bids supporting ONP initiatives	-400
Additional Workforce savings	-1,000
Total Potential Mitigating Actions	**-3,500**
Mitigating Actions to be Found	**3,080**

RAG rating category definitions

Savings schemes are categorised as *Red*, *Amber* or *Green* according to the certainty of the forecast achievement. Definitions for each rating are as follows:

- Green scheme: Started delivering in the current month or prior month and is expected to continue delivering for the remaining period.
- Amber scheme: Agreed plan in place and expected to deliver starting in a future month. Not yet started, therefore Amber due to the time factor risk.
- High-risk Amber scheme: Provisional allocation to Divisions of remaining pipeline schemes. To be agreed by the Executive Team and worked through within Divisions.
- Red scheme: No plan in place and not expected to achieve.

Savings delivery summary



Value & Sustainability workstream	YTD Achieved (£'000)	Target (£'000)	Recurrent (£'000)	Non-recurrent (£'000)	Annual forecast savings (£'000)	Forecast FYE (£'000)	Distance from target (£'000)
Bed capacity optimisation	0	£2,747	£1,600		£1,600	£3,200	£1,147
Continuing Health Care	1,489	£5,578	£1,988	£4,855	£6,842	£1,988	-£1,264
Corporate	1,016	£7,031	£875	£5,900	£6,775	£875	£256
Efficiency (Outpatients Programme)	0	£100	£0		£0	£0	£100
Enhanced Care		£0					£0
Estates Rationalisation	154	£662	£158	£419	£577	£158	£85
Evidence Based Interventions	0	£500	£0		£0	£0	£500
Medicines Management	2,584	£8,157	£7,532	£1,695	£9,227	£10,919	-£1,070
Mental Health & LD site transformation	148	£453	£453		£453	£453	£0
Non-Pay	2,979	£7,450	£3,817	£7,356	£11,173	£4,166	-£3,723
SLAs	561	£819	£1,017	£1,247	£2,264	£1,022	-£1,445
Theatre Capacity consolidation	0	£500	£0		£0	£0	£500
Therapies Service Review	599	£975	£238	£654	£892	£239	£83
Workforce	1,472	£9,965	£3,421	£1,713	£5,134	£4,070	£4,831
Total	**11,001**	**£44,937**	**£21,097**	**£23,840**	**£44,937**	**£27,088**	**-£0**

Primary Care and Community

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
PCCS 01	Termination of ODTC lease	R	Month 1	Green	40	95
PCCS 02	Improved sickness management	R	Month 1	Green	0	280
PCCS 03	GMS Improvement grants	R	Month 1	Green	0	0
PCCS 03a	GMS Improvement grants	NR	In Year	Green	83	200
PCCS 04	D2S Crumlin and Cwmfelinfach	R	Month 1	Green	0	0
PCCS 05	GP OOHs admin	R	Month 1	Green	3	6
PCCS 06	GP OOHs touchbooks	R	Month 1	Green	0	5
PCCS 07	Nursing Streamlining savings	R	Month 1	Green	0	66
PCCS 08	Non recurrent vacancy savings	NR	Month 1	Green	21	51
PCCS 09	Monnow Vale SLA - MDT element	R	In Year	Green	0	6
PCCS 10	Non-Pay reductions	R	In Year	Green	10	24
PCCS 11	Stock Control	R	In Year	Green	1	2
PCCS 12	NR contract handback benefits	NR	In Year	Green	88	2,000
PCCS 13	Stock Control	NR	In Year	Green	0	5
PCCS 14	Using information from other sources therefore alleviating the need for a section 12 assessment	R	In Year	Green	25	60
PCCS 15	Direct Delivery Deep Dive	NR	In Year	Green	115	315
PCCS 16	Unitary Charge Refund	NR	In Year	Green	63	63
PCCS 17	GMS - Enhanced services review	NR	In Year	Green	0	1,456
PCCS 18	CDS - income generation	NR	In Year	Green	4	15
PCCS 19	MBI locum VAT saving	R	In Year	Green	20	49
PCCS 20	DMP increase in private income fees	R	In Year	Green	6	12
PCCS 21	Reduction in locum costs	R	In Year	Green	75	250
PCCS 22	Community Pharmacy validation	NR	In Year	Green	0	300

PCCS 23	Reduction in bank and agency costs	R	In Year	Green	0	54
PCCS 24	Reduction in bank and agency costs	R	In Year	Green	0	27
PCCS 25	Glyn Ebbw Closure	R	In Year	Green	0	23
PCCS 26	Re-structure of business support team	R	In Year	Green	2	12
PCCS 27	GMS recurrent forecast reduction - deep dive	R	In Year	Green	133	600
PCCS 28	25/26 clawback benefit	NR	In Year	Green	307	307
PCCS 29	Medicines Waste	NR	In Year	Amber	0	14
		Minimum Savings Target		**6,700**	**995**	**6,296**
		Distance from target (over)/under		**404**		

Prescribing

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
PCC100	Stoma Team Phase 2	NR	Month 1	Green	61	149
PCC101.1	Dietitians	R	Month 1	Green	22	80
PCC101.2	Waste Reduction Scheme	R	Month 1	Green	109	260
PCC101.3	Pharmacy Led Savings	R	Month 1	Green	11	50
PCC101.4	Scriptswitch Acute	R	Month 1	Green	79	201
PCC101.5	Scriptswitch Repeat	R	Month 1	Green	95	661
PCC101.6	Sitagliptin switch from other liptins	R	Month 1	Green	16	523
PCC101.7	Empagliflozin switch to Dapagliflozin	R	Month 1	Green	0	186
PCC101.8	Denosumab switch to AN OTHER	R	Month 1	Green	18	56
PCC101.9	Perampanel LOE	R	Month 1	Green	0	50
PCC101.10	Brivacetum LOE	R	Month 1	Green	0	197
PCC101.11a	Additional Pharmacy Savings-GP Dressings	R	Month 1	Green	60	152
PCC101.11b	Additional Pharmacy Savings-BGTS	R	Month 1	Green	4	40
PCC101.11c	Additional Pharmacy Savings-Edoxaban switches to other DOACs	R	Month 1	Green	14	225
PCC101.11d	Additional Pharmacy Savings-Estriol Cream	R	Month 1	Green	2	60
PCC101.11e	Additional Pharmacy Savings-High Cost Specials / Red Drugs	R	Month 1	Green	21	60
PCC101.12	Miscellaneous Drug Cost Savings	NR	In Year	Green	528	872
PCC101.13	Further Drug Cost Savings inc Respiratory inhaler switch	R	In Year	Amber	0	375
		Minimum Savings Target		**2,513**	**1,040**	**4,197**
		Distance from target (over)/under		**(1,684)**		

Complex Care

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD Achieved £'000	Full year Forecast £'000
CHC-01	Database Cleanse	NR	Month 1	Green	0	1,240
CHC-01b	Database Cleanse Addition	NR	In Year	Green	0	500
CHC-02	Nursing Streamliner Savings	R	Month 1	Green	10	24
CHC-03	26-27 inflation not requested	NR	In Year	Green	182	281
CHC-04	26-27 inflation awarded less than cap 5.25%	NR	In Year	Green	44	106
CHC-05	High Cost Placment review GP	NR	In Year	Green	45	201
CHC-06	Efficiencies	NR	In Year	Green	156	1,097
		Minimum Savings Target		**1,504**	**438**	**3,449**
		Distance from target (over)/under		**(1,945)**		

Mental Health and Learning Disabilities

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD Achieved £'000	Full year Forecast £'000
MH-01	Older Adult Agency Premium Saving Medical Staffing	R	Month 1	Green	16	38
MH-02	CHC Acorn Project	R	Month 1	Green	151	362
MH-03	Nursing - Streamliner Savings	R	Month 1	Green	110	244
MH-04	CHC Repat Hireath	R	Month 1	Green	69	195
MH-05	CHC Utilisation of Exisiting Provision	R	Month 1	Green	35	131
MH-06	Community Advocacy Contract Reduction	R	Month 1	Green	22	53
MH-07	Ty Lafant Variable Pay Saving	R	In Year	Green	148	356
MH-08	Admin Reductions	R	In Year	Green	15	67
MH-09	MH Transformation	R	In Year	Green	0	97
MH-10	LD High Cost Placement Review	R	In Year	Green	72	330
MH-11	CHC Rightsizing	NR	In Year	Green	133	133
MH-12	CHC Data Base Review	NR	In Year	Green	65	293
MH-13	CHC Growth Reduction - In House Services	R	In Year	Green	242	458
MH-14	H&F CHC Dispute	NR	In Year	Green	0	500
MH-15	CHC Growth	NR	In Year	Green	178	428
MH-16	CHC - Management of demand / growth	NR	In Year	Amber	0	0
MH-16a	CHC - Management of demand / growth R	R	In Year	Green	30	238

MH-17	Medicines Waste SBAR	R	In Year	Amber	0	2
MH-18	CHC Inflationary Uplifts	R	In Year	Green	0	250
		Minimum Savings Target		**3,063**	**1,286**	**4,174**
		Distance from target (over)/under		**(1,111)**		

Surgery

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
SUR-01	Faricimab Price change (IMTP SUR-01)	R	In Year	Green	334	659
SUR-03	10% reduction in 8b head orthoptist salary	NR	Month 1	Green	0	0
SUR-03a	Orthoptist workforce changes - 8b	R	In Year	Green	1	10
SUR-04	24% reduction in B7 orthoptist salary	NR	Month 1	Green	0	0
SUR-04a	Orthoptist worhforce changes - 7	R	In Year	Green	2	16
SUR-05	2 consultant vacancies not filled until Sept 26	NR	Month 1	Green	162	162
SUR-06	5 consultant sessions held until recruitment (SBAR)	NR	Month 1	Green	22	22
SUR-08	Dermatology: IMF tests	R	Month 1	Green	0	24
SUR-09	Dermatology: Surgical Kit	R	Month 1	Green	0	48
SUR-11	Haem: Not to replace B3 maternity leave (2 months) 16HRS	NR	Month 1	Green	2	2
SUR-12	Haem: Clinical trials	R	Month 1	Green	0	10
SUR-15	Haem: Clinical trials (no A-sceptic protection)	R	Month 1	Amber	0	0
SUR-16	Rheum: Nurse initative to reduce drug waste	R	Month 1	Green	0	10
SUR-17	Rheum: B6 OT 0.4 until August 2026	NR	Month 1	Green	9	9
SUR-18	Rheum: biosimiar denosumab	R	Month 1	Green	11	25
SUR-19	4/2 NHH Think Pads	R	Month 1	Green	1	3
SUR-20	DES consignment in GUH vs loan prices	R	Month 1	Green	1	2
SUR-21	5% increase on Femoral head prices	R	Month 1	Green	1	2
SUR-22	Withdrawn of S&N hip distractor	R	Month 1	Green	10	24
SUR-23	Cessation of LEDA loan fees	R	Month 1	Green	11	28
SUR-24	Theatre power tool capital purchase to prevent monthly loan charges	R	Month 1	Green	35	84
SUR-25	cost avoidance of theatre stack maintenance from Stryker contract	R	Month 1	Green	5	17
SUR-26	Antibiotic Drugs - switch to oral from IV in GUH	R	Month 1	Amber	0	0
SUR-27	Perm LGI staff to reduce oncall cover costs	R	Month 1	Green	11	36
SUR-28	Replace single use with re-usable Thudicums and Tongue depressors NHH OPD	NR	Month 1	Green	0	3

SUR-29	ENT Treatment room Consumables	NR	Month 1	Green	0	2
SUR-30	alternative sinlge use nasendoscopes	NR	Month 1	Green	0	2
SUR-31	Orthodontic brackets	NR	Month 1	Green	0	2
SUR-32	Medicines Management: Additional	R	Month 1	Green	0	0
SUR-32a	Golimumab & Ambisome Biosimilars	R	Month 1	Green	34	49
SUR-33	Nursing - Streamliner Savings	R	Month 1	Green	0	143
SUR-34	Drugs Rebate Savings - additional rebate income	R	Month 1	Amber	0	0
SUR-36	Air+ Bulk Buy Saving	NR	Month 1	Green	2	5
SUR-37	BLX Putty Bulk Buy Saving	NR	Month 1	Green	5	13
SUR-38	Eylea Biosimilar 26/27	R	In Year	Green	417	1,000
SUR-39	Growth Reduction	R	In Year	Green	152	365
SUR-40	IMT rota gap. (6 months for consultant)	NR	In Year	Green	6	38
SUR-41	B6 CNS slippage until hours are recruited. July to October 2026	NR	In Year	Green	10	19
SUR-42	Specialty Registrar Recruitment Slippage (May to July)	NR	In Year	Green	10	10
SUR-43	Admin B4 Hold Vacancy 0.03 WTE on 1699	R	In Year	Green	0	1
SUR-44	Admin B4 replaced by B3 3006	R	In Year	Green	1	6
SUR-45	Consultant drop 0.5 session per week from July	NR	In Year	Green	2	8
SUR-46	ODP B7 Retire and Return from 1.00wte to 0.90wte form Aug 26 CC 1145	NR	In Year	Green	1	5
SUR-47	Physician Associate B7 Mat leave from October not backfilled	NR	In Year	Green	0	17
SUR-48	Specialist Surgeon leaving Jan 27 - hold vacancy until Apr 27 1.00wte	NR	In Year	Green	0	28
SUR-49	Service Contract on YYF Image Intensifier	R	In Year	Green	1	5
SUR-50	GUH B0, C0, SAU Ward Consumable Savings	R	In Year	Green	5	13
SUR-51	Drug Commercial Access Rebates	R	In Year	Amber	0	200
SUR-52	Drug Wastage across wards	R	In Year	Amber	0	44
SUR-53	Laser service contract ENT / Max Facs	NR	In Year	Green	0	2
SUR-54	Alternative theatre drapes project	NR	In Year	Green	1	5
SUR-55	Associate Specialist Hold Vacancy	NR	In Year	Green	3	15
SUR-56	Band 2 Admin Hold Vacancy	NR	In Year	Green	1	7
SUR-57	Band 2 HCSW Hold Vacancy	NR	In Year	Green	1	4
SUR-58	RN B5 Hold vacancy from reduction in hours from current staff	NR	In Year	Green	1	4
SUR-59	Only using disposable flexi sheets in theatre on pts with mobility issues	R	In Year	Green	0	2
SUR-60	Orthoptist cost code - workforce changes	R	In Year	Green	8	64
SUR-61	Standardisation of theatre instrument sets	R	In Year	Green	0	2
SUR-62	Reduced consumable expenditure on tubing etc	NR	In Year	Green	4	29

SUR-63	Increased replacement costs for lost Hearing Aids (from £65 to £75) patients approx. 800 pa	R	In Year	Green	1	8
SUR-64	B&L Lens Trial	NR	In Year	Green	0	14
		Minimum Savings Target		**3,109**	**1,285**	**3,328**
		Distance from target (over)/under		**(219)**		

Clinical Support Services

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD Achieved £'000	Full year Forecast £'000
CSS01	Out of Area High Cost Intervential Radiology Procedures	NR	Month 1	Green	60	176
CSS02	PHW Liver Ablation Activity Above Baseline	NR	Month 1	Green	57	162
CSS02b	PHW Liver Ablation Activity Above Baseline	NR	Month 1	Green	45	285
CSS03	Capitalisation of Casination Equipment hire	R	Month 1	Green	33	80
CSS04	WLI CAP Review	R	Month 1	Green	50	120
CSS05	Gamma Camera Maintenance not required for 1 year (NR)	NR	Month 1	Green	18	30
CSS06	Sysmex KPI Savings (NR)	NR	Month 1	Green	2	5
CSS07	BioFlash Service & Maintenance (NR)	NR	Month 1	Green	3	7
CSS08	Von Willebrand Screen ('R)	NR	Month 1	Green	0	0
CSS08a	Von Willebrand Screen ('R)	R	In Year	Green	6	14
CSS09	Siemen's MSC KPI (NR)	NR	Month 1	Green	17	40
CSS10	Coroner SLA increased PM fees	R	Month 1	Green	70	167
CSS11	Reduction in Biochemistry Bank Staff	R	Month 1	Green	13	30
CSS12	Reduce excess QC testing in microbiology	R	Month 1	Green	7	16
CSS13	Pre-Paid Postage Boxes for Referral Process	R	Month 1	Green	6	15
CSS14	IHC movement from Block 3 to main lab. Savng on deionised water	R	Month 1	Green	5	12
CSS15	Demand management Vitamin D primary care	R	Month 1	Green	0	7
CSS16	Repatriation of Teicoplanin	R	Month 1	Green	3	7
CSS17	Amalgamate UKAS Quality Assessment for all disciplines	R	Month 1	Green	1	3
CSS18	Decommission Andrology (SAMI) equipment	R	Month 1	Green	1	2
CSS19	CSS Critical Care - 80% maternity permanent backfill pilot	R	Month 1	Green	57	115
CSS20	Nursing - Streamliner Savings	R	Month 1	Green	38	91
CSS25	MRSA Consumables savings	NR	Month 1	Green	0	0
CSS25a	MRSA Consumables savings	R	In Year	Green	3	6
CSS26	Ambisome to generic amphotericin B liposomal (Tillomed brand)	R	Month 1	Green	7	14

CSS27	Cancer vacancy Slippgage	NR	In Year	Green	28	43
CSS27a	Cancer Staffing Review	R	In Year	Green	2	7
CSS28	Sysmex savings	R	In Year	Green	20	65
CSS29	Saving from using Specialty Dr against consultant	NR	In Year	Green	4	13
CSS30	Vacancy Slippages	NR	In Year	Green	12	37
CSS30a	Clinical Photography Staffing Review	R	In Year	Green	3	28
CSS31	Vacancy Slippages	NR	In Year	Green	17	52
CSS32	Non pay	NR	In Year	Green	8	8
CSS33	Maintenance Contracts - Revise Mobiles to PPM contracts only	R	In Year	Green	10	39
CSS34	Cardiff & Vale USS SLA (F&T Equipment)	R	In Year	Green	5	11
CSS35	Parrafin Wax (Change of supplier)	R	In Year	Green	1	3
CSS36	ESR test Reduction	R	In Year	Green	2	6
CSS37	Clotting Screens Reduction	R	In Year	Green	3	8
CSS38	Reduction in Lyme Serology	R	In Year	Green	0	2
CSS39	Talking Point Cessation	R	In Year	Green	0	7
CSS40	Reduction in Consultant Intensity Payments	R	In Year	Green	21	71
CSS42	Histology Consultant Run Rates	NR	In Year	Green	(1)	100
CSS43	Reduction in Procalcitonin	R	In Year	Green	9	30
CSS44	LINC recharge from DHCW	NR	In Year	Green	26	85
CSS45	POCT (COVID/Respiratory related)	NR	In Year	Green	55	55
CSS46	Repatriate Haemoglobinopathy testing from UHW	R	In Year	Green	0	13
CSS47	Genta Delivery/Environment Costs	R	In Year	Green	0	1
CSS48	NHH Theatres Non Pay PAR Level Adjustment	NR	In Year	Green	0	50
CSS49	YYF Theatres Non Pay PAR Level Adjustment	NR	In Year	Green	0	50
CSS50	RGH Theatres Non Pay PAR Level Adjustment	NR	In Year	Green	0	50
CSS51	CVC insertion packs savings	R	In Year	Green	2	10
CSS52	Welsh Blood Service - Blood Products Stock Management	NR	In Year	Green	300	300
CSS53	Contrast Stock Management	NR	In Year	Green	208	260
CSS54	Outsourced Reporting - Management of routine reports	NR	In Year	Green	54	140
CSS55	Outsourced Reporting - Price Reduction on Extension of contract	R	In Year	Green	0	145
CSS56	Pathology - Reduced variable pay due to lower sickness trend	R	In Year	Green	6	27
CSS56a	Radiology - Reduced variable pay due to lower sickness trend	R	In Year	Green	10	45
CSS57	Werfen Immunology Reimbursement for Send Away tests	NR	In Year	Green	0	51
CSS58	Microbiology Runrate Reduction	R	In Year	Green	30	135

CSS59	LIM Q1 & Q2 Project slippage	NR	In Year	Green	0	82
CSS61	Pathology Workforce Review	R	In Year	Green	6	45
CSS64	Pharmacy Wastage Saving	R	In Year	Amber	0	6
CSS65	Non-Pay Review	R	In Year	Green	11	88
CSS66	Variable Pay Reduction	R	In Year	Green	19	19
CSS67	Pac Vacancy Slippage	NR	In Year	Green	6	6
CSS68	Pathology Workforce Review	NR	In Year	Green	0	47
CSS69	Radiology Workforce Slippage	NR	In Year	Green	16	16
		Minimum Savings Target		**2,762**	**1,392**	**3,658**
		Distance from target (over)/under		**(897)**		

Medicine

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
Med-01	fampridine/Fampyra/Neurology/homecare	R	Month 1	Green	0	15
Med-02	nintedanib-Ofev/Respiratory/homecare	R	Month 1	Green	42	616
Med-03	perampaentl/Fycompa/Neurology/WP10	R	Month 1	Green	0	1
Med-04	brivaracetam/Briviact/neurology/WP10	R	Month 1	Green	0	17
Med-05	HSCW sickness reduction savings	R	Month 1	Green	58	464
Med-06	Nursing streamliner savings	R	Month 1	Green	0	234
Med-07	Diabetic Pump pricing	NR	Month 1	Green	52	124
Med-08	National Priorities/Best Value Biosimilars - Omalizumab (Omlyclo)	R	In Year	Green	42	105
Med-09	Ambisome to generic amphotericin B liposomal (Tillomed brand)	R	In Year	Green	11	23
Med-10	National Priiorities-COTE-Denosumab-biosimilar	R	In Year	Green	59	157
Med-11	Insourcing endoscopy savings	R	In Year	Green	23	78
Med-12	Procurement savings on diabetes sensors	R	In Year	Green	22	100
Med-13	YYF - Switch from NDE to DE for specialty reg	R	In Year	Green	5	23
Med-14	YYF- release of 15hrs ward clerk	R	In Year	Green	2	10
Med-15	YYF- Stop purchase of incontenance sheets	R	In Year	Green	2	7
Med-16	Nephrology Drug (Budesomide) - growth does not materialise. Estimate	NR	In Year	Green	281	754
Med-17	Mounjaro rebate @ approx £11k/mth	R	In Year	Green	48	116
Med-18	IV infliximab switch	R	In Year	Amber	0	30
Med-19	Ustkinumab S/C switch	R	In Year	Amber	0	18
Med-20	Medicines waste SBAR	R	In Year	Amber	0	78

Med-21	Green schemes 2% savings target NR (added month 4)	NR	In Year	Amber	0	116
Med-22	Green schemes 2% savings target Recurring (added month 4)	R	In Year	Amber	0	190
Med-23	Green schemes 2% savings target Recurring (added month 4)	R	In Year	Amber	0	42
Med-24	Vedolizumab price reduction	R	In Year	Green	90	622
		Minimum Savings Target		**3,611**	**738**	**3,938**
		Distance from target (over)/under		**(328)**		

Urgent Care

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD Achieved £'000	Full year Forecast £'000
CURG-01	Close eLGH Transfer Lounges	R	Month 1	Green	0	212
CURG-02	Streamliner Savings	R	Month 1	Green	11	26
CURG-04	Stock Savings	R	Month 1	Green	7	10
CURG-05	DN Slippage	NR	In Year	Green	10	52
CURG-06	Medicines Waste SBAR	R	In Year	Green	0	1
		Minimum Savings Target		**868**	**28**	**301**
		Distance from target (over)/under		**566**		

Families and Therapies

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD Achieved £'000	Full year Forecast £'000
F&T01a	1% Drugs Target applied to Directorates that have a drugs spend	R	Month 1	Green	1	5
F&T01b	1% Drugs Target applied to Directorates that have a drugs spend	R	Month 1	Green	5	21
F&T01c	1% Drugs Target applied to Directorates that have a drugs spend	R	Month 1	Green	16	70
F&T01d	1% Drugs Target applied to Directorates that have a drugs spend	R	Month 1	Green	1	5
F&T01e	1% Drugs Target applied to Directorates that have a drugs spend	R	Month 1	Green	6	14
F&T02a	Nursing Streamliner Savings	R	Month 1	Green	0	44
F&T02b	Nursing Streamliner Savings	R	Month 1	Green	0	18
F&T02c	Nursing Streamliner Savings	R	Month 1	Green	0	18
F&T02d	Nursing Streamliner Savings	R	Month 1	Green	0	11
F&T03	8d - Deputy CD of Therapies	R	Month 1	Green	52	124
F&T04	8b - RH CaMHS Directorate Manager	NR	Month 1	Green	15	15

F&T05	8b - JT Obs & Gynae Directorate Manager	NR	Month 1	Green	7	7
F&T06	Assistant Divisonal Director - CL 2 Sessions	R	Month 1	Green	9	29
F&T07	Not replacing KO 0.76wte 8a leaves July-26	R	Month 1	Green	9	38
F&T08	EH 0.50wte 8c Consultant Nurse	R	Month 1	Green	14	63
F&T09	Dexcom Qtr 1 rebate Diabetes pump contract ended 31.12.25 agreement to continue for Qtr1	NR	Month 1	Green	15	22
F&T10	Reduction in banding 8 hours band 7 to band 6	R	Month 1	Green	2	4
F&T11	Maternity of B3 (Mon)	NR	Month 1	Green	0	5
F&T12	Maternity of B3 (Caer)	NR	Month 1	Green	1	3
F&T13	Maternity of B5 (BG)	NR	Month 1	Green	0	6
F&T14	Vacancy Newport B6	NR	Month 1	Green	14	14
F&T15	Bcg Vaccines	R	Month 1	Green	1	3
F&T16	Psychologist post 3 months	NR	Month 1	Green	10	10
F&T17	Consultant psychologist 2 months	NR	Month 1	Green	17	17
F&T18	LWAS coordinator 6 months	NR	Month 1	Green	4	6
F&T19	Hold EPU funding without using backfill	NR	Month 1	Green	5	13
F&T20	Purchased annual leave	NR	Month 1	Green	11	11
F&T21	Reduction in hours - Band 8a - 0.20 wte	R	Month 1	Green	7	16
F&T22	Reduction in hours - Stroke - Band 4 - 0.1	NR	Month 1	Green	2	4
F&T23	Career Break - RGH - Band 3	NR	Month 1	Green	5	5
F&T24	Vacancy - CYP - Band 6 - 1.00	NR	Month 1	Green	10	10
F&T25	Vacancy - RGH - Band 7 0.80	NR	Month 1	Green	10	10
F&T26	Vacancy - GUH - Band 4	NR	Month 1	Green	8	8
F&T27	Vacancy -RGH - Band 4 - 1.00 wte	NR	Month 1	Green	7	7
F&T28	Reduction in Hours - Band 6 - NHH - 0.40 wte	NR	Month 1	Green	6	6
F&T29	Vacancy - Band 6 - NHH - 0.20 wte	NR	Month 1	Green	2	9
F&T30	Band 7 physio slippage 2 months	NR	Month 1	Green	31	31
F&T31	Band 6 slippage 1 months	NR	Month 1	Green	13	13
F&T32	0.1 WTE 8b - not backfilled	NR	Month 1	Green	3	8
F&T33	Printing and Postage: drive to reduce printing and postage where possible	R	Month 1	Green	3	6
F&T34	Purchase of annual leave 2026/2027	NR	Month 1	Green	8	20
F&T35	Slippage for 2.5 Band 5 Vacancies (April - June 2026)	NR	Month 1	Green	24	24
F&T36	Staff Member left B3 - Slippage while post is going through TRAC	NR	Month 1	Green	5	5
F&T37	Hold vacancy B3	NR	Month 1	Green	6	6
F&T38	Purchase of Annual Leave/ Planned unpaid leave	NR	Month 1	Green	2	5
F&T39	Stationary - scrutinise any requests for- essential only	NR	Month 1	Green	0	1

F&T40	Cruse Bereavement reduced spend	NR	In Year	Green	14	14
F&T41	CAATT - Band 6 1.0WTE AHP vacancy	NR	Month 1	Green	5	5
F&T42	CAATT - HOLD Band 6 0.80 AHP recruitment	NR	Month 1	Green	7	7
F&T43	CAATT - purchase of annual leave	NR	Month 1	Green	1	1
F&T44	SMS - Band 7 physio slippage 2 months	NR	Month 1	Green	8	8
F&T45	SMS - Rehab Co-ordinator slippage	NR	Month 1	Green	9	9
F&T46	SMS - Assistant Psychologist post 0.5wte 3 months	NR	Month 1	Green	7	7
F&T47	Reduction in Band 3 adminsitration hours - 11hours	NR	Month 1	Green	4	10
F&T48	Vacant 0.6 wte 8a Paeds Psychology for 1 month	NR	Month 1	Green	4	4
F&T49	Vacant 0.6 8B IPBS vacancy for 2 months	NR	Month 1	Green	9	9
F&T50	Convert 0.5 8a GAS vacancy into 0.2 8B	NR	Month 1	Green	9	22
F&T51	Band 7 maternity leave starting in June	NR	Month 1	Green	4	13
F&T52	Buy back annual leave savings	NR	Month 1	Green	3	7
F&T53	1.0 wte b6 vacancy cost centre 3566	NR	Month 1	Green	26	26
F&T54	0.69 wte b4 vacancy cost centre 3572	NR	Month 1	Green	12	12
F&T55	1.0 wte b6 vacancy cost centre 3554	NR	Month 1	Green	6	6
F&T56	0.8 wte b2 vacancy cost centre 2640	NR	Month 1	Green	9	9
F&T57	0.8 wte b6 vacancy cost centre 3542	NR	Month 1	Green	17	17
F&T58	1.0 wte A&C b3 vacancy cost centre 3542	NR	Month 1	Green	9	9
F&T59	0.67 wte A&C vacancy cost centre 3542	NR	Month 1	Green	10	10
F&T60	0.21 wte b6 vacancy cost centre 3552	NR	Month 1	Green	5	5
F&T61	0.2 wte b7 vacancy cost centre 3552	NR	Month 1	Green	7	7
F&T62	20k non pay reduction due to slippage	NR	In Year	Green	8	20
F&T63	Maternity Induction of Labour product switch, Cook to Kimal	R	Month 1	Green	9	22
F&T64	Paracetamol switch – providing oral rather than IV paracetamol has a cost saving of 48K	R	Month 1	Green	0	0
F&T65	accomodation costs	NR	Month 1	Green	0	0
F&T66	storage containers	NR	Month 1	Green	1	3
F&T67	Band 4 AP post	NR	Month 1	Green	16	39
F&T68	Band 4 AP post	NR	Month 1	Green	16	39
F&T69	Band 3 admin post	NR	Month 1	Green	14	34
F&T70	Ethyl chloride replacement	R	Month 1	Green	7	17
F&T71	Admin saving Band 4 to Band 3	R	Month 1	Green	1	2
F&T72	SLA - Provision of Ultrasound Quality Assurance Services	R	Month 1	Green	(0)	(0)
F&T73	Continue to hold 3.75 Acute Snr Nurse's hours	R	Month 1	Green	3	7
F&T74	Further reduction in Acute Snr Nurse's hours by 3.75 from 5.4.26 (cost centre 2616)	R	Month 1	Green	3	8

F&T75	Hold 3 hours arising from partial retirement of Band 4 med secretary	R	Month 1	Green	1	3
F&T76	Hold 1 Clinical Director session	R	Month 1	Green	6	15
F&T77	Hold 1 of 4 sessions relinquished by 2 Neonatologists	R	Month 1	Green	7	16
F&T78	Hold Diabetes admin hours	R	Month 1	Green	1	1
F&T79	Cost avoidance: Annual maintenance contract for new echo machine St Woolos CYP OP from 30 March 2026, avoided since included in capital cost.	NR	Month 1	Green	0	1
F&T80	TYPPS Cessation of Service	R	In Year	Green	16	41
F&T81	Cost avoidance: council tax @ £2505 pa and TV license @ £180 for No. 2 Mitchell Close.	R	Month 1	Green	1	3
F&T82	Cost avoidance: restrict Twinkle license to 7 concurrent users	R	Month 1	Green	2	2
F&T83	Vacancy slippage B5 Orthotist X 2	NR	In Year	Green	18	27
F&T84	MSK Podiatry Vacancy Slippage	NR	In Year	Green	12	12
F&T85	Vacancy Slippage B5 Core Podiatry 6/12 vacancy slippage	NR	In Year	Green	15	18
F&T86	Vacancy slippage B5 Orthotist X 2	NR	In Year	Green	7	16
F&T87	Hold 3.75 hours weekly arising from partial retirement Band 7 Prac. Educator	NR	In Year	Green	0	3
F&T88	Hold 2 of 4 sessions relinquished by Consultant general Paediatrician	NR	In Year	Green	17	17
F&T89	Hold 1 session relinquished by Consultant general paediatrician	NR	In Year	Green	7	7
F&T90	Continue to hold 1.07 Band 2 ward clerk vacancy on Paediatric Unit (cost centre 2633/2634)	NR	In Year	Green	15	21
F&T91	Cabotegravir PrEP pause: this then injectable PrEP that has been NICE approved.It was not funded. Cabotegravir injectable PrEP is HIV prevention for those who cannot take oral medication. Halting its provision will mean detrimental impact on those who are unable to take the standard cheaper HIV prevention medication Truvada which could lead to people contracting HIV. If we don't deliver Cabotegravir PrEP for those eligible we will be going again the direction of the Health Minister.	NR	In Year	Green	10	24
F&T93	Secure generic supply of Desogestrel: generic product at £3.25/pack.	R	In Year	Green	12	30
F&T94	Delayed recruitment to vacant consultant sessions by 7 months	NR	In Year	Green	0	30
F&T95	Hold vacancy B3	NR	In Year	Green	3	3
F&T96	Hold vacancy B5	NR	In Year	Green	4	4
F&T97	Hold Vacancy - Current Band 4 who is graduating and has secured a Band 5 post elsewhere	NR	In Year	Green	1	1
F&T98	Mobile phones - aim to further reduce use within service	R	In Year	Green	0	0
F&T99	Travel- continue to scrutinse and reduce travel within service	R	In Year	Green	0	0
F&T100	Cabotegravir PrEP pause: injectable PrEP that has been NICE approved It was not funded.	NR	In Year	Green	8	26
F&T101	ELT - Saving on Band 7 salary if appointed 01/07/2026	NR	In Year	Green	15	15

F&T102	COT - Not backfilling 0.6wte Band 6 OT until June then backfilling with BOS 0.5 WTE	NR	In Year	Green	9	10
F&T103	ISET - Band 3 HCSW reduced from 1.0WTE to 0.6WTE	R	In Year	Green	6	13
F&T104	ISET - reduction in lease cars from 3 to 2	R	In Year	Green	0	4
F&T105	Ty -Fforest - 0.5 wte Band 4 delayed starting until July	NR	In Year	Green	4	4
F&T106	Primary Care - Delayed Band 5 OT Rotation post not starting until July	NR	In Year	Green	11	11
F&T107	CAMHS CHC 0.5 WTE Band 4 Admin	NR	In Year	Green	8	19
F&T108	CAHMS CMHT Turnover Slippage TW	NR	In Year	Green	4	4
F&T109	50% pay for DC	NR	In Year	Green	12	21
F&T110	Maternity Leave - HES (April - June)	NR	In Year	Green	4	4
F&T111	Band 5 0.8 WTE - Slippage while post goes through Trac	NR	In Year	Green	6	6
F&T112	Band 4 1.0 WTE - Slippage while post goes through Trac	NR	In Year	Green	2	2
F&T113	Maternity Leave - HES(April - June)	NR	In Year	Green	2	2
F&T114	Feasability Project PNMH	NR	In Year	Green	13	30
F&T115	Feasability Project PNMH	NR	In Year	Green	15	34
F&T116	Band 3 Sec to band 2 x 1 so far, onging	R	In Year	Green	1	2
F&T117	Hold band 4 position	NR	In Year	Green	17	29
F&T118	3 x dropped sessions replaced by AHPs	R	In Year	Green	24	58
F&T119	Invoice received 220042577 - Package came in less than expected due to this being a package of care that flexes	NR	In Year	Green	0	0
F&T120	Invoice received 220040604 - Package came in less than expected due to this being a package of care that flexes	NR	In Year	Green	4	4
F&T121	Invoice number 220040609 - Package came in less than expected due to this being a package of care that flexes	NR	In Year	Green	0	0
F&T122	Inv received 70255390 - Package came in less than expected due to this being a package of care that flexes	NR	In Year	Green	8	8
F&T123	Inv received 220042509 - Package came in less than expected due to this being a package of care that flexes	NR	In Year	Green	1	1
F&T124	Invoice received 220040606 - Package came in less than expected due to this being a package of care that flexes	NR	In Year	Green	21	21
F&T125	Inv received 20040613 - Package came in less than expected due to this being a package of care that flexes	NR	In Year	Green	0	0
F&T126	1.0 wte b6 vacancy cost centre 3566 (post no. 251)	NR	In Year	Green	5	10
F&T127	1.0 wte b6 vacancy cost centre 3566 (post no. 245)	NR	In Year	Green	5	10
F&T128	0.5 wte b7 vacancy cost centre 3542 (post no. 623)	NR	In Year	Green	12	15
F&T129	1.0 wte b7 vacancy cost centre 3570 (post no. 357)	NR	In Year	Green	13	19
F&T130	0.23 wte b7 vacancy cost centre 3543 (post no. 331)	NR	In Year	Green	6	7

F&T131	0.19 wte b7 vacancy cost centre 3570 (post no. 359)	NR	In Year	Green	5	7
F&T132	LAC nurse LTS	NR	In Year	Green	8	8
F&T133	Podiatry Support Worker Vacancy Slippage	NR	In Year	Green	4	6
F&T134	B3 1.80 wte delayed Recruitment Med Secs cost centre 1703	NR	In Year	Green	23	23
F&T135	B4 0.95 wte delayed Recruitment Med Secs cost centre 1703	NR	In Year	Green	17	17
F&T136	B3 0.71 wte delayed Recruitment Med Secs cost centre 3164	NR	In Year	Green	11	11
F&T137	B3 0.80 wte delayed Recruitment Med Secs cost centre 3169	NR	In Year	Green	12	12
F&T138	Valaciclovir suppressive HSV treatment	R	In Year	Green	1	8
F&T139	Home Care Additional 6 patients above targets	R	In Year	Green	9	21
F&T140	Staff Turnover B7 1.0 WTE	NR	In Year	Green	6	10
F&T141	Dropped 17 hours in Child Health Admin B3 from April	NR	In Year	Green	7	16
F&T142	Reduction in Packages of Care that Flex	NR	In Year	Green	41	41
F&T143	Continue to hold 1 session relinquished by Consultant Community Paediatrician Dr MH as partial retirement from ? May 2024 (cost centre 3417)	NR	In Year	Green	5	5
F&T144	GWICES review	R	In Year	Green	0	21
F&T145	Band 7 0.6 WTE psych post- slippage whilst post goes through TRAC	NR	In Year	Green	2	2
F&T146	Band 7 0.6 WTE paed post- Post holder retiring, unable to recruit	NR	In Year	Green	2	2
F&T147	Caerphilly Generic HV B6 unfilled vacancies (5 months from Apr)	NR	In Year	Green	46	46
F&T148	Pelvic Power Partnerships: Engaging marginalised community groups in pelvic health services R&D (2 year only)	R	In Year	Green	0	8
F&T149	Hold 2 of 4 sessions relinquished by Consultant general Paediatrician- relates to 4 sessions	NR	In Year	Green	7	30
F&T150	Medicines Waste SBAR	NR	In Year	Amber	0	5
F&T151	Pelvic Power Partnerships: Engaging marginalised community groups in pelvic health services Yr1 £7,634 Yr2 £8,169	R	In Year	Green	0	8
F&T152	Band 8a 0.6 WTE Vacancy delayed Recruitment	NR	In Year	Green	21	25
F&T153	Band 7 1 WTE Vacancy Delayed Recruitment	NR	In Year	Green	16	16
F&T154	RM Delayed Backfill 8a	NR	In Year	Green	12	12
F&T155	Workforce banding optimisation	R	In Year	Green	1	5
F&T156	Delayed Backfill B7	NR	In Year	Green	6	18
F&T157	Delayed Backfill B7	NR	In Year	Green	12	24
F&T158	Cancelation of Mobile phone SIMs 69 numbers	R	In Year	Green	1	6
F&T159	Reduction of Admin band 3 by 0.2WTE not filling into	R	In Year	Green	3	7
F&T160	Release of Prior Year Accrual	NR	In Year	Green	4	4
F&T161	Dexcom G7 Saving	NR	In Year	Green	37	37

F&T162	YYF POD Midwife led unit	R	In Year	Green	0	17
F&T163	B2 1 wte delayed Recruitment Med Secs cost centre 1703	NR	In Year	Green	6	6
F&T164	B2 delayed recruitment Cc3164	NR	In Year	Green	1	1
F&T165	B5 Incremental slippage Cc3169	NR	In Year	Green	1	1
F&T166	B2 delayed recruitment Cc8573	NR	In Year	Green	2	2
		Minimum Savings Target		**3,028**	**1,350**	**2,370**
		Distance from target (over)/under		**658**		

Estates and Facilities

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
EAF03	RE:FIT	R	Month 1	Green	116	522
EAF04	Gas pricing	R	Month 1	Green	432	1,036
EAF05	St Woolos Building Rates Rebate	NR	Month 1	Green	56	112
EAF06	St Woolos ongoing rateable value change	R	Month 1	Green	20	40
EAF07	GUH Rateable value reduction	R	Month 1	Green	89	179
EAF08	Whistl Contract Review	NR	Month 1	Green	92	92
EAF09	Mattress Spend Plan	NR	In Year	Green	57	250
EAF10	GUH Rates	NR	In Year	Green	38	307
EAF11	STW Postage Spend Review	NR	In Year	Green	168	168
EAF12	Mendelgief Road Rates Rebate	NR	In Year	Green	10	35
EAF13	Vending Machine Royalties	R	In Year	Green	71	71
EAF14	SRU Rates	NR	In Year	Green	15	87
		Minimum Savings Target		**1,959**	**1,164**	**2,899**
		Distance from target (over)/under		**(941)**		

Corporate

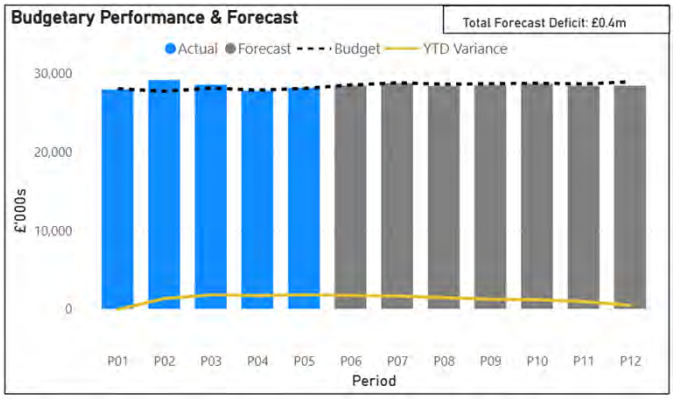
Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
CORP-10	Corporate Pay Savings - 2%	NR	Month 1	Green	12	28
CORP-20	WAST Rebate	NR	In Year	Green	0	100
CORP-31	Bed Rationalisation	R	In Year	Amber	0	1,600
CORP02	2% Corporate Pay Savings	NR	Month 1	Green	77	185
CORP18	VAT Reclaim	NR	In Year	Green	76	76
CORP21	Study Leave	NR	In Year	Green	0	3,527
CORP22	VAT Reclaim	NR	In Year	Green	0	124
CORP024	Reduced Non-pay Spend	NR	In Year	Green	0	89
CORP025	Holding Vacancies	NR	In Year	Green	0	150
CORP12	Corporate 2% Pay Savings	R	Month 1	Green	40	179
CORP26	Legal fees (Review of Ongoing Tribunals)	NR	In Year	Green	0	200
CORP27	Review of Advertising Costs	NR	In Year	Green	0	30
CORP04	Corporate Pay Savings 2%	R	Month 1	Green	38	172
CORP08	Corporate Pay Savings 2%	NR	Month 1	Green	34	82
CORP06	Corporate 2% Pay Savings	NR	Month 1	Green	30	71
CORP14	Band 9 secondment (GM)	NR	In Year	Green	70	168
CORP15	Band 9 secondment (NM)	NR	In Year	Green	39	130
CORP07	Corporate Pay Savings 2%	R	Month 1	Green	218	524
CORP29	Hold vacancies in Programmes	NR	In Year	Green	0	112
CORP30	Hold spend against training budget	NR	In Year	Green	0	15
CORP09	Corporate 2% Pay Savings	NR	Month 1	Green	0	0
CORP23	Held 8d vacancy	NR	In Year	Green	0	20
Corp-01	Recruited Band 7 Senior Project Manager (FTC 20 months) to procure the new Risk Managerment System. Recruited from B8b vacancy	NR	Month 1	Green	11	27
CORP05	Corporate 2% Pay Savings	NR	Month 1	Green	10	21
CORP03	Corporate Pay Savings 2%	NR	Month 1	Green	38	91
CORP16	Caerphilly LA review	NR	In Year	Green	96	96
CORP19	Health Protection review	NR	In Year	Green	0	59
CORP28	Hold vancancies	NR	In Year	Green	0	177
CORP11	Corporate 2% Pay Savings	NR	Month 1	Green	28	125
CORP17	IPFR AB Review	NR	In Year	Green	198	198

Minimum Savings Target	**2,149**	**1,016**	**8,375**
Distance from target (over)/under	**(6,226)**		

Contracting and Commissioning

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year
					Achieved £'000	Forecast £'000
CC01	Cwm Taf Commissioning Expenditure LTA	R	Month 1	Green	177	425
CC02	Cwm Taf Provider Income LTA	R	Month 1	Green	94	225
CC03	Outsource anticipated favourable position	NR	In Year	Green	0	650
CC04	Favourable settlement of NHS Gloucester contract	NR	In Year	Green	0	100
CC05	Reduced Drug expenditure at Velindre CC	R	In Year	Green	0	100
CC06	Provision release for Ophthalmology complications	NR	In Year	Green	0	450
		Minimum Savings Target		**2,533**	**271**	**1,950**
		Distance from target (over)/under		**583**		

Divisional analysis – Primary Care & Community



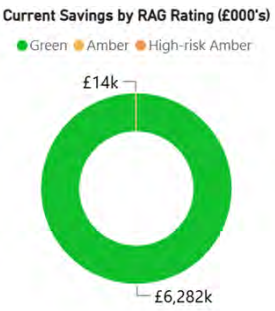
Key drivers of forecast deficit:

- £4.8m Community Nursing and Medic variable pay costs (including, sickness, surge beds and COTE agency)
- £1.1m GPs in OOH's –annual leave uplift for sessional GP's
- £0.3m Optometry contract growth
- (£2.1m) GMS deep-dive deep dive into 25/26 and impact on 26/27 forecast - mainly supplementary services and sustainability support
- (£1.1m) Hospital pharmacy vacancies
- (£1.0m) NR Savings from contract handbacks
- (£0.6m) Direct Delivery Vaccines
- (£0.3m) Community Pharmacy Contract
- (£0.6m) Other net variances

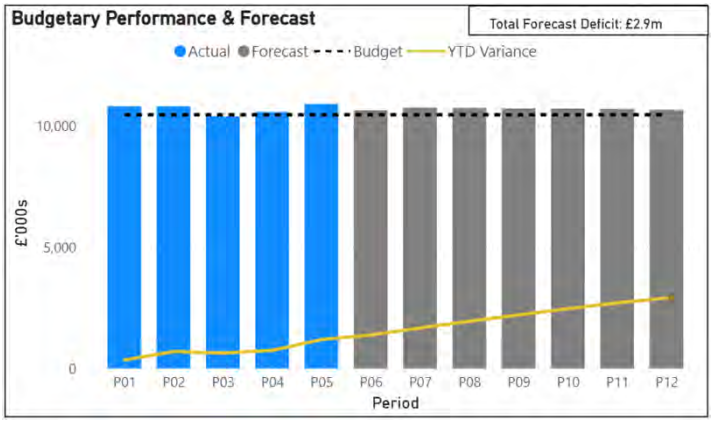
DIVISIONAL EXPENDITURE/FORECAST RUN-RATE	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(6,275)	(125)	(3,347)	(3,565)	(3,263)	(3,226)	(3,169)	(3,273)	(3,161)	(3,168)	(3,236)	(3,207)	**(39,016)**
Pay	10,360	10,470	10,601	10,428	10,285	10,530	10,449	10,462	10,453	10,569	10,536	10,435	**125,578**
Non pay	23,865	18,788	21,311	20,914	21,143	21,147	21,448	21,218	21,191	21,272	21,113	21,207	**254,617**
Net Expenditure	**27,951**	**29,134**	**28,565**	**27,777**	**28,165**	**28,451**	**28,727**	**28,407**	**28,482**	**28,673**	**28,413**	**28,435**	**341,179**
Budget	**28,042**	**27,720**	**28,115**	**27,866**	**28,074**	**28,526**	**28,791**	**28,620**	**28,678**	**28,740**	**28,648**	**28,919**	**340,740**
Variance	**(92)**	**1,414**	**450**	**(89)**	**91**	**(76)**	**(64)**	**(213)**	**(196)**	**(67)**	**(235)**	**(484)**	**439**

Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Efficiency (Outpatients Programme)	1	0	0	0	0	0	0	0	
Estates Rationalisation	3	42	40	-3	118	118	0	118	
Medicines Management	2	0	0	0	14	14	0	0	14
Non-Pay	18	727	835	108	5,284	5,364	80	703	4,661
SLAs	1	0	0	0	6	6	0	6	
Workforce	16	145	121	-25	875	795	-80	744	51
Total	**41**	**915**	**995**	**80**	**6,296**	**6,296**	**0**	**1,570**	**4,726**



Divisional analysis – Prescribing



Key drivers of forecast deficit:

The forecast outturn is £2.901m, which is £1.264m favourable to the planned position of £4.165m. The favourable variance is primarily driven by a £0.200m non-recurrent reduction in drug spend and £1.047m of additional savings.

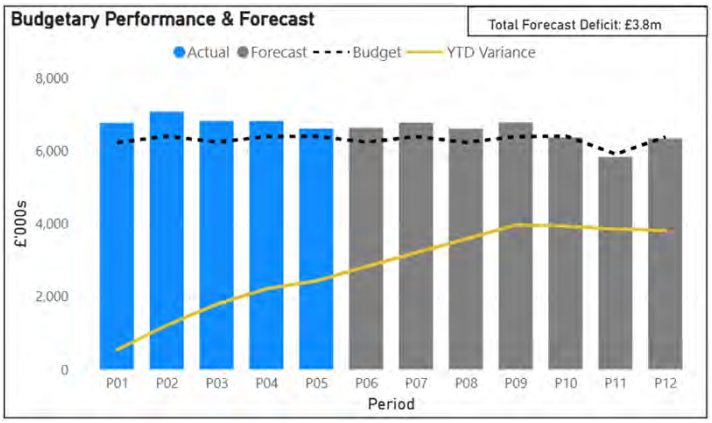
Full-Year Forecast Assumptions:
Growth based on 0% (last month: 1.24%)
Average item price £8.18 (last month: £8.08)

DIVISIONAL EXPENDITURE/FORECAST RUN-RATE	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(330)	(330)	(355)	(603)	(385)	(385)	(381)	(383)	(383)	(372)	(373)	(375)	**(4,655)**
Pay	26	27	26	26	28	30	30	30	30	30	30	30	**341**
Non pay	11,112	11,112	10,732	11,150	11,267	11,002	11,107	11,092	11,077	11,062	11,047	11,007	**132,769**
Net Expenditure	**10,808**	**10,809**	**10,404**	**10,573**	**10,910**	**10,647**	**10,756**	**10,739**	**10,724**	**10,720**	**10,704**	**10,662**	**128,455**
Budget	**10,463**	**10,463**	**10,463**	**10,463**	**10,463**	**10,463**	**10,463**	**10,463**	**10,463**	**10,463**	**10,463**	**10,463**	**125,553**
Variance	**346**	**346**	**(59)**	**110**	**447**	**184**	**293**	**276**	**261**	**257**	**241**	**199**	**2,901**

Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Medicines Management	19	1,157	979	-178	4,047	4,048	1	3,176	872
Workforce	1	61	61	0	149	149	0		149
Total	**20**	**1,218**	**1,040**	**-178**	**4,196**	**4,197**	**1**	**3,176**	**1,021**

Divisional analysis – Complex Care



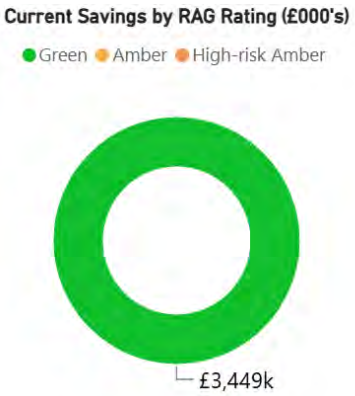
Key drivers of forecast deficit:

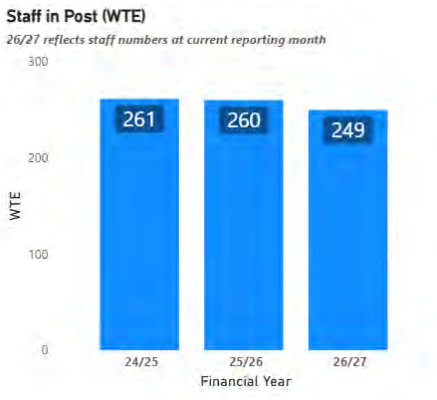
- £3.9m CHC/DTA/FNC *(£2.7m unfunded fee uplifts included in forecast)*
- £0.1m IRP overspend
- (£0.2m) CAHT and central underspends

DIVISIONAL EXPENDITURE/FORECAST RUN-RATE	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(10)	(8)	(9)	(9)	(12)	(8)	(6)	(6)	(6)	(6)	(6)	(6)	**(92)**
Pay	1,203	1,327	1,232	1,190	1,229	1,237	1,206	1,216	1,211	1,234	1,225	1,203	**14,714**
Non pay	5,582	5,766	5,602	5,644	5,402	5,411	5,581	5,404	5,583	5,148	4,617	5,150	**64,889**
Net Expenditure	**6,775**	**7,084**	**6,826**	**6,825**	**6,619**	**6,640**	**6,781**	**6,614**	**6,788**	**6,377**	**5,836**	**6,347**	**79,512**
Budget	**6,236**	**6,409**	**6,247**	**6,400**	**6,406**	**6,244**	**6,398**	**6,239**	**6,398**	**6,413**	**5,916**	**6,390**	**75,697**
Variance	**540**	**676**	**578**	**425**	**213**	**396**	**383**	**375**	**390**	**(36)**	**(81)**	**(43)**	**3,814**

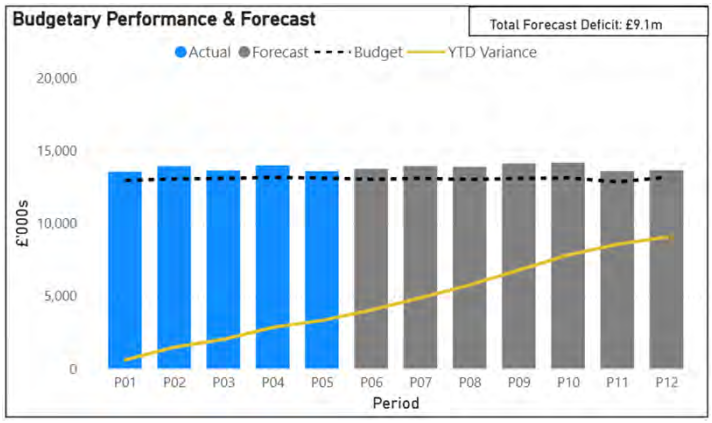
Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Continuing Health Care	9	212	438	226	3,449	3,449	0	24	3,425
Workforce	2	0	0	0	0	0	0	0	
Total	**11**	**212**	**438**	**226**	**3,449**	**3,449**	**0**	**24**	**3,425**





Divisional analysis – Mental Health & Learning Disabilities



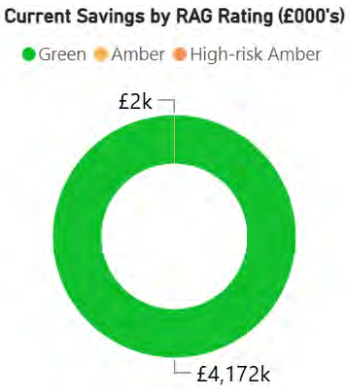
Key drivers of forecast deficit:

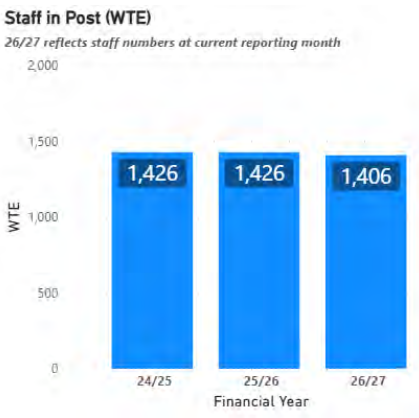
- £5.0m overspend commissioned placements (£3.0 fee uplifts, £2.9m growth)
- £5.1m overspend on inpatient wards within Older Adult, Adult & Learning Disabilities, High Observations Driving the position
- £0.8m Medical Staffing
- £0.4m Drugs
- (£2.2m) Vacancies across Community Teams & Older Adult Psychology.

DIVISIONAL EXPENDITURE/FORECAST RUN-RATE	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(210)	(183)	(341)	(303)	(192)	(185)	(266)	(182)	(182)	(266)	(182)	(276)	**(2,767)**
Pay	7,791	7,811	7,943	7,904	7,795	8,014	7,982	8,026	8,070	8,060	7,979	7,969	**95,345**
Non pay	5,978	6,307	6,035	6,394	5,993	5,925	6,234	6,054	6,237	6,375	5,803	5,973	**73,307**
Net Expenditure	**13,560**	**13,936**	**13,636**	**13,995**	**13,596**	**13,754**	**13,949**	**13,899**	**14,125**	**14,169**	**13,600**	**13,667**	**165,885**
Budget	**12,961**	**13,056**	**13,095**	**13,172**	**13,122**	**13,035**	**13,099**	**13,021**	**13,098**	**13,133**	**12,854**	**13,180**	**156,827**
Variance	**599**	**880**	**541**	**823**	**474**	**718**	**850**	**878**	**1,028**	**1,036**	**745**	**487**	**9,059**

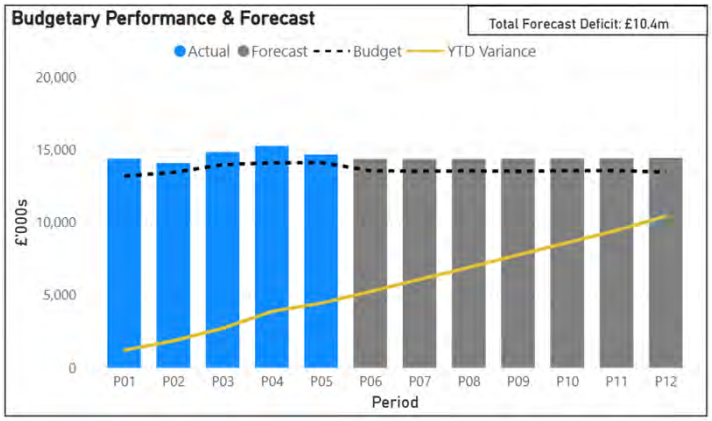
Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Continuing Health Care	13	940	975	35	3,552	3,318	-234	1,964	1,354
Efficiency (Outpatients Programme)	1	0	0	0	0	0	0	0	
Medicines Management	1		0	0	2	2	0	2	
Mental Health & LD Site Transformation	2	0	148	148	453	453	0	453	
SLAs	1	22	22	0	53	53	0	53	
Workforce	8	141	141	0	349	349	0	349	
Total	**26**	**1,103**	**1,286**	**183**	**4,409**	**4,174**	**-234**	**2,820**	**1,354**





Divisional analysis – Surgery



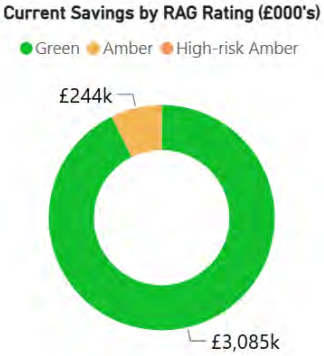
Key drivers of forecast deficit:

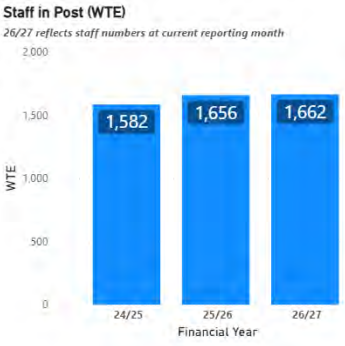
- £3.6m Drugs
- £2.2m Medical Variable Pay
- £1.2m Urgent/Cancer
- £1.2m Unfunded Posts
- £0.5m Non-pay
- £0.4m Breast Unit
- £0.3m Robot Consumables Costs
- £0.2m Our Next Patient
- £0.2m Glaucoma Hub
- £0.2m Nursing Variable Pay
- £0.1m Robot Maintenance

DIVISIONAL EXPENDITURE/FORECAST RUN-RATE	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(710)	(641)	(643)	(799)	(726)	(731)	(764)	(764)	(764)	(764)	(764)	(765)	**(8,837)**
Pay	10,552	10,616	11,201	11,082	10,984	10,667	10,699	10,707	10,720	10,736	10,737	10,767	**129,468**
Non pay	4,554	4,121	4,287	4,994	4,428	4,440	4,432	4,439	4,439	4,439	4,439	4,451	**53,464**
Net Expenditure	**14,396**	**14,095**	**14,845**	**15,278**	**14,687**	**14,377**	**14,367**	**14,382**	**14,395**	**14,411**	**14,412**	**14,452**	**174,095**
Budget	**13,192**	**13,451**	**13,979**	**14,114**	**14,125**	**13,567**	**13,534**	**13,558**	**13,528**	**13,567**	**13,568**	**13,474**	**163,658**
Variance	**1,204**	**644**	**866**	**1,164**	**562**	**810**	**833**	**824**	**866**	**844**	**844**	**979**	**10,438**

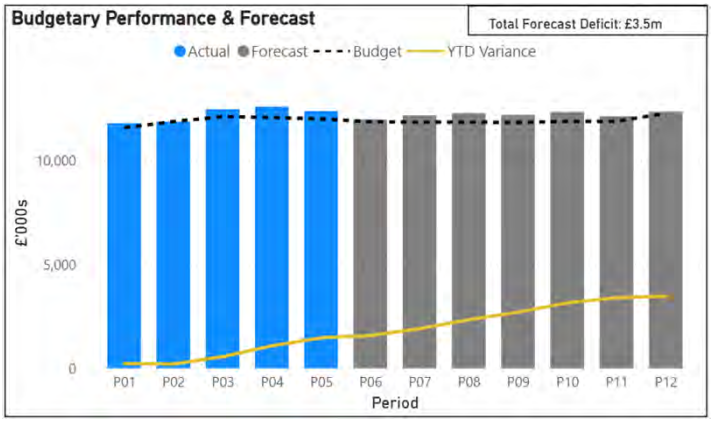
Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Efficiency (Outpatients Programme)	1	0	0	0	0	0	0	0	
Evidence Based Interventions	1	0	0	0	0	0	0	0	
Medicines Management	12	1,065	947	-118	2,805	2,341	-464	2,341	
Non-Pay	26	105	85	-21	360	360	0	283	77
Therapies Service Review	5	19	11	-8	116	90	-26	90	0
Workforce	26	295	243	-52	537	537	0	186	351
Total	**71**	**1,484**	**1,285**	**-199**	**3,818**	**3,328**	**-490**	**2,900**	**428**





Divisional analysis – Clinical Support Services



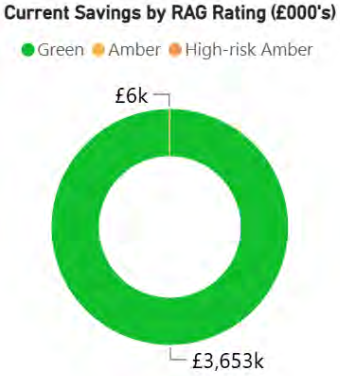
Key drivers of forecast deficit:

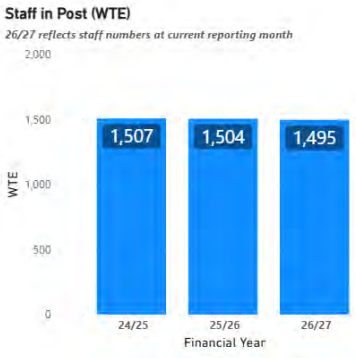
- £1.0m National & Diagnostic Digital Implementation Costs
- £0.8m Performance related
  - £0.2m Planned Care
  - £0.3m 8wk Diagnostics
  - £0.3m Additional Cancer
- £1.7m Operational costs
  - £0.9m Theatres Non Pay
  - £0.8m Anaesthetics
  - £0.6m Critical Care
  - (£0.6m) Diagnostics

DIVISIONAL EXPENDITURE/FORECAST RUN-RATE	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(449)	(555)	(410)	(520)	(517)	(497)	(503)	(497)	(497)	(497)	(497)	(497)	**(5,938)**
Pay	9,422	9,519	9,755	9,696	9,727	9,496	9,488	9,594	9,591	9,621	9,540	9,556	**115,005**
Non pay	2,827	2,897	3,126	3,417	3,171	2,980	3,188	3,184	3,099	3,211	3,092	3,291	**37,482**
Net Expenditure	**11,800**	**11,860**	**12,472**	**12,593**	**12,381**	**11,979**	**12,172**	**12,280**	**12,193**	**12,334**	**12,135**	**12,350**	**146,549**
Budget	**11,580**	**11,879**	**12,113**	**12,072**	**12,000**	**11,865**	**11,840**	**11,851**	**11,829**	**11,887**	**11,888**	**12,271**	**143,075**
Variance	**220**	**(19)**	**359**	**520**	**380**	**113**	**332**	**429**	**365**	**447**	**246**	**80**	**3,474**

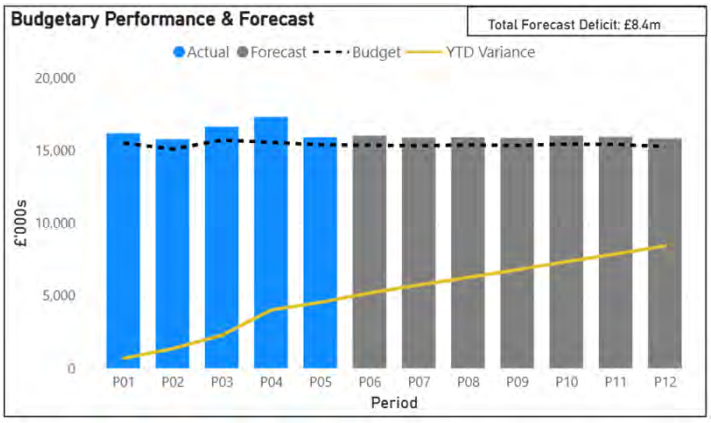
Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Efficiency (Outpatients Programme)	1	0	0	0	0	0	0	0	
Medicines Management	2	5	7	3	17	20	3	20	
Non-Pay	39	276	836	560	1,892	1,872	-20	724	1,148
SLAs	6	343	233	-109	846	846	0	167	679
Theatre Capacity Consolidation	1	0	0	0	0	0	0	0	
Workforce	23	264	315	51	799	920	121	597	322
Total	**72**	**888**	**1,392**	**504**	**3,555**	**3,658**	**103**	**1,508**	**2,150**





Divisional analysis – Medicine



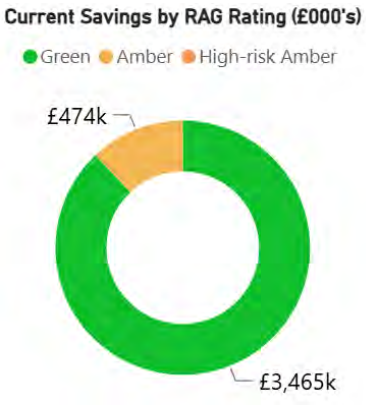
Key drivers of forecast deficit:

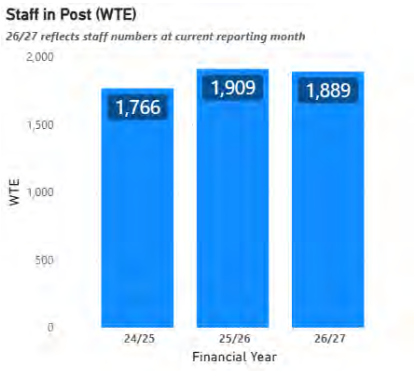
- £3.3m Nursing variable pay (enh. care, vacancies, sickness)
- £1.0m Drugs growth & activity
- £0.9m Additional Resident Doctors (compliant rotas)
- £0.9m M&SE and Maintenance contracts
- £0.7m ONP / H45/ Critical Incident (Apr -Mar 27)
- £0.5m Nephrology drug
- £0.3m Diab. Business Case staffing
- £0.3m, RTT 8wk diagnostic Gastro activity Apr-Jul
- £0.3m other net variances

DIVISIONAL EXPENDITURE/FORECAST RUN-RATE													
	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(287)	(261)	(281)	(367)	(319)	(282)	(282)	(282)	(282)	(282)	(282)	(282)	**(3,488)**
Pay	12,606	12,612	13,142	13,305	12,853	12,679	12,651	12,707	12,674	12,752	12,726	12,625	**153,332**
Non pay	3,879	3,431	3,781	4,382	3,381	3,625	3,523	3,491	3,485	3,547	3,512	3,497	**43,535**
Net Expenditure	**16,198**	**15,781**	**16,643**	**17,320**	**15,916**	**16,022**	**15,893**	**15,917**	**15,878**	**16,017**	**15,956**	**15,840**	**193,379**
Budget	**15,523**	**15,105**	**15,721**	**15,576**	**15,397**	**15,374**	**15,337**	**15,393**	**15,358**	**15,452**	**15,421**	**15,289**	**184,944**
Variance	**675**	**677**	**922**	**1,744**	**519**	**648**	**556**	**524**	**520**	**565**	**535**	**551**	**8,436**

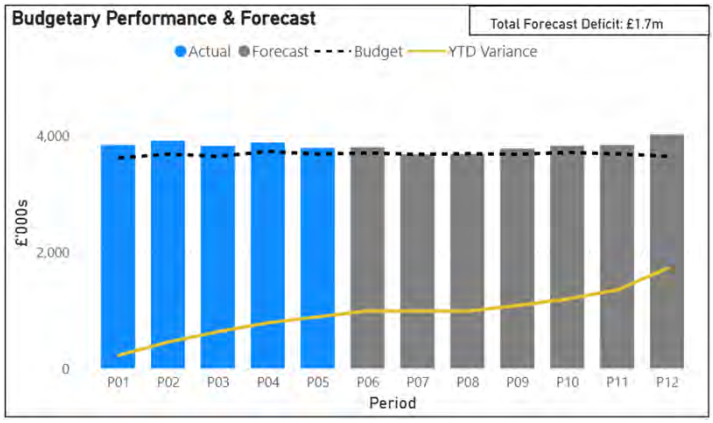
Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Bed Capacity Optimisation	2	0	0	0	0	0	0	0	
Efficiency (Outpatients Programme)	1	0	0	0	0	0	0	0	
Medicines Management	14	641	574	-67	2,214	2,551	337	1,797	754
Non-Pay	5	57	99	41	237	350	113	226	124
Workforce	13	123	65	-58	1,095	1,037	-58	921	116
Total	**35**	**822**	**738**	**-84**	**3,546**	**3,938**	**392**	**2,944**	**994**





Divisional analysis – Urgent Care



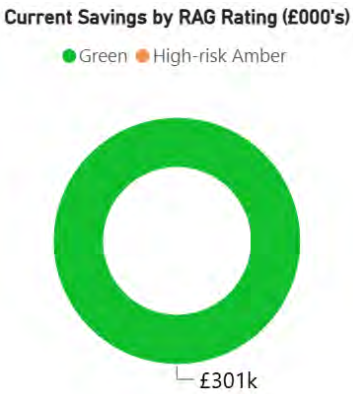
Key drivers of forecast deficit:

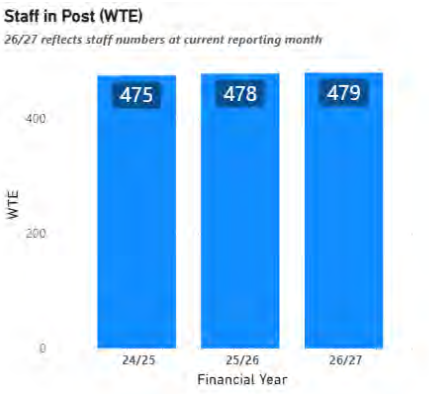
- £0.7m ED Interim Clinical Model
- £0.6m Paeds/CEAU Pilot (4 months)
- £0.5m 45-min ambulance handover (12 months)
- £0.3m SDEC Boarding & Triage Nurse Cover (12 months)

DIVISIONAL EXPENDITURE/FORECAST RUN-RATE	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(187)	(165)	(195)	(135)	(142)	(178)	(178)	(178)	(178)	(188)	(188)	(188)	**(2,100)**
Pay	3,758	3,830	3,762	3,753	3,684	3,722	3,589	3,593	3,686	3,744	3,759	3,937	**44,816**
Non pay	269	246	257	263	246	258	270	270	270	270	270	270	**3,159**
Net Expenditure	**3,840**	**3,911**	**3,824**	**3,880**	**3,787**	**3,802**	**3,681**	**3,685**	**3,778**	**3,826**	**3,841**	**4,019**	**45,874**
Budget	**3,618**	**3,681**	**3,645**	**3,728**	**3,685**	**3,702**	**3,680**	**3,691**	**3,680**	**3,713**	**3,687**	**3,645**	**44,154**
Variance	**222**	**230**	**179**	**152**	**103**	**100**	**1**	**(5)**	**98**	**113**	**154**	**373**	**1,720**

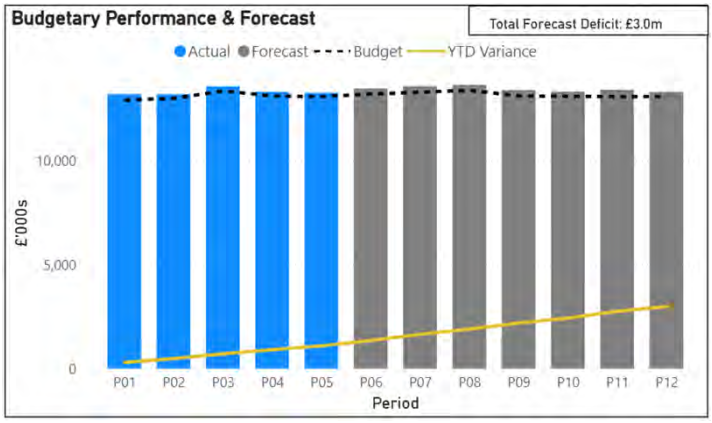
Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Medicines Management	1		0	0	1	1	0	1	
Non-Pay	1	4	7	3	8	10	3	10	
Workforce	9	31	21	-10	319	290	-29	238	52
Total	**11**	**35**	**28**	**-7**	**328**	**301**	**-27**	**249**	**52**





Divisional analysis – Family & Therapies



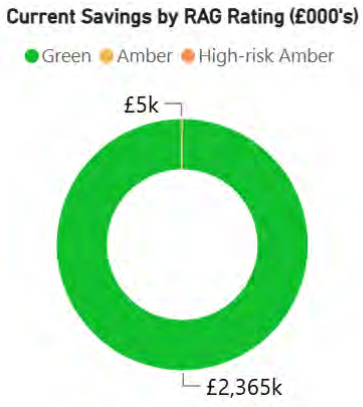
Key drivers of forecast deficit:

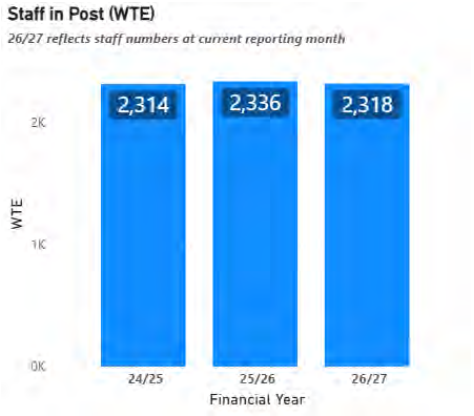
- £1.9m Medical sustainability/workforce pressures in Gynae, Paediatrics & Neonates
- £1.4m Maternity sustainability /workforce pressures associated with high levels of maternity and sickness leave coupled with high C-Section rate 48.8% (Avg 25-26 41%) driving non-pay.
- £0.5m CHC Demand
- (£0.8m) SARC and other offsetting variances

DIVISIONAL EXPENDITURE/FORECAST RUN-RATE													
	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(782)	(805)	(838)	(908)	(797)	(794)	(797)	(798)	(798)	(795)	(795)	(803)	**(9,712)**
Pay	12,362	12,275	12,512	12,403	12,442	12,459	12,460	12,444	12,453	12,439	12,525	12,426	**149,201**
Non pay	1,616	1,723	1,906	1,816	1,619	1,808	1,924	1,999	1,743	1,684	1,685	1,684	**21,206**
Net Expenditure	**13,196**	**13,193**	**13,579**	**13,311**	**13,264**	**13,473**	**13,587**	**13,644**	**13,398**	**13,328**	**13,415**	**13,307**	**160,695**
Budget	**12,908**	**12,999**	**13,355**	**13,107**	**13,083**	**13,211**	**13,293**	**13,388**	**13,112**	**13,093**	**13,081**	**13,085**	**157,715**
Variance	**287**	**194**	**224**	**204**	**181**	**262**	**294**	**256**	**286**	**235**	**334**	**222**	**2,980**

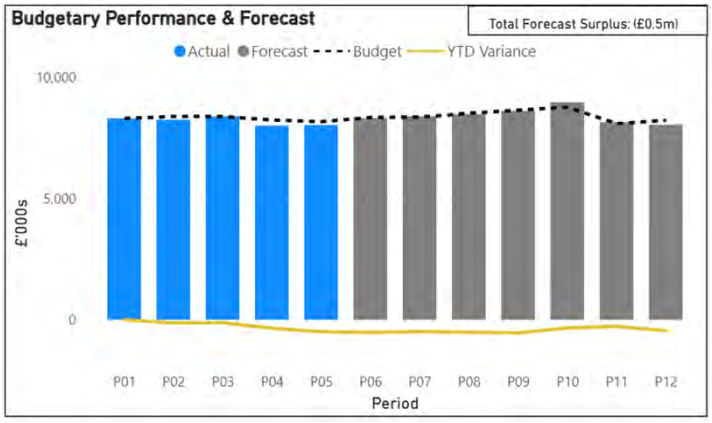
Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Continuing Health Care	8	76	76	0	76	76	0		76
Efficiency (Outpatients Programme)	1	0	0	0	0	0	0	0	
Estates Rationalisation	1	0	0	0	0	0	0	0	
Medicines Management	14	90	77	-13	276	249	-27	194	55
Non-Pay	13	92	68	-24	171	127	-45	63	64
SLAs	4	38	34	-4	68	59	-9	41	18
Therapies Service Review	72	566	588	22	780	802	22	148	654
Workforce	67	456	506	50	998	1,057	59	386	671
Total	**180**	**1,319**	**1,350**	**31**	**2,370**	**2,370**	**1**	**832**	**1,539**





Divisional analysis – Estates & Facilities



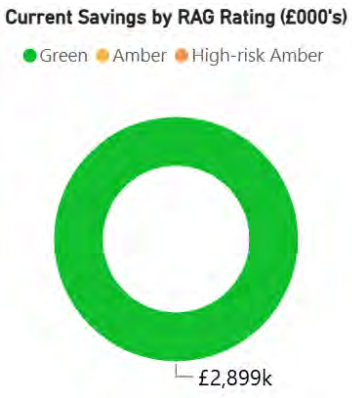
Key drivers of forecast deficit:

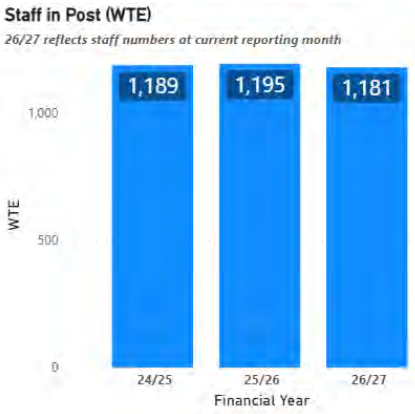
- £0.6m Building maintenance
- £0.3m Building demolitions
- £0.1m Other net variances
- (£0.8m) Rates
- (£0.7m) Vacancies

DIVISIONAL EXPENDITURE/FORECAST RUN-RATE													
	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(403)	(489)	(429)	(451)	(463)	(486)	(373)	(444)	(452)	(461)	(442)	(530)	**(5,422)**
Pay	4,563	4,678	4,733	4,613	4,757	4,761	4,606	4,714	4,595	4,917	4,810	4,497	**56,244**
Non pay	4,145	4,066	4,089	3,850	3,737	4,046	4,162	4,219	4,481	4,517	3,786	4,082	**49,180**
Net Expenditure	**8,305**	**8,256**	**8,393**	**8,013**	**8,030**	**8,321**	**8,395**	**8,490**	**8,625**	**8,973**	**8,153**	**8,049**	**100,002**
Budget	**8,309**	**8,386**	**8,386**	**8,240**	**8,172**	**8,347**	**8,363**	**8,518**	**8,652**	**8,767**	**8,091**	**8,228**	**100,457**
Variance	**(3)**	**(130)**	**7**	**(227)**	**(141)**	**(27)**	**32**	**(28)**	**(28)**	**206**	**62**	**(179)**	**(456)**

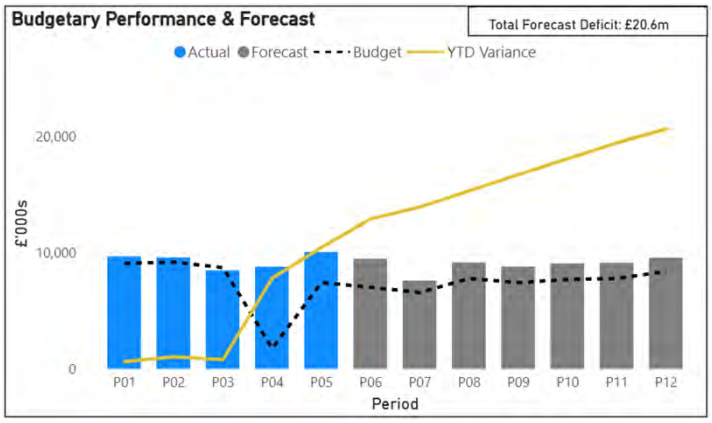
Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Bed Capacity Optimisation	1	0	0	0	0	0	0	0	
Estates Rationalisation	4	76	114	38	334	459	125	40	419
Non-Pay	10	982	1,050	68	2,508	2,440	-68	1,808	632
Workforce	2	0	0	0	0	0	0	0	
Total	**17**	**1,058**	**1,164**	**106**	**2,842**	**2,899**	**57**	**1,848**	**1,051**





Divisional analysis – Corporate



Key drivers of forecast deficit:

- £21.0m Welsh Risk Pool (forecast spend in M12)
- £0.8m Ongoing litigation
- £0.4m IPFR
- £2.1m Miscellaneous Contract Uplifts
- £0.7m Office 365
- (£3.5m) Savings (Study Leave)

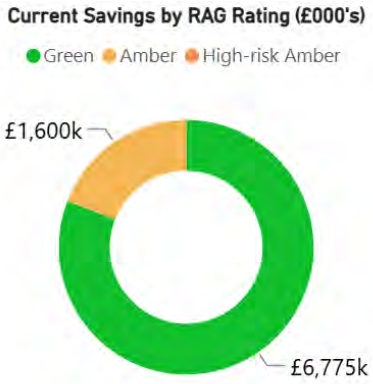
DIVISIONAL EXPENDITURE/FORECAST RUN-RATE													
	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(1,733)	(1,872)	(1,869)	(1,992)	(1,754)	(1,782)	(3,235)	(1,968)	(1,967)	(1,988)	(1,947)	(1,948)	**(24,054)**
Pay	6,452	6,497	5,768	6,310	6,373	6,491	5,716	5,776	5,785	5,795	5,752	5,769	**72,484**
Non pay	4,948	4,956	4,559	4,445	5,423	4,752	5,101	5,335	4,971	5,255	5,316	5,738	**60,799**
Net Expenditure	**9,667**	**9,581**	**8,458**	**8,763**	**10,043**	**9,461**	**7,582**	**9,143**	**8,790**	**9,062**	**9,121**	**9,558**	**109,229**
Budget	**9,056**	**9,173**	**8,693**	**1,749**	**7,409**	**7,002**	**6,553**	**7,758**	**7,398**	**7,686**	**7,755**	**8,371**	**88,603**
Variance	**610**	**408**	**(235)**	**7,014**	**2,634**	**2,459**	**1,029**	**1,384**	**1,392**	**1,376**	**1,366**	**1,187**	**20,626**

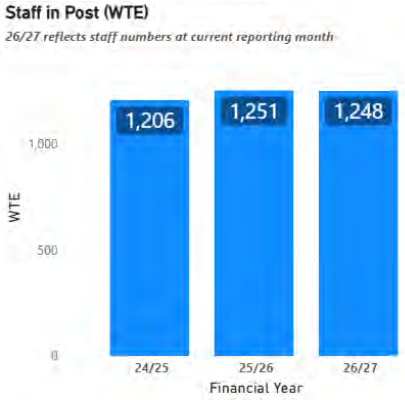
	Annual budget £000s	YTD Reported Variance £000s	Full-year Forecast at M05 £000s	Full-year Forecast at M04 £000s	Movement £000s
Corporate / Exec budgets:-					
Finance & Performance	7,115	**(690)**	(4,237)	(3,987)	(250)
Workforce & OD	10,815	**208**	(129)	101	(230)
Nurse Director	8,703	**141**	460	460	0
Chief Executive and non officer members	6,521	**(127)**	(497)	(447)	(50)
Planning	20,926	**(25)**	(19)	(19)	0
Digital, Data & Technology	32,079	**1,392**	2,507	2,946	(439)
Therapies	1,792	**30**	56	76	(20)
Corporate Governance	1,292	**(23)**	(49)	(49)	0
Public Health	6,778	**(803)**	(388)	(211)	(177)
Medical Director	4,463	**(40)**	218	218	(0)
Litigation	(20,632)	**9,949**	23,739	23,739	(0)
Shared Service	0	**(1)**	0	0	0
Total Corporate Directorates	**79,852**	**10,013**	**21,660**	**22,826**	**(1,166)**

Corporate continued...

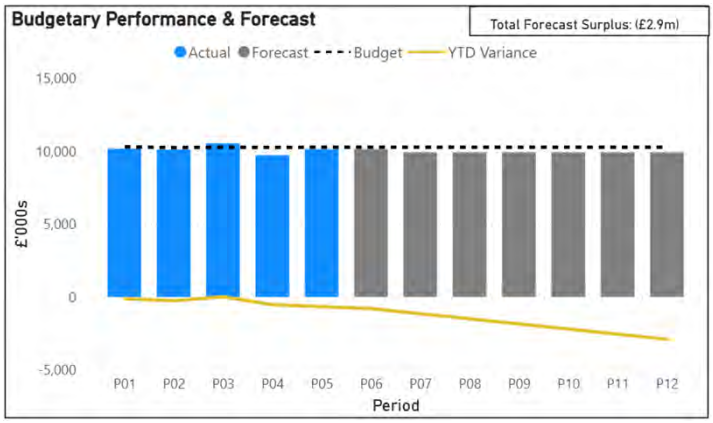
Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Bed Capacity Optimisation	1		0	0	1,600	1,600	0	1,600	
Corporate	30	1,022	1,016	-6	6,817	6,775	-42	875	5,900
Workforce	12	0	0	0	0	0	0	0	
Total	**43**	**1,022**	**1,016**	**-6**	**8,417**	**8,375**	**-42**	**2,475**	**5,900**





Divisional analysis – Contracting & Commissioning



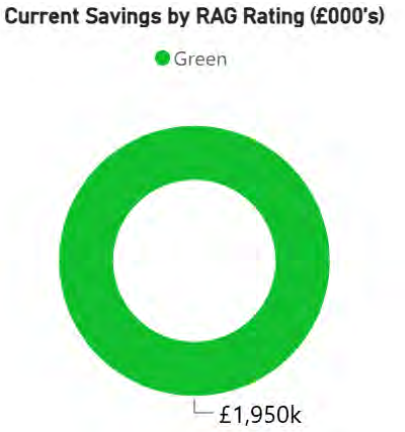
Key drivers of forecast deficit:

- (£1.9m) Recurrent CTM contract saving
- (£0.7m) CTM LTA Saving
- (£1.3m) Outsource contract expected release
- (£0.1m) NHS Gloucester settlement
- (£0.1m) Velindre Drugs
- £0.7m Velindre activity growth (unfunded)
- £0.2m Velindre FYE developments (unfunded)

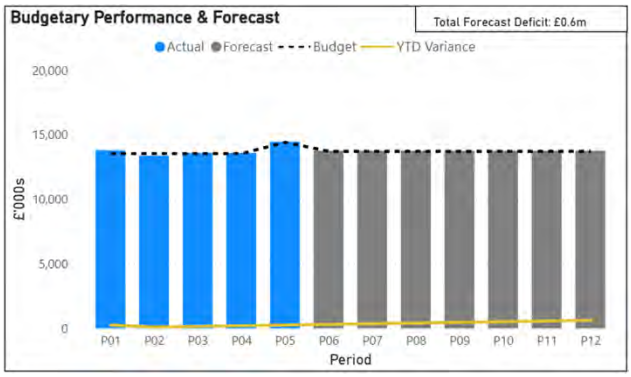
DIVISIONAL EXPENDITURE/FORECAST RUN-RATE	M01 (£000's)	M02 (£000's)	M03 (£000's)	M04 (£000's)	M05 (£000's)	M06 (£000's)	M07 (£000's)	M08 (£000's)	M09 (£000's)	M10 (£000's)	M11 (£000's)	M12 (£000's)	Forecast Outturn (£000's)
Income	(1,626)	(1,626)	(1,626)	(1,647)	(1,626)	(1,626)	(1,626)	(1,626)	(1,626)	(1,626)	(1,626)	(1,626)	**(19,536)**
Pay	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Non pay	11,787	11,729	12,158	11,358	11,758	11,758	11,541	11,541	11,541	11,541	11,541	11,541	**139,791**
Net Expenditure	**10,160**	**10,102**	**10,531**	**9,711**	**10,131**	**10,131**	**9,915**	**9,915**	**9,915**	**9,915**	**9,915**	**9,915**	**120,255**
Budget	**10,295**	**10,237**	**10,266**	**10,245**	**10,266**	**10,266**	**10,266**	**10,266**	**10,266**	**10,266**	**10,266**	**10,266**	**123,172**
Variance	**(135)**	**(135)**	**265**	**(535)**	**(135)**	**(135)**	**(351)**	**(351)**	**(351)**	**(351)**	**(351)**	**(352)**	**(2,917)**

Savings summary (£'000)

Value & Sustainability Category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to plan	Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance to Plan	Full Year: Forecast Recurrent	Full Year: Forecast Non Recurrent
Non-Pay	1	0	0	0	650	650	0		650
SLAs	5	271	271	0	1,300	1,300	0	750	550
Total	**6**	**271**	**271**	**0**	**1,950**	**1,950**	**0**	**750**	**1,200**



Divisional Analysis – JCC Specialist Services

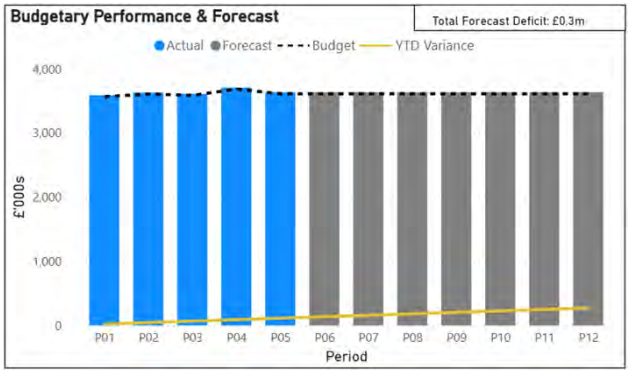


Key drivers of the forecast position

- The WHSSC forecast reflects the JCC Integrated Commissioning Plan agreed by Chief Executives including the 1.11% uplift with the expectation that a further £2.5m savings are made to deliver the AB reported forecast. There are currently no savings plans in place to cover this £2.5m shortfall.

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD Achieved £'000	Full year Forecast £'000
					0	0

Divisional Analysis – JCC Ambulance Services



- Overspend is reflective of the agreed IMTP
- The ABUHB plan is net of an expected savings achievement of £2.5m by JCC.

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD Achieved £'000	Full year Forecast £'000
					0	0

Reserves

The reserves held at 31st August 2026 is £20.0m.

The reserves include some elements of risky income associated with the submitted plan, with £1.9m currently shown within the tables as 'Income Assumed at Risk' and the pay award and Resident Doctors actual value is not yet confirmed. The Health Board will liaise with Welsh Government to confirm these elements of assumed income.
A proposal is with the Executive Team to delegate budget from Reserves and into Divisional positions with respect to specific cost pressures identified as part of the IMTP process. The cost pressures to be funded and the delegated budgets will be agreed by the Executive team and submitted to the Board for approval in due course.
Funding will continue to be reviewed with further anticipated allocations being retained within reserves pending delegation.

7769-ALLOCATIONS TO BE DELEGATED

Confirmed or Anticipated	R/ NR	Description	26/27
Anticipated	R	Pay Award 26/27	451,376
Anticipated	R	Pay Award 2627 Bank	2,047,291
Anticipated		Pay Award 26/27 - Band 3 Pay Step 1 Increase - Substantive	113,276
Anticipated		Pay Award 2627 - Band 3 Pay Step 1 Increase - Bank - current band 3	13,850
Anticipated	R	M&D pay award to be confirmed	406,433
Confirmed	NR	Neighbourhood District Nursing	158,283
Confirmed	R	Urgent Care 6 Goals	128,000
Confirmed	NR	Immunisation GMS	148,925
Confirmed	NR	Immunisation HCHS	282,080
		Confirmed Allocations to be apportioned	**3,749,514**

7501-SUPPORTING FINANCIAL POSITION

Description	26/27
2026-27 Rollover Balance	1,711,665
Band 2-3 (cost pressure)	704,157
Winter	2,000,000
Local Investments	1,138,000
Our Next Patient (45 Minute Handover)	1,000,000
Performance-Medicine (Endoscopy/Gastro)	1,000,000
Performance-various RTT efficiency targets	1,000,000
Performance-Diagnostics	500,000
Cancer	2,100,000
Initial Allocation Roundings	(581)
2526 R&D NI delegation	(34,759)
Contract & Commissioning Pay Mapping reversal	612,722
IT Revenue to Capital (M1 & M2)	29,295
IT Revenue to Capital (M3)	10,661
IT Revenue to Capital (M4)	7,992
IT Revenue to Capital (M5)	9,196
Planned Care Infrastructure	91,254
Total Supporting Financial position	**11,879,602**

7777-STRATEGIC FUNDING - Income Assumed at Risk

Description	26/27
DPIF Funding	568,000
Pay Award 2627 - Band 3 Pay Step 1 Increase - Bank Assimilated 2-3's	506,463
Resident Doctor Contracts for existing resident doctors contract salary uplifts + 3.5%	803,468
Total deficit b/f	**1,877,931**

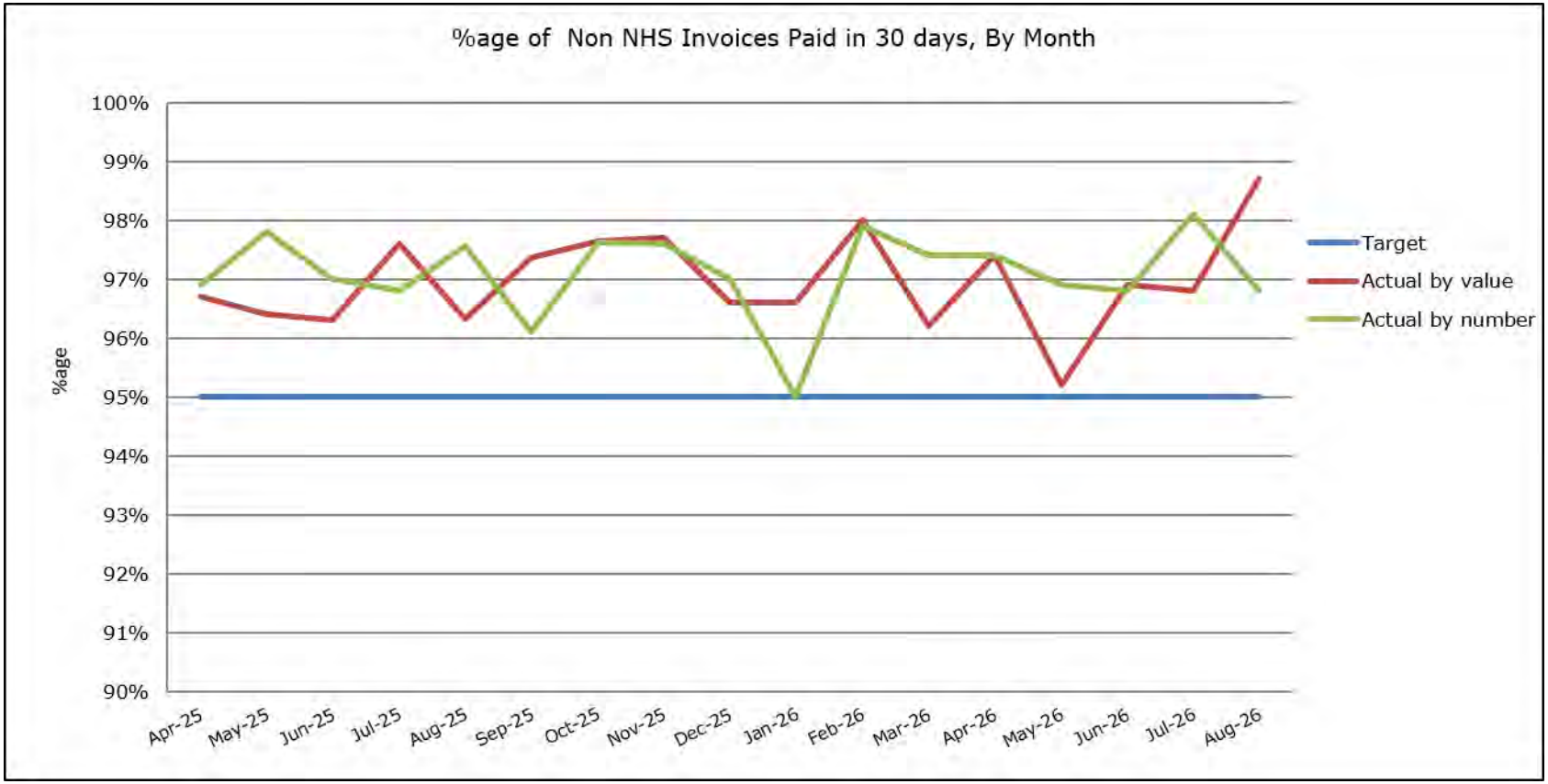
7565-Planned Care Recovery

Description	26/27
RTT - 104 Week Delivery (Planned Care Recovery Tranche 1) - Orthopaedic Spines	923,901
RTT - 104 Week Delivery (Planned Care Recovery Tranche 1) - ENT	678,229
Diagnostic (8-week) (Planned Care Recovery Tranche 1)	400,000
RTT & Diagnostic Validation (Planned Care Recovery Tranche 1) - RTT	250,000
RTT & Diagnostic Validation (Planned Care Recovery Tranche 1) - Diagnostic	250,000
Total Contingency	**2,502,130**

Public Sector Payment Policy (PSPP)

The HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods/services in August 2026.

The target to pay 95% of NHS invoices within 30 days has been achieved in month.

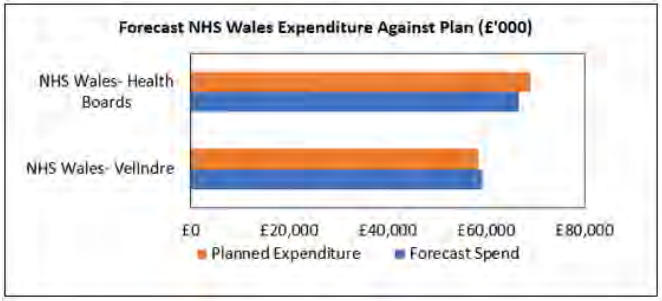


Contracting and Commissioning – LTA Spend & Income

Month/Financial Year: - Month 05 (August) 2026-27

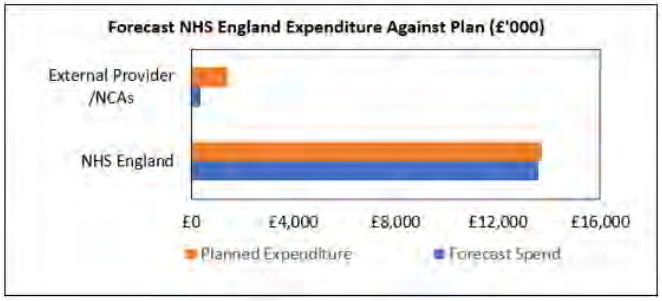
At Month 5 the year to date financial performance for Contracting and Commissioning is c£674k underspend against the delegated budget with a forecast year of £2,917k surplus.

The key elements contributing to this position at Month 5 are as follows:



NHS Wales Expenditure

Expenditure in NHS Wales contracts is in line with the IMTP assumptions, including LTA inflation, pay awards and increased NICE drug expenditure.
A saving has been made by renegotiating the baseline with Cwm Taf UHB.

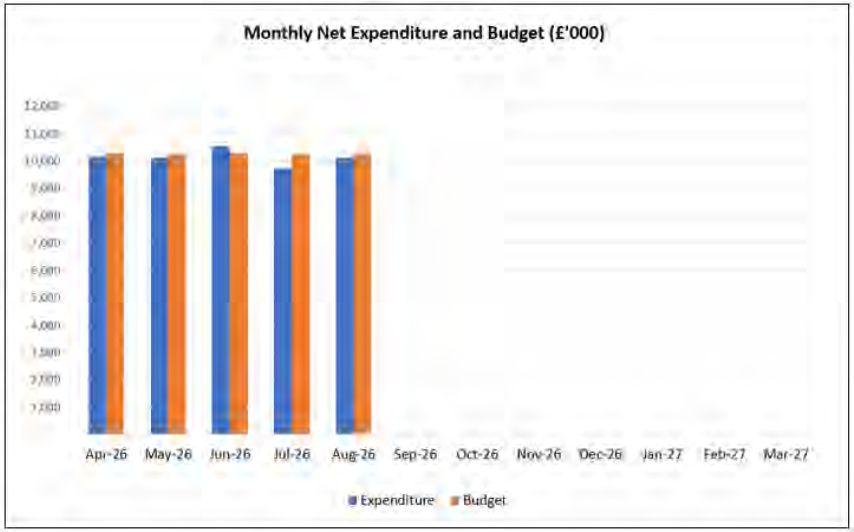


NHS England Expenditure

Contract Expenditure with NHS England organisations is in line with the IMTP assumptions, including LTA inflation and revised activity baselines.

Provider Income

Provider income is in line with IMTP assumptions, including LTA inflation and pay award funding being received by commissioners on a pass-through basis.



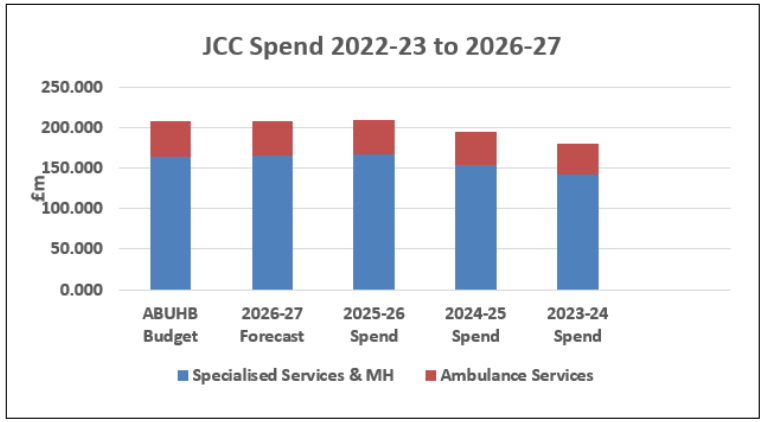
Key Issues 2026-27

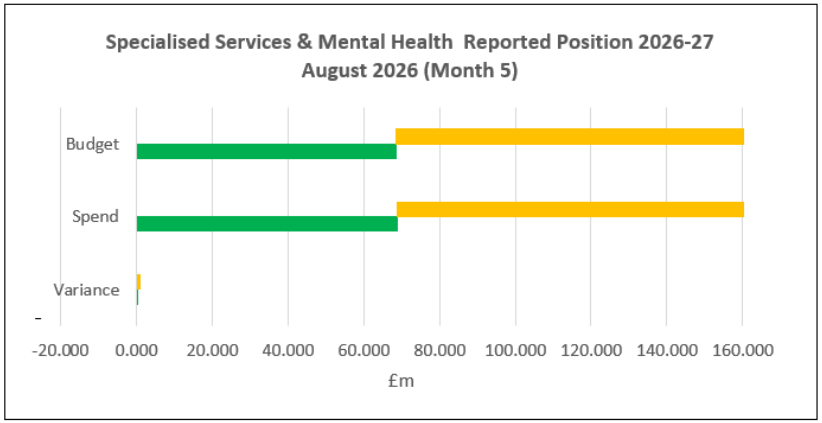
- All LTAs have been agreed ahead of the WG deadline and have been signed by ABUHB and the other Health Board/Trust
- An annual saving of c£1.8m from previous LTA negotiations with Cwm Taf resulted in a recurrent benefit within the HB position.
- A new saving by further reducing the Cwm Taf LTA baseline has been achieved in 2026-27 worth £650k recurrently.
- The expenditure being forecast for cancer services at Velindre is in line with the provider forecast (c£3.3m growth in NICE drugs funded above 2025-26 and c£735k activity growth that is unfunded)

Joint Commissioning Committee (formerly WHSSC & EASC) Financial Position 2026-27

Period: Month 05 2026-27 –

The Month 5 financial position for the Joint Commissioning Committee is a forecast overspend of £0.898m. The JCC plan presented to Chief Executives in March was ratified on the basis that £2.5m reduction (ABUHB share) in expenditure/savings would be found. It is the expectation of the Health Board that JCC deliver within this agreed figure and this position has been reflected in the M5 ABUHB reported position, however, a risk remains of £1.6m.





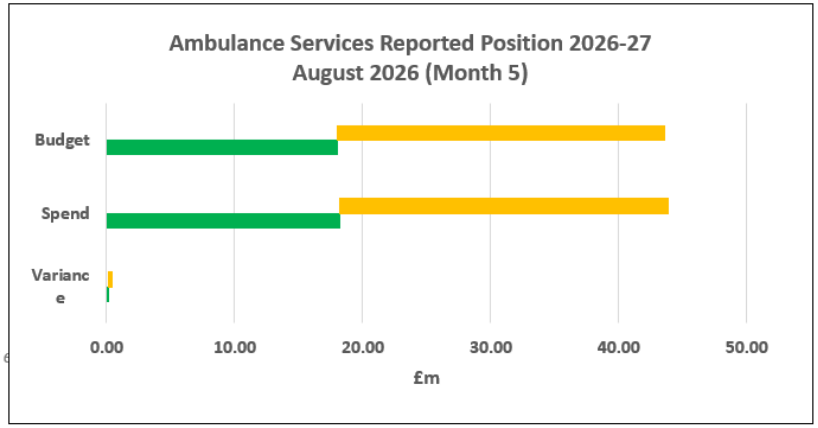
Key Issues 2025-26

Specialised Services

- At present JCC are only reporting £0.800m additional savings achievement against the £2.5m savings target leaving a outturn forecast risk of £1.6m
- Key risk areas for 2026-27
  - Delivery of Savings Plans
  - Provider Overperformance
  - Slippage on Developments

EASC

- Key risk areas for 2026-27
  - Unfunded Provider pressures
  - Confirmation of allocation assumptions



Balance Sheet

Balance sheet as at 31st August 2026	2026/27 Opening balance £000s	31st August 2026 £000s	Movement £000s
Fixed Assets	1,003,597	1,022,700	19,102
Other Non current assets	143,072	186,573	43,501
Current Assets			
Inventories	9,794	9,940	145
Trade and other receivables	177,858	167,931	(9,927)
Cash	5,551	2,905	(2,646)
Non-current assets 'Held for Sale'	0	0	0
Total Current Assets	193,203	180,776	(12,427)
Liabilities			
Trade and other payables	232,094	204,602	(27,492)
Provisions	245,761	274,830	29,069
	477,855	479,432	1,577
	862,018	910,617	48,599
Financed by:-			
General Fund	612,791	647,412	34,621
Revaluation Reserve	249,226	263,205	13,978
	862,018	910,617	48,599

General Fund: This represents the difference in the year-to-date resource allocation budget and actual cash draw down including capital.

Fixed Assets:- The main movements since the end of 2025/26 relate to:

- An increase of £11.1m relating to capital programme purchase additions.
- An increase of £28.7m as a result of upwards revaluations caused by Indexation for land & buildings
- A decrease of £19.9m due to depreciation charged in year.
- A net decrease of £0.7m in renewals and depreciation for IFRS16 leased assets

Other Non-Current Assets: This relates to an increase in Welsh Risk Pool claims due in more than one year of £44.3m and a decrease in intangible assets and non-current investment assets of £0.8m since the end of 2025/26.

Inventories: The increase in year relates to changes in stock held within the divisions

Current Assets, Trade & Other Receivables: The main movements since the end of 2025/26 relate to:

- A decrease in the value of Welsh Risk Pool claims due in less than one year of £23.2m
- Offset by an increase in the value of debts outstanding on the Accounts Receivable system since the end of March 2026 of £2.9m
- An increase in the value of prepayments held £6.2m
- A net increase in the value of NHS & Non-NHS accruals of £3.6m
- And an increase in VAT receivables of £0.6m since the end of March.

Cash: The cash balance held at the end of April is £2.91m. This is split as:

- £2.76m Revenue Cash
- £0.15m Capital Cash

Liabilities, Trade & Other Payables:
The movement since the end of 2025/26 relates to a number of issues, the most significant of which are:-

- Decreases in Accruals totalling £10.8m (Capital - £5.2m and NHS - £5.6m)
- Decreases in the value of the level of invoices held for payment from the year end of £6.8m and the value of GRNI of £5.7m,
- A significant decrease in Other Creditors totalling £14.8m
- And a decrease in the liability for lease payments of £1.1m
- These are offset by an increase in Non-NHS Accruals of £14.1m

Provisions:

- This is due to an overall increase in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £28.4m and an increase in other provisions of £0.7m.

Health Board Income
WG Funding Allocations: £1.96bn

Confirmed allocation at August 2026/27

	£'000
HCHS	1,743,314
GMS	129,525
Pharmacy	38,151
Dental	38,476
Total Confirmed Allocations - August 2026	**1,949,466**
Plus Anticipated Allocation - August 2026	**12,746**
Total Allocations - August 2026	**1,962,212**

Other Income:

The HB receives income from a number of sources other than WG, based on the year-to-date income, this is forecast to be approximately £129.6m (£131.5m for 25/26). The majority of this income is delegated to budget holders and therefore nets against their delegated budget positions. The main areas for income are: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Estimated funding (allocations & income) for the UHB totals £2.09bn (£2.15bn for 25/26).

WG Revenue Resource Limit : Anticipated Allocations (August)

Funding Type	Description	Value £'000	Recurrent / Non Recurrent
GMS	GMS Refresh	1,603	R
GMS	Dispensing Drs and PADMS funding 26-27	1,087	R
HCHS	Capital - DEL Depreciation - Baseline Surplus/Shortfall	(1,256)	NR
HCHS	Capital - DEL Depreciation - Strategic	6,464	NR
HCHS	Capital - DEL Depreciation - Accelerated	348	NR
HCHS	Capital - DEL Depreciation - IFRS 16 Leases	(480)	NR
HCHS	Capital - AME Depreciation - IFRS 16 Leases (Peppercorn)	62	NR
HCHS	Capital - AME Depreciation - Donated Assets	330	NR
HCHS	Capital - AME Depreciation - Impairments	6,905	NR
HCHS	Capital - AME Depreciation - Impairment reversals	(14,751)	NR
HCHS	Capital - Removal of Donated assets / Gvnt grant receipts	(100)	NR
HCHS	Revenue Lease Payment Budget Reduction (IFRS16 Equip)	(1,562)	NR
HCHS	Revenue Lease Payment Budget Reduction (IFRS16 Prop)	(1,519)	NR
HCHS	Clinical Excellence Awards (CDA's)	232	R
HCHS	AHW:Prevention & Early Years allocation	1,114	R
HCHS	Welsh Risk Pool Risk Share agreement	(29,515)	NR
HCHS	VSM/ESP Pay Awards 2025-26	89	R
HCHS	Pay Awards A4C 26-27	26,786	R
HCHS	NDIP Funding 26/27	569	NR
HCHS	ESR Contract Increase	1,647	NR
HCHS	A2A Sanctuary Model	50	NR
HCHS	MCA DOLS MH Advocacy Funding	433	NR
HCHS	DPIF Funding	568	NR
HCHS	Planned Care Transformation Fund – Optometry Community Pathways	143	NR
HCHS	Medical and Dental pay award 2026-27	7,747	R
HCHS	Planned Care Recovery - 104 week waits - T&O, GS, Ophthal	1,300	R
HCHS	A4C Pay Award - Band 3 Payscale Uplift	953	R
HCHS	CHC Direct Payments Implementation (remaining 50%)	58	NR
HCHS	Womens Health Hubs	46	NR
HCHS	Junior Doctors Contract Reform	803	R
HCHS	Planned Care Recovery 2026-27: Tranche 1 Funding	2,502	NR
HCHS	Meningitis B immunisation programme vaccine costs	89	NR
	Total Anticipated: Per Ledger	**12,746**	

Confirmed Allocations - August 2026	**1,949,466**
Total 2026/27 Allocations - August 2026	**1,962,212**

Capital Planning & Performance Month 05 2026/27

	2026/27				
	Original Plan £000	Revised Plan £000	Spend to M5 £000	Forecast Outturn £000	Variance £000
Source:					
Discretionary Capital:					
Approved Discretionary Capital Funding Allocation	14,456	14,456		14,456	0
Less TEF Contribution	-2,501	-2,501		-2,501	0
Less AWCP Brokerage 25/26	-150	-2,021		-2,021	0
NBV of Assets Disposed	0	3		3	0
Total Approved Discretionary Funding	11,805	9,937		9,937	0
All Wales Capital Programme Funding:					
AWCP Approved Funding	15,385	22,905		22,905	0
Total Approved AWCP Funding	15,385	22,905		22,905	0
Total Capital Funding / Capital Resource Limit (CRL)	**27,190**	**32,842**		**32,842**	**0**
Applications:					
Discretionary Capital:					
Commitments B/f From 2025/26	895	589	-178	514	-75
Statutory Allocations	600	600	228	659	59
Other Commitments	1,050	1,054	725	1,054	0
Divisional Priorities	5,806	3,990	511	3,949	-40
Corporate Priorities	250	250	0	125	-125
Informatics National Priority & Sustainability	2,292	915	168	915	0
Remaining DCP Contingency	912	2,539	0	2,501	-38
Total Discretionary Capital	**11,805**	**9,937**	**1,455**	**9,718**	**-219**
All Wales Capital Programme:					
NHH Satellite Radiotherapy Centre	0	324	14	324	0
RGH – Block 1 and 2 Demolition and Car Park	250	258	3	258	0
Ty Gwent - Works	0	46	3	46	0
Centralised Decontamination Unit RGH	0	221	50	221	0
Reinforced Aerated Autoclave Concrete, Nevill Hall Hospital	0	413	-71	413	0
Targeted Estates Fund	9,636	9,961	5,904	9,961	0
REFIT Decarbonisation Programme	4,790	4,357	2,773	4,357	0
IRCF - Monmouth Health and Wellbeing Centre	0	104	3	104	0
IRCF - Aber Valley Health and Wellbeing Centre	0	842	144	842	0
Housing with Care Fund Schemes	0	170	14	170	0
DPIF - Electronic Prescribing and Medicines Administration (ePMA)	685	702	415	702	0
DPIF - RISP	24	24	24	24	0
DPIF - Digital Eye Care	0	8	0	8	0
Backlog Maintenance 2024-25	0	47	7	47	0
End of Year Funding 2025-26	0	230	227	230	0
End of Year Digital Funding - January 2026	0	97	13	102	5
VPAG Funding	0	6	-2	6	0
RGH Gamma Camera Replacement	0	2,738	142	2,952	214
Mental Health Quality and Safety Schemes 2026-27	0	550	0	550	0
Digital Backlog Funding	0	1,116	0	1,116	0
Estates Backlog Funding	0	691	0	691	0
Total AWCP Capital	**15,385**	**22,905**	**9,665**	**23,124**	**219**
Total Programme Allocation and Expenditure	**27,190**	**32,842**	**11,119**	**32,842**	**0**
Forecast Break Even against Overall Capital Resource Limit					**0**

Capital Performance

The approved Capital Resource Limit (CRL) as at Month 5 totals £32.842m including disposal proceeds totalling £0.003m. The forecast outturn against the overall CRL for 2026/27 is break even.

The NHH Satellite Radiotherapy scheme opened to patients on the 30th June 2025. The final account for the building works is being agreed with the contractor. A slippage request of £0.324m has been approved into 2026/27 to allow associated smaller works and expenditure against the arts budget to continue.

The Centralised Decontamination Unit at RGH works completed in March 2026 and the unit was opened in May. Slippage of £0.221m into 2026/27 has been approved to manage costs associated with the commissioning period and installation of equipment. Final costs are being reviewed, and any underspend will be confirmed back to WG in September.

The Targeted Estates Funding (TEF) programme continues into 2026/27 with an approved allocation of £9.961m. Expenditure is progressing well with 59% of the allocation spent by the end of August. Virements were approved in May to fund additional carpark drainage works at Llanfrechfa Grange which are nearing completion. The project team are reviewing any further potential underspends and where these arise will request reallocation of funds to other high-priority estates schemes.

The two-year REFIT Decarbonisation programme works are progressing well with 64% of the current year's allocation spent by the end of August. Works are expected to complete in March 2027 which takes into account the delay to the GUH solar installation workstream arising for the additional works required to the related Llanfrechfa Grange Carpark scheme.

Slippage requests have been approved into 2026/27 to continue the Outline Business Cases (OBC) for Abervalley and Monmouth Health and Well-being Centres. In addition, a further £0.424m has been approved in April for the Abervalley scheme to cover the increased costs required to complete the OBC. The Abervalley OBC is expected to be submitted to WG for approval in quarter four.

The overall forecast outturn for the RGH Gamma Camera replacement scheme is now anticipated to be an overspend of £305k due to an expected increase in works costs. The tender is currently being progressed to confirm final construction costs. The programme assumes the equipment will be installed in March 2027. The overspend has been reduced by £0.092m in the current year to reflect the reimbursement to the Discretionary programme for fees incurred in 2025/26.

Additional funding totalling £1.807m has been received in month in relation to Digital and Estates Backlog funding.

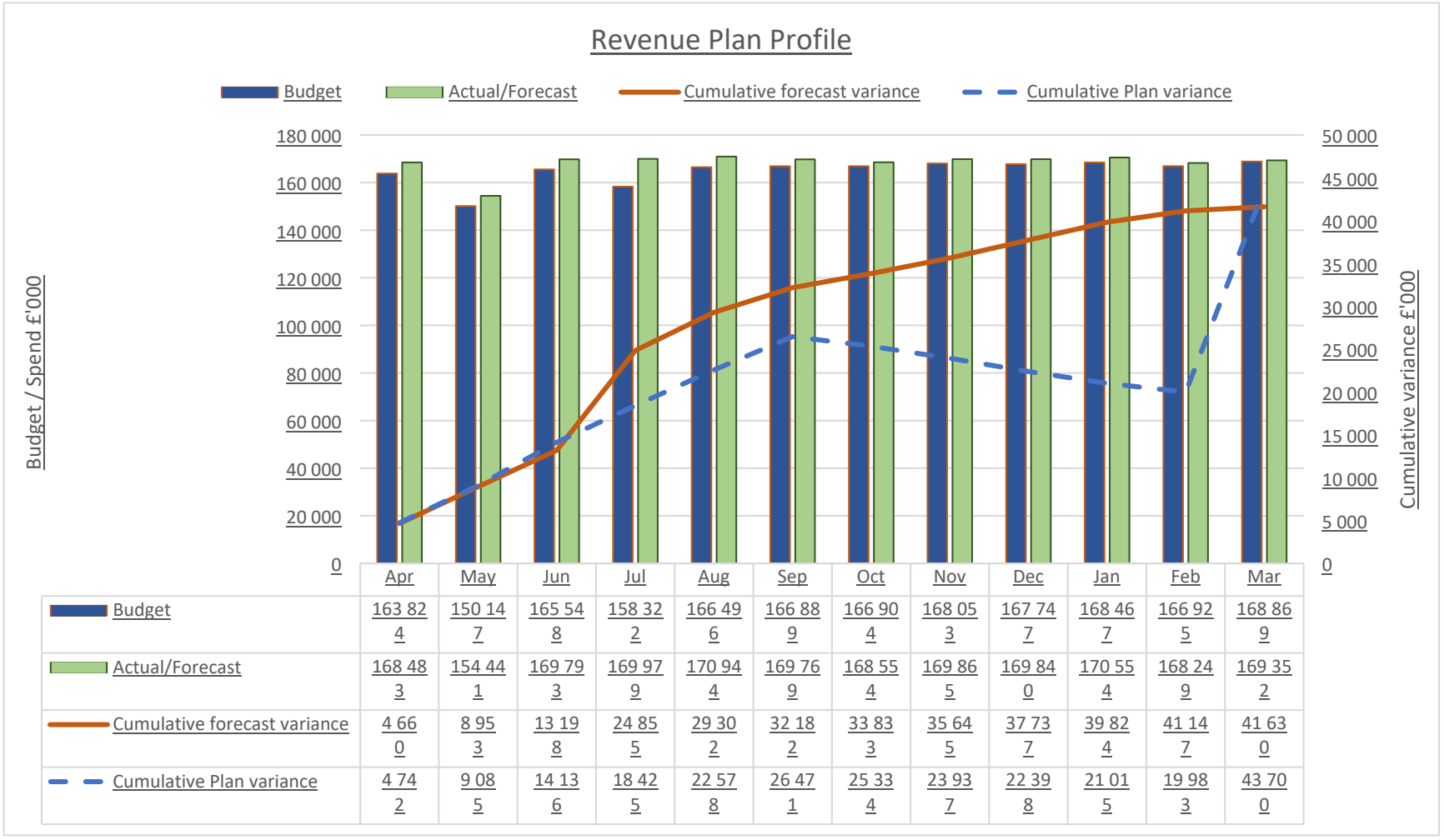
The Health Board Discretionary Capital Programme (DCP) forecast for 2026/27 is £9.718m at Month 5 made up of:

- 2026/27 DCP Funding - £14.456m
- Less 30% TEF contribution - (£2.501m)
- Less 2025/26 AWCP scheme brokerage - (£2.021m)
- Less 2026/27 AWCP scheme overspends (inc. RGH Gamma Camera) – (£0.311m)
- Plus, reimbursement of DCP Fees re: RGH Gamma Camera Replacement - £0.092m
- Plus Disposal Proceeds 2025/26 - £0.003m

The unallocated contingency at the end of month five is £2.5m, an increase of £2.1m from the previous month mainly due to reduced forecast spends for existing schemes. The largest reduction (£1.428m) relates to the Digital renewal of Electronic Observations Licences which were previously budgeted at £1.6m. The total scheme cost has reduced to £0.844m following a reduction in the expected renewal term to 15 months, and AWCP funding received for this scheme in August (£0.672m) has reduced the DCP requirement to £0.172m. Further forecast reductions have also been agreed against the GUH ED Extension Phase 2 project (£0.200m – slippage to 27/28), Phase two Anti-ligature bedroom doors (£0.157m – part funded by AWCP), Defibrillator replacements (£0.059m – procurement saving), Six facet survey scheme (£0.125m – slippage to 27/28) and other approved works and equipment replacements (£0.094m – procurement savings and new AWCP funding).

In addition to the unallocated contingency, schemes totalling £1.328m approved within the opening programme are paused pending reprioritisation to address emerging urgent digital, equipment and estates pressures. A significant risk has emerged relating to “Compute and Storage” which is the hardware replacement for the two data centres at GUH and YAB supporting 95% of the HB systems. A business case is being finalised in relation to this urgent requirement. The paused schemes and emerging risks will be considered by the Executive Team in September

Revenue Plan Profile –



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget	163 824	150 147	165 548	158 322	166 496	166 889	166 904	168 053	167 747	168 467	166 925	168 869
Actual/Forecast	168 483	154 441	169 793	169 979	170 944	169 769	168 554	169 865	169 840	170 554	168 249	169 352
Cumulative forecast variance	4 660	8 953	13 198	24 855	29 302	32 182	33 833	35 645	37 737	39 824	41 147	41 630
Cumulative Plan variance	4 742	9 085	14 136	18 425	22 578	26 471	25 334	23 937	22 398	21 015	19 983	43 700

GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN** **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 September 2026
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Winter Plan 2025/26 Evaluation and Development of Winter Plan 2026/27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Director of Strategy, Planning & Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Claire Nelson, Deputy Director of Strategy, Planning & Partnerships Paul Steynor, Head of System Planning & Performance

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 Health Board and wider Gwent region are currently preparing for Winter 2026/27. As part of the preparations, a review has been taken of the Winter Plan 2025/26 to evaluate its delivery and impact and consider whether the planned mitigations were implemented, how actual winter demand compared with the planning assumptions, and what can be learned for future winter resilience planning. This review is attached as Appendix 1. A draft Winter Plan for 2026/27 is attached as Appendix 2. The draft plan sets out the current actions in place or to be taken to improve whole system resilience

in the run up and during Winter. As the plan continues to be refined, critically following receipt of national modelling, a RAG rating of the current position against these actions is included.

The Board is asked to:

- Note the evaluation of the Winter Plan 2025/26 and the learning that can be applied in constructing the Winter Plan for 2026/27
- Note the current Winter Plan for 2026/27 is undergoing further iteration, including assessment of resources and an update will go to the Partnerships, Population Health and Planning Committee in October following receipt of modelling,
- Approve the early version of the Winter Plan for 2026/27 to be submitted to NHS P&I as requested

Cefndir / Background

A letter was received from the Managing Director of NHS Wales Performance and Improvement (NHS P&I) and the Chief Social Care Officer for Wales on 23rd July 2026 setting out the requirements for early planning, strong partnership working and proactive action to manage winter pressures.

A template for completing a regional self-assessment, regional assurance and a Health and Care Resilience Plan for the period 1 December 2026 to 31 January 2027 was included. The template is structured around the aim of delivering safer and more resilient urgent and emergency care through prevention, reduced escalation, elimination of corridor care, improved flow and a stronger integrated community response.

Three deadlines were outlined in the letter:

- By 31st July identify and notify NHS and Social Care Leads of any significant risks, concerns or barriers to delivery by exception
- By 27th August fully complete and submit the template to support a national readiness assessment
- By 25th September test plans against a most likely demand scenario and extreme pressure scenario, update plans where appropriate and submit with Health Board and Director of Social Services assurance

After consultation with leads across the Health Board and the Regional Partnership Board (RPB), a response was submitted on 31st July to NHS P&I and Social Services by the designated Senior Responsible Officer (SRO) for Winter Planning within the Health Board: Director of Strategy, Planning and Partnerships. This return outlined the risks and concerns with delivering against Winter pressures which included:

- System capacity and flow
- Care Home and Community sector capacity and resilience
- Health inequalities and vulnerable populations
- Vaccination uptake
- Funding and resource constraints
- Demand management
- Independent Contractor negotiations
- Delays in national communications and modelling

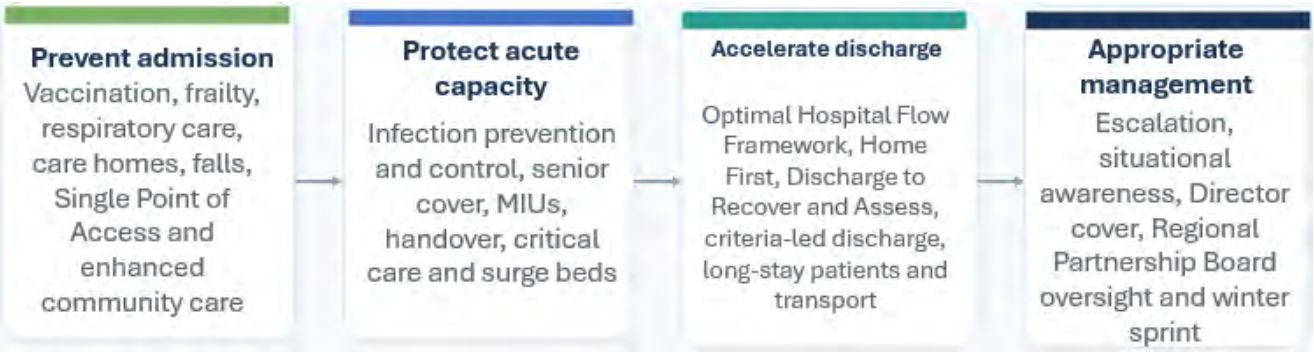
The self assessment templates were submitted by 27th August with Health Board and wider partner input. The majority of actions reported a partial compliance with further work to be undertaken. Further details of these are shown in Appendix 2.

Asesiad / Assessment

A review of the Winter Plan 2025/26 highlighted key learning which has informed the development of the 2026/27 Winter Plan. Lessons include:

- The respiratory wave was not the main pressure
- Whole system demand and constrained flow exceeded forecast
- Additional capacity brought online and Single Point of Access pathways worked
- Implementation of schemes to support with flow and capacity did not realise their full potential due to timeliness of recruitment and sickness

The Winter Plan 2026/27 has been developed in line with previous Winter Plans and lessons learnt and the self-assessment templates provided by NHS Wales Performance Improvement (P&I)/Welsh Government. The four main aims of the whole system Winter Plan 2026/27 are to:



It is proposed that existing governance arrangements are used rather than duplicate essentially:

- For regional partners - Integrated Discharge Board with escalation to Gwent Directors of Local Authorities and Gwent Chief Executives
- Within the Health Board – Use “Our Next Patient” and Urgent and Emergency Care Board with escalation through to Executive Committee
- Individual workstreams i.e. Continuing Health care (CHC) and Vaccinations will continue to be monitored through existing arrangements and feed into the Winter plan reporting as required.

Further work is required on the winter plan for 2026/27 so it remains a dynamic document. Work includes:

- Completion of the modelling in line with Public Health Wales intelligence once this is made available
- An assessment of resources for Winter plan in line with review of UEC funding
- Detailed day by day operational actions which are due in November in preparation for the scheduled Winter Sprint
- An updated position will be presented to the Partnership, Population Health and Planning Committee on 13th October 2026

The current version of the Winter Plan was presented and approved in the Regional Partnership Board on 15th September.

Argymhelliad / Recommendation

The Board is asked to:

- Note the evaluation of the Winter Plan 2025/26 and the learning that can be applied in constructing the Winter Plan for 2026/27
- Note the current Winter Plan for 2026/27 is undergoing further iteration and an update will go to the Partnerships, Population Health and Planning Committee in October following receipt of modelling,
- Approve the early version of the Winter Plan for 2026/27 to be submitted to NHS P&I as requested

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	SRR100F: There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population. SRR007A: There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	5. Timely Care 1.1 Health Promotion, Protection and Improvement 2.3 Falls Prevention 2. Safe Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Partnership First
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Learning from winter 2025/26 and the national Winter Sprint approach.
Rhestr Termau: Glossary of Terms:	ARI: Acute Respiratory Infection GUH: Grange University Hospital SPOA: Single Point of Access

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

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

Review of 2025/26 Winter Plan

1. Situation

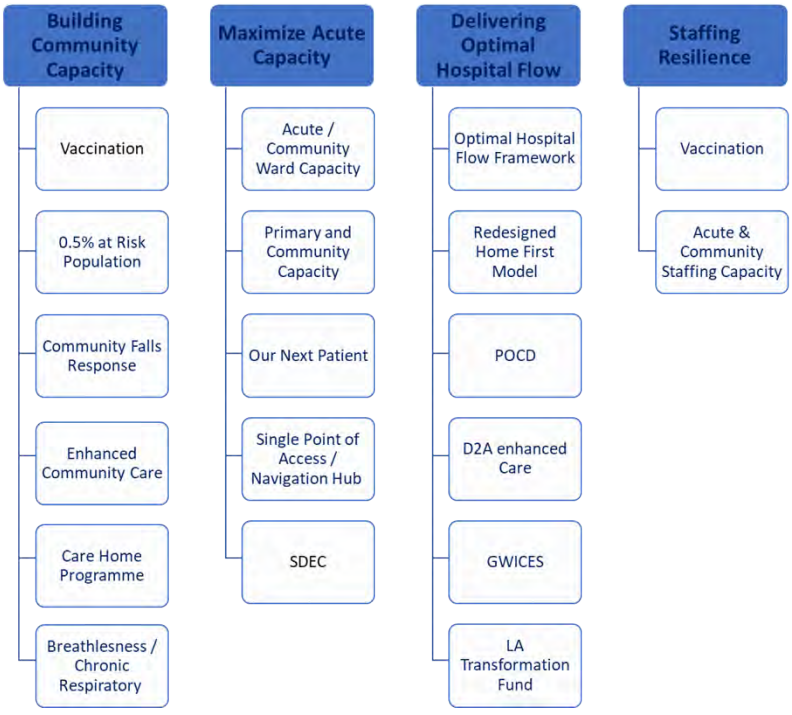
This report evaluates the delivery and impact of the Health Board's Winter Plan 2025/26 considering whether the planned mitigations were implemented, how actual winter demand compared with the planning assumptions, and what can be learned for future winter resilience planning.

2. Background

The 2025/26 Winter Plan focussed on lessons from the Winter plans of the three preceding years which ranged from the 2022/23 high risk post pandemic capacity plan based around respiratory uncertainty and therefore a large bed requirement to the 2024/25 Plan which had clear and quantified plans in response to the National 50 day discharge challenge. Unlike the 2024/25 Winter Plan, no national funding was made available by Welsh Government to support Winter Plans in 2025/26.

A draft Winter Plan which preceded receipt of national modelling scenarios was presented to the Board in September 2025 and focused on four main themes with priority actions under each as outlined below:

Fig 1: Themes and Priorities of the Draft Winter Plan 2025/26



Following receipt in October 2025 of national modelling scenarios for Covid, Influenza and RSV, the Health Board combined the respiratory scenarios with local demand data to forecast the likely scenarios for system admissions and occupancy and the consequential timing requirements for additional capacity. These scenarios were presented to the Board in November 2025 alongside the other main components of the Winter Plan which included:

- Increasing Vaccination uptake
- Additional acute and community bed capacity
- Expansion of the Grange University Hospital Emergency Department waiting and assessment area
- Single Point of Access (SPoA), falls response, discharge-to-assess
- Wider partnership actions being taken through the Regional Partnership Board.

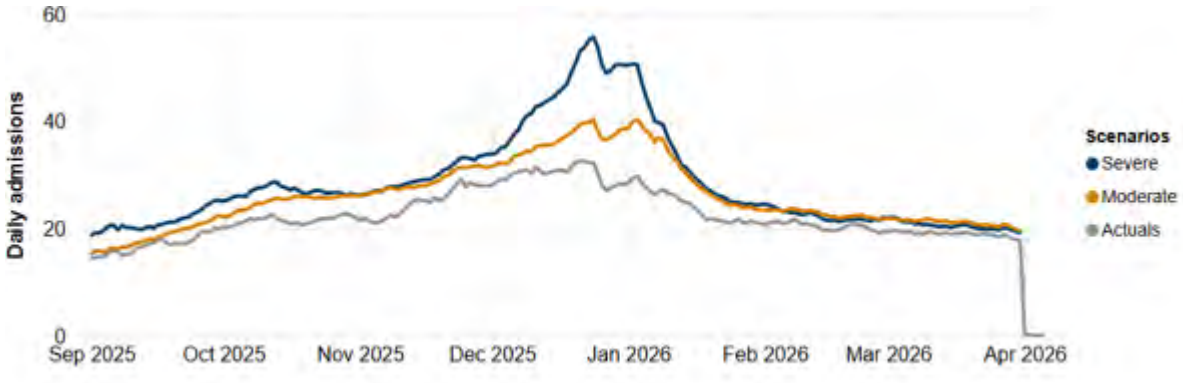
An interim review of progress of implementing the Health Board's and wider Healthcare system's Winter Plan 2025/26 was presented to the January 2026 Board meeting along with a status of the current health and care system position and an update on the Critical Incident called in January 2026.

3. Assessment

3.1 Actual Acute Respiratory Infection activity compared to modelling

Compared with both the national moderate and severe planning scenarios, actual Acute Respiratory Infection (ARI) activity during Winter 2025/26 was consistently lower in terms of both admissions and bed occupancy although the overall seasonal profile broadly mirrored the modelled trajectories.

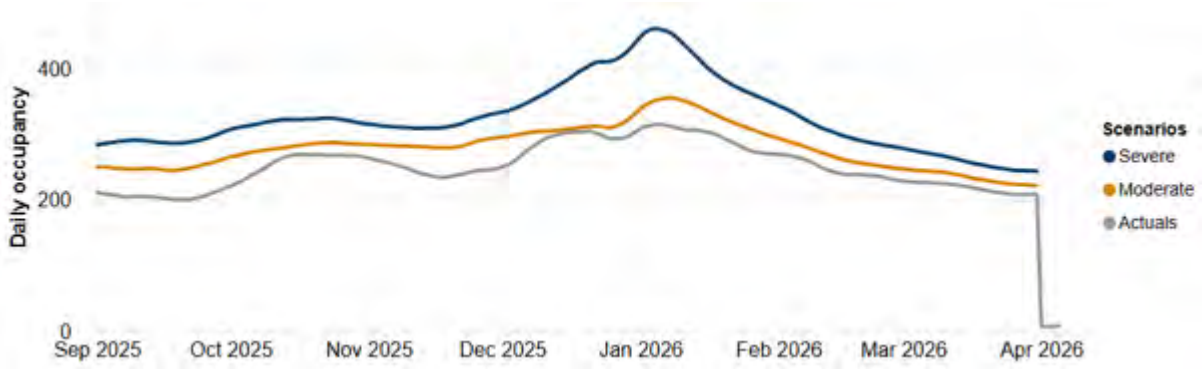
Fig. 2: Actual Acute Respiratory Daily Admissions against the modelled scenarios Sept 2025-Apr 2026



Admissions increased steadily from September, rising from around 15 admissions per day to a peak of approximately 30 to 32 admissions per day in late December, before declining rapidly through January and returning towards baseline levels by March. This compared favourably with the moderate scenario, which anticipated a peak of around 40 admissions per day, and remained significantly below the severe scenario peak of approximately 55 to 56 admissions per day.

The impact of this lower than expected admission activity is evident in the occupancy profile shown below in Fig.3. Actual respiratory occupancy peaked at approximately 310 to 320 beds during January, compared with around 350 to 360 beds in the moderate scenario and approximately 460 beds in the severe scenario. At peak, actual occupancy was around 40 beds lower than the moderate scenario and more than 140 beds lower than the severe scenario, representing a substantial variance against both modelled scenarios.

Fig. 3: Actual Acute Respiratory Infection Occupancy against the modelled scenarios Sept 2025-Apr 2026



While ARI demand increased through the winter period as expected, the scale of the surge was considerably more modest than planned for, particularly during December and early January when the gap between actual and modelled activity was greatest. This suggests that the system experienced a respiratory season that was materially less severe than the upper planning assumptions, with actual activity remaining approximately 20% below the moderate scenario at peak and more than 40% below the severe scenario.

This also indicates that the dominant pressure for the Health Board was broader acute demand and constrained patient flow rather than an unusually severe respiratory season.

3.2 Overall Occupancy

Despite national ARI modelling indicating that admissions and occupancy remained below both the moderate and severe planning scenarios throughout Winter 2025/26, overall occupancy across the Health Board system exceeded forecast levels from January onwards. While ARI demand followed a less severe trajectory than anticipated, other factors appear to have contributed significantly to sustained bed pressures, including increased non-respiratory emergency demand, rising patient acuity, longer lengths of stay, discharge constraints, and broader flow challenges across the health and social care system. The fact that total system occupancy remained above forecast despite lower than expected respiratory occupancy indicates that the principal drivers of pressure during the latter part of the winter period were

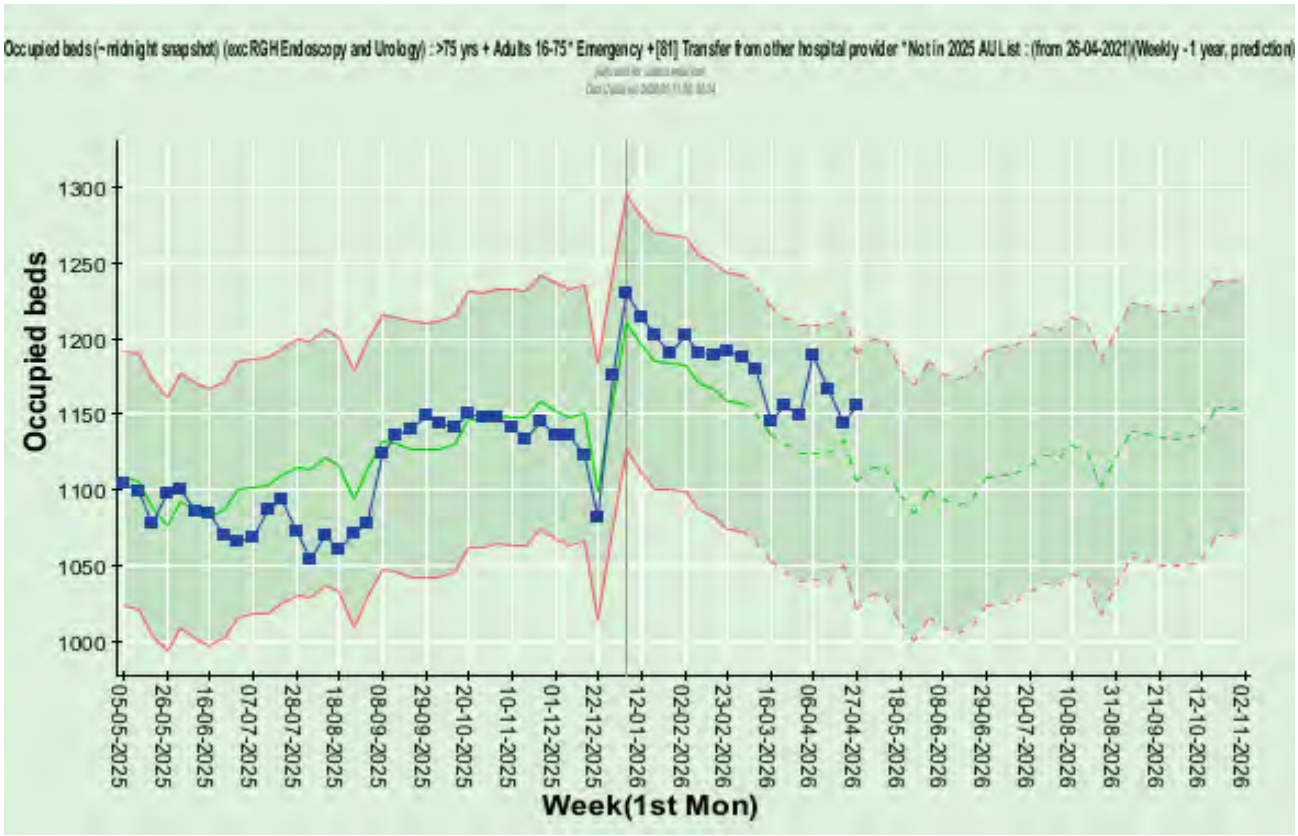
wider operational and demand related factors rather than excess respiratory infection activity alone.

The occupancy forecast for Winter 2025/26 was based on average weekly midnight occupancy for emergency admissions only and patients aged 16 years and over. During the pre-winter period, occupied bed utilisation remained relatively stable and closely aligned to forecast levels. Actual occupancy generally fluctuated between approximately 1,130 and 1,150 beds, broadly tracking the gradual increase in forecast occupancy as winter approached.

While there was some week-to-week variation, there was no sustained divergence between actual and expected activity, indicating that system pressures remained largely within anticipated levels. The peak winter period was characterised by a significant and rapid escalation in bed occupancy, with actual occupancy increasing to approximately 1,230 beds in January, representing the highest level observed during the period. Although occupancy reduced through February and March, the pace of improvement was slower than anticipated within the forecast trajectory.

Actual occupancy remained consistently above forecast for much of the period, suggesting that winter pressures had a more prolonged impact than expected. By the end of March, occupancy had reduced from its peak but had not returned to the levels predicted within the recovery trajectory, indicating continued underlying demand and constrained capacity across the system.

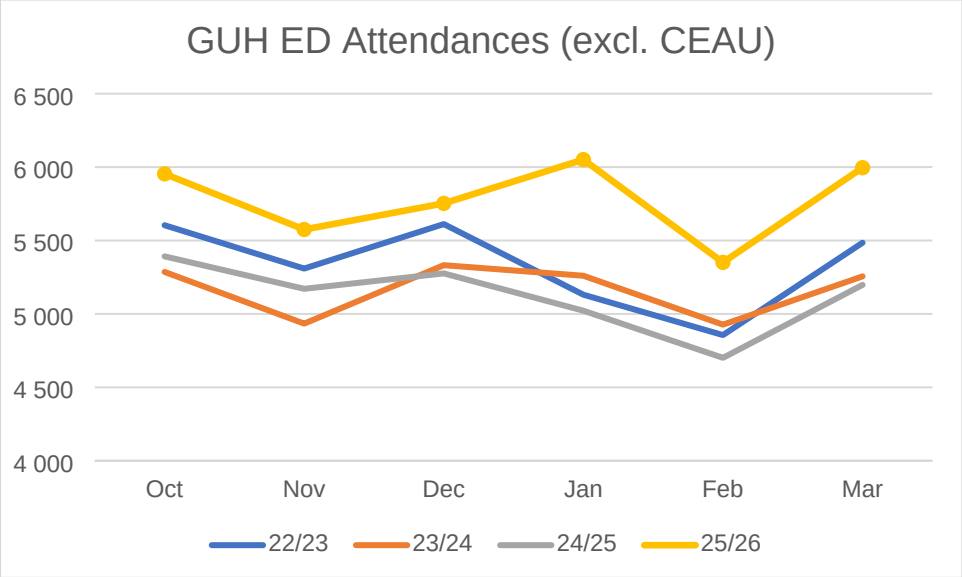
Fig. 4: Local Occupancy Modelling and Actual



3.3 Emergency Department attendances

Adult attendances at the GUH Emergency Department (ED) were consistently higher during Winter 2025/26 than in the preceding three winters, with activity exceeding historical levels in every month shown. January 2026 stands out as the point at which demand diverged most markedly from previous years with attendances peaking at approximately 6,000 in January 2026, compared with around 5,100 in January 2024/25, representing an increase of almost 900 attendances (18%). Even during the seasonal decrease in February due to the shorter month, attendances remained substantially above previous years at approximately 5,350 compared with 4,700 in February 2024/25. Across the six month period, monthly attendances were typically between 400 and 900 higher than those seen during the previous winter. Attendances across the entirety of 2025/26 were 10.1% higher than 2024/25, while the October to March period recorded a 12.7% increase compared with the same period in the previous year, indicating a slight winter bias driven by the exceptionally high demand observed in January.

Fig. 5: Grange University Hospital Emergency Department Attendances between Oct-Mar over the last four years 2022/23-2025/26



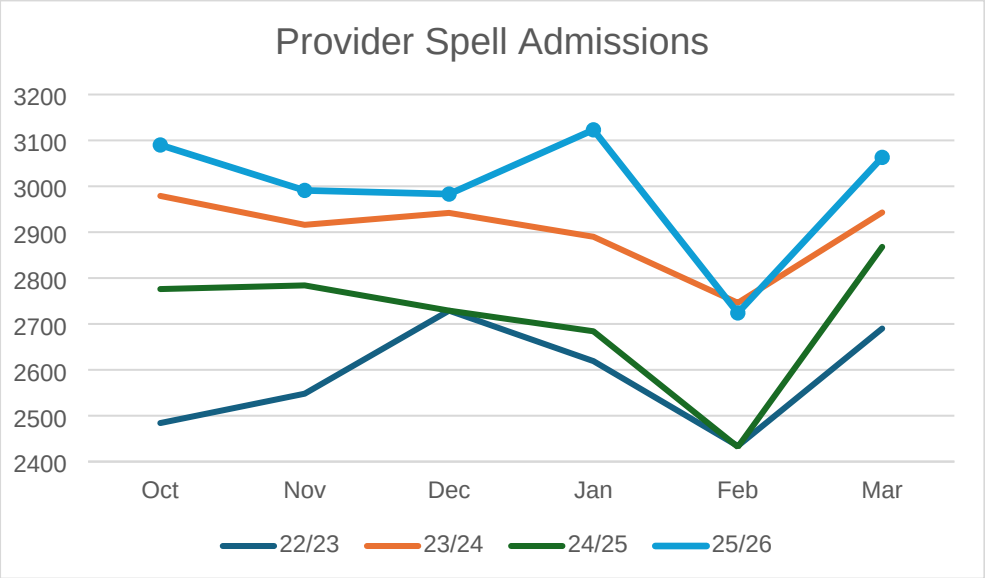
3.4 Emergency Provider Spell Admissions

Emergency provider spell admissions provide perhaps the clearest evidence that the elevated occupancy experienced across the Health Board during Winter 2025/26 was associated with increased demand for hospital admission rather than respiratory pressures alone.

Provider spell admissions were consistently higher than in previous years, with the period from October 2025 to January 2026 showing the highest activity across the

four-year trend. Admissions peaked at approximately 3,120 in January 2026, compared with around 2,680 in January 2024/25, 2,890 in January 2023/24 and 2,620 in January 2022/23. This represents an increase of approximately 440 admissions (16%) compared with the previous winter and more than 500 admissions (19%) compared with 2022/23. The scale of this increase closely mirrors the rise seen in GUH ED attendances during the same month and suggests that the January surge translated directly into additional inpatient demand. The October to March winter period recorded a 10.5% increase in admissions compared with the previous year, against a whole-year increase of 5.8% between 2024/25 and 2025/26, further indicating that demand growth was concentrated within the winter period.

Fig. 6: Health Board Provider Spell Admissions between Oct-Mar over the last four years 2022/23-2025/26



3.5 Additional capacity and estate

The planned additional acute and community capacity was mobilised substantially as intended. Twenty-two rehabilitation beds opened on St Arvan's Ward, Chepstow Community Hospital on 19th December and on 30th December ten medical beds opened on D7W, Royal Gwent Hospital and a further thirteen from 4th January. The intention was to gradually stand down capacity as pressures reduced but due to operational pressures both wards closed around the same time. The benefit in phasing was recognised as a key lesson for future planning.

Feedback from operational colleagues was that the D7W capacity was a success with appropriate staffing and patient cohort selection, reduced length of stay compared to previous winter wards and no significant quality or safety concerns. The pull model

used on the ward was viewed positively and has since influenced practice within core medical wards.

St Arvans ward in Chepstow was also reported to have been a success with initial recruitment concerns largely overcome and strong leadership contributing to a positive patient experience and provided valuable capacity. Some accommodation challenges remained due to services relocated to create the ward.

Additional capacity commissioned at Ty Glas y Dorlan, Torfaen which provides flats for respite and reablement saw occupancy at around 90% which was utilised consistently throughout the winter. Provided valuable support to patient flow and discharge but further opportunities exist to strengthen local authority engagement to improve patient flow into commissioned capacity.

The use of additional Hospital at Home capacity, increased domiciliary care provision and care home and community-based alternatives to admission were also reviewed and agreed to be valuable in reducing demand on hospital services but noted that further work is required to assess overall impact and value.

Phase 1 of the Grange University Hospital (GUH) Emergency Department extension to create a larger rapid assessment/waiting area, was completed on 17 December.

3.6 Admission avoidance and community response

Single Point of Access (SPoA) demonstrated measurable activity early in winter. By the January progress report it had undertaken 185 interventions over 38 days, with a reported 58% conveyance/admission avoidance rate and 109 patients using alternative pathways, excluding enhanced Local General Hospital pathways. The model continued to divert a proportion of patients away from hospital admission, further details of this are available in a SPoA evaluation reported completed in April 2026.

Other planned community interventions progressed with varying degrees of success. Additional Hospital to Home capacity was financially approved but could not fully be implemented because of recruitment difficulties and sickness.

Additional Level 1 falls response capacity received Regional Implementation Fund (RIF) approval but did not go live until February, meaning that it did not contribute during the January peak. Frailty/neighbourhood MDT arrangements were at different stages of maturity across boroughs, and the rapid frailty response was being tested at enhanced Local General Hospital sites.

3.7 Discharge, flow and Pathway of Care delays

Discharge and flow remained the main constraint during peak winter pressure. Pathway of Care delays increased from 165 in November to 223 in December, with the largest increase relating to patients awaiting social care assessment. During the January Critical Incident, patients waited in ED and the medical assessment unit for

admission, in some cases for up to five days, and medical patients were boarded across wards, assessment areas, therapy/day rooms and multiple sites.

The first Winter Sprint (8-22 December) supported stronger discharge performance and helped normalise pre-noon discharge practice, with examples of good practice including the Community Assessment Lounge, extended weekend pharmacy and therapy input. However, it did not achieve the anticipated impact on weekend discharge rates, ambulance handover delays or ED waits over 24 hours. The sprint also identified persistent cross-system issues including local authority referral processes, Trusted Assessor arrangements and reliance on paper-based ward-round processes.

3.8 Vaccination

Influenza vaccination uptake improved during 2025/26 with uptake for residents aged 65 years and over at 73.9%, compared with 72.9% in 2024/25 and 73.0% across Wales.

Fig 7 below shows that there was marked geographic variation, particularly for children aged 2-3, ranging from 38.2% in Torfaen and 41.5% in Newport to 67.6% in Monmouthshire.

Fig. 7: Summary of Influenza vaccination uptake as of 31st March 2026 by Local Authority for the three priority groups

Summary by Health Board and Local Authority of General Practice **(31/03/2026)**

		Children 2 to 3 years			16y to 64y in a clinical risk group			65y and older		
		Immunised	Denominator	Uptake (%)	Immunised	Denominator	Uptake (%)	Immunised	Denominator	Uptake (%)
Aneurin Bevan UHB	Blaenau Gw..	819	1,414	57.9%	5,613	13,091	42.9%	10,717	15,118	70.9%
	Caerphilly	1,895	3,418	55.4%	13,630	30,750	44.3%	28,539	38,978	73.2%
	Monmouths..	1,173	1,737	67.5%	7,712	15,565	49.5%	21,768	27,658	78.7%
	Newport	1,622	3,844	42.2%	10,723	26,105	41.1%	20,917	29,012	72.1%
	Torfaen	779	1,962	39.7%	7,280	17,070	42.6%	15,505	21,058	73.6%
	AB Total	6,288	12,375	50.8%	44,958	102,581	43.8%	97,446	131,824	73.9%
Wales	Wales	27,662	58,888	47.0%	215,163	503,916	42.7%	528,891	724,719	73.0%

Staff influenza vaccination uptake increased to 46.45%, compared with 37.31% in 2024/25. These are positive year-on-year improvements, although they indicate that substantial proportions of both staff and eligible population groups remained unvaccinated.

Fig. 8: Uptake of Health Board Staff Influenza Vaccination by Division

Division Group	Employed	Immunised	Uptake	Remaining to Target
CHC / Complex Care	290	138	47.59%	80
Clinical Support Services	1,680	868	51.67%	392
Corporate WF & OD	1,344	657	48.88%	351
Estates & Facilities	1,554	622	40.03%	544
Family & Therapies	2,685	1,420	52.89%	594
Medicine	2,031	805	39.64%	718
Mental Health & LD	1,553	521	33.55%	644
Primary & Community	2,046	972	47.51%	563
Surgery	1,812	926	51.10%	433
Urgent Care	541	287	53.05%	119
Total	**15,536**	**7,216**	**46.45%**	**4,436**

3.9 Finance

The original winter plan was costed at approximately **£1.9m–£2.0m**. The Winter ward expenditure remained broadly within the agreed financial envelope with D7 West, St Arvans and Tŷ Glas y Dorlan all operated below planned expenditure due to earlier closure, vacancies and non-pay efficiencies. Capitalisation of some set-up costs reduced revenue expenditure.

Additional winter pressures outside the formal winter plan created further costs, including:

- Critical incident measures
- Boarding mitigation
- Ambulance handover initiatives
- ED extension arrangements
- Additional domiciliary care
- Increased critical care acuity

4. Overall effectiveness and lessons for 2026/27

Based on the evidence available, the Health Board's Winter Plan 2025/26 was effective. It delivered capacity and pathway mitigations and supported the Health Board through a winter in which respiratory activity was less severe than planned but wider emergency demand was significantly higher. However, high occupancy, delayed flow and the January Critical Incident show that the system remained vulnerable to non-respiratory demand and discharge constraints.

Learning for 2026/27 is that future winter planning should be based on a whole-system capacity model rather than respiratory demand alone and discharge capacity by pathway and Local Authority also needs further assessment. Investment was required to implement the Winter Plan and the knowledge of the winter pressures that created costs outside of it should be considered in future plans.

Draft Winter Preparedness Plan 2026/27

1. Introduction

This draft Winter Preparedness Plan 2026/27 ('Winter Plan') sets out the actions being taken by the Health Board and partners to improve whole system flow in advance of and during Winter 2026/27. The actions aim to improve system resilience across Health, Social Care, Welsh Ambulance Services Trust (WAST), Primary and Community services and the Regional Partnership Board. It shows the Gwent Region's RAG rated response to Welsh Government's recent Winter Preparedness self-assessment for the 2026/27 winter period which highlights where further work is required.

2. Purpose, Aims and Objectives

The Winter Plan sets out how the Gwent Health and Care system will prepare for, manage and recover from the increased demand, operational pressures and workforce constraints expected during winter 2026/27.

It covers the period of 1st December 2026-31st January 2027 period with particular focus on a pre-Christmas winter sprint and Christmas and New Year.

The plan applies across acute, community and primary care, social care, ambulance services, care homes, mental health, palliative and end of life care and relevant third sector support.

It is intended to support safe, coordinated management of winter demand while protecting planned and critical care by:

- Preventing avoidable deterioration, conveyance and admission through vaccination, proactive frailty and respiratory care, care-home support, falls response, community pharmacy, Single Point of Access (SPOA), Enhanced Community Care (ECC) and alternatives to hospital attendance.

- Protecting acute capacity through earlier infection prevention and control (IPC) action, rapid senior decision-making, Same Day Emergency Care (SDEC)/Minor Injuries Unit (MIU) pathways, ambulance handover improvement, critical care surge arrangements and scenario-based acute/community bed plans.

- Minimising Discharge delays through use of the Optimal Hospital Flow Framework (OHFF), Home First, Discharge to Recover and Assess (D2RA), criteria-led discharge, Trusted Assessor arrangements, action on clinically optimised and long-stay patients, seven-day working and flexible transport availability.

- Maintaining effective operational command through a whole-system escalation framework, real-time situational awareness, clear executive/director cover, regional governance and a targeted winter sprint before Christmas.

The objectives of the Winter Plan are to ensure:

- Home and community first using the least restrictive, clinically appropriate setting and avoiding conveyance or admission where safe alternatives exist.
- Flow is a whole-system responsibility: admission avoidance, front-door processes, inpatient flow and discharge must operate as a single pathway rather than separate entities.
- Actions are taken early: agreed escalation triggers are used to intervene before pressure becomes critical.
- Seven-day capacity is in place where the demand profiles shows this is required
- Shared data across health and care partners is used to make operational decisions
- Protection of planned care capacity where possible: surge actions should be risk-assessed and avoid unnecessary displacement of cancer, urgent, long waits and diagnostic activity.

3. Related Documents

The Winter Plan should be read alongside:

- The Health Board's Urgent and Emergency Stabilisation and Improvement Plan
- Organisation's existing Business Continuity Plans
- Infection Prevention and Control procedures
- Critical Care surge arrangements
- Relevant Standard Operating Procedures I.e. Critical Care and Infection Control

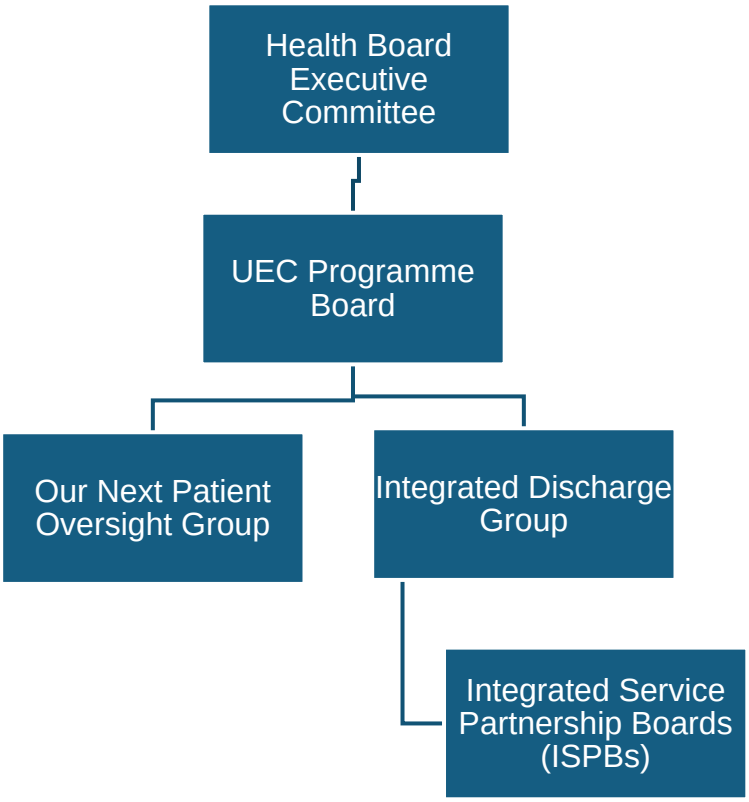
4. Governance and Accountability

It is proposed that the existing regional governance arrangements for Urgent and Emergency Care (UEC) are used to provide one clear route for assurance, escalation, support and challenge to the Winter Plan. The UEC Programme Board will provide overarching oversight, supported by programme management, operational and divisional groups covering the relevant workstreams. These governance arrangements are set out in Diagram 1 below.

There are several informal meetings that also support implementation of the Winter plan including fortnightly meetings between Health Board operational colleagues and Local Authority Heads of Service, monthly Gwent Directors meetings and monthly Local Authorities/Health Board Chief Executive meetings.

Some groups will increase their frequency of meeting to provide the required additional focus on cross-system escalation, rapid decision making and enhanced planning for the Christmas and New Year period.

Diagram 1: Governance arrangements for the Winter Plan



In terms of escalation:

- For regional partners - Integrated Discharge Board with escalation to Gwent Directors of Local Authorities and Gwent Chief Executives
- Within the Health Board – Use “Our Next Patient” and Urgent and Emergency Care Board with escalation through to Executive Committee

The Region’s Strategic Immunisation Group and Vaccination Operational Group will oversee delivery of the vaccination plans. The Vaccination actions will be monitored by the existing Vaccination Operational Group.

The Health Board Senior Responsible Officer has been identified as the Executive Director of Strategy, Planning and Partnerships. They will be responsible for:

- Reporting delivery of the Winter Plan to the Health Board and the Regional Partnership Board
- Ensuring that an Equality Impact Assessment and Health Impact Assessment are undertaken on the Winter Plan prior whilst it continues to be developed and working with partners on mitigations for any groups disproportionately affected by it.

- Working with the Health Board's Chief Operating Officer and Directors of Social Services to undertake the Winter Plan exercise, record learning and amend the final plan.

5. Role of Health Board Executives and Directors of Social Care

Strong, visible, and consistent leadership is fundamental to the successful delivery of the Winter plan. Health Board Executives and Directors of Social Care will play a pivotal role in:

- Setting clear direction to ensure that care is delivered in the right place, first time
- Ensuring ownership and accountability for delivery, performance and quality
- Providing visible leadership including at the UEC Programme Board and sub-groups and frontline engagement

6. Workstream Details

The self-assessment and previous Winter Plans have identified respiratory illness, frailty, falls, workforce availability, infection outbreaks, community capacity, delayed discharge and the Christmas/New Year holiday period as the principal sources of winter risk and therefore form the workstreams of the Winter Plan.

The below table sets out these workstreams and the current position of them:

The Winter plan assumes that demand and operational pressure will not be uniform and that the system must be able to move from business-as-usual to enhanced and surge responses at short notice.

Via the Regional Partnership Board on 15th September, further work is underway within the four ISPBs to be clearer on local place based actions that will support the winter plan, with a focus in vaccinations, falls and warm homes. These updates will feature in the next iteration of plan.

Appendix 2: Winter Preparedness

Workstream	Actions	Current position
Vaccinations	Deliver the agreed influenza, COVID-19 and RSV plans, with targeted outreach to staff, care-home residents and communities with lower uptake. Use uptake intelligence and partnership communications to reduce inequity.	Flu, COVID-19 and RSV (Respiratory Syncitial Virus) programmes are in place. Uptake will be reported to the Vaccination Operational Group with dashboards available by practice.
	Maximise frontline staff flu vaccination through trained vaccinators, peer champions, roaming provision and walk-in access at vaccination centres.	
	Maintain school-age flu vaccination, including arrangements for home-educated children, pupil referral units and other non-mainstream settings.	Plans are in place but school vaccination capacity is constrained by changes to the Human Medicines Regulations from 1 April 2026, which reduces the previous Healthcare Support Worker (HCSW) delivery model.
	Identify eligible working-age adults under 65 with relevant comorbidities and strengthen proactive vaccination, pre-winter health checks and access to antivirals.	Raised at Regional Partnerships Groups to agree targeted partnership communications and uptake intelligence for low-uptake groups and review through winter governance.
Frailty and Community Demand	Maintain the Acute Front Door Frailty offer at Grange University Hospital and use the Caerphilly older-person pathway pilot to strengthen rapid frailty assessment and in-reach.	Caerphilly pilot aligned to older person pathway programme review rapid frailty model aiming to strengthen in reach processes. Acute Frailty at the Front Door remains in operation at GUH.
	Use the Populations at Risk programme, primary care virtual MDTs, care-home support and proactive care principles to identify people at highest risk of urgent care use.	Robust process of Populations at Risk management led by DMD. DSS offered to practices but limited take up. Revised DSS expected which may improve this.
	Increase the number of people with current urgent-care/crisis plans that can be accessed by relevant services, recognising the current information-sharing limitations	Multiagency forums/ planning meetings in place for frequent attenders. Hiraeth Specialist Psychology service complete

		individual management plans for EUPD patients, all staff involved with 136 can access
	Continue ECC and intermediate-care pathways including CRT, START, D2RA, Home First reablement, step-up/step-down provision, Parklands and Ty Glas y Dorlan.	Regular meetings both at operational (boroughs) and tactical (divisional) level to ensure that there is reactive flow for patients to return home. S33 discussions are ongoing - Enhanced community care and intermediate care services are in place across Gwent provision includes CRT, START, D2RA, Home First reablement, step up and step down beds, Parklands Care Home and Ty Glas y Dorlan beds.
Community Nursing	Move District Nursing weekend capacity towards the expected 80% of average weekday capacity and monitor weekend contacts. Attach the day-by-day staffing profile for the winter period.	Weekend District Nursing capacity is reported as moving towards 72% of weekday capacity against an expectation of approximately 80%.
	Maintain palliative and end-of-life support through community nursing and hospice partnerships.	Need to confirm specialist palliative care weekend arrangements and out-of-hours capacity.
	Continue care-home falls training, lifting-equipment access, medical triage/head-injury pathways and provider engagement. Monitor vacancies, outbreaks, closures and admission restrictions through winter governance.	Sufficient residential and nursing care home capacity is currently available. Maintain provider engagement and capacity monitoring; remind Social Care managers to complete timely assessments and escalate closures, bed losses or admission restrictions by 01/11/2026 and throughout winter.
	Maintain Local Authority front-door services five days per week, with Emergency Duty Team cover outside these hours and at weekends	In place
Respiratory Pathways	Establish a consistent method to identify high-risk COPD patients across localities and confirm the proactive engagement offer before 1 November 2026.	High-risk COPD identification is not yet fully established

	Ensure post-exacerbation care bundles are provided at discharge, with referral to CRT COPD Homecare where appropriate and follow-up support within 14 days.	Post-exacerbation bundles and 14-day support are in place
	Review alternatives to ED attendance for patients who cannot be safely managed at home and address identified community service gaps by November 2026.	In place in order to support current rapid release protocols and to support CRT functions, however will require greater focus and consideration of service gaps in order to support winter resilience
	Ensure access to Pulmonary Rehabilitation within 2–4 weeks after an exacerbation	Pulmonary rehabilitation (PR) waits are around 10 weeks in Caerphilly and Torfaen versus the required 2–4 weeks. Options appraisal completed to align PR across 5 Boroughs to PCCS but will require funding.
	Use nationally agreed COPD, asthma, RSV bronchiolitis and community-acquired pneumonia guidance across primary and community teams; monitor prescribing/clinical compliance.	National agreed guidance's shared with teams across community and primary care, monitoring will be undertaken throughout this period using prescribing data and clinical dashboards
	Continue appraisal of remote monitoring for selected high-risk respiratory patients, subject to resource availability.	C & V model scoped, Red, Amber, Green which can be replicated but would require additional resource.
Infection, Prevention and Control	Health boards must follow Infection Prevention and Control guidance to reduce Acute Respiratory Infections transmission.	SOP for escalation and HB policy in place
	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed..	SOP for winter escalation, cubicle risk assessment available, IPT support 7 days working when 2 or more outbreaks
	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.	Continue HCAI improvement work including care bundles, validation audits, antimicrobial stewardship, enhanced cleaning and senior-nurse oversight.

	Complete outstanding fit testing and ESR recording for relevant staff groups and ensure PPE stock/flow is resilient to increased demand.	H&S leading the delivery access to staff and limited assessors
Acute Demand and Flow	Development and delivery of a plan capable of effectively managing periods of increased demand for UEC whilst not impacting on planned care capacity (inclusive of up to date bed modelling and confirmation of surge capacity Funded and Unfunded).	Bed surge plan will be completed in Sept reflecting bed modelling and community options such as Hospital to Home, step down beds and will include continued delivery of the Rapid Release Protocol. A bed surge plan is being developed using acute and community bed modelling, with an intention to have one acute and one community surge ward available. The exact funded/unfunded bed levels, staffing model and activation for opening them is to be confirmed.
Critical Care	Emergency Critical Care bed capacity plans are in place to ensure timely access for emergency admissions throughout the winter period.	Emergency critical care bed capacity plans and SOP in place for winter as per previous winter, with clearly defined escalation triggers and activation processes, maintain oversight of critical care bed occupancy - December 2026
	Emergency Critical Care bed capacity plans are in place to ensure timely access for emergency admissions throughout the winter period.	Critical care surge plan and SOP in place for winter as per previous winter, monitor capacity, occupancy, staffing levels and patient flow through regular performance reporting - December 2026
Discharge	A Memorandum of Understanding (MOU) is in place with Local Authority to ensure sufficient services are in place to support discharge at pace, ensuring appropriate leadership arrangements in place. Escalation processes have been agreed with Local Authority partners to prioritise hospital discharges.	MOU signed off and in place, initial focus Monmouthshire and Blaenau Gwent to access patients in NHH and YYF on behalf of each other, evaluation of impact and plan to roll out to further localities, current arrangements include Home First, provision on the Stroke

		ward are YYF health-led initiation of packages of care and reconfiguration of Home First to increase back door capacity within community hospitals. Escalation processes have been agreed with Local Authority partners to prioritise hospital discharges. Align the integrated discharge hub at RGH with the Hospital to Home service, creating a more integrated approach to progressing discharges, improving efficiency, and reducing delays. Development of single referral form for community interventions, including therapy services and IV antibiotic pathways Progress the data and digital workstream, including providing Local Authority access to the newly developed single-point discharge data entry system, which is planned for implementation in October.
	Health Board and WAST are working together to plan resources available to support discharge without delay and maximise the effective use of discharge lounges.	Health Board and WAST continue to work together to plan resource to support discharge and use of discharge lounges with a particular focus at GUH

	Community services are aligned to discharge demand and Home First pathways without compromising quality or safety.	Hospital to Home will work alongside Home First to support safe discharge where possible where funding & resource allows.
	Robust action focused processes are in place to regularly review clinically optimised patients and support timely and appropriate discharge to the most appropriate setting.	Daily Board Rounds and weekly LOS meetings in place across all acute and community sites reviewing patients to support timely discharge, scrutiny panel to review top 20 longest staying patients. Continue monitoring delays, actions and escalations throughout winter.
	Weekly review of all patients with a length of stay over 21 days, irrespective of whether the patient is clinically optimised or not.	Weekly LOS meetings in place across all acute and community sites reviewing patients, review criteria varies across site, all patients are reviewed daily as part of the board round. Long-stay patient review arrangements are in place, but full assurance requires confirmation that every patient with a stay over 21 days is reviewed weekly, with attendance, actions, ownership and escalation consistently recorded.
	Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of discharges to be expedited.	Five-day discharge targets by ward have been profiled to include weekend discharges
	Criteria-led discharge arrangements are in place and operating effectively to support pre-midday and weekend discharges.	Simplified SOP developed, supported by sticker in patient notes, developing digital system to track progress across Divisions
	Trajectories and monitoring arrangements are in place to achieve at least 33% of inpatient discharges before midday across seven days.	Trajectory monitoring arrangements are in place but 33% performance is not always achieved.
Winter Sprint	Deliver a winter sprint from 7 to 21 December 2026, using learning from previous sprints and with oversight through the Integrated Discharge Improvement Board and wider system governance.	Learning from previous sprints has been shared through the Integrated Discharge

		Board and wider system governance. Detailed planning in train
	Confirm detailed day-by-day operational actions for the sprint, including discharge, community capacity, staffing, transport and senior decision-making.	To be planned in November 2026.
	Confirm named executive/director-level cover across health, social care and the RPB for 22 December 2026 to 3 January 2027	Health Board on call rota confirmed – awaiting confirmation of social care

7. Next Steps

- Complete whole-system demand and bed modelling on receipt of Public Health Wales modelling
- Confirm resource implications for surge capacity and workforce and other shortfalls in plan such as COPD discharge support.
- Health Board Divisional workshop 2nd October to review winter plans
- Confirmation of ISPB key actions
- Complete QEIA and quality-risk review
- Confirm and set out Executive cover for the Christmas and New Year period.
- Test the plan through a winter exercise
- Update to Partnership, Population Health and Planning Committee in October 2026

ANNEX A – Welsh Government template

Winter Preparedness and Delivery 2026/2027: Regional Self-Assessment Template
Please complete and return to: NHSPI.Uecresilience@wales.nhs.uk (see instructions tab for submission deadlines).

Primary Drivers	Levers	Key Interventions	Key Actions	Implementation Deadline	Metrics/Performance data	Lead Organisation e.g. NHS/Social care or both via RPB.	Implementation Status (please select)	Risks to Delivery	Actions in Place and Timeline
1. Proactive Frailty Care in the Community (CbD)	**Prevention and Population Health**	Vaccination: staff/ at risk/ over 65s	Increasing uptake of influenza vaccination among staff groups using the Influenza Vaccination Lessons Learned 25/26, maximising vaccination champions; peer vaccinators; MECC; and uptake, monitoring roaming immunisation teams and improved accessibility	01/12/2026	Influenza vaccination uptake in HB staff and those with direct patient contact	Health Board with support from RPB for social care staff.	Fully	Clinical leadership, peer vaccinator capacity, clinic access across all sites and staff motivation	Delivery plans for influenza, COVD-19 and RSV have been agreed and submitted to VPW through the Vaccination Operational Group. Senior cross-divisional oversight will be provided throughout Winter by the Strategic Immunisation Group. Framework for action to support Winter resilience be agreed at the RPB/ISPB workshop on 20th Aug.
			Ensure equitable and timely provision of Flu vaccination to School age children, including Electively Home Educated children and those in Pupil Referral Units and Youth Offender Institutes	01/12/2026	Influenza vaccination uptake among primary & secondary school aged children	Health Board with support from the Local Authority Chief Education Officers.	Partially	Recent changes in the Human Medicines Regulations (as of 1st April 2026) has significantly restricted the scope of practice of HSCWs in delivery of the programme. In previous years the workforce model has operated on a ratio of 1 Registered Nurse to 3 HCSWs. Under the new regulations HCSWs cannot be utilised in the role they have played in previous flu seasons, significantly reducing capacity to deliver the schools programme. To deliver same levels require an RN workforce for which there is no idenfied revenue. Other risks include: Parental consent, cultural and religious beliefs, competing school priorities, pupil absenteeism, school	Delivery plans for influenza, COVD-19 and RSV have been agreed and submitted to VPW through the Vaccination Operational Group. Senior cross-divisional oversight will be provided through the Strategic Immunisation Group. Framework for action to support Winter resilience be agreed at the RPB/ISPB workshop on 20th Aug. Paper to HB Exec team on challenges post Human Med Regs Act

								closures due to adverse weather, and access for children who are home educated or receiving EOTAS	
			Increase uptake of COVID, Flu and RSV vaccines to protect against winter respiratory illnesses, ensuring that the reduction of inequities is prioritised by targeting low-uptake groups and care home residents, utilising uptake monitoring	01/12/2026	Influenza, COVID-19 and RSV vaccination uptake among care home residents and identified low uptake groups.	Health Board with support from RPB partners to engage residential care homes and low-uptake groups.	Fully	Engagement with cluster based delivery model for influenza and COVID-19 vaccination in care homes and the capacity and capability to provide outreach to low-uptake groups through the mobile vaccination unit and walk-in clinics. Unequal uptake and outbreaks in care settings may increase demand and staff absence.	Delivery plans for influenza, COVD-19 and RSV have been agreed and submitted to VPW through the Vaccination Operational Group. Senior cross-divisional oversight will be provided through the Strategic Immunisation Group. Framework for action to support Winter resilience be agreed at the RPB/ISPB workshop on 20th Aug. Utilise targeted partnership communications and uptake intelligence for low-uptake groups and care homes; review through winter governance.
		Frailty	Existing action: Work with UEC Programme to implement the essential requirement of the Acute Front Door Frailty Service as agreed with UEC Programme	01/11/2026	No of admissions avoided	NHS/Social Care	Partially	Capacity of resources versus growing demand , skilled advanced workforce	Caerphilly pilot aligned to older person pathway programme review rapid frailty model, strengthen in reach processes. Acute Frailty at the Front Door remains in operation at GUH a.k.a. CAL - existing action
			Existing action: Issue and support implementation guidance for providers of general medical services (Frailty 0.5%)	01/11/2026	Total patients presented to virtual MDTs in community Number of unique patients presented to virtual MDTs in community	NHS	Partially	Practice participation	DSS offered out to practices, limited take up. Revised DSS expected which may improve the position with greater clarity -existing action
			Existing action: Local Health Boards and Local Authorities to collaborate to continue to increase referrals to Enhanced Community Care (ECC) and Multi Professional Wrap Around Care (including Reablement). Self-Assessment and subsequent planning should consider and	01/11/2026	Total number of service users on the DN caseload Total number of DN unique service users seen in month Referrals accepted by Rapid Response	NHS/Social Care	Partially	Workforce and financial pressures continue to present challenges across the system. The planned separation of services currently delivered through the Section 33 arrangement is currently being disaggregated. Two joint task and finish groups have been set up to review service delivery and financial planning, working	Regular meetings both at operational (boroughs) and tactical (divisional) level to ensure that there is excellent reactive flow for patients to return home. S33 discussions are ongoing - Enhanced community care and intermediate care services are in place across Gwent provision includes CRT, START, D2RA, Home First reablement, step up and step down neds, Parklands Care Home and Ty Glas y Dorlan beds - existing action

			advise improvement trajectories					collaboratively to assess risks, identify opportunities, and develop sustainable solutions. In parallel, further work is being undertaken to clarify the need for any alternative agreements	
			Existing action: Local 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 week day. Self-Assessment and subsequent planning should consider and advise improvement trajectories against target expectation	01/11/2026	Number of weekend DN patient contacts DN average contacts per single weekend day	NHS	Partially	Internal recruitment restricts the ability to recruit	Provision of robust weekend structure which is moving toward 72% Monitoring process in place led by Divisional Nurse - existing action
			Implement 'neighbourhood level' timely, accessible, coordinated and TEC enabled Information, Advice and Assistance (IAA)	01/11/2026	No of people accessing neighbourhood IAA services	Social Care	Not	Funding to secure digital equipment to implement and interface with existing digital systems	Scoping required to understand current existing systems in place across localities in preparation for proactive implementation over the winter - November 2026

			Enhanced management of key areas of urgent and emergency care community demand within community setting - Care homes (admission avoidance and alternative pathways to conveyance)	01/11/2026	Number of patients conveyed to hospital from care home settings	NHS	Partially	WAST conveyance remains steady. Care homes are independent entities who can chose what to engage with CIW regulations escalation rather than other management Staff availability may affect the capability to deliver and sustain the planned service arrangements throughout the winter period Care-home falls training; lifting-equipment access; conveyances avoided; workforce shortages, provider instability or restricted admissions may reduce capacity.	CH work will be delivered by boroughs providing excellent opportunity for local engagement Central group will work tactically to continue to provide education, equipment and escalation support; and strategically by supporting innovation and escalation upward - in place Admission avoidance and alternatives to conveyance are supported by staff training in responding to people who fall, access to appropriate lifting equipment, a pilot providing medical triage for fallers, and new head-injury pathways - existing action Continue falls training, lifting-equipment provision and the medical-triage/head-injury pathways; monitor provider sustainability, capacity and outbreak escalation triggers through winter.
			Existing action: Proactive management of 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 services	01/12/2026	Total patients presented to virtual MDTs in community Number of unique patients presented to virtual MDTs in community	NHS/Social Care	Partially	Lack of funding resulting in cost pressure to division Community Falls programme has been suspended	Robust process of Populations at Risk management led by DMD Clear workstreams reporting to this which are monitored against agreed outcomes - existing action
	Chronic Conditions (Proactive Care)	COPD bundle	Respiratory winter planning including applying a proactive COPD High Risk bundle to COPD management: Health Boards should use available data to identify high-risk patients and engage with them proactively before the winter period	01/11/2026	No of localities completed mapping	NHS	Not	Inconsistent availability and quality of data, alongside variation in engagement processes across localities, may limit the ability to accurately identify and proactively engage high-risk patients ahead of winter pressures	Scoping required to understand current existing data to identify high risk patients and understand current engagement process in place across localities in preparation for proactive winter engagement - November 2026

			Ensure all patients receive the BTS Post-Exacerbation Care Bundle and are followed up within 14 days of hospital discharge	01/11/2026	No of patients receiving COPD care bundle	NHS	Partially	Delays in provision of discharge bundles, inconsistent referral to CRT COPD Homecare, or limited capacity within community services may result in patients not receiving timely post-discharge support	Secondary care provide bundles to patients upon discharge, referring to CRT COPD Homecare if appropriate [6 steps] for 14 day support and care prior to discharge or referral back to RACU in secondary care - in place
			Develop clear pathways offering alternatives to Emergency Department attendance for patients who cannot be safely managed at home	01/11/2026	No of COPD patients managed at home	NHS	Partially	In place in order to support current rapid release protocols and to support CRT functions, however will require greater focus and consideration of service gaps in order to support OPP and winter resilience	Review of community resource and services to support demand over winter - November 2026
			Ensure access to Pulmonary Rehabilitation within 2–4 weeks after an exacerbation	01/11/2026	No of patients accessing Pulmonary Rehabilitation	NHS	Partially	Current waits to access PR are IRO of 10 weeks for Caerphilly and Torfaen. PR responsibility for Newport, Monmouthshire and Blaenau Gwent sits with Secondary Care	Options appraisal completed to align PR across 5 Boroughs to PCCS - decision to work collaboratively - - existing action
			Existing action: Work via community by design led by Respiratory Network to consider remote monitoring options for selected high-risk patients	01/11/2026	tbc	NHS	Not	Ability to absorb additional demand within current resources	C & V model scoped, Red, Amber, Green Model which can be replicated model would require additional resource - existing action
			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	01/11/2026	Prescribing compliance against national compliance	NHS	Partially	Clinical variation across teams	National agreed guidance's shared with teams across community and primary care, monitoring will be undertaken throughout this period using prescribing data and clinical dashboards

	Urgent and Same Day Care	Integrated Community frailty pathways (via 999/SPoA/IAA/ECC e.g. falls)	Health boards/WAST to ensure updated / accurate Directory of Services to support reducing hospital conveyances	01/11/2026	Reduction in hospital conveyance	NHS supported by WAST	Partially	Funding to develop digital solution to support Directory of Services across Health Board/WAST, access to alternative pathways via the Health Board Flow Centre	Promote alternative pathways via Health Board Flow Centre with WAST via the Demand Management Group, September 2026
			Provide assurance that arrangements/processes are in place to bring forward repeat prescribing and medication ordering ahead of the Christmas and New Year period, particularly for dispensing practices (applicable to all GP practices and especially dispensing doctor practices).	01/11/2026	N/A	NHS	Partially	Fixed prescribing schedules preventing early authorisation patients leaving supplies to last minute, adverse weather impacting upon ability to collect medication	Liaise with comms to compose patient messaging, circulate patient messaging beginning November to patients and partners. Liaise with GMS to compose and issue guidance to practices regarding prescribing practices and to align dispensing messages for dispensing doctors with community pharmacy. Reinforce messaging around avoidance of post dated scripts especially with EPS to minimise friction in the system and raise awareness of ability to issue an additional batch over the Xmas period or during times of potential extreme weather. Liaise with engagement team to support messaging in the community. Refresh messaging weekly from Nov 1st. GMS and Community Pharmacy work jointly with independent contractors to ensure mechanisms are in place ahead of the period. . Specific primary care assurance on bringing forward repeat prescriptions and medication orders ahead of the Christmas and New Year period should be confirmed separately.
			Health Boards to promote community pharmacy services (Sore Throat Test and Treat / UTI services).	01/12/2026	Number of Sore Throat Test consultations undertaken under the common ailments scheme, Number of UTI consultations undertaken under the common ailments scheme, Number of common aliments scheme consultations undertaken (Inc STT and UTI), Number of 'Pharmacist Independent Prescribing Service' (PIPS) Consultations	NHS	Fully	Limited reach of HB comms and engagement	Liaise with comms to support messaging around CAS, Reinforce eligibility and access - conscious of increased workload within pharmacy during the busy Christmas dispensing period. Liaise with engagement to do same . Start messaging mid November to recognise work and capacity issues associated with Flu delivery, reinforce messaging weekly.
			Provide planned District Nursing staffing levels for each day across the period expressed as a % of the average weekday day capacity.	01/11/2026		NHS	Fully		

			Enhanced management of key areas of urgent and emergency care community demand within community setting - L1 and L2 falls response pathways.	01/11/2026	WAST Level 1 & Level 2 incident attendances and Conveyances	Health Board commissioned to WAST/SJAC	Fully	Capacity to maintain service levels through SJAC, WAST and CAATT Demand profile associated with frailty - funding cessage at end of Mar 2027	Level 1: Additional L1 coverage approved for expansion to a 24-hour service provided by SJAC Level 2: - approved AHP resource and alternative governance arrangements from Sept 2026 providing 12-hour daytime service with a paramedic and therapist. Aiming to provide 7 day 12 hour Level 2 coverage supported with AHP resource aligned to ABUHB's CAATT service rotating out to the WAST vehicle
			Implement Single Point of Access to Urgent Care (LHBs) as a component of enhanced regional system navigation providing at minimum a 5 day service operating 12 hours a day.	01/12/2026	No of admissions avoided	NHS	Partially	Sustainable workforce resource, including staff with clinical skills set to navigate system, accessing alternative pathways. Lack of funding available and workforce availability to operate SPOA	Confirm SPoA model to support delivery of the Older Person Pathway at YYF, including existing resource i.e. APP and access to virtual advice to include frailty, September 2026 Local Authority operates a front door service five days a week, emergency duty team provides cover outside these hours and at weekends
			Within an integrated IAA model of care, ensure of continuation of the six goals programme community-based falls response framework.	01/12/2026	WAST Level 1 & Level 2 incident attendances and Conveyances	Health Board commissioned to WAST/SJAC/ RPB oversight	Partially	Capacity to maintain service levels through SJAC, WAST and CAATT Demand profile associated with frailty	Level 1: Additional L1 coverage approved for expansion to a 24-hour service provided by SJAC Level 2: - approved AHP resource and alternative governance arrangements from Sept 2026 providing 12-hour daytime service with a paramedic and therapist. Aiming to provide 7 day 12 hour Level 2 coverage supported with AHP resource aligned to ABUHB's CAATT service rotating out to the WAST vehicle
	Front Door Admission Avoidance	Acute Frailty Units and Protected SDEC	Health Boards/ WAST to promote and utilise appropriate pathways for hospital avoidance i.e.: SDEC/MIUs/Community services to reduce conveyances.	01/12/2026	No of admissions avoided No of SDEC attendances No of MIU attendances Reduction in hospital conveyance	NHS	Partially	Capacity in community services to support hospital avoidance Availability of services seven days a week to support hospital avoidance	Promote alternative pathways via Health Board Flow Centre with WAST via the Demand Management Group, September 2026 MIU open seven days a week
			Existing action: Actions to achieve Handover 45 based on agreed trajectories.	01/12/2026	% Ambulance Handovers within 45 mins	NHS	Partially	Discharge delays Insufficient SDEC capacity Poor system wide co-ordination	Discharge Improvement Programme - UEC Plan in place SDEC operating five days a week - in place Maintenance of Rapid Release Protocol - positive August data Delivery trajectory for December 2026 95%
			Existing action: achieve 60 minute target for ED wait to be seen (i.e. rapid assessment at the front door).	01/12/2026	< 60 mins to see Clinician - GUH ED	NHS	Not	High demand over winter period Prolonged stays in ED Insufficient alternative pathways	Review skills mix of clinical decision maker in ED

			Actions to ensure appropriate admission criteria followed to avoid unnecessary admission (Home First approach).	01/12/2026	No of admissions avoided. Home First referrals.	NHS/social care	Partially	Limited availability of community alternatives. Rising demand, workforce pressure	Promote alternative pathways via Health Board Flow Centre - in place. Continue the Home First model, including a designated social worker for each Local Authority working with acute and community teams; monitor pathway use and outcomes through the Integrated Discharge Board.
2. Protect Acute Hospital Capacity	**Infection Prevention and Control**	Earlier IPC Triggers	Health boards must follow Infection Prevention and Control guidance to reduce Acute Respiratory Infections transmission.	01/12/2026	HB policy reflects national ARI escalation SOP developed and discussed on 18.08.26 IPAS agenda, weekly monitoring of prevalence	NHS	Partially	Patient environment i.e. shared facilities, capacity and demand, lack of isolation facilities, staff and visitors symptomatic, vaccination uptake	SOP for escalation, HB policy, vaccination programme, point of care testing within assessment areas, transmission precautions
			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.	01/11/2026	Monitored monthly and shared with Divisions current position for C difficile 72 cases reported for April – July 2026. This is 6 less than the equivalent period 2025/26. This is a HB rate of 35.8 per 100,000 population, Staph aureus blood stream infections 64 cases reported for April – July 2026. This is 13 more than the equivalent period 2025/26. This is a HB rate of 31.82 per 100,000 population, E coli 128 cases reported for April – July 2026. This is 14 more than the equivalent period 2025/26. This is a HB rate of 63.65 per 100,000 population, Klebsiella 45 cases reported for April – July 2026. This is 5 more than the equivalent period 2025/26. This is a HB rate of 19.33 per 100,000 population, pseudomonas 15 cases reported for April - July 2026. This is 1 more than the equivalent period 2025/26. This is a HB rate of 7.46 per 100,000 population	NHS	Partially	Patient placement and environment i.e. shared facilities, capacity and demand, lack of isolation facilities, compliance with fundamental infection prevention, environmental cleaning. Patients own endogenous infection risks	HB policy, care bundles, validation audits and senior nurse monitoring, establish RCA process, Datix reporting, access to enhanced cleaning methodology, key linking champions, antimicrobial stewardship, standard precautions including hand hygiene
		Scenario-based bed modelling with Protected Surge Plans	Development and delivery of a plan capable of effectively managing periods of increased demand for UEC whilst not impacting on planned care capacity (inclusive of up to date bed modelling and confirmation of	01/12/2026	% Ambulance Handovers within 45 mins < 60 mins to see Clinician - GUH ED No of patients streamed to SDEC No of discharges per ward per month	NHS	Partially		Bed surge plan will be complete in Sept reflecting bed modelling and community options such as Hospital to Home, step down beds and will include continued delivery of the Rapid Release Protocol - December 2026

			surge capacity Funded and Unfunded).						
			Residential / nursing care home capacity (including nursing and residential care homes). Please provide additional bed numbers where appropriate and how you have been engaging with local care home providers in your region and beyond if applicable)	01/11/2026	N/A	NHS/Social Care	Fully	Care home vacancies will vary; currently 172 vacancies across Gwent. Workforce shortages, outbreaks, provider sustainability and specialist-placement constraints may reduce available capacity.	Sufficient residential and nursing care home capacity is currently available. Maintain provider engagement and capacity monitoring; remind Social Care managers to complete timely assessments and escalate closures, bed losses or admission restrictions by 01/11/2026 and throughout winter.
	Acute Capacity is the 'Right Size'		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)	01/12/2026	Number of paediatric escalation days attributable to capacity pressures	NHS	Partially	Increased waiting times, delays in assessment and treatment	Develop and agree an all-Wales paediatric surge and escalation framework, including clear triggers, actions, and governance arrangements, clarify national lead
			Emergency Critical Care bed capacity plans are in place to ensure timely access for emergency admissions throughout the winter period.	01/12/2026	Critical care bed occupancy	NHS	Fully	Planned critical care surge capacity cannot be sustained due to workforce shortages, high level of demand, delayed transfers from critical care and completing operational pressures	Emergency critical care bed capacity plans and SOP in place for winter as per previous winter, with clearly defined escalation triggers and activation processes, maintain oversight of critical care bed occupancy - December 2026
			Ensure a fully updated Critical Care surge plan is in place, including workforce surge arrangements and clear escalation pathways, to ensure safe expansion of capacity to support increased Winter ARI.	01/12/2026	Critical care bed occupancy	NHS	Fully	Planned critical care surge capacity cannot be sustained due to workforce shortages, high level of demand, delayed transfers from critical care and completing operational pressures	Critical care surge plan and SOP in place for winter as per previous winter, monitor capacity, occupancy, staffing levels and patient flow through regular performance reporting - December 2026
			Existing action: Actions to eliminate 12 hour ED waits based on agreed trajectories.	01/12/2026	12 Hour Compliance - GUH ED	NHS	Partially	Sustained reductions in corridor care may not be maintained if patient flow pressures increase, leading to renewed use of non-designated clinical spaces and potential impacts on patient safety, experience, and quality of care	Our Next Patient rapid release protocol has focused on timely patient flow to support reducing corridor care. Through this protocol there has been a move away from corridor care on the first floor and the use of care in non-designated clinical spaces will remain under review - existing action

			Existing action: Actions to achieve Handover 45 based on agreed trajectories.	01/10/2026	% Ambulance Handovers within 45 mins	NHS	Partially	Periods of high demand may impact achievement of Handover 45 and agreed trajectory targets, resulting in delays in patient flow.	Our Next Patient Rapid Release Protocol has focused on timely patient flow and delivery of the Handover 45 and agreed trajectories - existing action
			Existing action: achieve 60 minute target for ED wait to be seen (i.e. rapid assessment at the front door).	01/12/2026	< 60 mins to see Clinician - GUH ED	NHS	Partially	Workforce shortages, increase in demand and competing operational pressure may impact the ability to achieve 60 minute target	Senior clinical decision maker presence, streaming and redirection processes, timely patient discharge - existing action
			Elimination of corridor care.	01/12/2026	No of boarded patients	NHS	Partially	Increased demand and capacity pressures may hinder elimination of corridor care, affecting timely delivery of safe and efficient patient care	Our Next Patient rapid release protocol has focused on timely patient flow to support reducing corridor care. Through this protocol there has been a move away from corridor care on the first floor and the use of care in non-designated clinical spaces will remain under review - existing action
			Health Boards to ensure clear escalation bed modelling that is inclusive of community beds with engagement from primary care teams that oversee community beds. This should include clear surge capacity plans based on most likely and extreme pressure scenarios.	01/11/2026	No of discharge per ward per month Proportion of discharges before 12pm Proportion of discharges made on weekends Reduction in length of stay	NHS	Partially	Surge beds not opened or operationalised in a timely manner due to workforce shortages, insufficient rosters estate and equipment constraints financial pressure and completing operational demands Clear agreed escalation plan for community hospitals	Development of bed model and plan including workforce plan, rosters and equipment, aligned to demand and capacity modelling, based on learning from previous winter, plan to open two wards, one acute and one community, Primary Care to provide oversight of community beds aligned to community capacity such as hospital to home and frailty - November 2026. Align to agreed full capacity boarding plan with associated escalation process - November 2026
			A plan is in place to ensure operational resilience of mental health urgent care including 111#2, crisis alternatives, crisis resolution home treatment teams, inpatient services and S136 capacity including senior decision makers.	01/11/2026	Divisional performance dashboard 111#2 dashboard 4 hour target ICAUCT dashboard	NHS	Partially	Bed Capacity Staff sickness respiratory illness	Winter surge not expected for MH, less affected by seasonal factors Transformation of crisis service with dedicated team in progress will stabilise service and continue 4 hour compliance. Increase resilience of community teams with functional approach Focus on bed flow - Sprint to start Sept 26 136 suite staffed 24/7, robust S12 rota in place Flu vacc roll out/ Flu champions in place
			Identify the people who frequently access mental health urgent care services and the people at high risk of mental health crisis and ensure they have	01/11/2026	MHA data	Multiagency	Partially	Multi agency cooperation Robustness of joint planning	Multiagency forums/ planning meetings in place for frequent attenders. Hiraeth Specialist Psychology service complete individual management plans for EUPD patients, all staff involved with 136 can access

			a person centred crisis plan in place that is known and accessible to the person, their carers or supporters as agreed and the relevant services.						
			Ensure plans in place and describe the plans to cover: 1. Social worker capacity 2. Capacity for community and hospital-based assessments. 3. Social care packages (including domiciliary care availability/Reablement assurance (Assurance around capacity to Right Size Package)	01/11/2026	No of discharges per ward per month Reduction in length of stay	NHS/Social Care	Partially	Previously agreed escalation cards for Local Authority reporting Workforce availability, growing complexity, financial pressure and provider capacity may affect assessments and packages.	Review escalation cards with the LAs and ensure robust performance reporting Local authorities will maintain close oversight of staffing pressures and work collaboratively to redeploy available workforce capacity where operationally appropriate and required Additional social work assessment capacity has been introduced through the POCD grant, this capacity is available throughout the year and will support the winter response Assessment capacity is available across hospital and community settings, although further work is required to strengthen consistency, visibility and demonstrated outcomes
			Existing action: Implement the actions identified within the UEC Hospital Pressures Plan.	01/12/2026	% Ambulance Handovers within 45 mins < 60 mins to see Clinician - GUH ED No of patients streamed to SDEC No of discharges per ward per month	NHS	Partially	Sustained increase in demand, workforce shortages, delayed discharges, insufficient escalation capacity, limited community capacity and social care provision and inconsistent implementation of agreed operational flow processes	Establishment of clear executive and operational oversight through weekly Our Next Patient to deliver the plan, monitoring of key performance indicators, robust escalation arrangements, delivery of the rapid release protocol, strengthen discharge processes through D2RA, criteria led discharge, trusted assessor arrangements, maximise bed capacity and patient flow through the Optimal Hospital Flow Framework and escalation emerging risks - existing action
3. Discharge Without Delay	**Early and seven-day discharge**	NEPTS, DRRA, CHC, step-down rehab (ECC/Hospital at Home)	Existing action: Consistent delivery of the six goals programme 'optimal hospital flow framework'.	01/11/2026	No of discharge per ward per month Proportion of discharges before 12pm Proportion of discharges made on weekends Reduction in length of stay	NHS	Partially	Inconsistent adoption of standardised processes, insufficient system wide engagement, limited community and social care capacity, inadequate digital and performance data and completing operational pressure	OHFF is a key element of UEC Plan. . Tractions has been made within community wards and acceleration of progress in acute wards in the quarter preceding Christmas 2026

			Existing action: Applying a proportionate approach to 7-day health and social care working to enable discharge of people during the weekend and prevent admission.	01/10/2026	Proportion of Discharges made on weekends	NHS/Social Care	Partially	Insufficient workforce capacity across health and social care, limited availability of community services and packages of care at weekends, restricted access to diagnostics, pharmacy and transport. CRT Services and DN operating 7 days a week, with limited access to social care services via home first team	Oversight and escalation arrangements through UEC Improvement and Stabilisation Plan, monthly Integrated Discharge Board to progress collaborative work with local authorise, fortnightly oversight meeting with WAST to reinforce and develop admission avoidance pathways - existing work. Social care services will operate on a business-as-usual basis throughout the period. The Emergency Duty Team (EDT) will provide out-of-hours cover, while domiciliary care, residential care and supported living services will continue as normal
			Undertaking Decision Support Tools (DST)/Continuing Health Care (CHC) process in the community to reduce CHC related discharge delays in hospital.	01/11/2026	CHC databases Commissioning team data dashboards	NHS/LA	Fully	BAU	DST process well embedded across Gwent. Coordination of process via MH&LD commissioning team
			Existing action: Consistent delivery of the Trusted Assessor model.	01/11/2026	No of discharge per ward per month	NHS/Social Care	Partially	Variation in roles across Gwent, insufficient workforce capacity, unclear roles and responsibilities	MOU signed off and in place, initial focus Monmouthshire and Blaenau Gwent to access patients in NHH and YYF on behalf of each other, evaluation of impact and plan to roll out to further localities, current arrangements include Home First, provision on the Stroke ward are YYF health-led initiation of packages of care and reconfiguration of Home First to increase back door capacity within community hospitals- existing action. We will continue the mapped Trusted Assessor model, using proportional assessment, shared standards and transparent communication; monitor acceptance and timeliness through discharge governance.
			Existing action: Embed D2RA Pathways into practice (optimising the Home First approach).	01/11/2026	People allocated to a D2RA pathway or No Pathway Allocated within 1 Day of admission, People clinically optimised and allocated a D2RA pathway or No Pathway Allocated, People Discharged to each D2RA Pathway 0, 1, 2, 3 and No Pathway Allocated, Median Length of stay for each pathway and No Pathway Allocated	NHS/Social Care	Partially	D2RA pathways are nor consistently embedded into routine practice due to variable staff understanding, inconsistent application of pathway criteria, limited community capacity and workforce constraints. Optimal process in place for POCD reporting and escalation of clinically	Continue to embed the Optimal Hospital Flow Framework across all sites, oversight through Divisional leads with oversight from Integrated Discharge Improvement, training and awareness sessions to be held to reinforce D2RA principles and definition of expected date of discharge and ward live dashboards in place to monitor D2RA compliance - existing action. Continue with actions and review opportunities to improve approach

								optimised patients, including weekly scrutiny panel for longest lengths of stay. Demand, community capacity and inconsistent pathway visibility may delay transfer or recovery.	
			Existing action: Implement and apply criteria led discharge to support pre-midday and weekend discharges.	01/11/2026	Proportion of Discharges before 12pm, Proportion of Discharges made on weekends	NHS/Social Care	Partially	Implementation of criteria led discharge is not consistently adopted across wards due to variable clinical engagement. Full MDT engagement, education and change of culture	SOP developed and clear governance and clinical oversight, standardise CLD pathways, delivery of training, monitor ward level compliance and discharge outcomes, oversight through monthly Integrated Discharge Improvement Board, chaired by Deputy Chief Operating Officer - existing action. Rolling out across all community hospital
			Existing action: Management of pathway of care delays and clinically optimised patients.	01/11/2026	HOWIS POCDs Census	NHS/Social Care	Partially	Clear process in place for POCD reporting and escalation of clinically optimised patients, including weekly scrutiny panel for longest lengths of stay. Workforce challenges, CHC challenges, Task and finish group now in place.	Re-enforce escalation over the winter period. Maintain action-focused reviews of pathway-of-care delays and clinically optimised patients; use shared data and escalate system constraints through the Integrated Discharge Board and GASP.

			Hospital Discharge/care transfer capacity - Hospital discharge and care transfer arrangements (including Home First pathways and discharge capacity/ NEPTS Capacity or community transport capacity in place, along with ensuring third sector support in place to ensure settling in support in place.)	01/11/2026	No of discharge per ward per month	NHS/Social Care	Partially	Insufficient patient transport capacity, limited availability of NEPTS, late discharge decisions, poor coordination between hospital, transport and social care teams	Associate Director - Patient Transportation to provide strategic oversight of patient transport arrangements, monitor transport related discharge delays, lead escalation where capacity constraints are identified and work with operational, community and system partners to ensure transport service support timely and efficient patient discharge - ongoing through regular oversight meetings with WAST and operational teams. Hospital discharge and care transfer capacity is supported by Home First, Home First Backdoor, Hospital to Home, Hospital to a Healthier Home, the Post Hospital Discharge Project, Patient Transport Clinical Support, the GUH Discharge Team, Patient Flow, Medicine and Surgery discharge provision, the Hospital Social Work/Discharge Hub, Brokerage, START, D2RA and reablement pathways. Care & Repair and Age Connect provide third-sector support for safe transitions home and post-discharge support. Health input is still required to confirm winter transport arrangements, including NEPTS and community transport capacity.
			Existing action: Actions to prevent deconditioning and maintain function.	01/11/2026	Reduction in length of stay	NHS/Social Care	Partially	Workforce capacity constraints, completing operational pressures, limited therapy and rehabilitation process. Boarding consistency in meaningful activity spaces	Deconditioning workstream under Discharge Improvement Programme implement ward-based improvement projects focused on early mobilisation, rehabilitation, nutrition and hydration - existing action.
4. Effective Operational Command	**Early Escalation triggers and actions**	Whole system Escalation Framework and NHS P&I resilience monitoring	Develop regional operational resilience plans for the period 01 December 2026 – 31 January 2027 inclusive of any MADE events pre and post-Christmas periods.	01/11/2026	N/A	NHS/Social Care	Not	Stakeholder engagement, competing operational priorities, work and resource constraints and unclear governance Uncertainty re system priorities and affordability of additional capacity plans e.g. winter ward	Development of operational resilience plans over Dec/Jan, including the MADE event - stakeholder engagement through existing governance structures November 2026. Complete the regional system resilience plan through GASP/RPB governance, incorporating joint surge planning, community alternatives, shared risks and escalation arrangements by 01/11/2026.
			A winter sprint is planned 7th to 21st December 2026. Develop detailed day by day regional operational resilience	01/11/2026	N/A	NHS/Social Care/RPB	Partially	Partner availability, workforce pressure and data timeliness may limit delivery during the sprint.	Development of plan for winter sprint, based on learning from previous sprints, oversight and governance via Integrated Discharge Improvement Board , delivery of

			plans and actions associated with the winter sprint.						winter sprint in December 2026 - plan to be in place November 2026
			Oversight and Escalation (Health, Social Care & RPB) Executive/Director level presence / support over 22 December 2026 – 3 January 2027	01/11/2026	N/A	NHS/Social Care	Partially	Oversight and escalation not robust during the winter period due to ineffective governance, delayed decision making and limited system wide co-ordination. Holiday-period availability and fragmented situational awareness may delay decisions or escalation.	Oversight and escalation arrangement will be in place for the period through weekly Our Next Patient (Health) and through the monthly Integrated Discharge Board (Health and Social Care) 22nd December 2026 and 3rd January 2027 - November 2026. Maintain oversight through board and ward rounds, flow meetings, long-stay reviews, Heads of Service meetings and the Integrated Discharge Board; confirm executive/director cover for 22/12/2026–03/01/2027. RPB RSO role to continue.
			Implement updated Escalation Framework and associated triggers and actions	01/10/2026	N/A	NHS/Social Care	Partially	Inconsistent application of the escalation processes, inadequate real-time data and insufficient engagement from system partners. Capacity within operational areas to develop	Implement escalation framework for winter - October 2026. PCC - escalation cards in development by service leads with target of 1st October

Winter Preparedness and Delivery 2026/2027: Regional Assurance Template
Please complete and return to: NHSPI.Uecresilience@wales.nhs.uk (see instructions tab for submission deadlines).

Primary Driver	Assurance Questions	Assurance Rating (please select)	Lead Organisation e.g. NHS/Social care or both via RPB.	Actions Required to Provide Full Assurance
1. Proactive Frailty in the Community (CbD)	**Vaccination and Prevention**			
	1. Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults and the annual winter flu and covid vaccination campaigns.	Partial	NHS	Capacity to address complacency and build confidence among priority cohorts particularly in deprived communities where uptake is typically low. Embed the Equity Action Plan across all vaccination programmes to reduce inequalities in access and uptake, ensuring targeted interventions are focused on underserved and at-risk populations. Review and evaluate the effectiveness of designated nurse (DN) and Neighbourhood Care Network (NCN) support for winter respiratory vaccination campaigns, using uptake data and stakeholder feedback to identify good practice, address gaps and inform future campaign planning
	2. In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.	Partial	NHS	Ability to engage with working age adults under the age of 65 alongside pre-winter health checks. Evidence that all eligible patients under 65 with relevant comorbidities have been identified, proactively contacted and encouraged to receive their vaccinations, offered a pre-winter health check and have clear, timely access to antiviral treatments where clinically appropriate. This should be supported by documented care pathways, monitoring of uptake and outcomes, and audit evidence demonstrating that continuity of care is being delivered effectively within the community
	3. There is a plan in place to maximise flu vaccination uptake amongst frontline staff and achieve Welsh Government vaccination expectations for 2026/27.	Partial	NHS	Vaccination Service will support the Staff Flu Campaign by delivering a revised and enhanced training programme for vaccinators, incorporating video-based learning and self-assessment tools to improve accessibility, consistency and competency. To maximise convenience and increase uptake, staff will be able to attend any designated vaccination centre without the need for a pre-booked appointment, providing flexible access to vaccination at a time and location that suits their working arrangements
	Identification and Proactive Management of High-Risk Populations			
	4. Health Boards have identified high-risk COPD patients and implemented a proactive winter respiratory care plan including bundle compliance, post-discharge follow-up and access to pulmonary rehabilitation.	No	NHS	Scoping of current pathways to adjustment to meet assurance requirements
	5. High-risk populations, including people living with frailty, respiratory disease, long-term conditions and care home residents, are identified and proactively managed before and during winter, through coordinated	Partial	NHS/Social Care	Populations at Risk steering group is chaired by DMD and has clear workstreams for which colleagues report against an agreed framework. Outcome measurement remains challenging and lack of access to GP and WAST pt level data compounds Enhanced community care and intermediate care services are in place across Gwent provision includes CRT, START, D2RA, Home First reablement, step up and step down neds, Parklands Care Home and Ty Glas y Dorlan bed

	community, ECC and Primary Care interventions to reduce deterioration, conveyance and admission.			
	Frailty Services and Admission Avoidance			
	6. Proactive frailty and care home support arrangements are in place, including identification and management of people at highest risk of urgent care attendance, admission or conveyance.	Partial	NHS/Social Care	Populations at Risk, Care Home Programme, sustainable workforce model and standardisation of services. Continue care-home falls training, lifting-equipment provision, medical-triage pilot and head-injury pathways. Confirm the process for identifying highest-risk residents and report activity, conveyances avoided and escalation arrangements through winter.
	7. The Acute Front Door Frailty Service is operating in line with the agreed essential requirements.	Partial	NHS	Community Assessment Lounge operating at GUH supported by Home First and Community Admission Avoidance Team. Embed robust in reach model consistently, sustain integrated front door model
	8. Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.	Partial	NHS/Social Care	FCP has been espoused by the division and work is ongoing to increase the number of people who have an active plan however difficulties experienced in ensuring this is available to all relevant organisations and associated issues with keeping current and relevant.
	Community Capacity, Urgent Response and Alternatives to Hospital			
	9. District Nurse, ECC and Primary Care have sufficient workforce, skill mix and 7-day capacity to meet winter demand safely.			
	10. Community alternatives to hospital attendance are in place including Single Point of Access, Remote Integrated Care Services, step-down facilities, community pharmacy pathways and falls response services, services delivering enhanced community care (ECC) with evidence of utilisation and impact.	Partial	NHS/Social Care	SPOA- planning ongoing for winter following two week MADE event approach. Routine processes in place for Community Pharmacy services, Falls response services and ECC. PEoLC - Community Nursing Teams work closely with hospices to support patients PDD and support for palliation. SPC are not currently working weekends. However, this is urgently being addressed by divisional management team. SPOA - planning ongoing for winter following two week approach. ECC/ICS GPOOH Community Pharmacy
	11. There is a plan in place across all partners for: a. Palliative and end of life care over the winter period b. SPOA in place for a minimum 5 days per week (12 hours per day) c. Enhanced Community Care & Intermediate Care Services d. GP out-of-hours capacity e. Community pharmacy out-of-hours capacity	Partial	NHS/Social Care	SPOA is currently under review as part of the UEC pan to ensure a sustainable model is in place Local Authority operates a front door service five days a week from 08:00 - 17:00, the emergency duty team provides cover outside these hours and at weekends, maintaining access to urgent support across the full week
	Demand, Capacity, Surge Planning and Protection of Planned and Critical Care			

2. Protect Acute Hospital Capacity	12. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to most likely and extreme pressure surges in whole system demand; supported by a comprehensive surge plan including workforce and escalation arrangements.	No	NHS	Undertake patient demand modelling and develop surge plan. Clairty requested on timelines for national modelling
	13. Bed modelling has been completed (Acute & Community) with a clear process for escalation during peak periods that will not impact on planned care delivery.	No	NHS	Undertake bed modelling for acute and community and develop bed plan
	14. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	No	NHS	Develop elective and cancer delivery plans
	15. Critical Care bed capacity plans and a fully updated Critical Care surge plan, including workforce escalation arrangements, are in place.	Full	NHS	Emergency critical care bed capacity plans and SOP in place for winter as per previous winter, with clearly defined escalation triggers and activation processes, maintain oversight of critical care bed occupancy
	Workforce Resilience and Clinical Decision-Making Capacity			
	16. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Partial	NHS/Social Care	Health - Safe to start daily review of staffing levels and reviewed escalation process aligned to demand Social Care will maintain close oversight of staffing pressures and work collaboratively to redeploy available workforce capacity where operational appropriate and required
	Infection Prevention and Control (IPC) Preparedness			
	17. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Partial	NHS	SOP reviewed, influenza policy to be reviewed for patients pathways, implementation plan for new transmission based precautions (TBP) policy, some staff require mask fit testing in line with the new changes for TBP, laboratory capacity re timely testing or the support of point of care testing
	18. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Partial	NHS	H&S leading the delivery access to staff and limited assessors
	19. A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Full	NHS	SOP for winter escalation, cubicle risk assessment available, IPT support 7 days working when 2 or more outbreaks
	System Partnership and Discharge Governance			

	20. A Memorandum of Understanding (MOU) is in place with Local Authority to ensure sufficient services are in place to support discharge at pace, ensuring appropriate leadership arrangements in place. Escalation processes have been agreed with Local Authority partners to prioritise hospital discharges.	Partial	NHS/Social Care	MOU signed off and in place, initial focus Monmouthshire and Blaenau Gwent to access patients in NHH and YYF on behalf of each other, evaluation of impact and plan to roll out to further localities, current arrangements include Home First, provision on the Stroke ward are YYF health-led initiation of packages of care and reconfiguration of Home First to increase back door capacity within community hospitals. Escalation processes have been agreed with Local Authority partners to prioritise hospital discharges.
	21. Health Board and WAST are working together to plan resources available to support discharge without delay and maximise the effective use of discharge lounges.	Partial	NHS/WAST	Health Board and WAST continue to work together to plan resource to support discharge and use of discharge lounges with a particular focus at GUH
	22. Community services are aligned to discharge demand and Home First pathways without compromising quality or safety.			H2H will work alongside Home First to support safe discharge where possible where funding & resource allows.
	Clinically Optimised Patients and Length of Stay Management			
3. Discharge Without Delay	23. Robust action focused processes are in place to regularly review clinically optimised patients and support timely and appropriate discharge to the most appropriate setting.	Full	NHS/Social Care	Daily Board Rounds and weekly LOS meetings in place across all acute and community sites reviewing patients to support timely discharge, scrutiny panel to review top 20 longest staying patients. Continue monitoring delays, actions and escalations throughout winter.
	24. Weekly review of all patients with a length of stay over 21 days, irrespective of whether the patient is clinically optimised or not.	Partial	NHS/Social Care	Weekly LOS meetings in place across all acute and community sites reviewing patients, review criteria varies across site, all patients are reviewed daily as part of the board round. Long-stay patient review arrangements are in place, but full assurance requires confirmation that every patient with a stay over 21 days is reviewed weekly, with attendance, actions, ownership and escalation consistently recorded.
	Seven-Day Discharge and Discharge Performance			
	25. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of discharges to be expedited.	Partial	NHS/Social Care	Five-day discharge targets by ward have been profiled to include weekend discharges
	26. Criteria-led discharge arrangements are in place and operating effectively to support pre-midday and weekend discharges.	Partial	NHS	Simplified SOP developed, supported by sticker in patient notes, developing digital system to track progress across Divisions
	27. Trajectories and monitoring arrangements are in place to achieve at least 33% of inpatient discharges before midday across seven days.	Full	NHS	Trajectory and monitoring arrangements in place
4. Effective Operational Command	**Governance, Assurance and Accountability**			
	28. The Board has assured the Health Board/Trust elements of the region's Winter	No	NHS	Board to be assured in September2026

Preparedness Plan for 2026/27.			
29. The Director(s) of Social Services have assured the Social Services elements of the region's Winter Preparedness Plan for 2026/27.	No	Social Care	Director of Social Service to provide assurance September 2026
30. The Executive Lead accountable for the winter period has been identified, and has ensured that mechanisms are in place to keep the Board informed of emerging pressures and the response to those pressures.	No	NHS	Executive Lead to inform Board in September 2026
Quality, Risk and Impact Assessment			
31. A robust quality and equality impact assessment (QEIA) informed the development of the Health Board/Trust's plan and this has been reviewed by the Board.	No	NHS	QEIA to be undertaken and shared with Board September 2026
32. The Board has considered key quality risks and is assured that appropriate mitigations are in place for baseline, moderate, and extreme escalations of winter pressures.	No	NHS	Board will consider the key quality risks in September 2026
System-wide Planning and Partnership Working			
33. The Winter Preparedness plan has been developed with appropriate engagement across all system partners and arrangements are in place to respond to increased demand across: a. Local Health Boards b. NHS Trusts c. Welsh Ambulance Services University NHS Trust (national ambulance and NHS 111 Wales services) d. Social Care e. Local Authorities f. Primary care g. Community Services h. Palliative Care I. Mental Health Services	No	NHS/Social Care/WAST	Winter preparedness plan to be developed in partnership with all system partners to ensure a coordinated response, informed by the learning and evaluation from the previous winter Brokerage and delivery of domiciliary care, reablement and other packages of care will continue as business as usual. Most local authorities have moved to an assessment led model, improving flow, reducing length of stay and increasing capacity across the system
34. The Winter Preparedness Plan addresses the key actions outlined in the Regional Self-Assessment and the plan has been developed, tested and ratified through the Regional Partnership Board.	No	NHS/Social Care/WAST	Winter preparedness plan to be developed and will address the key actions outlined in the Regional Self-Assessment
Exercising, Testing and Preparedness			

	35. The Winter Preparedness Plan has been tested during a winter exercise (with primary care and community pathways included), the outcome reviewed, and lessons learned incorporated.	No	NHS/Social Care/WAST	Winter preparedness plan to be tested informed by the learning and evaluation from the previous winter
	Operational Command, Escalation and Situational Awareness			
	36. Robust operational command, co-ordination and escalation arrangements are in place throughout the winter period, including appropriately resourced and tested on-call arrangements and leadership support for operational medical and nursing leaders across acute, primary, community and partner services to enable intelligence sharing, risk management and effective system-wide decision-making.	Full	NHS	Operational command and escalation processes in place alongside robust BAU processes and BCI Processes Regional coordination, governance, performance reporting and alignment of winter planning are supported through the Integrated Discharge Board, with oversight from GASP and the Regional Partnership Board. Operational oversight is maintained through regular board and ward rounds, flow meetings, fishbowl reviews, long-stay patient meetings, meetings with Heads of Adult Service and the Integrated Discharge Board. RPB reis#nstating RSO role for winter
	37. Plans are in place to monitor and report real-time pressures using agreed NHS Wales escalation and reporting arrangements.	Full	NHS/Social Care	Plans will be developed and in place to monitor report pressures

Local Health and Care System Resilience Plans for Winter (1 December 2026 – 31 January 2027)

Please provide details of the anticipated position for key service areas outlined below for the winter period. Not required if elements are identified in Regional Self Assessment/Assurance Template.

Please see instructions tab for further details.

Service Area				
Enhanced management of key areas of urgent and emergency care community demand within community setting				
1. L1 and L2 falls response pathways				
2. Symptoms of breathlessness				
3. Care homes (admission avoidance and alternative pathways to conveyance)				
Community and primary care capacity (inc. GP in-hours capacity) Specifically provide assurance that arrangements/processes are in place to bring forward repeat prescribing and medication ordering ahead of the Christmas and New Year period, particularly for dispensing practices (applicable to all GP practices and especially dispensing doctor practices)				
Provide planned District Nursing staffing levels for each day across the period expressed as a % of the average weekday day capacity.				
Palliative and End of Life Care				
SPOA in place minimum 5 days a week (12 hours a day)				
Enhanced Community Care & Intermediate Care Services				

GP out-of-hours capacity				
Community pharmacy out-of-hours capacity				
In-hospital acute and community site bed capacity (i.e. ability to open temporary capacity at times of pressure. Please provide additional bed numbers, where appropriate).				
In-hospital staffing capacity (including plans for surge capacity)				
Residential / nursing care home capacity (including nursing and residential care homes. Please provide additional bed numbers where appropriate and how you have been engaging with local care home providers in your region and beyond if applicable)				
Social worker capacity				
Capacity for community and hospital-based assessments.				
Trusted Assessor model				
Social care packages (including domiciliary care availability/Reablement assurance and assurance around capacity to Right size Package)				
Oversight & Escalation (Health, Social Care & RPB) Executive/Director level presence / support over 01 December 2026 – 31st January 2027 (e.g. gold command)				

Hospital Discharge/care transfer capacity Hospital discharge and care transfer arrangements (including Home First pathways and discharge capacity/ NEPTS Capacity or community transport capacity in place, along with ensuring third sector support in place to ensure settling in support in place.)				
Additional communications plans				