

Agenda

10:45 - 10:45

AGENDA

0 min

 0. AGENDA Bwrdd BIPBA 29 Ionawr 2026.pdf (4 pages)

10:45 - 11:20

1. MATERION RHAGARWEINIOL

35 min

1.1. Rhagarweiniad

I'w Nodi *Cadeirydd*

1.2. Croeso ac Ymddiheuriadau

I'w Nodi *Cadeirydd*

1.3. Datganiadau o Fuddiannau

Er Sicrwydd *Cadeirydd*

1.4. Adroddiad y Prif Weithredwr

Er Sicrwydd *Prif Weithredwr*

 1.4 Chief Executive Officer Report (January 2026).pdf (13 pages)

1.5. Adroddiad Risg

Er Sicrwydd *Cyfarwyddwr Llywodraethu Corfforaethol*

-  1.5 Risk Report Public.pdf (18 pages)
-  1.5i Public Appx 2 Strategic RR.pdf (44 pages)
-  1.5ii Public Appx 3 Corporate Risk Register (CRR).pdf (75 pages)

11:20 - 11:40

2. PROFIAD CLEIFION/STAFF

20 min

2.1. Stori'r Claf

Er Sicrwydd *Cyfarwyddwr Gweithredol Nyrsio a Phrofiad Cleifion*

- Mamolaeth (brysbennu)

11:40 - 12:20

3. PENNU CYFEIRIAD STRATEGOL

40 min

3.1. Adroddiad Materion Allweddol Pwyllgor Iechyd y Boblogaeth

Er Sicrwydd *Cadeirydd y Pwyllgor*

 3.1 Population Health 3As Key Issues Report (December 2025).pdf (3 pages)

3.2. Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau

12:20 - 14:20
120 min

4. YM MLWYDDYN CYFLENWI: ANSAWDD, DIOGELWCH, PERFFORMIAD AC ADNODDAU

4.1. Adroddiad Amenedigol

Er Sicrwydd

Cyfarwyddwr Gweithredol Nyrsio a Phrofiad Cleifion

4.1.1. Adroddiad y Pwyllgor Amenedigol

 4.1i Perinatal Committee Report.pdf (24 pages)

4.1.2. Cynllun Gwella Amenedigol

 4.1ii Perinatal Improvement Plan Report.pdf (24 pages)

 4.1iii Appendix A Perinatal Improvement Plan.pdf (11 pages)

4.2. Adroddiad Materion Allweddol y Pwyllgor Ansawdd a Diogelwch

Er Sicrwydd

Cadeirydd y Pwyllgor

 4.2 Quality and Safety 3As Key Issues Report (January 2026).pdf (4 pages)

EGWYL CYSUR (20-MUNUD)

13:00pm – 13:20pm

4.3. Adroddiad Perfformiad Integredig

Er Sicrwydd

Cyfarwyddwyr Gweithredol

 4.3 WG Escalation Update & IPR (January 2026).pdf (22 pages)

 4.3i Appendix 1 - DRAFT IPR January 2026.pdf (59 pages)

 4.3ii Appendix 2 - Theatre Utilisation.pdf (11 pages)

4.4. Adroddiad Cyllid

Er Sicrwydd

Cyfarwyddwr Gweithredol Cyllid a Pherfformiad

 4.4 Finance Report Month 09 2025-26.pdf (29 pages)

4.5. Adroddiad Materion Allweddol y Pwyllgor Perfformiad a Chyllid

Er Sicrwydd

Cadeirydd y Pwyllgor

4.5.1. Tachwedd 2025

 4.5i Performance and Finance 3As Key Issues Report (November 2025).pdf (4 pages)

4.5.2. Rhagfyr 2025

 4.5ii Performance and Finance 3As Key Issues Report (December 2025).pdf (4 pages)

14:20 - 14:45
25 min

5. POBL

5.1. Adroddiad Materion Allweddol y Pwyllgor Gweithlu a Datblygu Sefydliadol

Er Sicrwydd

Cadeirydd y Pwyllgor

 5.1 Workforce and OD 3As Key Issues Report (December 2025).pdf (4 pages)

5.2. Trefnu ar gyfer Llwyddiant

I'w Gymeradwyo

Cyfarwyddwr y Gweithlu a Datblygu Sefydliadol

-  5.2 Organised for success programme update.pdf (10 pages)
-  5.2i O4S TOR V7 31st October 2025.pdf (6 pages)
-  5.2ii Director Portfolios.pdf (1 pages)

EGWYL CYSUR (10-MUNUD)

14:45pm – 14:55pm

14:45 - 16:00

75 min

6. LLYWODRAETHU

6.1. Adroddiad Materion Allweddol y Pwyllgor Archwilio

Er Sicrwydd

Cadeirydd y Pwyllgor

6.1.1. Tachwedd 2025

-  6.1i Audit 3As Key Issues Report (November 2025).pdf (4 pages)

6.1.2. Ionawr 2026

-  6.1ii Audit 3As Key Issues Report (January 2026).pdf (3 pages)

6.2. Adroddiad Materion Allweddol y Pwyllgor Cronfeydd Elusenol

Er Sicrwydd

Cadeirydd y Pwyllgor

-  6.2 Charitable Funds Committee (Approval of Accounts) January 2026.pdf (2 pages)

6.3. Adrodd Archwilio Cymru

Er Sicrwydd

Archwilio Cymru

6.3.1. Crynodeb Archwilio Blynnyddol Archwilio Cymru

-  6.3i Crynodeb Archwilio Blynnyddol Archwilio Cymru.pdf (16 pages)

6.3.2. Asesiad Strwythuredig BIPBA 2025

-  6.3ii Asesiad Strwythuredig BIPBA 2025.pdf (45 pages)

6.4. Adroddiad Llywodraethu Corfforaethol

Er Sicrwydd

Cyfarwyddwr Llywodraethu Corfforaethol

-  6.4 Corporate Governance Report.pdf (13 pages)

6.5. Cofnodion cyfarfodydd blaenorol Bwrdd BIPBA

I'w Gymeradwyo

Cyfarwyddwr Llywodraethu Corfforaethol

6.5.1. 23 Hydref 2025 (Arbennig)

-  6.5i Cofnodion Bwrdd Arbennig BIPBA 23 Hydref 2025.pdf (6 pages)

6.5.2. 27 Tachwedd 2025

-  6.5ii Cofnodion Bwrdd BIPBA 27 Tachwedd 2025.pdf (37 pages)

6.5.3. 16 Rhagfyr 2025 (Arbennig)

 6.5iii Cofnodion Bwrdd Arbennig BIPBA 16 Rhagfyr 2025.pdf (10 pages)

6.6. Cofnod Gweithredu

Er Sicrwydd *Cyfarwyddwr Llywodraethu Corfforaethol*

 6.6 SBUHB Board Log 2025-26.pdf (3 pages)

16:00 - 16:15

15 min

7. EITEMAU I'W NODI

7.1. Adroddiad Cyngori'r Bwrdd

I'w Nodi *Cadeiryddion y Grwpiau Ymgynghorol*

 7.1 Board Advisory Groups Report.pdf (4 pages)

7.1.1. Fforwm Partneriaeth y Bwrdd Iechyd

 7.1i HB Partnership Forum.pdf (3 pages)

7.1.2. Grŵp Cyfeirio Rhanddeiliad

 7.1ii Key issues highlight report SRG - January 26.pdf (2 pages)

7.2. Adroddiad y Cadeirydd

I'w Nodi *Cadeirydd*

 7.2 Chair's Report - January 2026.pdf (4 pages)

16:15 - 16:30

15 min

8. EITEMAU I'W DRAFOD

8.1. Unrhyw Fusnes Arall

I'w Draford *Cadeirydd*

8.2. Adolygu effeithiolrwydd y cyfarfod

I'w Draford *Cadeirydd*

16:30 - 16:30

0 min

9. CYFARFOD NESAF BWRDD BIPBA

I'w Nodi *Cadeirydd*

- Dydd Iau 26 Mawrth 2026



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

CYFARFOD BWRDD BIPBA

Dydd Iau 29 Ionawr 2026

10:45am – 4:30pm

Ystafell y Mileniwm, Pencadlys PBA

AGENDA

Rhif yr Eitem:	Enw'r Eitem	Arweinydd	Amseria dau	Diben
RHAN 1. MATERION RHAGARWEINIOL				
1.1	Yn unol â darpariaeth Adran 1(2) o Ddeddf Cyrff Cyhoeddus (Derbyniadau i Gyfarfodydd) 1960, penderfynwyd y dylid gwahardd cynrychiolwyr y wasg ac aelodau eraill o'r cyhoedd o ran gyntaf y cyfarfod ar y sail y byddai'n niweidiol i fuddiant y cyhoedd oherwydd natur gyfrinachol y busnes a drafodwyd. Mae'r rhan hon o'r cyfarfod eisoes wedi'i chynnal mewn sesiwn breifat.	Cadeirydd	10:45am – 10:50am	I'w Nodi
1.2	Croeso ac Ymddiheuriadau			
1.3	Datganiadau o Fuddiannau			
1.4	Adroddiad y Prif Swyddog Gweithredol	Prif Weithredwr	10:50am	Er Sicrwydd
1.5	Adroddiad Risg	Cyfarwyddwr Llywodraethu Corfforaethol	11:10am	Er Sicrwydd
RHAN 2. PROFIAD CLEIFION/STAFF				
2.1	Stori'r Claf Mamolaeth (brysbennu)	Cyfarwyddwr Gweithredol Nyrsio a Phrofiad y Claf	11:20am	Er Sicrwydd



RHAN 3. PENNU CYFEIRIAD STRATEGOL

3.1	Adroddiad Materion Allweddol Pwyllgor Iechyd y Boblogaeth	Cadeirydd y Pwyllgor	11:40am	Er Sicrwydd
3.2	Adroddiad Cynllunio a Phartneriaethau	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau	11:50am	Er Sicrwydd

RHAN 4. CYFLAWNIAD Y FLWYDDYN: ANSAWDD, DIOGELWCH, PERFFORMIAD AC ADNODDAU

4.1	Gwasanaethau Amenedigol - Adroddiad y Pwyllgor Amenedigo - Cynllun Gwella Amenedigol	Cyfarwyddwr Gweithredol Nysio a Phrofiad y Claf	12:20am	Er Sicrwydd
4.2	Adroddiad Materion Allweddol y Pwyllgor Answdd a Diogelwch	Cadeirydd y Pwyllgor	12:50pm	Er Sicrwydd

EGWYL CYSUR: 13:00pm – 13:20pm (20-MUNUD)

4.3	Adroddiad Perfformiad Integredig	Cyfarwyddwr Gweithredol	13:20pm	Er Sicrwydd
4.4	Adroddiad Cyllid	Cyfarwyddwr Gweithredol Cyllid a Pherfformiad	13:45pm	Er Sicrwydd
4.5	Adroddiad Materion Allweddol y Pwyllgor Perfformiad a Chyllid - Tachwedd 2025 - Rhagfyr 2025	Cadeirydd y Pwyllgor	14:05pm	Er Sicrwydd

RHAN 5. POBL

5.1	Adroddiad Materion Allweddol y Pwyllgor Gweithlu a Datblygu Sefydliadol	Cadeirydd y Pwyllgor	14:20pm	Er Sicrwydd
5.2	Trefnu ar gyfer Llwyddiant	Cyfarwyddwr y Gweithlu a Datblygu Sefydliadol	14:30pm	I'w Gymeradwyo



EGWYL CYSUR: 14:45pm – 14:55pm (10-MUNUD)

RHAN 6. LLYWODRAETHU

6.1	Adroddiad Materion Allweddol y Pwyllgor Archwilio i. Tachwedd 2025 ii. Ionawr 2026	Cadeirydd y Pwyllgor	14:55pm	Er Sicrwydd
6.2	Adroddiad Materion Allweddol y Pwyllgor Cronfeydd Elusennol	Cadeirydd y Pwyllgor	15:05pm	Er Sicrwydd
6.3	- Crynodeb Archwilio Blynnyddol Archwilio Cymru - Asesiad Strwythuredig BIPBA 2025	Archwilio Cymru	15:15pm	Er Sicrwydd
6.4	Adroddiad Llywodraethu Corfforaethol	Cyfarwyddwr Llywodraethu Corfforaethol	15:35pm	Er Sicrwydd
6.5	Cofnodion cyfarfodydd blaenorol Bwrdd BIPBA: i. 23 Hydref 2025 (Arbennig) ii. 27 Tachwedd 2025 iii. 16 Rhagfyr 2025 (Arbennig)	Cyfarwyddwr Llywodraethu Corfforaethol	15:45pm	I'w Gymeradwyo
6.6	Cofnod Gweithredu	Cyfarwyddwr Llywodraethu Corfforaethol	15:50pm	Er Sicrwydd

RHAN 7. EITEMAU I'W NODI

7.1	Adroddiad Grwpiau Ymgynghorol y Bwrdd i. Fforwm Partneriaeth y Bwrdd Iechyd ii. Grŵp Adnoddau Rhanddeiliaid	Cadeiryddion Grwpiau Ymgynghorol	16:00pm	I'w Nodi
7.2	Adroddiad y Cadeirydd	Cadeirydd		I'w Nodi

RHAN 8. EITEMAU I'W TRAFOD

8.1	Unrhyw Fater Arall	Cadeirydd	16:15pm	I'w Drafod
8.2	Adolygiad o effeithiolrwydd cyfarfodydd	Cadeirydd		I'w Drafod



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

Cyfarfod nesaf Bwrdd BIPBA: Dydd Iau 26 Mawrth 2026



Un Bae Ar y Cyd
One Bay Way



Meeting Date	29 January 2026	Agenda Item	1.4	
Name of Meeting	SBUHB Board			
Report Title	Chief Executive's Report			
Report Author	Abigail Harris, Chief Executive Officer			
Report Sponsor	Abigail Harris, Chief Executive Officer			
Presented by	Abigail Harris, Chief Executive Officer			
Freedom of Information	Open			
Purpose of the Report	To provide the Board with an update on key strategic issues since the last full Board meeting.			
Key Issues	• Summary of delivery against organisational priorities, including current performance and progress on key milestones • Key risks and strategic updates requiring the Board's attention • Overview of escalation and accountability mechanisms			
Specific Action Required	Information	Discussion	Assurance	Approval
<i>(please choose one only)</i>	☐	☐	☒	☐
Recommendations	Members are asked to: CONSIDER the contents of the report.			

CHIEF EXECUTIVE'S REPORT

1. Introduction

We began 2026 facing significant challenges, with sustained operational pressures and the ongoing constraints of our financial position.

Despite these pressures, work has continued at pace to recover our position and to maintain progress across our organisational priorities. This is testament to the leadership, resilience and dedication of our colleagues; we do not take this for granted and are committed to working together to improve the system for the benefit of our population and for our colleagues.

This report provides the Board with an update on our latest position since the November meeting, outlining delivery against our priorities, key risks requiring Board oversight, and the escalation and accountability arrangements in place to support continued progress.

2. Our Priority Programmes – key updates

a. Improving maternity and neonatal services (service in Targeted Intervention – level 4)

- i. Our Perinatal Improvement Plan is presented to Board today for approval; it addresses implementation of each of the recommendations of the SBUHB Independent Review of Maternity and Neonatal Services and details the progress made since the review publication and the further actions we are taking to respond to the recommendations.
- ii. The Inaugural Perinatal Improvement Programme Executive Board was held in December 2025, with workstreams agreed and executive and service leads assigned. Workstream meetings have been held and arranged for the remainder of 2026. Outputs will be reported via the Perinatal Improvement Executive Programme Board. I chaired the second meeting of the Perinatal Improvement Programme Board in early January.
- iii. The Perinatal Committee meets monthly and reviews all key metrics for perinatal services. The perinatal service does not currently have any elements of care that would flag as a negative outlier.

b. Transforming Mental Health Services

- i. At our Board meeting in November, we received an update on the Mental Health Transformation Programme with a particular focus on estates. The Board approved the commencement of the business case process for the interim solution (temporary moves, to reconfigure the estate to ensure that use of the best estate is maximised and that pathways are reconfigured to improve patient care) and commencement of formal discussions with Welsh Government on the capital requirements. The Board also approved the commencement of the business case process for the longer-term solution (to design and build a purpose built, fit for purpose Adult Mental Health and Older People's Mental Health facility). It was agreed that more formal discussions would commence with Welsh Government.
- ii. Since then, these discussions have taken place and indicated that it is likely we will need to review our options and focus on development of the longer-term solution and of a short-term contingency plan to mitigate immediate risks. We have also received updated information regarding our ability to adapt Neath Port Talbot Hospital during the final period of the Private Finance Initiative Contract. It is accepted that the adult inpatient facilities are not fit for purpose and to not facilitate modern, therapeutic mental health services and therefore agreement on the solution is required urgently.
- iii. It is important to note that the Mental Health Transformation Programme is much wider than estates and has also been set up to address quality and safety concerns through a redesigned service model and associated workforce plans to ensure we are delivering a modernised service that meets the needs of our population; the inaugural Executive Led Programme Board took place on 13 January 2026 bringing together key stakeholders to drive this ambitious transformation forward.
- iv. Progress is being made across all workstreams; the digital workstream is implementing Rio, with full electronic patient record integration with local authorities and will be the first in Wales to do so. Nurse establishment reviews are underway and the quality and safety workstream is making progress on key priorities.
- v. Following a planned Joint Commissioning Committee (JCC) visit to our medium secure unit (Caswell Clinic) in September, several concerns were raised and as such a

temporary pause to new admissions was agreed. We have worked closely with JCC to address these concerns and were notified on the 8 January that the service could reopen for new admissions, a decision which was supported by positive feedback following an unannounced visit by JCC on the 7 January.

c. Maintaining momentum with our planned care improvement (Enhanced Monitoring – level 3 planned care and Targeted Intervention- level 4 cancer)

- i. As reported in our Integrated Performance Report we remain on track to deliver the Ministerial requirements as set out in our plan. We are maintaining 0 patients waiting over 52 weeks for an outpatient appointment and 0 patients over 104 weeks for total wait. This is despite continued increases in referrals.
- ii. Further improvement work is ongoing in relation to improving our efficiency and productivity, including theatre utilisation, and outpatient efficiency and modernisation. Since our last Board meeting, in partnership with our external strategic partner, we launched an elective theatre toolkit in January; this aims to support front line teams with the standardisation and optimisation of our processes based on best practice guidelines.
- iii. The Planned Care Board has also refreshed the outpatient workstream to reflect new delivery expectations and with a focus on reducing waits for follow up appointments.
- iv. Disappointingly, in October, our cancer performance in relation to the Single Cancer Pathway fell to 56% and then 52% in November 2025. This deterioration is largely due to delayed pathology reporting. Plans are being developed to address this and to prioritise reporting for those patients for whom a timely diagnosis is key. A cancer improvement plan is in development to ensure there is greater focus on securing the improvement needed to deliver the deescalation target and the 2026/2027 planning guidance target

d. Emergency and urgent care (targeted intervention – level 4)

- i. As reported in the Integrated Performance Report, we have seen some of the highest levels of ambulance conveyance to Morriston and high Emergency Department attendances and emergency admissions.

- ii. We started the year in a significantly challenged position, with increased demand at the front door, a low discharge profile and therefore severely compromised flow resulting in an exceptionally full hospital and long ambulance waits. Due to these pressures, we declared two Business Continuity Incidents (BCI), on Tuesday 6 January and on Sunday 11 January, for the first time since March 2025. Owing to the hard work of our teams, we were able to recover the position quickly on both occasions, however, the system remains extremely pressured and continued and focussed leadership and monitoring is required.
- iii. We issued an open letter to the public on Monday 12 January 2026 to explain our urgent and emergency care position, the drivers behind the position and the actions we are taking. This letter is included as annex 1 to this report.
- iv. We have a significant number of patients in acute beds who have completed their treatment and no longer need to receive hospital-based care (clinically optimised patients); we continue to work with our partners in the local authority to expedite discharge.
- v. To support in the reduction of the number of clinically optimised patients at Morriston, we repurposed an empty ward at Singleton Hospital, utilising a staffing model aligned to patient need and with clear length of stay targets, to expedite flow and reduce harm from delays and infection risks. We started to open the first 30 beds on 5th January. As well as being the right thing to do for our patients, the new staffing model will cost less to deliver and enable the closure of surge beds creating space for us to establish a decant ward at Morriston Hospital. We are developing a phased plan to open further wards aligned to this model.
- vi. We met the Welsh Government target for Pathway of Care Delays in November, however, the number of patients with a Pathway of Care Delay remains a considerable concern both in terms of risk of patient deconditioning and deterioration of independence and impact on flow but also financial impact.
- vii. On 15 January, we welcomed the new Chief Executive of the Welsh Ambulance Services Trust to Morriston Hospital where she visited all areas of emergency and urgent care provision located there. She was able to see first hand the improvements we have made and confirmed her commitment to working with us to continue to secure system wide improvements so that patients access to the

most appropriate service to meet their presenting needs in a timely way – right across the emergency and urgent care system.

e. Financial Recovery and Sustainability (targeted intervention – level 4)

- i. Recovery and Sustainability Board continues to meet fortnightly to oversee and direct the financial recovery and sustainability programme.
- ii. On 10 December, we held a face to face 'Top 100 Leaders' session with senior operational and clinical leaders within the organisation to review the financial position and the actions we must take to ensure we live within our means and make every pound count; we are holding a follow up session on the 4 February to review our progress.
- iii. On 16 December we held a Special Public Board Meeting to discuss our Month 8 financial position and agree enhanced controls, which included:
 - A 50% reduction in nursing variable pay
 - A 50% reduction in other staffing groups
 - Travel restrictions (except where related to clinical care)
 - Full cessation of printing/printing/stationery and books except those directly required to support to clinical care
 - Full cessation of all study leave not mandated via continued professional development
 - A restriction on catalogue items with bans in areas such as furniture and fitting except in exceptional circumstances
 - Deferral of discretionary spend
- iv. Our Month 9 position, which will be discussed in detail in Board today, reflects that our variable pay spend is the lowest to date (£4.2m). However, we have not delivered our savings target in month, and so we must now redouble our efforts to deliver the savings required to meet our planned deficit position by the end of 2025/2026 and put us on the best possible footing as we enter 2026/2027. Continued oversight, strengthened governance, and collective leadership focus will be essential as we progress our recovery plan.

- v. Looking forward to 2026/2027 and beyond, the Board will discuss our draft Integrated Medium-Term Plan and service, workforce, financial assumptions today, aligned to the delivery of our strategy and of the Welsh Government planning framework.
- vi. Work is progressing at pace to establish a Delivery Unit, bringing together our functions relating to business intelligence and performance management, improvement and programme management so that we have an engine room to drive forward our service improvement and transformation which is key to becoming fiscally sustainable. We aim to have this in place by April 1 2027.
- vii. We recognise the importance of working with our staff representative colleagues as we develop our plans and to engage on the difficult decisions we are needing to make in light of the financial position. We plan to hold board meetings with all the board advisory groups over the next six months as part of the planning process. This includes the Health Partnership Forum, the Health Professionals Forum and the Stakeholder Reference Group.

3. Risks and Strategic Updates for Board Awareness

a. RTT data issue (Betsi Cadwalader Health Board)

Following discussions with the Chief Statistician, the publication of referral to treatment (RTT) waiting times for Betsi Cadwalader was suspended in November due to concerns about accuracy of the data submitted by the health board in recent months, including anomalies in reported waiting list size, and inconsistency with operational activity letters. We are aware of the specific issue relating to the anomaly at BCU and have undertaken checks locally. We are assured that this issue does not apply to waiting lists at SBUHB.

Welsh Government requested all health boards provide assurance on validation processes.

We will undertake a structured and comprehensive review of RTT waiting lists, aligned to the Best Practice Guide, with the following key areas of focus:

- Validation of all RTT pathway stages across planned care waiting lists, ensuring accurate stage allocation, appropriate pathway closures, and correct recording of outcomes.

- Targeted prioritisation of Stages 2 and 3, recognising the scale of variation and the opportunity for rapid improvement, particularly within post-diagnostic, follow-up and unknown pathways
- Use and enhancement of WPAS validation functionality, including the enablement and deployment of automated and AI-supported validation tools to support consistency, efficiency and sustainability beyond the exercise period.

b. Gorseinon Ward Transfer

In October 2025, the Board approved the transfer of West Ward beds from Gorseinon to Singleton Hospital due to staffing-related safety concerns. We remain committed to Gorseinon's long-term future and will engage on its role in Q1 2026/2027 as part of our Clinical Services Strategic Plan (CSSP) development.

In the meantime, we will hold a listening event for service users in and around Gorseinon which will be fed into the CSSP process.

c. Update on Regional Pathology

Memorandum of Understanding (MoU)

A Transitional Memorandum of Understanding (MoU) for the Regional Pathology Programme was written in 2023 and approved by both Public Health Boards in March 2025. The MoU has been developed to provide a governance framework to enable both organisations to work together on the details of a South West Wales Regional Pathology Service. It is designed to facilitate the sharing of information, joint procurement, and the development of service design, staff engagement initiatives, programme governance, and regional leadership arrangements.

Since the MoU approval, the work of the Regional Pathology Programme has evolved, with changes to the dates and programme structure which will be reflected in a revised MoU.

The changes will be made to the document in the coming weeks. The final MoU will be presented to the Extraordinary Regional Joint Committee on the 16 of February 2026 and at both Special Health Board meetings later that same week.

Preferred site for South-West Wales Cellular Pathology Laboratory

A Regional workshop has been scheduled for 2 February 2026 to determine a preferred site for a South-West Wales Cellular Pathology Laboratory. Three sites are being considered, which have met the required hurdle criteria, previously outlined in the Board Paper received at both the Hywel

Dda and Swansea Bay Public Health Board meetings in September 2025. This work is being progressed by the Regional Cellular Pathology Capital Working Group, chaired by the Executive Director of Strategy and Planning in Hywel Dda University Health Board, which sits within the agreed Regional Cellular Pathology Programme governance structure.

A South-West Wales Cellular Pathology Laboratory Options Appraisal paper will be prepared following the workshop, outlining the preferred regional option for Welsh Government consideration.

The process and timeline to approve this paper prior to Welsh Government submission has been defined as:

- Regional Joint Committee for review and endorsement at a single-issue meeting, which has been scheduled virtually on 16 February 2026.
- Swansea Bay UHB for approval at a Special Board meeting, which has been scheduled virtually on 17 February 2026.
- Hywel Dda UHB for approval at an Extraordinary Board meeting, which is scheduled for Thursday 19 February 2026.

4. Escalation and Accountability Arrangements **a. Escalation Status update**

On 16 December, the Cabinet Secretary for Health and Social Care released a written statement confirming that he had accepted recommendations from Welsh Government officials related to changes in the escalation status to a number of NHS organisations.

This confirmed there was no change to our status, with escalation levels as follows:

- Level 4 for finance, strategy and planning and performance and outcomes related to HCAs, cancer and urgent and emergency care
- Level 4 for maternity and neonatal services
- Level 3 for performance and outcomes related to planned care and CAMHS

The achievements that the Board has made for planned care and more recent improvements in urgent and emergency care were recognised, however, further feedback from the Director General of Health and Social Care Wales/NHS Chief Executive Officer outlined further rationale for the decision not to de-escalate in the domains, and what must be achieved before de-escalation is considered. This is summarised below:

- Urgent and emergency care- Further evidence that improvements are sustainable and will extend across the entire pathway with a focus on improving patient flow, improvements in emergency department performance and reducing pathway of care delays.
- Planned care- reduction in number of patients waiting for follow up appointments and reduction in diagnostic waits.
- Cancer- 60% compliance with single cancer pathway standard for three consecutive months will results in automatic de-escalation.
- Infection protection control, complaints handling and service issues within mental health, maternity and neonatal relating to capacity, staffing, infrastructure and quality of care – must be addressed in a compassionate and timely manner.
- Finance- respond to recommendations of strategic partner in full, implement a robust financial recovery plan and route map to balance with defined milestones, alongside strengthen improvements in financial governance, control and sustainable financial management with improved productivity and efficiency.

We continue to progress actions to achieve de-escalation through our priority programme boards and through our Performance and Assurance Framework. We will continue to report progress through our monthly escalation report, which is received at each Board meeting. We have received feedback from Internal Audit on our escalation arrangements recommending areas where we should strengthen our processes. This work is in train.

b. Public Accountability Meeting

On 18 December, the Health Board participated in our first Public Accountability Meeting with the Cabinet Secretary for Health and Social Care. These meetings, alongside the regular meetings the Cabinet Secretary holds with NHS Chairs, form an important element of how Welsh Ministers hold the NHS to account for delivering against our priorities and represent a key first step in the Cabinet Secretary's determination to provide greater public transparency in accountability arrangements.

Our organisation was represented at the meeting by ten Board members, comprising of independent and executive members.

The meeting took the form of questioning by the Cabinet Secretary and his senior officials on key areas of performance aligned to the themes of:

- Financial sustainability and planning
- Improving access for all
- Getting services right for the future
- Strengthening how we run the NHS

The meeting was supported by a written evidence paper submitted in advance of the meeting and I have attached this as Annex 2 to my report.

The meeting was intended to be accessible for anyone to watch live on the day, however unfortunately a technical issue meant that there is no video and only a sound recording available. This can be found on the Welsh Government YouTube channel.

The meeting provided an appropriate challenge, however we felt that we presented a balanced and transparent account of the organisation, we owned our areas of weakness and were clear on our plans to address those.

We welcomed the opportunity to be held to account, as accountability helps us improve and drives us forward. At the time of writing, we have not received the Cabinet Secretary's letter to the Chair following the meeting but this is expected imminently.

Annex 1

Open letter to the public

Monday 12 January 2026

Dear all,

Over the past week, Morriston Hospital's Emergency Department and other front door services have faced very high demand, leading us to declare two business continuity incidents. We want to update you on the situation and thank everyone who has used our services for their patience.

Over the last six months, we have made real improvements in urgent and emergency care:

- Faster ambulance handovers and fewer delays outside the department
- More patients discharged home or to community care, creating space inside the ED
- Reduced ambulance queues and faster response times in the community
- Shorter waiting times inside the department
- Less overcrowding, improving patient dignity and staff working conditions

These improvements have only been possible thanks to our staff, local authority partners, the third sector, and the understanding of our patients and families.

While some individuals have still waited too long at times—and we apologise for this—the overall trend has been positive. However, in the last week we have seen a sharp rise in ambulance arrivals and walk-ins, combined with fewer patients being discharged despite being medically fit. This has caused overcrowding and long waits, affecting patients and their families, and for that we are truly sorry.

Our system relies on keeping patients moving through hospital and into the community. Recently that "flow" has been disrupted by high demand, infection-related ward closures, and difficulties discharging patients from Morriston, Neath Port Talbot and Singleton.

This is why we declared business continuity incidents over the last seven days — the first since March last year. Doing so allows us to take exceptional

steps, such as calling in staff on their days off. In light of the infection-related ward closures we are also reviewing visiting on a ward by ward basis in Morriston. In the meantime, we ask that anybody with any symptoms of Norovirus or similar refrain from visiting their loved ones to avoid further spread and bed closures which impact our ability to keep patients safe.

Given the time of year, flu levels and winter weather, we expect pressures to rise again, even though we aim to recover quickly. Our focus is on safely increasing and speeding up discharges, because medically fit patients who stay in hospital unnecessarily can quickly lose independence.

We are working closely with local authorities, who provide the care packages patients often need before they can go home. Families and friends can also help by making sure practical arrangements—such as keys or basic food supplies—are ready for discharge.

We are proud of the progress made over recent months, but it is important to be open when pressures are high. We hope this letter explains our current position and reassures you that our long-term direction of travel remains positive.

With regards,

Jan Williams
Cadeirydd / Chair

Abigail Harris
Prif Weithredwr | Chief Executive



Meeting Date	29 January 2026	Agenda Item	1.5
Name of Meeting	SBUHB Board		
Report Title	Risk Report		
Report Author	Neil Thomas, Assistant Head of Risk & Assurance		
Report Sponsor	Hazel Lloyd, Director of Corporate Governance		
Presented by	Hazel Lloyd, Director of Corporate Governance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to present the Health Board Strategic Risk Register (SRR) and Corporate Risk Register (CRR) to the Board for assurance.		
Key Issues	- Following the adoption of the SRR and CRR in November 2025, this report presents both registers following review of risks by their Executive Leads in December and a summary of key movements since they were received by the Board in November. - The SRR contains 17 risks, six of which have a score of 20 or above. - The CRR contains 25 risks, of which 20 have risk scores at, or above, the Health Board's risk appetite threshold. - The report presents a summary of high-scoring risks recorded and managed by individual services/specialties within Service Group operational risk registers.		
Specific Action Required <i>(please choose one only)</i>	Information	Discussion	Assurance
	☐	☐	☒
Recommendations	Members are asked to: RECEIVE the Health Board Strategic Risk Register and Corporate Risk Register, information in respect of receipt of individual risks for oversight by Board Committees, and a summary of movements. RECEIVE a summary of the risks recorded and managed by services/specialties within Service Group operational risk registers. CONSIDER whether further assurance is required on any risks and their management.		

RISK REPORT

1 INTRODUCTION

- 1.1 The purpose of this report is to present the Health Board Risk Register (HBRR) to the Board for assurance, and to provide the Board with an update on progress on the reset of the Board assurance and risk management arrangements.

2 BACKGROUND

- 2.1 The Strategic Risk Register (SRR) is intended to summarise the principal risks to the Health Board (at the strategic level) that could impact successful delivery of one of the organisation's five strategic objectives, typically over medium to long-term timeframes ('horizon 3').
- 2.2 The Corporate Risk Register (CRR) is intended to record significant corporate or operational risks escalated by services to Executive / Corporate Director level and agreed for oversight at Board / Committee level. The timescales within which these risks are anticipated to impact are typically short to medium term ('horizon 2'). The decision to escalate to the CRR is informed by consideration of the level of risk against the Board's appetite statement (currently under review) alongside the following criteria:
- The risk is above tolerance level and there is nothing that the risk owner can do to reduce it within tolerance level within an acceptable timeframe.
 - The risk is above tolerance and options to treat the risk are outside the delegated levels of control assigned to the risk owners.
 - The risk presents a significant threat to the achievement of Health Board objectives or targets.
 - The risk is assessed to be of significant concern (typically prompted by a very high local assessment of risk level)
 - The risk is shared across areas of the organisation and coordination of treatment may be complex.
- 2.3 The Risk Management Group (RMG) considers and agrees the escalation and/or de-escalation of risks (through its Chair where

required), as part of the review of the operational risk register, on behalf of the Management Board. It subsequently reports decisions to the Management Board. There may be cases where the RMG takes decisions to the wider Management Board / Executive team for consideration and agreement.

- 2.4 Each Service Group and Corporate Directorate has an Operational Risk Register (ORR) recording risks to the delivery of their services. Risks can be highlighted for escalation / de-escalation at any time, and the risk owner has the responsibility to do this where required. However, as part of the monthly cycle, Service Group Directors have a prompt to consider and submit any risks within their local ORR that they wish to escalate to Board Directors to consider including on the CRR. For risks already on the CRR which may require escalation/de-escalation, the monthly CRR & SRR review cycle provides an opportunity for Board Directors' consideration.

3 GOVERNANCE AND RISK ISSUES

3.1 Strategic Risk Register (SRR) Update

- 3.1.1 Following its adoption by the Health Board in November 2025, the SRR has been circulated amongst Directors during December for update.

The SRR contains 17 risks, six of which have a score of 20 or above. The table at **Appendix 1** summarises the current position in comparison to the previous edition of the SRR and indicates the last time that Board Committees received risks for oversight. The full December 2025 SRR is included at **Appendix 2** and where recent changes have been made, these have been reflected in **red** font within each risk.

- 3.1.2 The current risk score level has changed for one risk:

Ref	Risk Title	Score Trend	Comment
4.1	Staff Health & Wellbeing and Organisational Performance	↑	Score increased 12 to 16 This follows discussion at Workforce & OD Committee in December 2025 and review by the Director of Workforce & OD. The change reflects the increase in sickness absence

			over the last two months and the fact that we remain an outlier compared with other health boards.

There are no other changes in current risk score or assurance levels reported.

Following this first cycle of review of the SRR and CRR the Chief Executive has tasked Executive Leads with further areas for review. These will be taken forward during the next cycle.

3.2 Corporate Risk Register (CRR) Update

3.2.1 Following its adoption by the Health Board in November 2025, the CRR has been circulated amongst Directors during November & December for update.

The CRR contains 25 risks. The December 2025 CRR is included at **Appendix 3**. Where recent changes have been made, these have been reflected in **red** font within each risk. In addition to risks presented there, the following risks are deemed sensitive and are overseen in private session of Board and/or Committees:

- HBR 60 *Cyber Security*
- HBR 101 *Industrial Action*

The profile of risk scores within the HBRR is as follows:

Risk Analysis	Number of Risks	
	Oct 2025 CRR	Dec 2025 CRR
Risk Score of 25	1	1
Risk Score of 20	14	13
Risk Score of 16	5	6
Risk Score 9-15	5	5
Risk Score of 5-8	0	0
Risk Score of 1-4	0	0

Risk Analysis	Number of Risks	
	Oct 2025 CRR	Dec 2025 CRR
Total	25	25

3.2.2 Corporate Risk Register Changes

Key changes in risks scores since the last meeting are:

CHANGES	NUMBER
New risks	1
Risks with increased scores	Nil
Risks with reduced scores	Nil
Risks de-escalated / closed	1

3.2.3 New Risks

The following risk has been added to the Corporate Risk Register:

Risk Ref	New Risks	Lead Exec Director & Committee	Current Risk Score
108	WCCIS/Connecting care - Provision of an Integrated Health Record for MH&LD and PCT If the Connecting Care programme fails to deliver a digital solution that meets the operational, clinical, and reporting needs of Mental Health & Learning Disabilities (MH&LD) and Community & Therapies services, then wider MH&LD, Community and Therapies teams will lack access to timely, accurate, and shared information across care settings, resulting in fragmented service delivery, limited availability of high-quality data for performance monitoring and informed decision making, increased duplication of effort, and elevated clinical and governance risks. This includes the potential for further Regulation 28 reports, as previous Prevention of	Director of Digital Digital Data Research & Innovation Committee	16

Risk Ref	New Risks	Lead Exec Director & Committee	Current Risk Score
	Future Deaths (PFD) notices have explicitly cited the absence of an integrated electronic system as a contributing factor to avoidable harm. Without a fit-for-purpose solution, the Health Board may be unable to fulfil the actions required under Regulation 28, particularly around effective information sharing and risk management across agencies. <i>[Full description within Register]</i>		

3.2.4 Closed Risks

The risk CRR101 *Industrial Action (Healthcare Support Workers)* has been closed – further detail is reported in Closed session.

3.2.5 Committee Oversight of CRR Risks

There are 20 risks that are assessed as reaching the Board's current risk appetite threshold. The Board's Committees receive regular reports on their allocated risks, highlighting key steps taken to manage risk to an acceptable level. Reports also include updates on those risks below appetite, in recognition of the Board's aspiration to reduce risks further. The below table lists risks above appetite and presents alongside each risk, the Committee overseeing the risk and the last version of the CRR it received.

Ref	Risk Title	Current Score	Executive Lead	Committee Oversight	CRR Version Received
4	Healthcare Acquired Infection	20	EMD	QSC Nov 2025	Sep 2025
43	Deprivation of Liberty Safeguards	16	EDON	QSC Nov 2025	Sep 2025
50	Access to Cancer Services	20	COO	PFC Oct 2025	Sep 2025



Ref	Risk Title	Current Score	Executive Lead	Committee Oversight	CRR Version Received
60	Cyber Security	20	DODIG	DDRIC Nov 2025	Sep 2025
61	Paediatric Dental GA Service (Parkway)	16	COO	QSC Nov 2025	Sep 2025
64	Health & Safety Infrastructure	20	DOF	QSC Nov 2025	Sep 2025
66	Access to SACT (Cancer Services)	20	EMD	QSC Nov 2025	Sep 2025
69	Safeguarding: Adolescents on Adult Mental Health Wards	20	COO	QSC Nov 2025	Sep 2025
80	Inability to Transfer Patients	20	COO	QSC Nov 2025	Sep 2025
85	Non-Compliance with ALN Act	20	EDAHPHS	QSC Nov 2025	Sep 2025
89	Healthcare Nursing Staff Level (HMPS)	20	EDON	QSC Nov 2025	Sep 2025
90	Non-compliance with UK-GDPR Article 15 regarding Subject Access Requests	20	DODIG	DDRIC Nov 2025	Sep 2025
92	Finance Forecast Deficit	25	DOF	PFC Oct 2025	Sep 2025
93	Reduced Capital Funds	20	DOF	PFC Oct 2025	Sep 2025



Ref	Risk Title	Current Score	Executive Lead	Committee Oversight	CRR Version Received
96	Develop an Approvable IMTP (statutory compliance)	20	DOPP	PFC Oct 2025	Sep 2025
98	Overall condition/compliance and suitability of Health Board Estate	20	DOF	PFC Oct 2025	Sep 2025
99	Failure to implement the population health strategy approaches at the required scale	20	DOPH	PHC ¹ Mar 2025	Jan 2025
104	Failure to meet Tier 1 targets in Clinical Coding Completeness	20	DODIG	DDRIC Nov 2025	Sep 2025
106	Emissions Reduction	20	DOPP	PFC	Not yet received
107	EPRR & Recovery	20	DOPP	PFC	Not yet received

Please refer to **Appendix 1** for a glossary of Board Director and Committee abbreviations. Committees also receive risks below the appetite threshold as below:

Ref	Risk Title	Current Score	Executive Lead	Committee Oversight	CRR Version Received
3	Recruitment of Consultant	16	DOWOD	QSC Nov 2025	Sep 2025

¹ NB while this was the last Risk Report from the Risk & Assurance (R&A) team to be received by the Committee, the Committee received a report on risk in June from the Director of Public Health. The Committee will receive its next report from the R&A team in March 2026.

Ref	Risk Title	Current Score	Executive Lead	Committee Oversight	CRR Version Received
	Medical & Dental Staff				
36	Paper Record Storage	16	DODIG	DDRIC Nov 2025	Sep 2025
52	Impact Assessment Requirements	12	DICE	PFC Oct 2025	Sep 2025
53	Compliance with Welsh Language Standards	15	EDON	Board Nov 2025	Oct 2025
93	Finance: Reduced Capital Funds	12	DOF	PFC Oct 2025	Sep 2025
94	CAMHS: Failure to Meet Required Standards of Performance	12	COO	PFC Oct 2025	Sep 2025
100	Partnerships & Collaboration	12	DOPP	PHC Mar 2025	Jan 2025
105	Increased Cost of replacement Pathology System LIMS	16	DODIG	DDRIC Nov 2025	Sep 2025
108	WCCIS / Connecting care - Provision of an Integrated Health Record for MH&LD and PCT	16	DODIG	DDRIC	Not yet received

As noted earlier, the full CRR at **Appendix 3** includes all risks above and below the appetite threshold, together with details of key controls in place to manage risk and actions being taken to address them further.

NB In addition to the extracts received by Committees as set out above, the Audit Committee receives the full risk registers (both the SRR and CRR) to support its overarching role in providing the Board

with assurance on the operation of the system of risk management framework.

3.3 Operational Service Risks

3.3.1 In addition to the risks escalated and accepted onto the CRR, individual services within Service Groups record and manage operational risks to their service provision within local risk operational risk registers (ORR).

3.3.2 The RMG activity in first two quarters of the year focused on quality and assurance in respect of Service Group risk registers.

The RMG did not meet in September to allow Service Groups to focus on ORR review and assurance work to support reporting of content to Board & Committee level. While it intended reconvening to review this in October, this and the November meetings did not go ahead, due to urgent meeting clashes for key members. However, meetings directly with Service Groups maintained the focus quality-related review work required. This supported reporting of the summary position to the Board in November.

3.3.3 The table below presents the position in respect of operational risks recorded at service level as having a current risk score of 20 or above, by individual risk owners, within the context of the services they provide and being managed locally within Service Groups (not on CRR or SRR). There were 78 risks recorded at the beginning of January 2026 – the equivalent figure in March 2025 was 106.

These risks summarised by Risk Type are presented as below, together with the movement across categories during the period.

NUMBERS OF RISKS SCORING 20+ BY RISK TYPE	MHLD	Morriston	NPTS	PCT	Total Jan 2026	Total Mar 2025
Compliance with Legislation & Statutory/Regulatory Inspections		4	1		5	6
Environment, Estates & Infrastructure	6	2	3		11	9
Financial Management		1			1	4
Governance & Assurance	3			1	4	2
Health and Safety			1		1	1

NUMBERS OF RISKS SCORING 20+ BY RISK TYPE	MHLD	Morriston	NPTS	PCT	Total Jan 2026	Total Mar 2025
Information Governance & Communication		1			1	-
Medical Devices, Equipment & Supplies		5	5	1	11	15
Patient Safety	1		1		2	5
Sustainable Services	4	18	7	2	31	44
Workforce & OD	3	5	1	2	11	20
Grand Total	17	36	19	6	78	106

3.3.4 While RMG meetings did not go ahead, information was provided in November and December, including extracts from operational risk registers listing risks scoring 16 or above, to inform discussions at the Executive Performance Review meetings with Service Groups.

To enhance future oversight of operational risk within services, routine Executive performance review meetings will now include Executive Director level scrutiny of risks; Service Group Directors have been advised that this will be a more prominent feature.

3.3.5 As part of Organised for Success the role of corporate groups including the Executive Team is currently subject to review. In addition to the Performance Review meeting above, consideration is being given to future Executive Team meetings as the mechanism for senior corporate management oversight of risks, particularly those held at Board level.

3.3.6 In respect of further developments to support operational management of risk and the link to Board-level risk reporting and assurance, risk training slides have already been refreshed to reflect the new register arrangements and structural arrangements.

During Quarter 4 of 2025/26, the Risk & Assurance Team plans to develop documented procedures that set out in more detail the processes for risk management that are not already covered within policy. These will be supplemented with updated guidance where required and will inform further refresh of training.

3.3.7 To improve oversight of aged risks, the Management Board has received information of risks on the corporate risk register summarised by age. Further information will continue to be reported

to Management Board / Executive Team to support oversight and the reduction of risks. An update on this will be reported to the Audit Committee during 2026/7 after a number of review cycles.

4 **FINANCIAL IMPLICATIONS**

This report does not present any matters for decision with financial implications. There may be financial implications arising from actions required to improve the treatment of risks included on the risk register. Where this is the case, they are highlighted within individual risk register entries or dedicated Board/ Committee papers for information.

5. **RECOMMENDATIONS**

Members are asked to:

- **RECEIVE** the Health Board Strategic Risk Register and Corporate Risk Register and **consider** the information in respect of receipt of individual risks for oversight by Board Committees, and the summary of movements.
- **RECEIVE** a summary of the risks recorded and managed by services/specialties within Service Group operational risk registers.
- **CONSIDER** whether the Board needs further assurance is on any of the risks identified, together with the management thereof.

Governance and Assurance		
Link to Enabling Objectives (please choose)	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Ensuring the organisation has robust risk management arrangements that ensure organisational risks are captured, assessed, monitored and managed, supports the quality, safety & experience of patients receiving care and staff working in the UHB.		
Financial Implications		
This report does not present any matters for decision with financial implications. There may be financial implications arising from actions required to improvement the treatment of risks entered on the HBRR. Where this is the case they are highlighted within individual risk register entries for information.		
Legal Implications (including equality and diversity assessment)		
It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks faced by the organisation, as failure to do so could have legal implications for the UHB.		
Staffing Implications		
All staff have a responsibility for promoting risk management, adhering to SBUHB policies and have a personal responsibility for patients' safety as well as their own and colleague's health and safety. Executive Directors/Service		

Group Directors are responsible for the review of their operational risks and escalation of those requiring board-level oversight SBUHB.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The HBRR sets out the framework for how SBUHB will make an assessment of existing and future emerging risks, and how it will plan to manage and prepare for those risks.

Report History	This report updates on risk matters received in Nov 2025.

Appendices	Appendix 1 – Strategic Risk Register (SRR) Summary Appendix 2 – Strategic Risk Register (SRR) detail Appendix 3 – Corporate Risk Register (CRR) detail

SRR Ref	Strategic Risk	Lead Director	Risk Score			Overall Assurance		Committee Oversight ²
			Previously	Currently	Target	Previously	Currently	
Objective 1: People of Swansea Bay live healthier, equitable and more equitable and prosperous lives								
1.1	Population Health Approaches to Address Health Inequity	DOPH	20	20	9	Moderate	Moderate	PHC
Objective 2: Care is high quality, safe, efficient and delivers the best possible outcomes for people								
2.1	Urgent & Emergency Care	COO	16	16	12	Moderate	Moderate	PFC Jan 2026 Receiving Dec 25 SRR
2.2	Planned Care	COO	12	12	8	Good	Good	PFC Jan 2026 Receiving Dec 25 SRR
2.3	Cancer Care	COO	20	20	12	Moderate	Moderate	PFC Jan 2026 Receiving Dec 25 SRR
2.4	Quality, Safety & Patient Outcomes	EDON	16	16	12	Good	Good	QSC
2.5	Listening to People	EDON	16	16	9	Moderate	Moderate	QSC
2.6	Maternity & Neonatal Service Transformation	EDON	16	16	9	Good	Good	QSC

² This column indicates the Committee to which the risk is assigned, the last meeting to received it (bold) and the version of the SRR received. Entries without dates reflect Committee yet to receive the SRR.

SRR Ref	Strategic Risk	Lead Director	Risk Score			Overall Assurance		Committee Oversight ²
			Previously	Currently	Target	Previously	Currently	
2.7	Mental Health Transformation	COO	16	16	8	Moderate	Moderate	QSC
Objective 3: Care is delivered in safe and appropriate settings supported by innovative digital solutions								
3.1	Partnerships & Collaboration	DOPP	12	12	8	Good	Good	QSC
3.2	Maintaining Our Estate	DOF	20	20	12	Moderate	Moderate	PFC Jan 2026 Receiving Dec 25 SRR
3.3	Sustainability of Digital Services	DODIG	20	20	15	Good	Good	DDRIC Jan 2026 Receiving Dec 25 SRR
3.4	Failure to Deliver Digital Transformation	DODIG	20	20	10	Good	Good	DDRIC Jan 2026 Receiving Dec 25 SRR
3.5	Research, Development & Innovation	EMD	12	12	4	Good	Good	DDRIC Jan 2026 Receiving Dec 25 SRR
Objective 4: The health board is a great place to work where staff feel valued and work together towards a common goal								
4.1	Staff Health & Wellbeing and Organisational Performance	DOWOD	12	16	8	Moderate	Moderate	WODC Dec 2025 received Nov 25 SRR
4.2	Leadership & Management	DOWOD	12	12	8	Moderate	Moderate	WODC Dec 2025 received Nov 25 SRR

SRR Ref	Strategic Risk	Lead Director	Risk Score			Overall Assurance		Committee Oversight ²
			Previously	Currently	Target	Previously	Currently	
4.3	Culture & Values	DOWOD	12	12	8	Moderate	Moderate	WODC Dec 2025 received Nov 25 SRR
Objective 5: The health board is a resilient, financially sustainable and responsible organisation								
5.1	Achieving Financial Sustainability	DOF	25	25	15	Good	Good	PFC Jan 2026 Receiving Dec 25 SRR

Glossary of abbreviations:

Director Leads:		Committees:	
COO	Chief Operating Officer	AC	Audit Committee
DICE	Director of Insight, Communication & Engagement	DDRIC	Digital, Data, Research & Innovation
DOCG	Director of Corporate Governance	PFC	Performance & Finance
DODIG	Director of Digital	PHC	Population Health
DOF	Director of Finance & Performance	QSC	Quality & Safety
DOPH	Director of Public Health	WODC	Workforce & Organisational Development
DOPP	Director of Planning & Partnerships		
DOWOD	Director of Workforce & Organisational Development		
EDON	Director of Nursing & Patient Experience		
EDAHPHS	Director of Allied Health Professions & Health Sciences		
EMD			

Director Leads:		Committees:	
	Medical Director		

Strategic Risk Register

Dec 2025

Risk ID Number SRR-1.1	Risk Label – Population Health Approaches to Address Health Inequity Risk Description – If our staff do not understand and act on the provisions of the Population Health Strategy, and develop the capability and capacity to enact a system approach to addressing the challenges of improving the health of the entire population, then there is a risk that we will not develop effective systems, processes and partnerships to incorporate and deliver population health approaches outlined in the Strategy. This could result in worsening health in our population, widening health inequalities and a failure in our statutory duty as a health board.

Risk Score	Consequence	Likelihood	Overall Score	Trend	Strategic Objective	People of Swansea Bay live healthier, equitable and more equitable and prosperous lives
Inherent Score	5	5	25		Lead Director / Risk Owner	Director of Public Health
Current Score	5	4	20		Monitoring Committee	Population Health Committee
Target Score	3	3	9	N/A	Risk Appetite	T.B.C.
Risk Score Over Time	Nov 2025	Dec 2025				
	20	20				

Related Risk on Corporate Risk Register		
Linked or associated risks which sit in the register immediately below the Strategic Risk Register		
Risk ID	Description	Score
52 (1763)	Statutory Compliance: Engagement & Impact Assessment The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	12
100 (TBC)	A lack of a robust approach to partnerships & collaboration If the health board does not have effective structures, processes and working relationships with its external partners, there is a risk that areas of work dependent upon collaboration with partners may not deliver what is required in a timely way, impacting on the delivery of health board priorities.	12

Key Controls	
<i>What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?</i>	
Control Ref	Control
1	Strategy Execution: The Public Health Team have implemented and are pursuing an evidence-based engagement focused strategy execution methodology to support implementation of the Population Health Strategy
2	Governance: The Population Health Committee has been established to provide governance oversight of the Population Health Strategy.
3	Engagement: Engagement across the organisation in support of strategy execution has been extensive and encompassed all Service Delivery Groups and Corporate Departments to build competence, capability and capacity to enact strategy.
4	Strategic Planning: Population health has been integrated into key organisational processes (planning, business case development, partnerships, performance, strategy development).
5	Leadership: Strategy execution approach has developed tactical and operational level leadership to support strategy execution.
6	Performance Management: Reporting progress on Population Health Strategy execution through the Health Board Service Delivery Group quarterly performance
7	Policy Alignment: Wellbeing of Future Generations Act 2015 outlines 5 ways of working which provide a framework to embed sustainable development in public sector organisations in Wales.
8	Strategic objectives: The Population Health Strategy has been integrated into the SBUHB Strategic Objectives. Strategic indicators have been developed to support measurement of population health gain.
9	Further work to be developed in relation to children & young people services. This will be considered as part of the Health Boards work on the CYP strategic plan.
10	Further work to develop internal governance and leadership in relation to Partnerships & Collaboration.

Assurance on Control				
What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
1	Evidence based strategy execution model in place for Population Health Strategy	Organisational focus on strategy production. No agreed execution methodology or mechanism to measure and evaluate strategy implementation. Strategy implementation since March 2023 has focused on engagement to build capability, capacity & literacy around population health. Agreement through Population Health Committee and Executive to adopt CORE20Plus5 methodology as the foundation to develop organisational population health plan enabling executive ownership of portfolios and development of robust programmes with population health measures.	Population Heath Strategy Internal Audit Completed Jan 25	Reasonable
2	There is limited understanding and focus and reporting on Population Health at service delivery level across the organisation.	Population Health & Partnerships Committee has been subject of a review (Dec 24). Review Outcome is to separate population health and partnerships with revised governance arrangements. The terms of reference for both groups are being designed to ensure that there is read across both agendas. In addition to this the redesign of the governance arrangements will see population health reported to the Population Health Committee from all other SBUHB governance Committees.	The Audit Committee has received a Population Health Internal Audit report in May 2025.	Limited
3	Stakeholder engagement draws together vital strategy execution components leadership, planning, stakeholder engagement, decision making and human resources to navigate complexity. An enabling function that provides direction, translation of strategy and commitment of resources to collaborative working.	Favoured organisational approach to strategy execution is to develop and measure defined programmes of work aligned to executive portfolios. Introduction of CORE20Plus5 methodology by Director of Public Health to support executive ownership of portfolios and development of population health priorities and measures.	WFGA outline five ways of working as the behaviours required to embed sustainable development in public service organisations.	Limited
4	SDGs are familiar with the requirements to consider Population Health. Literacy and local priorities are being developed and planned.	SBUHB has no strategic population health plan. Population Health Audit recommendations support the development of a strategic plan.	Welsh Government planning guidance for 2025/26 makes explicit a requirement to plan and deliver population health and preventative approaches to healthcare.	Unsatisfactory
5	Tactical leadership to develop population health priorities identified across all SDGs	Executive leadership and ownership of population health in SBUHB is not consistent. Competing priorities and organisation culture focused on service delivery and targeted intervention targets.	Clear policy direction from Welsh Government and NHS Leadership to deliver population health and prevention approaches.	Limited
6	SDGs are required to report on population health and there are monthly review meetings held with Executive Directors.	Organisational performance focus is on meeting Welsh Government targets and compliance with Targeted Intervention status. Reporting Population health Audit recommendations through SBUHB performance mechanisms will be a key driver to improving delivery.	NHS Organisations are expected to report on population health and Prevention (JET/IQPD etc)	Unsatisfactory
7	Policy requirements incorporated into service level documentation.	Strategic engagement with WFG Commissioners Office. WFGA five ways of working not embedded as a behavioural framework to support delivery of sustainable development.	WFGA journey checker in place and reported for SBUHB	Reasonable
8	Strategic Objectives incorporate the Population Health Strategy. PHS implementation not routinely report at SG board level.	Board approved strategic objectives in place. Outline strategic indicators developed to monitor progress on improving health and wellbeing of the population. Tactical capability and system level measures require developing against agreed SDG population health priorities.		Reasonable
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.				Moderate

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls / systems / processes / governance mechanisms we have in place are working effectively? What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
1	Leadership	Leadership is identified as influencing engagement, motivation and decision making in developing a strategy supportive culture, creation of alignment and enabling collaboration. A lack of leadership engagement and consistency, leaders not prioritising the PHS, lack of understanding has been identified as barriers. Senior leaders are perceived as having limited understanding of the purpose of the PHS.	All Executives & Service Group Directors	31/10/2025	May 25: CORE20Plus5 methodology accepted by Population Health Committee & Executive
2	Long term thinking/planning	Long-term thinking and approaches are identified as critical factors/enablers to PHS execution. Limited long-term thinking and planning capability. Recovery and Sustainability Programme, Welsh Government planning and finance cycles are all short term.	Director of Planning & Partnerships	Ongoing	
3	Culture & Context	SBUHB is a service delivery focused organisation. Strategy execution is not a primary focus for executives and there is limited understanding of what is required to enact strategy in a complex operating environment. In addition, to this there is limited tactical capability and for a to enact strategy operationally and an absence of a recognised organisational methodology.	CEO & Executive Directors	Ongoing	Board focus on becoming a population health focused and competent organisation.
4	Strategic Planning, Management & Alignment	SBUHB has in place 5 strategic objectives that underpin our high-quality organisational vision. Organisational structure, planning, finance, human resources, performance and decision making need to be aligned in pursuit of these objectives. Integration of PHS into strategic planning processes is as an enabler. A lack of clear organisational population health plan and population health priorities at SDG level is a major barrier. Strategic planning capability to support strategy execution is immature. Leadership engagement has been identified as a key enabler supporting improved strategic planning capability and supporting alignment of people, structure, process, finance and technology to execute the PHS.	Director of Planning & Partnerships	31/01/2026	May 25: Population Health Committee timeout session agreement to utilise CORE20Plus5 and align executive ownership to portfolios Jun 25: Executive Steering Group developing thinking to better align cross cutting portfolios across service delivery mechanisms, streamline reporting and develop more robust performance mechanisms. Includes the development of Planning & Finance Assurance Group (PFAG) to replace existing business case process.
5	Measurement	Development of the measurement and performance infrastructure to demonstration of impact of PHS execution was identified as a key condition and enabler.	Director of Public Health	31/01/2026	Oct 24: Initial outcome measures developed for strategic objective 1 Jun 25: Organisational performance infrastructure being developed; population health measures being revised by Public Health Team
6	Organisational Structuring	Established Population Health governance mechanism. Absence of executive ownership of distinct population health priorities and the tactical forums to organise resources, finance and activity in pursuit of population health gain.	All Executive Directors & SDG Directors	31/10/2025	Nov 24: Population Health & Partnerships Committee disaggregated. Population Health Committee established including representation from primary care Jun 25: Executive Steering Group developing thinking to better align cross cutting portfolios across service delivery mechanisms, streamline reporting and develop more robust performance mechanisms. Includes the development of Planning & Finance Assurance Group (PFAG) to replace existing business case process.

Additional Comments

Risk ID Number SRR-2.1	Risk Label – Urgent & Emergency Care Risk Description – If we do not have enough staff and physical capacity organised effectively across all services, including primary and secondary care, to meet the urgent physical and mental health needs of adults and children, there is a risk that we will be unable to improve access to timely, safe, effective, and person-centred unscheduled care, resulting in potential for patient harm, increases in length of stay, placement of patients in unsuitable places, and a negative impact on patient & staff experience

Risk Score	Consequence	Likelihood	Overall Score	Trend	Strategic Objective	Care is high quality, safe, efficient and delivers the best possible outcomes for people
Inherent Score	4	5	20		Lead Director / Risk Owner	C.O.O.
Current Score	4	4	16		Monitoring Committee	Performance & Finance Committee
Target Score	3	4	12	N/A	Risk Appetite	T.B.C.
Risk Score Over Time	Nov 2025	Dec 2025				
	16	16				

Related Risk on Corporate Risk Register Linked or associated risks which sit in the register immediately below the Strategic Risk Register			
Risk ID	Short Name	Description	Score
80 (1832)	Transfer of Clinically Optimised Patients	Risk that we fail to significantly reduce the number of Clinically Optimised Patients in hospital beds. A deficit in the availability of appropriate community / domiciliary care results in unacceptable delays in discharging patients from acute hospital beds. As a result, patients can decompensate and never gain the independence that could have been available from an early discharge.	20

Key Controls <i>What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?</i>	
Control Ref	Control
1	Standard reporting of the UEC system capacity and risk aligned to the WG National Escalation and De-escalation framework through the national Integrated UEC dashboard
2	Daily Director led safety huddle with system wide representation to maintain oversight of system pressures, patient access to UEC services and any risk that may impact service delivery, to support tactical decision making.
3	Daily participation in the national risk huddle to present HB escalation status, risk and mitigating actions
4	Robust governance and reporting of UEC indicators both locally and nationally with corrective actions, planned tests of change and outputs – UEC Board/Community and Older Persons Board (RPB), P&F Committee, IQPD
5	Work programmes are in place in relation to the national Six Goals for Urgent and Emergency Care framework with ongoing
6	UEC improvement programme underpinned by quality improvement methodology.
7	Use of surge capacity and temporary workforce solutions to support improved flow and access t urgent and emergency care services
8	Focussed plan to deliver a reduced level of clinically optimised patients occupying Health Board beds.

Assurance on Control <i>What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?</i>				
Control Ref	1st Line Assurance	2nd Line Assurance	3rd Line Assurance	Strength of Control
1	Standard reporting of the UEC system capacity and risk aligned to the WG National Escalation and De-escalation framework through the national Integrated UEC dashboard.			Reasonable

2	Daily Director led safety huddle with system wide representation to maintain oversight of system pressures, patient access to UEC services and any risk that may impact service delivery.	Formal reporting from the 'Director of the Day' to internal stakeholders.		Reasonable
3	Daily participation in the national risk huddle to present HB escalation status, risk and mitigating actions.			Reasonable
4	Robust governance and reporting of UEC indicators both locally and nationally with corrective actions, planned tests of change and outputs – UEC Board/Community and Older Persons Board (RPB), P&F Committee, IQPD			Reasonable
5	Information on delivery against the national Six Goals for Urgent and Emergency Care framework is monitored by the UEC Programme Board and reported to the national Six Goal team. Some gaps in delivery of the UEC services across the seven-day period.			Limited
6	Progress against the UEC improvement programme is monitored by UEC Programme Board.			Reasonable
7	Variable pay expenditure, bed utilisation and ward & assessment unit occupancy levels are monitored. 'Your next patient' dashboard developed to support.			Limited
8	Management undertakes weekly monitoring of clinically optimised patient numbers, by Pathway, LOS and delay reason. COP position is reported to UEC Board, Communities and Older Persons Board.			Limited
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.				Limited

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?</i> <i>What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
1	Evidence of delivery against the national Six Goals for Urgent and Emergency Care framework with ongoing work programmes in place. Some gaps in delivery of the UEC services across the seven-day period.	Incremental shift to seven-day services through opportunistic funding and redesign of existing resource including the medical rota with increased weekend provision and Sunday SDEC service.	COO	Completed – subject to review	In place
2	Clinically optimised patient flow and the impact of high numbers of this patient cohort on the Morriston site impeding flow and delivery of timely urgent care.	Pathway of Care action plan in place – monitored weekly. Weekly reporting of the Pathway of Care Delays position. Agreement to proceed to formal OCP to secure the temporary Integrated Discharge Hub as a key part of the operating platform. Deloitte supporting capacity and demand work to enable improved understanding of the gaps in provision. Community Services review in progress supported by external Consultant. Plan to decant 30 COP patients from Morriston to Singleton to release acute capacity as from 5th January 26.	COO	31/03/2025	

3	Ability to close surge capacity on the Morriston site in line with the recovery and sustainability plan with an increasing demand profile and high numbers of clinically optimised and clinically safe for transfer patients remaining in Morriston.	As above.	COO	30/11/2025	
4	Evidence of a surge in winter illness presentations requiring isolation facilities. Limited isolation beds on the Morriston site which leads to potential spread and exposure to illness resulting in reduced acute capacity from ward closures and higher levels of staff absence.	Rapid swabbing however limited numbers of swabs available. Daily IPC review meetings regarding use of available isolation capacity. Hospital site cohort plans to be developed to minimise prolonged delays in the ED. New absence reporting processes in place to address the high levels of staff absence. Compliance with Infection Prevention and Control procedures	Executive Nurse Director/COO	Systems in place and business as usual	In place

Additional Comments
18/12/25: Register entry reviewed & updated.

Risk ID Number SRR-2.2	Risk Label – Planned Care Risk Description – If we do not have enough staff and physical capacity organised effectively across all services, including primary and secondary care, to meet the non-urgent physical and mental health needs of adults and children, there is a risk that we will be unable to improve access to timely, safe, effective, and person-centred planned care, resulting in a potential for patient harm, increases in length of stay, placement of patients in unsuitable places, and a negative impact on patient & staff experience

Risk Score	Consequence	Likelihood	Overall Score	Trend	Strategic Objective	Care is high quality, safe, efficient and delivers the best possible outcomes for people
Inherent Score	4	4	16		Lead Director / Risk Owner	COO
Current Score	4	3	12		Monitoring Committee	Performance & Finance Committee
Target Score	4	2	8	N/A	Risk Appetite	T.B.C.
Risk Score Over Time	Nov 2025	Dec 2025				
	12	12				

Related Risk on Corporate Risk Register Linked or associated risks which sit in the register immediately below the Strategic Risk Register			
Risk ID	Short Name	Description	Score

Key Controls <i>What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?</i>	
Control Ref	Control
1	Specialty level capacity and demand models set out the baseline capacity and identify solutions to bridge the gap in 2025/26.
2	Planned care trajectories have been developed (and shared with Welsh Government).
3	Processes are in place to monitor performance against those trajectories internally (and with Welsh Government as part of Targeted Intervention).
4	There is focused intervention within the 10 specialties with the longest waits to support delivery.
5	Long waiting patients are outsourced to the independent sector, where it is appropriate to do so.
6	Additional activity is being delivered on weekends (via insourcing), which is working towards reducing the wait for outpatient appointment to below 26 weeks.
7	There is ongoing internal and external validation of waiting lists
8	All long waiting patients receive clinical reviews to ascertain continued need for surgery.
9	Complaints and concerns in respect of waiting times are monitored to identify issues and trends.
10	A Planned Care Programme Board and the associated transformation programmes are in place across outpatients and theatres to develop services.

Assurance on Control				
<i>What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?</i>				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
3-6	A Targeted Intervention (TI) dashboard presents live data on performance to support monitoring by COO, performance and operational teams.			Reasonable
3-6	Weekly monitoring meetings chaired by the Assistant Director of Performance review/monitor progress against delivery plans.			Reasonable
7-9	Updates on metrics such as validation, clinical reviews, complaints & concerns are fed into Planned Care Board.			Reasonable
10	There are highlight reports that go to Planned Care Board on each of the programme streams.			Reasonable
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.				Good

Gaps in Control and/or Assurance		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
<i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?</i>					
<i>What more do we need to do to control this risk, that we are not already doing?</i>					
1	There is scope to improve assurance that Health Board processes are optimised.	The Clinical Committee which has been set up to support the Planned Care & Cancer Board (PCCB) will ask clinical leads from each of the services managed under the PCCB to review their arrangements against ‘optimal practice’ as determined by the national Clinical Implementation Network (CIN) and to present their findings to the PCCB.	COO/Assistant Director of Ops Planned Care & Cancer	28/02/2026	On track

Additional Comments

Risk ID Number SRR-2.3	Risk Label – Cancer Care Risk Description – If we do not have enough staff and physical capacity organised effectively across all services, including primary and secondary care, to provide timely diagnosis and treatment of adults and children, there is a risk that we will be unable to improve provision of safe, effective, and person-centred cancer care, resulting in a potential for patient harm, poor outcomes, and a negative impact on patient & staff experience. This will impact not only on SBU patients but those of partner organisations depending on this health board as a regional centre for cancer care.

Risk Score	Consequence	Likelihood	Overall Score	Trend	Strategic Objective	Care is high quality, safe, efficient and delivers the best possible outcomes for people
Inherent Score	4	5	20		Lead Director / Risk Owner	COO
Current Score	5	4	20		Monitoring Committee	Performance & Finance Committee
Target Score	4	3	12	N/A	Risk Appetite	T.B.C.
Risk Score Over Time	Nov 2025	Dec 2025				
	20	20				

Related Risk on Corporate Risk Register Linked or associated risks which sit in the register immediately below the Strategic Risk Register			
Risk ID	Short Name	Description	Score
66 (1834)	Access to Cancer Services (SACT)	The demand & complexity of planned treatment regime for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.	20

Key Controls <i>What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?</i>	
Control Ref	Control
1	Processes are in place to manage each individual case on the Single Cancer Pathway (SCP), with enhanced monitoring & weekly monitoring of action plans for top 6 tumour sites.
2	Initiatives are in place to protect surgical capacity to support Single Cancer Pathways.
3	Performance discussions by tumour-site focus on compliance with the following targets: - o First outpatient appointment by Day 10 - o Deliver a decision to treat (DTT) by day 31
4	Outsourcing solutions are in place to support pathology turnaround times for urgent suspect cancer.
5	The COO is leading targeted discussions with most pressurised tumour sites to understand barriers to complying with national optimal pathways for cancer
6	Cancer improvement group meets monthly.

Assurance on Control <i>What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?</i>				
Control Ref	1st Line Assurance	2nd Line Assurance	3rd Line Assurance	Strength of Control
1-4	A Targeted Intervention (TI) dashboard presents live data on performance to support monitoring at tumour site and health board scrutiny meetings.			Adequate
1-4	Weekly Targeted Intervention monitoring meetings chaired by			Limited

	Cancer Services to review compliance with the 62 day pathway and track backlog volumes.			
1-4	Bi-weekly Cancer meetings chaired by the Deputy Chief Operating Officer review NOP adherence and delivery of 62 day target			Adequate
1-4	Planned Care & Cancer Board chaired by COO reviews Cancer Performance information.			Adequate
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.				Moderate

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?</i> <i>What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>		Lead Director	Due Date	Progress
1	Assurance of optimal effectiveness of control arrangements.	New Assistant Director of Operations is reviewing governance arrangements and their operation to ensure they perform optimally.		COO	28/02/2026	On track

Additional Comments
In addition to internal monitoring, monthly Targeted Intervention monitoring meetings are held with Welsh Government.

Risk ID Number SRR 2.4	Risk Label – Quality, Safety & Patient Outcomes Risk Description – If we do not have robust quality governance systems and processes, use our data intelligently, and develop a strong safety culture that supports learning, then we will not deliver safe, effective and responsive care to our patients, resulting in increases in avoidable harm and mortality and poorer clinical outcomes.

Risk Score		Consequence		Likelihood		Overall Score		Trend		Strategic Objective		Care is high quality, safe, efficient and delivers the best possible outcomes for people									
Inherent Score		4		5		20				Lead Director / Risk Owner		Executive Director of Nursing									
Current Score		4		4		16				Monitoring Committee		Quality & Safety Committee									
Target Score		4		3		12		N/A		Risk Appetite		T.B.C.									
Risk Score Over Time		Nov 2025		Dec 2025																	
		16		16																	

Related Risk on Corporate Risk Register		
Linked or associated risks which sit in the register immediately below the Strategic Risk Register		
Risk ID	Description	Score
4 (739)	Healthcare Acquired Infection Risk of patients acquiring infection as a result of contact with the health care system, resulting in avoidable harm, impact on service capacity, and failure to achieve national infection reduction goals.	20
61 (1587)	Paediatric Dental GA Service – Parkway Safety risk of general anaesthetic procedures performed on children outside of an acute hospital setting. Repatriation of service to acute site delayed which means the health board continues to commission services for delivery outside of national guidance attracting reputational risk. There is also an associated risk in that the diagnosing clinician does not deliver the care to the patient resulting in increased risk of need for multiple GAs.	16

Key Controls	
<i>What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?</i>	
Control Ref	Control
1	Quality and Safety Process Framework
2	Annual Strategy Quality Plan
3	Quality Assurance Framework
4	Quality Impact Assessment Process

Assurance on Control				
<i>What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?</i>				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
1	Service group quality and safety group scrutiny. Weekly executive Quality Huddle	Service group reporting into QSG sub-groups (PSEG, PSCG, COEG, Safeguarding, IPC, QPPB). Service group performance reviews. Quality dashboard reporting to QSG (monthly), reporting to QSC (bi-monthly) and Management Board (monthly) Service group presentation at QSG (quarterly)	A&A Review – Quality Management System SBUHB-2324-003 (June 2024) – Reasonable Assurance Audit Wales Structured Assessment.	Reasonable

2	Reporting from action owners within annual strategic quality plan	Quarterly reporting to QSG Quarterly reporting to QSC and Management Board		Reasonable
3	Quality assurance visits within service groups. Service group AMaT scrutiny.	Service group bi-monthly updates to PSCG. PSCG bi-monthly reporting to QSG Corporate Quality Assurance audit programme and reporting into PSCG. Service group Quality Assurance Audit programmes and reporting to PSCG	HIW reviews Llais reviews A&A Review – Quality Assurance SBUHB-2425-009 (March 2025) – Limited Assurance Independent Members’ visiting programme	Limited
4	QIA scrutiny within service groups’ management boards for service groups decisions QIA scrutiny in Management Board for HB wide decisions	Board scrutiny of QIAs		Limited
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.				Good

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively? What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
1	Individual, team and service level understanding of the Quality Assurance Process Framework requires embedding.	Self-assessment tool being developed for service groups to assess themselves against the framework and wider QMS	Head of Q & S	28/02/2026	On track
2	The Quality Strategy does not clearly align with organisational objectives, and actions within the implementation plan require review	Strategy mid-point review to reflect HB-wide work to align strategic direction	Exec Director of Planning Head of Q & S	31/12/2025 (expected 28.2.26)	Off Track
3	Service groups need to ensure that quality assurance audits are completed regularly. AMaT completeness at service group level requires improvement.	Bi-monthly reporting from service groups to PSCG, as part of internal audit management actions. Service group reporting on assurance activities to QSC on quarterly basis.	Service Group Medical and Nurse Directors	31/12/2025	Off Track
4	The Quality Impact Assessment process is not fully embedded across organisation	Meeting with Head of Q & S and Head of Corporate Governance to agree process	Head of Q & S	31/05/2025	Complete
		Process relaunched	Head of Corporate Governance	21/07/2025	Complete
		Internal review of implementation		28/02/2026	Not Started

Additional Comments
Delivery of the management actions for the internal audit review of the Quality Assurance Framework will improve the level of assurance within this control. The Quality Impact assessment process has been launched within the HB but requires re-launch as uptake has been low. There is national work underway to develop a QMS self-assessment tool for Health Boards and an internal testing of the tool is underway, the outcome of this will result in an action plan which will strengthen all areas of our QMS. 05/01/2026: Actions reviewed in line with progress made. Further review to be undertaken by QSC Execs as part of next iteration review.

Risk ID Number SRR-2.5	Risk Label – Listening to People Risk Description – If we do not listen to and act upon the issues raised by people there is a risk that matters of concern to them will continue unaddressed, resulting in dissatisfaction, the potential for poor outcomes, greater regulatory intervention and loss of public trust and confidence.

Risk Score	Consequence	Likelihood	Overall Score	Trend	Strategic Objective	Care is high quality, safe, efficient and delivers the best possible outcomes for people
Inherent Score	4	5	20		Lead Director / Risk Owner	Executive Director of Nursing
Current Score	4	4	16		Monitoring Committee	Quality & Safety Committee
Target Score	3	3	9	N/A	Risk Appetite	T.B.C.
Risk Score Over Time	Nov 2025	Dec 2025				
	16	16				

Related Risk on Corporate Risk Register Linked or associated risks which sit in the register immediately below the Strategic Risk Register			
Risk ID	Short Name	Description	Score

Key Controls <i>What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?</i>	
Control Ref	Control
1	Putting Things Right framework. Complaints performance reporting.
2	Early resolution services (e.g., PALS) People’s Experience Framework. Compliments.
3	Stakeholder engagement structures (ARG, Bay Youth, MVP, BAME)
4	Community engagement events

Assurance on Control <i>What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?</i>				
Control Ref	1st Line Assurance	2nd Line Assurance	3rd Line Assurance	Strength of Control
1	Divisional complaints handling Service group quality and safety group oversight	Service group reporting to PSCG (bi-monthly) PFT reporting to PSCG (bi-monthly) Beacon dashboard scrutiny (monthly in Exec Huddle) Weekly executive quality and safety huddle PSCG reporting to QSG QSG reporting to QSC and Management Board	Welsh Risk Pool Annual Assessment	Unsatisfactory
2	Service group quality and safety group oversight. Friends and Family and All Wales questionnaire data at service group level Delivery of People’s Experience Framework	Service group reporting to PSEG (bi-monthly) PFT reporting to PSEG (bi-monthly) Patient Experience reporting to PSEG	Internal audit of People’s Experience Framework	Reasonable

		PSEG reporting to QSG QSG reporting to QSC and Management Board Patient stories at Board and other groups		
3	DICE reports to PSEG Llais membership of PSEG	PSEG reporting to QSG QSG reporting to QSC and Management Board	Llais thematic reports	Reasonable
4	DICE reports to PSEG	PSEG reporting to QSG QSG reporting to QSC and Management Board	Llais thematic reports	Reasonable
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.				Moderate

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?</i> <i>What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
1	a) Revised PTR framework being issued in 2025.	Implementation of framework once received.	EDON	01/04/2026	On track
	b) Number of overdue concerns within service groups.	EDON review of concerns processes within service groups to look for potential improvements		31/12/2025	Complete

Additional Comments
Jan 26: Final LTP framework not received from WG, due date revised to reflect this Action 1a: The level of overdue concerns responses is deteriorating, requiring revised ways of working across the corporate teams and within service groups. This is overseen by the Listening to People Programme Board. Action 1b: When the revised PTR guidance is issued this risk will require re-review as there will be implications for our model of delivery and a revised model is being developed.

Risk ID Number SRR-2.6	Risk Label – Maternity & Neonatal Service Transformation Risk Description – If we do not respond in a timely and effective way to the recommendations of the External Review of Maternity & Neonatal services, there is a risk that matters of concern identified within the report will not be addressed, resulting in a lack of demonstrable improvement to quality, low morale and wellbeing amongst staff (with associated implications for recruitment and retention) and a potential loss of wider public confidence in these services.

Risk Score		Consequence		Likelihood		Overall Score		Trend		Strategic Objective		Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships											
Inherent Score		4		5		20				Lead Director / Risk Owner		Executive Director of Nursing & Patient Experience											
Current Score		4		4		16				Monitoring Committee		Quality & Safety Committee											
Target Score		3		3		9		N/A		Risk Appetite		T.B.C.											
Risk Score Over Time		Nov 2025		Dec 2025																			
		16		16																			

Related Risk on Corporate Risk Register												
Linked or associated risks which sit in the register immediately below the Strategic Risk Register												
Risk ID	Description											Score

Key Controls	
What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?	
Control Ref	Control
1	Appointment of new leadership roles (e.g., Clinical Director of Midwifery, Clinical Director of Womens Health, Associated Service Group Director, Associate Service Group Medical Director, Service Group Medical Director)
2	Establishment of a Perinatal Committee and enhanced governance structures.
3	Implementation of a maternity and neonatal dashboard for real-time monitoring
4	All-Wales MEWS tool has been implemented to identify and escalate deteriorating condition of pregnant women.
5	All Clinical Maternity staff attend Infant Fetal Surveillance training annually
6	Engagement with families through Maternity and Neonates Voices Partnership and community outreach.
7	Womens Experience Specialist Midwife role is in place to support wider engagement with women, families and the community.
8	Forward Audit Plan in place (this will be revised in view of the Independent Review report recommendations to ensure the ongoing assessment of implementation and impact continues throughout the year.)
9	Publication of a clear, time-bound action plan addressing all review recommendations (due Nov 2025 – see Actions) with regular progress updates reported to the Perinatal Committee.
10	Recruitment of a Project Manager to support and oversee the action plan and evidence base to demonstrate implementation and delivery of the report recommendations.
11	Ongoing support from the Chair and Oversight Panel members of the external review for 18 months to provide assurance and scrutiny in relation to actions and recommendations

Assurance on Control				
What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
4,5,6,7	Perinatal dashboard for real time data monitoring by the Division and Service Group of key performance metrics along with exceptions from the perinatal assurance group.	Board oversight of service improvement using agreed outcome, process and experience measures via the Perinatal Committee – Chairs report presented at Board level meetings.	Chair and Oversight Panel members of the external review for 18 months to provide assurance and scrutiny in relation to progress in addressing actions and recommendations.	Reasonable
8	Elements of Forward Audit Plan are reviewed at Perinatal Assurance Group.	Elements of Forward Audit Plan is reviewed at Perinatal Committee and overview is maintained at COEG (and monitored by WG).	Chair and Oversight Panel members of the external review for 18 months to provide assurance and scrutiny in relation to progress in addressing actions and recommendations.	Limited
5	Reporting of compliance rate for completion of annual Infant Fetal Surveillance training by clinical Maternity staff at Perinatal Committee.	Board oversight of service improvement using agreed outcome, process and experience measures via the Perinatal Committee – Chairs report presented at Board level meetings.	Chair and Oversight Panel members of the external review for 18 months to provide assurance and scrutiny in relation to progress in addressing actions and recommendations.	Reasonable
Current Overall Assurance Rating				Good

Gaps in Control and/or Assurance		Actions to Address Gaps in Control and/or Assurance		Lead Director	Due Date	Progress
Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively? What more do we need to do to control this risk, that we are not already doing?		What are we going to do, by when, to further manage and mitigate this risk?				
1	Consolidation of actions for oversight.	Development and approval of an action plan to deliver recommended improvements required by the Independent Review.		Executive Director of Nursing & Patient Experience	30/11/2025	In Progress
2	Improvement to triage access arrangements.	Development of business case and improvement programme objectives to implement a 24-hour Triage line.		Clinical Director of Midwifery, Clinical Director for Women's health	31/03/2026	In progress
3	Gap analysis against national standard.	Benchmark local service provision against the Perinatal Engagement Framework for Wales.		Clinical Director of Midwifery	31/12/2025	In Progress
4	Improvements to record-keeping arrangements.	Launch of Digital Maternity Electronic Record.		Clinical Director of Midwifery	31/03/2026	In Progress

Additional Comments

Risk ID Number SRR 2.7	Risk Label – Mental Health Transformation Risk Description – If we do not organise ourselves effectively, and secure and direct sufficient resource and effort to priority areas set out within our mental health and learning disability transformation plan, then there is a risk that we will not transform our environments and the delivery of care sufficiently and in a timely way in line with the recommendations of the mental health transformation plan and in line with the All-Wales Strategy for Mental Health & Wellbeing. This may result in poor patient experience, outcomes and at worst incidents of avoidable harm.

Risk Score		Consequence		Likelihood	Overall Score	Trend	Strategic Objective		Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships					
Inherent Score		4		5	20		Lead Director / Risk Owner		C.O.O.					
Current Score		4		4	16		Monitoring Committee		Quality & Safety Committee and MH and LD Transformation Program Board					
Target Score		4		2	8	N/A	Risk Appetite		T.B.C.					
Risk Score Over Time	Nov 2025		Dec 2025											
	16		16											

Related Risk on Corporate Risk Register			
Linked or associated risks which sit in the register immediately below the Strategic Risk Register			
Risk ID	Short Name	Description	Score
CRR69	Adolescents admitted to Adult MH wards	Risk of inappropriate settings resulting in 'safeguarding issues'. The Welsh Government has requested that health boards identify secondary care inpatient facilities for the care of adolescents in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.	20
CRR94	CAMHS failure to meet required standards of performance	The CAMHS service is unable to meet the required level of performance due to workforce deficits in the team across all staff groups including medics, psychological therapies and nursing.	12

Key Controls	
What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?	
Control Ref	Control
1	Programme in place, with Chief Operating Officer (COO) as nominated Senior Responsible Officer (SRO), with formally agreed Project Initiation Documentation.
2	Programme Board with formal terms of reference (TOR), chaired by COO, reports periodically to Board / Quality & Safety Committee
3	Programme structure incorporates workstream groups to address: information; quality & safety; service redesign; workforce; estates. Each has TOR and reports to the Driver Group (see below).
4	External expert engaged to challenge & support the Service Group
5	There is a Driver Group, chaired by the independent expert, to oversee the workstream groups, provide challenge, and report into the Programme Board.
6	Key quality indicators have been identified aligned to improvements required
7	Engagement & partnership involvement has been strengthened, particularly in respect of modernisation & redesign workstreams.
8	Communication & activities relating to transformation feed into weekly MHLd management team and divisional meetings, and MHLd management board meeting (which includes partner agencies and service users).
9	Regular engagement sessions with staff.

Assurance on Control <i>What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?</i>				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
1	Workstreams report into the Driver Group (fortnightly).	Driver Group chaired by independent expert reviews & challenges activities of programme workstreams provides assurance to the Programme Board.	All five workstream are chaired by and a HB Executive or a nominated deputy	Substantial
2		Transformation Program Lead report to the full Board on a bimonthly basis with progress and updates, next due on the 27 th Nov		Substantial
3		Monthly updates to informal Exec meeting by Transformation Program Lead.		Reasonable
4			HIW inspection reports have identified areas for improvement in a number of areas (areas with open improvement plans listed): Tawe Clinic, Cefn Coed (inspection Oct 2025) Community MH Team (Swansea North) (review Jul 2025) Laurels & Briary Specialist Residential Unit (inspection Apr 2025) Tonna Hospital Suite 2 (inspection Oct 2024) Caswell Clinic (inspection Sep 2023) Ward F, NPT Hospital (inspection May 2023) Bryn Afon LD Hospital (inspection Jan 2023) Tawe Clinic, Cefn Coed (inspection Mar 2022) NHS Performance and Improvement Report Aug (Adult MH inpatient and crisis service pathways review)	Limited
5			JCC Review of Caswell Clinic Medium Secure Facility in Oct 2025, has highlighted issues to be resolved (and six priority areas).	Limited
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.				Moderate

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?</i> <i>What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
1	Leadership	Leadership is identified as influencing engagement, motivation and decision making in developing a strategy and implementation plan from the work within the Transformation Program. This needs to be at all levels of the organisation to influence such significant change across a service.	All Executives & Service Group Directors		
2	Review of actions for oversight as the Transformation Program continues to progress.	Development and approval of an implementation plan to deliver recommended improvements required by the MH Transformation Program which incorporates the NHS PI Adult MH Review.	All Executives & Service		

			Group Directors		

Additional Comments
18/12/25: Register reviewed. No change.

Risk ID Number SRR-3.1	Risk Label – Partnerships and Collaboration Risk Description – If the health board does not have effective structures, processes and working relationships with its external partners, there is a risk that areas of work dependent upon collaboration with partners may not deliver what is required in a timely way, impacting on the delivery of health board priorities.

Risk Score	Consequence	Likelihood	Overall Score	Trend	Strategic Objective	People of Swansea Bay live healthier, equitable and more equal and prosperous lives
Inherent Score	4	4	16	↔	Lead Director / Risk Owner	Director of Planning & Partnerships
Current Score	4	3	12		Monitoring Committee	Quality & Safety Committee
Target Score	4	2	8	N/A	Risk Appetite	T.B.C.
Risk Score Over Time	Nov 2025	Dec 2025				
	12	12				

Related Risk on Corporate Risk Register		
Linked or associated risks which sit in the register immediately below the Strategic Risk Register		
Risk ID	Description	Score

Key Controls	
<i>What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?</i>	
Control Ref	Control
1	Further work to be developed in relation to children & young people services. This will be considered as part of the Health Boards work on the CYP strategic plan.
2	Further work to develop internal governance and leadership in relation to Partnerships & Collaboration.

Assurance on Control				
<i>What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?</i>				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
1	A SBUHB Strategic Plan for CYP will enable improved leadership and a strategic approach, both internally and externally. Feedback received from two CYP events held in 2024/2025 – the events included CYP leaders from across SBUHB.	Commitment made by Management Board to improve the position strategically for children & young people.	Audit to be undertaken in relation to CYP Services.	Reasonable
2	Ongoing commitment to develop and improve the role of the Strategic Partnerships Group (SPG) . The SPG will provide oversight of partnership discussions, including the WGRPB and the Public Service Boards (PSB), and inform Management Board and SBUHB Board on partnership activity and decisions.	Embedding of the Collaborative and Partnerships Framework and the SBUHB approach to Partnerships – Framework approved by Management Board in December 2024 .	The work of the SBUHB Partnerships Teams including the SPG and the Framework are in line with the Shared Services Audit undertaken in 2023/24. All developments to date have been with the recommendations made. In addition to the audit recommendations, a Partnerships Tracker is in development.	Reasonable
Current Overall Assurance Rating Reasonable Assurance - Alignment of Partnership priorities with the Health Board Annual Plan has been undertaken. The SBUHB Annual Plan for 2025/26 outlines clear priorities for working with PSB and RPB and governance and leadership arrangements strengthened to support delivery.				Good

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively? What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
1	Commitment to the SBUHB approach to partnerships and collaboration	Raising the visibility of the external partnerships by informing the Management Board and SBUHB Board and listening to colleagues both internally and externally on any improvements to be made.	Marie Davies	Mar 2026	On track
2	There is scope to provide increased visibility and strategic leadership in respect of Children & Young People.	The establishment of the Women, Children & Young People’s Care Programme Board will provide increased visibility and strategic leadership in these key priority areas. A workshop in December was co-chaired by the Executive Director of Nursing and the Chief Operating Officer and the first meeting is scheduled for February 2026.	Marie Davies	Feb 2026	On track
3	Partnership governance: There is scope to improve oversight of the health board’s statutory duties and requirements in relation to partnerships and assurance at Board/Committee.	The Partnerships Tracker is now agreed and the first report will be submitted to audit committee in January 2026. The ongoing review and maintenance of the tracker will be the responsibility of the planning & partnerships team.	Marie Davies	Jan 2026	On track
Additional Comments					
17/12/25: Further developments in relation to Children & Young People, and partnership governance overall, have been reflected in the Actions section above.					

Risk ID Number SRR-3.2	Risk Label – Maintaining our Estate Risk Description – If we do not secure sufficient funding and employ that effectively to address priority areas of deterioration within our estate within primary and secondary care, then our buildings and/or associated infrastructure may fail in part or wholly, resulting in increased risk to patient and staff safety, and the disruption of service provision.

Risk Score	Consequence	Likelihood	Overall Score	Trend	Strategic Objective	Care is delivered in safe and appropriate settings supported by innovative digital solutions
Inherent Score	5	4	20	↔	Lead Director / Risk Owner	Director of Finance & Performance
Current Score	5	4	20		Monitoring Committee	Performance & Finance Committee
Target Score	4	3	12	N/A	Risk Appetite	TBC
Risk Score Over Time	Nov 2025	Dec 2025				
	20	20				

Related Risk on Corporate Risk Register		
Linked or associated risks which sit in the register immediately below the Strategic Risk Register		
Risk ID	Description	Score
64 (2159)	Health and Safety Infrastructure Insufficient resource and capacity of the health, safety and fire function to maintain legal and regulatory compliance.	20

Key Controls	
What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?	
Control Ref	
1	Planned Preventative Maintenance prioritising highest risks dependent on funding availability e.g. Year 2 Targeted Estate Fund 25/27 (TEF), Discretionary availability.
2	There is an Essential Infrastructure Replacement programme – however, this is subject to availability of decant facility and progress of Business Case to obtain funding. Morriston Service Group have noted the need for a decant facility to be available from the end of the Emergency Department Test of Change from March 2026.
3	Electrical resilience is tested through Black Starts on both sites, Singleton and Morriston. Provision of further resilience is subject to funding of N+1, Sub stations and back-up generators, and alternative additional HV supply facilitated by Access Road (Felindre Sub-station).
4	There is an Estates Strategy in place informed by a 6 Facet Survey. That survey has now been superseded by the review and upgrade of the health board asset register to form a baseline for capital investment planning as well as the actual condition / life expectancy of plant.
5	Reactive Maintenance is ongoing. However, demands are increasing due to more frequent breakdowns and the age of the estate infrastructure, which is becoming more resource intensive with limited capacity and capability especially with regard to 24/7 shift cover and associated business continuity risks.
6	Adult Mental Health, Forensic Services and Learning Disabilities engagement on Business Case.

Assurance on Control				
What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
1	PPM: Monthly SLT meetings with Capital and Estates reviewing risks and new DATIX notifications.	Engagement with Independent Members on site walkabouts. Reports to Performance and Finance Committee are scrutinised and the Committee reports to Board to Alert, Advise or Assure on matters received.		Substantial

	• Reports bi-monthly to the Capital and Estates Board. • Fortnightly meetings with Performance and Finance Executive Director highlighting risks that impact on business continuity. • Bi-monthly reporting to Welsh Government through Capital Resource Meetings. • Assistant Director chairing all compliance groups and reporting through Capital and Estates Board. • Presentations to Estates Task and Finish Group with Independent Members. • Paper to Health Board covering Capital and Estates progress, risks and challenges.			
2 & 3	ESSENTIAL INFRASTRUCTURE MAINTENANCE & ELECTRICAL RESILIENCE TESTING: • Monthly SLT meetings with Capital and Estates reviewing risks and new DATIX notifications. • Reports bi-monthly to the Capital and Estates Board. • Fortnightly meetings with Performance and Finance Executive Director highlighting risks that impact on business continuity. • Bi-monthly reporting to Welsh Government through Capital Resource Meetings. • Assistant Director chairing all compliance groups and reporting through Capital and Estates Board. • Presentations to Estates Task and Finish Group with Independent Members. • Paper to Health Board covering Capital and Estates progress, risks and challenges. The absence of decant facility is a constraint to undertaking works, hence the assessment of level of control effectiveness as Limited.	Engagement with Independent Members on site walkabouts. Reports to Performance and Finance Committee are scrutinised and the Committee reports to Board to Alert, Advise or Assure on matters received.		Limited
4	REACTIVE MAINTENANCE: • Monthly SLT meetings with Capital and Estates reviewing risks and new DATIX notifications. • Reports bi-monthly to the Capital and Estates Board. • Fortnightly meetings with Performance and Finance Executive Director highlighting risks that impact on business continuity. • Bi-monthly reporting to Welsh Government through Capital Resource Meetings. • Assistant Director chairing all compliance groups and reporting through Capital and Estates Board. • Presentations to Estates Task and Finish Group with Independent Members. • Paper to Health Board covering Capital and Estates progress, risks and challenges.	Engagement with Independent Members on site walkabouts. Reports to Performance and Finance Committee are scrutinised and the Committee reports to Board to Alert, Advise or Assure on matters received.		Reasonable

5	ESTATES STRATEGY: Delivery of Estates Strategy is dependent upon the availability of capital & revenue funding. As such the level of control effectiveness to deliver the strategy and address estates priorities at place is assessed to be limited. This has implications for the effectiveness of the response to known matters within mental health & learning disability services, amongst others.			Limited
All			Internal Audit reports received on Estates matters as follows: Estates Condition (Oct 2023) – Limited Assurance Estates Condition (Mar 2025) – Reasonable Assurance Estates Assurance: Follow Up (Mar 2024) – Reasonable Assurance	Reasonable
All			HIW Inspection findings in the below areas: Tawe Clinic, MHL D (Mar 2022 & Oct 2025 indicative) Ward F NPTH, MHL D (May 2023) Caswell Clinic, MHL D (Sep 2023) Tonna Suite 2, MHL D (Oct 2024) Laurels & Briary, MHL D (Apr 2025) Oakwood & Ward M, Morriston (Jan 2023)	Limited
All			JCC Review findings in the below service: Caswell Clinic, MHL D (Oct 2025)	Limited
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.				Moderate

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively? What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>		Lead Director	Due Date	Progress
1	There is a need to focus on capacity, capability and resilience and to increase organisational understanding of the Estates department's contribution to the safety of the built environment and the quality of the patient experience. There are significant risks associated with an under resourced, ageing and inconsistently trained workforce that is struggling to maintain the operational viability of an estate that was not built to deliver modern healthcare interventions and is mostly 40 years old. NHS trained staff with knowledge and experience of healthcare estate are the most capable resource for ensuring a quality service that clinical colleagues can rely on. Gaps and weaknesses in both capacity and capability are most often filled through reliance on contractors. Some of this intervention will always be necessary given the highly specialised and complex nature of the estate infrastructure but compared with other Health Boards Swansea Bay has a disproportionately high reliance on contractors. Failure to plan and invest may deliver short term cash reductions but will result in systemic failure and much higher cost to the Health Board.	An OCP proposal that deals with legacy capacity issues; legacy industrial relations issues; and essential capacity to respond to Business Continuity risks and longer-term sustainability is pending final approval in line with current Health Board financial processes. When this is approved the aim is to submit it to the HR Sub Committee on the 4 th December so that the OCP process may commence. This OCP would be fully funded from existing approved budgets. Furthermore, approval from the Executive Director Performance and Finance requires additional savings to be generated to at least equal the key posts. It is also important to note that this OCP is intended to facilitate a more holistic approach to reducing the Health Boards run rate through more effective utilisation of the estates resource.		ED P&F	4 th December 2025	On track
2	Availability of funding from Welsh Government and the level of discretionary funding which needs to increase.	Business continuity and estates risks are being reviewed with bi-monthly Welsh Government Capital Resource meeting.		ED P&F	1 st February 2026	On track

3	Gap in information on extend of work required in Learning Disabilities estate.	A detailed survey of the condition of premises within the health board LD estates is required in order to identify areas of high and intermediate risk for works to be carried out this year.	ED P&F	31 st March 2026	On track

Additional Comments

Risk ID Number SRR-3.3	Risk Label – Sustainability of Digital Services Risk Description – If the organisation is unable to maintain & replace existing digital systems & infrastructure in a timely manner, there is a risk that this could lead to system failures and cybersecurity vulnerabilities, resulting in disruptions in clinical service delivery. This risk encompasses the need for ongoing investment in digital assets to ensure they remain functional & secure. Factors contributing to this risk include financial constraints, aging infrastructure, & the need for continuous updates & support to meet evolving service requirements.

Risk Score	Consequence	Likelihood	Overall Score	Trend	Strategic Objective	Care is delivered in safe and appropriate settings supported by innovative digital solutions
Inherent Score	5	5	25		Lead Director / Risk Owner	Director of Digital
Current Score	5	4	20		Monitoring Committee	Digital, Data, Research & Innovation Committee
Target Score	5	3	15	N/A	Risk Appetite	T.B.C.
Risk Score Over Time	Nov 2025	Dec 2025				
	20	20				

Related Risk on Corporate Risk Register		
Linked or associated risks which sit in the register immediately below the Strategic Risk Register		
Risk ID	Description	Score
60 (2003)	Cyber Security and Resilience <i>Full details are presented within CRR</i>	20
105	Significant increased cost for the replacement Pathology System LIMS If the new Laboratory Information Management (LIMS) system is not live before 31st December 2025 then there will be significant more cost across NHS Wales which could impact the Health Board’s financial plans in 2025/26 and 2026/27. Costs would have to be covered to avoid pathology losing access to the current LIMS system resulting in the inability of pathology to deliver diagnostic results and blood transfusion services across all Health Board services including emergency, acute, primary and community services	20

Key Controls	
<i>What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?</i>	
Control Ref	Control
1	Cyber Security Policy and mandatory Cyber Security training in place
2	Programme in place for management of legacy systems and infrastructure
3	Ten-year Financial Plan for replacement of devices and infrastructure. Prioritisation in place to ensure consideration given to highest areas of risk.
4	Immutable backup process in place
5	Active monitoring of, and protection of, networks, systems and infrastructure
6	Service level Business Continuity Plans in place to mitigate the impact of an outage, managed by the Emergency Preparedness Resilience and Response (EPRR) team
7	Review process following all major Digital incidents
8	Digital Strategy in place

Assurance on Control <i>What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?</i>				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
1	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Services Management Group (DSMG) Reports to IGCA Reports to Digital Leadership Group (DLG) Digital Operations KPI Monthly Review meeting	Regular reports to Management Board and DDRI	Annual NIS compliance assessment, DHCW Cyber Resilience Unit Independent penetration and vulnerability testing Internal Audits: - SBUHB 2324-19 Technical Resilience (23/24) - SBUHB 2324-17 SIGNAL System (23/24)	Reasonable
2	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Services Management Group (DSMG) Reports to Digital Leadership Group (DLG) Monthly Digital Finance meeting Monthly Capital Finance meeting Digital Operations KPI Monthly Review meeting	Regular reports to Management Board and DDRI Quarterly Performance and Finance Review	Annual NIS compliance assessment, DHCW Cyber Resilience Unit Independent penetration and vulnerability testing Internal Audit: SBUHB 2324-19 Technical Resilience (23/24) Digital Transformation Review – Audit Wales (25/26)	Reasonable
3	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Services Management Group (DSMG) Reports to Digital Leadership Group (DLG) Monthly Digital Finance meeting Monthly Capital Finance meeting	Regular reports to Management Board and DDRI Quarterly Performance and Finance Review		Reasonable
4	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Services Management Group (DSMG) Digital Operations KPI Monthly Review meeting	Regular reports to Management Board and DDRI	Annual NIS compliance assessment, DHCW Cyber Resilience Unit Independent penetration and vulnerability testing Internal Audit: SBUHB 2324-19 Technical Resilience (23/24)	Reasonable
5	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Services Management Group (DSMG) Reports to IGCA Reports to Digital Leadership Group (DLG) Digital Operations KPI Monthly Review meeting	Regular reports to Management Board and DDRI	Annual NIS compliance assessment, DHCW Cyber Resilience Unit Independent penetration and vulnerability testing Internal Audits: - SBUHB 2324-19 Technical Resilience (23/24) - SBUHB 2324-17 SIGNAL System (23/24)	Reasonable
6	Reports to Digital Services Management Group (DSMG) EP	Escalation to Management Board	Internal Audits: - SBUHB 2324-19 Technical Resilience (23/24) - SBUHB 2324-17 SIGNAL System (23/24)	Reasonable
7	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Services Management Group (DSMG) Reports to IGCA Digital Operations KPI Monthly Review meeting	Regular reports to Management Board and DDRI	Annual NIS compliance assessment, DHCW Cyber Resilience Unit Independent penetration and vulnerability testing Internal Audits: - SBUHB 2324-19 Technical Resilience (23/24) - SBUHB 2324-20 Digital Support (23/24)	Reasonable
8	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register	Regular reports to Management Board and DDRI Quarterly Performance and Finance Review	Internal Audit: SBUHB 2425-18 BI Strategy Implementation (24/25)	Reasonable

Reports to Digital Services Management Group (DSMG) Reports to IGCAG Reports to Digital Leadership Group (DLG) Monthly Digital Finance meeting Monthly Capital Finance meeting Digital Operations KPI Monthly Review meeting		Digital Transformation Review – Audit Wales (25/26)	
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.			Good

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?</i> <i>What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
1	2023/2024 Internal Audit on technical resilience has the outstanding key finding “Not all sites containing core infrastructure items have fire suppression. We note that this is partly due to those areas which are not within a data centre having dual use. Without fire suppression there is an increased risk of loss of service, in particular during out of hours”. Recommendation was “Consideration should be given to installing fire suppression. Potentially using a system that can be turned off when the room is in use by staff.”	Management response was “Fire suppression is installed in the data centre at Morriston Hospital but not in the data centre at NPT Hospital. This is planned for 2023/24 and capital funding is agreed”. Delays have been caused outside of Digital’s control – due to requirement of working with Keir (PFI) and ventilation design within the room. Installation expected Summer 2025.	Director of Digital	31/03/24	Off track
2	2023/2024 Internal Audit on technical resilience has the outstanding key finding “The Business Continuity Plan (BCP) includes planning for loss of server rooms, although we note that there is limited detail for this, with an instruction to ‘...use other rooms to relocate DR equipment’. We also note that as failover is not automatic, there is a need to readdress the network; however, this is not clear within the BCP. As such, there is no formal Disaster Recovery (DR) plan that sets out exactly what will be done in the event of a major failure of service. We also note that whilst the key information is in place to enable recovery of individual services, the use of this in a disaster scenario relies in the user knowing where the information is and how to use it. We note that DR plans may need to be invoked late at night, by an individual who may not be familiar with the service. Whilst Digital Services operate an on call rota, and if necessary will declare an incident in order to bring key individuals on site, the current DR planning may lead to delays in service restoration.” Recommendation was “A more structured disaster recovery plan should be defined that builds on the information already available.”	Management response was “The DR plan going forward will change depending on the outcome to the first action above. A more structured plan will then be developed.” It was later noted that the action is being considered with the work to implement layer 2 connectivity between Morriston and NPT data centres, the appropriate documentation prepared but unable to be tested until network implementation complete. Completion of action expected July 2025.	Director of Digital	30/06/24	Off Track
3	2023/2024 Internal Audit on systems software development has the outstanding key finding “SBUHB is aware of best practice in the development of code and the team has undertaken a training session using Udemy, with the intention to have further courses once a month. However, currently there is no requirement to complete security review and code is not screened for vulnerabilities before being released. We note that there is an intent to trial ‘OWASP ZAP’, a penetration testing tool that helps developers detect and find vulnerabilities in web applications, however this is dependent on funds being made available.” Recommendation was “A process to assess the need for security review of developments, dependant on risk and complexity, should be established, with security input provided as required.”	Management response relating to first outstanding action was “Code security and secure development process to be documented as part of the Software Development Handbook.” Handbook production in progress, but delayed – due Q2 2025-26	Director of Digital	31.05.2025	Off Track

Additional Comments
22/12/25: Register reviewed. Assurances updated.

Risk ID Number SRR-3.4	Risk Label – Failure to Deliver Digital Transformation Risk Description – If the organisation does not implement or utilise digital solutions to support and transform care provision across the Health Board it will hinder the organisations’ ability to achieve its strategic objectives and improvements in service delivery. Without appropriate digital solutions in place there is a risk that the Health Board will not be able to: meet the needs of its population; ensure care is of high quality and is efficient; provide effective care in an environment that best meets the needs of the patient; address the constraints and issues arising from the reliance on the paper record; recruit and retain staff; collect and interpret data to inform decision making and monitor performance to aid service improvements; or exploit new technologies, such as AI and remote monitoring, that can support improving the quality and sustainability of service delivery. This risk is driven by constraints such as insufficient capital or revenue, limited capacity & capability within digital, Service Group and Corporate teams, clinical and service leadership/ownership for digital transformation, data and data infrastructure & other resource limitations such as procurement and contract management.

Risk Score		Consequence		Likelihood	Overall Score	Trend	Strategic Objective		Care is delivered in safe and appropriate settings supported by innovative digital solutions				
Inherent Score		5		5	25	↔	Lead Director / Risk Owner		Director of Digital				
Current Score		5		4	20		Monitoring Committee		Digital, Data, Research & Innovation Committee				
Target Score		5		2	10	N/A	Risk Appetite		T.B.C.				
Risk Score Over Time	Nov 2025	Dec 2025											
	20	20											

Related Risk on Corporate Risk Register		
Linked or associated risks which sit in the register immediately below the Strategic Risk Register		
Risk ID	Description	Score
36 (1043)	Paper Record Storage Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records, then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards. There is an increased fire risk where medical records are stored outside of the medical record libraries.	16
104 (443)	Clinical Coding Completeness There is a risk that clinical notes for inpatient episodes will not be coded in a timely way, resulting in insufficient coded data to support effective service planning for population health needs and inadequate data being available for mortality review/quality and safety purposes, with increased risk of failure to spot variances that are negatively impacting levels of patient care and potentially causing avoidable deaths	20

Key Controls	
What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?	
Control Ref	Control
1	Robust project management framework and governance in place within Digital Services
2	Benefits framework and methodology in place within Digital Services
3	HB Business Case Assurance Group process provides scrutiny to ensure digital resources are considered for all projects
4	Digital Services prioritisation process in place to ensure that requests for digital solutions are considered in terms of alignment to the strategic objective, technical solutions and financial implications. Project Boards established for all significant projects.
5	Clinical Reference Group established, providing a forum for engagement with and feedback from clinicians in respect of digital solutions and enhancements, and the strategic direction of digital services. Digital meetings with Service Delivery Groups to identify and prioritise requirements, monitor progress with implementation, and address issues with business-as-usual activities.
6	Receipt, approval and recording of changes/updates made to all existing digital solutions via the Digital Services Change Advisory Board.
7	The Health Board has representation on national groups such as Advanced Analytics Group (AAG), all Wales Business Intelligence & Data Warehousing Group and Welsh Modelling Collaborative.
8	IMTP, Digital Strategy, Business Intelligence Strategic Plan, along with Digital Procurement Policy, a number of Health Records and other Digital policies

Assurance on Control				
What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
1	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Leadership Group (DLG) Monthly Digital Finance meeting Monthly Capital Finance meeting Digital Project Review Group Reports to Information Governance and Cyber Assurance Group (IGCAG)	Regular reports to Management Board and DDRI Quarterly Performance and Finance Review	Internal Audit: SBUHB 2324-20 Digital Support (23/24) Digital Transformation Review – Audit Wales (25/26) Annual IG Toolkit submission	Reasonable
2	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Leadership Group (DLG) Monthly Digital Finance meeting Monthly Capital Finance meeting Digital Project Review Group	Regular reports to Management Board and DDRI Quarterly Performance and Finance Review	Internal Audit: SBUHB 2526-19 Benefits Realisation (25/26)	Reasonable
3	Reports to Digital Leadership Group (DLG) Digital Project Review Group	Regular reports to Management Board and DDRI Quarterly Performance and Finance Review	Internal Audit: SBUHB 2526-19 Benefits Realisation (25/26) Digital Transformation Review – Audit Wales (25/26)	Reasonable
4	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Leadership Group (DLG) Digital Project Review Group	Regular reports to Management Board and DDRI Quarterly Performance and Finance Review	Internal Audit: SBUHB 2324-20 Digital Support (23/24) Management of the Delivery of National Systems (25/26)	Reasonable
5	Reports to Digital Leadership Group (DLG) Reports to Information Governance and Cyber Assurance Group (IGCAG)	Regular reports to Management Board and DDRI	Internal Audit: SBUHB 2526-19 Benefits Realisation (25/26) Digital Transformation Review – Audit Wales (25/26) Annual IG Toolkit submission	Reasonable
6	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Services Management Group (DSMG)	Regular reports to Management Board and DDRI	Internal Audits: - SBUHB 2324-18 Software / System Development (23/24) - SBUHB 2526-21 Management of the Delivery of National Systems (25/26)	Reasonable
7	Reports to Digital Services Management Group (DSMG) Reports to Digital Leadership Group (DLG)	Regular reports to Management Board and DDRI	Internal Audit: SBUHB 2526-21 Management of the Delivery of National Systems (25/26) Digital Transformation Review – Audit Wales (25/26)	Reasonable
8	Reports to bimonthly Digital Services Business Meeting Monthly Digital Risk Management Group / Risk Register Reports to Digital Services Management Group (DSMG) Reports to Information Governance and Cyber Assurance Group (IGCAG) Reports to Digital Leadership Group (DLG)	Regular reports to Management Board and DDRI Quarterly Performance and Finance Review	Internal Audits: - SBUHB 2425-18 BI Strategy Implementation (24/25) - SBUHB 2425-19 Records Management (24/25) Digital Transformation Review – Audit Wales (25/26) Annual IG Toolkit submission	Reasonable

Monthly Digital Finance meeting Monthly Capital Finance meeting Digital Project Review Group			
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.			Good

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?</i> <i>What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
1	2024/2025 Internal Audit on records management has the outstanding key finding "SBUHB has produced Records Management guidance for Health Records in the form of the Health Records Policy, the Health Records Storage and Security Policy, the Health Records Compilation Policy, the Minimum Retention and Destruction Policy and the Health Records Tracking Policy. However, we note that these policies are more directly applicable to the acute health record, and do not contain information covering all aspects, such as record retention and destruction processes. The three areas reviewed acknowledged that the overarching policies existed, however, due to these being more directly relevant to the acute health record, and the lack of more detailed guidance to enhance the policies, departments have sourced and are following guidance from other organisations." Recommendation was "Inappropriate records management guidance"	Management response was "All the Acute Health Records Policies are currently under review, and will be updated and expanded to include the management and governance of non-acute and corporate records also. Enhanced detail will also be included over the full records lifecycle." The Health Records Policies have been updated and approved by IGCG, awaiting approval from DDRI in May 2025.	Director of Digital	31/03/25	Off Track
2	2024/2025 Internal Audit on records management has the outstanding key finding "Due to the lack of coordinated management for the storage of records, as noted above there are a number of external providers holding health board records. The costs vary between the providers, as such the health board may not be sourcing the best value storage." Recommendation was "A review of the storage of records should be undertaken in order to establish the full health board need, and to identify the most suitable locations for storage of records which should take into account the requirements once appropriate disposal of records; as noted in MA5 has been undertaken."	Management response was "A Multi-Disciplinary Project Group will be established following the centralisation of the acute health records service to Ty Samlet, which will be completed by the 1/4/25. The project group will review the Health Board' wide storage requirements and will encompass all the associated security/retention and disposal of records aspects highlighted within the audit report."	Director of Digital	31/05/25	OnTrack
3	2024/2025 Internal Audit on records management has the outstanding key finding "The HB utilises Transmedia for external record storage from multiple departments, including Workforce. However, our review noted that the only contract in place with Transmedia is for the storage of Pathology materials. Spend with the company is more than double the contracted value, which may leave the health board open to legal challenges. We also note that the lack of a formal contract for storage other than Pathology items introduces uncertainty regarding Transmedia's responsibilities in managing personal records, raising potential GDPR compliance concerns." Recommendation was "The arrangements for storage of records other than Pathology at Transmedia should be formalised with a contract or agreement that clearly states the requirements and responsibilities for records storage."	Management response was "A contract/agreement will be developed to formalise the storage of all other records stored at Transmedia which clearly defines the requirements and responsibilities for storage of all records if SBHB continues to store records within this third-party storage facility."	Director of Digital	30/06/25	OnTrack
4	2024/2025 Internal Audit on records management has the outstanding key finding "Our review of the transportation of records for all of the areas noted that records are being sent via internal mail, within private vehicles and in unsealed containers. As such the transportation of records may not meet the requirement of the Health	Management response was "All the Acute Health Records Policies are currently under review, and will be updated and expanded to include the management and governance of non-acute and corporate records also. Enhanced detail will also be included over the full records lifecycle." The Health Records Policies have been updated and approved by	Director of Digital	31/03/25	Off Track

	Records Storage and Security Policy and best practice guidance.” Recommendation was “Guidance on the transportation of records should be provided which extends beyond the acute health record”	IGCAG, awaiting approval from DDRI in May 2025			
5	2024/2025 Internal Audit on records management has the outstanding key finding “During the review, it became evident that some departments are retaining records beyond the designated retention periods partly due to the lack of health board guidance. The Occupational Therapy department has not destroyed any records since 2019 and continues to retain records dating back to 2010. Similarly, the Workforce and Organisational Development (WOD) team has also refrained from destroying records. The retention of records past defined removal dates may result in a breach of the GDPR requirements and exacerbates storage pressures.” Recommendation was “All departments should be reminded of the need to destroy records appropriately in accordance with retention periods”	Management response was “A Multi-Disciplinary Project Group will be set up to review the destruction programme across all SBUHB record services.” The requirement to destroy records appropriately in accordance with Retention and Destruction periods forms part of the agenda taken forward by the Multi-Disciplinary Project Group which first met in April 2025, with representation from the Services that were audited. Progress has been made within the services since the audit was undertaken. An action plan will be developed which will highlight the progress made to date	Director of Digital	09/02/25	Off Track
6	2024/2025 Internal Audit on systems software development has the outstanding key finding “There is no formal guidance in place setting out how to manage the deployment of software, as such there is no requirement to gain approval from the user department to confirm they are ready before its release. In addition, there is a lack of a formal requirement to assess the need for a back out plan for deployments and ensure these are in place as appropriate” Recommendation was “Guidance should be provided on how to manage deployment and release of software. This should ensure that user departments approve the release and timing and that appropriate back out plans are in place”	Management response was “Software deployment and release processes to be documented within the Software Development Handbook. All releases are managed by agreement between the product specialist, user departments and software development. Once agreed a change management request is raised in accordance with the SBUHB Change Management governance process. Within the request are details relating to timing, downtime and back out plans. The approach to releases is defined on a case-by-case basis depending on the technical nature, scale and complexity of the release. There is no formal guidance in place setting out how to manage the deployment of software, as such there is no requirement to gain approval from the user department to confirm they are ready before its release.”	Director of Digital	31.05.25	On Track
7	2024/2025 Wales Audit Office review of operational governance has the outstanding key finding “During our fieldwork, service groups raised concerns about the availability and quality of management information. Whilst the expertise within the Health Board’s Business Intelligence Unit was recognised, its limited resources was seen as a barrier to providing the data analytical support that was require.” Recommendation was “The Health Board should review the capacity within its Business Intelligence Unit to ensure it is adequately resourced to support service groups in effectively interrogating data and information”	Management response was “The Business Intelligence team structure has recently changed so that the Business Intelligence partners cover subject areas rather than service delivery groups. This ensures a greater balance of support across the health board areas, including Quality and Safety, while still allowing the same level of support for the SDGs. Under the direction of Executive Leads, a new business intelligence delivery model is being developed which aims to use the skillsets across multiple corporate and service group teams in a more effective way to help address resourcing capacity issues”	Director of Digital	31.01.25	Off Track

Additional Comments

22/12/25: Register reviewed. Assurances updated.

Risk ID Number SRR 3.5	Risk Label – Research, Development & Innovation Risk Description – If we do not identify and capitalise upon opportunities to engage in research and development, there is a risk that we will not continue to deliver high quality care and potential opportunities to work more effectively, more efficiently and/or to generate income, may be missed, resulting in reduced options to address other strategic objectives, and the reduced attractiveness of the organisation for the recruitment and retention of staff.

Risk Score	Consequence	Likelihood	Overall Score	Trend	Strategic Objective	Care is high quality, safe, efficient and delivers the best possible outcomes for people
Inherent Score	4	4	16		Lead Director / Risk Owner	Executive Medical Director
Current Score	4	3	12		Monitoring Committee	Digital, Data, Research & Innovation Committee
Target Score	2	2	4		Risk Appetite	T.B.C.
Risk Score Over Time	Nov 2025	Dec 2025				
	12	12				

Related Risk on Corporate Risk Register		
Linked or associated risks which sit in the register immediately below the Strategic Risk Register		
Risk ID	Description	Score

Key Controls	
<i>What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?</i>	
Control Ref	Control
1	Research, development and innovation bridging strategy for 2025-26
2	Relationship with Swansea University, including Joint Clinical Research Facility
3	Regional approach agreed with Hywel Dda University Health Board
4	Process for submitting bids against the Voluntary Scheme for Branded Medicines, Pricing, Access and Growth (VPAG)
5	Work to strengthen oncology commercial clinical research through the membership of Commercial Research Delivery Wales (CRDW)

Assurance on Control				
<i>What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?</i>				
Control Ref	1st Line Assurance	2nd Line Assurance	3rd Line Assurance	Strength of Control
1	- Self-assessment against the NHS Wales Research and Development Framework mapped to the strategy - Research and Development Governance Group terms of reference are agreed and first meeting arranged for February 2026.	- Endorsed by the Management Board and Digital, Data, Research and Innovation Committee in March 2025, with approval from the Board in May 2025. - Regular progress reports to be provided to the committee thereafter.	- Discussed with Welsh Government and Health and Care Research Wales (HCRW) in March 2025 with support given to the strategy. - Performance and finance meetings with HCRW.	Reasonable
2	- Memorandum of understanding (MoU) in place - Regular meetings with Swansea University as part of the Joint Research Studies Committee	- Concerns/issues to be flagged to the Management Board/Digital, Data, Research and Development Committee - Bi-annual JCRF board chaired by the Deputy Medical		Limited

		Director at which JCRF confirm performance and finance positions		
3	Meetings between Executive Medical Directors and Chief Executives of both health boards to agree proposals	Terms of reference drafted for a regional delivery and oversight group for the research and innovation workstream, with the first meeting arranged for 1st October 2025	- Approach agreed by Regional Joint Committee in May 2025 - Progress updates now a standing agenda item	Reasonable
4	- Discussions at Research and Development Senior Management Team at the time bids open - Agreement of Executive Medical Director of bids submission	Reports on scheme and progress to the Management Board and Digital, Data, Research and Innovation Committee	- Feedback from HCRW following scrutiny of bids and advisement of decisions - Attendance at HCRW VPAG meetings	Reasonable
5	- Senior Management Team discussions. - Meetings with key services to identify risks to delivery, for example, pharmacy and radiology, and to agree mitigating actions. - Task and finish group established by clinical oncologist – this will be replaced by a clinical trial steering group once the final report has been submitted.	- Task and finish oncology group comprising research and development and oncology representation from both health boards Reporting line into regional delivery and oversight group has been established.	Update on progress to be shared with the Regional Joint Committee as part of the AAA reports from the regional oversight and delivery group	Reasonable
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified.				Good

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively? What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
1	1 st line of assurance gap as no operational level governance group is in place to oversee performance, risk, finance and delivery of the strategy objectives.	Amended: Terms of reference have been agreed for the Research and Development Governance Group to have day-to-day oversight of research and development delivery. The first meeting will take place in February 2026 and will provide reports to the Digital, Data, Research and Innovation Committee.	Executive Medical Director	30/11/2025	Completed
2	3 rd line of assurance gap as there is no formal mechanism in place between the health board and Swansea University to ensure delivery of the MoU and discuss concerns/risks, such as access to CT/MRI scanners	Amended: Discussion commenced with Swansea University and agreement in principle to establish a partnership group; Draft terms of reference circulated for discussion at a follow-up meeting in February 2026	Executive Medical Director	30/03/2026	On track
3	2 nd line assurance gap as there is a need for a regional oversight group to monitor and drive forward to establishment of a regional research and development strategy	Terms of reference drafted for a regional delivery and oversight group for the research and innovation workstream, with the first meeting taking place on 1 st October 2025.	Executive Medical Director	01/10/2025	Completed
4	1 st line assurance gap as there are opportunities to open VPAG applications across all specialities, but given the short turnaround time for the recent bids, oncology was the focus	Amended: Included as part of the research and development governance group terms of reference.	Executive Medical Director	30/11/2025	Completed
5	3 rd line assurance gap as the opportunities to strengthen oncology commercial trials access is potentially on a regional basis	This will be part of the initial workstreams to establish a regional research and development strategy and will feed into the progress reports to the regional delivery and oversight group for the research and innovation workstream.	Executive Medical Director	30/12/2025	Completed

Additional Comments
1. A sub-committee for research and development was in place but was put on hiatus during the pandemic. The establishment of a board level committee is an opportunity to revisit the arrangements; 2. Changes in personnel at both health board and university level have meant a change in communication channels and identified the need for a more formal approach; 3. Processes for applying for VPAG monies are still in development by HCRW as the scheme was only launched in 2024 therefore the health board is still adapting its approach.

Risk ID Number SRR-4.1	Risk Label – Staff Health & Wellbeing and Organisational Performance Risk Description – There is a risk of a negative impact to staff wellbeing due to the psychological and physical impact of the sustained pressure of work, continued transformation of services and the challenge in reconciling continued high levels of clinical and non-clinical demand with available resources. This could lead to high levels of sickness absence, reduced organisational and individual effectiveness, higher staff turnover and staff burnout. This is exacerbated at times of industrial action which remains a risk in 2025/26.

Risk Score		Consequence	Likelihood	Overall Score	Trend	Strategic Objective	The health board is a great place to work where staff feel valued and work together towards a common goal						
Inherent Score		3	4	12	↑	Lead Director / Risk Owner	Director of Workforce & OD						
Current Score		4	4	16		Monitoring Committee	Workforce & OD Committee						
Target Score		2	4	8	N/A	Risk Appetite	T.B.C.						
Risk Score Over Time	Nov 2025	Dec 2025											
	12	12											

Related Risk on Corporate Risk Register													
Linked or associated risks which sit in the register immediately below the Strategic Risk Register													
Risk ID	Description											Score	
3 (843)	Recruitment of Consultant Medical and Dental Staff Due to national shortages, there is a risk that that the health board will be unable to recruit consultant medical & dental staff into particular hard to fill roles which may result in difficulties fulfilling rotas on all sites, and adverse impact upon patient safety, service provision, quality and financial matters.											16	
101	Industrial Action (Healthcare Support Workers) <i>Full details are presented within CRR</i>											12	

Key Controls	
What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?	
Control Ref	Control
1	People Strategy
2	Staff Health & Wellbeing Plan
3	Managing attendance at work national policy
4	Sickness absence reporting

Assurance on Control				
What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
1	Strategy progress reports monitored through Management Group	Strategy progress reports assured through Workforce & OD Committee		Reasonable
2	Plan developed through Staff Health & Wellbeing Group	Plan approved through Management Board	Plan assured through Workforce & OD Committee	Limited
3	Adherence to policy monitored through monthly performance meetings	Adherence to policy assured through Management Group	Adherence to policy assured through Workforce & OD Committee	Limited
4	Trend data included in Integrated Performance Report for review by Management Group	Trend data included in Integrated Performance Report assured through Workforce & OD Committee	Integrated Performance Report assured through Board	Reasonable

Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.				Moderate		
Gaps in Control and/or Assurance		Actions to Address Gaps in Control and/or Assurance		Lead Director	Due Date	Progress
Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?		What are we going to do, by when, to further manage and mitigate this risk?				
What more do we need to do to control this risk, that we are not already doing?						
1	Gaps in recording and reporting of return-to-work interviews	IT solution being explored		DW&OD	30/9/25	On track
2	Gaps in reporting on staff who have met the triggers/who are on formal stages of the policy	Reporting solution being explored		DW&OD	30/9/25	On track
Additional Comments						
02/01/2026: Following discussion at Workforce & OD Committee, the Lead Director has reviewed the risk level for this area and increased the current score to 16, in view of an increase in sickness absence over the last two months and the fact that we remain an outlier compared to other health boards.						

Risk ID Number SRR-4.2	Risk Label – Leadership and Management Risk Description – Without compassionate and effective leadership at all levels of the organisation there is a risk that staff will lack the confidence to enable informed decision-making at the appropriate level to continuously improve and transform our services, resulting in a lack of commitment, poor staff engagement, poor communication, deterioration of staff wellbeing, and difficulty in recruiting and retaining the staff we need.

Risk Score		Consequence		Likelihood		Overall Score		Trend		Strategic Objective		The health board is a great place to work where staff feel valued and work together towards a common goal											
Inherent Score		4		3		12				Lead Director / Risk Owner		Director of Workforce & OD											
Current Score		4		3		12				Monitoring Committee		Workforce & OD Committee											
Target Score		4		2		8		N/A		Risk Appetite		T.B.C.											
Risk Score Over Time		Nov 2025		Dec 2025																			
		12		12																			

Related Risk on Corporate Risk Register													
Linked or associated risks which sit in the register immediately below the Strategic Risk Register													
Risk ID	Description												Score

Key Controls	
What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?	
Control Ref	Control
1	People Strategy
2	Leadership Development Plan
3	Joint Leadership Network (with Hywel Dda)
4	Management Development Plan
5	Staff Survey

Assurance on Control				
What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
1	People Strategy Highlight report reviewed through Management Group	People Strategy Highlight Report assured through Workforce & OD Committee		Reasonable
2	Leadership Plan approved through Management Group	Leadership Plan assured through Workforce & OD Committee		Limited
3	Terms of reference and highlight reports reviewed through Regional Steering Group	Progress on leadership network assured through Regional Joint Committee		Limited
4	Management Development Plan approved through Management Group	Management Development Plan approved through Workforce & OD Committee		Limited
5	Staff Survey results reviewed through Service Group Boards	Health board level results reviewed through Management Board	Staff survey results and action plans assured through Workforce	Reasonable

	with local action plans developed for areas requiring improvement	with organisational action plan developed for top 3 areas requiring improvement	and OD Committee	
	Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.			Moderate

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?</i> <i>What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>		Lead Director	Due Date	Progress
1	National leadership offer still in development delaying the refresh of the local leadership and management development plans	Refreshed leadership and management development plans to be considered by Management Group in August 2025		Director of WOD	31/08/25	On Track

Additional Comments

Risk ID Number SRR-4.3	Risk Label – Culture, Values & Behaviours Risk Description – If we do not foster a cohesive culture in line with our organisational values, there is a risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience.

Risk Score	Consequence	Likelihood	Overall Score	Trend	Strategic Objective	The health board is a great place to work where staff feel valued and work together towards a common goal
Inherent Score	4	3	12		Lead Director / Risk Owner	Director of Workforce & OD
Current Score	4	3	12		Monitoring Committee	Workforce & OD Committee
Target Score	4	2	8	N/A	Risk Appetite	T.B.C.
Risk Score Over Time	Nov 2025	Dec 2025				
	12	12				

Related Risk on Corporate Risk Register		
Linked or associated risks which sit in the register immediately below the Strategic Risk Register		
Risk ID	Description	Score

Key Controls	
<i>What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?</i>	
Control Ref	Control
1	Health board values and behavioural framework
2	One Bay Way Organisational Standards
3	Staff survey feedback and action plans
4	Freedom to speak up service
5	Employee relations (managed through Social Partnership Forum)

Assurance on Control				
<i>What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?</i>				
Control Ref	1st Line Assurance	2nd Line Assurance	3rd Line Assurance	Strength of Control
1	Values and behavioural framework developed through staff engagement	Embedding of values and behaviours assured through Workforce & OD Committee	Values and behavioural Framework agreed by Board	Reasonable
2	Organisational standards (One Bay Way) developed through staff engagement	Embedding of organisational standards assured through Workforce	One Bay Way Organisational Standards agreed by Board	Limited
3	Staff survey plans developed at Service Group and health board level	Staff survey plans approved through Management Group	Staff survey plans assured through Workforce & OD Committee	Reasonable
4	Regular Freedom to Speak up Reports to Management Group	Freedom to Speak Up Service assured through Workforce & OD Committee	Speak up in confidence culture assured through Board	Reasonable

Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.	Moderate

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?</i> <i>What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>		Lead Director	Due Date	Progress
1	Values well embedded across the health board. Further work to do to embed associated behaviours	Refresh and relaunch of behavioural framework		Director of W&OD	Jan 2026	Not started
2	Colleagues do not understand the concept of One Bay Way	Refresh, relabel and relaunch One Bay Way as organisational standards		Director of W&OD	April 2027	Not started
3	Lack of benchmark data included in current Freedom to Speak up Reporting	Benchmark data to be included		Director of W&OD	Oct 2025	On Track

Additional Comments

Risk ID Number SRR-5.1	Risk Label – Achieving Financial Sustainability Risk Description – If we fail to manage our costs effectively, whilst optimising productivity and effectiveness, then we will not return to financial balance. This will result in poor use of public funds, and an inability to provide sustainable services for our patients.

Risk Score		Consequence	Likelihood	Overall Score	Trend	Strategic Objective	The health board is a resilient, financially sustainable and responsible organisation					
Inherent Score		5	5	25	↔	Lead Director / Risk Owner	Director of Finance & Performance					
Current Score		5	5	25		Monitoring Committee	Performance & Finance Committee					
Target Score		5	3	15	N/A	Risk Appetite	T.B.C.					
Risk Score Over Time	Nov 2025	Dec 2025										
	25	25										

Related Risk on Corporate Risk Register												
Linked or associated risks which sit in the register immediately below the Strategic Risk Register												
Risk ID	Description											Score
92 (3444)	Finance: Forecast Deficit Risk Forecast deficit is not met due to insufficient progress on run rate reduction, and the saving targets required across all areas are not achieved.											25
93 (3448)	Finance: Reduced capital funds Reduced discretionary capital funds and reduced National NHS funds requiring a restricted Capital Plan for 2024/25.											12

Key Controls	
What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?	
Control Ref	Control
1	Annual Accountability Letters and Budgetary Management Framework
2	Recovery & Sustainability Board oversight of the identification and delivery of strategic long terms savings programmes.
3	Budgetary management approach which requires all Service Groups to produce a Finance Strategy each year.
4	Continued transparent exchange of position with NHS Wales Performance & Improvement and Welsh Government
5	A financial planning and reporting process is in place which dovetails with the wider IMTP production timetable. These provide a schedule of planning activities intended to support the production of a financially balanced and sustainable IMTP, aligned to the statutory requirements of the Health Board.

Assurance on Control				
What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?				
Control Ref	1 st Line Assurance	2 nd Line Assurance	3 rd Line Assurance	Strength of Control
1	Finance-specific monthly performance meetings held between Exec Directors and Service Group Directors receives assurances from SGD on development of plans and in-year delivery of plans and savings.			Reasonable
2			WG monthly monitoring returns and letters, signed by CEO and DoF.	Reasonable
3		Reports received and scrutinised by P&F Committee, including from the Recovery & Sustainability Board, and PFC reports		Reasonable

		onward 3As reports to the Health Board		
4			Review of annual accounts by Audit Wales, and subsequent issue of ISA 260	Reasonable
5			Audit Wales Report – Cost Savings Arrangements (2024)	Limited
			A&A Report – Savings Programme (2023)	Reasonable
Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.				Good

Gaps in Control and/or Assurance <i>Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?</i> <i>What more do we need to do to control this risk, that we are not already doing?</i>		Actions to Address Gaps in Control and/or Assurance <i>What are we going to do, by when, to further manage and mitigate this risk?</i>	Lead Director	Due Date	Progress
1	Signed/Agreed Accountability Letters are received after the start of the financial year	Continue to enhance the process to achieve a position whereby Accountability Letters are signed off/agreed prior to the commencement of the financial year.	Director of Finance & Performance	31/03/2026	

Additional Comments
18/12/25: SRR template updated to reflect reduction in CRR risk 93 <i>Finance: Reduced capital funds.</i>

Key / Convention

Strength of Control	Level of Overall Assurance
Substantial – The identified control(s) provide a strong mechanism for controlling the risk. Few matters require attention, which are advisory or compliance in nature.	Significant – Key governance, risk management and control processes in place provide significant assurance that the risk(s) is/are being managed effectively. Evidence demonstrates that systems and processes are being consistently applied and implemented. Outcomes are consistently achieved across all relevant areas.
Reasonable – The identified control(s) provide a reasonable mechanism for controlling the risk, albeit there is scope to strengthen this further. Some matters require management attention in control design or compliance.	Good - Key governance, risk management and control processes in place provide a good level of assurance that the risk(s) is/are being managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented, but no across all relevant areas. Outcomes are generally achieved, but with inconsistencies in some areas.
Limited – The identified control(s) provide only limited/partial mechanisms for controlling the risk. There are notable weaknesses which require management attention.	Moderate – Key governance, risk management and control processes in place provide moderate assurance that the risk(s) is/are being managed effectively. Evidence is available to demonstrate that systems and processes are being applied, but is insufficient to demonstrate implementation across all relevant areas. There is some evidence that outcomes are being achieved, but this is inconsistent and/or there are risks to current performance.
Unsatisfactory – The identified control(s) is/are not effective in providing a mechanism for controlling the risk. Action is required to address the whole control framework in this area.	Weak – Key governance, risk management and control processes in place provide only weak assurance that the risk(s) is/are being managed effectively. There is only limited evidence available that systems and processes are being applied or implemented.

Lines of Assurance
First - This is the internal control environment put in place by Managers. It will typically include reports which detail their plans, performance monitoring data, and the results of local checks and reviews of controls within departments performing relevant day-to-day operational activities. Examples would include: - Results of compliance reviews undertaken within Departments/Functions, and reported to senior management - Progress and/or performance reports received by SDG Boards / Committee Sub-Groups
Second – This level of assurance is often referred to as organisational oversight. It is typically provided by Health Board corporate departments and functions which do not directly manage or deliver specific services, but which oversee and report on how controls are operating, thus providing a greater separation from day-to-day management. Typically, this level of assurance is typically provided to the Board or one of its committees (which allows Independent Members to bring an additional level of challenge and scrutiny), as well as to senior management groups (e.g., Management Board). Examples would include: - Reports on the results of Infection Control Audits undertaken by the IP&C Team - Reports on Fire Safety Audits - Progress and/or performance reports received by the Board or one of its committees
Third – This is independent assurance, which typically comes from outside the organisation. Examples would include reports received from: - NWSSP Audit & Assurance - Audit Wales - Healthcare Inspectorate Wales - Llais - Royal colleges

CORPORATE RISK REGISTER

December 2025

CORPORATE RISK REGISTER – HEATMAP OF RISKS

Impact/Consequences	5			53: Compliance with Welsh Language Standards	60: Cyber Security 66: Access to Cancer Services – SACT 69: Adolescents being admitted to Adult MH wards 107: EPRR and Recovery	92: Finance: Forecast Deficit
	4			52: Impact Assessment Requirements 93: Finance: Reduced capital funds Reduced from 20 94: CAMHS failure to meet required standards of performance 100: Partnerships & Collaboration 101: Industrial Action (HCSW) Closed	03: Recruitment of Consultant Medical and Dental Staff 36: Paper Record Storage 43: Deprivation of Liberty Safeguards 61: Paediatric Dental GA Service 105: Increased Cost of replacement Pathology System LIMS 108: WCCIS/Connecting care NEW	04: Healthcare Acquired Infection 64: H&S Infrastructure 80: Transfer of Clinically Optimised Patients 85: Non-Compliance with ALN Act 89: Healthcare Nursing Staff Levels (HMP) 90: Subject Access Requests 96: Failure to Develop an Approvable IMTP 104: Clinical Coding Completeness 106: Emissions Reduction
	3					
	2					
	1					
C X L		1	2	3	4	5
		Likelihood				

Corporate Risk Register Dashboard

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
1 - People of Swansea Bay live healthier, equitable and prosperous lives	52 (1763)	Statutory Compliance: Engagement & Impact Assessment The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	Apr 2019	16	12	➔	Dec 2025	Director of Insight Communication & Engagement	Performance & Finance Committee
1 - People of Swansea Bay live healthier, equitable prosperous lives	100	A lack of a robust approach to partnerships & collaboration If the health board does not have effective structures, processes and working relationships with its external partners, there is a risk that areas of work dependent upon collaboration with partners may not deliver what is required in a timely way, impacting on the delivery of health board priorities.	May 2024	12	12	➔	Dec 2025	Executive Director of Planning & Partnerships	Population Health Committee
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people	4 (739)	Healthcare Acquired Infection Risk of patients acquiring infection as a result of contact with the health care system, resulting in avoidable harm, impact on service capacity, and failure to achieve national infection reduction goals.	Apr 2019	20	20	➔	Dec 2025	Executive Medical Director	Quality & Safety Committee
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	94 (3516)	CAMHS failure to meet required standards of performance The CAMHS service is unable to meet the required level of performance due to workforce deficits in the team across all staff groups including medics, psychological therapies and nursing.	Oct 2023	20	12	➔	Dec 2025	Chief Operating Officer	Performance & Finance Committee
2 - Care is high quality, safe,	80 (1832)	Transfer of Clinically Optimised Patients Risk that we fail to significantly reduce the number of	May 2021	20	20	➔	Dec 2025	Chief Operating Officer	Quality & Safety

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
efficient, and delivers the best possible outcomes for people in partnerships		Clinically Optimised Patients in hospital beds. A deficit in the availability of appropriate community / domiciliary care results in unacceptable delays in discharging patients from acute hospital beds. As a result, patients can decompensate and never gain the independence that could have been available from an early discharge.							Committee
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	61 (1587)	Paediatric Dental GA Service – Parkway Safety risk of general anaesthetic procedures performed on children outside of an acute hospital setting. Repatriation of service to acute site delayed which means the health board continues to commission services for delivery outside of national guidance attracting reputational risk. There is also an associated risk in that the diagnosing clinician does not deliver the care to the patient resulting in increased risk of need for multiple GAs.	Apr 2019	15	16	➔	Dec 2025	Chief Operating Officer	Quality & Safety Committee
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	66 (1834)	Access to Cancer Services (SACT) The demand & complexity of planned treatment regime for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.	Nov 2019	25	20	➔	Dec 2025	Executive Medical Director	Quality & Safety Committee
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	69 (1418)	Adolescents are being admitted to adult mental health wards Risk related to adolescent patients being admitted to Adult MH inpatient wards – Inappropriate settings potentially resulting in 'Safeguarding Issues'. The WG has requested that Health Boards identify Secondary Care inpatient facilities for the care of adolescents. In Swansea Bay University Health	Feb 2020	20	20	➔	Dec 2025	Chief Operating Officer	Quality & Safety Committee

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
		Board Ward F NPT Hospital is the dedicated receiving facility with one bed identified.							
3 - Care is delivered in safe and appropriate settings	64 (2159)	Health and Safety Infrastructure Insufficient resource and capacity of the health, safety and fire function to maintain legal and regulatory compliance.	Sep 2019	20	20	➔	Dec 2025	Executive Director of Finance & Performance	Quality & Safety Committee
3 - The delivery of care is supported by innovative digital solutions	36 (1043)	Storage of Paper Records Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards.	Apr 2019	20	16	➔	Dec 2025	Director of Digital	Digital, Data Research & Innovation Committee
3 The delivery of care is supported by innovative digital solutions	60 (2003)	Cyber Security (In Committee Risk) The level of cyber security incidents is at an unprecedented level and health is a known target.	Jul 2019	20	20	➔	Dec 2025	Director of Digital	Digital, Data Research & Innovation Committee
3 - The delivery of care is supported by innovative digital solutions	104	Failure to meet Tier 1 targets in Clinical Coding Completeness There is a risk that clinical notes for inpatient episodes will not be coded in a timely way.	May 2025	12	20	➔	Dec 2025	Director of Digital	Digital Data & Innovation Committee
3 - The delivery of care is supported by innovative digital solutions	105	Significant increased cost for the replacement Pathology System LIMS If the new Laboratory Information Management (LIMS) system is not live before 31st December 2025 then there will be significant more cost across NHS Wales which could impact the Health Board's financial plans in 2025/26 and 2026/27. Costs would have to be covered to avoid pathology losing access to the current LIMS system resulting in the inability of	May 2025	25	20	➔	Dec 2025	Director of Digital	Digital Data & Innovation Committee

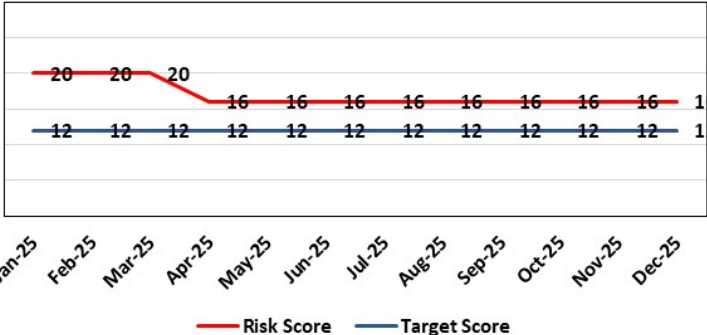
Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
		pathology to deliver diagnostic results and blood transfusion services across all Health Board services including emergency, acute, primary and community services							
3 - The delivery of care is supported by innovative digital solutions	108	WCCIS/Connecting care - Provision of an Integrated Health Record for MH&LD and PCT NEW RISK If the Connecting Care programme fails to deliver a digital solution that meets the operational, clinical, and reporting needs of Mental Health & Learning Disabilities (MH&LD) and Community & Therapies services, Then wider MH&LD, Community and Therapies teams will lack access to timely, accurate, and shared information across care settings, resulting in fragmented service delivery, limited availability of high-quality data for performance monitoring and informed decision making, increased duplication of effort, and elevated clinical and governance risks. This includes the potential for further Regulation 28 reports, as previous Prevention of Future Deaths (PFD) notices have explicitly cited the absence of an integrated electronic system as a contributing factor to avoidable harm. Without a fit-for-purpose solution, the Health Board may be unable to fulfil the actions required under Regulation 28, particularly around effective information sharing and risk management across agencies.	Dec 2025	20	16	New risk	Dec 2025	Director of Digital	Digital Data & Innovation Committee
4 - The health board is a great place to work where staff feel valued and work	3 (843)	Recruitment of Consultant Medical and Dental Staff Due to national shortages, there is a risk that that the health board will be unable to recruit consultant medical & dental staff into particular hard to fill roles	Apr 2019	20	16	➔	Dec 2025	Executive Director of Workforce & OD	Workforce & OD Committee

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
together towards a common goal		which may result in difficulties fulfilling rotas on all sites, and adverse impact upon patient safety, service provision, quality and financial matters.							
4 - The health board is a great place to work where staff feel valued and work together towards a common goal	89 (3071)	Healthcare Nursing Staff Levels (HMPS) There is a risk that the men in HMP Swansea will not receive the appropriate standard of care. This is due to the fact that the nursing establishment within the prison no longer fully meets the changed demographics and numbers of men being detained.	Nov 2022	20	20	➔	Dec 2025	Executive Director of Nursing & Patient Experience	Quality & Safety Committee
4 - The health board is a great place to work where all staff feel valued and work together towards a common goal	101	Industrial Action (Healthcare Support Workers) CLOSED (In Committee Risk) Due to inconsistencies in the bandings of healthcare support workers across the UK and NHS Wales at a band two and three level, action is being taken in partnership with Unison and the RCN to address inequalities against the context of limited financial resource availability. [Full description In Committee]	Jul 2024	20	12	Closed	Dec 2025	Executive Director of Workforce & OD	Workforce & OD Committee
5 - The health board is a resilient, sustainable and responsible organisation	43 (1514)	DoLS Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty/Liberty Protection Safeguards within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.	Apr 2019	16	16	➔	Dec 2025	Executive Director of Nursing & Patient Experience	Quality & Safety Committee

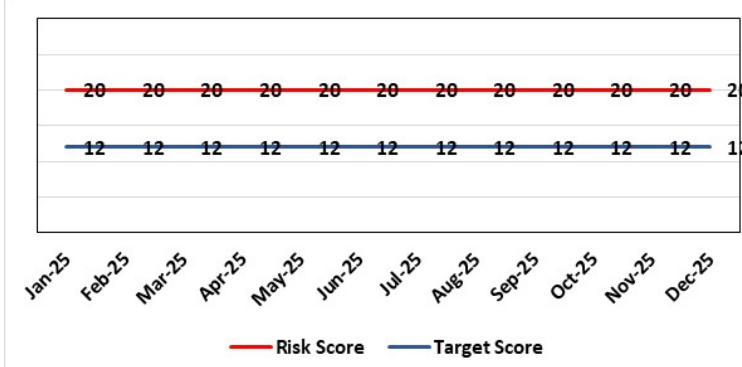
Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
5 - The health board is a resilient, sustainable and responsible organisation	53 (1762)	Welsh Language Standards Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	Apr 2019	15	15	➔	Dec 2025	Executive Director of Nursing & Patient Experience	Health Board (Welsh Language Group)
5 - The health board is a resilient, sustainable and responsible organisation	85 (2561)	Non-Compliance with ALN Act There is a risk of the Health Board not fulfilling the statutory requirements of the Additional Learning Needs and Education Tribunal (Wales) Act 2018 (the ALN Act) within the timescales that are required under the ALN Act, resulting in non-compliance with these duties.	May 2022	25	20	➔	Dec 2025	Executive Director of Allied Health Professions & Health Sciences	Quality & Safety Committee
5 - The health board is a resilient, sustainable and responsible organisation	90 (2796)	Subject Access Request Risk Due to insufficient resources and inconsistent processes across Swansea Bay University Health Board, there is a risk that Subject Access Requests (SARs) will not be fulfilled in compliance with UK-GDPR Article 15, resulting in potential breaches of personal data which could cause distress and lead to a loss of public and government confidence in the Health Board's trustworthiness and legal standing.	Jan 2023	16	20	➔	Dec 2025	Director of Digital	Digital, Data Research & Innovation Committee
5 - The health board is a resilient, financially sustainable and responsible organisation	92 (3444)	Finance: Forecast Deficit Risk Forecast deficit is not met due to insufficient progress on run rate reduction, and the saving targets required across all areas are not achieved.	Jun 2023	20	25	➔	Dec 2025	Executive Director of Finance & Performance	Performance & Finance Committee
5 - The health board is a resilient, financially	93 (3448)	Finance: Reduced capital funds Reduced from 20 Reduced discretionary capital funds and reduced National NHS funds requiring a restricted Capital Plan for 2024/25.	Jun 2024	20	12	⬇	Dec 2025	Executive Director of Finance & Performance	Performance & Finance Committee

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
sustainable and responsible organisation									
5 - The health board is a resilient, sustainable and responsible organisation	96	Failure to Develop an Approvable IMTP (statutory compliance) If we fail to have an approvable Integrated Medium-Term Plan (IMTP) for 2026/27 then we will not meet our statutory duty to break even and may lose public confidence.	Oct 2025	20	20	➔	Dec 2025	Executive Director of Planning & Partnerships	Performance & Finance Committee
5 - The health board is a resilient, sustainable and responsible organisation	106	Emissions Reduction If we do not identify funding and implement appropriate actions effectively and in a timely way, there is a risk that we will not deliver the emissions reduction targets of 16% by 2025 and 34% by 2030 as determined in the NHS Wales Decarbonisation Strategic Delivery Plan (DSDP 2021). This could result in failure to achieve Health Board targets, undermine achievement of national targets, and expose the Health Board to potential reputational damage in the eyes of Welsh Government and the wider public.	Oct 2025	20	20	➔	Dec 2025	Executive Director of Planning & Partnerships	Performance & Finance Committee
5 - The health board is a resilient, sustainable and responsible organisation	107	EPRR & Recovery If the health board lacks adequate and effective emergency preparedness, planning, response and recovery at both corporate and operational levels, there is a risk that it may not be able to respond and recover promptly, efficiently, or effectively to a major incident, business continuity, or critical incident. This could lead to: Negative impacts on patient care delivery in both acute and non-acute settings; Potential harm or injury to patients and/or staff; Non-compliance with statutory obligations under the Civil	Oct 2025	25	20	➔	Dec 2025	Executive Director of Planning & Partnerships	Population Health Committee

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
		Contingencies Act 2004; Legal actions and financial penalties; Reputational damage and diminished public trust.							

Datix ID Number: 843 Date Opened: April 2019		Date Last Reviewed: December 2025		HBR Ref Number: 3 Risk Target Date: 31/03/2026		Current Risk Rating 4 x 4 = 16	
Objective: The health board is a great place to work where all staff feel valued and work together towards a common goal			SRR Ref: 4.1	Director Lead: Tina Ricketts, Director of Workforce and OD			Assuring Committee: Workforce & OD Committee
Risk: Recruitment of consultant medical & dental staff in hard to fill roles. Due to national shortages, there is a risk that that the health board will be unable to recruit consultant medical & dental staff into particular hard-to-fill roles which may result in difficulties fulfilling rotas on all sites, and adverse impact upon patient safety, service provision, quality and financial matters.							
Risk Rating (consequence x likelihood): Inherent: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 = 12					Rationale for current score: National shortages of numbers in some areas can lead to: • Inability to recruit sufficient numbers of trainees to fulfil rotas on all sites • Inability to attract non training grades to complete rotas • Inability to fill Consultant grade posts in some specialties with adverse effects on patient safety and employer relations. Inability to recruit sufficient registered nursing staff. Risk score has been reviewed and reflects current position across services as a whole. Services with particular difficulties are listed under the Assurance section. Where risk at service level is significant and/or interdependencies could lead to service collapse, these will be escalated separately.		
			Rationale for target score: This remains a challenge and is also a national problem.				
Controls (What is currently in place to manage the risk?)				Further Actions (What more are we going to do to address the risk?)			
• Regular monitoring of recruitment position with reports to Executive Team and Board via Medical Director and Medical Workforce Board. • Specialty based local workforce boards established to monitor and control specific issues. The Health Board Workforce & OD Committee will seek assurance of medical workforce plans to maintain services. • Engagement of the Deanery about recruitment position. • Weekly workforce delivery meetings with Executive Medical Director to review progress against critical medical and clinical posts • Working with specialist agency and head-hunters to improve chances to fill hard to recruit posts • Working with a marketing agency to develop a branding and attraction campaign for the health board.				Action		Lead	Deadline
				Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment		Service Group Medical Directors	31/03/2026
				The Medical Workforce Group continues to monitor recruitment and junior doctor's rotas.		Executive Medical Director	31/03/2026
				Continue to recruit internationally where appropriate.		Director W&OD	31/03/2026
				Continue to work with head-hunters		Director W&OD	31/03/2026

• Consideration of the RPO (Recruitment Process Outsourcing) model. • Implemented the CESR (Certificate of Eligibility for Specialist Registration) framework to grow our own consultants • Revised Consultant Development Programme, sponsored by the Medical Director.			
Assurances (How do we know if the things we are doing are having an impact?) • General situation monitored through W&OD Committee • Regular communication with Deanery • Ongoing and targeted recruitment campaigns • Monitoring by Service Group teams and specialty based local workforce boards • Monthly workforce planning and deployment taskforce meetings with service groups • Weekly workforce delivery meetings with CEO as above • Areas currently experiencing recruitment difficulties are: mental health, oncology, anaesthetics, acute care physicians, care of the elderly, pathology and haematology.	Gaps in assurance (What additional assurances should we seek?) Locum cover Adequate supply of doctors who can work in this country Ability to flexibly deploy doctors in training. Dedicated work between workforce and finance to review and confirm budgeted medical workforce establishment by service group to confirm SIP and vacancy factor.		
Additional Comments / Progress Notes 28/10/2025: The Health Board is considering introducing a Medacs Bank which will include a Recruitment Process Outsourcing (RPO) offer which could help with some hard to fill consultant roles.			

Datix ID Number: 739 Date Opened: Apr 2019		Date Last Reviewed: December 2025	HBR Ref Number: 4 Risk Target Date: 31/03/2026		Current Risk Rating 4 x 5 = 20
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships			SRR Ref: 2.4	Director Lead: Richard Evans, Executive Medical Director Assuring Committee: Quality & Safety Committee	
Risk: Healthcare Acquired Infection (HCAI) Risk of patients acquiring infection as a result of contact with the health care system, resulting in avoidable harm, impact on service capacity, and failure to achieve Tier 1 national infection reduction goals.					
Risk Rating (consequence x likelihood): Inherent: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12				Rationale for current score: Health Board incidence of key Tier 1 infections per 100,000 population above All Wales rates, indicating Health Board’s population at greater risk of infection. High occupancy rates & frequent ward moves associated with increased risk of infection transmission. Lack of decant facilities compromises environment deep cleaning & decontamination and planned preventative maintenance programmes.	
		Rationale for target score: Improved governance structures for IPC and antimicrobial stewardship will drive improved local ownership and embed responsibility for these priorities for all levels of staff. Adequately maintained & clean environments facilitate good IPC & minimise infection risks. Reduced occupancy & frequency of patient moves mitigate against infection transmission. Compliant ventilation systems and water safety minimise infection risks. Access to timely data on infections, training, antimicrobial stewardship, cleaning at ward/unit/practice level enables Service Groups to identify areas for focused QI programmes, drive improvement, & effectively measure outcomes.			
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)		
• Policies, procedures, protocols and guidelines supplement the National Infection Control Manual. • Infection Prevention & Control (IPC) related training provided programmes. • Surveillance of infections, with early identification of increased incidence, and instigation of controls. • Antimicrobial stewardship programmes and systems of monitoring and feedback. • Provision of cleaning service to meet National Standards of Cleanliness. IPCT meet regularly with the Domestic service teams and the service groups to prioritise the provision of enhanced cleaning hours to areas with a high incidence of			Action	Lead	Deadline
			Revised: Achieve 80% compliance with IPC mandatory training (Levels 1 & 2) in all staff groups.	Service Group Directors	31/03/2026
			Achieve reduction in Tier 1 infections to meet de-escalation criteria for intervention targets	Service Group Directors	31/03/2026

infection/outbreaks. • Engineering controls for water safety, ventilation, and decontamination. • Infection Prevention Improvement Plans 2025/26 for HB and Service Groups were approved by the Health Board's Infection Prevention & Control Strategic Group on 29/04/2025. Progress is reported at Service Group Infection Control Committees, Health Board Infection Prevention & Control Group, Quality & Safety Group, Quality & Safety Committee, and Management Board. These include trajectories to meet national targets and report performance against them. • The Health Board has been escalated to Targeted Intervention for its position relating to healthcare associated infection (HCAI). Governance processes for HCAI have been revised to provide strengthened scrutiny and assurance.			
Assurances (How do we know if the things we are doing are having an impact?) • Clear Corporate and Service Group IPC Assurance Framework in place. • Infection Prevention Improvement Plans for HB and Service Groups with progress reported at SG Infection Control Committees, HB Infection Prevention & Control Group, Quality & Safety Group and at Management Board. These include trajectories to meet national targets and report performance against them. This is also reported to Quality & Safety Committee. • Ongoing monitoring of infection control rates. • QI projects across the organisation Quality Improvement Project focusing on antimicrobial stewardship within MHSG _AMU; including an MDT AMS ward round reviewing choice of antibiotics and improve the outcome to switch from IV to oral administration route. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Annual completion of IPC Level 2 mandatory training for all HB staff. • Compliance and validation systems for water safety, ventilation systems and decontamination. • Revised and strengthened governance structure for HCAI, including monthly meetings of Executive HCAI Scrutiny Group. • Service group Medical Director led HCAI case review meetings take place: to determine if the infection episodes were avoidable, and to identify where improvements can be made to achieve better patient outcomes.	Gaps in assurance (What additional assurances should we seek?) • High occupancy rates & frequent ward moves associated with increased risk of infection transmission. Additional beds introduced to wards as a result of the “UEC Test of Change” pilot, reducing the space between beds. • Lack of single room availability, leading to delays in isolating patients with infections and increasing risks to patient contacts. • Increased numbers of clinically optimised patients remaining in hospital leads to increased length of stay, increased risk of over-occupancy and over-crowding, with consequence of increasing risks of acquisition of infection. • General infrastructure of the aging hospital estate compromises the ability to clean and decontaminate effectively. • Antimicrobial prescribing, relating particularly to total volume of antibiotics, with the SBUHB having second highest total volume of antibiotics prescribed in primary care in Wales. • Lack of decant facilities compromises environment deep cleaning & decontamination and planned preventative maintenance programmes. • Varying levels of IPC responsibility embedded across all disciplines and groups, with variable medical engagement at all levels in infection prevention-related Quality Improvements programmes. • Not all staff groups have achieved IPC Level 1& 2 training compliance.		
Additional Comments / Progress Notes			

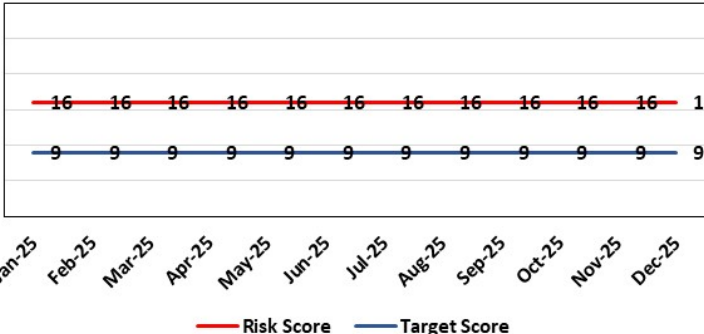
17/12/2025: The HB received WHC 2025 039 Antimicrobial Stewardship and Infection Prevention and Control Improvement Goals for 2025-27 will be incorporated into the HB Improvement goals for 2026/27.

HCAI position: Tier One Target Organism Progress to end of Nov 2025.

- *C. difficile* – 10 hospital onset cases (target 6).
- * Combined (hospital onset and community onset) cumulative total – 155 cases.
- *Staph. aureus* – 4 hospital onset cases (target 3).
- * Combined cumulative total - 83 cases.
- *E. coli* - 5 hospital onset cases (target 4).
- * Combined cumulative total - 193 cases.
- *Klebsiella* spp. - 3 hospital onset cases (target 4).
- * Combined cumulative total – 77 cases.
- *Pseudomonas aeruginosa* (Not included within targeted interventions) * Combined cumulative total – 18 cases.

IPC training compliance target >80% is being maintained. ESR reporting compliance levels as of Nov 30th, 2025: Level 1 = 90.34%, Level 2 = 85.19%

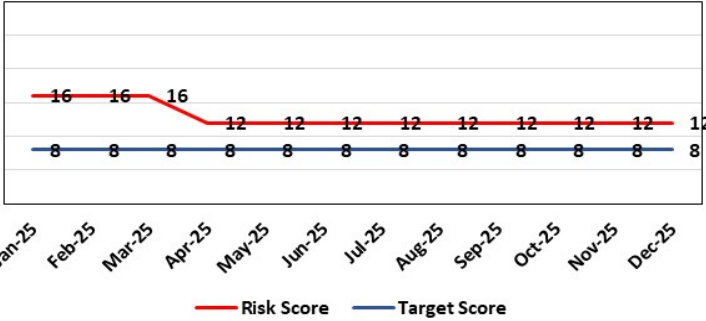
Several QI projects are taking place across the Service Groups to reduce HCAI's including a project to reduce urinary catheter associated infections, ward rounds to improve Antimicrobial Stewardship (AMS) and IV to oral switch (IVPOS) and additional projects are being proposed within the *C. difficile* collaborative.

Datix ID Number: 1043 Date Opened: Apr 2019		Date Last Reviewed: December 2025	HBR Ref Number: 36 Risk Target Date: TBC		Current Risk Rating 4 x 4 = 16																																							
Objective: Care is delivered in partnership with our communities in safe and appropriate settings, supported by innovative digital solutions, research, development and innovation			SRR Ref: 3.4	Director Lead: Matt John, Director of Digital Assuring Committee: Digital, Research & Innovation Committee For information: Quality & Safety Committee																																								
Risk: Paper Record Storage Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records, then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards. There is an increased fire risk where medical records are stored outside of the medical record libraries.																																												
Risk Rating (consequence x likelihood): Inherent: 4 x 5 = 20 Current: 4 x 4 = 16 Target: 3 x 3 =9		 <table><caption>Risk Score and Target Score Data</caption><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>16</td><td>9</td></tr><tr><td>Feb-25</td><td>16</td><td>9</td></tr><tr><td>Mar-25</td><td>16</td><td>9</td></tr><tr><td>Apr-25</td><td>16</td><td>9</td></tr><tr><td>May-25</td><td>16</td><td>9</td></tr><tr><td>Jun-25</td><td>16</td><td>9</td></tr><tr><td>Jul-25</td><td>16</td><td>9</td></tr><tr><td>Aug-25</td><td>16</td><td>9</td></tr><tr><td>Sep-25</td><td>16</td><td>9</td></tr><tr><td>Oct-25</td><td>16</td><td>9</td></tr><tr><td>Nov-25</td><td>16</td><td>9</td></tr><tr><td>Dec-25</td><td>16</td><td>9</td></tr></tbody></table>		Month	Risk Score	Target Score	Jan-25	16	9	Feb-25	16	9	Mar-25	16	9	Apr-25	16	9	May-25	16	9	Jun-25	16	9	Jul-25	16	9	Aug-25	16	9	Sep-25	16	9	Oct-25	16	9	Nov-25	16	9	Dec-25	16	9	Rationale for current score: C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment. Increased risk of fire where records are stored outside of the medical record libraries. L - we know this happens from incidents raised Rationale for target score: C - The increased development and adoption of the digital record will reduce the need for the paper health record being available at the point of care. L - The increased development and adoption of the digital record, the introduction of RFID and the approach to management of the paper record identified in the Business case process should reduce the amount of paper required to be stored and managed.	
Month	Risk Score	Target Score																																										
Jan-25	16	9																																										
Feb-25	16	9																																										
Mar-25	16	9																																										
Apr-25	16	9																																										
May-25	16	9																																										
Jun-25	16	9																																										
Jul-25	16	9																																										
Aug-25	16	9																																										
Sep-25	16	9																																										
Oct-25	16	9																																										
Nov-25	16	9																																										
Dec-25	16	9																																										
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)																																									
- There is a plan in place to increase the functionality of the electronic record to document patient care. The delivery of the plan is overseen by the Digital Leadership Group and progress provided to Management Board. (Supported by individual project boards as appropriate). - Records managed by the Medical Records libraries are RFID-tagged (Radio Frequency Identification) and location tracked. - Medical Record libraries are regularly risk assessed for fire by health and safety. - Alternative offsite storage arrangements have been identified. - All records must be documented on the Information Asset Register (IAR).			Action	Lead	Deadline																																							
			Allow for new process to stabilise and evaluate benefits of new centralised unit.	Head of Health Records & Clinical Coding	28/02/2026																																							
Assurances (How do we know if the things we are doing are having an impact?) RFID has been implemented for the acute record improving the management			Gaps in assurance (What additional assurances should we seek?) Investment required supporting the delivery and operational costs of the Digital strategy.																																									

and storage of records • Health Records performance reports developed in line with RFID technology • Attainment of the Tier 1 Health Board target for clinical coding completeness which relies on the timely availability and quality of the Paper record and electronic sources • Monitoring complaints and incident reporting. • Electronic record is being implemented in accordance with the plan e.g. implementation of WNCR (Welsh Nursing Care Record), ETR (Electronic Test Requesting), HEPMA (Hospital Electronic Prescribing and Medicines Administration)	Reliance on DHCW (Digital Health & Care Wales) for delivery of the solution for a fully electronic patient record. Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes. Process for ensuring clinical adoption of electronic ways of working and cessation of adding information to the paper record that is already available electronically needs to be agreed and enforced by the Health Board. Impact of the infected Blood Inquiry on the health board's ability to destroy notes and the change in the records code of practice is being reviewed by the Director of Digital.
Additional Notes 22/12/2025 – Reviewed – no further amendments.	

Datix ID Number: 1514 Date Opened: Apr 2019		Date Last Reviewed: December 2025	HBR Ref Number: 43 Risk Target Date: TBC		Current Risk Rating 4 x 4 = 16																																							
Objective: The health board is a resilient, sustainable and responsible organisation			SRR Ref: N/A	Director Lead: Elizabeth Rix, Executive Director of Nursing Assuring Committee: Quality & Safety Committee For Information: Mental Health Legislation Committee																																								
Risk: Deprivation of Liberty Safeguards Due to a limited resources within the MCA/DoLS (Mental Capacity Act/Deprivation of Liberty Safeguards) service (lack of Best Interest Assessor resource and signatory approval) there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.																																												
Risk Rating (consequence x likelihood): Inherent: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 2 = 6		 <table><caption>Risk Score and Target Score Data</caption><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>20</td><td>6</td></tr><tr><td>Feb-25</td><td>20</td><td>6</td></tr><tr><td>Mar-25</td><td>20</td><td>6</td></tr><tr><td>Apr-25</td><td>20</td><td>6</td></tr><tr><td>May-25</td><td>16</td><td>6</td></tr><tr><td>Jun-25</td><td>16</td><td>6</td></tr><tr><td>Jul-25</td><td>16</td><td>6</td></tr><tr><td>Aug-25</td><td>16</td><td>6</td></tr><tr><td>Sep-25</td><td>16</td><td>6</td></tr><tr><td>Oct-25</td><td>16</td><td>6</td></tr><tr><td>Nov-25</td><td>16</td><td>6</td></tr><tr><td>Dec-25</td><td>16</td><td>6</td></tr></tbody></table>		Month	Risk Score	Target Score	Jan-25	20	6	Feb-25	20	6	Mar-25	20	6	Apr-25	20	6	May-25	16	6	Jun-25	16	6	Jul-25	16	6	Aug-25	16	6	Sep-25	16	6	Oct-25	16	6	Nov-25	16	6	Dec-25	16	6	Rationale for current score: Multiple breaches in statutory duty Breaches confirmed as expected at least as frequently as weekly, but not daily. No claims received to date.	
Month	Risk Score	Target Score																																										
Jan-25	20	6																																										
Feb-25	20	6																																										
Mar-25	20	6																																										
Apr-25	20	6																																										
May-25	16	6																																										
Jun-25	16	6																																										
Jul-25	16	6																																										
Aug-25	16	6																																										
Sep-25	16	6																																										
Oct-25	16	6																																										
Nov-25	16	6																																										
Dec-25	16	6																																										
		Rationale for target score: Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease. Risk target date indicates date of review following mitigating actions																																										
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)																																									
• Duty system in place. Duty BIA (Best Interest Assessors) scrutinise referrals and liaise with managing authority to ensure safeguards are in place to mitigate risks. • Four signatory authorisers in place. • Monthly Performance & Assurance Meeting • Monthly Legislative Assurance Meeting with Group Nurse Director and Finance.			Action		Lead																																							
						Deadline																																						
Assurances (How do we know if the things we are doing are having an impact?) Monthly Legislative Assurance Meeting with Group Nurse Director and Finance. Quarterly reports to Mental Health & Legislative Committee on MCA/DoLS compliance.			Gaps in assurance (What additional assurances should we seek?) Current resources • 3 substantive BIA (3 wte) • 6 external BIA (£250 per assessment) • 4 (band 8) signatories • Specialist Practitioner Band 7 vacancy – out to advert. Additional 4 WTE BIAs required to meet service demands. Substantive BIA’s role includes additional duties compared to external BIA whose only role is to complete form 3a of the DoLS process. In																																									

	addition to form 3a completion, substantive BIA also undertake the following to meet service demand (Daily Duty Rota to scrutinise referrals; Facilitate Level 3 MCA/DoLS Training; Capacity Assessments; Advice and support to Managing Bodies; Support during Best Interest Meetings)
Additional Comments / Progress Notes	
20/11/2025: Breach data at the end of October reported at 3. Band 7 Specialist Practitioner appointed and going through recruitment checks. Risk score remains at 16. To review monthly.	
17/12/2025: Due to breaches remaining low for last 3 months the risk is currently under review and will be discussed at the next service group RMG in January.	

Datix ID Number: 1763 Date Opened: Apr 2019		Date Last Reviewed: December 2025		HBR Ref Number: 52 Risk Target Date: TBC		Current Risk Rating 4 x 3 = 12																																							
Objective: People of Swansea Bay live healthier, fairer and more prosperous lives			SRR Ref: 1.1		Director Lead: Richard Thomas, Director of Communications and Engagement Assuring Committee: Performance & Finance Committee																																								
Risk: Impact Assessment Requirements The Health Board does not have sufficient skills & resource in place to undertake integrated equality impact assessments in line with strategic service change and policy development.																																													
Risk Rating (consequence x likelihood): Inherent: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 4 x 2 = 8		<table><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>16</td><td>8</td></tr><tr><td>Feb-25</td><td>16</td><td>8</td></tr><tr><td>Mar-25</td><td>16</td><td>8</td></tr><tr><td>Apr-25</td><td>12</td><td>8</td></tr><tr><td>May-25</td><td>12</td><td>8</td></tr><tr><td>Jun-25</td><td>12</td><td>8</td></tr><tr><td>Jul-25</td><td>12</td><td>8</td></tr><tr><td>Aug-25</td><td>12</td><td>8</td></tr><tr><td>Sep-25</td><td>12</td><td>8</td></tr><tr><td>Oct-25</td><td>12</td><td>8</td></tr><tr><td>Nov-25</td><td>12</td><td>8</td></tr><tr><td>Dec-25</td><td>12</td><td>8</td></tr></tbody></table>			Month	Risk Score	Target Score	Jan-25	16	8	Feb-25	16	8	Mar-25	16	8	Apr-25	12	8	May-25	12	8	Jun-25	12	8	Jul-25	12	8	Aug-25	12	8	Sep-25	12	8	Oct-25	12	8	Nov-25	12	8	Dec-25	12	8	Rationale for current score: - Current lack of required skills / staff to deliver requirements. - Risk lowered to 12 because new Integrated Impact Assessment process developed and being tested across a range of issues. Rationale for target score: - All of these areas need to have adequate resourcing and robust processes / policies in place for the organisation to make robust plans, engage public confidence and meet our statutory and public duties.	
Month	Risk Score	Target Score																																											
Jan-25	16	8																																											
Feb-25	16	8																																											
Mar-25	16	8																																											
Apr-25	12	8																																											
May-25	12	8																																											
Jun-25	12	8																																											
Jul-25	12	8																																											
Aug-25	12	8																																											
Sep-25	12	8																																											
Oct-25	12	8																																											
Nov-25	12	8																																											
Dec-25	12	8																																											
Controls (What is currently in place to manage the risk?)				Further Actions (What more are we going to do to address the risk?)																																									
- Robust policies and processes to be in place for Impact Assessment going forward. - EIA responsibilities incorporated into wider Impact Assessments. - Development of Strategic Equality Group across organisation to support processes.				Action		Lead	Deadline																																						
				Roll out Impact Assessment process across organisation. Training and integration with planning processes across the organisation will be required.		Assistant Director of Insight, Charity & Engagement & DICE	31/01/2026																																						
Assurances (How do we know if the things we are doing are having an impact?) Advice on Equality Impact Assessment and then wider Impact Assessments available across organisation supported by robust policies and procedures, overseen by Strategic Equality Group.				Gaps in assurance (What additional assurances should we seek?) Participation from across organisation in Strategic Equality Group.																																									
Additional Comments / Progress Notes 29/10/2025: Actions in relation to new structure not taken forward at this stage – further discussions required with Chief Executive and Director of W&OD as part of roll out of Organised for Success. Roll out of IIA (Integrated Impact Assessment) training delayed as a result of staff absence within DICE but targeted support being provided to high profile changes where IIAs are required e.g. Gorseinon.																																													

Datix ID Number: 1762 Date Opened: Apr 2019		Date Last Reviewed: December 2025		HBR Ref Number: 53 Risk Target Date: 31/03/2026 (Review point)		Current Risk Rating 5 x 3 = 15																																							
Objective: The health board is a resilient, sustainable and responsible organisation			SRR Ref: N/A		Director Lead: Elizabeth Rix, Executive Director of Nursing Assuring Committee: Health Board (Welsh Language Group)																																								
Risk: Welsh Language Standards Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.																																													
Risk Rating (consequence x likelihood): Inherent: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9		<table><caption>Risk Score and Target Score Data</caption><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>15</td><td>9</td></tr><tr><td>Feb-25</td><td>15</td><td>9</td></tr><tr><td>Mar-25</td><td>15</td><td>9</td></tr><tr><td>Apr-25</td><td>15</td><td>9</td></tr><tr><td>May-25</td><td>15</td><td>9</td></tr><tr><td>Jun-25</td><td>15</td><td>9</td></tr><tr><td>Jul-25</td><td>15</td><td>9</td></tr><tr><td>Aug-25</td><td>15</td><td>9</td></tr><tr><td>Sep-25</td><td>15</td><td>9</td></tr><tr><td>Oct-25</td><td>15</td><td>9</td></tr><tr><td>Nov-25</td><td>15</td><td>9</td></tr><tr><td>Dec-25</td><td>15</td><td>9</td></tr></tbody></table>			Month	Risk Score	Target Score	Jan-25	15	9	Feb-25	15	9	Mar-25	15	9	Apr-25	15	9	May-25	15	9	Jun-25	15	9	Jul-25	15	9	Aug-25	15	9	Sep-25	15	9	Oct-25	15	9	Nov-25	15	9	Dec-25	15	9	Rationale for current score: As a consequence of an internal assessment of the Standards and their impact on the UHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards. This position has been confirmed/verified via an independent baseline assessment. There has been an increase of 512% in the demand for translation services since May 2024, this is an increasing trend. Capacity within the current team is based on previous activity, meaning our reliance on external translators and associated costs has increased. Rationale for target score: Working through its related improvement plan the likelihood of noncompliance will reduce as awareness and staff training in response to the Standards, is raised. Risk Target Date refreshed to indicate a review point following completion of actions planned for 2025/26.	
Month	Risk Score	Target Score																																											
Jan-25	15	9																																											
Feb-25	15	9																																											
Mar-25	15	9																																											
Apr-25	15	9																																											
May-25	15	9																																											
Jun-25	15	9																																											
Jul-25	15	9																																											
Aug-25	15	9																																											
Sep-25	15	9																																											
Oct-25	15	9																																											
Nov-25	15	9																																											
Dec-25	15	9																																											
Controls (What is currently in place to manage the risk?)				Further Actions (What more are we going to do to address the risk?)																																									
• An independent baseline assessment of the Health Board’s position against the Standards has been undertaken. This is in addition to the Health Board’s own self-assessment. • Work to implement the recommendations in the above baseline assessment was completed in 2023. • An online staff Welsh Language Skills Survey has been launched. This resulted in a response rate of 15% • We have a record of staff Welsh language skills for 58% of our staff and continue to work to improve this. • Close constructive working relationships are in place with the Welsh Language Commissioner’s Office • Strong networks are in place amongst Welsh Language Officers (WLO) across NHS Wales to inform learning and development of responses to the Standards. • Proactive communication and marketing activity is being undertaken across the Health Board to raise awareness of Welsh language compliance, customer				Action	Lead	Deadline																																							
				Review demand for translation services to ascertain whether activity level return to their baseline level	Welsh Language Officer	31/03/2026																																							

service standards and training opportunities. • Plan to provide clinical consultations through the medium of Welsh launched in 2024 (Standard 110 and Standard 110a) – this is progressing well within some areas, though more focussed work is required in stroke services, care of the elderly and children and young people’s services.			
Assurances (How do we know if the things we are doing are having an impact?) 1. Compliance with Statutory requirements outlined in Welsh Language Act and related Standards. 2. Meetings with the Welsh Language Commissioner. 3. Self-Assessment against the requirements of More Than Just Words. 4. Production of an Annual Report. 5. Reporting to QSG 6. Outcome of compliance spot checks 7. Welsh Language Delivery Group has been re-established and met in September 2025; a quarterly programme of meetings has been established.	Gaps in assurance (What additional assurances should we seek?) Formal and regular reporting to the Board will recommence with the production of the next annual report. Incorporation of relevant Welsh Language Standards into ward assurance processes. Welsh Language Delivery Group to be re-established, following nomination of chair.		
Additional Comments / Progress Notes 13/10/25: A paper is being presented to Management Board in October proposing that recording of language skills on ESR is mandated from January 1st 2026 – this will improve the Health Board position in relation to Standard 96.			

Datix ID Number: 1587 Date Opened: Apr 2019		Date Last Reviewed: December 2025	HBR Ref Number: 61 Risk Target Date: TBC		Current Risk Rating 4 X 4 = 16
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships			SRR Ref: 2.4	Director Lead: Deb Lewis, Chief Operating Officer Assuring Committee: Quality & Safety Committee	
Risk: Paediatric dental GA (General Anaesthetics)/Sedation services provided under contract from Parkway Clinic, Swansea. Medical Safety risk as general anaesthetics are performed on children outside of an acute hospital setting. Repatriation of service to acute site delayed due to theatre capacity which means the health board continues to commission services for delivery outside of national guidance (WHC 2018-09) attracting reputational risk. There is also an associated risk in that the diagnosing clinician does not deliver the care to the patient resulting in increased risk of need for multiple General Anaesthetics.					
Risk Rating (consequence x likelihood): Inherent: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8				Rationale for current score: There is no immediate access to crash team/ICU facilities in in Parkway Clinic – the client group are undergoing GA (general anaesthetic)/sedation. Paediatric GA/Sedation services provided under contract from Parkway Clinic, Swansea continue due to lack of capacity for these patients to be accommodated in Secondary Care.	
				Rationale for target score: Relocation of the paediatric general anaesthetics service [provided by Parkway Clinic] to a hospital site being treated as a priority.	
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)		
Consultant Anaesthetist present for every general anaesthetic clinic. Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients New care pathway implemented - no direct referrals to provider for general anaesthetics. Multi-drug sedation ceased from Sep 2018 in line with WHC 2018 009 Revised SLA (Service Level Agreement)/Service Specification HIW (Healthcare Inspectorate Wales) Inspection Visit Documentation provided to Health Board All extended general anaesthetics cases require approval from paediatric specialist prior to treatment.			Action		Lead
Assurances (How do we know if the things we are doing are having an impact?) RMC (Referral Management Centre) collate referral and treatment outcome data for review by Paediatric Specialist			Gaps in assurance (What additional assurances should we seek?) Deputy Chief Operating Officer-led Task & Finish Group is no longer in place – it will need to be re-established to progress transfer when		

Regular clinical meeting arranged with Parkway to discuss individual cases/concerns Regular clinical/ management meeting for CDS/primary care management team to discuss service pathway /concerns/issues arising.	theatre capacity is agreed. Pressures on the Princess of Wales special care dental general anaesthetics list and this service is considered alongside any plans for the Parkway contract.
Additional Comments / Progress Notes 06/05/2025: Health Board Management Board agreed that current contract with provider will be extended for 2+1 years whilst the Health Board explores capital bid for regional service as part of wider Paediatrics Day Case Unit 20/11/2025: This risk remains as at last update (04/08/2025).	

Datix ID Number: 2159 Date Opened: September 2019		Date Last Reviewed: December 2025	HBR Ref Number: 64 Risk Target Date: 31/03/2026		Current Risk Rating 4 X 5 = 20																																							
Objective: Care is delivered in partnership with our communities in safe and appropriate settings, supported by innovative digital solutions, research, development and innovation			SRR Ref: 3.2		Director Lead: Darren Griffiths, Director of Finance & Performance Assuring Committee: Quality & Safety Committee																																							
Risk: Health & Safety (H&S) Infrastructure Insufficient resource and capacity of the health, safety and fire function within SBUHB to maintain legal and regulatory compliance for the workforce and for the sites across SBUHB.																																												
Risk Rating (consequence x likelihood): Inherent: 5 x 4 = 20 Current: 4 x 5 = 20 Target: 4 x 3 = 12		<table><caption>Risk Score and Target Score Data</caption><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>20</td><td>12</td></tr><tr><td>Feb-25</td><td>20</td><td>12</td></tr><tr><td>Mar-25</td><td>20</td><td>12</td></tr><tr><td>Apr-25</td><td>20</td><td>12</td></tr><tr><td>May-25</td><td>20</td><td>12</td></tr><tr><td>Jun-25</td><td>20</td><td>12</td></tr><tr><td>Jul-25</td><td>20</td><td>12</td></tr><tr><td>Aug-25</td><td>20</td><td>12</td></tr><tr><td>Sep-25</td><td>20</td><td>12</td></tr><tr><td>Oct-25</td><td>20</td><td>12</td></tr><tr><td>Nov-25</td><td>20</td><td>12</td></tr><tr><td>Dec-25</td><td>20</td><td>12</td></tr></tbody></table>		Month	Risk Score	Target Score	Jan-25	20	12	Feb-25	20	12	Mar-25	20	12	Apr-25	20	12	May-25	20	12	Jun-25	20	12	Jul-25	20	12	Aug-25	20	12	Sep-25	20	12	Oct-25	20	12	Nov-25	20	12	Dec-25	20	12	Rationale for current score: The Health Board received 12 Health & Safety Executive (HSE) improvement notices during 2019-20 covering various Health & Safety legal breaches covering a range of areas. There is the potential for future multiple notices for not meeting legal requirements based on current available resources. Due to retirement resources in the team has reduced and the risk level increased to 20. Rationale for target score: Compliance with the notices and to have sufficient resources to implement a sustainable health and safety provision to support the legal requirements of the Health Board and demonstrate that suitable resources are in place to undertake the roles and responsibilities of the department, also to undertake suitable and sufficient training, provide corporate overview/audit to ensure practices are being employed in the workplace.	
Month	Risk Score	Target Score																																										
Jan-25	20	12																																										
Feb-25	20	12																																										
Mar-25	20	12																																										
Apr-25	20	12																																										
May-25	20	12																																										
Jun-25	20	12																																										
Jul-25	20	12																																										
Aug-25	20	12																																										
Sep-25	20	12																																										
Oct-25	20	12																																										
Nov-25	20	12																																										
Dec-25	20	12																																										
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)																																									
- Assistant Director of Health and Safety in post to support strengthening and develop the H&S function to support the organisation. Business case submitted for additional resources. - Health and Safety Operational Group and the Health and Safety Committee monitor compliance. Refreshed the Fire Safety Group with additional controls in place. - Fire risk assessments (FRA) are being prioritised to reduce the number of FRA overdue and to bring up to date. However, due to leavers and recruitment, resource levels have fluctuated along with compliance levels that are continually monitored. - Fire training in place and fire wardens in place			Action	Lead	Deadline																																							
			Having completed staffing structure review, next action is to work through Health Board governance processes to ensure affordability and to agree a risk-based, phased approach to implement any agreed structure going forward.	Assistant Director of Capital and H&S	31/03/2026																																							

Fire risk assessment schedule in place for the next 12 months concentrating on sleeping risk areas to maintain 100% compliance in these areas, and other non-sleeping risk areas are regularly reviewed, with the frequency of these moved to 18-monthly or 2-yearly, dependent upon the overall risk of the premises.			
Assurances (How do we know if the things we are doing are having an impact?) - Monitoring through the appropriate group/committees (H&S committee) to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. - Site visits/tours to identify compliance and gaps in compliances.	Gaps in assurance (What additional assurances should we seek?) Health and safety, capital and estates now sit under the umbrella of Finance and is currently going through a restructure, with the H&S structure also included in this and will be phased in, with a target date of 31/03/2026 for the proposed new structure to be in place. Compared to other Health Boards SBUHB does not have the same level of structures and is unable to undertake audits/inspections or provide the level of support to service groups ie cover to provide appropriate levels of training, support and auditing in all areas (Manual Handling; Violence & Aggression/Case Management; Health & Safety' Fire Safety and Fit Testing).		
Additional Comments / Progress Notes 27/08/2025: Successful conclusion to interviews [Head of H&S post], with an agreed commencement date 01/11/2025. No change in overall risk rating, with risks monitored and prioritised within current resources. 27/10/2025: Overall risks are monitored and prioritised covering Manual Handling, Violence & Aggression, Health & Safety and Fire with mitigations and action plans developed to address prioritised risks within current resources i.e. On-going discussions with Fire and Rescue to address issues raised by Mid & West Wales Fire & Rescue Service (MWWFRS), with identified mitigations planned to address 'Your Next Patient' challenges. 24/11/2025: Risk remains at 20, with no changes in current resources within health & safety team. We continue working with MWWFRS to mitigate the challenges of 'Your Next Patient' on each of the wards, with a target date of end of November 2025.			

Datix ID Number: 1834 Date Opened: November 2019		Date Last Reviewed: December 2025		HBR Ref Number: 66 Risk Target Date: 28/02/2026		Current Risk Rating 5 X 4 = 20																																							
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships			SRR Ref: 2.3		Director Lead: Richard Evans, Executive Medical Director Assuring Committee: Quality & Safety Committee																																								
Risk: Access to SACT (Systemic Anti-Cancer Therapy) The demand & complexity of planned treatment regime for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.																																													
Risk Rating (consequence x likelihood): Inherent: 5 x 5 = 25 Current: 5 x 4 = 20 Target: 2 x 2 = 4		 <table><caption>Risk Score and Target Score Data</caption><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>25</td><td>4</td></tr><tr><td>Feb-25</td><td>25</td><td>4</td></tr><tr><td>Mar-25</td><td>25</td><td>4</td></tr><tr><td>Apr-25</td><td>25</td><td>4</td></tr><tr><td>May-25</td><td>25</td><td>4</td></tr><tr><td>Jun-25</td><td>25</td><td>4</td></tr><tr><td>Jul-25</td><td>25</td><td>4</td></tr><tr><td>Aug-25</td><td>20</td><td>4</td></tr><tr><td>Sep-25</td><td>20</td><td>4</td></tr><tr><td>Oct-25</td><td>20</td><td>4</td></tr><tr><td>Nov-25</td><td>20</td><td>4</td></tr><tr><td>Dec-25</td><td>20</td><td>4</td></tr></tbody></table>			Month	Risk Score	Target Score	Jan-25	25	4	Feb-25	25	4	Mar-25	25	4	Apr-25	25	4	May-25	25	4	Jun-25	25	4	Jul-25	25	4	Aug-25	20	4	Sep-25	20	4	Oct-25	20	4	Nov-25	20	4	Dec-25	20	4	Rationale for current score: Demand for SACT continues to exceed current service capacity. Ongoing workforce challenges persist within the Chemotherapy Day Unit (CDU) and Pharmacy Technical Services (PTS), impacting service delivery. Patient waiting times remain elevated, with a continued number of breaches against SACT Key Performance Indicators (KPIs). The introduction of new cancer diagnoses and NICE-approved treatments necessitates the implementation of additional SACT regimens, further straining resources. Approval has been granted for additional treatment chairs, and initial recruitment to posts successful. Training of staff is essential prerequisite before this expansion can be operationalised. It is likely to take until Feb 2026 to fully train. Improved performance from Q4 24/25 to Q1 25/26.	
					Month	Risk Score	Target Score																																						
					Jan-25	25	4																																						
Feb-25	25	4																																											
Mar-25	25	4																																											
Apr-25	25	4																																											
May-25	25	4																																											
Jun-25	25	4																																											
Jul-25	25	4																																											
Aug-25	20	4																																											
Sep-25	20	4																																											
Oct-25	20	4																																											
Nov-25	20	4																																											
Dec-25	20	4																																											
Rationale for target score: Reduced delays in treatment will reduce risk of harm.																																													
Controls (What is currently in place to manage the risk?)				Further Actions (What more are we going to do to address the risk?)																																									
- Review of scheduling by staff to ensure all chairs used appropriately. - A daily scrutinizing process in progress to micro-manage individual cases, deferrals etc. - Changes made to prescribing & authorising processes to improve workflow for PTS reducing potential delays to supply and administration of treatment. - Responsibility for checking bisphosphonate prescriptions in CDU moved to nursing staff to free up Pharmacy capacity allowing them to focus on key clinical tasks within Pharmacy.				Action	Lead	Deadline																																							
				Recruiting to posts (dependency on recruitment process changes)	Divisional Manager (Cancer)	28/02/2026																																							
				Training of new staff (full competency)	SACT Training Team / Pharmacy	28/02/2026																																							

• Joint project with Nuclear Medicine to streamline pathways and prioritise SACT patients appropriately halved the average time waiting for MUGA/EDTA tests required before starting SACT. • Increased homecare capacity • Adopted principles from UK SACT board publication: General Principles to Support Systemic anti-Cancer Therapy Aseptic Pressures September 2023			
Assurances (How do we know if the things we are doing are having an impact?) • To support increased demand, additional funding has been secured to expand the nursing establishment, ensuring appropriate staffing levels during the unit's core operating hours. • Posts are currently out to advert or in the recruitment process. Once successful appointments are made and training is completed, improvements in performance are expected to be reflected in service delivery metrics. • Waiting times are tracked against the new SACT metrics, which are based on treatment intent rather than average waiting times, providing a more outcome-focused measure. These metrics are reported through our Cancer Performance Report to Welsh Government, the Management Board, and internally via governance structures within NPTSSG, where Oncology services are hosted. • Patient experience continues to be monitored through the Friends and Family Test and the Welsh Cancer Patient Experience Survey, in line with our Putting Things Right (PTR) procedures. • The SBU Capacity Task and Finish Group meets monthly to analyse demand and capacity gaps. Common delay themes are identified and reviewed monthly, with a quarterly report presented to the SACT Consultant Meeting and the Divisional Business Meeting to inform service planning. • Current breach trends are primarily linked to CDU capacity constraints and SACT booking delays, as evidenced in quarterly reporting. Work is ongoing to explore new models of care in addition to the approved posts to address these issues.	Gaps in assurance (What additional assurances should we seek?) Workforce requirements have and continue to be mapped to identify the additional capacity needed to meet both current and projected future demand for SACT services. While initial funding has been secured to support the first phase of this work, it does not guarantee the sustainability of future capacity. This marks the beginning of a phased approach to workforce planning and service development		

Priority & wait		Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
P1	Treatments started	2	1	3	0	0	1
	</=2 days	50%	100%	67%	0%	0%	100%
	3-14 days	50%	0%	33%	0%	0%	0%
	15-21 days	0%	0%	0%	0%	0%	0%
	>21 days	0%	0%	0%	0%	0%	0%
P2	Treatments started	40	44	37	49	46	43
	</=2 days	0%	0%	30%	0%	0%	0
	3-14 days	35%	23%	27%	29%	28%	26%
	15-21 days	18%	20%	49%	55%	39%	40%
	>21 days	48%	57%	22%	16%	33%	35%
P3	Treatments started	13	7	9	9	10	8
	</=2 days	0%	0%	0%	0%	0%	0%
	3-14 days	8%	0%	22%	0%	30%	0%
	15-21 days	31%	43%	44%	56%	50%	25%
	>21 days	62%	57%	33%	44%	20%	75%

Welsh SACT performance metrics – P2 to start within 14 days. P3 to start within 21 days

Additional Comments / Progress Notes

16/12/2025

Performance remains steady and improved on this time last year

Performance might dip due to Christmas break but measures in place to mitigate against risk

Risk score discussed regularly – no change at present

Some issues remain with backfill of pharmacy posts, timeline for completion of training may need to be reassessed.

Nursing posts to be determined (band 3/4) but will require less training so should not have same impact on ability to increase capacity.

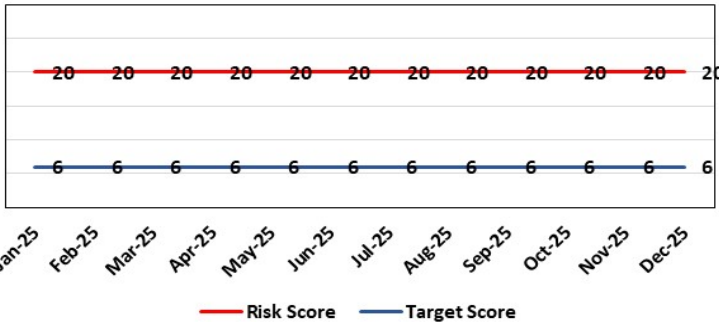
Datix ID Number: 1418 Date Opened: February 2020		Date Last Reviewed: December 2025	HBR Ref Number: 69 Risk Target Date: See Target Rationale		Current Risk Rating 5 X 4 = 20
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships			SRR Ref: 2.7	Director Lead: Deb Lewis, Chief Operating Officer Supporting Director: Elizabeth Rix, Executive Director of Nursing Assuring Committee: Quality & Safety Committee	
Risk: Issues related to adolescent patient admission to adult mental health inpatient wards Risk of inappropriate settings resulting in 'Safeguarding Issues'. The Welsh Government has requested that Health Boards identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.					
Risk Rating (consequence x likelihood): Inherent: 2 x 3 = 6 Current: 5 x 4 = 20 Target: 2 x 3 = 6				Rationale for current score: Every health board is required to have an admission facility for adolescent Mental Health patients. Whilst ward F has been identified as the single point of access in SBU and provides access to a bed for adolescent admissions if available at the time of request it is a mixed sex adult ward. Therefore, the facilities are less than ideal for young patients in crisis.	
				Rationale for target score: The longer-term aim for the Health Board remains to create an admission facility for adolescent Mental Health patients but this will not be possible until the new Adult Inpatient Unit is built.	
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)		
Safeguarding Training for Staff, Joint protocol with Cwm Taf LHB [CAMHS] currently subject to review, Local SBUHB policy on providing care to young people in this environment. This includes the requirement for all such patients on admission to be subject to Level 3 Safe and Supportive observations. Only Adolescents within 16-18 age range are admitted to the adult ward. The health board works with CAMHS to make sure that the length of stay is as short as possible.					
			Action	Lead	Deadline
			Next service group review of effectiveness of current controls.	Head of Nursing (Mental Health) & Clinical Directors	01/02/2026
Assurances (How do we know if the things we are doing are having an impact?) Individual Rooms with en Suite Facilities, Joint working with CAMHS, monitoring of staff training, Monitoring of admissions by the MH&LD SG Legislation Committee of the Health Board. The ongoing issues with the risks presented by the use of this has recently been raised at an all-Wales level with Welsh Government and a formal review is anticipated. The Service Group continues to flag the risk particularly in light of Ward F being identified as the SPOA for AMH in the Health Board which			Gaps in assurance (What additional assurances should we seek?)		

has resulted in an increase in acuity and a greater concentration of individuals who are experiencing the early crisis of admission - this has served to increase the already identified risks for young people in the environment.	
Additional Comments / Progress Notes 18/11/2025: No change. Admissions have been infrequent. 17/12/2025: No change to the current arrangements and controls. Requirement for adult inpatient new build to accommodate appropriate facilities. Currently being reviewed under the MH Transformation Programme. There has been a marked reduction in admissions of young people to adult inpatient wards since 2024. Score has been reinstated to 20 on SDG Risk in line with All Wales position and given the critical clinical risks should an admission be required.	

Datix ID Number: 1832 Date Opened: May 2021		Date Last Reviewed: December 2025		HBR Ref Number: 80 Risk Target Date: 31/12/2025		Current Risk Rating 4 x 5 = 20																																								
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships			SRR Ref: 2.1		Director Lead: Deb Lewis, Chief Operating Officer Assuring Committee: Quality & Safety Committee																																									
Risk: Transfer of Clinically Optimised Patients Risk that we fail to significantly reduce the number of Clinically Optimised Patients in hospital beds. A deficit in the availability of appropriate community / domiciliary care results in unacceptable delays in discharging patients from acute hospital beds. As a result, patients can decompensate and never gain the independence that could have been available from an early discharge. Lack of access to same day domiciliary care/emergency placements in the community hinders ability to avoid admission and associated harms.																																														
Risk Rating (consequence x likelihood): Inherent: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 2 = 8		 <table><caption>Risk Score Data</caption><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>20</td><td>8</td></tr><tr><td>Feb-25</td><td>20</td><td>8</td></tr><tr><td>Mar-25</td><td>20</td><td>8</td></tr><tr><td>Apr-25</td><td>20</td><td>8</td></tr><tr><td>May-25</td><td>20</td><td>8</td></tr><tr><td>Jun-25</td><td>20</td><td>8</td></tr><tr><td>Jul-25</td><td>20</td><td>8</td></tr><tr><td>Aug-25</td><td>20</td><td>8</td></tr><tr><td>Sep-25</td><td>20</td><td>8</td></tr><tr><td>Oct-25</td><td>20</td><td>8</td></tr><tr><td>Nov-25</td><td>20</td><td>8</td></tr><tr><td>Dec-25</td><td>20</td><td>8</td></tr></tbody></table>			Month	Risk Score	Target Score	Jan-25	20	8	Feb-25	20	8	Mar-25	20	8	Apr-25	20	8	May-25	20	8	Jun-25	20	8	Jul-25	20	8	Aug-25	20	8	Sep-25	20	8	Oct-25	20	8	Nov-25	20	8	Dec-25	20	8	Rationale for current score: • Sustained levels of clinically optimised patients (COPs) leading to overcrowding within ED, use of inappropriate or overuse of decant capacity in ED and delays in accessing medical bed capacity, clearly emerged as themes. • Constraints in relation to all patient flows out of Morriston to a more appropriate clinical setting, identified and included in an expanded risk. • Delay in discharge for clinically optimised patients can result in deterioration of their condition. • Increase in demand for Pathway 1. Rationale for target score: Targeted reduction of Clinically Optimised patients remains a priority for the HB in order to minimise risk of avoidable harm to patients within the HB and in the wider community.		
Month	Risk Score	Target Score																																												
Jan-25	20	8																																												
Feb-25	20	8																																												
Mar-25	20	8																																												
Apr-25	20	8																																												
May-25	20	8																																												
Jun-25	20	8																																												
Jul-25	20	8																																												
Aug-25	20	8																																												
Sep-25	20	8																																												
Oct-25	20	8																																												
Nov-25	20	8																																												
Dec-25	20	8																																												
Controls (What is currently in place to manage the risk?)				Further Actions (What more are we going to do to address the risk?)																																										
• One of the measures under targeted intervention is to see a reduction in pathway of care delays, which specifically supports the reduction in the number of clinically optimised patients. • Review is undertaken on a patient-by-patient basis – with explicit action agreed in order to progress transfer to appropriate clinical setting. • Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement • Weekly escalation meetings are held with health and social service colleagues to ensure the requirements of the patients are reviewed and patients are pulled through the system where possible.				Action		Lead	Deadline																																							
				Work programme and governance structure agreed by local partnership (health board & local authorities) to work up sustainable D2RA model.		Associate Director UEC	31/03/2026																																							
				Formal agreement through Communities and Older Persons Board to proceed to OCP for health employees to deliver the D2RA hub and recruitment into Swansea LA,		Service Group Director (PCT)	31/01/2026																																							

Planned transfer of 30 COP patients (Pathway 3) from Morriston to Singleton 5th Jan 26 to enable closure of the AMU surge area reliant on a temporary workforce model.	with a limited offer from NPT LA.		
Assurances (How do we know if the things we are doing are having an impact?) - Patient level dashboard allows breakdown by delay type - Regular (weekly) COP reviews and escalations - Shared vision with NPT & Swansea LA CEOs agreed and governance structure with Executive Directors for sign off - POCD reporting into the UEC and Communities and Older Persons Boards.	Gaps in assurance (What additional assurances should we seek?) Capacity and demand exercise required to inform reshaping of community services		
Additional Comments / Progress Notes 12/05/2025: Action previously completed: The Care Action Committee (CAC) focus on reducing the impact of clinically optimised patients within acute hospitals. The Health Board engaged with the work from the CAC and currently developing the Winter Plan for 24/25, of which reducing COPs will be a key focus. This work is being taken forward by the Associate SGD PCTS to ensure cross-boundary support. Integrated Discharge hub now established from within existing resources following a successful test of change. Positive turnaround of patients from front door services reducing admission demand and long-term care demand. Roll-out of true Discharge to Recover then Assess (D2RA) principles/ activity planned in conjunction with Local Authority partners to improve timeliness of all discharges (which will positively impact COP position) 17/07/2025: Action complete: Reintroduce D2RA Principles across the Health Board with external consultancy support 16/10/2025: See HBR1 for update on related actions ('Test of Change' and advanced D2RA work; discharge improvement sprint (focusing on COP wards) to free up bed capacity/ improve flow across Morriston site; refresh of the Optimal Hospital Flow Framework at Board Rounds via sustainable ward-level discharge coaching and support.) Exploring a revised model of COP management health board wide. 19/11/2025: POCD are being reviewed by Deloitte. CW has agreed with DL that there will not be an OCP because there are no substantive posts in the IDH. 18/12/2025: Process mapping, capacity and demand of Pathway 2 supported by Deloitte in progress. Audit of Pathway 2 bed utilisation being undertaken 18/12/25 – planned workshop Jan 26 to consolidate findings and agree work programme to re-engineer Pathway 2 bed pool.			

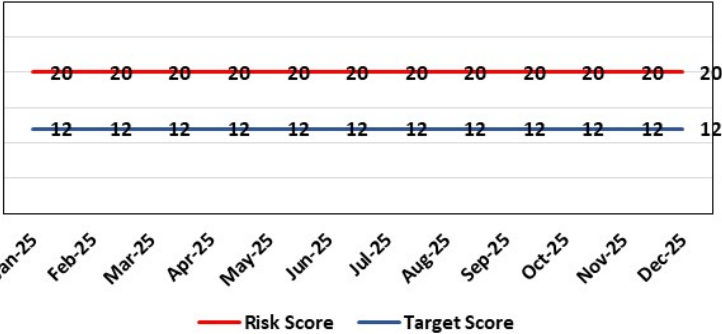
Datix ID Number: 2561 Date Opened: May 2022		Date Last Reviewed: December 2025	HBR Ref Number: 85 Risk Target Date: 31/07/2026	Current Risk Rating 4 x 5 = 20
Objective: The health board is a resilient, sustainable and responsible organisation		SRR Ref: N/A	Director Lead: Christine Morrell, Director of Therapies & Health Sciences Assuring Committee: Quality & Safety Committee	
Risk: Non-Compliance with ALN Act There is a risk of the Health Board not fulfilling the statutory requirements of the Additional Learning Needs and Education Tribunal (Wales) Act 2018 (the ALN Act) within the timescales that are required under the ALN Act, resulting in non-compliance with these duties. The Health Board has a digital infrastructure that provides data regarding its compliance with its statutory duties under Sections 65 and 20 of the ALN Act. These duties relate to the timely provision of information to support Education planning and decision-making (Section 65), and to timely decision-making about relevant Health provision followed by delivery of this provision where it is found to be required (Section 20). Data for 2025 shows there are breaches against both duties with a high level of frequency (as at July 2025, breaches are generally occurring on an approximately daily basis). Data is not currently reliably captured with regard to the Health Board fulfilling its duty to secure (deliver) additional learning provision where this is identified following a Section 20 referral, so assurance regarding this duty is limited. In addition to the above: • The Health Board is currently unable to provide assurance with its duty to notify Education of pre-school children with probable ALN under Section 64 of the legislation. This risk is caused by process and data quality issues. • The Health Board has not established a process by which it fulfils its legal duties for post-16 learners in partnership with local Further Education Institutes. There is a need to establish this process. Potential consequences of the risk of the Health Board not fulfilling the statutory requirements of the ALN Act within the timescales required are: non-compliance with statutory duties; parent / carer and young peoples' dissatisfaction leading to complaints and legal challenge; reputational impact; and children failing to access the multi-agency support that they need with their learning needs, leading to poor outcomes.				
Risk Rating (consequence x likelihood): Inherent: 5 x 5 = 25 Current: 4 x 5 = 20 Target: 2 x 3 = 6		Rationale for current score: 2025 compliance data shows that the Health Board is breaching multiple statutory duties (duties under both Sections 65 and 20 of the ALN Act) with a high level of frequency (approximately daily). The Health Board is currently unable to provide assurance regarding compliance with its legal duties under Section 64 of the Act, The risk consequence is major (multiple breaches of a statutory duty - 4) and the likelihood is expected (breaches occurring approximately daily - 5). hence the current risk score of 20.		

 The chart displays two data series over a 12-month period from January 2025 to December 2025. The 'Risk Score' is represented by a red line at a constant value of 20. The 'Target Score' is represented by a blue line at a constant value of 6. The x-axis labels are Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, and Dec-25. The y-axis has markers at 6 and 20.	Rationale for target score: As the ALN Act is new legislation, there remains some ongoing likelihood of risk events during the initial phases of implementation, though with lessened consequences as a result of mitigating actions.												
Controls (What is currently in place to manage the risk?) - Designated Educational Clinical Lead Officer (DECLO) is in post, providing a single point for direction and co-ordination of the Health Board’s activity under the ALN Act. The post is a statutory requirement. - Operational processes through which the Health Board fulfils its statutory duties under the ALN Act are in place. - Health Board ALN Steering Group has been established, with ALN Operational Group working under the governance of this, - There is close and ongoing collaborative working with Local Authority Education partners, including their involvement in the ALN Steering and Operational Groups as noted above. - Activity is planned to develop a clear understanding of the causes of the current risk and to identify the actions required to mitigate the risk. This activity will be progressed within the relevant Service Groups’ ALN governance structures with oversight of the ALN Steering Group.	Further Actions (What more are we going to do to address the risk?) <table><tr><th>Action</th><th>Lead</th><th>Deadline</th></tr><tr><td>Revise processes through which the Health Board fulfils its duty under Section 64 of the ALN Act and ensure that accurate and reliable data is available.</td><td>DECLO</td><td>28/02/2026</td></tr><tr><td>Establish process through which Health Board fulfils its legal duties with local college partners</td><td>DECLO</td><td>31/03/2026</td></tr><tr><td>Ensure ALN performance metrics are embedded in all relevant Service Groups’ governance structures, with strengthened accountability arrangements</td><td>DECLO</td><td>31/03/2026</td></tr></table>	Action	Lead	Deadline	Revise processes through which the Health Board fulfils its duty under Section 64 of the ALN Act and ensure that accurate and reliable data is available.	DECLO	28/02/2026	Establish process through which Health Board fulfils its legal duties with local college partners	DECLO	31/03/2026	Ensure ALN performance metrics are embedded in all relevant Service Groups’ governance structures, with strengthened accountability arrangements	DECLO	31/03/2026
Action	Lead	Deadline											
Revise processes through which the Health Board fulfils its duty under Section 64 of the ALN Act and ensure that accurate and reliable data is available.	DECLO	28/02/2026											
Establish process through which Health Board fulfils its legal duties with local college partners	DECLO	31/03/2026											
Ensure ALN performance metrics are embedded in all relevant Service Groups’ governance structures, with strengthened accountability arrangements	DECLO	31/03/2026											
Assurances (How do we know if the things we are doing are having an impact?) - The Health Board has a digital infrastructure to monitor compliance - There is regular reporting on compliance with the ALN Act that is now data-informed through the Patient Safety and Compliance Group. - The Health Board has an ALN Steering Group, chaired by the Deputy Director for Allied Health Professions and Health Sciences, ensuring oversight at a senior level within all impacted operational and corporate areas. The Health Board also has an ALN Operational Group, chaired by the DECLO, to co-ordinate activity	Gaps in assurance (What additional assurances should we seek?)												

required to address the risk. The Operational Group has an ALN workplan and reports are made to the Steering Group regarding progress	
Additional Comments / Progress Notes 22/12/2026: Activity is ongoing to strengthen governance and accountability arrangements for ALN Act compliance through operational Service Groups. Service Group updates will be provided to the ALN Steering Group, chaired by the EDAHPHS, in January 2026. The previous action regarding securing longer-term business and project management support has been removed as this is not directly linked to ALN Act compliance. There has been some delay in progressing work involving local colleges and adult Health Board services, and consequently the deadline for one action has been adjusted,	

Datix ID Number: 3071 Date Opened: November 2022		Date Last Reviewed: December 2025	HBR Ref Number: 89 Target Risk Date: TBC		Current Risk Rating 4 x 5 = 20																																							
Objective: The health board is a great place to work where all staff feel valued and work together towards a common goal			SRR Ref: 4.1	Director Lead: Elizabeth Rix, Executive Director of Nursing Supporting Director: Deb Lewis, Chief Operating Officer Assuring Committee: Quality & Safety Committee																																								
Risk: Healthcare Nursing Staff Levels at HMP Swansea There is a risk that the men in HMP Swansea will not receive the appropriate standard of care. This is because the nursing establishment within the prison no longer fully meets the changed demographics and numbers of men being detained. The maximum operational capacity of the Prison can reach circa 480 men. The Health Board investment into the Prison is based on delivering services to 250 men. This was also highlighted as a risk in the June 2022 HIW governance review. In addition, there is no head room built into the Prison nursing establishment, so periods of sickness, leave and study render the roster short.																																												
Risk Rating (consequence x likelihood): Inherent: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 2 x 2 = 4		 <table><caption>Risk Score and Target Score Data</caption><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>20</td><td>4</td></tr><tr><td>Feb-25</td><td>20</td><td>4</td></tr><tr><td>Mar-25</td><td>20</td><td>4</td></tr><tr><td>Apr-25</td><td>20</td><td>4</td></tr><tr><td>May-25</td><td>20</td><td>4</td></tr><tr><td>Jun-25</td><td>20</td><td>4</td></tr><tr><td>Jul-25</td><td>20</td><td>4</td></tr><tr><td>Aug-25</td><td>20</td><td>4</td></tr><tr><td>Sep-25</td><td>20</td><td>4</td></tr><tr><td>Oct-25</td><td>20</td><td>4</td></tr><tr><td>Nov-25</td><td>20</td><td>4</td></tr><tr><td>Dec-25</td><td>20</td><td>4</td></tr></tbody></table>		Month	Risk Score	Target Score	Jan-25	20	4	Feb-25	20	4	Mar-25	20	4	Apr-25	20	4	May-25	20	4	Jun-25	20	4	Jul-25	20	4	Aug-25	20	4	Sep-25	20	4	Oct-25	20	4	Nov-25	20	4	Dec-25	20	4	Rationale for current score: Consequence major – unable to fully deliver on the recommendations of HIW due to low healthcare staffing numbers, further impacted during periods of sickness or absence as no headroom. Recommendations also raised in Prison & Probation Ombudsman reports. Likelihood expected – suboptimal care provided on a daily basis.	
Month	Risk Score	Target Score																																										
Jan-25	20	4																																										
Feb-25	20	4																																										
Mar-25	20	4																																										
Apr-25	20	4																																										
May-25	20	4																																										
Jun-25	20	4																																										
Jul-25	20	4																																										
Aug-25	20	4																																										
Sep-25	20	4																																										
Oct-25	20	4																																										
Nov-25	20	4																																										
Dec-25	20	4																																										
		Rationale for target score: Consequence minor – With sufficient staffing numbers the prison will be able to deliver on HIW recommendations and fully implement the actions in the Health Delivery Plan. Likelihood unlikely – With full establishment and headroom, suboptimal care is less likely.																																										
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)																																									
Daily communication with the Governor about the availability and priority of healthcare nursing staff. Pharmacy technician role established – can administer drugs to support nursing establishment. Agreed that Health Care Support Workers to be 2 nd checkers for CD drugs and to support substance withdrawal monitoring (awaiting accreditation). Bank and agency staff are used in a limited way, when skillset allows. E-roster implemented and scrutinised with regular reporting to Service Group Patient Safety & Compliance Group. Escalation for overtime and additional hours to fill shortfalls.			Action Review of staffing in prison. Royal College of Psychiatrists Substance Misuse and Mental Health Baseline assessment completed – analysis of outcome and agreement of further action next. (Following financial deep dives)	Lead Deputy Head of Nursing	Deadline 31/01/2026																																							
Assurances (How do we know if the things we are doing are having an impact?)			Gaps in assurance (What additional assurances should we seek?) Implementation and reporting of clinical audits. Audit framework for																																									

Prison feedback and complaint process Progress reporting on action plans through Service Group PS&C Group, and Health Board Q&S structures (via Patient Safety & Compliance Group).	HMP Swansea in development - Clinical Pathways/Audits and Health Promotion groups taking forward.
Additional Comments / Progress Notes 19/11/25 - 2 WTE band 6 appointed, 3.5 WTE band 5 posts submitted to TRAC for approval. Reduction in variable pay noted. HMP position paper was not presented at PCT operational board on 28/10/25, this report highlights a programme of work to address recommendations from the Healthcare Needs Assessment (HNA) 2024 and QHNSMH 2024 (Quality Network for Prison Mental Health Services – Royal College of Psychiatrists) and Healthcare Inspectorate Wales (HIW) 2022 Inspection recommendations, await date to present. 30/12/25 – Approval for 3.5 WTE Band 5 agreed on 29/12/25, will now follow recruitment process. Continued scrutiny with rosters for use of variable pay, it is noted that this will improve once 3.5 WTE Band 5 are in post. DHON and NGD to meet early January 2026 to review workforce.	

Datix ID Number: 2796 Date Opened: January 2023		Date Last Reviewed: December 2025	HBR Ref Number: 90 Target Risk Date: TBC	Current Risk Rating 4 x 5 = 20																																							
Objective: The health board is a resilient, sustainable and responsible organisation		SRR Ref: N/A	Director Lead: Matt John, Director of Digital Assuring Committee: Digital, Research & Innovation Committee																																								
Risk: Subject Access Request Risk Due to insufficient resources and inconsistent processes across Swansea Bay University Health Board, there is a risk that Subject Access Requests (SARs) will not be fulfilled in compliance with UK-GDPR Article 15, resulting in potential breaches of personal data which could cause distress and lead to a loss of public and government confidence in the Health Board’s trustworthiness and legal standing. Additional Potential Consequences: - Regulatory Enforcement: ICO (Information Commissioner’s Office) may impose fines up to 4% of annual turnover for serious breaches. While the ICO has not historically issued fines for SAR breaches, this may change, especially as enforcement activity increases. A recent reprimand issued by the ICO to another NHS Trust, signals heightened regulatory scrutiny. - Operational Disruption: Staff diverted from priority tasks to manage SARs, affecting service delivery - Legal Exposure: Increased risk of litigation & claims from individuals with compromised data rights.																																											
Risk Rating (consequence x likelihood): Inherent: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 4 x 3 = 12		 <table><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr><tr><td>Jan-25</td><td>20</td><td>12</td></tr><tr><td>Feb-25</td><td>20</td><td>12</td></tr><tr><td>Mar-25</td><td>20</td><td>12</td></tr><tr><td>Apr-25</td><td>20</td><td>12</td></tr><tr><td>May-25</td><td>20</td><td>12</td></tr><tr><td>Jun-25</td><td>20</td><td>12</td></tr><tr><td>Jul-25</td><td>20</td><td>12</td></tr><tr><td>Aug-25</td><td>20</td><td>12</td></tr><tr><td>Sep-25</td><td>20</td><td>12</td></tr><tr><td>Oct-25</td><td>20</td><td>12</td></tr><tr><td>Nov-25</td><td>20</td><td>12</td></tr><tr><td>Dec-25</td><td>20</td><td>12</td></tr></table>			Month	Risk Score	Target Score	Jan-25	20	12	Feb-25	20	12	Mar-25	20	12	Apr-25	20	12	May-25	20	12	Jun-25	20	12	Jul-25	20	12	Aug-25	20	12	Sep-25	20	12	Oct-25	20	12	Nov-25	20	12	Dec-25	20	12
Month	Risk Score	Target Score																																									
Jan-25	20	12																																									
Feb-25	20	12																																									
Mar-25	20	12																																									
Apr-25	20	12																																									
May-25	20	12																																									
Jun-25	20	12																																									
Jul-25	20	12																																									
Aug-25	20	12																																									
Sep-25	20	12																																									
Oct-25	20	12																																									
Nov-25	20	12																																									
Dec-25	20	12																																									
Rationale for current score: C – This is assessed to be Major (score 4) under the Governance & Assurance risk domain of health board policy. Given the heightened external scrutiny of Swansea Bay University Health Board’s Maternity and Mental Health services, failure to comply with SAR requirements or mis-sharing of sensitive information in these areas could result in multiple complaints, loss of public confidence, negative media coverage, and/or criticism by Welsh government. L- The probability of one of these potential consequences occurring is currently considered to score 5 (expected – greater than 50% chance) due to the sustained and growing backlog of SARs, particularly in the Maternity and Children and Young People (CYP) services, along with 2024/25 statistics showing 65% of SARs are released without full clinical approval. These areas are experiencing a surge in requests following media coverage, with further increases expected. The complexity and sensitivity of these cases, combined with limited resources and inconsistent processes, make delays and errors expected. While the risk of an ICO fine remains low, the frequency of breaches, solicitor correspondence, complaints, ICO involvement and claims for financial compensation is already high and likely to escalate.																																											

		Rationale for target score: C – As above L – Additional resources would allow the organisation to make significant improvements to the process by which SARs are managed. Being able to adequately comply with legal requirements reduces the likelihood of enforcement action and fines from the ICO, as well as minimising the risk of reputational damage.						
Controls (What is currently in place to manage the risk?)		Further Actions (What more are we going to do to address the risk?) <table> <tr> <th>Action</th><th>Lead</th><th>Deadline</th></tr> <tr> <td>Implement detailed Action Plan in line with the timescales outlined within the Plan</td><td>Data Protection Officer/Head of Health Records</td><td>31/03/2026</td></tr> </table>	Action	Lead	Deadline	Implement detailed Action Plan in line with the timescales outlined within the Plan	Data Protection Officer/Head of Health Records	31/03/2026
Action	Lead	Deadline						
Implement detailed Action Plan in line with the timescales outlined within the Plan	Data Protection Officer/Head of Health Records	31/03/2026						
- Approved SAR Policy: Provides a formal framework for consistent SAR handling. - Dedicated SAR Lead (Band 7 IG Manager): Ensures operational oversight and coordination. - Defined Governance Roles: SIRO, Caldicott Guardian, and DPO roles are in place and active. - Legal and Risk Advice: Accessed for complex SARs to ensure lawful and appropriate handling. - Escalation to Information Governance & Cyber Assurance Group (IGCAG): Enables timely intervention and oversight of emerging issues - SAR Working Group monitoring: Tracks delivery of actions and feeds into governance structures.								
Assurances (How do we know if the things we are doing are having an impact?) - Bi-monthly reporting to DDRI: Provides regular oversight and visibility at committee level. - IGCAG oversight: Chaired by the SIRO and attended by key governance leads. - Escalation reports to Management Board and DDRI: Ensures senior leadership awareness. - Internal audit findings: Highlighted resource gaps and informed improvement planning.		Gaps in assurance (What additional assurances should we seek?) Internal audit report identified the requirement to invest in resources to address gap in assurance.						
Additional Comments Background and Context: The Health Board faces a sustained increase in both the volume and complexity of SARs, driven by technological advancements, expanded data availability, and evolving communication practices (e.g. use of WhatsApp and non-corporate email channels). This surge has outpaced existing capacity, including that of professional and expert staff, with many requests exceeding statutory response times and lacking adequate redaction or clinical review. The fragmented nature of record-keeping—spanning paper files, multiple systems, and sensitive content— and inconsistent handling procedures across departments further complicates timely and compliant disclosures.								

During the 24/25 financial year, the acute SAR team processed 8,652 requests for data. This excludes other areas of SBUHB who manage their own SAR. Each SAR application may involve multiple requests for Health Care Professionals (HCPs) to approval the release of information. The 8,652 applications resulted in 9,102 requests to HCPs to approve, with an additional 4561 released without specific approval based on an 'open consent' given previously. Of the requests to approve, 48% (4,366) did not reply within 7 days and therefore this data was released without approval. Therefore only 35% of all SAR requests are released with full HCP oversight. The acute SAR team note that of the 8,652 requests into them, 124 were unable to be completed within the 28-day mandatory timescale. Of these 124, 104 were relating to Children and Young People (CYP) and 18 related to complex email enquiries. Whilst these figures may not appear significant in comparison to the total annual requests received, it is important to recognise that the time required to address these CYP and complex emails is considerable and places an excessive pressure on the organisation, e.g. A large email search may result in 10,000-15,000 emails, all requiring oversight and review, often taking weeks to complete for each request.

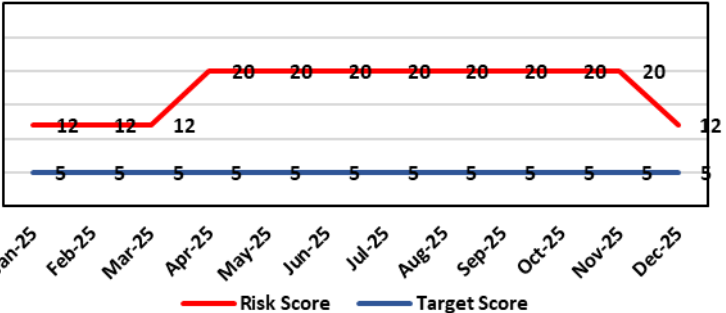
During 2024/25, SBU received 10 SAR complaints from the public, an additional 3 SAR complaints from the ICO, and reported 1 SAR breach to the ICO.

Progress Notes

04/12/2025: Met with Caldicott Guardian on 17/11/25 to discuss a number of actions on the Action Plan. Some actions requiring CG input have subsequently been marked as complete.

Datix ID Number: 3444 Date Opened: June 2023		Date Last Reviewed: December 2025	HBR Ref Number: 92 Risk Target Date: 31/03/2026		Current Risk Rating 5 x 5 = 25
Objective: The health board is a resilient, sustainable and responsible organisation			SRR Ref: 5.1	Director Lead: Darren Griffiths, Director of Finance and Performance Assuring Committee: Performance & Finance Committee	
Risk: Forecast Deficit Forecast deficit is not met due to (1) insufficient progress on run rate reduction, (2) the saving targets required across all areas are not achieved.					
Risk Rating (consequence x likelihood): Inherent: 5 x 4 = 20 Current: 5 x 5 = 25 Target: 5 x 1 = 5				Rationale for current score: • Delivery of the deficit plan is predicated on a combination of savings and run rate reductions • Consequence is significant as failure to deliver the plan could impact service delivery if cost reduction required later in the year • A deficit plan is a failure to meet a statutory duty Rationale for target score: • The consequence will not change given the important of financial delivery and its relationship with the delivery of the Health Board recovery and sustainability plan • Reducing likelihood to 1 supports a confidence that the deficit plan will be delivered.	
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)		
The Health Board is doing the following: • Accountability Letters and Budgetary Management Framework were issued to all Directors in April 2025, which set the expectation and budget for 2025/26. • Introduced in Q3 of 2024/25 the Health Board has put in place further oversight via the Recovery & Sustainability Board, which reported directly to PFC and is chaired by the CEO. This Board is held bi-weekly. • Supporting the R&S Board is the R&S Team, which for 2025/26 has dedicated resource to lead the programmes of work agreed for 2025/26, of which the Board has agreed on 5 key areas. • Budgetary Management approach 2025/26 requires all Services Groups to produce a Financial Strategy by end May 2025. • Continued transparent exchange of position with NHS Executive & Welsh Government, with both weekly and monthly meetings with the NHS Executive. • Standard Day 5 Finance Reports on Variable Pay, Savings Performance and Flash report published via SharePoint site.			Action	Lead	Deadline
			Extension to commissioning of external support (Deloitte), in collaboration with Welsh Government, which commenced on 14 th July 2025. Provide further support for core areas of financial delivery for 2025/26 and establishment of a sustainable position into 2026/27.	Director of Finance & Performance	28/02/2026
			Assessment of the action to address the gap to deliver £58.7m was provided to both Performance & Finance Committee and at a special meeting of the Board in	Director of Finance & Performance	31/03/2026

- Variable Pay Cap agreed by the organisation to deliver £32m of savings as set out in the Financial Framework dated 30th June 2025 as well as further enhancements of controls agreed through Q2, Q3 via Recovery & Sustainability Board. - Strengthening of the Recovery & Sustainability governance and controls aligned to the initial recommendations from work by Deloitte (external partner). - The Health Board has developed with its strategic external partner (Deloitte) a clear plan to deliver the £55.4m savings required for 2025/26.	mid-December. Following the agreed actions the Finance Team will provide updates on progress against these as part of the core monthly reporting for the remainder of 2025/26.		
Assurances (How do we know if the things we are doing are having an impact?) The Health Board financial performance is reviewed and monitored through: - WG Monthly Monitoring Returns and letter signed by CEO and DOF - Monthly financial performance meetings - Monthly performance meetings (New 2025/26) - Performance & Finance Committee - Independent Member briefings - Recovery & Sustainability Board - Routine reporting to Board of most recent monthly position and financial forecasts - Weekly meetings with the NHS Executive - Monthly TI Meetings with NHS Executive - Face to Face meetings with Director Finance for NHS Wales	Gaps in assurance (What additional assurances should we seek?)		
Additional Comments / Progress Notes 21/10/2025: First formal feedback from our external strategic partner has been held jointly with the Health Board and Welsh Government, aligned to the deliverables of the contract. Feedback was initially in draft, and work is ongoing to finalise the reports. 03/11/2025: Service Group Directors and Finance Business partners were required to provide robust forecast for 2025/26 and recurrent impact, including savings delivery for Check & Challenge meeting with Director of Finance & Performance on 4 November. This work was put in place to support the wider assessment of the Health Board's forecast to 31st March 2026. Work has been completed and the gap to deliver £58.7m assessed and presented to Performance & Finance Committee at end November.			

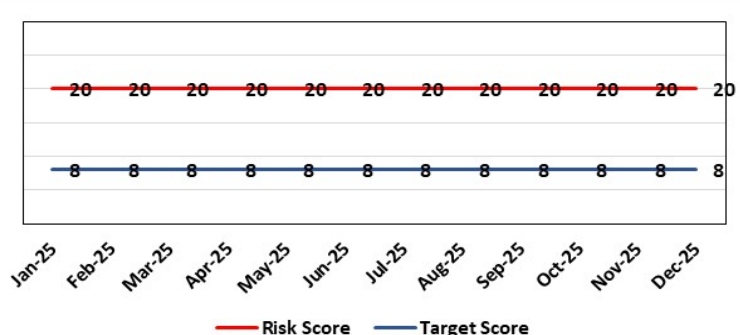
Datix ID Number: 3448 Date Opened: June 2024		Risk score reduced from 20 Date Last Reviewed: December 2025		HBR Ref Number: 93 Risk Target Date: 31/03/2026		Current Risk Rating 4 x 3 = 12			
Objective: The health board is a resilient, sustainable and responsible organisation				SRR Ref: 5.1		Director Lead: Darren Griffiths, Director of Finance and Performance Assuring Committee: Performance & Finance Committee			
Risk: Reduced Capital Funds Reduced National NHS funds available for major capital schemes requiring a restricted Capital Plan for 2025/26.									
Risk Rating (consequence x likelihood): Inherent: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 5 x 1 = 5									
		Rationale for current score: • The Health Board has been advised that its discretionary capital allocation for 2025/26 is £13.875m. • The funding available within the Capital Resource Limit (CRL) will not meet the demands for capital investment. Discretionary capital is deployed to replace ageing medical devices & equipment; to address backlog maintenance of premises; and to support small scale, non-National service improvements with capital investments • The outcome of the national capital prioritisation exercise means some major capital scheme business cases are on hold. A number of high-risk priority schemes will require funding support from WG, including interim measures for ED and Acute Adult Mental Health In-patients services. • All assumed income to achieve a balanced plan has now been received from Welsh Government. • Slippage funding of £4.8m received from Welsh Government in November. • Additional funding bids £4.4m submitted to Welsh Government 11th December. • Potential consequences of this risk are the inability to achieve the ambitions set out within health board plans; the potential failure of ageing equipment leading to service disruption; the exposure to potential environmental health & safety risks. • Following the receipt of additional funding which reduces the immediate in-year pressure on the medical equipment and digital replacement programmes, and with all income risks removed, the risk rating is lowered from 20 to 12.							
		Rationale for target score: The target score expresses the aspiration of the health board for							

		addressing this risk. The target date indicated above reflects the point which the current actions are anticipated to reduce the risk, though knowledge of the actual funding available is required to reduce it further and this is not available until some months into the financial year.

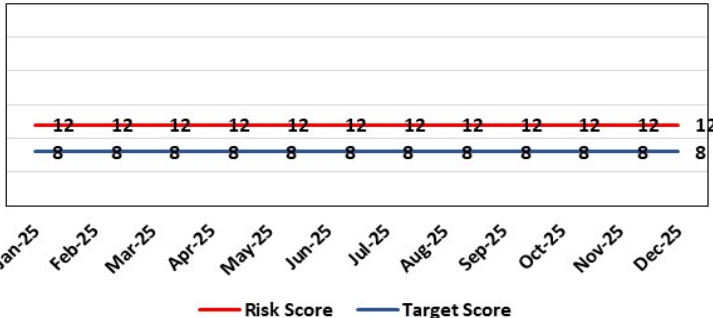
Controls (What is currently in place to manage the risk?)	Further Actions (What more are we going to do to address the risk?)		
The Health Board is doing the following: - Regular dialogue with Welsh Government regarding capital requirements. - Clear communication and reporting of the capital position, the risks and limitations. - Close management of all schemes to ensure slippage is understood along with the impact on service. - Clear prioritisation of any new requirements recognising the current constraints	Action	Lead	Deadline
	Routine review and flexing of plan as spending is committed through the year. Routine monitoring processes will identify any potential slippage and will deploy this on risk-based basis.	Director of Finance & Performance	Monthly through the financial year as plan is dynamic
	Examine the specific prioritisation and phasing of capital investment to meet health board objectives through the Capital & Estates Taskforce.	Director of Finance & Performance	Bi-Monthly
	Maintenance of risks through the Capitalisation Prioritisation Group should additional WG funding become available later in the year.	Assistant Director of Finance (Strategy & Planning)	On-going
Assurances (How do we know if the things we are doing are having an impact?) The Health Board capital position is reviewed and monitored through: - Quarterly capital prioritisation group - Performance & Finance Committee quarterly finance report - Capital & Estates Taskforce - Capital & Estates Board - Capital Management Group - Monthly Monitoring Returns to Welsh Government.	Gaps in assurance (What additional assurances should we seek?) Reporting on impact of constraints to the capital programme on service delivery.		
Additional Comments / Progress Notes 16/10/25: There are new constraints on the national funding position which is putting pressure on the local in-year capital plan. Decisions made on fixing the in-year CRL position on 31 st October with WG will need to take account of the new unfunded local pressures. 23/11/25: Risk remains at 20 following Performance & Finance Committee meeting 28/10/25. CRLs fixed with WG 30/10/25. Additional £4.780m in-year funding bids submitted to WG 6/11/25. 17/12/25: Slippage funding of £4.8m received from Welsh Government in November. Following the receipt of additional funding which reduces the immediate in-year pressure on the medical equipment and digital replacement programmes, and with all income risks removed, the risk rating is lowered from 20 to 12.			

Datix ID Number: 3516 Date Opened: October 2023		Date Last Reviewed: December 2025	HBR Ref Number: 94 Risk Target Date: TBC		Current Risk Rating 4 x 3 = 12	
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships			SRR Ref: 2.7	Director Lead: Deb Lewis, Chief Operating Officer Assuring Committee: Performance & Finance Committee For information: Quality & Safety Committee		
Risk: CAMHS failure to meet required standards of performance The CAMHS service is unable to meet the required level of performance due to workforce deficits in the team across all staff groups including medics, psychological therapies and nursing. Data quality review has been completed and new processes are in place to ensure it is accurate. Links to other CAMHS risk register entries: (Ref: 3373 (ADHD)/ 3346 open / 3350 open)						
Risk Rating (consequence x likelihood): Inherent: 4 x 5 = 20 Current: 4 x 3 = 12 Target: 3 x 3 = 9				Rationale for current score: Marked improvement in the performance against the Mental health Measure for CAMHS. Data validation for new patients complete. Current risk score 12 in view of improved performance however this reflects the fragility in the workforce to deliver sustained performance. Work is still ongoing within CAMHS to maintain and improves the situation.		
		Rationale for target score: The rationale for the target score is linked to successful recruitment and more timely access to services for children and young persons which will reduce risk.				
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)			
Ongoing recruitment into nursing and medical staff groups. Psychology and Therapies are fully recruited. Use of temporary agency workforce in nursing at premium pay rates to sustain current levels of performance Recent appointment into psychological therapies lead posts. -Exploring fixed term appt of Band 5 psychological therapies support staff to improve performance.			Action		Lead	Deadline
			Continued efforts at recruitment. Recovery Plan in place.		Associate Service Director	31/01/2026
Assurances (How do we know if the things we are doing are having an impact?) As above with controls. -Monthly CAMHS Directorate meeting in place where performance and workforce are scrutinised -Reporting into Weekly Business Team and MH & LD management board. - Mental Health Division Quarterly Performance Review -Reporting into SBU Performance & Finance Committee and IQPD (Integrated Quality			Gaps in assurance (What additional assurances should we seek?)			

& Performance Delivery) meeting with Welsh Government	
Additional Comments / Progress Notes 11/12/2025 CAMHS 1a: remains generally consistent. CAMHS Part 1B: Recruitment to vacancies has been successful, however additional vacancies and maternity leave weakens the capacity pool to almost pre-recruitment levels Despite this, the recovery plan roll out is underway, which includes changes to the delivery of the initial therapeutic offer for 1:1 intervention, which enables young people to commence support more quickly. This has resulted in 3 months of small, but consistent improvement in the Part 1B performance irrespective of staffing challenges, which is now at 66% (Submitted for Nov 2025) Weekly meetings continue over booking and utilisation of capacity and using our staffing resource as flexibly as possible	

Datix ID Number: 3571 Date Opened: October 2023		Date Last Reviewed: December 2025		HBR Ref Number: 96 Target Date: 31/03/2026		Current Risk Rating 4 x 5 = 20																																							
Objective: The health board is a resilient, financially sustainable and responsible organisation			SRR Ref: 5.1		Director Lead: Marie Davies, Executive Director of Planning & Partnerships Assuring Committee: Performance & Finance Committee																																								
Risk: Failure to Develop an Approvable IMTP (statutory compliance) If we fail to have an approvable Integrated Medium-Term Plan (IMTP) for 2026/27 then we will not meet our statutory duty to break even and may lose public confidence.																																													
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 2 = 8		<table><caption>Risk Score Data</caption><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>20</td><td>8</td></tr><tr><td>Feb-25</td><td>20</td><td>8</td></tr><tr><td>Mar-25</td><td>20</td><td>8</td></tr><tr><td>Apr-25</td><td>20</td><td>8</td></tr><tr><td>May-25</td><td>20</td><td>8</td></tr><tr><td>Jun-25</td><td>20</td><td>8</td></tr><tr><td>Jul-25</td><td>20</td><td>8</td></tr><tr><td>Aug-25</td><td>20</td><td>8</td></tr><tr><td>Sep-25</td><td>20</td><td>8</td></tr><tr><td>Oct-25</td><td>20</td><td>8</td></tr><tr><td>Nov-25</td><td>20</td><td>8</td></tr><tr><td>Dec-25</td><td>20</td><td>8</td></tr></tbody></table>			Month	Risk Score	Target Score	Jan-25	20	8	Feb-25	20	8	Mar-25	20	8	Apr-25	20	8	May-25	20	8	Jun-25	20	8	Jul-25	20	8	Aug-25	20	8	Sep-25	20	8	Oct-25	20	8	Nov-25	20	8	Dec-25	20	8	Rationale for current score: The Health Board does not have a WG approved IMTP and has been placed in enhanced monitoring for Finance, Strategy and Planning following the inability of the Health Board to submit a balanced IMTP since March 2023. Given the All-Wales financial context, the Health Board was not able to submit an IMTP in March 2025. It has instead developed an Annual Plan 25/26 set in a three-year context. Rationale for target score: The target remains to develop a financially balanced IMTP so that we meet our statutory duties.	
Month	Risk Score	Target Score																																											
Jan-25	20	8																																											
Feb-25	20	8																																											
Mar-25	20	8																																											
Apr-25	20	8																																											
May-25	20	8																																											
Jun-25	20	8																																											
Jul-25	20	8																																											
Aug-25	20	8																																											
Sep-25	20	8																																											
Oct-25	20	8																																											
Nov-25	20	8																																											
Dec-25	20	8																																											
Controls (What are we currently doing about the risk?) - As per the Welsh Government de-escalation criteria for Strategy and Planning, work has commenced to update and realign the Health Board’s strategy and clinical services strategic plan. - As per the Welsh Government de-escalation criteria for Strategy and Planning, work has been undertaken to assess the Health Board against the planning maturity matrix and develop an action plan in response. This will be reported via the Board Planning & Partnerships formal report. - The Recovery and Sustainability Board monitors delivery of agreed actions in relation to the financial position. - The Annual Plan Oversight Group has been superseded by the Integrated Planning and Performance Review Meeting which takes on a quarterly basis and is chaired by the CEO with the purpose of providing formal management oversight to the delivery of the Annual Plan, and to act as a forum for future planning discussions. - Plan development will continue to be subject to robust challenge and scrutiny through regular briefings to Independent Members, Performance and Finance Committee (now meeting twice a month, once informally and once formally) and				Mitigating actions (What more should we do?) <table><thead><tr><th>Action</th><th>Lead</th><th>Deadline</th></tr></thead><tbody><tr><td>Refresh Clinical Services Strategic Plan</td><td>Executive Director of Planning & Partnerships/ Medical Director</td><td>31/03/2026</td></tr><tr><td>Recovery and Sustainability Board to continue to focus on savings delivery and now shift to a more sustainable approaches in the longer term. A new monthly performance review regime and Executive Team members to oversee thematic savings workstreams and support Service Groups to meet targets.</td><td>Executive Director of Finance and Performance</td><td>31/03/2026</td></tr></tbody></table>			Action	Lead	Deadline	Refresh Clinical Services Strategic Plan	Executive Director of Planning & Partnerships/ Medical Director	31/03/2026	Recovery and Sustainability Board to continue to focus on savings delivery and now shift to a more sustainable approaches in the longer term. A new monthly performance review regime and Executive Team members to oversee thematic savings workstreams and support Service Groups to meet targets.	Executive Director of Finance and Performance	31/03/2026																														
Action	Lead	Deadline																																											
Refresh Clinical Services Strategic Plan	Executive Director of Planning & Partnerships/ Medical Director	31/03/2026																																											
Recovery and Sustainability Board to continue to focus on savings delivery and now shift to a more sustainable approaches in the longer term. A new monthly performance review regime and Executive Team members to oversee thematic savings workstreams and support Service Groups to meet targets.	Executive Director of Finance and Performance	31/03/2026																																											

with detailed oversight from the Board itself.				
Assurances (How do we know if the things we are doing are having an impact?) Progress against the delivery of the plan will be scrutinised through strengthened governance supported by a new performance management and accountability framework.		Gaps in assurance (What additional assurances should we seek?)		
Additional Comments / Progress Notes				
17/12/2025: Register entry reviewed & updated.				

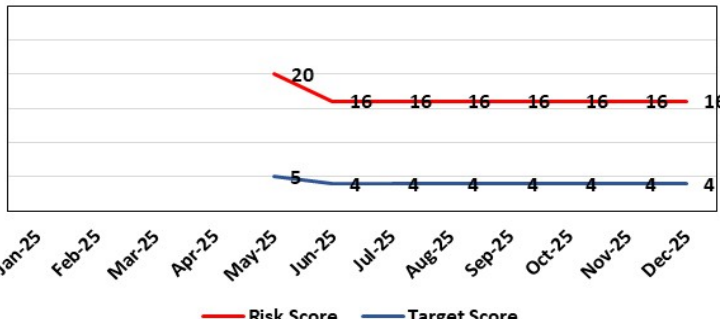
Datix ID Number: TBC Date Opened: May 2024		Date Last Reviewed: December 2025	HBR Ref Number: 100 Target Risk Date: 28/02/2026		Current Risk Rating 4 x 3 = 12																																							
Objective: People of Swansea Bay live healthier, fairer and more prosperous lives			SRR Ref: 1.1	Director Lead: Marie Davies, Executive Director of Planning & Partnerships Assuring Committee: Population Health Committee																																								
Risk: A lack of a robust approach to partnerships & collaboration If the health board does not have effective structures, processes and working relationships with its external partners at the Public Services Board (PSB) and/or Regional Partnerships Board (RPB), there is a risk that areas of work dependent upon collaboration with partners may not deliver what is required in a timely way, impacting on the delivery of health board priorities.																																												
Risk Rating (consequence x likelihood): Inherent: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 4 x 2 = 8		<table><caption>Risk Rating Data</caption><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr><tr><td>Jan-25</td><td>12</td><td>8</td></tr><tr><td>Feb-25</td><td>12</td><td>8</td></tr><tr><td>Mar-25</td><td>12</td><td>8</td></tr><tr><td>Apr-25</td><td>12</td><td>8</td></tr><tr><td>May-25</td><td>12</td><td>8</td></tr><tr><td>Jun-25</td><td>12</td><td>8</td></tr><tr><td>Jul-25</td><td>12</td><td>8</td></tr><tr><td>Aug-25</td><td>12</td><td>8</td></tr><tr><td>Sep-25</td><td>12</td><td>8</td></tr><tr><td>Oct-25</td><td>12</td><td>8</td></tr><tr><td>Nov-25</td><td>12</td><td>8</td></tr><tr><td>Dec-25</td><td>12</td><td>8</td></tr></table>		Month	Risk Score	Target Score	Jan-25	12	8	Feb-25	12	8	Mar-25	12	8	Apr-25	12	8	May-25	12	8	Jun-25	12	8	Jul-25	12	8	Aug-25	12	8	Sep-25	12	8	Oct-25	12	8	Nov-25	12	8	Dec-25	12	8	Rationale for current score: Currently the likelihood of non-delivery of partnership priorities that meet expectations is possible. Rationale for target score: The occurrence of non-delivery of partnership priorities will reduce with an improved partnership approach within the Health Board, although given the complex nature of partnership working it is unlikely to completely eradicate the risk.	
Month	Risk Score	Target Score																																										
Jan-25	12	8																																										
Feb-25	12	8																																										
Mar-25	12	8																																										
Apr-25	12	8																																										
May-25	12	8																																										
Jun-25	12	8																																										
Jul-25	12	8																																										
Aug-25	12	8																																										
Sep-25	12	8																																										
Oct-25	12	8																																										
Nov-25	12	8																																										
Dec-25	12	8																																										
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)																																									
• Senior Health Board leadership is now embedded across the West Glamorgan Regional Partnerships Board (WGRPB) governance to improve visibility and decision making, and the internal Strategic Partnerships Group the Population Health Committee – both established in 2023, provide oversight for external partnerships. • Collaborative Partnerships Framework has been agreed by SBUHB Management Board, setting out a Health Board approach to Partnerships. • The Annual Plan 2025/26 outlines clear priorities for working with PSB and RPB Board and governance and leadership arrangements have been strengthened to support delivery • The Director of Planning & Partnerships and the Chief Operating Officer meet weekly with Directors of Social Services and are continuing to align work programmes and develop trusted relationships. Two key areas of work that are being integrated/closely aligned are: 6 Goals programme to be integrated into			SB)		Lead	Deadline																																						

RPB governance and RPB Emotional Wellbeing & Mental Health programme will be aligned through governance and reporting structures. • A Partnerships Tracker has been developed and presented to the Audit Committee. The Partnerships Tracker will provide greater oversight of the health board's statutory duties and requirements, and a report will go to Audit Committee three times a year.			
Assurances (How do we know if the things we are doing are having an impact?) Strategic Partnerships Group (SPG) in place and provides oversight of partnership discussions, including the WGRPB and the Public Service Boards (PSB). Regular updates and assurance are provided to Health Board via the Director of Planning and Partnerships Management Board report. Collaborative Framework and the Partnerships Tracker are both tools developed to support the Health Board become a better partner with greater oversight.	Gaps in assurance (What additional assurances should we seek?)		
Additional Comments / Progress Notes 17/12/2025: • Children & Young People – The establishment of the Women, Children & Young People's Care Programme Board will provide increased visibility and strategic leadership in these key priority areas. A workshop in December was co-chaired by the Executive Director of Nursing and the Chief Operating Officer and the first meeting is scheduled for February 2026. • Partnerships governance – The Partnerships Tracker is now agreed and the first report will be submitted to audit committee in January 2026. The ongoing review and maintenance of the tracker will be the responsibility of the planning & partnerships team. The risk level will be re-assessed following the establishment of the SBUHB Women, Children & Young People's Programme Board and Plan for Children & Young People (target risk date field updated to reflect this).			

Datix ID Number: 443 Date Opened: May 2025		Date Last Reviewed: December 2025		HBR Ref Number: 104 Risk Target Date: 31/03/2027		Current Risk Rating 4 x 5 = 20																																								
Objective: Care is delivered in partnership with our communities in safe and appropriate settings, supported by innovative digital solutions, research, development and innovation			SRR Ref: 3.4		Director Lead: Matt John, Director of Digital Assuring Committee: Digital Data & Innovation Committee For information: Quality & Safety Committee																																									
Risk: Failure to meet Tier 1 targets in Clinical Coding Completeness Because: The volume of new inpatient episodes exceeds the available clinical coding staff capacity; There are difficulties recruiting and retaining a sufficient number of trained clinical coding staff to address the gap, and clinical information is not always of sufficient quality or completeness electronically (such as DALs) to support swift coding. There is a risk that: Clinical notes for inpatient episodes will not be coded in a timely way. Resulting in: The non-achievement of the Tier 1 Welsh Government target (which is that 95% of inpatient activity should be coded within 30-days of discharge); Insufficient coded data to support effective service planning for population health needs; Inadequate data being available for mortality review/quality and safety purposes, with increased risk of failure to spot variance that are negatively impacting levels of patient care and potentially causing avoidable deaths; Negative impact on accuracy of analysis to understand how resources are being allocated and used at Health Board level and national level (programme budgeting); Delays in claiming casemix sensitive contract lines with JCC, Hywel Da and Cwm Taff (circa 70m per annum value in total) due to lack of coding data.																																														
Risk Rating (consequence x likelihood): Inherent: 3 x 4 = 12 Current: 4 x 5 = 20 Target: 4 x 3 =12		 <table><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr><tr><td>Jan-25</td><td>20</td><td>12</td></tr><tr><td>Feb-25</td><td>20</td><td>12</td></tr><tr><td>Mar-25</td><td>20</td><td>12</td></tr><tr><td>Apr-25</td><td>20</td><td>12</td></tr><tr><td>May-25</td><td>20</td><td>12</td></tr><tr><td>Jun-25</td><td>20</td><td>12</td></tr><tr><td>Jul-25</td><td>20</td><td>12</td></tr><tr><td>Aug-25</td><td>20</td><td>12</td></tr><tr><td>Sep-25</td><td>20</td><td>12</td></tr><tr><td>Oct-25</td><td>20</td><td>12</td></tr><tr><td>Nov-25</td><td>20</td><td>12</td></tr><tr><td>Dec-25</td><td>20</td><td>12</td></tr></table>			Month	Risk Score	Target Score	Jan-25	20	12	Feb-25	20	12	Mar-25	20	12	Apr-25	20	12	May-25	20	12	Jun-25	20	12	Jul-25	20	12	Aug-25	20	12	Sep-25	20	12	Oct-25	20	12	Nov-25	20	12	Dec-25	20	12	Rationale for current score: C - Insufficient coding data will negatively impact service planning for population health needs and inadequate data being available for mortality review/quality and safety purposes. This could result in failures at spotting patterns of variance that are negatively impacting levels of patient care and potentially causing avoidable deaths. Clinically coded activity is also used to understand how resources are being allocated and used at Health Board level and national level (programme budgeting), and therefore a reduction in coding completeness will impact on the accuracy of this analysis. It is also used to claim casemix sensitive contract lines with JCC, Hywel Da and Cwm Taff of circa 70m per annum with lack of coding data impacting on the timeliness in making these claims. L - Tier 1 target is currently not being met on a regular basis.		
Month	Risk Score	Target Score																																												
Jan-25	20	12																																												
Feb-25	20	12																																												
Mar-25	20	12																																												
Apr-25	20	12																																												
May-25	20	12																																												
Jun-25	20	12																																												
Jul-25	20	12																																												
Aug-25	20	12																																												
Sep-25	20	12																																												
Oct-25	20	12																																												
Nov-25	20	12																																												
Dec-25	20	12																																												

		Rationale for target score: C - Insufficient coding data will negatively impact service planning for population health needs and inadequate data being available for mortality review/quality and safety purposes. This could result in failures at spotting patterns of variance that are negatively impacting levels of patient care and potentially causing avoidable deaths. Clinically coded activity is also used to understand how resources are being allocated and used at Health Board level and national level (programme budgeting), and therefore a reduction in coding completeness will impact on the accuracy of this analysis. It is also used to claim casemix sensitive contract lines with JCC, Hywel Da and Cwm Taff of circa 70m per annum with lack of coding data impacting on the timeliness in making these claims. L – Increase in what can be coded electronically, unit centralisation, greater staff retention and the development of an auto-coding model will lead to increased capacity and a reduction in likelihood for targets not being met.												
Controls (What is currently in place to manage the risk?)		Further Actions (What more are we going to do to address the risk?)												
• A three-year coding modernisation plan has been approved by executive board on 26th February 2025. This plan will see the implementation of an auto-coding solution and a re-banding of the clinical coding department within existing budgets to attain Tier 1 targets by 27/28. • The coding management team assess the staffing complement on a daily basis to ensure resources are deployed in the most efficient and effective manner, in line with demand and clinical coding priorities. • There is a comprehensive training programme in place for new Trainee Coders. • The Clinical Coding Departments raise incidents when clinical information is missing from the patient’s health records and prevents the activity being coded in a timely manner. These incidents are highlighted at the Directorate Business Meetings held on a monthly basis as part of the Clinical Coding Key Performance Indicators. • Clinical coding staff performance continues to be monitored and discussed during the monthly Clinical Coding Managers Meetings, which are chaired by the Head of Health Records & Clinical Coding, and an update is also reported and presented on the Health Board Performance Scorecard.		<table><tr><th>Action</th><th>Lead</th><th>Deadline</th></tr><tr><td>Auto-coding Model in production with Neurology Day-Case Episodes</td><td>Head of Digital Intelligence Programmes</td><td>30/12/2025</td></tr><tr><td>Auto-coding model in production for two specialties</td><td>Head of Digital Intelligence Programmes</td><td>28/02/2026</td></tr><tr><td>Additional working from home days to be added for staff due to increase in electronic coding opportunities.</td><td>Head of Health Records & Clinical Coding</td><td>31/12/2025</td></tr></table>	Action	Lead	Deadline	Auto-coding Model in production with Neurology Day-Case Episodes	Head of Digital Intelligence Programmes	30/12/2025	Auto-coding model in production for two specialties	Head of Digital Intelligence Programmes	28/02/2026	Additional working from home days to be added for staff due to increase in electronic coding opportunities.	Head of Health Records & Clinical Coding	31/12/2025
		Action	Lead	Deadline										
		Auto-coding Model in production with Neurology Day-Case Episodes	Head of Digital Intelligence Programmes	30/12/2025										
		Auto-coding model in production for two specialties	Head of Digital Intelligence Programmes	28/02/2026										
Additional working from home days to be added for staff due to increase in electronic coding opportunities.	Head of Health Records & Clinical Coding	31/12/2025												

An App has been developed by Digital Intelligence that shows any relevant data relating to a patient episode from different systems including Signal, TOMs, EPOA and DAL in one place. This will reduce the number of systems a clinical coder needs to log into.			
Assurances (How do we know if the things we are doing are having an impact?) - Attainment of the Tier 1 Health Board target for clinical coding completeness which relies on the timely availability and quality of the paper record and electronic sources. Coding 95% of in-patient activity within 30 days of discharge is a tier 1 Welsh Government target that is currently not being achieved regularly within SBU – with an average of circa 74% for 24/25. Performance is reported to Digital Business Meeting every 3 months, and to Digital, Data, Research & Innovations Committee via a Coding Paper. - Episodes are coded from paper and electronic sources; the ability to code from electronic sources improves the timeliness & accuracy; approximately 52,000 episodes of 150,000 episodes are coded from electronic sources currently. This is reported to Digital Business Meeting every 3 months, and to Digital, Data, Research & Innovations Committee via a Coding Paper. - An Audit has been carried out by NHS Wales Assurance and Audit Services of the Coding Department was completed in June 2024 with a result of limited assurance. In response a twelve-point action plan was developed of which one action remains which is the escalation of the coding risk to the Health Board Risk register.	Gaps in assurance (What additional assurances should we seek?) - Investment required supporting the delivery and operational costs of the Digital strategy. - Replacing qualified coders who have left the department with trainees reduces productivity - the only mitigation against this is an auto-coding product to increase productivity and re-banding across coding department to put staff at same bandings as NHS England and help staff retention – the investment required for this is yet to be funded. - The Quality of Discharge Summary provision and standard of clinical information available at the point of coding requires improvement to assist with prompt and accurate coding. There continues to be missing clinical information at the point of coding, preventing accurate and timely coding. - Incomplete DALs.		
Additional Comments / Progress Notes Supplementary Notes: - Coding 95% of in-patient activity within 30 days of discharge is a tier 1 Welsh Government target that is currently not being achieved regularly within SBU – with an average of circa 74% for 24/25. - Contract coders and overtime have been used to achieve that 75% average which has stopped due to the current financial situation of the Health Board. - Retaining and recruiting qualified coding staff is a big challenge due to higher bandings in England and the availability of digitised record to allow home working. 6 WTE qualified coders have been lost to English Health Boards or DHCW in the last 3 years due to higher bandings with a further 2WTE retiring. This has resulted in circa 44% of the current coding WTE being trainees/unqualified. Currently, there are 5 qualified coder vacancies (June 2025). Progress Notes: 08/12/2025 – Auto-Coding Model date has been amended to December - currently in final testing ahead of potential go-live week commencing 8th December.			

Datix ID Number: 3114 Date Opened: May 2025		Date Last Reviewed: December 2025	HBR Ref Number: 105 Target Date: TBC		Current Risk Rating: 4 x 4 = 16																																							
Objective: Care is delivered in partnership with our communities in safe and appropriate settings, supported by innovative digital solutions, research, development and innovation			SRR Ref: 3.3	Director Lead: Matt John, Director of Digital Supporting Director: Chris Morrell, EDAHPHS Assuring Committee: Digital, Data & Innovation Committee For information: Quality & Safety Committee																																								
Risk: Significant increased cost for the replacement Pathology System LIMS If the new Laboratory Information Management (LIMS) system is not live before 31 st March 2026 then there will be significant additional cost across NHS Wales which could impact the Health Board’s financial plans in 2025/26 and 2026/27. Costs would have to be covered to avoid pathology losing access to the current LIMS system resulting in the inability of pathology to deliver diagnostic results and blood transfusion services across all Health Board services including emergency, acute, primary and community services.																																												
Risk Rating (consequence x likelihood): Inherent: 5 x 5 = 25 Current: 4 x 4 = 16 Target: 4 x 1 = 5		 <table><caption>Risk Score and Target Score Data</caption><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td></td><td></td></tr><tr><td>Feb-25</td><td></td><td></td></tr><tr><td>Mar-25</td><td></td><td></td></tr><tr><td>Apr-25</td><td></td><td></td></tr><tr><td>May-25</td><td>20</td><td>5</td></tr><tr><td>Jun-25</td><td>16</td><td>4</td></tr><tr><td>Jul-25</td><td>16</td><td>4</td></tr><tr><td>Aug-25</td><td>16</td><td>4</td></tr><tr><td>Sep-25</td><td>16</td><td>4</td></tr><tr><td>Oct-25</td><td>16</td><td>4</td></tr><tr><td>Nov-25</td><td>16</td><td>4</td></tr><tr><td>Dec-25</td><td>16</td><td>4</td></tr></tbody></table>		Month	Risk Score	Target Score	Jan-25			Feb-25			Mar-25			Apr-25			May-25	20	5	Jun-25	16	4	Jul-25	16	4	Aug-25	16	4	Sep-25	16	4	Oct-25	16	4	Nov-25	16	4	Dec-25	16	4	Rationale for current score: Consequence – Additional costs could be in region of approximately £1m for the Health Board depending on the length of delay Likelihood – probable (10-50% chance currently) – due to being off-track on project and lack of confirmed back-up plan. Rationale for target score: Consequence as above Likelihood will be negligible if effective system / mitigations put in place in time	
Month	Risk Score	Target Score																																										
Jan-25																																												
Feb-25																																												
Mar-25																																												
Apr-25																																												
May-25	20	5																																										
Jun-25	16	4																																										
Jul-25	16	4																																										
Aug-25	16	4																																										
Sep-25	16	4																																										
Oct-25	16	4																																										
Nov-25	16	4																																										
Dec-25	16	4																																										
Controls (What is currently in place to manage the risk?)			Further Actions (What more are we going to do to address the risk?)																																									
Configuring and testing the new LIMS system with the aim of go-live with all disciplines before 31st March 2026 SBUHB Pathology services are working in collaboration with other Health Boards and Trusts to share configuration and testing as part of a national programme. The project has agreed a go-live of Cellular Pathology in November. However, national replanning is still underway for other disciplines (Microbiology, Andrology, Blood Sciences and Blood Transfusion) to secure go-live dates before 31 st March 2026 when funding for the national programme ends. The two months allocated by the national programme for User Acceptance Testing has been extended to over 12 months as the number of defects in the system remains high. There remain significant defects to be addressed by the supplier, most notably for Blood Sciences			Action	Lead	Deadline																																							
			Determine what additional local costs may be attracted due to extending the project from 31 st December 2025 until 31 st March 2026 and how these could be funded.	SBUHB Project Team	31/12/2025																																							
			Continue to work in collaboration with other NHS Wales organisations to challenge supplier delivery and secure go-live dates before 31 st March 2026.	SBUHB Project Team	31/03/2026																																							

with over 400 defects – over 300 of which must either be resolved or worked around before go-live. Pursuing only a ‘Minimal Viable Product’ to avoid scope-creep SBUHB Pathology Services are only seeking to pursue a safe replacement system, known as a ‘Minimal Viable Product’. This is to eliminate the possibility of testing timescales being extended. Other Health Boards and Trusts report they are following the same approach. Challenging the supplier and Digital Health and Care Wales for their technical delivery The supplier is responsible for addressing any defects identified during testing. Digital Health and Care Wales (DHCW) are responsible for delivering some of the technical integrations (in addition to co-ordinating the national programme). The SBUHB Project Team, through the programme governance, challenge the supplier and DHCW to deliver on their commitments.	Determine what additional local costs may be attracted due to extending the project into financial year 26/27.	Head of Digital Planning	31/03/2026
Assurances (How do we know if the things we are doing are having an impact?) National Programme Board SBUHB, together with all Health Boards, Trusts and the supplier belong to the national LIMS Programme Board. The Programme Board receives updates on Digital Health and Care Wales progress towards procuring extended licenses, or a replacement of, the current remote access software. The Programme Board receives updates on testing activities, including metrics showing the number of outstanding system issues. It is chaired by the Executive Director of Allied Health Professions and Health Science for Aneurin Bevan University Health Board. SBUHB Project Team A Project Manager is in place to manage the SBUHB Project Team on daily basis. Operational Delivery Network LIMS 2.0 Sub-Group SBUHB work in regional partnership with Hywel Dda University Health Board (HDUHB) and hold a joint, monthly Operational Delivery Network LIMS 2.0 Sub-Group, which receives reports from the SBUHB and HDUHB Project Managers,	Gaps in assurance (What additional assurances should we seek?) Meeting the costs of extending the project and access to the current LIMS A national mitigation plan was previously proposed that would enable go-lives of all SBUHB pathology disciplines by 31st December 2025. The national programme has since reported they have extended the programme until 31st March 2026. Welsh Government have confirmed they will cover the £1.6m cost of the mitigation plan that would fund the programme until 31st December 2025. Digital Health and Care Wales are seeking to cover a further £0.87m of national costs not previously included in the mitigation plan, that would fund national components of the programme until 31st March 2026. The SBUHB project needs to determine what additional local costs		

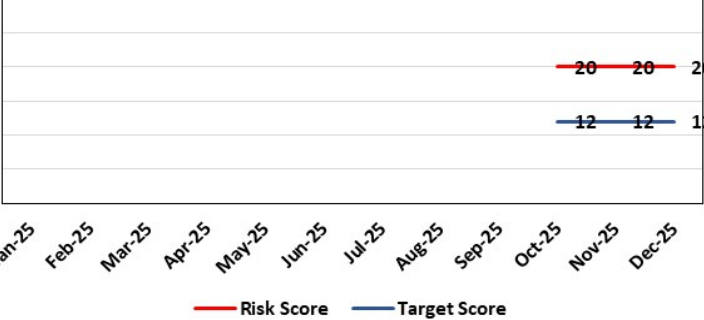
along with Programme Managers from the supplier and Digital Health and Care Wales. This group is jointly chaired by the SBUHB Clinical Lead for Laboratory Medicine and HDUHB Head of Pathology Service, who are also Senior Responsible Officers for the SBUHB and HDUHB projects. Morrison Management Board The SBUHB project regularly reports progress to the Morrison Management Board. Digital, Data, Research and Innovation Committee The SBUHB project regularly reports progress to the Digital, Data, Research and Innovation Committee.	may be attracted due to extending the project from 31st December 2025 until 31st March 2026 and how these could be funded. Resource Constraints All available staff are committed to the programme, with no external resources readily available. This has contributed to the programme’s red RAG status.									
Additional Comments / Progress Notes User Acceptance Testing sign-off User Acceptance Testing across Wales was originally expected to take place across the two months of September and October 2024. However, a significant number of issues in the system, coupled with partial delivery of integrations between the LIMS and national systems managed by Digital Health and Care Wales, were identified early in the process. Maintaining the availability of Pathology staff to undertake testing across an extended duration, alongside maintaining service delivery, has also been challenging. User Acceptance Testing has been extended to, depending on the pathology discipline, around twelve months. Go-lives have not been delayed by the same amount and the decreased duration between the end of User Acceptance Testing and go-live puts additional pressure on the project: <table><tr><td></td><td>Previously</td><td>Currently</td></tr><tr><td>Duration of User Acceptance Testing</td><td>2 months</td><td>12 months</td></tr><tr><td>Duration between User Acceptance Testing sign-off and go-live</td><td>3 months</td><td>1 month</td></tr></table>			Previously	Currently	Duration of User Acceptance Testing	2 months	12 months	Duration between User Acceptance Testing sign-off and go-live	3 months	1 month
	Previously	Currently								
Duration of User Acceptance Testing	2 months	12 months								
Duration between User Acceptance Testing sign-off and go-live	3 months	1 month								
Business Continuity The Health Board’s current Business Continuity Plan to address a failure in digital pathology systems is to revert back to paper based reporting, which is unsustainable and would only be effective over a very short-term period (days). Blood Transfusion services in other part of Wales SBUHB Blood Transfusion are the only Blood Transfusion service in Wales that have successfully migrated onto the current LIMS system. Other Blood Transfusion services use other legacy systems and will potentially be impacted after the 15th December 2025 in other ways (e.g. by having to extend support for their existing legacy systems).										

Pathology resource for testing

Testing is reliant on the knowledge and skills of Health Board staff whose availability is limited, having to manage testing alongside normal service delivery. With a national shortage of Biomedical Scientists, there is no readily available external resource to support this process.

11/11/2025 – The pathology Operational Delivery Network LIMS sub-group chair has written to the LIMS national programme chair to request that the Backup Plan and the costs estimated within it be revisited given the increasing likelihood that go lives will take place in the new financial year.

09/12/2025 - Costs shared with 9th December 2025 Programme Board show a cost after 31st March 2026 of £3.3m per quarter, with £0.4m of those costs apportioned to SBUHB.

Datix ID Number: TBC Date Opened: October 2025		Date Last Reviewed: December 2025		HBR Ref Number: 106 Target Date: TBC		Current Risk Rating: 4 x 5 = 20																																							
Objective: The health board is a resilient, sustainable and responsible organisation			SRR Ref: N/A		Director Lead: Marie Davies, Director of Planning & Partnerships Assuring Committee: Performance & Finance Committee																																								
Risk: Emissions Reduction																																													
If we do not identify funding and implement appropriate actions effectively and in a timely way, there is a risk that we will not deliver the emissions reduction targets of 16% by 2025 and 34% by 2030 as determined in the NHS Wales Decarbonisation Strategic Delivery Plan (DSDP 2021). This could result in failure to achieve Health Board targets, undermine achievement of national targets, and expose the Health Board to potential reputational damage in the eyes of Welsh Government and the wider public.																																													
Risk Rating (consequence x likelihood): Inherent: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 = 12		<table><caption>Risk Score and Target Score Data</caption><thead><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr></thead><tbody><tr><td>Jan-25</td><td>20</td><td>12</td></tr><tr><td>Feb-25</td><td>20</td><td>12</td></tr><tr><td>Mar-25</td><td>20</td><td>12</td></tr><tr><td>Apr-25</td><td>20</td><td>12</td></tr><tr><td>May-25</td><td>20</td><td>12</td></tr><tr><td>Jun-25</td><td>20</td><td>12</td></tr><tr><td>Jul-25</td><td>20</td><td>12</td></tr><tr><td>Aug-25</td><td>20</td><td>12</td></tr><tr><td>Sep-25</td><td>20</td><td>12</td></tr><tr><td>Oct-25</td><td>20</td><td>12</td></tr><tr><td>Nov-25</td><td>20</td><td>12</td></tr><tr><td>Dec-25</td><td>20</td><td>12</td></tr></tbody></table>			Month	Risk Score	Target Score	Jan-25	20	12	Feb-25	20	12	Mar-25	20	12	Apr-25	20	12	May-25	20	12	Jun-25	20	12	Jul-25	20	12	Aug-25	20	12	Sep-25	20	12	Oct-25	20	12	Nov-25	20	12	Dec-25	20	12	Rationale for current score: Consequence: 4 – based on Governance and Assurance domain outcome of: Low performance rating (low confidence of external stakeholders and Welsh Government connected to potential delay slippage/delay in delivery of targets) Likelihood: 5 – We are expecting to miss first targets. Rationale for target score: Likelihood: 3 - Reduced likelihood of low performance rating through actions taken and engagement with stakeholders nationally.	
Month	Risk Score	Target Score																																											
Jan-25	20	12																																											
Feb-25	20	12																																											
Mar-25	20	12																																											
Apr-25	20	12																																											
May-25	20	12																																											
Jun-25	20	12																																											
Jul-25	20	12																																											
Aug-25	20	12																																											
Sep-25	20	12																																											
Oct-25	20	12																																											
Nov-25	20	12																																											
Dec-25	20	12																																											
Controls (What is currently in place to manage the risk?)				Further Actions (What more are we going to do to address the risk?)																																									
- Board leadership is provided by the Executive Director of Planning and Partnerships. There is a supporting governance structure in place. - There is a Climate Action Plan (CAP) 2024-26. - A Climate Action Plan Implementation Group manages the delivery of improvement actions, reporting to the Swansea Bay Steering Group prior to Management Board. - Measures required to achieve emissions reduction objectives are integrated into other strategies and plans, including: Estates Strategy; IMTP; Quality Strategy; Sustainable Travel Strategy; Healthy & Sustainable Catering Strategy; Value Based Healthcare, People Strategy; Population Health Strategy - Climate change & decarbonisation is a component part of the prioritisation for Capital Projects across NHS Wales organisations.				NHS Wales Shared Services Partnership led: Working with suppliers on carbon reduction plans. NWSSP require any contract over £5 million have a Carbon Reduction Plan, that can then provide a more accurate emissions factor supporting calculation. Furthermore, there is a Health Board responsibility not to over purchase items and ensure stock is utilised prior to reorder to remove any waste/expiry of dates.		Director of Planning & Partnerships (SRO, but action led by NWSSP)	Ongoing																																						

- Health Board takes part of the wider Welsh Government Health and Social Care Climate Emergency Programme governance through membership and participation on: - Buildings, Estates, Land Use Planning Programme Board - Transport and Procurement Programme Board - Approach to Healthcare Programme Board - Adaptation Programme Board - Community of Experts - Adaptation Accelerator Programme - DSDP Refresh Working Group - The Health Board has contracted three 'Sustainability Clinical Leads' including an ED (Emergency Department) Consultant, a Consultant Anaesthetist, and NAU (Neurology Ambulatory Unit) Manager. They are driving sustainable healthcare work in the health board including Green ED, Greener Theatres, Green Group and other initiatives as well as wider NHS Wales and Royal College networks. - Participation on the Public Services Boards in Swansea and Neath Port Talbot sharing best practice and investigating opportunities for collaboration.	Appropriate lead within the CAP will meet with potential funders and partners, and ongoing sourcing of funding / collaboration opportunities identified.	Director of Planning & Partnerships	Ongoing
	A Revised national DSDP is expected to be published in September 2025. The Health Board will be able to re-assess its position and alignment with refresh of the CAP which is being undertaken concurrently.	Director of Planning & Partnerships	31/03/2026
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
- Annual carbon emissions data: This is reported to Welsh government annually, based on a financial year. There are three emissions measures reported. The Health Board has some success in meeting the target for Scope 1 and 2 emissions, but the scope 3 emissions are off target. <i>See Additional Comments at foot of this template for definition of measures and performance figures.</i> - CAP Delivery Plan & RAID (Risks Actions Issues & Decisions) log: Implementation of the CAP is reviewed and updated monthly and received at Climate Action Plan Implementation group. CAP actions are on track. - DSDP Delivery Plan & RAID log: Implementation of the DSDP is reviewed and updated monthly and received at Climate Action Plan Implementation group. DSDP elements are amber/red due to external constraints, particularly around funding. - DCR reporting and benchmarking: Bi-annual reporting (Q1/2 and Q3/4) on DSDP-only actions is benchmarked against other NHS Wales Organisations, comparing progress, risks, and issues. This is not currently comparable due to differences in interpretation of the RAG system.	- Source of emissions: The Health Board has made significant reductions on the emissions from the Estates with the RE:Fit programme and development of the solar farm powering Morriston Hospital. However, most Health Board emissions are indirect, predominantly from the Supply Chain, and harder to reduce. - Funding stream: The SBU Climate Action Plan (CAP) has been developed to be achievable cost neutrally. However, the NHS Wales Decarbonisation Strategic Delivery Plan (DSDP), published in 2021, was developed by the Carbon Trust and directly targets emissions from buildings. However, suitable resource to implement the actions was not provided by Welsh Government or NHS Wales to support delivery of the plan. There is an expectation that additional funding be absorbed into Health Board financial plans. This is not feasible, recognising decarbonising buildings costs more than £60 million.		

- Benchmarking: An annual review is undertaken within SBU against progress in the wider health sector and other relevant developments in sustainability and climate related work. This highlights that the Health Board is aware of work, but it can be hard to replicate. This will be partially addressed through the established Sustainable Healthcare Working, led by the Deputy Medical Director.
- Annual CAP reporting: Progress report and assurance to Welsh Government around local Health Board actions as detailed in the CAP being undertaken in addition to those in the DSDP.
- NWSSP internal audit review: Audit conducted for period Sep-23 to Apr-24 reported Limited assurance due to Welsh Government not having any dedicated funding stream. This risk has been continuously reflected in the DCR reporting process to WG. In addition, periodic updates are provided internally to the Head of Compliance which informs reporting to Audit Committee.
- Funding stream: The SBU Climate Action Plan (CAP) has been developed to be achievable cost neutrally. However, the NHS Wales Decarbonisation Strategic Delivery Plan (DSDP), published in 2021, was developed by the Carbon Trust and directly targets emissions from buildings. However, suitable resource to implement the actions was not provided by Welsh Government or NHS Wales to support delivery of the plan. There is an expectation that additional funding be absorbed into Health Board financial plans. This is not feasible, recognising decarbonising buildings costs more than £60 million.

Additional Comments: Targets Explained:

Public Sector Emissions Reporting:

Annual carbon emissions reporting to Welsh Government calculating emissions associated with Health Board Activities (based on financial year).

- Scope 1: Direct emissions from owned or controlled sources including natural gas, fleet, fluorinated gases and anaesthetic gases
- Scope 2: Indirect emissions from the purchase and use of electricity
- Scope 3: All other indirect emissions that occur in the upstream and downstream activities of an organisation this includes supply chain, business travel, commuting, waste, water, and processes associated with electrical distribution and extracting fossil fuels.

Context: Climate Emergency was declared by Welsh Government in 2019, leading to the Net Zero Wales ambition for the Welsh public sector to collectively reach net zero by 2030. In response NHS Wales developed a 'Decarbonisation Strategic Delivery Plan (DSDP)' (published in 2021).

The Health Board has some success in meeting the target for Scope 1 and 2 emissions, largely driven by the development of the solar farm and Re:Fit energy efficiency programme managed by Estates. This is despite new categories being added since establishment of the baseline including kerosene, fluorinated gases and anaesthetic gases. A total of 76% of the Health Board's emissions are part of the supply chain – emissions reductions in this space will be dependent on suppliers actively working on reducing their own emissions and sharing this information with the Health Board. NWSSP is leading on this with all contracts over £5million requiring a carbon reduction plan. In 2023/24 this data (tier 2 / supplier specific) was available for 223 suppliers reducing total emissions by 35,954.54 tCO₂e. Supply chain data was also removed where it would be reported by another NHS Wales organisation or wider Welsh Public Sector body.

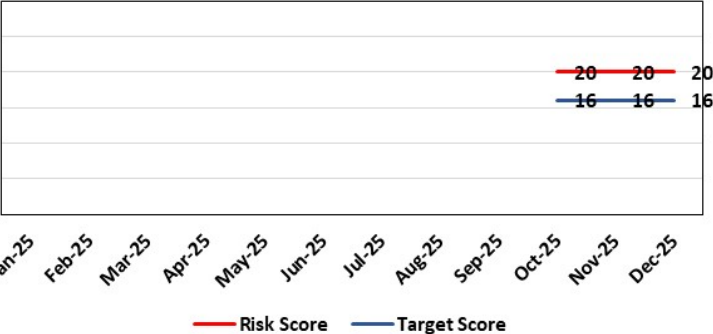
Annual carbon emissions data is reported to Welsh government annually, based on a financial year. This calculates emissions associated with health board activities (and so reflects outcome of activities aimed at managing risks to delivery). Most recent performance (2023/24) against WG revised 2018/19 baseline is:

Scope		2018/19* (tCO ₂ e)	2023/24 (tCO ₂ e)
1	Direct emissions from owned or controlled sources incl. natural gas, gas oil, kerosene, fleet, fluorinated gases, anaesthetic gases	26,123.40	21,444.26

2	Indirect emissions from the purchase/use of electricity incl. grid electricity		
3	All other indirect emissions (up/downstream) incl. supply chain, commuting, business travel, water, waste, well to tank and transmission and distribution (grid)	110,063.30	120,499.95
Total		136,186.70	141,944.21

*Readjusted baseline from WG, based on the change in footprint: ABMU to SBU

Progress Notes

Datix ID Number: TBC		Date Last Reviewed: December 2025		HBR Ref Number: 107		Current Risk Rating:	
Date Opened: October 2025				Target Date: TBC		5 x 4 = 20	
Objective: The health board is a resilient, sustainable and responsible organisation			SRR Ref: N/A		Director Lead: Marie Davies, Director of Planning & Partnerships		
					Assuring Committee: Performance & Finance Committee		
Risk: Emergency Preparedness, Resilience and Response, (EPRR) and Recovery							
If the health board lacks adequate and effective emergency preparedness, planning, response and recovery at both corporate and operational levels, there is a risk that it may not be able to respond and recover promptly, efficiently, or effectively to a major incident, business continuity, or critical incident. This could lead to: Negative impacts on patient care delivery in both acute and non-acute settings; Potential harm or injury to patients and/or staff; Non-compliance with statutory obligations under the Civil Contingencies Act 2004; Legal actions and financial penalties; Reputational damage and diminished public trust.							
Risk Rating (consequence x likelihood): Inherent: 5 x 5 = 25 Current: 5 x 4 = 20 Target: 4 x 4 = 16					Rationale for current score: The current score is aligned with the Wales Risk and Preparedness Register and reflects the Health Board’s compliance with statutory obligations under the Civil Contingencies Act and NHS Wales EPRR standards. It also considers assurance processes in place, including regular audits, training compliance, and business continuity planning. These controls provide a robust framework for preparedness; however, residual risk remains due to external dependencies, inter-agency coordination challenges, supply chain vulnerabilities, and the evolving nature of threats such as cyber incidents, climate-related events, and public health emergencies.		
					Rationale for target score: Achieving the target score will require enhanced compliance with EPRR training, strengthened governance, and fully embedded business continuity arrangements across all critical services. In addition, improved interoperability with partner agencies, robust assurance processes, and investment in risk mitigation measures, such as cyber security, supply chain resilience, utilities and climate adaptation, will further reduce organisational vulnerability. These actions will collectively support effective preparedness, coordinated response, and timely recovery in the event of major incidents or emergencies, aligning with national standards and statutory obligations. The target score also reflects a commitment to continuous improvement through regular exercising and testing of plans, lessons learned from incidents, and ongoing engagement with stakeholders to ensure resilience remains dynamic and responsive to emerging risks.		

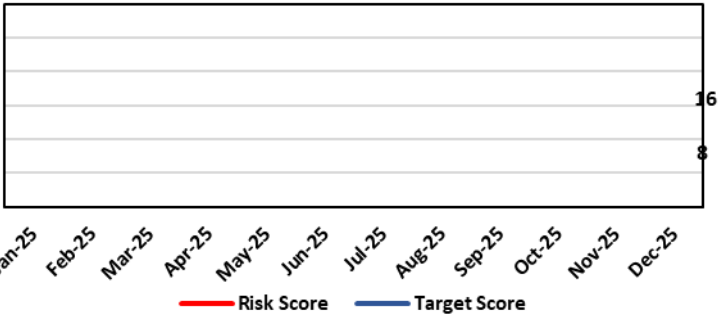
Controls (What is currently in place to manage the risk?)	Further Actions (What more are we going to do to address the risk?)		
• There is an Executive Director nominated as lead for Civil Contingences (the Director of Planning & Partnerships). • A comprehensive business continuity management (BCM) process is in place, allowing services to assess and manage risks across the five key business continuity (BC) areas (premises, people, service, utilities, and supplies) and implement suitable mitigations. The BC framework serves as a guide for departments to develop their own specific BC procedures. • An overarching Strategic BC Procedure outlines the management processes, escalation protocols, and response structures to ensure effective command, control, and coordination during a significant disruption. In addition, each Service Delivery Group has an overarching Tactical BC Procedure outlining the tactical management processes, escalation protocols and response structures for effective command and control and coordination. • A Emergency Preparedness, Resilience, and Response (EPRR) strategy and program is in place to oversee and ensure enhanced assessment, preparedness, prevention, response, and recovery strategies. These aim to ensure there is the capacity and capability to be resilient, prepared and for staff to have the right skills and to have the correct plans to safely and effectively respond and recover from emergencies. This has been shaped by consideration of lessons identified from previous emergency incidents and exercises; the management of shared risks; and the impacts outlined in the EPRR risk and preparedness register. • The organisation has fully established emergency preparedness, resilience, and response (EPRR) measures, with the EPRR work and training programs aligned to meet Civil Contingency statutory requirements. Oversight is provided by the EPRR Oversight Group. • A range of emergency response protocols, including a major incident procedure, has been developed. To support, there is a suite of emergency procedures at national and regional levels to address and mitigate national, regional, and local risks as effectively as possible. These risks are identified in the Health Board EPRR Risk and Preparedness register and aligned to National Risk Register, Wales Risk and Preparedness Register, Local Resilience Forum (LRF) Community Risk Register, and respective local authority risk registers.	Amended: Training & Competency: • Ensure full compliance with EPRR training requirements for all relevant staff. • Refresher training and scenario-based learning for key roles,	Executive Director of Planning and Partnerships	31/03/2026
	Amended: Business Continuity Management: • Embed and test business continuity plans across all critical services. • Ensure plans include critical resilience and alternative arrangements.	Executive Director of Planning and Partnerships	31/03/2026

• The Health Board actively participates in the NHS Executive Health Emergency Planning Advisory group and its sub-groups, which provide a platform for discussing and advancing NHS emergency preparedness and planning policies. Additionally, the HB is involved in the Wales Resilience Partnership Group and South Wales Local Resilience Forum and contributes to various pan-Wales/regional groups. The Health Board works closely with local partners and is a member of both Neath Port Talbot and Swansea Local Authority risk groups. • The HB EPRR arrangements are aligned to the HB Strategic vision and objectives. EPRR not only helps the HB to comply with the legal requirements but also reinforces the delivery of high-quality, safe, and equitable services, as well as supports the long-term sustainability and resilience of the organisation. • There is a holistic approach to building, strengthening, and maintaining the EPRR work programme with consideration to leadership and governance (and ensuring these are up to date to ensure clear accountability), training and workforce development, scenario planning and exercises, risk management, community engagement and continuous improvement, including the conduct of regular audits and assurance checks against NHS Wales EPRR standards. This allows delivery of care to be of high quality, efficient, resilient, and adaptable during times of crisis. • Exercising & Continuous Improvement: Scheduling regular internal training and exercises simulations; capturing lessons identified from incidents and exercises and integration into plans.			
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)		
• The EPRR Strategy Group is responsible for overseeing the strategy and implementation of the EPRR work plan. It operates under the coordination of the corporate Strategy Directorate, with the programme focused on achieving Civil Contingency responsibilities, conducting thorough risk assessments, and facilitating training, exercises, and lessons learned. A digital dashboard is in place to support the monitoring of the EPRR work programme. • The HB delivers various exercises to test the effectiveness of current arrangements and response procedures and key training programmes. A comprehensive HB training and exercise strategy is established, covering operational, tactical, and strategic response levels.	• EPRR is a corporate function and must be recognised as a vital, cross-cutting service to ensure EPRR considerations are integrated into all HB operations. Progress is being made in this area, but further work is needed. Service Delivery Groups must designate appropriate managerial resources to take on EPRR responsibilities within their respective services. These individuals should have the necessary seniority to make decisions and drive the required work programme forward. Additionally, EPRR mapping has been undertaken for the HB Strategic vision and objectives evidencing where HB-wide work programmes need to incorporate resilience, with EPRR clearly defined as a critical		

- Local procedures (including Major Incident and Emergency Response procedures) are regularly reviewed to incorporate the latest UK and national guidance, as well as lessons identified from actual events. Following each live incident, a debrief is conducted, and the findings are documented in the SBUHB lessons identified register.
- As part of the EPRR Work Programme and within the Digital Dashboard, the EPRR Strategy Group monitors and ensures that all business continuity procedures are kept up to date. Identified gaps in business continuity management are taken forward by the respective Service Delivery Group and cross cutting services EPRR
- The EPRR Strategy Group oversees the HB EPRR risk register, which includes the necessary mitigations for consequence management. This informs the EPRR work programme and training and exercising strategy.
- Risks associated with health included in the Wales Risk and Preparedness Register are included on the South Wales Local Resilience Forum Risk Register and the specific health risks are discussed in the Local Resilience Health Group. This work informs multi-agency, regional resilience, and response arrangements.
- The EPRR Strategy Group currently provides annual updates to the Management Board, with a summary to the Health Board. This includes presenting the Major Incident Procedures, which are reviewed each year, submitting the NHS Executive Annual Report for approval, and offering a comprehensive EPRR update. The update covers challenges, achievements, and other emergency response arrangements.
- The six statutory duties shape the overarching EPRR work programme, with progress monitored through the Digital Dashboard and discussed at the EPRR Strategy Group. Indicator of achievement of 2025/26 objective is: As a Category 1 Responder organisation under the Civil Contingencies Act 2004, HB meets the six statutory duties. Assurance of this is provided through the NHS Executive Annual Report, which is signed by the HB CEO and presented to the Management Board. The report also includes an update on the delivery of the HB EPRR work programme.
- Business Continuity audit report
- Additionally, to support the HB EPRR Training and Exercising Strategy, HB takes every opportunity to participate in national and regional exercises. These

pillar in supporting these efforts. However, further clarity is needed regarding the specific gaps or challenges hindering the full integration and effectiveness of EPRR within these processes.

exercises are then discussed in the various resilience forums, as mentioned earlier.	
Additional Comments / Progress Notes 06/11/2025: Management are looking to Increase general staff awareness of roles & responsibilities in the event of an emergency by mandating the NHS Wales “Introduction to Emergencies” e-learning within the health board. 27/11/2025: Rationales and actions updated. 05/12/2025: Controls and actions sections revised.	

Datix ID Number: 4334		CRR Ref Number: 108		Current Risk Rating																																								
Date opened: December 2025 NEW RISK		Date last reviewed: December 2025		Target Risk Date: 31/03/2029																																								
4 x 4 = 16																																												
Objective: Care is delivered in safe and appropriate settings supported by innovative digital solutions		SRR Ref: 3.4		Director Lead: Director of Digital																																								
				Assuring Committee: Digital, Data, Research and Innovation																																								
Risk: WCCIS/Connecting care - Provision of an Integrated Health Record for MH&LD and PCT																																												
If the Connecting Care programme fails to deliver a digital solution that meets the operational, clinical, and reporting needs of Mental Health & Learning Disabilities (MH&LD) and Community & Therapies services,																																												
Then wider MH&LD, Community and Therapies teams will lack access to timely, accurate, and shared information across care settings, resulting in fragmented service delivery, limited availability of high-quality data for performance monitoring and informed decision making, increased duplication of effort, and elevated clinical and governance risks. This includes the potential for further Regulation 28 reports, as previous Prevention of Future Deaths (PFD) notices have explicitly cited the absence of an integrated electronic system as a contributing factor to avoidable harm. Without a fit-for-purpose solution, the Health Board may be unable to fulfil the actions required under Regulation 28, particularly around effective information sharing and risk management across agencies.																																												
Whilst the issue facing current users across integrated teams from the loss of WCCIS will be largely mitigated through the approved procurement of replacement solutions through the strategic partnership with the supplier, there remains to be 3,000 users across MH&LD and PCT who continue to provide services without an appropriate digital solution to support them. The provision of a solution is a core component of the SBU Digital Strategy. A recent independent review of Mental Health and Learning Disability services at SBUHB identified the lack of a single digital solution as a critical barrier to safe and effective care, highlighting that fragmented systems and manual processes are contributing to clinical risk, delayed interventions, and repeated Regulation 28 reports due to inadequate access to shared electronic records.																																												
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 4 = 16 Target: 4 x 2 = 8		 <table><caption>Risk Score and Target Score Data</caption><tr><th>Month</th><th>Risk Score</th><th>Target Score</th></tr><tr><td>Jan-25</td><td>16</td><td>8</td></tr><tr><td>Feb-25</td><td>16</td><td>8</td></tr><tr><td>Mar-25</td><td>16</td><td>8</td></tr><tr><td>Apr-25</td><td>16</td><td>8</td></tr><tr><td>May-25</td><td>16</td><td>8</td></tr><tr><td>Jun-25</td><td>16</td><td>8</td></tr><tr><td>Jul-25</td><td>16</td><td>8</td></tr><tr><td>Aug-25</td><td>16</td><td>8</td></tr><tr><td>Sep-25</td><td>16</td><td>8</td></tr><tr><td>Oct-25</td><td>16</td><td>8</td></tr><tr><td>Nov-25</td><td>16</td><td>8</td></tr><tr><td>Dec-25</td><td>16</td><td>8</td></tr></table>		Month	Risk Score	Target Score	Jan-25	16	8	Feb-25	16	8	Mar-25	16	8	Apr-25	16	8	May-25	16	8	Jun-25	16	8	Jul-25	16	8	Aug-25	16	8	Sep-25	16	8	Oct-25	16	8	Nov-25	16	8	Dec-25	16	8	Rationale for current score: Likelihood – given the current trajectory of the national Connecting Care programme and its inability to provide a clear and timely roadmap for delivering a solution that meets the needs of Mental Health & Learning Disabilities (MH&LD) and Community & Therapies services. The removal of key components such as the Shared Care Record from the business case, the absence of a national Mental Health framework, and the lack of guaranteed funding all contribute to growing uncertainty. Local service groups have already escalated concerns through multiple risk registers, and the reliance on manual workarounds continues to expose wider teams to operational inefficiencies and clinical governance issues. Without urgent intervention or a credible alternative, the probability of service disruption and further Regulation 28 reports is increasingly likely. Consequence – there would continue to be a significant impact on quality of care and capacity of the MH&LD and PCT teams. The organisation would fail to address the requirements of Regulation 28 reports and there would continue to be a lack of quality data to allow performance monitoring and informed decision making on service transformation. This has a wider impact on the health service provision across the health board, including secondary care.	
Month	Risk Score	Target Score																																										
Jan-25	16	8																																										
Feb-25	16	8																																										
Mar-25	16	8																																										
Apr-25	16	8																																										
May-25	16	8																																										
Jun-25	16	8																																										
Jul-25	16	8																																										
Aug-25	16	8																																										
Sep-25	16	8																																										
Oct-25	16	8																																										
Nov-25	16	8																																										
Dec-25	16	8																																										

		Rationale for target score: Likelihood – If the health board introduce a solution for the wider community and mental health teams, then it is unlikely the consequence associated with system failure or not replacing the new system will occur and some reduction in risk level may be possible (though not to target). Consequence – the consequence of not having a digital solution to support integrated teams and the wider community and MHLTD teams will remain the same.												
Controls (What are we currently doing about the risk?) - Local Program Board has been established and is responsible for producing the business case and delivery of the interim measure - Regional Program Board is in place to ensure HB and councils are working together and align implementation of solutions - DHCW National Program Board is in place to deliver national approach		Mitigating actions (What more should we do?) <table> <tr> <th>Action</th><th>Lead</th><th>Deadline</th></tr> <tr> <td>Implement the new interim solution</td><td>Director of Digital</td><td>31/08/2026</td></tr> <tr> <td>Business case completed and approved for the expansion of the interim solution across all of paper based mental health teams</td><td>Director of Digital</td><td>Complete</td></tr> <tr> <td>Business case completed and approved for the provision of an Electronic Patient Record for the whole of Community and MH&LD</td><td>Director of Digital</td><td>31/03/2027</td></tr> </table>	Action	Lead	Deadline	Implement the new interim solution	Director of Digital	31/08/2026	Business case completed and approved for the expansion of the interim solution across all of paper based mental health teams	Director of Digital	Complete	Business case completed and approved for the provision of an Electronic Patient Record for the whole of Community and MH&LD	Director of Digital	31/03/2027
Action	Lead	Deadline												
Implement the new interim solution	Director of Digital	31/08/2026												
Business case completed and approved for the expansion of the interim solution across all of paper based mental health teams	Director of Digital	Complete												
Business case completed and approved for the provision of an Electronic Patient Record for the whole of Community and MH&LD	Director of Digital	31/03/2027												
Assurances (How do we know if the things we are doing are having an impact?) - Digital leadership group will have oversight of the delivery of the actions of the Local Program Board and reports to Management Board - Digital, Data, Research and Innovation Committee will have oversight of the overall plan and act as escalation route to Health Board if required.		Gaps in assurance (What additional assurances should we seek?) - The national approach has been delayed and is difficult to influence in terms of scope and timelines for delivery - The route to obtaining national funding to support the Health Board is not clear.												
Additional Comments The Welsh Community Care Information System (WCCIS) was developed to provide staff across health and social services with a single system and shared electronic record to enable delivery of more effective and efficient services. It is used by health board teams within mental health and community services, in addition to local authority social services teams, but the system will be discontinued from January 2026. SBUHB users are mainly operating within Integrated Teams and access the solution via the Swansea Council's contract with the system provider. - A business case for an interim solution to address the immediate needs of the current SBUHB users of WCCIS (integrated teams) was presented to and approved by Management Board on 19th December 2024. - The Health Board are continuing to support the National Program in the process for acquiring a longer-term solution - The procurement of the interim solution was completed at the end of 2025/26 and project implementation has commenced. - In September 2025 WG confirmed approval of funding to DHCW of the first year costs in the National OBC. Funding is only available in 2025/26 and a proportion of the funding is available to SBUHB to support the interim solution for integrated teams and next steps. There has been no formal commitment from WG of funding in future years.														

Update:

11/11/2025 - Business case for expansion of interim solution has been completed. Procurement has been approved by Director of Finance and CEO. So the 3rd action can be marked as completed.

09/12/2025- The business case contract has been awarded for the implementation of RIO in mental health and learning disabilities for 20 teams who are currently based on paper. Work has commenced on the implementation which is due to complete by 31st March 2026.

Risk Score Calculation

For each risk identified, the LIKELIHOOD & CONSEQUENCE mechanism will be utilised. Essentially this examines each of the risks and attempts to assess the likelihood of the event occurring (PROBABILITY) and the effect it could have on the Health Board (IMPACT). This process ensures that the Health Board will be focusing on those risks which require immediate attention rather than spending time on areas which are, relatively, a lower priority.

Risk Matrix	LIKELIHOOD (*)				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Probable	5 - Expected
CONSEQUENCE (**)					
1 - Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 - Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25



POPULATION HEALTH COMMITTEE Key Issues Report

The purpose of this report is to provide an overview of the matters identified by the Population Health Committee to be brought to the attention of the Board following discussions at the last meeting.

Date of Committee meeting:	4 December 2025
Members Present:	Four Members were present at the Population Health Committee: Stephen Spill, Nicola Matthews, Patricia Price and Nuria Zolle.
Quoracy:	YES
Group/Committee Chair:	Stephen Spill, Population Health Committee Chair.
Report Submitted by:	Corporate Governance.
Report Signed off by:	Stephen Spill, Population Health Committee Chair.
Date of Board receiving the report:	29 January 2026

1.	Agenda	The Population Health Committee convenes quarterly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert Minute Reference: 58/25	The Committee is alerting the Board to the following items (3): The Committee received a report on inequalities in premature mortality from cardiovascular disease. Members agreed that the Board should be alerted to the inequalities in premature cardiovascular mortality, with a clear explanation of the issue and a request for support in developing solutions.



	Minute Reference: 59/25	• The Committee received a report on smoking cessation and service fragility. Members agreed that the Board should be alerted to the fragility of the smoking cessation service, particularly the risks posed by short-term funding and the potential impact on service continuity and population health outcomes.
	Minute Reference: 57/25	• The Committee received a report on Lung Cancer Screening. The Committee agreed to alert the Board to receive the Lung Cancer Screening Report, noting its significance, the planned phased implementation, the dependencies on the Welsh Government funding, and the anticipated impact on diagnostic and treatment services.
3.	Assurance	The Committee is assuring the Board on the following items (5):
	Minute Reference: 62/25	• The Committee received a report on the Service Delivery Group – Population Health indicators.
	Minute Reference: 63/25	• The Committee received a report outlining the Annual Health Protection Partnership Plan. It was agreed to assure the Board that appropriate plans were in place to meet general health protection obligations.
	Minute Reference: 64/25	• The Committee received a Hepatitis B and C elimination plan report. Members agreed that the Board be assured that the elimination plan and supporting structures were in place and actively managed.
	Minute Reference: 66/25	• The Committee received an update on the Clinical Services Plan (CSP). The Committee wished to assure the Board that the CSP was progressing as a strategic framework with population health, prevention, and addressing inequalities as central themes. It was noted that the plan was not an operational blueprint but would guide future detailed service planning and investment.



	Minute Reference: 67/25	The Board could be assured that the CSP was being developed with a strong emphasis on population needs and whole system working, although tracking investment in prevention remained under development. • The Committee received the Terms of Reference report and accepted its Terms of Reference, which had previously been commented on, and noted that no major changes were raised during the meeting.
4.	Advise Minute Reference: 60/25	The Committee is advising the Board on the following items (1): • The Committee received an update on the Regional Whole Systems Approach to healthy weight progress update and the Child Measurement programme Wales. Members wished to advise the Board of the strategic importance of tackling obesity through system-wide action and continued partnership working. Members considered that this was not an immediate alert; however, the Board should be aware of its strategic significance and the need for sustained partnership and system-wide approaches.
5.	Review of Risks	The Population Health Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	None identified by the Committee Members.



Meeting Date	29 January 2026	Agenda Item	3.2
Name of Meeting	SBUHB Board		
Report Title	Planning & Partnerships Update		
Report Author	Marie Davies, Executive Director of Planning & Partnerships Karen Stapleton, Deputy Director of Planning & Partnerships Hannah Roan, Assistant Director of Planning & Partnerships Ian Langfield, Associate Programme Director for Tertiary & Specialist Services Planning Partnership Kelly Gillings, West Glamorgan Regional Transformation Programme Director		
Report Sponsor	Marie Davies, Executive Director of Planning & Partnerships		
Presented by	Marie Davies, Executive Director of Planning & Partnerships		
Freedom of Information	Open		
Purpose of the Report	This report provides an overview of the key activities and outputs relating to Strategic and Integrated Service Planning, Commissioning, Partnerships, Sustainability and Emergency Preparedness, Resilience and Response (EPRR) and Recovery Planning both within the Health Board and with our wider partners. Its purpose is to ensure alignment with national policy and Health Board strategic objectives to meet the current and future needs of our population and patients and, in doing so, to ensure that we work in partnership with our communities and key stakeholders. The report also outlines, where appropriate, the evolving planning structures, process and outputs and the local, regional and national planning reporting and assurance frameworks and outputs.		
Key Issues	The areas covered in this report reflect the Executive portfolio priorities: • Strategy & Strategic Programmes ○ Organisational Strategy ○ Strategic Clinical Services Plan • Annual Plan (Integrated Medium-Term Plan) • Partnership Plans ○ West Glamorgan Regional Partnership Board ○ Public Services Boards		



	○ Regional Specialised Services Provider Planning Partnership (RSSPPP) with Cardiff & Vale UHB • Commissioning ○ NHS Wales Joint Commissioning Committee (NWJCC) ○ Voluntary Sector ○ Regional ▪ Regional Partnership Board ▪ Area Planning Board ○ Individual Patient Commissioning • Sustainability & Climate Change • Emergency Preparedness Resilience and Response (EPRR) and Recovery • Wellbeing and Future Generations Act (WBFGA)			
Specific Action Required <i>(please choose one only)</i>	Information	Discussion	Assurance	Approval
	☐	☐	☐	☒
Recommendations	Members are asked to: • CONSIDER and AGREE the items as requested through the report.			



PLANNING AND PARTNERSHIPS REPORT

1. INTRODUCTION

This report provides an overview of the key activities and outputs relating to strategic and Integrated Service Planning, Commissioning, Partnerships, Sustainability and Emergency Preparedness, Resilience and Response (EPRR) and Recovery Planning and Wellbeing and Future Generations Act (WBFGA) both within the Health Board and with our wider partners.

2. BACKGROUND

This report provides oversight of the approach, priorities, key deliverables and timelines for the Health Board's:

- Strategy and supporting strategic programmes
- Integrated Medium Term Plan/Annual Plan
- Regional and Local Partnership Plans
- Commissioning – strategic, specialised, regional and local
- Sustainability & Climate Change
- Emergency Preparedness, Resilience, Response (EPRR) and Recovery
- Wellbeing and Generations Act (WBFGA)

3. STRATEGY AND STRATEGIC PROGRAMMES

3.1 ORGANISATIONAL STRATEGY

The organisational Strategy provides the direction for all Health Board's Plans and importantly will underpin the Clinical Strategic Plan in development and the Annual Plan 2026/27.

To support the ongoing promotion of the Organisational Strategy, external support has been commissioned to develop a professionally formatted version of the document. A short video has also been prepared and will be made available online with the final professional document by close of Q4 2025/26.

Summary overviews of the existing enabling Strategic Plans have been produced to ensure alignment with the Organisational Strategy (**Appendices 1a-1h**). These include overviews for:

- Capital Estates Strategic Plan
- Digital Strategic Plan
- Environment and Sustainability Strategic Plan overview
- Equality Strategic Plan
- People Strategic Plan
- Population Health Strategic Plan
- Quality Safety and Patient Experience Strategic Plan
- Research and Innovation Strategic Plan

The Health Board's progress against its strategic indicators will be reported to the Board in the Q4 Annual Plan 2025/26 reporting update.

3.2 CLINICAL SERVICES STRATEGIC PLAN

An Executive-led steering group is in place to oversee the core components of the Clinical Services Strategic Plan's (CSSP) development. To support the Steering Group and the development of the CSSP two Clinical Reference Groups have been established and held their first meetings in December 2025.

These two Clinical Reference Groups (CRG) together have a wide-ranging membership of clinical colleagues from across Primary and Secondary care. In the first instances the CRGs met as a CRG for Networked Hospitals with membership from across secondary care professionals with representation from primary and community care clinicians and the second CRG focussed on Integrated Community Care with majority membership from primary and community care including leaders from each of the primary care clusters with representation also present from secondary care settings.

These forums are providing crucial review and input of the key products of the CSSP:

1. The **framework** for the CSSP has been further presented and tested at a variety of forums including the Integrated Planning Group and Clinical Reference Groups. The drafted framework is now being updated and refined throughout January to respond to the feedback received.
2. The Public Health team developed a '**State of the Population**' report. This was presented to the Executive Working Group and the Clinical Reference Groups in December for review and comment and will be further refined in response. Work has also begun on developing templates and resources to support service, cohort or system specific needs assessments.
3. **Horizon scan reports** have been developed for 12 key themes describing the key future trends, potential impacts for the Health Board as well as the challenges and opportunities presented by the potential changes. These have been shared for with the CRGs comment and input and will be further developed in February.
4. An initial collation of information and data has taken place to inform a **Demand and Capacity Overview**. A summary of this information has been drafted and gaps in information identified. Further work is now being undertaken to complete the overview for the CSSP document.

An external engagement and communications company are supporting the Health Board in undertaking a two-phase engagement process. Phase one, taking place between January and March, will seek to re-engage our clinicians, public, staff and stakeholders on the principles already agreed through the extensive Changing for the Future programme. Phase two, taking place after the Senedd election purdah period in May, will move to engage on the content of the CSSP. Further detail of this process will be presented to the Management Board for agreement in February.

4. ANNUAL PLAN/IMTP

4.1 ANNUAL PLAN 2025/26 DELIVERY AND GOVERNANCE

The Q3 Integrated Planning and Performance review process will be incorporated into the Service Delivery Group Performance Review meetings recognising the significant operational time pressures in this quarter. The process will:

- review position against plan for service group and system programme plan (eg. planned care programme) planned priority actions for delivery in Q3
- identify the corrective actions required in Q4 to optimise delivery against plan
- to reconcile the corrective actions required with our recovery and sustainability priorities to deliver against our financial targets
- to assess and identify risks and mitigations required to optimise performance and delivery whilst making necessary adjustments to meet our financial commitment by end March 2026.

The Q3 Annual Plan delivery report will be submitted to Board alongside the March Integrated Performance Review Report.

4.2 ANNUAL PLAN 2026/27

An update was received by the Formal Executive meeting on 14th January setting out the process and timelines for the development of the Health Board Annual Plan 2026-2027.

The Annual Plan for 2026/2027 will remain within a three-year context to ensure strategic alignment and will clearly reflect the refreshed vision, mission and strategic objectives in our updated strategy alongside the emerging Clinical Strategic Plan.

On 3rd December 2025, the Annual Plan Development Workshop was held in person, attended by Executives, Recovery & Sustainability Programme Delivery Leads, Service Group Triumvirates and Corporate Leads. The Planning Context and core assumptions for 26/27 were clarified as:



- The Board's route to financial sustainability is grounded in making wide-ranging strategic and structural changes – in line with our strategy and emerging strategic clinical services plan.
- We must demonstrate a credible but stepped approach to financial sustainability, service performance, quality and safety
- We need to adopt a mindset of considering what represents value for money alongside a relentless focus and structured approach to driving efficiency.
- This is a collective leadership endeavour.
- We have a foundational plan to build upon through the programmes established in 2025-26.

The workshop confirmed the approach to the Annual Plan, structured into Programmes which are aligned to the existing Recovery & Sustainability themes with a focus on accelerating and amplifying the 2025-26 commitments that are based on opportunities identified through work with Deloitte. These are in addition to further core programmes for service transformation.

Following the December workshops, communication was issued to the Executive SROs, Delivery Leads and Service Groups to support the next phase of work. Executive SROs and Programme Delivery Leads have been working up the templated Plans on a Page (POAP) to be completed by 21st January 2026. The purpose is to summarise and consolidate the key information on the programme priorities, working collaboratively with Service Groups and corporate leads to provide the required detail (including financial savings, workforce reduction, and performance impact) for each project within their programme. This will ensure Plans can be quantified, triangulated and tested for feasibility to progress.

In parallel, Operational Delivery Plan templates have been issued to Service Groups/Corporate Divisional areas to capture the underpinning detail on what will be done at Divisional/Service level to address the Programme Priorities and defined projects.

NHS Planning Framework

Correspondence from Welsh Government was issued on 19th December 2025 to all Health Boards and NHS Organisations. This forms the NHS Planning Framework for 26/29 and includes:

- Letter from Cabinet Secretary to NHS Chairs outlining Strategic Priorities and requirements, with Annex 1 providing the Minimum Delivery Expectations 26/27 and Annex 2 setting out the revised mandated Enabling Actions 26/27



- Letter from NHS Wales Director General to CEOs stating governance arrangements and timelines for plan activities, including deadlines for the Accountability Officer letter and formal submission date of Plans.
- Welsh Health Circular Cover Letter regarding Finance allocations
- 2026-27 Health Board Allocation Circular
- 2026-27 Health Board Allocation Final Tables
- 2026-27 Health Board Allocation Explanatory Notes

It was noted that further documents are to follow, these include Planning Technical Guidance, the Ministerial Templates required for submission with Plans and the core Minimum Data Set. It is also expected the NHS Wales Performance Framework 26/29 will follow.

In summary,

- The Cabinet Secretary's 3-year strategic priorities that must be delivered by all Health Boards, remain broadly the same, however there is a strengthened emphasis on quality & safety, primary care and shift to population health management and prevention.
 - Timely Access to Care
 - Population Health and Prevention
 - Community by Design
 - Mental Health Access
 - Women's Health
 - Quality and Safety
- The Cabinet Secretary sets out refreshed Minimum Delivery Expectations for each Strategic Priority, and a mandated series of 'Adopt or Justify' Enabling Actions that are central to requirements of IMTPs/ Annual Plans for submission to Welsh Government on 31st March 2026.
- The expectation is to include a clear organisational assessment of the baseline position, and the improvements to be delivered, by enabling action, to feature as an annex to the plan.
- Plans must also include an assessment of progress in delivering the MAG recommendations on performance and productivity and the priorities set out in Improving Performance Together, as well as commitment to deliver these during 2026-27.

The NHS Wales Planning Framework has been consolidated into Actions Plans and issued to key leads to ensure there are clear actions in place to address the framework.



It should be noted that in addition to reducing delayed pathways of care and increasing weekend community nursing capacity, further national requirements and expectations for the Cabinet Secretary's Priority of Community By Design are expected to be specified by the Community By Design Transformation Programme Board. In the meantime, as set out in Agenda Item X 'Delivering Services via Community by Design', the establishment of a local Community by Design Transformation Group is being proposed. This Group will work closely with clusters to progress the priorities and link with the Annual Planning process. It will also be a vital forum contributing to the development of the Health Board's Clinical Services Strategic Plan.

Key Dates and Timelines Summary

18 th Dec - 21 st Jan	Individual Programmes	• Exec and Delivery Leads – refine and develop programme plans and determine quantified implications for performance and delivery, using Templated Plan on a Page. Deadline for completion 21st January to Planning Team. • Corporate leads review and align –e.g. digital & estates – to confirm priority deliverables
21 st - Jan - 23 rd Jan	R&S & Planning (incl Deloitte)	• Gateway review of 2026-27 programme plans received, identifying key risks/ issues/ gaps which need addressing.
26 th Jan	Engagement on Plans (virtual - Workshop in Singleton Chapel stood down)	• Share and triangulate programme plans • Programmes to respond to identified risks/ issues and gaps to address using response template to be issued by Planning.
29 th Jan	Board	• Update on Plan – high level draft and ongoing process
13 th Feb	CEO	• Submit Accountability Letter to Welsh Government as unable to submit an approvable IMTP
26 th Feb	Board Development	• Draft Plan to be shared with IMs for early sight and review. • Note CEO is reviewing Plan ahead of this on 20th Feb.



24 th Mar	P&F Committee	Scrutiny of Plan
26 th Mar	Board	Board receipt of final draft Annual Plan for approval
31 st Mar	CEO	Submit Annual Plan to Welsh Government

5. PARTNERSHIP PLANNING (REGIONAL AND LOCAL)

5.1 WEST GLAMORGAN REGIONAL PARTNERSHIP BOARD (WGRP B)

The WGRP B meeting took place on 11th December 2025. The agenda included a progress update on programme delivery, an update on the Regional Investment Fund (RIF) evaluation, progress with the capital programme, and a proposal to update WGRP B governance, which was approved at this meeting. The updated WGRP B governance will reflect a focus on three key areas of work;

- Communities and Older People – focussing on strengthening pathways in partnership to optimise our service capacity and quality of care to avoid admission to hospital and facilitate earlier discharge. This programme aligns with the Health Boards UEC Programme. The C&OP Programme is co-chaired by Dave Howes, Director of Social Services in Swansea Council and by the Health Board’s Craig Wilson.
- Regional Commissioning – this programme is focussing on developing a more consistent and integrated approach to the commissioning and delivery of Continuing Health Care (CHC) and other complex, ongoing care for our Mental Health and LD population and also for older adults and children with complex needs in our community. This programme aligns with the Health Board’s local CHC Programme.

This Regional Commissioning Programme also oversees the developing capital programme for the RPB.

The RPB Regional Commissioning Programme Board and the Health Board CHC Programme are chaired by Marie Davies.

- Mental Health – this programme will focus on reconfiguring our community service model in partnership with local authority and voluntary sector colleagues and will align with the Health Board’s Mental Health transformation programme with executive leadership from Deb Lewis.

Further detailed work will be undertaken in quarter 4 of 2025/26 led by the RPB team to further define and develop the work programme and qualifiable outcome for these three areas.

Appendix 2 provides members with a full update from the WGRPB and below is brief summary.

5.1.1 Progress with WGRPB Area Plan Priority Areas by Programme

The WGRPB continues to drive transformation across health and social care, with a strong emphasis on co-production, integration, and prevention. Strategic programmes are all progressing, guided by a shared vision of seamless, person-centred care.

Notable advances include the development of innovative models such as, enhancing discharge pathways and 'Stronger for Longer' strategy, alongside robust performance monitoring through tools like PowerBI dashboards. In addition, collaborative efforts have led to improved operational performance on Pathways of Care.

The Carers Partnership Board has streamlined governance and continues to refine respite provision, develop employer guidance, and pilot awareness initiatives in primary care settings. Dementia services are being enhanced through regional strategy engagement, expanded resources, and the piloting of connector roles, while the Wellbeing and Learning Disability Programme is embedding user-led approaches and accessible information to support better engagement. Emotional wellbeing and mental health initiatives are advancing joint commissioning models, expanding digital resources, and embedding community psychology, with a focus on early intervention and data-driven planning. Children and young people's services are prioritising emotional wellbeing, transition, accommodation, and multi-agency collaboration, with the 'No Wrong Door' model and regional business cases supporting complex needs.

Despite challenges such as funding changes impacting neurodiverse services, the partnership remains committed to shared learning, best practice, and continuous improvement. The Regional Commissioning Programme is developing protocols for joint working, service specifications, and market stability, ensuring that care models are sustainable and responsive to evolving needs. Engagement with communities, third sector partners, and statutory agencies underpins all programmes, fostering a culture of innovation, accountability, and inclusivity. As the partnership moves forward, the focus remains on delivering integrated, high-quality care that empowers individuals and communities to thrive, supported by robust data, collaborative leadership, and a clear strategic direction.

The Board is asked **to consider** the progress made to deliver the Action Plan Priorities for 2025-2026.

5.2 PUBLIC SERVICES BOARDS

5.2.1 PSB Wellbeing Objectives

Both Public Service Boards met formally in October, with a full update provided in the previous Board report. During Q3, PSB workstreams continued progressing the wellbeing objectives. In Q4, both PSBs will meet again, and Swansea PSB will host its annual Partnership Forum in February. The Health Board has been asked to host the 2026/27 'Walking in Our Shoes' event, previously hosted by Natural Resources Wales (2025/26) and Mid & West Fire & Rescue Service (2024/25).

5.2.2 Future Generations Commissioner's 10-year Report

The Commissioner's report included recommendations for Health Boards and PSBs, and all have now finalized their responses and submitted by the deadline in October. Over the coming months the Health Board will work through the PSBs arrangements to ensure that the recommendations from the Commissioner's report are fully integrated into both Well-being Plans and Objectives.

In December, members of the Health Board's Management Board received a report on how the recommendations will be progressed both internally and externally and the proposed alignment to the Health Board's revised governance arrangements – the Management Board paper is attached as **Appendix 3**. The Management Board paper highlighted that the Health Board has committed to embedding the principles of the WBFGA into our organisational culture, strategic planning, and decision-making processes. The paper provides the outcome of a mapping exercise against the Health Board's Strategic Objectives and some high-level actions to be delivered by departments across the Health Board as follows:

- Embedding FGCO report recommendations into the CSP development, ensuring alignment with organisational strategy
- Developing the right culture / leadership for driving implementation of the Act (using the organisational strategy and strategic objectives as a key frame for this)
- Mapping preventative spend and putting health equity at the heart of placemaking
- Collaboration with PSBs and regional partners will ensure alignment with local well-being plans and Marmot principles, tackling health inequalities and climate resilience collectively.



5.2.3 UK Pride in Place Programme

The UK Pride in Place Programme replaces the UK shared prosperity fund (ends on the 31/03/26) with two funds that are mainly capital funds - £20 million is available over 10 years for each neighbourhood (1 in Swansea, 1 in NPT). Both Swansea & Neath Port Talbot local authorities are working on identifying two neighbourhoods that meet the selection criteria. Health Board representatives were invited to participate in the Stakeholder Engagement hosted by the two local authorities independently in December, and the importance of ensuring that selection and prioritisation is based on evidence and data, including the health needs of the Swansea Bay population was raised. The Health Board will continue to engage in the process and support the local authorities as required.

*The Board is asked **to agree** that we continue to work closely with both Swansea and Neath PSBs to ensure alignment with the Health Board's strategic and tactical planning and delivery processes and plans on a continuous basis.*

5.3 TATA Steel Update

The Health Impact Assessment (HIA) Steering Group has overseen the tendering work to commission the HIA. The tender evaluation process is now complete and a contract to undertake the work has now been issued. The grant agreement between Neath Port Talbot Council (NPT CBC) and the Health Board, established to fund the HIA, has also been signed and the HIA work programme will commence at the beginning of January 2026 – a workshop with the HIA supplier and key stakeholders will take place on 13th January 2026. A revised terms of reference for the HIA Steering Group will be established to take on board the Steering Group's role in HIA progress assurance, with the Group's reporting arrangements linking in with the newly formed People & Skills workstream, reporting up to the Tata Steel UK Transition Board.

NPT CBC, in its role as an accountable body, has ringfenced funding to support local mental health and wellbeing initiatives via the establishment of a TATA Steel UK Mental Health & Well-being Community Fund. Health Board colleagues are contributing to the development of the objectives and outcomes of this fund.

5.4 REGIONAL AND SPECIALISED SERVICES PROVIDER PLANNING PARTNERSHIP (RSSPPP)

The RSSPPP is a collaborative forum for Swansea Bay University Health Board and Cardiff and Vale University Health Board (CAV UHB). Its purpose is to develop a unified approach to delivering sustainable specialised services across the two tertiary centres in South Wales. It meets monthly.

At the meeting on 19th December 2025, members received an update on the recent joint workshop with cardiac surgeons and anaesthetists. Key outcomes included:

- Implementing a twin-track approach to reduce waiting times in South East Wales by utilising capacity within Morriston Hospital. The twin track approach involves:
 - Prioritising patients with the longest waiting times to ensure timely access to care.
 - Adopting a cohort-based referral model, enabling the referral of patients from specific areas in South East Wales directly into Morriston Hospital.
- Establishing an Operational Delivery Network for cardiac surgery across South Wales.

Members recommended that these proposals be submitted to each organisation's Board for approval.

The group also received an update on the development of the NHS Wales Joint Commissioning Committee (NWJCC) Integrated Medium Term Plan (IMTP) and agreed to apply the Tertiary Services Oversight Group (TSOG) prioritisation process to review provider risks not addressed within the NWJCC IMTP.

Further discussion focused on strategic delivery models for specialised services. Members agreed that additional engagement with TSOG is required to refine the models and criteria for identifying candidate services before submission to the Management Board.

6. COMMISSIONING

The Corporate Commissioning team is responsible for procuring services that meet the needs of our population through assessing needs; planning and prioritising services; and purchasing and monitoring the effectiveness of services in delivering the best health outcomes possible for our communities. The team's remit has significantly expanded over the years with voluntary sector commissioning coming into the team in 2024 and 2025 will see the team's remit grow further with the proposed introduction of centralised Complex Care/ Continuing Health Care (CHC) Commissioning.

The following sections highlight the key commissioning priorities and proposed actions for the Health Board.

6.1 INTER HEALTH BOARD COMMISSIONING

In December 2025, Health Boards were instructed by Welsh Government to confirm, by 27th February 2026, that arrangements for 2026/27 are in place with other Health Boards through Long Term Agreements (LTAs). Commissioning and Finance teams are actively working with neighbouring Health Boards to finalise LTA documentation and the supporting financial schedules for provider and commissioner contracts ahead of the deadline. To support this process, the Health Board is developing a comprehensive suite of commissioner and provider intentions for 2026/27. These intentions will set out the Health Board's key commissioning priorities and areas of focus for the upcoming financial year. They will provide clarity on the services and outcomes the Health Board aims to achieve, ensuring alignment with strategic objectives and national policy requirements. By clearly articulating these priorities, the Health Board seeks to strengthen collaboration with providers and partners, drive improvements in service delivery, and ensure resources are targeted effectively to meet population health needs.

A national finance-led working group has been established to develop 'Once for Wales' principles and processes for defining and monitoring Long Term Agreements (LTAs). This work is necessary as many existing LTA arrangements are historic and require review, particularly in light of post-COVID changes in patient flows and service delivery models. The development of these principles will continue throughout 2026/27; however, this should not prevent Health Boards from agreeing the 2026/27 contracting arrangements within the required timeframe.

Furthermore, through the Regional Joint Committee, SBUHB and Hywel Dda University Health Board have committed to reviewing and updating their commissioning arrangements to ensure they accurately reflect care pathways, the true cost of service delivery, and regional models of care.

6.2 PARTNERSHIP COMMISSIONING

6.2.1 Area Planning Board (APB)

Area Planning Boards (APBs) were established in 2010 as part of the new arrangements to deliver the Welsh Government Substance Misuse Strategy 'Working Together to Reduce Harm'. The APBs were intended to provide a regional framework, to:

- Strengthen partnership working and strategic leadership in the delivery of the substance misuse strategy; and,
- Enhance and improve the key functions of planning, commissioning and performance management.

The Western Bay APB (WBAPB) includes representatives from Neath Port Talbot County Borough Council, City and County of Swansea, Swansea Bay University Health Board (SBUHB), His Majesty's Prison and Probation Service Wales, the Police and Crime Commissioner for South Wales, South Wales

Police, and HM Fire and Rescue. A Welsh Government Substance Misuse Team member attends in an advisory capacity.

For the past two years, WBAPB has progressed a transformation programme to adopt an alliance commissioning model comprising clinical and non-clinical services.

Clinical Services

A new clinical services model has been co-designed through stakeholder workshops, including individuals with lived experience. The vision is for all clinical services to be delivered by SBUHB under the alliance. Service Group Leads are assessing readiness and feasibility against the agreed specification and developing implementation plans. While the alliance will formally commence on 1st April 2026, full implementation will take several years and require significant transformation, including introducing GP shared care arrangements.

The most immediate change for SBUHB will be assuming responsibility for clinical services within Criminal Justice settings from 1 April 2026. These services—currently commissioned by the Office of the Police and Crime Commissioner and His Majesty's Prison Service —will transfer to the alliance funding pool and be allocated to SBUHB. Planning is underway to ensure continuity of service during this transition. The Health Board is collaborating closely with the Area Planning Board Team to develop the specification for Criminal Justice Services, with a focus on ensuring that the financial envelope is fully aligned to the required level of service. This approach is intended to mitigate any financial risk to the Health Board in taking on responsibility for these services.

Non-Clinical Services

The procurement process for non-clinical services, delivered by voluntary sector organisations, concluded successfully in December 2025 following a competitive dialogue process. The evaluation panel consisted of representations from SBUHB, City and County of Swansea, Neath Port Talbot County Borough Council, WBAPB, Office of Police and Crime Commissioner, His Majesty's Prison Service, South- Wales Police, and people with lived/living experience. The non-clinical services budget is £2.2m, with SBUHB contributing £230,921 per annum, the remainder is funded by other statutory partners and Welsh Government Substance Misuse Action Funds (SMAF).

The contract for non-clinical services for the Western Bay Drug and Alcohol Alliance has been successfully awarded. However, at the time of writing this report, the formal award letter had not yet been issued, as final details of the Collaboration Agreement were still being agreed by the statutory

partners. It is anticipated that verbal confirmation of the contract award will be available to share at the Health Board meeting on 29th January 2026.

Once the award has been confirmed, mobilisation plans will be enacted in preparation for service commencement on 1 April 2026, including collaboration with SBUHB to ensure integrated pathways.

6.3 INDIVIDUAL PATIENT COMMISSIONING

The Health Board's Continuing Healthcare (CHC) Transformation programme continues to make good progress and the following workstreams have been identified as part of the Health Board's Recovery and Sustainability Programme:

- **Joint Funding Arrangements-** To work closely with Local Authority partners to standardise both joint funding processes and funding splits across the system
- **Operating Model-** Optimising the CHC operating model to deliver high-quality, person-centred care and ensure financial sustainability, requiring more efficient, integrated working across SBUHB and Local Authorities to meet rising demand amid limited resources.
- **Market Management-** Proactively manage and shape the market to improve value for money by engaging large/critical suppliers for renegotiation of packages, inflation management and to understand the opportunity to reduce spot purchasing.
- **Package Rightsizing and Reviews-** Ensuring timely completion of outstanding reviews and implementation of outcomes to ensure care packages are accurately aligned with people's needs.

Work is underway to develop clear and measurable actions for 26/27 that will be built into the Health Board's Annual Plan as well as progressing actions in Q4 25/26 to achieve this year's savings target.

Other key actions for Q4 25/26 include:

- **CHC Digital System-** The National Complex Care Database (NCCD), currently in use, was developed ten years ago. Over time, extensive local modifications have resulted in inconsistent data insights across Health Boards. Digital Health and Care Wales have confirmed that the NCCD should now be decommissioned and cannot be further upgraded or amended. As part of the National Value and Sustainability programme, Welsh Government have prioritised supporting Health Boards with implementation of a digital system for Continuing Health care (CHC) and complex care and have allocated funding to Health Boards for 3 years to cover licence costs. For SBUHB, work is underway at pace to ensure appropriate procurement and internal governance processes are completed.



- **Direct Payments for CHC**- Currently in Wales, Direct Payments are only available to those receiving social care through local councils however, from 1st April 2026, Direct Payments for CHC are set to be introduced under the Health and Social Care (Wales) Act 2025. This legislation allows individuals assessed for CHC to receive direct payments to secure their own healthcare services, enhancing their control and choice over their care. A national project is in place to support Health Boards with the implementation of Direct Payments and SBUHB is actively engaged through participation in the national workstreams:
 - Commissioning Advice, Coordination, Care & Support
 - Eligibility Principles based on Care Needs & Safety, Personal Assistant (PA) Training
 - Health Board Training & Communication
 - Guidance, National Communication & Information
 - Governance
 - Finance

An internal Direct Payments subgroup has also been established to oversee local implementation and progress of actions that fall out of the national workstreams. Dialogue has also commenced with our Local Authority colleagues to learn from their experience of managing Direct Payments and to also explore any potential joint working opportunities.

The financial, operational and population-level risks to the Health Board associated with implementing Direct Payments are currently uncertain, due to limited clarity around the likely volume of requests. The internal sub-group is undertaking modelling work to estimate potential demand and associated risks. Costings are also being sought for the financial mechanisms required to track and process transactions for patients in receipt of Direct Payments. This level of uncertainty is shared across all Health Boards, reinforcing the importance of SBUHB's active involvement in all national sub-groups. A detailed paper on Direct Payments, including a full implementation plan and risk assessment, will be presented to the Board in March 2026.

*The Board is asked **to consider** the actions underway to strengthen strategic and partnership commissioning arrangements, aimed at reducing risk and enhancing the quality of services for our citizens.*

*The Board is asked **to be aware** of the progress in awarding the contract for non-clinical services within the Western Bay Drug and Alcohol Alliance, and **to acknowledge** the planning work underway for the Health Board to assume responsibility for delivering all clinical services under the alliance's commissioning model.*

7. SUSTAINABILITY/ CLIMATE CHANGE

The Planning & Partnerships Team hosts the Health Board's Sustainability and Climate Change function.

The Health Board climate change programme was established in 2021, with the development of a decarbonisation plan. Since then, the programme has widened to include annual emissions reports, emissions reduction, and climate adaptation with Public Services Boards (PSBs) from 2024.

Welsh Health Circular (WHC/2025/005) requires all NHS organisations to complete a Climate Change Risk and Opportunity Assessment (CCROA) by December 2025. The purpose of the CCROA is to identify risks and opportunities related to climate change and to inform future adaptation actions, helping the Health Board strengthen its resilience against climate-related impacts.

Appendix 4 contains the Health Board's CCROA. In order to compile the CCROA, the Health Board undertook a climate adaptation literacy session, distributed questionnaires, Service Group / Corporate area meetings, sessions with Green Group, formation of a task and finish group, and regular updates to the Climate Action Plan Implementation Group. This initial focuses primarily on service delivery and has been shaped by the input of the key representatives from Mental Health & Learning Disabilities; Primary Care, Community & Therapies (including buildings); GP contractor; Morriston Hospital; Singleton Hospital, Neath Port Talbot Hospital; Support Services; Workforce & OD; Commissioning; Estates & Capital Planning; and Digital. It also involved pilot with a GP from Upper Valleys cluster to test whether the Welsh Government toolkit was appropriate in this situation.

The CCROA process identified 135 risks across the Health Board and recognised there is significant work already occurring that supports climate adaptation, which includes improving patient hydration, ability to work from home, digital tools to enable offsite consultations, preventative maintenance, and Welsh Health Technical Memorandums. The most consistent risk treatment utilised was the Business Continuity Process, with impacts from climate change being considered to varying degrees. However, as climate related 'events' become more frequent and 'normal' there will be a need for better consideration of how 'prevention' of these incidents can be achieved over reactivity.

The proposed approach for the Health Board is to accept the risks scoring less than 12, with further risk treatments and investigations developed for the 33 risks scoring greater than 12. Some elements require further investigation being managed internally, and others requiring an All-Wales approach. The risks will be incorporated into the Health Board's refreshed

Climate Action Plan which will be taken through internal sign off in February 2026 and shared with Board in March 2026.

Furthermore, from the CCROA undertaken by NHS Wales organisations in 2025, it was recognised there are areas where there are risks, but not sufficient evidence bases to understand them. These areas have been identified by a collaborative group of Climate Preparedness Leads, nominated individuals who attended two training sessions by Local Partnerships, arranged by Welsh Government. The Leads also recognise the current challenges around funding and resourcing. To individually address each area within NHS Wales would result in significant duplication and waste of resources. Therefore, it has been proposed that the most effective way would be to build an evidence base and understand risks at a systems level. A proposal for building an all-Wales approach to climate adaption has been drafted and will be taken through the Health Board's Directors of Planning for consideration.

*The Board is asked **to endorse** the Health Board's Climate Change Risk and Opportunity Assessment (CCROA) and be aware of further work required to integrate the results of the CCROA into the refreshed Climate Action Plan.*

8. EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR) AND RECOVERY

The EPRR programme continues to strengthen organisational readiness, statutory compliance, and Health Board resilience through focused work on planning, training, exercising and governance improvements. The December 2025 update highlights notable progress as well as persistent challenges requiring continued organisational attention.

Key Achievements and Progress

- **Training & Exercising:**

- Major incident, business continuity, and communications exercises were successfully delivered across all Service Delivery Groups (SDGs), including Welsh Ambulance Service Trust, (WAST) -led no-notice, major incident communications testing, HB-wide, business continuity and major incident communications exercises, Exercise Ventus 2, (a Health Board major incident exercise for clinical teams) and multi-agency flooding exercise (Exercise Water World 2), where there was Health Board gold representation.
- Silver Commander training compliance has begun to improve (now 51% overall), while Gold compliance has decreased to 64%, this is due to staffing changes.



- **Business Continuity Management, (BCM):**

- Internal Audit (Jan–Feb 2025) provided *limited assurance* but significant progress has been made, including delivery of BC tabletop exercises across all SDGs. The identified learning from these exercises is being progressed and monitored by the Health Board EPRR Oversight Group.
- Three of 21 audit actions remain outstanding, primarily linked to risk management processes and Directorate of Information, Communication and Engagement, (DICE) approvals (eg. warning & informing templates and a crisis comms framework).
- A HB-wide digital/telephony outage on 22 October demonstrated markedly improved organisational response and resilience.

- **Major Incident Procedure Review:**

- The suite of Major Incident Procedures was reviewed, approved and formally relaunched in December 2025, supported by a communications campaign.

- **Regional & National Alignment:**

- Updated NHS Wales Mass Casualty Incident Arrangements have been adopted.
- The HB contributed to Exercise Pegasus (national pandemic preparedness) with further internal pandemic plan testing scheduled for early 2026.

Governance, Oversight & Risk

The **EPRR Oversight Group** continues to strengthen statutory compliance through structured monitoring and improved service engagement, with a continued focus on attendance and consistency.

- A digital performance dashboard is being enhanced further to automate monitoring of Business Continuity Procedure, (BCPs) review dates and commander training compliance.
- The overarching aim is for EPRR to be embedded into daily business, providing system wide readiness, assurance and coordination by strengthening business continuity arrangements, training and supporting multi-agency alignment.
- Persistent challenges include:
 - Inconsistent understanding of EPRR roles across services.
 - Ongoing training and BCP compliance gaps.
 - Varied participation from some Silver on-call representatives in multi-agency exercising.



- Delayed progress on the development of a Health Board National Power Outage Framework workstream due to resource constraints within Estates Directorate. A group will be established in January 2026.
- Outstanding actions related to crisis communications.

Forward Look & 2026 Priorities

- Further strengthening preparedness in high-risk areas: Chemical, Biological, Radiological, Nuclear, (CBRN), pandemic response, national power outage planning.
- Updating the EPRR risk register following Wales Risk and Preparedness and local reviews.
- Delivering the developing 2026 EPRR training and exercise programme, including a HB pandemic exercise, distribution of countermeasures testing, and a 3-yearly live Major Incident exercise, alongside the core training programme.
- Continued focus on embedding EPRR within operational planning and ensuring accountability across all Services.

Overall Position

*The Board is asked **to note** the priorities and progress made through strengthened governance and enhanced oversight, and to take assurance that focused action continues in areas where gaps remain; specifically, Business Continuity compliance, training uptake, and the resourcing of key resilience workstreams. Sustained cross organisational engagement, clear prioritisation, and appropriate investment will be essential to maintaining statutory EPRR readiness.*

*The Board is also asked **to approve** the SBUHB Severe Weather Procedure v4 (**Appendix 5**).*



Governance and Assurance		
Link to Enabling Objectives <i>(please choose)</i>	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
The content of this report describes the planning process and approach that will ensure an appropriate and integrated focus and approach to delivering improvements in quality, safety and patient experience.		
Financial Implications		
The content of this report describes the planning process and approach that will support an approach, both strategic and tactical, that aims to deliver our target control total in 3 years.		
Legal Implications (including equality and diversity assessment)		
There are no immediate direct legal implications arising from this report although all service changes – strategic and tactical – will be subject to equality, health and quality impact assessments.		
Staffing Implications		
The content of this report describes the planning process and approach that will ensure an appropriate and integrated approach to workforce planning at both strategic and tactical level and in collaboration with our partners.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		

Our wellbeing objectives and ways of working, as described in the Wellbeing of Future Generations legislation, are reflected in our planning guidance and documentation for both our IMTP and strategic plans.	
Report History	The first Planning & Partnerships report was submitted to the Health Board for information and discussion on 29 th May 2025.



Meeting Date	29 January 2026	Agenda Item	4.1i	
Name of Meeting	SBUHB Board			
Report Title	Perinatal Committee Report			
Report Author	Kathyrn Greaves – Director of Midwifery Sujoy Banerjee – Associate Service Group Medical Director - CYPWH			
Report Sponsor	Elizabeth Rix, Executive Director of Nursing and Patient Experience			
Presented by	Elizabeth Rix, Executive Director of Nursing and Patient Experience			
Freedom of Information	Open			
Purpose of the Report	The purpose of the paper is to provide the Board with an update: from the Perinatal Committee, assurance and information relating to the risks to quality, safety and patient experience in maternity and neonatal services, with escalation of any key areas of concern.			
Key Issues	A Perinatal Improvement Programme has commenced in 4 workstreams headed by an executive member following the recommendations of the oversight panel with a view to implement the recommendations of the external review. The Perinatal Committee continues to monitor quality, safety and patient engagement and experience outcomes (business as usual) and provides a system of Alert, Advice, Assure to Quality and Safety Committee and Management Board			
Specific Action Required (please choose one only)	Information	Discussion	Assurance	Approval
	☐	☐	☒	☐
Recommendations	Members are to: BE ADVISED THAT: The Perinatal Improvement Plan Executive Programme Board will develop and monitor improvement plans in response to the Independent Review, All Wales Self-			



Assessment and other improvement actions, will be triangulated and any gaps will be added to the overall improvement plan.

- Perinatal Improvement Programme Executive Board was held in December 2025, with workstreams agreed, Executive and service Leads assigned. Workstream meetings arranged and outputs will be reported via the Perinatal Improvement Programme Board.
- Perinatal Committee meets monthly and reviews all key metrics for perinatal services.

BE ASSURED THAT:

- The Perinatal Service does not currently have any elements of care that would flag as a Negative Outlier.
- Any stillbirths or neonatal deaths have been reported through the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) process.

BE ALERTED TO:

- There has been a strong steer nationally that there will be an All Wales maternity triage service developed as a recommendation from the All-Wales Perinatal Assessment. The Perinatal Improvement Plan Executive Programme Board has agreed to pause development of a standalone SBUHB model pending publication of the Assessment (due end of Jan 2026).
- Mitigating action to provide a single point of contact triage phoneline will be complete by February 2026. Calls will be to a single telephone entry point where women will be directed to the appropriate department based on their needs. This process will ensure that all calls for maternity triage are directed to one place.

Perinatal Committee Report

1. INTRODUCTION

This report is intended to provide assurance and information relating to the risks to quality, safety and patient experience in maternity and neonatal services, with escalation of any key areas of concern.

2. BACKGROUND

The Perinatal Committee was established in June 2025, to provide assurance to the Board that an evidence based, quality assured, safe and sustainable service for women, people and babies receiving maternity and neonatal care at Swansea Bay University Health Board.

The Perinatal Committee reports directly into Quality and Safety Committee and noted via Service Group Quality, Safety & Risk Group and Senior Leadership Team.

The Perinatal Committee focuses on the business-as-usual activities provided across our perinatal services. Matters relating to the Perinatal Improvement Plan are reported separately via the Perinatal Improvement Programme Board and into Management Board.

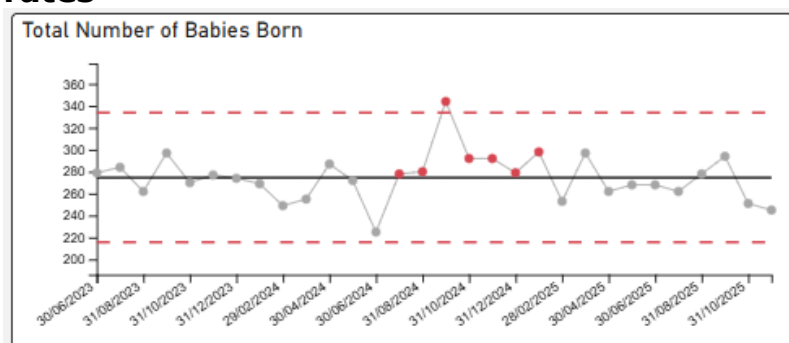
3. GOVERNANCE AND RISK ISSUES

Information and graphs/tables to be included by Service leads:

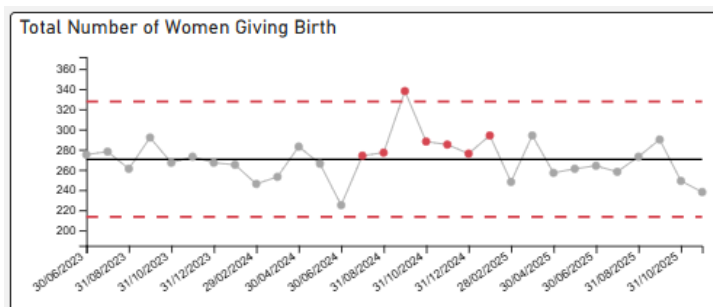
Key updates from Perinatal Committee

As previously agreed, the following measures are some of the high-level information we review within our perinatal committee.

3.1 Number of births, caesarean section births and Surgical Site Infection rates



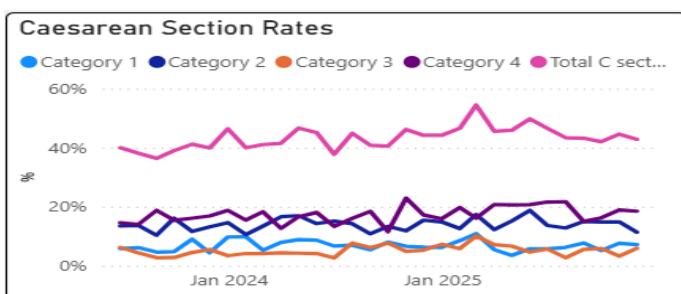
In November 2025,
238 women gave
birth and 249 babies
were born. Normal
variation



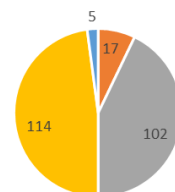
Classification of Caesarean Sections

Elective – Includes Category 3 and 4

Emergency – Includes Category 1 and 2

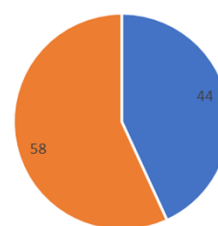


Mode of Birth



Mode of birth
Caesarean Section
Vaginal birth after caesarean section
Instrumental (assisted)
Vaginal

Category of Caesarean Section



Emergency
Elective

NHS maternity statistics data sets suggest caesarean sections should account for 42% of births (2023/2024), there is a national upward trend in C-Sections with Swansea Bay University Health Board (SBUHB) rates recorded as 43% (as seen above). National Maternity and Perinatal Audit (NMPA) data published in 2025 (reports 2023 data i.e. lags by 2 years) reports UK planned caesarean section rate as 16.4% (15.1-17.9%). SBUHB planned caesarean section rates were 19.87% in 2023 (outlier in NMPA report), 22.85% in 2024 and 25.2% in 2025. This is consistent with an increasing trend of planned C-sections which has been reported nationally. In some parts of the UK this mode of birth has been reported as being higher than vaginal births for the first time in recorded data collection.

In contrast our Emergency C-section rate is not an outlier on NMPA report. This suggests a greater influence of maternal choice in relation to elective C-section as a mode of delivery.

A C-section working group has been established to provide women with comprehensive and balanced information, enabling them to make fully informed decisions regarding their care.

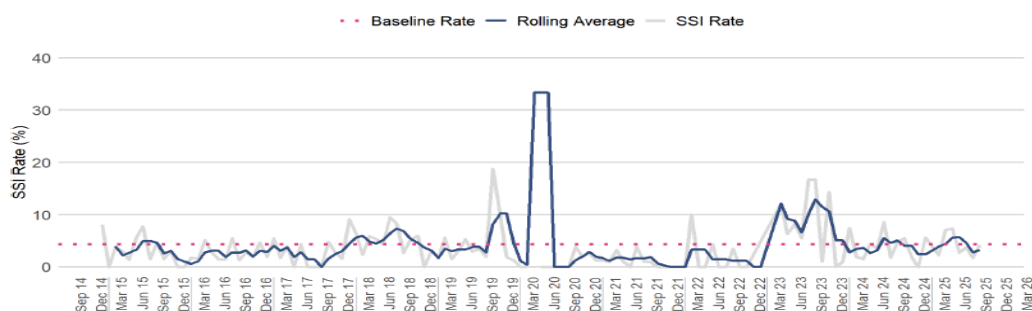
Surgical Site Infection:



Surgical Site Infection (SSI) data for all C-section shows a decrease in quarter of the number of infections reported with improvements in compliance of reporting to provide accurate data capture and tracking (Source: Public Health Wales)

Hospital and health board data from 01 Oct 2024 - 30 Sep 2025

	SSI Rate	Change	Valid data
Singleton			
Q4 2024 - Q3 2025	3.88%	↓10.8%	99.93%
Q4 2021 - Q3 2024 *	4.35%		79.8%
SBUHB			
Q4 2024 - Q3 2025	3.88%	↓10.8%	99.93%
Q4 2021 - Q3 2024 *	4.35%		79.8%



Local SSI rates

There is an increase in the SSI rate for October 2025 of 13.64%. On review of all swabs taken for potential of SSI, a majority of the swabs taken were taken under Primary care. As part of local quality improvement, Midwives have undergone training in the identification and reporting of SSI. Therefore, it is unclear from documentation of swabs taken by the Primary care team if there were true symptoms of an SSI or if correct cleaning of wound was undertaken prior to the swabs. The service has reinforced the need for Community Midwives to be the point of contact to review wounds within 28 days from birth.

Public Health Wales Healthcare Associated Infection, Antimicrobial Resistance & Prescribing Programme (HARP) team have confirmed that the definition of SSI and parameters for reporting have been standardised to <14 days. Therefore, the service to report SSI <14 days from January 2026. To continue data collection for <28 days until January 2026 due to ongoing Quality Improvement (QI) project.



3.2 Neonatal Mortality and Morbidity

All stillbirths, Neonatal Deaths and brain injury cases are reported via Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE). MBRRACE's purpose is to identify patterns, causes, and preventable factors in maternal and perinatal mortality and morbidity.

All cases receive internal and where indicated external investigation using the Perinatal Mortality Review Tool to support understanding and identify any modifiable causes to support families understand the causes of the death or brain injury and to support both local and national learning for improvement. Families are encouraged to be engaged with this process and have an assigned point of contact, who welcomes questions to be included within the review. The crude rate for Perinatal deaths in 2023 from MBRRACE was 7.49/1000 births with a stabilised and adjusted rate of 5.87 (95% CI at 4.84-7.76). In 2024 the crude rate was 5.72/1000 births (awaiting stabilised and adjusted rates). The 2025 data updated till the end of November calculates the crude perinatal mortality as 5.06/1000 births, but we will need to wait for full years data to get an accurate crude mortality rate. MBRRACE has not published the 2024 data yet and we are unable to report the adjusted and stabilised mortality rates until the publication of the MBRRACE report. MBRRACE report data in quarter 3 2026/27 each year.

3.2.1 Stillbirths from January – November 2025

There have been 11 stillbirths during this period, all are included in the MBRRACE reporting data. One case did not receive any antenatal care within Swansea Bay; one was an unknown pregnancy that delivered pre-hospital with maternity services involved postnatally to provide care and support. Based on current rates of stillbirth in the UK the national rate for number of births for a unit our size is 12 to 13.

3.2.2 Neonatal Deaths from January – November 2025

There have been seven neonatal deaths between January 2025 and November 2025 and of these cases five are reportable to MBRRACE as two were over 28 days of life. Of these five, only two will be represented in the MBRRACE report as deaths <24 weeks gestation are not included in the final report for analysis. The three deaths not included in MBRRACE analysis were extremely pre-term (less than 24 weeks) at the limit of viability.

There have been no deaths reported since August 2025. This is lower than what has been seen in recent years for SBUHB. We need to include December data before drawing firm conclusions.

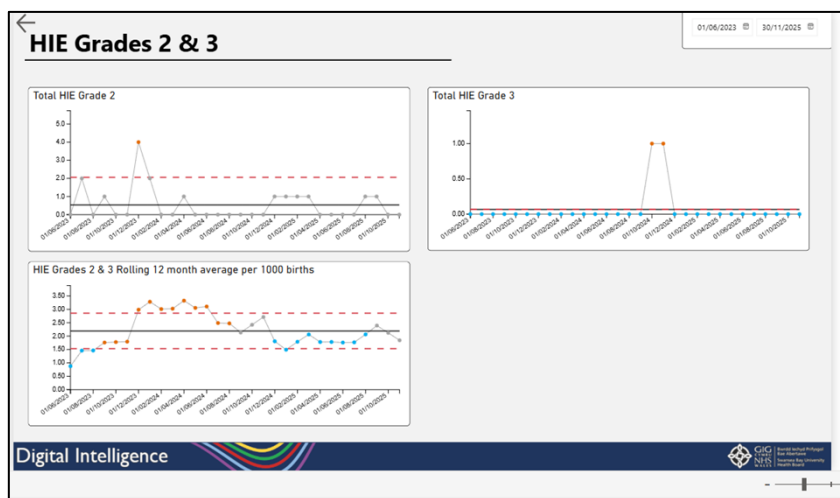
3.2.3 Hypoxic-Ischemic Encephalopathy (HIE) from January – November 2025

There have been five cases of HIE reported in this period. All babies survived to discharge with good outcomes. There is limited data published to allow National

benchmarking. Latest published data from National Neonatal Research Database (NNRD) is 4 years out of date (Department of Health, 2021 data). This reports a UK average incidence for Moderate and Severe HIE cases of 1.59/1000 births (1.49-1.70).

Due to the low number of HIE and births in SBUHB a rolling 12-month HIE incidence reporting is more appropriate. This shows that in November our moderate to severe rolling 12-month HIE rate was 1.84/1000 births. This represents a 45% decrease since its peak in April 2024 of 3.32/1000 births.

The 2025 HIE rate up until November was 1.68/1000 births.



3.3 Triage Metrics

Birmingham Symptom Specific Obstetric Triage System (BSOTS) is the Maternity services emergency department to support women experiencing concerns or urgent complications with their pregnancy or postnatal period. The following metrics help the system understand how effective, efficient, timely and safe our triage system is in responding to these.

In October 466 women were reviewed in triage and assessed for ongoing care requirements.

Initial triage within 15 minutes, standard is 90% - rate in October 90.80%.

Category	Category description	Number and percentage of total cases in month
Red	Number of women requiring ongoing immediate care	3 (0.6%)
Orange	Number of women requiring ongoing care within 15 minutes	68 (14.5%)
Yellow	Number of women requiring ongoing care within 1 hour	320 (68.8%)

Green	Number of women requiring ongoing care within 4 hours	46 (9.8%)
Uncoded cases		29 (6.2%)

Communication has been sent to remind staff of the requirement for all cases to be coded. There were no incidents relating to harm reported in month. There were 4 incidents reported due to delay in obtaining medical review following initial assessment and risk stratification for yellow, amber and red pathways, which amounts to a breach of time for review of 6.9%. There were no incidents relating to harm reported as a result. Where breach in time to review is identified, an additional measure which looks at what time review was achieved will be introduced.

Singleton Maternity Triage Team celebrated 1 year since roll out of BSOTS in November 2024. During this period 5955 women attended for review - 4426 women self-referred, 526 were referred by Antenatal Clinic, 588 were referred by other allied health professionals. Congratulations to the team for their hard work, dedication and commitment to improving safety for our women, babies and service.

3.4 Third and fourth-degree tears

Changes to clinical coding of some outcomes had shown a lag in data being updated on the Perinatal Dashboard. This has been resolved at pace to enable service oversight.

Latest data published by the National Maternity and Neonatal Audit (NMPA, 2023 data) reports a UK incidence of 3.29% (2.60-3.80) for 3rd and 4th degree perineal tear. Reviewing 2025 data, SBUHB would have a rate of 3.37/1000 births which is within the 95% confidence limit for UK data and shows a reduction from 2024 data of 4.08/1000 births. This figure can be as high as 6% for first time mothers. SBUHB do not currently stratify data by parity, but this will be a future consideration.

The use of instruments at birth carries a higher risk of sustaining perineal trauma. The NHS Wales data dictionary has been consulted and confirms how the calculation should be made. Using this data standard to calculate 3rd/4th degree tears the rate for November 2025 is 0.68%. When benchmarked against national data, SBUHB performs well. The Royal College of Obstetricians and Gynaecologist reports a national rate of 2.9%. (Green Top Guideline No.29).

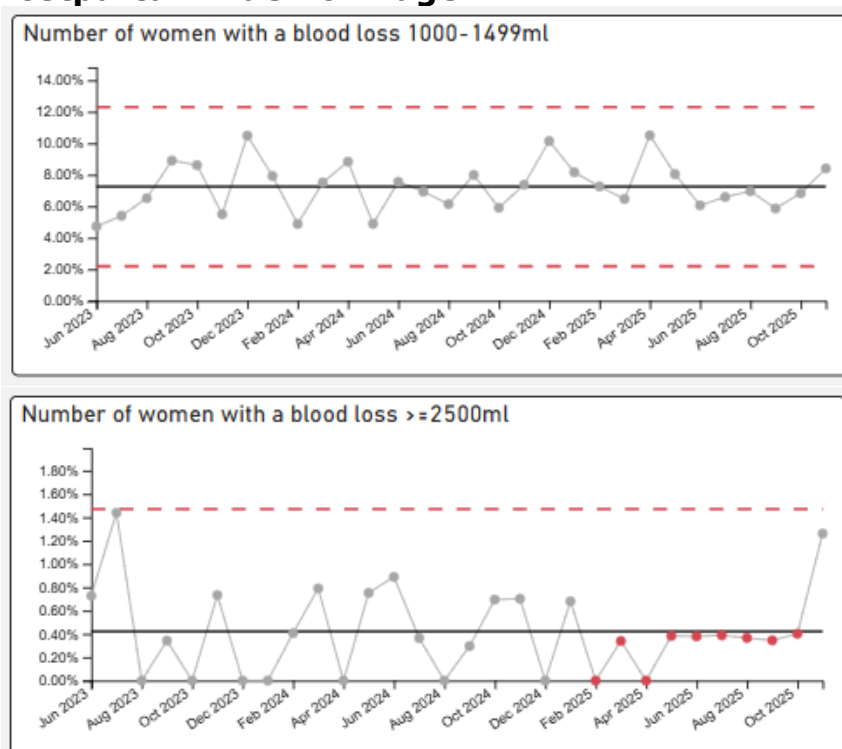
Episiotomy rate for November in SBUHB was 10.5%. National data for all births in the UK is not collected via the National Maternity Perinatal Audit. However, according to the NHS Maternity Statistics, England for 2023/24, the rate of vaginal births with episiotomy was 13.9%. All instrumental births are currently reviewed including an audit of elective episiotomy. Any learning is fed to the quality



improvement project that is looking for interventions and mitigations to reduce the occurrence of third and fourth-degree tears and the risk factors associated with perineal trauma.

A future consideration for the Perinatal Dashboard is disaggregating the episiotomy rate by mode of birth. We will explore the potential delivery of this data by the end of quarter 4 2025/26.

3.5 Postpartum Haemorrhage



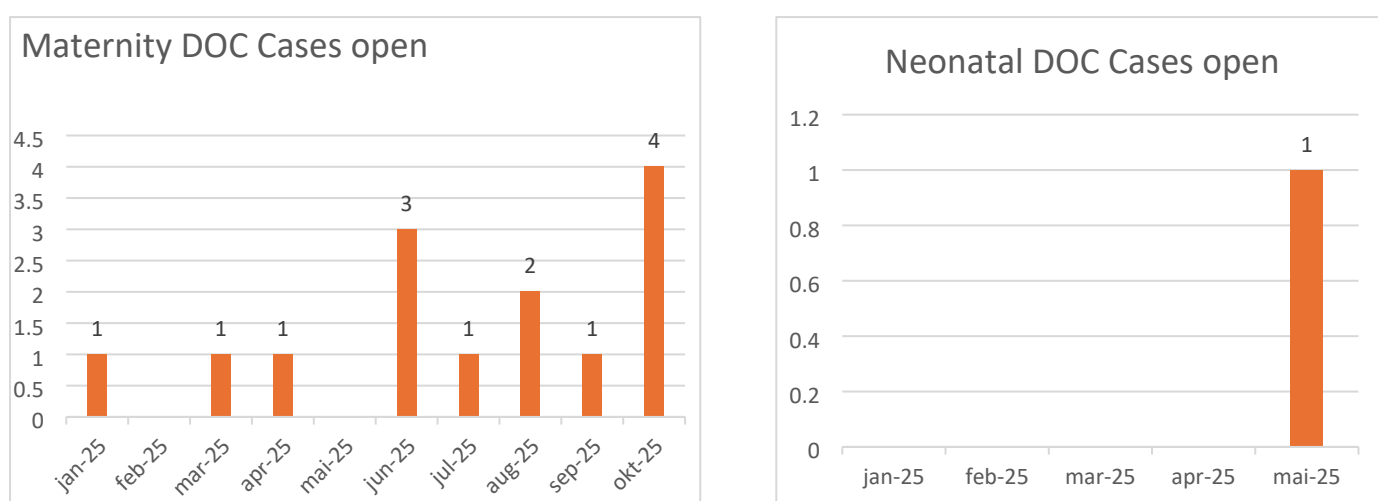
In November, the service experienced a very small number of cases involving blood loss that met the criteria for reportable obstetric haemorrhage. Each of these cases was promptly subjected to a rapid review by the Multi-Disciplinary Team (MDT) to ensure there were no breaches in duty, confirm compliance with management guidance, and identify any early learning opportunities. All cases were appropriately risk assessed and managed, and each occurred in the context of complex birth modes where the likelihood of haemorrhage is inherently higher. Importantly, these events remained within national benchmarking standards.

The NMPA published 2023 data for National benchmarking and reported postpartum haemorrhage incidence as 3.41/1000 births (2.98-3.79). SBUHB rate for postpartum haemorrhage in 2025 was reported as 2.49/1000 births, lower than the National benchmark. This showed a steady reduction from 2024 data, of 3.51/1000 births.

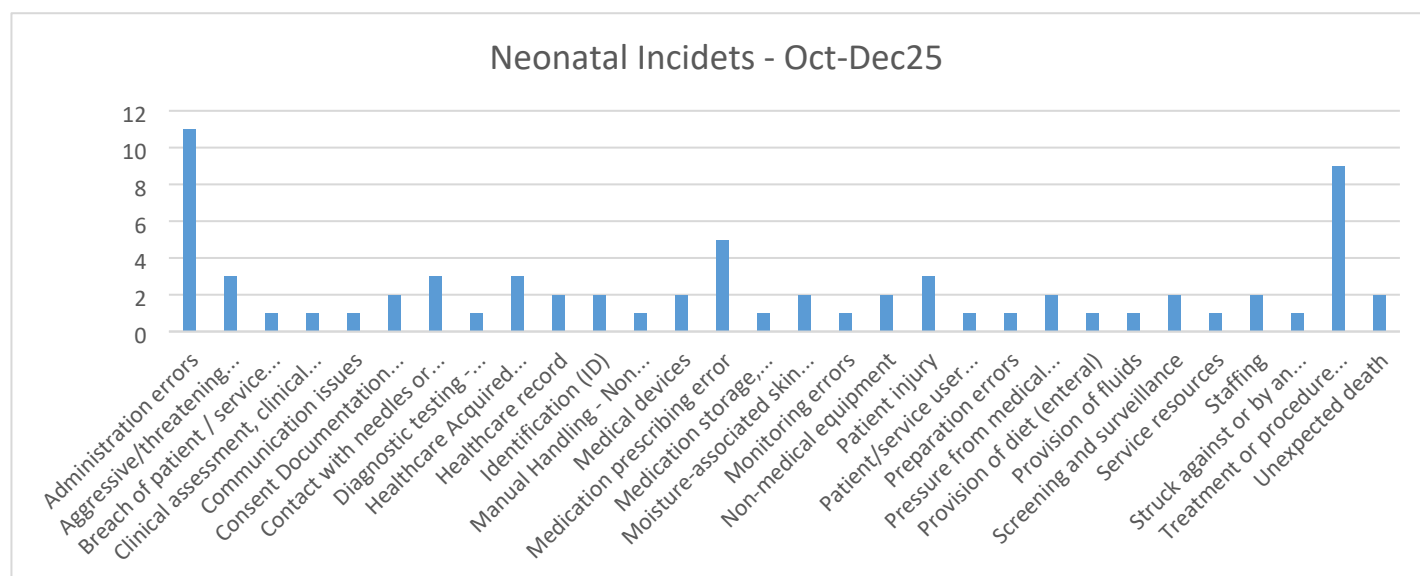
3.6 Perinatal Incident Reporting

Work continues to maintain the improvement in the reduction of overdue open incidents across perinatal services, this includes weekly incident review meetings, rapid reviews of any incident of moderate harm and above, with early learning identified and shared. Significant improvement is noted with regards to open incidents, incident investigation and closure processes. Learning is identified and disseminated regularly through safety alerts where applicable, monthly Risky Business Newsletters, and risk meetings across the perinatal services. Complaint resolution back log has been reduced to just 3 months except cases requiring external review or Coroner's input. Duty of Candour (DoC) processes are in place and timely. The Legal redress cases are reducing slowly.

Perinatal DoC cases – as at 01.12.2025

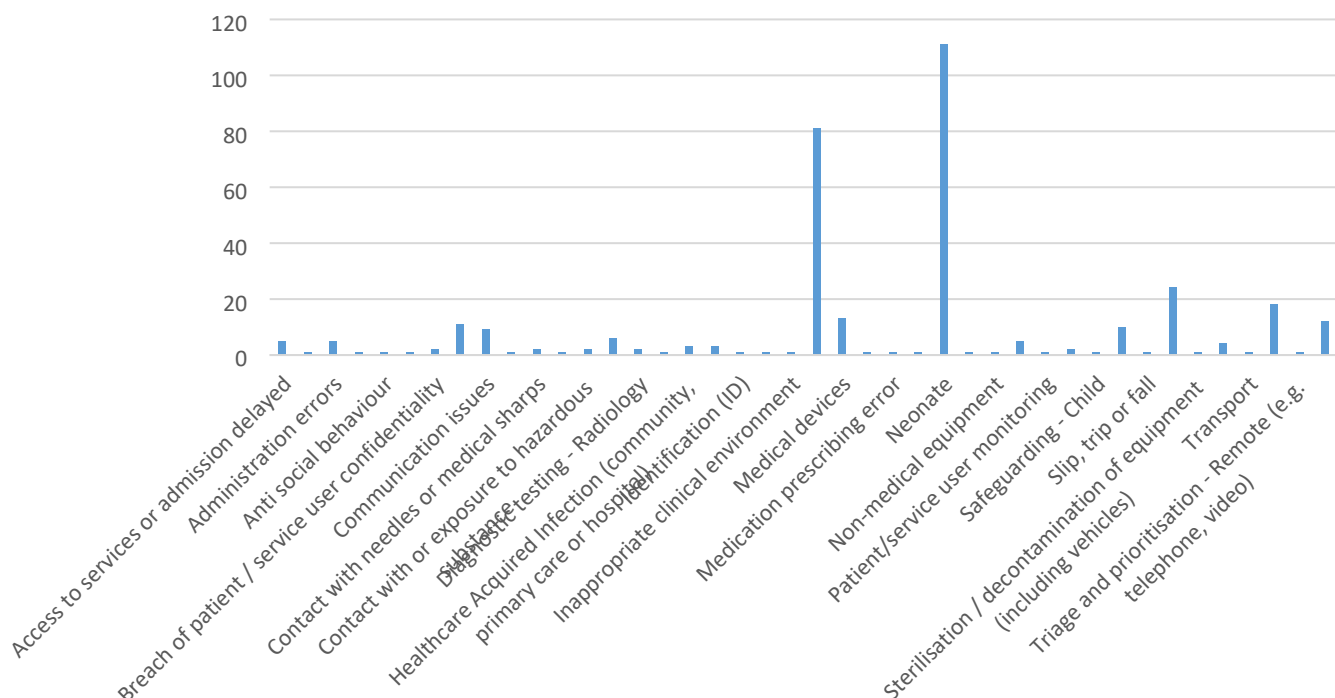


Types of incidents – Perinatal Services – 01/10/25-31/12/2025



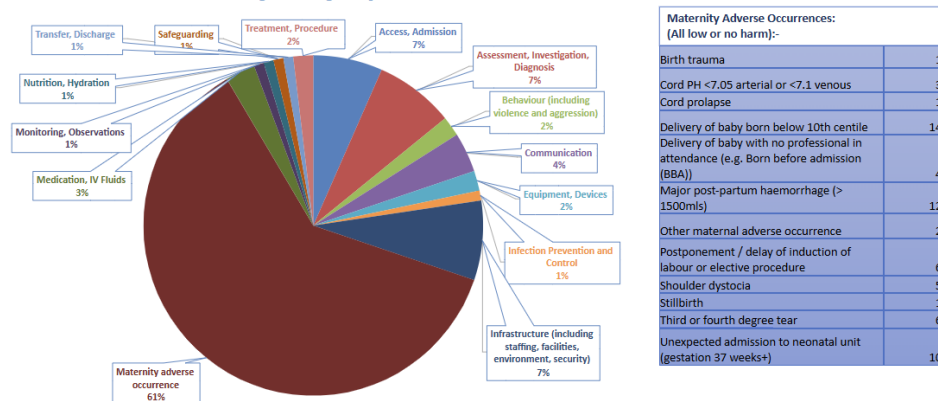


Obstetric Incidents - Oct-Dec25



The highest category of incident is classified under 'neonates'. The Maternity trigger list refers to the mandatory reporting of incidents within the service under Maternity and Neonatal. A further break down of incidents in relation to these categories can be seen in the below chart.

Incident review – Maternity Newly Reported Incidents: 01/11/2025 – 30/11/2025



The mandatory reporting of incidents includes unexpected term admission to the neonatal unit and babies born small for gestational age, shoulder dystocia and baby born prior to arrival. All unexpected term admissions to the neonatal unit are reviewed by the perinatal multi-disciplinary team for individual learning and

thematic review. Thematic review has identified quality improvement opportunities such as the implementation of 'ASTRA' - Avoiding Short Term Respiratory Admissions to the Neonatal unit. The outcome of the ASTRA quality improvement cycle will be reported at Perinatal Committee and reported via this mechanism to board.

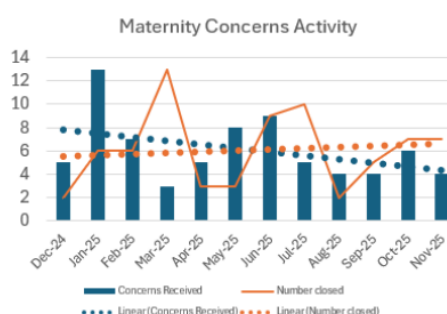
3.7 Patient Feedback and Experience

The service continues to capture feedback via friends and family, and we are the pilot site for the NHS core questionnaire. The Core Questionnaire pilot sends a text to users of our services at five points during their pregnancy, the responses are received and responded to by the senior midwifery and nursing team. Where concerns are raised, direct contact is made with the family, either on the ward, or via a telephone call to talk about their experience and we work with the woman and family to ensure improvements are made.

Common themes from patient feedback are around access to services, in particular waiting times within antenatal clinic. An antenatal clinic review is in progress which will consider a number of complex care requirements involving the coordination of several services to streamline and minimise waits for women.

There are currently 13 outstanding Perinatal formal concerns and whilst five are overdue they are in active management. Two are in an external review process, four in final stages of completion and one due to close following a meeting with the women.

Perinatal Concerns Outstanding – as at 01.12.2025



- Maternity have 13 formal concerns open – of which 5 concerns are currently overdue
- Neonates have 2 formal concerns open – of which 1 concern is currently overdue

Engagement with Diverse Communities – Maternity Services

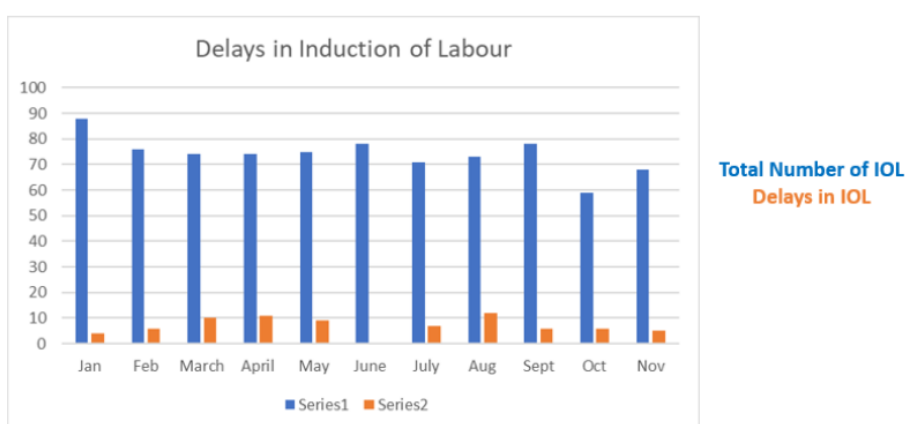
Swansea Bay University Health Board's maternity services are actively progressing initiatives to ensure inclusive, culturally sensitive care informed by lived experiences. Current actions include collaboration with community groups such as the 'Mums and Toddlers Foundation' and 'Chai and Chat' to gather feedback and strengthen representation in service planning. Work is underway to establish a Black, Asian, and Minority Ethnic (BAME) Advisory Network to embed

diverse voices in policy and improvement decisions. Feedback mechanisms, including Civica surveys and outreach sessions, are being expanded with translation support and cultural awareness questions. Staff engagement in equality, diversity, and inclusion (EDI) training and events continues, alongside implementation of fast-track antenatal services for BAME families. Inclusive practices are visible across clinical areas through multilingual signage, diverse educational materials, and access to interpretation services. Future plans include enhanced demographic data collection, culturally inclusive communications, and recruitment of diverse representation within the Maternity Voices Partnership.

3.8 Induction of Labour delays

Delays in induction of labour continue to be monitored and escalated to ensure clinical prioritisation and service requirements to improve flow based on clinical acuity. All delays are Datix reported to ensure any triangulation of any harm as a result. Through this process, no delays reported have resulted in harm.

Delays in Induction of Labour



3.9 Workforce

There have been some challenges within the Neonatal medical workforce due to unavailability, this has been mitigated with flexible working arrangements which has meant there has been no gap in service. A Neonatal Consultant was successfully recruited on the 9th of December, with 1 expected return following maternity leave in January.

Obstetric workforce – 2 fixed term gaps for career break and other leave have been covered with no vacancies impacting on services.



Workforce – Establishments and Vacancies – Month 2025

Neonatal Medical Staffing

Grade	Establishment (WTE)	Vacancy
Consultant	11	0
Speciality Registrar	15	0
8A Nurse Practitioner	4	0
8B Nurse Practitioner	2	0

Neonatal Nursing**

Band	Establishment (WTE)	Vacancy (WTE)
7	13.92	2.52
6	32.09	11.25
5	36.88	Over 19.84
4	3.41	0.96

Neonatal Consultant recruitment for substantive post – appointed on 9th December
Consultant to return from Mat leave January 2026
1 Consultant 0.8 WTE LTS

BAPM Standards Compliance (Nursing)

	Shift Level	% Shifts at BAPM	% Bank Nursing	Ave Person on Shift	Ave Nurse required on Shift	Additional shifts required for BAPM
Singleton NICU	3	% 100	% 0.16	11.94	3.23	0.0
National Average	3	% 86.81	% 6.92	N/A	N/A	N/A

Workforce – Training Compliance

NLS Neonatal Training	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Nursing	100%	100%	100%	81%	97%	99%	95%	95%	95%	95%	95%	88%	
Consultants	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Junior - Tier 1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Junior - Tier 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	

MoNET training	Compliance
Consultants	82%
T1 + T2	75%
ANNP	100%
Band 7	80%
Band 6	95%
Band 5	78%
Total	85%



Workforce – Establishments and Vacancies – Month 2025

Obstetric and Gynaecology Medical Staffing, including Gynaecology Oncology

Grade	Establishment (WTE)	Vacancy
Consultant	22	1 (retirement)
Speciality Registrar	12	0

Antenatal Clinic

Band	Establishment (WTE)	Vacancy (WTE)
Neath	3.57	0.4
Singleton	7.83	1.19

Vacancies for NPT ANC filled and Singleton ANC being shortlisted

Midwifery – Obstetric Unit

Band	Establishment (WTE)	Vacancy (WTE)
7	12.96	0.86
6	71.43	10.26
5	20.04	>20.04*
4	8.08	1.76
3	5.21	3.32
2	14.28	8.47

Over establishment of Band 5 Midwives, 6 Band 5 Midwives due to progress to Band 6 by end of November 2025.

Midwifery – community

Band	Establishment (WTE)	Vacancy (WTE)
Band 7	8	0
Band 6/5	38.16	0
Band 3	6.8	1.8



Perinatal workforce Training and Compliance

Statutory and Mandatory Training	Jan-25	Feb-25	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25	Sept-25	Oct-25	Nov-25
* Welsh Government Target 85%											
Medical Staff											
Obstetric	94%	88%	96%	93%	82%	78%	91%	85.4%	81%	81.0%	85.4%
Neonatal	91%	91%	87%	86%	86%	87.1%	86%	84.8%	76.3%	80.4%	88.63%
Additional Clinical Services											
Maternity	92%	92%	86%	88%	91%	92.9%	94%	93.5%	91.5%	91.5%	93.0%
Neonatal	82%	82%	94%	94%	86%	100%	100%	100%	97.3%	97.3%	97.3%
Nursing and Midwifery											
Maternity	94%	94%	92%	93%	95%	95.5%	96%	96.1%	94.8%	94.8%	95.4%
Neonatal	94%	94%	92%	85%	94%	95.2%	95%	95.6%	92.4%	92.4%	95.2%



Workforce – Training Compliance

Maternity Training	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25	Sept-25	Oct-25	Nov-25
Prompt														
Obstetric Medical Staff	100%	100%	100%	100%	98%	95%	95%	95%	95%	96%	100%	100%	95%	95%
Midwifery	95%	96%	92%	91%	89%	95.5%	92%	92%	95%	99%	99%	97%	95%	91%
Anaesthetics	100%	100%	100%	100%	98%	100%	98%	98%	98%	100%	100%	100%	100%	98%
Community PROMPT														96%
Fetal Surveillance	94%	94%	94%	94%	94%	94%	96%	94%	97%	97%	97%	99%	88%	98%
Maternity Workshop														14%
NLS	95%	96%	94%	90%	93%	91%	95%	93%	97%	99%	95%	96%	94%	94%
Gap Grow														
Obstetric	100%	97%	83%	*Excl	*Excl	100%	100%	100%	95%	97%	95%	91%	90%	88%
Midwives	95%	91%	91%	85%	73%	86%	76%	90%	96.2%	96%	94%	91%	90%	89%
Safeguarding														
Safeguarding People (F2F)														
VAWDASV														
Midwives														
Obstetrics														



GAP Grow

Midwives – Targeted intervention. All Midwives emailed to complete before end of month.
Obstetric – Emailed to Clinical Lead – for one to one meetings if not completed by end of month

Compliance is improving across the board and individual staff out of compliance have been emailed to complete their mandatory training. Respective line managers will follow this up.

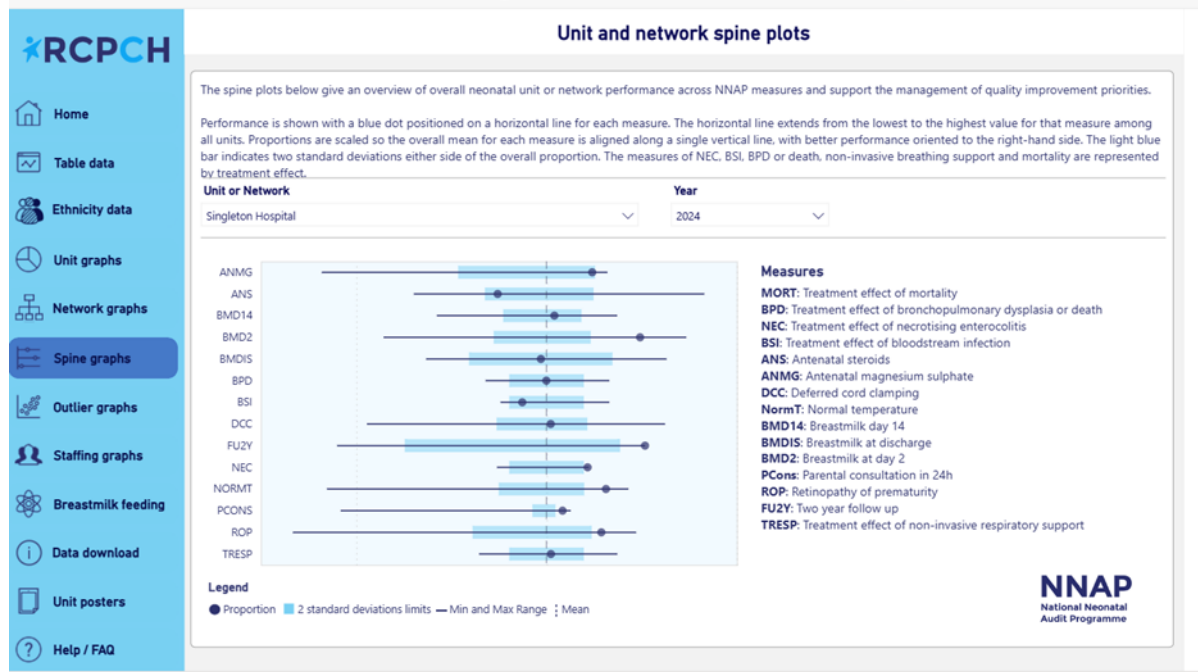
3.10 Infection Prevention and Control

Improvement plans have been put in place to support infection control in ward areas. Matron audits have identified areas that need focus and action plans implemented to improve. This is being benchmarked against the bi-quarterly validations. Infection Control Team corporate inspection continues and any learning identified is being included in the improvement plan which is monitored via the Perinatal Committee. There were 2 infections in Quarter 3, 1 e.Coli on the Obstetric Unit and 1 klebsiella in Neonatal services.



3.11 Neonatal National Audit and Performance (NNAP)/PERIPrem Cymru – context and figures

Summary of NNAP 2024 data and monitoring



The data above shows the National Neonatal Audit Programme spine plot for Singleton hospital for 2024. This information confirms that we are within expected parameters (within 2 standard deviations, light blue bar) for all measures apart from BMD2 (Breastmilk on day 2), FUY2 (2-year follow-up), NORMT (normal temperature) and ROP (retinopathy screening on time) where we are performing better than expected (positive outliers).

The service is not a negative outlier in any of the measures in 2024. The service is below the mean (but within 2 standard deviations so not significant) in the following areas:

The suboptimal timing of antenatal steroid administration remains a recognised challenge across Wales and the wider UK. This issue is primarily driven by the inherent difficulty in accurately predicting preterm birth and ensuring that steroid administration aligns with the optimal clinical window.

An All-Wales multidisciplinary working group has been established to develop a national strategy to improve practice in this area. This work is being led by Swansea Bay University Health Board, with initial scoping outputs expected by summer 2026.

The forthcoming implementation of the All-Wales Electronic Patient Record (BadgerNet) will further support improvements in clinical decision making. By

providing timely, comprehensive access to antenatal and neonatal records, including for women transferred between Health Boards for neonatal cot availability, BadgerNet, will enable clinicians to more accurately assess clinical history and optimise the timing of antenatal steroid administration in the absence of accurate predictive screening.

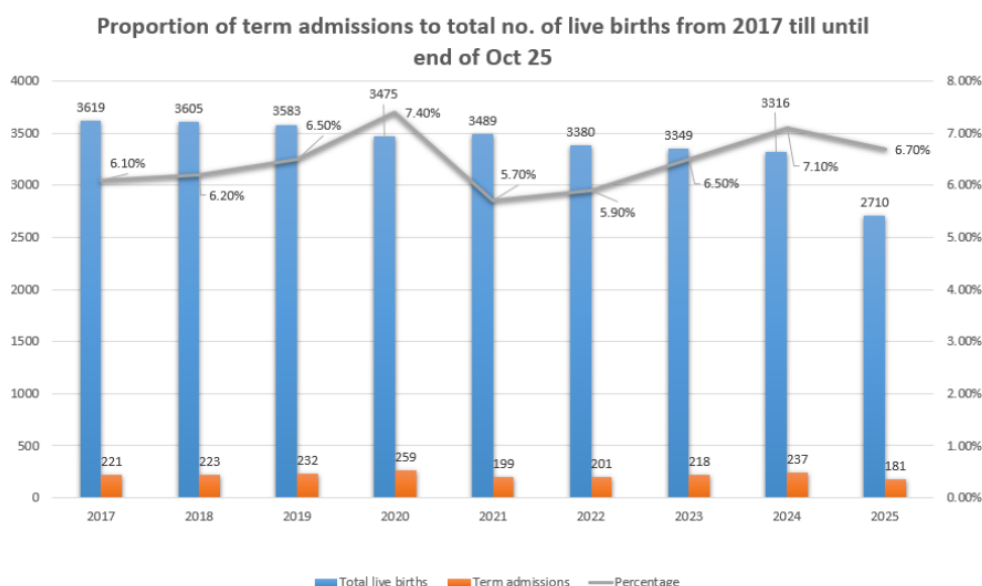
Bloodstream infection – the data has improved from 15% of babies <32 weeks with bloodstream infections in 2023 to 9.5% in 2024 and a reduction in the treatment effect from 10.5 to 3.6 in 2024. This is excellent progress, having been negative outliers for this measure in 2023. The service remains fully committed to reduction of infection with scrutiny of all cases of positive blood cultures and high priority given to infection prevention and control.

Breastmilk at discharge – our data is very close to the mean with an improvement from 57% in 2023 to 64.3% in 2024. There is a very active and engaged infant feeding team who have successfully achieved UNICEF Baby Friendly Initiative accreditation and the Bliss Silver award in 2025 showing ongoing improvements.

Bronchopulmonary Dysplasia – again, this measure is very close to the mean showing that this is not a significant problem and the service has shown an improvement from the 2023 data. A successful quality improvement project demonstrated a significant improvement in use of non-invasive respiratory support (another NNAP measure) which is a related measure of respiratory care and a protective factor in the development of the condition. We are continuing to monitor this measure and use evidence-based medicine to improve care in this area.

3.12 Avoiding Term Admission into Neonatal services

The service is managing and reviewing term admissions to the neonatal unit in real time and has moved the caseload into business as usual. The principal reason for admission is respiratory distress of the new-born; data analysis shows that 70% of these admissions is following planned caesarean birth. The service implemented a quality improvement project in April of this year in which high flow oxygen is delivered for up to one hour of life prior to assessing if admission to neonatal unit is required. This is carried out at the bedside mitigating any separation of mother and baby. It is too early to assess how successful this programme has been but will be reported following completion of the improvement cycle to board via the Perinatal Committee Report.



3.13 Risk Register

The perinatal Risk Register governance process and controls is set up to provide a single, controlled view of clinical and operational risks across maternity and neonatal services, ensuring timely mitigation, escalation, and assurance to the Board.

The governance structure and accountability are owned using established roles and functions of the governance process with risk ownership clearly articulated for each area. Control owners and overall accountability for Perinatal Risk governance is delegated to the Head of Midwifery and Director of Midwifery for sign off the register submissions. The Lead Midwife Quality Improvement Practitioner for Maternity/Neonatal Services ensures compliance with policy, supports risk scoring, DATIX quality, and trend analysis.

The Service Group Quality, Safety and Risk Committee receives the register, monitors progress, which is reviewed and updated monthly and escalates to Service Group Quality & Safety Committee/Board as required.

Board is informed and assured having oversight via Perinatal Committee reporting.

Risk assessments > 20 x1

A high scoring risk relating to the full implementation of the Computerised CTG system remains on the register; however, significant progress has been made, and the risk is expected to be resolved the 2nd of February.

The test server was successfully updated on 23 January, with formal testing scheduled for 26–27 January. Subject to successful testing, the system is planned to go live on 2 February. Once implemented, this risk will be closed as the digital

platform will provide enhanced monitoring, improved clinical decision support, and greater consistency in fetal surveillance.

The service continues to follow established governance processes throughout implementation to ensure a safe and seamless transition.

Risk assessments >16 x2 scoring 16

Two risks currently score 16 and remain under close management. Both have clear mitigations in place, are monitored through established governance processes, and are not associated with any adverse outcomes.

Risk assessments < 16 x9 scoring less than 16

A review of current maternity and neonatal risks rated below 16 indicates that while several operational challenges remain, all are being actively managed with clear mitigation in place. No issues currently pose an immediate threat to patient safety or service continuity.

3.14 Quality Improvement Approach, Methodology and Programmes

Perinatal services adopt structured Quality Improvement methodology to ensure safe, reliable, evidence-based care for women, babies, and families. The approach is grounded in recognised improvement science frameworks and national priorities, combining local data driven change with strong multidisciplinary collaboration.

The core principles of the Perinatal Quality Improvement (QI) approach are focused on:

1. Understanding the System

Perinatal care is complex and highly interdependent. QI begins with:

- Mapping pathways (antenatal, intrapartum, postnatal and neonatal).
- Identifying variation or gaps in safety and outcomes.
- Listening to service users, including women with lived experience, partners, and advocacy groups.

2. Using Structured Methodology

Most perinatal QI programmes draw from:

- Model for Improvement (IHI), using aim statements and PDSA cycles.
- Human Factors to support improving reliability of clinical systems.
- Safety science which includes early warning systems and escalation frameworks.

3. Data-Driven Decision-Making

Perinatal QI uses:

- Real-time safety dashboards
- Incident and outcome analysis (e.g., DATIX, PMRT, MBRRACE)
- Service user feedback
- Statistical process control (SPC) charts to track change over time

4. Multidisciplinary Collaboration

Teams commonly include midwifery, obstetrics, neonatology, anaesthetics, public health, digital teams, and (critically) women/families.

5. Continuous Learning Culture

QI in perinatal settings supports:

- Daily safety huddles
- Maternity/neonatal safety champions
- Learning from excellence
- Shared learning via the Maternity and Neonatal network

Perinatal Quality Improvement Programmes

Below are some examples QI programmes undertaken within Swansea Bay University Health Board.

1. Reducing Perinatal Mortality and Morbidity

- Saving Babies' Lives Care Bundle (SBLCB) implementation
 - Improving detection of fetal growth restriction
 - Increasing smoking cessation support
 - Optimising fetal monitoring in labour
- Enhanced surveillance of stillbirths using gap analysis and learning frameworks
- PROMPT training for obstetric emergencies
- Improved induction of labour pathways to reduce delays and variation

2. Safer Maternity and Neonatal Care

- Implementation of MEWS/NEWT2 to improve early recognition of deterioration
- Maternity Early Warning Chart standardisation across Wales which has been implemented locally.
- Education and training programme (national programme) to improve CTG interpretation and intrapartum fetal monitoring
- Reducing postpartum haemorrhage (PPH) through risk assessment and response bundles
- Improving escalation processes during intrapartum emergencies based on the PROMPT and MONET education programmes

3. Improving Birth Equity and Personalised Care

- Programmes focused on reducing inequities in outcomes for ethnic minority groups and deprived communities
- Continuity of carer model optimisation
- Enhancing shared decision-making applying the BERAIn tool for clinicians and women in:
 - Mode of birth
 - VBAC counselling
 - Induction of labour discussions

- Implementation of our Fast Track service, an emergency point of entry for women who are pregnant where English is not their first language via Maternity Triage.

4. Neonatal QI Programmes

- Reducing neonatal hypoglycaemia
- Implementing and leading on the PeriPREM Cymru programme aimed at optimisation of pre-term infants with a focus on 10 interventions of which here is an example:
 - Optimising early breast milk provision
 - Improving thermal care pathways
 - Optimising delayed cord clamping and physiological stabilisation
- Reducing admission of term babies to neonatal units through implementation of Avoiding Term Admission to the Neonatal Unit programme (ATAIN)
- ASTRA – a quality Improvement programme designed to test a change of at the bedside PEEP for babies born via cesaerean birth requiring immediate respiratory support with their mothers, assessing whether a long period of respiratory support and the time of transition from in-utero to life outside of the womb prevents admission to the Neonatal Unit.

5. Digital Quality Improvement in Perinatal Care

- Adoption of digital maternity records, BadgerNet electronic patient record
- Real-time digital dashboards for safety metrics
- Improving data quality for submissions to national audits

6. Workforce, Culture and Safety Initiatives

- Just Culture and restorative practice approaches by applying a systems lens to learning
- Staff experience, wellbeing and retention plan (SEWR)
- Team communication and safety culture education and training. Civility in work delivered via the PROMPT training programme
- Multidisciplinary simulation and drills in Neonatal services which now includes Maternity services and teams

3.1.15 National Awards.

Swansea Bay University Health Board's maternity and neonatal services continue to demonstrate excellence through strong patient validated recognition and organisational accolades. In the past year, the service has secured multiple acknowledgements that reinforce its commitment to high quality, compassionate and continuously improving care.

Our teams received a substantial number of Patient Choice Award nominations, underscoring the trust and gratitude expressed by women, birthing people and families across the region. These nominations reflect exemplary professionalism,

safe clinical practice and emotionally intelligent care—core components of the Health Board's service quality ambition.

- **WINNER** – NHS Wales Team Culture Award - Perinatal Excellence to Reduce Injury in Premature birth Cymru: Reducing Variation in Evidence-Based Perinatal Optimisation in Wales for 'Pob Babi Bob Tro' – Clinically Led by clinicians from Swansea Bay. The team were also recognised as winners for their outstanding contribution to Healthcare Improvement.
- **Shortlisted** – NHS Wales Safe Care Award - Improving Patient Safety through Multi-Disciplinary Handover of High-Risk Antenatal Women.
- **Shortlisted** – Nursing Times Award - Midwife of the Year - Shaunna-Leigh Clarris - Swansea Bay University Health Board for her work aimed at reducing surgical site infections following cesaerean birth.
- **Shortlisted** – British Association Perinatal Medicine – Outstanding Team Award – Neurodevelopment team, Peer Support team and the ANNP Team.
- **WINNER** – Neonatal Nursing Awards - Outstanding Team Award – Tissue Team – contributions to the Nano Preterm Skin Care Guidelines.
- **Shortlisted** – Neonatal Nursing Awards – Outstanding Team – Medicines Management Team.
- **WINNER** – Chief Nursing Officer for Wales Award – Fastrack Service – Implementation of open emergency access service for women whose first language is not English for concerns in pregnancy. This has been recognised as an exemplar with all Perinatal Teams across Wales asked to implement this service.
- **Special recognition** – Midwife of the Year – Mariposa Awards – Rebecca Taylor, Swansea Bay University Health Board 2025 presented to pregnancy, baby and child bereavement heroes.

4. FINANCIAL IMPLICATIONS

As previously advised, there will be some financial implications because of the recommendations from the Independent Review, these are currently being developed as part of developing the improvement plan.

5. RECOMMENDATION

BE ADVISED THAT:

- The Perinatal Improvement Plan Executive Programme Board will develop and monitor improvement plans in response to the Independent Review, All Wales Self-Assessment and other improvement actions, will be triangulated and any gaps will be added to the overall improvement plan.
- Perinatal Improvement Programme Executive Board was held in December 2025, with workstreams agreed, Executive and service Leads assigned. Workstream meetings arranged and outputs will be reported via the Perinatal Improvement Programme Board.

- Perinatal Committee meets monthly and reviews all key metrics for perinatal services.

BE ASSURED THAT:

- The Perinatal Service does not currently have any elements of care that would flag as a Negative Outlier.
- Any stillbirths or neonatal deaths have been reported through the MBRRACE process.

BE ALERTED TO:

- There has been a strong steer nationally that there will be an All Wales maternity triage service developed as a recommendation from the All-Wales Perinatal Assessment. The Perinatal Improvement Plan Executive Programme Board has agreed to pause development of a standalone SBUHB model pending publication of the Assessment (due end of Jan 2026).
- Mitigating action to provide a single point of contact triage phoneline will be complete by February 2026. Calls will be to a single telephone entry point where women will be directed to the appropriate department based on their needs. This process will ensure that all calls for maternity triage are directed to one place.



Governance and Assurance		
Link to Enabling Objectives <i>(please choose)</i>	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☐
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☐
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☐
Quality, Safety and Patient Experience		
The Perinatal Committee reports directly into Quality and Safety Committee and noted via Service Group Quality, Safety & Risk Group and Senior Leadership Team. Key updates were received via Perinatal Committee and key measures of the high-level information have been included in section 3 of this report		
Financial Implications		
As previously advised, there will be some financial implications because of the recommendations from the Independent Review, these are currently being developed as part of developing the improvement plan.		
Legal Implications (including equality and diversity assessment)		
Nil outlined within this report		
Staffing Implications		
There have been some challenges within the Neonatal medical workforce due to unavailability, this has been mitigated with flexible working arrangements which has meant there has been no gap in service. A Neonatal Consultant was successfully recruited on the 9 th December, with 1 expected return following maternity leave in January.		

Obstetric workforce – 2 fixed term gaps for career break and other leave have been covered with no vacancies impacting on services.	
Report History	The Perinatal Committee reports directly into Quality and Safety Committee and noted via Service Group Quality, Safety & Risk Group and Senior Leadership Team. Last reported November 2025.
Appendices	Nil



Meeting Date	29 January 2026	Agenda Item	4.1	
Name of Meeting	SBUHB Board			
Report Title	Perinatal Improvement Plan			
Report Author	Ffion Green, Programme Lead Kathy Greaves, Clinical Director of Midwifery			
Report Sponsor	Elizabeth Rix, Executive Director of Nursing and Patient Experience			
Presented by	Elizabeth Rix, Executive Director of Nursing and Patient Experience			
Freedom of Information	Open			
Purpose of the Report	The purpose of the paper is to: • Present the Perinatal Improvement Plan which addresses the implementation of each of the recommendations of the SBUHB Independent Review of Maternity and Neonatal Services; and • Details the progress made since the Review's publication.			
Key Issues	• The paper provides progress to date on addressing the improvements required by the Independent Review for Maternity and Neonatal Services to provide a high quality, safe and sustainable maternity and neonatal services in SBUHB. • Highlights the outstanding actions needed to deliver the Review recommendations and present a detailed plan and how the organisation will achieve the improvements needed.			
Specific Action Required <i>(please choose one only)</i>	Information	Discussion	Assurance	Approval
	☐	☐	☒	☒
Recommendations	Members are asked to: APPROVE: • Approval in principle of the Perinatal Improvement Plan to go to the Independent Oversight Panel for scrutiny. BE ASSURED: • The organisation has a comprehensive plan to address the recommendations of the			



	SBUHB Independent Review of Maternity and Neonatal Services, Family Led Review of Maternity Services, and "Having a baby in Neath Port Talbot and Swansea Report" Llais Report and any actions required following the pending publication of the All-Wales Assessment of Perinatal Services. • Progress made since the publication of the Independent Review on key safety actions. • The Perinatal Improvement Plan is underpinned by a robust governance and assurance structure. BE ALERTED TO: • Maternity Triage: There has been a strong steer nationally that there will be an All Wales maternity triage service developed as a recommendation from the All-Wales Perinatal Assessment. Perinatal Improvement Plan Executive Programme Board has agreed to pause development of a standalone SBUHB model pending publication of the Assessment (due end of Jan 2026). Mitigating action to provide a single point of contact triage phoneline will be complete by February 2026. Calls will be to a single telephone entry point where women will be directed to the appropriate department based on their needs. This process will ensure that all calls for maternity triage are directed to one place. • Paediatric radiology: Outsourcing of paediatric radiology provision as an interim mitigation measure. There is a need for potential regional solution to provide long term assurance and sustainability of service provision.

PERINATAL IMPROVEMENT PLAN

1. INTRODUCTION

This report is to accompany the presentation of the Perinatal Improvement Plan, outlining implementation of each of the recommendations of the SBUHB Independent Review of Maternity and Neonatal Services, the Family Led Review of Maternity Services and "Having a baby in Neath Port Talbot and Swansea Report" published by Llais.

The report provides some details on progress against the recommendations of the reviews since their publication, including on critical safety measures highlighted as high priority actions by the Independent Oversight Panel of the Independent Review.

Lastly the report highlights areas of concern and proposed mitigation.

2. BACKGROUND

SBUHB provides care to women and their families for approximately 3,500 births a year. The service has a tertiary Neonatal unit, therefore provides care to babies from 22 weeks gestation onwards across South Wales and from neighbouring Health Boards. The service has a Free-standing Midwifery Unit, Alongside Midwifery Unit and Obstetric unit.

The Independent Review of Maternity and Neonatal Service in Swansea Bay, published in July 2025, identified a range of issues that impacted on women and families during their pregnancy, birthing and postnatal journey. A Family Led Review of Maternity Services, also published in July 2025, and "Having a baby in Neath Port Talbot and Swansea Report" published by Llais in May 2025 highlighted similar issues and clear common themes. In response to the Independent Review, the Service was escalated from Level 3 to Level 4 by Welsh Government.

The Independent Review identified 10 priority recommendations, as follows:

1. Establish a single point of access for maternity triage for all women.
2. Delivery of consistent care with senior clinical staff oversight
3. Implementation of the Maternity Early Warning Scores (MEWS)
4. Improve Quality of Investigations
5. Delivery of compassionate and trauma-informed care
6. Improvements in governance processes
7. Attendance for all maternity staff for fetal monitoring training



8. Develop and implement a robust process for booking and prioritising women undergoing induction of labour.
9. Review and revise all policies and procedures within the maternity and neonatal service.
10. Develop and implement a wider engagement plan.

Beyond the thematic areas highlighted above, the Independent Review includes 69 specific recommendations (32 Maternity-specific recommendations; 24 Neonatal-specific recommendations; and 13 Additional Clinical Recommendations). Most recommendations are time-sensitive and require delivery in the coming 12 months. Several of the recommendations require service change (including recruitment and procuring of additional service provision), engagement, and realignment of processes and operating models.

This report details the progress the organisation has already made towards achieving the improvements needed in our Perinatal services and provide assurance in relation to our strategic plans to deliver the recommendations. Lastly the report highlights areas of concern, where timescales stated in the Independent Review may not be achievable, the rationale for this and the mitigation that we are putting in place as an interim measure.

3. GOVERNANCE AND RISK ISSUES

3.1 Development of the Perinatal Improvement Programme and associated Governance

The Perinatal Improvement Plan is appended to this document and details actions, progress, ownership and timescales for delivery. It is a live document which will be updated regularly, and the next section of this report will describe progress to date and look towards our next steps in achieving the improvements highlighted by the Independent Review.

Following initial developments and testing with the Independent Oversight Panel of a high-level Improvement Plan, the Panel has provided a steer that the 10 thematic recommendations and additional clinical recommendations, along with any additional recommendations that will emerge following the All-Wales Self Assessment process (due to be published imminently), be integrated into four workstreams for operational delivery. Adopting this approach to delivery limits silos between thematic recommendations and ensures appropriate prioritisation of actions in an agreed approach with the Service Group. This report provides an update on the 10 thematic recommendations, crossed referenced with the four workstreams. Due to the importance of the Perinatal Improvement Programme,



Executive/Corporate Directors are named leads on the workstreams, with responsibility for strategic director and planning. Named leads within the Service Delivery Groups will ensure coordination of the operational activities necessary.

Workstreams are grouped as follows as follows:

- **Workstream 1: Clinical Critical Safety Actions**, Executive Medical Director, Richard Evans:
 - Maternity triage
 - Induction of labour prioritisation
 - Two site working, risk mitigation, early warning scores
 - Multidisciplinary training
 - Investigations/learning/actions
 - Senior level supervision/oversight
 - Escalation/raising clinical concerns
- **Workstream 2: Family Engagement**, Executive Director of Corporate Nursing and Patient Experience, Elizabeth Rix:
 - Response to harm, including Harmed Patient Pathway
 - Decision making and consent
 - Birth trauma
 - Culture/behaviours, cultural awareness and diversity
- **Workstream 3: Workforce / leadership / education and training**, Executive Director of Workforce & OD, Tina Ricketts:
 - Compassion/culture/cultural awareness
 - Behaviours
 - Trauma informed care
 - Education and training monitoring
- **Workstream 4: Governance**, Director of Corporate Governance, Hazel Lloyd:
 - Board reporting
 - Complaints/incidents/claims processes
 - Structures and processes
 - Clinical guidelines
 - External relationships and reporting
 - Investigations and learning

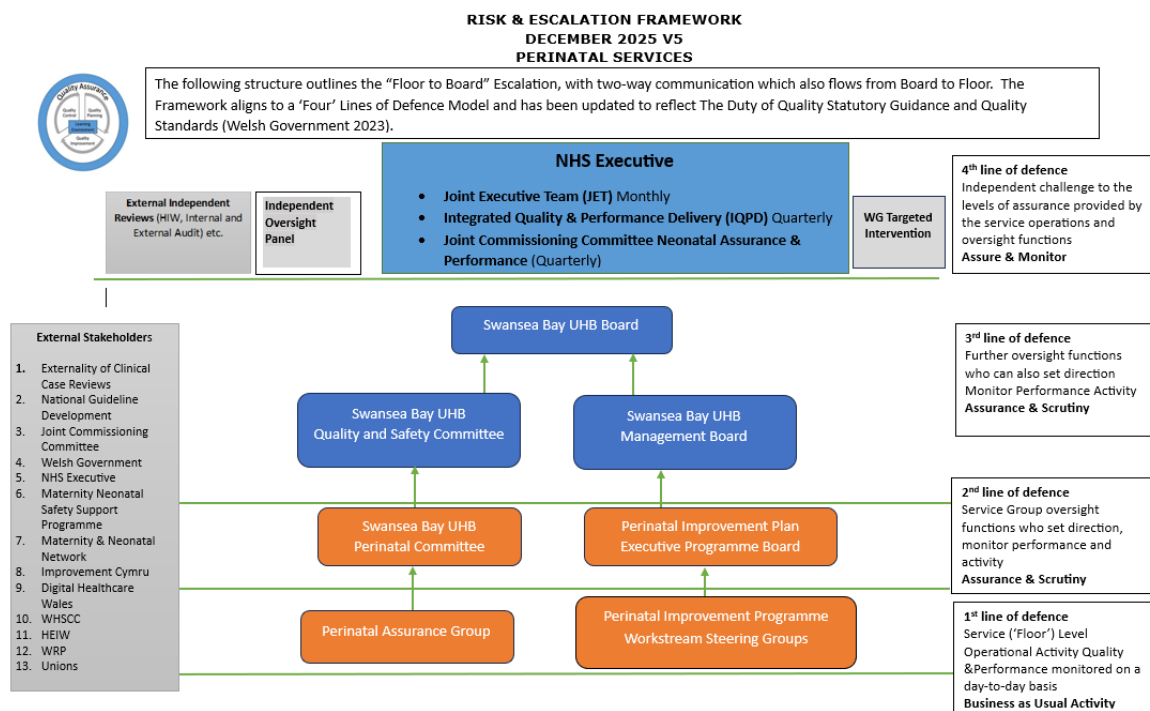
Each Workstream has a Steering Group that meets regularly with key personnel from the service group and relevant corporate directorates to identify and deliver priorities outlines in the Perinatal Improvement Plan.

There is a clear distinction between the work forming part of the Perinatal Improvement Plan and the “business as usual” activities relating to perinatal services. As such, we have reviewed and established defined

governance processes that underpin both sets of activities, as described in Figure 1.

The Perinatal Improvement Plan Executive Programme Board held its inaugural meeting in December 2025. Chaired by the CEO, the Executive Programme Board focuses on the Improvement Plan and its delivery. It meets bimonthly and reports directly to Board. A report template has been developed to ensure each named Executive Accountable Lead provides an update for their respective Workstream summarising ongoing progress, highlighting programme slippage and associated risks, as a standing agenda item.

Figure 1



By contrast, the Perinatal Committee, established July 2025, provides a report to Board, based on evidence, quality assurance, safety and sustainability of service for women, people and babies receiving maternity and neonatal care at Swansea Bay University Health Board (SBUHB). The Perinatal Committee meets monthly and reports to Quality and Safety Committee, and Board.

There are two Perinatal Safety Champions, the Executive Director of Nursing and Patient Experience and an SBUHB Independent Board Member, who are both part of the core membership of the Perinatal Committee and the Quality and Safety Committee.

In order to ensure the Improvement Programme and the “business as usual” governance mechanisms dovetail to avoid silos, gaps and ensure resource is not duplicated, there is representation from key individuals on both groups. Furthermore, there is interlinking between the Steering Groups and Perinatal Assurance Group. Not only does this enable the timely sharing of information and alignment of improvement processes that impact all elements of the perinatal services, it supports our longer-term intentions to embed improvement centrally into the service at the conclusion of the Improvement Programme.

3.2 Progress on Thematic Recommendations

R1 Establish a single point of access for maternity triage for all women. (PIP Workstream Action Reference 1.1.1-1.1.4)

Women and their families reported inconsistent access and poor experiences in maternity triage services. Delays or incorrect triage advice can impact maternal outcomes. Implementing a unified triage telephone system will improve patient safety and patient experiences and improve quality and outcomes. Since the Independent Review was published, we have developed and tested a model for a unified triage system. The model ensure staffing models and are data-driven, and monitoring of feedback mechanisms. The service established a dedicated 24/7 maternity triage process within Swansea Bay University Health Board in November 2024, improving patient safety, streamlining clinical workflows, and enhancing patient experience by providing immediate access to qualified midwives and middle-grade doctors for urgent maternity concerns. The service follows the Birmingham Symptom Specific Obstetric Triage System (BSOTS) model, ensuring structured assessments, timely escalation, and equitable access to care.

While the establishment of the service has been in development, measures have already been taken to improve maternity triage, ensuring clinical escalation as appropriate to ensure patients are treated by the right person, at the right time and in the right place. As of November 2024, BSOTS has been used in SBUHB to ensure a more standardised approach to risk assessment, prioritisation and escalation of all women (including those deemed to be low risk) who attend the maternity triage department,. Data tracking is supporting the service to provide assurance of the timely review and appropriate escalation of women requiring urgent medical review. The service has been supporting the All-Wales programme in other Health Boards based on our successful implementation and delivery of the BSOTS pathways. In November 2025, 45.3 women were seen in triage; 93% were seen within the standard triage time. Triage performance is monitored via

the Perinatal Assurance Group, which feeds into the Perinatal Committee and to Quality & Safety Committee, through to Board.

There has been a strong steer nationally that there will be an All Wales maternity triage service developed as a recommendation from the All-Wales Perinatal Assessment. An All-Wales approach will require a collaborative approach to developing and implementing a strategic maternity triage model, with an associated financial commitment. As such, a decision was made at an Extraordinary Meeting of the Perinatal Improvement Plan Executive Programme Board on 20 January 2026, to temporarily pause further progression of a standalone fully independent maternity triage model until the imminent publication of the All-Wales Perinatal Assessment.

Since the publication of the Independent Review, rostering has been adjusted to provide medical cover during peak periods of activity for triage. To continue to mitigate risk while the preferred service model is confirmed and established, we will ensure all calls to the service have a single telephone entry point where women will be directed to the appropriate department based on their needs. This process will ensure that all calls for maternity triage are directed to one place. This is anticipated to be in place in February 2026.

Mitigating action delivery date: February 2026

Full action delivery date: Dependent on outcome of All-Wales Perinatal Self Assessment outcome – anticipated by end of January 2026 for publication.

R2 Delivery of consistent care with senior clinical staff oversight (PIP Workstream Action Reference 1.7.1-1.7.3)

A lack of senior oversight in complex cases led to variable outcomes. To ensure the safety of women and babies, appropriate senior clinical presence in high-risk deliveries and neonatal care must be available.

In September 2025, benchmarking against the Royal College of Obstetrics and Gynaecology (RCOG) and British Association of Perinatal Medicine (BAPM) standards of staffing ratios to provide senior oversight and support was completed to ensure care of sick babies is overseen by a Senior Consultant presence, clearly articulated and recorded within the clinical records. Similarly, senior clinical staff must have a mandatory presence in operative vaginal births, including rotational births, forceps or assisted breech births and complex caesarean births must be attended by senior clinical staff. The (Therapy Outcomes Measure System (TOMS) will be used from February 2026 to collect the data to audit presence of senior obstetricians in complex births. The findings will be presented at the Intrapartum Forum and recorded within the Service's Quality and Safety Forum meetings. Any identified concerns will be escalated through the

Perinatal Committee as appropriate, and on to Quality and Safety Committee, through to Board.

The Perinatal Improvement Plan contains actions to develop an audit cycle and key indicators to provide assurance which include care planning underpinning decision making, and births by birth mode.

Compliance rates with Royal College of Obstetrics and Gynaecology (RCOG) and British Association of Perinatal Medicine (BAPM) are reported to the Perinatal Committee on a monthly basis, along with key indicators. We are achieving RCOG and BAPM compliance in terms of the presence of senior level consultants on labour and neonatal wards with 12 hours per day 7 days per week cover. In Maternity, Senior Clinical Staff (specialty grade / consultant) is on site for 22.5 hours a day with back up non-resident consultant on call during out of hours. In Neonatal services, there is a Neonatal Consultant non-resident on call out of hours. This is in line with current BAPM standards for a tertiary Neonatal Unit with our intensive care activity.

Since the publication of the Independent Review, the service has welcomed a number of visits, including from Independent Members, the Independent Midwife, the Independent Oversight Panel Observer. Feedback has been positive, with visitors recognising a Multidisciplinary Team with "sense of togetherness" underpinned by visible and present leadership.

Action delivered: November 2025

R3 Implementation of the Maternity Early Warning Scores (MEWS) (PIP Workstream Action Reference 1.3.1; 1.5.1)

The Review highlighted an inconsistent use of Maternity Early Warnings Scores (MEWS) tools across sites. Appropriate use of MEWS supports better identification of pregnancy risks and supports early intervention where needed. The Newborn Early Warning Track and Trigger Framework (NEWTT2) was implemented to support perinatal teams to apply comprehensive risk assessments and standardise enhanced monitoring and care escalation for newborns using the NEWTT2 framework. This framework is designed for use in postnatal care settings including the neonatal unit, delivery suite, postnatal ward and transitional care unit.

MEWS was launched on the 15 July 2025 following completion of staff training. Phase 1 of the MEWS and NEWTT2 rollout across all maternal services was completed by July 2025, with audits confirming robust and appropriate use. This has been successfully implemented with further areas for national standardisation noted as a result, that being the High Dependency Unit charts which use differing parameters to the All-

Wales MEWS. This has been corrected locally but is a requirement for the All-Wales Programme to consider. In addition:

- Rollout to admitting units commenced with the Emergency Department as part of a maternal safety bundle (MEWS, VTE risk assessment, and obstetric team discussion when needed). The ED and Gynaecology rollout was completed in January 2026, with all other admitting units finished by March 2026.
- NEWTT2 was launched in March 2025, the postnatal ward manager and specialist neonatal examination midwife have undertaken audits following implementation.

Performance and usage of these tools are monitored via the Perinatal Assurance Group, which feeds into the Perinatal Committee and to Quality and Safety Committee, through to Board.

Action delivered January 2026; monitoring and assurance in place on a rolling basis, via the Perinatal Assurance Group, which feeds into the Perinatal Committee and to Quality and Safety Committee, through to Board.

R4 Improve Quality of Investigations (PIP Workstream Action Reference 1.6.1; 4.4.1-4.4.2)

The Independent Review detailed that insufficient scrutiny was applied when things go wrong. Examples were highlighted of investigations being of poor quality, with women and families not getting the early and compassionate answers they sought, and missed opportunities to learn and improve as an organisation. The trauma experienced by some women and their families when things went wrong, was compounded by the organisation's handling of concerns and incidents, particularly around bereavement care and trauma support.

Key areas of progress:

Enhanced Governance and Scrutiny

- A structured governance framework has been implemented to ensure rigorous scrutiny and accountability. The Obstetric Clinical Incident Review Meeting, held weekly, provides a multi-disciplinary platform for systematic review of all incidents. This process is complemented by robust monitoring of incident and complaint management through the Perinatal Assurance Group and Perinatal Committee, with clear escalation and reporting to the Health Board.
- Case Strategy Meetings now deliver immediate oversight of safety actions, define the scope of investigations, and appoint lead investigators to ensure proportionality and transparency. These



meetings also identify cases requiring external independent review, reinforcing impartiality and public confidence. Crucially, early and proactive engagement with families is embedded in the process, enabling timely updates and inviting families to contribute areas of concern for inclusion in the investigation scope.

Improved Investigation Standards

- All staff involved in case investigations and reviews have completed the Health Board's Patient Safety Investigation Training, delivered by the Patient Safety Team. A structured onboarding process ensures that new staff are directed to current training sessions, reinforcing a consistent and high-quality approach to investigations across the service.
- Investigations are now conducted through a systemic lens, utilizing the Yorkshire Contributory Factors Framework. This approach ensures that reviews are comprehensive, timely, and learning-oriented, moving away from a culture of blame and instead focusing on identifying contributory factors and driving sustainable improvement.

Compassionate Engagement with Families

- A Family Liaison Pathway has been developed to align with statutory Duty of Quality and Duty of Candour requirements. This pathway ensures early, transparent, and empathetic communication with families following an incident, reinforcing trust and organisational accountability.
- A comprehensive review of Bereavement Care and Perinatal Mental Health Support Services has been undertaken, including specialist midwifery and psychological support provision. This review ensures robust mechanisms and pathways are in place to provide timely, compassionate care and mitigate the risk of compounded trauma for families. To secure long-term resilience and sustainability, a plan is in development to strengthen service capacity and embed best practice across the Health Board.
- A Specialist Women's Experience Midwife is listening to a broad spectrum of women to gather their insights and experiences. These are being used to develop service improvements consistent with the listen and act philosophy. Since their appointment into post, the Specialist Women's Experience Midwife has supported the organisation's work to actively progress inclusive, culturally sensitive care informed by lived experiences, working with the Health Board's diverse outreach workers.

Learning and Continuous Improvement

- The service has implemented the 'Risky Business' Newsletter as a key communication tool to cascade learning across all staff groups. This publication provides clear feedback on insights gained through incident reporting and outlines the system-level mitigations



implemented to prevent recurrence. By promoting transparency and shared learning, the newsletter supports a culture of continuous improvement and strengthens patient safety governance across maternity services.

- Embedded real-time feedback mechanisms from women and families to inform service improvements. The NHS Core Questionnaire, initially piloted in mid-2025, has now transitioned into a national programme across Wales, actively capturing feedback from women throughout pregnancy, birth, and the postnatal period. This initiative enables real-time insight and intervention, allowing the service to respond promptly to emerging concerns and prevent issues from escalating. By embedding this feedback mechanism, Swansea Bay Maternity Services are strengthening responsiveness to women's and families' needs, supporting continuous improvement, and aligning with national quality priorities.

Cultural Change and Staff Support

- Delivered training in Duty of Candour and compassionate communication for all maternity staff.
- The service is actively engaging with Diverse Cymru through completion of a structured workbook designed to support the identification and reduction of health inequalities. This focuses on improving the experiences of women and families from Black and ethnic minority communities, ensuring that maternity care is inclusive, culturally sensitive, and aligned with the Health Board's commitment to equity and quality.

Strengthened staff wellbeing to support those involved in adverse events and promote a learning culture.

- A comprehensive Perinatal Staff Experience, Wellbeing, and Retention Plan has been developed, focusing on the unique needs of staff delivering high-intensity, complex care. This plan prioritises workforce sustainability, psychological wellbeing, and retention, ensuring that staff are supported to deliver safe, high-quality maternity services while mitigating the impact of occupational stress and burnout. The strategy aligns with the Health Board's commitment to creating a resilient, engaged workforce and safeguarding service continuity.

In November 2025, the Perinatal Services team secured participation in the NHS Wales Performance and Improvement's Quality Management System (QMS) Prototyping Programme, which will offer an excellent opportunity for growth, maturity, and deeper understanding. It will support us in embedding the QMS more fully across our service, ensuring we become a quality driven service that considers all components of the QMS as a way

of working; planning, improvement, assurance, and control. This opportunity will provide valuable learning of successes and any failures of implementing a QMS framework for all Perinatal services, which could be adapted to other services within SBHUB, as well as other Health boards across Wales.

Action delivery date: May 2026.

R5 Delivery of compassionate and trauma-informed care (PIP Workstream Action Reference 3.1.1-3.1.3; 3.4.1-3.4.3)

Insensitive care, a lack of compassion and poor integration of emotional and psychological support into routine maternity care were apparent in the Independent Review findings. Inadequate support for minority groups, including language barriers and cultural insensitivity were also highlighted as a recurrent issue. Furthermore, the Review highlighted that there was limited psychological support for staff exposed to distressing incidents. Ensuring we embed a trauma-informed approach underpinned by compassionate leadership and behaviours in our Perinatal services is multilayered and will require a phased approach.

Phase 1: Compassionate care should be effectively modelled and delivered by leaders and managers in the Perinatal Service. Since the Review's publication, we have developed a Multidisciplinary Team Development Programme co-designed with Health Education and Improvement Wales (HEIW) and initially supported by Professor Michael West. The sessions, being delivered between February and April 2026, will deliver a coaching leadership programme for the Perinatal Clinical Leadership team, supporting transformational change to embed sustainable culture of improved behaviours and accountability. Evaluation of this pilot programme will measure success prior to wider roll-out both locally and nationally. This evaluation will inform the next phases of cascade from April 2026 across the wider directorate. Continued collaboration with HEIW and the national programme will also enable scalability as required, along with adapted internal modalities and versions of delivery i.e. digital options.

Phase 2 of this theme will focus on a training programme and delivery schedule in trauma-informed care. To facilitate the timely need for this to be delivered, we will engage an external provider to produce a bespoke training programme to be used across Perinatal Services. Phase 3 will require detailed exploration of service requirements associated with an enhanced provision of psychology-led therapeutic services.

Phase 1 delivery: April 2026



Phase 2 delivery: September 2026

Phase 3 delivery: September 2026

R6 Improvements in governance processes (PIP Workstream Action Reference 4.1.1-4.1.3)

The Independent Review highlighted that governance structures and processes in maternity and neonatal services lacked clarity and oversight. Between 2021 and 2024 there were significant weaknesses in governance which resulted in the maternity service being overwhelmed by overlapping action plans; confusing governance meeting structures; blurring of roles; poor recording of meetings; siloed committees; poor risk management; weak development and revision of clinical guidelines; and an absence of a clinical audit plan prior to 2025.

As described in Section 3.1, a full review and redesign of governance arrangements linked to “business as usual” and improvement activities has been implemented. Both have clear routes to Board and are subject to regular monitoring via the Alert Advise Assure (AAA) model replicated throughout other services. Furthermore, service redesign was implemented on 1 December 2025, bringing maternity and neonatal services, as well as gynaecology and children services, into one unified service – Perinatal Services – which alleviates silos, and provides alignment in the governance structure.

Action delivered: December 2025

R7 Attendance for all maternity staff for fetal monitoring training (PIP Workstream Action Reference 1.5.1)

The Independent Review reported inconsistent training in fetal monitoring. Specific issues around fetal monitoring, delays in transferring women to the operating theatre, and communication and documentation within the clinical teams to support early intervention were also highlighted. Clearly this has the potential to impact outcomes for mothers and babies.

Arrangements are in place to ensure the Obstetric and Midwifery workforce undertake fetal monitoring training in line with the All-Wales Intrapartum Fetal Surveillance (IFS) training package. This includes attending the IFS study day, attending four cardiotocograph (CTG) reflections for obstetric doctors and three reflections with Intelligent Intermittent Auscultation (IIA) the additional element for midwives. Current compliance for the IFS study day is 97% and the IFS passports to demonstrate the attendance of reflections are due to be submitted September 2025. Fetal surveillance compliance is reported as an overall combined score for midwives and

obstetricians with current compliance at 97%, reported on a monthly basis to Perinatal Committee.

Mandatory training compliance is continually monitored as part of the Health Board's workforce assurance framework. Performance against these requirements is reported through the Perinatal Committee as a suite of workforce metrics, providing clear oversight and assurance to the Board on staff competency and regulatory compliance.

- PROMPT training compliance for Obstetric workforce 95%
- PROMPT training compliance for Midwifery workforce 95%
- PROMPT training compliance for Anaesthetic workforce 98%
- GAP Grow training compliance for Obstetric workforce is 95% and Midwifery workforce is 96%
- Neonatal Life Support (NLS) compliance for Neonatal Consultant workforce 100%
- NLS compliance for Neonatal Nursing 95%
- NLS compliance for Neonatal Juniors Tier 1 – 90.9% and Tier 2 – 100%
- NLS compliance for Midwifery workforce (undertaken during mandatory training) 97%

Action delivered: December 2025.

R8 Develop and implement a robust process for booking and prioritising women undergoing induction of labour. (PIP Workstream Action Reference 1.2.1-1.2.3)

Persistent delays in Induction of Labour (IOL) are linked to inconsistent prioritisation and variable scheduling processes, which can lead to poorer postnatal outcomes and experiences. To address these challenges, the Steering Group will lead the development and governance of a formal prioritisation framework.

Multi-disciplinary handovers in the Perinatal Service have been in place twice per day since April 2024, which enables a formalised transfer of patient care between staff within the Service. Planned activity including Induction of Labour and on-going Induction of labour are discussed at these handovers, risk assessed and prioritisation with staggered admissions of new inductions of labour timetabled.

Induction scheduling is risk-based, with prioritisation guided by clinical urgency and maternal/fetal indicators. Daily handover huddles support dynamic adjustments, mitigating delays and ensuring safety-critical cases are addressed promptly. Any delay greater than 24 hours is escalated to the senior team and DATIX reported this enables the team to triangulate



any adverse outcomes with delays in treatment. Since September 2025, delayed or re-scheduled Induction of Labour has been reviewed by the Perinatal Committee Report for monitoring and or escalation to Board.

Further actions to be delivered through the Perinatal Improvement Plan include:

Phase 1:

- Establishing standardised triage and prioritisation criteria to ensure equitable and timely allocation of IOL slots.
- Implementing a digital IOL booking system, aligned with the rollout of BadgerNet in March 2026, to improve transparency, workflow efficiency, and oversight of demand and capacity.
- Introducing a standardised risk assessment process for all women undergoing IOL, ensuring consistent clinical decision-making and escalation.

Phase 2:

- Exploring the feasibility of a dedicated elective obstetric theatre on the labour ward to reduce delays caused by theatre availability and to safeguard timely progression of IOL pathways; recognising the impact of a rising caesarean section birth rate which is impacting on flow through labour ward leading to delays in induction of labour and ongoing care planning.

Phase 1 Delivery - March 2026.

Phase 2 Delivery – End 2026 feasibility progression

R9 Review and revise all policies and procedures within the maternity and neonatal service (PIP Workstream Action Reference 4.3.1)

The Independent Review identified multiple instances of outdated or inconsistent guidelines within Maternity and Neonatal Services, presenting a significant risk to safe and effective care. In response, the service has undertaken a comprehensive review and redesign of its guideline management approach to ensure alignment with best practice and national standards.

A Maternity and Neonatal Guidelines Group is being established and will be operational by March 2026, underpinned by formal Terms of Reference and defined core membership, to provide structured oversight of guideline management. The Group will ensure a cyclical review, adoption, and rollout of all perinatal guidelines, prioritising critical safety standards, national directives, and NICE recommendations.

Key deliverables include:



- 100% review of locally owned guidelines within agreed timelines.
- Benchmarking and embedding national guidance into clinical practice.
- Integration of workforce heatmap KPIs to monitor compliance.
- Inclusion of auditable standards within the forward audit plan to provide assurance on implementation and adherence.

This governance structure strengthens clinical quality, mitigates risk, and ensures alignment with national safety priorities. Our current compliance across all guidelines sits at 88%, however, this is an aggregated figure that includes local service guidelines, which are within the service's gift to manage, as well as wider Health Board policies and national policies that are beyond the control of the Perinatal Service teams.

Action to be delivered: March 2026, with prioritisation given to guidelines in urgent need of review.

R10 Develop and implement a wider engagement plan (PIP Workstream Action Reference 2.1.1-2.1.6; 2.2.1-2.2.4; 2.3.1-2.3.2)

The Independent Review emphasised in strong terms that women and their families did not feel listened to; felt their concerns were dismissed during their care; and felt their care lacked compassion. Furthermore, there had been limited engagement with women and families using the services, further exacerbating the negative experiences. That's why at the heart of our engagement activity is a focus on listening and acting. One without the other doesn't work.

This was reinforced at a Perinatal Learning event held on 19 November 2025 to share learning and experiences with a multiprofessional and multi-organisation audience. The event heard directly from women who had used our services and others with lived experiences from elsewhere. Their input was particularly powerful, emphasising to the wider audience (which included Perinatal staff from Swansea Bay and Health Boards the length and breadth of Wales) the importance of listening and acting.

The engagement agenda going forward is based on a model of:

1. Service specific engagement undertaken by the service itself, mostly using its own contact with service users
2. Service specific engagement undertaken by corporate teams, particularly DICE and the independent review's engagement lead
3. Always on engagement at a pan Health Board level which sees generic engagement activity offering up insights and feedback relevant to the maternity and neonatal services.

4. Gathering of data from various sources to triangulate with the feedback obtained from the three sources above

At the same time, it is important to recognise that while engagement feedback secured over the last 12 months or so has already helped shape the Improvement Plan, further engagement feedback will continue on an ongoing basis.

This means that the product of our engagement will continue to influence and shape our actions, living up to our listen and act approach. An example of this will be the triage service which will benefit from feedback generated through engagement, helping ensure that it is delivered in a way that is not just clinically excellent but also meets the needs of service users (culturally appropriate, easy to understand etc).

Central to the service specific engagement outlined is the employment of a Specialist Women's Experience Midwife who is listening to a broad spectrum of women to gather their insights and experiences. These are being used to develop service improvements consistent with the listen and act philosophy. Since their appointment into post, the Specialist Women's Experience Midwife has supported the organisation's work to actively progress inclusive, culturally sensitive care informed by lived experiences, working with the Health Board's diverse outreach workers.

In terms of broader engagement (points 2 and 3) work is underway to develop a Network of Sounding Boards that builds on work being undertaken as part of the Women's Health Plan.

Fundamental to this is the in-depth mapping of groups across the Swansea and Neath Port Talbot areas, a piece of work that is being undertaken by the relevant Council for Voluntary Services (CVSs). Both of the CVSs have been commissioned to undertake this detailed mapping and the work is due to be completed by April 2026.

The detailed nature of the mapping will provide our Health Board with a broad cross-section of networks and groups with whom we can engage going forwards, with a particular focus on the most deprived communities where many issues raised within the Independent Review that influence maternal and neonatal outcomes were more prevalent.

The mapping will include a wide range of informal and formal groups such as mother and toddler groups, exercise classes, coffee mornings and choirs. Some of these groups will be more suitable for "always on" engagement around generic activities (where the agenda will be broad and open) whereas others will be suitable for Perinatal specific engagement activities.



Once the mapping is completed, we will establish a “Sounding Boards Network”, working in conjunction with third sector partners and support groups, to guide our work in building relationships with lesser heard communities, and include a Women’s Network to create a space where women and their families feel safe and heard in shaping their care experience.

The network will be an important part of our ‘always on’ engagement across the organisation. It will form our blueprint for Perinatal engagement.

Current actions include:

- Collaboration with community groups such as the ‘Mums and Toddlers Foundation’ and ‘Chai and Chat’ to gather feedback and strengthen representation in planning and delivery of services.
- Work is also underway as part of the Perinatal engagement blueprint to establish an Minority Ethnic Sounding Board to embed diverse voices in policy and improvement decisions.
- Feedback mechanisms, including Civica surveys and outreach sessions are being expanded with translation support and cultural awareness questions.
- Staff participation in equality, diversity, and inclusion (EDI) training and events continues, alongside implementation of fast-track antenatal services for minority ethnic families.
- Inclusive practices are visible across clinical areas through multilingual signage, diverse educational materials, and access to interpretation services.
- Our website content dedicated to Perinatal Services is being reviewed and strengthened in order to provide better information to women and their families in an easy to read and accessible way
- Future plans include establishment of the Women’s Network Sounding Board, enhanced demographic data collection, culturally inclusive communications, and recruitment of diverse representation within the Maternity and Neonatal Voices Partnership.
- The service has also completed a comprehensive benchmarking exercise against the Health Education Inspectorate Wales (HEIW) Perinatal Engagement Plan. This analysis has informed the development of a strengthened local Engagement Plan designed to enhance outreach and involvement across Swansea Bay communities. The findings and proposed actions were presented to the Perinatal Committee, providing assurance on alignment with national expectations and on the service’s commitment to continuous improvement in perinatal engagement.
- Listening and engagement activities have also been undertaken by the Chief Executive Officer, Executive Director of Nursing and Patient



Experience, Oversight Panel Lead for family engagement with members of the Chinese and Muslim communities.

- Develop a Perinatal Engagement Strategy, triangulating existing intelligence data and insights gathered through listening and learning activities, to build a strategic approach to all elements of perinatal engagement. The Perinatal Engagement Strategy will include development of a "Harmed Patient Pathway", recognising the need to prevent secondary harm, and to focus on healing, accountability, and proper, timely communication rather than just investigation. The pathway will dovetail into other programme activities linked to trauma informed care, as well as our improved investigations process.

Action delivery date: Stakeholder mapping April 2026 / rolling programme of engagement

Action delivery date: Perinatal Engagement Strategy June 2026

3.3 Updates on areas needing immediate action

The Independent Review highlighted several areas where immediate action needed to be taken:

- **Induction of labour prioritisation** – progress and next steps described in Section 3.2 (R8).
- **Maternity Triage** – progress and next steps described in Section 3.2 (R1)
- **Implementation of MEWS** - progress and next steps described in Section 3.2 (R3)
- **Two-site working (PIP Workstream Action Reference 1.3.1-1.3.2)** – The development and rollout of an Intensive Care Standard Operating Procedure was implemented in Autumn 2025. Since the rollout, only one pregnant patient has been admitted to ITU. ITU admissions metrics are reported to the Perinatal Committee on a monthly basis. Since July 2025, Perinatal Services have been embedded into the Health Board three daily safety huddles and provide situation report which is disseminated across the Health Board. Implementation of the national Maternity Early Warning Score (MEWS) has supported the service's ability to identify deteriorating woman with appropriate escalation for medical review and treatment

Further benchmarking of our processes for two-site working is being undertaken, seeking best practice for multicentre site. Longer term consideration of single site working and location of Perinatal Services for future service modelling and future proofing of service will form



part of discussions linked to the next Clinical Services Plan. A Standard Operating Procedure for women in a non-maternity setting is in development, which will include coproduction of pre-emptive care planning and delivery of perinatal care in patients with complex medical issues. Formalised Terms of Reference for a Perinatal MDT and escalation process for high risk, complex care will support this work.

We are monitoring non-compliance with ITU SOP for pregnant women requiring care in non-maternity settings. This is managed via the local risk register in the Maternity Service; with exception reporting to Perinatal Committee on monthly basis.

- **Paediatric Radiology (PIP Workstream Action Reference 1.4.1- 1.4.2)** The Independent Review highlighted that increased specialist resource is required to ensure in and out of hours coverage for paediatric radiology, particularly for neonatal cranial ultrasound. Radiology images are currently interpreted by neonatal medical staff. Despite repeated efforts, the service has been unable to recruit additional paediatric specialist radiologists. While appointing another paediatric radiologist remains a requirement for the health board, the fragility of paediatric radiology services across Wales means that alternative long term reporting options will be considered, including the development of a regional model.

In the interim, the Perinatal Improvement Plan Executive Programme Board has approved outsourcing of plain films as of February 2026 to a third party organisation that meets the service demands. Images are reviewed in line with BAPM guidelines that give specifics on timely reporting of diagnostic imaging, with compliance to agreed departmental turnaround times stratified by clinical priority (e.g., urgent, priority, routine). Performance monitoring is via exception reporting to SDG Quality & Safety Forum.

4. FINANCIAL IMPLICATIONS

As noted in report, there are known financial implications linked to programme activity, specifically maternity triage staffing establishment, radiology provision, and trauma-informed care. Scoping details for an additional obstetrics theatre linked to Induction of Labour will include costs. These developments are subject to usual Health Board scrutiny processes and will follow these routes accordingly.



5. RECOMMENDATION

Members are asked to:

APPROVE:

- Approval in principle of the Perinatal Improvement Plan to go to the Independent Oversight Panel.

BE ASSURED:

- The organisation has a comprehensive plan to address the recommendations of the SBUHB Independent Review of Maternity and Neonatal Services, Family Led Review of Maternity Services, Llais Review and any actions required following the pending publication of the All-Wales Assessment of Perinatal Services.
- Progress made since the publication of the Independent Review on key safety actions.
- The Perinatal Improvement Plan is underpinned by a robust governance and reporting structure.

BE ALERTED TO:

- **Maternity Triage:** There has been a strong steer nationally that there will be an All Wales maternity triage service developed as a recommendation from the All-Wales Perinatal Assessment. Perinatal Improvement Plan Executive Programme Board has agreed to pause development of a standalone SBUHB model pending publication of the All-Wales Perinatal Self-Assessment (due end of Jan 2026). Mitigating action to provide a single point of contact triage phonenumber will be complete by February 2026. Calls will be to a single telephone entry point where women will be directed to the appropriate department based on their needs. This process will ensure that all calls for maternity triage are directed to one place.
- **Paediatric radiology:** Outsourcing of paediatric radiology provision as an interim mitigation measure. There is a need for potential regional solution to provide long term assurance and sustainability of service provision.



Governance and Assurance

Link to Enabling Objectives (*please choose*)

Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities

Partnerships for Improving Health and Wellbeing	☒

Co-Production and Health Literacy	☒

Digitally Enabled Health and Wellbeing	☒

Deliver better care through excellent health and care services achieving the outcomes that matter most to people

Best Value Outcomes and High Quality Care	☒

Partnerships for Care	☒

Excellent Staff	☒

Digitally Enabled Care	☒

Outstanding Research, Innovation, Education and Learning	☐

Health and Care Standards

(*please choose*)

Staying Healthy	☒

Safe Care	☒

Effective Care	☒

Dignified Care	☒

Timely Care	☒

Individual Care	☒

Staff and Resources	☒

Quality, Safety and Patient Experience

The health board is dedicated to ensuring that pregnancy and childbirth is a safe and positive experience for all service users in order to support healthy life choices and to give children the best start in life. This requires safe and effective maternity and neonatal services. The actions identified within this paper will support us in achieving these goals.

Financial Implications

As noted in report, there are known financial implications linked to programme activity, specifically maternity triage staffing establishment, radiology provision, and trauma-informed care. Scoping details for an additional obstetrics theatre linked to Induction of Labour will include costs. However, these will enable the improvements needed to realise the recommendations highlighted in the Independent Review.

Legal Implications (including equality and diversity assessment)

There are no legal implications associated with the report.

Staffing Implications



There are some staffing implications noted in the report, linked to training and recruitment.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The health board has a 10-year vision to be a high-quality organisation. Work being undertaken to address the concerns raised and to de-escalate from enhanced monitoring will not only support that vision but develop maternity and neonatal services which are safe and sustainable in the longer-term.

Report History	Oversight of Quality and Outcomes in Maternity and Neonatal Services (27 March 2025) Perinatal Committee and Independent Review Update Report (25 September 2025) Perinatal Report (27 November 2025)

Appendices	Perinatal Improvement Plan

Workstream 1: Clinical Critical Safety Actions

What does this theme encompass:	Immediate safety recommendations from the Ind Review including: •Triage •Induction of labour prioritisation •Two site working, risk mitigation, early warning scores •Neonatal radiology •Multidisciplinary training •Investigations/learning/actions •Senior level supervision/oversight •Escalation/raising clinical concerns						
	Executive Accountable Lead: Executive Medical Director (Richard Evans)						
	Operational Lead: Associate Service Group Medical Director CYP&W (Sujoy Banerjee)						
Group members: Deputy Executive Medical Director (Raj Krishnan) Neonatal Clinical Lead (Jo Webb) Clinical Director for Perinatal & Gynaecology Services (Madhu Dey) Head of Midwifery (Cath Harris) Obstetric Clinical Lead (Najiya Ali) Clinical Lead Anaesthetist – Singleton Site (Eleanor Lewis)			Dates of Steering Group Meetings for 2026: 6 January, 14:30 – 15:30 3 March, 14:00 – 15:00 7 May, 09:00 – 10:00 7 July, 14:30 – 15:30 1 September, 14:30 – 15:30 3 November, 14:30 – 15:30				
Themes	Overarching Action	Action ref	Action Detail	Owner	Timescales	Outcomes/Metrics (unless otherwise described, Reporting and monitoring is via Perinatal Committee)	Progress to date (inc date of update)
		1.1.1	Women and families have reported inconsistent access and variable experiences when contacting maternity triage services. Delays or incorrect triage advice pose risks to maternal safety and clinical outcomes. Implementation of a fully staffed triaged system, medical and midwifery staffing aligning with BSOTS methodology, aligning with guidance from the Royal College of Obstetrician and Gynaecologists and the Royal College of Midwives. The single point of access telephone number will support women to be directed to the appropriate departments based on thier enquiry, ensuring that all women requiring triage services will be directed to Maternity Triage as the single triage service.	Head of Midwifery	Sep-26		Dec 2025: Revised business case presentation at the Planning and Finance Assurance Subgroup. Jan 2026: Funding agreement for roles need for service still unconfirmed; recruitment not underway. Revised business case will be presented toPlanning and Finance Assurance Group on 21 Jan 26, which, if approved, will enable next steps. Escalate to Perinatal Improvement Exec Programme Board. January 2026: Business casefor new service being finalised. Current service able to provide appropriate cover between 12pm and 5pm, which is the evidenced highest acuity point. However, this can be impacted by staff availability. Requires further funding for 24/7 service. On-call service provided from 5pm by clinical staff who are also covering other areas, such as labour ward. Any incidents are logged on Datix and monthly audits undertaken of targets to identify and address any concerns. January 2026: There has been a strong steer nationally that there will be an All Wales maternity triage service developed as a recommendation from the All-Wales Perinatal Assessment 20 Jan 2026: Perinatal Improvement Plan Executive Programme Board agreed to pause development of a standalone SBUHB model pending publication of the All-Wales Perinatal Self-Assessment (due end of Jan 2026).
		1.1.2	Single point of access telephone number for women and families in Swansea Bay while full service is established. Realignment of current arrangement to ensure the temporary telephone number will provide a menu of options for women so they can be directed to the appropriate departments based on thier enquiry, ensuring that all women requiring triage services will be directed to Maternity Triage as the single triage service.	Head of Midwifery	Feb-26	% of women seen within primary target of 15 mins; secondary target of 30 mins; outcomes for those who are not seen in target time and those who leave before being triaged. % of dropped calls from the single point of access telephone number to Maternity Triage. Reported to Perinatal Committee on a monthly basis, and through Quality	March 2025: The development work including scripts for a single telephone number as the point of access for women and families to Swansea Bay Maternity Services completed. The service were advised to pause this work as this did not provide assurances for the implementation of a Maternity Triage Servcie which was aligned to the BSOTS model and RCOG best practice guaiance. Jan 2026: CH has shared script for options on single line with key stakeholders for feedback, these have been Welsh Translated and sent for recording. Jan 2026: Single telephone number request and communications plan for staff, women and wider stakeholders in development. Planned go live date Feb 2026.

Maternity Triage	1.1 Establish a dedicated 24/7 telephone triage service within maternity services to improve patient safety, streamline clinical workflows and enhance patient satisfaction	1.1.3	Establishment of a Single telephone access as outlined in model approved by SBUHB Board in July 2025. Establish effectiveness of BSOTS by benchmarking against standards (completed by Independent Midwife Nov 2025) and audit the quality of the telephone contacts with women and % of dropped calls.	Head of Midwifery	Sep-26	and Safety Committee. Development of risk to be added to local risk register to monitor delays in BSOTS guidance for appropriate escalation.	Nov 2024: Implementation of BSOTS within SBUHB has ensured a more standardised approach to risk assessment, prioritisation and escalation of women who attend the maternity triage department. In September 2025, 493 women were seen in triage; 98% were seen within the standard triage time. Sept 2025: Development of a business case to enable a full front door Maternity Triage service with a dedicated core set of midwives to provide a 24 hour telephone triage service separate to the clinical care requirements of a midwifery triage team (already in place). The business case also includes the requirement of a middle grade medical workforce to escalate women with urgent needs to maintain safety and mitigate compounded risk of delays impacting clinical outcomes for women and babies. Nov 2025: Business case reviewed and tested by Independent Obstetric Panel to provide assurances that the business case is robust and articulates the resource requirements to provide a safe, timely and effective Maternity Triage Service. Nov 2025: Independent Midwife assessment of Maternity Triage Service, benchmarked against RCOG guidance. Areas of non-compliance correlate to % recording of % dropped calls to triage, medical staffing and a separate telephone triage line mandated by Midwives 24 hours in an area away from clinical triage area of care. Reported to QSC and Board via the Perinatal Committee Report.
		1.1.4	Progress recruitment of staff (both midwifery and obstetrics) to provide robust maternity triage service as outlined in high level model approved in principle by SBUHB Board in July 2025. Improve the environment by ensuring that telephone triage is not co-located and is in an area that ensure privacy for triage calls.	Head of Midwifery / Clinical Director for Perinatal & Gynaecology Services	Sep-26	Staffing model fully established and trained at service launch due date	Nov 2024: Implementation of BSOTS, additional clinical midwife funded to ensure compliance with BSOTS staffing requirements - 2 midwives available 24 hours to provide clinical triage within the setting. Middle grade roster realignment to provide cover between the hours of 12pm - 5pm which is an interim measure to provide timely access to medical expertise when patient acuity increases as demonstrated by audited data. Ongoing BSOTS data reporting to ensure any breaches in review time are cross referenced to any harm events reported as a result of delays. Board alerted via the Perinatal Committee report. Dec 2025: Revised business case presentation at the Planning and Finance Assurance Subgroup. Jan 2026: Business case amendments to enable funding for roles for service being finalised. Risk of slippage - posts yet to be approved through vacancy authorisation process; recruitment and training time will require 3-4 months from approval. Jan 2026: There has been a strong steer nationally that there will be an All Wales maternity triage service developed as a recommendation from the All-Wales Perinatal Assessment. 20 Jan 2026: Perinatal Improvement Plan Executive Programme Board agreed to pause development of a standalone SBUHB model pending publication of the All-Wales Perinatal Self-Assessment (due end of Jan 2026).
about (IOL) Prioritisation	1.2 Develop and implement a robust process for booking and prioritising women undergoing induction of labour	1.2.1	Development of a digital system for booking and prioritisation of induction of labour	Consultant Women's Health / Deputy Head of Midwifery	Apr-26	proportion of IOL booked digitally;	Jan 2026: Full implementation will happen with Badgernet at the end of March 2026. Dedicate training will be provided as part of implementation.
		1.2.2	Development of standardised referral form template to ensure consistent information detailing Risk Assessment for every induction of labour. Develop a bookings process which includes triage of planned inductions of labour ensuring those with the highest level of risk are prioritised at the start of the working week. Implement multidisciplinary safety huddle which focus on review of booked IOL, check prioritisation category, assess staffing and bed capacity, identify risks or delays agree escalation actions if required.	Consultant Women's Health / Deputy Head of Midwifery	Apr-26	Proportion of IOL where risk assessment undertaken; proportion of IOLs undertaken as per risk assessment time frame; number of postponement or cancellation of IOL; number of adverse outcomes where IOL was undertaken out of sync with risk assessment or were delayed. Reported to Perinatal Committee on a monthly basis, and through Quality and Safety Committee. Locally reviewed through Maternity Services Risk Register (reviewed monthly and reported through Service's Quality, Safety and Risk Forum). Data to be periodically reviewed by peer unit to benchmarking performance.	April 2024: Multi-disciplinary hand overs twice per day. Planned activity including Induction of Labour and ongoing Induction of labour are discussed at these hand overs, risk assessed and prioritisation with staggered admissions of new inductions of labour timetabled. Sept 2025: Delayed or re-scheduled Induction of Labour DATIX reported and reviewed by the Perinatal Committee Report for monitoring and or escalation to Board. Jan 2026: IOL SOP sourced from another HB in England and being used as a template to adapt and develop an SBUHB bespoke version. Jan 2026: Working group to develop digital booking form on Badgernet. Currently using a paper-diary which consultants use to prioritise and this is communicated at MDT meetings twice a day.

Induction Of Labour		1.2.3	Capacity and demand for caesarean birth impacting on the Induction of Labour pathway with access to one only fully functioning theatre on labour ward - review and consider the opportunity to move planned caesarean birth off Labour Ward and away from acute labour needs of women. 1. Consider the impact of a rising caesarean section birth rate which is impacting on flow through labour ward leading to delays in induction of labour and ongoing care planning. 2. Explore establishment of elective obstetrics theatre to avoid delay of continuation of IOL (RCOG Labour Ward Solution Good Practice No.10 2010 - a guide to obstetric theatre requirements standards). / (Providing Quality Care for Women - A framework for Maternity Service Standards RCOG (20085) 7.2.3.5 There must be separate provision of staffing and resources to enable elective work to run independently of emergency work, in particular to prevent delays to both emergency and elective procedures and provision of analgesia in labour)	Clinical Director for Perinatal & Gynaecology Services / Directorate Manager Perinatal & Gynaecology	Business Case approval and submission to WGH by Health Board by the end of 2026	None at present - to be discussed after approval	Jan 2024: Elective Obstetric cases (by risk selection - lowest risk cases due to the location of Neonatal Services should a baby require resuscitation) x2 lists per week in main theatres Singleton. High Risk cases require planned birth on the Labour Ward creating risk for labouring women requiring an emergency section during planned births. Second obstetric theatre available and would be utilised in an emergency and main theatre staffing and capacity to run two theatres simultaneously. Planned caesarean births rising with current rate of category 4 (elective and 3 (at a time that suits the safety of the service) being 18.5% and 5.8%. Overall Caesarean birth rate 43.2% of all births in month and a landscape of 28% induction of labour rate. March 2025: Capacity and demand concerns escalated for service consideration. Date 2025: Commenced exploratory discussions and location of dedicated elective obstetric theatres. Jan 2026: Scoping exercise underway.
Two-site working	Ensure robust SOP is in place for admissions to ITU during the pregnancy pathway	1.3.1	Develop and implement Standard Operating Procedure for women in a non-maternity setting. (All-Wales Maternity Early Warning Score (MEWS) Standard Operational Procedure Morriston Emergency Department). SOP to include coproduction of pre-emptive care planning and delivery of perinatal care in patients with complex medical issues. Also to include formalised Terms of Reference for Perinatal MDT and escalation process for high risk, complex care.	Associate Service Group Medical Director CYP&W / CD of Midwifery / Clinical Director for Perinatal & Gynaecology Services / Consultant Neonatologist	Apr-26	Exception report of non-compliance with SOP for pregnant women requiring care in non-maternity settings. Monitored via local risk register in Service; and reporting by exception to Perinatal Committee on monthly basis.	July 2025: Development of SOP between Maternity and ITU Team - COMPLETED July 2025: ITU admissions metrics included in the Perinatal Committee report - COMPLETED July 2025: Perinatal services embedded into the Health Board 3 daily safety huddles and provide sit rep which is reported across the SBUHB - COMPLETED July 2025: Implementation of the national Maternity Early Warning Score (MEWS) - tool to support and identify the deteriorating woman with appropriate escalation for medical review and treatment - COMPLETED. July 2025: MDT implemented for any admissions in Morriston to support safe and effective care planning Sept 2025: SOP ratified by both Maternity a NPTSSG and Intensive Care MSG, signed off and ratified via Intrapartum Forum and noted at the service group's Quality and Safety Group -- ACTION COMPLETED Jan 2026: SOP to be reviewed and considered as a Health Board wide SOP for any woman admitted to any part of the service pregnant requiring MDT are planning and support - In Progress Jan 2026: Health Board consideration of single site working and location of Perinatal Service for future service modelling and future proofing of services. Jan 2026: Implementation of MEWS in other key areas, Gynaecology (COMPLETED), ED (COMPLETED with ongoing audit). (RAILLS to provide update to dates) NB existing Neonatal SOPs in place include Framework Plan for the Management of Possible Delivery of Pre-Term Infant At Morriston Hospital, Swansea; the neonatal guidelines on Sharepoint for 'newborn resuscitation' and 'Early Care of very Premature Babies'. In addition, for transport, the Standard Operating Procedures of CHANTS (Cymru inter-Hospital Acute Neonatal Transfer Service).
		1.3.2	Benchmarking and site visit exercise with other hospitals with two site settings to ensure our process is robust.		Apr-26	Testing of process through teaching and education exercises	Jan 2026: Only one site identified currently i.e. Liverpool. Clinical Leads to make contact and get SOP in action for comparison, and arrange visit to
Perinatal Radiology	Ensure the provision of full time paediatric radiology, including a mechanism for reviewing cranial USS in neonates.	1.4.1	Provision of suitable coverage either through local recruitment or SLA provision with another Health Board, funding agreement needs confirmation. Increased specialist resource is required to ensure in and out of hours coverage for paediatric radiology, particularly for neonatal cranial ultrasound. Radiology images are currently interpreted by neonatal medical staff. As an interim solution, the service plans to outsource image reporting. Despite repeated efforts, the service has been unable to recruit additional paediatric specialist radiologists. While appointing another paediatric radiologist remains a requirement for the health board, the fragility of paediatric radiology services across Wales means that alternative long term reporting options will be considered, including the development of a regional model.	Executive Medical Director	Dec-26	Images to be reviewed in line with BAPM guidelines; specifically timely reporting of diagnostic imaging, with compliance to agreed departmental turnaround times stratified by clinical priority (e.g., urgent, priority, routine). Exception reporting to SDG Quality & Safety Forum	Jan 2026: proposal need to agree specific requirements and way forward. Jan 2026: Discussions to commence at regional forum

Neonatal		1.4.2	Interim action: agree interim outsourcing arrangement for working hours currently not staffed and OOH provision, including funding.	Executive Medical Director	Feb-26	Images to be reviewed in line with BAPM guidelines; specifically timely reporting of diagnostic imaging, with compliance to agreed departmental turnaround times stratified by clinical priority (e.g., urgent, priority, routine). Exception reporting to SDG Quality & Safety Forum	Jan 2026: Approval for provision of outsourcing of service on interim basis agreed by PIP Executive Programme Board 20.01.26.
Multidisciplinary training	Ensure standardisation of training and usage of safety measures and tools linked to maternity and neonatal outcomes	1.5.1	Introduce the current maternity-specific early warning score tool to all areas where pregnant women are cared for. Ensure standardisation of training and usage of safety measures and tools linked to maternity and neonatal. Specifically: 1. Implementation of MEWS and NEWTT2 in Perinatal Services 2. Consider wider service implementation of MEWS where pregnant women access health services across the Health Board. 3. Consider wider service implementation of NEWTT2 where new-born babies may require care outside of perinatal services. 4. Provide ongoing assurances via audit that the tools are being used and evidence of escalation when scores indicate medical review required and achieved.	Associate Service Group Medical Director CYP&W / CD of Midwifery / Clinical Director for Perinatal & Gynaecology Services / Consultant Neonatologist	COMPLETE	Consistent usage of systems, including MEWS, NEWTTs, PROMPT, IFS and NLS. Training compliance reported to Perinatal Committee on monthly basis.	March 2025: Implementation of NEWTT2 across Perinatal services - COMPLETED July 2025: included in the Matron monthly audit on AMAT for long term sustainability of assurances. July 2025: Implementation of the national Maternity Early Warning Score (MEWS) - tool to support and identify the deteriorating woman with appropriate escalation for medical review and treatment - COMPLETED. July 2025: PROMPT training includes the new MEWS to align scenario based training to the current tools to monitor the deterioration of women. Oct 2025: Audit undertaken to test compliance with the new tool to detect deterioration of the new-born - COMPLETED Jan 2026: Implementation of MEWS in other key areas, Gynaecology (COMPLETED), ED (COMPLETED). Recognition of Acute Deterioration And Resuscitation (RADAR) to provide update to dates)
Investigations, learning and actions	Ensure improved timeliness and quality of dissemination/cascading of learning relating to investigations/concerns to operational teams	1.6.1	Communication following serious adverse events must be prioritised, and appropriate multidisciplinary reviews conducted within reasonable timescales, and in line with MBRRACE-UK and serious incident review guidance. 1. Establish whether existing timescales are in place for safety critical updates, and if not, establish standards of 24/48 hours, including records of dissemination. 2. Ensure non safety critical learning is cascaded via monthly "Risky Business" newsletter, including records of dissemination. 3. Engage with service governance processes and monitoring to assess performance.	Matron Neonates, Quality, Safety & Risk Nurse Specialist Neonates, Consultant Neonatologist (Arun Ramachandran), Consultant Obs & Gynae (Ellie Price), Interim Matron Maternity, Senior Advanced Neonatal Nurse Practitioner; Lead Midwife Quality Improvement Practitioner for Maternity Services	May-26	Learning to be formalised and documented via Clinical Audit Plans	April 2023: All National reportable incidents are incident reported and undergo a rapid review following first lining. First lining of incidents occurs daily Monday-Friday. All incidents are discussed in Maternity safety brief meeting Monday-Friday. All incidents identified as a NRI where care contributed to harm are reported and a strategy meeting is arranged following rapid review within 72 hours of first lining. All strategy reviews include executive chair, service group leads and PSIT for scrutiny. During the strategy meetings, make safe's are discussed, immediate actions, contact with the family and continued engagement plan and scope of investigation. All immediate actions and immediate make safe's are recorded and uploaded to the datax record for evidence in support for LFER. All incidents that are MBRRACE reportable are reported as NRI as identified as 'Must Reports'. These include notification to the PSIT and progress of incidents discussed in two weekly meetings with the Head of Assurance and NPTSSG Quality and Governance leads. All NRIs including must reports are escalated through Perinatal assurance to Perinatal committee for ward to board learning.
Level supervision / oversight	Delivery of consistent care with senior clinical staff oversight in line with policy mandates	1.7.1	To oversee the care of sick babies Senior Consultant presence needs to be clearly articulated within the clinical records. Develop and audit cycle and key indicators to provide assurance which include care planning underpinning decision making.	Clinical Director for Perinatal & Gynaecology Services / Consultant Neonatologist	COMPLETE		Nov 2025: RCOG and BAPM Senior Consultant presence: In Maternity, Senior Clinical Staff (specialty grade / consultant) is on site for 22.5 hours a day with back up non-resident consultant on call during out of hours. The neonatal unit has already implemented an interim 13 hour, seven day, on-site consultant rota from April 2025 in line with British Association of Perinatal Medicine (BAPM) guidelines, facilitated by the appointment of an additional locum consultant. These are currently in place. COMPLETED
		1.7.2	Senior clinician staff must have a mandatory presence in operative vaginal births, including rotational births, forceps or assisted breech births and complex caesarean births must be attended by senior clinical staff. Develop an audit cycle and key indicators to provide assurance which include births by birth mode. An audit will be undertaken using the TOMS system to review senior obstetric presence for: 1) operative vaginal births, including rotational forceps deliveries in theatre and 2) complex caesarean sections over a six-month period.	Associate Service Group Medical Director CYP&W / CD of Midwifery / Clinical Director for Perinatal & Gynaecology Services	COMPLETE	Interim measure: Benchmarking against BAPM guidelines already achieved. Additional measures to be embedded via Badgenet implementation (April 26), include presence at deliveries < 28 weeks gestation, presence at complicated CS or rotational forceps deliveries. Reported to Perinatal Committee on a monthly basis, including workforce metrics.	Nov 2025: RCOG and BAPM Senior clinician presence In Maternity, Senior Clinical Staff (specialty grade / consultant) is on site for 22.5 hours a day with back up non-resident consultant on call during out of hours. The neonatal unit has already implemented an interim 13 hour, seven day, on-site consultant rota from April 2025 in line with British Association of Perinatal Medicine (BAPM) guidelines, facilitated by the appointment of an additional locum consultant. These are currently in place. COMPLETED Jan 2026: TOMS - data collection will commence from February 2026. The audit findings will be presented at the Intrapartum Forum and recorded within the Q&S meeting. Any identified concerns will be escalated through the Perinatal Committee as appropriate.

Escalating / raising of clinical concerns	Senior leadership Ensure an embedded culture that enables staff to feel safe and able to raise and report clinical concerns	1.7.3	Consider revision of rota in labour ward and neonatal ward to ensure full coverage at BAPM recommendations	Associate Service Group Medical Director CYP&W / CD of Midwifery / Clinical Director for Perinatal & Gynaecology Services / Consultant Neonatologist	COMPLETE	Ongoing Benchmarking against BAPM guidelines. Reported to Perinatal Committee on a monthly basis, including workforce metrics.	Sep 2025: Benchmarking against the RCOG and BAPM standards of staffing ratios to provide senior oversight and support - COMPLETE
		1.8.1	Strategic culture development of a Multidisciplinary team leadership department programme designed and initially supported by Professor Michael West.	Workstream 3 (HR BP / Associate Service Group Director)	Apr-26	Triple AAA reporting through Perinatal Committee / Guardians Service / Reporting via audits and visits / staff survey / Trade Unions / Workforce Heatmap	Jan 2026: 6 sessions run between Feb 2026 and April 2026.

Workstream 2: Family Engagement

What does this theme encompass:	Listening and acting to ensure mothers and families at the heart of our decision making and service delivery, with a focus including: •Response to harm, including "Harmed Patient Pathway" •Decision making and consent •Investigations and learning •Birth trauma •Culture/behaviours, cultural awareness and diversity •Continuous improvement

Executive Accountable Lead: Executive Director of Nursing and Patient Experience (Elizabeth Rix)

Operational Lead: Head of Midwifery (Cath Harris)

Group members: Assistant Director of Insight, Commuications and Engagement (Jo Abbot-Davies) Head of Engagement (Nicola O’Sullivan) Patient Experience Midwife (Hannah Gardener) Quality, Safety & Risk Nurse Specialist - Neonates (Leanne Richards) Lead Midwife Quality Improvement Practitioner for Maternity Services (Kate Bannister) Service Manager Neonatology (Sam Jones) Consultant Midwife (Vic Owens) Kate Burke Diverse Outreach Workers team Patient Feedback Team Public Health Team	Dates of Steering Group Meetings for 2026: 6 January, 13:00-14:00 4 March, 10:00-11:00 5 May, 13:00-14:00 7 July, 11:00-12:00 9 September, 10:00-11:00 3 November, 11:00-12:00

Themes	Overarching Action	Action ref	Action Detail (inc ref no)	Owner	Timescales	Outcomes/Metrics	Progress to date (inc date of update)
Map sources of data, evidence and intelligence in relation to engagement	2.1. Produce a map of all sources of data, evidence and intelligence on our patients and their families experiences when accessing perinatal services, including: oListening in real time oListening when things have gone wrong oListening/engaging on future improvements	2.1.1	Map sources of feedback received through internal SBUHB channels, including QR code feedback, patient comments, feedback received to staff, feedback of staff.	Head of Midwifery	Complete	Captured in report to Perinatal Committee	
		2.1.2	Map external sources of feedback, including patient experience, complaints, incident reviews, reviews by external regulators	Patient Feedback Team	Quarterly from Apr 26	Single report of data produced with thematic learnings and insights	Jan 26: Constituent parts produced, work to be done to develop unified report
		2.1.3	Map post-independent review engagement undertaken by Oversight Panel Family Engagement Lead, ensuring feedback and actions are captured.	Ken Sutton / Assistant Director of Insight, Commuications and Engagement	Quarterly	Ensure any feedback is incorporated into overall engagement	Jan 2026: mapped engagement completed to date and regular catch ups diarised.
		2.1.4	Overlay mapped data with engagement intelligence to ensure robust and accurate reflection of feedback.	Assistant Director of Insight, Commuications and Engagement / Head of Engagement	Jul-26	Single integrated report collating all info in lines 7-10 received, considered and conclusions and actions reported to Perinatal Committee	Jan 26: Identified component parts, need to agree single forum for benchmarking prior to feeding back to Perinatal Committee.
		2.1.5	Review role and scope of the Maternity and Neonatal Voices Partnership in line with Llais guidance to ensure women and their families have robust presentation via the Partnership	Assistant Director of Insight, Commuications and Engagement / Head of Engagement / Head of Midwifery	Apr-26	Updated scope and terms of reference (as appropriate)	Jan 26: initial discussions with Llais commenced with a view to agreeing the way forwards.
		2.1.6	Develop a Perinatal Engagement Strategy, triangulating existing intelligence data. Strategy to include development of a "Harmed Patient Pathway".	Insight, Commuications and Engagement / Head of Engagement / Head of Midwifery / ED of Corporate Nursing & Patient Experience	Jun-26	Improved feedback and indicators from patients, trainees, HEIW site visits, Quality indicators, perinatal KPIs	Jan 26: scoping work underway on Harmed Patient Pathway

Stakeholder map	2.2 Finalise stakeholder mapping to ensure comprehensive plan for ongoing inclusive engagement: (a) specifically on MatNeo by the Service Group (b) specifically on MatNeo by DICE and other corporate teams (c) as part of the Health Board's 'always on' engagement process facilitated by DICE which generates feedback on any aspect of the Health Board's activities	2.2.1	Utilising NPT and Swansea CVSs, finalise stakeholder map including record of engagement to date and stakeholder categorisation.	Assistant Director of Insight, Communications and Engagement / Head of Engagement	Apr-26	All groups and mechanisms mapped and collated in engagement programme	Jan 26: commissioning undertaken; work commenced and expected to be completed by end of financial year
		2.2.2	Utilise Diverse Outreach Workers team to ensure capture of seldom heard voices and people who can't speak up.	Assistant Director of Insight, Communications and Engagement / Head of Engagement	in place, quarterly touchpoints	Ensure any feedback is incorporated into overall engagement	Jan 26: scope of work agreed and ongoing programme of developing relationships
		2.2.3	Develop engagement plan/framework for Perinatal team to support listening opportunities, feedback loops and to embed learning across the service based on our patient data, evidence and intelligence	Assistant Director of Insight, Communications and Engagement / Head of Engagement / Head of Midwifery	Quarterly from Apr 26	Single report of data produced with thematic learnings and insights	Jan 26: Identified component parts, need to agree single forum for benchmarking prior to feeding back to Perinatal Committee.
		2.2.4	Develop Women's Network sounding board, with feeder sounding boards specific to Perinatal Services	Assistant Director of Insight, Communications and Engagement / Head of Engagement / Head of Midwifery	Apr-26	All groups and mechanisms mapped into Women's Network and feeder sounding boards	April 26: first gathering / engagement activity held
Evolve Perinatal Improvement Plan using engagement feedback	2.3 Develop mechanisms to review the Perinatal Improvement Plan against feedback from stakeholders	2.3.1	Using the service specific engagement approach, ensure families' feedback is captured; and ensure that we test and evolve the Improvement Plan based on this. Also take advantage of any 'always on' engagement feedback relevant to the agenda.	Assistant Director of Insight, Communications and Engagement / Head of Engagement / Head of Midwifery	Quarterly	Improved feedback and indicators from patients, trainees, HEIW site visits, Quality indicators, perinatal KPIs	From April 26
		2.3.2	Pilot engagement approach as part of the maternity triage service changes that are in progress (link to Workstream 1)	Assistant Director of Insight, Communications and Engagement / Head of Engagement / Head of Midwifery	Feb-26	Improved feedback and indicators from patients, trainees, HEIW site visits, Quality indicators, perinatal KPIs, including triage metrics	Feb 26: Gather feedback from mothers of their experience of the new maternity triage service changes once they are implemented. Timing dependent on new triage implementation date.
Develop an always on engagement approach	2.4 Develop and adapt the organisation's "always on" approach to engagement to specific perinatal model, ensuring robust two-way feedback cycle	2.4.1	Evaluate pilot approach used for triage and amend and apply to an "always on" engagement approach	Assistant Director of Insight, Communications and Engagement / Head of	Mar-26	Single report of data produced with thematic learnings and insights	April 26: first gathering / engagement activity held
		2.4.2	Facilitate meaningful engagement opportunities for the Specialist Women's Experience Midwife, building on knowledge gleaned from the 'always on' engagement approach, particularly targeting hard to reach and disadvantaged groups	Assistant Director of Insight, Communications and Engagement / Specialist Women's Experience Midwife	Quarterly from April 26	Feedback shared as and when generated with the Head of Midwifery and Assistant Director of Insight, Communications and Engagement to enable the listen and act approach	
Population Health	2.5 Translate feedback into actions, focusing on Population Health improvements.	2.5.1	Coproduction of messaging relating to perinatal outcomes, e.g. smoking cessation, weight management, mapping against deprivation and worst served/at highest risk communities.	Public Health team	Mar-26		
		2.5.2	Coproduction of comms plan relating to Public Health team proposal for maternal weight management service	Assistant Director of Insight, Communications and Engagement / Head of Engagement / Head of Midwifery / Public Health Team	Feb-26		Jan 2026: Public Health team leading on development of (business case for maternal weight management service.

Workstream 3: Workforce / leadership / education and training

What does this theme encompass:	Leadership & Culture - Compassionate leadership/culture / behaviours Cultural awareness for minority groups Trauma informed care
Executive Accountable Lead: Executive Director of Workforce & OD (Tina Ricketts)	
Operational Lead: Associate Service Group Director, Children, Young People and Women's Services (Michelle Mason-Gawne)	
Group members: HR Business Partner (Jess Harris) Directorate Manager for Perinatal Services and Gynaecology Services (Abi Morris) Clinical Director for Perinatal & Gynaecology Services (Madhu Dey) Head of Midwifery (Cath Harris) Clinical Education Team TBC Psychology Service (Vanessa Hammond / Matt Lewis) Others to be coopted as needed	Dates of Steering Group Meetings for 2026: 6 January, 11:00-12:00 3 February, 09:00-10:00 3 March, 10:00-11:00 2 April, 13:00-14:00 5 May, 10:30-11:30 2 June, 13:00-14:00 8 July, 13:00-14:00 5 August, 10:00-11:00 8 September, 16:00-17:00 3 November, 15:00-16:00 8 December, 13:00-14:00

Themes	Overarching Action	Action ref	Action Detail	Owner	Timescales	Watch Metrics	Progress to date
Leadership and Culture	3.1 Ensure that our Perinatal Services have compassionate leadership, culture and behaviours	3.1.1	Develop and deliver a Multidisciplinary Team Development Programme co-designed and initially supported by Professor Michael West. This is a pilot programme aligned to national roll out led by HEIW. (Appendix 1). Pilot programme to be attended by senior leadership of Perinatal Services.	Associate Service Group Director /Associate Service Group Medical Director CYP&W	Apr-26	Workforce KPIs via the Heatmap, staff feedback, feedback from Guardian service and Trade Unions, and staff survey results.	Jan 2026: 6 sessions run between Feb 2026 and April 2026.
		3.1.2	Evaluation of this pilot programme will measure success prior to wider roll-out both locally and nationally. This evaluation will inform the next phases of cascade from April 2026 as appropriate. Continued collaboration with HEIW and the national programme will also enable scalability as required, along with adapted internal modalities and versions of delivery i.e. digital options.	HEIW/SBU HR BP and OD Lead	Quarter 1		Jan 2026: To commence in April 2026.
		3.1.3	Development of a Perinatal Staff experience, wellbeing and retention plan (SEWR) to cover all staff groups of Perinatal Services.	Directorate Manager, Clinical Director & Head of Midwifery - Perinatal & Gynae	Apr-26		Jan 2026: In development, meeting on 15.1.26 to scope out next steps with Perinatal Leadership Team. SEWR themes are aligned with key compentent themes of the improvement plan with specific reference to this workstream.
Cultural awareness for minority groups	3.2 Develop appropriate education and training linked to feedback from patients, families and groups representing patients from minority groups and communities who are less heard.	3.2.1	Ensure mandatory training relating to Equality, Diversity & Human Rights is completed across the service.	Directorate Manager, Clinical Director & Head of Midwifery - Perinatal & Gynae	Monthly reporting	Training Compliance Data	Jan 2026: Monthly monitoring and reporting in place via Perinatal Assurance Group.
		3.2.2	Ensure staff are aware of and are able to access translation services for women and families who require them.	Directorate Manager, Clinical Director & Head of Midwifery - Perinatal & Gynae	Mar-26	Patient feedback, site visit feedback, staff feedback, quality and safety data, ER cases, Chaplaincy, Datix, feedback from Trade Unions.	
Education and Training	3.3 Develop a documented Education and Training Plan for Perinatal Services	3.3.1	Develop a documented plan for education and training for Perinatal Training (also outlined in the draft Perinatal SEWR Plan) that includes four pillars of Mandatory & Statutory Training; Essential to Role; CPD; Personal Development Offer. To cover all staff groups of Perinatal Services.	Directorate Manager, Clinical Director & Head of Midwifery - Perinatal & Gynae	Jun-26	Training Compliance Data	Jan 2026: Further discussion at meeting on 15.1.26 to scope out next steps with Perinatal Leadership Team. Make use of PDN to support pulling this document together.
Trauma informed		3.4.1	Explore service requirements associated with an enhance provision of psychology-led therapeutic services.	Vanessa Hammond / Matt Lewis / Kathy Greaves (TBC)	Service changes to be in place by Sep 2026		Jan 2026: scoping underway
		3.4.2	Undertake recruitment exercise related to business case	Directorate Manager	Sep-26	Pending business case progress	

Trauma Info Care	3.4 Establishment of a psychology-led therapeutic perinatal service	3.4.3	Agree training programme and delivery schedule in trauma informed care to be rolled out to all staff groups of Perinatal Services.	Directorate Manager / Clinical Director & Head of Midwifery / Associate Service Group Medical Director CYP&W	Sep-26	% of staff attending training; Workforce KPIs via the Heatmap, Patient feedback, site visit feedback, staff feedback, quality and safety data, ER cases, Chaplaincy, Datix, feedback from Trade Unions	

Workstream 4: Governance

What does this theme encompass:	Immediate safety recommendations from the Ind Review including: •Board reporting •Complaints/incidents/claims processes •Structures and processes •Clinical guidelines •External relationships and reporting						
	Executive Accountable Lead: Director of Corporate Governance (Hazel Lloyd)						
	Operational Lead: Clinical Director of Midwifery (Kathy Greaves)						
Group members: Head of Assurance and Regulation (Rebecca Nix) Head of Corporate Governance (Kate Morgan) Senior Advanced Neonatal Nurse Practitioner (Gemma Davies) Lead Midwife Quality Improvement Practitioner for Maternity Services (Kate Bannister)		Dates of Steering Group Meetings for 2026: 6 January, 14:30 – 15:30 5 February, 14:30-15:30 4 March, 14:00-15:00 1 April, 10:00-11:00 6 May, 14:00-15:00 3 June, 11:00-12:00 8 July, 14:00-15:00 5 August, 13:00-14:00 4 September, 13:00-14:00 7 October, 14:00-15:00 4 November, 13:00-14:00 2 December, 14:00-15:00					
Themes	Overarching Action	Action ref	Action Detail (inc ref no)	Owner	Timescales	Outcomes/Metrics (unless otherwise described, Reporting and monitoring is via Perinatal Committee)	Progress to date (inc date of update)
Governance for Perinatal Improvement Programme	4.1 Agree & define governance for Perinatal Improvement Programme (PIP).	4.1.1	Establishment and clear definition of governance structure for PIP, underpinned by appropriate documentation to ensure robust and timely reporting to Board (Appendix 2).	Exec Director Nursing & Patient Experience / Director of Corporate Governance / Programme Lead	COMPLETE	Establishment and clear definition of governance structure for PIP, underpinned by appropriate documentation to ensure robust and timely reporting to Board. Clear reporting framework for key indicators of maternal and neonatal outcomes and performance indicators, including critical events, time limited pathways, MBBRACE, NNAP, and workforce KPIs based on heatmap.	Dec 2025: Perinatal Improvement Plan Executive Programme Board established, chaired by CEO. Meeting on bimonthly basis, with monthly update papers submitted to SBU Management Board. Formal reporting to Board also uses existing processes and follow governance framework to Alert, Assure and Advise. Terms of Reference also make provision to include recommendations to be actioned from All-Wales Self Assessment on Maternity and Neonatal Services once published.
		4.1.2	Clarify "business as usual" governance to provide assurance on perinatal performance sitting outside of Perinatal Improvement Plan reporting mechanisms.	Exec Director Nursing & Patient Experience / Director of Corporate Governance / Programme Lead	COMPLETE	Clear definition of governance structure for operational "business as usual", underpinned by appropriate documentation to ensure robust and timely reporting to Quality and Safety Committee. Clear reporting framework for key indicators of maternal and neonatal outcomes and performance indicators, including critical events, time limited pathways, MBBRACE, NNAP, and workforce KPIs based on heatmap.	July 2025: Perinatal Committee established, chaired by Exec Director of Nursing and Patient Experience. Reporting on a monthly basis on business as usual performance, including . Reporting into Q&S Committee. Underpinned at operational level by Perinatal Assurance Group. Formal reporting to Q&S follows governance framework to Alert, Assure and Advise.
		4.1.3	Ensure that there is a robust understanding from Ward to Board of the Governance process for the Perinatal Services - link into Perinatal Services Education and Training (Workstream 3) to build into induction process and in learning offers.	Senior Advanced Neonatal Nurse Practitioner / Lead Midwife Quality Improvement Practitioner for Maternity Services / Service Group leads	Jun-26	Training compliance data	

Benchmarking	4.2 Benchmarking against other Health Boards of governance processes to seek out best practice and provide highest levels of assurance for SBUHB processes	4.2.1	Undertake comparison exercise against other Health Boards to compare SBUHB perinatal governance arrangements, and highlight any gaps and or areas the organisation provides a higher level of assurance. Integrate learning into our processes.	Head of Corporate Governance	Mar-26	Comparison of arrangements and desktop testing to map any gaps in our arrangements	
Guidelines Group	4.3 Establish Maternity and Neonatal Guidelines Group to ensure cyclical review, adoption and rollout of perinatal guidelines, with priority given to critical safety/national and NICE guidelines	4.3.1	Establish Maternity and Neonatal Guidelines Group, underpinned by ToR and core membership, to ensure cyclical review, adoption and rollout of perinatal guidelines, with priority given to critical safety/national and NICE guidelines. Reporting through Perinatal Committee in line with "business as usual" governance arrangements. Ensure administrative activities are aligned with existing processes on WISDOM (mat) and COIN (Neonates) and develop a system for monitoring, tracking and reporting using AMaT.	Clinical Director of Midwifery / Senior Advanced Neonatal Nurse Practitioner / Lead Midwife Quality Improvement Practitioner for Maternity Services	Mar-26	Timely review of guidelines ensuring 100% of locally owned are reviewed, that national guidance is benchmarked adopted and embedded into services; workforce heatmap KPIs; auditable standards are included on the forward audit plan.	Jan 2026: terms of reference (Guidelines/Audit Forum) drafted, annual schedule for meetings in progress. Percentage of guidelines in date monitored via Forward Audit plan in draft. Workforce metrics embedded and presented at Perinatal Committee. Current compliance across all guidelines sits at 88%, however, this is an aggregated figure that includes local service guidelines, which are within the service's gift to manage, as well as wider Health Board policies and national policies that are beyond the control of the Perinatal Service teams.
Investigations, learning and actions	4.4 Ensure improved timeliness and quality of dissemination/cascading of learning relating to investigations/concerns to operational teams	4.4.1	The Board must ensure that, where there is a clear trigger for independence or external review, this is actioned; examples would be a very serious incident, serious birth injury, maternal death, or mortality review. The Board must ensure greater involvement of families in investigations. - Perinatal governance processes demonstrate triggers for independent reviews. - Perinatal governance processes demonstrate how the service engaged with families subject to a case review, provided feedback and disseminated learning across the service on completion of the reviews. - Perinatal services to demonstrate how immediate 'Make Safes' are identified and cascaded urgently at the time of identification. - Perinatal services and Health Board governance structure must demonstrate floor to Board and Board to floor reporting for assurance and escalation purposes.	Director of Corporate Governance	May-26	Requires adjustment to the governance process and policy	Maternity services have commissioned external reviews for all Maternal deaths since November 2024. All NRI where care was not considered contributory are escalated for external review for transparency and learning. At present, this is facilitated through expert independent clinicians and the service is absorbing the expenses for these reviews. At present, perinatal services have four external reviews outstanding. Where the service identified a BOD has occurred, the service is undertaking the review, with the acknowledgement experts will be instructed at redress / claim stage for causation to ensure reviews are timely for families. At present, external reviews are taking over 12 months to return, despite experts confirming timing during instruction. The perinatal service engages all families who undergo a HIE, Stillbirth, Neonatal death, Maternity death or incident triggering a DOC. All families have face to face meeting during admission and point of contact. All families receive written confirmation and are provided with a questionnaire to be able to engage in the review process and ask questions. At present, the service is reviewing a SOP for continued engagement with families, to ensure families are kept informed of progress of review throughout investigation. All parental feedback is included within the review and addressed by the MDT. All Stillbirths, HIE, Neonatal deaths, Maternal deaths and incidents triggering DOC
		4.4.2	External input is critical in ensuring that learning from mortality reviews is maximised. Development of reciprocal arrangements with other UK networks to participate in case reviews would ensure a true 'fresh eyes' approach.	Director of Corporate Governance	May-26		At present, Perinatal services are commissioning external reviews through the legal team - instructing expert clinicians to provide an opinion. This has been costly and timely for the service.



QUALITY AND SAFETY COMMITTEE Key Issues Report

The purpose of this report, is to provide an overview of the matters identified by the Quality and Safety Committee to be brought to the attention of the Board following discussions at the last meeting.

Date of Committee meeting:		8 January 2026
Members Present:		Five Members were present at the Quality and Safety Committee: Jean Church, Anne-Louise Ferguson, David Martin Lloyd, Nicola Matthews and Steve Spill
Quoracy:		YES
Group/Committee Chair:		Jean Church
Report Submitted by:		Corporate Governance
Report Signed off by:		Jean Church, Quality and Safety Committee Chair
Date of Board receiving the report:		29 January 2026
1.	Agenda	The Quality and Safety Committee convenes bi-monthly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert	The Committee is alerting the Board to the following items (6):
	Minute Reference: 07/26	• Perinatal Committee: The Board is alerted to the Single Point of Access Maternity Triage System which is due to launch in April 2026 and which is dependent on the recruitment of newly qualified midwives and approval of the case to support change in the Obstetric Workforce implications highlighted within the report. While overall performance remained positive, the triage process continued to require attention to ensure timely assessment and prioritisation of women presenting with unscheduled pregnancy-related



		concerns. The Committee received assurance from the continuing development of the Perinatal Committee report.
	Minute Reference: 08/26	• Mental Health Transformation Programme: Concerns were raised regarding the 94 open serious incidents, including 47 cases breaching the 120-day investigation target and an average of 12 new incidents arising each month. This level of backlog and delay continues to present a material risk to the Organisation. The Committee agreed that the Board must be made aware of this position and should receive an update on the work being led by Elizabeth Rix to restructure staffing and processes in order to improve the timeliness and quality of serious incident investigations with the ambition to significantly reduce if not close by end March 2026.
	Minute Reference: 10/26	• Governance Structure covering the oversight and risk assessment process for Your Next Patient, Bed closure and Clinically Optimised Patients reduction plan: The anticipated Report was not presented to Committee due to a miscommunication on dates. The Paper will be presented at the next Board meeting. The Committee highlighted the ongoing unresolved risks and emphasised the need for clearer evidence that risk assessments and safeguards were being applied consistently. The next Committee meeting to be held on 5 February will receive a deep dive Report covering the following areas: ○ Plan to close surge beds/beds in Morriston and timeline ○ Model of care for the patients in Singleton and how this is being managed ○ Plan to reduce the risks of blocking fire doors ○ Oversight of YNP ○ Risk assessing areas and patients process
	Minute Reference: 11/26	• Health and Safety Deep Dive including; Estates and Capital report: Significant failures were identified in Respiratory Protective Equipment (RPE), with only 4 of 13 powered respirators operational, highlighting immediate staff-safety risks and revealing wider weaknesses in routine equipment governance,



	Minute Reference: 11/26 Minute Reference: 12/26	maintenance and fault-reporting processes that require Board attention. • Health and Safety Deep Dive including; Estates and Capital report: Risks were highlighted regarding limited Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)2025/26 ,19 reported 5 in time, 14 late; training capacity impacted due to limited resources (albeit new package developed and delivered to 479 staff, with implications for organisational compliance and staff safety. • Incoming Referral, Workforce and OD Committee to the Quality and Safety Committee: Minor Injuries Unit (MIU) report on staff feeling unsafe, security and overall patient safety to the Quality and Safety Committee for oversight and follow-up on patient safety concerns: Serious concerns were raised regarding staff safety, environmental risks within the Minor Injuries Unit, and gaps in security capability, including the inability to lock down the department, alongside a rising trend in violence and aggression. These risks are foreseeable and significant, requiring immediate senior-level attention to ensure robust safeguards, strengthened governance oversight, and coordinated engagement with security and policing partners to protect both staff and patients. The Committee requested the current risk score (16) be revisited.
3.	Assurance Minute Reference: 07/26	The Committee is assuring the Board on the following items (1): • Perinatal Committee: The Committee was assured that the Perinatal Service Board report provided a comprehensive and robust overview of current performance and quality standards. The report demonstrated that the service was functioning effectively, with no aspects of care identified as negative outliers. This reflected strong governance, adherence to clinical standards, and a continued commitment to patient safety and improvement.



4.	Advise Minute Reference: 06/26 Minute Reference: 06/26 Minute Reference: 06/26 Minute Reference: 08/26	The Committee is advising the Board on the following items (4): • Quality and Safety Group report: Internal Audit Report of Control Drug Governance (Nov.2022) It was highlighted that a further internal audit was to be undertaken during the final quarter of this year (2025/26) to address the delayed response to closing down all matters highlighted in this Audit. • Quality and Safety Group report: End of Life Care. It was stressed that the Board should be informed that resources have not yet been identified to support Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) activity, which requires urgent attention to provide patients and families with appropriate levels of care • Quality and Safety Group report: It was emphasised that the Board should be made aware of the reopening of the Caswell Clinic, ensuring understanding of this development and its implications for service provision. • Mental Health Transformation Programme: All Quality and Safety priority areas now have clearly defined actions and timelines in place, demonstrating strengthened governance and improved oversight of delivery. Lack of cohesion across workstreams will be addressed via the Programme Board.
5.	Review of Risks	The Quality and Safety Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	Board is asked to consider the alerts (6), advice (4) and assurance (1) provided above. Additionally, the Committee is seeking guidance from Board on defining the scope of services provided to HMP Parc, highlighting recurring concerns about resourcing and operational impact on the Minor Injuries Unit.

Meeting Date	29 January 2026	Agenda Item	4.3
Name of Meeting	SBUHB Board		
Report Title	Welsh Government (WG) Oversight and Escalation Update and SBUHB Integrated Performance Report		
Report Author	Meghann Protheroe, Head of Health Board Performance		
Report Sponsor	Deb Lewis, Chief Operating Officer and SRO for Targeted Intervention Darren Griffiths, Director of Finance and Performance		
Presented by	Deb Lewis, Chief Operating Officer and SRO for Targeted Intervention		
Freedom of Information	Open		
Purpose of the Report	To provide the Board with a summary of the performance and outcomes issues for the services escalated as part of WG Oversight and Escalation Framework, along with a general update of the Health Boards Performance against the Key Strategic Objectives.		
Key Issues	This report provides a monthly update on all areas of delivery currently in escalation against WG Oversight and Escalation Framework, namely: Level 4 • Maternity and Neonates (escalated in July 2025). • Finance, strategy and planning. • Performance and outcomes relating to cancer, Urgent and Emergency Care and quality of care related to HCAs. Level 3 • Performance and outcomes relating to planned care and CAMHS. The attached Integrated Performance report (IPR) is a routine report that provides an overview of how the Health Board is performing against the National Delivery measures and key local quality and safety measures. The IPR includes an update against four three priority areas for the Health Board: 1. Welsh Government Escalation (RAG Rating status)		

	2. Performance against the Health Boards 5 Strategic Objectives 3. Service Specific Updates The Performance metrics outlined within Section two of the Integrated Performance Report have been aligned to the Health Boards five Strategic Objectives. Key Updates will therefore be provided against the five Strategic Objectives below: - 1. People of Swansea Bay live healthier, equitable and more equal and prosperous lives 2. Care is high quality, safe, efficient and delivers the best possible outcomes for people 3. Care is delivered in safe and appropriate settings supported by innovative digital solutions 4. The health board is a great place to work where staff feel valued and work together towards a common goal 5. The health board is a resilient, financially sustainable and responsible organisation An additional section has been included in the report which will provide "Service Specific Updates" as and when requested by the Performance and Finance Committee work programme. In this paper, the following service specific updates will be included: - Neurodevelopmental Disorders Service (Appendix 1) - Theatre Utilisation (Appendix 2)			
Specific Action Required <i>(Please choose one only)</i>	Information	Discussion	Assurance	Approval
	☐	☐	☒	☐
Recommendations	Members are asked to: • CONSIDER the monthly update in respect of performance against escalation measures and de-escalation criteria. • ACKNOWLEDGE and DISCUSS the Health Board performance against key measures and targets.			
Appendices	Appendix 1: Integrated Performance Report Appendix 2: Theatre Utilisation			

WELSH GOVERNMENT OVERSIGHT AND ESCALATION UPDATE

1. INTRODUCTION

The previous reports have described the actions and longer-term proposals being developed and implemented in response to services escalated to targeted intervention status. The reports provided an update on the operational programme to manage the delivery of improved performance and outcomes for services under targeted intervention.

The current report will provide an update against all levels of Oversight and Escalation of services within Swansea Bay University Health Board (SBUHB) and will include;

Performance against Areas of Targeted Intervention (Level 4)

- Cancer
- Urgent & Emergency Care
- Quality of Care related to Healthcare Acquired Infections
- Maternity and Neonatal Services
- Finance
- Strategy and Planning

Performance against Areas of Enhanced Monitoring (Level 3)

- Planned Care
- Child and Adolescent Mental Health

2. BACKGROUND

Following WG tripartite meeting in December 2023, SBUHB was notified of an escalation of performance monitoring for performance and outcomes from enhanced monitoring to Targeted Intervention. The services listed in the introduction of this report were specifically included in the escalation.

On 12th April 2024, SBUHB had its inception meeting with Welsh Government colleagues and on 24 April 2024 the first quarterly meeting was held with the Chief Executive of NHS Wales. Quarterly meetings subsequently alternate with formal Joint Executive Team (JET) meetings. Monthly review meetings are with WG officers focussing on key updates against the escalated areas. The Chief Operating Officer is the Senior Responsible Officer (SRO) for targeted intervention and each work programme is supported by senior management and clinical leads.

Summarised updates against the escalation levels will be provided throughout this report.

Following the Tripartite meeting in February 2025, the levels of escalation have been revised and updated as follows;

- Child and Adolescent Mental Health Services de-escalated from level 4 (targeted intervention) to level 3 (enhanced monitoring).
- Planned care de-escalated from level 4 (targeted intervention) to level 3 (enhanced monitoring).

Updated de-escalation criteria was provided by WG in April 2025 which provided updated targets for several areas within Level 3 Enhanced Monitoring. The updated de-escalation criteria can be seen throughout the paper.

Following the publication of the Independent Maternity and Neonatal Review published on 15 July 2025, the decision was made to escalate Maternity and Neonates to Level 4 (Targeted Intervention) from Level 3 Enhanced Monitoring. Updated de-escalation criteria relating to Maternity & Neonates was published in September 2025 and has been incorporated into this paper.

3. PERFORMANCE AGAINST THE TARGETED INTERVENTION SERVICES

3.1 Cancer

Criteria to Achieve	Current Performance
• 60% performance maintained for 3 months against the Single Cancer Pathway (SCP) target.	• September – 60% • October – 56% • November – 52%

Actions being taken to improve include:

- Continued focus on front end of pathway for all specialties
- Commencing demand and capacity work in relation to the cancer pathway supported by Transformation Team
- Outsourcing pathology backlog for Skin, Urology and LGI
- Detailed Dermatology demand and capacity exercise, supported by Healthcare Systems Engineering team currently in progress.
- Phase 2, business case development for the long-term provision of complex gynae-oncology surgery commences.

3.2 Urgent and Emergency Care

Criteria to Achieve	Current Performance
A continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months (Based on quarter 2 and 3 2023 baseline).	- October – 173 (19% increase) - November – 162 (6.4% reduction) - December – 329 (103% increase)
Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board.	- October – 9.17% - November – 8.83% - December – 9.95%
Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes.	- October – 90.28% - November – 89.62% - December – 84.87%
A continuous reduction in delayed pathways of care of 5% for three consecutive months and then maintained for three months (based on Oct-Dec 23 baseline).	- October – 186 - November – 179 - December – 169 (In target)
Assessment of declared BCIs, including reasons why, actions taken, and lessons learnt.	BCI declared 6th – 8th January and 11th – current. (Robust weekend plans are in place to minimise risk and to maintain patient flow).

Actions being taken to improve include:

- Full implementation of D2RA model** – Focus on D2RA has rapidly shifted into understanding the demand and capacity position for pathway 2 beds and utilisation of that bed pool. Therapy led audit undertaken in December of all patients occupying a pathway 2 bed. Data analysis in progress with Deloitte's support. Early indication is that there is opportunity to work with Local Authority partners to potentially reduce the Pathway 2 bed pool and enhance the Pathway 1 offer. The reset fortnight in December demonstrated good opportunity for partnership working, with a focus on those patients who are clinically optimised. This process has continued and there has been some improvement in patient flow. Planning for the transfer of 30 clinically optimised patients from Morriston to Singleton took place during December 2025 and the plan was implemented w/c 5th January 2026.

- **UEC Care co-ordination Hub** – The single point of access has been in place since the 1st October 2025 and the first data submission took place on the 21st November. There is specific focus on the “clinical conversation before convey”, aimed at reducing conveyance of patients from care homes where clinically appropriate to do so. Work is also focussed on the management of patients who fall with the implementation of a level 2 Falls service made up of therapy technicians and a registered therapist, supported by St Johns ambulance provision.
- **Pathway of Care Delays (PoCD)** – SBUHB has seen a recent increase in the POCDs. Focussed attention on this position continues following the learning from reset fortnight with a daily review meeting taking place to focus on flow.
- **Revised flow operating model:** The revised operating models implemented as part of the test of change in Morriston remain in place. However, increase in demand for emergency care, high levels of patient occupancy driven by medical bed day utilisation has challenged the Health Board’s ability to maintain flow and thus the level of ambulance handover performance achieved following the tests of change. The emergency pressures have tipped the Health Board into two formal Business Continuity incidents, consistent with the pattern currently seen across NHS Wales. A complicated Infection Control picture further contributes to the interruption of patient flow with capacity reduced as a result of winter illnesses.
- **UEC capital redesign** – Recent communication from the Chief Executive to the Director General of NHS Wales sets out an urgency to progress to an Electronic Patient Record across the Urgent and Emergency care services. Whilst there remains ambition to co-locate front door assessment processes with the emergency department, this programme of work cannot be progressed in the absence of Capital investment.

Elements of the above are all linked to front door assessment in patient pathways, and complex discharge is being tested via the Quality Improvement process around the thematic review of Urgent and Emergency Care Services. Deloitte are leading on this work as part of the financial recovery and sustainability programme.

3.3 Maternity and Neonatal Services

On 12th December 2023, maternity and neonatal services were escalated to level 3 (enhanced monitoring) following an assessment of issues and concerns related to staffing levels, quality and safety issues, the issues within the HIW unannounced inspection at Singleton as set out in the

report published on the 15 December 2023. Subsequently, in July 2025, following receipt of the Independent Review report, the decision was made to escalate Maternity and Neonatal Services to Level 4 – Targeted Intervention.

Detailed progress against these areas will be provided as part of the Perinatal Committee, chaired by the Executive Director of Nursing. However, a summary of progress can be found in the table below:

Criteria to Achieve	Current Performance
Ensure that the recommendations and actions in the Independent Review are progressed in line with agreed timescales and report progress to Welsh Government monthly, highlighting risks to delivery.	- Perinatal improvement programme has been established Dec 2025 - Exec led workstreams are underway Dec 2025 - Quarterly Perinatal updates to Board ongoing
Ensure that the agreed actions in the family-led review into Swansea Bay maternity services are progressed in line with agreed timescales and report progress to Welsh Government monthly, highlighting risks to delivery.	- The agreed actions of the family led review have been integrated to the Independent Review improvement plan – Jan 2026
Receive a positive assessment from the Welsh Government independent observer on progress against the agreed maternity and neonatal action plan.	- We await the outcome of the assessment process – anticipated Jan/Feb 2026
Agree a set of sustainability conditions with Welsh Government that can be used to track improvements.	- Have developed Perinatal reporting to Board through Quality & Safety committee Jul 2025 - Routinely reviewing staff retention and well-being plan – revised plan launching Q4 2026 - Pulse surveys underway – quarterly - Robust Governance processes in place – Dec 2025



Criteria to Achieve	Current Performance
Evidence effective Board scrutiny and oversight of maternity and neonatal services.	Governance structure in place – July 2025; updated Dec 2025  Appendix 2 Perinatal Governanc
Embed the maternity and neo-natal dashboard across the service to demonstrate that data is driving real decision making.	Complete
Regularly review the risk register, appropriate risk management, and mitigations.	The risk register is reviewed at monthly Perinatal committee and flagged at Quality & Safety Committee and through to the Board
Regularly review against agreed outcomes to demonstrate that there is continued embedding of the LRI/NRIs, complaints and concerns process within quality governance, ensuring responses in a timely manner.	- Monthly reporting through Perinatal Committee and Board - Ward to Board reporting
Evidence a joint and effective PMRT meetings across the service with engagement of affected families.	Ongoing Part of the improvement plan and reported through perinatal committee
Maintain the required staffing establishment at appropriate numbers and grades.	Ongoing - Reported monthly through Perinatal committee, into Quality & Safety committee and into Board. - Key element of performance report
Achieve and maintain training compliance rates for all staff in maternity and neonatal services.	Complete Reviewed at monthly performance and perinatal committee – key element of the report
Demonstrate required corrective action against Patient Reported Outcome Measures and Patient	Ongoing All reported monthly through Perinatal



Criteria to Achieve	Current Performance
Reported Experience Measures data for maternity and neonatal services.	committee, into Quality & Safety committee and into Board. - Additional requirements included in perinatal improvement plan
Evidence how women and family feedback shapes service design within the health board.	Ongoing – Perinatal Improvement Plan outlines engagement blueprint as follows: - Service specific engagement undertaken by the service itself, mostly using its own contact with service users; ongoing rolling programme with reporting through Perinatal Committee. - Service specific engagement undertaken by corporate teams, particularly DICE and the independent review's engagement lead - "Always on" engagement at a pan Health Board level which sees generic engagement activity offering up insights and feedback relevant to the maternity and neonatal services. Ongoing - Mapping of groups across the Swansea and Neath Port Talbot areas – to be completed April 2026 - Develop a Network of Sounding Boards that builds on work being undertaken as part of the Women's Health Plan – April 2026
Provide assurance that clinical leadership is consistent, visible, effective, and that leadership development support is in place.	Ongoing - Senior clinical staff present as required by BAPM guidance; underpinned by audit cycle and key



Criteria to Achieve	Current Performance
	indicators which include care planning in decision making. Reported to Perinatal Committee on monthly basis. - Multidisciplinary Team Development Programme rooted in compassionate leadership, culture and behaviours to be delivered between Feb and April 2026
• Provide assurance and evidence of an improving culture through appropriate surveys, and/or qualitative assessment for maternity and neo-natal services.	Ongoing - Reported through monthly Perinatal committee and includes: ○ Workforce heat maps that cover staff feedback ○ Patient feedback ○ Guardian service ○ Patient voices forum ○ Pulse surveys ○ Feedback from all visitors reporting positive change

3.4 HCAI Improvements

Criteria to Achieve	Current Performance
• Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by board Quality Safety (Q&S) Committee and Board.	• Embedded Quality Improvement approach in this area, monitored closely via Q&S Committee and Board.
• The Health Board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs.	• In place

Criteria to Achieve	Current Performance
<i>C.difficile</i>: reduce the number of hospital onset infections by 40% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 10 cases to no more than 6 per month)	- October -5 - November – 10 - December - 10
Staph aureus: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 4 cases to no more than 3 per month)	- October – 4 - November – 4 - December - 3
E-coli: reduce the number of hospital onset infections by 20% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 5 cases to no more than 4 per month)	- October – 5 - November – 5 - December - 4
Klebsiella: reduce the number of hospital onset infections by 10% and maintain for 3 months based on 2017/18 figures (baseline – 54 cases in 2017/18, reduce to average of at most 4 per month)	- October - 4 - November – 3 - December - 7

From the beginning of December 2025, there were 19 new infection related incident/outbreaks (non-C. difficile related), involving two or more patients affecting a total of 76 patients (124 bed days lost). These new incidents/outbreaks occurred over 19 wards, with concurrent infections in several wards.

- **Mental Health:** Two incidents, one with Norovirus, one with a respiratory virus (15 bed days lost).
- **Morriston:** Ten incidents. Three associated to COVID-19, four to Influenza and three to Norovirus. Two wards were affected by concurrent incidents of Influenza and Norovirus (Total bed days lost 82).
- **Neath Port Talbot:** Five incidents across three wards. One ward affected by Norovirus, one ward had concurrent incidents associated to Norovirus and Covid-19, and one ward had concurrent infections associated to Covid-19 and Influenza. (Total bed days lost 15).
- **Singleton:** two incidents affecting two wards, both associated to Influenza A. (Total bed days lost 12).

There were five new *C. difficile* periods of increased incidence (PII) detected involving thirteen patients in total, with one new transmission event between two patients.

HCAI case review themes:

Over occupancy, insufficient single room capacity, inability to decant bays and deep clean (4D clean) the care environment and patient equipment.

Patient risk factors that may have contributed to the development of *C. difficile* infection episodes include old age, prolonged and frequent admissions to health care settings, multiple co-morbidities and antibiotic requirements to treat other infections.

Actions being taken to improve include:

- Gold *C. difficile* High Incidence Management Group.
- Monitoring of *C. difficile* Standards: Risk Assessment & Governance Framework.
- Continuation of QI Project in Acute Medical Unit focusing on AMS and 72-hour review and improving switch to oral route for administration.
- Scoping exercise to explore the feasibility of extending role of ward based enhanced cleaner.
- Trial of new Microfibre cleaning systems
- Primary care QI projects to reduce urinary tract infections in care home residents.
- Scoping the development of an equipment decontamination facility.
- Review of prescribing guidelines for antibiotic prophylaxis during prolonged surgical interventions.

3.5 Finance

The Health Board's assessment on performance against the £58.7m deficit has three components Operational Pressure, Savings Target, and Planned Deficit. Performance against these three elements at Month 9 is summarised in Table 1 below. At Month 9 there was an In-Month deficit of £3.8m, which is £1.0m below the £58.7m planned deficit, with the YTD position reporting a £55.2m deficit, which is £11.2m above £58.7m plan.



Elements of In Month	Quarter 1	Quarter 2	Mth 7	Mth 8	Mth 9	YTD
	£M	£M	£M	£M	£M	£M
- Delegated Budgetary Position	(2.15)	(0.64)	(0.94)	(0.41)	(2.14)	(6.27)
- N/R Opportunities	(0.28)	(1.45)	(0.10)	(0.38)	(0.66)	(2.87)
- Shortfall NI Funding	0.34	1.03	0.34	0.34	0.34	2.40
Total Part 1: Operational Pressures	(2.08)	(1.06)	(0.70)	(0.44)	(2.46)	(6.74)
Saving Target						
- 12th Savings Target	13.85	13.85	4.62	4.62	4.62	41.55
- Less Actual In Month Delivery	(2.29)	(8.59)	(4.69)	(4.87)	(3.22)	(23.65)
Total Part 2 = Savings Delivery Impact	11.57	5.26	(0.07)	(0.25)	1.40	17.90
Financial Deficit Plan						
- 12th Deficit Value	14.68	14.68	4.89	4.89	4.89	44.03
Total Part 3 = Deficit Plan	14.68	14.68	4.89	4.89	4.89	44.03
Deficit/ (Surplus) In Month Performance	24.16	18.87	4.13	4.20	3.83	55.18

It is clear from the Table above that the Year-to-Date issue remains the non-delivery of savings. This shortfall in delivery YTD is in part mitigated by 'Delegated Budget' position underspending and the central N/R opportunities as set out in the 11 September submission delivering (as reported in the Table above). Whilst excluding the non-delivery of saving most areas are within the delegated operational budgets, the key exception to this is Mental Health & LD Services. Throughout the year there have been pressures linked to pay and CHC but also Temporary Adult Placements. The latter issue has resulted in an in-month pressure of £0.7m, with YTD expenditure of £5.3m. During November the service saw the highest number of patients in Temporary Adult Placements at 33, which at the time of closing the ledger for Month 9 was at 25. This pressure will need to continue to reduce through Q4 and managed alongside the other pressures linked to ENIC and Nurse Streamline numbers that the Health Board will need to mitigate in-year.

On savings performance the submission made on 11 September 2025 set out the Plan to deliver the £55.4m savings in 2025/26. This was a combination of (1) Part A - budgetary releasing savings delivery supported by our external strategic partner; alongside (2) Part B - delivery of underspends in the operational budgets specifically around the corporate directorates and N/R opportunities. The monitoring of the performance for Part A is undertaken through the existing governance arrangements, using the Health Board's savings trackers. This data is then used to complete the WG Monthly Monitoring Return (MMR) Savings Tables. However, as Part B are improvements in run rate and not a formal budgetary savings this element of the plan is not reported in

Savings Tables of the WG MMR or standard trackers. A summary of the assessed performance is provided in the table:

Month 9 MMR Position			
Part	Category Scheme	11 Sept Plan £M	Forecast Delivery £M
A	Green Amber	26.6	34.2
	Red / Pipeline	20.2	0.0
	Total Part A	46.8	34.2
B	NR Opportunities	4.6	4.6
	Corporate Underspend	4.0	4.0
	Total Part B	8.6	8.6
Total		55.4	42.8

With regard to the delivery of the £46.8m the top section of the below demonstrates the original plan at 11 September, the plans as per the trackers at Month 9 and the forecast delivery at Month 9. The scheme type is split based on the Amber and Green as per the MMR, Local Red schemes, Local Pipeline ideas and those schemes presented by Deloitte. As the Local Red schemes, Local Pipeline ideas and those schemes presented by Deloitte move to Green and Amber the value of the Plan figure will reduce. As you will see from the table there is still significant work to be completed to ensure the two parts of the Deloitte schemes translate to Green and Amber.

Type Scheme	@ 11 Sept Plan £M	@ Mth 9 Plan £M	@ Mth 9 Tracker Forecast Delivery £M	Gap Between Savings Plan & Forecast @ Mth 9 £M
Amber	3.3	0.8	0.7	(0.1)
Green	23.3	29.9	33.5	3.6
Local Pipeline Schemes	1.7	0.6	0.0	(0.6)
Deloitte Schemes Part 1	6.8	5.9	0.0	(5.9)
Deloitte Scheme Part 2	9.0	8.4	0.0	(8.4)
Local Red Schemes	2.7	1.2	0.0	(1.2)
	46.8	46.8	34.2	(12.6)
NR Opportunities	4.6	4.6	4.6	0.0
Corporate Underspend	4.0	4.0	4.0	0.0
	8.6	8.6	8.6	0.0
	55.4	55.4	42.8	(12.6)

The focus on savings is critical both in terms of supporting the 2025/26 delivery but also on mitigating the impact on the Underlying Deficit, particularly given the £6.9m Deloitte Part 1 Plan had a recurrent impact of £29m.

Post Month 9 closedown the Health Board undertook an assessment of the 2025/26 outturn based on data provided by Service Areas in November 2025 and the actual trend over Quarter 3. Without further intervention and actions, the Health Board will likely end the year £10m-£12m above plan. The actions and mitigations needed are detailed below and are no different to those previously agreed and noted by the Board and are summarised below:

- **16th December Special Board meeting**, approved a paper that set out the actions to address the savings shortfall. In summary the actions to address the savings shortfall agreed were:
 - Urgent emergency Care (UEC) – reconfiguration of beds to manage Clinically Optimised Patients via a new model to be in place 5 January 2026.
 - CHC - continued focus on repatriation of patients and address Social Work support for package reviews by 16 January 2026.
 - Variable Pay minimum 50% reduction in nursing variable pay with cap within Allocate in place by 15 December 2025.
 - Variable Pay - other staff group minimum 50% reduction (excluding WLI and some ADH) to be enacted by 19 December 2025.
 - Bans effective from 15 December 2025 building on previous controls already agreed to increase certainty:
 - all travel, except those directly linked clinical care
 - all Printing/Stationery/Books except those directly linked to clinical care
 - all Study leave that not mandated/urgent via professional CPD
 - catalogue restriction with ban on areas such as Furniture and Fittings except in exceptions circumstances
 - Deferral of discretionary spend where possible 7.

Of the above list, the majority of this was due to commence from the end of Month 9, although there was a £0.5m reduction in variable pay in Month 9. Delivery will be tracked and reported from Month 10.

- **Further Opportunities Non-Recurrent managed centrally:** there are a currently 13 areas of opportunities under assessment to establish viability and value to support the delivery of the £58.7m on a non-recurrent basis. If all delivered to 100% these would provide a maximum of £7m.

The likely outcome is that the delivery of the £58.7m will be met through a combination of the actions agreed at 16 December Special Board meetings and materialisation of some of the further opportunities,

although it is the first set of actions that will be critical in delivering the recurrent position in 2026/27.

3.6 Planning

Updates against the de-escalation criteria outlined by Welsh Government can be found below;

De-escalation Criteria	Actions – Updated Jan 2026
Submission of a balanced and credible three-year medium-term plan or acceptable annual plan in line with the current planning framework.	• Revised NHS Wales Planning Framework and financial allocation received from Welsh Government on 19th December 2025. • Work progressing at pace to consolidate and quantify the Annual Plan priorities aligned to the existing R&S Programmes, into appropriately quantified plans that deliver both the opportunities identified through the Deloitte work, as well as addressing national requirements, i.e. Minimum Delivery Expectations and Enabling Actions 26/27 set out by the Cabinet Secretary. • Key next steps in providing an Annual Plan for Board approval for submission to Welsh Gov on 31st March, involve engagement and detailed assessment of the Plans being developed by Programmes by 21st January 2026
Evidence of a clear roadmap and implementation of the health board's Clinical Services Plan.	• First meetings of the Clinical Reference Groups for Integrated Community Care and Networked Hospitals held 16 and 18 of December. With broad representation from across secondary and primary care. • First draft of 'State of the Nations' Report and Overview Demand and Capacity completed • Draft overview of strategic Demand and Capacity completed



De-escalation Criteria	Actions – Updated Jan 2026
Welsh Government's confidence in delivery based on an assessment against an agreed planning maturity matrix	- Re-assessment of SBUHB position completed. Action Plan and supporting evidence being collated. - Re-assessment submitted to Welsh Government 28 November
Progress made with regional planning	- Previous Regional Joint Committee 18th August. Subgroup updates were received for: Regional Health Economy, Clinical Services Planning, Workforce and OD, Data and Digital, Finance and Commissioning, Research and Innovation. - The Regional Drive and Delivery Group, Chaired jointly by Abi Harris and Phil Kloer, met on 16 October and provides oversight of subgroup work programmes. - Full updates are scheduled to be reviewed at the next RJC meeting 22 January.

4. PERFORMANCE AGAINST THE ENHANCED MONITORING SERVICES

4.1 Planned Care

Criteria to Achieve	Current Performance (December 2025)
100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 months.	100%
Continuous improvement towards 75% of all open outpatient pathways waiting less than 26 weeks.	78.44%
100% of open pathways to be waiting less than 104 weeks and maintained for 3 months.	100%
Continuous improvement towards 80% of all open pathways waiting less than 36 weeks.	75.11%

Criteria to Achieve	Current Performance (December 2025)
12% reduction in the number of patients delayed by 100% for their follow up appointment in three consecutive months and maintained for 3 months (Based on the November 2024 baseline).	20.76% increase against baseline
68% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for 3 months.	71.94% - meets de-escalation criteria
85% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months.	66.84%
85% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 months.	43.95%
85% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks and maintained for 3 months.	67.65%
90% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months.	100%

Actions being taken to improve include:

- Robust monitoring via live dashboards
- Weekly monitoring meetings chaired by Service Group Directors
- Bi-weekly oversight meeting chaired by the Chief Operating Officer
- Specific support commissioned for Gynaecology improvement plans

4.2 CAMHS

Criteria to Achieve	Current Performance
80% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral.	- October – 98% - November – 97% - December – 98%

70% of therapeutic interventions started within 28 days following an assessment by LPMHSS.	- October -65% - November – 66% - December – 70%
85% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan.	- October – 95% - November – 92% - December -98%

Actions being taken to improve include:

• CAMHS Part 1B:

- Recruitment to vacancies has been successful (1.65wte recruited, due to start in February and March 2026), however sickness and maternity leave weakens the capacity pool to almost pre-recruitment levels presently. The CAMHS Directorate continues to utilise agency staff to offset staffing gap.
- Despite this, the recovery plan roll out is underway, which includes changes to the delivery of the initial therapeutic offer for 1:1 intervention, which enables young people to commence support more quickly and the offer of SilverCloud support for those suitable.
- This has resulted in 4 months of small, but consistent improvement in the Part 1B performance irrespective of staffing challenges, which is now at 70% (submitted for Dec 2025)
- Weekly meetings continue to oversee booking and clinic capacity utilisation, and to utilise our staffing resource as flexibly as possible.

Important update: The Swansea-based clinic space (Ty'r Meddwl) has been closed until April 2026 due to water ingress requiring roof replacement. Whilst Part 1A and Part 1B activity is being prioritised, the loss of 6 clinic rooms 5 days per week (40% room capacity) will have an impact on staffing capacity, who will need to utilise various alternative community-based locations requiring travel time.

5. INTEGRATED PERFORMANCE REPORT

The detailed Integrated Performance Report can be found in **Appendix 1** of the attached report. The purpose of this report is to provide an update on current performance of the Health Board at the end of the most recent reporting window in delivering key performance measures outlined in the NHS Wales Delivery Framework, local Quality & Safety

measures, updates against Welsh Government De-escalation targets and routine reporting against measures outlined within the NHS Wales Planning Framework.

In alignment with the revised Swansea Bay University Health Board (SBUHB) Performance and Assurance Framework, the Integrated Performance Report has been reviewed and will now update against three key areas: -

1. Welsh Government Escalation
2. Performance against the Health Boards 5 Strategic Objectives
3. Service Specific Updates

As and when required, the Integrated Performance Report will provide 'Action and Intervention' focus on areas of performance which are off target or an area of concern for the Executives. Additionally, as and when Committee/Board members are concerned with an area of Performance, they can request that an Action and Intervention focus be undertaken within the IPR. An 'Action and Intervention' focus will provide a deeper look into the service and will provide detailed action steps which are being taken to recover performance.

The Performance metrics outlined within Section two of the Integrated Performance Report have been aligned to the Health Boards five Strategic Objectives. Key Updates will therefore be provided against the five Strategic Objectives below: -

1. People of Swansea Bay live healthier, equitable and more equal and prosperous lives
2. Care is high quality, safe, efficient and delivers the best possible outcomes for people
3. Care is delivered in safe and appropriate settings supported by innovative digital solutions
4. The health board is a great place to work where staff feel valued and work together towards a common goal
5. The health board is a resilient, financially sustainable and responsible organisation

An additional section has been included in the report which will provide "Service Specific Updates" as and when requested by the Performance and Finance Committee work programme.

In this paper, the following service specific updates will be included:

- Neurodevelopmental Disorders Service (Appendix 1)
- Theatre Utilisation (Appendix 2)

6. RECOMMENDATION

Members are asked to:

- **CONSIDER** the monthly update in respect of performance against escalation measures and de-escalation criteria.
- **ACKNOWLEDGE** and **DISCUSS** the Health Board performance against key measures and targets

Governance and Assurance		
Link to Enabling Objectives <i>(please choose)</i>	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☐
	Timely Care	☒
	Individual Care	☐
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Outlined within the body of the paper but in summary considerable backlog of patients awaiting a diagnostic and treatment services across a range of services. Issues of harm in relation to high levels of HCAs noted.		
Financial Implications		
Funding not yet agreed for 26/27		
Legal Implications (including equality and diversity assessment)		
Delay to diagnosis and treatment potential in service delivery		
Staffing Implications		
Additional support staffing required to deliver the programme		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
Report History	First comprehensive update presented.	
Appendices	Appendix 1: Integrated Performance Report Appendix 2: Theatre Utilisation	

Swansea Bay University Health Board Integrated Performance Report January 2026

Report Overview

The Health Board Integrated Performance Report will provide updates against all areas under escalation with Welsh Government, all performance metrics outlined within the NHS Wales Performance Framework 202-26, along with updates against the Delivery Expectations and the Ministerial Enabling actions as outlined in the NHS Wales Planning Framework 2025-2028



Section 1: Updates against all Escalation areas with Welsh Government



Section 2: Performance against the Health Board's Strategic Objectives



Section 3: Service Specific Updates



Section 1:

Updates against all Escalation areas with Welsh Government

Delivery against Targeted Intervention and Enhanced Monitoring Criteria 2025/26

TI Area (Level 4)	Criteria to achieve	 Dashboard	Performance (Dec -25)
Cancer	60% performance maintained for 3 months against the SCP target.		52% (Nov- 25)
UEC	Continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months (Based on Q2/Q3 2023 baseline)		329 (104% increase)
	Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across HB		9.95%
	Median time from arrival at emergency department to assessment by a clinical decision maker should not exceed 60 minutes		84.87%
	Continuous reduction in delayed pathways of care of 5% for three consecutive months and then maintained for three months (based on Oct-Dec 23 baseline)		169 (5.6% Reduction)
HCAIs	A clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs.		In place
	C-Diff: reduce the number of hospital onset infections by 40% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 10 cases to no more than 6 per month		10 cases
	Staph aureus: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 4 cases to no more than 3 per month		3 cases
	E-coli: reduce the number of hospital onset infections by 20% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 5 cases to no more than 4 per month)		4 cases
	Klebsiella: reduce the number of hospital onset infections by 10% and maintain for 3 months based on 2017/18 figures (baseline – 54 cases in 2017/18, reduce to average of at most 4 per month)		7 cases
Finance	Detailed Updates included in the monthly Escalation Report		
Strategy & Planning	Detailed Updates included in the monthly Escalation Report		
Maternity & Neonates	Detailed Updates included in the monthly Perinatal Report		

Delivery against Targeted Intervention and Enhanced Monitoring Criteria 2025/26

Escalation Area (Level 3)	Criteria to achieve	Performance (Dec-25)
CAMHS	80% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral	98%
	70% of therapeutic interventions started within 28 days following an assessment by LPMHS	70%
	85% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan	98%
Planned Care	100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 month	100%
	Continuous improvement towards 75% of all open outpatient pathways waiting less than 26 weeks	78.44%
	100% of open pathways to be waiting less than 104 weeks and maintained for 3 months	100%
	Continuous improvement towards 80% of all open pathways waiting less than 36 weeks	75.11%
	12% reduction in the number of patients delayed by 100% for their follow up appointment in three consecutive months and maintained for 3 months (Based on the November 2024 baseline.)	20.76%
	68% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for 3 months	71.94%
	85% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months	66.84%
	85% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 month	43.95%
	85% of patients waiting for a NOUS and non cardiac MRI to be waiting less than 8 weeks and maintained for 3 months.	67.65%
	90% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months	100%

Section 2:

Summary of the performance against the Health Boards Strategic Objectives

SBUHB Strategic Objectives and Quality Aspects

Our refreshed Strategic Objectives –aligned to ‘a Healthier Wales’ articulate the future state of Swansea Bay UHB as a high-quality organisation. We have set out what this looks like for our population, communities, staff , partners and services and are developing strategic indicators that will tell us if our efforts are delivering our objectives

People of Swansea Bay live healthier, equitable and more equal and prosperous lives



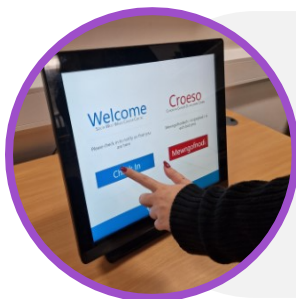
- Every child has the best start in life
- All children, young people and adults are enabled to maximise their capabilities and have control over their lives
- Good work and fair employment is created for all
- A healthy standard of living is ensured for all
- Healthy and sustainable places are created through placemaking
- The role and impact of ill-health prevention is strengthened
- Racism, discrimination and their outcomes are tackled
- Environmental sustainability and health equity are pursued together

Care is high quality, safe, efficient and delivers the best possible outcomes for people



- Care is safe, it helps people and avoids harm
- Care is evidence based, effective and improves outcomes
- Care is timely and delivered by the right person in the right place
- Care is efficient
- Care delivers equitable outcomes regardless of demographic, socioeconomic or geographic factors
- Care is person centred and delivered with compassion, dignity and mutual respect

Care is delivered in safe and appropriate settings supported by innovative digital solutions



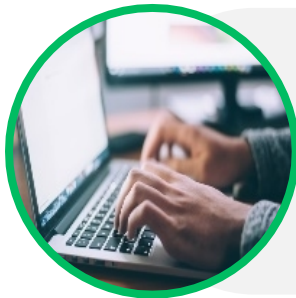
- Care is delivered around the patient in the most appropriate setting as close to home as possible supported by digital and data solutions
- Care settings are fit for purpose, appropriately designed and equipped
- Secure, trusted and insightful data and digital platforms empower staff to deliver more and higher quality care and improved patient outcomes and population health
- We have a digitally inclusive culture, where patients, clinicians and non-clinical colleagues work collaboratively to create effective and efficient services and patients are empowered to make informed and meaningful choices about their health and care
- Through where and how they are delivered, services contribute to the environmental, economic, social and cultural well-being of Swansea Bay

The health board is a great place to work where staff feel valued and work together towards a common goal



- Our Workforce is engaged, motivated and healthy; they feel valued, fairly-rewarded and supported
- The Health Board is recognised as an employer of choice
- We have a well-planned workforce with the right number of skilled people working on the right things
- People feel ready for our digital future
- People are supported to develop the skills and capabilities they need
- People role model collective and compassionate leadership and live our values
- We are diverse and inclusive, ensuring all voices are heard

The health board is a resilient, financially sustainable and responsible organisation



- The health board is financially balanced and able to invest in service transformation and change
- Decisions are made balancing short-term improvements and long-term impacts
- Resources are used efficiently and proportionately, reducing waste and variation
- The environmental impact of health care delivery in Swansea Bay is minimised
- The health board invests in and works with others locally and responsibly, using our assets to positively contribute to the community
- Citizen stakeholders are meaningfully involved and engaged in decision making
- The health board has the capacity to effectively plan for and respond to incident and emergencies

People of Swansea Bay live healthier, equitable and more equal and prosperous lives



- Every child has the best start in life
- All children, young people and adults are enabled to maximise their capabilities and have control over their lives
- Good work and fair employment is created for all
- A healthy standard of living is ensured for all

- Healthy and sustainable places are created through placemaking
- The role and impact of ill-health prevention is strengthened
- Racism, discrimination and their outcomes are tackled
- Environmental sustainability and health equity are pursued together

Childhood Immunisations		Target	Sep-25
Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	DE	95%	90.2%
Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	DE	90%	84.2%
Influenza & Covid Immunisations			
Percentage uptake of the influenza vaccine in adults 65 years and over	DE	75%	67.6% (25/26)
Percentage uptake of the COVID-19 vaccination for all those eligible	DE	75%	51.9% (Nov-25)
Smoking Cessation			
Percentage of adult smokers who make a quit attempt via smoking cessation services		5% Annual target	N/A
Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks		40% annual target	N/A
Screening			
Percentage of patients offered an index colonoscopy procedure within 4 weeks		90%	Please note: PHW data is currently not available for the measures outlined in the Performance Framework
Percentage of well babies entering the new-born hearing screening programme within 4 weeks		90%	
Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life		95%	



Targeted Intervention Measure



Ministerial Delivery Expectation

RAG Rating Key

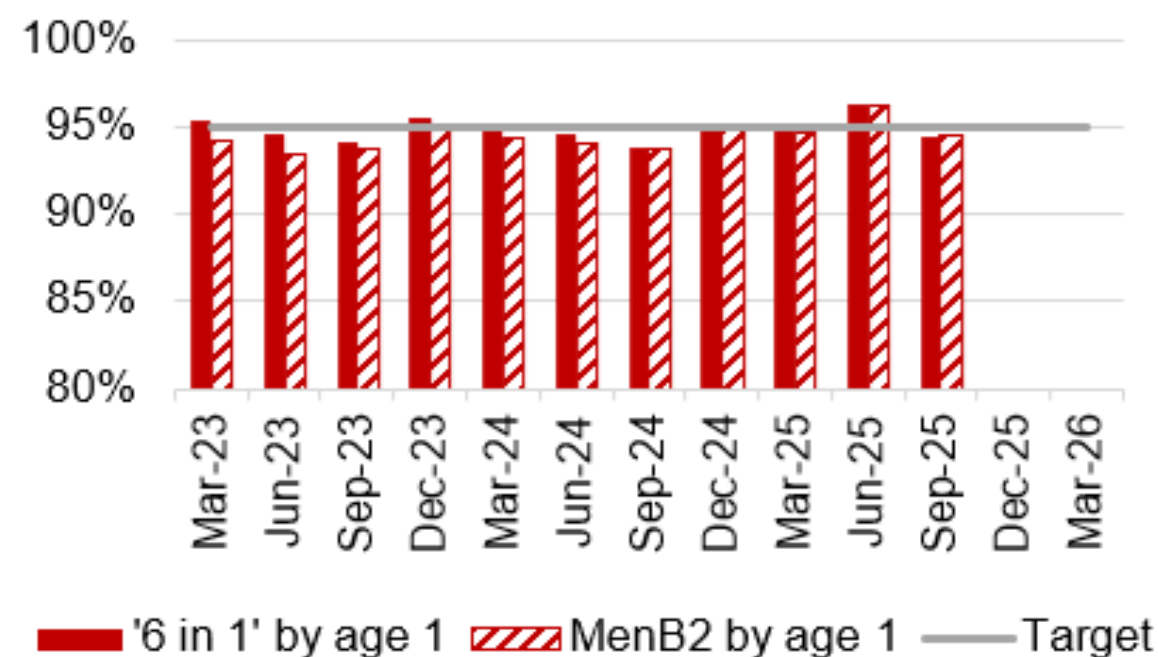
Off Target

Within 10% of target

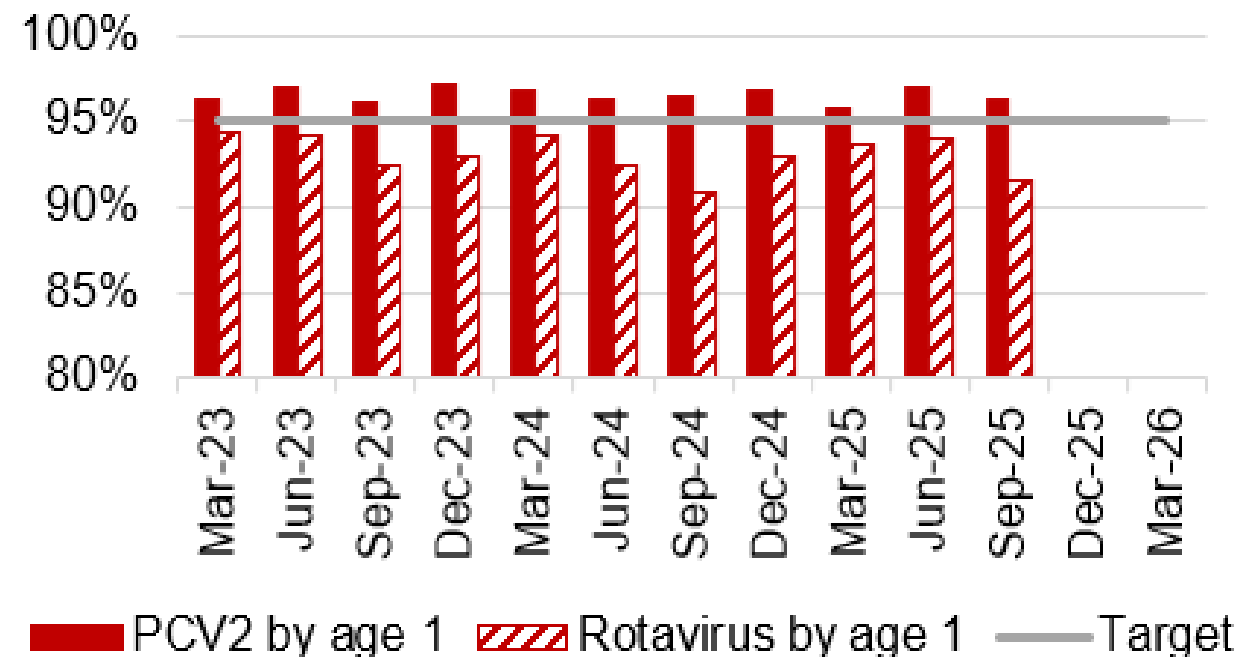
On Target

Immunisations

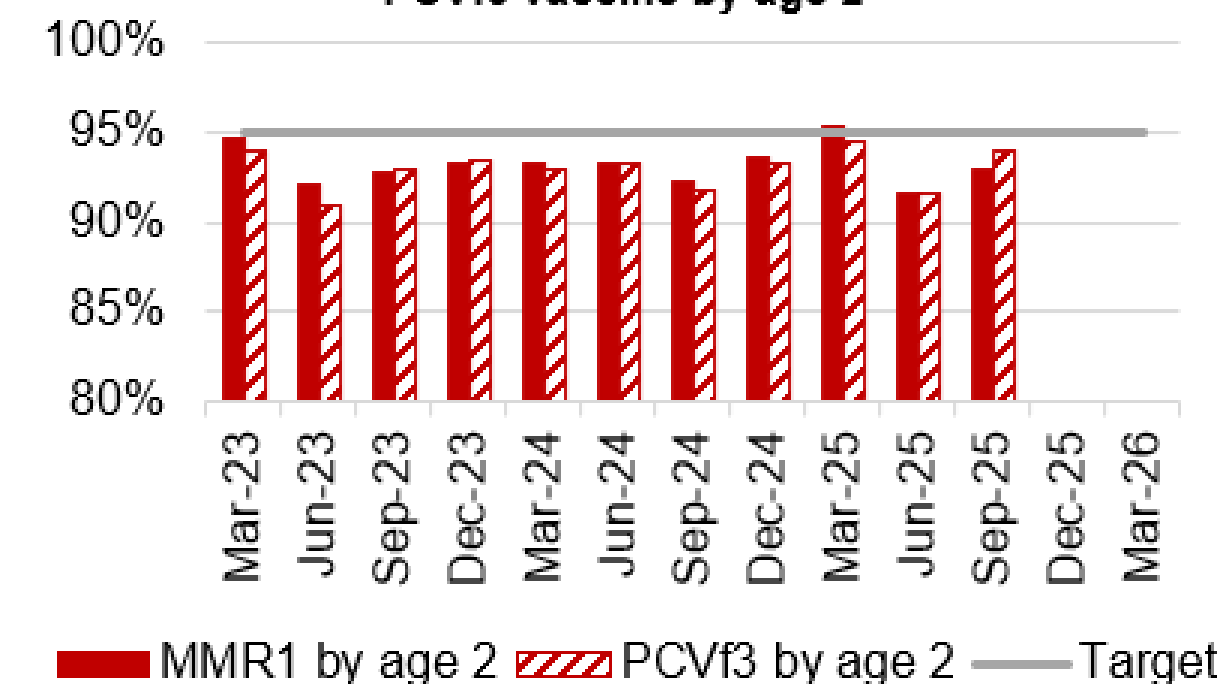
% children who received 3 doses of the '6 in 1' vaccine & MenB2 vaccine by age 1



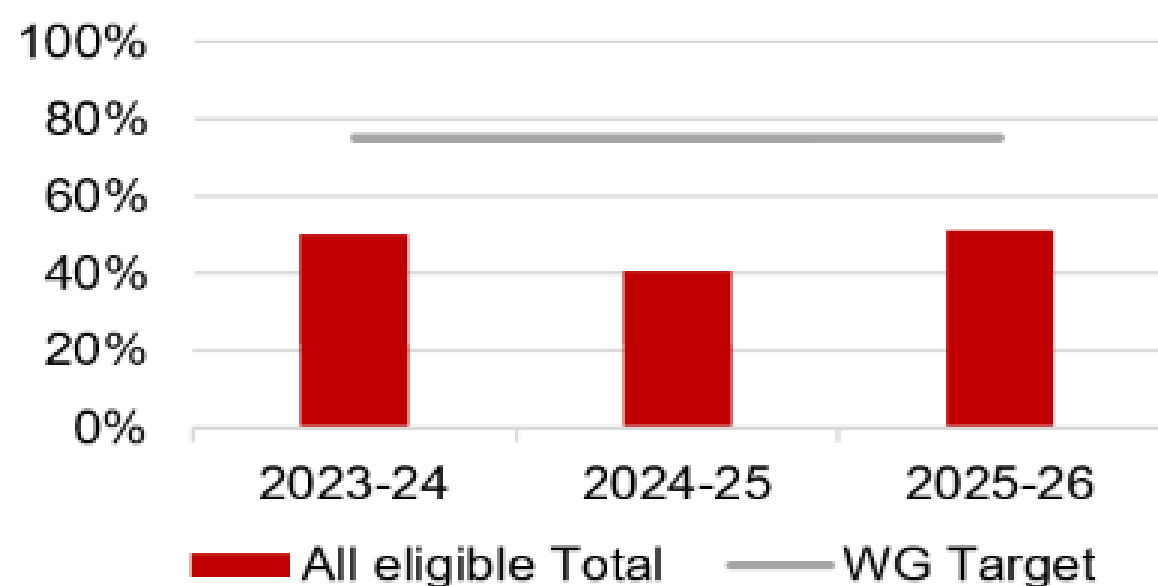
% children who received PCV2 vaccine & Rotavirus vaccine by age 1



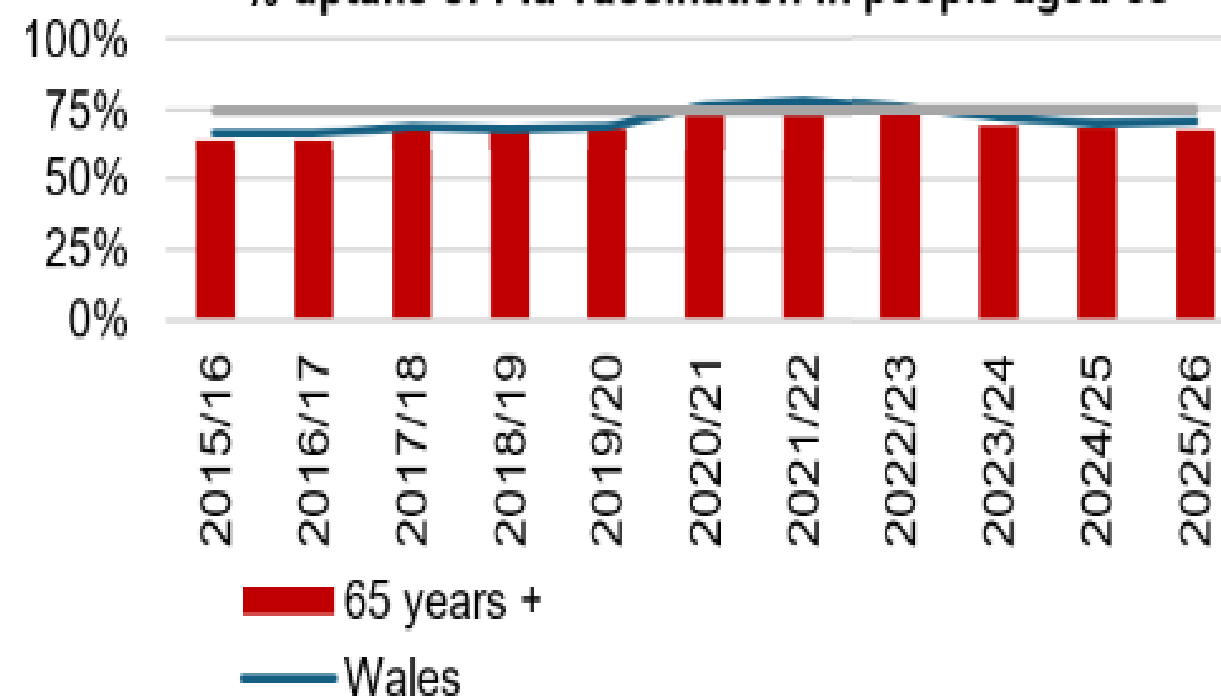
% children who received MMR1 vaccine & PCVf3 vaccine by age 2



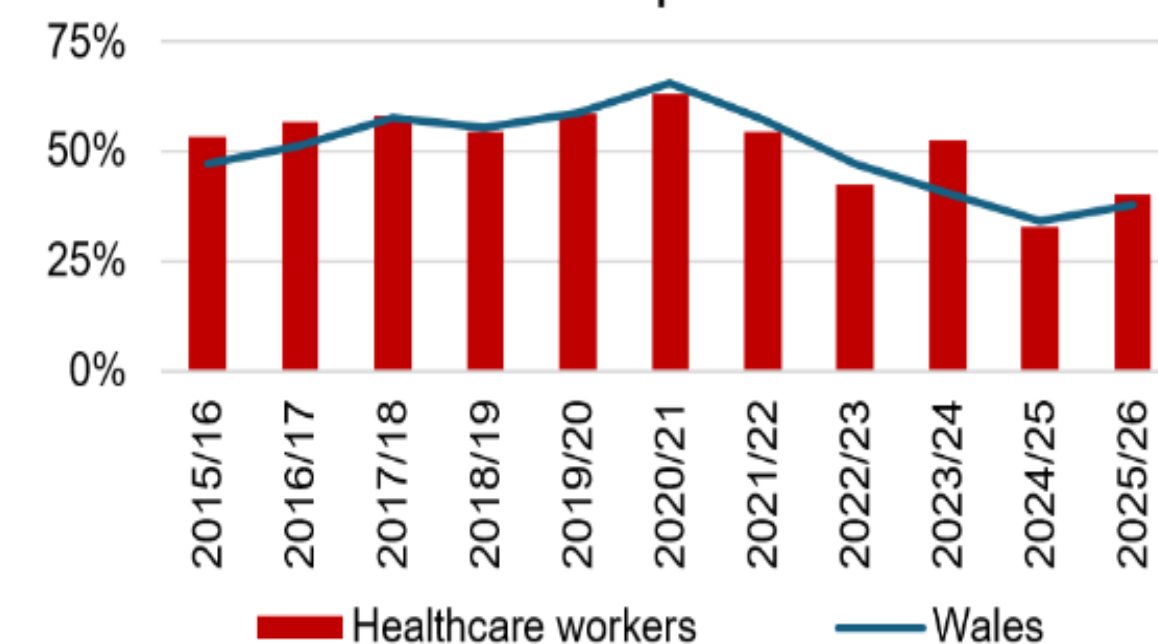
% uptake of the COVID-19 vaccination for those eligible (Autumn Booster)



% uptake of Flu vaccination in people aged 65+



% uptake of Flu vaccination in Healthcare Workers with direct patient contact



Actions/Updates

- Performance against the immunisation targets is reported in arrears on a quarterly basis
- Updated targets have been set for the new financial year which can be seen on the graphs above

Care is high quality, safe, efficient and delivers the best possible outcomes for people



- Care is safe, it helps people and avoids harm
- Care is evidence based, effective and improves outcomes
- Care is timely and delivered by the right person in the right place
- Care is efficient

- Care delivers equitable outcomes regardless of demographic, socioeconomic or geographic factors
- Care is person centred and delivered with compassion, dignity and mutual respect

Accident & Emergency	Target	Dec-25
4 -hour performance	95%	71.96%
12-hour performance	DE TI	1,053
Number of Delayed Pathways of Care (HB wide)	DE TI	Continuous Reduction 169
Number of cancelled Electives	0	17
Median time of arrival to assessment within 60 minutes	TI	97% 84.87%
Ambulance		
Median emergency ambulance response time to purple: arrest category calls	6-8 minutes	6.41
Median emergency ambulance response time to red: emergency category calls	6-8 minutes	7.41
Total Handovers lost over 15 minutes	0	938
Total Handover Delays > 45 minutes	0	396



Targeted Intervention Measure



Ministerial Delivery Expectation

RAG Rating Key



Off Target



Within 10% of target



On Target

Care is high quality, safe, efficient and delivers the best possible outcomes for people

Stroke	Target	Nov -25
Percentage of admission within 4 hours	95%	37.5%
Percentage of stroke patients receiving a CT scan within 20 minutes	40%	11.5%
Percentage of patients assessed by a stroke consultant within 14 hours	95%	48.1%
Percentage of patients to receive a mechanical Thrombectomy	10%	0%
Planned Care	Target	Dec – 25
Percentage of patients waiting < 26 weeks for an outpatient appointment	75%	78.44%
Total number of patients waiting < 36 weeks	80%	75%
Number of patients waiting at Stage 1 > 52 Weeks	0	0
Total number of patients waiting > 104 Weeks	0	0
Diagnostics & Therapies	Target	Dec – 25
Number of patients waiting > 8 weeks for diagnostics	0	6,042
Number of patients waiting > 8 weeks for an Endoscopy	0	1,760
Number of patients waiting > 14 weeks for Therapies	0	0
Number of children waiting > 6 weeks for Audiology	0	127

TI

Targeted Intervention Measure

DE

Ministerial Delivery Expectation

RAG Rating Key

Off Target

Within 10% of target

On Target

Care is high quality, safe, efficient and delivers the best possible outcomes for people

FUNB	Target	Dec -25
Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date (All Specialties)	N/A	77,580
Total number of patients waiting 100% over their target date TI	0	46,418
Total number of patients waiting for a follow-up appointment	N/A	162,627
Mental Health & Learning Disabilities	Target	Dec – 25
Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral DE	80%	98%
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS DE	80%	89%
Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health DE	80%	41.7%
Quality & Safety	Target	Dec – 25
Number of service user feedback experience responses on CIVICA	Monthly improvement	5,489
Percentage of complaint responses sent within 30 working days	80%	54% (Oct-25)
Number of Nationally Reported Incidents	N/A	13
Number of New Never Events	N/A	0



Targeted Intervention Measure



Ministerial Delivery Expectation

RAG Rating Key



Off Target



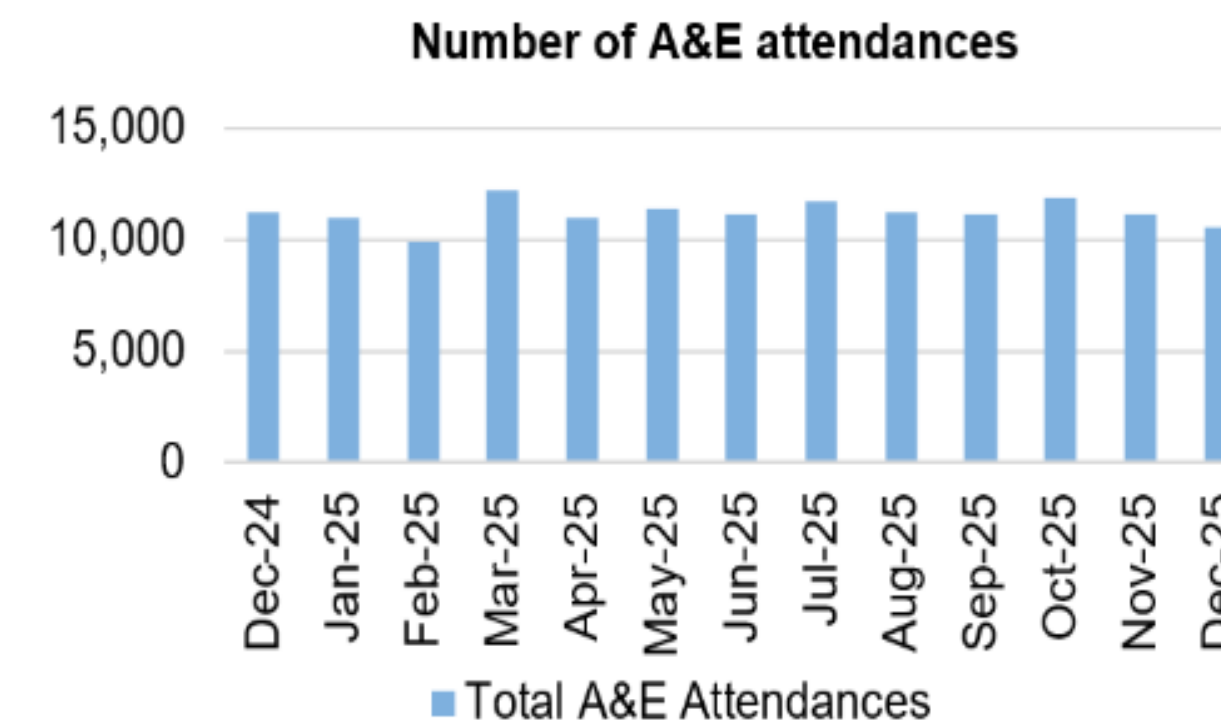
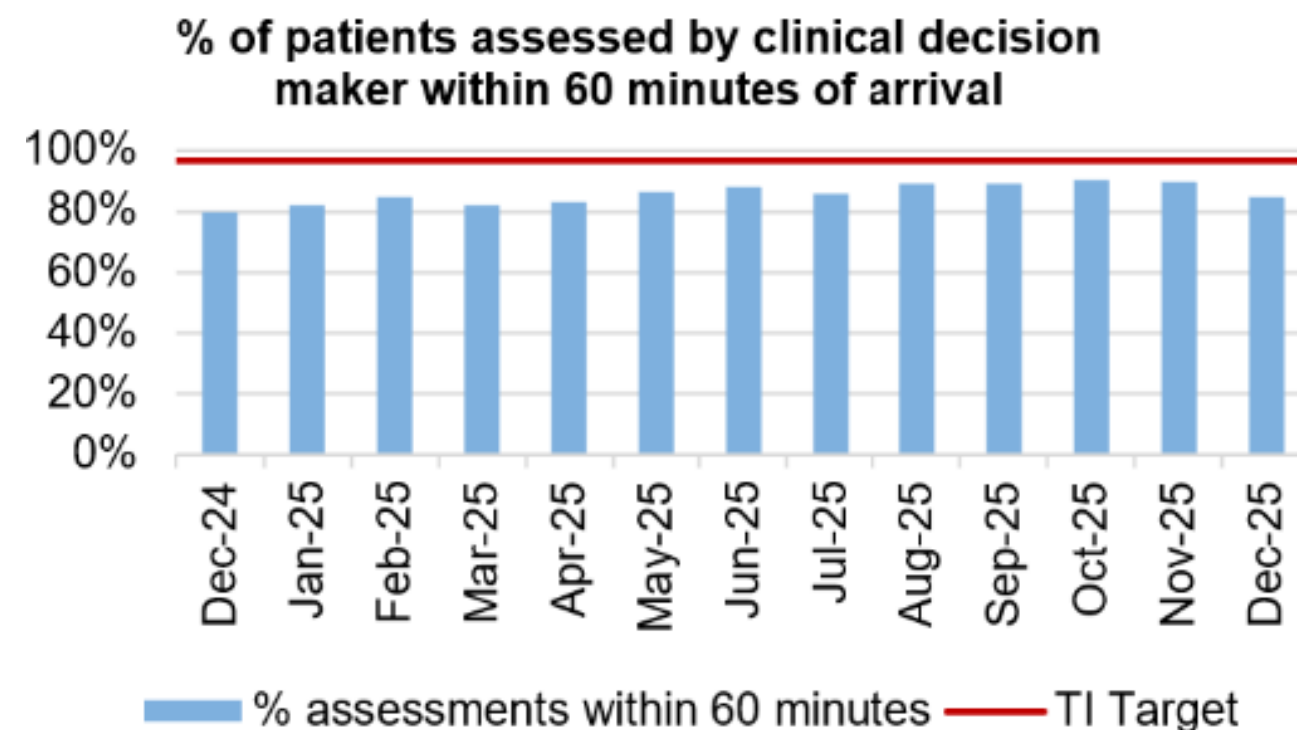
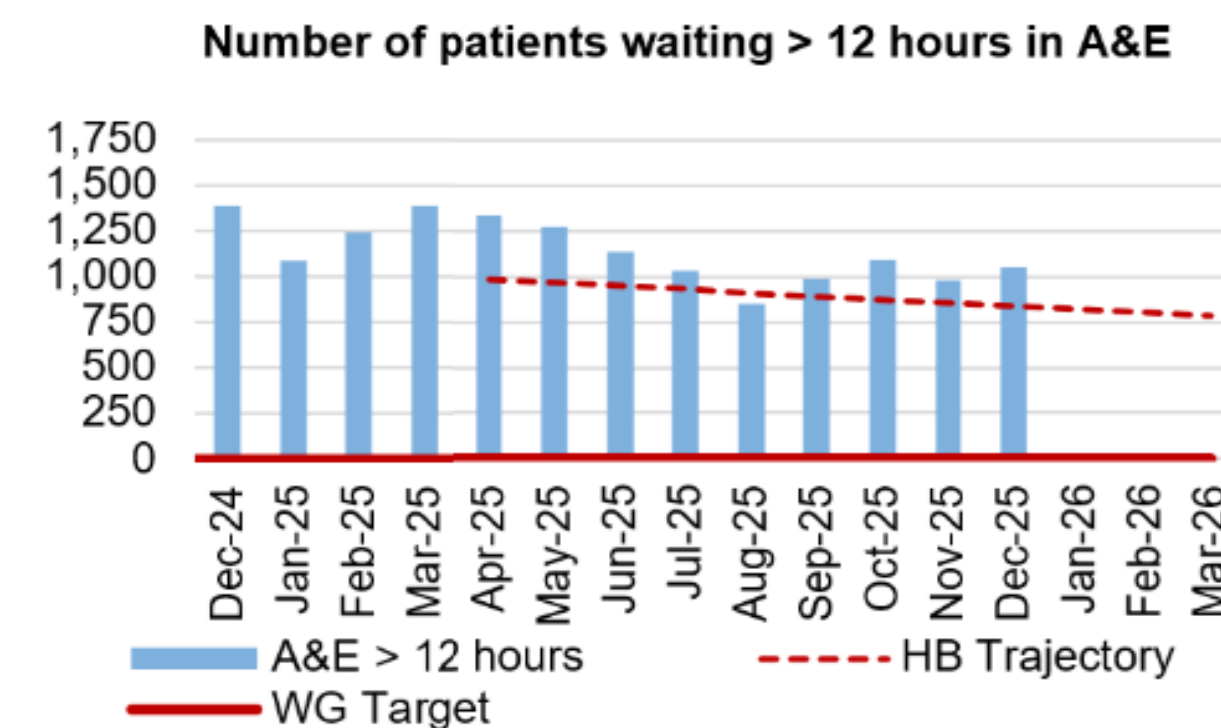
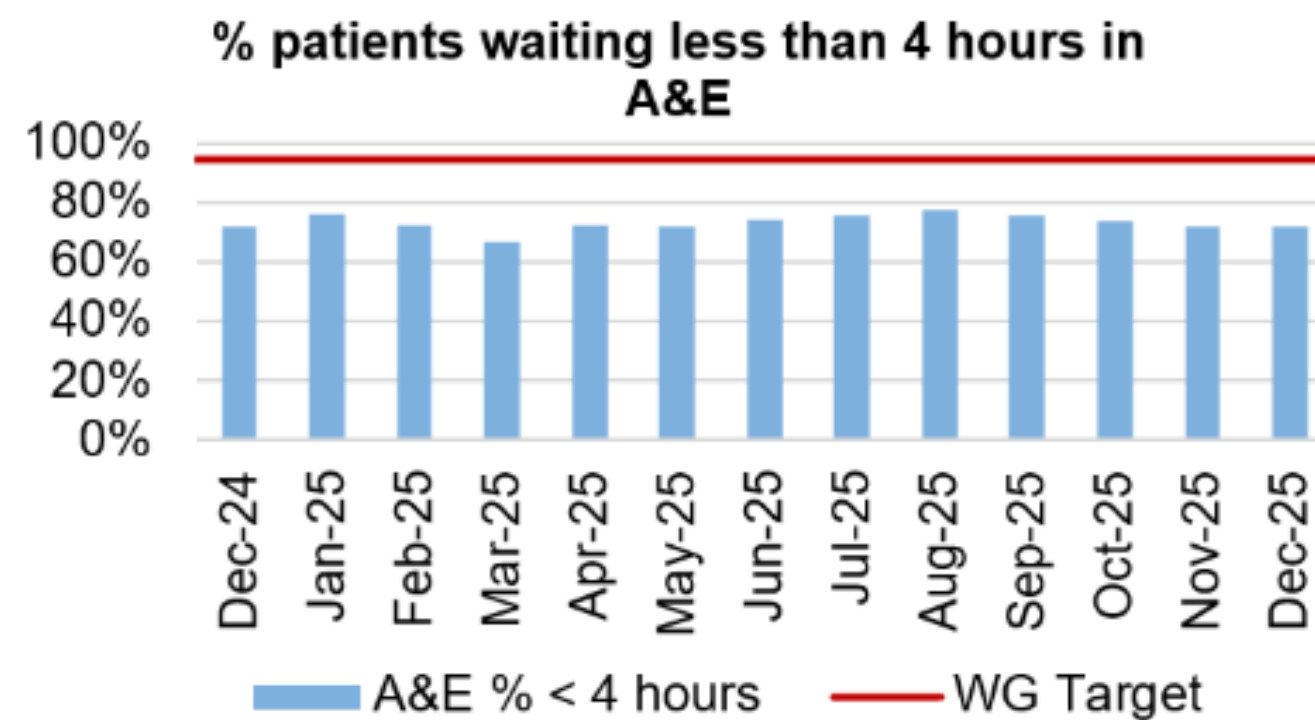
Within 10% of target



On Target

Unscheduled Care



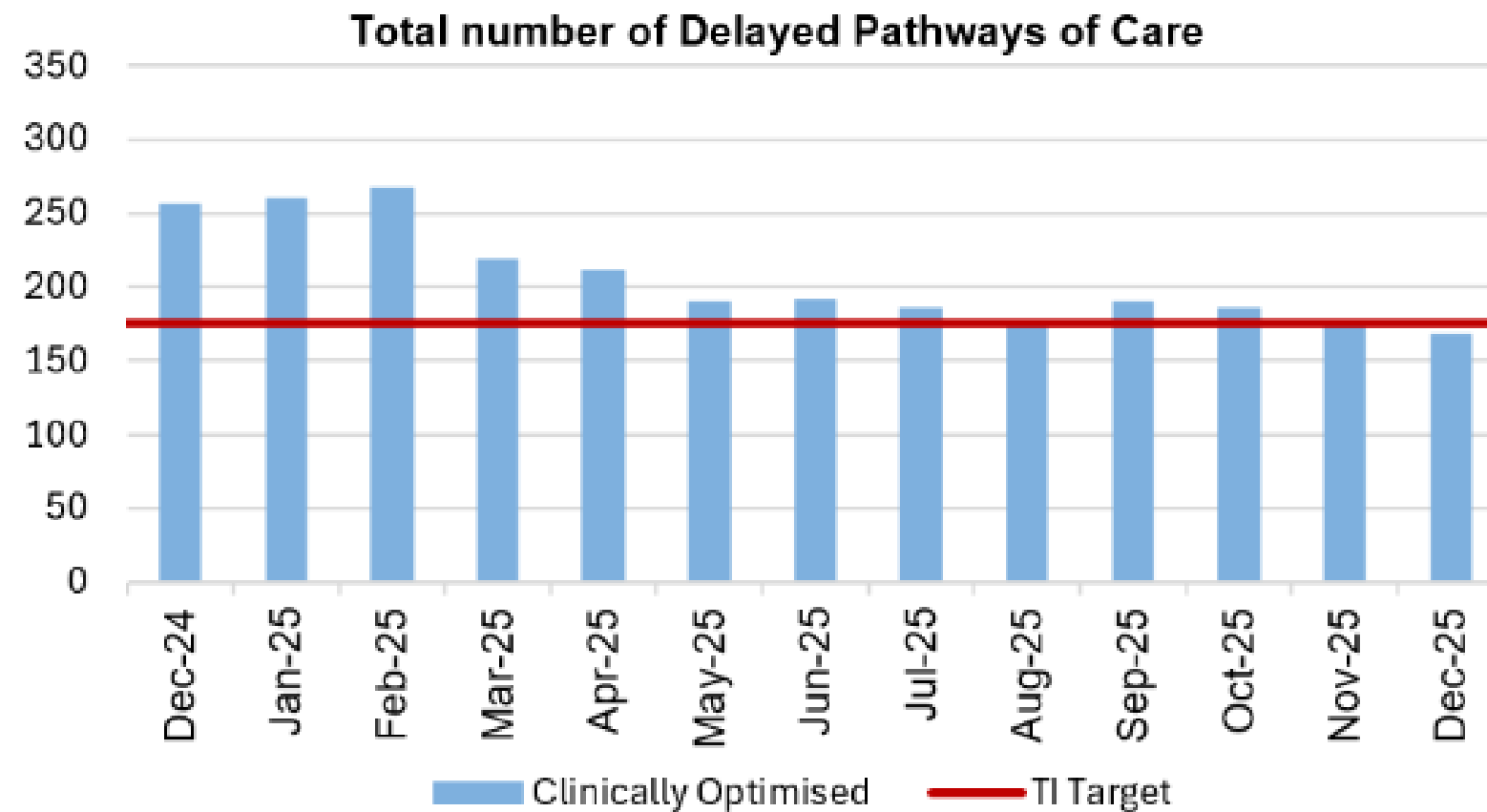


Actions/Updates

- Full implementation of D2RA model** – Focus on D2RA has rapidly shifted into understanding the demand and capacity position for pathway 2 beds and utilisation of that bed pool. Therapy led audit undertaken in December of all patients occupying a pathway 2 bed. Data analysis in progress with Deloitte's support. Early indication is that there is opportunity to work with Local Authority partners to potentially reduce the Pathway 2 bed pool and enhance the Pathway 1 offer. The reset fortnight in December demonstrated good opportunity for partnership working, with a focus on those patients who are clinically optimised. This process has continued and there has been some improvement in patient flow. Planning for the transfer of 30 clinically optimised patients from Morriston to Singleton took place during December 2025 and the plan was implemented w/c 5th January 2026.
- UEC Care co-ordination Hub** – The single point of access has been in place since the 1st October 2025 and the first data submission took place on the 21st November. There is specific focus on the "clinical conversation before convey", aimed at reducing conveyance of patients from care homes where clinically appropriate to do so. Work is also focussed on the management of patients who fall with the implementation of a level 2 Falls service made up of therapy technicians and a registered therapist, supported by St Johns ambulance provision.



Pathways of Care Delay: Action & Intervention



Site	Delayed Pathways of Care: December 9th	Delayed Pathways of Care: December 17th	Delayed Pathways of Care: December 23rd	Delayed Pathways of Care: December 30th
Learning Disabilities	9	9	9	9
Mental Health	34	36	33	33
Morriston Hospital	95	73	65	70
Neath Port Talbot Hospital	38	33	27	34
Singleton Hospital	21	18	15	19
Total	197	169	149	165



WG target -15% reduction in total delays,
20% reduction in assessment delays,
20% reduction in total days delayed from March 2024 baseline

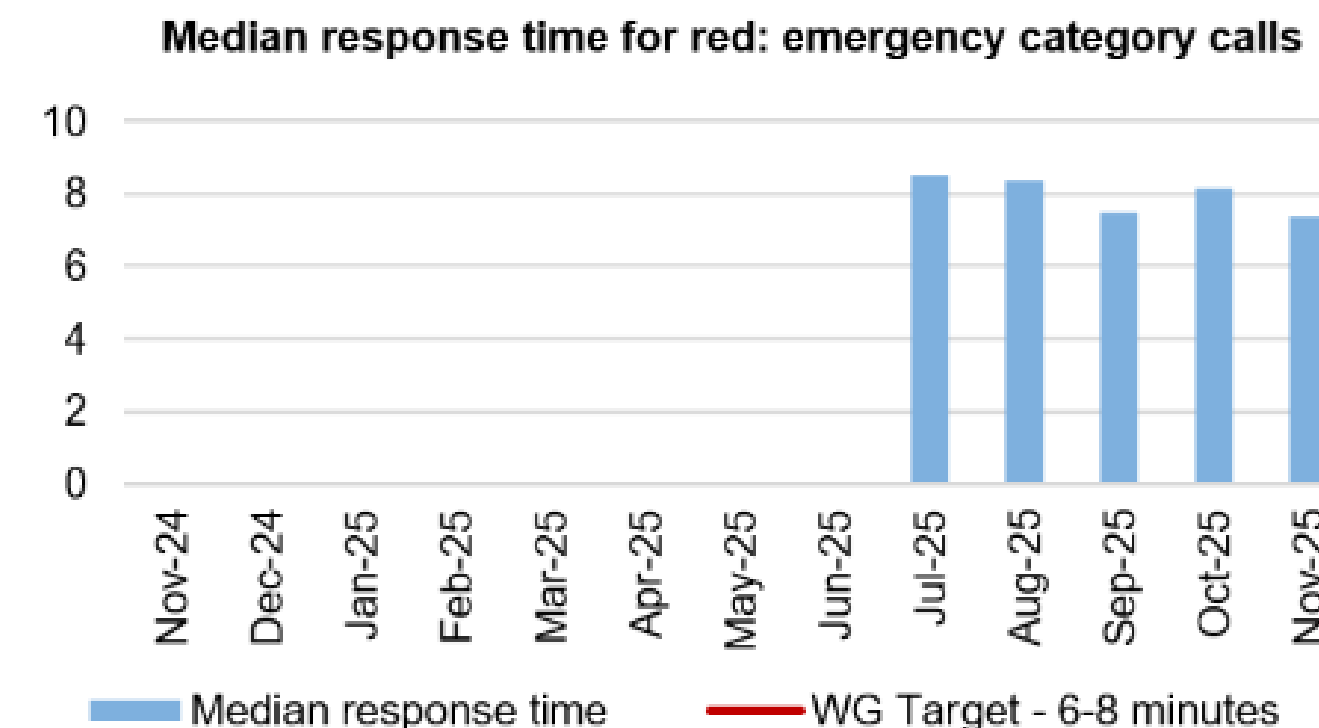
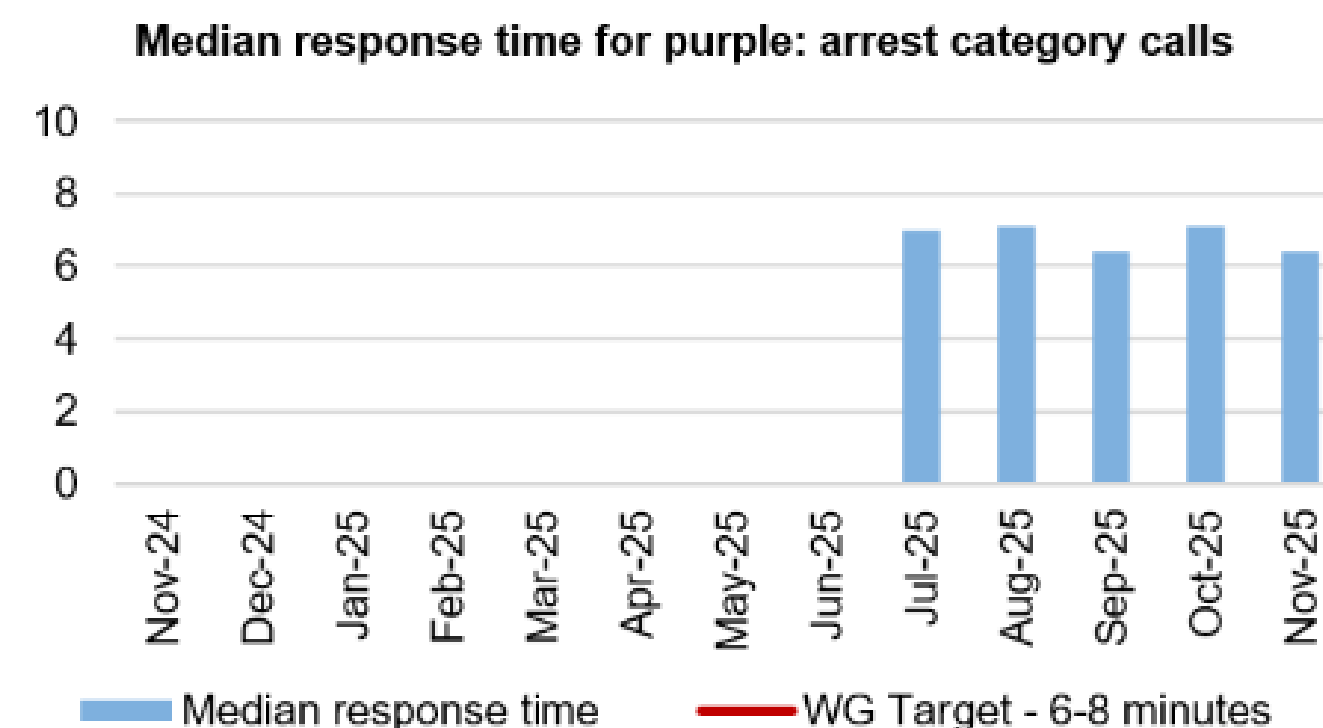
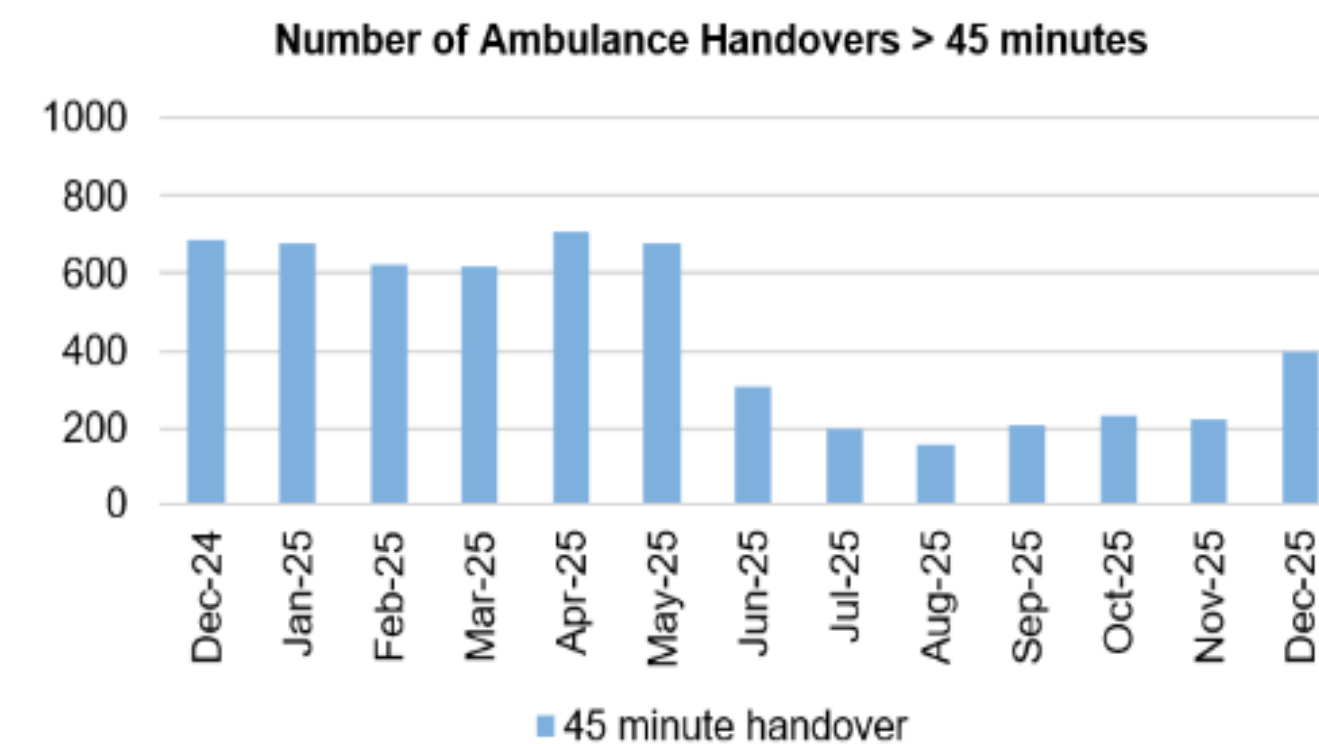
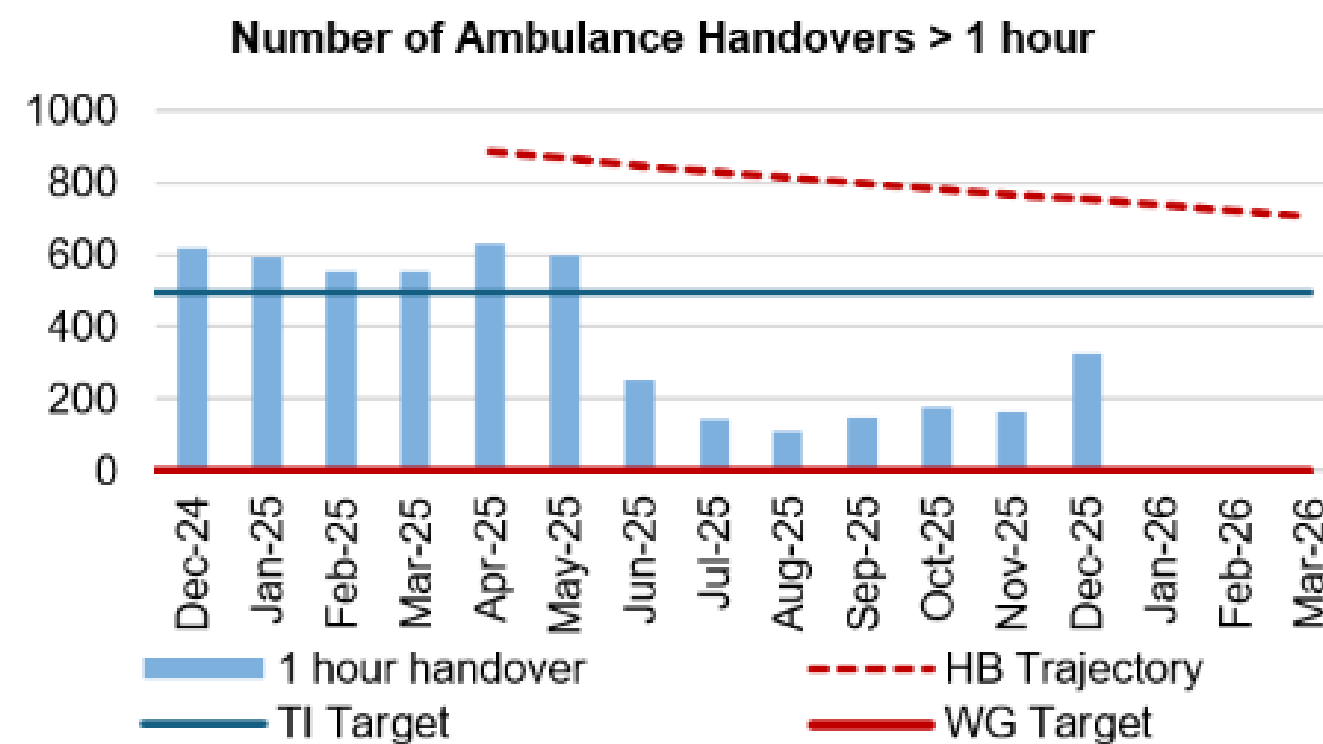


What have we done to achieve the positive reduction

- Discharge Sprint utilized to focus on long delay cohort, of which 2/3 discharged – ongoing reviews on back of success
- Established assessment and recovery beds to support earlier decision-making and flow
- Adjusted IDH processes to better meet increased demand and acuity
- Increased use of alternative settings to reduce pressure on acute beds
- Maintained a multi-agency focus on longest delays, supported by POCD sprint approaches
- Used existing escalation and coordination arrangements to manage system pace and complexity

What specific improvements will be delivered?

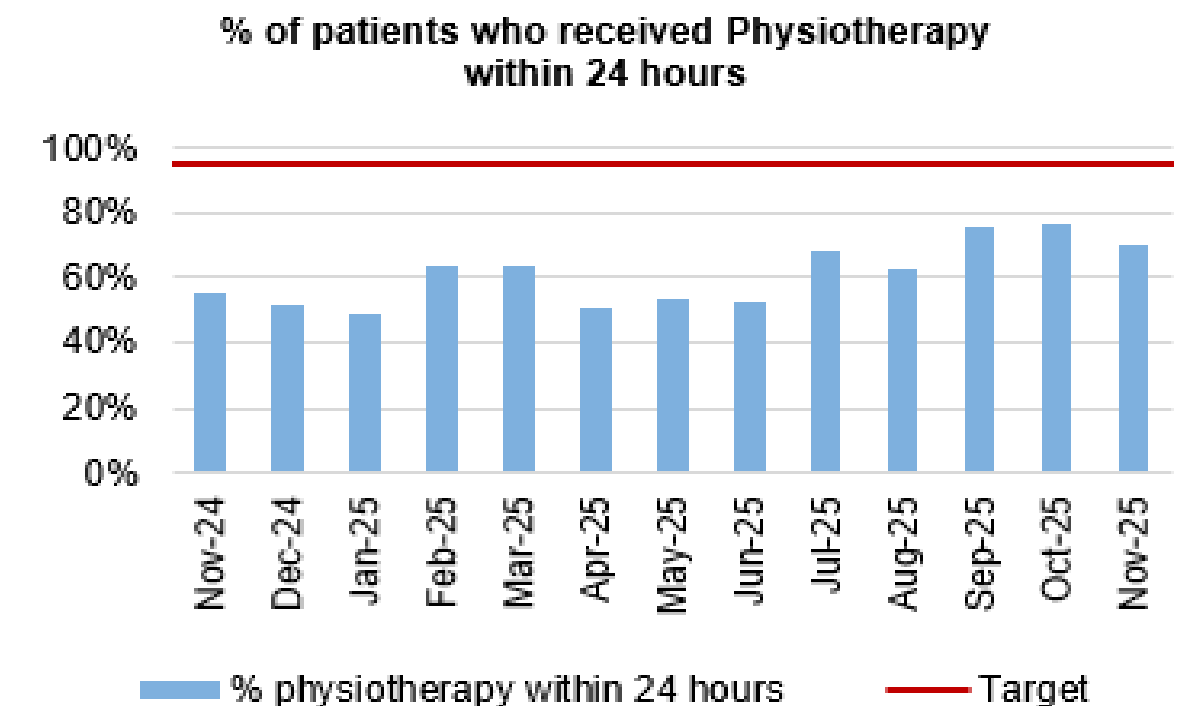
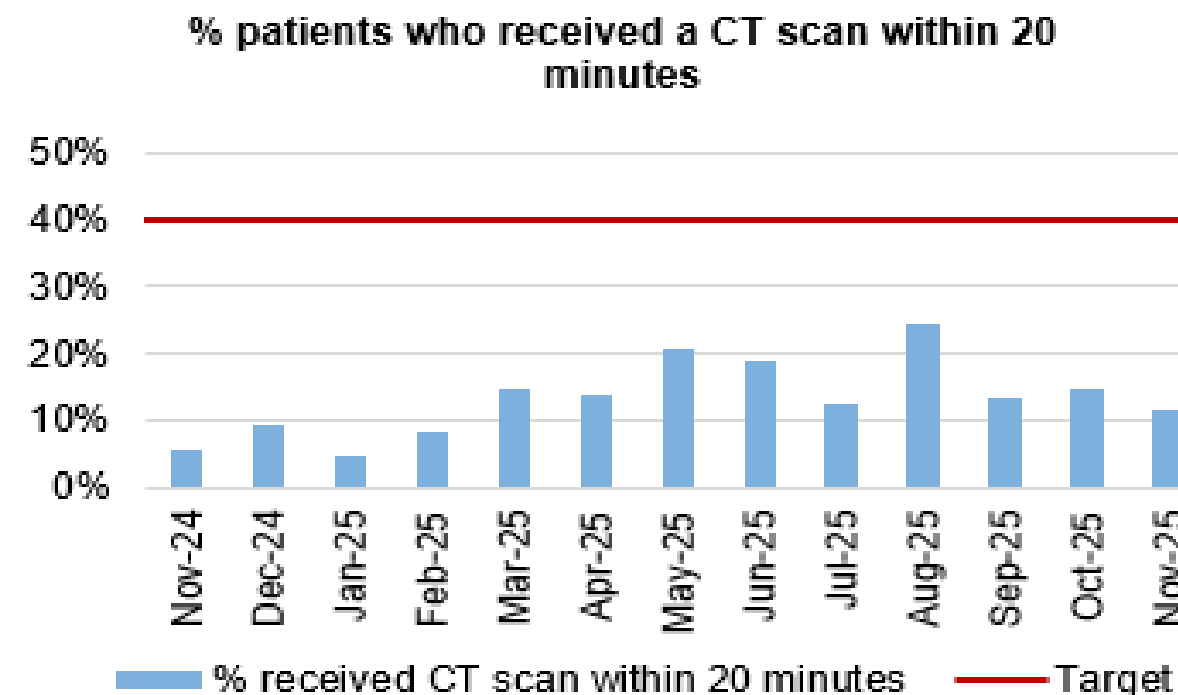
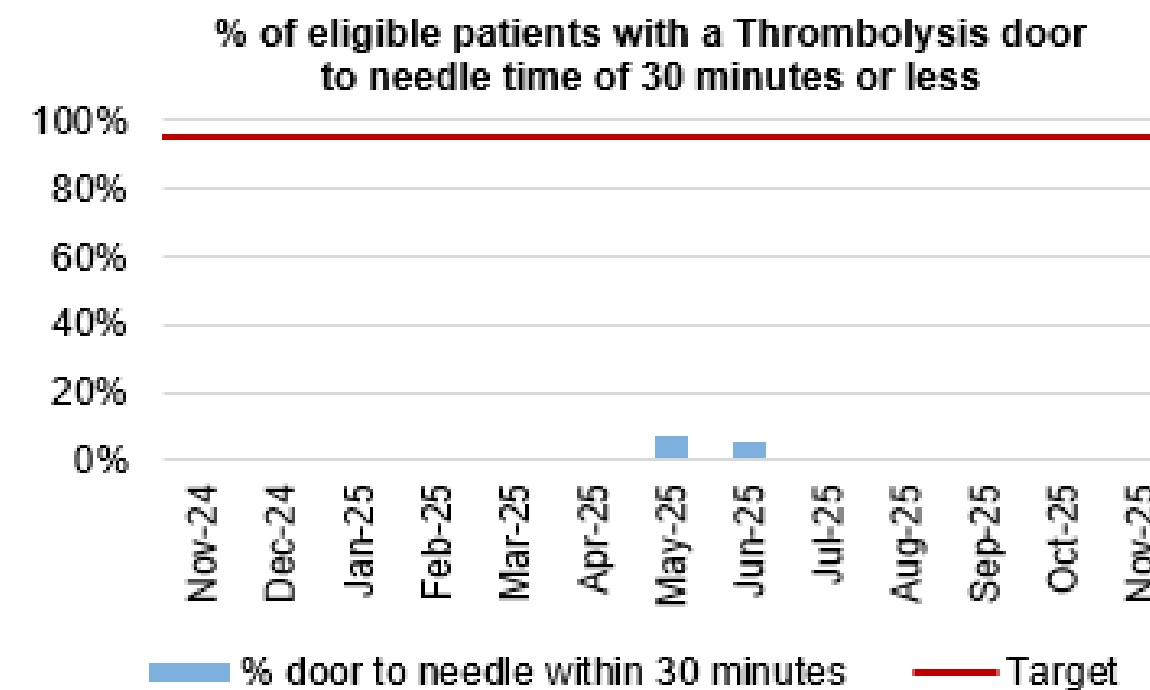
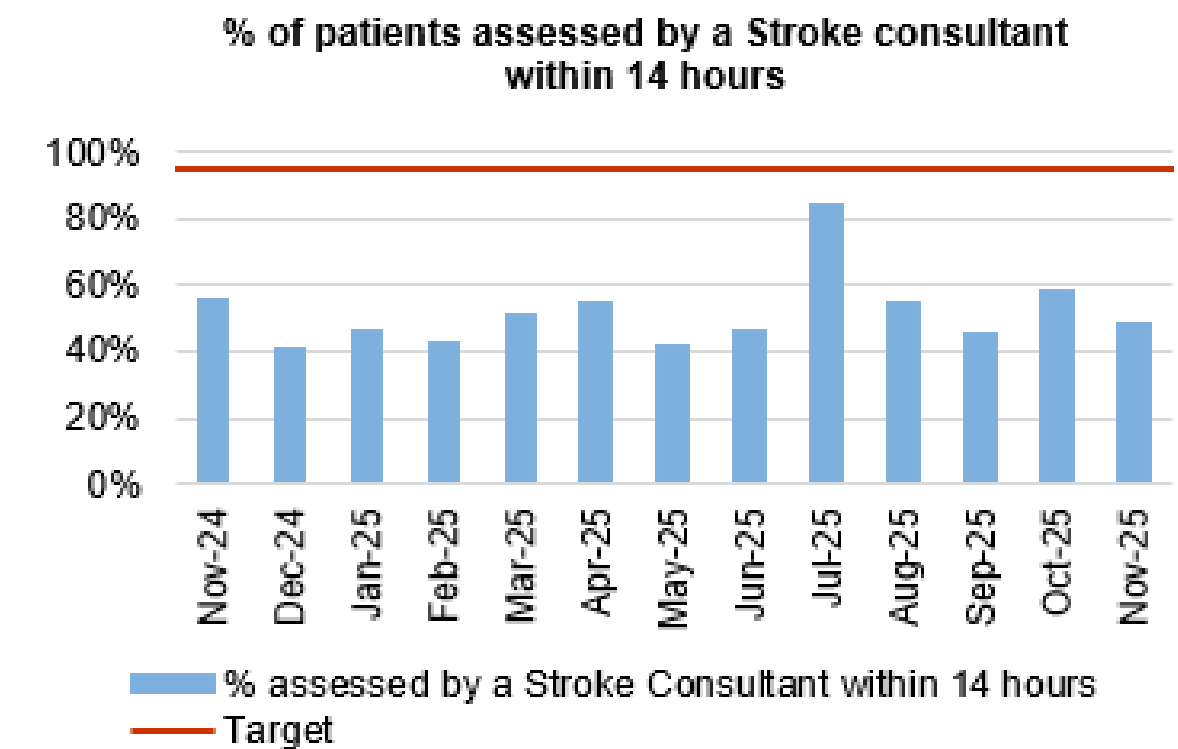
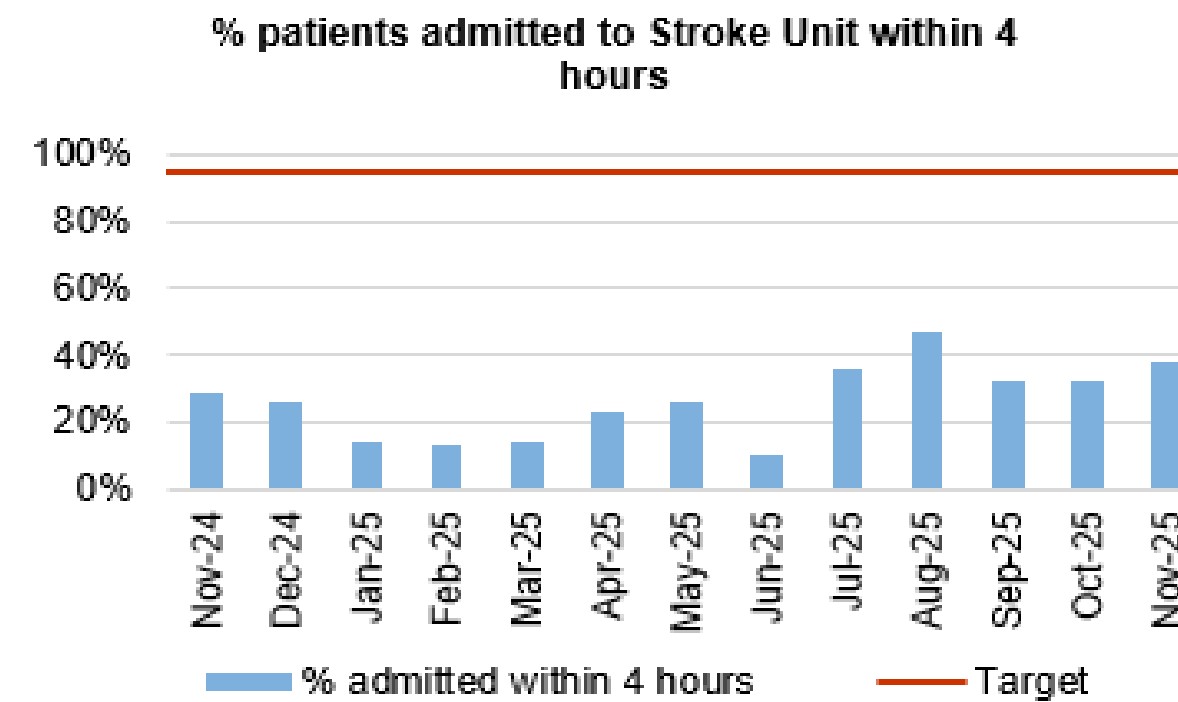
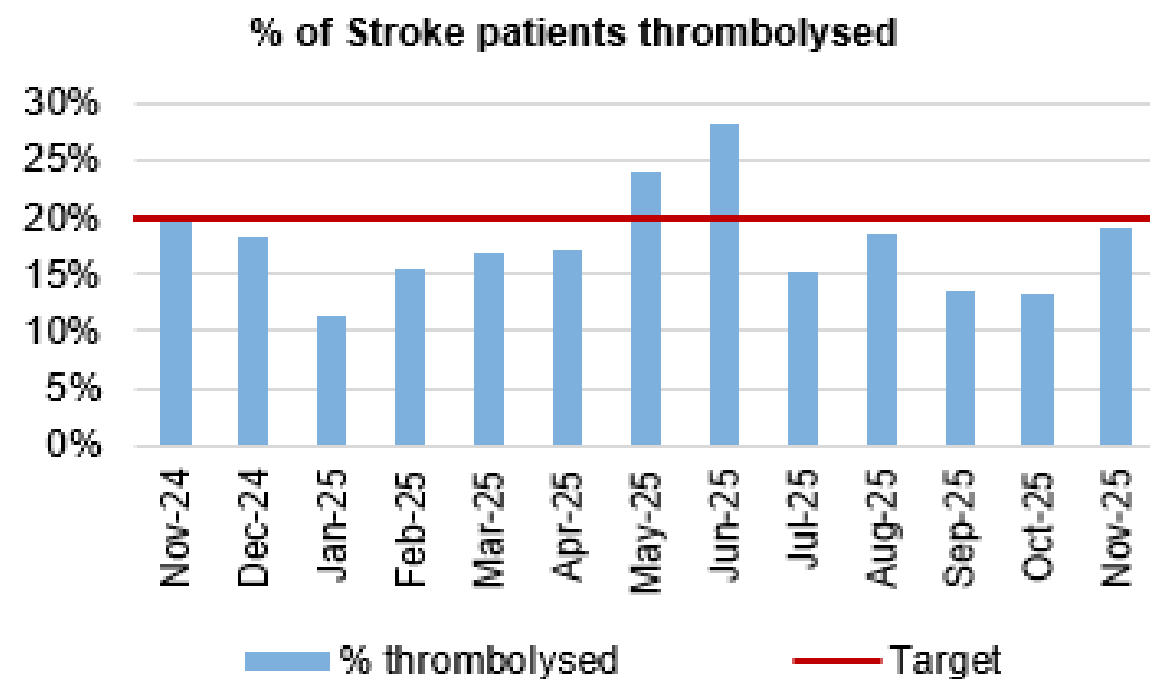
- Further optimize assessment and recovery bed models
- Continue refining IDH processes to improve consistency and timeliness
- Expand and standardize alternative settings to support discharge and flow
- Progress joint work on NPT transfers to Singleton
- Maintain POCD sprint methodologies and system-wide coordination
- Deloitte Activity in conjunction with West Glamorgan:
 - Map D2RA pathways
 - Process mapping workshops
 - Changes required escalated to appropriate board
- Reduce LOS through improved Board Rounds and enhanced MDT approach



Actions/Updates

- **Revised flow operating model:** The revised operating models implemented as part of the test of change in Morriston remain in place. However, increase in demand for emergency care, high levels of patient occupancy driven by medical bed day utilisation has challenged the Health Board's ability to maintain flow and thus the level of ambulance handover performance achieved following the tests of change. The emergency pressures have tipped the Health Board into two formal Business Continuity incidents, consistent with the pattern currently seen across NHS Wales. A complicated Infection Control picture further contributes to the interruption of patient flow with capacity reduced as a result of winter illnesses.
- **UEC capital redesign** – Recent communication from the Chief Executive to the Director General of NHS Wales sets out an urgency to progress to an Electronic Patient Record across the Urgent and Emergency care services. Whilst there remains ambition to co-locate front door assessment processes with the emergency department, this programme of work cannot be progressed in the absence of Capital investment.

Stroke

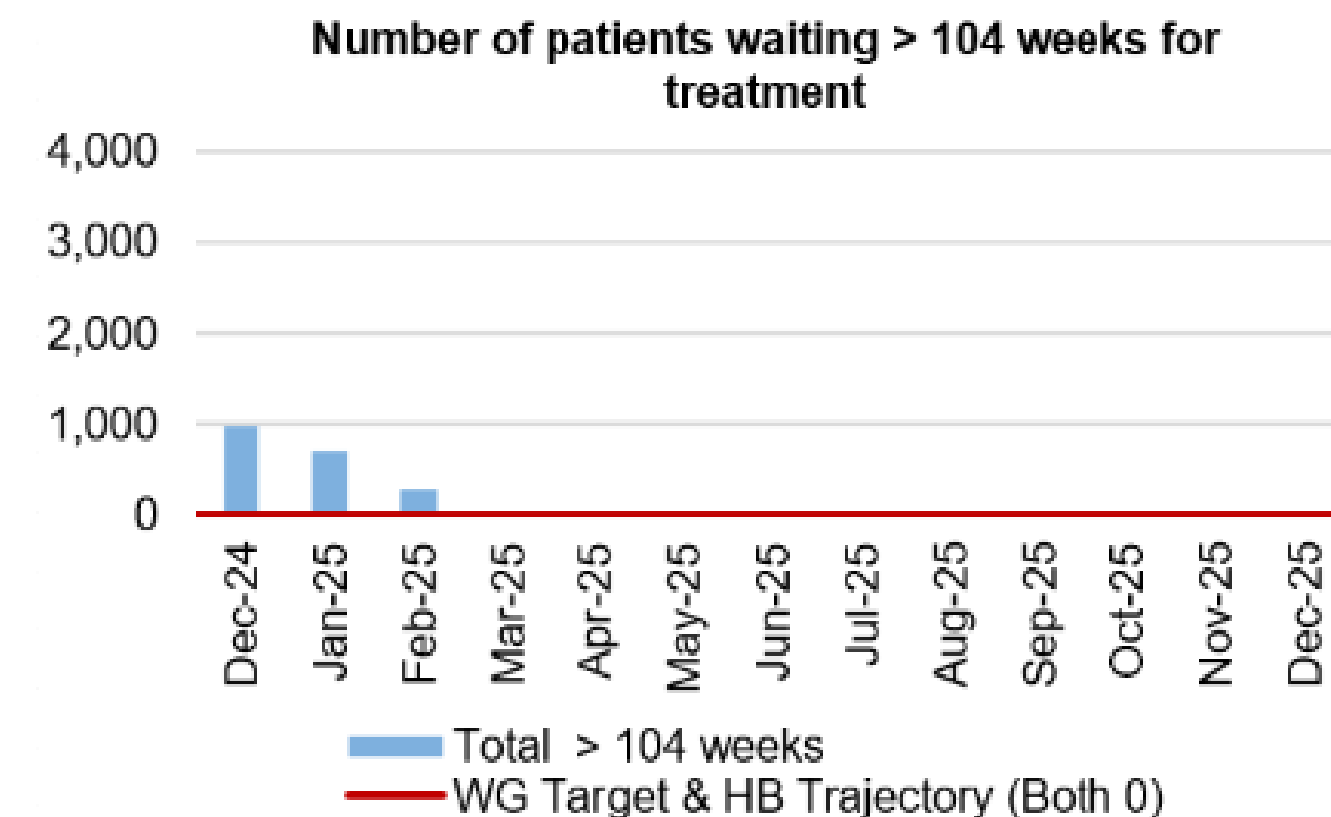
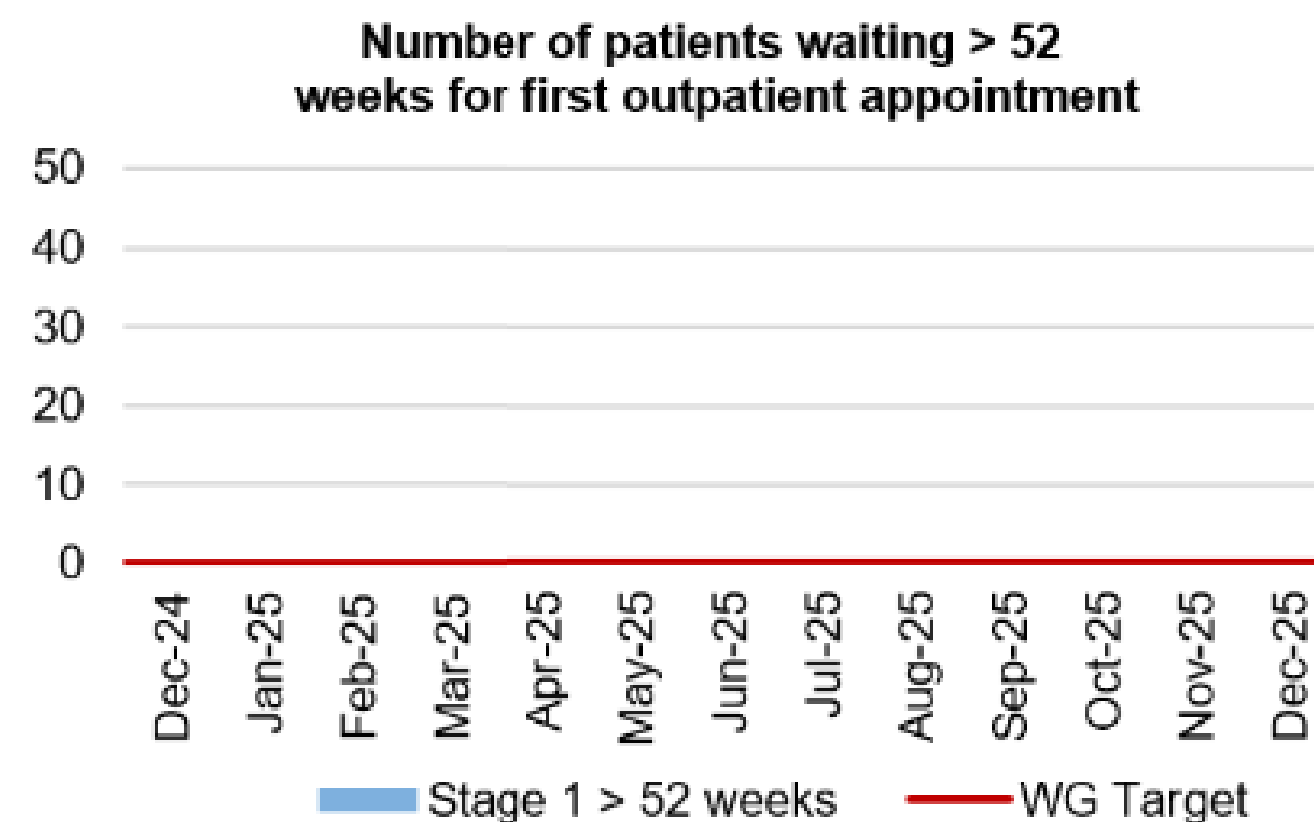
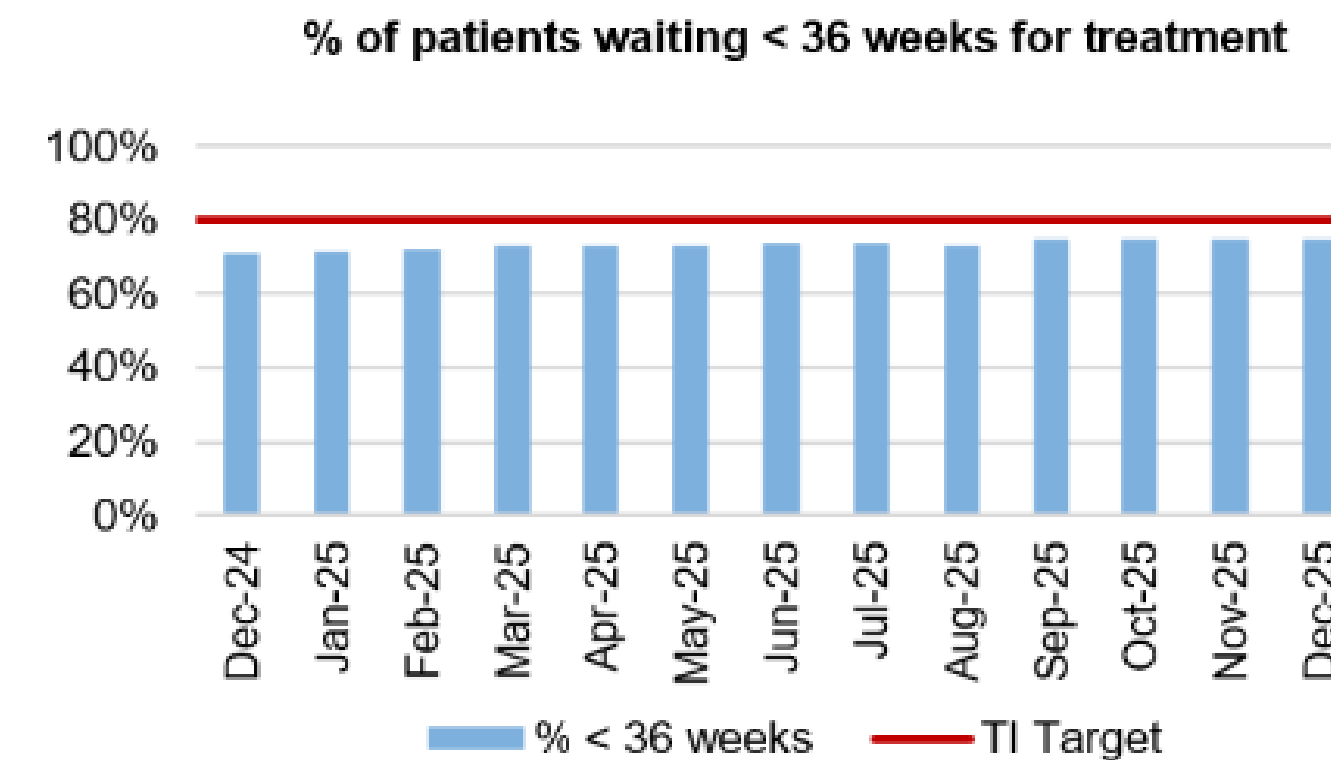
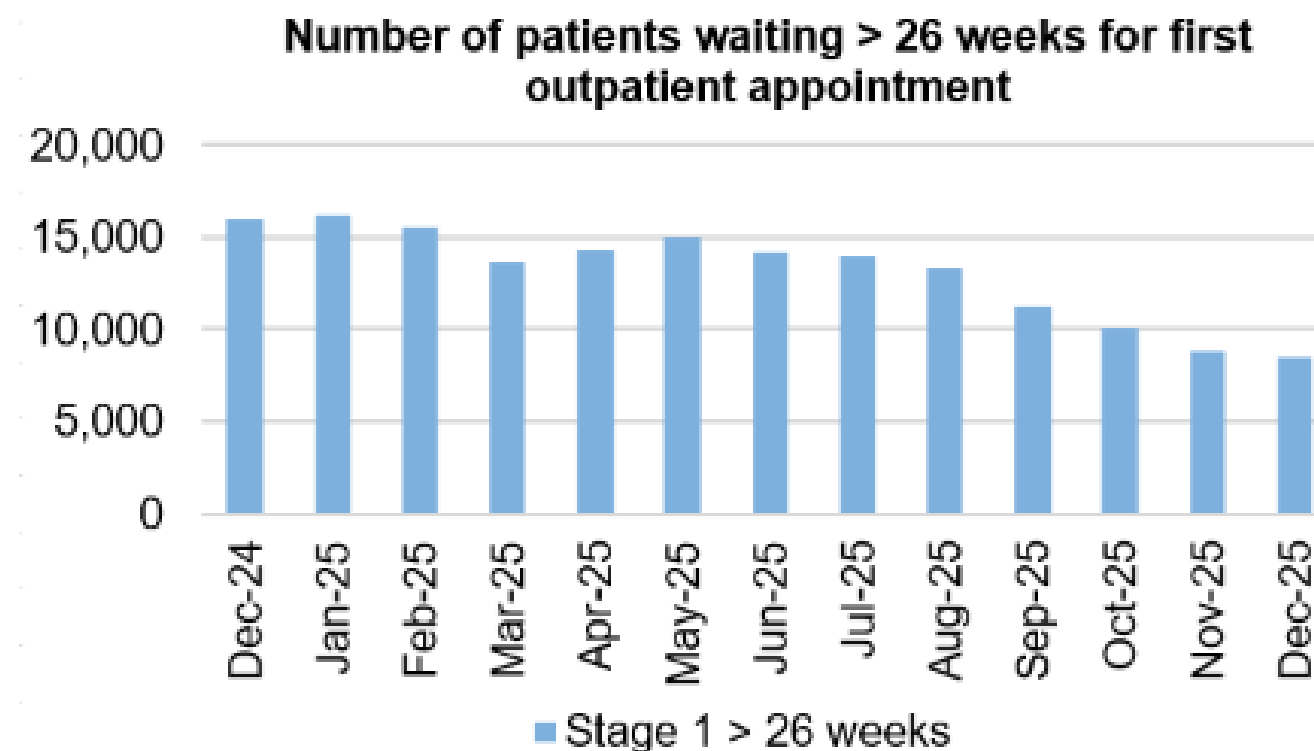


Actions/Updates

- The directorate management team have introduced several successful 'Stroke Tests of Change' in order to improve the flow of stroke patients between Morriston and Neath Port Talbot Hospital, and several actions are currently underway to support further improvement:
 - Further increase the stroke Ring-Fenced capacity to enable timely admission
 - Development of a dedicated stroke weekend plan
 - Implementation and expansion of the CT Perfusion service which will improve access to Thrombolysis and increase compliance
 - Introduction of the Tenecteplase to improve time to Thrombolysis
 - Implementation of the stroke ACP/CNS Pre-Triage Assessment
 - Expansion of the stroke specialised team - CNS/ACP cover 07:30am to midnight 7 days per week.

Planned Care

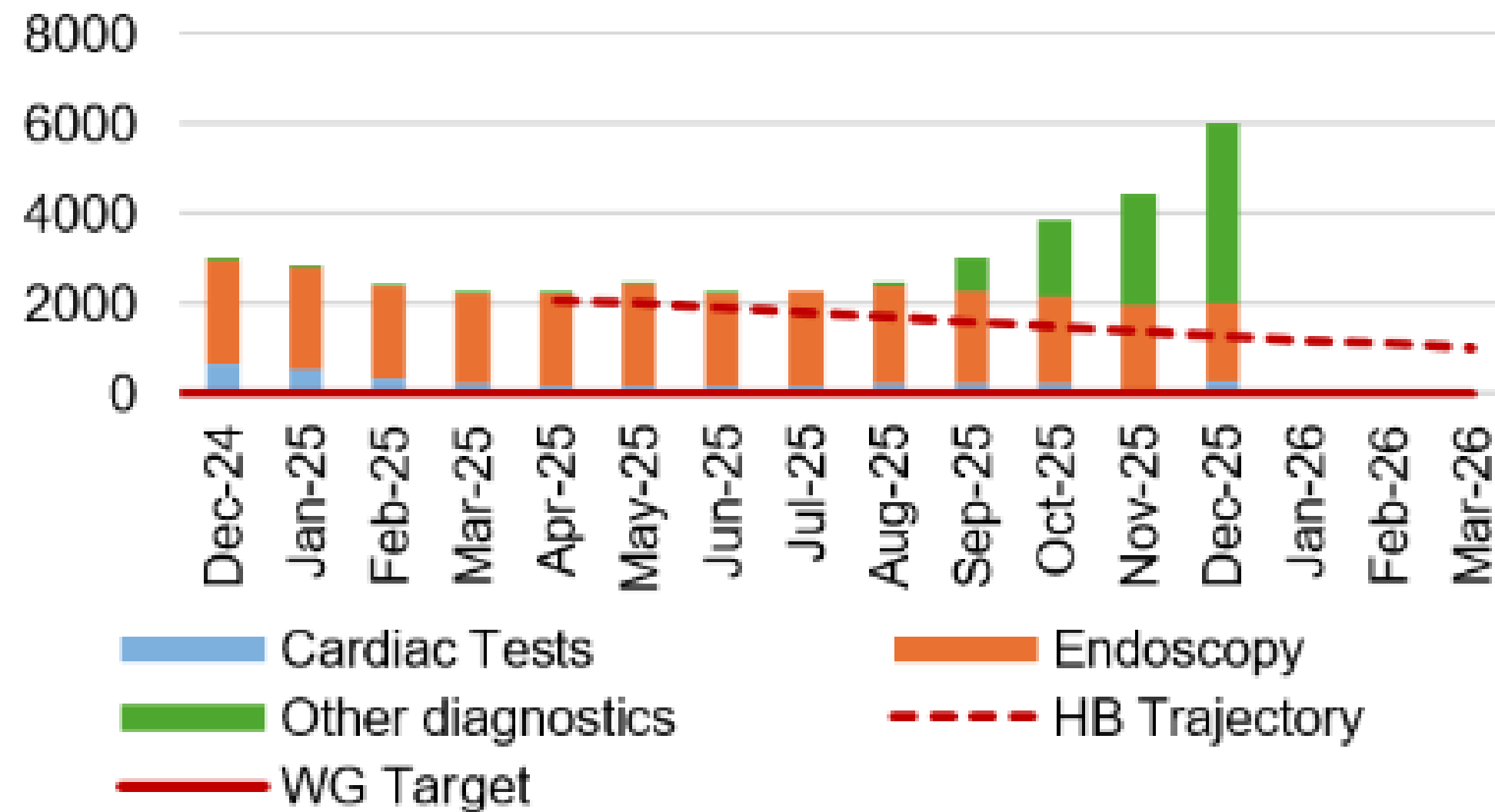




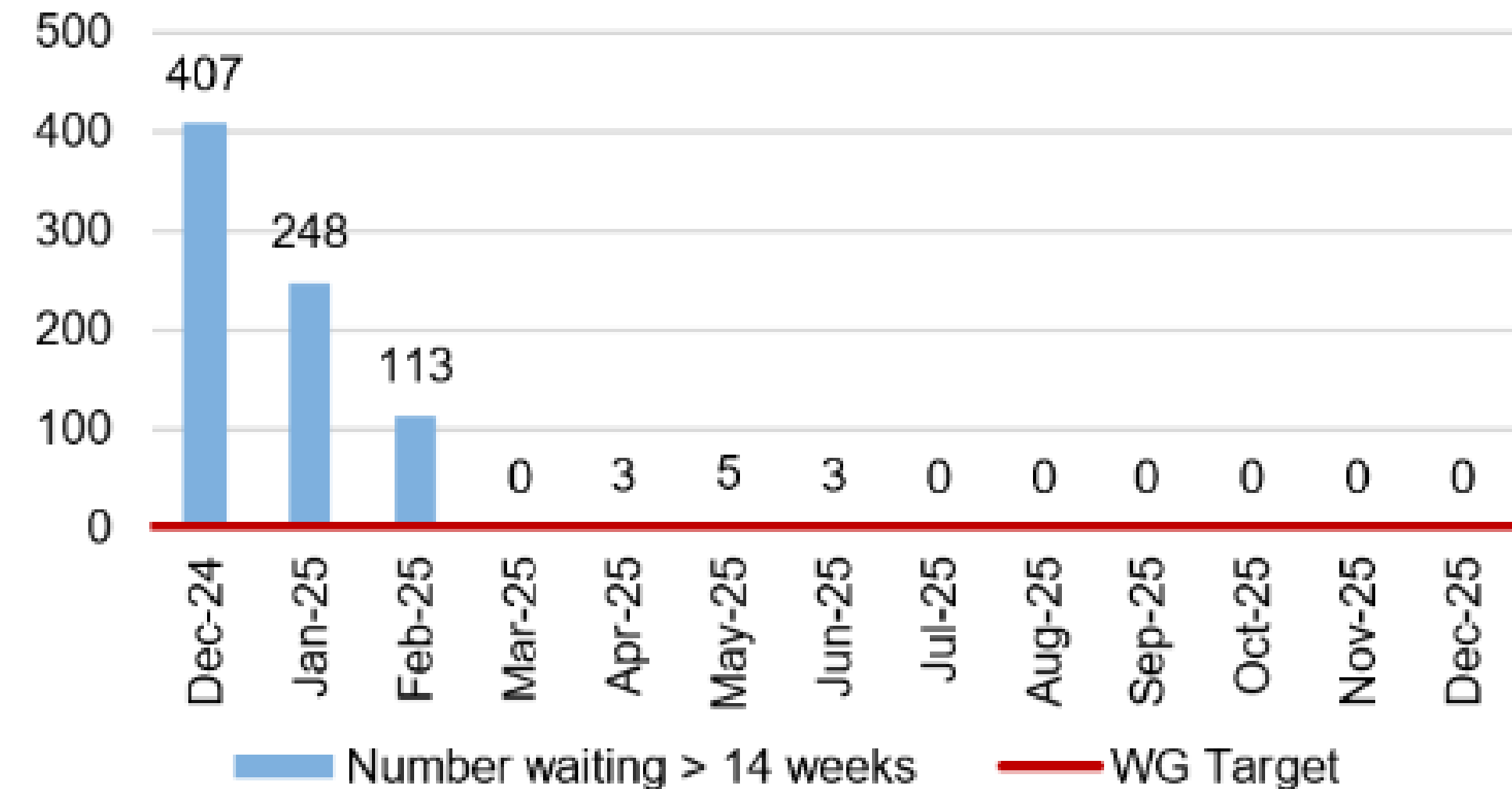
Actions/Updates

- The Health Board have maintained the Stage 1 > 52 weeks target of 0 for December 2025.
- The Health Board have maintained the number of patients waiting > 104 weeks for treatment target of 0 for December 2025.
- Focus has now been placed on achieving a new Targeted Intervention Target for patients waiting >36 weeks for treatment. Welsh Government have provided updated de-escalation criteria for all planned care metrics which reflect encouragement towards an improved position.
- Key Risks to delivery include the current physical infrastructure to hold additional clinics, workforce availability, funding and willingness of patients to attend out of hours

Number patients waiting > 8 weeks for diagnostics



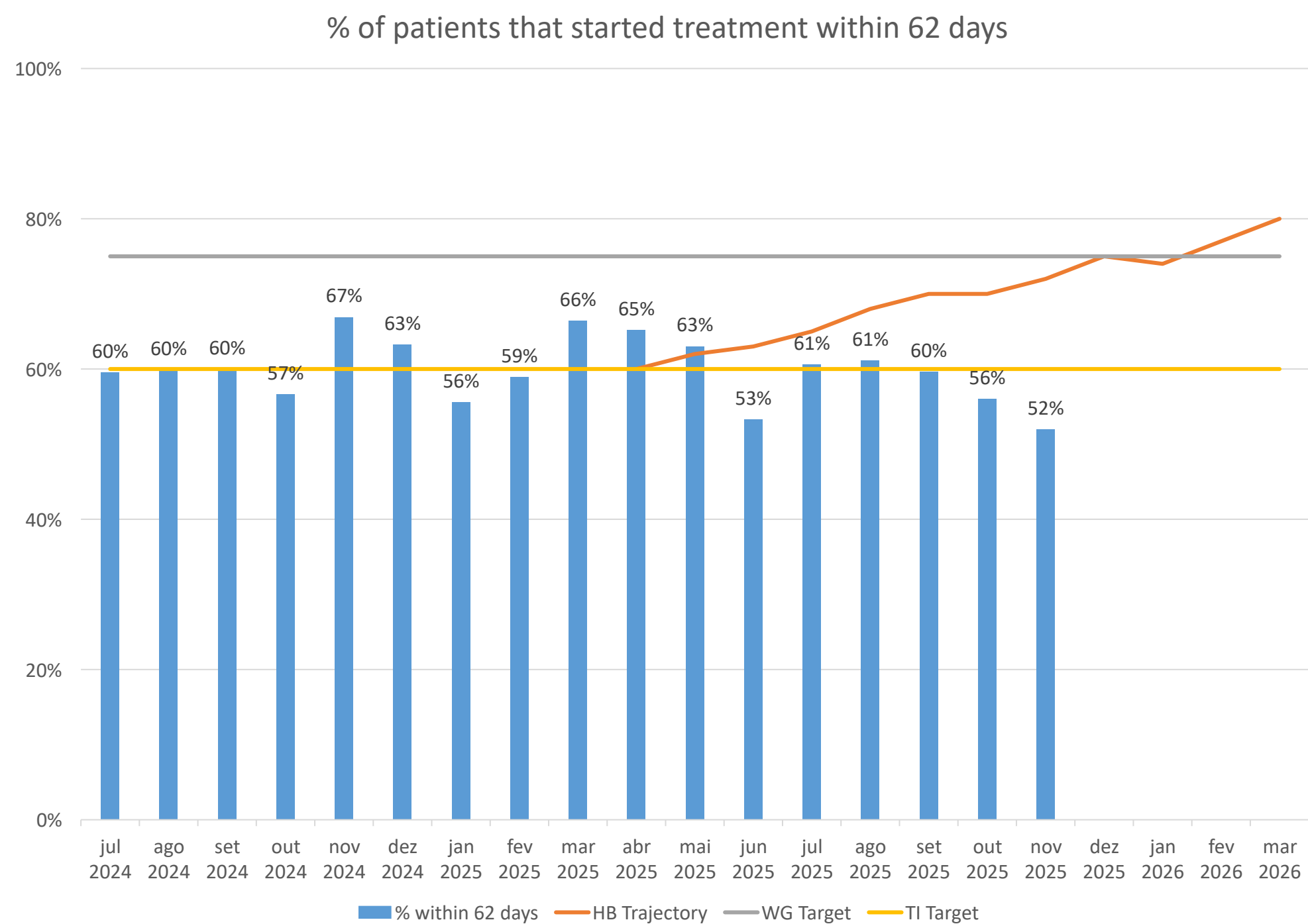
Number of patients waiting > 14 weeks for Therapies



Actions/Updates

- The total number of patients waiting > 8 weeks for diagnostics has increased in December to 6,042 compared to 4,434 in November 2025. The increase in the number of patients waiting > 8 weeks for diagnostics is mainly a result of a significant increase in Radiology waits.
- As part of the recovery plan, the WG have funded a mobile Endoscopy unit which has been sited on Morriston Hospital to support additional capacity. The unit was unfortunately non-operational throughout the month of December 2025, due to a leak in the roof. The unit has however been running live activity again since the 30th December and is supporting the reduction of the number of patients waiting > 8 weeks for an Endoscopy.
- The number of patients waiting > 14 weeks for therapies has been reported as 0 in December 2025

Cancer Performance & Breaches

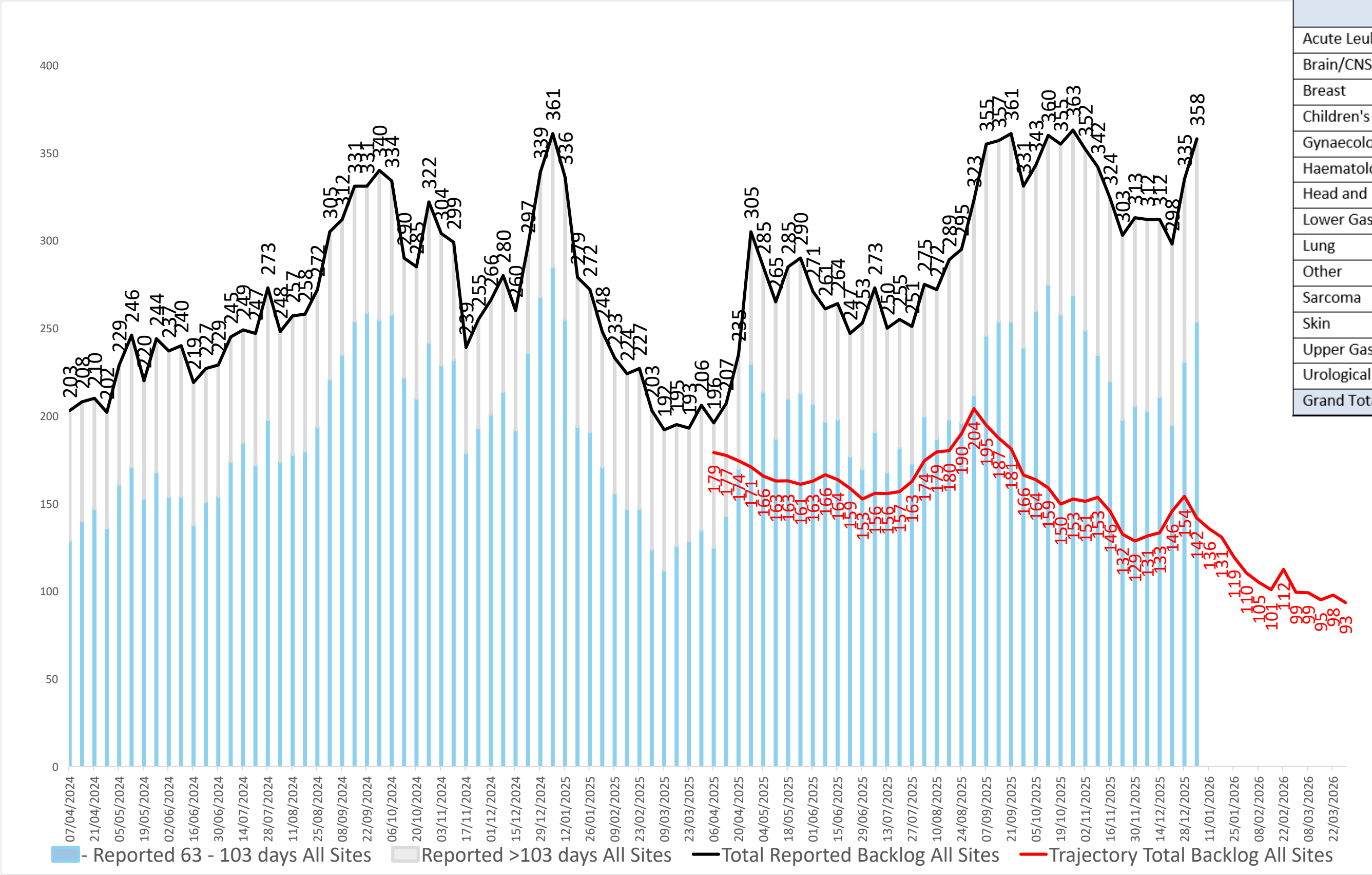


Patients who breached target	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
Head and neck	3	3	6	7	5	8	9	10
Upper Gastrointestinal	1	6	3	9	3	7	8	5
Lower Gastrointestinal	11	11	26	16	12	16	13	12
Lung	9	19	11	3	11	9	13	6
Sarcoma	2	0	1	1	2	0	0	1
Skin(c)	16	9	8	16	9	12	14	7
Brain/CNS	1	0	0	0	0	0	0	0
Breast	10	10	13	4	7	12	8	13
Gynaecological	2	10	8	6	5	5	4	6
Urological	20	20	33	31	20	29	22	23
Haematological	4	7	11	8	6	9	6	4
Other	1	0	1	1	0	0	2	1
Grand Total	80	95	121	102	80	107	99	88

Actions/Updates

- Disappointingly, in October performance fell to 56% and then to 52% in November 2025. It is worth noting that the volume treated in November was particularly low, the lowest since February 2022. There are approximately 60 pathways that are awaiting pathology results at the time of submission, this reduction is predominantly noted for the skin pathway, where volumes reported are 63% lower than November 2024. This is due to delayed pathology reporting, as such we expect the number of confirmed and treated cancers, and consequently performance, will increase at resubmission.
- Early indications are that performance between July and September will increase by 1-2%, October performance has already increased to 58% with results still outstanding.
- Proactive arrangements are being made with pathology to ensure 4-8 weeks notice for the authorisation of results to support our SCP position at first submission and reduce variation at resubmission**

Cancer Backlog



	First OPA	Diagnostic One Stop	Diagnostic	Followup	MDM	Treatment	Grand Total
Acute Leukaemia	0	0	0	0	0	0	0
Brain/CNS	0	0	0	0	0	0	0
Breast	0	1	5	0	0	1	7
Children's Cancer	1	0	0	0	0	1	2
Gynaecological	0	0	30	6	0	4	40
Haematological	0	0	3	4	1	1	9
Head and Neck	1	0	6	2	6	3	18
Lower Gastrointestinal	0	0	78	7	2	21	108
Lung	0	0	4	9	0	6	19
Other	0	0	1	0	1	0	2
Sarcoma	0	0	1	1	1	1	4
Skin	2	18	13	9	0	18	60
Upper Gastrointestinal	0	0	17	5	1	6	29
Urological	0	0	19	18	0	23	60
Grand Total	4	19	177	61	12	85	358

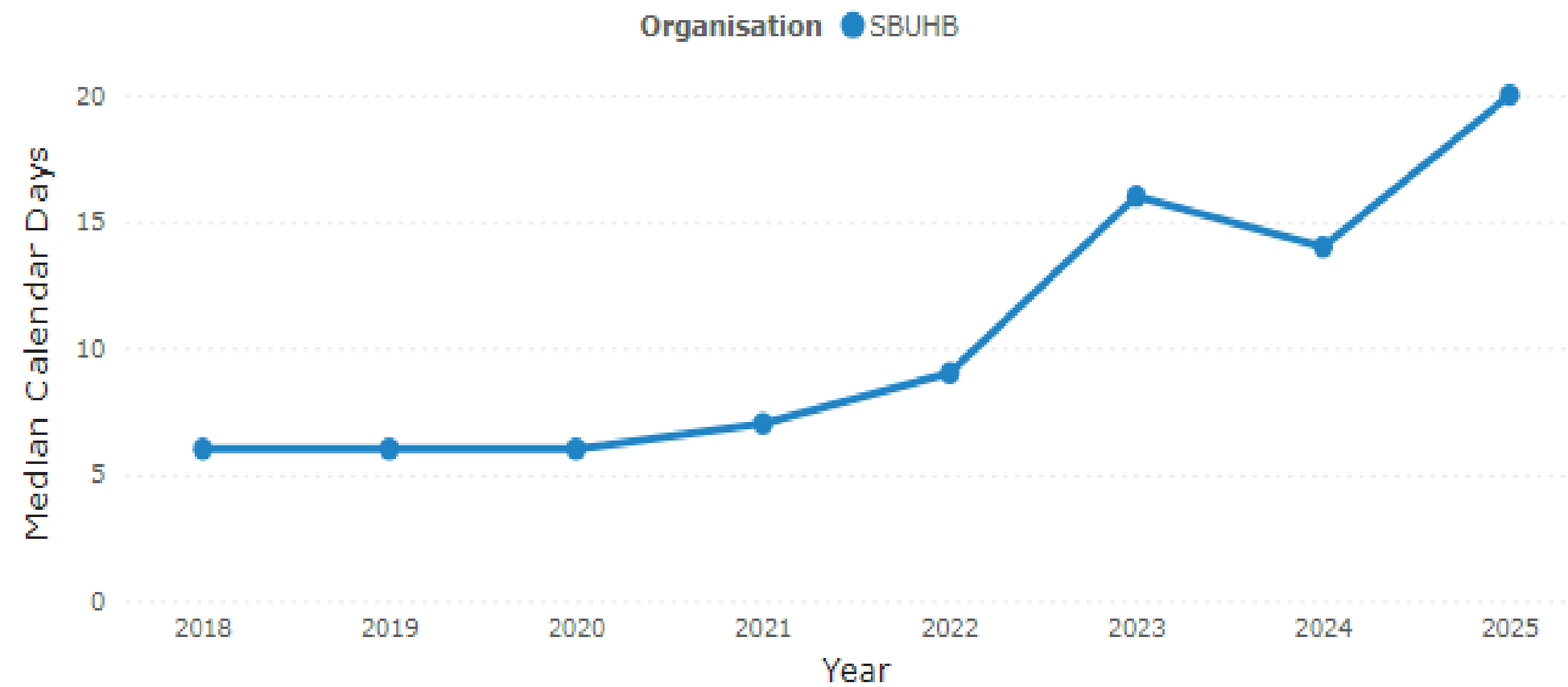
Tumour Site	63 - 103 days		≥104 Backlog		Total Backlog	Trajectory for w/e 04/01/26	Above or Below
	Number reported	+ / -	Number reported	+ / -			
Acute Leuk.	0	0	0	0	0	0	0
Brain/CNS	0	0	0	0	0	0	0
Breast	7	2	0	0	7	6	1
Children's	2	2	0	0	2	0	2
Gynaecological	36	10	4	-5	40	19	21
Haematological	7	-2	2	-1	9	8	1
Head and Neck	16	0	2	0	18	5	13
Lower GI (Excl. BSW)	31	4	10	0	41	23	85
LGI of which are BSW	36	5	31	4	67	-	-
Lung	13	0	6	0	19	17	2
Other	2	1	0	0	2	2	0
Sarcoma	3	-1	1	0	4	5	-1
Skin	49	4	11	-1	60	22	38
Upper GI	15	0	14	1	29	13	16
Urological	37	-2	23	2	60	22	38
Grand Total	254	23	104	0	358	142	216

Actions/Updates

- All cancer tracking vacancies were filled in November 2025.
- An increase in the cancer backlog was anticipated at the end of December, moving into January as a consequence of the holiday period and patient led deferrals.

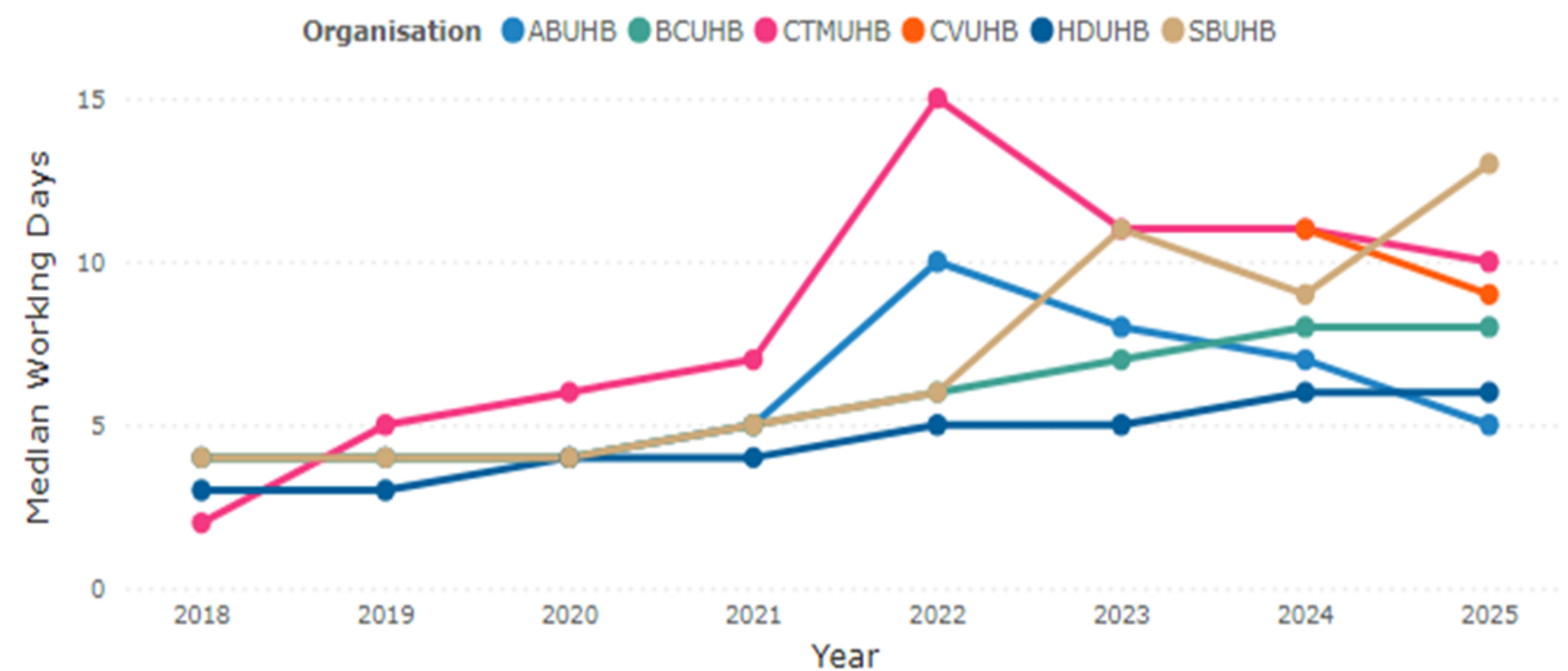
All Cellular Pathology Samples

TAT: from Received to First Authorised (Median)



SCP Samples

TAT: from Received to First Authorised (Median)

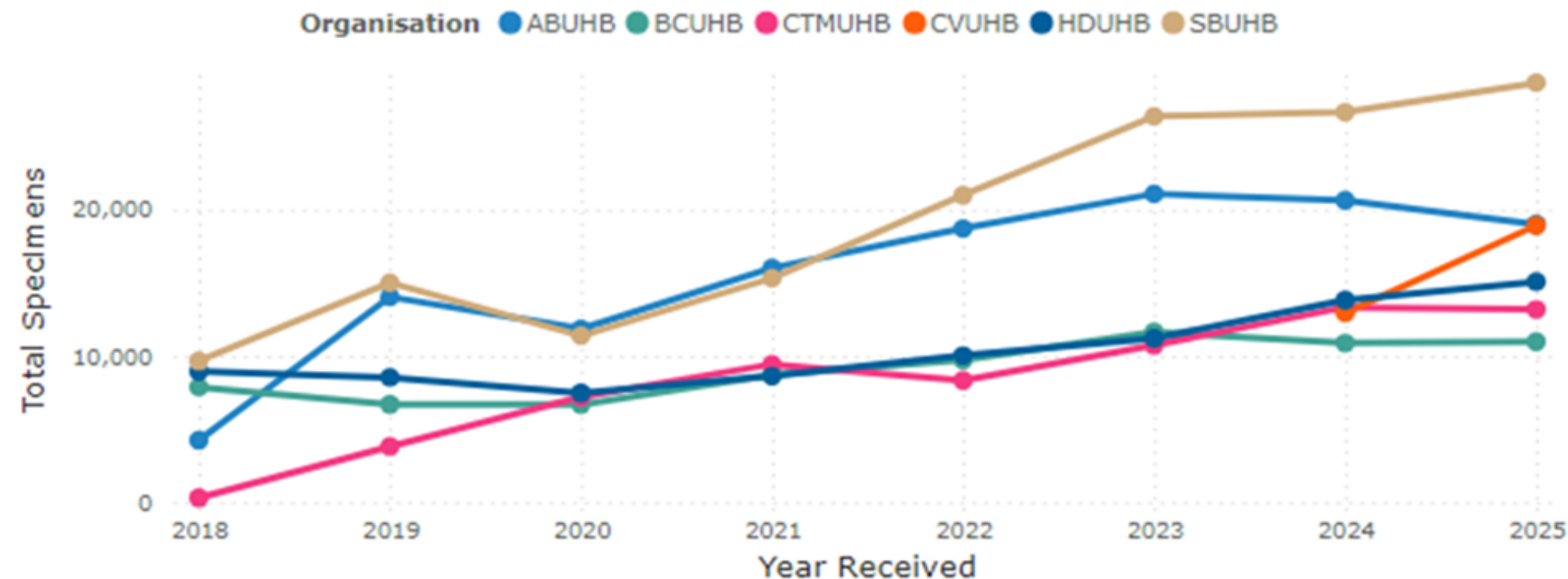


Actions/Updates

- Turnaround Time (TAT) overall have increased in the last year, reaching a peak in December 2025.
- Single Cancer Pathway TAT's have followed the same pattern; however, the median is lower due to the samples being prioritised.
- Additional outsourcing was commissioned in October 2025 to address the accumulated backlog of skin and GI SCP samples following the cessation of planned care outsourcing during a three-month period prior to September 2025.
- An escalation process has been implemented internally so that SCP samples can be identified and expedited on request to ensure samples reach MDT as soon as possible, TAT's still remain too high.
- Consultant staffing has reduced further in Q3 25/26 due to retirement and short-term notice of a resignation of a locum, vacant sessions are being used to supplement additional outsourcing whilst recruitment is attempted to increase the current staff in post.
- Additional BMS hours are still being relied upon to supplement the existing workforce whilst ongoing recruitment takes place.

SCP Samples

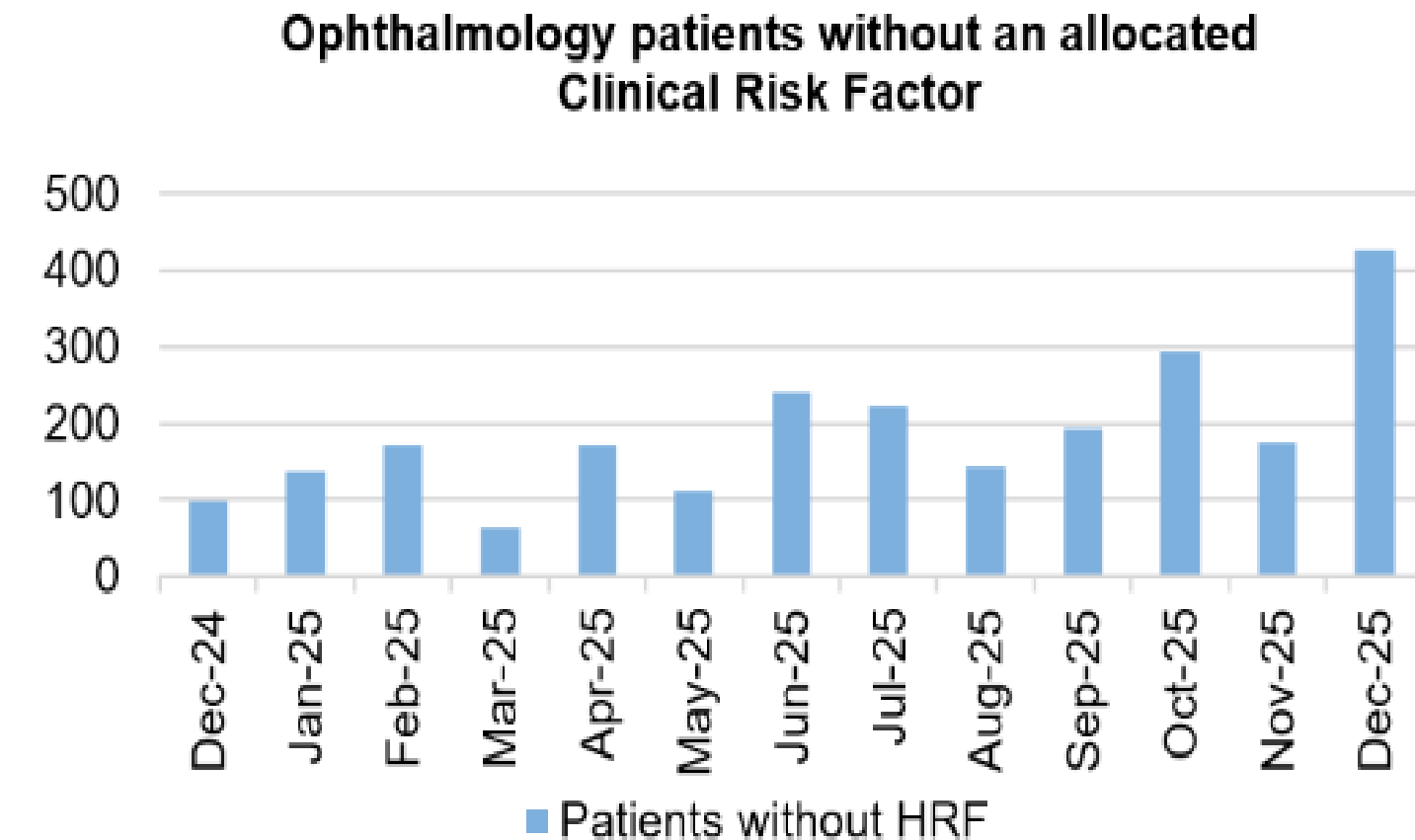
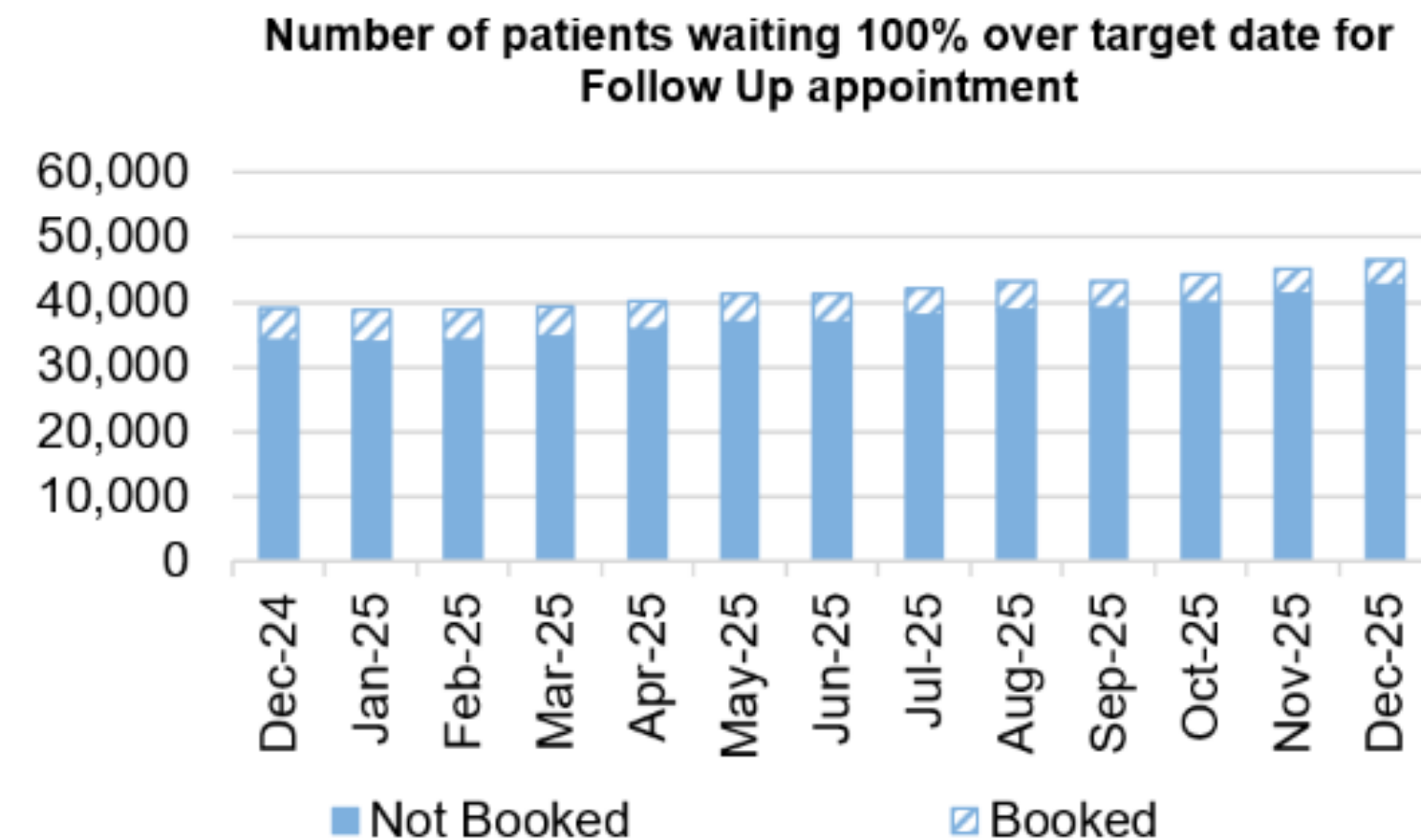
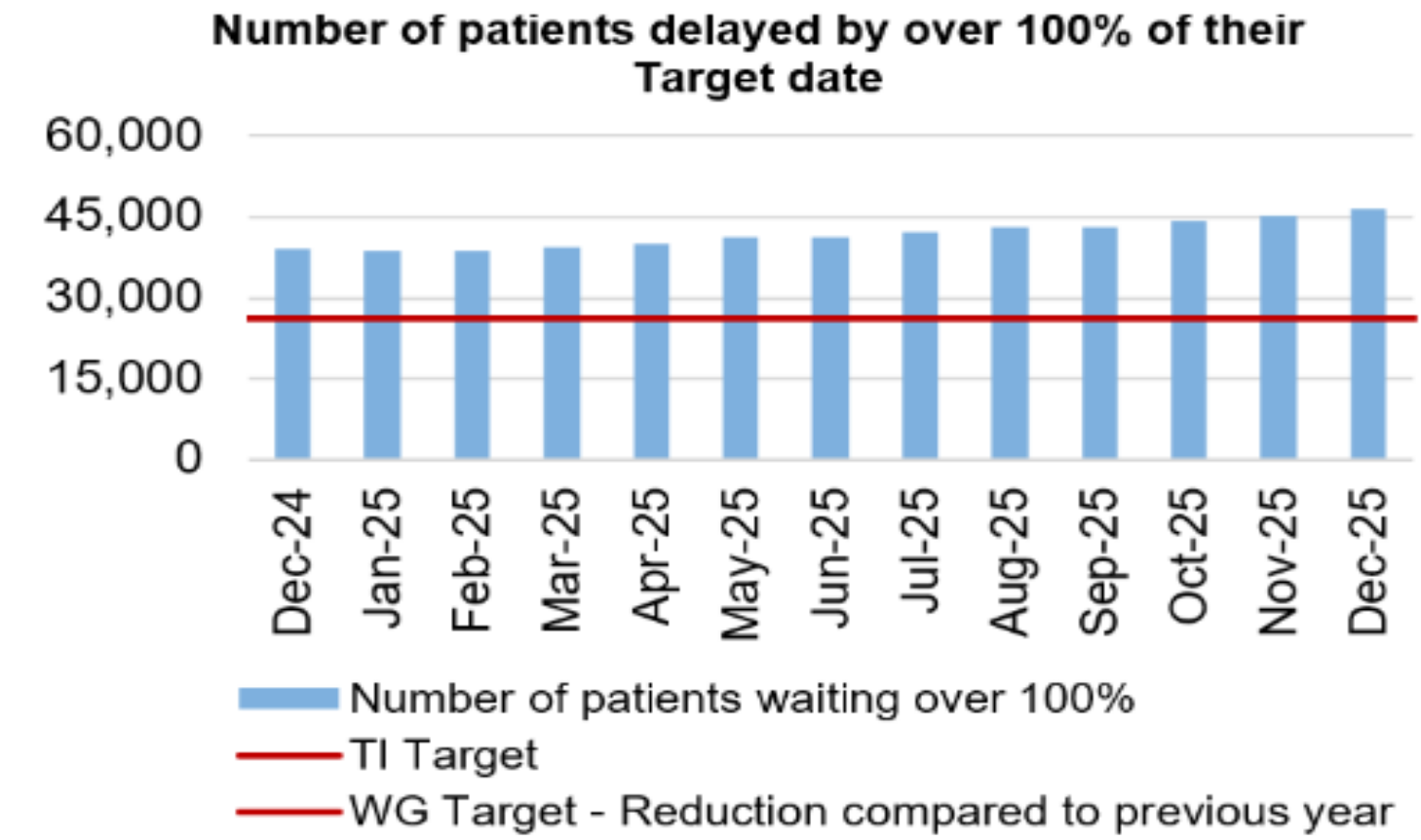
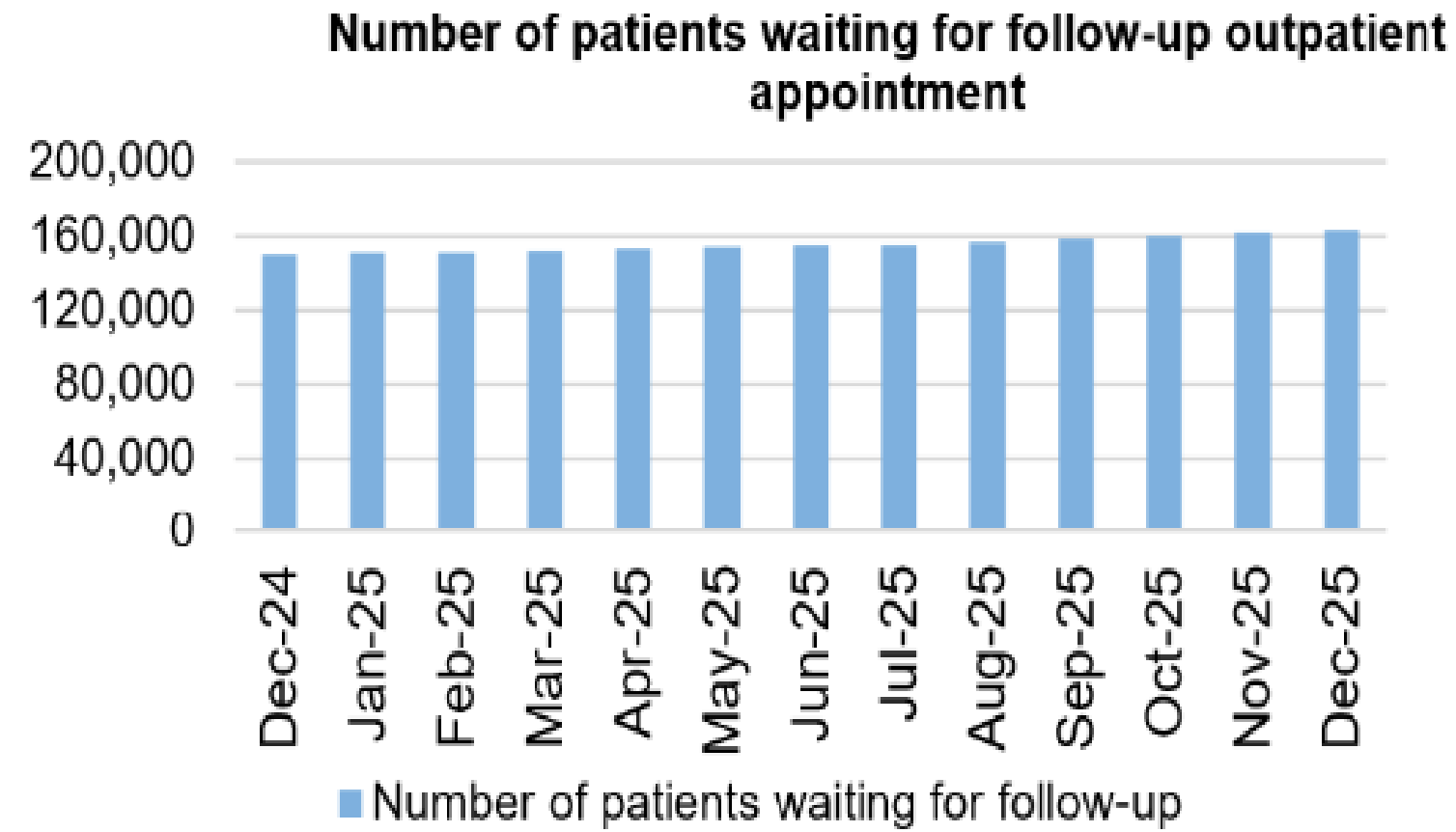
Total Specimens Received by LHB



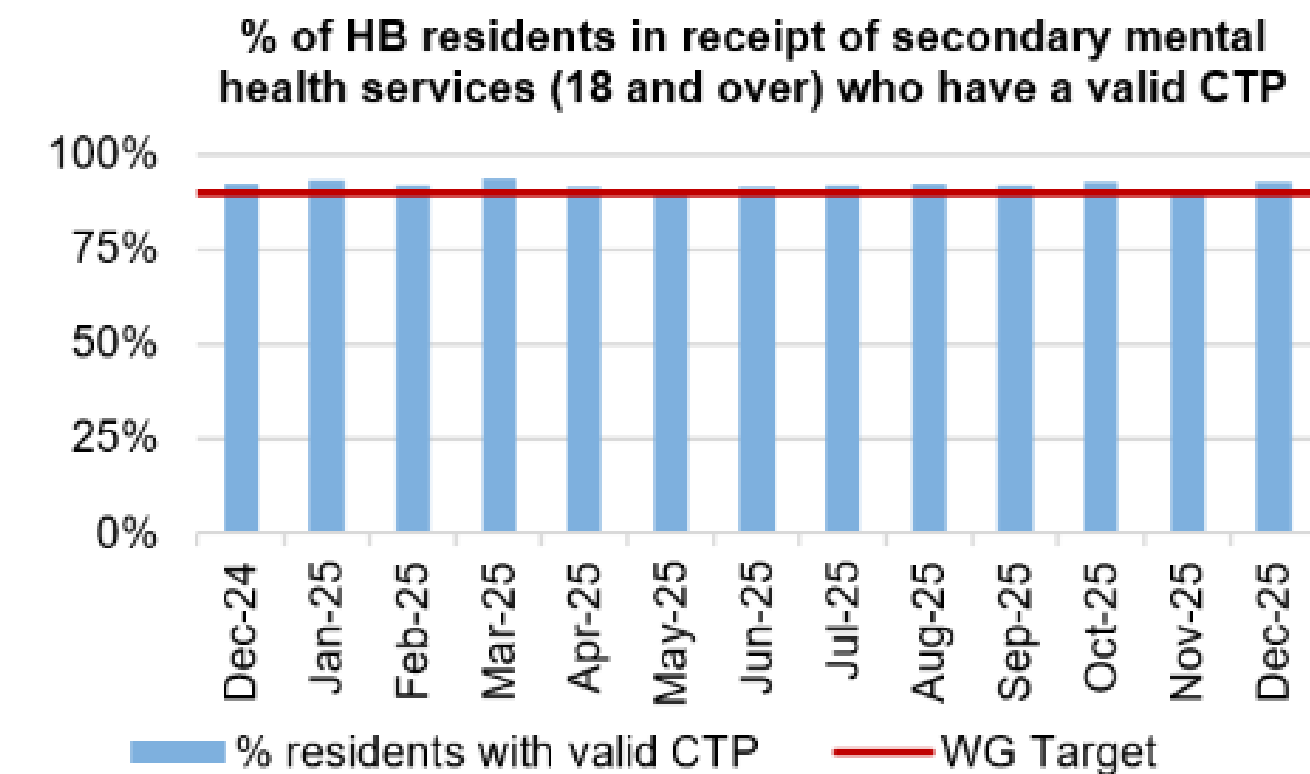
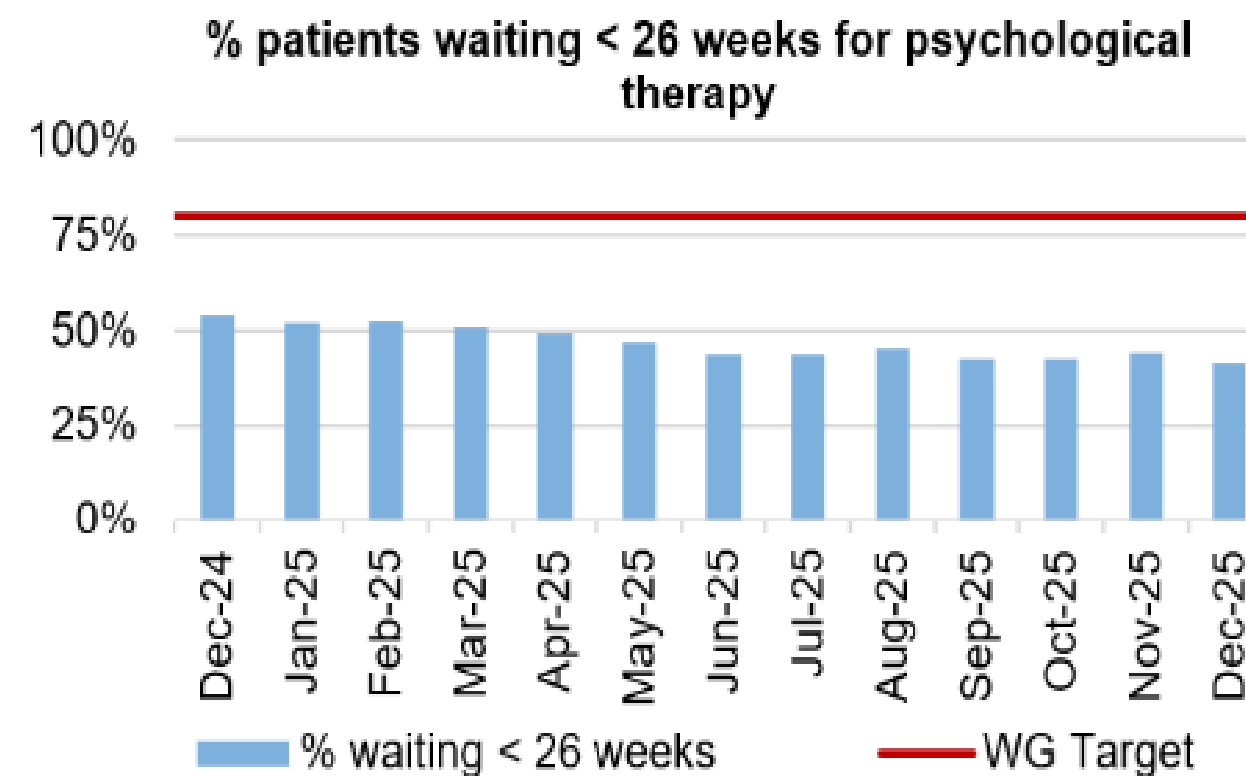
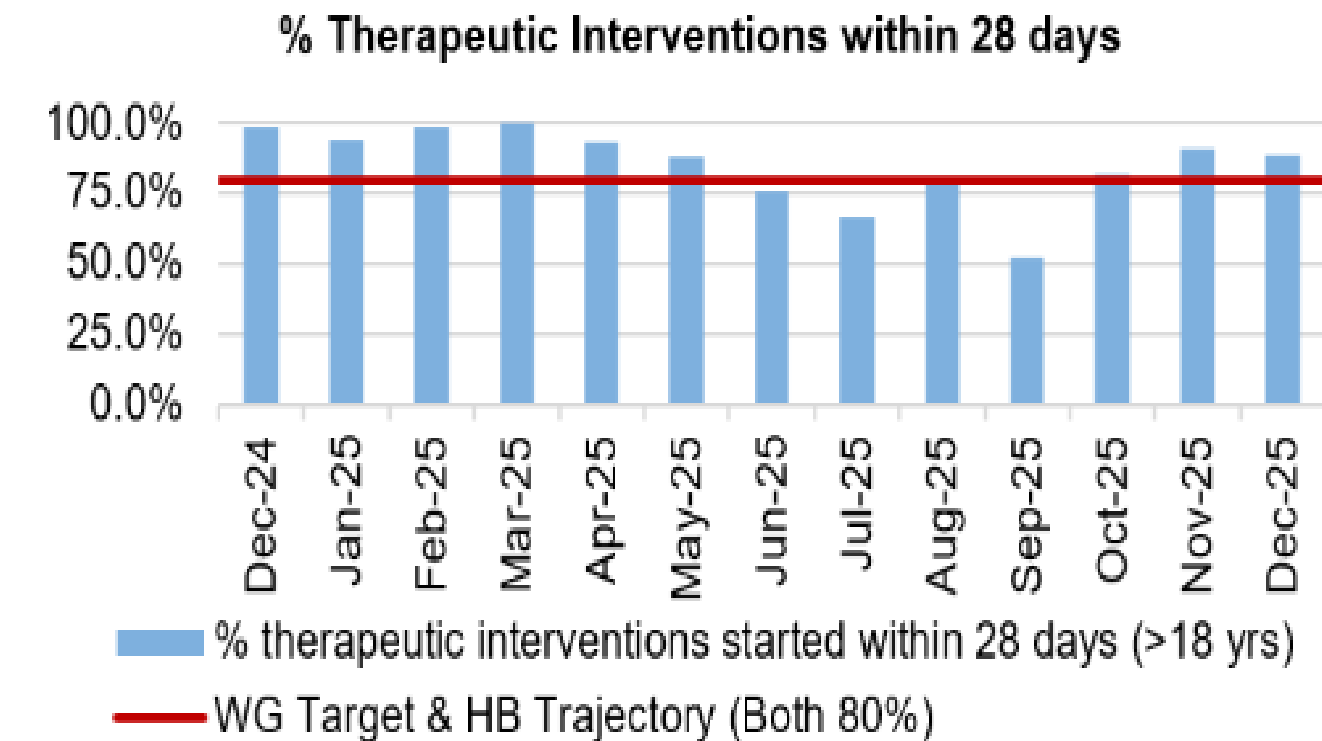
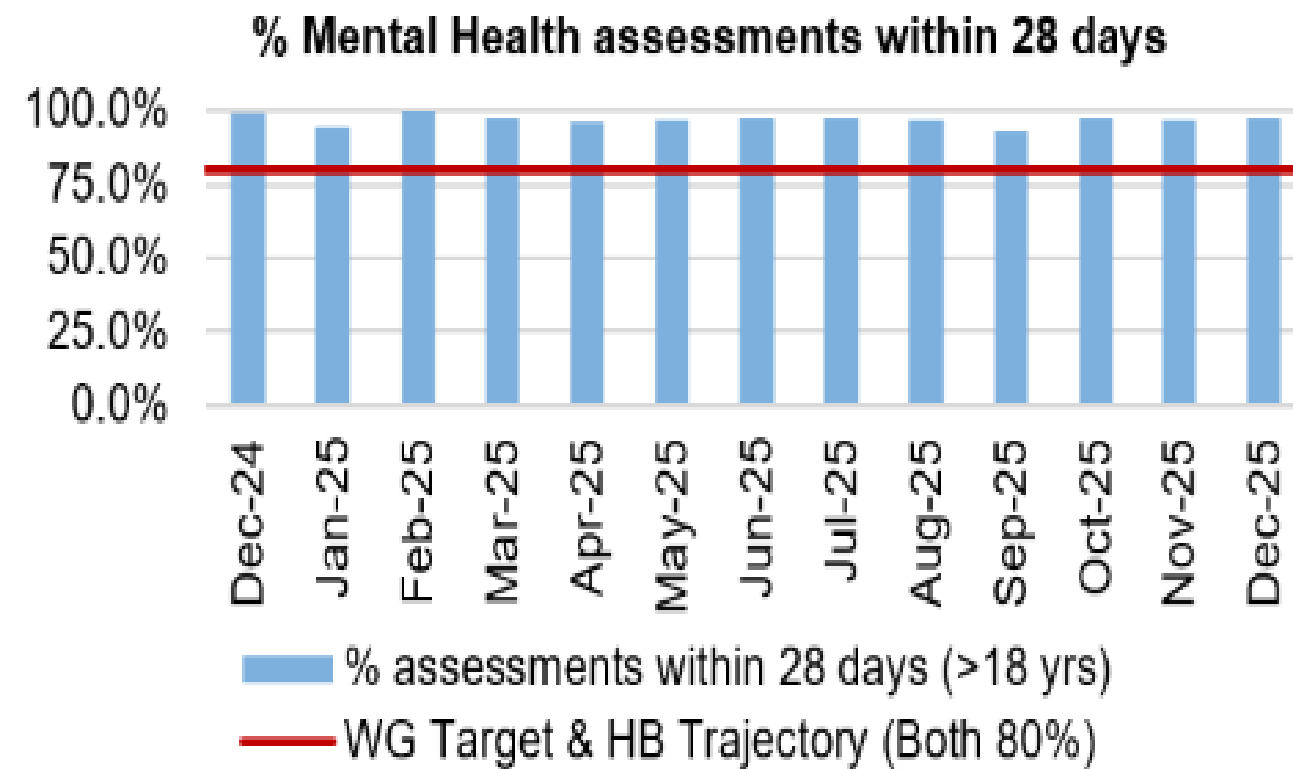
Actions/Updates

- The national Cellular Pathology Dashboard shows that SBUHB as an organisation has by far the highest volume of SCP requests processed via its laboratory.
- This does not fit with the population size of the organisation in comparison to our peers, this warrants further investigation by tumour site and specialty, this has been identified as an issue through the analysis work Deloitte are currently supporting.
- The viability of the CTM SLA has also been reviewed, there is scope to disaggregate this and provide an option to reduce demand into cellular pathology from outside of SBUHB in 2026/27, thus providing clinical capacity back into the system, full financial analysis will be available in February, a formal request will then be made to our executive team via Morriston SLT to serve notice on the current agreement.
- The service is considering options as to how the level of activity required to meet the current demand levels can be delivered from 1st April, formal paper will come to execs via Morriston SLT in February.

Follow-Ups & Activity



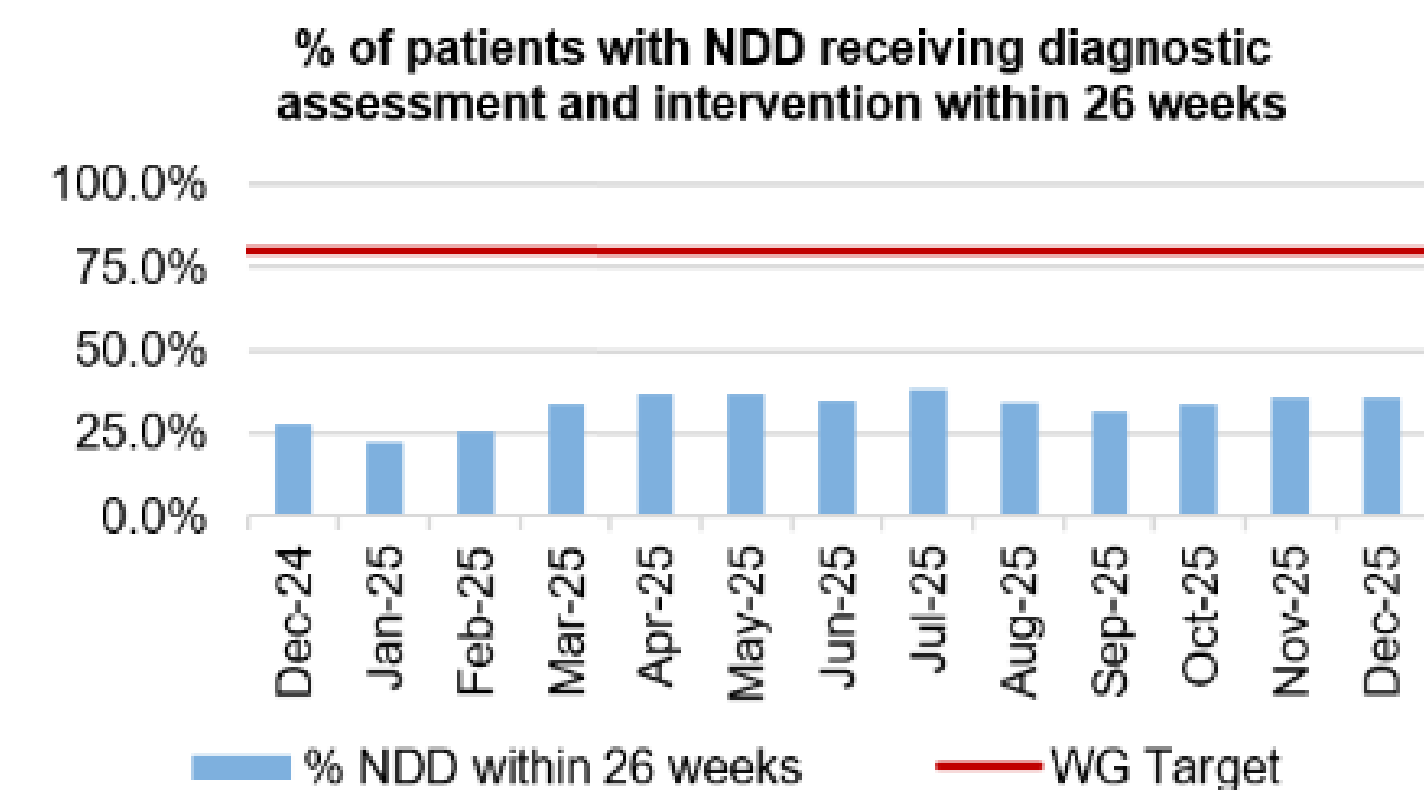
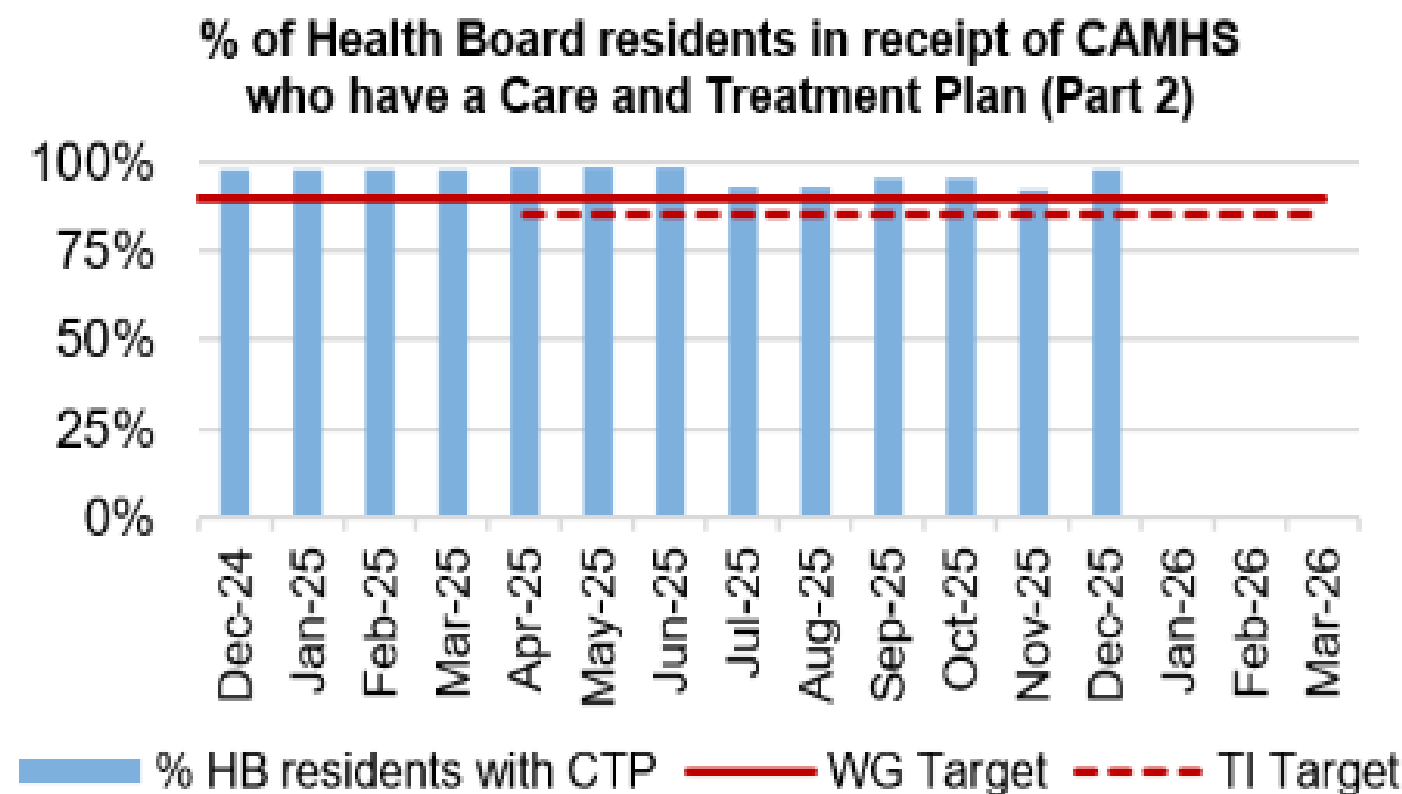
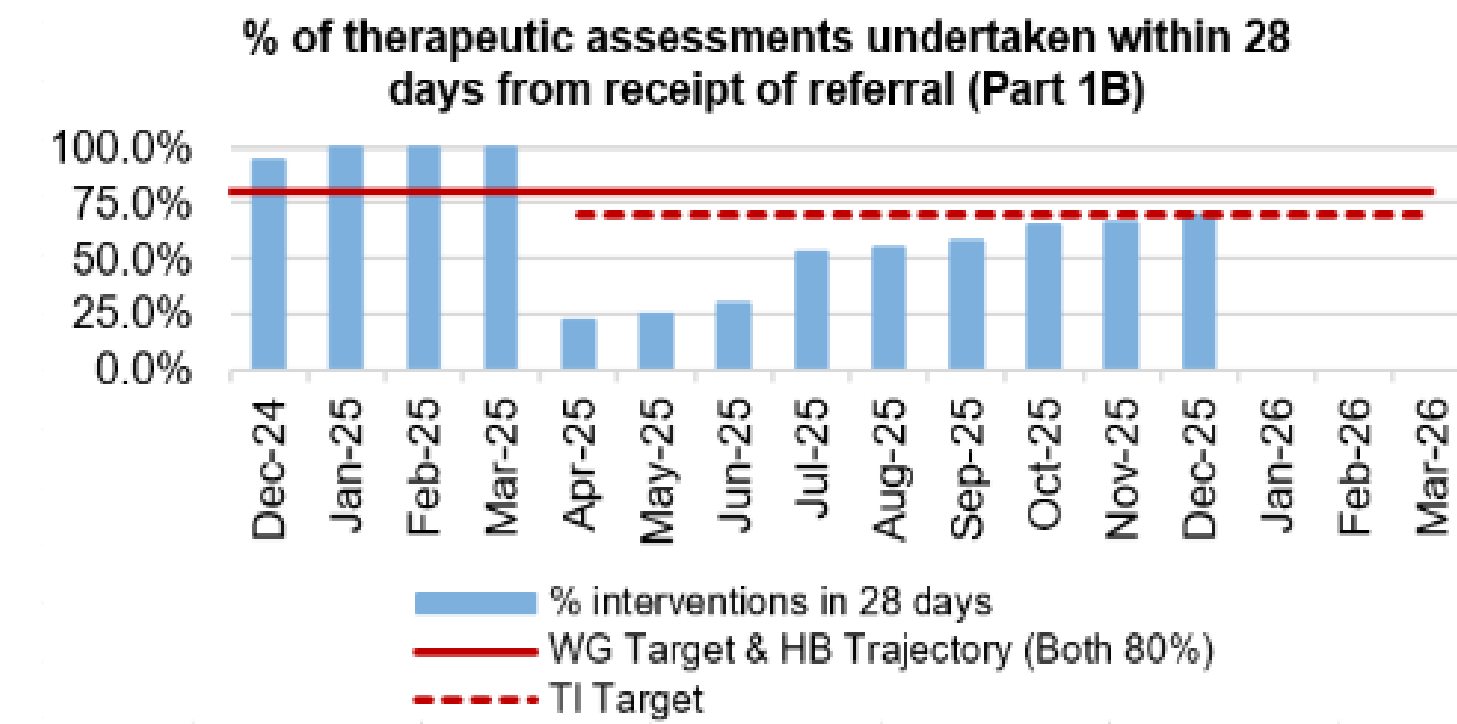
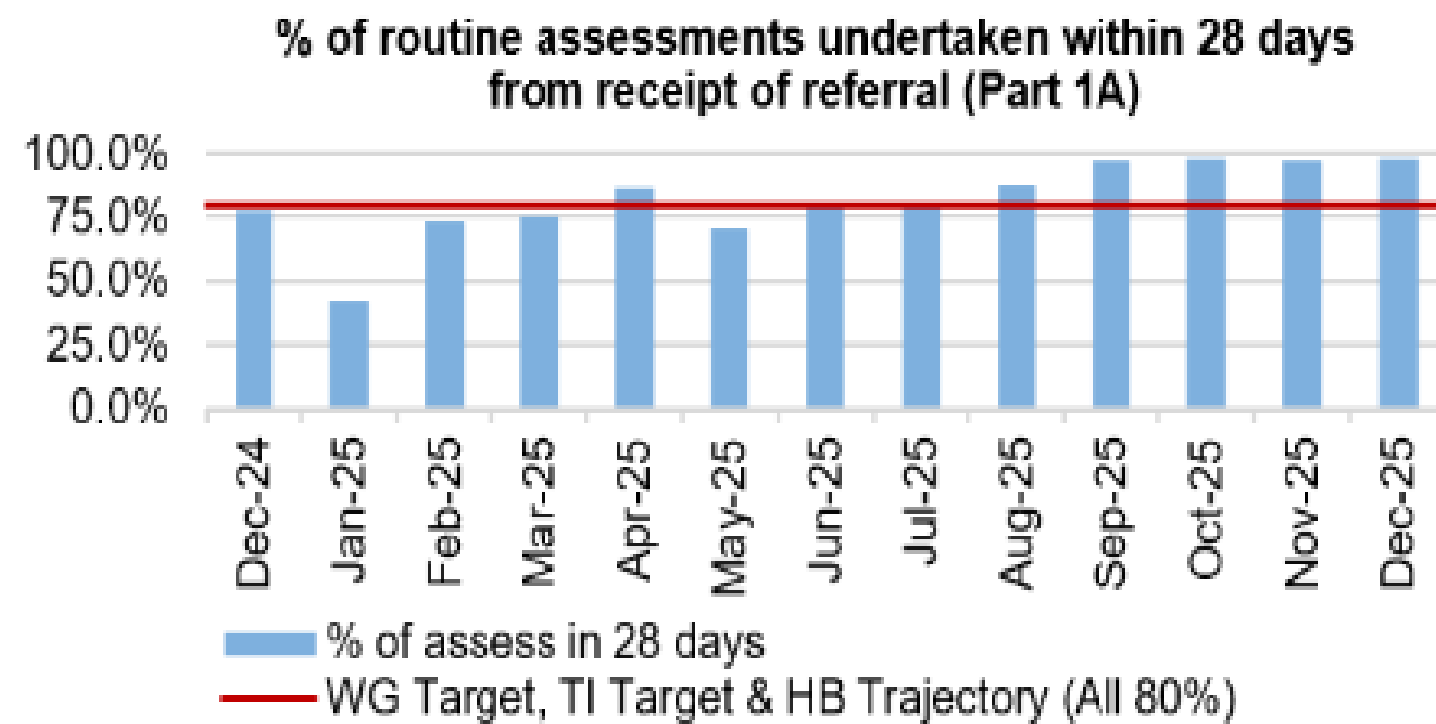
Mental Health & Learning Disabilities



Actions/Updates

- The service continues to meet all of the Welsh Government targets, apart from for patients waiting < 26 weeks for Psychological therapies. Waits within this area continue to be a concern Nationally and the service are working closely with Welsh Government colleagues for a solution.
- The Health Board continues to report on the work being undertaken as part of the Transformation programme, routine updated are provided to Board.

Child and Adolescent Mental Health Service (CAMHS)

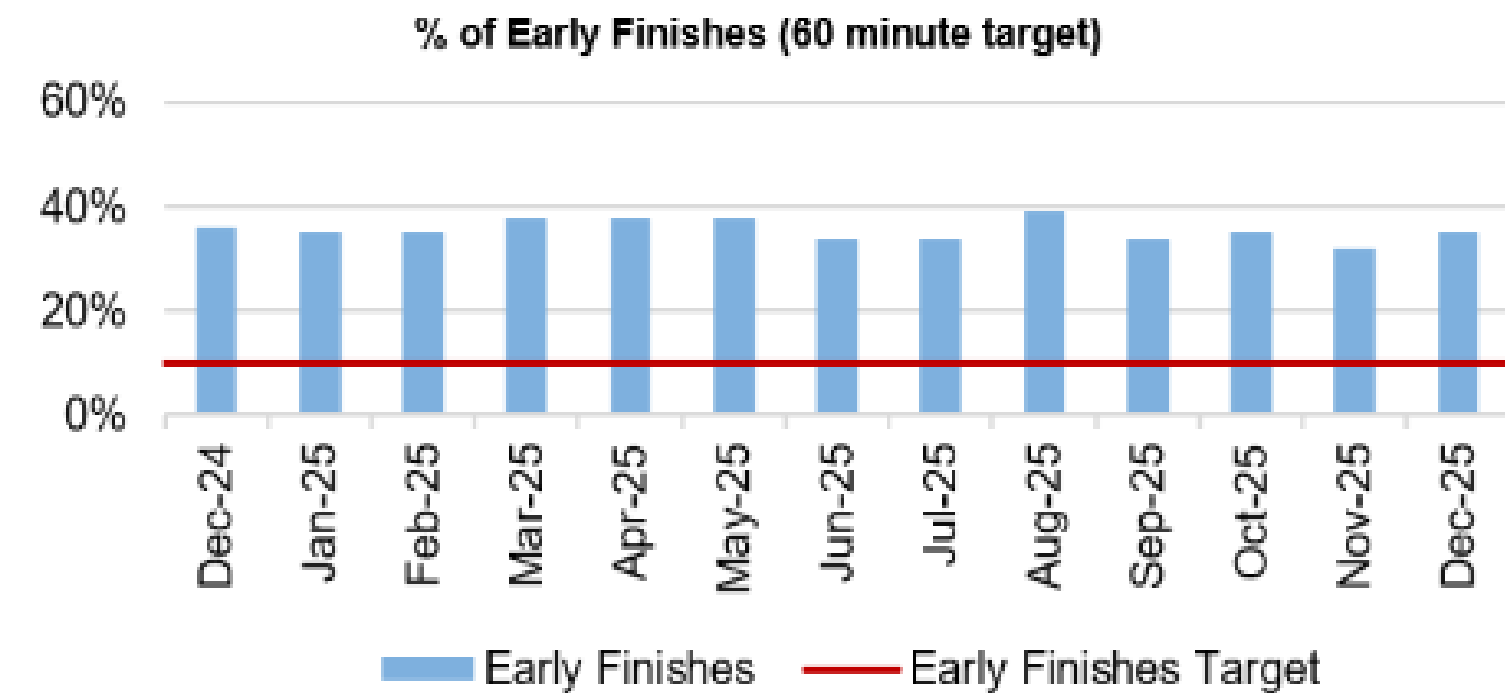
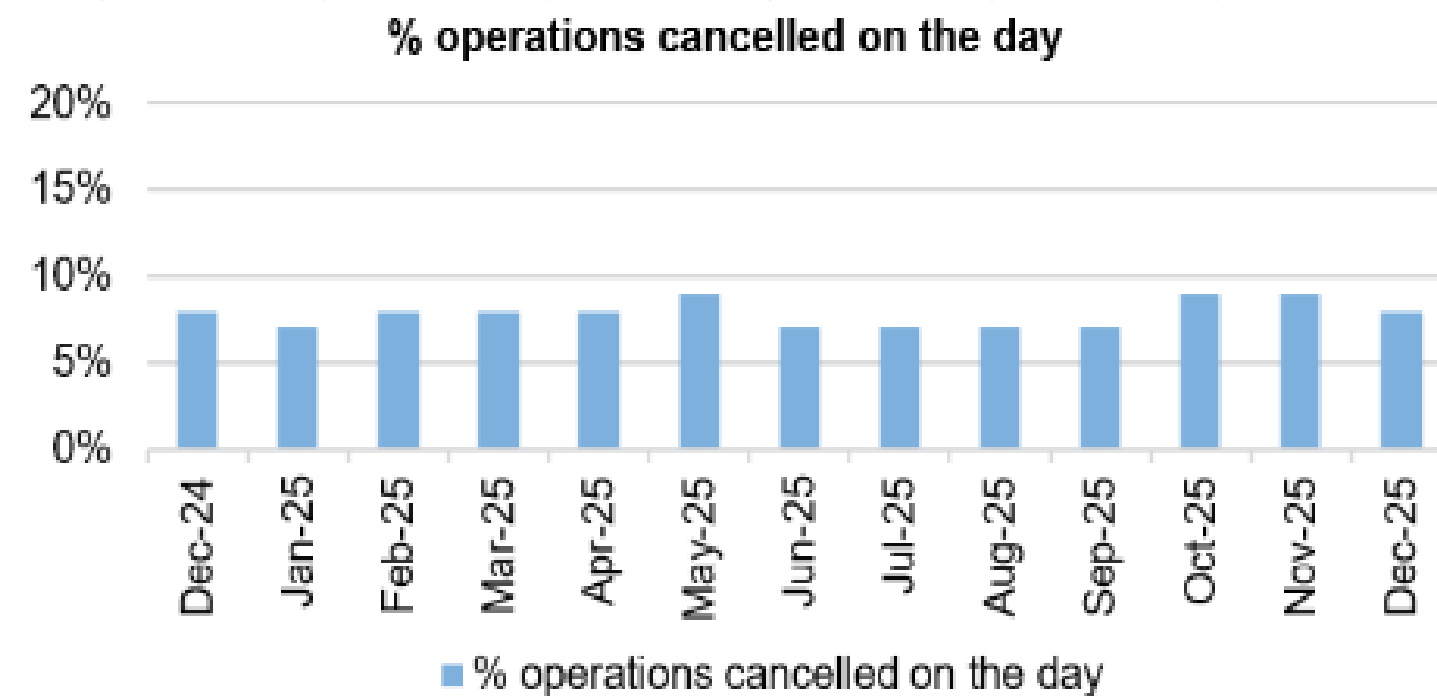
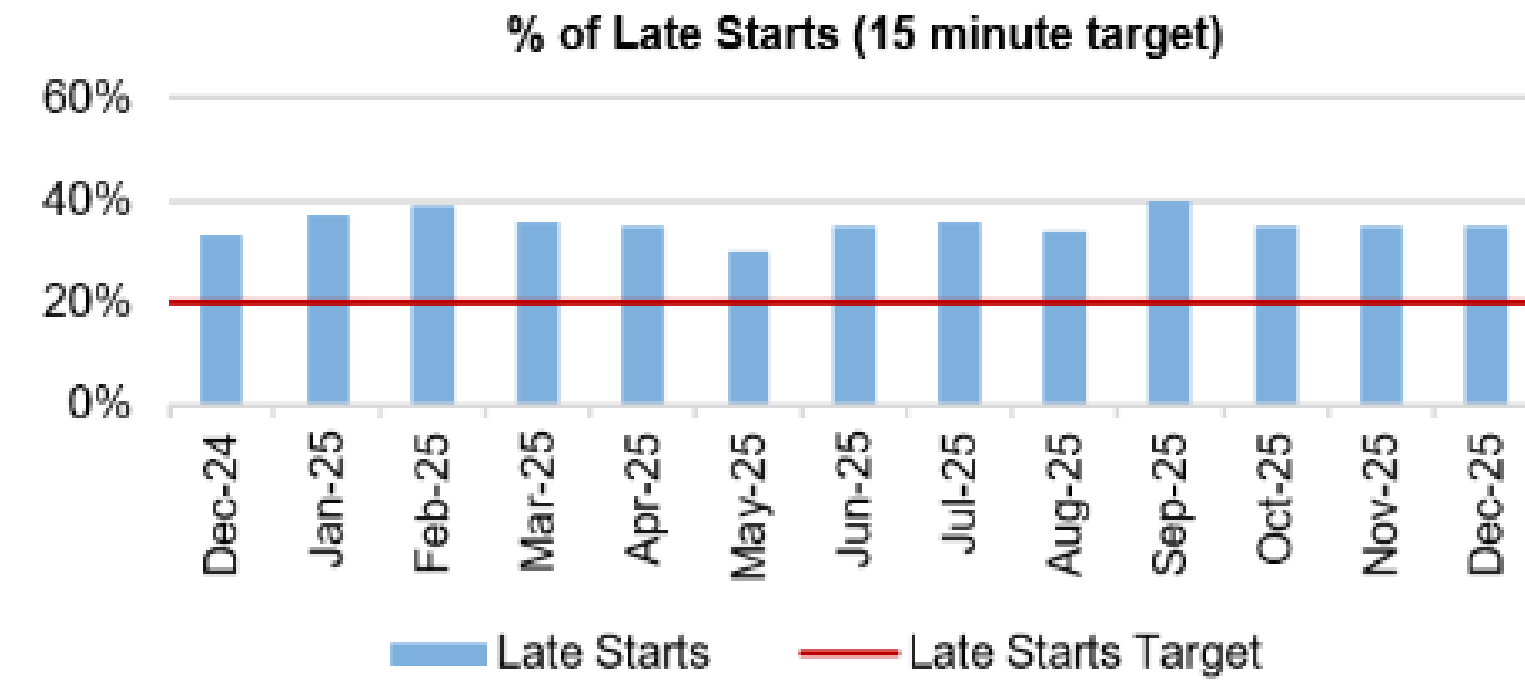
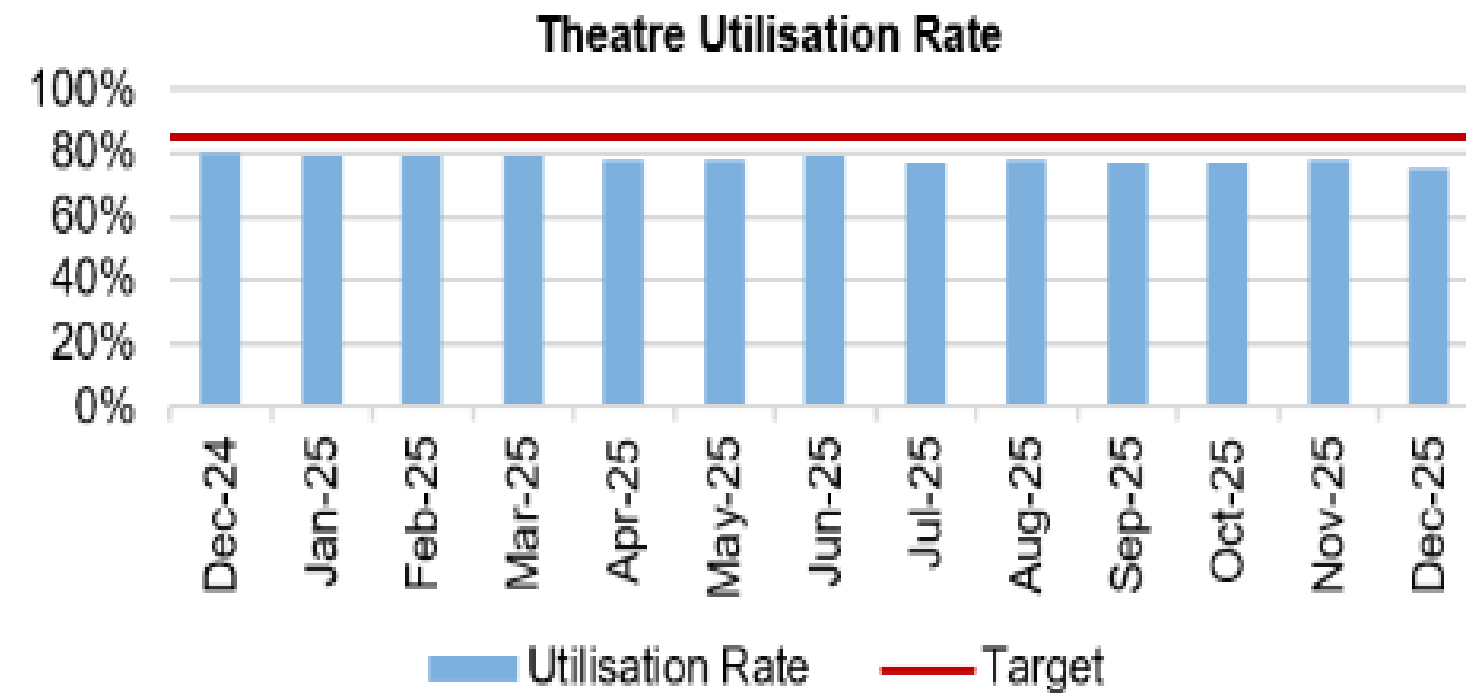


Actions/Updates

• CAMHS Part 1B:

- Recruitment to vacancies has been successful (1.65wte recruited, due to start in February and March 2026), however sickness and maternity leave weakens the capacity pool to almost pre-recruitment levels presently. The CAMHS Directorate continues to utilise agency staff to offset staffing gap.
- This has resulted in 4 months of small, but consistent improvement in the Part 1B performance irrespective of staffing challenges, which is now at 70% (submitted for Dec 2025). Weekly meetings continue to oversee booking and clinic capacity utilisation, and to utilise our staffing resource as flexibly as possible.
- Part 1A has been maintained at 98% in December, with Part 2 also maintaining performance against the trajectory reporting 98% in December.

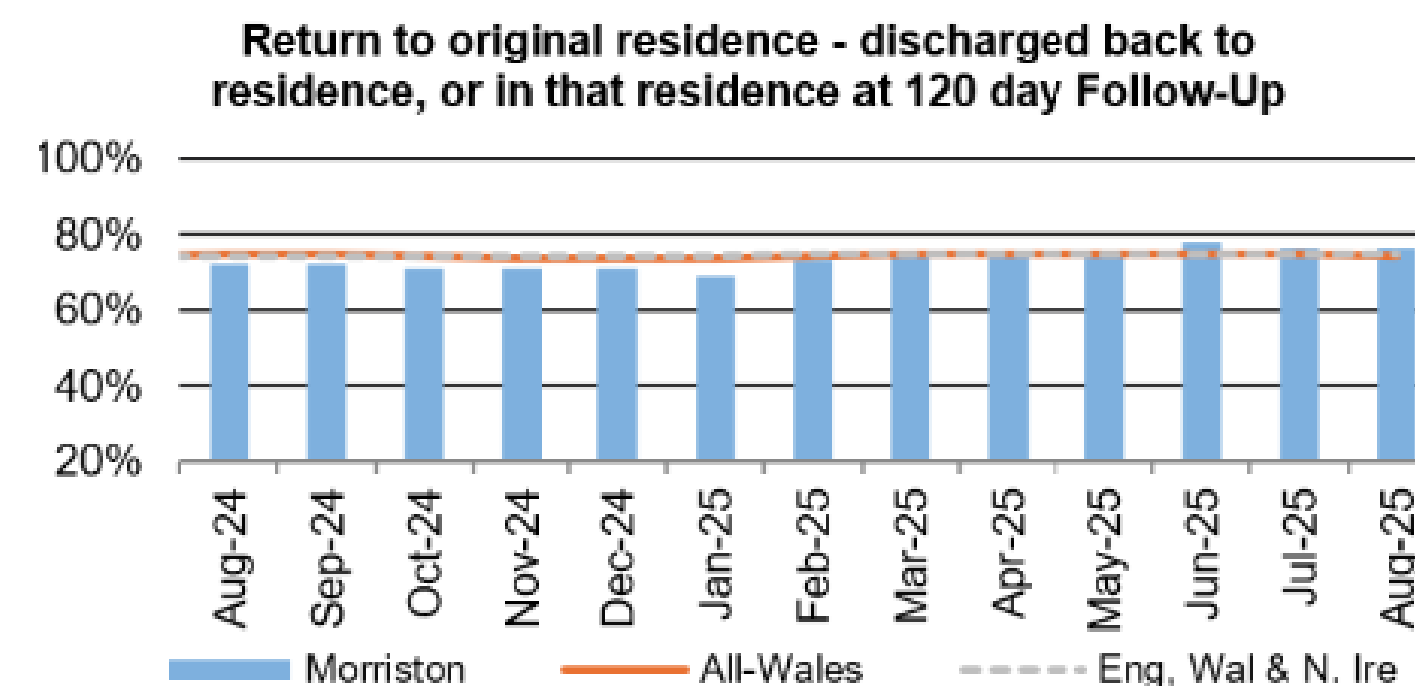
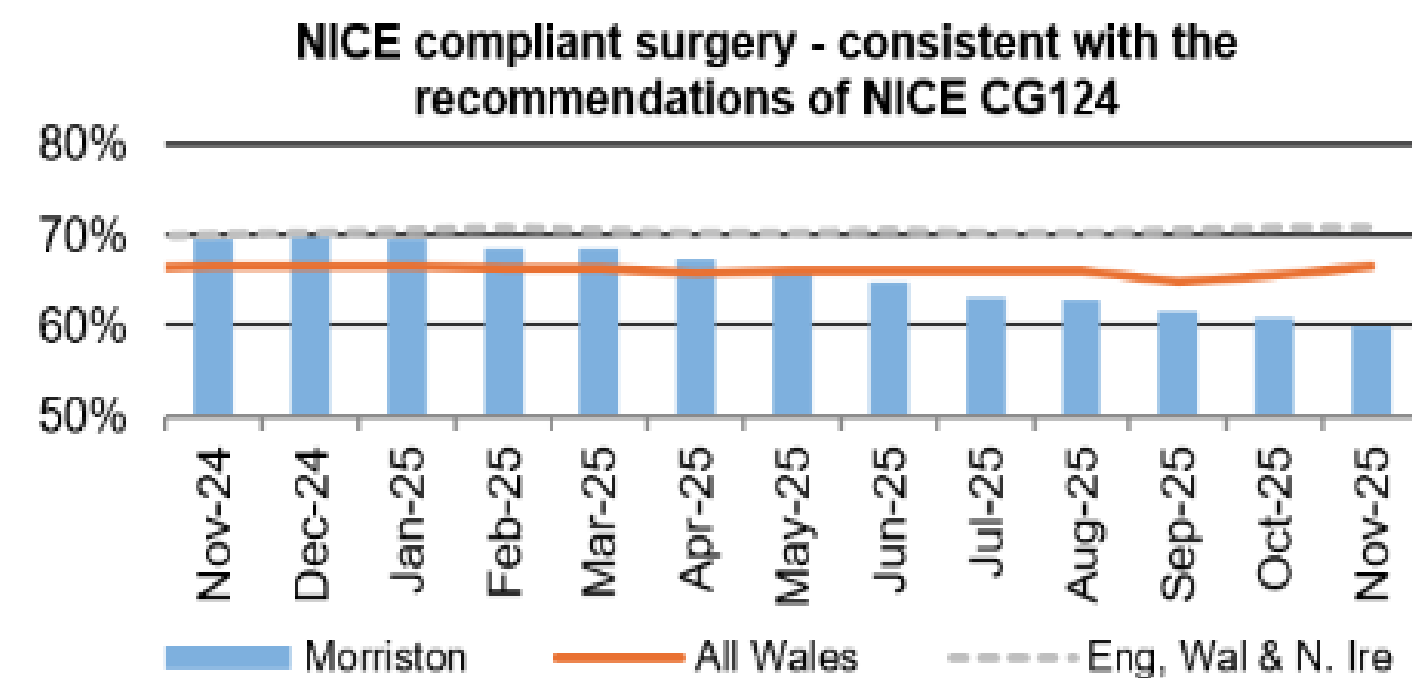
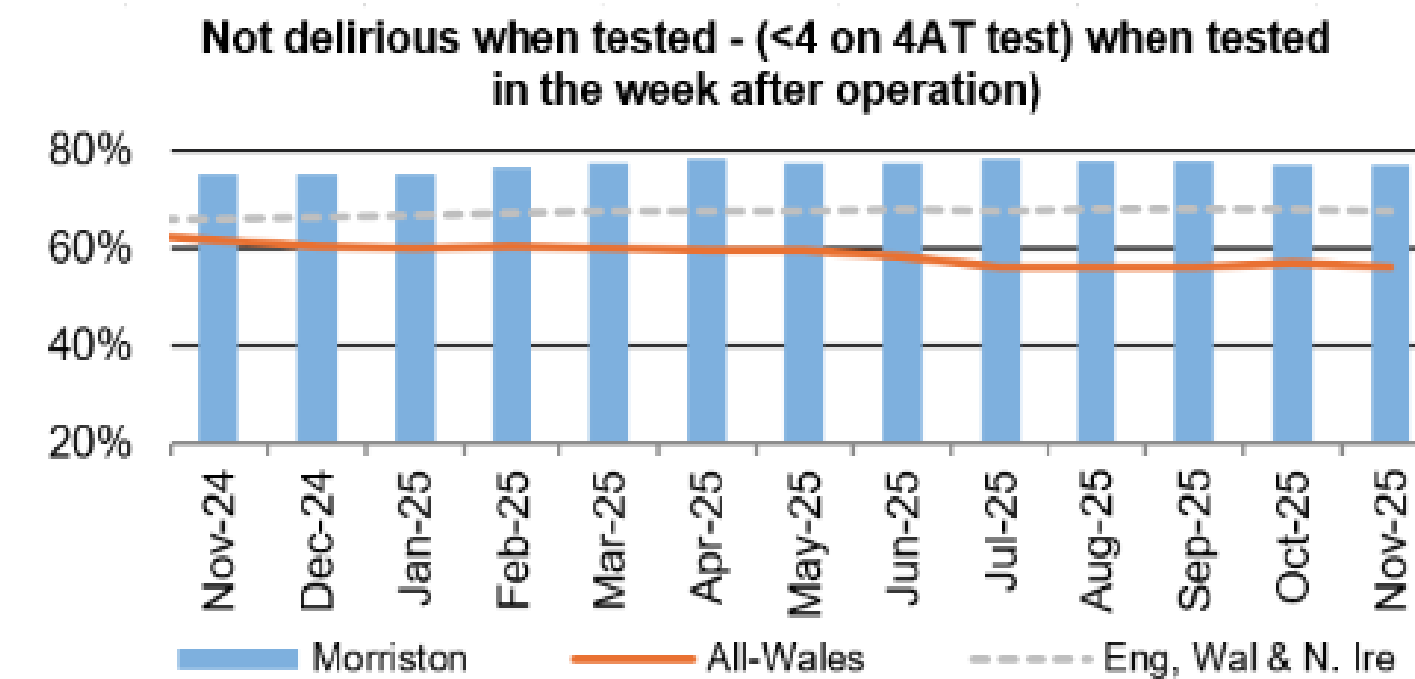
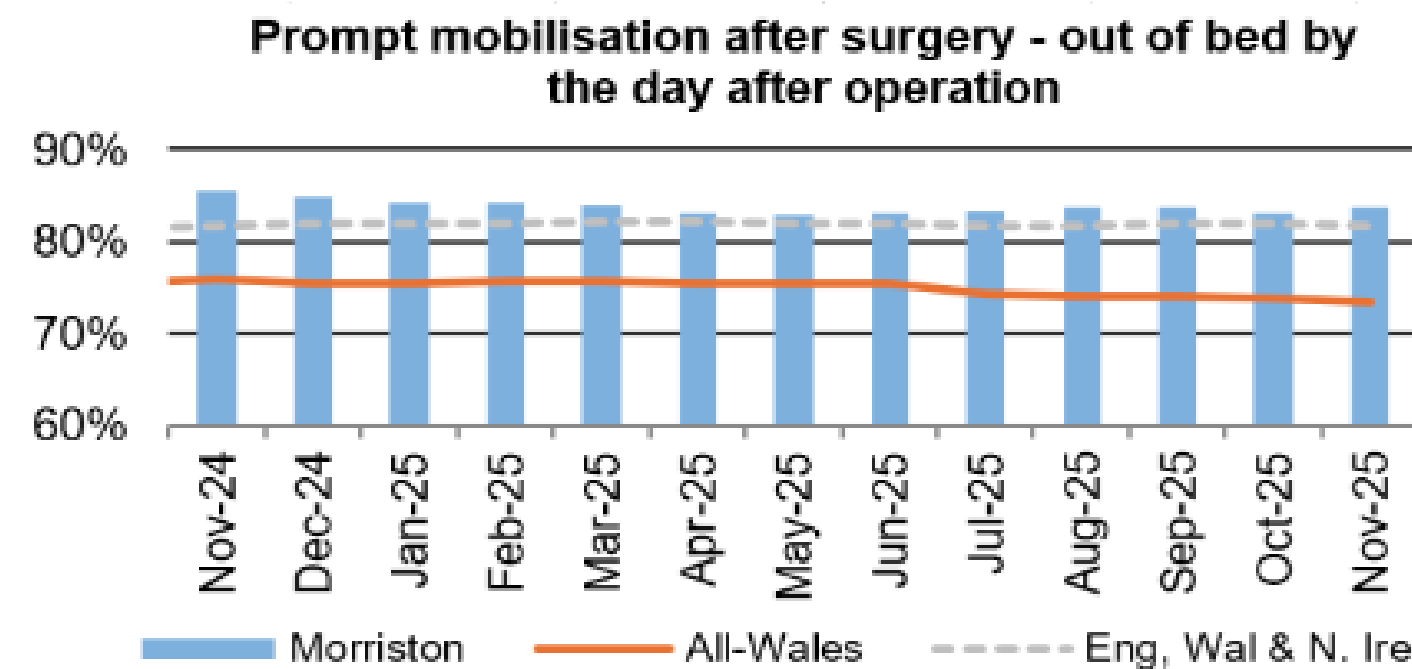
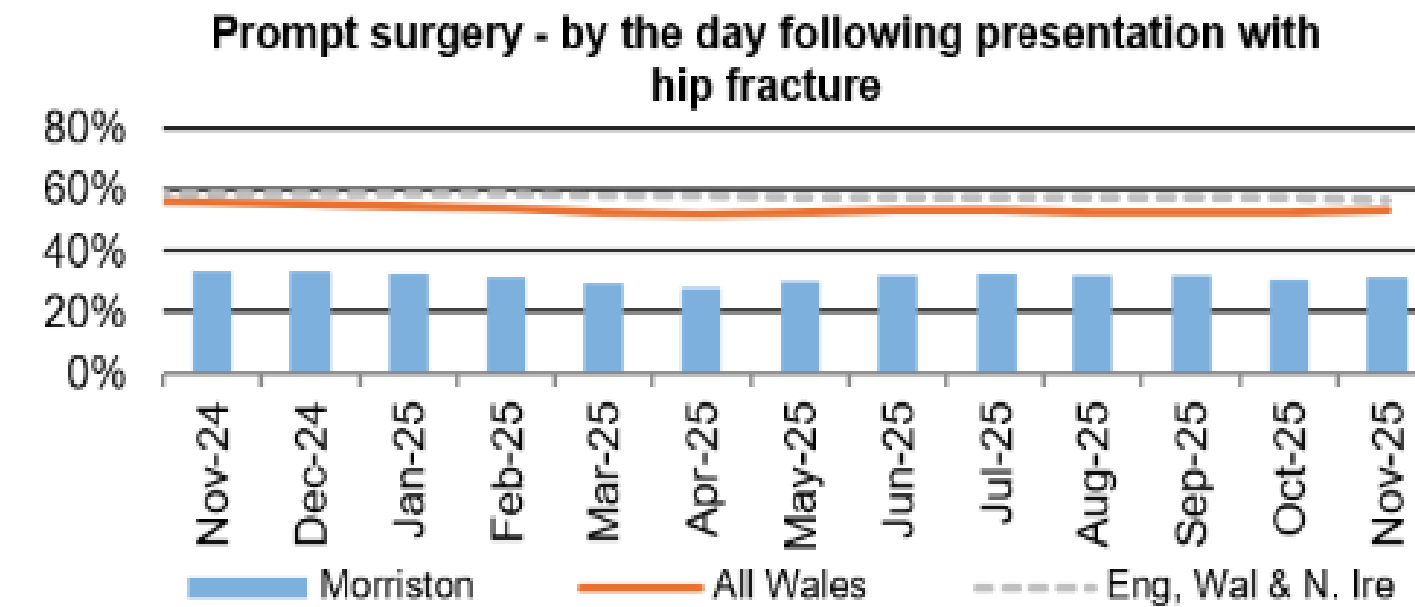
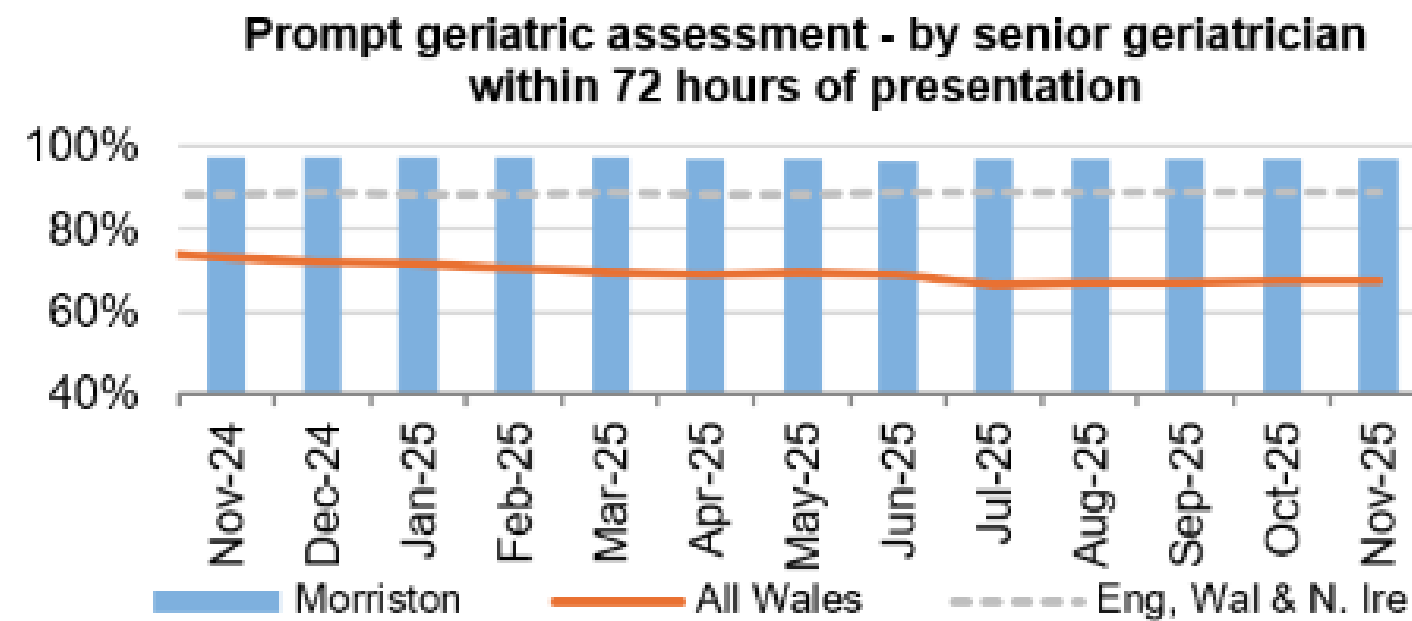
Theatre Efficiency



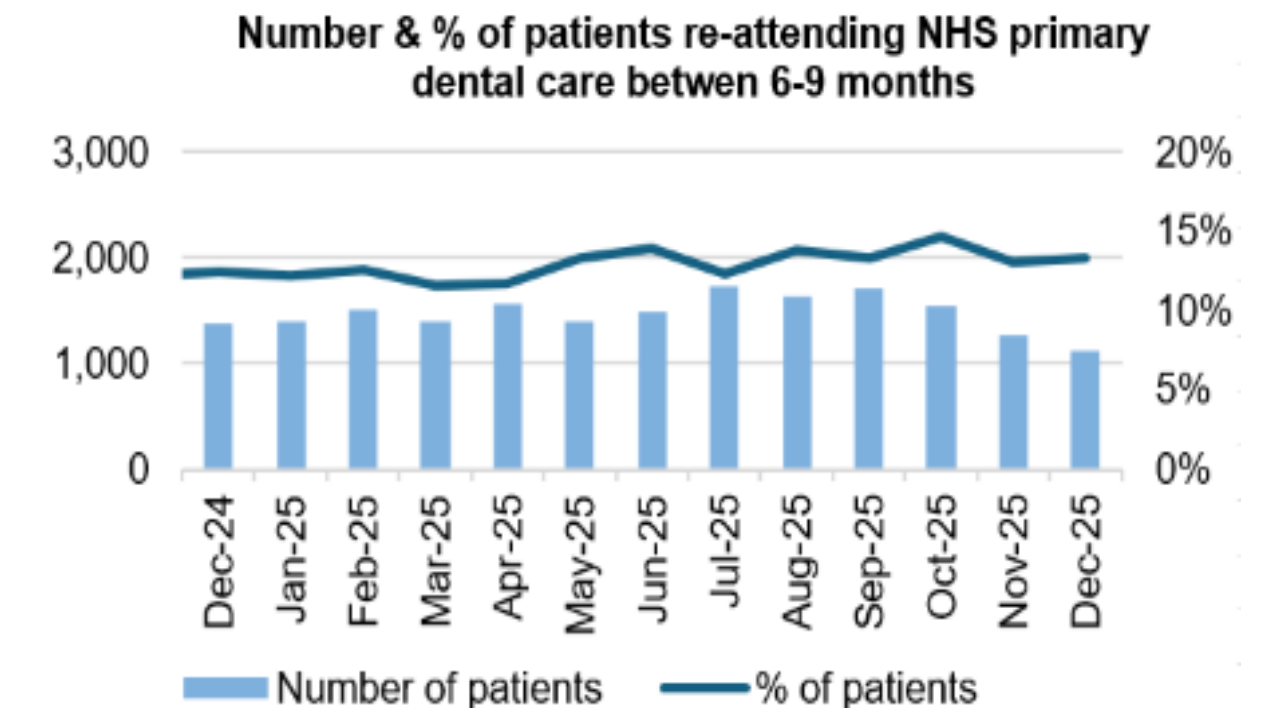
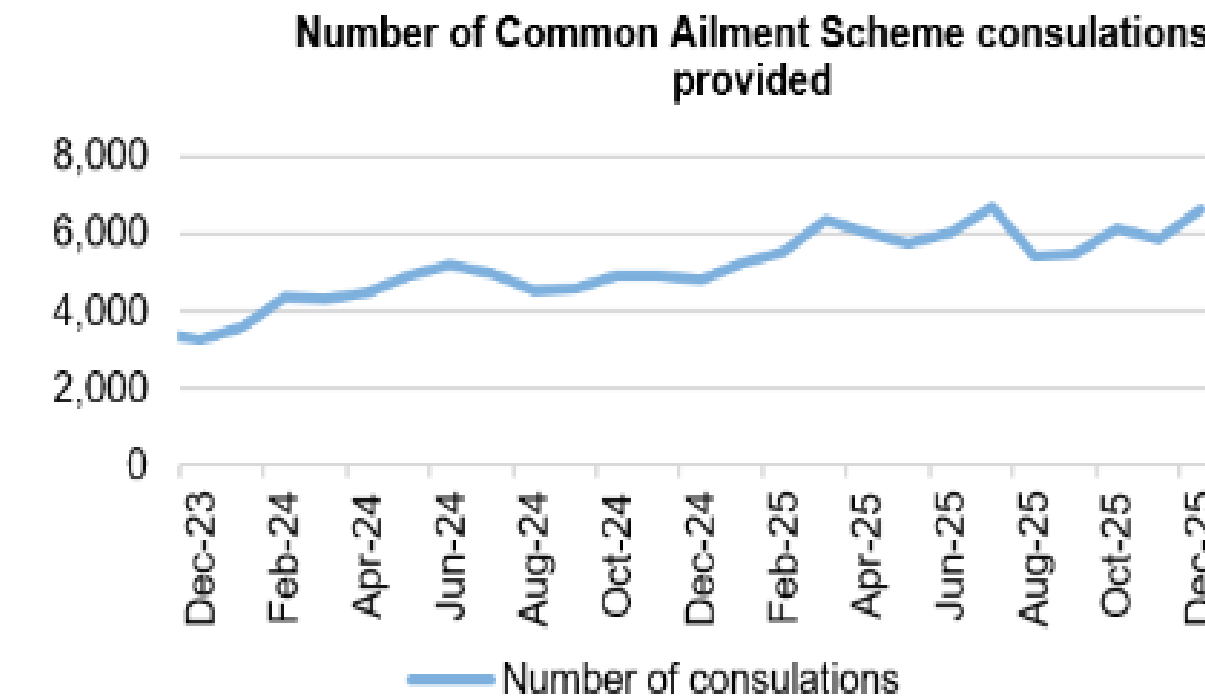
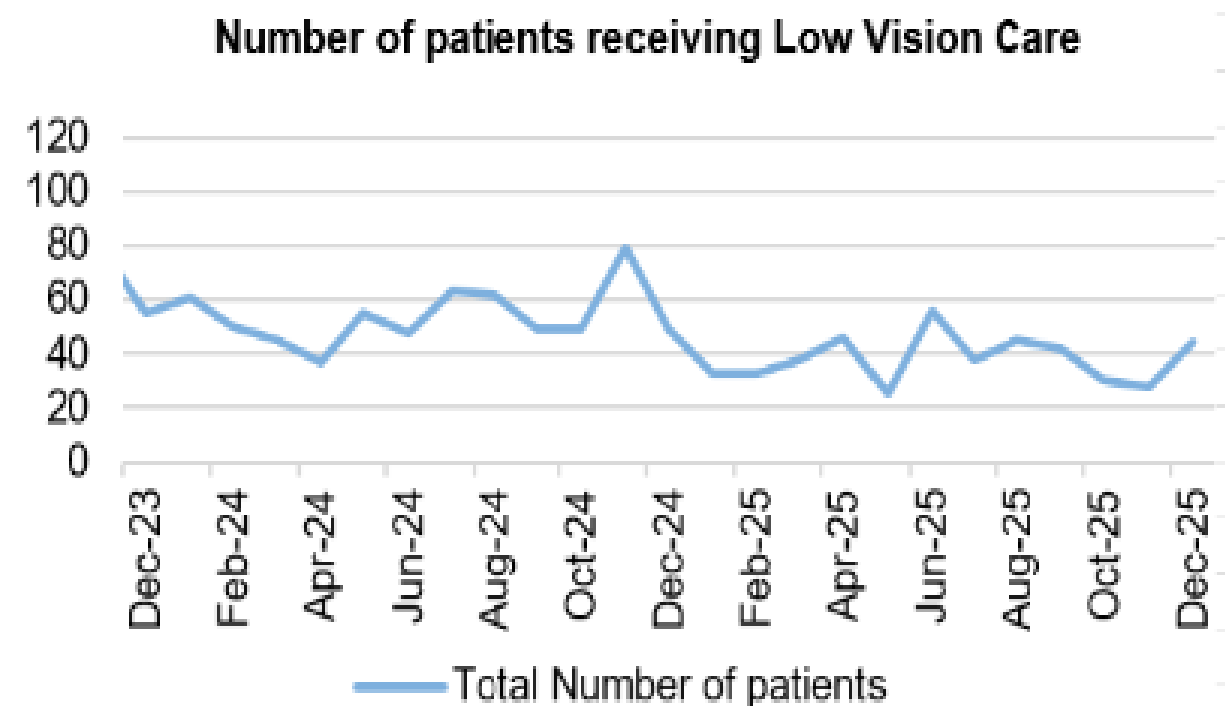
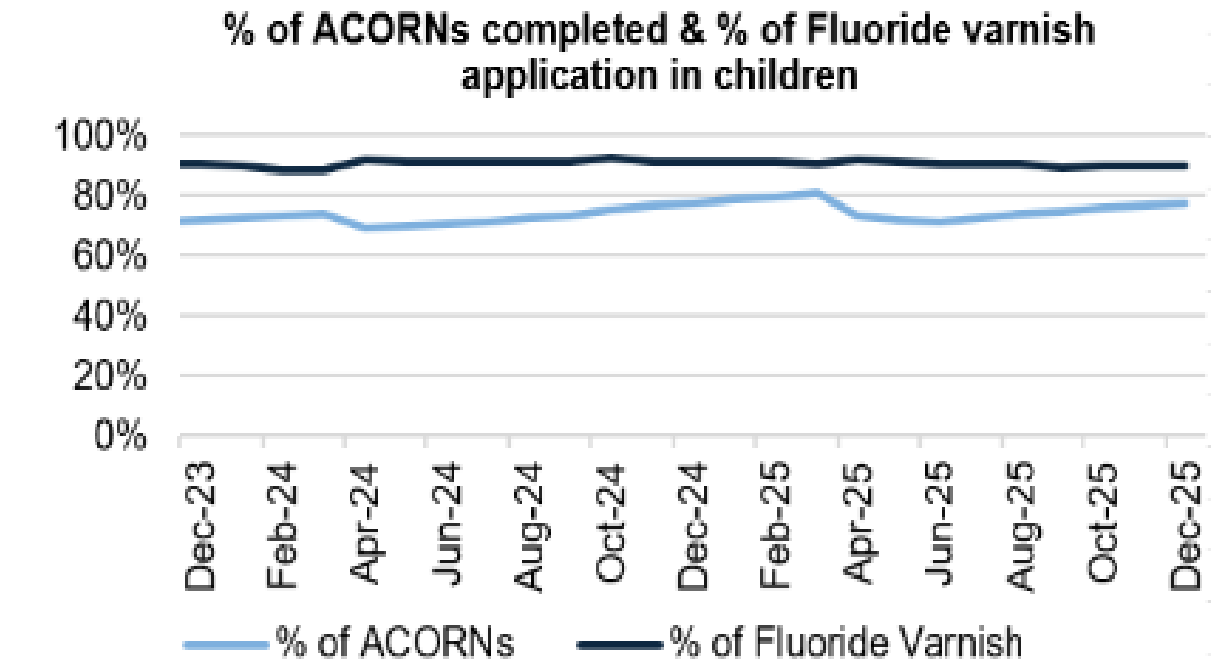
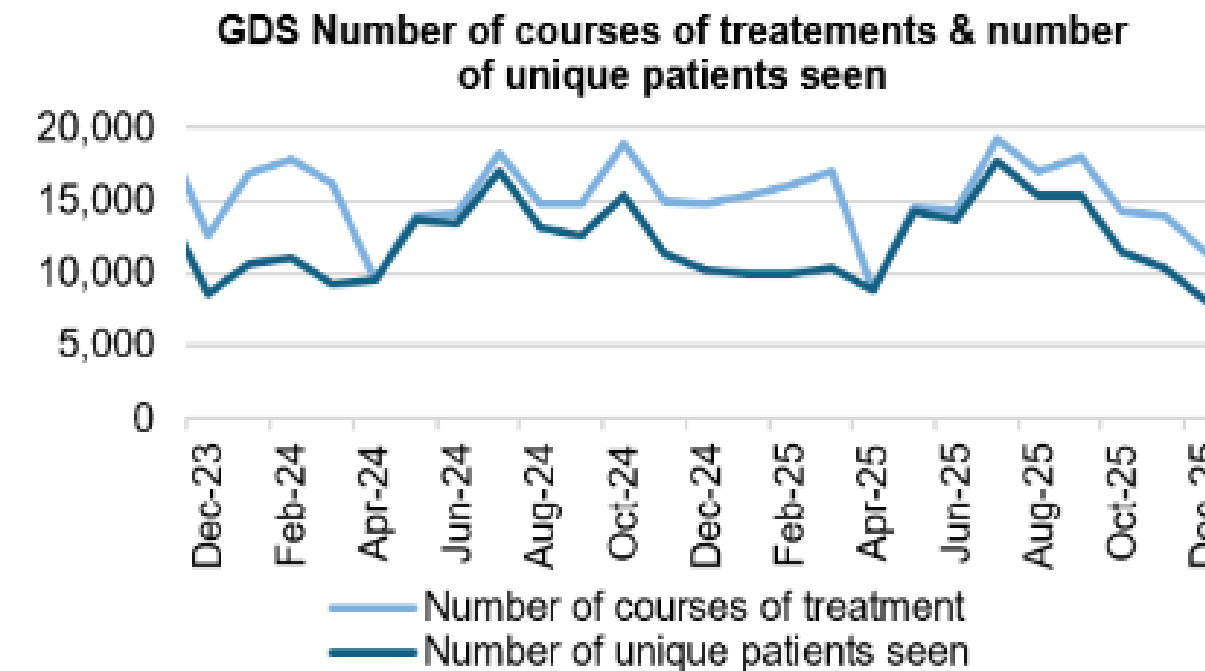
Actions/Updates

- The Planning Framework sets out enabling actions that must underpin the delivery priorities to successfully achieve the core service and changes required. These include value projects, digital innovations, workforce developments, financial sustainability and ways of working. The enabling actions and planning framework have been incorporated into SBUHB's Theatre performance framework and work is currently underway to report against these measures.
- A specific update around Theatre performance has been included in Appendix 1.

Fractured Neck of Femur (NOF)



Primary Care

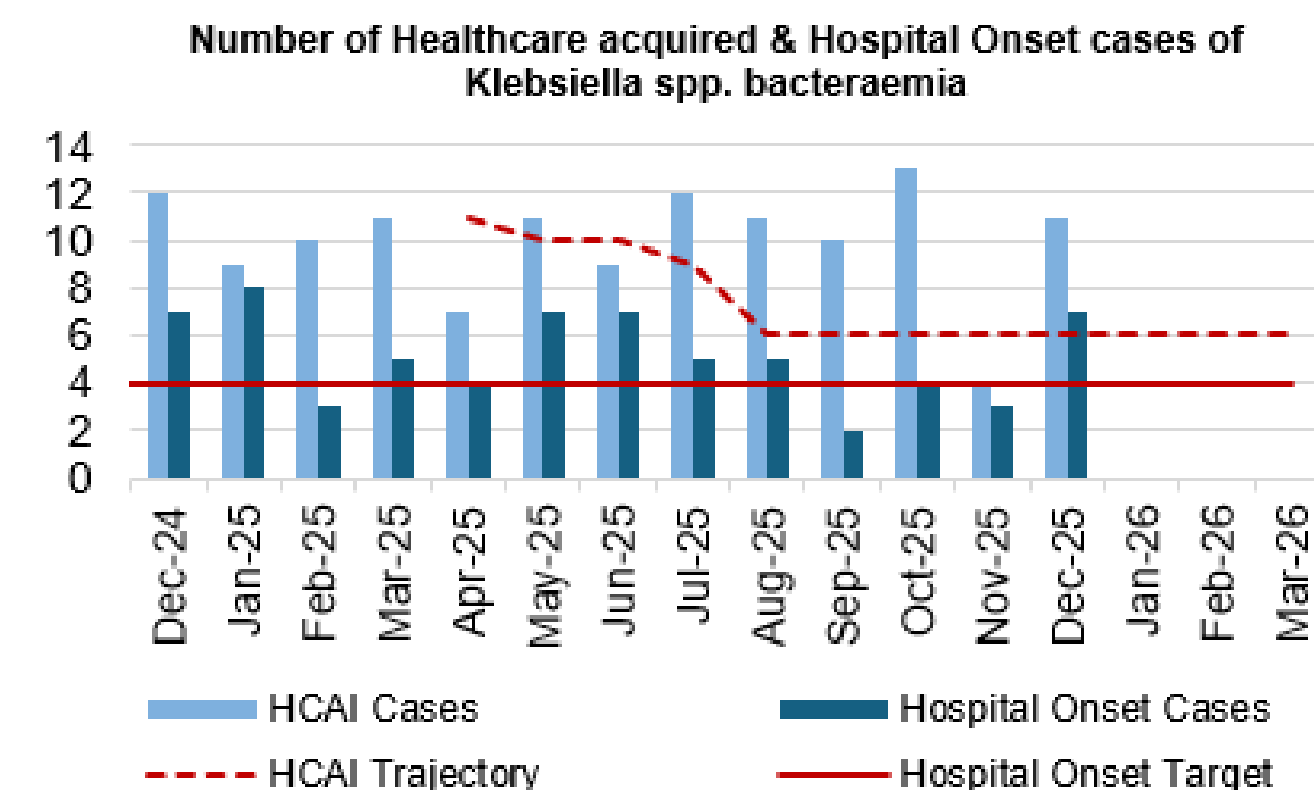
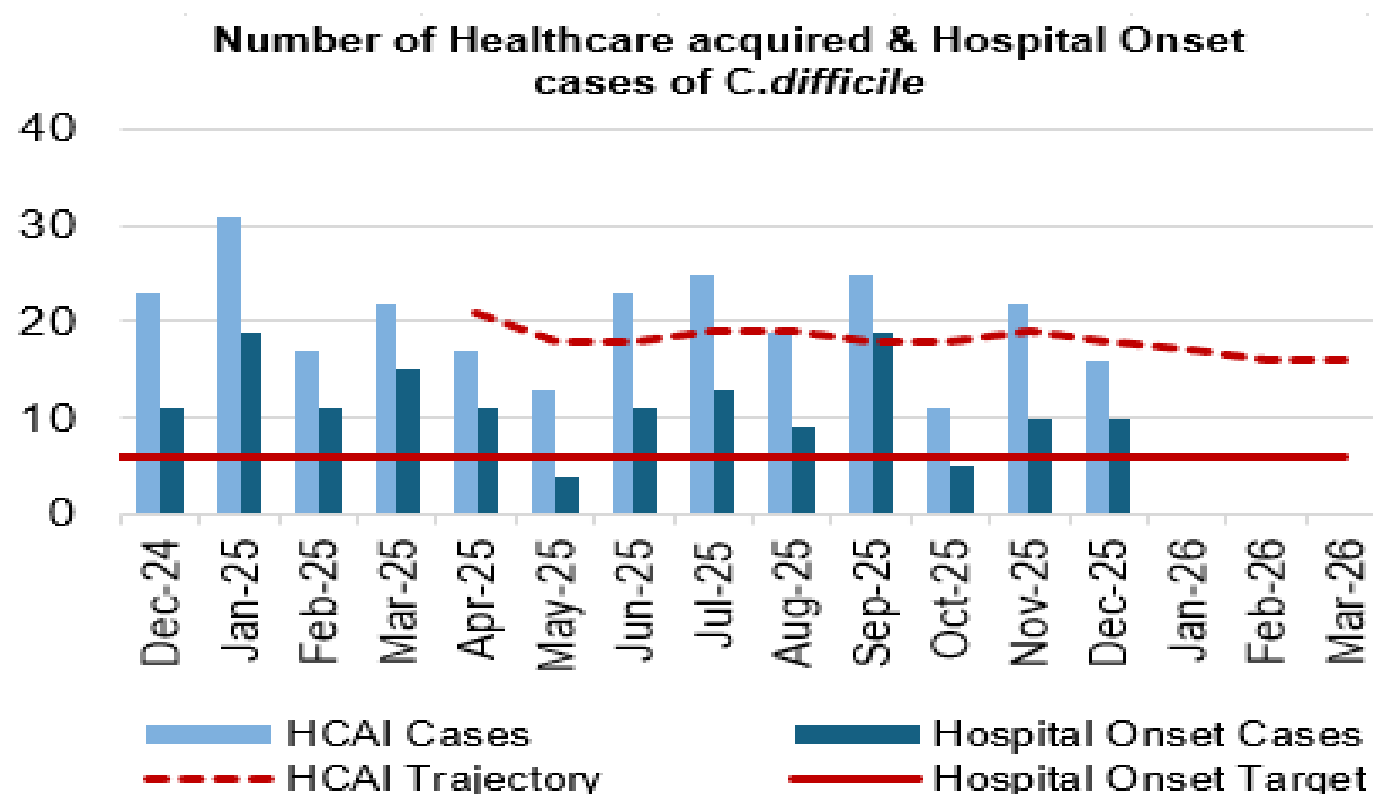
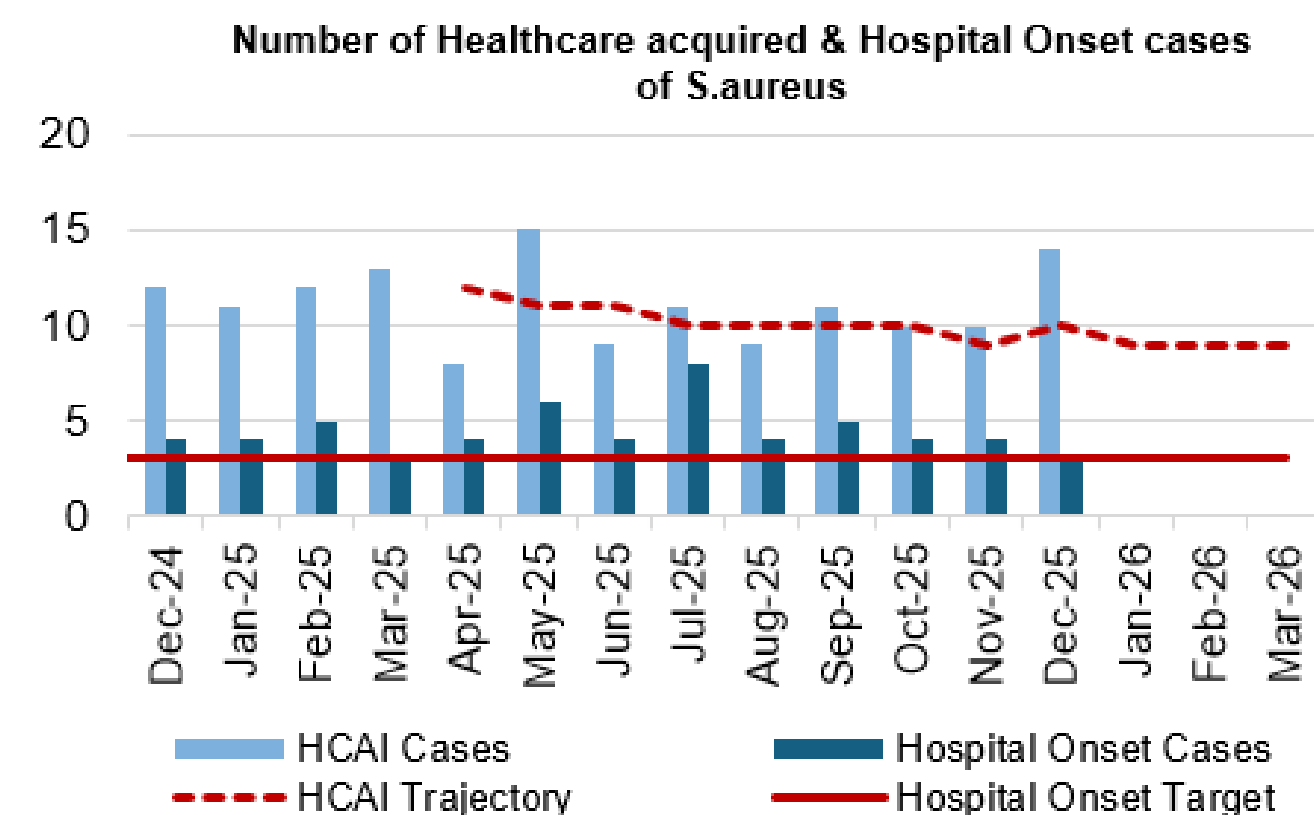
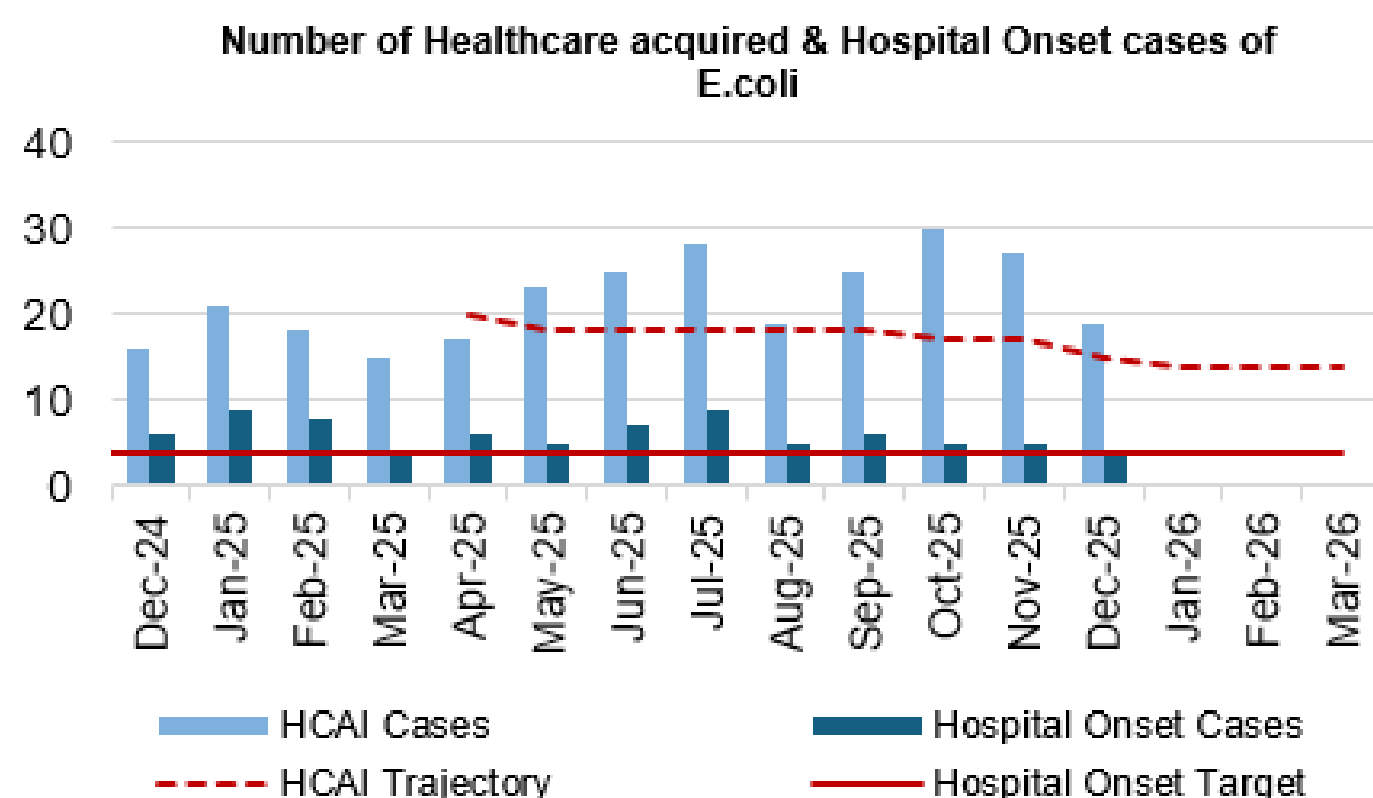


Actions/Updates

- GMS escalation levels are currently remaining steady as we head into the winter period.
- The number of ACORNs completed is showing a steady increase towards the target as the year goes on.
- Fluoride varnish remains over target for both children and adults.
- The number of patients for eye health care Wales (emergency eye care) has increased from an average of 2,245 per month last year to an average of 2,641 per month this year to date. There is a slight increase in the number of patients receiving low vision services with an increase in domiciliary visits in particular.
- Common ailments consultations continue to increase with an average of 900 more consultations per month in comparison to 24/25. If this trend continues this would be a further 17% increase on last year.

Quality & Safety

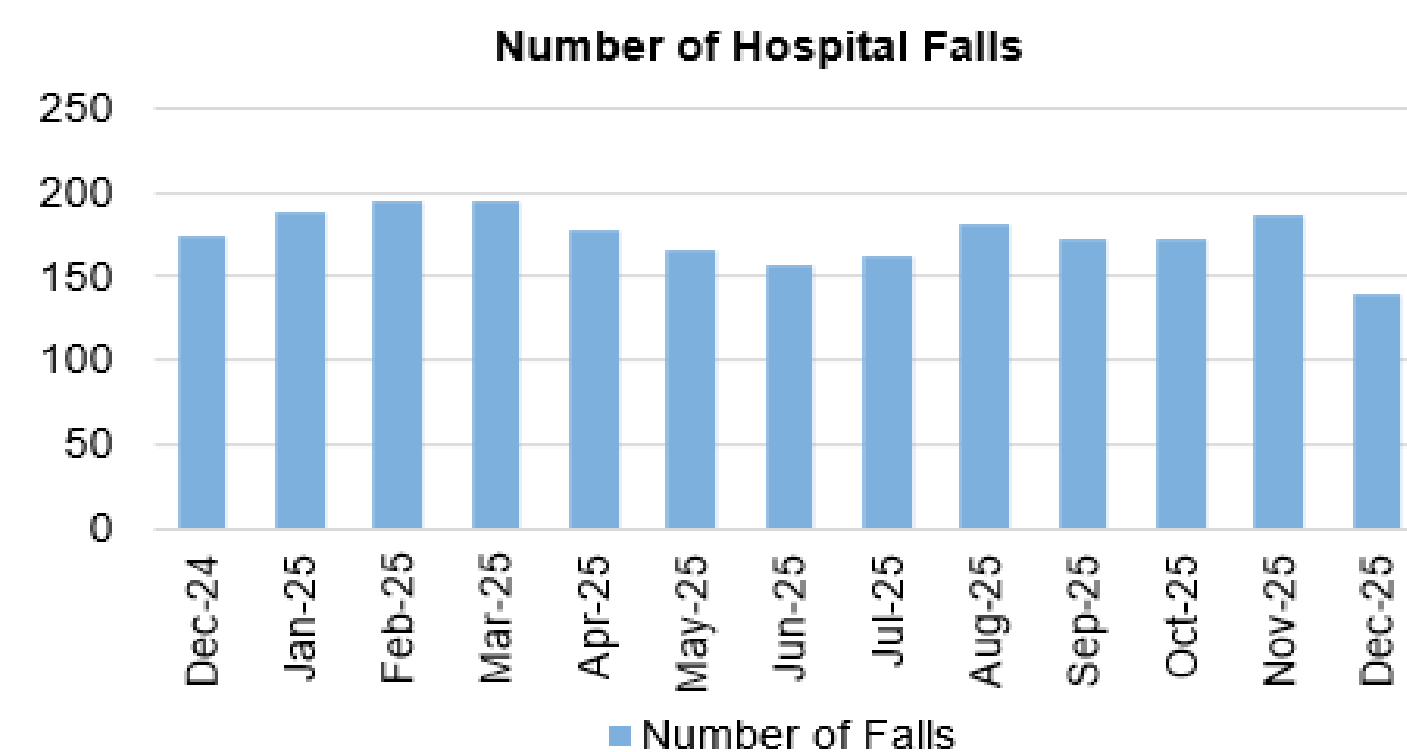
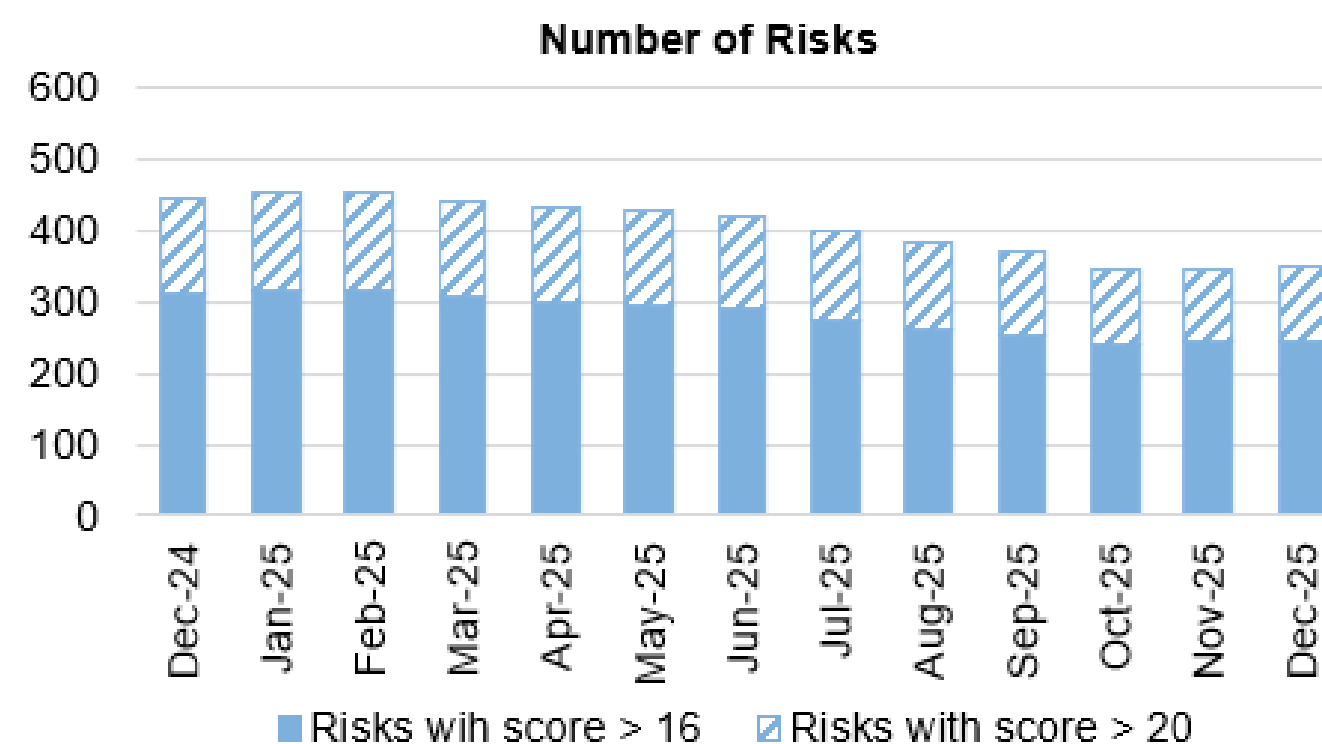
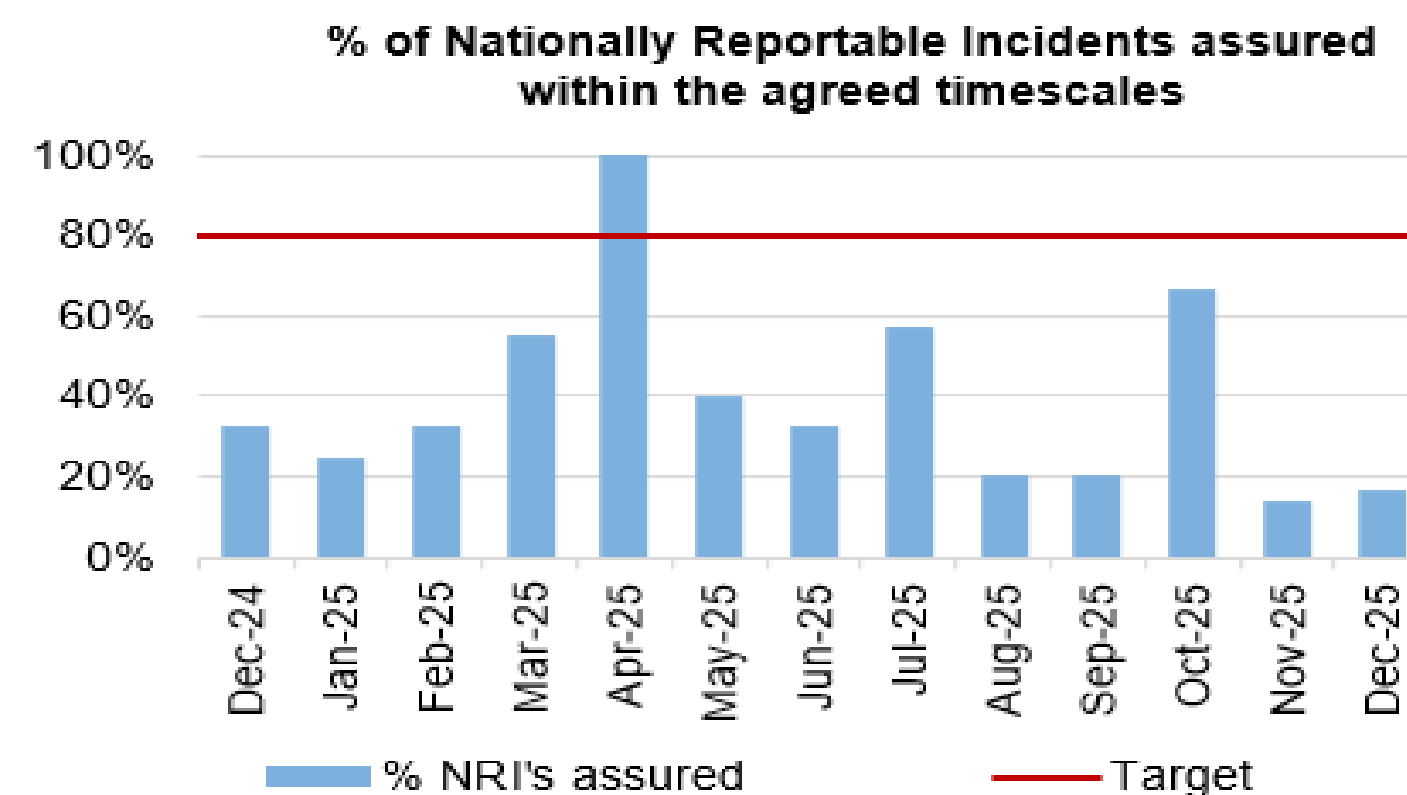
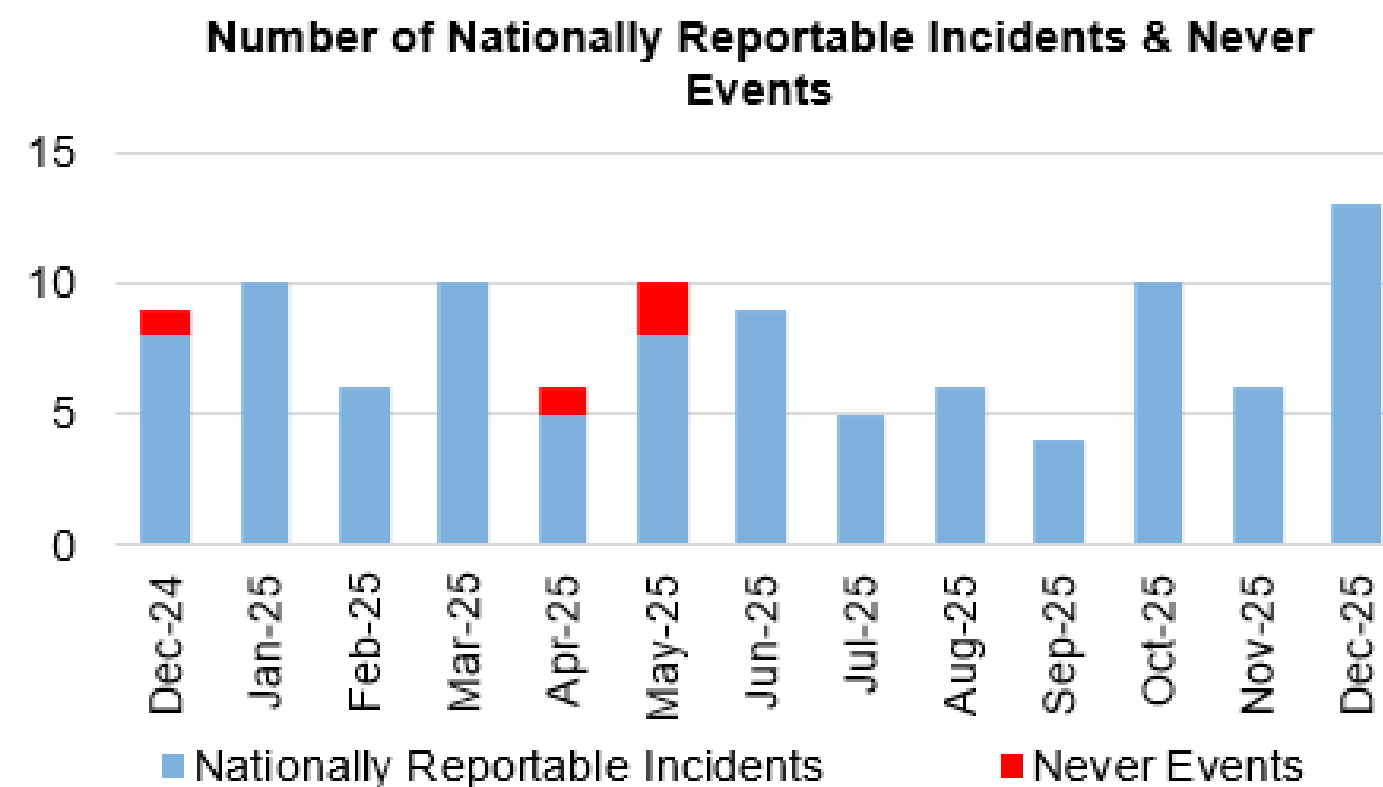




Actions/Updates

- Gold *C. difficile* High Incidence Management Group.
- Monitoring of *C. difficile* Standards: Risk Assessment & Governance Framework. Continuation of QI Project in Acute Medical Unit focusing on AMS and 72-hour review and improving switch to oral route for administration.
- Scoping exercise to explore the feasibility of extending role of ward based enhanced cleaner. Trial of new Microfibre cleaning systems
- Primary care QI projects to reduce urinary tract infections in care home residents.
- Scoping the development of an equipment decontamination facility.
- Review of prescribing guidelines for antibiotic prophylaxis during prolonged surgical interventions.

Serious Incidents and Risks



Actions/Updates

- There were 13 Nationally Reported Incidents reported in December 2025 and there were no new never events reported. The detail surrounding the nature of the reported NRI's can be found on the subsequent pages.
- In December 2025, there were 105 open risks with a score >20 recorded for the Health Bord which is slightly higher than the figure reported in November. There were 246 open risks with a score >16, which again is a slight increase compared to 243 in November 2025.
- There were 140 hospital falls recorded in December 2025

NRIs/NE's/EWNs – December 2025

What is the data telling us?

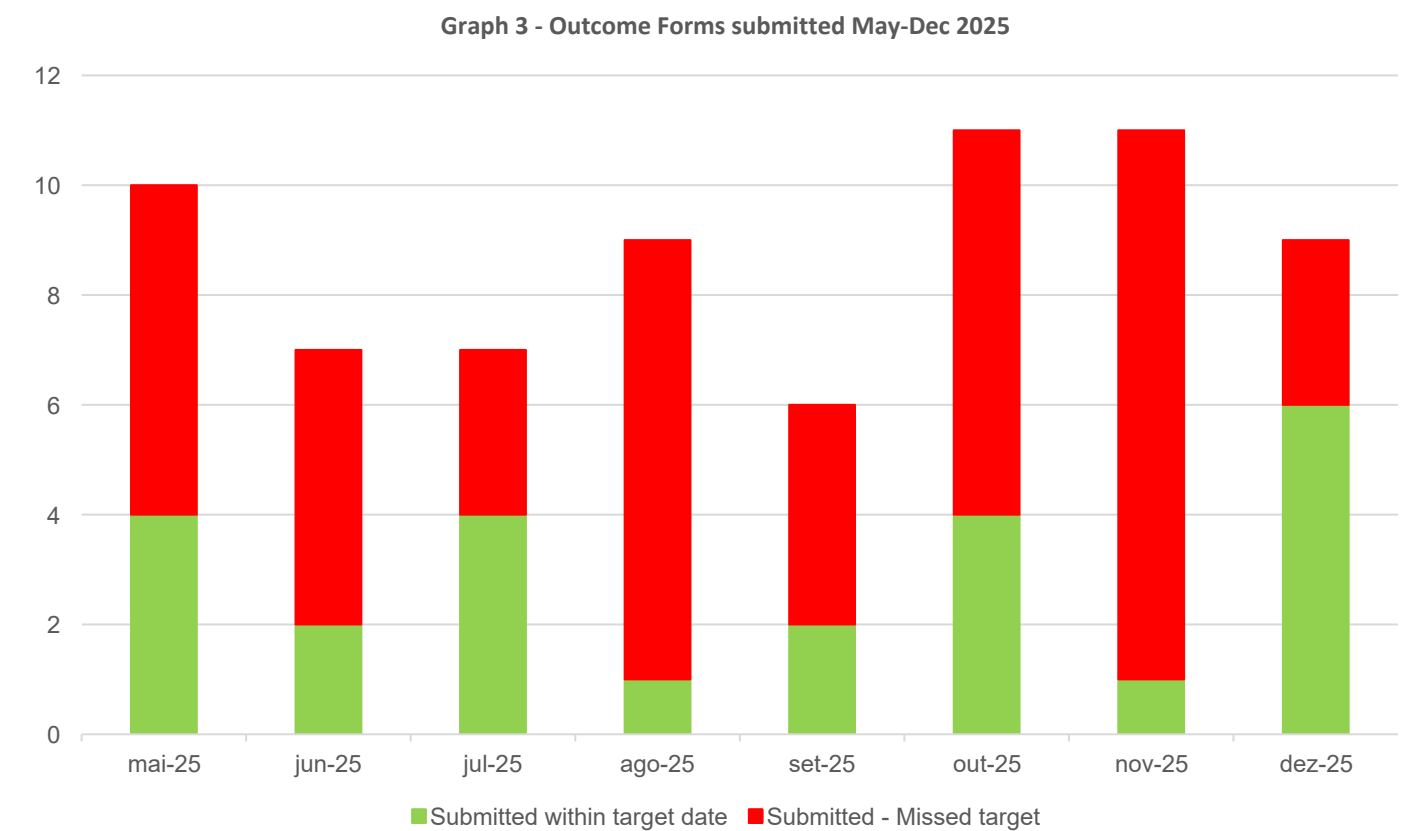
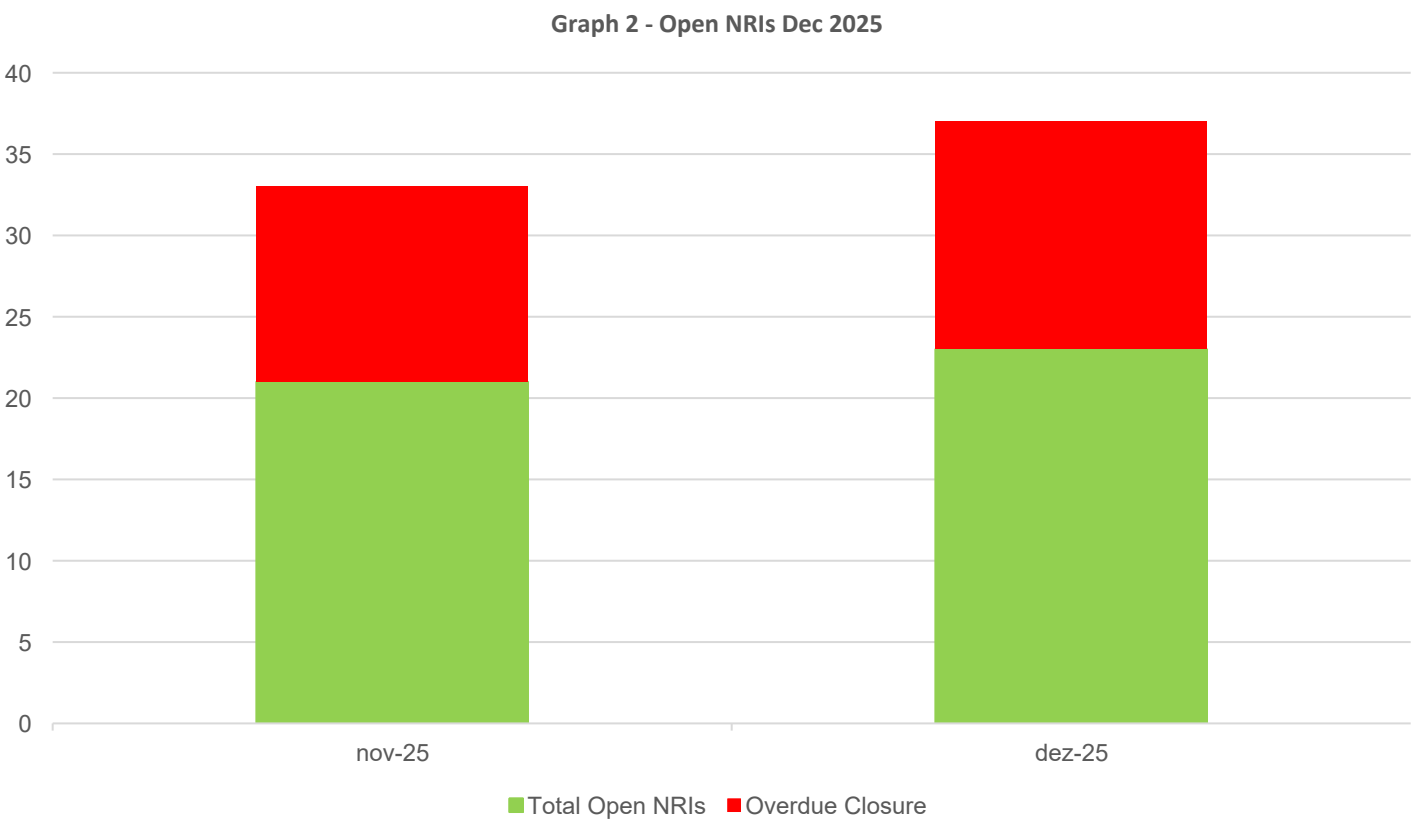
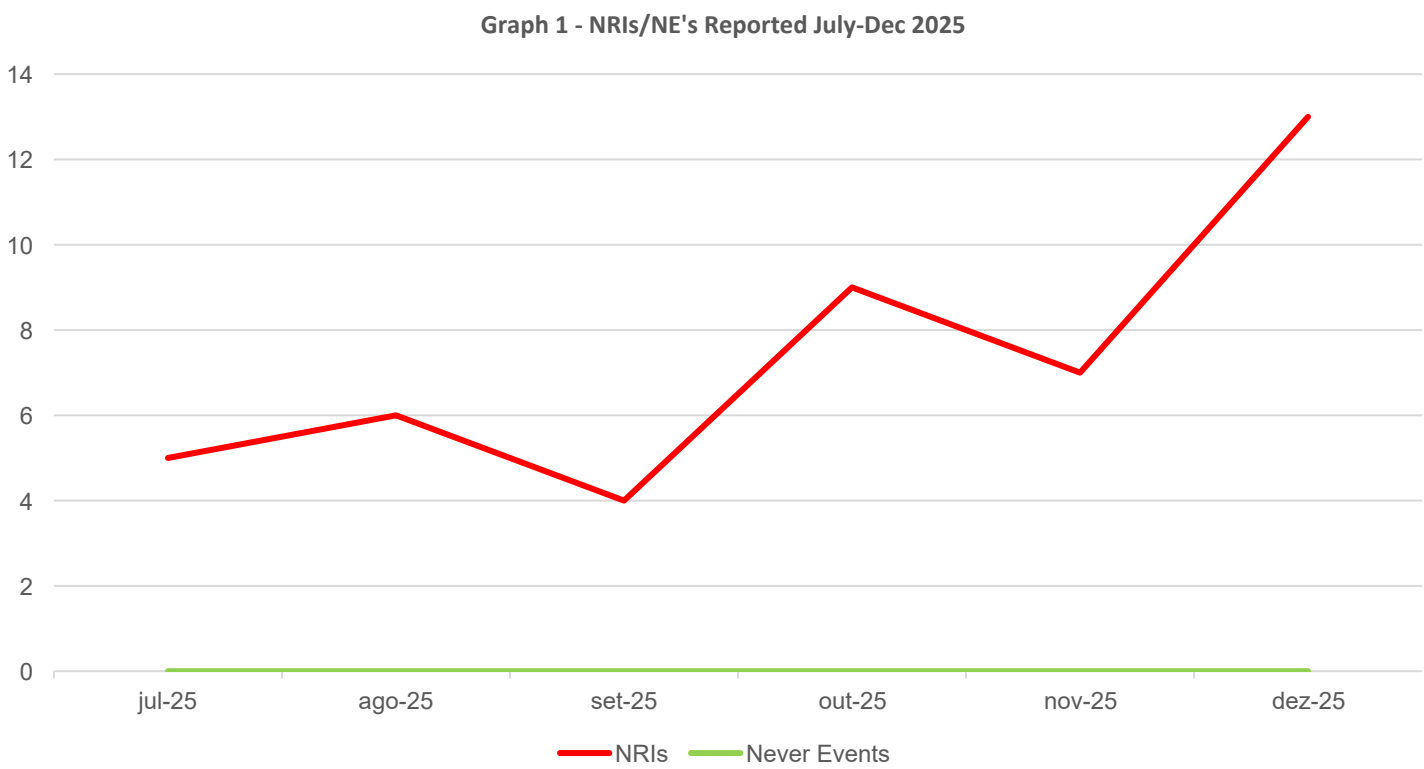
- **Graph 1** – Number of NRIs/NE's reported to P&I (includes retrospective reporting of: 3 avoidable in-patient falls; 1 avoidable pressure damage; 1 prison death; 2 Must Reports)
- **Graph 2** – 37 NRIs open with NHSWP&I – 14 open past closure date of which 6 are awaiting outcome of external reviews; 2 infant deaths require receipt of external review before closure can occur; 6 remain under investigation
- **Graph 3** – Outcome forms submitted in month (67% performance)

What are we doing about it?

- Weekly review with PSI investigator to:
 - ✓ monitor progress of corporate investigations; identify barriers
 - ✓ escalate outstanding actions required
- Fortnightly service group meetings:
 - ✓ service group investigations - progress towards closure date discussed
 - ✓ updates on PSI investigation given
 - ✓ escalate to service group barriers identified with corporate PSI investigations
- Service Group Directors contacted separately for outstanding actions
- Data presented and discussed at health board Patient Safety and Compliance Group; Quality and Safety Group; Patient Stakeholder and Experience Group - Service Group assurance sought against outstanding actions for completion of investigation / outcome form

What do we expect to see change and when?

- Reduction in number of overdue investigation outcomes forms
- Reduction in number of NRIs/NEs reported through recommendations/learning monthly.



EWNs – December 2025

- Ombudsman Public Interest report re Orthopaedic waiting times
- Patient known previously to SBU MH Services charged with murder in Birmingham area
- Abscondment of patient detained under Section 3 MHA (has since returned)
- NMC hearing – gross misconduct
- GMS – data breach involving patient email addresses
- Risk or adverse publicity - Parents approached 'Wales On-line' following care episode

NRI Learning (YCFFs) – December 2025

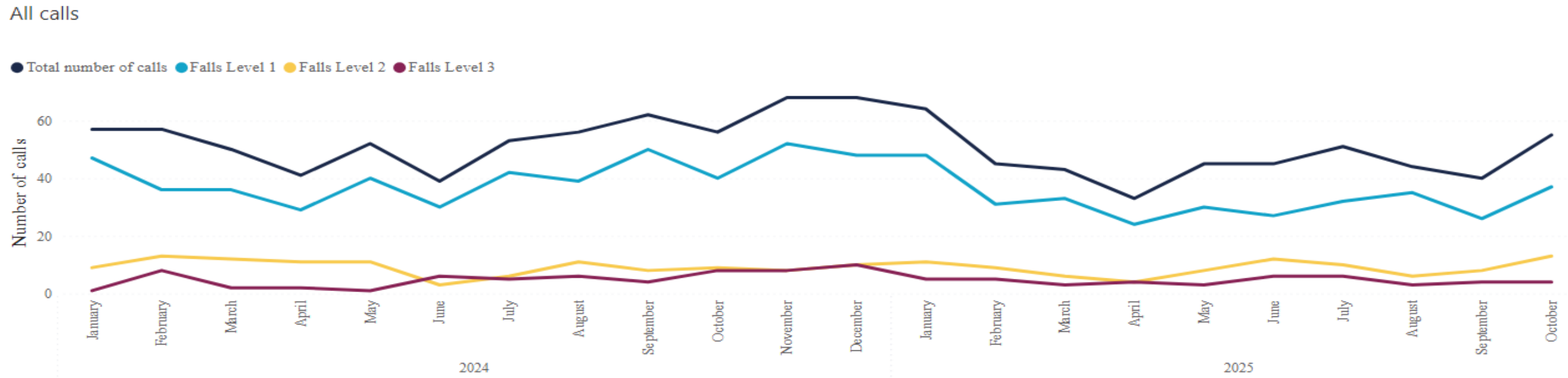
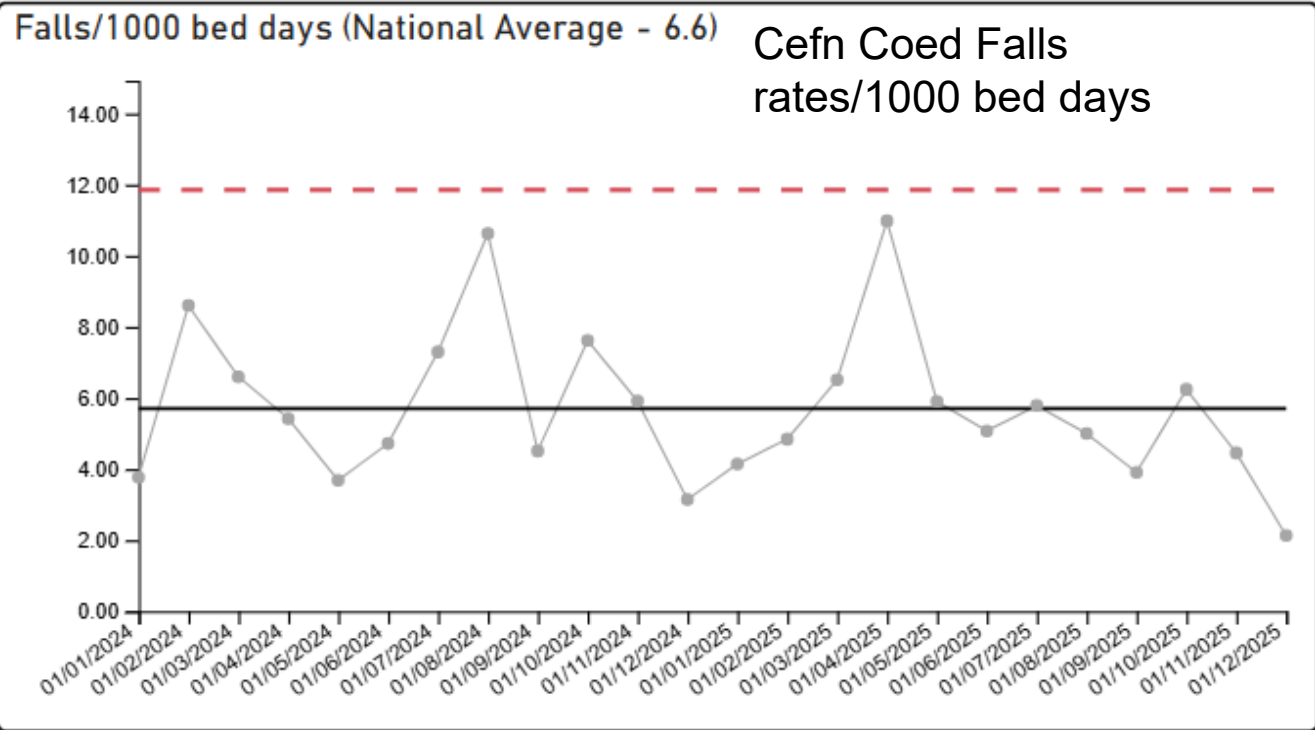
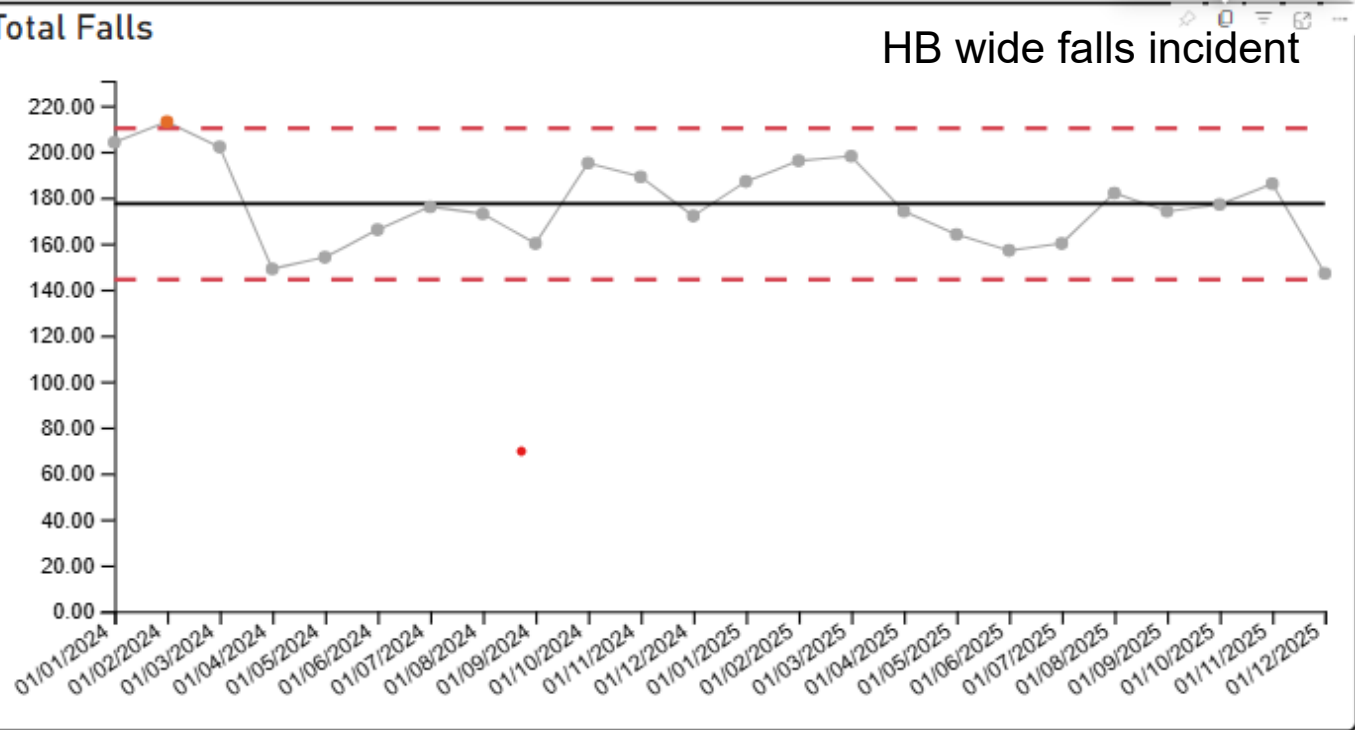
Domain 1 – Situational Factors	Team Factors: - Absence of feedback - Known to mobilise with Zimmer frame without assistance – patient on 15-min checks - Low staff morale due to ward move - Staff from other areas have joined to support team but needed to settle - Although evidence of turning patient 4-hrly, gaps seen on skin bundle Individual Staff Factors: - Ward recently relocated from neighbouring hospital	Patient factors: - Birth outside midwifery led guidance a home. Counselling of risks documented in detail - Uncooperative at times / did not always accept help when offered - Complex medical history with LD/MH diagnoses - Extreme pre-term infant born at 22+2 weeks – expected mortality due to risks BAPM framework - History of previous falls suffering fractured NOF and ongoing cognitive impairment - Declining mobility (COPD/AF/frailty) – identified placement in nursing home prior to admission to hospital
Domain 2 – Local Working Conditions	Workload and staffing issues: - Staff sickness within team – maintained with support from other areas - Due to vacancies in RNs/sickness – reliant on bank staff each shift Leadership, supervision and roles: - Unclear responsibilities – CTP did not accurately reflect services open to the patient at the time of the incident - MHS assessment not undertaken as required following assessment by LD Psych – lack of understanding of process for initiating MHA assessment - Failure to undertake 15-min checks in place	Drugs, equipment and supplies: - Recommendation from external review for community midwives to carry pulse oximetry, oxygen and portable suction - Recommendation in relation to PPH management in Community - Multiple mattress failures have occurred on ward. On initial transfer to ward, approx. 1/3 of the mattresses delivered failed
Domain 3 – Organisational Factors	Physical environment: - No mobile phone signal at property Support from other departments: - Delay in provision of care due to lack of organisational clarity between MH & LD services - Transfer to an appropriate ward/hospital - Difficulties in finding a bed - Lack of out of hours support	Staff training and education: TVNs and PDNs providing updated training to staff due to knowledge gaps identified
Domain 4 – External factors	National Policies: Infection prevention management	
Domain 5 – Communication and Culture	Safety culture: - Patient Safety awareness - Lack of awareness of harm - Attitude to risk management - The presence of spilled water on floor likely contributed to fall due to loss of balance/slipping - Previous pressure damage reported on the ward not identified to the wider team	Verbal and Written communication: - Poor communication between staff. - Poor communication/handover between teams - Documentation did not clearly record the rationale for not using flat lifting equipment following the fall despite the patient's known injury history and difficulties weight-bearing. - Inconsistencies in the Purpose T and skin inspection assessments. - Not clearly documented on SIGNAL when PU identified - Poor written communication



What is the Data telling us?:

In-patient falls rate remains below National average
December 2025 saw the lowest reported incidents for falls in for 18 months (15% lower than same time previous year)
Falls rate by ward has seen biggest reduction at Cefn Coed site across all older persons wards
Falls related attendance to MIU down 14% compared to same time last year. ED MGH up 4% when comparing the same period.
There have been 5 NRI falls related incidents in the last 12 months (Sept'24-Aug'25) compared to 10 in the previous 12 months = 50% decrease
Care Home falls project continuing roll out – now live across 8 homes and preparatory work across other sites complete – current ambulance call out rate at under 17% (compared to previous 94%)

Safe Care partnership work on deconditioning progressing



Underlying causes:

- Ageing population with increasing frailty picture
- Increased demand on WAST and front door services
- Limited alternative WAST response to level 1 and level 2 falls regionally
- Inconsistent approach to falls advice in community/primary care
- Reduced access and provision of falls clinics across region
- Insufficient access to appropriate strength and balance exercise provision
- Some ward areas including AMU do not have an environment which enables safe monitoring of patients at risk of falls
- Risk assessment and care planning inconsistent and inaccurate in some areas of HB

What are we doing about it:

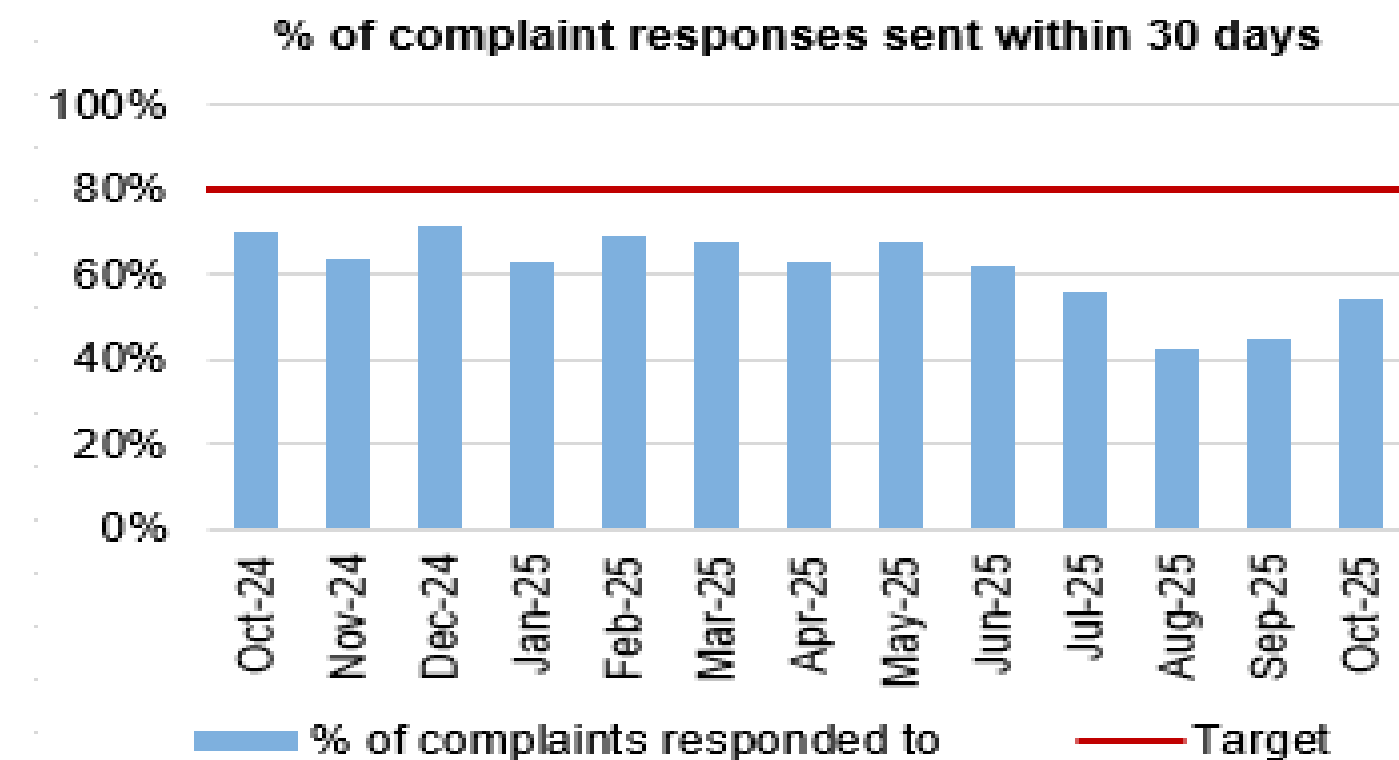
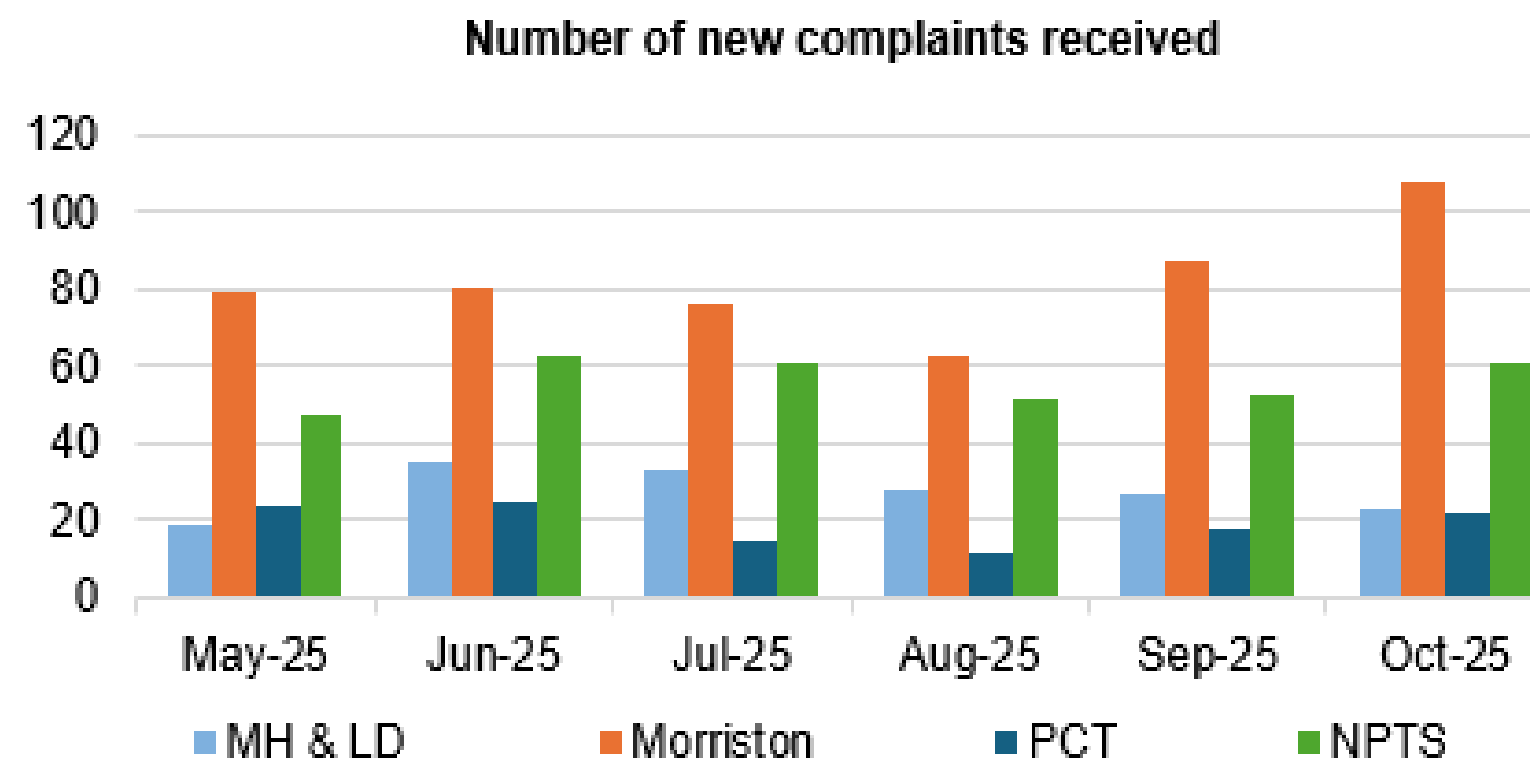
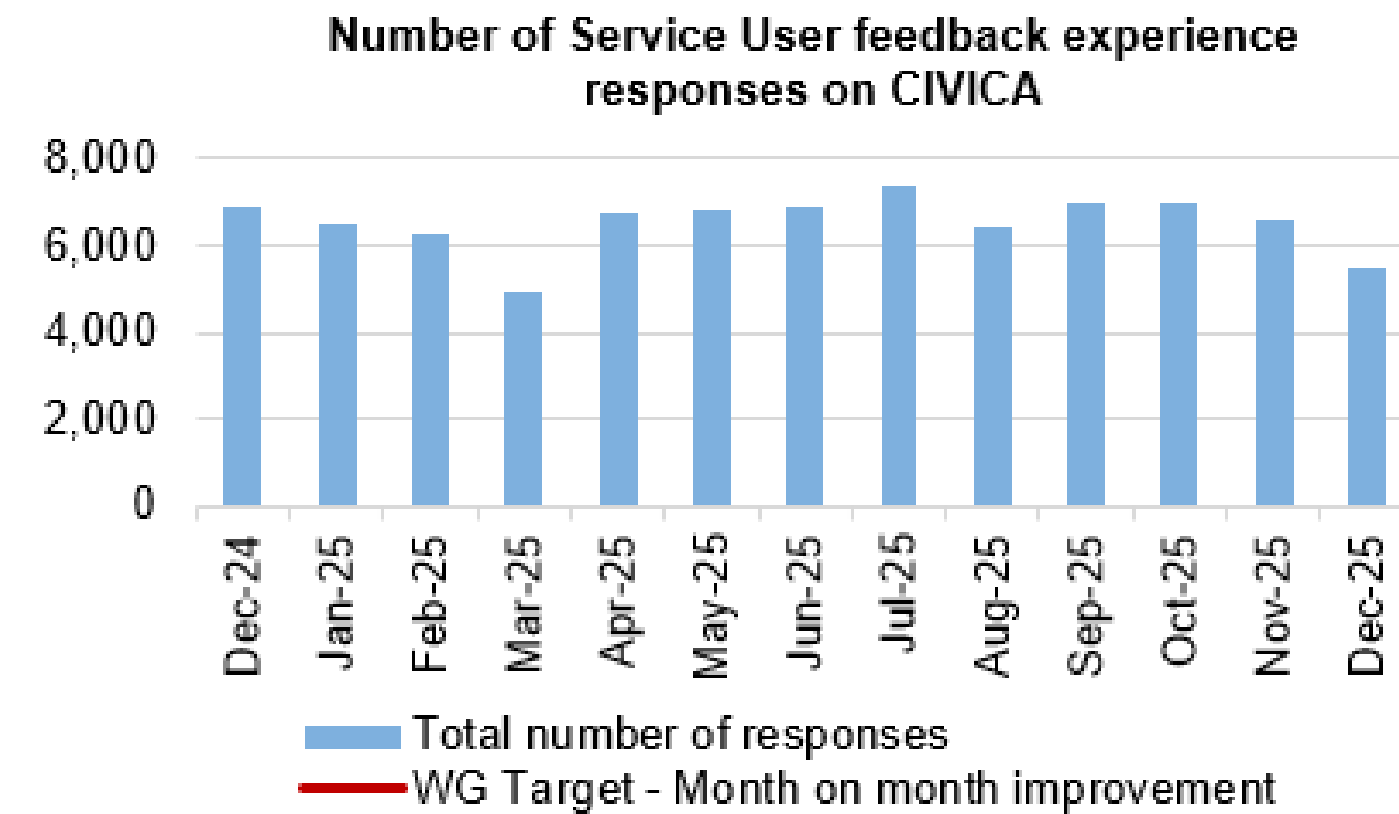
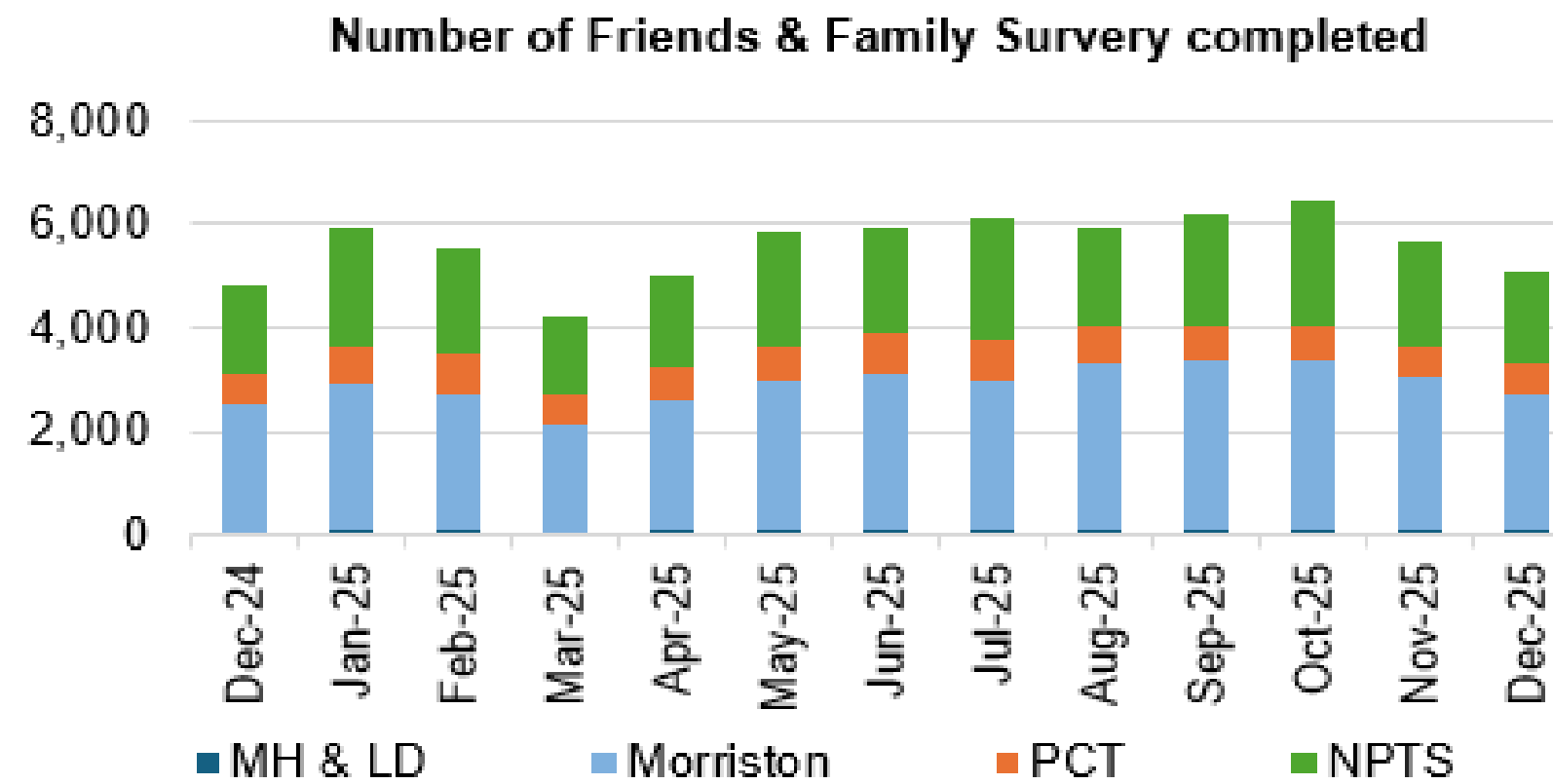
- Regional Falls Prevention taskforce enabling collaboration
- Primary Care action plan agreed
- Roll out of level 1 falls response across care homes and Dom care
- Enhanced falls response service launched (initial data suggests 50% stay home rate from otherwise inevitable conveyence)
- Falls page on Waiting Well internet pages
- Falls response project won NHS Wales award and shortlisted for HSJ award
- Safe Care partnership work on deconditioning concluded
- 3 patient engagement events attended with over 40 meaningful interactions with members of public re falls prevention and active ageing

What do we expect to see change?

- Reduction in WAST call out from care homes following falls incident (goal – 30% reduction per site by March '26) - ON TRACKI
- Falls rate not exceeding 5.0 (falls/1000beddays) over proceeding 12 months – ON TRACK
- Reduction in conveyance to hospital via WAST for level 2 falls (WG target of 25% reduction) - OFF TRACK - initial data suggests minimal impact currently on level 2 falls however service evolving to offer enhanced response to patients in ED and OPAU to improve admission rates



Patient Experience & Concerns



Actions/Updates

- There were 5,070 friends and family surveys completed in December 2025 which is a reduction on the previous month where 5,565 surveys were completed.
- Of those surveys completed, the 92% of patients would highly recommend the services they received.
- There were 224 concerns received in October 2025, and 54% of those concerns had responses sent within 30 days in October.³⁷

Complaints – December 2025

What is the data telling us?

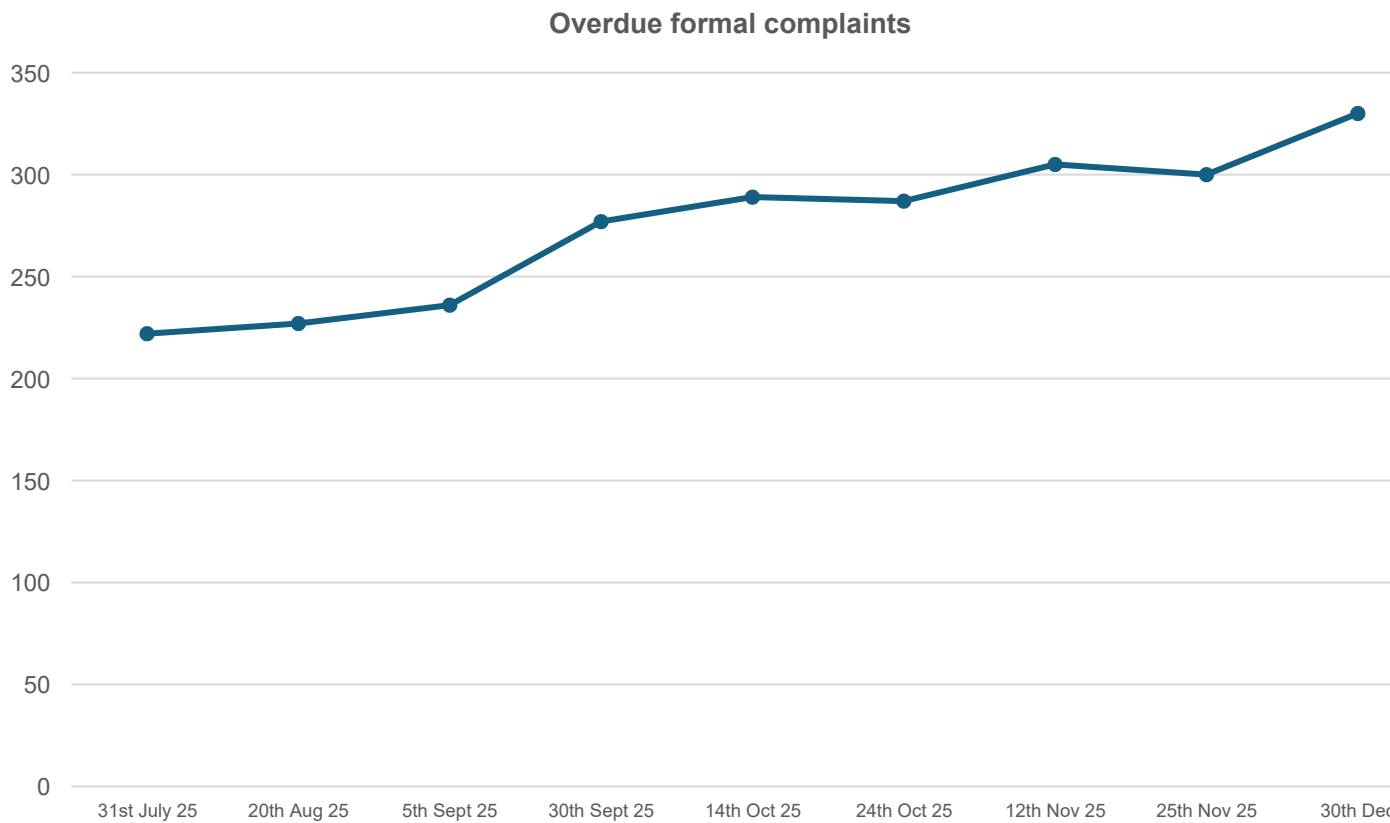
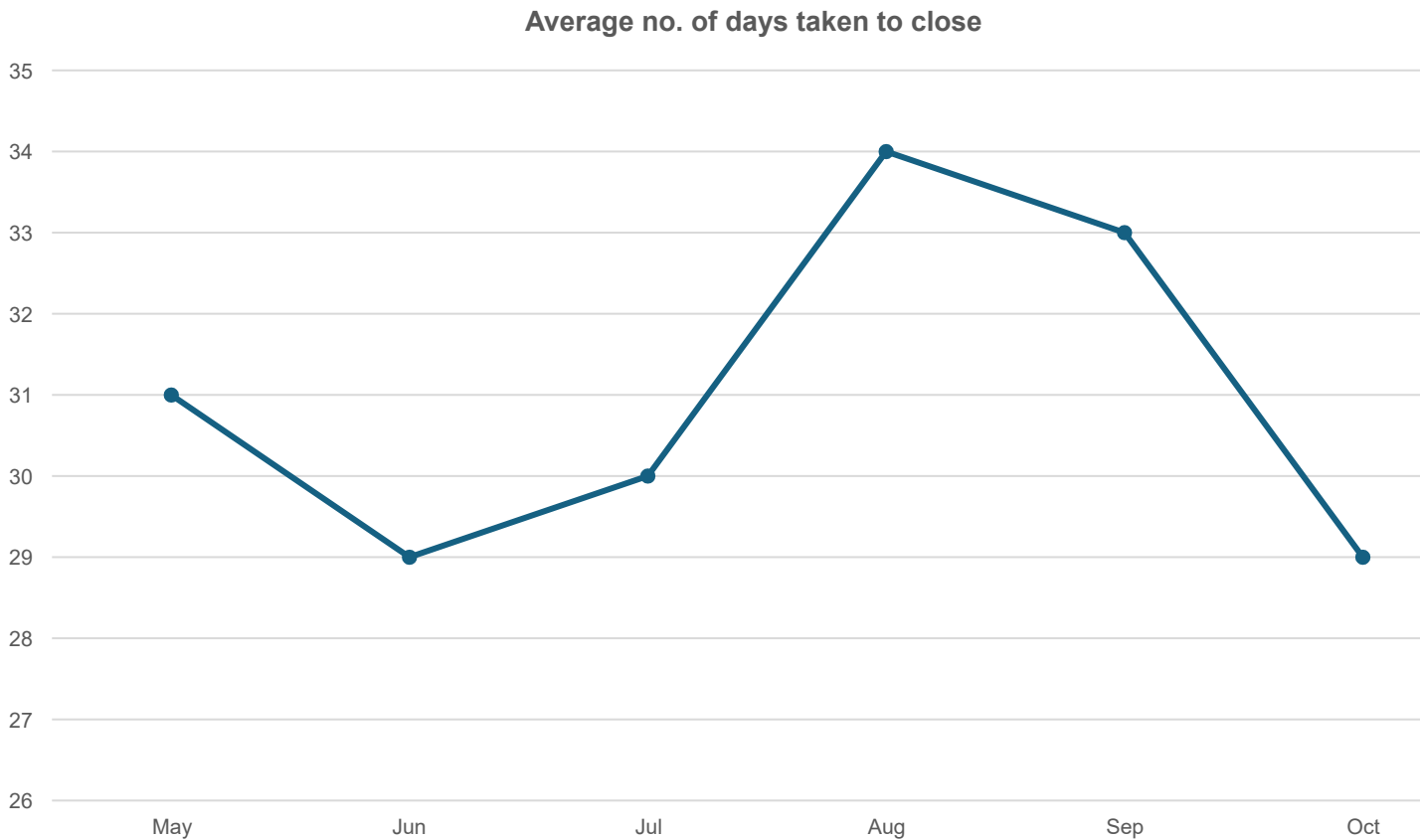
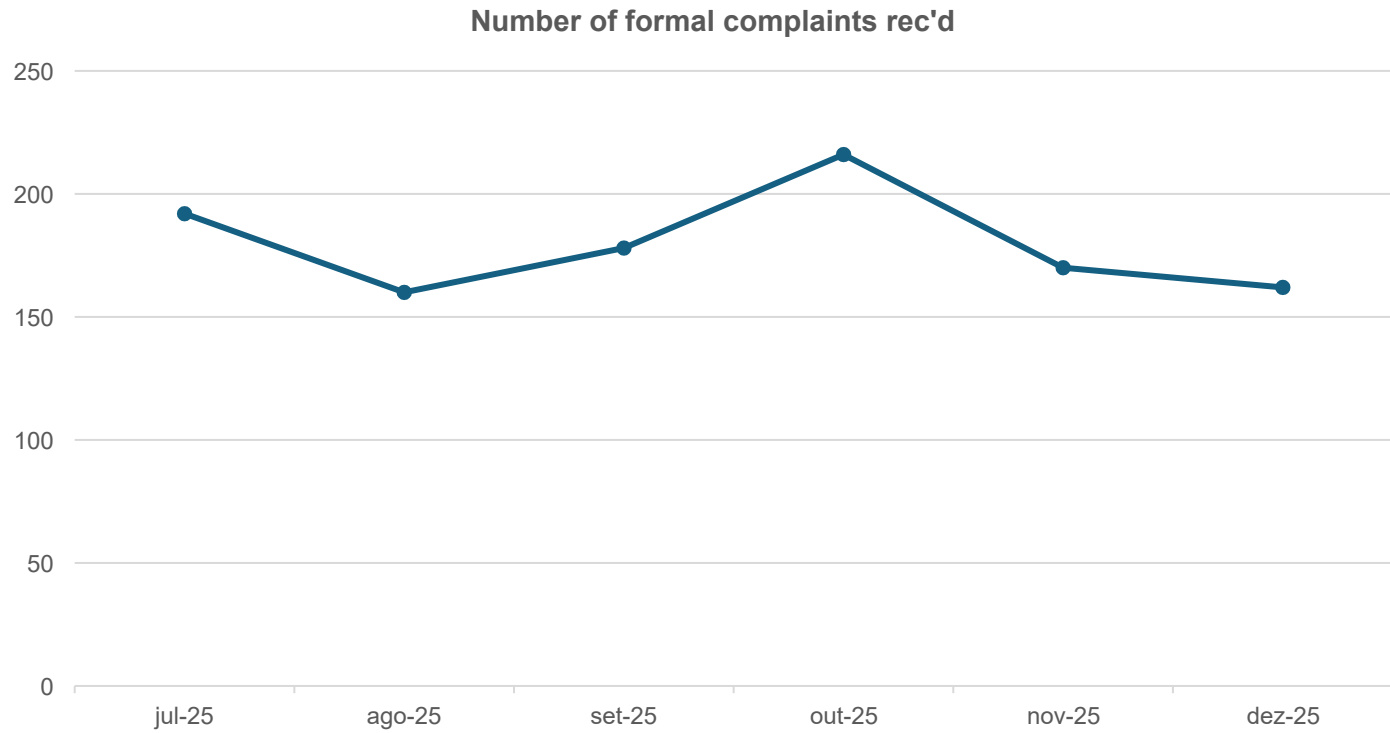
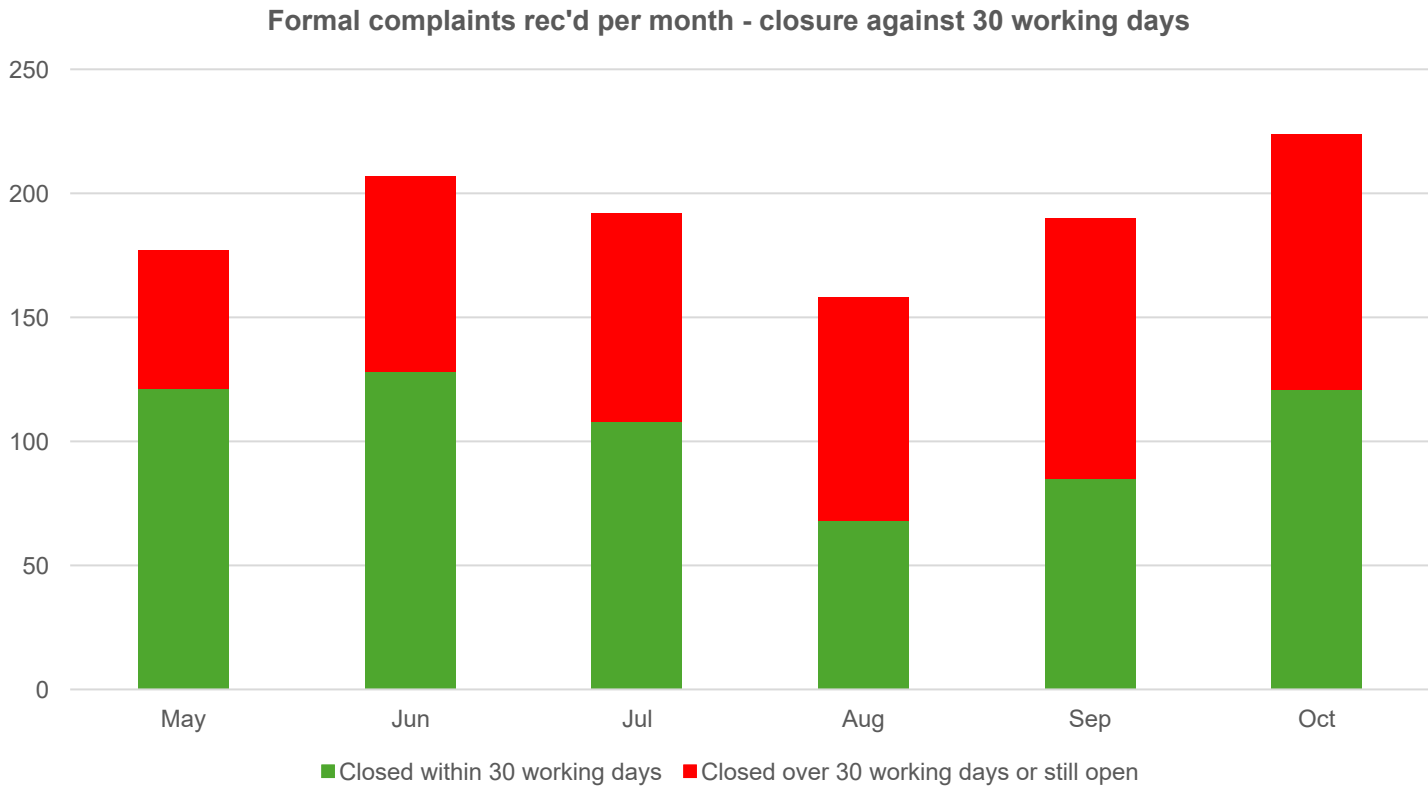
- Graph 1 – is indicating that a number of complaints are not compliant with the 30 working day target for responding to formal complaints in line with the Putting Things Right Guidance.
- Graph 2 – 162 new formal complaints in December which is a decrease compared to 170 in November.
- Graph 3 - The average number of days taken to close a formal complaint has decreased by 4 working days compared to the previous month. Average days for October being 29 days which is within the Welsh Government target of 30 working days.
- Graph 4 - The number of overdue formal complaints is increasing bi-weekly. As of the 30th December, 330 formal complaints were overdue

What are we doing about it?

- Bi-weekly report run on all overdue complaints which is sent to each Service Groups requesting updates.
- Bi-weekly drop-in sessions where complaint handlers can join to discuss any issues.
- Bi-weekly meetings with Service Groups to discuss open complaints and Ombudsman cases.
- Test to Change in SNPT to trial new way of managing complaints and trying to resolve early on.

What do we expect to see change and when?

- Reduction in the overdue complaints by January 2026, in readiness for the new Putting Things Right Guidance being introduced in April 2026.
- Early engagement with the complainant combined with listening meetings which will support an empathetic and compassionate handling of the complaint.



****Please note two graphs only go up as far as October, this is due to the 30 working days for complaints received in Nov/Dec not being up yet**

Patient Experience – December 2025

What is the data telling us?

- Graph 1 – Illustrates that Swansea Bay UHB's overall score consistently exceeds the benchmark of 85%, maintaining a performance of 90% or higher.
- Graph 2 – Displays the overall satisfaction scores across the different Service Groups.
- Graph 3 – Highlights wards/clinics achieving scores above 100%, based on more than 25 responses..
- Graph 4 – Identifies the wards/clinics with the lowest satisfaction percentages.

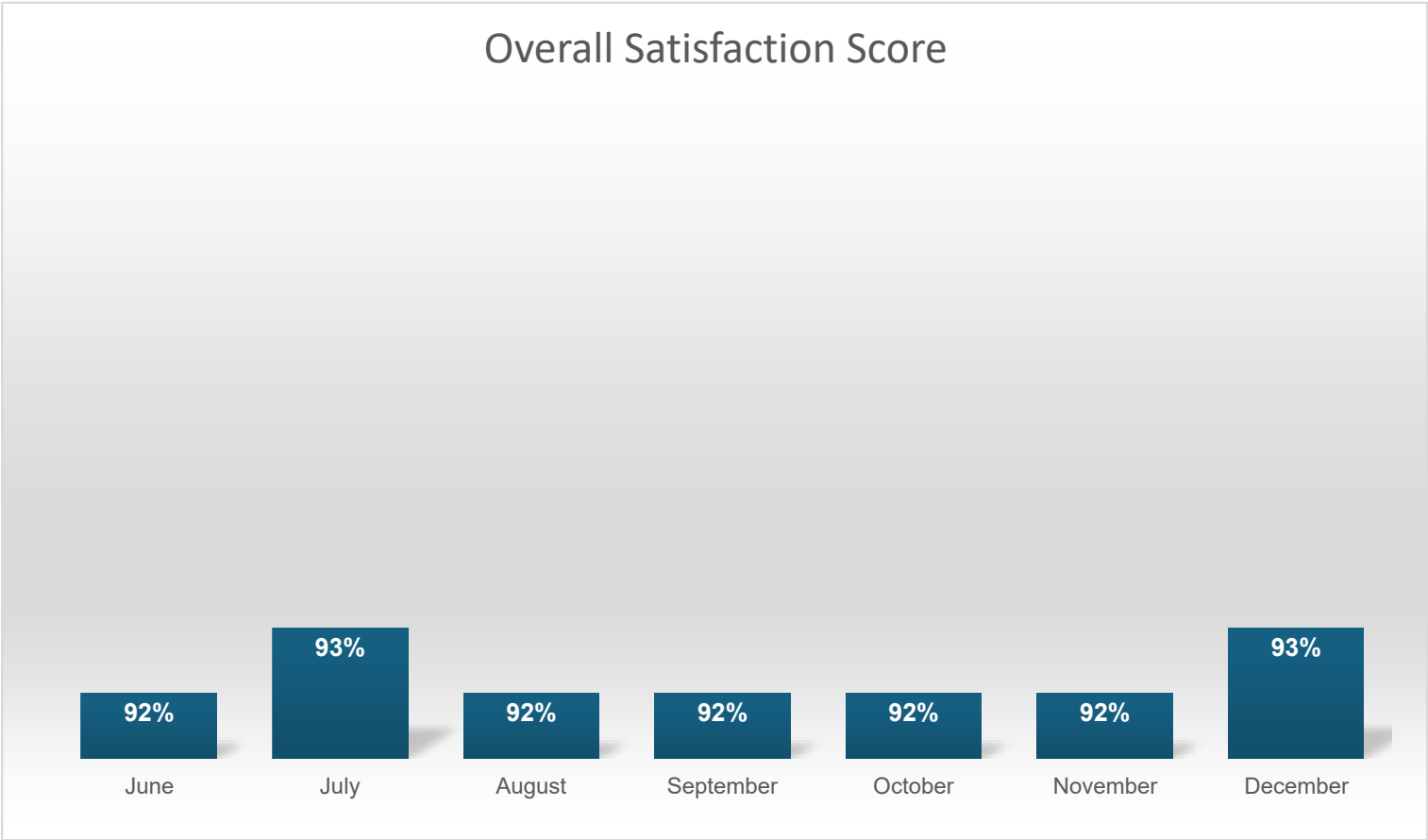
What are we doing about it?

- The system generates weekly feedback summaries for Service Group Leads, enabling timely action on low scores and recognition of positive feedback and comments.
- Ongoing drop-in feedback sessions are held to support teams in using Civica effectively and managing their feedback constructively.
- For alerts flagged as very poor or poor, the Action Manager is triggered. This tool tracks the progress and resolution of issues within Civica, managed by the PALS and Quality & Safety departments.

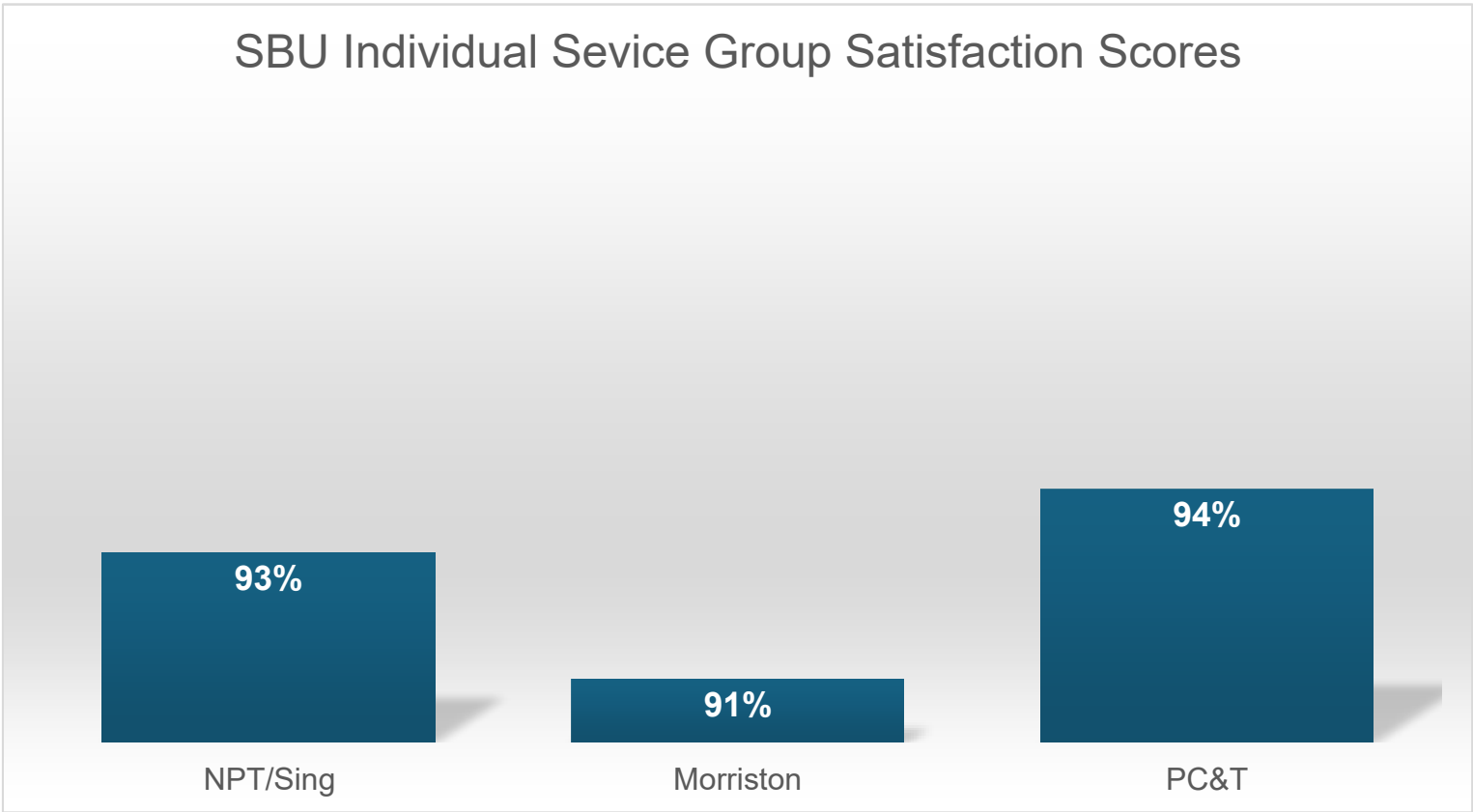
What do we expect to see change and when?

- We expect departments to take ownership of their low scores and implement improvements based on the feedback provided. Our role is to ensure timely alerts and supply weekly comment reports to support this process.

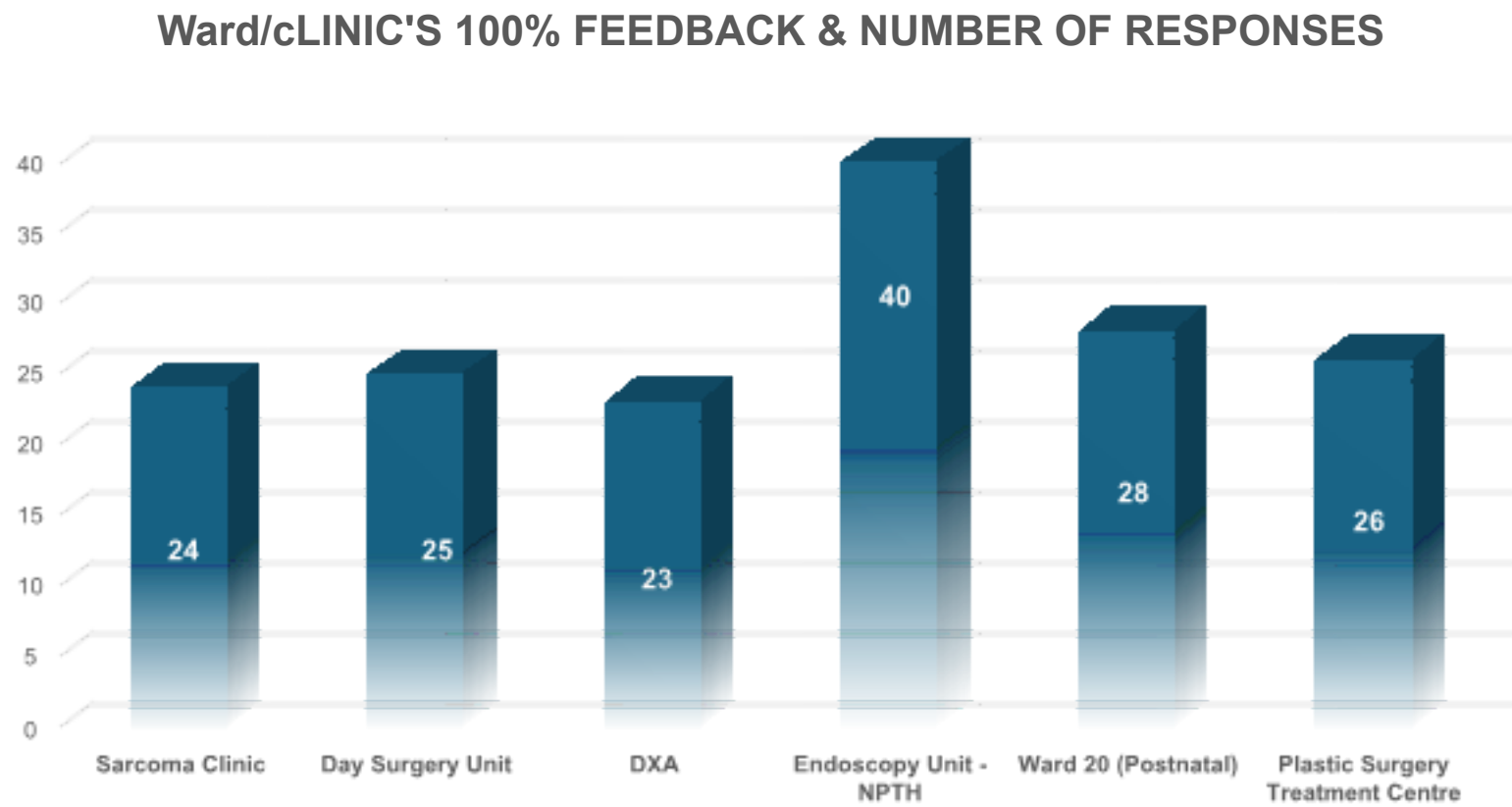
Graph 1



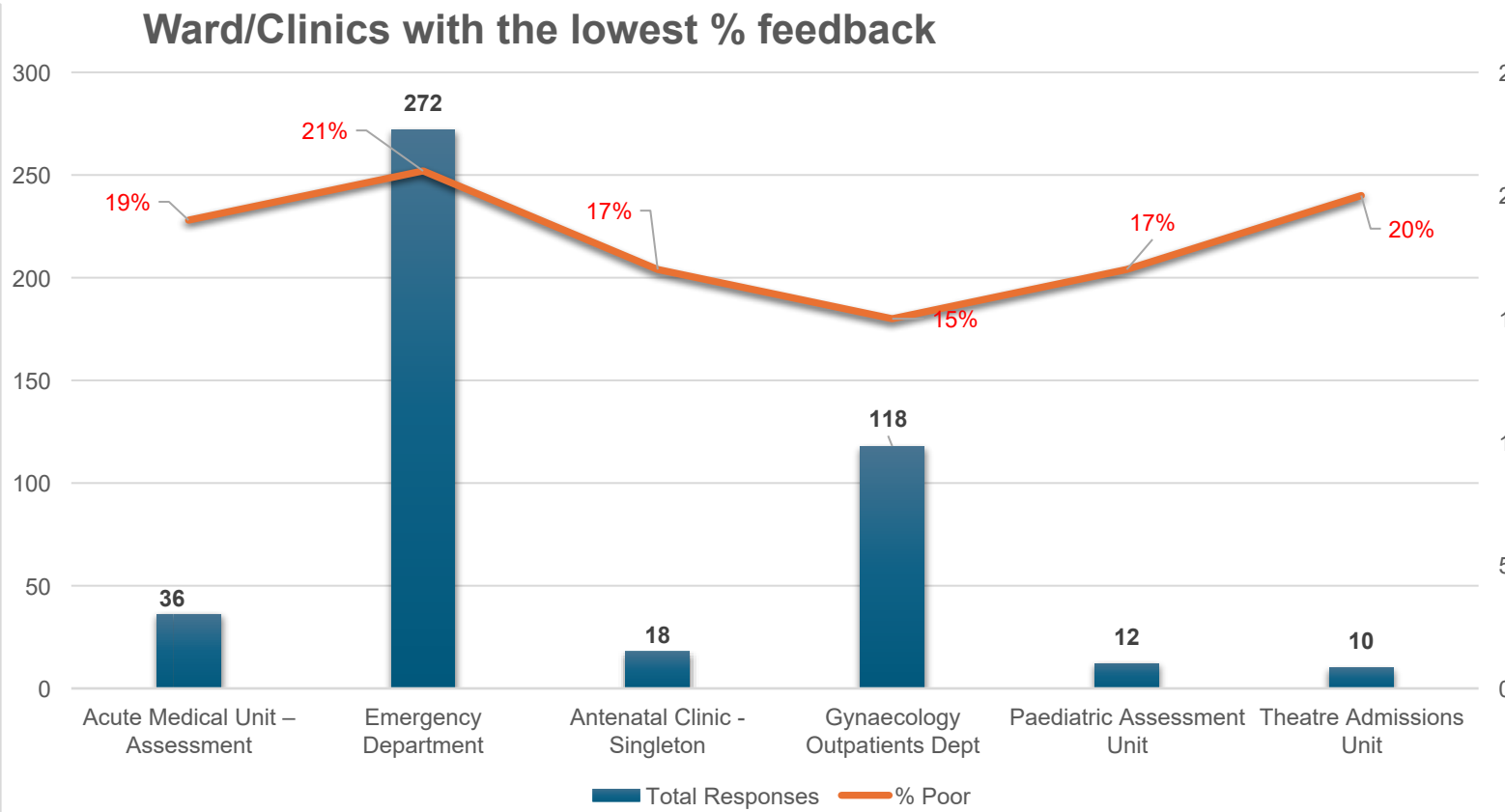
Graph 2

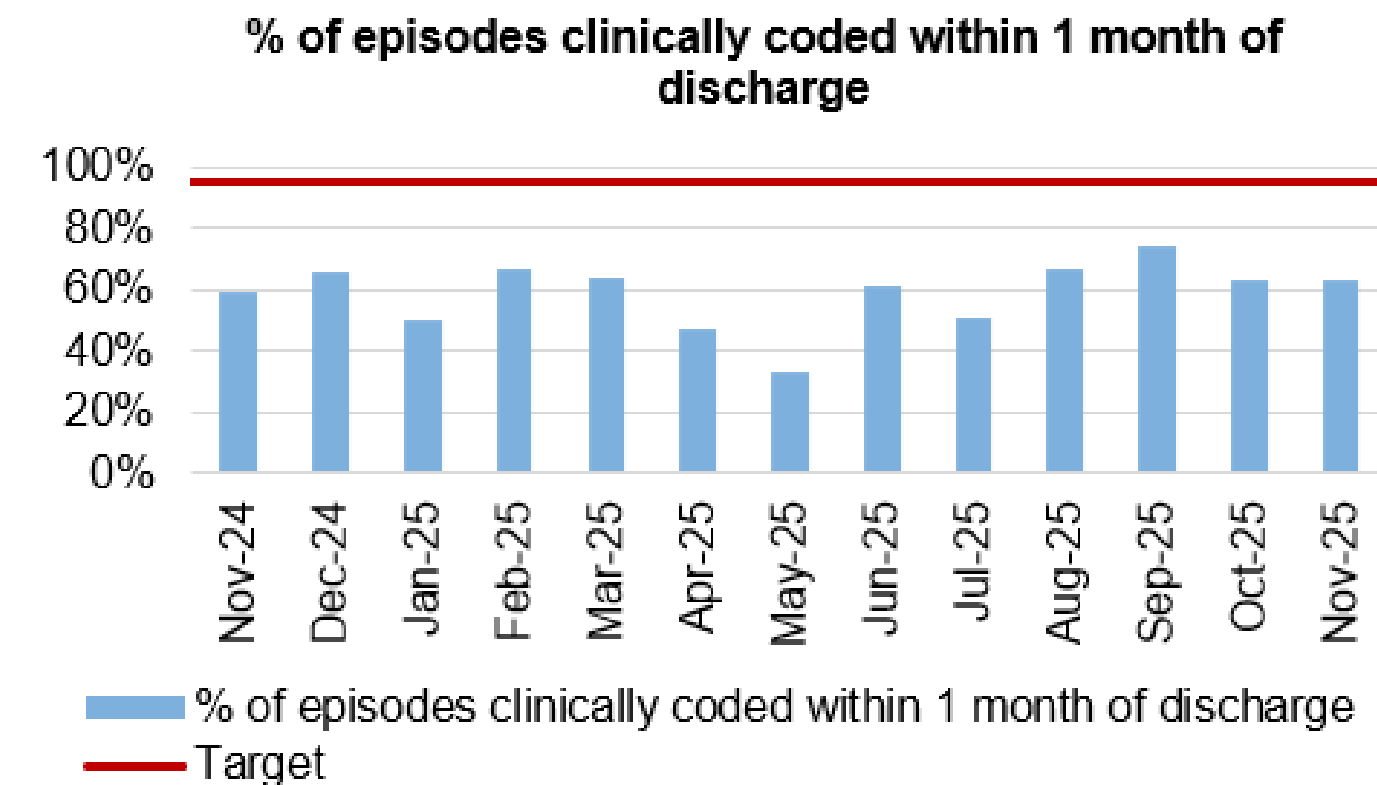
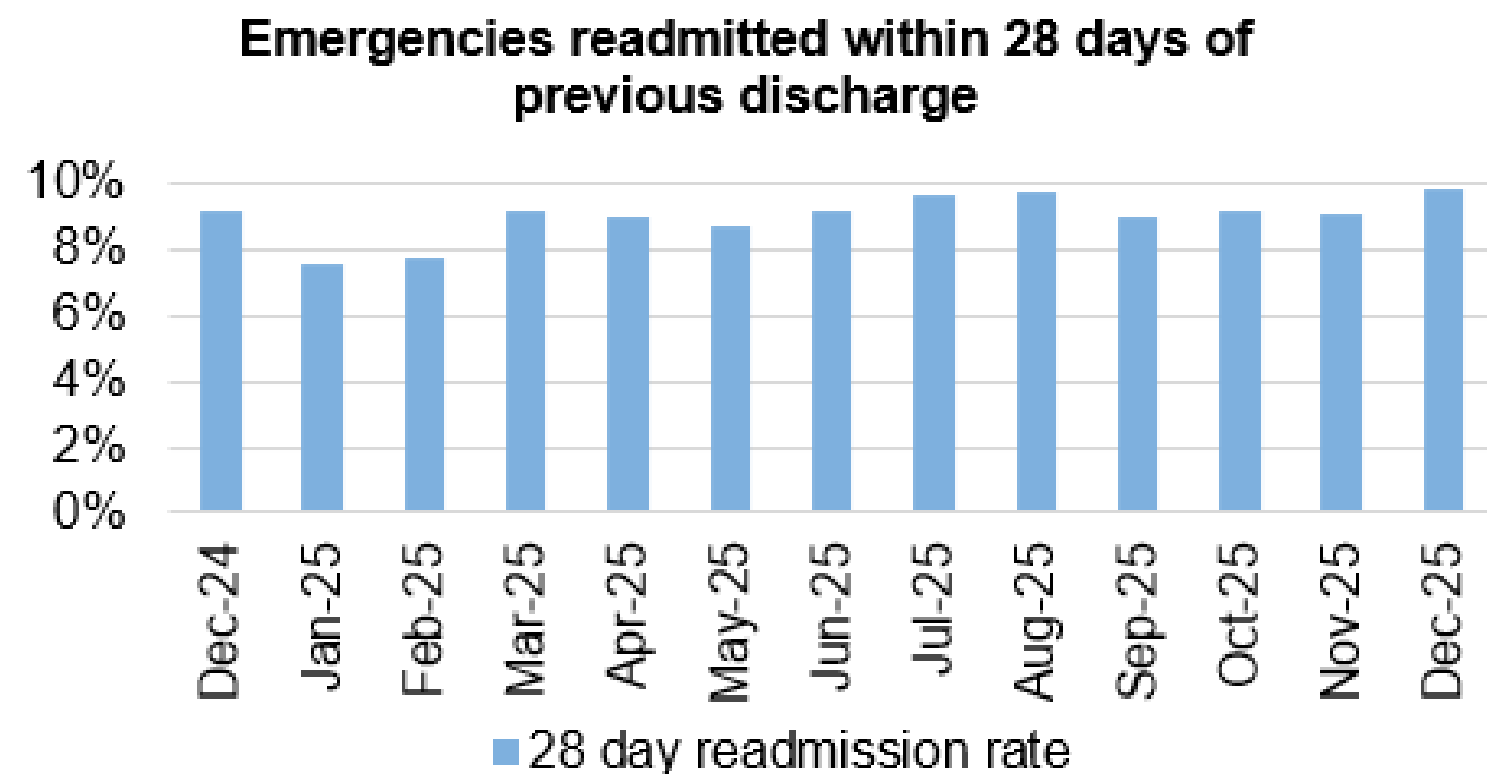
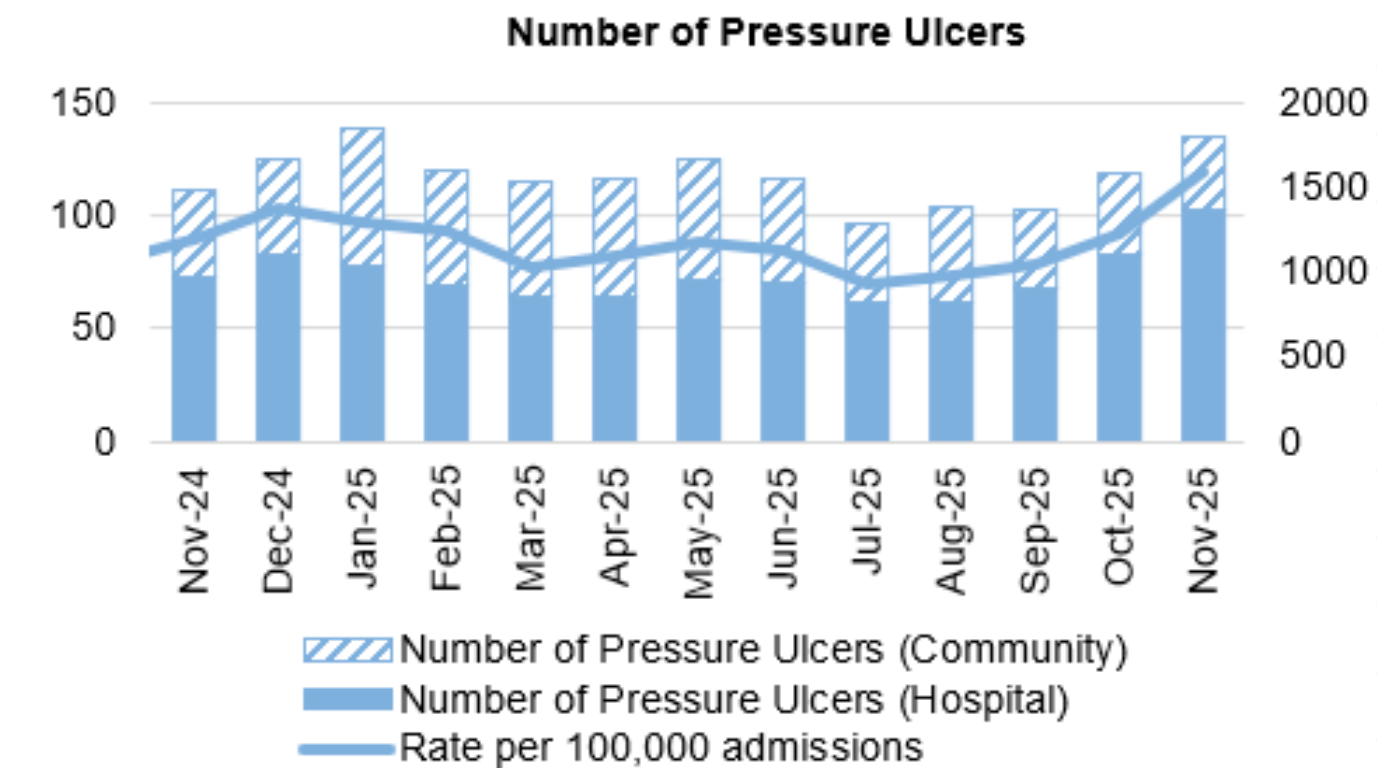
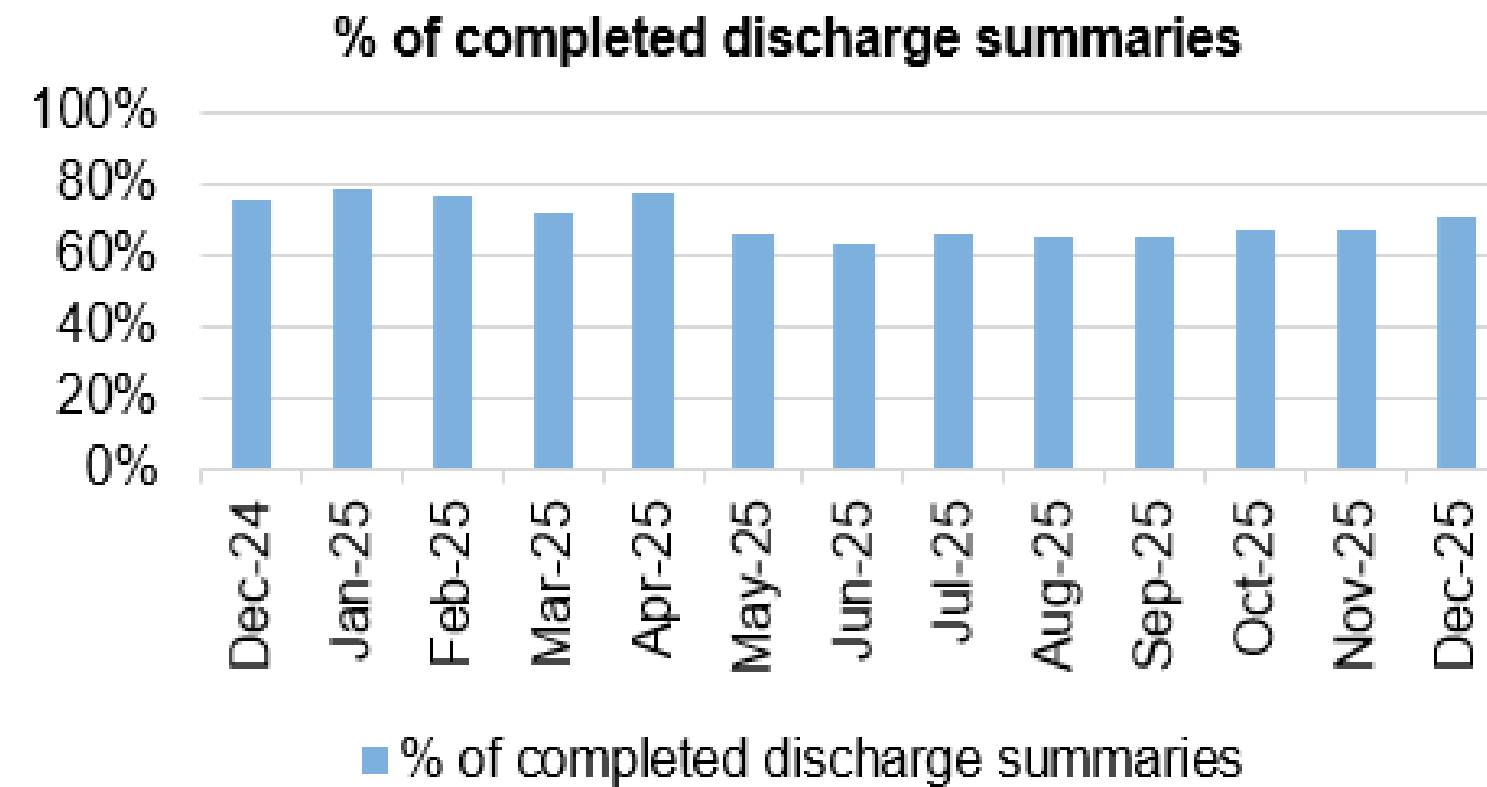


Graph 3



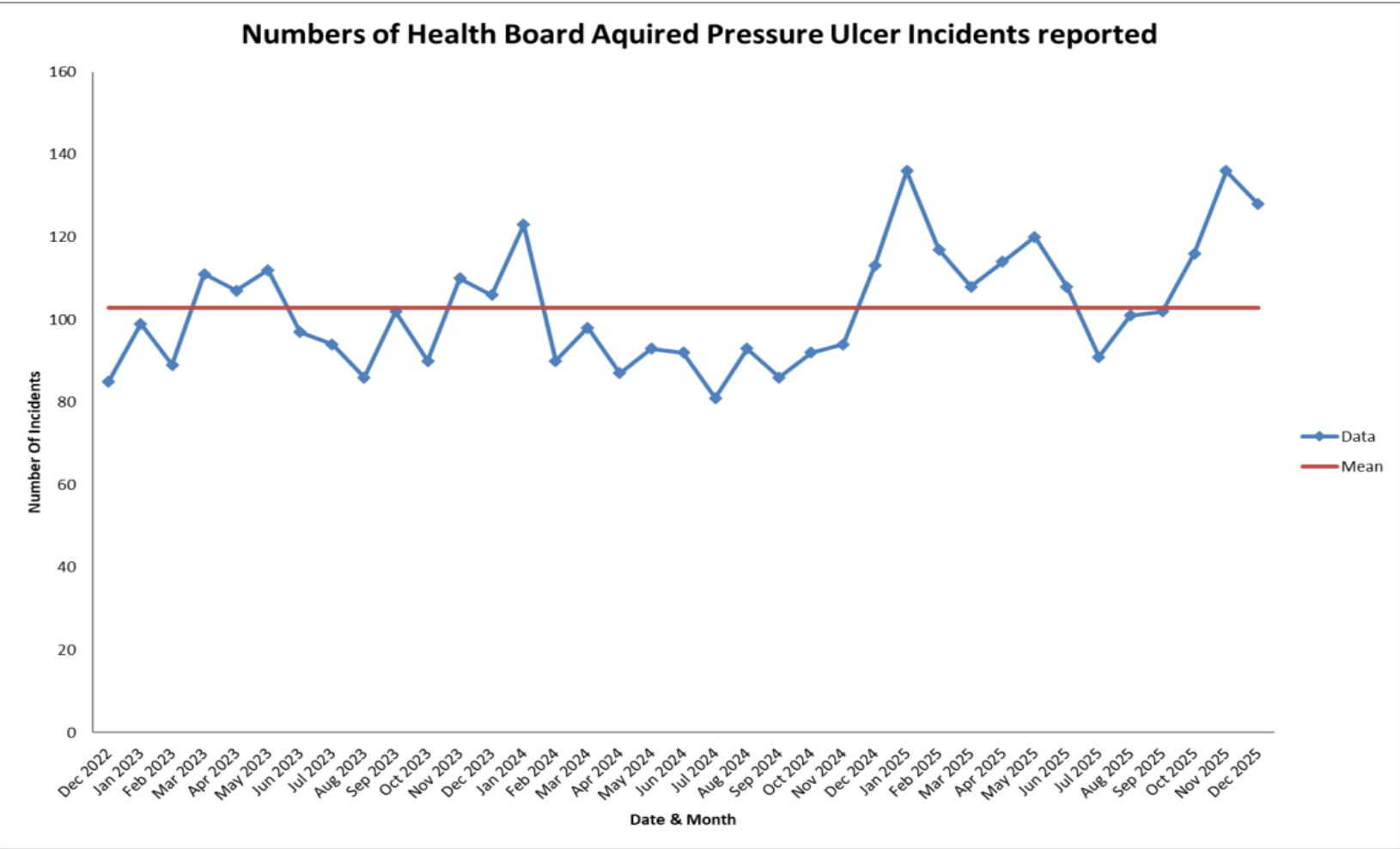
Graph 4



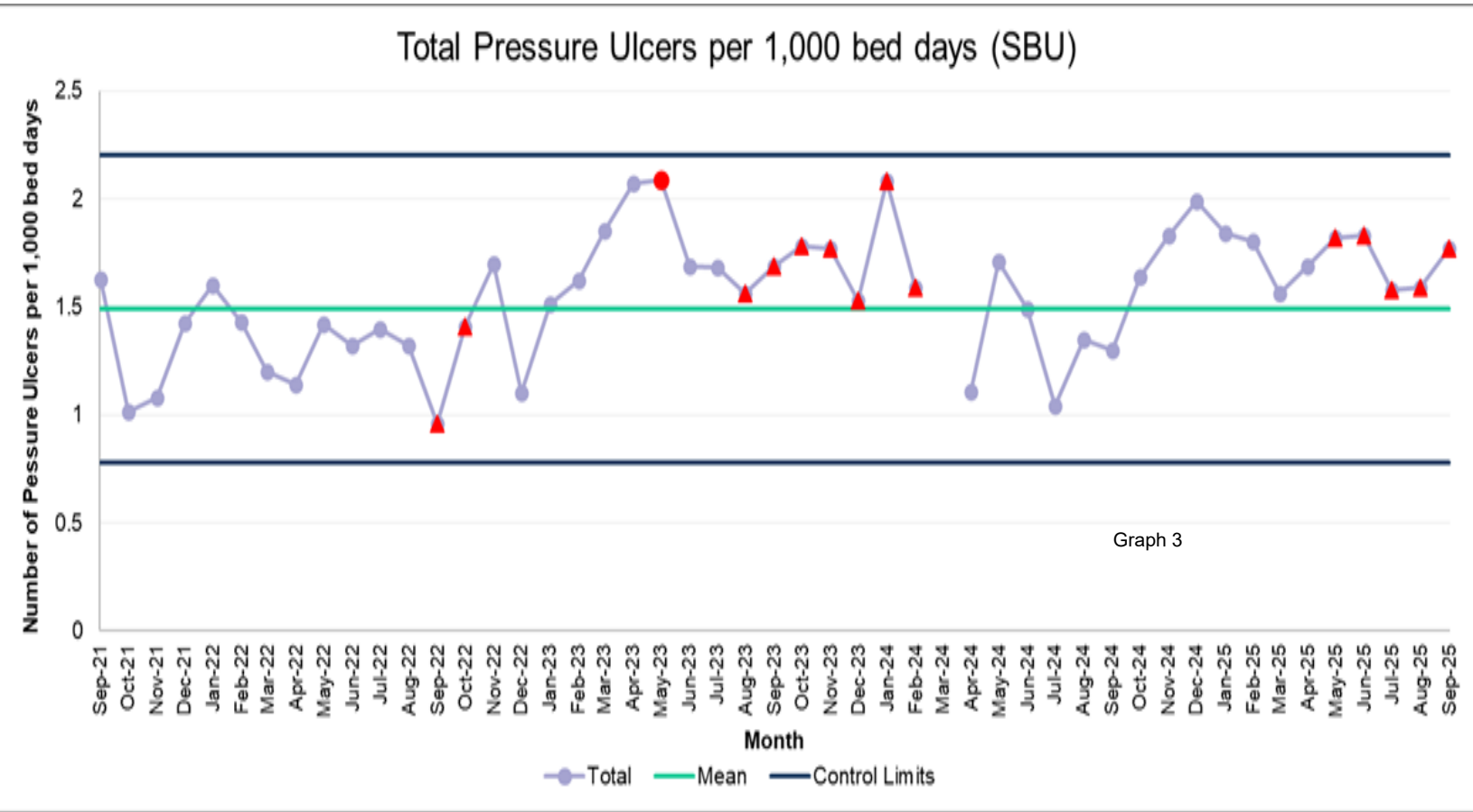


Actions/Updates

- The percentage of completed discharge summaries was 71% in December 2025, which is higher than the figure which was reported in November.
- There were 134 Pressure Ulcers reported in November 2025, of which 32 were recorded in the Community.
- The percentage of episodes clinically coded within 1 month of discharge remained the same in November, reporting 63%.



Graph 1 Total numbers of Incidents HB aquired. November and December require cleansing and scrutinising, not a reflective number.



Graph 3

Quarter 3 2025 : 9 % reduction in total numbers of HB aquired incidents reported and 15 % reduction comparing April - Nov 2024 to April to Nov 2025.

Primary and community services have seen 27% decrease compared to the previous 2 quarters. (PCS shows quarter-to-quarter fluctuations: both increases and decreases. A sustained decrease is atypical and should be examined carefully).

The inpatient incident rate is 1.8 per 1,000 bed days, 0.1 % increase to previous quarter. Morriston has seen a total rate reduction from (**R2.4**) to (**R 2.1**) NPSSG has seen a total rate of (**R 1.5**).

The highest inpatient rates were observed in Morriston (**R 2.6**) early 2025, and the lowest NPSSG (**R 1.1**). PCS rates prove challenging due to inaccuracy on caseload dashboards. These figures are reflecting increased numbers but do not reflect avoidability status.

Severity: 90 % of all HBA incidents remain superficial in nature .

10% are deep in nature.

76% of deep damage ulcers developed under **PCS** in patients’ own homes, **24 %** In our hospital settings.

The HB have seen an 8% reduction in deep tissue damage reflecting the last cleansed data.

70% all HBA investigated deemed **unavoidable (15% improvement)**- since Quarter 1

Over 90% of all community damage incidents investigated were deemed unavoidable.

Governance & Learning Of incidents closed in the last quarter: we now see an Improving picture that 65% of all incidents have been investigated and closed. This still requires work and the efficiency of investigating and scrutiny is key to this.

70% deemed **unavoidable** 30% deemed avoidable, which is a significant improvement however with **35%** not investigated or closed, this does not reflect total status until end of next quarter.

Actions to Address Pressure Ulcers:

Governance & Oversight: Pressure Ulcer Strategic Group, scrutiny panels, peer reviews.

Audits & Data: audits and review

Education & Training: Multilayered education across staff groups

Pathways & Policies: Development of PU pathways, policies, and improvement plans

Resources & Technology: Centralised Tissue Viability service, digital wound imaging, bed contract finalisation. Shared education, champions and skills programme

Collaboration: Shared responsibility and learning

Leadership- Strengthen leadership and accountability

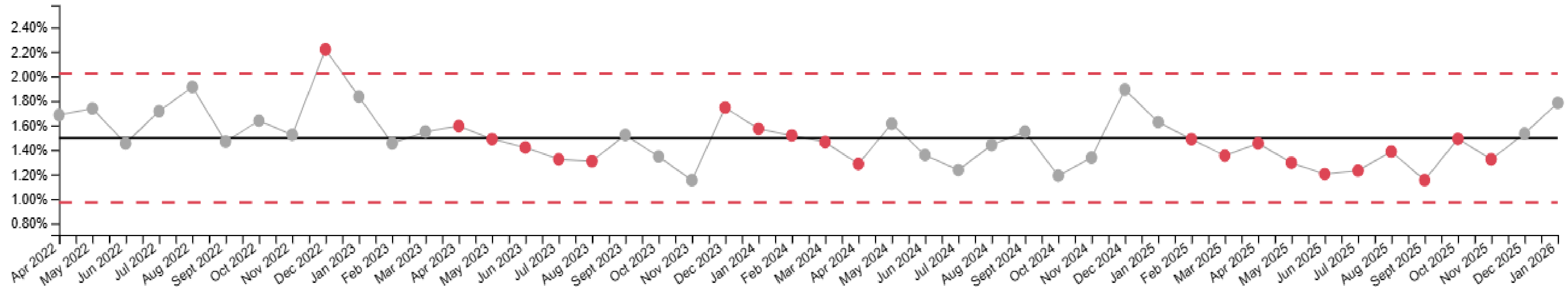
Improvement Goals

- ↓ 20% PU rates in acute sites; ≤1.6/1000 bed days.
- ↓ 20 % avoidable PU in HB.
- ↓ Reduce total number of HBA incidents by 10%
- ↓ Reduce HB aquired Deep damage by 10%
- Improved staff skills, governance, and learning culture.
- Equitable access to tissue viability services & medical photography across sites.**
- Better supported care homes.
- Patients consistently receive “right care, right time.”



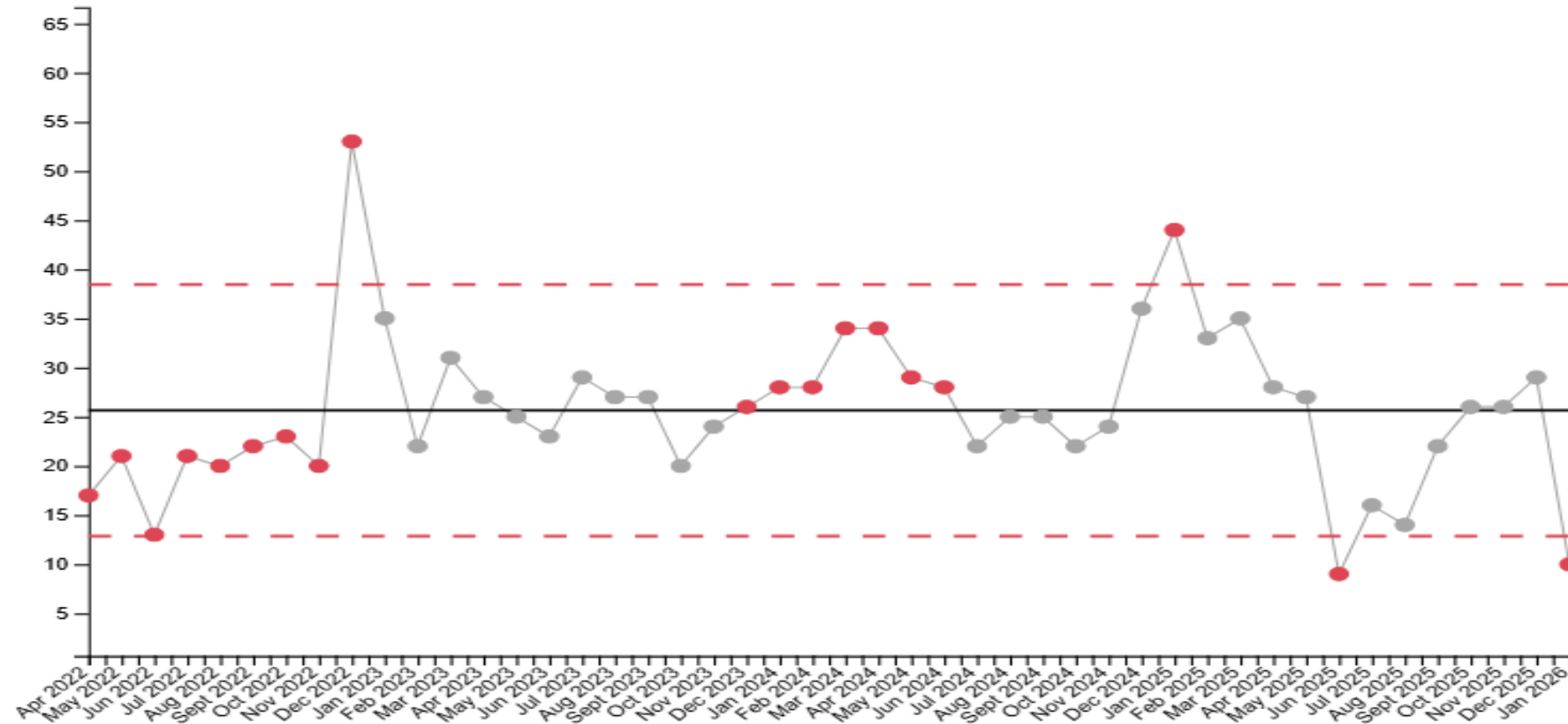
Mortality: Action & Intervention

Crude Mortality Rate



The summary of deaths in the Emergency Department can be seen below:

Deaths in ED



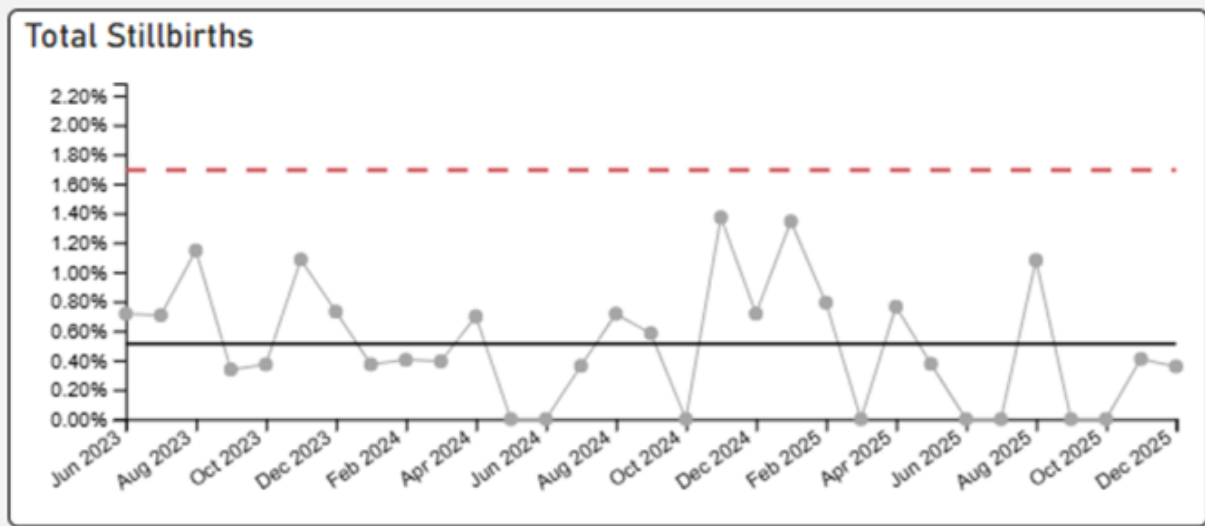
Mortality Data Summary

- The crude mortality rate has seen an increase in December 2025, reporting 1.53% compared to the previous figure of 1.32% in November 2025.
- Crude mortality over the last 4 years is within the control limits and the recent data reflects the predicted decline of mortality as expected during summer months
- The summary of deaths in the Emergency Department has remained relatively stable in recent months

Maternity & Neonates

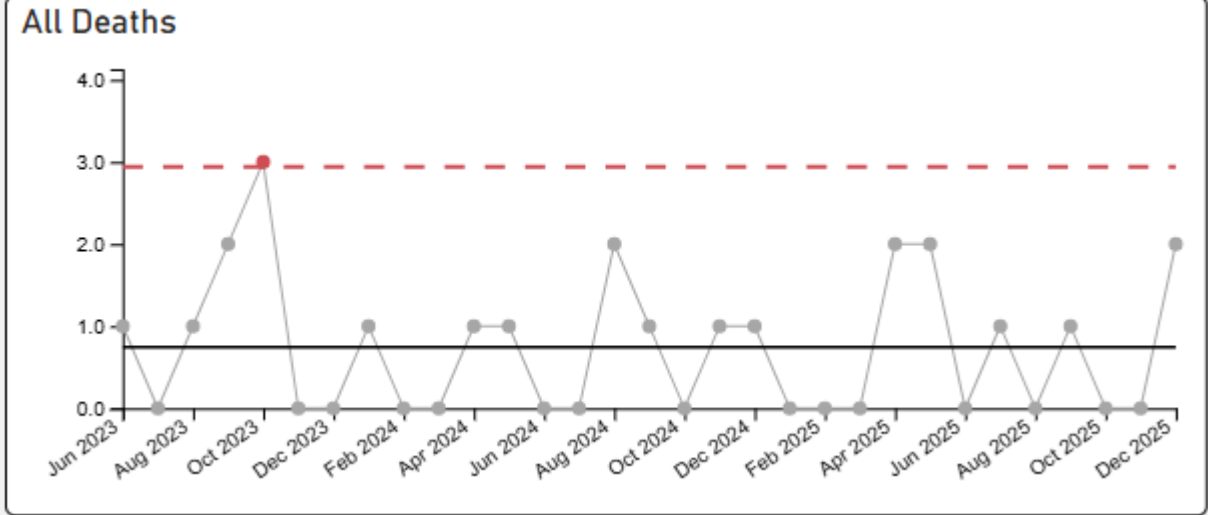


Perinatal Mortality - Stillbirths



There have been 11 stillbirths during this period, all are included in the MBRRACE reporting data. One case did not receive any antenatal care within Swansea Bay; one was an unknown pregnancy that delivered pre-hospital with maternity services involved postnatally to provide care and support.

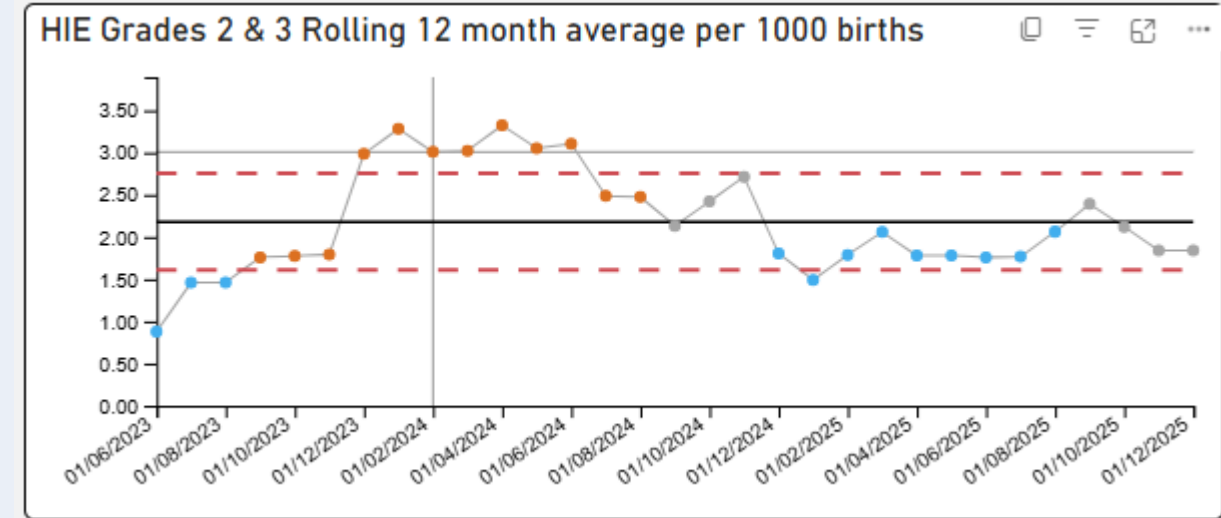
Perinatal Mortality - Neonatal Deaths



There have been no deaths reported since August 2025. This is lower than what has been seen in recent years for SBUHB. December data required to make a final assessment.

There have been seven neonatal deaths between January 2025 and November 2025 and of these cases only five are reportable to MBRRACE as two were over 28 days of life. Of these five, only two will be represented in the MBRRACE report as deaths <24 weeks gestation are not included in the final report for analysis. The three deaths not included in MBRRACE analysis were extremely pre-term (less than 24 weeks) at the limit of viability .

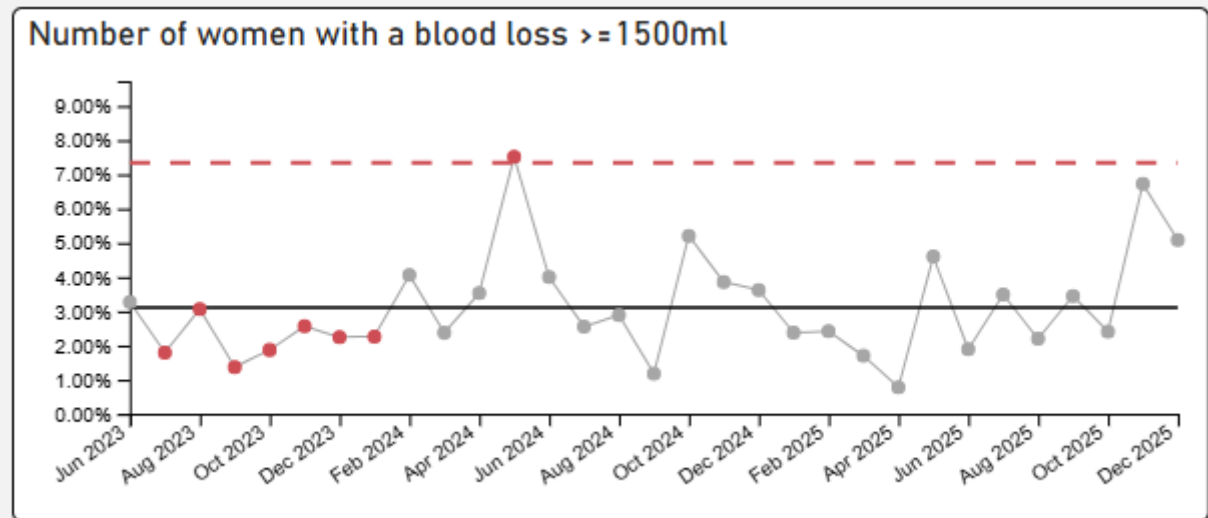
Perinatal Morbidity – HIE Grade 2 and 3



Due to the low number of HIE and births in SBUHB a rolling 12-month HIE incidence reporting is more appropriate. This shows that in November our moderate to severe rolling 12-month HIE rate was 1.84/1000 births. This represents a 45% decrease since its peak in April 2024 of 3.32/1000 births. The 2025 HIE rate up until November was 1.68/1000 births.

There have been five cases of HIE reported in this period. All babies survived to discharge with good outcomes. There is limited data published to allow National benchmarking. Latest published data from National Neonatal Research Database (NNRD) is 4 years out of date (Department of Health, 2021 data). This reports a UK average incidence for Moderate and Severe HIE cases of 1.59/1000 births (1.49-1.70).

Maternal Morbidity – PPH <1.5litres



The NMPA published 2023 data for National benchmarking and reported postpartum haemorrhage incidence as 3.41/1000 births (2.98-3.79). SBUHB rate for postpartum haemorrhage in 2025 was reported as 2.49/1000 births, lower than the National benchmark. This showed a steady reduction from 2024 data, of 3.51/1000 births.

Maternity Triage - BSOTS

Birmingham Symptom Specific Obstetric Triage System (BSOTS) is the Maternity services emergency department to support women experiencing concerns or urgent complications with their pregnancy or postnatal period. The following metrics help the system understand how effective, efficient, timely and safe our triage system is in responding to these.

In October 466 women were reviewed in triage and assessed for ongoing care requirements. Initial trigae within 15 minutes, standard is 90% - rate in October 90.80%.

There were 4 incidents reported due to delay in obtaining medical review following initial assessment and risk stratification for yellow, amber and red pathways, which amounts to a breach of time for review of 6.9%. There were no incidents relating to harm reported as a result. Where breach in time to review is identified, an additional measure which looks at what time review was achieved will be introduced.

Singleton Maternity Triage Team celebrated 1 year since roll out of BSOTS in November 2024. During this period 5955 women attended for review - 4426 women self-referred, 526 were referred by Antenatal Clinic, 588 were referred by other allied health professionals.

Workforce – Maternity Staffing Establishment

Workforce – Neonatal Staffing Establishment

Workforce – Establishments and Vacancies – November 2025

Neonatal Medical Staffing

Grade	Establishment (WTE)	Vacancy
Consultant	11	0
Speciality Registrar	15	0
8A Nurse Practitioner	4	0
8B Nurse Practitioner	2	0

Neonatal Nursing**

Band	Establishment (WTE)	Vacancy (WTE)
7	13.92	2.52
6	32.09	11.25
5	36.88	Over 19.84
4	3.41	0.96
3	2	0
2	2.40	1.6

BAPM Standards Compliance (Nursing)

	Unit Level	% Shifts at BAPM	% bank Nursing	Ave Nurse on Shift	Ave Nurse required on Shift	Additional shifts required for BAPM
Singleton NICU	3	% 100	% 0.16	11.94	3.23	0.0
National Average	3	% 86.81	% 6.92	N/A	N/A	N/A

Neonatal Consultant recruitment for substantive post – appointed on 9th December
Consultant to return from Mat leave January 2026
1 Consultant 0.8 WTE LTS

Workforce – Establishments and Vacancies – November 2025

Obstetric and Gynaecology Medical Staffing- including Gynaecology Oncology

Grade	Establishment (WTE)	Vacancy
Consultant	22	2 (Fixed term gaps)
Speciality Registrar	12	0

Antenatal Clinic

Band	Establishment (WTE)	Vacancy (WTE)
Neath	3.57	0.4
Singleton	7.83	1.19

Vacancies for NPT ANC filled and Singleton ANC being shortlisted



Midwifery – Obstetric Unit

Band	Establishment (WTE)	Vacancy (WTE)
7	12.96	0.86
6	71.43	10.26
5	20.04	>20.04*
4	8.08	1.76
3	5.21	3.32
2	14.28	8.47

Over establishment of Band 5 Midwives. 6 band 5 Midwives due to progress to Band 6 by end of November 2025.

Midwifery – community

Band	Establishment (WTE)	Vacancy (WTE)
Band 7	8	0
Band 6/5	38.16	0
Band 3	6.8	1.8

Perinatal Training Compliance

Workforce – Training Compliance

NLS Neonatal Training	Nov - 24	Dec - 24	Jan - 25	Feb - 25	Mar - 25	Apr - 25	May - 25	June - 25	July - 25	Aug - 25	Sept - 25	Oct - 25	Nov - 25
Nursing	100%	100%	100%	91%	97%	99%	95%	95%	95%	95%	95%	88%	
Consultants	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Juniors - Tier 1	100%	100%	100%	100%	100%	100%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	
Juniors - Tier 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	

MoNET training	Compliance
Consultants	82%
T1 + T2	75%
ANNP	100%
Band 7	80%
Band 6	95%
Band 5	78%
Total	85%



Perinatal workforce Training and Compliance

Statutory and Mandatory Training		Jan - 25	Feb - 25	Mar - 25	Apr - 25	May - 25	June - 25	July - 25	Aug - 25	Sept - 25	Oct - 25	Nov - 25
* Welsh Government Target 85%												
Medical Staff	Obstetric	94%	88%	96%	93%	82%	78%	91%	85.4%	81%	81.0%	85.4%
	Neonatal	91%	91%	87%	86%	86%	87.1%	86%	84.8%	76.3%	80.4%	88.63%
Additional Clinical Services	Maternity	92%	92%	86%	88%	91%	92.9%	94%	93.5%	91.5%	91.5%	93.0%
	Neonatal	82%	82%	94%	94%	86%	100%	100%	100%	97.3%	97.3%	97.3%
Nursing and Midwifery	Maternity	94%	94%	92%	93%	95%	95.5%	96%	96.1%	94.8%	94.8%	95.4%
	Neonatal	94%	94%	92%	85%	94%	95.2%	95%	95.6%	92.4%	92.4%	95.2%



Workforce – Training Compliance

Maternity Training		Oct - 24	Nov - 24	Dec - 24	Jan - 25	Feb - 25	Mar - 25	Apr - 25	May - 25	June - 25	July - 25	Aug - 25	Sept - 25	Oct - 25	Nov - 25
Prompt	Obstetric Medical Staff	100%	100%	100%	100%	98%	95%	95%	95%	95%	96%	100%/92%	100%/92%	95%	95%
	Midwifery	95%	96%	92%	91%	89%	95.5%	92%	92%	95%	99%	99%	97%	95%	91%
	Anaesthetics	100%	100%	100%	100%	98%	100%	98%	98%	98%	100%	91%/100%	100%	100%	98%
	Community PROMPT														96%
Fetal Surveillance		94%	94%	94%	94%	94%	94%	96%	94%	97%	97%	97%	99%	88%	98%
Maternity Workshop															14%
NLS		95%	96%	94%	90%	93%	91%	95%	93%	97%	99%	95%	96%	94%	94%
Gap Grow	Obstetric	100%	97%	83%	*Excep	*Excep	100%	100%	100%	95%	97%	95%	71%	75%	88%
	Midwives	95%	91%	91%	85%	73%	86%	76%	90%	96.2%	96%	94%	88%	90%	89%

Safeguarding	Safeguarding People (F2F)	VAWDASV
Midwives	97.4%	95.28%
Obstetrics	76.47%	82.97%



GAP Grow
Midwives – Targeted intervention. All Midwives emailed to complete before end of month.
Obstetric – Emailed to Clinical Lead – for one to one meetings if not completed by end of month

There have been some challenges within the Neonatal medical workforce due to unavailability, this has been mitigated with flexible working arrangements which has meant there has been no gap in service. A Neonatal Consultant was successfully recruited on the 9th December, with 1 expected return following maternity leave in January.

Obstetric workforce – 2 fixed term gaps for career break and other leave have been covered with no vacancies impacting on services.

Training compliance is improving across the board and individual staff out of compliance have been emailed to complete their mandatory training. Respective line managers follow up is in place.

Care is delivered in safe and appropriate settings supported by innovative digital solutions



- Care is delivered around the patient in the most appropriate setting as close to home as possible supported by digital and data solutions
- Care settings are fit for purpose, appropriately designed and equipped
- Secure, trusted and insightful data and digital platforms empower staff to deliver more and higher quality care and improved patient outcomes and population health
- We have a digitally inclusive culture, where patients, clinicians and non-clinical colleagues work collaboratively to create effective and efficient services and patients are empowered to make informed and meaningful choices about their health and care
- Through where and how they are delivered, services contribute to the environmental, economic, social and cultural well-being of Swansea Bay

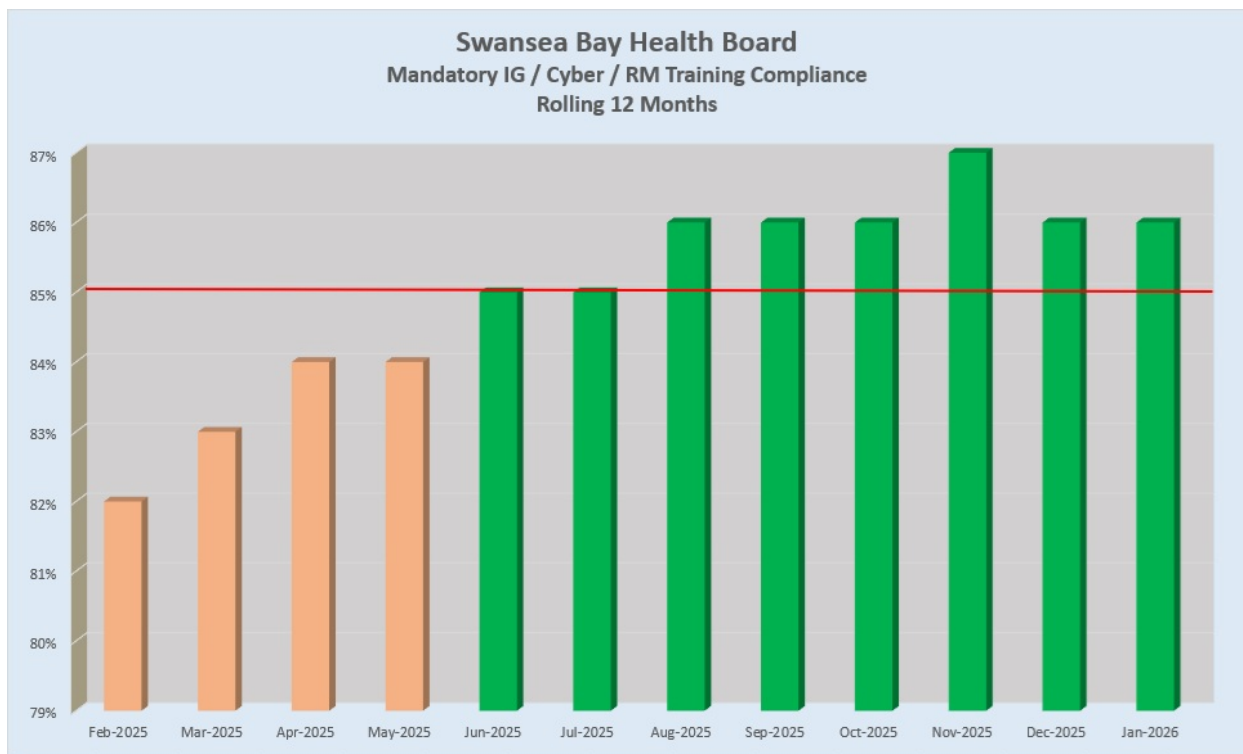
Communication with primary care	Target	Oct 25	Nov 25	Dec 25
% of discharge letters sent to GP	100%	69%	73%	71%
Digital Inclusion	Target			
Total number of citizens that have downloaded the NHS Wales App	TBC	72,651	75,406	77,829 (16% of population)
Total number of outpatients that have downloaded the Swansea Bay Patient Portal	50%	33,949	37,388	40,699 (14% of outpatients)
% of Digital Health Assessment forms Completion Rate	60%	34.32%	27.22%	56.15% (2652 completed forms)
Diagnostic requesting				
% of secondary care pathology tests raised electronically	90%	83%	83.2%	85%
% of primary care pathology tests raised electronically	95%	95%	95%	95%
Supporting safe discharge	Target			
% of patients with a recorded estimated date of discharge	100%	38%	35%	37%

Care is delivered in safe and appropriate settings supported by innovative digital solutions

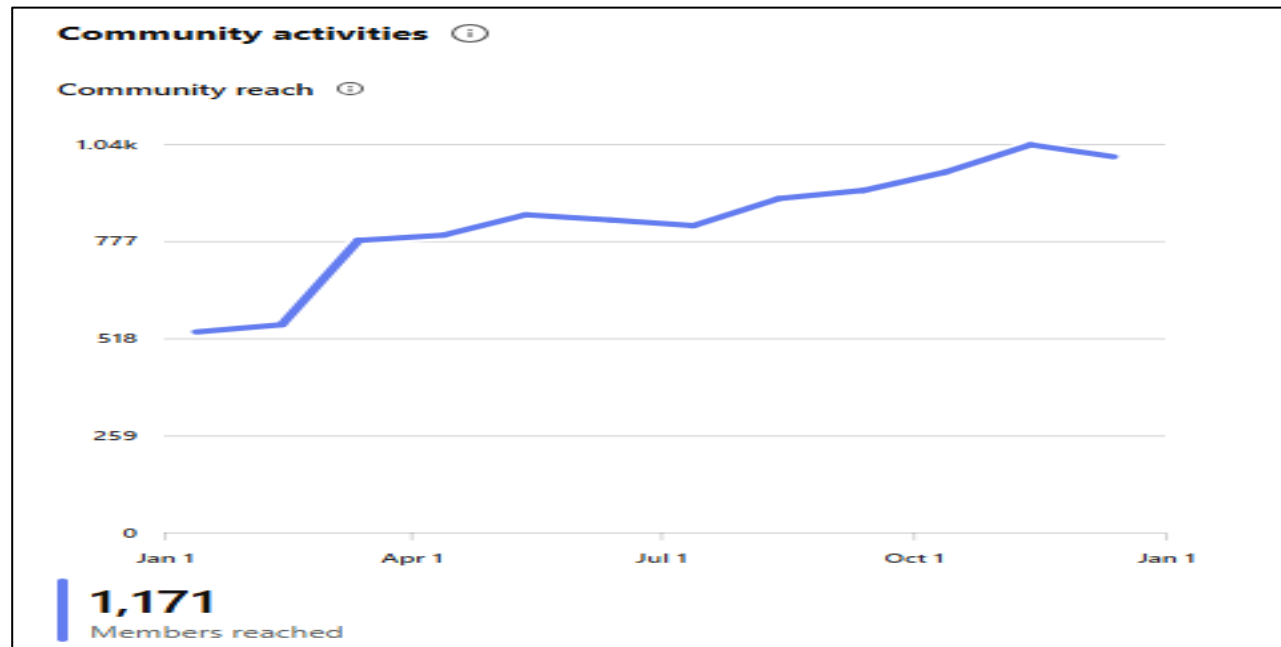


- Care is delivered around the patient in the most appropriate setting as close to home as possible supported by digital and data solutions
- Care settings are fit for purpose, appropriately designed and equipped
- Secure, trusted and insightful data and digital platforms empower staff to deliver more and higher quality care and improved patient outcomes and population health
- We have a digitally inclusive culture, where patients, clinicians and non-clinical colleagues work collaboratively to create effective and efficient services and patients are empowered to make informed and meaningful choices about their health and care
- Through where and how they are delivered, services contribute to the environmental, economic, social and cultural well-being of Swansea Bay

National and Local Digital System availability	Target	Oct 25	Nov 25	Dec 25
National	99.90%	99.96%	99.98%	99.998%
Local	99.90%	99.996%	100%	100%
Data Driven Organisation	Target	Oct 25	Nov 25	Dec 25
No. Staff attended Digital Intelligence Data Literacy Course	10	0	10	0
No. Unique Users Accessed Digital Intelligence Analytical Tools	356	493	480	456



M365 Digital Champions engagement over the previous 12 months



Care is delivered in safe and appropriate settings supported by innovative digital solutions



- Care is delivered around the patient in the most appropriate setting as close to home as possible supported by digital and data solutions
- Care settings are fit for purpose, appropriately designed and equipped
- Secure, trusted and insightful data and digital platforms empower staff to deliver more and higher quality care and improved patient outcomes and population health
- We have a digitally inclusive culture, where patients, clinicians and non-clinical colleagues work collaboratively to create effective and efficient services and patients are empowered to make informed and meaningful choices about their health and care
- Through where and how they are delivered, services contribute to the environmental, economic, social and cultural well-being of Swansea Bay

A summary of the digital projects and their delivery status has been outlined below for Quarter 3:

Title	RAG Status	Rationale for RAG Status
D01 & D04 - Unscheduled and Emergency Care Solution encompassing delivery of the WECDS dataset	Amber	There is a requirement to provide a digital system to span UEC, rationalising the 7 different systems currently deployed across the UEC footprint. The solution must deliver against the WECDS dataset whilst also serving as replacement solution for the national WEDS solution in the MIU. The contract for WEDS in the MIU expires in May 2026. The digital team along with operational colleagues are developing a document to set out the proposed way forward for consideration by Execs at the end of Jan.
D02 - Pathology digital system replacement (LIMS 2.0)	Red	SBUHB Cellular Pathology's go-live was delayed from November due to defect resolution and bulk data upload issues. A revised date of 12 January 2026 is confirmed. Blood Sciences aims for an ambitious Wales-wide go-live by end of Q1, but 217 critical defects pose significant risk. Microbiology is planned for a "big bang" implementation by April 2026, with confidence in meeting this deadline. Blood Bank faces risks as its current LIMS module becomes unsupported from August 2026, and the national migration plan is only now being worked up. To mitigate delays, a backup plan with estimated SBUHB costs of £0.4m per quarter is under review. These delays are recorded on the Health Board risk register (Datix ID 3114, score 16).
D03 - Radiology digital systems replacement (RISP)	Red	SBUHB is scheduled to go live with the Radiology system on 23 February 2026, with strong resource commitment across digital and operational teams. Quarter 3 saw good progress in system configuration and PACS data migration. Risks remain around testing (starting 5 January) and checks of scanner connectivity (21 January–11 February) potentially surfacing critical defects. The project team is closely monitoring the critical path and dependencies with DHCW, Soliton, and Philips. Concerns persist about Philips' capacity to meet milestones; escalations continue, including a request to meet with their Managing Director in early January. Financial risk exists if Philips misses deadlines, with a potential impact of £150k. The Fuji PACS contract has been extended to March 2027 as mitigation to any further delays.

Care is delivered in safe and appropriate settings supported by innovative digital solutions

Title	RAG Status	Rationale for RAG Status
D05 - Patient Portal/NHS App	Green	
D06 - Connecting Care (Rio Implementation across Integrated Teams)	Green	
D07 - Hybrid Mail	Green	
D08 - Signal	Green	
D09 - Welsh Clinical Portal - Hospital Initiated Referrals	Green	
D10 - Digital Health Assessments	Green	
D11 - Welsh Nursing Care Record - Paediatrics	Green	
D12 - Digital Maternity Cymru	Amber	RAG status remains as Amber due to ongoing concerns regarding the limited integrations scheduled for delivery in readiness for go live in March 2026. A clinical risk assessment has been undertaken, which is being escalated nationally. There is also slippage within the configuration workstream, however the team remain committed to working to meet the challenging timescales which were agreed nationally.
D13 - e-Prescribing & Meds Management (shared medicines record)	Amber	There is still a dependency on System C to provide us with development timescales and costs. We are working with System C to review what is required to develop the integration to the SMR, with a view this capability will be on their roadmap for 26/27.
D14 - WPAS and associated services disaggregation	Green	
D15 - Implement Open Eyes (Open ERS/Open EPR)	Amber	Open Eyes continues to well received by the Ophthalmology Service. Welsh Government have written to all organisations to mandate the implementation of the Electronic Referral System solution to support WGOS pathways which is currently being configured nationally by DHCW. Timescales for completion are unavailable. In addition, DHCW are yet to engage with Health Boards to agree a rollout schedule.
D16 - Welsh Intensive Care Information System - Implementation	Green	
D17 - Expand Electronic Test Requesting to cardiology	Amber	Timescales elongated for a number of integrations due to: - Awaiting supplier quote for Development (SpaceLabs) - Timelines extended for all cardiology integrations - New API DHCW Process to undertake
D18 - Systemic Anti-Cancer Therapy (SACT)	Green	Contract extended for 3 years. New procurement process for replacement system being planned
D19 - In-Touch - Go Live with 'In Touch' in Singleton Hospital	Green	

Care is delivered in safe and appropriate settings supported by innovative digital solutions

Title	RAG Status	Rationale for RAG Status
D20 - Millcare System in Sexual Health	Green	
D21 - WPAS Roll out across Mental Health, Learning Disabilities and Primary Care and Therapies	Green	
D22- Cyber Secure Back Ups	Green	
D23 - NPT wireless equipment replacement	Amber	Prioritisation of another Delivery Action with support ending soon (D29 - Call Manager Upgrade to Cloud Voice)
D24 - Laptop, PC, iPad and Printer Replacement	Green	
D25 - Additional Server Equipment including Storage	Green	
D26 - Imprivata Rollout	Green	
D27 - Implement New Core Network at Morriston & Singleton	Amber	
D28 - Windows 10 Removal	Green	
D29 - Call Manager Upgrade to Cloud Voice	Amber	The implementation had stalled in Q3 due to the lack response from a third-party supplier (Call Recording Supplier). Work now continues with the migration partner and the migration is now due to commence in January 2026.
D31 - Creation of a measures to be visualised in Dashboard pulling data from various systems	Green	
D32- Re-banding of Coding Staff and Development of Auto-coding Software	Green	
D33 - Data Literacy and Value	Green	
D34 - National Data Resource (NDR)	Green	
D35- Health Records Centralisation	Green	
D36 - Digital Cellular Pathology	Amber	Publication of national Invitation to Tender delayed as not all Health Boards have yet agreed a Business Case.
D37 - eTriage	Amber	This is on hold as the requirements to integrate with WEDS (Symphony) did not make the investment worthwhile, due to the Symphony contract expiring August 2026. SBUHB will continue to engage with DHCW to inform the integration requirements for the UEC App.

The health board is a great place to work where staff feel valued and work together towards a common goal

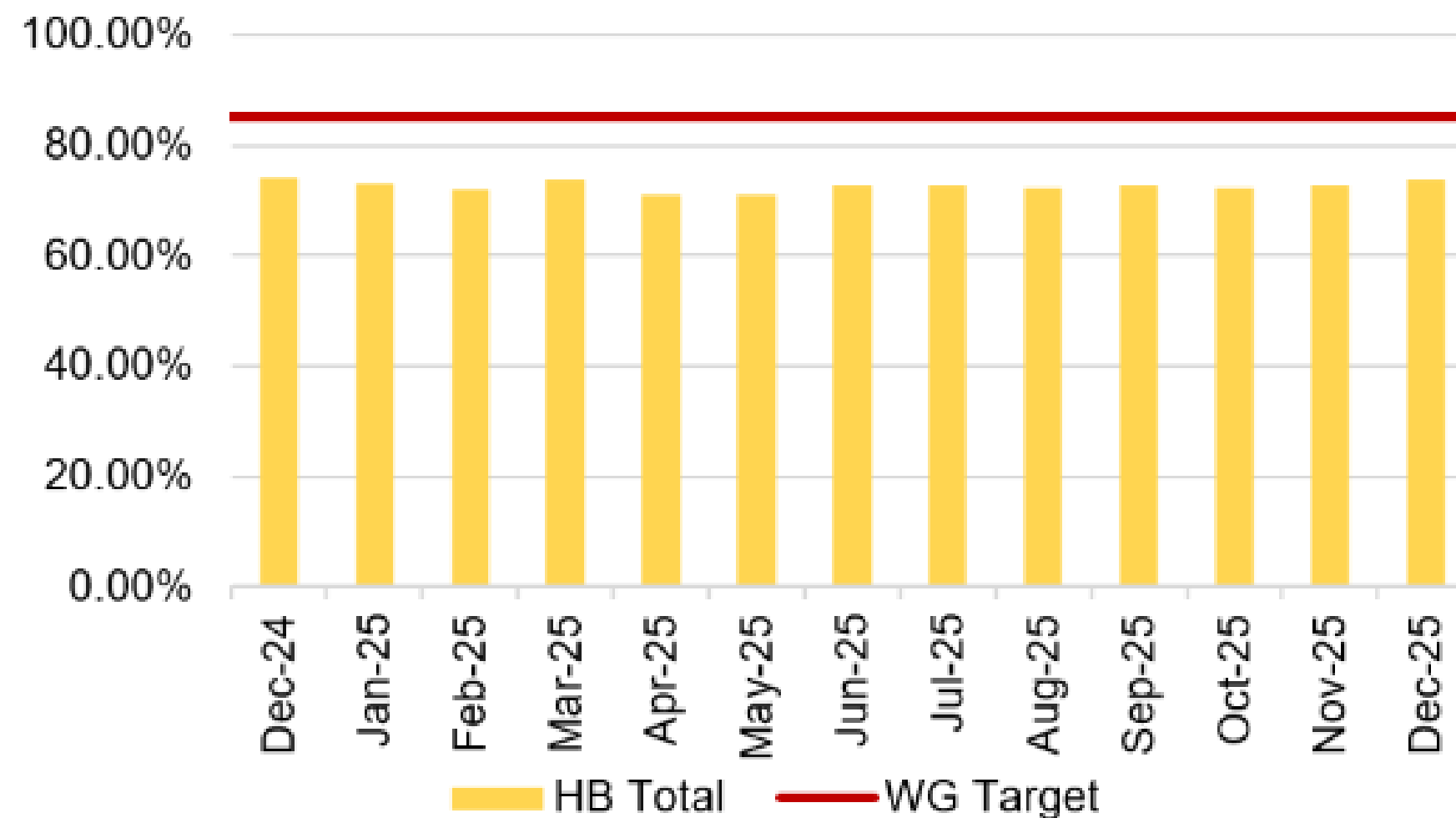


- Our Workforce is engaged, motivated and healthy; they feel valued, fairly-rewarded and supported
- The Health Board is recognised as an employer of choice
- We have a well-planned workforce with the right number of skilled people working on the right things

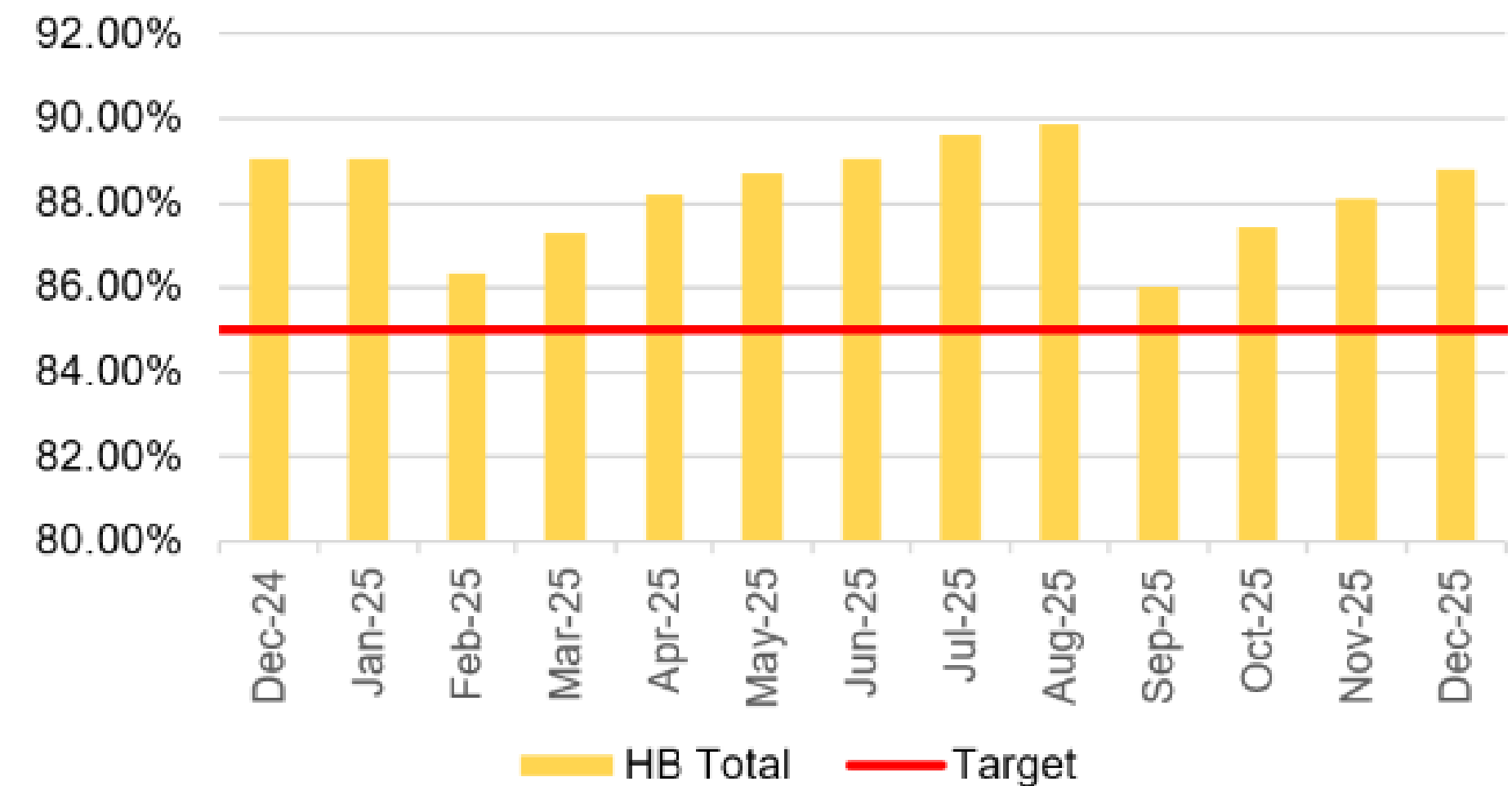
- People feel ready for our digital future
- People are supported to develop the skills and capabilities they need
- People role model collective and compassionate leadership and live our values
- We are diverse and inclusive, ensuring all voices are heard



% of staff who have had a PADR in previous 12 months

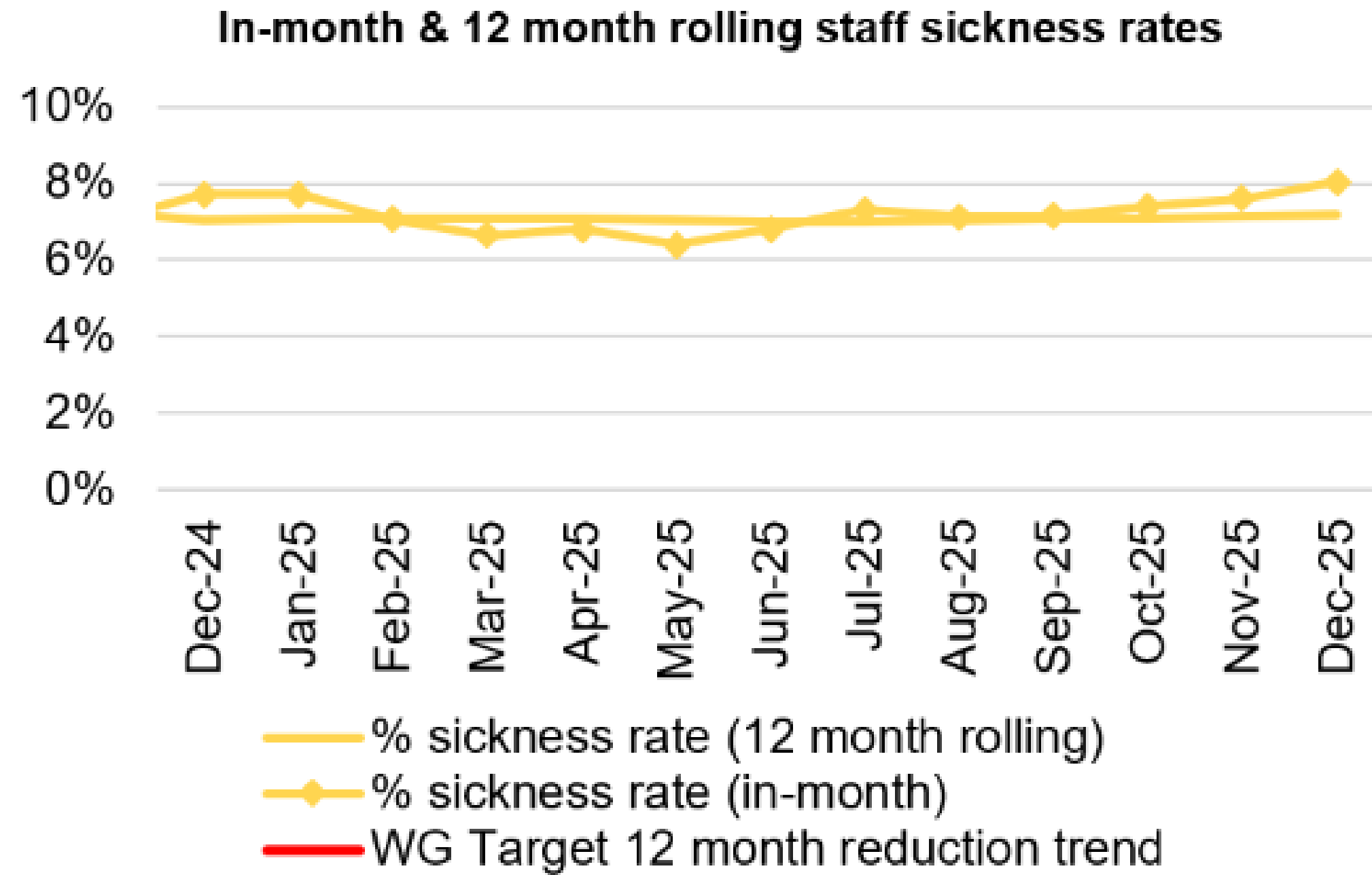


% of staff who have completed all statutory & mandatory training modules



Actions/Updates:

- Performance against the performance and development review compliance has improved slightly in December 2025 to 73.73% from 72.79% in November 2025. Performance is currently below the Welsh Government target of 85%
- Compliance with the 85% Welsh Government target has been maintained over the last year with regards to staff completing mandatory training. Performance has improved slightly to 88.79% in December 2025 from 88.10% in November 2025.



November 2025		
Reason	FTE Days Lost	%
Anxiety/Stress/Depression/Other psychiatric illnesses	12,168.16	37.7%
Cold, Cough, Flu - Influenza	4,105.96	12.7%
Other musculoskeletal problems	3,031.99	9.4%
Gastrointestinal problems	2,078.51	6.4%
Other known causes - not elsewhere classified	1,649.89	5.1%

Actions/Updates:

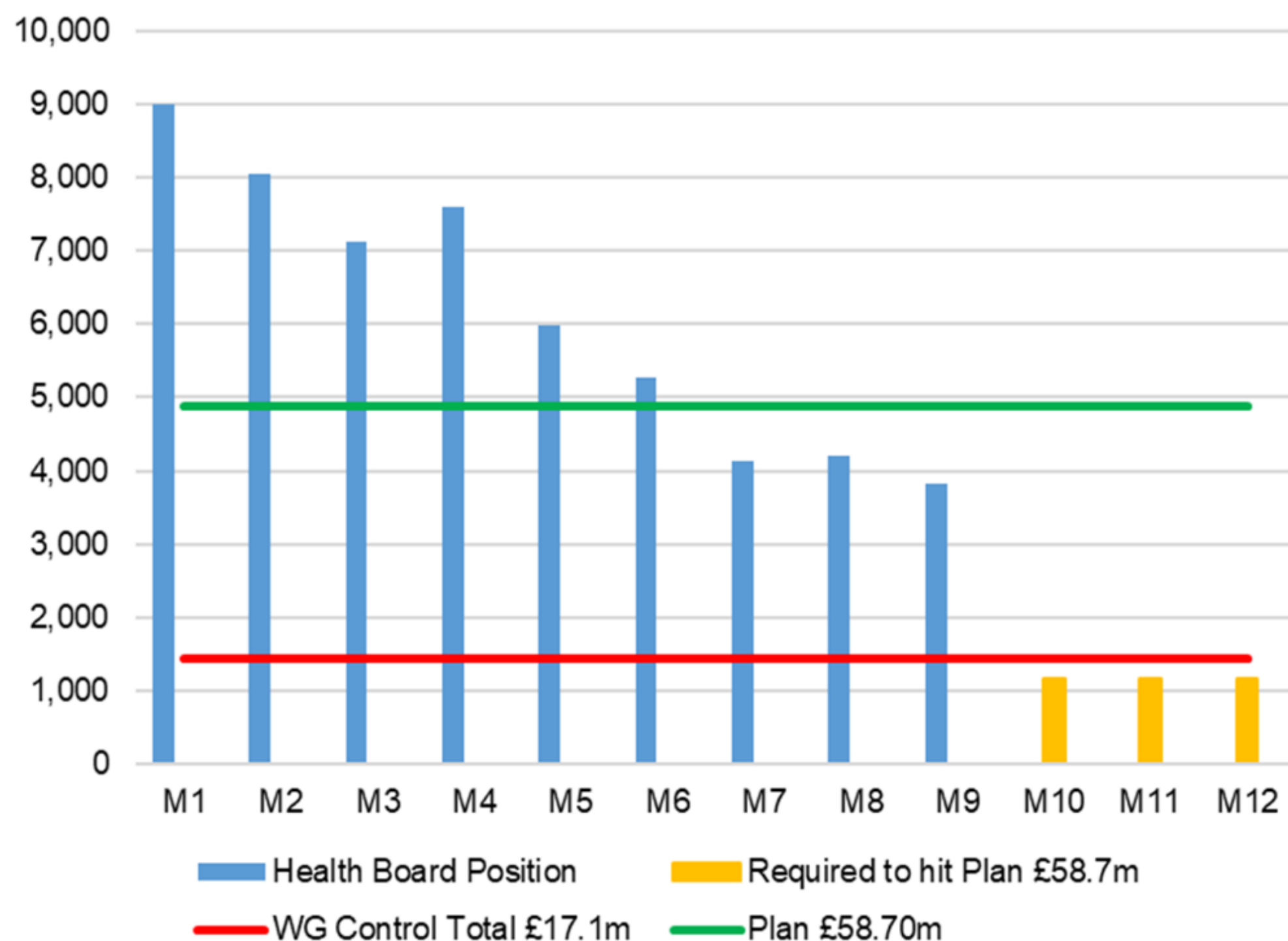
- The in-month workforce sickness rates have increased slightly in December 2025 to 8.04% from 7.60% in November 2025
- The 12-month rolling rate also increased slightly in December 2025, reporting 7.17% compared to 7.13% in November 2025.
- Anxiety/Stress/Depression/Other psychiatric illnesses has remained the top reason for sickness absence over the last year
- Detailed pieces of work are being undertaken within the service groups to address large areas of sickness with workforce colleagues

The health board is a resilient, financially sustainable and responsible organisation



- The health board is financially balanced and able to invest in service transformation and change
- Decisions are made balancing short-term improvements and long-term impacts
- Resources are used efficiently and proportionately, reducing waste and variation
- The environmental impact of health care delivery in Swansea Bay is minimised
- The health board invests in and works with others locally and responsibly, using our assets to positively contribute to the community
- Citizen stakeholders are meaningfully involved and engaged in decision making
- The health board has the capacity to effectively plan for and respond to incident and emergencies

Financial Performance 2025/26



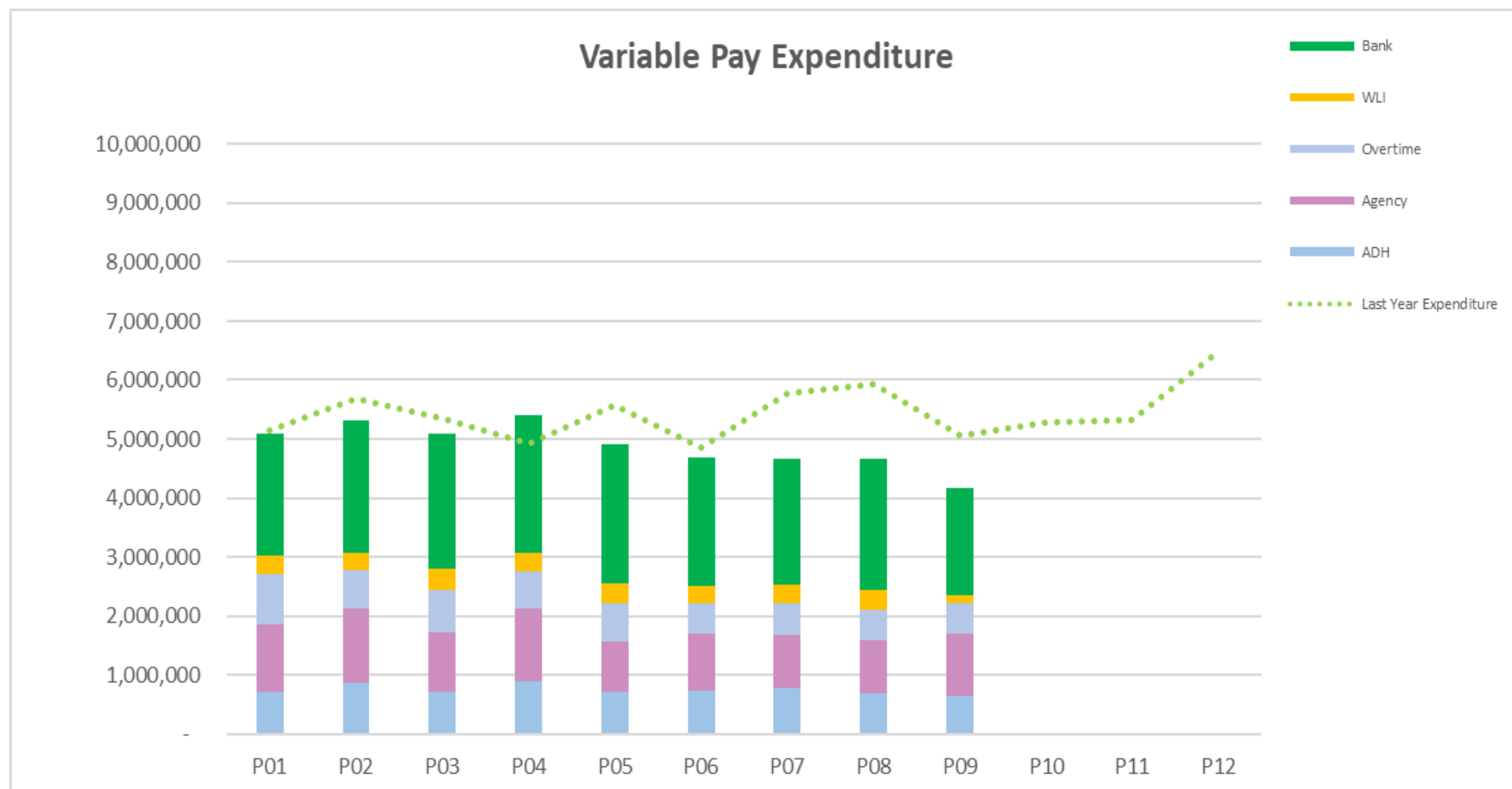
Revenue Financial Position

The Plan submitted at the end of March, which has not been approved reported a £58.7m deficit with a requirement to deliver £55.4m of savings. The Control Total for the Health Board set by Welsh Government remains £17.1m.

In Month 09 there is an in-month overspend of £3.8m which is £1.1m below the planned deficit of £4.9m for the month.

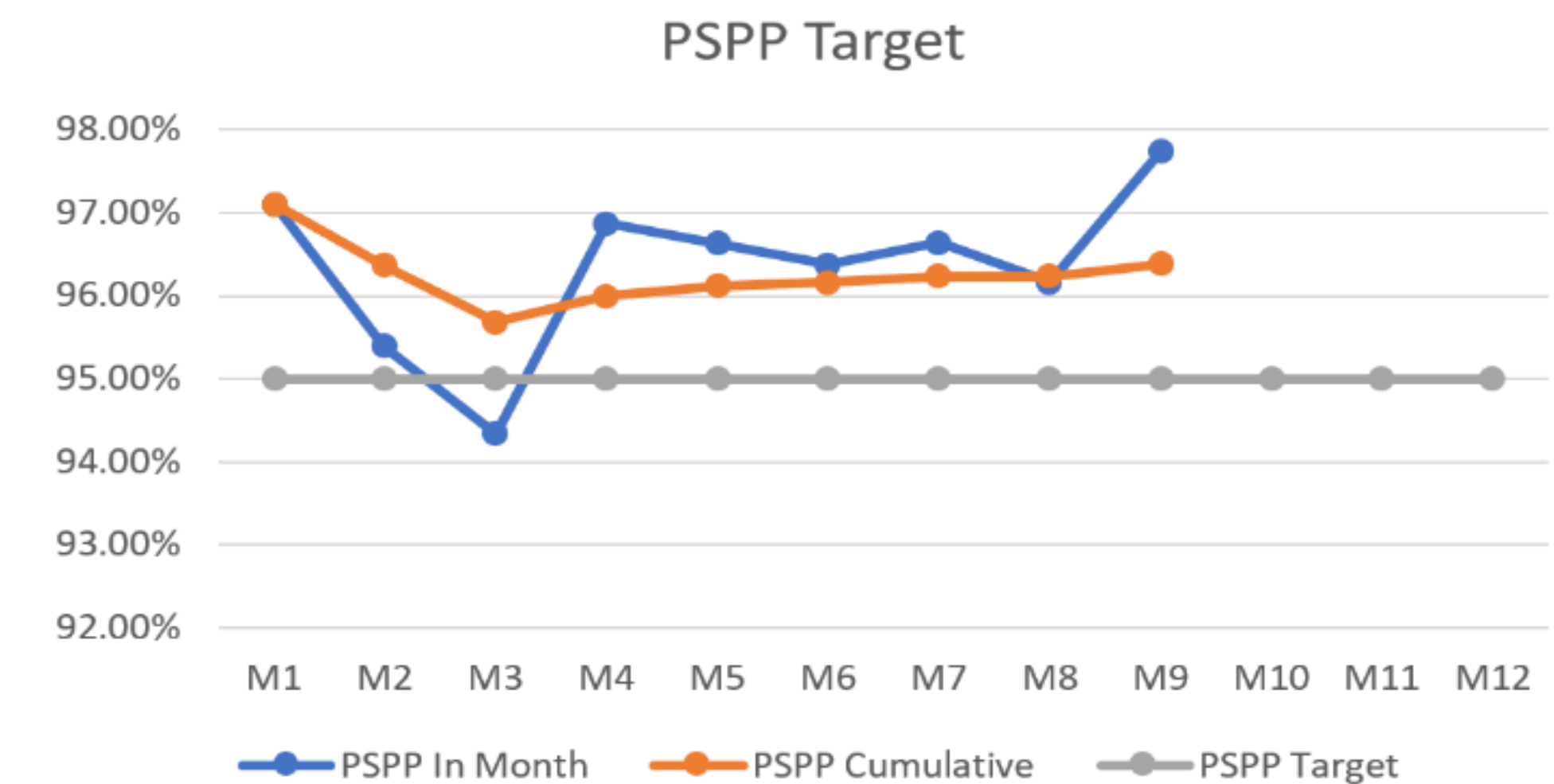
The YTD overspend is £55.2m. This is £11.2m above the planned deficit of £44m.

The health board is a resilient, financially sustainable and responsible organisation



Workforce Spend

- The pay budgets are underspent by £1.1m in Month
- Variable pay is £0.904m lower in December 2025 (£4.161m vs £5.065m) when compared to the same period last year.
- The biggest spends are attributable to ADH, Bank and Agency which make up 84% of the total variable pay spend.

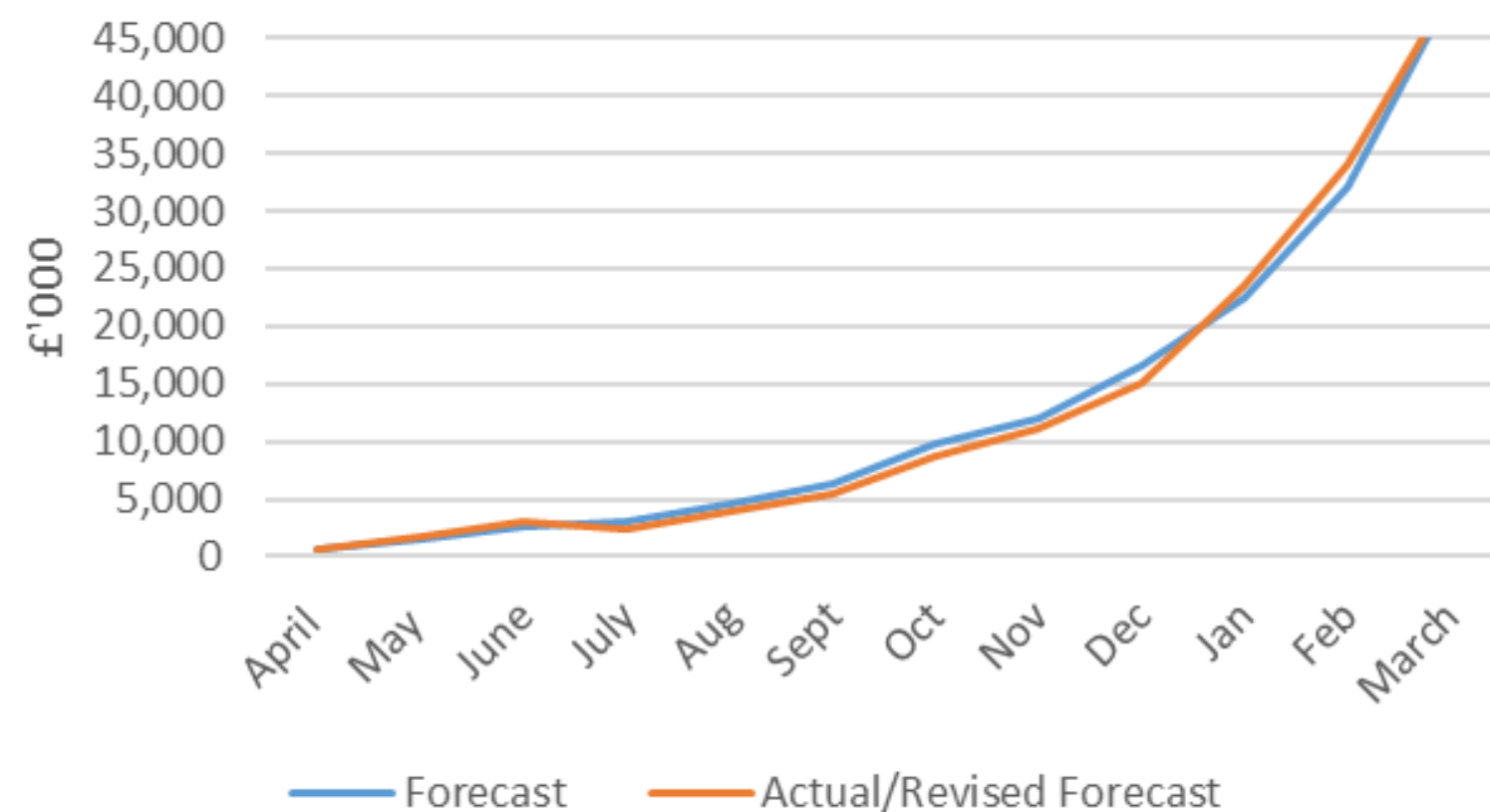


Percentage of non-NHS invoices paid within 30 days of receipt of goods or valid invoice

- PSPP was achieved in month at 97.74% vs a target of 95%. (Cumulatively we remain above the target at 96.38%).
- There still remains issues with delays in receipting of invoices which is affecting the achievement of PSPP.

The health board is a resilient, financially sustainable and responsible organisation

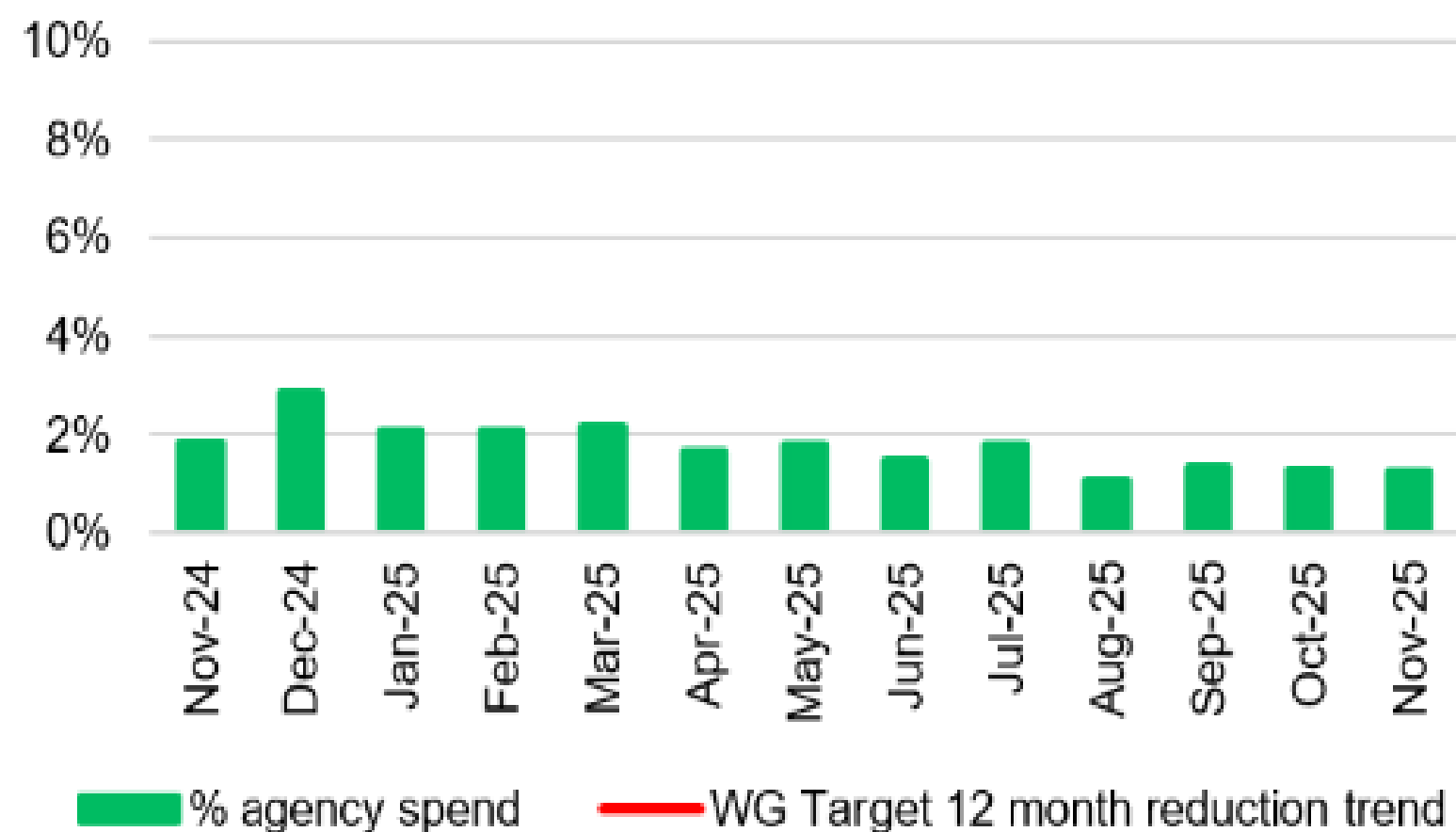
Capital - Cumulative Performance to Plan



Capital Financial Position

- The forecast outturn capital position for 2025/26 is an overspend of £0.140m. Allocations are anticipated from Welsh Government which will balance this position.
- Any All Wales Capital schemes where a high/medium risk is reported are closely monitored and discussed at the Capital Review progress meetings with Welsh Government.

Agency spend as a % of the total pay bill



Agency spend as a % of the total pay bill

- Agency spend as a total percentage of the total play bill has decreased in November 2025 to 1.24% from 1.25% in October 2025.

Section 3: Service Specific Updates

Neurodevelopmental Disorders Service

Improvement actions

- Increased sessional commitment of Specialist Grade, General Paediatrics from 4 sessions to 6 sessions into the ND Service WEF beginning of December 2025. Clinician has completed the CPD accredited ADHD course for Professionals facilitated by Sheffield Children’s NHS Foundation Trust, in partnership with the British Academy of Childhood Disability (BACD); they are now continuing with their in-house training with our SB UHB ND team.
- Audit of ADHD pathway underway to identify further efficiencies; time allocated for Specialist Grade to liaise with ADHD Clinicians in neighbouring UHBs to share best practice and prudent working practices.
- Insourcing process - tender exercise concluded. Regrettably no contract was able to be awarded following tender evaluation. Permission granted to pursue opportunities to reduce the overall numbers of CYP waiting >104 weeks with procurement, further update awaited.

Number of referrals received

	ADHD	ASD	Dual Diagnosis	Total
Year				
2018	500	654		1154
2019	384	638		1022
2020	278	541	46	865
2021	275	502	111	888
2022	288	675	188	1151
2023	272	529	245	1046
2024	279	425	242	946
2025	341	398	241	980

Performance

- EOM December 2025 Waiting List Overview bottom right.
- Final three months of 2025 saw an increased number of referrals. The number of referrals received by the Service during 2025, when compared with 2024, (top right) were slightly higher overall.
- Clinical capacity impacted by absence (1.5 wte) for the period reported. One member of the team has recently returned to work, currently on phased return.

December 2025 EOM Waiting List

Weeks Wait Group	ADHD	ASD	Dual Diagnosis	ADHD/ASD	Total
<=11 weeks	103	102		105	310
12-17 weeks	31	44		25	100
18-25 weeks	39	36		18	93
26-35 weeks	51	69		25	145
36-51 weeks	56	86		29	171
>51 weeks	183	188		229	600
Total	463	525		431	1419



Meeting Date	27 January 2026	Agenda Item		
Report Title	Theatre Utilisation			
Report Author	Rhodri Davies, Associate Service Group Director, Surgery Sam Jenkins, Directorate Manager, Surgical Specialties			
Report Sponsor	Deb Lewis, Chief Operating Officer			
Presented by	Rhodri Davies, Associate Service Group Director, Surgery			
Freedom of Information	Open			
Purpose of the Report	The purpose of this report is to provide deep dive information on Theatre Utilisation across the Health Board, highlighting Neath Port Talbot Hospital (NPTH) and Singleton performance, with a particular focus on Ophthalmology.			
Key Issues	• The ministerial target of 85% for theatre utilisation is a key performance area for the Health Board • Whilst improvements have been made in some surgical specialties, others are underutilising their theatre capacity • Morriston is achieving the 85% target on average; however, services at Singleton and NPTH theatre suites are not. • To address the utilisation performance at Singleton and NPT Hospitals, there is improvement work ongoing. This paper sets out some examples of the work underway to improve performance.			
Specific Action Required (please choose one only)	Information	Discussion	Assurance	Approval
	☒	☐	☒	☐
Recommendations	Members are asked to: • ACKNOWLEDGE- Theatres utilisation update and the actions taken to improve the overall performance in a sustainable and consistent manner.			



Theatre Utilisation

1. INTRODUCTION

This report provides deep dive information on Theatre Utilisation across the Health Board (HB) with a particular focus on Neath Port Talbot Hospital (NPTH) and Ophthalmology, given the performance in those areas, setting out the improvement work either underway or planned to commence.

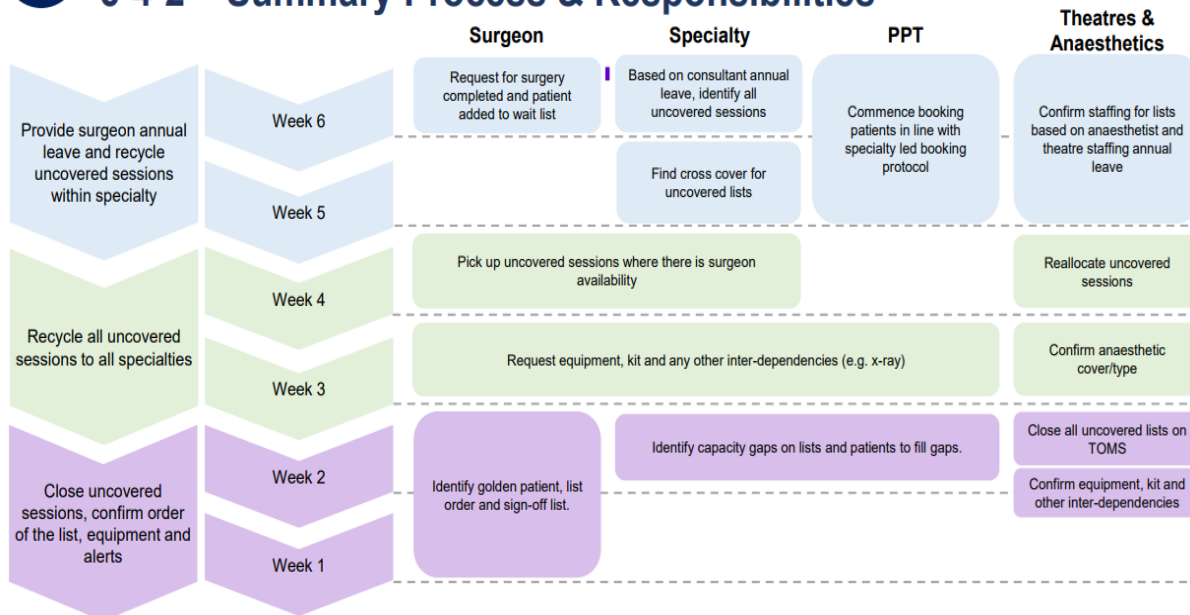
2. BACKGROUND

Operating theatres represent one of the most resource-intensive areas of the NHS, where even marginal gains in utilisation can significantly improve patient outcomes, reduce waiting lists and enhance financial stability. SBUHB operates a large and complex theatre estate across Morriston, Singleton, and Neath Port Talbot Hospitals, comprising 37 theatres in total. Ongoing demands for elective care recovery is such that the HB has prioritised theatre performance within its operational and strategic plans as it strives for improved efficiency and productivity within core capacity.

The Performance and Finance Committee (PFC) will be aware of the Ministerial target for Health Boards to achieve **85% theatre utilisation**, based on the **GIRFT (Getting It Right First Time)** recommendations for efficient theatre productivity. A nationally recognised improvement process for theatre utilisation is “**6-4-2**”. This process is illustrated below:



6-4-2 – Summary Process & Responsibilities



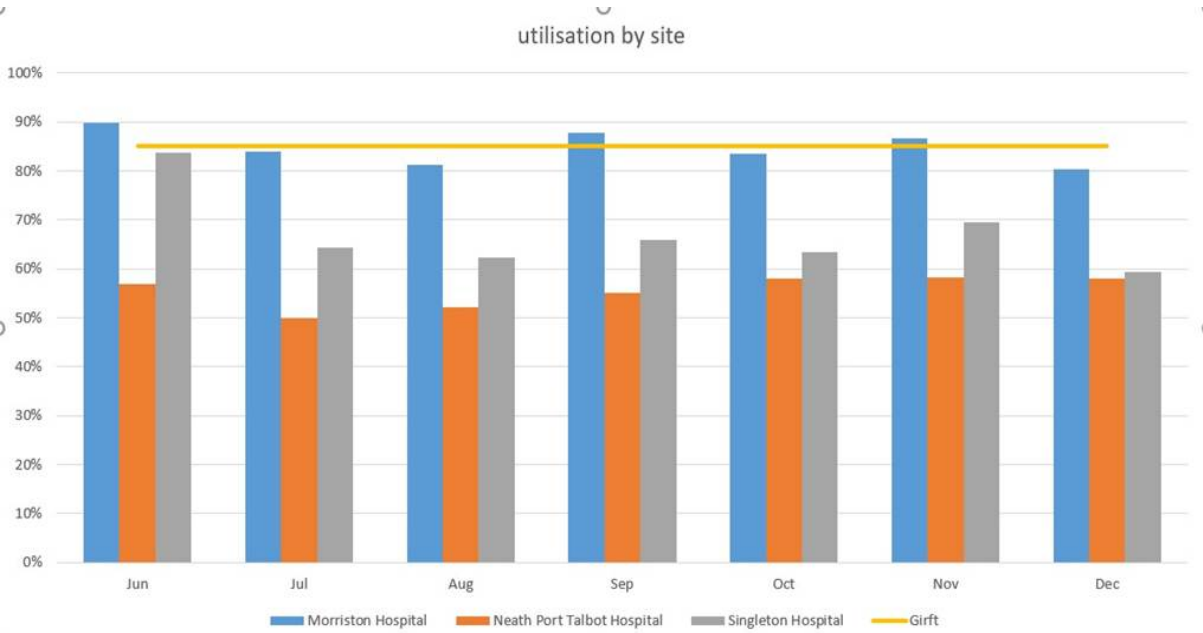
An Internal Audit review of Theatre Utilisation was undertaken in July 2025 and concluded in November 2025. The audit provided **reasonable assurance** to the Board and highlighted the following strengths:

- Robust governance arrangements are in place to support the efficient use of theatre resources.
- Key performance indicators are established to monitor theatre efficiency and productivity, particularly utilisation, with actions identified to drive improvement where needed.
- A clear and appropriate reporting framework exists for theatre utilisation.
- Processes are in place to ensure the quality and accuracy of data used for monitoring performance.

However, the report provided **limited assurance** regarding the availability of approved policies and procedures to support the effective use of theatre resources. In particular, it noted gaps in clearly defined roles and responsibilities accessible to staff.

3. Theatre Utilisation Performance

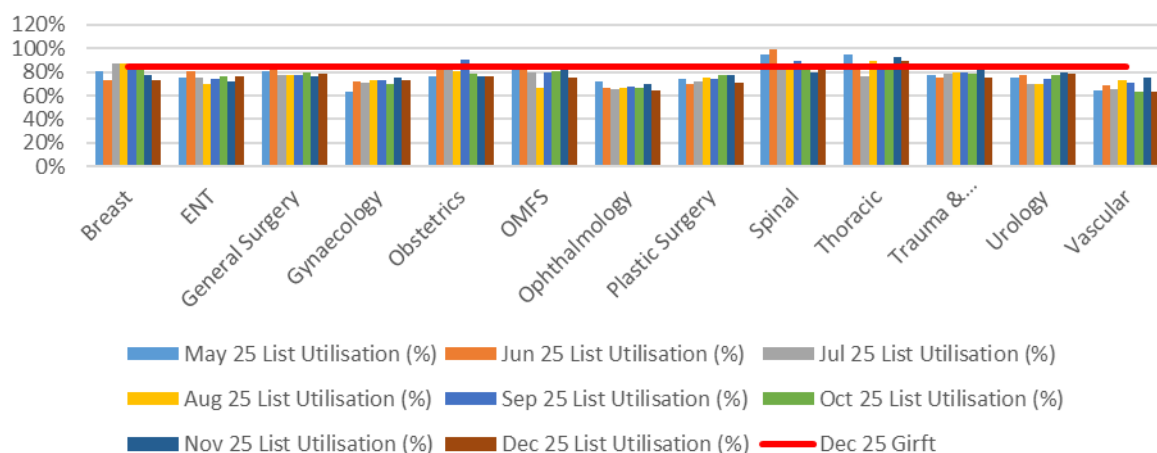
Graph 1 below highlights the utilisation by hospital theatre suite. It highlights that Morriston utilisation is consistently near the Ministerial target of 85%. However, NPT and Singleton Hospital suites are underperforming consistently against the target. Given that the NPTH site is largely protected from acute and emergency site pressures, unlike Morriston, this is a concerning picture.



Graph 1- Utilisation by site

Graph 2 below shows theatre utilisation broken down by the surgical specialties that use theatres the most across all sites. The surgical specialties with the lowest utilisation are Vascular (63.0%), Ophthalmology (64.0%) and Plastic Surgery (71.0%)

HB wide utilisation past 6 months

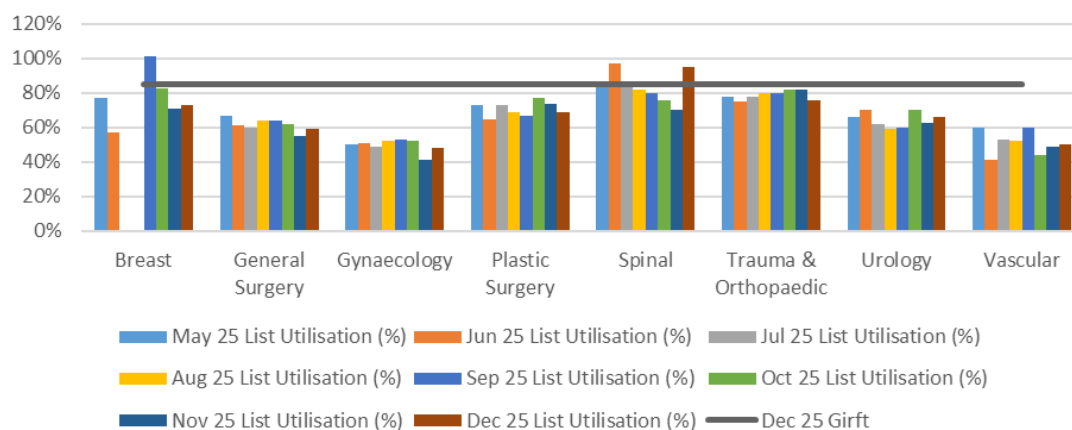


Graph 2- HB wide utilisation over last 6 months

3.1 Focus on NPTH

Given the poor performance against theatre utilisation in NPTH, Graph 3 below shows the following specialties that are utilising the lists in NPTH on a regular basis. Trauma, Orthopaedics and Spinal generally are achieving close to the 85% target at NPTH but other specialties are struggling such as Gynaecology, Plastics and Vascular.

NPTH utilisation past 6 months



Graph 3- Specialties that are utilising the lists in NPTH



Table 1 below highlights the performance in percentages per surgical specialty.

Specialty	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
▲												
Breast	73%	83%	54%	77%	57%			101%	83%	71%	73%	65%
General Surgery	40%	36%	70%	67%	61%	60%	64%	64%	62%	55%	59%	63%
Gynaecology	42%	51%	42%	50%	51%	49%	52%	53%	52%	41%	48%	62%
Plastic Surgery	73%	77%	66%	73%	65%	73%	69%	67%	77%	74%	69%	45%
Spinal	84%	82%	87%	86%	97%	85%	82%	80%	76%	70%	95%	83%
Trauma & Orthopaedic	81%	84%	78%	78%	75%	78%	80%	80%	82%	82%	76%	85%
Urology	76%	77%	73%	66%	70%	62%	59%	60%	70%	63%	66%	51%
Vascular	42%	44%	66%	60%	41%	53%	52%	60%	44%	49%	50%	55%

Table 1 – utilisation rates by specialty from Feb 25- Jan 26 (noting Jan 26 2wks data only) for NPT

The table illustrates an improving picture in T&O and Spinal, which is a result of significant work carried out in the areas with the implementation of a weekly scheduling approach. The meeting adopts an MDT approach to list scrutiny; where surgeons, theatre staff, anaesthetics and management team go through the previous week's activity in detail as well as the forward look into the next 2 weeks of activity. This approach has seen list utilisation improve across those surgical areas and is now being taken forward in other specialties.

3.2 Focus on Singleton

Singleton performance has improved over the last year; however, some specialties are under-performing in a way that then impacts on the overall performance. Table 2 below highlights the key specialties utilising theatres on site and their individual performance.

Specialty	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
▲												
Breast	93%	88%	69%	79%	88%	92%	89%	83%	86%	80%	82%	84%
ENT	62%	76%	63%	77%	76%	80%	69%	79%	81%	77%	76%	59%
General Surgery	85%	80%	85%	84%	82%	79%	74%	81%	78%	76%	79%	73%
Gynaecology	86%	79%	58%	63%	77%	82%	80%	78%	75%	84%	77%	69%
Obstetrics	85%	87%	75%	76%	84%	83%	81%	90%	79%	76%	76%	74%
OMFS	80%	76%	76%	93%	63%	72%	80%	69%	51%	72%	70%	
Ophthalmology	67%	69%	69%	72%	68%	67%	67%	68%	67%	69%	64%	73%
Plastic Surgery	72%	71%	68%	84%	78%	69%	76%	79%	81%	73%	78%	79%
Trauma & Orthopaedic			102%			93%	86%	102%	63%	123%	98%	
Vascular	58%	76%	73%									

Table 2 - utilisation rates by specialty from Feb 25- Jan 26 (noting Jan 26 2wks data only) for Singleton

The Theatres Operational Group has a scrutiny process in place, which aims to identify lower performing specialties to support them to improve performance. Given the list utilisation figures for Ophthalmology, there has been some additional scrutiny as well as action taken by the service recently.

3.3 Focus on Ophthalmology

Ophthalmology Services in Swansea Bay University Health Board are based in Singleton Hospital and operate from Theatre 6 in Main Theatres and in Theatre A, B & C in Singleton Day Surgery Unit.

A Need for Improvement

The service faced challenges with underutilisation of theatre time, particularly due to late starts/early finishes and variability in list completion. Looking at the data on the Theatre Dashboard, Theatre Utilisation data revealed that Ophthalmology sessions often finished earlier than scheduled, resulting in lost capacity. This was compounded by inconsistent case allocation and operational delays. The Senior Team in Ophthalmology recognised that without optimising current resources, requests for additional theatre time would lack justification.

Therefore, the improvement initiative aimed to:

- Increase the number of cases per list.
- Minimise downtime between cases.
- Standardise processes across surgeons.

Therefore, it was agreed that a 'back to basics' audit was required to better understand how theatres were operating. In order to achieve this the service devised two key strategies:

1. Data Driven Audit
2. Observational Insights

Data Driven Audit

The Theatre Staff in Day Surgery Unit (DSU) agreed to undertake an audit (appendix 1) in real time during every theatre session across DSU in December. The team completed the below proforma for each list to note the following key metrics:

1. Planned Start Time vs Actual Start Time
2. Planned Finish Time vs Actual Finish Time
3. Planned Number of Cases vs Actual Number of Cases

This information has been key in enabling the service to better understand patterns, trends and themes across the operating lists in DSU.

Observational Insights

Operational leaders attended theatre sessions to observe real-time workflows, uncovering practical barriers such as delays in patient transfer and equipment readiness.

A standout observation has been the clinical engagement from consultant surgeons and theatre teams to improve. Surgeons were actively involved in reviewing utilisation data and improvement plans, ensuring buy-in and transparency. Furthermore, Theatre Matrons actively encouraged the operational leaders to attend and were forthcoming with advice to further improve efficiencies and utilisation.

Outcomes and Next Steps

The Ophthalmology Senior Team have met to discuss the early findings of the audit and have devised a robust action plan to implement and secure improvement.

A common theme identified with the audit has been late starts across both DSU & Main Theatres. A late start is defined as a list delayed by more than 15 minutes. This is supported by the data on the Theatre Dashboard, which you can see below:

Specialty	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Ophthalmology	49%	50%	52%	55%	52%	70%	53%	54%	61%

Consequently, this will be the focus for the coming weeks to ensure all lists start promptly. There is the possibility that this may impact theatre early finishes initially but it is a priority for the service to ensure lists start on time. The next step will then be to ensure once all lists are starting on time, the booking Team will ensure all lists are booked to full capacity.

Over time, the audit and resulting actions are expected to lead to:

- **More cases per theatre list**, bringing activity in line with national benchmarks.
- **Fewer early finishes**, helping to maximise theatre time and overall productivity.



- **A stronger partnership between clinical and operational teams,** supporting a culture of continuous improvement.

To note, during the month of January there is on-going theatre observations by the Directorate Manager.

Job Planning Event

The information gathered from the observations and audit will inform conversations and objective settings in the next round of consultant job planning. Ophthalmology Services, with the support of Medical HR, are planning to job plan the entire department in one day on 28th January. This will ensure that the cycle of job plans is aligned with the demand and capacity of the department. This is a pivotal component of improving our use of core capacity moving into the new financial year. Theatre productivity will be at the forefront of these conversations and clear theatre objectives will be set with each consultant.

3.4 Elective Surgery Toolkit

The Theatres and Anaesthetics team have been working with Deloitte colleagues, as part of their focus on financial recovery through improved theatre productivity. As a result, an **elective surgery toolkit** has been developed in conjunction with Deloitte colleagues. This has been designed to address where the HB was unable to give reasonable assurance on clear policies and procedures for theatre utilisation in the internal audit assessment (as referenced previously).

The toolkit was launched in **Theatres Operational Group on 6th January 2026**, with implementation from **12th January**.

The aim of the toolkit is to provide clinicians and service managers with a reference guide to allow effective use of theatre capacity for their services. It is essentially pulling all the various processes and resources together that have been developed over the last year into one place and ensuring roles and responsibilities are clearly defined. It also details changes being made to meeting structures and the expectations on everyone for smarter more efficient theatre scheduling.



4. GOVERNANCE AND RISK ISSUES

A number of initiatives have been introduced over the past year to strengthen the scrutiny and management of theatre utilisation. The recent Internal Audit report on Theatre Utilisation recognises this progress. However, further improvement is still required in some surgical specialties. The introduction of the **Elective Surgery Toolkit** in January, along with focused specialty-level work—such as the Ophthalmology example highlighted in this paper—is expected to support continued improvement in theatre utilisation.

A significant risk to the Ophthalmology cataract pathway is the need to secure **additional Pre-Assessment capacity** to match the increased theatre capacity being developed. At present, the service is dependent on **additional Planned Care Funding** to provide the extra Pre-Assessment clinics required.

The service is also exploring opportunities to expand **pre-operative assessment capacity** within the main clinic footprint recently established at Singleton Hospital.

5. FINANCIAL IMPLICATIONS

There are no additional financial implications identified as part of this report. However, it is important to note that significant Welsh Government funding is being spent across the surgical specialties and theatres services to achieve ministerial Referral to Treatment (RTT) targets. Given the financial outlook for NHS Wales next year, the risk of reduced funding will mean services will need to deliver performance but with reduced or no additional funding. As a result, theatre utilisation, aligned to comprehensive job planning, will be of paramount importance to ensure capacity is delivered within core funding.

6. RECOMMENDATION

The Performance and Finance Committee is asked to:

- **ACKNOWLEDGE** the Theatres utilisation update and the actions taken to improve the overall performance in a sustainable and consistent manner.



Governance and Assurance

Link to Enabling Objectives (please choose)	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐

Health and Care Standards

(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☐
	Timely Care	☒
	Individual Care	☐
	Staff and Resources	☐

Quality, Safety and Patient Experience

Improving theatre utilisation will enhance patient experience by increasing the number of operations performed, which will result in reduced waiting lists for surgery

Financial Implications

There are no additional financial implications identified as part of this report. It is important to note that significant Welsh Government funding is being spent across the surgical specialties and theatres services to achieve ministerial RTT targets. Given the financial outlook for NHS Wales next year, the risk of reduced funding will mean services will need to deliver performance but with reduced or no additional funding. As a result, theatre utilisation will be of paramount importance to ensure capacity is delivered within core funding.

Legal Implications (including equality and diversity assessment)

There are no legal implications to consider.

Staffing Implications

To run an effective theatre service requires access to skilled theatre staff, surgeons and anaesthetists along with other key resources along the surgical pathway including referral from primary care, through to the outpatient clinic, Pre-Assessment and admission for surgery.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)



Optimizing theatre capacity across the Health Board will support an improved delivery against waiting time standards, whilst ensuring the effective deployment of resources reducing variation in cost and resources.

Report History	
Appendices	Appendix 1 – theatre audit template



Meeting Date	29 January 2026	Agenda Item	4.4
Name of Meeting	SBUHB Board		
Report Title	Financial Report – Month 9 2025/26		
Report Author	Samantha Moss, Deputy Director of Finance Gemma Pearson, Finance Business Partner Crystal Davies, Principal Finance Manager		
Report Sponsor	Darren Griffiths, Executive Director of Finance and Performance		
Presented by	Darren Griffiths, Executive Director of Finance and Performance		
Freedom of Information	Open		
Purpose of the Report	The report advises the Board of the Health Board on the financial position for Month 9 2025/26 (December 2025) and risks regarding the current forecast revenue year end outturn and the further actions required to address the delivery of the Annual Plan.		
Key Issues	The report invites the Board to note and discuss the detailed revenue analysis of the financial position for Month 9 2025/26 (December 2025). The report includes a summary of the key drivers of the revenue position either at Service level or by expenditure type (i.e. Non-Pay/Pay). Risk will have been considered on the basis of the information provided within the report and the score updated where necessary. The report invites the Board to note the Cash position, key Balance Sheet movements and the Capital position. Whilst the key messages are provided within the main body of the report, further information is provided in the Appendices.		
Specific Action Required <i>(please choose one only)</i>	Information	Discussion	Assurance
	☐	☐	☒
			Approval
			☒



Recommendations	Members are asked to: • ACKNOWLEDGE the 2025/26 Financial Plan, and the Health Board's and Welsh Government's inability to approve it given the planned deficit of £58.7m • CONSIDER and comment upon the Health Board's financial performance for Month 9 2025/26, including cash, capital and balance sheet. • SUPPORT the implementation of the actions to address the savings gap and assessed position to reach the £58.7m plan. • SUPPORT the continued focus on the actions and choices agreed at 16 December 2025 Special Board, reflected in the Public Accountability Meeting and the need to deliver these in full to mitigate risks to the position which have emerged since the Health Board 2025/26 plan was developed in March 2025. • AGREE the development of the further actions set out, should traction not be forthcoming in month 10: - • Further variable pay controls • Implementation of 104 week cohort delivery only (urgent, emergency and cancer care unaffected) • Implementation of revised bed model • Further restriction of non pay spend • DISCUSS the risks to the position at Month 9.

FINANCIAL REPORT – MONTH 9 2025/26

1. INTRODUCTION

The report invites the Board to note the detailed analysis of the Month 9 (November 2025) revenue financial position, along with Cash and Capital.

2. BACKGROUND

The Health Board has two key statutory duties to achieve:

- **To submit an Integrated Medium-Term Plan (IMTP) to secure compliance with breakeven over 3 years.**

2023/24 3-year plan submitted

2024/25 3-year plan submitted

2025/26 3-year plan submitted

The Health Board will fail to meet this in 2025/26 as its plan will not breakeven over 3 years.

- **To achieve financial breakeven over a rolling three-year period, which commenced on 1st April 2023 and will end on 31st March 2026.**

2023/24 Deficit Control Total £17.1m achieved

2024/25 Deficit Control Total £43.7m achieved

2025/26 Deficit Plan £58.7m

The Health Board will fail to achieve this Statutory Duty.

Summary of Performance against Key Financial Targets

Financial KPIs: To ensure that net operating costs do not exceed the revenue resource limit set by Welsh Government	Value £'000
Reported in-month financial position – deficit/(surplus)	3.826
Reported cumulative financial position – deficit/(surplus)	55.193
Capital KPIs: To ensure that costs do not exceed the capital resource limit set by Welsh Government	Value £'000
Reported year to date financial position – deficit/(surplus)	(1.383)
Forecast outturn financial position – deficit/(surplus) (prior to additional allocations)	0.140
PSPP Target: To pay a minimum of 95% of all non NHS creditors within 30 days of receipt of goods or a valid invoice	Value %
Cumulative year to date % of invoices paid within 30 days (by number)	96.4%

3. FINANCIAL PLAN

The Annual Plan submitted to Welsh Government on 31st March 2025 included a financial assessment, as summarised in the table below:

Elements of the Plan		Financial Assessment @ 31st March 2025 £M
Operational Pressure	Financial Assessment ULD	92.5
	Growth/Inflation	33.7
	Net Impact Commissioning	3.1
	Offset WGFunding	(15.2)
Total		114.1
Savings Target		(55.4)
Financial Deficit Plan		58.7

Welsh Government (WG) issued a letter to the Health Board on 6 June 2025 indicating that the planning process has been closed in order to focus on delivery and improvement. WG issued a further letter on 18 August requesting an update on the Annual Financial Plan and actions being taken by the Health Board for submission by 11 September. This document was presented at the Special Board Meeting on the 11 September which provided full details of the actions and milestones to achieve the original £55.4m savings to support the delivery of the original plan submission made in March 2025. Progress against this Plan is detailed in sections below.

Therefore, at Month 9 the forecast for 2025/26 remains as per the original plan submission of £58.7m.

4. FINANCIAL PERFORMANCE

FINANCIAL REPORT REVENUE – MONTH 9.

The Health Board’s assessment on performance against the £58.7m deficit has three components Operational Pressure, Savings Target, and Planned Deficit. Performance against these three elements at Month 9 is summarised in Table 1 below. At Month 9 there was an In-Month deficit of £3.8m, which is £1.0m below the £58.7m planned deficit, with the YTD position reporting a £55.2m deficit, which is £11.2m above £58.7m plan.



Elements of In Month	Quarter 1	Quarter 2	Mth 7	Mth 8	Mth 9	YTD
	£M	£M	£M	£M	£M	£M
- Delegated Budgetary Position	(2.15)	(0.64)	(0.94)	(0.41)	(2.14)	(6.27)
- N/R Opportunities	(0.28)	(1.45)	(0.10)	(0.38)	(0.66)	(2.87)
- Shortfall NI Funding	0.34	1.03	0.34	0.34	0.34	2.40
Total Part 1: Operational Pressures	(2.08)	(1.06)	(0.70)	(0.44)	(2.46)	(6.74)
Saving Target						
- 12th Savings Target	13.85	13.85	4.62	4.62	4.62	41.55
- Less Actual In Month Delivery	(2.29)	(8.59)	(4.69)	(4.87)	(3.22)	(23.65)
Total Part 2= Savings Delivery Impact	11.57	5.26	(0.07)	(0.25)	1.40	17.90
Financial Deficit Plan						
- 12th Deficit Value	14.68	14.68	4.89	4.89	4.89	44.03
Total Part 3= Deficit Plan	14.68	14.68	4.89	4.89	4.89	44.03
Deficit/ (Surplus) In Month Performance	24.16	18.87	4.13	4.20	3.83	55.18

It is clear from the Table above that the Year-to-Date (YTD) issue remains the non-delivery of savings. This shortfall in delivery YTD is in part mitigated by 'Delegated Budget' position underspending and the central N/R opportunities as set out in the 11 September 2025 submission delivering (as reported in the Table above). Whilst excluding the non-delivery of saving most areas are within the delegated operational budgets, the key exception to this is Mental Health & Learning Disability Services. Throughout the year there have been pressures linked to pay and Continuing Healthcare (CHC) but also Temporary Adult Placements. The latter issue has resulted in an in-month pressure of £0.7m, with YTD expenditure of £5.3m. During November 2025 the service saw the highest number of patients in Temporary Adult Placements at 33, which at the time of closing the ledger for Month 9 was at 25. This pressure will need to continue to reduce through Q4 and managed alongside the other pressures linked to Employers National Insurance (ENIC) and Nurse Streamline numbers that the Health Board will need to mitigate in-year.

On savings performance the submission made on 11 September 2025 set out the Plan to deliver the £55.4m savings in 2025/26. This was a combination of (1) Part A - budgetary releasing savings delivery supported by our external strategic partner; alongside (2) Part B - delivery of underspends in the operational budgets specifically around the corporate directorates and N/R opportunities. The monitoring of the performance for Part A is undertaken through the existing governance arrangements, using the Health Board's savings trackers. This data is then used to complete the WG Monthly Monitoring Return (MMR) Savings Tables. However, as Part B are improvements in run rate and not a formal budgetary savings this



element of the plan is not reported in Savings Tables of the WG MMR or standard trackers. A summary of the assessed performance and the profile of delivery over 2025/26 is provided in the following two tables:

Summary Performance against £55.4m

Month 9 MMR Position			
Part	Category Scheme	11 Sept Plan £M	Forecast Delivery £M
A	Green Amber	26.6	34.2
	Red / Pipeline	20.2	0.0
	Total Part A	46.8	34.2
B	NR Opportunities	4.6	4.6
	Corporate Underspend	4.0	4.0
	Total Part B	8.6	8.6
Total		55.4	42.8

Profile of the delivery of the £8.6m, along with the RAG rating is provided below:

	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Mth 10	Mth 11	Mth 12	Total	RAG
NR Opportunities	0	0	(0.3)	(0.5)	(0.5)	(0.5)	(0.1)	(0.4)	(0.7)	(0.7)	(0.7)	(0.4)	(4.6)	
Corporate Underspend	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(4.0)	

With regard to the delivery of the £46.8m element, which is the traditional savings required, the top section of the table below demonstrates the original plan at 11 September 2025, the plans as per the trackers at Month 9 and the forecast delivery at Month 9. The scheme type is split based on the Amber and Green as per the MMR, Local Red schemes, Local Pipeline ideas and those schemes presented by Deloitte. As the Local Red schemes, Local Pipeline ideas and those schemes presented by Deloitte move to Green and Amber the value of the Plan figure will reduce. As you will see from the table there is still significant work to be completed to ensure the two parts of the Deloitte schemes translate to Green and Amber.

Table 2c: Summary of Savings Plan and Forecast Delivery:



Type Scheme	@ 11 Sept Plan £M	@ Mth 9 Plan £M	@ Mth 9 Tracker Forecast Delivery £M	Gap Between Savings Plan & Forecast @ Mth 9 £M
Amber	3.3	0.8	0.7	(0.1)
Green	23.3	29.9	33.5	3.6
Local Pipeline Schemes	1.7	0.6	0.0	(0.6)
Deloitte Schemes Part 1	6.8	5.9	0.0	(5.9)
Deloitte Scheme Part 2	9.0	8.4	0.0	(8.4)
Local Red Schemes	2.7	1.2	0.0	(1.2)
	46.8	46.8	34.2	(12.6)
NR Opportunities	4.6	4.6	4.6	0.0
Corporate Underspend	4.0	4.0	4.0	0.0
	8.6	8.6	8.6	0.0
	55.4	55.4	42.8	(12.6)

The focus on savings is critical both in terms of supporting the 2025/26 delivery but also on mitigating the impact on the Underlying Deficit, particularly given the £6.9m Deloitte Part 1 Plan had a recurrent impact of £29m.

Post Month 9 closedown the Health Board undertook an assessment of the 2025/26 outturn based on data provided by Service Areas in November 2025 and the actual trend over Quarter 3. Without further intervention and actions, the Health Board will likely end the year £10m-£12m above plan. The actions and mitigations needed are detailed below and are no different to those previously agreed and noted by the Board and are summarised below:

- **16 December 2025 Special Board meeting**, approved a paper that set out the actions to address the savings shortfall. In summary the actions to address the savings shortfall agreed were:
 - Urgent emergency Care (UEC) – reconfiguration of beds to manage Clinically Optimised Patients via a new model to be in place 5 January 2026.
 - CHC - continued focus on repatriation of patients and address Social Work support for package reviews by 16 January 2026.
 - Variable Pay minimum 50% reduction in nursing variable pay with cap within Allocate in place by 15 December 2025.
 - Variable Pay - other staff group minimum 50% reduction (excluding WLI and some ADH) to be enacted by 19 December 2025.
 - Bans effective from 15 December 2025 building on previous controls already agreed to increase certainty:
 - all travel, except those directly linked clinical care



- all Printing/Stationery/Books except those directly linked to clinical care
 - all Study leave that not mandated/urgent via professional CPD
 - catalogue restriction with ban on areas such as Furniture and Fittings except in exceptions circumstances
 - Deferral of discretionary spend where possible 7.
- As per the 16 December 2026 plan the majority of these actions were due to commence from the end of Month 9, although there was a £0.5m reduction in variable pay in Month 9. The Delivery will be tracked and reported from Month 10 and incorporated the monthly Finance Performance reported presented to Performance & Finance Committee.
 - Delivery of the actions above to the full value set out will close the savings gap in the Health Board's 2025/26 plan
 - **Further actions** will be required if the extant plan does not have traction in Month 10 (January 2026). These were discussed by the Executive Team on 26 January 2026 and include: -
 - Increase in variable pay restriction from 50% to 75%. It was estimated that 50% reduction would provide £2.3m reduction in Month 10-12. If this isn't delivered in month 10 the target would need to increase to £3.5m in Month 11 and 12, which will be equivalent to a 75% reduction.
 - The Health Board has committed to the continued delivery of its 104 week planned care target through months 10-12. This remains the case. Analysis is anticipated by 2 February 2026 which will identify theatre lists with non cohort patients in them (outside of emergency, urgent and cancer care). The plan is to move any 104 week premium rate cases into planned cases to reduce variable pay and consumable spend. The commitment to 104 week delivery will not be affected.
 - A detailed analysis will be available by 2 February 2026 which will set out the optimal bed model for the 3 acute hospitals across the Health Board. The intention of this analysis is to identify the highest cost beds within the Health Board and to set out how those bed numbers can be reduced in line with pathway improvements service realignment.
 - Non pay restrictions are already in place with plans to reduce spend by 50% for months 10-12. Following receipt of the month 10 financial position further one-off restrictions will be considered until the end of the financial year. An analysis on the options for this is currently underway with our strategic partner.
 - **Further Opportunities Non-Recurrent managed centrally:** these are summarised in the table below and will continue to be



assessed to establish viability and value to support the delivery of the £58.7m on a non-recurrent basis.

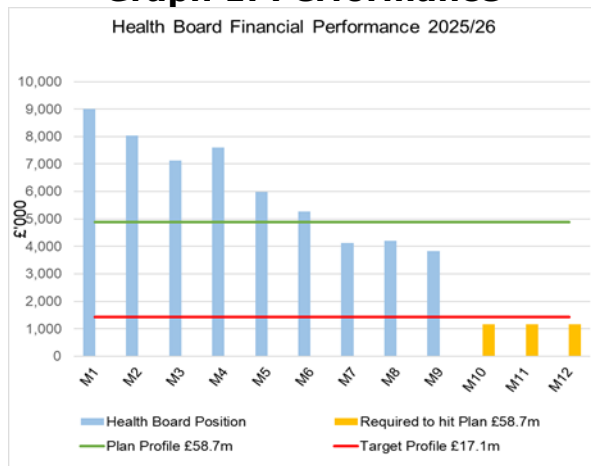
Summary N/R Opportunities @ Month 9

Further Opportunities N/R	£'000	RAG	Next Steps
PCT CHC Growth Reserve	(785)		Further Review of CHC post Mth 9
PCT Further CHC 23/24 Balance Sheet Release	(1,200)		Finalisation of assessment of B/S
PCT Programme Slippage	(357)		Further Review of programme Q4
PCT Funding Frailty from RIF/RPB	(500)		Discussions COO to confirm
Morrison National IT Programme Slippage	(312)		Finalise value Q4
Morrison OOH Contracting	(163)		Finalisation of contract
Morrison In Year Devices Accrual Review	(400)		Finalise value Q4
Morrison Year End Balance Sheet - Pay issue	(750)		Further discussions ongoing
NPTS Slippage on Investments	(300)		Further discussions ongoing
Balance Funding in Main Reserves	(798)		
Balance Sheet Central from 24/25	(548)		
NWSSP Distribution Rebate 2025/26	(440)		
SIFT Forecast Underspend	(606)		Finalise value Q4
Total	(7,159)		

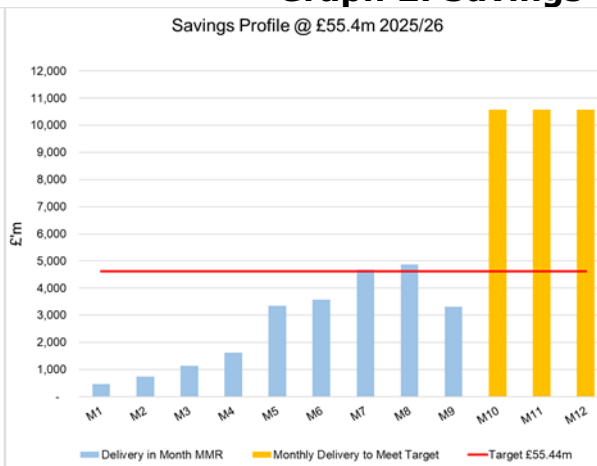
The likely outcome is that the delivery of the £58.7m will be met through a combination of the actions agreed at 16 December 2025 Special Board meetings and materialisation of some of the further opportunities, although it is the first set actions that will be critical in delivering the recurrent position in 2026/27.

With regards to the overall financial performance at Month 9, **Graph 1** below reflects the actual financial performance in each month, with the orange bars reflecting the performance required to achieve the original plan of £58.7m. **Graph 2** outlines the savings delivered to date as the blue bars against the monthly target set (red line), and the orange bars reflect the level of savings required in future months to achieve the £55.4m target aligned to the £58.7m plan.

Graph 1: Performance



Graph 2: Savings





4.1. Key Drivers by Service Area In-Month

The key drivers of the Month 9 position are summarised in the table below. Further detail at a Health Board level of expenditure on Income, Pay and Non-Pay, is also provided in Appendix 1.

Month 9 - In Month	TOTAL	MH/LD	PCT	NPTS	Morr	COO	Estates (inc Finance)	Corporate Directorates	Central
£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Plan 1: Plan									
In Month Deficit Plan	4.89								4.89
Part 2: Delivery 2025/26 Target £55.4m & Run Rate									
Delivery £55.4m Savings	1.30	(0.14)	0.25	0.61	0.67	0.07	0.06	(0.01)	(0.21)
Delivery of Run Rate Target	(1.09)						(0.06)	(0.65)	(0.38)
Sub Total Part 2	0.21	(0.14)	0.25	0.61	0.67	0.07	0.00	(0.66)	(0.59)
Part 3: Operational Pressures Above Underlying Deficit									
Income									
- JCC Performance	(0.34)				(0.34)				
- Dental PCR Income	0.14		0.14						
- Other	(0.09)		0.05	(0.08)		(0.05)			
Pay (including VP)	0.00								
- Medical	0.21	0.08		0.14					
- Nursing (inc UQ)	(0.20)	0.06	0.06	(0.34)	0.02				
- A&C	(0.51)		(0.07)		(0.17)	(0.08)	(0.19)		
- Other	(0.47)	(0.06)	(0.36)	(0.01)			(0.05)		
Surge Beds	0.00								
- Gorseinon	0.06		0.06						
- Singleton/NPT	0.00								
- Morriston	0.00								
Non-Pay	0.00								
- Secondary Care Drugs	0.00								
- Clinical Consumables	0.84			0.41	0.43				
- Estates (Building Materials / Energy)	0.00								
- Finance (PFI) Energy	0.00								
- COO (Provisions)	0.00								
- CHC (inc LAC)	0.39	0.53	(0.15)						
- CHC Temporary Adult MH Placements	0.78	0.78							
- Dental Contract Clawback/handback for 24/25	(0.10)		(0.10)						
- Primary Care Prescribing	0.00								
- Primary Care contractor	0.01		0.01						
- Other Primary Care	(0.33)		(0.33)						
- GP OOH provision	0.01		0.01						
- Other Non Pay	(0.03)	0.08	0.10	(0.20)	(0.05)	0.04			
Corporate Directorate Balance	0.09							0.09	
Sub Total Part 3	0.47	1.47	(0.57)	(0.08)	(0.11)	(0.10)	(0.24)	0.09	0.00
Part 4: Central Codes									
- Central Z Codes	(1.08)								(1.08)
- NR Opportunities	(0.66)								(0.66)
Sub Total Part 4	(1.74)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(1.74)
Total Variance	3.826	1.33	(0.32)	0.53	0.56	(0.026)	(0.233)	(0.576)	2.56
Total In Month Budget		13.42	29.90	33.72	33.41	3.51	5.63	27.31	
Variance as % Budget		10%	(1%)	2%	2%	(1%)	(4%)	(2%)	



4.2. Key Drivers by Service Area YTD

Month 9 - YTD	TOTAL	MH/LD	PCT	NPTS	Morr	COO	Estates (inc Finance)	Corporate Directorates	Central
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Plan 1: Plan									
YTD/In Mth Deficit Plan	44.00								44.00
Part 2: Delivery 2025/26 Target £55.4m & Run Rate									
Non Delivery £55.4m Savings	17.84	1.67	5.47	6.94	4.25	1.14	0.57	0.18	(2.38)
Non Delivery of Run Rate Target	(9.60)						(0.58)	(5.22)	0.20
Sub Total Part 2	12.24	1.67	5.47	6.94	4.25	1.14	(0.01)	(5.04)	(2.18)
Part 3: Operational Pressures Above Underlying Deficit Income									
- JCC Performance	(1.33)				(1.33)				
- Dental PCR Income	0.38		0.38						
- Other	(0.64)		0.05	(0.56)		(0.10)	(0.03)		
Pay (including VP)									
- Medical	0.22	0.86	(0.26)	(0.52)	0.14				
- Nursing (inc UQ)	0.49	1.67	(0.28)	(1.17)	0.27				
- A&C	(2.23)	(0.45)	(0.39)	(0.06)	(0.53)	(0.36)	(0.30)	(0.13)	
- Other	(1.88)	(0.28)	(1.77)	0.15	0.19	0.14	(0.31)		
Surge Beds									
- Gorseinon	0.66		0.66						
- Singleton/NPT	0.00								
- Morriston	0.00								
Non-Pay									
- Secondary Care Drugs	(0.30)	(0.04)	0.04	(0.30)					
- Clinical Consumables	1.89		(0.07)	(0.06)	2.02				
- Estates (Building Materials / Energy)	(0.59)	(0.02)					(0.57)		
- Finance (PFI) Energy	(0.27)						(0.27)		
- COO (Provisions)	(0.21)					(0.21)			
- CHC (inc LAC)	0.96	2.17	(1.21)						
- CHC Temporary Adult MH Placements	5.39	5.39							
- Dental Contract Clawback for 24/25	(0.31)		(0.31)						
- Primary Care Prescribing	0.01			0.01					
- Primary Care contractor	(0.09)		(0.09)						
- Other Primary Care	(0.33)		(0.33)						
- GP OOH provision	0.36		0.36						
- Other Non Pay	(0.81)	0.29	(0.28)	(0.28)	(0.10)	(0.33)	(0.12)	0.00	(0.00)
Corporate Directorate Balance	(1.08)			(0.01)				(1.07)	
Sub Total Part 3	0.28	9.58	(3.51)	(2.80)	0.65	(0.85)	(1.60)	(1.19)	(0.00)
Part 4: Central Codes									
- Central Z Codes	1.54								1.54
- NR Opportunities	(2.87)								(2.87)
Sub Total Part 4	(1.33)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(1.33)
Total	55.194	11.245	1.965	4.138	4.901	0.295	(1.611)	(6.233)	40.493
Total YTD Budget		115.312	226.908	300.090	290.784	45.975	25.282	225.702	
Variance as % Budget		10%	1%	1%	2%	1%	-6%	-3%	

5. KEY AREAS OF NOTE

5.1. Savings

The in-month delivery was £3.32m against a target of £4.62m; on a YTD basis the undelivered savings gap is £17.99m. Further details on savings at the point the Month 9 ledger was closed (7 January), are provided in Appendix 2.



5.2. Capital

The approved Capital Resource Limit (CRL) value issued on 5th January is £50.502m. The approved CRL value includes Discretionary Capital, schemes under the All-Wales Capital Programme and new/renewal IFRS 16 Leases.

Outturn Performance

The forecast outturn shows an overspend position of £0.140m. Allocations are anticipated on the following schemes, which will provide a balanced position.

Scheme	£m	Narrative
IRCF – Cymmer / Croeserw Health & Wellbeing Centre Fees	0.140	Funding approved.

The following allocations are classed as risks.

Scheme	£m / Risk Level	Narrative
Positron Emission Tomography (PET) Service, Singleton Hospital	0.494 / High	There has been further slippage on this scheme due to design queries covering the main Air Handling Unit (AHU) and the potential impact on the overall scheme if the space was not sufficient. The contractor undertook a further review of the AHU design to ensure the plant could be accommodated within the design. As part of the review the lint walkways were deemed unsafe and had to be replaced. These had to be designed and installed to ensure the area was safe to work. These works have consequently resulted in additional programme slippage which will be managed by the Health Board.

Scheme	£m / Risk Level	Narrative
Replacement Diagnostic and Treatment Equipment 2025-26	0.594 / High	The variance in Table I is £0.906m but £0.312m of this variance is not a Capital scheme underspend, it represents the cost of mobile hire in relation to the CT Scanner at Morriston which is accounted for as a revenue cost. However, there have been ongoing design delays in relation to the Interventional Radiology (IR) - Fluoroscopy 2 programme at Morriston Hospital resulting in slippage which is to be managed by the Health Board.
DPIF – RISP	0.270 / Medium	The RISP programme continues to report a lack of confidence in relation to Philips' ability to deliver against a revised plan of a 23rd February 2026 go-live based upon current performance, escalations continue, including a request to meet their Managing Director in January. Data migration has progressed with testing and checks on scanner connectivity planned throughout January and into February. The risk of slipping against the programme remains, since other Health Boards go-live before Swansea Bay and they are advising of slippages within their programmes which will have a consequential impact on ours. The Project Team is closely monitoring the critical path and dependencies with DHCW, Soliton and Philips. The Fuji PACS contract has been



Scheme	£m / Risk Level	Narrative
		extended to March 2027 as mitigation. Initial charges are due for payment upon stable operations, therefore any delays will potentially impact upon the health boards requirement to utilise both the Owned Asset Capital funding and the IFRS 16 Capital funding in 2025-26. In terms of Owned Asset funding, the current view is that £270k is at risk of not being spent if we do not achieve go-live on 23rd February 2026. A further update will be provided if there is any contractual change which confirms definite slippage into next year. The IFRS 16 RISP considerations are described in the narrative of Table Q.

All other schemes are low risk and any variances are linked to planned contributions from discretionary and in some instances payback of prior year fees.

Capital Disposals

There are no further property disposals planned for 2025/26.

5.3. Balance Sheet

The key issues in respect of the statement of financial position movements are as follows:

- The inventory value has decreased from £10.731m at the end of November 2025 to £10.384m at the end of December 2025, a decrease of £0.347m. This movement relates to Pharmacy.
- There has been an increase in trade receivables from £293.660m at the end of November 2025 to £293.660m at the end of December



2025, an increase of £6.025m. This relates to an increase in NHS Debtors (£4.509m) and an increase in the WRP (Welsh Risk Pool) debtor of £1.737m.

- The closing December 2025 cash balance of £1.275m.
- The trade and other payables figure saw a decrease from £224.559m at the end of November 2025, to £216.004m at the end of December 2025, a decrease of £8.555m. This comprises a decrease in Accruals and NHS creditors.
- Provisions saw an increase of £1.043m from £219.856m at the end of November 2025 to £220.899m at the end of December 2025. This increase relates to Clinical Negligence provision.

5.4. Cash

As at the end of December 2025, the Health Board had a cash balance of £1.275m.

The Board formally approved the submission to WG for cash support to 31st March 2026 at its meeting in November 2025. The letter, dated 28 November 2025, confirmed a cash shortfall of £85.328m. This was made up of Strategic cash support of £55.0m (see first table below) and Working Capital support of £30.3m (see second table below).

Strategic Cash Support	£'000
Forecast I&E Deficit	(58,660)
Cash Movement in year	(25,596)
Revenue working capital cash	19,280
Revenue working capital cash - reimbursement to Capital	6,532
Opening Cash Balance	3,444
Total	(55,000)

Working Capital Support	£'000
Revenue	(19,280)
Revenue - reimbursement to Capital	(6,532)
Capital - owned capital	0
Capital - IFRS 16	(4,516)
Total	(30,328)

Our detailed cashflow shows that we are likely to require the cash support during the w/c 16 March 2026.



The cash flow is updated daily and a full review of the cash forecast is currently being undertaken monthly, to ensure that any changes to our cash requirements can be communicated in a timely manner to WG.

5.5. Public Sector Payment Policy (PSPP)

The Health Board achieved the 95% PSPP target, with the % of Non-NHS Invoices Paid within 30 Days in Quarter 3 being 96.8% for the quarter and 96.4% YTD.

NHS payment compliance for invoices paid within 30 days was, however, below 95% with the quarterly performance being 87.2%, which is a deterioration from Quarter 1 and 2. The Health Board remains focussed on improving PSPP compliance for NHS invoices and ensuring that performance remains above 95% for non-NHS invoices.

6. GOVERNANCE AND RISK ISSUE

There are two Board level financial risks:

6.1. Achieving financial plan (HBR92) with the key elements as follows:

- Risk of delivery of savings quantum
- Risk of operational overspend being in excess of funding available agreed via the Financial Plan
- Risk of commitment of reserves (e.g. NICE) being above reserves available.
- Risk of achieving the actions and options outlined in the 2025/26 Financial Recovery & Sustainability Assessment.

Based on the financial performance to Month 9 and the shortfall in the delivery of savings YTD, to deliver the deficit plan of £58.7m, it is recommended that the Health Board Corporate Risk Register continues to reflect a **risk score of 25**.

Within the YTD and assessment to 31st March 2026 the Health Board is managing the following pressures:

- ENIC Shortfall Funding
- Nurse Stream Lining (144 WTE)
- MHLG SG Temp Adult Placements
- MHLG SG Operational Pressures Variable Pay and CHC

Whilst these may currently be mitigated on a non-recurrent basis there will be a recurrent impact on the Underlying Deficit.

The key risks to the in-year and underlying deficit are:



- Non-delivery of the current Planned and Unplanned mitigations totalling £12.2m
 - JCC Caswell Provider = £1.2m+
 - JCC General Risk = £0.5m
 - Planned Care Recovery Funding shortfall = £0.8m
- The focus on Risks within the WG submissions for Month 9, revolved around three key issues.

6.2. Availability of capital (HBR93). This risk was re-opened in 2022/23 given the reduction in discretionary capital allocation. Due to the additional capital funding provided during 2024/25 the risk score was reduced to 12. The score was increased in June 2025 to reflect risks regarding Emergency Department and Adult Acute Mental Health. The current assessment is to continue with the **risk score of 20**. This risk will be reviewed following the capital plan update to Performance and Finance Committee in January 2026 given that the outlook is now a balanced outturn for 2025/26.

7. RECOMMENDATIONS

Members are asked to:

- **ACKNOWLEDGE** the 2025/26 Financial Plan, and the Health Board's and Welsh Government's inability to approve it given the planned deficit of £58.7m
- **CONSIDER** and comment upon the Health Board's financial performance for Month 9 2025/26, including cash, capital and balance sheet.
- **SUPPORT** the implementation of the actions to address the savings gap and assessed position to reach the £58.7m plan.
- **SUPPORT** the continued focus on the actions and choices agreed at 16 December 2025 Special Board, reflected in the Public Accountability Meeting and the need to deliver these in full to mitigate risks to the position which have emerged since the Health Board 2025/26 plan was developed in March 2025.
- **AGREE** the development of the further actions set out, should traction not be forthcoming in month 10: -
 - Further variable pay controls
 - Implementation of 104 week cohort delivery only (urgent, emergency and cancer care unaffected)
 - Implementation of revised bed model
 - Further restriction of non pay spend
- **DISCUSS** the risks to the position at Month 9.



Governance and Assurance		
Link to Enabling Objectives <i>(please choose)</i>	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☐
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
<i>(please choose)</i>	Staying Healthy	☐
	Safe Care	☐
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☐
Quality, Safety and Patient Experience		
Financial Governance supports quality, safety, and patient experience		
Financial Implications		
The Board is reporting a forecast year-end deficit financial outturn.		
Legal Implications (including equality and diversity assessment)		
No implications		
Staffing Implications		
No implications		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
No implications		
Report History	Updates on the financial position are provided at every meeting.	
Appendices	Appendix 1 – Variances by Area and Type of Spend Appendix 2 – Savings Position @ Mth 9	



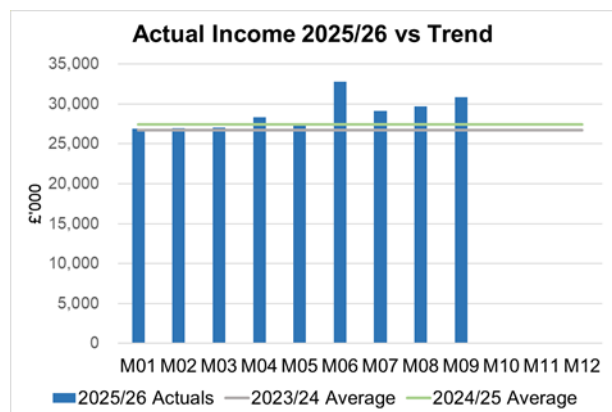
APPENDIX 1 – FURTHER DETAIL ON VARIANCES BY AREA & TYPE OF SPEND

1. Overview Financial Position

Part Plan	Detail	£'000	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	YTD
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Part 1: Plan												
Opening Plan	Opening Plan	58,660	4,888	4,888	4,888	4,888	4,888	4,888	4,888	4,888	4,888	43,994
	In Year WG funding (recurrent)	0										-
	Revised Plan	58,660	4,888	4,888	4,888	4,888	4,888	4,888	4,888	4,888	4,888	43,994
Total Part 1		58,660	4,888	4,888	4,888	4,888	4,888	4,888	4,888	4,888	4,888	43,994
Part 2: Delivery Delegated Budgets												
Service Groups Part A	Mental Health & LD	0	1,244	1,334	1,559	1,445	1,209	718	1,020	1,392	1,325	11,246
	Morriston	0	1,546	1,324	1,070	575	486	108	(161)	(532)	565	4,981
	NPT & Singleton (inc PC Prescribing)	0	789	261	495	877	492	421	162	112	536	4,145
	PC & Community	0	789	792	293	281	237	200	(102)	(208)	(314)	1,968
	Sub Total	0	4,368	3,711	3,417	3,178	2,424	1,447	919	764	2,112	22,340
Corporate Directorates Part A	Board Secretary	0	(50)	8	(72)	32	(29)	(20)	(4)	17	35	(83)
	Chief Operating Officer	0	173	(26)	61	157	151	127	(127)	(193)	(26)	297
	Director of Strategy (Nicole)	0	(22)	(37)	(34)	34	(35)	(21)	(49)	(58)	(41)	(263)
	Director of Strategy (LTA Contracting)	0	(79)	(83)	(63)	(49)	(191)	(82)	(53)	(160)	(6)	(766)
	Director of Strategy (RIF)	0	0	0	0	0	0	0	0	0	0	0
	Estates Only	0	(52)	(76)	(82)	(396)	(193)	280	(141)	(109)	(112)	(881)
	Finance, Capital Planning, CF & R&D	0	(58)	(73)	(158)	(36)	(105)	(67)	(59)	(61)	(121)	(738)
	Digital	0	(197)	(238)	(333)	(343)	(233)	(182)	(403)	(196)	(157)	(2,282)
	Medical Director	0	(16)	(10)	(11)	(17)	(32)	(21)	(28)	(22)	(19)	(176)
	Nurse Director	0	(31)	(72)	(58)	(202)	(101)	(99)	(90)	(92)	(72)	(817)
	Workforce & OD	0	(106)	(24)	(95)	99	90	(87)	(65)	(24)	(59)	(271)
	DICE	0	(38)	(32)	(37)	(34)	(31)	(30)	(31)	(29)	(33)	(295)
	Director of Therapies	0	(15)	(16)	(27)	(19)	(18)	(18)	(31)	(25)	29	(140)
	Public Health	0	(101)	(107)	(50)	(58)	(131)	(156)	(242)	(248)	(251)	(1,344)
	Clinical Medical School	0	0	0	0	0	0	0	0	0	0	0
	Research & Development	0	0	0	0	0	0	0	0	0	0	0
	EMRTS	0	21	(31)	(63)	8	114	61	50	53	(13)	200
	Sub Total	0	(571)	(817)	(1,019)	(824)	(744)	(315)	(1,273)	(1,147)	(846)	(7,556)
Total Part 2		0	3,797	2,894	2,398	2,354	1,680	1,132	(354)	(383)	1,266	14,784
Part 3: Corporate Cost Centres (Z Codes)												
Total Part 3		0	317	260	111	852	(105)	(257)	(304)	76	(1,669)	(718)
Part 4 Reserves Unutilised												
Total Part 4		0	0	0	(275)	(484)	(483)	(483)	(100)	(380)	(664)	(2,869)
Total Performance Against RRL												
Deficit /(Surplus) Against RRL		58,660	9,003	8,042	7,123	7,611	5,980	5,280	4,128	4,201	3,826	55,193

2. Overview of Income

The table below compared the income performance in Month 9 to the average levels of 2023/24 and 2024/25.





Income had increased in Month 9 due to rebates relating to the price increase in the Mounjaro drug and additional income received within the Clinical Research Unit and additional funding received for the Clinical Medical school (SIFT).

In addition the Joint Commissioning Committee (JCC) Income as a provider over-performed by £0.6m in-month (£2.1m over-performance YTD). This has been driven by TAVI and Cardiology activity in Morriston.

2.1 JCC Income

The Health Board monitors performance on a monthly basis for JCC activity, which is predominantly delivered via the Morriston Service Group. Throughout the financial year there are variance movements linked to performance.

The table below provides a summary of the performance at Month 9 for each speciality area.

JCC Specialty Areas	Performance YTD vs LTA £'000
ALAC	Over Performing
TAVI	Over Performing
Bariatrics	Over Performing
Burns	Over Performing
Cardiac Surgery	Under Performing
Cardiology	Over Performing
CLP	Under Performing
EMRTS	Over Performing
Haematology	Under Performing
NICE	Over Performing
NICU	Over Performing
Orthoplastics	Under Performing
Plastics	Over Performing
PNMH	Under Performing
Rehab	Under Performing
Renal	Over Performing
SABR	Over Performing
Sarcoma	Over Performing
Thoracic	Under Performing
WFI	Under Performing



2.2 Anticipated Income

The below table highlights anticipated income the Health Board expects to receive during 2025/26. The current deficit plan of £58.7m is predicated on receipt of these Welsh Government funds at the levels anticipated.

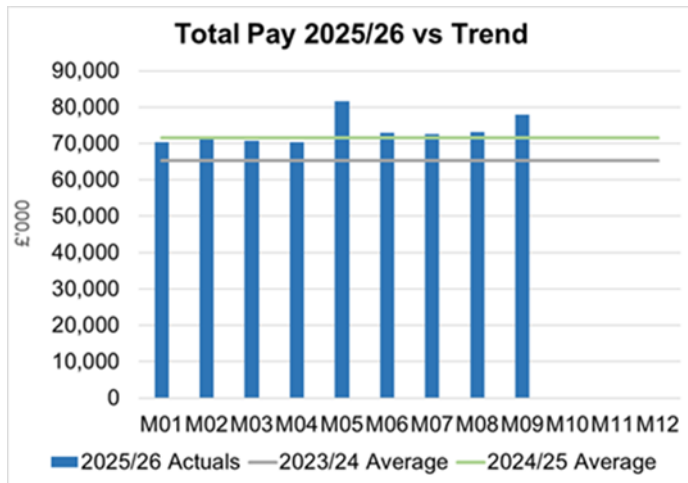
Anticipated Income	
Workforce Uplift	9.0
Capital	6.9
Planned Care - Phase 2 Cataract Surgery	2.5
Planned Care - Phase 2 Cataract Surgery	2.4
Planned Care - Phase 5 Q3	1.7
Planned Care - Phase 5 Q4	1.6
Planned Care - Phase 1 Q2	1.6
GP Refresh	1.3
Planned Care - Phase 1 Q1 Costs	1.1
Planned Care - Phase 4 Outpatient Diagnostics	0.8
Planned Care - Phase 3 Outpatient Activity	0.6
National Outpatient Plan - Minor Operations Procedures	0.4
Womens Health - Pathfinder Establishment	0.3
Planned Care - Phase 1 Q1	0.3
Clinical Excellence Award	0.2
CYP Sanctuary	0.2
Traumatic Stress Wales (TSW)	0.2
Women's Health - Pathfinder Establishment	0.2
Planned Care Transformation	0.2
All Wales International Recruitment	0.2
Varicella Immunisations	0.1
Planned Care - SPPC - Part 2	0.0
Digital Priority Investment Fund (DPIF)	0.0
Planned Care - Phase 4 Plain Film Oral Surgery Clinics	0.0
NWSSP WRP additional contribution - Return WG	(5.5)
Grand Total	26.3

3. Pay, Agency & Other Variable Pay Expenditure

Total Pay

The Month 9 actual total remains higher than the prior two years average (as shown in the graph below). Within Month 9 actuals are the recognition payments and arrears linked to the Band 2-3.

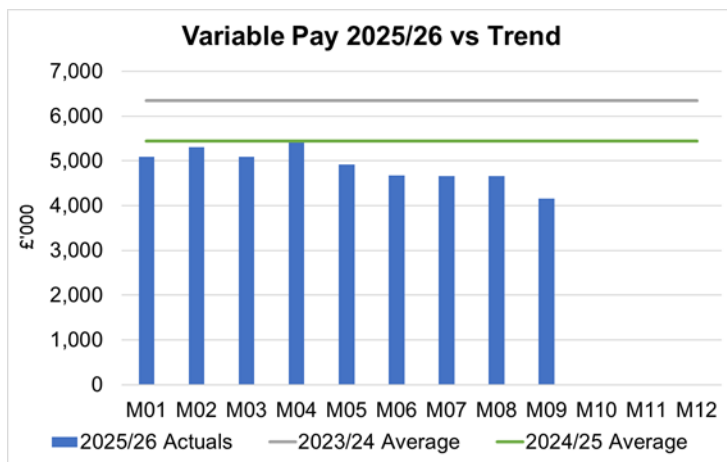
From a budget against variance perspective, Month 9 pay is broadly in line with the prior month; the continued vacancy freeze primarily in Admin & Clerical and other Pay Controls being the driver for this. Variable pay expenditure has reduced in Month 9, as detailed below.



Note - 2023/24 and 2024/25 values have been notionally increased by pay award uplifts for comparison to current value of 2025/26 pay value.

Variable Pay

Variable pay is £0.9m lower in Month 9 2025/26 (£4.161m vs £5.065m) when compared to the same period last year (graph below shows this year's actual versus prior year's average) and is £0.5m lower than Month 8 2025/26.



Variable Pay is classified by the Health Board into the following categories: Agency, Bank, Overtime, Waiting List Initiatives (WLI) and Irregular Sessions, a breakdown of the spend into these categories is provided below.

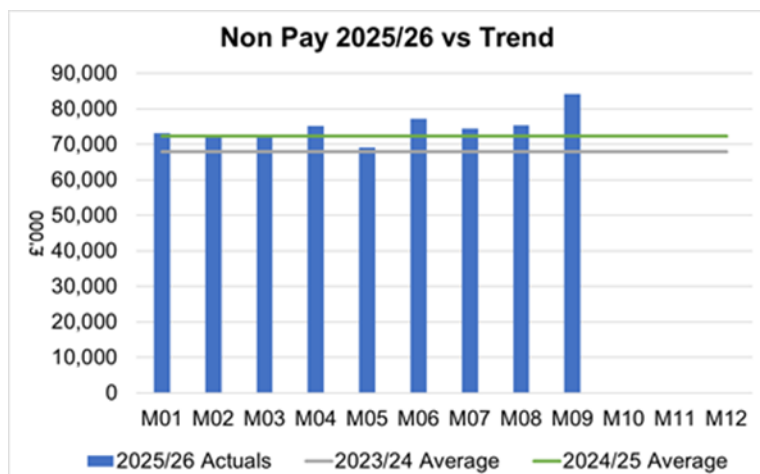


Variable Pay Spend

Variable Pay Expenditure £k		£k	£k	£k	£k	£k
		Quarter 1	Quarter 2	Quarter 3	YTD Total	Average per quarter FY2425
ADH	Medical & Dental	2,317	2,339	2,128	6,784	2,171
	Nursing & Midwifery	0	8	10	19	
	Other	0	0	1	1	
ADH Total		2,317	2,347	2,140	6,803	
	Additional Clinical Services	407	300	364	1,071	594
	Healthcare Scientists	403	395	413	1,210	468
	Medical & Dental	1,746	1,848	1,511	5,106	1,967
	Nursing & Midwifery	489	279	407	1,175	1,176
	Other	354	222	145	721	759
Agency Total		3,399	3,044	2,840	9,282	
	Additional Clinical Services	3,944	3,840	3,409	11,193	3,544
	Nursing & Midwifery	2,194	2,250	2,197	6,641	2,196
	Other	442	777	544	1,762	331
Bank Total		6,580	6,867	6,151	19,597	
	Allied Health Professionals	319	310	307	936	288
	Estates and Ancillary	418	457	401	1,275	390
	Nursing & Midwifery	780	498	372	1,651	790
	Other	693	522	481	1,695	583
Overtime Total		2,210	1,787	1,561	5,557	
WLI		977	963	790	2,730	1,093
WLI Total		977	963	790	2,730	
Grand Total		15,482	15,006	13,481	43,969	16,349

4. Overview Non-Pay

Actual Non-Pay expenditure for Month 9 is higher than the last 2 year's average expenditure levels (as shown in the graph below). This increase is linked to payments made via LTA, which will include pass through costs for JCC, reflection of uplift to the GMS contract for 25/26 (£3.5m) and Dental Contract for 25/26 (£1.0m) both of which are funded by WG:





Below are further details on the key areas of non-pay:

4.1. Clinical Consumables

This area overall has an in-month overspend of £0.7m. Within the ledger the gross income is reflected within the income lines and not netted off against expenditure and so overall the Health Board position is not adversely affected. The main drivers within this category of clinical consumable expenditure include heart valves & pacemakers. This category also includes secondary care drugs, a breakdown of the categories of Clinical Consumables is provided below.

Clinical Consumables Category	Budget YTD £'000	Actual YTD £'000	Variance YTD £'000
M&SE Consumables	32,026	32,757	731
Implants	11,941	12,531	590
Laboratory and X-Ray Equipment	6,254	7,024	770
M&SE & X-Ray Maintenance	4,252	4,537	285
Clinical Contractual Services	4,127	3,734	(394)
Appliances and ALAC	3,478	3,213	(265)
Other Clinical costs	1,620	1,658	38
Total	63,698	65,453	1,756

4.2. Primary Care Prescribing

Prescribing was slightly overspent (£0.04m) in-month and YTD at a £0.2m overspend following receipt of the latest dataset (October 2025).

4.3. CHC

In Month 9 CHC was overspent by £1.2m (YTD £6.2m). Expenditure on Adult Mental Health placements remained broadly unchanged in-month to £0.8m. The pressure continues at £0.5m for growth (Month 8 £0.3m) more than the Plan after the recognition of some retrospective charges in-month.

An analysis of actual expenditure and patient numbers for 2025/26, along with the average values from 2024/25 is provided in table below.



CHC Analysis by Month

Service Area	PCT Group		Mental Health		Learning Disabilities		Total	
	Patient No.	£	Patient No.	£	Patient No.	£	Patient No.	£
Average 2024/25	494	3,242,737	213	1,811,724	206	2,303,441	914	7,357,902
Mth 1	430	3,037,077	231	2,206,207	225	2,136,372	886	7,379,656
Mth 2	431	3,120,919	249	2,298,129	221	2,154,428	901	7,573,476
Mth 3	433	2,834,204	253	2,508,283	223	2,138,697	909	7,481,185
Mth 4	439	3,825,399	267	2,580,430	225	2,283,173	931	8,689,001
Mth 5	440	3,238,633	251	2,542,646	229	2,766,724	920	8,548,003
Mth 6	449	3,396,224	239	2,238,663	229	2,197,542	917	7,832,430
Mth 7	443	3,242,695	271	2,417,577	232	2,346,135	946	8,006,408
Mth 8	437	3,031,665	268	2,850,511	230	2,182,416	935	8,064,593
Mth 9	439	3,243,126	274	2,862,076	231	2,473,372	944	8,578,574
Total		28,969,942		22,504,522		20,678,859		72,153,324

Please note:

- PCT Group numbers are based on bed days
- MHLG Group are based on cases
- PCT Group does not include the Singleton/NPT element. The NPTS element which covers Children and Young People CHC patients is provided internally by the Health Board and as such is part of the wider NPTS position and is not recorded in the ledger as PCT/MH/LD CHC.

4.4. Maternity Review

The total costs for this are allocated to a dedicated Cost Centre (6F34).

Expenditure Type	P09-26 £	YTD £
Consultancy Fees	18,790	483,782
Legal Fees	0	15,173
Other	8,214	8,672
Total	27,004	507,627

4.5. Z Codes (Section 1,3-4 Table Point 1 Appendix 1)

The narrative below groups together the key elements of the Z codes detailed in Point 1 of this appendix.

- Contracting: SLA /LTA performance: JCC (previously WHSSC), LTA and SLA contract income and expenditure are transacted within this area and financial performance reported. NICE approved high-cost drugs and associated LTAs are also transacted and monitored against targets set. In addition to this, non-contracted activity income in relation to English foundation trusts invoiced on a quarterly basis are reported.
- Capital: The Finance Capital Team manage a number of cost centres covering the PFI, IFRS16 and Depreciation charges for assets both owned and donated are transacted here.



- RRL and Central Reserves: The WG funding received at the start of the year is tracked within this area. Any anticipated allocations in year are also transacted through these codes. Other HB wide funding received from HEIW and SIFT is also captured in here. All central reserves remain within the Z cost centres.
- Corporate income and expenditure. Any income and expenditure that is not service group specific is transacted and reported through a number of corporate Z cost centres, examples include, payroll and pension costs, VAT recovery, losses and receipts in relation to funding from Welsh Risk Pool, overseas visitors' income and Road Traffic Accident income.

4.6. LTA Values & Forecast performance

The table below is based on Month 8 activity undertaken by other Health Boards and Trusts for Swansea Bay residents (SBU Commissioner) and activity undertaken by Swansea Bay for residents of other Health Boards.

SBU Commissioner				SBU Provider			
	Forecast	Total			Forecast	Total	
	perf	expenditure			perf	Income	
	variance at	including			variance at	including	
	LTA - 2025/26	M8	performance		LTA - 2025/26	M8	performance
	£	£	£		£	£	£
Health Board contracts and associated invoices							
Aneurin Bevan	260,470	23,429	283,899		1,199,549	146,592	1,346,141
Cardiff & Vale	4,555,702	166,500	4,722,202		4,869,606	101,669	4,971,275
Cwm Taf Morgannwg LTA	20,806,856	-5,413,065	15,393,791		21,331,999	-1,011,539	20,320,460
Cwm Taf Morgannwg Clinical Capacity SLAs	1,678,062	-778,261	899,801		1,821,297	-302,500	1,518,797
Hywel Dda	5,263,444	-881,138	4,382,306		42,203,153	1,899,167	44,102,320
Powys	1,577,206	-286,823	1,290,383		10,352,745	467,780	10,820,525
Velindre	906,817	-1,121	905,696				
Univ Hosps Bristol & Weston NHS FT	259,892	0	259,892				
	35,308,449	-7,170,479	28,137,970		81,778,349	1,301,169	83,079,518
JCC	154,054,772	831,298	154,886,070		155,883,151	2,553,036	158,436,187
Total	189,363,221	-6,339,181	183,024,040		237,661,500	3,854,205	241,515,705

The above figures include the annual contract values plus invoices relating to patient activity. SBU Commissioner Performance variances are based on information received from each organisation. Forecast performance variances are subject to fluctuations and exclude NICE drug recharges.

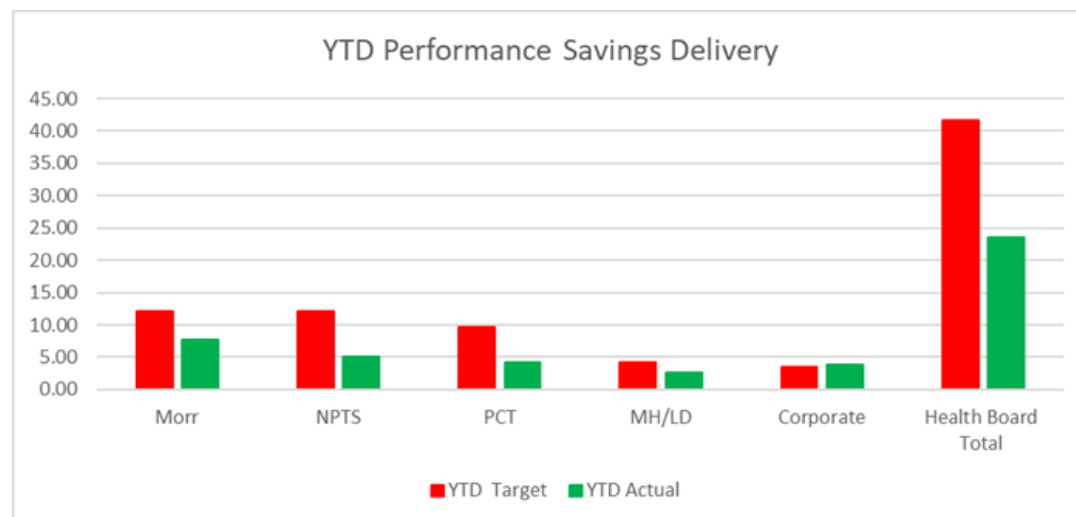
APPENDIX 2 – SAVINGS

1. Summary of Savings Position as at December 2025 (Month 9)

The section below reflects performance against the original £55.4m requirement taken from the Savings Trackers.

2. Summary of Savings Position as at December 2025 (Month 9)

The below graph clearly shows the gap between the YTD savings target in red and the level of actual savings delivered in green, with full details provided in the table.





Service Area	Savings Delivery						
	Annual Plan Target	In Mth Target	In Mth Actual	In Mth Variance	YTD Target	YTD Actual	YTD Variance
	£M	£M	£M	£M	£M	£M	£M
Morr	16.08	1.34	0.67	(0.67)	12.06	7.66	(4.41)
NPTS	16.12	1.34	0.74	(0.61)	12.09	5.15	(6.94)
PCT	12.98	1.08	0.83	(0.25)	9.74	4.27	(5.47)
MH/LD	5.70	0.47	0.62	0.14	4.27	2.61	(1.67)
Nursing Director	0.04	0.00	0.00	0.00	0.03	0.03	0.00
Medical Director	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Workforce & OD	0.36	0.03	0.05	0.02	0.27	0.20	(0.07)
Digital Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Estates	1.39	0.12	0.05	(0.06)	1.05	0.47	(0.58)
Finance, Capital Planning, CF, R&S &PFI	0.13	0.01	0.01	0.00	0.10	0.10	0.00
Board Secretary	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Chief Operating Officer	1.98	0.16	0.10	(0.07)	1.48	0.34	(1.14)
Dir Therapies	0.13	0.01	0.00	(0.01)	0.10	0.00	(0.10)
DICE	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Director of Strategy (Corporate)	0.01	0.00	(0.00)	(0.00)	0.01	0.01	(0.00)
Public Health Wales	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Central Budget N/R Opportunities	0.51	0.04	0.25	0.21	0.38	2.76	2.38
TOTAL	55.44	4.62	3.32	(1.30)	41.58	23.59	(17.99)

In summary the £58.7m plan required the Health Board to deliver £55.4m of savings. In Month 9 there was an underachievement of savings totalling £1.3m. YTD there remains a shortfall of £18m. This is the key issue in the delivery of the 2025/26 financial position.

3. Savings schedule as at December 2025

An element of £55.4m plan submitted on the 11 September 2025 was not going to be delivered through savings, a proportion was to be achieved via Non-Recurrent Opportunities and underspend in operational budgets which relates to the Gap reported in the first table. The first below table provides a summary of the planned savings schemes, which total £46.9m, broken down by Pipeline, Red, Amber and Red. The second table provides the full reconciliation of the £55.4m and how the £8.6m will be achieved.



Service Area	Annual Plan Target	Planned Schemes					
		Pipeline Schemes	Red Schemes	Amber Schemes	Green Schemes	Total	Gap / (Surplus) to Target
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Morriston	16.08	5.89	1.30	0.45	7.79	15.43	0.65
NPTS	16.12	4.34	0.00	0.32	7.71	12.37	3.75
PCT	12.98	1.37	0.00	0.00	4.77	6.14	6.85
MH/LD	5.70	1.53	0.00	0.00	4.38	5.91	(0.21)
Nursing Director	0.04	0.29	0.00	0.00	0.04	0.33	(0.29)
Medical Director	0.00	0.02	0.00	0.00	0.00	0.02	(0.02)
Workforce & OD	0.36	0.14	0.00	0.00	0.36	0.50	(0.14)
Digital Services	0.00	0.33	0.00	0.00	0.00	0.33	(0.33)
Estates	1.39	0.31	0.00	0.00	0.51	0.81	0.58
Finance, Cap Planning, CF, PFI & R&S	0.13	0.11	0.00	0.00	0.25	0.36	(0.23)
Board Secretary	0.00	0.07	0.00	0.00	0.00	0.07	(0.07)
Chief Operating Officer	1.98	0.28	0.00	0.00	0.63	0.90	1.07
Dir Therapies	0.13	0.04	0.00	0.00	0.00	0.04	0.09
DICE	0.00	0.01	0.00	0.00	0.00	0.01	(0.01)
Director of Strategy	0.01	0.02	0.00	0.00	0.01	0.03	(0.02)
Public Health Wales	0.00	0.03	0.00	0.00	0.00	0.03	(0.03)
Central Budget N/R Opportunities	0.51	0.10	0.00	0.00	3.47	3.58	(3.07)
TOTAL	55.44	14.88	1.30	0.77	29.93	46.88	8.56

Ref	RAG	Plan £M
B3	Amber	3.3
B3	Green	23.3
C2	Pipeline (Local)	1.7
C3	Pipeline C3	6.8
D1-D3	Pipeline D1, D2 or D3	9.0
C1	Red (Trackers)	2.7
Sub Total Savings Trackers		46.8
C1	Red (Corporate Stretch)	1.5
B2	NR Opportunities	4.6
B1	Corporate Underspend	2.5
Sub Total Other Actions		8.6
TOTAL		55.4



PERFORMANCE AND FINANCE COMMITTEE Key Issues Report

The purpose of this report is to provide an overview of the matters identified by the Performance and Finance Committee to be brought to the attention of the Board following discussions at the last meeting.

Date of Committee meeting:	25 November 2025
Members Present:	Four Members were present at the Performance and Finance Committee, Patricia Price, Committee Chair, Independent Member, Jean Church, Independent Member, Reena Owen, Independent Member, Anne-Louise Ferguson, Independent Member.
Quoracy:	YES
Group/Committee Chair:	Patricia Price, Performance and Finance Committee Chair.
Report Submitted by:	Corporate Governance.
Report Signed off by:	Patricia Price, Performance and Finance Committee Chair Darren Griffiths, Director of Finance and Performance.
Date of Board receiving the report:	29 January 2026

1.	Agenda	The Performance and Finance Committee convenes monthly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert	The Committee is alerting the Board to the following items (3): • Service Group Financial Position: Morriston Service Group: The Committee agreed to alert the Board to the Morriston Service Group's £6.4m deficit shortfall. It was noted that, despite ongoing work to achieve savings and reduce staff unavailability and variable pay, no clear solution had been identified to address the deficit. The position was already contingent upon the closure



	Minute Reference: 205/25	of surge beds in Morriston, which was recognised as a significant challenge. The Committee noted a projected £10m financial risk for 2026/27 arising from continued difficulties in delivering savings, managing variable pay, and addressing staff unavailability. These concerns were considered sufficient to warrant placing the matter on alert for the Board. • Month Seven Financial position: The Committee agreed to alert the Board to the current low level of assurance in achieving the £58.7m deficit target and noted significant concerns about the opening financial position for 2026–27. It was acknowledged that savings from executive-led programmes and enhanced controls had not yet materialised, and assurance remained dependent on progress over the coming weeks. Members recognised that while the route to cash savings was clear, delivery required robust accountability through the Recovery and Sustainability (R&S) Board. Immediate critical actions included converting red-rated savings, implementing bed base reductions despite winter pressures, tightening controls on variable pay, and strengthening programme leadership. Additional measures involved weekly executive reviews of variable pay requests, improved flow through a proposed step-down ward in Singleton Hospital and embedding a revised performance management framework in Quarter One 2026–27. The Committee agreed to highlight both the current low assurance and the actions underway in its communication to the Board. • Recovery and Sustainability (R&S) Update: The Committee agreed to alert the Board to the key issues identified within the finance papers. These included the urgent need to enhance delivery capacity and programme leadership, the critical role of the Board in holding executive colleagues to account for delivery, and the
	Minute Reference: 206/25	



		requirement to implement a revised Performance Management Framework.
3.	Assurance Minute Reference: 207/25 Minute Reference: 207/25 Minute Reference: 208/25	The Committee is assuring the Board on the following items (3): • Month Seven Integrated Performance (IPR)/Escalation Report: The Committee considered the monthly update on performance against escalation measures and de-escalation criteria and took assurance from the report. Also, the Committee acknowledged and discussed Health Board performance against key measures and targets. Member recognised delivery of the 2025/26 Annual Plan in Quarter Two. • Urgent and Emergency Care (UEC)/Clinically Optimised Patients (COP) update: The Committee took assurance from the update. • Quarter two Continuing Healthcare Performance report and Centralisation of the CHC Commissioning function: The Committee considered the contents of the report and took assurance from the information presented.
4.	Advise	The Committee is advising the Board on the following items (1): • Plans to improve out-of-hours service provision in Urgent and Emergency Care (UEC): The Committee acknowledged that Urgent and Emergency Care services operate continuously; however, gaps in medical, nursing, and specialist cover remain during evenings and weekends, as most services are not fully operational during these periods. Seven-day working was a Welsh Government and Health Board priority, but full implementation would require substantial investment; current efforts are focused on targeted service extension and learning from the experiences of other Health Board's. The following were noted:



		- A review of community services was currently underway to inform future out-of-hours service provision, including virtual wards and domiciliary care. This review would also inform the work on capacity to deliver the discharge to recover and assess pathway. - The funding has been secured to support the older persons assessment unit to run seven days a week and to expand the single point of access hub, with recruitment efforts ongoing. - The Same Day Emergency Care (SDEC) has been identified as another significant area of focus, with support from Deloitte and the Welsh Government for a 90-day sprint aimed at improving winter resilience.
5.	Review of Risks	The Performance and Finance Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	None identified during the meeting.





PERFORMANCE AND FINANCE COMMITTEE Key Issues Report

The purpose of this report is to provide an overview of the matters identified by the Performance and Finance Committee to be brought to the attention of the Board following discussions at the last meeting.

Date of Committee meeting:	16 December 2025
Members Present:	Five Members were present at the Performance and Finance Committee, Patricia Price, Committee Chair, Independent Member, Stephen Spill, Vice Chair, Martin Lloyd, Independent Member, Reena Owen, Independent Member, Anne-Louise Ferguson, Independent Member.
Quoracy:	YES
Group/Committee Chair:	Patricia Price, Performance and Finance Committee Chair.
Report Submitted by:	Corporate Governance.
Report Signed off by:	Patricia Price, Performance and Finance Committee Chair Darren Griffiths, Director of Finance and Performance.
Date of Board receiving the report:	29 January 2026.

1.	Agenda	The Performance and Finance Committee convenes monthly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert	The Committee is alerting the Board to the following items (3):
	Minute Reference: 220/25	Neath Port Talbot Singleton Service Group: An end-of-year overspend was forecast for the Service Group largely driven by the shortfall in savings delivery. £8m savings were predicted against a target of £16.1m. The overall yearend overspend was forecast at £6.2m, including a £1m primary care prescribing



Minute
Reference:
173/25

overspend and potential nondelivery of risks increasing the gap to £9.4m.

Recurrent savings were forecast as £8.9m and would result in a savings shortfall of £7.2m in 2026-27.

The Service Group continues to work to address savings delivery in collaboration with the executive-led savings schemes. Ongoing efforts are also being made to address sickness 'hotspots' through staff engagement, well-being work and improving adherence to sickness management policy, with some improvement seen in levels of long-term sickness. There is recognition that the quality of conversations related to sickness management need improvement

- **Month Eight Financial Position and Recovery and Sustainability Update:** The Committee had seen and discussed plans to close the £13m savings deficit and deliver the full £55.4m savings as planned. Committee members noted the difficulty in assessing confidence levels when the savings outlined had not yet come through the savings trackers / ledger. However, members welcomed the continued focus on recurrent savings.

Variable pay reduction was now to be enabled through a stringent system control in the first instance with ongoing daily executive decision making and a line of sight to known challenges across the system. Non-pay control would be through a ban on certain categories of spend with a 50% reduction as a minimum expected.

Confidence levels in the granularity of the savings plan had therefore increased, however, members requested ongoing frequent reporting. Updates to include the Urgent Emergency Care (UEC) planned savings to be delivered via the opening of appropriately staffed surge beds in Singleton for clinically optimised patients and the subsequent closure of acute surge beds in Morriston. This was seen to be challenging given the system flow issues in Morriston and potential for increased winter demand. Also requested were regular updates on the repatriation of adult mental health private placements that stood at 33 in November.



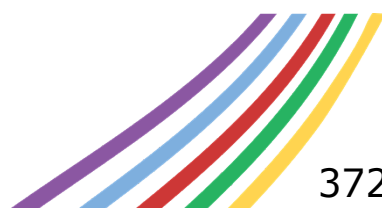
	Minute Reference: 219/25	• Escalation Report and the Integrated Performance Report for month Eight: The Committee considered the monthly update regarding performance against escalation measures and de-escalation criteria. It acknowledged and discussed the Health Board's performance against key measures and targets. The Committee agreed to alert the Board to the absence of 24/7 stroke consultant cover and proposed escalation, noting that other Health Boards with comparable demand had already established this provision.
3.	Assurance Minute Reference: 219/25	The Committee is assuring the Board on the following items (1): • Escalation Report and the Integrated Performance Report for month Eight: Members took assurance from updates provided that included an enhanced level of detail in relation to endoscopy, cancer care and stroke.
4.	Advise	The Committee is advising the Board on the following items (1): • The Women's Health Hub: An update was requested as part of any other business. The Chief Operating Officer confirmed that the initiative was a Pathfinder project due to go live at the end of March 2026. She noted that the hub would focus on virtual access and the upskilling of clinicians to support long-term sustainability. Although the Welsh Government had expressed a preference for a physical hub, she stated that a virtual model provided greater equity and would remain sustainable should additional funding not be secured. A substantive update/report on the Women's Health Hub would come to the February 2026 meeting.
5.	Review of Risks	The Performance and Finance Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

7.	Actions to be considered by Board	None identified during the meeting.





WORKFORCE AND OD COMMITTEE Key Issues Report

The purpose of this report is to provide an overview of the matters identified by the Workforce and OD Committee to be brought to the attention of the Board following discussions at the last meeting.

Date of Committee meeting:	11 December 2025
Members Present:	Three Members were present at the Workforce and OD Committee: Jean Church, Andrew Griffiths, and Reena Owen.
Quoracy:	YES
Group/Committee Chair:	Reena Owen, Workforce and OD Committee Chair.
Report Submitted by:	Corporate Governance.
Report Signed off by:	Reena Owen, Workforce and OD Committee Chair Tina Ricketts, Director of Workforce and OD.
Date of Board receiving the report:	29 January 2026.

1.	Agenda	The Workforce and OD Committee convene bi-monthly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert Minute Reference: 103/25	The Committee is alerting the Board to the following items (3): • Staff Story: Minor Injury Unit (MIU): The Committee acknowledged and agreed that the updated Workforce Plan, incorporating actions relating to protected non-clinical education time and security on site, would be returned to the Committee for review in February 2026. It was further agreed that the Workforce and OD team would provide support to MIU in the development of the revised workforce plan.



	Minute Reference: 104/25 Minute Reference: 105/25	In addition, the Committee agreed that, given the number and seriousness of unresolved issues (vacancy rate for Emergency Nurse Practitioners, protected education time, on site security) an alert should be issued to the Board. The alert would indicate that assurance could not currently be provided and would be accompanied by a summary of actions being taken to address the outstanding matters, which have been referred to the Management Board. • Workforce risks and issues affecting the Mental Health and Learning Disabilities (MH&LD) Service Group: The Committee agreed that the Board should be alerted to concerns regarding high sickness rates, PADR compliance below target, and high Health Care Support Worker (HCSW) vacancies. It was further agreed that the MH&LD Interim Service Group Director would provide a subsequent report in April 2026, setting out timescales and the outcomes of the nurse staffing review. • Strategic Risk Register including a referral from Audit Committee – Operational Risk: Workforce Shortages: The Committee agreed to alert the Board that a review of strategic, corporate, and operational workforce risks was in progress, with updates expected by February 2026.
3.	Assurance Minute Reference: 109/25	The Committee is assuring the Board on the following items (4): • Annual Nurse Staffing Levels (Wales) Act 2016 report. The Committee agreed to take assurance from the report, as it demonstrated compliance with the Nurse Staffing Levels (Wales) Act 2016 and outlined a clear plan for ongoing and future workforce measurement. It was further agreed that no formal alert would be issued; the Committee confirmed satisfaction with the current position and the direction of travel for further workforce assurance.



	Minute Reference: 110/25	• Gorseinon Staffing Issues. The Committee agreed to refer patient safety and quality audit issues to the Quality and Safety Committee for ongoing monitoring. The Committee also agreed that assurance was taken from the report regarding improvements in staffing, oversight, and sickness management, with continued monitoring and further updates planned. • Staff vaccination rates report. The Committee was assured that proactive measures were in place to improve staff flu vaccination rates, including targeted outreach, enhanced communication, and myth-busting initiatives, with continued efforts planned to increase uptake. • HEIW visit report for Obstetrics and Gynaecology. The Committee took assurance from the report, recognising significant progress in culture and training, while noting the remaining focus on improving and auditing handover documentation. It was further agreed that the report provided assurance regarding the status of Obstetrics and Gynaecology following the HEIW visit.
	Minute Reference: 111/25	
	Minute Reference: 112/25	
4.	Advise	The Committee is advising the Board on the following items (3):
	Minute Reference: 106/25	• The Director of Workforce and OD report. The Committee was advised by the information presented within the report that they had been updated on the key national issues impacting the workforce. • Health Board strategic workforce plan overview and progress updates report. The Committee agreed to advise the Board that a comprehensive review of workforce planning was underway, focusing on aligning top-down financial requirements with bottom-up service needs and ensuring clarity in establishment definitions and reduction targets. The Committee was assured that more detailed reconciliation and financial alignment would be presented at future meetings.
	Minute Reference: 107/25	



	Minute Reference: 108/25	It was acknowledged that no formal alert was issued; however, the Committee recognised the importance of ongoing monitoring and updates, particularly considering financial pressures and the need for clarity on establishment definitions and reduction targets. • Variable, pay plan overview and progress updates report. The Committee agreed that there was only limited assurance at this stage regarding variable pay controls, due to ongoing cultural and accountability challenges. It was further agreed to advise the Board that additional reinforcement through the development of a new variable pay accountability frameworks for managers would be monitored for impact.
5.	Review of Risks	The Workforce and OD Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	None identified by the Committee Members.





Meeting Date	29 January 2026	Agenda Item	5.2																											
Name of Meeting	SBUHB Board																													
Report Title	Organised for Success Programme Update																													
Report Author	Tina Ricketts, Director of Workforce & OD & Matt Lewis, Programme Lead																													
Report Sponsor	Tina Ricketts, Director of Workforce & OD																													
Presented by	Tina Ricketts, Director of Workforce & OD																													
Freedom of Information	Open																													
Purpose of the Report	This report updates the Board on the progress of the Organised for Success programme. The current status of the programme is as follows: <table><tr><th>Phase</th><th>Description</th><th>Status</th></tr><tr><td>A</td><td>Executive Portfolios</td><td>Stage 1 completed</td></tr><tr><td>B</td><td>Deputy/ Tier 2 Management Structure</td><td>In progress</td></tr><tr><td>C</td><td>The Establishment of a Delivery Unit</td><td>In progress</td></tr><tr><td>D</td><td>Joint Posts across the Regional Partnership</td><td>Not started</td></tr><tr><td>E</td><td>The establishment of a new care group structure</td><td>In progress</td></tr><tr><td>F</td><td>A review of the care group leadership structure – confirming the Triumvirate Leadership model (e.g. operationally led or clinically led)</td><td>In progress for Service Group Tri level</td></tr><tr><td>G</td><td>A review of the number of divisions or directorates within each new care group to ensure spans of control are reasonable and equitable. This will include a review of the specialities and services managed under each of the care groups to ensure they are organised in the best way for our patients</td><td>In planning</td></tr><tr><td>H</td><td>A review of the number of management layers within the new care groups with the aim to have a maximum of 6 layers,</td><td>In planning</td></tr></table>			Phase	Description	Status	A	Executive Portfolios	Stage 1 completed	B	Deputy/ Tier 2 Management Structure	In progress	C	The Establishment of a Delivery Unit	In progress	D	Joint Posts across the Regional Partnership	Not started	E	The establishment of a new care group structure	In progress	F	A review of the care group leadership structure – confirming the Triumvirate Leadership model (e.g. operationally led or clinically led)	In progress for Service Group Tri level	G	A review of the number of divisions or directorates within each new care group to ensure spans of control are reasonable and equitable. This will include a review of the specialities and services managed under each of the care groups to ensure they are organised in the best way for our patients	In planning	H	A review of the number of management layers within the new care groups with the aim to have a maximum of 6 layers,	In planning
Phase	Description	Status																												
A	Executive Portfolios	Stage 1 completed																												
B	Deputy/ Tier 2 Management Structure	In progress																												
C	The Establishment of a Delivery Unit	In progress																												
D	Joint Posts across the Regional Partnership	Not started																												
E	The establishment of a new care group structure	In progress																												
F	A review of the care group leadership structure – confirming the Triumvirate Leadership model (e.g. operationally led or clinically led)	In progress for Service Group Tri level																												
G	A review of the number of divisions or directorates within each new care group to ensure spans of control are reasonable and equitable. This will include a review of the specialities and services managed under each of the care groups to ensure they are organised in the best way for our patients	In planning																												
H	A review of the number of management layers within the new care groups with the aim to have a maximum of 6 layers,	In planning																												



		where appropriate, from Board to front line staff with a focus for this programme on the top 4 layers (Tri, Division, Directorate, speciality/ service)	
	I	A review of the wraparound support for each new care group (e.g. HRBP, Finance BP) to ensure this is reasonable and equitable	Not started
	J	A review of corporate functions sitting in/ out of care groups to ascertain the most appropriate design of the function (e.g. hub and spoke, centralised)	Not Started
Key Issues	The executive team portfolios have been reviewed and updated. These can be found in appendix two. Work has commenced on the executive team deputy structure. This will be completed by 31st March 2026. A central delivery unit will be established and headed up by a new role of Director of Delivery, subject to approval. The job description is being developed and the role submitted to vacancy control panel for scrutiny before being evaluated and advertised. The following functions are being considered for the delivery unit, subject to further engagement and consultation: • PMO programme/ project management • Transformation • Improvement • Business Intelligence • Performance The unit will be staffed within existing resource, who subject to consultation, will be redeployed into the unit. The unit will focus our existing capability and capacity on Health Board priorities and is critical to the delivery of the Organised for Success Programme.		



	Service Group Tri's have been consulted on the new Care Group Structure and whether the top tier of management should be clinically or operationally led (phases E&F). The consultation closed on 4th January 2026 with the following outcomes: • Support has been received for the establishment of 6 Care Groups with a proposed change in name for the Neighbourhood Care Group to Integrated Community Services Care Group, which has been accepted and is recommended to the Board for approval. The next step is to undertake wider engagement and consultation on what services should sit within each Care Group and how these should be grouped into Directorates. • There was mixed feedback on whether we should move to a clinically led model and what that model should look like with concerns raised about the tight timeline for this to be implemented by 1st April 2026. This feedback has been accepted, and it is recommended that wider consultation and engagement across the organisation is undertaken to determine the preferred leadership model. • Planning will continue at pace to establish the new care group structures and to support the identification of priority services for transformation as we move from a geographically based operational model to a thematic service model. • Given the above it is recommended that the go live date for the new Care Group structure is pushed back to 1 September 2026.			
Specific Action Required <i>(please choose one only)</i>	Information	Discussion	Assurance	Approval
	☐	☐	☐	☒
Recommendations	The Board is asked to: • RECEIVE the updated executive team portfolios • PROVIDE FEEDBACK on the proposed functions of the delivery unit			



	• CONSIDER the outcome of the consultation related to phases E&F noting that further engagement and consultation is recommended on the proposed leadership model • APPROVE the planning and development of a new operating model (moving from 4 x Service Groups to 6 x Care Groups) with a go live date of 1 September 2026 • APPROVE the new name of Integrated Community Services Care Group in place of Neighbourhood Care Group

Organised for Success Programme

1. Introduction/ Background

The Organised for Success programme has been set up to support us to be organised in the most effective way to delivery in year and medium terms improvements. The programme is a key enabler in the delivery of the savings benefit associated with headcount reduction (as identified by the Recovery and Sustainability Board), which will include a management restructure of our clinical services and corporate functions.

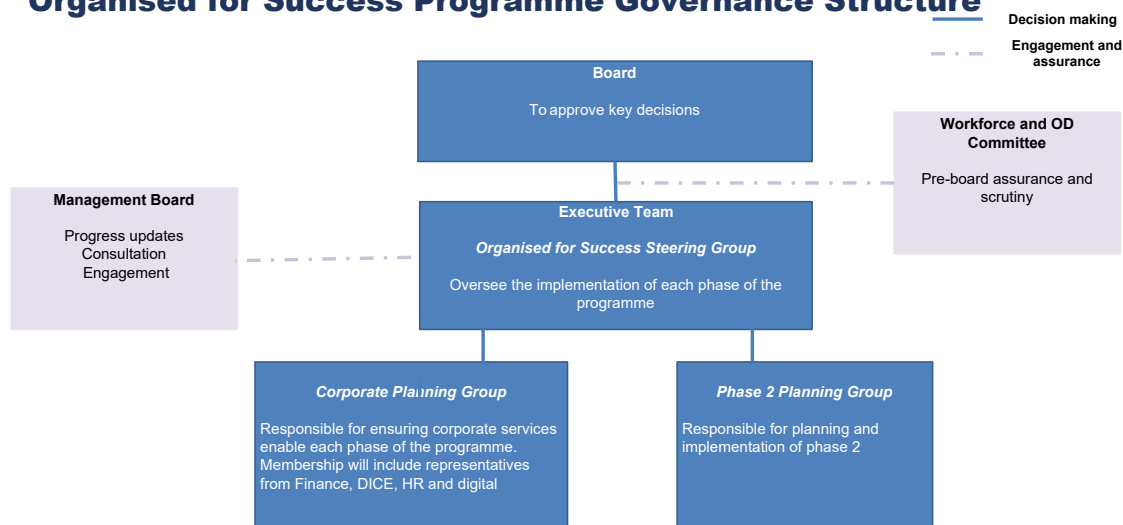
This programme of work will review executive portfolios, service group structures and management spans of control and will make recommendations on how we organise ourselves for success. The programme will also bring together our PMO, transformation, business intelligence, performance and improvement capability through the establishment of a Delivery Unit.

2. Terms of Reference

As a reminder the terms of reference of the programme are set out in **appendix 1**.

The governance structure for the programme is set out in the diagram below. The Formal Executive Team Meeting will be the Steering Group for the programme with key decisions being made by the Board. The Management Board will receive regular progress updates and will be consulted and engaged on key decisions.

Organised for Success Programme Governance Structure





3. Executive Portfolios

The review of the executive team portfolios has been completed. The updated portfolios are set out in **appendix 2** for information.

The portfolios may be subject to further review following the resignation of the Director of Finance. This will be completed by 31st March 2026.

4. Executive Team Deputy Structure

Meetings are taking place with each executive team director to review their deputy structure in response to the changes to executive team portfolios.

This work will be completed by 31st March 2026.

5. Central Delivery Unit

A central delivery unit will be established and headed up by a new role of Director of Delivery. The job description is being developed and will be subject to vacancy control scrutiny and job evaluation. The following functions are being considered for the delivery unit, subject to consultation:

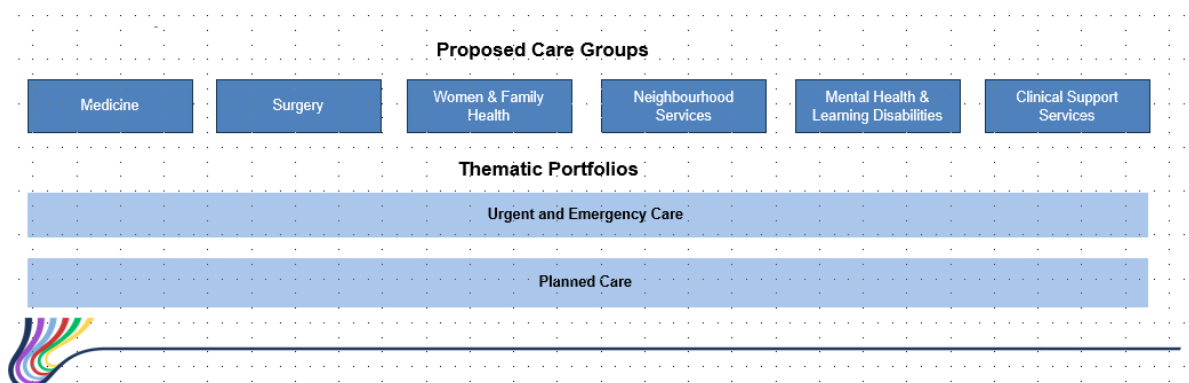
- PMO programme/ project management
- Transformation
- Improvement
- Business Intelligence
- Performance

Stage 1 will be to “lift and shift” the agreed functions into the delivery unit. Stage 2, a review of how the delivery unit should be structured, will be led by the Director of Delivery when they are in post (subject to the post being approved).

6. Proposed Care Group Structure

The proposed Care Group Structure is as follows. The consultation with the Service Group Tri’s closed on 4th January 2026. There was support for the 6 Care Group structure. However, there was strong views that the Neighbourhood Services Care Group should be renamed, which has been accepted. The Board is asked to approve the new name of “Integrated Community Services Care Group”.

Further consultation and engagement will take place on the structure and content of each Care Group i.e. where each service/ speciality will sit and how they will be grouped.



There was mixed feedback on whether we should move to a clinically led model with concerns raised about the tight timeline for this to be implemented by 1st April 2026. This feedback has been accepted, and it is recommended that wider consultation and engagement across the organisation is undertaken to determine the preferred leadership model.

Planning will continue at pace to establish the new care group structures and to support the identification of priority services for transformation as we move from a geographically based operational model to a thematic based service model.

Given the above it is recommended that the go live date for the new Care Group structure is pushed back to 1st September 2026.

7. Key Risks

The Board should be aware of the following risks:

Key Risks	Current risk rating	Mitigating Actions	Risk Owner
There is a risk that the implementation of the programme will be delayed due to lack of programme management capacity	8	Programme Lead appointed and commenced full-time on 2 nd January 2026	Director of Workforce & OD
There is a risk that the challenging timelines of the programme will not be met due to senior colleagues not seeing this programme as a priority/ not releasing the required resource	12	The resourcing of the programme will be overseen by the Steering Group. The establishment of a central delivery unit has been incorporated in phase 1 of the programme. This will be responsible for	Director of Workforce & OD



		ensuring that all key HB programmes are adequately resourced.	
There is a risk that the operational performance of the Health Board is negatively impacted as colleagues become distracted with the programme/ associated organisational change processes	9	Operational performance will be overseen by the central delivery unit. The establishment of a delivery unit has been incorporated in phase 1 of the programme. Gateways are being developed for each phase of the programme so that a decision can be made on whether we are in a position to "go" safely. The criteria for each gateway will be shared with the Board for approval.	Chief Operating Officer Programme Lead
The programme will require a restructure of our budgets and corporate systems (e.g. the Electronic Staff Record System). There is a risk that this may limit the capacity of the corporate teams to work on other priorities.	12	Two planning groups have been set up with one focused on the restructure of our budgets and corporate systems. Regular updates on progress will be provided to the Steering Group. The impact on other priorities will be managed through the delivery unit.	Programme Lead

8. Next Steps

The programme lead's priorities are as follows:

- Working with the Director of Workforce & OD to update executive team job descriptions to reflect the portfolio changes
- Supporting the Director of Planning and Partnerships and the Executive Team to articulate the proposed function and remit of the Delivery Unit, with a subsequent step of drafting a consultation document, including those in scope



- Supporting the Chief Operating Officer with the outcome report for phase E&F following the closure of the consultation on 4th January 2026.
- Setting up and leading the two planning groups
- Drafting the gateway criteria for each phase of the programme

9. Recommendations

The Board is asked to:

- **RECEIVE** the updated executive team portfolios
- **PROVIDE FEEDBACK** on the proposed functions of the delivery unit
- **CONSIDER** the outcome of the consultation related to phases E&F noting that further engagement and consultation is recommended on the proposed leadership model
- **APPROVE** the planning and development of a new operating model (moving from 4 x Service Groups to 6 x Care Groups) with a go live date of 1 September 2026
- **APPROVE** the new name of Integrated Community Services Care Group in place of Neighbourhood Care Group



Governance and Assurance		
Link to Enabling Objectives (please choose)	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High-Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☐
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☒
Quality, Safety and Patient Experience		
The aim of phase 2 of the programme is to structure our services to improve patient experience. Currently services are structured on a geographical basis.		
Financial Implications		
The financial savings from the programme have not yet been quantified as we are still working through potential scenarios including the impact of the pay protection policy.		
Legal Implications (including equality and diversity assessment)		
An equality and diversity impact assessment will be undertaken for each phase of the programme.		
Staffing Implications		
The aim of the programme is to see a reduction in management tiers and equity in spans of control where possible. Staffing implications are still being scoped.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
As set out in the report.		
Report History	Not applicable	
Appendices	1. Organised for Success Terms of Reference v7 2. Executive Team Portfolios	

Organised for Success Programme

Terms of Reference v7 31st October 2025

1.0 Context

Following from feedback from across the organisation, there is a recognised need to review how we are organised so that we are best placed to respond to the challenges we face in the most effective and efficient way, balancing short-term actions required to ensure delivery of in-year targets, and our longer term goals as set out in our refreshed strategy, Better Health, Better Care, Better Lives. We also know from both internal and external feedback (including internal and external audit, independent reviews) that we don't yet have the right operating framework in place that aligns planning, performance, accountability and delivering – from Board through to front line services.

From recent reviews it has become evident that some clinical services (e.g. Emergency Department, Perinatal and Mental Health) need a period of enhanced management oversight to improve patient and staff experience at pace. Furthermore, staff survey results and other workforce metrics, such as high sickness absence rates, indicate that there is variability in the capacity and capability of managers across the health board impeding on our ability to deliver our strategic objectives and priorities.

Our clinical services plan will be the vehicle through which we review and refresh our plans for how best to configure and delivery our clinical services – recognising the need to delivery more care through integrated community services which provide care closer to home, increase digitally enabled care, and focus more of our resources on population health management through better prevention and early intervention to tackle the widening health inequities in our communities.

Our workforce has grown by c2,200 over the last five years despite a large proportion (c26%) of our services transferring to a neighbouring health board. We are currently delivering services in a way that is unaffordable with a current cost reduction requirement of around 8% in 2025/26 and similar for 2026/7. This requires us to be more radical and injecting more pace in to transforming our services, so they are sustainable – in terms of quality and safety, cost and workforce. Our current pay bill is unaffordable and needs to reduce by a minimum of 10% to ensure we remain sustainable into the future. This requires short term action to significantly reduce what it costs to delivery our services and medium-term service transformation, building on the successes we see every day.

The Organised for Success programme has been set up to support us to be organised in the most effective way to delivery in year and medium terms improvements – to set us up so we can be successful for the populations we serve, for our team colleagues across the organisation and for Ministers, to whom we are ultimately accountable.

The Organised for Success Programme is a key enabler in the delivery of the savings benefit associated with headcount reduction (as identified by the Recovery and Sustainability Board), which will include a management restructure of our clinical services and corporate functions. This programme of work will review executive portfolios, service group structures and management spans of control and will make recommendations on how we organise ourselves for success.

2.0 Programme Scope

The programme will include:

Phase 1 – Executive Portfolios/ Delivery Unit

- a) A review of executive portfolios
- b) A review of the deputy/ tier 2 management structure (those reporting to an executive director)
- c) The establishment of a delivery unit to bring together our PMO, transformation and improvement capability
- d) To explore the opportunity for joint appointments to support regional working with Hywel Dda

Phase 2 – Service Group Structures

- e) The establishment of a new care group structure
- f) A review of the care group leadership structure – confirming the Triumvirate Leadership model (e.g. operationally led or clinically led)
- g) A review of the number of divisions or directorates within each new care group to ensure spans of control are reasonable and equitable. This will include a review of the specialities and services managed under each of the care groups to ensure they are organised in the best way for our patients
- h) A review of the number of management layers within the care groups with the aim to have a maximum of 6 layers, where appropriate, from Board to front line staff with a focus for this programme on the top 4 layers (Tri, Division, Directorate, speciality/ service).

Phase 3 – Corporate Service Structures

- i) A review of the wraparound support for each new care group (e.g. HRBP, Finance BP) to ensure this is reasonable and equitable
- j) A review of corporate functions sitting in/ out of the new care groups to ascertain the most appropriate design of the function (e.g. hub and spoke, centralised)

3.0 Out of scope

- Medical and dental staff with the exception of Medical Directors, Clinical Directors and Clinical Leads
- Agenda for change staff with the exception of those in an operational managerial position of band 7 and above and this forms 100% of their work

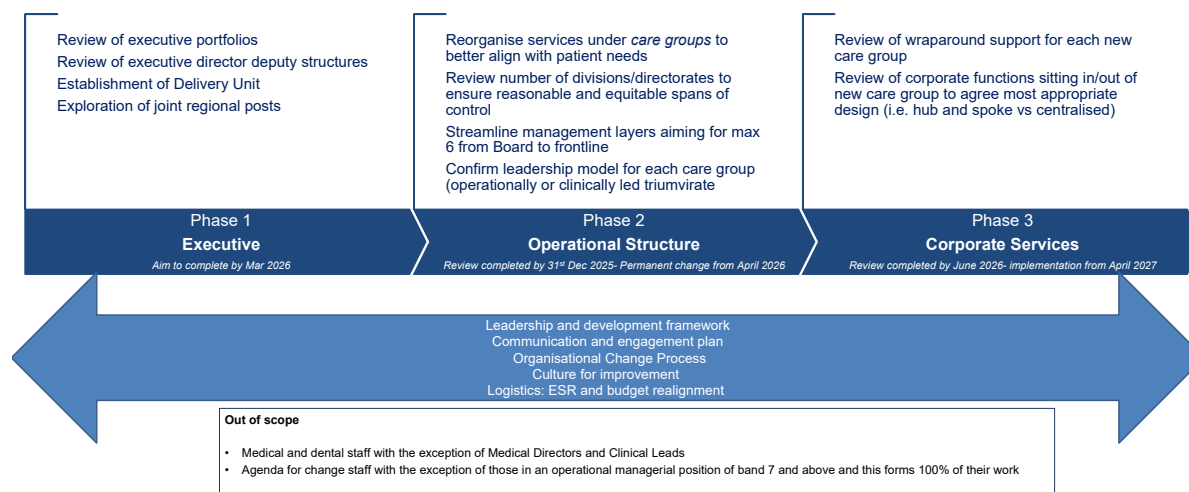
4.0 Phased Approach

The programme plan is set out in the diagram below:

Phasing and scope of the programme

The programme is in early initiation phase, which means we are just getting started in setting up programme arrangements to help organise our effective delivery

The programme will be delivered in 3 phases:



There are 5 enablers to the programme:

1. Leadership and management development framework
2. Programme communications and engagement plan
3. Performance Management Framework
4. Accountability Framework
5. Single Improvement Methodology

We are still modelling how these enablers will interface with the programme.

The programme will be undertaken in 3 phases with the ambitious implementation dates detailed in the following table:

Phase 1	Phase 2	Phase 3
A: - Review completed by - New portfolios in place by 1/01/26 B: - Review completed by 31/12/25 - New structure in place by 01/01/26 C: - Review completed by 31/03/26 D:	E: - Review completed by 31/12/25 - New structure in place 01/04/26 F: - Review completed by 31/12/25 - Permanent change 01/04/26 G: - Review completed by 31/03/26 - Permanent change 01/04/26	I: - Review completed by 30/09/26 - Implementation date of 01/04/27 J: - Review completed by 30/09/26 - Implementation date of 01/04/27

Review completed by 31/03/26	H: - Review completed by 31/03/26 - Permanent change 01/04/26	

Appropriate staff engagement and organisational change processes will be undertaken for each stage of the programme (A to J) in line with the Organisational Change Policy.

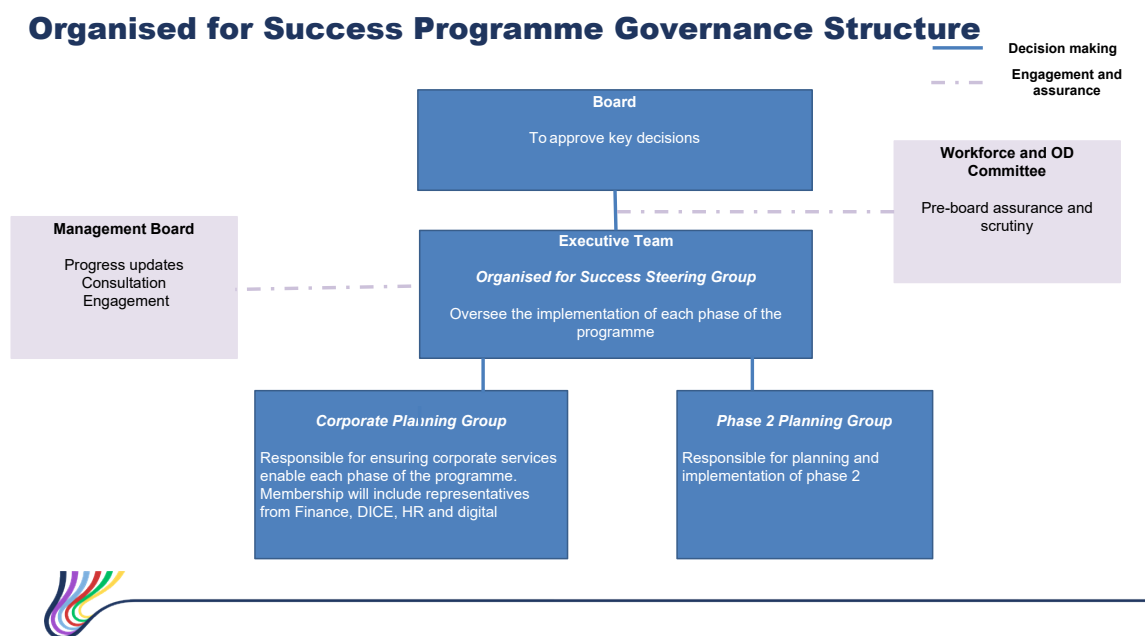
5.0 Interdependencies

The change in service group structure will require a restructure of budgets, the electronic staff records system and other workforce IT systems. The programme plan will therefore include a support service resource plan (from existing resource) to enable this activity.

Permanent changes to the service group structures will come into effect at the beginning of the new financial year (April 2026) to avoid new hierarchies being established in-year.

6.0 Governance

The Governance structure for the programme is set out in the following diagram:



Two planning groups will be established.

The corporate planning group will support the required changes to the financial ledger, budget structures, workforce IT systems and digital systems. Membership will include representatives from Finance, DICE, HR and digital.

The Phase 2 Planning Group will support the planning and implementation of phase 2 and will include operational and staff group representation.

The lead for each phase of the programme is as follows:

Phase	Description	Proposed Lead
A	Executive Portfolios	Chief Executive officer
B	Deputy/ Tier 2 Management Structure	Director of Workforce & OD working with each of the Executive Directors
C	The Establishment of a Delivery Unit	Director of Workforce & OD working with Deloittes
D	Joint Posts across the Regional Partnership	Chief Executive officer
E	The establishment of a new care group structure	Chief Operating Officer
F	A review of the care group leadership structure – confirming the Triumvirate Leadership model (e.g. operationally led or clinically led)	Director of Workforce & OD working with the Executive Team
G	A review of the number of divisions or directorates within each new care group to ensure spans of control are reasonable and equitable. This will include a review of the specialities and services managed under each of the care groups to ensure they are organised in the best way for our patients	Chief Operating Officer working with the Care Group Tri's
H	A review of the number of management layers within the new care groups with the aim to have a maximum of 6 layers, where appropriate, from Board to front line staff with a focus for this programme on the top 4 layers (Tri, Division, Directorate, speciality/ service)	Director of Workforce & OD working with Chief Operating Officer
I	A review of the wraparound support for each new care group (e.g. HRBP, Finance BP) to ensure this is reasonable and equitable	Director of Workforce & OD
J	A review of corporate functions sitting in/ out of care groups to ascertain the most appropriate design of the function (e.g. hub and spoke, centralised)	Director of Workforce & OD

The Director of Workforce & OD will be the overall programme lead and will be responsible for providing programme updates to relevant forums.

7.0 Programme RACI Table

Responsible, Accountable, Consulted, Informed

Deliverable	Board	WOD Committee	Exec team steering group	Corporate Planning Group	Phase 2 Implementation Group	Management Board	Service Groups
Final sign off on key strategic decisions	A	C	R	C	I	C	C
Oversee implementation	I	I	A/R	C	C	C	C
Provide progress updates	I	I	A/R	C	C	C	I
Pre-Board assurance and scrutiny	I	A	R	I	I	I	I
Plan each phase of the programme	I	I	A	R	C	C	I
Deliver phase 2 implementation	I	I	A	C	R	C	I

Swansea Bay University Health Board – Proposed Care Group Tri Functional Map for Consultation

Medical & Dental	Chief Operating Officer	Director of Finance, Capital & Estates	Director of Nursing and Patient Experience	Director of Planning and Partnerships	Director of Workforce/ OD	Director of Corporate Governance	Director of Digital	Director of Insight, Communications & Engagement	Director of Public Health	Director of Allied Health Professions and Health Science
Professional leadership, regulation and performance of doctors, dentists and physician associates	Operational and delivery lead for planned/ elective care	Health Board recovery and sustainability programme, encompassing planning and delivery across agreed programmes	Professional leadership, regulation and performance for nurses, midwives and health visitors	Organisational strategy and strategic planning framework	People strategy	Corporate Governance & Regulatory Compliance	Digital strategy	Communications and engagement	Advisor to the Board on all aspects of public and population health	Professional leadership, regulation and performance for allied health professions, optometrists, pharmacists and healthcare scientists
Clinical Services Plan	Delivery of planned care improvement and agenda	Financial services	Clinical Education for nurses, midwives and health visitors and healthcare support workers	Lead for Integrated medium term plan Annual plan	Organisational development	Board Secretariat	Digital Organisational Change	Strategic communications and engagement adviser to the Board	Population Health	Optometrists, pharmacists and healthcare scientists
Medical Appraisal and Revalidation	Operational and delivery lead for urgent and emergency care	Financial management, reporting and costing		Commissioning services from other health boards and outside Wales	Corporate, Learning and Development	Corporate Risk Management	Operational & clinical system alignment	Reputation management	Health inequalities	Clinical education for allied health professions and healthcare scientists
Medical Job Planning					Workforce Equality, Diversity & Inclusion	Operational Risk	Digital transformation	Corporate briefings	Public health programmes Lead eg Healthy Schools, HWHW, Core 20 Plus 5	Strategic Rehabilitation Framework
Study leave, professional leave and sabbatical leave for doctors	Responsible for patient flow and site services escalation management	Financial planning	Oversight lead for Perinatal Services Improvement	Continued healthcare commissioning lead	Occupational Health	Legal Services	Digital governance & assurance	Accessible information standards	Professional leadership, regulation, education and performance for Registered Public Health Practitioners and Consultants	Human Tissue Act
Medical Education & Training		Financial governance			Staff Health & Wellbeing	Independent members appointments	IT Networks	Patient Engagement		Human Fertilisation and Embryology Authority
Medical staff engagement	Operational and delivery lead for primary care & community services	Capital financial management	Quality Strategy and annual quality statement	Lead for Joint Commissioning Committee	Employee Relations	Gifts and hospitality	Data Centre	Ongoing public Engagement		
Clinical outcomes and clinical effectiveness		Capital programme	Health and care standards	Lead for Individual Patient Funding Requests	Workforce Planning	Board Assurance Framework	IT hardware	Stakeholder Engagement	Lead for Regional Health Protection function including LA and community interface (infection control, community clusters/outbreaks, environmental health, regulatory eg AIDS Control Act)	Blood Products
Mortality & Medical Examiners Officer	Operational and delivery lead for mental health and learning disabilities services	Estate strategy and development	Patient Safety strategy		Recruitment and retention	Freedom of Information	IT Service Desk	Staff Engagement		Radiation Protection
Medicines Management		Site master planning	Patient Safety Incident Response	Lead for strategic partnerships (local authorities, 3 rd sector etc) including chair of Area Planning Board	Medical Staffing	External Audit	Cyber Security			Medical Devices
Infection Prevention & Control	Operational and delivery lead for women, children and family services	Estates and hard facilities management	Quality contracting & performance		Single improvement methodology	Internal Audit	Health records	Lead for Public Engagement and consultation on service change		Additional learning needs Act 2008
Clinical audit	Seasonal planning, including winter operational plan and delivery	Health & Safety	Patient Experience	Planning lead for a regional collaboration for health (RJC)	Temporary workforce	HM Coroner lead relationship	Clinical System Contract Management and Service Level Agreements			Allied health professions and healthcare scientist workforce strategy
Research & Development Innovation		Contracts and commercial	Patient concerns/ Putting things right		Workforce IT systems	Lead for Covid Inquiry	System Administration, Testing, Configuration and Training	Welsh Language Standards	National immunisation framework lead	Lead for hosted Lymphoedema service
Consent	Transfer of Care Hub operational management and development of new ways of working to facilitate	Counter Fraud Procurement	Clinical risk management	Lead for Integrated Performance Improvement, Monitoring and Assurance	Payroll	Annual Report	EPR Developers, Architecture & Design Health Records	Lead for Swansea Bay Health Charity - income generation, fund engagement and line management of charity team	Lead for Public Health Partnerships - PSB interface	Genomics national delivery plan lead
Caldicott Guardian		Catalogue Management	Clinical lead for Continuing Healthcare	Healthcare Systems Engineering	International recruitment	Standing Orders/ Standing Financial Instructions	Registration Authority (Smartcards)		Public Health Lead to Area Planning Board for substance misuse	Bevan Commission
Clinical ethics		Consortium Management	Safeguarding including Mental Capacity Act and DOLs	Value Based Healthcare	Staff bank	Corporate Health Board Policies/Procedures	Digital Annual Delivery Plan	Public Affairs	Line management of public health team functions eg screening, immunisations, smoking cessation, early years, child public health	SRO for Regional Pathology Transformation Programme
Critical Care	Oversight lead for improved discharge services	Charitable Funds Accounts	Carers	Information Management	Freedom to Speak Up	Common Seal & Contracts	Digital Projects Management	Strategic Equity Plan (overall accountability for the SEP with delivery split between W&OD (workforce) and DICE (other stakeholders)		SRO for PET Programme
Organ donation			Prison Services	Business Intelligence	Social Partnership Relations	HQ Accommodation/Site Management	Digital applications		Supporting distributed leadership of the public health function on an all Wales basis – PHW and DPH Wales interface	Womens Health national delivery plan
Library services	Oversight lead for Mental health/ Learning disabilities improvement		Nursing and midwifery digital strategy	Data quality and standards	Relationship lead for Shared Service Wales	Board effectiveness	SIRO		Anchor institution lead/ Foundational Health Economy/ Regional Health Economy	Diagnostics national delivery plan lead
Executive lead for relationship with Swansea University			Nursing and midwifery documentation	Clinical Coding		Monitoring/ reporting on external inspections				Mortuary
SRO Spinal Network	Oversight lead for Emergency Department Improvement		Digital Literacy and Competence in nursing and midwifery	Information Governance Lead for Sustainability						Health Professions Forum
SRO Major Trauma Network	Soft Facilities Management		Support relationship with Health Inspectorate Wales and Public Service Ombudsman	Lead for Wellbeing of Future Generations Act Strategic project delivery and support (PMO/ Transformation/ value based healthcare team)						Adferiad Long Covid Programme
SRO Emergency Retrieval & Transport Service (EMRTS)	Armed Forces		Chaplaincy and Spiritual Services	Voluntary sector strategy and third sector service level agreements						Genomics Board
SRO, Hepatopancreaticobiliary (HPB) Programme Board (joint, with EMD Cardiff & Vale UHB)	Primary Care Liaison		Volunteering Services	Emergency Preparedness, Resilience and Response (EPRR)						
Deputy CEO Responsibilities: Oversight lead for future Cancer services improvement	Security		Care after death – bereavement/ end of life							
Lead for oversight of hosted services	MTC ODN hosted service		Welsh language translation services							



AUDIT COMMITTEE Key Issues Report

The purpose of this report is to provide an overview of the matters identified by the Audit Committee to be brought to the attention of the Board following discussions at the last meeting.

Date of Committee meeting:	20 November 2025
Members Present:	Three Members were present at the Audit Committee: Andrew Griffiths, Patricia Price and Nuria Zolle.
Quoracy:	YES
Group/Committee Chair:	Nuria Zolle, Audit Committee
Report Submitted by:	Corporate Governance.
Report Signed off by:	Nuria Zolle, Audit Committee Chair
Date of Board receiving the report:	29 January 2026

1.	Agenda	The Audit Committee convenes bi-monthly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert	The Committee is alerting the Board to the following items (0):
3.	Assurance	The Committee is assuring the Board on the following items (7): • Corporate Governance Policies: The Committee had received and reviewed the Claim Management Policy and the Standards of Business Conduct Policy. • Internal Audit: The internal audit plan had been received, delays in management responses and their rationale had been discussed, a report on areas where challenges persist would be considered.



	Minute Reference: 123/25 Minute reference: 128/25 Minute reference: 130/25 Minute reference: 132/25 Minute reference: 133/25	• Audit Wales Performance Progress: The Audit plan had been received and that work was underway on the charity accounts, alongside other accounts. • Financial Control Procedure: The Financial controls had been reviewed and were satisfactory. • Procurement: The single tender report had been received and scrutinised, with a request for additional information on Item #24 to follow. • Emergency Medical Retrieval and Transfer Service (EMRTS) Annual Report: The EMRTS Annual Report had been reviewed, highlighting the update on relocation and staff engagement. • Spinal Services Operational Delivery Network (ODN) Annual Report: The Spinal Services Operational Delivery Network (ODN) Annual Report, had been reviewed and discussed, and the risks identified would be monitored and reported as appropriate.
4.	Advise	The Committee is advising the Board on the following items (8): • Strategic Risk: A new system was in place for Risk Management, the Committee was happy for it to be implemented at this stage, the Committee would oversee how it operated in practice. • Audit (Internal and Audit Wales) Management Protocol: A new process was in place; the Committee would monitor its operation in practice. • Internal Audit: All Internal Audit reports had been reviewed at the Audit Committee meeting. - Key findings and priority issues from each report would be highlighted in the report back to the Board. - Reports reviewed included: - o Theatres Utilisation: Reasonable assurance, with a high-priority finding on lack of clinical engagement in the Theatre Quality and Safety Standards framework and governance issues;



		- o Vaccination and Immunisation: Reasonable assurance, with findings on misalignment between strategic plans, lack of SMART objectives, and limited evaluation of interventions; - o Digital Benefits Realisation: Substantial assurance, with minor issues around consistency in benefits management outside the digital services team; - o Medical Study Leave: Reasonable assurance, with a high-priority finding on inconsistent approvals and lack of formal reporting framework; - o Community Pharmacy: Reasonable assurance, with medium-priority findings on payments before SLAs are signed and limited formal reporting to Board/Committees.
	Minute reference: 124/25	• Audit Wales Structured Assessment: The Structured Assessment report had been received, and the management response was awaited.
	Minute reference: 125/25	• Audit Wales Unscheduled Care: The Unscheduled Care report was received, key findings were highlighted, and further assurances on management actions were sought.
	Minute reference: 126/25	• Audit Wales National Fraud Initiative (NFI) Briefing: A briefing was received and an update on progress had been requested.
	Minute reference: 127/25	• Finance Update: The Finance update was received. The Committee also highlighted that specific actions were requested to strengthen financial controls and that further updates on these actions would be provided to the Committee.
	Minute reference: 129/25	• Value for Money / Recovery and Sustainability: Governance arrangements for recovery and sustainability had been received, further work was underway, and assurance discussions were ongoing across Committees.



5.	Review of Risks	The Audit Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	Consider the alerts (0), assurances (7) and advice (8) mentioned above.





AUDIT COMMITTEE Key Issues Report

The purpose of this report, is to provide an overview of the matters identified by the Audit Committee to be brought to the attention of the Board following discussions at the last meeting.

Date of Committee meeting:	15 January 2026
Members Present:	FOUR Members were present at the Audit Committee: Nuria Zolle, Andrew Griffiths, Patricia Price and Steve Spill.
Quoracy:	YES
Group/Committee Chair:	Nuria Zolle, Audit Committee
Report Submitted by:	Corporate Governance.
Report Signed off by:	Nuria Zolle, Audit Committee Chair
Date of Board receiving the report:	29 January 2026

1.	Agenda	The Audit Committee convenes bi-monthly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert	The Committee is alerting the Board to the following items (0):
3.	Assurance	The Committee is assuring the Board on the following items (4):
	Minute Reference: 04/26	• Strategic Risk Report: The Committee confirmed that it had reviewed the Risk Register and proposed improvements relating to risk scoring, the inclusion of commentary, and the assurance ratings.



	Minute Reference: 05/26 Minute Reference: 06/26 Minute Reference: 07/26	• Audit tracker and Status Recommendations: The Committee reported continued reduction in overdue actions, reflecting improved progress and strengthened oversight. While this was a positive development, the overall pace of delivery remained a concern, particularly in relation to mortuary services, where actions are significantly overdue and lack clearly defined milestones. Additional thematic analysis had enhanced visibility of outstanding issues, and transparent reporting had been maintained through the retention of original due dates. Strengthened oversight and clearer progress tracking would be required to ensure sustained improvement. The Committee would receive a further report in March 2026 and invite Executive leads to provide an update on the overdue pathology internal audit report actions. • Partnership Governance Tracker: The Committee had reviewed the partnership update and agreed the use of the partnership tracker to enhance governance, oversight and assurance. • Internal Audit Progress Reports: The Committee reviewed the internal audit plan, discussed the delays in management responses and the reasons provided, and noted that a further report would be considered on areas where challenges persist.
4.	Advise Minute Reference: 07/26 Minute Reference: 09/26	The Committee is advising the Board on the following items (5): • Internal Audit Progress Reports: The Committee reviewed the follow-up actions and the current closure position and approved the change in scope to the internal audit plan, which refocuses the urgent and emergency care review to align with the recent Audit Wales report and avoid duplication. • Structured Assessment 2025: The Committee had reviewed both the Audit Wales work plan and the management responses to the structured assessment.



5.	Review of Risks	The Audit Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	Consider the alerts (0), assurances (4) and advice (2) mentioned above.





CHARITABLE FUNDS COMMITTEE (APPROVAL OF ACCOUNTS) Key Issues Report

The purpose of this report is to provide an overview of the matters identified by the Population Health Committee to be brought to the attention of the Board following discussions at the last meeting.

Date of Committee meeting:	13 January 2026
Members Present:	Two Members were present at the Charitable Funds Committee (Approval of Accounts): Stephen Spill and Nicola Matthews.
Quoracy:	YES
Group/Committee Chair:	Nicola Matthews, Charitable Funds Committee Chair.
Report Submitted by:	Corporate Governance.
Report Signed off by:	Nicola Matthews, Population Health Committee Chair.
Date of Board receiving the report:	29 January 2026

1.	Agenda	The Charitable Funds Committee convenes quarterly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert	N/A
3.	Assurance	N/A
4.	Advise	The Committee is advising the Board on the following items (5): The Committee approved the Audit Wales Audit Plan 2025.
	Minute Reference: 06/26	



	Minute Reference: 07/26	• The Committee approved the 2024-25 Annual Accounts report. • The Committee approved the Charity Annual Report 2024-25. • The Committee approved the Audit Wales ISA260 report. • The Committee discussed the Committee Terms of Reference. It was indicated that the primary area under review was the Committee’s membership.
	Minute Reference: 08/26	
	Minute Reference: 09/26	
	Minute Reference: 10/26	
5.	Review of Risks	The Charitable Funds Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	The Trustees’ meeting held on 16 January 2026 approved the above reports following consideration by the Committee.



Bwrdd Iechyd Prifysgol Bae Abertawe – Crynodeb Archwilio Blynyddol 2025

Dyddiad cyhoeddi: Ionawr 2026



Cynnwys

Cynnwys	2
Rhagair	4
Ciplun archwilio	6
Canfyddiadau'r archwiliad o'r cyfrifon	8
Canfyddiadau archwilio perfformiad	10
Ansawdd archwilio	14
Rhagor o wybodaeth	15

Mae'r ddogfen hon wedi'i pharatoi fel rhan o waith a gyflawnir yn unol â swyddogaethau statudol.

Nid yw'r Archwilydd Cyffredinol, Swyddfa Archwilio Cymru a staff Swyddfa Archwilio Cymru yn derbyn unrhyw atebolrwydd mewn perthynas ag unrhyw ddibyniaeth neu ddefnydd arall o'r ddogfen hon gan unrhyw aelod, cyfarwyddwr, swyddog neu gyflogai arall yn eu rhinwedd unigol, nac unrhyw ddefnydd gan unrhyw drydydd parti.

I gael rhagor o wybodaeth, neu os oes angen unrhyw un o'n cyhoeddiadau arnoch mewn fformat a/neu iaith arall, cysylltwch â ni dros y ffôn ar 029 2032 0500, neu e-bostiwch post@archwilio.cymru.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi. We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay

Mae'r ddogfen hon hefyd ar gael yn Saesneg. This document is also available in English.

Rhagair



Adrian Crompton

Archwilydd
Cyffredinol Cymru

Mae'n bleser gennyf rannu fy Gynodeb Archwilio Blynnyddol ar gyfer Bwrdd Iechyd Prifysgol Bae Abertawe (y Bwrdd Iechyd). Mae'n crynhoi prif ganfyddiadau fy ngwaith archwilio yn 2025 a wnaed i gyflawni fy nghyfrifoldebau o dan Ddeddf Archwilio Cyhoeddus (Cymru) 2004 a Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015.

Rhoddais farn ar a oedd y cyfrifon wedi'u paratoi'n briodol ac a roddodd farn wir a theg, ym mhob agwedd faterol, ac a yw gwariant ac incwm wedi'u defnyddio at y dibenion a fwriadwyd ac yn unol â'r awdurdodau sy'n eich llywodraethu.

Mae fy nhîm archwilio hefyd wedi asesu a yw'r Bwrdd Iechyd wedi gwneud trefniadau priodol ar gyfer sicrhau economi, effeithlonrwydd ac effeithiolrwydd yn ei ddefnydd o adnoddau, ac wedi gweithredu yn unol â'r egwyddor datblygu cynaliadwy. Wrth wneud hynny, mae fy nhîm archwilio wedi ymgymryd â'm gwaith asesu strwythuredig blynnyddol ac wedi adolygu gwasanaethau gofal wedi'i gynllunio, a gwasanaethau gofal brys ac argyfwng. Fel y nodir yn fy nghynllun archwilio, mae'r adolygiadau hyn wedi'u cynnal yn unol â [safonau Sefydliad Rhyngwladol y Goruchaf Sefydliadau Archwilio \(INTOSAI\)](#).

Ar adeg cyhoeddi'r crynodeb hwn, cafodd y Bwrdd Iechyd ei ddwysáu i Lefel 3 ar gyfer Gofal Cynlluniedig a Gwasanaethau Iechyd Meddwl Plant a'r Glasoed o dan [Drefniadau uwchgyfeirio ac ymyrryd GIG Cymru](#). Fe'i cynyddwyd hefyd i Lefel 4 ar gyfer Cyllid, Strategaeth a Chynllunio, Gofal Brys ac Argyfwng, Gwasanaethau Canser, Heintiau Cysylltiedig â Gofal Iechyd (HCAs) a Gwasanaethau Mamolaeth a Newyddenedigol.

Mae'r canfyddiadau archwilio manwl ar gyfer pob un o'm hadolygiadau wedi'u nodi yn yr adroddiadau priodol y mae fy nhîm archwilio wedi'u cyflwyno i'r Pwyllgor Archwilio trwy gydol y flwyddyn. Mae'r adroddiadau archwilio perfformiad ar gael ar [wefan Archwilio Cymru](#) ac mae dolenni pellach ar gael yn y crynodeb.

Dylid rhannu'r Crynodeb Archwilio Blynyddol gyda'r Bwrdd. Yna byddaf yn rhoi'r crynodeb ar gael i'r cyhoedd ar [wefan Archwilio Cymru](#).

Hoffwn estyn fy niolchgarwch i staff y Bwrdd Iechyd am eu cymorth a'u cydweithrediad drwy gydol fy archwiliad.

Ciplun archwilio



Derbyniais y cyfrifon drafft yn unol â'r dyddiad cau statudol ar 2 Mai 2025. Roedd ansawdd y cyfrifon drafft a'r papurau gwaith yn dda.



Cyn y dyddiad cau statudol o 30 Mehefin 2025, cyhoeddais farn wirioneddol a theg heb gymhwysterau, a barn rheoleiddrwydd cymwysedig. Cyhoeddais hefyd adroddiad sylweddol ar y cyfrifon.

Nid oedd unrhyw gamddatganiadau heb eu cywiro yn y cyfrifon. Nid oedd unrhyw faterion arwyddocaol eraill i'w hadrodd.



Canfu fy ngwaith archwilio perfformiad fod gan y Bwrdd Iechyd drefniadau llywodraethu da, ac mae'r Bwrdd yn parhau i ddatblygu ac aeddfedu. Fodd bynnag, mae ei sefyllfa ariannol yn parhau i fod yn bryder sylweddol. Rhagwelir diffyg sylweddol ar ddiwedd y flwyddyn ac mae cyflawni'r cynllun cynilo yn heriol, gyda'r Bwrdd Iechyd yn dal i fethu â dangos cydbwysedd ariannol yn y tymor byr neu ganolog.

Mae cynnydd yn cael ei wneud i leihau rhai o'r aros dewisol hiraf ond mae mwy i'w wneud. Mae perfformiad gofal brys ac achos brys yn parhau i fod yn bryder ac yn cael ei effeithio'n andwyol gan oedi wrth ryddhau o'r ysbyty.



Gwnaeth fy nhîm archwilio sawl argymhelliad i'r Bwrdd Iechyd sy'n canolbwyntio ar gryfhau cynllunio gwasanaethau, rheoli, rheolaethau ariannol, a chefnogaeth trawsnewid, wrth wella effeithlonrwydd gweithredol a chynhyrchiant i wella gofal cleifion a chynaliadwyedd system.



Mae rhywfaint o waith heb ei wneud o hyd o'm Cynllun Archwilio dyddiedig Ebrill 2025. Mae fy nhîm yn disgwyl cwblhau'r rhan fwyaf o'r gwaith hwn erbyn mis Mawrth 2026.

Canfyddiadau'r archwiliad o'r cyfrifon

Mae paratoi cyfrifon blynyddol yn rhan hanfodol o ddangos stiwardiaeth arian cyhoeddus. Mae'r cyfrifon yn dangos perfformiad ariannol y sefydliad ac yn nodi ei asedau net, costau gweithredu net, enillion a cholledion, a llif arian. Mae fy archwiliad blynyddol o'r cyfrifon hynny yn rhoi barn ar a yw'r cyfrifon wedi'u paratoi'n briodol ac yn rhoi golwg wir a theg, ym mhob agwedd sylweddol, a'r defnydd priodol ('rheoleiddrwydd') o arian cyhoeddus.

Disgrifir fy nghyfrifoldebau wrth archwilio'r cyfrifon yn fy nghyhoeddiadau Datganiad o Gyfrifoldebau, sydd ar gael ar wefan Archwilio Cymru.

Cyflwynwyd y cyfrifon drafft i'w harchwilio ar 2 Mai 2025. Roedd hyn yn unol â'r dyddiad cau o 2 Mai 2025 a osodwyd gan Lywodraeth Cymru. Roedd ansawdd y cyfrifon drafft a gyflwynwyd i'w harchwilio yn dda.

Fy marn archwilio

Rhaid i mi adrodd materion sy'n codi o fy ngwaith i'r rhai sy'n gyfrifol am lywodraethu i'w hystyried cyn i mi gyhoeddi fy marn archwilio ar y cyfrifon. Adroddais y materion hyn yn fy Adroddiad Archwilio Cyfrifon i'r Pwyllgor Archwilio a'r Bwrdd ar 25 Mehefin 2025.

Gwir a theg

Gwnaed nifer fach o newidiadau i'r cyfrifon drafft sy'n deillio o fy ngwaith archwilio. Nid oedd unrhyw gamddatganiadau heb eu cywiro ac nid oedd unrhyw faterion arwyddocaol eraill i'w hadrodd.

Nid oedd fy ngwaith yn nodi unrhyw wendidau materol mewn rheolaethau mewnol (fel sy'n berthnasol i'm harchwiliad), ac ni wnes unrhyw argymhellion.

Daeth i'r casgliad bod cyfrifon y Bwrdd Iechyd wedi'u paratoi'n briodol ac yn gywir yn sylweddol a chyhoeddi barn archwilio ddigymhwysu arnynt.

Rheoleiddrwydd

Caniateir i'r Bwrdd Iechyd dderbyn incwm ac ysgwyddo gwariant mewn ffyrdd sy'n dilyn y rheolau a osodwyd gan yr awdurdodau sy'n ei lywodraethu. Lle nad yw Bwrdd Iechyd yn cyflawni cydbwysedd ariannol, mae ei wariant yn fwy na'i bwerau i wario ac felly mae'n rhaid i mi gymhwyso fy marn rheolaidd.

Ni chyflawnodd y Bwrdd Iechyd gydbwysedd ariannol ar gyfer y cyfnod o dair blynedd a ddaeth i ben ar 31 Mawrth 2025, yr wyf yn credu ei fod y tu allan i'w bwerau i wario, felly rwyf wedi cyhoeddi barn gymwys ar reoleiddrwydd y trafodion ariannol yng nghyfrifon 2024-25 y Bwrdd Iechyd. Roedd y sefyllfa ar ddiwedd y flwyddyn yn ddiffyg o £42.4 miliwn. Cyfrannodd hyn ynghyd â'r alldroeon ar gyfer y ddwy flynedd flaenorol at sefyllfa ddiffyg tair blynedd o £57.4 miliwn.

Ochr yn ochr â'm barn archwilio, rhoddais adroddiad sylweddol ar gyfrifon y Bwrdd Iechyd i dynnu sylw at y methiant i gyflawni cydbwysedd ariannol a'r methiant i gael cynllun tair blynedd cymeradwy.

Cyfrifon Cyfan y Llywodraeth

Fe wnes i hefyd adolygiad o ffurflen Cyfrifon y Llywodraeth Gyfan. Daeth i'r casgliad bod y wybodaeth cydgrynhoi gwrthbarti yn gyson â sefyllfa ariannol y Bwrdd Iechyd ar 31 Mawrth 2025 a bod y ffurflen wedi'i pharatoi yn unol â chyfarwyddiadau'r Trysorlys.

Canfyddiadau archwilio perfformiad

Asesiad strwythuredig

Edrychodd fy nhîm ar ba mor dda y mae'r Bwrdd Iechyd yn cael ei lywodraethu ac a yw'n gwneud y defnydd gorau o'i adnoddau.

Canfyddais fod gan y Bwrdd Iechyd drefniadau llywodraethu da a darperir gwybodaeth o ansawdd uchel i gefnogi craffu. Mae ymrwymiad parhaus i glywed gan gleifion, defnyddwyr gwasanaethau, a staff o hyd.

Yn ddiweddar, mae'r Bwrdd Iechyd wedi cytuno ar strategaeth hirdymor ddiwygiedig ac mae gwaith wedi dechrau i sicrhau bod y sefydliad wedi'i sefydlu ar gyfer llwyddiant. Fodd bynnag, nid yw fframwaith rheoli perfformiad diwygiedig wedi'i wneud yn llawn eto.

Mae sefyllfa ariannol y Bwrdd Iechyd yn dal i fod yn bryder sylweddol, gyda diffyg diwedd blwyddyn 2025–26 a ragwelir o £58.7 miliwn ar gyfer 2025–26 ac mae cyflawni'r cynllun arbed yn her. Ar fis chwech, dim ond £10.9 miliwn o arbedion oedd gan y Bwrdd Iechyd yn erbyn y targed blynnyddol o £55.4 miliwn.

Fe wnes i bedwar argymhelliad yn canolbwyntio ar:

- gwella trefniadau tryloywder cyhoeddus;
- ehangu adrodd ar ddatganiadau buddiannau cydymffurfio;
- gwella adrodd a goruchwyllo ymweliadau aelodau'r Bwrdd a cherdded o gwmpas; ac
- ymgorffori'r Fframwaith Rheoli Perfformiad a chynyddu goruchwyliaeth o statws cynyddu grwpiau gwasanaeth.

Mae'r Bwrdd Iechyd wedi gweithredu chwe argymhelliad eithriadol ers fy adroddiad asesu strwythuredig diwethaf. Mae pedwar argymhelliad yn parhau i fod ar y gweill, ac mae naw wedi'u disodli gan argymhellion newydd a wnaed eleni.

Rheoli gofal wedi'i gynllunio

Edrychodd fy nhîm ar y cynnydd y mae'r Bwrdd Iechyd yn ei wneud wrth fynd i'r afael â'i heriau gofal arfaethedig a lleihau ei ôl-groniad rhestr aros.

Gwelais fod y Bwrdd Iechyd yn gwneud cynnydd da wrth fynd i'r afael â rhai o'i aros hiraf. Fodd bynnag, mae angen iddo ddatblygu cynlluniau ar gyfer gwelliannau gofal cynlluniedig mwy cynaliadwy yng nghyd-destun yr heriau ariannol y mae'n eu hwynebu. Mae angen i'r Bwrdd Iechyd hefyd fynd i'r afael â nifer o aneffeithlonrwydd o fewn ei ddarpariaeth gwasanaeth a chryfhau ei ddull o nodi ac adrodd ar niwed sy'n deillio o oedi gofal wedi'i gynllunio.

Fe wnes i wyth argymhelliad yn canolbwyntio ar:

- cynllunio gwasanaeth;
- cynllunio galw a chapasiti;
- trawsnewid gwasanaeth;
- diweddarau'r gofrestr risg Gofal Cynlluniedig;
- monitro effaith cyllid ychwanegol;
- cyfleoedd ar gyfer gwelliannau effeithlonrwydd a chynhyrchiant pellach;
- sefydlu un pwynt cyswllt o dan y polisi Hyrwyddo, Atal a Pharatoi ar gyfer Gofal Cynlluniedig¹; a
- rheoli risgiau clinigol sy'n gysylltiedig ag aros hir.

Llif cleifion allan o'r ysbyty

Edrychodd fy nhîm ar ba mor dda y mae'r Bwrdd Iechyd a'i bartneriaid awdurdodau lleol yn sicrhau rhyddhau cleifion allan o'r ysbyty yn amserol. Wrth wneud hynny, edrychodd fy nhîm hefyd ar y cynnydd a wnaed gan y

¹ Hyrwyddo, Atal a Pharatoi ar gyfer gofal wedi'i gynllunio. Roedd angen cyflwyno Cam 1 erbyn mis Mawrth 2024. Roedd hyn yn cynnwys sefydlu un pwynt cyswllt i bobl gael mynediad at wybodaeth a chymorth ar ôl atgyfeirio at ofal eilaidd arbenigol.

Bwrdd Iechyd wrth fynd i'r afael â'm hargymhellion cynllunio rhyddhau 2017.

Er bod partneriaid yn dangos ymrwymiad i wella llif cleifion allan o'r ysbyty, mae perfformiad yn parhau i fod yn hynod heriol. Rhaid i bartneriaid barhau i weithio ar y cyd i liniaru'r heriau sy'n gysylltiedig â llai o gapasiti gweithlu a chymhlethdod cynyddol y galw. Mae angen rhagor o waith hefyd gan bartneriaid i barhau i ddatblygu systemau a rennir i reoli gwybodaeth a sicrhau bod gweithgareddau a risg yn cael eu cyfuno a'u monitro ar sail system gyfan.

Canfyddais hefyd fod y Bwrdd Iechyd wedi gwneud cynnydd araf wrth fynd i'r afael â'r argymhellion blaenorol a wnes i i helpu i wella cynllunio rhyddhau.

Fe wnes i naw argymhelliad, pob un ohonynt yn berthnasol i'r Bwrdd Iechyd. Roedd y rhain yn canolbwyntio ar:

- gwella ansawdd cadw cofnodion;
- gwneud y mwyaf o ollyngiadau penwythnosau;
- adolygu llwybrau rhyddhau;
- gwella hyfforddiant ac arweiniad ar gynllunio rhyddhau;
- ymgorffori'r model Aseswr Dibynadwy;
- ehangu aelodaeth Bwrdd Portffolio Gofal Brys a Brys y Chwe Nod;
- gan gynnwys gweithgaredd awdurdod lleol, partner a Bwrdd Partneriaeth Rhanbarthol yn y gofrestr risg;
- datblygu cofrestr risg ranbarthol gydag awdurdodau lleol drwy drefniadau gweithio'r Bwrdd Partneriaeth Rhanbarthol; ac
- cryfhau perfformiad adrodd i'r Bwrdd.

Gofal Brys ac Argyfwng: Trefniadau ar gyfer Rheoli Galw

Edrychodd fy nhîm ar ba mor dda mae'r Bwrdd Iechyd yn rheoli'r galw am ofal brys ac argyfwng i leihau pwysau diangen ar y system.

Gwelais fod cynllun clir ar gyfer gofal brys ac argyfwng, ynghyd â goruchwyliaeth gref ar lefel weithredol a chorfforaethol. Fodd bynnag, ar adeg fy archwiliad roedd perfformiad gwael yn parhau i fod yn broblem mewn meysydd gan gynnwys oedi trosglwyddo ambiwlansys. Roedd

angen cryfhau ymgysylltiad staff a chleifion, yn ogystal ag adrodd ar sut mae'r Bwrdd Iechyd yn defnyddio arian ychwanegol.

Fe wnes i wyth argymhelliad yn canolbwyntio ar:

- cryfhau rheoli risg o fewn cynlluniau;
- trefniadau cyllido ar gyfer y Rhaglen Chwe Nod;
- cyfathrebu sut mae gwasanaethau i'w defnyddio gan staff a'r cyhoedd;
- gwasanaethau cyfeirio ar wefannau meddygon teulu a phractisau deintyddol;
- monitro cydymffurfiaeth â² chanllawiau SDEC cenedlaethol;
- sicrhau adborth rheolaidd i gleifion a staff i lywio cynlluniau; ac
- adrodd ar wariant cyllid ychwanegol.

Mae gwaith archwilio perfformiad yn dal i fynd rhagddo

Ar adeg adrodd, roedd yr adolygiadau canlynol o Gynllun Archwilio 2025 yn dal i fynd rhagddo yn y Bwrdd Iechyd:

- dilyniant llywodraethu ansawdd;
- trawsnewid digidol;
- gwasanaethau canser; ac
- rheoli ystadau.

² Gofal Brys yr Un Diwrnod

Ansawdd archwilio

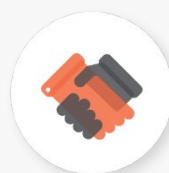
Mae ein hymrwymiad i ansawdd archwilio yn Archwilio Cymru yn absoliwt. Credwn fod ansawdd archwilio yn ymwneud â chael pethau'n iawn y tro cyntaf.

Rydym yn defnyddio model tair llinell o sicrwydd i ddangos sut rydym yn cyflawni hyn. Rydym wedi sefydlu Pwyllgor Ansawdd Archwilio i gydlyn a goruchwyllo'r trefniadau hynny. Rydym yn destun craffu annibynnol ar ein gwaith gan Sefydliad y Cyfrifwyr Siartredig yng Nghymru a Lloegr ac mae Cadeirydd ein Bwrdd yn gweithredu fel cyswllt i'n Bwrdd ar ansawdd archwilio. Am ragor o wybodaeth gweler [Adroddiad Ansawdd Archwilio 2024](#).



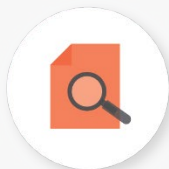
Ein Pobl

- Dewis y tîm cywir
- Defnyddio arbenigwyr
- - Goruchwyliaeth ac adolygu



Trefniadau ar gyfer sicrhau ansawdd archwilio Dewis y tîm cywir

- Plattform archwilio
- Moeseg
- Canllawiau
- Diwylliant
- Dysgu a datblygu
- Arweinyddiaeth
- Cymorth technegol



Sicrwydd annibynnol

- Adolygiadau Ansawdd Allanol
- Adolygiadau â thema
- Adolygiadau oer
- Dadansoddiad o wraidd y problem
- Adolygiad gan gymheiriaid
- Pwyllgor Ansawdd Archwilio
- Monitro allanol

Rhagor o wybodaeth

Mae gan Archwilio Cymru ystod o adnoddau i gefnogi'r gwaith o graffu ar gyrff cyhoeddus Cymru, a'u cefnogi i barhau i wella'r gwasanaethau y maent yn eu darparu i bobl Cymru.

Ewch i'n gwefan i ddod o hyd i:



Ein cyhoeddiadau sy'n ymdrin â'n gwaith archwilio mewn cyrff cyhoeddus.



Gwybodaeth am ein gwaith sydd ar ddod a'n blaenraglen waith ar gyfer archwilio perfformiad.



Offer data i'ch helpu i ddeall tueddiadau gwariant cyhoeddus yn well.



Manylion ein gwaith a'n digwyddiadau Arfer Da, gan gynnwys rhannu arferion sy'n dod i'r amlwg a mewnwelediadau o'n gwaith archwilio.



Ein cylchlythyr sy'n rhoi diweddariadau rheolaidd i chi ar ein gwaith archwilio gwasanaethau cyhoeddus, arfer da, a digwyddiadau.



Archwilio Cymru

Ffôn: 029 2032 0500

Ffacs: 029 2032 0600

Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru

Gwefan www.archwilio.cymru

Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

We welcome correspondence and
telephone calls in Welsh and English.



Asesiad Strwythuredig

2025

Bwrdd Iechyd Prifysgol Bae Abertawe

Rhagfyr 2025

Amdanom ni

Rydym wedi paratoi a chyhoeddi'r adroddiad hwn o dan adran 61(3)(b) o Ddeddf Archwilio Cyhoeddus Cymru 2004.

© Archwilydd Cyffredinol Cymru 2025

Cewch aildddefnyddio'r cyhoeddiad hwn (heb gynnwys logos ac eithrio fel rhan annatod o'r ddogfen) am ddim mewn unrhyw fformat neu gyfrwng.

Os byddwch yn ei aildddefnyddio, mae'n rhaid i'ch aildddefnydd fod yn gywir ac mae'n rhaid nad yw mewn cyd-destun camarweiniol. Mae'n rhaid cydnabod y deunydd fel hawlfraint Archwilydd Cyffredinol Cymru ac mae'n rhaid i chi roi teitl y cyhoeddiad hwn. Lle'r ydym wedi nodi unrhyw ddeunydd hawlfraint trydydd parti, bydd angen i chi gael caniatâd gan y deiliaid hawlfraint dan sylw cyn aildddefnyddio.

Os byddwch angen unrhyw gymorth gyda'r ddogfen hon

Os hoffech ragor o wybodaeth, neu os byddwch angen unrhyw un o'n cyhoeddiadau mewn fformat neu iaith amgen:

- ffoniwch ni ar 029 2032 0500
- anfonwch e-bost atom yn post@archwilio.cymru

Gallwch ddefnyddio'r Gymraeg neu'r Saesneg pan fyddwch yn cysylltu â ni – byddwn yn ymateb i chi yn yr iaith yr ydych yn ei defnyddio.

Ni fydd gohebu yn Gymraeg yn arwain at oedi.

This document is also available in English.

Mae Archwilio Cymru yn dilyn y safonau archwilio perfformiad rhyngwladol a gyhoeddir gan Sefydliad Rhyngwladol y Goruchaf Sefydliadau Archwilio/International Organization of Supreme Audit Institutions (INTOSAI).

Cynnwys

Cipolwg archwilio	4
Ffeithiau a ffigurau allweddol	6
Ein canfyddiadau	7
Argymhellion	27
1 Ynglŷn â'n gwaith	29
2 Argymhellion archwilio blaenorol	32
3 Ymateb y rheolwyr	38
4 Termau allweddol yn yr adroddiad hwn	42
5 Amdanom ni	45

Cipolwg archwilio

Yr hyn yr edrychwyd arno

- 1 Fe wnaethom edrych ar ba mor dda y mae Bwrdd Iechyd Prifysgol Bae Abertawe (y Bwrdd Iechyd) yn cael ei lywodraethu ac a yw'n gwneud y defnydd gorau o'i adnoddau. Edrychwyd ar bedwar maes yn benodol:
 - pa mor dda mae ei fwrdd yn gweithio;
 - sut mae'n cadw golwg ar risgiau, perfformiad, ansawdd gwasanaeth, ac argymhellion;
 - sut mae'n cynhyrchu cynlluniau a strategaethau allweddol; a
 - sut mae'n rheoli ei gyllid.
- 2 Fe wnaethom hefyd edrych ar gynnydd y Bwrdd Iechyd wrth weithredu argymhellion o:
 - adroddiadau asesu strwythuredig blaenorol; a
 - ein hadroddiad 2024 ar arbedion costau;

Pam mae hyn yn bwysig

- 3 Mae cyrff y GIG yn parhau i wynebu ystod eang o heriau sy'n gysylltiedig â'r angen i foderneiddio a thrawsnewid gwasanaethau i ddelio â chyllid cyfyngedig, galw cynyddol, ôl-groniadau triniaeth, prinder gweithlu, ac ystâd sy'n heneiddio. Felly, mae'n bwysicach nag erioed i fyrddau cyrff y GIG gael trefniadau llywodraethu corfforaethol ac ariannol cryf ar waith. Mae hyn yn helpu i roi sicrwydd iddyn nhw eu hunain, y cyhoedd, a rhanddeiliaid allweddol eu bod yn cymryd y camau cywir i ddarparu gwasanaethau diogel, o ansawdd uchel ac i ddefnyddio arian cyhoeddus yn ddoeth.

Yr hyn rydyn ni wedi'i ddarganfod

- 4 Mae gan y Bwrdd lechyd drefniadau llywodraethu da sy'n galluogi'r Bwrdd a'i bwyllgorau i redeg yn effeithiol. Mae gwybodaeth o ansawdd uchel yn parhau i gefnogi craffu, ac mae ymrwymiad parhaus i glywed gan gleifion, defnyddwyr gwasanaeth a staff o hyd. Fodd bynnag, rydym yn parhau i ddod o hyd i feysydd lle gellid gwella tryloywder y Bwrdd ymhellach.
- 5 Mae cymorth allanol yn helpu'r Bwrdd i ddatblygu ac aeddfedu, ac mae cynnydd wedi'i wneud i gryfhau trefniadau ar gyfer rheoli risg ymhellach. Mae'r Bwrdd lechyd wedi cytuno ar strategaeth hirdymor ddiwygiedig yn ddiweddar, ac mae gwaith wedi dechrau i sicrhau bod y sefydliad wedi'i sefydlu ar gyfer llwyddiant. Ond nid yw fframwaith rheoli perfformiad diwygiedig yn llawn ar waith eto ac mae argymhellion archwilio yn cymryd amser i fynd i'r afael â nhw.
- 6 Y pryder mwyaf fodd bynnag yw sefyllfa ariannol y Bwrdd lechyd. Rhagwelir diffyg sylweddol ar ddiwedd y flwyddyn ar gyfer 2025-26 gyda chynllun cynilo presennol y Bwrdd lechyd yn sylweddol oddi ar y trywydd iawn. Nid oedd y Bwrdd na Llywodraeth Cymru yn gallu cymeradwyo Cynllun Blyneddol y Bwrdd lechyd oherwydd y sefyllfa ariannol. Mae cefnogaeth ychwanegol gan Lywodraeth Cymru fel rhan o'i threfniadau cynyddu ac ymyrraeth yn dechrau helpu. Ond mae cynlluniau cynilo yn dymor byr ac mae'r gallu i reoli'r sefyllfa yn weddill misoedd y flwyddyn ariannol yn her. Heb weithredu penderfynol a pharhaus, mae'r sefyllfa ariannol yn peryglu dirywiad pellach.

Yr hyn rydyn ni'n ei argymhell

- 7 Rydym wedi gwneud pedwar argymhelliad i'r Bwrdd lechyd, sy'n canolbwyntio ar
 - gwella trefniadau tryloywder cyhoeddus;
 - ehangu adrodd ar ddatganiadau buddiannau cydymffurfio;
 - gwella adrodd a goruchwyllo ymweliadau aelodau'r Bwrdd a cherdded o gwmpas; ac
 - ymgorffori'r Fframwaith Rheoli Perfformiad a chynyddu goruchwyliaeth o statws cynyddu grwpiau gwasanaeth.

Ffeithiau a ffigurau allweddol

O dan drefniadau cynyddu ac ymyrraeth Llywodraeth Cymru, mae'r Bwrdd Iechyd ar Lefel 4 ar gyfer Cyllid, Strategaeth a Chynllunio, Gofal Brys ac Argyfwng, Gwasanaethau Canser, Heintiau sy'n Gysylltiedig â Gofal Iechyd (HCAIs), Gwasanaethau Mamolaeth a Gwasanaethau Newyddenedigol. Mae hefyd ar Lefel 3 ar gyfer Gofal Cynlluniedig a Gwasanaethau Iechyd Meddwl Plant a'r Glasoed.

Nid oes gan y Bwrdd Iechyd Gynllun Blynyddol neu Gynllun Tymor Canolig Integredig cymeradwy ar gyfer 2025-26.

Ni chyflawnodd y Bwrdd Iechyd ei ddyletswydd ariannol i dorri hyd yn oed ar ei wariant refeniw dros y cyfnod o dair blynedd 2022-25, gan adrodd diffyg cronol o £57.4 miliwn ar gyfer 2022-25.

Yn 2024-25, cyflawnodd y Bwrdd Iechyd arbedion o £51.6 miliwn, yn erbyn targed arbedion o £26.1 miliwn. Roedd dros £37 miliwn yn ailadroddus.

Mae'r Bwrdd Iechyd yn rhagweld diffyg diwedd blwyddyn o £58.7 miliwn ar gyfer 2025-26, yn erbyn disgwyliad Llywodraeth Cymru o £42.5 miliwn a chyfanswm rheoli o £17.1 miliwn. Ar fis chwech, dim ond £10.9 miliwn o arbedion y mae'r Bwrdd Iechyd wedi cyflawni yn erbyn y targed blynyddol o £55.4 miliwn.

Mae'r Bwrdd Iechyd wedi gweithredu chwe argymhelliad eithriadol yn llawn ers ein hadroddiad asesu strwythuredig diwethaf. Mae pedwar argymhelliad yn parhau i fod ar y gweill, ac mae naw wedi'u disodli gan argymhellion newydd a wnaed eleni.

Ein canfyddiadau

Effeithiolrwydd ac agored y Bwrdd

Mae'r Bwrdd a'i bwyllgorau yn parhau i weithio'n dda ond mae angen gwelliannau ar bapurau hwyr, polisïau sydd wedi dyddio, datganiadau o fuddiant, adroddiadau cerdded rownd ac eglurder atgyfeirio traws-bwyllgor

Busnes bwrdd yn agored i'r cyhoedd

- 8 Canfuom, er bod y Bwrdd yn parhau i fod yn ymrwymedig i gynnal ei fusnes mewn modd agored, mae cyfleoedd o hyd i wella hyn ymhellach:
 - gall aelodau o'r cyhoedd fynychu cyfarfodydd cyhoeddus y Bwrdd yn bersonol, ond nid yw ffrydio byw ar gael o hyd;
 - mae'r Bwrdd lechyd yn cyhoeddi recordiadau o gyfarfodydd cyhoeddus y Bwrdd o fewn 24 awr, ond mae yna adegau o hyd pan mae'n anodd i'r gwyliwr weld pwy sy'n siarad;
 - Mae papurau cyhoeddus y Bwrdd ar gael bum diwrnod cyn pob cyfarfod ar ei wefan, ond nid yw hyn bob amser yn wir am bapurau pwyllgor; a
 - er y gall aelodau o'r cyhoedd ofyn am arsylwi cyfarfodydd pwyllgorau, nid yw'r Bwrdd lechyd yn hyrwyddo hyn, ac nid yw dyddiadau ac amseroedd cyfarfodydd pwyllgor yn y dyfodol ar y wefan (er bod cofnodion wedi'u cadarnhau ar gyfer cyfarfodydd y Bwrdd a'r pwyllgor yn cael eu llwytho i fyny yn brydlon i'r wefan.
- 9 Mae'r Bwrdd yn defnyddio sesiynau preifat dim ond pan fo angen i drafod pynciau sensitif. Darperir crynodeb o'r trafodaethau hyn yng nghyfarfod cyhoeddus nesaf y Bwrdd fel rhan o'r adroddiad Llywodraethu Corfforaethol. Mae'r adroddiad hwn hefyd yn cynnwys gwybodaeth am Gylchlythyrau lechyd Cymru a dderbyniwyd yn ogystal â chymhwyso unrhyw gamau gweithredu'r

Cadeirydd. Fodd bynnag, nid oes llawer o fanylion ar y costau neu'r goblygiadau adnoddau sy'n gysylltiedig â Chairs Actions.

- 10 Mae'r Bwrdd Iechyd wedi cymryd camau i sicrhau bod dogfennau allweddol yn gyfredol ar ei wefan gan gynnwys Strategaeth Pobl 2024-2029, ond mae rhai dogfennau yn dal i fod yn anodd dod o hyd iddynt neu sydd wedi dyddio. Mae angen i'r Bwrdd Iechyd ddiweddarau ei wefan, gan alluogi mynediad haws at wybodaeth werthfawr i'r cyhoedd, a pharhau i wella cyfeirio at ddigwyddiadau gan ddefnyddio cyfryngau cymdeithasol.
- 11 Mae gan y Bwrdd Iechyd Grŵp Cyfeirio Rhanddeiliaid i ddod â chynrychiolwyr o grwpiau cymunedol lleol, sefydliadau eiriolaeth cleifion, a rhwydweithiau cydraddoldeb ac amrywiaeth at ei gilydd. Mae'r Bwrdd Iechyd hefyd yn rhedeg Fforwm Gweithwyr Gofal Iechyd a Fforwm Partneriaeth gweithredol. Er bod pob fforwm yn adrodd yn rheolaidd i'r Bwrdd, nid yw Cadeiryddion y grwpiau hyn yn mynychu'r Bwrdd, gan gyfyngu ar eu cynrychiolaeth.

Cefnogi ymddygiad bwrdd effeithiol

- 12 Mae gan y Bwrdd Iechyd drefniadau llywodraethu clir a chyfoes sy'n helpu'r Bwrdd a'i bwyllgorau i redeg yn effeithiol. Mae'r Pwyllgor Archwilio yn sicrhau bod rheolaethau llywodraethu allweddol ar waith ac yn cael eu dilyn. Mae hyn yn cynnwys goruchwyllo cydymffurfiaeth rheolaidd â Rheolau Sefydlog, Cyfarwyddiadau Ariannol Sefydlog a Chynllun Cadw a Dirprwyo. Derbyniodd y pwyllgor ddiweddariadau ar y rhain ym mis Mawrth 2025 a Medi 2025.
- 13 Mae gan y Bwrdd Iechyd drefniadau priodol ar waith i hyrwyddo a sicrhau didwylledd a phriodoldeb. Mae'r Cofrestrau Datganiadau o Fuddiant, Anrhegion a Lletygarwch yn gyfredol ac yn cael eu hadolygu gan y Pwyllgor Archwilio (Medi 2025) ac mae copi cyfredol ar gael ar wefan y Bwrdd Iechyd. Er, mae polisi Safonau Ymddygiad Busnes y Bwrdd Iechyd wedi dod i ben yn ddiweddar¹. Yn 2022, argymhellodd Archwiliad Mewnol fod y Bwrdd Iechyd yn cryfhau ei drefniadau trwy ehangu'r Datganiadau o Ddiddordeb i gynnwys staff â swydd eilaidd sydd mewn rolau gwneud penderfyniadau. Nid yw'r Bwrdd Iechyd wedi rhoi hyn ar waith eto.

¹ Medi 2025

14 Mae'r Bwrdd Iechyd wedi gwneud cynnydd wrth fynd i'r afael â pholisïau sydd wedi dyddio. Ym mis Mawrth 2025, roedd gan y Bwrdd Iechyd 183 o bolisïau ac roedd 39 ohonynt wedi dyddio. Roedd llawer o'r rhain (28) yn bolisïau Llywodraeth Cymru y mae'r Bwrdd Iechyd wedi adrodd eu bod yn dal i fodoli wrth aros am adolygiad cenedlaethol. Fodd bynnag, roedd 11 yn bolisïau'r Bwrdd Iechyd. O ystyried bod rhai o'r polisïau hyn yn arwyddocaol, er enghraifft yn ymwneud â datgelu a gwahardd, mae angen canolbwyntio parhaus ar sicrhau eu bod yn gyfredol.

Sicrwydd ar effeithiolrwydd y Cyd-bwyllgor Comisiynu

- 15 Sefydlwyd y Cyd-bwyllgor Comisiynu (JCC) ym mis Ebrill 2024 fel cyd-bwyllgor o'r saith bwrdd iechyd yng Nghymru. Mae'r JCC yn cynllunio ac yn comisiynu ystod o wasanaethau arbenigol a gwasanaethau gofal iechyd eraill, gan gynnwys gwasanaethau meddygol brys, ar ran y saith bwrdd iechyd.
- 16 Fel rhan o'r asesiad strwythuredig eleni, fe wnaethom adolygu a yw'r Bwrdd yn derbyn y lefel gywir o sicrwydd ar fusnes JCC, yn ogystal â chyfranogiad y Bwrdd Iechyd mewn cyfarfodydd a gweithgareddau JCC. Mae ein gwaith yn dangos bod y Bwrdd a'r Pwyllgor Ansawdd a Diogelwch yn derbyn sicrwydd arferol ar waith y JCC. Ym mis Mawrth 2025, cyflwynodd Cadeirydd y JCC a'r Prif Gomisiynydd gyflwyniad i aelodau'r Bwrdd, gan roi trosolwg o waith y Pwyllgor.

Effeithiolrwydd cyfarfodydd bwrdd a phwyllgor

- 17 Ers ein hasesiad strwythuredig diwethaf, mae newidiadau i strwythur y pwyllgor a chylchoedd cyfarfodydd wedi setlo i mewn. Mae cylch gorchwyl y pwyllgor yn gyfredol, ac mae rhaglenni gwaith yn adlewyrchu cwmbras llawn busnes y Bwrdd. Mae gwell dull o gynllunio agenda, er bod rhai materion wedi bod eleni gyda phapurau hwyr neu bapurau nad ydynt ar gael i'r cyhoedd cyn y cyfarfod sy'n peryglu lleihau effeithiolrwydd craffu a thryloywder.

- 18 Mae'r Bwrdd lechyd yn ystyried yn briodol sut mae ei bwyllgorau yn gweithio ac yn gwneud newidiadau os oes angen. Ym mis Mawrth 2025, diwygiodd y Bwrdd lechyd gylch gwaith y pwyllgor lechyd a Phartneriaethau Poblogaeth i ganolbwyntio ar lechyd y Boblogaeth yn unig. Rydym wedi arsylwi mwy o ffocws ar lechyd y Boblogaeth, ac rydym yn nodi gwaith diweddar mewn meysydd gan gynnwys clefyd cardiofasgwlaidd. Mae sicrwydd ar bartneriaethau bellach yn cael ei ddarparu'n uniongyrchol i'r Bwrdd gyda'r Pwyllgor Archwilio yn parhau i oruchwylio trefniadau llywodraethu partneriaeth. Mae goruchwyliaeth dda o bartneriaethau, ac rydym yn trafod hyn ymhellach ym **mharagraff 50**. Ym mis Mai 2025, penododd y Bwrdd lechyd Gadeirydd newydd y Pwyllgor Ansawdd a Diogelwch sy'n gyrru ffocws gwell newydd ar faterion ansawdd.
- 19 Mae cyfarfodydd bwrdd a phwyllgor yn parhau i gael eu cadeirio'n dda, ac mae'r rhan fwyaf ohonynt yn rhedeg i amser. Mae Aelodau Annibynnol yn cymryd rhan lawn mewn cyfarfodydd, gan ddarparu'r swm a'r lefel briodol o her yn ogystal â chraffu ar y wybodaeth a gyflwynir. Fodd bynnag, bu cynnydd yn y croesgyfeirio adroddiadau rhwng pwyllgorau. Gall hyn arwain at ddryswch a dyblygu diangen oni bai bod pwrpas a gweithredoedd disgwyledig pob atgyfeiriad wedi'u diffinio'n glir. Er mwyn mynd i'r afael â hyn, mae'r Cyfarwyddwr Llywodraethu Corfforaethol wedi cyflwyno atgyfeiriadau pwyllgor newydd a log cynllun gweithredu. Nod y cofnod hwn yw sicrhau bod Aelodau Annibynnol yn penodi'r rhesymeg a'r canlyniadau arfaethedig wrth gyfeirio eitemau rhwng pwyllgorau, gan helpu i atal gorlwytho agenda a chynnal craffu effeithiol.
- 20 Mae'r Bwrdd lechyd wedi cyflwyno strwythur newydd i'w brosesau cynyddu o bwyllgorau i'r Bwrdd. Mae'r adrodd 3A newydd² bellach yn nodwedd safonol yng nghyfarfodydd y Bwrdd ac mae Cadeiryddion Pwyllgorau yn defnyddio'r fformat hwn ar gyfer eu hadroddiadau. Mae'r dull yn sicrhau adrodd cyson, strwythuredig ac yn cryfhau goruchwyliaeth trwy dynnu sylw at faterion, camau gweithredu a lefelau sicrwydd allweddol.

² Rhybuddio, Sicrwydd a Chynghori

21 Mae'r Bwrdd a'i bwyllgorau yn parhau i dderbyn gwybodaeth o ansawdd uchel sy'n cefnogi gwneud penderfyniadau, craffu a herio effeithiol. Fodd bynnag, mae rhai papurau yn dal i fod yn hir. Mae'r Bwrdd lechyd yn parhau i ddarparu cymorth a hyfforddiant i awduron adrodd i gyflwyno materion a risgiau allweddol yn gliriach ac yn gryno, ar lafar ac yn ysgrifenedig. Er bod papurau'n cael eu hanfon a'u llwytho i fyny ar amser yn bennaf, gwelsom enghreifftiau o bapurau a gyflwynwyd ar y diwrnod fel y cyflwyniad ailgynllunio gofal heb ei drefnu yng nghyfarfod y Bwrdd ym mis Gorffennaf 2025. Gallai hyn effeithio ar allu'r Aelodau Annibynnol i ymgymryd â herio a chraffu effeithiol.

Clywed gan staff a defnyddwyr gwasanaeth

22 Mae'r Bwrdd yn parhau i fod yn ymrwymedig i glywed gan gleifion, staff a defnyddwyr gwasanaeth. Mae'r Bwrdd a'r Pwyllgor Ansawdd a Diogelwch yn parhau i ddefnyddio straeon cleifion a staff i lywio eu gwaith, sy'n gytbwys ac yn cydnabod heriau'r Bwrdd lechyd. Mae'r Pwyllgor Ansawdd a Diogelwch yn derbyn adroddiad manwl ar brofiad cleifion bob chwarter, sy'n cynnwys adborth a gasglwyd trwy'r Arolwg Ffrindiau a Theuluoedd.

23 Mae'r Bwrdd lechyd yn defnyddio ystod o ddulliau i glywed gan gleifion a defnyddwyr gwasanaeth o gefndiroedd amrywiol, gan gynnwys ymgysylltu cymunedol da â grwpiau prin eu cyrraedd. Mae aelodau'r bwrdd hefyd yn ymweld â gwasanaethau rheng flaen trwy ymweliadau unigol ac fel rhan o gerdded ffurfiol. Fodd bynnag, nid oes unrhyw adroddiad ffurfiol o'r gweithgareddau hyn i'r Pwyllgor Ansawdd a Diogelwch. Nid oes system gofnodi ganolog o ymweliadau a fyddai'n helpu i leihau'r risg o ddyblygu ond hefyd yn sicrhau bod yr holl wasanaethau yn cael eu cwmpasu gan y gweithgareddau hyn. Yn ogystal, nid oes unrhyw adroddiadau ar gamau a gymerwyd mewn ymateb i faterion a ganfuwyd. Mae'r Bwrdd lechyd wedi cydnabod hyn a bydd yn cyflwyno adroddiadau i sicrhau goruchwyliaeth.

Cydlyniant y Bwrdd a gwelliant parhaus

24 Mae gan y Bwrdd lechyd bellach dîm gweithredol sefydlog yn dilyn y penodiad sylweddol i sawl rôl. Ers ein hasesiad strwythuredig diwethaf, mae'r Bwrdd lechyd wedi penodi:

- Cyfarwyddwr Cynllunio a Phartneriaethau ym mis Chwefror 2025;

- Cyfarwyddwr Nyrsio a Phrofiad Cleifion ym mis Mawrth 2025;
- Cyfarwyddwr Gweithlu ac OD ym mis Mai 2025; a
- Cyfarwyddwr Dros Dro Iechyd y Cyhoedd tan fis Mawrth 2026³.

25 Ym mis Hydref 2025, ailalinio ei Bortffolios Gweithredol fel rhan o'i raglen 'Trefnu ar gyfer Llwyddiant⁴'. Mae'r newidiadau yn cynnwys:

- y portffolio perfformiad yn symud o Gyfarwyddwr Cyllid i'r Cyfarwyddwr Cynllunio a Phartneriaethau;
- deallusrwydd busnes yn symud o'r Cyfarwyddwr Digidol i'r Cyfarwyddwr Cynllunio a Phartneriaethau; a
- profiad cleifion, digwyddiadau a chwynion sy'n symud o'r Cyfarwyddwr Llywodraethu Corfforaethol i'r Cyfarwyddwr Nyrsio a Phrofiad Cleifion.

26 Ym mis Medi 2025, penodwyd y Bwrdd Iechyd hefyd i rôl Prif Swyddog Busnes newydd. Mae'r rôl hon yn darparu cefnogaeth strategol yn uniongyrchol i'r Prif Weithredwr a Chadeirydd y Bwrdd Iechyd.

27 Mae angen i'r Bwrdd Iechyd gwblhau dau gam sy'n weddill o'r rhaglen 'Trefnu ar gyfer Llwyddiant' o hyd. Mae Cam 2, a oedd ar y gweill yn ystod ein hadolygiad ac sydd wedi'i drefnu i'w gwblhau erbyn Ebrill 2026, yn cynnwys ailstrwythuro gwasanaethau o fodel a arweinir yn ddaearyddol i un yn seiliedig ar fath o wasanaeth. Mae'r cam hwn hefyd yn cynnwys adolygu nifer yr adrannau a'r cyfarwyddiaethau, yn ogystal ag asesu haenau rheoli i'w lleihau lle bo hynny'n briodol. Bydd Cam 3, sydd i fod i ddod i ben erbyn Ebrill 2027, yn canolbwyntio ar adolygu cymorth cofleidiol ar gyfer grwpiau gwasanaeth a gwasanaethau cymorth corfforaethol, gyda'r nod o leihau dyblygu.

³ Mae'r Cyfarwyddwr Iechyd Cyhoeddus ar hyn o bryd wedi'i secondio i Lywodraeth Cymru

⁴ Y rhaglen Trefnu ar gyfer Llwyddiant yw menter strategol y Bwrdd Iechyd i drawsnewid darparu gofal iechyd trwy wella ansawdd, tegwch a mynediad at wasanaethau ledled y rhanbarth.

- 28 Mae gan y Bwrdd grŵp sefydlog o Aelodau Annibynnol, gyda phob un ond un swydd wedi'i llenwi. Ar adeg ein gwaith, roedd swydd yr Aelod Cyswllt dros Wasanaethau Cymdeithasol yn wag ac wedi bod ers i'r aelod blaenorol adael ym mis Mehefin 2025. Roedd y Bwrdd lechyd yn gweithio gyda phartneriaid awdurdodau lleol i benodi eilydd. Mae'r Bwrdd lechyd wedi cydnabod yr angen am gynrychiolaeth benodol ar faterion "Cynhwysiant a Pherthyn" yn y Bwrdd ac ar adeg ein gwaith roedd yn edrych i benodi aelod cyswllt⁵ o'r Bwrdd i ymgymryd â'r rôl hon.
- 29 Mae'r Bwrdd lechyd wedi parhau â'i raglen ffurfiol o adolygiadau effeithiolrwydd pwyllgorau ac wedi datblygu cynlluniau gweithredu i wneud gwelliannau, gyda chynnydd yn cael ei adrodd i'r Bwrdd yn rheolaidd. Mae'r Bwrdd hefyd wedi parhau â'i raglen ddatblygu dros y flwyddyn ddiwethaf ac wedi canolbwyntio ar ystod o feysydd gan gynnwys parodrwydd gaeaf, cynllun blyneddol, strategaeth sefydliadol, rhaglen 'Trefnu ar gyfer Llwyddiant', effeithiolrwydd y Bwrdd, a rheoli risg strategol. Mae'r Bwrdd lechyd wedi comisiynu'r Sefydliad Llywodraethu Da (GGI) i gyflwyno rhaglen ddatblygu'r Bwrdd yn 2025-26.

⁵ Nid yw aelodau cyswllt yn aelodau pleidleisio llawn o'r Bwrdd, eu rôl yw cyfrannu arbenigedd, mewnwelediad, a safbwyntiau rhanddeiliaid i drafodaeth y Bwrdd.

Darparu sicrwydd bwrdd

Mae angen i'r Bwrdd lechyd ymgorffori ei fframwaith rheoli perfformiad diwygiedig yn llawn, gwella adrodd ansawdd a sicrhau bod argymhellion yn cael eu gweithredu

Rheoli risgiau strategol a chorfforaethol

- 30 Mae'r Bwrdd lechyd yn datblygu Cofrestr Risg Strategol (SRR), a fydd hefyd yn Fframwaith Sicrwydd y Bwrdd. Ar adeg ein gwaith, roedd hyn yn y drafft. Roedd y Bwrdd lechyd wedi cynnal sesiynau gydag Aelodau Annibynnol i roi'r wybodaeth ddiweddaraf am y datblygiad a'r cynnydd hyd yma. Ym mis Mehefin 2025, hwylusodd y Sefydliad Llywodraethu Da weithdy'r Bwrdd i ddatblygu archwaeth risg a chynnal mapio risg strategol. Mae'r Bwrdd lechyd yn bwriadu cyflwyno ei Gofrestr Risg Strategol wedi'i chwblhau yng nghyfarfod y Bwrdd ym mis Tachwedd 2025.
- 31 Ar hyn o bryd, mae'r Bwrdd lechyd yn rheoli ei risgiau trwy ei Gofrestr Risg y Bwrdd lechyd. Fodd bynnag, mae hyn yn weithredol iawn o ran ffocws. Ar adeg ein gwaith, roedd y Bwrdd lechyd yn adolygu ei drefniadau ar gyfer rheoli risgiau corfforaethol ac mae'n bwriadu cyflwyno Cofrestr Risg Gorfforaethol ar gyfer risgiau traws-sefydliadol a Chofrestr Risg Weithredol ar gyfer risgiau sy'n cael eu cynyddu o grwpiau gwasanaeth. Mae'r Bwrdd lechyd yn bwriadu cwblhau'r gwaith hwn erbyn Ebrill 2026.
- 32 Mae gan y Bwrdd lechyd Gynllun Gweithredu Rheoli Risg wedi'i feddwl yn dda, sy'n cael ei ddiweddarau'n rheolaidd. Mae'r dull o reoli risg wedi'i nodi'n glir ym Mholisi Rheoli Risg y Bwrdd lechyd. Adolygodd y Bwrdd lechyd ei archwaeth risg ddiwethaf ym mis Tachwedd 2023 ond mae'n bwriadu diweddarau hyn i'w gymeradwyo ym mis Tachwedd 2025.
- 33 Mae Pwyllgor Archwilio'r Bwrdd lechyd yn parhau i oruchwylio rheoli risg yn effeithiol, tra bod pwyllgorau eraill yn craffu ar y risgiau corfforaethol a roddwyd iddynt. Mae'r Bwrdd a'r pwyllgorau yn derbyn diweddariadau rheolaidd gydag adroddiadau cryno sy'n tynnu sylw at risgiau newydd a newidiadau mewn sgoriau risg yn glir. Mae Grŵp Rheoli Risg yn darparu craffu a sicrwydd dros brosesau uwchgyfeirio a dad-ddwysáu.

34 Ym mis Medi 2024, adolygodd Archwiliad Mewnol y trefniadau rheoli risg o fewn grwpiau gwasanaeth (a fydd yn llywio Cofrestr Risg y Bwrdd Iechyd). Rhoddodd sicrwydd rhesymol ar y prosesau corfforaethol ar waith, ond argymhellodd welliannau mewn profi, monitro ac adolygu risgiau ar lefel grŵp gwasanaeth a chorfforaethol. Ym mis Mai 2025, adolygodd Archwilio Mewnol hefyd y gweithdrefnau ar gyfer nodi, rheoli ac adrodd risgiau strategol a gweithredol allweddol trwy'r BAF a'r gofrestr risg gorfforaethol. Rhoddodd sicrwydd rhesymol ar y trefniadau hyn a bydd yn cynnal adolygiad pellach yn 2026.

Rheoli perfformiad

35 Mae Fframwaith Rheoli Perfformiad y Byrddau Iechyd yn nodi'r trefniadau ar gyfer rheoli perfformiad a chyfeirio mewn perthynas â chyllid, perfformiad ac ansawdd. Ym mis Mai 2025, diweddarodd y Bwrdd Iechyd y fframwaith. Mae'r fframwaith diwygiedig yn cryfhau'r trefniadau adolygu perfformiad ar gyfer grwpiau gwasanaeth a chyfarwyddiaethau corfforaethol, ac yn cyd-fynd â Fframwaith Goruchwyllo a Chyfeirio GIG Cymru. Mae'r fframwaith yn glir ar gyfrifoldebau ac ymgysylltiad y tîm gweithredol cyfan i sicrhau goruchwyliaeth a chraffu ar draws cyllid, perfformiad ac ansawdd. Fodd bynnag, ar adeg ein gwaith, nid oedd y Bwrdd wedi cymeradwyo'r fframwaith diwygiedig. Ni chafwyd unrhyw adroddiad ar statws cynyddu'r grwpiau gwasanaeth na chyfarwyddiaethau corfforaethol fel y disgrifir yn y fframwaith.

36 Mae'r sefyllfa ariannol bresennol yn tynnu sylw at yr angen i'r Bwrdd Iechyd wella ei ddull o ddal timau gweithredol i gyfrif am gyflawni. Nododd ein Adolygiad 2024 o Drefniadau Arbed Costau wendidau ar gyfer y broses ddwysáu fewnol ar gyfer grwpiau gwasanaeth a chyfarwyddiaethau corfforaethol sy'n tanberfformio, gan argymhell adolygiad cynhwysfawr o'r trefniadau hyn. Fodd bynnag, nid yw'r argymhelliad hwn wedi'i weithredu eto. Trwy ein gwaith asesu strwythuredig, rydym hefyd wedi dod o hyd i gyfleoedd i gryfhau hyfforddiant ar reoli ariannol a chyllideb ar gyfer staff gweithredol er bod y Bwrdd Iechyd wedi rhoi rhywfaint o hyfforddiant ar-lein 'Brilliant Basics.'

37 Mae'r Bwrdd Iechyd wedi parhau i wella ei adroddiadau perfformiad sefydliadol. Mae'r Bwrdd a'r Pwyllgor Perfformiad a Chyllid yn derbyn yr Adroddiad Perfformiad Integredig (IPR) ym mhob cyfarfod. Diweddarodd y Bwrdd Iechyd yr IPR eleni i olrhain cynnydd yn erbyn ei dair blaenoriaeth allweddol:

- Meysydd perfformiad cynyddu Llywodraeth Cymru;
- pum amcan strategol y Bwrdd Iechyd; a
- chymau gweithredu galluogi Ysgrifennydd y Cabinet.

38 Mae IPR y Bwrdd Iechyd yn darparu trosolwg da o berfformiad ac mae'r crynodeb gweithredol yn tynnu sylw at feysydd tanberfformiad yn ogystal â chymau gweithredu. Mae swyddogion hefyd yn cynhyrchu deifio dwfn misol i feysydd penodol sy'n peri pryder yn y Pwyllgor IPR ar gyfer Perfformiad a Chyllid, er enghraifft gwasanaethau niwro-ddatblygiadol, endosgopi, a theatrau. Yn dilyn ein hargymhelliad blaenorol y dylai'r Bwrdd gynyddu ei ffocws ar ofal sylfaenol, mae'n galonogol gweld cyflwyno rhaglen dreigl o ddeifio dwfn gofal sylfaenol yng nghyfarfodydd y Bwrdd. Fodd bynnag, yn fwy eang, mae cyfleoedd o hyd i wella cyflwyno data perfformiad trwy atebion digidol a chynnwys data cymharol gan gyrff eraill y GIG yng Nghymru.

Monitro ansawdd a diogelwch

39 Mae gan y Bwrdd Iechyd strategaeth ansawdd sy'n ymrwymo i ddarparu gofal o ansawdd uchel. Mae'r dyletswyddau statudol o Ddeddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020 yn sail i'r strategaeth. Bydd y Bwrdd Iechyd yn adolygu'r strategaeth ansawdd yng ngoleuni ei strategaeth sefydliadol wedi'i diweddarau a lansiwyd ym mis Medi 2025. Ar adeg ein gwaith, roeddem yn cynnal dilyniant o'n Adolygiad 2022 o Drefniadau Llywodraethu Ansawdd.

40 Mae goruchwyliaeth y Pwyllgor Ansawdd a Diogelwch o ansawdd gwasanaethau yn ystod y 12 mis diwethaf wedi cael ei gynorthwyo gan ddiweddariadau ar gynnydd yn erbyn blaenoriaethau ansawdd y Bwrdd Iechyd⁶, yr Adroddiad Ansawdd Blynnyddol ym mis Medi 2025 a sawl deifio dwfn⁷.

41 Fodd bynnag, mae bylchau yn y wybodaeth y mae'r Pwyllgor yn ei derbyn. Mae'r Bwrdd Iechyd yn parhau i ddarparu'r un adroddiad i'r Pwyllgor Ansawdd a Diogelwch ag adroddiad y pwyllgor Perfformiad a Chyllid. Ar adeg ein gwaith, roedd y Bwrdd Iechyd yn datblygu dangosfwrdd ansawdd amser real. Bydd hyn yn galluogi'r Pwyllgor i symud o adolygiad ôl-weithredol i oruchwyliaeth rhagweithiol, gan wella'r gallu i nodi risgiau a thueddiadau sy'n dod i'r amlwg.

Olrhain a monitro argymhellion

42 Mae'r Bwrdd Iechyd yn parhau i gael trefniadau da ar gyfer olrhain argymhellion archwilio mewnol ac allanol. Mae gan y Bwrdd Iechyd olrhain archwilio ar gyfer argymhellion Archwilio Cymru ac Archwilio Mewnol, y mae Cyfarwyddwyr Gweithredol yn eu diweddarau, eu hadolygu a'u craffu yn eu Pwyllgor Gwaith. Mae'r Bwrdd Iechyd yn adrodd ar gynnydd ym mhob Pwyllgor Archwilio.

43 Eleni, mae'r Bwrdd Iechyd wedi gwella ei ddull o fonitro argymhellion Arolygiaeth Gofal Iechyd Cymru. Derbyniodd y Pwyllgor Ansawdd a Diogelwch yr Adroddiad Arolygiadau Allanol ym mis Gorffennaf 2025, sy'n

⁶ Blaenoriaethau cyfredol yw atal niwed o gwympiadau, difrod pwysau, gofal diwedd oes a maeth a hydradiad.

⁷ Mae deifio dwfn wedi canolbwyntio ar feysydd penodol o ansawdd clinigol a diogelwch cleifion, gan gynnwys gofal diwedd oes, maeth a hydradu, strôc, ac asesiadau risg ligature.

crynhoi gweithgarwch arolygu diweddar ar draws y Bwrdd Iechyd. Roedd yr adroddiad yn cynnwys canfyddiadau gan gyrff fel Arolygiaeth Gofal Iechyd Cymru (AGIC). Derbyniodd y Pwyllgor sicrwydd bod grwpiau gwasanaeth wedi datblygu cynlluniau gweithredu mewn ymateb i ganfyddiadau'r arolygiad a bod adolygiadau dilynol ar y gweill.

44 Er gwaethaf y trefniadau a ddisgrifir uchod, mae ein hadolygiad o gynnydd y Bwrdd Iechyd i fynd i'r afael ag argymhellion blaenorol wedi canfod safbwynt cymysg, gyda:

- chwech allan o 22 argymhelliad o adroddiadau asesu strwythuredig blaenorol bellach wedi'u cwblhau. Mae pedwar ar y gweill, gyda thri heb eu dechrau eto a naw wedi'u disodli; a
- saith allan o 13 argymhelliad o'n hadroddiad arbedion cost bellach wedi'u cwblhau. Trafodwn hyn yn fwy ym **mharagraff 68**.

45 Mae'r lefel hon o gynnydd yn awgrymu y gallai ymagwedd y Bwrdd Iechyd at weithredu argymhellion fod yn gryfach. Dylai'r Bwrdd Iechyd gynnwys cynnydd gydag argymhellion archwilio fel rhan o'i Fframwaith Rheoli Perfformiad i gryfhau atebolrwydd.

Paratoi strategaethau a chynlluniau

Mae'r Bwrdd Iechyd wedi adnewyddu ei strategaeth sefydliadol ac yn cryfhau ei weithio mewn partneriaeth ond mae angen sicrhau bod yr holl strategaethau sylfaenol yn cyd-fynd

Cynhyrchu strategaethau a chynlluniau allweddol

- 46 Lansiodd y Bwrdd Iechyd ei strategaeth hirdymor wedi'i hadnewyddu 'Bae Abertawe Iachach' yn ei Gyfarfod Cyffredinol Blyneddol ym mis Medi 2025. Datblygodd y Bwrdd Iechyd y strategaeth trwy ymgysylltu cynhwysfawr â rhanddeiliaid a phartneriaid. Mae'r strategaeth yn adeiladu ar ei gweledigaeth hirdymor y cytunwyd arno i greu dyfodol i bawb yng nghymuned y Bwrdd Iechyd fyw a heneiddio'n dda. Mae'r strategaeth yn darparu fframwaith cynllunio ar gyfer holl weithgareddau'r Bwrdd Iechyd, wedi'i adeiladu o amgylch pum amcan strategol. Mae pob amcan yn cynnwys mesurau llwyddiant diffiniedig ar gyfer 2028 a 2032.
- 47 Ar hyn o bryd mae'r Bwrdd Iechyd yn datblygu Cynllun Gwasanaethau Clinigol newydd. Er bod y cynllun cynharach yn cwmpasu'r cyfnod 2019–2024, mae'r fersiwn wedi'i diweddaru yn dal i fynd rhagddo a bydd yn cyd-fynd â'r strategaeth sefydliadol wedi'i hadnewyddu. Yr amserlen ar gyfer cymeradwyo yw Mawrth 2026.
- 48 Ar hyn o bryd mae'r Bwrdd Iechyd yn gweithio i Gynllun Blyneddol gan nad oedd yn gallu cyflwyno Cynllun Tymor Canolig Integredig tair blynedd cymeradwy wedi'i gytbwys yn ariannol i Lywodraeth Cymru. Mae'r Bwrdd Iechyd wedi parhau i ddangos ymgysylltiad da wrth ddatblygu'r cynllun. Fodd bynnag, nid oedd y cynllun yn cyrraedd y targedau ariannol a osodwyd gan Lywodraeth Cymru ac ar adeg ein gwaith, nid oedd yn cael ei gymeradwyo gan y Bwrdd a Llywodraeth Cymru oherwydd y sefyllfa ariannol sy'n gwaethygu a'r diffyg a ragwelir ar gyfer 2025-26. Rydym yn trafod heriau ariannol y Bwrdd Iechyd yn fanylach ym **mharagraff 59**.

- 49 Mae'r Cynllun Blynyddol yn cyd-fynd â'r strategaeth hirdymor fel cynllun cyflawni. Mae'r Cynllun Blynyddol wedi'i strwythuro o amgylch y pum amcan strategol ac mae'n dwyn ynghyd y strategaethau ategol fel y Strategaeth Pobl, y Strategaeth Ddigidol, a'r Strategaeth Ystadau.

Sicrwydd y Bwrdd ar weithio mewn partneriaeth

- 50 Mae'r Bwrdd yn derbyn diweddariadau rheolaidd ar waith partneriaeth. Mae hyn yn cynnwys y bwrdd partneriaeth rhanbarthol, byrddau gwasanaethau cyhoeddus, a chydweithio â byrddau ieuchyd eraill gan gynnwys Bwrdd Iechyd Prifysgol Hywel Dda. Mae adroddiadau i'r Bwrdd yn tynnu sylw at y cyfleoedd a'r heriau o weithio mewn partneriaeth.
- 51 Ers y llynedd, mae'r Bwrdd Iechyd wedi sefydlu Cyd-bwyllgor Rhanbarthol ffurfiol gyda Bwrdd Iechyd Prifysgol Hywel Dda. Cyfarfu'r pwyllgor am y tro cyntaf ym mis Ionawr 2025 ac mae'n cyfarfod bob chwarter. Mae ei gylch gorchwyl, y cytunwyd arnynt gan y ddau Fwrdd, yn nodi pum amcan rhanbarthol. Mae'r rhain yn canolbwyntio ar yr economi ieuchyd ranbarthol, gwasanaethau clinigol, swyddogaethau corfforaethol, y rhaglen gyfalaf ranbarthol, ac ymchwil, arloesi a rhagoriaeth. Mae rhaglen waith bwrpasol gydag arweinyddiaeth ar y cyd wedi'i ddiffinio'n glir yn cefnogi pob amcan. Fodd bynnag, mae'r cynnydd ar draws y pum rhaglen yn amrywio, gan eu bod ar wahanol gamau datblygu.
- 52 Mae'r Cyd-bwyllgor Rhanbarthol wedi cyfarfod dair gwaith ers ei sefydlu ac mae'n dal i ymgorffori ei brosesau. Canfu ein harsylwi graffu cadarn, ymdeimlad o gyfrifoldeb a rennir rhwng y ddau fwrdd ieuchyd a mwy o barodrwydd i weithio gyda'i gilydd. Er bod disgwyl i atebion rhanbarthol gefnogi cynaliadwyedd gwasanaeth hirdymor, codwyd pryderon gan swyddogion gweithredol ac Aelodau Annibynnol am y gallu i ddatblygu a chyflawni'r rhaglenni hyn tra hefyd yn rheoli pwysau gweithredol uniongyrchol.

Monitro cyflwyno strategaethau/cynlluniau

- 53 Mae gan y Bwrdd Iechyd drefniadau da ar y cyfan ar gyfer monitro cyflawni cynlluniau a strategaethau corfforaethol, ond mae cyfleoedd o hyd i gryfhau'r trefniadau hyn ymhellach.

- 54 Mae'r Cynllun Blynyddol yn nodi newidiadau gwasanaeth, cerrig milltir a blaenoriaethau allweddol ar gyfer 2025-26. Mae'r Cynllun Blynyddol yn cael ei gefnogi gan fesurau canlyniadau diffiniedig a llinellau sylfaen i gefnogi monitro. Fodd bynnag, nid yw'r Bwrdd lechyd wedi diweddaru'r Bwrdd eto ar gynnydd yn erbyn cyflawni'r cerrig milltir hyn. Mae diweddariad wedi'i gynllunio ar gyfer cyfarfod y Bwrdd ym mis Tachwedd 2025. Er ein bod yn cydnabod nad yw'r Cynllun Blynyddol wedi'i gymeradwyo, mae angen monitro cynnydd yn erbyn cyflawni'r camau gweithredu a nodwyd o hyd. Nid yw'r Bwrdd lechyd hefyd wedi adrodd yn ffurfiol ar ei gynnydd yn erbyn ei amcanion llesiant fel rhan o'i ddyletswydd o dan Ddeddf Llesiant Cenedlaethau'r Dyfodol (2015).
- 55 Er mwyn cefnogi cyflawni, mae'r Bwrdd lechyd wedi datblygu ystod o gynlluniau a strategaethau galluogi, y rhan fwyaf ohonynt yn cynnwys cerrig milltir clir. Mae'r Bwrdd yn dirprwyo strategaeth a goruchwyliaeth cynllun i'w bwyllgorau yn briodol. Mae swyddogion yn darparu diweddariadau ar strategaethau a rhaglenni allweddol, ac rydym wedi gweld monitro da o gyflawni. Rydym wedi gweld gwelliannau penodol eleni i fonitro cyflawni'r Strategaeth Bobl a'r Strategaeth Ddigidol.
- 56 Mae'r Bwrdd lechyd wedi cydnabod nad yw ei holl strategaethau galluogi presennol yn cyd-fynd â'r strategaeth hirdymor newydd a'i amserlen. Mae'r Bwrdd lechyd yn mynd i'r afael â hyn ar hyn o bryd.

Rheoli cyllid

Er gwaethaf bod mecanweithiau goruchwyllo a rheoli ar waith, mae'r sefyllfa ariannol yn dal i fod yn bryder sylweddol ac mae mewn perygl o ddirywiad pellach

Bodloni amcanion a dyletswyddau ariannol

57 Ni chyflawnodd y Bwrdd Iechyd ei holl ddyletswyddau ariannol yn 2024-25. O'r tair dyletswydd, cyrhaeddodd ei derfyn adnoddau cyfalaf, gan adrodd tanwariant bach o £61,000. Fodd bynnag, ni wnaeth:

- gwariant o fewn ei derfyn adnoddau refeniw ar gyfer y cyfnod 2022-25;
- Cynllun Tymor Canolig Integredig tair blynedd ar gyfer 2024-27 cael ei chytuno arno.

58 Gosododd Llywodraeth Cymru ddiffyg targed o £17.1 miliwn i'r Bwrdd Iechyd ar gyfer 2024-25. Ni wnaeth y Bwrdd Iechyd gwrdd â hyn, gan adrodd diffyg diwedd blwyddyn o £42.4 miliwn. Rhoddodd Llywodraeth Cymru hefyd gefnogaeth ychwanegol yn 2024-25 o ddryniad rheolaidd o £6.4 miliwn.

59 Nid oes gan y Bwrdd Iechyd gynllun ariannol cytbwys ar gyfer 2025-2026. Ni allai'r Bwrdd gefnogi na derbyn y cynllun gan ei fod yn amlinellu diffyg rhagolwg diwedd y flwyddyn o £58.7 miliwn, yn erbyn diffyg targed Llywodraeth Cymru o £17.1 miliwn. Nid yw Llywodraeth Cymru wedi cymeradwyo'r cynllun gan ei fod yn llawer llai na diffyg targed y Bwrdd Iechyd. Cododd Llywodraeth Cymru bryderon hefyd am gyfradd a graddfa'r dirywiad o sefyllfa ariannol y Bwrdd Iechyd.

60 Ym mis Mehefin 2025, cyfathrebodd Llywodraeth Cymru i'r Bwrdd Iechyd ddisgwyliad diwygiedig ar gyfer 2025-26. Dyma oedd bod yn rhaid i'r diffyg diwedd y flwyddyn, o leiaf, fod yn hafal i sefyllfa alldro 2024-25 o ddiffyg o £42.5 miliwn.

- 61 Roedd y cynnydd yn y cynnydd yn y cynnydd yn cyd-fynd â chyllid ychwanegol gan Lywodraeth Cymru a ddefnyddiodd y Bwrdd lechyd i gomisiynu cymorth gan Deloitte ym mis Gorffennaf 2025. Maent wedi bod yn gweithio gyda'r Bwrdd lechyd i adolygu cynlluniau ariannol, rheolaethau a llywodraethu ariannol. Mae eu gwaith hefyd yn cefnogi cyflawni cynlluniau tactegol a chynlluniau cynilo ar gyfer 2025-26 a'r blynyddoedd i ddod.
- 62 Ym mis chwech 2025-26, mae sefyllfa rhagolwg diwedd blwyddyn y Bwrdd lechyd yn dal i fod ar ddiffyg o £58.7 miliwn. Fodd bynnag, mae pwysau gweithredol a chyfraddau rhedeg hyd yma yn uwch na'r llwybr arfaethedig. Ar gyfer misoedd sy'n weddill y flwyddyn ariannol, bydd angen i'r Bwrdd lechyd danwario ar ei gyflawni gweithredol i fodloni ei ragolwg.

Trefniadau cynllunio ariannol

- 63 Yn 2024, sefydlodd y Bwrdd lechyd Fwrdd Adfer a Chynaliadwyedd (RSB). Mae'r RSB yn goruchwyllo rhaglen o waith i ddod o hyd i gynlluniau cynilo a monitro cyflawniad ac mae ganddo gynrychiolwyr o bob rhan o grwpiau gwasanaeth a chyfarwyddiaethau corfforaethol. Mae gan y Bwrdd lechyd hanes cryf o gyflawni arbedion. Yn 2024-25, cyflawnodd y Bwrdd lechyd arbedion o £51.6 miliwn yn erbyn targed o £26.1 miliwn, gyda £37.3 miliwn o arbedion rheolaidd.⁸
- 64 Ar hyn o bryd mae'r Bwrdd lechyd oddi ar y trywydd iawn ar ei gynlluniau cynilo yn 2025-26. Mae angen i'r Bwrdd lechyd wneud arbedion blynyddol o £55.4 miliwn. Fodd bynnag, ym mis chwech, dim ond £10.9 miliwn y mae'r Bwrdd lechyd wedi cyflawni o'i gymharu â'i darged o £27.7 miliwn o flwyddyn hyd yma. Mae lefel yr arbedion a gyflawnwyd dros y tair blynedd diwethaf yn golygu bod angen i gynlluniau yn mynd ymlaen fod yn fwy rhyddhau arian parod ac yn strategol ac yn drawsnewidiol. Mae gan y Bwrdd lechyd gynllun arbed ar waith sydd wedi nodi arbedion o £46.4 miliwn, gan adael bwlch cynilo o £9 miliwn. Nid yw'r Bwrdd lechyd wedi asesu eto faint o'i arbedion presennol sy'n ailadroddus, gan ei gwneud hi'n anodd deall yr effaith hirdymor ar ei sefyllfa ariannol. Mae'r ffocws ar hyn o bryd ar y cyflawni yn ystod y flwyddyn, ac nid yw'r Bwrdd lechyd wedi datblygu cynllun ariannol hirdymor eto.

⁸ Mae'r arbedion cronol ers cyflawni 2022 yn dod i gyfanswm o £138.6 miliwn

- 65 Mae'r RSB yn canolbwyntio ar nifer o gynlluniau arbedion, sy'n cynnwys cynlluniau gweithlu, gofal iechyd parhaus, gofal brys ac argyfwng, caffael, rheoli meddyginiaethau a gofal wedi'i gynllunio. Canfu ein hadolygiad yn 2025 sy'n mynd i'r afael â'r heriau gofal arfaethedig, gyfleoedd ar gyfer mwy o effeithlonrwydd a chynhyrchiant mewn perthynas â gwella'r defnydd o theatrau, gwneud y mwyaf o'r defnydd o gapasiti cleifion allanol a chynyddu'r defnydd o lawdriniaethau dydd.
- 66 Mae Aelodau Annibynnol wedi mynegi pryder ynglŷn â gallu a gallu'r RSB i gyflawni ei raglen. Ar adeg ein gwaith, roedd Deloitte yn cadeirio'r RSB, ond mae disgwyl i'w contract ddod i ben ym mis Tachwedd 2025.
- 67 Mae'r Bwrdd Iechyd yn hysbysu'r Bwrdd am yr arbedion angenrheidiol i gyflawni cydbwysedd ariannol, y dull arbedion, a'r risg o beidio â chyflawni. Lle mae cynlluniau oddi ar y trywydd iawn, mae cynlluniau ar waith i adfer y sefyllfa. Fodd bynnag, nid ydym wedi gweld unrhyw ddysgiad wedi'i adrodd ar gynlluniau a fethwyd neu sy'n tangyflawni o flynyddoedd ariannol blaenorol neu gyfredol. Ar adeg ein gwaith, roedd y Bwrdd Iechyd yn dechrau prosesau cynllunio ar gyfer 2026-27, gyda thrafodaethau i'w cynnal yng nghanol mis Tachwedd ar drafodaethau ar gynlluniau strategol a thrawsnewidiol.
- 68 Yn 2024, adolygodd Archwilio Cymru ymagwedd y Bwrdd Iechyd at arbed costau. O'r 13 argymhelliad yn yr adroddiad hwnnw, mae'r Bwrdd Iechyd wedi gwneud cynnydd ond mae ganddo fwy i'w wneud: saith wedi'u cwblhau, pump yn dal i fynd rhagddo, ac nid yw un wedi dechrau eto. Mae'r meysydd lle mae angen cynnydd pellach ynddynt yn cynnwys **Atodiad 2**.

Trefniadau rheoli ariannol

- 69 Mae gan y Bwrdd Iechyd y rheolaethau ariannol disgwylledig ar waith. Mae'r Bwrdd yn adolygu ei Reolau Sefydlog a'i Gyfarwyddiadau Ariannol Sefydlog yn rheolaidd, yn fwyaf diweddar ym mis Medi 2025. Mae'r Bwrdd Iechyd hefyd yn parhau i gael trefniadau da ar gyfer sicrhau cydymffurfiaeth ag offerynnau statudol, ac i adrodd a herio toriadau. Fodd bynnag, mae'r sefyllfa ariannol bresennol yn golygu bod angen iddo wella ei drefniadau.
- 70 Mae angen i'r Bwrdd Iechyd wella ei drefniadau yn sylweddol ar gyfer dal deiliaid cyllideb i gyfrif am gyflawni targedau ariannol. Er gwaethaf grwpiau gwasanaeth a chyfarwyddiaethau corfforaethol yn llofnodi llythyrau atebolrwydd, a data ariannol manwl ar gael, mae gorwariant sylweddol o hyd.

- 71 Mae'r Bwrdd yn dirprwyo goruchwyliaeth ariannol i'r Pwyllgor Archwilio a'r Pwyllgor Perfformiad a Chyllid. Mae'r pwyllgorau hyn yn cyflawni eu cyfrifoldebau yn briodol. Mae hyn yn cynnwys goruchwyllo adroddiadau ar gydymffurfiaeth â phrosesau a rheolaethau ariannol, a sicrwydd o waith Archwilio Mewnol a Gwrth-Dwylo. Mae'r Bwrdd lechyd hefyd yn adrodd ar bryniannau gwerth uchel a chatau tendr sengl.
- 72 Cyflwynodd y Bwrdd lechyd ddatganiadau ariannol drafft o ansawdd da ar gyfer archwilio allanol o fewn yr amserlenni gofynnol. Ni chanfu ein harchwiliad unrhyw gamddatganiadau materol ond canfu rhai meysydd lle roedd angen gwneud cywiriadau. Fe wnaethom gyhoeddi barn ddiamod mewn perthynas â gwir a thegwch y cyfrifon ond rheoleiddrwydd cymwys oherwydd bod y Bwrdd lechyd wedi torri ei derfyn adnoddau refeniw dros y cyfnod o dair blynedd 2022–2025. Mae hwn yn wariant afreolaidd a oedd yn gofyn i'r farn rheoleiddrwydd fod yn gymwys.

Monitro perfformiad ariannol

- 73 Mae trefniadau da ar gyfer goruchwyllo perfformiad ariannol, ond maent yn canolbwyntio ar y pwysau presennol ac yn rhoi ychydig o sicrwydd ar yr effaith ar flynyddoedd i ddod.
- 74 Mae'r Bwrdd a'r Pwyllgor Perfformiad a Chyllid yn derbyn adroddiad perfformiad ariannol rheolaidd. Mae'r adroddiad yn nodi'n glir y sefyllfa refeniw, y sefyllfa a ragwelir, yn ogystal â pherfformiad yn erbyn y targed arbedion gofynnol, gwariant cyfalaf, costau sy'n gysylltiedig â gweithgarwch a gomisiynwyd a thalu anfonebau nad ydynt yn y GIG. Mae'r Bwrdd lechyd wedi cryfhau trefniadau ymhellach drwy'r Pwyllgor Perfformiad a Chyllid drwy sicrhau bod grwpiau gwasanaeth yn darparu cyflwyniadau adroddiadau ariannol bob chwarter.
- 75 Mae gwybodaeth fanwl yn parhau i gael ei darparu i'r Bwrdd a'r pwyllgor Perfformiad a Chyllid ar yrwyr cost allweddol, amrywiadau ar gyfer pob un o'r grwpiau gwasanaeth a'r cyfarwyddiaethau corfforaethol, a'r risgiau sy'n gysylltiedig â pheidio â chyflawni arbedion. Mae Cofrestr Risg y Bwrdd lechyd hefyd yn cynnwys risgiau sy'n gysylltiedig â chyflawni'r cynllun ariannol. Mae'r Pwyllgor Perfformiad a Chyllid yn parhau i gyfarfod yn fisol oherwydd perfformiad ariannol cyfredol y Bwrdd lechyd. Mae'r Pwyllgor hefyd yn derbyn diweddariadau rheolaidd ar waith yr RSB, gan gynnwys cyflwyniadau gan Deloitte.

- 76 Mae'r Bwrdd Iechyd hefyd yn destun lefelau sylweddol uwch o ofynion craffu, herio ac adrodd gan Lywodraeth Cymru oherwydd ei statws cynyddu. Fodd bynnag, mae goruchwyllo a chraffu yn canolbwyntio ar y flwyddyn ariannol gyfredol, a'r materion a'r risgiau sylweddol ar gyflawni yn ystod y flwyddyn. Ar hyn o bryd nid oes llawer o ffocws ar flynyddoedd y dyfodol.

Argymhellion

77 Mae'r tabl canlynol yn manylu ar yr argymhellion sy'n deillio o'n gwaith.

Argymhellion

A1	Dylai'r Bwrdd lechyd wella tryloywder y Bwrdd drwy: 1.1. sicrhau bod cynnwys ei wefan yn gyfredol; 1.2. gweithredu ffrydio byw o'r Bwrdd, gyda gwell gallu i wylwyr adnabod siaradwyr; a 1.3. sicrhau bod dyddiadau a phapurau cyfarfodydd y Bwrdd a'r pwyllgor yn welededd ac yn brydlondeb (paragraff 8).
A2	Dylai'r Bwrdd lechyd weithredu argymhelliad Archwilio Mewnol 2022 i ddiweddarau ei Bolisi Safonau Ymddygiad Busnes i gynnwys y gofyniad i staff mewn swyddi eilaidd mewn rolau gwneud penderfyniadau er mwyn osgoi gwrthdaro buddiannau. Yn ogystal, dylid monitro cydymffurfiaeth bob chwe mis a'i adrodd i'r Pwyllgor Archwilio (paragraff 13)
A3	Dylai'r Bwrdd lechyd gyhoeddi amserlen ymweliadau ac adrodd canlyniadau a chatau gweithredu o ymweliadau aelodau'r Bwrdd a cherdded o gwmpas i'r Pwyllgor Ansawdd a Diogelwch (paragraff 23)
A4	Dylai'r Bwrdd lechyd gryfhau ei drefniadau rheoli perfformiad ymhellach drwy: 4.1 ymgorffori'r fframwaith yn llawn i gynnal grwpiau gwasanaeth i gyfrif am perfformiad cyllid, ac ansawdd (paragraff 35); 4.2 gan gynnwys cynnydd gydag argymhellion archwilio o fewn y fframwaith i ddal grwpiau gwasanaeth i gyfrif am berfformiad, cyllid ac ansawdd (paragraff 45); a 4.3 adrodd yn rheolaidd ar y statws cynyddu ar gyfer pob grŵp gwasanaeth a chyfarwyddiaeth gorfforaethol i'r pwyllgor Perfformiad a Chyllid (paragraff 35).

Atodiadau

1 Ynglŷn â'n gwaith

Cwmpas yr archwiliad

Edrychwyd ar y meysydd canlynol ar gyfer y cyfnod Mehefin i Hydref 2025:

- Pa mor dda mae'r bwrdd yn gweithio.
- Pa mor dda mae'r bwrdd yn goruchwyllo risgiau, perfformiad, ac ansawdd a diogelwch gwasanaethau ac yn olrhain argymhellion.
- Pa mor dda mae'r corff yn paratoi strategaethau a chynlluniau allweddol.
- Pa mor dda mae'r corff yn rheoli ei gyllid.

Ni wnaethom edrych ar drefniadau gweithredol y corff.

Cwestiynau a meini prawf archwilio

Cwestiynau

Aeth ein harchwiliad i'r afael â'r cwestiynau canlynol:

- A yw'r Bwrdd yn cynnal ei fusnes yn briodol, yn effeithiol ac yn dryloyw?
- A oes dull corfforaethol cadarn o reoli risgiau, perfformiad, ac ansawdd a diogelwch gwasanaethau?
- A oes dull corfforaethol cadarn o gynhyrchu cynlluniau strategol a goruchwyllo eu cyflawni?
- A oes dull corfforaethol cadarn o gynllunio, rheoli a pherfformiad ariannol?

Meini prawf

Cafodd ein cwestiynau archwilio eu llunio gan:

- Rheolau Sefydlog enghreifftiol, cadw a dirprwyo pwerau.
- Cyfarwyddiadau ariannol sefydlog enghreifftiol.
- Cylchlythyrau a chanllawiau iechyd perthnasol Llywodraeth Cymru.
- Y Canllaw Llywodraethu Da ar gyfer Byrddau GIG Cymru (Ail Argraffiad).

Dulliau

Fe wnaethom adolygu ystod o ddogfennau, gan gynnwys:

- Papurau a chofnodion y Bwrdd a'r pwyllgor.
- Dogfennau llywodraethu allweddol, gan gynnwys Rheolau Sefydlog a Chyfarwyddiadau Ariannol Sefydlog.
- Strategaethau a chynlluniau allweddol, gan gynnwys y Cynllun Blynyddol.
- Dogfennau rheoli risg allweddol, gan gynnwys Fframwaith Sicrwydd y Bwrdd.
- Adroddiad Blynyddol, gan gynnwys y Datganiad Llywodraethu Blynyddol.
- Polisiâu a gweithdrefnau perthnasol.
- Adroddiadau a baratowyd gan gyrff allanol perthnasol eraill.

Fe wnaethom gyfnewid â'r rhanddeiliaid allweddol canlynol:

- Cadair;
- Prif Weithredwr;
- Cyfarwyddwr Cyllid;
- Cyfarwyddwr Cynllunio a Phartneriaethau;
- Cyfarwyddwr Dros Dro Iechyd y Cyhoedd;
- Cyfarwyddwr Datblygu'r Gweithlu a Sefydliadol;
- Cyfarwyddwr Llywodraethu Corfforaethol;
- Cadeirydd y Pwyllgor Archwilio;
- Cadeirydd y Pwyllgor Ansawdd a Diogelwch;
- Cadeirydd y Pwyllgor Perfformiad a Chyllid;

Gwelsom gyfarfodydd y Bwrdd yn ogystal â chyfarfodydd o'r pwyllgorau canlynol:

- Pwyllgor Archwilio;
- Pwyllgor Perfformiad a Chyllid;
- Pwyllgor Iechyd y Boblogaeth;
- Pwyllgor Ansawdd a Diogelwch; a
- Phwyllgor Datblygu'r Gweithlu a Sefydliadol.

2 Argymhellion archwilio blaenorol

Argymhellion rhagorol o adroddiadau asesu strwythuredig blaenorol

Mae'r tabl isod yn nodi'r cynnydd a wnaed gan y Bwrdd Iechyd wrth weithredu argymhellion sy'n weddill o adroddiadau asesu strwythuredig blaenorol.

Argymhellion 2022

- A2** Gellid gwella adrodd ar gynnydd yn erbyn y cynlluniau clinigol a chorfforaethol sy'n cefnogi'r Cynllun Gwasanaethau Clinigol (CSP) ar bob lefel. Dylai'r Bwrdd Iechyd wella adrodd i'r Bwrdd Rheoli er mwyn galluogi cynnydd yn erbyn pob cynllun i gael ei olrhain yn hawdd (**wedi'i ddisodli, paragraff 47**).
- A3** Er bod y BAF wedi gwella, mae cyfleoedd i'w ddatblygu a'i wella ymhellach. Dylai'r Bwrdd Iechyd sicrhau bod prif risgiau'r BAF yn adlewyrchu'r strategaeth hirdymor, yn ogystal â sicrhau bod rheolaethau, sicrwydd a lliniariadau yn gynhwysfawr ac yn gadarn. Dylai hyn gynnwys sicrwydd sy'n ymwneud ag ystadau (**disodliwyd, paragraff 30**).
- A5** Mae'r Adroddiad Perfformiad Integredig wedi gwella ond mae cyfleoedd i'w wella ymhellach. Dylai'r Bwrdd Iechyd edrych ar gyfleoedd i ddefnyddio atebion digidol i gyflwyno'r adroddiad yn ogystal â chynnwys data cymharol ar gyfer cyrff eraill y GIG ledled Cymru (**ar y gweill, paragraff 37**).
- A6** Mae'r broses ar gyfer gwneud newidiadau ar gyfer amserlenni ar gyfer cwblhau argymhellion archwilio yn aneglur. Yn ogystal, nid yw argymhellion a wneir gan sefydliadau gan gynnwys Arolygiaeth Gofal Iechyd Cymru a'r Uned Gyflenwi hefyd yn cael eu olrhain na'u craffu gan y pwyllgor priodol nac yn cael eu cynnwys ar y traciwr argymhellion archwilio. Dylai'r Bwrdd Iechyd:
- b) sicrhau monitro a chraffu priodol ar gynnydd wrth fynd i'r afael â chamau gweithredu sy'n ymwneud ag argymhellion gan gyrrff arolygu ac adolygu allanol eraill (**Complete, paragraff 43**)

A7 Mae cyfleoedd yn bodoli i wella tryloywder busnes y Bwrdd a'r pwyllgor ymhellach. Dylai'r Bwrdd lechyd:

- a) sicrhau bod polisiau a gweithdrefnau ar y wefan gyhoeddus, yn ogystal â strategaethau allweddol yn gyfredol ac yn hygyrch. Wrth wneud hynny, dylid dileu dogfennau hŷn er mwyn osgoi dryswch (**disodli, Argymhelliad 1.1 2025**).
- b) sicrhau bod cofnodion a gadarnhawyd o gyfarfodydd y Bwrdd a'r pwyllgor yn cael eu llwytho i fyny i'r wefan gyhoeddus mewn modd amserol (**disodli, Argymhelliad 1.3 2025**).
- c) sicrhau bod adrodd ffurfiol ar Weithredoedd y Cadeirydd yn cynnwys mwy o fanylion ar gostau neu oblygiadau adnoddau ehangach, yn enwedig os yw'r weithred yn faterol ei natur (**heb ei ddechrau, paragraff 9**).

Argymhellion 2023

A1 Mae cyfleoedd yn bodoli i wella tryloywder busnes y Bwrdd a'r Pwyllgor ymhellach. Dylai'r Bwrdd lechyd:

- a) adolygu'r systemau a'r prosesau a ddefnyddir i ffrydio cyfarfodydd y Bwrdd yn fyw, gyda'r bwriad o wella ansawdd sain a gweledol (**disodli, Argymhelliad R1.2 2025**); a
- b) sicrhau bod holl gyfarfodydd y Bwrdd a digwyddiadau eraill, megis y Cyfarfod Cyffredinol Blyneddol, yn cael eu hyrwyddo drwy sianeli cyfryngau cymdeithasol y Bwrdd lechyd (**ar y gweill, paragraff 8**).

A3 Mae walkarounds bwrdd yn ad-hoc ac yn canolbwyntio gormod ar wasanaethau gofal eilaidd. Dylai'r Bwrdd lechyd:

- a) datblygu fframwaith ar gyfer ymweliadau i alluogi dull cyson (**disodli, Argymhelliad 3 2025**); a
- b) sicrhau bod themâu a champau allweddol sy'n deillio o'r ymweliadau yn cael eu hadrodd i'r Pwyllgor Ansawdd a Diogelwch (**disodli, Argymhelliad 3 2025**).

A6 Mae'r Adroddiad Perfformiad Integredig yn cyfeirio at berfformiad gofal sylfaenol. Fel rhan o'r adnewyddiad arfaethedig, dylai'r Bwrdd lechyd sicrhau bod mwy o ffocws ar berfformiad gofal sylfaenol (**ar y gweill, paragraff 38**).

- A9** Er gwaethaf yr heriau ariannol sy'n wynebu'r Bwrdd lechyd, nid yw dau lythyr atebolrwydd wedi'u llofnodi eto. Dylai'r Bwrdd lechyd sicrhau bod pob llythyr atebolrwydd ar gyfer 2023-24 yn cael ei lofnodi **(cyflawn, paragraff 70)**.

Argymhellion 2024

A1 Dylai'r Bwrdd lechyd:

- 1.1.** datblygu strategaeth hirdymor, wedi'i alinio â'i weledigaeth hirdymor, sy'n diffinio'r atebion a'r penderfyniadau gwasanaeth cynaliadwy gofynnol ar gyfer y tymor canolig i'r tymor hwy, tra hefyd yn darparu ffocws cryf ar ieuchyd ac atal poblogaeth **(complete, paragraff 46)**.
 - 1.2** datblygu cynllun ariannol cytbwys sy'n gysylltiedig â'r strategaeth hirdymor newydd **(heb ei gyhwyn, paragraff 59)**; a
 - 1.3** adolygu a lle bo'n briodol adnewyddu strategaethau a chynlluniau galluogi perthnasol (h.y. ystadau, digidol, gweithlu, gwasanaethau clinigol) i sicrhau eu bod yn cyd-fynd â'r strategaeth hirdymor newydd **(ar y gweill, paragraff 56)**.
- A2** Mae angen i'r Bwrdd lechyd sicrhau bod y Bwrdd a'i bwyllgorau yn monitro a chraffu ar gynnydd yn rheolaidd yn erbyn cyflawni ei amcanion llesiant **(heb ei gyhwyn, paragraff 54)**
- A3** Mae angen i'r Bwrdd lechyd sicrhau bod trefniadau'r Bwrdd a'r pwyllgorau ar gyfer monitro a chraffu ar gyflawni cynlluniau cynilo'r Bwrdd lechyd yn gallu dal perfformiad ar draws y cyfanrwydd o gynlluniau cynilo sydd ar waith **(cyflawn, paragraff 70)**.
- A4** Mae angen i'r Bwrdd lechyd gryfhau perchnogaeth ac atebolrwydd argymhellion archwilio i sicrhau bod argymhellion yn cael eu hystyried mewn modd amserol **(disodliwyd, Argymhelliad 2025 R4.2)**.
- A5** Dylai'r Bwrdd lechyd fynd i'r afael â'r materion sydd ar hyn o bryd yn ei atal rhag ffrydio cyfarfodydd cyhoeddus y Bwrdd **(disodliwyd, Argymhelliad 2025 1.2)**.
- A6** Mae angen i'r Bwrdd lechyd wella cynllunio agenda ar gyfer pwyllgorau er mwyn sicrhau bod digon o amser ar gael i ymdrin ag eitemau **(cyflawn, paragraff 17)**.

- A7** Dylai'r Bwrdd lechyd drosglwyddo'r cyfrifoldeb am bryderon a chwynion cleifion gan y Cyfarwyddwr Llywodraethu Corfforaethol i Gyfarwyddwr Gweithredol priodol (**cyflawn, paragraff 25**).

Argymhellion o'n Adolygiad 2024 o Drefniadau Arbed Costau

Mae'r tabl isod yn nodi'r cynnydd a wnaed gan y Bwrdd lechyd wrth weithredu argymhellion o'n Adolygiad 2024 o Drefniadau Arbed Costau.

- A1

Dylai'r Bwrdd lechyd barhau i weithio gyda'i gyfarwyddiaethau corfforaethol a'i grwpiau gwasanaeth i sicrhau bod eu cyllidebau sylfaenol yn gywir. Bydd hyn yn sicrhau bod dealltwriaeth gytunedig o'r sefyllfa ariannol ac yn darparu llinell sylfaen gliriach i gyflawni unrhyw effeithlonrwydd ariannol **(cyflawnwyd)**.
- A2

Mae angen i'r Bwrdd lechyd sicrhau bod ei gynlluniau arbed ar gyfer 2024-25 a thu hwnt yn seiliedig ar ddadansoddiad a gweithredu ehangach a mwy systematig o'r cyfleoedd sy'n bodoli, sy'n cynnwys tynnu ar ddata a deallusrwydd o'r VAULT, ffrydiau gwaith y Bwrdd Gwerth a Chynaliadwyedd, adolygiadau GIRFT, a gwaith Grant Thornton ar yr ASMR. Fel rhan o'r gwaith hwn, mae angen i'r Bwrdd lechyd sicrhau bod ganddo ddigon o allu a gallu (corfforaethol ac o fewn cyfarwyddiaethau corfforaethol a grwpiau gwasanaeth) i ddadansoddi a defnyddio'r data a'r deallusrwydd yn effeithiol i nodi, datblygu a darparu cyfleoedd arbed hyfyw ar gyfer 2024-25 a thu hwnt **(cyflawnwyd)**
- A3

Mae angen i'r Bwrdd lechyd weithio'n gyflym ac ar draws ei grwpiau gwasanaeth a'i gyfarwyddiaethau corfforaethol i ddatblygu a gweithredu dull mwy strwythuredig o ddatblygu effeithlonrwydd ac arbedion trawsnewidiol, trawswasanaeth i sicrhau bod ei arbedion yn cael eu rhoi ar sail fwy cynaliadwy **(Ar y gweill)**
- A4

Dylai'r Bwrdd lechyd roi trefniadau priodol ar waith i sicrhau ei hun bod yr holl staff perthnasol yn cymhwyso ei broses porth CIP mewn modd cyson, yn enwedig mewn perthynas â:

a)

y ffordd y ceisir barn defnyddwyr gwasanaeth a rhanddeiliaid i gynhyrchu syniadau arbedion **(cyflawnwyd)**, a

b)

y broses ar gyfer nodi ac asesu effeithiau posibl cynlluniau arbed ar ansawdd a diogelwch cleifion **(cyflwanwyd)**.

- A5.1** Dylai'r Bwrdd lechyd wneud gwelliannau i'r ffordd y mae'n adrodd ar arbedion cost drwy sicrhau bod adroddiadau arbedion i'r Bwrdd a'r pwyllgorau yn y dyfodol yn mynegi'r holl arbedion y mae angen i'r sefydliad eu cyflawni bob blwyddyn i gwrdd â'i gyfanswm diffyg rheolaeth Llywodraeth Cymru **(cyflawnwyd)**.
- A5.2** Dylai'r Bwrdd lechyd barhau i weithio gyda grwpiau gwasanaeth a chyfarwyddiaethau corfforaethol i sicrhau bod unrhyw iteriad o'r olrhain a'r adroddiad cynilo yn y dyfodol yn diwallu eu hanghenion ac yn darparu 'un ffynhonnell y gwir' ar gyfer cynilion ac effeithlonrwydd ariannol sy'n cael ei ddefnyddio'n gyson ar draws y sefydliad **(cyflawnwyd)**.
- A6** Dylai'r Bwrdd lechyd fonitro effeithiolrwydd ei ddull newydd o ddyrannu arbedion yn rheolaidd i sicrhau bod grwpiau gwasanaeth a chyfarwyddiaethau corfforaethol yn ei weithredu fel y cynlluniwyd **(ar y gweill)**
- A7** Dylai'r Bwrdd lechyd nodi a llenwi'n gyflym unrhyw fylchau gallu ariannol neu gapasiti sy'n bodoli ar draws y sefydliad er mwyn sicrhau bod staff perthnasol, fel deiliaid cyllideb, yn meddu ar y wybodaeth a'r sgiliau angenrheidiol i nodi a darparu cyfleoedd arbed hyfyw **(ar y gweill)**.
- A8** Dylai'r Bwrdd lechyd barhau i asesu a gwella i ba raddau y mae clinigwyr yn ymwneud yn ddigonol ac yn cefnogi cynlluniau effeithlonrwydd ac arbed **(cyflawnwyd)**.
- A9** Dylai'r Bwrdd lechyd sicrhau bod ei adolygiad o'r broses ddwysáu fewnol yn nodi diffygion yn y broses bresennol ac yn arwain at broses sy'n canolbwyntio mwy ar weithredu sy'n nodi'n glir y camau sydd eu hangen i fynd i'r afael ag unrhyw danberfformiad arbedion **(heb ei gychwyn, paragraff 35)**
- A10** Dylai'r Bwrdd lechyd sicrhau bod ei gynllunio arbedion ar gyfer 2025-26 yn dechrau'n gynharach a mwy o bwyslais ar reoli'r risg gynhenid o fewn ei arbedion a nodwyd trwy ganolbwyntio ar symud ei gynlluniau coch ac ambr i gynlluniau gwyrdd a nodi lefel uwch o gyfleoedd cynilo rheolaidd **(ar y gweill, paragraff 65)**
- A11** Dylai'r Bwrdd lechyd gryfhau ei drefniadau ar gyfer rhannu arfer gorau a dysgu ar gynlluniau cynilo gyda grwpiau gwasanaeth a chyfarwyddiaethau corfforaethol **(ar y gweill, paragraff 65)**

3 Ymateb y rheolwyr

Cyf	Argymhelliad	Sylwebaeth ar gamau gweithredu arfaethedig	Dyddiad cwblhau gweithredoedd wedi'u cynllunio	Swyddog cyfrifol (teitl)
A1	Dylai'r Bwrdd lechyd wella tryloywder y Bwrdd drwy:	Bydd y Bwrdd lechyd yn cwblhau ymarfer meincnodi i ddeall y prosesau, y protocolau a'r seilwaith i gefnogi'r wefan. Adroddiad sy'n crynhoi'r adolygiad meincnod a'r opsiynau i'w cyflwyno i'r Bwrdd Rheoli ym mis Mawrth 2026.	Mawrth 2026	Cyfarwyddwr Mewnwelediadau, Cyfathrebu ac Ymgysylltu
	1.1. sicrhau bod cynnwys ei wefan yn gyfredol;	Mae'r Bwrdd lechyd wedi bod yn profi ymarferoldeb ffrydio byw, a bydd hyn yn cael ei weithredu ym mis Ionawr 2026.	Ionawr 2026	Cyfarwyddwr Llywodraethu Corfforaethol
	1.2. gweithredu ffrydio byw o'r Bwrdd, gyda gwell gallu i wylwyr adnabod siaradwyr; a	Yn ddiweddar, mae'r Bwrdd lechyd wedi prynu camerâu newydd i gefnogi gwell gwelededd siaradwyr.	Ionawr 2026	Cyfarwyddwr Llywodraethu Corfforaethol
	1.3. sicrhau bod dyddiadau a phapurau cyfarfodydd y Bwrdd a'r pwyllgor yn welededd ac yn amserol (paragraff 8).	Proses ar gyfer cyhoeddi adroddiadau'r Bwrdd a'r Pwyllgor i'w		

Cyf	Argymhelliad	Sylwebaeth ar gamau gweithredu arfaethedig	Dyddiad cwblhau gweithredoedd wedi'u cynllunio	Swyddog cyfrifol (teitl)
		diwygio a darparu hyfforddiant i Dîm Gwasanaethau Bwrdd SBU.		
A2	Dylai'r Bwrdd lechyd weithredu argymhelliad Archwilio Mewnol 2022 i ddiweddarau ei Bolisi Safonau Ymddygiad Busnes i gynnwys y gofyniad i staff mewn swyddi eilaidd mewn rolau gwneud penderfyniadau er mwyn osgoi gwrthdaro buddiannau. Yn ogystal, dylid monitro cydymffurfiaeth bob chwe mis a'i adrodd i'r Pwyllgor Archwilio (paragraff 13)	Mae'r polisi wedi'i ddiweddarau a'i ymgynghori o fewn y sefydliad a bydd yn cael ei gyflwyno i'r Pwyllgor Archwilio i'w gymeradwyo.	Tachwedd 2025	Cyfarwyddwr Llywodraethu Corfforaethol

Cyf	Argymhelliad	Sylwebaeth ar gamau gweithredu arfaethedig	Dyddiad cwblhau gweithredoedd wedi'u cynllunio	Swyddog cyfrifol (teitl)
A3	Dylai'r Bwrdd lechyd gyhoeddi amserlen ymweliadau ac adrodd ar ganlyniadau a chatau gweithredu o ymweliadau aelodau'r Bwrdd a cherdded o gwmpas i'r Pwyllgor Ansawdd a Diogelwch (paragraff 23)	Bydd y Pwyllgor Ansawdd a Diogelwch yn derbyn ac yn ystyried amserlen yr ymweliadau ar gyfer 2026/2027 a manylion yr ymweliadau a'r canlyniadau.	Chwefror 2026	Cyfarwyddwr Gweithredol Nysio
A4	Dylai'r Bwrdd lechyd gryfhau ei drefniadau rheoli perfformiad ymhellach drwy:	Bydd y Fframwaith yn cael ei ail-lansio ym mis Ionawr 2026.	Ionawr 2026	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau
	4.1 ymgorffori'r fframwaith yn llawn i ddal grwpiau gwasanaeth i gyfrif am berfformiad, cyllid ac ansawdd (paragraff 35); 4.2 gan gynnwys cynnydd gydag argymhellion archwilio o fewn y fframwaith i ddal grwpiau gwasanaeth i gyfrif am berfformiad, cyllid ac ansawdd (paragraff 45); a		Mehefin 2026	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau
	4.3 adrodd yn rheolaidd ar y statws cynyddu ar gyfer pob	Proses ar gyfer adrodd yn rheolaidd ar y statws cynnydd ar gyfer y	Mawrth 2026	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau

Cyf	Argymhelliad	Sylwebaeth ar gamau gweithredu arfaethedig	Dyddiad cwblhau gweithredoedd wedi'u cynllunio	Swyddog cyfrifol (teitl)
	grŵp gwasanaeth a chyfarwyddiaeth gorfforaethol i'r pwyllgor Perfformiad a Chyllid (paragraff 35).	Grwpiau Gofal Clinigol a'r Cyfarwyddiaethau Corfforaethol i'w datblygu yn Ch4. Adroddwyd bod adroddiadau arferol ar statws cynnydd yn dechrau yn Ch1 2026/27 ac adrodd i'r Pwyllgor Perfformiad a Chyllid ar lefelau cynyddu chwe mis i gyd-fynd â chyhoeddiad Llywodraeth Cymru ar lefelau cynyddu a byddai'n cynnwys statws uwchgyfeirio Grwpiau Gofal Clinigol.	Mehefin 2026	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau

4 Termau allweddol yn yr adroddiad hwn

Teler	Disgrifiad
Fframwaith Sicrwydd y Bwrdd	Mae Fframwaith Sicrwydd Bwrdd yn nodi'r risgiau sy'n gysylltiedig ag amcanion strategol y sefydliad, a'r rheolaethau a'r sicrwydd sydd ar waith i reoli'r risgiau hynny.
Strategaeth Glinigol	Mae Strategaeth Glinigol yn gynllun hirdymor sy'n helpu i lunio sut mae gwasanaethau gofal iechyd yn cael eu cynllunio a'u darparu i ddiwallu anghenion cleifion a chymunedau.
Cofrestr Risg Corfforaethol	Mae Cofrestr Risg Gorfforaethol yn nodi risgiau sylweddol y sefydliad (naill ai'r rhai sydd â sgoriau uchel neu effaith sefydliad gyfan) a'r camau gweithredu sydd ar waith i'w rheoli.
Gwrth-dwyll	Mae gwrth-dwyll yn cyfeirio at y gweithgaredd a wneir gan y sefydliad i atal, canfod ac ymchwilio i dwyllo, llwgrwobrwyo a llygredd. Mae'r gwaith hwn yn cael ei arwain gan Wasanaeth Gwrth-Dwyll y GIG (CFS) Cymru, sy'n gweithredu o dan Bartneriaeth Gwasanaethau a Rennir GIG Cymru.
Cynllun Tymor Canolig Integredig	Mae Cynllun Tymor Canolig Integredig yn gynllun tair blynedd sy'n nodi sut y bydd y sefydliad yn darparu ei wasanaethau, yn rheoli ei weithlu, ac yn cwrdd â'i ddyletswyddau ariannol i dorri hyd yn oed. Mae'r sefydliad yn cyflwyno ei gynllun i Lywodraeth Cymru i'w gymeradwyo.
Llywodraethu Ansawdd	Llywodraethu ansawdd yw'r cyfuniad o strwythurau, prosesau ac ymddygiadau a ddefnyddir gan sefydliad, yn enwedig ei fwrdd, i arwain a sicrhau perfformiad o ansawdd uchel, gan gynnwys diogelwch, effeithiolrwydd a phrofiad cleifion.

Teler	Disgrifiad
Cofrestr Buddiannau	Mae'r Gofrestr Buddiannau yn helpu i sicrhau tryloywder drwy gofnodi unrhyw fuddiannau personol neu fusnes aelodau a staff y Bwrdd a allai ddylanwadu ar benderfyniadau.
Cynllun Cadw a Dirprwyo	Mae'r Cynllun Cadw a Dirprwyo yn nodi pa gyfrifoldebau sy'n aros gyda'r Bwrdd, a pha rai sy'n cael eu trosglwyddo i bwyllgorau a swyddogion gweithredol, ynghyd â threfniadau adrodd i sicrhau goruchwyliaeth briodol.
Gweithred Tendr Sengl	Gweithredu Tendr Sengl yw pan fydd sefydliad yn prynu nwyddau neu wasanaethau gan un cyflenwr heb fynd trwy broses gystadleuol, fel arfer oherwydd mai dim ond un opsiwn addas neu angen brys sydd yna.
Cyfarwyddiadau Ariannol Sefydlog	Mae Cyfarwyddiadau Ariannol Sefydlog yn nodi'r cyfrifoldebau, y polisiâu a'r gweithdrefnau ariannol a fabwysiadwyd gan y sefydliad.
Rheolau Sefydlog	Mae rheolau sefydlog yn nodi'r rheolau a'r gweithdrefnau y mae'r sefydliad yn gweithredu ac yn gwneud penderfyniadau.
Deddf Llesiant Cenedlaethau'r Dyfodol (2015)	Mae'r Ddeddf hon yn ei gwneud yn ofynnol i gyrff cyhoeddus yng Nghymru weithio'n gynaliadwy ac ar y cyd i wella llesiant ar draws meysydd cymdeithasol, economaidd, amgylcheddol a diwylliannol, drwy osod nodau hirdymor (a elwir yn amcanion llesiant), cynnwys dinasyddion, a gwneud penderfyniadau sy'n ystyried yr effaith ar genedlaethau'r dyfodol.

Amdanom ni

Mae Archwilydd Cyffredinol Cymru yn annibynnol ar Lywodraeth Cymru a'r Senedd. Swyddogaeth yr Archwilydd Cyffredinol yw archwilio ac adrodd ar gyfrifon Llywodraeth Cymru, y GIG yng Nghymru a chyrrff cyhoeddus cysylltiedig eraill, ynghyd â rhai cynghorau a chyrrff llywodraeth leol eraill. Mae'r Archwilydd Cyffredinol hefyd yn adrodd ar ddefnydd y sefydliadau hyn o adnoddau ac yn awgrymu ffyrdd y gallant wella.

Mae'r Archwilydd Cyffredinol yn cyflawni ei waith gyda chymorth staff ac adnoddau eraill gan Swyddfa Archwilio Cymru, sy'n gorff a sefydlwyd i gynorthwyo, cynghori a monitro gwaith yr Archwilydd Cyffredinol.

Archwilio Cymru yw'r term ymbarél a ddefnyddir ar gyfer Archwilydd Cyffredinol Cymru a Swyddfa Archwilio Cymru. Mae'r rhain yn endidau cyfreithiol ar wahân â'r swyddogaethau gwahanol a amlinellir uchod. Nid yw Archwilio Cymru ei hun yn endid cyfreithiol.



Archwilio Cymru

Ffôn: 029 2032 0500

Ffacs: 029 2032 0600

Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru

Gwefan: www.archwilio.cymru

Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

We welcome correspondence and
telephone calls in Welsh and English.



Meeting Date	29 January 2026	Agenda Item	6.4
Name of Meeting	SBUHB Board		
Report Title	Corporate Governance Report		
Report Author	Claire Mulcahy, Corporate Governance Manager		
Report Sponsor	Hazel Lloyd, Director of Corporate Governance		
Presented by	Hazel Lloyd, Director of Corporate Governance		
Freedom of Information	Open		
Purpose of the Report	To report on corporate governance matters arising since the previous meeting.		
Key Issues	The Corporate Governance report provides the Board with a comprehensive update on key governance matters since the last meeting. This report provides updates as set out below: • Matters considered In-Committee – November 2025 • Welsh Health Circulars (Appendix 1) • Common Seal Register (Appendix 2) • Board Work Programme (Appendix 3) • Cross Committee working actions (Appendix 4)		
Specific Action Required (<i>please choose one only</i>)	Information	Discussion	Assurance
	☐	☐	☒
Recommendations	Members are asked to: • RECEIVE for ASSURANCE: - The Matters considered In-Committee at the Board meeting; - Welsh Health Circulars; - The Common Seal Register; - Board Work Programme; - Cross Committee working; and • AGREE to the Audit Committee overseeing the implementation of the Board Effectiveness Action Plan.		

CORPORATE GOVERNANCE REPORT

1. INTRODUCTION

To report on Corporate Governance matters arising since the previous meeting.

2. BACKGROUND

The Board should receive a number of reports on Corporate Governance matters; this report included all updates required at this time.

3. GOVERNANCE AND RISK ISSUES

(i) Matters Considered In-Committee

In accordance with Standing Orders, SBUHB reports matters considered in private session, to the next available public meeting of the Board.

The November In-Committee Board session included:

- **A Key Issues Report from In-Committee Board Committee meetings;** an assurance report on key issues discussed at recent Committee meetings;
- A report on Mental Health Transformation Programme and Estate and Capital Implications;
- A report on Maternity and Neonatal Expenditure;
- A report on Issues reserved for Board Approval.

(ii) Welsh Health Circulars (WHCs) (Appendix 1)

Welsh Government issues WHCs around specific topics; these are available on the [Welsh Government website](#), including details on the risks and governance issues. The items issued within the current reporting timeframe are included within **Appendix 1**.

(iii) Common Seal Register

In-line with Standing Orders, the Board receives a report on the affixing of the Common Seal. **Appendix 2** sets out the latest position.

(iv) Board Work Programme

At each meeting, the Board receives a copy of its Work Programme and **Appendix 3** sets this out.

(v) Cross Committee Working

A workshop was held in December 2020⁵ to consider cross Committee working with the Committee Chairs and Executive leads for each Committee.

Actions were identified, as set out in **Appendix 4**, to strengthen the governance for the purpose of cross Committee working. The intention is to use these actions, the actions from a Board effectiveness review and the actions from the Structured Assessment, Audit Wales report, to form a Board Effectiveness Action Plan (BEAP). It is proposed the Audit Committee oversee the BEAP implementation on behalf of the Board, with the Board receiving an update on a six-monthly basis.

4. FINANCIAL IMPLICATIONS

There are no financial implications arising within this report.

5. RECOMMENDATIONS

Members are asked to:

- **RECEIVE** for **ASSURANCE**:
 - The Matters considered In-Committee at the November 2025 Board meeting;
 - Welsh Health Circulars;
 - The Common Seal Register;
 - Board Work Programme;
 - Committee Alerts to Board; and
- **AGREE** to the Audit Committee overseeing the implementation of the Board Effectiveness Action Plan.



Governance and Assurance		
Link to Enabling Objectives <i>(please choose)</i>	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High-Quality Care	☐
	Partnerships for Care	☒
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☐
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Welsh health circulars provide advice, guidance and information relating to changes in process or services which work to enhance services.		
Financial Implications		
There are no financial implications associated with this report.		
Legal Implications (including equality and diversity assessment)		
Any legal implications relating to Welsh health circulars would be identified in the individual documents.		
Staffing Implications		
There are no staffing implications contained within this report.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
Welsh health circulars provide advice, guidance and information relating to changes in process or services which work to enhance the way in which NHS Wales organisations function and would therefore potentially have individual long-term impacts.		
Report History	This report is a standard item on the board's business cycle.	



Appendices	Appendix 1 - Welsh Health Circulars Log Appendix 2 - Common Seal Register Appendix 3 - Board Work Programme Appendix 4 - Cross Committee working

Appendix 1

WELSH HEALTH CIRCULARS LOG

WHC Number and Title	Date Received by Email	Recipients Taking Action
WHC/2025/051 Safety netting discharge leaflets for adults and children	09.12.2025	Health Board Medical Directors, Executive Directors of Nursing, Heads of Emergency Departments, Clinical Directors, Sepsis leads



Appendix 2

COMMON SEAL REGISTER

Document Number	Date Signed	Document Details
89.25	10.12.25	NEC4 Engineering And Construction Short Contract in relation to Ventilation Installation at Mother and Baby Unit at Tonna Hospital
90.25	10.12.25	NEC4 Engineering And Construction Short Contract in relation to Dafen Unit Strip Out Works
91.25	10.12.25	NEC4 Engineering And Construction Short Contract in relation to Pathology Analysers at Morriston Hospital
92.25	10.12.15	NEC4 Engineering And Construction Short Contract in relation to Works at Health Centres
93.25	10.12.25	NEC4 Engineering And Construction Short Contract in relation to Cefn Coed Hospital Ward Refurbishment Phase1
94.25	10.12.25	NEC4 Professional Service Short Contract in relation to Cooling System Implementation in Six Patient Bedrooms at Tonna Hospital
95.25	10.12.25	NEC4 Professional Service Short Contract in relation to Proposed Main Theatres 1,2,3 & 4 AHU Plant Upgrades At Singleton Hospital
96.25	10.12.25	NEC4 Professional Service Short Contract in relation to Morriston Pathology Refurb - Main Lab Equipment Relocation
97.25	10.12.25	NEC4 Professional Service Short Contract (PSC) Option A Mechanical And Electrical Designer Services in relation to Refurbishment Works Tawe Clinic Cefn Coed Hospital
98.25	10.12.25	NEC4 Engineering And Construction Short Contract in relation to Ward 18 Obstetrics Theatre Birthing Bay at Singleton Hospital (Feasibility Works)
99.25	10.12.25	NEC4 Professional Service Short Contract in relation to Singleton Hospital West Ward Plant Room Supply 4 No. PHE's Only



100.25	10.12.25	NEC4 Engineering And Construction Short Contract Damper Replacement Scheme Morriston Hospital
101.25	10.12.25	Lease Of Room At Gowerton Pharmacy, 22 Mill Street, Gowerton, Swansea SA4 3ED
102.25	10.12.25	Lease relating to Part Of Ground Floor (North) At Anchor Court, Ocean Park, Cardiff CF24 5JW
103.25	10.12.25	NEC4 Professional Service Short Contract In relation to the Section 136 Suite in Neath Port Talbot Hospital
104.25	10.12.25	NEC4 Professional Services Short Contract (PSC) Option A Mechanical And Electrical Designer Services In relation to Morriston Hospital Electrical Infrastructure Review
105.25	10.12.25	Agreement For NEC4 Engineering And Construction Contract Relating to refurbishment of the existing Cedar Ward following a recent fire at Glanrhyd Hospital
106.25	10.12.25	NEC4 Professional Service Short Contract In relation to the Seclusion Room in Neath Port Talbot Hospital
107.25	10.12.25	NEC4 Professional Services Contract (PSC) Option A Mechanical And Electrical Designer Services In relation to DR room, Morriston ED
108.25	10.12.25	NEC4 Professional Service Short Contract In relation to Cefn Coed Hospital MEP Service Diversions
109.25	10.12.25	NEC4 Professional Services Contract (PSC) Option A Cost Advisor Services In relation to Interventional Fluoroscopy 2, Morriston
110.25	10.12.25	NEC4 Professional Services Contract (PSC) Option A



		Mechanical And Electrical Designer Services In relation to Interventional Fluroscopy 2, Morriston
111.25	17.12.25	NEC4 Engineering And Construction Short Contract In relation to Ystalyfera Clinic Roof Repairs
112.25	17.12.25	NEC4 Engineering And Construction Short Contract in relation to Ystalyfera Clinic – Window and Door Replacement
113.25	17.12.25	NEC4 Engineering And Construction Short Contract in relation to Cefn Coed Fencing
114.25	17.12.25	NEC4 Engineering And Construction Contract Option A in relation to Plantroom 5 & 8 and the Plate Heat Exchangers Plant (Rev 3) at Morriston Hospital
115.25	17.12.25	NEC4 Engineering And Construction Short Contract in relation to New Steam Duct and Heating Controls at Morriston Hospital



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

Appendix 3

BOARD WORK PROGRAMME 2025/26

Topic	Lead	May-25	(Accounts)	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26
Preliminary Matters								
Patient/Staff Story	Director of Nursing and Patient Experience							
Minutes of the Previous Meeting	Director of Corporate Governance							
Action Log	Director of Corporate Governance							
Chair's Report	Chair (verbal)							
Chief Executive's Report	Director of Corporate Governance							
Quality, Safety and Performance								
Committee Key Issue Reports (3As)	Director of Corporate Governance							
Maternity and Neonatal External Review	Director of Corporate Governance							
Gold Command Maternity and Neonatal (superseded by the above)	Medical Director							
Mental Health Report (inc. assurance assessment from NHS Exec)	Chief Operating Officer			2 of 3		3 of 3		
Perinatal	Director of Nursing and Patient Experience							
Healthcare Inspectorate Wales Annual Report 2024-25	Director of Nursing and Patient Experience							



Topic	Lead	May-25	(Accounts)	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26
Risk Register	Director of Corporate Governance							
Board Assurance Framework	Director of Corporate Governance							
Annual Report and Governance Statement	Director of Corporate Governance							
Annual Accounts and ISA260	Director of Finance							
Strategic Items								
Discretionary Capital Plan	Director of Strategy							
Budget and Financial Allocations	Director of Finance							
Major Incident Plan	Director of Strategy							
Progress report on Estates Strategy	Director of Finance and Performance							
Progress report on Population Health Strategy	Director of Public Health							*
Digital Strategy	Director of Digital							
Planning and Partnerships	Director of Planning							*
Winter Plan	Chief Operating Officer							
Mental Health Transformation Report	Chief Operating Officer							
People								
Quarterly workforce resilience report	Director of Workforce and OD							
Governance								
Corporate Governance Report	Director of Corporate Governance							



Topic	Lead	May-25	(Accounts)	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26
Welsh Language Standards	Director of Corporate Governance							
Review of Standing Orders	Director of Corporate Governance							
Annual Report	Director of Corporate Governance							
Accountability Report	Director of Corporate Governance							
Advisory Group Report (inc 3x Group Key Issues Reports)	Director of Corporate Governance							
Structured Assessment and Audit Letter	Director of Corporate Governance							
Items Already Considered by Committees								
Finance Report	Director of Finance							
Performance Report	Director of Finance							
Escalation Report (reporting through the IPR as above)	Chief Operating Officer							
Nurse Staffing Levels (Wales) Act 2016	Director of Nursing and Patient Experience							
Progress Against the Annual Plan	Executive Director of Planning and Partnerships	Qtr 4		Qtr 1		Qtr 2		* Qtr 3
Additional Items								
May – Dental report	Chief Operating Officer							
July – GMS	Chief Operating Officer							
September – Community Pharmacy	Chief Operating Officer							
November – Optometry	Chief Operating Officer							
January – Phlebotomy	Chief Operating Officer							



Topic	Lead	May-25	(Accounts)	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26
March – District Nursing	Chief Operating Officer							
Digital Eye Care	Director of Digital							
Public Service Ombudsman Report and Annual Letter	Director of Nursing and Patient Experience							
Climate Adaptation Strategy	Executive Director of Planning and Partnerships							
Approval of Microsoft Office Enterprise License Agreement	Director of Digital							
Maturity Matrix	Executive Director of Planning and Partnerships							
Annual Plan (final for approval)	Executive Director of Planning and Partnerships							
Education Commissioning Process for 2027-28	Director of Workforce and OD							



Bwrdd Iechyd Prifysgol Bae Abertawe (BIPBA)
Cofnodion o Gyfarfod Arbennig y Bwrdd
a gynhaliwyd ar 23 Hydref 2025 am 10:00am

Yn bresennol:		
Jan Williams	(JW)	Cadeirydd
Stephen Spill	(SS)	Is-gadeirydd
Abigail Harris	(AH)	Prif Swyddog Gweithredol
Jean Church	(JC)	Aelod Annibynnol
Marie Davies	(MD)	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau
Deb Lewis	(DL)	Prif Swyddog Gweithredu/Cyfarwyddwr Gweithredol Gofal Sylfaenol a Chymunedol ac Iechyd Meddwl ac Anableddau Dysgu
Anne-Louise Ferguson	(ALF)	Aelod Annibynnol
Andrew Griffiths	(AG)	Aelod Annibynnol
Darren Griffiths	(DG)	Cyfarwyddwr Gweithredol Cyllid a Pherfformiad
Keith Lloyd	(KL)	Aelod Annibynnol
Martin Lloyd	(ML)	Aelod Annibynnol
Nicola Matthews	(NM)	Aelod Annibynnol
Reena Owen	(RO)	Aelod Annibynnol
Patricia Price	(PP)	Aelod Annibynnol
Tina Ricketts	(TR)	Cyfarwyddwr Gweithredol y Gweithlu a Datblygu Sefydliadol
Liz Rix	(LR)	Cyfarwyddwr Gweithredol Nyrsio a Phrofiad Cleifion
Nuria Zolle	(NZ)	Aelod Annibynnol (trwy Teams)

Yn Bresennol:		
Matthew John	(MJ)	Cyfarwyddwr Digidol
Dr Raj Krishnan	(RK)	Dirprwy Gyfarwyddwr Meddygol Gweithredol
Hazel Lloyd	(HL)	Cyfarwyddwr Llywodraethu Corfforaethol
Carys Richards	(CR)	Uwch Reolwr Llywodraethu Corfforaethol
Claire Taylor	(CT)	Llais
Richard Thomas	(RT)	Cyfarwyddwr Mewnwelediad, Cyfathrebu ac Ymgysylltu

Ymddiheuriadau:		
Pat Dunmore	(PD)	Cadeirydd Grŵp Cyfeirio Rhanddeiliaid
Richard Evans	(RE)	Cyfarwyddwr Meddygol Gweithredol a Dirprwy Brif Weithredwr



Christine Morrell	(CM)	Cyfarwyddwr Gweithredol Therapiau a Gwyddor Iechyd
Gill Richardson	(GR)	Cyfarwyddwr Gweithredol Iechyd y Cyhoedd (Dros Dro)

Acronymau			
BIPBA	Bwrdd Iechyd Prifysgol Bae Abertawe	LIC	Llywodraeth Cymru
CALI	Cyferwerth ag Amser Llawn	HCSW	Gweithiwr Cymorth Gofal Iechyd
AaGIC	Addysg a Gwella Iechyd Cymru	RN	Nyrs Gofrestredig

Dechreuodd y cyfarfod am 10:01.

Cyfeirnod y Cofnod:	Eitem ar yr Agenda

RHAN 1. MATERION RHAGARWEINIOL

1.1 CROESO A SYLWADAU CYFLWYNIADOL

183/25	Wrth agor y cyfarfod, estynnodd JW groeso cynnes i'r rhai a oedd yn bresennol yn bersonol, a'r rhai ar-lein. Esboniodd, fel Corff Llywodraethol y sefydliad, fod gan y Bwrdd ystod o gyfrifoldebau a oedd yn cael eu cyflawni'n ffurfiol drwy gyfarfodydd y Bwrdd bob deufis, gydag agenda cynhwysfawr. Roedd adegau pan oedd rhaid i'r Bwrdd gyfarfod y tu allan i'r cylch cyfarfodydd hwn a dyma oedd yr achos heddiw, gyda'r unig bwrpas o ystyried y mater Gweithiwr Cymorth Gofal Iechyd (HCSW) Band 2/3. Aeth JW ymlaen i ddweud bod BIPBA yn un o'r cyflogwyr mwyaf yng Nghymru, gyda 12800 o staff cyferwerth ag amser llawn (CALI), 14% ohonynt yn Weithwyr Cymorth Gofal Iechyd, sef sylfaen y gweithlu, a'u rôl yn ganolog yng ngofal a phrofiad cyffredinol cleifion. Roedd gan y Bwrdd ddyletswydd gofal a chyfrifoldeb dros iechyd a lles yr holl staff; roedd JW yn ymwybodol y byddai hyn yn swnio'n wag i'r Gweithwyr Cymorth Gofal, a oedd o'r farn bod y Bwrdd wedi'u bradychu ac wedi mynd yn ôl ar ei air i wneud y taliadau perthnasol ym mis Rhagfyr. Ar ran holl aelodau'r Bwrdd, ymddiheurodd JW am y dicter, y gofid a'r siom a achoswyd gan y penderfyniad i 'oedi ym mis Medi'.



	Nid oedd y Bwrdd erioed wedi bwriadu torri'r cytundeb ac roedd wedi gweithredu'n ddidwyll drwyddo draw; deilliodd yr 'oedi' o'r ddealltwriaeth bod y Cytundeb Cenedlaethol ar fin dod i ben a'r awydd gwirioneddol i sicrhau bod staff Iechyd, Gofal a Lles yn gyfartal â gweddill Cymru. Fel y digwyddodd, ni chafwyd casgliad o'r fath ac roedd y Bwrdd wedi gweld, gwrando ar, a darllen am yr effaith ddofn ar staff, yn rhannol drwy gyflwyno deiseb gyda 2000 o lofnodion. Cydnabu aelodau'r bwrdd yr effaith niweidiol ar ymddiriedaeth ac ymrwymodd i weithio'n ddiflino i'w hadeiladu, gan ddechrau bryd hynny ac yno.
1.2 YMDDIHEURIADAU AM ABSENOLDEB	
184/25	Cafwyd ymddiheuriadau gan: • Richard Evans, a gynrychiolir gan Dr Raj Krishnan • Chris Morrell • Gill Richardson • Pat Dunmore
1.3 DATGANIAD O FUDDIANNAU	
185/25	Nid oedd unrhyw ddatganiadau y tu allan i'r rhai sydd eisoes ar y Gofrestr Datganiadau o Fuddiant.
RHAN 2. PRIF AGENDA	
2.1 DEISEB 'GWEITHWYR GOFAL IECHYD WEDI'U BRADYCHU – BWRDD IECHYD BAE ABERTAWE CADWCH AT EICH ADDEWID'	
186/25	Gwahoddodd JW TR i gyflwyno'r eitem hon. Cadarnhaodd TR ei bod hi, a dirprwyaeth o'r Bwrdd, wedi cyfarfod â staff a'u cynrychiolwyr ddydd Mawrth, 21 Hydref, ac wedi derbyn y Ddeiseb â 2000 o lofnodion. Cyflwynodd hi nawr i'w derbyn a'i gydnabod yn ffurfiol. DERBYNIODD y Bwrdd y Ddeiseb a'i CHYDNABOD YN FFURFIOL.
2.2 ADRODDIAD GWEITHWYR CYMORTH GOFAL IECHYD BAND 2/3	



187/25	Cyfeiriodd TR at sylwadau agoriadol JW a rhoddodd gefndir ychwanegol, sef bod trafodaethau wedi dechrau ym mis Mai 2024, gyda BIPBA yn ymrwmo i gytundeb lleol gydag Unison ar 9 Rhagfyr 2024, wedi'i hwyluso trwy Gyflogwyr GIG Cymru. Roedd hyn yn ymrwmo BIPBA i wneud taliadau i'r staff dan sylw erbyn 31 Rhagfyr 2025. Bryd hynny, roedd BIPBA yn deall y byddai byrddau iechyd eraill yn dilyn, trwy Gytundeb Cenedlaethol. Adroddodd TR ar gasgliad proses ddilysu gadarn: o'r 1133 o Weithwyr Cymorth Gofal Iechyd o fewn y cwrdd, roedd 1105 (97%) yn bodloni'r meini prawf ar gyfer uwchraddio i fand 3. Y dyddiad cau ar gyfer cyflogres mis Rhagfyr oedd 23 Hydref 2025 ac roedd yn rhaid i'r Bwrdd gwblhau'r cytundeb heddiw, er mwyn galluogi'r swyddogaeth gyflogres i brosesu'r taliadau mewn pryd ar gyfer cyflogres 21 Rhagfyr 2025. Roedd oedi wrth gwblhau'r Cytundeb Cenedlaethol yn golygu nad oedd safbwynt cenedlaethol terfynol, ac roedd cytundeb BIPBA yn unol â fersiwn 14, a oedd mewn grym ym mis Rhagfyr 2024. Diolchodd JW i TR am ei briff a gwahoddodd gwestiynau a sylwadau: Croesawodd RO yr adroddiad a gallu'r Bwrdd i anrhydeddu'r ymrwymiad i wneud taliad ym mis Rhagfyr; roedd hi wedi bod yn rhan o ddirprwyaeth y Bwrdd ar 21 Hydref ac wedi cael y profiad yn un dwys. Roedd ailadeiladu ymddiriedaeth yn hanfodol, ac edrychodd RO ar y Bwrdd i wneud hyn. Diolchodd i bawb a fu'n rhan o lywio ffordd gadarnhaol trwy fater mor gymhleth. Adleisiodd JC sylwadau RO a chydabu'r angen i ailadeiladu perthnasoedd â staff. Cadarnhaodd TR fod cyfarfod wedi'i drefnu gydag Unison a Phwyllgor Negodi Gweithiwr cymorth gofal iechyd (HCSW) yn syth ar ôl cyfarfod y Bwrdd; byddai cyfres o ddigwyddiadau ymgysylltu a chyfathrebu yn digwydd, i ddechrau ailadeiladu perthnasoedd ymddiriedus a hefyd i glywed yn uniongyrchol gan rai o'r staff dan sylw. Cysylltodd SS ei hun â'r sylwadau a wnaed gan y Cadeirydd ar ddechrau'r cyfarfod a'r rhai a wnaed gan gydweithwyr eraill ar y Bwrdd. Yna gwahoddodd JW AH fel Prif Weithredwr, a'r Swyddog Atebol, i wneud sylwadau. Mynegodd AH ei hymddiheuriadau diffuant am y gofid a'r dicter a achoswyd gan y penderfyniad anodd i oedi'r gweithrediad ym mis Medi 2025; roedd y Bwrdd wedi bod eisiau sicrhau bod staff Gweithwyr Cymorth Gofal Iechyd ym Mae Abertawe yn cael cydraddoldeb â chydweithwyr ledled Cymru ac wedi deall bod cwblhau'r Cytundeb Cenedlaethol ar fin digwydd.



Roedd y Bwrdd wedi clywed lleisiau staff yn glir iawn a diolchodd AH i gydweithwyr Unison a'r staff hynny a oedd wedi lleisio eu pryderon, gan bwysleisio'r pwysigrwydd a roddodd y Bwrdd ar glywed gan staff rheng flaen. Mynegodd ei diolch hefyd i gydweithwyr BIPBA ac i gydweithwyr Llywodraeth Cymru am eu gwaith caled wrth alluogi'r Bwrdd i gyrraedd y sefyllfa heddiw.

Roedd hwn yn fater cymhleth, a diolchodd AH i'r staff a oedd yn rhan o'r ymarferion dilysu unigol dros fisoedd yr haf, gan ddod i ben ym mis Awst 2025. Rhoddodd trylwyrdd y broses sicrwydd i'r Bwrdd. Heddiw, cymerodd gam sylweddol a chroesawgar ymlaen a chyfle i ddechrau ailadeiladu ymddiriedaeth, gan fod y Bwrdd yn gwerthfawrogi'r Fforwm Partneriaeth fel rhan allweddol o'i beirianwaith cydweithio.

Yna myfyriodd AH ar rôl Gweithwyr Cymorth Gofal Iechyd fel rhan hanfodol o deulu BIPBA; nhw a dreuliodd y mwyaf o amser gyda chleifion ac a gyfrannodd yn sylweddol at ofal a phrofiad cyffredinol cleifion.

Cyfeiriodd AH hefyd at gyfrifoldebau statudol ehangach y Bwrdd, ac yn enwedig y gofyniad i weithredu o fewn ei ddyraniad adnoddau.

Roedd y sefydliad mewn diffyg ariannol ar hyn o bryd ac roedd yn rhaid iddo bennu trywydd tair blynedd, i ddychwelyd i wasanaeth a chynaliadwyedd ariannol. Byddai hyn yn gofyn am ddylunio, a chyflawni, nifer o gamau cynllunio'r gweithlu, moderneiddio gwasanaethau a gwella gwasanaethau, yn unol ag amcanion strategol BIPBA.

Gwnaeth y Bwrdd y canlynol:

- **CYMERADWYDYD** y taliadau i Weithwyr Cymorth Gofal Iechyd Band 2 yng nghyflogres Rhagfyr 2025.
- **CYDNABUWYD** cefnogaeth Llywodraeth Cymru i fynd i'r afael â hyn yn 2025/26.
- **CYTUNWYD** y byddai'r costau refeniw a'r manteision parhaus yn rhan o'r broses gynllunio ariannol ar gyfer 2026/27.
- **CYDNABUWYD** bod y taliad cydnabyddiaeth yn daliad arbennig a fyddai angen cymeradwyaeth Llywodraeth Cymru.
- **CYTUNWYD** i drosglwyddo goruchwyliaeth y broses weithredu Band 2/3 a moderneiddio'r gweithlu sy'n parhau i foderneiddio i'r Pwyllgor Gweithlu a Datblygu Sefydliadol.

RHAN 3. EITEMAU I'W TRAFOD



3.1 UNRHYW FATER ARALL

188/25

Dyweddodd JW fod mater arall wedi dod i'r amlwg dros nos, ar ffurf Llythyr Agored gan y garfan myfyrwyr nyrsio ym Mhrifysgol Abertawe, a oedd yn agosáu at ddiwedd eu hyfforddiant ac a fyddai'n chwilio am swydd fel nyrs gofrestredig (RN) yn fuan. Gofynnodd JW i LR roi cefndir y mater i'r Bwrdd.

Dyweddodd LR fod y garfan nyrsio yn agosáu at ddiwedd eu hyfforddiant; nid oedd gan BIPBA unrhyw swyddi gwag cangen oedolion Band 5 ar hyn o bryd, ond roedd gwaith ar y gweill i nodi cyfleoedd, yn BIPBA, ac mewn byrddau iechyd cyfagos. Roedd hi'n gweithio'n agos gydag Addysg a Gwella Iechyd Cymru (AaGIC) a'r Prifysgolion i archwilio pob opsiwn posibl.

Cadarnhaodd JW gyda KL y byddai Prifysgol Abertawe yn cynnig cefnogaeth a chytunodd i weithredu hyn gyda chydweithwyr yn y Brifysgol. **CAM GWEITHREDU: KL**

Gofynnodd JW i HL ddosbarthu'r Llythyr Agored i aelodau'r Bwrdd ac i LR ddod ag adroddiad i gyfarfod y Bwrdd ym mis Tachwedd, i gynnwys y dimensiwn Cymru gyfan ehangach a'r goblygiadau ar gyfer cynllunio gweithlu strategol. **CAM GWEITHREDU: HL, LR**

Gwnaeth y Bwrdd y canlynol:

CYDNABUWYD cyflwyno Llythyr Agored gan garfan o fyfyrwyr nyrsio ym Mhrifysgol Abertawe.

CYTUNWYD i dderbyn adroddiad ffurfiol yng nghyfarfod y Bwrdd ym mis Tachwedd.

Cyfarfod Nesaf y Bwrdd Iechyd: Cyfarfod nesaf Bwrdd BIPBA:

Dydd Iau 27 Tachwedd 2025, Prifysgol Abertawe

Daeth y cyfarfod i ben am 10:19.



Bwrdd Iechyd Prifysgol Bae Abertawe (BIPBA)
Cofnodion Cyfarfod y Bwrdd a gynhaliwyd ar
27 Tachwedd 2025 am 10:00am

Yn bresennol:		
Jan Williams	(JW)	Cadeirydd
Stephen Spill	(SS)	Is-gadeirydd
Abigail Harris	(AH)	Prif Swyddog Gweithredol
Richard Evans	(RE)	Cyfarwyddwr Meddygol Gweithredol a Dirprwy Brif Weithredwr
Jean Church	(JC)	Aelod Annibynnol
Marie Davies	(MD)	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau
Pat Dunmore	(PD)	Cadeirydd Grŵp Cyfeirio Rhanddeiliaid
Anne-Louise Ferguson	(ALF)	Aelod Annibynnol
Andrew Griffiths	(AG)	Aelod Annibynnol
Darren Griffiths	(DG)	Cyfarwyddwr Gweithredol Cyllid a Pherfformiad
Deb Lewis	(DL)	Prif Swyddog Gweithredu/Cyfarwyddwr Gweithredol Gofal Sylfaenol a Chymunedol ac Iechyd Meddwl ac Anableddau Dysgu
Keith Lloyd	(KL)	Aelod Annibynnol
Martin Lloyd	(ML)	Aelod Annibynnol
Nicola Matthews	(NM)	Aelod Annibynnol
Reena Owen	(RO)	Aelod Annibynnol
Gill Richardson	(GR)	Cyfarwyddwr Gweithredol Iechyd y Cyhoedd (Dros Dro)
Tina Ricketts	(TR)	Cyfarwyddwr Gweithredol y Gweithlu a Datblygu Sefydliadol
Liz Rix	(LR)	Cyfarwyddwr Gweithredol Nyrsio a Phrofiad Cleifion
Nuria Zolle	(NZ)	Aelod Annibynnol

Yn Bresennol:		
Denise Chaffer	(DC)	Adolygydd Allanol
Matthew John	(MJ)	Cyfarwyddwr Digidol
Hazel Lloyd	(HL)	Cyfarwyddwr Llywodraethu Corfforaethol
Sharon Miller	(SM)	Cyfarwyddwr Grŵp Gwasanaeth Cyswllt
Sam Page	(SP)	Pennaeth Gofal Sylfaenol
Carys Richards	(CR)	Uwch Reolwr Llywodraethu Corfforaethol
Claire Tailor	(CT)	Llais



Richard Thomas	(RT)	Cyfarwyddwr Mewnwelediad, Cyfathrebu ac Ymgysylltu
Nerissa Vaughan	(NV)	Cyfarwyddwr Strategaeth Dros Dro
Melanie Walker	(MW)	Adolygydd Allanol

Ymddiheuriadau:

Christine Morrell	(CM)	Cyfarwyddwr Gweithredol Therapiau a Gwyddor Iechyd
Patricia Price	(PP)	Aelod Annibynnol
Hugo Van Woerden	(HVW)	Dirprwy Gyfarwyddwr Iechyd y Cyhoedd

Acronymau

BIPBA	Bwrdd Iechyd Prifysgol Bae Abertawe	AAB	Adran Achosion Brys
CALI	Cyfwerth ag Amser Llawn	MBU	Uned Mam a Baban
LIC	Llywodraeth Cymru	BSOTS	System Brysbennu Obstetreg sy'n Benodol i Symptomau Birmingham
PPC	Pwyllgor Perfformiad a Chyllid	IR	Adolygiad Annibynnol
HCSW	Gweithiwr Cymorth Gofal Iechyd	MBBRACE	Mamau a Babanod: Lleihau Risg Drwy Archwiliadau ac Ymholiadau Cyfrinachol
HEFA	Awdurdod Ffrwythlondeb ac Embryoleg Dynol	HIE	Enseffalopathi hypocsig-isgemig
JCC	Cydbwyllgor Comisiynu	NHSPI	Perfformiad a Gwella GIG Cymru
VCSE	Menter Wirfoddol, Gymunedol a Chymdeithasol	IPFR / IFPR	Cais am Gyllid i Gleifion Unigol
CCE	Cofnod Electronig am Gleifion	PSB	Bwrdd Gwasanaeth Cyhoeddus
OPMH	Iechyd Meddwl Pobl Hŷn	ITU	Uned Therapi Dwys
YCC	Ysbyty Cefn Coed	QSC	Y Pwyllgor Ansawdd a Diogelwch
CIC (CHC)	Gofal Iechyd Parhaus y GIG	NPTSSG	Grŵp Gwasanaeth Castell-nedd Port Talbot Singleton
RPB	Bwrdd Partneriaeth Rhanbarthol	NSLWA	Deddf Lefelau Staff Nyrsio (Cymru)
BIPHDd	Bwrdd Iechyd Prifysgol Hywel Dda	PSPP	Polisi Taliadau'r Sector Cyhoeddus
WGOS	Gwasanaethau Offthalmoleg Cyffredinol Cymru		



Dechreuodd y cyfarfod am 10:09.

Cyfeirnod y Cofnod:	Eitem ar yr Agenda
RHAN 1. MATERION RHAGARWEINIOL	
1.1 CROESO A SYLWADAU CYFLWYNIADOL	
	Croesawodd JW bawb i'r cyfarfod, gan ddiolch hefyd i Brifysgol Abertawe am ddarparu'r lleoliad. Fel Corff Llywodraethol y sefydliad, y Bwrdd oedd â'r lefel uchaf o ran gwneud penderfyniadau, gyda rheolaeth dros £1.8bn o arian cyhoeddus, cyflogaeth o 14,500 o staff cyfwerth ag amser llawn (CaLL), a darpariaeth gwasanaethau i tua 400,000 o bobl ledled Abertawe a Chastell-nedd Port Talbot. Gwnaeth hyn BIPBA yn un o'r cyrff cyhoeddus mwyaf yn y DU. Amlinellodd JW rôl y Bwrdd fel corff iechyd y boblogaeth strategol, gyda dyletswydd statudol i hyrwyddo a diogelu iechyd y cyhoedd. Roedd agenda'r cyfarfod yn cwmpasu lled cyfrifoldebau'r Bwrdd; roedd llywodraeth agored yn bwysig, a rhoddodd y cyfarfod lwyfan i aelodau'r Bwrdd ddal ein hunain yn atebol i'r cyhoedd ac i egluro'r rhesymeg dros benderfyniadau a wnaed yn cwmpasu'r tair cyfnod amser y bu'r Bwrdd yn gweithio ynddynt: tymor hir, tymor canolig a thymor byr. Drwy'r Cadeirydd, roedd y Bwrdd yn atebol i Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol a dangosodd ei atebolrwydd i'r cyhoedd drwy gyfarfodydd agored y Bwrdd. Yn ogystal, byddai aelodau'r Bwrdd yn cymryd rhan mewn Cyfarfod Atebolrwydd Cyhoeddus ar 18 Rhagfyr, dan gadeiryddiaeth Ysgrifennydd y Cabinet. Roedd hon yn nodwedd newydd o gyfundrefn atebolrwydd GIG Cymru. Yn y tymor hir, roedd gan y Bwrdd gyfrifoldebau am osod y cyfeiriad strategol ac adeiladu a chynnal partneriaethau strategol, gan gydnabod pwysigrwydd cydweithio. Yna mapiodd JW yr eitemau allweddol ar yr agenda yn erbyn cyfrifoldebau'r Bwrdd, gan amlygu maint yr heriau a'r agenda newid sylweddol sy'n wynebu'r sefydliad. Roedd BIPBA hefyd yn sefydliad oedd yn canolbwyntio ar bobl; roedd y Bwrdd wedi ymrwymo i sicrhau y gallai pobl ddod i'r gwaith a bod yn eu hunain gorau, dilys, heb fod yn destun unrhyw anfantais na gwahaniaethu ac yn hyderus y gallent



	siarad yn ddiogel. Yn olaf, tynnodd JW sylw at y ffyrdd yr oedd yr agenda yn adlewyrchu pob math o lywodraethu.
1.2 YMDDIHEURIADAU AM ABSENOLDEB	
	Dywedodd JW fod Chris Morrell a Pat Price wedi ymddiheuro am y cyfarfod.
1.3 DATGANIAD O FUDDIANNAU	
	Nid oedd unrhyw ddatganiadau o fuddiant y tu allan i'r rhai sydd eisoes ar y Gofrestr Datganiadau Buddiant.
1.4 ADRODDIAD Y PRIF WEITHREDWR	
	Wrth gyflwyno'r Adroddiad, tynnodd AH sylw at: • Cynhaliwyd y Digwyddiad Dysgu Mamolaeth a Newyddenedigol ar 19 Tachwedd; estynnodd ei diolch i'r teuluoedd a oedd wedi mynychu ac a rannodd eu straeon personol. Byddai diweddariad mwy manwl ar wasanaethau mamolaeth a newyddenedigol yn dilyn yn ddiweddarach yn y cyfarfod. • Y gwelliannau i sefyllfa'r llwybr gofal brys ac argyfwng, gyda BIPBA yn nodi'r gwelliant mwyaf arwyddocaol. Cyfeiriodd AH at yr ailosodiad a ddechreuodd ar 8 Rhagfyr, gan adrodd bod Llywodraeth Cymru (LIC) wedi cyhoeddi pythefnos ailosod cenedlaethol yn cwmpasu'r un dyddiadau; byddai gwelededd cyfarwyddwyr gweithredol yn cynyddu ar draws pob safle, gyda chydweithwyr gweithredol yn ymuno â rowndiau ward yn ôl yr angen. Byddai oedi hir i gleifion sy'n aros am atebion tai yn cael ei drafod gyda phartneriaid awdurdodau lleol. Yn ogystal ag arhosiad hir diangen yn yr ysbyty, a arweiniodd at ganlyniadau gwaeth i gleifion, roedd y goblygiadau ariannol yn sylweddol, ac yn gyfraniad allweddol at y diffyg ariannol. • Y trafodaethau manwl yn y Pwyllgor Perfformiad a Chyllid (PFC) ar y cynllun adfer ariannol wedi'i ddiweddarau. • Y cyfarfod Atebolrwydd Cyhoeddus sydd ar ddod ar 18 Rhagfyr; byddai'r pecyn gwybodaeth yn rhestru'r holl faterion allweddol a byddai pob aelod o'r Bwrdd sy'n mynychu'r cyfarfod yn bersonol yn cymryd amser i baratoi'n llawn dros yr wythnosau nesaf. Diolchodd JW i AH a gwahoddodd sylwadau.



	Rhoddodd TR ddiweddariad ar swydd gweithiwr cymorth gofal iechyd (HCSW) Band 2/3, gan gadarnhau bod y cytundeb cenedlaethol bellach ar waith ar draws pob BI; roedd taliad i staff ar 19 Rhagfyr yn golygu bod BIPBA mewn sefyllfa berffaith i anrhydeddu ei ymrwymiad. Gofynnodd NM am y camau sydd ar y gweill i sicrhau cynaliadwyedd Sefydliad Ffrwythlondeb Cymru. Cadarnhaodd AH fod yr Awdurdod Ffrwythloni Dynol ac Embryoleg (HEFA), y Rheoleiddiwr, wedi croesawu derbyn yr holl wybodaeth a ddarparwyd; roedd hyn wedi mynd i'r afael â rhai o'r pryderon dienw a godwyd, ac roedd gan y gwasanaeth Berson Cyfrifol bellach. Cyfeiriodd AH hefyd at oblygiadau maint a graddfa'r amlen gwasanaeth presennol a'r trafodaethau gyda'r Cyd-bwyllgor Comisiynu (JCC) i sicrhau ateb cynaliadwy. Tynnodd JC sylw at y ddwy wobr i staff BIPBA yng Ngwobrau GIG Cymru yn ddiweddar (i) <i>Rhagoriaeth Amenedigol i Leihau Anafiadau mewn Geni Cynamserol Cymru: Lleihau Amrywiad mewn Optimeiddio Amenedigol sy'n Seiliedig ar Dystiolaeth yng Nghymru</i>: Enillodd <i>Pob Babi Bob Tro</i> Wobr Diwylliant Tîm GIG Cymru a'r Wobr Cyfraniad Rhagorol at Wella Gofal Iechyd, a (ii) Ymateb i Gwympiadau: <i>Lleihau Niwed drwy Grymuso Staff Cartrefi a Chartrefi Gofal</i> a enillodd Wobr Dull Systemau Cyfan GIG Cymru. Llongyfarchodd AH hefyd yr holl staff dan sylw, fel y gwnaeth holl aelodau'r Bwrdd, gan groesawu'n arbennig y wobr enillwyd cyffredinol i'r tîm amenedigol. YSTYRIODD y Bwrdd y diweddariad a ddarparwyd a CHYMERODD SICRWYDD o'i gynnwys a'r drafodaeth.
1.5 ADRODDIAD RISG	
	Wrth gyflwyno'r adroddiad hwn, cyfeiriodd HL at y bwriad i greu tair lefel o gofrestrau risg, gan ddiffinio risgiau strategol, corfforaethol a gweithredol. Cynlluniwyd y gofrestr risg gorfforaethol i gyd-fynd yn agos eto ag amcanion strategol BIPBA Gwahoddodd JW NZ i wneud sylwadau o safbwynt y Pwyllgor Archwilio. Croesawodd NZ yr aliniad â'r amcanion strategol; cydnabu hefyd fod gwaith pellach i'w wneud, gan gynnwys triongli risgiau, i atal ystyried un risg ar ei phen ei hun. Cynigiodd NZ y dylid ailosod risg yn ystod yr ychydig fisoedd nesaf. Cadarnhaodd JW y byddai'r gweithdy sydd ar ddod ar weithio trawsbwyllgorau, gyda hwyluso gan TR, yn cynnwys adolygiad o ddyraniad risg strategol ar draws y pwyllgorau.



Croesawodd JC y newidiadau, gyda risgiau clir a roddodd welededd clir i gadeiryddion pwyllgorau ar risg strategol. Tynnodd sylw at y gwaith sydd ei angen o hyd i sicrhau dull cyson o sgorio. Adeiladodd ALF ar y pwynt hwn, gan ofyn am yr amserlen o amgylch hyn.

Cadarnhaodd TR y bwriad i ailosod, i gynnwys adolygiad o'r fethodoleg sgorio. Byddai WODC yn goruchwyllo'r rhaglen hyfforddi ynghylch cysondeb sgorio ac yn adrodd yn ôl i'r Bwrdd.

Cam Gweithredu: RO/TR

Gwnaeth y Bwrdd y canlynol:

- **DERBYN** y Gofrestr Risg Strategol a'r Gofrestr Risg Gorfforaethol newydd, ynghyd â manylion y prosesau ategol.
- **CYDNABOD** mabwysiadu'r defnydd o'r Gofrestr Risg Strategol a'r Gofrestr Risg Gorfforaethol gan y Bwrdd a'i Bwyllgorau mewn cyfarfodydd yn y dyfodol, ar gyfer craffu a sicrhau trefniadau rheoli risg.
- **CYTUNO** i dderbyn adroddiad pellach ar yr ailosodiad, i gynnwys y rhaglen hyfforddi gysylltiedig ar sgorio risg.

RHAN 2. PROFIAID CLEIFION/STAFF

2.1 STORI'R CLAF

- **TAITH SAM I ADFERIAD**

Cyflwynodd LR stori'r claf, gan ganolbwyntio ar Sam a oedd wedi profi digwyddiad a newidiodd ei fywyd; roedd y trawma wedi ei adael ag anableddau corfforol a seicolegol.

Siaradodd Sam am yr effeithiau seicolegol damwain a'r effaith ar ei iechyd meddwl, ei deulu a'i fywyd cymdeithasol. Yn dilyn diagnosis o Anhwylder Straen Ôl-drawmatig, dechreuodd Sam dderbyn triniaeth, gan gynnwys trwy gymryd rhan mewn dosbarth therapi grŵp. Roedd hyn yn anodd iddo i ddechrau ond cydnabu wedi hynny ei fod wedi ei helpu'n aruthrol. Dros gyfnod y therapi grŵp, canfu Sam ei fod wedi dechrau cysylltu ag eraill; disgrifiodd y staff fel rhai empathig a deallus, gan ddisgrifio sut roeddent yn hyblyg o ran y gefnogaeth oedd ar gael i ddiwallu ei anghenion penodol. Roedd y therapi wedi



caniatáu iddo ddatblygu cyflwr meddwl llawer mwy cadarnhaol a chydabod ei fod wedi *'newid fy mywyd'*.

Esboniodd LR, yn dilyn amharodrwydd cychwynnol i ymgysylltu, fod Sam wedi canfod bod y gwasanaeth ar-lein yn iawn iddo. Defnyddiodd y Grŵp Sefydlogi Trawma, stori Sam nawr i helpu ac annog eraill i ymgysylltu.

Cafodd AH ei synnu gan angen Sam am iachâd iechyd meddwl, yn ogystal â thriniaeth ar gyfer ei drawma corfforol; roedd hyn yn adlewyrchu neges debyg i'r un a rannwyd gan deuluoedd yn y Gynhadledd Mamolaeth a Newyddenedigol ddiweddar.

CROESAWODD y Bwrdd stori'r claf a **DIOLCHODD** i Sam am rannu ei brofiadau. **CYDNABU** aelodau'r Bwrdd bwysigrwydd cefnogaeth seicolegol, yn ogystal â gwasanaethau adferiad corfforol, i bobl a oedd wedi profi anaf trawmatig.

RHAN 3. PENNU CYFEIRIAD STRATEGOL

3.1 RHAGLEN TRAWSNEWID IECHYD MEDDWL A GOBLYGIADAU YSTÂD/CYFALAF

Cyfeiriodd DL at y wybodaeth fanwl a nodwyd yn y papur a'r argymhellion gerbron y Bwrdd; cynghorodd i'r Bwrdd am ddechrau gwaith ffurfiol ym mis Mehefin 2025, i ddatblygu cyfres o gynigion i fynd i'r afael â thrawsnewid y gwasanaeth iechyd meddwl dros dro a thymor hir. Byddai DL nawr yn cadeirio Bwrdd Rhaglen Trawsnewid, gyda chefnogaeth ymroddedig i reoli'r rhaglen.

Yna trodd at MW, i grynhoi gwaith hyd yma'r Rhaglen Trawsnewid Sefydliadol, gan gynnwys crynodeb o'r opsiynau a ystyriwyd ar gyfer yr ateb ystâd dros dro.

Nododd MW ddiweddariadau o bob ffrwd waith o'r Rhaglen Trawsnewid. O ddiddordeb arbennig oedd:

- Dechrau gwaith ar weithredu Cofnod Cleifion Electronig (EPR) Rio.
- Mesur y bwlch rhwng y sefydliad nyrsio presennol a gofynion Iechyd Meddwl Deddf Staffio Mwy Diogel.



- Cynnydd ar y gwaith o ailgynllunio'r gwasanaeth, gan gynnwys gweithio mewn partneriaeth gadarnhaol gydag awdurdodau lleol a mentrau gwirfoddol, cymunedol a chymdeithasol (VCSE).
- Adolygiad o brosesau ansawdd a diogelwch allweddol.

Yna disgrifiodd MW y gwasanaeth cleifion mewnol presennol, sydd wedi'i leoli ar nifer o safleoedd ar draws ardal BIPBA, pob un â chyfyngiadau sylweddol o ran ystâd ac amgylchedd. Rhestrodd y saith opsiwn, gweithiodd drwyddynt yn fanwl, cyn eu culhau. Tynnodd sylw at gyflwyno Opsiwn 7, a awgrymwyd gan rai Ymgynghorwyr Iechyd Meddwl Pobl Hŷn (OPMH). Tynnodd MW sylw at Opsiwn 4 fel yr opsiwn a ffefrir ar hyn o bryd, sef cydgrynhoi gwasanaethau Iechyd Meddwl Oedolion yn Ysbyty Cefn Coed (YCC), gwasanaethau Iechyd Meddwl Oedolion yn Ysbyty Castell-nedd Port Talbot a chadw Ysbyty Tonna. Amcangyfrifir y byddai cost cyfalaf yr opsiwn hwn yn £34m, gyda chostau refeniw yn niwtral.

Roedd Opsiwn 5 yn debyg o ran dyluniad i Opsiwn 4, a'r gwahaniaeth oedd cadw gwasanaeth Tonna yn y tymor byr yn yr Opsiwn olaf. Esboniodd MW oblygiadau pob un a chyfeiriodd hefyd at yr ateb tymor hwy. Nid oedd Llywodraeth Cymru wedi cefnogi'r achos busnes diwethaf, gan arwain at oedi yn y cynllunio tymor hwy; gallai'r ateb tymor hwy gymryd saith mlynedd neu fwy i'w wireddu nawr, am gost amcangyfrifedig o £214m.

Ychwanegodd NV sylwadau a daeth MW i ben drwy amlinellu ymrwymiad y Bwrdd i gynnal ymarfer ymgysylltu dwys yn y Flwyddyn Newydd, yn dilyn cwblhau'r opsiynau ac egluro'r amserlen ar gyfer datblygu'r achos busnes. Byddai'r gwaith hwn yn adeiladu ar ymgynghoriadau blaenorol, ynghyd â'r gwaith ymgysylltu a wnaed fel rhan o agenda'r Rhaglen Trawsnewid gyfredol.

Diolchodd JW i DL, MW ac NV am y crynodeb; yna cyfeiriodd aelodau'r Bwrdd at y cyfoeth o wybodaeth a oedd yn y papur ategol ar yr opsiynau ac ar ymgysylltu. Gwahoddodd gwestiynau, ar sail thema, gan ddechrau gyda'r rhai sy'n canolbwyntio ar **gyllid**:

Cyfeiriodd JC at y cynnydd sylweddol yn y costau cyfalaf, o'i gymharu â'r amcangyfrifon cychwynnol; o ystyried y sefyllfa ariannol heriol, gofynnodd am sicrwydd ynghylch dibynadwyedd yr amcangyfrifon diwygiedig. Gwnaeth sylwadau hefyd ar: (i) yr angen i gynnal cynnydd ar gyflymder, a (ii) rôl gwasanaethau cymunedol a gwasanaethau a ddarperir gan asiantaethau partner, a'r ymgysylltiad â nhw.



Cyfeiriodd ALF at heriau seilwaith sylweddol ar safle YCC a gofynnodd a oeddent wedi'u cynnwys yn y gost gyfalaf amcangyfrifedig o £34m. Ceisiodd NZ wybodaeth am y costau o amgylch y goblygiadau i'r gweithlu.

Ceisiodd AG ragor o wybodaeth am argaeledd ac amseriad cyllid cyfalaf, o ystyried effaith hyn ar amserlenni cyflawni.

Wrth ymateb i'r pwyntiau uchod, cynghorodd DG y gallai costau newid wrth i'r broses gynllunio fynd rhagddi, ochr yn ochr ag eglurhad o ddyluniad yr opsiynau a ffeifir a chyfluniad y gwasanaeth. Byddai comisiynu cynghorydd costau, rhan arferol o'r broses achos busnes, o gymorth gyda'r gwaith hwn. Byddai costau refeniw yn dibynnu ar ddyluniad yr opsiwn a ddewisir. Awgrymodd asesiad cychwynnol y byddai nifer y gwelyau yn aros yr un fath fwy neu lai ond yn cael ei gefnogi gan seilwaith llawer gwell; roedd y cynnig yn cynnwys amcangyfrifon ar gyfer costau atgyweirio a chynnal a chadw.

Cyfeiriodd AH at y ddwy amserlen gyfochrog: un yn canolbwyntio ar yr amser sydd ei angen i gyflawni'r ateb dros dro a'r llall ar yr ateb hirdymor. Rhaid i gynlluniau hefyd nodi darpariaeth parhad busnes pe bai methiant seilwaith trychinebus wrth weithredu'r ateb dros dro; byddai BIPBA yn gweithio gyda phartneriaid yr awdurdod lleol a'r trydydd sector ar hyn. Roedd AH hefyd yn cydnabod pwysigrwydd ymateb amserol i waith cynnal a chadw parhaus, gyda mwy o bresenoldeb gweithlu ystadau ar y safle i gynnal a/neu atgyweirio unrhyw ddifrod i'r seilwaith yn gyflym.

Cyfeiriodd ALF at gostau atgyweirio a chynnal a chadw Ysbryd y Coed. Cadarnhaodd MW fod y cynnig yn cynnwys amcangyfrifon ar gyfer atgyweiriadau, er mwyn sicrhau ei fod yn addas ar gyfer darparu gwasanaethau i oedolion. Roedd costau wedi cynyddu, yn unol ag asesiad mwy manwl y cynghorydd costau.

Tynnodd JC sylw at y cyllid sylweddol sydd ei angen i gefnogi'r rhaglen drawsnewid arfaethedig; ceisiodd sicrwydd ynghylch rheolaeth gadarn o'r ateb dros dro, er mwyn sicrhau tryloywder a rheolaeth o oblygiadau ariannol, ochr yn ochr â rheoli cyllideb dynn, tra hefyd yn bodloni gofynion diogelwch a rheoli risg.

Wrth ymateb, cyfeiriodd AH at sefydlu Bwrdd Rhaglen a fyddai'n cynnwys adnoddau rheoli rhaglenni. Byddai'n gweithredu ochr yn ochr â ffrydiau gwaith cyfredol dan arweiniad Deloitte ac yn sicrhau cydymffurfiaeth â gofynion Perfformiad a Gwellu GIG Cymru (NHSPi); byddai'r dull yn galluogi triongli effeithiol. Roedd yn rhaid i'r broses fod yn ddeinamig, er mwyn ymateb i newidiadau i'r model gwasanaeth gweithredol wrth i'r broses gynllunio ddatblygu. Gyda'i gilydd, byddai'r tri safbwynt yn cipio ac yn ystyried cyfanswm y gwariant ac yn



sicrhau'r defnydd gorau o adnoddau. Cyfeiriodd AH at y gwariant Gofal Iechyd Parhaus y GIG (CHC) cost uchel presennol ar leoliadau iechyd meddwl fel un cyfle i ailfuddsoddi arian mewn gwasanaethau a ddarperir yn agosach at adref, gan osgoi lleoliadau y tu allan i'r ardal oni bai bod hynny'n gwbl angenrheidiol.

O ran llywodraethu, cadarnhaodd AH sefydlu Grŵp Rheoli Cyfalaf i gynnal goruchwyliaeth o bob llinyn o waith a sicrhau bod y prosiect cyffredinol yn parhau ar y trywydd iawn o ran cyflawni a gwariant cyfalaf; roedd costau wedi codi'n sylweddol ar gyfer gofal iechyd meddwl mwy cymhleth a byddai llywodraethu a goruchwyliaeth effeithiol yn hanfodol i gyflawni trawsnewid gwasanaeth o fewn yr adnoddau sydd ar gael.

Ceisiodd KL sicrwydd ynghylch cynnwys costau gwasanaethau cymunedol fel rhan o gostau cyffredinol y rhaglen drawsnewid, gan gynnwys costau refeniw sy'n gysylltiedig â'r gweithlu.

Cadarnhaodd TR y byddai'r Cynllun Gweithlu Strategol yn darparu llinell sylfaen, gyda chasglu data eisoes ar waith ar gyfer rhai grwpiau staff; byddai dadansoddiad o'r gwariant cyfredol ar bob grŵp staff, ynghyd â nodi unrhyw ofynion buddsoddi, yn rhan o'r broses gynllunio ar gyfer 2026/27.

Cefnogodd MW y dull hwn, gan nodi bod y sefyllfa ariannol o ran staffio dros dro yn cael ei llywio i raddau helaeth gan y sefydliadau staffio presennol; gallai'r gwaith sydd ar y gweill i adolygu'r sefydliadau hynny, a thrwy hynny leihau'r ddibyniaeth ar staff dros dro a oedd yn wynebu costau uwch, ryddhau cyllid sylweddol i fynd i'r afael â'r angen am fwy o staff uwch a phrofiadol. Byddai grwpio wardiau hefyd yn arwain at wasanaethau llai ynysig a'r cyfle i reoli staffio'n fwy effeithiol ar draws sylfaen gwelyau ehangach.

O ran y **model gwasanaeth gweithredol**, cyfeiriodd JW at yr Adolygiad Gwasanaethau Cymunedol ehangach sydd ar y gweill ar hyn o bryd a gofynnodd am y cysylltiad â'r rhaglen trawsnewid iechyd meddwl. Cynghorodd DL, er nad oedd unrhyw drefniadau ffurfiol ar waith, y byddai'r Adolygiad yn ddiamau yn adlewyrchu darpariaeth gwasanaethau iechyd meddwl mewn gofal sylfaenol a chymunedol. Cefnogodd AH hyn, gan gydnabod yr angen i ystyried cyfanrwydd y ddarpariaeth gwasanaethau iechyd meddwl, gan gynnwys gwasanaethau gofal sylfaenol a ddarperir fel rhan o GMS. Dim ond canran fach o gyfanswm y bobl a oedd yn derbyn cymorth gwasanaeth iechyd meddwl yn y gymuned oedd gofal cleifion mewnol, ac roedd dull seiliedig ar glwstwr cymunedol yn gosod gofal yn agosach at adref; deilliodd y ffocws cychwynnol ar ofal cleifion mewnol o'r angen brys i sicrhau amgylchedd diogel ar gyfer gofal. Cynghorodd AH y



byddai'r Bwrdd Trawsnewid newydd yn sbarduno cynnydd ac y byddai'r Bwrdd yn ystyried model gweithredu wedi'i gostio'n llawn yng nghyfarfod mis Mawrth 2026.

Cyfeiriodd NM at y costau sy'n gysylltiedig â lleoliadau iechyd meddwl dros dro i oedolion; y gorwariant uchaf ar gyfer Mis 7; cadarnhaodd JW y byddai'r model gwasanaeth gweithredol yn ystyried ac yn lleihau lleoliadau y tu allan i'r ardal. Adroddodd DL fod lleoliadau y tu allan i'r ardal wedi lleihau; roedd y rhain yn digwydd yn bennaf ar benwythnosau pan oedd uwch staff yn tueddu i fod yn llai ar gael. Roedd gwaith ar y gweill i gytuno ar lefel staffio ar benwythnosau ar ddydd Iau bob wythnos. Cyfeiriodd DL hefyd at y model sydd ar waith yn Ngwlad yr Haf a'r dysgu o hynny, gan gynnwys gwasanaethau cymorth ychwanegol yn y gymuned. Cynghorodd MW fod gwasanaeth ymateb cymunedol wedi cymryd peth amser i'w adeiladu; roedd modelau a oedd yn canolbwyntio mwy ar ymyrraeth argyfwng gymunedol ar gael ac roedd y rhain yn tueddu i arwain at lai o welyau cleifion mewnol. Roedd Grŵp Gwasanaeth Iechyd Meddwl ac Anableddau Dysgu yn pennu'r metrigau oedd eu hangen i roi hyder mewn gwneud penderfyniadau clinigol o dan y model hwnnw. Croesawodd AG gynnwys y cyfleoedd digidol yng nghynllun y model gweithredu.

O ran **ymgysylltu â staff**, cyfeiriodd JC at ohebiaeth gan rai ymgynghorwyr oedolion ac Iechyd Meddwl Pobl Hŷn at y Cadeirydd a'r Prif Swyddog Gweithredol, yn rhannu barn a chynigion amgen ar gyfer datblygu gwasanaethau. Gofynnodd am yr ymateb i'r llythyr a'r dull ehangach o ymgysylltu â staff. Cadarnhaodd JW fod holl aelodau'r Bwrdd wedi gweld y llythyr, ynghyd â'r ateb. Roedd croeso cynnes i bob ymgynghorydd barhau i wneud eu cyfraniadau wrth i'r gwaith ddatblygu, fel yr oedd yr holl staff.

Crynhodd MW yr ystod o gyfleoedd ymgysylltu sydd eisoes ar waith, gan gynnwys cylchlythyrau, sesiynau galw heibio a chyfarfodydd penodol gydag ymgynghorwyr iechyd meddwl Iechyd Meddwl y Cyhoedd a gwasanaethau oedolion. Roedd yr olaf wedi galluogi'r ymgynghorwyr i drafod opsiynau eraill a rhannu syniadau. Roedd diwrnod datblygu ar 17 Tachwedd, gyda gwahoddiad agored i bob ymgynghorydd, wedi cynnwys cyflwyniad ar y cynnydd gyda'r rhaglen drawsnewid, gan gynnwys manylion am yr opsiynau ystâd dan ystyriaeth. Dywedodd MW, er bod gan rai cydweithwyr ymgynghorol safbwyntiau cryf ac yn gwrthwynebu Opsiwn 4, fod nifer o rai eraill wedi nodi eu cefnogaeth i'r newidiadau arfaethedig. Byddai cyfleoedd gwahoddiad agored eraill yn y misoedd nesaf.



O ran **materion diogelwch**, tynnodd ALF sylw at bwysigrwydd yr agenda diogelwch yn yr Uned Mamau a Babanod (MBU), Ysbyty Tonna; gofynnodd am y defnydd o ddysgu o ddigwyddiadau i wella diogelwch. Sicrhaodd MW y Bwrdd fod yr Unedau Mamau a Babanod yn wasanaeth a redir yn dda gyda thîm clinigol cryf; roedd gan unedau o'r fath lefel o risg bob amser, ac roedd gan yr Uned Mamau a Babanod ffocws cryf ar ansawdd a diogelwch i sicrhau dysgu. Fodd bynnag, roedd y seilwaith yn Tonna ymhell o fod yn ddelfrydol, gan ei fod wedi'i leoli mewn adeilad dros dro gyda chyfleoedd cyfyngedig i arsylwi rhyngweithiadau teuluol. Argymhellodd MW drafodaethau ffurfiol cynnar gyda'r Pwyllgor Comisiynu ar y Cyd i gytuno ar ateb parhaol.

Ar yr Uned Mamau a Babanod, nododd AH y byddai Opsiwn 4 yn gadael y gwasanaeth hwnnw a ward y bobl hŷn ar y safle yn Tonna – dau wasanaeth ar gyfer grwpiau cleifion gwahanol iawn. Fodd bynnag, roedd argaeledd staff eraill ar y safle yn darparu rhywfaint o gefnogaeth wrth gefn i'r Uned Mamau a Babanod. Pe bai'n dod yn wasanaeth annibynnol, byddai'n rhaid i'r sefydliad staffio adlewyrchu hynny. Cadarnhaodd AH ei bod wedi codi'r pryderon hyn gyda chydweithwyr y Prif Swyddog Gweithredol ac wedi estyn gwahoddiad agored i ymweld â'r safle ac arsylwi'r pryderon yn ymwneud â'r ystâd; byddai'n codi'r mater yn ffurfiol gyda'r JCC, er mwyn sicrhau'r lefel ariannu briodol ar gyfer gwasanaeth mor ynysig.

Cyfeiriodd JC at yr Adroddiad Asesu Risg Clymu Allanol a gomisiynwyd yn dilyn cymeradwyaeth y Bwrdd a'r angen am ddiweddariadau ar waith sy'n gysylltiedig â'r ddarpariaeth gwasanaeth gyfredol.

Cadarnhaodd MW fod y gwaith a wnaed yn ystod misoedd yr haf wedi nodi problemau gwella ymarfer, yn unol â rhaglen Cymru gyfan ar Wardiau Diogel ac yn ymwneud yn bennaf â diwylliant a hyfforddiant. Byddai'r rhaglen tymor byr yn mynd i'r afael â rhai materion, tra byddai eraill yn fwy heriol i'w datrys.

O ran **cynnwys cleifion a defnyddwyr gwasanaeth**, gofynnodd CT am gynnwys cleifion yn natblygiad yr opsiynau. Amlinellodd RT y camau a gymerwyd dros amser i ymgysylltu â chleifion a'u teuluoedd; roedd y rhain yn cynnwys pum proses ymgysylltu helaeth, y mwyaf diweddar yn 2022; cyfeiriodd at dudalen 17 o'r adroddiad a oedd yn ceisio cymeradwyaeth y Bwrdd ar gyfer proses ymgysylltu ffurfiol ddechrau 2026; byddai hyn yn ddwys a chytunodd RT i roi gwybodaeth i CT y tu allan i'r cyfarfod.

Cam Gweithredu: RT

Rhoddodd MW fanylion pellach am waith y tîm gwella ansawdd wrth ymweld â wardiau a cheisio barn cleifion; roedd y dull a fabwysiadwyd



wedi bod yn fedrus ac wedi cefnogi cleifion a oedd yn betrusgar i rannu eu barn i ddechrau. Roedd y tîm hefyd wedi cael mynediad at rwydwaith a phrosesau ymgysylltu'r Bwrdd Partneriaeth Ranbarthol (RPB); roedd gwaith penodol wedi'i gynllunio ar gyfer gwasanaethau'r Iechyd Meddwl Pobl Hŷn, i geisio barn cleifion, teuluoedd a gofalwyr. Byddai'r gwaith hwn yn elwa o gyngor a gynigir gan Gomisiynydd Pobl Hŷn Cymru a thrwy ddefnyddio canllawiau ar ymgysylltu o ansawdd uchel.

Cadarnhaodd JW y byddai hi ac AH yn cyfarfod â Chadeirydd a Phrif Weithredwr Llais yn y Flwyddyn Newydd ar amrywiaeth o faterion, gan gynnwys egwyddorion newid gwasanaeth ac ymgysylltu â'r cyhoedd. Myfyriodd SS ar yr angen i gynnal **cyflymder** a datblygu materion a nodwyd yn gynharach heb oedi. Gofynnodd am ddiwedd disgwyledig y rhaglen drawsnewid ac adroddodd DL y byddai adroddiad y Bwrdd ar gyfer cyfarfod mis Mawrth 2026 yn cynnwys amserlenni a cherrig milltir.

Cytunodd AH â phwysigrwydd cynnal cyflymder a pheidio â cholli momentwm; roedd cyflawni amserlenni yn hanfodol.

Gan symud ymlaen at **yr opsiynau**, holodd KL am yr angen i ddefnyddio adeilad Ysbryd y Coed ar gyfer Gwasanaethau Cleifion Mewnol i Oedolion, o ystyried y pryderon a godwyd gan rai cydweithwyr Iechyd Meddwl Pobl Hŷn; roedd yn ymwybodol bod adeiladau modiwlaidd ar gael ar gyfer wardiau iechyd meddwl, gan nodi Ward Kingfisher ym Mryste. Awgrymodd KL archwiliad pellach o ddull modiwlaidd

Cynghorodd DG fod Opsiynau 4 a 5 yn ymddangos fel yr opsiynau mwyaf rhesymol; byddai unrhyw opsiwn a fyddai'n gofyn am adeiladau newydd neu unedau modiwlaidd ychwanegol ar safle CCH yn gofyn am uwchraddio seilwaith sylweddol a byddai'n destun ansicrwydd rheoliadau cynllunio'r awdurdod lleol.

Dywedodd MW fod y Grŵp Gorchwyl a Gorffen wedi adolygu'r cysyniad o adeilad modiwlaidd. Roedd unedau tebyg yn Lloegr wedi'u hadeiladu o frics yn hytrach na rhai modiwlaidd ac yn darparu cynllun ward feddygol a fyddai'n anodd ei aildefnyddio; byddai seilwaith strwythur modiwlaidd yn golygu'r un costau â dewis wedi'i adeiladu o frics. Cynigiodd MW adolygu'r wybodaeth oedd ar gael gan KL ac ymateb yn gyflym.

Cam Gweithredu: KL/MW

Ceisiodd JW gytundeb i ddiystyru Opsiynau 1,2,3,6 7, gan adael Opsiwn 4 fel yr Opsiwn a ffefrir, ond heb eithrio Opsiwn 5 yn llwyr ar hyn o bryd. Roedd RO yn awyddus i archwilio pob posibilrwydd a



gofynnodd a allai'r gwaith pellach gynnwys potensial adeilad modiwlaid.

Myfyriodd AH ar y gwaith sylweddol a wnaed hyd yma i lunio'r opsiynau arfaethedig; roedd ychwanegiadau sy'n seiliedig ar seilwaith yn peri risg i wneud y costau'n anfforddiadwy. Byddai adolygiad cyflym o'r deunydd sydd ar gael yn helpu i egluro'r sefyllfa.

Mynegodd aelodau'r Bwrdd ddewis dros Opsiwn 4 ond cytunodd i beidio ag eithrio Opsiwn 5 yn llwyr ar hyn o bryd. Cefnogodd SS hyn ond tynnodd sylw at yr amserlen hirach ar gyfer cyflawni Opsiwn 5. Diolchodd JW i'r holl gyflwynwyr a chyfranwyr am ddadl fanwl, a gynhaliwyd yn ysbryd her adeiladol. Byddai'r Bwrdd Trawsnewid yn goruchwyllo'r broses ymgysylltu ac yn cynhyrchu adroddiad penderfyniad ar gyfer cyfarfod y Bwrdd ym mis Mawrth 2026.

Gwahoddodd JW yr holl staff sy'n gweithio yn y gwasanaethau Iechyd Meddwl ac Anabledau Dysgu i gymryd rhan yn y broses ymgysylltu, gan fod y Bwrdd yn awyddus i glywed gan bawb, o ystyried pwysigrwydd y penderfyniad.

Gwnaeth y Bwrdd y canlynol:

- **TRAFOD** cynnwys yr adroddiad.
- **YSTYRIED** cynnydd y Rhaglen Trawsnewid.
- **ADOLYGU'r** opsiynau, gan gynnwys yr holl oblygiadau o ran yr ystâd a'r amgylchedd. Yna diystyriodd y Bwrdd Opsiynau 1,2,3,6,7.
- **DADANSODDI'R** costau sy'n gysylltiedig ag Opsiynau 4 a 5
- **CYMERADWYO** Opsiwn 4 fel yr opsiwn a ffefrir, er nad yw'n gwahardd Opsiwn 5 yn llwyr ar hyn o bryd. Dylai'r ddogfen ymgysylltu nodi'r wybodaeth am ddefnyddio strwythurau modiwlaid.
- **RHOI CYMERADWYAETH** i ddechrau'r broses achos busnes ar gyfer y Datrysiad Dros Dro a **CHYMERADWYWD** hefyd agor trafodaethau ffurfiol gyda Llywodraeth Cymru ar y gofynion cyfalaf.
- **CYMERADWYO** cynnal proses ymgysylltu ffurfiol yn y Flwyddyn Newydd.
- **RHOI CYMERADWYAETH** i ddechrau'r broses achos busnes ar gyfer yr ateb tymor hir.
- **CYMERADWYO** dull i'r JCC agor trafodaethau ar yr ateb parhaol ar gyfer yr Uned Mamau a Babanod

Nesaf, trafododd y bwrdd eitem 4.1 ar yr agenda cyn dychwelyd at eitem 3.2 ar yr agenda.



3.2 ADRODDIAD CYNLLUNIO A PHARTNERIAETHAU

Cyfeiriodd MD at y papur a'r atodiadau; roedd y rhain yn darparu'r manylion sy'n sail i'r amrywiol faterion a gwmpesir gan yr adroddiad Cynllunio a Phartneriaethau. Crynhodd MD y materion a drafodwyd er gwybodaeth a/neu i'w cymeradwyo; roedd y rhain yn cynnwys:

- Camau gweithredu sy'n gysylltiedig â chynllunio strategol a thymor hwy.
- Cynnydd gyda'r Cynllun Ardal drwy'r Bwrdd Partneriaeth Ranbarthol (RPB).
- Cymeradwyaeth ar gyfer y gwaith strategol a amlinellwyd gyda'r Bwrdd Gwasanaeth Cyhoeddus (BGC).
- Cadarnhau polisiau IFPR, sydd eisoes yn destun craffu gan y QSC.
- Cymeradwyaeth o'r fframwaith cenedlaethol ar gyfer oedolion ifanc.
- Y strategaeth addasu sy'n datblygu sy'n gysylltiedig â BGC Abertawe.
- Cymeradwyo'r Gweithdrefnau Digwyddiadau Mawr wedi'u diweddarau.

Diolchodd JW i MD am ei chrynodeb a gwahoddodd gwestiynau: Ceisiodd JC ragor o wybodaeth am adroddiadau sganio'r gorwel. Cyfeiriodd hefyd at y polisi IPFR a chyfeiriad at gyflawni erbyn diwedd mis Mawrth 2026. Wrth ymateb, cadarnhaodd MD fod adroddiadau sganio'r gorwel yn ffurfio papurau atodol sy'n gysylltiedig â'r broses gynllunio strategol. O ran y polisi IPFR, cadarnhaodd fod amserlen Mawrth 2026 yn cynrychioli'r dyddiad ar gyfer cwblhau'r broses adolygu.

Tynnodd JC sylw hefyd at y gwerth blynyddol o £5 miliwn ar iechyd meddwl ac anabledd dysgu, sy'n gysylltiedig â'r cytundeb cenedlaethol ar gyfer oedolion ifanc; nid arian newydd oedd hwn, ond roedd yn gysylltiedig â chyllid lefel system sydd ar gael.

YSTYRIODD y Bwrdd yr adroddiad a **CHYMERADWYODD**, **CYDNABU** a **CHADARNHODD** yr eitemau fel y gofynnwyd drwy gydol yr adroddiad.

RHAN 4. CYFLAWNIADAU YN Y FLWYDDYN: ANSAWDD, DIOGELWCH, PERFFORMIAD AC ADNODDAU

4.1 GWASANAETHAU AMENEDIGOL



- **ADRODDIAD Y PWYLLGOR AMENEDIGOL**
- **ADRODDIAD Y PANEL GORUCHWYLIO**

Adroddiad y Pwyllgor Amenedigol

Trafododd y Bwrdd yr eitem Agenda hon ar ôl 3.1 cyn dychwelyd at eitem Agenda 3.2.

Wrth gyflwyno'r eitem hon, rhoddodd LR rywfaint o gefndir a chyddestun, gan gynnwys sefydlu'r Pwyllgor Amenedigol ym mis Mehefin 2025, gyda chylch gwaith i (i) ystyried ac ymateb i safonau a chanlyniadau ansawdd allweddol yn barhaus, (ii) goruchwyllo'r Rhaglen Wella, a (iii) ymateb i argymhellion yr Adolygiad Annibynnol Mamolaeth.

Yna rhoddodd LR grynodedb o'r dangosyddion a'r data allweddol:

- Roedd 290 o fenywod wedi rhoi genedigaeth ym mis Medi, gan roi enedigaeth i 294 o fabanod.
- Roedd cyfanswm y gyfradd toriad Cesaraidd yn 40%, gyda chyfradd dethol o 16.2%.
- Y cyfraddau marwolaethau a morbidrwydd, gyda deg genedigaeth farw wedi'u hadrodd yn y cyfnod adrodd diwethaf. Roedd cyfradd marw-enedigaethau'r DU yn 2.94%, ar gyfer Cymru roedd yn 3.63%, a chyfradd BIPBA yn 1.29%. Roedd pob colled yn drawmatig i'r teuluoedd dan sylw a chadarnhaodd LR fod y gwasanaeth cymorth galaru wedi'i gryfhau, gyda gwaith ar y gweill i gryfhau cymorth newyddenedigol hefyd. Roedd yr holl staff wedi derbyn hyfforddiant profedigaeth.
- Roedd saith marwolaeth newyddenedigol wedi digwydd rhwng Ionawr a Medi, ac roedd dau ohonynt yn adroddadwy gan MBBRACE.
- Adroddwyd chwe achos o enseffalopathi isgemig hypocsig HIE, gyda chanlyniad da i bob baban wrth ei ryddhau.
- Roedd recriwtio i swyddi bydwreigiaeth yn golygu bod BIPBA bellach wedi'i or-sefydlu'n dros dro o fydwragedd newydd gymhwyso; byddai hyn yn ail-gydbwyso â'r recriwtio i swyddi band 6. Roedd gwasanaethau newyddenedigol hefyd wedi gor-recriwtio i swyddi band 5, ac roedd yr holl staff wedi cwblhau hyfforddiant arbenigol yn llwyddiannus.
- Recriwtio i bob swydd ymgynghorydd newyddenedigol.
- Statws allanolyn positif mewn tri maes o'r archwiliad cenedlaethol newyddenedigol, heb unrhyw ddangosyddion allanolyn negyddol. Roedd pedwar maes naill ai islaw neu



uwchlaw cyfartaledd Cymru, pob un yn destun craffu manwl, gyda chynlluniau gweithredu ar waith.

- Mesur ac adrodd ar bob oedi wrth ysgogi esgor; o'r 78 ysgogiad ym mis Medi, roedd chwech yn destun oedi. Roedd blaenoriaethu clinigol ar waith gyda goruchwyliaeth ddyddiol a 'chyfarfod' clinigol; roedd casglu data digidol hefyd yn cael ei archwilio.
- Cyfranogiad BIPBA mewn holiadur craidd y GIG; roedd hyn yn gofyn am farn menywod beichiog mewn pum cam yn ystod bechiogrwydd. Byddai cyfle i deuluoedd sydd â phryderon, neu a adroddodd am brofiad negyddol, drafod y rhain ymhellach.

Gan droi at argymhellion yr Adolygiad Annibynnol (IR), adroddodd LR fod:

- Roedd system brysbennu unedig ar waith; deilliodd hyn o weithredu model asesu System Brysbennu Obstetrig Penodol i Symptomau Birmingham (BSOTS) ym mis Tachwedd 2024. Roedd asesiad bydwreigiaeth pwrpasol ar waith ond nid oedd yn gweithredu 24/7 ar hyn o bryd. Roedd y gwasanaeth 24/7 llawn wedi'i drefnu ar gyfer mis Mawrth 2026 a byddai'n y cyntaf yng Nghymru.
- Roedd yr amser a gymerwyd i flaenoriaethu yn amrywio o 15 i 30 munud. Nid oedd unrhyw ddigwyddiadau'n gysylltiedig â brysbennu wedi bod yn ystod y 12 mis diwethaf.
- Ar waith dau safle, roedd yr Uned Therapi Dwys a'r timau amenedigol wedi cryfhau trefniadau cyfathrebu; fodd bynnag, roedd y sefyllfa ar wahân yn parhau i fod yn risg.
- Roedd gweithdy llwyddiannus gyda'r Panel Goruchwyllo ar 17 Tachwedd wedi profi'n addysgiadol iawn, gyda phedair thema allweddol yn cael eu nodi, er mwyn datblygu 10 argymhelliad yr Adolygiad Annibynnol, pob un ag arweinyddiaeth weithredol. Roedd cyfarfod cyntaf y Bwrdd Rhaglen Wella wedi'i drefnu ar gyfer mis Rhagfyr, gyda mecanwaith adrodd rheolaidd ar waith.

Diolchodd JW i LR am ei chrynodeb ac yna gwahoddodd gwestiynau: Canfu RO fod y diweddariad yn gadarnhaol iawn, gan groesawu lefel y manylder a'r defnydd o feincnodi; cafodd sicrwydd o'r dull hwn. O ran brysbennu, holodd RO ynghylch y posibilrwydd o gyflymu'r gwasanaeth 24/7 llawn. Wrth ymateb, cynghorodd LR y byddai hyn yn gofyn am fuddsoddiad a recriwtio; dyma fyddai'r gwasanaeth 24/7 cyntaf yng Nghymru a byddai angen amser paratoi. Gofynnodd NZ hefyd am frysennu a thybed a oedd Mawrth 2026 yn gyraeddadwy, o ystyried yr heriau o ran adnoddau a recriwtio. Croesawodd y Rhaglen Gwella a lleoliad y 10 argymhelliad yn y cyd-



destun ehangach, gyda goruchwyliaeth ar lefel y Pwyllgor Safonau a Chyfarwyddwyr ar ran y Bwrdd.

Ar fater buddsoddi, atgoffodd JW y Bwrdd na allai fuddsoddi arian nad oedd ganddo ac y byddai'r Weithrediaeth yn gweithio drwy'r dulliau o wrthbwysu'r gost yn erbyn arbedion eraill. Roedd hyn yn angenrheidiol, gan fod y Panel Goruchwyllo wedi nodi'r argymhelliad hwn fel y risg uchaf, gan olygu bod angen gweithredu ar frys.

Cam Gweithredu: AH

Cyfeiriodd KL at y data a gasglwyd ar gyfer y gwahanol ddangosyddion a gofynnodd am y posibilrwydd o ddadelfeniad i lefel safle.

Cadarnhaodd LR fod hyn yn bosibl.

Wrth wneud sylwadau ar y wobr arian gan BLISS i'r tîm newyddenedigol, y tro cyntaf yng Nghymru, canmolodd AH y tîm am ei ymgyrch i wella'n barhaus, fel yr oedd yn wir ar draws y gwasanaeth mamolaeth a'r gwasanaeth cyfan. Ymunodd y Bwrdd cyfan ag AH i estyn llongyfarchiadau cynnes i'r tîm.

Gwnaeth y Bwrdd y canlynol:

- **CROESAWU**'r gefnogaeth rheoli prosiect sydd ar waith, i ddatblygu ac yna ffurfio rhan o oruchwyliaeth y Cynllun Gwella, mewn ymateb i'r Adolygiad Annibynnol.
- **CEFNOGI** Bwrdd Gweithredol y Rhaglen Gwella Amenedigol, gan ddechrau ym mis Rhagfyr 2025.
- **CYDNABOD** y byddai'r Pwyllgor Amenedigol yn cyfarfod yn fisol, ac yn adolygu'r holl fetrigau allweddol ar gyfer gwasanaethau amenedigol.
- **CROESAWU**'r adborth o'r Digwyddiad Dysgu a gynhaliwyd ar 19/11/25, gyda dros 200 o fynychwyr o bob cwr o Gymru a'r DU.
- **CYTUNO I DDERBYN** y Cynllun Gwella Amenedigol terfynol yng nghyfarfod y Bwrdd ym mis Ionawr 2026, sydd bellach yn rhan o Raglen Wella ehangach.
- **CYMRYD SICRIFYDD** gan y canlynol:
 - Y ffaith nad oedd gan y Gwasanaeth Amenedigol unrhyw allanolion negyddol ar hyn o bryd; roedd y pedwar maes naill ai islaw neu uwchlaw cyfartaledd Cymru yn destun craffu manwl.
 - Sicrhaodd y broses MBBRACE fod pob marw-enedigaeth yn cael ei hadrodd yn ôl yr angen.
 - Adrodd 6 achos o HIE i MBBRACE yn y cyfnod hwn.
- **DERBYN Y RHYBUDD** mewn perthynas â'r gwasanaeth brysbennu 24/7, a ddisgwyllir ei lansio ym mis Mawrth 2026.



Byddai'r Bwrdd yn ystyried cyngor pellach ar hyn fel rhan o drafodaethau Cynllun Blynnyddol 2026/27.

Adroddiad y Panel Goruchwyllo

Croesawodd JW DC, a ymunodd â'r cyfarfod drwy Teams, i gyflwyno Adroddiad cyntaf y Panel Goruchwyllo (y Panel).

Tynnodd DC sylw at y canlynol:

- Rôl y Panel dros y flwyddyn nesaf a'i amcanion allweddol; roedd hyn yn cynnwys rôl y ffrind beirniadol, ochr yn ochr â rôl sicrwydd a gyflawnir gan Ann Gow, fel arsylwr Ysgrifennydd y Cabinet.
- Gallai'r ystod o arbenigedd ar y Panel gynorthwyo BIPBA ar ei daith gwella. Roedd holl aelodau'r panel wedi cynnig eu mewnbwn i gefnogi'r gwaith gwella.
- Y cyfarfod rhwng aelodau'r Panel ac arweinwyr gwasanaeth BIPBA i roi adborth ar y drafft Cynllun Gwella; y prif faes pryder oedd y ddibyniaeth ar y Cyfarwyddwr Gweithredol Nyrsio i gyflawni'r rhaglen wella gyfan. Byddai gan ddull mwy dosbarthol o atebolrwydd ac arweinyddiaeth ar draws y tîm gweithredol fanteision a byddai'n sicrhau bod y ffactorau diogelwch hollbwysig a oedd yn gofyn am arweinyddiaeth feddygol benodol yn cael sylw.
- Y cynnydd croesawgar ar frysbennu; y risg allweddol oedd yr angen am un llwybr i bob menyw feichiog, ynghyd â'r mesurau lliniaru a roddwyd ar waith yn y cyfamser.
- Y gweithdy adeiladol a gynhaliwyd ar 17 Tachwedd; gallai hyn ffurfio sail i ddull parhaus.
- Byddai Bwrdd Rhaglen dan arweiniad gweithredol yn helpu BIPBA yn ei ymateb i'r adroddiad a hefyd gydag ymgysylltu â'r cyhoedd yn ehangach.
- Roedd yr adborth cadarnhaol o'r Gynhadledd ar 18 Tachwedd yn ddechrau da ar gyfer sgwrs barhaus rhwng BIPBA a'r cyhoedd. Dylid cynnwys staff rheng flaen mewn unrhyw waith dilynol.

Daeth DC i ben drwy rannu newyddion trist. Bu farw'r Athro Tim Draycott, a oedd wedi darparu neges fideo ar gyfer y Gynhadledd, yn sydyn. Byddai hi'n cysylltu â RT ynglŷn ag amseriad cyhoeddi'r neges, fel teyrnged i'r Athro Draycott; gofynnodd JW a'r Bwrdd cyfan i DC gyfleu eu cydymdeimlad diffuant i'w deulu.

Wrth ymateb i'r diweddariad, dywedodd JC ei bod wedi mynychu'r gynhadledd ac wedi ei chael hi'n addysgiadol iawn. Gofynnodd am ymgorffori'r dysgu o'r pwynt hwn, gan gynnwys y wybodaeth a gafwyd



	gan yr arbenigwyr a siaradodd ar y diwrnod a phrofiadau buddiol teuluoedd a defnyddwyr gwasanaeth. Cyfeiriodd DC at y drafodaeth yn y Gynhadledd ar gyfiawnder adferol, roedd teuluoedd eisiau gwybod sut y byddai pethau'n newid; roedd dros 1000 o deuluoedd wedi ymgysylltu â'r Adolygiad Annibynnol a'r neges lethol oedd un o barodrwydd i weithio gyda BIPBA ar wella gwasanaethau. Roedd y rhai a oedd wedi rhannu eu profiadau yn glir y gallai prosesau ymchwiliol, gwrthwynebol presennol waethygu niwed yn hytrach na lleddfu gofid ac ychwanegu at eu trawma. Argymhellodd ddefnyddio mwy o adborth ar straeon teuluol ar lefel leol/weithredol, yn ogystal ag ar lefel y Bwrdd. Cofiodd ALF un stori yn y Gynhadledd am fam newydd nad oedd yn gwybod sut na ble i geisio cymorth. Dywedodd DC nad oedd un pwynt mynediad at gymorth o'r fath ac awgrymodd y gallai BIPBA ymchwilio i arfer da yn ddefnyddiol. Roedd NZ hefyd wedi mynychu'r Gynhadledd ac wedi canfod bod y ddadl ar sut i ymgysylltu â chymunedau yn bwerus iawn; roedd y cyfleoedd yn ymestyn y tu hwnt i ofal mamolaeth a newyddenedigol, i bob gwasanaeth. Diolchodd JW i DC am yr adborth, am rannu amcanion y Panel, y cynnig o ddull 'ffrind beirniadol' a'r sylwadau ar ddrafft cyntaf y Cynllun Gwella. Roedd hi'n edrych ymlaen at gael diweddariadau chwarterol pellach gan y Panel. CROESAWODD y Bwrdd y cyntaf mewn cyfres o adroddiadau Panel Goruchwylio chwarterol a DIOLCHODD i'r Panel Goruchwylio am eu cynnig o gyngor ac arbenigedd parhaus.
4.2 ADRODDIAD PERFFORMIAD INTEGREDIG CYNNYDD Y CYNLLUN BLYNYDDOL (CHWARTER 2)	
	Ar gynnydd: Adroddodd DL ychydig o newid yn lefelau'r cynnydd; roedd hyn yn siomedig o ystyried y cynnydd a wnaed hyd yn hyn. Tynnodd sylw at y canlynol: - Y safbwynt ar iechyd meddwl, a drafodwyd eisoes yn fanwl yn gynharach yn y cyfarfod. - Ychydig o newid ar ofal wedi'i gynllunio, gyda 'phwyntiau cyfyng' yn parhau i fod yn ddiagnosteg ac apwyntiadau dilynol. Roedd yr uned endosgopi symudol ar waith fel y cynlluniwyd.



- Y lefelau sylweddol o welliant ar Ofal Brys ac Argyfwng ers mis Mehefin 2025; roedd y cylch adrodd tri mis yn golygu bod oedi cyn cyhoeddi data i gadarnhau hyn.
- Cyflawni targedau cancer am dri mis yn olynol, sy'n golygu bod dad-ddwysáu yn debygol. Roedd wroleg a chanserau gastroberfeddol isaf yn parhau i fod yn heriol.

Diolchodd JW i DL a gwahoddodd RE i roi'r wybodaeth ddiweddaraf am Heintiau a Gafwyd yn yr Ysbyty.

Cyfeiriodd RE at y sefyllfa gyffredinol, gyda ffigurau'n amrywio a dim gwelliant amlwg. Yr haint a oedd yn peri'r pryder mwyaf oedd C.Diff gyda rhai achosion yn ddiweddar ar wardiau. Amlinellodd gamau gweithredu sydd ar y gweill i fynd i'r afael â hyn, gan gynnwys ffocws ar hylendid dwylo ac arferion glanhau; fodd bynnag, roedd y dull trosglwyddo yn amgylcheddol, gan ei gwneud hi'n anodd dileu'r sborau. Cafodd hyn ei waethygu gan nifer uwch o welyau â defnydd a llif cynyddol. Byddai'r Grŵp Heintiau a Gafwyd yn yr Ysbyty newydd yn rhoi ystyriaeth frys i fesurau pellach. Dywedodd DL fod data diweddar ar y sefyllfa ym mis Tachwedd yn dangos rhywfaint o welliant.

Gofynnodd NM am y sefyllfa o ran mynediad cleifion strôc at sganiau CT o fewn y targed awr; tynnodd sylw hefyd at nifer y cwynion diweddar am wasanaeth fflebotomi Singleton. Wrth ymateb, eglurodd DL fod cyflymder mynediad at sgan CT yn dibynnu'n rhannol ar gyflwyniad y claf, gyda'r rhai a oedd yn cyrraedd mewn ambiwlans yn fwy tebygol o gael sgan wrth gyrraedd. Roedd cleifion a oedd yn cyflwyno eu hunain yn tueddu i aros i frysbenno ac adnabod arwyddion a oedd yn dynodi strôc bosibl. Cafodd y rhan fwyaf o gleifion eu sganio o fewn pedair awr.

O ran fflebotomi, cydnabu DL y pryderon ynghylch yr aros am y gwasanaeth. Roedd rhywfaint o fynediad at fflebotomi mewn lleoliadau gofal sylfaenol, yn ogystal â'r gwasanaethau a ddarperir ar safleoedd ysbytai. Roedd adolygiad o'r broses gyfan ar y gweill i benderfynu ar yr opsiynau gorau i gynyddu mynediad a byddai'r Bwrdd yn derbyn adroddiad llawn yn ei gyfarfod ym mis Ionawr 2026. Yn y cyfnod dros dro, roedd DL wedi ailgyfeirio rhywfaint o amser fflebotomi o waith ar y ward i gefnogi gwell mynediad at apwyntiadau cleifion allanol a drefnwyd. Ychwanegodd LR fanylion am y gwaith oedd ar y gweill gyda'r gwasanaeth i fynd i'r afael â phryderon ynghylch cyfathrebu â chleifion.

O ran gwasanaethau strôc, dywedodd DL fod ymarfer meincnodi Safonau Strôc Genedlaethol ar y gweill; byddai hi'n rhannu canlyniad hynny gyda'r Bwrdd.



Cam Gweithredu: DL

Ar berfformiad:

Rhoddodd TR ddiweddariad ar absenoldeb oherwydd salwch, gan nodi cyfradd ychydig yn uwch o 7.4% ym mis Hydref o'i gymharu â 7.3% ym mis Hydref 2024. Pan gafodd ei gyfrifo fel dyddiau a gollwyd oherwydd absenoldeb salwch, roedd hyn yn cyfateb i 29732 o ddiwrnodau coll. Roedd y ffocws ar absenoldeb salwch hirdymor wedi arwain at ostyngiad, ond roedd absenoldeb salwch tymor byr wedi cynyddu 0.7% dros yr un cyfnod. Roedd hyn yn effeithio'n bennaf ar staff band is a oedd yn adrodd am salwch sy'n gysylltiedig â straen. Cynlluniwyd mesurau ataliol ar waith i sicrhau nad oedd salwch tymor byrrach yn ymestyn i absenoldeb salwch tymor hwy.

Adroddodd LR ar ddau faes gwelliant: (i) atal cwympiadau; roedd camau gweithredu mewn ysbytai a chartrefi gofal wedi arwain at ostyngiad o 8.4% mewn cwympiadau a llai o dderbyniadau annisgwyl o gartrefi gofal, a (ii) gostyngiad o 50% mewn niwed difrifol o wlsrau pwysau.

Nododd GR y cyfraddau mewn perthynas â brechu, rhoi'r gorau i ysmegu a gweithgareddau sgrinio. Bu rhywfaint o gynnydd o ran nifer y bobl sy'n cael eu brechu, ond roedd angen ymdrech ar y cyd i gynyddu'r cyfraddau ymhellach ond byddai'n bwysig eu cynyddu, yn enwedig o ystyried effaith y fflw a phwysau'r gaeaf.

Gwahoddodd JW aelodau'r Bwrdd Gweithredol i dynnu sylw at unrhyw faterion nad oeddent eisoes wedi'u trafod.

Cyfeiriodd AH at effaith llwybrau gofal oedi ar lif ac ar ofal brys a gofal heb ei drefnu. Tynnodd DL sylw hefyd at lwybrau gofal oedi, ynghyd â chynhyrchiant ac effeithlonrwydd.

Cadarnhaodd DL fod timau BIPBA yn gweithio'n agos gyda Deloitte ar gamau gweithredu i leihau llwybrau gofal oedi ond nad oedd y niferoedd yn gwella. Roedd nifer o gleifion cymhleth yn cael eu gohirio'n amhriodol mewn ysbyty aciwt ar hyn o bryd, gan gynnwys wyth claf oedd yn ddigartref a heb unrhyw bosibilrwydd o gael eu rhyddhau heb ddarparu rhywfaint o lety; pwysleisiodd y risgiau o arhosiad hir diangen yn yr ysbyty i'r unigolion dan sylw a brys gweithio ar y cyd â phartneriaid yr awdurdod lleol a'r trydydd sector i sicrhau cefnogaeth briodol mewn lleoliadau priodol. Roedd y gwaith hwn yn cynnwys cyfres o weithdai amlddisgyblaethol i gytuno ar gamau gweithredu ar y cyd.

YSTYRIODD y Bwrdd y diweddariad perfformiad yn erbyn y mesurau uwchgyfeirio a'r meini prawf dad-ddwysáu, cymerodd **SICRWYDD** o'r adroddiad a'r camau gweithredu a amlinellwyd a **CHEFNOGODD** waith



cydweithredol brys pellach gyda phartneriaid i leihau llwybrau gofal oedi.

4.3 ADRODDIAD CYLLID

Cyfeiriodd DG at yr adroddiad manwl a thynnodd sylw at y canlynol:

- Rhagolwg Mis 07 ar gyfer 2025/26; arhosodd hyn fel yn y cyflwyniad cynllun gwreiddiol o £58.7m.
- O ran refeniw, diffyg Mis 07 o £4.13m oedd y sefyllfa ddiffyg orau hyd yma.
- Y diffyg cronnus o £47.16m; roedd hyn £12.9m yn uwch na'r sefyllfa ofynnol.
- Gadawodd y rhagolwg £11.5m i gwmpasu'r pum mis sy'n weddill o'r flwyddyn 2025/26, sy'n cyfateb i £2.3m y mis, sy'n sylweddol is na'r mis gorau hyd yma o £4.13m.
- Y cynllun ar waith ar gyfer y £55.4m; roedd bwlch cyflawni rhagolwg o £14.8m yn parhau, gyda dau faes allweddol o fethiant i gyflawni: £6.8m o syniadau ar gyfer y gwaith a £9m mewn rheolaethau cynyddol a gostyngiadau mewn gwariant.
- Y gwariant yn ôl Grŵp Gwasanaeth; Grŵp Gwasanaeth Iechyd Meddwl Anabledau Dysgu oedd â'r gorwariant mwyaf, yn bennaf twf yn gysylltiedig â Gofal Iechyd Parhaus, lleoliadau oedolion cost uchel dros dro a gwariant ar gyflog amrywiol
- Y gwariant ar gyfalaf; byddai hyn yn cydbwysu ar ddiwedd y flwyddyn.
- Y balans arian parod: roedd hyn yn is na tharged BIPBA.
- Cydymffurfiaeth â Pholisi Taliadau'r Sector Cyhoeddus (PSPP), sef 96.2% hyd yma eleni, yn erbyn targed o 95%. Roedd cydymffurfiaeth â thaliadau o fewn 30 diwrnod islaw 95% gyda sefyllfa hyd yma o 89.2% yn ystod y flwyddyn.
- Y cais am gymeradwyaeth ffurfiol y Bwrdd ar y llythyr arian parod strategol sydd wedi'i atodi i'r adroddiad. Roedd hyn yn arfer arferol ar yr adeg hon o'r flwyddyn, i alw am arian parod ychwanegol i fodloni ymrwymadau talu BIPBA yn y flwyddyn ariannol.

Dywedodd DG ei fod ef ac AH wedi cyfarfod â Phrif Weithredwr GIG Cymru a Chyfarwyddwr Cyllid GIG Cymru yn ddiweddar i'w trafod y sefyllfa ariannol. Yna gwnaeth sylwadau ar yr arbedion o £6.8m a wnaed mewn partneriaeth â Deloitte; roedd cyflawni yn hanfodol wrth leihau'r bwlch yn y cynllun cyflawni diwedd blwyddyn, fel yr oedd y camau i leihau cyflog amrywiol, gwariant gofal wedi'i gynllunio a



gwariant nad yw'n gyflog o £9m erbyn diwedd y flwyddyn. Ni chynhwyswyd y gostyngiadau gwariant hyn yn y traciwr ffurfiol ond roeddent yn ffurfio elfen allweddol o'r gostyngiad gwariant i gyflawni'r diffyg o £58.7m. Ailadroddodd DG fod cyflawni'r ddwy elfen yn hanfodol, er mwyn rhoi hyder i gyflawni'r alldro diwedd blwyddyn gofynnol.

Diolchodd JW i DG am y diweddariad ac, yn absenoldeb PP, gwahoddodd RO i roi cyngor i'r Pwyllgor Perfformiad a Chyllid. Cadarnhaodd RO fod y Pwyllgor Perfformiad a Chyllid wedi craffu'n fanwl ar y sefyllfa ariannol yn gynharach yr wythnos honno. Er bod y cynllun a'r camau gweithredu gofynnol yn glir, roedd y Pwyllgor yn pryderu bod y gyfradd redeg wedi aros yr un fath ar y pwynt hwnnw a bod yr arbedion terfynol o'r ffrydiau gwaith dan arweiniad y weithrediaeth yn dal i fod ar goll o'r traciwr arbedion.

Nododd RO rai o'r camau gweithredu uniongyrchol sydd eu hangen, gan gynnwys: gostyngiad mewn cyflog amrywiol; sylfaen gwelyau diwygiedig, yn enwedig o ran cleifion sydd wedi'u hoptimeiddio'n glinigol; cynnydd yn yr awydd i fentro mewn perthynas â chymeradwyo cyflog amrywiol; cryfhau'r tîm adferiad a chynaliadwyedd; cyfarfodydd atebolrwydd wythnosol dan arweiniad Deloitte; a goruchwyliaeth barhaus gan Aelodau Annibynnol o'r cynlluniau manwl.

Gwahoddodd JW SS i wneud sylwadau. Cadarnhaodd fod tîm Deloitte yn ystyried bod yr amcan gofynnol yn gyraeddadwy; fodd bynnag, roedd yn dibynnu ar BIPBA yn manteisio ar y cyfle; roedd hyn yn ymwneud yn bennaf â rheoli a lleihau cyflogau amrywiol. Roedd gan aelodau'r PFC hyder cyfyngedig y byddai sefyllfa mis Tachwedd yn dangos unrhyw welliant sylweddol.

Adroddodd JC ei bod wedi cael cyfarfod diweddar gyda thîm Deloitte ac oedd yn heriol. Mynegodd rywfaint o siom ynghylch y cynnydd cyfyngedig; bu'n rhaid i Grŵp Gwasanaeth Treforys sicrhau arbedion o £6.4m a galwodd JC am ddadansoddiad manwl o weithgarwch a chostau, gyda negeseuon clir ar atebolrwydd a chyfrifoldeb dros gyflawni. Roedd rhaid i'r dull fforensig o nodi arbedion fynd rhagddo ochr yn ochr â champau pendant a chryf.

Rhannodd ALF y siom a fynegwyd gan dîm Deloitte ynghylch y cynnydd araf wrth drosi cynigion yn arbedion gwirioneddol, gan fod y fethodoleg wedi gweithio i fwy nag 20 o sefydliadau eraill.

Cyfeiriodd JC at yr arbedion posibl o ymyrraeth well mewn gwasanaethau fferyllfa a dyfynnodd waith diweddar a wnaed yn yr Uned Gardiaidd yn Nhreforys a oedd wedi arwain at arbedion o £85k.



Yn sicr roedd cyfleoedd i gyflawni'r raddfa hon o welliant mewn gwasanaethau eraill BIPBA.

Sicrhaodd NZ y Bwrdd fod y Pwyllgor Archwilio (AC) wedi nodi arwyddion o atebolrwydd cynyddol; roedd cynnydd ond nid ar y cyflymder angenrheidiol. Pwysleisiodd bwysigrwydd meithrin gallu wrth wireddu buddion a pheidio â gadael unrhyw un mewn unrhyw amheuaeth ynghylch y targed arbedion gwirioneddol. Roedd hi hefyd â diddordeb mewn deall mwy am yr ymarfer ailraddio band 2/3.

O ran cyflog amrywiol, roedd yr AG o'r farn na fyddai gostyngiadau yn y maes gwariant hwn, ar eu pen eu hunain, yn cau'r bwlch. Roedd y Bwrdd wedi pennu'r camau gweithredu oedd eu hangen ar draws yr agenda ariannol ac roedd y diffyg cyflymder o ran cyflawni yn destun pryder.

Cytunodd AH na fyddai cyflawni arbedion a gostyngiadau cyfradd rhedeg hyd yma yn cau'r bwlch presennol yn llwyr ond fe wnaethant roi rhywfaint o hyder; cydnabu fod angen gweithredu ar frys ar leihau cyflog amrywiol a byddai'n galw ar gydweithwyr Gweithredol i ddal eu nerth a herio pob cais am awdurdodi staff banc/asiantaeth yn drylwyr. Roedd asesiadau diogelwch a risg priodol yn bwysig ac roedd y Gweithredwyr yn cyfarfod yn rheolaidd ag arweinwyr y Grŵp Gwasanaeth, i drafod y broses ac i egluro'r neges atebolrwydd a chyfrifoldeb. Ym mis Ionawr 2026 byddai proses uwchgyfeirio Grŵp Gwasanaeth gwelyau; byddai Aelodau Annibynnol yn cael sesiwn friffio ar hyn ac yn cyfarfod ag arweinwyr y Grŵp Gwasanaeth, i ganolbwyntio ar adferiad a chynaliadwyedd. Roedd AH eisoes wedi codi'r potensial ar gyfer ymyriadau pellach gan wasanaethau fferyllfa a diolchodd i JC am godi'r pwynt hwn.

Aeth AH ymlaen i gyfeirio at gamau gweithredu eraill sydd ar y gweill gan gynnwys (i) yr angen i gael gwared ar welyau ymchwydd o'r system; (ii) yr oriau agor estynedig a gynlluniwyd ar gyfer Uned Mân Anafiadau Ysbyty Castell-nedd Port Talbot; a (iii) bod gwaith yn mynd rhagddo ar ward nad oedd dan arweiniad meddyg yn Ysbyty Singleton i ddarparu ar gyfer cleifion nad oedd angen gofal lefel aciwt arnynt. Croesawodd NZ y diweddariad a phwysleisiodd yr angen i flaenoriaethu cyfleoedd i arbed costau.

Cytunodd AH a gwnaeth dri phwynt ychwanegol ar:

- Ailgynllunio'r gweithlu i ail-lunio'r model gwasanaeth a lleihau rhai o'r haenau rhwng y rheng flaen a'r Bwrdd.
- Yr angen i barhau i reoli absenoldeb oherwydd salwch yn gadarn; roedd gan BIPBA y cyfraddau absenoldeb oherwydd salwch uchaf o'r holl fyrddau iechyd ac roedd yn rhaid cael gwell cydbwysedd rhwng rheolaeth gadarn a lles staff.



- Y ffocws ar y 100 o bobl uchaf mewn rolau arweinyddiaeth ar draws BIPBA i sicrhau ymgysylltiad llawn wrth fynd i'r afael â'r sefyllfa ariannol. Byddai sesiwn datblygu'r Bwrdd ar 17 Rhagfyr hefyd yn ystyried dull dadansoddi a chynllunio Deloitte.

Myfyriodd JC ar y llwybr tair blynedd a phwysigrwydd cadw hyn mewn cof ochr yn ochr ag arbedion yn ystod y flwyddyn. Roedd yn rhaid i BIPBA dderbyn y lefel gywir o ad-daliad am wasanaethau a ddarparwyd ar ran byrddau iechyd eraill, ac osgoi lefelau stoc o uchel yn ddiangen.

Cyfeiriodd TR at *Drefnu ar gyfer Llwyddiant* a'r ystod o fetrigau caled a meddal a fyddai'n cefnogi mynd i'r afael â diwylliant sefydliadol a dull effeithlon o foderneiddio'r gweithlu. Tynnodd sylw at yr angen i fynd i'r afael â'r camau gweithredu a ddarparodd y manteision mwyaf yn gyntaf, drwy'r strwythur gweithredol cywir, yr arweinwyr cywir, y fethodoleg gwella gywir a nifer wedi'i hailffocysu a'i lleihau o flaenoriaethau.

Gan gyfeirio at sylwadau'r JC, cynghorodd DG y byddai fframwaith cynllunio a chyllid 2026/27 yn cael ei osod yng nghyd-destun llwybr tair blynedd, y byddai'n disgrifio'r trefniadau atebolrwydd yn glir ac y byddai'n ymgorffori'r pwyntiau a wnaed. Roedd wedi codi'r mater o ad-daliad gan fyrddau iechyd eraill gyda LIC a byddai'n parhau i wneud hynny.

Cyfeiriodd SS hefyd at sylwadau JC ar y llwybr tair blynedd; roedd yn rhaid i BIPBA orffen y flwyddyn hon mewn sefyllfa dda yn barod ar gyfer 2026/27; fodd bynnag, roedd amser bellach yn gyfyngedig i gyflawni'r bwlch a oedd, yng nghyd-destun y dyraniad ariannol cyffredinol, yn gymharol fach a dylai fod yn gyflawnadwy. Cytunodd AH a chynghorodd y byddai'r Bwrdd yn derbyn opsiynau a dewisiadau pellach mewn cyfarfod arbennig o'r Bwrdd ym mis Rhagfyr; byddai'r rhain yn cynnwys dull mwy mesuredig o ran gweithgaredd dewisol a modelau cyflawni gwahanol.

Gwahoddodd JW RE i esbonio'r meddwl y tu ôl i'r model cyflawni arfaethedig ar gyfer cleifion sydd wedi'u optimeiddio'n glinigol.

Esboniodd RE nad oedd angen gofal ysbyty aciwt mwyach ar gleifion a oedd wedi'u optimeiddio'n glinigol; roedd aros mewn lleoliad aciwt pan nad oedd hyn yn angenrheidiol mwyach yn rhoi unigolion mewn perygl ac yn cyfyngu ar eu potensial i ail-alluogi ac adsefydlu. Yn yr un modd, roedd defnydd o'r fath o welyau ysbyty aciwt yn golygu na allai'r rhai oedd angen gofal aciwt ei gael ac na allai staff cymwys iawn ac arbenigol ddefnyddio eu sgiliau i'r effaith orau. Byddai'r model



arfaethedig yn sicrhau bod cleifion sydd wedi'u optimeiddio'n glinigol yn derbyn y lefel briodol o ofal.

Diolchodd JW i RE am yr esboniad ac yna crynhodd y trafodaethau. Atgoffodd aelodau'r Bwrdd o'u hymrwymiad i gyflawni (i) y targed arbedion o £55.4m a (ii) cyflawni'r diffyg o £58.7m. Gofynnodd, yng ngoleuni'r trafodaethau ar y sefyllfa ariannol ar ddiwedd mis 07, a oedd unrhyw un eisiau ailystyried yr ymrwymiad hwnnw. Yn absenoldeb unrhyw arwydd o'r fath, cofnododd JW gadarnhad y Bwrdd o'i ymrwymiad.

Wrth ailddatgan ei hymrwymiad i gyflawni, gwnaeth JC sylwadau ar y wybodaeth, y sgiliau a'r arbenigedd sylweddol y gallai'r Aelodau Annibynnol eu cynnig i'r cydweithwyr Gweithredol i gefnogi cyflawni'r targedau gofynnol. Croesawodd JW yr atgof hwn, gan gydnabod bod y Bwrdd yn Gorff Llywodraethu Unedol a bod gan Aelodau Annibynnol ddwy rôl: craffu/dal i gyfrif a hefyd cynghori, cefnogi a chymhwyso eu harbenigedd a'u profiad penodol i waith cyfunol y Bwrdd.

Mewn pwynt olaf, cyfeiriodd DG at y llythyr Arian Parod Cyfalaf Gweithredol a Strategol 2025/26, a nodir yn Atodiad 3, a cheisiodd gymeradwyaeth y Bwrdd i'w gyflwyno i Lywodraeth Cymru. Gwnaeth y Bwrdd y canlynol:

- **CYDNABOD** bod y diffyg o £58.7m a gynhwyswyd yng Nghynllun Ariannol 2025/26 wedi atal y Bwrdd a LIC rhag ei gymeradwyo.
- **YSTYRIED** a **GWNEUD SYLWADAU AR** berfformiad ariannol BIPBA ym Mis 07 2025/26, gan gynnwys darpariaethau arian parod, cyfalaf a thaflen fantolen.
- **GOFYN** bod y camau a nodwyd hyd yma yn cael eu gweithredu i fynd i'r afael â'r bwlch arbedion o £15m, yn unol â phenderfyniadau'r Bwrdd.
- **TRAFOD A CHYDNABOD** y risgiau i'r sefyllfa ym Mis 07 ond **AILGADARNHAU** ei ymrwymiad i gyflawni arbedion o £55.4m, a'r targed diffyg o £58.7m.
- **GOFYN** i nodi camau gweithredu a dewisiadau ychwanegol i liniaru risgiau i'r sefyllfa bresennol a **CHYTUNODD** i dderbyn y rhain mewn cyfarfod arbennig o'r Bwrdd ym mis Rhagfyr.
- **CYMERADWYO'r** llythyr Arian Parod Cyfalaf Strategol a Gweithiol 2025/26 fel y nodir yn Atodiad 3.

4.4 ADRODDIAD MATERION ALLWEDDOL Y PWYLLGOR ANSAWDD A DIOGELWCH



	Cadarnhaodd JC fod trafodaethau cynharach wedi ymdrin â'r pwyntiau allweddol. Roedd AHW ac LR yn gweithio gyda HL ar y metrigau cywir i'r Pwyllgor eu hystyried. CYMERODD y Bwrdd SYLW O gynnwys yr adroddiad.
4.5 ADRODDIAD MATERION ALLWEDDOL Y PWYLLGOR PERFFORMIAD A CHYLLID i. MEDI 2025 ii. HYDREF 2025	
	Cadarnhaodd RO fod trafodaethau cynharach wedi ymdrin â'r holl bwyntiau allweddol. CYMERODD y Bwrdd SYLW O gynnwys yr adroddiad.
4.6 ADRODDIAD MATERION ALLWEDDOL Y PWYLLGOR DIGIDOL, DATA, YMCHWIL AC ARLOESI	
	Nid oedd gan AG unrhyw faterion penodol i'w codi. CYMERODD y Bwrdd SYLW O gynnwys yr adroddiad.
4.7 OPTOMETREG	
	Wrth gyflwyno'r eitem hon, cynghorodd SM mai dyma'r papur olaf mewn cyfres o bedwar papur yn cyfeirio at wasanaethau contractwyr gofal sylfaenol ac yn gysylltiedig â gwasanaethau optometreg. Amlinellodd newidiadau mawr sydd ar y gweill, gyda'r bwriad strategol o ddarparu ystod well o wasanaethau mewn gofal sylfaenol yn hytrach nag mewn ysbytai; byddai llwybrau clinigol yn cael eu darparu yn y gymuned lle bynnag y byddai hynny'n briodol. Roedd 32 o bractisau optometreg yn ardal BIPBA; roedd Gwasanaethau Offthalmoleg Cyffredinol Cymru yn nodi pum lefel o ofal: • Roedd Lefel 1 a Lefel 2 yn cyfeirio at wasanaethau gorfodol. • Roedd Lefel 3 yn cyfeirio at wasanaethau golwg gwan, roedd y rhain yn ddewisol gyda 15 o bractisau optometreg yn darparu gofal lefel 3 ar hyn o bryd. • Roedd Lefel 4 yn cyfeirio at lwybrau retina a glawcoma, gyda phum practis yn darparu'r gwasanaeth hwn ar hyn o bryd a disgwylir mwy dros amser.



- Roedd Lefel 5 yn cyfeirio at ragnodi annibynnol mewn optometreg gymunedol, gyda 14 o optometryddion o 11 practis yn rhagnodi ar hyn o bryd.

Cyfeiriodd SM hefyd at y papur atodol a oedd yn nodi'r ddarpariaeth clwstwr; cydnabu fod hyn yn y camau cynnar o ddatblygiad a byddai'n tyfu dros amser, gan gynorthwyo i ryddhau gofal a ddarparwyd yn flaenorol mewn ysbytai. Cyfeiriodd hefyd at yr enwebiad i'r Cynghorydd Optometreg ar gyfer Gwobr Optometreg Cymru.

Cyfeiriodd DL at y gwahaniaethau yn y ddarpariaeth gwasanaethau ar sail ranbarthol, gyda Bwrdd Iechyd Prifysgol Hywel Dda (BIPHDd) yn darparu mwy o gymorth cymunedol ar hyn o bryd; cadarnhaodd y disgwyliad y byddai BIPBA yn symud yn gyflymach nawr i wasanaethau cymorth cymunedol.

Gofynnodd NM sut roedd y cyhoedd yn gwybod pa wasanaethau oedd ar gael a'r ffordd orau o gael mynediad atynt. Cyfeiriodd SM at Safonau Mynediad a Chomisiynu Cymru gyfan a chadarnhaodd fod gwaith ar y gweill i ddeall yn well sut mae gwasanaethau gofal sylfaenol yn cyfathrebu â'r cyhoedd; byddai cyfleoedd cyfryngau cymdeithasol hefyd yn cael eu harchwilio gyda rhaglen gyfathrebu dreigl ar gyfer gofal sylfaenol i gynyddu gwelededd gwasanaethau i'r cyhoedd.

Gofynnodd ALF am y boblogaeth anoddach eu cyrraedd nad ydynt efallai'n weithredol ar gyfryngau cymdeithasol, cadarnhaodd SM ddisgwyliadau clir gan Lywodraeth Cymru ar opsiynau cyfathrebu eang.

Cyfeiriodd NZ hefyd at yr angen i gyfathrebu drwy ystod o opsiynau i sicrhau bod gwybodaeth yn cyrraedd cynifer o bobl â phosibl.

Gofynnodd a oedd unrhyw ystyriaeth wedi'i gwneud o arbedion costau neu osgoi costau.

Cynghorodd DL y byddai'r dull rhanbarthol cyson sy'n seiliedig ar y gymuned yn arwain at fwy o effeithlonrwydd a chynhyrchiant.

Croesawodd JW y gyfres o bedwar papur a oedd wedi bod yn addysgiadol ac yn llawn gwybodaeth; estynnodd ei diolch i SM am gydlynw a chyflwyno'r gyfres o bapurau.

Gwnaeth y Bwrdd y canlynol:

- **DERBYN** yr adroddiad Optometreg a oedd yn rhoi trosolwg eang o wasanaethau optometreg gofal sylfaenol a ddarperir ar gyfer cymunedau BIPBA.
- **CYDNABOD** y cynnydd sylweddol a wnaed wrth weithredu gwasanaethau WGOS.



4.8 DIWEDDARIAD CYFALAF AC YSTADAU

Croesawodd JW y papur hwn fel y papur cyfalaf ac ystadau cyfun cyntaf. Gwahoddodd DG i dynnu sylw at y materion allweddol.

Tynnodd DG sylw at

- Cymeradwywyd Strategaeth Ystadau BIPBA (y Strategaeth) yn 2023, a dyma oedd sail y dull strategol o reoli ystadau. Pryd hynny, roedd Llywodraeth Cymru wedi canmol y Strategaeth ac wedi defnyddio'r dull a'r fformat fel templed ar gyfer byrddau iechyd eraill.
- Y ffaith bod 75% o'r ystâd bresennol yn fwy na 30 mlwydd oed, gan ei gwneud hi'n heriol darparu gofal clinigol modern. Arweiniodd oedran yr ystâd hefyd at gynydd yn y galw am waith cynnal a chadw ac roedd ôl-groniad o waith cynnal a chadw wedi cronni dros amser; rhoddwyd blaenoriaeth i faterion risg uchel, ond parhaodd risgiau eraill.
- Adnewyddu'r model gwasanaethau clinigol; byddai hyn yn ddiamau yn cynnwys ystyried yr ystâd a'i haddasrwydd at ei ddiben.
- Y pedwar cynllun sydd angen cyllid cyfalaf tymor byr ar frys: gofal aciwt i oedolion yn CCH; yr adran achosion brys (ED) yn Ysbyty Treforys; patholeg gellog ranbarthol; a Ward Taith yn Ysbyty Glanrhyd.
- Y lle cyfyngedig i symud a'r angen i sicrhau bod mwy o gapasiti symud ar gael i gefnogi rhaglenni cynnal a chadw.

Diolchodd JW i DG am y diweddariad; roedd yn ddarlleniad difrifol. Yna gwahoddodd AH gwestiynau:

Cyfeiriodd ALF at y £400k ar gyfer safle Ysbyty Castell-nedd Port Talbot; gofynnodd a oedd hyn yn ymwneud â gwaith cynnal a chadw cyfredol neu a oedd yn gysylltiedig â'r trefniant PFI. Cadarnhaodd DG fod yr holl waith cynnal a chadw ar gyfer Ysbyty Castell-nedd Port Talbot yn rhan o'r cytundeb PFI, (roedd dau adeilad ar y safle dan berchnogaeth BIPBA ac wedi'u heithrio o'r cytundeb PFI).

Myfyriodd JC ar ganmoliaeth LIC i'r Strategaeth; roedd trafodaethau ac adroddiadau'r Bwrdd yn 2025/26 wedi cynnwys cyfeiriad at bryderon sylweddol yn ymwneud ag ystadau a methiannau seilwaith trychinebus posibl. Roedd hwn yn bwynt arwyddocaol a gofynnodd JW i DG gynhyrchu briff ar gynllunio parhad busnes sy'n gysylltiedig ag ystadau.

Cam Gweithredu: DG



Croesawodd NZ yr eglurder ar risg a'r camau gweithredu gofynnol a nodir yn y papur, a mynegodd bryder ynghylch effeithiau'r risgiau a effeithiodd ar lawer o ystâd y bwrdd iechyd.

Cofiodd RO am dro yn Ysbyty Treforys, pan oedd methiant trydan wedi atal gweithgaredd y theatr; roedd hyn yn enghraifft o'r broblem seilwaith. Mynegodd bryder hefyd ynghylch diffyg cyfleusterau dywallt dŵr ar y safle a'r goblygiadau ar gyfer atal a rheoli heintiau. Cytunodd DL a chyfeiriodd at y cynllun i agor ward yn Singleton fel ffordd o ddarparu cyfleuster adleoli ar safle Treforys.

Adeiladodd AH ar y pwynt olaf, gan nodi'r bwriad i nodi rhaglen ffurfiol ar gyfer symud wardiau a chanolbwyntio ar yr agenda atal a rheoli heintiau fel rhan o hynny.

Gwnaeth y Bwrdd y canlynol:

- **TRAFOD** cynnwys manwl yr adroddiad a **CHYDNABOD** y risgiau sylweddol sy'n deillio ohono, ynghyd â'r camau lliniaru sydd eu hangen i reoli'r cyfyngiadau.
- **CYDNABOD** pwysigrwydd y wybodaeth yn y broses o wneud penderfyniadau, yn enwedig o ystyried y rhyngwyneb clir rhwng asesiadau ystadau a'r Cynllun Gwasanaethau Clinigol.
- **TRAFOD** a **CHYTUNO** ar amserlenni ar gyfer diweddariadau cynnydd a goruchwyliaeth ar lefel y Bwrdd.
- **CADARNHAU**'r angen am gyfleusterau adleoli i greu lle ar gyfer gwaith cynnal a chadw a datblygiadau, ac i symud yr agenda atal a rheoli heintiau ymlaen.
- **CADARNHAU** moderneiddio gweithlu'r ystadau i gynyddu recriwtio a chadw staff i ddiwallu anghenion BIPBA.
- **CYDNABOD** y gwaith sydd ar y gweill i ddatblygu opsiynau ar gyfer modelau ariannu yn y dyfodol a allai gyflymu gwaith datblygu cyfalaf.

RHAN 5. POBL

5.1 ADRODDIAD MATERION ALLWEDDOL Y PWYLLGOR GWEITHLU A DARPARU DIWYGOL

Cadarnhaodd RO nad oedd ganddi ddim i'w ychwanegu at y manylion a nodwyd yn yr adroddiad.

CYMERODD y Bwrdd **SYLW O** gynnwys yr adroddiad.

5.2 DIWEDDARIAD RHAGLEN WEDI'I DREFNU AR GYFER LLWYDDIANT



Wrth gyflwyno'r adroddiad, nododd TR y Rhaglen fel galluogwr clir i gynorthwyo BIPBA i ddod yn sefydliad perfformio uchel. Adroddodd fod:

- y Rhaglen wedi defnyddio gwybodaeth o nifer o ffynonellau, gan gynnwys risgiau strategol, papurau'r Bwrdd, metrigau gweithlu caled a meddal a bwriadau cynllunio.
- Roedd y cyfnod ansefydlogrwydd diweddar gyda nifer o newidiadau i'r Bwrdd ac uwch arweinyddiaeth wedi effeithio ar ddatblygiad sefydliadol.
- Roedd angen dod allan o newidiadau i ddarparu gwasanaethau sy'n gysylltiedig â COVID-19, yng nghyd-destun sefyllfa ariannol heriol.
- Roedd consensws ynghylch yr arddull arweinyddiaeth a ffefrir yn bwysig.
- Roedd barn y staff, fel y'i mynegwyd yn yr Arolwg Staff, yn addysgiadol.
- Roedd yr amrywiad mewn capasiti a gallu rheoli yn fater allweddol.
- Roedd arwyddion o ymddiriedaeth gyfyngedig ymhlith y gweithlu, a oedd yn amlwg mewn sgoriau ymgysylltiad a metrigau ehangach fel cyfraddau absenoldeb oherwydd salwch, yn ddirgel.

I fynd i'r afael â hyn, cynigiodd TR strategaeth tair blynedd, yn cynnwys: Blwyddyn 1 - cael y pethau sylfaenol yn iawn; Blwyddyn 2 - trawsnewid; a Blwyddyn 3 - atgyfnerthu. Gofynnodd am gymeradwyaeth y Bwrdd ar Gylch Gorchwyl y Rhaglen, gan gynghori y byddai hyn yn cynnwys gweithio'n rhanbarthol gyda BIPHDd. Byddai Cam 1 hefyd yn cynnwys cyflwyno Uned Gyflawni, gan ddod â swyddogaethau rheoli prosiectau a gwella, sydd wedi'u gwasgaru ar draws y sefydliad ar hyn o bryd, i mewn i dîm unedig, cydlynol. Byddai ymgynghoriad ar Gam 2 yn lansio cyn bo hir, gan gynnig symud oddi wrth fodel sy'n seiliedig ar leoliad i fodel grŵp gofal thematig, wedi'i drefnu o amgylch gwasanaethau a llwybrau cleifion. Byddai hyn yn golygu ailgrwpio arbenigeddau i wneud y gorau o gynhyrchiant ac effeithlonrwydd a chynyddu buddion i gleifion. Byddai'r ymgynghoriad hefyd yn cwmpasu'r model arweinyddiaeth a ffefrir, wedi'i gefnogi gan raglen datblygu arweinyddiaeth i gyfarparu arweinwyr â'r sgiliau a'r cymwyseddau cywir. Byddai Cam 3 yn fformatio grwpiau gofal fel unedau busnes, wedi'u cynllunio i lwyddo a chyda mynediad at gymorth.



Byddai strategaeth gyfathrebu ar gyfer pob cam, gydag ymgysylltiad cryf, ymgorffori rheoli perfformiad a llinellau atebolrwydd clir. Yna cyfeiriodd TR at bwynt JC ar ddiwylliant a phwysleisiodd bwysigrwydd lleihau nifer y blaenoriaethau, gyda metrigau clir ac un fethodoleg gwella; gyda'i gilydd, byddai'r nodweddion hyn yn sbarduno dull sefydliad-gyfan, wedi'i ategu gan werthoedd ac ymddygiadau a rennir. Byddai strwythur llywodraethu'r rhaglen yn cynnwys grŵp llywio ar lefel weithredol gyda'r Bwrdd yn ystyried y penderfyniadau strategol allweddol.

Diolchodd JW i TR am y gwaith helaeth oedd ei angen i gyrraedd y pwynt hwn; yna gofynnodd am sylwadau/cwestiynau.

Cymeradwyodd SS y gwaith a'i nod bwriadedig. Gofynnodd a ddylai Cyfnod 3 ddigwydd yn gynharach, er mwyn cael yr effaith fwyaf; amlinellodd TR y rhesymeg y tu ôl i'r cyfnodau, gan dynnu sylw at bwysigrwydd yr Uned Gyflawni yng Nghyfnod 1.

Croesawodd NZ y drafodaeth; roedd yn ategu'r wybodaeth yn y papur. Cwestiynodd a fyddai proses newid mor arwyddocaol ar hyn o bryd yn tynnu sylw oddi ar yr agenda weithredol frys. Wrth ymateb, cynghorodd TR y byddai Cam 2, mewn gwirionedd, yn clystyru timau presennol gyda'i gilydd mewn ffordd fwy cydlynol ac yn cynorthwyo cynhyrchiant ac effeithlonrwydd.

Gofynnodd NZ hefyd a fyddai'r amserlenni arfaethedig yn caniatáu digon o amser ar gyfer ymgysylltu ystyrion â staff. Derbyniodd TR yr angen i ddod o hyd i'r cydbwysedd cywir rhwng cyflymder y newid a rhoi amser i staff weithio drwy'r newidiadau. Roedd brys i'r ailstrwythuro, fodd bynnag, i symleiddio'r trefniadau presennol ac i wneud y gorau o'r dalent arweinyddiaeth a rheolaeth ddiamheuol sy'n amlwg ar draws BIPBA.

O ran y risg o dynnu sylw oddi wrth gyflawni'r agenda weithredol frys, roedd TR a DL ill dau yn cydnabod hyn fel risg anochel a oedd yn gofyn am oruchwyliaeth a gweithredu gan reolwyr cadarn. Ceisiodd NZ gynnwys y risg hon ar y gofrestr risgiau berthnasol. Cefnogodd cydweithwyr y bwrdd hwn.

Cam Gweithredu: HL

Croesawodd JC fformat syml a chlir y cynnig; myfyriodd ar raddfa sylweddol y rhaglen newid a fyddai'n gofyn am newid mawr mewn diwylliant mewn rhai meysydd. Roedd angen ymrwymiad ar draws y sefydliad i wneud cynnydd a chyflawni. Gofynnodd am sicrwydd bod cynllun wrth gefn ar gael, pe bai unrhyw rwystrau i newid yn codi. Cadarnhaodd TR y bwriad i gymhwyso offeryn asesu 'Adolygiad Porth', gyda goruchwyliaeth lefel weithredol o'r broses.



Gofynnodd ALF am gofnodi'r hyn a oedd wedi gweithio'n dda o dan y model rheoli lleol, i lywio'r rhaglen newid; gofynnodd hefyd am wybodaeth am gymhwyso model y grŵp gofal mewn mannau eraill. Dywedodd DL fod sawl bwrdd iechyd wedi symud i ffwrdd o fodelau lleol a bod eraill yn bwriadu gwneud hynny. Roedd model llwybr gofal yn tueddu at ddiogelwch ac ansawdd darpariaeth gwasanaeth mwy cyson, gyda llai o ddull seilo.

Croesawodd LR y strwythur cyfan-BIPBA y byddai'r cynnig yn ei gyflawni, roedd hyn yn cryfhau llywodraethu ac yn lleihau'r haenau rhwng cleifion, y rheng flaen a'r Bwrdd. Roedd hi'n cydnabod y byddai rhai heriau ond roedd hi'n hyderus y byddai'r dull graddol yn helpu i reoli hynny.

Croesawodd AH y cynnydd, gan gydnabod nad oedd un strwythur perffaith gan fod rhyngwynebau rhwng gwasanaethau a swyddogaethau yn anochel. Byddai'r model arfaethedig yn rhoi amser i staff clinigol ystyried a chynllunio gwasanaethau ar sail gwelliant parhaus, gyda'r Weithrediaeth a'r Bwrdd yn cadw eu ffocws strategol ar alluogi newid.

CYMERADWYDD y Bwrdd Gylch Gorchwyl y Rhaglen wedi'i Drefnu ar gyfer Llwyddiant a **CHYMERADWYDD** y strwythur llywodraethu ar gyfer y Rhaglen, fel y'i nodir yn yr adroddiad.

5.3 DEDDF LEFELAU STAFF NYRSIO (CYMRU) 2016

Wrth gyflwyno'r adroddiad, cyfeiriodd LR at y newidiadau sefydliadol y cytunwyd arnynt, yn dilyn yr adolygiad aciwtedd; cadarnhaodd gydymffurfiaeth â gofynion Deddf Staffio Nyrsys (Cymru) 2016. Mewn ymateb i ymholiad gan KL, cadarnhaodd LR fod y niferoedd yn cynnwys myfyrwyr nyrsio.

Gwnaeth y Bwrdd y canlynol:

- **CYMRYD SYLW** o gynnwys y papur hwn.
- **CYMRYD SICRIFYDD** bod BIPBA yn cyflawni ei gyfrifoldebau o dan y Ddeddf Lefelau Staffio Nyrsys (NSLWA), fel yr amlinellwyd yn Atodiad 3.
- **CYMERODD SICRIFYDD** bod BIPBA yn cyflawni ei ddyletswydd statudol o dan Adran 25B o'r Ddeddf Lefelau Staffio Nyrsys, yn seiliedig ar y dystiolaeth a gyflwynwyd yn y papur a'r atodiadau cysylltiedig.
- **CYDNABOD** y newidiadau y cytunwyd arnynt i sefydliadau nyrsio a ariennir, yn deillio o adolygiad aciwtedd Mehefin 2024 ac fel y cytunwyd yng nghyfarfod y Bwrdd ar 28 Tachwedd 2024.



- **CYDNABOD** y sefydliadau a ailgyfrifwyd o archwiliadau aciwtedd Ionawr 2025 (fel y manylir yn Atodiad 2) a oedd yn cefnogi cydymffurfiaeth â gofynion statudol y Ddeddf Lefelau Staffio Nyrsys.
- **CYDNABOD** bod y dilysu wedi'i gwblhau o'r set sgiliau Band 2 i Fand 3 ar draws pob ward wedi'i gydnabod fel pwysau cost.
- **CYMERADWYO'r** newidiadau gofynnol i'r sefydliadau nyrsio a ariennir yn dilyn archwiliad aciwtedd chwemisol Mehefin 2025, gan gynnwys cymeradwyo'r effaith ariannol ychwanegol a'r pwysau cost o ganlyniad i effaith ariannol ychwanegol dros flwyddyn lawn o £25,334 i Dreforys; arbediad cost o £220,165 i Grŵp Gwasanaeth Singleton Castell-nedd Port Talbot (NPTSSG) (yr oedd £104,055 ohono yn anghylchol tan ddiwedd y flwyddyn ariannol).
- **CYDNABOD** bod y newidiadau wedi sicrhau cydymffurfiaeth barhaus â'r Ddeddf Lefelau Staffio Nyrsys.

RHAN 6. LLYWODRAETHU

6.1 ADRODDIAD MATERION ALLWEDDOL Y PWYLLGOR ARCHWILIO

Rhybuddiodd NZ y Bwrdd am golledion taliadau arbennig a gofnodwyd rhwng mis Ebrill 2025 a mis Gorffennaf 2025; roedd hyn yn cyfateb i bron i £692k; cyfeiriodd hefyd at yr angen i ymateb i gwynion mewn modd amserol. Cadarnhaodd fod yr holl faterion eraill wedi cael eu hystyried yn ystod y cyfarfod heddiw.

CYMERODD y Bwrdd **SYLW O** gynnwys yr adroddiad.

6.2 ADRODDIAD MATERION ALLWEDDOL PWYLLGOR DEDDFWRIAETH IECHYD MEDDWL

Cadarnhaodd ALF nad oedd unrhyw faterion penodol i'w codi.

CYMERODD y Bwrdd **SYLW O** gynnwys yr adroddiad.

6.3 ADRODDIAD MATERION ALLWEDDOL Y PWYLLGOR CRONFEYDD ELUSENNOL

Cadarnhaodd NM nad oedd unrhyw faterion penodol i'w codi.

CYMERODD y Bwrdd **SYLW O** gynnwys yr adroddiad.



6.4 ADRODDIAD LLYWODRAETHU CORFFOROL

- ADOLYGIAD O'R RHEOLAU SEFYDLOG**

Rhoddodd HL y wybodaeth ddiweddaraf am yr adolygiad o'r Rheolau Sefydlog a materion eraill.

Gwnaeth y Bwrdd y canlynol:

- **DERBYN** y Materion a ystyriwyd yn y Pwyllgor yng nghyfarfod diwethaf y Bwrdd; Cylchlythyrau Iechyd Cymru; y Gofrestr Sêl Gyffredin; Cylch Busnes y Bwrdd.
- **CYMERADWYO'r** Rheolau Sefydlog a'r Cyfarwyddiadau Ariannol Sefydlog.

6.5 COFNOD O GYFARFODYDD BLAENOROL BWRDD BIPBA

i. **11 MEDI 2025**

ii. **25 MEDI 2025**

CYMERADWYO'r Bwrdd y ddau set o gofnodion fel cofnod gwir a chywir o'r cyfarfodydd.

6.6 LOG GWEITHREDU

Rhoddodd HL ddiweddariad ar y Log Camau Gweithredu a'r sefyllfa yn erbyn pob cam gweithredu.

RHAN 7. EITEMAU I'W NODI

7.1 ADRODDIAD GRWPFAU CYNGHORI'R BWRDD

i. **FFORWM PARTNERIAETH Y BWRDD IECHYD**

NODODD y Bwrdd adroddiad Fforwm Partneriaeth y Bwrdd Iechyd.

7.2 ADRODDIAD BLYNYDDOL AROLYGIAETH GOFAL IECHYD CYMRU

NODODD y Bwrdd Adroddiad Blynyddol Arolygiaeth Gofal Iechyd Cymru 2024-25.

7.3 ADRODDIAD A LLYTHYR BLYNYDDOL OMBWDSMON Y GWASANAETH CYHOEDDUS



	NODODD y Bwrdd Adroddiad a Llythyr Blynnyddol yr Ombwdsmon Gwasanaeth Cyhoeddus.
7.4 ADRODDIAD Y CADEIRYDD	
	NODODD y Bwrdd Adroddiad y Cadeirydd.
RHAN 8. EITEMAU I'W TRAFOD	
8.1 UNRHYW FATER ARALL	
	Dywedodd JW mai dyma fyddai cyfarfod olaf Bwrdd KL fel Cyngorydd Marchnata, gan ei fod yn camu i lawr ddiwedd mis Rhagfyr. Myfyriodd ar y digwyddiadau allweddol yn ystod ei gyfnod yn y swydd, ac yn enwedig rôl y Bwrdd wrth lywio'r sefydliad drwy bandemig Covid-19. Roedd KL wedi gwasanaethu ar nifer o bwyllgorau'r Bwrdd, wedi cefnogi Rhaglen ARCH a menter Bargen Ddinesig Abertawe. Roedd gan BIPBA bartneriaeth gref â Phrifysgol Abertawe a byddai KL yn parhau i gefnogi'r agenda mewn nifer o ffyrdd, gan gynnwys fel Athro Seiciatreg a chadeirydd Technoleg Iechyd Cymru. Ymunodd holl gydweithwyr y Bwrdd â KL i ddymuno'n dda iddo ar gyfer y dyfodol. Diolchodd KL i JW am ei geiriau caredig a diolchodd i'w holl gydweithwyr am eu dymuniadau gorau. Roedd wedi croesawu'r cyfle i wasanaethu ar y Bwrdd ac yn edrych ymlaen at barhau â'i gyfranogiad yn y dyfodol.
8.2 ADOLYGIAD O EFFEITHIOLRWYDD CYFARFODYDD	
	Darparodd AG grynodedb o'r cyfarfod, gan grynhoi'r ystod heriol ac amrywiol o faterion a drafodwyd a pha mor hanfodol yw gwneud penderfyniadau effeithiol ar lefel y Bwrdd. Byddai'n rhannu ei nodyn briffio gyda HL i'w adolygu a dysgu ar gyfer cyfarfod Ionawr 2026.
Cyfarfod Nesaf y Bwrdd Iechyd: 29 Ionawr 2026	

Daeth y cyfarfod i ben am 16:01.



Bwrdd Iechyd Prifysgol Bae Abertawe (BIPBA)
Cofnodion Cyfarfod Arbennig y Bwrdd
a gynhaliwyd ar 16 Rhagfyr 2025 am 2:00pm

Yn bresennol:		
Jan Williams	(JW)	Cadeirydd
Stephen Spill	(SS)	Is-gadeirydd
Abigail Harris	(AH)	Prif Swyddog Gweithredol
Marie Davies	(MD)	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau
Richard Evans	(RE)	Cyfarwyddwr Meddygol Gweithredol a Dirprwy Brif Weithredwr
Deb Lewis	(DL)	Prif Swyddog Gweithredu/Cyfarwyddwr Gweithredol Gofal Sylfaenol a Chymunedol ac Iechyd Meddwl ac Anableddau Dysgu
Anne-Louise Ferguson	(ALF)	Aelod Annibynnol
Andrew Griffiths	(AG)	Aelod Annibynnol
Darren Griffiths	(DG)	Cyfarwyddwr Gweithredol Cyllid a Pherfformiad
Keith Lloyd	(KL)	Aelod Annibynnol
Martin Lloyd	(ML)	Aelod Annibynnol
Nicola Matthews	(NM)	Aelod Annibynnol
Reena Owen	(RO)	Aelod Annibynnol
Patricia Price	(PP)	Aelod Annibynnol
Tina Ricketts	(TR)	Cyfarwyddwr Gweithredol y Gweithlu a Datblygu Sefydliadol
Liz Rix	(LR)	Cyfarwyddwr Gweithredol Nyrsio a Phrofiad y Claf
Nuria Zolle	(NZ)	Aelod Annibynnol (trwy Teams)

Yn Bresennol:		
Matthew John	(MJ)	Cyfarwyddwr Digidol
Hazel Lloyd	(HL)	Cyfarwyddwr Llywodraethu Corfforaethol
Carys Richards	(CR)	Uwch Reolwr Llywodraethu Corfforaethol
Richard Thomas	(RT)	Cyfarwyddwr Mewnwelediad, Cyfathrebu ac Ymgysylltu

Ymddiheuriadau:		
Jean Church	(JC)	Aelod Annibynnol
Christine Morrell	(CM)	Cyfarwyddwr Gweithredol Therapiau a Gwyddor Iechyd
Gill Richardson	(GR)	Cyfarwyddwr Gweithredol Iechyd y Cyhoedd (Dros Dro)



Arsylwyr

Ashleigh O'Callaghan AO Prif Swyddog Busnes

Acronymau

BIPBA	Bwrdd Iechyd Prifysgol Bae Abertawe	LIC	Llywodraeth Cymru
CIC (CHC)	Gofal Iechyd Parhaus y GIG	IM	Iechyd Meddwl
JCC	Cydbwyllgor Comisiynu	MIU	Uned Mân Anafiadau
AD (LD)	Anabledd Dysgu	PPC	Pwyllgor Perfformiad a Chyllid

Dechreuodd y cyfarfod am 14:03.

Cyfeirnod y Cofnod:	Eitem ar yr Agenda

RHAN 1. MATERION RHAGARWEINIOL

1.1 CROESO A SYLWADAU CYFLWYNIADOL

220/25	Estynnodd JW groeso cynnes i bawb a oedd yn bresennol yn y cyfarfod. Nododd rôl y Bwrdd fel Corff Llywodraethol y sefydliad, gan gyfarfod bob deufis, gydag agenda a oedd yn cwmpasu lled cyfrifoldebau'r Bwrdd. Roedd achlysuron pan oedd yn rhaid i'r Bwrdd gyfarfod y tu allan i'r cylch cyfarfodydd arferol, i ystyried materion penodol; byddai'r cyfarfod arbennig hwn yn derbyn adroddiad ar yr asesiad ariannol diweddaraf o'r heriau ariannol a'r camau gweithredu i gau'r bwlch arbedion, a'r camau gweithredu sydd eu hangen i fynd i'r afael â nhw.

1.2 YMDDIHEURIADAU AM ABSENOLDEB

221/25	Roedd Jean Church, Nuria Zolle, Keith Lloyd, Chris Morrell, a Gill Richardson wedi cyflwyno eu hymddiheuriadau am y cyfarfod.

1.3 DATGANIAD O FUDDIANNAU

222/25	Nid oedd unrhyw ddatganiadau o fuddiant heblaw am y rhai a nodwyd eisoes ar y gofrestr.



RHAN 2. PRIF AGENDA

2.1 Y CYNLLUN 2025/26 A'R ASESIAD ARIANNOL DIWEDDAREDIG

223/25

Ymddiheurodd JW i'r Bwrdd am gyhoeddi'r adroddiad yn hwyr; roedd hyn yn deillio o'r angen i gyflwyno'r sefyllfa ddiweddaraf bosibl, yn barod ar gyfer y Cyfarfod Atebolrwydd Cyhoeddus gydag Ysgrifennydd y Cabinet a swyddogion Llywodraeth Cymru (LIC) ar 18 Rhagfyr 2025. Gwahoddodd DG i arwain aelodau'r Bwrdd drwy'r adroddiad, gan dynnu sylw at y materion allweddol i'w trafod a'u hystyried.

Cyfeiriodd DG at bwrpas yr adroddiad: nodi'r camau gweithredu ar y cyd sydd eu hangen i fynd i'r afael â'r bwlch cynilo. Tynnodd sylw at y canlynol:

- Y diffyg o £4.2m ym mis 08; dyma oedd yr ail safle gorau yn y flwyddyn hyd yma;
- Y sefyllfa o £51.4m hyd yma; roedd hyn £12.3m yn uwch na'r cynllun a nodwyd ac yn caniatáu gorwariant o uchafswm o £7.3m yn ystod chwarter olaf 2025/26, sy'n cyfateb i £1.8m neu well y mis.
- Nododd y cynllun opsiynau arbed gwerth £55.4m, gyda rhagolwg o gyflawniad o £42.4m, gyda £33.8m o hyn yn cyfeirio at gynlluniau arbed a roddwyd ar draciwr LIC ac £8.6m o gyfleoedd eraill yn ystod y flwyddyn.
- Y ffocws allweddol ar gyfer elfen arbedion y Cynllun oedd cynlluniau dan arweiniad y Weithrediaeth a rheolaethau ychwanegol diwedd blwyddyn ar wariant; cyfeiriodd DG at y diweddariad sefyllfa a geir ar Dudalen 9 yr adroddiad a chadarnhaodd y byddai'r swm, os caiff ei gyflawni, bron yn ddigonol i gau'r bwlch arbedion.
- Roedd y gwaith wedi'i gynllunio i ddiwygio'r model gwelyau; roedd y gwaith hwn wedi dechrau, i'w weithredu ym mis Ionawr 2026; byddai'n helpu i liniaru'r her bresennol o ran gwella llif a rhyddhau capasiti yn ôl i'r system.
- Cyfleoedd gwella gofal brys ac argyfwng, gan gynnwys craffu ar, ac ailgynllunio'r gweithlu yn, yr Uned Mân Anafiadau (MIU) ac ysbyty Castell-nedd Port Talbot. Roedd cynlluniau cymunedol hefyd yn destun craffu drwy Adolygiad Gwasanaethau



	Cymunedol, a ddisgwylir i ddarparu canfyddiadau cychwynnol ddiwedd mis Rhagfyr 2025. • Byddai'r ffaith bod arbedion o £6.8m a gyflawnwyd yn 2025/26 yn arwain at oddeutu £30m o arbedion cylchol yn 2026/27. • Camau pellach ar gyflog amrywiol, gan gynnwys rheolaethau a ddatblygwyd gyda chefnogaeth y partner strategol (Deloitte), i'w cymhwyso ar draws y gweithlu. Bellach, roedd cyfarwyddwyr gweithredol yn craffu ar swyddi gwag ac yn eu llofnodi, gyda chyflwyniad rheolaethau seiliedig ar systemau, gan gynnwys dyraniad cyllideb yn seiliedig ar oriau, i sicrhau gweithrediad drwy gydol y mis. • Effaith (i) salwch ac absenoldeb a (ii) y cynnydd diweddar mewn aciwtedd trwy lwybrau brys; roedd y ddau hyn yn gosod galwadau ychwanegol ar wasanaethau wrth i gyfnod y Nadolig agosáu. • Y cais gan Lywodraeth Cymru i ddarparu 3000 o apwyntiadau cleifion allanol ychwanegol y flwyddyn a llawdriniaeth bariatrig a chardiaidd ychwanegol, i gefnogi'r sefyllfa Cymru gyfan; pwysleisiodd y Cyfarwyddwr Cyffredinol bwysigrwydd sicrhau iawndal llawn am y gweithgaredd ychwanegol hwn. • Rheolaethau ychwanegol wedi'u sefydlu ar faterion di-dâl, gyda staff uwch yn craffu ar geisiadau prynu ac yn eu cymeradwyo; roedd hyn yn cynnwys ystyried y potensial i atal mynediad i rai llinellau catalog wrth i ddiwedd y flwyddyn ariannol agosáu. Roedd ymarfer ar y gweill i nodi gohirio archebu yn ddiogel tan 2026/27. • Y cynlluniau y gellir eu gweithredu – a nodir ar Dudalen 9 – i gyrraedd y bwlch o £13.1m; roedd y rhain yn cyfrif am £11.7m gan arwain at ddiffyg o £1.4m sydd eto i'w gwrdd ag ef. • Y camau nesaf a'r cyfleoedd ychwanegol a nodwyd ar Dudalennau 11 a 12 o'r adroddiad. Ceisiwyd cefnogaeth y Bwrdd i ymgymryd â gwaith pellach ar bedwar cam gweithredu: (i) Ymestyn y bwlch cyflog amrywiol o'r lefel bresennol o 50% i 60%, gan ryddhau £1.4m ychwanegol, gydag asesiadau effaith yn sicrhau ystyriaeth ffocws o ddiogelwch. (ii) Newidiadau i'r model gofal brys a gofal heb ei drefnu, gyda ffocws ar ailgynllunio'r Uned Mân Anafiadau;



	byddai hyn yn rhyddhau effaith rhan-flwyddyn o tua £0.4m. (iii) Roedd capasiti'r theatr a gynlluniwyd yn fwy na'r hyn sy'n ofynnol i drin y 1,397 o bobl sy'n aros am driniaeth fel rhan o'r ymrwymiad 104 wythnos. Ym mis Ionawr 2026 byddai gwaith i gohortio cleifion a gwneud y defnydd gorau o argaeledd theatrau, gan leihau capasiti lle bo modd, ac arbed costau cyflog amrywiol a chostau nad ydynt yn gysylltiedig â chyflog - byddai meintioli arbedion yn dilyn. (iv) Adolygiad manwl, yn ystod Chwarter 4, o Gytundebau Hirdymor ar draws yr holl ddarparwyr, fel y'i hamlygwyd gan y partner strategol. O'u hystyried gyda'i gilydd, cynghorodd DG y byddai digon o werth yn y camau gweithredu pellach hyn i gau'r bwlch rhwng £13.1m ac £11.7m. Roedd y Pwyllgor Perfformiad a Chyllid (PFC) wedi ystyried y camau gweithredu y bore hwnnw ac roedd yr adroddiad gerbron y Bwrdd yn adlewyrchu trafodaethau'r PFC. Diolchodd JW i DG am ei ddiweddariad manwl; gwahoddodd AH i wneud sylwadau cyn agor y drafodaeth. Cydnabu AH yr angen i wthio ymhellach ar arbedion yn Chwarter 4 a dywedodd fod y Tîm Gweithredol wedi trafod a chymeradwyo'r camau gweithredu. Myfyriodd ar yr angen i osod y camau cyflog amrywiol yng nghyd-destun cynnydd sylweddol yn nifer y staff cyffredinol yn ystod y blynnyddoedd diwethaf. Byddai tîm Deloitte yn cefnogi'r gwaith i ysgogi arbedion ac ymdrin â'r diffyg sylfaenol, gyda'r camau gweithredu ychwanegol a gynigiwyd ar gyfer Chwarter 4 wedi'u cynllunio i gyflymu'r ddarpariaeth. Gwahoddodd JW gwestiynau ar sail thema, gan ddechrau gydag iechyd meddwl: Cyfeiriodd NM at gynlluniau i leihau nifer y lleoliadau iechyd meddwl y tu allan i'r ardal a gofynnodd sut y byddai gwasanaethau'n darparu gofal diogel yn lleol. Ceisiodd ML gadarnhad y byddai cynllunio gwasanaethau iechyd meddwl (IM) a gwasanaethau anabledd dysgu (AD) yn adlewyrchu anghenion gwahanol y ddau grŵp o gleientiaid. Ceisiodd RO gadarnhad o ymgysylltiad partneriaid awdurdod lleol, o ystyried yr angen i weithio mewn partneriaeth i ailwladoli pobl, yn enwedig i opsiynau gofal yn y gymuned.



Gan ymateb i'r pwyntiau hyn yn eu tro, cynghorodd AH:

- (i) O ran lleoliadau y tu allan i'r ardal, roedd cyfarfodydd gweithredol ar y gweill gyda'r Grŵp Gwasanaeth IMCD i benderfynu ar y ffordd orau o osgoi lleoliadau o'r fath; byddai adolygiad achos wrth achos yn sicrhau'r defnydd gorau posibl o welyau a gwasanaethau lleol, gyda chraffu ychwanegol ar leoliadau a wneir y tu allan i'r ardal. Hefyd, adroddodd MD fod lleoliadau a ariannwyd o dan gategori Gofal Iechyd Parhaus y GIG (CHC) cyffredinol nid yn unig yn cynnwys lleoliadau a ariannwyd yn llawn gan y GIG, ond hefyd pecynnau gofal a ariannwyd ar y cyd a gofynion gwasanaeth ôl-ofal adran 117 a fyddai'n cynnwys gweithio mewn partneriaeth. Byddai cyflwyno system ddigidol i gasglu data yn caniatáu olrhain gwell a gwell a rheolaeth agosach ar leoliadau y tu allan i'r ardal. Cadarnhaodd DL y bwriad i wella'r seilwaith lleol, i ysgogi'r defnydd gorau o gapasiti arbenigol lleol; roedd hwn yn fater Cymru gyfan a byddai'n golygu gweithio gyda'r Cydbwyllgor Comisiynu (JCC) hefyd ar lefel leol, ar sut y gallai cleifion gamu i lawr yn ddiogel o'r ysbyty i ofal â chymorth cymunedol.
- (ii) Cadarnhaodd AH fod gwasanaethau Iechyd Meddwl ac Anabledd Dysgu yn cael eu hystyried ar y cyd, fel rhan o'r un Grŵp Gwasanaeth, ac ar wahân, o ran modelau gwasanaeth; roedd ymarfer 'plymio dwfn' mwy manwl i'r dyraniadau cyllideb ar gyfer y ddau wasanaeth ar y gweill, gyda'r cyfarfod cyntaf, a fynychwyd gan Deloitte, yn ystyried y gyfradd rhedeg gormodol o 12% yn erbyn y gyllideb ar gyflog amrywiol. Roedd hwn yn ddefnydd uwch o gyflog amrywiol nag y gallai BIPBA ei fforddio, gyda defnydd diweddar o 130 Cyfwerth ag Amser Llawn mewn un wythnos ar draws y Grŵp Gwasanaeth; roedd hyn â goblygiadau diogelwch ac ansawdd yn ogystal â chostau. Byddai gwaith yn parhau ar gyflymder i fynd i'r afael â cheisiadau brys sy'n seiliedig ar aciwtedd y tu allan i'r ardal.
- (iii) O ran gweithio mewn partneriaeth, cydnabu AH yr angen i gydweithio i adfer lleoliadau presennol y tu



allan i'r ardal yn ogystal â chymryd camau i osgoi unrhyw leoliadau pellach o'r fath oni bai ei bod yn gwbl anochel. Gofynnodd JW am y lefel o hyder sy'n gysylltiedig â'r lefel hon o adfer. Wrth ymateb, cadarnhaodd DL y byddai diogelwch cleifion yn hollbwysig a bod lle i ddefnyddio gwasanaethau lleol yn fwy effeithiol.

Gan droi at **Ofal Brys ac Argyfwng**, cyfeiriodd PP at yr arbedion arfaethedig o £1.6m drwy weithredu model gwasanaeth penodol ar gyfer cleifion sydd wedi'u hoptimeiddio'n glinigol; gofynnodd am lefel yr hyder yng nghyflawniad y cynllun i leihau nifer y cleifion sydd wedi'u hoptimeiddio'n glinigol o leiaf 100 erbyn diwedd mis Mawrth. Roedd hon yn broblem ledled Cymru a cheisiodd PP wybodaeth am gost y categori hwn o glaf i BIPBA.

Wrth ymateb, myfyriodd DL ar y ffaith bod darparu gofal i'r garfan hon o gleifion mewn lleoliad aciwt yn amhriodol ac o bosibl yn niweidiol, gan arwain at ddadgyflyru a lleihau'r posibilrwydd o ddychwelyd i fyw'n annibynnol. Roedd cleifion a oedd wedi'u hoptimeiddio'n glinigol wedi'u gwasgaru ar draws safleoedd ysbytai, ar wardiau gyda chleifion ag anghenion aciwtedd uchel ac a oedd yn sâl iawn. Roedd rhoi cleifion oedd wedi'u hoptimeiddio'n glinigol gyda'i gilydd yn haws addasu modelau staffio a gwasanaeth i ddiwallu eu hanghenion yn well. Roedd BIPBA yn ariannu swydd gweithiwr cymdeithasol pwrpasol i gynnal cynllunio gweithredol ar gyfer rhyddhau a thrwybwn. Byddai'r 30 claf cychwynnol yn trosglwyddo yn ystod wythnos 5 Ionawr 2026, gyda chohortau pellach yn ymuno â nhw, unwaith y byddai'r model gofal wedi'i wreiddio.

O ran y costau amcangyfrifedig, cynghorodd DG fod 100 o gleifion sydd wedi'u hoptimeiddio'n glinigol yn cyfateb i bedair ward aciwt, gyda'r staffio a'r ddarpariaeth gwasanaeth yn unig yn debygol o gyfateb i £6 miliwn y flwyddyn.

O ran y sefyllfa ehangach o ran gofal brys ac heb ei drefnu, myfyriodd AH ar yr angen i atal derbyniadau oherwydd y firws anadlol yn y gaeaf lle bo modd, gan wneud y defnydd gorau o wardiau rhithwir ar draws pob clwstwr gofal sylfaenol. Gofynnodd JW am adroddiad i'r Bwrdd ym mis Ionawr 2026, ar y model ward rithwir, i gynnwys nifer y gwelyau sydd ar gael a'r defnydd fesul clwstwr. **Cam Gweithredu: DL**

Cydnabu JW y pwynt a wnaeth PP am ddyraniad LIC i awdurdodau lleol i gefnogi'r agenda cynllunio ar gyfer y gaeaf; byddai gweithio



mewn partneriaeth ar draws yr agenda llwybrau gofal oedi yn rhan o'r cyfarfod ar 18 Rhagfyr.

Cydnabu MD fod hyn yn broblem ledled Cymru, gyda'r sefyllfa'n dirywio ar draws byrddau iechyd; amlinellodd rôl y Byrddau Partneriaeth Rhanbarthol wrth oruchwylio'r ddarpariaeth yn erbyn cynlluniau gaeaf ar draws y system.

O ran **costau nad ydynt yn gysylltiedig â chyflogau**, ceisiodd NM sicrwydd bod y rheolaethau tynnach ar gaffael ac archebu eitemau nad ydynt yn gysylltiedig â chyflogau wedi treiddio i lawr drwy'r sefydliad, gyda chanlyniadau clir i Grwpiau Gwasanaeth ac Adrannau na wnaethant gyflawni eu cyfraniad at y sefyllfa ddiffyg.

Pwysleisiodd AH yr angen i'r sefydliad cyfan ddeall y camau gweithredu eithriadol sydd eu hangen yn ystod Chwarter 4 i gyflawni'r sefyllfa ariannol; byddai ffocws cryf ar ddiogelwch, gyda phob penderfyniad yn cael ei ategu gan asesiadau risg cadarn. Roedd yn rhaid i arweinwyr gymryd perchnogaeth a chyfrifoldeb, a byddai fframwaith perfformiad ac atebolrwydd wedi'i fewnosod yn nodi canlyniadau clir methu â chyflawni. Roedd Fforwm yr Arweinwyr Uchaf wedi cyfarfod, a nodwyd gofynion yr holl ddeiliaid cyllideb gyda'i gilydd. Ceisiodd AH gyfranogiad yr holl staff wrth gynhyrchu syniadau ar gyfer arbedion.

O ran **cyfathrebu ac ymgysylltu â staff**, ceisiodd ALF sicrwydd bod staff yn ymwybodol o'r sefyllfa ariannol dyngedfennol ond hefyd na ddylent beryglu diogelwch ac ansawdd. Gofynnodd am y negeseuon i staff ar y pwynt hwn.

Gwahoddodd AH RT i roi'r wybodaeth ddiweddaraf am gyfathrebu ac ymgysylltu; pwysleisiodd bwysigrwydd bod yr holl staff yn chwarae eu rhan. Cadarnhaodd LR ei bod hi'n cyfarfod yn rheolaidd â staff drwy fforymau proffesiynol ac wedi gofyn i gydweithwyr ledaenu'r negeseuon allweddol. Roedd ymgysylltiad cyson yn hanfodol. Roedd addasu archwaeth risg y Bwrdd yn ôl yr angen a chynnal asesiadau risg rheolaidd i gefnogi gwneud penderfyniadau hefyd yn hanfodol. Gofynnodd JW i RE ddisgrifio'r trefniadau sydd ar waith i gyfathrebu â staff meddygol ac ymgysylltu â nhw; crynhodd y prif weithwyr proffesiynol ar gyfer a'i gyfarfodydd rheolaidd ag arweinwyr clinigol a chyfarwyddwyr clinigol.

Cyfeiriodd DG at anghysondebau mewn gwariant ar draws rhai meysydd a'r cyfleoedd i wella effeithlonrwydd. Defnyddiodd yr enghreifftiau o atebion digidol i leihau costau argraffu, rheoli salwch ac absenoldeb yn fwy cyson, lleihau hyd gwahanol arosiadau, a gwella cynhyrchiant theatrau.



Cafodd ALF ei sicrhau gan yr ymatebion; awgrymodd y byddai staff eisiau gweld sut y gallai lleihau cyflog amrywiol gynorthwyo i gynnal ansawdd a diogelwch, gan fod yn rhaid i reolaethau wneud gwahaniaeth.

Gan ddychwelyd at y pwynt hwnnw, cytunodd RT, ar ddiwedd y flwyddyn, y byddai'n bwysig dogfennu effaith yr holl gamau a gymerwyd.

Roedd RO yn pryderu bod **yr amserlenni'n** dynn; gofynnodd a oedd Deloitte wedi mynegi barn ar gyraeddadwyedd. Sicrhaodd DG y Bwrdd fod tîm Deloitte wedi gweithio ochr yn ochr ag ef a chydweithwyr BIPBA drwyddo draw. Roedd yr opsiynau wedi'u llunio'n dda; roedd yr amserlenni'n adlewyrchu brys y gofynion arbed; dylai'r rheolaethau sydd ar waith nawr, ac fel y'u cynigiwyd, alluogi cyflawniad.

Ar ran NZ, ceisiodd JW sicrwydd bod cyfleoedd anghylchol yn ymarferol yn yr amser oedd ar gael a bod y gwaith sylfaen yn ei le i gefnogi'r ddarpariaeth. Roedd NZ eisiau atgoffa'r Bwrdd o'r pwysigrwydd y byddai Archwilio Cymru yn ei roi ar hyn wrth roi ei farn allanol ar ddiwedd y flwyddyn. Wrth ymateb, cadarnhaodd DG y gallai roi sicrwydd y byddai'r cyfleoedd yn cael eu cyflawni ac nad oedd ganddo unrhyw bryderon proffesiynol ynghylch y camau gweithredu i'w hadolygu; cyfeiriodd at Dudalen 14 o'r papur, a oedd yn nodi'r cyfleoedd yn fanwl. Cytunodd DG i drafod y mater gyda NZ y tu allan i'r cyfarfod. **Cam Gweithredu: DG/NZ**

Cyfeiriodd SS at y llwybr i gyrraedd y £58.7m drwy'r arbedion a nodwyd yn yr adroddiad: nid oedd llawer o hyblygrwydd. Cododd y posibilrwydd y byddai problemau annisgwyl yn dod i'r amlwg yn ystod y gaeaf a gofynnodd i gydweithwyr yn y Weithrediaeth am lefel yr hyblygrwydd yn y system i ymateb, o ystyried mai dim ond tri mis oedd ar ôl o'r flwyddyn ariannol.

Cadarnhaodd AH fod cyfarfod wythnosol y Weithrediaeth wedi neilltuo cryn dipyn o amser i yrru cyflawniad y cynllun ariannol yn ei flaen, gyda thracio ar waith i fonitro cynnydd a sicrwydd. Cydnabu'r angen i ddarparu llif data amserol, yn enwedig o ran cynllunio penwythnosau a'r angen i olrhain camau gweithredu drwy Grwpiau Gwasanaeth ac i lawr i lefel adrannol, er mwyn asesu cynnydd. Cadarnhaodd SS fod hyn yn rhoi rhywfaint o sicrwydd iddo.

Gwahoddodd JW y bwrdd i godi unrhyw feysydd eraill o gwestiynu. Nid oedd unrhyw ddatganiadau eraill. Yna symudodd ymlaen at yr argymhellion, gan geisio cymeradwyaeth y Bwrdd ar gyfer pob argymhelliad yn ei dro.



Mynegodd JW ei diolch i DG a'i chydweithwyr am yr adroddiad ac am fynd â'r aelodau Bwrdd drwy'r cynigion yn fanwl.

Gwnaeth y Bwrdd y canlynol:

- **YSTYRIED** yr opsiynau a gyflwynwyd i fynd i'r afael â Chynllun Ariannol 2025/26 a'r targed arbedion o £55.4m.
- **YSTYRIED** yr holl risgiau sy'n gysylltiedig â'r opsiynau a gyflwynwyd.
- **CYTUNO ar** yr argymhellion a nodir yn Adran 4 yr adroddiad.
- **YSTYRIED** cyfleoedd pellach ochr yn ochr â'r risgiau yr oedd angen eu lliniaru o hyd.
- **CYTUNO ar** y camau gweithredu i gyflawni arbedion o £11.7m yn unol â'r cynllun presennol.
- **CYTUNO ar** y gwaith pellach a nodir yn adran 4 i gau'r bwlch o £13.1m.
- **CYDNABOD** yr amddiffyniad yn y cynllun gofal wedi'i gynllunio ar gyfer cyflawniad yn erbyn y targed 104 wythnos a CHYTUNODD i gynnal hyn.
- **CYTUNO** i ystyried lliniaru a chynlluniau wrth gefn pellach (pe bai risgiau ychwanegol yn codi trwy fonitro'r sefyllfa ariannol yn rheolaidd) trwy'r Bwrdd Adferiad a Chynaliadwyedd, gyda goruchwyliaeth gan y Pwyllgor Perfformiad a Chyllid.

Cyfarfod nesaf Bwrdd BIPBA: Dydd Iau 29 Ionawr 2026

Daeth y cyfarfod i ben am 15:05.

SBUHB Board Log 2025-26

Meeting Date	Type of Meeting	Minute Ref	Agenda Item (Number & Title)	Narrative	Assigned to (Individual)	Supporting (additional staff members)	Update	Status
27/11/2025	Public Board	204/25	4.8 CAPITAL AND ESTATES UPDATE	JC reflected on WG commendation of the Strategy; Board discussions and reports in 2025/26 had included reference to significant estate-related concerns and potential catastrophic infrastructure failings. This was a significant point and JW asked DG to produce a briefing on estates-related business continuity planning Action: DG	Executive Director of Finance and Performance (DG)			Open
16/12/2025	Special Public Board	223/25	2.1 THE 2025/26 PLAN AND UPDATED FINANCIAL ASSESSMENT	On behalf of NZ, JW sought assurance that non recurrent opportunities were feasible in the time available and that the groundwork in place to support delivery. NZ wanted to remind the Board of the importance that Audit Wales would place on this when giving its external opinion at the year-end. Responding, DG confirmed that he could give assurance for the delivery of the opportunities and that he had no professional concerns around the actions to be reviewed; he referred to Page 14 of the paper, that set out the opportunities in detail. DG agreed to discuss the matter with NZ outside of the meeting. Action: DG/NZ	Executive Director of Finance and Performance (DG)	Nuria Zolle		Open
27/11/2025	Public Board	206/25	5.2 ORGANISED FOR SUCCESS PROGRAMME UPDATE	On the risk of distraction from delivery of the urgent operational agenda, both TR and DL recognised this as an inevitable risk that required firm management oversight and action. NZ sought the inclusion of this risk on the relevant risk register. Board colleagues supported this. Action: HL	Director of Corporate Governance (HL)		Action is underway and will be reported in the next risk report to Board in March 2026.	Underway (with update)
31/07/2025	Public Board		4.6 GENERAL MEDICAL SERVICES	JW suggested that CW and SM return to a future meeting, with a specific 'ask' that the Board would frame, through the Population Health Committee, on the role of primary care in delivering the population health agenda.	Executive Director of Public Health (Interim GR)	Vice Chair (Steve Spill)	19/01 Action shared with SM & CW to work with Penny Cresswell-Jones as the Public Health Consultant link. 19/11 GR an update will come to March Population Health Committee. 18/08 SS advised that the overarching "what does PC do in the PH arena needs more time and thought. I would suggest a target date either of December or the next one. Gill to advise.	Underway (with update)
29/05/2025	Public Board	78/25	Audit Committee Key Issues Report	In addition, NZ drew attention to the need to agree a debt write off of £2500, in accordance with regulations. DG confirmed the need for a write off, as pursuit of the matter had not proved successful. Responding to the request for a zero-tolerance approach to audit findings that impacted on patient safety and quality, AH agreed to explore this further and to report back to the Board.	Chief Executive Officer (AH)	HL / LC	15/10 HL has requested LC to run a report focussing on any overdue, open actions, specifically those noted. Going forward any new actions from new audits will report into Weekly Execs as part of the monthly Exec report on open IA/AW actions for regular discussion and taking forward. By January we aim to be moving to AMaT.	Underway (with update)
11/09/2025	Public Board	148/25	2.1 ANNUAL PLAN - FINANCE UPDATE	DG to provide a separate briefing on the Financial position to the Stakeholder Reference Group; PD welcomed this.	Executive Director of Finance and Performance (DG)		Arrangements made for the Deputy Director of Finance to attend the next Stakeholder Reference Group.	Underway (with update)

SBUHB Board Log 2025-26

Meeting Date	Type of Meeting	Minute Ref	Agenda Item (Number & Title)	Narrative	Assigned to (Individual)	Supporting (additional staff members)	Update	Status
11/09/2025	Public Board	148/25	2.1 ANNUAL PLAN - FINANCE UPDATE	SS referred to the £9m 'gap' and sought further detail and assurance on this component. Responding, DG advised that actions to deliver this included a reduction of £6.25m in variable pay spend, £750k gain through theatre efficiency, with the remainder identified from procurement controls. DG agreed to provide a detailed briefing on these actions.	Executive Director of Finance and Performance (DG)		Currently being drafted. Will provide a verbal update at the Board and circulate a separate note.	Underway (with update)
25/09/2025	Public Board	155/25	1.5 CHIEF EXECUTIVE'S REPORT	On the new road access to Morriston Hospital, DG confirmed that the City and County of Swansea had received a full planning application; the Planning Committee would consider it in October/November and DG agreed to provide an update to the Board following this. KL welcomed the progress, reminding the Board that the work on the Swansea city Deal first identified the need for a new road.	Executive Director of Finance and Performance (DG)		Awaiting November planning meeting of the City and County of Swansea Local Authority which is the date we believe the application will be considered. Update available after that. Timescales not in control of HB.	Underway (with update)
25/09/2025	Public Board	158/25	3.2 PLANNING AND PARTNERSHIPS REPORT	JW invited DG to comment on the resource allocation process, and he outlined the specialty costing approach. SBUHB provided £140m to assist JCC services and there was then a need to ensure that SBUHB received the right funding level for its services. This was explored in detail as part of the full pathway approach to budgeting, providing a different perspective on the distribution of resources. There could be an 'information lag' in respect of service provision; 2024/25 data would be available in October, following completion of the accounting process. JW asked DG to supply a detailed briefing outside the meeting.	Executive Director of Finance and Performance (DG)		Discussions still ongoing at an All Wales level through the costing group - likely update available in Q1 2026/27 as work will be done in Q4 2025/26	Underway (with update)
25/09/2025	Public Board	165/25	4.7 COMMUNITY PHARMACY	SBUHB did not hold information on the translation facilities at individual community pharmacy level, but all pharmacies could access language line translation services JW asked SM to review the ways in which SBUHB could improve its records on language options available in community pharmacy settings.	Chief Operating Officer (DL)	Sharon Miller, Associate Service Group Director	19/11 SM In discussion with community pharmacy Wales (CPW) we are planning to undertake a baseline assessment of community pharmacies against the recently issued all Wales communication standards. This is expected to take place, following discussion in the new year.	Underway (with update)
29/05/2025	Public Board	79/25	Mental Health Legislation Committee Key Issues Report	DL drew attention to the increase in BI assessment linked to the ageing population; this was the case in both mental health and general hospital settings. She agreed to investigate further and explore options to improve the efficiency and timeliness of the process.	Chief Operating Officer (DL)	Director of Population Health	21/11 Sarah Morse confirmed to COO's office that she is working with the Programme Manager on a 9–12-month plan outlining all wards across the Health Board, including dates for workshops and the implementation schedule, which will be shared once the completed plan is finalised. Additionally, she noted that the BI tool, along with a SOP that was approved by Board earlier this year, was designed to support professionals in making BI discharge decisions where there is no conflict. In practice, it has been shown to work effectively and helps reduce length of stay, with wider engagement now needed to support consistent use of the tool and the Board Round implementation work to be used to promote and embed it.	Underway (with update)

SBUHB Board Log 2025-26

Meeting Date	Type of Meeting	Minute Ref	Agenda Item (Number & Title)	Narrative	Assigned to (Individual)	Supporting (additional staff members)	Update	Status
29/05/2025	Public Board		Integrated Performance Report	NM asked about the 265 patients whose waiting time had exceeded 63 days, seeking more detail on how long the waits actually were and the communication with patients during that time. DL assured the Board that there were communication arrangements in place and agreed to supply further detail on actual waiting times, including the longest time.	Chief Operating Officer (DL)	Director of Population Health	20/11 Information supplied by Hannah Parsons: There are 324 patients currently beyond the 63-day target. 80% have had recent contact (within the last two weeks), have an upcoming appointment, or have recently agreed a date, providing assurance that communication is being maintained across the cohort. Around 30% of patients have recorded periods of unavailability (2–70 days), which has contributed to extended waits. Patients with longer gaps in contact are primarily those awaiting histology, BSW patients where contact data is held externally, and those awaiting robotic surgery but who have been informed of expected delays in clinic. Of the 10 “not yet seen” patients, the majority are BSW referrals; all have either been recently contacted, rebooked, risk assessed, or have appointments arranged. Longest waits (up to 279 days) are linked to diagnostic complexity, multiple MDT reviews, patient unavailability or consent issues, tertiary referrals, non-USC imaging delays, and national PET tracer supply problems earlier this year. All longest-wait patients now have treatment planned or imminent, with learning identified where pathways could have been shorter. Overall, robust communication processes are in place, and pathway issues are being addressed on a patient-level basis.	Underway (with update)
		73/25						
31/07/2025	Public Board		3.1 POPULATION HEALTH COMMITTEE KEY ISSUES REPORT	DG commented on the significance of this work to the future financial sustainability of SBUHB services. He advised of discussions with Hywel Dda University Health Board (H DUHB) colleagues on the allocation of resources to support the population health and prevention agenda. The Board would receive updates on the work in the coming months.	Executive Director of Finance and Performance (DG)		Work is progressing well. Discussion with both Health Economic Unit and Swansea University/Welsh Government have commenced. Work is targeting the January Regional Joint Committee meeting.	Underway (with update)
		121/25						
25/09/2025	Public Board		3.1 POPULATION HEALTH COMMITTEE KEY ISSUES REPORT	The second alert referred to the all-Wales Diabetes Prevention Programme in place across all eight clusters in SBUHB. Public Health Wales had reviewed the effectiveness of the programme, with its report anticipated in the near future. Funding arrangements differed across the clusters, with five clusters funded through external resources, expected to end in March 2026. Collectively this would result in a loss of £430k, and maintaining the programme would require SBUHB to provide this additional resource. DG acknowledged the challenge in identifying resources but recognised the value of the programme. He would make enquiries about the funding position for 2026/27 and possible options.	Executive Director of Finance and Performance (DG)		DG has followed up - no confirmation yet. National meeting regarding the Public Health Wales element to be held in week commencing 24 November 2025.	Underway (with update)
		157/25						
27/11/2025	Public Board		1.5 RISK REPORT	TR confirmed the intention to reset, to include a review of the scoring methodology. WODC would oversee the training programme around consistency of scoring and report back to the Board. Action: RO/TR	Executive Director of Workforce and OD (TR)	Reena Owen	A review of the workforce operational, corporate and strategic risks will be undertaken with a report to WOD Committee in February 2026	Underway (with update)
		193/25						
27/11/2025	Public Board		4.2 INTEGRATED PERFORMANCE REPORT - ANNUAL PLAN PROGRESS (QTR 2)	On stroke services, DL advised that a National Stroke Standards benchmarking exercise was underway; she would share the outcome from that with the Board. Action: DL	Chief Operating Officer (DL)		Standards are yet to be published and unlikely to be available before the end of March 2026.	Underway (with update)
		198/25						



Meeting Date	29 January 2026	Agenda Item	7.1	
Name of Meeting	SBUHB Board			
Report Title	Board Advisory Group Report			
Report Author	Claire Mulcahy, Corporate Governance Manager			
Report Sponsor	Hazel Lloyd, Director of Corporate Governance			
Presented by	Hazel Lloyd, Director of Corporate Governance			
Freedom of Information	Open			
Purpose of the Report	The purpose of the report is to provide the Board with an update from its Advisory Groups.			
Key Issues	The Board has three Advisory Groups: - Health Board Partnership Forum; - Health Professionals' Forum; and - Stakeholder Reference Group In-line with Standing Orders, each Group submits a report to the Board, summarising the discussions at each meeting. This report covers: - Health Board Partnership Forum held on 20 November 2025, 29 December 2025 and 5 January 2026. - Stakeholder Reference Group held on the 15 January 2026			
Specific Action Required <i>(Please choose one only)</i>	Information	Discussion	Assurance	Approval
	☒	☐	☒	☐
Recommendations	Members are asked to: RECEIVE the discussions of the: - Health Board Partnership Forum held on 20 November 2025, 29 December and 5 January 2026. - Stakeholder Reference Group held on the 15 January 2026.			

BOARD ADVISORY GROUP REPORTS

1. Introduction

The purpose of the report is to provide the Board with an update from its Advisory Groups.

2. Background

The Board has three Advisory Groups – Stakeholder Reference Group, Health Board Partnership Forum and Health Professionals’ Forum. In-line with Standing Orders, each one submits a report to the Board following each meeting; this report covers the main issues from:

- Health Board Partnership Forum held on 20 November 2025, 29 December and 5 January 2026.
- Stakeholder Reference Group on 15 January 2026.

3. Governance And Risk Issues

(i) Health Board Partnership Forum

The group received the following;

- An update from the Chief Executive on Health Board Priorities;
- The Band 2/3 Matter;
- An update on HR Policy;
- An update on the Organised for Success Programme;
- An update on the work of the Best Practice Review Group in relation to Workforce Processes;
- An update on the Health Board’s nominations at the NHS Wales Awards;
- An update on the work being undertaken in relation to Exit Interviews;
- The Workforce Metrics Report;
- An update on Finance.

The full report is set out in **Appendix 1**.

(ii) Stakeholder Reference Group

The group received the following;

- The Financial challenges and Budget Overview
- The Patient Portal Rollout and Digital Access
- An update on the Mental Health Services Review

- An update on the recent challenges Urgent and Emergency Care Flow and Discharges
- An update on the membership recruitment for key representative roles.

The full report is set out in **Appendix 2.**

(iii) Health Professionals' Forum

The last Health Professionals' Forum took place on 9 June 2025 and is due to reconvene on the 15 February 2026. This reflects the change in Chair, and the appointment made by Welsh Government of Helen Annandale, Clinical Director Allied Health Professions & Audiology as the new Chair.

4. Financial Implications

There are no financial implications, as these are not decision-making groups/fora.

5. Recommendation

Members are asked to:

RECEIVE the discussions of the:

- Health Board Partnership Forum held on 20 November 2025, 29 December 2025 and 5 January 2026.
- Stakeholder Reference Group on 15 January 2026.



Governance and Assurance		
Link to Enabling Objectives (Please choose)	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High-Quality Care	☐
	Partnerships for Care	☒
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education & Learning	☐
Health and Care Standards		
(Please choose)	Staying Healthy	☐
	Safe Care	☐
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☒
Quality, Safety and Patient Experience		
The Advisory Groups, amongst other areas, consider the quality and safety of services from patient and staff perspectives. They also consider the experience of patients and staff. These reports provide assurance to the board that effective scrutiny is taking place to ensure quality, safety, patient and staff experience are of the right level.		
Financial Implications		
There are no financial implications.		
Legal Implications (including equality and diversity assessment)		
There are no legal implications but the Health Board has a statutory duty to have these advisory groups within its governance structure.		
Staffing Implications		
While there are no staffing implications to the report, there may be staffing issues included in the highlight report from the Health Board Partnership Forum.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The Groups have a strategic focus to their agendas and provide a view on the future plans which will support delivery of the Health Board's short, medium & long-term plans.		
Report History	Standing Board item.	
Appendices	Appendix 1; Health Board Partnership Forum Appendix 2; Stakeholder Reference Group	



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board



		Agenda Item	7.1i
SBUHB Board, 29 January 2026			
Freedom of Information Status		Open	
Reporting Committee	Health Board Partnership Forum		
Author	Kim Clee -Workforce Manager		
Lead Executive Director (s)	Tina Ricketts - Executive Director of Workforce and OD		
Date of meetings	20 Nov 2025, 29 Dec 2025 and 5 Jan 2026		
Summary of matters considered by the Health Board Partnership Forum			
1. Items for Negotiation			
1.1 Band 2/3 Matter			
It was confirmed that the Health Board had now made a commitment to making the associated payments to staff in December’s pay.			
1.2 HR Policy Update			
An update was received on consultation papers submitted to Policy Subgroup.			
2. Items for Consultation			
2.1 Health Board Priorities			
The Chief Executive Officer attended the Partnership forum on 20 th November 2025 to provide a detailed update on the priorities of the Health Board including the challenging financial position. Two extraordinary Social Partnership Forum meetings were held in December and January to address the concerns raised by staffside about the enhanced controls the Health Board are putting in place to respond to the financial challenge. There was good attendance from the executive team at both meetings and this was welcomed by staffside. A set of frequently asked questions were developed as an output from these meetings and these have been published on the intranet. The Chair of Staffside (or nominated deputy) has been invited to attend the Recovery & Sustainability Programme Board as a regular attendee. Staffside have also been invited to observe the weekly vacancy control panel.			
Staffside colleagues were informed that the Maternity Services Learning event had been very successful with around 250 attendees from across Wales. Some of the parents affected by the issues shared their stories and the Health Board has committed to learn lessons from their experiences.			

The efforts of staff to ensure flu vaccination uptake was commended but staff still need to be encouraged to come forward for vaccination.

2.2 Organised for Success

Staffside were updated on the progress of the Organised for Success Programme which commenced in October 2025. It was agreed that this would be a standing agenda item at the meeting.

It was explained that the second phase of the programme is to engage and consult on how our clinical services are structured with the suggestion that the four geographically based service groups will move to six thematic based care groups. Phase three of the process is looking at the wrap around services including corporate services , to ensure the care groups have adequate and appropriate support.

Within the scope of this restructuring will be those individuals in management roles, from band 7 and above, although it will not include clinical ward managers. It was stated that there will be no planned compulsory redundancies as part of this programme. The purpose of the programme is to de-layer the management to bring the Board and Ward closer together, which is an important measure in terms of our ability to be flexible and agile, to provide the best service to patients and to support staff.

2.3 Best Practice Review

An update was received on the work of the joint Best Practice review group, which was established in 2023 to look at a range of issues in relation to workforce processes to ensure they were undertaken in a timely manner and with the employee being at the centre of the process.

In terms of respect and resolution cases, clarification of responsibilities in relation to communicating with the staff involved is crucial and this is being looked at as an area for improvement

Improvements resulting from the Best Practice review includes:

- Suspension guidance for employees and managers on what to expect.
- Introduction of a management review to ensure the right process is being used.
- Stand-alone training module for sickness absence and development of "how to" guides.
- Disciplinary officer training.
- Respect and resolution formal guidance for leaders.

3. Items for Information

3.1 NHS Wales Awards

The Health Board had a number of nominations for the NHS Wales awards and won in two categories: The Whole Health Care system award relating to Falls Response and the NHS Wales Team Culture Award relating to Perinatal Excellence. This is a national project led by Swansea Bay which also won the overall Outstanding Contribution award.

3.2 Exit Interviews

An update was received on the work being undertaken in relation to Exit interviews. The purpose of the project is to complement the exit interview process that already exists within the service groups in an innovative way, making best use of digital solutions. A quantitative Microsoft Form will be made available to staff on the intranet, and the data will be fed into the Business Information System creating a digital dashboard which will highlight themes but will not identify individuals. The quantitative detail on the form is aligned with our People Strategy e.g. values, being a high-quality organisation, flexible working and speaking up safely. Staff can still have a one-to-one conversation with their manager if they wish or raise any concerns with Trade unions or HR Business Partners if necessary.

3.3 Workforce Metrics

A paper was received on the workforce metrics which are now being reported in a format that tracks progress against the elements of the People Strategy.

Key risks and issues/matters of concern of which the board needs to be made aware:	
Staffside have requested earlier involvement in the key decisions of the Heath Board in particular those relating to the financial challenges.	
Delegated action by the committee:	
Not applicable	
Reports and presentations were received from:	
Abi Harris – Chief Executive Darren Griffiths- Director of Finance Tina Ricketts – Director of Workforce & OD Sharon Vickery-Assistant Director of Workforce & OD Emma Owen -Head of Workforce Effectiveness and Analytics Natalie Mills-Retention Lead Jessica Rogers- Head of HR Ops and Business Partners	
Highlights from sub-groups reporting into this committee:	
Organisational change updates HR Policy development updates	
Matters referred to other committees	
None identified	
Date of next Social Partnership Forum:	22 January 2026



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board



		Agenda Item	7.1ii
Stakeholder Reference Group			
Freedom of Information Status		Open	
Reporting Committee	SBUHB Board		
Author	Joanne Abbott Davies, Assistant Director of DICE Catrin Evans, Engagement Manager		
Lead Executive Director (s)	Richard Thomas, Director of DICE		
Date of meeting	15 January 2026		
Summary of matters considered by the Stakeholder Reference Group at its meeting on 15 January 2026			
Financial Challenges and Budget Overview A detailed discussion took place regarding the Health Board’s overall expenditure breakdown focusing on the challenging financial position, current deficit, and the need for both immediate and long-term savings.			
Patient Portal Rollout and Digital Access A question was raised regarding the Patient Portal as some members had not heard or used the system. Its benefits, current limitations, accessibility concerns for older and vulnerable populations and strategies for wider promotion and support were discussed. Overall, the concept was welcomed, particularly the potential benefits in terms of enhanced patient experience and efficiencies.			
Mental Health Services Review An update was provided on the review of Mental Health Services, including the likely need to pause further work on the preparation of proposals for interim estate changes at Cefn Coed Hospital following discussions with the Welsh Government and private partners. It was noted that the Health Board would engage widely with input from third sector organisations and service users on any changes to the future service model at the appropriate time.			
Urgent and Emergency Care Flow and Discharge Challenges Members were advised of recent improvements within the Urgent and Emergency Care Flow and the ongoing challenges, which had resulted in the Health Board declaring a Business Continuity Incident recently. The introduction of a discharge ward at Singleton Hospital and the impact of clinically optimised patients on hospital flow were discussed, together with the complex issue of delayed discharges due to poor home conditions and hoarding.			

Membership Update

An update was received on the membership recruitment for key representative roles. The process for nominating a new Vice Chair had been shared and the importance of publicising opportunities to ensure diverse and committed leadership within the SRG was noted.

Key risks and issues/matters of concern of which the board needs to be made aware:

None

Delegated action by the committee:

None

Main sources of information received:

Reports and papers from Health Board.

Highlights from sub-groups reporting into this committee:

N/A

Matters referred to other committees

None

Date of next meeting

19 March 2026



Meeting Date	29 January 2026	Agenda Item	7.2	
Name of Meeting	SBUHB Board			
Report Title	Chair's Report to the Board			
Report Author	Ebony Smith, Executive Support Manager			
Report Sponsor	Jan Williams, Chair			
Presented by	Jan Williams, Chair			
Freedom of Information	Open			
Purpose of the Report	The purpose of the report is to advise the Board of the Chair's key activities, since the last formal Board meeting in November 2025.			
Key Issues	The report provides an update on the following: - Board recruitments - External Relationships - Site visits			
Specific Action Required <i>(please choose one only)</i>	Information	Discussion	Assurance	Approval
	☐	☐	☒	☐
Recommendations	Members are asked to: - TAKE COGNISANCE of the Chair's activities since the last Board meeting in November 2025.			

CHAIR'S REPORT TO THE BOARD

1. INTRODUCTION

The purpose of this report is to advise the Board of the Chair's key activities since the last formal Board meeting in November 2025.

2. BACKGROUND

Each meeting, the Chair briefs the Board on key activities since the last meeting. The Chair also uses the opportunity to provide verbal updates, if appropriate.

3. GOVERNANCE

Areas of focus since November include:

Governance and Accountability meetings

- Chair quarterly review meeting with Welsh Government Cabinet Secretary for Health & Social Care – 1 December
- SBU HB Public Accountability Meeting with Welsh Government Cabinet Secretary for Health & Social Care – 18 December
- Chaired Interview Panel to make recommendation to the Cabinet Secretary on the Board Independent Member (University) position – 8 January

Visits

- Visit to ED, Morriston Hospital, Saturday 6 December
- Chair & CEO visit to Maggie's Centre for Cancer, Singleton, with Dame Laura Lee, CEO – 8 December
- Visit to Garngoch Hospital with Nicola Matthews, IM – 9 December
- Visit to Bae Nadolig winners at Morriston & Singleton – 30 December
- Visit to Caswell Clinic with Elizabeth Rix, Director of Nursing & Patient Experience – 19 January
- Visit to Wards at Singleton Hospital – 20 January

External relationships

MSs / MPs:

- MS/MP Briefing meetings on 19 December 2025 and 16 January 2026



Other External Partners:

- Meeting with Gaynor Richards, Executive Director of Neath Port Talbot Community Voluntary Service – 22 December

Joint working

- Chair & CEO meeting with Joint Commissioning Committee (JCC) re: Caswell Clinic – 8 December
- West Glamorgan Regional Partnership Board – 11 December
- Southwest Wales Corporate Joint Committee – 15 January
- Regional Joint Committee Meeting, SBU HB & Hywel Dda HB – 22 January

Events:

- Judging Bae Nadolig entries (Christmas decoration competition – chance to win funds from Swansea Bay Health Charity to spend on something which improves wellbeing in hospital areas for staff or patients or both)

Other Meetings to note:

- Meeting with Judith Paget, Director General Strategy for Welsh Government, to discuss One Wales Public Services – 3 December
- National Leadership Group Meeting Integrated Community Care System (ICCS) – 10 December
- Chair & Independent Members meeting with SBU Public Health Team – 15 January
- Chair & CEO regular meetings with Good Governance Institute (GGI) – 15 December 2025 and 26 January 2026
- Regular Monitoring Meeting with Guardian Service – 26 January
- Chair Peer Group Meeting – 27 January

4. RECOMMENDATION

Members are asked to:

- **TAKE COGNISANCE OF** the activities of the Chair since the last Board meeting in November 2025.



Governance and Assurance		
Link to Enabling Objectives <i>(please choose)</i>	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	x ☐
	Co-Production and Health Literacy	x ☐
	Digitally Enabled Health and Wellbeing	x ☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	x ☐
	Partnerships for Care	x ☐
	Excellent Staff	x ☐
	Digitally Enabled Care	x ☐
	Outstanding Research, Innovation, Education and Learning	x ☐
Health and Care Standards		
(please choose)	Staying Healthy	x ☐
	Safe Care	x ☐
	Effective Care	x ☐
	Dignified Care	x ☐
	Timely Care	x ☐
	Individual Care	x ☐
	Staff and Resources	x ☐
Quality, Safety and Patient Experience		
Quality, safety and patient experience are one of the board's main priorities. The role of the Chair is to ensure mechanisms are in place to deliver these both internally and through working with partners.		
Financial Implications		
There are no financial implications to consider except as outlined for Chair's action.		
Legal Implications (including equality and diversity assessment)		
There are no legal implications.		
Staffing Implications		
There are no staffing implications.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The Chair has responsibility for ensuring a robust board and governance structure is in place to secure the long-term future of the organisation.		
Report History	Standing agenda item for the board.	
Appendices	N/A	